Non-Insured Health Benefits First Nations and Inuit Health Branch

Drug Benefit ListSeptember 2020

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.canada.gc.ca/nihb



Department of Indigenous Services Canada Non-Insured Health Benefits

Introduction Drug Benefit List

Effective September 2020

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1. Background on Non-Insured Health Benefits (NIHB) Program

The Non-Insured Health Benefits (NIHB) Program of the Department of Indigenous Services Canada provides clients (registered First Nations and recognized Inuit) with coverage for a range of health benefits, including prescription drugs and over-the-counter medications, dental and vision care, medical supplies and equipment, mental health counselling, and transportation to access health services not available locally. 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

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: 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 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 <u>DTAC</u> 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 <u>DTAC</u> 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 Director of Policy Development - Pharmacy Non-Insured Health Benefits First Nations and Inuit Health Branch, Department of Indigenous Services Canada 10 Rue Wellington - Suite 1455 Postal Locator 1909D (Jeanne Mance Building) Gatineau, Quebec K1A 0H4

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. 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, pCPA, 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
- the cost is reduced, or scientific evidence indicates that the advantages outweigh any additional cost; or
- 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:

- 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 19 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 G

- · 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

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-parkinsonian drugs
Anti-platelet aggregation drugs
BPH Drugs
Cardiovascular drugs
Enzyme preparations
Drugs for treatment of bone diseases
GI Anti-inflammatory drugs
Thyroid therapy

Proton pump inhibitors Urinary anti-spasmotics NSAIDs

H2-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 ST 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 to support management of chronic renal failure.

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. End of life 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 End of life Care formulary includes medications and nutritional supplements used to provide comfort to those near the end of life.

Requests for any of the DINs on the end of life Care formulary will generate an End of Life Care Application Form, faxed to the prescriber. Once completed and submitted, the recipient will be eligible for all medications on the End of life 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 End of Life Care Application Form.

8. Formulary for adjunct medications used during active cancer treatment formulary The NIHB Program has established a new formulary to streamline access to adjunctive (non-chemotherapy) medications frequently used by clients undergoing active cancer treatment.

Clients who are approved for oral chemotherapy drugs are given access to all of the medications and nutritional supplements in the formulary. Additionally, clients who request, and are approved, for one of the medications on the formulary for a cancer-related indication are also granted access.

Clients are automatically enrolled for a period of six months. If cancer treatment is of a longer duration, access to the formulary will be granted to align with the treatment duration. In the event that treatment duration is not known and the treatment plan extends beyond six months, access to this formulary may be extended upon request.

9. Nutritional products formulary

The Non-Insured Health Benefits (NIHB) Program has established a nutrition product formulary for clients who require medically necessary nutrition products.

Clients who request and obtain approval will be granted access based on their condition. The length of approval and type of benefit will vary by nutrition product and/or life stage.

Select nutrition products are also included in the following special formularies: End of Life Care Formulary, Formulary for Chronic Renal Patients and Formulary for Adjunct Medications Used During Active Cancer Treatment.

10. 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.

11. General information

Sources of information about the NIHB Program include:

• The NIHB section of the Government of Canada website which provides background information on the Program and a copy of the DBL. This can be found at: http://www.canada.ca/nihb

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

Non-Insured Health Benefits
First Nations and Inuit Health Branch, Department of Indigenous Services Canada
10 Rue Wellington - Suite 1455
Postal Locator 1909D (Jeanne Mance Building)
Gatineau, Quebec K1A 0H4

12. NIHB privacy code

The NIHB Program 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, and the Government Security Policy.

13. Pharmacologic-therapeutic classification of drugs

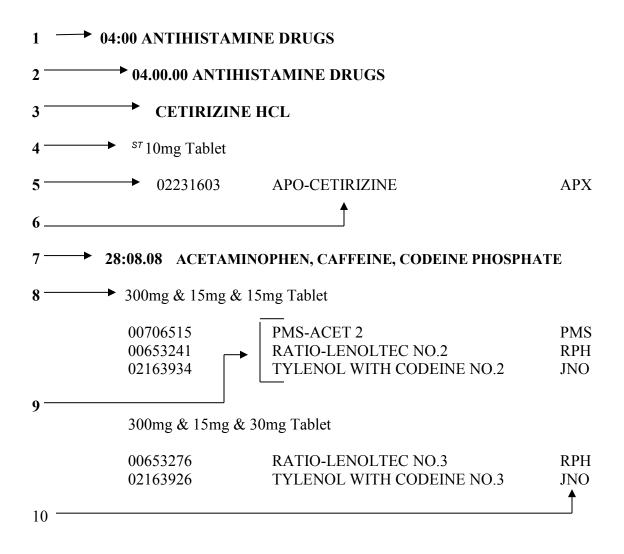
The drugs in the NIHB DBL are classified according to the AHFS Pharmacologic-Therapeutic classification developed by the American Society of Health-System Pharmacists for the purposes of the AHFS Drug Information.

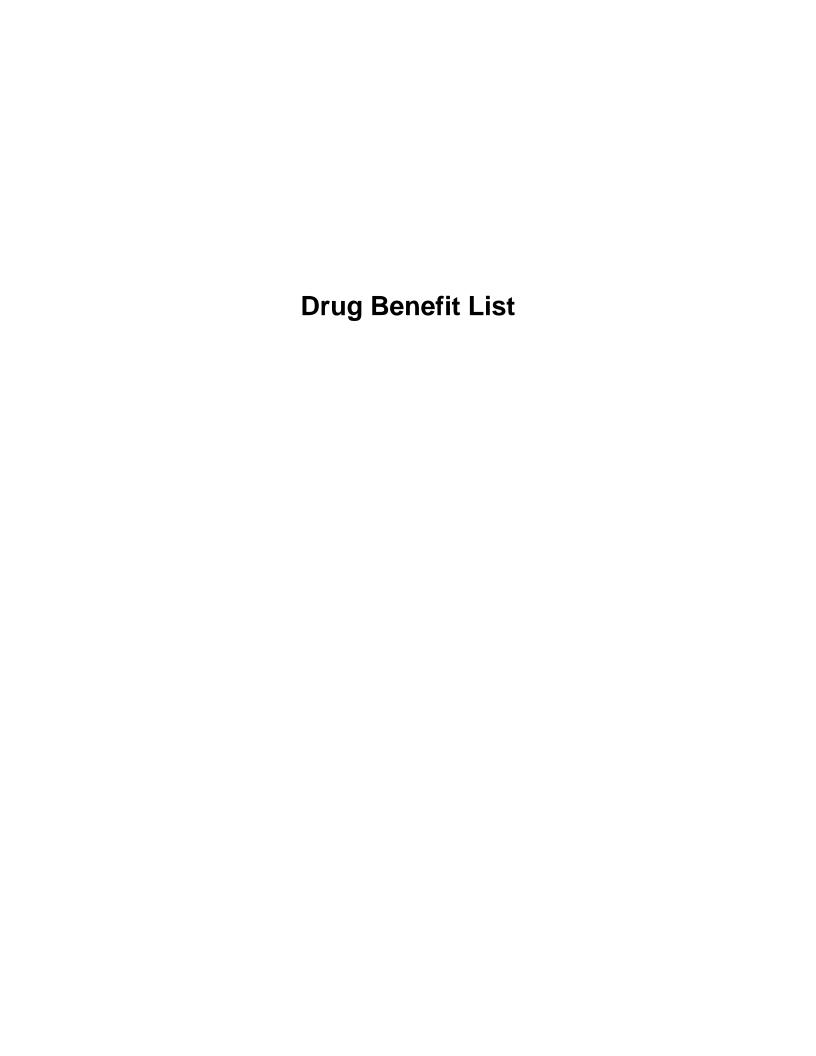
Permission to use this system has been granted by the American Society of Health-System Pharmacists. The Society is not responsible for the accuracy of transpositions from the original context.

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. ST 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





A:00 ANTILLI	STAMINE DRUGS		04.08.00.48	ITIHISTAMINE DRUGS	
04:04.04 ANTI	HISTAMINE DRUGS		CETIRIZINE	HYDROCHLORIDE	
DIPHENHYDRA	MINE HYDROCHLORIDE		ST 20MG TABL		
ST 25MG CAPSUL	F		02427141		MAR
	DP-DIPHENHYDRAMINE	PMS	02491125	MINT-CETIRIZINE	MIN
ST 50MG CAPSUL			02315963	PMS-CETIRIZINE	PMS
	- DP-DIPHENHYDRAMINE	PMS	02427192		PHA
ST 2.5MG/ML ELIX			01900978		MCL
	LLERGY ELIXIR	TAN	DESLORATA	ADINE	
00804193 A	LLERNIX ELIXIR	TEV	ST 0.5MG/ML S	SYRUP	
00792705 Pf	MS-DIPHENHYDRAMINE	PMS	02247193	AERIUS KIDS	BAY
ST 12.5MG/5ML EL	IXIR		ST 5MG TABLE	:T	
02298503 D	IPHENHYDRAMINE	JMP	02243919	AERIUS	BAY
50MG/ML LIQU	ID		02338424		APX
00596612 D	IPHENHYDRAMINE	SDZ	02298155	DESLORATADINE ALLERGY	PMS
02219336 DI	IPHENIST	OMG	FEVOFENAS	CONTROL	
00878200 PI	MS-DIPHENHYDRAMINE	PMS	FEXOFENAL	INE HYDROCHLORIDE	
ST 1.25MG/ML SO	LUTION		ST 60MG TABL	ET	
	HILDREN'S BENADRYL ALLERGY	MCL	02231462	ALLEGRA 12 HOUR	SAC
ST 2.5MG/ML SOL			^{S7} 120MG TAB	LET	
02019736 BI	ENADRYL	MCL	02242819	ALLEGRA 24 HOUR	SAC
ST 25MG TABLET			LORATADIN	E	
02176483 AI		TEV	ST 1MG/ML SY	RIIP	
	LLERGY	TAN		CLARITIN KIDS	BAY
	LLERGY FORMULA	VTH	ST 10MG TABL		27
02097583 AI		TEV		24 HOUR ALLERGY REMEDY	VTH
	ENADRYL ALLERGY	MCL	02375990		APX
	IPHENHYDRAMINE ADRYL	JMP RIV	02418959		APX
02239029 N/ ST 50MG TABLET	ADRIL	KIV	02243880	APO-LORATADINE	APX
	LLERGY EXTRA STRENGTH	TAN	00782696	CLARITIN ALLERGY	BAY
	LLERNIX EXTRA STRENGTH	TEV	02366444	LORATADINE	APX
	IPHENHYDRAMINE	JMP	04:92.00 AN	ITIHISTAMINE DRUGS	
	HISTAMINE DRUGS	Olvii	KETOTIFEN		
			KETOTIFEN	FUMARATE	
CHLORPHENIR	AMINE MALEATE		ST 0.2MG/ML S	YRUP	
ST 4MG TABLET				ZADITEN	TEV
00738972 C	HLOR-TRIPOLON	BAY	ST 1MG TABLE		
00021288 TI	EVA-PHENIRAM	TEV	00577308	ZADITEN	TEV
ST 12MG TABLET	(EXTENDED RELEASE)				
00738964 C	HLOR-TRIPOLON	BAY			
04:08.00 ANTI	HISTAMINE DRUGS				
CETIRIZINE HY	DROCHLORIDE				
· - · · · · · · · · · · · · · · · · · ·					
^{sτ} 1MG/ML SYRU 02238337 R		MOL			
02238337 RI	EACTINE	MCL			
	LLERGY RELIEF	PMS			
	PO-CETIRIZINE	APX			
02375095 CI		APX			
	AMP-CETIRIZINE	JMP			
		MAR			
		1417.71.7			
02427133 M		MCI			
02427133 M 02223554 RI		MCL			
02427133 M 02223554 RI		MCL APX			

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		Non-insured nearth be	ileiits
08:00 ANTI-INFECTIVE AGENTS		08:12.06 CEPHALOSPORINS	
08:08.00 ANTHELMINTICS		CEFADROXIL	
		500MG CAPSULE	
IVERMECTIN		02240774 APO-CEFADROXIL	APX
3MG TABLET		02311062 PRO-CEFADROXIL	PDL
02480557 STROMECTOL	FRS	02235134 TEVA-CEFADROXIL	TEV
MEBENDAZOLE		CEFAZOLIN SODIUM	
100MG TABLET		500MG POWDER FOR SOLUTION	
00556734 VERMOX	JSO	02108119 CEFAZOLIN	TEV
PYRANTEL PAMOATE		02237137 CEFAZOLIN	FKD
50MG SUSPENSION		02308932 CEFAZOLIN	SDZ
02412470 JAMP-PYRANTEL PAMOATE	JMP	1G POWDER FOR SOLUTION	022
125MG TABLET	JIVII	02108127 CEFAZOLIN	TEV
01944363 COMBANTRIN	MCL	02237138 CEFAZOLIN	FKD
08:12.02 AMINOGLYCOSIDES		02308959 CEFAZOLIN	SDZ
		02437112 CEFAZOLIN	RAX
AMIKACIN SULFATE		10G POWDER FOR SOLUTION	
Limited use benefit (prior approval required).		02108135 CEFAZOLIN	TEV
250MG LIQUID		02237140 CEFAZOLIN	FKD
02242971 AMIKACIN SULFATE	SDZ	02308967 CEFAZOLIN	SDZ
GENTAMICIN SULFATE		02437120 CEFAZOLIN	RAX
1MG/ML SOLUTION		PDIN FOR EXTEMPORANEOUS MIXTURE	LINUZ
02082136 GENTAMICIN IV	BAX	99506000 CEFAZOLIN STERILE INFUSION	UNK
1.6MG/ML SOLUTION		CEFIXIME	
02082152 GENTAMICIN IV	BAX	20MG/ML POWDER FOR SUSPENSION	
10MG/ML SOLUTION		00868965 SUPRAX	ODN
02268531 GENTAMICIN	SDZ	100MG POWDER FOR SUSPENSION	
40MG/ML SOLUTION		02468689 AURO-CEFIXIME	AUR
02225131 CIDOMYCIN	UNK	400MG TABLET	
02242652 GENTAMICIN	SDZ	02432773 AURO-CEFIXIME	AUR
PDIN FOR EXTEMPORANEOUS MIXTURE		00868981 SUPRAX	ODN
99506004 GENTAMYCIN STERILE INFUSION	UNK	CEFPROZIL	
TOBRAMYCIN		25MG/ML POWDER FOR SUSPENSION	
28MG CAPSULE		02329204 TARO-CEFPROZIL	SUN
02365154 TOBI PODHALER	BGP	50MG/ML POWDER FOR SUSPENSION	
1.2G POWDER FOR SOLUTION		02293579 TARO-CEFPROZIL	SUN
00533688 TOBRAMYCIN	FKD	250MG TABLET	
02285150 TOBRAMYCIN	RAX	02292998 APO-CEFPROZIL	APX
10MG/ML SOLUTION	=145	02347245 AURO-CEFPROZIL	AUR
02230639 TOBRAMYCIN	FKD	02302179 SANDOZ CEFPROZIL 02293528 TARO-CEFPROZIL	SDZ SUN
02241209 TOBRAMYCIN	SDZ	500MG TABLET	SUN
40MG/ML SOLUTION 02420287 JAMP-TOBRAMYCIN	JMP	02293005 APO-CEFPROZIL	APX
02230640 TOBRAMYCIN	FKD	02347253 AURO-CEFPROZIL	AUR
02241210 TOBRAMYCIN	SDZ	02302187 SANDOZ CEFPROZIL	SDZ
02382814 TOBRAMYCIN	MYL	02293536 TARO-CEFPROZIL	SUN
99005069 TOBRAMYCINE	UNK	CEFTAZIDIME	
60MG SOLUTION		Limited use benefit (prior approval required).	
02389622 TEVA-TOBRAMYCIN	TEV	1G POWDER FOR SOLUTION	
300MG SOLUTION		00886971 CEFTAZIDIME	FKD
02443368 TOBRAMYCIN INHALATION	SDZ	02437848 CEFTAZIDIME	RAX
		02212218 FORTAZ 1G	GSK
		2G POWDER FOR SOLUTION	0011
		00886955 CEFTAZIDIME	FKD
		02437856 CEFTAZIDIME	RAX

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08:12.06 CEPHALOSPORINS		08:12.06 CEPHALOSPORINS	
CEFTAZIDIME		CEPHALEXIN	
Limited use benefit (prior approval required).			
		250MG POWDER FOR SUSPENSION	
2G POWDER FOR SOLUTION	001/	02469189 LUPIN-CEPHALEXIN	LUP
02212226 FORTAZ 2G	GSK	250MG TABLET	4 D)/
3G POWDER FOR SOLUTION	DAV	00768723 APO-CEPHALEX	APX
02439522 CEFTAZIDIME 6G POWDER FOR SOLUTION	RAX	02470578 AURO-CEPHALEXIN 02177781 PMS-CEPHALEXIN	AUR PMS
00886963 CEFTAZIDIME	FKD	02177781 PMS-CEPHALEXIN 00583413 TEVA-CEPHALEXIN	TEV
02437864 CEFTAZIDIME	RAX	500MG TABLET	ΙĽV
02212234 FORTAZ 6G	GSK	00768715 APO-CEPHALEX	APX
CEFTRIAXONE SODIUM	OOK	02470586 AURO-CEPHALEXIN	AUR
		00828866 CEPHALEXIN-500	PDL
250MG POWDER FOR SOLUTION		02177803 PMS-CEPHALEXIN	PMS
02250276 CEFTRIAXONE	PFI	00583421 TEVA-CEPHALEXIN	TEV
02289679 CEFTRIAXONE	FKD	08:12.07 MISCELLANEOUS B-LACTAM	
02292262 CEFTRIAXONE	SDZ	ANTIBIOTICS	
02325594 CEFTRIAXONE	RAX		
1G POWDER FOR SOLUTION	חבו	AZTREONAM	
02250292 CEFTRIAXONE 02287633 CEFTRIAXONE	PFI TEV	Limited use benefit (prior approval required).	
02287633 CEFTRIAXONE 02292270 CEFTRIAXONE	SDZ	For the management of cystic fibrosis (CF) in patients if the	
02325616 CEFTRIAXONE	RAX	following criteria are met:	
2G POWDER FOR SOLUTION	IVAX	 patient has CF with chronic pulmonary Pseudomonas 	
02250306 CEFTRIAXONE	PFI	aeruginosa infections; andprescribed by a clinician with experience in the diagnosis	
02292289 CEFTRIAXONE	SDZ	and treatment of CF.	
02325624 CEFTRIAXONE	RAX	75MG POWDER FOR SOLUTION	
10G POWDER FOR SOLUTION		02329840 CAYSTON	GIL
02325632 CEFTRIAXONE SODIUM FOR BP	RAX	ERTAPENEM	OIL
PDIN FOR EXTEMPORANEOUS MIXTURE			
99506001 CEFTRIAXONE STERILE INFUSION	UNK	Limited use benefit (prior approval required).	
CEFUROXIME AXETIL		1G POWDER FOR SOLUTION	
25MG/ML GRANULES FOR SUSPENSION		02247437 INVANZ	FRS
02212307 CEFTIN	GSK	MEROPENEM	
250MG TABLET	GSK	Limited use benefit (prior approval required).	
02244393 APO-CEFUROXIME	APX	500MG POWDER FOR SOLUTION	
02344823 AURO-CEFUROXIME	APL	02378787 MEROPENEM	SDZ
02212277 CEFTIN	GSK	1G POWDER FOR SOLUTION	
500MG TABLET	Join	02378795 MEROPENEM	SDZ
02244394 APO-CEFUROXIME	APX	02436507 MEROPENEM	RAX
02344831 AURO-CEFUROXIME	APL	08:12.12 MACROLIDES	
02212285 CEFTIN	GSK	AZITHROMYCIN	
02311453 PRO-CEFUROXIM	PDL	, _	
CEPHALEXIN		20MG/ML POWDER FOR SUSPENSION	DMC
250MG CAPSULE		02418452 PMS-AZITHROMYCIN 02332388 SANDOZ AZITHROMYCIN	PMS
00342084 TEVA-CEPHALEXIN	TEV	0223716 ZITHROMAX	SDZ PFI
500MG CAPSULE	I L V	40MG/ML POWDER FOR SUSPENSION	FII
00342114 TEVA-CEPHALEXIN	TEV	02418460 PMS-AZITHROMYCIN	PMS
25MG/ML POWDER FOR SUSPENSION	I L V	02332396 SANDOZ AZITHROMYCIN	SDZ
00015547 KEFLEX	PED	02223724 ZITHROMAX	PFI
00342106 TEVA-CEPHALEXIN	TEV	100MG POWDER FOR SUSPENSION	
50MG/ML POWDER FOR SUSPENSION	· _ v	02482363 AURO-AZITHROMYCIN	AUR
00035645 KEFLEX	PED	200MG POWDER FOR SUSPENSION	
00342092 TEVA-CEPHALEXIN	TEV	02482371 AURO-AZITHROMYCIN	AUR
125MG POWDER FOR SUSPENSION		250MG TABLET	
02469170 LUPIN-CEPHALEXIN	LUP	02480700 AG-AZITHROMYCIN	ANG

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08:12.12 MA	CROLIDES		08:12.12 MA	CROLIDES	
AZITHROMY	CIN		ERYTHROMY	YCIN	
250MG TABI	FT		333MG CAP	SULE (ENTERIC COATED)	
	APO-AZITHROMYCIN	APX	00873454		PFI
02330881	AZITHROMYCIN	SAN	250MG TABI		
02442434	AZITHROMYCIN	SIV		ERYTHRO BASE	AAP
02278499	DOM-AZITHROMYCIN	DPC		CIN STEARATE	
02452308	JAMP-AZITHROMYCIN	JMP			
02452324	MAR-AZITHROMYCIN	MAR	250MG TABI		
02479680	NRA-AZITHROMYCIN	UNK		ERYTHRO-S	AAP
02261634	PMS-AZITHROMYCIN	PMS	FIDAXOMICII	N	
02310600	PRO-AZITHROMYCINE	PDL	Limited use bene	fit (prior approval required).	
02275309	RIVA-AZITHROMYCIN	RIV	For the treatment	t of confirmed severe* Clostridium E	Difficile
02265826	SANDOZ AZITHROMYCIN	SDZ	infection (CDI); a		Jilliche
02267845	TEVA-AZITHROMYCIN	TEV	 fidaxomicin has 	s been prescribed or recommended	
02212021	ZITHROMAX	PFI	infectious disease	e specialist or gastroenterologist; a	nd
600MG TABI				mented allergy (immune-mediated ince to oral vancomycin resulting in	
	PMS-AZITHROMYCIN	PMS	discontinuation of		
	ZITHROMAX	PFI	• or	•	
CLARITHROI	MYCIN		 after an unsucce vancomycin; and 	cessful but adequate** trial of oral	
25MG/ML GF	RANULES FOR SUSPENSION			h vancomycin is not an option***; a	nd
02146908	BIAXIN	BGP		t a high risk of hospitalization due to	
02408988	CLARITHROMYCIN	SAN	complications; ar		
02390442	TARO-CLARITHROMYCIN	TAR	fidaxomicin is b	peing used as monotherapy.	
50MG/ML GF	RANULES FOR SUSPENSION		Notes:		
02244641	BIAXIN	BGP		n is defined as having any of the fo	
02408996	CLARITHROMYCIN	SAN		blood cell count > 15,000 mm3 and	
02390450	TARO-CLARITHROMYCIN	TAR		ry with rising serum creatinine ≥ 1.5 or ≥ 175 micromoles/L; pseudomem	
250MG TABI	_ET		colitis, hypotension	on, shock or megacolon.	
02274744	APO-CLARITHROMYCIN	APX		rial of oral vancomycin is considere	
01984853	BIAXIN	BGP	least 10 days of t times daily.	herapy with a dose of at least 125n	ng four
02324482	CLARITHROMYCIN	PDL		with fidaxomicin in recurrent CDI wi	II be
02442469	CLARITHROMYCIN	SIV	considered in syr	nptomatic patients who require trea	tment of
02466120	CLARITHROMYCIN	SAN		lved CDI episode. This is defined a	
02471388	M-CLARITHROMYCIN	MAN		episode occurring within 2 to 8 wee from the date of diagnosis.	ks of a
02247573	PMS-CLARITHROMYCIN	PMS			
02361426	RAN-CLARITHROMYCIN	RBY	200MG TABI 02387174		ED6
	SANDOZ CLARITHROMYCIN	SDZ			FRS
02248804	TEVA-CLARITHROMYCIN	TEV	08:12.16 PE		
500MG TABI	APO-CLARITHROMYCIN	APX	AMOXICILLIN	N	
02126710	BIAXIN	BGP	250MG CAPS	SULE	
02324490	CLARITHROMYCIN	PDL		AMOXICILLIN	SAN
02442485	CLARITHROMYCIN	SIV	00628115	APO-AMOXI	APX
02351005	DOM-CLARITHROMYCIN	DPC	02388073	AURO-AMOXICILLIN	AUR
02471396	M-CLARITHROMYCIN	MAN	02433060	JAMP-AMOXICILLIN	JMP
02247574	PMS-CLARITHROMYCIN	PMS	00406724	NOVAMOXIN	TEV
02361434	RAN-CLARITHROMYCIN	RBY	02230243	PMS-AMOXICILLIN	PMS
02346532	RIVA-CLARITHROMYCIN	RIV	500MG CAPS	SULE	
02266547	SANDOZ CLARITHROMYCIN	SDZ	02477726	AG-AMOXICILLIN	ANG
02248805	TEVA-CLARITHROMYCIN	TEV	02352729	AMOXICILLIN	SAN
500MG TABI	LET (EXTENDED RELEASE)		02401509	AMOXICILLIN	SIV
02403196	ACT CLARITHROMYCIN XL	TEV	00628123	APO-AMOXI	APX
02413345	APO-CLARITHROMYCIN XL	APX	02388081	AURO-AMOXICILLIN	AUR
02244756	BIAXIN XL	BGP	02433079	JAMP-AMOXICILLIN	JMP
			00406716	NOVAMOXIN	TEV
			02230244	PMS-AMOXICILLIN	PMS

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08:12.16 PENICILLINS		08:12.16 PENICILLINS	
AMOXICILLIN		AMPICILLIN	
500MG CAPSULE		PDIN FOR EXTEMPORANEOUS MIXTURE	
00644315 PRO AMOX	PDL	99506005 AMPICILLIN STERILE INFUSION	UNK
25MG/ML GRANULES FOR SUSPENSION		CLOXACILLIN SODIUM	
00452149 NOVAMOXIN	TEV	250MG CAPSULE	
01934171 NOVAMOXIN	TEV	00337765 TEVA-CLOXACILLIN	TEV
50MG/ML GRANULES FOR SUSPENSION		500MG CAPSULE	
02352753 AMOXICILLIN	SAN	00337773 TEVA-CLOXACILLIN	TEV
02401541 AMOXICILLIN	SIV	25MG/ML GRANULES FOR SOLUTION	
02352788 AMOXICILLIN (SUGAR REDUCED)	SAN	00337757 TEVA-CLOXACILLIN	TEV
00452130 NOVAMOXIN	TEV	PENICILLIN G BENZATHINE	
01934163 NOVAMOXIN	TEV		
25MG/ML POWDER FOR SUSPENSION		600,000U/ML SUSPENSION	
00628131 APO-AMOXI	APX	02291924 BICILLIN	PFI
02230245 PMS-AMOXICILLIN	PMS	PENICILLIN G POTASSIUM	
50MG/ML POWDER FOR SUSPENSION		1MU INJECTION	
00628158 APO-AMOXI	APX	00773727 NOVO-PENICILLIN G POTASSIUM	NOP
02230880 APO-AMOXI SUGAR FREE	APX	PENICILLIN G SODIUM	
02230246 PMS-AMOXICILLIN	PMS		
00644331 PRO-AMOX	PDL	10MU POWDER FOR SOLUTION	
125MG TABLET (CHEWABLE)	TE\	02220296 PENICILLIN G	FKD
02036347 NOVAMOXIN	TEV	1000000U POWDER FOR SOLUTION	
250MG TABLET (CHEWABLE)		02220261 PENICILLIN G SODIUM	FKD
02036355 NOVAMOXIN	TEV	5000000U POWDER FOR SOLUTION	
AMOXICILLIN, CLAVULANIC ACID		02220288 PENICILLIN G SODIUM	FKD
25MG & 6.25MG/ML POWDER FOR SUSPENSION		PDIN FOR EXTEMPORANEOUS MIXTURE	
01916882 CLAVULIN 125 F	GSK	99506003 PENICILLIN G STERILE INFUSION	UNK
40MG & 5.7MG/ML POWDER FOR SUSPENSION		PENICILLIN V POTASSIUM	
02288559 APO-AMOXI CLAV	APX	25MG/ML POWDER FOR SOLUTION	
02238831 CLAVULIN 200	GSK	00642223 APO PEN VK	APX
50MG & 12.5MG/ML POWDER FOR SUSPENSION		60MG/ML POWDER FOR SOLUTION	
01916874 CLAVULIN 250 F	GSK	00642231 APO PEN VK	APX
80MG & 11.4MG/ML POWDER FOR SUSPENSION		300MG TABLET	
02238830 CLAVULIN 400	GSK	00642215 PEN-VK	AAP
250MG & 125MG TABLET		PIPERACILLIN, TAZOBACTAM	
02243350 APO-AMOXI CLAV	APX	·	
500MG & 125MG TABLET		Limited use benefit (prior approval required).	
02243351 APO-AMOXI CLAV	APX	2G & 0.25G POWDER FOR SOLUTION	
01916858 CLAVULIN 500 F	GSK	02401312 PIPERACILLIN AND TAZOBACTAM	ALV
02482576 SANDOZ AMOXI-CLAV	SDZ	02299623 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
875MG & 125MG TABLET		02370158 PIPERACILLIN	TEV
02245623 APO-AMOXI CLAV	APX	SODIUM/TAZOBACTAM SODIUM	I L V
02238829 CLAVULIN 875	GSK	3G & 0.375G POWDER FOR SOLUTION	
02482584 SANDOZ AMOXI-CLAV	SDZ	02401320 PIPERACILLIN AND TAZOBACTAM	ALV
AMPICILLIN		02299631 PIPERACILLIN	SDZ
250MG CAPSULE		SODIUM/TAZOBACTAM SODIUM	
00020877 TEVA-AMPICILLIN	TEV	02308452 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	APX
500MG CAPSULE		02362627 PIPERACILLIN	RAX
00020885 TEVA-AMPICILLIN	TEV	SODIUM/TAZOBACTAM SODIUM	IVAX
1G POWDER FOR SOLUTION		02370166 PIPERACILLIN	TEV
01933345 AMPICILLIN SODIUM	TEV	SODIUM/TAZOBACTAM SODIUM	
2G POWDER FOR SOLUTION		4G & 0.5G POWDER FOR SOLUTION	
02226995 AMPICILLIN	FKD	02401339 PIPERACILLIN AND TAZOBACTAM	ALV
01933353 AMPICILLIN SODIUM	TEV	02299658 PIPERACILLIN	SDZ
02462346 AMPICILLIN SODIUM FOR BP	AUR	SODIUM/TAZOBACTAM SODIUM	

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00:40 4C DE	NICH LINC		00:42 40 OUINOLONES	<u> </u>
08:12.16 PENICILLINS			08:12.18 QUINOLONES	
PIPERACILL	IN, TAZOBACTAM		CIPROFLOXACIN HYDROCHLORIDE	
Limited use bene	efit (prior approval required).		750MG TABLET	
4G & 0.5G P	OWDER FOR SOLUTION		02247341 ACT CIPROFLOXACIN T	ΈV
02308460	PIPERACILLIN	APX	02229523 APO-CIPROFLOX A	PX
0000005	SODIUM/TAZOBACTAM SODIUM	DAY		MP
02362635	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX		AR
02370174	PIPERACILLIN	TEV		ЛIN
020.0	SODIUM/TAZOBACTAM SODIUM			MS
12G & 1.5G	POWDER FOR SOLUTION			RIV
02330547	PIPERACILLIN	SDZ		DZ PT
	SODIUM/TAZOBACTAM SODIUM	5417		UN
02377748	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX	LEVOFLOXACIN HEMIHYDRATE	UIN
36G & 4 5G	POWDER FOR SOLUTION			
02439131	PIPERACILLIN	RAX	Limited use benefit (prior approval not required).	
02100101	SODIUM/TAZOBACTAM SODIUM	1000	Coverage will be limited to 14 tablets every 14 days, followed	
08:12.18 QU	JINOLONES		by a 14 day lockout.	
•	ACIN HYDROCHLORIDE		250MG TABLET	
			02315424 ACT LEVOFLOXACIN T	ΈV
	SUSPENSION		02284707 APO-LEVOFLOXACIN A	PX
02237514		BAY	02284677 PMS-LEVOFLOXACIN PI	MS
250MG TAB		TE\		DΖ
	ACT CIPROFLOXACIN	TEV	500MG TABLET	
02229521	APO-CIPROFLOX	APX		ΈV
02381907 02353318	AURO-CIPROFLOXACIN CIPROFLOXACIN	AUR SAN		PX
02386119	CIPROFLOXACIN	SIV		DL
02380358	JAMP-CIPROFLOXACIN	JMP		MS
02379686	MAR-CIPROFLOXACIN	MAR		DZ
02423553	MINT-CIPROFLOX	MIN	750MG TABLET 02315440 ACT LEVOFLOXACIN T	ΈV
02248437	PMS-CIPROFLOXACIN	PMS		EV PX
02317796	PRO-CIPROFLOXACIN	PDL		MS
02251221	RIVA-CIPROFLOXACIN	RIV		DZ
02248756	SANDOZ CIPROFLOXACIN	SDZ	LEVOFLOXACIN HEMIHYDRATE (QUINSAIR)	
02379627	SEPTA-CIPROFLOXACIN	SPT	,	
02303728	TARO-CIPROFLOX	SUN	Limited use benefit (prior approval required).	
02266962	TARO-CIPROFLOXACIN	TAR	For the management of cystic fibrosis (CF) in patients 18	
500MG TAB	LET		years or older if the following criteria are met:	
02247340	ACT CIPROFLOXACIN	TEV	 patient has CF with chronic pulmonary Pseudomonas aeruginosa infections; and 	
02229522		APX	 prescribed by a clinician with experience in the diagnosis 	
02381923		AUR	and treatment of CF; and	
02444887		BMI	patient has had a previous trial of tobramycin by inhalation that has been ineffective or not tolerated or tobramycin is	
02353326	CIPROFLOXACIN	SAN	that has been ineffective or not tolerated or tobramycin is contraindicated; and	
02386127		SIV	 patient is not using another inhaled antibiotic(s) to treat 	
02251280 02380366	DOM-CIPROFLOXACIN JAMP-CIPROFLOXACIN	DPC JMP	pulmonary P. aeruginosa infections, either concurrently or for	
02379694	MAR-CIPROFLOXACIN	MAR	antibiotic cycling during off-treatment periods.	
02423561	MINT-CIPROFLOX	MIN	Note: NIHB coverage is limited to 240 mg twice daily in cycles	
02248438	PMS-CIPROFLOXACIN	PMS	of 28 days on followed by 28 days off.	
02445344	PRIVA-CIPROFLOXACIN	PHA	240MG SOLUTION	
02317818	PRO-CIPROFLOXACIN	PDL	02442302 QUINSAIR U	NK
02251248	RIVA-CIPROFLOXACIN	RIV		
02248757	SANDOZ CIPROFLOXACIN	SDZ		
02379635	SEPTA-CIPROFLOXACIN	SPT		
02303736	TARO-CIPROFLOX	SUN		
02266970	TARO-CIPROFLOXACIN	TAR		

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08:12.18 QU	INOLONES		08:12.24 TE	TRACYCLINES	
MOXIFI OXA	CIN HYDROCHLORIDE		DOXYCYCLII	NE HYCLATE	
	fit (prior approval not required).		100MG TAB		
				TEVA-DOXYCYCLINE	TEV
by a 14 day locke	limited to 14 tablets every 14 days, fo	llowed		NE HYDROCHLORIDE	
			_		
400MG TABI	AG-MOXIFLOXACIN	ANG	50MG CAPS		440
	APO-MOXIFLOXACIN	APX	02084090	MINOCYCLINE TEVA-MINOCYCLINE	AAP TEV
	AURO-MOXIFLOXACIN	AUR	100MG CAP		I⊏V
02447266	BIO-MOXIFLOXACIN	BMI		MINOCYCLINE	AAP
02443929	JAMP-MOXIFLOXACIN	JMP		TEVA-MINOCYCLINE	TEV
02447061	JAMP-MOXIFLOXACIN	JMP		INE HYDROCHLORIDE	124
02447053	MAR-MOXIFLOXACIN	MAR			
02457814	MED-MOXIFLOXACIN	GMP	250MG CAP		
02472791	M-MOXIFLOXACIN	MAN		TETRACYCLINE	AAP
02462974	MOXIFLOXACIN	PDL	08:12.28 MIS	SCELLANEOUS ANTIBIO	TICS
02450976	RIVA-MOXIFLOXACIN	RIV	CLINDAMYC	IN HYDROCHLORIDE	
02383381	SANDOZ MOXIFLOXACIN	SDZ	150MG CAP	eill E	
02375702	TEVA-MOXIFLOXACIN	TEV		APO-CLINDAMYCIN	APX
NORFLOXAC	CIN			AURO-CLINDAMYCIN	AUR
400MG TABL	FT		00030570		PFI
	NORFLOXACIN	AAP	02483734		JMP
	LFONAMIDES	700	02479923		MAN
			02468476		RIV
SULFAMETH	OXAZOLE, TRIMETHOPRIM			TEVA-CLINDAMYCIN	TEV
40MG & 8MG	S/ML SUSPENSION		300MG CAP		•
00726540	TEVA-TRIMEL	TEV		APO-CLINDAMYCIN	APX
100MG & 20I	MG TABLET			AURO-CLINDAMYCIN	AUR
00445266	SULFATRIM PEDIATRIC	APX	02182866		PFI
400MG & 80I	MG TABLET			JAMP CLINDAMYCIN	JMP
00445274	SULFATRIM	APX	02479931		MAN
00510637	TEVA-TRIMEL	TEV		TEVA-CLINDAMYCIN	TEV
800MG & 160	OMG TABLET			XTEMPORANEOUS MIXTURE	
00512524	PROTRIN DF	PDL	99506008	CLINDAMYCIN STERILE INFUSIO	ON UNK
00445282	SULFATRIM DS	APX	CLINDAMYC	IN PALMITATE HYDROCHL	ORIDE
00510645	TEVA-TRIMEL DS	TEV		_	
SULFASALA	ZINE			OWDER FOR SOLUTION	DEL
500MG TABI	ET			DALACIN C	PFI
	PMS-SULFASALAZINE	PMS	CLINDAMYC	IN PHOSPHATE	
	SALAZOPYRIN	PFI	150MG/ML I	NJECTION	
	LET (ENTERIC COATED)		02139286	CLINDAMYCIN	FKD
	PMS-SULFASALAZINE	PMS	02230535	CLINDAMYCIN	SDZ
	SALAZOPYRIN EN	PFI	02230540	CLINDAMYCIN	SDZ
	TRACYCLINES		00260436	DALACIN C PHOSPHATE	PFI
			02215683	NOVO-CLINDAMYCIN	NOP
DOXYCYCLI	NE HYCLATE		12MG SOLU	TION	
100MG CAPS	SULE		02408511	CLINDAMYCIN IV INFUSION	SDZ
00740713	APO-DOXY	APX	18MG SOLU		
00817120	DOXYCIN	RIV	02408538	CLINDAMYCIN IV INFUSION	SDZ
02351234	DOXYCYCLINE	SAN			
00725250	TEVA-DOXYCYCLINE	TEV			
100MG TABI	_ET				
00874256	APO-DOXY	APX			
00860751	DOXYCIN	RIV			
02351242	DOXYCYCLINE	SAN			
00887064	DOXYTAB	PDL			

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08:12.28 MISCELLANEOUS ANTIBIOTICS COLISTIN

Limited use benefit (prior approval required).

For the management of cystic fibrosis (CF) in patients if the following criteria are met:

- patient has CF with chronic pulmonary Pseudomonas aeruginosa infections; and
- prescribed by a clinician with experience in the diagnosis and treatment of CF.

150MG POWDER FOR SOLUTION

02244849	COLISTIMETHATE FOR U.S.P	RAX
00476420	COLY-MYCIN M PARENTERAL	ERF

LINEZOLID

Limited use benefit (prior approval required).

Tablets:

- for treatment of proven vancomycin-resistant enterococci (VRE) infections; or
- 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.

Oral liquid:

- when linezolid cannot be administered orally in the above mentioned situations;
- plus at least one of the following:
- 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.

100MG POWDER FOR SUSPENSION

02243686	ZYVOXAM	PFI			
2MG SOLUT	ION				
02481278	LINEZOLID	JMP			
2MG/ML SO	LUTION				
02243685	ZYVOXAM	PFI			
600MG TABI	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.

ST 550MG TABLET

02410702 ZAXINE SLX

08:12.28 MISCELLANEOUS ANTIBIOTICS VANCOMYCIN HYDROCHLORIDE

Limited use benefit (prior approval required).

Used for the treatment of patients diagnosed with symptomatic Clostridium difficile infection.

Note: Oral vancomycin is not appropriate for systemic infections due to poor absorption from the GI tract.

125MG CAPSULE

02407744	JAMP-VANCOMYCIN	JMP				
02430185	PMS-VANCOMYCIN	PMS				
00800430	VANCOCIN	SEA				
02377470	VANCOMYCIN	FKD				
02380544	VANCOMYCIN	UNK				
250MG CAPSULE						
02407752	JAMP-VANCOMYCIN	JMP				
00788716	VANCOCIN	SEA				
02377489	VANCOMYCIN	FKD				
02380552	VANCOMYCIN	UNK				

VANCOMYCIN HYDROCHLORIDE (INJECTION)

500MG POWDER FOR SOLUTION

SUUNIG PON	DER FOR SOLUTION	
02139375	VANCOMYCIN	FKD
02230191	VANCOMYCIN	PFI
02394626	VANCOMYCIN	SDZ
02342855	VANCOMYCIN HYDROCHLORIDE	RAX
1,000MG PC	WDER FOR SOLUTION	
02230192	VANCOMYCIN	PFI
02396386	VANCOMYCIN	RAX
1G POWDER	R FOR SOLUTION	
02139383	VANCOMYCIN	FKD
02394634	VANCOMYCIN	SDZ
02342863	VANCOMYCIN HYDROCHLORIDE	RAX
5G POWDER	R FOR SOLUTION	
02139243	VANCOMYCIN	FKD
02378337	VANCOMYCIN	PFI
02394642	VANCOMYCIN	SDZ
10G POWDE	ER FOR SOLUTION	
02241807	VANCOMYCIN	FKD
02378345	VANCOMYCIN	PFI
02394650	VANCOMYCIN	SDZ
02405830	VANCOMYCIN HYDROCHLORIDE	RAX

08:14.04 ALLYLAMINES

TERBINAFINE HYDROCHLORIDE

250MG TABLET

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

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08:14.08 AZ	OLES		08:14.08 AZOLES	
FLUCONAZO			KETOCONAZOLE	
150MG CAP			200MG TABLET	
	APO-FLUCONAZOLE	APX		APX
02462168	BIO-FLUCONAZOLE	BMI		TEV
02311690	CANESORAL	BAY	VORICONAZOLE	
	DIFLUCAN	PFI	Limited use benefit (prior approval required).	
02432471	JAMP-FLUCONAZOLE	JMP		
	MAR-FLUCONAZOLE	MAR	For the treatment of patients with invasive aspergillosis; or For the treatment of culture proven invasive candidiasis with	
	NOVO-FLUCONAZOLE	NOP	documented resistance to fluconazole.	
	PMS-FLUCONAZOLE	PMS	50MG TABLET	
	PRIVA-FLUCONAZOLE	PHA		APX
	RIVA-FLUCONAZOLE	RIV		SDZ
	OWDER FOR SOLUTION	חבו		TEV
	DIFLUCAN	PFI		PFI
50MG TABL		TC\/	200MG TABLET	
	ACT FLUCONAZOLE	TEV		APX
	APO-FLUCONAZOLE	APX MYL		SDZ
	MYLAN-FLUCONAZOLE PMS-FLUCONAZOLE	PMS		TEV
	TARO-FLUCONAZOLE	TAR		PFI
	TEVA-FLUCONAZOLE	TEV	08:14.28 POLYENES	
100MG TAB		ΙΕV		
	ACT FLUCONAZOLE	TEV	NYSTATIN	
02237371	APO-FLUCONAZOLE	APX	100000U/ML ORAL LIQUID	
02246109	DOM-FLUCONAZOLE	DPC	99113755 NYSTATIN 100,000U SUSP (QC)	JNK
02245293	MYLAN-FLUCONAZOLE	MYL	100,000U/ML SUSPENSION	
	PMS-FLUCONAZOLE	PMS	02125145 DOM-NYSTATIN	DPC
	PRO-FLUCONAZOLE	PDL		JMP
	TARO-FLUCONAZOLE	TAR	00792667 PMS-NYSTATIN P	PMS
	TEVA-FLUCONAZOLE	TEV	02194201 TEVA-NYSTATIN	TEV
		ILV	08:16.04 ANTITUBERCULOSIS AGENTS	
SULFATE)	ZOLE (ISAVUCONAZONIUM		ETHAMBUTOL HYDROCHLORIDE	
•	fit (prior approval required).			
Limited doe bene	int (prior approval required).		100MG TABLET	0011
	t of invasive mucormycosis (IM) in adults; of			BSH
	t of invasive aspergillosis (IA) in adults whe	n	400MG TABLET	DOLL
	al voriconazole has failed; or lerance or contraindication to voriconazole			BSH
Documented into	icianice of dominantididation to voliconazore		ISONIAZID	
	e prescribed by or in consultation with an		10MG/ML SOLUTION	
Infectious Diseas	e specialist.		00265500 ISOTAMINE \	VAE
100MG CAP	SULE		00577812 PDP-ISONIAZID F	PED
02483971	CRESEMBA	UNK	100MG TABLET	
200MG POW	DER FOR SOLUTION		00261270 ISOTAMINE \	VAE
02483998	CRESEMBA	UNK	00577790 PDP-ISONIAZID F	PED
ITRACONAZ	OLE		300MG TABLET	
100MG CAP	SULF		00272655 ISOTAMINE	VAE
	MINT-ITRACONAZOLE	MIN	00577804 PDP-ISONIAZID F	PED
02047454	SPORANOX	JSO	PDIN FOR EXTEMPORANEOUS MIXTURE	
POWDER		000	99503031 ISONIAZID ORAL LIQUID L	JNK
	ITRACONAZOLE PDR	MDS	PYRAZINAMIDE	
10MG SOLU		•	500MG TABLET	
	JAMP ITRACONAZOLE	JMP		PED
10MG/ML S				VAE
	SPORANOX	JSO	30200001 12010 210	- ,
55 15 17				

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		Non-insured Health Bei	ICIIC
08:16.04 ANTITUBERCULOSIS AGENTS		08:18.08 ANTIRETROVIRALS	
RIFABUTIN		ATAZANAVIR SULFATE	
150MG CAPSULE		150MG CAPSULE	
02063786 MYCOBUTIN	PFI	02456877 MYLAN-ATAZANAVIR	MYL
RIFAMPIN		02248610 REYATAZ	BMS
RIFAMEIN		02443791 TEVA-ATAZANAVIR	TEV
150MG CAPSULE		200MG CAPSULE	
02091887 RIFADIN	SAC	02456885 MYLAN-ATAZANAVIR	MYL
00393444 ROFACT	UNK	02248611 REYATAZ	BMS
300MG CAPSULE	040	02443813 TEVA-ATAZANAVIR	TEV
02092808 RIFADIN	SAC	300MG CAPSULE	
00343617 ROFACT	UNK	02456893 MYLAN-ATAZANAVIR	MYL
PDIN FOR EXTEMPORANEOUS MIXTURE 99503022 RIFAMPIN ORAL LIQUID	UNK	02294176 REYATAZ	BMS
	UNK	02443821 TEVA-ATAZANAVIR	TEV
08:16.92 MISCELLANEOUS		DARUNAVIR	
ANTIMYCOBACTERIALS		600MG TABLET	
DAPSONE		02487241 APO-DARUNAVIR	APX
100MG TABLET		800MG TABLET	
02041510 DAPSONE	JAC	02487268 APO-DARUNAVIR	APX
02481227 MAR-DAPSONE	MAR	DARUNAVIR (DARUNAVIR PROPYLENE	
02489058 RIVA-DAPSONE	RIV	GLYCOLATE)	
08:18.04 ADAMANTANES		•	
AMANTADINE HYDROCHLORIDE		600MG TABLET	ALID
AWANTADINE HTDROCHLORIDE		02486121 AURO-DARUNAVIR	AUR
100MG CAPSULE		DARUNAVIR ETHANOLATE	
01990403 PMS-AMANTADINE	PED	75MG TABLET	
10MG/ML SYRUP		02338432 PREZISTA	JSO
02022826 PMS-AMANTADINE	PED	150MG TABLET	
08:18.08 ANTIRETROVIRALS		02369753 PREZISTA	JSO
ABACAVIR SUFLATE, LAMIVUDINE		400MG TABLET	
600MG & 300MG TABLET		02324016 PREZISTA	JSO
02458381 PMS-ABACAVIR/LAMIVUDINE	PMS	600MG TABLET	100
ABACAVIR SULFATE		02324024 PREZISTA	JSO
		800MG TABLET	JSO
20MG/ML SOLUTION		02393050 PREZISTA	350
02240358 ZIAGEN	VII	DARUNAVIR ETHANOLATE, COBICISTAT	
300MG TABLET	ADV	150MG & 800MG TABLET	
02396769 APO-ABACAVIR	APX	02426501 PREZCOBIX	JSO
02480956 MINT-ABACAVIR 02240357 ZIAGEN	MIN VII	DOLUTEGRAVIR SODIUM	
	VII	50MG TABLET	
ABACAVIR SULFATE, LAMIVUDINE		02414945 TIVICAY	VII
600MG & 300MG TABLET		DOLUTEGRAVIR SODIUM, RILPIVIRINE	
02399539 APO-ABACAVIR-LAMIVUDINE	APX	HYDROCHLORIDE	
02454513 AURO-ABACAVIR/LAMIVUDINE	AUR		
02269341 KIVEXA	VII	50MG & 25MG TABLET	\ /II
02450682 MYLAN-ABACAVIR/LAMIVUDINE	MYL	02475774 JULUCA	VII
02416662 TEVA-ABACAVIR/LAMIVUDINE	TEV	DORAVIRINE	
ABACAVIR SULFATE, LAMIVUDINE,		100MG TABLET	
DOLUTEGRAVIR SODIUM		02481545 PIFELTRO	FRS
600MG & 300MG & 50MG TABLET		EFAVIRENZ	
02430932 TRIUMEQ	VII	50MG CAPSULE	
ABACAVIR SULFATE, LAMIVUDINE, ZIDOVU	JDINE	02239886 SUSTIVA	BMS
300MG & 150MG & 300MG TABLET		200MG CAPSULE	
02416255 APO-ABACAVIR-LAMIVUDINE-	APX	02239888 SUSTIVA	BMS
ZIDOVUDINE			

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08:18.08 ANTIRETROVIRALS 08:18.08 ANTIRETROVIRALS
150MG TABLET
02418428 AURO-EFAVIRENZ AUR 02192683 3TC VII 02458233 JAMP-EFAVIRENZ JMP 02369052 APO-LAMIVUDINE APX 02381524 MYLAN-EFAVIRENZ MYL 300MG TABLET VII 02246045 SUSTIVA BMS 02247825 3TC VII 02389762 TEVA-EFAVIRENZ TEV 02369060 APO-LAMIVUDINE APX EFAVIRENZ, EMTRICITABINE, TENOFOVIR LAMIVUDINE, DOLUTEGRAVIR SODIUM DISOPROXIL FUMARATE 300MG & 50MG TABLET 02491753 DOVATO VII 02468247 APO-EFAVIRENZ-EMTRICITABINE- TENOFOVIR APX LAMIVUDINE, TENOFOVIR DISOPROXIL FUMARATE, DORAVIRINE FUMARATE, DORAVIRINE DORAVIRINE FRS 02487284 MYLAN- EFAVIRENZ-EMTRICITABINE/TENO FOVIR DISOPROXIL FUMARATE MYL 300MG & 300MG & 100MG TABLET EAMIVUDINE, ZIDOVUDINE LAMIVUDINE, ZIDOVUDINE 02487284 PMS-EFAVIRENZ/EMTRICITABINE/TENO PMS 150MG & 300MG TABLET LAMIVUDINE, ZIDOVUDINE APX 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO SDZ 023755
02458233 JAMP-EFAVIRENZ JMP 02369052 APO-LAMIVUDINE APX 02381524 MYLAN-EFAVIRENZ MYL 300MG TABLET VII 02246045 SUSTIVA BMS 02247825 3TC VII 02389762 TEVA-EFAVIRENZ TEV 02369060 APO-LAMIVUDINE APX EFAVIRENZ, EMTRICITABINE, TENOFOVIR LAMIVUDINE, DOLUTEGRAVIR SODIUM DISOPROXIL FUMARATE 300MG & 50MG TABLET 02491753 DOVATO VII 02468247 APO-EFAVIRENZ-EMTRICITABINE-TENOFOVIR APX LAMIVUDINE, TENOFOVIR DISOPROXIL FUMARATE, DORAVIRINE FUMARATE, DORAVIRINE 02300699 ATRIPLA GIL MYLAN-EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE DELSTRIGO FRS 02487284 PMS-EFAVIRENZ-EMTRICITABINE-TENOFOVIR DELSTRIGO FRS 02487284 PMS-EFAVIRENZ-EMTRICITABINE-TENOFOVIR 150MG & 300MG TABLET LAMIVUDINE-ZIDOVUDINE APX 02484676 SANDOZ SDZ 02375540 APO-LAMIVUDINE-ZIDOVUDINE APX COLVIDOR SDZ
02381524 MYLAN-EFAVIRENZ MYL 300MG TABLET 02246045 SUSTIVA BMS 02247825 3TC VII 02389762 TEVA-EFAVIRENZ TEV 02369060 APO-LAMIVUDINE APX EFAVIRENZ, EMTRICITABINE, TENOFOVIR DISOPROXIL TENOFOVIR LAMIVUDINE, TBNOFOVIR DISOPROXIL TENOFOVIR DISOPROXI
02246045 SUSTIVA BMS 02247825 3TC VII 02389762 TEVA-EFAVIRENZ TEV 02369060 APO-LAMIVUDINE APX EFAVIRENZ, EMTRICITABINE, TENOFOVIR DISOPROXIL FUMARATE LAMIVUDINE, DOLUTEGRAVIR SODIUM 00MG & 200MG & 300MG TABLET 02491753 DOVATO VII 02468247 APO-EFAVIRENZ-EMTRICITABINE- TENOFOVIR APX LAMIVUDINE, TENOFOVIR DISOPROXIL FUMARATE, DORAVIRINE 02300699 ATRIPLA GIL MYLAN- MYL 0248121 MYLAN- EFAVIRENZ/EMTRICITABINE/TENO DELSTRIGO FRS 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR LAMIVUDINE, ZIDOVUDINE LAMIVUDINE, ZIDOVUDINE 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO SDZ 02375540 APO-LAMIVUDINE/ZIDOVUDINE APX FOVIRE SANDOZ EFAVIRENZ/EMTRICITABINE/TENO SDZ 02414414 AURO-LAMIVUDINE/ZIDOVUDINE AUR
DISOPROXIL FUMARATE 600MG & 200MG & 300MG TABLET 02468247 APO-EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL MYLAN-EFAVIRENZ-EMTRICITABINE-TENOFOVIR 02461412 MYLAN-EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE 02487284 PMS-EFAVIRENZ-EMTRICITABINE-TENOFOVIR 02487284 PMS-EFAVIRENZ-EMTRICITABINE-TENOFOVIR 0248676 SANDOZ SDZ 02414414 AURO-LAMIVUDINE-ZIDOVUDINE AUR
DISOPROXIL FUMARATE 600MG & 200MG & 300MG TABLET 02468247 APO-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02300699 ATRIPLA 02461412 MYLAN- MYL EFAVIRENZ/EMTRICITABINE/TENOFOVIR 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02484676 SANDOZ SDZ EFAVIRENZ/EMTRICITABINE/TENO 02484676 SANDOZ SDZ EFAVIRENZ/EMTRICITABINE/TENO 02414414 AURO-LAMIVUDINE/ZIDOVUDINE 300MG & 50MG TABLET 02491753 DOVATO VII 4PX LAMIVUDINE, TENOFOVIR DISOPROXIL FUMARATE, DORAVIRINE 300MG & 300MG & 100MG TABLET 02482592 DELSTRIGO FRS LAMIVUDINE, ZIDOVUDINE 150MG & 300MG TABLET 02484676 APO-LAMIVUDINE-ZIDOVUDINE APX 02414414 AURO-LAMIVUDINE/ZIDOVUDINE AUR
DISOPROXIL FUMARATE 600MG & 200MG & 300MG TABLET 02468247 APO-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02300699 ATRIPLA 02461412 MYLAN- MYL EFAVIRENZ/EMTRICITABINE/TENOFOVIR 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02484676 SANDOZ SDZ EFAVIRENZ/EMTRICITABINE/TENO 02484676 SANDOZ SDZ EFAVIRENZ/EMTRICITABINE/TENO 02414414 AURO-LAMIVUDINE/ZIDOVUDINE 300MG & 50MG TABLET 02491753 DOVATO VII 4PX LAMIVUDINE, TENOFOVIR DISOPROXIL FUMARATE, DORAVIRINE 300MG & 300MG & 100MG TABLET 02482592 DELSTRIGO FRS LAMIVUDINE, ZIDOVUDINE 150MG & 300MG TABLET 02484676 APO-LAMIVUDINE-ZIDOVUDINE APX 02414414 AURO-LAMIVUDINE/ZIDOVUDINE AUR
600MG & 200MG & 300MG TABLET 02491753 DOVATO VII 02468247 APO-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02300699 ATRIPLA 02461412 MYLAN- EFAVIRENZ/EMTRICITABINE/TENO FOVIR DISOPROXIL FUMARATE 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOVIR 02491753 DOVATO VII APX LAMIVUDINE, TENOFOVIR DISOPROXIL FUMARATE, DORAVIRINE 02482592 DELSTRIGO FRS LAMIVUDINE, ZIDOVUDINE 150MG & 300MG TABLET 02375540 APO-LAMIVUDINE-ZIDOVUDINE APX 02414414 AURO-LAMIVUDINE/ZIDOVUDINE AUR
02468247 APO-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02300699 ATRIPLA 02461412 MYLAN- EFAVIRENZ/EMTRICITABINE/TENO FOVIR DISOPROXIL FUMARATE 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOVIR 024844414 AURO-LAMIVUDINE/ZIDOVUDINE APX 02414414 AURO-LAMIVUDINE/ZIDOVUDINE AUR
TENOFOVIR 02300699 ATRIPLA 02461412 MYLAN- EFAVIRENZ/EMTRICITABINE/TENO FOVIR DISOPROXIL FUMARATE 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOURD 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO FOR CONTRICITABINE/TENO FOR CONTRICITABINE/TENO FOR CONTRICITABINE/TENO FUMARATE, DORAVIRINE 300MG & 300MG & 100MG TABLET 02482592 DELSTRIGO FRS LAMIVUDINE, ZIDOVUDINE 150MG & 300MG TABLET 02375540 APO-LAMIVUDINE-ZIDOVUDINE APX EFAVIRENZ/EMTRICITABINE/TENO FOR CONTRICITABINE/TENO FO
02461412 MYLAN- EFAVIRENZ/EMTRICITABINE/TENO FOVIR DISOPROXIL FUMARATE 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO EFAVIRENZ/EMTRICITABINE/TENO EFAVIRENZ/EMTRICITABINE/TENO EFAVIRENZ/EMTRICITABINE/TENO EVALUATION OF COMMON A SOUNG & 100MG & 100MG TABLET 02482592 DELSTRIGO EAUSTON LAMIVUDINE, ZIDOVUDINE 150MG & 300MG TABLET 150MG & 300MG TABLET 02484676 APO-LAMIVUDINE-ZIDOVUDINE APX EFAVIRENZ/EMTRICITABINE/TENO EVALUATION OF COMMON TABLET 02482592 DELSTRIGO FRS LAMIVUDINE, ZIDOVUDINE 150MG & 300MG & 100MG TABLET 02482592 DELSTRIGO FRS LAMIVUDINE, ZIDOVUDINE 150MG & 300MG TABLET 02484676 APO-LAMIVUDINE-ZIDOVUDINE APX EFAVIRENZ/EMTRICITABINE/TENO EVALUATION OF COMMON TABLET 150MG & 300MG TABLET
EFAVIRENZ/EMTRICITABINE/TENO FOVIR DISOPROXIL FUMARATE 02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR 02484676 SANDOZ EFAVIRENZ/EMTRICITABINE/TENO SDZ EFAVIRENZ/EMTRICITABINE/TENO 02482592 DELSTRIGO FRS LAMIVUDINE, ZIDOVUDINE 150MG & 300MG TABLET 02375540 APO-LAMIVUDINE-ZIDOVUDINE APX 02414414 AURO-LAMIVUDINE/ZIDOVUDINE AUR
02487284 PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR PMS 02484676 SANDOZ SDZ 02375540 APO-LAMIVUDINE-ZIDOVUDINE APX EFAVIRENZ/EMTRICITABINE/TENO 02414414 AURO-LAMIVUDINE/ZIDOVUDINE AUR
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EFAVIRENZ/EMTRICITABINE/TENO 02414414 AURO-LAMIVUDINE/ZIDOVUDINE AUR
FOVID
1 OVIK 10239213 COMBIVIR 1/II
02202540 TEVA
FFAVIRENZ/EMTRICITABINE/TENO 02367247 TEVA-LAWIVODINE/ZIDOVODINE TEV
FOVIR LOPINAVIR, RITONAVIR
EMTRICITABINE, BICTEGRAVIR (BICTEGRAVIR 80MG & 20MG/ML SOLUTION
SODIUM), TENOFOVIR ALAFENAMIDE 02243644 KALETRA ABV
200MG & 50MG & 25MG TABLET 100MG & 25MG TABLET
02478579 BIKTARVY GIL 02312301 KALETRA ABV
EMTRICITABINE, COBICISTAT, ELVITEGRAVIR, 200MG & 50MG TABLET 02285533 KALETRA ABV
TENOFOVIR ALAFENAMIDE MARAVIROC
200MG & 150MG & 10MG TABLET 150MG TABLET
02449498 GENVOYA GIL 02299844 CELSENTRI VII
EMTRICITABINE, RILPIVIRINE
HYDROCHLORIDE, TENOFOVIR ALAFENAMIDE 02299852 CELSENTRI VII
200MG & 25MG & 25MG TABLET NELFINAVIR MESYLATE
02461463 ODEFSEY GIL 50MG/G POWDER
ETRAVIRINE 02238618 VIRACEPT PFI
100MG TABLET 250MG TABLET
02306778 INTELENCE JSO 02238617 VIRACEPT PFI
200MG TABLET 625MG TABLET
02375931 INTELENCE JSO 02248761 VIRACEPT PFI
FOSAMPRENAVIR CALCIUM NEVIRAPINE
50MG/ML SUSPENSION 200MG TABLET
02261553 TELZIR VII 02318601 AURO-NEVIRAPINE APL
700MG TABLET 02405776 JAMP NEVIRAPINE JMP
02261545 TELZIR VII 02387727 MYLAN-NEVIRAPINE MYL
LAMIVUDINE 400MG TABLET (EXTENDED RELEASE)
5MG SOLUTION 02427931 APO-NEVIRAPINE XR APX
02239194 HEPTOVIR GSK RALTEGRAVIR POTASSIUM
10MG/ML SOLUTION 400MG TABLET
02192691 3TC VII 02301881 ISENTRESS FRS
100MG TABLET
02393239 APO-LAMIVUDINE HBV APX
02239193 HEPTOVIR GSK

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08:18.08 ANTIRETROVIRALS 08:18.08 ANTIRETROVIRALS RILPIVIRINE HYDROCHLORIDE **ZIDOVUDINE** 25MG TABLET **100MG CAPSULE** 02370603 EDURANT JSO 01946323 APO-ZIDOVUDINE APX 01902660 RETROVIR VII **RITONAVIR** 10MG/ML SYRUP **100MG TABLET** 01902652 RETROVIR VII 02357593 NORVIR ABV 08:18.20 INTERFERONS SAQUINAVIR MESYLATE **INTERFERON ALFA-2B 500MG TABLET** 6,000,000IU/ML SOLUTION HLR 02279320 INVIRASE 02238674 INTRON A **FRS** TENOFOVIR DISOPROXIL FUMARATE 10,000,000IU/ML SOLUTION Limited use benefit (prior approval required). 02238675 INTRON A **FRS** 10.000.000IU/VIAL SOLUTION For the treatment of patients with HIV-1 infection who have failed or have experienced adverse events to an alternative 02223406 INTRON A FRS agent: or **PEGINTERFERON ALFA-2A** For the treatment of patients with chronic hepatitis B infection who have cirrhosis documented on radiologic or histologic Limited use benefit (prior approval required). grounds and a HBV concentration above 2,000 IU/mL. For the treatment of patients with chronic hepatitis B infection 245MG TABLET who have a HBV DNA concentration above 2.000 IU/mL GII 02247128 VIREAD without decompensated cirrhosis, upon the written request of 300MG TABLET a hepatologist or other specialist in this area. 02451980 APO-TENOFOVIR APX 180MCG/0.5ML SOLUTION 02460173 AURO-TENOFOVIR AUR 02248077 PEGASYS HLR 02479087 JAMP-TENOFOVIR JMP PEGINTERFERON ALFA-2B, RIBAVIRIN 02452634 MYLAN-TENOFOVIR DISOPROXIL MYL Limited use benefit (prior approval required). NPH 02472511 NAT-TENOFOVIR 02453940 PMS-TENOFOVIR **PMS** For the treatment of chronic hepatitis C in patients who are 02403889 TEVA-TENOFOVIR TEV treatment naïve, upon the written request of a hepatologist or other specialist in this area. TENOFOVIR DISOPROXIL FUMARATE. • for genotypes 1, 4, 5 and 6, an initial 24 week supply will be **EMTRICITABINE** approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is **200MG & 300MG TABLET** undetectable at 12 weeks (48 weeks total); or GIL 02274906 TRUVADA • for genotypes 2 or 3, initial coverage for a maximum of 24 300MG & 200MG TABLET weeks will be approved. Renewals will not be covered. 02452006 APO-EMTRICITABINE-TENOFOVIR APX 50MCG/0.5ML & 200MG KIT 02487012 **JMP** 02254573 PEGETRON KIT **FRS** EMTRICITABINE/TENOFOVIR **PEGINTERFERON BETA-1A DISOPROXIL FUMARATE** 02443902 MYL MYI AN-Limited use benefit (prior approval required). **EMTRICITABINE/TENOFOVIR** DISOPROXIL As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 PMS-EMTRICITABINE-TENOFOVIR **PMS** 02461110 McDonald clinical criteria and magnetic resonance imaging 02399059 TEVA-EMTRICITABINE/TENOFOVIR TFV (MRI) evidence, when prescribed by a neurologist TENOFOVIR DISOPROXIL FUMARATE, experienced in the management of RRMS. **EMTRICITABINE, COBICISTAT, ELVITEGRAVIR** And for patients who meet all of the following criteria: 150MG & 200MG & 150MG & 300MG TABLET • patient has had a clinical relapse and/or new MRI activity in 02397137 STRIBILD the last two years: and GII • patient is fully ambulatory for 100 meters without aids; and TENOFOVIR DISOPROXIL FUMARATE, • patient is 18 years of age or older. **EMTRICITABINE, RILPIVIRINE HYDROCHLORIDE** 94MCG INJECTION 200MG & 25MG & 300MG TABLET 02444402 PLEGRIDY UNK

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125MCG LIQUID

02444399 PLEGRIDY

UNK

GIL

BOE

02374129 COMPLERA

TIPRANAVIR

250MG CAPSULE 02273322 APTIVUS

SOBELTAMIVIR SAMCICLOVIR SAMCICLOVIR APX C229035 APO-FAMICICLOVIR APX C229034 APO-FAMICICLOVIR APX C229035 APO-FAMICICLOVIR APX	08:18.28 NEURAMINIDASE INHIBITORS		08:18.32 NUCLEOSIDES AND	
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02304848 TAMÍFLU		NPH	125MG TABLET	
Q227888 TAMIFLU	02304848 TAMIFLU	HLR		APX
O22349456 TAMIFLU	45MG CAPSULE			APU
Table Tabl	02472643 NAT-OSELTAMIVIR	NPH	02278081 PMS-FAMCICLOVIR	PMS
02241472 TAMIFLU HLR 023085890 ACT FAMICICLOVIR ACG 6MG POWDER FOR SUSPENSION 02231842 TAMIFLU HLR 022292041 APO-FAMICICLOVIR APV 08:18.32 NUCLEOTIDES 02278103 PMS-FAMICICLOVIR PMS 40MG/ML SUSPENSION 0229088 APO-FAMICICLOVIR ACG 0888157 ZOVIRAX GSK 02177102 FAMVIR APX 02207621 APO-ACYCLOVIR APX 02278693 APO-FAMICICLOVIR APX 02207624 MYLAN-ACYCLOVIR MYL GANCICLOVIR SODIUM SDZ 02207638 APO-ACYCLOVIR TEV SOMMG FOWDER FOR SOLUTION 02162695 CYTOVENE CHE 022265969 TEVA-ACYCLOVIR MYL VALACYCLOVIR HYDROCHLORIDE CHE 022265969 TEVA-ACYCLOVIR MYL VALACYCLOVIR HYDROCHLORIDE APX 022265967 TEVA-ACYCLOVIR MYL O22695822 APO-VALACYCLOVIR APX 02227648 MYLAN-ACYCLOVIR MYL O2269582 APO-VALACYCLOVIR	02304856 TAMIFLU	HLR	02278634 SANDOZ FAMCICLOVIR	SDZ
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## 400MG TABLET 02207648			GANCICLOVIR SODIUM	
02207648 APO-ACYCLOVIR APX 02162695 CYTOVENE CHE 02242463 MYLAN-ACYCLOVIR MYL SOMMG TABLET 02295827 TEVA-ACYCLOVIR APX 02405464 MYLAN-ACYCLOVIR MYL 02307365 APO-ACYCLOVIR MYL 02307365 APO-ACYCLOVIR MYL 02307365 APO-ACYCLOVIR MYL 02307365 DAMP-VALACYCLOVIR APX 02405404 MYLAN-ACYCLOVIR MYL 0230736 DOM-VALACYCLOVIR DPV 02285975 TEVA-ACYCLOVIR TEV 02441454 JAMP-VALACYCLOVIR JMP ADEFOVIR DIPIVOXIL 02351579 MYLAN-ALACYCLOVIR MYL 02351579 MYLAN-ALACYCLOVIR MYL 02351579 MYLAN-VALACYCLOVIR MYL 02351579 MYLAN-VALACYCLOVIR MYL 02351579 MYLAN-VALACYCLOVIR MYL 02351579 MYLAN-VALACYCLOVIR PHA 02151579 MYLAN-VALACYCLOVIR PHA 02151579 MYLAN-VALACYCLOVIR PHA 02151579 MYLAN-VALACYCLOVIR PHA 02315173 PRO-VALACYCLOVIR PRIVAVAILACYCLOVIR P		v	500MG POWDER FOR SOLUTION	
02242463 MYLAN-ACYCLOVIR TEV 500MG TABLET 02285967 TEVA-ACYCLOVIR TEV 500MG TABLET 02297656 APO-ACYCLOVIR APX 02405040 AURO-VALACYCLOVIR APX 0228575 TEVA-ACYCLOVIR MYL 02307936 DOM-VALACYCLOVIR DPC 0228575 TEVA-ACYCLOVIR TEV 02441454 JAWPALACYCLOVIR JMP ADEFOVIR DIPIVOXIL Limited use benefit (prior approval required). For the treatment of chronic hepatitis B infection when used in combination with lamivudine, a sed efined by an increase in HBV DINA of ≥ 1 log10 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 02396955 APO-ADEFOVIR APX 02442823 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. 10.5MG TABLET 02396955 APO-ENTECAVIR APX 02446777 AURO-ENTECAVIR APX 02446777 AURO-ENTECAVIR BMS 02467232 JAMP ENTECAVIR BMS 02467232 JAMP ENTECAVIR JMP 02245777 VALCYTE HLR 125MG TABLET 025MG TABLET 125MG TABLET 125MG TABLET 125MG TABLET 125MG TABLET 125MG TABLET 125MG TABLET		APX	02162695 CYTOVENE	CHE
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	125MG TABLET			
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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 at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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

GLECAPREVIR, PIBRENTASVIR

Limited use benefit (prior approval required).

For treatment-naïve or treatment-experienced adult patients with genotypes 1, 2, 3, 4, 5, 6 with; or For the treatment of direct acting antivirals (DAA)-experienced2 adult patients with genotype 1 with:

- chronic hepatitis C at any fibrosis stage (F0-F4); and
- detectable levels of HCV RNA in the last 12 months;

For genotypes 1, 2, 3, 4, 5 or 6, treatment-experienced is defined as a patient who has been previously treated with interferon, peginterferon (P), ribavirin (R) and/or sofosbuvir (SOF) (PR, SOF + PR, SOF + RBV), but no prior treatment experience with an NS3/4A protease inhibitor or NS5A inhibitor

• For genotype 1, DAA treatment-experienced is defined as a patient who has been previously treated with DAA regimens containing NS5A inhibitor [daclatasvir (DCV) + SOF or DCV + PR or ledipasvir/sofosbuvir, but no prior treatment experience with NS3/4A protease inhibitors] or containing NS3/4A protease inhibitors [simeprevir+SOF or simeprevir+PR or boceprevir+PR or telaprevir+PR, but no prior treatment experience with an NS5Ainhibitor].

100MG & 40MG TABLET

02467550 MAVIRET

ABV

RIBAVIRIN

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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.

200MG TABLET

02439212 IBAVYR PED

400MG TABLET

02425890 IBAVYR PED

600MG TABLET

02425904 IBAVYR PED

08:18.40 HCV ANTIVIRALS SOFOSBUVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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 at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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 at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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

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08:18.40 HCV ANTIVIRALS		08:36.00 URINARY ANTI-INFECTIVES	
SOFOSBUVIR, VELPATASVIR, VOXILAPREV	/IR	FOSFOMYCIN TROMETHAMINE	
Limited use benefit (prior approval required).		3G/PK POWDER FOR SOLUTION	
For treatment-experienced adult patients with:		02240335 MONUROL	PAL
 chronic hepatitis C at any fibrosis stage (F0-F4); and 		3G POWDER FOR SOLUTION	
 detectable levels of HCV RNA in the last 12 months; 		02473801 JAMP-FOSFOMYCIN	JMP
andtreatment-experienced having failed a prior therapy with	an	NITROFURANTOIN	
HCV regimen containing:	all	100MG CAPSULE	
NS5A inhibitor: daclatasvir (Daklinza), elbasvir (part of		02063662 MACROBID	ALL
Zepatier), ledipasvir (part of Harvoni), ombitasvir (part of Holkira Pak), velpatasvir (part of Epclusa) for genotype 1,	2	02455676 PMS-NITROFURANTOIN	PMS
3, 4, 5 or 6; or	Ζ,	50MG CAPSULE (DELAYED RELEASE)	
• sofosbuvir (Sovaldi) without an NS5A inhibitor for genoty	ре	02231015 TEVA-NITROFURANTOIN	TEV
1, 2, 3 or 4.		100MG CAPSULE (DELAYED RELEASE)	
400MG & 100MG & 100MG TABLET		02231016 TEVA-NITROFURANTOIN	TEV
02467542 VOSEVI	GIL	50MG TABLET	
08:30.04 AMEBICIDES		00319511 NITROFURANTOIN	AAP
PAROMOMYCIN SULFATE		100MG TABLET	A A D
250MG CAPSULE		00312738 NITROFURANTOIN PDIN FOR EXTEMPORANEOUS MIXTURE	AAP
02078759 HUMATIN	ERF	99503004 NITRO-FURANTOIN ORAL LIQUID	UNK
08:30.08 ANTIMALARIALS		TRIMETHOPRIM	ONIX
CHLOROQUINE PHOSPHATE			
		100MG TABLET	A A D
250MG TABLET		02243116 TRIMETHOPRIM 200MG TABLET	AAP
99105293 CHLOROQUINE (PHOS.) (PQ)	UNK	02243117 TRIMETHOPRIM	AAP
00021261 TEVA-CHLOROQUINE	TEV	PDIN FOR EXTEMPORANEOUS MIXTURE	7471
HYDROXYCHLOROQUINE SULFATE		99503017 TRIMETHOPRIM ORAL LIQUID	UNK
200MG TABLET			
02246691 APO-HYDROXYQUINE	APX		
02491427 JAMP HYDROXYCHLOROQUINE SULFATE	JMP		
02424991 MINT-HYDROXYCHLOROQUINE	MIN		
02017709 PLAQUENIL	SAC		
PRIMAQUINE PHOSPHATE			
26.3MG TABLET			
02017776 PRIMAQUINE	SAC		
08:30.92 MISCELLANEOUS			
ANTIPROTOZOALS			
ATOVAQUONE			
150MG/ML SUSPENSION			
02217422 MEPRON	GSK		
METRONIDAZOLE			
500MG CAPSULE			
02248562 APO-METRONIDAZOLE	APX		
02470284 AURO-METRONIDAZOLE	AUR		
01926853 FLAGYL	ODN		
250MG TABLET			
00545066 METRONIDAZOLE	AAP		
PDIN FOR EXTEMPORANEOUS MIXTURE	1.15.11.2		
99503012 METRONIDAZOLE ORAL LIQUID	UNK		

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10:00 ANTINEOPLASTIC AGENTS 10:00.00 ANTINEOPLASTIC AGENTS ABIRATERONE ACETATE

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage

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 ≤ 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.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression

250MG TABLET

02371065	ZYTIGA	JSO
02371065	ZYTIGA	JSC

500MG TABLET

02457113 ZYTIGA JSO

AFATINIB DIMALEATE

Limited use benefit (prior approval required).

Criteria for initial 6-month coverage:

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 renewal every 6 months:

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

10:00.00 ANTINEOPLASTIC AGENTS ALECTINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

First-line treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC); or Second-line treatment of patients with locally advanced not amenable to curative therapy or metastatic NSCLC who have disease progression on or intolerance to crizotinib;

- to be used as monotherapy; and
- disease is anaplastic lymphoma kinase (ALK)-positive; and
- patient has a good performance status.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

150MG CAPSULE

02458136	ALECENSARO	HLR

ANASTROZOLE

1MG TABLET

02351218	ACH-ANASTROZOLE	ACC
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
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
02394898	TEVA-ANASTROZOLE	TEV

APALUTAMIDE

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of non-metastatic castration-resistant prostate cancer patients (nmCRPC) who meet all the following criteria:

- used in combination with androgen deprivation therapy (ADT); and
- have no detectable distant metastases by either CT, MRI or technetium-99m bone scan; and
- are at high risk* of developing metastases; and
- have no risk factors for seizures; and
- have a good ECOG performance status (0 or 1)

* High risk is defined as a prostate-specific antigen doubling time of ≤ 10 months during continuous ADT

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or unacceptable toxicity.

60MG TABLET

02478374 ERLEADA

JSO

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10:00.00 ANTINEOPLASTIC AGENTS AXITINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the second-line treatment of patients with advanced or metastatic clear cell renal carcinoma after failure of prior therapy with a first-line agent.

Patients are only eligible for either everolimus or axitinib in the second-line setting, but not sequential use of both agents except in cases of intolerance.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

1MG TABLET

02389630	INLYTA	PFI
5MG TABLE	Т	
02389649	INLYTA	PFI

BICALUTAMIDE

50MG TABLET

02325985	ACH-BICALUTAMIDE	ACC
02296063	APO-BICALUTAMIDE	APX
02184478	CASODEX	AZC
02357216	JAMP-BICALUTAMIDE	JMP
02275589	PMS-BICALUTAMIDE	PMS
02311038	PRO-BICALUTAMIDE	PDL
02371324	RAN-BICALUTAMIDE	RBY
02270226	TEVA-BICALUTAMIDE	TEV

BOSUTINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

Patients has Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia (CML); and

- patient has an ECOG performance status of 0 to 2;
- and
- documented resistance/disease progression to at least one prior oral tyrosine kinase inhibitor [TKI] (imatinib, dasatinib or nilotinib); or
- documented intolerance to one prior oral TKI (imatinib, dasatinib or nilotinib) where subsequent treatment with an alternative oral TKI is not clinically appropriate.

Criteria for renewal every 12 months:

Confirmation from the clinician that the patient has experienced hematologic and/or cytogenic response and is expected to continue to do so and has not developed unacceptable toxicities.

4	_	^.		_	_		_		_	
1	u	UI	VI	G	П.	А	В	L	E	ı

02419149	BOSULIF	PFI
500MG TAB	LET	
02419157	BOSULIF	PFI

BUSERELIN ACETATE

6.3MG/IMPLANT IMPLANT

02225158 SUPREFACT (NASAL)

O.SIVIG/IIVIF L	ANTINELANI	
02228955	SUPREFACT DEPOT 2 MONTHS	CHE
9.45MG/IMP	LANT IMPLANT	
02240749	SUPREFACT DEPOT 3 MONTHS	CHE
1MG/ML SO	LUTION	
02225166	SUPREFACT	CHE
	02228955 9.45MG/IMP 02240749 1MG/ML SO	02228955 SUPREFACT DEPOT 2 MONTHS 9.45MG/IMPLANT IMPLANT 02240749 SUPREFACT DEPOT 3 MONTHS 1MG/ML SOLUTION 02225166 SUPREFACT

10:00.00 ANTINEOPLASTIC AGENTS BUSULFAN

2MG TABLET

00004618 MYLERAN ASP

CABOZANTINIB (CABOZANTINIB MALATE)

Limited use benefit (prior approval required).

Initial coverage for 4 months:

For the treatment of patients with advanced renal cell carcinoma (RCC) who have received at least one prior vascular endothelial growth factor receptor (VEGFR) tyrosine kinase inhibitor (TKI) therapy.

• patient has good performance status with an ECOG of 0 to 2

Criteria for renewal every 4 months:

There is no objective evidence of disease progression.

*NIHB coverage is only provided for one of axitinib (Inlyta) or cabozantinib (Cabometyx) in the third-line setting for intermediate or poor risk patients treated with nivolumab (Opdivo) and ipilimumab (Yervoy) first-line and VEGF TKI secondline.

20MG TABLET

02480824	CABOMETYX	IPS
40MG TABL	ET	
02480832	CABOMETYX	IPS
60MG TABL	ET	
02480840	CABOMETYX	IPS

CAPECITABINE

150MG TABLET

02426757	ACH-CAPECITABINE	ACC
02421917	SANDOZ CAPECITABINE	SDZ
02457490	TARO-CAPECITABINE	TAR
02400022	TEVA-CAPECITABINE	TEV
02238453	XELODA	HLR
500MG TABI	LET	
02426765	ACH-CAPECITABINE	ACC
02421925	SANDOZ CAPECITABINE	SDZ
02457504	TARO-CAPECITABINE	TAR

TEV

HLR

CERITINIB

02400030

02238454

Limited use benefit (prior approval required).

XELODA

Criteria for initial 12-month coverage:

Second-line treatment of patients with locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer (NSCLC) who have disease progression on or intolerance to crizotinib; and

TEVA-CAPECITABINE

- to be used as monotherapy; and
- disease is anaplastic lymphoma kinase (ALK)-positive; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

150MG CAPSULE

02436779	ZYKADIA	NVR

CHLORAMBUCIL

2MG TABLET

00004626 LEUKERAN ASP

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CHE

10:00.00 ANTINEOPLASTIC AGENTS COBIMETINIB

Limited use benefit (prior approval required).

Criteria for initial 6-month coverage:

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.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

20MG TABLET

02452340 COTELLIC

HLR

CRIZOTINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

First-line treatment of patients with advanced non-small cell lung cancer (NSCLC); or

Second-line treatment of patients with advanced NSCLC who have received one prior chemotherapy regimen.*; and

- patient is anaplastic lymphoma kinase (ALK)-positive; and
- patient has an ECOG performance status of 0 to 2.

*Patients who have progressed during or following first-line therapy with crizotinib are not eligible to receive crizotinib as a second-line therapy.

Criteria for renewal every 12 months:

The patient has experienced a hematologic and/or cytogenic response to crizotinib and is expected to continue to do so.

200MG CAPSULE

02384256 XALKORI PFI

CYCLOPHOSPHAMIDE

25MG TABLET

02241795 PROCYTOX BAX

50MG TABLET

02241796 PROCYTOX BAX

10:00.00 ANTINEOPLASTIC AGENTS DABRAFENIB

Limited use benefit (prior approval required).

1. First-line treatment of patients with metastatic or unresectable melanoma.

Criteria for initial 6-month coverage:

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 trametinib (Mekinist)

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; and
- patient is previously untreated.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

- 2. Adjuvant treatment of patients with cutaneous melanoma. Criteria for maximum 12-month coverage:
- in combination with trametinib for the adjuvant treatment of patients with stage IIIA (limited to lymph node metastases of >1 mm) to stage IIID (8th edition of the American Joint Committee on Cancer Staging System) cutaneous melanoma; and
- patient has documented BRAF V600 mutation cutaneous melanoma; and
- disease must be completely resected including in-transit metastases*: and
- patient has an ECOG performance status of 0 to 1.

Maximum duration of therapy is 12 months.

* Presence of regional lymph nodes with micrometastases after sentinel lymph node biopsy alone is allowed.

50MG CAPSULE

 02409607
 TAFINLAR
 NVR

 75MG CAPSULE
 02409615
 TAFINLAR
 NVR

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10:00.00 ANTINEOPLASTIC AGENTS **ENZALUTAMIDE**

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of patients with metastatic castrationresistant 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 ≤2 and no risk factors for seizures;
- 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.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

Criteria for initial 12-month coverage:

For the treatment of non-metastatic castration-resistant prostate cancer patients (nmCRPC) who meet all the following criteria:

- · used in combination with androgen deprivation therapy (ADT): and
- are at high risk* of developing metastases; and
- have no risk factors for seizures; and
- have a good ECOG performance status (0 or 1).
- * high risk is defined as a prostate-specific antigen doubling time (PSADT) of \leq 10 months during continuous ADT.

Criteria for renewal every 12 months:

40MG CAPSULE

02407329 XTANDI AST

ERLOTINIB HYDROCHLORIDE

02/61962 ADO EDI OTINID

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

02401002	APO-ERLOTINID	AFA
02483912	NAT-ERLOTINIB	NPH
02269007	TARCEVA	HLR
02377691	TEVA-ERLOTINIB	TEV
100MG TABI	LET	
02461870	APO-ERLOTINIB	APX
02454386	PMS-ERLOTINIB	PMS
02269015	TARCEVA	HLR
02377705	TEVA-ERLOTINIB	TEV

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.

150MG TABLET

02461889	APO-ERLOTINIB	APX
02454394	PMS-ERLOTINIB	PMS
02269023	TARCEVA	HLR
02377713	TEVA-ERLOTINIB	TEV

ETOPOSIDE

50MG CAPSULE

00616192 VEPESID CHE

EVEROLIMUS

Limited use benefit (prior approval required).

For the treatment of:

- advanced breast cancer according to established criteria.
- advanced or metastatic renal cell carcinoma (mRCC) according to established criteria.
- progressive, unresectable, well or moderately differentiated, locally advanced or metastatic pancreatic neuroendocrine tumors (pNet) according to established criteria.
- non-functional neuroendocrine tumors (Nets) of gastrointestinal or lung origin (GIL) according to established criteria.

(Please refer to Appendix A).

2.5MG TABLET

023692	257 AFI	NITOR	ı	NVR
024632	229 TE\	/A-EVEROLIMU	S	TEV
5MG TA	BLET			
023395	501 AFI	NITOR	1	NVR
024632	237 TE\	/A-EVEROLIMU	S	TEV
10MG T	ABLET			
023395	528 AFI	NITOR	ı	NVR
024632	253 TE\	/A-EVEROLIMU	S	TEV
2MG TA	BLET FO	R SUSPENSION	I	
024256	645 AFI	NITOR DISPERA	<u>z</u> 1	NVR
3MG TA	BLET FO	R SUSPENSION	l	
024256	653 AFI	NITOR DISPERA	<u>z</u> 1	NVR
5MG TA	BLET FO	R SUSPENSION	l	
024256	61 AFI	NITOR DISPERA	<u>z</u> 1	NVR
EXEMES	ΓΑΝΕ			

25MG TABLET

02390183	ACT EXEMESTANE	TEV
02419726	APO-EXEMESTANE	APX
02242705	AROMASIN	PF
02407841	MED-EXEMESTANE	GMP
02408473	TEVA-EXEMESTANE	TEV

FLUDARABINE PHOSPHATE

10MC TABLET

IUNG TABL	- 1	
02246226	FLUDARA	SAC

FLUTAMIDE

250MG TABLET

02238560 FLUTAMIDE AAP

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10:00.00 ANTINEOPLASTIC AGENTS FLUTAMIDE

250MG TABLET

02230104 PMS-FLUTAMIDE PMS

GEFITINIB

Limited use benefit (prior approval required).

Criteria for initial 6-month coverage:

For the treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) who meet all of the following criteria:

- first-line treatment: and
- EGFR mutation positive; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

250MG TABLET

02468050	APO-GEFITINIB	APX
02248676	IRESSA	AZC
02487748	SANDOZ GEFITINIB	SDZ

HYDROXYUREA

500MG CAPSULE

02247937	APO-HYDROXYUREA	APX
00465283	HYDREA	BMS
02242920	MYI AN-HYDROXYURFA	MYL

IBRUTINIB

Limited use benefit (prior approval required).

For the treatment of:

- previously untreated chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) (first-line) according to established criteria.
- chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) (second-line) according to established criteria.
- relapsed/refractory mantle cell lymphoma (MCL) according to established criteria.

(Please refer to Appendix A):

140MG CAPSULE

02434407 IMBRUVICA JSO

IDELALISIB

Limited use benefit (prior approval required).

Criteria for initial 6-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 renewal every 6 months:

There is no objective evidence of disease progression.

100MG TABLET

TOOM O 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; or

For the treatment of patients with gastrointestinal stromal tumour; or

For newly diagnosed adult patients with Philadelphia chromosome-positive (CML); or

For the treatment of adult patients with Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL).

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 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).

2.5MG CAPSULE

	02459418	REVLIMID	UNK
	5MG CAPSU	JLE	
	02304899	REVLIMID	UNK
	10MG CAPS	ULE	
	02304902	REVLIMID	UNK
	15MG CAPS	ULE	
	02317699	REVLIMID	UNK
	20MG CAPS	ULE	
	02440601	REVLIMID	UNK
25MG CAPSULE			
	02317710	REVLIMID	UNK

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10:00.00 ANTINEOPLASTIC AGENTS **LENVATINIB**

Limited use benefit (prior approval required).

1. Unresectable Hepatocellular Carcinoma (HCC):

Criteria for initial 4-month coverage:

For the first-line treatment of adult patients with unresectable HCC; and

- patient has a Child-Pugh A liver function status; and
- patient has an ECOG performance status of 0 to 1; and
- patient meets the inclusion criteria of the REFLECT trial:
- patient does not have ≥50% of liver occupation;
- patient does not have clear invasion of the bile duct or portal vein at the main portal branch;
- patient does not have a history of or current brain or subdural metastases.

Criteria for renewal every 4 months:

There is no objective evidence of disease progression.

2. Differentiated thyroid cancer (DTC)

Criteria for initial 4-month coverage:

Used as monotherapy for treatment of patients with locally recurrent or metastatic, progressive DTC; and

- DTC is refractory to radioactive iodine treatment; and
- have an ECOG performance status of ≤ 2;and
- patient meets the eligibility criteria of the SELECT trial as follows:
- pathologically confirmed differentiated thyroid cancer (patients with anaplastic or medullary thyroid cancer are not
- evidence of iodine-131 refractory disease according to at least one of the following criteria:
- at least one measurable lesion without iodine uptake on any iodine-131 scan
- at least one measurable lesion that had progressed according to RECIST criteria within 12 months after iodine-131 therapy despite iodine-131 avidity at the time of treatment
- total lifetime radioactive iodine dose greater than 600 mCi (millicurie)
- radiologic evidence of progression within the previous 13 months
- no prior therapy with a tyrosine kinase inhibitor or have received one prior treatment regimen with a tyrosine kinase

Criteria for renewal every 4 months:

nere is no objective evidence of disease progression.		2MG TABLET
4MG CAPSULE		00004715 ALKERAN ASP
02484056 LENVIMA	EIS	MERCAPTOPURINE
8MG CAPSULE		50MG TABLET
02468220 LENVIMA	EIS	02415275 MERCAPTOPURINE RAX
10MG CAPSULE		
02450321 LENVIMA	EIS	00004723 PURINETHOL TEV
12MG CAPSULE		METHOTREXATE SODIUM
02484129 LENVIMA	EIS	7.5MG SOLUTION
14MG CAPSULE		02320029 METOJECT UNK
02450313 LENVIMA	EIS	02454823 METOJECT SUBCUTANEOUS UNK
20MG CAPSULE		10MG SOLUTION
02450305 LENVIMA	EIS	02454831 METOJECT SUBCUTANEOUS UNK
24MG CAPSULE		10MG/0.4ML SOLUTION
02450291 LENVIMA	EIS	02422174 METHOTREXATE PMS
		10MG/ML SOLUTION
		02182947 METHOTREXATE PFI

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10:00.00 ANTINEOPLASTIC AGENTS LETROZOLE

LETROZOLE		
ST 2.5MG TABL	ET	
02338459	ACH-LETROZOLE	ACC
02358514	APO-LETROZOLE	APX
02392496	BIO-LETROZOLE	BMI
02231384	FEMARA	NVR
02373009	JAMP-LETROZOLE	JMP
02402025	LETROZOLE	PDL
	MAR-LETROZOLE	MAR
	MED-LETROZOLE	GMP
02421585	NAT-LETROZOLE	NPH
	PMS-LETROZOLE	PMS
	RAN-LETROZOLE	RBY
	RIVA-LETROZOLE	RIV
	SANDOZ LETROZOLE	SDZ
	TEVA-LETROZOLE	TEV
	ZINDA-LETROZOLE	UNK
LEUPROLIDE	ACETATE	
10.5MG/VIAL	POWDER FOR SUSPENSION	
02248239	ELIGARD	SAC
22.5MG/VIAL	POWDER FOR SUSPENSION	
02248240	ELIGARD	SAC
30MG/VIAL F	POWDER FOR SUSPENSION	
02248999	ELIGARD	SAC
45MG/VIAL F	POWDER FOR SUSPENSION	
02268892	ELIGARD	SAC
LOMUSTINE		
10MG CAPS	ULE	
00360430	CEENU	BMS
40MG CAPS	ULE	
00360422	CEENU	BMS
MEGESTROL	. ACETATE	
40MG TABLE	ĒΤ	
	MEGESTROL	AAP
160MG TABL	.ET	
02195925	MEGESTROL	AAP
MELPHALAN		
2MG TABLE	т	
00004715		ASP
MERCAPTOR		7.01
50MG TABLE		DAY
	MERCAPTOPURINE	RAX
	PURINETHOL	TEV
METHOTREX	ATE SODIUM	
7 5MG SOLL	ITION	

10:00.00 ANTINEOPLASTIC AGENTS **METHOTREXATE SODIUM**

	12.5MG SOLUTION			
	02454750	METOJECT SUBCUTANEOUS	UNK	
15MG SOLUTION				
	02454858	METOJECT SUBCUTANEOUS	UNK	
	15MG/0.6ML	SOLUTION		
	02422182	METHOTREXATE	PMS	
	17.5MG SOL	.UTION		
	02454769	METOJECT SUBCUTANEOUS	UNK	
	20MG SOLU	TION		
	02454866	METOJECT SUBCUTANEOUS	UNK	
	20MG/0.8ML	SOLUTION		
	02422190	METHOTREXATE	PMS	
	22.5MG SOL	.UTION		
	02454777	METOJECT SUBCUTANEOUS	UNK	
	25MG SOLU	TION		
	02454874	METOJECT SUBCUTANEOUS	UNK	
	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	APX	
	02170698	PMS-METHOTREXATE	PMS	
	10MG TABLET			
	02182750	METHOTREXATE	PFI	

MIDOSTAURIN

Limited use benefit (prior approval required).

Criteria for 12-month coverage:

- patient has newly diagnosed FMS-like tyrosine kinase 3 (FLT3)-mutated acute myeloid leukemia (AML); and
- patient's FLT3-mutation status has been confirmed; and
- midostaurin is being used in combination with standard cytarabine and daunorubicin (or idarubicin) induction and cytarabine consolidation chemotherapy; and
- patient has an ECOG performance status of 0 to 2.

25MG	CAPSUL	F

02466236 RYDAPT NVR

MITOTANE

500MG TABLET

HRA 00463221 LYSODREN

10:00.00 ANTINEOPLASTIC AGENTS **NILOTINIB**

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

Patients has newly diagnosed Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia in chronic phase; or

Patient has chronic phase or accelerated phase Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia;

- patient has disease progression/resistance to imatinib; or
- documented intolerance to a prior oral TKI (imatinib. dasatinib or bosutinib).

Criteria for renewal every 12 months:

Confirmation from the clinician that the patient has experienced hematologic and/or cytogenic response and is expected to continue to do so and has not developed unacceptable toxicities.

150MG CAPSULE

02368250 TASIGNA NVR 200MG CAPSULE

02315874 TASIGNA

NILUTAMIDE

50MG TABLET

CHE 02221861 ANANDRON

OLAPARIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

- maintenance treatment of adult patients with high grade serous epithelial ovarian fallopian tube cancer; or
- primary peritoneal cancer;
- and
- platinum-sensitive disease; and
- relapsed BRCA-mutated disease (germline or somatic as detected by approved testing)
- have completed at least two previous lines of platinumbased chemotherapy; and
- radiologic response (complete or partial response) to their most recent platinum-based chemotherapy regimen as per the SOLO-2 trial; and
- patient has an ECOG performance status of 0 to 2;
- · olaparib is used as monotherapy

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

50MG CAPSULE

02454408 LYNPARZA AZC.

100MG TABLET

02475200 LYNPARZA AZC

150MG TABLET

02475219 LYNPARZA

AZC

NVR

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10:00.00 ANTINEOPLASTIC AGENTS OSIMERTINIB

Limited use benefit (prior approval required).

1. First-line treatment of locally advanced or metastatic nonsmall cell lung cancer (NSCLC)

Criteria for initial 12-month coverage:

Patient with locally advanced (not amenable to curative intent therapy) or metastatic non-small cell lung cancer whose tumors have epidermal growth factor receptor (EGFR) mutations (exon 19 deletions [exon 19 del] or exon 21 [L858R]); and

- patient is previously untreated in the locally advanced or metastatic setting; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no clinically meaningful disease progression or unacceptable toxicity.

2. Subsequent treatment of locally advanced or metastatic non-small cell lung cancer (NSCLC)

Criteria for initial 12-month coverage:

Patient with locally advanced or metastatic NSCLC who has progressed on epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor therapy; and

- patient is EGFR T790M mutation- positive; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

40MG TABLET

02456214 TAGRISSO AZC

80MG TABLET

02456222 TAGRISSO AZC

10:00.00 ANTINEOPLASTIC AGENTS PALBOCICLIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of post-menopausal clients with estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer; and

- the patient has not received any prior treatment for metastatic disease (first-line treatment); and
- palbociclib will be used in combination with an aromatase inhibitor; and
- patient has an ECOG performance status of 0 to 2; and
- patient is not resistant to prior (neo)adjuvant aromatase inhibitor therapy; and
- patient does not have active or uncontrolled metastases to the central nervous system.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

0

Criteria for initial 12-month coverage:

For in combination with fulvestrant, for the treatment of patients with hormone receptor (HR)-positive, HER2-negative locally advanced or metastatic breast cancer (mBC) whose disease has progressed after prior endocrine therapy.

• patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

75MG CAPSULE

02453150 IBRANCE PFI

100MG CAPSULE

02453169 IBRANCE PFI

125MG CAPSULE

02453177 IBRANCE PFI

PAZOPANIB

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

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10:00.00 ANTINEOPLASTIC AGENTS **POMALIDOMIDE**

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of relapsed or refractory multiple myeloma who meet all of the following criteria:

- used in combination with dexamethasone; and
- patient has relapsed or is refractory to at least two treatment regimens, including both bortezomib and lenalidomide; and
- patient has demonstrated disease progression on the last regimen.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or development of unacceptable toxicity to pomalidomide requiring discontinuation of therapy.

1MG CAPSULE

02419580 POMALYST

2MG CAPSULE

02419599 POMALYST UNK

3MG CAPSULE

02419602 POMALYST UNK

4MG CAPSULE

02419610 POMALYST UNK

PONATINIB HYDROCHLORIDE

Limited use benefit (prior approval required).

Criteria for initial 6-month coverage:

For the treatment of patients who have confirmed T315i mutation positive disease, independent of previous TKI

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 renewal every 6 months:

There is no objective evidence of disease progression.

15MG TABLET

02437333 ICLUSIG ARI

45MG TABLET

02437341 ICLUSIG

PROCARBAZINE HYDROCHLORIDE

50MG CAPSULE

00012750 MATULANE UNK

10:00.00 ANTINEOPLASTIC AGENTS **REGORAFENIB**

Limited use benefit (prior approval required).

1. For the treatment of Gastrointestinal Stromal Tumors

Criteria for initial six-month coverage:

For patients with Gastrointestinal Stromal Tumors (GIST) who have failed or are unable to tolerate imatinib and sunitinib

• patient has an ECOG performance status of 0 or 1;

Note: Regorafenib will not be funded concomitantly with imatinib or sunitinib.

Criteria for assessment every 12 months: There is no objective evidence of disease progression.

2. For the treatment of Hepatocellular Carcinoma (HCC) Criteria for initial six-month coverage:

Patient diagnosed with unresectable HCC; and

- patient has been previously treated with sorafenib or lenvatinib; and
- patient was able to tolerate sorafenib as defined in the RESorCE trial criteria (≥400mg/day for ≥20 days of the last 28 days of treatment); and
- patient has a Child-Pugh class status of A; and
- patient has an ECOG performance status of 0 to 1

Criteria for assessment every 12 months:

There is no objective evidence of disease progression.

40MG TABLET

UNK

02403390 STIVARGA

RAY

RIBOCICLIB (RIBOCICLIB SUCCINATE)

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of post-menopausal clients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.

- the patient has not received any prior treatment for metastatic disease (first-line treatment); and
- ribociclib will be used in combination with letrozole; and
- patient has an ECOG performance status of 0 to 2; and
- patient is not resistant* to prior (neo)adjuvant nonsteroidal aromatase inhibitor therapy (NSAI); and
- patient does not have active or uncontrolled metastases to the central nervous system.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or unacceptable toxicity.

*Resistance is defined as disease progression occurring during or within 12 months following aromatase inhibitor therapy.

200MG TABLET

02473569 KISQALI

NVR

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ARI

10:00.00 ANTINEOPLASTIC AGENTS 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

RUXOLITINIB

Limited use benefit (prior approval required).

1. For the treatment of myelofibrosis:

Criteria for initial 6-month coverage:

- intermediate to high risk symptomatic myelofibrosis as assessed using the Dynamic International Prognostic Scoring System (DIPSS) Plus; or
- patient has symptomatic splenomegaly;
- and
- patient has an ECOG performance status of 0 to 3; and
- patient previously untreated or refractory to other treatment.

Criteria for renewal every 12 months:

- reduction in spleen size; or
- improvement in disease symptoms.
- 2. For the treatment of patients with polycythemia vera:

Criteria for initial 6-month coverage:

Disease is resistant to hydroxyurea (HU) according to the modified European LeukemiaNet Criteria defined as below: After 3 months of at least 2g/day of HU or at the maximally tolerated HU dose, patient showed:

- need for phlebotomy to keep hematocrit < 45%; or
- uncontrolled myeloproliferation (platelet > 400x109/L and WBC > 10x109/L); or
- failure to reduce massive splenomegaly > 50% as measured by palpation.
- 01
- Patient is intolerant to HU according to the modified European LeukemiaNet Criteria defined below: After any dose of HU, patient showed:
- absolute neutrophil count < 1.0 x 109/L , or platelet < 100x109/L or hemoglobin < 100 g/L at the lowest dose of HU required to achieve a response (response defined as hematocrit < 45% without phlebotomy, and/or all of the following: platelet $\leq 400x109/L$, WBC ≤ 10 x 109/L, and non-palpable spleen); or
- presence of leg ulcers or other unacceptable HU-related non-hematological toxicities (such as mucocutaneous manifestations, gastrointestinal symptoms, pneumonitis or fever, defined as Common Terminology Criteria for Adverse Events (CTCAE) version 3.0 grade 3 or 4, or more than one week of CTCAE version 3.0 grade 2, or permanent discontinuation of HU, or interruption of HU until toxicity resolved, or hospitalization due to HU toxicity).
- and
- patient has an ECOG performance status of 0 to 3.

Criteria for renewal every 12 months:

- reduction in spleen size; or
- improvement in disease symptoms.

5MG TABLET

02388006 JAKAVI

1. For the treatment of myelofibrosis:

Limited use benefit (prior approval required).

10:00.00 ANTINEOPLASTIC AGENTS

Criteria for initial 6-month coverage:

RUXOLITINIB

- intermediate to high risk symptomatic myelofibrosis as assessed using the Dynamic International Prognostic Scoring System (DIPSS) Plus; or
- patient has symptomatic splenomegaly;
- and
- patient has an ECOG performance status of 0 to 3; and
- patient previously untreated or refractory to other treatment.

Criteria for renewal every 12 months:

- reduction in spleen size; or
- improvement in disease symptoms.
- 2. For the treatment of patients with polycythemia vera:

Criteria for initial 6-month coverage:

Disease is resistant to hydroxyurea (HU) according to the modified European LeukemiaNet Criteria defined as below: After 3 months of at least 2g/day of HU or at the maximally tolerated HU dose, patient showed:

- need for phlebotomy to keep hematocrit < 45%; or
- uncontrolled myeloproliferation (platelet > 400x109/L and WBC > 10x109/L); or
- failure to reduce massive splenomegaly > 50% as measured by palpation.
- or
- Patient is intolerant to HU according to the modified European LeukemiaNet Criteria defined below: After any dose of HU, patient showed:
- absolute neutrophil count < 1.0 x 109/L , or platelet < 100x109/L or hemoglobin < 100 g/L at the lowest dose of HU required to achieve a response (response defined as hematocrit < 45% without phlebotomy, and/or all of the following: platelet $\leq 400x109/L$, WBC ≤ 10 x 109/L, and non-
- presence of leg ulcers or other unacceptable HU-related non-hematological toxicities (such as mucocutaneous manifestations, gastrointestinal symptoms, pneumonitis or fever, defined as Common Terminology Criteria for Adverse Events (CTCAE) version 3.0 grade 3 or 4, or more than one week of CTCAE version 3.0 grade 2, or permanent discontinuation of HU, or interruption of HU until toxicity resolved, or hospitalization due to HU toxicity).
- and
- patient has an ECOG performance status of 0 to 3.

Criteria for renewal every 12 months:

- · reduction in spleen size; or
- · improvement in disease symptoms.

10MG TABLET

02434814 JAKAVI

NVR

15MG TABLET

palpable spleen); or

02388014 JAKAVI

NVR

20MG TABLET

02388022 JAKAVI

NVR

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NVR

10:00.00 ANTINEOPLASTIC AGENTS SUNITINIB MALATE

Limited use benefit (Prior approval required).

Criteria for initial 6-month coverage:

• 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;

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Criteria for initial 12-month coverage:

- Documented, progressive, unresectable, well or moderately differentiated, locally advanced or metastatic pancreatic neuroendocrine tumors; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

250MG CAPSULE

THIOGUANINE

40MG TABLET

00282081 L

02241096 TEMODAL

02395312 ACT TEMOZOLOMIDE

LANVIS

02443554 TARO-TEMOZOLOMIDE

There is no objective evidence of disease progression.

There is no objective evidence of disease progression.				
12.5MG CAPSULE				
02280795	SUTENT	PFI		
25MG CAPSULE				
02280809	SUTENT	PFI		
50MG CAPS	ULE			
02280817	SUTENT	PFI		
TAMOXIFEN	CITRATE			
10MG TABL	ET			
00812404	APO-TAMOX	APX		
00851965	TEVA-TAMOXIFEN	TEV		
20MG TABL	ET			
00812390	APO-TAMOX	APX		
02048485	NOLVADEX-D	AZC		
00851973	TEVA-TAMOXIFEN	TEV		
TEMOZOLOMIDE				
5MG CAPSU	ILE			
02441160	ACT TEMOZOLOMIDE	ACG		
02443473	TARO-TEMOZOLOMIDE	TAR		
02241093	TEMODAL	FRS		
20MG CAPS	ULE			
	ACT TEMOZOLOMIDE	ACG		
02443481	TARO-TEMOZOLOMIDE	TAR		
	TEMODAL	FRS		
	100MG CAPSULE			
02395282		ACG		
	TARO-TEMOZOLOMIDE	TAR		
02241095		FRS		
140MG CAP				
	ACT TEMOZOLOMIDE	ACG		
	APO-TEMOZOLOMIDE	APX		
	TARO-TEMOZOLOMIDE	TAR		
02312794	TEMODAL	FRS		

10:00.00 ANTINEOPLASTIC AGENTS TRAMETINIB

Limited use benefit (prior approval required).

1. First-line treatment of patients with metastatic or unresectable melanoma.

Criteria for initial 6-month coverage:

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 dabrafenib (Tafinlar)

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; and
- patient is previously untreated.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

- 2. Adjuvant treatment of patients with cutaneous melanoma. Criteria for maximum 12-month coverage:
- in combination with trametinib for the adjuvant treatment of patients with stage IIIA (limited to lymph node metastases of >1 mm) to stage IIID (8th edition of the American Joint Committee on Cancer Staging System) cutaneous melanoma; and
- patient has documented BRAF V600 mutation cutaneous melanoma; and
- disease must be completely resected including in-transit metastases*; and
- patient has an ECOG performance status of 0 to 1.

Maximum duration of therapy is 12 months.

* Presence of regional lymph nodes with micrometastases after sentinel lymph node biopsy alone is allowed.

0.5MG TABL	.ET	
02409623	MEKINIST	NVR
2MG TABLE	т	
02409658	MEKINIST	NVR
TRETINOIN		
10MG CAPS	ULE	
02145839	VESANOID	CHE
TRIPTORELI	N PAMOATE	
3.75MG/VIAI	POWDER FOR SUSPENSION	
02240000	TRELSTAR	UNK
11.25MG/VI	AL POWDER FOR SUSPENSION	
02243856	TRELSTAR	UNK
22.5MG POV	VDER FOR SUSPENSION	
02412322	TRELSTAR	UNK

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ACG

TAR

FRS

ASP

10:00.00 ANTINEOPLASTIC AGENTS VANDETANIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For patients with symptomatic and/or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease; and

• an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

100MG TABLET

02378582 CAPRELSA

SAC

300MG TABLET

02378590 CAPRELSA

SAC

VEMURAFENIB

Limited use benefit (prior approval required).

Criteria for initial 6-month coverage:

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.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

ST 240MG TABLET

02380242 ZELBORAF HLR

10:00.00 ANTINEOPLASTIC AGENTS VENETOCLAX

Limited use benefit (prior approval required).

1. Monotherapy treatment in adult patients with chronic lymphocytic leukemia (CLL)

Criteria for initial 12-month coverage:

For the treatment of CLL who meet all of the following criteria: Venclexta will be used as monotherapy; and

- patient has received at least one prior therapy; and
- patient has failed a B-cell receptor inhibitor (BCRi) or is intolerant to prior ibrutinib therapy; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or unacceptable toxicity.

2. In combination with rituximab for the treatment of chronic lymphocytic leukemia (CLL)

Criteria for 12-month coverage of venetoclax:

For the treatment of CLL; and

- in combination with rituximab; and
- patient has received at least one prior therapy; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

02458063 VENCLEXTA

There is no objective evidence of disease progression or unacceptable toxicity.

Coverage is for a maximum duration of two years.

10MG TABLET 02458039 VENCLEXTA ABV 50MG TABLET 02458047 VENCLEXTA ABV 100MG TABLET 02458055 VENCLEXTA ABV

ABV

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12:00 AUTONOMIC DRUGS

12:04.00 PARASYMPATHOMIMETIC AGENTS

BETHANECHOL CHLORIDE

10MG TABL	ET	
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.

ST 5MG TABLET

02362260	APO-DONEPEZIL	APX
02232043	ARICEPT	PFI
02400561	AURO-DONEPEZIL	AUR
02412853	BIO-DONEPEZIL	BMI
02402645	DONEPEZIL	ACC
02416417	DONEPEZIL	PDL
02420597	DONEPEZIL	SIV
02426846	DONEPEZIL	SAN
02475278	DONEPEZIL	RIV
02416948	JAMP-DONEPEZIL	JMP
02402092	MAR-DONEPEZIL	MAR
02467453	M-DONEPEZIL	MAN
02408600	MINT-DONEPEZIL	MIN
02439557	NAT-DONEPEZIL	NPH
02322331	PMS-DONEPEZIL	PMS
02328666	SANDOZ DONEPEZIL	SDZ
02428482	SEPTA DONEPEZIL	SPT
02381508	TARO-DONEPEZIL	SUN
02340607	TEVA-DONEPEZIL	TEV
10MG TABL	ET	
02362279	APO-DONEPEZIL	APX
02232044	ARICEPT	PFI
02400588	AURO-DONEPEZIL	AUR
02412861	BIO-DONEPEZIL	BMI
02402653	DONEPEZIL	ACC
02416425	DONEPEZIL	PDL
02420600	DONEPEZIL	SIV

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.

$^{\text{ST}}$ 10MG TABLET

02426854	DONEPEZIL	SAN
02475286	DONEPEZIL	RIV
02416956	JAMP-DONEPEZIL	JMP
02402106	MAR-DONEPEZIL	MAR
02467461	M-DONEPEZIL	MAN
02408619	MINT-DONEPEZIL	MIN
02439565	NAT-DONEPEZIL	NPH
02322358	PMS-DONEPEZIL	PMS
02328682	SANDOZ DONEPEZIL	SDZ
02428490	SEPTA DONEPEZIL	SPT
02381516	TARO-DONEPEZIL	SUN
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 (GĎS) 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.

ST 8MG CAPSULE (EXTENDED RELEASE)

ONIO OA	OOLL (LATENDLD RELLACE	- ,
0242515	7 AURO-GALANTAMINE EI	R AUR
0244301	5 GALANTAMINE	SAN
0241657	3 GALANTAMINE ER	PDL
0242082	1 MAR-GALANTAMINE ER	MAR
0233943	9 MYLAN-GALANTAMINE E	ER MYL
0231694	3 PAT-GALANTAMINE ER	JSO

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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

ST 8MG CAPSULE (EXTENDED RELEASE) 02398370 PMS-GALANTAMINE ER

00869945 PROSTIGMIN

02216345 SALAGEN **PYRIDOSTIGMINE BROMIDE**

00869961 MESTINON

ST 180MG TABLET (EXTENDED RELEASE) 00869953 MESTINON-SR

ST 5MG TABLET

ST 60MG TABLET

PILOCARPINE HYDROCHLORIDE

02402483 PILOCARPINE HYDROCHLORIDE

 Alzheimer's disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

ST 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 JSO 02398389 PMS-GALANTAMINE ER **PMS** ST 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 JSO 02398397 PMS-GALANTAMINE ER **PMS NEOSTIGMINE BROMIDE** ST 15MG TABLET

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.

IVIIVISE OF IVIOCA	iess triari 10.			
ST 1.5MG CAPSULE				
02336715	APO-RIVASTIGMINE	APX		
02242115	EXELON	NVR		
02485362	JAMP RIVASTIGMINE	JMP		
02401614	MED-RIVASTIGMINE	GMP		
02306034	PMS-RIVASTIGMINE	PMS		
02416999	RIVASTIGMINE	PDL		
02324563	SANDOZ RIVASTIGMINE	SDZ		
ST 3MG CAPSU	ILE			
02336723	APO-RIVASTIGMINE	APX		
02242116	EXELON	NVR		
02485370	JAMP RIVASTIGMINE	JMP		
02401622	MED-RIVASTIGMINE	GMP		
02306042	PMS-RIVASTIGMINE	PMS		
02417006	RIVASTIGMINE	PDL		
02324571		SDZ		
ST 4.5MG CAPS	BULE			
02336731	APO-RIVASTIGMINE	APX		
02242117	EXELON	NVR		
02485389	JAMP RIVASTIGMINE	JMP		
02401630	MED-RIVASTIGMINE	GMP		
02306050	PMS-RIVASTIGMINE	PMS		
02417014	RIVASTIGMINE	PDL		
02324598		SDZ		
ST 6MG CAPSU	LE			
02336758	APO-RIVASTIGMINE	APX		
02242118	EXELON	NVR		
02485397	JAMP RIVASTIGMINE	JMP		
02401649	MED-RIVASTIGMINE	GMP		
02306069	PMS-RIVASTIGMINE	PMS		
02417022	RIVASTIGMINE	PDL		
02324601	SANDOZ RIVASTIGMINE	SDZ		
ST 2MG/ML SO				
02245240	EXELON	NVR		

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PMS

VAE

RAX AMD

BSH

BSH

12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

ACLIDINIUM BROMIDE

400MCG POWDER

02409720 TUDORZA GENUAIR AZC

GLYCOPYRRONIUM BROMIDE

50MCG CAPSULE

02394936 SEEBRI BREEZHALER NVR

HYOSCINE BUTYLBROMIDE

ST 10MG TABLET

00363812 BUSCOPAN SAC

INDACATEROL MALEATE, GLYCOPYRRONIUM BROMIDE

Open benefit (prior approval is not required).

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

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

*As defined by the Canadian Thoracic Society COPD classification. Moderate: shortness of breath from COPD causing the patient to stop after walking approximately 100 meters (or after a few minutes) on the level. Severe: shortness of breath from COPD resulting in the patient being too breathless to leave the house or breathless after undressing, or the presence of chronic respiratory failure or clinical signs of right heart failure.

110MCG & 50MCG CAPSULE

02418282 ULTIBRO BREEZHALER NVR

IPRATROPIUM BROMIDE

20MCG/INHALATION AEROSOL

02247686 ATROVENT HFA BOE 0.03% NASAL SPRAY

00040500 DOM ID

02240508DOM-IPRATROPIUMDPC02239627PMS-IPRATROPIUMPMS

21MCG NASAL SPRAY

02246083 IPRAVENT AAP

42MCG NASAL SPRAY 02246084 IPRAVENT

125MCG/ML SOLUTION

125MCG/ML SOLUTION

02231135 PMS-IPRATROPIUM PMS

250MCG/ML SOLUTION

 02126222
 APO-IPRAVENT
 APX

 02231136
 PMS-IPRATROPIUM
 PMS

 02231244
 PMS-IPRATROPIUM
 PMS

 02231245
 PMS-IPRATROPIUM
 PMS

99001446 RATIO-IPRATROPIUM RPH
02216221 TEVA-IPRATROPIUM STERINEBS TEV

IPRATROPIUM BROMIDE, SALBUTAMOL SULFATE

0.2MG & 1MG/ML SOLUTION

02272695 TEVA-COMBO STERINEBS TEV

100MCG & 20MCG SOLUTION

02419106 COMBIVENT RESPIMAT BOE

12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

TIOTROPIUM BROMIDE MONOHYDRATE

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
02245664 TRIMEBUTINE AAP

UMECLIDINIUM BROMIDE

62.5MCG POWDER

02423596 INCRUSE ELLIPTA GSK

UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE

Open benefit (prior approval is not required).

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

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

*As defined by the Canadian Thoracic Society COPD classification. Moderate: shortness of breath from COPD causing the patient to stop after walking approximately 100 meters (or after a few minutes) on the level. Severe: shortness of breath from COPD resulting in the patient being too breathless to leave the house or breathless after undressing, or the presence of chronic respiratory failure or clinical signs of right heart failure.

62.5MCG/25MCG POWDER

02418401 ANORO ELLIPTA

GSK

12:12.04 ALPHA ADRENERGIC AGONISTS MIDODRINE HYDROCHLORIDE

2.5MG TABLET

 02278677
 APO-MIDODRINE
 APX

 02473984
 MAR-MIDODRINE
 MAR

5MG TABLET

 02278685
 APO-MIDODRINE
 APX

 02473992
 MAR-MIDODRINE
 MAR

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AAP

12:12.08 BETA ADRENERGIC AGONISTS ACLIDINIUM BROMIDE, FORMOTEROL FUMARATE DIHYDRATE

Open benefit with (prior approval is not required).

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

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

*As defined by the Canadian Thoracic Society COPD classification. Moderate: shortness of breath from COPD causing the patient to stop after walking approximately 100 meters (or after a few minutes) on the level. Severe: shortness of breath from COPD resulting in the patient being too breathless to leave the house or breathless after undressing, or the presence of chronic respiratory failure or clinical signs of right heart failure.

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

12:12.08 BETA ADRENERGIC AGONISTS 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

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

6MCG & 200MCG/INHALATION POWDER

02245386 SYMBICORT 200 TURBUHALER

AZC

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

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12:12.08 BETA ADRENERGIC AGONISTS **INDACATEROL MALEATE**

Limited use benefit (prior approval required).

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

- are not adequately controlled with either ipratropium. tiotropium or a short acting beta-agonist; or
- have moderate to severe COPD, as defined by spirometry.

75MCG CAPSULE

02376938 ONBREZ BREEZHALER NVR

OLODATEROL HYDROCHLORIDE, TIOTROPIUM BROMIDE MONOHYDRATE

2.5MCG & 2.5MCG SOLUTION

02441888 INSPIOLTO RESPIMAT BOF

ORCIPRENALINE SULFATE

2MG/ML SYRUP

02236783 ORCIPRENALINE AAP

SALBUTAMOL SULFATE

100MCG/INHALATION AEROSOL

02232570	AIROMIR	VAE
02245669	APO-SALBUTAMOL HFA	APX
02419858	SALBUTAMOL HFA	SAN
02326450	TEVA-SALBUTAMOL HFA	TEV
02241497	VENTOLIN HFA	GSK

2MG CAPSULE

99111294	SALBUTAMOL (QC)	UNK		
100MCG INHALER				
09858115	SALAMOL CFC-FREE	UNK		
09991688	SALAMOL CFC-FREE	UNK		

09858116 SALBUTAMOL ALDO-UNION (ON) 200MCG POWDER

02243115 VENTOLIN DISKUS **GSK**

0.5MG/ML SOLUTION

02208245	PMS-SALBUTAMOL	PMS
1MG/ML SO	LUTION	
02216949	DOM-SALBUTAMOL	DPC

02208229	PMS-SALBUTAMOL	PMS
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
02213486	VENTOLIN RESPIRATOR	GSK

12:12.08 BETA ADRENERGIC AGONISTS 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, shortduration 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

02231129 SEREVENT DISKUS

GSK

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 longacting 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; and
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

25MCG & 125MCG AEROSOL 02245126 ADVAIR 125

02245126	ADVAIR 125	GSK
25MCG & 25	OMCG AEROSOL	
02245127	ADVAIR 250	GSK
50MCG & 10	OMCG POWDER	
02240835	ADVAIR 100 DISKUS	GSK
02494507		PMS
	PROPIONATE/SALMETEROL DPI	
02495597	WIXELA INHUB	MYL
50MCG & 25	OMCG POWDER	
02240836	ADVAIR 250 DISKUS	GSK
02494515		PMS
	PROPIONATE/SALMETEROL DPI	
02495600	WIXELA INHUB	MYL
50MCG & 50	0MCG POWDER	
02240837	ADVAIR 500 DISKUS	GSK
02494523	PMS-FLUTICASONE PROPIONATE/SALMETEROL DPI	PMS
02495619	WIXELA INHUB	MYL

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

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JMP

12:12.12 ALPHA AND BETA ADRENERGIC 12:20.04 CENTRALL ACTING SKELETAL **AGONISTS MUSCLE RELAXANTS EPINEPHRINE** CYCLOBENZAPRINE HYDROCHLORIDE Limited use benefit (prior approval is not required). 0.5MG/ML SOLUTION 00578657 EPIPEN JR MYL For relief of muscle spasm associated with acute, painful 1MG/ML SOLUTION musculoskeletal conditions. **FRF** 00155357 ADRENALIN Coverage is limited to 60mg per day for three (3) weeks renewable every two (2) months. 00721891 EPINEPHRINE PFI 00509558 **EPIPEN** MYL ST 10MG TABLET JAMP-CYCLOBENZAPRINE .IMP 02357127 12:16.00 SYMPATHOLYTIC AGENTS 02212048 PMS-CYCLOBENZAPRINE **PMS** DIHYDROERGOTAMINE MESYLATE 02242079 RIVA-CYCLOBENZAPRINE RIV 1MG/ML LIQUID 02080052 TEVA-CYCLOBENZAPRINE TE\/ 00027243 DIHYDROERGOTAMINE RAX **TIZANIDINE HYDROCHLORIDE** 4MG/ML LIQUID Limited use benefit (prior approval required). 02228947 MIGRANAL RAX For treatment of spasticity in patients with multiple sclerosis, 12:16.04 ALPHA-ADRENERGIC BLOCKING who have failed therapy with or are intolerant to baclofen. **AGENTS 4MG TABLET ALFUZOSIN HYDROCHLORIDE** 02239170 PAL-TIZANIDINE PAI ST 10MG TABLET (EXTENDED RELEASE) 02259893 TIZANIDINE AAP SIV 02447576 ALFUZOSIN 12:20.08 DIRECT-ACTING SKELETAL APX 02315866 APO-ALFUZOSIN **MUSCLE RELAXANTS** 02443201 AURO-ALFUZOSIN **AUR DANTROLENE SODIUM** 02304678 SANDOZ ALFUZOSIN SDZ 02245565 XATRAL SAC 25MG CAPSULE TAMSULOSIN HYDROCHLORIDE 01997602 DANTRIUM PPH 12:20.12 GABA-DERIVATIVE SKELETAL ST 0.4MG CAPSULE (SUSTAINED RELEASE) **MUSCLE RELAXANTS** 02294265 RATIO-TAMSULOSIN TEV 09857334 RATIO-TAMSULOSIN **RPH BACLOFEN** 02319217 SANDOZ TAMSULOSIN SDZ $^{\rm ST}$ 10MG TABLET 02281392 TEVA-TAMSULOSIN TEV 02139332 APO-BACLOFEN **APX** ST 0.4MG TABLET (EXTENDED RELEASE) 02152584 **BACLOFEN PDL** APX 02362406 APO-TAMSULOSIN 02287021 **BACLOFEN** SAN 02270102 BOE FI OMAX 02138271 DOM-BACLOFEN DPC 02340208 SANDOZ TAMSULOSIN SDZ **NVR** 00455881 LIORESAL 02413612 **TAMSULOSIN** PDL 02088398 MYLAN-BACLOFEN MYL 02427117 **TAMSULOSIN** SAN **PMS** 02063735 PMS-BACLOFEN 02429667 **TAMSULOSIN** SIV 02242150 **RIVA-BACLOFEN** RIV 02368242 **TEVA-TAMSULOSIN** TEV ST 20MG TABLET 12:20.04 CENTRALL ACTING SKELETAL 02139391 APO-BACLOFEN APX **MUSCLE RELAXANTS** 02152592 **BACLOFEN PDL** CYCLOBENZAPRINE HYDROCHLORIDE 02287048 **BACLOFEN** SAN DPC 02138298 DOM-BACLOFEN Limited use benefit (prior approval is not required). 02088401 **MYLAN-BACLOFEN** MYL For relief of muscle spasm associated with acute, painful 02063743 PMS-BACLOFEN **PMS** musculoskeletal conditions. 02242151 RIVA-BACI OFFN RIV Coverage is limited to 60mg per day for three (3) weeks PDIN FOR EXTEMPORANEOUS MIXTURE renewable every two (2) months. 99503011 BACLOFEN ORAL LIQUID UNK ST 10MG TABLET 02177145 APO-CYCLOBENZAPRINE APX 02348853 **AURO-CYCLOBENZAPRINE AUR** 02220644 **CYCLOBENZAPRINE** PDL 02287064 **CYCLOBENZAPRINE** SAN 02424584 **CYCLOBENZAPRINE** SIV 02238633 DOM-CYCLOBENZAPRINE DPC

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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.

ST 2MG GUM

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

ST 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.

ST 1MG LOZENGE

80007461	THRIVE NICOTINE LOZENGES	NVC	
ST 2MG LOZEN	IGE		
02247347	NICORETTE LOZENGE	KIM	
80007464	THRIVE NICOTINE LOZENGES	NVC	
ST 4MG LOZENGE			
02247348	NICORETTE I OZENGE	KIM	

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.

- NIHB clients are eligible to receive:
- up to 252 nicotine patches of any listed brand in a 12-month period; and
- one course of an as-needed nicotine replacement therapy (NRT) product (i.e. gum, lozenge or inhaler) in a 12-month period; and
- up to 180 tablets of Zyban in a 12-month period; and
- up to 165 tablets of Champix in a 12-month period.

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.

ST 2MC CLIM

2MG GUM				
80025660	CHU NICOTINE ANTI SMOKING AID	UNK		
94799974	THRIVE GUM (NS)	NVC		
ST 1MG LOZEN	GE			
80061161	NICHIT	EUR		
ST 2MG LOZEN	GE			
80059877	NICHIT	EUR		
ST 7MG PATCH				
01943057	HABITROL	NVC		
80051602	NICOTINE TRANSDERMAL	APX		
80044393	TRANSDERMAL NICOTINE	ACG		
ST 14MG PATC	Н			
01943065	HABITROL	NVC		
80051600	NICOTINE TRANSDERMAL	APX		
80013549	NICOTINE TRANSDERMAL SYSTEM	ADD		
80044392	TRANSDERMAL NICOTINE	ACG		
ST 16MG PATCH				
80014321	NICOTINE TRANSDERMAL SYSTEM	ADD		
ST 18MG PATC	Н			
02241227	TRANSDERMAL NICOTINE PATCHDAY	NVC		
ST 21MG PATC	Н			
01943073	HABITROL	NVC		
80051603	NICOTINE TRANSDERMAL	APX		
80014250	NICOTINE TRANSDERMAL SYSTEM	ADD		
80044389	TRANSDERMAL NICOTINE	ACG		
ST 36MG PATC	Н			
02093111	NICODERM	KIM		
ST 53MG PATC	Н			
02241228	TRANSDERMAL NICOTINE PATCHDAY	NVC		
ST 78MG PATC	Н			
02093138	NICODERM	KIM		
ST 114MG PATCH				

KIM

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02093146 NICODERM

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

NICOTINE (SPRAY)

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

For smoking cessation:

Coverage is limited to 3450 sprays 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 spray when one year has elapsed from the day the initial prescription was filled.

1MG ORAL SPRAY

80038858 NICORETTE QUICKMIST

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.

ST 0.5MG TABLET

02419882	APO-VARENICLINE	APX
02291177	CHAMPIX	PFI
02426226	TEVA-VARENICLINE	TEV
ST 0.5MG & 1M	G TABLET	
02435675	APO-VARENICLINE	APX
02298309	CHAMPIX STARTER PACK	PFI
02426781	TEVA-VARENICLINE	TEV
ST 1MG TABLE	T	
02419890	APO-VARENICLINE	APX
02291185	CHAMPIX	PFI
02426234	TEVA-VARENICLINE	TEV

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20:00 BLOOD FORMATION		20:04.04 IRON PREPARATIONS	
COAGULATION AND		FERROUS SULFATE	
THROMBOSIS		$^{s au}$ 300MG TABLET	
20:04.04 IRON PREPARATIONS		02246733 EURO-FERROUS SULFATE	EUR
		02248699 FERODAN	ODN
FERROUS FUMARATE		00346918 FERROUS SULFATE	PMT
100MG CAPSULE		00782114 FERROUS SULFATE	VTH
80061196 MFER FUMARATE	MAN	00031100 FERROUS SULPHATE	JMP
ST 300MG CAPSULE		80057416 M-SULFATE FERREUX	MAN
02237556 EUROFER	EUR	00586323 PMS-FERROUS SULFATE	PMS
00482064 NEO-FER	NEB	IRON	
01923420 PALAFER	VAE	ST 100MG CAPSULE	
ST 20MG SUSPENSION		80024232 JAMP-FER	JMP
80029822 JAMP-FERROUS FUMARATE	JMP	12.5MG/ML LIQUID	
ST 60MG/ML SUSPENSION		02243333 FERRLECIT	SAC
01923439 PALAFER	VAE	IRON (IRON ISOMALTOSIDE 1000)	
ST 300MG/5ML SUSPENSION		,	
02246590 FERRATE	EUR	100MG SOLUTION	1.15.11.2
ST 100MG TABLET		02477777 MONOFERRIC	UNK
80024544 JAMP FERROUS FUMARATE	JMP	IRON DEXTRAN	
ST 300MG TABLET		50MG/ML LIQUID	
00031089 FERROUS FUMARATE	WAM	02221780 INFUFER	SDZ
FERROUS GLUCONATE		50MG/ML SOLUTION	
ST 300MG TABLET		02205963 DEXIRON	UNK
00545031 APO-FERROUS GLUCONATE	APX	IRON SUCROSE	
00031097 FERROUS GLUCONATE	JMP	20MG/ML SOLUTION	
00041157 FERROUS GLUCONATE	ADA	02243716 VENOFER	UNK
02244532 FERROUS GLUCONATE	PMT	PDIN FOR EXTEMPORANEOUS MIXTURE	Ortic
80000435 FERROUS GLUCONATE	NUR	99506015 IRON SUCROSE STERILE	UNK
80002426 FERROUS GLUCONATE	WNP	INFUSION	Ortic
80006316 FERROUS GLUCONATE	UNK	POLYSACCHARIDE IRON COMPLEX	
80009681 WAMPOLE FERROUS GLUCONATE	WAM	Limited use benefit (prior approval not required).	
ST 324MG TABLET		Elithica ase beliefit (prior approval flot requirea).	
00582727 IRON FERROUS GLUCONATE	VTH	For children 12 years of age or under.	
FERROUS SULFATE		15MG POWDER	
ST 30MG/ML LIQUID		80033717 FERAMAX POWDER WATER	BSY
80008295 JAMP FERROUS SULFATE LIQUID5	JMP	SOLUBLE POLYSACCHARIDE	
ST 75MG/ML LIQUID	JIVII	IRON COMPLEX	
00762954 ENFAMIL FERINSOL	MJO	20:12.04 ANTICOAGULANTS	
80008309 JAMP FERROUS SULFATE	JMP	ACENOCOUMAROL	
ST 6MG/ML SOLUTION	OIVII	ST 1MG TABLET	
00017884 ENFAMIL FERINSOL	MJO	00010383 SINTROM	PAL
02242863 PEDIAFER	EUR	ST 4MG TABLET	FAL
ST 15MG/ML SOLUTION	LOIX	00010391 SINTROM	PAL
02237385 FERODAN INFANT DROPS	ODN	00010391 SINTROW	FAL
02232202 PEDIAFER	EUR		
02222574 PMS-FERROUS SULFATE	PMS		
ST 30MG/ML SOLUTION			
00758469 FERODAN	ODN		
00792675 PMS-FERROUS SULFATE	PMS		
ST 125MG/ML SOLUTION	•		
00816035 PMS-FERROUS SULFATE	PMS		
ST 60MG TABLET	-		
80012039 IRON	WNP		

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20:12.04 ANTICOAGULANTS **APIXABAN**

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥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).

For the treatment of venous thromboembolism: deep vein thrombosis (DVT) or pulmonary embolism (PE)

ST 2.5MG TABLET

02377233 ELIQUIS

ST 5MG TABLET

02397714 ELIQUIS BMS

DABIGATRAN ETEXILATE MESILATE

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥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).

110MG CAPSULE				
APO-DABIGATRAN	APX			
PRADAXA	BOE			
150MG CAPSULE				
APO-DABIGATRAN	APX			
	APO-DABIGATRAN PRADAXA SULE			

02358808 PRADAXA **DALTEPARIN SODIUM**

2.500IU/0.2ML SOLUTION

18,000IU/0.72ML SOLUTION 02352680 FRAGMIN

•			
02132621	FRAGMIN		PFI
3,500IU/0.28	ML SOLUTION		
02430789	FRAGMIN		PFI
5,000IU/0.2N	IL SOLUTION		
02132648	FRAGMIN		PFI
7,500IU/0.3N	IL SOLUTION		
02352648	FRAGMIN		PFI
10,000IU/0.4	ML SOLUTION		
02352656	FRAGMIN		PFI
10,000IU/ML	SOLUTION		
02132664	FRAGMIN		PFI
12,500IU/0.5	ML SOLUTION		
02352664	FRAGMIN		PFI
15,000IU/0.6ML SOLUTION			
02352672	FRAGMIN		PFI

20:12.04 ANTICOAGULANTS **DALTEPARIN SODIUM**

25,000IU/ML SOLUTION 02231171 FRAGMIN

PFI

EDOXABAN (EDOXABAN TOSYLATE MONOHYDRATE)

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥1) with non-valvular atrial fibrillation who require edoxaban 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

45MO TABLET

BMS

BOE

For the treatment of venous thromboembolism: deep vein thrombosis (DVT) or pulmonary embolism (PE)

15MG TABLET			
02458640	LIXIANA	SEV	
30MG TABL	ET		
02458659	LIXIANA	SEV	
60MG TABL	ET		
02458667	LIXIANA	SEV	
ENOXAPARII	N 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		
	LOVENOX	SAC	
150MG/1.0M	L SOLUTION		
02242692	LOVENOX HP	SAC	
150MG/ML S	SOLUTION		
02378469	LOVENOX HP	SAC	
300MG/3ML	SOLUTION		
02236564	LOVENOX	SAC	
HEPARIN			
INJECTION			
09991680	HEPARIN IV FLUSH SYR	UNK	
HEPARIN SO	DIUM		
100U/ML LIG	QUID		
00727520	HEPARIN LEO	LEO	
1,000U/ML L	IQUID		
00453811	HEPARIN LEO	LEO	
1,000 U/ML \$	SOLUTION		
02303086	HEPARIN SODIUM (MULTIDOSE VIAL-WITH PRESERVATIVE)	SDZ	

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PFI

20:12.04 ANTICOAGULANTS HEPARIN SODIUM

10,000 U/ML SOLUTION

02303108	HEPARIN SODIUM (MULTIDOSE	SDZ
	VIAL-WITH PRESERVATIVE)	
02303094	HEPARIN SODIUM (SINGLE USE VIAL-PRESERVATIVE FREE)	SDZ

5000U SOLUTION

02456958 HEPARIN SODIUM UNK

10,000U SOLUTION

02392453 HEPARIN SODIUM FKD

NADROPARIN CALCIUM

9,500IU/ML SOLUTION

02236913 FRAXIPARINE ASP

19,000IU/ML SOLUTION

02240114 FRAXIPARINE FORTE ASP

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 ≥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).

ST 15MG TABLET

02378604 XARELTO BAY

*** 20MG TABLET

02378612 XARELTO BAY

RIVAROXABAN (10)

Limited use benefit (prior approval not required).

For the prevention of venous thromboembolism following total knee replacement or total hip replacement surgery, for up to 35 days.

ST 10MG TABLET

02316986 XARELTO BAY

20:12.04 ANTICOAGULANTS RIVAROXABAN (CAD,PAD)

Limited use benefit (prior approval required).

Rivaroxaban will be used in combination with acetylsalicylic acid for the prevention of stroke, myocardial infarction, and cardiovascular death, and for the prevention of acute limb ischemia and mortality in patients with concomitant coronary artery disease (CAD) and peripheral artery disease (PAD) as defined below:

- 1. Patient has CAD defined as having one or more of the following:
- myocardial infarction within the last 20 years; or
- multi-vessel coronary disease (i.e., stenosis of ≥ 50% in two or more coronary arteries, or in one coronary territory if at least one other territory has been revascularized) with symptoms or history of stable or unstable angina; or
- multi-vessel percutaneous coronary intervention; or
- multi-vessel coronary artery bypass graft surgery
- and
- aged 65 years or older; or
- aged younger than 65 years and presents with documented atherosclerosis or revascularization involving at least two vascular beds (coronary and other vascular) or has at least two additional risk factors.*
- * Additional risk factors include: current smoker, diabetes mellitus, estimated glomerular filtration rate <60mL/min, heart failure, non-lacunar ischemic stroke 1 month or more ago.

and

- 2. Patient has PAD defined as having one or more of the following:
- previous aorto-femoral bypass surgery, limb bypass surgery, or percutaneous transluminal angioplasty revascularization of the iliac or infrainguinal arteries; or
- previous limb or foot amputation for arterial vascular disease; or
- history of intermittent claudication with an anklebrachial index less than 0.90 or significant peripheral artery stenosis (≥ 50%) documented by angiography or by duplex ultrasound; or
- previous carotid revascularization or asymptomatic carotid artery stenosis greater than or equal to 50%, as diagnosed by duplex ultrasound or angiography.

DAV

LEO

2.5MG TABLET

02429470 INNOHEP

02480808	XARELIU	BAY
TINZAPARIN	SODIUM	
2,500IU/0.25	ML SOLUTION	
02229755	INNOHEP	LEO
3,500IU/0.35	ML SOLUTION	
02358158	INNOHEP	LEO
4,500IU/0.45	ML SOLUTION	
02358166	INNOHEP	LEO
8,000IU/0.4N	IL SOLUTION	
02429462	INNOHEP	LEO
10,000IU/0.5	ML SOLUTION	
02231478	INNOHEP	LEO
10,000IU/ML	SOLUTION	
02167840	INNOHEP	LEO
12,000IU/0.6	ML SOLUTION	

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					00
20:12.04 ANTI	COAGULANTS		-	ATELET AGGREGATION	
TINZAPARIN S	ODIUM		INI	HIBITORS	
14,000IU/0.7ML	SOLUTION		CLOPIDOGR	EL BISULFATE	
02358174 IN		LEO	ST 75MG TABL	FT	
16,000IU/0.8ML				ACT CLOPIDOGREL	TEV
02429489 IN		LEO	02252767		APX
18,000IU/0.9ML			02416387		AUR
02358182 II		LEO	02385813		SIV
20,000IU/ML S	OLUTION		02394820		PDL
02229515 IN	NNOHEP	LEO	02400553		SAN
WARFARIN SO	DIUM		02378507		DPC
ST 1MG TABLET			02415550	JAMP-CLOPIDOGREL	JMP
	DO WAREARIN	APX	02422255	MAR-CLOPIDOGREL	MAR
	.PO-WARFARIN :OUMADIN	BMS	02238682	PLAVIX	SAC
	ARO-WARFARIN	TAR	02348004	PMS-CLOPIDOGREL	PMS
ST 2MG TABLET	ARU-WARFARIN	IAR	02388529	RIVA-CLOPIDOGREL	RIV
	DO MAREARIN	ADV	02359316	SANDOZ CLOPIDOGREL	SDZ
	PO-WARFARIN	APX	02379813	TARO-CLOPIDOGREL	RBY
	COUMADIN	BMS	02293161	TEVA-CLOPIDOGREL	TEV
02242681 Τ ^{sτ} 2.5MG TABLE1	ARO-WARFARIN -	TAR	TICAGRELO	R	
		APX		efit (prior approval not required).	
	.PO-WARFARIN :OUMADIN	BMS	Limitod doo bone	(prior approval flot rodaliou).	
	ARO-WARFARIN	TAR		t of Acute Coronary Syndrome, defined	
ST 3MG TABLET	ARO-WARFARIN	IAK		or myocardial infarction, when initiated i	
	DO MADEADIN	APX	nospital in consu	Itation with a specialist in cardiology, cascular & thoracic surgery, internal med	ardiac
	PO-WARFARIN			ry. Treatment must be in combination w	
	COUMADIN	BMS	low dose ASA.	,	
	ARO-WARFARIN	TAR			
ST 4MG TABLET	DO MAREARIN	ADV	Special authoriza	ation may be granted for 12 months.	
	PO-WARFARIN	APX	60MG TABL	ET	
	COUMADIN	BMS		BRILINTA	AZC
	ARO-WARFARIN	TAR	$^{\rm s au}$ 90MG TABL	ET	
ST 5MG TABLET	DO MADEADIN	ADV	02368544	BRILINTA	AZC
	PO-WARFARIN	APX	TICLOPIDINI	E HYDROCHLORIDE	
	COUMADIN	BMS	ST 250MG TAB	IFT	
	ARO-WARFARIN	TAR		TICLOPIDINE	AAP
6MG TABLET	COLIMA DIN	DMC		MATOPOIETIC AGENTS	7471
	OUMADIN	BMS			
02242000 1 ST 7.5MG TABLE 1	ARO-WARFARIN -	TAR	FILGRASTIM		
	ARO-WARFARIN	TAR	300MCG/ML	INJECTION	
ST 10MG TABLET		IAK	09853464	NEUPOGEN (ON)	AMG
	PO-WARFARIN	APX	99001454	NEUPOGEN (QC)	AMG
01918362 C		BMS	300MCG SO	LUTION	
	ARO-WARFARIN	TAR	02441489	GRASTOFIL	APX
		IAR	300MCG/ML	SOLUTION	
-	TELET AGGREGATION			NEUPOGEN	AMG
INHIBITORS		480MCG SO	LUTION		
ANAGRELIDE I	HYDROCHLORIDE		02454548	GRASTOFIL	APX
ST 0.5MG CAPSUI	LE				
02236859 A		SHI			
	MS-ANAGRELIDE	PMS			
	ANDOZ ANAGRELIDE	SDZ			

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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. ≥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 109/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 SOLUTION

RGP 02484153 FULPHILA

10MG/ML SOLUTION

02249790 NEULASTA **AMG**

PEGFILGRASTIM (LAPELGA)

6MG SOLUTION

02474565 LAPELGA APX

PLERIXAFOR

Limited use benefit (prior approval 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);
- 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;
- 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 HEMORRHEOLOGIC AGENTS **PENTOXIFYLLINE**

ST 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

UNK

MOUTHWASH

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04:00 04PDIOV400III 4D DDII00		24-04-09 CARRIOTONIC ACENTS
24:00 CARDIOVASCULAR DRUGS		24:04.08 CARDIOTONIC AGENTS
24:04.04 ANTIARRHYTHMIC AGENTS		DIGOXIN
AMIODARONE HYDROCHLORIDE		^{sτ} 0.0625MG TABLET
sr 100MG TABLET		02335700 TOLOXIN PED
02292173 PMS-AMIODARONE	PMS	^{sτ} 0.125MG TABLET
ST 200MG TABLET	1 IVIO	02335719 TOLOXIN PED
02364336 AMIODARONE	SAN	^{sτ} 0.250MG TABLET
02385465 AMIODARONE	SIV	02335727 TOLOXIN PED
02246194 APO-AMIODARONE	APX	24:04.92 MISCELLANEOUS CARDIAC
02246331 DOM-AMIODARONE	DPC	DRUGS
02242472 PMS-AMIODARONE	PMS	IVABRADINE (IVABRADINE HYDROCHLORIDE)
02309661 PRO-AMIODARONE	PDL	Limited use benefit (prior approval required).
02247217 RIVA-AMIODARONE	RIV	
02243836 SANDOZ AMIODARONE	SDZ	For the treatment of stable chronic heart failure with New York
02239835 TEVA-AMIODARONE	TEV	Heart Association (NYHA) class II or III symptoms in adult patients if the following criteria are met:
ST PDIN FOR EXTEMPORANEOUS MIXTURE		left ventricular ejection fraction ≤ 35%; and
99503016 AMIODARONE ORAL LIQUID	UNK	• resting heart rate must be documented as ≥ 77 bpm on
DISOPYRAMIDE		average using either an ECG on at least three separate visits or by continuous monitoring; and
ST 100MG CAPSULE		 patient has had at least one hospitalization due to heart
02224801 RYTHMODAN	SAC	failure in the last year; and
FLECAINIDE ACETATE		NYHA class II to III symptoms despite at least four weeks of treatment with an angiotomain converting entry me inhibitor.
ST 50MG TABLET		treatment with an angiotensin converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB) in
02275538 APO-FLECAINIDE	APX	combination with a beta blocker and, if tolerated, a
02459957 AURO-FLECAINIDE	AUR	mineralocorticoid receptor antagonist (MRA).
ST 100MG TABLET	AUN	5MG TABLET
02275546 APO-FLECAINIDE	APX	02459973 LANCORA SEV
02459965 AURO-FLECAINIDE	AUR	7.5MG TABLET
MEXILETINE HYDROCHLORIDE	7.01	02459981 LANCORA SEV
		24:06.04 BILE ACID SEQUESTRANTS
^{S7} 100MG CAPSULE		CHOLESTYRAMINE RESIN
02230359 TEVA-MEXILETINE	TEV	ST 4G POWDER FOR SUSPENSION
ST 200MG CAPSULE	TE\ /	
02230360 TEVA-MEXILETINE	TEV	02455609 CHOLESTYRAMINE-ODAN ODN 02478595 JAMP-CHOLESTYRAMINE JMP
PROCAINAMIDE HYDROCHLORIDE		00890960 OLESTYR PMS
ST 250MG CAPSULE		02210320 OLESTYR PMS
00713325 APO-PROCAINAMIDE	APX	COLESEVELAM HYDROCHLORIDE
ST 250MG TABLET (EXTENDED RELEASE)		
00638692 PROCAN SR	ERF	ST 3.75G POWDER FOR SUSPENSION
PROPAFENONE HYDROCHLORIDE		02432463 LODALIS VAE
ST 150MG TABLET		ST 625MG TABLET
02243324 APO-PROPAFENONE	APX	02373955 LODALIS VAE
02457172 MYLAN-PROPAFENONE	MYL	COLESTIPOL HYDROCHLORIDE
02343053 PROPAFENONE	SAN	ST 5G GRANULES
00603708 RYTHMOL	BGP	00642975 COLESTID PFI
ST 300MG TABLET		ST 1G TABLET
02243325 APO-PROPAFENONE	APX	02132680 COLESTID PFI
02457164 MYLAN-PROPAFENONE	MYL	24:06.05 CHOLESTEROL ABSORPTION
02294575 PMS-PROPAFENONE	PMS	INHIBITORS
02343061 PROPAFENONE	SAN	EZETIMIBE
00603716 RYTHMOL	BGP	
24:04.08 CARDIOTONIC AGENTS		ST 10MG TABLET 02425610 ACH-EZETIMIBE ACC
DIGOXIN		02425610 ACH-EZETIMIBE ACC 02475898 AG-EZETIMIBE ANG
ST 0.05MG/ML SOLUTION		024778098 AG-EZETIMIBE ANG
02242320 TOLOXIN	PED	02469286 AURO-EZETIMIBE AUR

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		Non-insured nearth ben	ients
24:06.05 CHOLESTEROL ABSORPTION		24:06.06 FIBRIC ACID DERIVATIVES	
INHIBITORS		GEMFIBROZIL	
EZETIMIBE		ST 600MG TABLET	
ST 10MG TABLET		01979582 APO-GEMFIBROZIL	APX
02422549 EZETIMIBE	PDL	02142074 TEVA-GEMFIBROZIL	TEV
02429659 EZETIMIBE	SIV	24:06.08 HMG-COA REDUCTASE	
02431300 EZETIMIBE	SAN	INHIBITORS	
02478544 EZETIMIBE	RIV		
02247521 EZETROL	FRS	ATORVASTATIN CALCIUM	
02423235 JAMP-EZETIMIBE	JMP	$^{\rm s au}$ 10MG TABLET	
02422662 MAR-EZETIMIBE	MAR	02457741 ACH-ATORVASTATIN CALCIUM	ACC
02467437 M-EZETIMIBE	MAN	02478145 AG-ATORVASTATIN	ANG
02423243 MINT-EZETIMIBE	MIN	02295261 APO-ATORVASTATIN	APX
02481669 NRA-EZETIMIBE	UNK	02346486 ATORVASTATIN	PDL
02416409 PMS-EZETIMIBE	PMS	02348705 ATORVASTATIN	SAN
02425238 PRIVA-EZETIMIBE	PHA	02396424 ATORVASTATIN	APX
02419548 RAN-EZETIMIBE	RBY	02399377 ATORVASTATIN	PMS
02416778 SANDOZ EZETIMIBE	SDZ	02475022 ATORVASTATIN	RIV
02354101 TEVA-EZETIMIBE	TEV	02411350 ATORVASTATIN-10	SIV
24:06.06 FIBRIC ACID DERIVATIVES		02407256 AURO-ATORVASTATIN	AUR
BEZAFIBRATE		02481189 BIO-ATORVASTATIN	BMI
		02399482 DOM-ATORVASTATIN	DPC
ST 200MG TABLET	5140	02391058 JAMP-ATORVASTATIN	JMP
02240331 PMS-BEZAFIBRATE	PMS	02230711 LIPITOR	UNK
ST 400MG TABLET (EXTENDED RELEASE)		02454017 MAR-ATORVASTATIN	MAR
02083523 BEZALIP SR	ALL	02471167 M-ATORVASTATIN	MAN
02453312 JAMP-BEZAFIBRATE	JMP	02479508 MINT-ATORVASTATIN	MIN
FENOFIBRATE		02392933 MYLAN-ATORVASTATIN	MYL
ST 67MG CAPSULE		02476517 NRA-ATORVASTATIN	UNK
02243180 AA-FENO-MICRO	AAP	02482886 PRIVA-ATORVASTATIN	PHA
ST 100MG CAPSULE		02417936 REDDY-ATORVASTATIN	REC
02225980 FENOFIBRATE	AAP	02422751 RIVA-ATORVASTATIN 02324946 SANDOZ ATORVASTATIN	RIV SDZ
ST 160MG CAPSULE		02324946 SANDOZ ATORVASTATIN 02313707 TARO-ATORVASTATIN	SUN
02250004 FENOMAX	CIP	02310899 TEVA-ATORVASTATIN	TEV
ST 200MG CAPSULE		st 20MG TABLET	ΙΕV
02239864 AA-FENO-MICRO	AAP	02457768 ACH-ATORVASTATIN CALCIUM	ACC
02240360 FENO-MICRO	PDL	02477106 ACH-ATORVASTATIN CALCIONI 02478153 AG-ATORVASTATIN	ANG
ST 48MG TABLET		02295288 APO-ATORVASTATIN	APX
02269074 LIPIDIL EZ	BGP	02346494 ATORVASTATIN	PDL
02390698 SANDOZ FENOFIBRATE E	SDZ	02348713 ATORVASTATIN	SAN
ST 100MG TABLET		02396432 ATORVASTATIN	APX
02246859 APO-FENO-SUPER	APX	02399385 ATORVASTATIN	PMS
02288044 SANDOZ FENOFIBRATE S	SDZ	02475030 ATORVASTATIN	RIV
ST 145MG TABLET		02411369 ATORVASTATIN-20	SIV
02269082 LIPIDIL EZ	BGP	02407264 AURO-ATORVASTATIN	AUR
02390701 SANDOZ FENOFIBRATE E	SDZ	02481197 BIO-ATORVASTATIN	BMI
^{sτ} 160MG TABLET		02399490 DOM-ATORVASTATIN	DPC
02246860 APO-FENO-SUPER	APX	02391066 JAMP-ATORVASTATIN	JMP
02241602 LIPIDIL SUPRA	BGP	02230713 LIPITOR	UNK
02288052 SANDOZ FENOFIBRATE S	SDZ	02454025 MAR-ATORVASTATIN	MAR
GEMFIBROZIL		02471175 M-ATORVASTATIN	MAN
ST 300MG CAPSULE		02479516 MINT-ATORVASTATIN	MIN
01979574 APO-GEMFIBROZIL	APX	02392941 MYLAN-ATORVASTATIN	MYL
02241608 DOM-GEMFIBROZIL	DPC	02476525 NRA-ATORVASTATIN	UNK
02239951 PMS-GEMFIBROZIL	PMS	02482894 PRIVA-ATORVASTATIN	PHA
02241704 TEVA-GEMFIBROZIL	TEV	02417944 REDDY-ATORVASTATIN	REC
· · · · · · · · · · · · · · · · · · ·	-		

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	IG-COA REDUCTASE HIBITORS		24:06.08 HMG-COA REDUCTASE INHIBITORS	
ATORVASTA	ATIN CALCIUM		FLUVASTATIN SODIUM	
ST 20MG TABL	FT		ST 20MG CAPSULE	
	RIVA-ATORVASTATIN	RIV	02299224 TEVA-FLUVASTATIN	TEV
	SANDOZ ATORVASTATIN	SDZ	ST 40MG CAPSULE	,
	TARO-ATORVASTATIN	SUN	02299232 TEVA-FLUVASTATIN	TEV
02310902	TEVA-ATORVASTATIN	TEV	ST 80MG TABLET (EXTENDED RELEASE)	
ST 40MG TABL	ET		02250527 LESCOL XL	NVR
02457776	ACH-ATORVASTATIN CALCIUM	ACC	LOVASTATIN	
02478161	AG-ATORVASTATIN	ANG		
02295296	APO-ATORVASTATIN	APX	ST 20MG TABLET	TC\/
02346508	ATORVASTATIN	PDL	02248572 ACT LOVASTATIN	TEV
02348721	ATORVASTATIN	SAN	02220172 APO-LOVASTATIN	APX
02396440	ATORVASTATIN	APX	02353229 LOVASTATIN	SAN
02399393	ATORVASTATIN	PMS	02246013 PMS-LOVASTATIN ST 40MG TABLET	PMS
02411377	ATORVASTATIN-40	SIV		TE\ /
02407272	AURO-ATORVASTATIN	AUR	02248573 ACT LOVASTATIN	TEV
02481200	BIO-ATORVASTATIN	BMI	02220180 APO-LOVASTATIN	APX
02399504	DOM-ATORVASTATIN	DPC	02353237 LOVASTATIN	SAN
02391074	JAMP-ATORVASTATIN	JMP	02246014 PMS-LOVASTATIN	PMS
02230714	LIPITOR	UNK	PRAVASTATIN SODIUM	
02454033	MAR-ATORVASTATIN	MAR	ST 10MG TABLET	
02471183	M-ATORVASTATIN	MAN	02440644 ACH-PRAVASTATIN	ACC
02392968	MYLAN-ATORVASTATIN	MYL	02243506 APO-PRAVASTATIN	APX
02476533	NRA-ATORVASTATIN	UNK	02458977 AURO-PRAVASTATIN	AUR
02482908	PRIVA-ATORVASTATIN	PHA	02446251 BIO-PRAVASTATIN	BMI
02417952	REDDY-ATORVASTATIN	REC	02249723 DOM-PRAVASTATIN	DPC
02422786	RIVA-ATORVASTATIN	RIV	02330954 JAMP-PRAVASTATIN	JMP
02324962	SANDOZ ATORVASTATIN	SDZ	02432048 MAR-PRAVASTATIN	MAR
02313723	TARO-ATORVASTATIN	SUN	02317451 MINT-PRAVASTATIN	MIN
02310910	TEVA-ATORVASTATIN	TEV	02476274 M-PRAVASTATIN	MAN
ST 80MG TABL	ET		02247655 PMS-PRAVASTATIN	PMS
02457784	ACH-ATORVASTATIN CALCIUM	ACC	02356546 PRAVASTATIN	SAN
02478188	AG-ATORVASTATIN	ANG	02389703 PRAVASTATIN	SIV
02295318	APO-ATORVASTATIN	APX	02243824 PRAVASTATIN-10	PDL
02346516	ATORVASTATIN	PDL	02445379 PRIVA-PRAVASTATIN	PHA
02348748	ATORVASTATIN	SAN	02284421 RAN-PRAVASTATIN	RBY
02396459	ATORVASTATIN	APX	02468700 SANDOZ PRAVASTATIN	SDZ
02399407	ATORVASTATIN	PMS	02247008 TEVA-PRAVASTATIN	TEV
02475057	ATORVASTATIN	RIV	ST 20MG TABLET	
02411385	ATORVASTATIN-80	SIV	02440652 ACH-PRAVASTATIN	ACC
02407280	AURO-ATORVASTATIN	AUR	02243507 APO-PRAVASTATIN	APX
02481219	BIO-ATORVASTATIN	BMI	02458985 AURO-PRAVASTATIN	AUR
02391082	JAMP-ATORVASTATIN	JMP	02446278 BIO-PRAVASTATIN	BMI
02243097	LIPITOR	UNK	02249731 DOM-PRAVASTATIN	DPC
02454041	MAR-ATORVASTATIN	MAR	02330962 JAMP-PRAVASTATIN	JMP
02471191	M-ATORVASTATIN	MAN	02432056 MAR-PRAVASTATIN	MAR
02479532	MINT-ATORVASTATIN	MIN	02317478 MINT-PRAVASTATIN	MIN
02392976	MYLAN-ATORVASTATIN	MYL	02476282 M-PRAVASTATIN	MAN
02476541	NRA-ATORVASTATIN	UNK	02247656 PMS-PRAVASTATIN	PMS
02482916	PRIVA-ATORVASTATIN	PHA	00893757 PRAVACHOL	BMS
02417960	REDDY-ATORVASTATIN	REC	02356554 PRAVASTATIN	SAN
02422794	RIVA-ATORVASTATIN	RIV	02389738 PRAVASTATIN	SIV
02324970	SANDOZ ATORVASTATIN	SDZ	02243825 PRAVASTATIN-20	PDL
02313758	TARO-ATORVASTATIN	SUN	02445395 PRIVA-PRAVASTATIN	PHA
02310929	TEVA-ATORVASTATIN	TEV	02284448 RAN-PRAVASTATIN	RBY

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24:06.08 HMG-COA REDUCTASE INHIBITORS		24:06.08 HMG-COA REDUCTASE INHIBITORS	
PRAVASTATIN SODIUM		ROSUVASTATIN CALCIUM	
ST 20MG TABLET	007	ST 10MG TABLET	MAD
02468719 SANDOZ PRAVASTATIN	SDZ	02413078 MAR-ROSUVASTATIN	MAR
02247009 TEVA-PRAVASTATIN	TEV	02399172 MED-ROSUVASTATIN	GMP
ST 40MG TABLET	400	02477491 NRA-ROSUVASTATIN	UNK
02440660 ACH-PRAVASTATIN	ACC	02378531 PMS-ROSUVASTATIN	PMS
02243508 APO-PRAVASTATIN	APX	02445425 PRIVA-ROSUVASTATIN	PHA RIV
02458993 AURO-PRAVASTATIN	AUR	02380056 RIVA-ROSUVASTATIN 02381184 ROSUVASTATIN	
02446286 BIO-PRAVASTATIN 02249758 DOM-PRAVASTATIN	BMI DPC	02381184 ROSUVASTATIN 02405636 ROSUVASTATIN	PDL SAN
02330970 JAMP-PRAVASTATIN	JMP	02403030 ROSUVASTATIN 02411636 ROSUVASTATIN	SIV
02432064 MAR-PRAVASTATIN	MAR	02338734 SANDOZ ROSUVASTATIN	SDZ
02317486 MINT-PRAVASTATIN	MIN	02382652 TARO-ROSUVASTATIN	SUN
02476290 M-PRAVASTATIN	MAN	02354616 TEVA-ROSUVASTATIN	TEV
02247657 PMS-PRAVASTATIN	PMS	ST 20MG TABLET	124
02222051 PRAVACHOL	BMS	02438933 ACH-ROSUVASTATIN	ACC
02356562 PRAVASTATIN	SAN	02477068 AG-ROSUVASTATIN	ANG
02389746 PRAVASTATIN	SIV	02337991 APO-ROSUVASTATIN	APX
02243826 PRAVASTATIN-40	PDL	02442590 AURO-ROSUVASTATIN	AUR
02445409 PRIVA-PRAVASTATIN	PHA	02444984 BIO-ROSUVASTATIN	BMI
02284456 RAN-PRAVASTATIN	RBY	02247163 CRESTOR	AZC
02468727 SANDOZ PRAVASTATIN	SDZ	02386720 DOM-ROSUVASTATIN	DPC
02247010 TEVA-PRAVASTATIN	TEV	02391279 JAMP-ROSUVASTATIN	JMP
ROSUVASTATIN CALCIUM		02413086 MAR-ROSUVASTATIN	MAR
		02399180 MED-ROSUVASTATIN	GMP
ST 5MG TABLET		02477505 NRA-ROSUVASTATIN	UNK
02438917 ACH-ROSUVASTATIN	ACC	02378558 PMS-ROSUVASTATIN	PMS
02477033 AG-ROSUVASTATIN	ANG	02445433 PRIVA-ROSUVASTATIN	PHA
02337975 APO-ROSUVASTATIN	APX	02380064 RIVA-ROSUVASTATIN	RIV
02442574 AURO-ROSUVASTATIN	AUR	02381192 ROSUVASTATIN	PDL
02444968 BIO-ROSUVASTATIN	BMI	02405644 ROSUVASTATIN	SAN
02265540 CRESTOR	AZC	02411644 ROSUVASTATIN	SIV
02386704 DOM-ROSUVASTATIN	DPC	02338742 SANDOZ ROSUVASTATIN	SDZ
02391252 JAMP-ROSUVASTATIN	JMP	02382660 TARO-ROSUVASTATIN	SUN
02413051 MAR-ROSUVASTATIN	MAR	02354624 TEVA-ROSUVASTATIN	TEV
02399164 MED-ROSUVASTATIN	GMP	ST 40MG TABLET	
02477483 NRA-ROSUVASTATIN 02378523 PMS-ROSUVASTATIN	UNK PMS	02438941 ACH-ROSUVASTATIN	ACC
02378523 PMS-ROSUVASTATIN 02445417 PRIVA-ROSUVASTATIN	PHA	02477076 AG-ROSUVASTATIN	ANG
02380013 RIVA-ROSUVASTATIN	RIV	02338009 APO-ROSUVASTATIN	APX
02381176 ROSUVASTATIN	PDL	02442604 AURO-ROSUVASTATIN	AUR
02405628 ROSUVASTATIN	SAN	02444992 BIO-ROSUVASTATIN	BMI
02411628 ROSUVASTATIN	SIV	02247164 CRESTOR	AZC
02338726 SANDOZ ROSUVASTATIN	SDZ	02391287 JAMP-ROSUVASTATIN	JMP
02382644 TARO-ROSUVASTATIN	SUN	02413108 MAR-ROSUVASTATIN	MAR
02354608 TEVA-ROSUVASTATIN	TEV	02399199 MED-ROSUVASTATIN	GMP
ST 10MG TABLET	124	02477513 NRA-ROSUVASTATIN	UNK
02438925 ACH-ROSUVASTATIN	ACC	02378566 PMS-ROSUVASTATIN	PMS
02477041 AG-ROSUVASTATIN	ANG	02380102 RIVA-ROSUVASTATIN	RIV
02337983 APO-ROSUVASTATIN	APX	02381206 ROSUVASTATIN	PDL
02442582 AURO-ROSUVASTATIN	AUR	02405652 ROSUVASTATIN	SAN
02444976 BIO-ROSUVASTATIN	BMI	02411652 ROSUVASTATIN	SIV
02247162 CRESTOR	AZC	02338750 SANDOZ ROSUVASTATIN	SDZ
02386712 DOM-ROSUVASTATIN	DPC	02382679 TARO-ROSUVASTATIN	SUN
02391260 JAMP-ROSUVASTATIN	JMP	02354632 TEVA-ROSUVASTATIN	TEV
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24:06.08 HMG-COA REDUCTASE **INHIBITORS**

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

MONE TABLET CAMPAGE	SIMVASTATIN			SIMVASTATI	N	
02247011 APO-SIMVASTATIN APX 02247014 APO-SIMVASTATIN APX 02405148 AURO-SIMVASTATIN AUR 2249172 AURO-SIMVASTATIN BIO 02253747 DOM-SIMVASTATIN DPC 02484471 BIO-SIMVASTATIN BMI 02375936 JAMP-SIMVASTATIN JMP 02251631 DOM-SIMVASTATIN DPC 03375932 JAMP-SIMVASTATIN JMP 02256621 JAMP-SIMVASTATIN JMP 02469979 PHARMA-SIMVASTATIN PMS 02370932 JMR-SIMVASTATIN MIN 02247827 SANDOZ SIMVASTATIN PMS 0247004 PHARMA-SIMVASTATIN PMS 02247827 SANDOZ SIMVASTATIN SDZ 02269287 PMS-SIMVASTATIN PMS 02250144 TEVA-SIMVASTATIN SUN 0248781 PRIVA-SIMMASTATIN SIV 02247022 SIMVASTATIN AND 02247023 SIMVASTATIN SUN 02480069 AG-SIMVASTATIN ANG 02249723 SIMVASTATIN SUN 02490699 AG-SIMVASTATIN	5MG TABLET			40MG TABL	ET	
02405148 AURO-SIMVASTATIN AUR 02405172 AURO-SIMVASTATIN AUR 0225747 DOM-SIMVASTATIN DPC 0248471 BIO-SIMVASTATIN DMC 02376961 JAMP-SIMVASTATIN DPC 02255771 DOM-SIMVASTATIN DPC 02376936 MAR-SIMVASTATIN MAR 02376566 DM-SIMVASTATIN MPC 02376936 MAR-SIMVASTATIN MIN 02376966 DM-SIMVASTATIN MIN 02469979 PHARIM-SIMVASTATIN PMS 02376967 MINT-SIMVASTATIN MIN 02269262 PMS-SIMVASTATIN PMS 0237627 MINT-SIMVASTATIN MMR 02247827 SANDOZ SIMVASTATIN SIV 02485761 PRIVA-SIMVASTATIN PMS 02250144 TEVA-SIMVASTATIN TEV 02386291 SIMVASTATIN SIV 02250144 TEVA-SIMVASTATIN TEV 02386292 PMS-SIMVASTATIN SIV 02250144 TEVA-SIMVASTATIN TEV 02386293 SIMVASTATIN SIV 02260156 APO-SIMVASTATIN	02480050	AG-SIMVASTATIN	ANG	02480085	AG-SIMVASTATIN	ANG
02253747 DOM-SIMVASTATIN DPC 02484471 BIO-SIMVASTATIN DPC 022516919 JOM-SIMVASTATIN DPC 02253771 DOM-SIMVASTATIN DPC 02375936 MAR-SIMVASTATIN JMP 02256621 JOM-SIMVASTATIN DPC 02375932 MINT-SIMVASTATIN MIN 023769621 JAMP-SIMVASTATIN JMP 02469979 PHARIM-SIMVASTATIN PMS 0247000 PHARMA-SIMVASTATIN MIN 02689625 PMS-SIMVASTATIN PMS 0247004 PHARMA-SIMVASTATIN PMS 02247827 SANDOZ SIMVASTATIN SDZ 02289287 PMS-SIMVASTATIN PMS 0228913 TARO-SIMVASTATIN TEV 0236921 SIMVASTATIN SIV 02250144 TEV-SIMVASTATIN ANG 02247012 SIMVASTATIN SIV 02240125 APS-SIMVASTATIN ANG 02359179 TEV-SIMVASTATIN SIV 0248069 AG-SIMVASTATIN ANG 02329174 TARO-SIMVASTATIN SIV 0249012 APS-SIMVASTATIN	02247011	APO-SIMVASTATIN	APX	02247014	APO-SIMVASTATIN	APX
DOM-SIMVASTATIN DPC DOM-SIMVASTATIN DPC D2251937	02405148	AURO-SIMVASTATIN	AUR	02405172	AURO-SIMVASTATIN	AUR
02375591 JAMP-SIMVASTATIN JMP 02281643 DOM-SIMVASTATIN DPC 02375036 MAR-SIMVASTATIN MIN 02375601 JAMP-SIMVASTATIN JMP 02469979 PHARMA-SIMVASTATIN PMS 02372960 MAR-SIMVASTATIN MIN 02375060 MAR-SIMVASTATIN MIN 02375060 MAR-SIMVASTATIN MIN 02375060 MAR-SIMVASTATIN MIN 02469979 PHARMA-SIMVASTATIN PMS 0247004 PHARMA-SIMVASTATIN PMS 0247004 PHARMA-SIMVASTATIN PMS 0247004 PHARMA-SIMVASTATIN PMS 0247004 PHARMA-SIMVASTATIN PMS 02247827 SANDOZ SIMVASTATIN SUV 0246761 PRIVA-SIMVASTATIN PMS 02396321 TARO-SIMVASTATIN SUN 02247831 SANDOZ SIMVASTATIN SDZ 02560144 TEVA-SIMVASTATIN TEV 02366321 SIMVASTATIN SUN 02247012 SIMVASTATIN SUN 02375044 MAR-SIMVASTATIN MAR 02237904 MAR-SIMVASTATIN DPC 02247012 SIMVASTATIN DPC 022470218 SIMVASTATIN DPC 022470218 SIMVASTATIN DPC 022470218 SIMVASTATIN MAR 022379079 MAR-SIMVASTATIN MAR 022379079 MAR-SIMVASTATIN MAR 022379079 MAR-SIMVASTATIN MAR 02375079 MAR-SIMVASTATIN SIV 02260180 SIMVASTATIN SIV 02260180 SIMVASTATIN SIV 02260180 SIMVASTATIN SIV 02260180 MAR-SIMVASTATIN MAR 02260180 MA	02253747	DOM-SIMVASTATIN	DPC	02484471	BIO-SIMVASTATIN	BMI
02375036 MAR-SIMVASTATIN MAR 02375061 JAMP-SIMVASTATIN JMP 02372932 MINIT-SIMVASTATIN MIN 02375060 MAR-SIMVASTATIN MAR 02480939 PHARIMA-SIMVASTATIN PMS 02372067 MINIT-SIMVASTATIN MIN 0268052 PMS-SIMVASTATIN PMS 02470004 PHARIMA-SIMVASTATIN PMS 02470004 PHARIMA-SIMVASTATIN PMS 024805761 PRIVA-SIMVASTATIN PMS 02380291 SIMVASTATIN SIV 02480761 PRIVA-SIMVASTATIN PMS 0239317 TARO-SIMVASTATIN TEV 02280521 SIMVASTATIN SIV 02247823 SANDOZ SIMVASTATIN SIV 02247223 SIMVASTATIN SIV 02247223 SIMVASTATIN SIV 02247223 SIMVASTATIN SIV 02247012 APO-SIMVASTATIN AND 022247213 SIMVASTATIN SIV 02401616 AURO-SIMVASTATIN APX 02250179 TEVA-SIMVASTATIN TEV 02401616 AURO-SIMVASTATIN BMI 80MG TABLET 02263755 DOM-SIMVASTATIN DPC 02480093 AC-SIMVASTATIN APX 02280575 DOM-SIMVASTATIN DPC 02480093 AC-SIMVASTATIN APX 02281627 DOM-SIMVASTATIN DPC 02480093 AC-SIMVASTATIN APX 02281627 DOM-SIMVASTATIN DPC 02480093 AC-SIMVASTATIN APX 02375004 MAR-SIMVASTATIN DPC 02480093 AC-SIMVASTATIN APX 02375004 MAR-SIMVASTATIN DPC 02480093 AC-SIMVASTATIN APX 02375004 MINT-SIMVASTATIN DPC 02480093 AC-SIMVASTATIN APX 02375004 MINT-SIMVASTATIN DPC 02480093 AC-SIMVASTATIN DPC 024809967 PHARIMA-SIMVASTATIN DPC 02480997 AC-SIMVASTATIN DPC 02480979 AC-SIMVASTATIN DPC 02480979 AC-SIMVASTATIN DPC 02480979 AC-SIMVASTATIN DPC 02480979 AC-S	02281619	DOM-SIMVASTATIN	DPC	02253771	DOM-SIMVASTATIN	DPC
0.2372932 MINT-SIMVASTATIN	02375591	JAMP-SIMVASTATIN	JMP	02281643	DOM-SIMVASTATIN	DPC
02469979	02375036	MAR-SIMVASTATIN	MAR	02375621	JAMP-SIMVASTATIN	JMP
02269252 PMS-SIMVASTATIN	02372932	MINT-SIMVASTATIN	MIN	02375060	MAR-SIMVASTATIN	MAR
02247827 SANDOZ SIMVASTATIN SDZ 02269287 PMS-SIMVASTATIN PMS 02369291 TARO-SIMVASTATIN SUN 02247821 SANDOZ SIMVASTATIN SDZ 02250144 TEVA-SIMVASTATIN TEV 02368321 SIMVASTATIN SDZ 02250144 TEVA-SIMVASTATIN TEV 02368321 SIMVASTATIN SDZ 02247021 SIMVASTATIN SDZ 02247021 SIMVASTATIN SDZ 02247012 APO-SIMVASTATIN ANG 02247012 APO-SIMVASTATIN AUR 0084359 COCR FRS 0225075 TEVA-SIMVASTATIN TEV 02269755 DOM-SIMVASTATIN DPC 02480009 AG-SIMVASTATIN DPC 02480009 AG-SIMVASTATIN DPC 02480009 AG-SIMVASTATIN DPC 02480009 AG-SIMVASTATIN AUR 00843459 COCR FRS 02253755 DOM-SIMVASTATIN DPC 02480009 AG-SIMVASTATIN APX 0225175 APO-SIMVASTATIN APX 02251750 APO-SIMVASTATIN APX 02257600 AMP-SIMVASTATIN APX 02247015 APO-SIMVASTATIN APX 02375604 AMR-SIMVASTATIN AMR 02253798 DOM-SIMVASTATIN DPC 02480098 AG-SIMVASTATIN DPC 0247015 APO-SIMVASTATIN DPC 0247016 APO-SIMVASTATIN DPC 0247016 AMR-SIMVASTATIN DPC 0247021 AMR-SIMVASTATIN AMR 02250757 AMR-SIMVASTATIN AMR 02247024 AMR-SIMVASTATIN AMR 02247013 AMR-SIMVASTATIN AMR 02247024 AMR-SIMVASTAT	02469979	PHARMA-SIMVASTATIN	PMS	02372967	MINT-SIMVASTATIN	MIN
02386291 SIMVASTATIN	02269252	PMS-SIMVASTATIN	PMS	02470004	PHARMA-SIMVASTATIN	PMS
02239131 TARO-SIMVASTATIN TEV 02386321 SANDOZ SIMVASTATIN SIV 100KG TABLET 02247222 SIMVASTATIN SIV 100KG TABLET 02247222 SIMVASTATIN SIV 02247222 SIMVASTATIN SIV 02247222 SIMVASTATIN SIV 02247012 APO-SIMVASTATIN APX 02250179 TEVA-SIMVASTATIN SIV 02240156 AURO-SIMVASTATIN AUR 00884359 ZOCOR FRS COCK FRS COCK COCK	02247827	SANDOZ SIMVASTATIN	SDZ	02269287	PMS-SIMVASTATIN	PMS
1255144 TEVA-SIMVASTATIN	02386291	SIMVASTATIN	SIV	02485761	PRIVA-SIMVASTATIN	PHA
10MG TABLET	02329131	TARO-SIMVASTATIN	SUN	02247831	SANDOZ SIMVASTATIN	SDZ
02480069 AG-SIMVASTATIN ANG 02329174 TARO-SIMVASTATIN SUN 02247012 APO-SIMVASTATIN APX 02250179 TEVA-SIMVASTATIN TEV 02494156 AURO-SIMVASTATIN BMI 80MG TABLET COCOR FRS 02484455 BIO-SIMVASTATIN DPC 02480093 AG-SIMVASTATIN ANG 0225156 DOM-SIMVASTATIN DPC 02487016 APO-SIMVASTATIN ANG 02375605 JAMP-SIMVASTATIN JMP 02405180 AURO-SIMVASTATIN AUR 02375940 MINT-SIMVASTATIN MAR 02253798 DOM-SIMVASTATIN DPC 02375940 MINT-SIMVASTATIN PMS 02375648 JAMP-SIMVASTATIN DPC 02469280 PHARMA-SIMVASTATIN PMS 02375079 MINT-SIMVASTATIN MR 02247524 SANDOZ SIMVASTATIN SDZ 02470012 PHARMA-SIMVASTATIN MR 02247628 SANDOZ SIMVASTATIN SIV 02259195 MINT-SIMVASTATIN PMS 02329158 TARO-SIMVASTATIN </td <td>02250144</td> <td>TEVA-SIMVASTATIN</td> <td>TEV</td> <td>02386321</td> <td>SIMVASTATIN</td> <td>SIV</td>	02250144	TEVA-SIMVASTATIN	TEV	02386321	SIMVASTATIN	SIV
02247012 APO-SIMVASTATIN APX 02250179 TEVA-SIMVASTATIN TEV 02494455 BIO-SIMVASTATIN BMI 80MG TABLET 02253755 DOM-SIMVASTATIN DPC 02480093 AG-SIMVASTATIN ANG 02251627 DOM-SIMVASTATIN DPC 02480093 AG-SIMVASTATIN ANG 022517505 JAMP-SIMVASTATIN JMP 02405163 AURO-SIMVASTATIN AUR 02375040 JAMP-SIMVASTATIN JMP 02405180 AURO-SIMVASTATIN DPC 02375940 MINT-SIMVASTATIN MAR 02253798 DOM-SIMVASTATIN DPC 02469897 PHARMA-SIMVASTATIN PMS 02375649 JAMP-SIMVASTATIN DPC 02469878 PHAS-SIMVASTATIN PMS 02375649 JAMP-SIMVASTATIN MR 02247828 SANDOZ SIMVASTATIN PHA 02372975 MINT-SIMVASTATIN MIN 022478213 SIMVASTATIN SIV 02269255 PMS-SIMVASTATIN PMS 022478212 SIMVASTATIN SIV 02247012	10MG TABL	ET		02247223	SIMVASTATIN-40	PDL
02405156 AURO-SIMVASTATIN AUR 00884359 ZOCOR FRS 02484455 BIO-SIMVASTATIN BMI 80MG TABLET 02253755 DOM-SIMVASTATIN DPC 0248093 AG-SIMVASTATIN ANG 02281627 DOM-SIMVASTATIN DPC 02247015 APO-SIMVASTATIN APX 02375605 JAMP-SIMVASTATIN JMP 02405180 AURO-SIMVASTATIN AUR 02372940 MINT-SIMVASTATIN MIN 02257958 DOM-SIMVASTATIN DPC 02469987 PHARMA-SIMVASTATIN MIN 02237504 JAMP-SIMVASTATIN DPC 022469987 PHARMA-SIMVASTATIN PMS 02375079 MAR-SIMVASTATIN JMP 02247529 PMS-SIMVASTATIN PMS 02375079 MAR-SIMVASTATIN MIN 02247628 SANDOZ SIMVASTATIN SDZ 02470012 PHARMA-SIMVASTATIN PMS 02247021 SIMVASTATIN SIV 02269295 PMS-SIMVASTATIN SDZ 02247021 SIMVASTATIN SUN 02366348 S	02480069	AG-SIMVASTATIN	ANG	02329174	TARO-SIMVASTATIN	SUN
02484455 BIO-SIMVASTATIN BMI 80MG TABLET 02253755 DOM-SIMVASTATIN DPC 02480093 AG-SIMVASTATIN ANG 02251627 DOM-SIMVASTATIN DPC 02247015 APO-SIMVASTATIN APX 02375605 JAMP-SIMVASTATIN JMP 02405180 AURO-SIMVASTATIN AUR 02375944 MAR-SIMVASTATIN MIN 02251651 DOM-SIMVASTATIN DPC 0246987 PHARMA-SIMVASTATIN PMS 02375648 JAMP-SIMVASTATIN JMP 022469260 PMS-SIMVASTATIN PMS 02375679 MAR-SIMVASTATIN JMP 02247228 SANDOZ SIMVASTATIN PHA 02372975 MINT-SIMVASTATIN MIN 02247228 SANDOZ SIMVASTATIN SIV 02269295 PMS-SIMVASTATIN PMS 02247221 SIMVASTATIN SIV 02269295 PMS-SIMVASTATIN SIV 02239158 TARO-SIMVASTATIN SUN 02247623 SIMVASTATIN SIV 022407013 APO-SIMVASTATIN ANG AVA <t< td=""><td>02247012</td><td>APO-SIMVASTATIN</td><td>APX</td><td>02250179</td><td>TEVA-SIMVASTATIN</td><td>TEV</td></t<>	02247012	APO-SIMVASTATIN	APX	02250179	TEVA-SIMVASTATIN	TEV
02253755 DOM-SIMVASTATIN DPC 02480093 AG-SIMVASTATIN ANG 02281627 DOM-SIMVASTATIN DPC 02247015 APO-SIMVASTATIN APX 02375604 JAMP-SIMVASTATIN JMP 02405180 AURO-SIMVASTATIN AUR 02375944 MAR-SIMVASTATIN MAR 02253798 DOM-SIMVASTATIN DPC 02469987 PHARMA-SIMVASTATIN MIN 02281651 DOM-SIMVASTATIN DPC 02469987 PHARMA-SIMVASTATIN PMS 02375079 MAR-SIMVASTATIN JMP 02247828 SANDOZ SIMVASTATIN PMS 02375079 MAR-SIMVASTATIN MIN 02247828 SANDOZ SIMVASTATIN SDZ 02470012 PHARMA-SIMVASTATIN PMS 02386305 SIMVASTATIN SIV 02269295 PMS-SIMVASTATIN PMS 02329188 TARO-SIMVASTATIN SUN 02386348 SIMVASTATIN SIV 02250152 TEVA-SIMVASTATIN SUN 0236348 SIMVASTATIN SUN 02840077 AG-SIMVASTATIN	02405156	AURO-SIMVASTATIN	AUR	00884359	ZOCOR	FRS
02281627 DOM-SIMVASTATIN DPC 02247015 APO-SIMVASTATIN APX 02375605 JAMP-SIMVASTATIN JMP 02405180 AURO-SIMVASTATIN AUR 02375940 MINT-SIMVASTATIN MIN 02251651 DOM-SIMVASTATIN DPC 02469987 PHARMA-SIMVASTATIN PMS 02375648 JAMP-SIMVASTATIN JMP 02269260 PMS-SIMVASTATIN PMS 02375648 JAMP-SIMVASTATIN JMP 02486745 PRIVA-SIMVASTATIN PHA 02372975 MINT-SIMVASTATIN MIN 02386305 SIMVASTATIN SIV 02269295 PMS-SIMVASTATIN PMS 02347221 SIMVASTATIN SIV 02269295 PMS-SIMVASTATIN PMS 02329158 TARO-SIMVASTATIN SUN 02386348 SIMVASTATIN SIV 02250152 TEVA-SIMVASTATIN TEV 02247224 SIMVASTATIN SIV 02280152 TEVA-SIMVASTATIN ANG PDL 02247224 SIMVASTATIN SUN 02480077 AG-SIMVASTATI	02484455	BIO-SIMVASTATIN	BMI	80MG TABL	ET	
02375605 JAMP-SIMVASTATIN JMP 02405180 AURO-SIMVASTATIN AUR 02375044 MAR-SIMVASTATIN MAR 02253798 DOM-SIMVASTATIN DPC 02372940 MINT-SIMVASTATIN MIN 02281651 DOM-SIMVASTATIN DPC 02469967 PHARMA-SIMVASTATIN PMS 02375648 JAMP-SIMVASTATIN JMP 02269260 PMS-SIMVASTATIN PMS 02375079 MAR-SIMVASTATIN MAR 02485745 PRIVA-SIMVASTATIN PHA 02372975 MINT-SIMVASTATIN MIN 02386305 SIMVASTATIN SDZ 02470112 PHARMA-SIMVASTATIN PMS 02247221 SIMVASTATIN-10 PDL 02247233 SANDOZ SIMVASTATIN SDZ 02247221 SIMVASTATIN-10 PDL 02247224 SIMVASTATIN SDZ 02250152 TEVA-SIMVASTATIN TEV 02247224 SIMVASTATIN SIV 02480077 AG-SIMVASTATIN ANG APO-SIMVASTATIN APO-SIMVASTATIN SUS 02247013 APO-SIMVASTATIN <td>02253755</td> <td>DOM-SIMVASTATIN</td> <td>DPC</td> <td>02480093</td> <td>AG-SIMVASTATIN</td> <td>ANG</td>	02253755	DOM-SIMVASTATIN	DPC	02480093	AG-SIMVASTATIN	ANG
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02250160 TEVA-SIMVASTATIN TEV	02247222	SIMVASTATIN-20	PDL			
		TARO-SIMVASTATIN				
00884340 ZOCOR FRS	02250160	TEVA-SIMVASTATIN				
	00884340	ZOCOR	FRS			

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24:06.24

ALIROCUMAB

Limited use benefit (prior approval required).

Initial Coverage (12 weeks):

• For adult patients with heterozygous familial hypercholesterolemia (HeFH) who require additional lowering of low-density lipoprotein cholesterol (LDL-C) if the following clinical criteria are met:

• definite or probable diagnosis of HeFH using the Simon Broome or Dutch Lipid Network criteria or genetic testing; and

Patient is unable to reach an LDL-C target of < 2.0 mmol/L for secondary CVD prevention, or at least a 50% reduction in LDL-C from untreated baseline for primary prevention despite:

- confirmed adherence to a high-dose statin (e.g., atorvastatin 80 mg or rosuvastatin 40 mg) in combination with ezetimibe for a total of at least 3 months of continuous treatment:
- or
- patient is unable to tolerate at least two statins, with at least one statin initiated at the lowest daily starting dose; and
- for each statin (two statins in total), dose reduction was attempted to resolve intolerable myopathy or creatine kinase > 5 times the upper limit of normal rather than statin discontinuation: and
- for each statin (two statins in total), intolerable myopathy or creatine kinase > 5 times the upper limit of normal was reversed upon statin discontinuation, but reoccurred with statin rechallenge where clinically appropriate; and
- confirmed adherence to ezetimibe for a total of at least 3 months continuous treatment; and
- other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out;
- patient developed confirmed and documented rhabdomvolvsis:
- patient has a contraindication to statins; and
- confirmed adherence to ezetimibe for a total of at least 3 months continuous treatment.

Continued coverage (6 months):

- patient is adherent to therapy; and
- patient has achieved a reduction in LDL-C of at least 40% from baseline.
- Note: Annual coverage is limited to 26 prefilled syringes or prefilled pens per year.

75MG SOLUTION

02453754	PRALUENT	SAC
02453819	PRALUENT	SAC
150MG SOL	UTION	
02453762	PRALUENT	SAC
02453835	PRALUENT	SAC
	02453819 150MG SOL 02453762	02453754 PRALUENT 02453819 PRALUENT 150MG SOLUTION 02453762 PRALUENT 02453835 PRALUENT

24:06.24

EVOLOCUMAB

Limited use benefit (prior approval required).

Initial coverage criteria (Initial approval for 12 weeks): For adult patients with heterozygous familial hypercholesterolemia (HeFH) who require additional lowering of low-density lipoprotein cholesterol (LDL-C) if the following clinical criteria are met:

- definite or probable diagnosis of HeFH using the Simon Broome or Dutch Lipid Network criteria or genetic testing; and • patient is unable to reach an LDL-C target of < 2.0 mmol/L
- for secondary CVD prevention, or at least a 50% reduction in LDL-C from untreated baseline for primary prevention despite:
- confirmed adherence to a high-dose statin (e.g., atorvastatin 80 mg or rosuvastatin 40 mg) in combination with ezetimibe for a total of at least 3 months of continuous treatment:
- or
- patient is unable to tolerate at least two statins, with at least one statin initiated at the lowest daily starting dose; and
- for each statin (two statins in total), dose reduction was attempted to resolve intolerable myopathy or creatine kinase > 5 times the upper limit of normal rather than statin discontinuation: and
- for each statin (two statins in total), intolerable myopathy or creatine kinase > 5 times the upper limit of normal was reversed upon statin discontinuation, but reoccurred with statin rechallenge where clinically appropriate; and
- confirmed adherence to ezetimibe for a total of at least 3 months continuous treatment: and
- other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out;
- patient developed confirmed and documented rhabdomyolysis;
- patient has a contraindication to statins; and
- confirmed adherence to ezetimibe for a total of at least 3 months continuous treatment.

Note: Annual coverage is limited to 26 prefilled autoinjectors (140 mg every 2 weeks) or 12 automated Mini-Dosers with prefilled cartridges (420 mg once a month).

Renewal coverage criteria (Renewal for 6 months):

- patient is adherent to therapy; and
 patient has achieved a reduction in LDL-C of at least 40% from baseline.

Note: Annual coverage is limited to 26 prefilled Autoinjectors (140 mg every 2 weeks) or 12 automated Mini-Dosers with prefilled cartridges (420 mg once a month).

120MG SOLUTION

02459779 REPATHA **AMG** 140MG SOLUTION

02446057 REPATHA **AMG**

24:08.16 CENTRAL ALPHA-AGONISTS **CLONIDINE HYDROCHLORIDE**

ST 0.025MG TABLET

02304163 TEVA-CLONIDINE TEV

 $^{\text{ST}}$ 0.1MG TABLET

02462192 MINT-CLONIDINE MIN 02046121 TEVA-CLONIDINE TEV

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04 00 40 OFNED 41 ALBUM 100 ALBUM		04.40.00 NITDATES AND NITES	_
24:08.16 CENTRAL ALPHA-AGONISTS		24:12.08 NITRATES AND NITRITES	
CLONIDINE HYDROCHLORIDE		NITROGLYCERIN	
ST 0.2MG TABLET		ST 0.2MG PATCH	
00868957 APO-CLONIDINE	APX	02162806 MINITRAN VA	ŀΕ
02462206 MINT-CLONIDINE	MIN	02407442 MYLAN-NITRO MY	/L
02046148 TEVA-CLONIDINE	TEV	01911910 NITRO-DUR FR	≀S
ST PDIN FOR EXTEMPORANEOUS MIXTURE		00584223 TRANSDERM-NITRO NV	′R
99503021 CLONIDINE ORAL LIQUID	UNK	02230732 TRINIPATCH PA	۱L
METHYLDOPA		ST 0.4MG PATCH	
ST 125MG TABLET		02163527 MINITRAN VA	
00360252 METHYLDOPA	AAP	02407450 MYLAN-NITRO MY	
ST 250MG TABLET	,	01911902 NITRO-DUR FR	
00360260 METHYLDOPA	AAP	00852384 TRANSDERM-NITRO NV	
ST 500MG TABLET		02230733 TRINIPATCH PA	۱L
00426830 METHYLDOPA	AAP	ST 0.6MG PATCH	_
24:08.20 DIRECT VASODILATORS		02163535 MINITRAN VA	
		02407469 MYLAN-NITRO MY	
DIAZOXIDE		01911929 NITRO-DUR FR	
ST 100MG CAPSULE		02046156 TRANSDERM-NITRO NV 02230734 TRINIPATCH PA	
00503347 PROGLYCEM	FRS	ST 0.8MG PATCH	۱L
HYDRALAZINE HYDROCHLORIDE		02407477 MYLAN-NITRO MY	/ I
ST 10MG TABLET		02407477 NITRO-DUR FR	
00441619 APO-HYDRALAZINE	APX	0.4MG PUMP	٠٠
02457865 JAMP-HYDRALAZINE	JMP	02243588 MYLAN-NITRO MY	/1
02468778 MINT-HYDRALAZINE	MIN	02231441 NITROLINGUAL PUMPSPRAY SA	
ST 25MG TABLET		02238998 RHO-NITRO PUMPSPRAY SD	
00441627 APO-HYDRALAZINE	APX	ST 0.3MG TABLET	_
02457873 JAMP-HYDRALAZINE	JMP		FI
02468786 MINT-HYDRALAZINE	MIN	ST 0.6MG TABLET	
ST 50MG TABLET			FΙ
00441635 APO-HYDRALAZINE	APX	24:12.12 PHOSPHODIESTERASE	
02457881 JAMP-HYDRALAZINE	JMP	INHIBITORS	
02468794 MINT-HYDRALAZINE	MIN		
MINOXIDIL		SILDENAFIL CITRATE	
ST 2.5MG TABLET		Limited use benefit (prior approval required).	
00514497 LONITEN	PFI	Must be initiated by a Pulmonary Hypertension specialist	
ST 10MG TABLET	FII	widst be initiated by a r difficulty rispertension specialist	
00514500 LONITEN	PFI	Patients with World Health Organization (WHO) class III	
24:12.08 NITRATES AND NITRITES	111	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	
ISOSORBIDE DINITRATE		catheterization.	
ST 5MG TABLET		ST 20MG TABLET	
00670944 ISDN	AAP	02418118 APO-SILDENAFIL R AP	γX
ST 10MG TABLET		02412179 PMS-SILDENAFIL R PM	1S
00441686 ISDN	AAP	02279401 REVATIO UN	ΙK
00786667 PMS-ISOSORBIDE	PMS	02319500 TEVA-SILDENAFIL R TE	٠V
ST 30MG TABLET			
00441694 ISDN	AAP		
ISOSORBIDE-5-MONONITRATE			
ST 60MG TABLET (EXTENDED RELEASE)			
02272830 APO-ISMN	APX		
02126559 IMDUR	UNK		
02301288 PMS-ISMN	PMS		
02311321 PRO-ISMN	PDL		
525.152 100 foliat	. 52		

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24:12.12 PHOSPHODIESTERASE **INHIBITORS**

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.

ST 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.

ST 5MG TABLET

02307065 VOLIBRIS **GSK**

ST 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.

