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NON-INSURED HEALTH BENEFITS  
First Nations and Inuit Health Branch

**DRUG BENEFIT LIST**  
Fall 2017

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](http://www.healthcanada.gc.ca/nihb)

Canada 



**Health Canada  
Non-Insured Health Benefits**

**INTRODUCTION  
Drug Benefit List**

**Effective  
Fall 2017**

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## 1. BACKGROUND ON NON-INSURED HEALTH BENEFITS (NIHB) PROGRAM

The Non-Insured Health Benefits (NIHB) Program of Health Canada provides coverage for approximately 824,033 eligible registered First Nations and recognized Inuit with a limited range of medically necessary health-related goods and services not provided through private or provincial/territorial health insurance plans. These benefits complement provincial and territorial health care programs, such as physician and hospital care, as well as other First Nations and Inuit community-based programs and services. Benefits include drugs, medical transportation, dental care, medical supplies and equipment, crisis intervention counselling and vision care.

The authority for the NIHB Program is based on the 1979 Indian Health Policy which describes the responsibility for the health of First Nations as shared amongst various levels of government, the private sector and First Nations communities. As a result of this shared responsibility, when a benefit is covered under another plan, the federal government requires the coordination of benefits to ensure that the other plan meets its obligations.

## 2. PURPOSE OF THE NIHB DRUG BENEFIT LIST (DBL)

The Drug Benefit List (DBL) is a listing of the drugs provided as benefits by the NIHB Program. The DBL is updated regularly and published regularly. The listed drugs are those primarily used in a home or ambulatory setting. A prescription from a licensed practitioner is required for any listed drug to be processed as a benefit. Practitioners are health professionals authorized to prescribe drugs within the scope of practice in their province or territory. The DBL is a tool for prescribers and pharmacists that encourages the selection of optimal, cost-effective drug therapy.

## 3. DRUG REVIEW PROCESS

The review process for drug products that are considered for inclusion as a benefit under the NIHB Program varies depending on the type of drug submitted.

### 3.1 New Chemical Entities / New Combination Drug Products/ Existing Chemical Entities with New Indication

Submissions for new chemical entities, new combination drug products and existing chemical entities with new indications, must be sent to the Canadian Agency for Drugs and Technologies in Health (CADTH). Clinical and pharmacoeconomic reviews are coordinated by the Common Drug Review (CDR) Directorate, or by the pan-Canadian Oncology Drug Review (pCODR) for cancer therapies, and forwarded to their respective expert committees for recommendations on formulary listing. These recommendations are forwarded to participating drug plans, including the NIHB Program, for consideration. The NIHB Program and other drug plans make listing decisions based on these expert committee recommendations and other specific relevant factors, such as mandate, priorities and resources.

Please refer to CADTH for a list of requirements for manufacturers' submissions and a summary of procedures for the CDR or pCODR process. Inquiries should be directed to:

Canadian Agency for Drugs and Technologies in Health  
865 Carling Avenue, Suite 600  
Ottawa, Ontario K1S 5S8  
Telephone: (613) 226-2553  
Website: [www.cadth.ca](http://www.cadth.ca)

Please ensure a copy of the complete submission is also sent to NIHB either electronically to [NIHB.Drug.Submissions@hc-sc.gc.ca](mailto:NIHB.Drug.Submissions@hc-sc.gc.ca) or on compact CD to the mailing address indicated in section 3.2.2.4. Paper (binder) versions of drug submissions are no longer accepted by the NIHB Program.

### 3.2 Line Extensions, Generics and All Other Submissions

Submissions for line extensions, generics and all other submissions are reviewed internally or by the NIHB Drugs and Therapeutics Advisory Committee (DTAC). Generic drug products are considered for inclusion on the formulary based on provincial interchangeability lists and other relevant factors.

### 3.2.1 Drugs and Therapeutics Advisory Committee (DTAC)

The DTAC provides formulary listing recommendations for drug products to the NIHB Program. The NIHB Program makes listing decisions based on DTAC recommendations and other specific relevant factors, such as mandate, priorities and resources. The DTAC also contributes to the NIHB Drug Use Evaluation (DUE) Program which promotes safe, therapeutically effective and efficient use of drug therapy for First Nations and Inuit.

The DTAC is an advisory body of highly qualified health professionals who bring impartial and practical expert medical and pharmaceutical advice to the NIHB Program to promote improvement in the health outcomes of First Nations and Inuit clients through effective use of pharmaceuticals. The approach is evidence-based and the advice reflects medical and scientific knowledge, current utilization trends, current clinical practice, health care delivery and specific departmental client healthcare needs.

### 3.2.2 Submission Requirements

All submissions for drug products that are line extensions, generics and all other types of submissions must be submitted to the NIHB Program. Only drug products with a Health Canada Notice of Compliance (NOC) will be considered for provision as a benefit.

#### 3.2.2.1 Letter of Authorization

The manufacturer will provide a letter authorizing the NIHB Program to gain access to all information with respect to the product in the possession of Health Canada or of the government of any provinces or territory in Canada, Patented Medicine Prices Review Board (PMPRB) or CADTH.

#### 3.2.2.2 Justification for Consideration of Listing

The manufacturer will provide a statement indicating the rationale and evidence to justify the provision of the new product.

#### 3.2.2.3 General Information

Additional information should include:

- Evidence of approval by Health Canada, such as a Notice of Compliance (NOC) and Drug Identification Number (DIN) and
- Two therapeutic Classifications:
  - *American Hospital Formulary Service (AHFS) Pharmacologic Therapeutic Classification* and;
  - The World Health Organization's *Anatomical Therapeutic Chemical (ATC) Classification*

#### 3.2.2.4 Pricing and Marketing Information

The manufacturer must submit current price information for the drug product.

Manufacturers are required to notify the NIHB Program of any significant change to listed drug products. Significant changes include changes in DIN, product name, manufacturer or distributor, indication, product monograph, packaging, formulation, manufacturing specifications or discontinuation of a product. Notification of changes should be provided electronically to the NIHB Program.

All submissions for drug products, to be reviewed for inclusion on the NIHB DBL, must be sent to the NIHB Program electronically. Please send all drug submissions to the following email address: NIHB.Drug.Submissions@hc-sc.gc.ca. Submissions will also be accepted on compact CD when mailed to the following address:

C/o Manager of Policy Development - Pharmacy  
Non-Insured Health Benefits  
First Nations and Inuit Health Branch, Health Canada  
200 Eglantine Driveway, 9th Floor  
Postal Locator 1909D Tunney's Pasture  
Ottawa, Ontario K1A 0K9

Only ONE copy of the submission is required. Receipt of submission will be acknowledged electronically with a confirmatory email message. Paper (binder) versions of drug submissions are no longer accepted by the NIHB Program.

#### 4. BENEFIT CRITERIA

The following criteria are the framework for the NIHB Program DBL. The criteria provide the basis for decisions about drugs on the formulary relating to:

- A. Drug Benefit Listings
- B. Deletions
- C. Open Benefit
- D. Limited Use
- E. Exceptions
- F. Exclusions

All drugs that are to be either considered for listing or currently listed as Program benefits must, as a minimum:

1. be legally available for sale in Canada with an NOC;
2. be sold in Canada (proof may include a copy of the completed notification form issued under the Food and Drug Regulations or listing on a provincial drug benefit formulary);
3. be administered in a home setting or in other ambulatory care settings;
4. not be provided in a provincially/territorially covered setting (hospital/institution) or provided through provincially/territorial covered programs or clinics according to provincial/territorial legislation; and
5. be in accordance with NIHB Program mandate and policies.

##### A. Drug Benefit Listings

The NIHB Program, with assistance from the CDR, pCODR and the NIHB DTAC, balances a number of factors in making listing decisions about changes to the Drug Benefit List, such as:

- The needs of First Nations and Inuit clients;
- Accumulated scientific and clinical research on currently-listed drugs;
- Cost-benefit analysis;
- Availability of alternatives;
- Current health practices; and
- Policies and listings in provincial drug formularies.

**New formulations and new strengths** of listed products may be added or may replace previously approved products.

**Generic products** are added according to provincial/territorial interchangeability lists and other relevant factors.

**Combination products** are considered for listing if:

1. each component of the combination makes a contribution to the claimed effect;

2. a pharmacological or pharmaceutical rationale exists for the combination;
3. the dosage of each component (amount, frequency, duration) is safe and effective for a significant proportion of the patient population requiring such concurrent therapy as defined in the labeling of the drug; and
4. the cost is reduced, or scientific evidence indicates that the advantages outweigh any additional cost; or
5. an improvement in compliance, resulting in an increase in clinical effectiveness, is demonstrated.

**Long Acting (Sustained-Extended Release) Products** may be listed when:

1. clinical studies have demonstrated the safety and efficacy of the active ingredient when administered in the long acting form; and
2. a therapeutic advantage is demonstrated in the treatment of the disease entity for which the product is indicated (therapeutic advantage is defined as: improved efficacy relative to the conventional dosage with no increase in toxicity; or less toxicity with improved or similar efficacy); or
3. there is demonstrated improvement in compliance resulting in an increase in clinical effectiveness; or
4. there is evidence that the long acting product is at least as cost-effective as the best price alternative in the conventional form that is currently covered; or
5. there is no suitable conventional dosage form(s) of the drug listed that is readily available.

**Injectable Drug Products** will be considered if they are:

1. self-administered in a home or other ambulatory setting;
2. not part of a physician's standard office supply;
3. not provided in a provincially/territorially covered hospital or institution; or
4. not provided through provincially/territorial covered programs or clinics according to provincial/territorial legislation.

**B. Deletion Criteria**

The following deletion criteria guide the removal or delisting of a drug product from the NIHB drug benefit list. Drugs are deleted:

1. when a product is discontinued from the Canadian market;
2. when new products possessing clearly demonstrated therapeutic and safety advantages or improvements have been listed;
3. when new toxicity data shift the risk/benefit ratio to make the continued listing of the product inappropriate;
4. when new information demonstrates that the product does not have the anticipated therapeutic benefit;
5. when the purchase cost is disproportionate to the benefits provided; or

6. when the drug has a high potential for misuse or abuse.

**NOTE:** *Drugs may also be removed at the discretion of the Director General, NIHB Program when there are undesirable financial, supply or administrative implications to the continued listing of a product.*

### **C. Open Benefits**

Open benefits are the drugs listed in the NIHB DBL which do not have established criteria or prior approval requirements.

### **D. Limited Use Benefits**

Limited use drugs are drug products listed on the NIHB DBL that may be inappropriate for general listing, but have value in specific circumstances. These products will have specific criteria for provision as a benefit under the NIHB Program. A product will be designated for limited use when:

1. it has the potential for widespread use outside the indications for which benefit has been demonstrated;
2. it has proven effectiveness, but is associated with predictable severe adverse effects;
3. it is usually a second or third line choice for treatment and is required because of allergies, intolerance, treatment failure or noncompliance with a first line alternative; or
4. it is very costly and a therapeutically effective alternative is available as a benefit.

There are three types of limited use benefits:

1. Limited use benefits which do not require prior approval. These include but are not limited to:
  - Multivitamins (which are benefits for children up to six years of age); and
  - Prenatal and postnatal vitamins (which are benefits for women of childbearing age (12 to 50 years)).
2. Benefits which have a quantity and/or frequency limit. A maximum quantity of drug is allowed within a specified period of time. No prior approval is required for the recipient to obtain the allowable quantity of drug within the specified period. An example of a category of drugs with a quantity and frequency limit is smoking cessation products. Recipients are eligible to receive up to three treatment courses of nicotine replacement therapy (NRT) within a 12-month period with quantity limits, which include two courses of NRT patches and one course of NRT products used PRN (i.e. gums, lozenges, inhalers).
3. Limited use benefits which require prior approval (using the "Limited Use Drugs Request Form"). Limited use benefits and the criteria for their coverage are identified in the Drug Benefit List and also in Appendix A. The criteria are also listed on the forms faxed to prescribers for completion.

### **E. Exceptions**

Exception drugs are drug products which are not listed in the DBL. These drug products may be approved in special circumstances upon receipt of a completed "Exception Drugs Request Form" from the attending licensed practitioner.

- when the prescription is for a recognized clinical indication and dose which is supported by published evidence or authoritative opinion; and
- when there is significant evidence that the requested drug is superior to drugs already listed as program benefits; or
- when a patient has experienced an adverse reaction with a best-price alternative drug, and a

- higher cost alternative is requested by the prescriber; or
- when there is supporting evidence that available alternatives are ineffective, toxic, or contraindicated (personal preference alone does not justify an exception).

#### **F. Exclusions**

Exclusions are items not listed as benefits on the DBL and are not available through the exception or appeal processes. These include certain drug therapies for particular conditions which fall outside of the NIHB mandate and are not provided as benefits under the NIHB Program.

Examples of categories of drugs or drug products\* that are not considered for coverage under the NIHB Program under any circumstances are listed in Appendix E

- Anti-obesity drugs;
- Household products (e.g. regular soaps and shampoos);
- Cosmetics;
- Alternative therapies, including glucosamine and evening primrose oil;
- Megavitamins;
- Drugs with investigational/experimental status;
- Vaccines
- Medications for travel
- Hair growth stimulants;
- Fertility agents and impotence drugs;
- Selected over-the-counter products;
- Opioid containing cough preparations.

\*Note: List of excluded drugs or drug products is not exhaustive and may be modified as necessary

### **5. POLICIES**

#### **A. Best Price Alternative and Interchangeability**

The NIHB Program will reimburse only the best price (lowest cost) alternative product in a group of interchangeable drug products. Pharmacists must follow their provincial/territorial pharmacy legislation/policies to identify interchangeable products and to select the lowest-priced brand. (NIHB may not necessarily reimburse at the cost listed in the provincial drug plan formulary).

#### **B. “No Substitution” Claims**

NIHB will consider reimbursement for a higher-cost interchangeable product when a patient has experienced an adverse reaction with a lower-cost alternative. In such circumstances, the prescriber must provide the NIHB Program with:

1. a completed and signed Canada Vigilance Adverse Reaction Reporting Form: ‘*Report of suspected adverse reactions to health products in Canada*’ and,
2. the prescription with “*No Substitution*” or “*No Sub*” written by hand or typed on the prescription.

Upon receipt, the pharmacist will forward a copy of the prescription to NIHB for review. The prescriber is responsible for sending a copy of the form to the Canada Vigilance Program. Forms can be obtained by calling the Canada Vigilance Program at 1-866-234-2345 or by downloading a copy from Health Canada website at: [http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/ar-ei\\_form-eng.php](http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/ar-ei_form-eng.php)

*NOTE: The Canada Vigilance Adverse Reaction Reporting Form will not need to be resubmitted for renewals or new prescriptions of the same drug for the patient, although “No Sub” will still have to be written or typed on the prescription.*

#### **C. Prescription Quantities**

The normal quantity dispensed shall be the entire quantity of the drug prescribed. A maximum 100-day supply should be considered for those circumstances where the patient has been stabilized on a

medication and the prescriber feels that further adjustment during the prescribed period is unlikely. Prescriptions for opioids and benzodiazepines have a maximum 30-day supply. The physician may continue to prescribe a smaller quantity with repeats at certain intervals when it is in the patient's best interest.

#### D. Short Term Dispensing Policy

It is the Program's expectation that certain medications required for long-term maintenance therapy should be prescribed and dispensed in up to 100 days supplies. For refills for medications requiring short-term dispensing for a shorter time than 28 days due to compliance concerns, the Program will only reimburse a total of one dispensing fee per 28 days up to the regional maximum of the Program. These medications include (but are not limited to) the following:

Antihistamines	Anticoagulants	Immunosuppressants
Antiemetics for cancer chemotherapy (excluding nabilone)		Prokinetic agents
Synthetic antidiuretic hormone	Respiratory smooth muscle relaxants	
Alpha-adrenoreceptor Antagonists	Anti-dementia Drugs	Anti-gout Drugs
Anti-Parkinsonian Drugs	Anti-platelet aggregation Drugs	BPH Drugs
Cardiovascular Drugs	Enzyme Preparations	Drugs for Diabetes
Drugs for Treatment of Bone Diseases	GI Anti-inflammatory Drugs	Thyroid Therapy
Proton Pump Inhibitors	Urinary Anti-Spasmotics	NSAIDs
H <sub>2</sub> -Receptor Antagonists	OTCs (including vitamins)	
Other Drugs for Peptic Ulcer and Gastro-esophageal Reflux Disease (GERD)		

**Note:** This list may be amended as required and changes will be communicated through the quarterly on-line updates to the DBL. Medications on the Short term Dispensing list are identified in the DBL using the symbol <sup>ST</sup> beside the medication strength and dosage form.

The following are exceptions to the STD policy:

- Refills for intermittent treatment of a chronic disorder or refills of a medication which is prescribed to be taken on an "as needed" (PRN) basis. Note: Medications prescribed to be taken on an "as needed" (PRN) basis and dispensed chronically may be subject to audit and recovery.
- Prescriptions for dose changes.
- The following dosage forms: injectable and suppository.
- Refills or new prescriptions when prescribed/dispensed in accordance with a court order.
- Others as identified by the NIHB Program

#### Compensation

The compensation will be the lesser of the usual and customary fee up to the maximum negotiated NIHB regional dispensing fee for each 28 days supplied. NIHB will continue to audit and recover in instances where quantity reduction occurs.

#### Less than 28 Day Supply

For the medications listed below in which short-term dispensing is deemed medically necessary, the Program will compensate up to one full dispensing fee every seven days, up to the regional maximum of the Program. If these medications are dispensed daily, the Program will compensate 1/7th of this fee:

Anticonvulsants	Hormonal Contraceptives
Antidepressants	Needles & Syringes
Antipsychotics	Drug used in nicotine dependence
Benzodiazepines	Antimanic agents
Stimulants	Estrogens
Nicotine Replacement Therapy	Progestins

#### Implementation

When filling a new prescription for a chronic use drug, the Program will pay a full dispensing fee regardless of the days supply. A new prescription may include a dosage change or an intermittent treatment, based on an assessment by a prescriber.

When refilling a prescription for a chronic use drug that is for less than a 28 day supply or when a need for compliance packaging is identified by the prescriber, the Program will pay no more than one full dispensing fee per 28 day period. For the medications listed above the Program will pay no more than full dispensing fee per 7 day period.

A refill is defined as the second and all subsequent fills for a given strength and dosage of a drug.

## **6. FORMULARY FOR CHRONIC RENAL FAILURE PATIENTS**

Clients with chronic renal failure are eligible to receive a list of supplemental benefits that are not included in the NIHB DBL but which are required on a long-term basis. Some supplemental benefits include: darbepoetin alfa products (except in provinces where NIHB clients are eligible to receive darbepoetin alfa through the provincial programs), calcium products, multivitamins formulated for renal patients and select nutritional supplements formulated for renal patients.

New clients requiring drugs on the special formulary will be identified for coverage through the usual prior approval process. Once the client is confirmed as eligible, coverage will automatically be extended to all drugs in the special formulary for as long as needed.

## **7. PALLIATIVE CARE FORMULARY**

Clients diagnosed with a terminal illness and are near the end of life will be eligible to receive a list of supplemental benefits that are not included in the NIHB Drug Benefit List. The Palliative Care Formulary includes medications used to provide comfort to those near the end of life.

Requests for any of the DINs on the Palliative Care Formulary will generate a Palliative Care Application Form, faxed to the prescriber. Once completed and submitted, the recipient will be eligible for all medications on the Palliative Care Formulary for six months if the following criteria are met:

The client:

1. is not receiving care in a provincially covered hospital or provincially covered long-term care facility; and
2. has been diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less

If coverage is required beyond the initial six months, an additional six months will be granted upon receipt of another completed Palliative Care Application Form.

## **8. DRUG UTILIZATION EVALUATION**

A drug utilization evaluation, which is part of the point-of-service or on-line adjudication system, provides an analysis of both previous claims data and current claims data to identify potential drug-related problems. Messages are returned to pharmacists to alert them of the potential problems. These messages are intended to enhance pharmacy practice with additional information. Currently, the system monitors for:

- potential drug/drug interactions
- duplicate drugs
- duplicate therapy

As part of the NIHB Drug Use Evaluation (DUE) Program, DTAC reviews utilization patterns of medications billed to the NIHB program and provides advice to promote effective, efficient and optimal drug therapy to First Nations and Inuit recipients.

**9. GENERAL INFORMATION**

Sources of information about the NIHB Program include:

- The NIHB section of the Health Canada website which provides background information on the Program and a copy of the DBL. This can be found at: [www.healthcanada.gc.ca/nihb](http://www.healthcanada.gc.ca/nihb)
- NIHB DBL Updates are available to pharmacists and to prescribers via the Health Canada website. These updates can be found at: <http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php#drug-med>

Information about the NIHB Program can also be obtained by contacting:

Non-Insured Health Benefits  
First Nations and Inuit Health Branch  
200 Eglantine Driveway, 9th Floor  
Postal Locator 1909D  
Tunney's Pasture  
Ottawa, Ontario K1A 0K9

**10. NIHB PRIVACY CODE**

The NIHB Program of Health Canada is committed to protecting an individual's privacy and safeguarding the personal information in its possession. When a benefit request is received, the NIHB Program collects, uses, discloses and retains an individual's personal information according to the applicable federal privacy legislation. The information collected is limited to only that information required for the NIHB Program to administer and verify benefits.

As a program of the federal government, the NIHB Program must comply with the Privacy Act, the Canadian Charter of Rights and Freedoms, the Access to Information Act, the Treasury Board of Canada Privacy and Data Protection Policies, the Government Security Policy, and Health Canada's Security Policy.

**11. PHARMACOLOGIC-THERAPEUTIC CLASSIFICATION OF DRUGS**

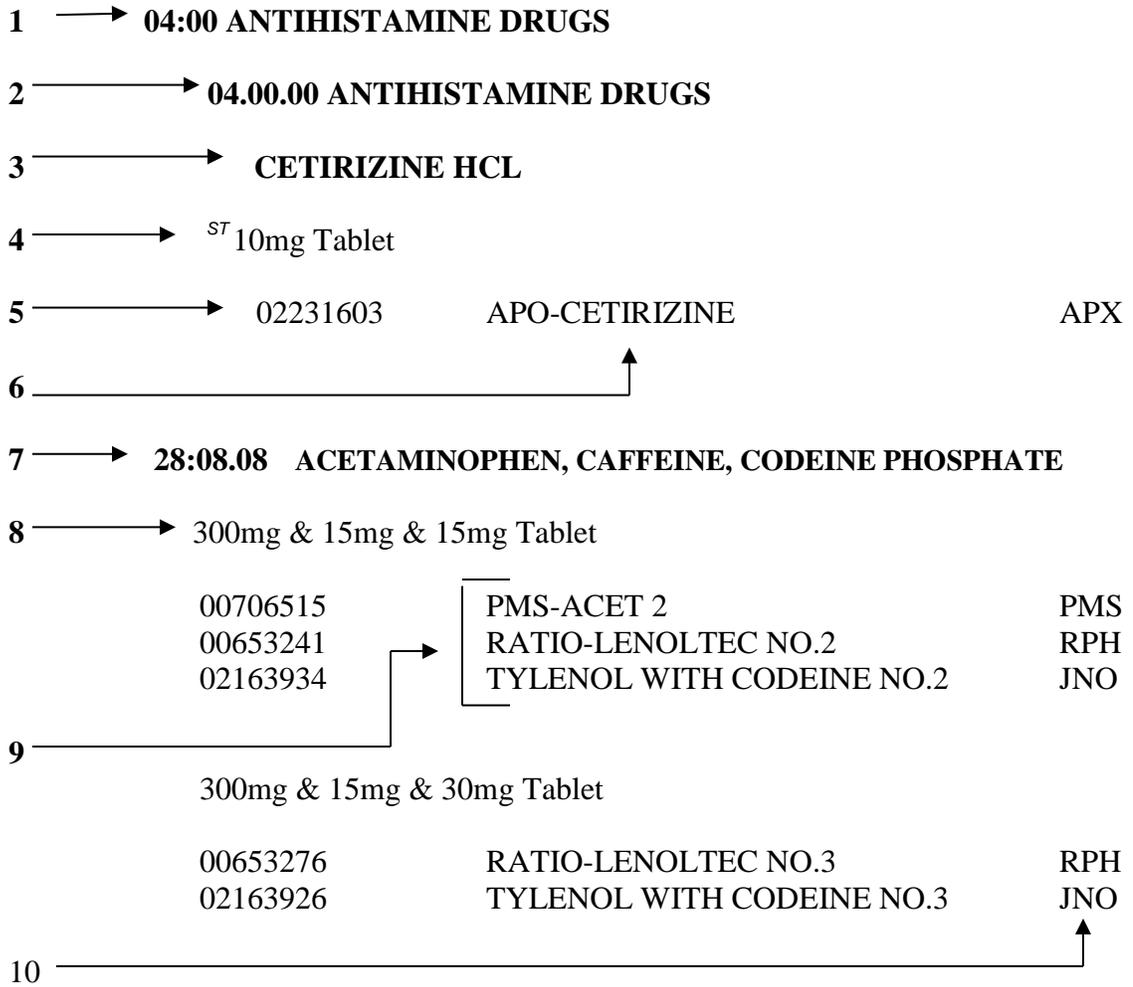
The drugs in the NIHB DBL are classified according to the *AHFS* Pharmacologic-Therapeutic classification developed by the American Society of Health-System Pharmacists for the purposes of the *AHFS Drug Information*.

Permission to use this system has been granted by the American Society of Health-System Pharmacists. The Society is not responsible for the accuracy of transpositions from the original context.

Drugs are listed alphabetically within each therapeutic classification according to their chemical names. Under each drug, acceptable products are listed.

## LEGEND

1. Pharmacologic-Therapeutic classification
2. Pharmacologic-Therapeutic sub-classification
3. Nonproprietary or generic name of the drug
4. Drug strength and dosage form. <sup>ST</sup> indicates the drug is identified as a chronic medication under the Short-Term Dispensing Policy.
5. Drug Identification Number (DIN), assigned by the Therapeutic Products Directorate of Health Canada, to uniquely identify the drug product as to its manufacturer, name and strength of active ingredients, route of administration and pharmaceutical dosage form
6. Brand name of the drug
7. List of all active ingredients in a combination product
8. Strengths of active ingredients in a combination product, listed in the same order as the ingredients
9. List of available brands of drugs. Provincial or territorial drug plan formularies should be consulted to determine interchangeable products and to identify best price (lowest cost) alternatives
10. Three letter identification code assigned to manufacturer



# **DRUG BENEFIT LIST**

**04:00 ANTIHISTAMINE DRUGS****04:04.04 ANTIHISTAMINE DRUGS****DIPHENHYDRAMINE HYDROCHLORIDE**<sup>ST</sup> **25MG CAPSULE**

00757683 PDP-DIPHENHYDRAMINE PMS

<sup>ST</sup> **50MG CAPSULE**

00757691 PDP-DIPHENHYDRAMINE PMS

<sup>ST</sup> **2.5MG/ML ELIXIR**

00833266 ALLERGY ELIXIR TAN

00804193 ALLERNIX ELIXIR TEV

02019736 BENADRYL MCL

00792705 PMS-DIPHENHYDRAMINE PMS

<sup>ST</sup> **12.5MG/5ML ELIXIR**

02298503 DIPHENHYDRAMINE JMP

<sup>ST</sup> **1.25MG/ML LIQUID**

02019698 BENADRYL CHILDRENS MCL

**50MG/ML LIQUID**

00596612 DIPHENHYDRAMINE SDZ

02219336 DIPHENIST OMG

00878200 PMS-DIPHENHYDRAMINE PMS

<sup>ST</sup> **25MG TABLET**

02176483 ALLER-AIDE TEV

01949454 ALLERGY TAN

02229492 ALLERGY FORMULA VTH

02097583 ALLERNIX TEV

02017849 BENADRYL MCL

02257548 DIPHENHYDRAMINE JMP

02239029 NADRYL RIV

<sup>ST</sup> **50MG TABLET**

02230398 ALLERGY EXTRA STRENGTH TAN

02097575 ALLERNIX EXTRA STRENGTH TEV

02257556 DIPHENHYDRAMINE JMP

**04:04.20 ANTIHISTAMINE DRUGS****CHLORPHENIRAMINE MALEATE**<sup>ST</sup> **4MG TABLET**

00738972 CHLOR-TRIPOLON BAY

00021288 NOVO-PHENIRAM TEV

<sup>ST</sup> **12MG TABLET (EXTENDED RELEASE)**

00738964 CHLOR-TRIPOLON BAY

**04:08.00 ANTIHISTAMINE DRUGS****CETIRIZINE HYDROCHLORIDE**<sup>ST</sup> **1MG/ML SYRUP**

02238337 REACTINE MCL

<sup>ST</sup> **10MG TABLET**

02315955 ALLERGY RELIEF PMS

02231603 APO-CETIRIZINE APX

02375095 CETIRIZINE APX

02451778 JAMP-CETIRIZINE JMP

02427133 MAR-CETIRIZINE MAR

02223554 REACTINE MCL

<sup>ST</sup> **20MG TABLET**

02453363 APO-CETIRIZINE APX

02450526 CETIRIZINE PDL

02427141 MAR-CETIRIZINE MAR

**04:08.00 ANTIHISTAMINE DRUGS****CETIRIZINE HYDROCHLORIDE**<sup>ST</sup> **20MG TABLET**

02315963 PMS-CETIRIZINE PMS

02427192 PRIVA-CETIRIZINE PHA

01900978 REACTINE MCL

**DESLOMATADINE**<sup>ST</sup> **0.5MG/ML SYRUP**

02247193 AERIUS KIDS BAY

<sup>ST</sup> **5MG TABLET**

02243919 AERIUS BAY

02369656 ALLERNIX MULTI SYMPTOM TEV

02338424 DESLOMATADINE APX

02298155 DESLOMATADINE ALLERGY CONTROL PMS

**FEXOFENADINE HYDROCHLORIDE**<sup>ST</sup> **60MG TABLET**

02231462 ALLEGRA 12 HOUR SAC

<sup>ST</sup> **120MG TABLET**

02242819 ALLEGRA 24 HOUR SAC

**LORATADINE**<sup>ST</sup> **1MG/ML SYRUP**

02241523 CLARITIN KIDS BAY

<sup>ST</sup> **10MG TABLET**

02280159 24 HOUR ALLERGY REMEDY VTH

02418959 ALLERTIN APX

02243880 APO-LORATADINE APX

00782696 CLARITIN BAY

02366444 LORATADINE APX

**04:92.00 ANTIHISTAMINE DRUGS****KETOTIFEN FUMARATE**<sup>ST</sup> **0.2MG/ML SYRUP**

00600784 ZADITEN TEV

<sup>ST</sup> **1MG TABLET**

00577308 ZADITEN TEV

**08:00 ANTI-INFECTIVE AGENTS****08:08.00 ANTHELMINTICS****MEBENDAZOLE****100MG TABLET**

00556734 VERMOX JSO

**PYRANTEL PAMOATE****50MG/ML SUSPENSION**

01944355 COMBANTRIN MCL

**125MG TABLET**

01944363 COMBANTRIN MCL

**08:12.02 AMINOGLYCOSIDES****AMIKACIN (AMIKACIN SULFATE)**

Limited use benefit (prior approval required).

**250MG LIQUID**

02242971 AMIKACIN SULFATE SDZ

**GENTAMICIN SULFATE****1MG/ML SOLUTION**

02082136 GENTAMICIN IV BAX

**1.4MG/ML SOLUTION**

01913530 GENTAMICIN SULFATE IN SODIUM CHLORIDE HOS

**1.6MG/ML SOLUTION**

02082152 GENTAMICIN IV BAX

**10MG/ML SOLUTION**

02268531 GENTAMICIN SDZ

**40MG/ML SOLUTION**

02225131 CIDOMYCIN UNK

02242652 GENTAMICIN SDZ

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99506004 GENTAMYCIN STERILE INFUSION UNK

**08:12.06 CEPHALOSPORINS****CEFACLOR****250MG CAPSULE**

02230263 APO-CEFACLOR APX

02237729 CEFACLOR IVX

**500MG CAPSULE**

02230264 APO-CEFACLOR APX

02237730 CEFACLOR IVX

**75MG/ML POWDER**

02237502 APO-CEFACLOR APX

**CEFADROXIL****500MG CAPSULE**

02240774 APO-CEFADROXIL APX

02311062 PRO-CEFADROXIL PDL

02235134 TEVA-CEFADROXIL TEV

**CEFAZOLIN SODIUM****500MG POWDER FOR SOLUTION**

02108119 CEFAZOLIN TEV

02237137 CEFAZOLIN FKD

02308932 CEFAZOLIN SDZ

**1G POWDER FOR SOLUTION**

02108127 CEFAZOLIN TEV

02237138 CEFAZOLIN FKD

**08:12.06 CEPHALOSPORINS****CEFAZOLIN SODIUM****1G POWDER FOR SOLUTION**

02297205 CEFAZOLIN HOS

02308959 CEFAZOLIN SDZ

02437112 CEFAZOLIN RAX

**10G POWDER FOR SOLUTION**

02108135 CEFAZOLIN TEV

02237140 CEFAZOLIN FKD

02297213 CEFAZOLIN HOS

02308967 CEFAZOLIN SDZ

02437120 CEFAZOLIN RAX

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99506000 CEFAZOLIN STERILE INFUSION UNK

**CEFIXIME****20MG/ML POWDER FOR SUSPENSION**

00868965 SUPRAX ODN

**400MG TABLET**

02432773 AURO-CEFIXIME AUR

00868981 SUPRAX ODN

**CEFPROZIL****25MG/ML POWDER FOR SUSPENSION**

02293943 APO-CEFPROZIL APX

02163675 CEFZIL BMS

02329204 RAN-CEFPROZIL RBY

02303426 SANDOZ CEFPROZIL SDZ

**50MG/ML POWDER FOR SUSPENSION**

02293951 APO-CEFPROZIL APX

02163683 CEFZIL BMS

02293579 RAN-CEFPROZIL RBY

02303434 SANDOZ CEFPROZIL SDZ

**250MG TABLET**

02292998 APO-CEFPROZIL APX

02347245 AURO-CEFPROZIL AUR

02293528 RAN-CEFPROZIL RBY

02302179 SANDOZ CEFPROZIL SDZ

**500MG TABLET**

02293005 APO-CEFPROZIL APX

02347253 AURO-CEFPROZIL AUR

02293536 RAN-CEFPROZIL RBY

02302187 SANDOZ CEFPROZIL SDZ

**CEFTAZIDIME (CEFTAZIDIME PENTAHYDRATE)**

Limited use benefit (prior approval required).

**1G POWDER FOR SOLUTION**

00886971 CEFTAZIDIME FKD

02437848 CEFTAZIDIME RAX

02212218 FORTAZ 1G GSK

**2G POWDER FOR SOLUTION**

00886955 CEFTAZIDIME FKD

02437856 CEFTAZIDIME RAX

02212226 FORTAZ 2G GSK

**3G POWDER FOR SOLUTION**

02439522 CEFTAZIDIME RAX

**6G POWDER FOR SOLUTION**

00886963 CEFTAZIDIME FKD

**08:12.06 CEPHALOSPORINS****CEFTAZIDIME (CEFTAZIDIME PENTAHYDRATE)**

Limited use benefit (prior approval required).

**6G POWDER FOR SOLUTION**

02437864	CEFTAZIDIME	RAX
02212234	FORTAZ 6G	GSK

**CEFTRIAXONE SODIUM****250MG POWDER FOR SOLUTION**

02250276	CEFTRIAXONE	HOS
02289679	CEFTRIAXONE	FKD
02292262	CEFTRIAXONE	SDZ
02292866	CEFTRIAXONE	HOS
02325594	CEFTRIAXONE	RAX

**1G POWDER FOR SOLUTION**

02250292	CEFTRIAXONE	HOS
02287633	CEFTRIAXONE	TEV
02292270	CEFTRIAXONE	SDZ
02292874	CEFTRIAXONE	HOS
02325616	CEFTRIAXONE	RAX

**2G POWDER FOR SOLUTION**

02250306	CEFTRIAXONE	HOS
02292289	CEFTRIAXONE	SDZ
02292882	CEFTRIAXONE	HOS
02325624	CEFTRIAXONE	RAX

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99506001	CEFTRIAXONE STERILE INFUSION	UNK
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**CEFUROXIME AXETIL****25MG/ML POWDER FOR SOLUTION**

02212307	CEFTIN	GSK
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**250MG TABLET**

02244393	APO-CEFUROXIME	APX
02344823	AURO-CEFUROXIME	APL
02212277	CEFTIN	GSK
02242656	RATIO-CEFUROXIME	TEV

**500MG TABLET**

02244394	APO-CEFUROXIME	APX
02344831	AURO-CEFUROXIME	APL
02212285	CEFTIN	GSK
02311453	PRO-CEFUROXIM	PDL
02242657	RATIO-CEFUROXIME	TEV

**CEPHALEXIN****250MG CAPSULE**

00342084	TEVA-CEPHALEXIN	TEV
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**500MG CAPSULE**

00342114	TEVA-CEPHALEXIN	TEV
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**25MG/ML POWDER FOR SUSPENSION**

02177862	DOM-CEPHALEXIN	DPC
00015547	KEFLEX	PED
00342106	TEVA-CEPHALEXIN	TEV

**50MG/ML POWDER FOR SUSPENSION**

02177870	DOM-CEPHALEXIN	DPC
00035645	KEFLEX	PED
00342092	TEVA-CEPHALEXIN	TEV

**250MG TABLET**

00768723	APO-CEPHALEX	APX
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**08:12.06 CEPHALOSPORINS****CEPHALEXIN****250MG TABLET**

02177846	DOM-CEPHALEXIN	DPC
00403628	KEFLEX	PED
02177781	PMS-CEPHALEXIN	PMS
00583413	TEVA-CEPHALEXIN	TEV

**500MG TABLET**

00768715	APO-CEPHALEX	APX
00828866	CEPHALEXIN	PDL
02177854	DOM-CEPHALEXIN	DPC
00244392	KEFLEX	PED
02177803	PMS-CEPHALEXIN	PMS
00583421	TEVA-CEPHALEXIN	TEV

**08:12.07 MISCELLANEOUS B-LACTAM ANTIBIOTICS****ERTAPENEM (ERTAPENEM SODIUM)**

Limited use benefit (prior approval required).

**1G POWDER FOR SOLUTION**

02247437	INVANZ	FRS
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**MEROPENEM (MEROPENEM TRIHYDRATE)**

Limited use benefit (prior approval required).

**500MG POWDER FOR SOLUTION**

02378787	MEROPENEM	SDZ
02218488	MERREM	AZC

**1G POWDER FOR SOLUTION**

02378795	MEROPENEM	SDZ
02436507	MEROPENEM	RAX
02218496	MERREM	AZC

**08:12.12 MACROLIDES****AZITHROMYCIN****20MG/ML POWDER FOR SUSPENSION**

02274566	GD-AZITHROMYCIN	PFI
02418452	PMS-AZITHROMYCIN	PMS
02332388	SANDOZ AZITHROMYCIN	SDZ
02223716	ZITHROMAX	PFI

**40MG/ML POWDER FOR SUSPENSION**

02274574	GD-AZITHROMYCIN	PFI
02418460	PMS-AZITHROMYCIN	PMS
02332396	SANDOZ AZITHROMYCIN	SDZ
02223724	ZITHROMAX	PFI

**250MG TABLET**

02255340	ACT AZITHROMYCIN	ACG
02247423	APO-AZITHROMYCIN	APX
02415542	APO-AZITHROMYCIN	APX
02330881	AZITHROMYCIN	SAN
02442434	AZITHROMYCIN	SIV
02278499	DOM-AZITHROMYCIN	DPC
02274531	GD-AZITHROMYCIN	PFI
02452308	JAMP-AZITHROMYCIN	JMP
02452324	MAR-AZITHROMYCIN	MAR
02278359	MYLAN-AZITHROMYCIN	MYL
02278588	PHL-AZITHROMYCIN	PHH
02261634	PMS-AZITHROMYCIN	PMS
02310600	PRO-AZITHROMYCINE	PDL

**08:12.12 MACROLIDES****AZITHROMYCIN****250MG TABLET**

02275309	RIVA-AZITHROMYCIN	RIV
02265826	SANDOZ AZITHROMYCIN	SDZ
02267845	TEVA-AZITHROMYCIN	TEV
02212021	ZITHROMAX	PFI

**600MG TABLET**

02256088	ACT AZITHROMYCIN	ACG
02261642	PMS-AZITHROMYCIN	PMS
02231143	ZITHROMAX	PFI

**CLARITHROMYCIN****25MG/ML GRANULES FOR SUSPENSION**

02146908	BIAXIN	BGP
02408988	CLARITHROMYCIN	SAN
02390442	TARO-CLARITHROMYCIN	TAR

**50MG/ML GRANULES FOR SUSPENSION**

02244641	BIAXIN	BGP
02408996	CLARITHROMYCIN	SAN
02390450	TARO-CLARITHROMYCIN	TAR

**250MG TABLET**

02274744	APO-CLARITHROMYCIN	APX
01984853	BIAXIN	BGP
02324482	CLARITHROMYCIN	PDL
02442469	CLARITHROMYCIN	SIV
02247573	PMS-CLARITHROMYCIN	PMS
02361426	RAN-CLARITHROMYCIN	RBV
02266539	SANDOZ CLARITHROMYCIN	SDZ
02248804	TEVA-CLARITHROMYCIN	TEV

**500MG TABLET**

02274752	APO-CLARITHROMYCIN	APX
02126710	BIAXIN	BGP
02324490	CLARITHROMYCIN	PDL
02442485	CLARITHROMYCIN	SIV
02351005	DOM-CLARITHROMYCIN	DPC
02247574	PMS-CLARITHROMYCIN	PMS
02361434	RAN-CLARITHROMYCIN	RBV
02346532	RIVA-CLARITHROMYCIN	RIV
02266547	SANDOZ CLARITHROMYCIN	SDZ
02248805	TEVA-CLARITHROMYCIN	TEV

**500MG TABLET (EXTENDED RELEASE)**

02403196	ACT CLARITHROMYCIN XL	ACG
02413345	APO-CLARITHROMYCIN XL	APX
02244756	BIAXIN XL	BGP

**ERYTHROMYCIN****250MG CAPSULE (ENTERIC COATED)**

00607142	ERYC	PFI
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**333MG CAPSULE (ENTERIC COATED)**

00873454	ERYC	PFI
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**250MG TABLET**

00682020	ERYTHRO BASE	AAP
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**ERYTHROMYCIN ESTOLATE****50MG/ML SUSPENSION**

00262595	NOVO-RYTHRO ESTOLATE	TEV
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**08:12.12 MACROLIDES****ERYTHROMYCIN ETHYLSUCCINATE****600MG TABLET**

00637416	ERYTHRO-ES	AAP
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**ERYTHROMYCIN STEARATE****250MG TABLET**

00545678	ERYTHRO-S	AAP
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**500MG TABLET**

00688568	ERYTHRO-S	AAP
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**08:12.16 PENICILLINS****AMOXICILLIN****250MG CAPSULE**

02352710	AMOXICILLIN	SAN
02401495	AMOXICILLIN	SIV
00628115	APO-AMOXI	APX
02388073	AURO-AMOXICILLIN	AUR
02433060	JAMP-AMOXICILLIN	JMP
02238171	MYLAN-AMOXICILLIN	MYL
00406724	NOVAMOXIN	TEV
02230243	PMS-AMOXICILLIN	PMS

**500MG CAPSULE**

02352729	AMOXICILLIN	SAN
02401509	AMOXICILLIN	SIV
00628123	APO-AMOXI	APX
02388081	AURO-AMOXICILLIN	AUR
02433079	JAMP-AMOXICILLIN	JMP
02238172	MYLAN-AMOXICILLIN	MYL
00406716	NOVAMOXIN	TEV
02230244	PMS-AMOXICILLIN	PMS
00644315	PRO AMOX	PDL

**25MG/ML GRANULES FOR SUSPENSION**

00452149	NOVAMOXIN	TEV
01934171	NOVAMOXIN	TEV

**50MG/ML GRANULES FOR SUSPENSION**

02352753	AMOXICILLIN	SAN
02401541	AMOXICILLIN	SIV
02352788	AMOXICILLIN (SUGAR REDUCED)	SAN
00452130	NOVAMOXIN	TEV
01934163	NOVAMOXIN	TEV

**25MG/ML POWDER FOR SUSPENSION**

00628131	APO-AMOXI	APX
02230245	PMS-AMOXICILLIN	PMS

**50MG/ML POWDER FOR SUSPENSION**

00628158	APO-AMOXI	APX
02230880	APO-AMOXI SUGAR FREE	APX
02230246	PMS-AMOXICILLIN	PMS
00644331	PRO-AMOX	PDL

**125MG TABLET (CHEWABLE)**

02036347	NOVAMOXIN	TEV
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**250MG TABLET (CHEWABLE)**

02036355	NOVAMOXIN	TEV
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**AMOXICILLIN, CLAVULANIC ACID****25MG & 6.25MG/ML POWDER FOR SUSPENSION**

02243986	APO-AMOXI CLAV	APX
01916882	CLAVULIN 125 F	GSK

**08:12.16 PENICILLINS****AMOXICILLIN, CLAVULANIC ACID****25MG & 6.25MG/ML POWDER FOR SUSPENSION**

02244646 RATIO-ACLAVULANATE TEV

**40MG & 5.7MG/ML POWDER FOR SUSPENSION**

02288559 APO-AMOXI CLAV APX

02238831 CLAVULIN 200 GSK

**50MG & 12.5MG/ML POWDER FOR SUSPENSION**

02243987 APO-AMOXI CLAV APX

01916874 CLAVULIN 250 F GSK

**80MG & 11.4MG/ML POWDER FOR SUSPENSION**

02238830 CLAVULIN 400 GSK

**250MG & 125MG TABLET**

02243350 APO-AMOXI CLAV APX

**500MG & 125MG TABLET**

02326515 AMOXI-CLAV PDL

02243351 APO-AMOXI CLAV APX

01916858 CLAVULIN 500 F GSK

02243771 RATIO-ACLAVULANATE TEV

**875MG & 125MG TABLET**

02326523 AMOXI-CLAV PDL

02245623 APO-AMOXI CLAV APX

02238829 CLAVULIN 875 GSK

02247021 RATIO-ACLAVULANATE TEV

**AMPICILLIN****250MG CAPSULE**

00020877 TEVA-AMPICILLIN TEV

**500MG CAPSULE**

00020885 TEVA-AMPICILLIN TEV

**50MG/ML LIQUID**

00603287 APO AMPI APX

**1G POWDER FOR SOLUTION**

01933345 AMPICILLIN SODIUM TEV

**2G POWDER FOR SOLUTION**

01933353 AMPICILLIN SODIUM TEV

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99506005 AMPICILLIN STERILE INFUSION UNK

**CLOXACILLIN SODIUM****250MG CAPSULE**

00337765 TEVA-CLOXACILLIN TEV

**500MG CAPSULE**

00337773 TEVA-CLOXACILLIN TEV

**25MG/ML GRANULES FOR SOLUTION**

00337757 TEVA-CLOXACILLIN TEV

**PENICILLIN G BENZATHINE****600,000U/ML SUSPENSION**

02291924 BICILLIN PFI

**PENICILLIN G POTASSIUM****1MU INJECTION**

00773727 NOVO-PENICILLIN G POTASSIUM NOP

**PENICILLIN G SODIUM****1MU POWDER FOR SOLUTION**

01930672 PENICILLIN G TEV

**08:12.16 PENICILLINS****PENICILLIN G SODIUM****5MU POWDER FOR SOLUTION**

00883751 PENICILLIN G TEV

**10MU POWDER FOR SOLUTION**

01930680 PENICILLIN G TEV

02220296 PENICILLIN G FKD

**1000000U POWDER FOR SOLUTION**

02220261 PENICILLIN G SODIUM FKD

**5000000U POWDER FOR SOLUTION**

02060094 CRYSTAPEN MYL

02220288 PENICILLIN G SODIUM FKD

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99506003 PENICILLIN G STERILE INFUSION UNK

**PENICILLIN V POTASSIUM****25MG/ML POWDER FOR SOLUTION**

00642223 APO PEN VK APX

**60MG/ML POWDER FOR SOLUTION**

00642231 APO PEN VK APX

00391603 NOVO-PEN VK NOP

**300MG TABLET**

00642215 PEN-VK AAP

**PIPERACILLIN (PIPERACILLIN SODIUM),  
TAZOBACTAM (TAZOBACTAM SODIUM)**

Limited use benefit (prior approval required).

**2G & 0.25G POWDER FOR SOLUTION**

02299623 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM SDZ

02370158 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM TEV

**3G & 0.375G POWDER FOR SOLUTION**

02299631 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM SDZ

02308452 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM APX

02362627 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM RAX

02370166 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM TEV

**4G & 0.5G POWDER FOR SOLUTION**

02299658 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM SDZ

02308460 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM APX

02362635 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM RAX

02370174 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM TEV

**12G & 1.5G POWDER FOR SOLUTION**

02330547 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM SDZ

02377748 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM RAX

**36G & 4.5G POWDER FOR SOLUTION**

02439131 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM RAX

## 08:12.18 QUINOLONES

## CIPROFLOXACIN HYDROCHLORIDE

## 100MG/ML SUSPENSION

02237514 CIPRO BAY

## 250MG TABLET

02247339 ACT CIPROFLOXACIN ACG  
 02229521 APO-CIPROFLOX APX  
 02381907 AURO-CIPROFLOXACIN AUR  
 02155958 CIPRO BAY  
 02353318 CIPROFLOXACIN SAN  
 02386119 CIPROFLOXACIN SIV  
 02380358 JAMP-CIPROFLOXACIN JMP  
 02379686 MAR-CIPROFLOXACIN MAR  
 02423553 MINT-CIPROFLOX MIN  
 02317427 MINT-CIPROFLOXACIN MIN  
 02245647 MYLAN-CIPROFLOXACIN MYL  
 02251310 PHL-CIPROFLOXACIN PHH  
 02248437 PMS-CIPROFLOXACIN PMS  
 02317796 PRO-CIPROFLOXACIN PDL  
 02303728 RAN-CIPROFLOX RBY  
 02246825 RATIO-CIPROFLOXACIN TEV  
 02251221 RIVA-CIPROFLOXACIN RIV  
 02248756 SANDOZ CIPROFLOXACIN SDZ  
 02379627 SEPTA-CIPROFLOXACIN SPT  
 02266962 TARO-CIPROFLOXACIN TAR  
 02161737 TEVA-CIPROFLOXACIN TEV

## 500MG TABLET

02247340 ACT CIPROFLOXACIN ACG  
 02229522 APO-CIPROFLOX APX  
 02381923 AURO-CIPROFLOXACIN AUR  
 02155966 CIPRO BAY  
 02353326 CIPROFLOXACIN SAN  
 02386127 CIPROFLOXACIN SIV  
 02251280 DOM-CIPROFLOXACIN DPC  
 02380366 JAMP-CIPROFLOXACIN JMP  
 02379694 MAR-CIPROFLOXACIN MAR  
 02423561 MINT-CIPROFLOX MIN  
 02317435 MINT-CIPROFLOXACIN MIN  
 02245648 MYLAN-CIPROFLOXACIN MYL  
 02251329 PHL-CIPROFLOXACIN PHH  
 02248438 PMS-CIPROFLOXACIN PMS  
 02317818 PRO-CIPROFLOXACIN PDL  
 02303736 RAN-CIPROFLOX RBY  
 02246826 RATIO-CIPROFLOXACIN TEV  
 02251248 RIVA-CIPROFLOXACIN RIV  
 02248757 SANDOZ CIPROFLOXACIN SDZ  
 02379635 SEPTA-CIPROFLOXACIN SPT  
 02266970 TARO-CIPROFLOXACIN TAR  
 02161745 TEVA-CIPROFLOXACIN TEV

## 750MG TABLET

02247341 ACT CIPROFLOXACIN ACG  
 02229523 APO-CIPROFLOX APX  
 02381931 AURO-CIPROFLOXACIN AUR  
 02155974 CIPRO BAY  
 02380374 JAMP-CIPROFLOXACIN JMP  
 02379708 MAR-CIPROFLOXACIN MAR  
 02423588 MINT-CIPROFLOX MIN

## 08:12.18 QUINOLONES

## CIPROFLOXACIN HYDROCHLORIDE

## 750MG TABLET

02317443 MINT-CIPROFLOXACIN MIN  
 02245649 MYLAN-CIPROFLOXACIN MYL  
 02251337 PHL-CIPROFLOXACIN PHH  
 02248439 PMS-CIPROFLOXACIN PMS  
 02303744 RAN-CIPROFLOX RBY  
 02246827 RATIO-CIPROFLOXACIN TEV  
 02251256 RIVA-CIPROFLOXACIN RIV  
 02248758 SANDOZ CIPROFLOXACIN SDZ  
 02379643 SEPTA-CIPROFLOXACIN SPT  
 02161753 TEVA-CIPROFLOXACIN TEV

## LEVOFLOXACIN HEMIHYDRATE

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

## 250MG TABLET

02315424 ACT LEVOFLOXACIN TEV  
 02284707 APO-LEVOFLOXACIN APX  
 02284677 PMS-LEVOFLOXACIN PMS  
 02298635 SANDOZ LEVOFLOXACIN SDZ  
 02248262 TEVA-LEVOFLOXACIN TEV

## 500MG TABLET

02315432 ACT LEVOFLOXACIN TEV  
 02284715 APO-LEVOFLOXACIN APX  
 02415879 LEVOFLOXACIN PDL  
 02284685 PMS-LEVOFLOXACIN PMS  
 02298643 SANDOZ LEVOFLOXACIN SDZ  
 02248263 TEVA-LEVOFLOXACIN TEV

## 750MG TABLET

02315440 ACT LEVOFLOXACIN TEV  
 02325942 APO-LEVOFLOXACIN APX  
 02305585 PMS-LEVOFLOXACIN PMS  
 02298651 SANDOZ LEVOFLOXACIN SDZ  
 02285649 TEVA-LEVOFLOXACIN TEV

## MOXIFLOXACIN HYDROCHLORIDE

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

## 400MG TABLET

02404923 APO-MOXIFLOXACIN APX  
 02432242 AURO-MOXIFLOXACIN AUR  
 02242965 AVELOX BAY  
 02443929 JAMP-MOXIFLOXACIN JMP  
 02447061 JAMP-MOXIFLOXACIN JMP  
 02447053 MAR-MOXIFLOXACIN MAR  
 02457814 MED-MOXIFLOXACIN GMP  
 02450976 RIVA-MOXIFLOXACIN RIV  
 02383381 SANDOZ MOXIFLOXACIN SDZ  
 02375702 TEVA-MOXIFLOXACIN TEV

## NORFLOXACIN

## 400MG TABLET

02229524 APO-NORFLOX APX  
 02269627 CO NORFLOXACIN OBT

**08:12.18 QUINOLONES****NORFLOXACIN****400MG TABLET**

02246596	PMS-NORFLOXACIN	PMS
02237682	TEVA-NORFLOXACIN	TEV

**08:12.20 SULFONAMIDES****SULFAMETHOXAZOLE****500MG TABLET**

00421480	APO SULFAMETHOXAZOLE	APX
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**SULFAMETHOXAZOLE, TRIMETHOPRIM****40MG & 8MG/ML SUSPENSION**

00726540	TEVA-TRIMEL	TEV
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**100MG & 20MG TABLET**

00445266	APO SULFATRIM PEDIATRIC	APX
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**400MG & 80MG TABLET**

00445274	APO SULFATRIM	APX
00510637	TEVA-TRIMEL	TEV

**800MG & 160MG TABLET**

00445282	APO SULFATRIM DS	APX
00512524	PROTRIN DF	PDL
00510645	TEVA-TRIMEL DS	TEV

**SULFASALAZINE****500MG TABLET**

00598461	PMS-SULFASALAZINE	PMS
02064480	SALAZOPYRIN	PFI

**500MG TABLET (ENTERIC COATED)**

00598488	PMS-SULFASALAZINE	PMS
02064472	SALAZOPYRIN EN	PFI

**08:12.24 TETRACYCLINES****DOXYCYCLINE HYCLATE****100MG CAPSULE**

00740713	APO-DOXY	APX
00817120	DOXYCIN	RIV
02351234	DOXYCYCLINE	SAN
00725250	TEVA-DOXYCYCLINE	TEV

**100MG TABLET**

00874256	APO-DOXY	APX
00860751	DOXYCIN	RIV
02351242	DOXYCYCLINE	SAN
00887064	DOXYTAB	PDL
02158574	TEVA-DOXYCYCLINE	TEV

**MINOCYCLINE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For patients who cannot tolerate other tetracyclines or doxycycline.

For patients with severe widespread acne who have failed on tetracycline or doxycycline.

**50MG CAPSULE**

02084090	APO-MINOCYCLINE	APX
02239667	DOM-MINOCYCLINE	DPC
02153394	MINOCYCLINE	PDL
02287226	MINOCYCLINE	SAN
02230735	MYLAN-MINOCYCLINE	MYL
02239238	PMS-MINOCYCLINE	PMS

**08:12.24 TETRACYCLINES****MINOCYCLINE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For patients who cannot tolerate other tetracyclines or doxycycline.

For patients with severe widespread acne who have failed on tetracycline or doxycycline.

**50MG CAPSULE**

02294419	PMS-MINOCYCLINE	PMS
02237313	SANDOZ MINOCYCLINE	SDZ
02108143	TEVA-MINOCYCLINE	TEV

**100MG CAPSULE**

02084104	APO-MINOCYCLINE	APX
02239668	DOM-MINOCYCLINE	DPC
02154366	MINOCYCLINE	PDL
02239982	MINOCYCLINE	IVX
02287234	MINOCYCLINE	SAN
02230736	MYLAN-MINOCYCLINE	MYL
02239239	PMS-MINOCYCLINE	PMS
02294427	PMS-MINOCYCLINE	PMS
02237314	SANDOZ MINOCYCLINE	SDZ
02108151	TEVA-MINOCYCLINE	TEV

**TETRACYCLINE HYDROCHLORIDE****250MG CAPSULE**

00580929	TETRACYCLINE	AAP
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**08:12.28 MISCELLANEOUS ANTIBIOTICS****CLINDAMYCIN HYDROCHLORIDE****150MG CAPSULE**

02245232	APO-CLINDAMYCIN	APX
02400529	CLINDAMYCIN	SAN
02248525	CLINDAMYCINE	PDL
00030570	DALACIN C	PFI
02258331	MYLAN-CLINDAMYCIN	MYL
02241709	TEVA-CLINDAMYCIN	TEV

**300MG CAPSULE**

02245233	APO-CLINDAMYCIN	APX
02436914	AURO-CLINDAMYCIN	AUR
02400537	CLINDAMYCIN	SAN
02248526	CLINDAMYCINE	PDL
02182866	DALACIN C	PFI
02258358	MYLAN-CLINDAMYCIN	MYL
02241710	TEVA-CLINDAMYCIN	TEV

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99506008	CLINDAMYCIN STERILE INFUSION	UNK
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**CLINDAMYCIN PALMITATE HYDROCHLORIDE****15MG/ML POWDER FOR SOLUTION**

00225851	DALACIN C	PFI
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**CLINDAMYCIN PHOSPHATE****150MG/ML INJECTION**

02139286	CLINDAMYCIN	FKD
02230535	CLINDAMYCIN	SDZ
02230540	CLINDAMYCIN	SDZ
02385716	CLINDAMYCIN	SDZ
00260436	DALACIN C PHOSPHATE	PFI

**08:12.28 MISCELLANEOUS ANTIBIOTICS**

**CLINDAMYCIN PHOSPHATE**

**150MG/ML INJECTION**

02215683 NOVO-CLINDAMYCIN NOP

**LINEZOLID**

Limited use benefit (prior approval required).

**Tablets:**

For treatment of proven vancomycin-resistant enterococci (VRE) infections.

For the treatment of proven methicillin-resistant staphylococcus aureus (MRSA) infections in patients who cannot tolerate vancomycin.

**I.V. Solution:**

When linezolid cannot be administered orally in the above mentioned situations;

**2MG/ML SOLUTION**

02402637 LINEZOLID TEV  
02243685 ZYVOXAM PFI

**600MG TABLET**

02426552 APO-LINEZOLID APX  
02422689 SANDOZ LINEZOLID SDZ  
02243684 ZYVOXAM PFI

**RIFAXIMIN**

Limited use benefit (prior approval required).

For reducing the risk of overt hepatic encephalopathy (HE) recurrence in patients:

- Who are unable to achieve adequate control of HE recurrence with a maximal tolerated dose of lactulose alone; AND
- When used in combination with a maximal tolerated dose of lactulose.

<sup>ST</sup> **550MG TABLET**

02410702 ZAXINE SLX

**VANCOMYCIN HYDROCHLORIDE**

Limited use benefit (prior approval required).

For the treatment of patients diagnosed with symptomatic Clostridium difficile infection who:

- are allergic, resistant or intolerant to metronidazole; OR
- have failed to respond to 4-6 days of oral metronidazole at doses of 500mg three times a day; OR
- have severe disease and initial doses are prescribed/recommended by an infectious disease or gastro-intestinal specialist.

**125MG CAPSULE**

02407744 JAMP-VANCOMYCIN JMP  
02430185 PMS-VANCOMYCIN PMS  
00800430 VANCOCIN MRL  
02377470 VANCOMYCIN FKD  
02380544 VANCOMYCIN UNK

**250MG CAPSULE**

02407752 JAMP-VANCOMYCIN JMP  
00788716 VANCOCIN MRL  
02377489 VANCOMYCIN FKD  
02380552 VANCOMYCIN UNK

**08:14.04 ALLYLAMINES**

**TERBINAFINE HYDROCHLORIDE**

**250MG TABLET**

02254727	ACT TERBINAFINE	ACG
02239893	APO-TERBINAFINE	APX
02320134	AURO-TERBINAFINE	AUR
02299275	DOM-TERBINAFINE	DPC
02357070	JAMP-TERBINAFINE	JMP
02031116	LAMISIL	NVR
02240807	PMS-TERBINAFINE	PMS
02294273	PMS-TERBINAFINE	PMS
02262924	RIVA-TERBINAFINE	RIV
02242735	TERBINAFINE	PDL
02353121	TERBINAFINE	SAN
02385279	TERBINAFINE	SIV
02240346	TEVA-TERBINAFINE	TEV

**08:14.08 AZOLES**

**FLUCONAZOLE**

**150MG CAPSULE**

02241895	APO-FLUCONAZOLE	APX
02311690	CANESORAL	BAY
02323419	CO FLUCONAZOLE	OBT
02141442	DIFLUCAN	PFI
02432471	JAMP-FLUCONAZOLE	JMP
02428792	MAR-FLUCONAZOLE	MAR
02243645	NOVO-FLUCONAZOLE	NOP
02246620	PMS-FLUCONAZOLE	PMS
02282348	PMS-FLUCONAZOLE	PMS
02433702	PRIVA-FLUCONAZOLE	PHA
02255510	RIVA-FLUCONAZOLE	RIV

**10MG/ML POWDER FOR SOLUTION**

02024152 DIFLUCAN PFI

**50MG TABLET**

02281260	ACT FLUCONAZOLE	ACG
02237370	APO-FLUCONAZOLE	APX
00891800	DIFLUCAN	PFI
02245292	MYLAN-FLUCONAZOLE	MYL
02245643	PMS-FLUCONAZOLE	PMS
02249294	TARO-FLUCONAZOLE	TAR
02236978	TEVA-FLUCONAZOLE	TEV

**100MG TABLET**

02281279	ACT FLUCONAZOLE	ACG
02237371	APO-FLUCONAZOLE	APX
02246109	DOM-FLUCONAZOLE	DPC
02245293	MYLAN-FLUCONAZOLE	MYL
02245644	PMS-FLUCONAZOLE	PMS
02310686	PRO-FLUCONAZOLE	PDL
02249308	TARO-FLUCONAZOLE	TAR
02236979	TEVA-FLUCONAZOLE	TEV

**ITRACONAZOLE**

**100MG CAPSULE**

02462559	MINT-ITRACONAZOLE	MIN
02047454	SPORANOX	JSO

**10MG/ML SOLUTION**

02231347	SPORANOX	JSO
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**08:14.08 AZOLES****KETOCONAZOLE****200MG TABLET**

02237235	APO-KETOCONAZOLE	APX
02231061	TEVA-KETOCONAZOLE	TEV

**VORICONAZOLE**

Limited use benefit (prior approval required).

For the treatment of patients with invasive aspergillosis; OR  
For the treatment of culture proven invasive candidiasis with documented resistance to fluconazole.

**50MG TABLET**

02409674	APO-VORICONAZOLE	APX
02399245	SANDOZ VORICONAZOLE	SDZ
02396866	TEVA-VORICONAZOLE	TEV
02256460	VFEND	PFI

**200MG TABLET**

02409682	APO-VORICONAZOLE	APX
02399253	SANDOZ VORICONAZOLE	SDZ
02396874	TEVA-VORICONAZOLE	TEV
02256479	VFEND	PFI

**08:14.28 POLYENES****NYSTATIN****100,000U/ML SUSPENSION**

02125145	DOM-NYSTATIN	DPC
02433443	JAMP-NYSTATIN	JMP
00792667	PMS-NYSTATIN	PMS
02194201	RATIO-NYSTATIN	TEV

**08:16.04 ANTITUBERCULOSIS AGENTS****ETHAMBUTOL HYDROCHLORIDE****100MG TABLET**

00247960	ETIBI	VAE
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**400MG TABLET**

00247979	ETIBI	VAE
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**ISONIAZID****10MG/ML SOLUTION**

00265500	ISOTAMINE	VAE
00577812	PDP-ISONIAZID	PED

**100MG TABLET**

00261270	ISOTAMINE	VAE
00577790	PDP-ISONIAZID	PED

**300MG TABLET**

00272655	ISOTAMINE	VAE
00577804	PDP-ISONIAZID	PED

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99503031	ISONIAZID ORAL LIQUID	UNK
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**PYRAZINAMIDE****500MG TABLET**

00618810	PDP-PYRAZINAMIDE	PED
00283991	TEBRAZID	VAE

**RIFABUTIN****150MG CAPSULE**

02063786	MYCOBUTIN	PFI
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**08:16.04 ANTITUBERCULOSIS AGENTS****RIFAMPIN****150MG CAPSULE**

02091887	RIFADIN	SAC
00393444	ROFACT	VAE

**300MG CAPSULE**

02092808	RIFADIN	SAC
00343617	ROFACT	VAE

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99503022	RIFAMPIN ORAL LIQUID	UNK
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**08:16.92 MISCELLANEOUS  
ANTIMYCOBACTERIALS****DAPSONE****100MG TABLET**

02041510	DAPSONE	JAC
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**08:18.04 ADAMANTANES****AMANTADINE HYDROCHLORIDE****100MG CAPSULE**

02130963	DOM-AMANTADINE	DPC
01990403	PMS-AMANTADINE	PED

**10MG/ML SYRUP**

02022826	PMS-AMANTADINE	PED
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**08:18.08 ANTIRETROVIRALS****ABACAVIR SUFLATE, LAMIVUDINE****600MG & 300MG TABLET**

02458381	PMS-ABACAVIR/LAMIVUDINE	PMS
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**ABACAVIR SULFATE****20MG/ML SOLUTION**

02240358	ZIAGEN	VII
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**300MG TABLET**

02396769	APO-ABACAVIR	APX
02240357	ZIAGEN	VII

**ABACAVIR SULFATE, LAMIVUDINE****600MG & 300MG TABLET**

02399539	APO-ABACAVIR-LAMIVUDINE	APX
02454513	AURO-ABACAVIR/LAMIVUDINE	AUR
02269341	KIVEXA	VII
02450682	MYLAN-ABACAVIR/LAMIVUDINE	MYL
02416662	TEVA-ABACAVIR/LAMIVUDINE	TEV

**ABACAVIR SULFATE, LAMIVUDINE,  
DOLUTEGRAVIR SODIUM****600MG & 300MG & 50MG TABLET**

02430932	TRIUMEQ	VII
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**ABACAVIR SULFATE, LAMIVUDINE, ZIDOVUDINE****300MG & 150MG & 300MG TABLET**

02416255	APO-ABACAVIR-LAMIVUDINE- ZIDOVUDINE	APX
02244757	TRIZIVIR	VII

**ATAZANAVIR SULFATE****150MG CAPSULE**

02456877	MYLAN-ATAZANAVIR	MYL
02248610	REYATAZ	BMS

**08:18.08 ANTIRETROVIRALS****ATAZANAVIR SULFATE****150MG CAPSULE**

02443791 TEVA-ATAZANAVIR TEV

**200MG CAPSULE**

02456885 MYLAN-ATAZANAVIR MYL

02248611 REYATAZ BMS

02443813 TEVA-ATAZANAVIR TEV

**300MG CAPSULE**

02456893 MYLAN-ATAZANAVIR MYL

02294176 REYATAZ BMS

02443821 TEVA-ATAZANAVIR TEV

**DARUNAVIR ETHANOLATE****75MG TABLET**

02338432 PREZISTA JSO

**150MG TABLET**

02369753 PREZISTA JSO

**400MG TABLET**

02324016 PREZISTA JSO

**600MG TABLET**

02324024 PREZISTA JSO

**800MG TABLET**

02393050 PREZISTA JSO

**DARUNAVIR ETHANOLATE, COBICISTAT****150MG & 800MG TABLET**

02426501 PREZCOBIX JSO

**DIDANOSINE****125MG CAPSULE (ENTERIC COATED)**

02244596 VIDEX EC BMS

**200MG CAPSULE (ENTERIC COATED)**

02244597 VIDEX EC BMS

**250MG CAPSULE (ENTERIC COATED)**

02244598 VIDEX EC BMS

**400MG CAPSULE (ENTERIC COATED)**

02244599 VIDEX EC BMS

**DOLUTEGRAVIR SODIUM****50MG TABLET**

02414945 TIVICAY VII

**EFAVIRENZ****50MG CAPSULE**

02239886 SUSTIVA BMS

**200MG CAPSULE**

02239888 SUSTIVA BMS

**600MG TABLET**

02418428 AURO-EFAVIRENZ AUR

02381524 MYLAN-EFAVIRENZ MYL

02246045 SUSTIVA BMS

02389762 TEVA-EFAVIRENZ TEV

**EFAVIRENZ, EMTRICITABINE, TENOFOVIR DISOPROXIL FUMARATE****600MG & 200MG & 300MG TABLET**

02300699 ATRIPLA BMS

**08:18.08 ANTIRETROVIRALS****EMTRICITABINE, COBICISTAT, ELVITEGRAVIR, TENOFOVIR ALAFENAMIDE****200MG & 150MG & 150MG & 10MG TABLET**

02449498 GENVOYA GIL

**ETRAVIRINE****100MG TABLET**

02306778 INTELENCE JSO

**200MG TABLET**

02375931 INTELENCE JSO

**FOSAMPRENAVIR CALCIUM****50MG/ML SUSPENSION**

02261553 TELZIR VII

**700MG TABLET**

02261545 TELZIR VII

**LAMIVUDINE****5MG SOLUTION**

02239194 HEPTOVIR GSK

**10MG/ML SOLUTION**

02192691 3TC VII

**100MG TABLET**

02393239 APO-LAMIVUDINE HBV APX

02239193 HEPTOVIR GSK

**150MG TABLET**

02192683 3TC VII

02369052 APO-LAMIVUDINE APX

**300MG TABLET**

02247825 3TC VII

02369060 APO-LAMIVUDINE APX

**LAMIVUDINE, ZIDOVUDINE****150MG & 300MG TABLET**

02375540 APO-LAMIVUDINE-ZIDOVUDINE APX

02414414 AURO-LAMIVUDINE/ZIDOVUDINE AUR

02239213 COMBIVIR VII

02387247 TEVA-LAMIVUDINE/ZIDOVUDINE TEV

**LOPINAVIR, RITONAVIR****80MG & 20MG/ML SOLUTION**

02243644 KALETRA ABV

**100MG & 25MG TABLET**

02312301 KALETRA ABV

**200MG & 50MG TABLET**

02285533 KALETRA ABV

**MARAVIROC****150MG TABLET**

02299844 CELSENTRI VII

**300MG TABLET**

02299852 CELSENTRI VII

**NELFINAVIR MESYLATE****50MG/G POWDER**

02238618 VIRACEPT PFI

**250MG TABLET**

02238617 VIRACEPT PFI

**08:18.08 ANTIRETROVIRALS****NELFINAVIR MESYLATE****625MG TABLET**

02248761 VIRACEPT PFI

**NEVIRAPINE****200MG TABLET**

02318601 AURO-NEVIRAPINE APL  
 02387727 MYLAN-NEVIRAPINE MYL  
 02405776 PMS-NEVIRAPINE PMS  
 02352893 TEVA-NEVIRAPINE TEV  
 02238748 VIRAMUNE BOE

**400MG TABLET (EXTENDED RELEASE)**

02427931 APO-NEVIRAPINE XR APX  
 02367289 VIRAMUNE XR BOE

**RALTEGRAVIR POTASSIUM****400MG TABLET**

02301881 ISENTRESS FRS

**RILPIVIRINE HYDROCHLORIDE****25MG TABLET**

02370603 EDURANT JSO

**RITONAVIR****80MG/ML SOLUTION**

02229145 NORVIR ABV

**100MG TABLET**

02357593 NORVIR ABV

**SAQUINAVIR MESYLATE****200MG CAPSULE**

02216965 INVIRASE HLR

**500MG TABLET**

02279320 INVIRASE HLR

**STAVUDINE****15MG CAPSULE**

02216086 ZERIT BMS

**20MG CAPSULE**

02216094 ZERIT BMS

**30MG CAPSULE**

02216108 ZERIT BMS

**40MG CAPSULE**

02216116 ZERIT BMS

**TENOFOVIR DISOPROXIL FUMARATE**

Limited use benefit (prior approval required).

For the treatment of patients with HIV-1 infection who have failed or have experienced adverse events to an alternative agent.

For the treatment of patients with chronic hepatitis B infection who have cirrhosis documented on radiologic or histologic grounds and a HBV concentration above 2,000 IU/mL.

**245MG TABLET**

02247128 VIREAD GIL

**TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE****200MG & 300MG TABLET**

02274906 TRUVADA GIL

**08:18.08 ANTIRETROVIRALS****TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE****300MG & 200MG TABLET**

02452006 APO-EMTRICITABINE-TENOFOVIR APX  
 02443902 MYLAN-EMTRICITABINE/TENOFOVIR MYL

DISOPROXIL

02461110 PMS-EMTRICITABINE-TENOFOVIR PMS

02399059 TEVA-EMTRICITABINE/TENOFOVIR TEV

**TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE, COBICISTAT, ELVITEGRAVIR****150MG & 200MG & 150MG & 300MG TABLET**

02397137 STRIBILD GIL

**TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE, RILPIVIRINE HYDROCHLORIDE****200MG & 25MG & 300MG TABLET**

02374129 COMPLERA GIL

**TIPRANAVIR****250MG CAPSULE**

02273322 APTIVUS BOE

**ZIDOVUDINE****100MG CAPSULE**

01946323 APO-ZIDOVUDINE APX

01902660 RETROVIR VII

**10MG/ML SYRUP**

01902652 RETROVIR VII

**08:18.20 INTERFERONS****INTERFERON ALFA-2B****6,000,000IU/ML SOLUTION**

02238674 INTRON A FRS

**10,000,000IU/ML SOLUTION**

02238675 INTRON A FRS

**10,000,000IU/VIAL SOLUTION**

02223406 INTRON A FRS

**15,000,000IU/ML SOLUTION**

02240693 INTRON A FRS

**25,000,000IU/ML SOLUTION**

02240694 INTRON A FRS

**50,000,000IU/ML SOLUTION**

02240695 INTRON A FRS

**PEGINTERFERON ALFA-2A**

Limited use benefit (prior approval required).

For the treatment of patients with chronic hepatitis B infection who have a HBV DNA concentration above 2,000 IU/mL without decompensated cirrhosis, upon the written request of a hepatologist or other specialist in this area.

**180MCG/0.5ML SOLUTION**

02248077 PEGASYS HLR

**08:18.20 INTERFERONS****PEGINTERFERON ALFA-2A, RIBAVIRIN**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or other specialist in this area.

- For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).
- For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

**180MCG/0.5ML & 200MG KIT**

02253429 PEGASYS RBV HLR

**180MCG/1ML & 200MG KIT**

02253410 PEGASYS RBV HLR

**PEGINTERFERON ALFA-2B, RIBAVIRIN**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or other specialist in this area.

- For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).
- For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

**50MCG/0.5ML & 200MG KIT**

02254573 PEGETRON KIT FRS

**80MCG/0.5ML & 200MG KIT**

02254581 PEGETRON FRS

**100MCG/0.5ML & 200MG KIT**

02254603 PEGETRON FRS

**120MCG/0.5ML & 200MG KIT**

02254638 PEGETRON FRS

**150MCG/0.5ML & 200MG KIT**

02254646 PEGETRON FRS

**08:18.32 NUCLEOSIDES AND NUCLEOTIDES****ACYCLOVIR****40MG/ML SUSPENSION**

00886157 ZOVIRAX GSK

**200MG TABLET**

02207621 APO-ACYCLOVIR APX

02242784 MYLAN-ACYCLOVIR MYL

02078627 RATIO-ACYCLOVIR TEV

02285959 TEVA-ACYCLOVIR TEV

**400MG TABLET**

02207648 APO-ACYCLOVIR APX

02242463 MYLAN-ACYCLOVIR MYL

02078635 RATIO-ACYCLOVIR TEV

02285967 TEVA-ACYCLOVIR TEV

**800MG TABLET**

02207656 APO-ACYCLOVIR APX

02242464 MYLAN-ACYCLOVIR MYL

02078651 RATIO-ACYCLOVIR TEV

02285975 TEVA-ACYCLOVIR TEV

**08:18.32 NUCLEOSIDES AND NUCLEOTIDES****ADEFOVIR DIPIVOXIL**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis B infection when used in combination with lamivudine in patients who have developed failure to lamivudine, as defined by an increase in HBV DNA of  $\geq 1 \log_{10}$  IU/mL above the nadir, measured on two separate occasions within an interval of at least one month, after the first three months of lamivudine therapy, and when failure to lamivudine is not due to poor adherence to therapy.

**10MG TABLET**

02420333 APO-ADEFOVIR APX

02247823 HEPSERA GIL

**ENTECAVIR MONOHYDRATE**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis B infection in patients with cirrhosis documented on radiologic or histologic grounds and a HBV DNA concentration above 2000IU/mL.

**0.5MG TABLET**

02396955 APO-ENTECAVIR APX

02448777 AURO-ENTECAVIR AUR

02282224 BARACLUDE BMS

02430576 PMS-ENTECAVIR PMS

**FAMCICLOVIR****125MG TABLET**

02305682 ACT FAMCICLOVIR ACG

02292025 APO-FAMCICLOVIR APX

02324865 FAMCICLOVIR PDL

02229110 FAMVIR NVR

02278081 PMS-FAMCICLOVIR PMS

02278634 SANDOZ FAMCICLOVIR SDZ

**250MG TABLET**

02305690 ACT FAMCICLOVIR ACG

02292041 APO-FAMCICLOVIR APX

02324873 FAMCICLOVIR PDL

02229129 FAMVIR NVR

02278103 PMS-FAMCICLOVIR PMS

02278642 SANDOZ FAMCICLOVIR SDZ

**500MG TABLET**

02305704 ACT FAMCICLOVIR ACG

02292068 APO-FAMCICLOVIR APX

02324881 FAMCICLOVIR PDL

02177102 FAMVIR NVR

02278111 PMS-FAMCICLOVIR PMS

02278650 SANDOZ FAMCICLOVIR SDZ

**GANCICLOVIR SODIUM****500MG POWDER FOR SOLUTION**

02162695 CYTOVENE HLR

**VALACYCLOVIR HYDROCHLORIDE****500MG TABLET**

02295822 APO-VALACYCLOVIR APX

02405040 AURO-VALACYCLOVIR AUR

02331748 CO VALACYCLOVIR OBT

02307936 DOM-VALACYCLOVIR DPC

**08:18.32 NUCLEOSIDES AND NUCLEOTIDES**

**VALACYCLOVIR HYDROCHLORIDE**

**500MG TABLET**

02441454	JAMP-VALACYCLOVIR	JMP
02441586	MAR-VALACYCLOVIR	MAR
02351579	MYLAN-VALACYCLOVIR	MYL
02298457	PMS-VALACYCLOVIR	PMS
02441861	PRIVA-VALACYCLOVIR	PHA
02315173	PRO-VALACYCLOVIR	PDL
02316447	RIVA-VALACYCLOVIR	RIV
02347091	SANDOZ VALACYCLOVIR	SDZ
02357534	TEVA-VALACYCLOVIR	TEV
02442000	VALACYCLOVIR	SIV
02454645	VALACYCLOVIR	SAN
02219492	VALTRES	GSK

**VALGANCICLOVIR HYDROCHLORIDE**

**50MG POWDER FOR SOLUTION**

02306085	VALCYTE	HLR
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**450MG TABLET**

02393824	APO-VALGANCICLOVIR	APX
02435179	AURO-VALGANCICLOVIR	AUR
02413825	TEVA-VALGANCICLOVIR	TEV
02245777	VALCYTE	HLR

**08:18.40 HCV ANTIVIRALS**

**ASUNAPREVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:  
 Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND  
 Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND  
 Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;  
 AND  
 Fibrosis stage of F2 or greater (Metavir scale or equivalent);  
 OR  
 Fibrosis stage less than F2 AND at least one of the following:  
 • Co-infection with HIV or hepatitis B virus;  
 • Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);  
 • Post organ transplant (liver and/or non-liver transplant);  
 • Extra-hepatic manifestations;  
 • Chronic kidney disease stage 3,4, or 5 as defined by the NKF KDOQI;  
 • Patient with diabetes receiving treatment with anti-diabetic drugs;  
 • Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**100MG CAPSULE**

02452294	SUNVEPRA	BMS
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**08:18.40 HCV ANTIVIRALS**

**DACLATASVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:  
 Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND  
 Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND  
 Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;  
 AND  
 Fibrosis stage of F2 or greater (Metavir scale or equivalent);  
 OR  
 Fibrosis stage less than F2 AND at least one of the following:  
 • Co-infection with HIV or hepatitis B virus;  
 • Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);  
 • Post organ transplant (liver and/or non-liver transplant);  
 • Extra-hepatic manifestations;  
 • Chronic kidney disease stage 3,4, or 5 as defined by the NKF KDOQI;  
 • Patient with diabetes receiving treatment with anti-diabetic drugs;  
 • Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**30MG TABLET**

02444747	DAKLINZA	BMS
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**60MG TABLET**

02444755	DAKLINZA	BMS
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**08:18.40 HCV ANTIVIRALS**

**ELBASVIR, GRAZOPREVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:  
 Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND  
 Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND  
 Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;  
 AND  
 Fibrosis stage of F2 or greater (Metavir scale or equivalent);  
 OR  
 Fibrosis stage less than F2 AND at least one of the following:  
 • Co-infection with HIV or hepatitis B virus;  
 • Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);  
 • Post organ transplant (liver and/or non-liver transplant);  
 • Extra-hepatic manifestations;  
 • Chronic kidney disease stage 3,4, or 5 as defined by the NKF KDOQI;  
 • Patient with diabetes receiving treatment with anti-diabetic drugs;  
 • Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**50MG & 100MG TABLET**

02451131 ZEPATIER

FRS

**08:18.40 HCV ANTIVIRALS**

**OMBITASVIR, PARITAPREVIR, RITONAVIR, DASABUVIR**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C virus (HCV) Genotype 1 infection in adults with a liver fibrosis stage  $\geq$  F2 (Metavir score or equivalent);  
 AND  
 Patient is unable to take the following chronic hepatitis C medications based on intolerance/contraindication:  
 • Epclusa (sofosbuvir-velpatasvir)  
 • Harvoni (ledipasvir-sofosbuvir)  
 • Zepatier (elbasvir-grazoprevir)  
 • Daklinza (daclatasvir) + Sunvepra (asunaprevir)

**Criteria & Duration**

Treatment naïve and experienced Genotype 1b, non-cirrhotic\* - 12 weeks.

Treatment naïve and experienced Genotype 1a, non-cirrhotic - 12 weeks in combination with RBV.

Treatment naïve and experienced Genotype 1b, cirrhotic - 12 weeks in combination with RBV.

Treatment naïve and experienced (prior relapses and prior partial responders) Genotype 1a, cirrhotic - 12 weeks in combination with RBV.

Treatment experienced Genotype 1a, with cirrhosis, and who have had a previous null response to pegIFN and RBV - 24 weeks in combination with RBV.

\*Holkira Pak with ribavirin is recommended in patients with an unknown Genotype 1 subtype or with mixed Genotype 1 infection.

**250MG & 12.5MG & 75MG & 50MG TABLET**

02436027 HOLKIRA PAK

ABV

**RIBAVIRIN**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C.

**200MG TABLET**

02439212 IBAVYR

PED

**400MG TABLET**

02425890 IBAVYR

PED

**600MG TABLET**

02425904 IBAVYR

PED

**SIMEPREVIR SODIUM**

Limited use benefit (prior approval required).

For the treatment of chronic Hepatitis C in treatment-naïve and treatment-experienced patients who meet all of the following criteria:

- Chronic hepatitis C virus (HCV) genotype 1 infection; AND
- Detectable levels of HCV RNA in the last six months; AND
- Fibrosis stage F2 or greater (Metavir scale or equivalent); AND

• Patient has not received a prior full therapeutic course of boceprevir or telaprevir.

Not eligible for coverage:

- Patients currently being treated with another HCV antiviral agent.
- Patients who have previously received a treatment course of Galexos (Re-treatment requests will not be considered).

**150MG CAPSULE**

02416441 GALEXOS

JSO

**08:18.40 HCV ANTIVIRALS**

**SOFOSBUVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:  
 Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND  
 Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND  
 Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;  
 AND  
 Fibrosis stage of F2 or greater (Metavir scale or equivalent);  
 OR  
 Fibrosis stage less than F2 AND at least one of the following:  
 • Co-infection with HIV or hepatitis B virus;  
 • Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);  
 • Post organ transplant (liver and/or non-liver transplant);  
 • Extra-hepatic manifestations;  
 • Chronic kidney disease stage 3,4, or 5 as defined by the NKF KDOQI;  
 • Patient with diabetes receiving treatment with anti-diabetic drugs;  
 • Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**400MG TABLET**

02418355 SOVALDI

GIL

**SOFOSBUVIR, LEDIPASVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:  
 Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND  
 Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND  
 Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;  
 AND  
 Fibrosis stage of F2 or greater (Metavir scale or equivalent);  
 OR  
 Fibrosis stage less than F2 AND at least one of the following:  
 • Co-infection with HIV or hepatitis B virus;  
 • Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);  
 • Post organ transplant (liver and/or non-liver transplant);  
 • Extra-hepatic manifestations;  
 • Chronic kidney disease stage 3,4, or 5 as defined by the NKF KDOQI;  
 • Patient with diabetes receiving treatment with anti-diabetic drugs;  
 • Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**400MG & 90MG TABLET**

02432226 HARVONI

GIL

**08:18.40 HCV ANTIVIRALS**

**SOFOSBUVIR, VELPATASVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:  
 Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND  
 Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND  
 Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;  
 AND  
 Fibrosis stage of F2 or greater (Metavir scale or equivalent);  
 OR  
 Fibrosis stage less than F2 AND at least one of the following:  
 • Co-infection with HIV or hepatitis B virus;  
 • Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);  
 • Post organ transplant (liver and/or non-liver transplant);  
 • Extra-hepatic manifestations;  
 • Chronic kidney disease stage 3,4, or 5 as defined by the NKF KDOQI;  
 • Patient with diabetes receiving treatment with anti-diabetic drugs;  
 • Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**400MG & 100MG TABLET**

02456370 EPCLUSA

GIL

**08:30.04 AMEBICIDES**

**PAROMOMYCIN SULFATE**

**250MG CAPSULE**

02078759 HUMATIN

ERF

**08:30.08 ANTIMALARIALS**

**CHLOROQUINE PHOSPHATE**

**250MG TABLET**

00021261 TEVA-CHLOROQUINE

TEV

**HYDROXYCHLOROQUINE SULFATE**

**200MG TABLET**

02246691 APO-HYDROXYQUINE

APX

02424991 MINT-HYDROXYCHLOROQUINE

MIN

02252600 MYLAN-HYDROXYCHLOROQUINE

MYL

02017709 PLAQUENIL

SAC

02311011 PRO-HYDROXYQUINE

PDL

**PRIMAQUINE PHOSPHATE**

**26.3MG TABLET**

02017776 PRIMAQUINE

SAC

**08:30.92 MISCELLANEOUS ANTIPROTOZOALS**

**ATOVAQUONE**

**150MG/ML SUSPENSION**

02217422 MEPRON

GSK

## 08:30.92 MISCELLANEOUS ANTIPROTOZOALS

### METRONIDAZOLE

#### 500MG CAPSULE

01926853	FLAGYL	ODN
02248562	METRONIDAZOLE	AAP
00783137	PMS-METRONIDAZOLE	PMS

#### 250MG TABLET

00545066	METRONIDAZOLE	AAP
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#### PDIN FOR EXTEMPORANEOUS MIXTURE

99503012	METRONIDAZOLE ORAL LIQUID	UNK
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## 08:36.00 URINARY ANTI-INFECTIVES

### FOSFOMYCIN TROMETHAMINE

Limited use benefit (prior approval required).

For the treatment of women (>12 years old) with:

- Urinary tract infections with organisms resistant to first line therapy; OR
- Urinary tract infections in pregnancy when first-line agents are contraindicated.

#### 3G/PK POWDER

02240335	MONUROL	PAL
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### NITROFURANTOIN

#### 50MG CAPSULE

02231015	TEVA-NITROFURANTOIN	TEV
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#### 100MG CAPSULE

02063662	MACROBID	ALL
02231016	TEVA-NITROFURANTOIN	TEV

#### 50MG TABLET

00319511	NITROFURANTOIN	AAP
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#### 100MG TABLET

00312738	NITROFURANTOIN	AAP
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#### PDIN FOR EXTEMPORANEOUS MIXTURE

99503004	NITRO-FURANTOIN ORAL LIQUID	UNK
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### TRIMETHOPRIM

#### 100MG TABLET

02243116	TRIMETHOPRIM	AAP
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#### 200MG TABLET

02243117	TRIMETHOPRIM	AAP
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#### PDIN FOR EXTEMPORANEOUS MIXTURE

99503017	TRIMETHOPRIM ORAL LIQUID	UNK
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**10:00 ANTINEOPLASTIC AGENTS****10:00.00 ANTINEOPLASTIC AGENTS****ABIRATERONE ACETATE**

Limited use benefit (prior approval required).

Initial coverage criteria (Initial approval for 12 months)  
For the treatment of metastatic castration resistant prostate cancer patients (mCRPC) who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy (ADT) and who have not received prior chemotherapy if they meet the following criteria:

- Used in combination with prednisone; AND
- Patient has an ECOG performance status of 0 or 1.

For the treatment of metastatic castration resistant prostate cancer patients (mCRPC) who progressed on docetaxel-based chemotherapy if they meet the following criteria:

- Used in combination with prednisone; AND
- Patient has an ECOG performance status  $\leq$  2; AND
- Abiraterone is not used as an add-on therapy to enzalutamide (Xtandi); AND
- Abiraterone has not been used in the pre-docetaxel setting.

Renewal coverage criteria (Renewal for 12 months)  
There is no objective evidence of disease progression

**250MG TABLET**

02371065 ZYTIGA JSO

**500MG TABLET**

02457113 ZYTIGA JSO

**AFATINIB DIMALEATE**

Limited use benefit (prior approval required).

For the treatment of patients with advanced Non-Small Cell Lung Cancer (NSCLC) who meet ALL of the following criteria:

- First line treatment of patients; AND
- EGFR mutation positive; AND
- Advanced or metastatic adenocarcinoma of the lung; AND
- An ECOG performance status of 0 or 1.

Criteria for assessment every six (6) month:

- There is no objective evidence of disease progression.

Use of afatinib precludes the use of any other EGFR inhibitor as a subsequent line of therapy.

**20MG TABLET**

02415666 GIOTRIF BOE

**30MG TABLET**

02415674 GIOTRIF BOE

**40MG TABLET**

02415682 GIOTRIF BOE

**ANASTROZOLE****1MG TABLET**

02351218 ACH-ANASTROZOLE ACC  
02394898 ACT ANASTROZOLE ACG  
02395649 ANASTROZOLE PDL  
02442736 ANASTROZOLE SAN  
02374420 APO-ANASTROZOLE APX  
02224135 ARIMIDEX AZC  
02392488 BIO-ANASTROZOLE BMI  
02339080 JAMP-ANASTROZOLE JMP  
02379562 MAR-ANASTROZOLE MAR  
02379104 MED-ANASTROZOLE GMP

**10:00.00 ANTINEOPLASTIC AGENTS****ANASTROZOLE****1MG TABLET**

02393573 MINT-ANASTROZOLE MIN  
02417855 NAT-ANASTROZOLE NPH  
02320738 PMS-ANASTROZOLE PMS  
02328690 RAN-ANASTROZOLE RBY  
02392259 RIVA-ANASTROZOLE RIV  
02338467 SANDOZ ANASTROZOLE SDZ  
02365650 TARO-ANASTROZOLE TAR  
02313049 TEVA-ANASTROZOLE TEV  
02427818 VAN-ANASTROZOLE VAN

**BICALUTAMIDE****50MG TABLET**

02325985 ACH-BICALUTAMIDE ACC  
02274337 ACT BICALUTAMIDE ACG  
02296063 APO-BICALUTAMIDE APX  
02382423 BICALUTAMIDE SIV  
02184478 CASODEX AZC  
02357216 JAMP-BICALUTAMIDE JMP  
02275589 PMS-BICALUTAMIDE PMS  
02311038 PRO-BICALUTAMIDE PDL  
02371324 RAN-BICALUTAMIDE RBY  
02276089 SANDOZ BICALUTAMIDE SDZ  
02270226 TEVA-BICALUTAMIDE TEV  
02428709 VAN-BICALUTAMIDE VAN

**BUSERELIN ACETATE****6.3MG/IMPLANT IMPLANT**

02228955 SUPREFACT DEPOT 2 MONTHS SAC

**9.45MG/IMPLANT IMPLANT**

02240749 SUPREFACT DEPOT 3 MONTHS SAC

**1MG/ML SOLUTION**

02225166 SUPREFACT SAC  
02225158 SUPREFACT (NASAL) SAC

**BUSULFAN****2MG TABLET**

00004618 MYLERAN ASP

**CAPECITABINE****150MG TABLET**

02426757 ACH-CAPECITABINE ACC  
02421917 SANDOZ CAPECITABINE SDZ  
02400022 TEVA-CAPECITABINE TEV  
02238453 XELODA HLR  
**500MG TABLET**  
02426765 ACH-CAPECITABINE ACC  
02421925 SANDOZ CAPECITABINE SDZ  
02400030 TEVA-CAPECITABINE TEV  
02238454 XELODA HLR

**CHLORAMBUCIL****2MG TABLET**

00004626 LEUKERAN ASP

**10:00.00 ANTINEOPLASTIC AGENTS****COBIMETINIB (COBIMETINIB FUMARATE)**

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for cobimetinib (Cotellic):

For the first-line treatment of patients with metastatic or unresectable melanoma in combination with vemurafenib (Zelboraf).

AND for patients who meet the following criteria:

- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG performance status of 0 to 1.

Renewal coverage criteria (6 months):

There is no objective evidence of disease progression.

**20MG TABLET**

02452340 COTELLIC HLR

**CYCLOPHOSPHAMIDE****25MG TABLET**

02241795 PROCYTOX BAX

**50MG TABLET**

02241796 PROCYTOX BAX

**DEGARELIX ACETATE****80MG POWDER FOR SOLUTION**

02337029 FIRMAGON FEI

**120MG POWDER FOR SOLUTION**

02337037 FIRMAGON FEI

**ENZALUTAMIDE**

Limited use benefit (prior approval required).

For the treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) who are/have:

- Asymptomatic or mildly symptomatic after failure of androgen deprivation therapy (ADT) who have not received prior chemotherapy; AND
- Have an ECOG performance status of 0 or 1 with no risk factors for seizures; OR
- Progressed on docetaxel-based chemotherapy with an ECOG performance status  $\leq 2$  and no risk factors for seizures; AND
- Would be an alternative to abiraterone for patients in the post-docetaxel setting but would not be an add-on therapy to abiraterone treatment.

Patients previously treated with abiraterone would not be eligible for enzalutamide unless unable to tolerate abiraterone.

Use of enzalutamide in the post-docetaxel setting is not permitted if previously used in the pre-chemotherapy setting.

**40MG CAPSULE**

02407329 XTANDI AST

**10:00.00 ANTINEOPLASTIC AGENTS****ERLOTINIB HYDROCHLORIDE**

Limited use benefit (prior approval required).

Treatment of non-small cell lung cancer (NSCLC) after failure of at least one prior chemotherapy regimen, and whose EGFR expression status is positive or unknown.

**25MG TABLET**

02269007 TARCEVA HLR

02377691 TEVA-ERLOTINIB TEV

**100MG TABLET**

02454386 PMS-ERLOTINIB PMS

02269015 TARCEVA HLR

02377705 TEVA-ERLOTINIB TEV

**150MG TABLET**

02454394 PMS-ERLOTINIB PMS

02269023 TARCEVA HLR

02377713 TEVA-ERLOTINIB TEV

**ETOPOSIDE****50MG CAPSULE**

00616192 VEPESID BMS

**EXEMESTANE****25MG TABLET**

02390183 ACT EXEMESTANE ACG

02419726 APO-EXEMESTANE APX

02242705 AROMASIN PFI

02407841 MED-EXEMESTANE GMP

02408473 TEVA-EXEMESTANE TEV

**FLUDARABINE PHOSPHATE****10MG TABLET**

02246226 FLUDARA SAC

**FLUTAMIDE****250MG TABLET**

02238560 APO-FLUTAMIDE APX

02230104 PMS-FLUTAMIDE PMS

02230089 TEVA-FLUTAMIDE TEV

**HYDROXYUREA****500MG CAPSULE**

02247937 APO-HYDROXYUREA APX

00465283 HYDREA BMS

02242920 MYLAN-HYDROXYUREA MYL

**IDELALISIB**

Limited use benefit (prior approval required).

Criteria for initial six month coverage:

- For the treatment of patients with relapsed chronic lymphocytic leukemia (CLL) in combination with rituximab. Treatment should continue until unacceptable toxicity or disease progression.

Criteria for assessment every six months:

- There is no objective evidence of disease progression.

**100MG TABLET**

02438798 ZYDELIG GIL

**150MG TABLET**

02438801 ZYDELIG GIL

**10:00.00 ANTINEOPLASTIC AGENTS****IMATINIB MESYLATE**

Limited use benefit (prior approval required).

- For the treatment of patients with chronic myeloid leukemia (CML) in blast crisis, accelerated phase, or in chronic phase.
- For the treatment of patients with gastrointestinal stromal tumour.
- For newly diagnosed adult patients with Philadelphia chromosome-positive (CML).

**100MG TABLET**

02355337	APO-IMATINIB	APX
02253275	GLEEVEC	NVR
02397285	NAT-IMATINIB	NPH
02431114	PMS-IMATINIB	PMS
02399806	TEVA-IMATINIB	TEV

**400MG TABLET**

02355345	APO-IMATINIB	APX
02253283	GLEEVEC	NVR
02397293	NAT-IMATINIB	NPH
02431122	PMS-IMATINIB	PMS
02399814	TEVA-IMATINIB	TEV

**LENALIDOMIDE**

Limited use benefit (prior approval not required).

For the treatment of:

- Myelodysplastic syndrome (MDS)
- Refractory/relapsed Multiple Myeloma after one prior therapy (MM-AOPT)
- Newly diagnosed Multiple Myeloma for patients who are not eligible for autologous stem cell transplant - (MM-TNE)
- Maintenance treatment for newly diagnosed Multiple Myeloma post-autologous stem cell transplant – (NDMM post-ASCT)

(Please refer to Appendix A).

**5MG CAPSULE**

02304899	REVLIMID	UNK
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**10MG CAPSULE**

02304902	REVLIMID	UNK
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**15MG CAPSULE**

02317699	REVLIMID	UNK
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**20MG CAPSULE**

02440601	REVLIMID	UNK
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**25MG CAPSULE**

02317710	REVLIMID	UNK
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**LETROZOLE**<sup>ST</sup> **2.5MG TABLET**

02338459	ACH-LETROZOLE	ACC
02358514	APO-LETROZOLE	APX
02392496	BIO-LETROZOLE	BMI
02231384	FEMARA	NVR
02373009	JAMP-LETROZOLE	JMP
02348969	LETROZOLE	ACG
02402025	LETROZOLE	PDL
02373424	MAR-LETROZOLE	MAR
02322315	MED-LETROZOLE	GMP
02421585	NAT-LETROZOLE	NPH
02309114	PMS-LETROZOLE	PMS

**10:00.00 ANTINEOPLASTIC AGENTS****LETROZOLE**<sup>ST</sup> **2.5MG TABLET**

02372282	RAN-LETROZOLE	RBV
02398656	RIVA-LETROZOLE	RIV
02344815	SANDOZ LETROZOLE	SDZ
02343657	TEVA-LETROZOLE	TEV
02378213	ZINDA-LETROZOLE	UNK

**LEUPROLIDE ACETATE****3.75MG/VIAL POWDER FOR SUSPENSION**

00884502	LUPRON DEPOT	ABV
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**7.5MG/VIAL POWDER FOR SUSPENSION**

00836273	LUPRON DEPOT	ABV
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**10.5MG/VIAL POWDER FOR SUSPENSION**

02248239	ELIGARD	SAC
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**11.25MG/VIAL POWDER FOR SUSPENSION**

02239834	LUPRON DEPOT	ABV
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**22.5MG/VIAL POWDER FOR SUSPENSION**

02248240	ELIGARD	SAC
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02230248	LUPRON DEPOT	ABV
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**30MG/VIAL POWDER FOR SUSPENSION**

02248999	ELIGARD	SAC
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02239833	LUPRON DEPOT	ABV
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**45MG/VIAL POWDER FOR SUSPENSION**

02268892	ELIGARD	SAC
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**LOMUSTINE****10MG CAPSULE**

00360430	CEENU	BMS
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**40MG CAPSULE**

00360422	CEENU	BMS
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**100MG CAPSULE**

00360414	CEENU	BMS
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**MEGESTROL ACETATE****40MG/ML SUSPENSION**

02168979	MEGACE	BMS
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**40MG TABLET**

02195917	MEGESTROL	AAP
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**160MG TABLET**

02195925	MEGESTROL	AAP
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**MELPHALAN****2MG TABLET**

00004715	ALKERAN	ASP
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**MERCAPTOPYRINE****50MG TABLET**

02415275	MERCAPTOPYRINE	RAX
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00004723	PURINETHOL	TEV
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**METHOTREXATE (METHOTREXATE DISODIUM)****2.5MG TABLET**

02170698	PMS-METHOTREXATE	PMS
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**METHOTREXATE SODIUM****10MG/0.4ML SOLUTION**

02422174	METHOTREXATE	PMS
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**10:00.00 ANTINEOPLASTIC AGENTS****METHOTREXATE SODIUM****10MG/ML SOLUTION**

02182947 METHOTREXATE PFI

**15MG/0.6ML SOLUTION**

02422182 METHOTREXATE PMS

**20MG/0.8ML SOLUTION**

02422190 METHOTREXATE PMS

**25MG/ML SOLUTION**

02419173 JAMP-METHOTREXATE JMP

02099705 METHOTREXATE TEV

02182777 METHOTREXATE PFI

02182955 METHOTREXATE PFI

02398427 METHOTREXATE SDZ

02417626 METHOTREXATE MYL

02422166 METHOTREXATE PMS

02422204 METHOTREXATE PMS

**2.5MG TABLET**

02182963 APO-METHOTREXATE PFI

02244798 RATIO-METHOTREXATE TEV

**10MG TABLET**

02182750 METHOTREXATE PFI

**MITOTANE****500MG TABLET**

00463221 LYSODREN BMS

**NILUTAMIDE****50MG TABLET**

02221861 ANANDRON SAC

**PAZOPANIB (PAZOPANIB HYDROCHLORIDE)**

Limited use benefit (prior approval required).

Initial coverage criteria ( 12 months)

For the first-line treatment of patients with advanced or metastatic clear cell renal carcinoma; AND  
Patient has an ECOG performance status of 0 to 2.

Renewal coverage criteria (12 months)

There is no objective evidence of disease progression.

**200MG TABLET**

02352303 VOTRIENT NVR

**10:00.00 ANTINEOPLASTIC AGENTS****PONATINIB HYDROCHLORIDE**

Limited use benefit (prior approval required).

Criteria for initial six (6) month coverage:

- For the treatment of patients who have confirmed T315i mutation positive disease, independent of previous TKI therapy; OR
  - Treatment of last resort for patients with intolerances or contraindications to imatinib and all other second generation TKI's (dasatinib, nilotinib, bosutinib); OR
  - For the treatment of patients with chronic phase chronic myeloid leukemia (CML) who have resistance/disease progression after at least two prior lines of TKI therapy where lclusig would be available as third-line TKI option; OR
  - For the treatment of patients with accelerated phase or blast phase CML or Ph+ ALL who have resistance or disease progression after at least one second generation TKI therapy; AND
  - An ECOG performance status of 0 to 2.
- Note: Second generation TKI's (dasatinib, nilotinib, bosutinib) are not covered as options after ponatinib.

Criteria for assessment every six (6) month:

- There is no objective evidence of disease progression.

**15MG TABLET**

02437333 ICLUSIG ARI

**45MG TABLET**

02437341 ICLUSIG ARI

**PROCARBAZINE HYDROCHLORIDE****50MG CAPSULE**

00012750 MATULANE UNK

**RITUXIMAB**

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Granulomatosis polyangiitis according to established criteria.
- Microscopic polyangiitis according to established criteria.

(Please refer to Appendix A).

**10MG/ML SOLUTION**

02241927 RITUXAN HLR

**SUNITINIB MALATE**

Limited use benefit (Prior approval required).

Criteria for initial six month coverage of Sutent:

- For patients with histologically proven unresectable or recurrent/metastatic GIST who have failed or are unable to tolerate imatinib therapy.
- Sunitinib will not be funded concomitantly with imatinib.

Criteria for assessment at every six months:

- There is no objective evidence of disease progression.

**12.5MG CAPSULE**

02280795 SUTENT PFI

**25MG CAPSULE**

02280809 SUTENT PFI

**50MG CAPSULE**

02280817 SUTENT PFI

**10:00.00 ANTINEOPLASTIC AGENTS**

**TAMOXIFEN CITRATE**

**10MG TABLET**

00812404	APO-TAMOX	APX
00851965	TEVA-TAMOXIFEN	TEV

**20MG TABLET**

00812390	APO-TAMOX	APX
02048485	NOLVADEX-D	AZC
00851973	TEVA-TAMOXIFEN	TEV

**TEMOZOLOMIDE**

Limited use benefit (prior approval required).

For treatment of adult patients with glioblastoma multiform or anaplastic astrocytoma, and documented evidence of recurrence or progression after standard therapy (resection, radiotherapy, and chemotherapy).

For treatment of adult patients with newly diagnosed glioblastoma multiform concomitantly with radiotherapy and then as maintenance treatment.

**5MG CAPSULE**

02441160	ACT TEMOZOLOMIDE	ACG
02443473	TARO-TEMOZOLOMIDE	TAR
02241093	TEMODAL	FRS

**20MG CAPSULE**

02395274	ACT TEMOZOLOMIDE	ACG
02443481	TARO-TEMOZOLOMIDE	TAR
02241094	TEMODAL	FRS

**100MG CAPSULE**

02395282	ACT TEMOZOLOMIDE	ACG
02443511	TARO-TEMOZOLOMIDE	TAR
02241095	TEMODAL	FRS

**140MG CAPSULE**

02395290	ACT TEMOZOLOMIDE	ACG
02413116	APO-TEMOZOLOMIDE	APX
02443538	TARO-TEMOZOLOMIDE	TAR
02312794	TEMODAL	FRS

**250MG CAPSULE**

02395312	ACT TEMOZOLOMIDE	ACG
02443554	TARO-TEMOZOLOMIDE	TAR
02241096	TEMODAL	FRS

**THIOGUANINE**

**40MG TABLET**

00282081	LANVIS	ASP
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**TRETINOIN**

**10MG CAPSULE**

02145839	VESANOID	CHE
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**TRIPTORELIN PAMOATE**

**3.75MG/VIAL POWDER FOR SUSPENSION**

02240000	TRELSTAR	ALL
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**11.25MG/VIAL POWDER FOR SUSPENSION**

02243856	TRELSTAR	ALL
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**22.5MG POWDER FOR SUSPENSION**

02412322	TRELSTAR	ALL
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**10:00.00 ANTINEOPLASTIC AGENTS**

**VEMURAFENIB**

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for vemurafenib (Zelboraf):  
 For the first-line treatment of patients with metastatic or unresectable melanoma as monotherapy; OR  
 For the first-line treatment of patients with metastatic or unresectable melanoma in combination with cobimetinib (Cotellic).

AND for patients who meet the following criteria:  
 • Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND  
 • Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND  
 • Patient has an ECOG performance status of 0 to 1.

Renewal coverage criteria (6 months):  
 There is no objective evidence of disease progression.

<sup>ST</sup> **240MG TABLET**

02380242	ZELBORAF	HLR
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**VINCRISTINE SULFATE**

**1MG/ML SOLUTION**

02143305	VINCRISTINE SULFATE	TEV
02183013	VINCRISTINE SULFATE	PFI

**12:00 AUTONOMIC DRUGS****12:04.00 PARASYMPATHOMIMETIC AGENTS****BETHANECHOL CHLORIDE****10MG TABLET**

01947958 DUVOID PAL

**25MG TABLET**

01947931 DUVOID PAL

**50MG TABLET**

01947923 DUVOID PAL

**DONEPEZIL HYDROCHLORIDE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

<sup>ST</sup> **5MG TABLET**

02419866	ACCEL-DONEPEZIL	ACP
02397595	ACT DONEPEZIL	ACG
02362260	APO-DONEPEZIL	APX
02232043	ARICEPT	PFI
02400561	AURO-DONEPEZIL	AUR
02412853	BIO-DONEPEZIL	BMI
02402645	DONEPEZIL	ACC
02416417	DONEPEZIL	PDL
02420597	DONEPEZIL	SIV
02425343	ECL-DONEPEZIL	ECL
02404419	JAMP-DONEPEZIL	JMP
02416948	JAMP-DONEPEZIL	JMP
02402092	MAR-DONEPEZIL	MAR
02359472	MYLAN-DONEPEZIL	MYL
02439557	NAT-DONEPEZIL	NPH
02322331	PMS-DONEPEZIL	PMS
02381508	RAN-DONEPEZIL	RBV
02412918	RIVA-DONEPEZIL	RIV
02328666	SANDOZ DONEPEZIL	SDZ
02428482	SEPTA DONEPEZIL	SPT
02340607	TEVA-DONEPEZIL	TEV

<sup>ST</sup> **10MG TABLET**

02419874	ACCEL-DONEPEZIL	ACP
02397609	ACT DONEPEZIL	ACG
02362279	APO-DONEPEZIL	APX
02232044	ARICEPT	PFI
02400588	AURO-DONEPEZIL	AUR
02412861	BIO-DONEPEZIL	BMI

**12:04.00 PARASYMPATHOMIMETIC AGENTS****DONEPEZIL HYDROCHLORIDE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

<sup>ST</sup> **10MG TABLET**

02402653	DONEPEZIL	ACC
02416425	DONEPEZIL	PDL
02420600	DONEPEZIL	SIV
02425351	ECL-DONEPEZIL	ECL
02404427	JAMP-DONEPEZIL	JMP
02416956	JAMP-DONEPEZIL	JMP
02402106	MAR-DONEPEZIL	MAR
02359480	MYLAN-DONEPEZIL	MYL
02439565	NAT-DONEPEZIL	NPH
02322358	PMS-DONEPEZIL	PMS
02381516	RAN-DONEPEZIL	RBV
02412934	RIVA-DONEPEZIL	RIV
02328682	SANDOZ DONEPEZIL	SDZ
02428490	SEPTA DONEPEZIL	SPT
02340615	TEVA-DONEPEZIL	TEV

**GALANTAMINE HYDROBROMIDE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

<sup>ST</sup> **8MG CAPSULE (EXTENDED RELEASE)**

02425157	AURO-GALANTAMINE ER	AUR
02443015	GALANTAMINE	SAN
02416573	GALANTAMINE ER	PDL
02420821	MAR-GALANTAMINE ER	MAR

**12:04.00 PARASYMPATHOMIMETIC AGENTS**

**GALANTAMINE HYDROBROMIDE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

<b><sup>ST</sup> 8MG CAPSULE (EXTENDED RELEASE)</b>			
02339439	MYLAN-GALANTAMINE ER	MYL	
02316943	PAT-GALANTAMINE ER	KLA	
02398370	PMS-GALANTAMINE ER	PMS	
02377950	TEVA-GALANTAMINE ER	TEV	
<b><sup>ST</sup> 16MG CAPSULE (EXTENDED RELEASE)</b>			
02425165	AURO-GALANTAMINE ER	AUR	
02443023	GALANTAMINE	SAN	
02416581	GALANTAMINE ER	PDL	
02420848	MAR-GALANTAMINE ER	MAR	
02339447	MYLAN-GALANTAMINE ER	MYL	
02316951	PAT-GALANTAMINE ER	KLA	
02398389	PMS-GALANTAMINE ER	PMS	
02377969	TEVA-GALANTAMINE ER	TEV	
<b><sup>ST</sup> 24MG CAPSULE (EXTENDED RELEASE)</b>			
02425173	AURO-GALANTAMINE ER	AUR	
02443031	GALANTAMINE	SAN	
02416603	GALANTAMINE ER	PDL	
02420856	MAR-GALANTAMINE ER	MAR	
02339455	MYLAN-GALANTAMINE ER	MYL	
02316978	PAT-GALANTAMINE ER	KLA	
02398397	PMS-GALANTAMINE ER	PMS	
02377977	TEVA-GALANTAMINE ER	TEV	

**NEOSTIGMINE BROMIDE**

<b><sup>ST</sup> 15MG TABLET</b>			
00869945	PROSTIGMIN	VAE	

**PILOCARPINE HYDROCHLORIDE**

<b><sup>ST</sup> 5MG TABLET</b>			
02402483	PILOCARPINE HYDROCHLORIDE	RAX	
02216345	SALAGEN	PFI	

**PYRIDOSTIGMINE BROMIDE**

<b><sup>ST</sup> 60MG TABLET</b>			
00869961	MESTINON	VAE	
<b><sup>ST</sup> 180MG TABLET (EXTENDED RELEASE)</b>			
00869953	MESTINON-SR	VAE	

**12:04.00 PARASYMPATHOMIMETIC AGENTS**

**RIVASTIGMINE HYDROGEN TARTRATE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

<b><sup>ST</sup> 1.5MG CAPSULE</b>			
02336715	APO-RIVASTIGMINE	APX	
02242115	EXELON	NVR	
02401614	MED-RIVASTIGMINE	GMP	
02305984	NOVO-RIVASTIGMINE	NOP	
02306034	PMS-RIVASTIGMINE	PMS	
02311283	RATIO-RIVASTIGMINE	TEV	
02416999	RIVASTIGMINE	PDL	
02324563	SANDOZ RIVASTIGMINE	SDZ	
<b><sup>ST</sup> 3MG CAPSULE</b>			
02336723	APO-RIVASTIGMINE	APX	
02242116	EXELON	NVR	
02401622	MED-RIVASTIGMINE	GMP	
02305992	NOVO-RIVASTIGMINE	NOP	
02306042	PMS-RIVASTIGMINE	PMS	
02311291	RATIO-RIVASTIGMINE	TEV	
02417006	RIVASTIGMINE	PDL	
02324571	SANDOZ RIVASTIGMINE	SDZ	
<b><sup>ST</sup> 4.5MG CAPSULE</b>			
02336731	APO-RIVASTIGMINE	APX	
02242117	EXELON	NVR	
02401630	MED-RIVASTIGMINE	GMP	
02306018	NOVO-RIVASTIGMINE	NOP	
02306050	PMS-RIVASTIGMINE	PMS	
02311305	RATIO-RIVASTIGMINE	TEV	
02417014	RIVASTIGMINE	PDL	
02324598	SANDOZ RIVASTIGMINE	SDZ	
<b><sup>ST</sup> 6MG CAPSULE</b>			
02336758	APO-RIVASTIGMINE	APX	
02242118	EXELON	NVR	
02401649	MED-RIVASTIGMINE	GMP	
02306026	NOVO-RIVASTIGMINE	NOP	
02306069	PMS-RIVASTIGMINE	PMS	
02311313	RATIO-RIVASTIGMINE	TEV	
02417022	RIVASTIGMINE	PDL	
02324601	SANDOZ RIVASTIGMINE	SDZ	

**12:04.00 PARASYMPATHOMIMETIC AGENTS****RIVASTIGMINE HYDROGEN TARTRATE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
  - Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
  - Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
  - Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.
- Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

<sup>ST</sup> **2MG/ML SOLUTION**

02245240 EXELON

NVR

**12:08.08 ANTIMUSCARINICS / ANTISPASMODICS****ACLIDINIUM BROMIDE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

**400MCG POWDER**

02409720 TUDORZA GENUAIR

AZC

**GLYCOPYRRONIUM BROMIDE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

**50MCG CAPSULE**

02394936 SEEBRI BREEZHALER

NVR

**HYOSCINE BUTYLBROMIDE****10MG TABLET**

00363812 BUSCOPAN

SAC

**INDACATEROL MALEATE, GLYCOPYRRONIUM BROMIDE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

**110MCG & 50MCG CAPSULE**

02418282 ULTIBRO BREEZHALER

NVR

**12:08.08 ANTIMUSCARINICS / ANTISPASMODICS****IPRATROPIUM BROMIDE****0.03% AEROSOL**

02163705 ATROVENT

SAC

**0.06% AEROSOL**

02163713 ATROVENT

SAC

**20MCG/INHALATION AEROSOL**

02247686 ATROVENT HFA

BOE

**0.03% NASAL SPRAY**

02240508 DOM-IPRATROPIUM

DPC

02246083 IPRAVENT

AAP

02239627 PMS-IPRATROPIUM

PMS

**0.06% NASAL SPRAY**

02246084 IPRAVENT

AAP

**125MCG/ML SOLUTION**

02231135 PMS-IPRATROPIUM

PMS

02097176 RATIO-IPRATROPIUM UDV

TEV

**250MCG/ML SOLUTION**

02126222 APO-IPRAVENT

APX

02239131 MYLAN-IPRATROPIUM

MYL

02231136 PMS-IPRATROPIUM

PMS

02231244 PMS-IPRATROPIUM

PMS

02231245 PMS-IPRATROPIUM

PMS

99001446 RATIO-IPRATROPIUM

RPH

02097168 RATIO-IPRATROPIUM UDV

TEV

02216221 TEVA-IPRATROPIUM STERINEBS

TEV

**IPRATROPIUM BROMIDE, SALBUTAMOL SULFATE****0.2MG & 1MG/ML SOLUTION**

02231675 COMBIVENT

BOE

02243789 RATIO-IPRA SAL

TEV

02272695 TEVA-COMBO STERINEBS

TEV

**100MCG & 20MCG SOLUTION**

02419106 COMBIVENT RESPIMAT

BOE

**TIOTROPIUM BROMIDE MONOHYDRATE**

Limited use benefit (prior approval required).

For patients with chronic obstructive pulmonary disease (COPD) and who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

**18MCG CAPSULE**

02246793 SPIRIVA

BOE

**2.5MCG SOLUTION**

02435381 SPIRIVA RESPIMAT

BOE

**TRIMEBUTINE MALEATE**

Limited use benefit (prior approval required).

For the treatment and relief of symptoms associated with functional bowel disorders including Irritable Bowel Syndrome (IBS), spastic colon, spastic colitis and mucous colitis; OR In postoperative paralytic ileus in order to accelerate the resumption of the intestinal transit following abdominal surgery.

**100MG TABLET**

02349027 AA-TRIMEBUTINE

AAP

## 12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

### TRIMEBUTINE MALEATE

Limited use benefit (prior approval required).

For the treatment and relief of symptoms associated with functional bowel disorders including Irritable Bowel Syndrome (IBS), spastic colon, spastic colitis and mucous colitis; OR In postoperative paralytic ileus in order to accelerate the resumption of the intestinal transit following abdominal surgery.

#### 100MG TABLET

02245663 TRIMEBUTINE AAP

#### 200MG TABLET

02349035 AA-TRIMEBUTINE AAP

00803499 MODULON APC

02245664 TRIMEBUTINE AAP

### UMECLIDINIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

#### 62.5MCG POWDER

02423596 INCRUSE ELLIPTA GSK

### UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

#### 62.5MCG/25MCG POWDER

02418401 ANORO ELLIPTA GSK

## 12:12.04 ALPHA ADRENERGIC AGONISTS

### MIDODRINE HYDROCHLORIDE

#### 2.5MG TABLET

02278677 MIDODRINE AAP

#### 5MG TABLET

02278685 MIDODRINE AAP

## 12:12.08 BETA ADRENERGIC AGONISTS

### ACLIDINIUM BROMIDE, FORMOTEROL FUMARATE DIHYDRATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- Moderate to severe COPD, as defined by spirometry; AND
- Inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

#### 400MCG & 12MCG POWDER

02439530 DUAKLIR GENUAIR AZC

## 12:12.08 BETA ADRENERGIC AGONISTS

### FLUTICASONE FUROATE, VILANTEROL TRIFENATATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

OR

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

#### 100MCG & 25MCG POWDER

02408872 BREO ELLIPTA GSK

### FLUTICASONE FUROATE, VILANTEROL TRIFENATATE (ASTHMA)

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

#### 200MCG & 25MCG POWDER

02444186 BREO ELLIPTA GSK

### FORMOTEROL FUMARATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of a rapid-onset, short-duration bronchodilator.

OR

For the treatment of Chronic Obstructive Pulmonary Disease (COPD) in patients not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist.

#### 12MCG/CAPSULE CAPSULE

02230898 FORADIL NVR

### FORMOTEROL FUMARATE DIHYDRATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of rapid onset, short duration bronchodilator.

#### 6MCG/DOSE POWDER

02237225 OXEZE TURBUHALER AZC

#### 12MCG/DOSE POWDER

02237224 OXEZE TURBUHALER AZC

**12:12.08 BETA ADRENERGIC AGONISTS**

**FORMOTEROL FUMARATE DIHYDRATE, BUDESONIDE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

OR

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

- 6MCG & 100MCG/INHALATION POWDER**  
02245385 SYMBICORT 100 TURBUHALER AZC
- 6MCG & 200MCG/INHALATION POWDER**  
02245386 SYMBICORT 200 TURBUHALER AZC

**FORMOTEROL FUMARATE DIHYDRATE, MOMETASONE FUROATE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of rapid onset, short duration bronchodilator.

- 5MCG & 100MCG/INHALATION AEROSOL**  
02361752 ZENHALE FRS
- 5MCG & 200MCG/INHALATION AEROSOL**  
02361760 ZENHALE FRS
- 5MCG & 50MCG/INHALATION AEROSOL**  
02361744 ZENHALE FRS

**INDACATEROL MALEATE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

- 75MCG CAPSULE**  
02376938 ONBREZ BREEZHALER NVR

**OLODATEROL HYDROCHLORIDE, TIOTROPIUM BROMIDE MONOHYDRATE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

- 2.5MCG & 2.5MCG SOLUTION**  
02441888 INSPIOLTO RESPIMAT BOE

**ORCIPRENALINE SULFATE**

- 2MG/ML SYRUP**  
02236783 ORCIPRENALINE AAP

**12:12.08 BETA ADRENERGIC AGONISTS**

**SALBUTAMOL SULFATE**

- 100MCG/INHALATION AEROSOL**  
02232570 AIROMIR VAE  
02245669 APO-SALVENT CFC FREE APX  
02326450 NOVO-SALBUTAMOL HFA TEV  
02419858 SALBUTAMOL HFA SAN  
02241497 VENTOLIN HFA GSK

- 0.5MG/ML SOLUTION**  
02208245 PMS-SALBUTAMOL PMS  
02239365 RATIO-SALBUTAMOL TEV

- 1MG/ML SOLUTION**  
02216949 DOM-SALBUTAMOL DPC  
02208229 PMS-SALBUTAMOL PMS  
01986864 RATIO-SALBUTAMOL TEV  
01926934 TEVA-SALBUTAMOL TEV  
02213419 VENTOLIN P.F GSK

- 2MG/ML SOLUTION**  
02208237 PMS-SALBUTAMOL PMS  
02173360 TEVA-SALBUTAMOL TEV  
02213427 VENTOLIN P.F GSK

- 5MG/ML SOLUTION**  
02139324 DOM-SALBUTAMOL DPC  
00860808 RATIO-SALBUTAMOL TEV  
02213486 VENTOLIN RESPIRATOR GSK

- 2MG TABLET**  
02146843 APO-SALVENT APX

- 4MG TABLET**  
02146851 APO-SALVENT APX

**SALMETEROL XINAFOATE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of a rapid-onset, short-duration bronchodilator.

OR

For the treatment of Chronic Obstructive Pulmonary Disease (COPD) in patients not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist.

- 50MCG/INHALATION POWDER**  
02214261 SEREVENT DISKHALER GSK  
02231129 SEREVENT DISKUS GSK

### 12:12.08 BETA ADRENERGIC AGONISTS SALMETEROL XINAFOATE, FLUTICASONE PROPIONATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

OR

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

#### 25MCG & 125MCG AEROSOL

02245126 ADVAIR 125 GSK

#### 25MCG & 250MCG AEROSOL

02245127 ADVAIR 250 GSK

#### 50MCG & 100MCG POWDER

02240835 ADVAIR 100 DISKUS GSK

#### 50MCG & 250MCG POWDER

02240836 ADVAIR 250 DISKUS GSK

#### 50MCG & 500MCG POWDER

02240837 ADVAIR 500 DISKUS GSK

### TERBUTALINE SULFATE

#### 500MCG/INHALATION POWDER

00786616 BRICANYL TURBUHALER AZC

### 12:12.12 ALPHA AND BETA ADRENERGIC AGONISTS

#### EPINEPHRINE

##### 0.15MG SOLUTION

02382059 ALLERJECT KAL

##### 0.3MG SOLUTION

02382067 ALLERJECT KAL

##### 0.5MG/ML SOLUTION

00578657 EPIPEN JR MYL

##### 1MG/ML SOLUTION

00155357 ADRENALIN ERF

00721891 EPINEPHRINE HOS

00509558 EPIPEN MYL

### 12:16.00 SYMPATHOLYTIC AGENTS

#### DIHYDROERGOTAMINE MESYLATE

##### 1MG/ML LIQUID

00027243 DIHYDROERGOTAMINE RAX

##### 4MG/ML LIQUID

02228947 MIGRANAL RAX

### 12:16.04 ALPHA-ADRENERGIC BLOCKING AGENTS

#### ALFUZOSIN HYDROCHLORIDE

##### <sup>ST</sup> 10MG TABLET (EXTENDED RELEASE)

02414759 ALFUZOSIN PDL

02447576 ALFUZOSIN SIV

### 12:16.04 ALPHA-ADRENERGIC BLOCKING AGENTS

#### ALFUZOSIN HYDROCHLORIDE

##### <sup>ST</sup> 10MG TABLET (EXTENDED RELEASE)

02315866 APO-ALFUZOSIN APX

02443201 AURO-ALFUZOSIN AUR

02304678 SANDOZ ALFUZOSIN SDZ

02314282 TEVA-ALFUZOSIN PR TEV

02245565 XATRAL SAC

#### TAMSULOSIN HYDROCHLORIDE

##### <sup>ST</sup> 0.4MG CAPSULE (SUSTAINED RELEASE)

02294265 RATIO-TAMSULOSIN TEV

09857334 RATIO-TAMSULOSIN RPH

02319217 SANDOZ TAMSULOSIN SDZ

02281392 TEVA-TAMSULOSIN TEV

##### <sup>ST</sup> 0.4MG TABLET (EXTENDED RELEASE)

02362406 APO-TAMSULOSIN APX

02270102 FLOMAX BOE

02340208 SANDOZ TAMSULOSIN SDZ

02413612 TAMSULOSIN PDL

02427117 TAMSULOSIN SAN

02429667 TAMSULOSIN SIV

02368242 TEVA-TAMSULOSIN TEV

### 12:20.04 CENTRALL ACTING SKELETAL MUSCLE RELAXANTS

#### CYCLOBENZAPRINE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

For relief of muscle spasm associated with acute, painful musculoskeletal conditions. Coverage is limited to 60mg per day for three (3) weeks renewable every two (2) months.

##### 10MG TABLET

02177145 APO-CYCLOBENZAPRINE APX

02348853 AURO-CYCLOBENZAPRINE AUR

02220644 CYCLOBENZAPRINE PDL

02287064 CYCLOBENZAPRINE SAN

02424584 CYCLOBENZAPRINE SIV

02238633 DOM-CYCLOBENZAPRINE DPC

02357127 JAMP-CYCLOBENZAPRINE JMP

02231353 MYLAN-CYCLOBENZAPRINE MYL

02249359 PHL-CYCLOBENZAPRINE PHH

02212048 PMS-CYCLOBENZAPRINE PMS

02242079 RIVA-CYCLOBENZAPRINE RIV

02080052 TEVA-CYCLOBENZAPRINE TEV

#### TIZANIDINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For treatment of spasticity in patients with multiple sclerosis, who have failed therapy with or are intolerant to baclofen.

##### 4MG TABLET

02239170 PAL-TIZANIDINE PAL

02259893 TIZANIDINE AAP

**12:20.08 DIRECT-ACTING SKELETAL  
MUSCLE RELAXANTS****DANTROLENE SODIUM****25MG CAPSULE**

01997602 DANTRIUM PPH

**12:20.12 GABA-DERIVATIVE SKELETAL  
MUSCLE RELAXANTS****BACLOFEN****10MG TABLET**

02139332	APO-BACLOFEN	APX
02152584	BACLOFEN	PDL
02287021	BACLOFEN	SAN
02138271	DOM-BACLOFEN	DPC
00455881	LIORESAL	NVR
02088398	MYLAN-BACLOFEN	MYL
02236963	PHL-BACLOFEN	PHH
02063735	PMS-BACLOFEN	PMS
02236507	RATIO-BACLOFEN	TEV
02242150	RIVA-BACLOFEN	RIV

**20MG TABLET**

02139391	APO-BACLOFEN	APX
02152592	BACLOFEN	PDL
02287048	BACLOFEN	SAN
02138298	DOM-BACLOFEN	DPC
00636576	LIORESAL	NVR
02088401	MYLAN-BACLOFEN	MYL
02236964	PHL-BACLOFEN	PHH
02063743	PMS-BACLOFEN	PMS
02236508	RATIO-BACLOFEN	TEV
02242151	RIVA-BACLOFEN	RIV

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99503011 BACLOFEN ORAL LIQUID UNK

**12:92.00 MISCELLANEOUS AUTONOMIC  
DRUGS****NICOTINE (GUM)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

## For smoking cessation:

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.

**<sup>ST</sup> 2MG GUM**

02091933	NICORETTE GUM	KIM
80015240	RUGBY NICOTINE POLACRILEX GUM	ACG
80000396	THRIVE NICOTINELL GUM	GSK

**<sup>ST</sup> 4MG GUM**

02091941	NICORETTE GUM	KIM
80000118	NICOTINE GUM	PER
80000402	THRIVE NICOTINELL GUM	NVC

**12:92.00 MISCELLANEOUS AUTONOMIC  
DRUGS****NICOTINE (INHALER)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

## For smoking cessation:

Coverage is limited to 945 doses 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.

**<sup>ST</sup> 10MG SPRAY**

02241742 NICORETTE INHALER KIM

**NICOTINE (LOZENGE)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

## For smoking cessation:

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.

**<sup>ST</sup> 1MG LOZENGE**

80007461 THRIVE NICOTINE LOZENGES NVC

**<sup>ST</sup> 2MG LOZENGE**

02247347 NICORETTE LOZENGE KIM

80007464 THRIVE NICOTINE LOZENGES NVC

**<sup>ST</sup> 4MG LOZENGE**

02247348 NICORETTE LOZENGE KIM

**NICOTINE (PATCH)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

## For smoking cessation:

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.

**<sup>ST</sup> 5MG PATCH**

02028697 NICOTROL TRANSDERMAL UNK

**<sup>ST</sup> 7MG PATCH**

01943057 HABITROL NVC

80044393 TRANSDERMAL NICOTINE ACG

**<sup>ST</sup> 10MG PATCH**

02029405 NICOTROL TRANSDERMAL UNK

**<sup>ST</sup> 14MG PATCH**

01943065 HABITROL NVC

80013549 NICOTINE TRANSDERMAL SYSTEM ADD

80044392 TRANSDERMAL NICOTINE ACG

**<sup>ST</sup> 15MG PATCH**

02029413 NICOTROL TRANSDERMAL UNK

## 12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

### NICOTINE (PATCH)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

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.

#### <sup>ST</sup> 18MG PATCH

02241227	TRANSDERMAL NICOTINE PATCHDAY	NVC
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#### <sup>ST</sup> 21MG PATCH

01943073	HABITROL	NVC
02241228	NICOTINE TRANSDERMAL	NVC
80014250	NICOTINE TRANSDERMAL SYSTEM	ADD
80044389	TRANSDERMAL NICOTINE	ACG

#### <sup>ST</sup> 35MG PATCH

02241226	TRANSDERMAL NICOTINE PATCHDAY	NVC
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#### <sup>ST</sup> 36MG PATCH

02093111	NICODERM	KIM
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#### <sup>ST</sup> 78MG PATCH

02093138	NICODERM	KIM
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#### <sup>ST</sup> 114MG PATCH

02093146	NICODERM	KIM
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### VARENICLINE TARTRATE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage will be limited to 165 tablets 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 varenicline (Champix®) when one year has elapsed from the day the initial prescription was filled.

#### <sup>ST</sup> 0.5MG TABLET

02291177	CHAMPIX	PFI
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#### <sup>ST</sup> 0.5MG & 1MG TABLET

02298309	CHAMPIX STARTER PACK	PFI
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#### <sup>ST</sup> 1MG TABLET

02291185	CHAMPIX	PFI
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## 20:00 BLOOD FORMATION COAGULATION AND THROMBOSIS

### 20:04.04 IRON PREPARATIONS

#### FERROUS FUMARATE

##### <sup>ST</sup> 300MG CAPSULE

02237556	EURO-FER	EUR
00482064	NEO-FER	NEB
01923420	PALAFER	VAE

##### <sup>ST</sup> 20MG SUSPENSION

80029822	JAMP-FERROUS FUMARATE	JMP
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##### <sup>ST</sup> 60MG/ML SUSPENSION

01923439	PALAFER	VAE
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##### <sup>ST</sup> 300MG/5ML SUSPENSION

02246590	FERRATE	EUR
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##### <sup>ST</sup> 300MG TABLET

80024544	JAMP FERROUS FUMARATE	JMP
00031089	JAMP-FERROUS FUMARATE	WAM

#### FERROUS GLUCONATE

##### <sup>ST</sup> 300MG TABLET

00545031	APO-FERROUS GLUCONATE	APX
00031097	FERROUS GLUCONATE	JMP
00041157	FERROUS GLUCONATE	ADA
02244532	FERROUS GLUCONATE	PMT
80002426	FERROUS GLUCONATE	WNP
80006316	FERROUS GLUCONATE	GFP
80009681	FERROUS GLUCONATE	WAM
80000435	NOVO-FERROGLUC	NUR

##### <sup>ST</sup> 324MG TABLET

00582727	FERROUS GLUCONATE	VTH
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#### FERROUS SULFATE

##### <sup>ST</sup> 30MG/ML LIQUID

80008295	JAMP FERROUS SULFATE LIQUID5	JMP
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##### <sup>ST</sup> 75MG/ML LIQUID

00762954	ENFAMIL FERINSOL	MJO
80008309	JAMP FERROUS SULFATE	JMP

##### <sup>ST</sup> 15MG/ML ORAL LIQUID

02237385	FERODAN INFANT DROPS	ODN
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##### <sup>ST</sup> 30MG/ML ORAL LIQUID

00758469	FERODAN	ODN
00792675	PMS-FERROUS SULFATE	PMS

##### <sup>ST</sup> 125MG/ML ORAL LIQUID

00816035	PMS-FERROUS SULFATE	PMS
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##### <sup>ST</sup> 6MG/ML SOLUTION

00017884	FER-INSYR	MJO
02242863	PEDIAFER	EUR

##### <sup>ST</sup> 15MG/ML SOLUTION

02232202	PEDIAFER	EUR
02222574	PMS-FERROUS SULFATE	PMS

##### <sup>ST</sup> 60MG TABLET

80012039	IRON	WNP
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##### <sup>ST</sup> 300MG TABLET

02246733	EURO-FERROUS SULFATE	EUR
02248699	FERODAN	ODN

### 20:04.04 IRON PREPARATIONS

#### FERROUS SULFATE

##### <sup>ST</sup> 300MG TABLET

00346918	FERROUS SULFATE	PMT
00782114	FERROUS SULFATE	VTH
00031100	JAMP-FERROUS SULFATE	JMP
80057416	M-SULFATE FERREUX	MAN
00586323	PMS-FERROUS SULFATE	PMS

#### IRON

##### <sup>ST</sup> 100MG CAPSULE

80024232	JAMP-FER	JMP
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##### 12.5MG/ML LIQUID

02243333	FERRLECIT	SAC
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#### IRON DEXTRAN

##### 50MG/ML LIQUID

02205963	DEXIRON	LUI
02221780	INFUFER	SDZ

#### IRON SUCROSE

##### 20MG/ML LIQUID

02243716	VENOFER	LUI
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##### PDIN FOR EXTEMPOREANEOUS MIXTURE

99506015	IRON SUCROSE STERILE INFUSION	UNK
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#### POLYSACCHARIDE IRON COMPLEX

Limited use benefit (prior approval not required).

For children 12 years of age or under.

##### 15MG POWDER

80033717	FERAMAX POWDER WATER SOLUBLE POLYSACCHARIDE IRON COMPLEX	BSY
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### 20:12.04 ANTICOAGULANTS

#### ACENOCOUMAROL

##### <sup>ST</sup> 1MG TABLET

00010383	SINTROM	PAL
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##### <sup>ST</sup> 4MG TABLET

00010391	SINTROM	PAL
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#### APIXABAN

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score  $\geq 1$ ) with non-valvular atrial fibrillation who require apixaban for the prevention of stroke and systemic embolism AND in whom:

- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

OR

For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)

##### <sup>ST</sup> 2.5MG TABLET

02377233	ELIQUIS	BMS
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**20:12.04 ANTICOAGULANTS**

**APIXABAN**

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score  $\geq 1$ ) with non-valvular atrial fibrillation who require apixaban for the prevention of stroke and systemic embolism AND in whom:

- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

OR

For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)

<sup>ST</sup> **5MG TABLET**

02397714 ELIQUIS BMS

**DABIGATRAN ETEXILATE MESILATE**

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score  $\geq 1$ ) with non-valvular atrial fibrillation who require dabigatran etexilate for the prevention of stroke and systemic embolism AND in whom:

- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

<sup>ST</sup> **110MG CAPSULE**

02312441 PRADAXA BOE

<sup>ST</sup> **150MG CAPSULE**

02358808 PRADAXA BOE

**DALTEPARIN SODIUM**

**2,500IU/0.2ML SOLUTION**  
02132621 FRAGMIN PFI

**3,500IU/0.28ML SOLUTION**  
02430789 FRAGMIN PFI

**5,000IU/0.2ML SOLUTION**  
02132648 FRAGMIN PFI

**7,500IU/0.3ML SOLUTION**  
02352648 FRAGMIN PFI

**10,000IU/0.4ML SOLUTION**  
02352656 FRAGMIN PFI

**10,000IU/ML SOLUTION**  
02132664 FRAGMIN PFI

**12,500IU/0.5ML SOLUTION**  
02352664 FRAGMIN PFI

**15,000IU/0.6ML SOLUTION**  
02352672 FRAGMIN PFI

**18,000IU/0.72ML SOLUTION**  
02352680 FRAGMIN PFI

**25,000IU/ML SOLUTION**  
02231171 FRAGMIN PFI

**20:12.04 ANTICOAGULANTS**

**ENOXAPARIN SODIUM**

**30MG/0.3ML SOLUTION**  
02012472 LOVENOX SAC

**40MG/0.4ML SOLUTION**  
02236883 LOVENOX SAC

**60MG/0.6ML SOLUTION**  
02378426 LOVENOX SAC

**80MG/0.8ML SOLUTION**  
02378434 LOVENOX SAC

**100MG/1ML SOLUTION**  
02378442 LOVENOX SAC

**150MG/1.0ML SOLUTION**  
02242692 LOVENOX HP SAC

**150MG/ML SOLUTION**  
02378469 LOVENOX HP SAC

**300MG/3ML SOLUTION**  
02236564 LOVENOX SAC

**HEPARIN SODIUM**

**100U/ML LIQUID**  
00727520 HEPARIN LEO LEO

**1,000U/ML LIQUID**  
00453811 HEPARIN LEO LEO

**10 U/ML SOLUTION**  
00725323 HEPARIN LOCK FLUSH HOS

**100 U/ML SOLUTION**  
00725315 HEPARIN LOCK FLUSH HOS

**1,000 U/ML SOLUTION**  
02303086 HEPARIN SODIUM (MULTIDOSE VIAL-WITH PRESERVATIVE) SDZ

**10,000 U/ML SOLUTION**  
02303108 HEPARIN SODIUM (MULTIDOSE VIAL-WITH PRESERVATIVE) SDZ

02303094 HEPARIN SODIUM (SINGLE USE VIAL-PRESERVATIVE FREE) SDZ

**10,000U SOLUTION**  
02392453 HEPARIN SODIUM FKD

**NADROPARIN CALCIUM**

**9,500IU/ML SOLUTION**  
02236913 FRAXIPARINE ASP

**19,000IU/ML SOLUTION**  
02240114 FRAXIPARINE FORTE ASP

**20:12.04 ANTICOAGULANTS****RIVAROXABAN**

Limited use benefit (prior approval required).

Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto) for Stroke Prevention in Atrial Fibrillation (SPAF)  
For at-risk patients (CHADS2 score  $\geq 1$ ) with non-valvular atrial fibrillation who require rivaroxaban for the prevention of stroke and systemic embolism AND in whom:

- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation is not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e., no access to INR testing service at a laboratory, clinic, pharmacy, and at home)

Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto) For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE).

<sup>ST</sup> **10MG TABLET**

02316986 XARELTO BAY

<sup>ST</sup> **15MG TABLET**

02378604 XARELTO BAY

<sup>ST</sup> **20MG TABLET**

02378612 XARELTO BAY

**TINZAPARIN SODIUM****2,500IU/0.25ML SOLUTION**

02229755 INNOHEP LEO

**3,500IU/0.35ML SOLUTION**

02358158 INNOHEP LEO

**4,500IU/0.45ML SOLUTION**

02358166 INNOHEP LEO

**8,000IU/0.4ML SOLUTION**

02429462 INNOHEP LEO

**10,000IU/0.5ML SOLUTION**

02231478 INNOHEP LEO

**10,000IU/ML SOLUTION**

02167840 INNOHEP LEO

**12,000IU/0.6ML SOLUTION**

02429470 INNOHEP LEO

**14,000IU/0.7ML SOLUTION**

02358174 INNOHEP LEO

**16,000IU/0.8ML SOLUTION**

02429489 INNOHEP LEO

**18,000IU/0.9ML SOLUTION**

02358182 INNOHEP LEO

**20,000IU/ML SOLUTION**

02229515 INNOHEP LEO

**WARFARIN SODIUM**<sup>ST</sup> **1MG TABLET**

02242924 APO-WARFARIN APX

01918311 COUMADIN BMS

02242680 TARO-WARFARIN TAR

<sup>ST</sup> **2MG TABLET**

02242925 APO-WARFARIN APX

01918338 COUMADIN BMS

02242681 TARO-WARFARIN TAR

**20:12.04 ANTICOAGULANTS****WARFARIN SODIUM**<sup>ST</sup> **2.5MG TABLET**

02242926 APO-WARFARIN APX

01918346 COUMADIN BMS

02242682 TARO-WARFARIN TAR

<sup>ST</sup> **3MG TABLET**

02245618 APO-WARFARIN APX

02240205 COUMADIN BMS

02242683 TARO-WARFARIN TAR

<sup>ST</sup> **4MG TABLET**

02242927 APO-WARFARIN APX

02007959 COUMADIN BMS

02242684 TARO-WARFARIN TAR

<sup>ST</sup> **5MG TABLET**

02242928 APO-WARFARIN APX

01918354 COUMADIN BMS

02242685 TARO-WARFARIN TAR

**6MG TABLET**

02240206 COUMADIN BMS

02242686 TARO-WARFARIN TAR

<sup>ST</sup> **7.5MG TABLET**

02242697 TARO-WARFARIN TAR

<sup>ST</sup> **10MG TABLET**

02242929 APO-WARFARIN APX

01918362 COUMADIN BMS

02242687 TARO-WARFARIN TAR

**20:12.14 PLATELET AGGREGATION INHIBITORS****ANAGRELIDE HYDROCHLORIDE**<sup>ST</sup> **0.5MG CAPSULE**

02236859 AGRYLIN SHI

02274949 PMS-ANAGRELIDE PMS

02260107 SANDOZ ANAGRELIDE SDZ

**20:12.18 PLATELET AGGREGATION INHIBITORS****CLOPIDOGREL BISULFATE**<sup>ST</sup> **75MG TABLET**

02303027 ACT CLOPIDOGREL ACG

02252767 APO-CLOPIDOGREL APX

02416387 AURO-CLOPIDOGREL AUR

02385813 CLOPIDOGREL SIV

02394820 CLOPIDOGREL PDL

02400553 CLOPIDOGREL SAN

02378507 DOM-CLOPIDOGREL DPC

02415550 JAMP-CLOPIDOGREL JMP

02422255 MAR-CLOPIDOGREL MAR

02408910 MINT-CLOPIDOGREL MIN

02351536 MYLAN-CLOPIDOGREL MYL

02238682 PLAVIX SAC

02348004 PMS-CLOPIDOGREL PMS

02379813 RAN-CLOPIDOGREL RBY

02388529 RIVA-CLOPIDOGREL RIV

02359316 SANDOZ CLOPIDOGREL SDZ

02293161 TEVA-CLOPIDOGREL TEV

**20:12.18 PLATELET AGGREGATION INHIBITORS**

**TICAGRELOR**

Limited use benefit (prior approval not required).