ST 62.5MG TABLET

03300303	APO-BOSENTAN	APX
02399202	AFO-BOSLINIAIN	AFA
02383012	PMS-BOSENTAN	PMS
02386275	SANDOZ BOSENTAN	SDZ
02398400	TEVA-BOSENTAN	TEV
02244981	TRACLEER	JSO
ST 125MG TAB	LET	
02383020	PMS-BOSENTAN	PMS

02386283 02244982 TRACLEER **DIPYRIDAMOLE**

ST 25MG TABLE	ET		
00895644	APO-DIPYRIDAMOLE	APX	
ST 50MG TABLET			

SANDOZ BOSENTAN

00571245 APO-DIPYRIDAMOLE

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SDZ

JSO

APX

24:12.92 MISCELLANEOUS VASODILATING AGENTS

DIPYRIDAMOLE

ST 50MG TABLET

00895652 APO-DIPYRIDAMOLE **APX** ST 75MG TABLET 00601845 APO-DIPYRIDAMOLE APX 00895660 APO-DIPYRIDAMOLE **APX**

DIPYRIDAMOLE, ACETYLSALICYLIC ACID

ST 200MG & 25MG CAPSULE (IMMEDIATE AND **EXTENDED RELEASE)**

02471051 TARO-DIPYRIDAMOLE/ ASA TAR

24:20.00 ALPHA ADRENERGIC BLOCKING **AGENTS**

DOXAZOSIN MESYLATE

DOMESSIN	MEGILAIL	
ST 1MG TABLE	Т	
02240588	APO-DOXAZOSIN	APX
02244527	PMS-DOXAZOSIN	PMS
02242728	TEVA-DOXAZOSIN	TEV
ST 2MG TABLE	Т	
02240589	APO-DOXAZOSIN	APX
02244528	PMS-DOXAZOSIN	PMS
02242729	TEVA-DOXAZOSIN	TEV
ST 4MG TABLE	Т	
02240590	APO-DOXAZOSIN	APX
02244529	PMS-DOXAZOSIN	PMS

02242730 TEVA-DOXAZOSIN PRAZOSIN HYDROCHLORIDE

ST 1MG TABLE	Т		
00882801	APO-PRAZO	A	٩PX
01934198	TEVA-PRAZOSIN	٦	TEV
ST 2MG TABLE	Т		
00882828	APO-PRAZO	A	٩PX
01934201	TEVA-PRAZOSIN	٦	TEV
ST 5MG TABLE	т		
00882836	APO-PRAZO	A	٩PX
01934228	TEVA-PRAZOSIN	7	TEV

TEV

TERAZOSIN HYDROCHLORIDE

ST 1MG TABLE	Т	
02234502	APO-TERAZOSIN	APX
02243746	DOM-TERAZOSIN	DPC
02243518	PMS-TERAZOSIN	PMS
02237476	TERAZOSIN	PDL
02350475	TERAZOSIN	SAN
02230805	TEVA-TERAZOSIN	TEV
ST 2MG TABLE	Т	
02234503	APO-TERAZOSIN	APX
02243747	DOM-TERAZOSIN	DPC
02243519	PMS-TERAZOSIN	PMS
02237477	TERAZOSIN	PDL
02350483	TERAZOSIN	SAN
02230806	TEVA-TERAZOSIN	TEV
ST 5MG TABLE	Т	
02234504	APO-TERAZOSIN	APX

				Non-insureu i	Tealth Denents
	PHA ADRENERGIC BL	OCKING		TA ADRENERGIC E	BLOCKING
_	ENTS		_	ENTS	
TERAZOSIN	HYDROCHLORIDE		ATENOLOL		
ST 5MG TABLE	Т		ST 50MG TABL		
	DOM-TERAZOSIN	DPC		MINT-ATENOL	MIN
	PMS-TERAZOSIN	PMS		PMS-ATENOLOL	PMS
	TERAZOSIN	PDL		RIVA-ATENOLOL	RIV
02350491		SAN		SEPTA-ATENOLOL	SPT
	TEVA-TERAZOSIN	TEV		TARO-ATENOLOL	SUN
ST 10MG TABL		A D.V		TENORMIN	AZC
	APO-TERAZOSIN	APX		TEVA-ATENOLOL	TEV
02243749	DOM-TERAZOSIN	DPC	ST 100MG TAB		400
02243521 02237479	PMS-TERAZOSIN TERAZOSIN	PMS PDL		ACT ATENOLOL AG-ATENOLOL	ACG ANG
	TERAZOSIN	SAN		APO-ATENOLOL	ANG
	TEVA-TERAZOSIN	TEV		ATENOLOL	PDL
				ATENOLOL	SIV
	TA ADRENERGIC BLC	CKING		ATENOLOL	SAN
AG	ENTS			BIO-ATENOLOL	BMI
ACEBUTOLO	L HYDROCHLORIDE			DOM-ATENOLOL	DPC
ST 100MG TABI	FT		02367572		JMP
	ACEBUTOLOL	PDL		MAR-ATENOLOL	MAR
	APO-ACEBUTOLOL	APX	02368048		MIN
	TEVA-ACEBUTOLOL	TEV		PMS-ATENOLOL	PMS
ST 200MG TABI				RIVA-ATENOLOL	RIV
	ACEBUTOLOL	PDL	02368668	SEPTA-ATENOLOL	SPT
	APO-ACEBUTOLOL	APX	02267993	TARO-ATENOLOL	SUN
	TEVA-ACEBUTOLOL	TEV	02039540	TENORMIN	AZC
ST 400MG TABI			02171805	TEVA-ATENOLOL	TEV
02164426	ACEBUTOLOL	PDL	ATENOLOL.	CHLORTHALIDONE	
02147629	APO-ACEBUTOLOL	APX	sτ 50MG & 25N		
02204533	TEVA-ACEBUTOLOL	TEV		AA-ATENIDONE	AAP
ATENOLOL				TENORETIC	AZC
25MG TABL	FT		ST 100MG & 25		7120
	AG-ATENOLOL	ANG		AA-ATENIDONE	APX
02326701	ATENOLOL	PDL		TENORETIC	AZC
02392194	BIO-ATENOLOL	BMI		L FUMARATE	
02367556	JAMP-ATENOLOL	JMP			
02371979	MAR-ATENOLOL	MAR	ST 5MG TABLE		
02368013	MINT-ATENOL	MIN		APO-BISOPROLOL	APX
02246581	PMS-ATENOLOL	PMS	02383055	BISOPROLOL	SIV
02277379	RIVA-ATENOLOL	RIV	02391589		SAN
02368633	SEPTA-ATENOLOL	SPT	02465612		MIN
02373963	TARO-ATENOLOL	SUN	02302632 02306999	PMS-BISOPROLOL PRO-BISOPROLOL	PMS PDL
02266660	TEVA-ATENOLOL	TEV	02306999		RIV
ST 50MG TABL	ET		02247439		SDZ
02255545	ACT ATENOLOL	ACG	02494035		SDZ
02369184	AG-ATENOLOL	ANG	02267470	TEVA-BISOPROLOL	TEV
00773689	APO-ATENOL	APX	ST 10MG TABL		ı L V
00828807	ATENOLOL	PDL	02256177	APO-BISOPROLOL	APX
02238316	ATENOLOL	SIV	02383063	BISOPROLOL	SIV
02466465	ATENOLOL	SAN	02391597	BISOPROLOL	SAN
02392178	BIO-ATENOLOL	BMI	02465620	MINT-BISOPROLOL	MIN
02229467	DOM-ATENOLOL	DPC	02302640	PMS-BISOPROLOL	PMS
02367564	JAMP-ATENOLOL	JMP		PRO-BISOPROLOL	PDL
02371987	MAR-ATENOLOL	MAR		RIVA-BISOPROLOL	RIV

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				Non-insured nearth	Denenis
	TA ADRENERGIC BLOCK ENTS	ING		TA ADRENERGIC BLOCK SENTS	ING
BISOPROLO	L FUMARATE		HYDROCHLO	OROTHIAZIDE, PINDOLOL	
ST 10MG TABLI	FT		^{S7} 10MG & 50N	•	
	SANDOZ BISOPROLOL	SDZ		VISKAZIDE	UNK
	SANDOZ BISOPROLOL	SDZ		. HYDROCHLORIDE	Onn
	TEVA-BISOPROLOL	TEV			
CARVEDILO			ST 100MG TAB		
				RIVA-LABETALOL	RIV
ST 3.125MG TA	 :			TRANDATE	PAL
	APO-CARVEDILOL	APX	^{S7} 200MG TAB		50.4
	AURO-CARVEDILOL	AUR		RIVA-LABETALOL	RIV
	CARVEDILOL	SIV		TRANDATE	PAL
02324504 02364913	CARVEDILOL CARVEDILOL	PDL SAN	METOPROL	OL TARTRATE	
02364913	DOM-CARVEDILOL	DPC	ST 25MG TABL	ET	
02368897	JAMP-CARVEDILOL	JMP	02246010	APO-METOPROLOL	APX
02245914		PMS	02252252	DOM-METOPROLOL-L	DPC
02268027	RAN-CARVEDILOL	RBY	02356813	JAMP-METOPROLOL-L	JMP
02252309	TEVA-CARVEDILOL	TEV	02296713	METOPROLOL	PDL
ST 6.25MG TAB		124	02248855	PMS-METOPROLOL-L	PMS
	APO-CARVEDILOL	APX	02315300	RIVA-METOPROLOL L	RIV
	AURO-CARVEDILOL	AUR		TEVA-METOPROLOL	TEV
	CARVEDILOL	SIV	$^{s au}$ 50MG TABL	ET	
	CARVEDILOL	PDL		APO METOPROLOL	APX
02364921	CARVEDILOL	SAN	00749354	APO METOPROLOL (TYPE L)	APX
02248749		DPC		DOM-METOPROLOL-B	DPC
02368900	JAMP-CARVEDILOL	JMP	02231121		DPC
02245915	PMS-CARVEDILOL	PMS	02356821		JMP
02268035	RAN-CARVEDILOL	RBY		METOPROLOL	PDL
02252317	TEVA-CARVEDILOL	TEV	02350394		SAN
ST 12.5MG TAB	LET			METOPROLOL-L	SIV
02247935	APO-CARVEDILOL	APX		PMS-METOPROLOL-B	PMS
02418517	AURO-CARVEDILOL	AUR		PMS-METOPROLOL-L	PMS
02248754	CARVEDILOL	SIV		RIVA-METOPROLOL L	RIV
02324520	CARVEDILOL	PDL		TEVA-METOPROLOL	TEV
02364948	CARVEDILOL	SAN		TEVA-METOPROLOL	TEV
02248750	DOM-CARVEDILOL	DPC	ST 100MG TAB		ADV
02368919	JAMP-CARVEDILOL	JMP		APO METOPROLOL (TYPE L)	APX
02245916	PMS-CARVEDILOL	PMS		APO-METOPROLOL (TYPE L)	APX
02268043	RAN-CARVEDILOL	RBY	02172569		DPC
02252325	TEVA-CARVEDILOL	TEV	02356848	DOM-METOPROLOL-L JAMP-METOPROLOL-L	DPC JMP
ST 25MG TABLI	ET		00648027		PDL
02247936	APO-CARVEDILOL	APX	02350408		
02418525	AURO-CARVEDILOL	AUR	02442132		SAN SIV
02248755	CARVEDILOL	SIV	02145421		PMS
02324539	CARVEDILOL	PDL		PMS-METOPROLOL-L	PMS
02364956	CARVEDILOL	SAN		RIVA-METOPROLOL L	RIV
02248751	DOM-CARVEDILOL	DPC		TEVA-METOPROLOL	TEV
02368927	JAMP-CARVEDILOL	JMP		TEVA-METOPROLOL	TEV
02245917	PMS-CARVEDILOL	PMS		LET (EXTENDED RELEASE)	· _ v
02268051	RAN-CARVEDILOL	RBY		APO-METOPROLOL SR	APX
	TEVA-CARVEDILOL	TEV		LOPRESOR SR	NVR
HYDROCHLO	DROTHIAZIDE, PINDOLOL			METOPROLOL SR	PDL
ST 10MG & 25M	IG TABLET			SANDOZ METOPROLOL SR	SDZ
	VISKAZIDE	UNK		LET (EXTENDED RELEASE)	-
				APO-METOPROLOL SR	APX

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24:24.00 BETA ADRENERGIC BLOCKI AGENTS	NG		TA ADRENERGIC BLOCK	ING
METOPROLOL TARTRATE		PROPRANOI	LOL HYDROCHLORIDE	
ST 200MG TABLET (EXTENDED RELEASE)		ST 80MG TABL	ET	
00534560 LOPRESOR SR	NVR	00582271	PMS-PROPRANOLOL	PMS
02303418 SANDOZ METOPROLOL SR	SDZ	00496502	TEVA-PROPRANOLOL	TEV
ST PDIN FOR EXTEMPORANEOUS MIXTURE		ST 120MG TAB	LET	
99503015 METOPROLOL ORAL LIQUID	UNK	00504335	APO PROPRANOLOL	APX
NADOLOL			PMS-PROPRANOLOL	PMS
ST 40MG TABLET			XTEMPORANEOUS MIXTURE	
00782505 NADOLOL	AAP		PROPRANOLOL ORAL LIQUID	UNK
ST 80MG TABLET		SOTALOL H	YDROCHLORIDE	
00782467 NADOLOL	AAP	ST 80MG TABL	ET	
ST 160MG TABLET		02210428	APO-SOTALOL	APX
00782475 NADOLOL	AAP	02238634	DOM-SOTALOL	DPC
PINDOLOL		02368617		JMP
ST 5MG TABLET			PMS-SOTALOL	PMS
00755877 APO-PINDOL	APX	02316528		PDL
00869007 TEVA-PINDOLOL	TEV	02272164		RIV
00417270 VISKEN	UNK	ST 160MG TAB		
ST 10MG TABLET	• • • • • • • • • • • • • • • • • • • •		APO-SOTALOL	APX
00755885 APO-PINDOL	APX	02238635		DPC
00869015 TEVA-PINDOLOL	TEV	02368625		JMP
00443174 VISKEN	UNK	02238327		PMS
ST 15MG TABLET		02316536	PRO-SOTALOL XTEMPORANEOUS MIXTURE	PDL
00755893 APO-PINDOL	APX		SOTALOL ORAL LIQUID	UNK
02238047 DOM-PINDOLOL	DPC			UNK
02231539 PMS-PINDOLOL	PMS	TIMOLOL MA	ALEATE	
00869023 TEVA-PINDOLOL	TEV	ST 5MG TABLE		
PROPRANOLOL (HEMANGIOL)			TIMOLOL	APX
Limited use benefit (prior approval required).		ST 10MG TABL		
		00755850		APX
For the treatment of proliferating infantile hemangioma requiring systemic therapy and at least one of the follow	ina:	ST 20MG TABL		
 life or function-threatening hemangioma; or 	nig.		TIMOLOL	APX
 ulcerated hemangioma with pain and/or lack of response 	nse to	24:28.08 DII	HYDROPYRIDINES	
simple wound care measures; orhemangioma with a risk of permanent scarring or		AMLODIPINE	BESYLATE	
disfigurement.		ST 2.5MG TABL	_ET	
3.75MG SOLUTION			ACT AMLODIPINE	ACG
02457857 HEMANGIOL	PFD	02326795	AMLODIPINE	PDL
PROPRANOLOL HYDROCHLORIDE			AMLODIPINE	SIV
		02419556	AMLODIPINE BESYLATE	ACC
ST 60MG CAPSULE (SUSTAINED RELEASE)		02392127	BIO-AMLODIPINE	BMI
02042231 INDERAL LA	PFI	02326825	DOM-AMLODIPINE	DPC
87 80MG CAPSULE (SUSTAINED RELEASE)	DEI	02357186	JAMP-AMLODIPINE	JMP
02042258 INDERAL LA	PFI	02468018	M-AMLODIPINE	MAN
120MG CAPSULE (SUSTAINED RELEASE)	DEI	02371707	MAR-AMLODIPINE	MAR
02042266 INDERAL LA ST 160MG CAPSULE (SUSTAINED RELEASE)	PFI	02476452		UNK
02042274 INDERAL LA	PFI	02469022		PMS
ST 10MG TABLET		02295148		PMS
00496480 TEVA-PROPRANOLOL	TEV	02444445		PHA
ST 20MG TABLET	. L v	02398877		RBY
00740675 TEVA-PROPRANOLOL	TEV	02331489		RIV
ST 40MG TABLET	•	02330474	SANDOZ AMLODIPINE SEPTA-AMLODIPINE	SDZ SPT
00496499 TEVA-PROPRANOLOL	TEV	02307704	OLI TA-AIVILODIFINE	351

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24:28.08 DIHYDROPYRIDINES 24:28.08 DIHYDROPYRIDINES **AMLODIPINE BESYLATE AMLODIPINE BESYLATE** ST 5MG TABLET **ST PDIN FOR EXTEMPORANEOUS MIXTURE ACT AMLODIPINE** ACG 99503003 AMLODIPINE ORAL LIQUID UNK 02297485 AG-AMLODIPINE ANG 02369230 AMLODIPINE BESYLATE. ATORVASTATIN 02326809 AMI ODIPINE PDL **CALCIUM** 02331284 **AMLODIPINE** SAN ST 5MG & 10MG TABLET 02385791 **AMLODIPINE** SIV 02411253 APO-AMLODIPINE-ATORVASTATIN APX 02429217 AMI ODIPINE JMP 02273233 CADUFT UNK 02419564 AMLODIPINE BESYLATE ACC GD-AMI ODIPINE-ATORVASTATIN UNK 02362759 02273373 APO-AMLODIPINE APX PMS-AMLODIPINE-ATORVASTATIN 02404222 **PMS** 02397072 **AURO-AMLODIPINE** AUR ST 5MG & 20MG TABLET 02392135 **BIO-AMLODIPINE** BMI 02411261 APO-AMI ODIPINE-ATORVASTATIN ΔPX 02326833 DOM-AMI ODIPINE DPC 02273241 CADUET UNK JAMP-AMI ODIPINE 02357194 .IMP 02362767 GD-AMLODIPINE-ATORVASTATIN UNK 02468026 M-AMI ODIPINE MAN 02404230 PMS-AMLODIPINE-ATORVASTATIN **PMS** 02371715 MAR-AMI ODIPINE MAR ST 5MG & 40MG TABLET 02362651 MINT-AMLODIPINE MIN 02411288 APO-AMLODIPINE-ATORVASTATIN APX 02272113 MYLAN-AMLODIPINE MYI 02273268 CADUET UNK 00878928 **NORVASC** UNK GD-AMLODIPINE-ATORVASTATIN 02362775 UNK 02476460 NRA-AMLODIPINE UNK $^{\rm s au}$ 5MG & 80MG TABLET PHARMA-AMLODIPINE 02469030 **PMS** 02411296 APO-AMLODIPINE-ATORVASTATIN APX 02284065 PMS-AMLODIPINE **PMS** 02273276 CADUFT UNK 02444453 PRIVA-AMLODIPINE PHA 02362783 GD-AMLODIPINE-ATORVASTATIN UNK 02321858 RAN-AMLODIPINE RBY ST 10MG & 10MG TABLET 02331497 RIVA-AMLODIPINE RIV 02411318 APO-AMLODIPINE-ATORVASTATIN APX SANDOZ AMLODIPINE 02284383 SD7 02273284 CADUET UNK 02357712 SEPTA-AMLODIPINE SPT 02362791 GD-AMLODIPINE-ATORVASTATIN UNK 02250497 **TEVA-AMLODIPINE** TFV 02404249 PMS-AMLODIPINE-ATORVASTATIN **PMS** ST 10MG TABLET ST 10MG & 20MG TABLET 02297493 **ACT AMI ODIPINE** ACG 02411326 APO-AMLODIPINE-ATORVASTATIN APX 02369249 AG-AMLODIPINE ANG 02273292 CADUET UNK 02326817 **AMLODIPINE** PDL 02362805 **GD-AMLODIPINE-ATORVASTATIN** UNK 02331292 **AMLODIPINE** SAN 02404257 PMS-AMLODIPINE-ATORVASTATIN **PMS** 02385805 **AMLODIPINE** SIV $^{\rm s7}$ 10MG & 40MG TABLET 02429225 **AMLODIPINE JMP** 02411334 APO-AMLODIPINE-ATORVASTATIN APX 02419572 AMLODIPINE BESYLATE ACC 02273306 CADUET UNK 02273381 APO-AMLODIPINE APX GD-AMLODIPINE-ATORVASTATIN 02362813 UNK 02397080 **AURO-AMLODIPINE AUR** $^{\rm s7}$ 10MG & 80MG TABLET 02392143 **BIO-AMLODIPINE** BMI 02411342 APO-AMLODIPINE-ATORVASTATIN APX 02326841 DOM-AMLODIPINE DPC 02273314 CADUFT UNK 02357208 JAMP-AMLODIPINE **JMP** 02362821 GD-AMLODIPINE-ATORVASTATIN UNK 02468034 M-AMLODIPINE MAN AMLODIPINE BESYLATE, TELMISARTAN 02371723 MAR-AMLODIPINE MAR 02362678 MINT-AMI ODIPINE MIN $^{\rm s au}$ 5MG & 40MG TABLET 02272121 MYLAN-AMLODIPINE MYL 02371022 TWYNSTA BOE 00878936 NORVASC UNK ST 5MG & 80MG TABLET 02476479 NRA-AMI ODIPINE UNK 02371049 TWYNSTA BOE 02469049 PHARMA-AMLODIPINE **PMS** ST 10MG & 40MG TABLET PMS-AMLODIPINE 02284073 **PMS** 02371030 TWYNSTA BOE 02444461 PRIVA-AMI ODIPINE PHA ST 10MG & 80MG TABLET 02321866 RAN-AMI ODIPINE RBY 02371057 TWYNSTA BOE 02331500 RIVA-AMLODIPINE RIV **FELODIPINE** 02284391 SANDOZ AMLODIPINE SDZ ST 2.5MG TABLET (EXTENDED RELEASE) SPT 02357720 SEPTA-AMLODIPINE 02452367 APO-FELODIPINE **APX** 02250500 **TEVA-AMLODIPINE** TEV 02057778 PLENDIL AZC

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				14011-1113dred Health	
24:28.08 DIF	HYDROPYRIDINES			SCELLANEOUS CALCIUM IANNEL BLOCKING AGEN	='
_			DII TIAZEM I	HYDROCHLORIDE	
	T (EXTENDED RELEASE)	45)/			
	APO-FELODIPINE	APX		SULE (CONTROLLED DELIVERY)	
00851779		AZC		DILTIAZEM CD	SAN
	SANDOZ FELODIPINE	SDZ		PMS-DILTIAZEM CD	PMS
	SANDOZ-FELODIPINE	SDZ		SULE (EXTENDED RELEASE)	
	ET (EXTENDED RELEASE)	45)/		ACT DILTIAZEM CD	TEV
	APO-FELODIPINE	APX		ACT DILTIAZEM T	TEV
00851787		AZC		CARDIZEM CD	VAE
	SANDOZ FELODIPINE	SDZ		DILTIAZEM CD	SIV
	SANDOZ-FELODIPINE	SDZ		DILTIAZEM TZ	PDL
NIFEDIPINE				MAR-DILTIAZEM T	MAR
ST 5MG CAPSU	ILE			SANDOZ DILTIAZEM CD	SDZ
	NIFEDIPINE	AAP		SANDOZ DILTIAZEM T	SDZ
	PMS-NIFEDIPINE	PMS	02271605	TEVA-DILTIAZEM	VAE
ST 10MG CAPS		1 1110		TEVA-DILTIAZEM CD	TEV
	NIFEDIPINE	AAP	02231150		VAE
	PMS-NIFEDIPINE	PMS	ST 180MG CAP	SULE (EXTENDED RELEASE)	
	ET (EXTENDED RELEASE)	1 IVIO	02370638	ACT DILTIAZEM CD	TEV
	ADALAT XL	BAY	02370492	ACT DILTIAZEM T	TEV
	ET (EXTENDED RELEASE)	DAT	02446006	DILTIAZEM CD	SIV
	ADALAT XL	BAY	02325314	DILTIAZEM TZ	PDL
	MYLAN-NIFEDIPINE	MYL	02465361	MAR-DILTIAZEM T	MAR
	NIFEDIPINE	PDL	02243339	SANDOZ DILTIAZEM CD	SDZ
	PMS-NIFEDIPINE	PMS	02245919	SANDOZ DILTIAZEM T	SDZ
	ET (EXTENDED RELEASE)	PIVIS	02271613	TEVA-DILTIAZEM	VAE
	ADALAT XL	BAY	02242539	TEVA-DILTIAZEM CD	TEV
		MYL	02231151	TIAZAC	VAE
	MYLAN-NIFEDIPINE		ST 240MG CAP	SULE (EXTENDED RELEASE)	
	NIFEDIPINE	PDL	02370646	ACT DILTIAZEM CD	TEV
	PMS-NIFEDIPINE	PMS	02370506	ACT DILTIAZEM T	TEV
NIMODIPINE			02446014	DILTIAZEM CD	SIV
ST 30MG TABL	ET		02325322	DILTIAZEM TZ	PDL
02325926	NIMOTOP	BAY	02465388	MAR-DILTIAZEM T	MAR
24.28 92 MIS	SCELLANEOUS CALCIUM-		02243340	SANDOZ DILTIAZEM CD	SDZ
	ANNEL BLOCKING AGENTS		02245920		SDZ
			02271621	TEVA-DILTIAZEM	VAE
DILTIAZEM F	HYDROCHLORIDE		02242540	TEVA-DILTIAZEM CD	TEV
ST 120MG CAPS	SULE (CONTROLLED DELIVERY)		02231152	TIAZAC	VAE
	APO-DILTIAZ CD	APX	ST 300MG CAP	SULE (EXTENDED RELEASE)	
02231472	DILTIAZEM CD	PDL		ACT DILTIAZEM CD	TEV
	DILTIAZEM CD	SAN		ACT DILTIAZEM T	TEV
	PMS-DILTIAZEM CD	PMS		DILTIAZEM CD	SIV
	SULE (CONTROLLED DELIVERY)	1 1110		DILTIAZEM TZ	PDL
	APO-DILTIAZ CD	APX		MAR-DILTIAZEM T	MAR
	DILTIAZEM CD	PDL	02243341		SDZ
	DILTIAZEM CD	SAN	02245921		SDZ
	PMS-DILTIAZEM CD	PMS		TEVA-DILTIAZEM	VAE
	SULE (CONTROLLED DELIVERY)	i ivio	02242541		TEV
	APO-DILTIAZ CD	APX	02231154		VAE
				SULE (EXTENDED RELEASE)	VAL
	DILTIAZEM CD	PDL			TE\/
	DILTIAZEM CD	SAN		ACT DILTIAZEM T	TEV
	PMS-DILTIAZEM CD	PMS		DILTIAZEM TZ	PDL
	SULE (CONTROLLED DELIVERY)	A D.V		MAR-DILTIAZEM T	MAR
	APO-DILTIAZ CD	APX		SANDOZ DILTIAZEM T	SDZ
02231057	DILTIAZEM CD	PDL	022/1056	TEVA-DILTIAZEM	VAE

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24:28.92 MISCELLANEOUS CALCIUM- CHANNEL BLOCKING AGENTS DILTIAZEM HYDROCHLORIDE "390MG CAPSULE (EXTENDED RELEASE) 00221195 TIAZAC "390MG TABLET 00771396 A-DUITIAZE 00982392 TEVA-DUITIAZEM 00982393 APO-CAPTO 0098393 APO					Non-insured nearth ben	ents	
"360MG CAPSULE (EXTENDED RELEASE) 02273115 TIAZAC AAP 02737317 AA-DLITAZ AAP 0682924 TEVA-DLITAZEM TEV 00717376 AA-DLITAZEM TEV 0771376 TEV 077137							
02231155 TIAZAC	DILTIAZEM H	HYDROCHLORIDE		BENAZEPRII	L HYDROCHLORIDE		
02231155 TIAZAC	ST 360MG CAP	SULF (EXTENDED RELEASE)		ST 20MG TARI	FT		
**3 30M6 TABLET **CAPTOPRIL			VAF			AAP	
00771376 AA-DILTIAZEM 0086292 TEVA-DILTIAZEM 00771384 AAZ 00862932 TEVA-DILTIAZEM 1EV 00791384 AAZ 00862932 TEVA-DILTIAZEM 1EV 00971384 AAZ 00862932 TEVA-DILTIAZEM 1EV 0098398 APO-CAPTO APX 00883985 APO-CAPTO APX 00883985 APO-CAPTO APX 00893985 APO-CAPTO APX 00893987 APO-CAPTO APX 01942980 TEVA-CAPTOPRIL TEV 10080 TABLET (EXTENDED RELEASE) 02259797 TIAZAC XC VAE 02259797 TIAZAC XC			V/ (L		DEIW VEEL THE	7011	
TeV			AAP	_			
## 60MG TABLET							
00771384 AA-DILTIAZ AAP 00893935 APO-CAPTO APX 00893935 APO-CAPTO APX 01942964 TEVA-CAPTOPRIL TEV 01942964 TEVA-CAPTOPRIL TEV 01942964 TEVA-CAPTOPRIL TEV 01942964 TEVA-CAPTOPRIL TEV 02256738 TIAZAC XC VAE 00893603 APO-CAPTO APX APX 02256746 TIAZAC XC VAE 01942972 TEVA-CAPTOPRIL TEV 02256754 TIAZAC XC VAE 01942972 TEVA-CAPTOPRIL TEV 02256752 TIAZAC XC VAE 00893617 APO-CAPTO APX 022567672 TIAZAC XC VAE 00893617 APO-CAPTOPRIL TEV 022567762 TIAZAC XC VAE 00893617 APO-CAPTOPRIL TEV 022567762 TIAZAC XC VAE 00893625 APO-CAPTO APX 02250770 TIAZAC XC VAE 00893625 APO-CAPTOPRIL PMS 02250770 TIAZAC XC VAE 01942999 TEVA-CAPTOPRIL PMS 022500740 VERELAN RGL 02230778 MYLAN-CILAZAPRIL MYL 022804074 VERELAN RGL 02280476 PMS-CAPTOPRIL PMS 022500740 VERELAN RGL 02280476 PMS-CAPTOPRIL PMS 022500740 VERELAN RGL 022804778 MYLAN-CILAZAPRIL PMS 022500740 VERELAN RGL 022804076 PMS-CILAZAPRIL PMS 022500740 PMS-CILAZAPRIL PMS 022500740 PMS-CILAZAPRIL PMS 02230792 MYLAN-VERAPAMIL MYL 02220050 MMS-CAPTOPRIL PMS 02230792 MYLAN-VERAPAMIL MYL 02220050 PMS-CILAZAPRIL MYL 02230792 MYLAN-VERAPAMIL MYL 02230796 MYLAN-VERAPAMIL MYL 02230796 MYLAN-VERAPAMIL MYL 02246987 APO-VERAP SR APX 02246987 APO-VERAP SR APX 02246987 APO-VERAP SR APX 02246989 APO-	ST 60MG TABL	ET				APX	
00862932 TEV-D-LITLAZEM **120MG TABLET** (EXTENDED RELEASE) 02256738 TIAZAC XC **120MG TABLET* (EXTENDED RELEASE) 02256746 TIAZAC XC **120MG TABLET* (EXTENDED RELEASE) 02256746 TIAZAC XC **120MG TABLET* (EXTENDED RELEASE) 02256746 TIAZAC XC **120MG TABLET** (EXTENDED RELEASE) 02256776 TIAZAC XC **120MG TABLET** (EXTENDED RELEASE) 02256770 TIAZAC XC **120MG CAPSULE (SUSTAINED RELEASE) 02100479 VERELAN 02100479 VERELAN 02100479 VERELAN 02100479 VERELAN 02100487 VERELAN 02100487 VERELAN 02100489 VERELAN 02100489 VERELAN 02100489 VERELAN 02100499 VERELAN 02237921 MYLAN-VERAPAMIL 00782491 APO-VERAP APX 02237922 MYLAN-VERAPAMIL 01911473 INHIBACE 01911474 APO-CILAZAPRIL 01911474 INHIBACE 01911474 INHIBACE 01911474 INHIBACE 01911474 INHIBACE 01911474 INHIBACE 01911475 INHIBACE 019			AAP				
**120MG TABLET (EXTENDED RELEASE) 02256738							
02256736 TIAZAC XC	ST 120MG TAB	LET (EXTENDED RELEASE)				TEV	
**190MG TABLET (EXTENDED RELEASE) 02256746 TIAZAC XC **240MG TABLET (EXTENDED RELEASE) 02256754 TIAZAC XC **240MG TABLET (EXTENDED RELEASE) 02256754 TIAZAC XC **300MG TABLET (EXTENDED RELEASE) 02256752 TIAZAC XC VAE 00893617 APO-CAPTO APX 01942990 TEVA-CAPTOPRIL TEV 02256762 TIAZAC XC VAE 00893625 APO-CAPTO APX 02256767 TIAZAC XC VAE 00893625 APO-CAPTO APX 02256770 TIAZAC XC VAE 02256770 TIAZAC XC VAE 00893625 APO-CAPTO APX 02256761 TIAZAC XC VAE 00893625 APO-CAPTO APX 02236781 TEVA-CAPTOPRIL PMS 02266770 TIAZAC XC VAE 00893625 APO-CAPTO APX 02236781 APC-CAPTOPRIL PMS 02266770 TIAZAC XC VAE 00893625 APO-CAPTO APX 02236781 APC-CAPTOPRIL PMS 02266770 TIAZAC XC VAE 00893625 APO-CAPTO APX 02236781 APC-CAPTOPRIL PMS 02291134 APC-CILAZAPRIL PMS 02291134 APC-CILAZAPRIL PMS 02230732 MYLAN-VERAPAMIL MYL 02230732 MYLAN-VERAPAMIL MYL 02230732 MYLAN-VERAPAMIL MYL 02246849 APO-VERAP SR 02246891 APO-VERAP SR 02246931 ISOPTIN SR 0BGP 02246891 APO-VERAP SR 02246931 ISOPTIN SR 0BGP 02246891 APO-VERAP SR 02246931 ISOPTIN SR 0BGP 02246991 APC-VERAP SR 02246991 APO-VERAP SR 02246991			VAE				
02256746 TIAZAC XC VAE 019429/2 TEVA-CAPTOPRIL 1EV "240MG TABLET (EXTENDED RELEASE) 02256754 TIAZAC XC VAE 01942980 TEVA-CAPTOPRIL TEVA-CAPTORRIL TEVA-CAP	ST 180MG TAB	LET (EXTENDED RELEASE)					
#*************************************			VAE			TEV	
02256754 TIAZAC XC							
### 300MG TABLET (EXTENDED RELEASE) 02256762		•	VAE				
0.225672 TIAZAC X C						TEV	
**360MG TABLET (EXTENDED RELEASE) 02256770 TIAZAC XC VERAPAMIL HYDROCHLORIDE 120MG CAPSULE (SUSTAINED RELEASE) 02100479 VERELAN 02100487 VERELAN 02100487 VERELAN 02100487 VERELAN 02100487 VERELAN 02100487 VERELAN 02100495 VERELAN 02201147 MYLAN-VERAPAMIL 02231142 APO-CILAZAPRIL 02291142 APO-CILAZAPRIL 02280450 PMS-CILAZAPRIL 02280450 PMS-		·	VAE				
02256770	ST 360MG TAB	LET (EXTENDED RELEASE)					
VERAPAMIL HYDROCHLORIDE CILAZAPRIL TEVA-CAPTOPRIL TEVA-CAPTORRIL APX 02100487 VERELAN RGL 02280142 PMS-CILAZAPRIL MYL 02291142 APO-CILAZAPRIL MYL 02280786 MYLAN-CILAZAPRIL MYL 02280786 MYLAN-CILAZAPRIL MYL 02246891 APO-VERAP APX 02280786 APO-CILAZAPRIL APX 02280786 <td></td> <td>· · · · · · · · · · · · · · · · · · ·</td> <td>VAE</td> <td></td> <td></td> <td></td>		· · · · · · · · · · · · · · · · · · ·	VAE				
120MG CAPSULE (SUSTAINED RELEASE)	VERAPAMII	HYDROCHI ORIDE				TEV	
02100479 VERLAN 02100487 VERLAN 02100487 VERLAN RGL 02283778 MYLAN-CILAZAPRIL MYL 02280742 PMS-CILAZAPRIL MYL 02280743 PMS-CILAZAPRIL APX 02100495 VERELAN RGL 02291142 APO-CILAZAPRIL APX 02291143 INHIBACE CHE 00782483 APO-VERAP APX 02237921 MYLAN-VERAPAMIL MYL 022807921 MYLAN-VERAPAMIL MYL 02237922 MYLAN-VERAPAMIL MYL 02237922 MYLAN-VERAPAMIL MYL 02246893 APO-VERAP RAPX 01907123 ISOPTIN SR 01907123 ISOPTIN SR 01907123 ISOPTIN SR 02210347 MYLAN-VERAPAMIL SR 02246894 APO-CILAZAPRIL PMS 02210347 MYLAN-VERAPAMIL SR 02246894 APO-CERAP SR 02246894 APO-VERAP SR 02246894 APO-VERAP SR 02246894 APO-VERAP SR 02246895 APO-VERAP SR 02246896 MYLAN-VERAPAMIL MYL 02230731 ISOPTIN SR 02246896 APO-VERAP SR 02246896 APO-VERAP SR 02246896 APO-VERAP SR 02240321 DOM-VERAPAMIL SR 022				CILAZAPRIL			
## 180MG CAPSULE (SUSTAINED RELEASE) 02100497 VERELAN RGL 02100497 VERELAN RGL ## 240MG CAPSULE (SUSTAINED RELEASE) 02100495 VERELAN RGL 02100495 VERELAN RGL 02100495 VERELAN RGL ## 25.6MG TABLET 00782483 APO-VERAP 02237921 MYLAN-VERAPAMIL 0782491 APO-VERAP 07824940				ST 1MG TABLE	т		
180MG CAPSULE (SUSTAINED RELEASE) 02283778 MYLAN-CILAZAPRIL MYL			RGL	02291134	APO-CILAZAPRIL	APX	
02100487 VERELAN RGL 02280442 PMS-CILAZAPRIL PMS "240MG CAPSULE (SUSTAINED RELEASE) 02100495 VERELAN RGL 02100495 VERELAN RGL 02291142 APO-CILAZAPRIL APX 10782481 APO-VERAP APX 02283786 MYLAN-CILAZAPRIL MYL 02237921 MYLAN-VERAPAMIL MYL 02280450 PMS-CILAZAPRIL MYL 0782491 APO-VERAP APX 02283786 MYLAN-CILAZAPRIL MYL 0782491 APO-VERAP APX 02280450 PMS-CILAZAPRIL PMS "120MG TABLET " 0782491 APO-VERAP APX 02280450 PMS-CILAZAPRIL MYL 02237922 MYLAN-VERAPAMIL MYL 019114481 INHBACE CHE 02237922 MYLAN-VERAPAMIL MYL 01911481 INHBACE CHE 02246893 APO-VERAP SR APX 02280469 PMS-CILAZAPRIL PMS 01907123 ISOPTIN SR BGP 02181479 INHBACE CILAZAPRIL PMS 0210347 MYLAN-VERAPAMIL MYL 02280469 PMS-CILAZAPRIL PMS 0210347 MYLAN-VERAPAMIL SR MYL 02280469 PMS-CILAZAPRIL PMS 01904123 ISOPTIN SR BGP 02181479 INHBACE PLUS CHE 02246894 APO-VERAP SR APX 0228987 APO-CILAZAPRIL/HCTZ APX 01934317 ISOPTIN SR BGP 02181479 INHBACE PLUS CHE 02460488 MYLAN-VERAPAMIL MYL 023313731 TEVA-CILAZAPRIL/HCTZ TEV "240MG TABLET (EXTENDED RELEASE) ENALAPRIL MALEATE 02246895 APO-VERAP SR APX 02284987 APO-CILAZAPRIL/HCTZ TEV "240MG TABLET (EXTENDED RELEASE) ENALAPRIL MALEATE 02240321 DOM-VERAPAMIL SR DPC 02291878 ACT ENALAPRIL APX 01943417 ISOPTIN SR BGP 02020025 APO-ENALAPRIL APX 02450496 MYLAN-VERAPAMIL SR DPC 02291878 ACT ENALAPRIL APX 02450496 MYLAN-VERAPAMIL MYL 02400650 ENALAPRIL SIV 24:32.04 ANGIOTENSIN-CONVERTING 0249950 MALAPRIL APX 02240321 DOM-VERAPAMILSR PMS 02442957 ENALAPRIL APX 02240321 DOM-VERAPAMILSR PMS 02442957 ENALAPRIL MAR ENZYME INHIBITORS BENAZEPRIL HYDROCHLORIDE 03352230 RAN-ENALAPRIL REY 02290332 BENAZEPRIL APP 02299933 SANDOZ ENALAPRIL REY 02290332 BENAZEPRIL APP 02300171 TARO-ENALAPRIL SIV 02290330 BENAZEPRIL APP 02300171 TARO-ENALAPRIL TARO 0						MYL	
02100495 VERELAN RGL 02291142 APO-CILAZAPRIL APX 022918283 APO-VERAP APX 02283786 MYLAN-CILAZAPRIL MYL 02283786 MYLAN-CILAZAPRIL MYL 02280450 PMS-CILAZAPRIL MYL 02280450 PMS-CILAZAPRIL MYL 02280450 PMS-CILAZAPRIL MYL 02280450 PMS-CILAZAPRIL PMS MYLAN-CILAZAPRIL APX 02291150 APO-CILAZAPRIL APX 02237922 MYLAN-VERAPAMIL MYL 01911481 INHIBACE CHE MYLAN-CILAZAPRIL APX 02283786 MYLAN-CILAZAPRIL APX 02281150 APO-CILAZAPRIL APX 02281150 APO-CILAZAPRIL APX 022810342 APO-VERAP SR APX 02280469 PMS-CILAZAPRIL PMS 01907123 SOPTIN SR BGP 02210347 MYLAN-CIRAPAMIL SR MYL MYLAN-CILAZAPRIL PMS 02210347 MYLAN-CIRAPAMIL SR MYL MYLAN-CILAZAPRIL PMS 02246894 APO-VERAP SR APX 02284987 APO-CILAZAPRIL/HCTZ APX APX 02246894 APO-VERAP SR APX 02284987 APO-CILAZAPRIL/HCTZ APX APX 02246894 APO-VERAPAMIL MYL 02313731 TEVA-CILAZAPRIL/HCTZ APX APX 02240321 SOPTIN SR BGP 02181479 INHIBACE PLUS CHE			RGL				
ST 80MG TABLET				ST 2.5MG TABL	.ET		
SOMG TABLET			RGL	02291142	APO-CILAZAPRIL	APX	
02237921 MYLAN-VERAPAMIL MYL 02289/86b PMS-CILAZAPRIL MYL 5″ 120MG TABLET 00782491 APO-VERAP APX 02291150 APO-CILAZAPRIL APX 02237922 MYLAN-VERAPAMIL MYL 01911481 IMHIBACE CHE 5″ 120MG TABLET (EXTENDED RELEASE) 02280469 MYLAN-CILAZAPRIL MYL 02246893 APO-VERAP SR APX 02280469 PMS-CILAZAPRIL MYL 01907123 ISOPTIN SR BGP 02280469 PMS-CILAZAPRIL PMS 01907123 ISOPTIN SR BGP 02280469 PMS-CILAZAPRIL PMS 01907437 MYLAN-VERAPAMIL SR MYL 02280469 PMS-CILAZAPRIL PMS 01934317 ISOPTIN SR BGP 02181479 INHIBACE PLUS CHE 02450488 MYLAN-VERAPAMIL SR MYL 02313731 TEVA-CILAZAPRIL/HCTZ TEV 02246895 APO-VERAP SR APX 02241479 INHIBACE PLUS CHE 02246949 MYLAN-VERAPAMIL SR MYL							
02237921 MYLAN-VERAPAMIL MYL 02280450 PMS-CILAZAPRIL PMS **120MG TABLET 00782491 APO-VERAP 02237922 MYLAN-VERAPAMIL MYL 02246893 APO-VERAP OZ283794 MYLAN-CILAZAPRIL MYL 02246893 APO-VERAP SR APX 02283794 MYLAN-CILAZAPRIL MYL 02246894 APO-VERAP SR APX 02280469 PMS-CILAZAPRIL PMS 01907123 ISOPTIN SR BGP 02210347 MYLAN-VERAPAMIL SR MYL ***********************************							
00782491			MYL			PMS	
02237922 MYLAN-VERAPAMIL MYL 02291150 APO-GILAZAPRIL APX 01911481 INHIBACE CHE CHE <td></td> <td></td> <td></td> <td>ST 5MG TABLE</td> <td>т</td> <td></td>				ST 5MG TABLE	т		
O2237922				02291150	APO-CILAZAPRIL	APX	
120MG TABLET (EXTENDED RELEASE)			MYL			CHE	
02246893		•				MYL	
02210347 MYLAN-VERAPAMIL SR MYL CILAZAPRIL, HYDROCHLOROTHIAZIDE 5° 180MG TABLET (EXTENDED RELEASE) 5° 5MG & 12.5MG TABLET 02246894 APO-VERAP SR APX 01934317 ISOPTIN SR BGP 02181479 INHIBACE PLUS CHE 02450488 MYLAN-VERAPAMIL MYL 02313731 TEVA-CILAZAPRIL/HCTZ TEV ** 240MG TABLET (EXTENDED RELEASE) ENALAPRIL MALEATE 02240895 APO-VERAP SR APX ST 2.5MG TABLET ENALAPRIL TEVA-CILAZAPRIL/HCTZ TEVA-CILAZAPRIL MACT ENALAPRIL MACT ENALAPRIL MACT ENALAPRIL <td co<="" td=""><td></td><td></td><td></td><td></td><td></td><td></td></td>	<td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
5T 180MG TABLET (EXTENDED RELEASE) ST 5MG & 12.5MG TABLET 02246894 APO-VERAP SR APX 02284987 APO-CILAZAPRIL/HCTZ APX 01934317 ISOPTIN SR BGP 02181479 INHIBACE PLUS CHE 02450488 MYLAN-VERAPAMIL MYL 02313731 TEVA-CILAZAPRIL/HCTZ TEV 5T 240MG TABLET (EXTENDED RELEASE) ENALAPRIL MALEATE 02246895 APO-VERAP SR APX DPC 02291878 ACT ENALAPRIL TEV 00742554 ISOPTIN SR BGP 02291878 ACT ENALAPRIL TEV 02450496 MYLAN-VERAPAMIL SR MYL 02400650 ENALAPRIL SAN 02237791 PMS-VERAPAMIL SR PMS 02440650 ENALAPRIL SAN 24:32.04 ANGIOTENSIN-CONVERTING 02459450 MAR-ENALAPRIL MR ENZYME INHIBITORS 02311402 PRO-ENALAPRIL MR BENAZEPRIL HYDROCHLORIDE 02300796 RIVA-ENALAPRIL RBY *** 5MG TABLET** 022909332 BENAZEPRIL AAP <				CII ΔΖΔΡΒΙΙ	HYDROCHI OROTHIAZIDE		
O2246894 APO-VERAP SR APX O2284987 APO-CILAZAPRIL/HCTZ APX O246894 APO-VERAP SR BGP O2181479 INHIBACE PLUS CHE O2450488 MYLAN-VERAPAMIL MYL O2313731 TEVA-CILAZAPRIL/HCTZ TEV TEV TEV O2246895 APO-VERAP SR APX O2246895 APO-VERAP SR APX O2240321 DOM-VERAPAMIL SR DPC O2291878 ACT ENALAPRIL TEV O0742554 ISOPTIN SR BGP O2020025 APO-ENALAPRIL APX O2237791 PMS-VERAPAMIL SR PMS O2440650 ENALAPRIL SIV ANGIOTENSIN-CONVERTING ENZYME INHIBITORS O2311402 PRO-ENALAPRIL SIV APX O2290332 BENAZEPRIL APA O2300796 RIVA-ENALAPRIL RBY O2290332 BENAZEPRIL APA O2300117 TARO-ENALAPRIL SDZ TARO-ENALAPRIL TAR O2290340 RENAZEPRIL TAR O2290340 RENAZEPRIL TAR O2290340 RENAZEPRIL APA O2300117 TARO-ENALAPRIL TAR O2290340 RENAZEPRIL TAR			MYL				
1934317 ISOPTIN SR		·					
02450488 MYLAN-VERAPAMIL MYL 02313731 TEVA-CILAZAPRIL/HCTZ TEV ***7240MG TABLET (EXTENDED RELEASE) 02246895 APO-VERAP SR APX 02240321 DOM-VERAPAMIL SR DPC 00742554 ISOPTIN SR BGP 02450496 MYLAN-VERAPAMIL MYL 02237791 PMS-VERAPAMIL SR PMS 02237791 PMS-VERAPAMIL SR PMS 24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS BENAZEPRIL HYDROCHLORIDE **** 5MG TABLET 02290332 BENAZEPRIL 02290332 BENAZEPRIL APR **** 5MG TABLET 02290330 BENAZEPRIL APR 02313731 TEVA-CILAZAPRIL/HCTZ ENALAPRIL 02291878 ACT ENALAPRIL 02291878 ACT ENALAPRIL APX 02291878 ACT ENALAPRIL 02290355 APO-ENALAPRIL SAN 02442957 ENALAPRIL 02459450 MAR-ENALAPRIL MAR 02459450 MAR-ENALAPRIL PDL 02300796 RIVA-ENALAPRIL RIV 02290332 BENAZEPRIL APP 02300717 TARO-ENALAPRIL TAR ***** 5MG TABLET 02290334 BENAZEPRIL 02290330 BENAZEPRIL APP							
ST 240MG TABLET (EXTENDED RELEASE)							
02246895			MYL			TEV	
DOC		•		ENALAPRIL	MALEATE		
16V				ST 2.5MG TABL	.ET		
Note				02291878	ACT ENALAPRIL	TEV	
02450496 02237791 MYLAN-VERAPAMIL PMS MYL PMS 02400650 02442957 ENALAPRIL ENALAPRIL ENALAPRIL ENZYME INHIBITORS SAN 02442957 24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS 02459450 MAR-ENALAPRIL POLENALAPRIL MAR BENAZEPRIL HYDROCHLORIDE 02352230 RAN-ENALAPRIL POLENALAPRIL RBY 02300796 02290332 RIVA-ENALAPRIL POL				02020025	APO-ENALAPRIL	APX	
24:32.04 ANGIOTENSIN-CONVERTING							
24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS 02459450 MAR-ENALAPRIL MAR D2311402 MAR-ENALAPRIL PDL BENAZEPRIL HYDROCHLORIDE 02352230 RAN-ENALAPRIL RBY ST 5MG TABLET 02290332 BENAZEPRIL AAP 02300117 TARO-ENALAPRIL SDZ ST 10MG TABLET ST 5MG TABLET 02300117 TARO-ENALAPRIL TARO-EN	02237791	PMS-VERAPAMIL SR	PMS				
ENZYME INHIBITORS 02311402 PRO-ENALAPRIL PDL BENAZEPRIL HYDROCHLORIDE 02352230 RAN-ENALAPRIL RBY ST 5MG TABLET 02300796 RIVA-ENALAPRIL RIV 02290332 BENAZEPRIL AAP 02300117 TARO-ENALAPRIL TAR ST 10MG TABLET 02290340 BENAZEPRII AAP ST 5MG TABLET ST 5MG TAB	24:32.04 AN	GIOTENSIN-CONVERTING					
BENAZEPRIL HYDROCHLORIDE 02352230 RAN-ENALAPRIL RBY ST 5MG TABLET 02300796 RIVA-ENALAPRIL RIV 02299332 BENAZEPRIL AAP ST 5MG TABLET 02290340 BENAZEPRIL AAP ** 5MG TABLET	EN	ZYME INHIBITORS					
ST 5MG TABLET 02300796 RIVA-ENALAPRIL RIVA-ENALAPRIL RIVA-ENALAPRIL SDZ 02290332 BENAZEPRIL AAP 02300117 TARO-ENALAPRIL TAR ST 10MG TABLET 02300340 BENAZEPRII AAP ST 5MG TABLET ST 5MG TABLET							
ST 5MG TABLET 02299933 SANDOZ ENALAPRIL SDZ 02290332 BENAZEPRIL AAP 02300117 TARO-ENALAPRIL TAR ST 10MG TABLET ST 5MG TABLET							
02290332 BENAZEPRIL AAP 02300117 TARO-ENALAPRIL TAR *** 10MG TABLET 02290340 BENAZEPRII AAP							
ST 10MG TABLET 02290340 BENAZEPRII AAP			AAP				
02200340 RENΔ7EPRII ΔΔP							
	02290340	BENAZEPRIL	AAP			TEV	

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24:32.04 ANGIOTENSIN-CONVERTING 24:32.04 ANGIOTENSIN-CONVERTING **ENZYME INHIBITORS ENZYME INHIBITORS FOSINOPRIL SODIUM ENALAPRIL MALEATE** ST 5MG TABLET ST 10MG TABLET 02019884 APO-ENALAPRIL APX 02247802 TEVA-FOSINOPRIL **TEV** 02400669 **ENALAPRIL** SAN ST 20MG TABLET **ENALAPRIL** 02442965 SIV APO-FOSINOPRII 02266016 APX 02459469 MAR-ENALAPRIL MAR 02303019 **FOSINOPRIL PDL** 02311410 PRO-ENALAPRIL **PDL** 02332574 **FOSINOPRIL RBY** RAN-FNAI APRII 02352249 RRY 02450306 **FOSINOPRIL** SAN 02300818 RIVA-ENALAPRIL RIV 02331012 JAMP-FOSINOPRIL **JMP** 02299941 SANDOZ ENALAPRIL SDZ 02255952 PMS-FOSINOPRIL **PMS** 02300125 TARO-ENALAPRIL TAR 02294532 RAN-FOSINOPRII RRY VASOTEC FRS 00708879 02247803 **TEVA-FOSINOPRIL** TFV ST 10MG TABLET LISINOPRIL 02291894 ACT ENALAPRIL TEV ST 5MG TABLET 02019892 APO-FNALAPRII **APX** 02217481 APO-LISINOPRIL **APX** 02400677 **ENALAPRIL** SAN 09853685 APO-LISINOPRIL APX 02442973 **FNAI APRII** SIV 02394472 AURO-LISINOPRII AUR 02444771 MAR-ENALAPRIL IDE 02361531 JAMP-LISINOPRIL **JMP** 02311429 PRO-ENALAPRIL **PDL** 02386232 LISINOPRII SIV **RBY** 02352257 RAN-FNAI APRII **PMS** 02292203 PMS-LISINOPRIL 02300826 RIVA-FNAI APRII RIV **PDL** 02310961 PRO-LISINOPRIL 02299968 SANDOZ ENALAPRIL SDZ 02294230 RAN-LISINOPRIL **RBY** 02300133 TARO-ENALAPRIL **TAR** SANDOZ LISINOPRIL 02289199 SD7 00670901 VASOTEC FRS 02285061 TEVA-LISINOPRIL (TYPE P) TFV ST 20MG TABLET 02285118 TEVA-LISINOPRIL (TYPE Z) TEV 02291908 ACT ENALAPRIL **TEV** 02049333 ZESTRIL AZC 02019906 APO-ENALAPRIL APX ST 10MG TABLET 02400685 FNAI APRII SAN 02217503 APO-LISINOPRIL APX 02442981 **ENALAPRIL** SIV 09853960 APO-LISINOPRIL APX 02444798 MAR-ENALAPRIL IDE AURO-LISINOPRIL AUR 02394480 PRO-ENALAPRIL PDI 02311437 02361558 JAMP-LISINOPRIL **JMP** 02352265 RAN-ENALAPRIL **RBY** 02386240 LISINOPRIL SIV 02300834 RIVA-ENALAPRIL RIV **PMS** 02292211 PMS-LISINOPRIL SDZ 02299976 SANDOZ ENALAPRIL 00839396 **PRINIVIL FRS** 02300141 TARO-ENALAPRIL TAR 02310988 PRO-LISINOPRII PDI 00670928 VASOTEC **FRS** 02294249 RAN-LISINOPRIL **RBY ST PDIN FOR EXTEMPORANEOUS MIXTURE** 02289202 SANDOZ LISINOPRIL SD7 99503013 ENALAPRIL ORAL LIQUID UNK 02285088 TEVA-LISINOPRIL (TYPE P) **TEV** ENALAPRIL MALEATE. 02285126 TEVA-LISINOPRIL (TYPE Z) **TEV HYDROCHLOROTHIAZIDE ZESTRIL** 02049376 AZC ST 20MG TABLET ST 5MG & 12.5MG TABLET 02217511 APO-LISINOPRIL **APX** 02352923 ENALAPRIL MALEATE/HCTZ AAP ST 10MG & 25MG TABLET 09854010 APO-LISINOPRIL APX 02394499 **AURO-LISINOPRIL AUR** 02352931 **ENALAPRIL MALEATE/HCTZ** AAP 02361566 JAMP-LISINOPRIL JMP 00657298 VASERETIC **FRS** 02386259 SIV LISINOPRII **FOSINOPRIL SODIUM** 02292238 PMS-LISINOPRIL **PMS** ST 10MG TABLET 00839418 PRINIVII **FRS** APO-FOSINOPRIL APX 02266008 02310996 PRO-LISINOPRII PDI 02303000 **FOSINOPRIL PDL** 02294257 RAN-LISINOPRIL **RBY** 02332566 **FOSINOPRIL RBY** 02289229 SANDOZ LISINOPRIL SDZ 02459388 **FOSINOPRIL** SAN 02285096 TEVA-LISINOPRIL (TYPE P) TEV 02331004 JAMP-FOSINOPRIL **JMP** 02285134 TEVA-LISINOPRIL (TYPE Z) TEV 02255944 PMS-FOSINOPRIL **PMS** 02049384 ZESTRIL **AZC** 02294524 **RAN-FOSINOPRIL RBY**

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	GIOTENSIN-CONVERTING ZYME INHIBITORS			IGIOTENSIN-CONVERTING	
	HYDROCHLOROTHIAZIDE			RIL ERBUMINE	
·					
ST 10MG & 12.5		CAN	4MG TABLE		CDZ
	LISINOPRIL/HCTZ (TYPE Z)	SAN SDZ		SANDOZ PERINDOPRIL ERBUMINE	SDZ
02302365		TEV	02464993		TEV
	TEVA-LISINOPRIL/HCTZ (TYPE P) TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV	8MG TABLE	AG-PERINDOPRIL	ANG
02301708	ZESTORETIC	AZC	02289296	APO-PERINDOPRIL	APX
ST 20MG & 12.5		AZC		AURO-PERINDOPRIL AURO-PERINDOPRIL	AUR
	LISINOPRIL/HCTZ (TYPE Z)	SAN		COVERSYL	SEV
	SANDOZ LISINOPRIL HCT	SDZ	02240024		JMP
02302373		TEV	02474840		MAR
02302144	,	TEV	02476789		MIN
02045737	ZESTORETIC	AZC	02470789		MAN
ST 20MG & 25N		AZO	02489031		UNK
02362961	LISINOPRIL/HCTZ (TYPE Z)	SAN	02479893		SIV
02302301	` ,	SDZ	02481650	PERINDOPRIL ERBUMINE	SAN
	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV	02488965	PERINDOPRIL ERBUMINE	PDL
02302132	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV	02470691		PMS
	ZESTORETIC	AZC	02483254		PHA
	IL ERBUMINE	AZO	02472031		RIV
PERINDOPR	IL ERBUIINE		02470241		SDZ
2MG TABLE	т			TEVA-PERINDOPRIL	TEV
02481677	AG-PERINDOPRIL	ANG		RIL ERBUMINE, INDAPAMIDE	
02289261	APO-PERINDOPRIL	APX		·	
02459817		AUR	^{sτ} 4MG & 1.25		
02123274	COVERSYL	SEV		COVERSYL PLUS	SEV
02477009	JAMP PERINDOPRIL	JMP	02470438		SDZ
02474824	MAR-PERINDOPRIL	MAR	02464020	ERBUMINE/ INDAPAMIDE	TEV
02476762	MINT-PERINDOPRIL	MIN	υ2464020 ST 8MG & 2.5N	TEVA-PERINDOPRIL/INDAPAMIDE	TEV
02482924	M-PERINDOPRIL ERBUMINE	MAN			ADV
02489015	NRA-PERINDOPRIL	UNK		APO-PERINDOPRIL-INDAPAMIDE COVERSYL PLUS HD	APX SEV
02479877	PERINDOPRIL ERBUMINE	SIV	02321653 02408201		_
02481634	PERINDOPRIL ERBUMINE	SAN	02406201	PERINDOPRIL/INDAPAMIDE	MYL
02488949	PERINDOPRIL ERBUMINE	PDL	02470446		SDZ
02470675	PMS-PERINDOPRIL	PMS	0200	ERBUMINE/ INDAPAMIDE HD	022
02483238	PRIVA-PERINDOPRIL ERBUMINE	PHA	02464039	TEVA-PERINDOPRIL/INDAPAMIDE	TEV
02472015	RIVA-PERINDOPRIL	RIV	QUINAPRIL		
02470225	SANDOZ PERINDOPRIL ERBUMINE	SDZ	ST 5MG TABLE	- -	
	TEVA-PERINDOPRIL	TEV		ACCUPRIL	PFI
4MG TABLE	AG-PERINDOPRIL	ANG		APO-QUINAPRIL	APX
02289288		APX	02240499		PMS
02459825		AUR	^{S7} 10MG TABL		I WIO
02123282		SEV		ACCUPRIL	PFI
02123262	JAMP PERINDOPRIL	JMP	02248500	APO-QUINAPRIL	APX
02477017	MAR-PERINDOPRIL	MAR	02340569		PMS
02474632	MINT-PERINDOPRIL	MIN	ST 20MG TABL		I WIO
02470770	M-PERINDOPRIL ERBUMINE	MAN		ACCUPRIL	PFI
02489023	NRA-PERINDOPRIL	UNK	02248501		APX
02479885		SIV	02340577		PMS
02481642		SAN	ST 40MG TABL		1 1013
02481042	PERINDOPRIL ERBUMINE	PDL		ACCUPRIL	PFI
02470683	PMS-PERINDOPRIL	PMS		APO-QUINAPRIL	APX
02470003	PRIVA-PERINDOPRIL ERBUMINE	PHA	02340585		PMS
02472023	RIVA-PERINDOPRIL	RIV	02040303	I MO-WORM INL	i WG

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24:32.04 ANGIOTENSIN-CONVERTINE	G	24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	
QUINAPRIL, HYDROCHLOROTHIAZIDE		RAMIPRIL	
ST 10MG & 12.5MG TABLET		5MG CAPSULE	
02237367 ACCURETIC	PFI	02486180 NRA-RAMIPRIL	UNK
02408767 APO-QUINAPRIL/HCTZ	APX	02469073 PHARMA-RAMIPRIL	PMS
02473291 AURO-QUINAPRIL HCTZ	AUR	02247918 PMS-RAMIPRIL	PMS
ST 20MG & 12.5MG TABLET	,	02483424 PRIVA-RAMIPRIL	PHA
02237368 ACCURETIC	PFI	02310074 PRO-RAMIPRIL	PDL
02408775 APO-QUINAPRIL/HCTZ	APX	02255324 RAMIPRIL	RIV
02473305 AURO-QUINAPRIL HCTZ	AUR	02287935 RAMIPRIL	SIV
ST 20MG & 25MG TABLET		02374854 RAMIPRIL	SAN
02237369 ACCURETIC	PFI	02310538 TARO-RAMIPRIL	SUN
02408783 APO-QUINAPRIL/HCTZ	APX	02247946 TEVA-RAMIPRIL	TEV
02473321 AURO-QUINAPRIL HCTZ	AUR	10MG CAPSULE	
RAMIPRIL		02477599 AG-RAMIPRIL	ANG
		02221853 ALTACE	VAE
ST 1.25MG CAPSULE		02251582 APO-RAMIPRIL	APX
02221829 ALTACE	VAE	02387417 AURO-RAMIPRIL	AUR
02251515 APO-RAMIPRIL	APX	02287986 DOM-RAMIPRIL	DPC
02387387 AURO-RAMIPRIL	AUR	02331144 JAMP-RAMIPRIL	JMP
02331101 JAMP-RAMIPRIL	JMP	02420481 MAR-RAMIPRIL	MAR
02420457 MAR-RAMIPRIL	MAR	02421321 MINT-RAMIPRIL	MIN
02469057 PHARMA-RAMIPRIL	PMS	02486199 NRA-RAMIPRIL	UNK
02295369 PMS-RAMIPRIL	PMS	02469081 PHARMA-RAMIPRIL	PMS
02310023 PRO-RAMIPRIL	PDL	02247919 PMS-RAMIPRIL	PMS
02299372 RAMIPRIL	RIV	02483432 PRIVA-RAMIPRIL	PHA
02308363 RAMIPRIL	SIV	02310104 PRO-RAMIPRIL	PDL
02310503 TARO-RAMIPRIL	SUN	02255332 RAMIPRIL	RIV
2.5MG CAPSULE		02287943 RAMIPRIL	SIV
02477572 AG-RAMIPRIL	ANG	02374862 RAMIPRIL	SAN
02221837 ALTACE	VAE	02310546 TARO-RAMIPRIL	SUN
02251531 APO-RAMIPRIL	APX	02247947 TEVA-RAMIPRIL	TEV
02387395 AURO-RAMIPRIL	AUR	ST 15MG CAPSULE	
02287951 DOM-RAMIPRIL	DPC	02325381 APO-RAMIPRIL	APX
02331128 JAMP-RAMIPRIL	JMP	02440334 JAMP-RAMIPRIL	JMP
02420465 MAR-RAMIPRIL	MAR	02420503 MAR-RAMIPRIL	MAR
02421305 MINT-RAMIPRIL	MIN	02421348 MINT-RAMIPRIL	MIN
02486172 NRA-RAMIPRIL	UNK	02343932 PMS-RAMIPRIL	PMS
02469065 PHARMA-RAMIPRIL	PMS	02425548 TARO-RAMIPRIL	SUN
02247917 PMS-RAMIPRIL	PMS	ST 1.25MG TABLET	
02483416 PRIVA-RAMIPRIL	PHA	02291398 SANDOZ RAMIPRIL	SDZ
02310066 PRO-RAMIPRIL	PDL	ST 2.5MG TABLET	
02255316 RAMIPRIL	RIV	02291401 SANDOZ RAMIPRIL	SDZ
02287927 RAMIPRIL	SIV	ST 5MG TABLET	
02374846 RAMIPRIL	SAN	02291428 SANDOZ RAMIPRIL	SDZ
02310511 TARO-RAMIPRIL	SUN	ST 10MG TABLET	
02247945 TEVA-RAMIPRIL	TEV	02291436 SANDOZ RAMIPRIL	SDZ
5MG CAPSULE	4110	RAMIPRIL, HYDROCHLOROTHIAZIDE	
02477580 AG-RAMIPRIL	ANG	,	
02221845 ALTACE	VAE	ST 2.5MG & 12.5MG TABLET	
02251574 APO-RAMIPRIL	APX	02283131 ALTACE HCT	VAE
02387409 AURO-RAMIPRIL	AUR	02354004 APO-RAMIPRIL/HCTZ	APX
02287978 DOM-RAMIPRIL	DPC	02449439 TARO-RAMIPRIL HCTZ	SUN
02331136 JAMP-RAMIPRIL	JMP	ST 5MG & 12.5MG TABLET	=
02420473 MAR-RAMIPRIL	MAR	02283158 ALTACE HCT	VAE
02421313 MINT-RAMIPRIL	MIN	02354012 APO-RAMIPRIL/HCTZ	APX

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		Non-insured nearth being	FIILS
24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS		24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS	
RAMIPRIL, HYDROCHLOROTHIAZIDE		CANDESARTAN CILEXETIL	
ST 5MG & 12.5MG TABLET		ST 4MG TABLET	
02449447 TARO-RAMIPRIL HCTZ	SUN	02379260 ACH-CANDESARTAN	ACC
ST 5MG & 25MG TABLET	•••	02365340 APO-CANDESARTAN	APX
02283174 ALTACE HCT	VAE	02239090 ATACAND	AZC
02354020 APO-RAMIPRIL/HCTZ	APX	02445786 AURO-CANDESARTAN	AUR
02449463 TARO-RAMIPRIL HCTZ	SUN	02388901 CANDESARTAN	SAN
ST 10MG & 12.5MG TABLET		02391171 PMS-CANDESARTAN	PMS
02283166 ALTACE HCT	VAE	02326957 SANDOZ CANDESARTAN	SDZ
02342154 PMS-RAMIPRIL-HCTZ	PMS	02380684 TARO-CANDESARTAN	SUN
02449455 TARO-RAMIPRIL HCTZ	SUN	ST 8MG TABLET	
ST 10MG & 25MG TABLET		02379279 ACH-CANDESARTAN	ACC
02283182 ALTACE HCT	VAE	02365359 APO-CANDESARTAN	APX
02354039 APO-RAMIPRIL/HCTZ	APX	02239091 ATACAND	AZC
02342170 PMS-RAMIPRIL-HCTZ	PMS	02445794 AURO-CANDESARTAN	AUR
02449471 TARO-RAMIPRIL HCTZ	SUN	02377934 CANDESARTAN	PDL
TRANDOLAPRIL		02388707 CANDESARTAN	SIV
ST 0.5MG CAPSULE		02388928 CANDESARTAN	SAN
02471868 AURO-TRANDOLAPRIL	AUR	02386518 JAMP-CANDESARTAN	JMP
02231457 MAVIK	BGP	02476916 MINT-CANDESARTAN	MIN
02357755 PMS-TRANDOLAPRIL	PMS	02391198 PMS-CANDESARTAN	PMS
02325721 SANDOZ TRANDOLAPRIL	SDZ	02326965 SANDOZ CANDESARTAN	SDZ
02415429 TEVA-TRANDOLAPRIL	TEV	02380692 TARO-CANDESARTAN	SUN
ST 1MG CAPSULE	1 = 4	02366312 TEVA-CANDESARTAN	TEV
02471876 AURO-TRANDOLAPRIL	AUR	ST 16MG TABLET	
02231459 MAVIK	BGP	02379287 ACH-CANDESARTAN	ACC
02357763 PMS-TRANDOLAPRIL	PMS	02365367 APO-CANDESARTAN	APX
02325748 SANDOZ TRANDOLAPRIL	SDZ	02239092 ATACAND	AZC
02415437 TEVA-TRANDOLAPRIL	TEV	02445808 AURO-CANDESARTAN	AUR
02488698 TRANDOLAPRIL	PDL	02377942 CANDESARTAN	PDL
ST 2MG CAPSULE		02388715 CANDESARTAN	SIV
02471884 AURO-TRANDOLAPRIL	AUR	02388936 CANDESARTAN	SAN
02231460 MAVIK	BGP	02386526 JAMP-CANDESARTAN 02476924 MINT-CANDESARTAN	JMP MIN
02357771 PMS-TRANDOLAPRIL	PMS	02476924 MINT-CANDESARTAN 02391201 PMS-CANDESARTAN	PMS
02325756 SANDOZ TRANDOLAPRIL	SDZ	02326973 SANDOZ CANDESARTAN	SDZ
02415445 TEVA-TRANDOLAPRIL	TEV	02380706 TARO-CANDESARTAN	SUN
02488701 TRANDOLAPRIL	PDL	02366320 TEVA-CANDESARTAN	TEV
ST 4MG CAPSULE		st 32MG TABLET	I L V
02471892 AURO-TRANDOLAPRIL	AUR	02379295 ACH-CANDESARTAN	ACC
02239267 MAVIK	BGP	02399105 APO-CANDESARTAN	APX
02357798 PMS-TRANDOLAPRIL	PMS	02311658 ATACAND	AZC
02325764 SANDOZ TRANDOLAPRIL	SDZ	02445816 AURO-CANDESARTAN	AUR
02415453 TEVA-TRANDOLAPRIL	TEV	02422069 CANDESARTAN	PDL
02488728 TRANDOLAPRIL	PDL	02435845 CANDESARTAN	SAN
24:32.08 ANGIOTENSIN II RECEPTOR		02386534 JAMP-CANDESARTAN	JMP
ANTAGONISTS		02391228 PMS-CANDESARTAN	PMS
AZILSARTAN MEDOXOMIL		02417340 SANDOZ CANDESARTAN	SDZ
		02380714 TARO-CANDESARTAN	SUN
ST 40MG TABLET		02366339 TEVA-CANDESARTAN	TEV
02381389 EDARBI	VAE	CANDESARTAN CILEXETIL,	
ST 80MG TABLET		HYDROCHLOROTHIAZIDE	
02381397 EDARBI	VAE		
		ST 16MG & 12.5MG TABLET	A 7.0
		02244021 ATACAND PLUS	AZC

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	GIOTENSIN II RECEPTOR TAGONISTS			IGIOTENSIN II RECEPTOR	
	TAN CILEXETIL, DROTHIAZIDE		IRBESARTA	N	
			150MG TAB	LET	
^{s⊤} 16MG & 12.5	MG TABLET		02365200	IRBESARTAN	PDL
02421038	AURO-CANDESARTAN HCT	AUR	02372371	IRBESARTAN	SAN
	CANDESARTAN-HCT	SIV	02385295	IRBESARTAN	SIV
02392275	CANDESARTAN-HCTZ	PDL	02418207	JAMP-IRBESARTAN	JMP
02394804	CANDESARTAN-HCTZ	SAN	02422999	MINT-IRBESARTAN	MIN
02473240	JAMP CANDESARTAN-HCT	JMP	02317079	PMS-IRBESARTAN	PMS
	PMS-CANDESARTAN HCTZ	PMS	02328488	SANDOZ IRBESARTAN	SDZ
	SANDOZ CANDESARTAN PLUS	SDZ	02406829		SUN
02395541		TEV		TEVA-IRBESARTAN	TEV
^{s⊤} 32MG & 12.5			300MG TAB		
	ATACAND PLUS	AZC	02474417		ANG
	AURO-CANDESARTAN HCT	AUR	02386984		APX
02473259	JAMP CANDESARTAN-HCT	JMP	02406128		AUR
	SANDOZ CANDESARTAN PLUS	SDZ		AVAPRO	SAC
	TEVA-CANDESARTAN/HCTZ	TEV	02446162		BMI
ST 32MG & 25Ν				IRBESARTAN	PDL
	ATACAND PLUS	AZC	02372398	IRBESARTAN	SAN
	AURO-CANDESARTAN HCT	AUR	02385309		SIV
02473267	JAMP CANDESARTAN-HCT	JMP	02418215	JAMP-IRBESARTAN	JMP
	SANDOZ CANDESARTAN PLUS	SDZ	02423006		MIN
EPOSARTAN	I MESYLATE		02317087		PMS
^{sτ} 400MG TABI	IFT		02328496		SDZ
	TEVETEN	BGP	02406837		SUN
ST 600MG TABI		ВО		TEVA-IRBESARTAN	TEV
	TEVETEN	BGP	IRBESARTA	N, HYDROCHLOROTHIAZIDE	
	I MESYLATE,		ST 150MG & 12	5MG TABLET	
	DROTHIAZIDE		02447878	AURO-IRBESARTAN HCT	AUR
			02241818	AVALIDE	SAC
ST 600MG & 12	·······		02385317	IRBESARTAN HCT	SIV
02253631	TEVETEN PLUS	BGP	02372886	IRBESARTAN/HCTZ	SAN
IRBESARTA	N		02365162	IRBESARTAN-HCTZ	PDL
75MG TABL	FT		02418223	JAMP-IRBESARTAN AND	JMP
	AG-IRBESARTAN	ANG		HYDROCHLOROTHIAZIDE	
02386968	APO-IRBESARTAN	APX	02392992	MINT-IRBESARTAN/HCTZ	MIN
02406098	AURO-IRBESARTAN	AUR	02328518	PMS-IRBESARTAN-HCTZ	PMS
02237923	AVAPRO	SAC	02363208	RAN-IRBESARTAN HCTZ	RBY
02446146	BIO-IRBESARTAN	BMI	02337428	SANDOZ IRBESARTAN HCT	SDZ
02365197	IRBESARTAN	PDL		TEVA-IRBESARTAN HCTZ	TEV
02372347	IRBESARTAN	SAN	^{s⊤} 300MG & 12	.5MG TABLET	
02385287	IRBESARTAN	SIV	02447886	AURO-IRBESARTAN HCT	AUR
02418193	JAMP-IRBESARTAN	JMP	02241819	AVALIDE	SAC
02422980	MINT-IRBESARTAN	MIN	02385325	IRBESARTAN HCT	SIV
02317060	PMS-IRBESARTAN	PMS	02372894	IRBESARTAN/HCTZ	SAN
02328461	SANDOZ IRBESARTAN	SDZ	02365170	IRBESARTAN-HCTZ	PDL
02406810	TARO-IRBESARTAN	SUN	02418231	JAMP-IRBESARTAN AND	JMP
02316390	TEVA-IRBESARTAN	TEV		HYDROCHLOROTHIAZIDE	
150MG TABI		- 	02393018	MINT-IRBESARTAN/HCTZ	MIN
02474409	AG-IRBESARTAN	ANG	02328526	PMS-IRBESARTAN-HCTZ	PMS
02386976	APO-IRBESARTAN	APX	02363216		RBY
02406101	AURO-IRBESARTAN	AUR		SANDOZ IRBESARTAN HCT	SDZ
02237924	AVAPRO	SAC		TEVA-IRBESARTAN HCTZ	TEV
02446154	BIO-IRBESARTAN	BMI	^{S7} 300MG & 25		
32110104		21111	02387662	APO-IRBESARTAN/HCTZ	APX

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				Non-insured ricardi	
	GIOTENSIN II RECEPTOR TAGONISTS			IGIOTENSIN II RECEPTOF ITAGONISTS	₹
IRBESARTAN	N, HYDROCHLOROTHIAZIDE		LOSARTAN I	POTASSIUM	
ST 300МG & 25	•		100MG TAB	LET	
	AURO-IRBESARTAN HCT	AUR		LOSARTAN	PDL
02385333	IRBESARTAN HCT	SIV		MINT-LOSARTAN	MIN
02372908	IRBESARTAN/HCTZ	SAN		PMS-LOSARTAN	PMS
02372908	IRBESARTAN-HCTZ	PDL		SANDOZ LOSARTAN	SDZ
02303169	JAMP-IRBESARTAN AND	JMP		SEPTA-LOSARTAN	SPT
02410230	HYDROCHLOROTHIAZIDE	JIVIF		TEVA-LOSARTAN	TEV
02393026	MINT-IRBESARTAN/HCTZ	MIN			I L V
02328534	PMS-IRBESARTAN-HCTZ	PMS		POTASSIUM,	
02363224	RAN-IRBESARTAN HCTZ	RBY	HYDROCHLO	OROTHIAZIDE	
02337444	SANDOZ IRBESARTAN HCT	SDZ	ST 50MG & 12.5	5MG TABLET	
	TEVA-IRBESARTAN HCTZ	TEV	02371235	APO-LOSARTAN/HCTZ	APX
LOSARTAN F		. — .	02423642	AURO-LOSARTAN HCT	AUR
			02230047	HYZAAR	FRS
100MG CAPS			02408244	JAMP-LOSARTAN HCTZ	JMP
99113701	LOSARTAN (PQ)	UNK	02388960	LOSARTAN HCT	SIV
25MG TABLI	ET		02427648	LOSARTAN/HCTZ	SAN
02441195	AG-LOSARTAN	ANG	02394391	LOSARTAN-HCTZ	PDL
02379058	APO-LOSARTAN	APX	02389657	MINT-LOSARTAN/HCTZ	MIN
02403323	AURO-LOSARTAN	AUR	02392224	PMS-LOSARTAN-HCTZ	PMS
02445964	BIO-LOSARTAN	BMI	02313375	SANDOZ LOSARTAN HCT	SDZ
02182815	COZAAR	FRS	02428539	SEPTA-LOSARTAN HCTZ	SPT
02398834	JAMP-LOSARTAN	JMP	02358263	TEVA-LOSARTAN/HCTZ	TEV
02388790	LOSARTAN	SIV	ST 100MG & 12	.5MG TABLET	
02388863	LOSARTAN	SAN	02371243	APO-LOSARTAN/HCTZ	APX
02394367	LOSARTAN	PDL	02423650	AURO-LOSARTAN HCT	AUR
02405733	MINT-LOSARTAN	MIN	02297841		FRS
02309750	PMS-LOSARTAN	PMS	02388979	LOSARTAN HCT	SIV
02313332	SANDOZ LOSARTAN	SDZ		LOSARTAN/HCTZ	SAN
02424967	SEPTA-LOSARTAN	SPT		LOSARTAN-HCTZ	PDL
02380838	TEVA-LOSARTAN	TEV		MINT-LOSARTAN/HCTZ	MIN
50MG TABLI	ET			PMS-LOSARTAN-HCTZ	PMS
02441209	AG-LOSARTAN	ANG		SANDOZ LOSARTAN HCT	SDZ
02353504	APO-LOSARTAN	APX		TEVA-LOSARTAN/HCTZ	TEV
02403331	AURO-LOSARTAN	AUR	ST 100MG & 25		
02445972	BIO-LOSARTAN	BMI	02371251	APO-LOSARTAN/HCTZ	APX
02182874	COZAAR	FRS	02423669	AURO-LOSARTAN HCT	AUR
02398842	JAMP-LOSARTAN	JMP	02241007		FRS
02388804	LOSARTAN	SIV	02408252		JMP
02388871	LOSARTAN	SAN	02388987		SIV
02394375	LOSARTAN	PDL		LOSARTAN/HCTZ	SAN
02405741	MINT-LOSARTAN	MIN		LOSARTAN/HCTZ	PDL
02309769	PMS-LOSARTAN	PMS	02389673		MIN
02313340	SANDOZ LOSARTAN	SDZ		PMS-LOSARTAN-HCTZ	PMS
02424975	SEPTA-LOSARTAN	SPT	02313383		SDZ
02357968	TEVA-LOSARTAN	TEV	02428547		SPT
100MG TABI		. — .		TEVA-LOSARTAN/HCTZ	
	AG-LOSARTAN	ANG			TEV
02353512	APO-LOSARTAN	APX	ULWESARTA	AN MEDOXOMIL	
02403358	AURO-LOSARTAN	AUR	40MG CAPS	ULE	
02445980	BIO-LOSARTAN	BMI	99113716	OLMESARTAN (QC)	UNK
02182882	COZAAR	FRS	ST 20MG TABL	` ,	
02182882	JAMP-LOSARTAN	JMP		ACT OLMESARTAN	TEV
02388812	LOSARTAN	SIV		AG-OLMESARTAN	ANG
02388898	LOSARTAN	SAN		APO-OLMESARTAN	APX
02300030	LOOMINIAN	OAN		-	

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					0.101110
	GIOTENSIN II RECEPTOR TAGONISTS			IGIOTENSIN II RECEPTOR ITAGONISTS	
OLMESARTA	N MEDOXOMIL		TELMISART	AN	
ST 20MG TABL		ALID	ST 40MG TABL		CD7
	AURO-OLMESARTAN GLN-OLMESARTAN	AUR GLK		SANDOZ TELMISARTAN TELMISARTAN	SDZ SAN
02469612	JAMP-OLMESARTAN	JMP		TELMISARTAN	SAN
02481057	OLMESARTAN	SAN		TELMISARTAN	PDL
02481037	OLMESARTAN	PDL		TELMISARTAN	ACC
02318660	OLMETEC	FRS		TEVA-TELMISARTAN	TEV
	PMS-OLMESARTAN	PMS	ST 80MG TABL	. = = =	1 L V
	SANDOZ OLMESARTAN	SDZ		APO-TELMISARTAN	APX
ST 40MG TABL		052		AURO-TELMISARTAN	AUR
	ACT OLMESARTAN	TEV		MICARDIS	BOE
	AG-OLMESARTAN	ANG		PHARMA-TELMISARTAN	PMS
02453460	APO-OLMESARTAN	APX	02375966	SANDOZ TELMISARTAN	SDZ
02443872	AURO-OLMESARTAN	AUR	02388952	TELMISARTAN	SAN
02469820	GLN-OLMESARTAN	GLK	02390353	TELMISARTAN	SIV
02461668	JAMP-OLMESARTAN	JMP	02395231	TELMISARTAN	PDL
02481065	OLMESARTAN	SAN	02407493	TELMISARTAN	ACC
02488752	OLMESARTAN	PDL	02432900	TELMISARTAN	PMS
02318679	OLMETEC	FRS	02320185	TEVA-TELMISARTAN	TEV
02461315	PMS-OLMESARTAN	PMS	TELMISART	AN, HYDROCHLOROTHIAZIDE	Ε
02443422 SANDOZ OLMESARTAN		SDZ	sτ 80MG & 12.5	·	
OLMESARTA	AN MEDOXOMIL,			ACH-TELMISARTAN HCTZ	ACC
HYDROCHLO	DROTHIAZIDE			AURO-TELMISARTAN HCTZ	AUR
ST 20MG & 12.5	MC TARLET			MICARDIS PLUS	BOE
	ACH-OLMESARTAN HCTZ	ACC		PMS-TELMISARTAN-HCTZ	PMS
	ACT OLMESARTAN HCT	TEV	02393557		SDZ
	APO-OLMESARTAN/HCTZ	APX	02390302		SIV
	AURO-OLMESARTAN HCTZ	AUR	02395355		SAN
ST 20MG/12.5М			02395525	TELMISARTAN-HCTZ	PDL
	OLMETEC PLUS	FRS	02433214	TELMISARTAN-HCTZ	PMS
s ⁷ 40MG & 12.5	MG TABLET		02330288	TEVA-TELMISARTAN HCTZ	TEV
	ACH-OLMESARTAN HCTZ	ACC	ST 80MG & 25N	NG TABLET	
02443120	ACT OLMESARTAN HCT	TEV	02419122	ACH-TELMISARTAN HCTZ	ACC
02453614	APO-OLMESARTAN/HCTZ	APX	02420031	APO-TELMISARTAN/HCTZ	APX
02476495	AURO-OLMESARTAN HCTZ	AUR	02456397	AURO-TELMISARTAN HCTZ	AUR
ST 40MG & 25M	IG TABLET		02318709	MICARDIS PLUS	BOE
02468964	ACH-OLMESARTAN HCTZ	ACC	02393565	SANDOZ TELMISARTAN HCT	SDZ
02443139	ACT OLMESARTAN HCT	TEV	02390310	TELMISARTAN HCTZ	SIV
02453622	APO-OLMESARTAN/HCTZ	APX	02395363	TELMISARTAN/HCTZ	SAN
02476509	AURO-OLMESARTAN HCTZ	AUR	02395533	TELMISARTAN-HCTZ	PDL
ST 40MG/12.5M	G TABLET		02433222	TELMISARTAN-HCTZ	PMS
02319624	OLMETEC PLUS	FRS	02379252	TEVA-TELMISARTAN HCTZ	TEV
ST 40MG/25MG	TABLET		VALSARTAN		
02319632	OLMETEC PLUS	FRS	ST 40MG TABL	ET	
TELMISARTA	AN		02371510	APO-VALSARTAN	APX
80MG CAPS	ULE		02414201		AUR
99113746 TELMISARTAN (QC)		UNK	02270528		NVR
ST 40MG TABL			02356740		SDZ
	APO-TELMISARTAN	APX		TARO-VALSARTAN	SUN
02453568	AURO-TELMISARTAN	AUR	02356643		TEV
02240769	MICARDIS	BOE		VALSARTAN	SAN
02486369	MINT-TELMISARTAN	MIN		VALSARTAN	PDL
02391236	PHARMA-TELMISARTAN	PMS	02384523	VALSARTAN	SIV

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	NGIOTENSIN II RECEPTOR NTAGONISTS		24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS	
VALSARTA			VALSARTAN, HYDROCHLOROTHIAZIDE	
ST 80MG TAB			ST 160MG & 25MG TABLET	
	APO-VALSARTAN	APX	02357011 TEVA-VALSARTAN/HCTZ	TEV
	B AURO-VALSARTAN	AUR	02367025 VALSARTAN HCT	SAN
	DIOVAN	NVR	02384752 VALSARTAN HCT	SIV
	SANDOZ VALSARTAN	SDZ	02367785 VALSARTAN-HCTZ	PDL
	TARO-VALSARTAN	SUN	ST 320MG & 12.5MG TABLET	1 02
02356651		TEV	02382571 APO-VALSARTAN/HCTZ	APX
	VALSARTAN	SAN	02408147 AURO-VALSARTAN HCT	AUR
	VALSARTAN	PDL	02308908 DIOVAN-HCT	NVR
	VALSARTAN	SIV	02356724 SANDOZ VALSARTAN HCT	SDZ
ST 160MG TA		0.0	02357038 TEVA-VALSARTAN/HCTZ	TEV
	APO-VALSARTAN	APX	02367033 VALSARTAN HCT	SAN
	6 AURO-VALSARTAN	AUR	02384760 VALSARTAN HCT	SIV
	2 DIOVAN	NVR	ST 320MG & 25MG TABLET	OIV
02356767		SDZ	02382598 APO-VALSARTAN/HCTZ	APX
	TARO-VALSARTAN	SUN	02408155 AURO-VALSARTAN HCT	AUR
02356678		TEV	02308916 DIOVAN-HCT	NVR
	VALSARTAN	SAN	02356732 SANDOZ VALSARTAN HCT	SDZ
	2 VALSARTAN	PDL	02357046 TEVA-VALSARTAN/HCTZ	TEV
	3 VALSARTAN	SIV	02367041 VALSARTAN HCT	SAN
ST 320MG TA		0.0	24:32.20 MINERALOCORTICOIDE	0/111
	5 APO-VALSARTAN	APX		
	AURO-VALSARTAN	AUR	(ALDOSTERONE) RECEPTOR	
	DIOVAN	NVR	ANTAGONISTS	
	5 SANDOZ VALSARTAN	SDZ	ENALAPRIL MALEATE	
02356686		TEV	ST 2.5MG TABLET	
02366975		SAN		IMD
	VALSARTAN	PDL	02474786 JAMP ENALAPRIL ST 5MG TABLET	JMP
	S VALSARTAN	SIV		IMD
	N, HYDROCHLOROTHIAZIDE	0.1	02474794 JAMP ENALAPRIL ST 10MG TABLET	JMP
	•		02474808 JAMP ENALAPRIL	JMP
	2.5MG TABLET		ST 20MG TABLET	JIVIF
	APO-VALSARTAN/HCTZ	APX	02474816 JAMP ENALAPRIL	JMP
	2 AURO-VALSARTAN HCT	AUR		JIVIF
	DIOVAN-HCT	NVR	EPLERENONE	
	SANDOZ VALSARTAN HCT	SDZ	Limited use benefit (prior approval required).	
02356996		TEV	For the treatment of patients with New York Heart Associa	tion
02367009		SAN	(NYHA) class II chronic heart failure with left ventricular	LIOIT
02384736		SIV	systolic dysfunction (with ejection fraction ≤ 35%), as an	
02367769		PDL	adjunct to standard therapy.	
	2.5MG TABLET		Note: Detients must be an entimal therapy with an engiste	noin
02382555		APX	Note: Patients must be on optimal therapy with an angiote converting-enzyme (ACE) inhibitor or an angiotensin-reception.	
	AURO-VALSARTAN HCT	AUR	blocker (ARB), and a beta-blocker (unless contraindicated	
02241901		NVR	the recommended dose or maximal tolerated dose.	
02356708		SDZ	25MG TABLET	
02357003		TEV	02323052 INSPRA	UNK
02367017		SAN	02471442 MINT-EPLERENONE	MIN
02384744		SIV	50MG TABLET	
	VALSARTAN-HCTZ	PDL	02323060 INSPRA	UNK
	25MG TABLET		02471450 MINT-EPLERENONE	MIN
	B APO-VALSARTAN/HCTZ	APX	HYDROCHLOROTHIAZIDE, SPIRONOLACTO	
	AURO-VALSARTAN HCT	AUR	·	
02246955		NVR	ST PDIN FOR EXTEMPORANEOUS MIXTURE	
02356716	S SANDOZ VALSARTAN HCT	SDZ	99503009 ALDACTAZIDE ORAL LIQUID	UNK

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24:32.20 MINERALOCORTICOIDE (ALDOSTERONE) RECEPTOR ANTAGONISTS

SPIRONOLACTONE

ST 25MG TABLET

 00028606
 ALDACTONE
 PFI

 00613215
 TEVA-SPIRONOLACTONE
 TEV

ST 100MG TABLET

 00285455
 ALDACTONE
 PFI

 00613223
 TEVA-SPIRONOLACTONE
 TEV

ST PDIN FOR EXTEMPORANEOUS MIXTURE

99503001 SPIRONOLACTONE ORAL LIQUID UNK

24:32.92

VALSARTAN, SACUBITRIL

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

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28:08.04 NONSTEROIDAL ANTI-

Limited use benefit (prior approval is not required).

ST 325MG TABLET (DELAYED RELEASE)

ACETYLSALICYLIC ACID

Kawasaki syndrome).

INFLAMMATORY AGENTS

ASA 80 mg tablets are a benefit to clients age 21 years and

under to allow access for use in pediatric conditions (e.g.

28:00 CENTRAL NERVOUS SYSTEM **AGENTS**

28:08.04 NONSTEROIDAL ANTI-**INFLAMMATORY AGENTS**

ACETYLSALICYLIC ACID

00010332

ENTROPHEN

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.