For the treatment of Acute Coronary Syndrome, defined as unstable angina or myocardial infarction, when initiated in hospital in consultation with a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery. Treatment must be in combination with low dose ASA. Special authorization may be granted for 12 months.

<sup>ST</sup> **90MG TABLET**  
02368544 BRILINTA AZC

**TICLOPIDINE HYDROCHLORIDE**

<sup>ST</sup> **250MG TABLET**  
02237701 APO-TICLOPIDINE APX  
02236848 TEVA-TICLOPIDINE TEV

**20:16.00 HEMATOPOIETIC AGENTS**

**FILGRASTIM**

**300MCG/ML INJECTION**  
09853464 NEUPOGEN (ON) AMG  
99001454 NEUPOGEN (QC) AMG

**300MCG SOLUTION**  
02441489 GRASTOFIL APX

**300MCG/ML SOLUTION**  
01968017 NEUPOGEN AMG

**480MCG SOLUTION**  
02454548 GRASTOFIL APX

**PEGFILGRASTIM**

Limited use benefit (prior approval required).

**CHEMOTHERAPY SUPPORT**

**Primary Prophylaxis**  
For use in previously untreated patients receiving a moderate to severely myelosuppressive chemotherapy regimen (i.e. ≥40% incidence of febrile neutropenia). Febrile neutropenia is defined as a temperature ≥38.5°C or >38.0°C three times in a 24 hour period and neutropenia with an absolute neutrophil count (ANC) <0.5 x 10<sup>9</sup>/L.

**Secondary Prophylaxis**  
For use in patients receiving myelosuppressive chemotherapy who have experienced an episode of febrile neutropenic sepsis or profound neutropenia in a previous cycle of chemotherapy; OR  
For use in patients who have experienced a dose reduction or treatment delay longer than one week, due to neutropenia.

The recommended dosage of pegfilgrastim is a single subcutaneous injection of 6 mg, administered once per cycle of chemotherapy. Pegfilgrastim should be administered no sooner than 24 hours after the administration of cytotoxic chemotherapy.

**10MG/ML SOLUTION**  
02249790 NEULASTA AMG

**20:16.00 HEMATOPOIETIC AGENTS  
PLERIXAFOR**

Limited use benefit (prior approval not required).

For use in combination with filgrastim to mobilize hematopoietic stem cells for subsequent autologous transplantation in patients with:

- Non-Hodgkin's lymphoma (NHL); OR
- Multiple myeloma (MM);

AND

- Prescribed by an oncologist or hematologist.

AND if one of the following are met

- A PBCD34+ count of < 10 cells/uL after 4 days of filgrastim; OR
- Less than 50% of the target CD34 yield is achieved on the 1st day of apheresis (after being mobilized with filgrastim alone or following chemotherapy); OR
- If a patient has failed a previous stem cell mobilization with filgrastim alone or following chemotherapy.

Reimbursement is limited to a maximum of 4 doses (0.24mg/kg given daily) for a single mobilization attempt. The dose of Mozobil is limited to a maximum of 40mg per day

**20MG SOLUTION**  
02377225 MOZOBIL SAC

**20:24.00 HEMORRHOLOGIC AGENTS**

**PENTOXIFYLLINE**

<sup>ST</sup> **400MG TABLET (EXTENDED RELEASE)**  
02230090 PENTOXIFYLLINE AAP

**20:28.16 HEMOSTATICS**

**TRANEXAMIC ACID**

**500MG TABLET**  
02064405 CYKLOKAPRON PFI  
02409097 GD-TRANEXAMIC ACID PFI  
02401231 TRANEXAMIC ACID RAX

**PDIN FOR EXTEMPORANEOUS MIXTURE**  
99503006 TRANEXAMIC DENTAL MOUTHWASH UNK

**24:00 CARDIOVASCULAR DRUGS****24:04.04 ANTIARRHYTHMIC AGENTS****AMIODARONE HYDROCHLORIDE****<sup>ST</sup> 100MG TABLET**

02292173 PMS-AMIODARONE PMS

**<sup>ST</sup> 200MG TABLET**

02364336 AMIODARONE SAN

02385465 AMIODARONE SIV

02246194 APO-AMIODARONE APX

02246331 DOM-AMIODARONE DPC

02240604 MYLAN-AMIODARONE MYL

02245781 PHL-AMIODARONE PHH

02242472 PMS-AMIODARONE PMS

02309661 PRO-AMIODARONE PDL

02247217 RIVA-AMIODARONE RIV

02243836 SANDOZ AMIODARONE SDZ

02239835 TEVA-AMIODARONE TEV

**<sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE**

99503016 AMIODARONE ORAL LIQUID UNK

**DISOPYRAMIDE****<sup>ST</sup> 100MG CAPSULE**

02224801 RYTHMODAN SAC

**FLECAINIDE ACETATE****<sup>ST</sup> 50MG TABLET**

02275538 FLECAINIDE AAP

01966197 TAMBOCOR VAE

**<sup>ST</sup> 100MG TABLET**

02275546 FLECAINIDE AAP

01966200 TAMBOCOR VAE

**MEXILETINE HYDROCHLORIDE****<sup>ST</sup> 100MG CAPSULE**

02230359 TEVA-MEXILETINE TEV

**<sup>ST</sup> 200MG CAPSULE**

02230360 TEVA-MEXILETINE TEV

**PROCAINAMIDE HYDROCHLORIDE****<sup>ST</sup> 250MG CAPSULE**

00713325 APO-PROCAINAMIDE APX

**<sup>ST</sup> 375MG CAPSULE**

00713333 APO-PROCAINAMIDE APX

**<sup>ST</sup> 500MG CAPSULE**

00713341 APO-PROCAINAMIDE APX

**<sup>ST</sup> 250MG TABLET (EXTENDED RELEASE)**

00638692 PROCAN SR ERF

**PROPAFENONE HYDROCHLORIDE****<sup>ST</sup> 150MG TABLET**

02243324 APO-PROPAFENONE APX

02245372 MYLAN-PROPAFENONE MYL

02294559 PMS-PROPAFENONE PMS

02343053 PROPAFENONE SAN

00603708 RYTHMOL BGP

**<sup>ST</sup> 300MG TABLET**

02243325 APO-PROPAFENONE APX

02245373 MYLAN-PROPAFENONE MYL

02294575 PMS-PROPAFENONE PMS

**24:04.04 ANTIARRHYTHMIC AGENTS****PROPAFENONE HYDROCHLORIDE****<sup>ST</sup> 300MG TABLET**

02343061 PROPAFENONE SAN

00603716 RYTHMOL BGP

**24:04.08 CARDIOTONIC AGENTS****DIGOXIN****<sup>ST</sup> 0.05MG/ML SOLUTION**

02242320 TOLOXIN PED

**<sup>ST</sup> 0.0625MG TABLET**

02335700 TOLOXIN PED

**<sup>ST</sup> 0.125MG TABLET**

02335719 TOLOXIN PED

**<sup>ST</sup> 0.250MG TABLET**

02335727 TOLOXIN PED

**24:06.04 BILE ACID SEQUESTRANTS****CHOLESTYRAMINE RESIN****<sup>ST</sup> 4G POWDER FOR SUSPENSION**

02455609 CHOLESTYRAMINE-ODAN ODN

00890960 OLESTYR PMS

02210320 OLESTYR PMS

**COLESEVELAM HYDROCHLORIDE****<sup>ST</sup> 625MG TABLET**

02373955 LODALIS VAE

**COLESTIPOL HYDROCHLORIDE****<sup>ST</sup> 5G GRANULES**

00642975 COLESTID PFI

02132699 COLESTID ORANGE PFI

**<sup>ST</sup> 1G TABLET**

02132680 COLESTID PFI

**24:06.05 CHOLESTEROL ABSORPTION INHIBITORS****EZETIMIBE****<sup>ST</sup> 10MG TABLET**

02414716 ACT EZETIMIBE ACG

02427826 APO-EZETIMIBE APX

02422549 EZETIMIBE PDL

02429659 EZETIMIBE SIV

02431300 EZETIMIBE SAN

02247521 EZETROL FRS

02423235 JAMP-EZETIMIBE JMP

02422662 MAR-EZETIMIBE MAR

02423243 MINT-EZETIMIBE MIN

02416409 PMS-EZETIMIBE PMS

02425238 PRIVA-EZETIMIBE PHA

02419548 RAN-EZETIMIBE RBY

02424436 RIVA-EZETIMIBE RIV

02416778 SANDOZ EZETIMIBE SDZ

02354101 TEVA-EZETIMIBE TEV

**24:06.06 FIBRIC ACID DERIVATIVES****BEZAFIBRATE****<sup>ST</sup> 200MG TABLET**

02240331 PMS-BEZAFIBRATE PMS

**<sup>ST</sup> 400MG TABLET (EXTENDED RELEASE)**

02083523 BEZALIP SR ACG

02453312 JAMP-BEZAFIBRATE JMP

**FENOFIBRATE****<sup>ST</sup> 67MG CAPSULE**

02243180 APO-FENO-MICRO APX

**<sup>ST</sup> 100MG CAPSULE**

02225980 APO-FENOFIBRATE APX

**<sup>ST</sup> 160MG CAPSULE**

02250004 FENOMAX CIP

**<sup>ST</sup> 200MG CAPSULE**

02239864 APO-FENO-MICRO APX

02240360 FENO-MICRO PDL

02250039 RATIO-FENOFIBRATE TEV

**<sup>ST</sup> 48MG TABLET**

02269074 LIPIDIL EZ BGP

02390698 SANDOZ FENOFIBRATE E SDZ

**<sup>ST</sup> 100MG TABLET**

02246859 APO-FENO-SUPER APX

02310228 PRO-FENO-SUPER PDL

02288044 SANDOZ FENOFIBRATE S SDZ

02289083 TEVA-FENOFIBRATE-S TEV

**<sup>ST</sup> 145MG TABLET**

02269082 LIPIDIL EZ BGP

02390701 SANDOZ FENOFIBRATE E SDZ

**<sup>ST</sup> 160MG TABLET**

02246860 APO-FENO-SUPER APX

02241602 LIPIDIL SUPRA BGP

02310236 PRO-FENO-SUPER PDL

02288052 SANDOZ FENOFIBRATE S SDZ

02289091 TEVA-FENOFIBRATE-S TEV

**GEMFIBROZIL****<sup>ST</sup> 300MG CAPSULE**

01979574 APO-GEMFIBROZIL APX

02241608 DOM-GEMFIBROZIL DPC

02239951 PMS-GEMFIBROZIL PMS

02241704 TEVA-GEMFIBROZIL TEV

**<sup>ST</sup> 600MG TABLET**

01979582 APO-GEMFIBROZIL APX

02142074 TEVA-GEMFIBROZIL TEV

**24:06.08 HMG-COA REDUCTASE****INHIBITORS****ATORVASTATIN CALCIUM****<sup>ST</sup> 10MG TABLET**

02295261 APO-ATORVASTATIN APX

02346486 ATORVASTATIN PDL

02348705 ATORVASTATIN SAN

02387891 ATORVASTATIN SIV

02396424 ATORVASTATIN APX

02411350 ATORVASTATIN-10 SIV

02407256 AURO-ATORVASTATIN AUR

**24:06.08 HMG-COA REDUCTASE****INHIBITORS****ATORVASTATIN CALCIUM****<sup>ST</sup> 10MG TABLET**

02355612 DOM-ATORVASTATIN DPC

02399482 DOM-ATORVASTATIN DPC

02391058 JAMP-ATORVASTATIN JMP

02230711 LIPITOR PFI

02392933 MYLAN-ATORVASTATIN MYL

02313448 PMS-ATORVASTATIN PMS

02399377 PMS-ATORVASTATIN PMS

02313707 RAN-ATORVASTATIN RBY

02350297 RATIO-ATORVASTATIN TEV

02417936 REDDY-ATORVASTATIN REC

02422751 RIVA-ATORVASTATIN RIV

02324946 SANDOZ ATORVASTATIN SDZ

02310899 TEVA-ATORVASTATIN TEV

**<sup>ST</sup> 20MG TABLET**

02295288 APO-ATORVASTATIN APX

02346494 ATORVASTATIN PDL

02348713 ATORVASTATIN SAN

02387905 ATORVASTATIN SIV

02396432 ATORVASTATIN APX

02411369 ATORVASTATIN-20 SIV

02407264 AURO-ATORVASTATIN AUR

02355620 DOM-ATORVASTATIN DPC

02399490 DOM-ATORVASTATIN DPC

02391066 JAMP-ATORVASTATIN JMP

02230713 LIPITOR PFI

02392941 MYLAN-ATORVASTATIN MYL

02313456 PMS-ATORVASTATIN PMS

02399385 PMS-ATORVASTATIN PMS

02313715 RAN-ATORVASTATIN RBY

02350319 RATIO-ATORVASTATIN TEV

02417944 REDDY-ATORVASTATIN REC

02422778 RIVA-ATORVASTATIN RIV

02324954 SANDOZ ATORVASTATIN SDZ

02310902 TEVA-ATORVASTATIN TEV

**<sup>ST</sup> 40MG TABLET**

02295296 APO-ATORVASTATIN APX

02346508 ATORVASTATIN PDL

02348721 ATORVASTATIN SAN

02387913 ATORVASTATIN SIV

02396440 ATORVASTATIN APX

02411377 ATORVASTATIN-40 SIV

02407272 AURO-ATORVASTATIN AUR

02355639 DOM-ATORVASTATIN DPC

02399504 DOM-ATORVASTATIN DPC

02391074 JAMP-ATORVASTATIN JMP

02230714 LIPITOR PFI

02392968 MYLAN-ATORVASTATIN MYL

02313464 PMS-ATORVASTATIN PMS

02399393 PMS-ATORVASTATIN PMS

02313723 RAN-ATORVASTATIN RBY

02350327 RATIO-ATORVASTATIN TEV

02417952 REDDY-ATORVASTATIN REC

02422786 RIVA-ATORVASTATIN RIV

**24:06.08 HMG-COA REDUCTASE  
INHIBITORS****ATORVASTATIN CALCIUM****<sup>ST</sup> 40MG TABLET**

02324962	SANDOZ ATORVASTATIN	SDZ
02310910	TEVA-ATORVASTATIN	TEV

**<sup>ST</sup> 80MG TABLET**

02295318	APO-ATORVASTATIN	APX
02346516	ATORVASTATIN	PDL
02348748	ATORVASTATIN	SAN
02387921	ATORVASTATIN	SIV
02396459	ATORVASTATIN	APX
02411385	ATORVASTATIN-80	SIV
02407280	AURO-ATORVASTATIN	AUR
02391082	JAMP-ATORVASTATIN	JMP
02243097	LIPITOR	PFI
02392976	MYLAN-ATORVASTATIN	MYL
02313472	PMS-ATORVASTATIN	PMS
02399407	PMS-ATORVASTATIN	PMS
02313758	RAN-ATORVASTATIN	RBV
02350335	RATIO-ATORVASTATIN	TEV
02417960	REDDY-ATORVASTATIN	REC
02422794	RIVA-ATORVASTATIN	RIV
02324970	SANDOZ ATORVASTATIN	SDZ
02310929	TEVA-ATORVASTATIN	TEV

**FLUVASTATIN SODIUM****<sup>ST</sup> 20MG CAPSULE**

02061562	LESCOL	NVR
02400235	SANDOZ FLUVASTATIN	SDZ
02299224	TEVA-FLUVASTATIN	TEV

**<sup>ST</sup> 40MG CAPSULE**

02061570	LESCOL	NVR
02400243	SANDOZ FLUVASTATIN	SDZ
02299232	TEVA-FLUVASTATIN	TEV

**<sup>ST</sup> 80MG TABLET (EXTENDED RELEASE)**

02250527	LESCOL XL	NVR
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**LOVASTATIN****<sup>ST</sup> 20MG TABLET**

02248572	ACT LOVASTATIN	ACG
02220172	APO-LOVASTATIN	APX
02353229	LOVASTATIN	SAN
02246013	PMS-LOVASTATIN	PMS
02312670	PRO-LOVASTATIN	PDL
02272288	RIVA-LOVASTATIN	RIV
02247056	SANDOZ LOVASTATIN	SDZ
02246542	TEVA-LOVASTATIN	TEV

**<sup>ST</sup> 40MG TABLET**

02248573	ACT LOVASTATIN	ACG
02220180	APO-LOVASTATIN	APX
02353237	LOVASTATIN	SAN
02246014	PMS-LOVASTATIN	PMS
02312689	PRO-LOVASTATIN	PDL
02272296	RIVA-LOVASTATIN	RIV
02247057	SANDOZ LOVASTATIN	SDZ
02246543	TEVA-LOVASTATIN	TEV

**24:06.08 HMG-COA REDUCTASE  
INHIBITORS****PRAVASTATIN SODIUM****<sup>ST</sup> 10MG TABLET**

02248182	ACT PRAVASTATIN	ACG
02243506	APO-PRAVASTATIN	APX
02249723	DOM-PRAVASTATIN	DPC
02330954	JAMP-PRAVASTATIN	JMP
02317451	MINT-PRAVASTATIN	MIN
02247655	PMS-PRAVASTATIN	PMS
02356546	PRAVASTATIN	SAN
02389703	PRAVASTATIN	SIV
02243824	PRAVASTATIN-10	PDL
02284421	RAN-PRAVASTATIN	RBV
02270234	RIVA-PRAVASTATIN	RIV
02247008	TEVA-PRAVASTATIN	TEV

**<sup>ST</sup> 20MG TABLET**

02248183	ACT PRAVASTATIN	ACG
02243507	APO-PRAVASTATIN	APX
02249731	DOM-PRAVASTATIN	DPC
02330962	JAMP-PRAVASTATIN	JMP
02317478	MINT-PRAVASTATIN	MIN
02257106	MYLAN-PRAVASTATIN	MYL
02247656	PMS-PRAVASTATIN	PMS
00893757	PRAVACHOL	BMS
02356554	PRAVASTATIN	SAN
02389738	PRAVASTATIN	SIV
02243825	PRAVASTATIN-20	PDL
02284448	RAN-PRAVASTATIN	RBV
02270242	RIVA-PRAVASTATIN	RIV
02247009	TEVA-PRAVASTATIN	TEV

**<sup>ST</sup> 40MG TABLET**

02248184	ACT PRAVASTATIN	ACG
02243508	APO-PRAVASTATIN	APX
02249758	DOM-PRAVASTATIN	DPC
02330970	JAMP-PRAVASTATIN	JMP
02317486	MINT-PRAVASTATIN	MIN
02247657	PMS-PRAVASTATIN	PMS
02222051	PRAVACHOL	BMS
02356562	PRAVASTATIN	SAN
02389746	PRAVASTATIN	SIV
02243826	PRAVASTATIN-40	PDL
02284456	RAN-PRAVASTATIN	RBV
02270250	RIVA-PRAVASTATIN	RIV
02247010	TEVA-PRAVASTATIN	TEV

**ROSUVASTATIN CALCIUM****<sup>ST</sup> 5MG TABLET**

02339765	ACT ROSUVASTATIN	ACG
02337975	APO-ROSUVASTATIN	APX
02442574	AURO-ROSUVASTATIN	AUR
02265540	CRESTOR	AZC
02386704	DOM-ROSUVASTATIN	DPC
02391252	JAMP-ROSUVASTATIN	JMP
02413051	MAR-ROSUVASTATIN	MAR
02399164	MED-ROSUVASTATIN	GMP
02397781	MINT-ROSUVASTATIN	MIN

**24:06.08 HMG-COA REDUCTASE  
INHIBITORS**

**ROSUVASTATIN CALCIUM**

<sup>ST</sup> **5MG TABLET**

02381265	MYLAN-ROSUVASTATIN	MYL
02378523	PMS-ROSUVASTATIN	PMS
02382644	RAN-ROSUVASTATIN	RBY
02380013	RIVA-ROSUVASTATIN	RIV
02381176	ROSUVASTATIN	PDL
02389037	ROSUVASTATIN	SIV
02405628	ROSUVASTATIN	SAN
02411628	ROSUVASTATIN-5	SIV
02338726	SANDOZ ROSUVASTATIN	SDZ
02354608	TEVA-ROSUVASTATIN	TEV

<sup>ST</sup> **10MG TABLET**

02339773	ACT ROSUVASTATIN	ACG
02337983	APO-ROSUVASTATIN	APX
02442582	AURO-ROSUVASTATIN	AUR
02247162	CRESTOR	AZC
02386712	DOM-ROSUVASTATIN	DPC
02391260	JAMP-ROSUVASTATIN	JMP
02413078	MAR-ROSUVASTATIN	MAR
02399172	MED-ROSUVASTATIN	GMP
02397803	MINT-ROSUVASTATIN	MIN
02381273	MYLAN-ROSUVASTATIN	MYL
02378531	PMS-ROSUVASTATIN	PMS
02382652	RAN-ROSUVASTATIN	RBY
02380056	RIVA-ROSUVASTATIN	RIV
02381184	ROSUVASTATIN	PDL
02389045	ROSUVASTATIN	SIV
02405636	ROSUVASTATIN	SAN
02411636	ROSUVASTATIN-10	SIV
02338734	SANDOZ ROSUVASTATIN	SDZ
02354616	TEVA-ROSUVASTATIN	TEV

<sup>ST</sup> **20MG TABLET**

02339781	ACT ROSUVASTATIN	ACG
02337991	APO-ROSUVASTATIN	APX
02442590	AURO-ROSUVASTATIN	AUR
02247163	CRESTOR	AZC
02386720	DOM-ROSUVASTATIN	DPC
02391279	JAMP-ROSUVASTATIN	JMP
02413086	MAR-ROSUVASTATIN	MAR
02399180	MED-ROSUVASTATIN	GMP
02397811	MINT-ROSUVASTATIN	MIN
02381281	MYLAN-ROSUVASTATIN	MYL
02378558	PMS-ROSUVASTATIN	PMS
02382660	RAN-ROSUVASTATIN	RBY
02380064	RIVA-ROSUVASTATIN	RIV
02381192	ROSUVASTATIN	PDL
02389053	ROSUVASTATIN	SIV
02405644	ROSUVASTATIN	SAN
02411644	ROSUVASTATIN-20	SIV
02338742	SANDOZ ROSUVASTATIN	SDZ
02354624	TEVA-ROSUVASTATIN	TEV

<sup>ST</sup> **40MG TABLET**

02339803	ACT ROSUVASTATIN	ACG
02338009	APO-ROSUVASTATIN	APX

**24:06.08 HMG-COA REDUCTASE  
INHIBITORS**

**ROSUVASTATIN CALCIUM**

<sup>ST</sup> **40MG TABLET**

02442604	AURO-ROSUVASTATIN	AUR
02247164	CRESTOR	AZC
02391287	JAMP-ROSUVASTATIN	JMP
02413108	MAR-ROSUVASTATIN	MAR
02399199	MED-ROSUVASTATIN	GMP
02397838	MINT-ROSUVASTATIN	MIN
02381303	MYLAN-ROSUVASTATIN	MYL
02378566	PMS-ROSUVASTATIN	PMS
02382679	RAN-ROSUVASTATIN	RBY
02380102	RIVA-ROSUVASTATIN	RIV
02381206	ROSUVASTATIN	PDL
02389061	ROSUVASTATIN	SIV
02405652	ROSUVASTATIN	SAN
02411652	ROSUVASTATIN-40	SIV
02338750	SANDOZ ROSUVASTATIN	SDZ
02354632	TEVA-ROSUVASTATIN	TEV

**SIMVASTATIN**

<sup>ST</sup> **5MG TABLET**

02248103	ACT SIMVASTATIN	ACG
02247011	APO-SIMVASTATIN	APX
02405148	AURO-SIMVASTATIN	AUR
02253747	DOM-SIMVASTATIN	DPC
02281619	DOM-SIMVASTATIN	DPC
02375591	JAMP-SIMVASTATIN	JMP
02375036	MAR-SIMVASTATIN	MAR
02372932	MINT-SIMVASTATIN	MIN
02246582	MYLAN-SIMVASTATIN	MYL
02281546	PHL-SIMVASTATIN	PHH
02252619	PMS-SIMVASTATIN	PMS
02269252	PMS-SIMVASTATIN	PMS
02329131	RAN-SIMVASTATIN	RBY
02247297	RIVA-SIMVASTATIN	RIV
02247827	SANDOZ SIMVASTATIN	SDZ
02284723	SIMVASTATIN	SAN
02386291	SIMVASTATIN	SIV
02250144	TEVA-SIMVASTATIN	TEV

<sup>ST</sup> **10MG TABLET**

02248104	ACT SIMVASTATIN	ACG
02247012	APO-SIMVASTATIN	APX
02405156	AURO-SIMVASTATIN	AUR
02253755	DOM-SIMVASTATIN	DPC
02281627	DOM-SIMVASTATIN	DPC
02375605	JAMP-SIMVASTATIN	JMP
02375044	MAR-SIMVASTATIN	MAR
02372940	MINT-SIMVASTATIN	MIN
02246583	MYLAN-SIMVASTATIN	MYL
02281554	PHL-SIMVASTATIN	PHH
02252635	PMS-SIMVASTATIN	PMS
02269260	PMS-SIMVASTATIN	PMS
02329158	RAN-SIMVASTATIN	RBY
02247298	RIVA-SIMVASTATIN	RIV
02247828	SANDOZ SIMVASTATIN	SDZ

**24:06.08 HMG-COA REDUCTASE  
INHIBITORS****SIMVASTATIN****<sup>ST</sup> 10MG TABLET**

02284731	SIMVASTATIN	SAN
02386305	SIMVASTATIN	SIV
02247221	SIMVASTATIN-10	PDL
02250152	TEVA-SIMVASTATIN	TEV
00884332	ZOCOR	FRS

**<sup>ST</sup> 20MG TABLET**

02248105	ACT SIMVASTATIN	ACG
02247013	APO-SIMVASTATIN	APX
02405164	AURO-SIMVASTATIN	AUR
02253763	DOM-SIMVASTATIN	DPC
02281635	DOM-SIMVASTATIN	DPC
02375613	JAMP-SIMVASTATIN	JMP
02375052	MAR-SIMVASTATIN	MAR
02372959	MINT-SIMVASTATIN	MIN
02246737	MYLAN-SIMVASTATIN	MYL
02281562	PHL-SIMVASTATIN	PHH
02252643	PMS-SIMVASTATIN	PMS
02269279	PMS-SIMVASTATIN	PMS
02329166	RAN-SIMVASTATIN	RBY
02247299	RIVA-SIMVASTATIN	RIV
02247830	SANDOZ SIMVASTATIN	SDZ
02284758	SIMVASTATIN	SAN
02386313	SIMVASTATIN	SIV
02247222	SIMVASTATIN-20	PDL
02250160	TEVA-SIMVASTATIN	TEV
00884340	ZOCOR	FRS

**<sup>ST</sup> 40MG TABLET**

02248106	ACT SIMVASTATIN	ACG
02247014	APO-SIMVASTATIN	APX
02405172	AURO-SIMVASTATIN	AUR
02253771	DOM-SIMVASTATIN	DPC
02281643	DOM-SIMVASTATIN	DPC
02375621	JAMP-SIMVASTATIN	JMP
02375060	MAR-SIMVASTATIN	MAR
02372967	MINT-SIMVASTATIN	MIN
02246584	MYLAN-SIMVASTATIN	MYL
02281570	PHL-SIMVASTATIN	PHH
02252651	PMS-SIMVASTATIN	PMS
02269287	PMS-SIMVASTATIN	PMS
02329174	RAN-SIMVASTATIN	RBY
02247300	RIVA-SIMVASTATIN	RIV
02247831	SANDOZ SIMVASTATIN	SDZ
02284766	SIMVASTATIN	SAN
02386321	SIMVASTATIN	SIV
02247223	SIMVASTATIN-40	PDL
02250179	TEVA-SIMVASTATIN	TEV
00884359	ZOCOR	FRS

**<sup>ST</sup> 80MG TABLET**

02248107	ACT SIMVASTATIN	ACG
02247015	APO-SIMVASTATIN	APX
02405180	AURO-SIMVASTATIN	AUR
02253798	DOM-SIMVASTATIN	DPC
02281651	DOM-SIMVASTATIN	DPC

**24:06.08 HMG-COA REDUCTASE  
INHIBITORS****SIMVASTATIN****<sup>ST</sup> 80MG TABLET**

02375648	JAMP-SIMVASTATIN	JMP
02375079	MAR-SIMVASTATIN	MAR
02372975	MINT-SIMVASTATIN	MIN
02246585	MYLAN-SIMVASTATIN	MYL
02281589	PHL-SIMVASTATIN	PHH
02252678	PMS-SIMVASTATIN	PMS
02269295	PMS-SIMVASTATIN	PMS
02329182	RAN-SIMVASTATIN	RBY
02247301	RIVA-SIMVASTATIN	RIV
02247833	SANDOZ SIMVASTATIN	SDZ
02284774	SIMVASTATIN	SAN
02386348	SIMVASTATIN	SIV
02247224	SIMVASTATIN-80	PDL
02250187	TEVA-SIMVASTATIN	TEV

**24:08.16 CENTRAL ALPHA-AGONISTS****CLONIDINE HYDROCHLORIDE****<sup>ST</sup> 0.025MG TABLET**

02304163	TEVA-CLONIDINE	TEV
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**<sup>ST</sup> 0.1MG TABLET**

02046121	TEVA-CLONIDINE	TEV
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**<sup>ST</sup> 0.2MG TABLET**

00868957	APO-CLONIDINE	APX
02046148	TEVA-CLONIDINE	TEV

**<sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE**

99503021	CLONIDINE ORAL LIQUID	UNK
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**METHYLDOPA****<sup>ST</sup> 125MG TABLET**

00360252	METHYLDOPA	AAP
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**<sup>ST</sup> 250MG TABLET**

00360260	METHYLDOPA	AAP
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**<sup>ST</sup> 500MG TABLET**

00426830	METHYLDOPA	AAP
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**METHYLDOPA, HYDROCHLOROTHIAZIDE****<sup>ST</sup> 250MG & 15MG TABLET**

00441708	APO METHAZIDE	APX
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**<sup>ST</sup> 250MG & 25MG TABLET**

00441716	APO METHAZIDE	APX
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**24:08.20 DIRECT VASODILATORS****DIAZOXIDE****<sup>ST</sup> 100MG CAPSULE**

00503347	PROGLYCEM	FRS
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**HYDRALAZINE HYDROCHLORIDE****<sup>ST</sup> 10MG TABLET**

00441619	APO-HYDRALAZINE	APX
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**<sup>ST</sup> 25MG TABLET**

00441627	APO-HYDRALAZINE	APX
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**<sup>ST</sup> 50MG TABLET**

00441635	APO-HYDRALAZINE	APX
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**24:08.20 DIRECT VASODILATORS**

**MINOXIDIL**

<sup>ST</sup> 2.5MG TABLET		
00514497 LONITEN		PFI
<sup>ST</sup> 10MG TABLET		
00514500 LONITEN		PFI

**24:12.08 NITRATES AND NITRITES**

**ISOSORBIDE DINITRATE**

<sup>ST</sup> 5MG TABLET		
00670944 ISDN		AAP
<sup>ST</sup> 10MG TABLET		
00441686 ISDN		AAP
00786667 PMS-ISOSORBIDE		PMS
<sup>ST</sup> 30MG TABLET		
00441694 ISDN		AAP

**ISOSORBIDE-5-MONONITRATE**

<sup>ST</sup> 60MG TABLET (EXTENDED RELEASE)		
02272830 APO-ISMN		APX
02126559 IMDUR		AZC
02301288 PMS-ISMN		PMS
02311321 PRO-ISMN		PDL

**NITROGLYCERIN**

<b>2% OINTMENT</b>		
01926454 NITROL		PAL
<sup>ST</sup> 0.2MG PATCH		
02162806 MINITRAN		VAE
02407442 MYLAN-NITRO		MYL
01911910 NITRO-DUR		FRS
00584223 TRANSDERM-NITRO		NVR
02230732 TRINIPATCH		PAL
<sup>ST</sup> 0.4MG PATCH		
02163527 MINITRAN		VAE
02407450 MYLAN-NITRO		MYL
01911902 NITRO-DUR		FRS
00852384 TRANSDERM-NITRO		NVR
02230733 TRINIPATCH		PAL
<sup>ST</sup> 0.6MG PATCH		
02163535 MINITRAN		VAE
02407469 MYLAN-NITRO		MYL
01911929 NITRO-DUR		FRS
02046156 TRANSDERM-NITRO		NVR
02230734 TRINIPATCH		PAL
<sup>ST</sup> 0.8MG PATCH		
02407477 MYLAN-NITRO		MYL
02011271 NITRO-DUR		FRS
<b>0.4MG PUMP</b>		
02393433 APO-NITROGLYCERIN		APX
02243588 MYLAN-NITRO		MYL
02231441 NITROLINGUAL PUMPSPRAY		SAC
02238998 RHO-NITRO PUMPSPRAY		SDZ
<sup>ST</sup> 0.3MG TABLET		
00037613 NITROSTAT		PFI
<sup>ST</sup> 0.6MG TABLET		
00037621 NITROSTAT		PFI

**24:12.12 PHOSPHODIESTERASE INHIBITORS**

**SILDENAFIL CITRATE**

Limited use benefit (prior approval required).

Must be initiated by a Pulmonary Hypertension specialist

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.

<sup>ST</sup> 20MG TABLET			
02418118 APO-SILDENAFIL R			APX
02412179 PMS-SILDENAFIL R			PMS
02319500 RATIO-SILDENAFIL R			TEV
02279401 REVATIO			PFI

**TADALAFIL**

Limited use benefit (prior approval required).

Must be initiated by a Pulmonary Hypertension specialist

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.

<sup>ST</sup> 20MG TABLET			
02338327 ADCIRCA			LIL
02421933 APO-TADALAFIL PAH			APX

**24:12.92 MISCELLANEOUS VASODILATING AGENTS**

**AMBRISENTAN**

Limited use benefit (prior approval required).

Maximum dose covered is 10 mg once 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; AND

- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

<sup>ST</sup> 5MG TABLET			
02307065 VOLIBRIS			GSK
<sup>ST</sup> 10MG TABLET			
02307073 VOLIBRIS			GSK

## 24:12.92 MISCELLANEOUS VASODILATING AGENTS

### BOSENTAN MONOHYDRATE

Limited use benefit (prior approval required).

Maximum dose covered is 125 mg twice 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; AND

- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

#### <sup>ST</sup> 62.5MG TABLET

02386194	ACT BOSENTAN	ACG
02399202	APO-BOSENTAN	APX
02383497	MYLAN-BOSENTAN	MYL
02383012	PMS-BOSENTAN	PMS
02386275	SANDOZ BOSENTAN	SDZ
02244981	TRACLEER	ACN

#### <sup>ST</sup> 125MG TABLET

02386208	ACT BOSENTAN	ACG
02383500	MYLAN-BOSENTAN	MYL
02383020	PMS-BOSENTAN	PMS
02386283	SANDOZ BOSENTAN	SDZ
02244982	TRACLEER	ACN

### DIPYRIDAMOLE

#### <sup>ST</sup> 25MG TABLET

00895644	APO-DIPYRIDAMOLE	APX
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#### <sup>ST</sup> 50MG TABLET

00571245	APO-DIPYRIDAMOLE	APX
00895652	APO-DIPYRIDAMOLE	APX

#### <sup>ST</sup> 75MG TABLET

00601845	APO-DIPYRIDAMOLE	APX
00895660	APO-DIPYRIDAMOLE	APX

### DIPYRIDAMOLE, ACETYSALICYLIC ACID

#### <sup>ST</sup> 200MG & 25MG CAPSULE

02242119	AGGRENOX	BOE
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## 24:20.00 ALPHA ADRENERGIC BLOCKING AGENTS

### DOXAZOSIN MESYLATE

#### <sup>ST</sup> 1MG TABLET

02240588	APO-DOXAZOSIN	APX
01958100	CARDURA-1	PFI
02244527	PMS-DOXAZOSIN	PMS
02242728	TEVA-DOXAZOSIN	TEV

#### <sup>ST</sup> 2MG TABLET

02240589	APO-DOXAZOSIN	APX
01958097	CARDURA-2	PFI
02244528	PMS-DOXAZOSIN	PMS
02242729	TEVA-DOXAZOSIN	TEV

#### <sup>ST</sup> 4MG TABLET

02240590	APO-DOXAZOSIN	APX
01958119	CARDURA-4	PFI

## 24:20.00 ALPHA ADRENERGIC BLOCKING AGENTS

### DOXAZOSIN MESYLATE

#### <sup>ST</sup> 4MG TABLET

02244529	PMS-DOXAZOSIN	PMS
02242730	TEVA-DOXAZOSIN	TEV

### PRAZOSIN HYDROCHLORIDE

#### <sup>ST</sup> 1MG TABLET

00882801	APO-PRAZO	APX
00560952	MINIPRESS	ERF
01934198	TEVA-PRAZOSIN	TEV

#### <sup>ST</sup> 2MG TABLET

00882828	APO-PRAZO	APX
00560960	MINIPRESS	ERF
01934201	TEVA-PRAZOSIN	TEV

#### <sup>ST</sup> 5MG TABLET

00882836	APO-PRAZO	APX
00560979	MINIPRESS	ERF
01934228	TEVA-PRAZOSIN	TEV

### TERAZOSIN HYDROCHLORIDE

#### <sup>ST</sup> 1MG TABLET

02234502	APO-TERAZOSIN	APX
02243746	DOM-TERAZOSIN	DPC
02243518	PMS-TERAZOSIN	PMS
02237476	TERAZOSIN	PDL
02350475	TERAZOSIN	SAN
02230805	TEVA-TERAZOSIN	TEV

#### <sup>ST</sup> 2MG TABLET

02234503	APO-TERAZOSIN	APX
02243747	DOM-TERAZOSIN	DPC
02243519	PMS-TERAZOSIN	PMS
02237477	TERAZOSIN	PDL
02350483	TERAZOSIN	SAN
02230806	TEVA-TERAZOSIN	TEV

#### <sup>ST</sup> 5MG TABLET

02234504	APO-TERAZOSIN	APX
02243748	DOM-TERAZOSIN	DPC
02243520	PMS-TERAZOSIN	PMS
02237478	TERAZOSIN	PDL
02350491	TERAZOSIN	SAN
02230807	TEVA-TERAZOSIN	TEV

#### <sup>ST</sup> 10MG TABLET

02234505	APO-TERAZOSIN	APX
02243749	DOM-TERAZOSIN	DPC
02243521	PMS-TERAZOSIN	PMS
02237479	TERAZOSIN	PDL
02350505	TERAZOSIN	SAN
02230808	TEVA-TERAZOSIN	TEV

## 24:24.00 BETA ADRENERGIC BLOCKING AGENTS

### ACEBUTOLOL HYDROCHLORIDE

#### <sup>ST</sup> 100MG TABLET

02164396	ACEBUTOLOL	PDL
02286246	ACEBUTOLOL	SAN
02147602	APO-ACEBUTOLOL	APX

**24:24.00 BETA ADRENERGIC BLOCKING AGENTS**

**ACEBUTOLOL HYDROCHLORIDE**

**<sup>ST</sup> 100MG TABLET**

02237721	MYLAN-ACEBUTOLOL	MYL
02237885	MYLAN-ACEBUTOLOL (TYPE S)	MYL
01926543	SECTRAL	SAC
02204517	TEVA-ACEBUTOLOL	TEV

**<sup>ST</sup> 200MG TABLET**

02164418	ACEBUTOLOL	PDL
02286254	ACEBUTOLOL	SAN
02147610	APO-ACEBUTOLOL	APX
02237722	MYLAN-ACEBUTOLOL	MYL
02237886	MYLAN-ACEBUTOLOL (TYPE S)	MYL
01926551	SECTRAL	SAC
02204525	TEVA-ACEBUTOLOL	TEV

**<sup>ST</sup> 400MG TABLET**

02164426	ACEBUTOLOL	PDL
02286262	ACEBUTOLOL	SAN
02147629	APO-ACEBUTOLOL	APX
02237723	MYLAN-ACEBUTOLOL	MYL
02237887	MYLAN-ACEBUTOLOL (TYPE S)	MYL
02204533	TEVA-ACEBUTOLOL	TEV

**ATENOLOL**

**<sup>ST</sup> 25MG TABLET**

02247182	ATENOLOL	SIV
02326701	ATENOLOL	PDL
02392194	BIO-ATENOLOL	BMI
02367556	JAMP-ATENOLOL	JMP
02371979	MAR-ATENOLOL	MAR
02368013	MINT-ATENOL	MIN
02303647	MYLAN-ATENOLOL	MYL
02246581	PMS-ATENOLOL	PMS
02373963	RAN-ATENOLOL	RBY
02277379	RIVA-ATENOLOL	RIV
02368633	SEPTA-ATENOLOL	SPT
02266660	TEVA-ATENOLOL	TEV

**<sup>ST</sup> 50MG TABLET**

02255545	ACT ATENOLOL	ACG
00773689	APO-ATENOL	APX
00828807	ATENOLOL	PDL
02238316	ATENOLOL	SIV
02392178	BIO-ATENOLOL	BMI
02229467	DOM-ATENOLOL	DPC
02367564	JAMP-ATENOLOL	JMP
02371987	MAR-ATENOLOL	MAR
02368021	MINT-ATENOL	MIN
02146894	MYLAN-ATENOLOL	MYL
02237600	PMS-ATENOLOL	PMS
02267985	RAN-ATENOLOL	RBY
02171791	RATIO-ATENOLOL	TEV
02242094	RIVA-ATENOLOL	RIV
02368641	SEPTA-ATENOLOL	SPT
02039532	TENORMIN	AZC

**<sup>ST</sup> 100MG TABLET**

02255553	ACT ATENOLOL	ACG
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**24:24.00 BETA ADRENERGIC BLOCKING AGENTS**

**ATENOLOL**

**<sup>ST</sup> 100MG TABLET**

00773697	APO-ATENOL	APX
00828793	ATENOLOL	PDL
02238318	ATENOLOL	SIV
02392186	BIO-ATENOLOL	BMI
02229468	DOM-ATENOLOL	DPC
02367572	JAMP-ATENOLOL	JMP
02371995	MAR-ATENOLOL	MAR
02368048	MINT-ATENOL	MIN
02147432	MYLAN-ATENOLOL	MYL
02237601	PMS-ATENOLOL	PMS
02267993	RAN-ATENOLOL	RBY
02171805	RATIO-ATENOLOL	TEV
02242093	RIVA-ATENOLOL	RIV
02368668	SEPTA-ATENOLOL	SPT
02039540	TENORMIN	AZC

**ATENOLOL, CHLORTHALIDONE**

**<sup>ST</sup> 50MG & 25MG TABLET**

02248763	APO-ATENIDONE	APX
02049961	TENORETIC	AZC
02302918	TEVA-ATENOLOL/CHLORTHALIDONE	TEV

**<sup>ST</sup> 100MG & 25MG TABLET**

02248764	APO-ATENIDONE	APX
02049988	TENORETIC	AZC
02302926	TEVA-ATENOLOL/CHLORTHALIDONE	TEV

**BISOPROLOL FUMARATE**

**<sup>ST</sup> 5MG TABLET**

02256134	APO-BISOPROLOL	APX
02383055	BISOPROLOL	SIV
02391589	BISOPROLOL	SAN
02302632	PMS-BISOPROLOL	PMS
02306999	PRO-BISOPROLOL	PDL
02247439	SANDOZ BISOPROLOL	SDZ
02267470	TEVA-BISOPROLOL	TEV

**<sup>ST</sup> 10MG TABLET**

02256177	APO-BISOPROLOL	APX
02383063	BISOPROLOL	SIV
02391597	BISOPROLOL	SAN
02302640	PMS-BISOPROLOL	PMS
02307006	PRO-BISOPROLOL	PDL
02247440	SANDOZ BISOPROLOL	SDZ
02267489	TEVA-BISOPROLOL	TEV

**CARVEDILOL**

**<sup>ST</sup> 3.125MG TABLET**

02247933	APO-CARVEDILOL	APX
02418495	AURO-CARVEDILOL	AUR
02248752	CARVEDILOL	SIV
02324504	CARVEDILOL	PDL
02364913	CARVEDILOL	SAN
02248748	DOM-CARVEDILOL	DPC
02368897	JAMP-CARVEDILOL	JMP

**24:24.00 BETA ADRENERGIC BLOCKING AGENTS****CARVEDILOL****<sup>ST</sup> 3.125MG TABLET**

02347512	MYLAN-CARVEDILOL	MYL
02245914	PMS-CARVEDILOL	PMS
02268027	RAN-CARVEDILOL	RBV
02252309	RATIO-CARVEDILOL	TEV

**<sup>ST</sup> 6.25MG TABLET**

02247934	APO-CARVEDILOL	APX
02418509	AURO-CARVEDILOL	AUR
02248753	CARVEDILOL	SIV
02324512	CARVEDILOL	PDL
02364921	CARVEDILOL	SAN
02248749	DOM-CARVEDILOL	DPC
02368900	JAMP-CARVEDILOL	JMP
02347520	MYLAN-CARVEDILOL	MYL
02245915	PMS-CARVEDILOL	PMS
02268035	RAN-CARVEDILOL	RBV
02252317	RATIO-CARVEDILOL	TEV

**<sup>ST</sup> 12.5MG TABLET**

02247935	APO-CARVEDILOL	APX
02418517	AURO-CARVEDILOL	AUR
02248754	CARVEDILOL	SIV
02324520	CARVEDILOL	PDL
02364948	CARVEDILOL	SAN
02248750	DOM-CARVEDILOL	DPC
02368919	JAMP-CARVEDILOL	JMP
02347555	MYLAN-CARVEDILOL	MYL
02245916	PMS-CARVEDILOL	PMS
02268043	RAN-CARVEDILOL	RBV
02252325	RATIO-CARVEDILOL	TEV

**<sup>ST</sup> 25MG TABLET**

02247936	APO-CARVEDILOL	APX
02418525	AURO-CARVEDILOL	AUR
02248755	CARVEDILOL	SIV
02324539	CARVEDILOL	PDL
02364956	CARVEDILOL	SAN
02248751	DOM-CARVEDILOL	DPC
02368927	JAMP-CARVEDILOL	JMP
02245917	PMS-CARVEDILOL	PMS
02268051	RAN-CARVEDILOL	RBV
02252333	RATIO-CARVEDILOL	TEV

**HYDROCHLOROTHIAZIDE, PINDOLOL****<sup>ST</sup> 10MG & 25MG TABLET**

00568627	VISKAZIDE	TPC
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**<sup>ST</sup> 10MG & 50MG TABLET**

00568635	VISKAZIDE	TPC
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**LABETALOL HYDROCHLORIDE****<sup>ST</sup> 100MG TABLET**

02106272	TRANDATE	PAL
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**<sup>ST</sup> 200MG TABLET**

02106280	TRANDATE	PAL
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**24:24.00 BETA ADRENERGIC BLOCKING AGENTS****METOPROLOL TARTRATE****<sup>ST</sup> 25MG TABLET**

02246010	APO-METOPROLOL	APX
02252252	DOM-METOPROLOL-L	DPC
02356813	JAMP-METOPROLOL-L	JMP
02296713	METOPROLOL	PDL
02442116	METOPROLOL-L	SIV
02248855	PMS-METOPROLOL-L	PMS
02315300	RIVA-METOPROLOL L	RIV
02261898	TEVA-METOPROLOL	TEV

**<sup>ST</sup> 50MG TABLET**

00618632	APO METOPROLOL	APX
00749354	APO METOPROLOL (TYPE L)	APX
02172550	DOM-METOPROLOL-B	DPC
02231121	DOM-METOPROLOL-L	DPC
02356821	JAMP-METOPROLOL-L	JMP
00397423	LOPRESOR	NVR
00648019	METOPROLOL	PDL
02350394	METOPROLOL	SAN
02442124	METOPROLOL-L	SIV
02145413	PMS-METOPROLOL-B	PMS
02230803	PMS-METOPROLOL-L	PMS
02315319	RIVA-METOPROLOL L	RIV
02354187	SANDOZ METOPROLOL (TYPE L)	SDZ
00648035	TEVA-METOPROLOL	TEV
00842648	TEVA-METOPROLOL	TEV

**<sup>ST</sup> 100MG TABLET**

00618640	APO METOPROLOL	APX
00751170	APO-METOPROLOL (TYPE L)	APX
02172569	DOM-METOPROLOL-B	DPC
02231122	DOM-METOPROLOL-L	DPC
02356848	JAMP-METOPROLOL-L	JMP
00397431	LOPRESOR	NVR
00648027	METOPROLOL	PDL
02350408	METOPROLOL	SAN
02442132	METOPROLOL-L	SIV
02145421	PMS-METOPROLOL-B	PMS
02230804	PMS-METOPROLOL-L	PMS
02315327	RIVA-METOPROLOL L	RIV
02354195	SANDOZ METOPROLOL (TYPE L)	SDZ
00648043	TEVA-METOPROLOL	TEV
00842656	TEVA-METOPROLOL	TEV

**<sup>ST</sup> 100MG TABLET (EXTENDED RELEASE)**

02285169	APO-METOPROLOL SR	APX
00658855	LOPRESOR SR	NVR
02351404	METOPROLOL SR	PDL
02303396	SANDOZ METOPROLOL SR	SDZ

**<sup>ST</sup> 200MG TABLET (EXTENDED RELEASE)**

02285177	APO-METOPROLOL SR	APX
00534560	LOPRESOR SR	NVR
02351412	METOPROLOL SR	PDL
02303418	SANDOZ METOPROLOL SR	SDZ

**<sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE**

99503015	METOPROLOL ORAL LIQUID	UNK
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**24:24.00 BETA ADRENERGIC BLOCKING AGENTS****NADOLOL****<sup>ST</sup> 40MG TABLET**

00782505 NADOLOL

AAP

**<sup>ST</sup> 80MG TABLET**

00782467 NADOLOL

AAP

**<sup>ST</sup> 160MG TABLET**

00782475 NADOLOL

AAP

**PINDOLOL****<sup>ST</sup> 5MG TABLET**

00755877 APO-PINDOL

APX

02231650 DOM-PINDOLOL

DPC

00828416 PINDOLOL

PDL

00869007 TEVA-PINDOLOL

TEV

00417270 VISKEN

TPC

**<sup>ST</sup> 10MG TABLET**

00755885 APO-PINDOL

APX

02238046 DOM-PINDOLOL

DPC

00828424 PINDOLOL

PDL

00869015 TEVA-PINDOLOL

TEV

00443174 VISKEN

TPC

**<sup>ST</sup> 15MG TABLET**

00755893 APO-PINDOL

APX

02238047 DOM-PINDOLOL

DPC

02231539 PMS-PINDOLOL

PMS

00869023 TEVA-PINDOLOL

TEV

**PROPRANOLOL HYDROCHLORIDE****<sup>ST</sup> 60MG CAPSULE (SUSTAINED RELEASE)**

02042231 INDERAL LA

PFI

**<sup>ST</sup> 80MG CAPSULE (SUSTAINED RELEASE)**

02042258 INDERAL LA

PFI

**<sup>ST</sup> 120MG CAPSULE (SUSTAINED RELEASE)**

02042266 INDERAL LA

PFI

**<sup>ST</sup> 160MG CAPSULE (SUSTAINED RELEASE)**

02042274 INDERAL LA

PFI

**<sup>ST</sup> 10MG TABLET**

00496480 TEVA-PROPRANOLOL

TEV

**<sup>ST</sup> 20MG TABLET**

00740675 TEVA-PROPRANOLOL

TEV

**<sup>ST</sup> 40MG TABLET**

00496499 TEVA-PROPRANOLOL

TEV

**<sup>ST</sup> 80MG TABLET**

00582271 PMS-PROPRANOLOL

PMS

00496502 TEVA-PROPRANOLOL

TEV

**<sup>ST</sup> 120MG TABLET**

00504335 APO PROPRANOLOL

APX

00582298 PMS-PROPRANOLOL

PMS

**<sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE**

99503014 PROPRANOLOL ORAL LIQUID

UNK

**SOTALOL HYDROCHLORIDE****<sup>ST</sup> 80MG TABLET**

02210428 APO-SOTALOL

APX

02270625 CO SOTALOL

OBT

02238634 DOM-SOTALOL

DPC

**24:24.00 BETA ADRENERGIC BLOCKING AGENTS****SOTALOL HYDROCHLORIDE****<sup>ST</sup> 80MG TABLET**

02368617 JAMP-SOTALOL

JMP

02238768 PHL-SOTALOL

PHH

02238326 PMS-SOTALOL

PMS

02316528 PRO-SOTALOL

PDL

02084228 RATIO-SOTALOL

TEV

02385988 SOTALOL

SIV

**<sup>ST</sup> 160MG TABLET**

02167794 APO-SOTALOL

APX

02270633 CO SOTALOL

OBT

02238635 DOM-SOTALOL

DPC

02368625 JAMP-SOTALOL

JMP

02238769 PHL-SOTALOL

PHH

02238327 PMS-SOTALOL

PMS

02316536 PRO-SOTALOL

PDL

02084236 RATIO-SOTALOL

TEV

02385996 SOTALOL

SIV

**<sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE**

99503023 SOTALOL ORAL LIQUID

UNK

**TIMOLOL MALEATE****<sup>ST</sup> 5MG TABLET**

00755842 APO-TIMOL

APX

01947796 TEVA-TIMOLOL

TEV

**<sup>ST</sup> 10MG TABLET**

00755850 APO-TIMOL

APX

01947818 TEVA-TIMOLOL

TEV

**<sup>ST</sup> 20MG TABLET**

00755869 APO-TIMOL

APX

01947826 TEVA-TIMOLOL

TEV

**24:28.08 DIHYDROPYRIDINES****AMLODIPINE BESYLATE****<sup>ST</sup> 2.5MG TABLET**

02297477 ACT AMLODIPINE

ACG

02326795 AMLODIPINE

PDL

02385783 AMLODIPINE

SIV

02392127 BIO-AMLODIPINE

BMI

02326825 DOM-AMLODIPINE

DPC

02280124 GD-AMLODIPINE

PFI

02357186 JAMP-AMLODIPINE

JMP

02371707 MAR-AMLODIPINE

MAR

02326760 PHL-AMLODIPINE

PHH

02295148 PMS-AMLODIPINE

PMS

02398877 RAN-AMLODIPINE

RBY

02331489 RIVA-AMLODIPINE

RIV

02330474 SANDOZ AMLODIPINE

SDZ

02357704 SEPTA-AMLODIPINE

SPT

**<sup>ST</sup> 5MG TABLET**

02297485 ACT AMLODIPINE

ACG

02326809 AMLODIPINE

PDL

02331284 AMLODIPINE

SAN

02385791 AMLODIPINE

SIV

02429217 AMLODIPINE

JMP

**24:28.08 DIHYDROPYRIDINES**

**AMLODIPINE BESYLATE**

<sup>ST</sup> **5MG TABLET**

02273373	APO-AMLODIPINE	APX
02397072	AURO-AMLODIPINE	AUR
02392135	BIO-AMLODIPINE	BMI
02326833	DOM-AMLODIPINE	DPC
02280132	GD-AMLODIPINE	PFI
02357194	JAMP-AMLODIPINE	JMP
02371715	MAR-AMLODIPINE	MAR
02362651	MINT-AMLODIPINE	MIN
02272113	MYLAN-AMLODIPINE	MYL
00878928	NORVASC	PFI
02326779	PHL-AMLODIPINE	PHH
02284065	PMS-AMLODIPINE	PMS
02321858	RAN-AMLODIPINE	RBY
02331497	RIVA-AMLODIPINE	RIV
02284383	SANDOZ AMLODIPINE	SDZ
02357712	SEPTA-AMLODIPINE	SPT
02250497	TEVA-AMLODIPINE	TEV
02426986	VAN-AMLODIPINE	VAN

<sup>ST</sup> **10MG TABLET**

02297493	ACT AMLODIPINE	ACG
02326817	AMLODIPINE	PDL
02331292	AMLODIPINE	SAN
02385805	AMLODIPINE	SIV
02429225	AMLODIPINE	JMP
02273381	APO-AMLODIPINE	APX
02397080	AURO-AMLODIPINE	AUR
02392143	BIO-AMLODIPINE	BMI
02326841	DOM-AMLODIPINE	DPC
02280140	GD-AMLODIPINE	PFI
02357208	JAMP-AMLODIPINE	JMP
02371723	MAR-AMLODIPINE	MAR
02362678	MINT-AMLODIPINE	MIN
02272121	MYLAN-AMLODIPINE	MYL
00878936	NORVASC	PFI
02326787	PHL-AMLODIPINE	PHH
02284073	PMS-AMLODIPINE	PMS
02321866	RAN-AMLODIPINE	RBY
02331500	RIVA-AMLODIPINE	RIV
02284391	SANDOZ AMLODIPINE	SDZ
02357720	SEPTA-AMLODIPINE	SPT
02250500	TEVA-AMLODIPINE	TEV
02426994	VAN-AMLODIPINE	VAN

<sup>ST</sup> **PDIN FOR EXTEMPORANEOUS MIXTURE**

99503003	AMLODIPINE ORAL LIQUID	UNK
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**AMLODIPINE BESYLATE, ATORVASTATIN CALCIUM**

<sup>ST</sup> **5MG & 10MG TABLET**

02411253	APO-AMLODIPINE-ATORVASTATIN	APX
02273233	CADUET	PFI
02362759	GD-AMLODIPINE-ATORVASTATIN	PFI
02404222	PMS-AMLODIPINE-ATORVASTATIN	PMS

<sup>ST</sup> **5MG & 20MG TABLET**

02411261	APO-AMLODIPINE-ATORVASTATIN	APX
02273241	CADUET	PFI

**24:28.08 DIHYDROPYRIDINES**

**AMLODIPINE BESYLATE, ATORVASTATIN CALCIUM**

<sup>ST</sup> **5MG & 20MG TABLET**

02362767	GD-AMLODIPINE-ATORVASTATIN	PFI
02404230	PMS-AMLODIPINE-ATORVASTATIN	PMS

<sup>ST</sup> **5MG & 40MG TABLET**

02411288	APO-AMLODIPINE-ATORVASTATIN	APX
02273268	CADUET	PFI
02362775	GD-AMLODIPINE-ATORVASTATIN	PFI

<sup>ST</sup> **5MG & 80MG TABLET**

02411296	APO-AMLODIPINE-ATORVASTATIN	APX
02273276	CADUET	PFI
02362783	GD-AMLODIPINE-ATORVASTATIN	PFI

<sup>ST</sup> **10MG & 10MG TABLET**

02411318	APO-AMLODIPINE-ATORVASTATIN	APX
02273284	CADUET	PFI
02362791	GD-AMLODIPINE-ATORVASTATIN	PFI
02404249	PMS-AMLODIPINE-ATORVASTATIN	PMS

<sup>ST</sup> **10MG & 20MG TABLET**

02411326	APO-AMLODIPINE-ATORVASTATIN	APX
02273292	CADUET	PFI
02362805	GD-AMLODIPINE-ATORVASTATIN	PFI
02404257	PMS-AMLODIPINE-ATORVASTATIN	PMS

<sup>ST</sup> **10MG & 40MG TABLET**

02411334	APO-AMLODIPINE-ATORVASTATIN	APX
02273306	CADUET	PFI
02362813	GD-AMLODIPINE-ATORVASTATIN	PFI

<sup>ST</sup> **10MG & 80MG TABLET**

02411342	APO-AMLODIPINE-ATORVASTATIN	APX
02273314	CADUET	PFI
02362821	GD-AMLODIPINE-ATORVASTATIN	PFI

**AMLODIPINE BESYLATE, TELMISARTAN**

<sup>ST</sup> **5MG & 40MG TABLET**

02371022	TWYNSTA	BOE
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<sup>ST</sup> **5MG & 80MG TABLET**

02371049	TWYNSTA	BOE
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<sup>ST</sup> **10MG & 40MG TABLET**

02371030	TWYNSTA	BOE
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<sup>ST</sup> **10MG & 80MG TABLET**

02371057	TWYNSTA	BOE
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**FELODIPINE**

<sup>ST</sup> **2.5MG TABLET (EXTENDED RELEASE)**

02452367	APO-FELODIPINE	APX
02057778	PLENDIL	AZC

<sup>ST</sup> **5MG TABLET (EXTENDED RELEASE)**

02452375	APO-FELODIPINE	APX
00851779	PLENDIL	AZC
02280264	SANDOZ FELODIPINE	SDZ
09857203	SANDOZ-FELODIPINE	SDZ

<sup>ST</sup> **10MG TABLET (EXTENDED RELEASE)**

02452383	APO-FELODIPINE	APX
00851787	PLENDIL	AZC
02280272	SANDOZ FELODIPINE	SDZ
09857204	SANDOZ-FELODIPINE	SDZ

**24:28.08 DIHYDROPYRIDINES****NIFEDIPINE****<sup>ST</sup> 5MG CAPSULE**

00725110	NIFEDIPINE	AAP
02235897	PMS-NIFEDIPINE	PMS

**<sup>ST</sup> 10MG CAPSULE**

00755907	NIFEDIPINE	AAP
02235898	PMS-NIFEDIPINE	PMS

**<sup>ST</sup> 10MG TABLET (EXTENDED RELEASE)**

02197448	APO-NIFED PA	APX
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**<sup>ST</sup> 20MG TABLET (EXTENDED RELEASE)**

02237618	ADALAT XL	BAY
02181525	APO-NIFED PA	APX

**<sup>ST</sup> 30MG TABLET (EXTENDED RELEASE)**

02155907	ADALAT XL	BAY
02349167	MYLAN-NIFEDIPINE	MYL
02421631	NIFEDIPINE	PDL
02442930	NIFEDIPINE	SIV
02418630	PMS-NIFEDIPINE	PMS

**<sup>ST</sup> 60MG TABLET (EXTENDED RELEASE)**

02155990	ADALAT XL	BAY
02321149	MYLAN-NIFEDIPINE	MYL
02421658	NIFEDIPINE	PDL
02442949	NIFEDIPINE	SIV
02416301	PMS-NIFEDIPINE	PMS

**NIMODIPINE****<sup>ST</sup> 30MG TABLET**

02325926	NIMOTOP	BAY
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**24:28.92 MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS****DILTIAZEM HYDROCHLORIDE****<sup>ST</sup> 120MG CAPSULE (CONTROLLED DELIVERY)**

02230997	APO-DILTIAZ CD	APX
02231472	DILTIAZEM CD	PDL
02400421	DILTIAZEM CD	SAN
02355752	PMS-DILTIAZEM CD	PMS

**<sup>ST</sup> 180MG CAPSULE (CONTROLLED DELIVERY)**

02230998	APO-DILTIAZ CD	APX
02231474	DILTIAZEM CD	PDL
02400448	DILTIAZEM CD	SAN
02355760	PMS-DILTIAZEM CD	PMS

**<sup>ST</sup> 240MG CAPSULE (CONTROLLED DELIVERY)**

02230999	APO-DILTIAZ CD	APX
02231475	DILTIAZEM CD	PDL
02400456	DILTIAZEM CD	SAN
02355779	PMS-DILTIAZEM CD	PMS

**<sup>ST</sup> 300MG CAPSULE (CONTROLLED DELIVERY)**

02229526	APO-DILTIAZ CD	APX
02231057	DILTIAZEM CD	PDL
02400464	DILTIAZEM CD	SAN
02355787	PMS-DILTIAZEM CD	PMS

**<sup>ST</sup> 120MG CAPSULE (EXTENDED RELEASE)**

02370611	ACT DILTIAZEM CD	ACG
02370441	ACT DILTIAZEM T	ACG
02097249	CARDIZEM CD	VAE

**24:28.92 MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS****DILTIAZEM HYDROCHLORIDE****<sup>ST</sup> 120MG CAPSULE (EXTENDED RELEASE)**

02445999	DILTIAZEM CD	SIV
02325306	DILTIAZEM TZ	PDL
02243338	SANDOZ DILTIAZEM CD	SDZ
02245918	SANDOZ DILTIAZEM T	SDZ
02271605	TEVA-DILTIAZEM	VAE
02242538	TEVA-DILTIAZEM CD	TEV
02231150	TIAZAC	VAE

**<sup>ST</sup> 180MG CAPSULE (EXTENDED RELEASE)**

02370638	ACT DILTIAZEM CD	ACG
02370492	ACT DILTIAZEM T	ACG
02097257	CARDIZEM CD	VAE
02446006	DILTIAZEM CD	SIV
02325314	DILTIAZEM TZ	PDL
02243339	SANDOZ DILTIAZEM CD	SDZ
02245919	SANDOZ DILTIAZEM T	SDZ
02271613	TEVA-DILTIAZEM	VAE
02242539	TEVA-DILTIAZEM CD	TEV
02231151	TIAZAC	VAE

**<sup>ST</sup> 240MG CAPSULE (EXTENDED RELEASE)**

02370646	ACT DILTIAZEM CD	ACG
02370506	ACT DILTIAZEM T	ACG
02097265	CARDIZEM CD	VAE
02446014	DILTIAZEM CD	SIV
02325322	DILTIAZEM TZ	PDL
02243340	SANDOZ DILTIAZEM CD	SDZ
02245920	SANDOZ DILTIAZEM T	SDZ
02271621	TEVA-DILTIAZEM	VAE
02242540	TEVA-DILTIAZEM CD	TEV
02231152	TIAZAC	VAE

**<sup>ST</sup> 300MG CAPSULE (EXTENDED RELEASE)**

02370654	ACT DILTIAZEM CD	ACG
02370514	ACT DILTIAZEM T	ACG
02097273	CARDIZEM CD	VAE
02446022	DILTIAZEM CD	SIV
02325330	DILTIAZEM TZ	PDL
02243341	SANDOZ DILTIAZEM CD	SDZ
02245921	SANDOZ DILTIAZEM T	SDZ
02271648	TEVA-DILTIAZEM	VAE
02242541	TEVA-DILTIAZEM CD	TEV
02231154	TIAZAC	VAE

**<sup>ST</sup> 360MG CAPSULE (EXTENDED RELEASE)**

02370522	ACT DILTIAZEM T	ACG
02325349	DILTIAZEM TZ	PDL
02245922	SANDOZ DILTIAZEM T	SDZ
02271656	TEVA-DILTIAZEM	VAE
02231155	TIAZAC	VAE

**<sup>ST</sup> 60MG CAPSULE (SUSTAINED RELEASE)**

02222957	APO-DILTIAZ SR	APX
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**<sup>ST</sup> 90MG CAPSULE (SUSTAINED RELEASE)**

02222965	APO-DILTIAZ SR	APX
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**<sup>ST</sup> 120MG CAPSULE (SUSTAINED RELEASE)**

02222973	APO-DILTIAZ SR	APX
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**24:28.92 MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS****DILTIAZEM HYDROCHLORIDE****<sup>ST</sup> 30MG TABLET**

00771376	APO DILTIAZ	APX
00862924	TEVA-DILTIAZEM	TEV

**<sup>ST</sup> 60MG TABLET**

00771384	APO DILTIAZ	APX
00862932	TEVA-DILTIAZEM	TEV

**<sup>ST</sup> 120MG TABLET (EXTENDED RELEASE)**

02256738	TIAZAC XC	VAE
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**<sup>ST</sup> 180MG TABLET (EXTENDED RELEASE)**

02256746	TIAZAC XC	VAE
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**<sup>ST</sup> 240MG TABLET (EXTENDED RELEASE)**

02256754	TIAZAC XC	VAE
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**<sup>ST</sup> 300MG TABLET (EXTENDED RELEASE)**

02256762	TIAZAC XC	VAE
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**<sup>ST</sup> 360MG TABLET (EXTENDED RELEASE)**

02256770	TIAZAC XC	VAE
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**VERAPAMIL HYDROCHLORIDE****120MG CAPSULE (SUSTAINED RELEASE)**

02100479	VERELAN	RGL
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**<sup>ST</sup> 180MG CAPSULE (SUSTAINED RELEASE)**

02100487	VERELAN	RGL
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**<sup>ST</sup> 240MG CAPSULE (SUSTAINED RELEASE)**

02100495	VERELAN	RGL
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**<sup>ST</sup> 80MG TABLET**

00782483	APO-VERAP	APX
02237921	MYLAN-VERAPAMIL	MYL
00812331	NOVO-VERAMIL	TEV

**<sup>ST</sup> 120MG TABLET**

00782491	APO-VERAP	APX
02237922	MYLAN-VERAPAMIL	MYL
00812358	NOVO-VERAMIL	TEV

**<sup>ST</sup> 120MG TABLET (EXTENDED RELEASE)**

02246893	APO-VERAP SR	APX
01907123	ISOPTIN SR	BGP
02210347	MYLAN-VERAPAMIL SR	MYL

**<sup>ST</sup> 180MG TABLET (EXTENDED RELEASE)**

02246894	APO-VERAP SR	APX
01934317	ISOPTIN SR	BGP
02450488	MYLAN-VERAPAMIL	MYL

**<sup>ST</sup> 240MG TABLET (EXTENDED RELEASE)**

02246895	APO-VERAP SR	APX
02240321	DOM-VERAPAMIL SR	DPC
00742554	ISOPTIN SR	BGP
02450496	MYLAN-VERAPAMIL	MYL
02211920	NOVO-VERAMIL SR	TEV
02238276	PHL-VERAPAMIL SR	PHH
02237791	PMS-VERAPAMIL SR	PMS
02312697	PRO-VERAPAMIL SR	PDL
02248082	RIVA-VERAPAMIL SR	RIV

**24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS****BENAZEPRIL HYDROCHLORIDE****<sup>ST</sup> 5MG TABLET**

02290332	BENAZEPRIL	AAP
00885835	LOTENSIN	NVR

**<sup>ST</sup> 10MG TABLET**

02290340	BENAZEPRIL	AAP
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**<sup>ST</sup> 20MG TABLET**

02273918	BENAZEPRIL	AAP
00885851	LOTENSIN	NVR

**CAPTOPRIL****<sup>ST</sup> 6.25MG TABLET**

01999559	APO-CAPTO	APX
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**<sup>ST</sup> 12.5MG TABLET**

00893595	APO-CAPTO	APX
01942964	TEVA-CAPTOPRIL	TEV

**<sup>ST</sup> 25MG TABLET**

00893609	APO-CAPTO	APX
01942972	TEVA-CAPTOPRIL	TEV

**<sup>ST</sup> 50MG TABLET**

00893617	APO-CAPTO	APX
01942980	TEVA-CAPTOPRIL	TEV

**<sup>ST</sup> 100MG TABLET**

00893625	APO-CAPTO	APX
02230206	PMS-CAPTOPRIL	PMS
01942999	TEVA-CAPTOPRIL	TEV

**CILAZAPRIL****<sup>ST</sup> 1MG TABLET**

02291134	APO-CILAZAPRIL	APX
02283778	MYLAN-CILAZAPRIL	MYL
02280442	PMS-CILAZAPRIL	PMS
02266350	TEVA-CILAZAPRIL	TEV

**<sup>ST</sup> 2.5MG TABLET**

02291142	APO-CILAZAPRIL	APX
02285215	CO CILAZAPRIL	OBT
01911473	INHIBACE	HLR
02283786	MYLAN-CILAZAPRIL	MYL
02280450	PMS-CILAZAPRIL	PMS
02266369	TEVA-CILAZAPRIL	TEV

**<sup>ST</sup> 5MG TABLET**

02291150	APO-CILAZAPRIL	APX
02285223	CO CILAZAPRIL	OBT
01911481	INHIBACE	HLR
02283794	MYLAN-CILAZAPRIL	MYL
02280469	PMS-CILAZAPRIL	PMS
02266377	TEVA-CILAZAPRIL	TEV

**CILAZAPRIL, HYDROCHLOROTHIAZIDE****<sup>ST</sup> 5MG & 12.5MG TABLET**

02284987	APO-CILAZAPRIL/HCTZ	APX
02181479	INHIBACE PLUS	HLR
02313731	NOVO-CILAZAPRIL/HCTZ	TEV

**ENALAPRIL MALEATE****<sup>ST</sup> 2.5MG TABLET**

02291878	ACT ENALAPRIL	ACG
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### 24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

#### ENALAPRIL MALEATE

##### <sup>ST</sup> 2.5MG TABLET

02020025	APO-ENALAPRIL	APX
02400650	ENALAPRIL	SAN
02442957	ENALAPRIL	SIV
02300036	MYLAN-ENALAPRIL	MYL
02311402	PRO-ENALAPRIL	PDL
02352230	RAN-ENALAPRIL	RBV
02300796	RIVA-ENALAPRIL	RIV
02299933	SANDOZ ENALAPRIL	SDZ
02300117	TARO-ENALAPRIL	TAR
02300680	TEVA-ENALAPRIL	TEV

##### <sup>ST</sup> 5MG TABLET

02291886	ACT ENALAPRIL	ACG
02019884	APO-ENALAPRIL	APX
02400669	ENALAPRIL	SAN
02442965	ENALAPRIL	SIV
02300044	MYLAN-ENALAPRIL	MYL
02311410	PRO-ENALAPRIL	PDL
02352249	RAN-ENALAPRIL	RBV
02300818	RIVA-ENALAPRIL	RIV
02299941	SANDOZ ENALAPRIL	SDZ
02300125	TARO-ENALAPRIL	TAR
02233005	TEVA-ENALAPRIL	TEV
00708879	VASOTEC	FRS

##### <sup>ST</sup> 10MG TABLET

02291894	ACT ENALAPRIL	ACG
02019892	APO-ENALAPRIL	APX
02400677	ENALAPRIL	SAN
02442973	ENALAPRIL	SIV
02300052	MYLAN-ENALAPRIL	MYL
02311429	PRO-ENALAPRIL	PDL
02352257	RAN-ENALAPRIL	RBV
02300826	RIVA-ENALAPRIL	RIV
02299968	SANDOZ ENALAPRIL	SDZ
02300133	TARO-ENALAPRIL	TAR
02233006	TEVA-ENALAPRIL	TEV
00670901	VASOTEC	FRS

##### <sup>ST</sup> 20MG TABLET

02291908	ACT ENALAPRIL	ACG
02019906	APO-ENALAPRIL	APX
02400685	ENALAPRIL	SAN
02442981	ENALAPRIL	SIV
02300060	MYLAN-ENALAPRIL	MYL
02311437	PRO-ENALAPRIL	PDL
02352265	RAN-ENALAPRIL	RBV
02300834	RIVA-ENALAPRIL	RIV
02299976	SANDOZ ENALAPRIL	SDZ
02300141	TARO-ENALAPRIL	TAR
02233007	TEVA-ENALAPRIL	TEV
00670928	VASOTEC	FRS

##### <sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE

99503013	ENALAPRIL ORAL LIQUID	UNK
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### 24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

#### ENALAPRIL MALEATE, HYDROCHLOROTHIAZIDE

##### <sup>ST</sup> 5MG & 12.5MG TABLET

02352923	APO-ENALAPRIL MALEATE/HCTZ	APX
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##### <sup>ST</sup> 10MG & 25MG TABLET

02352931	APO-ENALAPRIL MALEATE/HCTZ	APX
00657298	VASERETIC	FRS

#### FOSINOPRIL SODIUM

##### <sup>ST</sup> 10MG TABLET

02266008	APO-FOSINOPRIL	APX
02303000	FOSINOPRIL	PDL
02332566	FOSINOPRIL	RBV
02459388	FOSINOPRIL	SAN
02331004	JAMP-FOSINOPRIL	JMP
02255944	PMS-FOSINOPRIL	PMS
02294524	RAN-FOSINOPRIL	RBV
02247802	TEVA-FOSINOPRIL	TEV

##### <sup>ST</sup> 20MG TABLET

02266016	APO-FOSINOPRIL	APX
02303019	FOSINOPRIL	PDL
02332574	FOSINOPRIL	RBV
02459396	FOSINOPRIL	SAN
02331012	JAMP-FOSINOPRIL	JMP
02255952	PMS-FOSINOPRIL	PMS
02294532	RAN-FOSINOPRIL	RBV
02247803	TEVA-FOSINOPRIL	TEV

#### LISINOPRIL

##### <sup>ST</sup> 5MG TABLET

02271443	ACT LISINOPRIL	ACG
02217481	APO-LISINOPRIL	APX
09853685	APO-LISINOPRIL	APX
02394472	AURO-LISINOPRIL	AUR
02361531	JAMP-LISINOPRIL	JMP
02386232	LISINOPRIL	SIV
02292203	PMS-LISINOPRIL	PMS
02310961	PRO-LISINOPRIL	PDL
02294230	RAN-LISINOPRIL	RBV
02300958	RIVA-LISINOPRIL	RIV
02289199	SANDOZ LISINOPRIL	SDZ
02285061	TEVA-LISINOPRIL (TYPE P)	TEV
02285118	TEVA-LISINOPRIL (TYPE Z)	TEV
02049333	ZESTRIL	AZC

##### <sup>ST</sup> 10MG TABLET

02271451	ACT LISINOPRIL	ACG
02217503	APO-LISINOPRIL	APX
09853960	APO-LISINOPRIL	APX
02394480	AURO-LISINOPRIL	AUR
02361558	JAMP-LISINOPRIL	JMP
02386240	LISINOPRIL	SIV
02292211	PMS-LISINOPRIL	PMS
00839396	PRINIVIL	FRS
02310988	PRO-LISINOPRIL	PDL
02294249	RAN-LISINOPRIL	RBV
02300982	RIVA-LISINOPRIL	RIV

**24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS****LISINOPRIL****<sup>ST</sup> 10MG TABLET**

02289202	SANDOZ LISINOPRIL	SDZ
02285088	TEVA-LISINOPRIL (TYPE P)	TEV
02285126	TEVA-LISINOPRIL (TYPE Z)	TEV
02049376	ZESTRIL	AZC

**<sup>ST</sup> 20MG TABLET**

02271478	ACT LISINOPRIL	ACG
02217511	APO-LISINOPRIL	APX
09854010	APO-LISINOPRIL	APX
02394499	AURO-LISINOPRIL	AUR
02361566	JAMP-LISINOPRIL	JMP
02386259	LISINOPRIL	SIV
02274868	MYLAN-LISINOPRIL	MYL
02292238	PMS-LISINOPRIL	PMS
00839418	PRINIVIL	FRS
02310996	PRO-LISINOPRIL	PDL
02294257	RAN-LISINOPRIL	RBV
02300990	RIVA-LISINOPRIL	RIV
02289229	SANDOZ LISINOPRIL	SDZ
02285096	TEVA-LISINOPRIL (TYPE P)	TEV
02285134	TEVA-LISINOPRIL (TYPE Z)	TEV
02049384	ZESTRIL	AZC

**LISINOPRIL, HYDROCHLOROTHIAZIDE****<sup>ST</sup> 10MG & 12.5MG TABLET**

02362945	LISINOPRIL/HCTZ (TYPE Z)	SAN
02302365	SANDOZ LISINOPRIL HCT	SDZ
02302136	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV
02301768	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV
02103729	ZESTORETIC	AZC

**<sup>ST</sup> 20MG & 12.5MG TABLET**

02362953	LISINOPRIL/HCTZ (TYPE Z)	SAN
02302373	SANDOZ LISINOPRIL HCT	SDZ
02302144	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV
02301776	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV
02045737	ZESTORETIC	AZC

**<sup>ST</sup> 20MG & 25MG TABLET**

02362961	LISINOPRIL/HCTZ (TYPE Z)	SAN
02302381	SANDOZ LISINOPRIL HCT	SDZ
02302152	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV
02301784	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV
02045729	ZESTORETIC	AZC

**PERINDOPRIL ERBUMINE****<sup>ST</sup> 2MG TABLET**

02123274	COVERSYL	SEV
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**<sup>ST</sup> 4MG TABLET**

02123282	COVERSYL	SEV
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**<sup>ST</sup> 8MG TABLET**

02246624	COVERSYL	SEV
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**PERINDOPRIL ERBUMINE, INDAPAMIDE****<sup>ST</sup> 4MG & 1.25MG TABLET**

02246569	COVERSYL PLUS	SEV
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**24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS****PERINDOPRIL ERBUMINE, INDAPAMIDE****<sup>ST</sup> 8MG & 2.5MG TABLET**

02321653	COVERSYL PLUS HD	SEV
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**QUINAPRIL****<sup>ST</sup> 5MG TABLET**

01947664	ACCUPRIL	PFI
02248499	APO-QUINAPRIL	APX
02290987	GD-QUINAPRIL	PFI
02340550	PMS-QUINAPRIL	PMS
02415917	QUINAPRIL	PDL

**<sup>ST</sup> 10MG TABLET**

01947672	ACCUPRIL	PFI
02248500	APO-QUINAPRIL	APX
02290995	GD-QUINAPRIL	PFI
02340569	PMS-QUINAPRIL	PMS
02415925	QUINAPRIL	PDL

**<sup>ST</sup> 20MG TABLET**

01947680	ACCUPRIL	PFI
02248501	APO-QUINAPRIL	APX
02291002	GD-QUINAPRIL	PFI
02340577	PMS-QUINAPRIL	PMS
02415933	QUINAPRIL	PDL

**<sup>ST</sup> 40MG TABLET**

01947699	ACCUPRIL	PFI
02248502	APO-QUINAPRIL	APX
02291010	GD-QUINAPRIL	PFI
02340585	PMS-QUINAPRIL	PMS
02415941	QUINAPRIL	PDL

**QUINAPRIL, HYDROCHLOROTHIAZIDE****<sup>ST</sup> 10MG & 12.5MG TABLET**

02237367	ACCURETIC	PFI
02408767	APO-QUINAPRIL/HCTZ	APX

**<sup>ST</sup> 20MG & 12.5MG TABLET**

02237368	ACCURETIC	PFI
02408775	APO-QUINAPRIL/HCTZ	APX

**<sup>ST</sup> 20MG & 25MG TABLET**

02237369	ACCURETIC	PFI
02408783	APO-QUINAPRIL/HCTZ	APX

**RAMIPRIL****<sup>ST</sup> 1.25MG CAPSULE**

02295482	ACT RAMIPRIL	ACG
02221829	ALTACE	VAE
02251515	APO-RAMIPRIL	APX
02387387	AURO-RAMIPRIL	AUR
02331101	JAMP-RAMIPRIL	JMP
02420457	MAR-RAMIPRIL	MAR
02295369	PMS-RAMIPRIL	PMS
02310023	PRO-RAMIPRIL	PDL
02299372	RAMIPRIL	RIV
02308363	RAMIPRIL	SIV
02310503	RAN-RAMIPRIL	RBV
02438860	VAN-RAMIPRIL	VAN

**24:32.04 ANGIOTENSIN-CONVERTING  
ENZYME INHIBITORS****RAMIPRIL****<sup>ST</sup> 2.5MG CAPSULE**

02295490	ACT RAMIPRIL	ACG
02221837	ALTACE	VAE
02251531	APO-RAMIPRIL	APX
02387395	AURO-RAMIPRIL	AUR
02287951	DOM-RAMIPRIL	DPC
02331128	JAMP-RAMIPRIL	JMP
02420465	MAR-RAMIPRIL	MAR
02421305	MINT-RAMIPRIL	MIN
02247917	PMS-RAMIPRIL	PMS
02310066	PRO-RAMIPRIL	PDL
02255316	RAMIPRIL	RIV
02287927	RAMIPRIL	SIV
02374846	RAMIPRIL	SAN
02411563	RAMIPRIL-2.5	SIV
02310511	RAN-RAMIPRIL	RBV
02247945	TEVA-RAMIPRIL	TEV
02438879	VAN-RAMIPRIL	VAN

**<sup>ST</sup> 5MG CAPSULE**

02295504	ACT RAMIPRIL	ACG
02221845	ALTACE	VAE
02251574	APO-RAMIPRIL	APX
02387409	AURO-RAMIPRIL	AUR
02287978	DOM-RAMIPRIL	DPC
02331136	JAMP-RAMIPRIL	JMP
02420473	MAR-RAMIPRIL	MAR
02421313	MINT-RAMIPRIL	MIN
02247918	PMS-RAMIPRIL	PMS
02310074	PRO-RAMIPRIL	PDL
02255324	RAMIPRIL	RIV
02287935	RAMIPRIL	SIV
02374854	RAMIPRIL	SAN
02411571	RAMIPRIL-5	SIV
02310538	RAN-RAMIPRIL	RBV
02247946	TEVA-RAMIPRIL	TEV
02438887	VAN-RAMIPRIL	VAN

**<sup>ST</sup> 10MG CAPSULE**

02295512	ACT RAMIPRIL	ACG
02221853	ALTACE	VAE
02251582	APO-RAMIPRIL	APX
02387417	AURO-RAMIPRIL	AUR
02287986	DOM-RAMIPRIL	DPC
02331144	JAMP-RAMIPRIL	JMP
02420481	MAR-RAMIPRIL	MAR
02421321	MINT-RAMIPRIL	MIN
02247919	PMS-RAMIPRIL	PMS
02310104	PRO-RAMIPRIL	PDL
02255332	RAMIPRIL	RIV
02287943	RAMIPRIL	SIV
02374862	RAMIPRIL	SAN
02411598	RAMIPRIL-10	SIV
02310546	RAN-RAMIPRIL	RBV
02247947	TEVA-RAMIPRIL	TEV
02438895	VAN-RAMIPRIL	VAN

**24:32.04 ANGIOTENSIN-CONVERTING  
ENZYME INHIBITORS****RAMIPRIL****<sup>ST</sup> 15MG CAPSULE**

02325381	APO-RAMIPRIL	APX
02440334	JAMP-RAMIPRIL	JMP
02420503	MAR-RAMIPRIL	MAR
02421348	MINT-RAMIPRIL	MIN
02343932	PMS-RAMIPRIL	PMS
02425548	RAN-RAMIPRIL	RBV
02438909	VAN-RAMIPRIL	VAN

**<sup>ST</sup> 1.25MG TABLET**

02291398	SANDOZ RAMIPRIL	SDZ
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**<sup>ST</sup> 2.5MG TABLET**

02291401	SANDOZ RAMIPRIL	SDZ
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**<sup>ST</sup> 5MG TABLET**

02291428	SANDOZ RAMIPRIL	SDZ
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**<sup>ST</sup> 10MG TABLET**

02291436	SANDOZ RAMIPRIL	SDZ
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**RAMIPRIL, HYDROCHLOROTHIAZIDE****<sup>ST</sup> 2.5MG & 12.5MG TABLET**

02283131	ALTACE HCT	VAE
02354004	APO-RAMIPRIL/HCTZ	APX
02342138	PMS-RAMIPRIL-HCTZ	PMS

**<sup>ST</sup> 5MG & 12.5MG TABLET**

02283158	ALTACE HCT	VAE
02354012	APO-RAMIPRIL/HCTZ	APX
02342146	PMS-RAMIPRIL-HCTZ	PMS
02415887	RAMIPRIL-HCTZ	PDL

**<sup>ST</sup> 5MG & 25MG TABLET**

02283174	ALTACE HCT	VAE
02354020	APO-RAMIPRIL/HCTZ	APX
02342162	PMS-RAMIPRIL-HCTZ	PMS

**<sup>ST</sup> 10MG & 12.5MG TABLET**

02283166	ALTACE HCT	VAE
02342154	PMS-RAMIPRIL-HCTZ	PMS
02415895	RAMIPRIL-HCTZ	PDL

**<sup>ST</sup> 10MG & 25MG TABLET**

02283182	ALTACE HCT	VAE
02354039	APO-RAMIPRIL/HCTZ	APX
02342170	PMS-RAMIPRIL-HCTZ	PMS
02415909	RAMIPRIL-HCTZ	PDL

**TRANDOLAPRIL****<sup>ST</sup> 0.5MG CAPSULE**

02231457	MAVIK	BGP
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**<sup>ST</sup> 1MG CAPSULE**

02231459	MAVIK	BGP
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**<sup>ST</sup> 2MG CAPSULE**

02231460	MAVIK	BGP
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**<sup>ST</sup> 4MG CAPSULE**

02239267	MAVIK	BGP
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### 24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

#### AZILSARTAN MEDOXOMIL

##### <sup>ST</sup> 40MG TABLET

02381389	EDARBI	VAE
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##### <sup>ST</sup> 80MG TABLET

02381397	EDARBI	VAE
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#### CANDESARTAN CILEXETIL

##### <sup>ST</sup> 4MG TABLET

02379260	ACH-CANDESARTAN	ACC
02376520	ACT CANDESARTAN	ACG
02365340	APO-CANDESARTAN	APX
02239090	ATACAND	AZC
02388901	CANDESARTAN	SAN
02386496	JAMP-CANDESARTAN	JMP
02379120	MYLAN-CANDESARTAN	MYL
02391171	PMS-CANDESARTAN	PMS
02380684	RAN-CANDESARTAN	RBV
02425408	RIVA-CANDESARTAN	RIV
02326957	SANDOZ CANDESARTAN	SDZ

##### <sup>ST</sup> 8MG TABLET

02379279	ACH-CANDESARTAN	ACC
02376539	ACT CANDESARTAN	ACG
02365359	APO-CANDESARTAN	APX
02239091	ATACAND	AZC
02377934	CANDESARTAN	PDL
02388707	CANDESARTAN	SIV
02388928	CANDESARTAN	SAN
02395762	DOM-CANDESARTAN	DPC
02386518	JAMP-CANDESARTAN	JMP
02379139	MYLAN-CANDESARTAN	MYL
02391198	PMS-CANDESARTAN	PMS
02380692	RAN-CANDESARTAN	RBV
02425416	RIVA-CANDESARTAN	RIV
02326965	SANDOZ CANDESARTAN	SDZ
02366312	TEVA-CANDESARTAN	TEV

##### <sup>ST</sup> 16MG TABLET

02379287	ACH-CANDESARTAN	ACC
02376547	ACT CANDESARTAN	ACG
02365367	APO-CANDESARTAN	APX
02239092	ATACAND	AZC
02377942	CANDESARTAN	PDL
02388715	CANDESARTAN	SIV
02388936	CANDESARTAN	SAN
02386526	JAMP-CANDESARTAN	JMP
02379147	MYLAN-CANDESARTAN	MYL
02391201	PMS-CANDESARTAN	PMS
02380706	RAN-CANDESARTAN	RBV
02425424	RIVA-CANDESARTAN	RIV
02326973	SANDOZ CANDESARTAN	SDZ
02366320	TEVA-CANDESARTAN	TEV

##### <sup>ST</sup> 32MG TABLET

02379295	ACH-CANDESARTAN	ACC
02376555	ACT CANDESARTAN	ACG
02399105	APO-CANDESARTAN	APX
02311658	ATACAND	AZC

### 24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

#### CANDESARTAN CILEXETIL

##### <sup>ST</sup> 32MG TABLET

02422069	CANDESARTAN	PDL
02435845	CANDESARTAN	SAN
02386534	JAMP-CANDESARTAN	JMP
02379155	MYLAN-CANDESARTAN	MYL
02391228	PMS-CANDESARTAN	PMS
02380714	RAN-CANDESARTAN	RBV
02425432	RIVA-CANDESARTAN	RIV
02392267	SANDOZ CANDESARTAN	SDZ
02417340	SANDOZ CANDESARTAN	SDZ
02366339	TEVA-CANDESARTAN	TEV

#### CANDESARTAN CILEXETIL, HYDROCHLOROTHIAZIDE

##### <sup>ST</sup> 16MG & 12.5MG TABLET

02388650	ACT CANDESARTAN/HCT	ACG
02367866	APO-CANDESARTAN/HCTZ	APX
02244021	ATACAND PLUS	AZC
02421038	AURO-CANDESARTAN HCT	AUR
02394812	CANDESARTAN-HCT	SIV
02392275	CANDESARTAN-HCTZ	PDL
02394804	CANDESARTAN-HCTZ	SAN
02391295	PMS-CANDESARTAN HCTZ	PMS
02327902	SANDOZ CANDESARTAN PLUS	SDZ
02395541	TEVA-CANDESARTAN/HCTZ	TEV

##### <sup>ST</sup> 32MG & 12.5MG TABLET

02395126	APO-CANDESARTAN/HCTZ	APX
02332922	ATACAND PLUS	AZC
02421046	AURO-CANDESARTAN HCT	AUR
02420732	SANDOZ CANDESARTAN PLUS	SDZ
02395568	TEVA-CANDESARTAN/HCTZ	TEV

##### <sup>ST</sup> 32MG & 25MG TABLET

02395134	APO-CANDESARTAN/HCTZ	APX
02332957	ATACAND PLUS	AZC
02421054	AURO-CANDESARTAN HCT	AUR
02420740	SANDOZ CANDESARTAN PLUS	SDZ

#### EPOSARTAN MESYLATE

##### <sup>ST</sup> 400MG TABLET

02240432	TEVETEN	BGP
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##### <sup>ST</sup> 600MG TABLET

02243942	TEVETEN	BGP
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#### EPOSARTAN MESYLATE, HYDROCHLOROTHIAZIDE

##### <sup>ST</sup> 600MG & 12.5MG TABLET

02253631	TEVETEN PLUS	BGP
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#### IRBESARTAN

##### <sup>ST</sup> 75MG TABLET

02328070	ACT IRBESARTAN	ACG
02386968	APO-IRBESARTAN	APX
02406098	AURO-IRBESARTAN	AUR
02237923	AVAPRO	SAC
02365197	IRBESARTAN	PDL
02372347	IRBESARTAN	SAN

### 24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

#### IRBESARTAN

##### <sup>ST</sup> 75MG TABLET

02385287	IRBESARTAN	SIV
02418193	JAMP-IRBESARTAN	JMP
02422980	MINT-IRBESARTAN	MIN
02347296	MYLAN-IRBESARTAN	MYL
02317060	PMS-IRBESARTAN	PMS
02406810	RAN-IRBESARTAN	RBV
02316390	RATIO-IRBESARTAN	TEV
02425319	RIVA-IRBESARTAN	RIV
02328461	SANDOZ IRBESARTAN	SDZ
02315971	TEVA-IRBESARTAN	TEV
02427087	VAN-IRBESARTAN	VAN

##### <sup>ST</sup> 150MG TABLET

02328089	ACT IRBESARTAN	ACG
02386976	APO-IRBESARTAN	APX
02406101	AURO-IRBESARTAN	AUR
02237924	AVAPRO	SAC
02372193	DOM-IRBESARTAN	DPC
02365200	IRBESARTAN	PDL
02372371	IRBESARTAN	SAN
02385295	IRBESARTAN	SIV
02418207	JAMP-IRBESARTAN	JMP
02422999	MINT-IRBESARTAN	MIN
02347318	MYLAN-IRBESARTAN	MYL
02317079	PMS-IRBESARTAN	PMS
02406829	RAN-IRBESARTAN	RBV
02316404	RATIO-IRBESARTAN	TEV
02425327	RIVA-IRBESARTAN	RIV
02328488	SANDOZ IRBESARTAN	SDZ
02315998	TEVA-IRBESARTAN	TEV
02427095	VAN-IRBESARTAN	VAN

##### <sup>ST</sup> 300MG TABLET

02328100	ACT IRBESARTAN	ACG
02386984	APO-IRBESARTAN	APX
02406128	AURO-IRBESARTAN	AUR
02237925	AVAPRO	SAC
02365219	IRBESARTAN	PDL
02372398	IRBESARTAN	SAN
02385309	IRBESARTAN	SIV
02418215	JAMP-IRBESARTAN	JMP
02423006	MINT-IRBESARTAN	MIN
02347326	MYLAN-IRBESARTAN	MYL
02317087	PMS-IRBESARTAN	PMS
02406837	RAN-IRBESARTAN	RBV
02316412	RATIO-IRBESARTAN	TEV
02425335	RIVA-IRBESARTAN	RIV
02328496	SANDOZ IRBESARTAN	SDZ
02316005	TEVA-IRBESARTAN	TEV
02427109	VAN-IRBESARTAN	VAN

#### IRBESARTAN, HYDROCHLOROTHIAZIDE

##### <sup>ST</sup> 150MG & 12.5MG TABLET

02357399	ACT IRBESARTAN/HCT	ACG
02387646	APO-IRBESARTAN/HCTZ	APX

### 24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

#### IRBESARTAN, HYDROCHLOROTHIAZIDE

##### <sup>ST</sup> 150MG & 12.5MG TABLET

02447878	AURO-IRBESARTAN HCT	AUR
02241818	AVALIDE	SAC
02385317	IRBESARTAN HCT	SIV
02372886	IRBESARTAN/HCTZ	SAN
02365162	IRBESARTAN-HCTZ	PDL
02418223	JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	JMP
02392992	MINT-IRBESARTAN/HCTZ	MIN
02328518	PMS-IRBESARTAN-HCTZ	PMS
02363208	RAN-IRBESARTAN HCTZ	RBV
02330512	RATIO-IRBESARTAN HCTZ	TEV
02337428	SANDOZ IRBESARTAN HCT	SDZ
02316013	TEVA-IRBESARTAN/HCTZ	TEV

##### <sup>ST</sup> 300MG & 12.5MG TABLET

02357402	ACT IRBESARTAN/HCT	ACG
02387654	APO-IRBESARTAN/HCTZ	APX
02447886	AURO-IRBESARTAN HCT	AUR
02241819	AVALIDE	SAC
02385325	IRBESARTAN HCT	SIV
02372894	IRBESARTAN/HCTZ	SAN
02365170	IRBESARTAN-HCTZ	PDL
02418231	JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	JMP
02393018	MINT-IRBESARTAN/HCTZ	MIN
02328526	PMS-IRBESARTAN-HCTZ	PMS
02363216	RAN-IRBESARTAN HCTZ	RBV
02330520	RATIO-IRBESARTAN HCTZ	TEV
02337436	SANDOZ IRBESARTAN HCT	SDZ
02316021	TEVA-IRBESARTAN/HCTZ	TEV

##### <sup>ST</sup> 300MG & 25MG TABLET

02357410	ACT IRBESARTAN/HCT	ACG
02387662	APO-IRBESARTAN/HCTZ	APX
02447894	AURO-IRBESARTAN HCT	AUR
02385333	IRBESARTAN HCT	SIV
02372908	IRBESARTAN/HCTZ	SAN
02365189	IRBESARTAN-HCTZ	PDL
02418258	JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	JMP
02393026	MINT-IRBESARTAN/HCTZ	MIN
02328534	PMS-IRBESARTAN-HCTZ	PMS
02363224	RAN-IRBESARTAN HCTZ	RBV
02330539	RATIO-IRBESARTAN HCTZ	TEV
02337444	SANDOZ IRBESARTAN HCT	SDZ
02316048	TEVA-IRBESARTAN/HCTZ	TEV

#### LOSARTAN POTASSIUM

##### <sup>ST</sup> 25MG TABLET

02354829	ACT LOSARTAN	ACG
02379058	APO-LOSARTAN	APX
02403323	AURO-LOSARTAN	AUR
02445964	BIO-LOSARTAN	BMI
02182815	COZAAR	FRS
02398834	JAMP-LOSARTAN	JMP
02388790	LOSARTAN	SIV

**24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS**

**LOSARTAN POTASSIUM**

<sup>ST</sup> **25MG TABLET**

02388863	LOSARTAN	SAN
02394367	LOSARTAN	PDL
02405733	MINT-LOSARTAN	MIN
02368277	MYLAN-LOSARTAN	MYL
02309750	PMS-LOSARTAN	PMS
02313332	SANDOZ LOSARTAN	SDZ
02424967	SEPTA-LOSARTAN	SPT
02380838	TEVA-LOSARTAN	TEV
02426595	VAN-LOSARTAN	VAN

<sup>ST</sup> **50MG TABLET**

02354837	ACT LOSARTAN	ACG
02353504	APO-LOSARTAN	APX
02403331	AURO-LOSARTAN	AUR
02445972	BIO-LOSARTAN	BMI
02182874	COZAAR	FRS
02398842	JAMP-LOSARTAN	JMP
02388804	LOSARTAN	SIV
02388871	LOSARTAN	SAN
02394375	LOSARTAN	PDL
02405741	MINT-LOSARTAN	MIN
02368285	MYLAN-LOSARTAN	MYL
02309769	PMS-LOSARTAN	PMS
02404478	RAN-LOSARTAN	RBV
02313340	SANDOZ LOSARTAN	SDZ
02424975	SEPTA-LOSARTAN	SPT
02357968	TEVA-LOSARTAN	TEV
02426609	VAN-LOSARTAN	VAN

<sup>ST</sup> **100MG TABLET**

02354845	ACT LOSARTAN	ACG
02353512	APO-LOSARTAN	APX
02403358	AURO-LOSARTAN	AUR
02445980	BIO-LOSARTAN	BMI
02182882	COZAAR	FRS
02398850	JAMP-LOSARTAN	JMP
02388812	LOSARTAN	SIV
02388898	LOSARTAN	SAN
02394383	LOSARTAN	PDL
02405768	MINT-LOSARTAN	MIN
02368293	MYLAN-LOSARTAN	MYL
02309777	PMS-LOSARTAN	PMS
02404486	RAN-LOSARTAN	RBV
02313359	SANDOZ LOSARTAN	SDZ
02424983	SEPTA-LOSARTAN	SPT
02357976	TEVA-LOSARTAN	TEV
02426617	VAN-LOSARTAN	VAN

**LOSARTAN POTASSIUM, HYDROCHLOROTHIAZIDE**

<sup>ST</sup> **50MG & 12.5MG TABLET**

02388251	ACT LOSARTAN/HCT	ACG
02371235	APO-LOSARTAN/HCTZ	APX
02423642	AURO-LOSARTAN HCT	AUR
02230047	HYZAAR	FRS

**24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS**

**LOSARTAN POTASSIUM, HYDROCHLOROTHIAZIDE**

<sup>ST</sup> **50MG & 12.5MG TABLET**

02408244	JAMP-LOSARTAN HCTZ	JMP
02388960	LOSARTAN HCT	SIV
02427648	LOSARTAN/HCTZ	SAN
02394391	LOSARTAN-HCTZ	PDL
02389657	MINT-LOSARTAN/HCTZ	MIN
02378078	MYLAN-LOSARTAN HCTZ	MYL
02392224	PMS-LOSARTAN-HCTZ	PMS
02313375	SANDOZ LOSARTAN HCT	SDZ
02428539	SEPTA-LOSARTAN HCTZ	SPT
02358263	TEVA-LOSARTAN/HCTZ	TEV

<sup>ST</sup> **100MG & 12.5MG TABLET**

02388278	ACT LOSARTAN/HCT	ACG
02371243	APO-LOSARTAN/HCTZ	APX
02423650	AURO-LOSARTAN HCT	AUR
02297841	HYZAAR	FRS
02388979	LOSARTAN HCT	SIV
02427656	LOSARTAN/HCTZ	SAN
02394405	LOSARTAN-HCTZ	PDL
02389665	MINT-LOSARTAN/HCTZ	MIN
02378086	MYLAN-LOSARTAN HCTZ	MYL
02392232	PMS-LOSARTAN-HCTZ	PMS
02362449	SANDOZ LOSARTAN HCT	SDZ
02377144	TEVA-LOSARTAN/HCTZ	TEV

<sup>ST</sup> **100MG & 25MG TABLET**

02388286	ACT LOSARTAN/HCT	ACG
02371251	APO-LOSARTAN/HCTZ	APX
02423669	AURO-LOSARTAN HCT	AUR
02241007	HYZAAR DS	FRS
02408252	JAMP-LOSARTAN HCTZ	JMP
02388987	LOSARTAN HCT	SIV
02427664	LOSARTAN/HCTZ	SAN
02394413	LOSARTAN-HCTZ	PDL
02389673	MINT-LOSARTAN/HCTZ	MIN
02378094	MYLAN-LOSARTAN HCTZ	MYL
02392240	PMS-LOSARTAN-HCTZ	PMS
02313383	SANDOZ LOSARTAN HCT	SDZ
02428547	SEPTA-LOSARTAN HCTZ	SPT
02377152	TEVA-LOSARTAN/HCTZ	TEV

**OLMESARTAN MEDOXOMIL**

<sup>ST</sup> **20MG TABLET**

02442191	ACT OLMESARTAN	ACG
02453452	APO-OLMESARTAN	APX
02443864	AURO-OLMESARTAN	AUR
02461641	JAMP-OLMESARTAN	JMP
02318660	OLMETEC	FRS
02461307	PMS-OLMESARTAN	PMS
02443414	SANDOZ OLMESARTAN	SDZ

<sup>ST</sup> **40MG TABLET**

02442205	ACT OLMESARTAN	ACG
02453460	APO-OLMESARTAN	APX
02443872	AURO-OLMESARTAN	AUR

### 24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

#### OLMESARTAN MEDOXOMIL

##### <sup>ST</sup> 40MG TABLET

02461668	JAMP-OLMESARTAN	JMP
02318679	OLMETEC	FRS
02461315	PMS-OLMESARTAN	PMS
02443422	SANDOZ OLMESARTAN	SDZ

#### OLMESARTAN MEDOXOMIL, HYDROCHLOROTHIAZIDE

##### <sup>ST</sup> 20MG & 12.5MG TABLET

02443112	ACT OLMESARTAN HCT	ACG
02453606	APO-OLMESARTAN/HCTZ	APX

##### <sup>ST</sup> 20MG/12.5MG TABLET

02319616	OLMETEC PLUS	FRS
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##### <sup>ST</sup> 40MG & 12.5MG TABLET

02443120	ACT OLMESARTAN HCT	ACG
02453614	APO-OLMESARTAN/HCTZ	APX

##### <sup>ST</sup> 40MG & 25MG TABLET

02443139	ACT OLMESARTAN HCT	ACG
02453622	APO-OLMESARTAN/HCTZ	APX

##### <sup>ST</sup> 40MG/12.5MG TABLET

02319624	OLMETEC PLUS	FRS
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##### <sup>ST</sup> 40MG/25MG TABLET

02319632	OLMETEC PLUS	FRS
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#### TELMISARTAN

##### <sup>ST</sup> 40MG TABLET

02393247	ACT TELMISARTAN	ACG
02420082	APO-TELMISARTAN	APX
02453568	AURO-TELMISARTAN	AUR
02240769	MICARDIS	BOE
02376717	MYLAN-TELMISARTAN	MYL
02391236	PMS-TELMISARTAN	PMS
02375958	SANDOZ TELMISARTAN	SDZ
02388944	TELMISARTAN	SAN
02390345	TELMISARTAN	SIV
02395223	TELMISARTAN	PDL
02407485	TELMISARTAN	ACC
02432897	TELMISARTAN	PMS
02320177	TEVA-TELMISARTAN	TEV

##### <sup>ST</sup> 80MG TABLET

02393255	ACT TELMISARTAN	ACG
02420090	APO-TELMISARTAN	APX
02453576	AURO-TELMISARTAN	AUR
02240770	MICARDIS	BOE
02376725	MYLAN-TELMISARTAN	MYL
02391244	PMS-TELMISARTAN	PMS
02375966	SANDOZ TELMISARTAN	SDZ
02388952	TELMISARTAN	SAN
02390353	TELMISARTAN	SIV
02395231	TELMISARTAN	PDL
02407493	TELMISARTAN	ACC
02432900	TELMISARTAN	PMS
02320185	TEVA-TELMISARTAN	TEV

### 24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

#### TELMISARTAN, HYDROCHLOROTHIAZIDE

##### <sup>ST</sup> 80MG & 12.5MG TABLET

02419114	ACH-TELMISARTAN HCTZ	ACC
02393263	ACT TELMISARTAN/HCT	ACG
02420023	APO-TELMISARTAN/HCTZ	APX
02456389	AURO-TELMISARTAN HCTZ	AUR
02244344	MICARDIS PLUS	BOE
02401665	PMS-TELMISARTAN-HCTZ	PMS
02393557	SANDOZ TELMISARTAN HCT	SDZ
02390302	TELMISARTAN HCTZ	SIV
02395355	TELMISARTAN/HCTZ	SAN
02395525	TELMISARTAN-HCTZ	PDL
02433214	TELMISARTAN-HCTZ	PMS
02330288	TEVA-TELMISARTAN HCTZ	TEV

##### <sup>ST</sup> 80MG & 25MG TABLET

02419122	ACH-TELMISARTAN HCTZ	ACC
02393271	ACT TELMISARTAN/HCT	ACG
02420031	APO-TELMISARTAN/HCTZ	APX
02456397	AURO-TELMISARTAN HCTZ	AUR
02318709	MICARDIS PLUS	BOE
02393565	SANDOZ TELMISARTAN HCT	SDZ
02390310	TELMISARTAN HCTZ	SIV
02395363	TELMISARTAN/HCTZ	SAN
02395533	TELMISARTAN-HCTZ	PDL
02433222	TELMISARTAN-HCTZ	PMS
02379252	TEVA-TELMISARTAN HCTZ	TEV

#### VALSARTAN

##### <sup>ST</sup> 80MG CAPSULE

02236808	DIOVAN	NVR
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##### <sup>ST</sup> 40MG TABLET

02337487	ACT VALSARTAN	ACG
02371510	APO-VALSARTAN	APX
02414201	AURO-VALSARTAN	AUR
02270528	DIOVAN	NVR
02383527	MYLAN-VALSARTAN	MYL
02312999	PMS-VALSARTAN	PMS
02363062	RAN-VALSARTAN	RBV
02425440	RIVA-VALSARTAN	RIV
02356740	SANDOZ VALSARTAN	SDZ
02356643	TEVA-VALSARTAN	TEV
02366940	VALSARTAN	SAN
02367726	VALSARTAN	PDL
02384523	VALSARTAN	SIV

##### <sup>ST</sup> 80MG TABLET

02337495	ACT VALSARTAN	ACG
02371529	APO-VALSARTAN	APX
02414228	AURO-VALSARTAN	AUR
02244781	DIOVAN	NVR
02414147	DOM-VALSARTAN	DPC
02383535	MYLAN-VALSARTAN	MYL
02313006	PMS-VALSARTAN	PMS
02363100	RAN-VALSARTAN	RBV
02425459	RIVA-VALSARTAN	RIV
02356759	SANDOZ VALSARTAN	SDZ

## 24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

### VALSARTAN

#### <sup>ST</sup> 80MG TABLET

02356651	TEVA-VALSARTAN	TEV
02366959	VALSARTAN	SAN
02367734	VALSARTAN	PDL
02384531	VALSARTAN	SIV

#### <sup>ST</sup> 160MG TABLET

02337509	ACT VALSARTAN	ACG
02371537	APO-VALSARTAN	APX
02414236	AURO-VALSARTAN	AUR
02244782	DIOVAN	NVR
02383543	MYLAN-VALSARTAN	MYL
02313014	PMS-VALSARTAN	PMS
02363119	RAN-VALSARTAN	RBV
02425467	RIVA-VALSARTAN	RIV
02356767	SANDOZ VALSARTAN	SDZ
02356678	TEVA-VALSARTAN	TEV
02366967	VALSARTAN	SAN
02367742	VALSARTAN	PDL
02384558	VALSARTAN	SIV

#### <sup>ST</sup> 320MG TABLET

02337517	ACT VALSARTAN	ACG
02371545	APO-VALSARTAN	APX
02414244	AURO-VALSARTAN	AUR
02289504	DIOVAN	NVR
02383551	MYLAN-VALSARTAN	MYL
02344564	PMS-VALSARTAN	PMS
02425475	RIVA-VALSARTAN	RIV
02356775	SANDOZ VALSARTAN	SDZ
02356686	TEVA-VALSARTAN	TEV
02366975	VALSARTAN	SAN
02367750	VALSARTAN	PDL
02384566	VALSARTAN	SIV

### VALSARTAN, HYDROCHLOROTHIAZIDE

#### <sup>ST</sup> 80MG & 12.5MG TABLET

02382547	APO-VALSARTAN/HCTZ	APX
02408112	AURO-VALSARTAN HCT	AUR
02241900	DIOVAN-HCT	NVR
02356694	SANDOZ VALSARTAN HCT	SDZ
02356996	TEVA-VALSARTAN/HCTZ	TEV
02367009	VALSARTAN HCT	SAN
02384736	VALSARTAN HCT	SIV
02367769	VALSARTAN-HCTZ	PDL

#### <sup>ST</sup> 160MG & 12.5MG TABLET

02382555	APO-VALSARTAN/HCTZ	APX
02408120	AURO-VALSARTAN HCT	AUR
02241901	DIOVAN-HCT	NVR
02356708	SANDOZ VALSARTAN HCT	SDZ
02357003	TEVA-VALSARTAN/HCTZ	TEV
02367017	VALSARTAN HCT	SAN
02384744	VALSARTAN HCT	SIV
02367777	VALSARTAN-HCTZ	PDL

#### <sup>ST</sup> 160MG & 25MG TABLET

02382563	APO-VALSARTAN/HCTZ	APX
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## 24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

### VALSARTAN, HYDROCHLOROTHIAZIDE

#### <sup>ST</sup> 160MG & 25MG TABLET

02408139	AURO-VALSARTAN HCT	AUR
02246955	DIOVAN-HCT	NVR
02356716	SANDOZ VALSARTAN HCT	SDZ
02357011	TEVA-VALSARTAN/HCTZ	TEV
02367025	VALSARTAN HCT	SAN
02384752	VALSARTAN HCT	SIV
02367785	VALSARTAN-HCTZ	PDL

#### <sup>ST</sup> 320MG & 12.5MG TABLET

02382571	APO-VALSARTAN/HCTZ	APX
02408147	AURO-VALSARTAN HCT	AUR
02308908	DIOVAN-HCT	NVR
02356724	SANDOZ VALSARTAN HCT	SDZ
02357038	TEVA-VALSARTAN/HCTZ	TEV
02367033	VALSARTAN HCT	SAN
02384760	VALSARTAN HCT	SIV

#### <sup>ST</sup> 320MG & 25MG TABLET

02382598	APO-VALSARTAN/HCTZ	APX
02408155	AURO-VALSARTAN HCT	AUR
02308916	DIOVAN-HCT	NVR
02356732	SANDOZ VALSARTAN HCT	SDZ
02357046	TEVA-VALSARTAN/HCTZ	TEV
02367041	VALSARTAN HCT	SAN
02384779	VALSARTAN HCT	SIV

## 24:32.20 MINERALOCORTICOIDE (ALDOSTERONE) RECEPTOR ANTAGONISTS

### EPLERENONE

Limited use benefit (prior approval required).

For the treatment of patients with New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction (with ejection fraction  $\leq 35\%$ ), as an adjunct to standard therapy.

Note: Patients must be on optimal therapy with an angiotensin-converting-enzyme (ACE) inhibitor or an angiotensin-receptor blocker (ARB), and a beta-blocker (unless contraindicated) at the recommended dose or

#### 25MG TABLET

02323052	INSPRA	PFI
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#### 50MG TABLET

02323060	INSPRA	PFI
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### HYDROCHLOROTHIAZIDE, SPIRONOLACTONE

#### <sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE

99503009	ALDACTAZIDE ORAL LIQUID	UNK
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### SPIRONOLACTONE

#### <sup>ST</sup> 25MG TABLET

00028606	ALDACTONE	PFI
00613215	TEVA-SPIRONOLACTONE	TEV

#### <sup>ST</sup> 100MG TABLET

00285455	ALDACTONE	PFI
00613223	TEVA-SPIRONOLACTONE	TEV

**24:32.20 MINERALOCORTICOIDE  
(ALDOSTERONE) RECEPTOR  
ANTAGONISTS**

**SPIRONOLACTONE**

<sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE

99503001 SPIRONOLACTONE ORAL LIQUID UNK

**24:32.92**

**VALSARTAN (SACUBITRIL VALSARTAN SODIUM  
HYDRATE COMPLEX), SACUBITRIL  
(SACUBITRIL VALSARTAN SODIUM HYDRATE  
COMPLEX)**

Limited use benefit (prior approval required).

For the treatment of New York Heart Association (NYHA) class II or III heart failure if the following criteria are met:

- Must be initiated by a physician experienced in the treatment of heart failure; AND
- Left ventricular ejection fraction < 40%; AND
- NYHA class II to III symptoms despite at least four weeks of treatment with an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB); OR If your patient has a contraindication or intolerance to ACEI or ARBs;
- AND
- Must be used in combination with a beta blocker and an aldosterone antagonist (if tolerated); OR If your patient has a contraindication or intolerance to beta blockers or aldosterone antagonists.

**26MG & 24MG TABLET**

02446928 ENTRESTO NVR

**51MG & 49MG TABLET**

02446936 ENTRESTO NVR

**103MG & 97MG TABLET**

02446944 ENTRESTO NVR

## 28:00 CENTRAL NERVOUS SYSTEM AGENTS

### 28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

#### ACETYLSALICYLIC ACID

Limited use benefit (prior approval is not required).

ASA 80 mg tablets are a benefit to clients age 21 years and under to allow access for use in pediatric conditions (e.g. Kawasaki Syndrome).

<b>150MG SUPPOSITORY</b>		
00785547	ASA	PMS
<b>650MG SUPPOSITORY</b>		
00582867	ASA	PMS
<sup>ST</sup>	<b>80MG TABLET</b>	
02269139	ACETYLSALICYLIC ACID	JMP
02295563	LOWPRIN	EUR
02202360	RIVASA	RIV
<sup>ST</sup>	<b>325MG TABLET</b>	
00472468	APO ASA	APX
00530336	ASA	VTH
02150328	ASPIRIN	BAY
<sup>ST</sup>	<b>80MG TABLET (CHEWABLE)</b>	
02009013	ASAPHEN	PMS
02280167	ASATAB	ODN
02250675	EURO-ASA	EUR
02296004	LOWPRIN	SDZ
02429950	M-ASA	MAN
02311518	PRO-AAS	PDL
02202352	RIVASA	RIV
<sup>ST</sup>	<b>81MG TABLET (CHEWABLE)</b>	
02394790	ASA DAILY LOW DOSE	PMS
02243974	ENTROPHEN	PED
<sup>ST</sup>	<b>80MG TABLET (DELAYED RELEASE)</b>	
02427176	ASA EC	SAN
02238545	ASAPHEN	PMS
02283905	JAMP-ASA	JMP
02311496	PRO-AAS	PDL
<sup>ST</sup>	<b>81MG TABLET (DELAYED RELEASE)</b>	
02244993	ASA	PMS
02372177	ASA	VTH
02433044	ASA	PMS
02449277	ASA	TLI
02243101	ASA DAILY LOW DOSE	PMS
02377683	ASA DAILY LOW DOSE	APX
02426811	ASA EC	SAN
02242281	ENTROPHEN	PED
02283700	PRAXIS ASA DAILY LOW DOSE	PMS
02420279	RIVASA EC	RIV
<sup>ST</sup>	<b>162MG TABLET (DELAYED RELEASE)</b>	
02247550	ASAPHEN EC	PMS
<sup>ST</sup>	<b>325MG TABLET (DELAYED RELEASE)</b>	
02010526	ASA	VTH
02352427	ASATAB EC	ODN
02150417	ASPIRIN	BAY
00010332	ENTROPHEN	PED
02050161	ENTROPHEN	PED

## 28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

#### ACETYLSALICYLIC ACID

Limited use benefit (prior approval is not required).

ASA 80 mg tablets are a benefit to clients age 21 years and under to allow access for use in pediatric conditions (e.g. Kawasaki Syndrome).

<sup>ST</sup>	<b>325MG TABLET (DELAYED RELEASE)</b>	
00216666	NOVASEN	TEV
02284529	PMS-ASA EC	PMS
<sup>ST</sup>	<b>650MG TABLET (DELAYED RELEASE)</b>	
00794244	ASA	VTH
02352435	ASATAB EC	ODN
00229296	NOVASEN	TEV
02284537	PMS-ASA EC	PMS
<sup>ST</sup>	<b>81MG TABLET (ENTERIC COATED)</b>	
02243896	ASA DAILY LOW DOSE	PMS
02237726	ASPIRIN	BAY
02243801	EQUATE DAILY LOW-DOSE	PMS
02427206	JAMP-ASA EC	VTH
<sup>ST</sup>	<b>325MG TABLET (ENTERIC COATED)</b>	
00510696	ASA	APX
02285371	PMS-ASA EC	PMS
<sup>ST</sup>	<b>650MG TABLET (ENTERIC COATED)</b>	
00472476	ASA	APX
00010340	ENTROPHEN	PED
01905392	ENTROPHEN	PED

#### CELECOXIB

Limited use benefit (prior approval required).

For patients who have:

- A history of serious gastrointestinal complications (e.g. ulcer, bleeding, and perforation); OR
- Multiple (at least two) risk factors for serious gastrointestinal complications (e.g. age >60, concurrent use of ASA, SSRIs, corticosteroids, anticoagulants or antiplatelet agents).

<sup>ST</sup>	<b>100MG CAPSULE</b>	
02435632	ACCEL-CELECOXIB	ACP
02420155	ACT CELECOXIB	ACG
02418932	APO-CELECOXIB	APX
02445670	AURO-CELECOXIB	AUR
02426382	BIO-CELECOXIB	BMI
02239941	CELEBREX	PFI
02424371	CELECOXIB	PDL
02429675	CELECOXIB	SIV
02436299	CELECOXIB	SAN
02291975	GD-CELECOXIB	PFI
02424533	JAMP-CELECOXIB	JMP
02420058	MAR-CELECOXIB	MAR
02412497	MINT-CELECOXIB	MIN
02423278	MYLAN-CELECOXIB	MYL
02355442	PMS-CELECOXIB	PMS
02426366	PRIVA-CELECOXIB	PHA
02412373	RAN-CELECOXIB	RBV
02425386	RIVA-CELECOX	RIV
02321246	SANDOZ CELECOXIB	SDZ
02442639	SDZ CELECOXIB	SDZ

## 28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

### CELECOXIB

Limited use benefit (prior approval required).

For patients who have:

- A history of serious gastrointestinal complications (e.g. ulcer, bleeding, and perforation); OR
- Multiple (at least two) risk factors for serious gastrointestinal complications (e.g. age >60, concurrent use of ASA, SSRIs, corticosteroids, anticoagulants or antiplatelet agents).

#### <sup>ST</sup> 100MG CAPSULE

02288915 TEVA-CELECOXIB TEV

#### <sup>ST</sup> 200MG CAPSULE

02435640 ACCEL-CELECOXIB ACP  
 02420163 ACT CELECOXIB ACG  
 02418940 APO-CELECOXIB APX  
 02445689 AURO-CELECOXIB AUR  
 02426390 BIO-CELECOXIB BMI  
 02239942 CELEBEX PFI  
 02424398 CELECOXIB PDL  
 02429683 CELECOXIB SIV  
 02436302 CELECOXIB SAN  
 02291983 GD-CELECOXIB PFI  
 02424541 JAMP-CELECOXIB JMP  
 02420066 MAR-CELECOXIB MAR  
 02412500 MINT-CELECOXIB MIN  
 02399881 MYLAN-CELECOXIB MYL  
 02355450 PMS-CELECOXIB PMS  
 02426374 PRIVA-CELECOXIB PHA  
 02412381 RAN-CELECOXIB RBY  
 02425394 RIVA-CELECOX RIV  
 02321254 SANDOZ CELECOXIB SDZ  
 02442647 SDZ CELECOXIB SDZ  
 02288923 TEVA-CELECOXIB TEV

### DICLOFENAC SODIUM

#### 50MG SUPPOSITORY

02231506 PMS-DICLOFENAC PMS  
 02261928 SANDOZ-DICLOFENAC SDZ  
 00632724 VOLTAREN NVR

#### 100MG SUPPOSITORY

02231508 PMS-DICLOFENAC PMS  
 02261936 SANDOZ-DICLOFENAC SDZ  
 00632732 VOLTAREN NVR

#### <sup>ST</sup> 25MG TABLET

02231502 PMS-DICLOFENAC PMS

#### <sup>ST</sup> 50MG TABLET

02231503 PMS-DICLOFENAC PMS

#### <sup>ST</sup> 25MG TABLET (DELAYED RELEASE)

02231662 DOM-DICLOFENAC DPC  
 02302616 PMS-DICLOFENAC PMS

#### <sup>ST</sup> 50MG TABLET (DELAYED RELEASE)

02231663 DOM-DICLOFENAC DPC  
 02302624 PMS-DICLOFENAC PMS  
 02261960 SANDOZ-DICLOFENAC SDZ  
 00514012 VOLTAREN NVR

#### <sup>ST</sup> 25MG TABLET (ENTERIC COATED)

00839175 APO-DICLO APX

## 28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

### DICLOFENAC SODIUM

#### <sup>ST</sup> 25MG TABLET (ENTERIC COATED)

00808539 TEVA-DICLOFENAC TEV

#### <sup>ST</sup> 50MG TABLET (ENTERIC COATED)

00839183 APO-DICLO APX  
 00870978 DICLOFENAC PDL  
 02352397 DICLOFENAC EC SAN  
 00808547 TEVA-DICLOFENAC TEV

#### <sup>ST</sup> 75MG TABLET (EXTENDED RELEASE)

02162814 APO-DICLO SR APX  
 02224119 DICLOFENAC-SR PDL  
 02231664 DOM-DICLOFENAC SR DPC  
 02231504 PMS-DICLOFENAC PMS  
 02261901 SANDOZ-DICLOFENAC SR SDZ  
 02158582 TEVA-DICLOFENAC SR TEV  
 00782459 VOLTAREN NVR

#### <sup>ST</sup> 100MG TABLET (EXTENDED RELEASE)

02091194 APO-DICLO SR APX  
 02224127 DICLOFENAC-SR PDL  
 02231505 PMS-DICLOFENAC PMS  
 02261944 SANDOZ-DICLOFENAC SR SDZ  
 02048698 TEVA-DICLOFENAC SR TEV  
 00590827 VOLTAREN SR NVR

### DICLOFENAC SODIUM (TOPICAL)

Limited use benefit (prior approval required).

For the treatment of osteoarthritis when:

- pain is inadequately controlled with acetaminophen AND a non-steroidal anti-inflammatory (NSAID); OR
- there is contraindication to acetaminophen and NSAID; OR
- there is intolerance to acetaminophen and NSAID.

#### <sup>ST</sup> 1.5% SOLUTION

02354403 APO-DICLOFENAC APX  
 02434571 DICLOFENAC TOPICAL RAX  
 02356783 PMS-DICLOFENAC PMS  
 02420988 TARO-DICLOFENAC TAR

### DIFLUNISAL

#### <sup>ST</sup> 250MG TABLET

02039486 DIFLUNISAL AAP  
 02048493 NOVO-DIFLUNISAL TEV

#### <sup>ST</sup> 500MG TABLET

02039494 DIFLUNISAL AAP

### FLURBIPROFEN

#### <sup>ST</sup> 50MG TABLET

01912046 APO-FLURBIPROFEN APX  
 02100509 TEVA-FLURBIPROFEN TEV

#### <sup>ST</sup> 100MG TABLET

01912038 APO-FLURBIPROFEN APX  
 02100517 TEVA-FLURBIPROFEN TEV

### IBUPROFEN

#### <sup>ST</sup> 20MG/ML SUSPENSION

02232297 CHILDREN'S ADVIL PFI  
 02354799 CHILDREN'S EUROPROFEN PED  
 02242365 CHILDREN'S MOTRIN MCL

**28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS****IBUPROFEN**<sup>ST</sup> **40MG/ML SUSPENSION**

02242522	ADVIL PEDIATRIC DROPS	PFI
02238626	CHILDREN'S MOTRIN	MCL

<sup>ST</sup> **100MG TABLET**

02246403	ADVIL	PFI
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<sup>ST</sup> **200MG TABLET**

01933558	ADVIL	PFI
00441643	APO-IBUPROFEN	APX
02257912	IBUPROFEN	PMT
02272849	IBUPROFEN	VTH
02314754	IBUPROFEN	PMS
02314762	IBUPROFEN	PMS
02186934	MOTRIN	MCL
00629324	NOVO-PROFEN	TEV

<sup>ST</sup> **300MG TABLET**

00441651	APO IBUPROFEN	APX
00629332	NOVO-PROFEN	TEV

<sup>ST</sup> **400MG TABLET**

00506052	APO IBUPROFEN	APX
00636533	IBUPROFEN	PDL
02314770	IBUPROFEN	PMS
02317338	IBUPROFEN	PMT
02401290	JAMP-IBUPROFEN	JMP
00629340	NOVO-PROFEN	TEV
00836133	PMS-IBUPROFEN	PMS

<sup>ST</sup> **600MG TABLET**

00585114	APO IBUPROFEN	APX
00629359	NOVO-PROFEN	TEV

**INDOMETHACIN**<sup>ST</sup> **25MG CAPSULE**

00611158	APO INDOMETHACIN	APX
02461811	MINT-INDOMETHACIN	MIN
00337420	TEVA-INDOMETHACIN	TEV

<sup>ST</sup> **50MG CAPSULE**

00611166	APO INDOMETHACIN	APX
02461536	MINT-INDOMETHACIN	MIN
00337439	TEVA-INDOMETHACIN	TEV

**50MG SUPPOSITORY**

02231799	SANDOZ INDOMETHACIN	SDZ
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**100MG SUPPOSITORY**

01934139	RATIO-INDOMETHACIN	TEV
02231800	SANDOZ INDOMETHACIN	SDZ

**KETOPROFEN**<sup>ST</sup> **50MG CAPSULE**

00790427	KETOPROFEN	AAP
02150808	PMS-KETOPROFEN	PMS

**100MG SUPPOSITORY**

02015951	PMS-KETOPROFEN	PMS
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<sup>ST</sup> **50MG TABLET (ENTERIC COATED)**

00790435	KETOPROFEN-E	AAP
02150816	PMS-KETOPROFEN	PMS

<sup>ST</sup> **100MG TABLET (ENTERIC COATED)**

00842664	KETOPROFEN-E	AAP
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**28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS****KETOPROFEN**<sup>ST</sup> **100MG TABLET (ENTERIC COATED)**

02150824	PMS-KETOPROFEN	PMS
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<sup>ST</sup> **200MG TABLET (EXTENDED RELEASE)**

02172577	KETOPROFEN SR	AAP
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**MEFENAMIC ACID**<sup>ST</sup> **250MG CAPSULE**

02237826	DOM-MEFENAMIC ACID	DPC
02229452	MEFENAMIC	AAP
00155225	PONSTAN	AAP

**MELOXICAM**<sup>ST</sup> **7.5MG TABLET**

02250012	ACT MELOXICAM	ACG
02248973	APO-MELOXICAM	APX
02390884	AURO-MELOXICAM	AUR
02248605	DOM-MELOXICAM	DPC
02324326	MELOXICAM	PDL
02353148	MELOXICAM	SAN
02242785	MOBICOX	BOE
02255987	MYLAN-MELOXICAM	MYL
02248607	PHL-MELOXICAM	PHH
02248267	PMS-MELOXICAM	PMS
02258315	TEVA-MELOXICAM	TEV

<sup>ST</sup> **15MG TABLET**

02250020	ACT MELOXICAM	ACG
02248974	APO-MELOXICAM	APX
02390892	AURO-MELOXICAM	AUR
02248606	DOM-MELOXICAM	DPC
02324334	MELOXICAM	PDL
02353156	MELOXICAM	SAN
02242786	MOBICOX	BOE
02255995	MYLAN-MELOXICAM	MYL
02248608	PHL-MELOXICAM	PHH
02248268	PMS-MELOXICAM	PMS
02258323	TEVA-MELOXICAM	TEV

**MISOPROSTOL, DICLOFENAC SODIUM**<sup>ST</sup> **200MCG & 50MG TABLET**

02400596	SANDOZ DICLOFENAC MISOPROSTOL	SDZ
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<sup>ST</sup> **200MCG & 75MG TABLET**

02400618	SANDOZ DICLOFENAC MISOPROSTOL	SDZ
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<sup>ST</sup> **200MCG & 50MG TABLET (DELAYED RELEASE)**

01917056	ARTHROTEC	PFI
02341689	GD-DICLOFENAC/MISOPROSTOL	PFI

<sup>ST</sup> **200MCG & 75MG TABLET (DELAYED RELEASE)**

02229837	ARTHROTEC	PFI
02341697	GD-DICLOFENAC/MISOPROSTOL	PFI

<sup>ST</sup> **200MCG & 50MG TABLET (ENTERIC COATED)**

02397145	ACT DICLO-MISO	ACG
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<sup>ST</sup> **200MCG & 75MG TABLET (ENTERIC COATED)**

02397153	ACT DICLO-MISO	ACG
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### 28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

#### NAPROXEN

<b>500MG SUPPOSITORY</b>		
02017237	PMS-NAPROXEN	PMS
<b><sup>ST</sup> 25MG/ML SUSPENSION</b>		
02162431	NAPROXEN	PEI
<b><sup>ST</sup> 125MG TABLET</b>		
00522678	APO NAPROXEN	APX
<b><sup>ST</sup> 220MG TABLET</b>		
02362430	NAPROXEN	PMS
02385007	NAPROXEN SODIUM	APX
<b><sup>ST</sup> 250MG TABLET</b>		
00522651	APO-NAPROXEN	APX
00590762	NAPROXEN	PDL
02350750	NAPROXEN	SAN
00565350	TEVA-NAPROXEN	TEV
<b><sup>ST</sup> 275MG TABLET</b>		
02162725	ANAPROX	APU
00784354	APO-NAPRO-NA	APX
02351013	NAPROXEN SODIUM	SAN
00887056	NAPROXEN-NA	PDL
00778389	TEVA-NAPROXEN	TEV
<b><sup>ST</sup> 375MG TABLET</b>		
00600806	APO-NAPROXEN	APX
00655686	NAPROXEN	PDL
02350769	NAPROXEN	SAN
00627097	TEVA-NAPROXEN	TEV
<b><sup>ST</sup> 500MG TABLET</b>		
00592277	APO-NAPROXEN	APX
00618721	NAPROXEN	PDL
02350777	NAPROXEN	SAN
00589861	TEVA-NAPROXEN	TEV
<b><sup>ST</sup> 500MG TABLET</b>		
02162717	ANAPROX DS	APU
01940309	APO-NAPRO-NA DS	APX
02351021	NAPROXEN SODIUM DS	SAN
02153386	NAPROXEN-NA DF	PDL
02026600	TEVA-NAPROXEN DS	TEV
<b><sup>ST</sup> 250MG TABLET (ENTERIC COATED)</b>		
02246699	APO-NAPROXEN EC	APX
02350785	NAPROXEN EC	SAN
02243312	TEVA-NAPROXEN	TEV
<b><sup>ST</sup> 375MG TABLET (ENTERIC COATED)</b>		
02246700	APO-NAPROXEN EC	APX
02243432	MYLAN-NAPROXEN	MYL
02162415	NAPROSYN	APU
02350793	NAPROXEN EC	SAN
02294702	PMS-NAPROXEN EC	PMS
02310945	PRO-NAPROXEN	PDL
02243313	TEVA-NAPROXEN	TEV
<b><sup>ST</sup> 500MG TABLET (ENTERIC COATED)</b>		
02246701	APO-NAPROXEN EC	APX
02241024	MYLAN-NAPROXEN EC	MYL
02162423	NAPROSYN	APU
02350807	NAPROXEN EC	SAN
02294710	PMS-NAPROXEN EC	PMS

### 28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

#### NAPROXEN

<b><sup>ST</sup> 500MG TABLET (ENTERIC COATED)</b>		
02310953	PRO-NAPROXEN	PDL
02243314	TEVA-NAPROXEN	TEV
<b><sup>ST</sup> 750MG TABLET (EXTENDED RELEASE)</b>		
02162466	NAPROSYN	APU
<b>PIROXICAM</b>		
<b><sup>ST</sup> 10MG CAPSULE</b>		
00642886	APO PIROXICAM	APX
00695718	TEVA-PIROXICAM	TEV
<b><sup>ST</sup> 20MG CAPSULE</b>		
00642894	APO PIROXICAM	APX
00695696	TEVA-PIROXICAM	TEV

#### SULINDAC

<b><sup>ST</sup> 150MG TABLET</b>		
00745588	TEVA-SULINDAC	TEV
<b><sup>ST</sup> 200MG TABLET</b>		
00745596	TEVA-SULINDAC	TEV

#### TIAPROFENIC ACID

<b><sup>ST</sup> 200MG TABLET</b>		
02230827	PMS-TIAPROFENIC	PMS
02179679	TEVA-TIAPROFENIC	TEV
<b><sup>ST</sup> 300MG TABLET</b>		
02231060	DOM-TIAPROFENIC	DPC
02179687	TEVA-TIAPROFENIC	TEV

### 28:08.08 OPIATE AGONISTS

#### ACETAMINOPHEN, CAFFEINE CITRATE, CODEINE PHOSPHATE

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

<b>300MG &amp; 15MG &amp; 15MG TABLET</b>		
00653241	RATIO-LENOLTEC NO 2	TEV
02163934	TYLENOL WITH CODEINE NO.2	JSO
<b>300MG &amp; 15MG &amp; 30MG TABLET</b>		
00653276	RATIO-LENOLTEC NO 3	TEV
02163926	TYLENOL WITH CODEINE NO.3	JSO
<b>325MG &amp; 30MG &amp; 15MG TABLET</b>		
00293504	ATASOL 15	CHU
<b>325MG &amp; 30MG &amp; 30MG TABLET</b>		
00293512	ATASOL 30	CHU

**28:08.08 OPIATE AGONISTS****ACETAMINOPHEN, CODEINE PHOSPHATE**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

**32MG & 1.6MG/ML ELIXIR**

00816027 PMS-ACETAMINOPHEN PMS

**300MG & 30MG TABLET**

01999648 ACET CODEINE 30 PMS

02232658 PROCET-30 PDL

00608882 TEVA-EMTEC-30 TEV

00789828 TRIATEC-30 RIV

**ACETAMINOPHEN, OXYCODONE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

**325MG & 2.5MG TABLET**

01916491 PERCOCET-DEMI BMS

**325MG & 5MG TABLET**

02324628 APO-OXYCODONE/ACET APX

01916548 ENDOCET BMS

02361361 OXYCODONE/ACET SAN

02327171 OXYCODONE-ACET PDL

02242468 RIVACOCET RIV

02307898 SANDOZ SDZ

OXYCODONE/ACETAMINOPHEN

00608165 TEVA-OXYCOCET TEV

**ACETYSALICYLIC ACID, OXYCODONE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**325MG & 5MG TABLET**

00608157 RATIO-OXYCODAN TEV

**28:08.08 OPIATE AGONISTS****CODEINE MONOHYDRATE, CODEINE SULFATE TRIHYDRATE**

Limited use benefit (prior approval required).

For treatment of:

- chronic pain and palliative care patients as an alternative to products containing codeine in combination with acetaminophen or ASA with or without caffeine; OR
- chronic pain and palliative care patients as an alternative to regular release codeine tablets when large doses are required.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**50MG TABLET (EXTENDED RELEASE)**

02230302 CODEINE CONTIN CR PFR

**100MG TABLET (EXTENDED RELEASE)**

02163748 CODEINE CONTIN CR PFR

**150MG TABLET (EXTENDED RELEASE)**

02163780 CODEINE CONTIN CR PFR

**200MG TABLET (EXTENDED RELEASE)**

02163799 CODEINE CONTIN CR PFR

**CODEINE PHOSPHATE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**5MG/ML LIQUID**

00050024 CODEINE PHOSPHATE ATL

**2MG/ML SOLUTION**

00380571 LINCTUS CODEINE ATL

**15MG TABLET**

02009889 CODEINE RIV

00593435 RATIO-CODEINE TEV

**30MG TABLET**

02009757 CODEINE RIV

02243979 PMS-CODEINE PMS

00593451 RATIO-CODEINE TEV

**28:08.08 OPIATE AGONISTS****FENTANYL**

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**12MCG/HR PATCH**

02386844	CO FENTANYL	OBT
02395657	FENTANYL	PDL
02396696	MYLAN-FENTANYL MATRIX	MYL
02341379	PMS-FENTANYL MTX	PMS
02330105	RAN-FENTANYL MATRIX	RBY
02327112	SANDOZ FENTANYL	SDZ
02311925	TEVA-FENTANYL	TEV

**25MCG/HR PATCH**

02314630	APO-FENTANYL MATRIX	APX
02386852	CO FENTANYL	OBT
02275813	DURAGESIC	JSO
02395665	FENTANYL	PDL
02396718	MYLAN-FENTANYL MATRIX	MYL
02341387	PMS-FENTANYL MTX	PMS
02330113	RAN-FENTANYL MATRIX	RBY
02327120	SANDOZ FENTANYL	SDZ
02282941	TEVA-FENTANYL	TEV

**50MCG/HR PATCH**

02314649	APO-FENTANYL MATRIX	APX
02386879	CO FENTANYL	OBT
02275821	DURAGESIC	JSO
02395673	FENTANYL	PDL
02396726	MYLAN-FENTANYL MATRIX	MYL
02341395	PMS-FENTANYL MTX	PMS
02330121	RAN-FENTANYL MATRIX	RBY
02327147	SANDOZ FENTANYL	SDZ
02282968	TEVA-FENTANYL	TEV

**75MCG/HR PATCH**

02314657	APO-FENTANYL MATRIX	APX
02386887	CO FENTANYL	OBT
02275848	DURAGESIC	JSO
02395681	FENTANYL	PDL
02396734	MYLAN-FENTANYL MATRIX	MYL
02341409	PMS-FENTANYL MTX	PMS
02330148	RAN-FENTANYL MATRIX	RBY
02327155	SANDOZ FENTANYL	SDZ
02282976	TEVA-FENTANYL	TEV

**100MCG/HR PATCH**

02314665	APO-FENTANYL MATRIX	APX
02386895	CO FENTANYL	OBT
02275856	DURAGESIC	JSO
02395703	FENTANYL	PDL

**28:08.08 OPIATE AGONISTS****FENTANYL**

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**100MCG/HR PATCH**

02396742	MYLAN-FENTANYL MATRIX	MYL
02341417	PMS-FENTANYL MTX	PMS
02330156	RAN-FENTANYL MATRIX	RBY
02327163	SANDOZ FENTANYL	SDZ
02282984	TEVA-FENTANYL	TEV

**HYDROMORPHONE HYDROCHLORIDE**

Limited use benefit.

Prior approval required for controlled release capsules only. Regular release dosage forms are full benefits and do not require prior approval.

For treatment of moderate to severe chronic pain when other opioids such as morphine have been ineffective in controlling pain or in patients experiencing intolerable side effects.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**3MG CAPSULE (SUSTAINED RELEASE)**

02125323	HYDROMORPH CONTIN	PFR
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**4.5MG CAPSULE (SUSTAINED RELEASE)**

02359502	HYDROMORPH CONTIN	PFR
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**6MG CAPSULE (SUSTAINED RELEASE)**

02125331	HYDROMORPH CONTIN	PFR
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**9MG CAPSULE (SUSTAINED RELEASE)**

02359510	HYDROMORPH CONTIN	PFR
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**12MG CAPSULE (SUSTAINED RELEASE)**

02125366	HYDROMORPH CONTIN	PFR
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**18MG CAPSULE (SUSTAINED RELEASE)**

02243562	HYDROMORPH CONTIN	PFR
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**24MG CAPSULE (SUSTAINED RELEASE)**

02125382	HYDROMORPH CONTIN	PFR
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**30MG CAPSULE (SUSTAINED RELEASE)**

02125390	HYDROMORPH CONTIN	PFR
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**1MG/ML LIQUID**

00786535	DILAUDID	PFR
01916386	PMS HYDROMORPHONE	PMS

**3MG SUPPOSITORY**

01916394	PMS HYDROMORPHONE	PMS
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**1MG TABLET**

02364115	APO-HYDROMORPHONE	APX
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**28:08.08 OPIATE AGONISTS****HYDROMORPHONE HYDROCHLORIDE**

Limited use benefit.

Prior approval required for controlled release capsules only. Regular release dosage forms are full benefits and do not require prior approval.

For treatment of moderate to severe chronic pain when other opioids such as morphine have been ineffective in controlling pain or in patients experiencing intolerable side effects.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**1MG TABLET**

00705438	DILAUDID	PFR
00885444	PMS-HYDROMORPHONE	PMS
02319403	TEVA-HYDROMORPHONE	TEV

**2MG TABLET**

02364123	APO-HYDROMORPHONE	APX
00125083	DILAUDID	PFR
00885436	PMS-HYDROMORPHONE	PMS
02319411	TEVA-HYDROMORPHONE	TEV

**4MG TABLET**

02364131	APO-HYDROMORPHONE	APX
00125121	DILAUDID	PFR
00885401	PMS-HYDROMORPHONE	PMS
02319438	TEVA-HYDROMORPHONE	TEV

**8MG TABLET**

02364158	APO-HYDROMORPHONE	APX
00786543	DILAUDID	PFR
00885428	PMS-HYDROMORPHONE	PMS
02319446	TEVA-HYDROMORPHONE	TEV

**METHADONE HYDROCHLORIDE****POWDER**

00908835	METHADONE POWDER (OAT)	MDS
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**10MG/ML SOLUTION**

02244290	METADOL-D	PAL
02394596	METHADOSE	MAT
02394618	METHADOSE	MAT

**METHADONE HYDROCHLORIDE (BC ONLY)****10MG/ML ORAL LIQUID**

66999999	METHADOSE DEL. W DIRECT INTER (OAT)	UNK
67000000	METHADOSE DEL. W/OUT DIR INTER (OAT)	UNK
66999997	METHADOSE W DIRECT INTERACTION (OAT)	UNK
66999998	METHADOSE W/OUT DIRECT INTER (OAT)	UNK

**28:08.08 OPIATE AGONISTS****METHADONE HYDROCHLORIDE (METADOL)**

Limited use benefit (prior approval required) with the following criteria:

Prescriber is registered with Health Canada and is eligible to prescribe methadone for the management of pain; AND For the management of moderate to severe cancer pain or chronic non-cancer pain, as an alternative to other opioids; OR

For the management of pain for palliative care patients. Pharmacists may only dispense a maximum supply of 30 days at one time.

**1MG/ML SOLUTION**

02247694	METADOL	PAL
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**10MG/ML SOLUTION**

02241377	METADOL	PAL
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**1MG TABLET**

02247698	METADOL	PAL
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**5MG TABLET**

02247699	METADOL	PAL
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**10MG TABLET**

02247700	METADOL	PAL
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**25MG TABLET**

02247701	METADOL	PAL
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**MORPHINE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**1MG/ML SYRUP**

00614491	DOLORAL 1	ATL
00607762	RATIO-MORPHINE	TEV

**5MG/ML SYRUP**

00614505	DOLORAL 5	ATL
00607770	RATIO-MORPHINE	TEV

**10MG/ML SYRUP**

00690783	RATIO-MORPHINE	TEV
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**20MG/ML SYRUP**

00690791	RATIO-MORPHINE	TEV
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**MORPHINE SULFATE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**10MG CAPSULE (EXTENDED RELEASE)**

02019930	M-ESLON	ETH
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**15MG CAPSULE (EXTENDED RELEASE)**

02177749	M-ESLON	ETH
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**30MG CAPSULE (EXTENDED RELEASE)**

02019949	M-ESLON	ETH
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**28:08.08 OPIATE AGONISTS****MORPHINE SULFATE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

<b>60MG CAPSULE (EXTENDED RELEASE)</b>		
02019957 M-ESLON	ETH	
<b>100MG CAPSULE (EXTENDED RELEASE)</b>		
02019965 M-ESLON	ETH	
<b>200MG CAPSULE (EXTENDED RELEASE)</b>		
02177757 M-ESLON	ETH	
<b>20MG/ML DROP</b>		
00621935 STATEX	PAL	
<b>50MG/ML DROP</b>		
00705799 STATEX	PAL	
<b>5MG SUPPOSITORY</b>		
00632228 STATEX	PAL	
<b>10MG SUPPOSITORY</b>		
00632201 STATEX	PAL	
<b>20MG SUPPOSITORY</b>		
00596965 STATEX	PAL	
<b>1MG/ML SYRUP</b>		
00591467 STATEX	PAL	
<b>5MG/ML SYRUP</b>		
00591475 STATEX	PAL	
<b>10MG/ML SYRUP</b>		
00647217 STATEX	PAL	
<b>5MG TABLET</b>		
00594652 STATEX	PAL	
<b>10MG TABLET</b>		
00594644 STATEX	PAL	
<b>25MG TABLET</b>		
00594636 STATEX	PAL	
<b>50MG TABLET</b>		
00675962 STATEX	PAL	
<b>15MG TABLET (EXTENDED RELEASE)</b>		
02350815 MORPHINE SR	SAN	
02015439 MS CONTIN SR	PFR	
02244790 SANDOZ MORPHINE SR	SDZ	
02302764 TEVA-MORPHINE SR	TEV	
<b>30MG TABLET (EXTENDED RELEASE)</b>		
02350890 MORPHINE SR	SAN	
02014297 MS CONTIN SR	PFR	
02244791 SANDOZ MORPHINE SR	SDZ	
02302772 TEVA-MORPHINE SR	TEV	
<b>60MG TABLET (EXTENDED RELEASE)</b>		
02350912 MORPHINE SR	SAN	
02014300 MS CONTIN SR	PFR	
02244792 SANDOZ MORPHINE SR	SDZ	
02302780 TEVA-MORPHINE SR	TEV	
<b>100MG TABLET (EXTENDED RELEASE)</b>		
02014319 MS CONTIN SR	PFR	
02302799 TEVA-MORPHINE SR	TEV	

**28:08.08 OPIATE AGONISTS****MORPHINE SULFATE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

<b>200MG TABLET (EXTENDED RELEASE)</b>		
02014327 MS CONTIN SR	PFR	
02302802 TEVA-MORPHINE SR	TEV	
<b>5MG TABLET (IMMEDIATE RELEASE)</b>		
02014203 MS IR	PFR	
<b>10MG TABLET (IMMEDIATE RELEASE)</b>		
02014211 MS IR	PFR	
<b>20MG TABLET (IMMEDIATE RELEASE)</b>		
02014238 MS IR	PFR	
<b>30MG TABLET (IMMEDIATE RELEASE)</b>		
02014254 MS IR	PFR	

**MORPHINE SULFATE (KADIAN)**

Limited use benefit (prior approval required).

- For the treatment of opioid dependence where methadone and Suboxone are not available or not appropriate; OR
- For the treatment of chronic pain.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

<b>10MG CAPSULE (SUSTAINED RELEASE)</b>		
02242163 KADIAN	BGP	
09991310 KADIAN	MAY	
<b>20MG CAPSULE (SUSTAINED RELEASE)</b>		
02184435 KADIAN	BGP	
09991311 KADIAN	MAY	
<b>50MG CAPSULE (SUSTAINED RELEASE)</b>		
02184443 KADIAN	BGP	
09991312 KADIAN	MAY	
<b>100MG CAPSULE (SUSTAINED RELEASE)</b>		
02184451 KADIAN	BGP	
09991313 KADIAN	MAY	

**OXYCODONE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

<b>10MG SUPPOSITORY</b>		
00392480 SUPEUDOL	SDZ	
<b>20MG SUPPOSITORY</b>		
00392472 SUPEUDOL	SDZ	
<b>5MG TABLET</b>		
02325950 OXYCODONE	PDL	

**28:08.08 OPIATE AGONISTS**

**OXYCODONE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**5MG TABLET**

02231934	OXY-IR	PFR
02319977	PMS-OXYCODONE	PMS
00789739	SUPEUDOL	SDZ

**10MG TABLET**

02325969	OXYCODONE	PDL
02240131	OXY-IR	PFR
02319985	PMS-OXYCODONE	PMS
00443948	SUPEUDOL	SDZ

**20MG TABLET**

02325977	OXYCODONE	PDL
02319993	PMS-OXYCODONE	PMS
02262983	SUPEUDOL	SDZ

**20MG TABLET (IMMEDIATE RELEASE)**

02240132	OXY-IR	PFR
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**28:08.12 OPIATE PARTIAL AGONISTS**

**BUPRENORPHINE HYDROCHLORIDE,  
NALOXONE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For the treatment of opioid dependence when:

- The client must be 16 years or older.
- In cases where the client lives in a remote or isolated location, confirmation is required that the community has the ability to support Suboxone administration. These supports include the safe daily witnessing, storage and handling of the Suboxone doses. After this confirmation, NIHB will approve the Suboxone for the client.

**2MG & 0.5MG TABLET**

02408090	MYLAN-BUPRENORPHINE/NALOXONE	MYL
02424851	PMS-BUPRENORPHINE-NALOXONE	PMS
02295695	SUBOXONE	IND

**8MG & 2MG TABLET**

02408104	MYLAN-BUPRENORPHINE/NALOXONE	MYL
02424878	PMS-BUPRENORPHINE-NALOXONE	PMS
02295709	SUBOXONE	IND

**28:08.92 MISCELLANEOUS ANALGESICS  
AND ANTIPYRETICS**

**ACETAMINOPHEN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

**<sup>ST</sup> 80MG/ML DROP**

02027801	PEDIATRIX	TEV
00875988	TEMPRA INFANT	PAL

**<sup>ST</sup> 16MG/ML LIQUID**

01905848	ACETAMINOPHEN	TLI
00792713	PDP-ACETAMINOPHEN	PED
02263807	PEDIAPHEN	EUR
00884553	TEMPRA CHILDREN'S	PAL

**<sup>ST</sup> 32MG/ML LIQUID**

01901389	ACETAMINOPHEN	JMP
01958836	ACETAMINOPHEN	TLI
00792691	PDP-ACETAMINOPHEN	PED
02263831	PEDIAPHEN	EUR
02027798	PEDIATRIX	TEV
00875996	TEMPRA CHILDREN'S DOUBLE STRENGTH	PAL
02046040	TYLENOL	MCL

**<sup>ST</sup> 80MG/ML ORAL LIQUID**

01905864	ACETAMINOPHEN	TLI
02046059	TYLENOL	MCL

**<sup>ST</sup> 80MG/ML SOLUTION**

01904140	ACETAMINOPHEN	TAN
02237390	ACETAMINOPHEN	PER
00887587	PDP-ACETAMINOPHEN	PED
02263793	PEDIAPHEN	EUR

**120MG SUPPOSITORY**

00553328	ABENOL	GSK
01919385	ABENOL	PED
02230434	ACET 120	PED
02046660	PMS-ACETAMINOPHEN	PMS

**160MG SUPPOSITORY**

02230435	ACET	PED
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**325MG SUPPOSITORY**

01919393	ABENOL	PED
02230436	ACET 325	PED
02046687	PMS-ACETAMINOPHEN	PMS

**650MG SUPPOSITORY**

01919407	ABENOL	PED
02230437	ACET 650	PED
02046695	PMS-ACETAMINOPHEN	PMS

**<sup>ST</sup> 80MG TABLET**

01905856	ACETAMINOPHEN	TLI
02015676	ACETAMINOPHEN	TAN
02263815	PEDIAPHEN	EUR
02238295	TYLENOL JR STRENGTH FASTMELTS	MCL

## 28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

### ACETAMINOPHEN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

#### <sup>ST</sup> 160MG TABLET

02017431	ACETAMINOPHEN	RIV
02230934	ACETAMINOPHEN	TAN

#### <sup>ST</sup> 325MG TABLET

00382752	ACETAMINOPHEN	PDL
00605751	ACETAMINOPHEN	VTH
00743542	ACETAMINOPHEN	PMT
00789801	ACETAMINOPHEN	TLI
01938088	ACETAMINOPHEN	JMP
02022214	ACÉTAMINOPHÈNE	RIV
02362198	ACÉTAMINOPHÈNE	RIV
00544981	APO ACETAMINOPHEN	APX
02229873	APO-ACETAMINOPHEN	APX
02451018	M-ACETAMINOPHEN	MAN
00389218	NOVO-GESIC	TEV
00559393	TYLENOL	MCL
00723894	TYLENOL	MCL

#### <sup>ST</sup> 500MG TABLET

00386626	ACETAMINOPHEN	PDL
00549703	ACETAMINOPHEN	PMT
00605778	ACETAMINOPHEN	VTH
00789798	ACETAMINOPHEN	TLI
01939122	ACETAMINOPHEN	JMP
01962353	ACETAMINOPHEN	TAN
02252813	ACETAMINOPHEN	PMT
02255251	ACETAMINOPHEN	PMT
02022222	ACÉTAMINOPHÈNE	RIV
02362228	ACÉTAMINOPHÈNE	RIV
02362201	ACÉTAMINOPHÈNE BLASON SHIELD	RIV
00545007	APO ACETAMINOPHEN	APX
02229977	APO-ACETAMINOPHEN	APX
00013668	ATASOL FORTE	CHU
02355299	JAMP ACETAMINOPHEN BLAZON	JMP
02451123	M-ACETAMINOPHEN	MAN
00482323	NOVO-GESIC FORTE	TEV
00892505	PMS-ACETAMINOPHEN	PMS
00723908	TYLENOL	MCL
00559407	TYLENOL EXTRA STRENGTH	MCL

#### <sup>ST</sup> 80MG TABLET (CHEWABLE)

02017458	ACETAMINOPHEN	RIV
02129957	ACETAMINOPHEN	VTH

#### <sup>ST</sup> 160MG TABLET (CHEWABLE)

02142805	ACETAMINOPHEN	VTH
02263823	PEDIAPHEN	EUR

## 28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

### ACETAMINOPHEN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

#### <sup>ST</sup> 160MG TABLET (CHEWABLE)

02347792	TYLENOL JR STRENGTH FASTMELTS	MCL
02241361	TYLENOL JUNIOR STRENGTH	MCL

### FLOCTAFENINE

#### <sup>ST</sup> 200MG TABLET

02244680	FLOCTAFENINE	AAP
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#### <sup>ST</sup> 400MG TABLET

02244681	FLOCTAFENINE	AAP
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## 28:10.00 OPIATE ANTAGONISTS

### NALOXONE HYDROCHLORIDE

#### INJECTION

09991488	NALOXONE KIT	UNK
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#### 0.4MG/ML INJECTION

09991460	NALOXONE KIT	UNK
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#### 0.4MG SOLUTION

02453258	S.O.S NALOXONE HYDROCHLORIDE	SDZ
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#### 0.4MG/ML SOLUTION

02148706	NALOXONE	SDZ
02382482	NALOXONE	TEL
02382601	NALOXONE	SDZ
02393034	NALOXONE	OMG

#### 1MG/ML SOLUTION

02148714	NALOXONE	SDZ
02393042	NALOXONE	OMG

### NALTREXONE HYDROCHLORIDE

#### 50MG TABLET

02444275	APO-NALTREXONE	APX
02213826	REVIA	TEV

## 28:12.04 ANTICONVULSANTS - BARBITURATES

### PHENOBARBITAL

#### 5MG/ML ELIXIR

00645575	PHENOBARB	PED
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#### 100MG TABLET

00178829	PHENOBARB	PED
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### PRIMIDONE

#### <sup>ST</sup> 125MG TABLET

00399310	PRIMIDONE	AAP
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#### <sup>ST</sup> 250MG TABLET

00396761	PRIMIDONE	AAP
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**28:12.08 ANTICONVULSANTS -  
BENZODIAZEPINES****CLOBAZAM**<sup>ST</sup> **10MG TABLET**

02244638	APO-CLOBAZAM	APX
02248454	CLOBAZAM	PDL
02221799	FRISIUM	LUK
02244474	PMS-CLOBAZAM	PMS
02238334	TEVA-CLOBAZAM	TEV

**CLONAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **0.25MG TABLET**

02442027	CLONAZEPAM	SIV
02179660	PMS-CLONAZEPAM	PMS

<sup>ST</sup> **0.5MG TABLET**

02177889	APO-CLONAZEPAM	APX
02230366	CLONAPAM	VAE
02442035	CLONAZEPAM	SIV
02270641	CO CLONAZEPAM	OBT
02130998	DOM-CLONAZEPAM	DPC
02224100	DOM-CLONAZEPAM-R	DPC
02230950	MYLAN-CLONAZEPAM	MYL
02145227	PHL-CLONAZEPAM	PHH
02236948	PHL-CLONAZEPAM-R	PHH
02048701	PMS-CLONAZEPAM	PMS
02207818	PMS-CLONAZEPAM-R	PMS
02311593	PRO-CLONAZEPAM	PDL
02242077	RIVA-CLONAZEPAM	RIV
00382825	RIVOTRIL	HLR
02233960	SANDOZ CLONAZEPAM	SDZ
02239024	TEVA-CLONAZEPAM	TEV

<sup>ST</sup> **1MG TABLET**

02230368	CLONAPAM	VAE
02442043	CLONAZEPAM	SIV
02270668	CO CLONAZEPAM	OBT
02145235	PHL-CLONAZEPAM	PHH
02048728	PMS-CLONAZEPAM	PMS
02311607	PRO-CLONAZEPAM	PDL
02233982	SANDOZ CLONAZEPAM	SDZ

<sup>ST</sup> **2MG TABLET**

02177897	APO-CLONAZEPAM	APX
02230369	CLONAPAM	VAE
02442051	CLONAZEPAM	SIV
02270676	CO CLONAZEPAM	OBT
02131013	DOM-CLONAZEPAM	DPC
02230951	MYLAN-CLONAZEPAM	MYL
02145243	PHL-CLONAZEPAM	PHH
02048736	PMS-CLONAZEPAM	PMS
02311615	PRO-CLONAZEPAM	PDL

**28:12.08 ANTICONVULSANTS -  
BENZODIAZEPINES****CLONAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **2MG TABLET**

02242078	RIVA-CLONAZEPAM	RIV
00382841	RIVOTRIL	HLR
02233985	SANDOZ CLONAZEPAM	SDZ
02239025	TEVA-CLONAZEPAM	TEV

<sup>ST</sup> **PDIN FOR EXTEMPORANEOUS MIXTURE**

99503020	BENZODIAZEPINE ORAL LIQUID	UNK
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**28:12.12 ANTICONVULSANTS -  
HYDANTOINS****PHENYTOIN**<sup>ST</sup> **30MG CAPSULE**

00022772	DILANTIN	PFI
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<sup>ST</sup> **100MG CAPSULE**

00022780	DILANTIN	PFI
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<sup>ST</sup> **6MG/ML SUSPENSION**

00023442	DILANTIN	PFI
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<sup>ST</sup> **25MG/ML SUSPENSION**

00023450	DILANTIN	PFI
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02250896	TARO-PHENYTOIN	TAR
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<sup>ST</sup> **50MG TABLET**

00023698	DILANTIN INFATABS	PFI
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**28:12.20 ANTICONVULSANTS-  
SUCCINIMIDES****ETHOSUXIMIDE**<sup>ST</sup> **250MG CAPSULE**

00022799	ZARONTIN	ERF
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<sup>ST</sup> **50MG/ML SYRUP**

00023485	ZARONTIN	ERF
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**28:12.92 MISCELLANEOUS  
ANTICONVULSANTS****CARBAMAZEPINE**<sup>ST</sup> **20MG/ML SUSPENSION**

02367394	TARO-CARBAMAZEPINE	TAR
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02194333	TEGRETOL	NVR
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<sup>ST</sup> **200MG TABLET**

00402699	APO CARBAMAZEPINE	APX
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00504742	MAZEPINE	BMI
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02407515	TARO-CARBAMAZEPINE	TAR
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00010405	TEGRETOL	NVR
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00782718	TEVA-CARBAMAZEPINE	TEV
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<sup>ST</sup> **100MG TABLET (CHEWABLE)**

02231542	PMS-CARBAMAZEPINE	PMS
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**28:12.92 MISCELLANEOUS  
ANTICONVULSANTS**

**CARBAMAZEPINE**

<sup>ST</sup> **100MG TABLET (CHEWABLE)**

02244403	TARO-CARBAMAZEPINE	TAR
00369810	TEGRETOL	NVR

<sup>ST</sup> **200MG TABLET (CHEWABLE)**

02231540	PMS-CARBAMAZEPINE	PMS
02244404	TARO-CARBAMAZEPINE	TAR
00665088	TEGRETOL	NVR

<sup>ST</sup> **200MG TABLET (EXTENDED RELEASE)**

02413590	CARBAMAZEPINE	PDL
02238222	DOM-CARBAMAZEPINE	DPC
02231543	PMS-CARBAMAZEPINE	PMS
02261839	SANDOZ-CARBAMAZEPINE	SDZ
02237907	TARO-CARBAMAZEPINE	TAR
00773611	TEGRETOL	NVR

<sup>ST</sup> **400MG TABLET (EXTENDED RELEASE)**

02413604	CARBAMAZEPINE	PDL
02238223	DOM-CARBAMAZEPINE	DPC
02231544	PMS-CARBAMAZEPINE	PMS
02261847	SANDOZ-CARBAMAZEPINE	SDZ
02237908	TARO-CARBAMAZEPINE	TAR
00755583	TEGRETOL	NVR

**ESLICARBAZEPINE ACETATE**

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:

- Are under the care of a physician experienced in the treatment of epilepsy; AND
- Are currently receiving two or more antiepileptic medications; AND
- Have failed or demonstrated intolerance to at least two other antiepileptic medications.

<sup>ST</sup> **200MG TABLET**

02426862	APTIOM	SPC
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<sup>ST</sup> **400MG TABLET**

02426870	APTIOM	SPC
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<sup>ST</sup> **600MG TABLET**

02426889	APTIOM	SPC
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<sup>ST</sup> **800MG TABLET**

02426897	APTIOM	SPC
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**GABAPENTIN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

<sup>ST</sup> **100MG CAPSULE**

02256142	ACT GABAPENTIN	ACG
02244304	APO-GABAPENTIN	APX
02321203	AURO-GABAPENTIN	AUR
02243743	DOM-GABAPENTIN	DPC
02246314	GABAPENTIN	SIV
02353245	GABAPENTIN	SAN
02416840	GABAPENTIN	ACC

**28:12.92 MISCELLANEOUS  
ANTICONVULSANTS**

**GABAPENTIN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

<sup>ST</sup> **100MG CAPSULE**

02285819	GD-GABAPENTIN	PFI
02361469	JAMP-GABAPENTIN	JMP
02391473	MAR-GABAPENTIN	MAR
02248259	MYLAN-GABAPENTIN	MYL
02084260	NEURONTIN	PFI
02243446	PMS-GABAPENTIN	PMS
02310449	PRO-GABAPENTIN	PDL
02319055	RAN-GABAPENTIN	RBV
02251167	RIVA-GABAPENTIN	RIV
02244513	TEVA-GABAPENTIN	TEV

<sup>ST</sup> **300MG CAPSULE**

02256150	ACT GABAPENTIN	ACG
02244305	APO-GABAPENTIN	APX
02321211	AURO-GABAPENTIN	AUR
02243744	DOM-GABAPENTIN	DPC
02246315	GABAPENTIN	SIV
02353253	GABAPENTIN	SAN
02416859	GABAPENTIN	ACC
02285827	GD-GABAPENTIN	PFI
02361485	JAMP-GABAPENTIN	JMP
02391481	MAR-GABAPENTIN	MAR
02248260	MYLAN-GABAPENTIN	MYL
02084279	NEURONTIN	PFI
02243447	PMS-GABAPENTIN	PMS
02310457	PRO-GABAPENTIN	PDL
02319063	RAN-GABAPENTIN	RBV
02251175	RIVA-GABAPENTIN	RIV
02244514	TEVA-GABAPENTIN	TEV

<sup>ST</sup> **400MG CAPSULE**

02256169	ACT GABAPENTIN	ACG
02244306	APO-GABAPENTIN	APX
02321238	AURO-GABAPENTIN	AUR
02243745	DOM-GABAPENTIN	DPC
02246316	GABAPENTIN	SIV
02353261	GABAPENTIN	SAN
02416867	GABAPENTIN	ACC
02361493	JAMP-GABAPENTIN	JMP
02391503	MAR-GABAPENTIN	MAR
02248261	MYLAN-GABAPENTIN	MYL
02084287	NEURONTIN	PFI
02243448	PMS-GABAPENTIN	PMS
02310465	PRO-GABAPENTIN	PDL
02319071	RAN-GABAPENTIN	RBV
02251183	RIVA-GABAPENTIN	RIV
02244515	TEVA-GABAPENTIN	TEV

<sup>ST</sup> **600MG TABLET**

02293358	APO-GABAPENTIN	APX
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**28:12.92 MISCELLANEOUS  
ANTICONSULSANTS**

**GABAPENTIN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

<sup>ST</sup> **600MG TABLET**

02388200	GABAPENTIN	SIV
02392526	GABAPENTIN	ACC
02431289	GABAPENTIN	SAN
02285843	GD-GABAPENTIN	PFI
02402289	JAMP-GABAPENTIN	JMP
02397471	MYLAN-GABAPENTIN	MYL
02239717	NEURONTIN	PFI
02255898	PMS-GABAPENTIN	PMS
02310473	PRO-GABAPENTIN	PDL
02259796	RIVA-GABAPENTIN	RIV
02248457	TEVA-GABAPENTIN	TEV

<sup>ST</sup> **800MG TABLET**

02293366	APO-GABAPENTIN	APX
02388219	GABAPENTIN	SIV
02392534	GABAPENTIN	ACC
02431297	GABAPENTIN	SAN
02402297	JAMP-GABAPENTIN	JMP
02397498	MYLAN-GABAPENTIN	MYL
02239718	NEURONTIN	PFI
02255901	PMS-GABAPENTIN	PMS
02310481	PRO-GABAPENTIN	PDL
02259818	RIVA-GABAPENTIN	RIV
02247346	TEVA-GABAPENTIN	TEV

**LACOSAMIDE**

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:

- Are under the care of a physician experienced in the treatment of epilepsy; AND
- Are currently receiving two or more antiepileptic medications; AND
- Have failed or demonstrated intolerance to at least two other antiepileptic medications.

<sup>ST</sup> **50MG TABLET**

02357615	VIMPAT	UCB
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<sup>ST</sup> **100MG TABLET**

02357623	VIMPAT	UCB
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<sup>ST</sup> **150MG TABLET**

02357631	VIMPAT	UCB
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<sup>ST</sup> **200MG TABLET**

02357658	VIMPAT	UCB
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**LAMOTRIGINE**

<sup>ST</sup> **2MG TABLET**

02243803	LAMICTAL	GSK
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<sup>ST</sup> **5MG TABLET**

02240115	LAMICTAL	GSK
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**28:12.92 MISCELLANEOUS  
ANTICONSULSANTS**

**LAMOTRIGINE**

<sup>ST</sup> **25MG TABLET**

02245208	APO-LAMOTRIGINE	APX
02381354	AURO-LAMOTRIGINE	AUR
02142082	LAMICTAL	GSK
02302969	LAMOTRIGINE	PDL
02343010	LAMOTRIGINE	SAN
02428202	LAMOTRIGINE	SIV
02265494	MYLAN-LAMOTRIGINE	MYL
02246897	PMS-LAMOTRIGINE	PMS
02248232	TEVA-LAMOTRIGINE	TEV

<sup>ST</sup> **100MG TABLET**

02245209	APO-LAMOTRIGINE	APX
02381362	AURO-LAMOTRIGINE	AUR
02142104	LAMICTAL	GSK
02302985	LAMOTRIGINE	PDL
02343029	LAMOTRIGINE	SAN
02428210	LAMOTRIGINE	SIV
02265508	MYLAN-LAMOTRIGINE	MYL
02246898	PMS-LAMOTRIGINE	PMS
02248233	TEVA-LAMOTRIGINE	TEV

<sup>ST</sup> **150MG TABLET**

02245210	APO-LAMOTRIGINE	APX
02381370	AURO-LAMOTRIGINE	AUR
02142112	LAMICTAL	GSK
02302993	LAMOTRIGINE	PDL
02343037	LAMOTRIGINE	SAN
02428229	LAMOTRIGINE	SIV
02265516	MYLAN-LAMOTRIGINE	MYL
02246899	PMS-LAMOTRIGINE	PMS
02248234	TEVA-LAMOTRIGINE	TEV

**LEVETIRACETAM**

<sup>ST</sup> **250MG TABLET**

02274183	ACT LEVETIRACETAM	ACG
02285924	APO-LEVETIRACETAM	APX
02375249	AURO-LEVETIRACETAM	AUR
02403005	JAMP-LEVETIRACETAM	JMP
02247027	KEPPRA	UCB
02353342	LEVETIRACETAM	SAN
02399776	LEVETIRACETAM	ACC
02442531	LEVETIRACETAM	SIV
02454653	LEVETIRACETAM	PMS
02440202	NAT-LEVETIRACETAM	NPH
02296101	PMS-LEVETIRACETAM	PMS
02396106	RAN-LEVETIRACETAM	RBV

<sup>ST</sup> **500MG TABLET**

02274191	ACT LEVETIRACETAM	ACG
02285932	APO-LEVETIRACETAM	APX
02375257	AURO-LEVETIRACETAM	AUR
02297418	DOM-LEVETIRACETAM	DPC
02403021	JAMP-LEVETIRACETAM	JMP
02247028	KEPPRA	UCB
02353350	LEVETIRACETAM	SAN
02399784	LEVETIRACETAM	ACC

## 28:12.92 MISCELLANEOUS ANTICONSULSANTS

### LEVETIRACETAM

#### <sup>ST</sup> 500MG TABLET

02442558	LEVETIRACETAM	SIV
02454661	LEVETIRACETAM	PMS
02440210	NAT-LEVETIRACETAM	NPH
02296128	PMS-LEVETIRACETAM	PMS
02311380	PRO-LEVETIRACETAM	PDL
02396114	RAN-LEVETIRACETAM	RBV

#### <sup>ST</sup> 750MG TABLET

02274205	ACT LEVETIRACETAM	ACG
02285940	APO-LEVETIRACETAM	APX
02375265	AURO-LEVETIRACETAM	AUR
02403048	JAMP-LEVETIRACETAM	JMP
02247029	KEPPRA	UCB
02353369	LEVETIRACETAM	SAN
02399792	LEVETIRACETAM	ACC
02442566	LEVETIRACETAM	SIV
02454688	LEVETIRACETAM	PMS
02440229	NAT-LEVETIRACETAM	NPH
02296136	PMS-LEVETIRACETAM	PMS
02311399	PRO-LEVETIRACETAM	PDL
02396122	RAN-LEVETIRACETAM	RBV

#### PDIN FOR EXTEMPORANEOUS MIXTURE

99503026	LEVETIRACETAM ORAL LIQUID	UNK
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### PREGABALIN

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 to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

#### <sup>ST</sup> 25MG CAPSULE

02402912	ACT PREGABALIN	ACG
02394235	APO-PREGABALIN	APX
02433869	AURO-PREGABALIN	AUR
02402556	DOM-PREGABALIN	DPC
02435977	JAMP-PREGABALIN	JMP
02268418	LYRICA	PFI
02417529	MAR-PREGABALIN	MAR
02423804	MINT-PREGABALIN	MIN
02359596	PMS-PREGABALIN	PMS
02396483	PREGABALIN	PDL
02403692	PREGABALIN	SIV
02405539	PREGABALIN	SAN
02392801	RAN-PREGABALIN	RBV
02377039	RIVA-PREGABALIN	RIV
02390817	SANDOZ PREGABALIN	SDZ
02361159	TEVA-PREGABALIN	TEV

#### <sup>ST</sup> 50MG CAPSULE

02402920	ACT PREGABALIN	ACG
02394243	APO-PREGABALIN	APX

## 28:12.92 MISCELLANEOUS ANTICONSULSANTS

### PREGABALIN

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 to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

#### <sup>ST</sup> 50MG CAPSULE

02433877	AURO-PREGABALIN	AUR
02402564	DOM-PREGABALIN	DPC
02435985	JAMP-PREGABALIN	JMP
02268426	LYRICA	PFI
02417537	MAR-PREGABALIN	MAR
02423812	MINT-PREGABALIN	MIN
02359618	PMS-PREGABALIN	PMS
02396505	PREGABALIN	PDL
02403706	PREGABALIN	SIV
02405547	PREGABALIN	SAN
02392828	RAN-PREGABALIN	RBV
02377047	RIVA-PREGABALIN	RIV
02390825	SANDOZ PREGABALIN	SDZ
02361175	TEVA-PREGABALIN	TEV

#### <sup>ST</sup> 75MG CAPSULE

02402939	ACT PREGABALIN	ACG
02394251	APO-PREGABALIN	APX
02433885	AURO-PREGABALIN	AUR
02402572	DOM-PREGABALIN	DPC
02435993	JAMP-PREGABALIN	JMP
02268434	LYRICA	PFI
02417545	MAR-PREGABALIN	MAR
02424185	MINT-PREGABALIN	MIN
02359626	PMS-PREGABALIN	PMS
02396513	PREGABALIN	PDL
02403714	PREGABALIN	SIV
02405555	PREGABALIN	SAN
02392836	RAN-PREGABALIN	RBV
02377055	RIVA-PREGABALIN	RIV
02390833	SANDOZ PREGABALIN	SDZ
02361183	TEVA-PREGABALIN	TEV

#### <sup>ST</sup> 150MG CAPSULE

02402955	ACT PREGABALIN	ACG
02394278	APO-PREGABALIN	APX
02433907	AURO-PREGABALIN	AUR
02402580	DOM-PREGABALIN	DPC
02436000	JAMP-PREGABALIN	JMP
02268450	LYRICA	PFI
02417561	MAR-PREGABALIN	MAR
02424207	MINT-PREGABALIN	MIN
02359634	PMS-PREGABALIN	PMS
02396521	PREGABALIN	PDL
02403722	PREGABALIN	SIV
02405563	PREGABALIN	SAN

## 28:12.92 MISCELLANEOUS ANTICONSULSANTS

### PREGABALIN

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 to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

#### <sup>ST</sup> 150MG CAPSULE

02392844	RAN-PREGABALIN	RBY
02377063	RIVA-PREGABALIN	RIV
02390841	SANDOZ PREGABALIN	SDZ
02361205	TEVA-PREGABALIN	TEV

#### <sup>ST</sup> 300MG CAPSULE

02402998	ACT PREGABALIN	ACG
02394294	APO-PREGABALIN	APX
02436019	JAMP-PREGABALIN	JMP
02268485	LYRICA	PFI
02359642	PMS-PREGABALIN	PMS
02396548	PREGABALIN	PDL
02403730	PREGABALIN	SIV
02405598	PREGABALIN	SAN
02392860	RAN-PREGABALIN	RBY
02377071	RIVA-PREGABALIN	RIV
02390868	SANDOZ PREGABALIN	SDZ
02361248	TEVA-PREGABALIN	TEV

### RUFINAMIDE

Limited use benefit (prior approval required).

- For the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome in adults and children 4 years and older when prescribed by a neurologist or experienced specialist.
- Patient has failed or is intolerant to or has contraindications to at least two adjunctive antiepileptic drugs.

#### <sup>ST</sup> 100MG TABLET

02369613	BANZEL	EIS
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#### <sup>ST</sup> 200MG TABLET

02369621	BANZEL	EIS
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#### <sup>ST</sup> 400MG TABLET

02369648	BANZEL	EIS
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### TOPIRAMATE

#### <sup>ST</sup> 15MG CAPSULE

02239907	TOPAMAX	JSO
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#### <sup>ST</sup> 25MG CAPSULE

02239908	TOPAMAX	JSO
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#### <sup>ST</sup> 25MG TABLET

02351307	ACCEL-TOPIRAMATE	ACP
02287765	ACT TOPIRAMATE	ACG
02279614	APO-TOPIRAMATE	APX
02345803	AURO-TOPIRAMATE	APL
02271141	DOM-TOPIRAMATE	DPC
02435608	JAMP-TOPIRAMATE	JMP

## 28:12.92 MISCELLANEOUS ANTICONSULSANTS

### TOPIRAMATE

#### <sup>ST</sup> 25MG TABLET

02432099	MAR-TOPIRAMATE	MAR
02315645	MINT-TOPIRAMATE	MIN
02263351	MYLAN-TOPIRAMATE	MYL
02271184	PHL-TOPIRAMATE	PHH
02262991	PMS-TOPIRAMATE	PMS
02313650	PRO-TOPIRAMATE	PDL
02396076	RAN-TOPIRAMATE	RBY
02260050	SANDOZ TOPIRAMATE	SDZ
02431807	SANDOZ TOPIRAMATE	SDZ
02248860	TEVA-TOPIRAMATE	TEV
02230893	TOPAMAX	JSO
02356856	TOPIRAMATE	SAN
02389460	TOPIRAMATE	SIV
02395738	TOPIRAMATE	ACC

#### <sup>ST</sup> 50MG TABLET

02312085	PMS-TOPIRAMATE	PMS
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#### <sup>ST</sup> 100MG TABLET

02351315	ACCEL-TOPIRAMATE	ACP
02287773	ACT TOPIRAMATE	ACG
02279630	APO-TOPIRAMATE	APX
02345838	AURO-TOPIRAMATE	APL
02271168	DOM-TOPIRAMATE	DPC
02435616	JAMP-TOPIRAMATE	JMP
02432102	MAR-TOPIRAMATE	MAR
02315653	MINT-TOPIRAMATE	MIN
02263378	MYLAN-TOPIRAMATE	MYL
02271192	PHL-TOPIRAMATE	PHH
02263009	PMS-TOPIRAMATE	PMS
02313669	PRO-TOPIRAMATE	PDL
02396084	RAN-TOPIRAMATE	RBY
02260069	SANDOZ TOPIRAMATE	SDZ
02431815	SANDOZ TOPIRAMATE	SDZ
02248861	TEVA-TOPIRAMATE	TEV
02230894	TOPAMAX	JSO
02356864	TOPIRAMATE	SAN
02389487	TOPIRAMATE	SIV
02395746	TOPIRAMATE	ACC

#### <sup>ST</sup> 200MG TABLET

02351323	ACCEL-TOPIRAMATE	ACP
02287781	ACT TOPIRAMATE	ACG
02279649	APO-TOPIRAMATE	APX
02345846	AURO-TOPIRAMATE	APL
02271176	DOM-TOPIRAMATE	DPC
02435624	JAMP-TOPIRAMATE	JMP
02432110	MAR-TOPIRAMATE	MAR
02315661	MINT-TOPIRAMATE	MIN
02263386	MYLAN-TOPIRAMATE	MYL
02271206	PHL-TOPIRAMATE	PHH
02263017	PMS-TOPIRAMATE	PMS
02313677	PRO-TOPIRAMATE	PDL
02396092	RAN-TOPIRAMATE	RBY
02267837	SANDOZ TOPIRAMATE	SDZ
02431823	SANDOZ TOPIRAMATE	SDZ

## 28:12.92 MISCELLANEOUS ANTICONVULSANTS

### TOPIRAMATE

#### <sup>ST</sup> 200MG TABLET

02248862	TEVA-TOPIRAMATE	TEV
02230896	TOPAMAX	JSO
02356872	TOPIRAMATE	SAN
02395754	TOPIRAMATE	ACC

#### PDIN FOR EXTEMPORANEOUS MIXTURE

99503027	TOPIRAMATE ORAL LIQUID	UNK
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### VALPROIC ACID (DIVALPROEX SODIUM)

#### <sup>ST</sup> 125MG TABLET (ENTERIC COATED)

02239698	APO-DIVALPROEX	APX
02240341	DIVALPROEX	PDL
02400499	DIVALPROEX	SAN
00596418	EPIVAL	BGP
02458926	MYLAN-DIVALPROEX	MYL
02244138	PMS-DIVALPROEX	PMS
02239701	TEVA-DIVALPROEX	TEV

#### <sup>ST</sup> 250MG TABLET (ENTERIC COATED)

02239699	APO-DIVALPROEX	APX
02400502	DIVALPROEX	SAN
00596426	EPIVAL	BGP
02458934	MYLAN-DIVALPROEX	MYL
02244139	PMS-DIVALPROEX	PMS
02239702	TEVA-DIVALPROEX	TEV

#### <sup>ST</sup> 500MG TABLET (ENTERIC COATED)

02239700	APO-DIVALPROEX	APX
02400510	DIVALPROEX	SAN
00596434	EPIVAL	BGP
02459019	MYLAN-DIVALPROEX	MYL
02244140	PMS-DIVALPROEX	PMS
02239703	TEVA-DIVALPROEX	TEV

### VALPROIC ACID (SODIUM VALPROATE)

#### <sup>ST</sup> 250MG CAPSULE

02238048	APO-VALPROIC	APX
02231030	DOM-VALPROIC ACID	DPC
02100630	NOVO-VALPROIC	TEV
02230768	PMS-VALPROIC ACID	PMS
02239714	SANDOZ VALPROIC	SDZ

#### <sup>ST</sup> 500MG CAPSULE (ENTERIC COATED)

02231031	DOM-VALPROIC ACID	DPC
02218321	NOVO-VALPROIC	TEV
02229628	PMS-VALPROIC ACID	PMS

#### <sup>ST</sup> 50MG/ML SYRUP

02238370	APO-VALPROIC	APX
00443832	DEPAKENE	BGP
02238817	DOM-VALPROIC ACID	DPC
02236807	PMS-VALPROIC ACID	PMS

### VIGABATRIN

#### <sup>ST</sup> 500MG POWDER

02068036	SABRIL	LUK
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#### <sup>ST</sup> 500MG TABLET

02065819	SABRIL	LUK
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## 28:16.04 ANTIDEPRESSANTS AMITRIPTYLINE HYDROCHLORIDE

#### <sup>ST</sup> 10MG TABLET

00370991	AMITRIPTYLINE	PDL
02403137	APO-AMITRIPTYLINE	APX
00335053	ELAVIL	AAP
02435527	JAMP-AMITRIPTYLINE	JMP
00293911	LEVATE	BMI
02429861	MAR-AMITRIPTYLINE	MAR
00654523	PMS-AMITRIPTYLINE	PMS
02326043	TEVA-AMITRIPTYLINE	TEV

#### <sup>ST</sup> 25MG TABLET

00371009	AMITRIPTYLINE	PDL
02403145	APO-AMITRIPTYLINE	APX
00335061	ELAVIL	AAP
02435535	JAMP-AMITRIPTYLINE	JMP
02429888	MAR-AMITRIPTYLINE	MAR
00654515	PMS-AMITRIPTYLINE	PMS
02326051	TEVA-AMITRIPTYLINE	TEV

#### <sup>ST</sup> 50MG TABLET

00456349	AMITRIPTYLINE	PDL
02403153	APO-AMITRIPTYLINE	APX
00335088	ELAVIL	AAP
02435543	JAMP-AMITRIPTYLINE	JMP
00271152	LEVATE	BMI
02429896	MAR-AMITRIPTYLINE	MAR
00654507	PMS-AMITRIPTYLINE	PMS
02326078	TEVA-AMITRIPTYLINE	TEV

#### <sup>ST</sup> 75MG TABLET

02403161	APO-AMITRIPTYLINE	APX
00754129	ELAVIL	AAP
02435551	JAMP-AMITRIPTYLINE	JMP
00405612	LEVATE	BMI
02429918	MAR-AMITRIPTYLINE	MAR

### BUPROPION HYDROCHLORIDE (WELLBUTRIN)

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage of Wellbutrin XL and Bupropion SR is limited to 300 mg per day. (Note: this product will not be approved for coverage for smoking cessation).

#### <sup>ST</sup> 100MG TABLET (EXTENDED RELEASE)

02331616	BUPROPION SR	PDL
02391562	BUPROPION SR	SAN
02325373	PMS-BUPROPION SR	PMS
02285657	RATIO-BUPROPION	TEV
02275074	SANDOZ BUPROPION SR	SDZ

#### <sup>ST</sup> 150MG TABLET (EXTENDED RELEASE)

02439654	ACT BUPROPION XL	ACG
02325357	BUPROPION SR	PDL
02391570	BUPROPION SR	SAN
02382075	MYLAN-BUPROPION XL	MYL
02313421	PMS-BUPROPION SR	PMS
02285665	RATIO-BUPROPION	TEV
02275082	SANDOZ BUPROPION SR	SDZ
02237825	WELLBUTRIN SR	VAE
02275090	WELLBUTRIN XL	VAE

**28:16.04 ANTIDEPRESSANTS**

**BUPROPION HYDROCHLORIDE (WELLBUTRIN)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage of Wellbutrin XL and Bupropion SR is limited to 300 mg per day. (Note: this product will not be approved for coverage for smoking cessation).

**<sup>ST</sup> 300MG TABLET (EXTENDED RELEASE)**

02439662	ACT BUPROPION XL	ACG
02382083	MYLAN-BUPROPION XL	MYL
02275104	WELLBUTRIN XL	VAE

**BUPROPION HYDROCHLORIDE (ZYBAN)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

Coverage is limited to 180 tablets 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 bupropion hydrochloride when one year has elapsed from the day the initial prescription was filled.

**<sup>ST</sup> 150MG TABLET (EXTENDED RELEASE)**

02238441	ZYBAN	VAE
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**CITALOPRAM HYDROBROMIDE**

**<sup>ST</sup> 10MG TABLET**

02355248	ACCEL-CITALOPRAM	ACP
02325047	CITALOPRAM	PDL
02387948	CITALOPRAM	SIV
02430517	CITALOPRAM	JMP
02445719	CITALOPRAM	SAN
02273055	DOM-CITALOPRAM	DPC
02421739	ECL-CITALOPRAM	ECL
02370085	JAMP-CITALOPRAM	JMP
02371871	MAR-CITALOPRAM	MAR
02370077	MINT-CITALOPRAM	MIN
02429691	MINT-CITALOPRAM	MIN
02409003	NAT-CITALOPRAM	NPH
02273543	PHL-CITALOPRAM	PHH
02270609	PMS-CITALOPRAM	PMS
02303256	RIVA-CITALOPRAM	RIV
02431629	SEPTA-CITALOPRAM	SPT
02312336	TEVA-CITALOPRAM	TEV

**<sup>ST</sup> 20MG TABLET**

02355256	ACCEL-CITALOPRAM	ACP
02248050	ACT CITALOPRAM	ACG
02246056	APO-CITALOPRAM	APX
02275562	AURO-CITALOPRAM	AUR
02239607	CELEXA	LUD
02257513	CITALOPRAM	PDL
02353660	CITALOPRAM	SAN
02387956	CITALOPRAM	SIV
02430541	CITALOPRAM	JMP
02248942	DOM-CITALOPRAM	DPC
02313405	JAMP-CITALOPRAM	JMP
02371898	MAR-CITALOPRAM	MAR
02304686	MINT-CITALOPRAM	MIN
02429705	MINT-CITALOPRAM	MIN

**28:16.04 ANTIDEPRESSANTS**

**CITALOPRAM HYDROBROMIDE**

**<sup>ST</sup> 20MG TABLET**

02246594	MYLAN-CITALOPRAM	MYL
02409011	NAT-CITALOPRAM	NPH
02248944	PHL-CITALOPRAM	PHH
02248010	PMS-CITALOPRAM	PMS
02285622	RAN-CITALO	RBV
02303264	RIVA-CITALOPRAM	RIV
02248170	SANDOZ CITALOPRAM	SDZ
02355272	SEPTA-CITALOPRAM	SPT
02293218	TEVA-CITALOPRAM	TEV

**<sup>ST</sup> 30MG TABLET**

02296152	CTP 30	SPC
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**<sup>ST</sup> 40MG TABLET**

02355264	ACCEL-CITALOPRAM	ACP
02248051	ACT CITALOPRAM	ACG
02246057	APO-CITALOPRAM	APX
02275570	AURO-CITALOPRAM	AUR
02239608	CELEXA	LUD
02257521	CITALOPRAM	PDL
02353679	CITALOPRAM	SAN
02387964	CITALOPRAM	SIV
02430568	CITALOPRAM	JMP
02248943	DOM-CITALOPRAM	DPC
02313413	JAMP-CITALOPRAM	JMP
02371901	MAR-CITALOPRAM	MAR
02304694	MINT-CITALOPRAM	MIN
02429713	MINT-CITALOPRAM	MIN
02246595	MYLAN-CITALOPRAM	MYL
02409038	NAT-CITALOPRAM	NPH
02248945	PHL-CITALOPRAM	PHH
02248011	PMS-CITALOPRAM	PMS
02285630	RAN-CITALO	RBV
02303272	RIVA-CITALOPRAM	RIV
02248171	SANDOZ CITALOPRAM	SDZ
02355280	SEPTA-CITALOPRAM	SPT
02293226	TEVA-CITALOPRAM	TEV

**CLOMIPRAMINE HYDROCHLORIDE**

**<sup>ST</sup> 10MG TABLET**

00330566	ANAFRANIL	AAP
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**<sup>ST</sup> 25MG TABLET**

00324019	ANAFRANIL	AAP
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**<sup>ST</sup> 50MG TABLET**

00402591	ANAFRANIL	AAP
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**DESIPRAMINE HYDROCHLORIDE**

**<sup>ST</sup> 10MG TABLET**

02216248	DESIPRAMINE	AAP
02223341	NOVO-DESIPRAMINE	NOP

**<sup>ST</sup> 25MG TABLET**

02216256	DESIPRAMINE	AAP
02223325	NOVO-DESIPRAMINE	NOP

**<sup>ST</sup> 50MG TABLET**

02216264	DESIPRAMINE	AAP
02223333	NOVO-DESIPRAMINE	NOP
01946277	PMS DESIPRAMINE	PMS

**28:16.04 ANTIDEPRESSANTS****DESIPRAMINE HYDROCHLORIDE****<sup>ST</sup> 75MG TABLET**

02216272	DESIPRAMINE	AAP
02223368	NOVO-DESIPRAMINE	NOP
01946242	PMS DESIPRAMINE	PMS

**<sup>ST</sup> 100MG TABLET**

02216280	DESIPRAMINE	AAP
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**DOXEPIN HYDROCHLORIDE****<sup>ST</sup> 10MG CAPSULE**

02049996	APO-DOXEPIN	APX
00024325	SINEQUAN	AAP

**<sup>ST</sup> 25MG CAPSULE**

02050005	APO-DOXEPIN	APX
00024333	SINEQUAN	AAP

**<sup>ST</sup> 50MG CAPSULE**

02050013	APO-DOXEPIN	APX
00024341	SINEQUAN	AAP

**<sup>ST</sup> 75MG CAPSULE**

02050021	APO-DOXEPIN	APX
00400750	SINEQUAN	AAP

**<sup>ST</sup> 100MG CAPSULE**

02050048	APO-DOXEPIN	APX
00326925	SINEQUAN	AAP

**<sup>ST</sup> 150MG CAPSULE**

02050056	APO-DOXEPIN	APX
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**DULOXETINE HYDROCHLORIDE****<sup>ST</sup> 30MG CAPSULE (DELAYED RELEASE)**

02440423	APO-DULOXETINE	APX
02436647	AURO-DULOXETINE	AUR
02301482	CYMBALTA	LIL
02452650	DULOXETINE	PDL
02453630	DULOXETINE	SIV
02437082	DULOXETINE DR	TEV
02451913	JAMP-DULOXETINE	JMP
02446081	MAR-DULOXETINE	MAR
02438984	MINT-DULOXETINE	MIN
02426633	MYLAN-DULOXETINE	MYL
02429446	PMS-DULOXETINE	PMS
02438259	RAN-DULOXETINE	RBV
02451077	RIVA-DULOXETINE	RIV
02439948	SANDOZ DULOXETINE	SDZ

**<sup>ST</sup> 60MG CAPSULE (DELAYED RELEASE)**

02440431	APO-DULOXETINE	APX
02436655	AURO-DULOXETINE	AUR
02301490	CYMBALTA	LIL
02452669	DULOXETINE	PDL
02453649	DULOXETINE	SIV
02437090	DULOXETINE DR	TEV
02451921	JAMP-DULOXETINE	JMP
02446103	MAR-DULOXETINE	MAR
02438992	MINT-DULOXETINE	MIN
02426641	MYLAN-DULOXETINE	MYL
02429454	PMS-DULOXETINE	PMS
02438267	RAN-DULOXETINE	RBV
02451085	RIVA-DULOXETINE	RIV

**28:16.04 ANTIDEPRESSANTS****DULOXETINE HYDROCHLORIDE****<sup>ST</sup> 60MG CAPSULE (DELAYED RELEASE)**

02439956	SANDOZ DULOXETINE	SDZ
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**ESCITALOPRAM OXALATE****<sup>ST</sup> 10MG TABLET**

02313561	ACT ESCITALOPRAM	ACG
02295016	APO-ESCITALOPRAM	APX
02397358	AURO-ESCITALOPRAM	AUR
02263238	CIPRALEX	LUD
02424401	ESCITALOPRAM	PDL
02429039	ESCITALOPRAM	SIV
02430118	ESCITALOPRAM	SAN
02429780	JAMP-ESCITALOPRAM	JMP
02423480	MAR-ESCITALOPRAM	MAR
02407418	MINT-ESCITALOPRAM	MIN
02309467	MYLAN-ESCITALOPRAM	MYL
02440296	NAT-ESCITALOPRAM	NPH
02303949	PMS-ESCITALOPRAM	PMS
02426331	PRIVA-ESCITALOPRAM	PHA
02385481	RAN-ESCITALOPRAM	RBV
02428830	RIVA-ESCITALOPRAM	RIV
02364077	SANDOZ ESCITALOPRAM	SDZ
02318180	TEVA-ESCITALOPRAM	TEV

**<sup>ST</sup> 20MG TABLET**

02313588	ACT ESCITALOPRAM	ACG
02295024	APO-ESCITALOPRAM	APX
02397374	AURO-ESCITALOPRAM	AUR
02263254	CIPRALEX	LUD
02424428	ESCITALOPRAM	PDL
02429047	ESCITALOPRAM	SIV
02430126	ESCITALOPRAM	SAN
02429799	JAMP-ESCITALOPRAM	JMP
02423502	MAR-ESCITALOPRAM	MAR
02407434	MINT-ESCITALOPRAM	MIN
02309475	MYLAN-ESCITALOPRAM	MYL
02440318	NAT-ESCITALOPRAM	NPH
02303965	PMS-ESCITALOPRAM	PMS
02426358	PRIVA-ESCITALOPRAM	PHA
02385503	RAN-ESCITALOPRAM	RBV
02428857	RIVA-ESCITALOPRAM	RIV
02364085	SANDOZ ESCITALOPRAM	SDZ
02318202	TEVA-ESCITALOPRAM	TEV

**<sup>ST</sup> 10MG TABLET (ORALLY DISINTEGRATING)**

02454297	ACT ESCITALOPRAM ODT	ACG
02391449	CIPRALEX MELTZ	LUD

**<sup>ST</sup> 20MG TABLET (ORALLY DISINTEGRATING)**

02454300	ACT ESCITALOPRAM ODT	ACG
02391457	CIPRALEX MELTZ	LUD

**FLUOXETINE HYDROCHLORIDE****<sup>ST</sup> 10MG CAPSULE**

02400391	ACCEL-FLUOXETINE	ACP
02393441	ACH-FLUOXETINE	ACC
02242177	ACT FLUOXETINE	REC
02216353	APO-FLUOXETINE	APX
02385627	AURO-FLUOXETINE	AUR

**28:16.04 ANTIDEPRESSANTS****FLUOXETINE HYDROCHLORIDE****<sup>ST</sup> 10MG CAPSULE**

02448424	BIO-FLUOXETINE	BMI
02177617	DOM-FLUOXETINE	DPC
02286068	FLUOXETINE	SAN
02374447	FLUOXETINE	SIV
02401894	JAMP-FLUOXETINE	JMP
02392909	MAR-FLUOXETINE	MAR
02380560	MINT-FLUOXETINE	MIN
02237813	MYLAN-FLUOXETINE	MYL
02223481	PHL-FLUOXETINE	PHH
02177579	PMS-FLUOXETINE	PMS
02314991	PRO-FLUOXETINE	PDL
02018985	PROZAC	LIL
02405695	RAN-FLUOXETINE	RBV
02216582	TEVA-FLUOXETINE	TEV

**<sup>ST</sup> 20MG CAPSULE**

02400405	ACCEL-FLUOXETINE	ACP
02383241	ACH-FLUOXETINE	ACC
02242178	ACT FLUOXETINE	REC
02216361	APO-FLUOXETINE	APX
02385635	AURO-FLUOXETINE	AUR
02448432	BIO-FLUOXETINE	BMI
02177625	DOM-FLUOXETINE	DPC
02286076	FLUOXETINE	SAN
02374455	FLUOXETINE	SIV
02386402	JAMP-FLUOXETINE	JMP
02392917	MAR-FLUOXETINE	MAR
02380579	MINT-FLUOXETINE	MIN
02237814	MYLAN-FLUOXETINE	MYL
02223503	PHL-FLUOXETINE	PHH
02177587	PMS-FLUOXETINE	PMS
02315009	PRO-FLUOXETINE	PDL
00636622	PROZAC	LIL
02405709	RAN-FLUOXETINE	RBV
02216590	TEVA-FLUOXETINE	TEV

**<sup>ST</sup> 4MG/ML SOLUTION**

02231328	APO-FLUOXETINE	APX
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**20MG SOLUTION**

02459361	ODAN-FLUOXETINE	ODN
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**FLUVOXAMINE MALEATE****<sup>ST</sup> 50MG TABLET**

02255529	ACT FLUVOXAMINE	ACG
02231329	APO-FLUVOXAMINE	APX
02236753	FLUVOXAMINE	PDL
01919342	LUVOX	BGP
02239953	NOVO-FLUVOXAMINE	TEV
02218453	RATIO-FLUVOXAMINE	TEV
02303345	RIVA-FLUVOX	RIV
02247054	SANDOZ FLUVOXAMINE	SDZ

**<sup>ST</sup> 100MG TABLET**

02255537	ACT FLUVOXAMINE	ACG
02231330	APO-FLUVOXAMINE	APX
02236754	FLUVOXAMINE	PDL
01919369	LUVOX	BGP
02239954	NOVO-FLUVOXAMINE	TEV

**28:16.04 ANTIDEPRESSANTS****FLUVOXAMINE MALEATE****<sup>ST</sup> 100MG TABLET**

02218461	RATIO-FLUVOXAMINE	TEV
02303361	RIVA-FLUVOX	RIV
02247055	SANDOZ FLUVOXAMINE	SDZ

**IMIPRAMINE HYDROCHLORIDE****<sup>ST</sup> 10MG TABLET**

00360201	IMIPRAMINE	AAP
00021504	NOVO-PRAMINE	NOP

**<sup>ST</sup> 25MG TABLET**

00312797	IMIPRAMINE	AAP
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**<sup>ST</sup> 50MG TABLET**

00326852	IMIPRAMINE	AAP
00021520	NOVO-PRAMINE	NOP

**<sup>ST</sup> 75MG TABLET**

00644579	IMIPRAMINE	AAP
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**MAPROTILINE HYDROCHLORIDE****<sup>ST</sup> 25MG TABLET**

02158612	TEVA-MAPROTILINE	TEV
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**<sup>ST</sup> 50MG TABLET**

02158620	TEVA-MAPROTILINE	TEV
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**<sup>ST</sup> 75MG TABLET**

02158639	TEVA-MAPROTILINE	TEV
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**MIRTAZAPINE****<sup>ST</sup> 15MG TABLET**

02286610	APO-MIRTAZAPINE	APX
02411695	AURO-MIRTAZAPINE	AUR
02256096	MYLAN-MIRTAZAPINE	MYL
02273942	PMS-MIRTAZAPINE	PMS
02312778	PRO-MIRTAZAPINE	PDL
02250594	SANDOZ MIRTAZAPINE	SDZ

**<sup>ST</sup> 30MG TABLET**

02286629	APO-MIRTAZAPINE	APX
02411709	AURO-MIRTAZAPINE	AUR
02252287	DOM-MIRTAZAPINE	DPC
02370689	MIRTAZAPINE	SAN
02256118	MYLAN-MIRTAZAPINE	MYL
02248762	PMS-MIRTAZAPINE	PMS
02312786	PRO-MIRTAZAPINE	PDL
02243910	REMERON	FRS
02265265	RIVA-MIRTAZAPINE	RIV
02250608	SANDOZ MIRTAZAPINE	SDZ
02259354	TEVA-MIRTAZAPINE	TEV

**<sup>ST</sup> 45MG TABLET**

02286637	APO-MIRTAZAPINE	APX
02411717	AURO-MIRTAZAPINE	AUR
02256126	MYLAN-MIRTAZAPINE	MYL

**<sup>ST</sup> 15MG TABLET (ORALLY DISINTEGRATING)**

02299801	AURO-MIRTAZAPINE OD	AUR
02248542	REMERON RD	FRS
02279894	TEVA-MIRTAZAPINE OD	TEV

**<sup>ST</sup> 30MG TABLET (ORALLY DISINTEGRATING)**

02299828	AURO-MIRTAZAPINE OD	AUR
02248543	REMERON RD	FRS

**28:16.04 ANTIDEPRESSANTS****MIRTAZAPINE**

<sup>ST</sup> 30MG TABLET (ORALLY DISINTEGRATING)			
02279908	TEVA-MIRTAZAPINE OD	TEV	
<sup>ST</sup> 45MG TABLET (ORALLY DISINTEGRATING)			
02299836	AURO-MIRTAZAPINE OD	AUR	
02248544	REMERON RD	FRS	
02279916	TEVA-MIRTAZAPINE OD	TEV	

**MOCLOBEMIDE**

<sup>ST</sup> 100MG TABLET			
02232148	APO-MOCLOBEMIDE	APX	
02239746	TEVA-MOCLOBEMIDE	TEV	
<sup>ST</sup> 150MG TABLET			
02232150	APO-MOCLOBEMIDE	APX	
00899356	MANERIX	VAE	
02243218	PMS-MOCLOBEMIDE	PMS	
02239747	TEVA-MOCLOBEMIDE	TEV	
<sup>ST</sup> 300MG TABLET			
02240456	APO-MOCLOBEMIDE	APX	
02166747	MANERIX	VAE	
02243219	PMS-MOCLOBEMIDE	PMS	
02239748	TEVA-MOCLOBEMIDE	TEV	

**NORTRIPTYLINE HYDROCHLORIDE**

<sup>ST</sup> 10MG CAPSULE			
02223511	APO-NORTRIPTYLINE	APX	
00015229	AVENTYL	AAP	
<sup>ST</sup> 25MG CAPSULE			
02223538	APO-NORTRIPTYLINE	APX	
00015237	AVENTYL	AAP	

**PAROXETINE HYDROCHLORIDE**

<sup>ST</sup> 10MG TABLET			
02262746	ACT PAROXETINE	ACG	
02240907	APO-PAROXETINE	APX	
02383276	AURO-PAROXETINE	AUR	
02248447	DOM-PAROXETINE	DPC	
02368862	JAMP-PAROXETINE	JMP	
02411946	MAR-PAROXETINE	MAR	
02421372	MINT-PAROXETINE	MIN	
02248012	MYLAN-PAROXETINE	MYL	
02248913	PAROXETINE	PDL	
02282844	PAROXETINE	SAN	
02388227	PAROXETINE	SIV	
02027887	PAXIL	GSK	
02247750	PMS-PAROXETINE	PMS	
02248559	RIVA-PAROXETINE	RIV	
02269422	SANDOZ PAROXETINE	SDZ	
02431777	SANDOZ PAROXETINE	SDZ	
02248556	TEVA-PAROXETINE	TEV	
<sup>ST</sup> 20MG TABLET			
02262754	ACT PAROXETINE	ACG	
02240908	APO-PAROXETINE	APX	
02383284	AURO-PAROXETINE	AUR	
02248448	DOM-PAROXETINE	DPC	
02368870	JAMP-PAROXETINE	JMP	
02411954	MAR-PAROXETINE	MAR	

**28:16.04 ANTIDEPRESSANTS****PAROXETINE HYDROCHLORIDE**

<sup>ST</sup> 20MG TABLET			
02421380	MINT-PAROXETINE	MIN	
02248013	MYLAN-PAROXETINE	MYL	
02248914	PAROXETINE	PDL	
02282852	PAROXETINE	SAN	
02388235	PAROXETINE	SIV	
01940481	PAXIL	GSK	
02247751	PMS-PAROXETINE	PMS	
02248560	RIVA-PAROXETINE	RIV	
02269430	SANDOZ PAROXETINE	SDZ	
02431785	SANDOZ PAROXETINE	SDZ	
02248557	TEVA-PAROXETINE	TEV	
<sup>ST</sup> 30MG TABLET			
02262762	ACT PAROXETINE	ACG	
02240909	APO-PAROXETINE	APX	
02383292	AURO-PAROXETINE	AUR	
02248449	DOM-PAROXETINE	DPC	
02368889	JAMP-PAROXETINE	JMP	
02411962	MAR-PAROXETINE	MAR	
02421399	MINT-PAROXETINE	MIN	
02248014	MYLAN-PAROXETINE	MYL	
02248915	PAROXETINE	PDL	
02282860	PAROXETINE	SAN	
02388243	PAROXETINE	SIV	
01940473	PAXIL	GSK	
02247752	PMS-PAROXETINE	PMS	
02248561	RIVA-PAROXETINE	RIV	
02269449	SANDOZ PAROXETINE	SDZ	
02431793	SANDOZ PAROXETINE	SDZ	
02248558	TEVA-PAROXETINE	TEV	
<sup>ST</sup> 40MG TABLET			
02293749	PMS-PAROXETINE	PMS	
<b>PHENELZINE SULFATE</b>			
<sup>ST</sup> 15MG TABLET			
00476552	NARDIL	ERF	
<b>SERTRALINE HYDROCHLORIDE</b>			
<sup>ST</sup> 25MG CAPSULE			
02287390	ACT SERTRALINE	ACG	
02238280	APO-SERTRALINE	APX	
02390906	AURO-SERTRALINE	AUR	
02245748	DOM-SERTRALINE	DPC	
02357143	JAMP-SERTRALINE	JMP	
02399415	MAR-SERTRALINE	MAR	
02402378	MINT-SERTRALINE	MIN	
02242519	MYLAN-SERTRALINE	MYL	
02245824	PHL-SERTRALINE	PHH	
02244838	PMS-SERTRALINE	PMS	
02374552	RAN-SERTRALINE	RBY	
02248496	RIVA-SERTRALINE	RIV	
02245159	SANDOZ SERTRALINE	SDZ	
02353520	SERTRALINE	SAN	
02386070	SERTRALINE	SIV	
02241302	SERTRALINE-25	PDL	
02240485	TEVA-SERTRALINE	TEV	

**28:16.04 ANTIDEPRESSANTS****SERTRALINE HYDROCHLORIDE****<sup>ST</sup> 25MG CAPSULE**

02132702 ZOLOFT PFI

**<sup>ST</sup> 50MG CAPSULE**

02287404 ACT SERTRALINE ACG  
 02238281 APO-SERTRALINE APX  
 02390914 AURO-SERTRALINE AUR  
 02245749 DOM-SERTRALINE DPC  
 02357151 JAMP-SERTRALINE JMP  
 02399423 MAR-SERTRALINE MAR  
 02402394 MINT-SERTRALINE MIN  
 02242520 MYLAN-SERTRALINE MYL  
 02245825 PHL-SERTRALINE PHH  
 02244839 PMS-SERTRALINE PMS  
 02374560 RAN-SERTRALINE RBY  
 02248497 RIVA-SERTRALINE RIV  
 02245160 SANDOZ SERTRALINE SDZ  
 02353539 SERTRALINE SAN  
 02386089 SERTRALINE SIV  
 02241303 SERTRALINE-50 PDL  
 02240484 TEVA-SERTRALINE TEV  
 01962817 ZOLOFT PFI

**<sup>ST</sup> 100MG CAPSULE**

02287412 ACT SERTRALINE ACG  
 02238282 APO-SERTRALINE APX  
 02390922 AURO-SERTRALINE AUR  
 02245750 DOM-SERTRALINE DPC  
 02357178 JAMP-SERTRALINE JMP  
 02399431 MAR-SERTRALINE MAR  
 02402408 MINT-SERTRALINE MIN  
 02242521 MYLAN-SERTRALINE MYL  
 02245826 PHL-SERTRALINE PHH  
 02244840 PMS-SERTRALINE PMS  
 02374579 RAN-SERTRALINE RBY  
 02248498 RIVA-SERTRALINE RIV  
 02245161 SANDOZ SERTRALINE SDZ  
 02353547 SERTRALINE SAN  
 02386097 SERTRALINE SIV  
 02241304 SERTRALINE-100 PDL  
 02240481 TEVA-SERTRALINE TEV  
 01962779 ZOLOFT PFI

**TRANLYCYPROMINE SULFATE****<sup>ST</sup> 10MG TABLET**

01919598 PARNATE GSK

**TRAZODONE HYDROCHLORIDE****<sup>ST</sup> 50MG TABLET**

02147637 APO-TRAZODONE APX  
 02128950 DOM-TRAZODONE DPC  
 02236941 PHL-TRAZODONE PHH  
 01937227 PMS TRAZODONE PMS  
 02277344 RATIO-TRAZODONE TEV  
 02144263 TEVA-TRAZODONE TEV  
 02164353 TRAZODONE PDL  
 02348772 TRAZODONE SAN

**28:16.04 ANTIDEPRESSANTS****TRAZODONE HYDROCHLORIDE****<sup>ST</sup> 75MG TABLET**

02237339 PMS-TRAZODONE PMS

**<sup>ST</sup> 100MG TABLET**

02147645 APO-TRAZODONE APX  
 02128969 DOM-TRAZODONE DPC  
 02236942 PHL-TRAZODONE PHH  
 01937235 PMS TRAZODONE PMS  
 02277352 RATIO-TRAZODONE TEV  
 02144271 TEVA-TRAZODONE TEV  
 02164361 TRAZODONE PDL  
 02348780 TRAZODONE SAN

**<sup>ST</sup> 150MG TABLET**

02147653 APO-TRAZODONE D APX  
 02277360 RATIO-TRAZODONE TEV  
 02144298 TEVA-TRAZODONE TEV  
 02164388 TRAZODONE PDL  
 02348799 TRAZODONE SAN

**TRIMIPRAMINE MALEATE****<sup>ST</sup> 75MG CAPSULE**

02070987 TRIMIPRAMINE AAP

**<sup>ST</sup> 12.5MG TABLET**

00740799 TRIMIPRAMINE AAP

**<sup>ST</sup> 25MG TABLET**

00740802 TRIMIPRAMINE AAP

**<sup>ST</sup> 50MG TABLET**

00740810 TRIMIPRAMINE AAP

**<sup>ST</sup> 100MG TABLET**

00740829 TRIMIPRAMINE AAP

**VENLAFAXINE HYDROCHLORIDE****<sup>ST</sup> 37.5MG CAPSULE (EXTENDED RELEASE)**

02304317 ACT VENLAFAXINE XR ACG  
 02331683 APO-VENLAFAXINE XR APX  
 02452839 AURO-VENLAFAXINE XR AUR  
 02299291 DOM-VENLAFAXINE XR DPC  
 02237279 EFFEXOR XR PFI  
 02360020 GD-VENLAFAXINE XR PFI  
 02310279 MYLAN-VENLAFAXINE XR MYL  
 02278545 PMS-VENLAFAXINE XR PMS  
 02380072 RAN-VENLAFAXINE XR RBY  
 02307774 RIVA-VENLAFAXINE XR RIV  
 02310317 SANDOZ VENLAFAXINE XR SDZ  
 02275023 TEVA-VENLAFAXINE XR TEV  
 02339242 VENLAFAXINE XR PDL  
 02354713 VENLAFAXINE XR SAN  
 02385929 VENLAFAXINE XR SIV

**<sup>ST</sup> 75MG CAPSULE (EXTENDED RELEASE)**

02304325 ACT VENLAFAXINE XR ACG  
 02331691 APO-VENLAFAXINE XR APX  
 02452847 AURO-VENLAFAXINE XR AUR  
 02299305 DOM-VENLAFAXINE XR DPC  
 02237280 EFFEXOR XR PFI  
 02360039 GD-VENLAFAXINE XR PFI  
 02310287 MYLAN-VENLAFAXINE XR MYL  
 02278553 PMS-VENLAFAXINE XR PMS

**28:16.04 ANTIDEPRESSANTS****VENLAFAXINE HYDROCHLORIDE****<sup>ST</sup> 75MG CAPSULE (EXTENDED RELEASE)**

02380080	RAN-VENLAFAXINE XR	RBY
02307782	RIVA-VENLAFAXINE XR	RIV
02310325	SANDOZ VENLAFAXINE XR	SDZ
02275031	TEVA-VENLAFAXINE XR	TEV
02339250	VENLAFAXINE XR	PDL
02354721	VENLAFAXINE XR	SAN
02385937	VENLAFAXINE XR	SIV

**<sup>ST</sup> 150MG CAPSULE (EXTENDED RELEASE)**

02304333	ACT VENLAFAXINE XR	ACG
02331705	APO-VENLAFAXINE XR	APX
02452855	AURO-VENLAFAXINE XR	AUR
02299313	DOM-VENLAFAXINE XR	DPC
02237282	EFFEXOR XR	PFI
02360047	GD-VENLAFAXINE XR	PFI
02310295	MYLAN-VENLAFAXINE XR	MYL
02278561	PMS-VENLAFAXINE XR	PMS
02380099	RAN-VENLAFAXINE XR	RBY
02307790	RIVA-VENLAFAXINE XR	RIV
02310333	SANDOZ VENLAFAXINE XR	SDZ
02275058	TEVA-VENLAFAXINE XR	TEV
02339269	VENLAFAXINE XR	PDL
02354748	VENLAFAXINE XR	SAN
02385945	VENLAFAXINE XR	SIV

**28:16.08 ANTIPSYCHOTIC AGENTS****ARIPIPIRAZOLE**

Limited use benefit (prior approval required).

For the treatment of schizophrenia and schizoaffective disorders in patients:

- who have intolerance or lack of response to an adequate trial of another antipsychotic agent; OR
- a contraindication to another antipsychotic agent.

**<sup>ST</sup> 2MG TABLET**

02322374	ABILIFY	BMS
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**<sup>ST</sup> 5MG TABLET**

02322382	ABILIFY	BMS
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**<sup>ST</sup> 10MG TABLET**

02322390	ABILIFY	BMS
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**<sup>ST</sup> 15MG TABLET**

02322404	ABILIFY	BMS
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**<sup>ST</sup> 20MG TABLET**

02322412	ABILIFY	BMS
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**<sup>ST</sup> 30MG TABLET**

02322455	ABILIFY	BMS
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**ARIPIPIRAZOLE (MAINTENA)****300MG INJECTION**

02420864	ABILIFY MAINTENA	OTS
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**400MG INJECTION**

02420872	ABILIFY MAINTENA	OTS
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**28:16.08 ANTIPSYCHOTIC AGENTS****ASENAPINE MALEATE**

Limited use benefit (prior approval required).

For the acute treatment of manic or mixed episodes associated with bipolar I disorder as either:

- Monotherapy, after a trial of lithium or divalproex sodium has failed or is contraindicated, and trials of two atypical antipsychotic agents have failed due to intolerance or lack of response; OR
- Co-therapy with lithium or divalproex sodium, after trials of two atypical antipsychotic agents have failed due to intolerance or lack of response.

**<sup>ST</sup> 5MG TABLET**

02374803	SAPHRIS	FRS
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**<sup>ST</sup> 10MG TABLET**

02374811	SAPHRIS	FRS
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**CHLORPROMAZINE HYDROCHLORIDE****25MG/ML LIQUID**

00743518	CHLORPROMAZINE	SDZ
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**<sup>ST</sup> 25MG TABLET**

00232823	TEVA-CHLORPROMAZINE	TEV
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**<sup>ST</sup> 50MG TABLET**

00232807	TEVA-CHLORPROMAZINE	TEV
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**<sup>ST</sup> 100MG TABLET**

00232831	TEVA-CHLORPROMAZINE	TEV
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**CLOZAPINE****<sup>ST</sup> 25MG TABLET**

02248034	AA-CLOZAPINE	AAP
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00894737	CLOZARIL	HLS
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02247243	GEN-CLOZAPINE	MYL
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**<sup>ST</sup> 50MG TABLET**

02305003	GEN-CLOZAPINE	MYL
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**<sup>ST</sup> 100MG TABLET**

02248035	AA-CLOZAPINE	AAP
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00894745	CLOZARIL	HLS
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02247244	GEN-CLOZAPINE	MYL
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**<sup>ST</sup> 200MG TABLET**

02305011	GEN-CLOZAPINE	MYL
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**FLUPENTHIXOL DIHYDROCHLORIDE****<sup>ST</sup> 0.5MG TABLET**

02156008	FLUANXOL	LUD
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**<sup>ST</sup> 3MG TABLET**

02156016	FLUANXOL	LUD
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**FLUPENTIXOL DECANOATE****20MG/ML SOLUTION**

02156032	FLUANXOL DEPOT	LUD
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**100MG/ML SOLUTION**

02156040	FLUANXOL DEPOT	LUD
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**FLUPHENAZINE DECANOATE****25MG/ML LIQUID**

02091275	PMS-FLUPHENAZINE	PMS
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**100MG/ML LIQUID**

00755575	MODECATE	BMS
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02241928	PMS-FLUPHENAZINE	PMS
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**28:16.08 ANTIPSYCHOTIC AGENTS****FLUPHENAZINE HYDROCHLORIDE**

<sup>ST</sup> 1MG TABLET	00405345	FLUPHENAZINE	AAP
<sup>ST</sup> 2MG TABLET	00410632	FLUPHENAZINE	AAP
<sup>ST</sup> 5MG TABLET	00405361	FLUPHENAZINE	AAP
	00726354	PMS FLUPHENAZINE	PMS

**HALOPERIDOL**

<sup>ST</sup> 2MG/ML SOLUTION	00759503	PMS-HALOPERIDOL	PMS
<b>5MG/ML SOLUTION</b>			
	00808652	HALOPERIDOL	SDZ
	02366010	HALOPERIDOL	OMG
<sup>ST</sup> 0.5MG TABLET			
	00396796	APO HALOPERIDOL	APX
	00363685	TEVA-HALOPERIDOL	TEV
<sup>ST</sup> 1MG TABLET			
	00396818	APO HALOPERIDOL	APX
	00363677	TEVA-HALOPERIDOL	TEV
<sup>ST</sup> 2MG TABLET			
	00363669	TEVA-HALOPERIDOL	TEV
<sup>ST</sup> 5MG TABLET			
	00363650	TEVA-HALOPERIDOL	TEV
<sup>ST</sup> 10MG TABLET			
	00463698	APO-HALOPERIDOL	APX
	00713449	TEVA-HALOPERIDOL	TEV
<sup>ST</sup> 20MG TABLET			
	00768820	TEVA-HALOPERIDOL	TEV

**HALOPERIDOL DECANOATE**

<b>50MG/ML LIQUID</b>			
	02130297	HALOPERIDOL LA	SDZ
	02230707	PMS-HALOPERIDOL	PMS
<b>100MG/ML LIQUID</b>			
	02130300	HALOPERIDOL LA	SDZ
	02239640	HALOPERIDOL LA	OMG
	02230708	PMS-HALOPERIDOL	PMS

**LOXAPINE HYDROCHLORIDE**

<sup>ST</sup> 25MG/ML SOLUTION	02239101	XYLAC	PED
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**LOXAPINE SUCCINATE**

<sup>ST</sup> 2.5MG TABLET	02242868	XYLAC	PED
<sup>ST</sup> 5MG TABLET			
	02239918	DOM-LOXAPINE	DPC
	02230837	XYLAC	PED
<sup>ST</sup> 10MG TABLET			
	02239919	DOM-LOXAPINE	DPC
	02230838	XYLAC	PED
<sup>ST</sup> 25MG TABLET			
	02239920	DOM-LOXAPINE	DPC
	02230839	XYLAC	PED
<sup>ST</sup> 50MG TABLET			
	02239921	DOM-LOXAPINE	DPC

**28:16.08 ANTIPSYCHOTIC AGENTS****LOXAPINE SUCCINATE**

<sup>ST</sup> 50MG TABLET	02230840	XYLAC	PED
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**LURASIDONE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For the treatment of schizophrenia and schizoaffective disorders in patients:

- who have intolerance or lack of response to an adequate trial of another antipsychotic agent; OR
- a contraindication to another antipsychotic agent.

<sup>ST</sup> 20MG TABLET	02422050	LATUDA	SPC
<sup>ST</sup> 40MG TABLET	02387751	LATUDA	SPC
<sup>ST</sup> 60MG TABLET	02413361	LATUDA	SPC
<sup>ST</sup> 80MG TABLET	02387778	LATUDA	SPC
<sup>ST</sup> 120MG TABLET	02387786	LATUDA	SPC

**METHOTRIMEPRAZINE MALEATE**

<sup>ST</sup> 2MG TABLET	02238403	METHOPRAZINE	AAP
<sup>ST</sup> 5MG TABLET			
	02238404	METHOPRAZINE	AAP
	02232903	PMS-METHOTRIMEPRAZINE	PMS
<sup>ST</sup> 25MG TABLET			
	02238405	METHOPRAZINE	AAP
	01964925	NOVO-MEPRAZINE	NOP
<sup>ST</sup> 50MG TABLET			
	02238406	METHOPRAZINE	AAP

**OLANZAPINE**

<sup>ST</sup> 2.5MG TABLET			
	02325659	ACT OLANZAPINE	ACG
	02281791	APO-OLANZAPINE	APX
	02417243	JAMP-OLANZAPINE	JMP
	02421232	MAR-OLANZAPINE	MAR
	02337878	MYLAN-OLANZAPINE	MYL
	02311968	OLANZAPINE	PDL
	02372819	OLANZAPINE	SAN
	02385864	OLANZAPINE	SIV
	02303116	PMS-OLANZAPINE	PMS
	02403064	RAN-OLANZAPINE	RBV
	02337126	RIVA-OLANZAPINE	RIV
	02310341	SANDOZ OLANZAPINE	SDZ
	02276712	TEVA-OLANZAPINE	TEV
	02229250	ZYPREXA	LIL
<sup>ST</sup> 5MG TABLET			
	02325667	ACT OLANZAPINE	ACG
	02281805	APO-OLANZAPINE	APX
	02417251	JAMP-OLANZAPINE	JMP
	02421240	MAR-OLANZAPINE	MAR
	02337886	MYLAN-OLANZAPINE	MYL
	02311976	OLANZAPINE	PDL

## 28:16.08 ANTIPSYCHOTIC AGENTS

## OLANZAPINE

<sup>ST</sup> 5MG TABLET

02372827	OLANZAPINE	SAN
02385872	OLANZAPINE	SIV
02303159	PMS-OLANZAPINE	PMS
02403072	RAN-OLANZAPINE	RBV
02337134	RIVA-OLANZAPINE	RIV
02310368	SANDOZ OLANZAPINE	SDZ
02276720	TEVA-OLANZAPINE	TEV
02229269	ZYPREXA	LIL

<sup>ST</sup> 7.5MG TABLET

02325675	ACT OLANZAPINE	ACG
02281813	APO-OLANZAPINE	APX
02417278	JAMP-OLANZAPINE	JMP
02421259	MAR-OLANZAPINE	MAR
02337894	MYLAN-OLANZAPINE	MYL
02311984	OLANZAPINE	PDL
02372835	OLANZAPINE	SAN
02385880	OLANZAPINE	SIV
02303167	PMS-OLANZAPINE	PMS
02403080	RAN-OLANZAPINE	RBV
02337142	RIVA-OLANZAPINE	RIV
02310376	SANDOZ OLANZAPINE	SDZ
02276739	TEVA-OLANZAPINE	TEV
02229277	ZYPREXA	LIL

<sup>ST</sup> 10MG TABLET

02325683	ACT OLANZAPINE	ACG
02281821	APO-OLANZAPINE	APX
02417286	JAMP-OLANZAPINE	JMP
02421267	MAR-OLANZAPINE	MAR
02337908	MYLAN-OLANZAPINE	MYL
02311992	OLANZAPINE	PDL
02372843	OLANZAPINE	SAN
02385899	OLANZAPINE	SIV
02303175	PMS-OLANZAPINE	PMS
02403099	RAN-OLANZAPINE	RBV
02337150	RIVA-OLANZAPINE	RIV
02310384	SANDOZ OLANZAPINE	SDZ
02276747	TEVA-OLANZAPINE	TEV
02229285	ZYPREXA	LIL

<sup>ST</sup> 15MG TABLET

02325691	ACT OLANZAPINE	ACG
02281848	APO-OLANZAPINE	APX
02417294	JAMP-OLANZAPINE	JMP
02421275	MAR-OLANZAPINE	MAR
02337916	MYLAN-OLANZAPINE	MYL
02312018	OLANZAPINE	PDL
02372851	OLANZAPINE	SAN
02385902	OLANZAPINE	SIV
02303183	PMS-OLANZAPINE	PMS
02403102	RAN-OLANZAPINE	RBV
02337169	RIVA-OLANZAPINE	RIV
02310392	SANDOZ OLANZAPINE	SDZ
02276755	TEVA-OLANZAPINE	TEV
02238850	ZYPREXA	LIL

## 28:16.08 ANTIPSYCHOTIC AGENTS

## OLANZAPINE

<sup>ST</sup> 20MG TABLET

02417308	JAMP-OLANZAPINE	JMP
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<sup>ST</sup> 5MG TABLET (ORALLY DISINTEGRATING)

02327562	ACT OLANZAPINE ODT	ACG
02360616	APO-OLANZAPINE ODT	APX
02448726	AURO-OLANZAPINE ODT	AUR
02406624	JAMP OLANZAPINE ODT	JMP
02389088	MAR-OLANZAPINE ODT	MAR
02436965	MINT-OLANZAPINE ODT	MIN
02338645	OLANZAPINE ODT	PDL
02343665	OLANZAPINE ODT	SIV
02352974	OLANZAPINE ODT	SAN
02303191	PMS-OLANZAPINE ODT	PMS
02414090	RAN-OLANZAPINE ODT	RBV
02327775	SANDOZ OLANZAPINE ODT	SDZ
02321343	TEVA-OLANZAPINE ODT	TEV
02243086	ZYPREXA ZYDIS	LIL

<sup>ST</sup> 10MG TABLET (ORALLY DISINTEGRATING)

02327570	ACT OLANZAPINE ODT	ACG
02360624	APO-OLANZAPINE ODT	APX
02448734	AURO-OLANZAPINE ODT	AUR
02406632	JAMP OLANZAPINE ODT	JMP
02389096	MAR-OLANZAPINE ODT	MAR
02436973	MINT-OLANZAPINE ODT	MIN
02338653	OLANZAPINE ODT	PDL
02343673	OLANZAPINE ODT	SIV
02352982	OLANZAPINE ODT	SAN
02303205	PMS-OLANZAPINE ODT	PMS
02414104	RAN-OLANZAPINE ODT	RBV
02327783	SANDOZ OLANZAPINE ODT	SDZ
02321351	TEVA-OLANZAPINE ODT	TEV
02243087	ZYPREXA ZYDIS	LIL

<sup>ST</sup> 15MG TABLET (ORALLY DISINTEGRATING)

02327589	ACT OLANZAPINE ODT	ACG
02360632	APO-OLANZAPINE ODT	APX
02448742	AURO-OLANZAPINE ODT	AUR
02406640	JAMP OLANZAPINE ODT	JMP
02389118	MAR-OLANZAPINE ODT	MAR
02436981	MINT-OLANZAPINE ODT	MIN
02338661	OLANZAPINE ODT	PDL
02343681	OLANZAPINE ODT	SIV
02352990	OLANZAPINE ODT	SAN
02303213	PMS-OLANZAPINE ODT	PMS
02414112	RAN-OLANZAPINE ODT	RBV
02327791	SANDOZ OLANZAPINE ODT	SDZ
02243088	ZYPREXA ZYDIS	LIL

**28:16.08 ANTIPSYCHOTIC AGENTS****PALIPERIDONE PALMITATE**

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:

- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

**50MG/0.5ML SUSPENSION (EXTENDED RELEASE)**

02354217 INVEGA SUSTENNA JSO

**75MG/0.75ML SUSPENSION (EXTENDED RELEASE)**

02354225 INVEGA SUSTENNA JSO

**100MG/ML SUSPENSION (EXTENDED RELEASE)**

02354233 INVEGA SUSTENNA JSO

**150MG/1.5ML SUSPENSION (EXTENDED RELEASE)**

02354241 INVEGA SUSTENNA JSO

**PERICYAZINE****<sup>ST</sup> 5MG CAPSULE**

01926780 NEULEPTIL ERF

**<sup>ST</sup> 10MG CAPSULE**

01926772 NEULEPTIL ERF

**<sup>ST</sup> 20MG CAPSULE**

01926764 NEULEPTIL ERF

**<sup>ST</sup> 10MG/ML DROP**

01926756 NEULEPTIL ERF

**PERPHENAZINE****<sup>ST</sup> 3.2MG/ML LIQUID**

00751898 PMS PERPHENAZINE PMS

**<sup>ST</sup> 2MG TABLET**

00335134 PERPHENAZINE AAP

**<sup>ST</sup> 4MG TABLET**

00335126 PERPHENAZINE AAP

**<sup>ST</sup> 8MG TABLET**

00335118 PERPHENAZINE AAP

**<sup>ST</sup> 16MG TABLET**

00335096 PERPHENAZINE AAP

00726206 PMS PERPHENAZINE PMS

**PIMOZIDE****<sup>ST</sup> 2MG TABLET**

00313815 ORAP AAP

02245432 PIMOZIDE AAP

**<sup>ST</sup> 4MG TABLET**

00313823 ORAP AAP

02245433 PIMOZIDE AAP

**PIPOTIAZINE PALMITATE****50MG/ML INJECTION**

00894672 PIPORTIL L4 SAC

**28:16.08 ANTIPSYCHOTIC AGENTS****PROCHLORPERAZINE****10MG SUPPOSITORY**

00753688 PMS-PROCHLORPERAZINE PMS

00789720 SANDOZ PROCHLORPERAZINE SDZ

**PROCHLORPERAZINE MALEATE****<sup>ST</sup> 5MG TABLET**

00753661 PMS-PROCHLORPERAZINE PMS

00886440 PROCHLORAZINE AAP

**<sup>ST</sup> 10MG TABLET**

00753637 PMS-PROCHLORPERAZINE PMS

00886432 PROCHLORAZINE AAP

**PROCHLORPERAZINE MESYLATE****5MG/ML SOLUTION**

00753645 PMS PROCHLORPERAZINE PMS

**QUETIAPINE FUMARATE****<sup>ST</sup> 25MG TABLET**

02316080 ACT QUETIAPINE ACG

02313901 APO-QUETIAPINE APX

02390205 AURO-QUETIAPINE AUR

02447193 BIO-QUETIAPINE BMI

02298996 DOM-QUETIAPINE DPC

02330415 JAMP-QUETIAPINE JMP

02438003 MINT-QUETIAPINE MIN

02439158 NAT-QUETIAPINE NPH

02296551 PMS-QUETIAPINE PMS

02317346 PRO-QUETIAPINE PDL

02317893 QUETIAPINE SIV

02353164 QUETIAPINE SAN

02387794 QUETIAPINE ACC

02397099 RAN-QUETIAPINE RBY

02316692 RIVA-QUETIAPINE RIV

02313995 SANDOZ QUETIAPINE SDZ

02236951 SEROQUEL AZC

02284235 TEVA-QUETIAPINE TEV

02434024 VAN-QUETIAPINE VAN

**<sup>ST</sup> 50MG TABLET**

02361892 PMS-QUETIAPINE PMS

**<sup>ST</sup> 100MG TABLET**

02316099 ACT QUETIAPINE ACG

02313928 APO-QUETIAPINE APX

02390213 AURO-QUETIAPINE AUR

02447207 BIO-QUETIAPINE BMI

02299003 DOM-QUETIAPINE DPC

02330423 JAMP-QUETIAPINE JMP

02438011 MINT-QUETIAPINE MIN

02439166 NAT-QUETIAPINE NPH

02296578 PMS-QUETIAPINE PMS

02317354 PRO-QUETIAPINE PDL

02317907 QUETIAPINE SIV

02353172 QUETIAPINE SAN

02387808 QUETIAPINE ACC

02397102 RAN-QUETIAPINE RBY

02316706 RIVA-QUETIAPINE RIV

02314002 SANDOZ QUETIAPINE SDZ

## 28:16.08 ANTIPSYCHOTIC AGENTS

## QUETIAPINE FUMARATE

<sup>ST</sup> 100MG TABLET

02236952	SEROQUEL	AZC
02284243	TEVA-QUETIAPINE	TEV
02434032	VAN-QUETIAPINE	VAN

<sup>ST</sup> 200MG TABLET

02316110	ACT QUETIAPINE	ACG
02313936	APO-QUETIAPINE	APX
02390248	AURO-QUETIAPINE	AUR
02447223	BIO-QUETIAPINE	BMI
02299038	DOM-QUETIAPINE	DPC
02330458	JAMP-QUETIAPINE	JMP
02438046	MINT-QUETIAPINE	MIN
02439182	NAT-QUETIAPINE	NPH
02296594	PMS-QUETIAPINE	PMS
02317362	PRO-QUETIAPINE	PDL
02317923	QUETIAPINE	SIV
02353199	QUETIAPINE	SAN
02387824	QUETIAPINE	ACC
02397110	RAN-QUETIAPINE	RBY
02316722	RIVA-QUETIAPINE	RIV
02314010	SANDOZ QUETIAPINE	SDZ
02236953	SEROQUEL	AZC
02284278	TEVA-QUETIAPINE	TEV
02434040	VAN-QUETIAPINE	VAN

<sup>ST</sup> 300MG TABLET

02316129	ACT QUETIAPINE	ACG
02313944	APO-QUETIAPINE	APX
02390256	AURO-QUETIAPINE	AUR
02447258	BIO-QUETIAPINE	BMI
02299046	DOM-QUETIAPINE	DPC
02330466	JAMP-QUETIAPINE	JMP
02438054	MINT-QUETIAPINE	MIN
02439190	NAT-QUETIAPINE	NPH
02296608	PMS-QUETIAPINE	PMS
02317370	PRO-QUETIAPINE	PDL
02317931	QUETIAPINE	SIV
02353202	QUETIAPINE	SAN
02387832	QUETIAPINE	ACC
02397129	RAN-QUETIAPINE	RBY
02316730	RIVA-QUETIAPINE	RIV
02314029	SANDOZ QUETIAPINE	SDZ
02244107	SEROQUEL	AZC
02284286	TEVA-QUETIAPINE	TEV
02434059	VAN-QUETIAPINE	VAN

<sup>ST</sup> 50MG TABLET (EXTENDED RELEASE)

02417359	QUETIAPINE XR	SIV
02417782	QUETIAPINE XR	PDL
02407671	SANDOZ QUETIAPINE XRT	SDZ
02300184	SEROQUEL XR	AZC
02395444	TEVA-QUETIAPINE XR	TEV

<sup>ST</sup> 150MG TABLET (EXTENDED RELEASE)

02417367	QUETIAPINE XR	SIV
02417790	QUETIAPINE XR	PDL
02407698	SANDOZ QUETIAPINE XRT	SDZ
02321513	SEROQUEL XR	AZC

## 28:16.08 ANTIPSYCHOTIC AGENTS

## QUETIAPINE FUMARATE

<sup>ST</sup> 150MG TABLET (EXTENDED RELEASE)

02395452	TEVA-QUETIAPINE XR	TEV
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<sup>ST</sup> 200MG TABLET (EXTENDED RELEASE)

02417375	QUETIAPINE XR	SIV
02417804	QUETIAPINE XR	PDL
02407701	SANDOZ QUETIAPINE XRT	SDZ
02300192	SEROQUEL XR	AZC
02395460	TEVA-QUETIAPINE XR	TEV

<sup>ST</sup> 300MG TABLET (EXTENDED RELEASE)

02417383	QUETIAPINE XR	SIV
02417812	QUETIAPINE XR	PDL
02407728	SANDOZ QUETIAPINE XRT	SDZ
02300206	SEROQUEL XR	AZC
02395479	TEVA-QUETIAPINE XR	TEV

<sup>ST</sup> 400MG TABLET (EXTENDED RELEASE)

02417391	QUETIAPINE XR	SIV
02417820	QUETIAPINE XR	PDL
02407736	SANDOZ QUETIAPINE XRT	SDZ
02300214	SEROQUEL XR	AZC
02395487	TEVA-QUETIAPINE XR	TEV

<sup>ST</sup> 25MG TABLET (IMMEDIATE RELEASE)

02399822	MAR-QUETIAPINE	MAR
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<sup>ST</sup> 100MG TABLET (IMMEDIATE RELEASE)

02399830	MAR-QUETIAPINE	MAR
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<sup>ST</sup> 200MG TABLET (IMMEDIATE RELEASE)

02399849	MAR-QUETIAPINE	MAR
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<sup>ST</sup> 300MG TABLET (IMMEDIATE RELEASE)

02399857	MAR-QUETIAPINE	MAR
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## RISPERIDONE

<sup>ST</sup> 1MG/ML SOLUTION

02280396	APO-RISPERIDONE	APX
02279266	PMS-RISPERIDONE	PMS
02236950	RISPERDAL	JSO

<sup>ST</sup> 0.25MG TABLET

02282585	ACT RISPERIDONE	ACG
02282119	APO-RISPERIDONE	APX
02359529	JAMP-RISPERIDONE	JMP
02371766	MAR-RISPERIDONE	MAR
02359790	MINT-RISPERIDONE	MIN
02282240	MYLAN-RISPERIDONE	MYL
02258439	PHL-RISPERIDONE	PHH
02252007	PMS-RISPERIDONE	PMS
02312700	PRO-RISPERIDONE	PDL
02328305	RAN-RISPERIDONE	RBY
02240551	RISPERDAL	JSO
02356880	RISPERIDONE	SAN
02283565	RIVA-RISPERIDONE	RIV
02303655	SANDOZ RISPERIDONE	SDZ
02282690	TEVA-RISPERIDONE	TEV

<sup>ST</sup> 0.5MG TABLET

02282593	ACT RISPERIDONE	ACG
02282127	APO-RISPERIDONE	APX
02359537	JAMP-RISPERIDONE	JMP
02371774	MAR-RISPERIDONE	MAR

**28:16.08 ANTIPSYCHOTIC AGENTS**

**RISPERIDONE**

<sup>ST</sup> **0.5MG TABLET**

02359804	MINT-RISPERIDON	MIN
02282259	MYLAN-RISPERIDONE	MYL
02258447	PHL-RISPERIDONE	PHH
02252015	PMS-RISPERIDONE	PMS
02312719	PRO-RISPERIDONE	PDL
02328313	RAN-RISPERIDONE	RBY
02240552	RISPERDAL	JSO
02356899	RISPERIDONE	SAN
02283573	RIVA-RISPERIDONE	RIV
02303663	SANDOZ RISPERIDONE	SDZ
02264188	TEVA-RISPERIDONE	TEV

<sup>ST</sup> **1MG TABLET**

02282607	ACT RISPERIDONE	ACG
02282135	APO-RISPERIDONE	APX
02359545	JAMP-RISPERIDONE	JMP
02371782	MAR-RISPERIDONE	MAR
02359812	MINT-RISPERIDON	MIN
02282267	MYLAN-RISPERIDONE	MYL
02258455	PHL-RISPERIDONE	PHH
02252023	PMS-RISPERIDONE	PMS
02312727	PRO-RISPERIDONE	PDL
02328321	RAN-RISPERIDONE	RBY
02025280	RISPERDAL	JSO
02356902	RISPERIDONE	SAN
02283581	RIVA-RISPERIDONE	RIV
02279800	SANDOZ RISPERIDONE	SDZ
02264196	TEVA-RISPERIDONE	TEV

<sup>ST</sup> **2MG TABLET**

02282615	ACT RISPERIDONE	ACG
02282143	APO-RISPERIDONE	APX
02359553	JAMP-RISPERIDONE	JMP
02371790	MAR-RISPERIDONE	MAR
02359820	MINT-RISPERIDON	MIN
02282275	MYLAN-RISPERIDONE	MYL
02258463	PHL-RISPERIDONE	PHH
02252031	PMS-RISPERIDONE	PMS
02312735	PRO-RISPERIDONE	PDL
02328348	RAN-RISPERIDONE	RBY
02025299	RISPERDAL	JSO
02356910	RISPERIDONE	SAN
02283603	RIVA-RISPERIDONE	RIV
02279819	SANDOZ RISPERIDONE	SDZ
02264218	TEVA-RISPERIDONE	TEV

<sup>ST</sup> **3MG TABLET**

02282623	ACT RISPERIDONE	ACG
02282151	APO-RISPERIDONE	APX
02359561	JAMP-RISPERIDONE	JMP
02371804	MAR-RISPERIDONE	MAR
02359839	MINT-RISPERIDON	MIN
02282283	MYLAN-RISPERIDONE	MYL
02258471	PHL-RISPERIDONE	PHH
02252058	PMS-RISPERIDONE	PMS
02312743	PRO-RISPERIDONE	PDL
02328364	RAN-RISPERIDONE	RBY

**28:16.08 ANTIPSYCHOTIC AGENTS**

**RISPERIDONE**

<sup>ST</sup> **3MG TABLET**

02025302	RISPERDAL	JSO
02356929	RISPERIDONE	SAN
02283611	RIVA-RISPERIDONE	RIV
02279827	SANDOZ RISPERIDONE	SDZ
02264226	TEVA-RISPERIDONE	TEV

<sup>ST</sup> **4MG TABLET**

02282631	ACT RISPERIDONE	ACG
02282178	APO-RISPERIDONE	APX
02359588	JAMP-RISPERIDONE	JMP
02371812	MAR-RISPERIDONE	MAR
02359847	MINT-RISPERIDON	MIN
02282291	MYLAN-RISPERIDONE	MYL
02258498	PHL-RISPERIDONE	PHH
02252066	PMS-RISPERIDONE	PMS
02312751	PRO-RISPERIDONE	PDL
02328372	RAN-RISPERIDONE	RBY
02025310	RISPERDAL	JSO
02356937	RISPERIDONE	SAN
02283638	RIVA-RISPERIDONE	RIV
02279835	SANDOZ RISPERIDONE	SDZ
02264234	TEVA-RISPERIDONE	TEV

<sup>ST</sup> **0.5MG TABLET (ORALLY DISINTEGRATING)**

02413485	MYLAN-RISPERIDONE ODT	MYL
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<sup>ST</sup> **1MG TABLET (ORALLY DISINTEGRATING)**

02413493	MYLAN-RISPERIDONE ODT	MYL
02291789	PMS-RISPERIDONE ODT	PMS

<sup>ST</sup> **2MG TABLET (ORALLY DISINTEGRATING)**

02413507	MYLAN-RISPERIDONE ODT	MYL
02291797	PMS-RISPERIDONE ODT	PMS

<sup>ST</sup> **3MG TABLET (ORALLY DISINTEGRATING)**

02413515	MYLAN-RISPERIDONE ODT	MYL
02370697	PMS-RISPERIDONE ODT	PMS

<sup>ST</sup> **4MG TABLET (ORALLY DISINTEGRATING)**

02413523	MYLAN-RISPERIDONE ODT	MYL
02370700	PMS-RISPERIDONE ODT	PMS

**RISPERIDONE (CONSTA)**

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:

- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

**12.5MG INJECTION**

02298465	RISPERDAL CONSTA	JSO
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**25MG INJECTION**

02255707	RISPERDAL CONSTA	JSO
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<sup>ST</sup> **37.5MG INJECTION**

02255723	RISPERDAL CONSTA	JSO
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**28:16.08 ANTIPSYCHOTIC AGENTS****RISPERIDONE (CONSTA)**

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:

- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

**<sup>ST</sup> 50MG INJECTION**

02255758 RISPERDAL CONSTA JSO

**THIOPROPERAZINE MESYLATE****<sup>ST</sup> 10MG TABLET**

01927639 MAJEPTIL ERF

**THIOTHIXENE****<sup>ST</sup> 5MG CAPSULE**

00024449 NAVANE ERF

**TRIFLUOPERAZINE HYDROCHLORIDE****<sup>ST</sup> 1MG TABLET**

00345539 TRIFLUOPERAZINE AAP

**<sup>ST</sup> 2MG TABLET**

00312754 TRIFLUOPERAZINE AAP

**<sup>ST</sup> 5MG TABLET**

00312746 TRIFLUOPERAZINE AAP

**<sup>ST</sup> 10MG TABLET**

00326836 TRIFLUOPERAZINE AAP

**<sup>ST</sup> 20MG TABLET**

00595942 TRIFLUOPERAZINE AAP

**ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE****<sup>ST</sup> 20MG CAPSULE**

02298597 ZELDOX PFI

**<sup>ST</sup> 40MG CAPSULE**

02298600 ZELDOX PFI

**<sup>ST</sup> 60MG CAPSULE**

02298619 ZELDOX PFI

**<sup>ST</sup> 80MG CAPSULE**

02298627 ZELDOX PFI

**ZUCLOPENTHIXOL ACETATE****50MG/ML SOLUTION**

02230405 CLOPIXOL-ACUPHASE LUD

**ZUCLOPENTHIXOL DIHYDROCHLORIDE****200MG/ML SOLUTION**

02230406 CLOPIXOL DEPOT LUD

**<sup>ST</sup> 10MG TABLET**

02230402 CLOPIXOL LUD

**<sup>ST</sup> 25MG TABLET**

02230403 CLOPIXOL LUD

**28:20.04 AMPHETAMINES****DEXTROAMPHETAMINE SULFATE**

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents\* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

\* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

**<sup>ST</sup> 10MG CAPSULE (SUSTAINED RELEASE)**

01924559 DEXEDRINE SPANSULE PAL

**<sup>ST</sup> 15MG CAPSULE (SUSTAINED RELEASE)**

01924567 DEXEDRINE SPANSULE PAL

**<sup>ST</sup> 5MG TABLET**

02443236 APO-DEXTROAMPHETAMINE APX

01924516 DEXEDRINE PAL

**LISDEXAMFETAMINE DIMESYLATE**

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents\* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

\* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

**<sup>ST</sup> 10MG CAPSULE**

02439603 VYVANSE SHI

**<sup>ST</sup> 20MG CAPSULE**

02347156 VYVANSE SHI

**<sup>ST</sup> 30MG CAPSULE**

02322951 VYVANSE SHI

**<sup>ST</sup> 40MG CAPSULE**

02347164 VYVANSE SHI

**<sup>ST</sup> 50MG CAPSULE**

02322978 VYVANSE SHI

**<sup>ST</sup> 60MG CAPSULE**

02347172 VYVANSE SHI

**28:20.32 CNS STIMULANTS****METHYLPHENIDATE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents\* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

\* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

**<sup>ST</sup> 5MG TABLET**

02273950	APO-METHYLPHENIDATE	APX
02326221	METHYLPHENIDATE	PDL
02234749	PMS-METHYLPHENIDATE	PMS

**<sup>ST</sup> 10MG TABLET**

02249324	APO-METHYLPHENIDATE	APX
02326248	METHYLPHENIDATE	PDL
00584991	PMS-METHYLPHENIDATE	PMS

**<sup>ST</sup> 20MG TABLET**

02249332	APO-METHYLPHENIDATE	APX
02326256	METHYLPHENIDATE	PDL
00585009	PMS-METHYLPHENIDATE	PMS

**<sup>ST</sup> 18MG TABLET (EXTENDED RELEASE)**

02452731	APO-METHYLPHENIDATE ER	APX
02247732	CONCERTA	JSO
02413728	PMS-METHYLPHENIDATE ER	PMS
02315068	TEVA-METHYLPHENIDATE	TEV

**<sup>ST</sup> 20MG TABLET (EXTENDED RELEASE)**

02266687	APO-METHYLPHENIDATE SR	APX
02320312	SANDOZ METHYLPHENIDATE SR	SDZ

**<sup>ST</sup> 27MG TABLET (EXTENDED RELEASE)**

02452758	APO-METHYLPHENIDATE ER	APX
02250241	CONCERTA	JSO
02413736	PMS-METHYLPHENIDATE ER	PMS
02315076	TEVA-METHYLPHENIDATE	TEV

**<sup>ST</sup> 36MG TABLET (EXTENDED RELEASE)**

02452766	APO-METHYLPHENIDATE ER	APX
02247733	CONCERTA	JSO
02413744	PMS-METHYLPHENIDATE ER	PMS
02315084	TEVA-METHYLPHENIDATE	TEV

**<sup>ST</sup> 54MG TABLET (EXTENDED RELEASE)**

02330377	APO-METHYLPHENIDATE ER	APX
02247734	CONCERTA	JSO
02413752	PMS-METHYLPHENIDATE ER	PMS
02315092	TEVA-METHYLPHENIDATE	TEV

**28:20.80 WAKEFULNESS-PROMOTING AGENTS****MODAFINIL****<sup>ST</sup> 100MG TABLET**

02239665	ALERTEC	TEV
02285398	APO-MODAFINIL	APX
02430487	AURO-MODAFINIL	AUR

**28:20.80 WAKEFULNESS-PROMOTING AGENTS****MODAFINIL****<sup>ST</sup> 100MG TABLET**

02442078	BIO-MODAFINIL	BMI
02432560	MAR-MODAFINIL	MAR
02420260	TEVA-MODAFINIL	TEV

**28:20.92 MISC ANOREXIGENIC AGENTS & RESPIRATORY & CEREBRAL STIMULANT****CAFFEINE CITRATE**

Limited use benefit (prior approval not required).

For children up to 1 year of age

**POWDER**

00972037	CAFFEINE CITRATE	MDS
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**28:24.04 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BARBITURATES****PHENOBARBITAL****15MG TABLET**

00178799	PHENOBARB	PED
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**30MG TABLET**

00178802	PHENOBARB	PED
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**60MG TABLET**

00178810	PHENOBARB	PED
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**28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES****ALPRAZOLAM**

Limited use benefit (prior approval is 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.

**<sup>ST</sup> 0.25MG TABLET**

01908189	ALPRAZOLAM	PDL
02349191	ALPRAZOLAM	SAN
00865397	APO-ALPRAZ	APX
02400111	JAMP-ALPRAZOLAM	JMP
02137534	MYLAN-ALPRAZOLAM	MYL
02417634	NAT-ALPRAZOLAM	NPH
02404877	RIVA-ALPRAZOLAM	RIV
01913484	TEVA-ALPRAZOLAM	TEV
00548359	XANAX	PFI

**<sup>ST</sup> 0.5MG TABLET**

01908170	ALPRAZOLAM	PDL
02349205	ALPRAZOLAM	SAN
00865400	APO-ALPRAZ	APX
02400138	JAMP-ALPRAZOLAM	JMP
02137542	MYLAN-ALPRAZOLAM	MYL
02417642	NAT-ALPRAZOLAM	NPH
02404885	RIVA-ALPRAZOLAM	RIV

## 28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

### ALPRAZOLAM

Limited use benefit (prior approval is 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.

#### <sup>ST</sup> 0.5MG TABLET

01913492	TEVA-ALPRAZOLAM	TEV
00548367	XANAX	PFI

#### <sup>ST</sup> 1MG TABLET

02248706	ALPRAZOLAM	PDL
02243611	APO-ALPRAZ	APX
02400146	JAMP-ALPRAZOLAM	JMP
02229813	MYLAN-ALPRAZOLAM	MYL
02417650	NAT-ALPRAZOLAM	NPH
02404893	RIVA-ALPRAZOLAM	RIV
00723770	XANAX	PFI

#### <sup>ST</sup> 2MG TABLET

02243612	APO-ALPRAZ	APX
02400154	JAMP-ALPRAZOLAM	JMP
02229814	MYLAN-ALPRAZOLAM	MYL
02404907	RIVA-ALPRAZOLAM	RIV
00813958	XANAX TS	PFI

### BROMAZEPAM

Limited use benefit (prior approval is 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.

#### <sup>ST</sup> 1.5MG TABLET

02177153	APO-BROMAZEPAM	APX
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#### <sup>ST</sup> 3MG TABLET

02177161	APO-BROMAZEPAM	APX
02220520	BROMAZEPAM	PDL
00518123	LECTOPAM	HLR
02230584	TEVA-BROMAZEPAM	TEV

#### <sup>ST</sup> 6MG TABLET

02177188	APO-BROMAZEPAM	APX
02220539	BROMAZEPAM	PDL
00518131	LECTOPAM	HLR
02230585	TEVA-BROMAZEPAM	TEV

## 28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

### DIAZEPAM

Limited use benefit (prior approval is 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.

#### <sup>ST</sup> 1MG/ML SOLUTION

00891797	PMS-DIAZEPAM	PMS
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#### <sup>ST</sup> 2MG TABLET

00405329	APO DIAZEPAM	APX
02247490	PMS-DIAZEPAM	PMS

#### <sup>ST</sup> 5MG TABLET

00362158	APO DIAZEPAM	APX
00313580	DIAZEPAM	PDL
02247491	PMS-DIAZEPAM	PMS
00013285	VALIUM	HLR

#### <sup>ST</sup> 10MG TABLET

00405337	APO DIAZEPAM	APX
00434388	DIAZEPAM	PDL
02247492	PMS-DIAZEPAM	PMS

### DIAZEPAM (DIASSTAT)

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.

#### <sup>ST</sup> 5MG/ML GEL

02238162	DIASSTAT	VAE
09853340	DIASSTAT 2X10MG RECTAL PACK	ELN
09853430	DIASSTAT 2X15MG RECTAL PACK	ELN

### LORAZEPAM

Limited use benefit (prior approval is 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.

#### <sup>ST</sup> 0.5MG TABLET

00655740	APO-LORAZEPAM	APX
02410745	APO-LORAZEPAM SUBLINGUAL	APX
02041413	ATIVAN	PFI
02041456	ATIVAN	PFI
02245784	DOM-LORAZEPAM	DPG

## 28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

### LORAZEPAM

Limited use benefit (prior approval is 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.

#### <sup>ST</sup> 0.5MG TABLET

02351072	LORAZEPAM	SAN
00728187	PMS-LORAZEPAM	PMS
00655643	PRO-LORAZEPAM	PDL
00711101	TEVA-LORAZEPAM	TEV

#### <sup>ST</sup> 1MG TABLET

00655759	APO-LORAZEPAM	APX
02410753	APO-LORAZEPAM SUBLINGUAL	APX
02041421	ATIVAN	PFI
02041464	ATIVAN	PFI
02245785	DOM-LORAZEPAM	DPC
02351080	LORAZEPAM	SAN
00728195	PMS-LORAZEPAM	PMS
00655651	PRO-LORAZEPAM	PDL
00637742	TEVA-LORAZEPAM	TEV

#### <sup>ST</sup> 2MG TABLET

00655767	APO-LORAZEPAM	APX
02410761	APO-LORAZEPAM SUBLINGUAL	APX
02041448	ATIVAN	PFI
02041472	ATIVAN	PFI
02245786	DOM-LORAZEPAM	DPC
02351099	LORAZEPAM	SAN
00728209	PMS-LORAZEPAM	PMS
00655678	PRO-LORAZEPAM	PDL
00637750	TEVA-LORAZEPAM	TEV

### NITRAZEPAM

Limited use benefit (prior approval is 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.

#### <sup>ST</sup> 5MG TABLET

00511528	MOGADON	AAP
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#### <sup>ST</sup> 10MG TABLET

00511536	MOGADON	AAP
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## 28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

### OXAZEPAM

Limited use benefit (prior approval is 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.

#### <sup>ST</sup> 10MG TABLET

00402680	APO OXAZEPAM	APX
00497754	OXAZEPAM	PDL
00414247	OXPAM	BMI
00568392	RIVA OXAZEPAM	RIV

#### <sup>ST</sup> 15MG TABLET

00402745	APO OXAZEPAM	APX
00497762	OXAZEPAM	PDL
00568406	RIVA OXAZEPAM	RIV

#### <sup>ST</sup> 30MG TABLET

00402737	APO OXAZEPAM	APX
00497770	OXAZEPAM	PDL
00414263	OXPAM	BMI
00568414	RIVA OXAZEPAM	RIV

### TEMAZEPAM

Limited use benefit (prior approval is 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.

#### <sup>ST</sup> 15MG CAPSULE

02225964	APO-TEMAZEPAM	APX
00604453	RESTORIL	AAP
02229760	TEMAZEPAM	PDL
02230095	TEVA-TEMAZEPAM	TEV

#### <sup>ST</sup> 30MG CAPSULE

02225972	APO-TEMAZEPAM	APX
00604461	RESTORIL	AAP
02229761	TEMAZEPAM	PDL
02230102	TEVA-TEMAZEPAM	TEV

### TRIAZOLAM

Limited use benefit (prior approval is 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.

#### <sup>ST</sup> 0.25MG TABLET

00808571	TRIAZOLAM	AAP
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**28:24.92 MISCELLANEOUS ANXIOLYTICS,  
SEDATIVES, AND HYPNOTICS****BUSPIRONE HYDROCHLORIDE****<sup>ST</sup> 10MG TABLET**

02211076	APO-BUSPIRONE	APX
02223163	BUSPIRONE	PDL
02447851	BUSPIRONE	SAN
02230942	PMS-BUSPIRONE	PMS
02231492	TEVA-BUSPIRONE	TEV

**HYDROXYZINE HYDROCHLORIDE****<sup>ST</sup> 10MG CAPSULE**

00646059	APO HYDROXYZINE	APX
00738824	NOVO-HYDROXYZIN	TEV

**<sup>ST</sup> 25MG CAPSULE**

00646024	APO HYDROXYZINE	APX
00738832	NOVO-HYDROXYZIN	TEV

**<sup>ST</sup> 50MG CAPSULE**

00646016	APO HYDROXYZINE	APX
00738840	NOVO-HYDROXYZIN	TEV

**<sup>ST</sup> 2MG/ML SYRUP**

00024694	ATARAX	ERF
00741817	PMS HYDROXYZINE	PMS

**28:28.00 ANTIMANIC AGENTS****LITHIUM CARBONATE****<sup>ST</sup> 150MG CAPSULE**

02242837	APO-LITHIUM CARBONATE	APX
09857532	APO-LITHIUM CARBONATE	APX
00461733	CARBOLITH	VAE
02013231	LITHANE	ERF
02216132	PMS-LITHIUM CARBONATE	PMS

**<sup>ST</sup> 300MG CAPSULE**

02242838	APO-LITHIUM CARBONATE	APX
09857540	APO-LITHIUM CARBONATE	APX
00236683	CARBOLITH	VAE
00406775	LITHANE	ERF
02216140	PMS-LITHIUM CARBONATE	PMS

**<sup>ST</sup> 600MG CAPSULE**

02011239	CARBOLITH	VAE
02216159	PMS-LITHIUM CARBONATE	PMS

**<sup>ST</sup> 300MG TABLET (EXTENDED RELEASE)**

02266695	LITHMAX	AAP
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**LITHIUM CITRATE****<sup>ST</sup> 60MG/ML SYRUP**

02074834	PMS-LITHIUM CITRATE	PMS
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**28:32.28 SELECTIVE SEROTONIN  
AGONISTS****ALMOTRIPTAN MALATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**6.25MG TABLET**

02405792	APO-ALMOTRIPTAN	APX
02248128	AXERT	MCL

**28:32.28 SELECTIVE SEROTONIN  
AGONISTS****ALMOTRIPTAN MALATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**6.25MG TABLET**

02398435	MYLAN-ALMOTRIPTAN	MYL
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**12.5MG TABLET**

02424029	ALMOTRIPTAN	PDL
02405806	APO-ALMOTRIPTAN	APX
02248129	AXERT	MCL
02398443	MYLAN-ALMOTRIPTAN	MYL
02405334	SANDOZ ALMOTRIPTAN	SDZ

**NARATRIPTAN HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**1MG TABLET**

02237820	AMERGE	GSK
02314290	TEVA-NARATRIPTAN	TEV

**2.5MG TABLET**

02237821	AMERGE	GSK
02322323	SANDOZ NARATRIPTAN	SDZ
02314304	TEVA-NARATRIPTAN	TEV

**RIZATRIPTAN BENZOATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**5MG TABLET**

02393468	APO-RIZATRIPTAN	APX
02380455	JAMP-RIZATRIPTAN	JMP
02429233	JAMP-RIZATRIPTAN IR	JMP
02379651	MAR-RIZATRIPTAN	MAR

**10MG TABLET**

02381702	ACT RIZATRIPTAN	ACG
02393476	APO-RIZATRIPTAN	APX
02441144	AURO-RIZATRIPTAN	AUR
02380463	JAMP-RIZATRIPTAN	JMP
02429241	JAMP-RIZATRIPTAN IR	JMP
02379678	MAR-RIZATRIPTAN	MAR
02240521	MAXALT	FRS

**5MG TABLET (ORALLY DISINTEGRATING)**

02374730	ACT RIZATRIPTAN ODT	ACG
02393484	APO-RIZATRIPTAN RPD	APX
02240518	MAXALT RPD	FRS
02379198	MYLAN-RIZATRIPTAN ODT	MYL
02436604	NAT-RIZATRIPTAN ODT	NPH
02393360	PMS-RIZATRIPTAN RDT	PMS
02423456	RIVA-RIZATRIPTAN ODT	RIV
02442906	RIZATRIPTAN ODT	SAN
02446111	RIZATRIPTAN ODT	SIV
02415798	RIZATRIPTAN RDT	PDL
02351870	SANDOZ RIZATRIPTAN ODT	SDZ
02396661	TEVA-RIZATRIPTAN ODT	TEV

**28:32.28 SELECTIVE SEROTONIN  
AGONISTS****RIZATRIPTAN BENZOATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**10MG TABLET (ORALLY DISINTEGRATING)**

02374749	ACT RIZATRIPTAN ODT	ACG
02393492	APO-RIZATRIPTAN RPD	APX
02396203	DOM-RIZATRIPTAN RDT	DPC
02240519	MAXALT RPD	FRS
02379201	MYLAN-RIZATRIPTAN ODT	MYL
02436612	NAT-RIZATRIPTAN ODT	NPH
02393379	PMS-RIZATRIPTAN RDT	PMS
02423464	RIVA-RIZATRIPTAN ODT	RIV
02442914	RIZATRIPTAN ODT	SAN
02446138	RIZATRIPTAN ODT	SIV
02415801	RIZATRIPTAN RDT	PDL
02351889	SANDOZ RIZATRIPTAN ODT	SDZ
02396688	TEVA-RIZATRIPTAN ODT	TEV

**SUMATRIPTAN HEMISULFATE****5MG SPRAY**

02230418	IMITREX	GSK
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**20MG SPRAY**

02230420	IMITREX	GSK
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**SUMATRIPTAN SUCCINATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**6MG/0.5ML INJECTION**

99000598	IMITREX STAT DOSE KIT	GSK
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**12MG/ML SOLUTION**

02212188	IMITREX	GSK
02361698	TARO-SUMATRIPTAN	TAR

**25MG TABLET**

02257882	ACT SUMATRIPTAN	ACG
02270749	DOM-SUMATRIPTAN	DPC
02268906	MYLAN-SUMATRIPTAN	MYL
02256428	PMS-SUMATRIPTAN	PMS
02286815	TEVA-SUMATRIPTAN DF	TEV

**50MG TABLET**

02257890	ACT SUMATRIPTAN	ACG
02268388	APO-SUMATRIPTAN	APX
02270757	DOM-SUMATRIPTAN	DPC
02212153	IMITREX DF	GSK
02268914	MYLAN-SUMATRIPTAN	MYL
02256436	PMS-SUMATRIPTAN	PMS
02263025	SANDOZ SUMATRIPTAN	SDZ
02286521	SUMATRIPTAN	SAN
02324652	SUMATRIPTAN	PDL
02385570	SUMATRIPTAN DF	SIV
02286823	TEVA-SUMATRIPTAN DF	TEV

**100MG TABLET**

02257904	ACT SUMATRIPTAN	ACG
02268396	APO-SUMATRIPTAN	APX

**28:32.28 SELECTIVE SEROTONIN  
AGONISTS****SUMATRIPTAN SUCCINATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**100MG TABLET**

02270765	DOM-SUMATRIPTAN	DPC
02212161	IMITREX DF	GSK
02268922	MYLAN-SUMATRIPTAN	MYL
02256444	PMS-SUMATRIPTAN	PMS
02263033	SANDOZ SUMATRIPTAN	SDZ
02286548	SUMATRIPTAN	SAN
02324660	SUMATRIPTAN	PDL
02385589	SUMATRIPTAN DF	SIV
02239367	TEVA-SUMATRIPTAN	TEV
02286831	TEVA-SUMATRIPTAN DF	TEV

**ZOLMITRIPTAN**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**2.5MG TABLET**

02380951	APO-ZOLMITRIPTAN	APX
02389525	DOM-ZOLMITRIPTAN	DPC
02421623	JAMP-ZOLMITRIPTAN	JMP
02399458	MAR-ZOLMITRIPTAN	MAR
02419521	MINT-ZOLMITRIPTAN	MIN
02369036	MYLAN-ZOLMITRIPTAN	MYL
02421534	NAT-ZOLMITRIPTAN	NPH
02324229	PMS-ZOLMITRIPTAN	PMS
02401304	RIVA-ZOLMITRIPTAN	RIV
02362988	SANDOZ ZOLMITRIPTAN	SDZ
02313960	TEVA-ZOLMITRIPTAN	TEV
02379929	ZOLMITRIPTAN	PDL
02238660	ZOMIG	AZC

**2.5MG TABLET (ORALLY DISINTEGRATING)**

02438453	AG-ZOLMITRIPTAN ODT	ANG
02381575	APO-ZOLMITRIPTAN RAPID	APX
02428237	JAMP-ZOLMITRIPTAN ODT	JMP
02387158	MYLAN-ZOLMITRIPTAN ODT	MYL
02324768	PMS-ZOLMITRIPTAN ODT	PMS
02362996	SANDOZ ZOLMITRIPTAN ODT	SDZ
02428474	SEPTA-ZOLMITRIPTAN-ODT	SPT
02342545	TEVA-ZOLMITRIPTAN OD	TEV
02379988	ZOLMITRIPTAN ODT	PDL
02243045	ZOMIG RAPIMELT	AZC

**28:32.92 MISCELLANEOUS ANTIMIGRANE  
AGENTS****FLUNARIZINE HYDROCHLORIDE****5MG CAPSULE**

02246082	FLUNARIZINE	AAP
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**PIZOTIFEN MALATE****0.5MG TABLET**

00329320	SANDOMIGRAN	PAL
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**28:32.92 MISCELLANEOUS ANTIMIGRANE AGENTS****PIZOTIFEN MALATE****1MG TABLET**

00511552 SANDOMIGRAN DS PAL

**28:36.08 ANTIPARKINSONIAN AGENTS - ANTICHOLINERGIC AGENTS****BENZTROPINE MESYLATE****1MG/ML LIQUID**

02238903 BENZTROPINE OMEGA OMG

**1MG TABLET**

00706531 PDP-BENZTROPINE PED

**2MG TABLET**

00426857 PDP-BENZTROPINE PED

00587265 PMS-BENZTROPINE PMS

**ETHOPROPAZINE HYDROCHLORIDE****50MG TABLET**

01927744 PARSITAN ERF

**PROCYCLIDINE HYDROCHLORIDE****0.5MG/ML ELIXIR**

00587362 PDP-PROCYCLIDINE PED

**2.5MG TABLET**

00649392 PDP-PROCYCLIDINE PED

**5MG TABLET**

00587354 PDP-PROCYCLIDINE PED

**TRIHEXYPHENIDYL HYDROCHLORIDE****0.4MG/ML ELIXIR**

00885398 PMS-TRIHEXYPHENIDYL PMS

**2MG TABLET**

00545058 TRIHEXYPHENIDYL AAP

**5MG TABLET**

00545074 TRIHEXYPHENIDYL AAP

**28:36.12 ANTIPARKINSONIAN AGENTS - CATECHOL-O-METHYLTRANSFERASE (COMT) INHIBITORS****ENTACAPONE****<sup>ST</sup> 200MG TABLET**

02243763 COMTAN NVR

02390337 MYLAN-ENTACAPONE MYL

02380005 SANDOZ ENTACAPONE SDZ

02375559 TEVA-ENTACAPONE TEV

**28:36.16 ANTIPARKINSONIAN AGENTS - DOPAMINE PRECURSORS****LEVODOPA, BENSERAZIDE HYDROCHLORIDE****<sup>ST</sup> 50MG & 12.5MG CAPSULE**

00522597 PROLOPA HLR

**<sup>ST</sup> 100MG & 25MG CAPSULE**

00386464 PROLOPA HLR

**<sup>ST</sup> 200MG & 50MG CAPSULE**

00386472 PROLOPA HLR

**28:36.16 ANTIPARKINSONIAN AGENTS - DOPAMINE PRECURSORS****LEVODOPA, CARBIDOPA****<sup>ST</sup> 100MG & 10MG TABLET**

02195933 APO-LEVOCARB APX

02457954 MINT-LEVOCARB MIN

02244494 TEVA-LEVOCARBIDOPA TEV

**<sup>ST</sup> 100MG & 25MG TABLET**

02195941 APO-LEVOCARB APX

02457962 MINT-LEVOCARB MIN

02421488 PMS-LEVOCARB PMS

02311178 PRO-LEVOCARB PDL

00513997 SINEMET FRS

02244495 TEVA-LEVOCARBIDOPA TEV

**<sup>ST</sup> 250MG & 25MG TABLET**

02195968 APO-LEVOCARB APX

02457970 MINT-LEVOCARB MIN

00328219 SINEMET FRS

02244496 TEVA-LEVOCARBIDOPA TEV

**<sup>ST</sup> 100MG & 25MG TABLET (EXTENDED RELEASE)**

02272873 APO-LEVOCARB APX

02028786 SINEMET FRS

**<sup>ST</sup> 200MG & 50MG TABLET (EXTENDED RELEASE)**

02245211 APO-LEVOCARB APX

02421496 PMS-LEVOCARB PMS

00870935 SINEMET FRS

**LEVODOPA, CARBIDOPA, ENTACAPONE****<sup>ST</sup> 50MG & 12.5MG & 200MG TABLET**

02305933 STALEVO NVR

**<sup>ST</sup> 75MG & 18.75MG & 200MG TABLET**

02337827 STALEVO NVR

**<sup>ST</sup> 100MG & 25MG & 200MG TABLET**

02305941 STALEVO NVR

**<sup>ST</sup> 125MG & 31.25MG & 200MG TABLET**

02337835 STALEVO NVR

**<sup>ST</sup> 150MG & 37.5MG & 200MG TABLET**

02305968 STALEVO NVR

**28:36.20 ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR AGONISTS****BROMOCRIPTINE MESYLATE****<sup>ST</sup> 5MG CAPSULE**

02230454 BROMOCRIPTINE AAP

02238637 DOM-BROMOCRIPTINE DPC

02236949 PMS-BROMOCRIPTINE PMS

**<sup>ST</sup> 2.5MG TABLET**

02087324 BROMOCRIPTINE AAP

02238636 DOM-BROMOCRIPTINE DPC

02231702 PMS-BROMOCRIPTINE PMS

**28:36.20 ANTIPARKINSONIAN AGENTS -  
DOPAMINE RECEPTOR  
AGONISTS**

**CABERGOLINE**

Limited use benefit (prior approval required).

For treatment of hyperprolactinemia in patients who have failed therapy with or are intolerant to bromocriptine.

**0.5MG TABLET**

02301407	ACT CABERGOLINE	ACG
02455897	APO-CABERGOLINE	APX
02242471	DOSTINEX	PFI

**PRAMIPEXOLE DIHYDROCHLORIDE**

<sup>ST</sup> **0.25MG TABLET**

02297302	ACT PRAMIPEXOLE	ACG
02292378	APO-PRAMIPEXOLE	APX
02424061	AURO-PRAMIPEXOLE	AUR
02309017	DOM-PRAMIPEXOLE	DPC
02237145	MIRAPEX	BOE
09857268	MIRAPEX (ON)	BOE
02290111	PMS-PRAMIPEXOLE	PMS
02309122	PRAMIPEXOLE	SIV
02325802	PRAMIPEXOLE	PDL
02367602	PRAMIPEXOLE	SAN
02315262	SANDOZ PRAMIPEXOLE	SDZ
02269309	TEVA-PRAMIPEXOLE	TEV

<sup>ST</sup> **0.5MG TABLET**

02297310	ACT PRAMIPEXOLE	ACG
02292386	APO-PRAMIPEXOLE	APX
02424088	AURO-PRAMIPEXOLE	AUR
02241594	MIRAPEX	BOE
02290138	PMS-PRAMIPEXOLE	PMS
02309130	PRAMIPEXOLE	SIV
02325810	PRAMIPEXOLE	PDL
02367610	PRAMIPEXOLE	SAN
02315270	SANDOZ PRAMIPEXOLE	SDZ
02269317	TEVA-PRAMIPEXOLE	TEV

<sup>ST</sup> **1MG TABLET**

02297329	ACT PRAMIPEXOLE	ACG
02292394	APO-PRAMIPEXOLE	APX
02424096	AURO-PRAMIPEXOLE	AUR
02237146	MIRAPEX	BOE
09857269	MIRAPEX (ON)	BOE
02290146	PMS-PRAMIPEXOLE	PMS
02309149	PRAMIPEXOLE	SIV
02325829	PRAMIPEXOLE	PDL
02367629	PRAMIPEXOLE	SAN
02315289	SANDOZ PRAMIPEXOLE	SDZ
02269325	TEVA-PRAMIPEXOLE	TEV

<sup>ST</sup> **1.5MG TABLET**

02297337	ACT PRAMIPEXOLE	ACG
02292408	APO-PRAMIPEXOLE	APX
02424118	AURO-PRAMIPEXOLE	AUR
02237147	MIRAPEX	BOE
09857270	MIRAPEX (ON)	BOE
02290154	PMS-PRAMIPEXOLE	PMS
02309157	PRAMIPEXOLE	SIV

**28:36.20 ANTIPARKINSONIAN AGENTS -  
DOPAMINE RECEPTOR  
AGONISTS**

**PRAMIPEXOLE DIHYDROCHLORIDE**

<sup>ST</sup> **1.5MG TABLET**

02325837	PRAMIPEXOLE	PDL
02315297	SANDOZ PRAMIPEXOLE	SDZ
02269333	TEVA-PRAMIPEXOLE	TEV

**ROPINIROLE HYDROCHLORIDE**

<sup>ST</sup> **0.25MG TABLET**

02316846	ACT ROPINIROLE	ACG
02337746	APO-ROPINIROLE	APX
02352338	JAMP-ROPINIROLE	JMP
02326590	PMS-ROPINIROLE	PMS
02314037	RAN-ROPINIROLE	RBV
02232565	REQUIP	GSK
02353040	ROPINIROLE	SAN

<sup>ST</sup> **1MG TABLET**

02316854	ACT ROPINIROLE	ACG
02337762	APO-ROPINIROLE	APX
02352346	JAMP-ROPINIROLE	JMP
02326612	PMS-ROPINIROLE	PMS
02314053	RAN-ROPINIROLE	RBV
02232567	REQUIP	GSK
02353059	ROPINIROLE	SAN

<sup>ST</sup> **2MG TABLET**

02316862	ACT ROPINIROLE	ACG
02337770	APO-ROPINIROLE	APX
02352354	JAMP-ROPINIROLE	JMP
02326620	PMS-ROPINIROLE	PMS
02314061	RAN-ROPINIROLE	RBV
02232568	REQUIP	GSK

<sup>ST</sup> **5MG TABLET**

02316870	ACT ROPINIROLE	ACG
02337800	APO-ROPINIROLE	APX
02352362	JAMP-ROPINIROLE	JMP
02326639	PMS-ROPINIROLE	PMS
02314088	RAN-ROPINIROLE	RBV
02232569	REQUIP	GSK

**28:36.32 ANTIPARKINSONIAN AGENTS -  
MONOAMINE OXIDASE B  
INHIBITORS**

**SELEGILINE HYDROCHLORIDE**

<sup>ST</sup> **5MG TABLET**

02230641	APO-SELEGILINE	APX
02068087	TEVA-SELEGILINE	TEV

## 28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

### ACAMPROSATE CALCIUM

Limited use benefit (prior approval required).

For patients who have been abstinent from alcohol for at least four days and where available, are currently enrolled in an alcohol addiction treatment program.

#### 333MG TABLET (DELAYED RELEASE)

02293269 CAMPRAL MYL

### ATOMOXETINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:

- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

#### 10MG CAPSULE

02318024	APO-ATOMOXETINE	APX
02358190	ATOMOXETINE	AAP
02396904	ATOMOXETINE	PDL
02445883	ATOMOXETINE	SIV
02390469	DOM-ATOMOXETINE	DPC
02381028	PMS-ATOMOXETINE	PMS
02405962	RIVA-ATOMOXETINE	RIV
02386410	SANDOZ ATOMOXETINE	SDZ
02262800	STRATTERA	LIL
02314541	TEVA-ATOMOXETINE	TEV

#### 18MG CAPSULE

02318032	APO-ATOMOXETINE	APX
02358204	ATOMOXETINE	AAP
02396912	ATOMOXETINE	PDL
02390477	DOM-ATOMOXETINE	DPC
02378930	MYLAN-ATOMOXETINE	MYL
02381036	PMS-ATOMOXETINE	PMS
02386429	SANDOZ ATOMOXETINE	SDZ
02262819	STRATTERA	LIL
02314568	TEVA-ATOMOXETINE	TEV

#### 25MG CAPSULE

02318040	APO-ATOMOXETINE	APX
02358212	ATOMOXETINE	AAP
02396920	ATOMOXETINE	PDL
02445913	ATOMOXETINE	SIV
02390485	DOM-ATOMOXETINE	DPC
02378949	MYLAN-ATOMOXETINE	MYL
02381044	PMS-ATOMOXETINE	PMS
02405989	RIVA-ATOMOXETINE	RIV
02386437	SANDOZ ATOMOXETINE	SDZ
02262827	STRATTERA	LIL
02314576	TEVA-ATOMOXETINE	TEV

#### 40MG CAPSULE

02318059	APO-ATOMOXETINE	APX
02358220	ATOMOXETINE	AAP
02396939	ATOMOXETINE	PDL

## 28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

### ATOMOXETINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:

- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

#### 40MG CAPSULE

02445948	ATOMOXETINE	SIV
02390493	DOM-ATOMOXETINE	DPC
02378957	MYLAN-ATOMOXETINE	MYL
02381052	PMS-ATOMOXETINE	PMS
02405997	RIVA-ATOMOXETINE	RIV
02386445	SANDOZ ATOMOXETINE	SDZ
02262835	STRATTERA	LIL
02314584	TEVA-ATOMOXETINE	TEV

#### 60MG CAPSULE

02318067	APO-ATOMOXETINE	APX
02358239	ATOMOXETINE	AAP
02396947	ATOMOXETINE	PDL
02445956	ATOMOXETINE	SIV
02390515	DOM-ATOMOXETINE	DPC
02378965	MYLAN-ATOMOXETINE	MYL
02381060	PMS-ATOMOXETINE	PMS
02406004	RIVA-ATOMOXETINE	RIV
02386453	SANDOZ ATOMOXETINE	SDZ
02262843	STRATTERA	LIL
02314592	TEVA-ATOMOXETINE	TEV

#### 80MG CAPSULE

02318075	APO-ATOMOXETINE	APX
02358247	ATOMOXETINE	AAP
02378973	MYLAN-ATOMOXETINE	MYL
02404664	PMS-ATOMOXETINE	PMS
02422824	RIVA-ATOMOXETINE	RIV
02386461	SANDOZ ATOMOXETINE	SDZ
02279347	STRATTERA	LIL
02362511	TEVA-ATOMOXETINE	TEV

#### 100MG CAPSULE

02318083	APO-ATOMOXETINE	APX
02358255	ATOMOXETINE	AAP
02378981	MYLAN-ATOMOXETINE	MYL
02404672	PMS-ATOMOXETINE	PMS
02422832	RIVA-ATOMOXETINE	RIV
02386488	SANDOZ ATOMOXETINE	SDZ
02279355	STRATTERA	LIL
02362538	TEVA-ATOMOXETINE	TEV

### BETAHISTINE HYDROCHLORIDE

#### 8MG TABLET

02449145	AURO-BETAHISTINE	AUR
02280183	TEVA-BETAHISTINE	TEV

**28:92.00 MISCELLANEOUS CENTRAL  
NERVOUS SYSTEM AGENTS****BETAHISTINE HYDROCHLORIDE****16MG TABLET**

02374757	ACT BETAHISTINE	ACG
02449153	AURO-BETAHISTINE	AUR
02243878	SERC	BGP
02280191	TEVA-BETAHISTINE	TEV

**24MG TABLET**

02374765	ACT BETAHISTINE	ACG
02449161	AURO-BETAHISTINE	AUR
02247998	SERC	BGP
02280205	TEVA-BETAHISTINE	TEV

**TETRABENAZINE****25MG TABLET**

02407590	APO-TETRABENAZINE	APX
02199270	NITOMAN	VAE
02402424	PMS-TETRABENAZINE	PMS
02410338	TETRABENAZINE	RAX

## 32:00 CONTRACEPTIVES (NON-ORAL)

### 32:00.00 CONTRACEPTIVES (NON-ORAL)

#### CONDOM

##### DEVICE

99400527	CONDOM, LATEX, LUBRICATED	UNK
99400485	CONDOM, LATEX, LUBRICATED, NONOXYNOL	UNK
99400486	CONDOM, LATEX, NON-LUBRICATED	UNK
99400786	CONDOM, NON-LATEX, LUBRICATED	UNK

#### CONTRACEPTIVE DEVICE

##### DEVICE

00970905	CAYA CONTOURED DIAPHRAGM	TSN
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#### INTRAUTERINE DEVICE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 12 months.

##### DEVICE

00970328	FLEXI-T +300 IUD	TSN
00970336	FLEXI-T +380 IUD	TSN
98099999	FLEXI-TD	TSN
99401085	LIBERTE UT380 SHORT IUD	MSF
99401086	LIBERTE UT380 STANDARD IUD	MSF
00970379	MONA LISA 10	SEA
00970387	MONA LISA 5	SEA
00970395	MONA LISA N	SEA
99400482	NOVA-T	BEX

**36:00 DIAGNOSTIC AGENTS (DX)**

**36:26.00 DX - DIABETES MELLITUS**

**GLUCOSE OXIDASE, PEROXIDASE**

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:

- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

**ACCU-CHEK ADVANTAGE STRIP**

09853626	ACCU-CHEK ADVANTAGE	ROD
97799824	ACCU-CHEK ADVANTAGE	ROD

**ACCU-CHEK AVIVA STRIP**

09857178	ACCU-CHEK AVIVA	ROD
97799814	ACCU-CHEK AVIVA	ROD

**ACCU-CHEK COMPACT STRIP**

09854282	ACCU-CHEK COMPACT	ROD
97799962	ACCU-CHEK COMPACT	ROD

**ACCU-CHEK MOBILE STRIP**

09857452	ACCU-CHEK MOBILE BG	ROD
97799497	ACCU-CHEK MOBILE CASSETT	ROD

**ACCUTREND STRIP**

09853162	ACCUTREND	ROD
97799959	ACCUTREND	ROD

**ASCENSIA BREEZE 2 STRIP**

09857293	ASCENSIA BREEZE 2	BAY
97799748	ASCENSIA BREEZE 2	BAY

**ASCENSIA CONTOUR STRIP**

09857127	ASCENSIA CONTOUR	BAY
97799702	ASCENSIA CONTOUR	BAY

**BG STAR STRIP**

97799465	BG STAR	SAC
09857422	BG STAR (ON)	SAC

**CONTOUR NEXT STRIP**

97799459	CONTOUR NEXT	BAY
09857453	CONTOUR NEXT (ON)	BAY

**EZ HEALTH STRIP**

09857357	EZ HEALTH ORACLE	TRE
97799564	EZ HEALTH ORACLE	TRE

**FREESTYLE STRIP**

97799829	FREESTYLE	ABB
09857141	FREESTYLE (ON)	ABB

**FREESTYLE LITE STRIP**

97799597	FREESTYLE LITE	ABB
09857297	FREESTYLE LITE (ON)	ABB

**FREESTYLE PRECISION STRIP**

97799346	FREESTYLE PRECISION	ABB
09857502	FREESTYLE PRECISION (ON)	ABB

**36:26.00 DX - DIABETES MELLITUS**

**GLUCOSE OXIDASE, PEROXIDASE**

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:

- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

**GE200 STRIP**

97799373	GE200	AUC
09857525	GE200 (ON)	AUC

**ITEST STRIP**

09857348	ITEST	AUC
97799692	ITEST	AUC

**MEDI+SURE STRIP**

97799403	MEDI+SURE	MEC
09857432	MEDI+SURE (ON)	MEC

**NOVA MAX STRIP**

09857313	NOVA MAX	NCA
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**ONE TOUCH ULTRA STRIP**

09854290	ONE TOUCH ULTRA	JAJ
97799985	ONE TOUCH ULTRA	JAJ

**ONE TOUCH VERIO STRIP**

97799475	ONETOUCH VERIO	JAJ
09857392	ONETOUCH VERIO (ON)	JAJ

**PRECISION XTRA STRIP**

09854070	PRECISION XTRA	ABB
97799840	PRECISION XTRA	AUC

**SIDEKICK STRIP**

97799601	SIDEKICK	HOD
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**SPIRIT STRIP**

97799291	FIRST CANHEALTH SPIRIT	ARA
09857547	SPIRIT TEST STRIP (ON)	ARA

**SURE STEP STRIP**

97799355	SURE STEP	SKY
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**SURETEST STRIP**

09857522	SURETEST (ON)	SKY
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**TRUETEST STRIP**

97799532	TRUETEST	HOD
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**TRUETRACK STRIP**

09857283	TRUE TRACK	AUC
97799602	TRUE TRACK	HOD

**36:60.00 DX - THYROID FUNCTION**

**THYROTROPIN ALFA**

**0.9MG/ML POWDER FOR SOLUTION**

02246016	THYROGEN	GEE
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**36:88.00 DX - URINE AND FECES  
CONTENTS**

**URINE TEST STRIP**

**STRIP**

97799914 DIASTIX  
97799913 KETOSTIX

BAY  
BAY

**40:00 ELECTROLYTIC, CALORIC,  
AND WATER BALANCE****40:08.00 ALKALINIZING AGENTS****CITRIC ACID, SODIUM CITRATE**

66.8MG &amp; 100MG/ML SOLUTION

00721344 DICITRATE PMS

**SODIUM BICARBONATE**

325MG TABLET

00481912 XENEX SODIUM BICARBONATE XEN

**40:10.00 AMMONIA DETOXICANTS****LACTULOSE**<sup>ST</sup> 667MG/ML SYRUP

02242814 APO-LACTULOSE APX

02295881 JAMP-LACTULOSE JMP

02412268 LACTULOSE SAN

02247383 PHARMA-LACTULOSE PMS

00703486 PMS-LACTULOSE PMS

00854409 RATIO-LACTULOSE TEV

02331551 TEVA-LACTULOSE TEV

**40:12.00 REPLACEMENT PREPARATIONS****CALCIUM**<sup>ST</sup> 500MG CAPLET

80001408 OYSTER SHELL CALCIUM NUR

<sup>ST</sup> 5ML LIQUID

80004123 CARBOCAL EUR

<sup>ST</sup> 20MG/ML LIQUID

80054754 M-CAL MAN

80006877 WAMPOLE MINERAL CALCIUM WAM

<sup>ST</sup> 100MG LIQUID

80025527 SOLUCAL GREEN APPLE JMP

80025523 SOLUCAL RASPBERRY JMP

<sup>ST</sup> 1005MG/ML LIQUID

80043628 NU-CAL ODN

<sup>ST</sup> 20MG/ML ORAL LIQUID

80002626 SOLUCAL JMP

<sup>ST</sup> 500MG TABLET

00682039 APOCAL APX

80017732 CAL-500 PDL

02240240 CALCIUM PMT

02246040 CALCIUM JMP

80003658 CALCIUM WNP

80003773 CALCIUM TRI

80062015 CALCIUM CARBONATE SAN

02237352 EUROCAL EUR

80055526 M-CAL MAN

00618098 NU-CAL ODN

00622443 O-CALCIUM VTH

80001122 PHARMA-CAL PED

00705373 WAMPOLE CALCIUM WAM

02239356 WAMPOLE CALCIUM WAM

<sup>ST</sup> 500MG TABLET (CHEWABLE)

80027026 JAMP-CALCIUM CARBONATE JMP

**500MG TABLET (FILM COATED)**

80066648 BIOCALCIUM BMI

**40:12.00 REPLACEMENT PREPARATIONS****CALCIUM GLUCONATE, VIT D**<sup>ST</sup> 25MCG LIQUID

80068920 SOLUCAL D FORT CITRUS JMP

80069353 SOLUCAL D FORT GREEN APPLE JMP

**CALCIUM, VITAMIN D**<sup>ST</sup> 500MG LIQUID

80025543 SOLUCAL D CITRUS JMP

80025541 SOLUCAL D RASPBERRY JMP

<sup>ST</sup> 500MG & 1,000IU LIQUID

80025038 SOLUCAL D FORT JMP

<sup>ST</sup> 500MG & 400IU LIQUID

80061575 CALCITE LIQUIDE D 400 RIV

80054755 M-CAL D MAN

80008126 SOLUCAL D JMP

<sup>ST</sup> 500MG & 800IU LIQUID

80025722 JAMP CALCIUM JMP

LACTOGLUCONATE VITAMIN D

<sup>ST</sup> 500MG & 1,000IU TABLET80018540 JAMP CALCIUM CARBONATE  
VITAMIN D JMP

80019536 M CALCIUM VITAMINE D MAN

80050701 M-CAL D MAN

<sup>ST</sup> 500MG & 400IU TABLET

80012594 BIOCAL-D FORTE BMI

80004963 CALCITE 500 D 400 RIV

80004969 CALCIUM 500 + VIT D 400 TRI

80002623 CALCIUM VITAMIN D LEMON  
FLAVOUR JMP

80017190 CALD 400 PDL

80009628 CALODAN D 400 ODN

02245511 CARBOCAL D EUR

80002901 CARBOCAL D EUR

99100832 JAMP-CALCIUM + VITAMIN D JMP

80002122 J-CAL+D JMP

80025360 J-CAL+D JMP

80009412 M-CAL MAN

80013329 M-CAL D MAN

80002703 NU-CAL D ODN

80020974 OPUS CAL D OPU

80065914 RIVA-CAL D RIV

80006794 WAMPOLE CALCIUM VITAMIN D WAM

<sup>ST</sup> 500MG & 800IU TABLET

80019533 M CALCIUM VITAMINE D MAN

<sup>ST</sup> 600MG & 400IU TABLET

80021716 CALCIUM +VIT D WAM

<sup>ST</sup> 500MG & 1,000IU TABLET (CHEWABLE)80029083 JAMP CALCIUM CITRATE VITAMIN  
D JMP

80027787 JAMP-CALCIUM VITAMIN D JMP

**500MG & 400IU TABLET (FILM COATED)**

80066647 BIOCALCIUMD BMI

**ELECTROLYTES**<sup>ST</sup> MISCELLANEOUS

80023410 HYDRALYTE ELECTROLYTE HYD

<sup>ST</sup> 3.56G & 300MG & 470MG & 530MG POWDER

01931563 GASTROLYTE REGULAR SAC

**40:12.00 REPLACEMENT PREPARATIONS****ELECTROLYTES****<sup>ST</sup> POWDER FOR SOLUTION**

80027403 JAMP REHYDRALYTE JMP

**<sup>ST</sup> 2910MG POWDER FOR SOLUTION**

80026860 HYDRALYTE ELECTROLYTE HYD

**<sup>ST</sup> 0.856MG/ML SOLUTION**

80026861 HYDRALYTE ELECTROLYTE HYD

**<sup>ST</sup> 25MG & 2.2MG & 2.2MG & 0.9MG/ML SOLUTION**

00630365 PEDIALYTE ABB

02219883 PEDIATRIC ELECTROLYTE PMS

**MAGNESIUM****100MG TABLET**

80041590 JAMP-MAGNESIUM JMP

02068400 MAGNESIUM JAM

**MAGNESIUM GLUCOHEPTONATE****<sup>ST</sup> 25MG LIQUID**

80009357 MAGNESIUM JMP

**<sup>ST</sup> 100MG/ML ORAL LIQUID**

80004109 MAGNESIUM-ODAN ODN

00026697 ROUGIER-MAGNESIUM TEV

**MAGNESIUM GLUCONATE****<sup>ST</sup> 500MG TABLET**

80009539 JAMP-MAGNESIUM JMP

00555126 MAGLUCATE PED

**POTASSIUM CHLORIDE****<sup>ST</sup> 8MMOL CAPSULE (LONG ACTING)**

02244068 RIVA-K 8 RIV

**<sup>ST</sup> 600MG CAPSULE (LONG ACTING)**

02042304 MICRO K PAL

**<sup>ST</sup> 1,500MG LIQUID**

80024360 K-10 GSK

**<sup>ST</sup> 1.33MEQ/ML ORAL LIQUID**

02238604 PMS-POTASSIUM PMS

**<sup>ST</sup> 1,500MG ORAL LIQUID**

80024835 JAMP-POTASSIUM CHLORIDE JMP

**<sup>ST</sup> 8MMOL TABLET**

80008214 ODAN K 8 ODN

**<sup>ST</sup> 20MMOL TABLET**

80013007 JAMP K JMP

**<sup>ST</sup> 25MEQ TABLET**

80033602 JAMP-K EFFERVESCENT JMP

**<sup>ST</sup> 25MEQ TABLET (EFFERVESCENT)**

02085992 K LYTE WPC

**<sup>ST</sup> 25MMOL TABLET (EFFERVESCENT)**

80011428 EURO K EUR

**20MEQ TABLET (FILM COATED), EXTENDED RELEASE**

80071412 MK20 SOLUBLE MAN

**<sup>ST</sup> 8MMOL TABLET (LONG ACTING)**

00602884 APO-K APX

02246734 EURO K EUR

80013005 JAMP-K 8 JMP

80035346 MK 8 MAN

**<sup>ST</sup> 10MMOL TABLET (LONG ACTING)**

80026332 MK 10 MAN

**40:12.00 REPLACEMENT PREPARATIONS****POTASSIUM CHLORIDE****<sup>ST</sup> 20MMOL TABLET (LONG ACTING)**

80026265 BIO K-20 POTASSIUM BMI

02242261 EURO K EUR

80004415 ODAN K20 ODN

02243975 RIVA-K 20 RIV

**<sup>ST</sup> 600MG TABLET (LONG ACTING)**

80040226 SLOW-K NVR

**<sup>ST</sup> 780MG TABLET (LONG ACTING)**

80025624 MK 20 MAN

**<sup>ST</sup> 780MG TABLET (TIME RELEASE)**

80040412 K20 POTASSIUM UNK

**<sup>ST</sup> 1,500MG TABLET (TIME RELEASE)**

80040416 PHARMA-K20 PMS

80053887 PRO-K 20 PDL

**SODIUM CHLORIDE****0.9% INJECTION**

99002329 SODIUM CHLORIDE (SMALL VOL.) UNK

**0.9% SOLUTION**

00037818 BACTERIOSTATIC SODIUM CHLORIDE PFI

00037796 SODIUM CHLORIDE PFI

00060208 SODIUM CHLORIDE BAX

00402249 SODIUM CHLORIDE OMG

02150204 SODIUM CHLORIDE OMG

**40:18.00 ION-REMOVING AGENTS****SODIUM POLYSTYRENE SULFONATE****ORAL LIQUID**

01902776 KAYEXALATE SAC

**40:18.18 POTASSIUM - REMOVING AGENTS****CALCIUM POLYSTYRENE SULFONATE****1G POWDER FOR SOLUTION**

02017741 RESONIUM CALCIUM SAC

**SODIUM POLYSTYRENE SULFONATE****1G POWDER**

02026961 KAYEXALATE SAC

00765252 K-EXIT OMG

00755338 SOLYSTAT PED

**250MG/ML SUSPENSION**

00769533 SOLYSTAT PED

00769541 SOLYSTAT PED

**40:18.19 PHOSPHATE - REMOVING AGENTS****LANTHANUM CARBONATE HYDRATE**

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 aluminium based binders).