02050161 **ENTROPHEN** PED Kawasaki syndrome). 00216666 NOVASEN TFV $^{ exttt{s} au}$ 650MG TABLET (DELAYED RELEASE) 150MG SUPPOSITORY **PMS** 00785547 ASA 00794244 ASA VTH **650MG SUPPOSITORY** 02352435 ODN ASATAB EC 00582867 ASA **PMS** 00229296 NOVASEN TEV ST 80MG TABLET 02284537 PMS-ASA EC **PMS** ST 81MG TABLET (ENTERIC COATED) ACETYLSALICYLIC ACID .IMP 02269139 02295563 LOWPRIN **EUR** 02243896 ASA DAILY LOW DOSE **PMS** 02202360 RIVASA RIV 02237726 ASPIRIN BAY ST 325MG TABLET 02243801 **EQUATE DAILY LOW-DOSE** PMS APX 00472468 APO ASA 02427206 JAMP-ASA EC **VTH** ST 325MG TABLET (ENTERIC COATED) 00530336 ASA VTH 00510696 APX 02150328 ASPIRIN RAY ASA $^{\text{ST}}$ 80MG TABLET (CHEWABLE) 02285371 PMS-ASA EC **PMS PMS** ST 650MG TABLET (ENTERIC COATED) 02009013 **ASAPHEN** 02280167 **ASATAB** ODN APX 00472476 ASA 02250675 **EURO-ASA EUR** 00010340 **ENTROPHEN** PED 02296004 **LOWPRIN** SDZ 01905392 **ENTROPHEN** PFD 02429950 M-ASA MAN **CELECOXIB** 02311518 PRO-AAS PDL ST 100MG CAPSULE 02202352 **RIVASA** RIV 02420155 ACT CELECOXIB TEV **81MG TABLET (CHEWABLE)** 02437570 AG-CELECOXIB ANG 02394790 ASA DAILY LOW DOSE **PMS** 02418932 APO-CELECOXIB **APX** 02243974 ENTROPHEN PED 02445670 **AURO-CELECOXIB AUR** ST 80MG TABLET (DELAYED RELEASE) 02426382 **BIO-CELECOXIB** ВМІ 02427176 ASA FO SAN 02239941 **CFI FBRFX** UNK 02238545 **ASAPHEN PMS** 02424371 **CELECOXIB PDL** 02283905 JAMP-ASA **JMP** 02429675 **CELECOXIB** SIV PDI 02311496 PRO-AAS 02436299 **CELECOXIB** SAN 02485222 RIVASA EC RIV 02424533 JAMP-CELECOXIB **JMP 81MG TABLET (DELAYED RELEASE)** 02420058 MAR-CELECOXIB MAR APX 02461471 APO-ASA LD 02412497 MINT-CFI FCOXIB MIN 02244993 ASA **PMS** 02479737 NRA-CELECOXIB UNK 02372177 ASA VTH 02355442 PMS-CELECOXIB **PMS** 02433044 **PMS** ASA 02426366 PHA PRIVA-CELECOXIB 02449277 TLI ASA 02412373 **RAN-CELECOXIB RBY** 02377683 ASA DAILY LOW DOSE **APX** 02425386 **RIVA-CELECOX** RIV 02426811 ASA EC SAN SDZ CELECOXIB SDZ 02442639 02242281 **ENTROPHEN** PED ST 200MG CAPSULE 02283700 PRAXIS ASA DAILY LOW DOSE **PMS** 02420163 **ACT CELECOXIB** TEV 02420279 **RIVASA EC** RIV 02437589 AG-CELECOXIB ANG ST 162MG TABLET (DELAYED RELEASE) 02418940 APO-CFI FCOXIB APX 02247550 ASAPHEN EC **PMS** 02445689 **AURO-CELECOXIB AUR** ST 325MG TABLET (DELAYED RELEASE) 02426390 **BIO-CELECOXIB** BMI 02010526 ASA **VTH** 02239942 **CELEBREX** UNK 02352427 **ASATAB EC** ODN 02424398 **CELECOXIB PDL** 02150417 **ASPIRIN** BAY 02429683 **CELECOXIB** SIV

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PED

00.00.04.110			NOTIFICATION AND AND AND AND AND AND AND AND AND AN	
	INSTEROIDAL ANTI- FLAMMATORY AGENTS		28:08.04 NONSTEROIDAL ANTI- INFLAMMATORY AGENTS	
CELECOXIB			DICLOFENAC SODIUM	
ST 200MG САР	SIII E		ST 75MG TABLET (EXTENDED RELEASE)	
	CELECOXIB	SAN		TEV
02424541	JAMP-CELECOXIB	JMP		NVR
02420066	MAR-CELECOXIB	MAR	ST 100MG TABLET (EXTENDED RELEASE)	
02412500	MINT-CELECOXIB	MIN	•	APX
02479745	NRA-CELECOXIB	UNK		PDL
02355450	PMS-CELECOXIB	PMS		PMS
02426374	PRIVA-CELECOXIB	PHA		SDZ
02412381	RAN-CELECOXIB	RBY		NVR
02425394	RIVA-CELECOX	RIV	DICLOFENAC SODIUM (TOPICAL)	
02442647	SDZ CELECOXIB	SDZ		
	C DIETHYLAMINE		Limited use benefit (prior approval required).	
			For the treatment of osteoarthritis when:	
Limited use bene	efit (prior approval not required).		• pain is inadequately controlled with acetaminophen and a	
Coverage is limit	ed to 100 grams per month.		non-steroidal anti-inflammatory (NSAID); or	
1.16% GEL	,		 there is contraindication to acetaminophen and NSAID; or there is intolerance to acetaminophen and NSAID. 	
02290375	VOLTAREN EMULGEL	GSK	·	
02338580	VOLTAREN EMULGEL JOINT PAIN	GSK	ST 1.5% SOLUTION	
0200000	REGULAR STRENGTH	OOK		APX
2.32% GEL				TEL
02393190	VOLTAREN EMULGEL EXTRA	GSK		RAX
	STRENGTH			JMP
DICLOFENA	C SODIUM			PMS
50MG SUPP	OSITORY			TAR
	PMS-DICLOFENAC	PMS	DIFLUNISAL	
02261928	SANDOZ-DICLOFENAC	SDZ	ST 250MG TABLET	
00632724	VOLTAREN	NVR	02039486 DIFLUNISAL /	AAP
100MG SUP		INVIX	ST 500MG TABLET	
	PMS-DICLOFENAC	PMS	02039494 DIFLUNISAL /	AAP
02261936	SANDOZ-DICLOFENAC	SDZ	FLURBIPROFEN	
	VOLTAREN	NVR	ST 50MG TABLET	
	ET (DELAYED RELEASE)	IVVIX		AAP
02231662	DOM-DICLOFENAC	DPC	01912046 APO-FLURBIPROFEN / ST 100MG TABLET	AAP
	PMS-DICLOFENAC	PMS		AAP
	ET (DELAYED RELEASE)	1 WO		TEV
	DOM-DICLOFENAC	DPC		ΙĽV
	PMS-DICLOFENAC	PMS	IBUPROFEN	
	SANDOZ-DICLOFENAC	SDZ	ST 40MG DROP	
	VOLTAREN	NVR	02328445 ADVIL PEDIATRIC DROPS FEVER	PFI
	ET (ENTERIC COATED)		FROM COLDS OR FLU	
	APO-DICLO	APX	ST 40MG/ML DROP	
	TEVA-DICLOFENAC	TEV	02242522 ADVIL PEDIATRIC DROPS	PFI
	ET (ENTERIC COATED)			MCL
	APO-DICLO	APX	ST 20MG/ML SUSPENSION	
00870978		PDL		PFI
02352397		SAN		PED
02231503	PMS-DICLOFENAC	PMS		MCL
	TEVA-DICLOFENAC	TEV	ST 100MG SUSPENSION	
	ET (EXTENDED RELEASE)	-	02328437 CHILDREN'S ADVIL FEVER FROM	PFI
	APO-DICLO SR	APX	COLDS OR FLU	חבים
02224119		PDL	02280175 CHILDREN'S IBUPROFEN F ST 100MG TABLET	PER
02231664	DOM-DICLOFENAC SR	DPC		חבי
02231504	PMS-DICLOFENAC	PMS	02246403 ADVIL	PFI
02261901	SANDOZ-DICLOFENAC SR	SDZ		

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28:08.04 NONSTEROIDAL ANTI- INFLAMMATORY AGENTS		28:08.04 NONSTEROIDAL ANTI- INFLAMMATORY AGENTS	
IBUPROFEN		KETOPROFEN	
ST 200MG TABLET	DEL	ST 100MG TABLET (ENTERIC COATED)	A A D
01933558 ADVIL	PFI	00842664 KETOPROFEN-E	AAP
00441643 APO-IBUPROFEN	APX	02150824 PMS-KETOPROFEN	PMS
02257912 IBUPROFEN	JMP	ST 200MG TABLET (EXTENDED RELEASE)	A A D
02314754 IBUPROFEN	PMS	02172577 KETOPROFEN SR	AAP
02314762 IBUPROFEN 02368072 IBUPROFEN	PMS VTH	MEFENAMIC ACID	
02368072 IBUPROFEN 02368080 IBUPROFEN	VTH	ST 250MG CAPSULE	
02439689 IBUPROFEN	APX	02237826 DOM-MEFENAMIC ACID	DPC
02439727 IBUPROFEN	APX	02229452 MEFENAMIC	AAP
02186934 MOTRIN	MCL	00155225 PONSTAN	AAP
00629324 NOVO-PROFEN	TEV	MELOXICAM	
ST 300MG TABLET	ı L v	ST 7.5MG TABLET	
00441651 APO IBUPROFEN	APX	02250012 ACT MELOXICAM	TEV
00629332 NOVO-PROFEN	TEV	02248973 APO-MELOXICAM	APX
ST 400MG TABLET	I L V	02390884 AURO-MELOXICAM	AUR
02244577 ADVIL EXTRA STRENGTH	PFI	02248605 DOM-MELOXICAM	DPC
00506052 APO IBUPROFEN	APX	02353148 MELOXICAM	SAN
00636533 IBUPROFEN	PDL	02248267 PMS-MELOXICAM	PMS
02314770 IBUPROFEN	PMS	02258315 TEVA-MELOXICAM	TEV
02317338 IBUPROFEN	JMP	ST 15MG TABLET	I L V
02439735 IBUPROFEN	APX	02250020 ACT MELOXICAM	TEV
02401290 JAMP-IBUPROFEN	JMP	02248974 APO-MELOXICAM	APX
00629340 NOVO-PROFEN	TEV	02390892 AURO-MELOXICAM	AUR
00836133 PMS-IBUPROFEN	PMS	02248606 DOM-MELOXICAM	DPC
ST 600MG TABLET	1 1110	02324334 MELOXICAM	PDL
00585114 APO IBUPROFEN	APX	02353156 MELOXICAM	SAN
00629359 TEVA-PROFEN	TEV	02248268 PMS-MELOXICAM	PMS
600MG TABLET (EXTENDED RELEASE)		02258323 TEVA-MELOXICAM	TEV
02443562 ADVIL 12 HOUR	PFI	MISOPROSTOL, DICLOFENAC SODIUM	
INDOMETHACIN		·	
		ST 200MCG & 50MG TABLET	
ST 25MG CAPSULE		02400596 SANDOZ DICLOFENAC	SDZ
00611158 APO INDOMETHACIN	APX	MISOPROSTOL	
02461811 MINT-INDOMETHACIN	MIN	ST 200MCG & 75MG TABLET 02400618 SANDOZ DICLOFENAC	SDZ
00337420 TEVA-INDOMETHACIN	TEV	MISOPROSTOL	SDZ
ST 50MG CAPSULE		ST 200MCG & 50MG TABLET (DELAYED RELEASE)	
00611166 APO INDOMETHACIN	APX	01917056 ARTHROTEC	PFI
02461536 MINT-INDOMETHACIN	MIN	02341689 GD-DICLOFENAC/MISOPROSTOL	PFI
00337439 TEVA-INDOMETHACIN	TEV	02413469 PMS-DICLOFENAC-MISOPROSTOL	PMS
50MG SUPPOSITORY	0.5.7	ST 200MCG & 75MG TABLET (DELAYED RELEASE)	
02231799 SANDOZ INDOMETHACIN	SDZ	02229837 ARTHROTEC	PFI
100MG SUPPOSITORY	0.5.7	02341697 GD-DICLOFENAC/MISOPROSTOL	PFI
02231800 SANDOZ INDOMETHACIN	SDZ	02413477 PMS-DICLOFENAC-MISOPROSTOL	PMS
KETOPROFEN		NAPROXEN	
ST 50MG CAPSULE			
00790427 KETOPROFEN	AAP	500MG SUPPOSITORY	D
02150808 PMS-KETOPROFEN	PMS	02017237 PMS-NAPROXEN	PMS
100MG SUPPOSITORY		ST 25MG/ML SUSPENSION	
02015951 PMS-KETOPROFEN	PMS	02162431 NAPROXEN	PEI
ST 50MG TABLET (ENTERIC COATED)		ST 125MG TABLET	451
00790435 KETOPROFEN-E	AAP	00522678 APO NAPROXEN	APX
02150816 PMS-KETOPROFEN	PMS	ST 220MG TABLET	D140
		02362430 NAPROXEN	PMS

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	NSTEROIDAL ANTI- FLAMMATORY AGENTS		28:08.04 NONSTEROIDAL ANTI- INFLAMMATORY AGENTS
NAPROXEN	LAMMATORT AGENTO		PIROXICAM
S ^T 220MG TABI	. ET		ST 20MG CAPSULE
	NAPROXEN SODIUM	APX	20MG CAPSULE 00642894 APO PIROXICAM APX
ST 250MG TAB I		AFA	00695696 TEVA-PIROXICAM TEV
00522651	APO-NAPROXEN	APX	SULINDAC
	NAPROXEN	PDL	
	NAPROXEN	SAN	ST 150MG TABLET
	TEVA-NAPROXEN	TEV	00745588 TEVA-SULINDAC TEV
^{sτ} 275MG TABI		1 L V	ST 200MG TABLET
	ANAPROX	APU	00745596 TEVA-SULINDAC TEV
	APO-NAPRO-NA	APX	TIAPROFENIC ACID
	NAPROXEN SODIUM	SAN	ST 200MG TABLET
	NAPROXEN-NA	PDL	02230827 PMS-TIAPROFENIC PMS
	TEVA-NAPROXEN	TEV	02179679 TEVA-TIAPROFENIC TEV
ST 375MG TABI			ST 300MG TABLET
00600806	APO-NAPROXEN	APX	02231060 DOM-TIAPROFENIC DPC
	NAPROXEN	PDL	02179687 TEVA-TIAPROFENIC TEV
	NAPROXEN	SAN	28:08.08 OPIATE AGONISTS
00627097	TEVA-NAPROXEN	TEV	
ST 500MG TABI	LET		ACETAMINOPHEN, CAFFEINE CITRATE,
00592277	APO-NAPROXEN	APX	CODEINE PHOSPHATE
00618721	NAPROXEN	PDL	Limited use benefit (prior approval is not required).
02350777	NAPROXEN	SAN	
00589861	TEVA-NAPROXEN	TEV	For safety reasons NIHB has implemented a dose limit on
ST 550MG TABI	LET		acetaminophen. The limit accumulates against the amount of
02162717	ANAPROX DS	APU	acetaminophen claimed to the program from plain
01940309	APO-NAPRO-NA DS	APX	acetaminophen and/or acetaminophen in combination with
02351021	NAPROXEN SODIUM DS	SAN	opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is
02153386	NAPROXEN-NA DF	PDL	permitted in a 100-day period, for a total daily dose of
02026600	TEVA-NAPROXEN DS	TEV	3600mg/day.
ST 250MG TABI	LET (ENTERIC COATED)		300MG & 15MG & 15MG TABLET
02246699	APO-NAPROXEN EC	APX	00653241 RATIO-LENOLTEC NO 2 TEV
02350785	NAPROXEN EC	SAN	02163934 TYLENOL WITH CODEINE NO.2 JSO
02243312	TEVA-NAPROXEN	TEV	300MG & 15MG & 30MG TABLET
ST 375MG TABI	LET (ENTERIC COATED)		00653276 RATIO-LENOLTEC NO 3 TEV
02246700	APO-NAPROXEN EC	APX	02163926 TYLENOL WITH CODEINE NO.3 JSO
02162415	NAPROSYN	APU	ACETAMINOPHEN, CODEINE PHOSPHATE
02350793	NAPROXEN EC	SAN	Limited use benefit (prior approval is not required).
02294702	PMS-NAPROXEN EC	PMS	Entitled ase serient (prior approval is not required).
02310945	PRO-NAPROXEN	PDL	For safety reasons NIHB has implemented a dose limit on
	TEVA-NAPROXEN	TEV	acetaminophen. The limit accumulates against the amount of
ST 500MG TABI	LET (ENTERIC COATED)		acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with
02246701	APO-NAPROXEN EC	APX	opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e.
02162423	NAPROSYN	APU	Percocet®). A total of 360 grams of acetaminophen is
02350807	NAPROXEN EC	SAN	permitted in a 100-day period, for a total daily dose of
02294710	PMS-NAPROXEN EC	PMS	3600mg/day.
02310953	PRO-NAPROXEN	PDL	32MG & 1.6MG/ML ELIXIR
	TEVA-NAPROXEN	TEV	00816027 PMS-ACETAMINOPHEN PMS
	LET (EXTENDED RELEASE)		300MG & 30MG TABLET
	NAPROSYN	APU	00608882 TEVA-EMTEC-30 TEV
PIROXICAM			00789828 TRIATEC-30 RIV
$^{s au}$ 10MG CAPS	ULE		
00642886	APO PIROXICAM	APX	
00695718	TEVA-PIROXICAM	TEV	

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28:08.08 OPIATE AGONISTS 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 & 5MG TABLET

02324628	APO-OXYCODONE/ACET	APX
02361361	OXYCODONE/ACET	SAN
02242468	RIVACOCET	RIV
02307898	SANDOZ	SDZ
	OXYCODONE/ACETAMINOPHEN	
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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

325MG & 5MG TABLET

00608157 TEVA-OXYCODAN

TEV

BUPRENORPHINE (SUBLOCADE)

Limited use benefit (prior approval required).

For the management of moderate to severe opioid use disorder in adult patients who have been inducted and clinically stabilized on a transmucosal buprenorphinecontaining product; and

Patient must be induced and stabilized on an equivalent of 8 mg to 24 mg per day of transmucosal buprenorphine for a minimum of 7 days.

Note:

- the prescriber has experience in the diagnosis and management of opioid use disorder and certified under Sublocade Certification Program.
- Sublocade must be administered subcutaneously in the abdominal region by a healthcare provider.
- Sublocade should be used as part of a complete treatment plan that includes counselling and psychosocial support.
 client will be added to the Client Safety Program (CSP).

300MG SOLUTION (EXTENDED RELEASE)

02483092 SUBLOCADE IND

28:08.08 OPIATE AGONISTS CODEINE MONOHYDRATE, CODEINE SULFATE TRIHYDRATE

Limited use benefit (prior approval required).

For treatment of:

- chronic pain and patients that requires end of life care as an alternative to products containing codeine in combination with acetaminophen or ASA with or without caffeine; or
- chronic pain and patients that requires end of life care 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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

50MG TABLE	ET (EXTENDED RELEAS	E)
02230302	CODEINE CONTIN CR	PFR
100MG TABI	LET (EXTENDED RELEA	SE)
02163748	CODEINE CONTIN CR	PFR
150MG TABI	LET (EXTENDED RELEA	SE)
02163780	CODEINE CONTIN CR	PFR
200MG TABI	LET (EXTENDED RELEA	SE)
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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

5MG/ML LIQ	UID				
00050024	CODEINE PHOSPHATE	ATL			
2MG/ML SO	LUTION				
00380571	LINCTUS CODEINE	ATL			
15MG TABL					
02009889	CODEINE	RIV			
00593435	TEVA-CODEINE	TEV			
30MG TABL	30MG TABLET				
02009757	CODEINE	RIV			
00593451	TEVA-CODEINE	TEV			

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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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

12MCG/HR PATCH **PMS** 02341379 PMS-FENTANYL MTX SDZ 02327112 SANDOZ FENTANYL 02311925 TEVA-FENTANYL **TEV** 25MCG/HR PATCH 02341387 PMS-FENTANYL MTX **PMS** 02327120 SANDOZ FENTANYL SDZ 02282941 TEVA-FENTANYL TEV 50MCG/HR PATCH PMS 02341395 PMS-FENTANYL MTX SANDOZ FENTANYL SDZ 02327147 02282968 TEVA-FENTANYL TEV 75MCG/HR PATCH 02341409 PMS-FENTANYL MTX PMS 02327155 SANDOZ FENTANYL SDZ 02282976 TEVA-FENTANYL TEV 100MCG/HR PATCH 02341417 PMS-FENTANYL MTX **PMS** 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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

3MC CARSIII E (EYTENDED DEI EASE)

SIVIG CAPSU	LE (EXTENDED RELEAS	> ⊏)	
02476614	APO-HYDROMORPHON	NE APX	
4.5MG CAPS	SULE (EXTENDED RELE	ASE)	
02476622	APO-HYDROMORPHO!	NE APX	
6MG CAPSU	LE (EXTENDED RELEAS	SE)	
02476630	APO-HYDROMORPHON	NE APX	
9MG CAPSU	LE (EXTENDED RELEAS	SE)	
02476649	APO-HYDROMORPHON	NF APX	

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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

12MG CAPS	ULE (EXTENDED RELEASE)	
02476657	APO-HYDROMORPHONE	APX
18MG CAPS	ULE (EXTENDED RELEASE)	
02476665	APO-HYDROMORPHONE	APX
24MG CAPS	ULE (EXTENDED RELEASE)	
02476673	APO-HYDROMORPHONE	APX
30MG CAPS	ULE (EXTENDED RELEASE)	
02476681	APO-HYDROMORPHONE	APX
3MG CAPSU	JLE (SUSTAINED RELEASE)	
02125323	HYDROMORPH CONTIN	PFR
4.5MG CAPS	SULE (SUSTAINED RELEASE)	
02359502	HYDROMORPH CONTIN	PFR
6MG CAPSU	JLE (SUSTAINED RELEASE)	
02125331	HYDROMORPH CONTIN	PFR
9MG CAPSU	JLE (SUSTAINED RELEASE)	
02359510	HYDROMORPH CONTIN	PFR
12MG CAPS	ULE (SUSTAINED RELEASE)	
02125366	HYDROMORPH CONTIN	PFR
18MG CAPS	ULE (SUSTAINED RELEASE)	
02243562	HYDROMORPH CONTIN	PFR
24MG CAPS	ULE (SUSTAINED RELEASE)	
02125382	HYDROMORPH CONTIN	PFR
30MG CAPS	ULE (SUSTAINED RELEASE)	
02125390	HYDROMORPH CONTIN	PFR
1MG/ML LIC	UUD	
01916386	PMS HYDROMORPHONE	PMS
50MG SOLU	ITION	
02469413		RAX
	HYDROCHLORIDE HP 50	
3MG SUPPO		
	PMS HYDROMORPHONE	PMS
1MG TABLE	· -	
	APO-HYDROMORPHONE	APX
	DILAUDID	PFR
	PMS-HYDROMORPHONE	PMS
02319403	TEVA-HYDROMORPHONE	TEV
2MG TABLE	· -	
	APO-HYDROMORPHONE	APX
	DILAUDID	PFR
00885436		PMS
02319411	TEVA-HYDROMORPHONE	TEV
4MG TABLE		451
02364131	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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

4MG TABLET

00125121	DILAUDID	PFR
00885401	PMS-HYDROMORPHONE	PMS
02319438	TEVA-HYDROMORPHONE	TEV
8MG TABLE	т	
02364158	APO-HYDROMORPHONE	APX
00786543	DILAUDID	PFR
00885428	PMS-HYDROMORPHONE	PMS
02319446	TEVA-HYDROMORPHONE	TEV

METHADONE HYDROCHLORIDE

POWDER

00908835	METHADONE POWDER (OAT)	MDS			
10MG SOLU	10MG SOLUTION				
02481979	SANDOZ METHADONE	UNK			
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

METHADONE HYDROCHLORIDE (METADOL)

Limited use benefit (prior approval required) with the following criteria:

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 patients that requires end of life care. Pharmacists may only dispense a maximum supply of 30 days at one time.

1MG/ML SOLUTION

02247694	METADOL	PAL
10MG/ML SC	DLUTION	
02241377	METADOL	PAL
1MG TABLE	Т	
02247698	METADOL	PAL

28:08.08 OPIATE AGONISTS METHADONE HYDROCHLORIDE (METADOL)

Limited use benefit (prior approval required) with the following criteria:

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 patients that requires end of life care. Pharmacists may only dispense a maximum supply of 30 days at one time.

5MG TABLET

ONIO IADEL	•		
02247699	METADOL		PAL
10MG TABL	ET		
02247700	METADOL		PAL
25MG TABLET			
02247701	METADOL		ΡΔΙ

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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

1MG/ML SYRUP

00614491	DOLORAL 1	ATL
5MG/ML SY	RUP	
00614505	DOLORAL 5	ATL

MORPHINE SULFATE

02019930 M-ESLON

00594644 STATEX

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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

10MG CAPSULE (EXTENDED RELEASE)

15MG CAPS	ULE (EXTENDED	RELEASE)	
02177749	M-ESLON		ETH
30MG CAPS	ULE (EXTENDED	RELEASE)	
02019949	M-ESLON		ETH
60MG CAPS	ULE (EXTENDED	RELEASE)	
02019957	M-ESLON		ETH
100MG CAP	SULE (EXTENDE	D RELEASE)	
02019965	M-ESLON		ETH
200MG CAP	SULE (EXTENDE	D RELEASE)	
02177757	M-ESLON		ETH
5MG SUPPO	SITORY		
00632228	STATEX		PAL
10MG SUPP	OSITORY		
00632201	STATEX		PAL
20MG SUPP	OSITORY		
00596965	STATEX		PAL
5MG TABLE	Т		
00594652	STATEX		PAL
10MG TABL	ET		

ETH

PAL

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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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

25MG TABL	ET	
00594636	STATEX	PAL
50MG TABL	ET	
00675962	STATEX	PAL
15MG TABL	ET (EXTENDED RELEASE)	
02350815	MORPHINE SR	SAN
02015439	MS CONTIN SR	PFR
02244790	SANDOZ MORPHINE SR	SDZ
02302764	TEVA-MORPHINE SR	TEV
30MG TABL	ET (EXTENDED RELEASE)	
02350890	MORPHINE SR	SAN
	MS CONTIN SR	PFR
	SANDOZ MORPHINE SR	SDZ
	TEVA-MORPHINE SR	TEV
60MG TABL	ET (EXTENDED RELEASE)	
02350912	MORPHINE SR	SAN
02014300	MS CONTIN SR	PFR
	SANDOZ MORPHINE SR	SDZ
02302780	TEVA-MORPHINE SR	TEV
100MG TAB	LET (EXTENDED RELEASE)	
	MS CONTIN SR	PFR
	SANDOZ MORPHINE SR	SDZ
02302799	TEVA-MORPHINE SR	TEV
	LET (EXTENDED RELEASE)	
	MS CONTIN SR	PFR
	SANDOZ MORPHINE SR	SDZ
	TEVA-MORPHINE SR	TEV
	T (IMMEDIATE RELEASE)	
02014203		PFR
	ET (IMMEDIATE RELEASE)	
02014211		PFR
	ET (IMMEDIATE RELEASE)	
02014238		PFR
	ET (IMMEDIATE RELEASE)	
02014254		PFR
IORPHINE S	SUI FATE (KADIAN)	

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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

10MG CAPSULE (SUSTAINED RELEASE)

02242163 KADIAN

28:08.08 OPIATE AGONISTS 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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

10MG CAPS	ULE (SUS	TAINED RELEASE)	
09991310	KADIAN		MAY
20MG CAPS	ULE (SUS	TAINED RELEASE)	
02184435	KADIAN		BGP
09991311	KADIAN		MAY
50MG CAPS	ULE (SUS	TAINED RELEASE)	
02184443	KADIAN		BGP
09991312	KADIAN		MAY
100MG CAP	SULE (SU	STAINED 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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

10MG SUPP	10MG SUPPOSITORY				
00392480	SUPEUDOL	SDZ			
20MG SUPP	OSITORY				
00392472	SUPEUDOL	SDZ			
5MG TABLE	Т				
02231934	OXY-IR	PFR			
02319977	PMS-OXYCODONE	PMS			
00789739	SUPEUDOL	SDZ			
10MG TABL	ET				
02240131	OXY-IR	PFR			
02319985	PMS-OXYCODONE	PMS			
00443948	SUPEUDOL	SDZ			
20MG TABL	ET				
02319993	PMS-OXYCODONE	PMS			
02262983	SUPEUDOL	SDZ			
20MG TABL	20MG TABLET (IMMEDIATE RELEASE)				
02240132	OXY-IR	PFR			

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BGP

28:08.12 OPIATE PARTIAL AGONISTS BUPRENORPHINE (BUTRANS)

Limited use benefit (prior approval required).

For the following medical conditions:

- pain due to cancer
- chronic non-cancer pain-causing limitations in activities of daily living.
- prevention of precipitated withdrawal during buprenorphine/naloxone induction (max 3 x 20 mcg patches are covered)
- patient requires end of life care (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less)

*Guidelines indicate little evidence for opioid use for fibromyalgia, headache or back or neck pain without a neuropathic component.

5MCG PATC	H	
02341174	BUTRANS 5	PFR
10MCG PAT	СН	
02341212	BUTRANS 10	PFR
15MCG PAT	СН	
02450771	BUTRANS 15	PFR
20MCG PAT	СН	
02341220	BUTRANS 20	PFR

BUPRENORPHINE (SUBLOCADE)

Limited use benefit (prior approval required).

For the management of moderate to severe opioid use disorder in adult patients who have been inducted and clinically stabilized on a transmucosal buprenorphinecontaining product; and

Patient must be induced and stabilized on an equivalent of 8 mg to 24 mg per day of transmucosal buprenorphine for a minimum of 7 days.

Note:

- the prescriber has experience in the diagnosis and management of opioid use disorder and certified under Sublocade Certification Program.
- Sublocade must be administered subcutaneously in the abdominal region by a healthcare provider.
- Sublocade should be used as part of a complete treatment plan that includes counselling and psychosocial support.
- · client will be added to the Client Safety Program (CSP).

100MG SOLUTION (EXTENDED RELEASE)

02483084 SUBLOCADE IND

28:08.12 OPIATE PARTIAL AGONISTS BUPRENORPHINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the management of patients with opioid use disorder, in combination with psychosocial support:

- patient is stabilized on a dose of no more than 8 mg per day of sublingual buprenorphine/naloxone for the preceding 90 days; and
- patient is under the care of a health care provider with experience in the diagnosis and management of opioid use disorder; and
- the prescriber has been trained to implant the buprenorphine subdermal implant.

Approval is for a maximum of four lifetime doses. One package of 4 implants is approved at every 6 months (e.g. four times X package of 4 implants)

80MG IMPLANT

02474921 PROBUPHINE UNK

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 buprenorphine/naloxone administration. These supports include the safe daily witnessing, storage and handling of the buprenorphine/naloxone doses. After this confirmation, NIHB will approve the buprenorphine/naloxone for the client.

2MG & 0.5MG TABLET

02453908	ACT BUPRENORPHINE/NALOXONE	TEV
02424851	PMS-BUPRENORPHINE-	PMS
	NALOXONE	
02295695	SUBOXONE	IND
8MG & 2MG	TABLET	
02453916	ACT BUPRENORPHINE/NALOXONE	TEV
02424878	PMS-BUPRENORPHINE-	PMS
	NALOXONE	
02295709	SUBOXONE	IND
12MG & 3MG	G TABLET	
02468085	SUBOXONE	IND
16MG & 4M	G TABLET	
02468093	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.

ST 80MG/ML DROP

01904140 ACETAMINOPHEN

TAN

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28:08.92 MISCELLANEOUS ANALGESICS **AND ANTIPYRETICS**

ACETAMINOPHEN

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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.

3600mg/day.			3600mg/day.		
ST 80MG/ML DROP			ST 325MG TAB	LET	
01905864	ACETAMINOPHEN	TLI	00544981	APO ACETAMINOPHEN	APX
02263793	PEDIAPHEN	EUR	02229873	APO-ACETAMINOPHEN	APX
02027801	PEDIATRIX	TEV	00389218	NOVO-GESIC	TEV
00875988	TEMPRA INFANT	PAL	00559393	TYLENOL	MCL
02046059	TYLENOL	MCL	00723894	TYLENOL	MCL
ST 16MG/ML LI	QUID		ST 500MG TAB	LET	
01905848	ACETAMINOPHEN	TLI	00549703	ACETAMINOPHEN	PMT
00792713	PDP-ACETAMINOPHEN	PED	00605778	ACETAMINOPHEN	VTH
02263807	PEDIAPHEN	EUR	00789798	ACETAMINOPHEN	TLI
00884553	TEMPRA CHILDREN'S	PAL	01939122	ACETAMINOPHEN	JMP
ST 32MG/ML LI	QUID		01962353	ACETAMINOPHEN	TAN
01901389	ACETAMINOPHEN	JMP	02252813	ACETAMINOPHEN	PMT
01958836	ACETAMINOPHEN	TLI	02255251	ACETAMINOPHEN	PMT
00792691	PDP-ACETAMINOPHEN	PED	02362368	ACETAMINOPHEN	APX
02263831	PEDIAPHEN	EUR	02022222	ACÉTAMINOPHÈNE	RIV
02027798	PEDIATRIX	TEV	02362228	ACÉTAMINOPHÈNE	RIV
00875996	TEMPRA CHILDREN'S DOUBLE STRENGTH	PAL	02362201	ACÉTAMINOPHÈNE BLASON SHIELD	RIV
02046040	TYLENOL	MCL	00545007	APO ACETAMINOPHEN	APX
120MG SUP	POSITORY		02229977	APO-ACETAMINOPHEN	APX
00553328	ABENOL	GSK	02285797	EXTRA STRENGTH	VTH
02230434	ACET 120	PED		ACETAMINOPHEN	
02046660	PMS-ACETAMINOPHEN	PMS	02355299	JAMP ACETAMINOPHEN BLAZON	JMP
160MG SUP	POSITORY		00482323	NOVO-GESIC FORTE	TEV
02230435	ACET	PED	00892505	PMS-ACETAMINOPHEN	PMS
325MG SUP	POSITORY		00723908	TYLENOL	MCL
01919393	ABENOL	PED	00559407	TYLENOL EXTRA STRENGTH	MCL
02230436	ACET 325	PED	ST 80MG TABL	ET (CHEWABLE)	
02046687	PMS-ACETAMINOPHEN	PMS	01905856	ACETAMINOPHEN	TLI
650MG SUP	POSITORY		02017458	ACETAMINOPHEN	RIV
	ACET 650	PED	02129957	ACETAMINOPHEN	VTH
02046695	PMS-ACETAMINOPHEN	PMS	ST 160MG TAB	LET (CHEWABLE)	
ST 80MG TABL	ET		02017431	ACETAMINOPHEN	RIV
02015676	ACETAMINOPHEN	TAN	02142805	ACETAMINOPHEN	VTH
02263815	PEDIAPHEN	EUR	02237562	ACETAMINOPHEN	TLI
ST 160MG TAB	LET		02263823	PEDIAPHEN	EUR
02230934 ST 325MG TAB	ACETAMINOPHEN	TAN	02347792	TYLENOL JR STRENGTH FASTMELTS	MCL
00605751	ACETAMINOPHEN	VTH	02241361	TYLENOL JUNIOR STRENGTH	MCL
00743542			FLOCTAFEN	IINE	
	ACETAMINOPHEN	PMT	ST 200MG TAB	ICT	
00789801 01938088	ACETAMINOPHEN ACETAMINOPHEN	TLI JMP			۸۸۵
01936066	ACETAMINOPHEN ACETAMINOPHEN	TLI	02244680 ST 400MG TAB	FLOCTAFENINE	AAP
01977415		RIV			AAP
02022214	ACÉTAMINOPHÈNE ACÉTAMINOPHÈNE	RIV	02244681	FLOCTAFENINE	AAP
02302198	AULTAWIINUFFIENE	KIV			

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To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day. TARO-PHENYTOIN TAR ***50MG TABLET 00023698 DILANTIN INFATABS UNK 28:12.20 ANTICONVULSANTS- SUCCINIMIDES ETHOSUXIMIDE ***50MG TABLET 00023698 DILANTIN INFATABS UNK 28:12.20 ANTICONVULSANTS- SUCCINIMIDES **50MG CAPSULE*	28:10.00 OPIATE ANTAGONISTS		28:12.08 ANTICONVULSANTS -
Dispet Has NALOXONE KIT UNK O.4MG/MIL NIJECTION O.9991460 NALOXONE KIT UNK O.4MG/SOLUTION O.449706 NALOXONE SDZ O.4MG/SOLUTION O.449706 NALOXONE SDZ O.398342 NALOXONE TEL O.3393334 NALOXONE O.4MG/SOLUTION O.449714 NALOXONE O.449715 NACOXONE O.449714 NALOXONE O.449715 NALOXONE O.449715 NALOXONE O.449715 NALOXONE O.449715 NALOXONE O.449715 O.4	NALOXONE HYDROCHLORIDE		BENZODIAZEPINES
O.MAGMIL.INJECTION O.9991460 NALOXONE KIT O.9453268 S.O.S NALOXONE O.2453268 S.O.S NALOXONE O.2453268 S.O.S NALOXONE O.2453268 S.O.S NALOXONE O.2465326 NALOXONE O.2467676 NALOXONE O.2467676 NALOXONE O.2467676 NALOXONE O.2467671 NALOXONE O.2467761 NALOXONE O.2467671 NALOXONE O.2467761 NALOXONE O.2467761 NALOXONE O.24	INJECTION		CLONAZEPAM
Open	09991488 NALOXONE KIT	UNK	Limited use benefit (prior approval is not required).
UNIX Outgoing Ou	0.4MG/ML INJECTION		
0.44MG SOLUTION 0244876 S O.S NALOXONE	09991460 NALOXONE KIT	UNK	
0.245328 S.O.S NALOXONE HYDROCHLORIDE OLAGIDATION OCCUPIES A HYDROCHLORIDE OLAGIDATION OCCUPIES A CONTROL OF THE WITHOUT OLAGIDATION OCCUPIES A CONTROL OLAGIDATION OCCUPIES OLAGIDATION OCCUPIES A CONTROL OLAGIDATION OCCUPIES OLAGIDATE OLAGIDATION OCCUPIES OLAGIDATE OCCUPIES OLAGIDATION OCCUPIES OL	0.4MG SOLUTION		limit of 30 mg diazepam equivalents per day. This limit will be
0.2448706 NALOXONE	02453258 S.O.S NALOXONE	SDZ	calculated based on the total dose of all benzodiazepines a
O2148706 NALOXONE NALOXONE O28284282 ALOXONE OMG	HYDROCHLORIDE		client is receiving from NIHB within a 100-day period (i.e. 3
12/18/07/16 ALL-XONE SIZ 20393034 ALL-XONE OMG OMG OZ393036 ALL-XONE OMG OZ393036 ALL-XONE OMG OZ178789 APO-CLONAZEPAM APX OZ2933034 ALL-XONE OMG OZ278789 APO-CLONAZEPAM APX OZ2933042 NAL-XONE OMG OZ278789 APO-CLONAZEPAM PMS OZ278718 PMS-CLONAZEPAM PMS OZ278718 PMS-CLONAZEPAM PMS OZ27811593 PRO-CLONAZEPAM PMS OZ29811593 PRO-CLONAZEPAM PMS OZ2980477 RIVA-CLONAZEPAM PMS OZ2980477 RIVA-CLONAZEPAM PMS OZ2980477 RIVA-CLONAZEPAM PMS OZ248077 RIVA-CLONAZEPAM PMS OZ248077 RIVA-CLONAZEPAM PMS OZ248077 RIVA-CLONAZEPAM PMS OZ248078 APX OZ239024 TEVA-CLONAZEPAM PMS OZ248078 APX OZ239024 TEVA-CLONAZEPAM PMS OZ248078 PMS-CLONAZEPAM PMS OZ248078 PMS	0.4MG/ML SOLUTION		
02832482 NALOXONE OMG 02383474 NALOXONE OMG 02484714 NALOXONE SDZ 024393042 NALOXONE OMG 02484714 NALOXONE OMG 02483714 NALOXONE OMG 02483714 NALOXONE OMG 02483714 NALOXONE OMG 0248371 PMS-CLONAZEPAM PMS 02453873 NARCAN UNK 0245373 NARCAN UNK 0245373 NARCAN UNK 0245373 NARCAN UNK 0245375 NARCAN UNK 0245375 NARCAN UNK 0246375 NARCAN UNK 0246375 NARCAN UNK 0246475 APO-NALTREXONE APA 02454873 NALTREXONE HYDROCHLORIDE 02464275 APO-NALTREXONE APA 02454383 NALTREXONE HYDROCHLORIDE UNK 02464275 APO-NALTREXONE WINK 0246475 APO-NALTREXONE HYDROCHLORIDE UNK 02464738 NALTREXONE HYDROCHLORIDE UNK 02464738 NALTREXONE HYDROCHLORIDE UNK 02464738 NALTREXONE HYDROCHLORIDE UNK 0264575 PHENOBARB 0864575 PHENOBARB 0864576 PHENOBARB 0864575 PHENOBARB 0864576 PHENOBARB 0864576 PHENOBARB 0864576 PH	02148706 NALOXONE		
1	02382482 NALOXONE		
MISSME SDZ		OMG	
02148714 MALOXONE	1MG/ML SOLUTION		
AMA SPRAY			
Q2458187	02393042 NALOXONE	OMG	
02458187 NARCAN 09991475 NALOXONE NASAL SPRAY KIT UNK 09991475 NALOXONE NASAL SPRAY KIT UNK 00362825 RIVOTRIL 0244277 APO-NALTREXONE 02451883 NALTREXONE HYDROCHLORIDE 02213826 REVIA 02213827 REVIA 02213827 REVIA 02213828 REVIA 02213828 REVIA 02213828 REVIA 02231807 PRO-CLONAZEPAM PMS 02311617 PRO-CLONAZEPAM 02311615 PRO-CLONAZEPAM PDL 0246787 PHENOBARB 00465875 PHENOBARB 00465876 PRIMIDONE 00399310 PRIMIDONE 00399	4MG SPRAY		
MALTREXONE HYDROCHLORIDE 1002239024 TEVA-CLONAZEPAM TEV 1002444275 APO-NALTREXONE HYDROCHLORIDE UNK 02444275 APO-NALTREXONE HYDROCHLORIDE UNK 02243828 REVIA TEV 022430368 CLONAPAM VAE 02243828 REVIA PRO-NALTREXONE PRO-CLONAZEPAM PMS 02243828 REVIA PRO-CLONAZEPAM PMS 02244678 PMS-CLONAZEPAM PMS 02244678 PMS-CLONAZEPAM PMS 02244778 PMS-CLONAZEPAM PMS 022440778 PMS-CLONAZEPAM PMS 02240778 RIVA-CLONAZEPAM PMS 02234078 RIVA-CLONAZEPAM PMS 02239310 PRIMIDONE PMS 0382841 RIVOTRIL HLR 03939310 PRIMIDONE APP 0382841 RIVOTRIL HUR 0382841	02458187 NARCAN	UNK	
NALTREXONE HYDROCHLORIDE 50MG TABLET 02444275 APO-NALTREXONE APX 022451883 NALTREXONE VAL 8SHITURATES PHENOBARBITURATES PHENOBARBITAL 5MG/ML ELIXIR 00645575 PHENOBARB PED 10178829 PHENOBARB PED 10178829 PHENOBARB PED 10399310 PRIMIDONE ***125MG TABLET 00399310 PRIMIDONE ***125MG TABLET 00022772 DILANTIN UNK 02244474 PMS-CLOBAZAM PMS 022244474 PMS-CLOBAZAM PMS 02239334 TEVA-CLOBAZAM PMS 0202244474 PMS-CLOBAZAM PMS 02239350 DILANTIN UNK 02244474 PMS-CLOBAZAM PMS 02023936 DILANTIN UNK 02250896 TARO-PHENYTOIN ***100MG CAPSULE 00023742 DILANTIN UNK 02250896 TARO-PHENYTOIN TAR ***50MG TABLET 00023799 ZARONTIN UNK 02250MG CAPSULE 00023799 ZARONTIN EFF	09991475 NALOXONE NASAL SPRAY KIT	UNK	
March Marc	NALTREXONE HYDROCHLORIDE		
02444275 APO-NALTREXONE APX 02230388 CLONAPAM PMS 02213826 REVIA TEV 0248728 PMS-CLONAZEPAM PMS 02213826 REVIA TEV 02313607 RPC-CLONAZEPAM PDL 02313826 REVIA TEV 02313607 RPC-CLONAZEPAM PDL 02313826 REVIA TEV 02313607 RPC-CLONAZEPAM PDL 0248738 PMS-CLONAZEPAM PDL 0248738 PMS-CLONAZEPAM PDL 0248736 PMS-CLONAZEPAM PDL 02248736 PMS-CLONAZEPAM PMS 02248736 PMS-CLONAZEPAM PMS 02248736 PMS-CLONAZEPAM PMS 02248736 PMS-CLONAZEPAM PMS 02311615 PRO-CLONAZEPAM PMS 0231615 PRO-CLONAZEPAM PMS 0231301 PRIMIDONE PD 0239025 TEVA-CLONAZEPAM RIV 0339310 PRIMIDONE PD 023903020 BENZODIAZEPINE ORAL LIQUID UNK 0399310 PRIMIDONE APA			
02451883 NALTREXONE HYDROCHLORIDE UNK 02213826 REVIA TEV 02311607 PRO-CLONAZEPAM PMS PRO-CLONAZEPAM PNS PRO-CLONAZEPAM PRO-CLO	02444275 APO-NALTREXONE	APX	
02213826 REVIA TEV 28:12.04 ANTICONVULSANTS - BARBITURATES PHENOBARBITAL 5MG/ML ELIXIR 00645575 PHENOBARB 00645575 PHENOBARB 100MG TABLET 00178829 PHENOBARB PED 02244278 RIVA-CLONAZEPAM PNS 02311615 PRO-CLONAZEPAM PNS 02311615 PRO-CLONAZEPAM PNS 02311616 PRO-CLONAZEPAM PNS 02311615 PRO-CLONAZEPAM PNS 02311615 PRO-CLONAZEPAM PNS 02311615 PRO-CLONAZEPAM PNS 02311615 PRO-CLONAZEPAM PNS 02382841 RIVOTRIL 00382841 RIVOTRIL 00399205 TEVA-CLONAZEPAM PID 02239025 TEVA-CLONAZEPAM PNS 0399310 PRIMIDONE PPINIFOR EXTEMPORANEOUS MIXTURE 99503020 BENZODIAZEPINE ORAL LIQUID UNK 0399310 PRIMIDONE AAP 28:12.12 ANTICONVULSANTS - BENZODIAZEPINES CLOBAZAM PNS 02244638 APO-CLOBAZAM PNS 02246912 APO-PHENYTOIN SODIUM APX 00022772 DILANTIN UNK PNS 00022780 DILANTIN UNK PNS PNS PNS PNS PNS PNS PNS P	02451883 NALTREXONE HYDROCHLORIDE	UNK	
### STANS CAPS CONTROL SANTS - BARBITURATES PHENOBARBITAL ***OLONAPAM** ***PHENOBARBITAL** ***OLONAPAM** ***OLONAPAM** ***OLONAPAM** ***OLONAPAM** ***OLONAPAM** ***OLONAPAM** ***OLONAPAPAM** **OLONAPAPAM** ***OLONAPAPAM** ***ONAPAPA** ***OLONAPAPAM** ***ONAPAPA** ***OLONAPAPAM** ***ONAPAPA** ***ONAPAPA** ***OLONAPAPAM** ***ONAPAPA** ***ONAPAPA** ***OLONAPAPAM** ***ONAPAPA** ***OLONAPAPAM** ***ONAPAPA** ***ONAPAPA** ***ONAPAPA** ***ONAPAPA** ***OLONAPAPAM** ***ONAPAPA** ***ONAPAPA** ***OLONAPAPAM** ***ONAPAM** ***ONAPAPA** ***ONAPAPA** ***ONAPAPA** ***ONAPAPA** ***ONAPAPA** ***OOLONAPAM** ***OO	02213826 REVIA	TEV	
BARBITURATES PHENOBARBITAL \$MG/ML ELIXIR \$00645575 PHENOBARB \$00176829 PHENOBARB \$001768	28:12 04 ANTICONVIII SANTS -		
PHENOBARBITAL 5MG/ML ELIXIR 00645575 PHENOBARB PED 00645575 PHENOBARB PED 00645575 PHENOBARB PED 00718829 PHENOBARB PED 003892841 RIVA-CLONAZEPAM RIV 00399310 PRIMIDONE ***T 15MG TABLET 003996761 PRIMIDONE AAP 28:12.12 ANTICONVULSANTS - BENZODIAZEPINES CLOBAZAM ***T 10MG TABLET 002244078 APS-CLONAZEPAM PED 02339625 TEVA-CLONAZEPAM TEV PHENYTOINS ***T 10MG TABLET 00399761 PRIMIDONE AAP 28:12.12 ANTICONVULSANTS - BENZODIAZEPINES CLOBAZAM ***T 10MG TABLET 002244274 PMS-CLOBAZAM APX 002244474 PMS-CLOBAZAM PMS 02234633 APO-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 30 mg diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg 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. 3 000 diazepam equivalents power than the recommended usual adult dosage is up to 30 mg per day. This limit and the recommen			
### STORY OF CONSTRUCTION OF C			
SMG/ML ELIXIR 00645575 PHENOBARB PED 02242078 RIVA-CLONAZEPAM RIV 100MG TABLET 03082841 RIVOTRIL HLR 00178829 PHENOBARB PED 02239025 TEVA-CLONAZEPAM TEV PRIMIDONE ***125MG TABLET 99503020 BENZODIAZEPINE ORAL LIQUID UNK 0399310 PRIMIDONE APP 28:12.12 ANTICONVULSANTS - HYDANTOINS 0399310 PRIMIDONE APP PHENYTOIN 28:12.08 ANTICONVULSANTS - BENZODIAZEPINES CLOBAZAM ***10MG TABLET 0244678 APO-CLOBAZAM APX 02244474 PMS-CLOBAZAM PMS 02244474 PMS-CLOBAZAM PMS 02238334 TEVA-CLOBAZAM TEV 00022779 DILANTIN UNK CLONAZEPAM Limited use benefit (prior approval is not required). Limited use benefit (prior approval is not required). To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine as client is receiving from NIHB within a 100-day period (i.e. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day. **To 0.25MG TABLET* 00022799 ZARONTIN ERF	PHENOBARBITAL		
00645575 PHENOBARB PED 02242078 RIVA-CLONAZEPAM RIV 100MG TABLET 00382841 RIVOTRIL HLR 0039829 PHENOBARB PED 02239025 TEVA-CLONAZEPAM TEV PRIMIDONE ***T 125MG TABLET 99503020 BENZODIAZEPINE ORAL LIQUID UNK 00399310 PRIMIDONE AAP 28:12.12 ANTICONVULSANTS - ##*T 250MG TABLET HYDANTOINS 00396761 PRIMIDONE AAP PHENYTOINS ***BENZODIAZEPINES PHENYTOINS ***CLOBAZAM** ***T 10MG TABLET 0244638 APO-CLOBAZAM APX 00022772 DILANTIN UNK 02234474 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 NIH-B has implemented a benzodiazepine dose limit of 30 mg diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day. **T 0.25MG TABLET** **T 0.02479 UNINIDES** **T 0.00023490 DILANTIN INFATABS* **T 250MG CAPSULE** **T 250MG MG/ML SUSPENSION* **T 250MG MG/ML SUSPENSION* **T 250MG MG/ML SUSPENSION* **T 250MG TABLET** **T 0.0023450 DILANTIN INFATABS* **UCCINIMIDES** **T 250MG TABLET** **T 0.0023450 DILANTIN INFATABS* **UNIXIMIDE** **T 250MG TABLET** **T 250MG CAPSULE** **T 250MG TABLET** **T 0.0022799 ZARONTIN ERF	5MG/ML ELIXIR		
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PRIMIDONE "125MG TABLET 00399310 PRIMIDONE "37 250MG TABLET 00396761 PRIMIDONE AAP 28:12.08 ANTICONVULSANTS - BENZODIAZEPINES CLOBAZAM "47 10MG TABLET 02244638 APO-CLOBAZAM APX 02244474 PMS-CLOBAZAM PMS 02238324 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 benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day. "57 0.25MG TABLET 022639020 BENZODIAZEPINE ORAL LIQUID UNK 28:12.12 ANTICONVULSANTS - HYDANTOINS PHENYTOIN 37 30MG CAPSULE 00022772 DILANTIN UNK 97 100MG CAPSULE 00022780 DILANTIN UNK 00022780 DILANTIN UNK 002250896 TARO-PHENYTOIN TAR 187 50MG TABLET 00023450 DILANTIN UNK 02250896 TARO-PHENYTOIN TAR 28:12.20 ANTICONVULSANTS- SUCCINIMIDES ETHOSUXIMIDE "7 250MG CAPSULE 00022799 ZARONTIN ERF		PFD	
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28:12.12 ANTICONVULSANTS - ### PIMIDONE AAP 28:12.08 ANTICONVULSANTS - ### BENZODIAZEPINES CLOBAZAM **** 10MG TABLET 02244638 APO-CLOBAZAM APX 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 benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day. *** 10.25MG TABLET *** 250MG TABLET *** 28:12.12 ANTICONVULSANTS - HYDANTOINS *** 30MG CAPSULE *** 30MG CAPSULE *** 00022772 DILANTIN UNK *** 510MG CAPSULE *** 00022780 DILANTIN *** 00022480 DILANTIN *** 00023442 DILANTIN *** 00023442 DILANTIN *** 00023445 DILANTIN *** 00023450 DILANTIN *** 00023450 DILANTIN *** 00023698 DILANTIN INFATABS UNK *** 250MG TABLET *** 00023698 DILANTIN INFATABS UNK *** 28:12.20 ANTICONVULSANTS- *** SUCCINIMIDES *** 50MG CAPSULE *** 00022772 DILANTIN UNK *** 000224401 APO-PHENYTOIN SODIUM APX *** 00022442 DILANTIN *** 00023442 DILANTIN *** 00023442 DILANTIN *** 00023450 DILANTIN *** 00023698 DILANTIN INFATABS UNK *** 250MG TABLET *** 00023698 DILANTIN INFATABS UNK *** 250MG CAPSULE *			
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28:12.08 ANTICONVULSANTS - BENZODIAZEPINES CLOBAZAM ST 10MG TABLET 02244638 APO-CLOBAZAM 02244474 PMS-CLOBAZAM 02238334 TEVA-CLOBAZAM 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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day. ST 25MG TABLET 00022780 DILANTIN 00023442 DILANTIN 00023450 DILANTIN 00023450 DILANTIN 00023698 DILANTIN INFATABS UNK ST 50MG TABLET 00023698 DILANTIN INFATABS UNK 28:12.20 ANTICONVULSANTS- SUCCINIMIDE ST 250MG CAPSULE			HYDANTOINS
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ST 0.25MG TABLET 00022799 ZARONTIN ERF		E I UO 90 VIIMIDE	
00022700 27410111111			ST 250MG CAPSULE
02179660 PMS-CLONAZEPAM PMS	ST 0.25MG TABLET		00022799 ZARONTIN ERF
	02179660 PMS-CLONAZEPAM	PMS	

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28:12.20 ANTICONVULSANTS-SUCCINIMIDES

ETHOSUXIMIDE

ST 50MG/ML SYRUP

00023485 ZARONTIN

ERF

28:12.92 MISCELLANEOUS ANTICONVULSANTS

BRIVARACETAM

Limited use benefit (prior approval required).

For adjunctive therapy in adult patients with refractory partialonset 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; and
- are not receiving concurrent therapy with levetiracetam.

10MG TABLET

02452936	BRIVLERA		UCB
25MG TABL	ET		
02452944	BRIVLERA		UCB
50MG TABL	ET		
02452952	BRIVLERA		UCB
75MG TABL	ET		
02452960	BRIVLERA		UCB
100MG TABLET			
02452979	BRIVLERA		UCB

CARBAMAZEPINE

02261847

02237908

00755583 TEGRETOL

ST 20MG/ML SUSPENSION					
02367394	TARO-CARBAMAZEPINE	TAR			
02194333	TEGRETOL	NVR			
ST 200MG TAB	LET				
00402699	APO CARBAMAZEPINE	APX			
00504742	MAZEPINE	BMI			
02407515	TARO-CARBAMAZEPINE	TAR			
00010405	TEGRETOL	NVR			
00782718	TEVA-CARBAMAZEPINE	TEV			
ST 100MG TAB	LET (CHEWABLE)				
02244403	02244403 TARO-CARBAMAZEPINE TAR				
ST 200MG TAB	LET (CHEWABLE)				
02244404	TARO-CARBAMAZEPINE	TAR			
ST 200MG TAB	LET (EXTENDED RELEASE)				
02238222	DOM-CARBAMAZEPINE	DPC			
02231543	PMS-CARBAMAZEPINE	PMS			
02261839	SANDOZ-CARBAMAZEPINE	SDZ			
02237907	TARO-CARBAMAZEPINE	TAR			
00773611	TEGRETOL	NVR			
ST 400MG TAB	ST 400MG TABLET (EXTENDED RELEASE)				
02238223	DOM-CARBAMAZEPINE	DPC			
02231544	PMS-CARBAMAZEPINE	PMS			

SANDOZ-CARBAMAZEPINE

TARO-CARBAMAZEPINE

28:12.92 MISCELLANEOUS ANTICONVULSANTS

ESLICARBAZEPINE ACETATE

Limited use benefit (prior approval required).

For adjunctive therapy in adult patients with refractory partialonset 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.

200MG TABLET			
02426862	APTIOM	SPC	
ST 400MG TAB	LET		
02426870	APTIOM	SPC	
ST 600MG TABLET			
02426889	APTIOM	SPC	

ST 800MG TABLET

02426897 APTIOM SPC

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 30-day period, for a total daily dose of 4000 mg/day.

The gabapentin dose limit will be further reduced to 3600 mg per day. The new limit will be implemented region-by-region.

100MG CAPSULE

		
02477912	AG-GABAPENTIN	ANG
02244304	APO-GABAPENTIN	APX
02321203	AURO-GABAPENTIN	AUR
02450143	BIO-GABAPENTIN	BMI
02243743	DOM-GABAPENTIN	DPC
02246314	GABAPENTIN	SIV
02353245	GABAPENTIN	SAN
02416840	GABAPENTIN	ACC
02285819	GD-GABAPENTIN	PFI
02361469	JAMP-GABAPENTIN	JMP
02391473	MAR-GABAPENTIN	MAR
02084260	NEURONTIN	UNK
02243446	PMS-GABAPENTIN	PMS
02450097	PRIVA-GABAPENTIN	PHA
02310449	PRO-GABAPENTIN	PDL
02319055	RAN-GABAPENTIN	RBY
02251167	RIVA-GABAPENTIN	RIV
02244513	TEVA-GABAPENTIN	TEV
300MG CAP	SULE	
02477920	AG-GABAPENTIN	ANG
02244305	APO-GABAPENTIN	APX
02321211	AURO-GABAPENTIN	AUR
02450151	BIO-GABAPENTIN	BMI
02243744	DOM-GABAPENTIN	DPC
02246315	GABAPENTIN	SIV
02353253	GABAPENTIN	SAN
02416859	GABAPENTIN	ACC

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SDZ

TAR

NVR

28:12.92 MISCELLANEOUS **ANTICONVULSANTS**

GABAPENTIN

Limited use benefit (prior approval is not required).

02361485 JAMP-GABAPENTIN

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 30-day period, for a total daily dose of 4000 mg/day.

The gabapentin dose limit will be further reduced to 3600 mg per day. The new limit will be implemented region-by-region.

300MG CAPSULE

07 titil	• • • • • • • • • • • • • • • • • • • •
MAR-GABAPENTIN	MAR
NEURONTIN	UNK
PMS-GABAPENTIN	PMS
PRIVA-GABAPENTIN	PHA
PRO-GABAPENTIN	PDL
RAN-GABAPENTIN	RBY
RIVA-GABAPENTIN	RIV
TEVA-GABAPENTIN	TEV
SULE	
AG-GABAPENTIN	ANG
APO-GABAPENTIN	APX
AURO-GABAPENTIN	AUR
BIO-GABAPENTIN	BMI
DOM-GABAPENTIN	DPC
GABAPENTIN	SIV
GABAPENTIN	SAN
GABAPENTIN	ACC
JAMP-GABAPENTIN	JMP
MAR-GABAPENTIN	MAR
NEURONTIN	UNK
PMS-GABAPENTIN	PMS
PRIVA-GABAPENTIN	PHA
PRO-GABAPENTIN	PDL
RAN-GABAPENTIN	RBY
	NEURONTIN PMS-GABAPENTIN PRIVA-GABAPENTIN PRO-GABAPENTIN RAN-GABAPENTIN RIVA-GABAPENTIN TEVA-GABAPENTIN TEVA-GABAPENTIN AG-GABAPENTIN AURO-GABAPENTIN BIO-GABAPENTIN DOM-GABAPENTIN GABAPENTIN GABAPENTIN GABAPENTIN GABAPENTIN GABAPENTIN GABAPENTIN HOABAPENTIN MAR-GABAPENTIN NEURONTIN PMS-GABAPENTIN PRIVA-GABAPENTIN PRIVA-GABAPENTIN

02244515 TEVA-GABAPENTIN ST 600MG TABLET

02428342

02450194

02251183 RIVA-GABAPENTIN

02293358	APO-GABAPENTIN	APX		
02428334	AURO-GABAPENTIN	AUR		
02450186	BIO-GABAPENTIN	BMI		
02388200	GABAPENTIN	SIV		
02392526	GABAPENTIN	ACC		
02431289	GABAPENTIN	SAN		
02285843	GD-GABAPENTIN	PFI		
02402289	JAMP-GABAPENTIN	JMP		
02239717	NEURONTIN	UNK		
02255898	PMS-GABAPENTIN	PMS		
02310473	PRO-GABAPENTIN	PDL		
02259796	RIVA-GABAPENTIN	RIV		
02248457	TEVA-GABAPENTIN	TEV		
800MG TABI	800MG TABLET			
02293366	APO-GABAPENTIN	APX		

AURO-GABAPENTIN

BIO-GABAPENTIN

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 30-day period, for a total daily dose of 4000 mg/day.

The gabapentin dose limit will be further reduced to 3600 mg per day. The new limit will be implemented region-by-region.

ST 800MG TABLET

JMP

RIV

TEV

02388219	GABAPENTIN	SIV		
02392534	GABAPENTIN	ACC		
02431297	GABAPENTIN	SAN		
02402297	JAMP-GABAPENTIN	JMP		
02239718	NEURONTIN	UNK		
02255901	PMS-GABAPENTIN	PMS		
02310481	PRO-GABAPENTIN	PDL		
02259818	RIVA-GABAPENTIN	RIV		
02247346	TEVA-GABAPENTIN	TEV		
ST 600MG TABLET (IMMEDIATE RELEASE)				
02410990	GLN-GABAPENTIN	GLK		
ST 800MG TAB	LET (IMMEDIATE RELEASE)			

GLK

MIN

PMS

SDZ

LACOSAMIDE

Limited use benefit (prior approval required).

02411008 GLN-GABAPENTIN

For adjunctive therapy in adult patients with refractory partialonset 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.

57 50MG TABLET

02490560

02478226

02474697

02475332	AURO-LACOSAMIDE	AUR
02487802	MAR-LACOSAMIDE	MAR
02490544	MINT-LACOSAMIDE	MIN
02478196	PHARMA-LACOSAMIDE	PMS
02474670	SANDOZ LACOSAMIDE	SDZ
02472902	TEVA-LACOSAMIDE	TEV
02357615	VIMPAT	UCB
ST 100MG TAΒ	LET	
02475340	AURO-LACOSAMIDE	AUR
02487810	MAR-LACOSAMIDE	MAR
02490552	MINT-LACOSAMIDE	MIN
02478218	PHARMA-LACOSAMIDE	PMS
02474689	SANDOZ LACOSAMIDE	SDZ
02472910	TEVA-LACOSAMIDE	TEV
02357623	VIMPAT	UCB
ST 150MG TAB	LET	
02475359	AURO-LACOSAMIDE	AUR
02487829	MAR-LACOSAMIDE	MAR

MINT-LACOSAMIDE

PHARMA-LACOSAMIDE

SANDOZ LACOSAMIDE

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AUR

BMI

TEV

TEV

PMS

NPH

PMS

PDL

RBY

28:12.92 MISCELLANEOUS

LAMOTRIGINE

ST 150MG TABLET

LEVETIRACETAM

 $^{\rm ST}$ 250MG TABLET

ANTICONVULSANTS

02248234 TEVA-LAMOTRIGINE

02274183 ACT LEVETIRACETAM

02454688 LEVETIRACETAM

02396122 RAN-LEVETIRACETAM

NAT-LEVETIRACETAM

PMS-LEVETIRACETAM

PRO-LEVETIRACETAM

02440229

02296136

02311399

28:12.92 MISCELLANEOUS ANTICONVULSANTS

LACOSAMIDE

Limited use benefit (prior approval required).

For adjunctive therapy in adult patients with refractory partialonset 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

02302993 LAMOTRIGINE

LAMOTRIGINE

LAMOTRIGINE

MYLAN-LAMOTRIGINE

PMS-LAMOTRIGINE

02343037

02428229

02265516

02246899

 are currently re 	eceiving two or more antiepileptic		02274103	ACTLEVETIRACETAW	I⊏V
medications; and			02285924	APO-LEVETIRACETAM	APX
 have failed or demonstrated intolerance to at least two other antiepileptic medications. 			02375249	AURO-LEVETIRACETAM	AUR
			02450348	BIO-LEVETIRACETAM	BMI
ST 150MG TAB			02403005	JAMP-LEVETIRACETAM	JMP
02472929	TEVA-LACOSAMIDE	TEV	02247027	KEPPRA	UCB
02357631	VIMPAT	UCB	02353342	LEVETIRACETAM	SAN
ST 200MG TAB			02399776	LEVETIRACETAM	ACC
02475367	AURO-LACOSAMIDE	AUR	02442531	LEVETIRACETAM	SIV
02487837	MAR-LACOSAMIDE	MAR	02454653	LEVETIRACETAM	PMS
02490579	MINT-LACOSAMIDE	MIN	02440202	NAT-LEVETIRACETAM	NPH
02478234	PHARMA-LACOSAMIDE	PMS	02296101	PMS-LEVETIRACETAM	PMS
02474700	SANDOZ LACOSAMIDE	SDZ	02311372	PRO-LEVETIRACETAM 250	PDL
02472937	TEVA-LACOSAMIDE	TEV	02396106	RAN-LEVETIRACETAM	RBY
02357658	VIMPAT	UCB	02482274	RIVA-LEVETIRACETAM	RIV
LAMOTRIGII	NE		02461986	SANDOZ LEVETIRACETAM	SDZ
ST 2MG TABLE	:T		ST 500MG TAB	LET	
	LAMICTAL	GSK	02274191	ACT LEVETIRACETAM	TEV
ST 5MG TABLE		OOK	02285932	APO-LEVETIRACETAM	APX
	LAMICTAL	GSK	02375257	AURO-LEVETIRACETAM	AUR
ST 25MG TABL		OOK	02450356	BIO-LEVETIRACETAM	BMI
02245208	APO-LAMOTRIGINE	APX	02297418	DOM-LEVETIRACETAM	DPC
02381354	AURO-LAMOTRIGINE	AUR	02403021	JAMP-LEVETIRACETAM	JMP
02142082	LAMICTAL	GSK	02247028	KEPPRA	UCB
02302969	LAMOTRIGINE	PDL	02353350	LEVETIRACETAM	SAN
02343010	LAMOTRIGINE	SAN	02399784	LEVETIRACETAM	ACC
02428202	LAMOTRIGINE	SIV	02442558	LEVETIRACETAM	SIV
02265494	MYLAN-LAMOTRIGINE	MYL	02454661	LEVETIRACETAM	PMS
02246897	PMS-LAMOTRIGINE	PMS	02440210	NAT-LEVETIRACETAM	NPH
02248232	TEVA-LAMOTRIGINE	TEV	02296128	PMS-LEVETIRACETAM	PMS
ST 100MG TAB		124	02311380	PRO-LEVETIRACETAM	PDL
02245209	APO-LAMOTRIGINE	APX	02396114	RAN-LEVETIRACETAM	RBY
02381362	AURO-LAMOTRIGINE	AUR	02482282	RIVA-LEVETIRACETAM	RIV
02142104	LAMICTAL	GSK	02461994	SANDOZ LEVETIRACETAM	SDZ
02302985	LAMOTRIGINE	PDL	^{S7} 750MG TAB	LET	
02343029	LAMOTRIGINE	SAN	02274205	ACT LEVETIRACETAM	TEV
02428210	LAMOTRIGINE	SIV	02285940	APO-LEVETIRACETAM	APX
02265508	MYLAN-LAMOTRIGINE	MYL	02375265	AURO-LEVETIRACETAM	AUR
02246898	PMS-LAMOTRIGINE	PMS	02450364	BIO-LEVETIRACETAM	BMI
02248233	TEVA-LAMOTRIGINE	TEV	02403048	JAMP-LEVETIRACETAM	JMP
S ^T 150MG TAB			02247029	KEPPRA	UCB
02245210	APO-LAMOTRIGINE	APX	02353369	LEVETIRACETAM	SAN
02381370	AURO-LAMOTRIGINE	AUR	02399792	LEVETIRACETAM	ACC
02142112		GSK	02442566	LEVETIRACETAM	SIV
V2172112	L	331	02454688	I EVETIRACETAM	PMS

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PDL

SAN

SIV

MYL

PMS

28:12.92 MISCELLANEOUS **ANTICONVULSANTS**

LEVETIRACETAM

ST 750MG	TABLET	
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02482290	RIVA-LEVETIRACETAM	RIV
02462001	SANDOZ LEVETIRACETAM	SDZ
PDIN FOR E	XTEMPORANEOUS MIXTURE	
99503026	LEVETIRACETAM ORAL LIQUID	UNK

OXCARBAZEPINE

150MG TABLET

02284294	APO-OXCARBAZEPINE	APX				
02348381	APX-OXCARBAZEPINE	APX				
02440717	JAMP-OXCARBAZEPINE	JMP				
300MG TABLET						
02284308	APO-OXCARBAZEPINE	APX				

02440725 JAMP-OXCARBAZEPINE **JMP** 02242068 TRILEPTAL **NVR 600MG TABLET**

02284316	APO-OXCARBAZEPINE	APX
02348411	APX-OXCARBAZEPINE	APX
02440733	JAMP-OXCARBAZEPINE	JMP
02242069	TRILEPTAL	NVR

OXCARBAZEPINE (SUSPENSION)

Limited use benefit (prior approval is not required).

02348403 APX-OXCARBAZEPINE

For patients 19 years of age or over who are unable to swallow the tablet formulation due to:

- tube feeding; or
- severe dysphagia

Note: Trileptal (oxcarbazepine) suspension is an open benefit for patients 18 years of age and under and does not require prior approval for these patients.

• Oxcarbazepine tablets are an open benefit for patients of all ages and do not require prior approval.

60MG SUSPENSION

02244673 TRILEPTAL **NVR**

PERAMPANEL

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures or primary generalized tonic-clonic (PGTC) 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.

ST 2MG TABLET

02404516	FYCOMPA	1	EIS
ST 4MG TABLE	т		
02404524	FYCOMPA	J	EIS
ST 6MG TABLE	т		
02404532	FYCOMPA		EIS

ST 8MG TABLET

02404540 FYCOMPA

28:12.92 MISCELLANEOUS **ANTICONVULSANTS**

PERAMPANEL

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures or primary generalized tonic-clonic (PGTC) 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.

ST 10MG TABLET

02404559 FYCOMPA EIS ST 12MG TABLET 02404567 FYCOMPA **EIS**

PREGABALIN

APX

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.

02433877 AURO-PREGABALIN 02402564 DOM-PREGABALIN

02435985 JAMP-PREGABALIN

LYRICA

02467305 M-PREGABALIN

02479125 NRA-PREGABALIN

MAR-PREGABALIN

MINT-PREGABALIN

02268426

02417537

02423812

25MG CAPSULE

		
02480727	AG-PREGABALIN	ANG
02394235	APO-PREGABALIN	APX
02433869	AURO-PREGABALIN	AUR
02402556	DOM-PREGABALIN	DPC
02435977	JAMP-PREGABALIN	JMP
02268418	LYRICA	UNK
02417529	MAR-PREGABALIN	MAR
02423804	MINT-PREGABALIN	MIN
02467291	M-PREGABALIN	MAN
02479117	NRA-PREGABALIN	UNK
02359596	PMS-PREGABALIN	PMS
02396483	PREGABALIN	PDL
02403692	PREGABALIN	SIV
02405539	PREGABALIN	SAN
02476304	PREGABALIN	RIV
02377039	RIVA-PREGABALIN	RIV
02390817	SANDOZ PREGABALIN	SDZ
02392801	TARO-PREGABALIN	SUN
02361159	TEVA-PREGABALIN	TEV
50MG CAPS	ULE	
02480735	AG-PREGABALIN	ANG
02394243	APO-PREGABALIN	APX
02433877	AURO-PREGABALIN	AUR

DPC

JMP

UNK

MAR

MIN

MAN

UNK

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EIS

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.

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.

50MG CAPS			150MG CAPSULE		
02359618	PMS-PREGABALIN	PMS	02377063 RIVA-PREGABALIN	RIV	
02396505	PREGABALIN	PDL	02390841 SANDOZ PREGABALIN	SDZ	
02403706	PREGABALIN	SIV	02392844 TARO-PREGABALIN	SUN	
02405547	PREGABALIN	SAN	02361205 TEVA-PREGABALIN	TEV	
02476312	PREGABALIN	RIV	ST 300MG CAPSULE		
02377047	RIVA-PREGABALIN	RIV	02394294 APO-PREGABALIN	APX	
02390825	SANDOZ PREGABALIN	SDZ	02436019 JAMP-PREGABALIN	JMP	
02392828	TARO-PREGABALIN	SUN	02268485 LYRICA	UNK	
02361175	TEVA-PREGABALIN	TEV	02359642 PMS-PREGABALIN	PMS	
75MG CAPS	ULE		02396548 PREGABALIN	PDL	
02480743	AG-PREGABALIN	ANG	02403730 PREGABALIN	SIV	
02394251	APO-PREGABALIN	APX	02405598 PREGABALIN	SAN	
02433885	AURO-PREGABALIN	AUR	02476371 PREGABALIN	RIV	
02402572	DOM-PREGABALIN	DPC	02377071 RIVA-PREGABALIN	RIV	
02435993	JAMP-PREGABALIN	JMP	02390868 SANDOZ PREGABALIN	SDZ	
02268434	LYRICA	UNK	02392860 TARO-PREGABALIN	SUN	
02417545	MAR-PREGABALIN	MAR	02361248 TEVA-PREGABALIN	TEV	
02424185	MINT-PREGABALIN	MIN	RUFINAMIDE		
02467313	M-PREGABALIN	MAN	Limited use benefit (prior approval required).		
02479133	NRA-PREGABALIN	UNK	Zamitod doo bononi (prior approvai roquirod).		
02359626	PMS-PREGABALIN	PMS	For the adjunctive treatment of seizures associated with		
02396513	PREGABALIN	PDL	Lennox-Gastaux syndrome in adults and children 4 years a	nd	
02403714	PREGABALIN	SIV	older when prescribed by a neurologist or experienced specialist. Patient has failed or is intolerant to or has		
02405555	PREGABALIN	SAN	contraindications to at least two adjunctive antiepileptic drugs.		
02476320	PREGABALIN	RIV	ST 100MG TABLET	9-1	
02377055	RIVA-PREGABALIN	RIV	02369613 BANZEL	EIS	
02390833	SANDOZ PREGABALIN	SDZ	ST 200MG TABLET	EIS	
02392836	TARO-PREGABALIN	SUN	02369621 BANZEL	EIS	
02361183	TEVA-PREGABALIN	TEV		EIS	
150MG CAP	SULE		ST 400MG TABLET	FIC	
02480751	AG-PREGABALIN	ANG	02369648 BANZEL	EIS	
02394278	APO-PREGABALIN	APX	TOPIRAMATE		
02433907	AURO-PREGABALIN	AUR	ST 15MG CAPSULE		
02402580	DOM-PREGABALIN	DPC	02239907 TOPAMAX	JSO	
02436000	JAMP-PREGABALIN	JMP	ST 25MG CAPSULE		
02268450	LYRICA	UNK	02239908 TOPAMAX	JSO	
02417561	MAR-PREGABALIN	MAR	ST 25MG TABLET		
02424207	MINT-PREGABALIN	MIN	02351307 ACCEL-TOPIRAMATE	ACP	
02467321	M-PREGABALIN	MAN	02395738 ACH-TOPIRAMATE	ACC	
02479168	NRA-PREGABALIN	UNK	02475936 AG-TOPIRAMATE	ANG	
02359634	PMS-PREGABALIN	PMS	02279614 APO-TOPIRAMATE	APX	
02396521	PREGABALIN	PDL	02345803 AURO-TOPIRAMATE	AUR	
02403722	PREGABALIN	SIV	02271141 DOM-TOPIRAMATE	DPC	
02405563	PREGABALIN	SAN	02287765 GLN-TOPIRAMATE	GLK	
02476347	PREGABALIN	RIV	02435608 JAMP-TOPIRAMATE	JMP	
	*· ·-· ·				

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28:12.92 MISCELLANEOUS ANTICONVULSANTS	28:12.92 MISCELLANEOUS S ANTICONVULSANTS			
TOPIRAMATE		VALPROIC ACID (DIVALPROEX SODIUM)		
ST 25MG TABLET		ST 125MG TABLET (ENTERIC COATED)		
02432099 MAR-TOPIRAMATE	MAR	02239698 APO-DIVALPROEX	APX	
02315645 MINT-TOPIRAMATE	MIN	02400499 DIVALPROEX	SAN	
02263351 MYLAN-TOPIRAMATE	MYL	00596418 EPIVAL	BGP	
02262991 PMS-TOPIRAMATE	PMS	02458926 MYLAN-DIVALPROEX	MYL	
02313650 PRO-TOPIRAMATE	PDL	02244138 PMS-DIVALPROEX	PMS	
02396076 RAN-TOPIRAMATE	RBY	ST 250MG TABLET (ENTERIC COATED)		
02431807 SANDOZ TOPIRAMATE	SDZ	02239699 APO-DIVALPROEX	APX	
02248860 TEVA-TOPIRAMATE	TEV	02400502 DIVALPROEX	SAN	
02230893 TOPAMAX	JSO	00596426 EPIVAL	BGP	
02356856 TOPIRAMATE	SAN	02458934 MYLAN-DIVALPROEX	MYL	
02389460 TOPIRAMATE	SIV	02244139 PMS-DIVALPROEX	PMS	
ST 50MG TABLET	0.17	ST 500MG TABLET (ENTERIC COATED)	1 1110	
02312085 PMS-TOPIRAMATE	PMS	02239700 APO-DIVALPROEX	APX	
ST 100MG TABLET	1 WO	02400510 DIVALPROEX	SAN	
02351315 ACCEL-TOPIRAMATE	ACP	00596434 EPIVAL	BGP	
02395746 ACH-TOPIRAMATE	ACC	02459019 MYLAN-DIVALPROEX	MYL	
02475944 AG-TOPIRAMATE	ANG	02244140 PMS-DIVALPROEX	PMS	
02279630 APO-TOPIRAMATE	APX		I IVIO	
02345838 AURO-TOPIRAMATE	AUR	VALPROIC ACID (SODIUM VALPROATE)		
02271168 DOM-TOPIRAMATE	DPC	S [™] 250MG CAPSULE		
02287773 GLN-TOPIRAMATE	GLK	02238048 APO-VALPROIC	APX	
02435616 JAMP-TOPIRAMATE	JMP	02231030 DOM-VALPROIC ACID	DPC	
	MAR	02230768 PMS-VALPROIC ACID	PMS	
02432102 MAR-TOPIRAMATE	MIN	ST 500MG CAPSULE (ENTERIC COATED)		
02315653 MINT-TOPIRAMATE	MYL	02231031 DOM-VALPROIC ACID	DPC	
02263378 MYLAN-TOPIRAMATE		02229628 PMS-VALPROIC ACID	PMS	
02263009 PMS-TOPIRAMATE	PMS	ST 50MG/ML SOLUTION		
02313669 PRO-TOPIRAMATE	PDL	02238817 DOM-VALPROIC ACID	DPC	
02396084 RAN-TOPIRAMATE	RBY	02236807 PMS-VALPROIC ACID	PMS	
02431815 SANDOZ TOPIRAMATE	SDZ	ST 50MG/ML SYRUP		
02248861 TEVA-TOPIRAMATE	TEV	02238370 APO-VALPROIC	APX	
02230894 TOPAMAX	JSO	00443832 DEPAKENE	BGP	
02356864 TOPIRAMATE	SAN	VIGABATRIN		
02389487 TOPIRAMATE	SIV			
ST 200MG TABLET		ST 500MG POWDER FOR SOLUTION		
02351323 ACCEL-TOPIRAMATE	ACP	02068036 SABRIL	LUK	
02395754 ACH-TOPIRAMATE	ACC	$^{s\tau}$ 500MG TABLET		
02279649 APO-TOPIRAMATE	APX	02065819 SABRIL	LUK	
02345846 AURO-TOPIRAMATE	AUR	28:16.04 ANTIDEPRESSANTS		
02271176 DOM-TOPIRAMATE	DPC	AMITRIPTYLINE HYDROCHLORIDE		
02287781 GLN-TOPIRAMATE	GLK	AWITRIFTTEINETTIDROCTEORIDE		
02435624 JAMP-TOPIRAMATE	JMP	10MG TABLET		
02432110 MAR-TOPIRAMATE	MAR	02477963 AG-AMITRIPTYLINE	ANG	
02315661 MINT-TOPIRAMATE	MIN	00370991 AMITRIPTYLINE	PDL	
02263386 MYLAN-TOPIRAMATE	MYL	02403137 APO-AMITRIPTYLINE	APX	
02263017 PMS-TOPIRAMATE	PMS	00335053 ELAVIL	AAP	
02313677 PRO-TOPIRAMATE	PDL	02435527 JAMP-AMITRIPTYLINE	JMP	
02396092 RAN-TOPIRAMATE	RBY	00293911 LEVATE	BMI	
02431823 SANDOZ TOPIRAMATE	SDZ	02429861 MAR-AMITRIPTYLINE	MAR	
02248862 TEVA-TOPIRAMATE	TEV	00654523 PMS-AMITRIPTYLINE	PMS	
02230896 TOPAMAX	JSO	02490110 PRIVA-AMITRIPTYLINE	PHA	
02356872 TOPIRAMATE	SAN	02326043 TEVA-AMITRIPTYLINE	TEV	
PDIN FOR EXTEMPORANEOUS MIXTURE		25MG TABLET		
99503027 TOPIRAMATE ORAL LIQUID	UNK	02477971 AG-AMITRIPTYLINE	ANG	

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28:16.04 AN	TIDEPRESSANTS		28:16.04 AN	TIDEPRESSANTS	
	INE HYDROCHLORIDE		BUPROPION HYDROCHLORIDE (ZYBAN)		
AWIIIKIPITL	INE HTDROCHLORIDE			•	•
25MG TABL			approval is not re	efit with quantity and frequency lequired)	imits (prior
00371009	AMITRIPTYLINE	PDL	approvario not re	, (a. 100).	
02403145	APO-AMITRIPTYLINE	APX	For smoking ces	sation:	
00335061	ELAVIL	AAP	Coverage is limit	ed to 180 tablets during a one-y	year period
02435535	JAMP-AMITRIPTYLINE	JMP		on the date the first prescription	
02429888	MAR-AMITRIPTYLINE	MAR	this quantity has been reached the client is eligible again for		
	PMS-AMITRIPTYLINE	PMS		ropion hydrochloride when one	
02490129 02326051	PRIVA-AMITRIPTYLINE TEVA-AMITRIPTYLINE	PHA TEV	•	day the initial prescription was	filled.
50MG TABL		IEV		LET (EXTENDED RELEASE)	
02477998	AG-AMITRIPTYLINE	ANG	02238441		VAE
02477998	AMITRIPTYLINE	PDL	CITALOPRA	M HYDROBROMIDE	
	APO-AMITRIPTYLINE	APX	10MG TABL	ET	
	ELAVIL	AAP		AG-CITALOPRAM	ANG
02435543	JAMP-AMITRIPTYLINE	JMP	02448475	BIO-CITALOPRAM	BMI
00271152		BMI	02325047	CITALOPRAM	PDL
02429896	MAR-AMITRIPTYLINE	MAR	02387948	CITALOPRAM	SIV
	PMS-AMITRIPTYLINE	PMS	02430517	CITALOPRAM	JMP
02490137		PHA	02445719	CITALOPRAM	SAN
02326078		TEV	02273055	DOM-CITALOPRAM	DPC
ST 75MG TABL			02370085	JAMP-CITALOPRAM	JMP
02403161	APO-AMITRIPTYLINE	APX	02371871	MAR-CITALOPRAM	MAR
00754129	ELAVIL	AAP	02429691	MINT-CITALOPRAM	MIN
02435551	JAMP-AMITRIPTYLINE	JMP	02409003	NAT-CITALOPRAM	NPH
00405612	LEVATE	BMI	02477637	NRA-CITALOPRAM	UNK
02429918	MAR-AMITRIPTYLINE	MAR	02270609	PMS-CITALOPRAM	PMS
BUPROPION	HYDROCHLORIDE (WE	LLBUTRIN)	02303256	RIVA-CITALOPRAM	RIV
	•	,	02431629	SEPTA-CITALOPRAM	SPT
	LET (EXTENDED RELEASE)	DDI	02312336	TEVA-CITALOPRAM	TEV
	BUPROPION SR BUPROPION SR	PDL SAN	ST 20MG TABL		
	PMS-BUPROPION SR	PMS	02248050	ACT CITALOPRAM	SPC
	SANDOZ BUPROPION SR	SDZ	02339390	AG-CITALOPRAM	ANG
	LET (EXTENDED RELEASE)	SDZ	02246056	APO-CITALOPRAM	APX
02325357		PDL	02275562	AURO-CITALOPRAM	AUR
	BUPROPION SR	SAN	02448491	BIO-CITALOPRAM	BMI
	MYLAN-BUPROPION XL	MYL	02239607		LUD
02313421	PMS-BUPROPION SR	PMS	02257513	CITALOPRAM	PDL
02275082	SANDOZ BUPROPION SR	SDZ	02353660	CITALOPRAM	SAN
02475804	TARO-BUPROPION XL	SUN	02387956	CITALOPRAM	SIV
02439654	TEVA-BUPROPION XL	TEV	02430541	CITALOPRAM	JMP
02237825		VAE	02248942 02313405	DOM-CITALOPRAM JAMP-CITALOPRAM	DPC
	WELLBUTRIN XL	VAE	02371898	MAR-CITALOPRAM	JMP
	LET (EXTENDED RELEASE)		02429705	MINT-CITALOPRAM	MAR MIN
02382083	MYLAN-BUPROPION XL	MYL	02429703	NAT-CITALOPRAM	NPH
02475812	TARO-BUPROPION XL	SUN	02477645	NRA-CITALOPRAM	UNK
02439662	TEVA-BUPROPION XL	TEV	02248010	PMS-CITALOPRAM	PMS
02275104	WELLBUTRIN XL	VAE	02285622	RAN-CITALO	RBY
			02303264	RIVA-CITALOPRAM	RIV
			02248170	SANDOZ CITALOPRAM	SDZ
			02355272		SPT
				TEVA-CITALOPRAM	TEV
			ST 30MG TABL		•
			02296152		SPC

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28:16.04 ANTIDEPRESSANTS		28:16.04 ANTIDEPRESSANTS		
CITALOPRAM HYDROBROMIDE		DOXEPIN HYDROCHLORIDE		
ST 40MG TABLET		ST 75MG CAPSULE		
02248051 ACT CITALOPRAM	SPC	00400750 SINEQUAN	AAP	
02339404 AG-CITALOPRAM	ANG	ST 100MG CAPSULE		
02246057 APO-CITALOPRAM	APX	00326925 SINEQUAN	AAP	
02275570 AURO-CITALOPRAM	AUR	ST 150MG CAPSULE		
02448513 BIO-CITALOPRAM	BMI	02050056 DOXEPIN	APX	
02239608 CELEXA	LUD	DULOXETINE HYDROCHLORIDE		
02257521 CITALOPRAM	PDL			
02353679 CITALOPRAM	SAN	30MG CAPSULE (DELAYED RELEASE)	ANG	
02387964 CITALOPRAM	SIV	02475308 AG-DULOXETINE 02440423 APO-DULOXETINE	ANG	
02430568 CITALOPRAM	JMP	02436647 AURO-DULOXETINE	AUR	
02248943 DOM-CITALOPRAM	DPC	02301482 CYMBALTA	LIL	
02313413 JAMP-CITALOPRAM	JMP	02452650 DULOXETINE	PDL	
02371901 MAR-CITALOPRAM	MAR	02453630 DULOXETINE	SIV	
02429713 MINT-CITALOPRAM	MIN	02490889 DULOXETINE	SAN	
02409038 NAT-CITALOPRAM	NPH	02437082 DULOXETINE DR	TEV	
02477653 NRA-CITALOPRAM	UNK	02451913 JAMP-DULOXETINE	JMP	
02248011 PMS-CITALOPRAM	PMS	02446081 MAR-DULOXETINE	MAR	
02285630 RAN-CITALO	RBY	02473208 M-DULOXETINE	MAN	
02303272 RIVA-CITALOPRAM	RIV	02438984 MINT-DULOXETINE	MIN	
02248171 SANDOZ CITALOPRAM	SDZ	02482126 NRA-DULOXETINE	UNK	
02355280 SEPTA-CITALOPRAM	SPT	02429446 PMS-DULOXETINE	PMS	
02293226 TEVA-CITALOPRAM	TEV	02438259 RAN-DULOXETINE	RBY	
CLOMIPRAMINE HYDROCHLORIDE		02451077 RIVA-DULOXETINE	RIV	
ST 10MG TABLET		02439948 SANDOZ DULOXETINE	SDZ	
00330566 ANAFRANIL	AAP	60MG CAPSULE (DELAYED RELEASE)	052	
ST 25MG TABLET		02475316 AG-DULOXETINE	ANG	
00324019 ANAFRANIL	AAP	02440431 APO-DULOXETINE	APX	
ST 50MG TABLET		02436655 AURO-DULOXETINE	AUR	
00402591 ANAFRANIL	AAP	02301490 CYMBALTA	LIL	
DESIPRAMINE HYDROCHLORIDE		02452669 DULOXETINE	PDL	
		02453649 DULOXETINE	SIV	
ST 10MG TABLET	445	02490897 DULOXETINE	SAN	
02216248 DESIPRAMINE	AAP	02437090 DULOXETINE DR	TEV	
ST 25MG TABLET	445	02451921 JAMP-DULOXETINE	JMP	
02216256 DESIPRAMINE	AAP	02446103 MAR-DULOXETINE	MAR	
ST 50MG TABLET		02473216 M-DULOXETINE	MAN	
02216264 DESIPRAMINE	AAP	02438992 MINT-DULOXETINE	MIN	
01946277 PMS DESIPRAMINE	PMS	02482134 NRA-DULOXETINE	UNK	
ST 75MG TABLET	445	02429454 PMS-DULOXETINE	PMS	
02216272 DESIPRAMINE	AAP	02438267 RAN-DULOXETINE	RBY	
01946242 PMS DESIPRAMINE	PMS	02451085 RIVA-DULOXETINE	RIV	
ST 100MG TABLET	445	02439956 SANDOZ DULOXETINE	SDZ	
02216280 DESIPRAMINE	AAP	ESCITALOPRAM OXALATE		
DOXEPIN HYDROCHLORIDE		ST 10MG TABLET		
ST 10MG CAPSULE		02434652 ACH-ESCITALOPRAM	ACC	
02049996 DOXEPIN	APX	02477742 AG-ESCITALOPRAM	ANG	
00024325 SINEQUAN	AAP	02295016 APO-ESCITALOPRAM	ANG	
ST 25MG CAPSULE		02397358 AURO-ESCITALOPRAM	AUR	
02050005 DOXEPIN	APX	02481154 BIO-ESCITALOPRAM	BMI	
00024333 SINEQUAN	AAP	02263238 CIPRALEX	LUD	
ST 50MG CAPSULE		02303949 ESCITALOPRAM	PMS	
02050013 DOXEPIN	APX	02424401 ESCITALOPRAM	PDL	
00024341 SINEQUAN	AAP	02429039 ESCITALOPRAM	SIV	
		02723003 LOCITALOFINAIVI	317	

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28:16.04 AN	TIDEPRESSANTS		28:16.04 ANTIDEPRESSANTS	S
ESCITALOPE	RAM OXALATE		FLUOXETINE HYDROCHLORID	E
ST 10MG TABL	ET		ST 10MG CAPSULE	
02430118	ESCITALOPRAM	SAN	02448416 PRIVA-FLUOXETINE	PHA
02429780	JAMP-ESCITALOPRAM	JMP	02314991 PRO-FLUOXETINE	PDL
02423480	MAR-ESCITALOPRAM	MAR	02018985 PROZAC	LIL
02471418	M-ESCITALOPRAM	MAN	02405695 RAN-FLUOXETINE	RBY
02407418	MINT-ESCITALOPRAM	MIN	02479486 SANDOZ FLUOXETINI	E SDZ
02309467	MYLAN-ESCITALOPRAM	MYL	02216582 TEVA-FLUOXETINE	TEV
02440296	NAT-ESCITALOPRAM	NPH	ST 20MG CAPSULE	
02476851	NRA-ESCITALOPRAM	UNK	02383241 ACH-FLUOXETINE	ACC
02469243	PHARMA-ESCITALOPRAM	PMS	02242178 ACT FLUOXETINE	REC
02426331	PRIVA-ESCITALOPRAM	PHA	02216361 APO-FLUOXETINE	APX
02385481	RAN-ESCITALOPRAM	RBY	02385635 AURO-FLUOXETINE	AUR
02428830	RIVA-ESCITALOPRAM	RIV	02448432 BIO-FLUOXETINE	BMI
02364077	SANDOZ ESCITALOPRAM	SDZ	02177625 DOM-FLUOXETINE	DPC
02318180	TEVA-ESCITALOPRAM	TEV	02286076 FLUOXETINE	SAN
ST 20MG TABL	ET		02374455 FLUOXETINE	SIV
02434660	ACH-ESCITALOPRAM	ACC	02386402 JAMP-FLUOXETINE	JMP
02477769	AG-ESCITALOPRAM	ANG	02380579 MINT-FLUOXETINE	MIN
02295024	APO-ESCITALOPRAM	APX	02177587 PMS-FLUOXETINE	PMS
02397374	AURO-ESCITALOPRAM	AUR	02448408 PRIVA-FLUOXETINE	PHA
02481170	BIO-ESCITALOPRAM	BMI	02315009 PRO-FLUOXETINE	PDL
02263254	CIPRALEX	LUD	00636622 PROZAC	LIL
02303965	ESCITALOPRAM	PMS	02405709 RAN-FLUOXETINE	RBY
02424428	ESCITALOPRAM	PDL	02305488 RIVA-FLUOXETINE	RIV
02429047	ESCITALOPRAM	SIV	02479494 SANDOZ FLUOXETINI	E SDZ
02430126	ESCITALOPRAM	SAN	02216590 TEVA-FLUOXETINE	TEV
02429799	JAMP-ESCITALOPRAM	JMP	ST 40MG CAPSULE	
02423502	MAR-ESCITALOPRAM	MAR	02464640 PMS-FLUOXETINE	PMS
02407434	MINT-ESCITALOPRAM	MIN	ST 60MG CAPSULE	
02309475	MYLAN-ESCITALOPRAM	MYL	02464659 PMS-FLUOXETINE	PMS
02440318	NAT-ESCITALOPRAM	NPH	ST 4MG/ML SOLUTION	
02476878	NRA-ESCITALOPRAM	UNK	02231328 APO-FLUOXETINE	APX
02469251	PHARMA-ESCITALOPRAM	PMS	20MG SOLUTION	
02426358	PRIVA-ESCITALOPRAM	PHA	02459361 ODAN-FLUOXETINE	ODN
02385503	RAN-ESCITALOPRAM	RBY	FLUVOXAMINE MALEATE	OBIL
02428857	RIVA-ESCITALOPRAM	RIV		
02364085	SANDOZ ESCITALOPRAM	SDZ	^{S7} 50MG TABLET	
	TEVA-ESCITALOPRAM	TEV	02255529 ACT FLUVOXAMINE	ACG
	ET (ORALLY DISINTEGRATING)		02231329 APO-FLUVOXAMINE	APX
	ACT ESCITALOPRAM ODT	TEV	02236753 FLUVOXAMINE	PDL
	ET (ORALLY DISINTEGRATING)		01919342 LUVOX	BGP
	ACT ESCITALOPRAM ODT	TEV	02303345 RIVA-FLUVOX	RIV
	HYDROCHLORIDE	124	$^{s au}$ 100MG TABLET	
			02255537 ACT FLUVOXAMINE	ACG
ST 10MG CAPS	ULE		02231330 APO-FLUVOXAMINE	APX
02393441	ACH-FLUOXETINE	ACC	02236754 FLUVOXAMINE	PDL
02242177	ACT FLUOXETINE	REC	01919369 LUVOX	BGP
02216353	APO-FLUOXETINE	APX	02303361 RIVA-FLUVOX	RIV
02385627	AURO-FLUOXETINE	AUR	IMIPRAMINE HYDROCHLORIDE	E
02448424	BIO-FLUOXETINE	BMI		
02177617	DOM-FLUOXETINE	DPC	ST 10MG TABLET	
02286068	FLUOXETINE	SAN	00360201 IMIPRAMINE	AAP
02374447	FLUOXETINE	SIV	ST 25MG TABLET	=
02401894	JAMP-FLUOXETINE	JMP	00312797 IMIPRAMINE	AAP
02380560	MINT-FLUOXETINE	MIN	ST 50MG TABLET	
02177579	PMS-FLUOXETINE	PMS	00326852 IMIPRAMINE	AAP

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28:16.04 ANT	28:16.04 ANTIDEPRESSANTS			TIDEPRESSANTS	
IMIPRAMINE HYDROCHLORIDE			PAROXETINE HYDROCHLORIDE		
ST 75MG TABLET			ST 10MG TABL	ET	
00644579 I		AAP		AG-PAROXETINE	ANG
MIRTAZAPINE			02240907	APO-PAROXETINE	APX
			02383276	AURO-PAROXETINE	AUR
ST 15MG TABLET		45)/	02444909	BIO-PAROXETINE	BMI
	APO-MIRTAZAPINE	APX	02248447	DOM-PAROXETINE	DPC
	AURO-MIRTAZAPINE	AUR	02368862	JAMP-PAROXETINE	JMP
	MYLAN-MIRTAZAPINE	MYL	02411946	MAR-PAROXETINE	MAR
	PMS-MIRTAZAPINE	PMS	02421372	MINT-PAROXETINE	MIN
	PRO-MIRTAZAPINE	PDL	02467402	M-PAROXETINE	MAN
	SANDOZ MIRTAZAPINE	SDZ	02479753	NRA-PAROXETINE	UNK
ST 30MG TABLET		APX	02248913	PAROXETINE	PDL
	APO-MIRTAZAPINE		02282844	PAROXETINE	SAN
	AURO-MIRTAZAPINE	AUR	02388227	PAROXETINE	SIV
	DOM-MIRTAZAPINE	DPC	02027887	PAXIL	GSK
	MIRTAZAPINE MYLAN-MIRTAZAPINE	SAN MYL	02247750	PMS-PAROXETINE	PMS
		PMS	02444313	PRIVA-PAROXETINE	PHA
	PMS-MIRTAZAPINE PRO-MIRTAZAPINE	PDL	02248559	RIVA-PAROXETINE	RIV
02312766 F		FRS	02248556	TEVA-PAROXETINE	TEV
	SANDOZ MIRTAZAPINE	SDZ	ST 20MG TABL	ET	
	TEVA-MIRTAZAPINE	TEV	02262754	ACT PAROXETINE	ACG
02259354 ST 45MG TABLE 1	. =	ΙΕV	02475545	AG-PAROXETINE	ANG
	APO-MIRTAZAPINE	APX	02240908	APO-PAROXETINE	APX
	AURO-MIRTAZAPINE	AUR	02383284	AURO-PAROXETINE	AUR
	MYLAN-MIRTAZAPINE	MYL	02444917	BIO-PAROXETINE	BMI
	Γ (ORALLY DISINTEGRATING)	IVIIL	02248448	DOM-PAROXETINE	DPC
	AURO-MIRTAZAPINE OD	AUR	02368870	JAMP-PAROXETINE	JMP
	REMERON RD	FRS	02411954	MAR-PAROXETINE	MAR
	(ORALLY DISINTEGRATING)	110	02421380	MINT-PAROXETINE	MIN
	AURO-MIRTAZAPINE OD	AUR		M-PAROXETINE	MAN
	REMERON RD	FRS	02479761		UNK
	(ORALLY DISINTEGRATING)	1110		PAROXETINE	PDL
	AURO-MIRTAZAPINE OD	AUR		PAROXETINE	SAN
	REMERON RD	FRS		PAROXETINE	SIV
MOCLOBEMIC		1110	01940481		GSK
			02247751	PMS-PAROXETINE	PMS
ST 100MG TABLE				PRIVA-PAROXETINE	PHA
	MOCLOBEMIDE	AAP		RIVA-PAROXETINE	RIV
ST 150MG TABLE				TEVA-PAROXETINE	TEV
	MANERIX	VAE	ST 30MG TABL		400
	MOCLOBEMIDE	AAP		ACT PAROXETINE	ACG
	PMS-MOCLOBEMIDE	PMS	02475553		ANG
ST 300MG TABLE			02240909		APX
	MANERIX	VAE		AURO-PAROXETINE	AUR
	MOCLOBEMIDE	AAP	02444925		BMI
02243219 F	PMS-MOCLOBEMIDE	PMS	02248449		DPC
NORTRIPTYLI	NE HYDROCHLORIDE		02368889	JAMP-PAROXETINE	JMP
ST 10MG CAPSU	LE		02411962 02421399		MAR MIN
00015229		AAP			
ST 25MG CAPSU		**	02467429	M-PAROXETINE	MAN
00015237		AAP	02479788		UNK
	HYDROCHLORIDE	**	02248915	PAROXETINE PAROXETINE	PDL
			02282860		SAN SIV
ST 10MG TABLET			02388243		GSK
02262746	ACT PAROXETINE	ACG	01040473	1 / VAIL	JJK

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28:16.04 AN	TIDEPRESSANTS		28:16.04 AN	TIDEPRESSANTS	
	E HYDROCHLORIDE			E HYDROCHLORIDE	
ST 30MG TABLI			100MG CAP		
	PMS-PAROXETINE	PMS		AG-SERTRALINE	ANG
	PRIVA-PAROXETINE	PHA		APO-SERTRALINE	APX
	RIVA-PAROXETINE	RIV		AURO-SERTRALINE	AUR
	TEVA-PAROXETINE	TEV	02445069		BMI
ST 40MG TABLI			02245750		DPC
	PMS-PAROXETINE	PMS	02357178	JAMP-SERTRALINE	JMP
PHENELZINE	SULFATE		02399431		MAR
ST 15MG TABLI	ET		02402408	MINT-SERTRALINE	MIN
00476552	NARDIL	ERF	02488450		UNK
SERTRALINE	HYDROCHLORIDE		02244840 02445387		PMS PHA
OFMO CARO			02374579	RAN-SERTRALINE	RBY
25MG CAPS		4410	02248498		RIV
	AG-SERTRALINE	ANG	02245496		SDZ
02238280	APO-SERTRALINE	APX	02353547		SAN
02390906	AURO-SERTRALINE	AUR	02333347		SIV
02445042	BIO-SERTRALINE	BMI		SERTRALINE	JMP
02245748	DOM-SERTRALINE	DPC		SERTRALINE-100	PDL
02357143	JAMP-SERTRALINE	JMP	02240481		TEV
02399415	MAR-SERTRALINE	MAR	01962779		UNK
02402378 02488434	MINT-SERTRALINE NRA-SERTRALINE	MIN			UNIX
0244838		UNK PMS	TRANTLUTP	ROMINE SULFATE	
	PMS-SERTRALINE		^{sτ} 10MG TABL	ET	
02445352	PRIVA-SERTRALINE	PHA	01919598	PARNATE	GSK
02374552	RAN-SERTRALINE RIVA-SERTRALINE	RBY RIV	TRAZODONE	HYDROCHLORIDE	
02248496 02245159		SDZ	ST 50MG TABL	ET	
02245159	SANDOZ SERTRALINE	SDZ SAN		APO-TRAZODONE	APX
	SERTRALINE	SAN		DOM-TRAZODONE	DPC
02386070	SERTRALINE	JMP		PMS TRAZODONE	PMS
02469626 02241302	SERTRALINE	PDL		TEVA-TRAZODONE	TEV
02241302	SERTRALINE-25 TEVA-SERTRALINE	TEV		TRAZODONE	PDL
02240465		UNK		TRAZODONE	SAN
50MG CAPS		UNK	57 75MG TABL		SAN
02477890	AG-SERTRALINE	ANG		PMS-TRAZODONE	PMS
02238281	APO-SERTRALINE	APX	57 100MG TAB		FIVIS
02390914	AURO-SERTRALINE	AUR		APO-TRAZODONE	APX
02445050	BIO-SERTRALINE	BMI	02128969		DPC
02245749	DOM-SERTRALINE	DPC		PMS TRAZODONE	PMS
02243749	JAMP-SERTRALINE	JMP	02144271		TEV
02399423	MAR-SERTRALINE	MAR	02164361		PDL
02402394	MINT-SERTRALINE	MIN	02348780		SAN
02488442	NRA-SERTRALINE	UNK	ST 150MG TAB		OAN
02244839	PMS-SERTRALINE	PMS		APO-TRAZODONE D	APX
02445360	PRIVA-SERTRALINE	PHA		TEVA-TRAZODONE	TEV
02374560	RAN-SERTRALINE	RBY		TRAZODONE	PDL
02248497	RIVA-SERTRALINE	RIV		TRAZODONE	SAN
02245160	SANDOZ SERTRALINE	SDZ			OAN
02353539	SERTRALINE	SAN	IKIWIPKAWI	NE MALEATE	
02386089	SERTRALINE	SIV	ST 75MG CAPS	ULE	
02469634	SERTRALINE	JMP	02070987	TRIMIPRAMINE	AAP
02241303	SERTRALINE-50	PDL	^{S7} 12.5MG TAE	BLET	
02240484	TEVA-SERTRALINE	TEV	00740799	TRIMIPRAMINE	AAP
01962817		UNK	ST 25MG TABL	ET	
31002017		Oitit	00740802	TRIMIPRAMINE	AAP