For patients with elevated calcium levels despite discontinuation of calcium binder, and Vitamin D analogue and/or modification of dialysate calcium.

For patients with adynamic bone disease and low PTH levels (<100 pg/ml or <0.9 pmol/L) with normal or elevated calcium levels.

**250MG TABLET (CHEWABLE)**

02287145 FOSRENOL SHI

**500MG TABLET (CHEWABLE)**

02287153 FOSRENOL SHI

**750MG TABLET (CHEWABLE)**

02287161 FOSRENOL SHI

**1000MG TABLET (CHEWABLE)**

02287188 FOSRENOL SHI

**SEVELAMER HYDROCHLORIDE**

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 aluminium based binders).

For patients with elevated calcium levels despite discontinuation of calcium binder, and Vitamin D analogue and/or modification of dialysate calcium.

For patients with adynamic bone disease and low PTH levels (<100 pg/ml or <0.9 pmol/L) with normal or elevated calcium levels.

**800MG TABLET**

02244310 RENAGEL SAC

**40:20.00 CALORIC AGENTS****LEVOCARNITINE**

Limited use benefit (prior approval required).

For treatment of carnitine deficiency.

**100MG/ML LIQUID**

02144336 CARNITOR SIG

**200MG/ML SOLUTION**

02144344 CARNITOR IV SIG

**330MG TABLET**

02144328 CARNITOR SIG

**40:28.08 LOOP DIURETICS****ETHACRYNIC ACID****<sup>ST</sup> 25MG TABLET**

02258528 EDECRIN VAE

**40:28.08 LOOP DIURETICS****FUROSEMIDE****<sup>ST</sup> 10MG/ML SOLUTION**

02224720 LASIX SAC

**<sup>ST</sup> 20MG TABLET**

00396788 APO FUROSEMIDE APX

02247371 BIO-FUROSEMIDE BMI

00496723 FUROSEMIDE PDL

02351420 FUROSEMIDE SAN

02247493 PMS-FUROSEMIDE PMS

00337730 TEVA-FUROSEMIDE TEV

**<sup>ST</sup> 40MG TABLET**

00362166 APO FUROSEMIDE APX

02247372 BIO-FUROSEMIDE BMI

00397792 FUROSEMIDE PDL

02351439 FUROSEMIDE SAN

02247494 PMS-FUROSEMIDE PMS

00337749 TEVA-FUROSEMIDE TEV

**<sup>ST</sup> 80MG TABLET**

00707570 APO FUROSEMIDE APX

00667080 FUROSEMIDE PDL

02351447 FUROSEMIDE SAN

00765953 TEVA-FUROSEMIDE TEV

**<sup>ST</sup> 500MG TABLET**

02224755 LASIX SPECIAL SAC

**40:28.16 POTASSIUM SPARING DIURETICS****AMILORIDE****<sup>ST</sup> 5MG TABLET**

02249510 MIDAMOR AAP

**AMILORIDE, HYDROCHLOROTHIAZIDE****<sup>ST</sup> 5MG & 50MG TABLET**

00870943 AMI-HYDRO PDL

00784400 APO-AMILZIDE APX

01937219 NOVAMILOR TEV

**TRIAMTERENE, HYDROCHLOROTHIAZIDE****<sup>ST</sup> 50MG & 25MG TABLET**

00441775 APO TRIAZIDE APX

00519367 PRO-TRIAZIDE PDL

00532657 TEVA-TRIAMTERENE/HCTZ TEV

**40:28.20 TIAZIDE DIURETICS****HYDROCHLOROTHIAZIDE****<sup>ST</sup> 12.5MG TABLET**

02327856 APO-HYDRO APX

02274086 PMS-HYDROCHLOROTHIAZIDE PMS

**<sup>ST</sup> 25MG TABLET**

00326844 APO HYDRO APX

02247170 BIO-HYDROCHLOROTHIAZIDE BMI

00341975 HYDROCHLOROTHIAZIDE PDL

02360594 HYDROCHLOROTHIAZIDE SAN

02247386 PMS-HYDROCHLOROTHIAZIDE PMS

00021474 TEVA-HYDROCHLOROTHIAZIDE TEV

**<sup>ST</sup> 50MG TABLET**

00312800 APO HYDRO APX

02247171 BIO-HYDROCHLOROTHIAZIDE BMI

**40:28.20 THIAZIDE DIURETICS****HYDROCHLOROTHIAZIDE**<sup>ST</sup> **50MG TABLET**

02360608	HYDROCHLOROTHIAZIDE	SAN
02247387	PMS-HYDROCHLOROTHIAZIDE	PMS
00021482	TEVA-HYDROCHLOROTHIAZIDE	TEV

<sup>ST</sup> **100MG TABLET**

00644552	APO HYDRO	APX
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<sup>ST</sup> **PDIN FOR EXTEMPORANEOUS MIXTURE**

99503000	HYDROCHLOROTHIAZIDE ORAL LIQUID	UNK
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**SPIRONOLACTONE, HYDROCHLOROTHIAZIDE**<sup>ST</sup> **25MG & 25MG TABLET**

00180408	ALDACTAZIDE	PFI
00613231	TEVA-SPIRONOLACTONE/HCTZ	TEV

<sup>ST</sup> **50MG & 50MG TABLET**

00594377	ALDACTAZIDE	PFI
00657182	TEVA-SPIRONOLACTONE/HCTZ	TEV

**40:28.24 THIAZIDE LIKE DIURETICS****CHLORTHALIDONE**<sup>ST</sup> **50MG TABLET**

00360279	CHLORTHALIDONE	AAP
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<sup>ST</sup> **100MG TABLET**

00360287	APO CHLORTHALIDONE	APX
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**INDAPAMIDE**<sup>ST</sup> **1.25MG TABLET**

02245246	APO-INDAPAMIDE	APX
02239913	DOM-INDAPAMIDE	DPC
02373904	JAMP-INDAPAMIDE	JMP
02179709	LOZIDE	SEV
02240067	MYLAN-INDAPAMIDE	MYL
02240349	PHL-INDAPAMIDE	PHH
02239619	PMS-INDAPAMIDE	PMS
02312530	PRO-INDAPAMIDE	PDL
02247245	RIVA-INDAPAMIDE	RIV

<sup>ST</sup> **2.5MG TABLET**

02223678	APO-INDAPAMIDE	APX
02239917	DOM-INDAPAMIDE	DPC
02373912	JAMP-INDAPAMIDE	JMP
00564966	LOZIDE	SEV
02153483	MYLAN-INDAPAMIDE	MYL
02239620	PMS-INDAPAMIDE	PMS
02312549	PRO-INDAPAMIDE	PDL
02242125	RIVA-INDAPAMIDE	RIV
02231184	TEVA-INDAPAMIDE	TEV

**METOLAZONE**<sup>ST</sup> **2.5MG TABLET**

00888400	ZAROXOLYN	SAC
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**40:36.00 IRRIGATING SOLUTIONS****SODIUM CHLORIDE****0.9% SOLUTION**

00801267	SODIUM CHLORIDE	UNK
02058235	SODIUM CHLORIDE	RIT

**40:40.00 URICOSURIC AGENTS****SULFINPYRAZONE****200MG TABLET**

00441767	SULFINPYRAZONE	AAP
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**40:50.00 IRRIGATING SOLUTIONS****WATER****100% SOLUTION**

00038202	BACTERIOSTATIC WATER	HOS
00402257	STERILE WATER	OMG
02142546	STERILE WATER	PFI

## 48:00 RESPIRATORY TRACT AGENTS

### 48:02.00 ANTIFIBROTIC AGENTS

#### NINTEDANIB ESILATE

Limited use benefit (prior approval required).

Initial Request - Coverage is provided for a period of 7 months (6 months plus a 4 week allowance for repeat pulmonary function tests):

For the treatment of adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF) who meet the following criteria:

- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months; AND
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded; AND
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted; AND
- Patient is under the care of a physician with experience in IPF.

Renewal at 6 months - Coverage is provided for a period of 6 months:

- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of  $\geq 10\%$  from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Subsequent Renewals at 12 months and thereafter - Coverage is provided for a period of 12 months:

- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of  $\geq 10\%$  within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Combination use of Ofev (nintedanib) and Esbriet (pirfenidone) will not be provided.

#### 100MG CAPSULE

02443066 OFEV

BOE

#### 150MG CAPSULE

02443074 OFEV

BOE

### 48:02.00 ANTIFIBROTIC AGENTS

#### PIRFENIDONE

Limited use benefit (prior approval required).

Initial Request - Coverage is provided for a period of 7 months (6 months plus a 4 weeks allowance for repeat pulmonary function tests):

For the treatment of adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF) who meet the following criteria:

- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months; AND
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded; AND
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted; AND
- Patient is under the care of a physician with experience in IPF.

Renewal at 6 months - Coverage is provided for a period of 6 months:

- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of  $\geq 10\%$  from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Subsequent Renewals at 12 months and thereafter - Coverage is provided for a period of 12 months:

- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of  $\geq 10\%$  within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Combination use of Ofev (nintedanib) and Esbriet (pirfenidone) will not be provided.

#### 267MG CAPSULE

02393751 ESBRIET

HLR

### 48:10.24 LEUKOTRIENE MODIFIERS

#### MONTELUKAST SODIUM

Limited use benefit (prior approval required).

For treatment of:

- asthma when used in patients on concurrent steroid therapy; OR
- asthma patients not well controlled with or intolerant to inhaled corticosteroids.

#### <sup>ST</sup> 4MG GRANULES

02358611 SANDOZ MONTELUKAST

SDZ

02247997 SINGULAIR

FRS

#### <sup>ST</sup> 10MG TABLET

02374609 APO-MONTELUKAST

APX

02401274 AURO-MONTELUKAST

AUR

02376695 DOM-MONTELUKAST

DPC

02391422 JAMP-MONTELUKAST

JMP

02399997 MAR-MONTELUKAST

MAR

02408643 MINT-MONTELUKAST

MIN

02379333 MONTELUKAST

SAN

02379856 MONTELUKAST

PDL

**48:10.24 LEUKOTRIENE MODIFIERS**

**MONTELUKAST SODIUM**

Limited use benefit (prior approval required).

For treatment of:

- asthma when used in patients on concurrent steroid therapy; OR
- asthma patients not well controlled with or intolerant to inhaled corticosteroids.

<sup>ST</sup> **10MG TABLET**

02382474	MONTELUKAST	SIV
02379236	MONTELUKAST SODIUM	ACC
02368226	MYLAN-MONTELUKAST	MYL
02373947	PMS-MONTELUKAST	PMS
02389517	RAN-MONTELUKAST	RBV
02398826	RIVA-MONTELUKAST	RIV
02328593	SANDOZ MONTELUKAST	SDZ
02238217	SINGULAIR	FRS
02355523	TEVA-MONTELUKAST	TEV

**4MG TABLET (CHEWABLE)**

02377608	APO-MONTELUKAST	APX
02422867	AURO-MONTELUKAST	AUR
02442353	JAMP-MONTELUKAST	JMP
02399865	MAR-MONTELUKAST	MAR
02408627	MINT-MONTELUKAST	MIN
02379317	MONTELUKAST	SAN
02379821	MONTELUKAST	PDL
02382458	MONTELUKAST	SIV
02380749	MYLAN-MONTELUKAST	MYL
02354977	PMS-MONTELUKAST	PMS
02402793	RAN-MONTELUKAST	RBV
02330385	SANDOZ MONTELUKAST	SDZ
02243602	SINGULAIR	FRS
02355507	TEVA-MONTELUKAST	TEV

<sup>ST</sup> **5MG TABLET (CHEWABLE)**

02377616	APO-MONTELUKAST	APX
02422875	AURO-MONTELUKAST	AUR
02442361	JAMP-MONTELUKAST	JMP
02399873	MAR-MONTELUKAST	MAR
02408635	MINT-MONTELUKAST	MIN
02379325	MONTELUKAST	SAN
02379848	MONTELUKAST	PDL
02382466	MONTELUKAST	SIV
02380757	MYLAN-MONTELUKAST	MYL
02354985	PMS-MONTELUKAST	PMS
02402807	RAN-MONTELUKAST	RBV
02330393	SANDOZ MONTELUKAST	SDZ
02238216	SINGULAIR	FRS
02355515	TEVA-MONTELUKAST	TEV

**ZAFIRLUKAST**

Limited use benefit (prior approval required).

For treatment of asthma when used in patients on concurrent steroid therapy.

For asthma patients not well controlled with or intolerant to inhaled corticosteroids.

<sup>ST</sup> **20MG TABLET**

02236606	ACCOLATE	AZC
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**48:10.32 MAST CELL STABILIZERS**

**CROMOLYN SODIUM**

**100MG CAPSULE**

00500895	NALCROM	SAC
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**2% NASAL SPRAY**

02231390	APO-CROMOLYN	APX
01950541	RHINARIS-CS	PED

**10MG/ML SOLUTION**

02046113	PMS-SODIUM CROMOGLYCATE	PMS
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**48:48.00 VASODILATING AGENTS**

**BOSENTAN MONOHYDRATE**

Limited use benefit (prior approval required).

Maximum dose covered is 125 mg twice 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; AND

- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

<sup>ST</sup> **125MG TABLET**

02399210	APO-BOSENTAN	APX
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**48:92.00 MISCELLANEOUS RESPIRATORY  
TRACT AGENTS****OMALIZUMAB**

Limited use benefit (prior approval required).

Coverage is provided for an initial period of 24 weeks at a maximum dose of 300 mg every 4 weeks (6 injections over a 24 week period).

For the treatment of adults and adolescents (12 years of age or older) with moderate to severe chronic idiopathic urticaria (CIU) who remain symptomatic (presence of hives and/or associated itching) despite optimum management with H1 antihistamines; AND

Prescriber is experienced in the treatment of CIU (Allergist, Dermatologist, Immunologist, OR other authorized prescriber experienced in the treatment of CIU).

Treatment cessation could be considered for patients who experience complete symptom control (UAS-7 = 0) for at least 12 consecutive weeks at the end of a 24-week treatment period.

Renewal coverage is provided for 24 weeks at a maximum dose of 300 mg every 4 weeks (6 injections/24 weeks).

For the treatment of adults and adolescents (12 years of age or older) with moderate to severe chronic idiopathic urticaria (CIU);

AND

Patient stopped omalizumab after achieving complete symptom control (UAS-7 = 0) for at least 12 weeks while on treatment, but has experienced symptom relapse; OR  
Patient achieved complete symptom control, but for a period of less than 12 consecutive weeks; OR  
Patient achieved a partial response to treatment, defined as a  $\geq 9.5$ -point reduction in baseline urticaria activity score over 7 days (UAS-7).

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation may be considered should CIU symptoms reappear.

**150MG POWDER FOR SOLUTION**

02260565 XOLAIR

NVR

**52:00 EYE, EAR, NOSE AND THROAT (EENT)****52:02.00 EENT - ANTIALLERGIC AGENTS****CROMOLYN SODIUM****2% OPHTHALMIC SOLUTION**

02009277	CROMOLYN	PED
02230621	OPTICROM	ALL

**LEVOCABASTINE HYDROCHLORIDE****0.05% NASAL SPRAY**

02020017	LIVOSTIN	JSO
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**LODOXAMIDE TROMETHAMINE****0.1% SOLUTION**

00893560	ALOMIDE	NVR
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**NEDOCROMIL SODIUM****2% LIQUID**

02241407	ALOCRIAL	ALL
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**OLOPATADINE HYDROCHLORIDE****0.1% OPHTHALMIC SOLUTION**

02403986	ACT OLOPATADINE	ACG
02305054	APO-OLOPATADINE	APX
02422727	MINT-OLOPATADINE	MIN
02233143	PATANOL	NVR
02358913	SANDOZ OLOPATADINE	SDZ

**0.2% OPHTHALMIC SOLUTION**

02404095	ACT OLOPATADINE	ACG
02402823	APO-OLOPATADINE	APX
02420171	SANDOZ OLOPATADINE	SDZ

**0.1% SOLUTION**

02458411	JAMP-OLOPATADINE	JMP
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**52:04.04 EENT - ANTIBACTERIALS****CHLORAMPHENICOL****1% OINTMENT**

02026260	CHLORAMPHENICOL	UNK
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**0.5% SOLUTION**

02023857	CHLORAMPHENICOL	UNK
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**CIPROFLOXACIN HYDROCHLORIDE****0.3% OINTMENT**

02200864	CILOXAN	NVR
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**0.3% SOLUTION**

02263130	APO-CIPROFLOX	APX
01945270	CILOXAN	NVR
02387131	SANDOZ CIPROFLOXACIN	SDZ

**CIPROFLOXACIN HYDROCHLORIDE, DEXAMETHASONE****0.3%/0.1% SUSPENSION**

02252716	CIPRODEX	NVR
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**ERYTHROMYCIN****5MG OINTMENT**

00641324	ODAN-ERYTHROMYCIN	ODN
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**5MG/G OINTMENT**

02326663	ERYTHROMYCIN	STG
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**52:04.04 EENT - ANTIBACTERIALS****ERYTHROMYCIN****5MG/G OINTMENT**

01912755	PDP-ERYTHROMYCIN	PED
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**FRAMYCETIN SULFATE****0.5% DROP**

02224887	SOFRAMYCIN EYE	ERF
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**0.5% OINTMENT**

02224895	SOFRAMYCIN STERILE EYE	ERF
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**GATIFLOXACIN****0.3% SOLUTION**

02257270	ZYMAR	ALL
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**GENTAMICIN SULFATE****0.3% LIQUID**

00776521	PMS-GENTAMICIN SULFATE	PMS
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**0.3% OINTMENT**

02023776	GENTAMICIN	UNK
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**0.3% SOLUTION**

02023822	GENTAMICIN	UNK
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**MOXIFLOXACIN HYDROCHLORIDE**

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

**0.5% SOLUTION**

02404656	ACT MOXIFLOXACIN	ACG
02406373	APO-MOXIFLOXACIN	APX
02432218	PMS-MOXIFLOXACIN	PMS
02411520	SANDOZ MOXIFLOXACIN	SDZ
02252260	VIGAMOX	NVR

**OFLOXACIN****0.3% SOLUTION**

02248398	APO-OFLOXACIN	APX
02143291	OCUFLOX	ALL
02247189	SANDOZ OFLOXACIN	SDZ

**POLYMYXIN B SULFATE, BACITRACIN ZINC****500IU & 10,000IU/G OINTMENT**

02160889	OPTIMYXIN	SDZ
02239157	POLYSPORIN	JAJ

**POLYMYXIN B SULFATE, GRAMICIDIN****0.025MG & 10,000U/ML DROP**

00701785	OPTIMYXIN	SDZ
02239156	POLYSPORIN EYE AND EAR	JAJ

**POLYMYXIN B SULFATE, TRIMETHOPRIM SULFATE****10,000U & 1MG/ML SOLUTION**

02240363	PMS-POLYTRIMETHOPRIM	PMS
02011956	POLYTRIM	ALL
02239234	SANDOZ POLYTRIMETHOPRIM	SDZ

**SULFACETAMIDE SODIUM****10% SOLUTION**

02023830	SULFACETAMIDE	UNK
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**52:04.04 EENT - ANTIBACTERIALS****TOBRAMYCIN****0.3% OINTMENT**

00614254 TOBREX NVR

**0.3% SOLUTION**

02241755 SANDOZ TOBRAMYCIN SDZ

00513962 TOBREX NVR

**52:04.20 EENT - ANTIVIRALS****TRIFLURIDINE****1% SOLUTION**

00687456 VIROPTIC VAE

**52:04.92 EENT - MISCELLANEOUS ANTI-  
INFECTIVES****CHLORHEXIDINE GLUCONATE****0.12% MOUTHWASH**

02384272 GUM PAROEX SUS

02240433 PERICHLOR PMS

02237452 PERIDEX MAK

02207796 PERIOGARD CPA

**52:08.08 EENT - CORTICOSTEROIDS****BECLOMETHASONE DIPROPIONATE****50MCG/DOSE NASAL SPRAY**

02238796 APO-BECLOMETHASONE APX

02172712 MYLAN-BECLO AQ MYL

02228300 RIVANASE AQ RIV

**BUDESONIDE****100MCG/DOSE POWDER**

02035324 RHINOCORT TURBUHALER AZC

**64MCG/DOSE SPRAY**

02241003 MYLAN-BUDESONIDE AQ MYL

02231923 RHINOCORT AQUA MCL

**100MCG/DOSE SPRAY**

02230648 MYLAN-BUDESONIDE AQ MYL

**DEXAMETHASONE****0.1% OINTMENT**

00042579 MAXIDEX NVR

**0.1% SUSPENSION**

00042560 MAXIDEX NVR

**DEXAMETHASONE PHOSPHATE****0.1% SOLUTION**

02023865 DEXAMETHASONE UNK

00785261 PMS-DEXAMETHASONE PMS

**DEXAMETHASONE, TOBRAMYCIN****0.1% & 0.3% OINTMENT**

00778915 TOBRADEX NVR

**0.1% & 0.3% SUSPENSION**

00778907 TOBRADEX NVR

**FLUMETHASONE PIVALATE, CLIOQUINOL****0.02% & 1% DROP**

00074454 LOCACORTEN VIOFORM PAL

**52:08.08 EENT - CORTICOSTEROIDS****FLUNISOLIDE****0.25MG/ML PUMP**

02239288 APO-FLUNISOLIDE APX

**FLUOROMETHOLONE****0.1% DROP**

00247855 FML ALL

**0.1% SUSPENSION**

00756784 FLAREX NVR

00432814 SANDOZ FLUOROMETHOLONE SDZ

**FLUTICASONE FUROATE****100MCG POWDER**

02446561 ARNUITY ELLIPTA GSK

**200MCG POWDER**

02446588 ARNUITY ELLIPTA GSK

**FLUTICASONE PROPIONATE****50MCG/DOSE SPRAY**

02294745 APO-FLUTICASONE APX

02296071 RATIO-FLUTICASONE TEV

**FRAMYCETIN SULFATE, GRAMICIDIN,  
DEXAMETHASONE****5MG & 0.05MG/ML & 0.5MG DROP**

02224623 SOFRACORT EAR/EYE SAC

**MOMETASONE FUROATE****50MCG SPRAY**

02403587 APO-MOMETASONE APX

02238465 NASONEX FRS

**500MCG/ML SPRAY**

02449811 SANDOZ MOMETASONE SDZ

**PREDNISOLONE ACETATE****0.12% DROP**

00299405 PRED MILD ALL

**1% SUSPENSION**

00301175 PRED FORTE ALL

00700401 RATIO-PREDNISOLONE TEV

01916203 SANDOZ PREDNISOLONE SDZ

**PREDNISOLONE ACETATE, SULFACETAMIDE  
SODIUM****0.2% & 10% DROP**

00807788 BLEPHAMIDE ALL

**0.2% & 10% OINTMENT**

00307246 BLEPHAMIDE ALL

**0.5% & 10% SUSPENSION**

02023814 PREDNISOLONE/SULFACETAMIDE UNK

**PREDNISOLONE SODIUM PHOSPHATE****0.5% DROP**

02148498 MINIMS PREDNISOLONE VAE

**TRIAMCINOLONE ACETONIDE****55MCG SPRAY**

02437635 APO-TRIAMCINOLONE AQ APX

**55MCG/DOSE SPRAY**

02213834 NASACORT AQ SAC

**52:08.20 EENT - NONSTEROIDAL ANTI-INFLAMMATORY AGENTS****DICLOFENAC SODIUM****0.1% SOLUTION**

01940414 VOLTAREN OPHTHA NVR

**DICLOFENAC SODIUM (TOPICAL)**

Limited use benefit (prior approval required).

For the treatment of osteoarthritis when:

- pain is inadequately controlled with acetaminophen AND a non-steroidal anti-inflammatory (NSAID); OR
- there is contraindication to acetaminophen and NSAID; OR
- there is intolerance to acetaminophen and NSAID.

**0.1% SOLUTION**

02441020 APO-DICLOFENAC APX

02454807 SANDOZ DICLOFENAC OPHTHA SDZ

**KETOROLAC TROMETHAMINE****0.45% SOLUTION**

02369362 ACUVAIL ALL

**0.5% SOLUTION**

01968300 ACULAR ALL

02245821 APO-KETOROLAC AAP

**NEPAFENAC****0.1% SUSPENSION**

02308983 NEVANAC NVR

**0.3% SUSPENSION**

02411393 ILEVRO NVR

**52:12.00 EENT - CONTACT LENS SOLUTION****HYDROXYPROPYLMETHYLCELLULOSE****3MG SOLUTION**

02231289 GENTEAL NVR

**52:16.00 EENT - LOCAL ANESTHETICS****LIDOCAINE HYDROCHLORIDE****2% LIQUID**

00001686 XYLOCAINE VISCOUS AZC

**52:24.00 EENT - MYDRIATICS****ATROPINE SULFATE****1% SOLUTION**

02023695 ATROPINE UNK

00035017 ISOPTO ATROPINE NVR

02148358 MINIMS ATROPINE VAE

**CYCLOPENTOLATE HYDROCHLORIDE****0.5% DROP**

02148331 MINIMS CYCLOPENTOLATE VAE

**1% DROP**

00252506 CYCLOGYL NVR

02023644 CYCLOPENTOLATE UNK

02148382 MINIMS CYCLOPENTOLATE VAE

**DIPIVEFRIN HYDROCHLORIDE****0.1% LIQUID**

02242232 APO-DIPIVEFRIN APX

**52:24.00 EENT - MYDRIATICS  
PHENYLEPHRINE HYDROCHLORIDE****2.5% DROP**

02148447 MINIMS PHENYLEPHRINE VAE

00465763 MYDFRIN NVR

02027100 PHENYLEPHRINE UNK

**10% DROP**

02148455 MINIMS PHENYLEPHRINE VAE

**TROPICAMIDE****0.5% SOLUTION**

00000981 MYDRIACYL NVR

**1% SOLUTION**

00001007 MYDRIACYL NVR

**52:28.00 EENT - MOUTHWASHES AND GARGLES****BENZYDAMINE HYDROCHLORIDE**

Limited use benefit (prior approval required).

- For the treatment of radiation mucositis and oral ulcerative complications of chemotherapy.
- For use in immunocompromised patients who are at risk of mucosal breakdown.

**0.15% MOUTHWASH**

02239044 APO-BENZYDAMINE APX

02239537 DOM-BENZYDAMINE DPC

02229777 PHARIXIA PED

**52:32.00 EENT - VASOCONSTRICTORS****EPINEPHRINE****1MG/ML SOLUTION**

00155365 ADRENALIN ERF

**NAPHAZOLINE HYDROCHLORIDE****0.1% DROP**

00001147 ALBALON ALL

00390283 NAPHCN FORTE ALC

**52:40.04 EENT - ALPHA-ADRENERGIC AGONISTS****BRIMONIDINE TARTRATE****0.15% SOLUTION**

02248151 ALPHAGAN P ALL

02301334 BRIMONIDINE P AAP

**0.2% SOLUTION**

02236876 ALPHAGAN ALL

02260077 APO-BRIMONIDINE APX

02246284 PMS-BRIMONIDINE PMS

02243026 RATIO-BRIMONIDINE TEV

02305429 SANDOZ BRIMONIDINE SDZ

**TIMOLOL MALEATE, BRIMONIDINE TARTRATE****0.2% & 0.5% SOLUTION**

02248347 COMBIGAN ALL

**52:40.08 EENT - BETA-ADRENERGIC  
BLOCKING AGENTS****BETAXOLOL HYDROCHLORIDE****0.25% OPHTHALMIC SOLUTION**

01908448 BETOPTIC S NVR

**LEVOBUNOLOL HYDROCHLORIDE****0.25% OPHTHALMIC SOLUTION**

02241575 APO-LEVOBUNOLOL APX

02031159 RATIO-LEVOBUNOLOL TEV

**0.5% OPHTHALMIC SOLUTION**

00637661 BETAGAN ALL

**TIMOLOL MALEATE****0.25% OPHTHALMIC GEL SOLUTION**

02242275 TIMOLOL MALEATE-EX SDZ

**0.5% OPHTHALMIC GEL SOLUTION**

02290812 APO-TIMOP APX

02242276 TIMOLOL MALEATE-EX SDZ

00451207 TIMOPTIC PFR

**0.25% OPHTHALMIC SOLUTION**

00755826 APO-TIMOP APX

02238770 DOM-TIMOLOL DPC

02083353 PMS-TIMOLOL PMS

**0.5% OPHTHALMIC SOLUTION**

00755834 APO-TIMOP APX

02238771 DOM-TIMOLOL DPC

02447800 JAMP-TIMOLOL JMP

02083345 PMS-TIMOLOL PMS

02166720 SANDOZ TIMOLOL SDZ

**0.25% SOLUTION (LONG ACTING)**

02171880 TIMOPTIC-XE PFR

**0.5% SOLUTION (LONG ACTING)**

02171899 TIMOPTIC-XE PFR

**52:40.12 EENT - CARBONIC ANHYDRASE  
INHIBITORS****ACETAZOLAMIDE****250MG TABLET**

00545015 ACETAZOLAMIDE AAP

**BRINZOLAMIDE****1% SUSPENSION**

02238873 AZOPT NVR

**BRINZOLAMIDE, BRIMONIDINE TARTRATE****1% & 0.2% SUSPENSION**

02435411 SIMBRINZA NVR

**BRINZOLAMIDE, TIMOLOL MALEATE****1%/0.5% SUSPENSION**

02331624 AZARGA NVR

**DORZOLAMIDE HYDROCHLORIDE****2% OPHTHALMIC SOLUTION**

02216205 TRUSOPT FRS

02269090 TRUSOPT FRS

**20MG/ML OPHTHALMIC SOLUTION**

02316307 SANDOZ DORZOLAMIDE SDZ

**52:40.12 EENT - CARBONIC ANHYDRASE  
INHIBITORS****DORZOLAMIDE HYDROCHLORIDE****2% SOLUTION**

02459345 RIVA-DORZOLAMIDE RIV

**DORZOLAMIDE HYDROCHLORIDE, TIMOLOL  
MALEATE****20MG & 5MG OPHTHALMIC SOLUTION**

02437686 MED-DORZOLAMIDE-TIMOLOL GMP

**20MG & 5MG/ML OPHTHALMIC SOLUTION**

02404389 ACT DORZOTIMOLOL ACG

02299615 APO-DORZO-TIMOP APX

02240113 COSOPT FRS

02442426 PMS-DORZOLAMIDE-TIMOLOL PMS

02441659 RIVA-DORZOLAMIDE/TIMOLOL RIV

02344351 SANDOZ DORZOLAMIDE/TIMOLOL SDZ

02320525 TEVA-DORZOTIMOL TEV

**200MG & 5MG OPHTHALMIC SOLUTION**

02443090 MINT-DORZOLAMIDE/TIMOLOL MIN

**METHAZOLAMIDE****50MG TABLET**

02245882 METHAZOLAMIDE AAP

**52:40.20 EENT - MIOTICS****CARBACHOL****0.01% OPHTHALMIC SOLUTION**

00042544 MIOSTAT ALC

**PILOCARPINE HYDROCHLORIDE****2% OPHTHALMIC SOLUTION**

00000868 ISOPTO CARPINE NVR

**4% OPHTHALMIC SOLUTION**

00000884 ISOPTO CARPINE NVR

02023733 PILOCARPINE UNK

**PILOCARPINE NITRATE****2% DROP**

02148463 MINIMS PILOCARPINE VAE

**52:40.28 EENT - PROSTAGLANDIN  
AGENTS****BIMATOPROST****0.01% OPHTHALMIC SOLUTION**

02324997 LUMIGAN RC ALL

09857368 LUMIGAN RC (ON) ALL

09857398 LUMIGAN RC (ON) ALL

**0.03% OPHTHALMIC SOLUTION**

02429063 VISTITAN SDZ

**LATANOPROST****0.005% SOLUTION**

02254786 ACT LATANOPROST ACG

02296527 APO-LATANOPROST APX

02373041 GD-LATANOPROST PFI

02426935 MED-LATANOPROST GMP

02317125 PMS-LATANOPROST PMS

02341085 RIVA-LATANOPROST RIV

**52:40.28 EENT - PROSTAGLANDIN AGENTS****LATANOPROST****0.005% SOLUTION**

02367335	SANDOZ LATANOPROST	SDZ
02231493	XALATAN	PFI

**LATANOPROST, TIMOLOL MALEATE****0.005% & 0.5% SOLUTION**

02436256	ACT LATANOPROST/TIMOLOL	ACG
02414155	APO-LATANOPROST-TIMOP	APX
02373068	GD-LATANOPROST/TIMOLOL	PFI
02404591	PMS-LATANOPROST-TIMOLOL	PMS
02394685	SANDOZ LATANOPROST/TIMOLOL	SDZ
02246619	XALACOM	PFI

**50MCG & 5MG SOLUTION**

02459205	RIVA-LATANOPROST/TIMOLOL	RIV
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**TIMOLOL MALEATE, TRAVOPROST****0.5% & 0.004% SOLUTION**

02278251	DUOTRAV PQ	NVR
02413817	SANDOZ TRAVOPROST / TIMOLOL PQ	SDZ

**TRAVOPROST****0.004% SOLUTION**

02415739	APO-TRAVOPROST Z	APX
02413167	SANDOZ TRAVOPROST	SDZ
02412063	TEVA-TRAVOPROST Z	TEV
02318008	TRAVATAN Z	NVR

**52:92.00 MISCELLANEOUS EENT DRUGS****AFLIBERCEPT**

Limited use benefit (prior approval required).

For the treatment of:  
Diabetic Macular Edema (DME)  
Wet Age-Related Macular Degeneration (w-AMD)  
Retinal Vein Occlusion (RVO)

(Please refer to Appendix A).

**40MG SOLUTION**

02415992	EYLEA	BAY
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**ANETHOLE TRITHIONE****<sup>ST</sup> 25MG TABLET**

02240344	SIALOR	PMS
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**APRACLONIDINE HYDROCHLORIDE****0.5% OPHTHALMIC SOLUTION**

02076306	IOPIDINE	ALC
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**DEXTRAN 70, HYDROXYPROPYLMETHYLCELLULOSE****0.1% & 0.3% DROP**

01943308	TEARS NATURALE FREE	NVR
00743445	TEARS NATURALE II	NVR

**HYDROXYPROPYL CELLULOSE****5MG INSERT**

02250624	LACRISERT	ATO
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**52:92.00 MISCELLANEOUS EENT DRUGS****HYDROXYPROPYLMETHYLCELLULOSE****0.5% DROP**

00000809	ISOPTO TEARS	NVR
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**1% DROP**

00000817	ISOPTO TEARS	NVR
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**MACROGOL, PROPYLENE GLYCOL****15% & 20% GEL**

02220806	LUBRICATING	PMS
02352699	RHINARIS NASAL	PED
00551805	SECARIS	PED

**15% & 20% SPRAY**

00732230	LUBRICATING NASAL MIST	PMS
02354551	RHINARIS NASAL MIST	PED

**MINERAL OIL, WHITE PETROLATUM****55.5% & 42.5% OINTMENT**

00210889	REFRESH LACRI-LUBE	ALL
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**PETROLATUM, MINERAL OIL****80% & 20% OINTMENT**

02125706	SOOTHE NIGHT TIME	BSH
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**POLYVINYL ALCOHOL****1.4% OPHTHALMIC SOLUTION**

02229570	ARTIFICIAL TEARS	PED
00579408	TEARS PLUS	ALL

**RANIBIZUMAB**

Limited use benefit (prior approval required).

For the treatment of:  
Diabetic Macular Edema (DME)  
Wet Age-Related Macular Degeneration (w-AMD)  
Retinal Vein Occlusion (RVO)  
Choroidal Neovascularization secondary to pathologic myopia (mCNV)

(Please refer to Appendix A).

**10MG/ML SOLUTION**

02296810	LUCENTIS	NVR
02425629	LUCENTIS PFS	NVR

**SODIUM CARBOXYMETHYL CELLULOSE****0.5% DROP**

02049260	REFRESH PLUS	ALL
02231008	REFRESH TEARS	ALL

**1% DROP**

00870153	REFRESH CELLUVISC	ALL
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**10MG/ML SOLUTION**

02244650	REFRESH LIQUIGEL	ALL
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**SODIUM CHLORIDE****9MG/ML NASAL DROPS**

80024901	SALINEX	SDZ
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**0.7% NASAL SPRAY**

00810436	SALINE FROM OTRIVIN	NVC
00857777	SALINE FROM OTRIVIN	NVC

**5% OINTMENT**

00750816	MURO 128	BSH
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**52:92.00 MISCELLANEOUS EENT DRUGS****SODIUM CHLORIDE****5% OPHTHALMIC OINTMENT**

80046696 ODAN SODIUM CHLORIDE ODN

**5% OPHTHALMIC SOLUTION**

80046737 ODAN-SODIUM CHLORIDE ODN

**5% SOLUTION**

00750824 MURO 128 BSH

**9MG/ML SPRAY**

80024381 SALINEX SDZ

**VERTEPORFIN**

Limited use benefit (prior approval required).

For treatment of age related macular degeneration for patients with this diagnosis who are being treated by a certified ophthalmologist.

**15MG/VIAL POWDER FOR SOLUTION**

02242367 VISUDYNE VAE

**WHITE PETROLATUM, LANOLIN, MINERAL OIL****94% & 3% & 3% OINTMENT**

02444062 SYSTANE NVR

**56:00 GASTROINTESTINAL DRUGS****56:04.00 ANTACIDS AND ADSORBENTS****BISMUTH SUBSALICYLATE**

Limited use benefit (prior approval not required).

Coverage will be limited to 8 tablets a day every 14 days, followed by a 28 day lockout;  
OR

Coverage will be limited to 120mL a day every 14 days, followed by a 28 day lockout.

**262MG CAPLET**

00245730 BISMUTH JMP

**17.6MG/ML LIQUID**

02097079 PEPTO BISMOL PGI

**262MG TABLET**

02326582 BISMUTH SUBSALICYLATE UNK

02177994 PEPTO BISMOL PGI

**MAGNESIUM OXIDE****420MG TABLET**

00299448 MAGNESIUM OXIDE VAE

**56:08.00 ANTIDIARRHEA AGENTS****LOPERAMIDE HYDROCHLORIDE****<sup>ST</sup> 0.2MG/ML SOLUTION**

02192667 DIARR-EZE PMS

02016095 PMS-LOPERAMIDE PMS

**<sup>ST</sup> 2MG/15ML SOLUTION**

02291800 IMODIUM CALMING MCL

**<sup>ST</sup> 2MG TABLET**

02212005 APO-LOPERAMIDE APX

02229552 DIARR-EZE PMS

02248994 DIARRHEA RELIEF PMS

02256452 DIARRHEA RELIEF VTH

02239535 DOM-LOPERAMIDE DPC

02183862 IMODIUM MCL

02225182 LOPERAMIDE PDL

02228351 PMS-LOPERAMIDE PMS

02238211 RIVA-LOPERAMIDE RIV

02132591 TEVA-LOPERAMIDE TEV

**56:12.00 CATHARTICS AND LAXATIVES****BISACODYL****5MG SUPPOSITORY**

02410893 BISACODYL JMP

**10MG SUPPOSITORY**

02361450 BISACODYL JMP

00003875 DULCOLAX BOE

00582883 PMS-BISACODYL PMS

00404802 RATIO-BISACODYL TEV

02241091 THE MAGIC BULLET DCM

**<sup>ST</sup> 5MG TABLET**

00254142 DULCOLAX BOE

02246039 JAMP-BISACODYL JMP

00587273 PMS-BISACODYL PMS

**<sup>ST</sup> 5MG TABLET (DELAYED RELEASE)**

00545023 APO-BISACODYL APX

02273411 BISACODYL-ODAN ODN

**56:12.00 CATHARTICS AND LAXATIVES****CITRIC ACID, MAGNESIUM OXIDE, SODIUM PICOSULFATE****<sup>ST</sup> 12G & 3.5G & 10MG POWDER FOR SOLUTION**

02254794 PICO-SALAX FEI

02317966 PURG-ODAN ODN

**GLYCERINE****ADULT SUPPOSITORY**

00873462 GLYCERIN TEV

01926039 GLYCERIN WPC

02020394 GLYCERIN TEV

80029765 JAMP GLYCERIN JMP

**PEDIATRIC SUPPOSITORY**

02020815 GLYCERIN TEV

01926047 GLYCERIN FOR INFANTS WPC  
CHILDREN

**MACROGOL, POTASSIUM CHLORIDE, SODIUM BICARBONATE, SODIUM CHLORIDE, SODIUM SULFATE****<sup>ST</sup> 60G & 750MG & 1.68G & 1.46G & 5.68G/L SOLUTION**

00652512 GOLYTELY BTU

00777838 PEGLYTE PED

**MAGNESIUM CITRATE****<sup>ST</sup> 5.40% ORAL LIQUID**

00262609 CITRO MAG TEV

**<sup>ST</sup> 50MG/ML ORAL LIQUID**

80001809 CITRODAN ODN

**MAGNESIUM HYDROXIDE****<sup>ST</sup> 80MG/ML LIQUID**

02245289 MILK OF MAGNESIA PMS

**<sup>ST</sup> 80MG/ML ORAL LIQUID**

02150646 PHILLIPS MILK OF MAGNESIA BAY

**<sup>ST</sup> 311MG TABLET**

02150638 PHILIPS MAGNESIA BAY

**MINERAL OIL****<sup>ST</sup> 78% GEL**

00608734 LANSOYL AUP

02186926 LANSOYL SUGAR FREE AUP

**<sup>ST</sup> 100% LIQUID**

01935348 MINERAL OIL (HEAVY) RBW

**POLYETHYLENE GLYCOL 3350****POWDER**

09991007 POLYETHYLENE GLYCOL MDS

09991054 POLYETHYLENE GLYCOL 3350 MDS

**100% POWDER FOR SOLUTION**

02374137 EMOLAX JMP

02450070 M-PEG 3350 MAN

**<sup>ST</sup> 1G POWDER FOR SOLUTION**

02317680 LAX-A-DAY PED

02453193 LAX-A-DAY PHARMA PMS

02358034 PEG 3350 MDS

02346672 RELAXA RLI

02318164 RESTORALAX BAY

**56:12.00 CATHARTICS AND LAXATIVES****POLYETHYLENE GLYCOL 3350, SODIUM SULFATE, SODIUM BICARBONATE, SODIUM CHLORIDE, POTASSIUM CHLORIDE**

<sup>ST</sup> 60G & 750MG & 1.68G & 1.46G & 5.68G/L POWDER  
00677442 COLYTE PED

**POLYETHYLENE GLYCOL 3350, SODIUM SULFATE, SODIUM BICARBONATE, SODIUM CHLORIDE, POTASSIUM CHLORIDE, BISACODYL**

<sup>ST</sup> 59.55G & 5.74G & 1.69G & 1.46G & 0.76G & 5MG LIQUID  
02326302 BI-PEGLYTE PED

**PSYLLIUM MUCILLOID**

<sup>ST</sup> 50% POWDER  
00599875 MUCILLIUM PMS

<sup>ST</sup> 680MG/G POWDER

02174812 METAMUCIL FIBRE THERAPY ORIGINAL TEXTURE UNFLAVOURED PGI

02174790 METAMUCIL FIBRE THERAPY SMOOTH TEXTURE ORANGE FLAVOUR PGI

02174782 METAMUCIL FIBRE THERAPY SMOOTH TEXTURE ORANGE FLAVOUR (SUGAR-FREE) PGI

02174804 METAMUCIL FIBRE THERAPY SMOOTH TEXTURE UNFLAVOURED PGI

**SENNOSIDES**

<sup>ST</sup> 1.7MG/ML LIQUID  
80024394 JAMP SENNAQUIL JMP  
00367729 SENOKOT PFR

<sup>ST</sup> 1.7MG/ML ORAL LIQUID  
02144379 SENNALAX PMS  
02084651 SENNAPREP PMS

<sup>ST</sup> 8.6MG TABLET  
02247389 EURO-SENNA EUR  
80043280 M SENNOSIDES MAN  
80047592 OPUS SENNOSIDES OPU  
01949292 RIVA SENNA RIV  
02237105 SENNA LAXATIVE VTH  
02068109 SENNA SENNOSIDES PMS  
00026158 SENOKOT PFR

<sup>ST</sup> 9MG TABLET  
80019511 BIOSENNOSIDES BMI  
80054498 M SENNOSIDES MAN  
00896411 PMS-SENNOSIDES PMS  
80009595 SENNA JMP  
80009182 SENNOSIDES JMP

<sup>ST</sup> 12MG TABLET  
80055641 M-SENNOSIDES MAN  
00896403 PMS-SENNOSIDES PMS  
80009183 SENNOSIDES JMP

**SODIUM PHOSPHATE**

<sup>ST</sup> 180MG & 480MG/ML ORAL LIQUID  
02230399 PMS-PHOSPHATES PMS

**56:12.00 CATHARTICS AND LAXATIVES****SODIUM PHOSPHATE**

<sup>ST</sup> 0.9G ORAL SOLUTION  
80000689 PHOSLAX ODN

<sup>ST</sup> 60MG & 160MG/ML RECTAL LIQUID  
02096900 ENEMOL SODIUM PHOSPHATE DPC  
00009911 FLEET ENEMA KIM  
00108065 FLEET ENEMA PEDIATRIC KIM

<sup>ST</sup> 2.4G SOLUTION  
80034416 JAMP-SODIUM PHOSPHATE JMP

**SORBITOL, SODIUM CITRATE, SODIUM LAURYL SULFOACETATE**

<sup>ST</sup> 90MG & 9MG & 625MG ENEMA  
02063905 MICROLAX MCL

**56:14.00 CHOLELITHOLYTIC AGENTS****URSODIOL**

<sup>ST</sup> 250MG TABLET  
02273497 PMS-URSODIOL PMS  
02238984 URSO APC  
02426900 URSODIOL GLK

<sup>ST</sup> 500MG TABLET  
02273500 PMS-URSODIOL PMS  
02245894 URSO DS APC  
02426919 URSODIOL GLK

<sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE  
99503024 UROSODIOL ORAL LIQUID UNK

**56:16.00 DIGESTANTS****LACTASE**

<sup>ST</sup> 3,000U CAPLET  
02239139 DAIRY DIGESTIVE VTH

<sup>ST</sup> 4,500U CAPLET  
02239140 DAIRY DIGESTIVE VTH

<sup>ST</sup> ORAL LIQUID  
99100157 LACTEEZE DROPS AUP

<sup>ST</sup> 3 TABLET  
02181304 LACTEEZE GSC

<sup>ST</sup> 3,000U TABLET  
01951637 DAIRY AID TAN  
02230653 LACTAID KIM  
02017512 LACTOMAX STE

<sup>ST</sup> 4,500U TABLET  
02230654 LACTAID EXTRA STRENGTH KIM  
02224909 LACTOMAX EXTRA STE

<sup>ST</sup> 9,000U TABLET  
02231507 LACTAID ULTRA KIM

**LIPASE, AMYLASE, PROTEASE**

<sup>ST</sup> 6,000U & 30,000U & 19,000U CAPSULE  
02415194 CREON MINIMICROSPHERES 6 BGP

<sup>ST</sup> 8,000U & 30,000U & 30,000U CAPSULE  
00263818 COTAZYM FRS  
00502790 COTAZYM ECS 8 FRS

<sup>ST</sup> 20,000U & 55,000U & 55,000U CAPSULE  
00821373 COTAZYM ECS 20 FRS

**56:16.00 DIGESTANTS****LIPASE, AMYLASE, PROTEASE**

<sup>ST</sup> 4200U & 17500U & 10000U CAPSULE (ENTERIC COATED)		
00789445	PANCREASE MT 4	JSO
<sup>ST</sup> 10500U & 43750U & 25000U CAPSULE (ENTERIC COATED)		
00789437	PANCREASE MT 10	JSO
<sup>ST</sup> 16800U & 70000U & 40000U CAPSULE (ENTERIC COATED)		
00789429	PANCREASE MT 16	JSO
<sup>ST</sup> 5000U & 5100U & 320U GRANULES		
02445158	CREON MINIMICROSPHERES MICRO	BGP
<sup>ST</sup> 10440U & 56400U & 57100U TABLET		
02230019	VIKACE	APC
<sup>ST</sup> 20880U & 113400U & 112500U TABLET		
02241933	VIKACE	APC

**56:20.00 EMETICS****IPECAC****14MG/ML ORAL LIQUID**

00378801	IPECAC	XEN
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**56:22.08 ANTIHISTAMINES****DIMENHYDRINATE**

Limited use benefit (prior approval not required).

The NIHB Program implemented a dose coverage limit for DIMENHYDRINATE in June 2017 as part of a strategy to address safety concerns and potential misuse.

The dimenhydrinate dose limit is currently 400 mg per day for a total of 12,000 mg of dimenhydrinate in a 30-day period.

This limit applies only to the 15 mg and 50 mg tablets. Dimenhydrinate in liquid, suppository and injectable forms are not included in this limit.

**50MG/ML SOLUTION**

00392537	DIMENHYDRINATE	SDZ
00013579	GRAVOL	CHU

**25MG SUPPOSITORY**

00783595	GRAVOL	CHU
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**50MG SUPPOSITORY**

00392553	SANDOZ DIMENHYDRINATE	SDZ
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**100MG SUPPOSITORY**

00013609	GRAVOL	CHU
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<sup>ST</sup> **3MG/ML SYRUP**

00230197	GRAVOL	CHU
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<sup>ST</sup> **50MG TABLET**

00363766	APO DIMENHYDRINATE	APX
00013803	GRAVOL	CHU
02245416	JAMP-DIMENHYDRINATE	JMP
02377179	MOTION SICKNESS	APX
00399779	NAUSEATOL	SDZ
00586331	PMS-DIMENHYDRINATE	PMS
00021423	TEVA-DIMENATE	TEV
00605786	TRAVEL	VTH

**56:22.08 ANTIHISTAMINES****DOXYLAMINE SUCCINATE, PYRIDOXINE HYDROCHLORIDE**

<sup>ST</sup> 10MG & 10MG TABLET (DELAYED RELEASE)		
00609129	DICLECTIN	DUI

**56:22.20 5-HT3 RECEPTOR ANTAGONISTS****GRANISETRON HYDROCHLORIDE**

<sup>ST</sup> 1MG TABLET		
02308894	APO-GRANISETRON	APX
02452359	NAT-GRANISETRON	NPH

**ONDANSETRON HYDROCHLORIDE**

<sup>ST</sup> 4MG FILM		
02389983	ONDISSOLVE ODF	TAK

<sup>ST</sup> 8MG FILM		
02389991	ONDISSOLVE ODF	TAK

<sup>ST</sup> 0.8MG/ML SOLUTION		
02291967	ONDANSETRON	AAP
02229639	ZOFRAN	NVR

<sup>ST</sup> 4MG TABLET		
02296349	ACT ONDANSETRON	ACG
02288184	APO-ONDANSETRON	APX
02313685	JAMP-ONDANSETRON	JMP
02371731	MAR-ONDANSETRON	MAR
02305259	MINT-ONDANSETRON	MIN
02297868	MYLAN-ONDANSETRON	MYL
02417839	NAT-ONDANSETRON	NPH
02421402	ONDANSETRON	SAN
02278618	PHL-ONDANSETRON	PHH
02258188	PMS-ONDANSETRON	PMS
02312247	RAN-ONDANSETRON	RBY
02274310	SANDOZ ONDANSETRON	SDZ
02376091	SEPTA-ONDANSETRON	SPT
02264056	TEVA-ONDANSETRON	TEV
02213567	ZOFRAN	NVR

<sup>ST</sup> 8MG TABLET		
02296357	ACT ONDANSETRON	ACG
02288192	APO-ONDANSETRON	APX
02313693	JAMP-ONDANSETRON	JMP
02371758	MAR-ONDANSETRON	MAR
02305267	MINT-ONDANSETRON	MIN
02297876	MYLAN-ONDANSETRON	MYL
02417847	NAT-ONDANSETRON	NPH
02325160	ONDANSETRON	PDL
02421410	ONDANSETRON	SAN
02278626	PHL-ONDANSETRON	PHH
02258196	PMS-ONDANSETRON	PMS
02312255	RAN-ONDANSETRON	RBY
02274329	SANDOZ ONDANSETRON	SDZ
02376105	SEPTA-ONDANSETRON	SPT
02264064	TEVA-ONDANSETRON	TEV
02213575	ZOFRAN	NVR

<sup>ST</sup> 4MG TABLET (ORALLY DISINTEGRATING)		
02444674	SANDOZ ONDANSETRON ODT	SDZ
02239372	ZOFRAN ODT	NVR

<sup>ST</sup> 8MG TABLET (ORALLY DISINTEGRATING)		
02444682	SANDOZ ONDANSETRON ODT	SDZ

**56:22.20 5-HT3 RECEPTOR ANTAGONISTS****ONDANSETRON HYDROCHLORIDE**<sup>ST</sup> 8MG TABLET (ORALLY DISINTEGRATING)

02239373 ZOFTRAN ODT NVR

**56:22.32 MISCELLANEOUS ANTIEMETICS****APREPITANT**

Limited use benefit (prior approval required).

When used in combination with a 5-HT3 antagonist and dexamethasone for the prevention of acute and delayed nausea and vomiting due to highly emetogenic cancer chemotherapy (e.g. Cisplatin > 70mg/m2).

<sup>ST</sup> 80MG CAPSULE

02298791 EMEND FRS

<sup>ST</sup> 125MG CAPSULE

02298805 EMEND FRS

<sup>ST</sup> 125MG & 80MG CAPSULE

02298813 EMEND TRI-PACK FRS

**56:22.92 MISCELLANEOUS ANTIEMETICS****NABILONE**

Limited use benefit (prior approval required).

For patients who are experiencing nausea and vomiting due to cancer chemotherapy or radiation;

OR

Patient is palliative (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less).

**0.25MG CAPSULE**

02312263 CESAMET VAE

02358077 RAN-NABILONE RBY

02392925 TEVA-NABILONE TEV

**0.5MG CAPSULE**

02393581 ACT NABILONE ACG

02256193 CESAMET VAE

02380900 PMS-NABILONE PMS

02358085 RAN-NABILONE RBY

02384884 TEVA-NABILONE TEV

**1MG CAPSULE**

02393603 ACT NABILONE ACG

00548375 CESAMET VAE

02380919 PMS-NABILONE PMS

02358093 RAN-NABILONE RBY

02384892 TEVA-NABILONE TEV

**56:28.12 HISTAMINE H2-ANTAGONISTS****CIMETIDINE**<sup>ST</sup> 200MG TABLET

00584215 APO CIMETIDINE APX

00582409 NOVO-CIMETINE TEV

02229717 PMS-CIMETIDINE PMS

<sup>ST</sup> 300MG TABLET

00487872 APO CIMETIDINE APX

02231287 DOM-CIMETIDINE DPC

02227444 MYLAN-CIMETIDINE MYL

00582417 NOVO-CIMETINE TEV

02229718 PMS-CIMETIDINE PMS

**56:28.12 HISTAMINE H2-ANTAGONISTS****CIMETIDINE**<sup>ST</sup> 400MG TABLET

00600059 APO CIMETIDINE APX

02231288 DOM-CIMETIDINE DPC

02227452 MYLAN-CIMETIDINE MYL

00603678 NOVO-CIMETINE TEV

02229719 PMS-CIMETIDINE PMS

<sup>ST</sup> 600MG TABLET

00600067 APO CIMETIDINE APX

02231290 DOM-CIMETIDINE DPC

02227460 MYLAN-CIMETIDINE MYL

00603686 NOVO-CIMETINE TEV

02229720 PMS-CIMETIDINE PMS

<sup>ST</sup> 800MG TABLET

00749494 APO-CIMETIDINE APX

02227479 MYLAN-CIMETIDINE MYL

00663727 NOVO-CIMETINE TEV

02229721 PMS-CIMETIDINE PMS

**FAMOTIDINE**<sup>ST</sup> 20MG TABLET

01953842 APO-FAMOTIDINE APX

02351102 FAMOTIDINE SAN

02196018 MYLAN-FAMOTIDINE MYL

02022133 TEVA-FAMOTIDINE TEV

<sup>ST</sup> 40MG TABLET

01953834 APO-FAMOTIDINE APX

02351110 FAMOTIDINE SAN

02196026 MYLAN-FAMOTIDINE MYL

02022141 TEVA-FAMOTIDINE TEV

**NIZATIDINE**<sup>ST</sup> 150MG CAPSULE

00778338 AXID PED

02177714 PMS-NIZATIDINE PMS

<sup>ST</sup> 300MG CAPSULE

00778346 AXID PED

02177722 PMS-NIZATIDINE PMS

**RANITIDINE HYDROCHLORIDE**<sup>ST</sup> 15MG/ML SOLUTION

02280833 APO-RANITIDINE APX

02242940 TEVA-RANITIDINE TEV

<sup>ST</sup> 150MG TABLET

02248570 ACT RANITIDINE ACG

00733059 APO-RANITIDINE APX

02293471 MAXIMUM STRENGTH ACID REDUCER PMS

02245782 PHL-RANITIDINE PHH

02242453 PMS-RANITIDINE PMS

00740748 RANITIDINE PDL

02353016 RANITIDINE SAN

02385953 RANITIDINE SIV

02336480 RAN-RANITIDINE RBY

02247814 RIVA-RANITIDINE RIV

02243229 SANDOZ RANITIDINE SDZ

00828564 TEVA-RANITIDINE TEV

02212331 ZANTAC GSK

**56:28.12 HISTAMINE H2-ANTAGONISTS****RANITIDINE HYDROCHLORIDE****<sup>ST</sup> 300MG TABLET**

02248571	ACT RANITIDINE	ACG
00733067	APO-RANITIDINE	APX
02245783	PHL-RANITIDINE	PHH
02242454	PMS-RANITIDINE	PMS
00740756	RANITIDINE	PDL
02353024	RANITIDINE	SAN
02385961	RANITIDINE	SIV
02336502	RAN-RANITIDINE	RBY
02247815	RIVA-RANITIDINE	RIV
02243230	SANDOZ RANITIDINE	SDZ
02212358	ZANTAC	GSK

**56:28.28 PROSTAGLANDINS****MISOPROSTOL****<sup>ST</sup> 100MCG TABLET**

02244022	MISOPROSTOL	AAP
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**<sup>ST</sup> 200MCG TABLET**

02244023	MISOPROSTOL	AAP
02244125	PMS-MISOPROSTOL	PMS

**56:28.32 PROTECTANTS****SUCRALFATE****<sup>ST</sup> 200MG/ML SUSPENSION**

02103567	SULCRATE PLUS	APC
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**<sup>ST</sup> 1G TABLET**

02125250	APO-SUCRALFATE	APX
02100622	SULCRATE	APC
02045702	TEVA-SUCRALFATE	TEV

**56:28.36 PROTON-PUMP INHIBITORS****AMOXICILLIN, CLARITHROMYCIN,  
LANSOPRAZOLE****<sup>ST</sup> 500MG & 500MG & 30MG KIT**

02238525	HP-PAC	TAK
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**LANSOPRAZOLE**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

**<sup>ST</sup> 15MG CAPSULE (DELAYED RELEASE)**

02293811	APO-LANSOPRAZOLE	APX
02357682	LANSOPRAZOLE	SAN
02385767	LANSOPRAZOLE	SIV
02433001	LANSOPRAZOLE	PMS
02353830	MYLAN-LANSOPRAZOLE	MYL
02395258	PMS-LANSOPRAZOLE	PMS
02165503	PREVACID	TAK
02402610	RAN-LANSOPRAZOLE	RBY
02422808	RIVA-LANSOPRAZOLE	RIV
02385643	SANDOZ LANSOPRAZOLE	SDZ
02280515	TEVA-LANSOPRAZOLE	TEV

**<sup>ST</sup> 30MG CAPSULE (DELAYED RELEASE)**

02293838	APO-LANSOPRAZOLE	APX
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**56:28.36 PROTON-PUMP INHIBITORS****LANSOPRAZOLE**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

**<sup>ST</sup> 30MG CAPSULE (DELAYED RELEASE)**

02414775	DOM-LANSOPRAZOLE	DPC
02357690	LANSOPRAZOLE	SAN
02366282	LANSOPRAZOLE	PDL
02410389	LANSOPRAZOLE	SIV
02433028	LANSOPRAZOLE	PMS
02353849	MYLAN-LANSOPRAZOLE	MYL
02395266	PMS-LANSOPRAZOLE	PMS
02165511	PREVACID	TAK
02402629	RAN-LANSOPRAZOLE	RBY
02422816	RIVA-LANSOPRAZOLE	RIV
02280523	TEVA-LANSOPRAZOLE	TEV

**<sup>ST</sup> 30MG TABLET (DELAYED RELEASE)**

02385651	SANDOZ LANSOPRAZOLE	SDZ
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**PDIN FOR EXTEMPORANEOUS MIXTURE**

99503010	LANSOPRAZOLE ORAL LIQUID	UNK
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**LANSOPRAZOLE ODT**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

For children 12 years of age or under who are unable to swallow the capsule formulation; OR  
For patients with dysphagia or a feeding tube when the use of the capsule formulation is not possible.

(Please refer to Appendix A).

**<sup>ST</sup> 15MG TABLET (DELAYED RELEASE)**

02249464	PREVACID FASTAB	TAK
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**<sup>ST</sup> 30MG TABLET (DELAYED RELEASE)**

02249472	PREVACID FASTAB	TAK
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**OMEPRAZOLE MAGNESIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

**<sup>ST</sup> 20MG CAPSULE (DELAYED RELEASE)**

02245058	APO-OMEPRAZOLE	APX
00846503	LOSEC	AZC
02329433	MYLAN-OMEPRAZOLE	MYL
02339927	OMEPRAZOLE	PDL
02348691	OMEPRAZOLE	SAN
02385384	OMEPRAZOLE	SIV
02411857	OMEPRAZOLE-20	SIV
02320851	PMS-OMEPRAZOLE	PMS
02403617	RAN-OMEPRAZOLE	RBY
02296446	SANDOZ OMEPRAZOLE	SDZ

**<sup>ST</sup> 20MG TABLET (DELAYED RELEASE)**

02333430	DOM-OMEPRAZOLE DR	DPC
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**56:28.36 PROTON-PUMP INHIBITORS****OMEPRAZOLE MAGNESIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

**<sup>ST</sup> 20MG TABLET (DELAYED RELEASE)**

02420198	JAMP-OMEPRAZOLE DR	JMP
02190915	LOSEC	AZC
02439549	NAT-OMEPRAZOLE DR	NPH
02416549	OMEPRAZOLE	ACC
02310260	PMS-OMEPRAZOLE	PMS
02374870	RAN-OMEPRAZOLE	RBV
02260867	RATIO-OMEPRAZOLE	TEV
02402416	RIVA-OMEPRAZOLE DR	RIV
02295415	TEVA-OMEPRAZOLE	TEV

**PDIN FOR EXTEMPOREANEOUS MIXTURE**

99503002	OMEPRAZOLE ORAL LIQUID	UNK
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**PANTOPRAZOLE MAGNESIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

**<sup>ST</sup> 40MG TABLET (ENTERIC COATED)**

02408570	MYLAN-PANTOPRAZOLE T	MYL
02441853	PANTOPRAZOLE MAGNESIUM	UNK
02267233	TECTA	TAK
02440628	TEVA-PANTOPRAZOLE MAGNESIUM	TEV

**PANTOPRAZOLE SODIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

**<sup>ST</sup> 40MG TABLET (DELAYED RELEASE)**

02300486	ACT PANTOPRAZOLE	ACG
02292920	APO-PANTOPRAZOLE	APX
02415208	AURO-PANTOPRAZOLE	AUR
02310007	DOM-PANTOPRAZOLE	DPC
02357054	JAMP-PANTOPRAZOLE	JMP
02416565	MAR-PANTOPRAZOLE	MAR
02417448	MINT-PANTOPRAZOLE	MIN
02299585	MYLAN-PANTOPRAZOLE	MYL
02229453	PANTOLOC	TAK
02318695	PANTOPRAZOLE	PDL
02370808	PANTOPRAZOLE	SAN
02431327	PANTOPRAZOLE	RIV
02437945	PANTOPRAZOLE	PMS
02428180	PANTOPRAZOLE-40	SIV
02307871	PMS-PANTOPRAZOLE	PMS
02425378	PRIVA-PANTOPRAZOLE	PHA
02305046	RAN-PANTOPRAZOLE	RBV
02316463	RIVA-PANTOPRAZOLE	RIV

**56:28.36 PROTON-PUMP INHIBITORS****PANTOPRAZOLE SODIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

**<sup>ST</sup> 40MG TABLET (DELAYED RELEASE)**

02301083	SANDOZ PANTOPRAZOLE	SDZ
02285487	TEVA-PANTOPRAZOLE	TEV

**RABEPRAZOLE SODIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

**<sup>ST</sup> 10MG TABLET (ENTERIC COATED)**

02345579	APO-RABEPRAZOLE	APX
02408392	MYLAN-RABEPRAZOLE	MYL
02243796	PARIET	JSO
02310805	PMS-RABEPRAZOLE	PMS
02315181	PRO-RABEPRAZOLE	PDL
02385449	RABEPRAZOLE	SIV
02356511	RABEPRAZOLE EC	SAN
02298074	RAN-RABEPRAZOLE	RBV
02330083	RIVA-RABEPRAZOLE EC	RIV
02314177	SANDOZ RABEPRAZOLE	SDZ
02296632	TEVA-RABEPRAZOLE	TEV

**<sup>ST</sup> 20MG TABLET (ENTERIC COATED)**

02345587	APO-RABEPRAZOLE	APX
02320460	DOM-RABEPRAZOLE EC	DPC
02243797	PARIET	JSO
02310813	PMS-RABEPRAZOLE	PMS
02315203	PRO-RABEPRAZOLE	PDL
02385457	RABEPRAZOLE	SIV
02356538	RABEPRAZOLE EC	SAN
02298082	RAN-RABEPRAZOLE	RBV
02330091	RIVA-RABEPRAZOLE	RIV
02314185	SANDOZ RABEPRAZOLE	SDZ
02296640	TEVA-RABEPRAZOLE	TEV

**56:32.00 PROKINETIC AGENTS****DOMPERIDONE MALEATE****<sup>ST</sup> 10MG TABLET**

02103613	APO-DOMPERIDONE	APX
02238315	DOM-DOMPERIDONE	DPC
02236857	DOMPERIDONE	PDL
02238341	DOMPERIDONE	SIV
02350440	DOMPERIDONE	SAN
02369206	JAMP-DOMPERIDONE	JMP
02403870	MAR-DOMPERIDONE	MAR
02236466	PMS-DOMPERIDONE	PMS
02268078	RAN-DOMPERIDONE	RBV
01912070	RATIO-DOMPERIDONE	TEV
02157195	TEVA-DOMPERIDONE	TEV

**PDIN FOR EXTEMPOREANEOUS MIXTURE**

99503005	DOMPERIDONE ORAL LIQUID	UNK
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**56:32.00 PROKINETIC AGENTS****METOCLOPRAMIDE HYDROCHLORIDE**<sup>ST</sup> **1MG/ML SOLUTION**

02230433 METONIA PED

<sup>ST</sup> **5MG TABLET**

00842826 APO-METOCLOP APX

02230431 METONIA PED

<sup>ST</sup> **10MG TABLET**

00842834 APO-METOCLOP APX

02230432 METONIA PED

**56:36.00 ANTI-INFLAMMATORY AGENTS****BETAMETHASONE SODIUM PHOSPHATE****0.05MG/ML ENEMA**

02060884 BETNESOL PAL

**HYDROCORTISONE ACETATE****10% AEROSOL**

00579335 CORTIFOAM PAL

**100MG/60ML ENEMA**

02112736 CORTENEMA APC

**MESALAZINE****500MG SUPPOSITORY**

02112760 SALOFALK APC

**1G SUPPOSITORY**

02153564 PENTASA FEI

02242146 SALOFALK APC

**1G/100ML SUSPENSION**

02153521 PENTASA FEI

**2G/60G SUSPENSION**

02112795 SALOFALK APC

**4G/100ML SUSPENSION**

02153556 PENTASA FEI

**4G/60G SUSPENSION**

02112809 SALOFALK APC

<sup>ST</sup> **800MG TABLET (DELAYED RELEASE)**

02267217 ASACOL WAC

<sup>ST</sup> **400MG TABLET (ENTERIC COATED)**

01997580 ASACOL WAC

02171929 TEVA-5 ASA TEV

<sup>ST</sup> **500MG TABLET (ENTERIC COATED)**

02112787 SALOFALK APC

<sup>ST</sup> **500MG TABLET (EXTENDED RELEASE)**

02099683 PENTASA FEI

<sup>ST</sup> **1G TABLET (EXTENDED RELEASE)**

02399466 PENTASA FEI

<sup>ST</sup> **1.2G TABLET (EXTENDED RELEASE)**

02297558 MEZAVANT SHI

**OLSALAZINE SODIUM**<sup>ST</sup> **250MG CAPSULE**

02063808 DIPENTUM APU

**56:92.00 MISCELLANEOUS GI DRUGS****PINAVERIUM BROMIDE**

Limited use benefit (prior approval required).

For the treatment and relief of symptoms associated with functional bowel disorders including Irritable Bowel Syndrome (IBS), spastic colon, spastic colitis and mucous colitis; OR In postoperative paralytic ileus in order to accelerate the resumption of the intestinal transit following abdominal surgery.

**50MG CAPSULE**

00465240 DICETEL SPH

**50MG TABLET**

01950592 DICETEL BGP

**100MG TABLET**

02230684 DICETEL BGP

**60:00 GOLD COMPOUNDS****60:00.00 GOLD COMPOUNDS****AURANOFIN****3MG CAPSULE**

01916823 RIDAURA XED

**SODIUM AUROTHIOMALATE****10MG/ML SOLUTION**

01927620 MYOCHRYSSINE SAC

02245456 SODIUM AUROTHIOMALATE SDZ

**25MG/ML SOLUTION**

01927612 MYOCHRYSSINE SAC

**50MG/ML SOLUTION**

01927604 MYOCHRYSSINE SAC

02245458 SODIUM AUROTHIOMALATE SDZ

**64:00 HEAVY METAL ANTAGONISTS**

**64:00.00 HEAVY METAL ANTAGONISTS**

**PENICILLAMINE**

**250MG CAPSULE**

00016055 CUPRIMINE

VAE

**68:00 HORMONES AND SYNTHETIC  
SUBSTITUTES****68:04.00 ADRENALS****BECLOMETHASONE DIPROPIONATE****50MCG AEROSOL**

02242029 QVAR VAE

**100MCG AEROSOL**

02242030 QVAR VAE

**BUDESONIDE****100MCG INHALER**

00852074 PULMICORT TURBUHALER AZC

**200MCG INHALER**

00851752 PULMICORT TURBUHALER AZC

**400MCG INHALER**

00851760 PULMICORT TURBUHALER AZC

**0.125MG/ML SUSPENSION**

02229099 PULMICORT NEBUAMP AZC

**0.25MG/ML SUSPENSION**

01978918 PULMICORT NEBUAMP AZC

**0.5MG/ML SUSPENSION**

01978926 PULMICORT NEBUAMP AZC

**CICLESONIDE****100MG/INHALATION AEROSOL**

02285606 ALVESCO AZC

**200MG/INHALATION AEROSOL**

02285614 ALVESCO AZC

**CORTISONE ACETATE****25MG TABLET**

00280437 CORTISONE VAE

**DEXAMETHASONE****0.1MG/ML LIQUID**

01946897 PMS DEXAMETHASONE PMS

**0.5MG TABLET**

02261081 APO-DEXAMETHASONE APX

02237044 PHL-DEXAMETHASONE PHH

01964976 PMS DEXAMETHASONE PMS

02240684 RATIO-DEXAMETHASONE TEV

**0.75MG TABLET**

01964968 PMS DEXAMETHASONE PMS

**2MG TABLET**

02279363 PMS-DEXAMETHASONE PMS

**4MG TABLET**

02250055 APO-DEXAMETHASONE APX

02237046 PHL-DEXAMETHASONE PHH

01964070 PMS DEXAMETHASONE PMS

02311267 PRO-DEXAMETHASONE PDL

02240687 RATIO-DEXAMETHASONE TEV

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99503007 DEXAMETHASONE ORAL LIQUID UNK

**DEXAMETHASONE PHOSPHATE****4MG/ML LIQUID**

00664227 DEXAMETHASONE SDZ

01977547 DEXAMETHASONE RAX

**68:04.00 ADRENALS****DEXAMETHASONE PHOSPHATE****4MG/ML LIQUID**

02204266 DEXAMETHASONE-OMEGA OMG

**10MG/ML LIQUID**

00874582 DEXAMETHASONE SDZ

02204274 DEXAMETHASONE-OMEGA OMG

00783900 PMS-DEXAMETHASONE PMS

**FLUDROCORTISONE ACETATE****0.1MG TABLET**

02086026 FLORINEF PAL

**FLUTICASONE PROPIONATE****50MCG/INHALATION AEROSOL**

02244291 FLOVENT HFA GSK

**125MCG/INHALATION AEROSOL**

02244292 FLOVENT HFA GSK

**250MCG/INHALATION AEROSOL**

02244293 FLOVENT HFA GSK

**100MCG/DOSE POWDER**

02237245 FLOVENT DISKUS GSK

**250MCG/DOSE POWDER**

02237246 FLOVENT DISKUS GSK

**500MCG/DOSE POWDER**

02237247 FLOVENT DISKUS GSK

**HYDROCORTISONE ACETATE****10MG TABLET**

00030910 CORTEF PFI

**20MG TABLET**

00030929 CORTEF PFI

**METHYLPREDNISOLONE****4MG TABLET**

00030988 MEDROL PFI

**16MG TABLET**

00036129 MEDROL PFI

**METHYLPREDNISOLONE ACETATE****20MG/ML SUSPENSION**

01934325 DEPO-MEDROL PFI

**40MG/ML SUSPENSION**

00030759 DEPO-MEDROL PFI

01934333 DEPO-MEDROL PFI

02245400 METHYLPREDNISOLONE SDZ

02245407 METHYLPREDNISOLONE SDZ

**80MG/ML SUSPENSION**

00030767 DEPO-MEDROL PFI

01934341 DEPO-MEDROL PFI

02245406 METHYLPREDNISOLONE SDZ

02245408 METHYLPREDNISOLONE SDZ

**MOMETASONE FUROATE****200MCG POWDER**

02243595 ASMANEX TWISTHALER FRS

**400MCG POWDER**

02243596 ASMANEX TWISTHALER FRS

**68:04.00 ADRENALS****PREDNISOLONE SODIUM PHOSPHATE****1MG/ML SOLUTION**

02230619	PEDIAPRED	SAC
02245532	PMS-PREDNISOLONE	PMS

**PREDNISONONE****1MG TABLET**

00598194	APO PREDNISONONE	APX
00271373	WINPRED	AAP

**5MG TABLET**

00312770	APO PREDNISONONE	APX
00156876	PREDNISONONE	PDL
00021695	TEVA-PREDNISONONE	TEV

**50MG TABLET**

00550957	APO PREDNISONONE	APX
00232378	TEVA-PREDNISONONE	TEV

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99503008	PREDNISONONE ORAL LIQUID	UNK
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**TRIAMCINOLONE ACETONIDE****10MG/ML SUSPENSION**

01999761	KENALOG-10	BMS
02229540	TRIAMCINOLONE	SDZ

**40MG/ML SUSPENSION**

01999869	KENALOG-40	BMS
01977563	TRIAMCINOLONE	RAX
02229550	TRIAMCINOLONE	SDZ
09857128	TRIAMCINOLONE	UNK

**TRIAMCINOLONE DIACETATE****40MG/ML SUSPENSION**

01977555	TRIAMCINOLONE	RAX
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**68:08.00 ANDROGENS****DANAZOL****50MG CAPSULE**

02018144	CYCLOMEN	SAC
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**100MG CAPSULE**

02018152	CYCLOMEN	SAC
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**200MG CAPSULE**

02018160	CYCLOMEN	SAC
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**TESTOSTERONE CYPIONATE****100MG/ML SOLUTION**

00030783	DEPO-TESTOSTERONE	PFI
02246063	TESTOSTERONE CYPIONATE	SDZ

**TESTOSTERONE ENANTHATE****200MG/ML SOLUTION**

00029246	DELATESTRYL	VAE
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**TESTOSTERONE UNDECANOATE****40MG CAPSULE**

00782327	ANDRIOL	FRS
02322498	PMS-TESTOSTERONE	PMS
02421186	TARO-TESTOSTERONE	TAR

**68:12.00 CONTRACEPTIVES****DESOGESTREL, ETHINYL ESTRADIOL****<sup>ST</sup> 25MCG & 150MCG, 125MCG, 100MCG TABLET**

02272903	LINESSA 21	ASP
02257238	LINESSA 28	ASP

**ETHINYL ESTRADIOL, DESOGESTREL****<sup>ST</sup> 30MCG & 150MCG TABLET**

02317192	APRI 21	TEV
02317206	APRI 28	TEV
02396491	FREYA 21	MYL
02396610	FREYA 28	MYL
02042487	MARVELON 21	FRS
02042479	MARVELON 28	FRS
02410249	MIRVALA 21	APX
02410257	MIRVALA 28	APX
02420813	RECLIPSEN 21	ACG
02417464	RECLIPSEN 28	ACG

**ETHINYL ESTRADIOL, DROSPIRENONE****<sup>ST</sup> 0.02MG & 3MG TABLET**

02415380	MYA	APX
02321157	YAZ	BAY

**<sup>ST</sup> 0.03MG & 3MG TABLET**

02261723	YASMIN 21	BAY
02261731	YASMIN 28	BAY
02410788	ZAMINE 21	APX
02410796	ZAMINE 28	APX
02385058	ZARAH 21	OBT
02385066	ZARAH 28	OBT

**ETHINYL ESTRADIOL, ETHYNODIOL DIACETATE****<sup>ST</sup> 30MCG & 2MG TABLET**

00469327	DEMULEN 30 (21 DAY PACK)	PFI
00471526	DEMULEN 30 (28 DAY PACK)	PFI

**ETHINYL ESTRADIOL, ETONOGESTREL****<sup>ST</sup> 2.6MG & 11.4MG RING (SLOW-RELEASE)**

02253186	NUVARING	FRS
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**ETHINYL ESTRADIOL, LEVONORGESTREL****0.03MG & 0.15MG TABLET**

02398869	INDAYO	MYL
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**<sup>ST</sup> 0.15MG & 0.03MG TABLET**

02296659	SEASONALE	TEV
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**<sup>ST</sup> 20MCG & 100MCG TABLET**

02236974	ALESSE 21	PFI
02236975	ALESSE 28	PFI
02387875	ALYSENA 21	APX
02387883	ALYSENA 28	APX
02298538	AVIANE 21	TEV
02298546	AVIANE 28	TEV
02388138	ESME 21	MYL
02388146	ESME 28	MYL
02401185	LUTERA 21	OBT
02401207	LUTERA 28	OBT

**<sup>ST</sup> 30MCG & 0.05MG, 40MCG & 0.075MG, 30MCG & 0.125MG TABLET**

00707600	TRIQUILAR 21	BAY
00707503	TRIQUILAR 28	BAY

**68:12.00 CONTRACEPTIVES****ETHINYL ESTRADIOL, LEVONORGESTREL**<sup>ST</sup> **30MCG & 150MCG TABLET**

02042320	MIN-OVRAL 21	PFI
02042339	MIN-OVRAL 28	PFI
02387085	OVIMA 21	APX
02387093	OVIMA 28	APX
02295946	PORTIA 21	TEV
02295954	PORTIA 28	TEV

**ETHINYL ESTRADIOL, NORELGESTROMIN**<sup>ST</sup> **6MG & 0.6MG PATCH (EXTENDED RELEASE)**

02248297	EVRA	JSO
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**ETHINYL ESTRADIOL, NORETHINDRONE****35MCG & 0.5MG TABLET**

02187086	BREVICON 0.5/35 (21-DAY PACK)	PFI
02187094	BREVICON 0.5/35 (28-DAY PACK)	PFI
00317047	ORTHO 0.5/35 (21 DAY)	JSO
00340731	ORTHO 0.5/35 (28 DAY)	JSO

<sup>ST</sup> **35MCG & 1MG TABLET**

02189054	BREVICON 1/35 (21-DAY PACK)	PFI
02189062	BREVICON 1/35 (28-DAY PACK)	PFI
00372846	ORTHO 1/35 (21 DAY)	JSO
00372838	ORTHO 1/35 (28 DAY)	JSO
02197502	SELECT 1/35 (21-DAY)	PFI
02199297	SELECT 1/35 (28-DAY)	PFI

**ETHINYL ESTRADIOL, NORETHINDRONE ACETATE**<sup>ST</sup> **10MCG & 1MG TABLET**

02417456	LOLO	ALL
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<sup>ST</sup> **20MCG & 1MG TABLET**

00315966	MINESTRIN 1/20 (21-DAY)	WAC
00343838	MINESTRIN 1/20 (28-DAY)	WAC

<sup>ST</sup> **30MCG & 1.5MG TABLET**

00297143	LOESTRIN	WAC
00353027	LOESTRIN	WAC

**ETHINYL ESTRADIOL, NORGESTIMATE**<sup>ST</sup> **35MCG & 0.25MG TABLET**

01968440	CYCLON (21 DAY)	JSO
01992872	CYCLON (28 DAY)	JSO

**LEVONORGESTREL****0.75MG TABLET**

02364905	NEXT CHOICE	ACG
02371189	OPTION 2	PER
02241674	PLAN B	TEV

**1.5MG TABLET**

02433532	BACKUP PLAN ONESTEP	APX
02425009	CONTINGENCY ONE	MYL
02293854	PLAN B	TEV

**68:12.00 CONTRACEPTIVES****LEVONORGESTREL INTRAUTERINE INSERT**

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 2 years.

**13.5MG INSERT (EXTENDED-RELEASE)**

02408295	JAYDESS	BAY
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**52MG INSERT (EXTENDED-RELEASE)**

02243005	MIRENA	BAY
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**LEVONORGESTREL, ETHINYL ESTRADIOL**<sup>ST</sup> **0.15MG & 0.03MG & 0.01MG TABLET**

02346176	SEASONIQUE	TEV
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**NORETHINDRONE**<sup>ST</sup> **0.35MG TABLET**

02441306	JENCYCLA	SDZ
00037605	MICRONOR 28-DAY	JSO
02410303	MOVISSE	MYL

**NORETHINDRONE, ETHINYL ESTRADIOL****35MCG & 0.5MG, 35MCG & 1MG TABLET**

02187108	SYNPHASIC 21	PFI
02187116	SYNPHASIC 28	PFI

<sup>ST</sup> **35MCG & 500MCG, 35MCG & 750MCG, 35MCG & 1MG TABLET**

00602957	ORTHO 7/7/7 (21 DAY)	JSO
00602965	ORTHO 7/7/7 (28 DAY)	JSO

**NORGESTIMATE, ETHINYL ESTRADIOL**<sup>ST</sup> **25MCG & 0.180MG, 25MCG & 0.215MG, 25MCG & 0.25MG TABLET**

02401967	TRICIRA LO 21	APX
02401975	TRICIRA LO 28	APX
02258560	TRI-CYCLEN LO (21 DAY)	JSO
02258587	TRI-CYCLEN LO (28 DAY)	JSO

<sup>ST</sup> **35MCG & 0.180MG, 35MCG & 0.215MG, 35MCG & 0.25MG TABLET**

02028700	TRI-CYCLEN 21-DAY	JSO
02029421	TRI-CYCLEN 28-DAY	JSO

**ULIPRISTAL ACETATE**

Limited use benefit (prior approval not required).

Coverage will be limited to 90 tablets, benefits only for women age 18 to 60 years.

<sup>ST</sup> **5MG TABLET**

02408163	FIBRISTAL	ALL
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**68:16.04 ESTROGENS****CONJUGATED ESTROGENS**<sup>ST</sup> **0.625MG/G CREAM**

02043440	PREMARIN	PFI
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<sup>ST</sup> **0.3MG TABLET (EXTENDED RELEASE)**

02414678	PREMARIN	PFI
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<sup>ST</sup> **0.625MG TABLET (EXTENDED RELEASE)**

02414686	PREMARIN	PFI
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<sup>ST</sup> **1.25MG TABLET (EXTENDED RELEASE)**

02414694	PREMARIN	PFI
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**68:16.04 ESTROGENS****CONJUGATED ESTROGENS,  
MEDROXYPROGESTERONE ACETATE**

<sup>ST</sup> 0.625MG & 2.5MG TABLET		
02242878 PREMLUS	PFI	
<sup>ST</sup> 0.625MG & 5MG TABLET		
02242879 PREMLUS	PFI	

**ESTRADIOL**

<sup>ST</sup> 0.25MG GEL		
02424924 DIVIGEL	TEV	
<sup>ST</sup> 0.5MG GEL		
02424835 DIVIGEL	TEV	
<sup>ST</sup> 1MG GEL		
02424843 DIVIGEL	TEV	
<sup>ST</sup> 0.39MG PATCH		
02245676 ESTRADOT 25	NVR	
<sup>ST</sup> 0.585MG PATCH		
02243999 ESTRADOT 37.5	NVR	
<sup>ST</sup> 0.78MG PATCH		
02244000 ESTRADOT 50	NVR	
<sup>ST</sup> 1.17MG PATCH		
02244001 ESTRADOT 75	NVR	
<sup>ST</sup> 1.56MG PATCH		
02244002 ESTRADOT 100	NVR	
<sup>ST</sup> 5MG PATCH		
02243722 OESCLIM	SEA	
<sup>ST</sup> 10MG PATCH		
02243724 OESCLIM	SEA	
<sup>ST</sup> 2MG RING (SLOW-RELEASE)		
02168898 ESTRING	PFI	
<sup>ST</sup> 0.5MG TABLET		
02225190 ESTRACE	TRM	
<sup>ST</sup> 1MG TABLET		
02148587 ESTRACE	TRM	
<sup>ST</sup> 2MG TABLET		
02148595 ESTRACE	TRM	

**ESTRADIOL HEMIHYDRATE**

<sup>ST</sup> 0.06% GEL		
02238704 ESTROGEL	FRS	
<sup>ST</sup> 2MG PATCH		
02247499 CLIMARA 25	BAY	
<sup>ST</sup> 3.8MG PATCH		
02231509 CLIMARA 50	BAY	
<sup>ST</sup> 4MG PATCH		
02246967 SANDOZ ESTRADIOL DERM	SDZ	
<sup>ST</sup> 5.7MG PATCH		
02247500 CLIMARA 75	BAY	
<sup>ST</sup> 6MG PATCH		
02246968 SANDOZ ESTRADIOL DERM	SDZ	
<sup>ST</sup> 7.6MG PATCH		
02231510 CLIMARA 100	BAY	
<sup>ST</sup> 8MG PATCH		
02246969 SANDOZ ESTRADIOL DERM	SDZ	
<sup>ST</sup> 0.5MG TABLET		
02449048 LUPIN-ESTRADIOL	LUP	

**68:16.04 ESTROGENS****ESTRADIOL HEMIHYDRATE**

<sup>ST</sup> 1MG TABLET		
02449056 LUPIN-ESTRADIOL	LUP	
<sup>ST</sup> 2MG TABLET		
02449064 LUPIN-ESTRADIOL	LUP	
<sup>ST</sup> 10MCG VAGINAL TABLET		
02325462 VAGIFEM 10	NOO	

**ESTRADIOL, LEVONORGESTREL**

<b>4.4MG &amp; 1.39MG PATCH</b>		
02250616 CLIMARA PRO	BAY	

**ESTRADIOL, NORETHINDRONE ACETATE**

<sup>ST</sup> 0.51MG & 4.8MG PATCH		
02241837 ESTALIS	NVR	
<sup>ST</sup> 0.62MG & 2.7MG PATCH		
02241835 ESTALIS	NVR	

**ESTRONE**

<sup>ST</sup> 1MG/G CREAM		
00727369 ESTRAGYN	SEA	

**68:16.12 ESTROGEN AGONISTS-  
ANTAGONISTS****RALOXIFENE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For secondary prevention of osteoporosis in women who experience failure on bisphosphonates.  
For secondary prevention of osteoporosis in women who have a personal history or a first degree relative with a history of breast cancer.

<b>60MG TABLET</b>		
02358840 ACT RALOXIFENE	ACG	
02279215 APO-RALOXIFENE	APX	
02239028 EVISTA	LIL	
02358921 PMS-RALOXIFENE	PMS	
02415852 RALOXIFENE	PDL	
02312298 TEVA-RALOXIFENE	TEV	

**68:18.00 GONADOTROPINS****GOSERELIN ACETATE**

<b>3.6MG/DEPOT IMPLANT</b>		
02049325 ZOLADEX	AZC	

**NAFARELIN ACETATE**

<b>2MG/ML AEROSOL</b>		
02188783 SYNAREL	PFI	

**68:20.02 ALPHA-GLUCOSIDASE  
INHIBITORS****ACARBOSE**

<sup>ST</sup> 50MG TABLET		
02190885 GLUCOBAY	BAY	
<sup>ST</sup> 100MG TABLET		
02190893 GLUCOBAY	BAY	

**68:20.04 BIGUANIDES  
METFORMIN HYDROCHLORIDE**

<sup>ST</sup> **500MG TABLET**

02257726	ACT METFORMIN	ACG
02167786	APO-METFORMIN	APX
02438275	AURO-METFORMIN	AUR
02229994	DOM-METFORMIN	DPC
02421828	ECL-METFORMIN	ECL
02099233	GLUCOPHAGE	SAC
02229516	GLYCON	VAE
02380196	JAMP-METFORMIN	JMP
02380722	JAMP-METFORMIN BLACKBERRY	JMP
02378620	MAR-METFORMIN	MAR
02353377	METFORMIN	SAN
02378841	METFORMIN	MAR
02385341	METFORMIN FC	SIV
02388766	MINT-METFORMIN	MIN
02148765	MYLAN-METFORMIN	MYL
02223562	PMS-METFORMIN	PMS
02314908	PRO-METFORMIN	PDL
02269031	RAN-METFORMIN	RBY
02242974	RATIO-METFORMIN	TEV
02239081	RIVA-METFORMIN	RIV
02246820	SANDOZ METFORMIN FC	SDZ
02379767	SEPTA-METFORMIN	SPT
02045710	TEVA-METFORMIN	TEV

<sup>ST</sup> **850MG TABLET**

02257734	ACT METFORMIN	ACG
02229785	APO-METFORMIN	APX
02438283	AURO-METFORMIN	AUR
02242726	DOM-METFORMIN	DPC
02421836	ECL-METFORMIN	ECL
02162849	GLUCOPHAGE	SAC
02239214	GLYCON	VAE
02380218	JAMP-METFORMIN	JMP
02380730	JAMP-METFORMIN BLACKBERRY	JMP
02378639	MAR-METFORMIN	MAR
02353385	METFORMIN	SAN
02378868	METFORMIN	MAR
02385368	METFORMIN FC	SIV
02388774	MINT-METFORMIN	MIN
02229656	MYLAN-METFORMIN	MYL
02242589	PMS-METFORMIN	PMS
02314894	PRO-METFORMIN	PDL
02269058	RAN-METFORMIN	RBY
02242931	RATIO-METFORMIN	TEV
02242783	RIVA-METFORMIN	RIV
02246821	SANDOZ METFORMIN	SDZ
02379775	SEPTA-METFORMIN	SPT
02230475	TEVA-METFORMIN	TEV

**68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS**

**LINAGLIPTIN**

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.

<sup>ST</sup> **5MG TABLET**

02370921	TRAJENTA	BOE
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**LINAGLIPTIN, METFORMIN HYDROCHLORIDE**

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.

<sup>ST</sup> **2.5MG & 1000MG TABLET**

02403277	JENTADUETO	BOE
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<sup>ST</sup> **2.5MG & 500MG TABLET**

02403250	JENTADUETO	BOE
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<sup>ST</sup> **2.5MG & 850MG TABLET**

02403269	JENTADUETO	BOE
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**SAXAGLIPTIN HYDROCHLORIDE**

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.

<sup>ST</sup> **2.5MG TABLET**

02375842	ONGLYZA	AZC
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<sup>ST</sup> **5MG TABLET**

02333554	ONGLYZA	AZC
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**SAXAGLIPTIN HYDROCHLORIDE, METFORMIN HYDROCHLORIDE**

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.

<sup>ST</sup> **2.5MG & 1000MG TABLET**

02389185	KOMBOGLYZE	AZC
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<sup>ST</sup> **2.5MG & 500MG TABLET**

02389169	KOMBOGLYZE	AZC
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<sup>ST</sup> **2.5MG & 850MG TABLET**

02389177	KOMBOGLYZE	AZC
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**SITAGLIPTIN PHOSPHATE MONOHYDRATE**

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.

<sup>ST</sup> **25MG TABLET**

02388839	JANUVIA	FRS
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### 68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

#### SITAGLIPTIN PHOSPHATE MONOHYDRATE

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.

##### <sup>ST</sup> 50MG TABLET

0238847 JANUVIA FRS

##### <sup>ST</sup> 100MG TABLET

02303922 JANUVIA FRS

#### SITAGLIPTIN PHOSPHATE MONOHYDRATE, METFORMIN HYDROCHLORIDE

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.

##### <sup>ST</sup> 50MG & 1000MG TABLET

02333872 JANUMET FRS

##### <sup>ST</sup> 50MG & 500MG TABLET

02333856 JANUMET FRS

##### <sup>ST</sup> 50MG & 850MG TABLET

02333864 JANUMET FRS

##### <sup>ST</sup> 50MG & 1000MG TABLET (EXTENDED RELEASE)

02416794 JANUMET XR FRS

##### <sup>ST</sup> 50MG & 500MG TABLET (EXTENDED RELEASE)

02416786 JANUMET XR FRS

##### <sup>ST</sup> 100MG & 1000MG TABLET (EXTENDED RELEASE)

02416808 JANUMET XR FRS

### 68:20.08 INSULINS

#### INSULIN (30% NEUTRAL & 70% ISOPHANE) HUMAN BIOSYNTHETIC

##### 100U/ML INJECTION

00795879 HUMULIN 30/70 LIL

01959212 HUMULIN 30/70 CARTRIDGE LIL

09853855 HUMULIN 30/70 CARTRIDGE LIL

02024217 NOVOLIN GE 30/70 NOO

02025248 NOVOLIN GE 30/70 PENFILL NOO

09853812 NOVOLIN GE 30/70 PENFILL NOO

#### INSULIN (40% NEUTRAL & 60% ISOPHANE) HUMAN BIOSYNTHETIC

##### 100U/ML INJECTION

02024314 NOVOLIN GE 40/60 PENFILL NOO

#### INSULIN (50% NEUTRAL & 50% ISOPHANE) HUMAN BIOSYNTHETIC

##### 100U/ML INJECTION

02024322 NOVOLIN GE 50/50 PENFILL NOO

#### INSULIN (ISOPHANE) HUMAN BIOSYNTHETIC

##### 100U/ML INJECTION

00587737 HUMULIN N LIL

01959239 HUMULIN N (CARTRIDGE) LIL

02403447 HUMULIN N (KWIKPEN) LIL

### 68:20.08 INSULINS

#### INSULIN (ISOPHANE) HUMAN BIOSYNTHETIC

##### 100U/ML INJECTION

09853804 HUMULIN N 100U/ML (CARTRIDGE) LIL

02024225 NOVOLIN GE NPH NOO

09853782 NOVOLIN GE NPH 100U/ML PENFILL NOO

02024268 NOVOLIN GE NPH PENFILL NOO

#### INSULIN (ZINC CRYSTALLINE) HUMAN BIOSYNTHETIC (RDNA ORIGIN)

##### 100U/ML INJECTION

00586714 HUMULIN R LIL

09853766 HUMULIN R 100U/ML (CARTRIDGE) LIL

01959220 HUMULIN R CARTRIDGE LIL

#### INSULIN ASPART

##### 100U/ML INJECTION

02244353 NOVORAPID NOO

02245397 NOVORAPID NOO

02377209 NOVORAPID NOO

#### INSULIN BIOSYNTHETIC HUMAN BR

##### 100U SOLUTION

02415089 HUMULIN R (KWIKPEN) LIL

#### INSULIN DETEMIR

##### 100U/ML INJECTION

02412829 LEVEMIR FLEXTOUCH NOO

02271842 LEVEMIR PENFILL NOO

#### INSULIN GLARGINE

##### 100U/ML INJECTION

02245689 LANTUS SAC

02251930 LANTUS SAC

02294338 LANTUS SOLOSTAR SAC

#### INSULIN GLULISINE

##### 100U/ML INJECTION

02279479 APIDRA CARTRIDGE SAC

02294346 APIDRA SOLOSTAR SAC

02279460 APIDRA VIAL SAC

#### INSULIN HUMAN BIOSYNTHETIC

##### 100U/ML INJECTION

02024233 NOVOLIN GE TORONTO NOO

02024284 NOVOLIN GE TORONTO PENFILL NOO

09853774 NOVOLIN GE TORONTO PENFILL NOO

#### INSULIN LISPRO

##### 100U/ML INJECTION

02229704 HUMALOG LIL

02229705 HUMALOG (CARTRIDGE) LIL

02403412 HUMALOG (KWIKPEN) LIL

09853715 HUMALOG 100U/ML CARTRIDGE LIL

##### 200U/ML INJECTION

02439611 HUMALOG 200U/ML KWIKPEN LIL

#### INSULIN LISPRO, INSULIN LISPRO PROTAMINE

##### 100U/ML INJECTION

02240294 HUMALOG MIX 25 (CARTRIDGE) LIL

**68:20.08 INSULINS****INSULIN LISPRO, INSULIN LISPRO PROTAMINE****100U/ML INJECTION**

02403420	HUMALOG MIX 25 (KWIKPEN)	LIL
02240297	HUMALOG MIX 50 (CARTRIDGE)	LIL
02403439	HUMALOG MIX 50 (KWIKPEN)	LIL

**68:20.16 MEGLITINIDES****REPAGLINIDE****<sup>ST</sup> 0.5MG TABLET**

02321475	ACT REPAGLINIDE	ACG
02355663	APO-REPAGLINIDE	APX
02424258	AURO-REPAGLINIDE	AUR
02239924	GLUCONORM	NOO
02354926	PMS-REPAGLINIDE	PMS
02415968	REPAGLINIDE	PDL
02357453	SANDOZ REPAGLINIDE	SDZ

**<sup>ST</sup> 1MG TABLET**

02321483	ACT REPAGLINIDE	ACG
02355671	APO-REPAGLINIDE	APX
02424266	AURO-REPAGLINIDE	AUR
02239925	GLUCONORM	NOO
02354934	PMS-REPAGLINIDE	PMS
02415976	REPAGLINIDE	PDL
02357461	SANDOZ REPAGLINIDE	SDZ

**<sup>ST</sup> 2MG TABLET**

02321491	ACT REPAGLINIDE	ACG
02355698	APO-REPAGLINIDE	APX
02424274	AURO-REPAGLINIDE	AUR
02239926	GLUCONORM	NOO
02354942	PMS-REPAGLINIDE	PMS
02415984	REPAGLINIDE	PDL
02357488	SANDOZ REPAGLINIDE	SDZ

**68:20.18 SODIUM-GLUCOSE  
CONTRANSPORTER 2 (SGLT2)  
INHIBITORS****CANAGLIFLOZIN**

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.

**<sup>ST</sup> 100MG TABLET**

02425483	INVOKANA	JSO
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**<sup>ST</sup> 300MG TABLET**

02425491	INVOKANA	JSO
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**DAPAGLIFLOZIN PROPANEDIOL  
MONOHYDRATE**

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.

**<sup>ST</sup> 5MG TABLET**

02435462	FORXIGA	AZC
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**68:20.18 SODIUM-GLUCOSE  
CONTRANSPORTER 2 (SGLT2)  
INHIBITORS****DAPAGLIFLOZIN PROPANEDIOL  
MONOHYDRATE**

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.

**<sup>ST</sup> 10MG TABLET**

02435470	FORXIGA	AZC
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**EMPAGLIFLOZIN**

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.

**<sup>ST</sup> 10MG TABLET**

02443937	JARDIANCE	BOE
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**<sup>ST</sup> 25MG TABLET**

02443945	JARDIANCE	BOE
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**METFORMIN HYDROCHLORIDE,  
DAPAGLIFLOZIN (DAPAGLIFLOZIN  
PROPANEDIOL MONOHYDRATE)**

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.

**<sup>ST</sup> 850MG & 5MG TABLET**

02449935	XIGDUO	AZC
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**<sup>ST</sup> 1000MG & 5MG TABLET**

02449943	XIGDUO	AZC
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**68:20.20 ANTIDIABETIC AGENTS -  
SULFONYLUREAS****GLICLAZIDE****<sup>ST</sup> 80MG TABLET**

02245247	APO-GLICLAZIDE	APX
00765996	DIAMICRON	SEV
02248453	GLICLAZIDE	PDL
02287072	GLICLAZIDE	SAN
02229519	MYLAN-GLICLAZIDE	MYL
02238103	TEVA-GLICLAZIDE	TEV

**<sup>ST</sup> 30MG TABLET (EXTENDED RELEASE)**

02297795	APO-GLICLAZIDE MR	APX
02242987	DIAMICRON MR	SEV
02429764	GPC-GLICLAZIDE MR	UNK
02423286	MINT-GLICLAZIDE MR	MIN
02438658	MYLAN-GLICLAZIDE MR	MYL
02461323	SANDOZ GLICLAZIDE MR	SDZ

**<sup>ST</sup> 60MG TABLET (EXTENDED RELEASE)**

02407124	APO-GLICLAZIDE MR	APX
02356422	DIAMICRON MR	SEV

## 68:20.20 ANTIDIABETIC AGENTS - SULFONYLUREAS

### GLICLAZIDE

#### <sup>ST</sup> 60MG TABLET (EXTENDED RELEASE)

02423294	MINT-GLICLAZIDE MR	MIN
02439328	RAN-GLICLAZIDE	RBY
02461331	SANDOZ GLICLAZIDE MR	SDZ

### GLYBURIDE

#### <sup>ST</sup> 2.5MG TABLET

01913654	APO GLYBURIDE	APX
02224550	DIABETA	SAC
01959352	GLYBURIDE	PDL
02350459	GLYBURIDE	SAN
01913670	TEVA-GLYBURIDE	TEV

#### <sup>ST</sup> 5MG TABLET

01913662	APO GLYBURIDE	APX
02224569	DIABETA	SAC
02234514	DOM-GLYBURIDE	DPC
00720941	EUGLUCON	PMS
02350467	GLYBURIDE	SAN
02236734	PMS-GLYBURIDE	PMS
02316544	PRO-GLYBURIDE	PDL
02236548	RIVA-GLYBURIDE	PHH
01913689	TEVA-GLYBURIDE	TEV

### TOLBUTAMIDE

#### <sup>ST</sup> 500MG TABLET

00312762	TOLBUTAMIDE	AAP
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## 68:20.28 THIAZOLIDINEDIONES PIOGLITAZONE HYDROCHLORIDE

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

#### <sup>ST</sup> 15MG TABLET

02303442	ACCEL PIOGLITAZONE	ACP
02391600	ACH-PIOGLITAZONE	ACC
02302861	ACT PIOGLITAZONE	ACG
02242572	ACTOS	TAK
02302942	APO-PIOGLITAZONE	APX
02307634	DOM-PIOGLITAZONE	DPC
02397307	JAMP-PIOGLITAZONE	JMP
02326477	MINT-PIOGLITAZONE	MIN
02298279	MYLAN-PIOGLITAZONE	MYL
02307669	PHL-PIOGLITAZONE	PHH
02303124	PMS-PIOGLITAZONE	PMS
02312050	PRO-PIOGLITAZONE	PDL
02375850	RAN-PIOGLITAZONE	RBY
02297906	SANDOZ PIOGLITAZONE	SDZ
02274914	TEVA-PIOGLITAZONE	TEV
02434121	VAN-PIOGLITAZONE	VAN

#### <sup>ST</sup> 30MG TABLET

02303450	ACCEL PIOGLITAZONE	ACP
02339587	ACH-PIOGLITAZONE	ACC
02302888	ACT PIOGLITAZONE	ACG
02242573	ACTOS	TAK

## 68:20.28 THIAZOLIDINEDIONES

### PIOGLITAZONE HYDROCHLORIDE

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

#### <sup>ST</sup> 30MG TABLET

02302950	APO-PIOGLITAZONE	APX
02307642	DOM-PIOGLITAZONE	DPC
02365529	JAMP-PIOGLITAZONE	JMP
02326485	MINT-PIOGLITAZONE	MIN
02298287	MYLAN-PIOGLITAZONE	MYL
02307677	PHL-PIOGLITAZONE	PHH
02303132	PMS-PIOGLITAZONE	PMS
02312069	PRO-PIOGLITAZONE	PDL
02375869	RAN-PIOGLITAZONE	RBY
02297914	SANDOZ PIOGLITAZONE	SDZ
02274922	TEVA-PIOGLITAZONE	TEV
02434148	VAN-PIOGLITAZONE	VAN

#### <sup>ST</sup> 45MG TABLET

02303469	ACCEL PIOGLITAZONE	ACP
02339595	ACH-PIOGLITAZONE	ACC
02302896	ACT PIOGLITAZONE	ACG
02242574	ACTOS	TAK
02302977	APO-PIOGLITAZONE	APX
02307650	DOM-PIOGLITAZONE	DPC
02365537	JAMP-PIOGLITAZONE	JMP
02326493	MINT-PIOGLITAZONE	MIN
02298295	MYLAN-PIOGLITAZONE	MYL
02307723	PHL-PIOGLITAZONE	PHH
02303140	PMS-PIOGLITAZONE	PMS
02312077	PRO-PIOGLITAZONE	PDL
02375877	RAN-PIOGLITAZONE	RBY
02297922	SANDOZ PIOGLITAZONE	SDZ
02274930	TEVA-PIOGLITAZONE	TEV
02434156	VAN-PIOGLITAZONE	VAN

### ROSIGLITAZONE MALEATE

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

#### <sup>ST</sup> 2MG TABLET

02403366	APO-ROSIGLITAZONE	APX
02241112	AVANDIA	GSK

#### <sup>ST</sup> 4MG TABLET

02403374	APO-ROSIGLITAZONE	APX
02241113	AVANDIA	GSK

#### <sup>ST</sup> 8MG TABLET

02403382	APO-ROSIGLITAZONE	APX
02241114	AVANDIA	GSK

## 68:22.12 GLYCOGENOLYTIC AGENTS GLUCAGON RECOMBINANT DNA ORGIN

### 1MG/ML INJECTION

02333619	GLUCAGEN	NOO
02333627	GLUCAGEN HYPOKIT	NOO

**68:22.12 GLYCOGENOLYTIC AGENTS**

**GLUCAGON RECOMBINANT DNA ORGIN**

**1MG/ML INJECTION**

02243297 GLUCAGON LIL

**68:24.00 PARATHYROID**

**CALCITONIN SALMON (SYNTHETIC)**

**200IU/ML SOLUTION**

01926691 CALCIMAR SAC

**68:28.00 PITUITARY**

**DESMOPRESSIN ACETATE**

**4MCG/ML LIQUID**

00873993 DDAVP FEI

**0.1MG/ML NASAL SPRAY**

00402516 DDAVP FEI

00836362 DDAVP FEI

02242465 DESMOPRESSIN AAP

<sup>ST</sup> **0.1MG TABLET**

02284030 APO-DESMOPRESSIN APX

00824305 DDAVP FEI

02304368 PMS-DESMOPRESSIN PMS

02287730 TEVA-DESMOPRESSIN TEV

<sup>ST</sup> **0.2MG TABLET**

02284049 APO-DESMOPRESSIN APX

00824143 DDAVP FEI

02304376 PMS-DESMOPRESSIN PMS

02287749 TEVA-DESMOPRESSIN TEV

<sup>ST</sup> **60MCG TABLET (ORALLY DISINTEGRATING)**

02284995 DDAVP MELT FEI

<sup>ST</sup> **120MCG TABLET (ORALLY DISINTEGRATING)**

02285002 DDAVP MELT FEI

<sup>ST</sup> **240MCG TABLET (ORALLY DISINTEGRATING)**

02285010 DDAVP MELT FEI

**68:32.00 PROGESTINS**

**DIENOGEST**

Limited use benefit (prior approval required).

For the management of pelvic pain associated with endometriosis.

<sup>ST</sup> **2MG TABLET**

02374900 VISANNE BAY

**MEDROXYPROGESTERONE ACETATE**

**50MG/ML SUSPENSION**

00030848 DEPO-PROVERA PFI

**150MG/ML SUSPENSION**

00585092 DEPO-PROVERA PFI

02322250 MEDROXYPROGESTERONE SDZ

<sup>ST</sup> **2.5MG TABLET**

02244726 APO-MEDROXY APX

02253550 MEDROXY PDL

00708917 PROVERA PFI

02221284 TEVA-MEDROXYPROGESTERONE TEV

<sup>ST</sup> **5MG TABLET**

02244727 APO-MEDROXY APX

02253577 MEDROXY PDL

**68:32.00 PROGESTINS**

**MEDROXYPROGESTERONE ACETATE**

<sup>ST</sup> **5MG TABLET**

00030937 PROVERA PFI

02221292 TEVA-MEDROXYPROGESTERONE TEV

<sup>ST</sup> **10MG TABLET**

02277298 APO-MEDROXY APX

00729973 PROVERA PFI

02221306 TEVA-MEDROXYPROGESTERONE TEV

<sup>ST</sup> **100MG TABLET**

02267640 APO-MEDROXY APX

**PROGESTERONE**

Limited use benefit (prior approval required).

For the treatment of women:

- With postmenopausal symptoms who are intolerant to medroxyprogesterone acetate (MPA); OR
- Who are at risk of preterm birth; OR
- Who are using the medication to prevent miscarriage.

<sup>ST</sup> **100MG CAPSULE**

02166704 PROMETRIUM FRS

02439913 TEVA-PROGESTERONE TEV

**68:36.04 THYROID AGENTS**

**LEVOTHYROXINE SODIUM**

<sup>ST</sup> **0.025MG TABLET**

02264323 EUTHYROX SRO

02172062 SYNTHROID BGP

<sup>ST</sup> **0.05MG TABLET**

02213192 ELTROXIN ASP

02264331 EUTHYROX SRO

02172070 SYNTHROID BGP

<sup>ST</sup> **0.075MG TABLET**

02264358 EUTHYROX SRO

02172089 SYNTHROID BGP

<sup>ST</sup> **0.088MG TABLET**

02172097 SYNTHROID BGP

<sup>ST</sup> **0.1MG TABLET**

02213206 ELTROXIN ASP

02264374 EUTHYROX SRO

02172100 SYNTHROID BGP

<sup>ST</sup> **0.112MG TABLET**

02264390 EUTHYROX SRO

02171228 SYNTHROID BGP

<sup>ST</sup> **0.125MG TABLET**

02264404 EUTHYROX SRO

02172119 SYNTHROID BGP

<sup>ST</sup> **0.137MG TABLET**

02264412 EUTHYROX SRO

02233852 SYNTHROID BGP

<sup>ST</sup> **0.15MG TABLET**

02213214 ELTROXIN ASP

02264420 EUTHYROX SRO

02172127 SYNTHROID BGP

<sup>ST</sup> **0.175MG TABLET**

02264439 EUTHYROX SRO

02172135 SYNTHROID BGP

**68:36.04 THYROID AGENTS****LEVOTHYROXINE SODIUM**<sup>ST</sup> **0.2MG TABLET**

02213222	ELTROXIN	ASP
02264447	EUTHYROX	SRO
02172143	SYNTHROID	BGP

<sup>ST</sup> **0.3MG TABLET**

02213230	ELTROXIN	ASP
02264455	EUTHYROX	SRO
02172151	SYNTHROID	BGP

**LIOTHYRONINE SODIUM**<sup>ST</sup> **5MCG TABLET**

01919458	CYTOMEL	PFI
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<sup>ST</sup> **25MCG TABLET**

01919466	CYTOMEL	PFI
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**THYROID**<sup>ST</sup> **30MG TABLET**

00023949	THYROID	ERF
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<sup>ST</sup> **60MG TABLET**

00023957	THYROID	ERF
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<sup>ST</sup> **125MG TABLET**

00023965	THYROID	ERF
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**68:36.08 ANTITHYROID AGENTS****PROPYLTHIOURACIL**<sup>ST</sup> **50MG TABLET**

00010200	PROPYL-THYRACIL	PAL
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<sup>ST</sup> **100MG TABLET**

00010219	PROPYL-THYRACIL	PAL
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**THIAMAZOLE**<sup>ST</sup> **5MG TABLET**

00015741	TAPAZOLE	PAL
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<sup>ST</sup> **10MG TABLET**

02296039	TAPAZOLE	PAL
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**72:00 LOCAL ANESTHETICS**

**72:00.00 LOCAL ANESTHETICS**

**LIDOCAINE HYDROCHLORIDE**

**2% LIQUID**

01968823	LIDODAN VISCOUS	ODN
00811874	PMS-LIDOCAINE VISCOUS	PMS

## 84:00 SKIN AND MUCOUS MEMBRANE AGENTS (SMMA)

### 84:04.04 SMMA - ANTIBIOTICS

#### BACITRACIN ZINC

##### 500IU OINTMENT

00584908	BACITIN	PED
02351714	JAMP-BACITRACINE	JMP

#### CLINDAMYCIN PHOSPHATE

##### 2% CREAM

02060604	DALACIN	PFI
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##### 1% SOLUTION

02243659	CLINDA-T	VAE
00582301	DALACIN T	PFI
02266938	TARO-CLINDAMYCIN	TAR

##### PDIN FOR EXTEMPORANEOUS MIXTURE

99502000	CLINDAMYCIN IN DILUSOL OR DUONALC	UNK
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#### CLINDAMYCIN PHOSPHATE, BENZOYL PEROXIDE

##### 1% & 3% GEL

02382822	CLINDOXYL ADV	GSK
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##### 1% & 5% GEL

02248472	BENZACLIN	VAE
02243158	CLINDOXYL	GSK
02440180	TARO-CLINDAMYCIN/BENZOYL PEROXIDE	TAR

#### ERYTHROMYCIN, BENZOYL PEROXIDE

##### 3% & 5% GEL

02225271	BENZAMYCIN	VAE
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#### FUSIDATE SODIUM

##### 2% OINTMENT

00586676	FUCIDIN	LEO
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#### FUSIDIC ACID

##### 2% CREAM

00586668	FUCIDIN	LEO
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#### METRONIDAZOLE

##### 0.75% CREAM

02226839	METROCREAM	GAC
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##### 1% CREAM

02156091	NORITATE	VAE
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##### 0.75% GEL

02092832	METROGEL	GAC
02125226	NIDAGEL	VAE

##### 1% GEL

02297809	METROGEL	GAC
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##### 0.75% LOTION

02248206	METROLOTION	GAC
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#### METRONIDAZOLE, NYSTATIN

##### 500MG & 100,000IU SUPPOSITORY

01926829	FLAGYSTATIN	SAC
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### 84:04.04 SMMA - ANTIBIOTICS

#### MUPIROCIN

##### 2% OINTMENT

01916947	BACTROBAN	GSK
02279983	TARO-MUPIROCIN	TAR

#### MUPIROCIN CALCIUM

##### 2% CREAM

02239757	BACTROBAN	GSK
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#### POLYMYXIN B SULFATE, BACITRACIN ZINC

##### 10,000IU & 500IU OINTMENT

02304473	ANTIBIOTIC OINT	PMS
00876488	BACIMYXIN ONGUENT	PMS
00621366	BIODERM	ODN
02357569	JAMPOLYCIN	JMP
02237227	POLYSPORIN ANTIBIOTIC	JAJ
01942921	POLYTOPIC	SDZ

#### POLYMYXIN B SULFATE, GRAMICIDIN

##### 0.25MG & 10,000IU CREAM

02230844	POLYSPORIN ANTIBIOTIC	JAJ
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### 84:04.06 SMMA - ANTIVIRALS

#### ACYCLOVIR

##### 5% CREAM

02039524	ZOVIRAX	VAE
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##### 5% OINTMENT

00569771	ZOVIRAX	VAE
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### 84:04.08 SMMA - ANTIFUNGALS

#### BETAMETHASONE DIPROPIONATE, CLOTRIMAZOLE

##### 0.05% & 1% CREAM

00611174	LOTRIDERM	FRS
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#### CICLOPIROX OLAMINE

##### 1% CREAM

02221802	LOPROX	VAE
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##### 1% LOTION

02221810	LOPROX	VAE
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#### CLOTRIMAZOLE

##### 1% CREAM

02150867	CANESTEN	BAY
02150891	CANESTEN	BAY
00812366	CLOTRIMADERM	TAR
00812382	CLOTRIMADERM	TAR
02229380	CLOTRIMAZOLE	TAR
00874043	NEO-ZOL	PPI
00874051	NEO-ZOL	PPI

##### 2% CREAM

02150905	CANESTEN	BAY
00812374	CLOTRIMADERM	TAR

##### 1% & 200MG TABLET (CONTROLLED RELEASE)

02264099	CANESTEN COMBI-PAK COMFORTAB 3	BAY
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##### 1% & 500MG TABLET (CONTROLLED RELEASE)

02264102	CANESTEN COMBI-PAK COMFORTAB 1	BAY
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**84:04.08 SMMA - ANTIFUNGALS****KETOCONAZOLE****2% CREAM**

02245662 KETODERM TPT

**2% SHAMPOO**

02182920 NIZORAL JAJ

**MICONAZOLE NITRATE****2% CREAM**

02085852 MICATIN WPC

02231106 MICOZOLE TAR

02084309 MONISTAT 7 INS

02126567 MONISTAT DERM INS

**2% & 100MG CREAM/VAGINAL SUPPOSITORY**

02126257 MONISTAT 7 DUAL-PAK INS

**2% & 400MG CREAM/VAGINAL SUPPOSITORY**

02126249 MONISTAT 3 DUAL-PAK INS

**400MG OVULE**

02126605 MONISTAT 3 INS

**400MG SUPPOSITORY**

02171775 MICONAZOLE 3 DAY OVULE TREATMENT VTH

**NYSTATIN****25,000IU CREAM**

00716901 NYADERM TAR

**100,000IU CREAM**

00716871 NYADERM TAR

02194163 RATIO-NYSTATIN TEV

02194236 RATIO-NYSTATIN TEV

**100,000IU OINTMENT**

02194228 RATIO-NYSTATIN TEV

**TERBINAFINE HYDROCHLORIDE****1% CREAM**

02031094 LAMISIL NVR

**TERCONAZOLE****0.4% CREAM**

02247651 TARO-TERCONAZOLE TAR

**TOLNAFTATE****1% AEROSOL**

00576050 TINACTIN AEROSOL BAY

**1% CREAM**

00576034 TINACTIN BAY

**1% POWDER**

01919245 DRSCROLL'S ATHLETE'S FOOT SPRAY BAY

00576042 TINACTIN BAY

**84:04.12 SMMA - SCABICIDES AND PEDICULICIDES****CROTAMITON****10% CREAM**

00623377 EURAX CLC

**DIMETHICONE****50% SOLUTION**

02373785 NYDA GPB

**84:04.12 SMMA - SCABICIDES AND PEDICULICIDES****ISOPROPYL MYRISTATE****50% SOLUTION**

02279592 RESULTZ MDF

**PERMETHRIN****1% CREAM**

00771368 NIX INS

**5% CREAM**

02219905 NIX DERMAL GSK

**1% LIQUID**

02231480 KWELLADA-P MTC

**5% LOTION**

02231348 KWELLADA-P MTC

**PIPERONYL BUTOXIDE, PYRETHRINS****3% & 0.3% SHAMPOO**

02125447 R &amp; C SHAMPOO WITH CONDITIONER MTC

**84:04.92 SMMA - MISCELLANEOUS LOCAL ANTI-INFECTIVES****ISOPROPYL ALCOHOL****70% LIQUID**

00426539 DUONALC ICN

**METRONIDAZOLE****10% CREAM**

01926861 FLAGYL SAC

**POVIDONE-IODINE****10% SOLUTION**

00158348 BETADINE PFR

**SELENIUM SULFIDE****2.5% LOTION**

00594601 VERSEL VAE

**2.5% SHAMPOO**

00243000 EXTRA STRENGTH SELSUN SAC

**SILVER SULFADIAZINE****1% CREAM**

00323098 FLAMAZINE SNE

09854037 FLAMAZINE SMW

**84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS****AMCINONIDE****0.1% CREAM**

02192284 CYCLOCORT GSK

02247098 RATIO-AMCINONIDE TEV

02246714 TARO-AMCINONIDE TAR

**0.1% LOTION**

02192276 CYCLOCORT GSK

02247097 RATIO-AMCINONIDE TEV

**0.1% OINTMENT**

02192268 CYCLOCORT GSK

02247096 RATIO-AMCINONIDE TEV

**84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS****BECLOMETHASONE DIPROPIONATE****0.025% CREAM**

02089602 PROPADERM VAE

**BETAMETHASONE DIPROPIONATE****0.05% CREAM**

00688622 DIPROLENE FRS

00323071 DIPROSONE FRS

00849650 RATIO-TOPILENE TEV

00804991 RATIO-TOPISONE TEV

02122073 ROLENE RIV

02122049 ROSONE RIV

01925350 TARO-SONE TAR

**0.05% LOTION**

00862975 DIPROLENE FRS

00417246 DIPROSONE FRS

01927914 RATIO-TOPILENE TEV

00809187 RATIO-TOPISONE TEV

02122065 ROLENE RIV

02122030 ROSONE RIV

**0.05% OINTMENT**

00629367 DIPROLENE FRS

00344923 DIPROSONE FRS

00849669 RATIO-TOPILENE TEV

00805009 RATIO-TOPISONE TEV

02122081 ROLENE RIV

02122057 ROSONE RIV

**BETAMETHASONE DIPROPIONATE, SALICYLIC ACID****0.05% & 2% LOTION**

00578428 DIPROSALIC FRS

02245688 RATIO-TOPISALIC TEV

**0.05% & 3% OINTMENT**

00578436 DIPROSALIC FRS

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99500003 SALICYLIC ACID IN CORTICOSTEROID CREAM UNK

99501001 SALICYLIC ACID IN NON-MEDICATED OINTMENT UNK

**BETAMETHASONE VALERATE****0.05% CREAM**

00716618 BETADERM TAR

02357860 CELESTODERM V VAE

00535427 RATIO-ECTOSONE TEV

**0.1% CREAM**

00716626 BETADERM TAR

02357844 CELESTODERM V VAE

00804541 PREVEX B GSK

00535435 RATIO-ECTOSONE TEV

**0.05% LOTION**

00653209 RATIO-ECTOSONE TEV

**0.1% LOTION**

00716634 BETADERM TAR

00653217 RATIO-ECTOSONE TEV

00750050 RATIO-ECTOSONE TEV

**84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS****BETAMETHASONE VALERATE****0.1% LOTION**

01940112 RIVASONE RIV

00027944 VALISONE VAE

**0.05% OINTMENT**

00716642 BETADERM TAR

02357879 CELESTODERM V VAE

**0.1% OINTMENT**

00716650 BETADERM TAR

02357852 CELESTODERM V VAE

**BUDESONIDE, SODIUM CHLORIDE****0.02MG/ML ENEMA**

02052431 ENTOCORT TIL

**CALCIPOTRIOL, BETAMETHASONE DIPROPIONATE****0.5MG & 50MCG GEL**

02319012 DOVOBET LEO

**0.5MG & 50MCG OINTMENT**

02244126 DOVOBET LEO

**CLOBETASOL PROPIONATE****0.05% CREAM**

02213265 DERMOVATE TPT

02024187 MYLAN-CLOBETASOL MYL

02093162 NOVO-CLOBETASOL NOP

02232191 PMS-CLOBETASOL PMS

02309521 PMS-CLOBETASOL PMS

01910272 RATIO-CLOBETASOL TEV

02245523 TARO-CLOBETASOL TAR

**0.05% LOTION**

02213281 DERMOVATE TPT

02216213 MYLAN-CLOBETASOL MYL

02232195 PMS-CLOBETASOL PMS

01910299 RATIO-CLOBETASOL TEV

02245522 TARO-CLOBETASOL TAR

**0.05% OINTMENT**

02213273 DERMOVATE TPT

02026767 MYLAN-CLOBETASOL MYL

02126192 NOVO-CLOBETASOL NOP

02309548 PMS-CLOBETASOL PMS

01910280 RATIO-CLOBETASOL TEV

02245524 TARO-CLOBETASOL TAR

**CLOBETASONE BUTYRATE****0.05% CREAM**

02214415 SPECTRO ECZEMACARE GSK

**DESONIDE****0.05% CREAM**

02229315 PDP-DESONIDE PED

02154862 TRIDESILON PER

**0.05% OINTMENT**

02229323 PDP-DESONIDE PED

02154870 TRIDESILON PER

**84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS****DESOXIMETASONE****0.05% CREAM**

02221918 TOPICORT MILD VAE

**0.25% CREAM**

02221896 TOPICORT VAE

**0.05% GEL**

02221926 TOPICORT VAE

**0.25% OINTMENT**

02221934 TOPICORT VAE

**ESCULIN, FRAMYCETIN SULFATE, DIBUCAINE HYDROCHLORIDE, HYDROCORTISONE ACETATE****1% & 1% & 0.5% & 0.5% OINTMENT**

02247322 PROCTOL ODN

02223252 PROCTOSEDYL APC

02242527 SANDOZ PROCTOMYXIN HC SDZ

**10MG & 10MG & 5MG & 5MG OINTMENT**

02226383 RATIO-PROCTOSONE TEV

**1% & 1% & 0.5% & 0.5% SUPPOSITORY**

02247882 PROCTOL ODN

02223260 PROCTOSEDYL APC

02242528 SANDOZ PROCTOMYXIN HC SDZ

**10MG & 10MG & 5MG & 5MG SUPPOSITORY**

02226391 RATIO-PROCTOSONE TEV

**FLUOCINONIDE****0.05% CREAM**

02163152 LIDEMOL VAE

02161923 LIDEX VAE

00716863 LYDERM TPT

00598933 TIAMOL TPT

**0.05% GEL**

02161974 LIDEX VAE

02236997 LYDERM TPT

**0.01% LOTION**

00873292 DERMA-SMOOTHIE HIL

**0.025% OINTMENT**

02162512 SYNALAR VAE

**0.05% OINTMENT**

02161966 LIDEX VAE

02236996 LYDERM TPT

**0.01% SOLUTION**

02162504 SYNALAR VAE

**HALOBETASOL PROPIONATE****0.05% CREAM**

01962701 ULTRAVATE VAE

**0.05% OINTMENT**

01962728 ULTRAVATE VAE

**HYDROCORTISONE ACETATE****0.5% CREAM**

80021088 CORTATE BAY

00716820 HYDERM TAR

02242930 HYDROCORTISONE ACETATE TAR

**84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS****HYDROCORTISONE ACETATE****1% CREAM**

00192597 EMOCORT GSK

02412926 EUROHYDROCORTISONE EUR

00716839 HYDERM TAR

00564281 HYDROSONE TEV

80057189 JAMP-HYDROCORTISONE JMP

80066164 M-HC MAN

00804533 PREVEX HC GSK

**2.5% CREAM**

00595799 EMO CORT GSK

**0.5% LOTION**

80021087 CORTATE BAY

**1% LOTION**

00192600 EMO CORT GSK

80057191 JAMP-HYDROCORTISONE JMP

80066168 M-HC MAN

00578541 SARNA HC GSK

**0.5% OINTMENT**

80021085 CORTATE BAY

00716685 CORTODERM TAR

**1% OINTMENT**

00716693 CORTODERM OINT TAR

**HYDROCORTISONE ACETATE, UREA****1% & 10% CREAM**

00681989 DERMAFLEX HC PAL

**1.00% LOTION**

00681997 DERMAFLEX HC PAL

**HYDROCORTISONE ACETATE, ZINC SULFATE****0.5% & 0.5% OINTMENT**

02128446 ANODAN-HC ODN

00505773 ANUSOL HC CHU

02209764 EGOZINC-HC PMS

00607789 RATIO-HEMCORT-HC TEV

02179547 RIVA-HC RIV

02247691 SANDOZ ANUZINC HC SDZ

**10MG & 10MG SUPPOSITORY**

02236399 ANODAN-HC ODN

00476285 ANUSOL HC CHU

02210517 EGOZINC-HC PMS

00607797 RATIO-HEMCORT-HC TEV

02240112 RIVASOL-HC RIV

02242798 SANDOZ ANUZINC HC SDZ

**HYDROCORTISONE ACETATE, ZINC SULFATE MONOHYDRATE****0.5% & 0.5% OINTMENT**

02387239 JAMP-ZINC-HC JMP

**HYDROCORTISONE ACETATE, ZINC SULFATE, PRAMOXINE HYDROCHLORIDE****0.5% & 0.5% & 1% OINTMENT**

00505781 ANUGESIC HC MCL

02234466 PROCTODAN-HC ODN

**84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS****HYDROCORTISONE ACETATE, ZINC SULFATE, PRAMOXINE HYDROCHLORIDE****10MG & 10MG & 20MG SUPPOSITORY**

00476242	ANUGESIC HC	MCL
02240851	PROCTODAN-HC	ODN
02242797	SANDOZ ANUZINC HC PLUS	SDZ

**HYDROCORTISONE VALERATE****0.2% CREAM**

02242984	HYDROVAL	TPT
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**0.2% OINTMENT**

02242985	HYDROVAL	TPT
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**MOMETASONE FUROATE****0.1% CREAM**

00851744	ELOCOM	FRS
02367157	TARO-MOMETASONE	TAR

**0.1% LOTION**

00871095	ELOCOM	FRS
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**0.1% OINTMENT**

00851736	ELOCOM	FRS
02244769	PMS-MOMETASONE	PMS
02270862	PMS-MOMETASONE	PMS
02248130	RATIO-MOMETASONE	TEV
02264749	TARO-MOMETASONE	TAR
02266385	TARO-MOMETASONE	TAR

**PDIN FOR EXTEMPORANEOUS MIXTURE**

99500008	MOMETASONE CREAM	UNK
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**TRIAMCINOLONE ACETONIDE****0.1% CREAM**

02194058	ARISTOCORT R	VAE
00716960	TRIADERM	TAR

**0.5% CREAM**

02194066	ARISTOCORT C	VAE
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**0.1% OINTMENT**

02194031	ARISTOCORT R	VAE
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**0.1% PASTE**

01964054	ORACORT DENTAL PASTE	TAR
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**84:08.00 SMMA - ANTIPRURITICS AND LOCAL ANESTHETICS****LIDOCAINE HYDROCHLORIDE****2% SOLUTION**

02427745	JAMPOCAINE VISCOUS	JMP
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**LIDOCAINE, PRILOCAINE****2.5% & 2.5% CREAM**

00886858	EMLA	UNK
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**2.5% & 2.5% PATCH**

02057794	EMLA	UNK
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**84:16.00 SMMA - CELL STIMULANTS AND PROLIFERANTS****TRETINOIN****0.01% CREAM**

00897329	RETIN-A	VAE
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**84:16.00 SMMA - CELL STIMULANTS AND PROLIFERANTS****TRETINOIN****0.01% CREAM**

00657204	STIEVA-A	GSK
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**0.025% CREAM**

00897310	RETIN-A	VAE
00578576	STIEVA-A	GSK

**0.05% CREAM**

00443794	RETIN-A	VAE
00518182	STIEVA-A	GSK

**0.1% CREAM**

00870021	RETIN-A	VAE
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**0.01% GEL**

00870013	RETIN-A	VAE
01926462	VITAMIN A ACID	VAE

**0.025% GEL**

00443816	RETIN-A	VAE
01926470	VITAMIN A ACID	VAE

**0.05% GEL**

01926489	VITAMIN A ACID	VAE
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**84:24.12 BASIC OINTMENTS AND PROTECTANTS****DIMETHICONE****20% CREAM**

02060841	BARRIERE	WPC
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**PETROLATUM****67% CREAM**

00635189	PREVEX	GSK
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**ZINC OXIDE****15% CREAM**

02215799	ZINC OXIDE	HJS
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**25% OINTMENT**

00532576	PATE D'IHLE	TEV
00886327	PÂTE D'IHLE	ATL

**ZINC OXIDE, WHITE PETROLATUM****15% & 80.3% CREAM**

02337452	DIAPER RASH	HJS
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**40% OINTMENT**

02239160	ZINCOFAX EXTRA STRENGTH	PAL
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**84:28.00 KERATOLYTIC AGENTS****BENZOYL PEROXIDE****5% GEL**

02162113	BENZAGEL	CLC
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**5% LIQUID**

02162121	BENZAGEL	CLC
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**4% LOTION**

02413353	SPECTRO ACNECARE WASH	GSK
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**5% LOTION**

02166607	BENZAGEL 5	CLC
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**CANTHARIDIN, PODOPHYLLIN, SALICYLIC ACID****1% & 2% & 30% LIQUID**

00772011	CANTHARONE PLUS	DOR
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**84:28.00 KERATOLYTIC AGENTS****CANTHARIDIN, PODOPHYLLIN, SALICYLIC ACID****1% & 5% & 30% LIQUID**

00589500 CANTHACUR-PS PAL

**SALICYLIC ACID****170MG/ML GEL**

00614246 COMPOUND W GEL UNK

**20% LIQUID**

00690333 SOLUVER DPT

**26% LIQUID**

00754951 OCCLUSAL HP VAE

**27% LIQUID**

00837733 SOLUVER PLUS DPT

**40% MISCELLANEOUS**

01967878 CLEAR AWAY PLANTAR WART SYSTEM BAY

01974335 CLEAR AWAY WART REMOVER SYSTEM BAY

**4% SHAMPOO**

00666106 SEBCUR DPT

**SALICYLIC ACID-LACTIC ACID****16.716.7% LIQUID**

00370576 DUOFILM STI

**84:32.00 KERATOPLASTIC AGENTS****COAL TAR****10% GEL**

00344508 TARGEL ODN

**20% LIQUID**

00358495 ODAN LIQUOR CARBONIS DETERGENT ODN

**0.5% SHAMPOO**

02240645 NEUTROGENA JAJ

**1% SHAMPOO**

02307146 T/ THERAPEUTIC SHAMPOO EXTRA STRENGTH JAJ

**COAL TAR, SALICYLIC ACID****10% & 3% LIQUID**

00510335 TARGEL SA ODN

**10% & 4% SHAMPOO**

00666114 SEBCUR-T DPT

**84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS****ACITRETIN**

Open benefit (prior approval not required).

Soriatane should be used with caution in women of childbearing potential due to its teratogenicity. Pregnancy must be excluded. Effective contraception must be used. Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or dispensing this drug.

**<sup>ST</sup> 10MG CAPSULE**

02070847 SORIATANE ACG

**<sup>ST</sup> 25MG CAPSULE**

02070863 SORIATANE ACG

**84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS****ADAPALENE****0.1% CREAM**

02231592 DIFFERIN GAC

**0.1% GEL**

02148749 DIFFERIN GAC

**AZELAIC ACID****15% GEL**

02270811 FINACEA BAY

**CALCIPOTRIOL****50MCG/G OINTMENT**

01976133 DOVONEX LEO

**CAPSAICIN****0.025% CREAM**

02157101 CAPSAICIN VAE

02244952 ZODERM EUR

00740306 ZOSTRIX VAE

**0.075% CREAM**

02157128 CAPSAISIN VAE

02004240 ZOSTRIX HP VAE

**COLLAGENASE****250U OINTMENT**

02063670 SANTYL SNE

**FLUOROURACIL****5% CREAM**

00330582 EFUDEX VAE

**IMIQUIMOD**

Limited use benefit (prior approval required).

For the treatment of condylomata acuminata (genital warts) in patients who have failed:

- self-applied podophyllotoxin (podofilox 0.5% solution); OR
- provider-applied podophyllum resin (10%-25%).

**5% CREAM**

02239505 ALDARA P VAE

02407825 APO-IMIQUIMOD APX

**ISOTRETINOIN**

Open benefit (prior approval not required).

Accutane should be used with caution in women of childbearing potential due to its teratogenicity. Pregnancy must be excluded. Effective contraception must be used. Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or dispensing this drug.

**<sup>ST</sup> 10MG CAPSULE**

00582344 ACCUTANE ROCHE HLR

02257955 CLARUS MYL

**<sup>ST</sup> 40MG CAPSULE**

00582352 ACCUTANE ROCHE HLR

02257963 CLARUS MYL

## 84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

### PIMECROLIMUS

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

Note: Contraindicated in children less than 2 years of age.

#### 1% CREAM

02247238 ELIDEL VAE

### PODOFILOX

#### 0.5% SOLUTION

01945149 CONDYLINE SAC

### PODOPHYLLIN

#### 25% LIQUID

00598208 PODOFILM PAL

### SECUKINUMAB

Limited use benefit (prior approval required).

- Psoriasis according to established criteria.

(Please refer to Appendix A).

#### 150MG SOLUTION

02438070 COSENTYX NVR

### TACROLIMUS (PROTOPIC)

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

Note: Contraindicated in children less than 2 years of age.

#### 0.03% OINTMENT

02244149 PROTOPIIC LEO

#### 0.1% OINTMENT

02244148 PROTOPIIC LEO

### TAZAROTENE

#### 0.05% CREAM

02243894 TAZORAC ALL

#### 0.1% CREAM

02243895 TAZORAC ALL

#### 0.05% GEL

02230784 TAZORAC ALL

#### 0.1% GEL

02230785 TAZORAC ALL

## 86:00 SMOOTH MUSCLE RELAXANTS

### 86:12.00 GENITOURINARY SMOOTH MUSCLE RELAXANTS

#### TOLTERODINE TARTRATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

#### <sup>ST</sup> 1MG TABLET

02423308 MINT-TOLTERODINE MIN

#### <sup>ST</sup> 2MG TABLET

02423316 MINT-TOLTERODINE MIN

### 86:12.04 ANTIMUSCARINICS

#### DARIFENACIN HYDROBROMIDE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

#### 7.5MG TABLET (EXTENDED RELEASE)

02273217 ENABLEX MRL

#### 15MG TABLET (EXTENDED RELEASE)

02273225 ENABLEX MRL

#### FESOTERODINE FUMARATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

#### <sup>ST</sup> 4MG TABLET (EXTENDED RELEASE)

02380021 TOVIAZ PFI

#### <sup>ST</sup> 8MG TABLET (EXTENDED RELEASE)

02380048 TOVIAZ PFI

#### FLAVOXATE HYDROCHLORIDE

#### <sup>ST</sup> 200MG TABLET

00728179 URISPAS PAL

#### OXYBUTYNIN CHLORIDE

#### <sup>ST</sup> 1MG/ML SYRUP

02231089 APO-OXYBUTYNIN APX

02223376 PMS-OXYBUTYNIN PMS

#### <sup>ST</sup> 2.5MG TABLET

02240549 PMS-OXYBUTYNIN PMS

#### <sup>ST</sup> 5MG TABLET

02163543 APO-OXYBUTYNIN APX

02241285 DOM-OXYBUTYNIN DPC

02350238 OXYBUTYNIN SAN

### 86:12.04 ANTIMUSCARINICS

#### OXYBUTYNIN CHLORIDE

#### <sup>ST</sup> 5MG TABLET

02220636 OXYBUTYNINE PDL

02240550 PMS-OXYBUTYNIN PMS

02299364 RIVA-OXYBUTYNIN RIV

02230394 TEVA-OXYBUTYNIN TEV

#### SOLIFENACIN SUCCINATE

#### <sup>ST</sup> 5MG TABLET

02422239 ACT SOLIFENACIN ACG

02446375 AURO-SOLIFENACIN AUR

02424339 JAMP-SOLIFENACIN JMP

02428911 MED-SOLIFENACIN GMP

02443171 MINT-SOLIFENACIN MIN

02417723 PMS-SOLIFENACIN PMS

02437988 RAN-SOLIFENACIN RBY

02399032 SANDOZ SOLIFENACIN SDZ

02458144 SOLIFENACIN PDL

02458241 SOLIFENACIN SAN

02397900 TEVA-SOLIFENACIN TEV

02277263 VESICARE AST

#### <sup>ST</sup> 10MG TABLET

02422247 ACT SOLIFENACIN ACG

02446383 AURO-SOLIFENACIN AUR

02424347 JAMP-SOLIFENACIN JMP

02428938 MED-SOLIFENACIN GMP

02443198 MINT-SOLIFENACIN MIN

02417731 PMS-SOLIFENACIN PMS

02437996 RAN-SOLIFENACIN RBY

02399040 SANDOZ SOLIFENACIN SDZ

02458152 SOLIFENACIN PDL

02458268 SOLIFENACIN SAN

02397919 TEVA-SOLIFENACIN TEV

02277271 VESICARE AST

#### TOLTERODINE TARTRATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

#### <sup>ST</sup> 2MG CAPSULE (EXTENDED RELEASE)

02244612 DETROL LA PFI

02404184 MYLAN-TOLTERODINE ER MYL

02413140 SANDOZ TOLTERODINE LA SDZ

02412195 TEVA-TOLTERODINE LA TEV

#### <sup>ST</sup> 4MG CAPSULE (EXTENDED RELEASE)

02244613 DETROL LA PFI

02404192 MYLAN-TOLTERODINE ER MYL

02413159 SANDOZ TOLTERODINE LA SDZ

02412209 TEVA-TOLTERODINE LA TEV

#### <sup>ST</sup> 1MG TABLET

02369680 APO-TOLTERODINE APX

02239064 DETROL PFI

02299593 TEVA-TOLTERODINE TEV

**86:12.04 ANTIMUSCARINICS****TOLTERODINE TARTRATE**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

**<sup>ST</sup> 2MG TABLET**

02369699	APO-TOLTERODINE	APX
02239065	DETROL	PFI
02299607	TEVA-TOLTERODINE	TEV

**TROSPIDIUM CHLORIDE**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

**<sup>ST</sup> 20MG TABLET**

02275066	TROSEC	SPC
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**86:12.08 BETA-ADRENERGIC AGONISTS****MIRABEGRON**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

**<sup>ST</sup> 25MG TABLET (EXTENDED RELEASE)**

02402874	MYRBETRIQ	AST
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**<sup>ST</sup> 50MG TABLET (EXTENDED RELEASE)**

02402882	MYRBETRIQ	AST
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**86:16.00 RESPIRATORY SMOOTH MUSCLE RELAXANTS****OXTRIPHYLLINE****<sup>ST</sup> 20MG/ML ELIXIR**

00476366	CHOLEDYL	ERF
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**<sup>ST</sup> 100MG TABLET**

00441724	APO OXTRIPHYLLINE	APX
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**<sup>ST</sup> 200MG TABLET**

00441732	APO OXTRIPHYLLINE	APX
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**<sup>ST</sup> 300MG TABLET**

00511692	APO OXTRIPHYLLINE	APX
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**THEOPHYLLINE****<sup>ST</sup> 5.33MG/ML ELIXIR**

00466409	PULMOPHYLLINE	RIV
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01966219	THEOLAIR	VAE
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00627410	THEOPHYLLINE	ATL
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**<sup>ST</sup> 100MG TABLET (EXTENDED RELEASE)**

00692689	APO-THEO-LA	APX
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02230085	TEVA-THEOPHYLLINE	TEV
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**86:16.00 RESPIRATORY SMOOTH MUSCLE RELAXANTS****THEOPHYLLINE****<sup>ST</sup> 200MG TABLET (EXTENDED RELEASE)**

00692697	APO-THEO-LA	APX
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02230086	TEVA-THEOPHYLLINE	TEV
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**<sup>ST</sup> 300MG TABLET (EXTENDED RELEASE)**

00692700	APO-THEO-LA	APX
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02230087	TEVA-THEOPHYLLINE	TEV
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**<sup>ST</sup> 400MG TABLET (EXTENDED RELEASE)**

02360101	THEO ER	AAP
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02014165	UNIPHYL	PFR
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**<sup>ST</sup> 600MG TABLET (EXTENDED RELEASE)**

02360128	THEO ER	AAP
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02014181	UNIPHYL	PFR
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**88:00 VITAMINS****88:04.00 VITAMIN A****VITAMIN A**<sup>ST</sup> **10,000IU CAPSULE**

80054130	JAMP-VITAMIN A	JMP
00297720	VITAMIN A	JAM
00557447	VITAMIN A	VTH

**88:08.00 VITAMIN B COMPLEX****CYANOCOBALAMIN****100MCG/ML LIQUID**

00497533	VITAMIN B12	HOS
02241500	VITAMIN B12	SDZ

<sup>ST</sup> **200MCG/ML LIQUID**

80039903	BEDUZIL	ORM
80026092	JAMP-VITAMIN B12	JMP

**1,000MCG/ML LIQUID**

00626112	B-12	OMG
01987003	CYANOCOBALAMIN	RAX
02052717	CYANOCOBALAMIN	TAR
02413795	CYANOCOBALAMIN	MYL
02420147	JAMP-CYANOCOBALAMIN	JMP
00038830	VITAMIN B12	HOS
00521515	VITAMIN B12	SDZ

<sup>ST</sup> **1 TABLET**

80015276	JAMP-VITAMIN B12	JMP
80055741	M-B12	MAN
02237736	VITAMIN B12	VAE

<sup>ST</sup> **250MCG TABLET**

80015294	JAMP-VITAMIN B12	JMP
80055743	M-B12	MAN
00335940	VITAMIN B12	JAM
02239695	VITAMIN B12	PMT
80004053	VITAMIN B12	WNP

<sup>ST</sup> **1000MCG TABLET**

80028902	JAMP VITAMIN B12	JMP
80003575	VITAMIN B12	PMT
80006939	VITAMIN B12	WNP

**FOLIC ACID**<sup>ST</sup> **1MG TABLET**

00318973	FOLIC ACID	JAM
00647039	FOLIC ACID	VTH
02048841	FOLIC ACID	PMT
80000273	FOLIC ACID	WNP
80053274	JAMP FOLIC ACID	JMP
02236747	WAMPOLE FOLIC ACID	WAM

<sup>ST</sup> **5MG TABLET**

00426849	APO FOLIC ACID	APX
02285673	EURO-FOLIC	SDZ
02366061	JAMP-FOLIC ACID	JMP

<sup>ST</sup> **1000MCG TABLET**

02239882	FOLIC ACID	UNK
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**NIACIN**<sup>ST</sup> **50MG TABLET**

00041084	NIACIN	ADA
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**88:08.00 VITAMIN B COMPLEX****NIACIN**<sup>ST</sup> **500MG TABLET**

00309737	NIACIN	JAM
00557412	NIACIN	VTH
01939130	NIACIN	ODN
02247004	NIACIN	PMT

**PYRIDOXINE HYDROCHLORIDE**<sup>ST</sup> **25MG TABLET**

80056458	M-B6	MAN
00122645	VITAMIN B6	JAM
00232475	VITAMIN B6	ADA
01943200	VITAMIN B6	ODN
80002890	VITAMIN B6	JMP

<sup>ST</sup> **50MG TABLET**

00305227	VITAMIN B6	JAM
00608599	VITAMIN B6	ADA

<sup>ST</sup> **100MG TABLET**

00450677	B6	VTH
00263958	VITAMIN B6	VAE
00329185	VITAMIN B6	JAM
02239348	VITAMIN B6	PMT

**THIAMINE HYDROCHLORIDE****100MG/ML LIQUID**

02241983	BETAXIN	HOS
02193221	THIAMJECT	OMG
02243525	THIAMINE	RAX

**100MG/ML SOLUTION**

00816078	VITAMIN B1	SDZ
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<sup>ST</sup> **50MG TABLET**

02245506	EURO VITAMIN B1	EUR
80054199	M-B1	MAN
00268631	THIAMINE	VAE
80009633	VITAMIN B1	JMP

<sup>ST</sup> **100MG TABLET**

80054205	M-B1	MAN
00232467	VITAMIN B1	PED
00407011	VITAMIN B1	JAM
02239350	VITAMIN B1	PMT
80000352	VITAMIN B1	WNP
80009588	VITAMIN B1	JMP

**88:12.00 VITAMIN C****ASCORBIC ACID**<sup>ST</sup> **500MG CAPLET**

02163268	VITAMIN C	JAM
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<sup>ST</sup> **250MG TABLET**

00162515	VITAMIN C	PMT
00221244	VITAMIN C	ADA
00266051	VITAMIN C	PMT
00557811	VITAMIN C	VTH

<sup>ST</sup> **500MG TABLET**

00266086	ASCORBIC ACID	PMT
00041114	VITAMIN C	ADA
00322326	VITAMIN C	ADA
00557838	VITAMIN C	VTH

**88:12.00 VITAMIN C****ASCORBIC ACID****<sup>ST</sup> 500MG TABLET**

00784591 VITAMIN C  
 01922378 VITAMIN C  
 02243893 VITAMIN C  
 02244469 VITAMIN C  
 02245348 VITAMIN C  
 02245721 VITAMIN C  
 00322997 VITAMINE C  
 00036188 WAMPOLE VITAMIN C  
 00274240 WAMPOLE VITAMIN C

VTH  
 VAE  
 PMT  
 PMT  
 WNP  
 PMT  
 LAL  
 WAM  
 WAM

**VITAMIN C****<sup>ST</sup> 500MG TABLET**

80003328 VITAMIN C

WNP

**88:16.00 VITAMIN D****ALFACALCIDOL****<sup>ST</sup> 0.25MCG CAPSULE**

00474517 ONE ALPHA

LEO

**<sup>ST</sup> 1MCG CAPSULE**

00474525 ONE ALPHA

LEO

**<sup>ST</sup> 2MCG/ML DROP**

02240329 ONE-ALPHA

LEO

**CALCITRIOL****<sup>ST</sup> 0.25MCG CAPSULE**

02431637 CALCITRIOL-ODAN  
 00481823 ROCALTROL

ODN  
 HLR

**<sup>ST</sup> 0.5MCG CAPSULE**

02431645 CALCITRIOL-ODAN  
 00481815 ROCALTROL

ODN  
 HLR

**CHOLECALCIFEROL****<sup>ST</sup> 400IU CAPSULE**

80006629 DGEL  
 02242651 EURO D  
 80005560 RIVA-D

JMP  
 EUR  
 RIV

**<sup>ST</sup> 800IU CAPSULE**

80007769 DGEL

JMP

**<sup>ST</sup> 1,000IU CAPSULE**

80009635 VITAMIN D3

WAM

**<sup>ST</sup> 10,000IU CAPSULE**

02253178 EURO D

SDZ

**<sup>ST</sup> 50,000IU CAPSULE**

02301911 OSTO-D2

PAL

**<sup>ST</sup> 400IU LIQUID**

80001869 BABY DDROPS  
 80001792 DDROPS

DDP  
 DDP

**<sup>ST</sup> 400IU/ML LIQUID**

00762881 D VI INFANTS  
 80003038 JAMP VITAMIN D  
 02231624 PEDIAVIT D

MJO  
 JMP  
 EUR

**<sup>ST</sup> 1,000IU LIQUID**

80001791 DDROPS

DDP

**<sup>ST</sup> 400IU TABLET**

02238729 VITAMIN D

VTH

**88:16.00 VITAMIN D****CHOLECALCIFEROL****<sup>ST</sup> 400IU TABLET**

02240858 VITAMIN D  
 00765384 VITAMINE D  
 02240624 WAMPOLE VITAMIN D

PMT  
 LAL  
 WAM

**<sup>ST</sup> 1,000IU TABLET**

02245842 VITAMIN D3

PMT

**<sup>ST</sup> 10,000IU TABLET**

00821772 D-TABS  
 02417995 VITAMINE D

RIV  
 PDL

**ERGOCALCIFEROL****<sup>ST</sup> 50,000IU CAPSULE**

02237450 D-FORTE

SDZ

**<sup>ST</sup> 8 ORAL LIQUID**

02017598 DRISDOL

SAC

**<sup>ST</sup> 8,288IU/ML ORAL LIQUID**

80003615 ERDOL

ODN

**<sup>ST</sup> 8,288IU/ML SOLUTION**

80020776 D2-DOL

JMP

**VITAMIN D****<sup>ST</sup> 1 CAPSULE**

80063899 VIT D 1000

UNK

**<sup>ST</sup> 10MCG CAPSULE**

80063895 VIT D 400

UNK

**<sup>ST</sup> 200U CAPSULE**

02442256 VITAMIN D3

ORM

**<sup>ST</sup> 400IU CAPSULE**

80055196 M-D  
 80001145 PHARMA-D  
 80008590 VITAMINE D

MAN  
 PED  
 BMI

**<sup>ST</sup> 800IU CAPSULE**

80003010 EURO D  
 80008446 VITAMINE D

EUR  
 BMI

**<sup>ST</sup> 1,000IU CAPSULE**

80007766 DGEL  
 80055204 M-D  
 80008496 PHARMA-D  
 80043412 VITAMINE D

JMP  
 MAN  
 PMS  
 BMI

**<sup>ST</sup> 10,000IU CAPSULE**

02449099 JAMP-VITAMIN D  
 02371499 PHARMA-D

JMP  
 PMS

**<sup>ST</sup> 400IU LIQUID**

80038155 DECA XIL  
 80041145 DECA XIL

ORM  
 ORM

**<sup>ST</sup> 1,000IU LIQUID**

80007346 JAMP VITAMIN D  
 80028362 JAMP VITAMIN D  
 80028371 JAMP VITAMIN D

JMP  
 JMP  
 JMP

**<sup>ST</sup> 400IU ORAL LIQUID**

80019649 D3-DOL

JMP

**<sup>ST</sup> 800IU ORAL LIQUID**

80003285 PEDIAVIT D

EUR

**<sup>ST</sup> 25MCG TABLET**

80031157 VITAMIN D

WNP

**88:16.00 VITAMIN D****VITAMIN D**<sup>ST</sup> **400IU TABLET**

80002452	VITAMIN D	WNP
80009578	VITAMIN D	VAE

<sup>ST</sup> **1,000IU TABLET**

80002169	PHARMA-D	PMS
80051562	RIVA-D	RIV
80000436	VITAMIN D	JAM
80003663	VITAMIN D	WNP
80009580	VITAMIN D	VAE
80015278	WAMPOLE VITAMIN D	WAM

<sup>ST</sup> **10,000IU TABLET**

02379007	JAMP-VITAMIN D	JMP
02417685	VIDEXTRA	ORM

**88:20.00 VITAMIN E****VITAMIN E**

Limited use benefit (prior approval required).

For use in malabsorption

<sup>ST</sup> **100IU CAPSULE**

00122823	VITAMIN E	JAM
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<sup>ST</sup> **200IU CAPSULE**

00122831	VITAMIN E	JAM
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<sup>ST</sup> **400IU CAPSULE**

00122858	VITAMIN E	JAM
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<sup>ST</sup> **800IU CAPSULE (SOFTGEL)**

00330191	VITAMIN E	JAM
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<sup>ST</sup> **50IU ORAL LIQUID**

00480215	AQUASOL E	NVC
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<sup>ST</sup> **50IU/ML ORAL LIQUID**

02162075	AQUASOL E VITAMIN E	CLC
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**88:24.00 VITAMIN K****PHYTONADIONE****2MG/ML EMULSION**

00781878	VITAMIN K1	SDZ
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**10MG/ML EMULSION**

00804312	VITAMIN K1	SDZ
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**88:28.00 MULTIVITAMIN PREPARATIONS****MULTIVITAMINS (PEDIATRIC)**

Limited use benefit (prior approval is not required).

Pediatric multivitamins are benefits for children up to 6 years of age.

<sup>ST</sup> **DROP**

00762946	ENFAMIL POLYVISOL	MJO
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<sup>ST</sup> **450MG & 10MG & 30MG LIQUID**

80008471	JAMP VITAMIN A, D AND C	JMP
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<sup>ST</sup> **2,500IU & 666.67IU & 50MG/ML LIQUID**

00762903	ENFAMIL TRIVISOL	MJO
02229790	PEDIAVIT	EUR

<sup>ST</sup> **TABLET (CHEWABLE)**

80011134	CENTRUM JUNIOR COMPLETE	PFI
80020794	CENTRUM JUNIOR COMPLETE	PFI

**88:28.00 MULTIVITAMIN PREPARATIONS****MULTIVITAMINS (PEDIATRIC)**

Limited use benefit (prior approval is not required).

Pediatric multivitamins are benefits for children up to 6 years of age.

<sup>ST</sup> **TABLET (CHEWABLE)**

02247995	FLINTSTONES MULTIPLE VITAMINS PLUS IRON	BAY
02247975	FLINTSTONES MULTIPLE VITAMINS WITH EXTRA C	BAY

**MULTIVITAMINS (PRENATAL)**

Limited use benefit (prior approval is not required).

Prenatal and postnatal vitamins are benefits only for women of childbearing age (12 to 50 years).

<sup>ST</sup> **TABLET**

80042704	CENTRUM DHA	PFI
80045822	CENTRUM PRENATAL	PFI
80001842	NESTLÉ MATERNA	NES
02241235	PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	VTH
80005770	PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	PMT
02229535	WAMPOLE COMPLETE MULT-PRE AND POST NATAL WITH FOLIC ACID	WAM

**92:00 UNCLASSIFIED THERAPEUTIC AGENTS****92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS****BETAHISTINE HYDROCHLORIDE****16MG TABLET**

02330210 PMS-BETAHISTINE PMS

**24MG TABLET**

02330237 PMS-BETAHISTINE PMS

**EXTEMPORANEOUS MIXTURE****CREAM**

99500000 HYDROCORTISONE POWDER AND CLOTRIMAZOLE CREAM UNK

99500010 LCD IN CORTICOSTEROID CREAM UNK

99500009 LCD IN NON-MEDICATED CREAM UNK

99500002 MENTHOL &amp;/OR CAMPHOR IN STEROID UNK

99500004 MISCELLANEOUS COMPOUNDED TOPICAL CREAM UNK

99500001 STEROID AND ANTIFUNGAL CREAM UNK

99500006 SULFUR IN NON-MEDICATED CREAM UNK

**INJECTION**

99506021 MISCELLANEOUS COMPOUNDED INJECTION/INFUSION UNK

**LOTION**

99502001 MENTHOL &amp; CAMPHOR IN CORTICOSTEROID LOTION UNK

99502002 MISCELLANEOUS COMPOUNDED EXTERNAL LOTION UNK

**MISCELLANEOUS**

00915000 STERILE EXTEMPORANEOUS MIXTURE (QC) UNK

**OINTMENT**

99501006 ALL PURPOSE NIPPLE OINTMENT UNK

99501003 CALCIUM CHANNEL BLOCKER IN OINTMENT UNK

99501000 LCD IN CORTICOSTEROID OINTMENT UNK

99501005 LCD IN NON-MEDICATED OINTMENT UNK

99501004 MISCELLANEOUS COMPOUNDED TOPICAL OINTMENT UNK

99501002 SULFUR IN NON-MEDICATED OINTMENT UNK

**OPHTHALMIC AND OTIC SOLUTION**

99507000 MISCELLANEOUS COMPOUNDED EYE/EAR DROP UNK

**ORAL LIQUID**

99503028 ANTACID AND LIDOCAINE ORAL LIQUID UNK

99503029 MAGIC MOUTHWASH UNK

99503025 MISCELLANEOUS COMPOUNDED INTERNAL LIQUID UNK

**POWDER**

99504000 MISCELLANEOUS COMPOUNDED EXTERNAL POWDER UNK

**92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS****EXTEMPORANEOUS MIXTURE****POWDER**

99505000 MISCELLANEOUS COMPOUNDED INTERNAL POWDER UNK

**SUPPOSITORY**

99508000 MISCELLANEOUS COMPOUNDED SUPPOSITORY UNK

**GOSERELIN ACETATE****10.8MG/DEPOT IMPLANT**

02225905 ZOLADEX LA AZC

**OCTREOTIDE ACETATE****10MG/VIAL POWDER**

02239323 SANDOSTATIN LAR NVR

**20MG/VIAL POWDER**

02239324 SANDOSTATIN LAR NVR

**30MG/VIAL POWDER**

02239325 SANDOSTATIN LAR NVR

**50MCG/ML SOLUTION**

02413191 OCPHYL PED

02248639 OCTREOTIDE ACETATE OMEGA OMG

00839191 SANDOSTATIN NVR

**100MCG/ML SOLUTION**

02413205 OCPHYL PED

02248640 OCTREOTIDE ACETATE OMEGA OMG

00839205 SANDOSTATIN NVR

**200MCG/ML SOLUTION**

02248642 OCTREOTIDE ACETATE OMEGA OMG

02049392 SANDOSTATIN NVR

**500MCG SOLUTION**

02299453 OCTREOTIDE TEV

**500MCG/ML SOLUTION**

02413213 OCPHYL PED

02248641 OCTREOTIDE ACETATE OMEGA OMG

00839213 SANDOSTATIN NVR

**PENTOSAN POLYSULFATE SODIUM****100MG CAPSULE**

02029448 ELMIRON JSO

**USTEKINUMAB**

Limited use benefit (prior approval required).

• Psoriasis according to established criteria.

(Please refer to Appendix A).

**45MG/0.5ML SOLUTION**

02320673 STELARA JSO

**90MG/ML SOLUTION**

02320681 STELARA JSO

**92:01.00 NATURAL HEALTH PRODUCTS****FOLIC ACID****<sup>ST</sup> 1MG TABLET**

80061488 M-FOLIQUE MAN

**92:05.00 SERUMS****APIS MELLIFERA VENOM PROTEIN EXTRACT****1.1MG POWDER FOR SOLUTION**

01948903	PHARMALGEN HONEY BEE VENOM	ALK
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**120MCG POWDER FOR SOLUTION**

01948911	PHARMALGEN HONEY BEE VENOM	ALK
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**DOLICHOVESPULA ARENARIA VENOM PROTEIN****120MCG POWDER FOR SOLUTION**

01948946	PHARMALGEN YELLOW HORNET VENOM PROTEIN	ALK
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**DOLICHOVESPULA MACULATA VENOM PROTEIN EXTRACT****120MCG POWDER FOR SOLUTION**

01949004	PHARMALGEN WHITE FACED HORNET VENOM	ALK
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**HONEY BEE VENOM PROTEIN EXTRACT****120MCG POWDER FOR SOLUTION**

02226197	VENOMIL HONEY BEE VENOM	JUB
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**550MCG POWDER FOR SOLUTION**

02220075	HYMENOPTERA VENOM PRODUCT HONEY BEE VENOM	JUB
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**NON POLLEN****100,000U LIQUID**

00299979	ALLERGENIC EXTRACT NON POLLENS	ALK
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00514713	ALLERGENIC EXTRACTS	MSL
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**POLISTES SPP VENOM PROTEIN EXTRACT****1.1MG POWDER FOR SOLUTION**

01948970	PHARMALGEN WASP VENOM PROTEIN	ALK
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**POLLEN****4,300U/ML LIQUID**

00464988	POLLINEX R	BEN
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**100,000U LIQUID**

00299987	ALLERGENIC EXTRACT POLLENS	ALK
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**POLLEN AND NON POLLEN****20,000U LIQUID**

00648922	CENTER-AL	ALK
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**VENOM PROTEIN EXTRACT****3,300MCG POWDER FOR SOLUTION**

01948873	PHARMALGEN MIXED VESPID VENOM PROTEIN	ALK
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**VESPUA SPP VENOM PROTEIN EXTRACT****1.1MG POWDER FOR SOLUTION**

01948954	PHARMALGEN YELLOW JACKET VENOM PROTEIN	ALK
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**120MCG POWDER FOR SOLUTION**

01948962	PHARMALGEN YELLOW JACKET VENOM PROTEIN	ALK
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**WASP VENOM PROTEIN****120MCG POWDER FOR SOLUTION**

02226219	VENOMIL WASP VENOM PROTEIN	JUB
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**92:05.00 SERUMS****WASP VENOM PROTEIN****550MCG POWDER FOR SOLUTION**

02220091	HYMENOPTERA VENOM PRODUCT WASP VENOM PROTEIN	JUB
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**WHITE FACED HORNET VENOM PROTEIN****120MCG POWDER FOR SOLUTION**

02226235	VENOMIL WHITE-FACED HORNET VENOM PROTEIN	JUB
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**WHITE FACED HORNET VENOM PROTEIN, YELLOW HORNET VENOM PROTEIN, YELLOW JACKET VENOM PROTEIN****120MCG POWDER FOR SOLUTION**

01948881	PHARMALGEN MIXED VESPID VENOM PROTEIN	ALK
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02226294	VENOMIL MIXED VESPID VENOM PROTEIN	JUB
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**550MCG POWDER FOR SOLUTION**

02221314	HYMENOPTERA VENOM PRODUCT MIXED VESPID VENOM PROTEIN	JUB
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**YELLOW HORNET VENOM PROTEIN****120MCG/ML POWDER FOR SOLUTION**

02226251	VENOMIL YELLOW HORNET VENOM PROTEIN	JUB
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**550MCG POWDER FOR SOLUTION**

02220083	HYMENOPTERA VENOM PRODUCTS YELLOW HORNET VENOM PROTEIN	JUB
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**YELLOW JACKET VENOM PROTEIN****120MCG POWDER FOR SOLUTION**

02226286	VENOMIL YELLOW JACKET VENOM PROTEIN	JUB
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**550MCG POWDER FOR SOLUTION**

02220113	HYMENOPTERA VENOM PRODUCT YELLOW JACKET VENOM PROTEIN	JUB
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**92:08.00 5 ALFA REDUCTASE INHIBITORS****DUTASTERIDE**

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 adrenergic blocker.

OR

For use in combination therapy when monotherapy with an alpha-blocker is not sufficient.

**<sup>ST</sup> 0.5MG CAPSULE**

02412691	ACT DUTASTERIDE	ACG
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02404206	APO-DUTASTERIDE	APX
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02247813	AVODART	GSK
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02421712	DUTASTERIDE	PDL
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02429012	DUTASTERIDE	SIV
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02443058	DUTASTERIDE	SAN
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02416298	MED-DUTASTERIDE	GMP
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02428873	MINT-DUTASTERIDE	MIN
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02393220	PMS-DUTASTERIDE	PMS
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02427753	RIVA-DUTASTERIDE	RIV
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**92:08.00 5 ALFA REDUCTASE INHIBITORS**

**DUTASTERIDE**

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 adrenergic blocker.

OR

For use in combination therapy when monotherapy with an alpha-blocker is not sufficient.

<sup>ST</sup> **0.5MG CAPSULE**

02424444	SANDOZ DUTASTERIDE	SDZ
02408287	TEVA-DUTASTERIDE	TEV

**FINASTERIDE**

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.

<sup>ST</sup> **5MG TABLET**

02355043	ACH-FINASTERIDE	ACC
02354462	ACT FINASTERIDE	ACG
02365383	APO-FINASTERIDE	APX
02405814	AURO-FINASTERIDE	AUR
02376709	DOM-FINASTERIDE	DPC
02350270	FINASTERIDE	PDL
02445077	FINASTERIDE	SAN
02447541	FINASTERIDE	SIV
02357224	JAMP-FINASTERIDE	JMP
02389878	MINT-FINASTERIDE	MIN
02310112	PMS-FINASTERIDE	PMS
02010909	PROSCAR	FRS
02371820	RAN-FINASTERIDE	RBV
02306905	RATIO-FINASTERIDE	TEV
02455013	RIVA-FINASTERIDE	RIV
02322579	SANDOZ FINASTERIDE	SDZ
02348500	TEVA-FINASTERIDE	TEV
02428741	VAN-FINASTERIDE	VAN

**92:12.00 ANTIDOTES**

**LEUCOVORIN CALCIUM**

**5MG TABLET**

02170493	LEDERLE LEUCOVORIN	PFI
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**92:16.00 ANTIGOUT AGENTS**

**ALLOPURINOL**

<sup>ST</sup> **100MG TABLET**

00555681	ALLOPURINOL	PDL
02402769	APO-ALLOPURINOL	APX
02421593	JAMP-ALLOPURINOL	JMP
02396327	MAR-ALLOPURINOL	MAR
00402818	ZYLOPRIM	AAP

<sup>ST</sup> **200MG TABLET**

02130157	ALLOPURINOL	PDL
02402777	APO-ALLOPURINOL	APX
02421607	JAMP-ALLOPURINOL	JMP

**92:16.00 ANTIGOUT AGENTS**

**ALLOPURINOL**

<sup>ST</sup> **200MG TABLET**

02396335	MAR-ALLOPURINOL	MAR
00479799	ZYLOPRIM	AAP

<sup>ST</sup> **300MG TABLET**

00294322	ALLOPURINOL	APX
00555703	ALLOPURINOL	PDL
02402785	APO-ALLOPURINOL	APX
02421615	JAMP-ALLOPURINOL	JMP
02396343	MAR-ALLOPURINOL	MAR
00402796	ZYLOPRIM	AAP

<sup>ST</sup> **PDIN FOR EXTEMPORANEOUS MIXTURE**

99503018	ALLOPURINOL ORAL LIQUID	UNK
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**COLCHICINE**

**0.6MG TABLET**

00287873	COLCHICINE	SDZ
00572349	COLCHICINE	ODN
02373823	JAMP-COLCHICINE	JMP
02402181	PMS-COLCHICINE	PMS

**FEBUXOSTAT**

Limited use benefit (prior approval required).

For patients with symptomatic gout who have documented hypersensitivity to allopurinol.

<sup>ST</sup> **80MG TABLET**

02357380	ULORIC	TAK
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**92:24.00 BONE RESORPTION INHIBITORS**

**ALENDRONATE SODIUM**

<sup>ST</sup> **5MG TABLET**

02401118	ACCEL-ALENDRONATE	ACP
02381478	ACH-ALENDRONATE	ACC
02248727	APO-ALENDRONATE	APX
02384698	RAN-ALENDRONATE	RBV
02248251	TEVA-ALENDRONATE	TEV
02428717	VAN-ALENDRONATE	VAN

<sup>ST</sup> **10MG TABLET**

02401126	ACCEL-ALENDRONATE	ACP
02381486	ACH-ALENDRONATE	ACC
02248728	APO-ALENDRONATE	APX
02388545	AURO-ALENDRONATE	AUR
02394863	MINT-ALENDRONATE	MIN
02270129	MYLAN-ALENDRONATE	MYL
02384701	RAN-ALENDRONATE	RBV
02288087	SANDOZ ALENDRONATE	SDZ
02247373	TEVA-ALENDRONATE	TEV
02428725	VAN-ALENDRONATE	VAN

<sup>ST</sup> **40MG TABLET**

02258102	ACT ALENDRONATE	ACG
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<sup>ST</sup> **70MG TABLET**

02401134	ACCEL-ALENDRONATE	ACP
02381494	ACH-ALENDRONATE	ACC
02258110	ACT ALENDRONATE	ACG
02299712	ALENDRONATE	SIV
02352966	ALENDRONATE	SAN
02303078	ALENDRONATE-70	PDL

**92:24.00 BONE RESORPTION INHIBITORS****ALENDRONATE SODIUM****<sup>ST</sup> 70MG TABLET**

02248730	APO-ALENDRONATE	APX
02388553	AURO-ALENDRONATE	AUR
02282763	DOM-ALENDRONATE	DPC
02245329	FOSAMAX	FRS
02385031	JAMP-ALENDRONATE	JMP
02394871	MINT-ALENDRONATE	MIN
02286335	MYLAN-ALENDRONATE	MYL
02273179	PMS-ALENDRONATE	PMS
02284006	PMS-ALENDRONATE	PMS
02384728	RAN-ALENDRONATE	RBV
02270889	RIVA-ALENDRONATE	RIV
02288109	SANDOZ ALENDRONATE	SDZ
02261715	TEVA-ALENDRONATE	TEV
02428733	VAN-ALENDRONATE	VAN

**ALENDRONATE SODIUM, CHOLECALCIFEROL****<sup>ST</sup> 70MG & 2,800U TABLET**

02454467	APO-ALENDRONATE/VITAMIN D3	APX
02276429	FOSAVANCE	FRS
02403633	TEVA-ALENDRONATE/CHOLECALCIFEROL	TEV

**<sup>ST</sup> 70MG & 5,600U TABLET**

02454475	APO-ALENDRONATE/VITAMIN D3	APX
02314940	FOSAVANCE	FRS
02429160	SANDOZ ALENDRONATE/CHOLECALCIFEROL	SDZ
02403641	TEVA-ALENDRONATE/CHOLECALCIFEROL	TEV

**DENOSUMAB (PROLIA)**

Limited use benefit (prior approval required).

For women with postmenopausal osteoporosis who have failed or have a contraindication to bisphosphonates due to hypersensitivity or abnormalities of the esophagus (e.g., esophageal stricture or achalasia);

AND who have at least two of the following:

- age >70 years
- a prior fragility fracture
- a bone mineral density (BMD) T-score  $\leq$  -2.5

Maximum dose covered is 60mg per 6-month period.

**60MG/ML SOLUTION**

02343541	PROLIA	AMG
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**DENOSUMAB (XGEVA)**

Limited use benefit (prior approval required).

For the prevention of skeletal-related events (SREs) in patients with castrate-resistant prostate cancer (CRPC) with:

- one or more documented bone metastases; AND
- good performance status (ECOG performance status score of 0, 1, or 2).

**120MG/1.7ML SOLUTION**

02368153	XGEVA	AMG
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**92:24.00 BONE RESORPTION INHIBITORS****ETIDRONATE DISODIUM****<sup>ST</sup> 200MG TABLET**

02248686	ACT ETIDRONATE	ACG
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**ETIDRONATE DISODIUM, CALCIUM CARBONATE****<sup>ST</sup> 400MG & 500MG TABLET**

02263866	ACT ETIDROCAL	ACG
02324199	NOVO-ETIDRONATECAL	TEV

**PAMIDRONATE DISODIUM****6MG SOLUTION**

02249677	PAMIDRONATE	OMG
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**9MG SOLUTION**

02246599	PAMIDRONATE	FKD
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**30MG SOLUTION**

02264951	PAMIDRONATE	SDZ
02244550	PAMIDRONATE DISODIUM	PFI

**60MG SOLUTION**

02264978	PAMIDRONATE	SDZ
02244551	PAMIDRONATE DISODIUM	PFI

**90MG SOLUTION**

02264986	PAMIDRONATE	SDZ
02244552	PAMIDRONATE DISODIUM	PFI
02245999	PMS-PAMIDRONATE	PMS

**RISEDRONATE SODIUM****<sup>ST</sup> 5MG TABLET**

02242518	ACTONEL	WAC
02298376	TEVA-RISEDRONATE	TEV

**<sup>ST</sup> 30MG TABLET**

02239146	ACTONEL	ALL
02298384	TEVA-RISEDRONATE	TEV

**<sup>ST</sup> 35MG TABLET**

02246896	ACTONEL	ALL
02353687	APO-RISEDRONATE	APX
02406306	AURO-RISEDRONATE	AUR
02309831	DOM-RISEDRONATE	DPC
02368552	JAMP-RISEDRONATE	JMP
02357984	MYLAN-RISEDRONATE	MYL
02302209	PMS-RISEDRONATE	PMS
02347474	RISEDRONATE	PDL
02352141	RISEDRONATE	SIV
02370255	RISEDRONATE	SAN
02411407	RISEDRONATE-35	SIV
02341077	RIVA-RISEDRONATE	RIV
02327295	SANDOZ RISEDRONATE	SDZ
02298392	TEVA-RISEDRONATE	TEV

**<sup>ST</sup> 150MG TABLET**

02316838	ACTONEL	ALL
02377721	APO-RISEDRONATE	APX
02424177	PMS-RISEDRONATE	PMS
02413809	TEVA-RISEDRONATE	TEV

**92:24.00 BONE RESORPTION INHIBITORS**

**ZOLEDRONIC ACID MONOHYDRATE**

Limited use benefit (prior approval required).

For the treatment of Paget's disease. Coverage will be granted for one dose per 12 month period;  
OR  
For women with postmenopausal osteoporosis who would otherwise be eligible for coverage of oral bisphosphonates, but who have a contraindication to bisphosphonates due to hypersensitivity or abnormalities of the esophagus (e.g., esophageal stricture or achalasia);  
AND who have at least two of the following:

- age >70 years
- a prior fragility fracture
- a bone mineral density (BMD) T-score ≤ - 2.5.

**5MG/100ML SOLUTION**

02269198	ACLASTA	NVR
02415100	TARO-ZOLEDRONIC ACID	TAR
02408082	ZOLEDRONIC ACID	TEV
02422433	ZOLEDRONIC ACID	REC

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

**ABATACEPT**

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Polyarticular juvenile idiopathic arthritis (pJIA) according to established criteria.

(Please refer to Appendix A).

**250MG POWDER FOR SOLUTION**

02282097	ORENCIA	BMS
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**125MG SOLUTION**

02402475	ORENCIA	BMS
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**ADALIMUMAB**

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.
- Psoriasis according to established criteria.
- Crohn's disease according to established criteria.
- Polyarticular juvenile idiopathic arthritis (pJIA) according to established criteria.
- Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

**40MG/VIAL SOLUTION**

02258595	HUMIRA	ABV
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**92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS**

**CERTOLIZUMAB PEGOL**

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic arthritis according to established criteria.
- Ankylosing spondylitis according to established criteria.

(Please refer to Appendix A).

**200MG/ML SOLUTION**

02331675	CIMZIA	UCB
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**ETANERCEPT**

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.
- Polyarticular juvenile idiopathic arthritis (pJIA) according to established criteria.

(Please refer to Appendix A).

**25MG/VIAL INJECTION**

02242903	ENBREL	PED
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**50MG/ML INJECTION**

02274728	ENBREL	PED
99100373	ENBREL SURECLICK	AMG

**GOLIMUMAB**

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.
- Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

**50MG/0.5ML SOLUTION**

02324776	SIMPONI	JSO
02324784	SIMPONI	JSO

**100MG/ML SOLUTION**

02413175	SIMPONI	JSO
02413183	SIMPONI	JSO

**INFLIXIMAB (INFLECTRA)**

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.
- Psoriasis according to established criteria.
- Crohn's disease according to established criteria.
- Fistulizing Crohn's disease according to established criteria.
- Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

**100MG POWDER FOR SOLUTION**

02419475	INFLECTRA	HOS
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## 92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

### INFLIXIMAB (REMICADE)

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Crohn's disease according to established criteria.
- Fistulizing Crohn's disease according to established criteria.

(Please refer to Appendix A).

#### 100MG/VIAL POWDER FOR SOLUTION

02244016 REMICADE JSO

### LEFLUNOMIDE

#### <sup>ST</sup> 10MG TABLET

02256495 APO-LEFLUNOMIDE APX  
02241888 ARAVA SAC  
02351668 LEFLUNOMIDE SAN  
02415828 LEFLUNOMIDE PDL  
02288265 PMS-LEFLUNOMIDE PMS  
02283964 SANDOZ LEFLUNOMIDE SDZ  
02261251 TEVA-LEFLUNOMIDE TEV

#### <sup>ST</sup> 20MG TABLET

02256509 APO-LEFLUNOMIDE APX  
02241889 ARAVA SAC  
02351676 LEFLUNOMIDE SAN  
02415836 LEFLUNOMIDE PDL  
02288273 PMS-LEFLUNOMIDE PMS  
02283972 SANDOZ LEFLUNOMIDE SDZ  
02261278 TEVA-LEFLUNOMIDE TEV

### TOCILIZUMAB (IV)

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Systemic juvenile idiopathic arthritis (sJIA) according to established criteria.
- Polyarticular juvenile idiopathic arthritis (pJIA) according to established criteria.

(Please refer to Appendix A).

#### 80MG/4ML SOLUTION

02350092 ACTEMRA HLR

#### 200MG/10ML SOLUTION

02350106 ACTEMRA HLR

#### 400MG/20ML SOLUTION

02350114 ACTEMRA HLR

### TOCILIZUMAB (SC)

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.

(Please refer to Appendix A).

#### 162MG SOLUTION

02424770 ACTEMRA HLR

## 92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

### TOFACITINIB CITRATE

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.

(Please refer to Appendix A).

#### 5MG TABLET

02423898 XELJANZ PFI

## 92:44.00 IMMUNOSUPPRESSIVE AGENTS

### AZATHIOPRINE

#### <sup>ST</sup> 50MG TABLET

02242907 APO-AZATHIOPRINE APX  
02243371 AZATHIOPRINE-50 PDL  
00004596 IMURAN ASP  
02231491 MYLAN-AZATHIOPRINE MYL  
02236819 TEVA-AZATHIOPRINE TEV

#### <sup>ST</sup> PDIN FOR EXTEMPORANEOUS MIXTURE

99503019 AZATHIOPRINE ORAL LIQUID UNK

### CYCLOSPORINE

Limited use benefit (prior approval required).

For transplant therapy.

#### <sup>ST</sup> 10MG CAPSULE

02237671 NEORAL NVR

#### <sup>ST</sup> 25MG CAPSULE

02150689 NEORAL NVR  
02247073 SANDOZ CYCLOSPORINE SDZ

#### <sup>ST</sup> 50MG CAPSULE

02150662 NEORAL NVR  
02247074 SANDOZ CYCLOSPORINE SDZ

#### <sup>ST</sup> 100MG CAPSULE

02150670 NEORAL NVR  
02242821 SANDOZ CYCLOSPORINE SDZ

#### <sup>ST</sup> 100MG/ML SOLUTION

02244324 APO-CYCLOSPORINE APX  
02150697 NEORAL NVR

### MYCOPHENOLATE MOFETIL

Limited use benefit (prior approval required).

For transplant therapy.

#### <sup>ST</sup> 250MG CAPSULE

02383780 ACH-MYCOPHENOLATE ACC  
02352559 APO-MYCOPHENOLATE APX  
02192748 CELLCEPT HLR  
02386399 JAMP-MYCOPHENOLATE JMP  
02457369 MYCOPHENOLATE MOFETIL SAN  
02371154 MYLAN-MYCOPHENOLATE MYL  
02320630 SANDOZ MYCOPHENOLATE SDZ  
02364883 TEVA-MYCOPHENOLATE TEV

#### <sup>ST</sup> 500MG TABLET

02352567 APO-MYCOPHENOLATE APX  
02237484 CELLCEPT HLR  
02380382 JAMP-MYCOPHENOLATE JMP  
02378574 MYCOPHENOLATE ACC

**92:44.00 IMMUNOSUPPRESSIVE AGENTS****MYCOPHENOLATE MOFETIL**

Limited use benefit (prior approval required).

For transplant therapy.

**<sup>ST</sup> 500MG TABLET**

02457377	MYCOPHENOLATE MOFETIL	SAN
02370549	MYLAN-MYCOPHENOLATE	MYL
02313855	SANDOZ MYCOPHENOLATE	SDZ
02348675	TEVA-MYCOPHENOLATE	TEV

**MYCOPHENOLATE SODIUM**

Limited use benefit (prior approval required).

For transplant therapy.

**<sup>ST</sup> 180MG TABLET (ENTERIC COATED)**

02372738	APO-MYCOPHENOLIC ACID	APX
02264560	MYFORTIC	NVR

**<sup>ST</sup> 360MG TABLET (ENTERIC COATED)**

02372746	APO-MYCOPHENOLIC ACID	APX
02264579	MYFORTIC	NVR

**SIROLIMUS**

Limited use benefit (prior approval required).

Coverage will be provided as a second line therapy for patients failing mycophenolate mofetil.

**<sup>ST</sup> 1MG/ML SOLUTION**

02243237	RAPAMUNE	PFI
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**<sup>ST</sup> 1MG TABLET**

02247111	RAPAMUNE	PFI
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**TACROLIMUS MONOHYDRATE**

Limited use benefit (prior approval required).

For transplant therapy.

**<sup>ST</sup> 0.5MG CAPSULE**

02243144	PROGRAF	AST
02416816	SANDOZ TACROLIMUS	SDZ

**<sup>ST</sup> 1MG CAPSULE**

02175991	PROGRAF	AST
02416824	SANDOZ TACROLIMUS	SDZ

**<sup>ST</sup> 5MG CAPSULE**

02175983	PROGRAF	AST
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**<sup>ST</sup> 0.5MG CAPSULE (EXTENDED RELEASE)**

02296462	ADVAGRAF	AST
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**<sup>ST</sup> 1MG CAPSULE (EXTENDED RELEASE)**

02296470	ADVAGRAF	AST
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**<sup>ST</sup> 3MG CAPSULE (EXTENDED RELEASE)**

02331667	ADVAGRAF	AST
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**<sup>ST</sup> 5MG CAPSULE (EXTENDED RELEASE)**

02296489	ADVAGRAF	AST
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**<sup>ST</sup> 5MG CAPSULE (IMMEDIATE RELEASE)**

02416832	SANDOZ TACROLIMUS	SDZ
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**5MG/ML SOLUTION**

02176009	PROGRAF	AST
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**92:44.00 IMMUNOSUPPRESSIVE AGENTS****VEDOLIZUMAB**

Limited use benefit (prior approval required).

For the treatment of:

- Crohn's disease according to established criteria.
- Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

**300MG POWDER FOR SOLUTION**

02436841	ENTYVIO	TAK
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**92:92.00 OTHER MISCELLANEOUS THERAPEUTIC AGENTS****CYPROTERONE ACETATE****50MG TABLET**

00704431	ANDROCUR	BAY
02245898	CYPROTERONE	AAP
02390760	MED-CYPROTERONE	GMP
02395797	RIVA-CYPROTERONE	RIV

**CYPROTERONE ACETATE, ETHINYL ESTRADIOL****2MG & 35MCG TABLET**

02290308	CYESTRA-35	PAL
02233542	DIANE-35	BAY
02309556	NOVO-CYPROTERONE/ETHINYL ESTRADIOL	TEV
02425017	RAN-CYPROTERONE/ETHINYL ESTRADIOL	RBV

**INCOBOTULINUMTOXINA**

Limited use benefit (prior approval required).

For the treatment of:

- strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder in patients 12 years of age or older; OR
- cervical dystonia (spasmodic torticollis).

**50UNIT/VIAL POWDER FOR SOLUTION**

02371081	XEOMIN	MEZ
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**100U/VIAL POWDER FOR SOLUTION**

02324032	XEOMIN	MEZ
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**LANREOTIDE ACETATE****60MG/0.3ML SOLUTION (EXTENDED RELEASE)**

02283395	SOMATULINE AUTOGEL	IPS
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**90MG/0.3ML SOLUTION (EXTENDED RELEASE)**

02283409	SOMATULINE AUTOGEL	IPS
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**120MG/0.5ML SOLUTION (EXTENDED RELEASE)**

02283417	SOMATULINE AUTOGEL	IPS
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**92:92.00 OTHER MISCELLANEOUS  
THERAPEUTIC AGENTS****ONABOTULINUMTOXINA**

Limited use benefit (prior approval required).

For the treatment of:

- strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder in patients 12 years of age or older; OR
- cervical dystonia (spasmodic torticollis); OR
- urinary incontinence due to neurogenic detrusor over activity resulting from neurogenic bladder associated with MS or subcervical spinal cord injury.

**50IU INJECTION**

09857386 BOTOX ALL

**200IU INJECTION**

09857387 BOTOX ALL

**100IU POWDER FOR SOLUTION**

01981501 BOTOX ALL

**94:00 DEVICES****94:00.00 DEVICES****SPACER DEVICE**

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 2 spacer devices every 12 months.

**DEVICE**

96899962	AEROCHAMBER AC BOYZ	TRU
96899963	AEROCHAMBER AC GIRLZ	TRU
96899969	AEROCHAMBER PLUS FLOWVU LARGE	TRU
96899970	AEROCHAMBER PLUS FLOWVU MEDIUM	TRU
96899968	AEROCHAMBER PLUS FLOWVU MOUTH	TRU
96899971	AEROCHAMBER PLUS FLOWVU SMALL	TRU
96899977	AEROTRACH PLUS	UNK
96899956	COMPACT SPACE PLUS LARGE MASK	MIN
96899955	COMPACT SPACE PLUS MEDIUM MASK	MIN
96899953	COMPACT SPACE PLUS NO MASK	MIN
96899954	COMPACT SPACE PLUS SMALL MASK	MIN
99400507	E-Z SPACER	WEP
99400511	E-Z SPACER (MASK ONLY)	WEP
99400508	E-Z SPACER WITH SMALL MASK	WEP
99400501	OPTICHAMBER	AUC
96899961	OPTICHAMBER DIAMOND (CHAMBER)	AUC
96899958	OPTICHAMBER DIAMOND LARGE MASK	AUC
96899959	OPTICHAMBER DIAMOND MEDIUM MASK	AUC
96899960	OPTICHAMBER DIAMOND SMALL MASK	AUC
99400504	OPTICHAMBER LARGE MASK	AUC
99400503	OPTICHAMBER MEDIUM MASK	AUC
99400502	OPTICHAMBER SMALL MASK	AUC
99400505	OPTIHALER	AUC
99400787	POCKET CHAMBER	MCA
99400791	POCKET CHAMBER WITH ADULT MASK	MCA
99400788	POCKET CHAMBER WITH INFANT MASK	MCA
99400790	POCKET CHAMBER WITH MEDIUM MASK	MCA
99400789	POCKET CHAMBER WITH SMALL MASK	MCA
96899974	RESPICHAMBER SILICONE MEDIUM MASK	TRU
96899973	RESPICHAMBER SILICONE SMALL MASK	TRU
96899972	RESPICHAMBER VHC W MOUTHPIECE	TRU

**94:01.00 DEVICES (DIABETIC)****ADHESHIVE WIPES****MISCELLANEOUS**

97799671 SKIN PREP ADHESHIVE WIPES UNK

**INSULIN PUMP SUPPLIES**

Limited use benefit (prior approval required).

• Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR  
• Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

**DEVICE**

97799674 CARTRIDGE FOR IR200 UNK  
97799342 INSET 30 INFUSION SETS UNK  
99401038 INSULIN PUMP BATTERY AUC  
09991458 IV3000 SMW

**COMFORT ANGLED DEVICE**

97799682 COMFORT ANGLED INFSET 17MM UNK  
97799683 COMFORT ANGLED INFSET 17MM UNK

**COMFORT SHORT ANGLED DEVICE**

97799678 COMFORT SRT ANGLED INFSET 13 UNK  
97799679 COMFORT SRT ANGLED INFSET 13 UNK

**CONTACT DETACH DEVICE**

97799672 CONTACT DETACH 90 DEGREE  
6MMX60CM UNK  
97799610 CONTACT DETACH 90 DEGREE  
8MMX60CM UNK

**INSET II DEVICE**

97799685 INSET II 90 DEGREE 6MMX110CM UNK  
97799687 INSET II 90 DEGREE 6MMX60CM UNK  
97799684 INSET II 90 DEGREE 9MMX110CM UNK  
97799686 INSET II 90 DEGREE 9MMX60CM UNK

**MIO DEVICE**

97799491 MIO BLUE 6MMX18 MDT  
97799438 MIO BLUE 6MMX23 MDT  
97799490 MIO CLEAR 6MMX32 MDT  
97799489 MIO CLEAR 9MMX32 MDT  
97799492 MIO PINK 6MMX18 MDT  
97799437 MIO PINK 6MMX23 MDT

**OMNIPOD DEVICE**

09991327 PODS UNK

**PARADIGM SILHOUETTE DEVICE**

97799715 PARADIGM SILHOUETTE 13MMX 43 MDT  
97799485 PARADIGM SILHOUETTE  
13MMX18" MDT  
97799716 PARADIGM SILHOUETTE 13MMX23 MDT  
97799484 PARADIGM SILHOUETTE  
13MMX32" MDT  
97799718 PARADIGM SILHOUETTE 17MMX23 MDT  
97799483 PARADIGM SILHOUETTE  
17MMX32" MDT  
97799719 PARADIGM SILHOUETTE 17MMX43 MDT  
97799529 PARADIGM SILHOUETTE  
CANNULA 13MM MDT  
97799528 PARADIGM SILHOUETTE  
CANNULA 17MM MDT

**QUICK-SET DEVICE**

97799486 QUICK-SET 6MMX18 MDT

**94:01.00 DEVICES (DIABETIC)**

**INSULIN PUMP SUPPLIES**

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

**QUICK-SET DEVICE**

97799744	QUICK-SET 6MMX23 TUBING	MDT
97799487	QUICK-SET 6MMX32	MDT
97799743	QUICK-SET 6MMX43 TUBING	MDT
97799742	QUICK-SET 9MMX23 TUBING	MDT
97799488	QUICK-SET 9MMX32	MDT
97799741	QUICK-SET 9MMX43 TUBING	MDT

**RAPID-D DEVICE**

97799650	RAPID-D 10MM/110CM	ROD
97799652	RAPID-D 10MM/60CM	ROD
97799651	RAPID-D 10MM/80CM	ROD
97799656	RAPID-D 6MM/110CM	ROD
97799658	RAPID-D 6MM/60CM	ROD
97799657	RAPID-D 6MM/80CM	ROD
97799653	RAPID-D 8MM/110CM	ROD
97799655	RAPID-D 8MM/60CM	ROD
97799654	RAPID-D 8MM/80CM	ROD

**SURE-T DEVICE**

97799521	PARADIGM SURE-T 29G 6MMX18	MDT
97799520	PARADIGM SURE-T 29G 6MMX23	MDT
97799519	PARADIGM SURE-T 29G 8MMX23	MDT

**TENDER DEVICE**

97799644	TENDER-1 17MM/110CM	ROD
97799646	TENDER-1 17MM/60CM	ROD
97799645	TENDER-1 17MM/80CM	ROD
97799638	TENDER-2 17MM/110CM	ROD
97799640	TENDER-2 17MM/60CM	ROD
97799639	TENDER-2 17MM/80CM	ROD

**TENDER "MINI" DEVICE**

97799647	TENDER-1 MINI INF SET 13MM/110CM	ROD
97799649	TENDER-1 MINI INFSET 13MM/60CM	ROD
97799648	TENDER-1 MINI INFSET 13MM/80CM	ROD
97799641	TENDER-2 MINI INF SET 13MM/110CM	ROD
97799643	TENDER-2 MINI INFSET 13MM/60CM	ROD
97799642	TENDER-2 MINI INFSET 13MM/80CM	ROD

**ULTRAFLEX DEVICE**

97799665	ULTRAFLEX 1 10MM/110CM	ROD
97799667	ULTRAFLEX 1 10MM/60CM	ROD
97799666	ULTRAFLEX 1 10MM/80CM	ROD
97799668	ULTRAFLEX 1 8MM/110CM	ROD
97799670	ULTRAFLEX 1 8MM/60CM	ROD
97799669	ULTRAFLEX 1 8MM/80CM	ROD

**SYRINGE**

97799707	RESERVOIR PARADIGM 5X1.8ML	MDT
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**94:01.00 DEVICES (DIABETIC)**

**INSULIN PUMP SUPPLIES**

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

**SYRINGE**

97799706	RESERVOIR PARADIGM 7X3.0ML	MDT
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**ISOPROPYL ALCOHOL**

**0.5% PAD**

00809357	ALCOHOL SWABS	BTD
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**70% PAD**

00480452	ALCOHOL PREP	PDI
00977187	ALCOHOL SWABS 6893 BUTTERFLY	BTD
00977195	ALCOHOL SWABS 6896 (150)	BTD
02247809	ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS	TIP
99038349	ALCOHOL SWABS BD REGULAR	BTD
97799880	BD ALCOHOL SWABS	BTD
99438102	MONOJECT ALCOHOL WIPES	SHM
00795232	WEBCOL ALCOHOL PREP	COV

**LANCET**

**LANCET**

97799494	ACCU-CHEK FASTCLIK LANCET	ROD
97799495	ACCU-CHEK FASTCLIK LANCET	ROD
97799817	ACCU-CHEK MULTICLIX LANCET	ROD
97799946	ACCU-CHEK MULTICLIX LANCET	ROD
97799945	ACCU-CHEK SOFTCLIX LANCET	ROD
97799466	BG STAR LANCET	SAC
97799541	EZ HEALTH ORACLE LANCET	TRE
97799825	FINGERSTIX LANCET	BAY
97799292	FIRST CANADIAN HEALTH LANCETS	ARA
97799826	FREESTYLE LANCET	BAY
97799918	MICROLET LANCET	BAY
97799810	MPD THIN LANCET (NS)	MPD
97799811	MPD THIN LANCET (NS)	MPD
97799807	MPD ULTRA THIN LANCET (100)	MPD
97799808	MPD ULTRA THIN LANCET (200)	MPD
97799970	ONETOUCH ULTRASOFT LANCET	JAJ
97799348	ULTILET CLASSIC LANCET	UNK

**21G LANCET**

97799804	MONOLET 21G LANCET	TYC
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<sup>ST</sup> **28G LANCET**

97799232	DROPLET PERSONAL LANCET 28G	SFA
97799253	FIRST CANHEALTH 28G LANCET	ARA
97799766	ITEST SAFETY 28G LANCET	AUC
97799801	MONOLET THIN (MONOJECT) 28G	TYC

<sup>ST</sup> **30G LANCET**

97799233	DROPLET PERSONAL LANCET 30G	SFA
97799254	FIRST CANHEALTH 30G LANCET	ARA
97799388	MEDI+SURE SOFT 30G TWIST	MEC
97799389	MEDI+SURE SOFT 33G TWIST	MEC
97799431	ONE TOUCH DELICA 30G LANCET	JAJ

**94:01.00 DEVICES (DIABETIC)**

**LANCET**

**33G LANCET**

97799690	BD ULTRAFINE 33G LANCET	BTD
97799234	DROPLET PERSONAL LANCET 33G	SFA
97799255	FIRST CANHEALTH 33G LANCET	ARA
97799767	ITEST ULTRA-THIN 33G LANCET	AUC
97799501	ONETOUCH DELICA 33G LANCET	JAJ

**MAGNIFIER**

**DEVICE**

99400550	SYRINGE SCALE MAGNIFIER	UNK
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**PEN NEEDLE**

<sup>ST</sup> **NEEDLE**

97799433	BD AUTOSHIELD DUO SAFETY PEN NEEDLE	BDT
09991447	BD BLUNT 18GX1 1/2 FILTER	BDT
09991387	BD PRECISIONGLIDE 25GX1 NEEDLE	BTD
00909114	BD ULTRA-FINE III PEN NEEDLE	BTD
00897590	NOVOLIN-PEN NEEDLE	NOO
97799280	SURECOMFORT 29GX1/2 NEEDLE	UNK
97799269	SURECOMFORT 30GX5/16 NEEDLE	UNK
97799279	SURECOMFORT 31GX3/16 NEEDLE	UNK
97799268	SURECOMFORT 31GX5/16 NEEDLE	UNK
97799278	SURECOMFORT 32GX1/4 NEEDLE	UNK
97799267	SURECOMFORT 32GX5/32 NEEDLE	UNK

<sup>ST</sup> **29GX10MM NEEDLE**

97799238	DROPLET PEN NEEDLE 10MM 29G	SFA
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<sup>ST</sup> **29GX12.7MM NEEDLE**

97799561	SUPER-FINE STANDARD 29G-12.7MM	PMS
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<sup>ST</sup> **29GX12MM NEEDLE**

97799235	DROPLET PEN NEEDLE 12MM 29G	SFA
97799566	INSUPEN 29GX12MM NEEDLE	DPI
97799543	ULTICARE 29GX12MM PEN NEEDLE	UMI
97799991	UNIFINE 29G 12MM NEEDLE	AUC

<sup>ST</sup> **29GX8MM NEEDLE**

97799526	BD AUTOSHIELD PEN NEEDLES	BTD
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<sup>ST</sup> **30GX6MM NEEDLE**

97799911	NOVOFINE 30GX 6MM NEEDLE	NVC
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<sup>ST</sup> **30GX8MM NEEDLE**

97799567	INSUPEN 30GX8MM NEEDLE	DPI
97799910	NOVOFINE 30GX 8MM NEEDLE	NVC

<sup>ST</sup> **31GX4.5MM NEEDLE**

97799404	CLICKFINE PEN NEEDLE 31G 4.5MM	AUC
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<sup>ST</sup> **31GX5MM NEEDLE**

97799282	BD ULTRAFINE 31G 5MM PEN NEEDLE	BTD
97799239	DROPLET PEN NEEDLE 5MM 31G	SFA
97799563	SUPER-FINE MICRO 31G-5MM NEEDLE	PMS
97799426	UNIFINE PENTIPS 31GX5MM	AUC

<sup>ST</sup> **31GX6MM NEEDLE**

97799405	CLICKFINE PEN NEEDLE 31G 6MM	AUC
97799237	DROPLET PEN NEEDLE 6MM 31G	SFA

**94:01.00 DEVICES (DIABETIC)**

**PEN NEEDLE**

<sup>ST</sup> **31GX6MM NEEDLE**

97799364	INSULIN PEN NEEDLE 31GX6MM	MDT
97799569	INSUPEN 31GX6MM NEEDLE	DPI
97799545	ULTICARE 31GX6MM PEN NEEDLE	UMI
97799993	UNIFINE 31G.6MM NEEDLE	AUC

<sup>ST</sup> **31GX8MM NEEDLE**

97799281	BD ULTRAFINE 31G 8MM PEN NEEDLE	BTD
97799406	CLICKFINE PEN NEEDLE 31G 8MM	AUC
97799236	DROPLET PEN NEEDLE 8MM 31G	SFA
97799366	INSULIN PEN NEEDLE 31GX8MM	MDT
97799568	INSUPEN 31GX8MM NEEDLE	DPI
97799441	LIFE BRAND PEN NEEDLE 31G 8MM	HOD
97799562	SUPER-FINE XTRA 31G-8MM NEEDLE	PMS
97799544	ULTICARE 31GX8MM PEN NEEDLE	UMI
00963976	ULTRAFINE III NEEDLE 31G 8MM	BTD
97799992	UNIFINE 31G.8MM NEEDLE	AUC

<sup>ST</sup> **32GX4MM NEEDLE**

97799527	BD ULTRA-FINE NANO PEN NEEDLE	BTD
97799243	DROPLET PEN NEEDLE 4MM 32G	SFA
97799367	INSULIN PEN NEEDLE 32GX4MM	MDT
97799399	INSUPEN 32GX4MM NEEDLE	DPI
97799334	MONTKIDDY BLUE NEEDLE 32GX4MM	MDT
97799337	MONTKIDDY GREEN NEEDLE 32GX4MM	MDT
97799335	MONTKIDDY PINK NEEDLE 32GX4MM	MDT
97799336	MONTKIDDY YELLOW NEEDLE 32GX4MM	MDT
97799386	NOVOFINE PLUS 4MM NEEDLE	NOO
97799440	ULTICARE 32GX4MM PEN NEEDLE	DPI

<sup>ST</sup> **32GX5MM NEEDLE**

97799242	DROPLET PEN NEEDLE 5MM 32G	SFA
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<sup>ST</sup> **32GX6MM NEEDLE**

97799241	DROPLET PEN NEEDLE 6MM 32G	SFA
97799363	INSULIN PEN NEEDLE 32GX6MM	MDT
97799571	INSUPEN 32GX6MM NEEDLE	DPI

<sup>ST</sup> **32GX8MM NEEDLE**

97799240	DROPLET PEN NEEDLE 8MM 32G	SFA
97799365	INSULIN PEN NEEDLE 32GX8MM	MDT
97799570	INSUPEN 32GX8MM NEEDLE	DPI

<sup>ST</sup> **33GX4MM NEEDLE**

97799383	INSUPEN 33GX4MM NEEDLE	DPI
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**21G NEEDLE**

09991504	BD BUTTERFLY NEEDLE 21G	BTD
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<sup>ST</sup> **29G NEEDLE**

97799897	BD ULTRA-FINE PEN NEEDLE 29G	BTD
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<sup>ST</sup> **30G NEEDLE**

97799467	NOVOTWIST TIP 30G NEEDLE	NOO
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<sup>ST</sup> **32G NEEDLE**

97799821	NOVOFINE 32G TIP PEN NEEDLE	NOO
97799468	NOVOTWIST TIP 32G NEEDLE	NOO

**94:01.00 DEVICES (DIABETIC)****SHARPS CONTAINER****DEVICE**

99401026	BC SHARPS CONTAINER 1.4L	BTD
99401027	BD SHARPS CONTAINER 3.1L	BTD
99401033	SHARPS NESTABLE YELLOW LARGE 22.7L	UNK

**SYRINGE & NEEDLE****<sup>ST</sup> 27GX1/2 NEEDLE**

09991381	BD PRECISIONGLIDE 27GX1/2	BTD
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**<sup>ST</sup> 18G NEEDLE**

09991402	BD PRECISIONGLIDE 18GX1 1/2	BTD
09991401	BD PRECISIONGLIDE 18GX1 NEEDLE	BTD

**<sup>ST</sup> 25G NEEDLE**

09991385	BD PRECISIONGLIDE 25GX5/8	BTD
09991386	BD PRECISIONGLIDE 25GX7/8	BTD

**<sup>ST</sup> 26G NEEDLE**

09991384	BD PRECISIONGLIDE 26GX1/2	BTD
09991383	BD PRECISIONGLIDE 26GX3/8	BTD

**<sup>ST</sup> 27G NEEDLE**

09991382	BD PRECISIONGLIDE 27GX1 1/4	BTD
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**<sup>ST</sup> SYRINGE**

00977020	PLASTIPAK MICRO	BTD
97799510	ULTICARE LOW DEAD SPACE SYRINGE	UMI

**<sup>ST</sup> 0.25CC SYRINGE**

99002132	INSULIN SYR W/NEEDL 0.25CC	UNK
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**0.3CC SYRINGE**

00977961	BD MICRO-FINE 0.3CC SYRINGE	BTD
99002140	INSULIN SYR W/NEEDLE 0.3CC	UNK

**<sup>ST</sup> 0.5CC SYRINGE**

00920096	E-Z JE	RIV
99002159	INSULIN SYR W/NEEDLE 0.5CC	UNK
00977136	MONOJECT	BTD

**<sup>ST</sup> 0.5CC/1CC SYRINGE**

00977128	MONOJECT	MDT
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**<sup>ST</sup> 1CC SYRINGE**

00920061	E-Z JE	RIV
99002167	INSULIN SYR W/NEEDLE 1CC	UNK

**<sup>ST</sup> 1ML SYRINGE**

09991376	BD LUER-LOK TIP 1ML SYRINGE	BTD
09991375	BD SLIP TIP 1ML SYRINGE	BTD

**<sup>ST</sup> 3ML SYRINGE**

09991371	BD LUER-LOK TIP 3ML SYRINGE	BTD
09991372	BD SLIP TIP 3ML SYRINGE	BTD

**<sup>ST</sup> 5ML SYRINGE**

09991373	BD LUER-LOK TIP 5ML SYRINGE	BTD
09991374	BD SLIP TIP 5ML SYRINGE	BTD

**<sup>ST</sup> 8MM SYRINGE**

97799261	SURECOMFORT 5/16 IN 30GX0.3CC	UNK
97799272	SURECOMFORT 5/16 IN 30GX0.5CC	UNK
97799265	SURECOMFORT 5/16 IN 30GX1CC	UNK
97799273	SURECOMFORT 5/16 IN 31GX0.3CC	UNK
97799274	SURECOMFORT 5/16 IN 31GX0.3CC	UNK
97799263	SURECOMFORT 5/16 IN 31GX0.5CC	UNK
97799262	SURECOMFORT 5/16 IN 31GX1CC	UNK

**94:01.00 DEVICES (DIABETIC)****SYRINGE & NEEDLE****<sup>ST</sup> 10ML SYRINGE**

09991363	BD LUER-LOK TIP 10ML SYRINGE	BTD
09991364	BD SLIP TIP 10ML SYRINGE	BTD

**<sup>ST</sup> 12MM SYRINGE**

97799275	SURECOMFORT 1/2 IN 28GX1CC SYRINGE	UNK
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**<sup>ST</sup> 12.7MM SYRINGE**

97799257	SURECOMFORT 1/2 IN 28GX0.5CC	UNK
97799260	SURECOMFORT 1/2 IN 29GX0.3CC	UNK
97799259	SURECOMFORT 1/2 IN 29GX0.5CC	UNK
97799258	SURECOMFORT 1/2 IN 29GX1CC	UNK
97799264	SURECOMFORT 1/2 IN 30GX0.3CC	UNK
97799270	SURECOMFORT 1/2 IN 30GX0.5CC	UNK
97799271	SURECOMFORT 1/2 IN 30GX1CC	UNK

**<sup>ST</sup> 18GX1 1/2 SYRINGE**

09991349	BD LUER-LOK TIP 18GX1 1/2 SYRINGE	BTD
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**<sup>ST</sup> 20ML SYRINGE**

09991368	BD LUER-LOK TIP 20ML SYRINGE	BTD
09991369	BD SLIP TIP 20ML SYRINGE	BTD

**<sup>ST</sup> 21GX1 SYRINGE**

09991360	BD TUBERCULIN 21GX1 SYRINGE	BTD
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**<sup>ST</sup> 22GX1 1/2 SYRINGE**

09991341	BD LUER-LOK TIP 22GX1 1/2 SYRINGE	BTD
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**<sup>ST</sup> 23GX5/8 SYRINGE**

09991339	BD LUER-LOK TIP 25GX5/8 SYRINGE	BTD
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**<sup>ST</sup> 25GX1 SYRINGE**

09991338	BD LUER-LOK TIP 25GX1 SYRINGE	BTD
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**<sup>ST</sup> 25GX1 1/2 SYRINGE**

09991337	BD LUER-LOK TIP 25GX1 1/2 SYRINGE	BTD
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**<sup>ST</sup> 25GX5/8 SYRINGE**

09991359	BD TUBERCULIN 25GX5/8 SYRINGE	BTD
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**<sup>ST</sup> 26GX3/8 SYRINGE**

09991358	BD TUBERCULIN 26GX3/8 SYRINGE	BTD
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**<sup>ST</sup> 26GX5/8 SYRINGE**

09991361	BD SLIP TIP SUB Q 26G SYRINGE	BTD
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**<sup>ST</sup> 27GX1/2 SYRINGE**

09991356	BD TUBERCULIN 27GX1/2 SYRINGE	BTD
09991357	BD TUBERCULIN 27GX1/2 SYRINGE	BTD

**28GX0.5CC SYRINGE**

00920177	BD MICRO-FINE 28GX0.5CC SYRINGE	BTD
97799518	ULTICARE 1/2 IN 28GX0.5CC SYRINGE	UMI

**28GX1CC SYRINGE**

00920185	BD MICRO-FINE 28GX1CC SYRINGE	BTD
97799517	ULTICARE 1/2 IN 28GX1CC SYRINGE	UMI

**94:01.00 DEVICES (DIABETIC)****SYRINGE & NEEDLE**

<sup>ST</sup> <b>29GX0.3CC SYRINGE</b>		
97799509	ULTI SYG 1/2 IN 29GX0.3CC	UMI
97799999	ULTICARE 29GX0.3CC	AUC
97799887	ULTRA 29G3/10CC	BTD
<sup>ST</sup> <b>29GX0.5CC SYRINGE</b>		
97799888	BD ULTRA 29G.1/2CC SYRINGE	BTD
97799508	ULTI SYG 1/2 IN 29GX0.5CC	UMI
97799998	ULTICARE 29GX0.5CC	AUC
<sup>ST</sup> <b>29GX1CC SYRINGE</b>		
97799889	BD ULTRA 29G.1CC SYRINGE	BTD
97799507	ULTI SYG 1/2 IN 29GX1CC SYRINGE	UMI
97799997	ULTICARE 29GX0.1CC	AUC
<sup>ST</sup> <b>30GX0.3CC SYRINGE</b>		
97799551	ULTI SYG 1/2 IN 30GX0.3CC	UMI
97799506	ULTI SYG 5/16 IN 30GX0.3CC	UMI
97799996	ULTICARE 30GX0.3CC	AUC
97799886	ULTRA-FINE II 30GX0.3 CC SYRINGE	BTD
<sup>ST</sup> <b>30GX0.5CC SYRINGE</b>		
97799885	BD ULTRA-FINE II 30GX0.5CC SYRINGE	BTD
97799550	ULTI SYG 1/2 IN 30GX0.5CC	UMI
97799505	ULTI SYG 5/16 IN 30GX0.5CC	UMI
97799995	ULTICARE 30GX0.5CC	AUC
<sup>ST</sup> <b>30GX1CC SYRINGE</b>		
97799549	ULTI SYG 1/2 IN 30GX1CC SYRINGE	UMI
97799504	ULTI SYG 5/16 IN 30GX1CC SYRINGE	UMI
97799994	ULTICARE 30GX0.1CC	AUC
97799890	ULTRA-FINE II 30G.1CC	BTD
<sup>ST</sup> <b>30ML SYRINGE</b>		
09991377	BD LUER-LOK TIP 30ML SYRINGE	BTD
09991378	BD SLIP TIP 30ML SYRINGE	BTD
<sup>ST</sup> <b>31GX0.3CC SYRINGE</b>		
97799369	INSULIN 31GX0.3CC	MDT
97799548	ULTI SYG 5/16 IN 31GX0.3CC	UMI
97799513	ULTICARE 5/16 IN 31GX0.3CC SYRINGE	UMI
<sup>ST</sup> <b>31GX0.5CC SYRINGE</b>		
97799370	INSULIN 31GX0.5CC	MDT
97799547	ULTI SYG 5/16 IN 31GX0.5CC	UMI
97799512	ULTICARE 5/16 IN 31GX0.5CC SYRINGE	UMI
<sup>ST</sup> <b>31GX1CC SYRINGE</b>		
97799371	INSULIN 31GX1CC	MDT
97799546	ULTI SYG 5/16 IN 31GX1CC SYRINGE	UMI
97799511	ULTICARE 5/16 IN 31GX1CC SYRINGE	UMI
<sup>ST</sup> <b>31GX6MMX0.3CC SYRINGE</b>		
97799425	BD SYRINGE WITH ULTRA-FINE NEEDLE	BTD
<sup>ST</sup> <b>31X6MMX0.5CC SYRINGE</b>		
97799385	BD SYRINGE + NEEDLE	BTD

**94:01.00 DEVICES (DIABETIC)****SYRINGE & NEEDLE**

<sup>ST</sup> <b>31X6MMX1CC SYRINGE</b>		
97799384	BD SYRINGE + NEEDLE	BTD
<sup>ST</sup> <b>60ML SYRINGE</b>		
09991455	BD LUER-LOK TIP 60ML SYRINGE	BTD
09991454	BD SLIP TIP 60ML SYRINGE	BTD
<b>SYRINGE CASE</b>		
<b>DEVICE</b>		
99400552	MYHEALTH SYRINGE CASE-7	AUC
99400551	MYHEALTH SYRINGE CASE-SINGLE	AUC

**96:00 PHARMACEUTICAL AIDS****96:00.00 PHARMACEUTICAL AIDS****NUTRITIONAL SUPPLEMENT****POWDER**

09991319 SOURCE THICKEN UP 227G NVC

**THICKENING AGENT****POWDER**

12137029 RESOURCE THICKEN CLEAR NVC

**WATER****SOLUTION**

00905178 STERILE WATER UNK

99002264 STERILE WATER UNK

**APPENDIX A**  
**LIMITED USE BENEFITS AND CRITERIA**

**08:00 ANTI-INFECTIVE AGENTS****08:12.02 AMINOGLYCOSIDES****AMIKACIN (AMIKACIN SULFATE)**

Limited use benefit (prior approval required).

**250MG LIQUID**

02242971 AMIKACIN SULFATE SDZ

**08:12.06 CEPHALOSPORINS****CEFTAZIDIME (CEFTAZIDIME PENTAHYDRATE)**

Limited use benefit (prior approval required).

**1G POWDER FOR SOLUTION**

00886971 CEFTAZIDIME FKD

02437848 CEFTAZIDIME RAX

02212218 FORTAZ 1G GSK

**2G POWDER FOR SOLUTION**

00886955 CEFTAZIDIME FKD

02437856 CEFTAZIDIME RAX

02212226 FORTAZ 2G GSK

**3G POWDER FOR SOLUTION**

02439522 CEFTAZIDIME RAX

**6G POWDER FOR SOLUTION**

00886963 CEFTAZIDIME FKD

02437864 CEFTAZIDIME RAX

02212234 FORTAZ 6G GSK

**08:12.07 MISCELLANEOUS B-LACTAM ANTIBIOTICS****ERTAPENEM (ERTAPENEM SODIUM)**

Limited use benefit (prior approval required).

**1G POWDER FOR SOLUTION**

02247437 INVANZ FRS

**MEROPENEM (MEROPENEM TRIHYDRATE)**

Limited use benefit (prior approval required).

**500MG POWDER FOR SOLUTION**

02378787 MEROPENEM SDZ

02218488 MERREM AZC

**1G POWDER FOR SOLUTION**

02378795 MEROPENEM SDZ

02436507 MEROPENEM RAX

02218496 MERREM AZC

**08:12.16 PENICILLINS****PIPERACILLIN (PIPERACILLIN SODIUM), TAZOBACTAM (TAZOBACTAM SODIUM)**

Limited use benefit (prior approval required).

**2G & 0.25G POWDER FOR SOLUTION**

02299623 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM SDZ

02370158 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM TEV

**3G & 0.375G POWDER FOR SOLUTION**

02299631 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM SDZ

02308452 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM APX

02362627 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM RAX

02370166 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM TEV

**08:12.16 PENICILLINS****PIPERACILLIN (PIPERACILLIN SODIUM), TAZOBACTAM (TAZOBACTAM SODIUM)**

Limited use benefit (prior approval required).

**4G & 0.5G POWDER FOR SOLUTION**

02299658	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02308460	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	APX
02362635	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX
02370174	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

**12G & 1.5G POWDER FOR SOLUTION**

02330547	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02377748	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX

**36G & 4.5G POWDER FOR SOLUTION**

02439131	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX
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**08:12.18 QUINOLONES****LEVOFLOXACIN HEMIHYDRATE**

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

**250MG TABLET**

02315424	ACT LEVOFLOXACIN	TEV
02284707	APO-LEVOFLOXACIN	APX
02284677	PMS-LEVOFLOXACIN	PMS
02298635	SANDOZ LEVOFLOXACIN	SDZ
02248262	TEVA-LEVOFLOXACIN	TEV

**500MG TABLET**

02315432	ACT LEVOFLOXACIN	TEV
02284715	APO-LEVOFLOXACIN	APX
02415879	LEVOFLOXACIN	PDL
02284685	PMS-LEVOFLOXACIN	PMS
02298643	SANDOZ LEVOFLOXACIN	SDZ
02248263	TEVA-LEVOFLOXACIN	TEV

**750MG TABLET**

02315440	ACT LEVOFLOXACIN	TEV
02325942	APO-LEVOFLOXACIN	APX
02305585	PMS-LEVOFLOXACIN	PMS
02298651	SANDOZ LEVOFLOXACIN	SDZ
02285649	TEVA-LEVOFLOXACIN	TEV

**MOXIFLOXACIN HYDROCHLORIDE**

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

**400MG TABLET**

02404923	APO-MOXIFLOXACIN	APX
02432242	AURO-MOXIFLOXACIN	AUR
02242965	AVELOX	BAY
02443929	JAMP-MOXIFLOXACIN	JMP
02447061	JAMP-MOXIFLOXACIN	JMP
02447053	MAR-MOXIFLOXACIN	MAR
02457814	MED-MOXIFLOXACIN	GMP
02450976	RIVA-MOXIFLOXACIN	RIV
02383381	SANDOZ MOXIFLOXACIN	SDZ
02375702	TEVA-MOXIFLOXACIN	TEV

**08:12.24 TETRACYCLINES****MINOCYCLINE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For patients who cannot tolerate other tetracyclines or doxycycline.  
For patients with severe widespread acne who have failed on tetracycline or doxycycline.

**50MG CAPSULE**

02084090	APO-MINOCYCLINE	APX
02239667	DOM-MINOCYCLINE	DPC
02153394	MINOCYCLINE	PDL
02287226	MINOCYCLINE	SAN
02230735	MYLAN-MINOCYCLINE	MYL
02239238	PMS-MINOCYCLINE	PMS
02294419	PMS-MINOCYCLINE	PMS
02237313	SANDOZ MINOCYCLINE	SDZ
02108143	TEVA-MINOCYCLINE	TEV

**100MG CAPSULE**

02084104	APO-MINOCYCLINE	APX
02239668	DOM-MINOCYCLINE	DPC
02154366	MINOCYCLINE	PDL
02239982	MINOCYCLINE	IVX
02287234	MINOCYCLINE	SAN
02230736	MYLAN-MINOCYCLINE	MYL
02239239	PMS-MINOCYCLINE	PMS
02294427	PMS-MINOCYCLINE	PMS
02237314	SANDOZ MINOCYCLINE	SDZ
02108151	TEVA-MINOCYCLINE	TEV

**08:12.28 MISCELLANEOUS ANTIBIOTICS****LINEZOLID**

Limited use benefit (prior approval required).

Tablets:

For treatment of proven vancomycin-resistant enterococci (VRE) infections.  
For the treatment of proven methicillin-resistant staphylococcus aureus (MRSA) infections in patients who cannot tolerate vancomycin.

I.V. Solution:

When linezolid cannot be administered orally in the above mentioned situations;

**2MG/ML SOLUTION**

02402637	LINEZOLID	TEV
02243685	ZYVOXAM	PFI

**600MG TABLET**

02426552	APO-LINEZOLID	APX
02422689	SANDOZ LINEZOLID	SDZ
02243684	ZYVOXAM	PFI

**RIFAXIMIN**

Limited use benefit (prior approval required).

For reducing the risk of overt hepatic encephalopathy (HE) recurrence in patients:

- Who are unable to achieve adequate control of HE recurrence with a maximal tolerated dose of lactulose alone; AND
- When used in combination with a maximal tolerated dose of lactulose.

**<sup>ST</sup> 550MG TABLET**

02410702	ZAXINE	SLX
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**08:14.08 AZOLES****VORICONAZOLE**

Limited use benefit (prior approval required).

For the treatment of patients with invasive aspergillosis; OR  
For the treatment of culture proven invasive candidiasis with documented resistance to fluconazole.

**50MG TABLET**

02409674	APO-VORICONAZOLE	APX
02399245	SANDOZ VORICONAZOLE	SDZ
02396866	TEVA-VORICONAZOLE	TEV
02256460	VFEND	PFI

**200MG TABLET**

02409682	APO-VORICONAZOLE	APX
02399253	SANDOZ VORICONAZOLE	SDZ
02396874	TEVA-VORICONAZOLE	TEV
02256479	VFEND	PFI

**08:18.08 ANTIRETROVIRALS****TENOFOVIR DISOPROXIL FUMARATE**

Limited use benefit (prior approval required).

For the treatment of patients with HIV-1 infection who have failed or have experienced adverse events to an alternative agent.  
For the treatment of patients with chronic hepatitis B infection who have cirrhosis documented on radiologic or histologic grounds and a HBV concentration above 2,000 IU/mL.

**245MG TABLET**

02247128	VIREAD	GIL
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**08:18.20 INTERFERONS****PEGINTERFERON ALFA-2A**

Limited use benefit (prior approval required).

For the treatment of patients with chronic hepatitis B infection who have a HBV DNA concentration above 2,000 IU/mL without decompensated cirrhosis, upon the written request of a hepatologist or other specialist in this area.

**180MCG/0.5ML SOLUTION**

02248077	PEGASYS	HLR
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**PEGINTERFERON ALFA-2A, RIBAVIRIN**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or other specialist in this area.  
• For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).  
• For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

**180MCG/0.5ML & 200MG KIT**

02253429	PEGASYS RBV	HLR
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**180MCG/1ML & 200MG KIT**

02253410	PEGASYS RBV	HLR
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**PEGINTERFERON ALFA-2B, RIBAVIRIN**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or other specialist in this area.  
• For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).  
• For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

**50MCG/0.5ML & 200MG KIT**

02254573	PEGETRON KIT	FRS
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**80MCG/0.5ML & 200MG KIT**

02254581	PEGETRON	FRS
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**100MCG/0.5ML & 200MG KIT**

02254603	PEGETRON	FRS
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**08:18.20 INTERFERONS****PEGINTERFERON ALFA-2B, RIBAVIRIN**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or other specialist in this area.

- For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).
- For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

**120MCG/0.5ML & 200MG KIT**

02254638 PEGETRON

FRS

**150MCG/0.5ML & 200MG KIT**

02254646 PEGETRON

FRS

**08:18.32 NUCLEOSIDES AND NUCLEOTIDES****ADEFOVIR DIPIVOXIL**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis B infection when used in combination with lamivudine in patients who have developed failure to lamivudine, as defined by an increase in HBV DNA of  $\geq 1 \log_{10}$  IU/mL above the nadir, measured on two separate occasions within an interval of at least one month, after the first three months of lamivudine therapy, and when failure to lamivudine is not due to poor adherence to therapy.

**10MG TABLET**

02420333 APO-ADEFOVIR

APX

02247823 HEPSERA

GIL

**ENTECAVIR MONOHYDRATE**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis B infection in patients with cirrhosis documented on radiologic or histologic grounds and a HBV DNA concentration above 2000IU/mL.

**0.5MG TABLET**

02396955 APO-ENTECAVIR

APX

02448777 AURO-ENTECAVIR

AUR

02282224 BARACLUDE

BMS

02430576 PMS-ENTECAVIR

PMS

**08:18.40 HCV ANTIVIRALS****ASUNAPREVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:

Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND

Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND

Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

AND

Fibrosis stage of F2 or greater (Metavir scale or equivalent); OR

Fibrosis stage less than F2 AND at least one of the following:

- Co-infection with HIV or hepatitis B virus;
- Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);
- Post organ transplant (liver and/or non-liver transplant);
- Extra-hepatic manifestations;
- Chronic kidney disease stage 3,4, or 5 as defined by the NKF KDOQI;
- Patient with diabetes receiving treatment with anti-diabetic drugs;
- Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**100MG CAPSULE**

02452294 SUNVEPRA

BMS

**08:18.40 HCV ANTIVIRALS****DACLATASVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:

Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND

Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND

Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

AND

Fibrosis stage of F2 or greater (Metavir scale or equivalent); OR

Fibrosis stage less than F2 AND at least one of the following:

- Co-infection with HIV or hepatitis B virus;
- Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);
- Post organ transplant (liver and/or non-liver transplant);
- Extra-hepatic manifestations;
- Chronic kidney disease stage 3, 4, or 5 as defined by the NKF KDOQI;
- Patient with diabetes receiving treatment with anti-diabetic drugs;
- Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**30MG TABLET**

02444747 DAKLINZA

BMS

**60MG TABLET**

02444755 DAKLINZA

BMS

**ELBASVIR, GRAZOPREVR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:

Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND

Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND

Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

AND

Fibrosis stage of F2 or greater (Metavir scale or equivalent); OR

Fibrosis stage less than F2 AND at least one of the following:

- Co-infection with HIV or hepatitis B virus;
- Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);
- Post organ transplant (liver and/or non-liver transplant);
- Extra-hepatic manifestations;
- Chronic kidney disease stage 3, 4, or 5 as defined by the NKF KDOQI;
- Patient with diabetes receiving treatment with anti-diabetic drugs;
- Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**50MG & 100MG TABLET**

02451131 ZEPATIER

FRS

**OMBITASVIR, PARITAPREVR, RITONAVIR, DASABUVIR**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C virus (HCV) Genotype 1 infection in adults with a liver fibrosis stage  $\geq$  F2 (Metavir score or equivalent);

AND

Patient is unable to take the following chronic hepatitis C medications based on intolerance/contraindication:

- Epclusa (sofosbuvir-velpatasvir)
- Harvoni (ledipasvir-sofosbuvir)
- Zepatier (elbasvir-grazoprevir)
- Daklinza (daclatasvir) + Sunvepra (asunaprevir)

**Criteria & Duration**

Treatment naïve and experienced Genotype 1b, non-cirrhotic\* - 12 weeks.

Treatment naïve and experienced Genotype 1a, non-cirrhotic - 12 weeks in combination with RBV.

Treatment naïve and experienced Genotype 1b, cirrhotic - 12 weeks in combination with RBV.

Treatment naïve and experienced (prior relapses and prior partial responders) Genotype 1a, cirrhotic - 12 weeks in combination with RBV.

Treatment experienced Genotype 1a, with cirrhosis, and who have had a previous null response to pegIFN and RBV - 24 weeks in combination with RBV.

\*Holkira Pak with ribavirin is recommended in patients with an unknown Genotype 1 subtype or with mixed Genotype 1 infection.

**250MG & 12.5MG & 75MG & 50MG TABLET**

02436027 HOLKIRA PAK

ABV

**08:18.40 HCV ANTIVIRALS****RIBAVIRIN**

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C.

**200MG TABLET**

02439212 IBAVYR

PED

**400MG TABLET**

02425890 IBAVYR

PED

**600MG TABLET**

02425904 IBAVYR

PED

**SIMEPREVIR SODIUM**

Limited use benefit (prior approval required).

For the treatment of chronic Hepatitis C in treatment-naïve and treatment-experienced patients who meet all of the following criteria:

- Chronic hepatitis C virus (HCV) genotype 1 infection; AND
- Detectable levels of HCV RNA in the last six months; AND
- Fibrosis stage F2 or greater (Metavir scale or equivalent); AND
- Patient has not received a prior full therapeutic course of boceprevir or telaprevir.

Not eligible for coverage:

- Patients currently being treated with another HCV antiviral agent.
- Patients who have previously received a treatment course of Galexos (Re-treatment requests will not be considered).

**150MG CAPSULE**

02416441 GALEXOS

JSO

**SOFOSBUVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:

Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND

Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND

Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

AND

Fibrosis stage of F2 or greater (Metavir scale or equivalent); OR

Fibrosis stage less than F2 AND at least one of the following:

- Co-infection with HIV or hepatitis B virus;
- Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);
- Post organ transplant (liver and/or non-liver transplant);
- Extra-hepatic manifestations;
- Chronic kidney disease stage 3, 4, or 5 as defined by the NKF KDOQI;
- Patient with diabetes receiving treatment with anti-diabetic drugs;
- Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**400MG TABLET**

02418355 SOVALDI

GIL

**08:18.40 HCV ANTIVIRALS****SOFOSBUVIR, LEDIPASVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:

Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND

Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND

Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

AND

Fibrosis stage of F2 or greater (Metavir scale or equivalent); OR

Fibrosis stage less than F2 AND at least one of the following:

- Co-infection with HIV or hepatitis B virus;
- Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);
- Post organ transplant (liver and/or non-liver transplant);
- Extra-hepatic manifestations;
- Chronic kidney disease stage 3,4, or 5 as defined by the NKF KDOQI;
- Patient with diabetes receiving treatment with anti-diabetic drugs;
- Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**400MG & 90MG TABLET**

02432226 HARVONI

GIL

**SOFOSBUVIR, VELPATASVIR**

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection who meet ALL of the following criteria:

Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND

Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND

Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

AND

Fibrosis stage of F2 or greater (Metavir scale or equivalent); OR

Fibrosis stage less than F2 AND at least one of the following:

- Co-infection with HIV or hepatitis B virus;
- Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis);
- Post organ transplant (liver and/or non-liver transplant);
- Extra-hepatic manifestations;
- Chronic kidney disease stage 3,4, or 5 as defined by the NKF KDOQI;
- Patient with diabetes receiving treatment with anti-diabetic drugs;
- Woman of childbearing age planning pregnancy within the next 12 months

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

**400MG & 100MG TABLET**

02456370 EPCLUSA

GIL

**08:36.00 URINARY ANTI-INFECTIVES****FOSFOMYCIN TROMETHAMINE**

Limited use benefit (prior approval required).

For the treatment of women (>12 years old) with:

- Urinary tract infections with organisms resistant to first line therapy; OR
- Urinary tract infections in pregnancy when first-line agents are contraindicated.

**3G/PK POWDER**

02240335 MONUROL

PAL

**10:00 ANTINEOPLASTIC AGENTS****10:00.00 ANTINEOPLASTIC AGENTS****ABIRATERONE ACETATE**

Limited use benefit (prior approval required).

Initial coverage criteria (Initial approval for 12 months)

For the treatment of metastatic castration resistant prostate cancer patients (mCRPC) who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy (ADT) and who have not received prior chemotherapy if they meet the following criteria:

- Used in combination with prednisone; AND
- Patient has an ECOG performance status of 0 or 1.

For the treatment of metastatic castration resistant prostate cancer patients (mCRPC) who progressed on docetaxel-based chemotherapy if they meet the following criteria:

- Used in combination with prednisone; AND
- Patient has an ECOG performance status  $\leq$  2; AND
- Abiraterone is not used as an add-on therapy to enzalutamide (Xtandi); AND
- Abiraterone has not been used in the pre-docetaxel setting.

Renewal coverage criteria (Renewal for 12 months)

There is no objective evidence of disease progression

**250MG TABLET**

02371065 ZYTIGA

JSO

**500MG TABLET**

02457113 ZYTIGA

JSO

**AFATINIB DIMALEATE**

Limited use benefit (prior approval required).

For the treatment of patients with advanced Non-Small Cell Lung Cancer (NSCLC) who meet ALL of the following criteria:

- First line treatment of patients; AND
- EGFR mutation positive; AND
- Advanced or metastatic adenocarcinoma of the lung; AND
- An ECOG performance status of 0 or 1.

Criteria for assessment every six (6) month:

- There is no objective evidence of disease progression.

Use of afatinib precludes the use of any other EGFR inhibitor as a subsequent line of therapy.

**20MG TABLET**

02415666 GIOTRIF

BOE

**30MG TABLET**

02415674 GIOTRIF

BOE

**40MG TABLET**

02415682 GIOTRIF

BOE

**COBIMETINIB (COBIMETINIB FUMARATE)**

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for cobimetinib (Cotellic):

For the first-line treatment of patients with metastatic or unresectable melanoma in combination with vemurafenib (Zelboraf).

AND for patients who meet the following criteria:

- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG performance status of 0 to 1.

Renewal coverage criteria (6 months):

There is no objective evidence of disease progression.

**20MG TABLET**

02452340 COTELLIC

HLR

**10:00.00 ANTINEOPLASTIC AGENTS****ENZALUTAMIDE**

Limited use benefit (prior approval required).

For the treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) who are/have:

- Asymptomatic or mildly symptomatic after failure of androgen deprivation therapy (ADT) who have not received prior chemotherapy; AND
- Have an ECOG performance status of 0 or 1 with no risk factors for seizures; OR
- Progressed on docetaxel-based chemotherapy with an ECOG performance status  $\leq 2$  and no risk factors for seizures; AND
- Would be an alternative to abiraterone for patients in the post-docetaxel setting but would not be an add-on therapy to abiraterone treatment.

Patients previously treated with abiraterone would not be eligible for enzalutamide unless unable to tolerate abiraterone.

Use of enzalutamide in the post-docetaxel setting is not permitted if previously used in the pre-chemotherapy setting.

**40MG CAPSULE**

02407329 XTANDI

AST

**ERLOTINIB HYDROCHLORIDE**

Limited use benefit (prior approval required).

Treatment of non-small cell lung cancer (NSCLC) after failure of at least one prior chemotherapy regimen, and whose EGFR expression status is positive or unknown.

**25MG TABLET**

02269007 TARCEVA

HLR

02377691 TEVA-ERLOTINIB

TEV

**100MG TABLET**

02454386 PMS-ERLOTINIB

PMS

02269015 TARCEVA

HLR

02377705 TEVA-ERLOTINIB

TEV

**150MG TABLET**

02454394 PMS-ERLOTINIB

PMS

02269023 TARCEVA

HLR

02377713 TEVA-ERLOTINIB

TEV

**IDELALISIB**

Limited use benefit (prior approval required).

Criteria for initial six month coverage:

- For the treatment of patients with relapsed chronic lymphocytic leukemia (CLL) in combination with rituximab. Treatment should continue until unacceptable toxicity or disease progression.

Criteria for assessment every six months:

- There is no objective evidence of disease progression.

**100MG TABLET**

02438798 ZYDELIG

GIL

**150MG TABLET**

02438801 ZYDELIG

GIL

**IMATINIB MESYLATE**

Limited use benefit (prior approval required).

- For the treatment of patients with chronic myeloid leukemia (CML) in blast crisis, accelerated phase, or in chronic phase.
- For the treatment of patients with gastrointestinal stromal tumour.
- For newly diagnosed adult patients with Philadelphia chromosome-positive (CML).

**100MG TABLET**

02355337 APO-IMATINIB

APX

02253275 GLEEVEC

NVR

02397285 NAT-IMATINIB

NPH

02431114 PMS-IMATINIB

PMS

02399806 TEVA-IMATINIB

TEV

**400MG TABLET**

02355345 APO-IMATINIB

APX

02253283 GLEEVEC

NVR

**10:00.00 ANTINEOPLASTIC AGENTS****IMATINIB MESYLATE**

Limited use benefit (prior approval required).

- For the treatment of patients with chronic myeloid leukemia (CML) in blast crisis, accelerated phase, or in chronic phase.
- For the treatment of patients with gastrointestinal stromal tumour.
- For newly diagnosed adult patients with Philadelphia chromosome-positive (CML).

**400MG TABLET**

02397293 NAT-IMATINIB

NPH

02431122 PMS-IMATINIB

PMS

02399814 TEVA-IMATINIB

TEV

**LENALIDOMIDE**

Limited use benefit (prior approval not required).

For the treatment of Myelodysplastic syndrome (MDS)

Initial coverage criteria (Initial approval for 6 months):

- Demonstrated diagnosis of Myelodysplastic syndrome (MDS) on bone marrow aspiration; AND
- Documented presence of del(5q) abnormality by standard cytogenetic or fluorescence in situ hybridization; AND
- International prognostic scoring system (IPSS) risk category low or intermediate-1; AND
- Transfusion-dependent symptomatic anemia.

Renewal coverage criteria (Renewal for 12 months):

- Patient has demonstrated a reduction in transfusion requirements of at least 50%.

For the treatment of Refractory/relapsed Multiple Myeloma after one prior therapy (MM-AOPT)

Initial coverage criteria (Initial approval for 12 months):

- Progressive Multiple Myeloma; AND
- For use in combination with dexamethasone; AND
- Patient is refractory to initial or subsequent treatments or has relapsed after the conclusion of prior treatments and is suitable for further chemotherapy; OR
- Patient has completed at least one full treatment regimen as initial therapy and has demonstrated an intolerance to their current chemotherapy.

Renewal coverage criteria (Renewal for 12 months):

- There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

For the treatment of Newly diagnosed Multiple Myeloma for patients who are not eligible for autologous stem cell transplant - (MM-TNE)

Initial coverage criteria (Initial approval for 12 months):

- As a first-line treatment option for newly diagnosed patients with multiple myeloma who are not candidates for autologous stem-cell transplant; AND
- For use in combination with dexamethasone; AND
- Who have an ECOG performance status of 0 to 2.

Renewal coverage criteria (Renewal for 12 months):

- There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

For the maintenance treatment for newly diagnosed Multiple Myeloma post-autologous stem cell transplant

Initial coverage criteria (Initial approval for 12 months):

- Newly diagnosed Multiple Myeloma; AND
- The disease is stable or improved, with no evidence of progression after autologous stem-cell transplant.

Coverage is provided for lenalidomide at an initial dose of 10 mg daily. Doses adjustments of up to 15 mg daily may be required based on individual patient characteristics/response.

Renewal coverage criteria (Renewal for 12 months):

- There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

**5MG CAPSULE**

02304899 REVLIMID

UNK

**10MG CAPSULE**

02304902 REVLIMID

UNK

**15MG CAPSULE**

02317699 REVLIMID

UNK

**20MG CAPSULE**

02440601 REVLIMID

UNK

**25MG CAPSULE**

02317710 REVLIMID

UNK

**10:00.00 ANTINEOPLASTIC AGENTS****PAZOPANIB (PAZOPANIB HYDROCHLORIDE)**

Limited use benefit (prior approval required).

Initial coverage criteria ( 12 months)

For the first-line treatment of patients with advanced or metastatic clear cell renal carcinoma; AND  
Patient has an ECOG performance status of 0 to 2.

Renewal coverage criteria (12 months)

There is no objective evidence of disease progression.

**200MG TABLET**

02352303 VOTRIENT

NVR

**PONATINIB HYDROCHLORIDE**

Limited use benefit (prior approval required).

Criteria for initial six (6) month coverage:

- For the treatment of patients who have confirmed T315i mutation positive disease, independent of previous TKI therapy; OR
- Treatment of last resort for patients with intolerances or contraindications to imatinib and all other second generation TKI's (dasatinib, nilotinib, bosutinib); OR
- For the treatment of patients with chronic phase chronic myeloid leukemia (CML) who have resistance/disease progression after at least two prior lines of TKI therapy where Iclusig would be available as third-line TKI option; OR
- For the treatment of patients with accelerated phase or blast phase CML or Ph+ ALL who have resistance or disease progression after at least one second generation TKI therapy; AND
- An ECOG performance status of 0 to 2.

Note: Second generation TKI's (dasatinib, nilotinib, bosutinib) are not covered as options after ponatinib.

Criteria for assessment every six (6) month:

- There is no objective evidence of disease progression.

**15MG TABLET**

02437333 ICLUSIG

ARI

**45MG TABLET**

02437341 ICLUSIG

ARI

**RITUXIMAB**

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Initial coverage is provided for 24 weeks at a dose of 1000 mg x 2 doses at 0 & 2 weeks.

- Prescribed by a rheumatologist

For the treatment of adult patients with severely active rheumatoid arthritis who have failed to respond to a trial of an anti-TNF agent. Treatment should be combined with methotrexate. Rituximab should not be used in combination with anti-TNF agents.

For continued coverage for rituximab beyond twenty-four weeks, patient must meet all the following criteria:

- Initially prescribed by a rheumatologist;

AND

Patient has been assessed after the twentieth to twenty-fourth week of rituximab therapy and meets the response criteria of:

- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of GRANULOMATOSIS POLYANGIITIS OR MICROSCOPIC POLYANGIITIS

Coverage is provided at a dose of 375 mg/m<sup>2</sup>body surface area, administered as an IV infusion once weekly for 4 weeks.

For the induction of remission in patients with severely active granulomatosis with polyangiitis or microscopic polyangiitis; AND

- Who have failed an adequate trial of cyclophosphamide; OR
- Who have a contraindication to cyclophosphamide.

**10MG/ML SOLUTION**

02241927 RITUXAN

HLR

**10:00.00 ANTINEOPLASTIC AGENTS****SUNITINIB MALATE**

Limited use benefit (Prior approval required).

Criteria for initial six month coverage of Sutent:

- For patients with histologically proven unresectable or recurrent/metastatic GIST who have failed or are unable to tolerate imatinib therapy. Sunitinib will not be funded concomitantly with imatinib.

Criteria for assessment at every six months:

- There is no objective evidence of disease progression.

**12.5MG CAPSULE**

02280795 SUTENT

PFI

**25MG CAPSULE**

02280809 SUTENT

PFI

**50MG CAPSULE**

02280817 SUTENT

PFI

**TEMOZOLOMIDE**

Limited use benefit (prior approval required).

For treatment of adult patients with glioblastoma multiform or anaplastic astrocytoma, and documented evidence of recurrence or progression after standard therapy (resection, radiotherapy, and chemotherapy).

For treatment of adult patients with newly diagnosed glioblastoma multiform concomitantly with radiotherapy and then as maintenance treatment.

**5MG CAPSULE**

02441160 ACT TEMOZOLOMIDE

ACG

02443473 TARO-TEMOZOLOMIDE

TAR

02241093 TEMODAL

FRS

**20MG CAPSULE**

02395274 ACT TEMOZOLOMIDE

ACG

02443481 TARO-TEMOZOLOMIDE

TAR

02241094 TEMODAL

FRS

**100MG CAPSULE**

02395282 ACT TEMOZOLOMIDE

ACG

02443511 TARO-TEMOZOLOMIDE

TAR

02241095 TEMODAL

FRS

**140MG CAPSULE**

02395290 ACT TEMOZOLOMIDE

ACG

02413116 APO-TEMOZOLOMIDE

APX

02443538 TARO-TEMOZOLOMIDE

TAR

02312794 TEMODAL

FRS

**250MG CAPSULE**

02395312 ACT TEMOZOLOMIDE

ACG

02443554 TARO-TEMOZOLOMIDE

TAR

02241096 TEMODAL

FRS

**VEMURAFENIB**

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for vemurafenib (Zelboraf):

For the first-line treatment of patients with metastatic or unresectable melanoma as monotherapy; OR

For the first-line treatment of patients with metastatic or unresectable melanoma in combination with cobimetinib (Cotellic)

AND for patients who meet the following criteria:

- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG performance status of 0 to 1.

Renewal coverage criteria (6 months):

There is no objective evidence of disease progression.

<sup>ST</sup> **240MG TABLET**

02380242 ZELBORAF

HLR

**12:00 AUTONOMIC DRUGS****12:04.00 PARASYMPATHOMIMETIC AGENTS****DONEPEZIL HYDROCHLORIDE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

**<sup>ST</sup> 5MG TABLET**

02419866	ACCEL-DONEPEZIL	ACP
02397595	ACT DONEPEZIL	ACG
02362260	APO-DONEPEZIL	APX
02232043	ARICEPT	PFI
02400561	AURO-DONEPEZIL	AUR
02412853	BIO-DONEPEZIL	BMI
02402645	DONEPEZIL	ACC
02416417	DONEPEZIL	PDL
02420597	DONEPEZIL	SIV
02425343	ECL-DONEPEZIL	ECL
02404419	JAMP-DONEPEZIL	JMP
02416948	JAMP-DONEPEZIL	JMP
02402092	MAR-DONEPEZIL	MAR
02359472	MYLAN-DONEPEZIL	MYL
02439557	NAT-DONEPEZIL	NPH
02322331	PMS-DONEPEZIL	PMS
02381508	RAN-DONEPEZIL	RBY
02412918	RIVA-DONEPEZIL	RIV
02328666	SANDOZ DONEPEZIL	SDZ
02428482	SEPTA DONEPEZIL	SPT
02340607	TEVA-DONEPEZIL	TEV

**<sup>ST</sup> 10MG TABLET**

02419874	ACCEL-DONEPEZIL	ACP
02397609	ACT DONEPEZIL	ACG
02362279	APO-DONEPEZIL	APX
02232044	ARICEPT	PFI
02400588	AURO-DONEPEZIL	AUR
02412861	BIO-DONEPEZIL	BMI
02402653	DONEPEZIL	ACC
02416425	DONEPEZIL	PDL
02420600	DONEPEZIL	SIV
02425351	ECL-DONEPEZIL	ECL
02404427	JAMP-DONEPEZIL	JMP
02416956	JAMP-DONEPEZIL	JMP
02402106	MAR-DONEPEZIL	MAR
02359480	MYLAN-DONEPEZIL	MYL
02439565	NAT-DONEPEZIL	NPH
02322358	PMS-DONEPEZIL	PMS
02381516	RAN-DONEPEZIL	RBY
02412934	RIVA-DONEPEZIL	RIV
02328682	SANDOZ DONEPEZIL	SDZ

**12:04.00 PARASYMPATHOMIMETIC AGENTS****DONEPEZIL HYDROCHLORIDE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
  - Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
  - Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
  - Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.
- Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

<sup>ST</sup> **10MG TABLET**

02428490 SEPTA DONEPEZIL

SPT

02340615 TEVA-DONEPEZIL

TEV

**GALANTAMINE HYDROBROMIDE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
  - Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
  - Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
  - Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.
- Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

<sup>ST</sup> **8MG CAPSULE (EXTENDED RELEASE)**

02425157 AURO-GALANTAMINE ER

AUR

02443015 GALANTAMINE

SAN

02416573 GALANTAMINE ER

PDL

02420821 MAR-GALANTAMINE ER

MAR

02339439 MYLAN-GALANTAMINE ER

MYL

02316943 PAT-GALANTAMINE ER

KLA

02398370 PMS-GALANTAMINE ER

PMS

02377950 TEVA-GALANTAMINE ER

TEV

<sup>ST</sup> **16MG CAPSULE (EXTENDED RELEASE)**

02425165 AURO-GALANTAMINE ER

AUR

02443023 GALANTAMINE

SAN

02416581 GALANTAMINE ER

PDL

02420848 MAR-GALANTAMINE ER

MAR

02339447 MYLAN-GALANTAMINE ER

MYL

02316951 PAT-GALANTAMINE ER

KLA

02398389 PMS-GALANTAMINE ER

PMS

02377969 TEVA-GALANTAMINE ER

TEV

<sup>ST</sup> **24MG CAPSULE (EXTENDED RELEASE)**

02425173 AURO-GALANTAMINE ER

AUR

02443031 GALANTAMINE

SAN

02416603 GALANTAMINE ER

PDL

02420856 MAR-GALANTAMINE ER

MAR

02339455 MYLAN-GALANTAMINE ER

MYL

02316978 PAT-GALANTAMINE ER

KLA

02398397 PMS-GALANTAMINE ER

PMS

02377977 TEVA-GALANTAMINE ER

TEV

**12:04.00 PARASYMPATHOMIMETIC AGENTS****RIVASTIGMINE HYDROGEN TARTRATE**

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

- Diagnosis of mild to moderate Alzheimer's disease; AND
  - Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
  - Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
  - Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.
- Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:

- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

**<sup>ST</sup> 1.5MG CAPSULE**

02336715	APO-RIVASTIGMINE	APX
02242115	EXELON	NVR
02401614	MED-RIVASTIGMINE	GMP
02305984	NOVO-RIVASTIGMINE	NOP
02306034	PMS-RIVASTIGMINE	PMS
02311283	RATIO-RIVASTIGMINE	TEV
02416999	RIVASTIGMINE	PDL
02324563	SANDOZ RIVASTIGMINE	SDZ

**<sup>ST</sup> 3MG CAPSULE**

02336723	APO-RIVASTIGMINE	APX
02242116	EXELON	NVR
02401622	MED-RIVASTIGMINE	GMP
02305992	NOVO-RIVASTIGMINE	NOP
02306042	PMS-RIVASTIGMINE	PMS
02311291	RATIO-RIVASTIGMINE	TEV
02417006	RIVASTIGMINE	PDL
02324571	SANDOZ RIVASTIGMINE	SDZ

**<sup>ST</sup> 4.5MG CAPSULE**

02336731	APO-RIVASTIGMINE	APX
02242117	EXELON	NVR
02401630	MED-RIVASTIGMINE	GMP
02306018	NOVO-RIVASTIGMINE	NOP
02306050	PMS-RIVASTIGMINE	PMS
02311305	RATIO-RIVASTIGMINE	TEV
02417014	RIVASTIGMINE	PDL
02324598	SANDOZ RIVASTIGMINE	SDZ

**<sup>ST</sup> 6MG CAPSULE**

02336758	APO-RIVASTIGMINE	APX
02242118	EXELON	NVR
02401649	MED-RIVASTIGMINE	GMP
02306026	NOVO-RIVASTIGMINE	NOP
02306069	PMS-RIVASTIGMINE	PMS
02311313	RATIO-RIVASTIGMINE	TEV
02417022	RIVASTIGMINE	PDL
02324601	SANDOZ RIVASTIGMINE	SDZ

**<sup>ST</sup> 2MG/ML SOLUTION**

02245240	EXELON	NVR
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**12:08.08 ANTIMUSCARINICS / ANTISPASMODICS****ACLIDINIUM BROMIDE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

**400MCG POWDER**

02409720 TUDORZA GENUAIR

AZC

**GLYCOPYRRONIUM BROMIDE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

**50MCG CAPSULE**

02394936 SEEBRI BREEZHALER

NVR

**INDACATEROL MALEATE, GLYCOPYRRONIUM BROMIDE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

**110MCG & 50MCG CAPSULE**

02418282 ULTIBRO BREEZHALER

NVR

**TIOTROPIUM BROMIDE MONOHYDRATE**

Limited use benefit (prior approval required).

For patients with chronic obstructive pulmonary disease (COPD) and who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

**18MCG CAPSULE**

02246793 SPIRIVA

BOE

**2.5MCG SOLUTION**

02435381 SPIRIVA RESPIMAT

BOE

**TRIMEBUTINE MALEATE**

Limited use benefit (prior approval required).

For the treatment and relief of symptoms associated with functional bowel disorders including Irritable Bowel Syndrome (IBS), spastic colon, spastic colitis and mucous colitis; OR

In postoperative paralytic ileus in order to accelerate the resumption of the intestinal transit following abdominal surgery.

**100MG TABLET**

02349027 AA-TRIMEBUTINE

AAP

02245663 TRIMEBUTINE

AAP

**200MG TABLET**

02349035 AA-TRIMEBUTINE

AAP

00803499 MODULON

APC

02245664 TRIMEBUTINE

AAP

**UMECLIDIUM BROMIDE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

**62.5MCG POWDER**

02423596 INCRUSE ELLIPTA

GSK

**12:08.08 ANTIMUSCARINICS / ANTISPASMODICS****UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

**62.5MCG/25MCG POWDER**

02418401 ANORO ELLIPTA

GSK

**12:12.08 BETA ADRENERGIC AGONISTS****ACLIDINIUM BROMIDE, FORMOTEROL FUMARATE DIHYDRATE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- Moderate to severe COPD, as defined by spirometry; AND
- Inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

**400MCG & 12MCG POWDER**

02439530 DUAKLIR GENUAIR

AZC

**FLUTICASONE FUROATE, VILANTEROL TRIFENATATE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

OR

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

**100MCG & 25MCG POWDER**

02408872 BREO ELLIPTA

GSK

**FLUTICASONE FUROATE, VILANTEROL TRIFENATATE (ASTHMA)**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

**200MCG & 25MCG POWDER**

02444186 BREO ELLIPTA

GSK

**FORMOTEROL FUMARATE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of a rapid-onset, short-duration bronchodilator.

OR

For the treatment of Chronic Obstructive Pulmonary Disease (COPD) in patients not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist.

**12MCG/CAPSULE CAPSULE**

02230898 FORADIL

NVR

**FORMOTEROL FUMARATE DIHYDRATE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of rapid onset, short duration bronchodilator.

**6MCG/DOSE POWDER**

02237225 OXEZE TURBUHALER

AZC

**12MCG/DOSE POWDER**

02237224 OXEZE TURBUHALER

AZC

**12:12.08 BETA ADRENERGIC AGONISTS****FORMOTEROL FUMARATE DIHYDRATE, BUDESONIDE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

OR

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

**6MCG & 100MCG/INHALATION POWDER**

02245385 SYMBICORT 100 TURBUHALER

AZC

**6MCG & 200MCG/INHALATION POWDER**

02245386 SYMBICORT 200 TURBUHALER

AZC

**FORMOTEROL FUMARATE DIHYDRATE, MOMETASONE FUROATE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of rapid onset, short duration bronchodilator.

**5MCG & 100MCG/INHALATION AEROSOL**

02361752 ZENHALE

FRS

**5MCG & 200MCG/INHALATION AEROSOL**

02361760 ZENHALE

FRS

**5MCG & 50MCG/INHALATION AEROSOL**

02361744 ZENHALE

FRS

**INDACATEROL MALEATE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:

- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

**75MCG CAPSULE**

02376938 ONBREZ BREEZHALER

NVR

**OLODATEROL HYDROCHLORIDE, TIOTROPIUM BROMIDE MONOHYDRATE**

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

**2.5MCG & 2.5MCG SOLUTION**

02441888 INSPIOLTO RESPIMAT

BOE

**SALMETEROL XINAFOATE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of a rapid-onset, short-duration bronchodilator.

OR

For the treatment of Chronic Obstructive Pulmonary Disease (COPD) in patients not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist.

**50MCG/INHALATION POWDER**

02214261 SEREVENT DISKHALER

GSK

02231129 SEREVENT DISKUS

GSK

**12:12.08 BETA ADRENERGIC AGONISTS****SALMETEROL XINAFOATE, FLUTICASONE PROPIONATE**

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

OR

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:

- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

**25MCG & 125MCG AEROSOL**

02245126 ADVAIR 125

GSK

**25MCG & 250MCG AEROSOL**

02245127 ADVAIR 250

GSK

**50MCG & 100MCG POWDER**

02240835 ADVAIR 100 DISKUS

GSK

**50MCG & 250MCG POWDER**

02240836 ADVAIR 250 DISKUS

GSK

**50MCG & 500MCG POWDER**

02240837 ADVAIR 500 DISKUS

GSK

**12:20.04 CENTRALL ACTING SKELETAL MUSCLE RELAXANTS****CYCLOBENZAPRINE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

For relief of muscle spasm associated with acute, painful musculoskeletal conditions. Coverage is limited to 60mg per day for three (3) weeks renewable every two (2) months.

**10MG TABLET**

02177145 APO-CYCLOBENZAPRINE

APX

02348853 AURO-CYCLOBENZAPRINE

AUR

02220644 CYCLOBENZAPRINE

PDL

02287064 CYCLOBENZAPRINE

SAN

02424584 CYCLOBENZAPRINE

SIV

02238633 DOM-CYCLOBENZAPRINE

DPC

02357127 JAMP-CYCLOBENZAPRINE

JMP

02231353 MYLAN-CYCLOBENZAPRINE

MYL

02249359 PHL-CYCLOBENZAPRINE

PHH

02212048 PMS-CYCLOBENZAPRINE

PMS

02242079 RIVA-CYCLOBENZAPRINE

RIV

02080052 TEVA-CYCLOBENZAPRINE

TEV

**TIZANIDINE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For treatment of spasticity in patients with multiple sclerosis, who have failed therapy with or are intolerant to baclofen.

**4MG TABLET**

02239170 PAL-TIZANIDINE

PAL

02259893 TIZANIDINE

AAP

**12:92.00 MISCELLANEOUS AUTONOMIC DRUGS****NICOTINE (GUM)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

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.

**<sup>ST</sup> 2MG GUM**

02091933 NICORETTE GUM

KIM

**12:92.00 MISCELLANEOUS AUTONOMIC DRUGS****NICOTINE (GUM)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

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.

<sup>ST</sup> **2MG GUM**

80015240 RUGBY NICOTINE POLACRILEX GUM

ACG

80000396 THRIVE NICOTINELL GUM

GSK

<sup>ST</sup> **4MG GUM**

02091941 NICORETTE GUM

KIM

80000118 NICOTINE GUM

PER

80000402 THRIVE NICOTINELL GUM

NVC

**NICOTINE (INHALER)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

Coverage is limited to 945 doses 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.

<sup>ST</sup> **10MG SPRAY**

02241742 NICORETTE INHALER

KIM

**NICOTINE (LOZENGE)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

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.

<sup>ST</sup> **1MG LOZENGE**

80007461 THRIVE NICOTINE LOZENGES

NVC

<sup>ST</sup> **2MG LOZENGE**

02247347 NICORETTE LOZENGE

KIM

80007464 THRIVE NICOTINE LOZENGES

NVC

<sup>ST</sup> **4MG LOZENGE**

02247348 NICORETTE LOZENGE

KIM

**NICOTINE (PATCH)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

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.

<sup>ST</sup> **5MG PATCH**

02028697 NICOTROL TRANSDERMAL

UNK

<sup>ST</sup> **7MG PATCH**

01943057 HABITROL

NVC

80044393 TRANSDERMAL NICOTINE

ACG

<sup>ST</sup> **10MG PATCH**

02029405 NICOTROL TRANSDERMAL

UNK

<sup>ST</sup> **14MG PATCH**

01943065 HABITROL

NVC

80013549 NICOTINE TRANSDERMAL SYSTEM

ADD

80044392 TRANSDERMAL NICOTINE

ACG

**12:92.00 MISCELLANEOUS AUTONOMIC DRUGS****NICOTINE (PATCH)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

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.

**<sup>ST</sup> 15MG PATCH**

02029413 NICOTROL TRANSDERMAL

UNK

**<sup>ST</sup> 18MG PATCH**

02241227 TRANSDERMAL NICOTINE PATCHDAY

NVC

**<sup>ST</sup> 21MG PATCH**

01943073 HABITROL

NVC

02241228 NICOTINE TRANSDERMAL

NVC

80014250 NICOTINE TRANSDERMAL SYSTEM

ADD

80044389 TRANSDERMAL NICOTINE

ACG

**<sup>ST</sup> 35MG PATCH**

02241226 TRANSDERMAL NICOTINE PATCHDAY

NVC

**<sup>ST</sup> 36MG PATCH**

02093111 NICODERM

KIM

**<sup>ST</sup> 78MG PATCH**

02093138 NICODERM

KIM

**<sup>ST</sup> 114MG PATCH**

02093146 NICODERM

KIM

**VARENICLINE TARTRATE**

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage will be limited to 165 tablets 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 varenicline (Champix®) when one year has elapsed from the day the initial prescription was filled.

**<sup>ST</sup> 0.5MG TABLET**

02291177 CHAMPIX

PFI

**<sup>ST</sup> 0.5MG & 1MG TABLET**

02298309 CHAMPIX STARTER PACK

PFI

**<sup>ST</sup> 1MG TABLET**

02291185 CHAMPIX

PFI

**20:00 BLOOD FORMATION COAGULATION AND THROMBOSIS****20:04.04 IRON PREPARATIONS****POLYSACCHARIDE IRON COMPLEX**

Limited use benefit (prior approval not required).

For children 12 years of age or under.

**15MG POWDER**

80033717 FERAMAX POWDER WATER SOLUBLE POLYSACCHARIDE IRON COMPLEX

BSY

**20:12.04 ANTICOAGULANTS****APIXABAN**

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score  $\geq 1$ ) with non-valvular atrial fibrillation who require apixaban for the prevention of stroke and systemic embolism AND in whom:

- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

OR

For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)

<sup>ST</sup> **2.5MG TABLET**

02377233 ELIQUIS

BMS

<sup>ST</sup> **5MG TABLET**

02397714 ELIQUIS

BMS

**DABIGATRAN ETEXILATE MESILATE**

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score  $\geq 1$ ) with non-valvular atrial fibrillation who require dabigatran etexilate for the prevention of stroke and systemic embolism AND in whom:

- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

<sup>ST</sup> **110MG CAPSULE**

02312441 PRADAXA

BOE

<sup>ST</sup> **150MG CAPSULE**

02358808 PRADAXA

BOE

**RIVAROXABAN**

Limited use benefit (prior approval required).

Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto) for Stroke Prevention in Atrial Fibrillation (SPAF)

For at-risk patients (CHADS2 score  $\geq 1$ ) with non-valvular atrial fibrillation who require rivaroxaban for the prevention of stroke and systemic embolism AND in whom:

- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation is not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e., no access to INR testing service at a laboratory, clinic, pharmacy, and at home)

Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto)

For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE).

<sup>ST</sup> **10MG TABLET**

02316986 XARELTO

BAY

<sup>ST</sup> **15MG TABLET**

02378604 XARELTO

BAY

<sup>ST</sup> **20MG TABLET**

02378612 XARELTO

BAY

**20:16.00 HEMATOPOIETIC AGENTS****PEGFILGRASTIM**

Limited use benefit (prior approval required).

**CHEMOTHERAPY SUPPORT****Primary Prophylaxis**

For use in previously untreated patients receiving a moderate to severely myelosuppressive chemotherapy regimen (i.e.  $\geq 40\%$  incidence of febrile neutropenia). Febrile neutropenia is defined as a temperature  $\geq 38.5^{\circ}\text{C}$  or  $> 38.0^{\circ}\text{C}$  three times in a 24 hour period and neutropenia with an absolute neutrophil count (ANC)  $< 0.5 \times 10^9/\text{L}$ .

**Secondary Prophylaxis**

For use in patients receiving myelosuppressive chemotherapy who have experienced an episode of febrile neutropenic sepsis or profound neutropenia in a previous cycle of chemotherapy; OR

For use in patients who have experienced a dose reduction or treatment delay longer than one week, due to neutropenia.

The recommended dosage of pegfilgrastim is a single subcutaneous injection of 6 mg, administered once per cycle of chemotherapy. Pegfilgrastim should be administered no sooner than 24 hours after the administration of cytotoxic chemotherapy.

**10MG/ML SOLUTION**

02249790 NEULASTA

AMG

**PLERIXAFOR**

Limited use benefit (prior approval not required).

For use in combination with filgrastim to mobilize hematopoietic stem cells for subsequent autologous transplantation in patients with:

- Non-Hodgkin's lymphoma (NHL); OR
- Multiple myeloma (MM);

AND

- Prescribed by an oncologist or hematologist.

AND if one of the following are met

- A PBCD34+ count of  $< 10$  cells/uL after 4 days of filgrastim; OR
- Less than 50% of the target CD34 yield is achieved on the 1st day of apheresis (after being mobilized with filgrastim alone or following chemotherapy); OR
- If a patient has failed a previous stem cell mobilization with filgrastim alone or following chemotherapy.

Reimbursement is limited to a maximum of 4 doses (0.24mg/kg given daily) for a single mobilization attempt.

The dose of Mozobil is limited to a maximum of 40mg per day

**20MG SOLUTION**

02377225 MOZOBIL

SAC

**24:00 CARDIOVASCULAR DRUGS****24:12.12 PHOSPHODIESTERASE INHIBITORS****SILDENAFIL CITRATE**

Limited use benefit (prior approval required).

Must be initiated by a Pulmonary Hypertension specialist

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.

<sup>ST</sup> **20MG TABLET**

02418118 APO-SILDENAFIL R

APX

02412179 PMS-SILDENAFIL R

PMS

02319500 RATIO-SILDENAFIL R

TEV

02279401 REVATIO

PFI

**TADALAFIL**

Limited use benefit (prior approval required).

Must be initiated by a Pulmonary Hypertension specialist

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.

<sup>ST</sup> **20MG TABLET**

02338327 ADCIRCA

LIL

02421933 APO-TADALAFIL PAH

APX

**24:12.92 MISCELLANEOUS VASODILATING AGENTS****AMBRISENTAN**

Limited use benefit (prior approval required).

Maximum dose covered is 10 mg once 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; AND

- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

<sup>ST</sup> **5MG TABLET**

02307065 VOLIBRIS

GSK

<sup>ST</sup> **10MG TABLET**

02307073 VOLIBRIS

GSK

**BOSENTAN MONOHYDRATE**

Limited use benefit (prior approval required).

Maximum dose covered is 125 mg twice 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; AND

- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

<sup>ST</sup> **62.5MG TABLET**

02386194 ACT BOSENTAN

ACG

02399202 APO-BOSENTAN

APX

02383497 MYLAN-BOSENTAN

MYL

02383012 PMS-BOSENTAN

PMS

02386275 SANDOZ BOSENTAN

SDZ

02244981 TRACLEER

ACN

<sup>ST</sup> **125MG TABLET**

02386208 ACT BOSENTAN

ACG

02383500 MYLAN-BOSENTAN

MYL

02383020 PMS-BOSENTAN

PMS

02386283 SANDOZ BOSENTAN

SDZ

02244982 TRACLEER

ACN

**24:32.20 MINERALOCORTICOIDE (ALDOSTERONE) RECEPTOR ANTAGONISTS****EPLERENONE**

Limited use benefit (prior approval required).

For the treatment of patients with New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction (with ejection fraction  $\leq$  35%), as an adjunct to standard therapy.

Note: Patients must be on optimal therapy with an angiotensin-converting-enzyme (ACE) inhibitor or an angiotensin-receptor blocker (ARB), and a beta-blocker (unless contraindicated) at the recommended dose or maximal tolerated dose.

**25MG TABLET**

02323052 INSPRA

PFI

**50MG TABLET**

02323060 INSPRA

PFI

**24:32.92****VALSARTAN (SACUBITRIL VALSARTAN SODIUM HYDRATE COMPLEX), SACUBITRIL (SACUBITRIL VALSARTAN SODIUM HYDRATE COMPLEX)**

Limited use benefit (prior approval required).

For the treatment of New York Heart Association (NYHA) class II or III heart failure if the following criteria are met:

- Must be initiated by a physician experienced in the treatment of heart failure; AND
  - Left ventricular ejection fraction < 40%; AND
  - NYHA class II to III symptoms despite at least four weeks of treatment with an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB); OR If your patient has a contraindication or intolerance to ACEI or ARBs;
- AND
- Must be used in combination with a beta blocker and an aldosterone antagonist (if tolerated); OR If your patient has a contraindication or intolerance to beta blockers or aldosterone antagonists.

**26MG & 24MG TABLET**

02446928 ENTRESTO

NVR

**51MG & 49MG TABLET**

02446936 ENTRESTO

NVR

**103MG & 97MG TABLET**

02446944 ENTRESTO

NVR

**28:00 CENTRAL NERVOUS SYSTEM AGENTS****28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS****ACETYLSALICYLIC ACID**

Limited use benefit (prior approval is not required).

ASA 80 mg tablets are a benefit to clients age 21 years and under to allow access for use in pediatric conditions (e.g. Kawasaki Syndrome).

**<sup>ST</sup> 80MG TABLET**

02269139 ACETYLSALICYLIC ACID

JMP

02295563 LOWPRIN

EUR

02202360 RIVASA

RIV

**<sup>ST</sup> 80MG TABLET (CHEWABLE)**

02009013 ASAPHEN

PMS

02280167 ASATAB

ODN

02250675 EURO-ASA

EUR

02296004 LOWPRIN

SDZ

02429950 M-ASA

MAN

02311518 PRO-AAS

PDL

02202352 RIVASA

RIV

**<sup>ST</sup> 80MG TABLET (DELAYED RELEASE)**

02427176 ASA EC

SAN

02238545 ASAPHEN

PMS

02283905 JAMP-ASA

JMP

02311496 PRO-AAS

PDL

**DICLOFENAC SODIUM (TOPICAL)**

Limited use benefit (prior approval required).

For the treatment of osteoarthritis when:

- pain is inadequately controlled with acetaminophen AND a non-steroidal anti-inflammatory (NSAID); OR
- there is contraindication to acetaminophen and NSAID; OR
- there is intolerance to acetaminophen and NSAID.

**<sup>ST</sup> 1.5% SOLUTION**

02354403 APO-DICLOFENAC

APX

02434571 DICLOFENAC TOPICAL

RAX

02356783 PMS-DICLOFENAC

PMS

02420988 TARO-DICLOFENAC

TAR

**28:08.08 OPIATE AGONISTS****ACETAMINOPHEN, CAFFEINE CITRATE, CODEINE PHOSPHATE**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

**300MG & 15MG & 15MG TABLET**

00653241	RATIO-LENOLTEC NO 2	TEV
02163934	TYLENOL WITH CODEINE NO.2	JSO

**300MG & 15MG & 30MG TABLET**

00653276	RATIO-LENOLTEC NO 3	TEV
02163926	TYLENOL WITH CODEINE NO.3	JSO

**325MG & 30MG & 15MG TABLET**

00293504	ATASOL 15	CHU
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**325MG & 30MG & 30MG TABLET**

00293512	ATASOL 30	CHU
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**ACETAMINOPHEN, CODEINE PHOSPHATE**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

**32MG & 1.6MG/ML ELIXIR**

00816027	PMS-ACETAMINOPHEN	PMS
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**300MG & 30MG TABLET**

01999648	ACET CODEINE 30	PMS
02232658	PROCET-30	PDL
00608882	TEVA-EMTEC-30	TEV
00789828	TRIAEC-30	RIV

**ACETAMINOPHEN, OXYCODONE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

**325MG & 2.5MG TABLET**

01916491	PERCOCET-DEMI	BMS
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**325MG & 5MG TABLET**

02324628	APO-OXYCODONE/ACET	APX
01916548	ENDOCET	BMS
02361361	OXYCODONE/ACET	SAN
02327171	OXYCODONE-ACET	PDL
02242468	RIVACOCET	RIV
02307898	SANDOZ OXYCODONE/ACETAMINOPHEN	SDZ
00608165	TEVA-OXYCOCET	TEV

**ACETYLSALICYLIC ACID, OXYCODONE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**325MG & 5MG TABLET**

00608157	RATIO-OXYCODAN	TEV
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**28:08.08 OPIATE AGONISTS****CODEINE MONOHYDRATE, CODEINE SULFATE TRIHYDRATE**

Limited use benefit (prior approval required).

For treatment of:

- chronic pain and palliative care patients as an alternative to products containing codeine in combination with acetaminophen or ASA with or without caffeine; OR
- chronic pain and palliative care patients as an alternative to regular release codeine tablets when large doses are required.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**50MG TABLET (EXTENDED RELEASE)**

02230302 CODEINE CONTIN CR PFR

**100MG TABLET (EXTENDED RELEASE)**

02163748 CODEINE CONTIN CR PFR

**150MG TABLET (EXTENDED RELEASE)**

02163780 CODEINE CONTIN CR PFR

**200MG TABLET (EXTENDED RELEASE)**

02163799 CODEINE CONTIN CR PFR

**CODEINE PHOSPHATE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**5MG/ML LIQUID**

00050024 CODEINE PHOSPHATE ATL

**2MG/ML SOLUTION**

00380571 LINCTUS CODEINE ATL

**15MG TABLET**

02009889 CODEINE RIV

00593435 RATIO-CODEINE TEV

**30MG TABLET**

02009757 CODEINE RIV

02243979 PMS-CODEINE PMS

00593451 RATIO-CODEINE TEV

**FENTANYL**

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**12MCG/HR PATCH**

02386844 CO FENTANYL OBT

02395657 FENTANYL PDL

02396696 MYLAN-FENTANYL MATRIX MYL

02341379 PMS-FENTANYL MTX PMS

02330105 RAN-FENTANYL MATRIX RBY

02327112 SANDOZ FENTANYL SDZ

02311925 TEVA-FENTANYL TEV

**25MCG/HR PATCH**

02314630 APO-FENTANYL MATRIX APX

02386852 CO FENTANYL OBT

02275813 DURAGESIC JSO

02395665 FENTANYL PDL

**28:08.08 OPIATE AGONISTS****FENTANYL**

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**25MCG/HR PATCH**

02396718	MYLAN-FENTANYL MATRIX	MYL
02341387	PMS-FENTANYL MTX	PMS
02330113	RAN-FENTANYL MATRIX	RBV
02327120	SANDOZ FENTANYL	SDZ
02282941	TEVA-FENTANYL	TEV

**50MCG/HR PATCH**

02314649	APO-FENTANYL MATRIX	APX
02386879	CO FENTANYL	OBT
02275821	DURAGESIC	JSO
02395673	FENTANYL	PDL
02396726	MYLAN-FENTANYL MATRIX	MYL
02341395	PMS-FENTANYL MTX	PMS
02330121	RAN-FENTANYL MATRIX	RBV
02327147	SANDOZ FENTANYL	SDZ
02282968	TEVA-FENTANYL	TEV

**75MCG/HR PATCH**

02314657	APO-FENTANYL MATRIX	APX
02386887	CO FENTANYL	OBT
02275848	DURAGESIC	JSO
02395681	FENTANYL	PDL
02396734	MYLAN-FENTANYL MATRIX	MYL
02341409	PMS-FENTANYL MTX	PMS
02330148	RAN-FENTANYL MATRIX	RBV
02327155	SANDOZ FENTANYL	SDZ
02282976	TEVA-FENTANYL	TEV

**100MCG/HR PATCH**

02314665	APO-FENTANYL MATRIX	APX
02386895	CO FENTANYL	OBT
02275856	DURAGESIC	JSO
02395703	FENTANYL	PDL
02396742	MYLAN-FENTANYL MATRIX	MYL
02341417	PMS-FENTANYL MTX	PMS
02330156	RAN-FENTANYL MATRIX	RBV
02327163	SANDOZ FENTANYL	SDZ
02282984	TEVA-FENTANYL	TEV

**HYDROMORPHONE HYDROCHLORIDE**

Limited use benefit.

Prior approval required for controlled release capsules only. Regular release dosage forms are full benefits and do not require prior approval.

For treatment of moderate to severe chronic pain when other opioids such as morphine have been ineffective in controlling pain or in patients experiencing intolerable side effects.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**3MG CAPSULE (SUSTAINED RELEASE)**

02125323	HYDROMORPH CONTIN	PFR
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**28:08.08 OPIATE AGONISTS****HYDROMORPHONE HYDROCHLORIDE**

Limited use benefit.

Prior approval required for controlled release capsules only. Regular release dosage forms are full benefits and do not require prior approval.

For treatment of moderate to severe chronic pain when other opioids such as morphine have been ineffective in controlling pain or in patients experiencing intolerable side effects.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**4.5MG CAPSULE (SUSTAINED RELEASE)**

02359502 HYDROMORPH CONTIN PFR

**6MG CAPSULE (SUSTAINED RELEASE)**

02125331 HYDROMORPH CONTIN PFR

**9MG CAPSULE (SUSTAINED RELEASE)**

02359510 HYDROMORPH CONTIN PFR

**12MG CAPSULE (SUSTAINED RELEASE)**

02125366 HYDROMORPH CONTIN PFR

**18MG CAPSULE (SUSTAINED RELEASE)**

02243562 HYDROMORPH CONTIN PFR

**24MG CAPSULE (SUSTAINED RELEASE)**

02125382 HYDROMORPH CONTIN PFR

**30MG CAPSULE (SUSTAINED RELEASE)**

02125390 HYDROMORPH CONTIN PFR

**1MG/ML LIQUID**

00786535 DILAUDID PFR

01916386 PMS HYDROMORPHONE PMS

**3MG SUPPOSITORY**

01916394 PMS HYDROMORPHONE PMS

**1MG TABLET**

02364115 APO-HYDROMORPHONE APX

00705438 DILAUDID PFR

00885444 PMS-HYDROMORPHONE PMS

02319403 TEVA-HYDROMORPHONE TEV

**2MG TABLET**

02364123 APO-HYDROMORPHONE APX

00125083 DILAUDID PFR

00885436 PMS-HYDROMORPHONE PMS

02319411 TEVA-HYDROMORPHONE TEV

**4MG TABLET**

02364131 APO-HYDROMORPHONE APX

00125121 DILAUDID PFR

00885401 PMS-HYDROMORPHONE PMS

02319438 TEVA-HYDROMORPHONE TEV

**8MG TABLET**

02364158 APO-HYDROMORPHONE APX

00786543 DILAUDID PFR

00885428 PMS-HYDROMORPHONE PMS

02319446 TEVA-HYDROMORPHONE TEV

**28:08.08 OPIATE AGONISTS****METHADONE HYDROCHLORIDE (METADOL)**

Limited use benefit (prior approval required) with the following criteria:

Prescriber is registered with Health Canada and is eligible to prescribe methadone for the management of pain; AND  
For the management of moderate to severe cancer pain or chronic non-cancer pain, as an alternative to other opioids; OR  
For the management of pain for palliative care patients. Pharmacists may only dispense a maximum supply of 30 days at one time.

**1MG/ML SOLUTION**

02247694 METADOL PAL

**10MG/ML SOLUTION**

02241377 METADOL PAL

**1MG TABLET**

02247698 METADOL PAL

**5MG TABLET**

02247699 METADOL PAL

**10MG TABLET**

02247700 METADOL PAL

**25MG TABLET**

02247701 METADOL PAL

**MORPHINE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**1MG/ML SYRUP**

00614491 DOLORAL 1 ATL

00607762 RATIO-MORPHINE TEV

**5MG/ML SYRUP**

00614505 DOLORAL 5 ATL

00607770 RATIO-MORPHINE TEV

**10MG/ML SYRUP**

00690783 RATIO-MORPHINE TEV

**20MG/ML SYRUP**

00690791 RATIO-MORPHINE TEV

**MORPHINE SULFATE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**10MG CAPSULE (EXTENDED RELEASE)**

02019930 M-ESLON ETH

**15MG CAPSULE (EXTENDED RELEASE)**

02177749 M-ESLON ETH

**30MG CAPSULE (EXTENDED RELEASE)**

02019949 M-ESLON ETH

**60MG CAPSULE (EXTENDED RELEASE)**

02019957 M-ESLON ETH

**100MG CAPSULE (EXTENDED RELEASE)**

02019965 M-ESLON ETH

**200MG CAPSULE (EXTENDED RELEASE)**

02177757 M-ESLON ETH

**28:08.08 OPIATE AGONISTS****MORPHINE SULFATE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**20MG/ML DROP**

00621935 STATEX PAL

**50MG/ML DROP**

00705799 STATEX PAL

**5MG SUPPOSITORY**

00632228 STATEX PAL

**10MG SUPPOSITORY**

00632201 STATEX PAL

**20MG SUPPOSITORY**

00596965 STATEX PAL

**1MG/ML SYRUP**

00591467 STATEX PAL

**5MG/ML SYRUP**

00591475 STATEX PAL

**10MG/ML SYRUP**

00647217 STATEX PAL

**5MG TABLET**

00594652 STATEX PAL

**10MG TABLET**

00594644 STATEX PAL

**25MG TABLET**

00594636 STATEX PAL

**50MG TABLET**

00675962 STATEX PAL

**15MG TABLET (EXTENDED RELEASE)**

02350815 MORPHINE SR SAN

02015439 MS CONTIN SR PFR

02244790 SANDOZ MORPHINE SR SDZ

02302764 TEVA-MORPHINE SR TEV

**30MG TABLET (EXTENDED RELEASE)**

02350890 MORPHINE SR SAN

02014297 MS CONTIN SR PFR

02244791 SANDOZ MORPHINE SR SDZ

02302772 TEVA-MORPHINE SR TEV

**60MG TABLET (EXTENDED RELEASE)**

02350912 MORPHINE SR SAN

02014300 MS CONTIN SR PFR

02244792 SANDOZ MORPHINE SR SDZ

02302780 TEVA-MORPHINE SR TEV

**100MG TABLET (EXTENDED RELEASE)**

02014319 MS CONTIN SR PFR

02302799 TEVA-MORPHINE SR TEV

**200MG TABLET (EXTENDED RELEASE)**

02014327 MS CONTIN SR PFR

02302802 TEVA-MORPHINE SR TEV

**28:08.08 OPIATE AGONISTS****MORPHINE SULFATE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**5MG TABLET (IMMEDIATE RELEASE)**

02014203 MS IR PFR

**10MG TABLET (IMMEDIATE RELEASE)**

02014211 MS IR PFR

**20MG TABLET (IMMEDIATE RELEASE)**

02014238 MS IR PFR

**30MG TABLET (IMMEDIATE RELEASE)**

02014254 MS IR PFR

**MORPHINE SULFATE (KADIAN)**

Limited use benefit (prior approval required).

- For the treatment of opioid dependence where methadone and Suboxone are not available or not appropriate; OR
- For the treatment of chronic pain.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**10MG CAPSULE (SUSTAINED RELEASE)**

02242163 KADIAN BGP

09991310 KADIAN MAY

**20MG CAPSULE (SUSTAINED RELEASE)**

02184435 KADIAN BGP

09991311 KADIAN MAY

**50MG CAPSULE (SUSTAINED RELEASE)**

02184443 KADIAN BGP

09991312 KADIAN MAY

**100MG CAPSULE (SUSTAINED RELEASE)**

02184451 KADIAN BGP

09991313 KADIAN MAY

**OXYCODONE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**10MG SUPPOSITORY**

00392480 SUPEUDOL SDZ

**20MG SUPPOSITORY**

00392472 SUPEUDOL SDZ

**5MG TABLET**

02325950 OXYCODONE PDL

02231934 OXY-IR PFR

02319977 PMS-OXYCODONE PMS

00789739 SUPEUDOL SDZ

**10MG TABLET**

02325969 OXYCODONE PDL

02240131 OXY-IR PFR

02319985 PMS-OXYCODONE PMS

00443948 SUPEUDOL SDZ

**28:08.08 OPIATE AGONISTS****OXYCODONE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 400 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 12000 morphine equivalents over 30 days).

**20MG TABLET**

02325977	OXYCODONE	PDL
02319993	PMS-OXYCODONE	PMS
02262983	SUPEUDOL	SDZ

**20MG TABLET (IMMEDIATE RELEASE)**

02240132	OXY-IR	PFR
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**28:08.12 OPIATE PARTIAL AGONISTS****BUPRENORPHINE HYDROCHLORIDE, NALOXONE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For the treatment of opioid dependence when:

- The client must be 16 years or older.
- In cases where the client lives in a remote or isolated location, confirmation is required that the community has the ability to support Suboxone administration. These supports include the safe daily witnessing, storage and handling of the Suboxone doses. After this confirmation, NIHB will approve the Suboxone for the client.