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28:16.04 ANTIDEPRESSANTS		28:16 08 AN	TIPSYCHOTIC AGENTS	
TRIMIPRAMINE MALEATE		ARIPIPRAZOLE		
ST 50MG TABLET		ST 2MG TABLE		
00740810 TRIMIPRAMINE	AAP	02322374		OTS
ST 100MG TABLET			APO-ARIPIPRAZOLE	APX
00740829 TRIMIPRAMINE	AAP	02488000		PDL
VENLAFAXINE HYDROCHLORIDE		02460025		PMS
ST 37.5MG CAPSULE (EXTENDED RELEASE)		02466635		PMS
02304317 ACT VENLAFAXINE XR	TEV	02479346		RIV
02331683 APO-VENLAFAXINE XR	APX		SANDOZ ARIPIPRAZOLE	SDZ
02452839 AURO-VENLAFAXINE XR	AUR		TEVA-ARIPIPRAZOLE	TEV
02299291 DOM-VENLAFAXINE XR	DPC	ST 5MG TABLE		OTC
02237279 EFFEXOR XR	UNK	02322382		OTS
02471280 M-VENLAFAXINE XR	MAN		APO-ARIPIPRAZOLE	APX
02278545 PMS-VENLAFAXINE XR	PMS		ARIPIPRAZOLE	PDL
02307774 RIVA-VENLAFAXINE XR	RIV	02460033		PMS
02310317 SANDOZ VENLAFAXINE XR	SDZ	02466643		PMS
02380072 TARO-VENLAFAXINE XR	SUN	02479354		RIV
02275023 TEVA-VENLAFAXINE XR	TEV	02473666		SDZ
02339242 VENLAFAXINE XR	PDL		TEVA-ARIPIPRAZOLE	TEV
02354713 VENLAFAXINE XR	SAN	ST 10MG TABL		OTO
02385929 VENLAFAXINE XR	SIV	02322390		OTS
02489678 VENLAFAXINE XR	RIV		APO-ARIPIPRAZOLE	APX
ST 75MG CAPSULE (EXTENDED RELEASE)		02488027		PDL
02304325 ACT VENLAFAXINE XR	TEV	02460041		PMS
02331691 APO-VENLAFAXINE XR	APX	02466651		PMS
02452847 AURO-VENLAFAXINE XR	AUR	02479362		RIV
02299305 DOM-VENLAFAXINE XR	DPC	02473674		SDZ
02237280 EFFEXOR XR	UNK		TEVA-ARIPIPRAZOLE	TEV
02471299 M-VENLAFAXINE XR	MAN	ST 15MG TABL		0.70
02278553 PMS-VENLAFAXINE XR	PMS	02322404		OTS
02307782 RIVA-VENLAFAXINE XR	RIV		APO-ARIPIPRAZOLE	APX
02310325 SANDOZ VENLAFAXINE XR	SDZ	02488035		PDL
02380080 TARO-VENLAFAXINE XR	SUN	02460068		PMS
02275031 TEVA-VENLAFAXINE XR	TEV	02466678	PMS-ARIPIPRAZOLE	PMS
02339250 VENLAFAXINE XR	PDL	02479370	RIVA-ARIPIPRAZOLE	RIV
02354721 VENLAFAXINE XR	SAN	02473682		SDZ
02385937 VENLAFAXINE XR	SIV	02464179	TEVA-ARIPIPRAZOLE	TEV
02489686 VENLAFAXINE XR	RIV	ST 20MG TABL		0.70
ST 150MG CAPSULE (EXTENDED RELEASE)		02322412		OTS
02304333 ACT VENLAFAXINE XR	TEV		APO-ARIPIPRAZOLE	APX
02331705 APO-VENLAFAXINE XR	APX	02488043		PDL
02452855 AURO-VENLAFAXINE XR	AUR	02460076		PMS
02299313 DOM-VENLAFAXINE XR	DPC	02466686		PMS
02237282 EFFEXOR XR	UNK	02479389	RIVA-ARIPIPRAZOLE	RIV
02471302 M-VENLAFAXINE XR	MAN	02473690	SANDOZ ARIPIPRAZOLE	SDZ
02278561 PMS-VENLAFAXINE XR	PMS		TEVA-ARIPIPRAZOLE	TEV
02307790 RIVA-VENLAFAXINE XR	RIV	ST 30MG TABL		
02310333 SANDOZ VENLAFAXINE XR	SDZ	02322455		OTS
02380099 TARO-VENLAFAXINE XR	SUN		APO-ARIPIPRAZOLE	APX
02275058 TEVA-VENLAFAXINE XR	TEV	02488051	ARIPIPRAZOLE	PDL
02339269 VENLAFAXINE XR	PDL	02460084	AURO-ARIPIPRAZOLE	PMS
02354748 VENLAFAXINE XR	SAN	02466694	PMS-ARIPIPRAZOLE	PMS
02385945 VENLAFAXINE XR	SIV	02479397		RIV
02489694 VENLAFAXINE XR	RIV	02473704	SANDOZ ARIPIPRAZOLE	SDZ
		02464195	TEVA-ARIPIPRAZOLE	TEV

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		Non-insured Health Benefits	-
28:16.08 ANTIPSYCHOTIC AGENTS		28:16.08 ANTIPSYCHOTIC AGENTS	
ARIPIPRAZOLE (MAINTENA)		FLUPENTHIXOL DIHYDROCHLORIDE	
300MG INJECTION	OTC	ST 0.5MG TABLET	_
02420864 ABILIFY MAINTENA	OTS	02156008 FLUANXOL LUI	ט
400MG INJECTION	OTC		_
02420872 ABILIFY MAINTENA	OTS		ט
ASENAPINE MALEATE		FLUPENTIXOL DECANOATE	
Limited use benefit (prior approval required).		20MG/ML SOLUTION	
For the acute treatment of manic or mixed episodes		02156032 FLUANXOL DEPOT LUI	D
associated with bipolar I disorder as either:		100MG/ML SOLUTION	
 monotherapy, after a trial of lithium or divalproex sodium 		02156040 FLUANXOL DEPOT LUI	D
has failed or is contraindicated, and trials of two atypical antipsychotic agents have failed due to intolerance or lack of		FLUPHENAZINE DECANOATE	
response; or		25MG/ML LIQUID	
• co-therapy with lithium or divalproex sodium, after trials of		02091275 PMS-FLUPHENAZINE PM	s
two atypical antipsychotic agents have failed due to		100MG/ML LIQUID	•
intolerance or lack of response.		02241928 PMS-FLUPHENAZINE PM	s
ST 5MG TABLET		FLUPHENAZINE HYDROCHLORIDE	
02374803 SAPHRIS	FRS		
ST 10MG TABLET		st 1MG TABLET	_
02374811 SAPHRIS	FRS	00405345 FLUPHENAZINE AA	Р
BREXPIPRAZOLE		ST 2MG TABLET	_
0.25MG TABLET		00410632 FLUPHENAZINE AA	Р
02461749 REXULTI	OTS	ST 5MG TABLET	_
0.5MG TABLET		00405361 FLUPHENAZINE AA	
02461757 REXULTI	OTS	00726354 PMS FLUPHENAZINE PM:	S
1MG TABLET		HALOPERIDOL	
02461765 REXULTI	OTS	ST 2MG/ML SOLUTION	
2MG TABLET		00759503 PMS-HALOPERIDOL PM:	S
02461773 REXULTI	OTS	5MG/ML SOLUTION	
3MG TABLET		00808652 HALOPERIDOL SD	Z
02461781 REXULTI	OTS	02366010 HALOPERIDOL OMO	G
4MG TABLET		ST 0.5MG TABLET	
02461803 REXULTI	OTS	00396796 APO HALOPERIDOL AP	Χ
CHLORPROMAZINE HYDROCHLORIDE		00363685 TEVA-HALOPERIDOL TE	V
ST 25MG TABLET		ST 1MG TABLET	
00232823 TEVA-CHLORPROMAZINE	TEV	00396818 APO HALOPERIDOL AP.	
ST 50MG TABLET	1	00363677 TEVA-HALOPERIDOL TE	V
00232807 TEVA-CHLORPROMAZINE	TEV	ST 2MG TABLET	
ST 100MG TABLET	1	00363669 TEVA-HALOPERIDOL TE	V
00232831 TEVA-CHLORPROMAZINE	TEV	sr 5MG TABLET	
CLOZAPINE		00363650 TEVA-HALOPERIDOL TE	V
		ST 10MG TABLET	
ST 25MG TABLET		00463698 APO-HALOPERIDOL AP	
02248034 AA-CLOZAPINE	AAP	00713449 TEVA-HALOPERIDOL TE	V
00894737 CLOZARIL	HLS	ST 20MG TABLET	. ,
02247243 GEN-CLOZAPINE	MYL	00768820 TEVA-HALOPERIDOL TE	V
ST 50MG TABLET		HALOPERIDOL DECANOATE	
02458748 AA-CLOZAPINE	AAP	50MG/ML LIQUID	
02305003 GEN-CLOZAPINE ST 100MG TABLET	MYL	02130297 HALOPERIDOL LA SD	Z
	4 A D	02230707 PMS-HALOPERIDOL PM	S
02248035 AA-CLOZAPINE	AAP ui e	100MG/ML LIQUID	
00894745 CLOZARIL	HLS MVI	02130300 HALOPERIDOL LA SD	Z
02247244 GEN-CLOZAPINE ST 200MG TABLET	MYL	02239640 HALOPERIDOL LA OMO	G
02458756 AA-CLOZAPINE	AAP	02230708 PMS-HALOPERIDOL PM	S
02305011 GEN-CLOZAPINE	MYL		
SESSON SER SESENTIAL	/VI I L		_

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28:16.08 ANTIPSYCHOTIC AGENTS		28:16.08 ANTIPSYCHOTIC AGENTS	
LOXAPINE HYDROCHLORIDE		OLANZAPINE	
ST 25MG/ML SOLUTION		^{sτ} 2.5MG TABLET	
02239101 XYLAC	PED	02337126 RIVA-OLANZAPINE	RIV
LOXAPINE SUCCINATE		02310341 SANDOZ OLANZAPINE	SDZ
ST 2.5MG TABLET		02276712 TEVA-OLANZAPINE	TEV
02242868 XYLAC	PED	02229250 ZYPREXA	LIL
ST 5MG TABLET		ST 5MG TABLET	ADV
02239918 DOM-LOXAPINE	DPC	02281805 APO-OLANZAPINE 02417251 JAMP-OLANZAPINE	APX JMP
02230837 XYLAC	PED	02417251 JAMP-OLANZAPINE 02410168 MINT-OLANZAPINE	MIN
ST 10MG TABLET		02311976 OLANZAPINE	PDL
02239919 DOM-LOXAPINE	DPC	02372827 OLANZAPINE	SAN
02230838 XYLAC	PED	02385872 OLANZAPINE	SIV
ST 25MG TABLET		02303159 PMS-OLANZAPINE	PMS
02239920 DOM-LOXAPINE	DPC	02403072 RAN-OLANZAPINE	RBY
02230839 XYLAC	PED	02337134 RIVA-OLANZAPINE	RIV
ST 50MG TABLET		02310368 SANDOZ OLANZAPINE	SDZ
02239921 DOM-LOXAPINE	DPC	02276720 TEVA-OLANZAPINE	TEV
02230840 XYLAC	PED	02229269 ZYPREXA	LIL
LURASIDONE HYDROCHLORIDE		ST 7.5MG TABLET	
Limited use benefit (prior approval required).		02281813 APO-OLANZAPINE	APX
For the treatment of schizophrenia and schizoaffective		02417278 JAMP-OLANZAPINE	JMP
disorders in patients:		02410176 MINT-OLANZAPINE	MIN
• who have intolerance or lack of response to an adequate		02311984 OLANZAPINE	PDL
trial of another antipsychotic agent; or		02372835 OLANZAPINE	SAN
a contraindication to another antipsychotic agent.		02385880 OLANZAPINE	SIV
ST 20MG TABLET		02303167 PMS-OLANZAPINE	PMS
02422050 LATUDA	SPC	02403080 RAN-OLANZAPINE	RBY
ST 40MG TABLET	000	02337142 RIVA-OLANZAPINE	RIV
02387751 LATUDA	SPC	02310376 SANDOZ OLANZAPINE	SDZ
^{sr} 60MG TABLET 02413361 LATUDA	SPC	02276739 TEVA-OLANZAPINE 02229277 ZYPREXA	TEV LIL
ST 80MG TABLET	SPC	ST 10MG TABLET	LIL
02387778 LATUDA	SPC	02281821 APO-OLANZAPINE	APX
ST 120MG TABLET	SFC	02417286 JAMP-OLANZAPINE	JMP
02387786 LATUDA	SPC	02410184 MINT-OLANZAPINE	MIN
METHOTRIMEPRAZINE MALEATE	01 0	02311992 OLANZAPINE	PDL
		02372843 OLANZAPINE	SAN
ST 2MG TABLET		02385899 OLANZAPINE	SIV
02238403 METHOPRAZINE	AAP	02303175 PMS-OLANZAPINE	PMS
ST 5MG TABLET		02403099 RAN-OLANZAPINE	RBY
02238404 METHOPRAZINE	AAP	02337150 RIVA-OLANZAPINE	RIV
ST 25MG TABLET		02310384 SANDOZ OLANZAPINE	SDZ
02238405 METHOPRAZINE	AAP	02276747 TEVA-OLANZAPINE	TEV
ST 50MG TABLET	A A D	02229285 ZYPREXA	LIL
02238406 METHOPRAZINE	AAP	ST 15MG TABLET	
OLANZAPINE		02281848 APO-OLANZAPINE	APX
ST 2.5MG TABLET		02417294 JAMP-OLANZAPINE	JMP
02281791 APO-OLANZAPINE	APX	02410192 MINT-OLANZAPINE	MIN
02417243 JAMP-OLANZAPINE	JMP	02312018 OLANZAPINE	PDL
02410141 MINT-OLANZAPINE	MIN	02372851 OLANZAPINE	SAN
02311968 OLANZAPINE	PDL	02385902 OLANZAPINE	SIV
02372819 OLANZAPINE	SAN	02303183 PMS-OLANZAPINE	PMS
02385864 OLANZAPINE	SIV	02403102 RAN-OLANZAPINE	RBY
02303116 PMS-OLANZAPINE	PMS	02337169 RIVA-OLANZAPINE 02310392 SANDOZ OLANZAPINE	RIV SDZ
02403064 RAN-OLANZAPINE	RBY	02310392 SANDOZ OLANZAPINE	SDZ

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28:16.08 ANTIPSYCHOTIC AGENTS		28:16.08 ANTIPSYCHOTIC AGENTS	
OLANZAPINE		PALIPERIDONE PALMITATE	
		PALIPERIDONE PALMITATE	
ST 15MG TABLET		150MG/1.5ML SUSPENSION (EXTENDED RELEASE)	
02276755 TEVA-OLANZAPINE	TEV	02354241 INVEGA SUSTENNA	JSO
02238850 ZYPREXA	LIL	175MG SUSPENSION (EXTENDED RELEASE)	
ST 20MG TABLET		02455943 INVEGA TRINZA	JSO
02417308 JAMP-OLANZAPINE	JMP	263MG SUSPENSION (EXTENDED RELEASE)	
ST 5MG TABLET (ORALLY DISINTEGRATING)		02455986 INVEGA TRINZA	JSO
02327562 ACT OLANZAPINE ODT	TEV	350MG SUSPENSION (EXTENDED RELEASE)	
02360616 APO-OLANZAPINE ODT	APX	02455994 INVEGA TRINZA	JSO
02448726 AURO-OLANZAPINE ODT	AUR	525MG SUSPENSION (EXTENDED RELEASE)	
02406624 JAMP OLANZAPINE ODT	JMP	02456001 INVEGA TRINZA	JSO
02389088 MAR-OLANZAPINE ODT	MAR	PERICYAZINE	
02436965 MINT-OLANZAPINE ODT	MIN	ST 5MG CAPSULE	
02338645 OLANZAPINE ODT	PDL	01926780 NEULEPTIL	ERF
02343665 OLANZAPINE ODT 02352974 OLANZAPINE ODT	SIV	ST 10MG CAPSULE	
	SAN PMS	01926772 NEULEPTIL	ERF
		ST 20MG CAPSULE	
	RBY SDZ	01926764 NEULEPTIL	ERF
	LIL	ST 10MG/ML DROP	
02243086 ZYPREXA ZYDIS ST 10MG TABLET (ORALLY DISINTEGRATING)	LIL	01926756 NEULEPTIL	ERF
02327570 ACT OLANZAPINE ODT	TEV	PERPHENAZINE	
02360624 APO-OLANZAPINE ODT	APX		
02448734 AURO-OLANZAPINE ODT	AUR	ST 3.2MG/ML LIQUID	
02406632 JAMP OLANZAPINE ODT	JMP	00751898 PMS PERPHENAZINE	PMS
02389096 MAR-OLANZAPINE ODT	MAR	ST 2MG TABLET	
02436973 MINT-OLANZAPINE ODT	MIN	00335134 PERPHENAZINE	AAP
02338653 OLANZAPINE ODT	PDL	ST 4MG TABLET	
02343673 OLANZAPINE ODT	SIV	00335126 PERPHENAZINE	AAP
02352982 OLANZAPINE ODT	SAN	ST 8MG TABLET	
02303205 PMS-OLANZAPINE ODT	PMS	00335118 PERPHENAZINE	AAP
02414104 RAN-OLANZAPINE ODT	RBY	ST 16MG TABLET	4 A D
02327783 SANDOZ OLANZAPINE ODT	SDZ	00335096 PERPHENAZINE 00726206 PMS PERPHENAZINE	AAP
02243087 ZYPREXA ZYDIS	LIL		PMS
ST 15MG TABLET (ORALLY DISINTEGRATING)		PIMOZIDE	
02327589 ACT OLANZAPINE ODT	TEV	ST 2MG TABLET	
02360632 APO-OLANZAPINE ODT	APX	02245432 PIMOZIDE	AAP
02448742 AURO-OLANZAPINE ODT	AUR	ST 4MG TABLET	
02406640 JAMP OLANZAPINE ODT	JMP	02245433 PIMOZIDE	AAP
02389118 MAR-OLANZAPINE ODT	MAR	PIPOTIAZINE PALMITATE	
02436981 MINT-OLANZAPINE ODT	MIN	50MG/ML INJECTION	
02338661 OLANZAPINE ODT	PDL	00894672 PIPORTIL L4	SAC
02343681 OLANZAPINE ODT	SIV		SAC
02352990 OLANZAPINE ODT	SAN	PROCHLORPERAZINE	
02303213 PMS-OLANZAPINE ODT	PMS	10MG SUPPOSITORY	
02414112 RAN-OLANZAPINE ODT	RBY	00753688 PMS-PROCHLORPERAZINE	PMS
02327791 SANDOZ OLANZAPINE ODT	SDZ	00789720 SANDOZ PROCHLORPERAZINE	SDZ
02243088 ZYPREXA ZYDIS	LIL	PROCHLORPERAZINE MALEATE	
PALIPERIDONE PALMITATE		ST 5MG TABLET	
50MG/0.5ML SUSPENSION (EXTENDED RELEASE)		00753661 PMS-PROCHLORPERAZINE	PMS
02354217 INVEGA SUSTENNA	JSO	00886440 PROCHLORAZINE	AAP
75MG/0.75ML SUSPENSION (EXTENDED RELEASE)		ST 10MG TABLET	
02354225 INVEGA SUSTENNA	JSO	00753637 PMS-PROCHLORPERAZINE	PMS
100MG/ML SUSPENSION (EXTENDED RELEASE)	550	00886432 PROCHLORAZINE	AAP
02354233 INVEGA SUSTENNA	JSO		

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28:16.08 ANTIPSYCHOTIC AGENTS 28:16.08 ANTIPSYCHOTIC AGENTS PROCHLORPERAZINE MESYLATE **QUETIAPINE FUMARATE** ST 200MG TABLET **5MG/ML SOLUTION** 00753645 PMS PROCHLORPERAZINE PMS NPH 02439182 NAT-OUFTIAPINE 02296594 **PMS** PMS-OUFTIAPINE **QUETIAPINE FUMARATE** 02317362 **PRO-QUETIAPINE** PDI ST 25MG TABLET 02317923 QUETIAPINE SIV 02316080 **ACT QUETIAPINE** TEV 02353199 **QUETIAPINE** SAN APO-QUETIAPINE **APX** 02313901 02387824 QUETIAPINE ACC 02390205 **AURO-QUETIAPINE AUR** 02397110 **RAN-QUETIAPINE RBY** 02447193 **BIO-QUETIAPINE** BMI 02316722 RIVA-QUETIAPINE RIV DPC 02298996 DOM-QUETIAPINE 02314010 SANDOZ QUETIAPINE SD7 02330415 JAMP-QUETIAPINE **JMP** 02236953 **SEROQUEL** AZC 02399822 MAR-QUETIAPINE MAR 02284278 **TEVA-QUETIAPINE** TEV 02438003 MINT-OUETIAPINE MIN ST 300MG TABLET 02439158 **NAT-QUETIAPINE** NPH 02316129 **ACT QUETIAPINE** TFV 02296551 PMS-OUFTIAPINE **PMS** 02313944 **APO-QUETIAPINE APX** 02447088 PRIVA-QUETIAPINE PHA 02390256 AURO-QUETIAPINE AUR 02317346 **PRO-QUETIAPINE PDL** 02447258 **BIO-QUETIAPINE** BMI 02317893 QUETIAPINE SIV 02299046 DPC DOM-QUETIAPINE 02353164 QUETIAPINE SAN JAMP-QUETIAPINE JMP 02330466 02387794 **QUETIAPINE** ACC 02399857 MAR-QUETIAPINE MAR 02397099 **RAN-QUETIAPINE RBY** 02438054 MINT-QUETIAPINE MIN 02316692 **RIVA-QUETIAPINE** RIV 02439190 NAT-QUETIAPINE NPH 02313995 SANDOZ QUETIAPINE SDZ 02296608 PMS-QUETIAPINE **PMS** 02236951 **SEROQUEL** AZC 02317370 **PRO-QUETIAPINE PDL** 02284235 **TEVA-QUETIAPINE** TEV 02317931 QUETIAPINE SIV ST 50MG TABLET 02353202 **CUFTIAPINE** SAN **PMS-QUETIAPINE** 02361892 **PMS** 02387832 **QUETIAPINE** ACC ST 100MG TABLET 02397129 RAN-QUETIAPINE **RBY ACT QUETIAPINE** 02316099 **TFV** 02316730 RIVA-QUETIAPINE RIV 02313928 **APO-QUETIAPINE** APX 02314029 SANDOZ QUETIAPINE SD7 02390213 AURO-QUETIAPINE **AUR** 02244107 SFROQUEL AZC 02447207 **BIO-QUETIAPINE** BMI 02284286 **TEVA-QUETIAPINE** TEV 02299003 DOM-QUETIAPINE DPC **50MG TABLET (EXTENDED RELEASE)** JAMP-QUETIAPINE 02330423 JMP 02457229 APO-QUETIAPINE XR APX 02399830 MAR-QUETIAPINE MAR 02417359 QUETIAPINE XR SIV 02438011 MINT-QUETIAPINE MIN PDI 02417782 **QUETIAPINE XR** 02439166 **NAT-QUETIAPINE** NPH 02407671 SANDOZ QUETIAPINE XRT SDZ 02296578 **PMS-QUETIAPINE PMS** 02300184 SEROQUEL XR AZC 02317354 PRO-OUFTIAPINE PDI **TEVA-QUETIAPINE XR** TFV 02395444 02317907 **QUETIAPINE** SIV ST 150MG TABLET (EXTENDED RELEASE) 02353172 QUETIAPINE SAN 02457237 APO-QUETIAPINE XR **APX** 02387808 QUETIAPINE ACC SIV 02417367 QUETIAPINE XR 02397102 **RAN-QUETIAPINE RBY** 02417790 QUETIAPINE XR PDL 02316706 **RIVA-QUETIAPINE** RIV 02407698 SANDOZ QUETIAPINE XRT SD7 02314002 SANDOZ QUETIAPINE SDZ 02321513 SFROQUEL XR AZC 02236952 SEROQUEL AZC 02395452 TEVA-QUETIAPINE XR TEV 02284243 **TEVA-QUETIAPINE TEV** ST 200MG TABLET (EXTENDED RELEASE) ST 200MG TABLET 02457245 **APX** APO-QUETIAPINE XR 02316110 TEV **ACT QUETIAPINE** 02417375 QUETIAPINE XR SIV 02313936 **APO-QUETIAPINE APX** 02417804 QUETIAPINE XR **PDL** 02390248 **AURO-QUETIAPINE AUR** 02407701 SANDOZ QUETIAPINE XRT SDZ 02447223 **BIO-QUETIAPINE** BMI 02300192 SFROQUEL XR AZC 02299038 DOM-QUETIAPINE DPC **TEVA-QUETIAPINE XR** 02395460 TEV 02330458 JAMP-QUETIAPINE **JMP 300MG TABLET (EXTENDED RELEASE)** MAR 02399849 MAR-QUETIAPINE APX 02457253 APO-QUETIAPINE XR 02438046 MINT-QUETIAPINE MIN

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28:16.08 AN	TIPSYCHOTIC AGENTS		28:16.08 AN	TIPSYCHOTIC AGENTS	
QUETIAPINE FUMARATE			RISPERIDON	IE	
300MG TABI	LET (EXTENDED RELEASE)		1MG TABLE	т	
	QUETIAPINE XR	SIV	02252023	PMS-RISPERIDONE	PMS
02417812	QUETIAPINE XR	PDL	02312727	PRO-RISPERIDONE	PDL
02407728	SANDOZ QUETIAPINE XRT	SDZ	02328321	RAN-RISPERIDONE	RBY
02300206	SEROQUEL XR	AZC	02356902	RISPERIDONE	SAN
02395479	TEVA-QUETIAPINE XR	TEV	02283581	RIVA-RISPERIDONE	RIV
400MG TABI	LET (EXTENDED RELEASE)		02279800	SANDOZ RISPERIDONE	SDZ
02457261	APO-QUETIAPINE XR	APX	02264196	TEVA-RISPERIDONE	TEV
02417391	QUETIAPINE XR	SIV	2MG TABLE	Т	
02417820	QUETIAPINE XR	PDL	02369117	AG-RISPERIDONE	ANG
	SANDOZ QUETIAPINE XRT	SDZ	02282143	APO-RISPERIDONE	APX
02300214	SEROQUEL XR	AZC	02359553	JAMP-RISPERIDONE	JMP
	TEVA-QUETIAPINE XR	TEV	02371790	MAR-RISPERIDONE	MAR
	ET (IMMEDIATE RELEASE)		02359820	MINT-RISPERIDON	MIN
02475979	AG-QUETIAPINE	ANG	02252031	PMS-RISPERIDONE	PMS
RISPERIDON	E		02312735	PRO-RISPERIDONE	PDL
ST 1MG SOLUT	ION		02328348	RAN-RISPERIDONE	RBY
	JAMP-RISPERIDONE	JMP	02356910		SAN
ST 1MG/ML SO		0.00	02283603		RIV
	APO-RISPERIDONE	APX	02279819		SDZ
	PMS-RISPERIDONE	PMS		TEVA-RISPERIDONE	TEV
02236950	RISPERDAL	JSO	3MG TABLE		
0.25MG TAB				AG-RISPERIDONE	ANG
	AG-RISPERIDONE	ANG	02282151		APX
02282119	APO-RISPERIDONE	APX	02359561	JAMP-RISPERIDONE	JMP
02359529	JAMP-RISPERIDONE	JMP	02371804		MAR
02371766	MAR-RISPERIDONE	MAR	02359839	MINT-RISPERIDON	MIN
02359790	MINT-RISPERIDON	MIN	02252058	PMS-RISPERIDONE	PMS
02252007	PMS-RISPERIDONE	PMS	02312743	PRO-RISPERIDONE	PDL
02312700	PRO-RISPERIDONE	PDL	02328364	RAN-RISPERIDONE	RBY
02328305	RAN-RISPERIDONE	RBY	02356929	RISPERIDONE	SAN
02356880	RISPERIDONE	SAN	02283611		RIV
02283565	RIVA-RISPERIDONE	RIV	02279827		SDZ
02303655	SANDOZ RISPERIDONE	SDZ		TEVA-RISPERIDONE	TEV
02282690	TEVA-RISPERIDONE	TEV	4MG TABLE		4110
0.5MG TABL	ET			AG-RISPERIDONE	ANG
	AG-RISPERIDONE	ANG	02282178	APO-RISPERIDONE	APX
02282127	APO-RISPERIDONE	APX	02359588	JAMP-RISPERIDONE	JMP
02359537	JAMP-RISPERIDONE	JMP	02371812	MAR-RISPERIDONE	MAR
02371774	MAR-RISPERIDONE	MAR	02359847	MINT-RISPERIDON	MIN
02359804	MINT-RISPERIDON	MIN	02252066	PMS-RISPERIDONE	PMS
02252015	PMS-RISPERIDONE	PMS	02312751 02328372	PRO-RISPERIDONE	PDL RBY
02312719	PRO-RISPERIDONE	PDL		RAN-RISPERIDONE	
02328313	RAN-RISPERIDONE	RBY	02356937 02283638	RISPERIDONE RIVA-RISPERIDONE	SAN RIV
02356899	RISPERIDONE	SAN	02279835		SDZ
02283573	RIVA-RISPERIDONE	RIV		TEVA-RISPERIDONE	TEV
02303663	SANDOZ RISPERIDONE	SDZ		ET (ORALLY DISINTEGRATING)	ILV
02264188	TEVA-RISPERIDONE	TEV		MYLAN-RISPERIDONE ODT	MVI
1MG TABLE	т			T (ORALLY DISINTEGRATING)	MYL
02369095	AG-RISPERIDONE	ANG		MYLAN-RISPERIDONE ODT	NAVI
02282135	APO-RISPERIDONE	APX		T (ORALLY DISINTEGRATING)	MYL
02359545	JAMP-RISPERIDONE	JMP		•	N 43/1
02371782	MAR-RISPERIDONE	MAR		MYLAN-RISPERIDONE ODT	MYL
02359812	MINT-RISPERIDON	MIN		T (ORALLY DISINTEGRATING)	N 43/1
			02413515	MYLAN-RISPERIDONE ODT	MYL

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		Non-insured Health Bene	rits
28:16.08 ANTIPSYCHOTIC AGENTS		28:16.08 ANTIPSYCHOTIC AGENTS	
RISPERIDONE		ZUCLOPENTHIXOL DIHYDROCHLORIDE	
ST 4MG TABLET (ORALLY DISINTEGRATING)		ST 25MG TABLET	
02413523 MYLAN-RISPERIDONE ODT	MYL	02230403 CLOPIXOL	LUD
RISPERIDONE (CONSTA)		28:20.04 AMPHETAMINES	
12.5MG INJECTION		AMPHETAMINE, DEXTROAMPHETAMINE	
02298465 RISPERDAL CONSTA	JSO	Limited use benefit (prior approval is not required).	
25MG INJECTION		The NILLID Dragram introduced a deep payarage limit for	
02255707 RISPERDAL CONSTA	JSO	The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal	
ST 37.5MG INJECTION	100	with the potential misuse and abuse of these medications.	
02255723 RISPERDAL CONSTA ST 50MG INJECTION	JSO	The stimulant dose coverage limit is set at 100 mg of methylphenidate equivalents* per day for adults and children.	
02255758 RISPERDAL CONSTA	JSO	This limit is calculated based on the total dose of all	•
THIOPROPERAZINE MESYLATE	300	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.	
ST 10MG TABLET		and adjust the eligible dose little as required.	
01927639 MAJEPTIL	ERF	* To convert to methylphenidate equivalents, 1 mg of	
THIOTHIXENE		methylphenidate, or lisdexamfetamine is equal to 0.5 mg dextroamphetamine	
ST 5MG CAPSULE		·	
00024449 NAVANE	ERF	ST 5MG CAPSULE (EXTENDED RELEASE) 02439239 ACT AMPHETAMINE XR	TEV
TRIFLUOPERAZINE HYDROCHLORIDE		02248808 ADDERALL XR	UNK
ST 1MG TABLET		02445492 APO-AMPHETAMINE XR	APX
00345539 TRIFLUOPERAZINE	AAP	02440369 PMS-AMPHETAMINES XR	PMS
ST 2MG TABLET		02457288 SANDOZ AMPHETAMINE XR	SDZ
00312754 TRIFLUOPERAZINE	AAP	ST 10MG CAPSULE (EXTENDED RELEASE)	
ST 5MG TABLET		02439247 ACT AMPHETAMINE XR	TEV
00312746 TRIFLUOPERAZINE	AAP	02248809 ADDERALL XR	UNK
ST 10MG TABLET		02445506 APO-AMPHETAMINE XR	APX
00326836 TRIFLUOPERAZINE	AAP	02440377 PMS-AMPHETAMINES XR	PMS
ST 20MG TABLET		02457296 SANDOZ AMPHETAMINE XR	SDZ
00595942 TRIFLUOPERAZINE	AAP	ST 15MG CAPSULE (EXTENDED RELEASE)	TE\ /
ZIPRASIDONE HYDROCHLORIDE		02439255 ACT AMPHETAMINE XR 02248810 ADDERALL XR	TEV UNK
MONOHYDRATE		02246510 ADDERALE XX 02445514 APO-AMPHETAMINE XR	APX
ST 20MG CAPSULE		02440385 PMS-AMPHETAMINES XR	PMS
02449544 AURO-ZIPRASIDONE	AUR	02457318 SANDOZ AMPHETAMINE XR	SDZ
02298597 ZELDOX	UNK	ST 20MG CAPSULE (EXTENDED RELEASE)	
ST 40MG CAPSULE	AUR	02439263 ACT AMPHETAMINE XR	TEV
02449552 AURO-ZIPRASIDONE 02298600 ZELDOX	UNK	02248811 ADDERALL XR	UNK
ST 60MG CAPSULE	OIVIX	02445522 APO-AMPHETAMINE XR	APX
02449560 AURO-ZIPRASIDONE	AUR	02440393 PMS-AMPHETAMINES XR	PMS
02298619 ZELDOX	UNK	02457326 SANDOZ AMPHETAMINE XR	SDZ
ST 80MG CAPSULE		ST 25MG CAPSULE (EXTENDED RELEASE)	TC) (
02449579 AURO-ZIPRASIDONE	AUR	02439271 ACT AMPHETAMINE XR	TEV
02298627 ZELDOX	UNK	02248812 ADDERALL XR 02445530 APO-AMPHETAMINE XR	UNK APX
ZUCLOPENTHIXOL ACETATE		02440407 PMS-AMPHETAMINES XR	PMS
50MG/ML SOLUTION		02457334 SANDOZ AMPHETAMINE XR	SDZ
02230405 CLOPIXOL-ACUPHASE	LUD	ST 30MG CAPSULE (EXTENDED RELEASE)	
ZUCLOPENTHIXOL DIHYDROCHLORIDE		02439298 ACT AMPHETAMINE XR	TEV
		02248813 ADDERALL XR	UNK
200MG/ML SOLUTION	LUD	02445549 APO-AMPHETAMINE XR	APX
02230406 CLOPIXOL DEPOT ST 10MG TABLET	LUD	02440415 PMS-AMPHETAMINES XR	PMS
02230402 CLOPIXOL	LUD	02457342 SANDOZ AMPHETAMINE XR	SDZ
02200702 OLOT INOL	LOD		

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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 100 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

ST 10MG CAPS	ULE (SUSTAINED RELEASE)				
02448319	ACT DEXTROAMPHETAMINE SR	TEV			
01924559	DEXEDRINE SPANSULE	PAL			
ST 15MG CAPS	ULE (SUSTAINED RELEASE)				
02448327	ACT DEXTROAMPHETAMINE SR	TEV			
01924567	DEXEDRINE SPANSULE	PAL			
ST 5MG TABLET					
01924516	DEXEDRINE	PAL			
02443236	DEXTROAMPHETAMINE	AAP			

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 100 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

ST 10MG CAPSULE				
02439603	VYVANSE		SHI	
ST 20MG CAPS	ULE			
02347156	VYVANSE		SHI	
ST 30MG CAPS	ULE			
02322951	VYVANSE		SHI	
ST 40MG CAPS	ULE			
02347164	VYVANSE		SHI	
50MG CAPS	ULE			
02322978	VYVANSE		SHI	
ST 60MG CAPS	ULE			
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 100 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

ST 5MG TABLE	т	
02273950	APO-METHYLPHENIDATE	APX
	PMS-METHYLPHENIDATE	PMS
ST 10MG TABL	ET	
02249324	APO-METHYLPHENIDATE	APX
00584991	PMS-METHYLPHENIDATE	PMS
ST 20MG TABL	ET	
02249332	APO-METHYLPHENIDATE	APX
00585009	PMS-METHYLPHENIDATE	PMS
ST 18MG TABL	ET (EXTENDED RELEASE)	
02441934	ACT METHYLPHENIDATE ER	TEV
02452731	APO-METHYLPHENIDATE ER	APX
02247732	CONCERTA	JSO
02315068	TEVA-METHYLPHENIDATE	TEV
ST 20MG TABL	ET (EXTENDED RELEASE)	
02266687	APO-METHYLPHENIDATE SR	APX
02320312	SANDOZ METHYLPHENIDATE SR	SDZ
ST 27MG TABL	ET (EXTENDED RELEASE)	
02441942	ACT METHYLPHENIDATE ER	TEV
02452758	APO-METHYLPHENIDATE ER	APX
02250241	CONCERTA	JSO
02315076	TEVA-METHYLPHENIDATE	TEV
ST 36MG TABL	ET (EXTENDED RELEASE)	
02441950	ACT METHYLPHENIDATE ER	TEV
02452766	APO-METHYLPHENIDATE ER	APX
02247733	CONCERTA	JSO
02315084	TEVA-METHYLPHENIDATE	TEV
ST 54MG TABL	ET (EXTENDED RELEASE)	
02441969	ACT METHYLPHENIDATE ER	TEV
02330377	APO-METHYLPHENIDATE ER	APX
02247734	CONCERTA	JSO
02315092	TEVA-METHYLPHENIDATE	TEV
8.20 80 W	KEFUL NESS-PROMOTING	

28:20.80 WAKEFULNESS-PROMOTING AGENTS

MODAFINIL

ST 100MG TABLET					
02239665	ALERTEC	TEV			
02285398	APO-MODAFINIL	APX			
02430487	AURO-MODAFINIL	AUR			
02442078	BIO-MODAFINIL	BMI			
02432560	MAR-MODAFINIL	MAR			
02420260	TEVA-MODAFINIL	TEV			

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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

00178810 PHENOBARB

MDS

PED

28:24.04 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BARBITURATES

PHENOBARBITAL

 15MG TABLET

 00178799 PHENOBARB
 PED

 30MG TABLET

 00178802 PHENOBARB
 PED

 60MG TABLET

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 0.25MG TABLET

0.200		
01908189	ALPRAZOLAM	PDL
02349191	ALPRAZOLAM	SAN
00865397	APO-ALPRAZ	APX
01913484	TEVA-ALPRAZOLAM	TEV
00548359	XANAX	UNK
ST 0.5MG TABL	ET .	
01908170	ALPRAZOLAM	PDL
02349205	ALPRAZOLAM	SAN
00865400	APO-ALPRAZ	APX
01913492	TEVA-ALPRAZOLAM	TEV
00548367	XANAX	UNK
ST 1MG TABLE	Т	
02248706	ALPRAZOLAM	PDL
02243611	APO-ALPRAZ	APX
00723770	XANAX	UNK
ST 2MG TABLE	Т	
02243612	APO-ALPRAZ	APX
00813958	XANAX TS	UNK

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 1.5MG TABLET

02177153	APO-BROMAZEPAM	APX
ST 3MG TABLE	T	
02177161	APO-BROMAZEPAM	APX
02230584	TEVA-BROMAZEPAM	TEV
$^{\it ST}$ 6MG TABLE	T	
02177188	APO-BROMAZEPAM	APX
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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

$^{\rm ST}$ 1MG/ML SOLUTION

00891797	PMS-DIAZEPAM	PMS
ST 2MG TABLE	Т	
00405329	DIAZEPAM	AAP
02247490	PMS-DIAZEPAM	PMS
ST 5MG TABLE	Т	
00313580	DIAZEPAM	PDL
00362158	DIAZEPAM	AAP
02247491	PMS-DIAZEPAM	PMS
00013285	VALIUM	HLR
ST 10MG TABLET		
00405337	DIAZEPAM	AAP
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 30 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. 3,000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 5MG/ML GEL

02238162	DIASTAT	VAE
09853340	DIASTAT 2X10MG RECTAL PACK	ELN

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28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

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 30 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. 3,000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 5MG/ML GEL

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 0.5MG TABLET

00655740	APO-I ORAZEPAM	APX
02041413	ATIVAN	PFI
02041456	ATIVAN SUBLINGUAL	PFI
02351072	LORAZEPAM	SAN
02410745	LORAZEPAM SUBLINGUAL	AAP
00728187	PMS-LORAZEPAM	PMS
00655643	PRO-LORAZEPAM	PDL
00711101	TEVA-LORAZEPAM	TEV
ST 1MG TABLE	*	
00655759		APX
02041421		PFI
02041464		PFI
02351080	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SAN
02410753		AAP
00728195	PMS-LORAZEPAM	PMS
00655651		PDI
00637742	TEVA-LORAZEPAM	TFV
ST 2MG TABLE		
00655767	APO-I ORAZEPAM	APX
02041448	• 20.0	PFI
0_0	ATIVAN SUBI INGUAI	PFI
02351099	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SAN
02410761	LORAZEPAM SUBLINGUAL	AAP
00728209	PMS-LORAZEPAM	PMS
00655678	PRO-LORAZEPAM	PDL
00637750	TEVA-I ORAZEPAM	TEV
00031130	ILVA LONAZLI AW	1 L V

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 5MG TABLET

00511528	MOGADON	A	ΑP
10MG TABL	ET		
00511536	MOGADON	Д	ΑP

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 10MG TABLET

00402680	APO OXAZEPAM	APX
00497754	OXAZEPAM	PDL
00414247	OXPAM	BMI
00568392	RIVA OXAZEPAM	RIV
ST 15MG TABL		14.7
		ADV
00402745	APO OXAZEPAM	APX
00497762	OXAZEPAM	PDL
00568406	RIVA OXAZEPAM	RIV
ST 30MG TABL	ET	
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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 15MG CAPSULE

20MC CARSIII E			
	02230095	TEVA-TEMAZEPAM	TEV
	02229760	TEMAZEPAM	PDL
	02225964	TEMAZEPAM	APX
	00604453	RESTORIL	AAP

ST 30MG CAPSULE

00604461	RESTORIL	AAP
02225972	TEMAZEPAM	APX

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28:24.08 ANXIOLYTICS, SEDATIVES AND **HYPNOTICS - BENZODIAZEPINES**

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 30MG CAPSULE

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 0.25MG TABLET

ST 10MG TABLET

AAP 00808571 TRIAZOLAM

28:24.92 MISCELLANEOUS ANXIOLYTICS, SEDATIVES, AND HYPNOTICS

BUSPIRONE HYDROCHLORIDE

	- •	
02211076	APO-BUSPIRONE	APX
02223163	BUSPIRONE	PDL
02447851	BUSPIRONE	SAN
02230942	PMS-BUSPIRONE	PMS
02231492	TEVA-BUSPIRONE	TEV

HYDROXYZINE HYDROCHLORIDE

31 10MG CAPSULE			
00646059	HYDROXYZINE	APX	
00738824	NOVO-HYDROXYZIN	TEV	
ST 25MG CAPSULE			
00646024	HYDROXYZINE	APX	
00738832	NOVO-HYDROXYZIN	TEV	

00646016	HYDROXYZINE	APX
00738840	NOVO-HYDROXYZIN	TEV
ST 2MG/ML SYI	RUP	
00024694	ATARAX	ERF

28:28.00 ANTIMANIC AGENTS **LITHIUM CARBONATE**

00741817 PMS HYDROXYZINE

ST 150MG CAPSULE

57 50MG CAPSULE

02242837	APO-LITHIUM CARBONATE	APX
09857532	APO-LITHIUM CARBONATE	APX
00461733	CARBOLITH	BSH

28:28.00 ANTIMANIC AGENTS LITHIUM CARBONATE

ST 150MG CAPSULE			
02013231	LITHANE	ERF	
02216132	PMS-LITHIUM CARBONATE	PMS	
ST 300MG CAP	SULE		
02242838	APO-LITHIUM CARBONATE	APX	
09857540	APO-LITHIUM CARBONATE	APX	
00236683	CARBOLITH	BSH	
00406775	LITHANE	ERF	
02216140	PMS-LITHIUM CARBONATE	PMS	
ST 600MG CAP	SULE		
02011239	CARBOLITH	BSH	
02216159	PMS-LITHIUM CARBONATE	PMS	
ST 300MG TAB	LET (EXTENDED RELEASE)		
02266695	LITHMAX	AAP	
LITHIUM CITRATE			
ST 60MG/ML SYRUP			
02074834	PMS-LITHIUM CITRATE	PMS	

28:32.28 SELECTIVE SEROTONIN **AGONISTS**

ALMOTRIPTAN MALATE

Limited use benefit (prior approval is not required).

A total of 12 tablets are permitted in a 30-day period.

6.25MG TAB	LET	
02405792	APO-ALMOTRIPTAN	APX
02248128	AXERT	MCL
02398435	MYLAN-ALMOTRIPTAN	MYL
12.5MG TAB	LET	
02424029	ALMOTRIPTAN	PDL
02466821	ALMOTRIPTAN	SAN
02405806	APO-ALMOTRIPTAN	APX
02248129	AXERT	MCL
02398443	MYLAN-ALMOTRIPTAN	MYL

SDZ

TEV

02434849 TEVA-ALMOTRIPTAN NARATRIPTAN HYDROCHLORIDE

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

02405334 SANDOZ ALMOTRIPTAN

1MG TABLE	T	
02237820	AMERGE	GSK
02314290	TEVA-NARATRIPTAN	TEV
2.5MG TABL	.ET	
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 are permitted in a 30-day period.

5MG TABLET				
02393468	APO-RIZATRIPTAN	APX		
02380455	JAMP-RIZATRIPTAN	JMP		
02429233	JAMP-RIZATRIPTAN IR	JMP		

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PMS

28:32.28 SELECTIVE SEROTONIN **AGONISTS**

RIZATRIPTAN BENZOATE

Limited use benefit (prior approval is not required).

A total of 12 tablets are permitted in a 30-day period

5MG TABLET 02379651 MAR-RIZATRIPTAN MAR **10MG TABLET** 02381702 ACT RIZATRIPTAN TEV 02393476 APO-RIZATRIPTAN APX 02441144 AURO-RIZATRIPTAN **AUR** 02380463 JAMP-RIZATRIPTAN **JMP** JAMP-RIZATRIPTAN IR 02429241 **JMP** 02379678 MAR-RIZATRIPTAN MAR 02240521 MAXALT **FRS 5MG TABLET (ORALLY DISINTEGRATING)** 02483270 ACCEL-RIZATRIPTAN ODT ACP 02393484 APO-RIZATRIPTAN RPD **APX** 02465086 JAMP-RIZATRIPTAN ODT **JMP** 02462788 MAR-RIZATRIPTAN ODT MAR 02240518 MAXALT RPD **FRS** 02379198 MYLAN-RIZATRIPTAN ODT MYL 02436604 NAT-RIZATRIPTAN ODT NPH 02393360 PMS-RIZATRIPTAN RDT **PMS** 02442906 RIZATRIPTAN ODT SAN **RIZATRIPTAN ODT** SIV 02446111 PDL 02415798 RIZATRIPTAN RDT 02351870 SANDOZ RIZATRIPTAN ODT SDZ 02396661 TEVA-RIZATRIPTAN ODT TEV 10MG TABLET (ORALLY DISINTEGRATING) 02483289 ACCEL-RIZATRIPTAN ODT ACP 02393492 APO-RIZATRIPTAN RPD **APX** 02396203 DOM-RIZATRIPTAN RDT DPC 02465094 JAMP-RIZATRIPTAN ODT **JMP** 02462796 MAR-RIZATRIPTAN ODT MAR 02240519 MAXALT RPD **FRS** 02379201 MYLAN-RIZATRIPTAN ODT MYL 02436612 NAT-RIZATRIPTAN ODT NPH 02489384 NRA-RIZATRIPTAN ODT UNK 02393379 PMS-RIZATRIPTAN RDT **PMS** 02442914 RIZATRIPTAN ODT SAN 02446138 RIZATRIPTAN ODT SIV 02415801 RIZATRIPTAN RDT PDL 02351889 SANDOZ RIZATRIPTAN ODT SDZ

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.		
6MG/0.5ML	INJECTION	
99000598	IMITREX STAT DOSE KIT	GSI
12MG/ML S	OLUTION	
02212188	IMITREX	GSI
02361698	TARO-SUMATRIPTAN	TAI
25MG TABL	ET	
02270749	DOM-SUMATRIPTAN	DP
02268906	MYLAN-SUMATRIPTAN	MY
02256428	PMS-SUMATRIPTAN	PM:
02286815	TEVA-SUMATRIPTAN DF	TE
50MG TABL	ET	
02268388	APO-SUMATRIPTAN	AP.
02270757	DOM-SUMATRIPTAN	DP
02212153	IMITREX DF	GS
02268914	MYLAN-SUMATRIPTAN	MY
02256436	PMS-SUMATRIPTAN	PM
02263025	SANDOZ SUMATRIPTAN	SD
02286521	SUMATRIPTAN	SA
02324652	SUMATRIPTAN	PD
02385570	SUMATRIPTAN DF	SI
02286823	TEVA-SUMATRIPTAN DF	TE
100MG TAB	LET	
02257904	ACT SUMATRIPTAN	TE
02268396	APO-SUMATRIPTAN	AP
02270765	DOM-SUMATRIPTAN	DP
02212161	IMITREX DF	GS
02268922	MYLAN-SUMATRIPTAN	MY
02256444	PMS-SUMATRIPTAN	PM
02263033	SANDOZ SUMATRIPTAN	SD
02286548	SUMATRIPTAN	SA
02324660	SUMATRIPTAN	PD
02385589	SUMATRIPTAN DF	SI
02239367	TEVA-SUMATRIPTAN	TE
02286831	TEVA-SUMATRIPTAN DF	TE
ZOLMITRIPT	AN	
_imited use bene	efit (prior approval is not required).	
A total of 12 table	ets are permitted in a 30-day period.	
2.5MG SPR	AY	
02248992	ZOMIG	AZ

02396688 TEVA-RIZATRIPTAN ODT TEV SUM

UMATRIPTAN HEMISULFATE		02248992	ZOMIG	AZC
5MG SPRAY		5MG SPRAY	•	
02230418 IMITREX	GSK	02248993	ZOMIG	AZC
20MG SPRAY	OOK	2.5MG TABL	_ET	
02230420 IMITREX	GSK	02389525	DOM-ZOLMITRIPTAN	DPC
02230420 IIVIITILX	OSIK	02477106	JAMP ZOLMITRIPTAN	JMP
		02421623	JAMP-ZOLMITRIPTAN	JMP
		02399458	MAR-ZOLMITRIPTAN	MAR
		02419521	MINT-ZOLMITRIPTAN	MIN
		02421534	NAT-ZOLMITRIPTAN	NPH
		02324229	PMS-ZOLMITRIPTAN	PMS

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28:32.28 SELECTIVE SEROTONIN 28:36.08 ANTIPARKINSONIAN AGENTS - AGONISTS ANTICHOLINERGIC AGENTS			
ZOLMITRIPTAN		TRIHEXYPHENIDYL HYDROCHLORIDE	
Limited use benefit (prior approval is not required).		0.4MG/ML ELIXIR	
		*******	PMS
A total of 12 tablets are permitted in a 30-day period.		2MG TABLET	
2.5MG TABLET	007	00545058 TRIHEXYPHENIDYL	AAP
02362988 SANDOZ ZOLMITRIPTAN	SDZ	5MG TABLET	
02313960 TEVA-ZOLMITRIPTAN 02379929 ZOLMITRIPTAN	TEV PDL	00545074 TRIHEXYPHENIDYL	AAP
02238660 ZOMIG	AZC	28:36.12 ANTIPARKINSONIAN AGENTS -	
2.5MG TABLET (ORALLY DISINTEGRATING)	7.20	CATECHOL-O-	
02438453 AG-ZOLMITRIPTAN ODT	ANG	METHYLTRANSFERASE (COMT)	
02381575 APO-ZOLMITRIPTAN RAPID	APX	INHIBITORS	
02428237 JAMP-ZOLMITRIPTAN ODT	JMP	ENTACAPONE	
02324768 PMS-ZOLMITRIPTAN ODT	PMS		
02362996 SANDOZ ZOLMITRIPTAN ODT	SDZ	ST 200MG TABLET	
02428474 SEPTA-ZOLMITRIPTAN-ODT	SPT		NVR
02342545 TEVA-ZOLMITRIPTAN OD	TEV		SDZ TEV
02379988 ZOLMITRIPTAN ODT	PDL		ı L v
02442671 ZOLMITRIPTAN ODT	SAN	28:36.16 ANTIPARKINSONIAN AGENTS -	
02243045 ZOMIG RAPIMELT	AZC	DOPAMINE PRECURSORS	
28:32.92 MISCELLANEOUS ANTIMIGR	ANE	LEVODOPA, BENSERAZIDE HYDROCHLORIDE	
AGENTS		ST 50MG & 12.5MG CAPSULE	
FLUNARIZINE HYDROCHLORIDE		00522597 PROLOPA I	HLR
ST 5MG CAPSULE		ST 100MG & 25MG CAPSULE	
02246082 FLUNARIZINE	AAP	00386464 PROLOPA I	HLR
PIZOTIFEN MALATE		ST 200MG & 50MG CAPSULE	
0.5MG TABLET			HLR
00329320 SANDOMIGRAN	PAL	LEVODOPA, CARBIDOPA	
1MG TABLET	I AL	ST 100MG & 10MG TABLET	
00511552 SANDOMIGRAN DS	PAL	02195933 APO-LEVOCARB	APX
28:36.08 ANTIPARKINSONIAN AGENT	S -	02457954 MINT-LEVOCARB	MIN
ANTICHOLINERGIC AGENTS	_	02244494 TEVA-LEVOCARBIDOPA	TEV
		ST 100MG & 25MG TABLET	
BENZTROPINE MESYLATE			APX
1MG/ML LIQUID			MIN
02238903 BENZTROPINE OMEGA	OMG		PMS
ST 1MG TABLET			PDL
00706531 PDP-BENZTROPINE	PED		FRS TEV
ST 2MG TABLET	555	ST 250MG & 25MG TABLET	I L V
00426857 PDP-BENZTROPINE	PED		APX
00587265 PMS-BENZTROPINE	PMS		MIN
ETHOPROPAZINE HYDROCHLORIDE			FRS
50MG TABLET		02244496 TEVA-LEVOCARBIDOPA	TEV
01927744 PARSITAN	ERF	ST 100MG & 25MG TABLET (EXTENDED RELEASE)	
PROCYCLIDINE HYDROCHLORIDE		02272873 AA-LEVOCARB	APX
0.5MG/ML ELIXIR		$^{\rm s au}$ 200MG & 50MG TABLET (EXTENDED RELEASE)	
00587362 PDP-PROCYCLIDINE	PED		APX
2.5MG TABLET		02421496 PMS-LEVOCARB F	PMS
00649392 PDP-PROCYCLIDINE	PED		
5MG TABLET			
00587354 PDP-PROCYCLIDINE	PED		

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28:36.16 ANTIPARKINSONIAN AGENTS DOPAMINE PRECURSORS

LEVODOPA, CARBIDOPA (CARBIDOPA MONOHYDRATE)

Limited use benefit (prior approval required).

Initial coverage criteria (12 months):

For the treatment of patients with advanced levodoparesponsive Parkinson's disease; and

- patient has severe disability associated with at least 25% of the waking day in the off state*; and/or
- patient has ongoing, bothersome levodopa-induced dyskinesias, despite having tried frequent dosing of levodopa (at least five doses per day); and
- patient has failed an adequate trial of adjunctive medications if not contraindicated or contrary to judgement of prescriber; and
- patient is able to administer the medication and care for the administration port and infusion pump. Or alternatively, trained personnel or a care partner must be available to perform these tasks reliably; and
- patient does not have a contraindication to the insertion of a percutaneous endoscopic gastrostomy-jejunostomy (PEG-J tube); and
- patient does not have severe psychosis or dementia.
- * Time in the off state, frequency of motor fluctuations, and severity of associated disability should be assessed by a movement disorder subspecialist and be based on an adequate and reliable account from longitudinal specialist care, clinical interview of a patient and/or care partner, or motor symptom diary.

Criteria for renewal or for initial NIHB coverage in patients currently maintained on Duodopa (12 months):

- patient continues to demonstrate a significant reduction in the time spent in the off state; and/or
- patient has had a decrease in bothersome levodopainduced dyskinesias.

20MG & 5MG GEL

02292165 DUODOPA ABV

LEVODOPA, CARBIDOPA, ENTACAPONE

ST 50MG & 12.	5MG & 200M	G TABLET	
02305933	STALEVO		NVR
ST 75MG & 18.	75MG & 200N	IG TABLET	
02337827	STALEVO		NVR
ST 100MG & 25	MG & 200MG	TABLET	
02305941	STALEVO		NVR
ST 125MG & 31	.25MG & 200	MG TABLET	
02337835	STALEVO		NVR
ST 150MG & 37	.5MG & 200N	IG TABLET	
02305968	STALEVO		NVR

28:36.20 ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR AGONISTS

APOMORPHINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the acute, intermittent treatment of hypomobility "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) in patients with advanced Parkinson's disease (PD):

and

Patient is under the care of a physician with experience in the diagnosis and management of PD;

and

ST

Apomorphine (Movapo) is being used as adjunctive therapy in patients who are receiving optimized PD therapy (levodopa and derivatives and dopaminergic agonists) and still experiencing "off" episodes.

10MG SOLUTION

02459132 MOVAPO PAL

BROMOCRIPTINE MESYLATE

5T 5MG CAPSULE

BROMOCRIPTINE	AAP
DOM-BROMOCRIPTINE	DPC
PMS-BROMOCRIPTINE	PMS
.ET	
BROMOCRIPTINE	AAP
DOM-BROMOCRIPTINE	DPC
	DOM-BROMOCRIPTINE PMS-BROMOCRIPTINE ET BROMOCRIPTINE

PMS

AUR

CABERGOLINE

Limited use benefit (prior approval required).

02231702 PMS-BROMOCRIPTINE

For treatment of hyperprolactinemia in patients who have failed therapy with or are intolerant to bromocriptine.

0.5MG TABLET

02455897	APO-CABERGOLINE	APX
02242471	DOSTINEX	PFI

PRAMIPEXOLE DIHYDROCHLORIDE

02424096 AURO-PRAMIPEXOLE

ST 0.25MG TABLET

02297302	ACT PRAMIPEXOLE	TEV
02292378	APO-PRAMIPEXOLE	APX
02424061	AURO-PRAMIPEXOLE	AUR
02237145	MIRAPEX	BOE
09857268	MIRAPEX (ON)	BOE
02309122	PRAMIPEXOLE	SIV
02325802	PRAMIPEXOLE	PDL
02315262	SANDOZ PRAMIPEXOLE	SDZ
ST 0.5MG TABL	.ET	
02297310	ACT PRAMIPEXOLE	TEV
02292386	APO-PRAMIPEXOLE	APX
02424088	AURO-PRAMIPEXOLE	AUR
02309130	PRAMIPEXOLE	SIV
02325810	PRAMIPEXOLE	PDL
02315270	SANDOZ PRAMIPEXOLE	SDZ
ST 1MG TABLE	т	
02297329	ACT PRAMIPEXOLE	TEV
02292394	APO-PRAMIPEXOLE	APX

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DC	ITIPARKINSONIAN AGENTS - PAMINE RECEPTOR GONISTS		M	NTIPARKINSONIAN AGENT ONOAMINE OXIDASE B HIBITORS	'S -
PRAMIPEXO	LE DIHYDROCHLORIDE		SELEGILINE	HYDROCHLORIDE	
ST 1MG TABLE	T .		ST 5MG TABLE	=T	
	PRAMIPEXOLE	SIV		APO-SELEGILINE	APX
	PRAMIPEXOLE	PDL		TEVA-SELEGILINE	TEV
	SANDOZ PRAMIPEXOLE	SDZ		SCELLANEOUS CENTRAL	
ST 1.5MG TABL					
	ACT PRAMIPEXOLE	TEV		ERVOUS SYSTEM AGENTS	1
02292408	APO-PRAMIPEXOLE	APX	ACAMPROS	ATE CALCIUM	
02424118	AURO-PRAMIPEXOLE	AUR	Limited use ben	efit (prior approval required).	
02309157	PRAMIPEXOLE	SIV	For nationts who	o have been abstinent from alcohol for a	at loast
02325837	PRAMIPEXOLE	PDL		here available, are currently enrolled in	
02315297	SANDOZ PRAMIPEXOLE	SDZ		n treatment program.	
ROPINIROLE	HYDROCHLORIDE			BLET (DELAYED RELEASE)	
ST 0.25MG TAE	BLET			CAMPRAL	MYL
02337746	APO-ROPINIROLE	APX	ATOMOXET	INE HYDROCHLORIDE	
02352338	JAMP-ROPINIROLE	JMP	Limited use ben	efit (prior approval required).	
02326590	PMS-ROPINIROLE	PMS		at of mationts with Attacking Deficit	
	RAN-ROPINIROLE	RBY		nt of patients with Attention Deficit sorder (ADHD) who meet one of the foll	lowing
	ROPINIROLE	SAN	criteria:	oorder (ABAB) who most one or the fell	og
02316846		TEV		erance to methylphenidate or amphetar	nine; or
ST 1MG TABLE		45)/		on to stimulant medication; or of stimulant misuse or diversion; or	
	APO-ROPINIROLE	APX		recommended by a pediatrician or a	
02352346	JAMP-ROPINIROLE	JMP	psychiatrist.	, ,	
	PMS-ROPINIROLE	PMS	10MG CAPS	SULE	
	RAN-ROPINIROLE ROPINIROLE	RBY SAN	02318024	APO-ATOMOXETINE	APX
02316854	TEVA-ROPINIROLE	TEV	02358190	ATOMOXETINE	AAP
ST 2MG TABLE		ILV	02396904	ATOMOXETINE	PDL
02337770	APO-ROPINIROLE	APX	02445883	ATOMOXETINE	SIV
02352354	JAMP-ROPINIROLE	JMP	02467747		SAN
	PMS-ROPINIROLE	PMS	02471485	AURO-ATOMOXETINE	AUR
02314061	RAN-ROPINIROLE	RBY	02390469		DPC
	TEVA-ROPINIROLE	TEV	02381028		PMS
ST 5MG TABLE	т		02405962		RIV
02337800	APO-ROPINIROLE	APX	02386410		SDZ
02352362	JAMP-ROPINIROLE	JMP	02262800		LIL
02326639	PMS-ROPINIROLE	PMS	02314541		TEV
02314088	RAN-ROPINIROLE	RBY	18MG CAPS		A DV
02316870	TEVA-ROPINIROLE	TEV	02318032	APO-ATOMOXETINE ATOMOXETINE	APX AAP
ROTIGOTINE	∃		02396912		PDL
Limited use bene	efit (prior approval required).		02390912		SIV
	. ,		02467755		SAN
	levodopa for the treatment of patients with		02471493		AUR
	Parkinson's disease; and tly receiving treatment with levodopa.		02390477		DPC
2MG PATCH	, ,		02381036		PMS
	NEUPRO	UCB	02405970	RIVA-ATOMOXETINE	RIV
4MG PATCH		OOD	02386429	SANDOZ ATOMOXETINE	SDZ
	NEUPRO	UCB	02262819	STRATTERA	LIL
6MG PATCH			02314568	TEVA-ATOMOXETINE	TEV
02403935	NEUPRO	UCB	25MG CAPS	SULE	
8MG PATCH			02318040	APO-ATOMOXETINE	APX
02403943	NEUPRO	UCB	02358212	ATOMOXETINE	AAP
			02396920	ATOMOXETINE	PDL

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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

02362511

TEVA-ATOMOXETINE

- potential risk of stimulant misuse or diversion; or
- prescribed or recommended by a pediatrician or a psychiatrist.

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.

osychiatrist.			psychiatrist.		
25MG CAPS	BULE		100MG CAPSULE		
02445913	ATOMOXETINE	SIV	02318083 APO-ATOM	OXETINE	APX
02467763	ATOMOXETINE	SAN	02358255 ATOMOXET	ΓINE	AAP
02471507	AURO-ATOMOXETINE	AUR	02467828 ATOMOXET	ΓINE	SAN
02390485	DOM-ATOMOXETINE	DPC	02404672 PMS-ATOM	OXETINE	PMS
02381044	PMS-ATOMOXETINE	PMS	02422832 RIVA-ATOM	OXETINE	RIV
02405989	RIVA-ATOMOXETINE	RIV	02386488 SANDOZ A	TOMOXETINE	SDZ
02386437	SANDOZ ATOMOXETINE	SDZ	02279355 STRATTER	Α	LIL
02262827	STRATTERA	LIL	02362538 TEVA-ATOM	MOXETINE	TEV
02314576	TEVA-ATOMOXETINE	TEV	BETAHISTINE HYDRO	CHLORIDE	
40MG CAPS	SULE		OMC TABLET		
02318059	APO-ATOMOXETINE	APX	8MG TABLET 02449145 AURO-BETA	ALUCTINE	AUR
02358220	ATOMOXETINE	AAP			
02396939	ATOMOXETINE	PDL	02280183 TEVA-BETA	AHISTINE	TEV
02445948	ATOMOXETINE	SIV	16MG TABLET	ALHOTINE	ALID
02467771	ATOMOXETINE	SAN	02449153 AURO-BETA		AUR
02471515	AURO-ATOMOXETINE	AUR	02466449 BETAHISTI		SAN
02390493	DOM-ATOMOXETINE	DPC	02330210 PMS-BETAI	115 I INE	PMS
02381052	PMS-ATOMOXETINE	PMS	02243878 SERC	AL HOTING	BGP TEV
02405997	RIVA-ATOMOXETINE	RIV	02280191 TEVA-BETA	AHISTINE	IEV
02386445	SANDOZ ATOMOXETINE	SDZ	24MG TABLET	ALUCTINE	ALID
02262835	STRATTERA	LIL	02449161 AURO-BETA		AUR
02314584	TEVA-ATOMOXETINE	TEV	02466457 BETAHISTI		SAN
60MG CAPS	BULE		02330237 PMS-BETAI	115 I INE	PMS
02318067	APO-ATOMOXETINE	APX	02247998 SERC 02280205 TEVA-BETA	AL HOTING	BGP TEV
02358239	ATOMOXETINE	AAP			ΙΕV
02396947	ATOMOXETINE	PDL	DIMETHYL FUMARATE	1	
02445956	ATOMOXETINE	SIV	Limited use benefit (prior appre	oval required).	
02467798	ATOMOXETINE	SAN	As a first line thereny for the tr	contmont of rolonoing re	mitting
02471523	AURO-ATOMOXETINE	AUR	As a first-line therapy for the tr multiple sclerosis (RRMS) diag	anosed according to the	2017
02390515	DOM-ATOMOXETINE	DPC	McDonald clinical criteria and		
02381060	PMS-ATOMOXETINE	PMS	(MRI) evidence, when prescrib	ed by a neurologist	
02406004	RIVA-ATOMOXETINE	RIV	experienced in the manageme	nt of RRMS.	
02386453	SANDOZ ATOMOXETINE	SDZ	And for patients who meet all of	of the following criteria:	
02262843	STRATTERA	LIL	 patient has had a clinical relation 		
02314592	TEVA-ATOMOXETINE	TEV	the last two years; and		
80MG CAPS	SULE		patient is fully ambulatory for		ds; and
02318075	APO-ATOMOXETINE	APX	• patient is 18 years of age or		
02358247	ATOMOXETINE	AAP	120MG CAPSULE (DELA		
02467801	ATOMOXETINE	SAN	02404508 TECFIDERA		UNK
02471531	AURO-ATOMOXETINE	AUR	240MG CAPSULE (DELA	•	
02404664	PMS-ATOMOXETINE	PMS	02420201 TECFIDER	4	UNK
02422824	RIVA-ATOMOXETINE	RIV	TETRABENAZINE		
02386461	SANDOZ ATOMOXETINE	SDZ	25MG TABLET		
02279347	STRATTERA	LIL	02407590 APO-TETRA	ABENAZINE	APX

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TEV

28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

TETRABENAZINE

25MG TABLET

02199270NITOMANVAE02402424PMS-TETRABENAZINEPMS02410338TETRABENAZINERAX

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32:00 CONTRACEPTIVES (NON-ORAL)

32:00.00 CONTRACEPTIVES (NON-ORAL)

CONDOM

99400527	CONDOM, LATEX, LUBRICATED	UNK
99400486	CONDOM, LATEX, NON- LUBRICATED	UNK
99400786	CONDOM, NON-LATEX, LUBRICATED	UNK
09991648	FC2 FEMALE CONDOMS	UNK

CONTRACEPTIVE

DEVICE

09991647 TODAY SPONGE VAGINAL UNK CONTRACEPTIVE

09991646 VCF VAGINAL CONTRACEPTIVE UNK

FILM

FOAM

09991645 VCF FOAM VAGINAL UNK CONTRACEPTIVE

CONTRACEPTIVE DEVICE

DEVICE

00970905 CAYA CONTOURED DIAPHRAGM TSN

FEMCAP

DEVICE

09991642 CERVICAL UNK

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

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36:00 DIAGNOSTIC AGENTS (DX) 36:00.00 DIAGNOSTIC AGENTS (DX) **COAGULATION MONITORS**

Limited use benefit (prior approval required).

For monitoring the international normalized ratio (INR) in patients who require long-term oral anticoagulation. client has difficulty accessing laboratory-based INR testing.

Coverage is limited to 1 meter every 2 years.

ROD 97499983 COAGUCHEK INRANGE METER 97499986 COAGUCHEK XS KIT ROD

COAGULATION TEST

Limited use benefit (prior approval required).

For monitoring the international normalized ratio (INR) in patients who require long-term oral anticoagulation. · client has difficulty accessing laboratory-based INR testing.

STRIP

97499988	COAGUCHEK XS PT STRIPS 24	ROD
97499987	COAGUCHEK XS PT STRIPS 48	ROD
97499989	COAGUCHEK XS PT STRIPS 6	ROD

LANCET

Limited use benefit (prior approval not required).

The number of lancets that will be covered by the NIHB Program will depend on the client's medical treatment:

- clients managing diabetes with insulin will be allowed 800 lancets per 100 days.
- clients managing diabetes with high risk of causing hypoglycemia will be allowed 400 lancets per 365 days.
- · clients managing diabetes medication with low risk of causing hypoglycemia will be allowed 200 lancets per 365
- clients managing diabetes through diet/lifestyle therapy only (no insulin or anti-diabetes medications) will be allowed 200 lancets per 365 days.

Please note that the test strip limit is 800/100 days. Due to lancet pack sizes, 800 per 100 days will be reimbursed.

LANCET

97499991 COAGUCHEK LANCETS ROD

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 800 test strips per 100 days. A client can test up to eight 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.
- non-diabetic clients with rare conditions leading to symptomatic hypo or hyperglycemia will be allowed 800 test strips per 100 days.

STRIP		
09857563	ACCU-CHEK GUIDE (ON)	ROD
97799177	ACCU-CHEK GUIDE (SK)	ROD
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	
	ACCU-CHEK MOBILE BG	ROD
97799497	ACCU-CHEK MOBILE CASSETT	ROD
ACCUTREN	D STRIP	
09853162	ACCUTREND	ROD
97799959	ACCUTREND	ROD
ASCENSIA E	BREEZE 2 STRIP	
97799748	ASCENSIA BREEZE 2	BAY
09857293	BREEZE 2 BG (ON)	BAY
ASCENSIA (CONTOUR STRIP	
97799702	ASCENCIA CONTOUR	BAY
09857127	CONTOUR BG (ON)	BAY
BG STAR ST	TRIP	
97799465	BG STAR	SAC
CONTOUR N	IEXT 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	
	FREESTYLE LITE	ABB
09857297	FREESTYLE LITE (ON)	ABB

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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 800 test strips per 100 days. A client can test up to eight 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.
- non-diabetic clients with rare conditions leading to symptomatic hypo or hyperglycemia will be allowed 800 test strips per 100 days.

FREESTYLE PRECISION STRIP

97799346	FREESTYLE PRECISION	ABB
	FREESTYLE PRECISION (ON)	ABB
GE200 STRI	, ,	, 1,55
97799373	GE200	AUC
	GE200 (ON)	AUC
ITEST STRIF	,	,
09857348	ITEST	AUC
97799692	ITEST	AUC
MEDI+SURE	STRIP	
97799403	MEDI+SURE	MEC
09857432	MEDI+SURE (ON)	MEC
NOVA MAX		
09857313	NOVA MAX	NCA
ONE TOUCH	I ULTRA STRIP	
09854290	ONE TOUCH ULTRA	JAJ
97799985	ONE TOUCH ULTRA	JAJ
ONE TOUCH	I VERIO STRIP	
97799475	ONETOUCH VERIO	JAJ
09857392	ONETOUCH VERIO (ON)	JAJ
PRECISION	XTRA STRIP	
09854070	PRECISION XTRA	ABB
97799840	PRECISION XTRA	AUC
SIDEKICK S	TRIP	
97799601	SIDEKICK	HOD
SPIRIT STRI	P	
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
TRUETRACE		
	TRUE TRACK	AUC
97799602	TRUE TRACK	HOD

36:60.00 DX - THYROID FUNCTION THYROTROPIN ALFA

0.9MG/ML POWDER FOR SOLUTION

02246016 THYROGEN GEE

36:88.00 DX - URINE AND FECES CONTENTS

URINE TEST STRIP

STRIP

97799914 DIASTIX BAY 97799913 KETOSTIX BAY

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40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:08.00 ALKALINIZING AGENTS CITRIC ACID. SODIUM CITRATE

66.8MG & 100MG/ML SOLUTION

PMS 00721344 DICITRATE

POTASSIUM CITRATE

1080MG TABLET

UNK 02243768 KCITRA 10

SODIUM BICARBONATE

325MG TABLET

00481912 XENEX SODIUM BICARBONATE XEN

40:10.00 AMMONIA DETOXICANTS **LACTULOSE**

667MG SOLUTION

02469391	PMS-LACTULOSE-PHARMA	PMS
667MG/ML S	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

40:10.20

BENRALIZUMAB

Limited use benefit (prior approval required).

Initial coverage criteria (12 months):

For the adjunctive treatment of severe eosinophilic asthma in adults who are inadequately controlled with high-dose inhaled corticosteroids* plus one or more additional asthma controller(s) (e.g. long-acting beta-agonist); and

- patient has had a blood eosinophil count of ≥0.15x109/L before initiation of benralizumab; and
- patient is receiving maintenance treatment with oral corticosteroids (at a dose equivalent to ≥5mg prednisone per day) prior to starting benralizumab;
- patient has had a blood eosinophil count of ≥0.3x109/L within the 12-month period prior to starting benralizumab; and
- patient has experienced two or more clinically significant asthma exacerbations** within the 12-month period prior to starting benralizumab;
- and

- a baseline assessment of asthma symptom control using a validated asthma control questionnaire has been completed prior to the initiation of benralizumab; and
- patient is managed by a physician with expertise in the treatment of asthma.

Coverage for benralizumab is provided for a maximum dose of 30 mg administered subcutaneously once every 4 weeks for the first 3 doses, then once every 8 weeks thereafter. Fasenra will not be funded as a dual therapy with another biologic for the treatment of asthma.

Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period). Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Criteria for renewal or for initial NIHB coverage in patients currently maintained on Fasenra (12 months):

- patient has not experienced an increase in clinically significant asthma exacerbations** with benralizumab treatment; and
- for patients receiving maintenance oral corticosteroids, patient's oral corticosteroid maintenance dose has decreased from the pre-treatment dose. After the first 12 months. subsequent oral corticosteroid dose should be maintained; and
- the 12-month asthma control questionnaire score has improved from baseline, where baseline represents the initiation of treatment. After the first 12 months, subsequent scores should be maintained.
- * High-dose inhaled corticosteroid is defined as ≥ 500mcg of fluticasone propionate or equivalent daily.
- ** A clinically significant asthma exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized.

30MG SOLUTION

02473232 FASENRA

AZC

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40:12.00 RE	PLACEMENT PREPARATIO	NS	40:12.00 RE	PLACEMENT PREPARATION	IS
CALCIUM			CALCIUM, V	ITAMIN D	
ST 500MG CAPI	LET		ST 500MG& 800	DIU LIQUID	
80001408	OYSTER SHELL CALCIUM	NUR	80025722	JAMP CALCIUM	JMP
80001122	PHARMA-CAL	PED		LACTOGLUCONATE VITAMIN D	
ST 5ML LIQUID			500MG & 1,0	000IU TABLET	
80004123	CARBOCAL	EUR		CALCIUM 500 VITAMINE D1000	UNK
ST 20MG/ML LIC	QUID		80018540	JAMP CALCIUM CARBONATE	JMP
80054754	M-CAL	MAN	80019536	VITAMIN D	MAN
80002626	SOLUCAL	JMP	sτ 500MG & 40		IVIAIN
	WAMPOLE MINERAL CALCIUM	WAM		CALCITE 500 D 400	RIV
ST 100MG LIQU				CALCIUM 500 D 400	TRI
80043628		ODN		CALCIUM 500 VITAMINE D400	UNK
	SOLUCAL GREEN APPLE	JMP		CALCIUM 500 VITAMINE D400	UNK
	SOLUCAL RASPBERRY	JMP	80002623		JMP
ST 100MG ORA				FLAVOUR	
80034595	WAMPOLE CALCIUM FOR CHILDREN	PED	80009628	CALODAN D 400	ODN
ST 500MG TABL	* : ::== : :=: :		02245511	CARBOCAL D	EUR
80017732	== =	PDL	80002901	CARBOCAL D	EUR
	CALCIUM	PMT	99100832	JAMP-CALCIUM + VITAMIN D	JMP
02246040	CALCIUM	JMP	80002122		JMP
80003658	CALCIUM	WNP	80025360	J-CAL+D	JMP
80076097	CALCIUM	UNK	80013329		MAN
80003773	CALCIUM 500	TRI	80002703		ODN
80062015	CALCIUM CARBONATE	SAN	80020974		OPU
	EUROCAL	EUR	80065914		RIV
80055526	M-CAL	MAN		WAMPOLE CALCIUM VITAMIN D	WAM
00618098	NU-CAL	ODN	ST 500MG & 80		
00622443	O-CALCIUM	VTH		M CALCIUM VITAMINE D	MAN
80079608	PROCAL 500	PDL		000IU TABLET (CHEWABLE)	11.40
00705373	WAMPOLE CALCIUM	WAM	80029083	JAMP CALCIUM CITRATE VITAMIN D	JMP
02239356	WAMPOLE CALCIUM	WAM	80027787	JAMP-CALCIUM VITAMIN D	JMP
ST 500MG TABL	LET (CHEWABLE)		80050701		MAN
80027026	JAMP-CALCIUM CARBONATE	JMP		0IU TABLET (CHEWABLE)	
	LET (FILM COATED)			CALCIUM CARBONATE VITAMINE D	MAN
	BIOCALCIUM	BMI		0IU TABLET (CHEWABLE)	
CALCIUM GL	.UCONATE,VIT D			WAMPOLE CALCIUM AND D	WAM
ST 25MCG LIQU	IID		500MG & 40	0IU TABLET (FILM COATED)	
	SOLUCAL D FORT CITRUS	JMP	80066647	BIOCALCIUMD	BMI
	SOLUCAL D FORT GREEN APPLE	JMP	ELECTROLY	TES	
CALCIUM, VI	TAMIN D		s⊺ 5G/L LIQUID		
ST 10MG CAPLI	ET		80074173	PEDIALYTE	ABB
	PROCALD 400	PDL	ST MISCELLAN	IEOUS	
ST 500MG & 400	DIU CAPLET		80023410	HYDRALYTE ELECTROLYTE	HYD
80012594	BIOCALD FORTE	BMI	ST 3.56G & 300	MG & 470MG & 530MG POWDER	
ST 500MG LIQU	ID		01931563	GASTROLYTE REGULAR	SAC
80025543	SOLUCAL D CITRUS	JMP	ST POWDER FO	OR SOLUTION	
80025541	SOLUCAL D RASPBERRY	JMP	80026860	HYDRALYTE ELECTROLYTE	HYD
ST 500MG & 1,0	00IU LIQUID		80027403	JAMP REHYDRALYTE	JMP
80025038	SOLUCAL D FORT	JMP	ST 0.856MG/ML	SOLUTION	
ST 500MG & 400	DIU LIQUID			HYDRALYTE ELECTROLYTE	HYD
80061575	CALCITE LIQUIDE D 400	RIV		MG & 2.2MG & 0.9MG/ML SOLUTION	
80054755	M-CAL D	MAN		PEDIALYTE	ABB
80008126	SOLUCAL D	JMP	02219883	PEDIATRIC ELECTROLYTE	PMS

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### 40112.00 REPLACEMENT PREPARATIONS MAGNESIUM ### 28MG CAPLET 80005079 MAGNESIUM COMPLEX 30M1590 JAMP-MAGNESIUM JMP **20MG LOUGH MAGNESIUM GLUCONATE **20MG TABLET **30MG TAB			Non-insured health ben	ents
### CAPLET 10MEQ TABLET 3MM	40:12.00 REPLACEMENT PREPARATION	NS	40:12.00 REPLACEMENT PREPARATION	IS
25MG CAPLET	MAGNESIUM			
80009679 MAGRESIUM COMPLEX JAM 8002837 JAMPRCITEATE JAMP 20041590 JAMP-AMAGNESIUM JAMP 80028332 MK 10 MAN 2028400 MAGNESIUM GLUCOHEPTONATE 8002832 MK 10 MAN 2028957 MAGNESIUM JAMP 8002897 MAGNESIUM JAMP 8003897 MAGNESIUM JAMP 8003897 MAGNESIUM JAMP 8003897 MAGNESIUM JAMP 8003897 MAGNESIUM JAMP 80011428 EURO K EUR 80011428 EURO K EUR 80011428 EURO K EUR 80011428 EURO K EUR 8001140 MAGNESIUM-ODAN ODN 80004109 MAGNESIUM-ODAN ODN 80002409 MAGNESIUM-ODAN ODN 90728034 SODIUM CHLORIDE IG MMDS 9002829 SODIUM CHLORIDE IG 9002829 SODIUM CHLORIDE IG MMDS 9002829 SODIUM CHLORIDE IG 9002829 SODIUM CHLORIDE I	MACINEGIONI		101A00IOM OTTICATE	
100MG TABLET 80041590 JAMP-MAGNESIUM JAM 80023332 Mx 10 MAN 80023323 Mx 10 MAN MAGNESIUM JAM 80023332 Mx 10 MAN 80023323 Mx 10 MAN MAGNESIUM JAM 80023323 Mx 10 MAN MAN 80003867 CAUCIOHEPTONATE 80023667 ROUGIER MAGNESIUM JMP 7100MG/MIX OARL LIQUID 80014109 MAGNESIUM TEV 726MMC LABLET (EFFERVESCENT) MC				
80041590	80005079 MAGNESIUM COMPLEX	JAM		JMP
02089400 MAGNESIUM JAM 3'28MEO TABLET (EFFERVESCENT) JAMPA GRANESIUM GLUCOHEPTONATE 0208592 KLYTE WPC	100MG TABLET		ST 10MMOL TABLET	
MAGNESIUM GLUCOHEPTONATE 80033802 JAMP-K EFFERVESCENT 0286392 KLYTE WPC 0280392 KLYTE WPC WPC 0280392 KLYTE WPC	80041590 JAMP-MAGNESIUM	JMP	80026332 MK 10	MAN
**************************************	02068400 MAGNESIUM	JAM	ST 25MEQ TABLET (EFFERVESCENT)	
28MG LIQUID 80093937 MAGNESIUM JMP 80011428 EURO K EUR 100026897 ROUGIERMAGNESIUM TEV SODIUM CHLORIDE **100MG/ML SOLUTION 80004109 MAGNESIUM-ODAN ODN 90726364 SODIUM CHLORIDE IG **100MG/ML SOLUTION 80004109 MAGNESIUM-ODAN ODN 90726364 SODIUM CHLORIDE IG **100MG/ML SOLUTION 80004109 MAGNESIUM-ODAN ODN 90726364 SODIUM CHLORIDE (SMALL VOL.) UNK 800062929 MMAGNESIUM GLUCONATE 99002329 SODIUM CHLORIDE (SMALL VOL.) UNK 800062929 MMAGNESIUM GLUCONATE 940 00037818 BACTERIOSTATIC SODIUM CHLORIDE PFI 80006293 MAMP MAGNESIUM GLUCONATE 940 0003796 SODIUM CHLORIDE PFI 80006293 MAMP MAGNESIUM GLUCONATE 940 0003796 SODIUM CHLORIDE PFI 80006293 MAMP MAGNESIUM CHLORIDE IMP 0003796 SODIUM CHLORIDE PFI 800062704 JAMP POTASSIUM CHLORIDE IMP 0003796 SODIUM CHLORIDE MAX 80006293 SODIUM CHLORIDE MAX 80006293 SODIUM CHLORIDE MAX 800062704 JAMP POTASSIUM CHLORIDE IMP 0003796 SODIUM CHLORIDE MAX 800024335 JAMP-POTASSIUM CHLORIDE IMP 0003796 SODIUM CHLORIDE MAX 8000435 JAMP-POTASSIUM CHLORIDE IMP 0003796 SODIUM CHLORIDE MAX 90991564 NACL SALINE PFI 102246734 EURO K PAL 40:18.18 POTASSIUM PREMOVING AGENTS 80035346 MK 8 MAN 02244068 RIVA-K 8 RIV CHLORIDE SODIUM CHLORIDE SAC AGENTS 80035346 MK 8 MAN 02244068 RIVA-K 8 RIV CHLORIDE ON 02243975 RIVA-K 20 RIV CHLORIDE ON 0201774 RESONIUM CALCIUM SAC SODIUM POLYSTYRENE SULFONATE 800045415 ODAN K20 ODN 10400000000000000000000000000000000000	MAGNESIUM GLUCOHEPTONATE		80033602 JAMP-K EFFERVESCENT	JMP
## 30009357 MAGNESIUM JMP 80011428 LIPOK EUR O K EUR O K EUR O K SODIUM CHLORIDE 10 00026637 ROUGIER-MAGNESIUM TEV SODIUM CHLORIDE 16 CAPSULE 30002393 SODIUM CHLORIDE 16 CAPSULE 30002393 SODIUM CHLORIDE 16 MDS 30004109 MAGNESIUM-ODAN ODN 30726364 SODIUM CHLORIDE 16 MDS 30002393 SODIUM CHLORIDE 16 MDS 30002393 SODIUM CHLORIDE S	ST 25MC LIQUID		02085992 K LYTE	WPC
## 100MG/ML ORAL LIQUID ## 00026697 ROUGIER-MAGNESIUM TEV ## 100MG/ML SOLUTION ## 80004109 MAGNESIUM-ODAN ODN ## 80004109 MAGNESIUM-ODAN ODN ## 80006299 MAGNESIUM GLUCONATE ## 80006290 MAGNESIUM GLUCONATE ## 80006200 MAGNE		IMD	ST 25MMOL TABLET (EFFERVESCENT)	
00026897 ROUGIERAMAGNESIUM TEV SODIUM CHLORIDE		JIVIP	80011428 EURO K	EUR
**************************************		TE\ /	SODIUM CHLORIDE	
MAGNESIUM GLUCONATE		IEV		
MAGNESIUM GLUCONATE 39902329 SODIUM CHLORIDE (SMALL VOL.) UNK 39902329 SODIUM CHLORIDE (SMALL VOL.) UNK 39902329 SODIUM CHLORIDE (SMALL VOL.) UNK 39902329 SODIUM CHLORIDE CMALL VOL.) UNK 39902329 SODIUM CHLORIDE PFI CMALL VOL.) UNK 3990239 SODIUM CHLORIDE MAGNESIUM CHLORIDE DMG MO002249 SODIUM CHLORIDE OMG				
29MG TABLET 80062929 MMAGNESIUM GLUCONATE MAN 90002329 SODIUM CHLORIDE (SMALL VOL.) UNK 900037796 SODIUM CHLORIDE PFI 900037818 SODIUM CHLORIDE PFI 90003796 SODIUM CHLORIDE PFI 900037818 SODIUM CHLORIDE PFI 900037818 SODIUM CHLORIDE PFI 90003796 SODIUM CHLORIDE PFI 90003796 SODIUM CHLORIDE PFI 90003796 SODIUM CHLORIDE MAX 9000240304 MICRO K PAL 9091584 NACL SALINE PF UNK 9991584 NACL SALINE PF UNK NACL SALINE PF		ODN		MDS
29MG TABLET	MAGNESIUM GLUCONATE			
### S00062929 MMAGNESIUM GLUCONATE MAN 0037818 BACTERIOSTATIC SODIUM PFI 80009539 JAMP MAGNESIUM GLUCONATE MP 00037796 SODIUM CHLORIDE PFI 000555126 MAGLUCATE PED 0006208 SODIUM CHLORIDE DAX OMG	29MG TABLET		,	UNK
### 500MG TABLET 80009539 JAMP MAGNESIUM GLUCONATE		MAN		
80009539		1717 (14		PFI
O0555126 MAGLUCATE		IMP		
POTASSIUM CHLORIDE				
## 1500MG CAPSULE ## 80062704 JAMP POTASSIUM CHLORIDE EN JMP 09991564 NACL SALINE PF UNK ## 14,500MG LIQUID ## 13,30MEQ/ML SOLUTION ## 14,500MG LIQUID ## 14,500MG LIQUID ## 15,30MEQ/ML SOLUTION ## 16,30MEQ/ML SALET ## 16,3	*******	I LD		
SYRINGE	POTASSIUM CHLORIDE			
02042304 MICRO K PAL 09991564 NACL SALINE PF UNK	ST 600MG CAPSULE			OMG
## 1,500MG LIQUID ## 30024835 JAMP-POTASSIUM CHLORIDE ## 30024835 JAMP-POTASSIUM CHLORIDE ## 30024835 JAMP-POTASSIUM CHLORIDE ## 30024835 JAMP-POTASSIUM CHLORIDE ## 30024835 JAMP-POTASSIUM ## 30024835 JAMP-POTASSIUM ## 30024835 JAMP-POTASSIUM ## 30024836 JAMP-POTASSIUM ## 30024835 JAMP-POTASSIUM ## 30024835 JAMP-POTASSIUM ## 30024835 JAMP-POTASSIUM ## 30024835 JAMP-POTASSIUM ## 30035346 MK 8 ## 30035346 MK 8 ## 30035346 MK 8 ## 30035346 MK 8 ## 3002244058 RIVA-K 8 ## 30026245 BIO K-20 POTASSIUM ## 30026265 BIO K-20 POTASSIUM ## 3002626 BIO K-20 POTA	80062704 JAMP POTASSIUM CHLORIDE ER	JMP	SYRINGE	
## SODIUM POLYSTYRENE SULFONATE ## SAC	02042304 MICRO K	PAL	09991564 NACL SALINE PF	UNK
1.33MEQ/ML SOLUTION O2238604 PMS-POTASSIUM PMS O1902776 KAYEXALATE SAC	ST 1,500MG LIQUID		40:18.00 ION-REMOVING AGENTS	
1.33MEQ/MIL SOLUTION PMS ORAL LIQUID Decided PMS-POTASSIUM PMS O1902776 KAYEXALATE SAC	80024835 JAMP-POTASSIUM CHLORIDE	JMP	SODIUM DOI VETVDENE SUI FONATE	
02238604 PMS-POTASSIUM PMS	ST 1.33MEQ/ML SOLUTION		SODIUM POLISTIKENE SULFONATE	
Samol Tablet		PMS	ORAL LIQUID	
02246734 EURO K			01902776 KAYEXALATE	SAC
80035346 MK 8 MAN 02244068 RIVA-K 8 RIV CALCIUM POLYSTYRENE SULFONATE ***T20MMOLTABLET** 80026265 BIO K-20 POTASSIUM BMI 02017741 RESONIUM CALCIUM SAC 80013007 JAMP K JMP SODIUM POLYSTYRENE SULFONATE 8004415 ODAN K20 ODN 1G POWDER FOR SULFONATE 8004415 ODAN K20 ODN 0765252 K-EXIT OMG 0765252		FUR	40:18.18 POTASSIUM - REMOVING	
02244068				
ST 20MMOL TABLET				
80026265 BIO K-20 POTASSIUM BMI 02017741 RESONIUM CALCIUM SAC		IXIV	CALCIUM POLYSTYRENE SULFONATE	
02242261 EURO K EUR 02017741 RESONIUM CALCIUM SAC 80013007 JAMP K JMP SODIUM POLYSTYRENE SULFONATE 80004415 ODAN K20 ODN 1G POWDER 00765252 K-EXIT OMG 0MG 07780MG TABLET 00765252 K-EXIT OMG 0MG 07780MG TABLET (EXTENDED RELEASE) 1G POWDER FOR SUSPENSION SAC 08025624 MK 20 MAN 02026961 KAYEXALATE SAC SAC SAC SWILFONATE ODN 007473941 ODAN-SODIUM POLYSTYRENE ODN ODN SULFONATE ODN SULFONATE ODN 250MG SUSPENSION ODN 250MG SUSPENSION ODN ODN SULFONATE ODN		DMI	1G POWDER FOR SOLUTION	
80013007			02017741 RESONIUM CALCIUM	SAC
80004415			SODIUM POLYSTYRENE SULFONATE	
02243975 RIVA-K 20 RIV 0765252 K-EXIT OMG 80025624 MK 20 MAN 02026961 KAYEXALATE SAC 80013005 JAMP-K 8 JMP SULFONATE 80008214 ODAN K8 ODN 20MEQ TABLET (FILM COATED), EXTENDED RELEASE 80071412 MK20 SOLUBLE MAN 80040226 SLOWK NVR 87780MG TABLET (SUGAR COATED) 80040226 SLOWK NVR 87780MG TABLET (TIME RELEASE) 80040412 K20 POTASSIUM UNK 8771,500MG TABLET (TIME RELEASE) 80040416 PHARMA-K20 PMS POTASSIUM CITRATE 1080MG LIQUID MAN 0765252 K-EXIT OMG 0765252 K-EXIT OMG 1G POWDER FOR SUSPENSION 00226961 KAYEXALATE SAC 02473941 ODAN-SODIUM POLYSTYRENE ODN SULFONATE 90473968 ODAN-S				
ST 780MG TABLET				
80025624 MK 20 MAN 02026961 KAYEXALATE SAC ****SMMOL TABLET (EXTENDED RELEASE) 02473941 ODAN-SODIUM POLYSTYRENE SULFONATE ***ST 600MG TABLET (EXTENDED RELEASE) 00755338 SOLYSTAT PED 80008214 ODAN K8 ODN 250MG SUSPENSION ***20MEQ TABLET (FILM COATED), EXTENDED RELEASE 80071412 MK20 SOLUBLE MAN SULFONATE ***5T 600MG TABLET (SUGAR COATED) 250MG/ML SUSPENSION ***80040226 SLOWK NVR 00769541 SOLYSTAT PED 951 ABLET (TIME RELEASE) 80040412 K20 POTASSIUM UNK ***\$T 780MG TABLET (TIME RELEASE) 80040416 PHARMA-K20 PMS ***POTASSIUM CITRATE 1080MG LIQUID***		RIV		OMG
ST 8MMOL TABLET (EXTENDED RELEASE)			1G POWDER FOR SUSPENSION	
## 80013005 JAMP-K 8 JMP SULFONATE ## 600MG TABLET (EXTENDED RELEASE) ## 80008214 ODAN K8 ODN ## 20MEQ TABLET (FILM COATED), EXTENDED RELEASE ## 80071412 MK20 SOLUBLE MAN ## 600MG TABLET (SUGAR COATED) ## 80040226 SLOWK NVR ## 780MG TABLET (TIME RELEASE) ## 80040412 K20 POTASSIUM UNK ## 1,500MG TABLET (TIME RELEASE) ## 80040416 PHARMA-K20 PMS ## POTASSIUM CITRATE ## 1080MG LIQUID		MAN	02026961 KAYEXALATE	SAC
**************************************	· · · · · · · · · · · · · · · · · · ·			ODN
80008214 ODAN K8 ODN 20MEQ TABLET (FILM COATED), EXTENDED RELEASE 80071412 MK20 SOLUBLE MAN ST 600MG TABLET (SUGAR COATED) 80040226 SLOWK NVR 80040412 K20 POTASSIUM UNK ST 1,500MG TABLET (TIME RELEASE) 80040416 PHARMA-K20 PMS POTASSIUM CITRATE 1080MG LIQUID		JMP		
20MEQ TABLET (FILM COATED), EXTENDED RELEASE 80071412 MK20 SOLUBLE MAN ST 600MG TABLET (SUGAR COATED) 80040226 SLOWK NVR 00769541 SOLYSTAT PED **T 780MG TABLET (TIME RELEASE) 80040412 K20 POTASSIUM UNK **T 1,500MG TABLET (TIME RELEASE) 80040416 PHARMA-K20 PMS POTASSIUM CITRATE 1080MG LIQUID	,			PED
## 80071412 MK20 SOLUBLE MAN SULFONATE ## 600MG TABLET (SUGAR COATED) ## 80040226 SLOWK NVR 00769541 SOLYSTAT PED ## 780MG TABLET (TIME RELEASE) ## 80040412 K20 POTASSIUM UNK ## 1,500MG TABLET (TIME RELEASE) ## 80040416 PHARMA-K20 PMS ## POTASSIUM CITRATE ## 1080MG LIQUID				
*** 600MG TABLET (SUGAR COATED) *** 80040226 SLOWK NVR 00769541 SOLYSTAT PED **** 780MG TABLET (TIME RELEASE) *** 80040412 K20 POTASSIUM UNK **** 1,500MG TABLET (TIME RELEASE) *** 80040416 PHARMA-K20 PMS ***POTASSIUM CITRATE** *** 1080MG LIQUID**	20MEQ TABLET (FILM COATED), EXTENDED REI	LEASE		ODN
80040226 SLOWK NVR 00769541 SOLYSTAT PED ***T780MG TABLET (TIME RELEASE) 80040412 K20 POTASSIUM UNK ***T1,500MG TABLET (TIME RELEASE) 80040416 PHARMA-K20 PMS POTASSIUM CITRATE 1080MG LIQUID	80071412 MK20 SOLUBLE	MAN		
**************************************	ST 600MG TABLET (SUGAR COATED)			
80040412 K20 POTASSIUM UNK ST 1,500MG TABLET (TIME RELEASE) 80040416 PHARMA-K20 PMS POTASSIUM CITRATE 1080MG LIQUID	80040226 SLOWK	NVR	00/69541 SOLYSTAT	PED
** 1,500MG TABLET (TIME RELEASE) 80040416 PHARMA-K20 PMS POTASSIUM CITRATE 1080MG LIQUID	ST 780MG TABLET (TIME RELEASE)			
80040416 PHARMA-K20 PMS POTASSIUM CITRATE 1080MG LIQUID	80040412 K20 POTASSIUM	UNK		
80040416 PHARMA-K20 PMS POTASSIUM CITRATE 1080MG LIQUID	ST 1,500MG TABLET (TIME RELEASE)			
1080MG LIQUID	•	PMS		
1080MG LIQUID	POTASSIUM CITRATE			
800T1529 POTASSIUM CITRATE UNK		114.07		
	80011529 POTASSIUM CITRATE	UNK		

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40:18.19 PHOSPHATE - REMOVING AGENTS

IRON (SUCROFERRIC OXYHYDROXIDE)

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

500MG TABLET (CHEWABLE)

02471574 VELPHORO

UNK

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)

UNK	FOSRENOL	02287145
	LET (CHEWABLE)	500MG TABI
UNK	FOSRENOL	02287153
	LET (CHEWABLE)	750MG TABI
UNK	FOSRENOL	02287161
	BLET (CHEWABLE)	1000MG TAE
UNK	FOSRENOL	02287188

SEVELAMER CARBONATE

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

02461501	ACCEL-SEVELAMER	ACP
02354586	RENVELA	SAC

40:18.19 PHOSPHATE - REMOVING AGENTS

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

SAC

40:20.00 CALORIC AGENTS GLUCOSE

TABLET

97799899	BD GLUCOSE	BTD
4G TABLET		
09991092	DEX-4 GLUCOSE	UNK

LEVOCARNITINE

Limited use benefit (prior approval required).