**2MG & 0.5MG TABLET**

02408090	MYLAN-BUPRENORPHINE/NALOXONE	MYL
02424851	PMS-BUPRENORPHINE-NALOXONE	PMS
02295695	SUBOXONE	IND

**8MG & 2MG TABLET**

02408104	MYLAN-BUPRENORPHINE/NALOXONE	MYL
02424878	PMS-BUPRENORPHINE-NALOXONE	PMS
02295709	SUBOXONE	IND

**28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS****ACETAMINOPHEN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

**<sup>ST</sup> 80MG/ML DROP**

02027801	PEDIATRIX	TEV
00875988	TEMPRA INFANT	PAL

**<sup>ST</sup> 16MG/ML LIQUID**

01905848	ACETAMINOPHEN	TLI
00792713	PDP-ACETAMINOPHEN	PED
02263807	PEDIAPHEN	EUR
00884553	TEMPRA CHILDREN'S	PAL

**<sup>ST</sup> 32MG/ML LIQUID**

01901389	ACETAMINOPHEN	JMP
01958836	ACETAMINOPHEN	TLI
00792691	PDP-ACETAMINOPHEN	PED
02263831	PEDIAPHEN	EUR
02027798	PEDIATRIX	TEV
00875996	TEMPRA CHILDREN'S DOUBLE STRENGTH	PAL
02046040	TYLENOL	MCL

**<sup>ST</sup> 80MG/ML ORAL LIQUID**

01905864	ACETAMINOPHEN	TLI
02046059	TYLENOL	MCL

**28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS****ACETAMINOPHEN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

<sup>ST</sup> **80MG/ML SOLUTION**

01904140	ACETAMINOPHEN	TAN
00887587	PDP-ACETAMINOPHEN	PED
02263793	PEDIAPHEN	EUR

**120MG SUPPOSITORY**

01919385	ABENOL	PED
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**325MG SUPPOSITORY**

01919393	ABENOL	PED
02230436	ACET 325	PED
02046687	PMS-ACETAMINOPHEN	PMS

**650MG SUPPOSITORY**

01919407	ABENOL	PED
02230437	ACET 650	PED
02046695	PMS-ACETAMINOPHEN	PMS

<sup>ST</sup> **80MG TABLET**

01905856	ACETAMINOPHEN	TLI
02015676	ACETAMINOPHEN	TAN
02263815	PEDIAPHEN	EUR
02238295	TYLENOL JR STRENGTH FASTMELTS	MCL

<sup>ST</sup> **160MG TABLET**

02017431	ACETAMINOPHEN	RIV
02230934	ACETAMINOPHEN	TAN

<sup>ST</sup> **325MG TABLET**

00382752	ACETAMINOPHEN	PDL
00605751	ACETAMINOPHEN	VTH
00743542	ACETAMINOPHEN	PMT
00789801	ACETAMINOPHEN	TLI
01938088	ACETAMINOPHEN	JMP
02022214	ACÉTAMINOPHÈNE	RIV
02362198	ACÉTAMINOPHÈNE	RIV
00544981	APO ACETAMINOPHEN	APX
02229873	APO-ACETAMINOPHEN	APX
02451018	M-ACETAMINOPHEN	MAN
00389218	NOVO-GESIC	TEV
00559393	TYLENOL	MCL
00723894	TYLENOL	MCL

<sup>ST</sup> **500MG TABLET**

00386626	ACETAMINOPHEN	PDL
00549703	ACETAMINOPHEN	PMT
00605778	ACETAMINOPHEN	VTH
00789798	ACETAMINOPHEN	TLI
01939122	ACETAMINOPHEN	JMP
01962353	ACETAMINOPHEN	TAN
02252813	ACETAMINOPHEN	PMT
02255251	ACETAMINOPHEN	PMT
02022222	ACÉTAMINOPHÈNE	RIV
02362228	ACÉTAMINOPHÈNE	RIV

**28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS****ACETAMINOPHEN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

<sup>ST</sup> **500MG TABLET**

02362201	ACÉTAMINOPHÈNE BLASON SHIELD	RIV
00545007	APO ACETAMINOPHEN	APX
02229977	APO-ACETAMINOPHEN	APX
00013668	ATASOL FORTE	CHU
02355299	JAMP ACETAMINOPHEN BLAZON	JMP
00482323	NOVO-GESIC FORTE	TEV
00892505	PMS-ACETAMINOPHEN	PMS
00723908	TYLENOL	MCL
00559407	TYLENOL EXTRA STRENGTH	MCL

<sup>ST</sup> **80MG TABLET (CHEWABLE)**

02017458	ACETAMINOPHEN	RIV
02129957	ACETAMINOPHEN	VTH

<sup>ST</sup> **160MG TABLET (CHEWABLE)**

02142805	ACETAMINOPHEN	VTH
02263823	PEDIAPHEN	EUR
02347792	TYLENOL JR STRENGTH FASTMELTS	MCL
02241361	TYLENOL JUNIOR STRENGTH	MCL

**28:12.08 ANTICONVULSANTS - BENZODIAZEPINES****CLONAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **0.25MG TABLET**

02442027	CLONAZEPAM	SIV
02179660	PMS-CLONAZEPAM	PMS

<sup>ST</sup> **0.5MG TABLET**

02177889	APO-CLONAZEPAM	APX
02230366	CLONAPAM	VAE
02442035	CLONAZEPAM	SIV
02270641	CO CLONAZEPAM	OBT
02130998	DOM-CLONAZEPAM	DPC
02224100	DOM-CLONAZEPAM-R	DPC
02230950	MYLAN-CLONAZEPAM	MYL
02145227	PHL-CLONAZEPAM	PHH
02236948	PHL-CLONAZEPAM-R	PHH
02048701	PMS-CLONAZEPAM	PMS
02207818	PMS-CLONAZEPAM-R	PMS
02311593	PRO-CLONAZEPAM	PDL
02242077	RIVA-CLONAZEPAM	RIV
00382825	RIVOTRIL	HLR
02233960	SANDOZ CLONAZEPAM	SDZ
02239024	TEVA-CLONAZEPAM	TEV

<sup>ST</sup> **1MG TABLET**

02230368	CLONAPAM	VAE
02442043	CLONAZEPAM	SIV

**28:12.08 ANTICONVULSANTS - BENZODIAZEPINES****CLONAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **1MG TABLET**

02270668	CO CLONAZEPAM	OBT
02145235	PHL-CLONAZEPAM	PHH
02048728	PMS-CLONAZEPAM	PMS
02311607	PRO-CLONAZEPAM	PDL
02233982	SANDOZ CLONAZEPAM	SDZ

<sup>ST</sup> **2MG TABLET**

02177897	APO-CLONAZEPAM	APX
02230369	CLONAPAM	VAE
02442051	CLONAZEPAM	SIV
02270676	CO CLONAZEPAM	OBT
02131013	DOM-CLONAZEPAM	DPC
02230951	MYLAN-CLONAZEPAM	MYL
02145243	PHL-CLONAZEPAM	PHH
02048736	PMS-CLONAZEPAM	PMS
02311615	PRO-CLONAZEPAM	PDL
02242078	RIVA-CLONAZEPAM	RIV
00382841	RIVOTRIL	HLR
02233985	SANDOZ CLONAZEPAM	SDZ
02239025	TEVA-CLONAZEPAM	TEV

**28:12.92 MISCELLANEOUS ANTICONVULSANTS****ESLICARBAZEPINE ACETATE**

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:

- Are under the care of a physician experienced in the treatment of epilepsy; AND
- Are currently receiving two or more antiepileptic medications; AND
- Have failed or demonstrated intolerance to at least two other antiepileptic medications.

<sup>ST</sup> **200MG TABLET**

02426862	APTIOM	SPC
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<sup>ST</sup> **400MG TABLET**

02426870	APTIOM	SPC
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<sup>ST</sup> **600MG TABLET**

02426889	APTIOM	SPC
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<sup>ST</sup> **800MG TABLET**

02426897	APTIOM	SPC
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**GABAPENTIN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

<sup>ST</sup> **100MG CAPSULE**

02256142	ACT GABAPENTIN	ACG
02244304	APO-GABAPENTIN	APX
02321203	AURO-GABAPENTIN	AUR
02243743	DOM-GABAPENTIN	DPC
02246314	GABAPENTIN	SIV
02353245	GABAPENTIN	SAN
02416840	GABAPENTIN	ACC

**28:12.92 MISCELLANEOUS ANTICONVULSANTS****GABAPENTIN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

**<sup>ST</sup> 100MG CAPSULE**

02285819	GD-GABAPENTIN	PFI
02361469	JAMP-GABAPENTIN	JMP
02391473	MAR-GABAPENTIN	MAR
02248259	MYLAN-GABAPENTIN	MYL
02084260	NEURONTIN	PFI
02243446	PMS-GABAPENTIN	PMS
02310449	PRO-GABAPENTIN	PDL
02319055	RAN-GABAPENTIN	RBY
02251167	RIVA-GABAPENTIN	RIV
02244513	TEVA-GABAPENTIN	TEV

**<sup>ST</sup> 300MG CAPSULE**

02256150	ACT GABAPENTIN	ACG
02244305	APO-GABAPENTIN	APX
02321211	AURO-GABAPENTIN	AUR
02243744	DOM-GABAPENTIN	DPC
02246315	GABAPENTIN	SIV
02353253	GABAPENTIN	SAN
02416859	GABAPENTIN	ACC
02285827	GD-GABAPENTIN	PFI
02361485	JAMP-GABAPENTIN	JMP
02391481	MAR-GABAPENTIN	MAR
02248260	MYLAN-GABAPENTIN	MYL
02084279	NEURONTIN	PFI
02243447	PMS-GABAPENTIN	PMS
02310457	PRO-GABAPENTIN	PDL
02319063	RAN-GABAPENTIN	RBY
02251175	RIVA-GABAPENTIN	RIV
02244514	TEVA-GABAPENTIN	TEV

**<sup>ST</sup> 400MG CAPSULE**

02256169	ACT GABAPENTIN	ACG
02244306	APO-GABAPENTIN	APX
02321238	AURO-GABAPENTIN	AUR
02243745	DOM-GABAPENTIN	DPC
02246316	GABAPENTIN	SIV
02353261	GABAPENTIN	SAN
02416867	GABAPENTIN	ACC
02361493	JAMP-GABAPENTIN	JMP
02391503	MAR-GABAPENTIN	MAR
02248261	MYLAN-GABAPENTIN	MYL
02084287	NEURONTIN	PFI
02243448	PMS-GABAPENTIN	PMS
02310465	PRO-GABAPENTIN	PDL
02319071	RAN-GABAPENTIN	RBY
02251183	RIVA-GABAPENTIN	RIV
02244515	TEVA-GABAPENTIN	TEV

**<sup>ST</sup> 600MG TABLET**

02293358	APO-GABAPENTIN	APX
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**28:12.92 MISCELLANEOUS ANTICONVULSANTS****GABAPENTIN**

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

**<sup>ST</sup> 600MG TABLET**

02388200	GABAPENTIN	SIV
02392526	GABAPENTIN	ACC
02431289	GABAPENTIN	SAN
02285843	GD-GABAPENTIN	PFI
02402289	JAMP-GABAPENTIN	JMP
02397471	MYLAN-GABAPENTIN	MYL
02239717	NEURONTIN	PFI
02255898	PMS-GABAPENTIN	PMS
02310473	PRO-GABAPENTIN	PDL
02259796	RIVA-GABAPENTIN	RIV
02248457	TEVA-GABAPENTIN	TEV

**<sup>ST</sup> 800MG TABLET**

02293366	APO-GABAPENTIN	APX
02388219	GABAPENTIN	SIV
02392534	GABAPENTIN	ACC
02431297	GABAPENTIN	SAN
02402297	JAMP-GABAPENTIN	JMP
02397498	MYLAN-GABAPENTIN	MYL
02239718	NEURONTIN	PFI
02255901	PMS-GABAPENTIN	PMS
02310481	PRO-GABAPENTIN	PDL
02259818	RIVA-GABAPENTIN	RIV
02247346	TEVA-GABAPENTIN	TEV

**LACOSAMIDE**

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:

- Are under the care of a physician experienced in the treatment of epilepsy; AND
- Are currently receiving two or more antiepileptic medications; AND
- Have failed or demonstrated intolerance to at least two other antiepileptic medications.

**<sup>ST</sup> 50MG TABLET**

02357615	VIMPAT	UCB
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**<sup>ST</sup> 100MG TABLET**

02357623	VIMPAT	UCB
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**<sup>ST</sup> 150MG TABLET**

02357631	VIMPAT	UCB
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**<sup>ST</sup> 200MG TABLET**

02357658	VIMPAT	UCB
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**PREGABALIN**

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 to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

**<sup>ST</sup> 25MG CAPSULE**

02402912	ACT PREGABALIN	ACG
02394235	APO-PREGABALIN	APX
02433869	AURO-PREGABALIN	AUR

**28:12.92 MISCELLANEOUS ANTICONVULSANTS****PREGABALIN**

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 to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

**<sup>ST</sup> 25MG CAPSULE**

02402556	DOM-PREGABALIN	DPC
02435977	JAMP-PREGABALIN	JMP
02268418	LYRICA	PFI
02417529	MAR-PREGABALIN	MAR
02423804	MINT-PREGABALIN	MIN
02359596	PMS-PREGABALIN	PMS
02396483	PREGABALIN	PDL
02403692	PREGABALIN	SIV
02405539	PREGABALIN	SAN
02392801	RAN-PREGABALIN	RBV
02377039	RIVA-PREGABALIN	RIV
02390817	SANDOZ PREGABALIN	SDZ
02361159	TEVA-PREGABALIN	TEV

**<sup>ST</sup> 50MG CAPSULE**

02402920	ACT PREGABALIN	ACG
02394243	APO-PREGABALIN	APX
02433877	AURO-PREGABALIN	AUR
02402564	DOM-PREGABALIN	DPC
02435985	JAMP-PREGABALIN	JMP
02268426	LYRICA	PFI
02417537	MAR-PREGABALIN	MAR
02423812	MINT-PREGABALIN	MIN
02359618	PMS-PREGABALIN	PMS
02396505	PREGABALIN	PDL
02403706	PREGABALIN	SIV
02405547	PREGABALIN	SAN
02392828	RAN-PREGABALIN	RBV
02377047	RIVA-PREGABALIN	RIV
02390825	SANDOZ PREGABALIN	SDZ
02361175	TEVA-PREGABALIN	TEV

**<sup>ST</sup> 75MG CAPSULE**

02402939	ACT PREGABALIN	ACG
02394251	APO-PREGABALIN	APX
02433885	AURO-PREGABALIN	AUR
02402572	DOM-PREGABALIN	DPC
02435993	JAMP-PREGABALIN	JMP
02268434	LYRICA	PFI
02417545	MAR-PREGABALIN	MAR
02424185	MINT-PREGABALIN	MIN
02359626	PMS-PREGABALIN	PMS
02396513	PREGABALIN	PDL
02403714	PREGABALIN	SIV
02405555	PREGABALIN	SAN
02392836	RAN-PREGABALIN	RBV
02377055	RIVA-PREGABALIN	RIV

**28:12.92 MISCELLANEOUS ANTICONVULSANTS****PREGABALIN**

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 to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

**<sup>ST</sup> 75MG CAPSULE**

02390833 SANDOZ PREGABALIN	SDZ
02361183 TEVA-PREGABALIN	TEV

**<sup>ST</sup> 150MG CAPSULE**

02402955 ACT PREGABALIN	ACG
02394278 APO-PREGABALIN	APX
02433907 AURO-PREGABALIN	AUR
02402580 DOM-PREGABALIN	DPC
02436000 JAMP-PREGABALIN	JMP
02268450 LYRICA	PFI
02417561 MAR-PREGABALIN	MAR
02424207 MINT-PREGABALIN	MIN
02359634 PMS-PREGABALIN	PMS
02396521 PREGABALIN	PDL
02403722 PREGABALIN	SIV
02405563 PREGABALIN	SAN
02392844 RAN-PREGABALIN	RBY
02377063 RIVA-PREGABALIN	RIV
02390841 SANDOZ PREGABALIN	SDZ
02361205 TEVA-PREGABALIN	TEV

**<sup>ST</sup> 300MG CAPSULE**

02402998 ACT PREGABALIN	ACG
02394294 APO-PREGABALIN	APX
02436019 JAMP-PREGABALIN	JMP
02268485 LYRICA	PFI
02359642 PMS-PREGABALIN	PMS
02396548 PREGABALIN	PDL
02403730 PREGABALIN	SIV
02405598 PREGABALIN	SAN
02392860 RAN-PREGABALIN	RBY
02377071 RIVA-PREGABALIN	RIV
02390868 SANDOZ PREGABALIN	SDZ
02361248 TEVA-PREGABALIN	TEV

**RUFINAMIDE**

Limited use benefit (prior approval required).

• For the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome in adults and children 4 years and older when prescribed by a neurologist or experienced specialist.

• Patient has failed or is intolerant to or has contraindications to at least two adjunctive antiepileptic drugs.

**<sup>ST</sup> 100MG TABLET**

02369613 BANZEL	EIS
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**<sup>ST</sup> 200MG TABLET**

02369621 BANZEL	EIS
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**<sup>ST</sup> 400MG TABLET**

02369648 BANZEL	EIS
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**28:16.04 ANTIDEPRESSANTS****BUPROPION HYDROCHLORIDE (WELLBUTRIN)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage of Wellbutrin XL and Bupropion SR is limited to 300 mg per day. (Note: this product will not be approved for coverage for smoking cessation).

<sup>ST</sup> **100MG TABLET (EXTENDED RELEASE)**

02331616 BUPROPION SR	PDL
02391562 BUPROPION SR	SAN
02325373 PMS-BUPROPION SR	PMS
02285657 RATIO-BUPROPION	TEV
02275074 SANDOZ BUPROPION SR	SDZ

<sup>ST</sup> **150MG TABLET (EXTENDED RELEASE)**

02439654 ACT BUPROPION XL	ACG
02325357 BUPROPION SR	PDL
02391570 BUPROPION SR	SAN
02382075 MYLAN-BUPROPION XL	MYL
02313421 PMS-BUPROPION SR	PMS
02285665 RATIO-BUPROPION	TEV
02275082 SANDOZ BUPROPION SR	SDZ
02237825 WELLBUTRIN SR	VAE
02275090 WELLBUTRIN XL	VAE

<sup>ST</sup> **300MG TABLET (EXTENDED RELEASE)**

02439662 ACT BUPROPION XL	ACG
02382083 MYLAN-BUPROPION XL	MYL
02275104 WELLBUTRIN XL	VAE

**BUPROPION HYDROCHLORIDE (ZYBAN)**

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

Coverage is limited to 180 tablets 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 bupropion hydrochloride when one year has elapsed from the day the initial prescription was filled.

<sup>ST</sup> **150MG TABLET (EXTENDED RELEASE)**

02238441 ZYBAN	VAE
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**28:16.08 ANTIPSYCHOTIC AGENTS****ARIPIPIRAZOLE**

Limited use benefit (prior approval required).

For the treatment of schizophrenia and schizoaffective disorders in patients:

- who have intolerance or lack of response to an adequate trial of another antipsychotic agent; OR
- a contraindication to another antipsychotic agent.

<sup>ST</sup> **2MG TABLET**

02322374 ABILIFY	BMS
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<sup>ST</sup> **5MG TABLET**

02322382 ABILIFY	BMS
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<sup>ST</sup> **10MG TABLET**

02322390 ABILIFY	BMS
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<sup>ST</sup> **15MG TABLET**

02322404 ABILIFY	BMS
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<sup>ST</sup> **20MG TABLET**

02322412 ABILIFY	BMS
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<sup>ST</sup> **30MG TABLET**

02322455 ABILIFY	BMS
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**28:16.08 ANTIPSYCHOTIC AGENTS****ASENAPINE MALEATE**

Limited use benefit (prior approval required).

For the acute treatment of manic or mixed episodes associated with bipolar I disorder as either:

- Monotherapy, after a trial of lithium or divalproex sodium has failed or is contraindicated, and trials of two atypical antipsychotic agents have failed due to intolerance or lack of response; OR
- Co-therapy with lithium or divalproex sodium, after trials of two atypical antipsychotic agents have failed due to intolerance or lack of response.

<sup>ST</sup> **5MG TABLET**

02374803 SAPHRIS

FRS

<sup>ST</sup> **10MG TABLET**

02374811 SAPHRIS

FRS

**LURASIDONE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For the treatment of schizophrenia and schizoaffective disorders in patients:

- who have intolerance or lack of response to an adequate trial of another antipsychotic agent; OR
- a contraindication to another antipsychotic agent.

<sup>ST</sup> **20MG TABLET**

02422050 LATUDA

SPC

<sup>ST</sup> **40MG TABLET**

02387751 LATUDA

SPC

<sup>ST</sup> **60MG TABLET**

02413361 LATUDA

SPC

<sup>ST</sup> **80MG TABLET**

02387778 LATUDA

SPC

<sup>ST</sup> **120MG TABLET**

02387786 LATUDA

SPC

**PALIPERIDONE PALMITATE**

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:

- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

**50MG/0.5ML SUSPENSION (EXTENDED RELEASE)**

02354217 INVEGA SUSTENNA

JSO

**75MG/0.75ML SUSPENSION (EXTENDED RELEASE)**

02354225 INVEGA SUSTENNA

JSO

**100MG/ML SUSPENSION (EXTENDED RELEASE)**

02354233 INVEGA SUSTENNA

JSO

**150MG/1.5ML SUSPENSION (EXTENDED RELEASE)**

02354241 INVEGA SUSTENNA

JSO

**RISPERIDONE (CONSTA)**

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:

- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

**12.5MG INJECTION**

02298465 RISPERDAL CONSTA

JSO

**25MG INJECTION**

02255707 RISPERDAL CONSTA

JSO

**28:16.08 ANTIPSYCHOTIC AGENTS****RISPERIDONE (CONSTA)**

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:

- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

<sup>ST</sup> **37.5MG INJECTION**

02255723 RISPERDAL CONSTA

JSO

<sup>ST</sup> **50MG INJECTION**

02255758 RISPERDAL CONSTA

JSO

**28:20.04 AMPHETAMINES****DEXTROAMPHETAMINE SULFATE**

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents\* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

\* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

<sup>ST</sup> **10MG CAPSULE (SUSTAINED RELEASE)**

01924559 DEXEDRINE SPANSULE

PAL

<sup>ST</sup> **15MG CAPSULE (SUSTAINED RELEASE)**

01924567 DEXEDRINE SPANSULE

PAL

<sup>ST</sup> **5MG TABLET**

02443236 APO-DEXTROAMPHETAMINE

APX

01924516 DEXEDRINE

PAL

**LISDEXAMFETAMINE DIMESYLATE**

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents\* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

\* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

<sup>ST</sup> **10MG CAPSULE**

02439603 VYVANSE

SHI

<sup>ST</sup> **20MG CAPSULE**

02347156 VYVANSE

SHI

<sup>ST</sup> **30MG CAPSULE**

02322951 VYVANSE

SHI

<sup>ST</sup> **40MG CAPSULE**

02347164 VYVANSE

SHI

<sup>ST</sup> **50MG CAPSULE**

02322978 VYVANSE

SHI

<sup>ST</sup> **60MG CAPSULE**

02347172 VYVANSE

SHI

**28:20.32 CNS STIMULANTS****METHYLPHENIDATE HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents\* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

\* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

**<sup>ST</sup> 5MG TABLET**

02273950	APO-METHYLPHENIDATE	APX
02326221	METHYLPHENIDATE	PDL
02234749	PMS-METHYLPHENIDATE	PMS

**<sup>ST</sup> 10MG TABLET**

02249324	APO-METHYLPHENIDATE	APX
02326248	METHYLPHENIDATE	PDL
00584991	PMS-METHYLPHENIDATE	PMS

**<sup>ST</sup> 20MG TABLET**

02249332	APO-METHYLPHENIDATE	APX
02326256	METHYLPHENIDATE	PDL
00585009	PMS-METHYLPHENIDATE	PMS

**<sup>ST</sup> 18MG TABLET (EXTENDED RELEASE)**

02452731	APO-METHYLPHENIDATE ER	APX
02247732	CONCERTA	JSO
02413728	PMS-METHYLPHENIDATE ER	PMS
02315068	TEVA-METHYLPHENIDATE	TEV

**<sup>ST</sup> 20MG TABLET (EXTENDED RELEASE)**

02266687	APO-METHYLPHENIDATE SR	APX
02320312	SANDOZ METHYLPHENIDATE SR	SDZ

**<sup>ST</sup> 27MG TABLET (EXTENDED RELEASE)**

02452758	APO-METHYLPHENIDATE ER	APX
02250241	CONCERTA	JSO
02413736	PMS-METHYLPHENIDATE ER	PMS
02315076	TEVA-METHYLPHENIDATE	TEV

**<sup>ST</sup> 36MG TABLET (EXTENDED RELEASE)**

02452766	APO-METHYLPHENIDATE ER	APX
02247733	CONCERTA	JSO
02413744	PMS-METHYLPHENIDATE ER	PMS
02315084	TEVA-METHYLPHENIDATE	TEV

**<sup>ST</sup> 54MG TABLET (EXTENDED RELEASE)**

02330377	APO-METHYLPHENIDATE ER	APX
02247734	CONCERTA	JSO
02413752	PMS-METHYLPHENIDATE ER	PMS
02315092	TEVA-METHYLPHENIDATE	TEV

**28:20.92 MISC ANOREXIGENIC AGENTS & RESPIRATORY & CEREBRAL STIMULANT****CAFFEINE CITRATE**

Limited use benefit (prior approval not required).

For children up to 1 year of age

**POWDER**

00972037	CAFFEINE CITRATE	MDS
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**28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES****ALPRAZOLAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **0.25MG TABLET**

01908189	ALPRAZOLAM	PDL
02349191	ALPRAZOLAM	SAN
00865397	APO-ALPRAZ	APX
02400111	JAMP-ALPRAZOLAM	JMP
02137534	MYLAN-ALPRAZOLAM	MYL
02417634	NAT-ALPRAZOLAM	NPH
02404877	RIVA-ALPRAZOLAM	RIV
01913484	TEVA-ALPRAZOLAM	TEV
00548359	XANAX	PFI

<sup>ST</sup> **0.5MG TABLET**

01908170	ALPRAZOLAM	PDL
02349205	ALPRAZOLAM	SAN
00865400	APO-ALPRAZ	APX
02400138	JAMP-ALPRAZOLAM	JMP
02137542	MYLAN-ALPRAZOLAM	MYL
02417642	NAT-ALPRAZOLAM	NPH
02404885	RIVA-ALPRAZOLAM	RIV
01913492	TEVA-ALPRAZOLAM	TEV
00548367	XANAX	PFI

<sup>ST</sup> **1MG TABLET**

02248706	ALPRAZOLAM	PDL
02243611	APO-ALPRAZ	APX
02400146	JAMP-ALPRAZOLAM	JMP
02229813	MYLAN-ALPRAZOLAM	MYL
02417650	NAT-ALPRAZOLAM	NPH
02404893	RIVA-ALPRAZOLAM	RIV
00723770	XANAX	PFI

<sup>ST</sup> **2MG TABLET**

02243612	APO-ALPRAZ	APX
02400154	JAMP-ALPRAZOLAM	JMP
02229814	MYLAN-ALPRAZOLAM	MYL
02404907	RIVA-ALPRAZOLAM	RIV
00813958	XANAX TS	PFI

**BROMAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **1.5MG TABLET**

02177153	APO-BROMAZEPAM	APX
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<sup>ST</sup> **3MG TABLET**

02177161	APO-BROMAZEPAM	APX
02220520	BROMAZEPAM	PDL
00518123	LECTOPAM	HLR
02230584	TEVA-BROMAZEPAM	TEV

**28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES****BROMAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **6MG TABLET**

02177188	APO-BROMAZEPAM	APX
02220539	BROMAZEPAM	PDL
00518131	LECTOPAM	HLR
02230585	TEVA-BROMAZEPAM	TEV

**DIAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **1MG/ML SOLUTION**

00891797	PMS-DIAZEPAM	PMS
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<sup>ST</sup> **2MG TABLET**

00405329	APO DIAZEPAM	APX
02247490	PMS-DIAZEPAM	PMS

<sup>ST</sup> **5MG TABLET**

00362158	APO DIAZEPAM	APX
00313580	DIAZEPAM	PDL
02247491	PMS-DIAZEPAM	PMS
00013285	VALIUM	HLR

<sup>ST</sup> **10MG TABLET**

00405337	APO DIAZEPAM	APX
00434388	DIAZEPAM	PDL
02247492	PMS-DIAZEPAM	PMS

**DIAZEPAM (DIASTAT)**

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.

<sup>ST</sup> **5MG/ML GEL**

02238162	DIASTAT	VAE
09853340	DIASTAT 2X10MG RECTAL PACK	ELN
09853430	DIASTAT 2X15MG RECTAL PACK	ELN

**LORAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **0.5MG TABLET**

00655740	APO-LORAZEPAM	APX
02410745	APO-LORAZEPAM SUBLINGUAL	APX
02041413	ATIVAN	PFI
02041456	ATIVAN	PFI
02245784	DOM-LORAZEPAM	DPC
02351072	LORAZEPAM	SAN
00728187	PMS-LORAZEPAM	PMS

**28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES****LORAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **0.5MG TABLET**

00655643 PRO-LORAZEPAM	PDL
00711101 TEVA-LORAZEPAM	TEV

<sup>ST</sup> **1MG TABLET**

00655759 APO-LORAZEPAM	APX
02410753 APO-LORAZEPAM SUBLINGUAL	APX
02041421 ATIVAN	PFI
02041464 ATIVAN	PFI
02245785 DOM-LORAZEPAM	DPC
02351080 LORAZEPAM	SAN
00728195 PMS-LORAZEPAM	PMS
00655651 PRO-LORAZEPAM	PDL
00637742 TEVA-LORAZEPAM	TEV

<sup>ST</sup> **2MG TABLET**

00655767 APO-LORAZEPAM	APX
02410761 APO-LORAZEPAM SUBLINGUAL	APX
02041448 ATIVAN	PFI
02041472 ATIVAN	PFI
02245786 DOM-LORAZEPAM	DPC
02351099 LORAZEPAM	SAN
00728209 PMS-LORAZEPAM	PMS
00655678 PRO-LORAZEPAM	PDL
00637750 TEVA-LORAZEPAM	TEV

**NITRAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **5MG TABLET**

00511528 MOGADON	AAP
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<sup>ST</sup> **10MG TABLET**

00511536 MOGADON	AAP
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**OXAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **10MG TABLET**

00402680 APO OXAZEPAM	APX
00497754 OXAZEPAM	PDL
00414247 OXPAM	BMI
00568392 RIVA OXAZEPAM	RIV

<sup>ST</sup> **15MG TABLET**

00402745 APO OXAZEPAM	APX
00497762 OXAZEPAM	PDL
00568406 RIVA OXAZEPAM	RIV

**28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES****OXAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **30MG TABLET**

00402737	APO OXAZEPAM	APX
00497770	OXAZEPAM	PDL
00414263	OXPAM	BMI
00568414	RIVA OXAZEPAM	RIV

**TEMAZEPAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **15MG CAPSULE**

02225964	APO-TEMAZEPAM	APX
00604453	RESTORIL	AAP
02229760	TEMAZEPAM	PDL
02230095	TEVA-TEMAZEPAM	TEV

<sup>ST</sup> **30MG CAPSULE**

02225972	APO-TEMAZEPAM	APX
00604461	RESTORIL	AAP
02229761	TEMAZEPAM	PDL
02230102	TEVA-TEMAZEPAM	TEV

**TRIAZOLAM**

Limited use benefit (prior approval is 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.

<sup>ST</sup> **0.25MG TABLET**

00808571	TRIAZOLAM	AAP
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**28:32.28 SELECTIVE SEROTONIN AGONISTS****ALMOTRIPTAN MALATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**6.25MG TABLET**

02405792	APO-ALMOTRIPTAN	APX
02248128	AXERT	MCL
02398435	MYLAN-ALMOTRIPTAN	MYL

**12.5MG TABLET**

02424029	ALMOTRIPTAN	PDL
02405806	APO-ALMOTRIPTAN	APX
02248129	AXERT	MCL
02398443	MYLAN-ALMOTRIPTAN	MYL
02405334	SANDOZ ALMOTRIPTAN	SDZ

**28:32.28 SELECTIVE SEROTONIN AGONISTS****NARATRIPTAN HYDROCHLORIDE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**1MG TABLET**

02237820	AMERGE	GSK
02314290	TEVA-NARATRIPTAN	TEV

**2.5MG TABLET**

02237821	AMERGE	GSK
02322323	SANDOZ NARATRIPTAN	SDZ
02314304	TEVA-NARATRIPTAN	TEV

**RIZATRIPTAN BENZOATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**5MG TABLET**

02393468	APO-RIZATRIPTAN	APX
02380455	JAMP-RIZATRIPTAN	JMP
02429233	JAMP-RIZATRIPTAN IR	JMP
02379651	MAR-RIZATRIPTAN	MAR

**10MG TABLET**

02381702	ACT RIZATRIPTAN	ACG
02393476	APO-RIZATRIPTAN	APX
02441144	AURO-RIZATRIPTAN	AUR
02380463	JAMP-RIZATRIPTAN	JMP
02429241	JAMP-RIZATRIPTAN IR	JMP
02379678	MAR-RIZATRIPTAN	MAR
02240521	MAXALT	FRS

**5MG TABLET (ORALLY DISINTEGRATING)**

02374730	ACT RIZATRIPTAN ODT	ACG
02393484	APO-RIZATRIPTAN RPD	APX
02240518	MAXALT RPD	FRS
02379198	MYLAN-RIZATRIPTAN ODT	MYL
02436604	NAT-RIZATRIPTAN ODT	NPH
02393360	PMS-RIZATRIPTAN RDT	PMS
02423456	RIVA-RIZATRIPTAN ODT	RIV
02442906	RIZATRIPTAN ODT	SAN
02446111	RIZATRIPTAN ODT	SIV
02415798	RIZATRIPTAN RDT	PDL
02351870	SANDOZ RIZATRIPTAN ODT	SDZ
02396661	TEVA-RIZATRIPTAN ODT	TEV

**10MG TABLET (ORALLY DISINTEGRATING)**

02374749	ACT RIZATRIPTAN ODT	ACG
02393492	APO-RIZATRIPTAN RPD	APX
02396203	DOM-RIZATRIPTAN RDT	DPC
02240519	MAXALT RPD	FRS
02379201	MYLAN-RIZATRIPTAN ODT	MYL
02436612	NAT-RIZATRIPTAN ODT	NPH
02393379	PMS-RIZATRIPTAN RDT	PMS
02423464	RIVA-RIZATRIPTAN ODT	RIV
02442914	RIZATRIPTAN ODT	SAN
02446138	RIZATRIPTAN ODT	SIV
02415801	RIZATRIPTAN RDT	PDL

**28:32.28 SELECTIVE SEROTONIN AGONISTS****RIZATRIPTAN BENZOATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**10MG TABLET (ORALLY DISINTEGRATING)**

02351889 SANDOZ RIZATRIPTAN ODT	SDZ
02396688 TEVA-RIZATRIPTAN ODT	TEV

**SUMATRIPTAN SUCCINATE**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**6MG/0.5ML INJECTION**

99000598 IMITREX STAT DOSE KIT	GSK
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**12MG/ML SOLUTION**

02212188 IMITREX	GSK
02361698 TARO-SUMATRIPTAN	TAR

**25MG TABLET**

02257882 ACT SUMATRIPTAN	ACG
02270749 DOM-SUMATRIPTAN	DPC
02268906 MYLAN-SUMATRIPTAN	MYL
02256428 PMS-SUMATRIPTAN	PMS
02286815 TEVA-SUMATRIPTAN DF	TEV

**50MG TABLET**

02257890 ACT SUMATRIPTAN	ACG
02268388 APO-SUMATRIPTAN	APX
02270757 DOM-SUMATRIPTAN	DPC
02212153 IMITREX DF	GSK
02268914 MYLAN-SUMATRIPTAN	MYL
02256436 PMS-SUMATRIPTAN	PMS
02263025 SANDOZ SUMATRIPTAN	SDZ
02286521 SUMATRIPTAN	SAN
02324652 SUMATRIPTAN	PDL
02385570 SUMATRIPTAN DF	SIV
02286823 TEVA-SUMATRIPTAN DF	TEV

**100MG TABLET**

02257904 ACT SUMATRIPTAN	ACG
02268396 APO-SUMATRIPTAN	APX
02270765 DOM-SUMATRIPTAN	DPC
02212161 IMITREX DF	GSK
02268922 MYLAN-SUMATRIPTAN	MYL
02256444 PMS-SUMATRIPTAN	PMS
02263033 SANDOZ SUMATRIPTAN	SDZ
02286548 SUMATRIPTAN	SAN
02324660 SUMATRIPTAN	PDL
02385589 SUMATRIPTAN DF	SIV
02239367 TEVA-SUMATRIPTAN	TEV
02286831 TEVA-SUMATRIPTAN DF	TEV

**ZOLMITRIPTAN**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**2.5MG TABLET**

02380951 APO-ZOLMITRIPTAN	APX
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**28:32.28 SELECTIVE SEROTONIN AGONISTS****ZOLMITRIPTAN**

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

**2.5MG TABLET**

02389525	DOM-ZOLMITRIPTAN	DPC
02421623	JAMP-ZOLMITRIPTAN	JMP
02399458	MAR-ZOLMITRIPTAN	MAR
02419521	MINT-ZOLMITRIPTAN	MIN
02369036	MYLAN-ZOLMITRIPTAN	MYL
02421534	NAT-ZOLMITRIPTAN	NPH
02324229	PMS-ZOLMITRIPTAN	PMS
02401304	RIVA-ZOLMITRIPTAN	RIV
02362988	SANDOZ ZOLMITRIPTAN	SDZ
02313960	TEVA-ZOLMITRIPTAN	TEV
02379929	ZOLMITRIPTAN	PDL
02238660	ZOMIG	AZC

**2.5MG TABLET (ORALLY DISINTEGRATING)**

02438453	AG-ZOLMITRIPTAN ODT	ANG
02381575	APO-ZOLMITRIPTAN RAPID	APX
02428237	JAMP-ZOLMITRIPTAN ODT	JMP
02387158	MYLAN-ZOLMITRIPTAN ODT	MYL
02324768	PMS-ZOLMITRIPTAN ODT	PMS
02362996	SANDOZ ZOLMITRIPTAN ODT	SDZ
02428474	SEPTA-ZOLMITRIPTAN-ODT	SPT
02342545	TEVA-ZOLMITRIPTAN OD	TEV
02379988	ZOLMITRIPTAN ODT	PDL
02243045	ZOMIG RAPIMELT	AZC

**28:36.20 ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR AGONISTS****CABERGOLINE**

Limited use benefit (prior approval required).

For treatment of hyperprolactinemia in patients who have failed therapy with or are intolerant to bromocriptine.

**0.5MG TABLET**

02301407	ACT CABERGOLINE	ACG
02455897	APO-CABERGOLINE	APX
02242471	DOSTINEX	PFI

**28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS****ACAMPROSATE CALCIUM**

Limited use benefit (prior approval required).

For patients who have been abstinent from alcohol for at least four days and where available, are currently enrolled in an alcohol addiction treatment program.

**333MG TABLET (DELAYED RELEASE)**

02293269	CAMPRAL	MYL
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**ATOMOXETINE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:

- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

**10MG CAPSULE**

02318024	APO-ATOMOXETINE	APX
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**28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS****ATOMOXETINE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:

- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

**10MG CAPSULE**

02358190	ATOMOXETINE	AAP
02396904	ATOMOXETINE	PDL
02445883	ATOMOXETINE	SIV
02390469	DOM-ATOMOXETINE	DPC
02381028	PMS-ATOMOXETINE	PMS
02405962	RIVA-ATOMOXETINE	RIV
02386410	SANDOZ ATOMOXETINE	SDZ
02262800	STRATTERA	LIL
02314541	TEVA-ATOMOXETINE	TEV

**18MG CAPSULE**

02318032	APO-ATOMOXETINE	APX
02358204	ATOMOXETINE	AAP
02396912	ATOMOXETINE	PDL
02390477	DOM-ATOMOXETINE	DPC
02378930	MYLAN-ATOMOXETINE	MYL
02381036	PMS-ATOMOXETINE	PMS
02386429	SANDOZ ATOMOXETINE	SDZ
02262819	STRATTERA	LIL
02314568	TEVA-ATOMOXETINE	TEV

**25MG CAPSULE**

02318040	APO-ATOMOXETINE	APX
02358212	ATOMOXETINE	AAP
02396920	ATOMOXETINE	PDL
02445913	ATOMOXETINE	SIV
02390485	DOM-ATOMOXETINE	DPC
02378949	MYLAN-ATOMOXETINE	MYL
02381044	PMS-ATOMOXETINE	PMS
02405989	RIVA-ATOMOXETINE	RIV
02386437	SANDOZ ATOMOXETINE	SDZ
02262827	STRATTERA	LIL
02314576	TEVA-ATOMOXETINE	TEV

**40MG CAPSULE**

02318059	APO-ATOMOXETINE	APX
02358220	ATOMOXETINE	AAP
02396939	ATOMOXETINE	PDL
02445948	ATOMOXETINE	SIV
02390493	DOM-ATOMOXETINE	DPC
02378957	MYLAN-ATOMOXETINE	MYL
02381052	PMS-ATOMOXETINE	PMS
02405997	RIVA-ATOMOXETINE	RIV
02386445	SANDOZ ATOMOXETINE	SDZ
02262835	STRATTERA	LIL
02314584	TEVA-ATOMOXETINE	TEV

**60MG CAPSULE**

02318067	APO-ATOMOXETINE	APX
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**28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS****ATOMOXETINE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:

- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

**60MG CAPSULE**

02358239	ATOMOXETINE	AAP
02396947	ATOMOXETINE	PDL
02445956	ATOMOXETINE	SIV
02390515	DOM-ATOMOXETINE	DPC
02378965	MYLAN-ATOMOXETINE	MYL
02381060	PMS-ATOMOXETINE	PMS
02406004	RIVA-ATOMOXETINE	RIV
02386453	SANDOZ ATOMOXETINE	SDZ
02262843	STRATTERA	LIL
02314592	TEVA-ATOMOXETINE	TEV

**80MG CAPSULE**

02318075	APO-ATOMOXETINE	APX
02358247	ATOMOXETINE	AAP
02378973	MYLAN-ATOMOXETINE	MYL
02404664	PMS-ATOMOXETINE	PMS
02422824	RIVA-ATOMOXETINE	RIV
02386461	SANDOZ ATOMOXETINE	SDZ
02279347	STRATTERA	LIL
02362511	TEVA-ATOMOXETINE	TEV

**100MG CAPSULE**

02318083	APO-ATOMOXETINE	APX
02358255	ATOMOXETINE	AAP
02378981	MYLAN-ATOMOXETINE	MYL
02404672	PMS-ATOMOXETINE	PMS
02422832	RIVA-ATOMOXETINE	RIV
02386488	SANDOZ ATOMOXETINE	SDZ
02279355	STRATTERA	LIL
02362538	TEVA-ATOMOXETINE	TEV

**32:00 CONTRACEPTIVES (NON-ORAL)****32:00.00 CONTRACEPTIVES (NON-ORAL)****INTRAUTERINE DEVICE**

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 12 months.

**DEVICE**

00970328	FLEXI-T +300 IUD	TSN
00970336	FLEXI-T +380 IUD	TSN
98099999	FLEXI-TD	TSN
99401085	LIBERTE UT380 SHORT IUD	MSF
99401086	LIBERTE UT380 STANDARD IUD	MSF
00970379	MONA LISA 10	SEA
00970387	MONA LISA 5	SEA
00970395	MONA LISA N	SEA
99400482	NOVA-T	BEX

**36:00 DIAGNOSTIC AGENTS (DX)****36:26.00 DX - DIABETES MELLITUS****GLUCOSE OXIDASE, PEROXIDASE**

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:

- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

**ACCU-CHEK ADVANTAGE STRIP**

09853626 ACCU-CHEK ADVANTAGE	ROD
97799824 ACCU-CHEK ADVANTAGE	ROD

**ACCU-CHEK AVIVA STRIP**

09857178 ACCU-CHEK AVIVA	ROD
97799814 ACCU-CHEK AVIVA	ROD

**ACCU-CHEK COMPACT STRIP**

09854282 ACCU-CHEK COMPACT	ROD
97799962 ACCU-CHEK COMPACT	ROD

**ACCU-CHEK MOBILE STRIP**

09857452 ACCU-CHEK MOBILE BG	ROD
97799497 ACCU-CHEK MOBILE CASSETT	ROD

**ACCUTREND STRIP**

09853162 ACCUTREND	ROD
97799959 ACCUTREND	ROD

**ASCENSIA BREEZE 2 STRIP**

09857293 ASCENSIA BREEZE 2	BAY
97799748 ASCENSIA BREEZE 2	BAY

**ASCENSIA CONTOUR STRIP**

09857127 ASCENSIA CONTOUR	BAY
97799702 ASCENSIA CONTOUR	BAY

**BG STAR STRIP**

97799465 BG STAR	SAC
09857422 BG STAR (ON)	SAC

**CONTOUR NEXT STRIP**

97799459 CONTOUR NEXT	BAY
09857453 CONTOUR NEXT (ON)	BAY

**EZ HEALTH STRIP**

09857357 EZ HEALTH ORACLE	TRE
97799564 EZ HEALTH ORACLE	TRE

**FREESTYLE STRIP**

97799829 FREESTYLE	ABB
09857141 FREESTYLE (ON)	ABB

**FREESTYLE LITE STRIP**

97799597 FREESTYLE LITE	ABB
09857297 FREESTYLE LITE (ON)	ABB

**FREESTYLE PRECISION STRIP**

97799346 FREESTYLE PRECISION	ABB
09857502 FREESTYLE PRECISION (ON)	ABB

**GE200 STRIP**

97799373 GE200	AUC
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**36:26.00 DX - DIABETES MELLITUS****GLUCOSE OXIDASE, PEROXIDASE**

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:

- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

**GE200 STRIP**

09857525 GE200 (ON) AUC

**ITEST STRIP**

09857348 ITEST AUC

97799692 ITEST AUC

**MEDI+SURE STRIP**

97799403 MEDI+SURE MEC

09857432 MEDI+SURE (ON) MEC

**NOVA MAX STRIP**

09857313 NOVA MAX NCA

**ONE TOUCH ULTRA STRIP**

09854290 ONE TOUCH ULTRA JAJ

97799985 ONE TOUCH ULTRA JAJ

**ONE TOUCH VERIO STRIP**

97799475 ONETOUCH VERIO JAJ

09857392 ONETOUCH VERIO (ON) JAJ

**PRECISION XTRA STRIP**

09854070 PRECISION XTRA ABB

97799840 PRECISION XTRA AUC

**SIDEKICK STRIP**

97799601 SIDEKICK HOD

**SPIRIT STRIP**

97799291 FIRST CANHEALTH SPIRIT ARA

09857547 SPIRIT TEST STRIP (ON) ARA

**SURE STEP STRIP**

97799355 SURE STEP SKY

**SURETEST STRIP**

09857522 SURETEST (ON) SKY

**TRUETEST STRIP**

97799532 TRUETEST HOD

**TRUETRACK STRIP**

09857283 TRUE TRACK AUC

97799602 TRUE TRACK HOD

**40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE****40:18.19 PHOSPHATE - REMOVING AGENTS****LANTHANUM CARBONATE HYDRATE**

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 aluminium based binders).

For patients with elevated calcium levels despite discontinuation of calcium binder, and Vitamin D analogue and/or modification of dialysate calcium.

For patients with adynamic bone disease and low PTH levels (<100 pg/ml or <0.9 pmol/L) with normal or elevated calcium levels.

**250MG TABLET (CHEWABLE)**

02287145 FOSRENOL

SHI

**500MG TABLET (CHEWABLE)**

02287153 FOSRENOL

SHI

**750MG TABLET (CHEWABLE)**

02287161 FOSRENOL

SHI

**1000MG TABLET (CHEWABLE)**

02287188 FOSRENOL

SHI

**SEVELAMER HYDROCHLORIDE**

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 aluminium based binders).

For patients with elevated calcium levels despite discontinuation of calcium binder, and Vitamin D analogue and/or modification of dialysate calcium.

For patients with adynamic bone disease and low PTH levels (<100 pg/ml or <0.9 pmol/L) with normal or elevated calcium levels.

**800MG TABLET**

02244310 RENAGEL

SAC

**40:20.00 CALORIC AGENTS****LEVOCARNITINE**

Limited use benefit (prior approval required).

For treatment of carnitine deficiency.

**100MG/ML LIQUID**

02144336 CARNITOR

SIG

**200MG/ML SOLUTION**

02144344 CARNITOR IV

SIG

**330MG TABLET**

02144328 CARNITOR

SIG

**48:00 RESPIRATORY TRACT AGENTS****48:02.00 ANTIFIBROTIC AGENTS****NINTEDANIB ESILATE**

Limited use benefit (prior approval required).

Initial Request - Coverage is provided for a period of 7 months (6 months plus a 4 week allowance for repeat pulmonary function tests):

For the treatment of adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF) who meet the following criteria:

- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months; AND
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded; AND
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted; AND
- Patient is under the care of a physician with experience in IPF.

Renewal at 6 months - Coverage is provided for a period of 6 months:

- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of  $\geq 10\%$  from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Subsequent Renewals at 12 months and thereafter - Coverage is provided for a period of 12 months:

- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of  $\geq 10\%$  within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Combination use of Ofev (nintedanib) and Esbriet (pirfenidone) will not be provided.

**100MG CAPSULE**

02443066 OFEV

BOE

**150MG CAPSULE**

02443074 OFEV

BOE

**PIRFENIDONE**

Limited use benefit (prior approval required).

Initial Request - Coverage is provided for a period of 7 months (6 months plus a 4 weeks allowance for repeat pulmonary function tests):

For the treatment of adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF) who meet the following criteria:

- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months; AND
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded; AND
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted; AND
- Patient is under the care of a physician with experience in IPF.

Renewal at 6 months - Coverage is provided for a period of 6 months:

- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of  $\geq 10\%$  from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Subsequent Renewals at 12 months and thereafter - Coverage is provided for a period of 12 months:

- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of  $\geq 10\%$  within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Combination use of Ofev (nintedanib) and Esbriet (pirfenidone) will not be provided.

**267MG CAPSULE**

02393751 ESBRIET

HLR

**48:10.24 LEUKOTRIENE MODIFIERS****MONTELUKAST SODIUM**

Limited use benefit (prior approval required).

For treatment of:

- asthma when used in patients on concurrent steroid therapy; OR
- asthma patients not well controlled with or intolerant to inhaled corticosteroids.

<sup>ST</sup> **4MG GRANULES**

02358611 SANDOZ MONTELUKAST

SDZ

02247997 SINGULAIR

FRS

<sup>ST</sup> **10MG TABLET**

02374609 APO-MONTELUKAST

APX

02401274 AURO-MONTELUKAST

AUR

02376695 DOM-MONTELUKAST

DPC

02391422 JAMP-MONTELUKAST

JMP

**48:10.24 LEUKOTRIENE MODIFIERS****MONTELUKAST SODIUM**

Limited use benefit (prior approval required).

For treatment of:

- asthma when used in patients on concurrent steroid therapy; OR
- asthma patients not well controlled with or intolerant to inhaled corticosteroids.

<sup>ST</sup> **10MG TABLET**

02399997	MAR-MONTELUKAST	MAR
02408643	MINT-MONTELUKAST	MIN
02379333	MONTELUKAST	SAN
02379856	MONTELUKAST	PDL
02382474	MONTELUKAST	SIV
02379236	MONTELUKAST SODIUM	ACC
02368226	MYLAN-MONTELUKAST	MYL
02373947	PMS-MONTELUKAST	PMS
02389517	RAN-MONTELUKAST	RBY
02398826	RIVA-MONTELUKAST	RIV
02328593	SANDOZ MONTELUKAST	SDZ
02238217	SINGULAIR	FRS
02355523	TEVA-MONTELUKAST	TEV

**4MG TABLET (CHEWABLE)**

02377608	APO-MONTELUKAST	APX
02422867	AURO-MONTELUKAST	AUR
02442353	JAMP-MONTELUKAST	JMP
02399865	MAR-MONTELUKAST	MAR
02408627	MINT-MONTELUKAST	MIN
02379317	MONTELUKAST	SAN
02379821	MONTELUKAST	PDL
02382458	MONTELUKAST	SIV
02380749	MYLAN-MONTELUKAST	MYL
02354977	PMS-MONTELUKAST	PMS
02402793	RAN-MONTELUKAST	RBY
02330385	SANDOZ MONTELUKAST	SDZ
02243602	SINGULAIR	FRS
02355507	TEVA-MONTELUKAST	TEV

<sup>ST</sup> **5MG TABLET (CHEWABLE)**

02377616	APO-MONTELUKAST	APX
02422875	AURO-MONTELUKAST	AUR
02442361	JAMP-MONTELUKAST	JMP
02399873	MAR-MONTELUKAST	MAR
02408635	MINT-MONTELUKAST	MIN
02379325	MONTELUKAST	SAN
02379848	MONTELUKAST	PDL
02382466	MONTELUKAST	SIV
02380757	MYLAN-MONTELUKAST	MYL
02354985	PMS-MONTELUKAST	PMS
02402807	RAN-MONTELUKAST	RBY
02330393	SANDOZ MONTELUKAST	SDZ
02238216	SINGULAIR	FRS
02355515	TEVA-MONTELUKAST	TEV

**48:10.24 LEUKOTRIENE MODIFIERS****ZAFIRLUKAST**

Limited use benefit (prior approval required).

For treatment of asthma when used in patients on concurrent steroid therapy.

For asthma patients not well controlled with or intolerant to inhaled corticosteroids.

<sup>ST</sup> **20MG TABLET**

02236606 ACCOLATE

AZC

**48:48.00 VASODILATING AGENTS****BOSENTAN MONOHYDRATE**

Limited use benefit (prior approval required).

Maximum dose covered is 125 mg twice 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; AND

- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

<sup>ST</sup> **125MG TABLET**

02399210 APO-BOSENTAN

APX

**48:92.00 MISCELLANEOUS RESPIRATORY TRACT AGENTS****OMALIZUMAB**

Limited use benefit (prior approval required).

Coverage is provided for an initial period of 24 weeks at a maximum dose of 300 mg every 4 weeks (6 injections over a 24 week period).

For the treatment of adults and adolescents (12 years of age or older) with moderate to severe chronic idiopathic urticaria (CIU) who remain symptomatic (presence of hives and/or associated itching) despite optimum management with H1 antihistamines; AND  
Prescriber is experienced in the treatment of CIU (Allergist, Dermatologist, Immunologist, OR other authorized prescriber experienced in the treatment of CIU).

Treatment cessation could be considered for patients who experience complete symptom control (UAS-7 = 0) for at least 12 consecutive weeks at the end of a 24-week treatment period.

Renewal coverage is provided for 24 weeks at a maximum dose of 300 mg every 4 weeks (6 injections/24 weeks).

For the treatment of adults and adolescents (12 years of age or older) with moderate to severe chronic idiopathic urticaria (CIU);  
AND

- Patient stopped omalizumab after achieving complete symptom control (UAS-7 = 0) for at least 12 weeks while on treatment, but has experienced symptom relapse; OR
- Patient achieved complete symptom control, but for a period of less than 12 consecutive weeks; OR
- Patient achieved a partial response to treatment, defined as a  $\geq 9.5$ -point reduction in baseline urticaria activity score over 7 days (UAS-7).

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation may be considered should CIU symptoms reappear.

**150MG POWDER FOR SOLUTION**

02260565 XOLAIR

NVR

**52:00 EYE, EAR, NOSE AND THROAT (EENT) PREPARATIONS****52:28.00 EENT - MOUTHWASHES AND GARGLES****BENZYDAMINE HYDROCHLORIDE**

Limited use benefit (prior approval required).

- For the treatment of radiation mucositis and oral ulcerative complications of chemotherapy.
- For use in immunocompromised patients who are at risk of mucosal breakdown.

**0.15% MOUTHWASH**

02239044 APO-BENZYDAMINE

APX

02239537 DOM-BENZYDAMINE

DPC

02229777 PHARIXIA

PED

**52:92.00 MISCELLANEOUS EENT DRUGS****AFLIBERCEPT**

Limited use benefit (prior approval required).

For the treatment of:  
 Diabetic Macular Edema (DME)  
 Wet Age-Related Macular Degeneration (w-AMD)  
 Retinal Vein Occlusion (RVO)

Criteria for coverage of aflibercept (Eylea) for DME, RVO and w-AMD:

- Administered by a qualified ophthalmologist experienced in intravitreal injections
- Interval between doses not shorter than 1 month

Note: Coverage will be limited to a maximum of 1 vial of Eylea per eye treated every 30 days

1. For the treatment of diabetic macular edema (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 12%

2. Initial Coverage for the treatment of neovascular wet age-related macular degeneration (wAMD) 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 (< 3 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 Eylea for wAMD should be continued only in people who maintain adequate response to therapy

Treatment with Eylea 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 (2) 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 (3) consecutive visits.

3. 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).
- It is recommended that Eylea be administered once every month. The interval between two doses should not be shorter than one month. The treatment interval may be extended up to 3 months based on visual and anatomic outcomes. Prescribers are advised to periodically assess (every 1 to 2 months) the need for continued therapy.
- Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.

**40MG SOLUTION**

02415992 EYLEA

BAY

**52:92.00 MISCELLANEOUS EENT DRUGS****RANIBIZUMAB**

Limited use benefit (prior approval required).

For the treatment of:  
 Diabetic Macular Edema (DME)  
 Wet Age-Related Macular Degeneration (w-AMD)  
 Retinal Vein Occlusion (RVO)  
 Choroidal Neovascularization secondary to pathologic myopia (mCNV)

Criteria for coverage of ranibizumab (Lucentis) for DME, RVO, mCNV and w-AMD:

- Administered by a qualified ophthalmologist experienced in intravitreal injections
- Interval between doses not shorter than 1 month

Note: Coverage will be limited to a maximum of 1 vial of Lucentis per eye treated every 30 days

1. For the treatment of diabetic macular edema (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%

2. Initial Coverage for the treatment of neovascular wet age-related macular degeneration (wAMD) 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 (< 3 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 Lucentis for wAMD 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 (2) 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 (3) consecutive visits.

3. 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.

4. For the treatment of mCNV 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.

**10MG/ML SOLUTION**

02296810 LUCENTIS

NVR

02425629 LUCENTIS PFS

NVR

**VERTEPORFIN**

Limited use benefit (prior approval required).

For treatment of age related macular degeneration for patients with this diagnosis who are being treated by a certified ophthalmologist.

**15MG/VIAL POWDER FOR SOLUTION**

02242367 VISUDYNE

VAE

**56:00 GASTROINTESTINAL DRUGS****56:04.00 ANTACIDS AND ADSORBENTS****BISMUTH SUBSALICYLATE**

Limited use benefit (prior approval not required).

Coverage will be limited to 8 tablets a day every 14 days, followed by a 28 day lockout;  
OR  
Coverage will be limited to 120mL a day every 14 days, followed by a 28 day lockout.

**262MG CAPLET**

00245730 BISMUTH

JMP

**17.6MG/ML LIQUID**

02097079 PEPTO BISMOL

PGI

**262MG TABLET**

02326582 BISMUTH SUBSALICYLATE

UNK

02177994 PEPTO BISMOL

PGI

**56:22.08 ANTIHISTAMINES****DIMENHYDRINATE**

Limited use benefit (prior approval not required).

The NIHB Program implemented a dose coverage limit for DIMENHYDRINATE in June 2017 as part of a strategy to address safety concerns and potential misuse.

The dimenhydrinate dose limit is currently 400 mg per day for a total of 12,000 mg of dimenhydrinate in a 30-day period.

This limit applies only to the 15 mg and 50 mg tablets. Dimenhydrinate in liquid, suppository and injectable forms are not included in this limit.

<sup>ST</sup> **50MG TABLET**

00363766 APO DIMENHYDRINATE

APX

00013803 GRAVOL

CHU

02245416 JAMP-DIMENHYDRINATE

JMP

02377179 MOTION SICKNESS

APX

00586331 PMS-DIMENHYDRINATE

PMS

00021423 TEVA-DIMENATE

TEV

00605786 TRAVEL

VTH

**56:22.32 MISCELLANEOUS ANTIEMETICS****APREPITANT**

Limited use benefit (prior approval required).

When used in combination with a 5-HT3 antagonist and dexamethasone for the prevention of acute and delayed nausea and vomiting due to highly emetogenic cancer chemotherapy (e.g. Cisplatin > 70mg/m2).

<sup>ST</sup> **80MG CAPSULE**

02298791 EMEND

FRS

<sup>ST</sup> **125MG CAPSULE**

02298805 EMEND

FRS

<sup>ST</sup> **125MG & 80MG CAPSULE**

02298813 EMEND TRI-PACK

FRS

**56:22.92 MISCELLANEOUS ANTIEMETICS****NABILONE**

Limited use benefit (prior approval required).

For patients who are experiencing nausea and vomiting due to cancer chemotherapy or radiation;

OR

Patient is palliative (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less).

**0.25MG CAPSULE**

02312263 CESAMET

VAE

02358077 RAN-NABILONE

RBY

02392925 TEVA-NABILONE

TEV

**56:22.92 MISCELLANEOUS ANTIEMETICS****NABILONE**

Limited use benefit (prior approval required).

For patients who are experiencing nausea and vomiting due to cancer chemotherapy or radiation;

OR

Patient is palliative (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less).

**0.5MG CAPSULE**

02393581	ACT NABILONE	ACG
02256193	CESAMET	VAE
02380900	PMS-NABILONE	PMS
02358085	RAN-NABILONE	RBV
02384884	TEVA-NABILONE	TEV

**1MG CAPSULE**

02393603	ACT NABILONE	ACG
00548375	CESAMET	VAE
02380919	PMS-NABILONE	PMS
02358093	RAN-NABILONE	RBV
02384892	TEVA-NABILONE	TEV

**56:28.36 PROTON-PUMP INHIBITORS****LANSOPRAZOLE**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- All PPIs are equally efficacious
- Double dose PPI is not necessary for initial therapy
- Double dose PPI is effective in H. Pylori eradication; however, treatment is not needed beyond 14 days.

PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

All proton pump inhibitors (open benefit and limited use (LU) PPIs) have a maximum quantity limit of 400 tablets/capsules per 180 day period. This quantity limit will be in effect for the entire class of PPIs.

- For example, if a patient fills 30 tablets of rabeprazole, then switch to 30 tablets of omeprazole, then switch to 30 capsules of lansoprazole, this will count as 90 PPI tablets/capsules towards the quantity limit.
- Patients taking two rabeprazole 10mg tablets a day can be switched to one rabeprazole 20mg tablet a day to avoid reaching the quantity limit
- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

**<sup>ST</sup> 15MG CAPSULE (DELAYED RELEASE)**

02293811	APO-LANSOPRAZOLE	APX
02357682	LANSOPRAZOLE	SAN
02385767	LANSOPRAZOLE	SIV
02433001	LANSOPRAZOLE	PMS
02353830	MYLAN-LANSOPRAZOLE	MYL
02395258	PMS-LANSOPRAZOLE	PMS
02165503	PREVACID	TAK
02402610	RAN-LANSOPRAZOLE	RBV
02422808	RIVA-LANSOPRAZOLE	RIV
02385643	SANDOZ LANSOPRAZOLE	SDZ
02280515	TEVA-LANSOPRAZOLE	TEV

**<sup>ST</sup> 30MG CAPSULE (DELAYED RELEASE)**

02293838	APO-LANSOPRAZOLE	APX
02414775	DOM-LANSOPRAZOLE	DPC
02357690	LANSOPRAZOLE	SAN
02366282	LANSOPRAZOLE	PDL
02410389	LANSOPRAZOLE	SIV

**56:28.36 PROTON-PUMP INHIBITORS****LANSOPRAZOLE**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- All PPIs are equally efficacious
- Double dose PPI is not necessary for initial therapy
- Double dose PPI is effective in H. Pylori eradication; however, treatment is not needed beyond 14 days.

PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

All proton pump inhibitors (open benefit and limited use (LU) PPIs) have a maximum quantity limit of 400 tablets/capsules per 180 day period. This quantity limit will be in effect for the entire class of PPIs.

- For example, if a patient fills 30 tablets of rabeprazole, then switch to 30 tablets of omeprazole, then switch to 30 capsules of lansoprazole, this will count as 90 PPI tablets/capsules towards the quantity limit.
- Patients taking two rabeprazole 10mg tablets a day can be switched to one rabeprazole 20mg tablet a day to avoid reaching the quantity limit
- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

**<sup>ST</sup> 30MG CAPSULE (DELAYED RELEASE)**

02433028	LANSOPRAZOLE	PMS
02353849	MYLAN-LANSOPRAZOLE	MYL
02395266	PMS-LANSOPRAZOLE	PMS
02165511	PREVACID	TAK
02402629	RAN-LANSOPRAZOLE	RBY
02422816	RIVA-LANSOPRAZOLE	RIV
02280523	TEVA-LANSOPRAZOLE	TEV

**<sup>ST</sup> 30MG TABLET (DELAYED RELEASE)**

02385651	SANDOZ LANSOPRAZOLE	SDZ
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**LANSOPRAZOLE ODT**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

For children 12 years of age or under who are unable to swallow the capsule formulation; OR  
For patients with dysphagia or a feeding tube when the use of the capsule formulation is not possible.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- All PPIs are equally efficacious
- Double dose PPI is not necessary for initial therapy
- Double dose PPI is effective in H. Pylori eradication; however, treatment is not needed beyond 14 days.

PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

All proton pump inhibitors (open benefit and limited use (LU) PPIs) have a maximum quantity limit of 400 tablets/capsules per 180 day period. This quantity limit will be in effect for the entire class of PPIs.

- For example, if a patient fills 30 tablets of rabeprazole, then switch to 30 tablets of omeprazole, then switch to 30 capsules of lansoprazole, this will count as 90 PPI tablets/capsules towards the quantity limit.
- Patients taking two rabeprazole 10mg tablets a day can be switched to one rabeprazole 20mg tablet a day to avoid reaching the quantity limit
- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

**<sup>ST</sup> 15MG TABLET (DELAYED RELEASE)**

02249464	PREVACID FASTAB	TAK
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**<sup>ST</sup> 30MG TABLET (DELAYED RELEASE)**

02249472	PREVACID FASTAB	TAK
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**56:28.36 PROTON-PUMP INHIBITORS****OMEPRAZOLE MAGNESIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- All PPIs are equally efficacious
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PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

All proton pump inhibitors (open benefit and limited use (LU) PPIs) have a maximum quantity limit of 400 tablets/capsules per 180 day period. This quantity limit will be in effect for the entire class of PPIs.

- For example, if a patient fills 30 tablets of rabeprazole, then switch to 30 tablets of omeprazole, then switch to 30 capsules of lansoprazole, this will count as 90 PPI tablets/capsules towards the quantity limit.
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- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

<sup>ST</sup> **20MG CAPSULE (DELAYED RELEASE)**

02245058	APO-OMEPRAZOLE	APX
00846503	LOSEC	AZC
02329433	MYLAN-OMEPRAZOLE	MYL
02339927	OMEPRAZOLE	PDL
02348691	OMEPRAZOLE	SAN
02385384	OMEPRAZOLE	SIV
02411857	OMEPRAZOLE-20	SIV
02320851	PMS-OMEPRAZOLE	PMS
02403617	RAN-OMEPRAZOLE	RBY
02296446	SANDOZ OMEPRAZOLE	SDZ

<sup>ST</sup> **20MG TABLET (DELAYED RELEASE)**

02333430	DOM-OMEPRAZOLE DR	DPC
02420198	JAMP-OMEPRAZOLE DR	JMP
02190915	LOSEC	AZC
02439549	NAT-OMEPRAZOLE DR	NPH
02416549	OMEPRAZOLE	ACC
02310260	PMS-OMEPRAZOLE	PMS
02374870	RAN-OMEPRAZOLE	RBY
02260867	RATIO-OMEPRAZOLE	TEV
02402416	RIVA-OMEPRAZOLE DR	RIV
02295415	TEVA-OMEPRAZOLE	TEV

**56:28.36 PROTON-PUMP INHIBITORS****PANTOPRAZOLE MAGNESIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- All PPIs are equally efficacious
- Double dose PPI is not necessary for initial therapy
- Double dose PPI is effective in H. Pylori eradication; however, treatment is not needed beyond 14 days.

PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

All proton pump inhibitors (open benefit and limited use (LU) PPIs) have a maximum quantity limit of 400 tablets/capsules per 180 day period. This quantity limit will be in effect for the entire class of PPIs.

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- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

**<sup>ST</sup> 40MG TABLET (ENTERIC COATED)**

02408570	MYLAN-PANTOPRAZOLE T	MYL
02441853	PANTOPRAZOLE MAGNESIUM	UNK
02267233	TECTA	TAK
02440628	TEVA-PANTOPRAZOLE MAGNESIUM	TEV

**PANTOPRAZOLE SODIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- All PPIs are equally efficacious
- Double dose PPI is not necessary for initial therapy
- Double dose PPI is effective in H. Pylori eradication; however, treatment is not needed beyond 14 days.

PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

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Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

**<sup>ST</sup> 40MG TABLET (DELAYED RELEASE)**

02300486	ACT PANTOPRAZOLE	ACG
02292920	APO-PANTOPRAZOLE	APX
02415208	AURO-PANTOPRAZOLE	AUR
02310007	DOM-PANTOPRAZOLE	DPC
02357054	JAMP-PANTOPRAZOLE	JMP
02416565	MAR-PANTOPRAZOLE	MAR
02417448	MINT-PANTOPRAZOLE	MIN
02299585	MYLAN-PANTOPRAZOLE	MYL
02229453	PANTOLOC	TAK
02318695	PANTOPRAZOLE	PDL
02370808	PANTOPRAZOLE	SAN
02431327	PANTOPRAZOLE	RIV
02437945	PANTOPRAZOLE	PMS
02428180	PANTOPRAZOLE-40	SIV

**56:28.36 PROTON-PUMP INHIBITORS****PANTOPRAZOLE SODIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- All PPIs are equally efficacious
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PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

All proton pump inhibitors (open benefit and limited use (LU) PPIs) have a maximum quantity limit of 400 tablets/capsules per 180 day period. This quantity limit will be in effect for the entire class of PPIs.

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- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

<sup>ST</sup> **40MG TABLET (DELAYED RELEASE)**

02307871	PMS-PANTOPRAZOLE	PMS
02425378	PRIVA-PANTOPRAZOLE	PHA
02305046	RAN-PANTOPRAZOLE	RBY
02316463	RIVA-PANTOPRAZOLE	RIV
02301083	SANDOZ PANTOPRAZOLE	SDZ
02285487	TEVA-PANTOPRAZOLE	TEV

**RABEPRAZOLE SODIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- All PPIs are equally efficacious
- Double dose PPI is not necessary for initial therapy
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PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

All proton pump inhibitors (open benefit and limited use (LU) PPIs) have a maximum quantity limit of 400 tablets/capsules per 180 day period. This quantity limit will be in effect for the entire class of PPIs.

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- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

<sup>ST</sup> **10MG TABLET (ENTERIC COATED)**

02345579	APO-RABEPRAZOLE	APX
02408392	MYLAN-RABEPRAZOLE	MYL
02243796	PARIET	JSO
02310805	PMS-RABEPRAZOLE	PMS
02315181	PRO-RABEPRAZOLE	PDL
02385449	RABEPRAZOLE	SIV
02356511	RABEPRAZOLE EC	SAN
02298074	RAN-RABEPRAZOLE	RBY
02330083	RIVA-RABEPRAZOLE EC	RIV
02314177	SANDOZ RABEPRAZOLE	SDZ
02296632	TEVA-RABEPRAZOLE	TEV

**56:28.36 PROTON-PUMP INHIBITORS****RABEPRAZOLE SODIUM**

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- All PPIs are equally efficacious
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- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

**<sup>ST</sup> 20MG TABLET (ENTERIC COATED)**

02345587 APO-RABEPRAZOLE	APX
02320460 DOM-RABEPRAZOLE EC	DPC
02243797 PARIET	JSO
02310813 PMS-RABEPRAZOLE	PMS
02315203 PRO-RABEPRAZOLE	PDL
02385457 RABEPRAZOLE	SIV
02356538 RABEPRAZOLE EC	SAN
02298082 RAN-RABEPRAZOLE	RBY
02330091 RIVA-RABEPRAZOLE	RIV
02314185 SANDOZ RABEPRAZOLE	SDZ
02296640 TEVA-RABEPRAZOLE	TEV

**56:92.00 MISCELLANEOUS GI DRUGS****PINAVERIUM BROMIDE**

Limited use benefit (prior approval required).

For the treatment and relief of symptoms associated with functional bowel disorders including Irritable Bowel Syndrome (IBS), spastic colon, spastic colitis and mucous colitis; OR

In postoperative paralytic ileus in order to accelerate the resumption of the intestinal transit following abdominal surgery.

**50MG CAPSULE**

00465240 DICETEL	SPH
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**50MG TABLET**

01950592 DICETEL	BGP
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**100MG TABLET**

02230684 DICETEL	BGP
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**68:00 HORMONES AND SYNTHETIC SUBSTITUTES****68:12.00 CONTRACEPTIVES****LEVONORGESTREL INTRAUTERINE INSERT**

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 2 years.

**13.5MG INSERT (EXTENDED-RELEASE)**

02408295 JAYDESS	BAY
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**52MG INSERT (EXTENDED-RELEASE)**

02243005 MIRENA	BAY
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**68:12.00 CONTRACEPTIVES****ULIPRISTAL ACETATE**

Limited use benefit (prior approval not required).

Coverage will be limited to 90 tablets, benefits only for women age 18 to 60 years.

<sup>ST</sup> **5MG TABLET**

02408163 FIBRISTAL

ALL

**68:16.12 ESTROGEN AGONISTS-ANTAGONISTS****RALOXIFENE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For secondary prevention of osteoporosis in women who experience failure on bisphosphonates.

For secondary prevention of osteoporosis in women who have a personal history or a first degree relative with a history of breast cancer.

**60MG TABLET**

02358840 ACT RALOXIFENE

ACG

02279215 APO-RALOXIFENE

APX

02239028 EVISTA

LIL

02358921 PMS-RALOXIFENE

PMS

02415852 RALOXIFENE

PDL

02312298 TEVA-RALOXIFENE

TEV

**68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS****LINAGLIPTIN**

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.

<sup>ST</sup> **5MG TABLET**

02370921 TRAJENTA

BOE

**LINAGLIPTIN, METFORMIN HYDROCHLORIDE**

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.

<sup>ST</sup> **2.5MG & 1000MG TABLET**

02403277 JENTADUETO

BOE

<sup>ST</sup> **2.5MG & 500MG TABLET**

02403250 JENTADUETO

BOE

<sup>ST</sup> **2.5MG & 850MG TABLET**

02403269 JENTADUETO

BOE

**SAXAGLIPTIN HYDROCHLORIDE**

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.

<sup>ST</sup> **2.5MG TABLET**

02375842 ONGLYZA

AZC

<sup>ST</sup> **5MG TABLET**

02333554 ONGLYZA

AZC

**SAXAGLIPTIN HYDROCHLORIDE, METFORMIN HYDROCHLORIDE**

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.

<sup>ST</sup> **2.5MG & 1000MG TABLET**

02389185 KOMBOGLYZE

AZC

### 68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

#### SAXAGLIPTIN HYDROCHLORIDE, METFORMIN HYDROCHLORIDE

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.

<sup>ST</sup> **2.5MG & 500MG TABLET**

02389169 KOMBOGLYZE

AZC

<sup>ST</sup> **2.5MG & 850MG TABLET**

02389177 KOMBOGLYZE

AZC

#### SITAGLIPTIN PHOSPHATE MONOHYDRATE

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.

<sup>ST</sup> **25MG TABLET**

02388839 JANUVIA

FRS

<sup>ST</sup> **50MG TABLET**

02388847 JANUVIA

FRS

<sup>ST</sup> **100MG TABLET**

02303922 JANUVIA

FRS

#### SITAGLIPTIN PHOSPHATE MONOHYDRATE, METFORMIN HYDROCHLORIDE

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.

<sup>ST</sup> **50MG & 1000MG TABLET**

02333872 JANUMET

FRS

<sup>ST</sup> **50MG & 500MG TABLET**

02333856 JANUMET

FRS

<sup>ST</sup> **50MG & 850MG TABLET**

02333864 JANUMET

FRS

<sup>ST</sup> **50MG & 1000MG TABLET (EXTENDED RELEASE)**

02416794 JANUMET XR

FRS

<sup>ST</sup> **50MG & 500MG TABLET (EXTENDED RELEASE)**

02416786 JANUMET XR

FRS

<sup>ST</sup> **100MG & 1000MG TABLET (EXTENDED RELEASE)**

02416808 JANUMET XR

FRS

### 68:20.18 SODIUM-GLUCOSE CONTRANSPORTER 2 (SGLT2) INHIBITORS

#### CANAGLIFLOZIN

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.

<sup>ST</sup> **100MG TABLET**

02425483 INVOKANA

JSO

<sup>ST</sup> **300MG TABLET**

02425491 INVOKANA

JSO

**68:20.18 SODIUM-GLUCOSE CONTRANSPORTER 2 (SGLT2) INHIBITORS****DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE**

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.

<sup>ST</sup> **5MG TABLET**

02435462 FORXIGA

AZC

<sup>ST</sup> **10MG TABLET**

02435470 FORXIGA

AZC

**EMPAGLIFLOZIN**

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.

<sup>ST</sup> **10MG TABLET**

02443937 JARDIANCE

BOE

<sup>ST</sup> **25MG TABLET**

02443945 JARDIANCE

BOE

**METFORMIN HYDROCHLORIDE, DAPAGLIFLOZIN (DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE)**

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.

<sup>ST</sup> **850MG & 5MG TABLET**

02449935 XIGDUO

AZC

<sup>ST</sup> **1000MG & 5MG TABLET**

02449943 XIGDUO

AZC

**68:20.28 THIAZOLIDINEDIONES****PIOGLITAZONE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

<sup>ST</sup> **15MG TABLET**

02303442 ACCEL PIOGLITAZONE

ACP

02391600 ACH-PIOGLITAZONE

ACC

02302861 ACT PIOGLITAZONE

ACG

02242572 ACTOS

TAK

02302942 APO-PIOGLITAZONE

APX

02307634 DOM-PIOGLITAZONE

DPC

02397307 JAMP-PIOGLITAZONE

JMP

02326477 MINT-PIOGLITAZONE

MIN

02298279 MYLAN-PIOGLITAZONE

MYL

02307669 PHL-PIOGLITAZONE

PHH

02303124 PMS-PIOGLITAZONE

PMS

02312050 PRO-PIOGLITAZONE

PDL

02375850 RAN-PIOGLITAZONE

RBY

02297906 SANDOZ PIOGLITAZONE

SDZ

02274914 TEVA-PIOGLITAZONE

TEV

02434121 VAN-PIOGLITAZONE

VAN

<sup>ST</sup> **30MG TABLET**

02303450 ACCEL PIOGLITAZONE

ACP

02339587 ACH-PIOGLITAZONE

ACC

02302888 ACT PIOGLITAZONE

ACG

**68:20.28 THIAZOLIDINEDIONES****PIOGLITAZONE HYDROCHLORIDE**

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

<sup>ST</sup> **30MG TABLET**

02242573	ACTOS	TAK
02302950	APO-PIOGLITAZONE	APX
02307642	DOM-PIOGLITAZONE	DPC
02365529	JAMP-PIOGLITAZONE	JMP
02326485	MINT-PIOGLITAZONE	MIN
02298287	MYLAN-PIOGLITAZONE	MYL
02307677	PHL-PIOGLITAZONE	PHH
02303132	PMS-PIOGLITAZONE	PMS
02312069	PRO-PIOGLITAZONE	PDL
02375869	RAN-PIOGLITAZONE	RBY
02297914	SANDOZ PIOGLITAZONE	SDZ
02274922	TEVA-PIOGLITAZONE	TEV
02434148	VAN-PIOGLITAZONE	VAN

<sup>ST</sup> **45MG TABLET**

02303469	ACCEL PIOGLITAZONE	ACP
02339595	ACH-PIOGLITAZONE	ACC
02302896	ACT PIOGLITAZONE	ACG
02242574	ACTOS	TAK
02302977	APO-PIOGLITAZONE	APX
02307650	DOM-PIOGLITAZONE	DPC
02365537	JAMP-PIOGLITAZONE	JMP
02326493	MINT-PIOGLITAZONE	MIN
02298295	MYLAN-PIOGLITAZONE	MYL
02307723	PHL-PIOGLITAZONE	PHH
02303140	PMS-PIOGLITAZONE	PMS
02312077	PRO-PIOGLITAZONE	PDL
02375877	RAN-PIOGLITAZONE	RBY
02297922	SANDOZ PIOGLITAZONE	SDZ
02274930	TEVA-PIOGLITAZONE	TEV
02434156	VAN-PIOGLITAZONE	VAN

**ROSIGLITAZONE MALEATE**

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

<sup>ST</sup> **2MG TABLET**

02403366	APO-ROSIGLITAZONE	APX
02241112	AVANDIA	GSK

<sup>ST</sup> **4MG TABLET**

02403374	APO-ROSIGLITAZONE	APX
02241113	AVANDIA	GSK

<sup>ST</sup> **8MG TABLET**

02403382	APO-ROSIGLITAZONE	APX
02241114	AVANDIA	GSK

**68:32.00 PROGESTINS****DIENOGEST**

Limited use benefit (prior approval required).

For the management of pelvic pain associated with endometriosis.

<sup>ST</sup> **2MG TABLET**

02374900 VISANNE

BAY

**PROGESTERONE**

Limited use benefit (prior approval required).

For the treatment of women:

- With postmenopausal symptoms who are intolerant to medroxyprogesterone acetate (MPA); OR
- Who are at risk of preterm birth; OR
- Who are using the medication to prevent miscarriage.

<sup>ST</sup> **100MG CAPSULE**

02166704 PROMETRIUM

FRS

02439913 TEVA-PROGESTERONE

TEV

**84:00 SKIN AND MUCOUS MEMBRANE AGENTS (SMMA)****84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS****IMIQUIMOD**

Limited use benefit (prior approval required).

For the treatment of condylomata acuminata (genital warts) in patients who have failed:

- self-applied podophyllotoxin (podofilox 0.5% solution); OR
- provider-applied podophyllum resin (10%-25%).

**5% CREAM**

02239505 ALDARA P

VAE

02407825 APO-IMIQUIMOD

APX

**PIMECROLIMUS**

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

Note: Contraindicated in children less than 2 years of age.

**1% CREAM**

02247238 ELIDEL

VAE

**SECUKINUMAB**

Limited use benefit (prior approval required).

Coverage is provided for an initial period of 12 weeks at a dose of 300mg at Weeks 0, 1, 2 and 3, followed by 300mg per month starting at Week 4.

- Prescribed by a dermatologist

For the treatment of patients with moderate to severe PSORIASIS who meet all of the following criteria:

- Body surface area (BSA) involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region; AND
- Intolerance or lack of response to phototherapy; OR
- Inability to access phototherapy; AND
- Intolerance or lack of response to methotrexate (MTX) weekly oral or parenteral at 20 mg or greater (15 mg or greater if patient is > 65 years of age) for more than 8 weeks; AND
- Intolerance or lack of response to cyclosporine; OR
- A contraindication to methotrexate or cyclosporine.

Coverage beyond 12 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI):

- A 75% reduction in Psoriasis Area Severity Index (PASI) score; OR
- A ≥ 50% reduction in the Psoriasis Area Severity Index (PASI) score with a ≥ 5-point improvement in the Dermatology Life Quality Index (DLQI); OR
- A significant reduction in Body Surface Area (BSA) involved, with consideration of important areas such as the face, hands, feet or genital regions.

**150MG SOLUTION**

02438070 COSENTYX

NVR

**84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS****TACROLIMUS (PROTOPIC)**

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

Note: Contraindicated in children less than 2 years of age.

**0.03% OINTMENT**

02244149 PROTOPIC

LEO

**0.1% OINTMENT**

02244148 PROTOPIC

LEO

**86:00 SMOOTH MUSCLE RELAXANTS****86:12.00 GENITOURINARY SMOOTH MUSCLE RELAXANTS****TOLTERODINE TARTRATE**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

<sup>ST</sup> **1MG TABLET**

02423308 MINT-TOLTERODINE

MIN

<sup>ST</sup> **2MG TABLET**

02423316 MINT-TOLTERODINE

MIN

**86:12.04 ANTIMUSCARINICS****DARIFENACIN HYDROBROMIDE**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

**7.5MG TABLET (EXTENDED RELEASE)**

02273217 ENABLEX

MRL

**15MG TABLET (EXTENDED RELEASE)**

02273225 ENABLEX

MRL

**FESOTERODINE FUMARATE**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

<sup>ST</sup> **4MG TABLET (EXTENDED RELEASE)**

02380021 TOVIAZ

PFI

<sup>ST</sup> **8MG TABLET (EXTENDED RELEASE)**

02380048 TOVIAZ

PFI

**TOLTERODINE TARTRATE**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

<sup>ST</sup> **1MG TABLET**

02369680 APO-TOLTERODINE

APX

02239064 DETROL

PFI

02299593 TEVA-TOLTERODINE

TEV

<sup>ST</sup> **2MG TABLET**

02369699 APO-TOLTERODINE

APX

**86:12.04 ANTIMUSCARINICS****TOLTERODINE TARTRATE**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

<sup>ST</sup> **2MG TABLET**

02239065 DETROL

PFI

02299607 TEVA-TOLTERODINE

TEV

**TROSPIMUM CHLORIDE**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

<sup>ST</sup> **20MG TABLET**

02275066 TROSEC

SPC

**86:12.08 BETA-ADRENERGIC AGONISTS****MIRABEGRON**

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

<sup>ST</sup> **25MG TABLET (EXTENDED RELEASE)**

02402874 MYRBETRIQ

AST

<sup>ST</sup> **50MG TABLET (EXTENDED RELEASE)**

02402882 MYRBETRIQ

AST

**88:00 VITAMINS****88:20.00 VITAMIN E****VITAMIN E**

Limited use benefit (prior approval required).

For use in malabsorption

<sup>ST</sup> **100IU CAPSULE**

00122823 VITAMIN E

JAM

<sup>ST</sup> **200IU CAPSULE**

00122831 VITAMIN E

JAM

<sup>ST</sup> **400IU CAPSULE**

00122858 VITAMIN E

JAM

<sup>ST</sup> **800IU CAPSULE (SOFTGEL)**

00330191 VITAMIN E

JAM

<sup>ST</sup> **50IU ORAL LIQUID**

00480215 AQUASOL E

NVC

<sup>ST</sup> **50IU/ML ORAL LIQUID**

02162075 AQUASOL E VITAMIN E

CLC

**88:28.00 MULTIVITAMIN PREPARATIONS****MULTIVITAMINS (PEDIATRIC)**

Limited use benefit (prior approval is not required).

Pediatric multivitamins are benefits for children up to 6 years of age.

<sup>ST</sup> **DROP**

00762946 ENFAMIL POLYVISOL

MJO

**88:28.00 MULTIVITAMIN PREPARATIONS****MULTIVITAMINS (PEDIATRIC)**

Limited use benefit (prior approval is not required).

Pediatric multivitamins are benefits for children up to 6 years of age.

<sup>ST</sup> **450MG & 10MG & 30MG LIQUID**

80008471 JAMP VITAMIN A, D AND C

JMP

<sup>ST</sup> **2,500IU & 666.67IU & 50MG/ML LIQUID**

00762903 ENFAMIL TRIVISOL

MJO

02229790 PEDIAVIT

EUR

<sup>ST</sup> **TABLET (CHEWABLE)**

80011134 CENTRUM JUNIOR COMPLETE

PFI

80020794 CENTRUM JUNIOR COMPLETE

PFI

02247995 FLINTSTONES MULTIPLE VITAMINS PLUS IRON

BAY

02247975 FLINTSTONES MULTIPLE VITAMINS WITH EXTRA C

BAY

**MULTIVITAMINS (PRENATAL)**

Limited use benefit (prior approval is not required.).

Prenatal and postnatal vitamins are benefits only for women of childbearing age (12 to 50 years).

<sup>ST</sup> **TABLET**

80042704 CENTRUM DHA

PFI

80045822 CENTRUM PRENATAL

PFI

80001842 NESTLÉ MATERNA

NES

02241235 PRENATAL AND POSTPARTUM VITAMINS AND MINERALS

VTH

80005770 PRENATAL AND POSTPARTUM VITAMINS AND MINERALS

PMT

02229535 WAMPOLE COMPLETE MULT-PRE AND POST NATAL WITH FOLIC ACID

WAM

**92:00 UNCLASSIFIED THERAPEUTIC AGENTS****92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS****USTEKINUMAB**

Limited use benefit (prior approval required).

Coverage is provided for an initial period of 16 weeks. For patients  $\leq$  100 kg, the initial dose is 45 mg at week 0, followed by 45 mg at weeks 4 and 16.

Alternatively, ustekinumab 90 mg may be used in patients weighing more than 100 kg. Response must be assessed prior to a fourth dose and further doses will be provided only for responders.

- Prescribed by a dermatologist

For the treatment of patients with moderate to severe PSORIASIS who meet all of the following criteria:

- Body surface area (BSA) involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region; AND
- Intolerance or lack of response to phototherapy; OR
- Inability to access phototherapy; AND
- Intolerance or lack of response to methotrexate (MTX) weekly oral or parenteral at 20 mg or greater (15 mg or greater if patient is > 65 years of age) for more than 8 weeks; AND
- Intolerance or lack of response to cyclosporine; OR
- A contraindication to methotrexate or cyclosporine.

Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI):

- A 75% reduction in Psoriasis Area Severity Index (PASI) score; OR
- A  $\geq$  50% reduction in the Psoriasis Area Severity Index (PASI) score with a  $\geq$  5-point improvement in the Dermatology Life Quality Index (DLQI); OR
- A significant reduction in Body Surface Area (BSA) involved, with consideration of important areas such as the face, hands, feet or genital regions.

**45MG/0.5ML SOLUTION**

02320673 STELARA

JSO

**90MG/ML SOLUTION**

02320681 STELARA

JSO

**92:08.00 5 ALFA REDUCTASE INHIBITORS****DUTASTERIDE**

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 adrenergic blocker.

OR

For use in combination therapy when monotherapy with an alpha-blocker is not sufficient.

<sup>ST</sup> **0.5MG CAPSULE**

02412691	ACT DUTASTERIDE	ACG
02404206	APO-DUTASTERIDE	APX
02247813	AVODART	GSK
02421712	DUTASTERIDE	PDL
02429012	DUTASTERIDE	SIV
02443058	DUTASTERIDE	SAN
02416298	MED-DUTASTERIDE	GMP
02428873	MINT-DUTASTERIDE	MIN
02393220	PMS-DUTASTERIDE	PMS
02427753	RIVA-DUTASTERIDE	RIV
02424444	SANDOZ DUTASTERIDE	SDZ
02408287	TEVA-DUTASTERIDE	TEV

**FINASTERIDE**

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.

<sup>ST</sup> **5MG TABLET**

02355043	ACH-FINASTERIDE	ACC
02354462	ACT FINASTERIDE	ACG
02365383	APO-FINASTERIDE	APX
02405814	AURO-FINASTERIDE	AUR
02376709	DOM-FINASTERIDE	DPC
02350270	FINASTERIDE	PDL
02445077	FINASTERIDE	SAN
02447541	FINASTERIDE	SIV
02357224	JAMP-FINASTERIDE	JMP
02389878	MINT-FINASTERIDE	MIN
02310112	PMS-FINASTERIDE	PMS
02010909	PROSCAR	FRS
02371820	RAN-FINASTERIDE	RBY
02306905	RATIO-FINASTERIDE	TEV
02455013	RIVA-FINASTERIDE	RIV
02322579	SANDOZ FINASTERIDE	SDZ
02348500	TEVA-FINASTERIDE	TEV
02428741	VAN-FINASTERIDE	VAN

**92:16.00 ANTIGOUT AGENTS****FEBUXOSTAT**

Limited use benefit (prior approval required).

For patients with symptomatic gout who have documented hypersensitivity to allopurinol.

<sup>ST</sup> **80MG TABLET**

02357380	ULORIC	TAK
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**92:24.00 BONE RESORPTION INHIBITORS****DENOSUMAB (PROLIA)**

Limited use benefit (prior approval required).

For women with postmenopausal osteoporosis who have failed or have a contraindication to bisphosphonates due to hypersensitivity or abnormalities of the esophagus (e.g., esophageal stricture or achalasia);

AND who have at least two of the following:

- age >70 years
- a prior fragility fracture
- a bone mineral density (BMD) T-score  $\leq$  -2.5

Maximum dose covered is 60mg per 6-month period.

**60MG/ML SOLUTION**

02343541 PROLIA

AMG

**DENOSUMAB (XGEVA)**

Limited use benefit (prior approval required).

For the prevention of skeletal-related events (SREs) in patients with castrate-resistant prostate cancer (CRPC) with:

- one or more documented bone metastases; AND
- good performance status (ECOG performance status score of 0, 1, or 2).

**120MG/1.7ML SOLUTION**

02368153 XGEVA

AMG

**ZOLEDRONIC ACID MONOHYDRATE**

Limited use benefit (prior approval required).

For the treatment of Paget's disease. Coverage will be granted for one dose per 12 month period;

OR

For women with postmenopausal osteoporosis who would otherwise be eligible for coverage of oral bisphosphonates, but who have a contraindication to bisphosphonates due to hypersensitivity or abnormalities of the esophagus (e.g., esophageal stricture or achalasia);

AND who have at least two of the following:

- age >70 years
- a prior fragility fracture
- a bone mineral density (BMD) T-score  $\leq$  - 2.5.

**5MG/100ML SOLUTION**

02269198 ACLASTA

NVR

02415100 TARO-ZOLEDRONIC ACID

TAR

02408082 ZOLEDRONIC ACID

TEV

02422433 ZOLEDRONIC ACID

REC

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

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 500mg IV for patients weighting <60kg; 750mg IV for patients weighting 60kg to 100kg; and 1000mg IV for patients weighing >100kg. Initial IV doses are given at 0, 2, and 4 weeks, then every 4 weeks. Alternatively, a single weight-based IV loading dose is covered (if required), followed by 125mg SC weekly.

- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients  $\geq$  18 years who have failed:

- MTX (oral or parenteral) at a dose  $\geq$  20 mg weekly ( $\geq$  15 mg weekly if patient is  $\geq$  65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

AND (FOR IV FORMULATION ONLY):

- etanercept (sc) OR adalimumab (sc) OR golimumab (sc) OR certolizumab (sc) OR abatacept (sc) OR tocilizumab OR tofacitinib (po) or Inflectra (iv): for a minimum trial of 12 weeks.

Coverage beyond one year will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Coverage is provided for an initial period of 16 weeks at a dose of 10mg/kg for children weighing < 75kg; Pediatric patients weighing 75kg or more should be dosed according to the adult regimen, not to exceed a maximum dose of 1000mg. Doses are given at 0, 2, and 4 weeks, then every 4 weeks.

- Prescribed by a rheumatologist

In patients six to seventeen years of age who meet the following criteria:

- $\geq$  5 swollen joints; AND
- $\geq$  3 joints with limited range of motion and/or pain/tenderness; AND
- Condition is refractory to an adequate trial of a therapeutic dose of methotrexate.

Coverage beyond 16 weeks is based on a >30% improvement in 3 of 6 baseline clinical parameters

Patient has experienced 3 of 6 of the following variables:

- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR; AND
- No more than one of these variables has worsened by greater than 30%

**250MG POWDER FOR SOLUTION**

02282097 ORENCIA

BMS

**125MG SOLUTION**

02402475 ORENCIA

BMS

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

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 40 mg every two weeks.

- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients  $\geq 18$  years who have failed:

- MTX (oral or parenteral) at a dose  $\geq 20$  mg weekly ( $\geq 15$  mg weekly if patient is  $\geq 65$  years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond one year will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

- $>20\%$  reduction in number of tender and swollen joints; PLUS
- $>20\%$  improvement in Physician Global Assessment scale; PLUS either
- $>20\%$  improvement in Patient Global Assessment scale; OR
- $>20\%$  reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 40 mg every two weeks.

- Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:

- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids  $> 12$  hours per day for pain resulting from inflammation

AND patient is refractory to:

- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;
- PLUS a minimum of any two of the following:
- methotrexate weekly (weekly oral or parenteral) at 20mg or greater (15mg or greater if patient is  $>65$  years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:

- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)  $\geq 4$ ; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

Coverage beyond one year will be based on improvement according to the Psoriatic Arthritis Response Criteria (PsARC).

- Improvement in at least two of the four PsARC criteria, one of which has to be joint tenderness or swelling score, with no worsening in any of the four criteria. A response in joint count is determined by a reduction of  $\geq 30\%$ . A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.

3. For the treatment of ANKYLOSING SPONDYLITIS

Coverage is provided for an initial period of one year at a dose of 40 mg every two weeks.

- Prescribed by a rheumatologist
- BASDAI  $> 4$ ; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks; AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) (weekly oral or parenteral) weekly at 20 mg or greater (15 mg or greater if patient is  $>65$  years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond one year will be based on improvement in the BASDAI score.

- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.

4. For the treatment of patients with moderate to severe PSORIASIS who meet all of the following criteria:

Coverage is provided for an initial period of 16 weeks at a dose of 80 mg as an initial dose, followed by 40 mg every 2 weeks, starting one week after the initial dose.

- Prescribed by a dermatologist
- Body surface area (BSA) involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region; AND
- Intolerance or lack of response to phototherapy; OR
- Inability to access phototherapy; AND
- Intolerance or lack of response to methotrexate (MTX) (weekly oral or parenteral) at 20 mg or greater (15 mg or greater if patient is  $> 65$  years of age) for more

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than 8 weeks; AND

- Intolerance or lack of response to cyclosporine; OR
- A contraindication to methotrexate or cyclosporine.

Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI):

- A 75% reduction in Psoriasis Area Severity Index (PASI) score; OR
- A  $\geq$  50% reduction in the Psoriasis Area Severity Index (PASI) score with a  $\geq$  5-point improvement in the Dermatology Life Quality Index (DLQI); OR
- A significant reduction in Body Surface Area (BSA) involved, with consideration of important areas such as the face, hands, feet or genital regions.

5. For the treatment of moderately to severely active CROHN'S DISEASE

Coverage is provided for an initial period of 12 weeks at an induction dose of 160 mg, followed by 80 mg two weeks later. Maintenance therapy is provided at a dose not exceeding 40 mg every two weeks.

- Prescribed by a gastroenterology specialist

Patient meets the following criteria:

- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication;

PLUS

- Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
- 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR
- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks..

Coverage beyond the initial twelve-week period will be based on improvement in the CDAI or HBI scores.

- At least a 100-point reduction in the Crohn's Disease Activity Index (CDAI) OR at least a 3-point reduction in the Harvey Bradshaw Index (HBI).

6. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 24 mg/m<sup>2</sup> body surface area up to a maximum single dose of 40 mg every other week.

- Prescribed by a rheumatologist

In patients two years of age and older who meet the following criteria:

- $\geq$  5 swollen joints; AND
- $\geq$  3 joints with limited range of motion and/or pain/tenderness; AND
- Condition is refractory to an adequate trial of a therapeutic dose of methotrexate.

Coverage beyond the initial one-year period will be based on a 30% improvement in 3 of 6 clinical parameters

Patient has experienced 3 of 6 of the following variables:

- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR; AND
- No more than one of these variables has worsened by greater than 30%

7. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:

Coverage is provided for an initial period of 12 weeks at a dose of 160 mg at week 0, followed by 80 mg two weeks later and then 40 mg every two weeks thereafter.

- Prescribed by expert in gastroenterology
- Partial Mayo score > 4
- Inadequate response to conventional therapies:
  - 5-ASA 4grams/day for 6 weeks; PLUS
  - Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication.

Coverage beyond the initial 12 week period will be based on improvement in the partial Mayo score of  $\geq$  2 points.

**40MG/VIAL SOLUTION**

02258595 HUMIRA

ABV

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

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 400mg at weeks 0, 2, and 4, followed by 200mg every other week or 400mg every 4 weeks.  
 • Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients  $\geq 18$  years who have failed:

- MTX (oral or parenteral) at a dose  $\geq 20$  mg weekly ( $\geq 15$  mg weekly if patient is  $\geq 65$  years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 400mg at weeks 0, 2, and 4, followed by 200mg every other week or 400mg every 4 weeks.  
 • Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:

- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:

- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;
- PLUS a minimum of any two of the following:
- methotrexate weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:

- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)  $\geq 4$ ; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

Coverage beyond one year will be based on improvement according to the Psoriatic Arthritis Response Criteria (PsARC).

- Improvement in at least two of the four PsARC criteria, one of which has to be joint tenderness or swelling score, with no worsening in any of the four criteria. A response in joint count is determined by a reduction of  $\geq 30\%$ . A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.

3. For the treatment of ANKYLOSING SPONDYLITIS

Coverage is provided for an initial period of one year at a dose of 400mg at weeks 0, 2, and 4, followed by 200mg every other week or 400mg every 4 weeks.  
 • Prescribed by a rheumatologist

- BASDAI > 4; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks;
- AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) weekly at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond the initial three doses will be based on improvement in the BASDAI score.

- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.

**200MG/ML SOLUTION**

02331675 CIMZIA

UCB

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

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 50 mg weekly.

- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients  $\geq 18$  years who have failed:

- MTX (oral or parenteral) at a dose  $\geq 20$  mg weekly ( $\geq 15$  mg weekly if patient is  $\geq 65$  years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

- $>20\%$  reduction in number of tender and swollen joints; PLUS
- $>20\%$  improvement in Physician Global Assessment scale; PLUS either
- $>20\%$  improvement in Patient Global Assessment scale; OR
- $>20\%$  reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 50 mg weekly.

- Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:

- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids  $> 12$  hours per day for pain resulting from inflammation

AND patient is refractory to:

- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;
- PLUS a minimum of any two of the following:
- methotrexate (oral or parenteral) at 20mg or greater (15mg or greater if patient is  $>65$  years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:

- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)  $\geq 4$ ; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

Coverage beyond one year will be based on improvement according to the Psoriatic Arthritis Response Criteria (PsARC).

- Improvement in at least two of the four PsARC criteria, one of which has to be joint tenderness or swelling score, with no worsening in any of the four criteria. A response in joint count is determined by a reduction of  $\geq 30\%$ . A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.

3. For the treatment of ANKYLOSING SPONDYLITIS

Coverage is provided for an initial period of one year at a dose of 50 mg weekly.

- Prescribed by a rheumatologist
- BASDAI  $> 4$ ; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks; AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) weekly (oral or parenteral) at 20 mg or greater (15 mg or greater if patient is  $>65$  years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond one year will be based on improvement in the BASDAI score.

- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.

4. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Coverage is provided for children age 4 to 17, for an initial period of one year at a dose of 0.8 mg/kg/week body surface area up to a maximum single dose of 50 mg/week.

- Prescribed by a rheumatologist

In patients four to seventeen years of age and older who meet the following criteria:

- $\geq 5$  swollen joints; AND
- $\geq 3$  joints with limited range of motion and/or pain/tenderness; AND

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- Condition is refractory to an adequate trial of a therapeutic dose of methotrexate.

Coverage beyond the initial one-year period will be based on a 30% improvement in 3 of 6 clinical parameters.

Patient has experienced 3 of 6 of the following variables:

- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR

AND

- No more than one of these variables has worsened by greater than 30%

**25MG/VIAL INJECTION**

02242903 ENBREL

PED

**50MG/ML INJECTION**

02274728 ENBREL

PED

99100373 ENBREL SURECLICK

AMG

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

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 50 mg every month.

- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients  $\geq 18$  years who have failed:

- MTX (oral or parenteral) at a dose  $\geq 20$  mg weekly ( $\geq 15$  mg weekly if patient is  $\geq 65$  years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND

- MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX;
- A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond one year will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

- $>20\%$  reduction in number of tender and swollen joints; PLUS
- $>20\%$  improvement in Physician Global Assessment scale; PLUS either
- $>20\%$  improvement in Patient Global Assessment scale; OR
- $>20\%$  reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 50 mg every month.

- Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:

- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids  $> 12$  hours per day for pain resulting from inflammation

AND patient is refractory to:

- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;

PLUS a minimum of any two of the following:

- methotrexate weekly parenteral at 20mg or greater (15mg or greater if patient is  $>65$  years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:

- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)  $\geq 4$ ; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

Coverage beyond one year will be based on improvement according to the Psoriatic Arthritis Response Criteria (PsARC).

- Improvement in at least two of the four PsARC criteria, one of which has to be joint tenderness or swelling score, with no worsening in any of the four criteria. A response in joint count is determined by a reduction of  $\geq 30\%$ . A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.

3. For the treatment of ANKYLOSING SPONDYLITIS

Coverage is provided for an initial period of one year at a dose of 50 mg every month.

- Prescribed by a rheumatologist
  - BASDAI  $> 4$ ; AND
  - Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks;
- AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) (oral or parenteral) weekly at 20 mg or greater (15 mg or greater if patient is  $>65$  years of age) for more than 8 weeks; AND
  - Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond one year will be based on improvement in the BASDAI score.

- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.

4. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:

Coverage is provided for an initial period of three months at a dose of 200 mg at week 0, followed by 100 mg at week 2 and then 50 mg every four weeks thereafter.

- Prescribed by expert in gastroenterology
- Partial Mayo score  $> 4$
- Inadequate response to conventional therapies:
  - 5-ASA 4grams/day for 6 weeks; PLUS

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- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication.

The treating physician may utilize 100 mg every four weeks as a maintenance dose if necessary.

Coverage beyond one year will be based on a decrease in the partial Mayo score of  $\geq 2$  points and patients should be off corticosteroids.

**50MG/0.5ML SOLUTION**

02324776 SIMPONI

JSO

02324784 SIMPONI

JSO

**100MG/ML SOLUTION**

02413175 SIMPONI

JSO

02413183 SIMPONI

JSO

**92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS****INFLIXIMAB (INFLECTRA)**

Limited use benefit (prior approval required).

Coverage for INFLECTRA will be approved indefinitely.

1. For the treatment of severely active RHEUMATOID ARTHRITIS

- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients  $\geq 18$  years who have failed:

- MTX (oral or parenteral) at a dose  $\geq 20$  mg weekly ( $\geq 15$  mg weekly if patient is  $\geq 65$  years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND

- MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX;
- A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

- Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:

- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:

- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;

PLUS a minimum of any two of the following:

- methotrexate weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:

- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)  $\geq 4$ ; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

3. For the treatment of ANKYLOSING SPONDYLITIS

- Prescribed by a rheumatologist
- BASDAI > 4; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks; AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) weekly at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

4. For the treatment of patients with moderate to severe PSORIASIS who meet all of the following criteria:

- Prescribed by a dermatologist
  - Body surface area (BSA) involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region;
- AND
- Intolerance or lack of response to phototherapy; OR
  - Inability to access phototherapy;
- AND
- Intolerance or lack of response to methotrexate (MTX) weekly oral or parenteral (SC or IM) at 20 mg or greater (15 mg or greater if patient is > 65 years of age) for more than 8 weeks;
- AND
- Intolerance or lack of response to cyclosporine; OR
  - A contraindication to methotrexate or cyclosporine.

5. For the treatment of moderately to severely active CROHN'S DISEASE

- Prescribed by a gastroenterology specialist

Patient meets the following criteria:

- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication;
- PLUS
- Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
  - 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR

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- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks.

## 6. For the treatment of FISTULIZING CROHN'S DISEASE

- Prescribed by a gastroenterology specialist

Patient meets all the following criteria:

- Patients with actively draining perianal or enterocutaneous fistulae that are refractory to a course of appropriate antibiotic therapy (e.g. ciprofloxacin with or without metronidazole for a minimum of 3 weeks);

PLUS

Patient has failed a trial of one (1) immunosuppressive agent:

- Azathioprine 2 to 2.5 mg/kg/day for a minimum of 3 months or treatment discontinued at < 3 months due to severe adverse reactions.

OR

- 6-mercaptopurine 50-70 mg/day for a minimum of 3 months or treatment discontinued at <3 months due to severe adverse reactions.

## 7. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:

- Prescribed by expert in gastroenterology

- Partial Mayo score > 4

- Inadequate response to conventional therapies:

- 5-ASA 4grams/day for 6 weeks; PLUS

- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication.

**100MG POWDER FOR SOLUTION**

02419475 INFLECTRA

HOS

**92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS****INFLIXIMAB (REMICADE)**

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial three doses of 3 mg/kg, administered at 0, 2 and 6 weeks.

- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients  $\geq 18$  years who have failed:

- MTX (oral or parenteral) at a dose  $\geq 20$  mg weekly ( $\geq 15$  mg weekly if patient is  $\geq 65$  years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

- $>20\%$  reduction in number of tender and swollen joints; PLUS
- $>20\%$  improvement in Physician Global Assessment scale; PLUS either
- $>20\%$  improvement in Patient Global Assessment scale; OR
- $>20\%$  reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderately to severely active CROHN'S DISEASE

Coverage is provided for an initial three doses of 5 mg/kg, administered at 0, 2 and 6 weeks.

- Prescribed by a gastroenterology specialist

Patient meets the following criteria:

- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication; PLUS
- Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
- 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR
- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks.

Coverage beyond the initial three doses will be based on improvement in the CDAI or HBI scores.

- At least a 100-point reduction in the Crohn's Disease Activity Index (CDAI) OR at least a 3-point reduction in the Harvey Bradshaw Index (HBI).

3. For the treatment of FISTULIZING CROHN'S DISEASE

Coverage is provided for an initial three doses of 5 mg/kg, administered at 0, 2 and 6 weeks.

- Prescribed by a gastroenterology specialist

Patient meets all the following criteria:

- Patients with actively draining perianal or enterocutaneous fistulae that are refractory to a course of appropriate antibiotic therapy (e.g. ciprofloxacin with or without metronidazole for a minimum of 3 weeks);

PLUS

Patient has failed a trial of one (1) immunosuppressive agent:

- Azathioprine 2 to 2.5 mg/kg/day for a minimum of 3 months or treatment discontinued at  $< 3$  months due to severe adverse reactions. OR
- 6-mercaptopurine 50-70 mg/day for a minimum of 3 months or treatment discontinued at  $< 3$  months due to severe adverse reactions.

Coverage beyond the initial three doses will be based on improvement or closure of actively draining fistulae

- Closure of individual fistulae as evidenced by no, or minimal, fistulae drainage and bleeding.

**100MG/VIAL POWDER FOR SOLUTION**

02244016 REMICADE

JSO

**92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS****TOCILIZUMAB (IV)**

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for 16 weeks at an initial dose of 4 mg/kg/dose every 4 weeks.

- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients  $\geq 18$  years who have failed:

- MTX (oral or parenteral) at a dose  $\geq 20$  mg weekly ( $\geq 15$  mg weekly if patient is  $\geq 65$  years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND

- MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX;
- A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond 16 weeks, at a dose of up to 8 mg/kg/dose (maximum dose of 800 mg per infusion) every 4 weeks, is based on a 20% improvement from baseline in swollen and tender joint counts, plus a 20% improvement in 2 of 5 baseline clinical parameters.

- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of active SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS

Initial 16-week coverage is provided at a dose of 12 mg/kg once every two weeks for children weighing < 30 kg and 8 mg/kg for children weighing  $\geq 30$  kg.

- Prescribed by a rheumatologist

In patients two to seventeen years of age and older who meet the following criteria:

- Have responded inadequately to non-steroidal anti-inflammatory drugs (NSAIDs) and systemic corticosteroids (with or without methotrexate), due to intolerance or lack of efficacy.

Coverage beyond 16 weeks is based on a >30% improvement in 3 of 6 baseline clinical parameters

Patient has experienced 3 of 6 of the following variables:

- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR

AND

- No more than one of these variables has worsened by greater than 30%

3. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Initial 16-week coverage is provided at a dose of 10 mg/kg once every four weeks for children weighing < 30 kg and 8 mg/kg for children weighing  $\geq 30$  kg.

- Prescribed by a rheumatologist

In patients two years of age and older who meet the following criteria:

- $\geq 5$  swollen joints; AND
- $\geq 3$  joints with limited range of motion and/or pain/tenderness; AND
- Condition is refractory to an adequate trial of a therapeutic dose of methotrexate.

Coverage beyond 16 weeks is based on a >30% improvement in 3 of 6 baseline clinical parameters

Patient has experienced 3 of 6 of the following variables:

- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR; AND
- No more than one of these variables has worsened by greater than 30%

**80MG/4ML SOLUTION**

02350092 ACTEMRA

HLR

**200MG/10ML SOLUTION**

02350106 ACTEMRA

HLR

**400MG/20ML SOLUTION**

02350114 ACTEMRA

HLR

**92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS****TOCILIZUMAB (SC)**

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year. Initial approvals for patients < 100 kg will be for a dose of 162 mg every other week up to a maximum dose of 162 mg every week (Maximum 51 doses). For patients weighing 100 kg or more, coverage is provided at a dose of 162 mg weekly (Maximum 52 doses).  
 • Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:

• MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND

• MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX:

• A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

**162MG SOLUTION**

02424770 ACTEMRA

HLR

**TOFACITINIB CITRATE**

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage of tofacitinib in adult patients ≥ 18 years is provided at a MAXIMUM dose of 10mg daily for an initial period of one year.

• Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:

• MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND

• MTX in combination with at least two other DMARDs, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX:

• A combination of at least two DMARDs, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

**5MG TABLET**

02423898 XELJANZ

PFI

**92:44.00 IMMUNOSUPPRESSIVE AGENTS****CYCLOSPORINE**

Limited use benefit (prior approval required).

For transplant therapy.

**<sup>ST</sup> 10MG CAPSULE**

02237671 NEORAL

NVR

**<sup>ST</sup> 25MG CAPSULE**

02150689 NEORAL

NVR

02247073 SANDOZ CYCLOSPORINE

SDZ

**<sup>ST</sup> 50MG CAPSULE**

02150662 NEORAL

NVR

02247074 SANDOZ CYCLOSPORINE

SDZ

**92:44.00 IMMUNOSUPPRESSIVE AGENTS****CYCLOSPORINE**

Limited use benefit (prior approval required).

For transplant therapy.

<sup>ST</sup> **100MG CAPSULE**

02150670 NEORAL NVR

02242821 SANDOZ CYCLOSPORINE SDZ

<sup>ST</sup> **100MG/ML SOLUTION**

02244324 APO-CYCLOSPORINE APX

02150697 NEORAL NVR

**MYCOPHENOLATE MOFETIL**

Limited use benefit (prior approval required).

For transplant therapy.

<sup>ST</sup> **250MG CAPSULE**

02383780 ACH-MYCOPHENOLATE ACC

02352559 APO-MYCOPHENOLATE APX

02192748 CELLCEPT HLR

02386399 JAMP-MYCOPHENOLATE JMP

02457369 MYCOPHENOLATE MOFETIL SAN

02371154 MYLAN-MYCOPHENOLATE MYL

02320630 SANDOZ MYCOPHENOLATE SDZ

02364883 TEVA-MYCOPHENOLATE TEV

<sup>ST</sup> **500MG TABLET**

02352567 APO-MYCOPHENOLATE APX

02237484 CELLCEPT HLR

02380382 JAMP-MYCOPHENOLATE JMP

02378574 MYCOPHENOLATE ACC

02457377 MYCOPHENOLATE MOFETIL SAN

02370549 MYLAN-MYCOPHENOLATE MYL

02313855 SANDOZ MYCOPHENOLATE SDZ

02348675 TEVA-MYCOPHENOLATE TEV

**MYCOPHENOLATE SODIUM**

Limited use benefit (prior approval required).

For transplant therapy.

<sup>ST</sup> **180MG TABLET (ENTERIC COATED)**

02372738 APO-MYCOPHENOLIC ACID APX

02264560 MYFORTIC NVR

<sup>ST</sup> **360MG TABLET (ENTERIC COATED)**

02372746 APO-MYCOPHENOLIC ACID APX

02264579 MYFORTIC NVR

**SIROLIMUS**

Limited use benefit (prior approval required).

Coverage will be provided as a second line therapy for patients failing mycophenolate mofetil.

<sup>ST</sup> **1MG/ML SOLUTION**

02243237 RAPAMUNE PFI

<sup>ST</sup> **1MG TABLET**

02247111 RAPAMUNE PFI

**92:44.00 IMMUNOSUPPRESSIVE AGENTS****TACROLIMUS MONOHYDRATE**

Limited use benefit (prior approval required).

For transplant therapy.

**<sup>ST</sup> 0.5MG CAPSULE**

02243144 PROGRAF

AST

02416816 SANDOZ TACROLIMUS

SDZ

**<sup>ST</sup> 1MG CAPSULE**

02175991 PROGRAF

AST

02416824 SANDOZ TACROLIMUS

SDZ

**<sup>ST</sup> 5MG CAPSULE**

02175983 PROGRAF

AST

**<sup>ST</sup> 0.5MG CAPSULE (EXTENDED RELEASE)**

02296462 ADVAGRAF

AST

**<sup>ST</sup> 1MG CAPSULE (EXTENDED RELEASE)**

02296470 ADVAGRAF

AST

**<sup>ST</sup> 3MG CAPSULE (EXTENDED RELEASE)**

02331667 ADVAGRAF

AST

**<sup>ST</sup> 5MG CAPSULE (EXTENDED RELEASE)**

02296489 ADVAGRAF

AST

**<sup>ST</sup> 5MG CAPSULE (IMMEDIATE RELEASE)**

02416832 SANDOZ TACROLIMUS

SDZ

**5MG/ML SOLUTION**

02176009 PROGRAF

AST

**VEDOLIZUMAB**

Limited use benefit (prior approval required).

**1. For the treatment of moderately to severely active CROHN'S DISEASE**

Coverage is provided for an initial period of 14 weeks at a dose of 300 mg weeks zero, two and six and then every eight weeks. Maintenance therapy is provided at a dose not exceeding 300 mg every eight weeks.

- Prescribed by a gastroenterology specialist

Patient meets the following criteria:

- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication;

PLUS

- Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
- 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR
- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks.

Coverage beyond the initial 14 week period will be based on improvement in the CDAI or HBI scores.

- At least a 100-point reduction in the Crohn's Disease Activity Index (CDAI) OR at least a 3-point reduction in the Harvey Bradshaw Index (HBI).

**2. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:**

Coverage is provided for an initial period of 14 weeks at a dose of 300 mg at weeks zero, two and six and then every eight weeks. Maintenance therapy is provided at a dose not exceeding 300 mg every eight weeks.

- Prescribed by expert in gastroenterology
- Partial Mayo score > 4
- Inadequate response to conventional therapies:
  - 5-ASA 4grams/day for 6 weeks; PLUS
  - Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication.

Coverage beyond the initial 14 week period will be based on improvement in the partial Mayo score of  $\geq 2$  points.

**300MG POWDER FOR SOLUTION**

02436841 ENTYVIO

TAK

**92:92.00 OTHER MISCELLANEOUS THERAPEUTIC AGENTS****INCOBOTULINUMTOXINA**

Limited use benefit (prior approval required).

For the treatment of:

- strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder in patients 12 years of age or older;
- OR
- cervical dystonia (spasmodic torticollis).

**50UNIT/VIAL POWDER FOR SOLUTION**

02371081 XEOMIN

MEZ

**100U/VIAL POWDER FOR SOLUTION**

02324032 XEOMIN

MEZ

**ONABOTULINUMTOXINA**

Limited use benefit (prior approval required).

For the treatment of:

- strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder in patients 12 years of age or older;
- OR
- cervical dystonia (spasmodic torticollis); OR
- urinary incontinence due to neurogenic detrusor over activity resulting from neurogenic bladder associated with MS or subcervical spinal cord injury.

**50IU INJECTION**

09857386 BOTOX

ALL

**200IU INJECTION**

09857387 BOTOX

ALL

**100IU POWDER FOR SOLUTION**

01981501 BOTOX

ALL

**94:00 DEVICES****94:00.00 DEVICES****SPACER DEVICE**

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 2 spacer devices every 12 months.

**DEVICE**

96899962 AEROCHAMBER AC BOYZ	TRU
96899963 AEROCHAMBER AC GIRLZ	TRU
96899969 AEROCHAMBER PLUS FLOWVU LARGE	TRU
96899970 AEROCHAMBER PLUS FLOWVU MEDIUM	TRU
96899968 AEROCHAMBER PLUS FLOWVU MOUTH	TRU
96899971 AEROCHAMBER PLUS FLOWVU SMALL	TRU
96899977 AEROTRACH PLUS	UNK
96899956 COMPACT SPACE PLUS LARGE MASK	MIN
96899955 COMPACT SPACE PLUS MEDIUM MASK	MIN
96899953 COMPACT SPACE PLUS NO MASK	MIN
96899954 COMPACT SPACE PLUS SMALL MASK	MIN
99400507 E-Z SPACER	WEP
99400511 E-Z SPACER (MASK ONLY)	WEP
99400508 E-Z SPACER WITH SMALL MASK	WEP
99400501 OPTICHAMBER	AUC
96899961 OPTICHAMBER DIAMOND (CHAMBER)	AUC
96899958 OPTICHAMBER DIAMOND LARGE MASK	AUC
96899959 OPTICHAMBER DIAMOND MEDIUM MASK	AUC
96899960 OPTICHAMBER DIAMOND SMALL MASK	AUC
99400504 OPTICHAMBER LARGE MASK	AUC
99400503 OPTICHAMBER MEDIUM MASK	AUC
99400502 OPTICHAMBER SMALL MASK	AUC

**94:00.00 DEVICES****SPACER DEVICE**

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 2 spacer devices every 12 months.

**DEVICE**

99400505	OPTIHALER	AUC
99400787	POCKET CHAMBER	MCA
99400791	POCKET CHAMBER WITH ADULT MASK	MCA
99400788	POCKET CHAMBER WITH INFANT MASK	MCA
99400790	POCKET CHAMBER WITH MEDIUM MASK	MCA
99400789	POCKET CHAMBER WITH SMALL MASK	MCA
96899974	RESPICHAMBER SILICONE MEDIUM MASK	TRU
96899973	RESPICHAMBER SILICONE SMALL MASK	TRU
96899972	RESPICHAMBER VHC W MOUTHPIECE	TRU

**94:01.00 DEVICES (DIABETIC)****INSULIN PUMP SUPPLIES**

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

**DEVICE**

97799674	CARTRIDGE FOR IR200	UNK
97799342	INSET 30 INFUSION SETS	UNK
99401038	INSULIN PUMP BATTERY	AUC
09991458	IV3000	SMW

**COMFORT ANGLED DEVICE**

97799682	COMFORT ANGLED INFSET 17MM	UNK
97799683	COMFORT ANGLED INFSET 17MM	UNK

**COMFORT SHORT ANGLED DEVICE**

97799678	COMFORT SRT ANGLED INFSET 13	UNK
97799679	COMFORT SRT ANGLED INFSET 13	UNK

**CONTACT DETACH DEVICE**

97799672	CONTACT DETACH 90 DEGREE 6MMX60CM	UNK
97799610	CONTACT DETACH 90 DEGREE 8MMX60CM	UNK

**INSET II DEVICE**

97799685	INSET II 90 DEGREE 6MMX110CM	UNK
97799687	INSET II 90 DEGREE 6MMX60CM	UNK
97799684	INSET II 90 DEGREE 9MMX110CM	UNK
97799686	INSET II 90 DEGREE 9MMX60CM	UNK

**MIO DEVICE**

97799491	MIO BLUE 6MMX18	MDT
97799438	MIO BLUE 6MMX23	MDT
97799490	MIO CLEAR 6MMX32	MDT
97799489	MIO CLEAR 9MMX32	MDT
97799492	MIO PINK 6MMX18	MDT
97799437	MIO PINK 6MMX23	MDT

**OMNIPOD DEVICE**

09991327	PODS	UNK
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**PARADIGM SILHOUETTE DEVICE**

97799715	PARADIGM SILHOUETTE 13MMX 43	MDT
97799485	PARADIGM SILHOUETTE 13MMX18"	MDT
97799716	PARADIGM SILHOUETTE 13MMX23	MDT

**94:01.00 DEVICES (DIABETIC)****INSULIN PUMP SUPPLIES**

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

**PARADIGM SILHOUETTE DEVICE**

97799484	PARADIGM SILHOUETTE 13MMX32"	MDT
97799718	PARADIGM SILHOUETTE 17MMX23	MDT
97799483	PARADIGM SILHOUETTE 17MMX32"	MDT
97799719	PARADIGM SILHOUETTE 17MMX43	MDT
97799529	PARADIGM SILHOUETTE CANNULA 13MM	MDT
97799528	PARADIGM SILHOUETTE CANNULA 17MM	MDT

**QUICK-SET DEVICE**

97799486	QUICK-SET 6MMX18	MDT
97799744	QUICK-SET 6MMX23 TUBING	MDT
97799487	QUICK-SET 6MMX32	MDT
97799743	QUICK-SET 6MMX43 TUBING	MDT
97799742	QUICK-SET 9MMX23 TUBING	MDT
97799488	QUICK-SET 9MMX32	MDT
97799741	QUICK-SET 9MMX43 TUBING	MDT

**RAPID-D DEVICE**

97799650	RAPID-D 10MM/110CM	ROD
97799652	RAPID-D 10MM/60CM	ROD
97799651	RAPID-D 10MM/80CM	ROD
97799656	RAPID-D 6MM/110CM	ROD
97799658	RAPID-D 6MM/60CM	ROD
97799657	RAPID-D 6MM/80CM	ROD
97799653	RAPID-D 8MM/110CM	ROD
97799655	RAPID-D 8MM/60CM	ROD
97799654	RAPID-D 8MM/80CM	ROD

**SURE-T DEVICE**

97799521	PARADIGM SURE-T 29G 6MMX18	MDT
97799520	PARADIGM SURE-T 29G 6MMX23	MDT
97799519	PARADIGM SURE-T 29G 8MMX23	MDT

**TENDER DEVICE**

97799644	TENDER-1 17MM/110CM	ROD
97799646	TENDER-1 17MM/60CM	ROD
97799645	TENDER-1 17MM/80CM	ROD
97799638	TENDER-2 17MM/110CM	ROD
97799640	TENDER-2 17MM/60CM	ROD
97799639	TENDER-2 17MM/80CM	ROD

**TENDER "MINI" DEVICE**

97799647	TENDER-1 MINI INF SET 13MM/110CM	ROD
97799649	TENDER-1 MINI INFSET 13MM/60CM	ROD
97799648	TENDER-1 MINI INFSET 13MM/80CM	ROD
97799641	TENDER-2 MINI INF SET 13MM/110CM	ROD
97799643	TENDER-2 MINI INFSET 13MM/60CM	ROD
97799642	TENDER-2 MINI INFSET 13MM/80CM	ROD

**ULTRAFLEX DEVICE**

97799665	ULTRAFLEX 1 10MM/110CM	ROD
97799667	ULTRAFLEX 1 10MM/60CM	ROD
97799666	ULTRAFLEX 1 10MM/80CM	ROD
97799668	ULTRAFLEX 1 8MM/110CM	ROD

**94:01.00 DEVICES (DIABETIC)****INSULIN PUMP SUPPLIES**

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

**ULTRAFLEX DEVICE**

97799670 ULTRAFLEX 1 8MM/60CM

ROD

97799669 ULTRAFLEX 1 8MM/80CM

ROD

**SYRINGE**

97799707 RESERVOIR PARADIGM 5X1.8ML

MDT

97799706 RESERVOIR PARADIGM 7X3.0ML

MDT

**Appendix A - Limited Use Benefits and Criteria**

**Non-Insured Health Benefits**

AA-TRIMEBUTINE	17	ADVAIR 250	20	APO-MOXIFLOXACIN	2
<b>ABATACEPT</b>	<b>80</b>	ADVAIR 250 DISKUS	20	APO-MYCOPHENOLATE	93
ABENOL	35	ADVAIR 500 DISKUS	20	APO-MYCOPHENOLIC ACID	93
ABILIFY	42	AEROCHAMBER AC BOYZ	95	APO-OMEPRAZOLE	66
<b>ABIRATERONE ACETATE</b>	<b>9</b>	AEROCHAMBER AC GIRLZ	95	APO-OXYCODONE/ACET	27
<b>ACAMPROSATE CALCIUM</b>	<b>52</b>	AEROCHAMBER PLUS FLOWVU LARGE	95	APO-PANTOPRAZOLE	67
ACCEL PIOGLITAZONE	72	AEROCHAMBER PLUS FLOWVU MEDIUM	95	APO-PIOGLITAZONE	72
ACCEL-DONEPEZIL	14	AEROCHAMBER PLUS FLOWVU MOUTH	95	APO-PREGABALIN	39
ACCOLATE	60	AEROCHAMBER PLUS FLOWVU SMALL	95	APO-RABEPRAZOLE	68
ACCU-CHEK ADVANTAGE	55	AEROTRACH PLUS	95	APO-RALOXIFENE	70
ACCU-CHEK AVIVA	55	<b>AFATINIB DIMALEATE</b>	<b>9</b>	APO-RIVASTIGMINE	16
ACCU-CHEK COMPACT	55	<b>AFLIBERCEPT</b>	<b>61</b>	APO-RIZATRIPTAN	50
ACCU-CHEK MOBILE BG	55	AG-ZOLMITRIPTAN ODT	52	APO-RIZATRIPTAN RPD	50
ACCU-CHEK MOBILE CASSETT	55	ALDARA P	74	APO-ROSIGLITAZONE	73
ACCUTREND	55	ALMOTRIPTAN	49	APO-SILDENAFIL R	24
ACET 325	35	<b>ALMOTRIPTAN MALATE</b>	<b>49</b>	APO-SUMATRIPTAN	51
ACET 650	35	ALPRAZOLAM	46	APO-TADALAFIL PAH	24
ACET CODEINE 30	27	<b>ALPRAZOLAM</b>	<b>46</b>	APO-TEMAZEPAM	49
ACETAMINOPHEN	34	<b>AMBRISENTAN</b>	<b>25</b>	APO-TEMOZOLOMIDE	13
<b>ACETAMINOPHEN</b>	<b>34</b>	AMERGE	50	APO-TOLTERODINE	75
<b>ACETAMINOPHEN, CAFFEINE CITRATE, CODEINE PHOSPHATE</b>	<b>27</b>	<b>AMIKACIN (AMIKACIN SULFATE)</b>	<b>1</b>	APO-VORICONAZOLE	4
<b>ACETAMINOPHEN, CODEINE PHOSPHATE</b>	<b>27</b>	AMIKACIN SULFATE	1	APO-ZOLMITRIPTAN	51
<b>ACETAMINOPHEN, OXYCODONE HYDROCHLORIDE</b>	<b>27</b>	ANORO ELLIPTA	18	APO-ZOLMITRIPTAN RAPID	52
ACÉTAMINOPHÈNE	35	<b>APIXABAN</b>	<b>23</b>	<b>APREPITANT</b>	<b>63</b>
ACÉTAMINOPHÈNE BLASON SHIELD	36	APO ACETAMINOPHEN	35	APTIOM	37
ACETYLSALICYLIC ACID	26	APO DIAZEPAM	47	AQUASOL E	76
<b>ACETYLSALICYLIC ACID</b>	<b>26</b>	APO DIMENHYDRINATE	63	AQUASOL E VITAMIN E	76
<b>ACETYLSALICYLIC ACID, OXYCODONE HYDROCHLORIDE</b>	<b>27</b>	APO OXAZEPAM	48	ARICEPT	14
ACH-FINASTERIDE	78	APO-ACETAMINOPHEN	35	<b>ARIPIRAZOLE</b>	<b>42</b>
ACH-MYCOPHENOLATE	93	APO-ADEFOVIR	5	ASA EC	26
ACH-PIOGLITAZONE	72	APO-ALMOTRIPTAN	49	ASAPHEN	26
ACLASTA	79	APO-ALPRAZ	46	ASATAB	26
<b>ACLDINIUM BROMIDE</b>	<b>17</b>	APO-ATOMOXETINE	52	ASCENCIA CONTOUR	55
<b>ACLDINIUM BROMIDE, FORMOTEROL FUMARATE DIHYDRATE</b>	<b>18</b>	APO-BENZYDAMINE	60	ASCENCIA BREEZE 2	55
ACT BOSENTAN	25	APO-BOSENTAN	25	<b>ASENAPINE MALEATE</b>	<b>43</b>
ACT BUPROPION XL	42	APO-BROMAZEPAM	46	<b>ASUNAPREVIR</b>	<b>5</b>
ACT CABERGOLINE	52	APO-CABERGOLINE	52	ATASOL 15	27
ACT DONEPEZIL	14	APO-CLONAZEPAM	36	ATASOL 30	27
ACT DUTASTERIDE	78	APO-CYCLOBENZAPRINE	20	ATASOL FORTE	36
ACT FINASTERIDE	78	APO-CYCLOSPORINE	93	ATIVAN	47
ACT GABAPENTIN	37	APO-DEXTROAMPHETAMINE	44	ATOMOXETINE	53
ACT LEVOFLOXACIN	2	APO-DICLOFENAC	26	<b>ATOMOXETINE HYDROCHLORIDE</b>	<b>52</b>
ACT NABILONE	64	APO-DONEPEZIL	14	AURO-CYCLOBENZAPRINE	20
ACT PANTOPRAZOLE	67	APO-DUTASTERIDE	78	AURO-DONEPEZIL	14
ACT PIOGLITAZONE	72	APO-ENTECAVIR	5	AURO-ENTECAVIR	5
ACT PREGABALIN	39	APO-FENTANYL MATRIX	28	AURO-FINASTERIDE	78
ACT RALOXIFENE	70	APO-FINASTERIDE	78	AURO-GABAPENTIN	37
ACT RIZATRIPTAN	50	APO-GABAPENTIN	37	AURO-GALANTAMINE ER	15
ACT RIZATRIPTAN ODT	50	APO-HYDROMORPHONE	30	AURO-MONTELUKAST	58
ACT SUMATRIPTAN	51	APO-IMATINIB	10	AURO-MOXIFLOXACIN	2
ACT TEMOZOLOMIDE	13	APO-IMIQUIMOD	74	AURO-PANTOPRAZOLE	67
ACTEMRA	91	APO-LANSOPRAZOLE	64	AURO-PREGABALIN	39
ACTOS	72	APO-LEVOFLOXACIN	2	AURO-RIZATRIPTAN	50
<b>ADALIMUMAB</b>	<b>81</b>	APO-LINEZOLID	3	AVANDIA	73
ADCIRCA	24	APO-LORAZEPAM	47	AVELOX	2
<b>ADEFOVIR DIPIVOXIL</b>	<b>5</b>	APO-LORAZEPAM SUBLINGUAL	47	AVODART	78
ADVAGRAF	94	APO-METHYLPHENIDATE	45	AXERT	49
ADVAIR 100 DISKUS	20	APO-METHYLPHENIDATE ER	45	BANZEL	41
ADVAIR 125	20	APO-METHYLPHENIDATE SR	45	BARACLUDE	5
		APO-MINOCYCLINE	3	<b>BENZYDAMINE HYDROCHLORIDE</b>	<b>60</b>
		APO-MONTELUKAST	58	BG STAR	55
				BG STAR (ON)	55
				BIO-DONEPEZIL	14
				BISMUTH	63

**Appendix A - Limited Use Benefits and Criteria**

**Non-Insured Health Benefits**

<b>BISMUTH SUBSALICYLATE</b>	<b>63</b>	CYCLOBENZAPRINE	20	ENBREL	85
BISMUTH SUBSALICYLATE	63	<b>CYCLOBENZAPRINE</b>	<b>20</b>	ENBREL SURECLICK	85
<b>BOSENTAN MONOHYDRATE</b>	<b>25</b>	<b>HYDROCHLORIDE</b>		ENDOCET	27
BOTOX	95	<b>CYCLOSPORINE</b>	<b>92</b>	ENFAMIL POLYVISOL	76
BREO ELLIPTA	18	<b>DABIGATRAN ETEXILATE</b>	<b>23</b>	ENFAMIL TRIVISOL	77
BROMAZEPAM	46	<b>MESILATE</b>		<b>ENTECAVIR MONOHYDRATE</b>	<b>5</b>
<b>BROMAZEPAM</b>	<b>46</b>	<b>DACLATASVIR</b>	<b>6</b>	ENTRESTO	26
<b>BUPRENORPHINE</b>	<b>34</b>	DAKLINZA	6	ENTYVIO	94
<b>HYDROCHLORIDE, NALOXONE</b>		<b>DAPAGLIFLOZIN PROPANEDIOL</b>	<b>72</b>	<b>ENZALUTAMIDE</b>	<b>10</b>
<b>HYDROCHLORIDE</b>		<b>MONOHYDRATE</b>		EPCLUSA	8
<b>BUPROPION HYDROCHLORIDE</b>	<b>42</b>	<b>DARIFENACIN HYDROBROMIDE</b>	<b>75</b>	<b>EPLERENONE</b>	<b>25</b>
<b>(WELLBUTRIN)</b>		<b>DENOSUMAB (PROLIA)</b>	<b>79</b>	<b>ERLOTINIB HYDROCHLORIDE</b>	<b>10</b>
<b>BUPROPION HYDROCHLORIDE</b>	<b>42</b>	<b>DENOSUMAB (XGEVA)</b>	<b>79</b>	<b>ERTAPENEM (ERTAPENEM</b>	<b>1</b>
<b>(ZYBAN)</b>		DETROL	75	<b>SODIUM)</b>	
BUPROPION SR	42	DEXEDRINE	44	ESBRIET	58
<b>CABERGOLINE</b>	<b>52</b>	DEXEDRINE SPANSULE	44	<b>ESLICARBAZEPINE ACETATE</b>	<b>37</b>
<b>CAFFEINE CITRATE</b>	<b>45</b>	<b>DEXTROAMPHETAMINE SULFATE</b>	<b>44</b>	<b>ETANERCEPT</b>	<b>84</b>
CAFFEINE CITRATE	45	DIASTAT	47	EURO-ASA	26
CAMPRAL	52	DIASTAT 2X10MG RECTAL PACK	47	EVISTA	70
<b>CANAGLIFLOZIN</b>	<b>71</b>	DIASTAT 2X15MG RECTAL PACK	47	EXELON	16
CARNITOR	57	<b>DIAZEPAM</b>	<b>47</b>	EYLEA	61
CARNITOR IV	57	DIAZEPAM	47	EZ HEALTH ORACLE	55
CARTRIDGE FOR IR200	96	<b>DIAZEPAM (DIASTAT)</b>	<b>47</b>	E-Z SPACER	95
CEFTAZIDIME	1	DICETEL	69	E-Z SPACER (MASK ONLY)	95
<b>CEFTAZIDIME (CEFTAZIDIME</b>	<b>1</b>	<b>DICLOFENAC SODIUM (TOPICAL)</b>	<b>26</b>	E-Z SPACER WITH SMALL MASK	95
<b>PENTAHYDRATE)</b>		DICLOFENAC TOPICAL	26	<b>FEBUXOSTAT</b>	<b>78</b>
CELLCEPT	93	<b>DIENOGEST</b>	<b>74</b>	<b>FENTANYL</b>	<b>28</b>
CENTRUM DHA	77	DILAUDID	30	FENTANYL	28
CENTRUM JUNIOR COMPLETE	77	<b>DIMENHYDRINATE</b>	<b>63</b>	FERAMAX POWDER WATER	22
CENTRUM PRENATAL	77	DOLORAL 1	31	SOLUBLE POLYSACCHARIDE IRON	
<b>CERTOLIZUMAB PEGOL</b>	<b>83</b>	DOLORAL 5	31	COMPLEX	
CESAMET	63	DOM-ATOMOXETINE	53	<b>FESOTERODINE FUMARATE</b>	<b>75</b>
CHAMPIX	22	DOM-BENZYDAMINE	60	FIBRISTAL	70
CHAMPIX STARTER PACK	22	DOM-CLONAZEPAM	36	FINASTERIDE	78
CIMZIA	83	DOM-CLONAZEPAM-R	36	<b>FINASTERIDE</b>	<b>78</b>
CLONAPAM	36	DOM-CYCLOBENZAPRINE	20	FIRST CANHEALTH SPIRIT	56
<b>CLONAZEPAM</b>	<b>36</b>	DOM-FINASTERIDE	78	FLEXI-T +300 IUD	54
CLONAZEPAM	36	DOM-GABAPENTIN	37	FLEXI-T +380 IUD	54
CO CLONAZEPAM	36	DOM-LANSOPRAZOLE	64	FLEXI-TD	54
CO FENTANYL	28	DOM-LORAZEPAM	47	FLINTSTONES MULTIPLE	77
<b>COBIMETINIB (COBIMETINIB</b>	<b>9</b>	DOM-MINOCYCLINE	3	VITAMINS PLUS IRON	
<b>FUMARATE)</b>		DOM-MONTELUKAST	58	FLINTSTONES MULTIPLE	77
CODEINE	28	DOM-OMEPRAZOLE DR	66	VITAMINS WITH EXTRA C	
CODEINE CONTIN CR	28	DOM-PANTOPRAZOLE	67	<b>FLUTICASONE FUROATE,</b>	<b>18</b>
<b>CODEINE MONOHYDRATE,</b>	<b>28</b>	DOM-PIOGLITAZONE	72	<b>VILANTEROL TRIFENATATE</b>	
<b>CODEINE SULFATE TRIHYDRATE</b>		DOM-PREGABALIN	40	<b>FLUTICASONE FUROATE,</b>	<b>18</b>
<b>CODEINE PHOSPHATE</b>	<b>28</b>	DOM-RABEPRAZOLE EC	69	<b>VILANTEROL TRIFENATATE</b>	
CODEINE PHOSPHATE	28	DOM-RIZATRIPTAN RDT	50	<b>(ASTHMA)</b>	
COMFORT ANGLED INFSET 17MM	96	DOM-SUMATRIPTAN	51	FORADIL	18
COMFORT SRT ANGLED INFSET 13	96	DOM-ZOLMITRIPTAN	52	<b>FORMOTEROL FUMARATE</b>	<b>18</b>
COMPACT SPACE PLUS LARGE	95	DONEPEZIL	14	<b>FORMOTEROL FUMARATE</b>	<b>18</b>
MASK		<b>DONEPEZIL HYDROCHLORIDE</b>	<b>14</b>	<b>DIHYDRATE</b>	
COMPACT SPACE PLUS MEDIUM	95	DOSTINEX	52	<b>FORMOTEROL FUMARATE</b>	<b>19</b>
MASK		DUAKLIR GENUAIR	18	<b>DIHYDRATE, BUDESONIDE</b>	
COMPACT SPACE PLUS NO MASK	95	DURAGESIC	28	<b>FORMOTEROL FUMARATE</b>	<b>19</b>
COMPACT SPACE PLUS SMALL	95	<b>DUTASTERIDE</b>	<b>78</b>	<b>DIHYDRATE, MOMETASONE</b>	
MASK		DUTASTERIDE	78	<b>FUROATE</b>	
CONCERTA	45	ECL-DONEPEZIL	14	FORTAZ 1G	1
CONTACT DETACH 90 DEGREE	96	<b>ELBASVIR, GRAZOPREVIR</b>	<b>6</b>	FORTAZ 2G	1
6MMX60CM		ELIDEL	74	FORTAZ 6G	1
CONTACT DETACH 90 DEGREE	96	ELIQUIS	23	FORXIGA	72
8MMX60CM		EMEND	63	<b>FOSFOMYCIN TROMETHAMINE</b>	<b>8</b>
CONTOUR NEXT	55	EMEND TRI-PACK	63	FOSRENOL	57
CONTOUR NEXT (ON)	55	<b>EMPAGLIFLOZIN</b>	<b>72</b>	FREESTYLE	55
COSENTYX	74	ENABLEX	75	FREESTYLE (ON)	55
COTELLIC	9			FREESTYLE LITE	55

**Appendix A - Limited Use Benefits and Criteria**

**Non-Insured Health Benefits**

FREESTYLE LITE (ON)	55	JAMP-GABAPENTIN	38	MEDI+SURE	56
FREESTYLE PRECISION	55	JAMP-MONTELUKAST	58	MEDI+SURE (ON)	56
FREESTYLE PRECISION (ON)	55	JAMP-MOXIFLOXACIN	2	MED-MOXIFLOXACIN	2
GABAPENTIN	37	JAMP-MYCOPHENOLATE	93	MED-RIVASTIGMINE	16
<b>GABAPENTIN</b>	<b>37</b>	JAMP-OMEPRAZOLE DR	66	MEROPENEM	1
GALANTAMINE	15	JAMP-PANTOPRAZOLE	67	<b>MEROPENEM (MEROPENEM TRIHYDRATE)</b>	<b>1</b>
GALANTAMINE ER	15	JAMP-PIOGLITAZONE	72	MERREM	1
<b>GALANTAMINE HYDROBROMIDE</b>	<b>15</b>	JAMP-PREGABALIN	40	M-ESLON	31
GALEXOS	7	JAMP-RIZATRIPTAN	50	METADOL	31
GD-GABAPENTIN	38	JAMP-RIZATRIPTAN IR	50	<b>METFORMIN HYDROCHLORIDE, DAPAGLIFLOZIN (DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE)</b>	<b>72</b>
GE200	55	JAMP-ZOLMITRIPTAN	52	<b>METHADONE HYDROCHLORIDE (METADOL)</b>	<b>31</b>
GE200 (ON)	56	JAMP-ZOLMITRIPTAN ODT	52	METHYLPHENIDATE	45
GIOTRIF	9	JANUMET	71	<b>METHYLPHENIDATE HYDROCHLORIDE</b>	<b>45</b>
GLEEVEC	10	JANUMET XR	71	MINOCYCLINE	3
<b>GLUCOSE OXIDASE, PEROXIDASE</b>	<b>55</b>	JANUVIA	71	<b>MINOCYCLINE HYDROCHLORIDE</b>	<b>3</b>
<b>GLYCOPYRRONIUM BROMIDE</b>	<b>17</b>	JARDIANCE	72	MINT-DUTASTERIDE	78
<b>GOLIMUMAB</b>	<b>86</b>	JAYDESS	69	MINT-FINASTERIDE	78
GRAVOL	63	JENTADUETO	70	MINT-MONTELUKAST	59
HABITROL	21	KADIAN	33	MINT-PANTOPRAZOLE	67
HARVONI	8	KOMBOGLYZE	70	MINT-PIOGLITAZONE	72
HEPSERA	5	<b>LACOSAMIDE</b>	<b>39</b>	MINT-PREGABALIN	40
HOLKIRA PAK	6	LANSOPRAZOLE	64	MINT-TOLTERODINE	75
HUMIRA	82	<b>LANSOPRAZOLE</b>	<b>64</b>	MINT-ZOLMITRIPTAN	52
HYDROMORPH CONTIN	29	<b>LANSOPRAZOLE ODT</b>	<b>65</b>	MIO BLUE 6MMX18	96
<b>HYDROMORPHONE HYDROCHLORIDE</b>	<b>29</b>	<b>LANTHANUM CARBONATE HYDRATE</b>	<b>57</b>	MIO BLUE 6MMX23	96
IBAVYR	7	LATUDA	43	MIO CLEAR 6MMX32	96
ICLUSIG	12	LECTOPAM	46	MIO CLEAR 9MMX32	96
<b>IDELALISIB</b>	<b>10</b>	<b>LENALIDOMIDE</b>	<b>11</b>	MIO PINK 6MMX18	96
<b>IMATINIB MESYLATE</b>	<b>10</b>	<b>LEVOCARNITINE</b>	<b>57</b>	MIO PINK 6MMX23	96
<b>IMIQUIMOD</b>	<b>74</b>	LEVOFLOXACIN	2	<b>MIRABEGRON</b>	<b>76</b>
IMITREX	51	<b>LEVOFLOXACIN HEMIHYDRATE</b>	<b>2</b>	MIRENA	69
IMITREX DF	51	<b>LEVONORGESTREL INTRAUTERINE INSERT</b>	<b>69</b>	MODULON	17
IMITREX STAT DOSE KIT	51	LIBERTE UT380 SHORT IUD	54	MOGADON	48
<b>INCOBOTULINUMTOXINA</b>	<b>95</b>	LIBERTE UT380 STANDARD IUD	54	MONA LISA 10	54
INCRUSE ELLIPTA	17	<b>LINAGLIPTIN</b>	<b>70</b>	MONA LISA 5	54
<b>INDACATEROL MALEATE</b>	<b>19</b>	<b>LINAGLIPTIN, METFORMIN HYDROCHLORIDE</b>	<b>70</b>	MONA LISA N	54
<b>INDACATEROL MALEATE, GLYCOPYRRONIUM BROMIDE</b>	<b>17</b>	LINCTUS CODEINE	28	MONTELUKAST	59
INFLECTRA	89	<b>LINEZOLID</b>	<b>3</b>	<b>MONTELUKAST SODIUM</b>	<b>58</b>
<b>INFLIXIMAB (INFLECTRA)</b>	<b>88</b>	LINEZOLID	3	MONTELUKAST SODIUM	59
<b>INFLIXIMAB (REMICADE)</b>	<b>90</b>	<b>LISDEXAMFETAMINE DIMESYLATE</b>	<b>44</b>	MONUROL	8
INSET 30 INFUSION SETS	96	LORAZEPAM	47	<b>MORPHINE HYDROCHLORIDE</b>	<b>31</b>
INSET II 90 DEGREE 6MMX110CM	96	<b>LORAZEPAM</b>	<b>47</b>	MORPHINE SR	32
INSET II 90 DEGREE 6MMX60CM	96	LOSEC	66	<b>MORPHINE SULFATE</b>	<b>31</b>
INSET II 90 DEGREE 9MMX110CM	96	LOWPRIN	26	<b>MORPHINE SULFATE (KADIAN)</b>	<b>33</b>
INSET II 90 DEGREE 9MMX60CM	96	LUCENTIS	62	MOTION SICKNESS	63
INSPIOLTO RESPIMAT	19	LUCENTIS PFS	62	<b>MOXIFLOXACIN HYDROCHLORIDE</b>	<b>2</b>
INSPIRA	25	<b>LURASIDONE HYDROCHLORIDE</b>	<b>43</b>	MOZOBIL	24
INSULIN PUMP BATTERY	96	LYRICA	40	MS CONTIN SR	32
<b>INSULIN PUMP SUPPLIES</b>	<b>96</b>	M-ACETAMINOPHEN	35	MS IR	33
<b>INTRAUTERINE DEVICE</b>	<b>54</b>	MAR-DONEPEZIL	14	<b>MULTIVITAMINS (PEDIATRIC)</b>	<b>76</b>
INVANZ	1	MAR-GABAPENTIN	38	<b>MULTIVITAMINS (PRENATAL)</b>	<b>77</b>
INVEGA SUSTENNA	43	MAR-MONTELUKAST	15	MYCOPHENOLATE	93
INVOKANA	71	MAR-MOXIFLOXACIN	59	MYCOPHENOLATE MOFETIL	93
ITEST	56	MAR-PANTOPRAZOLE	2	<b>MYCOPHENOLATE MOFETIL</b>	<b>93</b>
IV3000	96	MAR-PREGABALIN	67	<b>MYCOPHENOLATE SODIUM</b>	<b>93</b>
JAMP ACETAMINOPHEN BLAZON	36	MAR-RIZATRIPTAN	40	MYFORTIC	93
JAMP VITAMIN A, D AND C	77	MAR-ZOLMITRIPTAN	50	MYLAN-ALMOTRIPTAN	49
JAMP-ALPRAZOLAM	46	M-ASA	52	MYLAN-ALPRAZOLAM	46
JAMP-ASA	26	MAXALT	50	MYLAN-ATOMOXETINE	53
JAMP-CYCLOBENZAPRINE	20	MAXALT RPD	50	MYLAN-BOSENTAN	25
JAMP-DIMENHYDRINATE	63	MED-DUTASTERIDE	78		
JAMP-DONEPEZIL	14				
JAMP-FINASTERIDE	78				