For treatment of carnitine deficiency.

100MG SOLUTION

02492105	ODAN LEVOCARNITINE	ODN
100MG/ML S	SOLUTION	
02144336	CARNITOR	UNK
200MG/ML S	SOLUTION	
02144344	CARNITOR	UNK
330MG TAB	LET	
02144328	CARNITOR	UNK

40:28.08 LOOP DIURETICS

ETHACRYNIC ACID

ST 25MG TABLET

FUROSEMIDE

ST 10MG/ML SOLUTION 02224720 LASIX

ST 20MG TABLET

00396788	APO FUROSEMIDE	APX
02247371	BIO-FUROSEMIDE	BMI
00496723	FUROSEMIDE	PDL
02351420	FUROSEMIDE	SAN
02466759	MINT-FUROSEMIDE	MIN
02247493	PMS-FUROSEMIDE	PMS
00337730	TEVA-FUROSEMIDE	TEV

ST 40MG TABL	ET	
00362166	APO FUROSEMIDE	APX
02247372	BIO-FUROSEMIDE	BMI
00397792	FUROSEMIDE	PDI

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10.00.00.10	00 DUIDETIOS		40.00.00 TIATIDE DUIDED	
	OP DIURETICS		40:28.20 TIAZIDE DIURETICS	
FUROSEMID	E		SPIRONOLACTONE, HYDROCHLOROTHIAZ	IDE
ST 40MG TABL	ET		ST 25MG & 25MG TABLET	
02351439	FUROSEMIDE	SAN	00613231 TEVA-SPIRONOLACTONE/HCTZ	TEV
02466767	MINT-FUROSEMIDE	MIN	ST 50MG & 50MG TABLET	
	PMS-FUROSEMIDE	PMS	00657182 TEVA-SPIRONOLACTONE/HCTZ	TEV
	TEVA-FUROSEMIDE	TEV	40:28.24 THIAZIDE LIKE DIURETICS	
ST 80MG TABL	EI APO FUROSEMIDE	APX	CHLORTHALIDONE	
	FUROSEMIDE	PDL	ST 50MG TABLET	
	FUROSEMIDE	SAN	00360279 CHLORTHALIDONE	AAP
	MINT-FUROSEMIDE	MIN	INDAPAMIDE	7441
	TEVA-FUROSEMIDE	TEV		
ST 500MG TABI			ST 1.25MG TABLET	
	LASIX SPECIAL	SAC	02245246 APO-INDAPAMIDE	APX
40.28 16 PO	TASSIUM SPARING DIURE	TICS	02373904 JAMP-INDAPAMIDE	JMP
	TAGGIOIN OF ARING BIORE	1100	02179709 LOZIDE 02240067 MYLAN-INDAPAMIDE	SEV MYL
AMILORIDE			ozz40067 MYLAN-INDAPAMIDE	IVIYL
ST 5MG TABLE	т		02223678 APO-INDAPAMIDE	APX
02249510	MIDAMOR	AAP	02373912 JAMP-INDAPAMIDE	JMP
AMILORIDE,	HYDROCHLOROTHIAZIDE		00564966 LOZIDE	SEV
ST 5MG & 50MC	TARI FT		02153483 MYLAN-INDAPAMIDE	MYL
	AA-AMILZIDE	AAP	02312549 PRO-INDAPAMIDE	PDL
	AMI-HYDRO	PDL	METOLAZONE	. 52
	NOVAMILOR	TEV		
TRIAMTERFI	NE, HYDROCHLOROTHIAZIDE		ST 2.5MG TABLET	
	·		00888400 ZAROXOLYN	SAC
ST 50MG & 25M		A DV	40:36.00 IRRIGATING SOLUTIONS	
	APO TRIAZIDE TEVA-TRIAMTERENE/HCTZ	APX TEV	SODIUM CHLORIDE	
	AZIDE DIURETICS	ΙΕV	0.9% SOLUTION	
			00801267 SODIUM CHLORIDE	UNK
HYDROCHLO	DROTHIAZIDE		40:40.00 URICOSURIC AGENTS	
ST 12.5MG TAB	LET		SULFINPYRAZONE	
	APO-HYDRO	APX		
	MINT-HYDROCHLOROTHIAZIDE	MIN	200MG TABLET	
	PMS-HYDROCHLOROTHIAZIDE	PMS	00441767 SULFINPYRAZONE	AAP
ST 25MG TABL		4 D.V	40:50.00 IRRIGATING SOLUTIONS	
00326844	APO HYDRO	APX	WATER	
02247170	BIO-HYDROCHLOROTHIAZIDE	BMI SAN	100% SOLUTION	
02360594 02426196	HYDROCHLOROTHIAZIDE MINT-HYDROCHLOROTHIAZIDE	MIN	00038202 BACTERIOSTATIC WATER	PFI
02426196	PMS-HYDROCHLOROTHIAZIDE	PMS	00402257 STERILE WATER	OMG
00021474	TEVA-HYDROCHLOROTHIAZIDE	TEV	02142546 STERILE WATER	PFI
ST 50MG TABLE				
00312800	APO HYDRO	APX		
02247171	BIO-HYDROCHLOROTHIAZIDE	BMI		
02360608	HYDROCHLOROTHIAZIDE	SAN		
	PMS-HYDROCHLOROTHIAZIDE	PMS		
00021482	TEVA-HYDROCHLOROTHIAZIDE	TEV		
ST 100MG TABI	LET			
00644552	APO HYDRO	APX		
ST PDIN FOR E	XTEMPORANEOUS MIXTURE			
99503000	HYDROCHLOROTHIAZIDE ORAL LIQUID	UNK		

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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:

- dagnosis 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 ≥ 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 ≥ 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 ≥ 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 ≥ 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

267MG TABLET

02464489 ESBRIET

HLR

801MG TABLET

02464500 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.

Montelukast is open benefit for children up to 17 years of age.

ST 4MG GRANULES

02358611 SANDOZ MONTELUKAST SDZ 02247997 SINGULAIR FRS

ST 10MG TABLET

 02374609
 APO-MONTELUKAST
 APX

 02401274
 AURO-MONTELUKAST
 AUR

 02445735
 BIO-MONTELUKAST
 UNK

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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.

Montelukast is open benefit for children up to 17 years of age.

ST 10MG TABLET DPC 02376695 DOM-MONTELUKAST 02391422 JAMP-MONTELUKAST **JMP** 02399997 MAR-MONTELUKAST MAR 02408643 MINT-MONTELUKAST MIN SAN 02379333 MONTEL UKAST 02379856 MONTELUKAST PDL 02382474 MONTELUKAST SIV 02379236 ACC MONTELUKAST SODIUM 02489821 NRA-MONTELUKAST UNK 02373947 PMS-MONTELUKAST **PMS** 02440350 PRIVA-MONTFI UKAST PHA 02389517 **RAN-MONTELUKAST RBY** 02398826 **RIVA-MONTELUKAST** RIV 02328593 SANDOZ MONTELUKAST SDZ **FRS** 02238217 **SINGULAIR** 02355523 TEVA-MONTELUKAST TEV **4MG TABLET (CHEWABLE)** APX 02377608 APO-MONTELUKAST 02422867 AURO-MONTELUKAST **AUR** 02442353 JAMP-MONTELUKAST **JMP** 02399865 MAR-MONTELUKAST MAR 02408627 MINT-MONTELUKAST MIN 02379821 MONTELUKAST PDL 02382458 **MONTELUKAST** SIV 02354977 PMS-MONTELUKAST **PMS** 02402793 **RAN-MONTELUKAST RBY** SDZ 02330385 SANDOZ MONTELUKAST 02243602 **FRS** SINGULAIR 02355507 TEVA-MONTELUKAST TEV ST 5MG TABLET (CHEWABLE) **APX** 02377616 APO-MONTELUKAST 02422875 AURO-MONTELUKAST **AUR** 02442361 JAMP-MONTELUKAST **JMP** 02399873 MAR-MONTELUKAST MAR 02408635 MINT-MONTELUKAST MIN 02379848 **MONTELUKAST PDL** MONTELUKAST 02382466 SIV 02354985 PMS-MONTELUKAST **PMS** 02402807 **RAN-MONTELUKAST RBY** 02330393 SANDOZ MONTELUKAST SDZ 02238216 SINGULAIR FRS 02355515 TEVA-MONTELUKAST TEV 48:10.32 MAST CELL STABILIZERS

CROMOLYN SODIUM

NALCROM

100MG CAPSULE 00500895

48:10.32 MAST CELL STABILIZERS **CROMOLYN SODIUM**

2% NASAL SPRAY

APX 02231390 APO-CROMOLYN PED 01950541 RHINARIS-CS 10MG/ML SOLUTION **PMS**

02046113 PMS-SODIUM CROMOGLYCATE

48:48.00 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.

ST 5MG TABLET

02475375 APO-AMBRISENTAN APX ST 10MG TABLET 02475383 APO-AMBRISENTAN APX

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.

ST 125MG TABLET

2.5MG TABLET

02412810 ADEMPAS

02399210 APO-BOSENTAN **APX**

RIOCIGUAT

Limited use benefit (prior approval required).

For the treatment of patients 18 years of age or older with chronic thromboembolic pulmonary hypertension (CTEPH) with World Health Organization (WHO) Functional Class 2 or 3 pulmonary hypertension with:

- inoperable CTEPH, World Health Organization (WHO) Group 4;
- or
- persistent or recurrent CTEPH after surgical treatment; and
- prescriber experienced in the diagnosis and treatment of CTEPH

0.5MG TABL	.ET	
02412764	ADEMPAS	BAY
1MG TABLE	Т	
02412772	ADEMPAS	BAY
1.5MG TABL	.ET	
02412799	ADEMPAS	BAY
2MG TABLE	Т	
02412802	ADEMPAS	BAY

BAY

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SAC

48:48.00 VASODILATING AGENTS SELEXIPAG

Limited use benefit (prior approval required).

For the treatment of adult patients with World Health Organization (WHO) functional class (FC) II to III pulmonary arterial hypertension (PAH), including idiopathic PAH, heritable PAH, PAH associated with connective tissue disorders or PAH associated with congenital heart disease:

- patient is under the care of a physician with experience in the diagnosis and treatment of PAH; and
- patient has failed to respond to first- and second-line PAH therapies; or
- patient has contraindications/intolerance to first- and second-line PAH therapies.

BLET		
UPTRAVI		JSO
BLET		
UPTRAVI		JSO
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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).

1. 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).

- 2. 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 ≥ 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

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	_		
52:00 EYE, EAR, NOSE AND THR	OAT	52:04.04 EENT - ANTIBACTERIALS	
(EENT) PREPARATIONS		FUSIDIC ACID	
52:02.00 EENT - ANTIALLERGIC AGEN	NTS	1% DROP	
	110	02243862 FUCITHALMIC	AMD
CROMOLYN SODIUM		GATIFLOXACIN	
2% OPHTHALMIC SOLUTION		0.3% SOLUTION	
02009277 CROMOLYN	PED	02257270 ZYMAR	ALL
02230621 OPTICROM	ALL	GATIFLOXACIN (GATIFLOXACIN HEMIHYDI	RATE)
DICLOFENAC SODIUM		·	- ,
0.1% SOLUTION		0.3% SOLUTION 02327260 APO-GATIFLOXACIN	APX
02475065 DICLOFENAC	UNK	MOXIFLOXACIN HYDROCHLORIDE	ALA
KETOTIFEN FUMARATE			
0.25MG SOLUTION		Limited use benefit (prior approval not required).	
02489651 JAMP-KETOTIFEN	JMP	Coverage will be limited to 14 tablets every 14 days, follow	ved
02400871 KETOTIFEN	RAX	by a 14 day lockout.	
LEVOCABASTINE HYDROCHLORIDE		0.5% SOLUTION	
0.05% NASAL SPRAY		02472120 JAMP-MOXIFLOXACIN	JMP
02020017 LIVOSTIN	JSO	MOXIFLOXACIN HYDROCHLORIDE	
LODOXAMIDE TROMETHAMINE		(OPHTHALMIC)	
		0.5% SOLUTION	
0.1% SOLUTION	NVR	02404656 ACT MOXIFLOXACIN	TEV
00893560 ALOMIDE	NVK	02406373 APO-MOXIFLOXACIN	APX
OLOPATADINE HYDROCHLORIDE		02432218 PMS-MOXIFLOXACIN	PMS
0.1% OPHTHALMIC SOLUTION		02411520 SANDOZ MOXIFLOXACIN	SDZ
02403986 ACT OLOPATADINE	ACG	02252260 VIGAMOX	NVR
02305054 APO-OLOPATADINE	APX	OFLOXACIN	
02422727 MINT-OLOPATADINE	MIN	0.3% SOLUTION	
02233143 PATANOL	NVR	02248398 APO-OFLOXACIN	APX
02358913 SANDOZ OLOPATADINE	SDZ	02143291 OCUFLOX	ALL
0.2% OPHTHALMIC SOLUTION 02404095 ACT OLOPATADINE	ACG	POLYMYXIN B SULFATE, BACITRACIN ZING	C
02402823 APO-OLOPATADINE	APX	500IU & 10,000IU/G OINTMENT	
02420171 SANDOZ OLOPATADINE	SDZ	02160889 OPTIMYXIN	SDZ
0.1% SOLUTION	052	02239157 POLYSPORIN	JAJ
02458411 JAMP-OLOPATADINE	JMP	POLYMYXIN B SULFATE, GRAMICIDIN	
52:04.04 EENT - ANTIBACTERIALS		•	
CIPROFLOXACIN HYDROCHLORIDE		0.025MG & 10,000U/ML DROP 00701785 OPTIMYXIN	SDZ
CIPROFLOXACIN HYDROCHLORIDE		02239156 POLYSPORIN EYE AND EAR	JAJ
0.3% OINTMENT		POLYMYXIN B SULFATE, TRIMETHOPRIM	J/J
02200864 CILOXAN	NVR	SULFATE	
0.3% SOLUTION	4.50/		
02263130 APO-CIPROFLOX	APX	10,000U & 1MG/ML SOLUTION	
01945270 CILOXAN 02387131 SANDOZ CIPROFLOXACIN	NVR SDZ	02240363 PMS-POLYTRIMETHOPRIM	PMS
	SDZ	02011956 POLYTRIM	ALL
CIPROFLOXACIN HYDROCHLORIDE, DEXAMETHASONE		02239234 SANDOZ POLYTRIMETHOPRIM	SDZ
		TOBRAMYCIN (OPHTHALMIC)	
0.3%/0.1% SUSPENSION		0.3% OINTMENT	
02252716 CIPRODEX	NVR	00614254 TOBREX	NVR
ERYTHROMYCIN		0.3% SOLUTION	
5MG OINTMENT		02241755 SANDOZ TOBRAMYCIN	SDZ
00641324 ODAN-ERYTHROMYCIN	ODN	00513962 TOBREX	NVR
5MG/G OINTMENT			
02326663 ERYTHROMYCIN	STG		
01912755 PDP-ERYTHROMYCIN	PED		

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			-
52:04.20 EENT - ANTIVIRALS		52:08.08 EENT - CORTICOSTEROIDS	
TRIFLURIDINE		FLUTICASONE FUROATE	
1% SOLUTION		100MCG POWDER	
00687456 VIROPTIC	VAE	02446561 ARNUITY ELLIPTA GSk	K
52:04.92 EENT - MISCELLANEOUS ANTI-		200MCG POWDER	
INFECTIVES		02446588 ARNUITY ELLIPTA GSK	K
CHLORHEXIDINE GLUCONATE		FLUTICASONE PROPIONATE	
		50MCG PUMP	
0.12% MOUTHWASH		02453738 TEVA-FLUTICASONE TEV	V
02462842 CHLORHEXIDINE	EUR	50MCG/DOSE SPRAY	
02384272 GUM PAROEX	SUS	02294745 APO-FLUTICASONE APX	Χ
02240433 PERICHLOR 02237452 PERIDEX	PED MAK	02296071 RATIO-FLUTICASONE TEV	V
	IVIAN	FRAMYCETIN SULFATE, GRAMICIDIN,	
52:08.00		DEXAMETHASONE	
FLUTICASONE PROPIONATE		5MG & 0.05MG/ML & 0.5MG DROP	
50MCG SPRAY		02224623 SOFRACORT EAR/EYE SAC	С
02248307 FLONASE ALLERGY RELIEF	GSK	MOMETASONE FUROATE	
52:08.08 EENT - CORTICOSTEROIDS			
BECLOMETHASONE DIPROPIONATE		50MCG SPRAY	.,
		02403587 APO-MOMETASONE AP> 02238465 NASONEX FRS	
50MCG/DOSE NASAL SPRAY	45)/	02475863 TEVA-MOMETASONE TEV	
02238796 APO-BECLOMETHASONE	APX	500MCG/ML SPRAY	V
02172712 MYLAN-BECLO AQ	MYL	02449811 SANDOZ MOMETASONE SDZ	7
BUDESONIDE		PREDNISOLONE ACETATE	_
64MCG/DOSE SPRAY			
02241003 MYLAN-BUDESONIDE AQ	MYL	0.12% DROP	
02231923 RHINOCORT AQUA	MCL	00299405 PRED MILD ALI	L
100MCG/DOSE SPRAY		1% DROP	
02230648 MYLAN-BUDESONIDE AQ	MYL	00301175 PRED FORTE ALI 1% SUSPENSION	L
DEXAMETHASONE		01916203 SANDOZ PREDNISOLONE SDZ	7
0.1% OINTMENT		00700401 TEVA-PREDNISOLONE TEV	
00042579 MAXIDEX	NVR	PREDNISOLONE ACETATE, SULFACETAMIDE	•
0.1% SUSPENSION		SODIUM	
00042560 MAXIDEX	NVR		
DEXAMETHASONE PHOSPHATE		0.2% & 10% DROP	
0.1% SOLUTION		00807788 BLEPHAMIDE ALL	L
02023865 DEXAMETHASONE	UNK	0.5% & 10% SUSPENSION 02023814 PREDNISOLONE/SULFACETAMIDE UNI	v
00785261 PMS-DEXAMETHASONE	PMS		^
DEXAMETHASONE, TOBRAMYCIN		PREDNISOLONE SODIUM PHOSPHATE	
0.1% & 0.3% OINTMENT		0.5% DROP	
00778915 TOBRADEX	NVR	02148498 MINIMS PREDNISOLONE VAE	Ε
0.1% & 0.3% SUSPENSION		TRIAMCINOLONE ACETONIDE	
00778907 TOBRADEX	NVR	55MCG SPRAY	
FLUMETHASONE PIVALATE, CLIOQUINOL		02437635 APO-TRIAMCINOLONE AQ APX	X
,		55MCG/DOSE SPRAY	
0.02% & 1% DROP	PAL	02213834 NASACORT AQ SAC	С
00074454 LOCACORTEN VIOFORM	PAL	52:08.20 EENT - NONSTEROIDAL ANTI-	
FLUOROMETHOLONE		INFLAMMATORY AGENTS	
0.1% DROP		DICLOFENAC SODIUM	
00247855 FML	ALL	0.1% SOLUTION	
0.1% SUSPENSION	NI) (D	0.1% SOLUTION 01940414 VOLTAREN OPHTHA NVF	R
00756784 FLAREX 00432814 SANDOZ FLUOROMETHOLONE	NVR SDZ	VICTOTIT VOLIANLIN OFIIIIA INVE	`
00402014 SAINDOZ FLOOROWETHOLONE	SUL		

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52:08.20 EENT - NONSTEROIDAL ANTI- INFLAMMATORY AGENTS		52:24.00 EENT - MYDRIATICS PHENYLEPHRINE HYDROCHLORIDE	
DICLOFENAC SODIUM (TOPICAL)			
Limited use benefit (prior approval required).		10% DROP 02148455 MINIMS PHENYLEPHRINE	VAE
		TROPICAMIDE	
For the treatment of osteoarthritis when: • pain is inadequately controlled with acetaminophen and a		0.5% SOLUTION	
non-steroidal anti-inflammatory (NSAID); or		00000981 MYDRIACYL	ALC
 there is contraindication to acetaminophen and NSAID; or there is intolerance to acetaminophen and NSAID. 	•	1% SOLUTION	, 0
0.1% SOLUTION		00001007 MYDRIACYL	ALC
02441020 APO-DICLOFENAC	APX	52:28.00 EENT - MOUTHWASHES AND	
02454807 SANDOZ DICLOFENAC OPHTHA	SDZ	GARGLES	
KETOROLAC TROMETHAMINE		BENZYDAMINE HYDROCHLORIDE	
0.45% SOLUTION		Limited use benefit (prior approval required).	
02369362 ACUVAIL	ALL		
0.5% SOLUTION		For the treatment of radiation mucositis and oral ulcerative complications of chemotherapy; or	
01968300 ACULAR	ALL	For use in immunocompromised patients who are at risk of	
02245821 APO-KETOROLAC	AAP	mucosal breakdown.	
NEPAFENAC		0.15% MOUTHWASH	
0.1% SUSPENSION		02239044 APO-BENZYDAMINE 02229777 PHARIXIA	APX PED
02308983 NEVANAC	NVR	02239537 PMS-BENZYDAMINE	PED
0.3% SUSPENSION		52:32.00 EENT - VASOCONSTRICTORS	1 IVIO
02411393 ILEVRO	NVR		
52:12.00 EENT - CONTACT LENS		EPINEPHRINE	
SOLUTION		1MG/ML SOLUTION	
HYDROXYPROPYLMETHYLCELLULOSE		00155365 ADRENALIN	ERF
3MG SOLUTION		NAPHAZOLINE HYDROCHLORIDE	
02231289 GENTEAL	ALC	0.1% DROP	
52:16.00 EENT - LOCAL ANESTHETICS		00001147 ALBALON	ALL
LIDOCAINE HYDROCHLORIDE		52:40.04 EENT - ALPHA-ADRENERGIC	
2% SOLUTION		AGONISTS	
00001686 XYLOCAINE VISCOUS	UNK	BRIMONIDINE TARTRATE	
52:24.00 EENT - MYDRIATICS		0.15% SOLUTION	
ATROPINE SULFATE		02248151 ALPHAGAN P	ALL
1% SOLUTION		02301334 BRIMONIDINE P 0.2% SOLUTION	AAP
02023695 ATROPINE	UNK	02236876 ALPHAGAN	ALL
00035017 ISOPTO ATROPINE	ALC	02260077 APO-BRIMONIDINE	APX
02148358 MINIMS ATROPINE	VAE	02246284 PMS-BRIMONIDINE	PMS
CYCLOPENTOLATE HYDROCHLORIDE		02305429 SANDOZ BRIMONIDINE	SDZ
0.5% DROP		TIMOLOL MALEATE, BRIMONIDINE TARTRA	ΓΕ
02148331 MINIMS CYCLOPENTOLATE	VAE	0.2% & 0.5% SOLUTION	
1% DROP		02248347 COMBIGAN	ALL
00252506 CYCLOGYL	ALC	52:40.08 EENT - BETA-ADRENERGIC	
02148382 MINIMS CYCLOPENTOLATE DIPIVEFRIN HYDROCHLORIDE	VAE	BLOCKING AGENTS	
		BETAXOLOL HYDROCHLORIDE	
0.1% LIQUID	ADV	0.25% OPHTHALMIC SOLUTION	
02242232 APO-DIPIVEFRIN PHENYLEPHRINE HYDROCHLORIDE	APX	01908448 BETOPTIC S	NVR
		LEVOBUNOLOL HYDROCHLORIDE	
2.5% DROP	\/^⊏	0.25% OPHTHALMIC SOLUTION	
02148447 MINIMS PHENYLEPHRINE 00465763 MYDFRIN	VAE ALC	02241575 APO-LEVOBUNOLOL	APX
02027100 PHENYLEPHRINE	UNK		

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		Hon mourea ricatin Ben	Ciito
52:40.08 EENT - BETA-ADRENERGIC BLOCKING AGENTS		52:40.12 EENT - CARBONIC ANHYDRASE INHIBITORS	
TIMOLOL MALEATE		DORZOLAMIDE HYDROCHLORIDE, TIMOLO	L
		MALEATE	_
0.25% OPHTHALMIC GEL SOLUTION			
02242275 TIMOLOL MALEATE-EX	SDZ	20MG & 5MG SOLUTION	
0.5% OPHTHALMIC GEL SOLUTION		02457539 JAMP DORZOLAMIDE-TIMOLOL	JMP
02242276 TIMOLOL MALEATE-EX	SDZ	METHAZOLAMIDE	
00451207 TIMOPTIC	PFR	50MG TABLET	
0.25% OPHTHALMIC SOLUTION		02245882 METHAZOLAMIDE	AAP
00755826 APO-TIMOP	APX		7771
02238770 DOM-TIMOLOL	DPC	52:40.20 EENT - MIOTICS	
02083353 PMS-TIMOLOL	PMS	CARBACHOL	
0.5% OPHTHALMIC SOLUTION		0.01% OPHTHALMIC SOLUTION	
00755834 APO-TIMOP	APX	00042544 MIOSTAT	ALC
02238771 DOM-TIMOLOL	DPC		ALC
02447800 JAMP-TIMOLOL	JMP	PILOCARPINE HYDROCHLORIDE	
02083345 PMS-TIMOLOL	PMS	2% OPHTHALMIC SOLUTION	
02166720 SANDOZ TIMOLOL	SDZ	00000868 ISOPTO CARPINE	NVR
0.50% OPHTHALMIC SOLUTION		4% OPHTHALMIC SOLUTION	
99113735 TIMOLOL MALEATE (QC)	UNK	00000884 ISOPTO CARPINE	NVR
0.5% SOLUTION (EXTENDED RELEASE)		02023733 PILOCARPINE	UNK
02171899 TIMOPTIC-XE	PFR	PILOCARPINE NITRATE	
52:40.12 EENT - CARBONIC ANHYDRASI			
	_	2% DROP	
INHIBITORS		02148463 MINIMS PILOCARPINE	VAE
ACETAZOLAMIDE		52:40.28 EENT - PROSTAGLANDIN	
250MG TABLET		AGENTS	
00545015 ACETAZOLAMIDE	AAP	BIMATOPROST	
BRINZOLAMIDE	700	DIMATORIOST	
BRINZOLAWIDE		0.01% OPHTHALMIC SOLUTION	
1% SUSPENSION		02324997 LUMIGAN RC	ALL
02238873 AZOPT	NVR	09857368 LUMIGAN RC (ON)	ALL
BRINZOLAMIDE, BRIMONIDINE TARTRATE		09857398 LUMIGAN RC (ON)	ALL
1% & 0.2% SUSPENSION		0.03% OPHTHALMIC SOLUTION	
	NI) (D	02429063 VISTITAN	SDZ
02435411 SIMBRINZA	NVR	LATANOPROST	
BRINZOLAMIDE, TIMOLOL MALEATE		0.005% SOLUTION	
1%/0.5% SUSPENSION			ADV
02331624 AZARGA	NVR	02296527 APO-LATANOPROST	APX
DORZOLAMIDE HYDROCHLORIDE		02373041 GD-LATANOPROST	UNK
		02426935 MED-LATANOPROST	GMP
2% OPHTHALMIC SOLUTION		02317125 PMS-LATANOPROST	PMS
02216205 TRUSOPT	FRS	02341085 RIVA-LATANOPROST	RIV
02269090 TRUSOPT	FRS	02367335 SANDOZ LATANOPROST	SDZ
20MG/ML OPHTHALMIC SOLUTION		02254786 TEVA-LATANOPROST	TEV
02316307 SANDOZ DORZOLAMIDE	SDZ	02231493 XALATAN	UNK
DORZOLAMIDE HYDROCHLORIDE, TIMOLO	L	50MCG SOLUTION	
MALEATE		02453355 JAMP LATANOPROST	JMP
20MG & 5MG OPHTHALMIC SOLUTION		LATANOPROST, TIMOLOL MALEATE	
02437686 MED-DORZOLAMIDE-TIMOLOL	GMP	0.005% & 0.5% SOLUTION	
20MG & 5MG/ML OPHTHALMIC SOLUTION	O	02436256 ACT LATANOPROST/TIMOLOL	ACG
02404389 ACT DORZOTIMOLOL	TEV	02414155 APO-LATANOPROST-TIMOP	APX
02299615 APO-DORZO-TIMOP	APX	02373068 GD-LATANOPROST/TIMOLOL	UNK
02240113 COSOPT	FRS	02404591 PMS-LATANOPROST-TIMOLOL	PMS
02442426 PMS-DORZOLAMIDE-TIMOLOL	PMS	02394685 SANDOZ LATANOPROST/TIMOLOL	SDZ
	RIV	02246619 XALACOM	UNK
		511.55.5 / ME 100m	5.410
02344351 SANDOZ DORZOLAMIDE/TIMOLOL	SDZ		

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52:40.28 EENT - PROSTAGLANDIN 52:92.00 MISCELLANEOUS EENT DRUGS AGENTS HYDROXYPROPYLMETHYLCELLULOSE			S
LATANOPROST, TIMOLOL MALEATE			
50MCG & 5MG SOLUTION 02453770 JAMP-LATANOPROST/TIMOLOL 02454505 MED-LATANOPROST-TIMOLOL LATANOPROSTENE BUNOD	JMP GMP	00000809 ISOPTO TEARS 1% SOLUTION 00000817 ISOPTO TEARS MACROGOL, PROPYLENE GLYCOL	ALC
0.024% SOLUTION		15% & 20% GEL	
02484218 VYZULTA TIMOLOL MALEATE, TRAVOPROST	BSH	02220806 LUBRICATING 02352699 RHINARIS NASAL 00551805 SECARIS	PMS PED PED
0.5% & 0.004% SOLUTION 02415305 APO-TRAVOPROST-TIMOP PQ 02278251 DUOTRAV PQ 02413817 SANDOZ TRAVOPROST / TIMOLOL PQ	APX NVR SDZ	15% & 20% SPRAY 00732230 LUBRICATING NASAL MIST 02354551 RHINARIS NASAL MIST MINERAL OIL, WHITE PETROLATUM	PMS PED
TRAVOPROST		55.5% & 42.5% OINTMENT	
0.003% SOLUTION 02457997 IZBA 0.004% SOLUTION 02415739 APO-TRAVOPROST Z	NVR APX	00210889 REFRESH LACRI-LUBE NATURAL HEALTH PRODUCT 100% SPRAY 80069578 SALINEX	ALL
02413167 SANDOZ TRAVOPROST	SDZ	PETROLATUM, MINERAL OIL	ONK
02318008 TRAVATAN Z	NVR	•	
TRAVOPROST-TIMOLOL		80% & 20% OINTMENT 02125706 SOOTHE NIGHT TIME	BSH
0.0040.5/% OPHTHALMIC SOLUTION		POLYVINYL ALCOHOL	ВОП
09857513 DUOTRAV PQ OP 52:92.00 MISCELLANEOUS EENT DRUG	ALC S	1.4% OPHTHALMIC SOLUTION	
AFLIBERCEPT	J	02229570 ARTIFICIAL TEARS	PED
Limited use benefit (prior approval required).		00579408 TEARS PLUS RANIBIZUMAB	ALL
For the treatment of: • diabetic macular edema (DME) • wet age-related macular degeneration (w-AMD) • retinal vein occlusion (RVO)		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).		 choroidal neovascularization secondary to pathologic 	
40MG SOLUTION 02415992 EYLEA	BAY	myopia (mCNV)	
ANETHOLE TRITHIONE		(Please refer to Appendix A).	
ST 25MG TABLET 02240344 SIALOR APRACLONIDINE HYDROCHLORIDE	PMS	10MG/ML SOLUTION 02296810 LUCENTIS 02425629 LUCENTIS PFS SODIUM CARBOXYMETHYL CELLULOSE	NVR NVR
0.5% OPHTHALMIC SOLUTION		0.5% DROP	
02076306 IOPIDINE DEXTRAN 70, HYDROXYPROPYLMETHYLCELLULOSE	NVR	02049260 REFRESH PLUS 02231008 REFRESH TEARS 1% DROP	ALL ALL
0.1% & 0.3% DROP		00870153 REFRESH CELLUVISC	ALL
01943308 TEARS NATURALE FREE	ALC	10MG/ML SOLUTION	A.I.I
00743445 TEARS NATURALE II	ALC	02244650 REFRESH LIQUIGEL SODIUM CHLORIDE	ALL
TI BROWN ROLL SEEDS COL			
5MG INSERT 02250624 LACRISERT	АТО	9MG/ML NASAL DROPS 80024901 SALINEX	SDZ
		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% SOLUTION

00750824 MURO 128 BSH 80046737 ODAN-SODIUM CHLORIDE ODN

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 CHE

WHITE PETROLATUM, LANOLIN, MINERAL OIL

94% & 3% & 3% OINTMENT

02444062 SYSTANE ALC

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56:00 GASTROINTESTINAL DRUGS 56:04.00 ANTACIDS AND ADSORBENTS		56:12.00 CATHARTICS AND LAXATIVES BISACODYL	
BISMUTH SUBSALICYLATE		ST 5MG TABLET (DELAYED RELEASE)	
			APX
Limited use benefit (prior approval not required).		02273411 BISACODYL-ODAN C	DDN
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.		CITRIC ACID, MAGNESIUM OXIDE, SODIUM PICOSULFATE	
followed by a 28 day lockout.		ST 12G & 3.5G & 10MG POWDER FOR SOLUTION	ггі
262MG CAPLET		02254794 PICO-SALAX 02317966 PURG-ODAN	FEI DDN
00245730 BISMUTH	JMP		אוטכ
17.6MG/ML SUSPENSION 02097079 PEPTO-BISMOL	PGI	GLYCERINE	
262MG TABLET	FGI	ADULT SUPPOSITORY	
02326582 BISMUTH SUBSALICYLATE	UNK		TEV
02177994 PEPTO BISMOL	PGI		VPC
MAGNESIUM OXIDE	1 01		TEV
WAGNESIUW OXIDE			JMP
420MG TABLET		PEDIATRIC SUPPOSITORY	
00299448 MAGNESIUM OXIDE	VAE		TEV
80082915 MAGNESIUM OXIDE	JMP	01926047 GLYCERIN FOR INFANTS W CHILDREN	VPC
835MG TABLET		MACROGOL, POTASSIUM CHLORIDE, SODIUM	л
00689785 HI POTENCY MAGNESIUM OXIDE	SWS	BICARBONATE, SODIUM CHLORIDE, SODIUM	
80082435 MAGNESIUM OXIDE	JMP	SULFATE	
SODIUM BICARBONATE			
325MG TABLET		⁵⁷ 60G & 750MG & 1.68G & 1.46G & 5.68G/L SOLUTION	
80072247 SODIUM BICARBONATE	MDS		BTU
56:08.00 ANTIDIARRHEA AGENTS			PED
LOPERAMIDE HYDROCHLORIDE		MAGNESIUM CITRATE	
		ST 5.40% SOLUTION	
0.2MG/ML SOLUTION	PMS		TEV
02016095 PMS-LOPERAMIDE ST 2MG/15ML SOLUTION	PIVIS	ST 50MG/ML SOLUTION	
02291800 IMODIUM CALMING	MCL	80001809 CITRODAN C	DDN
ST 2MG TABLET	WICL	MAGNESIUM HYDROXIDE	
02212005 APO-LOPERAMIDE	APX	ST 80MG/ML LIQUID	
02248994 DIARRHEA RELIEF	PMS	02245289 MILK OF MAGNESIA F	PMS
02256452 DIARRHEA RELIEF	VTH	02150646 PHILLIPS MILK OF MAGNESIA E	BAY
02225182 LOPERAMIDE	PDL	ST 311MG TABLET (CHEWABLE)	
02228351 PMS-LOPERAMIDE	PMS		BAY
02238211 RIVA-LOPERAMIDE	RIV	MINERAL OIL	
02132591 TEVA-LOPERAMIDE	TEV	ST 78% GEL	
56:12.00 CATHARTICS AND LAXATIVES			AUP
BISACODYL			AUP
		sr 100% LIQUID	
5MG SUPPOSITORY			RBW
02410893 BISACODYL	JMP	POLYETHYLENE GLYCOL 3350	
02458845 BISACODYL	UNK		
10MG SUPPOSITORY	IMP	POWDER	400
02361450 BISACODYL	JMP		MDS
00003875 DULCOLAX	BOE		MDS
00582883 PMS-BISACODYL 02241091 THE MAGIC BULLET	PMS DCM	ST 100% POWDER FOR SOLUTION	DED
s7 5MG TABLET	DOM		PER JNK
00254142 DULCOLAX	BOE		JNK JMP
00254142 DULCOLAX 02246039 JAMP-BISACODYL	JMP		JMP MAN
00587273 PMS-BISACODYL	PMS	02 1 00070	vi/\\IN
00001210 1 MO 210/100212			

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56:12.00 CA	THARTICS AND LAXATIV	ES	56:12.00 CATHARTICS AND LAXATIVES	
POLYETHYL	ENE GLYCOL 3350		SENNOSIDES	
ST 1G POWDER	R FOR SOLUTION		ST 12MG TABLET	
	LAX-A-DAY	PED	00896403 PMS-SENNOSIDES	PMS
02453193	LAX-A-DAY PHARMA	PMS	80009183 SENNOSIDES	JMP
	PEG 3350	MDS	ST 15MG TABLET	
02346672	RELAXA	RLI	02226030 EXLAX CHOCOLATED	NVC
02318164	RESTORALAX	BAY	43MG TABLET	
POLYETHYL	ENE GLYCOL 3350, SODIUM	Λ	80061813 SENNACE	VAN
	ODIUM BICARBONATE, SOL		8.6MG TABLET (FILM COATED)	
•	POTASSIUM CHLORIDE		80064362 SENNA SENNOSIDES NATURALS	UNK
•	G & 1.68G & 1.46G & 5.68G/L POW	DED	15MG TABLET (FILM COATED)	
00677442		PED	80054167 SENNOSIDES	UNK
			SODIUM PHOSPHATE	
	ENE GLYCOL 3350, SODIUN ODIUM BICARBONATE, SOE		ST 0.9G ORAL SOLUTION	
•	POTASSIUM CHLORIDE, BIS		80000689 PHOSLAX	ODN
•	•		ST 60MG & 160MG/ML RECTAL LIQUID	
	'4G & 1.69G & 1.46G & 0.76G & 5M		02096900 ENEMOL SODIUM PHOSPHATE	DPC
	BI-PEGLYTE	PED	00009911 FLEET ENEMA	KIM
PSYLLIUM M	IUCILLOID		00108065 FLEET ENEMA PEDIATRIC	KIM
ST 50% POWDE	R		ST 180MG & 480MG/ML SOLUTION	
	MUCILLIUM	PMS	02230399 PHOSPHATES	PMS
ST 680MG/G PC	OWDER		ST 2.4G SOLUTION	
02174812	METAMUCIL FIBRE THERAPY	PGI	80034416 JAMP-SODIUM PHOSPHATE	JMP
	ORIGINAL TEXTURE		ST 7G SOLUTION	
	UNFLAVOURED		02231170 ENEMA	HJS
02174790	METAMUCIL FIBRE THERAPY SMOOTH TEXTURE ORANGE	PGI	123MG TABLET (EFFERVESCENT)	
	FLAVOUR		80047562 JAMP-SODIUM PHOSPHATE	JMP
02174782	METAMUCIL FIBRE THERAPY SMOOTH TEXTURE ORANGE FLAVOUR (SUGAR-FREE)	PGI	SORBITOL, SODIUM CITRATE, SODIUM LAUF SULFOACETATE	RYL
02174804	METAMUCIL FIBRE THERAPY	PGI	^{S7} 90MG & 9MG & 625MG ENEMA	
	SMOOTH TEXTURE		02063905 MICROLAX	MCL
	UNFLAVOURED		56:14.00 CHOLELITHOLYTIC AGENTS	
SENNOSIDES	S		URSODIOL	
ST 1.7MG/ML LI	IQUID		ST 250MG TABLET	
80024394	JAMP SENNAQUIL	JMP	02472392 JAMP-URSODIOL	JMP
02144379	SENNALAX	PMS	02273497 PMS-URSODIOL	PMS
02084651	SENNAPREP	PMS	02238984 URSO	APC
00367729		PFR	02426900 URSODIOL	GLK
ST 8.6MG TABL			ST 500MG TABLET	
	M SENNOSIDES	MAN	02472406 JAMP-URSODIOL	JMP
	OPUS SENNOSIDES	OPU	02273500 PMS-URSODIOL	PMS
	RIVA SENNA	RIV	02245894 URSO DS	APC
ST 9MG TABLE			02426919 URSODIOL	GLK
	BIOSENNOSIDES	BMI	ST PDIN FOR EXTEMPORANEOUS MIXTURE	
02247389	EURO SENNA	EUR	99503024 UROSODIOL ORAL LIQUID	UNK
80054498	M SENNOSIDES	MAN	56:16.00 DIGESTANTS	
00896411	PMS-SENNOSIDES	PMS		
80009595	SENNA LAYATIVE	JMP	LACTASE	
02237105	SENNA CENNOCIDES	VTH	ST 3,000U CAPLET	
02068109	SENNA SENNOSIDES	PMS	02239139 DAIRY DIGESTIVE	VTH
	SENNOSIDES SENOKOT	JMP PFR	ST 4,500U CAPLET	
υυυ26158 ST 12MG TABLI		FFK	02239140 DAIRY DIGESTIVE	VTH
	M-SENNOSIDES	MAN	ST ORAL LIQUID	
000000-1	JEINIOOIDEO	IVIZ-(IV	99100157 LACTEEZE DROPS	AUP

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56:16.00 DIGESTANTS		56:22.08 ANTIHISTAMINES	
LACTASE		DIMENHYDRINATE	
ST 300MG TABLET		Limited use benefit (prior approval not required).	
80070358 JAMPLACTASE ENZYME	JMP	The NIHB Program implemented a dose coverage limit for	or
^{S7} 3,000U TABLET		dimenhydrinate in June 2017 as part of a strategy to addr	ress
01951637 DAIRYAID	TAN	safety concerns and potential misuse.	
02230653 LACTAID	KIM	The dimenhydrinate dose limit is currently 400 mg per da	v for
02017512 LACTOMAX	STE	a total of 12,000 mg of dimenhydrinate in a 30-day period	
ST 4,500U TABLET	1218.4		
02230654 LACTAID EXTRA STRENGTH	KIM	This limit applies only to the 15 mg and 50 mg tablets. Dimenhydrinate in liquid, suppository and injectable forms	o oro
02224909 LACTOMAX EXTRA	STE	not included in this limit.	s ale
ST 9,000U TABLET	IZINA	50MG/ML INJECTION	
02231507 LACTAID ULTRA	KIM	00392537 DIMENHYDRINATE	SDZ
LIPASE, AMYLASE, PROTEASE		00013579 GRAVOL	CHU
ST 8,000U & 30,000U & 30,000U CAPSULE		10MG LIQUID	CITO
00263818 COTAZYM	FRS	00392731 DIMENHYDRINATE	SDZ
00502790 COTAZYM ECS 8	FRS	25MG SUPPOSITORY	ODZ
ST 20,000U & 55,000U & 55,000U CAPSULE		00783595 GRAVOL	CHU
00821373 COTAZYM ECS 20	FRS	50MG SUPPOSITORY	0110
ST 10000U & 11200U & 730U CAPSULE (DELAYED		00392553 SANDOZ DIMENHYDRINATE	SDZ
RELEASE)		100MG SUPPOSITORY	ODZ
02200104 CREON MINIMICROSPHERES 10	ABB	00013609 GRAVOL	CHU
ST 25000U & 25500U & 1600U CAPSULE (DELAYED		ST 3MG/ML SYRUP	0110
RELEASE)	400	00230197 GRAVOL	CHU
01985205 CREON MINIMICROSPHERES 25	ABB	50MG TABLET	0.10
ST 5000U & 5100U & 320U GRANULES FOR SUSPENS (DELAYED RELEASE)	ION	02241532 ANTI-NAUSEANT	VTH
02445158 CREON MINIMICROSPHERES	BGP	00363766 APO DIMENHYDRINATE	APX
MICRO	БОР	00013803 GRAVOL	CHU
56:20.00 EMETICS		02245416 JAMP-DIMENHYDRINATE	JMP
		02377179 MOTION SICKNESS	APX
IPECAC		00586331 PMS-DIMENHYDRINATE	PMS
14MG/ML LIQUID		00021423 TEVA-DIMENATE	TEV
00378801 XENEX IPECAC	XEN	00605786 TRAVEL	VTH
56:22.00 ANTIEMETICS		DOXYLAMINE SUCCINATE, PYRIDOXINE	
NETUPITANT, PALONOSETRON		HYDROCHLORIDE	
(PALONOSETRON HYDROCHLORIDE)			
•		10MG & 10MG TABLET (DELAYED RELEASE)	D
Limited use benefit (prior approval required).		00609129 DICLECTIN	DUI
When used in combination with dexamethasone for the		56:22.20 5-HT3 RECEPTOR ANTAGONIS	STS
prevention of acute and delayed nausea and vomiting due	to	GRANISETRON HYDROCHLORIDE	
highly emetogenic cancer chemotherapy (eg. cisplatin > 70mg/m2).		ST 1MG TABLET	
3 ,		02308894 APO-GRANISETRON	APX
37 300MG & 0.5MG CAPSULE		02452359 NAT-GRANISETRON	NPH
02468735 AKYNZEO	PFR	ONDANSETRON HYDROCHLORIDE	
		ST 4MG FILM	
		02389983 ONDISSOLVE ODF	TAK
		ST 8MG FILM	
		02389991 ONDISSOLVE ODF	TAK
		ST 0.8MG/ML SOLUTION	_
		02291967 ONDANSETRON	AAP
		02229639 ZOFRAN	NVR
		4MG SOLUTION	
		02490617 JAMP ONDANSETRON	JMP
		ST 4MG TABLET	

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02478927 ACCEL-ONDANSETRON

ACP

		Non-insured nealth bene	ents	
56:22.20 5-HT3 RECEPTOR ANTAGONISTS		56:22.92 MISCELLANEOUS ANTIEMETICS		
ONDANSETRON HYDROCHLORIDE	ONDANSETRON HYDROCHI ORIDE			
		DOXYLAMINE SUCCINATE, PYRIDOXINE HYDROCHLORIDE		
ST 4MG TABLET	T E\ (
02296349 ACT ONDANSETRON	TEV	ST 10MG & 10MG TABLET (DELAYED RELEASE)		
02288184 APO-ONDANSETRON	APX	02413248 APO-DOXYLAMINE/B6	APX	
02313685 JAMP-ONDANSETRON	JMP	02406187 PMS-DOXYLAMINE-PYRIDOXINE	PMS	
02371731 MAR-ONDANSETRON	MAR	NABILONE		
02305259 MINT-ONDANSETRON	MIN	0.25MG CAPSULE		
02297868 MYLAN-ONDANSETRON	MYL	02312263 CESAMET	UNK	
02417839 NAT-ONDANSETRON	NPH	02358077 RAN-NABILONE	RBY	
02421402 ONDANSETRON	SAN	02392925 TEVA-NABILONE	TEV	
02258188 PMS-ONDANSETRON	PMS	0.5MG CAPSULE		
02312247 RAN-ONDANSETRON	RBY	02393581 ACT NABILONE	TEV	
02274310 SANDOZ ONDANSETRON	SDZ	02256193 CESAMET	UNK	
02376091 SEPTA-ONDANSETRON	SPT	02380900 PMS-NABILONE	PMS	
02213567 ZOFRAN	NVR	02358085 RAN-NABILONE	RBY	
ST 8MG TABLET	4.00	02384884 TEVA-NABILONE	TEV	
02478935 ACCEL-ONDANSETRON	ACP	1MG CAPSULE		
02296357 ACT ONDANSETRON	TEV	02393603 ACT NABILONE	TEV	
02288192 APO-ONDANSETRON	APX	00548375 CESAMET	UNK	
02313693 JAMP-ONDANSETRON	JMP	02380919 PMS-NABILONE	PMS	
02371758 MAR-ONDANSETRON	MAR	02358093 RAN-NABILONE	RBY	
02305267 MINT-ONDANSETRON	MIN	02384892 TEVA-NABILONE	TEV	
02297876 MYLAN-ONDANSETRON	MYL	56:28.12 HISTAMINE H2-ANTAGONISTS		
02417847 NAT-ONDANSETRON	NPH			
02325160 ONDANSETRON	PDL	CIMETIDINE		
02421410 ONDANSETRON	SAN	ST 200MG TABLET		
02258196 PMS-ONDANSETRON	PMS	00584215 CIMETIDINE	AAP	
02312255 RAN-ONDANSETRON	RBY	ST 300MG TABLET		
02274329 SANDOZ ONDANSETRON	SDZ	00487872 CIMETIDINE	AAP	
02376105 SEPTA-ONDANSETRON	SPT	02227444 MYLAN-CIMETIDINE	MYL	
02213575 ZOFRAN	NVR	ST 400MG TABLET		
ST 4MG TABLET (ORALLY DISINTEGRATING)	MAINI	00600059 CIMETIDINE	AAP	
02487330 MINT-ONDANSETRON ODT	MIN	ST 600MG TABLET		
02481723 ONDANSETRON ODT	SDZ	00600067 CIMETIDINE	AAP	
02444674 VPI-ONDANSETRON ODT	UNK	ST 800MG TABLET		
02239372 ZOFRAN ODT	NVR	00749494 CIMETIDINE	AAP	
ST 8MG TABLET (ORALLY DISINTEGRATING)	007	FAMOTIDINE		
02481731 ONDANSETRON ODT	SDZ			
02444682 VPI-ONDANSETRON ODT	UNK	10MG CAPSULE		
02239373 ZOFRAN ODT	NVR	99113721 FAMOTIDINE (QC)	UNK	
56:22.32 MISCELLANEOUS ANTIEMETIC	S	20MG CAPSULE		
APREPITANT		99113722 FAMOTIDINE (QC)	UNK	
Limited use benefit (prior approval required).		ST 20MG TABLET		
		01953842 APO-FAMOTIDINE	APX	
When used in combination with a 5-HT3 antagonist and		02351102 FAMOTIDINE	SAN	
dexamethasone for the prevention of acute and delayed		02273357 MAXIMUM STRENGTH PEPCID AC	MCL	
nausea and vomiting due to highly emetogenic cancer chemotherapy (e.g. Cisplatin > 70mg/m2).		02022133 TEVA-FAMOTIDINE	TEV	
sr 80MG CAPSULE		ST 40MG TABLET		
	EDC	01953834 APO-FAMOTIDINE	APX	
02298791 EMEND	FRS	02351110 FAMOTIDINE	SAN	
ST 125MG CAPSULE	ED0	02022141 TEVA-FAMOTIDINE	TEV	
02298805 EMEND	FRS	NIZATIDINE		
ST 125MG & 80MG CAPSULE	ED0	ST 150MG CAPSULE		
02298813 EMEND TRI-PACK	FRS	00778338 AXID	PED	
		02177714 PMS-NIZATIDINE	PMS	

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EC.20 42 LIG	STAMINE US ANTACONICT	•	56:20 26 DECTON DUMP INCIDENCE		
	STAMINE H2-ANTAGONIST	5	56:28.36 PROTON-PUMP INHIBITORS		
NIZATIDINE			AMOXICILLIN, CLARITHROMYCIN,		
ST 300MG CAP	SULE		LANSOPRAZOLE		
00778346		PED	ST 500MG & 500MG & 30MG KIT		
02177722	PMS-NIZATIDINE	PMS	02470780 APO-LANSOPRAZOLE-	APX	
RANITIDINE	HCL		AMOXICILLIN-CLARITHROMYCIN		
150MG CAP	elli E		02238525 HP-PAC	TAK	
	RANITIDINE (QC)	UNK	LANSOPRAZOLE		
	HYDROCHLORIDE	ONIX	Limited use benefit (prior approval not required).		
			Coverage will be limited to 400 tablets/capsules every 180		
ST 15MG/ML SO		4.504	days.		
02280833 ST 150MG TAB	APO-RANITIDINE	APX			
		TE\/	(Please refer to Appendix A).		
	ACT RANITIDINE	TEV	ST 15MG CAPSULE (DELAYED RELEASE)		
	APO-RANITIDINE	APX	02293811 APO-LANSOPRAZOLE	APX	
02463717	JAMP-RANITIDINE	JMP	02357682 LANSOPRAZOLE	SAN	
02443708	MAR-RANITIDINE	MAR	02385767 LANSOPRAZOLE	SIV	
02293471	MAXIMUM STRENGTH ACID	PMS	02433001 LANSOPRAZOLE	PMS	
00470504	REDUCER		02353830 MYLAN-LANSOPRAZOLE	MYL	
02473534	M-RANITIDINE	MAN	02395258 PMS-LANSOPRAZOLE	PMS	
02242453	PMS-RANITIDINE	PMS	02165503 PREVACID	TAK	
00740748	RANITIDINE	PDL	02422808 RIVA-LANSOPRAZOLE	RIV	
02353016	RANITIDINE	SAN	02385643 SANDOZ LANSOPRAZOLE	SDZ	
02385953	RANITIDINE	SIV	02402610 TARO-LANSOPRAZOLE	SUN	
02336480	RAN-RANITIDINE	RBY			
02247814	RIVA-RANITIDINE	RIV	02280515 TEVA-LANSOPRAZOLE	TEV	
02243229	SANDOZ RANITIDINE	SDZ	ST 30MG CAPSULE (DELAYED RELEASE)	4504	
ST 300MG TAB	LET		02293838 APO-LANSOPRAZOLE	APX	
02248571	ACT RANITIDINE	TEV	02414775 DOM-LANSOPRAZOLE	DPC	
	APO-RANITIDINE	APX	02357690 LANSOPRAZOLE	SAN	
02463725	JAMP-RANITIDINE	JMP	02366282 LANSOPRAZOLE	PDL	
02443716	MAR-RANITIDINE	MAR	02410389 LANSOPRAZOLE	SIV	
02473542	M-RANITIDINE	MAN	02433028 LANSOPRAZOLE	PMS	
02242454	PMS-RANITIDINE	PMS	02353849 MYLAN-LANSOPRAZOLE	MYL	
		PDL	02395266 PMS-LANSOPRAZOLE	PMS	
00740756	RANITIDINE		02165511 PREVACID	TAK	
02353024	RANITIDINE	SAN	02422816 RIVA-LANSOPRAZOLE	RIV	
02385961	RANITIDINE	SIV	02402629 TARO-LANSOPRAZOLE	SUN	
02336502	RAN-RANITIDINE	RBY	02280523 TEVA-LANSOPRAZOLE	TEV	
02247815	RIVA-RANITIDINE	RIV	ST 30MG TABLET (DELAYED RELEASE)		
02243230	SANDOZ RANITIDINE	SDZ	02385651 SANDOZ LANSOPRAZOLE	SDZ	
56:28.28 PR	OSTAGLANDINS		PDIN FOR EXTEMPORANEOUS MIXTURE	SDZ	
MICORDOCT	OI			LINUZ	
MISOPROST			99503010 LANSOPRAZOLE ORAL LIQUID	UNK	
s [™] 100MCG TA	BLET		LANSOPRAZOLE ODT		
	MISOPROSTOL	AAP	Limited use benefit (prior approval not required).		
ST 200MCG TA			Coverage will be limited to 400 tablets/capsules every 180		
	MISOPROSTOL	AAP	days.		
56:28.32 PR	OTECTANTS				
SUCRALFAT			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	
ST 200MG/ML S			the capsule formulation is not possible.	Ji	
	SULCRATE PLUS	APC	and dapodio formulation to not possible.		
ST 1G TABLET			(Please refer to Appendix A).		
02125250	APO-SUCRALFATE	APX	ST 15MG TABLET (DELAYED RELEASE)		
02100622	SULCRATE	APC	02249464 PREVACID FASTAB	TAK	
02045702	TEVA-SUCRALFATE	TEV	ST 30MG TABLET (DELAYED RELEASE)	17413	
			•	TAI	
	<u> </u>		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.

(Please refer to Appendix A).

ULE (DELAYED RELEASE)	
APO-OMEPRAZOLE	APX
LOSEC	AZC
OMEPRAZOLE	PDL
OMEPRAZOLE	SAN
OMEPRAZOLE-20	SIV
PMS-OMEPRAZOLE	PMS
RAN-OMEPRAZOLE	RBY
SANDOZ OMEPRAZOLE	SDZ
ET (DELAYED RELEASE)	
BIO-OMEPRAZOLE	BMI
JAMP-OMEPRAZOLE DR	JMP
LOSEC	AZC
NAT-OMEPRAZOLE DR	NPH
OMEPRAZOLE	ACC
RAN-OMEPRAZOLE	RBY
RIVA-OMEPRAZOLE DR	RIV
TEVA-OMEPRAZOLE	TEV
XTEMPORANEOUS MIXTURE	
OMEPRAZOLE ORAL LIQUID	UNK
	APO-OMEPRAZOLE LOSEC OMEPRAZOLE OMEPRAZOLE OMEPRAZOLE-20 PMS-OMEPRAZOLE RAN-OMEPRAZOLE SANDOZ OMEPRAZOLE ET (DELAYED RELEASE) BIO-OMEPRAZOLE JAMP-OMEPRAZOLE DR LOSEC NAT-OMEPRAZOLE DR OMEPRAZOLE RAN-OMEPRAZOLE RIVA-OMEPRAZOLE RIVA-OMEPRAZOLE DR TEVA-OMEPRAZOLE

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).

ST 40MG TABLE	ET (DELAYED RELEASE)	
02466147	PANTOPRAZOLE T	SAN
ST 40MG TABLE	ET (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).

40MG TABL	ET (DELAYED RELEASE)	
02478781	AG-PANTOPRAZOLE	ANG
02481588	AG-PANTOPRAZOLE SODIUM	ANG
02292920	APO-PANTOPRAZOLE	APX
02415208	AURO-PANTOPRAZOLE	AUR
02445867	BIO-PANTOPRAZOLE	BMI
02357054	JAMP-PANTOPRAZOLE	JMP
02416565	MAR-PANTOPRAZOLE	MAR
02417448	MINT-PANTOPRAZOLE	MIN

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

(Please refer to Appendix A).

40MG TABL	ET (DELAYED RELEASE)	
02467372	M-PANTOPRAZOLE	MAN
02471825	NRA-PANTOPRAZOLE	UNK
02229453	PANTOLOC	TAK
02318695	PANTOPRAZOLE	PDL
02370808	PANTOPRAZOLE	SAN
02431327	PANTOPRAZOLE	RIV
02437945	PANTOPRAZOLE	PMS
02439107	PANTOPRAZOLE	DPC
02428180	PANTOPRAZOLE-40	SIV
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.

(Please refer to Appendix A).

ST 10MG TABL	ET (ENTERIC COATED)	
02345579	APO-RABEPRAZOLE	APX
02243796	PARIET	JSO
02310805	PMS-RABEPRAZOLE	PMS
02315181	PRO-RABEPRAZOLE	PDL
02385449	RABEPRAZOLE	SIV
02356511	RABEPRAZOLE EC	SAN
02298074	RAN-RABEPRAZOLE	RBY
02314177	SANDOZ RABEPRAZOLE	SDZ
02296632	TEVA-RABEPRAZOLE	TEV
ST 20MG TABL	ET (ENTERIC COATED)	
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
02314185	SANDOZ RABEPRAZOLE	SDZ
02296640	TEVA-RABEPRAZOLE	TEV
56:32.00 PR	OKINETIC AGENTS	

DOMPERIDONE MALEATE

DOMI LINDONL MALLAIL					
ST 10MG TABLET					
02103613	APO-DOMPERIDONE	APX			
02445034	BIO-DOMPERIDONE	BMI			
02238315	DOM-DOMPERIDONE	DPC			
02236857	DOMPERIDONE	PDL			

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56:32.00 PROKINETIC AGENTS		56:36.00 ANTI-INFLAMMATORY AGENTS	
DOMPERIDONE MALEATE		MESALAZINE	
ST 10MG TABLET		ST 1G TABLET (EXTENDED RELEASE)	
02238341 DOMPERIDONE	SIV	•	ΞEI
02350440 DOMPERIDONE	SAN	ST 1.2G TABLET (EXTENDED RELEASE)	
02369206 JAMP-DOMPERIDONE	JMP	02297558 MEZAVANT S	SHI
02403870 MAR-DOMPERIDONE	MAR	OLSALAZINE SODIUM	
02236466 PMS-DOMPERIDONE	PMS	ST 250MG CAPSULE	
02445328 PRIVA-DOMPERIDONE	PHA		PU
02268078 RAN-DOMPERIDONE	RBY		PU
01912070 TEVA-DOMPERIDONE	TEV	56:92.00 MISCELLANEOUS GI DRUGS	
PDIN FOR EXTEMPORANEOUS MIXTURE		OBETICHOLIC ACID	
99503005 DOMPERIDONE ORAL LIQUID	UNK	Limited use benefit (prior approval required).	
METOCLOPRAMIDE HYDROCHLORIDE		Criteria for initial 12-month coverage:	
ST 1MG/ML SOLUTION		The patient has a confirmed diagnosis of primary biliary	
02230433 METONIA	PED	cholangitis (PBC), defined as:	
ST 5MG TABLET		positive antimitochondrial antibodies (AMA); or	
00842826 APO-METOCLOP	APX	liver biopsy results consistent with PBC.and	
02230431 METONIA	PED	The patient is under the care of a gastroenterologist,	
^{sτ} 10MG TABLET		hepatologist or internal medicine specialist with experience in	
00842834 APO-METOCLOP	APX	the treatment of PBC.	
02230432 METONIA	PED	The patient has received ursodeoxycholic acid (UDCA) for a	
56:36.00 ANTI-INFLAMMATORY AGENTS		minimum of 12 months and has experienced an inadequate	
BETAMETHASONE SODIUM PHOSPHATE		response to UDCA and can benefit from the addition of obeticholic acid. An inadequate response is defined as:	
0.05MG/ML ENEMA		 alkaline phosphatase (ALP) ≥ 1.67 x upper limit of normal 	
02060884 BETNESOL	PAL	(ULN); and/or • bilirubin > ULN and < 2 x ULN; and/or	
HYDROCORTISONE ACETATE		• evidence of compensated cirrhosis by fibroscan or biopsy.	
100MG/60ML ENEMA		 or The patient has experienced documented and unmanageable 	
02112736 CORTENEMA	APC	intolerance to UDCA.	
MESALAZINE			
500MG SUPPOSITORY		Criteria for renewal every 12 months: The patient continues to benefit from treatment with	
02112760 SALOFALK	APC	obeticholic acid as evidenced by:	
1G SUPPOSITORY	7.11 0	 a reduction in the ALP level to less than 1.67 x ULN; or 	
02474018 MEZERA	UNK	a 15% reduction in the ALP level compared with values beginning to a section with a beginning and a section of the se	
02153564 PENTASA	FEI	before beginning treatment with obeticholic acid.	
02242146 SALOFALK	APC	5MG TABLET	
1G/100ML SUSPENSION			NK
02153521 PENTASA	FEI	10MG TABLET	
2G/60G SUSPENSION			NK
02112795 SALOFALK	APC	PINAVERIUM BROMIDE	
4G/100ML SUSPENSION		Limited use benefit (prior approval required).	
02153556 PENTASA	FEI	For the treatment and relief of symptoms associated with	
4G/60G SUSPENSION		functional bowel disorders including Irritable Bowel Syndrome	
02112809 SALOFALK	APC	(IBS), spastic colon, spastic colitis and mucous colitis; or	
ST 500MG TABLET (DELAYED RELEASE)		In postoperative paralytic ileus in order to accelerate the	
02112787 SALOFALK	APC	resumption of the intestinal transit following abdominal surgery.	
ST 800MG TABLET (DELAYED RELEASE)		ů ,	
02267217 ASACOL	ALL	50MG CAPSULE	PH
ST 400MG TABLET (ENTERIC COATED)		00465240 DICETEL SI 50MG TABLET	r 17
01997580 ASACOL	ALL		PX
02171929 TEVA-5 ASA	TEV		GP
ST 500MG TABLET (EXTENDED RELEASE)		100MG TABLET	OI.
02099683 PENTASA	FEI		PX
			GP

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56:92.00 MISCELLANEOUS GI DRUGS **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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60:00 GOLD COMPOUNDS

60:00.00 GOLD COMPOUNDS

AURANOFIN

3MG CAPSULE

01916823 RIDAURA XED

SODIUM AUROTHIOMALATE

50MG/ML SOLUTION

02245458 SODIUM AUROTHIOMALATE SDZ

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64:00 HEAVY METAL ANTAGONISTS 64:00.00 HEAVY METAL ANTAGONISTS

PENICILLAMINE

250MG CAPSULE 00016055 CUPRIMINE

UNK

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O.AA HODMONEC AND OVALUET		CO.O.A.O. ADDENALC	
88:00 HORMONES AND SYNTHETI	C	68:04.00 ADRENALS	
SUBSTITUTES		DEXAMETHASONE PHOSPHATE	
68:04.00 ADRENALS		4MG/ML LIQUID	
BECLOMETHASONE DIPROPIONATE		01977547 DEXAMETHASONE	RAX
		02204266 DEXAMETHASONE-OMEGA	OMG
50MCG AEROSOL	\	10MG/ML LIQUID	
02242029 QVAR	VAE	00874582 DEXAMETHASONE	SDZ
100MCG AEROSOL	VAE	02204274 DEXAMETHASONE-OMEGA	OMG PMS
02242030 QVAR	VAE	00783900 PMS-DEXAMETHASONE	PIVIS
BUDESONIDE		FLUDROCORTISONE ACETATE	
3MG CAPSULE (SUSTAINED RELEASE)		0.1MG TABLET	
02229293 ENTOCORT	TIL	02086026 FLORINEF	PAL
100MCG POWDER		FLUTICASONE FUROATE, UMECLIDINIUM	
00852074 PULMICORT TURBUHALER	AZC	BROMIDE, VILANTEROL TRIFENATATE	
200MCG POWDER	470	Limited use benefit (prior approval required).	
00851752 PULMICORT TURBUHALER	AZC	For the constitution of the standard of the said of the standard	
400MCG POWDER	A 7.0	For the maintenance treatment of chronic obstructive pulmonary disease (COPD) including chronic bronchitis	
00851760 PULMICORT TURBUHALER	AZC	and/or emphysema who meet the following criteria:	
0.125MG SUSPENSION 02465949 TEVA-BUDESONIDE	TEV	 patients are not started on triple inhaled therapy as initial 	
0.125MG/ML SUSPENSION	ΙΕV	therapy for COPD; and patients have had an inadequate response to optimal dual	al
0.123MG/ML SOSPENSION 02229099 PULMICORT NEBUAMP	AZC	inhaled therapy* for COPD.	ai-
0.25MG/ML SUSPENSION	ALC		
0.1978918 PULMICORT NEBUAMP	AZC	*Dual-inhaled therapy refers to any combination of a long-	
0.5MG SUSPENSION	7120	acting muscarinic antagonist (LAMA), long-acting beta-2 agonist (LABA) or an inhaled corticosteroid (ICS).	
02465957 TEVA-BUDESONIDE	TEV	100MCG & 62.5MCG & 25MCG POWDER	
0.5MG/ML SUSPENSION		02474522 TRELEGY ELLIPTA	GSŁ
01978926 PULMICORT NEBUAMP	AZC	FLUTICASONE PROPIONATE	GSF
CICLESONIDE			
100MG/INHALATION AEROSOL		50MCG/INHALATION AEROSOL	
02285606 ALVESCO	AZC	02244291 FLOVENT HFA	GSŁ
200MG/INHALATION AEROSOL	AZC	125MCG/INHALATION AEROSOL	001
02285614 ALVESCO	AZC	02244292 FLOVENT HFA	GSŁ
CORTISONE ACETATE	AZO	250MCG/INHALATION AEROSOL	001
CONTISONE ACETATE		02244293 FLOVENT HFA	GSŁ
25MG TABLET		100MCG/DOSE POWDER 02237245 FLOVENT DISKUS	GSŁ
00280437 CORTISONE	VAE	250MCG/DOSE POWDER	Gor
DEXAMETHASONE		02237246 FLOVENT DISKUS	GSŁ
0.1MG/ML ELIXIR		500MCG/DOSE POWDER	Ooi
01946897 PMS DEXAMETHASONE	PMS	02237247 FLOVENT DISKUS	GSŁ
0.5MG TABLET		HYDROCORTISONE (HYDROCORTISONE	001
02261081 APO-DEXAMETHASONE	APX	SODIUM SUCCINATE)	
01964976 PMS DEXAMETHASONE	PMS	SODIUM SUCCINATE)	
0.75MG TABLET		100MG POWDER FOR SOLUTION	
01964968 PMS DEXAMETHASONE	PMS	00030600 SOLU-CORTEF ACT-O-VIAL	PF
2MG TABLET		250MG POWDER FOR SOLUTION	
02279363 PMS-DEXAMETHASONE	PMS	00030619 SOLU-CORTEF ACT-O-VIAL	PF
4MG TABLET		1G POWDER FOR SOLUTION	
02250055 APO-DEXAMETHASONE	APX	00030635 SOLU-CORTEF ACT-O-VIAL	PF
01964070 PMS DEXAMETHASONE	PMS	HYDROCORTISONE ACETATE	
PDIN FOR EXTEMPORANEOUS MIXTURE		10MG TABLET	
99503007 DEXAMETHASONE ORAL LIQUID	UNK	00030910 CORTEF	PF
DEXAMETHASONE PHOSPHATE		20MG TABLET	
4MG/ML LIQUID		00030929 CORTEF	PF
00664227 DEXAMETHASONE	SDZ		

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68:04.00 AD	RENALS		68:04.00 ADRENALS
METHYLPRE	DNISOLONE		PREDNISONE
4MG TABLE	т		5MG TABLET
00030988		PFI	00312770 APO PREDNISONE APX
16MG TABLI			00021695 TEVA-PREDNISONE TEV
00036129	MEDROL	PFI	50MG TABLET
METHYLPRE	DNISOLONE		00550957 APO PREDNISONE APX
	EDNISOLONE SODIUM SUCCIN	ATE)	00232378 TEVA-PREDNISONE TEV
•		. · · · - ,	PDIN FOR EXTEMPORANEOUS MIXTURE
40MG INJEC		DEL	99503008 PREDNISONE ORAL LIQUID UNK
	SOLU-MEDROL	PFI	TRIAMCINOLONE ACETONIDE
125MG INJE		חבו	40MC/ML IN IECTION
	SOLU-MEDROL	PFI	40MG/ML INJECTION 00990876 KENALOG-40 BMS
500MG INJE		חבו	10MG/ML SUSPENSION
1G INJECTIO	SOLU-MEDROL	PFI	01999761 KENALOG-10 BMS
		PFI	02229540 TRIAMCINOLONE SDZ
	SOLU-MEDROL SOLU-MEDROL	PFI	40MG/ML SUSPENSION
	DER FOR SOLUTION	FFI	01999869 KENALOG-40 BMS
	METHYLPREDNISOLONE SODIUM	TEV	01977563 TRIAMCINOLONE RAX
02231093	SUCCINATE	ΙLV	02229550 TRIAMCINOLONE SDZ
1G POWDER	R FOR SOLUTION		TRIAMCINOLONE DIACETATE
02241229	METHYLPREDNISOLONE SODIUM	TEV	TRIAMCINOLONE DIACETATE
	SUCCINATE		40MG/ML SUSPENSION
METHYLPRE	DNISOLONE ACETATE		01977555 TRIAMCINOLONE RAX
20MG/ML SU	JSPENSION		TRIAMCINOLONE HEXACETONIDE
01934325	DEPO-MEDROL	PFI	20MG SUSPENSION
40MG/ML SU	JSPENSION		02470632 TRIAMCINOLONE HEXACETONIDE UNK
00030759	DEPO-MEDROL	PFI	INJECTABLE
01934333	DEPO-MEDROL	PFI	68:08.00 ANDROGENS
02245400	METHYLPREDNISOLONE	SDZ	DANAZOL
02245407	METHYLPREDNISOLONE	SDZ	50MG CAPSULE
80MG/ML SU	JSPENSION		02018144 CYCLOMEN SAC
00030767	DEPO-MEDROL	PFI	100MG CAPSULE
01934341	DEPO-MEDROL	PFI	02018152 CYCLOMEN SAC
02245406	METHYLPREDNISOLONE	SDZ	200MG CAPSULE
02245408	METHYLPREDNISOLONE	SDZ	02018160 CYCLOMEN SAC
METHYLPRE	DNISOLONE ACETATE, LIDOC	AINE	
HYDROCHLO	ORIDE		TESTOSTERONE (TOPICAL)
40MG & 10M	IG SUSPENSION		Limited use benefit (prior approval required).
	DEPO-MEDROL WITH LIDOCAINE	PFI	The NIHB Program covers topical testosterone for the
	NE FUROATE		treatment of the following:
			orchiectomy, undescended testes, Klinefelter's; or
200MCG PO			 pituitary tumour or post-pituitary surgery with low testosterone; or
	ASMANEX TWISTHALER	FRS	AIDS-wasting syndrome with low testosterone; or
400MCG PO			 gender affirming hormone therapy.
	ASMANEX TWISTHALER	FRS	Neter Olden individuals with new energia symmetons and a
	ONE SODIUM PHOSPHATE		Note: Older individuals with non-specific symptoms such as, but not limited to, fatigue, malaise, or depression who have a
1MG/ML SO		040	low random testosterone level do not meet coverage criteria.
	PEDIAPRED	SAC	1% GEL
	PMS-PREDNISOLONE	PMS	02245345 ANDROGEL BGP
PREDNISON	E		02245346 ANDROGEL BGP
1MG TABLE	т		02463792 TARO-TESTOSTERONE TAR
	APO PREDNISONE	APX	02463806 TARO-TESTOSTERONE TAR
00271373	WINPRED	AAP	02280248 TESTIM PAL

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68:08.00 ANDROGENS		68:12.00 CONTRACEPTIVES	
TESTOSTERONE (TOPICAL)		ETHINYL ESTRADIOL, ETONOGESTREL	
` ,		·	
Limited use benefit (prior approval required).		ST 2.6MG & 11.4MG RING (SLOW-RELEASE)	- D0
The NIHB Program covers topical testosterone for the		02253186 NUVARING	FRS
treatment of the following:		ETHINYL ESTRADIOL, LEVONORGESTREL	
 orchiectomy, undescended testes, Klinefelter's; or pituitary tumour or post-pituitary surgery with low 		$^{s au}$ 0.03MG & 0.15MG TABLET	
testosterone; or		02398869 INDAYO	MYL
AIDS-wasting syndrome with low testosterone; or ander official hormone thereps.		ST 0.15MG & 0.03MG TABLET	
 gender affirming hormone therapy. 		02296659 SEASONALE	TEV
Note: Older individuals with non-specific symptoms such a		ST 20MCG & 100MCG TABLET	
but not limited to, fatigue, malaise, or depression who hav		02236974 ALESSE 21	PFI
low random testosterone level do not meet coverage criter	ia.	02236975 ALESSE 28	PFI
12.5MG GEL		02387875 ALYSENA 21	APX APX
02249499 ANDROGEL	BGP	02387883 ALYSENA 28 02298538 AVIANE 21	TEV
2.5MG PATCH		02298546 AVIANE 28	TEV
02239653 ANDRODERM	ALL	ST 30MCG & 0.05MG, 40MCG & 0.075MG, 30MCG &	1 L V
5MG PATCH 02245972 ANDRODERM	ALL	0.125MG TABLET	
*== · ** · = · · · · · = · · · · · · · ·	ALL	00707600 TRIQUILAR 21	BAY
TESTOSTERONE CYPIONATE		00707503 TRIQUILAR 28	BAY
100MG/ML SOLUTION		ST 30MCG & 150MCG TABLET	
00030783 DEPO-TESTOSTERONE	PFI	02042320 MIN-OVRAL 21	PFI
02246063 TESTOSTERONE CYPIONATE	SDZ	02042339 MIN-OVRAL 28	PFI
TESTOSTERONE ENANTHATE		02387085 OVIMA 21	APX
200MG/ML SOLUTION		02387093 OVIMA 28	APX
00029246 DELATESTRYL	VAE	02295946 PORTIA 21	TEV
TESTOSTERONE UNDECANOATE		02295954 PORTIA 28	TEV
40MG CAPSULE		ETHINYL ESTRADIOL, NORELGESTROMIN	
02322498 PMS-TESTOSTERONE	PMS	ST 6MG & 0.6MG PATCH (EXTENDED RELEASE)	
02421186 TARO-TESTOSTERONE	TAR	02248297 EVRA	JSO
68:12.00 CONTRACEPTIVES		ETHINYL ESTRADIOL, NORETHINDRONE	
DESOGESTREL, ETHINYL ESTRADIOL		35MCG & 0.5MG TABLET	
•		02187086 BREVICON 0.5/35 (21-DAY PACK)	PFI
ST 25MCG & 150MCG, 125MCG, 100MCG TABLET	• • • •	02187094 BREVICON 0.5/35 (28-DAY PACK)	PFI
02272903 LINESSA 21	ASP	ST 35MCG & 1MG TABLET	
02257238 LINESSA 28	ASP	02189054 BREVICON 1/35 (21-DAY PACK)	PFI
ETHINYL ESTRADIOL, DESOGESTREL		02189062 BREVICON 1/35 (28-DAY PACK)	PFI
ST 30MCG & 150MCG TABLET		02197502 SELECT 1/35 (21-DAY)	PFI
02317192 APRI 21	TEV	02199297 SELECT 1/35 (28-DAY)	PFI
02317206 APRI 28	TEV	ETHINYL ESTRADIOL, NORETHINDRONE	
02396491 FREYA 21	MYL	ACETATE	
02396610 FREYA 28	MYL	ST 10MCG & 1MG TABLET	
02042487 MARVELON 21	FRS	02417456 LOLO	ALL
02042479 MARVELON 28	FRS	ST 20MCG & 1MG TABLET	
02410249 MIRVALA 21	APX	00315966 MINESTRIN 1/20 (21-DAY)	ALL
02410257 MIRVALA 28	APX	00343838 MINESTRIN 1/20 (28-DAY)	ALL
ETHINYL ESTRADIOL, DROSPIRENONE		ST 30MCG & 1.5MG TABLET	
ST 0.02MG & 3MG TABLET		00297143 LOESTRIN	ALL
02415380 MYA	APX	00353027 LOESTRIN	ALL
02321157 YAZ	BAY	ETHINYL ESTRADIOL, NORGESTIMATE	
ST 0.03MG & 3MG TABLET	D 437	ST 35MCG & 0.25MG TABLET	
02261723 YASMIN 21	BAY	01968440 CYCLEN (21 DAY)	JSO
02261731 YASMIN 28 02410788 ZAMINE 21	BAY APX	01992872 CYCLEN (28 DAY)	JSO
02410788 ZAMINE 21 02410796 ZAMINE 28	APX APX		
OZTIOTOO ZAWIIINE ZO	дιΛ		

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68:12.00 CONTRACEPTIVES 68:12.00 CONTRACEPTIVES **LEVONORGESTREL ULIPRISTAL ACETATE** Limited use benefit (prior approval not required). 19.5MG INSERT (EXTENDED-RELEASE) BAY 02459523 KYLEENA For the preoperative treatment of moderate-to-severe signs 0.75MG TABLET and symptoms of uterine fibroids in adult clients of 02371189 OPTION 2 **PER** reproductive age; and for the intermittent treatment of moderate-to-severe signs and symptoms of uterine fibroids in 1.5MG TABLET adult clients of reproductive age who are not eligible for 02433532 BACKUP PLAN ONESTEP APX surgery, with the duration of each treatment course being CONTINGENCY ONE 02425009 MYI three months, if the following conditions are met: 02293854 PI AN B UNK • the patient is under the care of an obstetrician/gynecologist. patients receiving ulipristal acetate should have their liver LEVONORGESTREL INTRAUTERINE INSERT function tests monitored before, during, and after treatment. Limited use benefit with quantity and frequency limits (prior approval is not required). Coverage will be limited to a maximum of four courses of therapy for clients aged 18 to 60 years. Coverage is granted for 1 device every 2 years. ST 5MG TABLET 52MG INSERT (EXTENDED-RELEASE) 02408163 FIBRISTAL AΠ 02243005 MIRENA BAY 68:16.04 ESTROGENS LEVONORGESTREL, ETHINYL ESTRADIOL **CONJUGATED ESTROGENS** ST 0.15MG & 0.03MG & 0.01MG TABLET ST 0.625MG/G CREAM 02346176 SEASONIQUE TEV PFI 02043440 PREMARIN NORETHINDRONE ST 0.3MG TABLET (EXTENDED RELEASE) ST 0.35MG TABLET 02414678 PREMARIN PFI 02441306 JENCYCLA LUP ST 0.625MG TABLET (EXTENDED RELEASE) 00037605 MICRONOR 28-DAY JSO 02414686 PREMARIN PFI 02410303 MOVISSE MYL ST 1.25MG TABLET (EXTENDED RELEASE) NORETHINDRONE. ETHINYL ESTRADIOL 02414694 PREMARIN PFI **ESTRADIOL** 35MCG & 0.5MG, 35MCG & 1MG TABLET 02187108 SYNPHASIC 21 PFI ST 0.25MG GEL 02187116 SYNPHASIC 28 PFI 02424924 DIVIGEL SEA NORGESTIMATE, ETHINYL ESTRADIOL ST 0.5MG GEL 02424835 DIVIGEL SFA **ST 0.25MG & 0.035MG TABLET** ST 1MG GEL 02486318 TRI-JORDYNA 28 GLK 02424843 DIVIGEL SEA ST 25MCG & 0.180MG, 25MCG & 0.215MG, 25MCG & ST 25MCG PATCH 0.25MG TABLET 02401967 TRICIRA LO 21 APX 02245676 ESTRADOT 25 NVR 02401975 TRICIRA LO 28 SEA APX 02243722 OFSCLIM **37.5MCG PATCH** 02258560 TRI-CYCLEN LO (21 DAY) JSO 02258587 TRI-CYCLEN LO (28 DAY) JSO 02243999 ESTRADOT 37.5 **NVR** $^{\mbox{\scriptsize st}}$ 35MCG & 0.180MG, 35MCG & 0.215MG, 35MCG & ST 50MCG PATCH 0.25MG TABLET **NVR** 02244000 ESTRADOT 50 02028700 TRI-CYCLEN 21-DAY JSO 02243724 OESCLIM SFA 02029421 TRI-CYCLEN 28-DAY JSO ST 75MCG PATCH **NVR** 02244001 ESTRADOT 75 ST 100MCG PATCH 02244002 ESTRADOT 100 **NVR** ST 2MG RING (SLOW-RELEASE) PFI 02168898 ESTRING ST 0.5MG TABLET 02225190 ESTRACE **TRM** ST 1MG TABLET 02148587 ESTRACE **TRM** ST 2MG TABLET

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02148595 ESTRACE

TRM

68:16.04 ESTROGENS		68:18.04
ESTRADIOL HEMIHYDRATE		DEGARELIX ACETATE
ST 0.06% GEL		80MG POWDER FOR SOLUTION
02238704 ESTROGEL	FRS	02337029 FIRMAGON FE
ST 25MCG PATCH		120MG POWDER FOR SOLUTION
02247499 CLIMARA 25	BAY	02337037 FIRMAGON FE
ST 50MCG PATCH		68:18.08
02231509 CLIMARA 50	BAY	LEUPROLIDE ACETATE
02246967 SANDOZ ESTRADIOL DERM	SDZ	LEUPROLIDE ACETATE
ST 75MCG PATCH		3.75MG/VIAL POWDER FOR SUSPENSION
02247500 CLIMARA 75	BAY	00884502 LUPRON DEPOT ABV
02246968 SANDOZ ESTRADIOL DERM	SDZ	7.5MG/VIAL POWDER FOR SUSPENSION
ST 100MCG PATCH		00836273 LUPRON DEPOT ABV
02246969 SANDOZ ESTRADIOL DERM	SDZ	11.25MG/VIAL POWDER FOR SUSPENSION
^{sτ} 0.5MG TABLET		02239834 LUPRON DEPOT ABV
02449048 LUPIN-ESTRADIOL	LUP	22.5MG/VIAL POWDER FOR SUSPENSION
ST 1MG TABLET		02230248 LUPRON DEPOT ABV
02449056 LUPIN-ESTRADIOL	LUP	30MG/VIAL POWDER FOR SUSPENSION
ST 2MG TABLET		02239833 LUPRON DEPOT ABV
02449064 LUPIN-ESTRADIOL ST 10MCG VAGINAL TABLET	LUP	68:20.02 ALPHA-GLUCOSIDASE
02325462 VAGIFEM 10	NOO	INHIBITORS
	NOO	ACARBOSE
ESTRADIOL, NORETHINDRONE ACETATE		ST 50MG TABLET
ST 50MCG & 140MCG PATCH		02190885 GLUCOBAY BAY
02241835 ESTALIS	NVR	02494078 MAR-ACARBOSE MAR
ST 50MCG & 250MCG PATCH		ST 100MG TABLET
02241837 ESTALIS	NVR	02190893 GLUCOBAY BAY
ESTRONE		02494086 MAR-ACARBOSE MAR
ST 1MG/G CREAM		68:20.04 BIGUANIDES
00727369 ESTRAGYN	SEA	METFORMIN HYDROCHLORIDE
68:16.12 ESTROGEN AGONISTS-		
ANTAGONISTS		ST 500MG TABLET
RALOXIFENE HYDROCHLORIDE		02257726 ACT METFORMIN TEV
		02167786 APO-METFORMIN APX 02438275 AURO-METFORMIN AUR
Limited use benefit (prior approval required).		02229994 DOM-METFORMIN DPC
For secondary prevention of osteoporosis in clients who		02099233 GLUCOPHAGE SAC
experience failure on bisphosphonates; or		02229516 GLYCON VAE
For secondary prevention of osteoporosis in clients who have a personal history or a first degree relative with a history of	€	02380196 JAMP-METFORMIN JMP
breast cancer.		02353377 METFORMIN SAN
60MG TABLET		02378841 METFORMIN MAR
02358840 ACT RALOXIFENE	TEV	02385341 METFORMIN FC SIV
02279215 APO-RALOXIFENE	APX	02223562 PMS-METFORMIN PMS
02239028 EVISTA	LIL	02314908 PRO-METFORMIN PDL
68:18.00 GONADOTROPINS		02269031 RAN-METFORMIN RBY
GOSERELIN ACETATE		02242974 RATIO-METFORMIN TEV
GOSERELIN ACETATE		02239081 RIVA-METFORMIN RIV
3.6MG/DEPOT IMPLANT		02246820 SANDOZ METFORMIN FC SDZ
02049325 ZOLADEX	UNK	02379767 SEPTA-METFORMIN SPT
NAFARELIN ACETATE		ST 850MG TABLET
2MG/ML AEROSOL		02257734 ACT METFORMIN TEV 02229785 APO-METFORMIN APX
02188783 SYNAREL	PFI	02438283 AURO-METFORMIN AUR
		02242726 DOM-METFORMIN DPC
		02162849 GLUCOPHAGE SAC
		02239214 GLYCON VAE

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68:20.04 BIGUANIDES METFORMIN HYDROCHLORIDE

ST 850MG TABLET

02380218	B JAMP-METFORMIN	JMP
0235338	5 METFORMIN	SAN
02378868	8 METFORMIN	MAR
02385368	8 METFORMIN FC	SIV
02242589	9 PMS-METFORMIN	PMS
0231489	4 PRO-METFORMIN	PDL
02269058	8 RAN-METFORMIN	RBY
0224293	1 RATIO-METFORMIN	TEV
02242783	3 RIVA-METFORMIN	RIV
0224682	1 SANDOZ METFORMIN	SDZ
0237977	5 SEPTA-METFORMIN	SPT

68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

LINAGLIPTIN

Open benefit.

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.

ST 5MG TABLET

BOE 02370921 TRAJENTA

LINAGLIPTIN, METFORMIN HYDROCHLORIDE

Open benefit.

• 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.

ST 2.5MG & 100	OMG TABLET	
02403277	JENTADUETO	BOE
ST 2.5MG & 500	MG TABLET	
02403250	JENTADUETO	BOE
ST 2.5MG & 850	MG TABLET	
02403269	JENTADUETO	BOE

SAXAGLIPTIN HYDROCHLORIDE

Open benefit.

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 sulfonvlurea.

•			
ST 2.5MG TABL	ET		
02375842	ONGLYZA	AZ	C
ST 5MG TABLE	Т		
02333554	ONGLY7A	AZ	C

68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

SAXAGLIPTIN HYDROCHLORIDE. METFORMIN **HYDROCHLORIDE**

Open benefit.

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.

 $^{s\tau}$ 2.5MG & 1000MG TABLET 02389185 KOMBOGLYZE AZC **2.5MG & 500MG TABLET** 02389169 KOMBOGLYZE AZC **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.

ST 25MG TABLET 02388839 JANUVIA FRS ST 50MG TABLET 02388847 JANUVIA **FRS** ST 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.

 $^{\it st}$ 50MG & 1000MG TABLET **FRS** 02333872 JANUMET $^{s\tau}$ 50MG & 500MG TABLET 02333856 JANUMET **FRS** $^{\rm s au}$ 50MG & 850MG TABLET 02333864 JANUMET **FRS** ST 50MG & 1000MG TABLET (EXTENDED RELEASE) 02416794 JANUMET XR **FRS** ST 50MG & 500MG TABLET (EXTENDED RELEASE) 02416786 JANUMET XR **FRS** ST 100MG & 1000MG TABLET (EXTENDED RELEASE) 02416808 JANUMET XR **FRS**

68:20.06 INCRETIN MIMETICS

LIXISENATIDE

10MCG SOLUTION 02464276 ADLYXINE SAC **20MCG SOLUTION** 02464284 ADLYXINE SAC

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00.00.00.11:1	ODETINI MILLETICO		00.00.00	NOII-III SUITE I ITERITI DI	
	CRETIN MIMETICS		68:20.08 INS		
SEMAGLUTI	DE		INSULIN DEC	GLUDEC	
Open benefit.			100U SOLU	TION	
For the treatment	t of type 2 diabetes in combination with		02467879	TRESIBA	NOO
	when diet and exercise plus maximal		200U SOLU	TION	
	metformin do not achieve adequate		02467887		NOO
glycemic control.			INSULIN DET	ΓEMIR	
1MG SOLUT		NOO	100U/ML IN.	JECTION	
1.34MG SOL	OZEMPIC	NOO	02412829	LEVEMIR FLEXTOUCH	NOO
	OZEMPIC	NOO		LEVEMIR PENFILL	NOO
68:20.08 INS		1100	INSULIN GLA	ARGINE	
			100U/ML IN.	JECTION	
HUMAN BIOS	% NEUTRAL & 70% ISOPHANE)		02245689	LANTUS	SAC
HUIVIAN BIOS	STNINETIC		02251930	LANTUS	SAC
100U/ML IN				LANTUS SOLOSTAR	SAC
	HUMULIN 30/70	LIL	100U SOLU		
	HUMULIN 30/70 CARTRIDGE HUMULIN 30/70 CARTRIDGE	LIL LIL	02444844		LIL
	NOVOLIN GE 30/70	NOO	02461528 300U SOLU	BASAGLAR	LIL
	NOVOLIN GE 30/70 PENFILL	NOO		TOUJEO SOLOSTAR	SAC
	NOVOLIN GE 30/70 PENFILL	NOO	INSULIN GLU		SAC
	% NEUTRAL & 60% ISOPHANE)				
HUMAN BIOS	•		100U/ML IN.		040
100U/ML IN				APIDRA CARTRIDGE APIDRA SOLOSTAR	SAC SAC
	NOVOLIN GE 40/60 PENFILL	NOO		APIDRA VIAL	SAC
	% NEUTRAL & 50% ISOPHANE)	1100		MAN BIOSYNTHETIC	0/10
HUMAN BIOS	•				
100U/ML IN.			100U/ML IN. 02024233	NOVOLIN GE TORONTO	NOO
	NOVOLIN GE 50/50 PENFILL	NOO	02024284		NOO
	OPHANE) HUMAN BIOSYNTHET			NOVOLIN GE TORONTO PENFILL	NOO
•	•		INSULIN LIS		
100U/ML IN.					
	HUMULIN N HUMULIN N (CARTRIDGE)	LIL LIL	100U/ML IN	HUMALOG	LIL
02403447	HUMULIN N (KWIKPEN)	LIL		HUMALOG (CARTRIDGE)	LIL
09853804	HUMULIN N 100U/ML (CARTRIDGE)	LIL	02403412	· · · · · · · · · · · · · · · · · · ·	LIL
02024225	NOVOLIN GE NPH	NOO		HUMALOG 100U/ML CARTRIDGE	LIL
09853782	NOVOLIN GE NPH 100U/ML	NOO	200U/ML IN.	JECTION	
	PENFILL		02439611	HUMALOG 200U/ML KWIKPEN	LIL
	NOVOLIN GE NPH PENFILL	NOO	100U SOLU	TION	
•	IC CRYSTALLINE) HUMAN			HUMALOG	LIL
BIOSYNTHE	TIC (RDNA ORIGIN)		INSULIN LIS	PRO, INSULIN LISPRO PROTA	AMINE
100U/ML IN			100U/ML IN	JECTION	
	HUMULIN R	LIL	02240294	HUMALOG MIX 25 (CARTRIDGE)	LIL
	HUMULIN R 100U/ML (CARTRIDGE)	LIL		HUMALOG MIX 25 (KWIKPEN)	LIL
	HUMULIN R CARTRIDGE	LIL	02240297		LIL
INSULIN ASF	PARI			HUMALOG MIX 50 (KWIKPEN)	LIL
100U/ML IN	JECTION		LIXISENATIO	DE, INSULIN GLARGINE	
	NOVORAPID	NOO	33MCG & 10	00U SOLUTION	
02245397	NOVORAPID	NOO	02478293	SOLIQUA	SAC
02377209	NOVORAPID	NOO			
INPOLIN RIO	SYNTHETIC HUMAN BR				
100U SOLUT					
02415089	HUMULIN R (KWIKPEN)	LIL			

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68:20.16 MEGLITINIDES REPAGLINIDE

ST 0.5MG TABL	.ET	
02321475	ACT REPAGLINIDE	TEV
02355663	APO-REPAGLINIDE	APX
02424258	AURO-REPAGLINIDE	AUR
02239924	GLUCONORM	NOO
02354926	JAMP REPAGLINIDE	JMP
02415968	REPAGLINIDE	PDL
02357453	SANDOZ REPAGLINIDE	SDZ
ST 1MG TABLE	Т	
02321483	ACT REPAGLINIDE	TEV
02424266	AURO-REPAGLINIDE	AUR
02239925	GLUCONORM	NOO
02354934	JAMP REPAGLINIDE	JMP
02415976	REPAGLINIDE	PDL
02357461	SANDOZ REPAGLINIDE	SDZ
ST 2MG TABLE	Т	
02321491	ACT REPAGLINIDE	TEV
02355698	APO-REPAGLINIDE	APX
02424274	AURO-REPAGLINIDE	AUR
02239926	GLUCONORM	NOO
02354942	JAMP REPAGLINIDE	JMP

68:20.18 SODIUM-GLUCOSE CONTRANSPORTER 2 (SGLT2) INHIBITORS

REPAGLINIDE

02357488 SANDOZ REPAGLINIDE

CANAGLIFLOZIN

02415984

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.

ST **100MG TABLET** 02425483 INVOKANA

JSO

JSO

PDL

SDZ

 $^{\it ST}$ 300MG TABLET

02425491 INVOKANA

DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE

Open benefit.

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.

ST 5MG TABLET

02435462 FORXIGA AZC

ST 10MG TABLET

02435470 FORXIGA AZC

68:20.18 SODIUM-GLUCOSE CONTRANSPORTER 2 (SGLT2) INHIBITORS

EMPAGLIFLOZIN

Open benefit.

For the treatment of type 2 diabetes mellitus:

- in patients who did not achieve glycemic control with an adequate trial of metformin and a sulfonylurea; or
- to reduce the incidence of cardiovascular death in patients with established cardiovascular disease who did not achieve adequate glycemic control despite an appropriate trial of metformin

Established cardiovascular disease is defined as one of the following:

- history of myocardial infarction
- multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)
- single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina
- unstable angina with confirmed evidence of coronary multivessel or single-vessel disease
- history of ischemic or hemorrhagic stroke
- · occlusive peripheral artery disease.

ST 10MG TABLET

02443937 JARDIANCE BOE

ST 25MG TABLET

02443945 JARDIANCE BOE

METFORMIN HYDROCHLORIDE, DAPAGLIFLOZIN

Open benefit.

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.

 $^{s au}$ 850MG & 5MG TABLET

02449935 XIGDUO AZC

ST 1000MG & 5MG TABLET

02449943 XIGDUO AZC

METFORMIN HYDROCHLORIDE, EMPAGLIFLOZIN

Open benefit.

For the treatment of patients with type 2 diabetes mellitus in patients who are eligible to receive metformin and empagliflozin, to replace the individual components.

500MG & 12.5MG TABLET

 02456605
 SYNJARDY
 BOE

 500MG & 5MG TABLET
 02456575
 SYNJARDY
 BOE

 850MG & 12.5MG TABLET
 02456613
 SYNJARDY
 BOE

 850MG & 5MG TABLET
 02456583
 SYNJARDY
 BOE

 1000MG & 12.5MG TABLET
 02456621
 SYNJARDY
 BOE

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68:20.18 S	ODIUM-GLUCOSE		68:20.28 THIAZOLIDINEDIONES	
C	ONTRANSPORTER 2 (SGLT2)		PIOGLITAZONE HYDROCHLORIDE	
li I	NHIBITORS		ST 15MG TABLET	
METFORM	IN HYDROCHLORIDE,			MIN
EMPAGLIF	· · · · · · · · · · · · · · · · · · ·			PMS
Open benefit.				PDL
Open benefit.				RBY
	ent of patients with type 2 diabetes mellitus in		02297906 SANDOZ PIOGLITAZONE	SDZ
	re eligible to receive metformin and to replace the individual components.		ST 30MG TABLET	
	•		02339587 ACH-PIOGLITAZONE	ACC
	5MG TABLET 1 SYNJARDY	BOE	02302888 ACT PIOGLITAZONE	TEV
		BUE	02302950 APO-PIOGLITAZONE	APX
	NTIDIABETIC AGENTS -			JMP
S	BULFONYLUREAS			MIN
GLICLAZID)E			PMS
ST 80MG TAE	BLET			PDL
0224524		APX		RBY
0076599		SEV		SDZ
0224845	3 GLICLAZIDE	PDL	ST 45MG TABLET	
0228707	2 GLICLAZIDE	SAN		ACC
0223810	3 TEVA-GLICLAZIDE	TEV		TEV
ST 30MG TAE	BLET (EXTENDED RELEASE)			APX JMP
0229779	5 APO-GLICLAZIDE MR	APX		MIN
0224298	7 DIAMICRON MR	SEV		PMS
0242976	4 JAMP GLICLAZIDE-MR	JMP		PDL
0242328	6 MINT-GLICLAZIDE MR	MIN		RBY
0243865	8 MYLAN-GLICLAZIDE MR	MYL		SDZ
0246132	3 SANDOZ GLICLAZIDE MR	SDZ		SDZ
0246357		SUN	68:22.12 GLYCOGENOLYTIC AGENTS	
ST 60MG TAE	BLET (EXTENDED RELEASE)		GLUCAGON RECOMBINANT DNA ORGIN	
0240712		APX	1MG/ML INJECTION	
0235642		SEV	02333619 GLUCAGEN N	00
0242329		MIN	02333627 GLUCAGEN HYPOKIT N	00
0243932		SUN	02243297 GLUCAGON	LIL
0246133		SDZ	68:24.00 PARATHYROID	
GLYBURID	_		CALCITONIN SALMON (SYNTHETIC)	
^{s⊤} 2.5MG TA			,	
0191365		APX	200IU/ML SOLUTION 01926691 CALCIMAR	SAC
0195935		PDL		SAC
0235045		SAN	68:28.00 PITUITARY	
0191367		TEV	DESMOPRESSIN ACETATE	
ST 5MG TAB		A DV	4MCG/ML LIQUID	
	2 APO GLYBURIDE	APX	00873993 DDAVP	FEI
0223451		DPC	0.1MG/ML NASAL SPRAY	
0072094 0235046		PMS SAN	00402516 DDAVP	FEI
0223673		PMS	00836362 DDAVP	FEI
	9 TEVA-GLYBURIDE	TEV	02242465 DESMOPRESSIN	AAP
		I L V	ST 0.1MG TABLET	
	HIAZOLIDINEDIONES		00824305 DDAVP	FEI
PIOGLITAZ	ONE HYDROCHLORIDE		02284030 DESMOPRESSIN	APX
$^{s au}$ 15MG TAE	BLET			PMS
0239160	0 ACH-PIOGLITAZONE	ACC		TEV
0230286	1 ACT PIOGLITAZONE	TEV	ST 0.2MG TABLET	
0230294	2 APO-PIOGLITAZONE	APX	00824143 DDAVP	FEI
0239730	7 JAMP-PIOGLITAZONE	JMP	02284049 DESMOPRESSIN	APX

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		Non-insured Health	Benefits
68:28.00 PITUITARY		68:36.04 THYROID AGENTS	
DESMOPRESSIN ACETATE		LEVOTHYROXINE SODIUM	
ST 60MCG TABLET (ORALLY DISINTEGRATING)		ST 0.025MG TABLET	
02284995 DDAVP MELT	FEI	02172062 SYNTHROID	BGP
ST 120MCG TABLET (ORALLY DISINTEGRATING)		ST 0.05MG TABLET	20.
02285002 DDAVP MELT	FEI	02213192 ELTROXIN	ASP
ST 240MCG TABLET (ORALLY DISINTEGRATING)		02172070 SYNTHROID	BGP
02285010 DDAVP MELT	FEI	ST 0.075MG TABLET	20.
68:32.00 PROGESTINS		02172089 SYNTHROID	BGP
		s [™] 0.088MG TABLET	
DIENOGEST		02172097 SYNTHROID	BGP
Limited use benefit (prior approval required).		ST 0.1MG TABLET	
For the management of pelvic pain associated with		02213206 ELTROXIN	ASP
endometriosis.		02172100 SYNTHROID	BGP
ST 2MG TABLET		ST 0.112MG TABLET	
02493055 ASPEN-DIENOGEST	UNK	02171228 SYNTHROID	BGP
02374900 VISANNE	BAY	ST 0.125MG TABLET	
MEDROXYPROGESTERONE ACETATE	D/ (1	02172119 SYNTHROID	BGP
MEDICAT PROGESTERONE ACETATE		ST 0.137MG TABLET	
150MG/ML SUSPENSION		02233852 SYNTHROID	BGP
00585092 DEPO-PROVERA	PFI	ST 0.15MG TABLET	
02322250 MEDROXYPROGESTERONE	SDZ	02213214 ELTROXIN	ASP
ST 2.5MG TABLET		02172127 SYNTHROID	BGP
02244726 APO-MEDROXY	APX	ST 0.175MG TABLET	
02253550 MEDROXY	PDL	02172135 SYNTHROID	BGP
00708917 PROVERA	PFI	ST 0.2MG TABLET	
02221284 TEVA-MEDROXYPROGESTERONE	TEV	02213222 ELTROXIN	ASP
ST 5MG TABLET		02172143 SYNTHROID	BGP
02244727 APO-MEDROXY	APX	ST 0.3MG TABLET	
02253577 MEDROXY	PDL	02172151 SYNTHROID	BGP
00030937 PROVERA	PFI	LIOTHYRONINE SODIUM	
02221292 TEVA-MEDROXYPROGESTERONE	TEV		
$^{s\tau}$ 10MG TABLET		ST 5MCG TABLET	DEI
02277298 APO-MEDROXY	APX	01919458 CYTOMEL	PFI
00729973 PROVERA	PFI	ST 25MCG TABLET	
02221306 TEVA-MEDROXYPROGESTERONE	TEV	01919466 CYTOMEL	PFI
ST 100MG TABLET		THYROID	
02267640 APO-MEDROXY	APX	ST 30MG TABLET	
PROGESTERONE		00023949 THYROID	ERF
Limited use benefit (prior approval required).		ST 60MG TABLET	
		00023957 THYROID	ERF
For the treatment of clients: • with postmenopausal symptoms who are intolerant to		ST 125MG TABLET	
medroxyprogesterone acetate (MPA); or		00023965 THYROID	ERF
who are at risk of preterm birth; or		68:36.08 ANTITHYROID AGENTS	
who are using the medication to prevent miscarriage.		METHIMAZOLE	
In adults:			
• for use as Gender Affirming Hormone Therapy.		ST 5MG TABLET	MAD
100MG CAPSULE		02480107 MAR-METHIMAZOLE	MAR PAL
02476576 PMS-PROGESTERONE	PMS	00015741 TAPAZOLE ST 10MG TABLET	PAL
02166704 PROMETRIUM	FRS		MAD
02463113 REDDY-PROGESTERONE	REC	02480115 MAR-METHIMAZOLE 02296039 TAPAZOLE	MAR PAL
02439913 TEVA-PROGESTERONE	TEV	02296039 TAPAZOLE	PAL

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TEV

02439913 TEVA-PROGESTERONE

72:00 LOCAL ANESTHETICS

72:00.00 LOCAL ANESTHETICS LIDOCAINE HYDROCHLORIDE

2% LIQUID

00811874 PMS-LIDOCAINE VISCOUS

2% SOLUTION

01968823 LIDODAN VISCOUS ODN

PMS

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76:00 OXYTOCICS 76:00.00 OXYTOCICS MISOPROSTOL, MIFEPRISTONE

200MCG & 200MG TABLET 02444038 MIFEGYMISO

LIP

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MEMBRANE AGENTS (SMMA) 84:04.04 SMMA - ANTIBIOTICS SOURCE SO				Non modred ricular Bener	110
SALOALOA SIMMA - ANTIBIOTICS SOOMG & 100,000IU SUPPOSITORY SAC SACITRACIN ZINC 10126829 FLAGYSTATIN SAC SACITRACIN ZINC SOOMG & 100,000IU SUPPOSITORY SACITRACIN ZINC SOOMG & 100,000IU SUPPOSITORY SACITRACIN ZINC SOOMG & 100,000IU SUPPOSITORY SACITRACIN ZINC SACITRACIN Z	34:00 SKIN	AND MUCOUS		84:04.04 SMMA - ANTIBIOTICS	
SACINACIN ZINC 1908	MEM	BRANE AGENTS (SMM	1A)	METRONIDAZOLE, NYSTATIN	
SACITRACIN ZINC		•	,	500MG & 100 000HJ SUPPOSITORY	
SOU INTIMENT					SAC
1	BACITRACIN	ZINC			0, 10
DOLSH-910B BOLDHATE CLINDAMYCIN PHOSPHATE 2% CREAM 0.2006004 DALACIN PFI 1% SOLUTION PFI 1% SOLUTION PFI 10,000IU & 500IU OINTMENT POLYMYXIN B SULFATE, BACITRACIN ZINC PPI 10,000IU & 500IU OINTMENT PMS 0.2006020 DALACIN PFI 0.000IU & 500IU OINTMENT PMS 0.2006020 DALACIN PFI 0.000IU & 500IU OINTMENT PMS 0.2006020 DALACIN T PFI 0.000IU & 500IU OINTMENT PMS 0.2006020 DALACIN T PFI 0.000IU & 500IU OINTMENT PMS 0.2006020 DALACIN T PFI 0.000IU & 500IU OINTMENT PMS 0.2006020 DALACIN T PFI 0.000IU & 500IU OINTMENT PMS 0.2006020 DALACIN T PFI 0.000IU & 500IU OINTMENT PMS 0.2006020 DALACIN T PFI 0.000IU & 500IU OINTMENT DALACIN T PMS 0.2006020 DALACIN T DALACIN	500IU OINTN	MENT			
MUPIROCIN CALCIUM 2% CREAM	00584908	BACITIN	PED		
2%, CREAM	02351714	JAMP-BACITRACINE	JMP		TAR
2026064	CLINDAMYC	IN PHOSPHATE		MUPIROCIN CALCIUM	
02289769 DALACIN PFI	2% CREAM			2% CREAM	
19% SOLUTION POLYMYXIN B SULFATE, BACITRACIN ZINC		DALACIN	DEI	02239757 BACTROBAN	GSK
0.248378 C.I.NDAMYCIN PHOSPHATE T.DEPICAL T.D				POLYMYXIN B SULFATE, BACITRACIN ZINC	
TOPICAL			TFI	10 000III & 500III OINTMENT	
MASS	02100700			·	PMS
D00582301 DALACIN T	02243659	CLINDA-T	VAE		
POIN FOR EXTEMPORANEOUS MIXTURE 02357569 JAMPOLYCIN JAJ	00582301	DALACIN T	PFI		
POLY POR EXTEMPORANEOUS MIXTURE 99502000 CLINDAMYCIN IN DILUSOL OR DUONALC 1000001 & 500U TOPINC 502	02266938	TARO-CLINDAMYCIN	TAR		
Polymy Proper	PDIN FOR E	XTEMPORANEOUS MIXTURE			
CLINDAMYCIN PHOSPHATE, BENZOYL PEROXIDE	99502000	CLINDAMYCIN IN DILUSOL OR	UNK		
PROXIDE				10000U & 500U OINTMENT	
1% & 3% GEL		IN PHOSPHATE, BENZOYL			TAR
1% & 3% GEL	PEROXIDE			POLYMYXIN B SULFATE, BACITRACIN ZINC.	
02382822 CLINDOXYL ADV GSK 10,000U & 50∪±80,025MG OINTMENT 1% & 5% GEL 02248472 BENZACLIN VAE OC237226 POLYSPORIN TRIPLE JAJ 02248473 CLINDOXYL GSK POLYMYXIN B SULFATE, GRAMICIDIN 02464519 TARO-BENZOYL PEROXIDE / CLINDAMYCIN KIT 0230844 POLYSPORIN ANTIBIOTIC JAJ 02440180 TARO-CLINDAMYCIN/BENZOYL TAR 84:04.06 SMM - ANTIVIRALS PEROXIDE ERYTHROMYCIN, BENZOYL PEROXIDE 3% & 5% GEL 02225271 BENZAMYCIN VAE 02039524 ZOVIRAX VAE FUSIDATE SOIUM 2% OINTMENT 00569771 ZOVIRAX VAE 00586676 FUCIDIN LEO 0586667 FUCIDIN LEO 0586668 FUCIDIN LEO SINECATECHINS 10% OINTMENT 00411849 VEREGEN PAL 00586668 FUCIDIN LEO SINECATECHINS FUSIDIC ACID + HYDROCORTISONE ACETATE 2% & 1% CREAM 00238578 FUCIDIN LEO 02238578 FUCIDIN LEO 0358668 FUCIDIN LEO 0558668 FUCIDIN LEO 0558671 CERAM 00611174 LOTRIDERM FRA 00611174 LOTRIDERM FRA 00611174 LOTRIDERM FRA 00611174 LOTRIDERM VAE 002221802 LOPROX VAE 02221802 LOPROX VAE 02221802 LOPROX VAE 02221802 LOPROX VAE 02221802 LOPROX VAE 0.02221802 LOPROX VAE	1% & 3% GE	:L		· · · · · · · · · · · · · · · · · · ·	
19	02382822	CLINDOXYL ADV	GSK		
02243178	1% & 5% GE	:L		·	
0246159	02248472	BENZACLIN	VAE		JAJ
CLINDAMYCIN KIT 02230844 POLYSPORIN ANTIBIOTIC JAJ TARO-CLINDAMYCIN/BENZOYL PEROXIDE SWMA - ANTIVIRALS ERYTHROMYCIN, BENZOYL PEROXIDE SWMA - ANTIVIRALS 3% & 5% GEL	02243158	CLINDOXYL	GSK	POLYMYXIN B SULFATE, GRAMICIDIN	
PEROXIDE	02464519		TAR	•	JAJ
3% & 5% G S S S S S S S S S	02440180		TAR		
3% & 5% GEL	ERYTHROMY	YCIN, BENZOYL PEROXIDE		ACYCLOVIR	
NO NO NO NO NO NO NO NO	3% & 5% GE			5% CREAM	
FUSIDATE SODIUM 5% OINTMENT 02477130 APO-ACYCLOVIR APX 2% OINTMENT 00586976 FUCIDIN LEO SINECATECHINS 10% OINTMENT 02411849 VEREGEN PAL 00586668 FUCIDIN LEO 84:04.08 SMMA - ANTIFUNGALS PAL FUSIDIC ACID, HYDROCORTISONE ACETATE BETAMETHASONE DIPROPIONATE, CLOTRIMAZOLE 02238578 FUCIDIN H LEO 0.05% & 1% CREAM CLOTRIMAZOLE METRONIDAZOLE 00611174 LOTRIDERM FRS 11% CREAM CICLOPIROX OLAMINE CICLOPIROX OLAMINE 021252980 METROGEL GAC 02221802 LOPROX VAE 02297809 METROGEL GAC CLOTRIMAZOLE VAE 02297809 METROGEL GAC CLOTRIMAZOLE CLOTRIMAZOLE 02248206 METROGEL GAC CLOTRIMAZOLE			VΔE	02039524 ZOVIRAX	VAE
2% OINTMENT 02477130 APO-ACYCLOVIR APX 00586676 FUCIDIN LEO SINECATECHINS FUSIDIC ACID 10% OINTMENT 02411849 VEREGEN PAL 00586668 FUCIDIN LEO 84:04.08 SMMA - ANTIFUNGALS PAL FUSIDIC ACID, HYDROCORTISONE ACETATE BETAMETHA-SONE DIPROPIONATE, CLOTRIMAZOLE CLOTRIMAZOLE 02238578 FUCIDIN H LEO 0.05% & 1% CREAM CLOTRIDERM FRS 1% CREAM 00611174 LOTRIDERM FRS 0.75% GEL 00611174 LOPROX VAE 02156091 NORITATE BSH 1% CREAM CICLOPIROX CICLOPIROX VAE 02125226 NIDAGEL VAE 02221802 LOPROX VAE 02297809 METROGEL GAC CLOTRIMAZOLE CLOTRIMAZOLE 0.75% LOTION GAC CLOTRIMAZOLE VAE 0.75% LOTION CANESTEN BAY			VAL	5% OINTMENT	
NOR NOR	FUSIDATE S	ODIOW		02477130 APO-ACYCLOVIR	APX
10% OINTM				00569771 ZOVIRAX	VAE
2% CREAM	00586676	FUCIDIN	LEO	SINECATECHINS	
2% CREAM	FUSIDIC ACI	D		409/ CINTMENT	
NORTIFUE NORTIFUE	2% CREAM				DΔI
FUSIDIC ACID, HYDROCORTISONE ACETATE BETAMETHASONE DIPROPIONATE, CLOTRIMAZOLE 2% & 1% CREAM CLOTRIMAZOLE CLOTRIMAZOLE CLOTRIMAZOLE CREAM FRS METRONIDAZOLE 0.05% & 1% CREAM FRS 60611174 LOTRIDERM FRS 1% CREAM 0.0575% GEL CICLOPIROX OLAMINE FRS 0.75% GEL 1% CREAM VAE 1% CREAM VAE 02092832 METROGEL GAC 02221802 LOPROX VAE 02125226 NIDAGEL VAE 1% LOTION VAE 02297809 METROGEL GAC CLOTRIMAZOLE VAE 0.75% LOTION GAC CLOTRIMAZOLE BAY	00586668	FUCIDIN	LEO		IAL
2% & 1% CREAM BETAMETHASONE DIPROPIONATE, CLOTRIMAZOLE 02238578 FUCIDIN H LEO 0.05% & 1% CREAM METRONIDAZOLE 0.0611174 LOTRIDERM FRS 1% CREAM CICLOPIROX OLAMINE 02156091 NORITATE BSH 1% CREAM 02092832 METROGEL GAC 02221802 LOPROX VAE 02125226 NIDAGEL VAE 1% LOTION UPPROVIOUS VAE 02297809 METROGEL GAC CLOTRIMAZOLE 0.75% LOTION GAC CLOTRIMAZOLE 0.75% LOTION GAC CLOTRIMAZOLE 0.75% LOTION GAC CLOTRIMAZOLE 0.2248206 METROLOTION GAC CANESTEN	FUSIDIC ACI	D. HYDROCORTISONE ACET	ATE		
CEO TRIMAZUE METRONIDAZOLE 0.05% & 1% CREAM 1% CREAM CICLOPIROX OLAMINE 02156091 NORITATE BSH 1% CREAM 0.75% GEL GAC 02221802 LOPROX VAE 02092832 METROGEL GAC 1% LOTION VAE 02125226 NIDAGEL VAE 02221810 LOPROX VAE 1% GEL 02297809 METROGEL GAC CLOTRIMAZUE VAE 0.75% LOTION GAC 02150867 CANESTEN BAY		·		•	
METRONIDAZOLE 0.05% & 1% CREAM 1% CREAM CICLOPIROX OLAMINE 02156091 NORITATE BSH 1% CREAM 0.75% GEL 02092832 METROGEL GAC 02221802 LOPROX VAE 02125226 NIDAGEL VAE 1% LOTION VAE 1% GEL 02221810 LOPROX VAE 02297809 METROGEL GAC CLOTRIMAZOLE 0.75% LOTION GAC CLOTRIMAZOLE 02248206 METROLOTION GAC 02150867 CANESTEN BAY			1.50	CLOTRIMAZOLE	
02156091 NORITATE BSH 1% CREAM 0.75% GEL 02092832 METROGEL GAC 02221802 LOPROX VAE 02125226 NIDAGEL VAE 1% LOTION VAE 02221810 LOPROX VAE 1% GEL 02297809 METROGEL GAC CLOTRIMAZOLE CLOTRIMAZOLE VAE 0.75% LOTION GAC 02150867 CANESTEN BAY			LEO		FRS
02156091 NORITATE BSH 1% CREAM VAE 0.75% GEL VAE 02092832 METROGEL GAC 02221802 LOPROX VAE VAE 1% LOTION VAE 02221810 LOPROX VAE VAE 02221810 LOPROX VAE VAE 0.75% LOTION VAE 0.75% LOTION TW CREAM 0.75% LOTION BAY 0.2150867 CANESTEN CANESTEN BAY	1% CREAM				
0.75% GEL 02092832 METROGEL GAC 02221802 LOPROX VAE 02125226 NIDAGEL VAE 1% LOTION VAE 1% GEL 02221810 LOPROX VAE 02297809 METROGEL GAC CLOTRIMAZOLE 0.75% LOTION 1% CREAM 02248206 METROLOTION GAC 02150867 CANESTEN BAY	02156091	NORITATE	BSH		
02092832 METROGEL GAC 1% LOTION VAE 1% LOTION VAE 1% LOTION VAE 1% LOTION VAE 02221810 LOPROX VAE VAE 02297809 METROGEL GAC CLOTRIMAZOLE CLOTRIMAZOLE VAE 0.75% LOTION 1% CREAM CANESTEN BAY	0.75% GEL				\/A=
1% GEL 02221810 LOPROX VAE 02297809 METROGEL GAC CLOTRIMAZOLE 0.75% LOTION 1% CREAM 02248206 METROLOTION GAC 02150867 CANESTEN BAY	02092832	METROGEL	GAC		VAE
17% GEL O2297809 METROGEL GAC CLOTRIMAZOLE 0.75% LOTION 1% CREAM 02248206 METROLOTION GAC 02150867 CANESTEN BAY	02125226	NIDAGEL	VAE		\/A.
0.75% LOTION 1% CREAM 02248206 METROLOTION GAC 02150867 CANESTEN BAY	1% GEL				VAE
02248206 METROLOTION GAC 02150867 CANESTEN BAY	02297809	METROGEL	GAC	CLOTRIMAZOLE	
OZ 100007 O MILET EN	0.75% LOTIC	ON		1% CREAM	
02150891 CANESTEN BAY	02248206	METROLOTION	GAC	02150867 CANESTEN	BAY
				02150891 CANESTEN	BAY

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		Non mound make 201101110
84:04.08 SMMA - ANTIFUNGALS		84:04.08 SMMA - ANTIFUNGALS
CLOTRIMAZOLE		TOLNAFTATE
1% CREAM		1% AEROSOL
00812382 CLOTRIMADERM	TAR	00576050 TINACTIN AEROSOL BAY
00812366 CLOTRIMADERM VAGINAL 6	TAR	1% CREAM
02229380 CLOTRIMAZOLE	TAR	00576034 TINACTIN BAY
00874043 NEO-ZOL	PPI	1% POWDER
00874051 NEO-ZOL	PPI	01919245 DRSCHOLL'S ATHLETE'S FOOT BAY
2% CREAM		SPRAY
02150905 CANESTEN	BAY	00576042 TINACTIN BAY
00812374 CLOTRIMADERM VAGINAL 3	TAR	84:04.12 SMMA - SCABICIDES AND
1% & 200MG TABLET (CONTROLLED RELEASE)	IAIX	
02264099 CANESTEN COMBI-PAK	BAY	PEDICULICIDES
COMFORTAB 3	DAI	CROTAMITON
1% & 500MG TABLET (CONTROLLED RELEASE)		10% CREAM
02264102 CANESTEN COMBI-PAK	BAY	00623377 EURAX CLC
COMFORTAB 1		DIMETHICONE
500MG VAGINAL TABLET		
02150859 CANESTEN COMFORTAB 1	BAY	50% SOLUTION
KETOCONAZOLE		02373785 NYDA GPB
		ISOPROPYL MYRISTATE
2% CREAM	TDT	50% SOLUTION
02245662 KETODERM	TPT	02279592 RESULTZ MDF
2% SHAMPOO	LINUZ	PERMETHRIN
02182920 NIZORAL	UNK	
MICONAZOLE NITRATE		1% CREAM
2% CREAM		00771368 NIX INS
02085852 MICATIN MICONAZOLE NITRATE	WPC	5% CREAM
02231106 MICOZOLE	TAR	02219905 NIX DERMAL GSK
02084309 MONISTAT 7	INS	1% LIQUID
02126567 MONISTAT DERM	INS	02231480 KWELLADA-P MTC
2% & 100MG CREAM/VAGINAL SUPPOSITORY		5% LOTION
02126257 MONISTAT 7 DUAL-PAK	INS	02231348 KWELLADA-P MTC
2% & 400MG CREAM/VAGINAL SUPPOSITORY		PIPERONYL BUTOXIDE, PYRETHRINS
02126249 MONISTAT 3 DUAL-PAK	INS	3% & 0.3% SHAMPOO
400MG OVULE		02125447 R & C SHAMPOO WITH MTC
02126605 MONISTAT 3	INS	CONDITIONER
400MG SUPPOSITORY		84:04.92 SMMA - MISCELLANEOUS
02171775 MICONAZOLE 3 DAY OVULE	VTH	LOCAL ANTI-INFECTIVES
TREATMENT		
NYSTATIN		ISOPROPYL ALCOHOL
25,000IU CREAM		70% LIQUID
00716901 NYADERM	TAR	00426539 DUONALC ICN
100,000IU CREAM		METRONIDAZOLE
00716871 NYADERM	TAR	400/ CDEAM
02194236 RATIO-NYSTATIN	TEV	10% CREAM 01926861 FLAGYL SAC
02194163 TEVA-NYSTATIN	TEV	
100,000IU OINTMENT		POVIDONE-IODINE
02194228 RATIO-NYSTATIN	TEV	10% SOLUTION
TERBINAFINE HYDROCHLORIDE		00158348 BETADINE PFR
		SELENIUM SULFIDE
1% CREAM		
02031094 LAMISIL	NVR	2.5% LOTION
TERCONAZOLE		00594601 VERSEL VAE
0.4% CREAM		2.5% SHAMPOO
02247651 TARO-TERCONAZOLE	TAR	00243000 EXTRA STRENGTH SELSUN SAC

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			Non-insured nealth beliefits
	IMA - MISCELLANEOUS CAL ANTI-INFECTIVES		84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS
SILVER SUL	FADIAZINE		BETAMETHASONE DIPROPIONATE, SALICYLIC
			ACID
1% CREAM		CNE	DDIN FOR EVIENDORANIEOUS MINTURE
	FLAMAZINE	SNE	PDIN FOR EXTEMPORANEOUS MIXTURE
	FLAMAZINE	SMW	99501001 SALICYLIC ACID IN NON- UNI- MEDICATED OINTMENT
84:06.00 SM	IMA - ANTI-INFLAMMATORY		
AG	ENTS		BETAMETHASONE VALERATE
AMCINONIDI	=		0.05% CREAM
			00716618 BETADERM TAP
0.1% CREAM			02357860 CELESTODERM V VAI
	TARO-AMCINONIDE	TAR	00535427 RATIO-ECTOSONE TEV
0.1% LOTIO	N		0.1% CREAM
02247097	RATIO-AMCINONIDE	TEV	00716626 BETADERM TAR
0.1% OINTM	ENT		02357844 CELESTODERM V VAI
02247096	RATIO-AMCINONIDE	TEV	00535435 RATIO-ECTOSONE TEV
BECLOMETH	IASONE DIPROPIONATE		0.05% LOTION
			00653209 RATIO-ECTOSONE TEV
0.025% CRE		\	0.1% LOTION
	PROPADERM	VAE	00716634 BETADERM TAF
BETAMETHA	ASONE DIPROPIONATE		
0.05% CREA	νM		
	DIPROSONE	FRS	01940112 RIVASONE RIV
02122073		RIV	00027944 VALISONE VAI
02122049		RIV	0.05% OINTMENT
	TARO-SONE	TAR	00716642 BETADERM TAP
	TEVA-TOPILENE	TEV	02357879 CELESTODERM V VAI
		TEV	0.1% OINTMENT
	TEVA-TOPISONE	ΙΕV	00716650 BETADERM TAR
0.05% LOTIC		ED0	02357852 CELESTODERM V VAI
	DIPROSONE	FRS	BUDESONIDE, SODIUM CHLORIDE
02122065		RIV	0.02MG/ML ENEMA
02122030		RIV	02052431 ENTOCORT TI
	TEVA-TOPILENE	TEV	
	TEVA-TOPISONE	TEV	CALCIPOTRIOL, BETAMETHASONE
0.05% OINTI			DIPROPIONATE
	DIPROLENE	FRS	50MCG & 0.5MG AEROSOL (FOAM)
	DIPROSONE	FRS	02457393 ENSTILAR LEG
02122081	ROLENE	RIV	0.5MG & 50MCG GEL
02122057	ROSONE	RIV	02319012 DOVOBET LEG
00849669	TEVA-TOPILENE	TEV	0.5MG & 50MCG OINTMENT
00805009	TEVA-TOPISONE	TEV	02244126 DOVOBET LEG
BETAMETHA	ASONE DIPROPIONATE,		
CLOTRIMAZ	OLE .		CLOBETASOL PROPIONATE
0.050/ 9.40/	CDEAM		0.05% CREAM
0.05% & 1%		TAD	02213265 DERMOVATE TP
02496410	TARO- CLOTRIMAZOLE/BETAMETHASONE	TAR	02024187 MYLAN-CLOBETASOL MY
	DIPROPIONATE		02232191 PMS-CLOBETASOL PMS
RETAMETHA	ASONE DIPROPIONATE, SALICY	LIC	02309521 PMS-CLOBETASOL PMS
ACID	SONE DIFROFICIATE, SALICT	LIC	02245523 TARO-CLOBETASOL TAR
ACID			01910272 TEVA-CLOBETASOL TEV
0.05% & 2%	LOTION		0.05% LOTION
02245688	RATIO-TOPISALIC	TEV	02213281 DERMOVATE TP
0.05% & 3%	OINTMENT		02216213 MYLAN-CLOBETASOL MY
00578436	DIPROSALIC	FRS	02232195 PMS-CLOBETASOL PMS
PDIN FOR E	XTEMPORANEOUS MIXTURE		02245522 TARO-CLOBETASOL TAR
	SALICYLIC ACID IN	UNK	01910299 TEVA-CLOBETASOL TEV
	CORTICOSTEROID CREAM		STOTOZOG TEVA GEODETAGOE

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		Non-insured ficaltif Bei	
84:06.00 SMMA - ANTI-INFLAMMATOR AGENTS	Υ	84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS	•
CLOBETASOL PROPIONATE		FLUOCINONIDE	
0.05% OINTMENT		0.05% OINTMENT	
02213273 DERMOVATE	TPT	02161966 LIDEX	VAE
02026767 MYLAN-CLOBETASOL	MYL	02101900 EIDEX 02236996 LYDERM	TPT
02309548 PMS-CLOBETASOL	PMS	0.01% SOLUTION	" "
02245524 TARO-CLOBETASOL	TAR	02162504 SYNALAR	VAE
01910280 TEVA-CLOBETASOL	TEV	HALOBETASOL PROPIONATE	VAL
CLOBETASONE BUTYRATE	164		
		0.05% CREAM	
0.05% CREAM	0014	01962701 ULTRAVATE	UNK
02214415 SPECTRO ECZEMACARE	GSK	0.05% OINTMENT	
DESONIDE		01962728 ULTRAVATE	UNK
0.05% CREAM		HYDROCORTISONE ACETATE	
02229315 PDP-DESONIDE	PED	2.5% CREAM	
02154862 TRIDESILON	PER	02469421 SANDOZ HYDROCORTISONE	SDZ
0.05% OINTMENT		HYDROCORTISONE ACETATE, UREA	
02229323 PDP-DESONIDE	PED	·	
02154870 TRIDESILON	PER	1% CREAM	
DESOXIMETASONE		80073645 M-HC UREA	MAN
O OF9/ CDEAM		1% & 10% CREAM	DAI
0.05% CREAM	DCII	00681989 DERMAFLEX HC	PAL
02221918 TOPICORT MILD	BSH	1% LOTION	
0.25% CREAM	DOLL	80073689 M-HC UREA	MAN
02221896 TOPICORT	BSH	1.00% LOTION	D.4.1
0.05% GEL	DOLL	00681997 DERMAFLEX HC	PAL
02221926 TOPICORT	BSH	HYDROCORTISONE ACETATE, ZINC SULFA	ATE
0.25% OINTMENT 02221934 TOPICORT	BSH	0.5% & 0.5% OINTMENT	
		02128446 ANODAN-HC	ODN
ESCULIN, FRAMYCETIN SULFATE, DIBUC	AINE	00505773 ANUSOL HC	CHU
HYDROCHLORIDE, HYDROCORTISONE		02209764 EGOZINC-HC	PMS
ACETATE		00607789 RATIO-HEMCORT-HC	TEV
1% & 1% & 0.5% & 0.5% OINTMENT		02179547 RIVA-HC	RIV
02247322 PROCTOL	ODN	02247691 SANDOZ ANUZINC HC	SDZ
02223252 PROCTOSEDYL	APC	10MG & 10MG SUPPOSITORY	
02242527 SANDOZ PROCTOMYXIN HC	SDZ	02236399 ANODAN-HC	ODN
10MG & 10MG & 5MG & 5MG OINTMENT		00476285 ANUSOL HC	CHU
02226383 TEVA-PROCTOSONE	TEV	02210517 EGOZINC-HC	PMS
10MG & 10MG & 5MG & 5MG SUPPOSITORY		02240112 RIVASOL-HC	RIV
02247882 PROCTOL	ODN	02242798 SANDOZ ANUZINC HC	SDZ
02242528 SANDOZ PROCTOMYXIN HC	SDZ	HYDROCORTISONE ACETATE, ZINC SULFA	ATE
02226391 TEVA-PROCTOSONE	TEV	MONOHYDRATE	
FLUOCINONIDE		0.5% & 0.5% OINTMENT	
0.05% CREAM		02387239 JAMP-ZINC-HC	JMP
02163152 LIDEMOL	VAE	HYDROCORTISONE ACETATE, ZINC SULFA	ΔTF
02161923 LIDEX	VAE	PRAMOXINE HYDROCHLORIDE	·· - ,
00716863 LYDERM	TPT		
00598933 TIAMOL	TPT	0.5% & 0.5% & 1% OINTMENT	
0.05% GEL		00505781 ANUGESIC HC	MCL
02161974 LIDEX	VAE	02234466 PROCTODAN-HC	ODN
02236997 LYDERM	TPT	10MG & 10MG & 20MG SUPPOSITORY	
0.01% LOTION		00476242 ANUGESIC HC	MCL
00873292 DERMA-SMOOTHE	HIL	02240851 PROCTODAN-HC	ODN
0.025% OINTMENT		02242797 SANDOZ ANUZINC HC PLUS	SDZ
02162512 SYNALAR	VAE		

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84:06.00 SM	MA - ANTI-INFLAMMATORY		84:06.08	
AG	ENTS		HYDROCORTISONE ACETATE	
HYDROCORT	ΓISONE ACETATE-UREA		1% LOTION	
1% CREAM				SK
* *	JAMP-HYDROCORTISONE UREA	MAN	0.5% OINTMENT	
	TISONE VALERATE	1017 (14		SAY
			00716685 CORTODERM T	AR
0.2% CREAN			1% OINTMENT	
	HYDROVAL	TPT	00716693 CORTODERM T	AR
0.2% OINTM			84:08.00 SMMA - ANTIPRURITICS AND	
	HYDROVAL NE FUROATE	TPT	LOCAL ANESTHETICS	
			LIDOCAINE	
0.1% CREAN		ED0	Limited use benefit (prior approval not required).	
00851744		FRS		
	TARO-MOMETASONE	TAR	Coverage will be limited to 35 grams every 30 days.	
0.1% LOTIO 00871095		FRS	5% OINTMENT	
0.1% OINTM		FKS	02386836 JAMPOCAINE J	MP
0.176 011111		FRS	01963988 LIDODAN O	DN
	PMS-MOMETASONE	PMS	02083795 LIDODAN O	DN
	PMS-MOMETASONE	PMS	00001961 XYLOCAINE U	NK
	TARO-MOMETASONE	TAR	LIDOCAINE HCL	
	TEVA-MOMETASONE	TEV	5% OINTMENT	
	XTEMPORANEOUS MIXTURE	1 L V		NK
	MOMETASONE CREAM	UNK	LIDOCAINE HYDROCHLORIDE	111
	ONE ACETONIDE	OIVIX		
IRIAMCINOL	ONE ACETONIDE		2% SOLUTION	
0.1% CREAN			02427745 JAMPOCAINE VISCOUS J	MP
	ARISTOCORT R	VAE	LIDOCAINE, PRILOCAINE	
	TRIADERM	TAR	2.5% & 2.5% CREAM	
0.5% CREAN				NK
	ARISTOCORT C	VAE	2.5% & 2.5% PATCH	
0.1% OINTM				NK
	ARISTOCORT R	VAE	PHENAZOPYRIDINE HYDROCHLORIDE	
0.1% PASTE				
	ORACORT DENTAL PASTE	TAR	100MG TABLET	
84:06.08				RF
HYDROCORT	TISONE ACETATE		84:16.00 SMMA - CELL STIMULANTS AND PROLIFERANTS	
0.5% CREAN	1			
80021088	CORTATE	BAY	TRETINOIN	
00716820	HYDERM	TAR	0.01% CREAM	
02242930	HYDROCORTISONE ACETATE	TAR	00897329 RETIN-A U	NK
1% CREAM			00657204 STIEVA-A G	SK
00192597	EMOCORT	GSK	0.025% CREAM	
02412926	EUROHYDROCORTISONE	EUR	00897310 RETIN-A U	NK
00716839	HYDERM	TAR	00578576 STIEVA-A G	SK
00564281	HYDROSONE	TEV	0.05% CREAM	
80057178	JAMP-HC	JMP	00443794 RETIN-A U	NK
80057189	JAMP-HYDROCORTISONE	JMP	00518182 STIEVA-A G	SK
80066164	M-HC	MAN	0.01% GEL	
	PREVEX HC	GSK	00870013 RETIN-A U	NK
0.5% LOTION			01926462 VITAMIN A ACID V	ΆE
	CORTATE	BAY	0.025% GEL	
1% LOTION			00443816 RETIN-A U	NK
80057191	JAMP-HYDROCORTISONE	JMP	01926470 VITAMIN A ACID V	ΆE
80066168	M-HC	MAN		

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04.46.00 CMMA CELL CTIMULANTO AN	ın.	94.29 00 KEDATOLVTIC ACENTS	
84:16.00 SMMA - CELL STIMULANTS AN PROLIFERANTS	טו	84:28.00 KERATOLYTIC AGENTS	
		CANTHARIDIN, PODOPHYLLIN, SALICYLIC AC	CID
TRETINOIN		1% & 2% & 30% LIQUID	
0.05% GEL			DOR
01926489 VITAMIN A ACID	VAE	CLINDAMYCIN PHOSPHATE, TRETINOIN	
84:24.00 EMOLLIENTS, DEMULCENTS, AND PROTECTANTS		1.2% & 0.025% GEL 02359685 BIACNA TOPICAL	BSH
UREA		SALICYLIC ACID	
		170MG/ML GEL	
10% CREAM 80079497 UREMOL 10	ODN	00614246 COMPOUND W GEL	UNK
80005397 URISEC10	ODN	20% LIQUID	OHIL
20% CREAM	ODIV	00690333 SOLUVER	DPT
80083394 UREMOL	ODN	26% LIQUID	J
22% CREAM		00754951 OCCLUSAL HP	VAE
00396125 URISEC 22	ODN	27% LIQUID	
10% LOTION		00837733 SOLUVER PLUS	DPT
80079498 UREMOL 10	ODN	40% PLASTER	
12% LOTION		01967878 DR SCHOLLS CLEAR AWAY	BAY
00514896 URISEC 12	ODN	PLANTAR WART REMOVER SYSTEM	
84:24.12 BASIC OINTMENTS AND		01974335 DR SCHOLLS CLEAR AWAY WART	BAY
PROTECTANTS		REMOVER SYSTEM	DAI
DIMETHICONE		4% SHAMPOO	
		00666106 SEBCUR	DPT
20% CREAM 02060841 BARRIERE	WPC	84:32.00 KERATOPLASTIC AGENTS	
	VVFC	COAL TAR	
WHITE PETROLATUM			
71.5% OINTMENT		10% GEL 00344508 TARGEL	ODN
02277778 CRITIC-AID CLEAR	UNK	0.5% SHAMPOO	ODIN
ZINC OXIDE		02240645 NEUTROGENA	JAJ
15% CREAM		1% SHAMPOO	0710
02215799 ZINC OXIDE	HJS	02307146 T/ THERAPEUTIC SHAMPOO	JAJ
25% PASTE		EXTRA STRENGTH	
00532576 PATE D'IHLE	TEV	20% SOLUTION	
00886327 PÂTE D'IHLE	ATL		ODN
ZINC OXIDE, WHITE PETROLATUM		DETERGENT	
15% & 80.3% CREAM		COAL TAR, SALICYLIC ACID	
02337452 DIAPER RASH	HJS	10% & 3% GEL	
40% OINTMENT		00510335 TARGEL SA	ODN
02239160 ZINCOFAX EXTRA STRENGTH	PAL	10% & 4% SHAMPOO	
84:28.00 KERATOLYTIC AGENTS		00666114 SEBCUR-T	DPT
BENZOYL PEROXIDE		84:92.00 MISCELLANEOUS SKIN AND	
5% GEL		MUCOUS MEMBRANE AGENTS	
02162113 BENZAGEL	CLC	ACITRETIN	
4% LOTION	OLO	Open benefit (prior approval not required).	
02413353 SPECTRO ACNECARE WASH	GSK	Oprintary a should be used with a suiting to allow to	
5% LOTION		Soriatane should be used with caution in clients of childbearing potential due to its teratogenicity. Pregnancy	
02166607 BENZAGEL 5	CLC	must be excluded. Effective contraception must be used.	
5% SOLUTION		Manufacturer's literature regarding contraindications and	
02162121 BENZAGEL	CLC	warnings should be consulted prior to prescribing or dispensing this drug.	
CANTHARIDIN		sr 10MG CAPSULE	
1% LIQUID		02468840 MINT-ACITRETIN	MIN
80028872 CANTHACUR 07	PAL	02070847 SORIATANE	ALL
		02466074 TARO-ACITRETIN	TAR

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84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

ACITRETIN

Open benefit (prior approval not required).

Soriatane should be used with caution in clients 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.

ST 25MG CAPSULE

02468859	MINT-ACITRETIN	MIN
02070863	SORIATANE	ALL
02466082	TARO-ACITRETIN	TAR

ADAPALENE

0.1% CREAM

02231592	DIFFERIN	GAC
0.1% GEL		
02148749	DIFFERIN	GAC

0.3% GEL

AZELAIC ACID

15% GEL

02270811 FINACEA LEO

BRODALUMAB

Limited use benefit (prior approval required).

02274000 DIFFERIN XP

For the treatment of:

psoriasis according to established criteria.

(Please refer to Appendix A).

210MG SOLUTION

02473623 SILIQ VAE

CALCIPOTRIOL

50MCG/G OINTMENT

01976133 DOVONEX LEO

CAPSAICIN

0.025% CREAM

0215/101	CAPSAICIN	VAE
02244952	ZODERM	EUR
00740306	ZOSTRIX	VAE
0.075% CRE	AM	
02157128	CAPSAISIN	VAE
02004240	ZOSTRIX HP	VAE

COLLAGENASE

250U OINTMENT

02063670 SANTYL SNE

84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

DUPILUMAB

Limited use benefit (prior approval required).

Initial coverage criteria (4 months):

For adult patient with chronic moderate to severe atopic dermatitis who meet all the following criteria:

- patient has a score greater than or equal to 16 on the Eczema Area and Severity Index (EASI); and
- patient has a score greater than or equal to 8 on the Dermatology Life Quality Index (DLQI); and
- body surface area (BSA) of 10% or more is affected; and
- the disease is insufficiently controlled despite the use of topical treatments including at least two medium or high-potency topical corticosteroids and one topical calcineurin inhibitor: and
- intolerance or lack of response to phototherapy or inability to access phototherapy.

Criteria for renewal or for initial coverage in patients currently maintained on Dupixent (12 months):

- patient has an improvement of at least 75% in the EASI score compared to the baseline level; or
- patient has an improvement of at least 50% in the EASI score; and
- patient has had a decrease of at least five points on the DLQI questionnaire compared to the baseline.

150MG SOLUTION

02470365 DUPIXENT SAC

FLUOROURACIL

5% CREAM

00330582 EFUDEX VAE

IMIQUIMOD

GAC

١/٨٢

5% CREAM

02239505	ALDARA P	BSH
02407825	APO-IMIQUIMOD	APX
02482983	TARO-IMIQUIMOD PUMP	TAR

ISOTRETINOIN

Open benefit (prior approval not required).

Soriatane should be used with caution in clients 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.

ST 10MG CAPSULE

02397013 EPURIS

00582344	ACCUTANE ROCHE	HLR	
02257955	CLARUS	MYL	
02396971	EPURIS	CIP	
20MG CAPS	ULE		
02396998	EPURIS	CIP	
30MG CAPSULE			
02397005	EPURIS	CIP	
ST 40MG CAPS	ULE		
00582352	ACCUTANE ROCHE	HLR	
02257963	CLARUS	MYL	

CIP

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84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

IXEKIZUMAB

Limited use benefit (prior approval required).

For the treatment of:

- psoriatic arthritis according to established criteria.
- psoriasis according to established criteria.

(Please refer to Appendix A).

80MG SOLUTION

02455102 TALTZ LIL 02455110 TALTZ LIL

LUBRICANT

VAGINAL GEL

 09991643
 CAYA DIAPHRAGM
 TSN

 09991644
 CONTRAGEL GREEN
 TSN

PIMECROLIMUS

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

1% CREAM

02247238 ELIDEL VAE

PODOFILOX

0.5% SOLUTION

01945149 CONDYLINE SAC

PODOPHYLLIN

25% LIQUID

00598208 PODOFILM PAL

RISANKIZUMAB

Limited use benefit (prior approval required).

For the treatment of patients with moderate to severe psoriasis

(Please refer to Appendix A).

90MG SOLUTION

02487454 SKYRIZI ABV

SALICYLIC ACID, FLUOROURACIL

10% & 0.5% SOLUTION

02428946 ACTIKERALL CIP

SECUKINUMAB

Limited use benefit (prior approval required).

For the treatment of:

- psoriasis according to established criteria.
- psoriatic arthritis according to established criteria.
- ankylosing spondylitis according to established criteria.

(Please refer to Appendix A).

150MG/ML INJECTION

99101215 COSENTYX (STYLO) NVC 09857548 COSENTYX PEN (ON) NVC

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

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

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86:12.04 ANTIMUSCARINICS 86:00 SMOOTH MUSCLE **SOLIFENACIN SUCCINATE** RELAXANTS ST 5MG TABLET 86:12.04 ANTIMUSCARINICS TARO-SOLIFENACIN SUN 02437988 **DARIFENACIN HYDROBROMIDE** 02397900 TEVA-SOLIFENACIN TEV Limited use benefit (prior approval required). 02277263 **VESICARE AST** ST 10MG TABLET For the symptomatic relief of overactive bladder in patients: 02423383 APO-SOLIFENACIN APX • with symptoms of urinary frequency, urgency or urge 02446383 **AURO-SOLIFENACIN AUR** incontinence: and • who have failed on or are intolerant to therapy with 02424347 JAMP-SOLIFENACIN **JMP** immediate-release oxybutynin or solifenacin or tolterodine ER. 02428938 MED-SOLIFENACIN **GMP** 7.5MG TABLET (EXTENDED RELEASE) 02417731 PMS-SOLIFENACIN **PMS** 02273217 ENABLEX UNK 02399040 SANDOZ SOLIFENACIN SDZ 15MG TABLET (EXTENDED RELEASE) 02458152 SOLIFENACIN **PDL** 02273225 ENABLEX UNK 02458268 SOLIFENACIN SAN **FESOTERODINE FUMARATE** 02437996 **TARO-SOLIFENACIN** SUN 02397919 **TEVA-SOLIFENACIN** TFV Limited use benefit (prior approval required). 02277271 VESICARE AST For the symptomatic relief of overactive bladder in patients: **TOLTERODINE TARTRATE** • with symptoms of urinary frequency, urgency or urge incontinence; and ST 2MG CAPSULE (EXTENDED RELEASE) • who have failed on or are intolerant to therapy with 02244612 DETROL LA PFI immediate-release oxybutynin or solifenacin or tolterodine ER. 02404184 MYLAN-TOLTERODINE ER MYL ST 4MG TABLET (EXTENDED RELEASE) 02413140 SANDOZ TOLTERODINE LA SDZ 02380021 TOVIAZ PFI 02412195 TEVA-TOLTERODINE LA TFV ST 8MG TABLET (EXTENDED RELEASE) ST 4MG CAPSULE (EXTENDED RELEASE) PFI 02380048 TOVIAZ 02244613 **DETROL LA** PFI FLAVOXATE HYDROCHLORIDE 02404192 MYLAN-TOLTERODINE ER MYI 02413159 SANDOZ TOLTERODINE LA SDZ ST 200MG TABLET 02412209 TEVA-TOLTERODINE LA TEV PAL 00728179 URISPAS ST 1MG TABLET **OXYBUTYNIN CHLORIDE** 02369680 APO-TOLTERODINE APX ST 1MG/ML SYRUP 02239064 DETROI PFI 02231089 APO-OXYBUTYNIN **APX** 02423308 MINT-TOLTERODINE MIN 02223376 PMS-OXYBUTYNIN **PMS** 02299593 **TEVA-TOLTERODINE** TFV ST 2.5MG TABLET ST 2MG TABLET 02240549 PMS-OXYBUTYNIN **PMS** 02369699 ΔPX **APO-TOLTERODINE** ST 5MG TABLET 02239065 DETROI PFI 02163543 APO-OXYBUTYNIN APX 02423316 MINT-TOLTERODINE MIN 02241285 DOM-OXYBUTYNIN DPC 02299607 TEVA-TOLTERODINE TEV 02350238 **OXYBUTYNIN** SAN TROSPIUM CHLORIDE 02240550 PMS-OXYBUTYNIN **PMS** Limited use benefit (prior approval required). RIV 02299364 **RIVA-OXYBUTYNIN** 02230394 **TEVA-OXYBUTYNIN** TEV For the symptomatic relief of overactive bladder in patients: · with symptoms of urinary frequency, urgency or urge PROPIVERINE HYDROCHLORIDE incontinence; and **5MG TABLET** • who have failed on or are intolerant to therapy with immediate-release oxybutynin or solifenacin or tolterodine ER. 02460289 MICTORYL PEDIATRIC DUI ST 20MG TABLET SOLIFENACIN SUCCINATE 02488353 MAR-TROSPIUM MAR ST 5MG TABLET SPC 02275066 TROSEC 02423375 APO-SOLIFENACIN **APX** 02446375 **AURO-SOLIFENACIN AUR** 02424339 JAMP-SOLIFENACIN **JMP** 02428911 MED-SOLIFENACIN **GMP** 02417723 PMS-SOLIFFNACIN **PMS** 02399032 SANDOZ SOLIFENACIN SDZ

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PDL

SAN

02458144

02458241

SOLIFENACIN

SOLIFENACIN

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.

ST 25MG TABLET	(EXTENDED	RFI FASE)
ZUNG INDELI		ILLLAGE

02402874 MYRBETRIQ AST

ST 50MG TABLET (EXTENDED RELEASE)

02402882 MYRBETRIQ AST

86:16.00 RESPIRATORY SMOOTH MUSCLE RELAXANTS

OXTRIPHYLLINE

ST 20MG/ML ELIXIR

00476366 CHOLEDYL ERF

THEOPHYLLINE

ST 5.33MG/ML ELIXIR

 00466409
 PULMOPHYLLINE
 RIV

 01966219
 THEOLAIR
 VAE

 00627410
 THEOPHYLLINE
 ATL

ST 100MG TABLET (EXTENDED RELEASE)

00692689 APO-THEO-LA AAP

ST 200MG TABLET (EXTENDED RELEASE)

00692697 APO-THEO-LA AAP

ST 300MG TABLET (EXTENDED RELEASE)

00692700 APO-THEO-LA AAP

ST 400MG TABLET (EXTENDED RELEASE)

02360101 THEO ER AAP
02014165 UNIPHYL PFR

ST 600MG TABLET (EXTENDED RELEASE)

02360128 THEO ER AAP
02014181 UNIPHYL PFR

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		Non-insured ne	ditii Bononto
8:00 VITAMINS		88:08.00 VITAMIN B COMPLEX	
88:04.00 VITAMIN A		NIACIN	
VITAMIN A		ST 50MG TABLET	
		00041084 NIACIN	ADA
ST 10,000IU CAPSULE	IMP	ST 500MG TABLET	
80054130 JAMP-VITAMIN A	JMP VTH	00557412 NIACIN	VTH
00557447 VITAMIN A	VIH	01939130 NIACIN	ODN
88:08.00 VITAMIN B COMPLEX		02247004 NIACIN	PMT
CYANOCOBALAMIN		PYRIDOXINE HYDROCHLORIDE	
100MCG/ML LIQUID		ST 25MG TABLET	
02241500 VITAMIN B12	SDZ	80056458 M-B6	MAN
ST 200MCG/ML LIQUID		00122645 VITAMIN B6	JAN
80039903 BEDUZIL	ORM	00232475 VITAMIN B6	ADA
80026092 JAMP-VITAMIN B12	JMP	01943200 VITAMIN B6	ODN
1,000MCG/ML LIQUID		80002890 VITAMIN B6	JMP
00626112 B-12	OMG	ST 50MG TABLET	
02052717 CYANOCOBALAMIN	TAR	00305227 VITAMIN B6	JAM
02413795 CYANOCOBALAMIN	MYL	00608599 VITAMIN B6	ADA
02420147 JAMP-CYANOCOBALAMIN	JMP	ST 100MG TABLET	\ (T 1)
1,000MCG/ML SOLUTION	DAY	00450677 B6	VTH
01987003 CYANOCOBALAMIN	RAX	00263958 VITAMIN B6	VAE
00521515 VITAMIN B12 ST 250MCG TABLET	SDZ	00329185 VITAMIN B6 02239348 VITAMIN B6	JAM PMT
80015294 JAMP-VITAMIN B12	JMP	THIAMINE HYDROCHLORIDE	FIVII
80055743 M-B12	MAN	THIAMINE HTDROCHLORIDE	
00335940 VITAMIN B12	JAM	100MG/ML LIQUID	
02239695 VITAMIN B12	PMT	02193221 THIAMIJECT	OMG
80004053 VITAMIN B12	WNP	02243525 THIAMINE	RAX
ST 1000MCG TABLET		100MG/ML SOLUTION	
80028902 JAMP VITAMIN B12	JMP	00816078 VITAMIN B1	SDZ
80015276 JAMP-VITAMIN B12	JMP	ST 50MG TABLET	EUD
80055741 M-B12	MAN	02245506 EURO VITAMIN B1 80054199 M-B1	EUR MAN
02237736 VITAMIN B12	VAE	00268631 THIAMINE	VAE
80003575 VITAMIN B12	PMT	80009633 VITAMIN B1	JMP
80006939 VITAMIN B12	WNP	ST 100MG TABLET	JIVII
80012952 VITAMIN B12 SUBLINGUAL	JAM	80054205 M-B1	MAN
FOLIC ACID		00232467 VITAMIN B1	PED
ST 1MG TABLET		00407011 VITAMIN B1	JAM
00318973 FOLIC ACID	JAM	02239350 VITAMIN B1	PMT
00647039 FOLIC ACID	VTH	80000352 VITAMIN B1	WNP
02048841 FOLIC ACID	PMT	80009588 VITAMIN B1	JMP
80000273 FOLIC ACID	WNP	88:12.00 VITAMIN C	
80053274 JAMP FOLIC ACID	JMP	ASCORBIC ACID	
80061488 M-FOLIQUE	MAN		
02236747 WAMPOLE FOLIC ACID	WAM	ST 500MG CAPLET	
ST 5MG TABLET		02163268 VITAMIN C	JAM
00426849 FOLIC ACID	APX	ST 250MG TABLET	
02366061 JAMP-FOLIC ACID	JMP	00162515 VITAMIN C	PMT
02285673 SANDOZ FOLIC ACID	SDZ	00221244 VITAMIN C	ADA
ST 1000MCG TABLET	1.18.117	00266051 VITAMIN C	PMT VTH
02239882 FOLIC ACID	UNK	00557811 VITAMIN C ST 500MG TABLET	VTH
NIACIN		00266086 ASCORBIC ACID	PMT
ST 500MG CAPLET		00200000 ASCORBIC ACID 00041114 VITAMIN C	ADA
00309737 NIACIN	JAM	00322326 VITAMIN C	ADA
		00527838 VITAMIN C	,,,,,,

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				Non-insured Health De	FIIEIIIS
88:12.00 VIT	TAMIN C		88:16.00 VIT	TAMIN D	
ASCORBIC A	ACID		CHOLECALO	CIFEROL	
ST 500MG TABI	ET		^{s⊤} 1,000IU LIQI	IID	
	VITAMIN C	VTH	80001791		DDP
	VITAMIN C	VAE	ST 400IU TABL I		וטט
	VITAMIN C	PMT		VITAMIN D	VTH
	VITAMIN C	PMT		VITAMIN D	PMT
	VITAMIN C	WNP		VITAMINE D	LAL
	VITAMIN C	PMT		WAMPOLE VITAMIN D	WAM
	VITAMINE C	LAL	°7 1,000IU TAB		VVAIVI
	WAMPOLE VITAMIN C	WAM	•	VITAMIN D3	PMT
	WAMPOLE VITAMIN C	WAM	ST 10,000IU TA	************	FIVII
VITAMIN C	WAINI OLL VITAMIN C	VVAIVI	00821772		RIV
VII AWIIN C				VITAMINE D	PDL
^{sτ} 500MG TABI	LET				PDL
80003328	VITAMIN C	WNP	ERGOCALCI	FEROL	
80085369	VITAMIN C	WAM	ST 50,000IU CA	PSULE	
88:16.00 VIT	AMIN D		02237450	SANDOZ D-FORTE	SDZ
ALFACALCIE	201		ST 8,288IU/ML S	SOLUTION	
			80020776	D2-DOL	JMP
ST 0.25MCG CA	APSULE		80003615	ERDOL	ODN
00474517	ONE ALPHA	LEO	VITAMIN D		
ST 1MCG CAPS				OLU E	
00474525	ONE ALPHA	LEO	ST 10MCG CAP		LINUZ
ST 2MCG/ML DI	ROP			VIT D 400	UNK
02240329	ONE-ALPHA	LEO	ST 25MCG CAP		
CALCITRIOL				VIT D 1000	UNK
0.25MCG CA	ADSIII E			VITACELL VITAMIN D3 SOFTGELS	UNK
	CALCITRIOL	STS	ST 200U CAPSU		
	CALCITRIOL-ODAN	ODN		VITAMIN D3	ORM
	ROCALTROL	HLR	ST 400IU CAPS		
	TARO-CALCITRIOL	TAR		M-D	MAN
0.5MCG CAF		IAR		PHARMA-D	PED
		CTC	400U CAPSI		
	CALCITRIOL	STS		BIO-VITAMIN D3	BMI
	CALCITRIOL-ODAN	ODN	ST 800IU CAPS		
	ROCALTROL	HLR	80003010		EUR
	TARO-CALCITRIOL	TAR		VITAMINE D	BMI
CHOLECALO	FEROL		ST 1,000IU CAP		
ST 400IU CAPS	ULE		80007766		JMP
80006629	DGEL	JMP	80003707	EURO-D	EUR
02242651	EURO D	EUR	80055204	M-D	MAN
80005560	RIVA-D	RIV	80008496		PMS
ST 800IU CAPS	ULE		ST 10,000IU CA	PSULE	
80007769	DGEL	JMP	02371499	EURO-D	PMS
1,000IU CAP	SULE		02449099	JAMP-VITAMIN D	JMP
80027592		OPU	^{s⊤} 15MCG LIQI	סוע	
	VITAMIN D3	WAM	80013189	DDROPS BOOSTER	DDP
ST 10,000IU CA			s⊤ 400IU LIQUI	D	
02253178		SDZ	80019649	D3-DOL	JMP
ST 400IU LIQUII			80038155	DECAXIL	ORM
	BABY DDROPS	DDP	80041145	DECAXIL	ORM
80001792		DDP	ST 800IU LIQUI	D	
ST 400IU/ML LIC		55.	80003285	PEDIAVIT D	EUR
	D VI INFANTS	MJO	ST 1,000IU LIQI	JID	
	JAMP VITAMIN D	JMP	80007346	JAMP VITAMIN D	JMP
	PEDIAVIT D	EUR	80028362	JAMP VITAMIN D	JMP
02201024	5,,,,,,,,	LOIX	80028371	JAMP VITAMIN D	JMP

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			Non-insured Health Ben	ents
88:16.00 VITAMIN D		88:28.00 ML	ILTIVITAMIN PREPARATIONS	S
VITAMIN D		MULTIVITAN	IINS (CHILDREN AND YOUTH)	
ST 25MCG TABLET		Limited use bene	efit (prior approval is not required).	
80031157 VITAMIN D	WNP	Multivitamina ara	handita for children up to 10 years of ago	
ST 400IU TABLET			benefits for children up to 19 years of age	€.
80002452 VITAMIN D	WNP	ST DROP		
80009578 VITAMIN D	VAE		ENFAMIL POLYVISOL	MJO
ST 1,000IU TABLET			MG & 30MG LIQUID	
80002169 PHARMA-D	PMS		JAMP VITAMIN A, D AND C	JMP
80051562 RIVA-D	RIV	•	66.67IU & 50MG/ML LIQUID	
80000131 VITAMIN D	VTH		ENFAMIL TRIVISOL	MJO
80000436 VITAMIN D	JAM		PEDIAVIT	EUR
80003663 VITAMIN D	WNP	OMG TABLE		551
80009580 VITAMIN D	VAE		CENTRUM	PFI
80015278 WAMPOLE VITAMIN D	WAM		CENTRUM	PFI
ST 10,000IU TABLET			CENTRUM FOR WOMEN	PFI
02379007 JAMP-VITAMIN D	JMP	2MG TABLE		D 4) /
02417685 VIDEXTRA	ORM		ONE A DAY WOMEN	BAY
88:20.00 VITAMIN E		10MG TABL		DEI
VITAMIN E			STRESSTABS FOR WOMEN	PFI
		ST TABLET (CH	•	DEL
Limited use benefit (prior approval required).			CENTRUM JUNIOR COMPLETE	PFI
For use in malabsorption			CENTRUM JUNIOR COMPLETE	PFI
ST 100IU CAPSULE (SOFTGEL)		02247995	FLINTSTONES MULTIPLE VITAMINS PLUS IRON	BAY
00122823 VITAMIN E	JAM	02247975	FLINTSTONES MULTIPLE	BAY
ST 200IU CAPSULE (SOFTGEL)			VITAMINS WITH EXTRA C	
00122831 VITAMIN E	JAM	MULTIVITAN	IINS (PRENATAL)	
ST 400IU CAPSULE (SOFTGEL)		Limited use bene	efit (prior approval is not required.).	
00122858 VITAMIN E	JAM			
ST 800IU CAPSULE (SOFTGEL)		childbearing age	stnatal vitamins are benefits only for clients	S OT
00330191 VITAMIN E	JAM		(12 to 30 years).	
ST 20U/ML LIQUID		ST CAPSULE	OENTRUM RUM	DEI
09991656 AQUA-E/ML	UNK	80042704	CENTRUM DHA	PFI
ST 75U/ML LIQUID		ST TABLET	CENTRUM PREMATAL	DEL
09991652 AQUA-E	UNK	80045822		PFI
ST 50IU ORAL LIQUID		80080882		NES
00480215 AQUASOL E	NVC	80082297	MATERNA NESTL MATERNA	NES NES
ST 50IU/ML ORAL LIQUID		02241235	PRENATAL AND POSTPARTUM	VTH
02162075 AQUASOL E VITAMIN E	CLC	02241233	VITAMINS AND MINERALS	V 111
88:24.00 VITAMIN K PHYTONADIONE		80005770	PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	PMT
		02229535		WAM
2MG/ML EMULSION			AND POST NATAL WITH FOLIC	
00781878 VITAMIN K1	SDZ	0140 TABLE	ACID	
10MG/ML EMULSION		2MG TABLE		VITL
00804312 VITAMIN K1	SDZ	80004919	NATURES BOUNTY PRENATAL VITAMINS	VTH
88:28.00 MULTIVITAMIN PREPARATIONS		THIAMINE H	YDROCHLORIDE	
CALCIUM, VITAMIN D				
sr 500-400MGU TABLET		50MG TABL		05
80088060 BIO-CAL DR FORTE	BIO		OPUS VITAMINE B1	OPU
0 0.12 0.112	=.•	100MG TAB		OBL
		80049780	OPUS VITAMINE B1	OPU

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UNK

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS

EXTEMPORANEOUS MIXTURE

X I LIVIPORA	ANEOUS WILL TURE	
CAPSULE		
99505003	PHENAZOPYRIDINE COMPOUNDED	UNK
CREAM		
99500000	HYDROCORTISONE POWDER AND CLOTRIMAZOLE CREAM	UNK
99500010	LCD IN CORTICOSTEROID CREAM	UNK
99500009	LCD IN NON-MEDICATED CREAM	UNK
99500002	MENTHOL &/OR CAMPHOR IN STEROID	UNK
99500004	MISCELLANEOUS COMPOUNDED TOPICAL CREAM	UNK
99500001	STEROID AND ANTIFUNGAL CREAM	UNK
99500006	SULFUR IN NON-MEDICATED CREAM	UNK
LOTION		
99502001	MENTHOL & CAMPHOR IN CORTICOSTEROID LOTION	UNK
99502002	MISCELLANEOUS COMPOUNDED EXTERNAL LOTION	UNK
MISCELLAN	EOUS	
99505005	H2RA SOLID	UNK
00915000	STERILE EXTEMPORANEOUS MIXTURE (QC)	UNK
OINTMENT		
99501006	ALL PURPOSE NIPPLE OINTMENT	UNK
99501003	CALCIUM CHANNEL BLOCKER IN OINTMENT	UNK
99501008	DILTIAZEM 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
OPHTHALMI	C SOLUTION	
99507002	ANTIBIOTIC DROPS	UNK
99507001	ANTIFUNGAL DROPS	UNK
99507003	ANTIVIRAL DROPS	UNK
ORAL LIQUI	D	
99503028	ANTACID AND LIDOCAINE ORAL LIQUID	UNK
99503029	MAGIC MOUTHWASH	UNK
99503025	MISCELLANEOUS COMPOUNDED INTERNAL LIQUID	UNK
POWDER		
99505004	BACKORDER INTERNAL POWDER	UNK
99505000	MISCELLANEOUS COMPOUNDED INTERNAL POWDER	UNK

92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS

EXTEMPORANEOUS MIXTURE (GENDER AFFIRMING)

Limited use benefit (prior approval required).

For gender affirming hormone therapy.

INJECTION

00915312 GENDER AFFIRMING HORMONES

LIQUID

00915311 GENDER AFFIRMING TOPICAL UNK HORMONES

EXTEMPORANEOUS MIXTURE (LU)

Limited use benefit (prior approval required).

INJECTION

99506021 MISCELLANEOUS COMPOUNDED UNK INJECTION/INFUSION

MISCELLANEOUS

99504001 MISC LIMITED USE EXTERNAL UNK

COMPOUND MIXTURE

OPHTHALMIC AND OTIC SOLUTION

99507000 MISCELLANEOUS COMPOUNDED UNK EYE/EAR DROP

ORAL LIQUID

99503033 MISC LIMITED USE COMPOUND UNK INTERNAL
99503032 OPIOID COMPOUNDED UNK

POWDER

99504000 MISCELLANEOUS COMPOUNDED UNK EXTERNAL POWDER

SUPPOSITORY

99508000 MISCELLANEOUS COMPOUNDED UNK SUPPOSITORY

EXTEMPORANEOUS MIXTURE (NSAID)

Limited use benefit (prior approval not required).

Coverage will be limited to 100 grams every 30 days.

GEL

99501007 NSAID IN TRANSDERMAL BASE UNK

OINTMENT

99501009 TRANSDERMAL LIDOCAINE UNK
W/NSAID

GOSERELIN ACETATE

10.8MG/DEPOT IMPLANT
02225905 ZOLADEX LA

UNK

NVR

OCTREOTIDE ACETATE

10MG/VIAL POWDER FOR SUSPENSION (SUSTAINED RELEASE)

02239323 SANDOSTATIN LAR NVR

20MG/VIAL POWDER FOR SUSPENSION (SUSTAINED RELEASE)

02239324 SANDOSTATIN LAR NVR

30MG/VIAL POWDER FOR SUSPENSION (SUSTAINED RELEASE)

02239325 SANDOSTATIN LAR

50MCG/ML SOLUTION02248639 OCTREOTIDE ACETATE OMEGA OMG

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92:00.00 UNCLASSIFIED THERAPEUTIC		92:01.28
AGENTS		MULTIVITAMINS (PRENATAL)
OCTREOTIDE ACETATE		Limited use benefit (prior approval is not required.).
50MCG/ML SOLUTION 00839191 SANDOSTATIN	NVR	Prenatal and postnatal vitamins are benefits only for clients of childbearing age (12 to 50 years).
100MCG/ML SOLUTION 02248640 OCTREOTIDE ACETATE OMEGA 00839205 SANDOSTATIN	OMG NVR	80081007 MATERNA PRENATAL DHA NES 92:01.88 VITAMIN B COMPLEX
200MCG/ML SOLUTION	0140	CALCIUM, VITAMIN D
02248642 OCTREOTIDE ACETATE OMEGA 02049392 SANDOSTATIN	OMG NVR	·
500MCG/ML SOLUTION	IVIX	500-400MGU TABLET 80090977 BIO CAL-D3 BMI
02248641 OCTREOTIDE ACETATE OMEGA	OMG	VITAMIN C
PENTOSAN POLYSULFATE SODIUM		ST 500MG TABLET
100MG CAPSULE		80092665 VITAMIN C JAM
02029448 ELMIRON	JSO	VITAMIN D
QUINAGOLIDE (QUINAGOLIDE		1000UI CAPSULE
HYDROCHLORIDE)		80089250 BIO-VITAMINE D3 BMI
0.075MG TABLET		92:05.00 SERUMS
02223767 NORPROLAC	FEI	ALLERGENIC EXTRACTS POLLENS
USTEKINUMAB		40000U LIQUID
Limited use benefit (prior approval required). For the treatment of:		02247755 OMEGA ALLERGENIC EXTRACTS OMG POLLENS (SUSPAL)
 psoriasis according to established criteria. 		APIS MELLIFERA VENOM PROTEIN EXTRACT
(Please refer to Appendix A).		1.1MG POWDER FOR SOLUTION
45MG/0.5ML SOLUTION		01948903 PHARMALGEN HONEY BEE ALK
02320673 STELARA	JSO	VENOM
90MG/ML SOLUTION		120MCG POWDER FOR SOLUTION 01948911 PHARMALGEN HONEY BEE ALK
02320681 STELARA	JSO	VENOM
92:01.00 NATURAL HEALTH PRODUCTS		DOLICHOVESPULA ARENARIA VENOM PROTEIN
CANTHARIDIN		120MCG POWDER FOR SOLUTION
1%(W/V) LIQUID 80023975 CANTHARONE 07	DOR	01948946 PHARMALGEN YELLOW HORNET ALK VENOM PROTEIN
ISOPROPYL ALCOHOL 70% WIPE, MEDICATED		DOLICHOVESPULA MACULATA VENOM PROTEIN EXTRACT
80074942 MEDISURE ALCOHOL WIPES LACTASE	MDS	120MCG POWDER FOR SOLUTION 01949004 PHARMALGEN WHITE FACED ALK HORNET VENOM
ST 150MG TABLET		HONEY BEE VENOM PROTEIN EXTRACT
80018706 LACTASE 4500 FCCLU	JAM	120MCG POWDER FOR SOLUTION
NATURAL HEALTH PRODUCT		02226197 VENOMIL HONEY BEE VENOM JUB
1% CREAM		550MCG POWDER FOR SOLUTION
80066699 CORTIVERA H	VAN	02220075 HYMENOPTERA VENOM JUB PRODUCT HONEY BEE VENOM
PSYLLIUM MUCILLOID		NON POLLEN
^{sr} 3G POWDER 80013276 METAMUCIL FIBRE THERAPY	PGI	100,000U LIQUID
80013276 METAMUCIL FIBRE THERAPY SMOOTH TEXTURE 80013287 METAMUCIL FIBRE THERAPY	PGI	00299979 ALLERGENIC EXTRACT NON ALK POLLENS
SMOOTH TEXTURE SUGAR FREE	. 0.	POLISTES SPP VENOM PROTEIN EXTRACT
80015505 METAMUCIL SMOOTH TEXTURE	PGI	1.1MG POWDER FOR SOLUTION
UNFLAVOURED UNSWEETENED		01948970 PHARMALGEN WASP VENOM ALK PROTEIN

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92:05.00 SE	RUMS		92:05.00 SERUMS	
POLLEN			YELLOW JACKET VENOM PROTEIN	
	IOLUD			
4,300U/ML L	POLLINEX R	BEN	550MCG POWDER FOR SOLUTION 02220113 HYMENOPTERA VENOM	JUB
100,000U LI		DLIN	PRODUCT YELLOW JACKET	JOB
•	ALLERGENIC EXTRACT POLLENS	ALK	VENOM PROTEIN	
	D NON POLLEN		92:08.00 5 ALFA REDUCTASE INHIBITORS	;
			DUTASTERIDE	
20,000U LIQ		ALK	ST 0.5MG CAPSULE	
	CENTER-AL OTEIN EXTRACT	ALK		TEV
VENOW PRO	TEIN EXTRACT			APX
•	OWDER FOR SOLUTION			AUR
01948873	PHARMALGEN MIXED VESPID VENOM PROTEIN	ALK	02247813 AVODART	GSK
VECDIII A CI	PP VENOM PROTEIN EXTRACT		02421712 DUTASTERIDE	PDL
VESPULA SI	PP VENOW PROTEIN EXTRACT		02429012 DUTASTERIDE	SIV
	DER FOR SOLUTION			SAN
01948954	PHARMALGEN YELLOW JACKET VENOM PROTEIN	ALK		JMP
120MCG PO	WDER FOR SOLUTION			GMP.
	PHARMALGEN YELLOW JACKET	ALK		MIN
0.0.000	VENOM PROTEIN		02393220 PMS-DUTASTERIDE I 02427753 RIVA-DUTASTERIDE	PMS RIV
WASP VENO	M PROTEIN			SDZ
120MCG PO	WDER FOR SOLUTION			TEV
	VENOMIL WASP VENOM PROTEIN	JUB	FINASTERIDE	
	WDER FOR SOLUTION	002		
02220091	HYMENOPTERA VENOM	JUB	ST 5MG TABLET	۸.00
	PRODUCT WASP VENOM PROTEIN			ACC APX
WHITE FACE	D HORNET VENOM PROTEIN			AUR
120MCG PO	WDER FOR SOLUTION			DPC
	VENOMIL WHITE-FACED HORNET	JUB		PDL
	VENOM PROTEIN		02445077 FINASTERIDE	SAN
	ED HORNET VENOM PROTEIN,		02447541 FINASTERIDE	SIV
	RNET VENOM PROTEIN, YELLO)W	02357224 JAMP-FINASTERIDE	JMP
JACKET VEN	NOM PROTEIN		02389878 MINT-FINASTERIDE	MIN
120MCG PO	WDER FOR SOLUTION			PMS
01948881	PHARMALGEN MIXED VESPID	ALK		FRS
	VENOM PROTEIN			RBY
02226294	VENOMIL MIXED VESPID VENOM PROTEIN	JUB	02455013 RIVA-FINASTERIDE 02322579 SANDOZ FINASTERIDE	RIV SDZ
550MCG PO	WDER FOR SOLUTION			TEV
	HYMENOPTERA VENOM	JUB	92:12.00 ANTIDOTES	
	PRODUCT MIXED VESPID VENOM			
VEL 1 0 W 110	PROTEIN		LEUCOVORIN CALCIUM	
YELLOW HO	RNET VENOM PROTEIN		5MG TABLET	
120MCG/ML	POWDER FOR SOLUTION		02170493 LEDERLE LEUCOVORIN	PFI
02226251	VENOMIL YELLOW HORNET VENOM PROTEIN	JUB	92:16.00 ANTIGOUT AGENTS	
550MCG PO	WDER FOR SOLUTION		ALLOPURINOL	
02220083	HYMENOPTERA VENOM	JUB	100MG TABLET	
	PRODUCTS YELLOW HORNET		02481863 AG-ALLOPURINOL	ANG
VELLOW:	VENOM PROTEIN			PDL
YELLOW JA	CKET VENOM PROTEIN			APX
120MCG PO	WDER FOR SOLUTION			JMP
02226286	VENOMIL YELLOW JACKET	JUB		MAR AAP
	VENOM PROTEIN		00402010 ZILOFNIN	AAF

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92:16.00 ANTIGOUT AGENTS ALLOPURINOL

200MG TABLET

02481871	AG-ALLOPURINOL	ANG
02130157	ALLOPURINOL	PDL
02402777	APO-ALLOPURINOL	APX
02421607	JAMP-ALLOPURINOL	JMP
02396335	MAR-ALLOPURINOL	MAR
00479799	ZYLOPRIM	AAP
300MG TABI	LET	
02481898	AG-ALLOPURINOL	ANG
00294322	ALLOPURINOL	APX
00555703	ALLOPURINOL	PDL
02402785	APO-ALLOPURINOL	APX
02421615	JAMP-ALLOPURINOL	JMP
02396343	MAR-ALLOPURINOL	MAR
00402796	ZYLOPRIM	AAP
DDIN	VTEMBODANIEGUO MIVTUDE	

ST PDIN FOR EXTEMPORANEOUS MIXTURE

99503018 ALLOPURINOL ORAL LIQUID UNK

COLCHICINE

ST 0.6MG TABLET

00572349	COLCHICINE	ODN
02373823	JAMP-COLCHICINE	JMP
02402181	PMS-COLCHICINE	PMS
00287873	SANDOZ COLCHICINE	SDZ

FEBUXOSTAT

Limited use benefit (prior approval required).

For patients with symptomatic gout who have documented hypersensitivity to allopurinol.

ST 80MG TABLET

02490870	JAMP FEBUXOSTAT	JMP
02473607	MAR-FEBUXOSTAT	MAR
02466198	TEVA-FEBUXOSTAT	TEV
02357380	ULORIC	TAK

92:20.00 IMMUNOMODULAROTY AGENTS FINGOLIMOD (FINGOLIMOD HYDROCHLORIDE)

Limited use benefit (prior approval required).

Initial Coverage (one year):

For the treatment of patients with Relapsing Remitting Multiple Sclerosis (RRMS) who meet all of the following criteria:

- failure to respond to full and adequate courses of at least one initial disease-modifying therapy (an interferon, glatiramer acetate, dimethyl fumarate, ocrelizumab or teriflunomide) or documented intolerance to at least 2 therapies; and
- one or more clinically disabling relapses in the previous year; and
- significant increase in T2 lesion load compared with that from a previous MRI scan or at least one gadolinium-enhancing lesion; and
- requested and followed by a neurologist experienced in the management of RRMS: and
- recent Expanded Disability Status Scale (EDSS) score.

Renewal Coverage (two years):

- EDSS scores must be provided (exam must have occurred within that last 90 days).
- patients must be stable or have experienced no more than 1 disabling attack/relapse in the past year.

0.5MG CAPSULE

02475669	ACH-FINGOLIMOD	ACC
02469936	APO-FINGOLIMOD	APX
02365480	GILENYA	NVR
02487772	JAMP FINGOLIMOD	JMP
02474743	MAR-FINGOLIMOD	MAR
02469715	MYLAN-FINGOLIMOD	MYL
02469782	PMS-FINGOLIMOD	PMS
02482606	SANDOZ FINGOLIMOD	SDZ
02469618	TARO-FINGOLIMOD	TAR
02469561	TEVA-FINGOLIMOD	TEV

GLATIRAMER ACETATE

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

20MG SOLUTION

02245619 COPAXONE TEV 02460661 GLATECT PMS

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92:20.00 IMMUNOMODULAROTY AGENTS INTERFERON BETA-1A

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

30MCG INJECTION

09857395	AVONEX PEN		UNK	
99100763	AVONEX PEN		UNK	
60MCG POWDER FOR SOLUTION				
02267594	AVONEX		UNK	
22MCG SOL	UTION			
02237319	REBIF		SRO	
30MCG SOL	UTION			
02269201	AVONEX		UNK	
44MCG SOL	UTION			
02237318	REBIF		SRO	
02237320	REBIF		SRO	
66MCG SOL	UTION			
02318253	REBIF		SRO	
132MCG SO	LUTION			
02318261	REBIF		SRO	
02318288	REBIF		SRO	

INTERFERON BETA-1B

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

99100555 BETASERON INITIATION KIT

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

0.3MG INJECTION

0.3MG POWDER FOR SOLUTION				
02169649	BETASERON	BAY		
02337819	EXTAVIA	NVR		

92:20.00 IMMUNOMODULAROTY AGENTS OCRELIZUMAB

Limited use benefit (prior approval required).

- 1. For the treatment of relapsing-remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence who meet all of the following criteria:
- prescribed by a neurologist experienced in the management of RRMS; and
- patient has had a clinical relapse* and/or new MRI activity**
 in the last two years; and
- patient is fully ambulatory for 100 meters without aids. Expanded Disability Status Scale score (EDSS) of 5.5 or less.
- patient is 18 years of age or older.
- *. A clinical relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 24 hours in the absence of fever, preceded by stability for at least one month
- **. MRI activity is defined as any new multiple sclerosis lesion/s, expanding lesion/s, and/or enhancing lesion/s.

10

2. For the treatment of primary progressive multiple sclerosis (PPMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence who meet all of the following criteria:

Initial Coverage (one year)

- prescribed by a neurologist experienced in the management of PPMS; and
- expanded Disability Status Scale (EDSS) between 3.0 and 6.5; and
- score of at least 2.0 on the Functional Systems scale (FSS) for the pyramidal system due to lower extremity findings; and
- disease duration of less than 15 years for those with an EDSS greater than 5.0 or less than 10 years for those with an EDSS of 5.0 of less; and
- patient is 18 years of age or older.

Renewal Coverage for PPMS (one year):

• EDSS of less than 7.0.

30MG SOLUTION

02467224 OCREVUS

HLR

TERIFLUNOMIDE

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

14MG TABLET

02416328 AUBAGIO

GEE

92:24.00 BONE RESORPTION INHIBITORS ALENDRONATE SODIUM

ST 5MG TABLET

02381478 ACH-ALENDRONATE

ACC

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BAY

92:24.00 BC	NE RESORPTION INHIBITOR	RS	92:24.00 BONE RESORPTION INHIBITOR	RS
ALENDRONATE SODIUM			DENOSUMAB (PROLIA)	
			Limited use benefit (prior approval required).	
ST 5MG TABLE		ADV	Elittited use benefit (prior approval required).	
02248727 02384698	APO-ALENDRONATE RAN-ALENDRONATE	APX RBY	For the treatment of osteoporosis in patients who have a	
	TEVA-ALENDRONATE	TEV	significant fracture risk defined as either: moderate 10-year fracture risk (10% to 20%) with a prior	
ST 10MG TABL		ΙΕV	fragility fracture; or	
	ACH-ALENDRONATE	ACC	 high 10-year fracture risk (≥ 20%); 	
02248728	APO-ALENDRONATE	APX	• and	
	AURO-ALENDRONATE	AUR	 have a contraindication to oral bisphosphonates (e.g. hypersensitivity, esophageal abnormality, renal impairment 	t)· or
	RAN-ALENDRONATE	RBY	 have failed or have an intolerance to oral bisphosphonat 	
02288087	SANDOZ ALENDRONATE	SDZ	(e.g. hypersensitivity, esophageal abnormality, renal	
02247373	TEVA-ALENDRONATE	TEV	impairment).	
ST 70MG TABL	ET		60MG/ML SOLUTION	
02381494	ACH-ALENDRONATE	ACC	02343541 PROLIA	AMG
02299712	ALENDRONATE	SIV	DENOSUMAB (XGEVA)	
02352966	ALENDRONATE	SAN	Limited use benefit (prior approval required).	
02303078	ALENDRONATE-70	PDL	5	
02248730	APO-ALENDRONATE	APX	For the prevention of skeletal-related events (SREs) in patients with castrate-resistant prostate cancer (CRPC) with	h:
02388553	AURO-ALENDRONATE	AUR	 one or more documented bone metastases; and 	
02282763		DPC	• good performance status (ECOG performance status so	ore
02245329	FOSAMAX	FRS	of 0, 1, or 2).	
02385031	JAMP-ALENDRONATE	JMP	120MG/1.7ML SOLUTION	
02394871	MINT-ALENDRONATE	MIN	02368153 XGEVA	AMG
02273179	PMS-ALENDRONATE	PMS	ETIDRONATE DISODIUM	
02284006	PMS-ALENDRONATE	PMS	ST 200MG TABLET	
02384728	RAN-ALENDRONATE	RBY	02248686 ACT ETIDRONATE	TEV
02270889	RIVA-ALENDRONATE	RIV SDZ	PAMIDRONATE DISODIUM	
02288109 02261715	SANDOZ ALENDRONATE TEVA-ALENDRONATE	TEV		
			6MG SOLUTION	0110
	ATE SODIUM, CHOLECALCIFER	OL	02249677 PAMIDRONATE	OMG
ST 70MG & 2,80	00U TABLET		9MG SOLUTION	EKD
	APO-ALENDRONATE/VITAMIN D3	APX	02246599 PAMIDRONATE	FKD
02276429	FOSAVANCE	FRS	02249685 PAMIDRONATE DISODIUM OMEGA 30MG SOLUTION	OMG
02403633	TEVA-	TEV	02244550 PAMIDRONATE DISODIUM	PFI
	ALENDRONATE/CHOLECALCIFERO		60MG SOLUTION	FFI
^{S7} 70MG & 5,60	-		02244551 PAMIDRONATE DISODIUM	PFI
	APO-ALENDRONATE/VITAMIN D3	APX	90MG SOLUTION	
	FOSAVANCE	FRS	02244552 PAMIDRONATE DISODIUM	PFI
02429160		SDZ	02245999 PMS-PAMIDRONATE	PMS
	ALENDRONATE/CHOLECALCIFERO		RISEDRONATE SODIUM	1 1110
	L			
02403641	TEVA- ALENDRONATE/CHOLECALCIFERO	TEV	ST 5MG TABLET	
	L		02298376 TEVA-RISEDRONATE	TEV
			ST 30MG TABLET	TE\ (
			02298384 TEVA-RISEDRONATE	TEV
			ST 35MG TABLET	041
			02370255 RISEDRONATE	SAN
			02411407 RISEDRONATE-35	SIV
			02298392 TEVA-RISEDRONATE	TEV
			ST 150MG TABLET 02413809 TEVA-RISEDRONATE	TEV
				ΙĽV
			RISEDRONATE SODIUM (RISEDRONATE SODIUM HEMIPENTAHYDRATE)	
			ST 35MG TABLET	
			02246896 ACTONEL	ALL

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92:24.00 BONE RESORPTION INHIBITORS **RISEDRONATE SODIUM (RISEDRONATE SODIUM HEMIPENTAHYDRATE)**

ST 35MG TABLET

02353687	APO-RISEDRONATE	APX
02406306	AURO-RISEDRONATE	AUR
02309831	DOM-RISEDRONATE	DPC
02368552	JAMP-RISEDRONATE	JMP
02302209	PMS-RISEDRONATE	PMS
02347474	RISEDRONATE	PDL
02341077	RIVA-RISEDRONATE	RIV
02327295	SANDOZ RISEDRONATE	SDZ
150MG TABI	LET	
02316838	ACTONEL	ALL

02316838	ACTONEL	ALL
02377721	APO-RISEDRONATE	APX
02424177	PMS-RISEDRONATE	PMS

ZOLEDRONIC ACID MONOHYDRATE

Limited use benefit (prior approval required).

Maximum dose covered is 5mg per 12-month period For the treatment of Paget's disease; or For the treatment of osteoporosis in patients who have a significant fracture risk defined as either:

- moderate 10-year fracture risk (10% to 20%) with a prior fragility fracture; or
- high 10-year fracture risk (≥ 20%); and
- have a contraindication to oral bisphosphonates (e.g. hypersensitivity, esophageal abnormality, renal impairment); or
- have failed or have an intolerance to oral bisphosphonates (e.g. hypersensitivity, esophageal abnormality, renal impairment).

5MG/100ML SOLUTION

02269198	ACLASTA	NVR
02415100	TARO-ZOLEDRONIC ACID	TAR
02422433	ZOLEDRONIC ACID	RFC

92:32.00

ICATIBANT

Limited use benefit (prior approval required).

For the treatment of acute attacks of hereditary angioedema (HAE) in adults with lab-confirmed C1-esterase inhibitor deficiency (type I or type II); and

- treatment of acute non-laryngeal attacks of at least moderate severity; or
- treatment of acute laryngeal attacks; and
- is prescribed by physician with experience in the treatment of HAE.

Note: Limited to two (2) doses of prefilled syringes per dispense.

10MG SOLUTION

02425696 FIRAZYR UNK

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**

125MG SOLUTION

02402475 ORENCIA **BMS**

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.
- hidradenitis suppurativa according to established criteria.

(Please refer to Appendix A).

40MG/VIAL SOLUTION

02258595 HUMIRA

ABV

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 SOLUTION

02465574 CIMZIA

UCB

200MG/ML SOLUTION

UCB 02331675 CIMZIA

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

50MG/ML INJECTION

02274728 ENBREL PED 99100373 ENBREL SURECLICK **AMG**

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92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

ETANERCEPT (BRENZYS)

Limited use benefit (prior approval required).

For the treatment of:

- rheumatoid arthritis according to established criteria.
- ankylosing spondylitis according to established criteria.

(Please refer to Appendix A).

50MG SOLUTION

02455323	BRENZYS	UNK
02455331	BRENZYS	UNK

ETANERCEPT (ERELZI)

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 SOLUTION

02462877	ERELZI	SDZ
50MG SOLU	TION	
02462850	ERELZI	SDZ
02462869	ERELZI	SDZ

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
02324784	SIMPONI
100MG/ML S	SOLUTION
02413175	SIMPONI
02413183	SIMPONI

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
02470373	RENFLEXIS	UNK

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

ST 10MG TABLET

02478862	ACCEL-LEFLUNOMIDE	ACP
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
ST 20MG TABLE	ET	
02478870	ACCEL-LEFLUNOMIDE	ACP
02256509	APO-LEFLUNOMIDE	APX
02241889	ARAVA	SAC
02351676	LEFLUNOMIDE	SAN

PDL

PMS

SDZ

TEV

HLR

SARILUMAB

02261278

Limited use benefit (prior approval required).

02288273 PMS-LEFLUNOMIDE

02283972 SANDOZ LEFLUNOMIDE

02415836 LEFLUNOMIDE

For the treatment of:

• rheumatoid arthritis according to established criteria.

TEVA-LEFLUNOMIDE

(Please refer to Appendix A).

150MG SOLUTION

02460521	KEVZARA	SAC
02472961	KEVZARA	SAC
200MG SOL	UTION	
02460548	KEVZARA	SAC
02472988	KEVZARA	SAC

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

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92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

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).

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.
- giant cell arteritis according to established criteria.

(Please refer to Appendix A).

162MG SOLUTION

02424770 ACTEMRA HLR 02483327 ACTEMRA HLR

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

11MG TABLET (EXTENDED RELEASE)

02470608 XELJANZ XR PFI

92:44.00 IMMUNOSUPPRESSIVE AGENTS ALEMTUZUMAB

Limited use benefit (prior approval required).

Coverage is provided for two years (i.e. two treatment courses/ total of eight doses) for adult patients who meet all of the following criteria:

For the treatment of relapsing-remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence; and

- prescribed by a specialist with experience in the treatment of multiple sclerosis; and
- highly active disease defined by clinical and imaging features (i.e. significant increase in T2 lesion load compared with that from a previous MRI scan or at least one gadolinium-enhancing lesion) MRI report does not need to be submitted with the request; and
- failure to respond to full and adequate courses of at least two trials of disease-modifying therapies (DMT) for at least six months each or where any other DMT is contraindicated or otherwise unsuitable; and
- at least one relapse while on at least six months of a DMT within the last 10 years, and
- at least two attacks (first episode or relapse) in the previous two years, with at least one attack in the previous year; and
- an Expanded Disability Status Scale (EDSS) score of five (5) or less.

12MG SOLUTION

02418320 LEMTRADA GEE

AZATHIOPRINE

ST 50MG TABLET

02242907	APO-AZATHIOPRINE	APX
02243371	AZATHIOPRINE-50	PDL
00004596	IMURAN	ASP
02236819	TEVA-AZATHIOPRINE	TEV

ST PDIN FOR EXTEMPORANEOUS MIXTURE

99503019 AZATHIOPRINE ORAL LIQUID UNK

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92:44.00 IMMUNOSUPPRESSIVE AGENTS CLADRIBINE

Limited use benefit (prior approval required).

Initial Coverage (two years):

For the treatment of patients with Relapsing Remitting Multiple Sclerosis (RRMS) who meet all of the following criteria:

- failure to respond to full and adequate courses* of at least ONE initial disease-modifying therapy (DMT) (interferon, glatiramer, dimethyl fumarate, ocrelizumab or teriflunomide) or documented intolerance** to at least 2 DMTs; and
- one or more clinically disabling relapses in the previous year; and
- significant increase in T2 lesion load compared with that from a previous MRI scan or at least one gadoliniumenhancing lesion; and
- requested and followed by a neurologist experienced in the management of RRMS: and
- recent Expanded Disability Status Scale (EDSS) score***
- * failure to respond is defined as: a trial of at least 6 months and experienced at least one disabling relapse (attack) while on an initial DMT.
- ** intolerance is defined as: documented serious adverse effects or contraindications that are incompatible with further use of that class of drug.
- *** recent Expanded Disability Status Scale (EDSS) score less than or equal to 5.5 (i.e. patients must be able to ambulate at least 100 meters without assistance).

10MG TABLET

02470179 MAVENCLAD

SRO

CYCLOSPORINE

Limited use benefit (prior approval required).

For transplant therapy.

^{sτ} 10	ST 10MG CAPSULE			
0	2237671	NEORAL	NVR	
ST 25	MG CAPS	ULE		
0	2150689	NEORAL	NVR	
0	2247073	SANDOZ CYCLOSPORINE	SDZ	
ST 50 1	MG CAPS	ULE		
0	2150662	NEORAL	NVR	
0	2247074	SANDOZ CYCLOSPORINE	SDZ	
ST 10	OMG CAPS	SULE		
0	2150670	NEORAL	NVR	
0	2242821	SANDOZ CYCLOSPORINE	SDZ	
ST 10	OMG/ML S	OLUTION		
0	2244324	APO-CYCLOSPORINE	APX	
0	2150697	NEORAL	NVR	

92:44.00 IMMUNOSUPPRESSIVE AGENTS MEPOLIZUMAB

Limited use benefit (prior approval required).

For initial 12-month coverage:

For the adjunctive treatment of severe eosinophilic asthma in adults who are inadequately controlled with high-dose inhaled corticosteroids plus one or more additional asthma controller(s) (e.g. long-acting beta-agonist); and

- have had a blood eosinophil count of ≥0.15x109/L before initiation of Nucala (levels must have been drawn within 3 months of the start of treatment); or
- have had a blood eosinophil count of ≥0.3x109/L within the 12-month period prior to starting Nucala
- and
- show reversibility on spirometry (a rise in FEV1of at least 12% and at least 200 mL);
- and
- have experienced two or more clinically significant asthma exacerbations* in the past 12 months period prior to starting Nucala; or
- have received maintenance therapy with daily oral corticosteroids for at least 3 months prior to starting Nucala.

For 12-month renewal coverage:

For the adjunctive treatment of severe eosinophilic asthma in adult patients who have experienced a decrease in clinically significant exacerbations with mepolizumab treatment as demonstrated by:

- patient has experienced a decrease in clinically significant asthma exacerbations* with Nucala treatment; or
- patient's oral corticosteroid maintenance dose decreased by at least 25 % from the pre-treatment dose.

Coverage for Nucala is provided for a maximum dose of 100 mg every four weeks.

* A clinically significant asthma exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized.

100MG POWDER FOR SOLUTION

02449781	NUCALA	GSK
100MG SOL	UTION	
02492989	NUCALA	GSK
02492997	NUCALA	GSK

MYCOPHENOLATE MOFETIL

Limited use benefit (prior approval required).

For transplant therapy.

ST 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
T ANAMA DOWNER FOR CHERENCIAN		

HLR

APX

ST 200MG POWDER FOR SUSPENSION

02242145 CELLCEPT

ST 500MG TABLET

02352567 APO-MYCOPHENOLATE

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92:44.00 IMMUNOSUPPRESSIVE AGENTS 92:92.00 OTHER MISCELLANEOUS THERAPEUTIC AGENTS **MYCOPHENOLATE MOFETIL ABOBOTULINUMTOXINA** Limited use benefit (prior approval required). Limited use benefit (prior approval required). For transplant therapy ST 500MG TABLET Treatment of cervical dystonia (spasmodic torticollis) in HLR 02237484 CELL CEPT Symptomatic treatment of focal spasticity affecting upper 02380382 JAMP-MYCOPHENOLATE JMP limbs in adults: or 02378574 **MYCOPHENOLATE** ACC Lower limb spasticity in patients 2 years of age and older. 02457377 MYCOPHENOLATE MOFETIL SAN 300U POWDER FOR SOLUTION 02370549 MYLAN-MYCOPHENOLATE MYL 02460203 DYSPORT THERAPEUTIC **IPS** 02313855 SANDOZ MYCOPHENOLATE SDZ **500U POWDER FOR SOLUTION** 02348675 TEVA-MYCOPHENOLATE TEV 02456117 DYSPORT THERAPEUTIC **IPS MYCOPHENOLATE SODIUM CINACALCET (CINACALCET HYDROCHLORIDE)** Limited use benefit (prior approval required). **30MG TABLET** 02452693 APO-CINACALCET APX For transplant therapy. 02478900 AURO-CINACAI CET AUR ST 180MG TABLET (ENTERIC COATED) 02463814 CINACALCET UNK APX 02372738 APO-MYCOPHENOLIC ACID 02485028 JAMP CINACALCET JMP 02264560 MYFORTIC **NVR** 02480298 MAR-CINACALCET MAR ST 360MG TABLET (ENTERIC COATED) 02481987 M-CINACALCET MAN 02372746 APO-MYCOPHENOLIC ACID APX 02434539 MYLAN-CINACALCET MYL 02264579 **MYFORTIC NVR** 02472538 REDDY-CINACALCET **REC SIROLIMUS** 02456729 SANDOZ CINACALCET SD7 Limited use benefit (prior approval required). 02257130 **SENSIPAR AMG** 02441624 **TEVA-CINACALCET** TFV Coverage will be provided as a second line therapy for **60MG TABLET** patients failing mycophenolate mofetil. 02452707 APO-CINACALCET **APX** ST 1MG/ML SOLUTION 02478919 **AURO-CINACALCET AUR** 02243237 RAPAMUNE PFI 02463822 CINACAI CET UNK ST 1MG TABLET JAMP CINACALCET 02485036 JMP 02247111 RAPAMUNE PFI 02480301 MAR-CINACALCET MAR TACROLIMUS MONOHYDRATE 02481995 M-CINACALCET MAN Limited use benefit (prior approval required). 02434547 MYLAN-CINACALCET MYL 02472546 REDDY-CINACALCET REC For transplant therapy 02456737 SANDOZ CINACALCET SDZ ST 0.5MG CAPSULE 02257149 **SENSIPAR** AMG 02243144 PROGRAF AST 02441632 **TEVA-CINACALCET TEV** 02416816 SANDOZ TACROLIMUS SDZ 90MG TABLET ST 1MG CAPSULE APX 02452715 APO-CINACALCET AST 02175991 PROGRAF 02478943 **AURO-CINACALCET AUR** 02416824 SANDOZ TACROLIMUS SDZ 02463830 CINACALCET UNK ST 5MG CAPSULE 02485044 JAMP CINACALCET **JMP** 02175983 PROGRAF **AST** 02480328 MAR-CINACALCET MAR ST 0.5MG CAPSULE (EXTENDED RELEASE) 02482002 M-CINACALCET MAN 02296462 ADVAGRAF **AST** 02434555 MYLAN-CINACALCET MYL ST 1MG CAPSULE (EXTENDED RELEASE) 02472554 REDDY-CINACALCET RFC **AST** 02296470 ADVAGRAF 02456745 SANDOZ CINACALCET SDZ **ST 3MG CAPSULE (EXTENDED RELEASE) SENSIPAR** AMG 02257157 02331667 ADVAGRAF AST 02441640 TEVA-CINACALCET **TEV 5T 5MG CAPSULE (EXTENDED RELEASE)** CYPROTERONE ACETATE 02296489 ADVAGRAF AST **5T 5MG CAPSULE (IMMEDIATE RELEASE) 50MG TABLET** 02416832 SANDOZ TACROLIMUS SDZ 00704431 **ANDROCUR** BAY 5MG/ML SOLUTION 02245898 **CYPROTERONE** AAP 02176009 PROGRAF **AST** 02390760 MED-CYPROTERONE GMP

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02395797

RIVA-CYPROTERONE

RIV

92:92.00 OTHER MISCELLANEOUS THERAPEUTIC AGENTS

CYPROTERONE ACETATE, ETHINYL ESTRADIOL

2MG & 35MCG TABLET

02290308	CYESTRA-35	PAL
02233542	DIANE-35	BAY
02425017	RAN-CYPROTERONE/ETHINYL ESTRADIOL	RBY
02309556	TEVA-CYPROTERONE / ETHINYL	TEV

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

LANREOTIDE ACETATE

60MG/0.3ML SOLUTION (EXTENDED RELEASE)

02283395 SOMATULINE AUTOGEL IPS

90MG/0.3ML SOLUTION (EXTENDED RELEASE)

02283409 SOMATULINE AUTOGEL IPS

120MG/0.5ML SOLUTION (EXTENDED RELEASE)

02283417 SOMATULINE AUTOGEL IPS

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; or

overactive bladder.