**Appendix A - Limited Use Benefits and Criteria**

**Non-Insured Health Benefits**

MYLAN-BUPRENORPHINE/NALOXONE	34	ONBREZ BREEZHALER	19	PEGINTERFERON ALFA-2B, RIBAVIRIN	4
MYLAN-BUPROPION XL	42	ONE TOUCH ULTRA	56	PEPTO BISMOL	63
MYLAN-CLONAZEPAM	36	ONETOUCH VERIO	56	PERCOCET-DEMI	27
MYLAN-CYCLOBENZAPRINE	20	ONETOUCH VERIO (ON)	56	PHARIXIA	60
MYLAN-DONEPEZIL	14	ONGLYZA	70	PHL-CLONAZEPAM	36
MYLAN-FENTANYL MATRIX	28	OPTICHAMBER	95	PHL-CLONAZEPAM-R	36
MYLAN-GABAPENTIN	38	OPTICHAMBER DIAMOND (CHAMBER)	95	PHL-CYCLOBENZAPRINE	20
MYLAN-GALANTAMINE ER	15	OPTICHAMBER DIAMOND LARGE MASK	95	PHL-PIOGLITAZONE	72
MYLAN-LANSOPRAZOLE	64	OPTICHAMBER DIAMOND MEDIUM MASK	95	<b>PIMECROLIMUS</b>	<b>74</b>
MYLAN-MINOCYCLINE	3	OPTICHAMBER DIAMOND SMALL MASK	95	<b>PINAVERIUM BROMIDE</b>	<b>69</b>
MYLAN-MONTELUKAST	59	OPTICHAMBER DIAMOND SMALL MASK	95	<b>PIOGLITAZONE HYDROCHLORIDE</b>	<b>72</b>
MYLAN-MYCOPHENOLATE	93	OPTICHAMBER LARGE MASK	95	<b>PIPERACILLIN (PIPERACILLIN SODIUM), TAZOBACTAM (TAZOBACTAM SODIUM)</b>	<b>1</b>
MYLAN-OMEPRAZOLE	66	OPTICHAMBER MEDIUM MASK	95	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	1
MYLAN-PANTOPRAZOLE	67	OPTICHAMBER SMALL MASK	95	<b>PIRFENIDONE</b>	<b>58</b>
MYLAN-PANTOPRAZOLE T	67	OPTIHALER	96	<b>PLERIXAFOR</b>	<b>24</b>
MYLAN-PIOGLITAZONE	72	ORENCIA	80	PMS HYDROMORPHONE	30
MYLAN-RABEPRAZOLE	68	<b>OXAZEPAM</b>	<b>48</b>	PMS-ACETAMINOPHEN	27
MYLAN-RIZATRIPTAN ODT	50	OXAZEPAM	48	PMS-ATOMOXETINE	53
MYLAN-SUMATRIPTAN	51	OXEZE TURBUHALER	18	PMS-BOSENTAN	25
MYLAN-ZOLMITRIPTAN	52	OXPAM	48	PMS-BUPRENORPHINE-NALOXONE	34
MYLAN-ZOLMITRIPTAN ODT	52	OXYCODONE	33	PMS-BUPROPION SR	42
MYRBETRIQ	76	<b>OXYCODONE HYDROCHLORIDE</b>	<b>33</b>	PMS-CLONAZEPAM	36
<b>NABILONE</b>	<b>63</b>	OXYCODONE/ACET	27	PMS-CLONAZEPAM-R	36
<b>NARATRIPTAN HYDROCHLORIDE</b>	<b>50</b>	OXYCODONE-ACET	27	PMS-CODEINE	28
NAT-ALPRAZOLAM	46	OXY-IR	33	PMS-CYCLOBENZAPRINE	20
NAT-DONEPEZIL	14	<b>PALIPERIDONE PALMITATE</b>	<b>43</b>	PMS-DIAZEPAM	47
NAT-IMATINIB	10	PAL-TIZANIDINE	20	PMS-DICLOFENAC	26
NAT-OMEPRAZOLE DR	66	PANTOLOC	67	PMS-DIMENHYDRINATE	63
NAT-RIZATRIPTAN ODT	50	PANTOPRAZOLE	67	PMS-DONEPEZIL	14
NAT-ZOLMITRIPTAN	52	<b>PANTOPRAZOLE MAGNESIUM</b>	<b>67</b>	PMS-DUTASTERIDE	78
NEORAL	92	PANTOPRAZOLE MAGNESIUM	67	PMS-ENTECAVIR	5
NESTLÉ MATERNA	77	<b>PANTOPRAZOLE SODIUM</b>	<b>67</b>	PMS-ERLOTINIB	10
NEULASTA	24	PANTOPRAZOLE-40	67	PMS-FENTANYL MTX	28
NEURONTIN	38	PARADIGM SILHOUETTE 13MMX 43	96	PMS-FINASTERIDE	78
NICODERM	22	PARADIGM SILHOUETTE 13MMX18"	96	PMS-GABAPENTIN	38
NICORETTE GUM	20	PARADIGM SILHOUETTE 13MMX23	96	PMS-GALANTAMINE ER	15
NICORETTE INHALER	21	PARADIGM SILHOUETTE 13MMX32"	97	PMS-HYDROMORPHONE	30
NICORETTE LOZENGE	21	PARADIGM SILHOUETTE 17MMX23	97	PMS-IMATINIB	10
<b>NICOTINE (GUM)</b>	<b>20</b>	PARADIGM SILHOUETTE 17MMX32"	97	PMS-LANSOPRAZOLE	64
<b>NICOTINE (INHALER)</b>	<b>21</b>	PARADIGM SILHOUETTE 17MMX43	97	PMS-LEVOFLOXACIN	2
<b>NICOTINE (LOZENGE)</b>	<b>21</b>	PARADIGM SILHOUETTE CANNULA 13MM	97	PMS-LORAZEPAM	47
<b>NICOTINE (PATCH)</b>	<b>21</b>	PARADIGM SILHOUETTE CANNULA 17MM	97	PMS-METHYLPHENIDATE	45
NICOTINE GUM	21	PARADIGM SURE-T 29G 6MMX18	97	PMS-METHYLPHENIDATE ER	45
NICOTINE TRANSDERMAL	22	PARADIGM SURE-T 29G 6MMX23	97	PMS-MINOCYCLINE	3
NICOTINE TRANSDERMAL SYSTEM	21	PARADIGM SURE-T 29G 8MMX23	97	PMS-MONTELUKAST	59
NICOTROL TRANSDERMAL	21	PARIET	68	PMS-NABILONE	64
<b>NINTEDANIB ESILATE</b>	<b>58</b>	PAT-GALANTAMINE ER	15	PMS-OMEPRAZOLE	66
<b>NITRAZEPAM</b>	<b>48</b>	<b>PAZOPANIB (PAZOPANIB HYDROCHLORIDE)</b>	<b>12</b>	PMS-OXYCODONE	33
NOVA MAX	56	PDP-ACETAMINOPHEN	34	PMS-PANTOPRAZOLE	68
NOVA-T	54	PEDIAPHEN	34	PMS-PIOGLITAZONE	72
NOVO-GESIC	35	PEDIATRIX	34	PMS-PREGABALIN	40
NOVO-GESIC FORTE	36	PEDIAVIT	77	PMS-RABEPRAZOLE	68
NOVO-RIVASTIGMINE	16	PEGASYS	4	PMS-RALOXIFENE	70
OFEV	58	PEGASYS RBV	4	PMS-RIVASTIGMINE	16
<b>OLODATEROL HYDROCHLORIDE, TIOTROPIUM BROMIDE MONOHYDRATE</b>	<b>19</b>	PEGETRON	4	PMS-RIZATRIPTAN RDT	50
<b>OMALIZUMAB</b>	<b>60</b>	PEGETRON KIT	4	PMS-SILDENAFIL R	24
<b>OMBITASVIR, PARITAPREVIR, RITONAVIR, DASABUVIR</b>	<b>6</b>	<b>PEGFILGRASTIM</b>	<b>24</b>	PMS-SUMATRIPTAN	51
OMEPRAZOLE	66	<b>PEGINTERFERON ALFA-2A</b>	<b>4</b>	PMS-ZOLMITRIPTAN	52
<b>OMEPRAZOLE MAGNESIUM</b>	<b>66</b>	<b>PEGINTERFERON ALFA-2A, RIBAVIRIN</b>	<b>4</b>	PMS-ZOLMITRIPTAN ODT	52
OMEPRAZOLE-20	66			POCKET CHAMBER	96
<b>ONABOTULINUMTOXINA</b>	<b>95</b>				

## Appendix A - Limited Use Benefits and Criteria

## Non-Insured Health Benefits

POCKET CHAMBER WITH ADULT MASK	96	RAPID-D 6MM/80CM	97	RUGBY NICOTINE POLACRILEX GUM	21
POCKET CHAMBER WITH INFANT MASK	96	RAPID-D 8MM/110CM	97	<b>SALMETEROL XINAFOATE</b>	<b>19</b>
POCKET CHAMBER WITH MEDIUM MASK	96	RAPID-D 8MM/60CM	97	<b>SALMETEROL XINAFOATE, FLUTICASONE PROPIONATE</b>	<b>20</b>
POCKET CHAMBER WITH SMALL MASK	96	RAPID-D 8MM/80CM	42	SANDOZ ALMOTRIPTAN	49
PODS	96	RATIO-BUPROPION	28	SANDOZ ATOMOXETINE	53
<b>POLYSACCHARIDE IRON COMPLEX</b>	<b>22</b>	RATIO-CODEINE	78	SANDOZ BOSENTAN	25
<b>PONATINIB HYDROCHLORIDE</b>	<b>12</b>	RATIO-FINASTERIDE	27	SANDOZ BUPROPION SR	42
PRADAXA	23	RATIO-LENOLTEC NO 2	27	SANDOZ CLONAZEPAM	36
PRECISION XTRA	56	RATIO-LENOLTEC NO 3	27	SANDOZ CYCLOSPORINE	92
<b>PREGABALIN</b>	<b>39</b>	RATIO-MORPHINE	31	SANDOZ DONEPEZIL	14
PREGABALIN	40	RATIO-OMEPRAZOLE	66	SANDOZ LEVOPROXACIN	2
PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	77	RATIO-OXYCODAN	27	SANDOZ LINEZOLID	3
PREVACID	64	RATIO-RIVASTIGMINE	16	SANDOZ METHYLPHENIDATE SR	45
PREVACID FASTAB	65	RATIO-SILDENAFIL R	24	SANDOZ MINOCYCLINE	3
PRIVA-PANTOPRAZOLE	68	REMICADE	90	SANDOZ MONTELUKAST	58
PRO-AAS	26	RENAGEL	57	SANDOZ MORPHINE SR	32
PRO-CET-30	27	RESERVOIR PARADIGM 5X1.8ML	98	SANDOZ MOXIFLOXACIN	2
PRO-CLONAZEPAM	36	RESERVOIR PARADIGM 7X3.0ML	98	SANDOZ MYCOPHENOLATE	93
PRO-GABAPENTIN	38	RESPICHAMBER SILICONE MEDIUM MASK	96	SANDOZ NARATRIPTAN	50
<b>PROGESTERONE</b>	<b>74</b>	RESPICHAMBER SILICONE SMALL MASK	96	SANDOZ OMEPRAZOLE	66
PROGRAF	94	RESPICHAMBER VHC W MOUTHPIECE	96	SANDOZ	27
PROLIA	79	RESTORIL	49	OXYCODONE/ACETAMINOPHEN	
PRO-LORAZEPAM	48	REVATIO	24	SANDOZ PANTOPRAZOLE	68
PROMETRIUM	74	REVLIMID	11	SANDOZ PIOGLITAZONE	72
PRO-PIOGLITAZONE	72	<b>RIBAVIRIN</b>	7	SANDOZ PREGABALIN	40
PRO-RABEPRAZOLE	68	<b>RIFAXIMIN</b>	3	SANDOZ RABEPRAZOLE	68
PROSCAR	78	RISPERDAL CONSTA	43	SANDOZ RIVASTIGMINE	16
PROTOPIC	75	<b>RISPERIDONE (CONSTA)</b>	<b>43</b>	SANDOZ RIZATRIPTAN ODT	50
QUICK-SET 6MMX18	97	RITUXAN	12	SANDOZ SUMATRIPTAN	51
QUICK-SET 6MMX23 TUBING	97	<b>RITUXIMAB</b>	<b>12</b>	SANDOZ TACROLIMUS	94
QUICK-SET 6MMX32	97	RIVA OXAZEPAM	48	SANDOZ VORICONAZOLE	4
QUICK-SET 6MMX43 TUBING	97	RIVA-ALPRAZOLAM	46	SANDOZ ZOLMITRIPTAN	52
QUICK-SET 9MMX23 TUBING	97	RIVA-ATOMOXETINE	53	SANDOZ ZOLMITRIPTAN ODT	52
QUICK-SET 9MMX32	97	RIVA-CLONAZEPAM	36	SAPHRIS	43
QUICK-SET 9MMX43 TUBING	97	RIVACOCET	27	<b>SAXAGLIPTIN HYDROCHLORIDE</b>	<b>70</b>
RABEPRAZOLE	68	RIVA-CYCLOBENZAPRINE	20	<b>SAXAGLIPTIN HYDROCHLORIDE, METFORMIN HYDROCHLORIDE</b>	<b>70</b>
RABEPRAZOLE EC	68	RIVA-DONEPEZIL	14	<b>SECUKINUMAB</b>	<b>74</b>
<b>RABEPRAZOLE SODIUM</b>	<b>68</b>	RIVA-DUTASTERIDE	78	SEEBRI BREEZHALER	17
RALOXIFENE	70	RIVA-FINASTERIDE	78	SEPTA DONEPEZIL	14
<b>RALOXIFENE HYDROCHLORIDE</b>	<b>70</b>	RIVA-GABAPENTIN	38	SEPTA-ZOLMITRIPTAN-ODT	52
RAN-DONEPEZIL	14	RIVA-LANSOPRAZOLE	64	SEREVENT DISKHALER	19
RAN-FENTANYL MATRIX	28	RIVA-MONTELUKAST	59	SEREVENT DISKUS	19
RAN-FINASTERIDE	78	RIVA-MOXIFLOXACIN	2	<b>SEVELAMER HYDROCHLORIDE</b>	<b>57</b>
RAN-GABAPENTIN	38	RIVA-OMEPRAZOLE DR	66	SIDEKICK	56
<b>RANIBIZUMAB</b>	<b>62</b>	RIVA-PANTOPRAZOLE	68	<b>SILDENAFIL CITRATE</b>	<b>24</b>
RAN-LANSOPRAZOLE	64	RIVA-PREGABALIN	40	<b>SIMEPREVIR SODIUM</b>	<b>7</b>
RAN-MONTELUKAST	59	RIVA-RABEPRAZOLE	69	SIMPONI	87
RAN-NABILONE	63	RIVA-RABEPRAZOLE EC	68	SINGULAIR	58
RAN-OMEPRAZOLE	66	RIVA-RIZATRIPTAN ODT	50	<b>SIROLIMUS</b>	<b>93</b>
RAN-PANTOPRAZOLE	68	<b>RIVAROXABAN</b>	<b>23</b>	<b>SITAGLIPTIN PHOSPHATE MONOHYDRATE</b>	<b>71</b>
RAN-PIOGLITAZONE	72	RIVASA	26	<b>SITAGLIPTIN PHOSPHATE MONOHYDRATE, METFORMIN HYDROCHLORIDE</b>	<b>71</b>
RAN-PREGABALIN	40	RIVASTIGMINE	16	<b>SOFOSBUVIR</b>	<b>7</b>
RAN-RABEPRAZOLE	68	<b>RIVASTIGMINE HYDROGEN TARTRATE</b>	<b>16</b>	<b>SOFOSBUVIR, LEDIPASVIR</b>	<b>8</b>
RAPAMUNE	93	RIVA-ZOLMITRIPTAN	52	<b>SOFOSBUVIR, VELPATASVIR</b>	<b>8</b>
RAPID-D 10MM/110CM	97	RIVOTRIL	36	SOVALDI	7
RAPID-D 10MM/60CM	97	<b>RIZATRIPTAN BENZOATE</b>	<b>50</b>	<b>SPACER DEVICE</b>	<b>95</b>
RAPID-D 10MM/80CM	97	RIZATRIPTAN ODT	50		
RAPID-D 6MM/110CM	97	RIZATRIPTAN RDT	50		
RAPID-D 6MM/60CM	97	<b>ROSIGLITAZONE MALEATE</b>	<b>73</b>		
		<b>RUFINAMIDE</b>	<b>41</b>		

**Appendix A - Limited Use Benefits and Criteria**

**Non-Insured Health Benefits**

SPIRIT TEST STRIP (ON)	56	TEVA-HYDROMORPHONE	30	ULIPRISTAL ACETATE	70
SPIRIVA	17	TEVA-IMATINIB	10	ULORIC	78
SPIRIVA RESPIMAT	17	TEVA-LANSOPRAZOLE	64	ULTIBRO BREEZHALER	17
STATEX	32	TEVA-LEVOFLOXACIN	2	ULTRAFLEX 1 10MM/110CM	97
STELARA	77	TEVA-LORAZEPAM	48	ULTRAFLEX 1 10MM/60CM	97
STRATTERA	53	TEVA-METHYLPHENIDATE	45	ULTRAFLEX 1 10MM/80CM	97
SUBOXONE	34	TEVA-MINOCYCLINE	3	ULTRAFLEX 1 8MM/110CM	97
SUMATRIPTAN	51	TEVA-MONTELUKAST	59	ULTRAFLEX 1 8MM/60CM	98
SUMATRIPTAN DF	51	TEVA-MORPHINE SR	32	ULTRAFLEX 1 8MM/80CM	98
<b>SUMATRIPTAN SUCCINATE</b>	<b>51</b>	TEVA-MOXIFLOXACIN	2	<b>UMECLIDINIUM BROMIDE</b>	<b>17</b>
<b>SUNITINIB MALATE</b>	<b>13</b>	TEVA-MYCOPHENOLATE	93	<b>UMECLIDINIUM BROMIDE,</b>	<b>18</b>
SUNVEPRA	5	TEVA-NABILONE	63	<b>VILANTEROL TRIFENATATE</b>	
SUPEUDOL	33	TEVA-NARATRIPTAN	50	<b>USTEKINUMAB</b>	<b>77</b>
SURE STEP	56	TEVA-OMEPRAZOLE	66	VALIUM	47
SURETEST (ON)	56	TEVA-OXYCOET	27	<b>VALSARTAN (SACUBITRIL</b>	<b>26</b>
SUTENT	13	TEVA-PANTOPRAZOLE	68	<b>VALSARTAN SODIUM HYDRATE</b>	
SYMBICORT 100 TURBUHALER	19	TEVA-PANTOPRAZOLE	67	<b>COMPLEX), SACUBITRIL</b>	
SYMBICORT 200 TURBUHALER	19	MAGNESIUM		<b>(SACUBITRIL VALSARTAN</b>	
<b>TACROLIMUS (PROTOPIC)</b>	<b>75</b>	TEVA-PIOGLITAZONE	72	<b>SODIUM HYDRATE COMPLEX)</b>	
<b>TACROLIMUS MONOHYDRATE</b>	<b>94</b>	TEVA-PREGABALIN	40	VAN-FINASTERIDE	78
<b>TADALAFIL</b>	<b>24</b>	TEVA-PROGESTERONE	74	VAN-PIOGLITAZONE	72
TARCEVA	10	TEVA-RABEPRAZOLE	68	<b>VARENICLINE TARTRATE</b>	<b>22</b>
TARO-DICLOFENAC	26	TEVA-RALOXIFENE	70	<b>VEDOLIZUMAB</b>	<b>94</b>
TARO-SUMATRIPTAN	51	TEVA-RIZATRIPTAN ODT	50	<b>VEMURAFENIB</b>	<b>13</b>
TARO-TEMOZOLOMIDE	13	TEVA-SUMATRIPTAN	51	<b>VERTEPORFIN</b>	<b>62</b>
TARO-ZOLEDRONIC ACID	79	TEVA-SUMATRIPTAN DF	51	VFEND	4
TECTA	67	TEVA-TEMAZEPAM	49	VIMPAT	39
TEMAZEPAM	49	TEVA-TOLTERODINE	75	VIREAD	4
<b>TEMAZEPAM</b>	<b>49</b>	TEVA-VORICONAZOLE	4	VISANNE	74
TEMODAL	13	TEVA-ZOLMITRIPTAN	52	VISUDYNE	62
<b>TEMOZOLOMIDE</b>	<b>13</b>	TEVA-ZOLMITRIPTAN OD	52	<b>VITAMIN E</b>	<b>76</b>
TEMPRA CHILDREN'S	34	THRIVE NICOTINE LOZENGES	21	VITAMIN E	76
TEMPRA CHILDREN'S DOUBLE	34	THRIVE NICOTINELL GUM	21	VOLIBRIS	25
STRENGTH		<b>TIOTROPIUM BROMIDE</b>	<b>17</b>	<b>VORICONAZOLE</b>	<b>4</b>
TEMPRA INFANT	34	<b>MONOHYDRATE</b>		VOTRIENT	12
TENDER-1 17MM/110CM	97	TIZANIDINE	20	VYVANSE	44
TENDER-1 17MM/60CM	97	<b>TIZANIDINE HYDROCHLORIDE</b>	<b>20</b>	WAMPOLE COMPLETE MULT-PRE	77
TENDER-1 17MM/80CM	97	<b>TOCILIZUMAB (IV)</b>	<b>91</b>	AND POST NATAL WITH FOLIC	
TENDER-1 MINI INF SET	97	<b>TOCILIZUMAB (SC)</b>	<b>92</b>	ACID	
13MM/110CM		<b>TOFACITINIB CITRATE</b>	<b>92</b>	WELLBUTRIN SR	42
TENDER-1 MINI INFSET 13MM/60CM	97	<b>TOLTERODINE TARTRATE</b>	<b>75</b>	WELLBUTRIN XL	42
TENDER-1 MINI INFSET 13MM/80CM	97	TOVIAZ	75	XANAX	46
TENDER-2 17MM/110CM	97	TRACLEER	25	XANAX TS	46
TENDER-2 17MM/60CM	97	TRAJENTA	70	XARELTO	23
TENDER-2 17MM/80CM	97	TRANSDERMAL NICOTINE	21	XELJANZ	92
TENDER-2 MINI INF SET	97	TRANSDERMAL NICOTINE	22	XEOMIN	95
13MM/110CM		PATCHDAY		XGEVA	79
TENDER-2 MINI INFSET 13MM/60CM	97	TRAVEL	63	XIGDUO	72
TENDER-2 MINI INFSET 13MM/80CM	97	TRIAEC-30	27	XOLAIR	60
<b>TENOFOVIR DISOPROXIL</b>	<b>4</b>	<b>TRIAZOLAM</b>	<b>49</b>	XTANDI	10
<b>FUMARATE</b>		TRIAZOLAM	49	<b>ZAFIRLUKAST</b>	<b>60</b>
TEVA-ALPRAZOLAM	46	TRIMEBUTINE	17	ZAXINE	3
TEVA-ATOMOXETINE	53	<b>TRIMEBUTINE MALEATE</b>	<b>17</b>	ZELBORAF	13
TEVA-BROMAZEPAM	46	TROSEC	76	ZENHALE	19
TEVA-CLONAZEPAM	36	<b>TROSPIUM CHLORIDE</b>	<b>76</b>	ZEPATIER	6
TEVA-CYCLOBENZAPRINE	20	TRUE TRACK	56	ZOLEDRONIC ACID	79
TEVA-DIMENATE	63	TRUETEST	56	<b>ZOLEDRONIC ACID</b>	<b>79</b>
TEVA-DONEPEZIL	14	TUDORZA GENUAIR	17	<b>MONOHYDRATE</b>	
TEVA-DUTASTERIDE	78	TYLENOL	34	<b>ZOLMITRIPTAN</b>	<b>51</b>
TEVA-EMTEC-30	27	TYLENOL EXTRA STRENGTH	36	ZOLMITRIPTAN	52
TEVA-ERLOTINIB	10	TYLENOL JR STRENGTH	35	ZOLMITRIPTAN ODT	52
TEVA-FENTANYL	28	FASTMELTS		ZOMIG	52
TEVA-FINASTERIDE	78	TYLENOL JUNIOR STRENGTH	36	ZOMIG RAPIMELT	52
TEVA-GABAPENTIN	38	TYLENOL WITH CODEINE NO.2	27	ZYBAN	42
TEVA-GALANTAMINE ER	15	TYLENOL WITH CODEINE NO.3	27	ZYDELIG	10
				ZYTIGA	9

ZYVOXAM

3

**APPENDIX B  
SPECIAL FORMULARY FOR  
CHRONIC RENAL FAILURE PATIENTS**

The Special Formulary for Chronic Renal Failure Patients defines selected drugs (for example: darbepoetin alfa, calcium products, water-soluble multivitamin products and selected nutritional products formulated for renal patients) that are covered for identified eligible NIHB clients in chronic renal failure.

These drugs are covered in addition to the drugs and products listed in the NIHB Drug Benefit List.

**08:00 ANTI-INFECTIVE AGENTS****08:12.02 AMINOGLYCOSIDES****GENTAMICIN SULFATE****10MG/ML INJECTION**

02225123 CIDOMYCIN UNK

**40MG SOLUTION**

02457008 GENTAMICIN TEL

**TOBRAMYCIN****1.2G POWDER FOR SOLUTION**

00533688 TOBRAMYCIN FKD

02285150 TOBRAMYCIN RAX

**10MG/ML SOLUTION**

02230639 TOBRAMYCIN FKD

02241209 TOBRAMYCIN SDZ

**40MG/ML SOLUTION**

02420287 JAMP-TOBRAMYCIN JMP

02230640 TOBRAMYCIN FKD

02241210 TOBRAMYCIN SDZ

02382814 TOBRAMYCIN MYL

99005069 TOBRAMYCINE UNK

**08:12.06 CEPHALOSPORINS****CEFAZOLIN SODIUM****500MG POWDER FOR SOLUTION**

02437104 CEFAZOLIN RAX

**1G POWDER FOR SOLUTION**

02465469 CEFAZOLIN UNK

**10G POWDER FOR SOLUTION**

02452162 CEFAZOLIN FKD

02465477 CEFAZOLIN UNK

**20G POWDER FOR SOLUTION**

02237141 CEFAZOLIN FKD

**100G POWDER FOR SOLUTION**

02401029 CEFAZOLIN FKD

**08:12.28 MISCELLANEOUS ANTIBIOTICS****VANCOMYCIN HYDROCHLORIDE****500MG POWDER FOR SOLUTION**

02420295 JAMP-VANCOMYCIN JMP

02406535 MYLAN-VANCOMYCIN MYL

02342855 VAL-VANCOMYCIN VAE

02139375 VANCOMYCIN FKD

02230191 VANCOMYCIN PFI

02394626 VANCOMYCIN SDZ

02407914 VANCOMYCIN MYL

02411032 VANCOMYCIN RAX

02435713 VANCOMYCIN GMP

**1,000MG POWDER FOR SOLUTION**

02230192 VANCOMYCIN PFI

02396386 VANCOMYCIN RAX

02435721 VANCOMYCIN GMP

**08:12.28 MISCELLANEOUS ANTIBIOTICS****VANCOMYCIN HYDROCHLORIDE****1G POWDER FOR SOLUTION**

02420309 JAMP-VANCOMYCIN JMP

02406543 MYLAN-VANCOMYCIN MYL

02241821 PMS-VANCOMYCIN 1 G PMS

02342863 VAL-VANCOMYCIN VAE

02139383 VANCOMYCIN FKD

02394634 VANCOMYCIN SDZ

02407922 VANCOMYCIN MYL

**5G POWDER FOR SOLUTION**

02420317 JAMP-VANCOMYCIN JMP

02406551 MYLAN-VANCOMYCIN MYL

02139243 VANCOMYCIN FKD

02378337 VANCOMYCIN PFI

02394642 VANCOMYCIN SDZ

02407930 VANCOMYCIN MYL

**10G POWDER FOR SOLUTION**

02420325 JAMP-VANCOMYCIN JMP

02406578 MYLAN-VANCOMYCIN MYL

02405830 VAL-VANCOMYCIN VAE

02241807 VANCOMYCIN FKD

02378345 VANCOMYCIN PFI

02394650 VANCOMYCIN SDZ

02407949 VANCOMYCIN MYL

02411040 VANCOMYCIN RAX

**20:00 BLOOD FORMATION  
COAGULATION AND  
THROMBOSIS****20:16.00 HEMATOPOIETIC AGENTS****DARBEPOETIN ALFA****25MCG/ML SOLUTION**

02392313 ARANESP AMG

**40MCG/ML SOLUTION**

02392321 ARANESP AMG

**60MCG/ML SOLUTION**

02246348 ARANESP AMG

**100MCG/ML SOLUTION**

02391740 ARANESP AMG

02391759 ARANESP AMG

02392348 ARANESP AMG

99004917 ARANESP AMG

99004925 ARANESP AMG

**200MCG/ML SOLUTION**

02391767 ARANESP AMG

02391775 ARANESP AMG

02391783 ARANESP AMG

02392356 ARANESP AMG

99004909 ARANESP AMG

99004933 ARANESP AMG

The Special Formulary for Chronic Renal Failure Patients defines selected drugs (for example: darbepoetin alfa, calcium products, water-soluble multivitamin products and selected nutritional products formulated for renal patients) that are covered for identified eligible NIHB clients in chronic renal failure.

These drugs are covered in addition to the drugs and products listed in the NIHB Drug Benefit List.

<b>20:16.00 HEMATOPOIETIC AGENTS</b>		<b>40:12.00 REPLACEMENT PREPARATIONS</b>	
<b>DARBEPOETIN ALFA</b>		<b>SODIUM PHOSPHATE</b>	
<b>500MCG/ML SOLUTION</b>		<b>500MG TABLET</b>	
02391791 ARANESP	AMG	00225819 PHOSPHATE-NOVARTIS	NVC
02391805 ARANESP	AMG		
02391821 ARANESP	AMG	<b>ZINC GLUCONATE</b>	
02392364 ARANESP	AMG	<b>50MG TABLET</b>	
09857185 ARANESP	AMG	00503169 ZINC	VTH
		00505463 ZINC	JAM
<b>EPOETIN ALFA</b>		<b>56:00 GASTROINTESTINAL DRUGS</b>	
<b>1,000U/0.5ML SOLUTION</b>		<b>56:04.00 ANTACIDS AND ADSORBENTS</b>	
02231583 EPREX	JSO	<b>ALUMINUM HYDROXIDE</b>	
<b>2,000U/0.5ML SOLUTION</b>		<b>500MG CAPSULE</b>	
02231584 EPREX	JSO	02135620 BASALJEL	AUP
<b>3,000U/0.3ML SOLUTION</b>		<b>325MG/5ML ORAL LIQUID</b>	
02231585 EPREX	JSO	02125862 AMPHOJEL	AUP
<b>4,000U/0.4ML SOLUTION</b>		<b>320MG/ML SUSPENSION</b>	
02231586 EPREX	JSO	00572527 ALUGEL	ATL
<b>5000U/0.5ML SOLUTION</b>		<b>600MG TABLET</b>	
02243400 EPREX	JSO	02124971 AMPHOJEL	AUP
<b>6000U/0.6ML SOLUTION</b>		<b>CALCIUM</b>	
02243401 EPREX	JSO	<b>500MG TABLET</b>	
<b>8000U/0.8ML SOLUTION</b>		01970240 TUMS	GSK
02243403 EPREX	JSO	<b>750MG TABLET</b>	
<b>10,000/ML SOLUTION</b>		01967932 TUMS EXTRA STRENGTH	GSK
02231587 EPREX	JSO	<b>1,000MG TABLET</b>	
<b>20,000U/0.5ML SOLUTION</b>		02151138 TUMS ULTRA STRENGTH	GSK
02243239 EPREX	JSO	<b>SODIUM BICARBONATE</b>	
<b>30,000U/0.75ML SOLUTION</b>		<b>500MG TABLET</b>	
02288680 EPREX	JSO	80030520 JAMP-SODIUM BICARBONATE	JMP
<b>40,000U/ML SOLUTION</b>		80022194 SANDOZ SODIUM BICARBONATE	SDZ
02240722 EPREX	JSO	<b>56:12.00 CATHARTICS AND LAXATIVES</b>	
<b>40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE</b>		<b>SODIUM PHOSPHATE</b>	
<b>40:12.00 REPLACEMENT PREPARATIONS</b>		<b>TABLET</b>	
<b>CALCIUM</b>		80047562 JAMP-SODIUM PHOSPHATE	JMP
<b>500MG CAPSULE</b>		<b>84:00 SKIN AND MUCOUS MEMBRANE AGENTS (SMMA)</b>	
00648353 CALSAN	NVC	<b>84:04.04 SMMA - ANTIBIOTICS</b>	
<b>250MG TABLET</b>		<b>GENTAMICIN SULFATE</b>	
00645958 CALCIUM	NOP	<b>1MG OINTMENT</b>	
<b>625MG TABLET (COATED)</b>		00872881 PMS-GENTAMICIN	PMS
00682047 APOCAL	APX	<b>88:00 VITAMINS</b>	
<b>CALCIUM CARB-GLUCONOLACTATE</b>		<b>88:28.00 MULTIVITAMIN PREPARATIONS</b>	
<b>500MG TABLET</b>		<b>MULTIVITAMINS (PEDIATRIC)</b>	
02232482 CALCIUM SANDOZ FORTE	GSK	<b>CAPSULE</b>	
<b>1,000MG TABLET</b>		00123803 B COMPLEX PLUS C	JAM
02232483 CALCIUM-SANDOZ GRAMCAL	GSK		
<b>SODIUM PHOSPHATE</b>			
<b>123MG POWDER FOR SOLUTION</b>			
80027202 PHOSPHATE-NOVARTIS	NVR		

The Special Formulary for Chronic Renal Failure Patients defines selected drugs (for example: darbepoetin alfa, calcium products, water-soluble multivitamin products and selected nutritional products formulated for renal patients) that are covered for identified eligible NIHB clients in chronic renal failure.

These drugs are covered in addition to the drugs and products listed in the NIHB Drug Benefit List.

## 88:28.00 MULTIVITAMIN PREPARATIONS

### MULTIVITAMINS (PEDIATRIC)

#### TABLET

80007498 BC VITAMINS	WNP
02245391 DIAMINE	EUR
80001432 RENAVITE	MAC
00558796 STRESS PLEX	JAM

#### 1MG TABLET

80020788 JAMP-VITAMINS B C	JMP
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#### 300MCG TABLET

80063438 M-PLAVITE	MAN
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## 96:00 PHARMACEUTICAL AIDS

### 96:00.00 PHARMACEUTICAL AIDS

#### NUTRITIONAL SUPPLEMENT

##### ORAL LIQUID

09853154 BOOST FRUIT BEVERAGE	NES
95999970 BOOST HIPROTEIN	NES
95999963 BOOST ORIGINAL	NES
95999975 BOOST PLUS	NES
97904341 ENSURE	ABB
00801054 ENSURE HIGH PROTEIN	ABB
97904333 ENSURE PLUS	ABB
97904317 ENSURE WITH FIBRE	ABB
09853723 NEPRO	ABB
99002639 NEPRO	ABB
99100702 NEPRO CARB STEADY	ABB
00907995 NOVASOURCE	NVC
09854258 NOVASOURCE	NES
09853731 SUPLENA	ABB
99002647 SUPLENA	ABB

##### POWDER

09991056 RESOURCE BENEPROTEIN	NVC
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### VANCOMYCIN HYDROCHLORIDE

##### POWDER

99100176 VANCOMYCIN	MDS
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ALUGEL	2	ZINC GLUCONATE	2
<b>ALUMINUM HYDROXIDE</b>	<b>2</b>		
AMPHOJEL	2		
APOCAL	2		
ARANESP	1		
B COMPLEX PLUS C	2		
BASALJEL	2		
BC VITAMINS	3		
BOOST FRUIT BEVERAGE	3		
BOOST HIPROTEIN	3		
BOOST ORIGINAL	3		
BOOST PLUS	3		
CALCIUM	2		
<b>CALCIUM</b>	<b>2</b>		
<b>CALCIUM CARB- GLUCONOLACTATE</b>	<b>2</b>		
CALCIUM SANDOZ FORTE	2		
CALCIUM-SANDOZ GRAMCAL	2		
CALSAN	2		
CEFAZOLIN	1		
<b>CEFAZOLIN SODIUM</b>	<b>1</b>		
CIDOMYCIN	1		
<b>DARBEPOETIN ALFA</b>	<b>1</b>		
DIAMINE	3		
ENSURE	3		
ENSURE HIGH PROTEIN	3		
ENSURE PLUS	3		
ENSURE WITH FIBRE	3		
<b>EPOETIN ALFA</b>	<b>2</b>		
EPREX	2		
GENTAMICIN	1		
<b>GENTAMICIN SULFATE</b>	<b>1</b>		
JAMP-SODIUM BICARBONATE	2		
JAMP-SODIUM PHOSPHATE	2		
JAMP-TOBRAMYCIN	1		
JAMP-VANCOMYCIN	1		
JAMP-VITAMINS B C	3		
M-PLAVITE	3		
<b>MULTIVITAMINS (PEDIATRIC)</b>	<b>2</b>		
MYLAN-VANCOMYCIN	1		
NEPRO	3		
NEPRO CARB STEADY	3		
NOVASOURCE	3		
<b>NUTRITIONAL SUPPLEMENT</b>	<b>3</b>		
PHOSPHATE-NOVARTIS	2		
PMS-GENTAMICIN	2		
PMS-VANCOMYCIN 1 G	1		
RENAVITE	3		
RESOURCE BENEPROTEIN	3		
SANDOZ SODIUM BICARBONATE	2		
<b>SODIUM BICARBONATE</b>	<b>2</b>		
<b>SODIUM PHOSPHATE</b>	<b>2</b>		
STRESS PLEX	3		
SUPLENA	3		
<b>TOBRAMYCIN</b>	<b>1</b>		
TOBRAMYCIN	1		
TOBRAMYCINE	1		
TUMS	2		
TUMS EXTRA STRENGTH	2		
TUMS ULTRA STRENGTH	2		
VAL-VANCOMYCIN	1		
VANCOMYCIN	1		
<b>VANCOMYCIN HYDROCHLORIDE</b>	<b>1</b>		
ZINC	2		

**APPENDIX C**  
**PALLIATIVE CARE FORMULARY**

Effective April 1, 2009, recipients diagnosed with a terminal illness and are near the end of life will be eligible to receive a list of supplemental benefits that are not included in the NIHB Drug Benefit List. The Palliative Care Formulary includes medications used to provide comfort to those near the end of life.

Requests for any of the DINs below will generate a Palliative Care Application Form, faxed to the prescribing physician. Once completed and submitted, the recipient will be eligible for all medications on the Palliative Care Formulary if the following criteria are met:

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Please note: During the six month coverage period, a maximum 30 day supply will be reimbursed at any one time.

## 12:00 AUTONOMIC DRUGS

### 12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

#### ATROPINE SULFATE

##### 0.4MG/ML SOLUTION

02094681 ATROPINE	ALV
00960624 ATROPINE SULFATE	UNK

##### 0.6MG/ML SOLUTION

00012076 ATROPINE SULFATE	GSK
00392693 ATROPINE SULFATE	SDZ
00392782 ATROPINE SULFATE	SDZ

#### GLYCOPYRROLATE

##### 0.2MG/ML LIQUID

02039508 GLYCOPYRROLATE	SDZ
02382857 GLYCOPYRROLATE	OMG

#### HYOSCINE BUTYLBROMIDE

##### 20MG/ML SOLUTION

00363839 BUSCOPAN	SAC
02229868 HYOSCINE BUTYLBROMIDE	SDZ

#### SCOPOLAMINE HYDROBROMIDE

##### 0.4MG/ML SOLUTION

00541869 SCOPOLAMINE	HOS
02242810 SCOPOLAMINE	OMG

##### 0.6MG/ML SOLUTION

00541877 SCOPOLAMINE	HOS
02242811 SCOPOLAMINE	OMG

## 28:00 CENTRAL NERVOUS SYSTEM AGENTS

### 28:04.92 GENERAL ANESTHETICS, MISC.

#### KETAMINE HYDROCHLORIDE

##### 10MG/ML SOLUTION

00224391 KETALAR	ERF
02246795 KETAMINE	SDZ
02387301 KETAMINE	SDZ

### 28:04.92 GENERAL ANESTHETICS, MISC.

#### KETAMINE HYDROCHLORIDE

##### 50MG/ML SOLUTION

00224405 KETALAR	ERF
02246796 KETAMINE	SDZ
02387328 KETAMINE	SDZ
02387336 KETAMINE	SDZ

### 28:08.08 OPIATE AGONISTS

#### EXTEMPORANEOUS MIXTURE

##### INJECTION

99506019 FENTANYL STERILE INFUSION	UNK
99506017 HYDROMORPHONE HP STERILE INFUSION	UNK
99506018 MORPHINE HP STERILE INFUSION	UNK

#### FENTANYL

##### 12MCG/HR PATCH

02454440 APO-FENTANYL MATRIX	APX
02334186 DURAGESIC	JSO
99100480 FENTANYL	JNO
02376768 PAT-FENTANYL MATRIX	KLA

##### 25MCG/HR PATCH

02304120 FENTANYL TRANSDERMAL SYSTEM	ACG
02376776 PAT-FENTANYL MATRIX	KLA
02325403 RAN-FENTANYL MATRIX	RBY

##### 37MCG/HR PATCH

02386860 CO FENTANYL	OBT
02327139 SANDOZ FENTANYL	SDZ

##### 50MCG/HR PATCH

02304139 FENTANYL TRANSDERMAL SYSTEM	ACG
02376784 PAT-FENTANYL MATRIX	KLA
02325411 RAN-FENTANYL MATRIX	RBY

##### 75MCG/HR PATCH

02304147 FENTANYL TRANSDERMAL SYSTEM	ACG
02376792 PAT-FENTANYL MATRIX	KLA
02325438 RAN-FENTANYL MATRIX	RBY

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<b>28:08.08 OPIATE AGONISTS</b>	<b>28:08.08 OPIATE AGONISTS</b>
<b>FENTANYL</b>	<b>MORPHINE SULFATE</b>
<b>100MCG/HR PATCH</b>	<b>2MG/ML LIQUID</b>
02304155 FENTANYL TRANSDERMAL SYSTEM ACG	02242484 MORPHINE SULFATE SDZ
02376806 PAT-FENTANYL MATRIX KLA	<b>10MG LIQUID</b>
02325446 RAN-FENTANYL MATRIX RBY	00392588 MORPHINE SULFATE SDZ
<b>FENTANYL CITRATE</b>	<b>15MG LIQUID</b>
<b>50MCG/ML SOLUTION</b>	00392561 MORPHINE SULFATE SDZ
00888346 FENTANYL CITRATE HOS	<b>50MG/ML LIQUID</b>
02240434 FENTANYL CITRATE SDZ	02137267 MORPHINE SULPHATE HOS
<b>HYDROMORPHONE HYDROCHLORIDE</b>	<b>0.5MG/ML SOLUTION</b>
<b>2MG/ML SOLUTION</b>	02021056 MORPHINE LP EPIDURAL SDZ
02145901 HYDROMORPHONE SDZ	01949047 MORPHINE-EPD HOS
<b>10MG/ML SOLUTION</b>	<b>1MG/ML SOLUTION</b>
02145928 HYDROMORPHONE HP SDZ	02021048 MORPHINE LP SDZ
<b>20MG/ML SOLUTION</b>	01980696 MORPHINE SULFATE SDZ
02145936 HYDROMORPHONE HP SDZ	01949055 MORPHINE-EPD HOS
<b>50MG/ML SOLUTION</b>	<b>2MG/ML SOLUTION</b>
02146126 HYDROMORPHONE HP SDZ	00850314 MORPHINE SULFATE HOS
99003163 HYDROMORPHONE HP UNK	01964437 MORPHINE SULFATE SDZ
<b>100MG/ML SOLUTION</b>	<b>5MG/ML SOLUTION</b>
02244797 HYDROMORPHONE HP FORTE SDZ	01964429 MORPHINE SULFATE SDZ
<b>METHADONE HYDROCHLORIDE (BC ONLY)</b>	<b>10MG/ML SOLUTION</b>
<b>POWDER</b>	00850322 MORPHINE SULFATE HOS
09991180 METHADONE PDR (PAIN) UNK	<b>25MG/ML SOLUTION</b>
<b>METHADONE HYDROCHLORIDE (METADOL)</b>	00676411 MORPHINE HP SDZ
<b>1MG/ML SOLUTION</b>	<b>50MG/ML SOLUTION</b>
02247694 METADOL PAL	00617288 MORPHINE HP SDZ
<b>1MG TABLET</b>	<b>28:12.04 ANTICONVULSANTS - BARBITURATES</b>
02247698 METADOL PAL	<b>PHENOBARBITAL</b>
<b>5MG TABLET</b>	<b>30MG SOLUTION</b>
02247699 METADOL PAL	02304082 PHENOBARBITAL SODIUM SDZ
<b>10MG TABLET</b>	<b>120MG SOLUTION</b>
02247700 METADOL PAL	09857296 PHENOBARBITAL HOS
<b>25MG TABLET</b>	02304090 PHENOBARBITAL SODIUM SDZ
02247701 METADOL PAL	

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<b>28:12.12 ANTICONVULSANTS - HYDANTOINS</b>	<b>40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE</b>
<b>PHENYTOIN</b>	<b>40:28.08 LOOP DIURETICS</b>
50MG LIQUID	<b>FUROSEMIDE</b>
00780626 PHENYTOIN SODIUM	10MG/ML SOLUTION
SDZ	02382539 FUROSEMIDE
<b>28:16.08 ANTIPSYCHOTIC AGENTS</b>	SDZ
<b>METHOTRIMEPRAZINE HYDROCHLORIDE</b>	02384094 FUROSEMIDE
25MG/ML SOLUTION	ALV
01927698 NOZINAN	<b>52:00 EYE, EAR, NOSE AND THROAT (EENT)</b>
SAC	<b>52:92.00 MISCELLANEOUS EENT DRUGS</b>
<b>28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES</b>	<b>ARTIFICIAL SALIVA</b>
<b>DIAZEPAM</b>	0.05MG SPRAY
5MG/ML SOLUTION	02238696 MOISTIR
00399728 DIAZEPAM	PMS
02386143 DIAZEPAM	<b>56:00 GASTROINTESTINAL DRUGS</b>
SDZ	<b>56:22.20 5-HT3 RECEPTOR ANTAGONISTS</b>
<b>DIAZEPAM (DIASTAT)</b>	<b>GRANISETRON HYDROCHLORIDE</b>
5MG/ML GEL	1MG/ML SOLUTION
02238162 DIASTAT	02385414 GRANISETRON
09853340 DIASTAT 2X10MG RECTAL PACK	SDZ
09853430 DIASTAT 2X15MG RECTAL PACK	<b>ONDANSETRON HYDROCHLORIDE</b>
ELN	2MG/ML SOLUTION
ELN	02265524 ONDANSETRON
<b>LORAZEPAM</b>	02274418 ONDANSETRON
4MG/ML LIQUID	02279428 ONDANSETRON
02243278 LORAZEPAM	02390019 ONDANSETRON
SDZ	02390051 ONDANSETRON
2MG/ML SOLUTION	<b>56:22.92 MISCELLANEOUS ANTIEMETICS</b>
02438704 LORAZEPAM	<b>NABILONE</b>
SDZ	0.25MG CAPSULE
<b>MIDAZOLAM</b>	02441497 APO-NABILONE
1MG/ML SOLUTION	02345897 APP-NABILONE
02240285 MIDAZOLAM	02380897 PMS-NABILONE
02242904 MIDAZOLAM	APX
02243934 MIDAZOLAM	UNK
FKD	PMS
NOP	0.5MG CAPSULE
5MG/ML SOLUTION	02441500 APO-NABILONE
02240286 MIDAZOLAM	APX
02242905 MIDAZOLAM	
02243935 MIDAZOLAM	
02382903 MIDAZOLAM	
SDZ	

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<p><b>56:22.92 MISCELLANEOUS ANTIEMETICS</b></p> <p><b>NABILONE</b></p> <p><b>0.5MG CAPSULE</b></p> <p>02345927 APP-NABILONE UNK</p> <p><b>1MG CAPSULE</b></p> <p>02441519 APO-NABILONE APX</p> <p>02345935 APP-NABILONE UNK</p> <p><b>SCOPOLAMINE</b></p> <p><b>1.5MG PATCH</b></p> <p>00550094 TRANSDERM-V NVC</p> <p>80024336 TRANSDERM-V NVR</p> <p><b>56:28.12 HISTAMINE H2-ANTAGONISTS</b></p> <p><b>RANITIDINE HYDROCHLORIDE</b></p> <p><b>25MG/ML SOLUTION</b></p> <p>02256711 RANITIDINE SDZ</p> <p><b>56:32.00 PROKINETIC AGENTS</b></p> <p><b>METOCLOPRAMIDE HYDROCHLORIDE</b></p> <p><b>5MG/ML LIQUID</b></p> <p>02185431 METOCLOPRAMIDE SDZ</p> <p>02243563 METOCLOPRAMIDE OMEGA OMG</p> <p><b>56:92.00 MISCELLANEOUS GI DRUGS</b></p> <p><b>METHYLNALTREXONE BROMIDE</b></p> <p><b>20MG SOLUTION</b></p> <p>02308215 RELISTOR SLX</p> <p>02356481 RELISTOR SLX</p> <p>02356503 RELISTOR SLX</p>	<p><b>96:00.00 PHARMACEUTICAL AIDS</b></p> <p><b>NUTRITIONAL SUPPLEMENT</b></p> <p><b>ORAL LIQUID</b></p> <p>95999963 BOOST ORIGINAL NES</p> <p>95999975 BOOST PLUS NES</p> <p>97904341 ENSURE ABB</p> <p>00801054 ENSURE HIGH PROTEIN ABB</p> <p>97904333 ENSURE PLUS ABB</p> <p>97904317 ENSURE WITH FIBRE ABB</p>
<p><b>96:00 PHARMACEUTICAL AIDS</b></p> <p><b>96:00.00 PHARMACEUTICAL AIDS</b></p> <p><b>ADMINISTRATION DIN</b></p> <p><b>MISCELLANEOUS</b></p> <p>91500004 STERILE PREPERATION FEE UNK</p> <p><b>NUTRITIONAL SUPPLEMENT</b></p> <p><b>ORAL LIQUID</b></p> <p>09853154 BOOST FRUIT BEVERAGE NES</p> <p>95999970 BOOST HIPROTEIN NES</p>	

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**Appendix C - Palliative Care Formulary**

**Non-Insured Health Benefits**

<b>ADMINISTRATION DIN</b>	<b>4</b>	METOCLOPRAMIDE OMEGA	<b>4</b>
APO-FENTANYL MATRIX	1	<b>MIDAZOLAM</b>	<b>3</b>
APO-NABILONE	3	MIDAZOLAM	3
APP-NABILONE	3	MOISTIR	3
<b>ARTIFICIAL SALIVA</b>	<b>3</b>	MORPHINE HP	2
ATROPINE	1	MORPHINE HP STERILE INFUSION	1
ATROPINE SULFATE	1	MORPHINE LP	2
<b>ATROPINE SULFATE</b>	<b>1</b>	MORPHINE LP EPIDURAL	2
BOOST FRUIT BEVERAGE	4	<b>MORPHINE SULFATE</b>	<b>2</b>
BOOST HIPROTEIN	4	MORPHINE SULFATE	2
BOOST ORIGINAL	4	MORPHINE SULPHATE	2
BOOST PLUS	4	MORPHINE-EPD	2
BUSCOPAN	1	<b>NABILONE</b>	<b>3</b>
CO FENTANYL	1	NOZINAN	3
DIASTAT	3	<b>NUTRITIONAL SUPPLEMENT</b>	<b>4</b>
DIASTAT 2X10MG RECTAL PACK	3	ONDANSETRON	3
DIASTAT 2X15MG RECTAL PACK	3	<b>ONDANSETRON HYDROCHLORIDE</b>	<b>3</b>
DIAZEPAM	3	PAT-FENTANYL MATRIX	1
<b>DIAZEPAM</b>	<b>3</b>	PHENOBARBITAL	2
<b>DIAZEPAM (DIASTAT)</b>	<b>3</b>	<b>PHENOBARBITAL</b>	<b>2</b>
DURAGESIC	1	PHENOBARBITAL SODIUM	2
ENSURE	4	<b>PHENYTOIN</b>	<b>3</b>
ENSURE HIGH PROTEIN	4	PHENYTOIN SODIUM	3
ENSURE PLUS	4	PMS-NABILONE	3
ENSURE WITH FIBRE	4	RAN-FENTANYL MATRIX	1
<b>EXTEMPORANEOUS MIXTURE</b>	<b>1</b>	RANITIDINE	4
FENTANYL	1	<b>RANITIDINE HYDROCHLORIDE</b>	<b>4</b>
<b>FENTANYL</b>	<b>1</b>	RELISTOR	4
<b>FENTANYL CITRATE</b>	<b>2</b>	SANDOZ FENTANYL	1
FENTANYL CITRATE	2	SCOPOLAMINE	1
FENTANYL STERILE INFUSION	1	<b>SCOPOLAMINE</b>	<b>4</b>
FENTANYL TRANSDERMAL SYSTEM	1	<b>SCOPOLAMINE HYDROBROMIDE</b>	<b>1</b>
<b>FUROSEMIDE</b>	<b>3</b>	STERILE PREPERATION FEE	4
FUROSEMIDE	3	TRANSDERM-V	4
<b>GLYCOPYRROLATE</b>	<b>1</b>		
GLYCOPYRROLATE	1		
GRANISETRON	3		
<b>GRANISETRON HYDROCHLORIDE</b>	<b>3</b>		
HYDROMORPHONE	2		
HYDROMORPHONE HP	2		
HYDROMORPHONE HP FORTE	2		
HYDROMORPHONE HP STERILE INFUSION	1		
<b>HYDROMORPHONE HYDROCHLORIDE</b>	<b>2</b>		
<b>HYOSCINE BUTYLBROMIDE</b>	<b>1</b>		
HYOSCINE BUTYLBROMIDE	1		
KETALAR	1		
KETAMINE	1		
<b>KETAMINE HYDROCHLORIDE</b>	<b>1</b>		
LORAZEPAM	3		
<b>LORAZEPAM</b>	<b>3</b>		
METADOL	2		
<b>METHADONE HYDROCHLORIDE (BC ONLY)</b>	<b>2</b>		
<b>METHADONE HYDROCHLORIDE (METADOL)</b>	<b>2</b>		
METHADONE PDR (PAIN)	2		
<b>METHOTRIMEPRAZINE HYDROCHLORIDE</b>	<b>3</b>		
<b>METHYLNALTREXONE BROMIDE</b>	<b>4</b>		
METOCLOPRAMIDE	4		
<b>METOCLOPRAMIDE HYDROCHLORIDE</b>	<b>4</b>		

**APPENDIX D**  
**LIST OF DRUG MANUFACTURERS**

**Appendix D - List of Drug Manufacturers**
**Non-Insured Health Benefits**

MFR	Manufacturer Name	MFR	Manufacturer Name
AAP	AA PHARMA INCORPORATED	DOR	DORMER LABORATORIES INCORPORATED
ABB	ABBOTT LABORATORIES LIMITED	DPC	DOMINION PHARMACAL
ABV	ABBVIE CORPORATION	DPI	DOMREX PHARMA INCORPORATED
ACC	ACCORD HEALTHCARE INCORPORATED	DPT	DERMTEK PHARMA INCORPORATED
ACG	ACTAVIS GROUP PTC EHF	DUI	DUCHESNAY INCORPORATED
ACN	ACTELION PHARMACEUTICALS LIMITED	ECL	ECL PHARMA GROUP LIMITED
ACP	ACCEL PHARMA INCORPORATED	EIS	EISAI LIMITED
ADA	ADAMS LABS LIMITED	ELN	ELAN PHARMACEUTICALS INCORPORATED
ADD	AVEVA DRUG DELIVERY SYSTEMS INCORPORATED	ERF	ERFA CANADA INCORPORATED
ALC	ALCON CANADA INCORPORATED	ETH	ETHYPHARM INCORPORATED
ALK	ALK ABELLO A/S	EUR	EURO-PHARM INTERNATIONAL CANADA INCORPORATED
ALL	ALLERGAN INCORPORATED	FEI	FERRING INCORPORATED
ALV	ALVEDA PHARMACEUTICALS INCORPORATED	FKD	FRESENIUS KABI CANADA LIMITED
AMG	AMGEN CANADA INCORPORATED	FMC	FRESENIUS MEDICAL CARE NORTH AMERICA
ANG	ANGITA PHARMA INCORPORATED	FRS	MERCK FROSST CANADA LIMITED
APC	APTALIS PHARMA CANADA ULC	GAC	GALDERMA CANADA INCORPORATED
APL	AUROBINDO PHARMA LIMITED	GEE	GENZYME CANADA INCORPORATED
APU	ATNAHS PHARMA UK LIMITED	GFP	GFR PHARMA LIMITED
APX	APOTEX INCORPORATED	GIL	GILEAD SCIENCES INCORPORATED
ARA	ARA PHARMACEUTICALS INCORPORATED	GLK	GLENMARK PHARMACEUTICALS CANADA INCORPORATED
ARI	ARIAD PHARMACEUTICALS INCORPORATED	GMP	GENERIC MEDICAL PARTNERS INCORPORATED
ASP	ASPEN PHARMA TRADING LIMITED	GPB	G POHL-BOSKAMP GMBH & CO KG
AST	ASTELLAS PHARMA CANADA INCORPORATED	GSC	GELDA SCIENTIFIC & INDUSTRIAL DEVELOPMENT CORP
ATL	LABORATORIE ATLAS INCORPORATED	GSK	GLAXOSMITHKLINE INCORPORATED
ATO	ATON PHARMA INCORPORATED, A DIVISION OF VALEANT PHARMACEUTICALS NORTH AMERICA LLC	HIL	HILL DERMACEUTICALS INCORPORATED
AUC	AUTO CONTROL	HJS	H.J. SUTTON INDUSTRIES LIMITED
AUP	AURIUM PHARMA INCORPORATED	HLR	HOFFMAN-LAROCHE LIMITED
AUR	AURO PHARMA INCORPORATED	HLS	HLS THERAPEUTICS INC
AZC	ASTRAZENECA CANADA INCORPORATED	HOD	NIPRO DIAGNOSTICS CANADA LIMITED
BAX	BAXTER CORPORATION	HOS	HOSPIRA HEALTHCARE CORPORATION
BAY	BAYER INCORPORATED, HEALTHCARE/DIAGNOSTICS	HYD	HYDRATION PHARMACEUTICALS CANADA INCORPORATED
BDT	BECTON DICKINSON CANADA INCORPORATED	ICN	ICN CANADA LIMITED
BEN	BENCARD ALLERGY LABORATORIES	IND	INDIVIOR UK LIMITED
BEX	BERLEX CANADA INCORPORATED	INS	INSIGHT PHARMACEUTICALS LLC
BGP	BGP PHARMA ULC	IPS	IPSEN LIMITED
BMI	BIOMED 2002 INCORPORATED	IVX	IVAX PHARMACEUTICALS INCORPORATED
BMS	BRISTOL-MYERS SQUIBB CANADA	JAC	JACOBUS PHARMACEUTICAL COMPANY INCORPORATED
BOE	BOEHRINGER INGELHEIM (CANADA) LIMITED	JAJ	JOHNSON & JOHNSON
BSH	BAUSCH & LOMB CANADA INCORPORATED	JAM	C.E. JAMIESON COMPANY LIMITED
BSY	BIOSYENT PHARMA INCORPORATED	JMP	JAMP PHARMA CORPORATION
BTD	WEB PACK INTERNATIONAL INCORPORATED	JNO	JANSSEN-ORTHO INCORPORATED
BTU	BRAINTREE LABORATORIES INCORPORATED	JSO	JANSSEN INCORPORATED
CHE	CHEPLAPHARM ARZNEIMITTEL GMBH GERMANY	JUB	JUBILANT HOLLISTERSTIER LLC
CHU	CHURCH & DWIGHT CANADA CORP	KAL	KALEO INCORPORATED
CIP	CIPHER PHARMACEUTICALS INCORPORATED	KIM	MCNEIL CONSUMER HEALTHCARE, A DIVISION OF JOHNSON & JOHNSON INCORPORATED
CLC	COLUMBIA LABORATORIES CANADA INCORPORATED	KLA	PATRIOT A DIVISION OF JANSSEN INCORPORATED
COV	COVIDIEN CANADA	LAL	LABORATOIRE LALCO INCORPORATED
CPA	COLGATE-PALMOLIVE CANADA INCORPORATED	LAP	LABORATOIRE HRA PHARMA
DCM	D & C MOBILITY	LEO	LEO PHARMA INCORPORATED
DDP	THE D DROPS COMPANY INCORPORATED	LIL	ELI LILLY CANADA INCORPORATED

**Appendix D - List of Drug Manufacturers**
**Non-Insured Health Benefits**

MFR	Manufacturer Name	MFR	Manufacturer Name
LIP	LINEPHARMA INTERNATIONAL LIMITED	PMS	PHARMASCIENCE INCORPORATED
LUD	LUNDBECK CANADA INCORPORATED	PMT	PHARMETICS INCORPORATED
LUI	LUITPOLD PHARMACEUTICALS INCORPORATED	PPH	PAR PHARMACEUTICAL COMPANIES
LUK	LUNDBECK LLC	PPI	PRESTIGE PHARMA INCORPORATED
LUP	LUPIN PHARMA CANADA LIMITED	RAX	STERIMAX INC
MAC	MACDONALD'S PRESCRIPTION LAB LIMITED	RBP	RB PHARMACEUTICALS LIMITED
MAK	3M CANADA COMPANY	RBW	R.W. PACKAGING LIMITED
MAN	MANTRA PHARMA INCORPORATED	RBX	RANBAXY PHARMACEUTICALS CANADA INCORPORATED
MAR	MARCAN PHARMACEUTICALS INCORPORATED	REC	DR REDDYS LABORATORIES INCORPORATED
MAT	MALLINCKRODT CANADA ULC	RGL	RECRO GAINESVILLE LLC
MAY	MAYNE PHARMA (CANADA) INCORPORATED	RIT	THE RITEDOSE CORPORATION
MCA	MCARTHUR MEDICAL SALES INCORPORATED	RIV	LABORATORIE RIVA INCORPORATED
MCL	MCNEIL CONSUMER PRODUCTS COMPANY	RLI	RED LEAF MEDICAL INCORPORATED
MDF	MEDICAL FUTURES INCORPORATED	ROD	ROCHE DIAGNOSTICS
MDS	MEDISCA PHARMACEUTIQUE INCORPORATED	RPH	RATIOPHARM INCORPORATED
MDT	MEDTRONIC OF CANADA LIMITED	SAC	SANOFI-AVENTIS CANADA
MEC	MEDI+SURE CANADA INCORPORATED	SAN	SANIS HEALTH INCORPORATED
MEZ	MERZ PHARMACEUTICALS GMBH	SDZ	SANDOZ CANADA INCORPORATED
MIN	MINT PHARMACEUTICALS INCORPORATED	SEA	SEARCHLIGHT PHARMA INCORPORATED
MJO	MEAD JOHNSON CANADA INCORPORATED	SEV	SERVIER CANADA INCORPORATED
MPD	MEDICAL PLASTIC DEVICES INCORPORATED	SFA	HTL STREFA
MRL	MERUS LABS INTERNATIONAL INCORPORATED	SHI	SHIRE CANADA INCORPORATED
MSF	MEDISAFE DISTRIBUTION INCORPORATED	SHM	SHERWOOD INCORPORATED
MSL	MEDIC SAVOURE LIMITED	SIG	SIGMA-TAU PHARMACEUTICALS INCORPORATED
MTC	MEDTECH PRODUCTS INCORPORATED	SIV	SIVEM PHARMACEUTICALS ULC
MYL	MYLAN PHARMACEUTICALS ULC	SKY	LIFESCAN INCORPORATED, PART OF THE JOHNSON & JOHNSON
NCA	NOVA DIABETES CARE	SLX	SALIX PHARMACEUTICALS INCORPORATED
NEB	NEOBOURNE PHARMA LP	SMW	SMITH & NEPHEW CANADA
NES	NESTLÉ CANADA INCORPORATED	SNE	SMITH & NEPHEW INCORPORATED
NOO	NOVO NORDISK CANADA INCORPORATED	SPC	SUNOVION PHARMACEUTICALS CANADA INCORPORATED
NOP	NOVOPHARM LIMITED	SPH	SOLVAY PHARMA INCORPORATED
NPH	NATCO PHARMA CANADA INCORPORATED	SPT	SEPTA PHARMACEUTICALS INCORPORATED
NUR	NUTRICORP INTERNATIONAL	SRO	EMD SERONO A DIVISION OF EMD INCORPORATED CANADA
NVC	NOVARTIS CONSUMER HEALTH CANADA INCORPORATED	STE	STERIMAX INCORPORATED
NVR	NOVARTIS PHARMACEUTICALS CANADA INCORPORATED	STG	LABORATOIRES STERIGEN INCORPORATED
OBT	COBALT PHARMACEUTICALS COMPANY	STI	STIEFEL CANADA INCORPORATED
ODN	ODAN LABORATORIES LIMITED	SUS	SUNSTAR AMERICAS INCORPORATED
OMG	OMEGA LABORATORIES LIMITED	TAK	TAKEDA PHARMACEUTICALS AMERICA INCORPORATED
OPU	OPUS PHARMA	TAN	TANTA PHARMACEUTICALS INCORPORATED
ORM	ORIMED PHARMA INCORPORATED	TAR	TARO PHARMACEUTICALS INCORPORATED
OTS	OTSUKA PHARMACEUTICAL CORPORATION LIMITED	TEL	TELIGENT OU
PAL	PALADIN LABS INCORPORATED	TEV	TEVA CANADA LIMITED
PDI	PROFESSIONAL DISPOSABLES INTERNATIONAL LIMITED	TIL	TILLOTTS PHARMA GMBH
PDL	PRO DOC LIMITED	TIP	H & P INDUSTRIES / THE TRIAD-GROUP
PED	PENDOPHARM INCORPORATED	TLI	LABORATOIRES TRIANON INCORPORATED
PEI	PEDIAPHARM INCORPORATED	TPC	TRIBUTE PHARMACEUTICALS CANADA INCORPORATED
PER	PERRIGO INTERNATIONAL	TPT	TAROPHARMA, A DIVISION OF TARO PHARMACEUTICALS INCORPORATED
PFI	PFIZER CANADA INCORPORATED	TRE	TREMBLAY HARRISON INCORPORATED
PFR	PURDUE PHARMA	TRI	TRIANON LABORATORIES INCORPORATED
PGI	PROCTOR & GAMBLE INCORPORATED	TRM	ACERUS PHARMACEUTICALS CORPORATION
PHA	PHARMAPAR INCORPORATED		
PHH	PHARMEL INCORPORATED		

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MFR	Manufacturer Name
TRU	TRUDELL MEDICAL INTERNATIONAL
TSN	TRIMEDIC SUPPLY NETWORK LIMITED
TYC	KENDALL HEALTHCARE
UCB	UBC PHARMA INCORPORATED
UMI	ULTIMED, INCORPORATED
UNK	
VAE	VALEANT CANADA LIMITED
VAN	VANC PHARMACEUTICALS INCORPORATED
VII	VIIV HEALTHCARE ULC
VTH	VITA HEALTH PRODUCTS INCORPORATED
WAC	WARNER CHILCOTT CANADA CORPORATION
WAM	WAMPOLE INCORPORATED
WEP	WE PHARMACEUTICALS
WNP	WN PHARMACEUTICALS LIMITED
WPC	WELLSPRING PHARMACEUTICAL CANADA CORPORATION
XED	XEDITON PHARMACEUTICALS INCORPORATED
XEN	XENEX LABS INCORPORATED

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MFR	Manufacturer Name
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**APPENDIX E**  
**LIST OF EXCLUSIONS**

## Appendix E - Exclusions

## Non-Insured Health Benefits

Certain drug products are not within the scope of the program. These products will not be reimbursed as benefits under the NIHB Program:

Anti-obesity drugs;  
Household products (regular soaps and shampoos);  
Cosmetics;  
Alternative therapies, including glucosamine and evening primrose oil;  
Megavitamins;  
Drugs with investigational/experimental status;  
Vaccinations for travel indications;  
Hair growth stimulants;  
Fertility agents and impotence drugs;  
Selected over-the-counter products;  
Opioid containing cough preparations;  
Dalmane®, Somnol® and generics (flurazepam);  
Darvon® and 642® (propoxyphene);  
Fiorinal®, Fiorinal® C ¼, Fiorinal® C ½ and generics (Butalbital containing analgesics with and without codeine);  
Librium®, Solium®, Medilium® and generics (chlordiazepoxide);  
Stadol TM NS and generics (butorphanol tartrate nasal spray);  
Tranxene® and generics (clorazepate); and  
Imovane® and generics (zopiclone).

The following drugs are excluded from the NIHB Program as recommended by the Common Drug Review (CDR) and the NIHB Drugs and Therapeutics Advisory Committee (DTAC) because published evidence does not support the clinical value or cost of the drug relative to existing therapies, or there is insufficient clinical evidence to support coverage.

Of Note: The Appeal Process and the Emergency Supply Policy will not apply for the following drug products.

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DIN	MFR	Brand Name	Strength and Format
02248722	ALL	ACULAR LS	0.4% SOLUTION
02259052	AST	AMEVIVE	15MG/ML POWDER FOR SOLUTION
02247916	BAY	CIPRO XL	500MG TABLET (EXTENDED RELEASE)
02251787	BAY	CIPRO XL	1,000MG TABLET (EXTENDED RELEASE)
02248417	FEI	GYNAZOLE	2% CREAM
01926799	SAC	IMOVANE	7.5MG TABLET
02216167	SAC	IMOVANE	5MG TABLET
02244521	AZC	NEXIUM	20MG TABLET (DELAYED RELEASE)
02244522	AZC	NEXIUM	40MG TABLET (DELAYED RELEASE)
02241804	TAK	PANTOLOC	20MG TABLET (ENTERIC COATED)
02248503	GSK	PAXIL	12.5MG TABLET (EXTENDED RELEASE)
02248504	GSK	PAXIL	25MG TABLET (EXTENDED RELEASE)
02229437	FMC	PHOSLO	667MG TABLET
02256290	PFI	RELPAX	20MG TABLET
02256304	PFI	RELPAX	40MG TABLET

**APPENDIX F  
NEW LISTINGS**

**Appendix F - New Listings**

**Non-Insured Health Benefits**

The following items have been added to the NIHB Drug Benefit List since it was last published.

DIN	MFR	Brand Name	Strength and Dosage Form
02442191	ACG	ACT OLMESARTAN	20MG TABLET
02442205	ACG	ACT OLMESARTAN	40MG TABLET
02443112	ACG	ACT OLMESARTAN HCT	20MG & 12.5MG TABLET
02443120	ACG	ACT OLMESARTAN HCT	40MG & 12.5MG TABLET
02443139	ACG	ACT OLMESARTAN HCT	40MG & 25MG TABLET
02242971	SDZ	AMIKACIN SULFATE	250MG LIQUID
02399210	APX	APO-BOSENTAN	125MG TABLET
02455897	APX	APO-CABERGOLINE	0.5MG TABLET
02354403	APX	APO-DICLOFENAC	1.5% SOLUTION
02452006	APX	APO-EMTRICITABINE-TENOFOVIR	300MG & 200MG TABLET
02453452	APX	APO-OLMESARTAN	20MG TABLET
02453460	APX	APO-OLMESARTAN	40MG TABLET
02453606	APX	APO-OLMESARTAN/HCTZ	20MG & 12.5MG TABLET
02453614	APX	APO-OLMESARTAN/HCTZ	40MG & 12.5MG TABLET
02453622	APX	APO-OLMESARTAN/HCTZ	40MG & 25MG TABLET
02443864	AUR	AURO-OLMESARTAN	20MG TABLET
02443872	AUR	AURO-OLMESARTAN	40MG TABLET
02326582	UNK	BISMUTH SUBSALICYLATE	262MG TABLET
02465469	UNK	CEFAZOLIN	1G POWDER FOR SOLUTION
02465477	UNK	CEFAZOLIN	10G POWDER FOR SOLUTION
00886955	FKD	CEFTAZIDIME	2G POWDER FOR SOLUTION
00886963	FKD	CEFTAZIDIME	6G POWDER FOR SOLUTION
00886971	FKD	CEFTAZIDIME	1G POWDER FOR SOLUTION
02437848	RAX	CEFTAZIDIME	1G POWDER FOR SOLUTION
02437856	RAX	CEFTAZIDIME	2G POWDER FOR SOLUTION
02437864	RAX	CEFTAZIDIME	6G POWDER FOR SOLUTION
02439522	RAX	CEFTAZIDIME	3G POWDER FOR SOLUTION
02455609	ODN	CHOLESTYRAMINE-ODAN	4G POWDER FOR SUSPENSION
02452340	HLR	COTELLIC	20MG TABLET
02445158	BGP	CREON MINIMICROSPHERES MICRO	5000U & 5100U & 320U GRANULES
02060094	MYL	CRYSTAPEN	5000000U POWDER FOR SOLUTION
02017598	SAC	DRISDOL	8 ORAL LIQUID
00370576	STI	DUOFILM	16.716.71% LIQUID
02446928	NVR	ENTRESTO	26MG & 24MG TABLET
02446936	NVR	ENTRESTO	51MG & 49MG TABLET
02446944	NVR	ENTRESTO	103MG & 97MG TABLET
02436841	TAK	ENTYVIO	300MG POWDER FOR SOLUTION
02415992	BAY	EYLEA	40MG SOLUTION
02239882	UNK	FOLIC ACID	1000MCG TABLET
02212218	GSK	FORTAZ 1G	1G POWDER FOR SOLUTION
02212226	GSK	FORTAZ 2G	2G POWDER FOR SOLUTION
02212234	GSK	FORTAZ 6G	6G POWDER FOR SOLUTION
02459388	SAN	FOSINOPRIL	10MG TABLET
02459396	SAN	FOSINOPRIL	20MG TABLET
02239194	GSK	HEPTOVIR	5MG SOLUTION
02415089	LIL	HUMULIN R (KWIKPEN)	100U SOLUTION
02247437	FRS	INVANZ	1G POWDER FOR SOLUTION
80024544	JMP	JAMP FERROUS FUMARATE	300MG TABLET
02461641	JMP	JAMP-OLMESARTAN	20MG TABLET
02461668	JMP	JAMP-OLMESARTAN	40MG TABLET
02416786	FRS	JANUMET XR	50MG & 500MG TABLET (EXTENDED RELEASE)

**Appendix F - New Listings**

**Non-Insured Health Benefits**

The following items have been added to the NIHB Drug Benefit List since it was last published.

DIN	MFR	Brand Name	Strength and Dosage Form
02416808	FRS	JANUMET XR	100MG & 1000MG TABLET (EXTENDED RELEASE)
02181304	GSC	LACTEEZE	3 TABLET
02366444	APX	LORATADINE	10MG TABLET
02451018	MAN	M-ACETAMINOPHEN	325MG TABLET
02451123	MAN	M-ACETAMINOPHEN	500MG TABLET
02378787	SDZ	MEROPENEM	500MG POWDER FOR SOLUTION
02378795	SDZ	MEROPENEM	1G POWDER FOR SOLUTION
02436507	RAX	MEROPENEM	1G POWDER FOR SOLUTION
02218488	AZC	MERREM	500MG POWDER FOR SOLUTION
02218496	AZC	MERREM	1G POWDER FOR SOLUTION
80066164	MAN	M-HC	1% CREAM
02461536	MIN	MINT-INDOMETHACIN	50MG CAPSULE
02461811	MIN	MINT-INDOMETHACIN	25MG CAPSULE
02462559	MIN	MINT-ITRACONAZOLE	100MG CAPSULE
80071412	MAN	MK20 SOLUBLE	20MEQ TABLET (FILM COATED), EXTENDED RELEASE
02450070	MAN	M-PEG 3350	100% POWDER FOR SOLUTION
02456877	MYL	MYLAN-ATAZANAVIR	150MG CAPSULE
02456885	MYL	MYLAN-ATAZANAVIR	200MG CAPSULE
02456893	MYL	MYLAN-ATAZANAVIR	300MG CAPSULE
02458926	MYL	MYLAN-DIVALPROEX	125MG TABLET (ENTERIC COATED)
02458934	MYL	MYLAN-DIVALPROEX	250MG TABLET (ENTERIC COATED)
02459019	MYL	MYLAN-DIVALPROEX	500MG TABLET (ENTERIC COATED)
02426633	MYL	MYLAN-DULOXETINE	30MG CAPSULE (DELAYED RELEASE)
02426641	MYL	MYLAN-DULOXETINE	60MG CAPSULE (DELAYED RELEASE)
02443902	MYL	MYLAN-EMTRICITABINE/TENOFOVIR DISOPROXIL	300MG & 200MG TABLET
02385007	APX	NAPROXEN SODIUM	220MG TABLET
00773727	NOP	NOVO-PENICILLIN G POTASSIUM	1MU INJECTION
02299453	TEV	OCTREOTIDE	500MCG SOLUTION
00789437	JSO	PANCREASE MT 10	10500U & 43750U & 25000U CAPSULE (ENTERIC COATED)
00789429	JSO	PANCREASE MT 16	16800U & 70000U & 40000U CAPSULE (ENTERIC COATED)
00789445	JSO	PANCREASE MT 4	4200U & 17500U & 10000U CAPSULE (ENTERIC COATED)
02220261	FKD	PENICILLIN G SODIUM	1000000U POWDER FOR SOLUTION
02220288	FKD	PENICILLIN G SODIUM	5000000U POWDER FOR SOLUTION
02299623	SDZ	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	2G & 0.25G POWDER FOR SOLUTION
02299631	SDZ	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	3G & 0.375G POWDER FOR SOLUTION
02299658	SDZ	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	4G & 0.5G POWDER FOR SOLUTION
02308452	APX	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	3G & 0.375G POWDER FOR SOLUTION
02308460	APX	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	4G & 0.5G POWDER FOR SOLUTION
02330547	SDZ	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	12G & 1.5G POWDER FOR SOLUTION
02362627	RAX	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	3G & 0.375G POWDER FOR SOLUTION
02362635	RAX	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	4G & 0.5G POWDER FOR SOLUTION
02370158	TEV	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	2G & 0.25G POWDER FOR SOLUTION
02370166	TEV	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	3G & 0.375G POWDER FOR SOLUTION
02370174	TEV	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	4G & 0.5G POWDER FOR SOLUTION
02377748	RAX	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	12G & 1.5G POWDER FOR SOLUTION
02439131	RAX	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	36G & 4.5G POWDER FOR SOLUTION
02461110	PMS	PMS-EMTRICITABINE-TENOFOVIR	300MG & 200MG TABLET

**Appendix F - New Listings**

**Non-Insured Health Benefits**

The following items have been added to the NIHB Drug Benefit List since it was last published.

DIN	MFR	Brand Name	Strength and Dosage Form
02461307	PMS	PMS-OLMESARTAN	20MG TABLET
02461315	PMS	PMS-OLMESARTAN	40MG TABLET
96899974	TRU	RESPICHAMBER SILICONE MEDIUM MASK	DEVICE
96899973	TRU	RESPICHAMBER SILICONE SMALL MASK	DEVICE
02459345	RIV	RIVA-DORZOLAMIDE	2% SOLUTION
02455013	RIV	RIVA-FINASTERIDE	5MG TABLET
02459205	RIV	RIVA-LATANOPROST/TIMOLOL	50MCG & 5MG SOLUTION
00810436	NVC	SALINE FROM OTRIVIN	0.7% NASAL SPRAY
00857777	NVC	SALINE FROM OTRIVIN	0.7% NASAL SPRAY
02461323	SDZ	SANDOZ GLICLAZIDE MR	30MG TABLET (EXTENDED RELEASE)
02461331	SDZ	SANDOZ GLICLAZIDE MR	60MG TABLET (EXTENDED RELEASE)
02443414	SDZ	SANDOZ OLMESARTAN	20MG TABLET
02443422	SDZ	SANDOZ OLMESARTAN	40MG TABLET
02458144	PDL	SOLIFENACIN	5MG TABLET
02458152	PDL	SOLIFENACIN	10MG TABLET
80068920	JMP	SOLUCAL D FORT CITRUS	25MCG LIQUID
80069353	JMP	SOLUCAL D FORT GREEN APPLE	25MCG LIQUID
02307146	JAJ	T/ THERAPEUTIC SHAMPOO EXTRA STRENGTH	1% SHAMPOO
02443791	TEV	TEVA-ATAZANAVIR	150MG CAPSULE
02443813	TEV	TEVA-ATAZANAVIR	200MG CAPSULE
02443821	TEV	TEVA-ATAZANAVIR	300MG CAPSULE
02399059	TEV	TEVA-EMTRICITABINE/TENOFOVIR	300MG & 200MG TABLET
02306085	HLR	VALCYTE	50MG POWDER FOR SOLUTION
02230019	APC	VIOKACE	10440U & 56400U & 57100U TABLET
02241933	APC	VIOKACE	20880U & 113400U & 112500U TABLET
02352303	NVR	VOTRIENT	200MG TABLET
02352311	NVR	VOTRIENT	400MG TABLET
02449935	AZC	XIGDUO	850MG & 5MG TABLET
02449943	AZC	XIGDUO	1000MG & 5MG TABLET
02380242	HLR	ZELBORAF	240MG TABLET
02378213	UNK	ZINDA-LETROZOLE	2.5MG TABLET
02371065	JSO	ZYTIGA	250MG TABLET
02457113	JSO	ZYTIGA	500MG TABLET

# **ALPHABETICAL INDEX OF DRUG PRODUCTS**

**Health Canada**

**Non-Insured Health Benefits**

24 HOUR ALLERGY REMEDY	1	ACH-CANDESARTAN	50	ACT OLMESARTAN	52
3TC	10	ACH-CAPECITABINE	17	ACT OLMESARTAN HCT	53
AA-CLOZAPINE	77	ACH-FINASTERIDE	143	ACT OLOPATADINE	103
AA-TRIMEBUTINE	24	ACH-FLUOXETINE	73	ACT ONDANSETRON	111
<b>ABACA VIR SUF LATE, LAMIVUDINE</b>	<b>9</b>	ACH-LETROZOLE	19	ACT PANTOPRAZOLE	114
<b>ABACA VIR SUF LATE</b>	<b>9</b>	ACH-MYCOPHENOLATE	146	ACT PAROXETINE	75
<b>ABACA VIR SUF LATE, LAMIVUDINE</b>	<b>9</b>	ACH-PIOGLITAZONE	125	ACT PIOGLITAZONE	125
<b>ABACA VIR SUF LATE, LAMIVUDINE, DOLUTEGRA VIR SODIUM</b>	<b>9</b>	ACH-TELMISARTAN HCTZ	53	ACT PRAMIPEXOLE	90
<b>ABACA VIR SUF LATE, LAMIVUDINE, ZIDOVUDINE</b>	<b>9</b>	<b>ACITRETIN</b>	<b>134</b>	ACT PRAVASTATIN	36
<b>ABATACEPT</b>	<b>145</b>	ACLASTA	145	ACT PREGABALIN	69
ABENOL	64	<b>ACLIDINIUM BROMIDE</b>	<b>24</b>	ACT QUETIAPINE	80
ABILIFY	77	<b>ACLIDINIUM BROMIDE, FORMOTEROL FUMARATE DIHYDRATE</b>	<b>25</b>	ACT RALOXIFENE	121
ABILIFY MAINTENA	77	ACT ALENDRONATE	143	ACT RAMIPRIL	48
<b>ABIRATERONE ACETATE</b>	<b>17</b>	ACT AMLODIPINE	43	ACT RANITIDINE	112
<b>ACAMPROSATE CALCIUM</b>	<b>91</b>	ACT ANASTROZOLE	17	ACT REPAGLINIDE	124
<b>ACARBOSE</b>	<b>121</b>	ACT ATENOLOL	41	ACT RISPERIDONE	81
ACCEL PIOGLITAZONE	125	ACT AZITHROMYCIN	3	ACT RIZATRIPTAN	87
ACCEL-ALENDRONATE	143	ACT BETAHISTINE	92	ACT RIZATRIPTAN ODT	87
ACCEL-CELECOXIB	56	ACT BICALUTAMIDE	17	ACT ROPINIROLE	90
ACCEL-CITALOPRAM	72	ACT BOSENTAN	40	ACT ROSUVASTATIN	36
ACCEL-DONEPEZIL	22	ACT BUPROPION XL	71	ACT SERTRALINE	75
ACCEL-FLUOXETINE	73	ACT CABERGOLINE	90	ACT SIMVASTATIN	37
ACCEL-TOPIRAMATE	70	ACT CANDESARTAN	50	ACT SOLIFENACIN	136
ACCOLATE	101	ACT CANDESARTAN/HCT	50	ACT SUMATRIPTAN	88
ACCU-CHEK ADVANTAGE	94	ACT CELECOXIB	56	ACT TELMISARTAN	53
ACCU-CHEK AVIVA	94	ACT CIPROFLOXACIN	6	ACT TELMISARTAN/HCT	53
ACCU-CHEK COMPACT	94	ACT CITALOPRAM	72	ACT TEMOZOLOMIDE	21
ACCU-CHEK FASTCLIK LANCET	150	ACT CLARITHROMYCIN XL	4	ACT TERBINAFINE	8
ACCU-CHEK MOBILE BG	94	ACT CLOPIDOGREL	32	ACT TOPIRAMATE	70
ACCU-CHEK MOBILE CASSETT	94	ACT DICLO-MISO	58	ACT VALSARTAN	53
ACCU-CHEK MULTICLIX LANCET	150	ACT DILTIAZEM CD	45	ACT VENLAFAXINE XR	76
ACCU-CHEK SOFTCLIX LANCET	150	ACT DILTIAZEM T	45	ACTEMRA	146
ACCUPRIL	48	ACT DONEPEZIL	22	ACTONEL	144
ACCURETIC	48	ACT DORZOTIMOLOL	106	ACTOS	125
ACCUTANE ROCHE	134	ACT DUTASTERIDE	142	ACULAR	105
ACCU-TREND	94	ACT ENALAPRIL	46	ACUVAIL	105
ACEBUTOLOL	40	ACT ESCITALOPRAM	73	<b>ACYCLOVIR</b>	<b>12</b>
<b>ACEBUTOLOL HYDROCHLORIDE</b>	<b>40</b>	ACT ESCITALOPRAM ODT	73	ADALAT XL	45
<b>ACENOCOUMAROL</b>	<b>30</b>	ACT ETIDROCAL	144	<b>ADALIMUMAB</b>	<b>145</b>
ACET	64	ACT ETIDRONATE	144	<b>ADAPALENE</b>	<b>134</b>
ACET 120	64	ACT EXEMESTANE	18	ADCIRCA	39
ACET 325	64	ACT EZETIMIBE	34	<b>ADEFOVIR DIPIVOXIL</b>	<b>12</b>
ACET 650	64	ACT FAMCICLOVIR	12	<b>ADHESHIVE WIPES</b>	<b>149</b>
ACET CODEINE 30	60	ACT FINASTERIDE	143	ADRENALIN	27
ACETAMINOPHEN	64	ACT FLUCONAZOLE	8	ADVAGRAF	147
<b>ACETAMINOPHEN</b>	<b>64</b>	ACT FLUOXETINE	73	ADVAIR 100 DISKUS	27
<b>ACETAMINOPHEN, CAFFEINE CITRATE, CODEINE PHOSPHATE</b>	<b>59</b>	ACT FLUVOXAMINE	74	ADVAIR 125	27
<b>ACETAMINOPHEN, CODEINE PHOSPHATE</b>	<b>60</b>	ACT GABAPENTIN	67	ADVAIR 250	27
<b>ACETAMINOPHEN, OXYCODONE HYDROCHLORIDE</b>	<b>60</b>	ACT IRBESARTAN	50	ADVAIR 250 DISKUS	27
ACÉTAMINOPHÈNE	65	ACT IRBESARTAN/HCT	51	ADVAIR 500 DISKUS	27
ACÉTAMINOPHÈNE BLASON SHIELD	65	ACT LATANOPROST	106	ADVIL	58
<b>ACETAZOLAMIDE</b>	<b>106</b>	ACT LATANOPROST/TIMOLOL	107	ADVIL PEDIATRIC DROPS	58
ACETAZOLAMIDE	106	ACT LEVETIRACETAM	68	AERIUS	1
<b>ACETYLSALICYLIC ACID</b>	<b>56</b>	ACT LEVOFLOXACIN	6	AERIUS KIDS	1
ACETYLSALICYLIC ACID	56	ACT LISINAPRIL	47	AEROCHAMBER AC BOYZ	149
<b>ACETYLSALICYLIC ACID, OXYCODONE HYDROCHLORIDE</b>	<b>60</b>	ACT LOSARTAN	51	AEROCHAMBER AC GIRLZ	149
ACH-ALENDRONATE	143	ACT LOSARTAN/HCT	52	AEROCHAMBER PLUS FLOWVU LARGE	149
ACH-ANASTROZOLE	17	ACT LOVASTATIN	36	AEROCHAMBER PLUS FLOWVU MEDIUM	149
ACH-BICALUTAMIDE	17	ACT MELOXICAM	58	AEROCHAMBER PLUS FLOWVU MOUTH	149
		ACT METFORMIN	122	AEROCHAMBER PLUS FLOWVU	149
		ACT MOXIFLOXACIN	103	AEROTRACH PLUS	149
		ACT NABILONE	112	<b>AFATINIB DIMALEATE</b>	<b>17</b>
		ACT OLANZAPINE	78		
		ACT OLANZAPINE ODT	79		

**Health Canada**
**Non-Insured Health Benefits**

<b>AFLIBERCEPT</b>	<b>107</b>	<b>AMCINONIDE</b>	<b>130</b>	APO HYDRO	98
AGGRENOLX	40	AMERGE	87	APO HYDROXYZINE	87
AGRYLIN	32	AMI-HYDRO	98	APO IBUPROFEN	58
AG-ZOLMITRIPTAN ODT	88	<b>AMIKACIN (AMIKACIN SULFATE)</b>	<b>2</b>	APO INDOMETHACIN	58
AIROMIR	26	AMIKACIN SULFATE	2	APO METHAZIDE	38
ALBALON	105	<b>AMILORIDE</b>	<b>98</b>	APO METOPROLOL	42
ALCOHOL PREP	150	<b>AMILORIDE, HYDROCHLOROTHIAZIDE</b>	<b>98</b>	APO METOPROLOL (TYPE L)	42
ALCOHOL SWABS	150	AMIODARONE	34	APO NAPROXEN	59
ALCOHOL SWABS 6893 BUTTERFLY	150	<b>AMIODARONE HYDROCHLORIDE</b>	<b>34</b>	APO OXAZEPAM	86
ALCOHOL SWABS 6896 (150)	150	AMIODARONE ORAL LIQUID	34	APO OXTRIPHYLLINE	137
ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS	150	AMITRIPTYLINE	71	APO PEN VK	5
ALCOHOL SWABS BD REGULAR	150	<b>AMITRIPTYLINE HYDROCHLORIDE</b>	<b>71</b>	APO PIROXICAM	59
ALDACTAZIDE	99	AMLODIPINE	43	APO PREDNISON	119
ALDACTAZIDE ORAL LIQUID	54	<b>AMLODIPINE BESYLATE</b>	<b>43</b>	APO PROPRANOLOL	43
ALDACTONE	54	<b>AMLODIPINE BESYLATE, ATORVASTATIN CALCIUM</b>	<b>44</b>	APO SULFAMETHOXAZOLE	7
ALDARA P	134	<b>AMLODIPINE BESYLATE, TELMISARTAN</b>	<b>44</b>	APO SULFATRIM	7
ALENDRONATE	143	AMLODIPINE ORAL LIQUID	44	APO SULFATRIM DS	7
<b>ALENDRONATE SODIUM</b>	<b>143</b>	<b>AMOXICILLIN</b>	<b>4</b>	APO SULFATRIM PEDIATRIC	7
<b>ALENDRONATE SODIUM, CHOLECALCIFEROL</b>	<b>144</b>	AMOXICILLIN	4	APO TRIAZIDE	98
ALENDRONATE-70	143	AMOXICILLIN (SUGAR REDUCED)	4	APO-ABACAVIR	9
ALERTEC	84	<b>AMOXICILLIN, CLARITHROMYCIN, LANSOPRAZOLE</b>	<b>113</b>	APO-ABACAVIR-LAMIVUDINE	9
ALESSE 21	119	<b>AMOXICILLIN, CLAVULANIC ACID</b>	<b>4</b>	APO-ABACAVIR-LAMIVUDINE-ZIDOVUDINE	9
ALESSE 28	119	AMOXI-CLAV	5	APO-ACEBUTOLOL	40
<b>ALFACALCIDOL</b>	<b>139</b>	<b>AMPICILLIN</b>	<b>5</b>	APO-ACETAMINOPHEN	65
ALFUZOSIN	27	AMPICILLIN SODIUM	5	APO-ACYCLOVIR	12
<b>ALFUZOSIN HYDROCHLORIDE</b>	<b>27</b>	AMPICILLIN STERILE INFUSION	5	APO-ADEFOVIR	12
ALKERAN	19	ANAFRANIL	72	APO-ALENDRONATE	143
ALL PURPOSE NIPPLE OINTMENT	141	<b>ANAGRELIDE HYDROCHLORIDE</b>	<b>32</b>	APO-ALENDRONATE/VITAMIN D3	144
ALLEGRA 12 HOUR	1	ANANDRON	20	APO-ALFUZOSIN	27
ALLEGRA 24 HOUR	1	ANAPROX	59	APO-ALLOPURINOL	143
ALLER-AIDE	1	ANAPROX DS	59	APO-ALMOTRIPTAN	87
ALLERGENIC EXTRACT NON POLLENS	142	<b>ANASTROZOLE</b>	<b>17</b>	APO-ALPRAZ	84
ALLERGENIC EXTRACT POLLENS	142	ANASTROZOLE	17	APO-AMILZIDE	98
ALLERGENIC EXTRACTS	142	ANDRIOL	119	APO-AMIODARONE	34
ALLERGY	1	ANDROCUR	147	APO-AMITRIPTYLINE	71
ALLERGY ELIXIR	1	<b>ANETHOLE TRITHIONE</b>	<b>107</b>	APO-AMLODIPINE	44
ALLERGY EXTRA STRENGTH	1	ANODAN-HC	132	APO-AMLODIPINE-ATORVASTATIN	44
ALLERGY FORMULA	1	ANORO ELLIPTA	25	APO-AMOXI	4
ALLERGY RELIEF	1	ANTACID AND LIDOCAINE ORAL LIQUID	141	APO-AMOXI CLAV	4
ALLERJECT	27	ANTIBIOTIC OINT	129	APO-AMOXI SUGAR FREE	4
ALLERNIX	1	ANUGESIC HC	132	APO-ANASTROZOLE	17
ALLERNIX ELIXIR	1	ANUSOL HC	132	APO-ATENIDONE	41
ALLERNIX EXTRA STRENGTH	1	APIDRA CARTRIDGE	123	APO-ATENOL	41
ALLERNIX MULTI SYMPTOM	1	APIDRA SOLOSTAR	123	APO-ATOMOXETINE	91
ALLERTIN	1	APIDRA VIAL	123	APO-ATORVASTATIN	35
ALLOPURINOL	143	<b>APIS MELLIFERA VENOM PROTEIN EXTRACT</b>	<b>142</b>	APO-AZATHIOPRINE	146
<b>ALLOPURINOL</b>	<b>143</b>	<b>APIXABAN</b>	<b>30</b>	APO-AZITHROMYCIN	3
ALLOPURINOL ORAL LIQUID	143	APO ACETAMINOPHEN	65	APO-AZITHROMYCIN	3
ALMOTRIPTAN	87	APO AMPI	5	APO-BACLOFEN	28
<b>ALMOTRIPTAN MALATE</b>	<b>87</b>	APO ASA	56	APO-BECLOMETHASONE	104
ALOCRIAL	103	APO CARBAMAZEPINE	66	APO-BENZYDAMINE	105
ALOMIDE	103	APO CHLOROTHALIDONE	99	APO-BICALUTAMIDE	17
ALPHAGAN	105	APO CIMETIDINE	112	APO-BISACODYL	109
ALPHAGAN P	105	APO DIAZEPAM	85	APO-BISOPROLOL	41
ALPRAZOLAM	84	APO DILTIAZ	46	APO-BOSENTAN	40
<b>ALPRAZOLAM</b>	<b>84</b>	APO DIMENHYDRINATE	111	APO-BRIMONIDINE	105
ALTACE	48	APO FOLIC ACID	138	APO-BROMAZEPAM	85
ALTACE HCT	49	APO FUROSEMIDE	98	APO-BUSPIRONE	87
ALVESCO	118	APO GLYBURIDE	125	APO-CABERGOLINE	90
ALYSENA 21	119	APO HALOPERIDOL	78	APOCAL	96
ALYSENA 28	119			APO-CANDESARTAN	50
<b>AMANTADINE HYDROCHLORIDE</b>	<b>9</b>			APO-CANDESARTAN/HCTZ	50
<b>AMBRISENTAN</b>	<b>39</b>			APO-CAPTO	46
				APO-CARVEDILOL	41
				APO-CEFAZOLIN	2

**Health Canada**
**Non-Insured Health Benefits**

APO-CEFADROXIL	2	APO-GABAPENTIN	67	APO-MYCOPHENOLATE	146
APO-CEFPROZIL	2	APO-GEMFIBROZIL	35	APO-MYCOPHENOLIC ACID	147
APO-CEFUROXIME	3	APO-GLICLAZIDE	124	APO-NALTREXONE	65
APO-CELECOXIB	56	APO-GLICLAZIDE MR	124	APO-NAPRO-NA	59
APO-CEPHALEX	3	APO-GRANISETRON	111	APO-NAPRO-NA DS	59
APO-CETIRIZINE	1	APO-HALOPIRIDOL	78	APO-NAPROXEN	59
APO-CILAZAPRIL	46	APO-HYDRALAZINE	38	APO-NAPROXEN EC	59
APO-CILAZAPRIL/HCTZ	46	APO-HYDRO	98	APO-NEVIRAPINE XR	11
APO-CIMETIDINE	112	APO-HYDROMORPHONE	61	APO-NIFED PA	45
APO-CIPROFLOX	6	APO-HYDROXYQUINE	15	APO-NITROGLYCERIN	39
APO-CITALOPRAM	72	APO-HYDROXYUREA	18	APO-NORFLOX	6
APO-CLARITHROMYCIN	4	APO-IBUPROFEN	58	APO-NORTRIPTYLIN	75
APO-CLARITHROMYCIN XL	4	APO-IMATINIB	19	APO-OFLOXACIN	103
APO-CLINDAMYCIN	7	APO-IMIQUIMOD	134	APO-OLANZAPINE	78
APO-CLOBAZAM	66	APO-INDAPAMIDE	99	APO-OLANZAPINE ODT	79
APO-CLONAZEPAM	66	APO-IPRAVENT	24	APO-OLMESARTAN	52
APO-CLONIDINE	38	APO-IRBESARTAN	50	APO-OLMESARTAN/HCTZ	53
APO-CLOPIDOGREL	32	APO-IRBESARTAN/HCTZ	51	APO-OLOPATADINE	103
APO-CROMOLYN	101	APO-ISMN	39	APO-OMEPRAZOLE	113
APO-CYCLOBENZAPRINE	27	APO-K	97	APO-ONDANSETRON	111
APO-CYCLOSPORINE	146	APO-KETOCONAZOLE	9	APO-OXYBUTYNIN	136
APO-DESMOPRESSIN	126	APO-KETOROLAC	105	APO-OXYCODONE/ACET	60
APO-DEXAMETHASONE	118	APO-LACTULOSE	96	APO-PANTOPRAZOLE	114
APO-DEXTROAMPHETAMINE	83	APO-LAMIVUDINE	10	APO-PAROXETINE	75
APO-DICLO	57	APO-LAMIVUDINE HBV	10	APO-PINDOL	43
APO-DICLO SR	57	APO-LAMIVUDINE-ZIDOVUDINE	10	APO-PIOGLITAZONE	125
APO-DICLOFENAC	57	APO-LAMOTRIGINE	68	APO-PRAMIPEXOLE	90
APO-DILTIAZ CD	45	APO-LANSOPRAZOLE	113	APO-PRAVASTATIN	36
APO-DILTIAZ SR	45	APO-LATANOPROST	106	APO-PRAZO	40
APO-DIPIVEFRIN	105	APO-LATANOPROST-TIMOP	107	APO-PREGABALIN	69
APO-DIPYRIDAMOLE	40	APO-LEFLUNOMIDE	146	APO-PROCAINAMIDE	34
APO-DIVALPROEX	71	APO-LETROZOLE	19	APO-PROPAFENONE	34
APO-DOMPERIDONE	114	APO-LEVETIRACETAM	68	APO-QUETIAPINE	80
APO-DONEPEZIL	22	APO-LEVOBUNOLOL	106	APO-QUINAPRIL	48
APO-DORZO-TIMOP	106	APO-LEVOCARB	89	APO-QUINAPRIL/HCTZ	48
APO-DOXAZOSIN	40	APO-LEVOFLOXACIN	6	APO-RABEPRAZOLE	114
APO-DOXEPIN	73	APO-LINEZOLID	8	APO-RALOXIFENE	121
APO-DOXY	7	APO-LISINOPRIL	47	APO-RAMIPRIL	48
APO-DULOXETINE	73	APO-LITHIUM CARBONATE	87	APO-RAMIPRIL/HCTZ	49
APO-DUTASTERIDE	142	APO-LOPERAMIDE	109	APO-RANITIDINE	112
APO-EMTRICITABINE-TENOFOVIR	11	APO-LORATADINE	1	APO-REPAGLINIDE	124
APO-ENALAPRIL	47	APO-LORAZEPAM	85	APO-RISEDRONATE	144
APO-ENALAPRIL MALEATE/HCTZ	47	APO-LORAZEPAM SUBLINGUAL	85	APO-RISPERIDONE	81
APO-ENTECAVIR	12	APO-LOSARTAN	51	APO-RIVASTIGMINE	23
APO-ESCITALOPRAM	73	APO-LOSARTAN/HCTZ	52	APO-RIZATRIPTAN	87
APO-EXEMESTANE	18	APO-LOVASTATIN	36	APO-RIZATRIPTAN RPD	87
APO-EZETIMIBE	34	APO-MEDROXY	126	APO-ROPINIROLE	90
APO-FAMCICLOVIR	12	APO-MELOXICAM	58	APO-ROSIGLITAZONE	125
APO-FAMOTIDINE	112	APO-METFORMIN	122	APO-ROSUVASTATIN	36
APO-FELODIPINE	44	APO-METHOTREXATE	20	APO-SALVENT	26
APO-FENOFIBRATE	35	APO-METHYLPHENIDATE	84	APO-SALVENT CFC FREE	26
APO-FENO-MICRO	35	APO-METHYLPHENIDATE ER	84	APO-SELEGILINE	90
APO-FENO-SUPER	35	APO-METHYLPHENIDATE SR	84	APO-SERTRALINE	75
APO-FENTANYL MATRIX	61	APO-METOCLOP	115	APO-SILDENAFIL R	39
APO-FERROUS GLUCONATE	30	APO-METOPROLOL	42	APO-SIMVASTATIN	37
APO-FINASTERIDE	143	APO-METOPROLOL (TYPE L)	42	APO-SOTALOL	43
APO-FLUCONAZOLE	8	APO-METOPROLOL SR	42	APO-SUCRALFATE	113
APO-FLUNISOLIDE	104	APO-MINOCYCLINE	7	APO-SUMATRIPTAN	88
APO-FLUOXETINE	73	APO-MIRTAZAPINE	74	APO-TADALAFIL PAH	39
APO-FLURBIPROFEN	57	APO-MOCLOBEMIDE	75	APO-TAMOX	21
APO-FLUTAMIDE	18	APO-MODAFINIL	84	APO-TAMSULOSIN	27
APO-FLUTICASONE	104	APO-MOMETASONE	104	APO-TELMISARTAN	53
APO-FLUVOXAMINE	74	APO-MONTELUKAST	100	APO-TELMISARTAN/HCTZ	53
APO-FOSINOPRIL	47	APO-MOXIFLOXACIN	6	APO-TEMAZEPAM	86

**Health Canada**
**Non-Insured Health Benefits**

APO-TEMOZOLOMIDE	21	ATARAX	87	AURO-MONTELUKAST	100
APO-TERAZOSIN	40	ATASOL 15	59	AURO-MOXIFLOXACIN	6
APO-TERBINAFINE	8	ATASOL 30	59	AURO-NEVIRAPINE	11
APO-TETRABENAZINE	92	ATASOL FORTE	65	AURO-OLANZAPINE ODT	79
APO-THEO-LA	137	<b>ATAZANAVIR SULFATE</b>	<b>9</b>	AURO-OLMESARTAN	52
APO-TICLOPIDINE	33	<b>ATENOLOL</b>	<b>41</b>	AURO-PANTOPRAZOLE	114
APO-TIMOL	43	ATENOLOL	41	AURO-PAROXETINE	75
APO-TIMOP	106	<b>ATENOLOL, CHLORTHALIDONE</b>	<b>41</b>	AURO-PRAMIPEXOLE	90
APO-TOLTERODINE	136	ATIVAN	85	AURO-PREGABALIN	69
APO-TOPIRAMATE	70	ATOMOXETINE	91	AURO-QUETIAPINE	80
APO-TRAVOPROST Z	107	<b>ATOMOXETINE HYDROCHLORIDE</b>	<b>91</b>	AURO-RAMIPRIL	48
APO-TRAZODONE	76	ATORVASTATIN	35	AURO-REPAGLINIDE	124
APO-TRAZODONE D	76	<b>ATORVASTATIN CALCIUM</b>	<b>35</b>	AURO-RISEDRONATE	144
APO-TRIAMCINOLONE AQ	104	ATORVASTATIN-10	35	AURO-RIZATRIPTAN	87
APO-VALACYCLOVIR	12	ATORVASTATIN-20	35	AURO-ROSUVASTATIN	36
APO-VALGANCICLOVIR	13	ATORVASTATIN-40	35	AURO-SERTRALINE	75
APO-VALPROIC	71	ATORVASTATIN-80	36	AURO-SIMVASTATIN	37
APO-VALSARTAN	53	<b>ATOVAQUONE</b>	<b>15</b>	AURO-SOLIFENACIN	136
APO-VALSARTAN/HCTZ	54	ATRIPLA	10	AURO-TELMISARTAN	53
APO-VENLAFAXINE XR	76	ATROPINE	105	AURO-TELMISARTAN HCTZ	53
APO-VERAP	46	<b>ATROPINE SULFATE</b>	<b>105</b>	AURO-TERBINAFINE	8
APO-VERAP SR	46	ATROVENT	24	AURO-TOPIRAMATE	70
APO-VORICONAZOLE	9	ATROVENT HFA	24	AURO-VALACYCLOVIR	12
APO-WARFARIN	32	<b>AURANOFIN</b>	<b>116</b>	AURO-VALGANCICLOVIR	13
APO-ZIDOVUDINE	11	AURO-ABACAVIR/LAMIVUDINE	9	AURO-VALSARTAN	53
APO-ZOLMITRIPTAN	88	AURO-ALENDRONATE	143	AURO-VALSARTAN HCT	54
APO-ZOLMITRIPTAN RAPID	88	AURO-ALFUZOSIN	27	AURO-VENLAFAXINE XR	76
<b>APRACLONIDINE HYDROCHLORIDE</b>	<b>107</b>	AURO-AMLODIPINE	44	AVALIDE	51
<b>APREPITANT</b>	<b>112</b>	AURO-AMOXICILLIN	4	AVANDIA	125
APRI 21	119	AURO-ATORVASTATIN	35	AVAPRO	50
APRI 28	119	AURO-BETAHISTINE	91	AVELOX	6
APTOM	67	AURO-CANDESARTAN HCT	50	AVENTYL	75
APTIVUS	11	AURO-CARVEDILOL	41	AVIANE 21	119
AQUASOL E	140	AURO-CEFIXIME	2	AVIANE 28	119
AQUASOL E VITAMIN E	140	AURO-CEFPROZIL	2	AVODART	142
ARAVA	146	AURO-CEFUROXIME	3	AXERT	87
ARICEPT	22	AURO-CELECOXIB	56	AXID	112
ARIMIDEX	17	AURO-CIPROFLOXACIN	6	AZARGA	106
<b>ARIPIRAZOLE</b>	<b>77</b>	AURO-CITALOPRAM	72	<b>AZATHIOPRINE</b>	<b>146</b>
<b>ARIPIRAZOLE (MAINTENA)</b>	<b>77</b>	AURO-CLINDAMYCIN	7	AZATHIOPRINE ORAL LIQUID	146
ARISTOCORT C	133	AURO-CLOPIDOGREL	32	AZATHIOPRINE-50	146
ARISTOCORT R	133	AURO-CYCLOBENZAPRINE	27	<b>AZELAIC ACID</b>	<b>134</b>
ARNUITY ELLIPTA	104	AURO-DONEPEZIL	22	<b>AZILSARTAN MEDOXOMIL</b>	<b>50</b>
AROMASIN	18	AURO-DULOXETINE	73	AZITHROMYCIN	3
ARTHROTEC	58	AURO-EFAVIRENZ	10	<b>AZITHROMYCIN</b>	<b>3</b>
ARTIFICIAL TEARS	107	AURO-ENTECAVIR	12	AZOPT	106
ASA	56	AURO-ESCITALOPRAM	73	B-12	138
ASA DAILY LOW DOSE	56	AURO-FINASTERIDE	143	B6	138
ASA EC	56	AURO-FLUOXETINE	73	BABY DDROPS	139
ASACOL	115	AURO-GABAPENTIN	67	BACIMYXIN ONGUENT	129
ASAPHEN	56	AURO-GALANTAMINE ER	22	BACITIN	129
ASAPHEN EC	56	AURO-IRBESARTAN	50	<b>BACITRACIN ZINC</b>	<b>129</b>
ASATAB	56	AURO-IRBESARTAN HCT	51	BACKUP PLAN ONESTEP	120
ASATAB EC	56	AURO-LAMIVUDINE/ZIDOVUDINE	10	<b>BACLOFEN</b>	<b>28</b>
ASCENCIA CONTOUR	94	AURO-LAMOTRIGINE	68	BACLOFEN	28
ASCENCIA BREEZE 2	94	AURO-LEVETIRACETAM	68	BACLOFEN ORAL LIQUID	28
ASCORBIC ACID	138	AURO-LISINAPRIL	47	BACTERIOSTATIC SODIUM CHLORIDE	97
<b>ASCORBIC ACID</b>	<b>138</b>	AURO-LOSARTAN	51	BACTERIOSTATIC WATER	99
<b>ASENAPINE MALEATE</b>	<b>77</b>	AURO-LOSARTAN HCT	52	BACTROBAN	129
ASMANEX TWISTHALER	118	AURO-MELOXICAM	58	BANZEL	70
ASPIRIN	56	AURO-METFORMIN	122	BARACLUDE	12
<b>ASUNAPREVIR</b>	<b>13</b>	AURO-MIRTAZAPINE	74	BARRIERE	133
ATACAND	50	AURO-MIRTAZAPINE OD	74	BC SHARPS CONTAINER 1.4L	152
ATACAND PLUS	50	AURO-MODAFINIL	84	BD ALCOHOL SWABS	150

## Health Canada

## Non-Insured Health Benefits

BD AUTOSHIELD DUO SAFETY PEN NEEDLE	151	<b>BENZOYL PEROXIDE</b>	133	BREVICON 1/35 (21-DAY PACK)	120
BD AUTOSHIELD PEN NEEDLES	151	<b>BENZTROPINE MESYLATE</b>	89	BREVICON 1/35 (28-DAY PACK)	120
BD BLUNT 18GX1 1/2 FILTER	151	BENZTROPINE OMEGA	89	BRICANYL TURBUHALER	27
BD BUTTERFLY NEEDLE 21G	151	<b>BENZYDAMINE HYDROCHLORIDE</b>	105	BRILINTA	33
BD LUER-LOK TIP 10ML SYRINGE	152	BETADERM	131	BRIMONIDINE P	105
BD LUER-LOK TIP 18GX1 1/2 SYRINGE	152	BETADINE	130	<b>BRIMONIDINE TARTRATE</b>	105
BD LUER-LOK TIP 1ML SYRINGE	152	BETAGAN	106	<b>BRINZOLAMIDE</b>	106
BD LUER-LOK TIP 20ML SYRINGE	152	<b>BETAHISTINE HYDROCHLORIDE</b>	91	<b>BRINZOLAMIDE, BRIMONIDINE TARTRATE</b>	106
BD LUER-LOK TIP 22GX1 1/2 SYRINGE	152	<b>BETAMETHASONE DIPROPIONATE</b>	131	<b>BRINZOLAMIDE, TIMOLOL MALEATE</b>	106
BD LUER-LOK TIP 25GX1 SYRINGE	152	<b>BETAMETHASONE DIPROPIONATE, CLOTRIMAZOLE</b>	129	<b>BROMAZEPAM</b>	85
BD LUER-LOK TIP 25GX1 1/2 SYRINGE	152	<b>BETAMETHASONE DIPROPIONATE, SALICYLIC ACID</b>	131	BROMAZEPAM	85
BD LUER-LOK TIP 25GX5/8 SYRINGE	152	<b>BETAMETHASONE SODIUM PHOSPHATE</b>	115	BROMOCRIPTINE	89
BD LUER-LOK TIP 30ML SYRINGE	153	<b>BETAMETHASONE VALERATE</b>	131	<b>BROMOCRIPTINE MESYLATE</b>	89
BD LUER-LOK TIP 3ML SYRINGE	152	BETAXIN	138	<b>BUDESONIDE</b>	104
BD LUER-LOK TIP 5ML SYRINGE	152	<b>BETAXOLOL HYDROCHLORIDE</b>	106	<b>BUDESONIDE, SODIUM CHLORIDE</b>	131
BD LUER-LOK TIP 60ML SYRINGE	153	<b>BETHANECHOL CHLORIDE</b>	22	<b>BUPRENORPHINE HYDROCHLORIDE, NALOXONE HYDROCHLORIDE</b>	64
BD MICRO-FINE 0.3CC SYRINGE	152	BETNESOL	115	<b>BUPROPION HYDROCHLORIDE (WELLBUTRIN)</b>	71
BD MICRO-FINE 28GX0.5CC SYRINGE	152	BETOPTIC S	106	<b>BUPROPION HYDROCHLORIDE (ZYBAN)</b>	72
BD MICRO-FINE 28GX1CC SYRINGE	152	<b>BEZAFIBRATE</b>	35	BUPROPION SR	71
BD PRECISIONGLIDE 18GX1 1/2	152	BEZALIP SR	35	BUSCOPAN	24
BD PRECISIONGLIDE 18GX1 NEEDLE	152	BG STAR	94	<b>BUSERELIN ACETATE</b>	17
BD PRECISIONGLIDE 25GX1 NEEDLE	151	BG STAR (ON)	94	BUSPIRONE	87
BD PRECISIONGLIDE 25GX5/8	152	BG STAR LANCET	150	<b>BUSPIRONE HYDROCHLORIDE</b>	87
BD PRECISIONGLIDE 25GX7/8	152	BIAXIN	4	<b>BUSULFAN</b>	17
BD PRECISIONGLIDE 26GX1/2	152	BIAXIN XL	4	<b>CABERGOLINE</b>	90
BD PRECISIONGLIDE 26GX3/8	152	<b>BICALUTAMIDE</b>	17	CADUET	44
BD PRECISIONGLIDE 27GX1 1/4	152	BICALUTAMIDE	17	CAFFEINE CITRATE	84
BD PRECISIONGLIDE 27GX1/2	152	BICILLIN	5	<b>CAFFEINE CITRATE</b>	84
BD SHARPS CONTAINER 3.1L	152	<b>BIMATOPROST</b>	106	CAL-500	96
BD SLIP TIP 10ML SYRINGE	152	BIO K-20 POTASSIUM	97	CALCIMAR	126
BD SLIP TIP 1ML SYRINGE	152	BIO-AMLODIPINE	43	<b>CALCIPOTRIOL</b>	134
BD SLIP TIP 20ML SYRINGE	152	BIO-ANASTROZOLE	17	<b>CALCIPOTRIOL, BETAMETHASONE DIPROPIONATE</b>	131
BD SLIP TIP 30ML SYRINGE	153	BIO-ATENOLOL	41	CALCITE 500 D 400	96
BD SLIP TIP 3ML SYRINGE	152	BIOCALCIUM	96	CALCITE LIQUIDE D 400	96
BD SLIP TIP 5ML SYRINGE	152	BIOCALCIUMD	96	<b>CALCITONIN SALMON (SYNTHETIC)</b>	126
BD SLIP TIP 60ML SYRINGE	153	BIOCAL-D FORTE	96	<b>CALCITRIOL</b>	139
BD SLIP TIP SUB Q 26G SYRINGE	152	BIO-CELECOXIB	56	CALCITRIOL-ODAN	139
BD SYRINGE + NEEDLE	153	BIODERM	129	<b>CALCIUM</b>	96
BD SYRINGE WITH ULTRA-FINE NEEDLE	153	BIO-DONEPEZIL	22	CALCIUM	96
BD TUBERCULIN 21GX1 SYRINGE	152	BIO-FLUOXETINE	74	CALCIUM +VIT D	96
BD TUBERCULIN 25GX5/8 SYRINGE	152	BIO-FUROSEMIDE	98	CALCIUM 500 + VIT D 400	96
BD TUBERCULIN 26GX3/8 SYRINGE	152	BIO-HYDROCHLOROTHIAZIDE	98	CALCIUM CARBONATE	96
BD TUBERCULIN 27GX1/2 SYRINGE	152	BIO-LETROZOLE	19	CALCIUM CHANNEL BLOCKER IN OINTMENT	141
BD ULTRA 29G.1/2CC SYRINGE	153	BIO-LOSARTAN	51	<b>CALCIUM GLUCONATE,VIT D</b>	96
BD ULTRA 29G.1CC SYRINGE	153	BIO-MODAFINIL	84	<b>CALCIUM POLYSTYRENE SULFONATE</b>	97
BD ULTRAFINE 31G 5MM PEN NEEDLE	151	BIO-QUETIAPINE	80	CALCIUM VITAMIN D LEMON FLAVOUR	96
BD ULTRAFINE 31G 8MM PEN NEEDLE	151	BIOSENNOSIDES	110	<b>CALCIUM, VITAMIN D</b>	96
BD ULTRAFINE 33G LANCET	151	BI-PEGLYTE	110	CALD 400	96
BD ULTRA-FINE II 30GX0.5CC SYRINGE	153	BISACODYL	109	CALODAN D 400	96
BD ULTRA-FINE III PEN NEEDLE	151	<b>BISACODYL</b>	109	CAMPRAL	91
BD ULTRA-FINE NANO PEN NEEDLE	151	BISACODYL-ODAN	109	<b>CANAGLIFLOZIN</b>	124
BD ULTRA-FINE PEN NEEDLE 29G	151	BISMUTH	109	CANDESARTAN	50
<b>BECLOMETHASONE DIPROPIONATE</b>	104	BISMUTH SUBSALICYLATE	109	<b>CANDESARTAN CILEXETIL</b>	50
BEDUZIL	138	<b>BISMUTH SUBSALICYLATE</b>	109	<b>CANDESARTAN CILEXETIL, HYDROCHLOROTHIAZIDE</b>	50
BENADRYL	1	BISOPROLOL	41	CANDESARTAN-HCT	50
BENADRYL CHILDRENS	1	<b>BISOPROLOL FUMARATE</b>	41	CANDESARTAN-HCTZ	50
BENZAEPRIIL	46	BLEPHAMIDE	104	CANESORAL	8
<b>BENZAEPRIIL HYDROCHLORIDE</b>	46	<b>BOSENTAN MONOHYDRATE</b>	40	CANESTEN	129
BENZAFLIN	129	BOTOX	148		
BENZAGEL	133	BREO ELLIPTA	25		
BENZAGEL 5	133	BREVICON 0.5/35 (21-DAY PACK)	120		
BENZAMYCIN	129	BREVICON 0.5/35 (28-DAY PACK)	120		
BENZODIAZEPINE ORAL LIQUID	66				

## Health Canada

## Non-Insured Health Benefits

CANESTEN COMBI-PAK COMFORTAB 1	129	CHAMPIX STARTER PACK	29	CLIMARA PRO	121
CANESTEN COMBI-PAK COMFORTAB 3	129	CHILDREN'S ADVIL	57	CLINDAMYCIN	7
CANTHACUR-PS	134	CHILDREN'S EUROPROFEN	57	<b>CLINDAMYCIN HYDROCHLORIDE</b>	<b>7</b>
<b>CANTHARIDIN, PODOPHYLLIN, SALICYLIC ACID</b>	<b>133</b>	CHILDREN'S MOTRIN	57	CLINDAMYCIN IN DILUSOL OR DUONALC	129
CANTHARONE PLUS	133	<b>CHLORAMBUCIL</b>	<b>17</b>	<b>CLINDAMYCIN PALMITATE HYDROCHLORIDE</b>	<b>7</b>
<b>CAPECITABINE</b>	<b>17</b>	CHLORAMPHENICOL	103	<b>CLINDAMYCIN PHOSPHATE</b>	<b>7</b>
CAPSAICIN	134	<b>CHLORAMPHENICOL</b>	<b>103</b>	<b>CLINDAMYCIN PHOSPHATE, BENZOYL PEROXIDE</b>	<b>129</b>
<b>CAPSAICIN</b>	<b>134</b>	<b>CHLORHEXIDINE GLUCONATE</b>	<b>104</b>	CLINDAMYCIN STERILE INFUSION	7
CAPSAISIN	134	<b>CHLOROQUINE PHOSPHATE</b>	<b>15</b>	CLINDAMYCINE	7
<b>CAPTOPRIL</b>	<b>46</b>	<b>CHLORPHENIRAMINE MALEATE</b>	<b>1</b>	CLINDA-T	129
<b>CARBACHOL</b>	<b>106</b>	CHLORPROMAZINE	77	CLINDOXYL	129
<b>CARBAMAZEPINE</b>	<b>66</b>	<b>CHLORPROMAZINE HYDROCHLORIDE</b>	<b>77</b>	CLINDOXYL ADV	129
CARBAMAZEPINE	67	<b>CHLORTHALIDONE</b>	<b>99</b>	<b>CLOBAZAM</b>	<b>66</b>
CARBOCAL	96	CHLORTHALIDONE	99	CLOBAZAM	66
CARBOCAL D	96	CHLOR-TRIPOLON	1	<b>CLOBETASOL PROPIONATE</b>	<b>131</b>
CARBOLITH	87	<b>CHOLECALCIFEROL</b>	<b>139</b>	<b>CLOBETASONE BUTYRATE</b>	<b>131</b>
CARDIZEM CD	45	CHOLEDYL	137	<b>CLOMIPRAMINE HYDROCHLORIDE</b>	<b>72</b>
CARDURA-1	40	<b>CHOLESTYRAMINE RESIN</b>	<b>34</b>	CLONAPAM	66
CARDURA-2	40	CHOLESTYRAMINE-ODAN	34	CLONAZEPAM	66
CARDURA-4	40	<b>CICLESONIDE</b>	<b>118</b>	<b>CLONAZEPAM</b>	<b>66</b>
CARNITOR	98	<b>CICLOPIROX OLAMINE</b>	<b>129</b>	<b>CLONIDINE HYDROCHLORIDE</b>	<b>38</b>
CARNITOR IV	98	CIDOMYCIN	2	CLONIDINE ORAL LIQUID	38
CARTRIDGE FOR IR200	149	<b>CILAZAPRIL</b>	<b>46</b>	CLOPIDOGREL	32
CARVEDILOL	41	<b>CILAZAPRIL, HYDROCHLOROTHIAZIDE</b>	<b>46</b>	<b>CLOPIDOGREL BISULFATE</b>	<b>32</b>
<b>CARVEDILOL</b>	<b>41</b>	CIOXAN	103	CLOPIXOL	83
CASODEX	17	<b>CIMETIDINE</b>	<b>112</b>	CLOPIXOL DEPOT	83
CAYA CONTOURED DIAPHRAGM	93	CIMZIA	145	CLOPIXOL-ACUPHASE	83
CEENU	19	CIPRALEX	73	CLOTTRIMADERM	129
<b>CEFACLOR</b>	<b>2</b>	CIPRALEX MELTZ	73	<b>CLOTTRIMAZOLE</b>	<b>129</b>
CEFACLOR	2	CIPRO	6	CLOTTRIMAZOLE	129
<b>CEFADROXIL</b>	<b>2</b>	CIPRODEX	103	<b>CLOXACILLIN SODIUM</b>	<b>5</b>
CEFAZOLIN	2	CIPROFLOXACIN	6	<b>CLOZAPINE</b>	<b>77</b>
<b>CEFAZOLIN SODIUM</b>	<b>2</b>	<b>CIPROFLOXACIN HYDROCHLORIDE</b>	<b>6</b>	CLOZARIL	77
CEFAZOLIN STERILE INFUSION	2	<b>CIPROFLOXACIN HYDROCHLORIDE, DEXAMETHASONE</b>	<b>103</b>	CO CILAZAPRIL	46
<b>CEFIXIME</b>	<b>2</b>	CITALOPRAM	72	CO CLONAZEPAM	66
<b>CEFPROZIL</b>	<b>2</b>	<b>CITALOPRAM HYDROBROMIDE</b>	<b>72</b>	CO FENTANYL	61
CEFTAZIDIME	2	<b>CITRIC ACID, MAGNESIUM OXIDE, SODIUM PICOSULFATE</b>	<b>109</b>	CO FLUCONAZOLE	8
<b>CEFTAZIDIME (CEFTAZIDIME PENTAHYDRATE)</b>	<b>2</b>	<b>CITRIC ACID, SODIUM CITRATE</b>	<b>96</b>	CO NORFLOXACIN	6
CEFTIN	3	CITRO MAG	109	CO SOTALOL	43
CEFTRIAXONE	3	CITRODAN	109	CO VALACYCLOVIR	12
<b>CEFTRIAXONE SODIUM</b>	<b>3</b>	CLARITHROMYCIN	4	<b>COAL TAR</b>	<b>134</b>
CEFTRIAXONE STERILE INFUSION	3	<b>CLARITHROMYCIN</b>	<b>4</b>	<b>COAL TAR, SALICYLIC ACID</b>	<b>134</b>
<b>CEFURIXIME AXETIL</b>	<b>3</b>	CLARITIN	1	<b>COBIMETINIB (COBIMETINIB FUMARATE)</b>	<b>18</b>
CEFZIL	2	CLARITIN KIDS	1	CODEINE	60
CELEBREX	56	CLARUS	134	CODEINE CONTIN CR	60
<b>CELECOXIB</b>	<b>56</b>	CLAVULIN 125 F	4	<b>CODEINE MONOHYDRATE, CODEINE SULFATE TRIHYDRATE</b>	<b>60</b>
CELECOXIB	56	CLAVULIN 200	5	CODEINE PHOSPHATE	60
CELESTODERM V	131	CLAVULIN 250 F	5	<b>CODEINE PHOSPHATE</b>	<b>60</b>
CELEXA	72	CLAVULIN 400	5	<b>COLCHICINE</b>	<b>143</b>
CELLCEPT	146	CLAVULIN 500 F	5	COLCHICINE	143
CELSENTRI	10	CLAVULIN 875	5	<b>COLESEVELAM HYDROCHLORIDE</b>	<b>34</b>
CENTER-AL	142	CLEAR AWAY PLANTAR WART SYSTEM	134	COLESTID	34
CENTRUM DHA	140	CLEAR AWAY WART REMOVER SYSTEM	134	COLESTID ORANGE	34
CENTRUM JUNIOR COMPLETE	140	CLICKFINE PEN NEEDLE 31G 4.5MM	151	<b>COLESTIPOL HYDROCHLORIDE</b>	<b>34</b>
CENTRUM PRENATAL	140	CLICKFINE PEN NEEDLE 31G 6MM	151	<b>COLLAGENASE</b>	<b>134</b>
CEPHALEXIN	3	CLICKFINE PEN NEEDLE 31G 8MM	151	COLYTE	110
<b>CEPHALEXIN</b>	<b>3</b>	CLIMARA 100	121	COMBANTRIN	2
<b>CERTOLIZUMAB PEGOL</b>	<b>145</b>	CLIMARA 25	121	COMBIGAN	105
CESAMET	112	CLIMARA 50	121	COMBIVENT	24
CETIRIZINE	1	CLIMARA 75	121	COMBIVENT RESPIMAT	24
<b>CETIRIZINE HYDROCHLORIDE</b>	<b>1</b>				
CHAMPIX	29				

## Health Canada

## Non-Insured Health Benefits

COMBIVIR	10	CYCLOCORT	130	DESONIDE	131
COMFORT ANGLED INFSET 17MM	149	CYCLOGYL	105	DESOXIMETASONE	132
COMFORT SRT ANGLED INFSET 13	149	CYCLOMEN	119	DETROL	136
COMPACT SPACE PLUS LARGE MASK	149	CYCLOPENTOLATE	105	DETROL LA	136
COMPACT SPACE PLUS MEDIUM MASK	149	<b>CYCLOPENTOLATE HYDROCHLORIDE</b>	<b>105</b>	<b>DEXAMETHASONE</b>	<b>104</b>
COMPACT SPACE PLUS NO MASK	149	<b>CYCLOPHOSPHAMIDE</b>	<b>18</b>	DEXAMETHASONE	104
COMPACT SPACE PLUS SMALL MASK	149	<b>CYCLOSPORINE</b>	<b>146</b>	DEXAMETHASONE ORAL LIQUID	118
COMPLERA	11	CYESTRA-35	147	<b>DEXAMETHASONE PHOSPHATE</b>	<b>104</b>
COMPOUND W GEL	134	CYKLOKAPRON	33	<b>DEXAMETHASONE, TOBRAMYCIN</b>	<b>104</b>
COMTAN	89	CYMBALTA	73	DEXAMETHASONE-OMEGA	118
CONCERTA	84	CYPROTERONE	147	DEXEDRINE	83
<b>CONDOM</b>	<b>93</b>	<b>CYPROTERONE ACETATE</b>	<b>147</b>	DEXEDRINE SPANSULE	83
CONDOM, LATEX, LUBRICATED	93	<b>CYPROTERONE ACETATE, ETHINYL ESTRADIOL</b>	<b>147</b>	DEXIRON	30
CONDOM, LATEX, LUBRICATED, NONOXYNOL	93	CYTOMEL	127	<b>DEXTRAN 70, HYDROXYPROPYLMETHYLCELLULOSE</b>	<b>107</b>
CONDOM, LATEX, NON-LUBRICATED	93	CYTOVENE	12	<b>DEXTROAMPHETAMINE SULFATE</b>	<b>83</b>
CONDOM, NON-LATEX, LUBRICATED	93	D VI INFANTS	139	D-FORTE	139
CONDYLINE	135	D2-DOL	139	DGEL	139
<b>CONJUGATED ESTROGENS</b>	<b>120</b>	D3-DOL	139	DIABETA	125
<b>CONJUGATED ESTROGENS, MEDROXYPROGESTERONE ACETATE</b>	<b>121</b>	<b>DABIGATRAN ETEXILATE MESILATE</b>	<b>31</b>	DIAMICRON	124
CONTACT DETACH 90 DEGREE 6MMX60CM	149	<b>DACLATASVIR</b>	<b>13</b>	DIAMICRON MR	124
CONTACT DETACH 90 DEGREE 8MMX60CM	149	DAIRY DIGESTIVE	110	DIANE-35	147
CONTINGENCY ONE	120	DAIRY AID	110	DIAPER RASH	133
CONTOUR NEXT	94	DAKLINZA	13	DIARR-EZE	109
CONTOUR NEXT (ON)	94	DALACIN	129	DIARRHEA RELIEF	109
<b>CONTRACEPTIVE DEVICE</b>	<b>93</b>	DALACIN C	7	DIASTAT	85
CORTATE	132	DALACIN C PHOSPHATE	7	DIASTAT 2X10MG RECTAL PACK	85
CORTEF	118	DALACIN T	129	DIASTAT 2X15MG RECTAL PACK	85
CORTENEMA	115	<b>DALTEPARIN SODIUM</b>	<b>31</b>	DIASTIX	95
CORTIFOAM	115	<b>DANAZOL</b>	<b>119</b>	DIAZEPAM	85
CORTISONE	118	DANTRIUM	28	<b>DIAZEPAM</b>	<b>85</b>
<b>CORTISONE ACETATE</b>	<b>118</b>	<b>DANTROLENE SODIUM</b>	<b>28</b>	<b>DIAZEPAM (DIASTAT)</b>	<b>85</b>
CORTODERM	132	<b>DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE</b>	<b>124</b>	<b>DIAZOXIDE</b>	<b>38</b>
CORTODERM OINT	132	<b>DAPSONE</b>	<b>9</b>	DICETEL	115
COSENTYX	135	DAPSONE	9	DICITRATE	96
COSOPT	106	<b>DARIFENACIN HYDROBROMIDE</b>	<b>136</b>	DICLECTIN	111
COTAZYM	110	<b>DARUNAVIR ETHANOLATE</b>	<b>10</b>	DICLOFENAC	57
COTAZYM ECS 20	110	<b>DARUNAVIR ETHANOLATE, COBICISTAT</b>	<b>10</b>	DICLOFENAC EC	57
COTAZYM ECS 8	110	DDAVP	126	<b>DICLOFENAC SODIUM</b>	<b>57</b>
COTELLIC	18	DDAVP MELT	126	<b>DICLOFENAC SODIUM (TOPICAL)</b>	<b>57</b>
COUMADIN	32	DDROPS	139	DICLOFENAC TOPICAL	57
COVERSYL	48	DECAXIL	139	DICLOFENAC-SR	57
COVERSYL PLUS	48	<b>DEGARELIX ACETATE</b>	<b>18</b>	<b>DIDANOSINE</b>	<b>10</b>
COVERSYL PLUS HD	48	DELATESTRYL	119	<b>DIENOGEST</b>	<b>126</b>
COZAAR	51	DEMULEN 30 (21 DAY PACK)	119	DIFFERIN	134
CREON MINIMICROSPHERES 6	110	DEMULEN 30 (28 DAY PACK)	119	DIFLUCAN	8
CREON MINIMICROSPHERES MICRO	111	<b>DENOSUMAB (PROLIA)</b>	<b>144</b>	DIFLUNISAL	57
CRESTOR	36	<b>DENOSUMAB (XGEVA)</b>	<b>144</b>	<b>DIFLUNISAL</b>	<b>57</b>
CROMOLYN	103	DEPAKENE	71	<b>DIGOXIN</b>	<b>34</b>
<b>CROMOLYN SODIUM</b>	<b>101</b>	DEPO-MEDROL	118	DIHYDROERGOTAMINE	27
<b>CROTAMITON</b>	<b>130</b>	DEPO-PROVERA	126	<b>DIHYDROERGOTAMINE MESYLATE</b>	<b>27</b>
CRYSTAPEN	5	DEPO-TESTOSTERONE	119	DILANTIN	66
CTP 30	72	DERMAFLEX HC	132	DILANTIN INFATABS	66
CUPRIMINE	117	DERMA-SMOOTH	132	DILAUDID	61
<b>CYANOCOBALAMIN</b>	<b>138</b>	DERMOVATE	131	DILTIAZEM CD	45
CYANOCOBALAMIN	138	DESIPRAMINE	72	<b>DILTIAZEM HYDROCHLORIDE</b>	<b>45</b>
CYCLEN (21 DAY)	120	<b>DESIPRAMINE HYDROCHLORIDE</b>	<b>72</b>	DILTIAZEM TZ	45
CYCLEN (28 DAY)	120	DESLORATADINE	1	DIMENHYDRINATE	111
CYCLOBENZAPRINE	27	<b>DESLORATADINE</b>	<b>1</b>	<b>DIMENHYDRINATE</b>	<b>111</b>
<b>CYCLOBENZAPRINE HYDROCHLORIDE</b>	<b>27</b>	DESLORATADINE ALLERGY CONTROL	1	<b>DIMETHICONE</b>	<b>130</b>
		DESMOPRESSIN	126	DIOVAN	53
		<b>DESMOPRESSIN ACETATE</b>	<b>126</b>	DIOVAN-HCT	54
		<b>DESOGESTREL, ETHINYL ESTRADIOL</b>	<b>119</b>	DIPENTUM	115

**Health Canada**

**Non-Insured Health Benefits**

DIPHENHYDRAMINE	1	DOM-METOPROLOL-L	42	DROPLET PEN NEEDLE 8MM 32G	151
<b>DIPHENHYDRAMINE HYDROCHLORIDE</b>	<b>1</b>	DOM-MINOCYCLINE	7	DROPLET PERSONAL LANCET 28G	150
DIPHENIST	1	DOM-MIRTAZAPINE	74	DROPLET PERSONAL LANCET 30G	150
<b>DIPIVEFRIN HYDROCHLORIDE</b>	<b>105</b>	DOM-MONTELUKAST	100	DROPLET PERSONAL LANCET 33G	151
DIPROLENE	131	DOM-NYSTATIN	9	DRSCHOLL'S ATHLETE'S FOOT SPRAY	130
DIPROSALIC	131	DOM-OMEPRAZOLE DR	113	D-TABS	139
DIPROSONE	131	DOM-OXYBUTYNIN	136	DUAKLIR GENUAIR	25
<b>DIPYRIDAMOLE</b>	<b>40</b>	DOM-PANTOPRAZOLE	114	DULCOLAX	109
<b>DIPYRIDAMOLE, ACETYLSALICYLIC ACID</b>	<b>40</b>	DOM-PAROXETINE	75	DULOXETINE	73
<b>DISOPYRAMIDE</b>	<b>34</b>	DOMPERIDONE	114	DULOXETINE DR	73
DIVALPROEX	71	<b>DOMPERIDONE MALEATE</b>	<b>114</b>	<b>DULOXETINE HYDROCHLORIDE</b>	<b>73</b>
DIVIGEL	121	DOMPERIDONE ORAL LIQUID	114	DUOFILM	134
<b>DOLICHOVESPULA ARENARIA VENOM PROTEIN</b>	<b>142</b>	DOM-PINDOLOL	43	DUONALC	130
<b>DOLICHOVESPULA MACULATA VENOM PROTEIN EXTRACT</b>	<b>142</b>	DOM-PIOGLITAZONE	125	DUOTRAV PQ	107
DOLORAL 1	62	DOM-PRAMIPEXOLE	90	DURAGESIC	61
DOLORAL 5	62	DOM-PRAVASTATIN	36	<b>DUTASTERIDE</b>	<b>142</b>
<b>DOLUTEGRAVIR SODIUM</b>	<b>10</b>	DOM-PREGABALIN	69	DUTASTERIDE	142
DOM-ALENDRONATE	144	DOM-QUETIAPINE	80	DUVOID	22
DOM-AMANTADINE	9	DOM-RABEPRAZOLE EC	114	ECL-CITALOPRAM	72
DOM-AMIODARONE	34	DOM-RAMIPRIL	49	ECL-DONEPEZIL	22
DOM-AMLODIPINE	43	DOM-RISEDRONATE	144	ECL-METFORMIN	122
DOM-ATENOLOL	41	DOM-RIZATRIPTAN RDT	88	EDARBI	50
DOM-ATOMOXETINE	91	DOM-ROSUVASTATIN	36	EDECRIN	98
DOM-ATORVASTATIN	35	DOM-SALBUTAMOL	26	EDURANT	11
DOM-AZITHROMYCIN	3	DOM-SERTRALINE	75	<b>EFAVIRENZ</b>	<b>10</b>
DOM-BACLOFEN	28	DOM-SIMVASTATIN	37	<b>EFAVIRENZ, EMTRICITABINE, TENOFOVIR DISOPROXIL FUMARATE</b>	<b>10</b>
DOM-BENZYDAMINE	105	DOM-SOTALOL	43	EFFEXOR XR	76
DOM-BROMOCRIPTINE	89	DOM-SUMATRIPTAN	88	EFUDEX	134
DOM-CANDESARTAN	50	DOM-TERAZOSIN	40	EGOZINC-HC	132
DOM-CARBAMAZEPINE	67	DOM-TERBINAFINE	8	ELAVIL	71
DOM-CARVEDILOL	41	DOM-TIAPROFENIC	59	<b>ELBASVIR, GRAZOPREVIR</b>	<b>14</b>
DOM-CEPHALEXIN	3	DOM-TIMOLOL	106	<b>ELECTROLYTES</b>	<b>96</b>
DOM-CIMETIDINE	112	DOM-TOPIRAMATE	70	ELIDEL	135
DOM-CIPROFLOXACIN	6	DOM-TRAZODONE	76	ELIGARD	19
DOM-CITALOPRAM	72	DOM-VALACYCLOVIR	12	ELIQUIS	30
DOM-CLARITHROMYCIN	4	DOM-VALPROIC ACID	71	ELMIRON	141
DOM-CLONAZEPAM	66	DOM-VALSARTAN	53	ELCOM	133
DOM-CLONAZEPAM-R	66	DOM-VENLAFAXINE XR	76	ELTROXIN	126
DOM-CLOPIDOGREL	32	DOM-VERAPAMIL SR	46	EMEND	112
DOM-CYCLOBENZAPRINE	27	DOM-ZOLMITRIPTAN	88	EMEND TRI-PACK	112
DOM-DICLOFENAC	57	DONEPEZIL	22	EMLA	133
DOM-DICLOFENAC SR	57	<b>DONEPEZIL HYDROCHLORIDE</b>	<b>22</b>	EMO CORT	132
DOM-DOMPERIDONE	114	<b>DORZOLAMIDE HYDROCHLORIDE</b>	<b>106</b>	EMOCORT	132
DOM-FINASTERIDE	143	<b>DORZOLAMIDE HYDROCHLORIDE, TIMOLOL MALEATE</b>	<b>106</b>	EMOLAX	109
DOM-FLUCONAZOLE	8	DOSTINEX	90	<b>EMPAGLIFLOZIN</b>	<b>124</b>
DOM-FLUXETINE	74	DOVOBET	131	<b>EMTRICITABINE, COBICISTAT, ELVITEGRAVIR, TENOFOVIR ALAFENAMIDE</b>	<b>10</b>
DOM-GABAPENTIN	67	DOVONEX	134	ENABLEX	136
DOM-GEMFIBROZIL	35	<b>DOXAZOSIN MESYLATE</b>	<b>40</b>	ENALAPRIL	47
DOM-GLYBURIDE	125	<b>DOXEPIN HYDROCHLORIDE</b>	<b>73</b>	<b>ENALAPRIL MALEATE</b>	<b>46</b>
DOM-INDAPAMIDE	99	DOXYCIN	7	<b>ENALAPRIL MALEATE, HYDROCHLOROTHIAZIDE</b>	<b>47</b>
DOM-IPRATROPIUM	24	DOXYCYCLINE	7	ENALAPRIL ORAL LIQUID	47
DOM-IRBESARTAN	51	<b>DOXYCYCLINE HYCLATE</b>	<b>111</b>	ENBREL	145
DOM-LANSOPRAZOLE	113	<b>DOXYLAMINE SUCCINATE, PYRIDOXINE HYDROCHLORIDE</b>	<b>111</b>	ENBREL SURECLICK	145
DOM-LEVETIRACETAM	68	DOXYTAB	7	ENDOCET	60
DOM-LOPERAMIDE	109	DRISDOL	139	ENEMOL SODIUM PHOSPHATE	110
DOM-LORAZEPAM	85	DROPLET PEN NEEDLE 10MM 29G	151	ENFAMIL FERINSOL	30
DOM-LOXAPINE	78	DROPLET PEN NEEDLE 12MM 29G	151	ENFAMIL POLYVISOL	140
DOM-MEFENAMIC ACID	58	DROPLET PEN NEEDLE 4MM 32G	151	ENFAMIL TRIVISOL	140
DOM-MELOXICAM	58	DROPLET PEN NEEDLE 5MM 31G	151	<b>ENOXAPARIN SODIUM</b>	<b>31</b>
DOM-METFORMIN	122	DROPLET PEN NEEDLE 5MM 32G	151	<b>ENTACAPONE</b>	<b>89</b>
DOM-METOPROLOL-B	42	DROPLET PEN NEEDLE 6MM 31G	151	<b>ENTECAVIR MONOHYDRATE</b>	<b>12</b>
		DROPLET PEN NEEDLE 6MM 32G	151		
		DROPLET PEN NEEDLE 8MM 31G	151		

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ENTOCORT	131	ETHINYL ESTRADIOL, LEVONORGESTREL	119	FERRLECIT	30
ENTRESTO	55	ETHINYL ESTRADIOL, NORELGESTROMIN	120	<b>FERROUS FUMARATE</b>	<b>30</b>
ENTROPHEN	56	ETHINYL ESTRADIOL, NORETHINDRONE	120	<b>FERROUS GLUCONATE</b>	<b>30</b>
ENTYVIO	147	ETHINYL ESTRADIOL, NORETHINDRONE	120	FERROUS GLUCONATE	30
<b>ENZALUTAMIDE</b>	<b>18</b>	ETHINYL ESTRADIOL, NORETHINDRONE ACETATE	120	<b>FERROUS SULFATE</b>	<b>30</b>
EPCLUSA	15	ETHINYL ESTRADIOL, NORETHINDRONE ACETATE	120	FERROUS SULFATE	30
<b>EPINEPHRINE</b>	<b>27</b>	ETHINYL ESTRADIOL, NORGESTIMATE	120	<b>FESOTERODINE FUMARATE</b>	<b>136</b>
EPINEPHRINE	27	ETHOPROPAZINE HYDROCHLORIDE	89	<b>FEXOFENADINE HYDROCHLORIDE</b>	<b>1</b>
EPIPEN	27	ETHOSUXIMIDE	66	FIBRISTAL	120
EPIPEN JR	27	ETIBI	9	<b>FILGRASTIM</b>	<b>33</b>
EPIVAL	71	<b>ETIDRONATE DISODIUM</b>	<b>144</b>	FINACEA	134
<b>EPLERENONE</b>	<b>54</b>	<b>ETIDRONATE DISODIUM, CALCIUM CARBONATE</b>	<b>144</b>	<b>FINASTERIDE</b>	<b>143</b>
<b>EPOSARTAN MESYLATE</b>	<b>50</b>	<b>ETIPOSIDE</b>	<b>18</b>	FINASTERIDE	143
<b>EPOSARTAN MESYLATE, HYDROCHLOROTHIAZIDE</b>	<b>50</b>	<b>ETRAVIRINE</b>	<b>10</b>	FINGERSTIX LANCET	150
EQUATE DAILY LOW-DOSE	56	EUGLUCON	125	FIRMAGON	18
ERDOL	139	EURAX	130	FIRST CANADIAN HEALTH LANCETS	150
<b>ERGOCALCIFEROL</b>	<b>139</b>	EURO D	139	FIRST CANHEALTH 28G LANCET	150
<b>ERLOTINIB HYDROCHLORIDE</b>	<b>18</b>	EURO K	97	FIRST CANHEALTH 30G LANCET	150
<b>ERTAPENEM (ERTAPENEM SODIUM)</b>	<b>3</b>	EURO VITAMIN B1	138	FIRST CANHEALTH 33G LANCET	151
ERYC	4	EURO-ASA	56	FIRST CANHEALTH SPIRIT	94
ERYTHRO BASE	4	EUROCAL	96	FLAGYL	16
ERYTHRO-ES	4	EURO-FER	30	FLAGYSTATIN	129
<b>ERYTHROMYCIN</b>	<b>4</b>	EURO-FERROUS SULFATE	30	FLAMAZINE	130
ERYTHROMYCIN	103	EURO-FOLIC	138	FLAREX	104
<b>ERYTHROMYCIN ESTOLATE</b>	<b>4</b>	EUROHYDROCORTISONE	132	<b>FLAVOXATE HYDROCHLORIDE</b>	<b>136</b>
<b>ERYTHROMYCIN ETHYLSUCCINATE</b>	<b>4</b>	EURO-SENNA	110	FLECAINIDE	34
<b>ERYTHROMYCIN STEARATE</b>	<b>4</b>	EUTHYROX	126	<b>FLECAINIDE ACETATE</b>	<b>34</b>
<b>ERYTHROMYCIN, BENZOYL PEROXIDE</b>	<b>129</b>	EVISTA	121	FLEET ENEMA	110
ERYTHRO-S	4	EVRA	120	FLEET ENEMA PEDIATRIC	110
ESBRIET	100	EXELON	23	FLEXI-T +300 IUD	93
ESCITALOPRAM	73	<b>EXEMESTANE</b>	<b>18</b>	FLEXI-T +380 IUD	93
<b>ESCITALOPRAM OXALATE</b>	<b>73</b>	<b>EXTEMPORANEOUS MIXTURE</b>	<b>141</b>	FLEXI-TD	93
<b>ESCULIN, FRAMYCETIN SULFATE, DIBUCAINE HYDROCHLORIDE, HYDROCORTISONE ACETATE</b>	<b>132</b>	EXTRA STRENGTH SELSUN	130	FLINTSTONES MULTIPLE VITAMINS PLUS IRON	140
<b>ESLICARBAZEPINE ACETATE</b>	<b>67</b>	EYLEA	107	FLINTSTONES MULTIPLE VITAMINS WITH EXTRA C	140
ESME 21	119	EZ HEALTH ORACLE	94	FLOCTAFENINE	65
ESME 28	119	EZ HEALTH ORACLE LANCET	150	<b>FLOCTAFENINE</b>	<b>65</b>
ESTALIS	121	E-Z JE	152	FLOMAX	27
ESTRACE	121	E-Z SPACER	149	FLORINEF	118
<b>ESTRADIOL</b>	<b>121</b>	E-Z SPACER (MASK ONLY)	149	FLOVENT DISKUS	118
<b>ESTRADIOL HEMIHYDRATE</b>	<b>121</b>	E-Z SPACER WITH SMALL MASK	149	FLOVENT HFA	118
<b>ESTRADIOL, LEVONORGESTREL</b>	<b>121</b>	EZETIMIBE	34	FLUANXOL	77
<b>ESTRADIOL, NORETHINDRONE ACETATE</b>	<b>121</b>	<b>EZETIMIBE</b>	<b>34</b>	FLUANXOL DEPOT	77
ESTRADOT 100	121	EZETROL	34	<b>FLUCONAZOLE</b>	<b>8</b>
ESTRADOT 25	121	<b>FAMCICLOVIR</b>	<b>12</b>	FLUDARA	18
ESTRADOT 37.5	121	FAMCICLOVIR	12	<b>FLUDARABINE PHOSPHATE</b>	<b>18</b>
ESTRADOT 50	121	<b>FAMOTIDINE</b>	<b>112</b>	<b>FLUDROCORTISONE ACETATE</b>	<b>118</b>
ESTRADOT 75	121	FAMOTIDINE	112	<b>FLUMETHASONE PIVALATE, CLIOQUINOL</b>	<b>104</b>
ESTRAGYN	121	FAMVIR	12	FLUNARIZINE	88
ESTRING	121	<b>FEBUXOSTAT</b>	<b>143</b>	<b>FLUNARIZINE HYDROCHLORIDE</b>	<b>88</b>
ESTROGEL	121	<b>FELODIPINE</b>	<b>44</b>	<b>FLUNISOLIDE</b>	<b>104</b>
<b>ESTRONE</b>	<b>121</b>	FEMARA	19	<b>FLUOCINONIDE</b>	<b>132</b>
<b>ETANERCEPT</b>	<b>145</b>	<b>FENOFIBRATE</b>	<b>35</b>	<b>FLUOROMETHOLONE</b>	<b>104</b>
<b>ETHACRYNIC ACID</b>	<b>98</b>	FENOMAX	35	<b>FLUOROURACIL</b>	<b>134</b>
<b>ETHAMBUTOL HYDROCHLORIDE</b>	<b>9</b>	FENO-MICRO	35	FLUOXETINE	74
ETHINYL ESTRADIOL, DESOGESTREL	119	<b>FENTANYL</b>	<b>61</b>	<b>FLUOXETINE HYDROCHLORIDE</b>	<b>73</b>
ETHINYL ESTRADIOL, DROSPIRENONE	119	FENTANYL	61	FLUPENTHIXOL DIHYDROCHLORIDE	77
ETHINYL ESTRADIOL, ETHYNODIOL DIACETATE	119	FERAMAX POWDER WATER SOLUBLE POLYSACCHARIDE IRON COMPLEX	30	<b>FLUPENTHIXOL DECANOATE</b>	<b>77</b>
ETHINYL ESTRADIOL, ETONOGESTREL	119	FER-INSYR	30	FLUPHENAZINE	78
		FERODAN	30	<b>FLUPHENAZINE DECANOATE</b>	<b>77</b>
		FERODAN INFANT DROPS	30	<b>FLUPHENAZINE HYDROCHLORIDE</b>	<b>78</b>
		FERRATE	30	<b>FLURBIPROFEN</b>	<b>57</b>
				<b>FLUTAMIDE</b>	<b>18</b>

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**Non-Insured Health Benefits**

FLUTICASONE FUROATE	104	GD-DICLOFENAC/MISOPROSTOL	58	HONEY BEE VENOM PROTEIN EXTRACT	142
FLUTICASONE FUROATE, VILANTEROL TRIFENATATE	25	GD-GABAPENTIN	67	HP-PAC	113
FLUTICASONE FUROATE, VILANTEROL TRIFENATATE (ASTHMA)	25	GD-LATANOPROST	106	HUMALOG	123
FLUTICASONE PROPIONATE	104	GD-LATANOPROST/TIMOLOL	107	HUMALOG (CARTRIDGE)	123
FLUVASTATIN SODIUM	36	GD-QUINAPRIL	48	HUMALOG (KWIKPEN)	123
FLUVOXAMINE	74	GD-TRANEXAMIC ACID	33	HUMALOG 100U/ML CARTRIDGE	123
FLUVOXAMINE MALEATE	74	GD-VENLAFAXINE XR	76	HUMALOG 200U/ML KWIKPEN	123
FML	104	GE200	94	HUMALOG MIX 25 (CARTRIDGE)	123
FOLIC ACID	138	GE200 (ON)	94	HUMALOG MIX 25 (KWIKPEN)	124
FOLIC ACID	138	<b>GEMFIBROZIL</b>	35	HUMALOG MIX 50 (CARTRIDGE)	124
FORADIL	25	GEN-CLOZAPINE	77	HUMALOG MIX 50 (KWIKPEN)	124
FORMOTEROL FUMARATE	25	GENTAMICIN	2	HUMATIN	15
FORMOTEROL FUMARATE DIHYDRATE	25	GENTAMICIN IV	2	HUMIRA	145
FORMOTEROL FUMARATE DIHYDRATE, BUDESONIDE	26	<b>GENTAMICIN SULFATE</b>	2	HUMULIN 30/70	123
FORMOTEROL FUMARATE DIHYDRATE, MOMETASONE FUROATE	26	GENTAMICIN SULFATE IN SODIUM CHLORIDE	2	HUMULIN 30/70 CARTRIDGE	123
FORTAZ 1G	2	GENTAMYCIN STERILE INFUSION	2	HUMULIN N	123
FORTAZ 2G	2	GENTEAL	105	HUMULIN N (CARTRIDGE)	123
FORTAZ 6G	3	GENVOYA	10	HUMULIN N (KWIKPEN)	123
FORXIGA	124	GIOTRIF	17	HUMULIN N 100U/ML (CARTRIDGE)	123
FOSAMAX	144	GLEEVEC	19	HUMULIN R	123
FOSAMPRENAVIR CALCIUM	10	GLICLAZIDE	124	HUMULIN R (KWIKPEN)	123
FOSAVANCE	144	<b>GLICLAZIDE</b>	124	HUMULIN R 100U/ML (CARTRIDGE)	123
FOSFOMYCIN TROMETHAMINE	16	GLUCAGEN	125	HUMULIN R CARTRIDGE	123
FOSINOPRIL	47	GLUCAGEN HYPOKIT	125	HYDERM	132
FOSINOPRIL SODIUM	47	GLUCAGON	126	<b>HYDRALAZINE HYDROCHLORIDE</b>	38
FOSRENOL	98	<b>GLUCAGON RECOMBINANT DNA ORGIN</b>	125	HYDRALYTE ELECTROLYTE	96
FRAGMIN	31	GLUCOBAY	121	HYDREA	18
FRAMYCETIN SULFATE	103	GLUCONORM	124	HYDROCHLOROTHIAZIDE	98
FRAMYCETIN SULFATE, GRAMICIDIN, DEXAMETHASONE	104	GLUCOPHAGE	122	<b>HYDROCHLOROTHIAZIDE</b>	98
FRAXIPARINE	31	<b>GLUCOSE OXIDASE, PEROXIDASE</b>	94	HYDROCHLOROTHIAZIDE ORAL LIQUID	99
FRAXIPARINE FORTE	31	GLYBURIDE	125	<b>HYDROCHLOROTHIAZIDE, PINDOLOL</b>	42
FREESTYLE	94	<b>GLYBURIDE</b>	125	<b>HYDROCHLOROTHIAZIDE, SPIRONOLACTONE</b>	54
FREESTYLE (ON)	94	GLYCERIN	109	<b>HYDROCORTISONE ACETATE</b>	115
FREESTYLE LANCET	150	GLYCERIN FOR INFANTS CHILDREN	109	HYDROCORTISONE ACETATE	132
FREESTYLE LITE	94	<b>GLYCERINE</b>	109	HYDROCORTISONE ACETATE, UREA	132
FREESTYLE LITE (ON)	94	GLYCON	122	HYDROCORTISONE ACETATE, ZINC SULFATE	132
FREESTYLE PRECISION	94	<b>GLYCOPYRRONIUM BROMIDE</b>	24	HYDROCORTISONE ACETATE, ZINC SULFATE MONOHYDRATE	132
FREESTYLE PRECISION (ON)	94	<b>GOLIMUMAB</b>	145	HYDROCORTISONE ACETATE, ZINC SULFATE, PRAMOXINE HYDROCHLORIDE	132
FREYA 21	119	GOLYTELY	109	HYDROCORTISONE POWDER AND CLOTRIMAZOLE CREAM	141
FREYA 28	119	<b>GOSERELIN ACETATE</b>	121	<b>HYDROCORTISONE VALERATE</b>	133
FRISIUM	66	GPC-GLICLAZIDE MR	124	HYDROMORPH CONTIN	61
FUCIDIN	129	<b>GRANISETRON HYDROCHLORIDE</b>	111	<b>HYDROMORPHONE HYDROCHLORIDE</b>	61
FUROSEMIDE	98	GRASTOFIL	33	HYDROSONE	132
<b>FUROSEMIDE</b>	98	GRAVOL	111	HYDROVAL	133
FUSIDATE SODIUM	129	GUM PAROEX	104	<b>HYDROXYCHLOROQUINE SULFATE</b>	15
FUSIDIC ACID	129	HABITROL	28	<b>HYDROXYPROPYL CELLULOSE</b>	107
GABAPENTIN	67	<b>HALOBETASOL PROPIONATE</b>	132	<b>HYDROXYPROPYLMETHYLCELLULOSE</b>	105
GABAPENTIN	67	<b>HALOPERIDOL</b>	78	<b>E</b>	
GALANTAMINE	22	HALOPERIDOL	78	<b>HYDROXYUREA</b>	18
GALANTAMINE ER	22	<b>HALOPERIDOL DECANOATE</b>	78	<b>HYDROXYZINE HYDROCHLORIDE</b>	87
<b>GALANTAMINE HYDROBROMIDE</b>	22	HALOPERIDOL LA	78	HYMENOPTERA VENOM PRODUCT	142
GALEXOS	14	HARVONI	15	HONEY BEE VENOM	
<b>GANCICLOVIR SODIUM</b>	12	HEPARIN LEO	31	HYMENOPTERA VENOM PRODUCT	142
GASTROLYTE REGULAR	96	HEPARIN LOCK FLUSH	31	MIXED VESPID VENOM PROTEIN	
<b>GATIFLOXACIN</b>	103	<b>HEPARIN SODIUM</b>	31	HYMENOPTERA VENOM PRODUCT	142
GD-AMLODIPINE	43	HEPARIN SODIUM (MULTIDOSE VIAL-WITH PRESERVATIVE)	31	WASP VENOM PROTEIN	
GD-AMLODIPINE-ATORVASTATIN	44	HEPARIN SODIUM (SINGLE USE VIAL-PRESERVATIVE FREE)	31	HYMENOPTERA VENOM PRODUCT	142
GD-AZITHROMYCIN	3	HEPSERA	12	YELLOW JACKET VENOM PROTEIN	
GD-CELECOXIB	56	HEPTOVIR	10		
		HOLKIRA PAK	14		

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**Non-Insured Health Benefits**

HYMENOPTERA VENOM PRODUCTS YELLOW HORNET VENOM PROTEIN	142	<b>INSULIN LISPRO, INSULIN LISPRO PROTAMINE</b>	<b>123</b>	<b>ITRACONAZOLE</b>	<b>8</b>
<b>HYOSCINE BUTYLBROMIDE</b>	<b>24</b>	INSULIN PEN NEEDLE 31GX6MM	151	IV3000	149
HYZAAR	52	INSULIN PEN NEEDLE 31GX8MM	151	JAMP ACETAMINOPHEN BLAZON	65
HYZAAR DS	52	INSULIN PEN NEEDLE 32GX4MM	151	JAMP CALCIUM CARBONATE VITAMIN D	96
IBAVYR	14	INSULIN PEN NEEDLE 32GX6MM	151	JAMP CALCIUM CITRATE VITAMIN D	96
<b>IBUPROFEN</b>	<b>57</b>	INSULIN PEN NEEDLE 32GX8MM	151	JAMP CALCIUM LACTOGLUCONATE VITAMIN D	96
IBUPROFEN	58	INSULIN PUMP BATTERY	149	JAMP FERROUS FUMARATE	30
ICLUSIG	20	<b>INSULIN PUMP SUPPLIES</b>	<b>149</b>	JAMP FERROUS SULFATE	30
<b>IDELALISIB</b>	<b>18</b>	INSULIN SYR W/NEEDLE 0.25CC	152	JAMP FERROUS SULFATE LIQUIDS5	30
ILEVRO	105	INSULIN SYR W/NEEDLE 0.3CC	152	JAMP FOLIC ACID	138
<b>IMATINIB MESYLATE</b>	<b>19</b>	INSULIN SYR W/NEEDLE 0.5CC	152	JAMP GLYCERIN	109
IMDUR	39	INSULIN SYR W/NEEDLE 1CC	152	JAMP K	97
IMIPRAMINE	74	INSUPEN 29GX12MM NEEDLE	151	JAMP OLANZAPINE ODT	79
<b>IMIPRAMINE HYDROCHLORIDE</b>	<b>74</b>	INSUPEN 30GX8MM NEEDLE	151	JAMP REHYDRALYTE	97
<b>IMIQUIMOD</b>	<b>134</b>	INSUPEN 31GX6MM NEEDLE	151	JAMP SENNAQUIL	110
IMITREX	88	INSUPEN 31GX8MM NEEDLE	151	JAMP VITAMIN A, D AND C	140
IMITREX DF	88	INSUPEN 32GX4MM NEEDLE	151	JAMP VITAMIN B12	138
IMITREX STAT DOSE KIT	88	INSUPEN 32GX6MM NEEDLE	151	JAMP VITAMIN D	139
IMODIUM	109	INSUPEN 32GX8MM NEEDLE	151	JAMP-ALENDRONATE	144
IMODIUM CALMING	109	INSUPEN 33GX4MM NEEDLE	151	JAMP-ALLOPURINOL	143
IMURAN	146	INTELENCE	10	JAMP-ALPRAZOLAM	84
<b>INCOBOTULINUMTOXINA</b>	<b>147</b>	<b>INTERFERON ALFA-2B</b>	<b>11</b>	JAMP-AMITRIPTYLINE	71
INCRUSE ELLIPTA	25	<b>INTRAUTERINE DEVICE</b>	<b>93</b>	JAMP-AMLODIPINE	43
<b>INDACATEROL MALEATE</b>	<b>26</b>	INTRON A	11	JAMP-AMOXCILLIN	4
<b>INDACATEROL MALEATE, GLYCOPYRRONIUM BROMIDE</b>	<b>24</b>	INVANZ	3	JAMP-ANASTROZOLE	17
<b>INDAPAMIDE</b>	<b>99</b>	INVEGA SUSTENNA	80	JAMP-ASA	56
INDAYO	119	INVIRASE	11	JAMP-ASA EC	56
INDERAL LA	43	INVOKANA	124	JAMP-ATENOLOL	41
<b>INDOMETHACIN</b>	<b>58</b>	IOPIDINE	107	JAMP-ATORVASTATIN	35
INFLECTRA	145	IPECAC	111	JAMP-AZITHROMYCIN	3
<b>INFLIXIMAB (INFLECTRA)</b>	<b>145</b>	<b>IPECAC</b>	<b>111</b>	JAMP-BACITRACINE	129
<b>INFLIXIMAB (REMICADE)</b>	<b>146</b>	<b>IPRATROPIUM BROMIDE</b>	<b>24</b>	JAMP-BEZAFIBRATE	35
INFUFER	30	<b>IPRATROPIUM BROMIDE, SALBUTAMOL SULFATE</b>	<b>24</b>	JAMP-BICALUTAMIDE	17
INHIBACE	46	IPRAVENT	24	JAMP-BISACODYL	109
INHIBACE PLUS	46	IRBESARTAN	50	JAMP-CALCIUM + VITAMIN D	96
INNOHEP	32	<b>IRBESARTAN</b>	<b>50</b>	JAMP-CALCIUM CARBONATE	96
INSET 30 INFUSION SETS	149	IRBESARTAN HCT	51	JAMP-CALCIUM VITAMIN D	96
INSET II 90 DEGREE 6MMX110CM	149	<b>IRBESARTAN, HYDROCHLOROTHIAZIDE</b>	<b>51</b>	JAMP-CANDESARTAN	50
INSET II 90 DEGREE 6MMX60CM	149	IRBESARTAN/HCTZ	51	JAMP-CARVEDILOL	41
INSET II 90 DEGREE 9MMX110CM	149	IRBESARTAN/HCTZ	51	JAMP-CELECOXIB	56
INSET II 90 DEGREE 9MMX60CM	149	<b>IRON</b>	<b>30</b>	JAMP-CETIRIZINE	1
INSPIOLTO RESPIMAT	26	IRON	30	JAMP-CIPROFLOXACIN	6
INSPRA	54	<b>IRON DEXTRAN</b>	<b>30</b>	JAMP-CITALOPRAM	72
<b>INSULIN (30% NEUTRAL &amp; 70% ISOPHANE) HUMAN BIOSYNTHETIC</b>	<b>123</b>	<b>IRON SUCROSE</b>	<b>30</b>	JAMP-CLOPIDOGREL	32
<b>INSULIN (40% NEUTRAL &amp; 60% ISOPHANE) HUMAN BIOSYNTHETIC</b>	<b>123</b>	IRON SUCROSE STERILE INFUSION	30	JAMP-COLCHICINE	143
<b>INSULIN (50% NEUTRAL &amp; 50% ISOPHANE) HUMAN BIOSYNTHETIC</b>	<b>123</b>	ISDN	39	JAMP-CYANOCOBALAMIN	138
<b>INSULIN (ISOPHANE) HUMAN BIOSYNTHETIC</b>	<b>123</b>	ISENTRESS	11	JAMP-CYCLOBENZAPRINE	27
<b>INSULIN (ZINC CRYSTALLINE) HUMAN BIOSYNTHETIC (RDNA ORIGIN)</b>	<b>123</b>	ISONIAZID	9	JAMP-DIMENHYDRINATE	111
INSULIN 31GX0.3CC	153	ISONIAZID ORAL LIQUID	9	JAMP-DONEPEZIL	22
INSULIN 31GX0.5CC	153	<b>ISOPROPYL ALCOHOL</b>	<b>130</b>	JAMP-DULOXETINE	73
INSULIN 31GX1CC	153	<b>ISOPROPYL MYRISTATE</b>	<b>130</b>	JAMP-ESCITALOPRAM	73
<b>INSULIN ASPART</b>	<b>123</b>	ISOPTIN SR	46	JAMP-EZETIMIBE	34
<b>INSULIN BIOSYNTHETIC HUMAN BR</b>	<b>123</b>	ISOPTO ATROPINE	105	JAMP-FER	30
<b>INSULIN DETEMIR</b>	<b>123</b>	ISOPTO CARPINE	106	JAMP-FERROUS FUMARATE	30
<b>INSULIN GLARGINE</b>	<b>123</b>	ISOPTO TEARS	107	JAMP-FERROUS SULFATE	30
<b>INSULIN GLULISINE</b>	<b>123</b>	<b>ISOSORBIDE DINITRATE</b>	<b>39</b>	JAMP-FINASTERIDE	143
<b>INSULIN HUMAN BIOSYNTHETIC</b>	<b>123</b>	<b>ISOSORBIDE-5-MONONITRATE</b>	<b>39</b>	JAMP-FLUCONAZOLE	8
<b>INSULIN LISPRO</b>	<b>123</b>	ISOTAMINE	9	JAMP-FLUOXETINE	74
		<b>ISOTRETINOIN</b>	<b>134</b>	JAMP-FOLIC ACID	138
		ITEST	94	JAMP-FOSINOPRIL	47
		ITEST SAFETY 28G LANCET	150	JAMP-GABAPENTIN	67
		ITEST ULTRA-THIN 33G LANCET	151	JAMP-HYDROCORTISONE	132

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## Non-Insured Health Benefits

JAMP-IBUPROFEN	58	JENCYCLA	120	LCD IN CORTICOSTEROID OINTMENT	141
JAMP-INDAPAMIDE	99	JENTADUETO	122	LCD IN NON-MEDICATED CREAM	141
JAMP-IRBESARTAN	51	K LYTE	97	LCD IN NON-MEDICATED OINTMENT	141
JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	51	K-10	97	LECTOPAM	85
JAMP-K 8	97	K20 POTASSIUM	97	LEDERLE LEUCOVORIN	143
JAMP-K EFFERVESCENT	97	KADIAN	63	LEFLUNOMIDE	146
JAMP-LACTULOSE	96	KALETRA	10	<b>LEFLUNOMIDE</b>	<b>146</b>
JAMP-LETROZOLE	19	KAYEXALATE	97	<b>LENALIDOMIDE</b>	<b>19</b>
JAMP-LEVETIRACETAM	68	KEFLEX	3	LESCOL	36
JAMP-LISINAPRIL	47	KENALOG-10	119	LESCOL XL	36
JAMP-LOSARTAN	51	KENALOG-40	119	LETROZOLE	19
JAMP-LOSARTAN HCTZ	52	KEPPRA	68	<b>LETROZOLE</b>	<b>19</b>
JAMP-MAGNESIUM	97	<b>KETOCONAZOLE</b>	<b>9</b>	<b>LEUCOVORIN CALCIUM</b>	<b>143</b>
JAMP-METFORMIN	122	KETODERM	130	LEUKERAN	17
JAMP-METFORMIN BLACKBERRY	122	KETOPROFEN	58	<b>LEUPROLIDE ACETATE</b>	<b>19</b>
JAMP-METHOTREXATE	20	<b>KETOPROFEN</b>	<b>58</b>	LEVATE	71
JAMP-METOPROLOL-L	42	KETOPROFEN SR	58	LEVEMIR FLEXTOUCH	123
JAMP-MONTELUKAST	100	KETOPROFEN-E	58	LEVEMIR PENFILL	123
JAMP-MOXIFLOXACIN	6	<b>KETOROLAC TROMETHAMINE</b>	<b>105</b>	LEVETIRACETAM	68
JAMP-MYCOPHENOLATE	146	KETOSTIX	95	<b>LEVETIRACETAM</b>	<b>68</b>
JAMP-NYSTATIN	9	<b>KETOTIFEN FUMARATE</b>	<b>1</b>	LEVETIRACETAM ORAL LIQUID	69
JAMPOCAINE VISCOUS	133	K-EXIT	97	<b>LEVOBUNOLOL HYDROCHLORIDE</b>	<b>106</b>
JAMP-OLANZAPINE	78	KIVEXA	9	<b>LEVOCABASTINE HYDROCHLORIDE</b>	<b>103</b>
JAMP-OLMESARTAN	52	KOMBOGLYZE	122	<b>LEVOCARNITINE</b>	<b>98</b>
JAMP-OLOPATADINE	103	KWELLADA-P	130	<b>LEVODOPA, BENSERAZIDE</b>	<b>89</b>
JAMPOLYCIN	129	<b>LABETALOL HYDROCHLORIDE</b>	<b>42</b>	<b>HYDROCHLORIDE</b>	
JAMP-OMEPRAZOLE DR	114	<b>LACOSAMIDE</b>	<b>68</b>	<b>LEVODOPA, CARBIDOPA</b>	<b>89</b>
JAMP-ONDANSETRON	111	LACRISERT	107	<b>LEVODOPA, CARBIDOPA,</b>	<b>89</b>
JAMP-PANTOPRAZOLE	114	LACTAID	110	<b>ENTACAPONE</b>	
JAMP-PAROXETINE	75	LACTAID EXTRA STRENGTH	110	LEVOFLOXACIN	6
JAMP-PIOGLITAZONE	125	LACTAID ULTRA	110	<b>LEVOFLOXACIN HEMIHYDRATE</b>	<b>6</b>
JAMP-POTASSIUM CHLORIDE	97	<b>LACTASE</b>	<b>110</b>	<b>LEVONORGESTREL</b>	<b>120</b>
JAMP-PRAVASTATIN	36	LACTEEZE	110	<b>LEVONORGESTREL INTRAUTERINE</b>	<b>120</b>
JAMP-PREGABALIN	69	LACTEEZE DROPS	110	<b>INSERT</b>	
JAMP-QUETIAPINE	80	LACTOMAX	110	<b>LEVONORGESTREL, ETHINYL</b>	<b>120</b>
JAMP-RAMIPRIL	48	LACTOMAX EXTRA	110	<b>ESTRADIOL</b>	
JAMP-RISEDRONATE	144	<b>LACTULOSE</b>	<b>96</b>	<b>LEVOTHYROXINE SODIUM</b>	<b>126</b>
JAMP-RISPERIDONE	81	LACTULOSE	96	LIBERTE UT380 SHORT IUD	93
JAMP-RIZATRIPTAN	87	LAMICTAL	68	LIBERTE UT380 STANDARD IUD	93
JAMP-RIZATRIPTAN IR	87	LAMISIL	8	LIDEMOL	132
JAMP-ROPINIROLE	90	<b>LAMIVUDINE</b>	<b>10</b>	LIDEX	132
JAMP-ROSUVASTATIN	36	<b>LAMIVUDINE, ZIDOVUDINE</b>	<b>10</b>	<b>LIDOCAINE HYDROCHLORIDE</b>	<b>105</b>
JAMP-SERTRALINE	75	LAMOTRIGINE	68	<b>LIDOCAINE, PRILOCAINE</b>	<b>133</b>
JAMP-SIMVASTATIN	37	<b>LAMOTRIGINE</b>	<b>68</b>	LIDODAN VISCOUS	128
JAMP-SODIUM PHOSPHATE	110	<b>LANCET</b>	<b>150</b>	LIFE BRAND PEN NEEDLE 31G 8MM	151
JAMP-SOLIFENACIN	136	<b>LANREOTIDE ACETATE</b>	<b>147</b>	<b>LINAGLIPTIN</b>	<b>122</b>
JAMP-SOTALOL	43	LANSOPRAZOLE	113	<b>LINAGLIPTIN, METFORMIN</b>	<b>122</b>
JAMP-TERBINAFININE	8	<b>LANSOPRAZOLE</b>	<b>113</b>	<b>HYDROCHLORIDE</b>	
JAMP-TIMOLOL	106	<b>LANSOPRAZOLE ODT</b>	<b>113</b>	LINCTUS CODEINE	60
JAMP-TOPIRAMATE	70	LANSOPRAZOLE ORAL LIQUID	113	LINESA 21	119
JAMP-VALACYCLOVIR	13	LANSOYL	109	LINESA 28	119
JAMP-VANCOMYCIN	8	LANSOYL SUGAR FREE	109	LINEZOLID	8
JAMP-VITAMIN A	138	<b>LANTHANUM CARBONATE HYDRATE</b>	<b>98</b>	<b>LINEZOLID</b>	<b>8</b>
JAMP-VITAMIN B12	138	LANTUS	123	LIORESAL	28
JAMP-VITAMIN D	139	LANTUS SOLOSTAR	123	<b>LIOTHYRONINE SODIUM</b>	<b>127</b>
JAMP-ZINC-HC	132	LANVIS	21	<b>LIPASE, AMYLASE, PROTEASE</b>	<b>110</b>
JAMP-ZOLMITRIPTAN	88	LASIX	98	LIPIDIL EZ	35
JAMP-ZOLMITRIPTAN ODT	88	LASIX SPECIAL	98	LIPIDIL SUPRA	35
JANUMET	123	<b>LATANOPROST</b>	<b>106</b>	LIPITOR	35
JANUMET XR	123	<b>LATANOPROST, TIMOLOL MALEATE</b>	<b>107</b>	<b>LISDEXAMFETAMINE DIMESYLATE</b>	<b>83</b>
JANUVIA	122	LATUDA	78	LISINAPRIL	47
JARDIANCE	124	LAX-A-DAY	109	<b>LISINAPRIL</b>	<b>47</b>
JAYDESS	120	LAX-A-DAY PHARMA	109	<b>LISINAPRIL, HYDROCHLOROTHIAZIDE</b>	<b>48</b>
J-CAL+D	96	LCD IN CORTICOSTEROID CREAM	141	LISINAPRIL/HCTZ (TYPE Z)	48
				LITHANE	87

**Health Canada**
**Non-Insured Health Benefits**

LITHIUM CARBONATE	87	MAGNESIUM	97	M-B1	138
LITHIUM CITRATE	87	MAGNESIUM CITRATE	109	M-B12	138
LITHMAX	87	MAGNESIUM GLUCOHEPTONATE	97	M-B6	138
LIVOSTIN	103	MAGNESIUM GLUCONATE	97	M-CAL	96
LOCACORTEN VIOFORM	104	MAGNESIUM HYDROXIDE	109	M-CAL D	96
LODALIS	34	MAGNESIUM OXIDE	109	M-D	139
LODOXAMIDE TROMETHAMINE	103	MAGNESIUM OXIDE	109	MEBENDAZOLE	2
LOESTRIN	120	MAGNESIUM-ODAN	97	MED-ANASTROZOLE	17
LOLO	120	MAGNIFIER	151	MED-CYPROTERONE	147
LOMUSTINE	19	MAJEPTIL	83	MED-DORZOLAMIDE-TIMOLOL	106
LONITEN	39	MANERIX	75	MED-DUTASTERIDE	142
LOPERAMIDE	109	MAPROTILINE HYDROCHLORIDE	74	MED-EXEMESTANE	18
LOPERAMIDE HYDROCHLORIDE	109	MAR-ALLOPURINOL	143	MEDI+SURE	94
LOPINA VIR, RITONAVIR	10	MAR-AMITRIPTYLINE	71	MEDI+SURE (ON)	94
LOPRESOR	42	MAR-AMLODIPINE	43	MEDI+SURE SOFT 30G TWIST	150
LOPRESOR SR	42	MAR-ANASTROZOLE	17	MEDI+SURE SOFT 33G TWIST	150
LOPROX	129	MAR-ATENOLOL	41	MED-LATANOPROST	106
LORATADINE	1	MARAVIROC	10	MED-LETROZOLE	19
LORATADINE	1	MAR-AZITHROMYCIN	3	MED-MOXIFLOXACIN	6
LORAZEPAM	85	MAR-CELECOXIB	56	MED-RIVASTIGMINE	23
LORAZEPAM	86	MAR-CETIRIZINE	1	MEDROL	118
LOSARTAN	51	MAR-CIPROFLOXACIN	6	MED-ROSUVASTATIN	36
LOSARTAN HCT	52	MAR-CITALOPRAM	72	MEDROXY	126
LOSARTAN POTASSIUM	51	MAR-CLOPIDOGREL	32	MEDROXYPROGESTERONE	126
LOSARTAN POTASSIUM, HYDROCHLOROTHIAZIDE	52	MAR-DOMPERIDONE	114	MEDROXYPROGESTERONE ACETATE	126
LOSARTAN/HCTZ	52	MAR-DONEPEZIL	22	MED-SOLIFENACIN	136
LOSARTAN-HCTZ	52	MAR-DULOXETINE	73	MEFENAMIC	58
LOSEC	113	MAR-ESCITALOPRAM	73	MEFENAMIC ACID	58
LOTENSIN	46	MAR-EZETIMIBE	34	MEGACE	19
LOTRIDERM	129	MAR-FLUCONAZOLE	8	MEGESTROL	19
LOVASTATIN	36	MAR-FLUOXETINE	74	MEGESTROL ACETATE	19
LOVASTATIN	36	MAR-GABAPENTIN	67	MELOXICAM	58
LOVENOX	31	MAR-GALANTAMINE ER	22	MELOXICAM	58
LOVENOX HP	31	MAR-LETROZOLE	19	MELPHALAN	19
LOWPRIN	56	MAR-METFORMIN	122	MENTHOL & CAMPHOR IN CORTICOSTEROID LOTION	141
LOXAPINE HYDROCHLORIDE	78	MAR-MODAFINIL	84	MENTHOL &/OR CAMPHOR IN STEROID	141
LOXAPINE SUCCINATE	78	MAR-MONTELUKAST	100	MEPRON	15
LOZIDE	99	MAR-MOXIFLOXACIN	6	MERCAPTOPYRINE	19
LUBRICATING	107	MAR-OLANZAPINE	78	MERCAPTOPYRINE	19
LUBRICATING NASAL MIST	107	MAR-OLANZAPINE ODT	79	MEROPENEM	3
LUCENTIS	107	MAR-ONDANSETRON	111	MEROPENEM (MEROPENEM TRIHYDRATE)	3
LUCENTIS PFS	107	MAR-PANTOPRAZOLE	114	MERREM	3
LUMIGAN RC	106	MAR-PAROXETINE	75	MESALAZINE	115
LUMIGAN RC (ON)	106	MAR-PREGABALIN	69	M-ESLON	62
LUPIN-ESTRADIOL	121	MAR-QUETIAPINE	81	MESTINON	23
LUPRON DEPOT	19	MAR-RAMIPRIL	48	MESTINON-SR	23
LURASIDONE HYDROCHLORIDE	78	MAR-RISPERIDONE	81	METADOL	62
LUTERA 21	119	MAR-RIZATRIPTAN	87	METADOL-D	62
LUTERA 28	119	MAR-ROSUVASTATIN	36	METAMUCIL FIBRE THERAPY ORIGINAL TEXTURE UNFLAVOURED	110
LUVOX	74	MAR-SERTRALINE	75	METAMUCIL FIBRE THERAPY SMOOTH TEXTURE ORANGE FLAVOUR	110
LYDERM	132	MAR-SIMVASTATIN	37	METAMUCIL FIBRE THERAPY SMOOTH TEXTURE ORANGE FLAVOUR (SUGAR-FREE)	110
LYRICA	69	MAR-TOPIRAMATE	70	METAMUCIL FIBRE THERAPY SMOOTH TEXTURE UNFLAVOURED	110
LYSODREN	20	MAR-VALACYCLOVIR	13	METFORMIN	122
M CALCIUM VITAMINE D	96	MARVELON 21	119	METFORMIN FC	122
M SENNOSIDES	110	MARVELON 28	119	METFORMIN HYDROCHLORIDE	122
M-ACETAMINOPHEN	65	MAR-ZOLMITRIPTAN	88		
MACROBID	16	M-ASA	56		
MACROGOL, POTASSIUM CHLORIDE, SODIUM BICARBONATE, SODIUM CHLORIDE, SODIUM SULFATE	109	MATULANE	20		
MACROGOL, PROPYLENE GLYCOL	107	MAVIK	49		
MAGIC MOUTHWASH	141	MAXALT	87		
MAGLUCATE	97	MAXALT RPD	87		
MAGNESIUM	97	MAXIDEX	104		
		MAXIMUM STRENGTH ACID REDUCER	112		
		MAZEPINE	66		

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## Non-Insured Health Benefits

<b>METFORMIN HYDROCHLORIDE, DAPAGLIFLOZIN (DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE)</b>	<b>124</b>	MIDAMOR	98	MINT-TOLTERODINE	136
<b>METHADONE HYDROCHLORIDE</b>	<b>62</b>	MIDODRINE	25	MINT-TOPIRAMATE	70
<b>METHADONE HYDROCHLORIDE (BC ONLY)</b>	<b>62</b>	<b>MIDODRINE HYDROCHLORIDE</b>	<b>25</b>	MINT-ZOLMITRIPTAN	88
<b>METHADONE HYDROCHLORIDE (METADOL)</b>	<b>62</b>	MIGRANAL	27	MIO BLUE 6MMX18	149
METHADONE POWDER (OAT)	62	MILK OF MAGNESIA	109	MIO BLUE 6MMX23	149
METHADOSE	62	<b>MINERAL OIL</b>	<b>109</b>	MIO CLEAR 6MMX32	149
METHADOSE DEL. W DIRECT INTER (OAT)	62	MINERAL OIL (HEAVY)	109	MIO CLEAR 9MMX32	149
METHADOSE DEL. W/OUT DIR INTER (OAT)	62	<b>MINERAL OIL, WHITE PETROLATUM</b>	<b>107</b>	MIO PINK 6MMX18	149
METHADOSE W DIRECT INTERACTION (OAT)	62	MINISTRIN 1/20 (21-DAY)	120	MIO PINK 6MMX23	149
METHADOSE W/OUT DIRECT INTER (OAT)	62	MINISTRIN 1/20 (28-DAY)	120	MIOSTAT	106
<b>METHAZOLAMIDE</b>	<b>106</b>	MINIMS ATROPINE	105	<b>MIRABEGRON</b>	<b>137</b>
METHAZOLAMIDE	106	MINIMS CYCLOPENTOLATE	105	MIRAPEX	90
METHOPRAZINE	78	MINIMS PHENYLEPHRINE	105	MIRAPEX (ON)	90
METHOTREXATE	19	MINIMS PILOCARPINE	106	MIRENA	120
<b>METHOTREXATE (METHOTREXATE DISODIUM)</b>	<b>19</b>	MINIMS PREDNISOLONE	104	MIRTAZAPINE	74
<b>METHOTREXATE SODIUM</b>	<b>19</b>	MINIPRESS	40	<b>MIRTAZAPINE</b>	<b>74</b>
<b>METHOTRIMEPRAZINE MALEATE</b>	<b>78</b>	MINITRAN	39	MIRVALA 21	119
METHYLDOPA	38	MINOCYCLINE	7	MIRVALA 28	119
<b>METHYLDOPA</b>	<b>38</b>	<b>MINOCYCLINE HYDROCHLORIDE</b>	<b>7</b>	MISCELLANEOUS COMPOUNDED EXTERNAL LOTION	141
<b>METHYLDOPA, HYDROCHLOROTHIAZIDE</b>	<b>38</b>	MIN-OVRAL 21	120	MISCELLANEOUS COMPOUNDED EXTERNAL POWDER	141
METHYLPHENIDATE	84	MIN-OVRAL 28	120	MISCELLANEOUS COMPOUNDED EYE/EAR DROP	141
<b>METHYLPHENIDATE HYDROCHLORIDE</b>	<b>84</b>	<b>MINOXIDIL</b>	<b>39</b>	MISCELLANEOUS COMPOUNDED INJECTION/INFUSION	141
<b>METHYLPREDNISOLONE</b>	<b>118</b>	MINT-ALENDRONATE	143	MISCELLANEOUS COMPOUNDED INTERNAL LIQUID	141
METHYLPREDNISOLONE	118	MINT-AMLODIPINE	44	MISCELLANEOUS COMPOUNDED INTERNAL POWDER	141
<b>METHYLPREDNISOLONE ACETATE</b>	<b>118</b>	MINT-ANASTROZOLE	17	MISCELLANEOUS COMPOUNDED SUPPOSITORY	141
<b>METOCLOPRAMIDE HYDROCHLORIDE</b>	<b>115</b>	MINT-ATENOL	41	MISCELLANEOUS COMPOUNDED TOPICAL CREAM	141
<b>METOLAZONE</b>	<b>99</b>	MINT-CELECOXIB	56	MISCELLANEOUS COMPOUNDED TOPICAL OINTMENT	141
METONIA	115	MINT-CIPROFLOX	6	<b>MISOPROSTOL</b>	<b>113</b>
METOPROLOL	42	MINT-CIPROFLOXACIN	6	MISOPROSTOL	113
METOPROLOL ORAL LIQUID	42	MINT-CITALOPRAM	72	<b>MISOPROSTOL, DICLOFENAC SODIUM</b>	<b>58</b>
METOPROLOL SR	42	MINT-CLOPIDOGREL	32	<b>MITOTANE</b>	<b>20</b>
<b>METOPROLOL TARTRATE</b>	<b>42</b>	MINT-DORZOLAMIDE/TIMOLOL	106	MK 10	97
METOPROLOL-L	42	MINT-DULOXETINE	73	MK 20	97
METROCREAM	129	MINT-DUTASTERIDE	142	MK 8	97
METROGEL	129	MINT-ESCITALOPRAM	73	MK20 SOLUBLE	97
METROLOTION	129	MINT-EZETIMIBE	34	MOBICOX	58
METRONIDAZOLE	16	MINT-FINASTERIDE	143	<b>MOCLOBEMIDE</b>	<b>75</b>
<b>METRONIDAZOLE, NYSTATIN</b>	<b>129</b>	MINT-FLUOXETINE	74	<b>MODAFINIL</b>	<b>84</b>
<b>MEXILETINE HYDROCHLORIDE</b>	<b>34</b>	MINT-GLICLAZIDE MR	124	MODECATE	77
MEZAVANT	115	MINT-GLICLAZIDE MR	124	MODULON	25
M-FOLIQUÉ	141	MINT-HYDROXYCHLOROQUINE	15	MOGADON	86
M-HC	132	MINT-INDOMETHACIN	58	MOMETASONE CREAM	133
MICARDIS	53	MINT-IRBESARTAN	51	<b>MOMETASONE FUROATE</b>	<b>104</b>
MICARDIS PLUS	53	MINT-IRBESARTAN/HCTZ	51	MONA LISA 10	93
MICATIN	130	MINT-ITRACONAZOLE	8	MONA LISA 5	93
MICONAZOLE 3 DAY OVULE TREATMENT	130	MINT-LEVOCARB	89	MONA LISA N	93
<b>MICONAZOLE NITRATE</b>	<b>130</b>	MINT-LOSARTAN	52	MONISTAT 3	130
MICOZOLE	130	MINT-LOSARTAN/HCTZ	52	MONISTAT 3 DUAL-PAK	130
MICRO K	97	MINT-METFORMIN	122	MONISTAT 7	130
MICROLAX	110	MINT-MONTELUKAST	100	MONISTAT 7 DUAL-PAK	130
MICROLET LANCET	150	MINT-OLANZAPINE ODT	79	MONISTAT DERM	130
MICRONOR 28-DAY	120	MINT-OLOPATADINE	103	MONOJECT	152
		MINT-ONDANSETRON	111	MONOJECT ALCOHOL WIPES	150
		MINT-PANTOPRAZOLE	114	MONOLET 21G LANCET	150
		MINT-PAROXETINE	75	MONOLET THIN (MONOJECT) 28G	150
		MINT-PIOGLITAZONE	125	MONTELUKAST	100
		MINT-PRAVASTATIN	36	<b>MONTELUKAST SODIUM</b>	<b>100</b>
		MINT-PREGABALIN	69		
		MINT-QUETIAPINE	80		
		MINT-RAMIPRIL	49		
		MINT-RISPERIDON	81		
		MINT-ROSUVASTATIN	36		
		MINT-SERTRALINE	75		
		MINT-SIMVASTATIN	37		
		MINT-SOLIFENACIN	136		

## Health Canada

## Non-Insured Health Benefits

MONTELUKAST SODIUM	101	MYLAN-CARVEDILOL	42	MYLAN-SIMVASTATIN	37
MONTKIDDY BLUE NEEDLE 32GX4MM	151	MYLAN-CELECOXIB	56	MYLAN-SUMATRIPTAN	88
MONTKIDDY GREEN NEEDLE 32GX4MM	151	MYLAN-CILAZAPRIL	46	MYLAN-TELMISARTAN	53
MONTKIDDY PINK NEEDLE 32GX4MM	151	MYLAN-CIMETIDINE	112	MYLAN-TOLTERODINE ER	136
MONTKIDDY YELLOW NEEDLE 32GX4MM	151	MYLAN-CIPROFLOXACIN	6	MYLAN-TOPIRAMATE	70
MONUROL	16	MYLAN-CITALOPRAM	72	MYLAN-VALACYCLOVIR	13
<b>MORPHINE HYDROCHLORIDE</b>	<b>62</b>	MYLAN-CLINDAMYCIN	7	MYLAN-VALSARTAN	53
MORPHINE SR	63	MYLAN-CLOBETASOL	131	MYLAN-VENLAFAXINE XR	76
<b>MORPHINE SULFATE</b>	<b>62</b>	MYLAN-CLONAZEPAM	66	MYLAN-VERAPAMIL	46
<b>MORPHINE SULFATE (KADIAN)</b>	<b>63</b>	MYLAN-CLOPIDOGREL	32	MYLAN-VERAPAMIL SR	46
MOTION SICKNESS	111	MYLAN-CYCLOBENZAPRINE	27	MYLAN-ZOLMITRIPTAN	88
MOTRIN	58	MYLAN-DIVALPROEX	71	MYLAN-ZOLMITRIPTAN ODT	88
MOVISSE	120	MYLAN-DONEPEZIL	22	MYLERAN	17
<b>MOXIFLOXACIN HYDROCHLORIDE</b>	<b>6</b>	MYLAN-DULOXETINE	73	MYOCHRYSINE	116
MOZOBIL	33	MYLAN-EFAVIRENZ	10	MYRBETRIQ	137
MPD THIN LANCET (NS)	150	MYLAN-EMTRICITABINE/TENOFOVIR DISOPROXIL	11	<b>NABILONE</b>	<b>112</b>
MPD ULTRA THIN LANCET (100)	150	MYLAN-ENALAPRIL	47	NADOLOL	43
MPD ULTRA THIN LANCET (200)	150	MYLAN-ENTACAPONE	89	<b>NADOLOL</b>	<b>43</b>
M-PEG 3350	109	MYLAN-ESCITALOPRAM	73	<b>NADROPARIN CALCIUM</b>	<b>31</b>
MS CONTIN SR	63	MYLAN-FAMOTIDINE	112	NADRYL	1
MS IR	63	MYLAN-FENTANYL MATRIX	61	<b>NAFARELIN ACETATE</b>	<b>121</b>
M-SENNOSIDES	110	MYLAN-FLUCONAZOLE	8	NALCROM	101
M-SULFATE FERREUX	30	MYLAN-FLUOXETINE	74	NALOXONE	65
MUCILLIUM	110	MYLAN-GABAPENTIN	67	<b>NALOXONE HYDROCHLORIDE</b>	<b>65</b>
<b>MULTIVITAMINS (PEDIATRIC)</b>	<b>140</b>	MYLAN-GALANTAMINE ER	23	NALOXONE KIT	65
<b>MULTIVITAMINS (PRENATAL)</b>	<b>140</b>	MYLAN-GLICLAZIDE	124	<b>NALTREXONE HYDROCHLORIDE</b>	<b>65</b>
<b>MUPIROCIN</b>	<b>129</b>	MYLAN-GLICLAZIDE MR	124	<b>NAPHAZOLINE HYDROCHLORIDE</b>	<b>105</b>
<b>MUPIROCIN CALCIUM</b>	<b>129</b>	MYLAN-HYDROXYCHLOROQUINE	15	NAPHCN FORTE	105
MURO 128	107	MYLAN-HYDROXYUREA	18	NAPROSYN	59
MYA	119	MYLAN-INDAPAMIDE	99	NAPROXEN	59
MYCOBUTIN	9	MYLAN-IPRATROPIUM	24	<b>NAPROXEN</b>	<b>59</b>
MYCOPHENOLATE	146	MYLAN-IRBESARTAN	51	NAPROXEN EC	59
<b>MYCOPHENOLATE MOFETIL</b>	<b>146</b>	MYLAN-LAMOTRIGINE	68	NAPROXEN SODIUM	59
MYCOPHENOLATE MOFETIL	146	MYLAN-LANSOPRAZOLE	113	NAPROXEN SODIUM DS	59
<b>MYCOPHENOLATE SODIUM</b>	<b>147</b>	MYLAN-LISINAPRIL	48	NAPROXEN-NA	59
MYDFRIN	105	MYLAN-LOSARTAN	52	NAPROXEN-NA DF	59
MYDRIACYL	105	MYLAN-LOSARTAN HCTZ	52	<b>NARATRIPTAN HYDROCHLORIDE</b>	<b>87</b>
MYFORTIC	147	MYLAN-MELOXICAM	58	NARDIL	75
MYHEALTH SYRINGE CASE-7	153	MYLAN-METFORMIN	122	NASACORT AQ	104
MYHEALTH SYRINGE CASE-SINGLE	153	MYLAN-MINOCYCLINE	7	NASONEX	104
MYLAN-ABACAIVIR/LAMIVUDINE	9	MYLAN-MIRTAZAPINE	74	NAT-ALPRAZOLAM	84
MYLAN-ACEBUTOLOL	41	MYLAN-MONTELUKAST	101	NAT-ANASTROZOLE	17
MYLAN-ACEBUTOLOL (TYPE S)	41	MYLAN-MYCOPHENOLATE	146	NAT-CITALOPRAM	72
MYLAN-ACYCLOVIR	12	MYLAN-NAPROXEN	59	NAT-DONEPEZIL	22
MYLAN-ALENDRONATE	143	MYLAN-NAPROXEN EC	59	NAT-ESCITALOPRAM	73
MYLAN-ALMOTRIPTAN	87	MYLAN-NEVIRAPINE	11	NAT-GRANISETRON	111
MYLAN-ALPRAZOLAM	84	MYLAN-NIFEDIPINE	45	NAT-IMATINIB	19
MYLAN-AMIODARONE	34	MYLAN-NITRO	39	NAT-LETROZOLE	19
MYLAN-AMLODIPINE	44	MYLAN-OLANZAPINE	78	NAT-LEVETIRACETAM	68
MYLAN-AMOXICILLIN	4	MYLAN-OMEPRAZOLE	113	NAT-OMEPRAZOLE DR	114
MYLAN-ATAZANAVIR	9	MYLAN-ONDANSETRON	111	NAT-ONDANSETRON	111
MYLAN-ATENOLOL	41	MYLAN-PANTOPRAZOLE	114	NAT-QUETIAPINE	80
MYLAN-ATOMOXETINE	91	MYLAN-PANTOPRAZOLE T	114	NAT-RIZATRIPTAN ODT	87
MYLAN-ATORVASTATIN	35	MYLAN-PAROXETINE	75	NAT-ZOLMITRIPTAN	88
MYLAN-AZATHIOPRINE	146	MYLAN-PIOGLITAZONE	125	NAUSEATOL	111
MYLAN-AZITHROMYCIN	3	MYLAN-PRAVASTATIN	36	NAVANE	83
MYLAN-BACLOFEN	28	MYLAN-PROPAFENONE	34	<b>NEDOCROMIL SODIUM</b>	<b>103</b>
MYLAN-BECLO AQ	104	MYLAN-RABEPRAZOLE	114	<b>NELFINAVIR MESYLATE</b>	<b>10</b>
MYLAN-BOSENTAN	40	MYLAN-RISEDRONATE	144	NEO-FER	30
MYLAN-BUDESONIDE AQ	104	MYLAN-RISPERIDONE	81	NEORAL	146
MYLAN-BUPRENORPHINE/NALOXONE	64	MYLAN-RISPERIDONE ODT	82	<b>NEOSTIGMINE BROMIDE</b>	<b>23</b>
MYLAN-BUPROPION XL	71	MYLAN-RIZATRIPTAN ODT	87	NEO-ZOL	129
MYLAN-CANDESARTAN	50	MYLAN-ROSUVASTATIN	37	<b>NEPAFENAC</b>	<b>105</b>
		MYLAN-SERTRALINE	75	NESTLÉ MATERNA	140

## Health Canada

## Non-Insured Health Benefits

NEULASTA	33	NOVO-CLOBETASOL	131	<b>OFLOXACIN</b>	<b>103</b>
NEULEPTIL	80	NOVO-CYPROTERONE/ETHINYL ESTRADIOL	147	OLANZAPINE	78
NEUPOGEN	33	NOVO-DESIPRAMINE	72	<b>OLANZAPINE</b>	<b>78</b>
NEUPOGEN (ON)	33	NOVO-DIFLUNISAL	57	OLANZAPINE ODT	79
NEUPOGEN (QC)	33	NOVO-ETIDRONATECAL	144	OLESTYR	34
NEURONTIN	67	NOVO-FERROGLUC	30	<b>OLMESARTAN MEDOXOMIL</b>	<b>52</b>
NEUTROGENA	134	NOVOFINE 30GX 6MM NEEDLE	151	<b>OLMESARTAN MEDOXOMIL, HYDROCHLOROTHIAZIDE</b>	<b>53</b>
NEVANAC	105	NOVOFINE 30GX 8MM NEEDLE	151	OLMETEC	52
<b>NEVIRAPINE</b>	<b>11</b>	NOVOFINE 32G TIP PEN NEEDLE	151	OLMETEC PLUS	53
NEXT CHOICE	120	NOVOFINE PLUS 4MM NEEDLE	151	<b>OLODATEROL HYDROCHLORIDE, TIOTROPIUM BROMIDE MONOHYDRATE</b>	<b>26</b>
<b>NIACIN</b>	<b>138</b>	NOVO-FLUCONAZOLE	8	<b>OLOPATADINE HYDROCHLORIDE</b>	<b>103</b>
NIACIN	138	NOVO-FLUVOXAMINE	74	<b>OLSALAZINE SODIUM</b>	<b>115</b>
NICODERM	29	NOVO-GESIC	65	<b>OMALIZUMAB</b>	<b>102</b>
NICORETTE GUM	28	NOVO-GESIC FORTE	65	<b>OMBITASVIR, PARITAPREVIR, RITONAVIR, DASABUVIR</b>	<b>14</b>
NICORETTE INHALER	28	NOVO-HYDROXYZIN	87	OMEPRAZOLE	113
NICORETTE LOZENGE	28	NOVOLIN GE 30/70	123	<b>OMEPRAZOLE MAGNESIUM</b>	<b>113</b>
<b>NICOTINE (GUM)</b>	<b>28</b>	NOVOLIN GE 30/70 PENFILL	123	OMEPRAZOLE ORAL LIQUID	114
<b>NICOTINE (INHALER)</b>	<b>28</b>	NOVOLIN GE 40/60 PENFILL	123	OMEPRAZOLE-20	113
<b>NICOTINE (LOZENGE)</b>	<b>28</b>	NOVOLIN GE 50/50 PENFILL	123	<b>ONABOTULINUMTOXINA</b>	<b>148</b>
<b>NICOTINE (PATCH)</b>	<b>28</b>	NOVOLIN GE NPH	123	ONBREZ BREEZHALER	26
NICOTINE GUM	28	NOVOLIN GE NPH 100U/ML PENFILL	123	ONDANSETRON	111
NICOTINE TRANSDERMAL	29	NOVOLIN GE NPH PENFILL	123	<b>ONDANSETRON HYDROCHLORIDE</b>	<b>111</b>
NICOTINE TRANSDERMAL SYSTEM	28	NOVOLIN GE TORONTO	123	ONDISSOLVE ODF	111
NICOTROL TRANSDERMAL	28	NOVOLIN GE TORONTO PENFILL	123	ONE ALPHA	139
NIDAGEL	129	NOVOLIN-PEN NEEDLE	151	ONE TOUCH DELICA 30G LANCET	150
<b>NIFEDIPINE</b>	<b>45</b>	NOVO-MEPRAZINE	78	ONE TOUCH ULTRA	94
NIFEDIPINE	45	NOVO-PEN VK	5	ONE-ALPHA	139
<b>NILUTAMIDE</b>	<b>20</b>	NOVO-PENICILLIN G POTASSIUM	5	ONETOUCH DELICA 33G LANCET	151
<b>NIMODIPINE</b>	<b>45</b>	NOVO-PHENIRAM	1	ONETOUCH ULTRASOFT LANCET	150
NIMOTOP	45	NOVO-PRAMINE	74	ONETOUCH VERIO	94
<b>NINTEDANIB ESILATE</b>	<b>100</b>	NOVO-PROFEN	58	ONETOUCH VERIO (ON)	94
NITOMAN	92	NOVORAPID	123	ONGLYZA	122
<b>NITRAZEPAM</b>	<b>86</b>	NOVO-RIVASTIGMINE	23	OPTICHAMBER	149
NITRO-DUR	39	NOVO-RYTHRO ESTOLATE	4	OPTICHAMBER DIAMOND (CHAMBER)	149
NITROFURANTOIN	16	NOVO-SALBUTAMOL HFA	26	OPTICHAMBER DIAMOND LARGE MASK	149
<b>NITROFURANTOIN</b>	<b>16</b>	NOVOTWIST TIP 30G NEEDLE	151	OPTICHAMBER DIAMOND MEDIUM MASK	149
NITRO-FURANTOIN ORAL LIQUID	16	NOVOTWIST TIP 32G NEEDLE	151	OPTICHAMBER DIAMOND SMALL MASK	149
<b>NITROGLYCERIN</b>	<b>39</b>	NOVO-VALPROIC	71	OPTICHAMBER LARGE MASK	149
NITROL	39	NOVO-VERAMIL	46	OPTICHAMBER MEDIUM MASK	149
NITROLINGUAL PUMPSPRAY	39	NOVO-VERAMIL SR	46	OPTICROM	103
NITROSTAT	39	NU-CAL	96	OPTIHALER	149
NIX	130	NU-CAL D	96	OPTIMYXIN	103
NIX DERMAL	130	<b>NUTRITIONAL SUPPLEMENT</b>	<b>154</b>	OPTION 2	120
<b>NIZATIDINE</b>	<b>112</b>	NUVARING	119	OPUS CAL D	96
NIZORAL	130	NYADERM	130	OPUS SENNOSIDES	110
NOLVADEX-D	21	NYDA	130	ORACORT DENTAL PASTE	133
<b>NON POLLEN</b>	<b>142</b>	<b>NYSTATIN</b>	<b>9</b>	ORAP	80
<b>NORETHINDRONE</b>	<b>120</b>	O-CALCIUM	96	ORCIPRENALINE	26
<b>NORETHINDRONE, ETHINYL ESTRADIOL</b>	<b>120</b>	OCCLUSAL HP	134	<b>ORCIPRENALINE SULFATE</b>	<b>26</b>
<b>NORFLOXACIN</b>	<b>6</b>	OCPHYL	141	ORENCIA	145
<b>NORGESTIMATE, ETHINYL ESTRADIOL</b>	<b>120</b>	OCTREOTIDE	141	ORTHO 0.5/35 (21 DAY)	120
NORITATE	129	<b>OCTREOTIDE ACETATE</b>	<b>141</b>	ORTHO 0.5/35 (28 DAY)	120
<b>NORTRIPTYLINE HYDROCHLORIDE</b>	<b>75</b>	OCTREOTIDE ACETATE OMEGA	141	ORTHO 1/35 (21 DAY)	120
NORVASC	44	OCUFLOX	103	ORTHO 1/35 (28 DAY)	120
NORVIR	11	ODAN K20	97	ORTHO 7/7/7 (21 DAY)	120
NOVA MAX	94	ODAN K8	97	ORTHO 7/7/7 (28 DAY)	120
NOVAMILOR	98	ODAN LIQUOR CARBONIS DETERGENT	134	OSTO-D2	139
NOVAMOXIN	4	ODAN SODIUM CHLORIDE	108	OVIMA 21	120
NOVASEN	56	ODAN-ERYTHROMYCIN	103		
NOVA-T	93	ODAN-FLUOXETINE	74		
NOVO-CILAZAPRIL/HCTZ	46	ODAN-SODIUM CHLORIDE	108		
NOVO-CIMETINE	112	OESCLIM	121		
NOVO-CLINDAMYCIN	8	OFEV	100		

**Health Canada**
**Non-Insured Health Benefits**

OVIMA 28	120	PEDIAFER	30	PHENYLEPHRINE	105
<b>OXAZEPAM</b>	<b>86</b>	PEDIALYTE	97	<b>PHENYLEPHRINE HYDROCHLORIDE</b>	<b>105</b>
OXAZEPAM	86	PEDIAPHEN	64	<b>PHENYTOIN</b>	<b>66</b>
OXEZE TURBUHALER	25	PEDIAPRED	119	PHILIPS MAGNESIA	109
OXPAM	86	PEDIATRIC ELECTROLYTE	97	PHILLIPS MILK OF MAGNESIA	109
<b>OXTRIPHYLLINE</b>	<b>137</b>	PEDIATRIX	64	PHL-AMIODARONE	34
OXYBUTYNIN	136	PEDIAVIT	140	PHL-AMLODIPINE	43
<b>OXYBUTYNIN CHLORIDE</b>	<b>136</b>	PEDIAVIT D	139	PHL-AZITHROMYCIN	3
OXYBUTYNINE	136	PEG 3350	109	PHL-BACLOFEN	28
OXYCODONE	63	PEGASYS	11	PHL-CIPROFLOXACIN	6
<b>OXYCODONE HYDROCHLORIDE</b>	<b>63</b>	PEGASYS RBV	12	PHL-CITALOPRAM	72
OXYCODONE/ACET	60	PEGETRON	12	PHL-CLONAZEPAM	66
OXYCODONE-ACET	60	PEGETRON KIT	12	PHL-CLONAZEPAM-R	66
OXY-IR	64	<b>PEGFILGRASTIM</b>	<b>33</b>	PHL-CYCLOBENZAPRINE	27
OYSTER SHELL CALCIUM	96	<b>PEGINTERFERON ALFA-2A</b>	<b>11</b>	PHL-DEXAMETHASONE	118
PALAFER	30	<b>PEGINTERFERON ALFA-2A, RIBAVIRIN</b>	<b>12</b>	PHL-FLUOXETINE	74
<b>PALIPERIDONE PALMITATE</b>	<b>80</b>	<b>PEGINTERFERON ALFA-2B, RIBAVIRIN</b>	<b>12</b>	PHL-INDAPAMIDE	99
PAL-TIZANIDINE	27	PEGLYTE	109	PHL-MELOXICAM	58
PAMIDRONATE	144	<b>PEN NEEDLE</b>	<b>151</b>	PHL-ONDANSETRON	111
PAMIDRONATE DISODIUM	144	<b>PENICILLAMINE</b>	<b>117</b>	PHL-PIOGLITAZONE	125
<b>PAMIDRONATE DISODIUM</b>	<b>144</b>	PENICILLIN G	5	PHL-RANITIDINE	112
PANCREASE MT 10	111	<b>PENICILLIN G BENZATHINE</b>	<b>5</b>	PHL-RISPERIDONE	81
PANCREASE MT 16	111	<b>PENICILLIN G POTASSIUM</b>	<b>5</b>	PHL-SERTRALINE	75
PANCREASE MT 4	111	<b>PENICILLIN G SODIUM</b>	<b>5</b>	PHL-SIMVASTATIN	37
PANTOLOC	114	PENICILLIN G SODIUM	5	PHL-SOTALOL	43
PANTOPRAZOLE	114	PENICILLIN G STERILE INFUSION	5	PHL-TOPIRAMATE	70
<b>PANTOPRAZOLE MAGNESIUM</b>	<b>114</b>	<b>PENICILLIN V POTASSIUM</b>	<b>5</b>	PHL-TRAZODONE	76
PANTOPRAZOLE MAGNESIUM	114	PENTASA	115	PHL-VERAPAMIL SR	46
<b>PANTOPRAZOLE SODIUM</b>	<b>114</b>	<b>PENTOSAN POLYSULFATE SODIUM</b>	<b>141</b>	PHOSLAX	110
PANTOPRAZOLE-40	114	<b>PENTOXIFYLLINE</b>	<b>33</b>	<b>PHYTONADIONE</b>	<b>140</b>
PARADIGM SILHOUETTE 13MMX 43	149	PENTOXIFYLLINE	33	PICO-SALAX	109
PARADIGM SILHOUETTE 13MMX18"	149	PEN-VK	5	PILOCARPINE	106
PARADIGM SILHOUETTE 13MMX23	149	PEPTO BISMOL	109	PILOCARPINE HYDROCHLORIDE	23
PARADIGM SILHOUETTE 13MMX32"	149	PERCOCET-DEMI	60	<b>PILOCARPINE HYDROCHLORIDE</b>	<b>23</b>
PARADIGM SILHOUETTE 17MMX23	149	PERICHLOR	104	<b>PILOCARPINE NITRATE</b>	<b>106</b>
PARADIGM SILHOUETTE 17MMX32"	149	<b>PERICYAZINE</b>	<b>80</b>	<b>PIMECROLIMUS</b>	<b>135</b>
PARADIGM SILHOUETTE 17MMX43	149	PERIDEX	104	<b>PIMOZIDE</b>	<b>80</b>
PARADIGM SILHOUETTE CANNULA 13MM	149	<b>PERINDOPRIL ERBUMINE</b>	<b>48</b>	PIMOZIDE	80
PARADIGM SILHOUETTE CANNULA 17MM	149	<b>PERINDOPRIL ERBUMINE, INDAPAMIDE</b>	<b>48</b>	<b>PINAVERIUM BROMIDE</b>	<b>115</b>
PARADIGM SURE-T 29G 6MMX18	150	PERIOGARD	104	PINDOLOL	43
PARADIGM SURE-T 29G 6MMX23	150	<b>PERMETHRIN</b>	<b>130</b>	<b>PINDOLOL</b>	<b>43</b>
PARADIGM SURE-T 29G 8MMX23	150	PERPHENAZINE	80	<b>PIOGLITAZONE HYDROCHLORIDE</b>	<b>125</b>
PARIET	114	<b>PERPHENAZINE</b>	<b>80</b>	<b>PIPERACILLIN (PIPERACILLIN SODIUM), TAZOBACTAM (TAZOBACTAM SODIUM)</b>	<b>5</b>
PARNATE	76	<b>PETROLATUM</b>	<b>133</b>	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	5
<b>PAROMOMYCIN SULFATE</b>	<b>15</b>	<b>PETROLATUM, MINERAL OIL</b>	<b>107</b>	<b>PIPERONYL BUTOXIDE, PYRETHRINS</b>	<b>130</b>
PAROXETINE	75	PHARIXIA	105	PIPORTIL L4	80
<b>PAROXETINE HYDROCHLORIDE</b>	<b>75</b>	PHARMA-CAL	96	<b>PIPOTIAZINE PALMITATE</b>	<b>80</b>
PARSITAN	89	PHARMA-D	139	<b>PIRFENIDONE</b>	<b>100</b>
PATANOL	103	PHARMA-K20	97	<b>PIROXICAM</b>	<b>59</b>
PATE D'IHLE	133	PHARMA-LACTULOSE	96	<b>PIZOTIFEN MALATE</b>	<b>88</b>
PÂTE D'IHLE	133	PHARMALGEN HONEY BEE VENOM	142	PLAN B	120
PAT-GALANTAMINE ER	23	PHARMALGEN MIXED VESPID VENOM PROTEIN	142	PLAQUENIL	15
PAXIL	75	PHARMALGEN WASP VENOM PROTEIN	142	PLASTIPAK MICRO	152
<b>PAZOPANIB (PAZOPANIB HYDROCHLORIDE)</b>	<b>20</b>	PHARMALGEN WHITE FACED HORNET VENOM	142	PLAVIX	32
PDP-ACETAMINOPHEN	64	PHARMALGEN YELLOW HORNET VENOM PROTEIN	142	PLENDIL	44
PDP-BENZTROPINE	89	PHARMALGEN YELLOW JACKET VENOM PROTEIN	142	<b>PLERIXAFOR</b>	<b>33</b>
PDP-DESONIDE	131	<b>PHENELZINE SULFATE</b>	<b>75</b>	PMS DESIPRAMINE	72
PDP-DIPHENHYDRAMINE	1	PHENOBARB	65	PMS DEXAMETHASONE	118
PDP-ERYTHROMYCIN	103	<b>PHENOBARBITAL</b>	<b>65</b>	PMS FLUPHENAZINE	78
PDP-ISONIAZID	9			PMS HYDROMORPHONE	61
PDP-PROCYCLIDINE	89			PMS HYDROXYZINE	87
PDP-PYRAZINAMIDE	9			PMS PERPHENAZINE	80

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PMS PROCHLORPERAZINE	80	PMS-DULOXETINE	73	PMS-MISOPROSTOL	113
PMS TRAZODONE	76	PMS-DUTASTERIDE	142	PMS-MOCLOBEMIDE	75
PMS-ABACAVIR/LAMIVUDINE	9	PMS-EMTRICITABINE-TENOFOVIR	11	PMS-MOMETASONE	133
PMS-ACETAMINOPHEN	60	PMS-ENTECAVIR	12	PMS-MONTELUKAST	101
PMS-ALENDRONATE	144	PMS-ERLOTINIB	18	PMS-MOXIFLOXACIN	103
PMS-AMANTADINE	9	PMS-ESCITALOPRAM	73	PMS-NABILONE	112
PMS-AMIODARONE	34	PMS-EZETIMIBE	34	PMS-NAPROXEN	59
PMS-AMITRIPTYLINE	71	PMS-FAMCICLOVIR	12	PMS-NAPROXEN EC	59
PMS-AMLODIPINE	43	PMS-FENTANYL MTX	61	PMS-NEVIRAPINE	11
PMS-AMLODIPINE-ATORVASTATIN	44	PMS-FERROUS SULFATE	30	PMS-NIFEDIPINE	45
PMS-AMOXICILLIN	4	PMS-FINASTERIDE	143	PMS-NIZATIDINE	112
PMS-ANAGRELIDE	32	PMS-FLUCONAZOLE	8	PMS-NORFLOXACIN	7
PMS-ANASTROZOLE	17	PMS-FLUOXETINE	74	PMS-NYSTATIN	9
PMS-ASA EC	56	PMS-FLUPHENAZINE	77	PMS-OLANZAPINE	78
PMS-ATENOLOL	41	PMS-FLUTAMIDE	18	PMS-OLANZAPINE ODT	79
PMS-ATOMOXETINE	91	PMS-FOSINOPRIL	47	PMS-OLMESARTAN	52
PMS-ATORVASTATIN	35	PMS-FUROSEMIDE	98	PMS-OMEPRAZOLE	113
PMS-AZITHROMYCIN	3	PMS-GABAPENTIN	67	PMS-ONDANSETRON	111
PMS-BACLOFEN	28	PMS-GALANTAMINE ER	23	PMS-OXYBUTYNIN	136
PMS-BENZTROPINE	89	PMS-GEMFIBROZIL	35	PMS-OXYCODONE	64
PMS-BETAHISTINE	141	PMS-GENTAMICIN SULFATE	103	PMS-PAMIDRONATE	144
PMS-BEZAFIBRATE	35	PMS-GLYBURIDE	125	PMS-PANTOPRAZOLE	114
PMS-BICALUTAMIDE	17	PMS-HALOPERIDOL	78	PMS-PAROXETINE	75
PMS-BISACODYL	109	PMS-HYDROCHLOROTHIAZIDE	98	PMS-PHOSPHATES	110
PMS-BISOPROLOL	41	PMS-HYDROMORPHONE	62	PMS-PINDOLOL	43
PMS-BOSENTAN	40	PMS-IBUPROFEN	58	PMS-PIOGLITAZONE	125
PMS-BRIMONIDINE	105	PMS-IMATINIB	19	PMS-POLYTRIMETHOPRIM	103
PMS-BROMOCRIPTINE	89	PMS-INDAPAMIDE	99	PMS-POTASSIUM	97
PMS-BUPRENORPHINE-NALOXONE	64	PMS-IPRATROPIUM	24	PMS-PRAMIPEXOLE	90
PMS-BUPROPION SR	71	PMS-IRBESARTAN	51	PMS-PRAVASTATIN	36
PMS-BUSPIRONE	87	PMS-IRBESARTAN-HCTZ	51	PMS-PREDNISOLONE	119
PMS-CANDESARTAN	50	PMS-ISMN	39	PMS-PREGABALIN	69
PMS-CANDESARTAN HCTZ	50	PMS-ISOSORBIDE	39	PMS-PROCHLORPERAZINE	80
PMS-CAPTOPRIL	46	PMS-KETOPROFEN	58	PMS-PROPAFENONE	34
PMS-CARBAMAZEPINE	66	PMS-LACTULOSE	96	PMS-PROPRANOLOL	43
PMS-CARVEDILOL	42	PMS-LAMOTRIGINE	68	PMS-QUETIAPINE	80
PMS-CELECOXIB	56	PMS-LANSOPRAZOLE	113	PMS-QUINAPRIL	48
PMS-CEPHALEXIN	3	PMS-LATANOPROST	106	PMS-RABEPRAZOLE	114
PMS-CETIRIZINE	1	PMS-LATANOPROST-TIMOLOL	107	PMS-RALOXIFENE	121
PMS-CILAZAPRIL	46	PMS-LEFLUNOMIDE	146	PMS-RAMIPRIL	48
PMS-CIMETIDINE	112	PMS-LETROZOLE	19	PMS-RAMIPRIL-HCTZ	49
PMS-CIPROFLOXACIN	6	PMS-LEVETIRACETAM	68	PMS-RANITIDINE	112
PMS-CITALOPRAM	72	PMS-LEVOCARB	89	PMS-REPAGLINIDE	124
PMS-CLARITHROMYCIN	4	PMS-LEVOFLOXACIN	6	PMS-RISEDRONATE	144
PMS-CLOBAZAM	66	PMS-LIDOCAINE VISCOUS	128	PMS-RISPERIDONE	81
PMS-CLOBETASOL	131	PMS-LISINOPRIL	47	PMS-RISPERIDONE ODT	82
PMS-CLONAZEPAM	66	PMS-LITHIUM CARBONATE	87	PMS-RIVASTIGMINE	23
PMS-CLONAZEPAM-R	66	PMS-LITHIUM CITRATE	87	PMS-RIZATRIPTAN RDT	87
PMS-CLOPIDOGREL	32	PMS-LOPERAMIDE	109	PMS-ROPINIROLE	90
PMS-CODEINE	60	PMS-LORAZEPAM	86	PMS-ROSUVASTATIN	37
PMS-COLCHICINE	143	PMS-LOSARTAN	52	PMS-SALBUTAMOL	26
PMS-CYCLOBENZAPRINE	27	PMS-LOSARTAN-HCTZ	52	PMS-SENNOSIDES	110
PMS-DESMOPRESSIN	126	PMS-LOVASTATIN	36	PMS-SERTRALINE	75
PMS-DEXAMETHASONE	104	PMS-MELOXICAM	58	PMS-SILDENAFIL R	39
PMS-DIAZEPAM	85	PMS-METFORMIN	122	PMS-SIMVASTATIN	37
PMS-DICLOFENAC	57	PMS-METHOTREXATE	19	PMS-SODIUM CROMOGLYCAT	101
PMS-DILTIAZEM CD	45	PMS-METHOTRIMEPRAZINE	78	PMS-SOLIFENACIN	136
PMS-DIMENHYDRINATE	111	PMS-METHYLPHENIDATE	84	PMS-SOTALOL	43
PMS-DIPHENHYDRAMINE	1	PMS-METHYLPHENIDATE ER	84	PMS-SULFASALAZINE	7
PMS-DIVALPROEX	71	PMS-METOPROLOL-B	42	PMS-SUMATRIPTAN	88
PMS-DOMPERIDONE	114	PMS-METOPROLOL-L	42	PMS-TELMISARTAN	53
PMS-DONEPEZIL	22	PMS-METRONIDAZOLE	16	PMS-TELMISARTAN-HCTZ	53
PMS-DORZOLAMIDE-TIMOLOL	106	PMS-MINOCYCLINE	7	PMS-TERAZOSIN	40
PMS-DOXAZOSIN	40	PMS-MIRTAZAPINE	74	PMS-TERBINAFINE	8

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PMS-TESTOSTERONE	119	PRAVASTATIN	36	<b>PROCYCLIDINE HYDROCHLORIDE</b>	<b>89</b>
PMS-TETRABENAZINE	92	<b>PRAVASTATIN SODIUM</b>	<b>36</b>	PROCYTOX	18
PMS-TIAPROFENIC	59	PRAVASTATIN-10	36	PRO-DEXAMETHASONE	118
PMS-TIMOLOL	106	PRAVASTATIN-20	36	PRO-ENALAPRIL	47
PMS-TOPIRAMATE	70	PRAVASTATIN-40	36	PRO-FENO-SUPER	35
PMS-TRAZODONE	76	PRAXIS ASA DAILY LOW DOSE	56	PRO-FLUCONAZOLE	8
PMS-TRIHENXYPHENIDYL	89	<b>PRAZOSIN HYDROCHLORIDE</b>	<b>40</b>	PRO-FLUOXETINE	74
PMS-URSODIOL	110	PRECISION XTRA	94	PRO-GABAPENTIN	67
PMS-VALACYCLOVIR	13	PRED FORTE	104	<b>PROGESTERONE</b>	<b>126</b>
PMS-VALPROIC ACID	71	PRED MILD	104	PRO-GLYBURIDE	125
PMS-VALSARTAN	53	<b>PREDNISOLONE ACETATE</b>	<b>104</b>	PROGLYCEM	38
PMS-VANCOMYCIN	8	<b>PREDNISOLONE ACETATE, SULFACETAMIDE SODIUM</b>	<b>104</b>	PROGRAF	147
PMS-VENLAFAXINE XR	76	<b>PREDNISOLONE SODIUM PHOSPHATE</b>	<b>104</b>	PRO-HYDROXYQUINE	15
PMS-VERAPAMIL SR	46	PREDNISOLONE/SULFACETAMIDE	104	PRO-INDAPAMIDE	99
PMS-ZOLMITRIPTAN	88	<b>PREDNISONE</b>	<b>119</b>	PRO-ISMN	39
PMS-ZOLMITRIPTAN ODT	88	PREDNISONE	119	PRO-K 20	97
POCKET CHAMBER	149	PREDNISONE ORAL LIQUID	119	PRO-LEVETIRACETAM	69
POCKET CHAMBER WITH ADULT MASK	149	<b>PREGABALIN</b>	<b>69</b>	PRO-LEVOCARB	89
POCKET CHAMBER WITH INFANT MASK	149	PREGABALIN	69	PROLIA	144
POCKET CHAMBER WITH MEDIUM MASK	149	PREMARIN	120	PRO-LISINOPRIL	47
POCKET CHAMBER WITH SMALL MASK	149	PREPLUS	121	PROLOPA	89
PODOFILM	135	PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	140	PRO-LORAZEPAM	86
<b>PODOFILOX</b>	<b>135</b>	PREVACID	113	PRO-LOVASTATIN	36
<b>PODOPHYLLIN</b>	<b>135</b>	PREVACID FASTAB	113	PRO-METFORMIN	122
PODS	149	PREVEX	133	PROMETRIUM	126
<b>POLISTES SPP VENOM PROTEIN EXTRACT</b>	<b>142</b>	PREVEX B	131	PRO-MIRTAZAPINE	74
<b>POLLEN</b>	<b>142</b>	PREVEX HC	132	PRO-NAPROXEN	59
<b>POLLEN AND NON POLLEN</b>	<b>142</b>	PREZCOBIX	10	PROPADERM	131
POLLINEX R	142	PREZISTA	10	PROPAFENONE	34
POLYETHYLENE GLYCOL	109	PRIMAQUINE	15	<b>PROPAFENONE HYDROCHLORIDE</b>	<b>34</b>
<b>POLYETHYLENE GLYCOL 3350</b>	<b>109</b>	<b>PRIMAQUINE PHOSPHATE</b>	<b>15</b>	PRO-PIOGLITAZONE	125
POLYETHYLENE GLYCOL 3350	109	<b>PRIMIDONE</b>	<b>65</b>	<b>PROPRANOLOL HYDROCHLORIDE</b>	<b>43</b>
<b>POLYETHYLENE GLYCOL 3350, SODIUM SULFATE, SODIUM BICARBONATE, SODIUM CHLORIDE, POTASSIUM CHLORIDE</b>	<b>110</b>	PRIMIDONE	65	PROPRANOLOL ORAL LIQUID	43
<b>POLYETHYLENE GLYCOL 3350, SODIUM SULFATE, SODIUM BICARBONATE, SODIUM CHLORIDE, POTASSIUM CHLORIDE, BISACODYL</b>	<b>110</b>	PRINIVIL	47	<b>PROPYLTHIOURACIL</b>	<b>127</b>
<b>POLYMYXIN B SULFATE, BACITRACIN ZINC</b>	<b>103</b>	PRIVA-CELECOXIB	56	PROPYL-THYRACIL	127
<b>POLYMYXIN B SULFATE, GRAMICIDIN</b>	<b>103</b>	PRIVA-CETIRIZINE	1	PRO-QUETIAPINE	80
<b>POLYMYXIN B SULFATE, TRIMETHOPRIM SULFATE</b>	<b>103</b>	PRIVA-ESCITALOPRAM	73	PRO-RABEPRAZOLE	114
<b>POLYSACCHARIDE IRON COMPLEX</b>	<b>30</b>	PRIVA-EZETIMIBE	34	PRO-RAMIPRIL	48
POLYSPORIN	103	PRIVA-FLUCONAZOLE	8	PRO-RISPERIDONE	81
POLYSPORIN ANTIBIOTIC	129	PRIVA-PANTOPRAZOLE	114	PROSCAR	143
POLYSPORIN EYE AND EAR	103	PRIVA-VALACYCLOVIR	13	PRO-SOTALOL	43
POLYTOPIC	129	PRO AMOX	4	PROSTIGMIN	23
POLYTRIM	103	PRO-AAS	56	PROTOPIC	135
<b>POLYVINYL ALCOHOL</b>	<b>107</b>	PRO-AMIODARONE	34	PRO-TOPIRAMATE	70
<b>PONATINIB HYDROCHLORIDE</b>	<b>20</b>	PRO-AMOX	4	PRO-TRIAZIDE	98
PONSTAN	58	PRO-AZITHROMYCINE	3	PROTRIN DF	7
PORTIA 21	120	PRO-BICALUTAMIDE	17	PRO-VALACYCLOVIR	13
PORTIA 28	120	PRO-BISOPROLOL	41	PROVERA	126
<b>POTASSIUM CHLORIDE</b>	<b>97</b>	<b>PROCAINAMIDE HYDROCHLORIDE</b>	<b>34</b>	PRO-VERAPAMIL SR	46
<b>POVIDONE-IODINE</b>	<b>130</b>	PROCAN SR	34	PROZAC	74
PRADAXA	31	<b>PROCARBAZINE HYDROCHLORIDE</b>	<b>20</b>	<b>PSYLLIUM MUCILLOID</b>	<b>110</b>
PRAMIPEXOLE	90	PRO-CEFADROXIL	2	PULMICORT NEBUAMP	118
<b>PRAMIPEXOLE DIHYDROCHLORIDE</b>	<b>90</b>	PRO-CEFUROXIM	3	PULMICORT TURBUHALER	118
PRAVACHOL	36	PROCET-30	60	PULMOPHYLLINE	137
		PROCHLORAZINE	80	PURG-ODAN	109
		<b>PROCHLORPERAZINE</b>	<b>80</b>	PURINETHOL	19
		<b>PROCHLORPERAZINE MALEATE</b>	<b>80</b>	<b>PYRANTEL PAMOATE</b>	<b>2</b>
		<b>PROCHLORPERAZINE MESYLATE</b>	<b>80</b>	<b>PYRAZINAMIDE</b>	<b>9</b>
		PRO-CIPROFLOXACIN	6	<b>PYRIDOSTIGMINE BROMIDE</b>	<b>23</b>
		PRO-CLONAZEPAM	66	<b>PYRIDOXINE HYDROCHLORIDE</b>	<b>138</b>
		PROCTODAN-HC	132	QUETIAPINE	80
		PROCTOL	132	<b>QUETIAPINE FUMARATE</b>	<b>80</b>
		PROCTOSEDYL	132	QUETIAPINE XR	81
				QUICK-SET 6MMX18	149

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QUICK-SET 6MMX23 TUBING	150	RAN-NABILONE	112	RATIO-METFORMIN	122
QUICK-SET 6MMX32	150	RAN-OLANZAPINE	78	RATIO-METHOTREXATE	20
QUICK-SET 6MMX43 TUBING	150	RAN-OLANZAPINE ODT	79	RATIO-MOMETASONE	133
QUICK-SET 9MMX23 TUBING	150	RAN-OMEPRAZOLE	113	RATIO-MORPHINE	62
QUICK-SET 9MMX32	150	RAN-ONDANSETRON	111	RATIO-NYSTATIN	9
QUICK-SET 9MMX43 TUBING	150	RAN-PANTOPRAZOLE	114	RATIO-OMEPRAZOLE	114
<b>QUINAPRIL</b>	<b>48</b>	RAN-PIOGLITAZONE	125	RATIO-OXYCODAN	60
QUINAPRIL	48	RAN-PRAVASTATIN	36	RATIO-PREDNISOLONE	104
<b>QUINAPRIL, HYDROCHLOROTHIAZIDE</b>	<b>48</b>	RAN-PREGABALIN	69	RATIO-PROCTOSONE	132
QVAR	118	RAN-QUETIAPINE	80	RATIO-RIVASTIGMINE	23
R & C SHAMPOO WITH CONDITIONER	130	RAN-RABEPRAZOLE	114	RATIO-SALBUTAMOL	26
RABEPRAZOLE	114	RAN-RAMIPRIL	48	RATIO-SILDENAFIL R	39
RABEPRAZOLE EC	114	RAN-RANITIDINE	112	RATIO-SOTALOL	43
<b>RABEPRAZOLE SODIUM</b>	<b>114</b>	RAN-RISPERIDONE	81	RATIO-TAMSULOSIN	27
RALOXIFENE	121	RAN-ROPINIROLE	90	RATIO-TOPILENE	131
<b>RALOXIFENE HYDROCHLORIDE</b>	<b>121</b>	RAN-ROSUVASTATIN	37	RATIO-TOPIALIC	131
<b>RALTEGRAVIR POTASSIUM</b>	<b>11</b>	RAN-SERTRALINE	75	RATIO-TOPISONE	131
<b>RAMIPRIL</b>	<b>48</b>	RAN-SIMVASTATIN	37	RATIO-TRAZODONE	76
RAMIPRIL	48	RAN-SOLIFENACIN	136	REACTIVE	1
<b>RAMIPRIL, HYDROCHLOROTHIAZIDE</b>	<b>49</b>	RAN-TOPIRAMATE	70	RECLIPSEN 21	119
RAMIPRIL-10	49	RAN-VALSARTAN	53	RECLIPSEN 28	119
RAMIPRIL-2.5	49	RAN-VENLAFAXINE XR	76	REDDY-ATORVASTATIN	35
RAMIPRIL-5	49	RAPAMUNE	147	REFRESH CELLUVISC	107
RAMIPRIL-HCTZ	49	RAPID-D 10MM/110CM	150	REFRESH LACRI-LUBE	107
RAN-ALENDRONATE	143	RAPID-D 10MM/60CM	150	REFRESH LIQUIGEL	107
RAN-AMLODIPINE	43	RAPID-D 10MM/80CM	150	REFRESH PLUS	107
RAN-ANASTROZOLE	17	RAPID-D 6MM/110CM	150	REFRESH TEARS	107
RAN-ATENOLOL	41	RAPID-D 6MM/60CM	150	RELAXA	109
RAN-ATORVASTATIN	35	RAPID-D 6MM/80CM	150	REMERON	74
RAN-BICALUTAMIDE	17	RAPID-D 8MM/110CM	150	REMERON RD	74
RAN-CANDESARTAN	50	RAPID-D 8MM/60CM	150	REMICADE	146
RAN-CARVEDILOL	42	RAPID-D 8MM/80CM	150	RENAGEL	98
RAN-CEFPROZIL	2	RATIO-ACLAVULANATE	5	REPAGLINIDE	124
RAN-CELECOXIB	56	RATIO-ACYCLOVIR	12	<b>REPAGLINIDE</b>	<b>124</b>
RAN-CIPROFLOX	6	RATIO-AMCINONIDE	130	REQUIP	90
RAN-CITALO	72	RATIO-ATENOLOL	41	RESERVOIR PARADIGM 5X1.8ML	150
RAN-CLARITHROMYCIN	4	RATIO-ATORVASTATIN	35	RESERVOIR PARADIGM 7X3.0ML	150
RAN-CLOPIDOGREL	32	RATIO-BACLOFEN	28	RESONIUM CALCIUM	97
RAN-CYPROTERONE/ETHINYL ESTRADIOL	147	RATIO-BISACODYL	109	RESOURCE THICKEN CLEAR	154
RAN-DOMPERIDONE	114	RATIO-BRIMONIDINE	105	RESPICHAMBER SILICONE MEDIUM MASK	149
RAN-DONEPEZIL	22	RATIO-BUPROPION	71	RESPICHAMBER SILICONE SMALL MASK	149
RAN-DULOXETINE	73	RATIO-CARVEDILOL	42	RESPICHAMBER VHC W MOUTHPIECE	149
RAN-ENALAPRIL	47	RATIO-CEFUROXIME	3	RESTORALAX	109
RAN-ESCITALOPRAM	73	RATIO-CIPROFLOXACIN	6	RESTORIL	86
RAN-EZETIMIBE	34	RATIO-CLOBETASOL	131	RESULTZ	130
RAN-FENTANYL MATRIX	61	RATIO-CODEINE	60	RETIN-A	133
RAN-FINASTERIDE	143	RATIO-DEXAMETHASONE	118	RETROVIR	11
RAN-FLUOXETINE	74	RATIO-DOMPERIDONE	114	REVATIO	39
RAN-FOSINOPRIL	47	RATIO-ECTOSONE	131	REVIA	65
RAN-GABAPENTIN	67	RATIO-FENOFIBRATE	35	REVLIMID	19
RAN-GLICLAZIDE	125	RATIO-FINASTERIDE	143	REYATAZ	9
<b>RANIBIZUMAB</b>	<b>107</b>	RATIO-FLUTICASONE	104	RHINARIS NASAL	107
RAN-IRBESARTAN	51	RATIO-FLUVOXAMINE	74	RHINARIS NASAL MIST	107
RAN-IRBESARTAN HCTZ	51	RATIO-HEMCORT-HC	132	RHINARIS-CS	101
RANITIDINE	112	RATIO-INDOMETHACIN	58	RHINOCORT AQUA	104
<b>RANITIDINE HYDROCHLORIDE</b>	<b>112</b>	RATIO-IPRA SAL	24	RHINOCORT TURBUHALER	104
RAN-LANSOPRAZOLE	113	RATIO-IPRATROPIUM	24	RHO-NITRO PUMPSPRAY	39
RAN-LETROZOLE	19	RATIO-IPRATROPIUM UDV	24	<b>RIBAVIRIN</b>	<b>14</b>
RAN-LEVETIRACETAM	68	RATIO-IRBESARTAN	51	RIDAURA	116
RAN-LISINAPRIL	47	RATIO-IRBESARTAN HCTZ	51	<b>RIFABUTIN</b>	<b>9</b>
RAN-LOSARTAN	52	RATIO-LACTULOSE	96	RIFADIN	9
RAN-METFORMIN	122	RATIO-LENOLTEC NO 2	59	<b>RIFAMPIN</b>	<b>9</b>
RAN-MONTELUKAST	101	RATIO-LENOLTEC NO 3	59	RIFAMPIN ORAL LIQUID	9
		RATIO-LEVOBUNOLOL	106		

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<b>RIFAXIMIN</b>	<b>8</b>	RIVA-MIRTAZAPINE	74	SALICYLIC ACID IN CORTICOSTEROID CREAM	131
<b>RILPIVIRINE HYDROCHLORIDE</b>	<b>11</b>	RIVA-MONTELUKAST	101	SALICYLIC ACID IN NON-MEDICATED OINTMENT	131
RISEDRONATE	144	RIVA-MOXIFLOXACIN	6	<b>SALICYLIC ACID-LACTIC ACID</b>	<b>134</b>
<b>RISEDRONATE SODIUM</b>	<b>144</b>	RIVANASE AQ	104	SALINE FROM OTRIVIN	107
RISEDRONATE-35	144	RIVA-OLANZAPINE	78	SALINEX	107
RISPERDAL	81	RIVA-OMEPRAZOLE DR	114	<b>SALMETEROL XINAFOATE</b>	<b>26</b>
RISPERDAL CONSTA	82	RIVA-OXYBUTYNIN	136	<b>SALMETEROL XINAFOATE, FLUTICASONE PROPIONATE</b>	<b>27</b>
<b>RISPERIDONE</b>	<b>81</b>	RIVA-PANTOPRAZOLE	114	SALOFALK	115
RISPERIDONE	81	RIVA-PAROXETINE	75	SANDOMIGRAN	88
<b>RISPERIDONE (CONSTA)</b>	<b>82</b>	RIVA-PRAVASTATIN	36	SANDOMIGRAN DS	89
<b>RITONAVIR</b>	<b>11</b>	RIVA-PREGABALIN	69	SANDOSTATIN	141
RITUXAN	20	RIVA-QUETIAPINE	80	SANDOSTATIN LAR	141
<b>RITUXIMAB</b>	<b>20</b>	RIVA-RABEPRAZOLE	114	SANDOZ ALENDRONATE	143
RIVA OXAZEPAM	86	RIVA-RABEPRAZOLE EC	114	SANDOZ	144
RIVA SENNA	110	RIVA-RANITIDINE	112	ALENDRONATE/CHOLECALCIFEROL	
RIVA-ALENDRONATE	144	RIVA-RISEDRONATE	144	SANDOZ ALFUZOSIN	27
RIVA-ALPRAZOLAM	84	RIVA-RISPERIDONE	81	SANDOZ ALMOTRIPTAN	87
RIVA-AMIODARONE	34	RIVA-RIZATRIPTAN ODT	87	SANDOZ AMIODARONE	34
RIVA-AMLODIPINE	43	RIVA-ROSUVASTATIN	37	SANDOZ AMLODIPINE	43
RIVA-ANASTROZOLE	17	<b>RIVAROXABAN</b>	<b>32</b>	SANDOZ ANAGRELIDE	32
RIVA-ATENOLOL	41	RIVASA	56	SANDOZ ANASTROZOLE	17
RIVA-ATOMOXETINE	91	RIVASA EC	56	SANDOZ ANUZINC HC	132
RIVA-ATORVASTATIN	35	RIVA-SERTRALINE	75	SANDOZ ANUZINC HC PLUS	133
RIVA-AZITHROMYCIN	4	RIVA-SIMVASTATIN	37	SANDOZ ATOMOXETINE	91
RIVA-BACLOFEN	28	RIVASOL-HC	132	SANDOZ ATORVASTATIN	35
RIVA-CAL D	96	RIVASONE	131	SANDOZ AZITHROMYCIN	3
RIVA-CANDESARTAN	50	RIVASTIGMINE	23	SANDOZ BICALUTAMIDE	17
RIVA-CELECOX	56	<b>RIVASTIGMINE HYDROGEN TARTRATE</b>	<b>23</b>	SANDOZ BISOPROLOL	41
RIVA-CIPROFLOXACIN	6	RIVA-TERBINAFINE	8	SANDOZ BOSENTAN	40
RIVA-CITALOPRAM	72	RIVA-VALACYCLOVIR	13	SANDOZ BRIMONIDINE	105
RIVA-CLARITHROMYCIN	4	RIVA-VALSARTAN	53	SANDOZ BUPROPION SR	71
RIVA-CLONAZEPAM	66	RIVA-VENLAFAXINE XR	46	SANDOZ CANDESARTAN	50
RIVA-CLOPIDOGREL	32	RIVA-VERAPAMIL SR	46	SANDOZ CANDESARTAN PLUS	50
RIVACOET	60	RIVA-ZOLMITRIPTAN	88	SANDOZ CAPECITABINE	17
RIVA-CYCLOBENZAPRINE	27	RIVOTRIL	66	SANDOZ CEFPROZIL	2
RIVA-CYPROTERONE	147	<b>RIZATRIPTAN BENZOATE</b>	<b>87</b>	SANDOZ CELECOXIB	56
RIVA-D	139	RIZATRIPTAN ODT	87	SANDOZ CIPROFLOXACIN	6
RIVA-DONEPEZIL	22	RIZATRIPTAN RDT	87	SANDOZ CITALOPRAM	72
RIVA-DORZOLAMIDE	106	ROCALTROL	139	SANDOZ CLARITHROMYCIN	4
RIVA-DORZOLAMIDE/TIMOLOL	106	ROFACT	9	SANDOZ CLONAZEPAM	66
RIVA-DULOXETINE	73	ROLENE	131	SANDOZ CLOPIDOGREL	32
RIVA-DUTASTERIDE	142	ROPINIROLE	90	SANDOZ CYCLOSPORINE	146
RIVA-ENALAPRIL	47	<b>ROPINIROLE HYDROCHLORIDE</b>	<b>90</b>	SANDOZ DICLOFENAC MISOPROSTOL	58
RIVA-ESCITALOPRAM	73	<b>ROSIGLITAZONE MALEATE</b>	<b>125</b>	SANDOZ DICLOFENAC OPHTHA	105
RIVA-EZETIMIBE	34	ROSONE	131	SANDOZ DILTIAZEM CD	45
RIVA-FINASTERIDE	143	ROSUVASTATIN	37	SANDOZ DILTIAZEM T	45
RIVA-FLUCONAZOLE	8	<b>ROSUVASTATIN CALCIUM</b>	<b>36</b>	SANDOZ DIMENHYDRINATE	111
RIVA-FLUVOX	74	ROSUVASTATIN-10	37	SANDOZ DONEPEZIL	22
RIVA-GABAPENTIN	67	ROSUVASTATIN-20	37	SANDOZ DORZOLAMIDE	106
RIVA-GLYBURIDE	125	ROSUVASTATIN-40	37	SANDOZ DORZOLAMIDE/TIMOLOL	106
RIVA-HC	132	ROSUVASTATIN-5	37	SANDOZ DULOXETINE	73
RIVA-INDAPAMIDE	99	ROUGIER-MAGNESIUM	97	SANDOZ DUTASTERIDE	143
RIVA-IRBESARTAN	51	<b>RUFINAMIDE</b>	<b>70</b>	SANDOZ ENALAPRIL	47
RIVA-K 20	97	RUGBY NICOTINE POLACRILEX GUM	28	SANDOZ ENTACAPONE	89
RIVA-K 8	97	RYTHMODAN	34	SANDOZ ESCITALOPRAM	73
RIVA-LANSOPRAZOLE	113	RYTHMOL	34	SANDOZ ESTRADIOL DERM	121
RIVA-LATANOPROST	106	S.O.S NALOXONE HYDROCHLORIDE	65	SANDOZ EZETIMIBE	34
RIVA-LATANOPROST/TIMOLOL	107	SABRIL	71	SANDOZ FAMCICLOVIR	12
RIVA-LETROZOLE	19	SALAGEN	23	SANDOZ FELODIPINE	44
RIVA-LISINAPRIL	47	SALAZOPYRIN	7	SANDOZ FENOFIBRATE E	35
RIVA-LOPERAMIDE	109	SALAZOPYRIN EN	7	SANDOZ FENOFIBRATE S	35
RIVA-LOVASTATIN	36	SALBUTAMOL HFA	26	SANDOZ FENTANYL	61
RIVA-METFORMIN	122	<b>SALBUTAMOL SULFATE</b>	<b>26</b>		
RIVA-METOPROLOL L	42	<b>SALICYLIC ACID</b>	<b>134</b>		

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SANDOZ FINASTERIDE	143	SANDOZ SOLIFENACIN	136	SEREVENT DISKUS	26
SANDOZ FLUOROMETHOLONE	104	SANDOZ SUMATRIPTAN	88	SEROQUEL	80
SANDOZ FLUVASTATIN	36	SANDOZ TACROLIMUS	147	SEROQUEL XR	81
SANDOZ FLUVOXAMINE	74	SANDOZ TAMSULOSIN	27	SERTRALINE	75
SANDOZ GLICLAZIDE MR	124	SANDOZ TELMISARTAN	53	<b>SERTRALINE HYDROCHLORIDE</b>	<b>75</b>
SANDOZ INDOMETHACIN	58	SANDOZ TELMISARTAN HCT	53	SERTRALINE-100	76
SANDOZ IRBESARTAN	51	SANDOZ TIMOLOL	106	SERTRALINE-25	75
SANDOZ IRBESARTAN HCT	51	SANDOZ TOBRAMYCIN	104	SERTRALINE-50	76
SANDOZ LANSOPRAZOLE	113	SANDOZ TOLTERODINE LA	136	<b>SEVELAMER HYDROCHLORIDE</b>	<b>98</b>
SANDOZ LATANOPROST	107	SANDOZ TOPIRAMATE	70	<b>SHARPS CONTAINER</b>	<b>152</b>
SANDOZ LATANOPROST/TIMOLOL	107	SANDOZ TRAVOPROST	107	SHARPS NESTABLE YELLOW LARGE 22.7L	152
SANDOZ LEFLUNOMIDE	146	SANDOZ TRAVOPROST / TIMOLOL PQ	107	SIALOR	107
SANDOZ LETROZOLE	19	SANDOZ VALACYCLOVIR	13	SIDEKICK	94
SANDOZ LEVOFLOXACIN	6	SANDOZ VALPROIC	71	<b>SILDENAFIL CITRATE</b>	<b>39</b>
SANDOZ LINEZOLID	8	SANDOZ VALSARTAN	53	<b>SILVER SULFADIAZINE</b>	<b>130</b>
SANDOZ LISINAPRIL	47	SANDOZ VALSARTAN HCT	54	SIMBRINZA	106
SANDOZ LISINAPRIL HCT	48	SANDOZ VENLAFAXINE XR	76	<b>SIMEPREVIR SODIUM</b>	<b>14</b>
SANDOZ LOSARTAN	52	SANDOZ VORICONAZOLE	9	SIMPONI	145
SANDOZ LOSARTAN HCT	52	SANDOZ ZOLMITRIPTAN	88	<b>SIMVASTATIN</b>	<b>37</b>
SANDOZ LOVASTATIN	36	SANDOZ ZOLMITRIPTAN ODT	88	SIMVASTATIN	37
SANDOZ METFORMIN	122	SANDOZ-CARBAMAZEPINE	67	SIMVASTATIN-10	38
SANDOZ METFORMIN FC	122	SANDOZ-DICLOFENAC	57	SIMVASTATIN-20	38
SANDOZ METHYLPHENIDATE SR	84	SANDOZ-DICLOFENAC SR	57	SIMVASTATIN-40	38
SANDOZ METOPROLOL (TYPE L)	42	SANDOZ-FELODIPINE	44	SIMVASTATIN-80	38
SANDOZ METOPROLOL SR	42	SANTYL	134	SINEMET	89
SANDOZ MINOCYCLINE	7	SAPHRIS	77	SINEQUAN	73
SANDOZ MIRTAZAPINE	74	<b>SAQUINAVIR MESYLATE</b>	<b>11</b>	SINGULAIR	100
SANDOZ MOMETASONE	104	SARNA HC	132	SINTRON	30
SANDOZ MONTELUKAST	100	<b>SAXAGLIPTIN HYDROCHLORIDE</b>	<b>122</b>	<b>SIROLIMUS</b>	<b>147</b>
SANDOZ MORPHINE SR	63	<b>SAXAGLIPTIN HYDROCHLORIDE, METFORMIN HYDROCHLORIDE</b>	<b>122</b>	<b>SITAGLIPTIN PHOSPHATE MONOHYDRATE</b>	<b>122</b>
SANDOZ MOXIFLOXACIN	6	SDZ CELECOXIB	56	<b>SITAGLIPTIN PHOSPHATE MONOHYDRATE, METFORMIN HYDROCHLORIDE</b>	<b>123</b>
SANDOZ MYCOPHENOLATE	146	SEASONALE	119	SKIN PREP ADHESHIVE WIPES	149
SANDOZ NARATRIPTAN	87	SEASONIQUE	120	SLOW-K	97
SANDOZ OFLOXACIN	103	SEBCUR	134	<b>SODIUM AUROTHIOMALATE</b>	<b>116</b>
SANDOZ OLANZAPINE	78	SEBCUR-T	134	SODIUM AUROTHIOMALATE	116
SANDOZ OLANZAPINE ODT	79	SECARIS	107	<b>SODIUM BICARBONATE</b>	<b>96</b>
SANDOZ OLMESARTAN	52	SECTRAL	41	<b>SODIUM CARBOXYMETHYL CELLULOSE</b>	<b>107</b>
SANDOZ OLOPATADINE	103	<b>SECUKINUMAB</b>	<b>135</b>	SODIUM CHLORIDE	97
SANDOZ OMEPRAZOLE	113	SEEBRI BREEZHALER	24	<b>SODIUM CHLORIDE</b>	<b>97</b>
SANDOZ ONDANSETRON	111	SELECT 1/35 (21-DAY)	120	SODIUM CHLORIDE (SMALL VOL.)	97
SANDOZ ONDANSETRON ODT	111	SELECT 1/35 (28-DAY)	120	<b>SODIUM PHOSPHATE</b>	<b>110</b>
SANDOZ OXYCODONE/ACETAMINOPHEN	60	<b>SELEGILINE HYDROCHLORIDE</b>	<b>90</b>	<b>SODIUM POLYSTYRENE SULFONATE</b>	<b>97</b>
SANDOZ PANTOPRAZOLE	114	<b>SELENIUM SULFIDE</b>	<b>130</b>	<b>SOFOSBUVIR</b>	<b>15</b>
SANDOZ PAROXETINE	75	SENNA	110	<b>SOFOSBUVIR, LEDIPASVIR</b>	<b>15</b>
SANDOZ PIOGLITAZONE	125	SENNA LAXATIVE	110	<b>SOFOSBUVIR, VELPATASVIR</b>	<b>15</b>
SANDOZ POLYTRIMETHOPRIM	103	SENNA SENNOSIDES	110	SOFRACORT EAR/EYE	104
SANDOZ PRAMIPEXOLE	90	SENNALAX	110	SOFRAMYCIN EYE	103
SANDOZ PREDNISOLONE	104	SENNAPREP	110	SOFRAMYCIN STERILE EYE	103
SANDOZ PREGABALIN	69	<b>SENNOSIDES</b>	<b>110</b>	SOLIFENACIN	136
SANDOZ PROCHLORPERAZINE	80	SENNOSIDES	110	<b>SOLIFENACIN SUCCINATE</b>	<b>136</b>
SANDOZ PROCTOMYXIN HC	132	SENOKOT	110	SOLUCAL	96
SANDOZ QUETIAPINE	80	SEPTA DONEPEZIL	22	SOLUCAL D	96
SANDOZ QUETIAPINE XRT	81	SEPTA-AMLODIPINE	43	SOLUCAL D CITRUS	96
SANDOZ RABEPRAZOLE	114	SEPTA-ATENOLOL	41	SOLUCAL D FORT	96
SANDOZ RAMIPRIL	49	SEPTA-CIPROFLOXACIN	6	SOLUCAL D FORT CITRUS	96
SANDOZ RANITIDINE	112	SEPTA-CITALOPRAM	72	SOLUCAL D FORT GREEN APPLE	96
SANDOZ REPAGLINIDE	124	SEPTA-LOSARTAN	52	SOLUCAL D RASPBERRY	96
SANDOZ RISEDRONATE	144	SEPTA-LOSARTAN HCTZ	52	SOLUCAL GREEN APPLE	96
SANDOZ RISPERIDONE	81	SEPTA-METFORMIN	122	SOLUCAL RASPBERRY	96
SANDOZ RIVASTIGMINE	23	SEPTA-ONDANSETRON	111	SOLUVER	134
SANDOZ RIZATRIPTAN ODT	87	SEPTA-ZOLMITRIPTAN-ODT	88		
SANDOZ ROSUVASTATIN	37	SERC	92		
SANDOZ SERTRALINE	75	SEREVENT DISKHALER	26		
SANDOZ SIMVASTATIN	37				

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SOLUVER PLUS	134	SURE STEP	94	TARO-SUMATRIPTAN	88
SOLYSTAT	97	SURECOMFORT 1/2 IN 28GX0.5CC	152	TARO-TEMOZOLOMIDE	21
SOMATULINE AUTOGEL	147	SURECOMFORT 1/2 IN 28GX1CC	152	TARO-TERCONAZOLE	130
SOOTHE NIGHT TIME	107	SYRINGE		TARO-TESTOSTERONE	119
<b>SORBITOL, SODIUM CITRATE, SODIUM LAURYL SULFOACETATE</b>	<b>110</b>	SURECOMFORT 1/2 IN 29GX0.3CC	152	TARO-WARFARIN	32
SORIATANE	134	SURECOMFORT 1/2 IN 29GX0.5CC	152	TARO-ZOLEDRONIC ACID	145
SOTALOL	43	SURECOMFORT 1/2 IN 29GX1CC	152	<b>TAZAROTENE</b>	<b>135</b>
<b>SOTALOL HYDROCHLORIDE</b>	<b>43</b>	SURECOMFORT 1/2 IN 30GX0.3CC	152	TAZORAC	135
SOTALOL ORAL LIQUID	43	SURECOMFORT 1/2 IN 30GX0.5CC	152	TEARS NATURALE FREE	107
SOURCE THICKEN UP 227G	154	SURECOMFORT 1/2 IN 30GX1CC	152	TEARS NATURALE II	107
SOVALDI	15	SURECOMFORT 29GX1/2 NEEDLE	151	TEARS PLUS	107
<b>SPACER DEVICE</b>	<b>149</b>	SURECOMFORT 30GX5/16 NEEDLE	151	TEBRAZID	9
SPECTRO ACNECARE WASH	133	SURECOMFORT 31GX3/16 NEEDLE	151	TECTA	114
SPECTRO ECZEMACARE	131	SURECOMFORT 31GX5/16 NEEDLE	151	TEGRETOL	66
SPIRIT TEST STRIP (ON)	94	SURECOMFORT 32GX1/4 NEEDLE	151	TELMISARTAN	53
SPIRIVA	24	SURECOMFORT 32GX5/32 NEEDLE	151	<b>TELMISARTAN</b>	<b>53</b>
SPIRIVA RESPIMAT	24	SURECOMFORT 5/16 IN 30GX0.3CC	152	TELMISARTAN HCTZ	53
<b>SPIRONOLACTONE</b>	<b>54</b>	SURECOMFORT 5/16 IN 30GX0.5CC	152	<b>TELMISARTAN, HYDROCHLOROTHIAZIDE</b>	<b>53</b>
SPIRONOLACTONE ORAL LIQUID	55	SURECOMFORT 5/16 IN 30GX1CC	152	TELMISARTAN/HCTZ	53
<b>SPIRONOLACTONE, HYDROCHLOROTHIAZIDE</b>	<b>99</b>	SURECOMFORT 5/16 IN 31GX0.3CC	152	TELMISARTAN-HCTZ	53
SPORANOX	8	SURECOMFORT 5/16 IN 31GX0.5CC	152	TELZIR	10
STALEVO	89	SURECOMFORT 5/16 IN 31GX1CC	152	<b>TEMAZEPAM</b>	<b>86</b>
STATEX	63	SURETEST (ON)	94	TEMAZEPAM	86
<b>STAVUDINE</b>	<b>11</b>	SUSTIVA	10	TEMODAL	21
STELARA	141	SUTENT	20	<b>TEMOZOLOMIDE</b>	<b>21</b>
STERILE EXTEMPORANEOUS MIXTURE (QC)	141	SYMBICORT 100 TURBUHALER	26	TEMPRA CHILDREN'S	64
STERILE WATER	99	SYMBICORT 200 TURBUHALER	26	TEMPRA CHILDREN'S DOUBLE STRENGTH	64
STEROID AND ANTIFUNGAL CREAM	141	SYNALAR	132	TEMPRA INFANT	64
STIEVA-A	133	SYNAREL	121	TENDER-1 17MM/110CM	150
STRATTERA	91	SYNPHASIC 21	120	TENDER-1 17MM/60CM	150
STRIBILD	11	SYNPHASIC 28	120	TENDER-1 17MM/80CM	150
SUBOXONE	64	SYNTHROID	126	TENDER-1 MINI INF SET 13MM/110CM	150
<b>SUCRALFATE</b>	<b>113</b>	<b>SYRINGE &amp; NEEDLE</b>	<b>152</b>	TENDER-1 MINI INFSET 13MM/60CM	150
SULCRATE	113	<b>SYRINGE CASE</b>	<b>153</b>	TENDER-1 MINI INFSET 13MM/80CM	150
SULCRATE PLUS	113	SYRINGE SCALE MAGNIFIER	151	TENDER-1 MINI INFSET 13MM/80CM	150
SULFACETAMIDE	103	SYSTANE	108	TENDER-1 MINI INFSET 13MM/80CM	150
<b>SULFACETAMIDE SODIUM</b>	<b>103</b>	T/ THERAPEUTIC SHAMPOO EXTRA STRENGTH	134	TENDER-2 17MM/110CM	150
<b>SULFAMETHOXAZOLE</b>	<b>7</b>	<b>TACROLIMUS (PROTOPIC)</b>	<b>135</b>	TENDER-2 17MM/60CM	150
<b>SULFAMETHOXAZOLE, TRIMETHOPRIM</b>	<b>7</b>	<b>TACROLIMUS MONOHYDRATE</b>	<b>147</b>	TENDER-2 17MM/80CM	150
<b>SULFASALAZINE</b>	<b>7</b>	<b>TADALAFIL</b>	<b>39</b>	TENDER-2 MINI INF SET 13MM/110CM	150
SULFINPYRAZONE	99	TAMBOCOR	34	TENDER-2 MINI INFSET 13MM/60CM	150
<b>SULFINPYRAZONE</b>	<b>99</b>	<b>TAMOXIFEN CITRATE</b>	<b>21</b>	TENDER-2 MINI INFSET 13MM/80CM	150
SULFUR IN NON-MEDICATED CREAM	141	TAMSULOSIN	27	<b>TENOFOVIR DISOPROXIL FUMARATE</b>	<b>11</b>
SULFUR IN NON-MEDICATED OINTMENT	141	<b>TAMSULOSIN HYDROCHLORIDE</b>	<b>27</b>	<b>TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE</b>	<b>11</b>
<b>SULINDAC</b>	<b>59</b>	TAPAZOLE	127	<b>TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE, COBICISTAT, ELVITEGRAVIR</b>	<b>11</b>
SUMATRIPTAN	88	TARCEVA	18	<b>TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE, RILPIVIRINE HYDROCHLORIDE</b>	<b>11</b>
SUMATRIPTAN DF	88	TARGEL	134	TENORETIC	41
<b>SUMATRIPTAN HEMISULFATE</b>	<b>88</b>	TARGEL SA	134	TENORMIN	41
<b>SUMATRIPTAN SUCCINATE</b>	<b>88</b>	TARO-AMCINONIDE	130	TERAZOSIN	40
<b>SUNITINIB MALATE</b>	<b>20</b>	TARO-ANASTROZOLE	17	<b>TERAZOSIN HYDROCHLORIDE</b>	<b>40</b>
SUNVEPRA	13	TARO-CARBAMAZEPINE	66	TERBINAFINE	8
SUPER-FINE MICRO 31G-5MM NEEDLE	151	TARO-CIPROFLOXACIN	6	<b>TERBINAFINE HYDROCHLORIDE</b>	<b>8</b>
SUPER-FINE STANDARD 29G-12.7MM	151	TARO-CLARITHROMYCIN	4	<b>TERBUTALINE SULFATE</b>	<b>27</b>
SUPER-FINE XTRA 31G-8MM NEEDLE	151	TARO-CLINDAMYCIN	129	<b>TERCONAZOLE</b>	<b>130</b>
SUPEUDOL	63	TARO-CLINDAMYCIN/BENZOYL PEROXIDE	129	TESTOSTERONE CYPIONATE	119
SUPRAX	2	TARO-CLOBETASOL	131	<b>TESTOSTERONE CYPIONATE</b>	<b>119</b>
SUPREFACT	17	TARO-DICLOFENAC	57	<b>TESTOSTERONE ENANTHATE</b>	<b>119</b>
SUPREFACT (NASAL)	17	TARO-ENALAPRIL	47	<b>TESTOSTERONE UNDECANOATE</b>	<b>119</b>
SUPREFACT DEPOT 2 MONTHS	17	TARO-FLUCONAZOLE	8	TETRABENAZINE	92
SUPREFACT DEPOT 3 MONTHS	17	TARO-MOMETASONE	133	<b>TETRABENAZINE</b>	<b>92</b>
		TARO-MUPIROCIN	129		
		TARO-PHENYTOIN	66		
		TARO-SONE	131		

## Health Canada

## Non-Insured Health Benefits

TETRACYCLINE	7	TEVA-EMTRICITABINE/TENOFOVIR	11	TEVA-MOXIFLOXACIN	6
<b>TETRACYCLINE HYDROCHLORIDE</b>	<b>7</b>	TEVA-ENALAPRIL	47	TEVA-MYCOPHENOLATE	146
TEVA-5 ASA	115	TEVA-ENTACAPONE	89	TEVA-NABILONE	112
TEVA-ABACAVIR/LAMIVUDINE	9	TEVA-ERLOTINIB	18	TEVA-NAPROXEN	59
TEVA-ACEBUTOLOL	41	TEVA-ESCITALOPRAM	73	TEVA-NAPROXEN DS	59
TEVA-ACYCLOVIR	12	TEVA-EXEMESTANE	18	TEVA-NARATRIPTAN	87
TEVA-ALENDRONATE	143	TEVA-EZETIMIBE	34	TEVA-NEVIRAPINE	11
TEVA- ALENDRONATE/CHOLECALCIFEROL	144	TEVA-FAMOTIDINE	112	TEVA-NITROFURANTOIN	16
TEVA-ALFUZOSIN PR	27	TEVA-FENOFIBRATE-S	35	TEVA-NORFLOXACIN	7
TEVA-ALPRAZOLAM	84	TEVA-FENTANYL	61	TEVA-OLANZAPINE	78
TEVA-AMIODARONE	34	TEVA-FINASTERIDE	143	TEVA-OLANZAPINE ODT	79
TEVA-AMITRIPTYLINE	71	TEVA-FLUCONAZOLE	8	TEVA-OMEPRAZOLE	114
TEVA-AMLODIPINE	44	TEVA-FLUOXETINE	74	TEVA-ONDANSETRON	111
TEVA-AMPICILLIN	5	TEVA-FLURBIPROFEN	57	TEVA-OXYBUTYNYNIN	136
TEVA-ANASTROZOLE	17	TEVA-FLUTAMIDE	18	TEVA-OXYCO CET	60
TEVA-ATAZANAVIR	10	TEVA-FLUVASTATIN	36	TEVA-PANTOPRAZOLE	114
TEVA-ATENOLOL	41	TEVA-FOSINOPRIL	47	TEVA-PANTOPRAZOLE MAGNESIUM	114
TEVA-ATENOLOL/CHLOROTHALIDONE	41	TEVA-FUROSEMIDE	98	TEVA-PAROXETINE	75
TEVA-ATOMOXETINE	91	TEVA-GABAPENTIN	67	TEVA-PINDOLOL	43
TEVA-ATORVASTATIN	35	TEVA-GALANTAMINE ER	23	TEVA-PIOGLITAZONE	125
TEVA-AZATHIOPRINE	146	TEVA-GEMFIBROZIL	35	TEVA-PIROXICAM	59
TEVA-AZITHROMYCIN	4	TEVA-GLICLAZIDE	124	TEVA-PRAMIPEXOLE	90
TEVA-BETAHISTINE	91	TEVA-GLYBURIDE	125	TEVA-PRAVASTATIN	36
TEVA-BICALUTAMIDE	17	TEVA-HALOPERIDOL	78	TEVA-PRAZOSIN	40
TEVA-BISOPROLOL	41	TEVA-HYDROCHLOROTHIAZIDE	98	TEVA-PREDNISONE	119
TEVA-BROMAZEPAM	85	TEVA-HYDROMORPHONE	62	TEVA-PREGABALIN	69
TEVA-BUSPIRONE	87	TEVA-IMATINIB	19	TEVA-PROGESTERONE	126
TEVA-CANDESARTAN	50	TEVA-INDAPAMIDE	99	TEVA-PROPRANOLOL	43
TEVA-CANDESARTAN/HCTZ	50	TEVA-INDOMETHACIN	58	TEVA-QUETIAPINE	80
TEVA-CAPECITABINE	17	TEVA-IPRATROPIUM STERINEBS	24	TEVA-QUETIAPINE XR	81
TEVA-CAPTOPRIL	46	TEVA-IRBESARTAN	51	TEVA-RABEPRAZOLE	114
TEVA-CARBAMAZEPINE	66	TEVA-IRBESARTAN/HCTZ	51	TEVA-RALOXIFENE	121
TEVA-CEFADROXIL	2	TEVA-KETOCONAZOLE	9	TEVA-RAMIPRIL	49
TEVA-CELECOXIB	57	TEVA-LACTULOSE	96	TEVA-RANITIDINE	112
TEVA-CEPHALEXIN	3	TEVA-LAMIVUDINE/ZIDOVUDINE	10	TEVA-RISEDRONATE	144
TEVA-CHLOROQUINE	15	TEVA-LAMOTRIGINE	68	TEVA-RISPERIDONE	81
TEVA-CHLORPPROMAZINE	77	TEVA-LANSOPRAZOLE	113	TEVA-RIZATRIPTAN ODT	87
TEVA-CILAZAPRIL	46	TEVA-LEFLUNOMIDE	146	TEVA-ROSUVASTATIN	37
TEVA-CIPROFLOXACIN	6	TEVA-LETOZOLE	19	TEVA-SALBUTAMOL	26
TEVA-CITALOPRAM	72	TEVA-LEVOCARBIDOPA	89	TEVA-SELEGILINE	90
TEVA-CLARITHROMYCIN	4	TEVA-LEVOFLOXACIN	6	TEVA-SERTRALINE	75
TEVA-CLINDAMYCIN	7	TEVA-LISINOPRIL (TYPE P)	47	TEVA-SIMVASTATIN	37
TEVA-CLOBAZAM	66	TEVA-LISINOPRIL (TYPE Z)	47	TEVA-SOLIFENACIN	136
TEVA-CLONAZEPAM	66	TEVA-LISINOPRIL/HCTZ (TYPE P)	48	TEVA-SPIRONOLACTONE	54
TEVA-CLONIDINE	38	TEVA-LISINOPRIL/HCTZ (TYPE Z)	48	TEVA-SPIRONOLACTONE/HCTZ	99
TEVA-CLOPIDOGREL	32	TEVA-LOPERAMIDE	109	TEVA-SUCRALFATE	113
TEVA-CLOXACILLIN	5	TEVA-LORAZEPAM	86	TEVA-SULINDAC	59
TEVA-COMBO STERINEBS	24	TEVA-LOSARTAN	52	TEVA-SUMATRIPTAN	88
TEVA-CYCLOBENZAPRINE	27	TEVA-LOSARTAN/HCTZ	52	TEVA-SUMATRIPTAN DF	88
TEVA-DESMOPRESSIN	126	TEVA-LOVASTATIN	36	TEVA-TAMOXIFEN	21
TEVA-DICLOFENAC	57	TEVA-MAPROTILINE	74	TEVA-TAMSULOSIN	27
TEVA-DICLOFENAC SR	57	TEVA-MEDROXYPROGESTERONE	126	TEVA-TELMISARTAN	53
TEVA-DILTIAZEM	45	TEVA-MELOXICAM	58	TEVA-TELMISARTAN HCTZ	53
TEVA-DILTIAZEM CD	45	TEVA-METFORMIN	122	TEVA-TEMAZEPAM	86
TEVA-DIMENATE	111	TEVA-METHYLPHENIDATE	84	TEVA-TERAZOSIN	40
TEVA-DIVALPROEX	71	TEVA-METOPROLOL	42	TEVA-TERBINAFINE	8
TEVA-DOMPERIDONE	114	TEVA-MEXILETINE	34	TEVA-THEOPHYLLINE	137
TEVA-DONEPEZIL	22	TEVA-MINOCYCLINE	7	TEVA-TIAPROFENIC	59
TEVA-DORZOTIMOL	106	TEVA-MIRTAZAPINE	74	TEVA-TICLOPIDINE	33
TEVA-DOXAZOSIN	40	TEVA-MIRTAZAPINE OD	74	TEVA-TIMOLOL	43
TEVA-DOXYCYCLINE	7	TEVA-MOCLOBEMIDE	75	TEVA-TOLTERODINE	136
TEVA-DUTASTERIDE	143	TEVA-MODAFINIL	84	TEVA-TOLTERODINE LA	136
TEVA-EFAVIRENZ	10	TEVA-MONTELUKAST	101	TEVA-TOPIRAMATE	70
TEVA-EMTEC-30	60	TEVA-MORPHINE SR	63	TEVA-TRAVOPROST Z	107

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**Non-Insured Health Benefits**

TEVA-TRAZODONE	76	TOLOXIN	34	TRUE TRACK	94
TEVA-TRIAMTERENE/HCTZ	98	<b>TOLTERODINE TARTRATE</b>	<b>136</b>	TRUETEST	94
TEVA-TRIMEL	7	TOPAMAX	70	TRUSOPT	106
TEVA-TRIMEL DS	7	TOPICORT	132	TRUVADA	11
TEVA-VALACYCLOVIR	13	TOPICORT MILD	132	TUDORZA GENUAIR	24
TEVA-VALGANICLOVIR	13	<b>TOPIRAMATE</b>	<b>70</b>	TWYNSTA	44
TEVA-VALSARTAN	53	TOPIRAMATE	70	TYLENOL	64
TEVA-VALSARTAN/HCTZ	54	TOPIRAMATE ORAL LIQUID	71	TYLENOL EXTRA STRENGTH	65
TEVA-VENLAFAXINE XR	76	TOVIAZ	136	TYLENOL JR STRENGTH FASTMELTS	64
TEVA-VORICONAZOLE	9	TRACLEER	40	TYLENOL JUNIOR STRENGTH	65
TEVA-ZOLMITRIPTAN	88	TRAJENTA	122	TYLENOL WITH CODEINE NO.2	59
TEVA-ZOLMITRIPTAN OD	88	TRANDATE	42	TYLENOL WITH CODEINE NO.3	59
TEVETEN	50	<b>TRANDOLAPRIL</b>	<b>49</b>	<b>ULIPRISTAL ACETATE</b>	<b>120</b>
TEVETEN PLUS	50	TRANEXAMIC ACID	33	ULORIC	143
THE MAGIC BULLET	109	<b>TRANEXAMIC ACID</b>	<b>33</b>	ULTI SYG 1/2 IN 29GX0.3CC	153
THEO ER	137	TRANEXAMIC DENTAL MOUTHWASH	33	ULTI SYG 1/2 IN 29GX0.5CC	153
THEOLAIR	137	TRANSDERMAL NICOTINE	28	ULTI SYG 1/2 IN 29GX1CC SYRINGE	153
<b>THEOPHYLLINE</b>	<b>137</b>	TRANSDERMAL NICOTINE PATCHDAY	29	ULTI SYG 1/2 IN 30GX0.3CC	153
THEOPHYLLINE	137	TRANSDERMAL-NITRO	39	ULTI SYG 1/2 IN 30GX0.5CC	153
<b>THIAMAZOLE</b>	<b>127</b>	<b>TRANLYCYPROMINE SULFATE</b>	<b>76</b>	ULTI SYG 1/2 IN 30GX1CC SYRINGE	153
THIAMJECT	138	TRAVATAN Z	107	ULTI SYG 5/16 IN 30GX0.3CC	153
THIAMINE	138	TRAVEL	111	ULTI SYG 5/16 IN 30GX0.5CC	153
<b>THIAMINE HYDROCHLORIDE</b>	<b>138</b>	<b>TRAVOPROST</b>	<b>107</b>	ULTI SYG 5/16 IN 30GX1CC SYRINGE	153
<b>THICKENING AGENT</b>	<b>154</b>	TRAZODONE	76	ULTI SYG 5/16 IN 31GX0.3CC	153
<b>THIOGUANINE</b>	<b>21</b>	<b>TRAZODONE HYDROCHLORIDE</b>	<b>76</b>	ULTI SYG 5/16 IN 31GX0.5CC	153
<b>THIOPROPERAZINE MESYLATE</b>	<b>83</b>	TRELSTAR	21	ULTI SYG 5/16 IN 31GX1CC SYRINGE	153
<b>THIOTHIXENE</b>	<b>83</b>	<b>TRETINOIN</b>	<b>21</b>	ULTIBRO BREEZHALER	24
THRIVE NICOTINE LOZENGES	28	TRIADERM	133	ULTICARE 1/2 IN 28GX0.5CC SYRINGE	152
THRIVE NICOTINELL GUM	28	TRIAMCINOLONE	119	ULTICARE 1/2 IN 28GX1CC SYRINGE	152
THYROGEN	94	<b>TRIAMCINOLONE ACETONIDE</b>	<b>104</b>	ULTICARE 29GX0.1CC	153
THYROID	127	<b>TRIAMCINOLONE DIACETATE</b>	<b>119</b>	ULTICARE 29GX0.3CC	153
<b>THYROID</b>	<b>127</b>	<b>TRIAMTERENE,</b>	<b>98</b>	ULTICARE 29GX0.5CC	153
<b>THYROTROPIN ALFA</b>	<b>94</b>	<b>HYDROCHLOROTHIAZIDE</b>		ULTICARE 29GX12MM PEN NEEDLE	151
TIAMOL	132	TRIA TEC-30	60	ULTICARE 30GX0.1CC	153
<b>TIAPROFENIC ACID</b>	<b>59</b>	TRIAZOLAM	86	ULTICARE 30GX0.3CC	153
TIAZAC	45	<b>TRIAZOLAM</b>	<b>86</b>	ULTICARE 30GX0.5CC	153
TIAZAC XC	46	TRICIRA LO 21	120	ULTICARE 31GX6MM PEN NEEDLE	151
<b>TICAGRELOR</b>	<b>33</b>	TRICIRA LO 28	120	ULTICARE 31GX8MM PEN NEEDLE	151
<b>TICLOPIDINE HYDROCHLORIDE</b>	<b>33</b>	TRI-CYCLEN 21-DAY	120	ULTICARE 32GX4MM PEN NEEDLE	151
<b>TIMOLOL MALEATE</b>	<b>43</b>	TRI-CYCLEN 28-DAY	120	ULTICARE 5/16 IN 31GX0.3CC SYRINGE	153
<b>TIMOLOL MALEATE, BRIMONIDINE TARTRATE</b>	<b>105</b>	TRI-CYCLEN LO (21 DAY)	120	ULTICARE 5/16 IN 31GX0.5CC SYRINGE	153
<b>TIMOLOL MALEATE, TRAVOPROST</b>	<b>107</b>	TRI-CYCLEN LO (28 DAY)	120	ULTICARE 5/16 IN 31GX1CC SYRINGE	153
TIMOLOL MALEATE-EX	106	TRIDESILON	131	ULTICARE LOW DEAD SPACE SYRINGE	152
TIMOPTIC	106	TRIFLUOPERAZINE	83	ULTILET CLASSIC LANCET	150
TIMOPTIC-XE	106	<b>TRIFLUOPERAZINE HYDROCHLORIDE</b>	<b>83</b>	ULTRA 29G3/10CC	153
TINACTIN	130	TRIFLURIDINE	104	ULTRA-FINE II 30G.1CC	153
TINACTIN AEROSOL	130	TRIHXYPHENIDYL	89	ULTRA-FINE II 30GX0.3 CC SYRINGE	153
<b>TINZAPARIN SODIUM</b>	<b>32</b>	<b>TRIHXYPHENIDYL HYDROCHLORIDE</b>	<b>89</b>	ULTRAFINE III NEEDLE 31G 8MM	151
<b>TIOTROPIUM BROMIDE MONOHYDRATE</b>	<b>24</b>	TRIMEBUTINE	25	ULTRAFLEX 1 10MM/110CM	150
<b>TIPRANAVIR</b>	<b>11</b>	<b>TRIMEBUTINE MALEATE</b>	<b>24</b>	ULTRAFLEX 1 10MM/60CM	150
TIVICAY	10	<b>TRIMETHOPRIM</b>	<b>16</b>	ULTRAFLEX 1 10MM/80CM	150
TIZANIDINE	27	TRIMETHOPRIM	16	ULTRAFLEX 1 8MM/110CM	150
<b>TIZANIDINE HYDROCHLORIDE</b>	<b>27</b>	TRIMETHOPRIM ORAL LIQUID	16	ULTRAFLEX 1 8MM/60CM	150
TOBRADEX	104	TRIMIPRAMINE	76	ULTRAFLEX 1 8MM/80CM	150
<b>TOBRAMYCIN</b>	<b>104</b>	<b>TRIMIPRAMINE MALEATE</b>	<b>76</b>	ULTRAFLEX 1 8MM/80CM	150
TOBREX	104	TRINIPATCH	39	ULTRAVATE	132
<b>TOCILIZUMAB (IV)</b>	<b>146</b>	<b>TRIPTORELIN PAMOATE</b>	<b>21</b>	<b>UMECLIDINIUM BROMIDE</b>	<b>25</b>
<b>TOCILIZUMAB (SC)</b>	<b>146</b>	TRIQUILAR 21	119	<b>UMECLIDINIUM BROMIDE,</b>	<b>25</b>
<b>TOFACITINIB CITRATE</b>	<b>146</b>	TRIQUILAR 28	119	<b>VILANTEROL TRIFENATATE</b>	
TOLBUTAMIDE	125	TRIUMEQ	9	UNIFINE 29G 12MM NEEDLE	151
<b>TOLBUTAMIDE</b>	<b>125</b>	TRIZIVIR	9	UNIFINE 31G.6MM NEEDLE	151
<b>TOLNAFTATE</b>	<b>130</b>	<b>TROPICAMIDE</b>	<b>105</b>	UNIFINE 31G.8MM NEEDLE	151
		TROSEC	137	UNIFINE PENTIPS 31GX5MM	151
		<b>TROSPIUM CHLORIDE</b>	<b>137</b>	UNIPHYL	137
				<b>URINE TEST STRIP</b>	<b>95</b>

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URISPAS	136	<b>VERAPAMIL HYDROCHLORIDE</b>	<b>46</b>	WELLBUTRIN SR	71
UROSODIOL ORAL LIQUID	110	VERELAN	46	WELLBUTRIN XL	71
URSO	110	VERMOX	2	<b>WHITE FACED HORNET VENOM PROTEIN</b>	<b>142</b>
URSO DS	110	VERSEL	130	<b>WHITE FACED HORNET VENOM PROTEIN, YELLOW HORNET VENOM PROTEIN, YELLOW JACKET VENOM PROTEIN</b>	<b>142</b>
URSODIOL	110	<b>VERTEPORFIN</b>	<b>108</b>	<b>WHITE PETROLATUM, LANOLIN, MINERAL OIL</b>	<b>108</b>
<b>URSODIOL</b>	<b>110</b>	VESANOID	21	WINPRED	119
<b>USTEKINUMAB</b>	<b>141</b>	VESICARE	136	XALACOM	107
VAGIFEM 10	121	<b>VESPULA SPP VENOM PROTEIN EXTRACT</b>	<b>142</b>	XALATAN	107
VALACYCLOVIR	13	VFEND	9	XANAX	84
<b>VALACYCLOVIR HYDROCHLORIDE</b>	<b>12</b>	VIDEX EC	10	XANAX TS	85
VALCYTE	13	VIDEXTRA	140	XARELTO	32
<b>VALGANCICLOVIR HYDROCHLORIDE</b>	<b>13</b>	<b>VIGABATRIN</b>	<b>71</b>	XATRAL	27
VALISONE	131	VIGAMOX	103	XELJANZ	146
VALIUM	85	VIMPAT	68	XELODA	17
<b>VALPROIC ACID (DIVALPROEX SODIUM)</b>	<b>71</b>	<b>VINCRISTINE SULFATE</b>	<b>21</b>	XENEX SODIUM BICARBONATE	96
<b>VALPROIC ACID (SODIUM VALPROATE)</b>	<b>71</b>	VINCRISTINE SULFATE	21	XEOMIN	147
VALSARTAN	53	VIOKACE	111	XGEVA	144
<b>VALSARTAN</b>	<b>53</b>	VIRACEPT	10	XIGDUO	124
<b>VALSARTAN (SACUBITRIL VALSARTAN SODIUM HYDRATE COMPLEX), SACUBITRIL (SACUBITRIL VALSARTAN SODIUM HYDRATE COMPLEX)</b>	<b>55</b>	VIRAMUNE	11	XOLAIR	102
VALSARTAN HCT	54	VIRAMUNE XR	11	XTANDI	18
<b>VALSARTAN, HYDROCHLOROTHIAZIDE</b>	<b>54</b>	VIREAD	11	XYLAC	78
VALSARTAN-HCTZ	54	VIROPTIC	104	XYLOCAINE VISCOUS	105
VALTREX	13	VISANNE	126	YASMIN 21	119
VAN-ALENDRONATE	143	VISKAZIDE	42	YASMIN 28	119
VAN-AMLODIPINE	44	VISKEN	43	YAZ	119
VAN-ANASTROZOLE	17	VISTITAN	106	<b>YELLOW HORNET VENOM PROTEIN</b>	<b>142</b>
VAN-BICALUTAMIDE	17	VISUDYNE	108	<b>YELLOW JACKET VENOM PROTEIN</b>	<b>142</b>
VANCOCIN	8	VIT D 1000	139	ZADITEN	1
VANCOMYCIN	8	VIT D 400	139	<b>ZAFIRLUKAST</b>	<b>101</b>
<b>VANCOMYCIN HYDROCHLORIDE</b>	<b>8</b>	<b>VITAMIN A</b>	<b>138</b>	ZAMINE 21	119
VAN-FINASTERIDE	143	VITAMIN A	138	ZAMINE 28	119
VAN-IRBESARTAN	51	VITAMIN A ACID	133	ZANTAC	112
VAN-LOSARTAN	52	VITAMIN B1	138	ZARAH 21	119
VAN-PIOGLITAZONE	125	VITAMIN B12	138	ZARAH 28	119
VAN-QUETIAPINE	80	VITAMIN B6	138	ZARONTIN	66
VAN-RAMIPRIL	48	VITAMIN C	138	ZAROXOLYN	99
<b>VARENICLINE TARTRATE</b>	<b>29</b>	<b>VITAMIN C</b>	<b>139</b>	ZAXINE	8
VASERETIC	47	<b>VITAMIN D</b>	<b>139</b>	ZELBORAF	21
VASOTEC	47	VITAMIN D	139	ZELDOX	83
<b>VEDOLIZUMAB</b>	<b>147</b>	VITAMIN D3	139	ZENHALE	26
<b>VEMURAFENIB</b>	<b>21</b>	VITAMIN E	140	ZEPATIER	14
<b>VENLAFAXINE HYDROCHLORIDE</b>	<b>76</b>	<b>VITAMIN E</b>	<b>140</b>	ZERIT	11
VENLAFAXINE XR	76	VITAMIN K1	140	ZESTORETIC	48
VENOFER	30	VITAMINE C	139	ZESTRIL	47
<b>VENOM PROTEIN EXTRACT</b>	<b>142</b>	VITAMINE D	139	ZIAGEN	9
VENOMIL HONEY BEE VENOM	142	VOLIBRIS	39	<b>ZIDOVUDINE</b>	<b>11</b>
VENOMIL MIXED VESPID VENOM PROTEIN	142	VOLTAREN	57	<b>ZINC OXIDE</b>	<b>133</b>
VENOMIL WASP VENOM PROTEIN	142	VOLTAREN OPTHALM	105	ZINC OXIDE	133
VENOMIL WHITE-FACED HORNET VENOM PROTEIN	142	VOLTAREN SR	57	<b>ZINC OXIDE, WHITE PETROLATUM</b>	<b>133</b>
VENOMIL YELLOW HORNET VENOM PROTEIN	142	<b>VORICONAZOLE</b>	<b>9</b>	ZINCOFAX EXTRA STRENGTH	133
VENOMIL YELLOW JACKET VENOM PROTEIN	142	VOTRIENT	20	ZINDA-LETROZOLE	19
VENTOLIN HFA	26	VYVANSE	83	<b>ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE</b>	<b>83</b>
VENTOLIN P.F	26	WAMPOLE CALCIUM	96	ZITHROMAX	3
VENTOLIN RESPIRATOR	26	WAMPOLE CALCIUM VITAMIN D	96	ZOCOR	38
VEPESID	18	WAMPOLE COMPLETE MULT-PRE AND POST NATAL WITH FOLIC ACID	140	ZODERM	134
		WAMPOLE FOLIC ACID	138	ZOFRAN	111
		WAMPOLE MINERAL CALCIUM	96	ZOFRAN ODT	111
		WAMPOLE VITAMIN C	139	ZOLADEX	121
		WAMPOLE VITAMIN D	139	ZOLADEX LA	141
		<b>WARFARIN SODIUM</b>	<b>32</b>		
		<b>WASP VENOM PROTEIN</b>	<b>142</b>		
		<b>WATER</b>	<b>99</b>		
		WEBCOL ALCOHOL PREP	150		

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ZOLEDRONIC ACID	145
<b>ZOLEDRONIC ACID MONOHYDRATE</b>	<b>145</b>
<b>ZOLMITRIPTAN</b>	<b>88</b>
ZOLMITRIPTAN	88
ZOLMITRIPTAN ODT	88
ZOLOFT	76
ZOMIG	88
ZOMIG RAPIMELT	88
ZOSTRIX	134
ZOSTRIX HP	134
ZOVIRAX	12
<b>ZUCLOPENTHIXOL ACETATE</b>	<b>83</b>
<b>ZUCLOPENTHIXOL DIHYDROCHLORIDE</b>	<b>83</b>
ZYBAN	72
ZYDELIG	18
ZYLOPRIM	143
ZYMAR	103
ZYPREXA	78
ZYPREXA ZYDIS	79
ZYTIGA	17
ZYVOXAM	8