50IU INJECTION

09857386 BOTOX ALL

200IU INJECTION

09857387 BOTOX ALL

100IU POWDER FOR SOLUTION

01981501 BOTOX ALL

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94:00 DEVICES

94:00.00 DEVICES

SPACER DEVICE

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
00901012	INSPIRA CHAMBER W LARGE MASK	LUP
00900003	INSPIRA CHAMBER W MEDIUM MASK	LUP
00900001	INSPIRA CHAMBER W MOUTHPIECE	LUP
00900002	INSPIRA CHAMBER W SMALL MASK	LUP
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

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		
96899973	RESPICHAMBER SILICONE SMALL MASK	TRU
96899972	RESPICHAMBER VHC W MOUTHPIECE	TRU

94:01.00 DEVICES (DIABETIC)

ADHESHIVE WIPES

MISCEL	LANEOUS	

97799671 SKIN PREP ADHESHIVE WIPES UNK

DRESSING

DRESS

99401078 SN IV3000 1-HAND TRANS SMW

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	
COMFORT ANGLED DEVICE			

COMFORT S	SHORT ANGLED DEVICE	
97799683	COMFORT ANGLED INFSET 17MM	UNK
97799682	COMFORT ANGLED INFSET 17MM	UNK

97799678 COMFORT SRT ANGLED INFSET 13 UNK 97799679 COMFORT SRT ANGLED INFSET 13 UNK CONTACT DETACH DEVICE

97799672 CONTACT DETACH 90 DEGREE UNK
6MMX60CM
97799610 CONTACT DETACH 90 DEGREE UNK
8MMX60CM

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 MDT 97799490 MIO CLEAR 6MMX32 97799489 MIO CLEAR 9MMX32 MDT MIO PINK 6MMX18 97799492 MDT MIO PINK 6MMX23 MDT 97799437 **OMNIPOD DEVICE** 09991327 PODS UNK PARADIGM SILHOUETTE DEVICE

97799715 PARADIGM SILHOUETTE 13MMX 43 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.

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		TENDER "M	IINI" DEVICE	
97799485	PARADIGM SILHOUETTE	MDT	97799642	TENDER-2 MINI INFSET	ROD
97799716	PARADIGM SILHOUETTE 13MMX23	MDT		13MM/80CM	
97799484	PARADIGM SILHOUETTE	MDT	ULTRAFLE	(DEVICE	
97799718	PARADIGM SILHOUETTE 17MMX23	MDT	97799665	ULTRAFLEX 1 10MM/110CM	ROD
97799483	PARADIGM SILHOUETTE	MDT	97799667	ULTRAFLEX 1 10MM/60CM	ROD
97799719	PARADIGM SILHOUETTE 17MMX43	MDT	97799666	ULTRAFLEX 1 10MM/80CM	ROD
97799529	PARADIGM SILHOUETTE	MDT	97799668	ULTRAFLEX 1 8MM/110CM	ROD
	CANNULA 13MM		97799670	ULTRAFLEX 1 8MM/60CM	ROD
97799528	PARADIGM SILHOUETTE	MDT	97799669	ULTRAFLEX 1 8MM/80CM	ROD
QUICK-SET	CANNULA 17MM		643MMX" D		
97799486		MDT	09991616	INSET 6MMX43"	UNK
	QUICK-SET 6MMX18		2360IN/CM I		
97799744	QUICK-SET 6MMX23 TUBING	MDT		AUTOSOFT 30 13MM	UNK
97799487	QUICK-SET 6MMX32	MDT	97799198	AUTOSOFT 90 6MM	UNK
97799743	QUICK-SET 6MMX43 TUBING	MDT	97799199	AUTOSOFT 90 6MM	UNK
97799742	QUICK-SET 9MMX23 TUBING	MDT	97799200	AUTOSOFT 90 6MM	UNK
97799488	QUICK-SET 9MMX32	MDT	97799194	AUTOSOFT 90 9MM	UNK
97799741	QUICK-SET 9MMX43 TUBING	MDT	97799195	AUTOSOFT 90 9MM	UNK
RAPID-D DE		DOD	97799196	AUTOSOFT 90 9MM	UNK
97799650	RAPID-D 10MM/110CM	ROD	97799192	TRUSTEEL 6MM	UNK
97799652	RAPID-D 10MM/60CM	ROD	97799190	TRUSTEEL 8MM	UNK
97799651	RAPID-D 10MM/80CM	ROD	97799188	VARISOFT 13MM	UNK
97799656	RAPID-D 6MM/110CM	ROD	97799185	VARISOFT 17MM	UNK
97799658	RAPID-D 6MM/60CM	ROD	3280IN/CM I	DEVICE	
97799657	RAPID-D 6MM/80CM	ROD	97799191	TRUSTEEL 6MM	UNK
97799653	RAPID-D 8MM/110CM	ROD	97799189	TRUSTEEL 8MM	UNK
97799655	RAPID-D 8MM/60CM	ROD	97799187	VARISOFT 13MM	UNK
97799654	RAPID-D 8MM/80CM	ROD	97799184	VARISOFT 17MM	UNK
SURE-T DE\			43110IN/CM	DEVICE	
97799521	PARADIGM SURE-T 29G 6MMX18	MDT	97799201	AUTOSOFT 30 13MM	UNK
97799520	PARADIGM SURE-T 29G 6MMX23	MDT	97799197	AUTOSOFT 90 6MM	UNK
97799519	PARADIGM SURE-T 29G 8MMX23	MDT	97799193	AUTOSOFT 90 9MM	UNK
TENDER DE			97799186	VARISOFT 13MM	UNK
97799644	TENDER-1 17MM/110CM	ROD	DRESS		
97799646	TENDER-1 17MM/60CM	ROD	09991615	IV3000 STANDARD	SMW
97799645	TENDER-1 17MM/80CM	ROD	3ML NEEDL	E	
97799638	TENDER-2 17MM/110CM	ROD	00951417	T : SLIM X2 CARTRIDGE (SK)	UNK
97799640	TENDER-2 17MM/60CM	ROD	PATCH		
	TENDER-2 17MM/80CM	ROD	09991614	MMT-174 ADHESIVE	UNK
	INI" DEVICE		SYRINGE		
97799647	TENDER-1 MINI INF SET	ROD	97799707	RESERVOIR PARADIGM 5X1.8ML	MDT
07700040	13MM/110CM	DOD	97799706	RESERVOIR PARADIGM 7X3.0ML	MDT
97799649	TENDER-1 MINI INFSET 13MM/60CM	ROD	ISOPROPYL	ALCOHOL	
97799648	TENDER-1 MINI INFSET 13MM/80CM	ROD	70% PAD		
97799641	TENDER-2 MINI INF SET	ROD	00480452	ALCOHOL PREP	PDI
3000+1	13MM/110CM		00809357	ALCOHOL SWABS	BTD
97799643	TENDER-2 MINI INFSET 13MM/60CM	ROD	00977187	ALCOHOL SWABS 6893 BUTTERFLY	BTD

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MEC

AUC

94:01.00 DEVICES (DIABETIC) ISOPROPYL ALCOHOL

70% PAD

00977195	ALCOHOL SWABS 6896 (150)	BTD
02247809	ALCOHOL SWABS ANTISEPTIC	TIP
	SKIN CLEANERS	
99038349	ALCOHOL SWABS BD REGULAR	BTD
97799880	BD ALCOHOL SWABS	BTD
02248362	LORIS ALCOHOL SWABS	UNK
99438102	MONOJECT ALCOHOL WIPES	COV
00795232	WEBCOL ALCOHOL PREP	COV

LANCET

Limited use benefit (prior approval not required).

The number of lancets that will be covered by the NIHB Program will depend on the client's medical treatment:

- clients managing diabetes with insulin will be allowed 800 lancets per 100 days.
- clients managing diabetes with high risk of causing hypoglycemia will be allowed 400 lancets per 365 days.
- clients managing diabetes medication with low risk of causing hypoglycemia will be allowed 200 lancets per 365 days.
- clients managing diabetes through diet/lifestyle therapy only (no insulin or anti-diabetes medications) will be allowed 200 lancets per 365 days.

ACCULCUEZ FACTOLIZ LANCET

Please note that the test strip limit is 800/100 days. Due to lancet pack sizes, 800 per 100 days will be reimbursed.

LANCET

97799494	ACCU-CHEK FASTCLIK LANCET	ROD
97799495	ACCU-CHEK FASTCLIK LANCET	ROD
97799817	ACCU-CHEK MULTICLIX LANCET	ROD
97799945	ACCU-CHEK SOFTCLIX LANCET	ROD
97799946	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
97799140	ONETOUCH DELICAPLUS 30G LANCET	UNK
97799139	ONETOUCH DELICAPLUS 33G LANCET	UNK
97799970	ONETOUCH ULTRASOFT LANCET	JAJ
97799348	ULTILET CLASSIC LANCET	UNK
21G LANCE	Г	
97799804	MONOLET 21G LANCET	TYC
28G LANCE	Г	
97799232	DROPLET PERSONAL LANCET 28G	SFA
97799253	FIRST CANHEALTH 28G LANCET	ARA
97799801	MONOLET THIN (MONOJECT) 28G	TYC
30G LANCE	Г	
97799254	FIRST CANHEALTH 30G LANCET	ARA

94:01.00 DEVICES (DIABETIC) LANCET

Limited use benefit (prior approval not required).

The number of lancets that will be covered by the NIHB Program will depend on the client's medical treatment:

• clients managing diabetes with insulin will be allowed 800 lancets per 100 days.

- clients managing diabetes with high risk of causing hypoglycemia will be allowed 400 lancets per 365 days.
- clients managing diabetes medication with low risk of causing hypoglycemia will be allowed 200 lancets per 365 days.
- clients managing diabetes through diet/lifestyle therapy only (no insulin or anti-diabetes medications) will be allowed 200 lancets per 365 days.

Please note that the test strip limit is 800/100 days. Due to lancet pack sizes, 800 per 100 days will be reimbursed.

97799388 MEDI+SURE SOFT 30G TWIST

30G LANCET

97799389	MEDI+SURE SOFT 33G TWIST	MEC
97799431	ONE TOUCH DELICA 30G LANCET	JAJ
33G LANCE	Γ	
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

PEN NEEDLE

ST NEEDLE

97799433	BD AUTOSHIELD DUO SAFETY PEN NEEDLE	BTD
09991447	BD BLUNT 18GX1 1/2 FILTER	BTD
09991391	BD PRECISIONGLIDE 23GX1 1/4	BTD
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
ST 29GX10MM I	NEEDLE	
97799238	DROPLET PEN NEEDLE 10MM 29G	SFA
ST 29GX12.7MN	/ NEEDLE	
97799561	SUPER-FINE STANDARD 29G- 12.7MM	PMS
ST 29GX12MM I	NEEDLE	
97799235	DROPLET PEN NEEDLE 12MM 29G	SFA
97799566	INSUPEN 29GX12MM NEEDLE	DPI
97799543	ULTICARE 29GX12MM PEN NEEDLE	UMI
.==		

UNIFINE 29G 12MM NEEDLE

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97799991

94:01.00 DEVICES (DIABETIC) 94:01.00 DEVICES (DIABETIC)					
PEN NEEDLE			PEN NEEDLE		
				_	
ST 29GX8MM N			ST 32GX6MM N		
	BD AUTOSHIELD PEN NEEDLES	BTD	97799241	DROPLET PEN NEEDLE 6MM 32G	SFA
^{sт} 30GX6MM N			97799363	INSULIN PEN NEEDLE 32GX6MM	MDT
	NOVOFINE 30GX 6MM NEEDLE	NVC	97799571	INSUPEN 32GX6MM NEEDLE	DPI
ST 30GX8MM N			st 32GX8MM N		
97799567		DPI	97799240	DROPLET PEN NEEDLE 8MM 32G	SFA
	NOVOFINE 30GX 8MM NEEDLE	NVC	97799365	INSULIN PEN NEEDLE 32GX8MM	MDT
^{s⊤} 31GX4.5MM				INSUPEN 32GX8MM NEEDLE	DPI
97799404	CLICKFINE PEN NEEDLE 31G	AUC	st 33GX4MM N		
ST 04 OVERARA N	4.5MM			INSUPEN 33GX4MM NEEDLE	DPI
ST 31GX5MM N		DTD	st 315GXMM N		
97799282	BD ULTRAFINE 31G 5MM PEN NEEDLE	BTD		ULTICARE 31GX5MM PEN NEEDLE	UNK
97799239	DROPLET PEN NEEDLE 5MM 31G	SFA	s [™] 318GXMM N		
97799563	SUPER-FINE MICRO 31G-5MM	PMS	97799148	ULTICARE 31GX8MM PEN NEEDLE	UNK
97799303	NEEDLE	FIVIO	324GXMM N	IEEDLE	
97799426	UNIFINE PENTIPS 31GX5MM	AUC	97799160	BD NANO PRO 32GX4MM PEN	BTD
^{S™} 31GX6MM N				NEEDLE	
	CLICKFINE PEN NEEDLE 31G 6MM	AUC	97799147		UNK
97799237		SFA	ST 326GXMM N		
97799364	INSULIN PEN NEEDLE 31GX6MM	MDT		ULTICARE 32GX6MM PEN NEEDLE	UMI
97799569	INSUPEN 31GX6MM NEEDLE	DPI	21G NEEDL	-	
97799545	ULTICARE 31GX6MM PEN NEEDLE	UMI		BD BUTTERFLY NEEDLE 21G	BTD
97799993	UNIFINE 31G.6MM NEEDLE	AUC	sr 29G NEEDL		
ST 31GX8MM N				BD ULTRA-FINE PEN NEEDLE 29G	BTD
97799281	BD ULTRAFINE 31G 8MM PEN	BTD	s ⁷ 30G NEEDL		
00020.	NEEDLE	2.2		NOVOTWIST TIP 30G NEEDLE	NOO
97799406	CLICKFINE PEN NEEDLE 31G 8MM	AUC	s [⊤] 32G NEEDL		
97799236	DROPLET PEN NEEDLE 8MM 31G	SFA	97799821	NOVOFINE 32G TIP PEN NEEDLE	NOO
97799366	INSULIN PEN NEEDLE 31GX8MM	MDT	97799468	NOVOTWIST TIP 32G NEEDLE	NOO
97799568	INSUPEN 31GX8MM NEEDLE	DPI	SHARPS CO	NTAINER	
97799441	LIFE BRAND PEN NEEDLE 31G	HOD	DEVICE		
	8MM		99401026	BC SHARPS CONTAINER 1.4L	BTD
97799562	SUPER-FINE XTRA 31G-8MM	PMS	99401027	BD SHARPS CONTAINER 3.1L	BTD
	NEEDLE		09991639	BD SHARPS CONTAINER 3L	BTD
97799544	ULTICARE 31GX8MM PEN NEEDLE	UMI	99401033	SHARPS NESTABLE YELLOW	UNK
	ULTRAFINE III NEEDLE 31G 8MM	BTD	00101000	LARGE 22.7L	Ortic
	UNIFINE 31G.8MM NEEDLE	AUC	SYRINGE & I	NEEDLE	
ST 32GX4MM N					
97799527		BTD	ST 27GX1/2 NE		
07700040	NEEDLE	CE4		BD PRECISIONGLIDE 27GX1/2	BTD
97799243	DROPLET PEN NEEDLE 4MM 32G	SFA	ST 18G NEEDL		
97799367		MDT		BD PRECISIONGLIDE 18GX1 1/2	BTD
97799399		DPI	09991401	BD PRECISIONGLIDE 18GX1	BTD
97799334	MONTKIDDY BLUE NEEDLE 32GX4MM	MDT	ST OF O MEEDI	NEEDLE	
97799335	MONTKIDDY PINK NEEDLE	MDT	ST 25G NEEDL		DTD
91199333	32GX4MM	ו טועו		BD PRECISIONGLIDE 25GX5/8	BTD
97799336	MONTKIDDY YELLOW NEEDLE	MDT		BD PRECISIONGLIDE 25GX7/8	BTD
00000	32GX4MM		ST 26G NEEDL		
97799386	NOVOFINE PLUS 4MM NEEDLE	NOO	09991384		BTD
97799337	SiteSmart Coloured Pen Needles	MDT	09991383		BTD
	32GX4MM		ST 27G NEEDL		
97799440	ULTICARE 32GX4MM PEN NEEDLE	DPI		BD PRECISIONGLIDE 27GX1 1/4	BTD
ST 32GX5MM N	IEEDLE		SYRINGE		_
97799242	DROPLET PEN NEEDLE 5MM 32G	SFA	09991609	BD POSIFLUSH SP	BTD
			09991659	BD POSIFLUSH SP	BTD

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94:01.00 DEVICES (DIABETIC) 94:01.00 DEVICES (DIABETIC)					
SYRINGE & NEEDLE			SYRINGE &	•	
			ST 21GX1 SYRI		
SYRINGE	DI ACTIDAK MICOO	DTD			DTD
97799510	PLASTIPAK MICRO ULTICARE LOW DEAD SPACE	BTD UMI	ST 22GX1 1/2 S	BD TUBERCULIN 21GX1 SYRINGE	BTD
97799510 S ⁷ 0.25CC SYR	SYRINGE	Olvii	09991341	BD LUER-LOK TIP 22GX1 1/2	BTD
	INSULIN SYR W/NEEDL 0.25CC	UNK	ST 23GX5/8 SY	SYRINGE	
0.3CC SYRI		UNK	09991339	BD LUER-LOK TIP 25GX5/8	BTD
0.3CC 31Kii 00977961		BTD	09991339	SYRINGE	ыл
		UNK	ST 25GX1 SYRI		
99002140 ST 0.5CC SYRIN	INSULIN SYR W/NEEDLE 0.3CC	UNK		BD LUER-LOK TIP 25GX1 SYRINGE	BTD
0.9CC STRII 00920096		RIV	ST 25GX1 1/2 S		0.0
			09991337		BTD
	INSULIN SYR W/NEEDLE 0.5CC MONOJECT	UNK BTD	00001001	SYRINGE	0.0
		ыл	ST 25GX5/8 SY	RINGE	
ST 0.5CC/1CC S		MDT	09991359	BD TUBERCULIN 25GX5/8	BTD
*****	MONOJECT	MDT		SYRINGE	
ST 1CC SYRING		DI) (ST 26GX3/8 SY	RINGE	
00920061		RIV	09991358	BD TUBERCULIN 26GX3/8	BTD
	INSULIN SYR W/NEEDLE 1CC	UNK		SYRINGE	
ST 1ML SYRING			ST 26GX5/8 SY	RINGE	
	BD LUER-LOK TIP 1ML SYRINGE	BTD		BD SLIP TIP SUB Q 26G SYRINGE	BTD
	BD SLIP TIP 1ML SYRINGE	BTD	^{S7} 27GX1/2 SY	RINGE	
ST 3ML SYRING			09991356	BD TUBERCULIN 27GX1/2	BTD
	BD LUER-LOK TIP 3ML SYRINGE	BTD		SYRINGE	
	BD SLIP TIP 3ML SYRINGE	BTD	09991357	BD TUBERCULIN 27GX1/2	BTD
ST 5ML SYRING	GE .			SYRINGE	
	BD LUER-LOK TIP 5ML SYRINGE	BTD	28GX0.5CC		
	BD SLIP TIP 5ML SYRINGE	BTD	00920177	BD MICRO-FINE 28GX0.5CC SYRINGE	BTD
ST 8MM SYRING	GE		97799518	ULTICARE 1/2 IN 28GX0.5CC	UMI
	SURECOMFORT 5/16 IN 30GX0.3CC	UNK	97799516	SYRINGE	Olvii
97799272	SURECOMFORT 5/16 IN 30GX0.5CC	UNK	28GX1CC S		
97799265	SURECOMFORT 5/16 IN 30GX1CC	UNK	00920185	BD MICRO-FINE 28GX1CC	BTD
97799273	SURECOMFORT 5/16 IN 31GX0.3CC	UNK	00020100	SYRINGE	0.0
97799274	SURECOMFORT 5/16 IN 31GX0.3CC	UNK	97799517	ULTICARE 1/2 IN 28GX1CC	UMI
97799263	SURECOMFORT 5/16 IN 31GX0.5CC	UNK		SYRINGE	
	SURECOMFORT 5/16 IN 31GX1CC	UNK	ST 29GX0.3CC	SYRINGE	
ST 10ML SYRIN	IGE		97799509	ULTI SYG 1/2 IN 29GX0.3CC	UMI
09991363	BD LUER-LOK TIP 10ML SYRINGE	BTD	97799999	ULTICARE 29GX0.3CC	AUC
09991364	BD SLIP TIP 10ML SYRINGE	BTD	97799887	ULTRA 29G3/10CC	BTD
ST 12MM SYRIN	NGE		ST 29GX0.5CC	SYRINGE	
97799275	SURECOMFORT 1/2 IN 28GX1CC	UNK	97799888	BD ULTRA 29G.1/2CC SYRINGE	BTD
	SYRINGE		97799508	ULTI SYG 1/2 IN 29GX0.5CC	UMI
ST 12.7MM SYF	RINGE		97799998	ULTICARE 29GX0.5CC	AUC
97799257	SURECOMFORT 1/2 IN 28GX0.5CC	UNK	ST 29GX1CC S	YRINGE	
97799260	SURECOMFORT 1/2 IN 29GX0.3CC	UNK	97799889	BD ULTRA 29G.1CC SYRINGE	BTD
97799259	SURECOMFORT 1/2 IN 29GX0.5CC	UNK	97799507	ULTI SYG 1/2 IN 29GX1CC	UMI
97799258	SURECOMFORT 1/2 IN 29GX1CC	UNK		SYRINGE	
97799264	SURECOMFORT 1/2 IN 30GX0.3CC	UNK	97799997	ULTICARE 29GX0.1CC	AUC
97799270	SURECOMFORT 1/2 IN 30GX0.5CC	UNK	ST 30GX0.3CC	SYRINGE	
97799271	SURECOMFORT 1/2 IN 30GX1CC	UNK	97799551	ULTI SYG 1/2 IN 30GX0.3CC	UMI
^{S7} 18GX1 1/2 S	YRINGE		97799506	ULTI SYG 5/16 IN 30GX0.3CC	UMI
09991349	BD LUER-LOK TIP 18GX1 1/2	BTD	97799996	ULTICARE 30GX0.3CC	AUC
or.	SYRINGE		97799886	ULTRA-FINE II 30GX0.3 CC	BTD
SYRINGE SYRINGE					
09991368	BD LUER-LOK TIP 20ML SYRINGE	BTD	ST 30GX0.5CC	SYRINGE	
09991369	BD SLIP TIP 20ML SYRINGE	BTD	97799885	BD ULTRA-FINE II 30GX0.5CC SYRINGE	BTD

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94:01.00 DEVICES (DIABETIC) SYRINGE & NEEDLE

ST 30GX0.5CC	SYRINGE	
97799550	ULTI SYG 1/2 IN 30GX0.5CC	UMI
97799505	ULTI SYG 5/16 IN 30GX0.5CC	UMI
97799995	ULTICARE 30GX0.5CC	AUC
ST 30GX1CC SY	YRINGE	
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
ST 30ML SYRIN	IGE	
09991377	BD LUER-LOK TIP 30ML SYRINGE	BTD
09991378	BD SLIP TIP 30ML SYRINGE	BTD
ST 31GX0.3CC	SYRINGE	
97799369	INSULIN 31GX0.3CC	MDT
97799548	ULTI SYG 5/16 IN 31GX0.3CC	UMI
97799513	ULTICARE 5/16 IN 31GX0.3CC SYRINGE	UMI
ST 31GX0.5CC	SYRINGE	
97799370	INSULIN 31GX0.5CC	MDT
97799547	ULTI SYG 5/16 IN 31GX0.5CC	UMI
97799512	ULTICARE 5/16 IN 31GX0.5CC SYRINGE	UMI
ST 31GX1CC SY	YRINGE	
97799371	INSULIN 31GX1CC	MDT
97799546	ULTI SYG 5/16 IN 31GX1CC SYRINGE	UMI
97799511	ULTICARE 5/16 IN 31GX1CC SYRINGE	UMI
ST 31GX6MMX	0.3CC SYRINGE	
97799425	BD SYRINGE WITH ULTRA-FINE NEEDLE	BTD
ST 31Χ6ΜΜΧ0.	SCC SYRINGE	
97799385	BD SYRINGE + NEEDLE	BTD
ST 31Χ6ΜΜΧ1C	C SYRINGE	
97799384	BD SYRINGE + NEEDLE	BTD
ST 60ML SYRIN	IGE	
09991455	BD LUER-LOK TIP 60ML SYRINGE	BTD
09991454	BD SLIP TIP 60ML SYRINGE	BTD
SYRINGE CA	SE	
DEVICE		
99400552	MYHEALTH SYRINGE CASE-7	AUC
99400551	MYHEALTH SYRINGE CASE- SINGLE	AUC

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96:00 PHARMACEUTICAL AIDS 96:00.00 PHARMACEUTICAL AIDS ADMINISTRATION DIN

MISCELLANEOUS

00903725 REFUSAL TO FILL

ADULT

Limited use benefit (prior approval required).

Criteria for nutritional supplement coverage for adults

- sole source nutrition (more than 75% of intake is from nutritional supplement)
- unintentional weight loss
- wound care
- pre or post-surgery (6 months before or after date of surgery)
- other medical conditions not listed

ORAL LIQUID

95900061	BOOST DIABETIC 237ML LIQ	NES
95999963	BOOST ORIGINAL 237ML LIQ	NES
95900050	ENSURE 235ML LIQ	ABB
95900139	ENSURE FIBRE 235ML LIQ	ABB
95900140	GLUCERNA 237ML LIQ	ABB
95900076	ISOSOURCE 1.0 HP 250ML LIQ	NES
95900072	ISOSOURCE 1.2 CAL 1500ML LIQ	NES
95900071	ISOSOURCE 1.2 CAL 250ML LIQ	NES
95900073	ISOSOURCE 1.5 CAL 250ML LIQ	NES
95900209	ISOSOURCE FIBRE 1.2 CAL 250ML LIQ	NES
95900075	ISOSOURCE FIBRE 1.5 CAL 1500ML LIQ	NES
95900074	ISOSOURCE FIBRE 1.5 CAL 250ML LIQ	NES
95900077	ISOSOURCE HN WITH FIBRE 250ML LIQ	NES
95900217	JEVITY 1.5 CAL	ABB
95900082	JEVITY 1.5 CAL 235ML LIQ	ABB
95900078	JEVITY 235ML LIQ	ABB
95900220	NUTREN 1.5	NES
95900088	PEPTAMEN 1.5 1000ML LIQ	NES
95900087	PEPTAMEN 1.5 250ML LIQ	NES
95900086	PEPTAMEN 250ML LIQ	NES
95900091	PEPTAMEN WITH PREBIO 1000ML LIQ	NES
95900090	PEPTAMEN WITH PREBIO 250ML LIQ	NES
95900058	RESOURCE 2.0 237ML LIQ	NES
95900207	RESOURCE DIABETIC 1.5L	NES
95900062	RESOURCE DIABETIC 250ML LIQ	NES
95900130	VITAL 1.5 CAL 1000ML LIQ	ABB
95900128	VITAL PEPTIDE 1 CAL 220ML LIQ	ABB
95900129	VITAL PEPTIDE 1.5 CAL 220ML LIQ	ABB

BASES-EMULSIONS

Limited use benefit (prior approval required).

For the treatment of atopic dermatitis in children 0 to 18 years old.

Coverage is limited to 450 grams per month.

CREAM

09991668 EMOLLIENT FOR ADULTS GSK

96:00.00 PHARMACEUTICAL AIDS BASES-EMULSIONS

Limited use benefit (prior approval required).

For the treatment of atopic dermatitis in children 0 to 18 years old.

Coverage is limited to 450 grams per month.

CREAM

UNK

99000385 EMOLLIENT FOR CHILDREN

WPC

CHILDREN AND YOUTH

Limited use benefit (prior approval required).

Criteria for nutritional supplement coverage for children and youth (19 years and under)

- sole source nutrition (more than 75% of intake is from nutrition supplement)
- failure to thrive/growth faltering
- pre or post-surgery (6 months before or after date of surgery)
- · other medical conditions not listed

ORAL LIQUID

95900131	COMPLEAT PEDIATRIC 250ML LIQ	NES
95900133	NUTREN JR. 250ML LIQ	NES
95900177	PEDIASURE 235ML LIQ	ABB
95900142	PEDIASURE COM. GROW&GAIN 235ML LIQ	ABB
95900178	PEDIASURE FIBRE 235ML LIQ	ABB
95900179	PEDIASURE PLUS WITH FIBRE 235	ABB
95900135	PEPTAMEN JUNIOR 1.0 CAL 250ML LIQ	NES
95900136	PEPTAMEN JUNIOR 1.5 CAL 250ML LIQ	NES
95900137	RESOURCE JUST KIDS 1.5 CAL 237ML LIQ	NES
POWDER		
95900132	NEOCATE JR FIBER&IRON 400G PDR	UNK
95900143	PEDIASURE GROW&GAIN 400G PDR	ABB

DEVICE (METHADONE)

Limited use benefit (prior approval is not required).

Coverage is granted for 1 device.

MISCELLANEOUS

91500016 METHADONE LOCK BOX UNK

FRUCTOSE

POWDER

00905631 FRUCTOSE UNK

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UNK

96:00.00 PHARMACEUTICAL AIDS **INFANT FORMULATION**

Limited use benefit (prior approval required).

Criteria for infant formula coverage < 1 year of age (corrected gestational age for prematurity)

- contraindications for breastfeeding HIV, hepatitis C, active tuberculosis and herpetic lesions on breast. Please note, contraindications are in accordance with respective Health Canada and World Health Organization guidance.
- prematurity or low birth weight
- failure to thrive/growth faltering
- cow milk protein allergy
- other medical conditions not listed

95900007 ENFAMIL A+ 237ML LIQ

ORAL LIQUID

95900003	ENFAMIL A+ 385ML LIQ	MJO
95900152	ENFAMIL A+ ENFACARE 385ML LIQ	MJO
95900012	ENFAMIL LOWER IRON 385ML LIQ	MJO
95900026	NUTRAMIGEN A+ 945ML LIQ	MJO
95900000	SIMILAC ALIMENTUM 237ML LIQ	ABB
95900001	SIMILAC ALIMENTUM 945ML LIQ	ABB
POWDER		
95900164	ENFAMIL A+ 663G PDR	MJO
95900009	ENFAMIL A+ ENFACARE 363G PDR	MJO
95900155	ENFAMIL LOWER IRON 900G PDR	MJO
95900023	NEOCATE 400G PDR	UNK
95900021	NEOCATE JUNIOR 400G PDR	UNK
95900022	NEOCATE ONE 400G	UNK
95900025	NEOCATE W/ DHA & ARA 400G PDR	UNK
95900027	NUTRAMIGEN A+ LGG 561G PDR	MJO
95900035	PURAMINO A+ 400G PDR	MJO
95900112	PURAMINO A+ JUNIOR 400G PDR	MJO
95900047	SIMILAC ALIMENTUM 400G PDR	ABB
95900184	SIMILAC LOWER IRON 850G PDR	ABB
95900036	SIMILAC NEOSURE 363G PDR	ABB
95900044	SIMILAC PM 60/40 450G PDR	ABB

NUTRITIONAL SUPPLEMENT

THICKENING AGENT (POWDER)

95900123 SOURCE THICKEN UP 227G PDR **NES**

SIMPLY THICK 640Z BOTTLE

THICKENING AGENT

09991194

ĸ	П

	FUIVIF	
POWDER		
95900213	PURATHICK 125G PDR	UNK
12137029	RESOURCE THICKEN CLEAR	NVC
09991163	RESOURCE THICKEN UP 6.4G	NVC
THICKENING	G AGENT (KIT)	
95900118	SIMPLY THICK 64OZ BOTTLE PUMP	UNK
THICKENING	G AGENT (POWDER)	
95900190	GELMIX IAR 125G PDR	LINK

95900190	GELMIX JAR 125G PDR	UNK
95900113	RESOURCE THICKEN CLEAR 125G	NES
95900114	RESOURCE THICKEN UP 6.4G	NES
95900185	SIMPLY THICK HONEY 12G PDR	UNK
95900186	SIMPLY THICK NECTAR 6G PDR	UNK

96:00.00 PHARMACEUTICAL AIDS **THICKENING GEL**

09991563 STERILE WATER PF

ORAL LIQUID

09991164	SIMPLY THICK HONEY	UNK
09991035	SIMPLY THICK NECTAR	UNK
THICKENING	G AGENT (POWDER)	
95900119	SIMPLY THICK HONEY 200G	UNK
95900120	SIMPLY THICK NECTAR 200G	UNK

WATER

MJO

SOLUTION

SYRINGE	STERILE WATER	ONK
00002264	STERILE WATER	UNK
00905178	STERILE WATER	UNK

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UNK

Appendix A

Limited use benefits and criteria

08:00 ANTI-INFECTIVE AGENTS

08:12.02 AMINOGLYCOSIDES

AMIKACIN SULFATE

Limited use benefit (prior approval required).

250MG LIQUID

02242971 AMIKACIN SULFATE

SDZ

08:12.07 MISCELLANEOUS B-LACTAM ANTIBIOTICS

AZTREONAM

Limited use benefit (prior approval required).

For the management of cystic fibrosis (CF) in patients if the following criteria are met:

- patient has CF with chronic pulmonary Pseudomonas aeruginosa infections; and
- prescribed by a clinician with experience in the diagnosis and treatment of CF.

75MG POWDER FOR SOLUTION

02329840 CAYSTON GIL

MEROPENEM

Limited use benefit (prior approval required).

500MG POWDER FOR SOLUTION

02378787 MEROPENEM SDZ

1G POWDER FOR SOLUTION

02378795 MEROPENEM SDZ 02436507 MEROPENEM RAX

08:12.12 MACROLIDES

FIDAXOMICIN

Limited use benefit (prior approval required).

For the treatment of confirmed severe* Clostridium Difficile infection (CDI); and

- fidaxomicin has been prescribed or recommended by an infectious disease specialist or gastroenterologist; and
- there is a documented allergy (immune-mediated reaction) or severe intolerance to oral vancomycin resulting in discontinuation of vancomycin.
- or
- after an unsuccessful but adequate** trial of oral vancomycin; and
 retreatment with vancomycin is not an option***; and
- the patient is at a high risk of hospitalization due to severe complications; and
- fidaxomicin is being used as monotherapy.

- *. Severe infection is defined as having any of the following symptoms: white blood cell count > 15,000 mm3 and fever; acute kidney injury with rising serum creatinine ≥ 1.5 times premorbid level or ≥ 175 micromoles/L; pseudomembranous colitis, hypotension, shock or megacolon.

 **. An adequate trial of oral vancomycin is considered to be at least 10 days of therapy with a dose of at least 125mg four times daily.
- ***. Retreatment with fidaxomicin in recurrent CDI will be considered in symptomatic patients who require treatment of a previously resolved CDI episode. This is defined as a subsequent CDI episode occurring within 2 to 8 weeks of a previous episode from the date of diagnosis.

200MG TABLET

02387174 DIFICID **FRS**

08:12.16 PENICILLINS

PIPERACILLIN, TAZOBACTAM

Limited use benefit (prior approval required).

2G & 0.25G POWDER FOR SOLUTION

02401312 PIPERACILLIN AND TAZOBACTAM	ALV
02299623 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02370158 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

3G & 0.375G POWDER FOR SOLUTION

39 & 0.3759 FOWDER FOR SOLUTION	
02401320 PIPERACILLIN AND TAZOBACTAM	ALV
02299631 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02308452 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	APX
02362627 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX
02370166 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

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RAX

TEV

08:12.16 PENICILLINS

PIPERACILLIN. TAZOBACTAM

Limited use benefit (prior approval required).

4G & 0.5G POWDER FOR SOLUTION

	02401339 PIPERACILLIN AND TAZOBACTAM	ALV
	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 36G & 4.5G POWDER FOR SOLUTION

02439131 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM RAX

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	
500MG TABLET		
02315432 ACT LEVOFLOXACIN	TEV	
02284715 APO-LEVOFLOXACIN	APX	
02415879 LEVOFLOXACIN	PDL	
02284685 PMS-LEVOFLOXACIN	PMS	
02298643 SANDOZ LEVOFLOXACIN	SDZ	
750MG TABLET		

02315440 ACT LEVOFLOXACIN

 02325942 APO-LEVOFLOXACIN
 APX

 02305585 PMS-LEVOFLOXACIN
 PMS

 02298651 SANDOZ LEVOFLOXACIN
 SDZ

LEVOFLOXACIN HEMIHYDRATE (QUINSAIR)

Limited use benefit (prior approval required).

For the management of cystic fibrosis (CF) in patients 18 years or older if the following criteria are met:

- patient has CF with chronic pulmonary Pseudomonas aeruginosa infections; and
- prescribed by a clinician with experience in the diagnosis and treatment of CF; and
- patient has had a previous trial of tobramycin by inhalation that has been ineffective or not tolerated or tobramycin is contraindicated; and
- patient is not using another inhaled antibiotic(s) to treat pulmonary P. aeruginosa infections, either concurrently or for antibiotic cycling during off-treatment periods.

Note: NIHB coverage is limited to 240 mg twice daily in cycles of 28 days on followed by 28 days off.

240MG SOLUTION

02442302 QUINSAIR UNK

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

02478137 AG-MOXIFLOXACIN ANG
02404923 APO-MOXIFLOXACIN APX

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08:12.18 QUINOLONES

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

02432242 AURO-MOXIFLOXACIN	AUR
02447266 BIO-MOXIFLOXACIN	BMI
02443929 JAMP-MOXIFLOXACIN	JMP
02447061 JAMP-MOXIFLOXACIN	JMP
02447053 MAR-MOXIFLOXACIN	MAR
02457814 MED-MOXIFLOXACIN	GMP
02472791 M-MOXIFLOXACIN	MAN
02462974 MOXIFLOXACIN	PDL
02450976 RIVA-MOXIFLOXACIN	RIV
02383381 SANDOZ MOXIFLOXACIN	SDZ
02375702 TEVA-MOXIFLOXACIN	TEV

08:12.28 MISCELLANEOUS ANTIBIOTICS

COLISTIN

Limited use benefit (prior approval required).

For the management of cystic fibrosis (CF) in patients if the following criteria are met:

- patient has CF with chronic pulmonary Pseudomonas aeruginosa infections; and
- prescribed by a clinician with experience in the diagnosis and treatment of CF.

150MG POWDER FOR SOLUTION

02244849 COLISTIMETHATE FOR U.S.P RAX 00476420 COLY-MYCIN M PARENTERAL ERF

LINEZOLID

Limited use benefit (prior approval required).

Tablets

- for treatment of proven vancomycin-resistant enterococci (VRE) infections; or
- for the treatment of proven methicillin-resistant staphylococcus aureus (MRSA) infections in patients who cannot tolerate vancomycin.

I.V. solution:

 \bullet when linezolid cannot be administered orally in the above mentioned situations.

Oral liquid:

- when linezolid cannot be administered orally in the above mentioned situations;
- plus at least one of the following:
- 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.

100MG POWDER FOR SUSPENSION

 02243686 ZYVOXAM
 PFI

 2MG SOLUTION
 JMP

 02481278 LINEZOLID
 JMP

 2MG/ML SOLUTION
 PFI

 02243685 ZYVOXAM
 PFI

 600MG TABLET
 C2426552 APO-LINEZOLID

 02422689 SANDOZ LINEZOLID
 SDZ

 02243684 ZYVOXAM
 PFI

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08:12.28 MISCELLANEOUS ANTIBIOTICS

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.

ST 550MG TABLET

02410702 ZAXINE SLX

08:14.08 AZOLES

ISAVUCONAZOLE (ISAVUCONAZONIUM SULFATE)

Limited use benefit (prior approval required).

For the treatment of invasive mucormycosis (IM) in adults; or

For the treatment of invasive aspergillosis (IA) in adults when treatment with oral voriconazole has failed; or

Documented intolerance or contraindication to voriconazole.

Cresemba is to be prescribed by or in consultation with an Infectious Disease specialist.

100MG CAPSULE

02483971 CRESEMBA UNK

200MG POWDER FOR SOLUTION

02483998 CRESEMBA UNK

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

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

02409682 APO-VORICONAZOLEAPX02399253 SANDOZ VORICONAZOLESDZ02396874 TEVA-VORICONAZOLETEV02256479 VFENDPFI

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

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); or

• 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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08:18.20 INTERFERONS

PEGINTERFERON BETA-1A

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

94MCG INJECTION

02444402 PLEGRIDY UNK

125MCG LIQUID

02444399 PLEGRIDY UNK

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 ≥ 1 log10 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 GII

08:18.40 HCV ANTIVIRALS

ELBASVIR. GRAZOPREVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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

GLECAPREVIR, PIBRENTASVIR

Limited use benefit (prior approval required).

For treatment-naïve or treatment-experienced adult patients with genotypes 1, 2, 3, 4, 5, 6 with; or

For the treatment of direct acting antivirals (DAA)-experienced2 adult patients with genotype 1 with:

- chronic hepatitis C at any fibrosis stage (F0-F4); and
- detectable levels of HCV RNA in the last 12 months;

For genotypes 1, 2, 3, 4, 5 or 6, treatment-experienced is defined as a patient who has been previously treated with interferon, peginterferon (P), ribavirin (R) and/or sofosbuvir (SOF) (PR, SOF + PR, SOF + RBV), but no prior treatment experience with an NS3/4A protease inhibitor or NS5A inhibitor.

• For genotype 1, DAA treatment-experienced is defined as a patient who has been previously treated with DAA regimens containing NS5A inhibitor [daclatasvir (DCV) + SOF or DCV + PR or ledipasvir/sofosbuvir, but no prior treatment experience with NS3/4A protease inhibitors] or containing NS3/4A protease inhibitors [simeprevir+SOF or simeprevir+PR or boceprevir+PR, but no prior treatment experience with an NS5Ainhibitor].

100MG & 40MG TABLET

02467550 MAVIRET ABV

RIBAVIRIN

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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.

200MG TABLET

02439212 IBAVYR PED

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08:18.40 HCV ANTIVIRALS

RIBAVIRIN

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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

02425890 IBAVYR PED

600MG TABLET

02425904 IBAVYR PED

SOFOSBUVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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 at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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 at any fibrosis stage (F0-F4) 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 quantitative HCV RNA level taken in the last 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

SOFOSBUVIR, VELPATASVIR, VOXILAPREVIR

Limited use benefit (prior approval required).

For treatment-experienced adult patients with:

- chronic hepatitis C at any fibrosis stage (F0-F4); and
- detectable levels of HCV RNA in the last 12 months;
- and
- treatment-experienced having failed a prior therapy with an HCV regimen containing:
- NS5A inhibitor: daclatasvir (Daklinza), elbasvir (part of Zepatier), ledipasvir (part of Harvoni), ombitasvir (part of Holkira Pak), velpatasvir (part of Epclusa) for genotype 1, 2, 3, 4, 5 or 6; or
- sofosbuvir (Sovaldi) without an NS5A inhibitor for genotype 1, 2, 3 or 4.

400MG & 100MG & 100MG TABLET

02467542 VOSEVI GIL

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10:00.00 ANTINEOPLASTIC AGENTS

ABIRATERONE ACETATE

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage

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 ≤ 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.

Criteria for renewal every 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).

Criteria for initial 6-month coverage:

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 renewal every 6 months:

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

ALECTINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

First-line treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC); or

Second-line treatment of patients with locally advanced not amenable to curative therapy or metastatic NSCLC who have disease progression on or intolerance to crizotinib:

and

- to be used as monotherapy; and
- disease is anaplastic lymphoma kinase (ALK)-positive; and
- patient has a good performance status.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

150MG CAPSULE

02458136 ALECENSARO HLR

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APALUTAMIDE

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of non-metastatic castration-resistant prostate cancer patients (nmCRPC) who meet all the following criteria:

- used in combination with androgen deprivation therapy (ADT); and
- have no detectable distant metastases by either CT, MRI or technetium-99m bone scan; and
- are at high risk* of developing metastases; and
- have no risk factors for seizures; and
- have a good ECOG performance status (0 or 1)
- * High risk is defined as a prostate-specific antigen doubling time of ≤ 10 months during continuous ADT

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or unacceptable toxicity.

60MG TABLET

02478374 ERLEADA JSO

AXITINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the second-line treatment of patients with advanced or metastatic clear cell renal carcinoma after failure of prior therapy with a first-line agent.

Patients are only eligible for either everolimus or axitinib in the second-line setting, but not sequential use of both agents except in cases of intolerance.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

1MG TABLET

02389630 INLYTA PFI

5MG TABLET

02389649 INLYTA PFI

BOSUTINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

Patients has Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia (CML); and

- patient has an ECOG performance status of 0 to 2;
- and
- documented resistance/disease progression to at least one prior oral tyrosine kinase inhibitor [TKI] (imatinib, dasatinib or nilotinib); or
- documented intolerance to one prior oral TKI (imatinib, dasatinib or nilotinib) where subsequent treatment with an alternative oral TKI is not clinically appropriate.

Criteria for renewal every 12 months:

Confirmation from the clinician that the patient has experienced hematologic and/or cytogenic response and is expected to continue to do so and has not developed unacceptable toxicities.

100MG TABLET

02419149 BOSULIF PFI

500MG TABLET

02419157 BOSULIF PFI

CABOZANTINIB (CABOZANTINIB MALATE)

Limited use benefit (prior approval required).

Initial coverage for 4 months:

For the treatment of patients with advanced renal cell carcinoma (RCC) who have received at least one prior vascular endothelial growth factor receptor (VEGFR) tyrosine kinase inhibitor (TKI) therapy.

• patient has good performance status with an ECOG of 0 to 2

Criteria for renewal every 4 months:

There is no objective evidence of disease progression.

*NIHB coverage is only provided for one of axitinib (Inlyta) or cabozantinib (Cabometyx) in the third-line setting for intermediate or poor risk patients treated with nivolumab (Opdivo) and ipilimumab (Yervoy) first-line and VEGF TKI secondline.

20MG TABLET

02480824 CABOMETYX IPS

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CABOZANTINIB (CABOZANTINIB MALATE)

Limited use benefit (prior approval required).

Initial coverage for 4 months:

For the treatment of patients with advanced renal cell carcinoma (RCC) who have received at least one prior vascular endothelial growth factor receptor (VEGFR) tyrosine kinase inhibitor (TKI) therapy.

• patient has good performance status with an ECOG of 0 to 2

Criteria for renewal every 4 months:

There is no objective evidence of disease progression.

*NIHB coverage is only provided for one of axitinib (Inlyta) or cabozantinib (Cabometyx) in the third-line setting for intermediate or poor risk patients treated with nivolumab (Opdivo) and ipilimumab (Yervoy) first-line and VEGF TKI secondline.

40MG TABLET

02480832 CABOMETYX IPS

60MG TABLET

02480840 CABOMETYX IPS

CERITINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

Second-line treatment of patients with locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer (NSCLC) who have disease progression on or intolerance to crizotinib; and

- to be used as monotherapy; and
- disease is anaplastic lymphoma kinase (ALK)-positive; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

150MG CAPSULE

02436779 ZYKADIA NVR

COBIMETINIB

Limited use benefit (prior approval required).

Criteria for initial 6-month coverage:

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.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

20MG TABLET

02452340 COTELLIC HLR

CRIZOTINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

First-line treatment of patients with advanced non-small cell lung cancer (NSCLC); or

Second-line treatment of patients with advanced NSCLC who have received one prior chemotherapy regimen.*; and

- patient is anaplastic lymphoma kinase (ALK)-positive; and
- patient has an ECOG performance status of 0 to 2.

*Patients who have progressed during or following first-line therapy with crizotinib are not eligible to receive crizotinib as a second-line therapy.

Criteria for renewal every 12 months:

The patient has experienced a hematologic and/or cytogenic response to crizotinib and is expected to continue to do so.

200MG CAPSULE

02384256 XALKORI PFI

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DABRAFENIB

Limited use benefit (prior approval required).

1. First-line treatment of patients with metastatic or unresectable melanoma.

Criteria for initial 6-month coverage:

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 trametinib (Mekinist)

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; and
- patient is previously untreated.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

2. Adjuvant treatment of patients with cutaneous melanoma.

Criteria for maximum 12-month coverage:

- in combination with trametinib for the adjuvant treatment of patients with stage IIIA (limited to lymph node metastases of >1 mm) to stage IIID (8th edition of the American Joint Committee on Cancer Staging System) cutaneous melanoma; and
- patient has documented BRAF V600 mutation cutaneous melanoma; and
- disease must be completely resected including in-transit metastases*; and
- patient has an ECOG performance status of 0 to 1.

Maximum duration of therapy is 12 months.

* Presence of regional lymph nodes with micrometastases after sentinel lymph node biopsy alone is allowed.

50MG CAPSULE

02409607 TAFINLAR NVR

75MG CAPSULE

02409615 TAFINLAR NVR

ENZALUTAMIDE

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

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 ≤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.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

or

Criteria for initial 12-month coverage:

For the treatment of non-metastatic castration-resistant prostate cancer patients (nmCRPC) who meet all the following criteria:

- used in combination with androgen deprivation therapy (ADT), and
- are at high risk* of developing metastases; and
- have no risk factors for seizures; and
- have a good ECOG performance status (0 or 1).
- * high risk is defined as a prostate-specific antigen doubling time (PSADT) of ≤ 10 months during continuous ADT.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

40MG CAPSULE

02407329 XTANDI AST

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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

02461862 APO-ERLOTINIB	APX
02483912 NAT-ERLOTINIB	NPH
02269007 TARCEVA	HLR
02377691 TEVA-ERLOTINIB	TEV

100MG TABLET

02461870 APO-ERLOTINIB	APX
02454386 PMS-ERLOTINIB	PMS
02269015 TARCEVA	HLR
02377705 TEVA-ERLOTINIB	TEV

150MG TABLET

02461889 APO-ERLOTINIB	APX
02454394 PMS-ERLOTINIB	PMS
02269023 TARCEVA	HLR
02377713 TEVA-ERLOTINIB	TEV

EVEROLIMUS

Limited use benefit (prior approval required).

1. Advanced breast cancer

Criteria for initial 12-month coverage:

For documented hormone receptor positive, HER2 negative advanced breast cancer; and

- used in combination with exemestane; and
- patient has an ECOG performance status of 0 to 2, and
- patient's condition recurred or progressed on a non-steroidal aromatase inhibitor.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

2. Advanced or metastatic renal cell carcinoma (mRCC)

Criteria for initial 12-month coverage:

For documented advanced or metastatic clear cell renal carcinoma; and

For use as second- or third-line treatment of mRCC.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

3. Pancreatic neuroendocrine tumors (pNet)

Criteria for initial 12-month coverage:

For documented, progressive, unresectable, well or moderately differentiated, locally advanced or metastatic pancreatic neuroendocrine tumors; and

- patient has an ECOG performance status of 0 to 2; and
- for patients previously treated with other agents.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

4. Non-functional neuroendocrine tumors (Nets) of gastrointestinal or lung origin (GIL)

Criteria for initial 12-month coverage:

For documented unresectable, locally advanced or metastatic, progressive, well-differentiated non-functional Net-GIL in adults ≥18 years of age; and

- patient has documented radiological disease progression within the previous six months; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

2.5MG TABLET

02369257 AFINITOR	NVR
02463229 TEVA-EVEROLIMUS	TEV

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EVEROLIMUS

Limited use benefit (prior approval required).

1. Advanced breast cancer

Criteria for initial 12-month coverage:

For documented hormone receptor positive, HER2 negative advanced breast cancer; and

- used in combination with exemestane; and
- patient has an ECOG performance status of 0 to 2; and
- patient's condition recurred or progressed on a non-steroidal aromatase inhibitor.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

2. Advanced or metastatic renal cell carcinoma (mRCC)

Criteria for initial 12-month coverage:

For documented advanced or metastatic clear cell renal carcinoma; and

For use as second- or third-line treatment of mRCC.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

3. Pancreatic neuroendocrine tumors (pNet)

Criteria for initial 12-month coverage:

For documented, progressive, unresectable, well or moderately differentiated, locally advanced or metastatic pancreatic neuroendocrine tumors; and

- patient has an ECOG performance status of 0 to 2; and
- · for patients previously treated with other agents.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

4. Non-functional neuroendocrine tumors (Nets) of gastrointestinal or lung origin (GIL)

Criteria for initial 12-month coverage:

For documented unresectable, locally advanced or metastatic, progressive, well-differentiated non-functional Net-GIL in adults ≥18 years of age; and

- patient has documented radiological disease progression within the previous six months; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

5MG TABLET

02339501 AFINITOR	NVR
02463237 TEVA-EVEROLIMUS	TEV

10MG TABLET

02339528 AFINITOR NVR 02463253 TEVA-EVEROLIMUS TEV

2MG TABLET FOR SUSPENSION

02425645 AFINITOR DISPERZ NVR

3MG TABLET FOR SUSPENSION

02425653 AFINITOR DISPERZ NVR

5MG TABLET FOR SUSPENSION

02425661 AFINITOR DISPERZ NVR

GEFITINIB

Limited use benefit (prior approval required).

Criteria for initial 6-month coverage:

For the treatment of patients with ocally advanced or metastatic non-small cell lung cancer (NSCLC) who meet all of the following criteria:

- first-line treatment; and
- EGFR mutation positive; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

250MG TABLET

02468050 APO-GEFITINIB APX

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GEFITINIB

Limited use benefit (prior approval required).

Criteria for initial 6-month coverage:

For the treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) who meet all of the following criteria:

- · first-line treatment: and
- EGFR mutation positive; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

250MG TABLET

02248676 IRESSA AZC 02487748 SANDOZ GEFITINIB SDZ

IBRUTINIB

Limited use benefit (prior approval required).

1. For the treatment of previously untreated chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) (first-line)

Criteria for initial 12-month coverage:

As a first-line treatment option for newly diagnosed treatment naive chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL); and

- patient's prescriber has deemed that it would be inappropriate for the patient to receive treatment with a fludarabine-based regimen; and
- patient has high risk CLL, such that ibrutinib is preferred over anti-CD20 therapy, with one of the following cytogenic markers:
- chromosome 17p deletion [del(17p)]
- TP 53 mutation
- unmutated immunoglobulin heavy chain variable region (IgHV)
- other reason.

Note: Anti-CD20 therapy is not funded as a sequential treatment option after ibrutinib. Choice of ibrutinib as first-line therapy must take this into account. Ibrutinib is not funded as a sequential treatment option for patients who have progressed on idelalisib treatment in the relapsed setting.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

2. For the treatment of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) (second-line)

Criteria for initial 12-month coverage:

Demonstrated diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL); and

- patient has received at least one prior therapy to treat CLL/SLL; and
- patient's prescriber has deemed that it would be inappropriate for the patient to receive treatment or retreatment with a fludarabine-based regimen.

Note: Ibrutinib is not funded as a sequential treatment option for patients who have progressed on idealisib treatment in the relapsed setting.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

3. For the treatment of relapsed/refractory mantle cell lymphoma (MCL)

Criteria for initial 12-month coverage:

Demonstrated diagnosis of relapsed/refractory mantle cell lymphoma (MCL); and

• patient has received at least one prior therapy to treat MCL.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

140MG CAPSULE

02434407 IMBRUVICA JSO

IDELALISIB

Limited use benefit (prior approval required).

Criteria for initial 6-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 renewal every 6 months:

There is no objective evidence of disease progression.

100MG TABLET

02438798 ZYDELIG GIL

150MG TABLET

02438801 ZYDELIG GIL

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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; or

For the treatment of patients with gastrointestinal stromal tumour; or

For newly diagnosed adult patients with Philadelphia chromosome-positive (CML); or

For the treatment of adult patients with Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL).

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 required).

1. For the treatment of Myelodysplastic syndrome (MDS)

Criteria for initial 6-month coverage:

- 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.
- · Criteria for renewal every 12 months:

Patient has demonstrated a reduction in transfusion requirements of at least 50%.

2. For the treatment of Refractory/relapsed multiple myeloma after one prior therapy (MM-AOPT)

Criteria for initial 12-month coverage:

- 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.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

- 3. For the treatment of newly diagnosed multiple myeloma for patients who are not eligible for autologous stem cell transplant (MM-TNE) Criteria for initial 12-month coverage:
- 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.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

- 4. For the maintenance treatment for newly diagnosed multiple myeloma post-autologous stem cell transplant
- Criteria for initial 12-month coverage:
- · 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.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

2.5MG CAPSULE

02459418 REVLIMID UNK

5MG CAPSULE

02304899 REVLIMID UNK

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UNK

10:00.00 ANTINEOPLASTIC AGENTS

LENALIDOMIDE

Limited use benefit (prior approval required).

1. For the treatment of Myelodysplastic syndrome (MDS)

Criteria for initial 6-month coverage:

- 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.
- Criteria for renewal every 12 months:

Patient has demonstrated a reduction in transfusion requirements of at least 50%.

2. For the treatment of Refractory/relapsed multiple myeloma after one prior therapy (MM-AOPT)

Criteria for initial 12-month coverage:

- · 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.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

- 3. For the treatment of newly diagnosed multiple myeloma for patients who are not eligible for autologous stem cell transplant (MM-TNE) Criteria for initial 12-month coverage:
- 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.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

- 4. For the maintenance treatment for newly diagnosed multiple myeloma post-autologous stem cell transplant Criteria for initial 12-month coverage:
- 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.

Criteria for renewal every 12 months:

02317710 REVLIMID

There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

10MG CAPSULE

02304902 REVLIMID

15MG CAPSULE

02317699 REVLIMID

20MG CAPSULE

02440601 REVLIMID

UNK

25MG CAPSULE

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LENVATINIB

Limited use benefit (prior approval required).

1. Unresectable Hepatocellular Carcinoma (HCC):

Criteria for initial 4-month coverage:

For the first-line treatment of adult patients with unresectable HCC; and

- patient has a Child-Pugh A liver function status; and
- patient has an ECOG performance status of 0 to 1; and
- patient meets the inclusion criteria of the REFLECT trial:
- patient does not have ≥50% of liver occupation;
- patient does not have clear invasion of the bile duct or portal vein at the main portal branch;
- patient does not have a history of or current brain or subdural metastases.

Criteria for renewal every 4 months:

There is no objective evidence of disease progression.

2. Differentiated thyroid cancer (DTC)

Criteria for initial 4-month coverage:

Used as monotherapy for treatment of patients with locally recurrent or metastatic, progressive DTC; and

- DTC is refractory to radioactive iodine treatment; and
- have an ECOG performance status of ≤ 2; and
- patient meets the eligibility criteria of the SELECT trial as follows:
- pathologically confirmed differentiated thyroid cancer (patients with anaplastic or medullary thyroid cancer are not eligible)
- evidence of iodine-131 refractory disease according to at least one of the following criteria:
- at least one measurable lesion without iodine uptake on any iodine-131 scan
- at least one measurable lesion that had progressed according to RECIST criteria within 12 months after iodine-131 therapy despite iodine-131 avidity at the time of treatment
- total lifetime radioactive iodine dose greater than 600 mCi (millicurie)
- radiologic evidence of progression within the previous 13 months
- no prior therapy with a tyrosine kinase inhibitor or have received one prior treatment regimen with a tyrosine kinase inhibitor

Criteria for renewal every 4 months:

There is no objective evidence of disease progression.

4MG CAPSULE

02484056 LENVIMA 8MG CAPSULE	EIS
02468220 LENVIMA	EIS
10MG CAPSULE 02450321 LENVIMA 12MG CAPSULE	EIS
02484129 LENVIMA 14MG CAPSULE	EIS
02450313 LENVIMA 20MG CAPSULE	EIS
02450305 LENVIMA	EIS
24MG CAPSULE 02450291 LENVIMA	EIS

MIDOSTAURIN

Limited use benefit (prior approval required).

Criteria for 12-month coverage:

- patient has newly diagnosed FMS-like tyrosine kinase 3 (FLT3)-mutated acute myeloid leukemia (AML); and
- patient's FLT3-mutation status has been confirmed; and
- midostaurin is being used in combination with standard cytarabine and daunorubicin (or idarubicin) induction and cytarabine consolidation chemotherapy; and
 patient has an ECOG performance status of 0 to 2.

25MG CAPSULE

02466236 RYDAPT **NVR**

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NILOTINIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

Patients has newly diagnosed Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia in chronic phase; or Patient has chronic phase or accelerated phase Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia; and

- · patient has disease progression/resistance to imatinib; or
- documented intolerance to a prior oral TKI (imatinib, dasatinib or bosutinib).

Criteria for renewal every 12 months:

Confirmation from the clinician that the patient has experienced hematologic and/or cytogenic response and is expected to continue to do so and has not developed unacceptable toxicities.

150MG CAPSULE

02368250 TASIGNA NVR

200MG CAPSULE

02315874 TASIGNA NVR

OLAPARIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

- maintenance treatment of adult patients with high grade serous epithelial ovarian fallopian tube cancer; or
- primary peritoneal cancer;
- and
- platinum-sensitive disease; and
- relapsed BRCA-mutated disease (germline or somatic as detected by approved testing)
- have completed at least two previous lines of platinum-based chemotherapy; and
- radiologic response (complete or partial response) to their most recent platinum-based chemotherapy regimen as per the SOLO-2 trial; and
- patient has an ECOG performance status of 0 to 2;
- and
- · olaparib is used as monotherapy

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

50MG CAPSULE

02454408 LYNPARZA AZC

100MG TABLET

02475200 LYNPARZA AZC

150MG TABLET

02475219 LYNPARZA AZC

OSIMERTINIB

Limited use benefit (prior approval required).

1. First-line treatment of locally advanced or metastatic non-small cell lung cancer (NSCLC)

Criteria for initial 12-month coverage:

Patient with locally advanced (not amenable to curative intent therapy) or metastatic non-small cell lung cancer whose tumors have epidermal growth factor receptor (EGFR) mutations (exon 19 deletions [exon 19 del] or exon 21 [L858R]); and

- patient is previously untreated in the locally advanced or metastatic setting; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no clinically meaningful disease progression or unacceptable toxicity.

2. Subsequent treatment of locally advanced or metastatic non-small cell lung cancer (NSCLC)

Criteria for initial 12-month coverage:

Patient with locally advanced or metastatic NSCLC who has progressed on epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor therapy; and

- patient is EGFR T790M mutation- positive; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

40MG TABLET

02456214 TAGRISSO AZC

80MG TABLET

02456222 TAGRISSO AZC

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PALBOCICLIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of post-menopausal clients with estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer; and

- the patient has not received any prior treatment for metastatic disease (first-line treatment); and
- palbociclib will be used in combination with an aromatase inhibitor; and
- patient has an ECOG performance status of 0 to 2; and
- patient is not resistant to prior (neo)adjuvant aromatase inhibitor therapy; and
- patient does not have active or uncontrolled metastases to the central nervous system.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

or

Criteria for initial 12-month coverage:

For in combination with fulvestrant, for the treatment of patients with hormone receptor (HR)-positive, HER2-negative locally advanced or metastatic breast cancer (mBC) whose disease has progressed after prior endocrine therapy.

• patient has an ECOG performance status of 0 to 2

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

75MG CAPSULE

02453150 IBRANCE PFI

100MG CAPSULE

02453169 IBRANCE PFI

125MG CAPSULE

02453177 IBRANCE PFI

PAZOPANIB

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

POMALIDOMIDE

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of relapsed or refractory multiple myeloma who meet all of the following criteria:

- used in combination with dexamethasone; and
- patient has relapsed or is refractory to at least two treatment regimens, including both bortezomib and lenalidomide; and
- patient has demonstrated disease progression on the last regimen.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or development of unacceptable toxicity to pomalidomide requiring discontinuation of therapy.

1MG CAPSULE

02419580 POMALYST UNK

2MG CAPSULE

02419599 POMALYST UNK

3MG CAPSULE

02419602 POMALYST UNK

4MG CAPSULE

02419610 POMALYST UNK

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ARI

10:00.00 ANTINEOPLASTIC AGENTS

PONATINIB HYDROCHLORIDE

Limited use benefit (prior approval required).

Criteria for initial 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 renewal every 6 months:

There is no objective evidence of disease progression.

15MG TABLET

02437333 ICLUSIG

45MG TABLET

02437341 ICLUSIG ARI

REGORAFENIB

Limited use benefit (prior approval required).

1. For the treatment of Gastrointestinal Stromal Tumors (GIST)

Criteria for initial six-month coverage:

For patients with Gastrointestinal Stromal Tumors (GIST) who have failed or are unable to tolerate imatinib and sunitinib therapy; and

• patient has an ECOG performance status of 0 or 1;

Note: Regorafenib will not be funded concomitantly with imatinib or sunitinib.

Criteria for assessment every 12 months:

There is no objective evidence of disease progression.

2. For the treatment of Hepatocellular Carcinoma (HCC)

Criteria for initial six-month coverage:

Patient diagnosed with unresectable HCC; and

- patient has been previously treated with sorafenib or lenvatinib; and
- patient was able to tolerate sorafenib as defined in the RESorCE trial criteria (≥400mg/day for ≥20 days of the last 28 days of treatment); and
- patient has a Child-Pugh class status of A; and
- patient has an ECOG performance status of 0 to 1

Criteria for assessment every 12 months:

There is no objective evidence of disease progression.

40MG TABLET

02403390 STIVARGA BAY

RIBOCICLIB (RIBOCICLIB SUCCINATE)

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of post-menopausal clients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer:

- the patient has not received any prior treatment for metastatic disease (first-line treatment); and
- ribociclib will be used in combination with letrozole; and
- patient has an ECOG performance status of 0 to 2; and
- patient is not resistant* to prior (neo)adjuvant nonsteroidal aromatase inhibitor therapy (NSAI); and
- patient does not have active or uncontrolled metastases to the central nervous system

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or unacceptable toxicity.

*Resistance is defined as disease progression occurring during or within 12 months following aromatase inhibitor therapy.

200MG TABLET

02473569 KISQALI NVR

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HLR

10:00.00 ANTINEOPLASTIC AGENTS

RITUXIMAB

Limited use benefit (prior approval required).

1. For the treatment of severely active rheumatoid arthritis (RA)

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/m2body 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

RUXOLITINIB

Limited use benefit (prior approval required).

1. For the treatment of myelofibrosis:

Criteria for initial 6-month coverage:

- intermediate to high risk symptomatic myelofibrosis as assessed using the Dynamic International Prognostic Scoring System (DIPSS) Plus; or
- · patient has symptomatic splenomegaly;
- patient has an ECOG performance status of 0 to 3; and
- patient previously untreated or refractory to other treatment.

Criteria for renewal every 12 months:

- reduction in spleen size; or
- improvement in disease symptoms.
- 2. For the treatment of patients with polycythemia vera:

Criteria for initial 6-month coverage:

Disease is resistant to hydroxyurea (HU) according to the modified European LeukemiaNet Criteria defined as below:

- After 3 months of at least 2g/day of HU or at the maximally tolerated HU dose, patient showed:
- need for phlebotomy to keep hematocrit < 45%; or
- uncontrolled myeloproliferation (platelet > 400x109/L and WBC > 10x109/L); or
- failure to reduce massive splenomegaly > 50% as measured by palpation.
- Patient is intolerant to HU according to the modified European LeukemiaNet Criteria defined below:

After any dose of HU, patient showed:

- absolute neutrophil count < 1.0 x 109/L, or platelet < 100x109/L or hemoglobin < 100 g/L at the lowest dose of HU required to achieve a response (response defined as hematocrit < 45% without phlebotomy, and/or all of the following: platelet ≤ 400x109/L, WBC ≤ 10 x 109/L, and non-palpable spleen); or
- presence of leg ulcers or other unacceptable HU-related non-hematological toxicities (such as mucocutaneous manifestations, gastrointestinal symptoms, pneumonitis or fever, defined as Common Terminology Criteria for Adverse Events (CTCAE) version 3.0 grade 3 or 4, or more than one week of CTCAE version 3.0 grade 2, or permanent discontinuation of HU, or interruption of HU until toxicity resolved, or hospitalization due to HU toxicity).
- patient has an ECOG performance status of 0 to 3

Criteria for renewal every 12 months:

- reduction in spleen size; or
- improvement in disease symptoms.

5MG TABLET

02388006 JAKAVI **NVR**

10MG TARLET

02434814 JAKAVI **NVR**

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RUXOLITINIB

Limited use benefit (prior approval required).

1. For the treatment of myelofibrosis:

Criteria for initial 6-month coverage:

- intermediate to high risk symptomatic myelofibrosis as assessed using the Dynamic International Prognostic Scoring System (DIPSS) Plus; or
- patient has symptomatic splenomegaly;
- and
- patient has an ECOG performance status of 0 to 3; and
- patient previously untreated or refractory to other treatment.

Criteria for renewal every 12 months:

- reduction in spleen size; or
- improvement in disease symptoms.
- 2. For the treatment of patients with polycythemia vera:

Criteria for initial 6-month coverage:

Disease is resistant to hydroxyurea (HU) according to the modified European LeukemiaNet Criteria defined as below:

After 3 months of at least 2g/day of HU or at the maximally tolerated HU dose, patient showed:

- need for phlebotomy to keep hematocrit < 45%; or
- uncontrolled myeloproliferation (platelet > 400x109/L and WBC > 10x109/L); or
- failure to reduce massive splenomegaly > 50% as measured by palpation.
- or
- Patient is intolerant to HU according to the modified European LeukemiaNet Criteria defined below:

After any dose of HU, patient showed:

- absolute neutrophil count < 1.0 x 109/L , or platelet < 100x109/L or hemoglobin < 100 g/L at the lowest dose of HU required to achieve a response defined as hematocrit < 45% without phlebotomy, and/or all of the following: platelet ≤ 400x109/L , WBC ≤ 10 x 109/L , and non-palpable spleen); or
- presence of leg ulcers or other unacceptable HU-related non-hematological toxicities (such as mucocutaneous manifestations, gastrointestinal symptoms, pneumonitis or fever, defined as Common Terminology Criteria for Adverse Events (CTCAE) version 3.0 grade 3 or 4, or more than one week of CTCAE version 3.0 grade 2, or permanent discontinuation of HU, or interruption of HU until toxicity resolved, or hospitalization due to HU toxicity).
- and
- patient has an ECOG performance status of 0 to 3.

Criteria for renewal every 12 months:

- reduction in spleen size; or
- improvement in disease symptoms.

15MG TABLET

02388014 JAKAVI NVR

20MG TABLET

02388022 JAKAVI NVR

SUNITINIB MALATE

Limited use benefit (Prior approval required).

Criteria for initial 6-month coverage:

• 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;

or

Criteria for initial 12-month coverage:

- Documented, progressive, unresectable, well or moderately differentiated, locally advanced or metastatic pancreatic neuroendocrine tumors; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 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

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TRAMETINIB

Limited use benefit (prior approval required).

1. First-line treatment of patients with metastatic or unresectable melanoma.

Criteria for initial 6-month coverage:

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 dabrafenib (Tafinlar)

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; and
- patient is previously untreated.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

2. Adjuvant treatment of patients with cutaneous melanoma.

Criteria for maximum 12-month coverage:

- in combination with trametinib for the adjuvant treatment of patients with stage IIIA (limited to lymph node metastases of >1 mm) to stage IIID (8th edition of the American Joint Committee on Cancer Staging System) cutaneous melanoma; and
- patient has documented BRAF V600 mutation cutaneous melanoma; and
- disease must be completely resected including in-transit metastases*; and
- patient has an ECOG performance status of 0 to 1.

Maximum duration of therapy is 12 months.

* Presence of regional lymph nodes with micrometastases after sentinel lymph node biopsy alone is allowed.

0.5MG TABLET

02409623 MEKINIST **NVR**

2MG TABLET

02409658 MEKINIST **NVR**

VANDETANIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For patients with symptomatic and/or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease; and

• an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression.

100MG TABLET

02378582 CAPRELSA SAC

300MG TABLET

02378590 CAPRELSA SAC

VEMURAFENIB

Limited use benefit (prior approval required).

Criteria for initial 6-month coverage:

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.

Criteria for renewal every 6 months:

There is no objective evidence of disease progression.

ST 240MG TABLET

02380242 ZELBORAF HLR

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VENETOCLAX

Limited use benefit (prior approval required).

1. Monotherapy treatment in adult patients with chronic lymphocytic leukemia (CLL)

Criteria for initial 12-month coverage:

For the treatment of CLL who meet all of the following criteria:

Venclexta will be used as monotherapy; and

- patient has received at least one prior therapy; and
- patient has failed a B-cell receptor inhibitor (BCRi) or is intolerant to prior ibrutinib therapy; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or unacceptable toxicity.

2. In combination with rituximab for the treatment of chronic lymphocytic leukemia (CLL)

Criteria for 12-month coverage of venetoclax:

For the treatment of CLL; and

- in combination with rituximab; and
- patient has received at least one prior therapy; and
- patient has an ECOG performance status of 0 to 2.

Criteria for renewal every 12 months:

There is no objective evidence of disease progression or unacceptable toxicity.

Coverage is for a maximum duration of two years.

10MG TABLET

 02458039 VENCLEXTA
 ABV

 50MG TABLET
 02458047 VENCLEXTA

 100MG TABLET
 ABV

 02458055 VENCLEXTA
 ABV

 02458063 VENCLEXTA
 ABV

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.

ST 5MG TABLET

02362260 APO-DONEPEZIL	APX
02232043 ARICEPT	PFI
02400561 AURO-DONEPEZIL	AUR
02412853 BIO-DONEPEZIL	BMI
02402645 DONEPEZIL	ACC
02416417 DONEPEZIL	PDL
02420597 DONEPEZIL	SIV
02426846 DONEPEZIL	SAN
02475278 DONEPEZIL	RIV
02416948 JAMP-DONEPEZIL	JMP
02402092 MAR-DONEPEZIL	MAR
02467453 M-DONEPEZIL	MAN

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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.

ST 5MG TABLET

02408600 MINT-DONEPEZIL	MIN
02439557 NAT-DONEPEZIL	NPH
02322331 PMS-DONEPEZIL	PMS
02328666 SANDOZ DONEPEZIL	SDZ
02428482 SEPTA DONEPEZIL	SPT
02381508 TARO-DONEPEZIL	SUN
02340607 TEVA-DONEPEZIL	TEV

ST 10MG TARLET

10MG TABLET			
02362279 APO-DONEPEZIL	APX		
02232044 ARICEPT	PFI		
02400588 AURO-DONEPEZIL	AUR		
02412861 BIO-DONEPEZIL	BMI		
02402653 DONEPEZIL	ACC		
02416425 DONEPEZIL	PDL		
02420600 DONEPEZIL	SIV		
02426854 DONEPEZIL	SAN		
02416956 JAMP-DONEPEZIL	JMP		
02402106 MAR-DONEPEZIL	MAR		
02467461 M-DONEPEZIL	MAN		
02408619 MINT-DONEPEZIL	MIN		
02439565 NAT-DONEPEZIL	NPH		
02322358 PMS-DONEPEZIL	PMS		
02328682 SANDOZ DONEPEZIL	SDZ		
02428490 SEPTA DONEPEZIL	SPT		
02381516 TARO-DONEPEZIL	SUN		
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.

ST 8MG CAPSULE (EXTENDED RELEASE)

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

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APX

NVR

JMP

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.

ST 8MG CAPSULE (EXTENDED RELEASE)

02339439 MYLAN-GALANTAMINE ER	MYL
02316943 PAT-GALANTAMINE ER	JSO
02398370 PMS-GALANTAMINE ER	PMS

ST 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	JSO
02398389 PMS-GALANTAMINE ER	PMS

ST 24MG CAPSULE (EXTENDED RELEASE)

THIS ON SOLE (EXTENSES RELEASE)		
AUR		
SAN		
PDL		
MAR		
MYL		
JSO		
PMS		

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:

02336723 APO-RIVASTIGMINE

02485370 JAMP RIVASTIGMINE

02242116 EXELON

- 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.

ST 1.5MG CAPSULE

02336715 APO-RIVASTIGMINE	APX	
02242115 EXELON	NVR	
02485362 JAMP RIVASTIGMINE	JMP	
02401614 MED-RIVASTIGMINE	GMP	
02306034 PMS-RIVASTIGMINE	PMS	
02416999 RIVASTIGMINE	PDL	
02324563 SANDOZ RIVASTIGMINE	SDZ	
ST 3MG CAPSULE		

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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.

ST 3MG CAPSULE

-	4 A-DAIN	
	02324571 SANDOZ RIVASTIGMINE	SDZ
	02417006 RIVASTIGMINE	PDL
	02306042 PMS-RIVASTIGMINE	PMS
	02401622 MED-RIVASTIGMINE	GMP

ST 4.5MG CAPSULE

02336731 APO-RIVASTIGMINE	APX
02242117 EXELON	NVR
02485389 JAMP RIVASTIGMINE	JMP
02401630 MED-RIVASTIGMINE	GMP
02306050 PMS-RIVASTIGMINE	PMS
02417014 RIVASTIGMINE	PDL
02324598 SANDOZ RIVASTIGMINE	SDZ

ST 6MG CAPSULE

02336758 APO-RIVASTIGMINE	APX
02242118 EXELON	NVR
02485397 JAMP RIVASTIGMINE	JMP
02401649 MED-RIVASTIGMINE	GMP
02306069 PMS-RIVASTIGMINE	PMS
02417022 RIVASTIGMINE	PDL
02324601 SANDOZ RIVASTIGMINE	SDZ

ST 2MG/ML SOLUTION

02245240 EXELON NVR

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

	TABLET	
0224	5663 TRIMEBUTINE	AP
0234	9027 AA-TRIMEBUTINE	AP

200MG TABLET

02349035 AA-TRIMEBUTINE	AAP
02245664 TRIMEBUTINE	AAP

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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.

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

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12:12.08 BETA ADRENERGIC AGONISTS

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 & 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:

- are not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist; or
 have moderate to severe COPD, as defined by spirometry.

75MCG CAPSULE

02376938 ONBREZ BREEZHALER

NVR

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 rapidonset, 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

50MCG/INHALATION POWDER

02231129 SEREVENT DISKUS

GSK

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; and
- 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	
02494507 PMS-FLUTICASONE PROPIONATE/SALMETEROL DPI	PMS	
02495597 WIXELA INHUB	MYL	
50MCG & 250MCG POWDER		
02240836 ADVAIR 250 DISKUS	GSK	
02494515 PMS-FLUTICASONE PROPIONATE/SALMETEROL DPI	PMS	
02495600 WIXELA INHUB	MYL	
50MCG & 500MCG POWDER		
02240837 ADVAIR 500 DISKUS	GSK	
02494523 PMS-FLUTICASONE PROPIONATE/SALMETEROL DPI	PMS	
02495619 WIXELA INHUB	MYL	

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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.

ST 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
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.

ST 2MG GUM

02091933 NICORETTE GUM	KIM
80015240 RUGBY NICOTINE POLACRILEX GUM	ACG
80000396 THRIVE NICOTINELL GUM	GSK
ST 4MG GUM	
02091941 NICORETTE GUM	KIM

02091941 NICORETTE GUMKIM80000118 NICOTINE GUMPER80000402 THRIVE NICOTINELL GUMNVC

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.

ST 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.

ST 1MG LOZENGE

80007461 THRIVE NICOTINE LOZENGES

NVC

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12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

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.

ST 2MG LOZENGE

02247347 NICORETTE LOZENGE KIM 80007464 THRIVE NICOTINE LOZENGES NVC

ST 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.

- NIHB clients are eligible to receive:
- up to 252 nicotine patches of any listed brand in a 12-month period; and
- one course of an as-needed nicotine replacement therapy (NRT) product (i.e. gum, lozenge or inhaler) in a 12-month period; and
- up to 180 tablets of Zyban in a 12-month period; and
- up to 165 tablets of Champix in a 12-month period.

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.

1140 1111041	
ST 2MG GUM	
80025660 CHU NICOTINE ANTI SMOKING AID	UNK
94799974 THRIVE GUM (NS)	NVC
ST 1MG LOZENGE	
80061161 NICHIT	EUR
ST 2MG LOZENGE	
80059877 NICHIT	EUR
S [₹] 7MG PATCH	
01943057 HABITROL	NVC
80051602 NICOTINE TRANSDERMAL	APX
80044393 TRANSDERMAL NICOTINE	ACG
ST 14MG PATCH	
01943065 HABITROL	NVC
80013549 NICOTINE TRANSDERMAL SYSTEM	ADD
80044392 TRANSDERMAL NICOTINE ST 18MG PATCH	ACG
02241227 TRANSDERMAL NICOTINE PATCHDAY	NVC
ST 21MG PATCH	
01943073 HABITROL 80051603 NICOTINE TRANSDERMAL	NVC APX
80014250 NICOTINE TRANSDERMAL SYSTEM	APA ADD
80044389 TRANSDERMAL NICOTINE	ACG
ST 36MG PATCH	,,,,,
02093111 NICODERM	KIM
ST 53MG PATCH	
02241228 TRANSDERMAL NICOTINE PATCHDAY	NVC
ST 78MG PATCH	
02093138 NICODERM	KIM
ST 114MG PATCH	
02093146 NICODERM	KIM

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12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

NICOTINE (SPRAY)

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

For smoking cessation:

Coverage is limited to 3450 sprays 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 spray when one year has elapsed from the day the initial prescription was filled.

1MG ORAL SPRAY

80038858 NICORETTE QUICKMIST

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.

ST 0.5MG TABLET

02419882 APO-VARENICLINE	APX
02291177 CHAMPIX	PFI
02426226 TEVA-VARENICLINE	TEV

ST 0.5MG & 1MG TABLET

02435675 APO-VARENICLINE	APX
02298309 CHAMPIX STARTER PACK	PFI
02426781 TEVA-VARENICLINE	TEV

ST 1MG TABLET

1MG TABLET		
02419890 APO-VARENICLINE	APX	
02291185 CHAMPIX	PFI	
02426234 TEVA-VARENICLINE	TEV	

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 ≥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)

ST 2.5MG TABLET

02377233 ELIQUIS BMS

ST 5MG TABLET

02397714 ELIQUIS BMS

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20:12.04 ANTICOAGULANTS

DABIGATRAN ETEXILATE MESILATE

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥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).

110MG CAPSULE

02468905 APO-DABIGATRAN APX 02312441 PRADAXA BOE

150MG CAPSULE

02468913 APO-DABIGATRAN APX 02358808 PRADAXA BOE

EDOXABAN (EDOXABAN TOSYLATE MONOHYDRATE)

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥1) with non-valvular atrial fibrillation who require edoxaban 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)

15MG TABLET

02458640 LIXIANA SEV

30MG TABLET

02458659 LIXIANA SEV

60MG TABLET

02458667 LIXIANA SEV

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 ≥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).

ST 15MG TABLET

02378604 XARELTO BAY

ST 20MG TABLET

02378612 XARELTO BAY

RIVAROXABAN (10)

Limited use benefit (prior approval not required).

For the prevention of venous thromboembolism following total knee replacement or total hip replacement surgery, for up to 35 days

ST 10MG TABLET

02316986 XARELTO BAY

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20:12.04 ANTICOAGULANTS

RIVAROXABAN (CAD, PAD)

Limited use benefit (prior approval required).

Rivaroxaban will be used in combination with acetylsalicylic acid for the prevention of stroke, myocardial infarction, and cardiovascular death, and for the prevention of acute limb ischemia and mortality in patients with concomitant coronary artery disease (CAD) and peripheral artery disease (PAD) as defined below:

- 1. Patient has CAD defined as having one or more of the following:
- . myocardial infarction within the last 20 years; or
- multi-vessel coronary disease (i.e., stenosis of ≥ 50% in two or more coronary arteries, or in one coronary territory if at least one other territory has been revascularized) with symptoms or history of stable or unstable angina; or
- multi-vessel percutaneous coronary intervention; or
- multi-vessel coronary artery bypass graft surgery
- and
- aged 65 years or older; or
- aged younger than 65 years and presents with documented atherosclerosis or revascularization involving at least two vascular beds (coronary and other vascular) or has at least two additional risk factors.*
- * Additional risk factors include: current smoker, diabetes mellitus, estimated glomerular filtration rate <60mL/min, heart failure, non-lacunar ischemic stroke 1 month or more ago.

and

- 2. Patient has PAD defined as having one or more of the following:
- previous aorto-femoral bypass surgery, limb bypass surgery, or percutaneous transluminal angioplasty revascularization of the iliac or infrainguinal arteries; or
- previous limb or foot amputation for arterial vascular disease; or
- history of intermittent claudication with an anklebrachial index less than 0.90 or significant peripheral artery stenosis (≥ 50%) documented by angiography or by duplex ultrasound; or
- previous carotid revascularization or asymptomatic carotid artery stenosis greater than or equal to 50%, as diagnosed by duplex ultrasound or angiography.

2.5MG TABLET

02480808 XARELTO BAY

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.

60MG TABLET

02455005 BRILINTA AZC

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. ≥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 109/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

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20:16.00 HEMATOPOIETIC AGENTS

PLERIXAFOR

Limited use benefit (prior approval 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

24:04.92 MISCELLANEOUS CARDIAC DRUGS

IVABRADINE (IVABRADINE HYDROCHLORIDE)

Limited use benefit (prior approval required).

For the treatment of stable chronic heart failure with New York Heart Association (NYHA) class II or III symptoms in adult patients if the following criteria are met:

- left ventricular ejection fraction ≤ 35%; and
- resting heart rate must be documented as ≥ 77 bpm on average using either an ECG on at least three separate visits or by continuous monitoring; and
- patient has had at least one hospitalization due to heart failure in the last year; 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) in combination with a beta blocker and, if tolerated, a mineralocorticoid receptor antagonist (MRA).

5MG TABLET

02459973 LANCORA SEV

7.5MG TABLET

02459981 LANCORA SEV

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24:06.24

ALIROCUMAB

Limited use benefit (prior approval required).

Initial Coverage (12 weeks):

- For adult patients with heterozygous familial hypercholesterolemia (HeFH) who require additional lowering of low-density lipoprotein cholesterol (LDL-C) if the following clinical criteria are met:
- definite or probable diagnosis of HeFH using the Simon Broome or Dutch Lipid Network criteria or genetic testing;
- and

Patient is unable to reach an LDL-C target of < 2.0 mmol/L for secondary CVD prevention, or at least a 50% reduction in LDL-C from untreated baseline for primary prevention despite:

- confirmed adherence to a high-dose statin (e.g., atorvastatin 80 mg or rosuvastatin 40 mg) in combination with ezetimibe for a total of at least 3 months of continuous treatment;
- or
- patient is unable to tolerate at least two statins, with at least one statin initiated at the lowest daily starting dose; and
- for each statin (two statins in total), dose reduction was attempted to resolve intolerable myopathy or creatine kinase > 5 times the upper limit of normal rather than statin discontinuation; and
- for each statin (two statins in total), intolerable myopathy or creatine kinase > 5 times the upper limit of normal was reversed upon statin discontinuation, but reoccurred with statin rechallenge where clinically appropriate; and
- confirmed adherence to ezetimibe for a total of at least 3 months continuous treatment; and
- other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out;
- or
- patient developed confirmed and documented rhabdomyolysis;
- or
- patient has a contraindication to statins; and
- confirmed adherence to ezetimibe for a total of at least 3 months continuous treatment.

Continued coverage (6 months):

- patient is adherent to therapy; and
- patient has achieved a reduction in LDL-C of at least 40% from baseline.
- Note: Annual coverage is limited to 26 prefilled syringes or prefilled pens per year.

75MG SOLUTION

02453754 PRALUENT	SAC
02453819 PRALUENT	SAC
150MG SOLUTION	
02453762 PRALUENT	SAC
02453835 PRALUENT	SAC

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24:06.24

EVOLOCUMAB

Limited use benefit (prior approval required).

Initial coverage criteria (Initial approval for 12 weeks):

For adult patients with heterozygous familial hypercholesterolemia (HeFH) who require additional lowering of low-density lipoprotein cholesterol (LDL-C) if the following clinical criteria are met:

- definite or probable diagnosis of HeFH using the Simon Broome or Dutch Lipid Network criteria or genetic testing; and
- patient is unable to reach an LDL-C target of < 2.0 mmol/L for secondary CVD prevention, or at least a 50% reduction in LDL-C from untreated baseline for primary prevention despite:
- confirmed adherence to a high-dose statin (e.g., atorvastatin 80 mg or rosuvastatin 40 mg) in combination with ezetimibe for a total of at least 3 months of continuous treatment;
- or
- patient is unable to tolerate at least two statins, with at least one statin initiated at the lowest daily starting dose; and
- for each statin (two statins in total), dose reduction was attempted to resolve intolerable myopathy or creatine kinase > 5 times the upper limit of normal rather than statin discontinuation; and
- for each statin (two statins in total), intolerable myopathy or creatine kinase > 5 times the upper limit of normal was reversed upon statin discontinuation, but reoccurred with statin rechallenge where clinically appropriate; and
- confirmed adherence to ezetimibe for a total of at least 3 months continuous treatment; and
- other known determinants of intolerable symptoms or abnormal biomarkers have been ruled out;
- 01
- patient developed confirmed and documented rhabdomyolysis;
- or
- patient has a contraindication to statins; and
- confirmed adherence to ezetimibe for a total of at least 3 months continuous treatment.

Note: Annual coverage is limited to 26 prefilled autoinjectors (140 mg every 2 weeks) or 12 automated Mini-Dosers with prefilled cartridges (420 mg once a month).

Renewal coverage criteria (Renewal for 6 months):

- · patient is adherent to therapy; and
- patient has achieved a reduction in LDL-C of at least 40% from baseline.

Note: Annual coverage is limited to 26 prefilled Autoinjectors (140 mg every 2 weeks) or 12 automated Mini-Dosers with prefilled cartridges (420 mg once a month).

120MG SOLUTION

02459779 REPATHA AMG

140MG SOLUTION

02446057 REPATHA AMG

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.

ST 20MG TABLET

 02418118 APO-SILDENAFIL R
 APX

 02412179 PMS-SILDENAFIL R
 PMS

 02279401 REVATIO
 UNK

 02319500 TEVA-SILDENAFIL R
 TEV

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.

ST 20MG TABLET

02338327 ADCIRCA LIL
02421933 APO-TADALAFIL PAH APX

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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.

ST 5MG TABLET

02307065 VOLIBRIS **GSK**

 $^{\rm ST}$ 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.

ST 62.5MG TABLET

1	125MG TABLET	
	02244981 TRACLEER	JSO
	02398400 TEVA-BOSENTAN	TEV
	02386275 SANDOZ BOSENTAN	SDZ
	02383012 PMS-BOSENTAN	PMS
	02399202 APO-BOSENTAN	APX

ST 1

02383020 PMS-BOSENTAN	PMS
02386283 SANDOZ BOSENTAN	SDZ
02244982 TRACLEER	JSO

24:24.00 BETA ADRENERGIC BLOCKING AGENTS

PROPRANOLOL (HEMANGIOL)

Limited use benefit (prior approval required).

For the treatment of proliferating infantile hemangioma requiring systemic therapy and at least one of the following:

- life or function-threatening hemangioma; or
- ulcerated hemangioma with pain and/or lack of response to simple wound care measures; or
- hemangioma with a risk of permanent scarring or disfigurement.

3.75MG SOLUTION

02457857 HEMANGIOL PFD

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 ≤ 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	UNK
02471442 MINT-EPLERENONE	MIN
50MG TABLET	
02323060 INSPRA	UNK
02471450 MINT-EPLERENONE	MIN

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24:32.92

VALSARTAN, SACUBITRIL

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).

ST	8	01	И	G	T.	Α	В	L	Ε.	Ī

02269139 ACETYLSALICYLIC ACID	JMP
02295563 LOWPRIN	EUR
02202360 RIVASA	RIV

ST 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

80MG TABLET (DELAYED RELEASE)

02427176 ASA EC	SAN
02238545 ASAPHEN	PMS
02283905 JAMP-ASA	JMP
02311496 PRO-AAS	PDL
02485222 RIVASA FC	RIV

DICLOFENAC DIETHYLAMINE

Limited use benefit (prior approval not required).

Coverage is limited to 100 grams per month.

1.16% GEL

02290375 VOLTAREN EMULGEL	GSK
02338580 VOLTAREN EMULGEL JOINT PAIN REGULAR STRENGTH	GSK
2.32% GEL	
02393190 VOLTAREN EMULGEL EXTRA STRENGTH	GSK

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28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS 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.

ST 1.5% SOLUTION

02354403 APO-DICLOFENAC	APX
02476134 DICLOFENAC SODIUM	TEL
02434571 DICLOFENAC TOPICAL	RAX
02472309 JAMP DICLOFENAC TOPICAL	JMP
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

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	
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 & 5MG TABLET

02324628 APO-OXYCODONE/ACET	APX
02361361 OXYCODONE/ACET	SAN
02242468 RIVACOCET	RIV
02307898 SANDOZ OXYCODONE/ACETAMINOPHEN	SDZ
00608165 TEVA-OXYCOCET	TEV

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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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

325MG & 5MG TABLET

00608157 TEVA-OXYCODAN

TEV

TEV

BUPRENORPHINE (SUBLOCADE)

Limited use benefit (prior approval required).

For the management of moderate to severe opioid use disorder in adult patients who have been inducted and clinically stabilized on a transmucosal buprenorphine-containing product; and

Patient must be induced and stabilized on an equivalent of 8 mg to 24 mg per day of transmucosal buprenorphine for a minimum of 7 days.

Note

- the prescriber has experience in the diagnosis and management of opioid use disorder and certified under Sublocade Certification Program.
- Sublocade must be administered subcutaneously in the abdominal region by a healthcare provider.
- · Sublocade should be used as part of a complete treatment plan that includes counselling and psychosocial support.
- · client will be added to the Client Safety Program (CSP).

300MG SOLUTION (EXTENDED RELEASE)

02483092 SUBLOCADE IND

CODEINE MONOHYDRATE, CODEINE SULFATE TRIHYDRATE

Limited use benefit (prior approval required).

For treatment of:

- chronic pain and patients that requires end of life care as an alternative to products containing codeine in combination with acetaminophen or ASA with or without caffeine; or
- chronic pain and patients that requires end of life care 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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 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).

00593435 TEVA-CODEINE

To promote safe, therapeutically effective and efficient use of drug therapy, NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

5MG/ML LIQUID

00050024 CODEINE PHOSPHATE ATL

2MG/ML SOLUTION

00380571 LINCTUS CODEINE ATL

15MG TABLET

02009889 CODEINE RIV

30MG TABLET

02009757 CODEINE RIV

00593451 TEVA-CODEINE TEV

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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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

12MCG/HR PATCH	
02341379 PMS-FENTANYL MTX	PMS
02327112 SANDOZ FENTANYL	SDZ
02311925 TEVA-FENTANYL	TEV
25MCG/HR PATCH	
02341387 PMS-FENTANYL MTX	PMS
02327120 SANDOZ FENTANYL	SDZ
02282941 TEVA-FENTANYL	TEV
50MCG/HR PATCH	
02341395 PMS-FENTANYL MTX	PMS
02327147 SANDOZ FENTANYL	SDZ
02282968 TEVA-FENTANYL	TEV
75MCG/HR PATCH	
02341409 PMS-FENTANYL MTX	PMS
02327155 SANDOZ FENTANYL	SDZ
02282976 TEVA-FENTANYL	TEV
100MCG/HR PATCH	
02341417 PMS-FENTANYL MTX	PMS
02327163 SANDOZ FENTANYL	SDZ

HYDROMORPHONE HYDROCHLORIDE

02282984 TEVA-FENTANYL

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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

3MG CAPSULE (EXTENDED RELEASE)	
02476614 APO-HYDROMORPHONE	APX
4.5MG CAPSULE (EXTENDED RELEASE)	
02476622 APO-HYDROMORPHONE	APX
6MG CAPSULE (EXTENDED RELEASE)	
02476630 APO-HYDROMORPHONE	APX
9MG CAPSULE (EXTENDED RELEASE)	
02476649 APO-HYDROMORPHONE	APX
12MG CAPSULE (EXTENDED RELEASE)	
02476657 APO-HYDROMORPHONE	APX
18MG CAPSULE (EXTENDED RELEASE)	
02476665 APO-HYDROMORPHONE	APX
24MG CAPSULE (EXTENDED RELEASE)	
02476673 APO-HYDROMORPHONE	APX
30MG CAPSULE (EXTENDED RELEASE)	
02476681 APO-HYDROMORPHONE	APX

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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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

3MG CAPSULE (SUSTAINED RELEASE)	
02125323 HYDROMORPH CONTIN	PFR
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	
01916386 PMS HYDROMORPHONE	PMS
50MG SOLUTION	
02469413 HYDROMORPHONE HYDROCHLORIDE HP 50	RAX
3MG SUPPOSITORY	
3MG SUPPOSITORY 01916394 PMS HYDROMORPHONE	PMS
	PMS
01916394 PMS HYDROMORPHONE	PMS APX
01916394 PMS HYDROMORPHONE 1MG TABLET	
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE	APX
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID	APX PFR
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE	APX PFR PMS
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE	APX PFR PMS TEV
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID	APX PFR PMS TEV APX PFR
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE	APX PFR PMS TEV APX PFR PMS
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE 02319411 TEVA-HYDROMORPHONE	APX PFR PMS TEV APX PFR
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE 02319411 TEVA-HYDROMORPHONE	APX PFR PMS TEV APX PFR PMS TEV
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE 02319411 TEVA-HYDROMORPHONE 4MG TABLET 02364131 APO-HYDROMORPHONE	APX PFR PMS TEV APX PFR PMS TEV APX
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE 02319411 TEVA-HYDROMORPHONE 4MG TABLET 02364131 APO-HYDROMORPHONE 00125121 DILAUDID	APX PFR PMS TEV APX PFR PMS TEV APX PFR
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE 02319411 TEVA-HYDROMORPHONE 4MG TABLET 02364131 APO-HYDROMORPHONE	APX PFR PMS TEV APX PFR PMS TEV APX
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE 02319411 TEVA-HYDROMORPHONE 4MG TABLET 02364131 APO-HYDROMORPHONE 00125121 DILAUDID 00885401 PMS-HYDROMORPHONE	APX PFR PMS TEV APX PFR PMS TEV APX PFR PMS
01916394 PMS HYDROMORPHONE 1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE 02319411 TEVA-HYDROMORPHONE 4MG TABLET 02364131 APO-HYDROMORPHONE 00125121 DILAUDID 00885401 PMS-HYDROMORPHONE 02319438 TEVA-HYDROMORPHONE	APX PFR PMS TEV APX PFR PMS TEV APX PFR PMS
1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE 02319411 TEVA-HYDROMORPHONE 4MG TABLET 02364131 APO-HYDROMORPHONE 00125121 DILAUDID 00885401 PMS-HYDROMORPHONE 00125121 DILAUDID 00885401 PMS-HYDROMORPHONE 02319438 TEVA-HYDROMORPHONE 8MG TABLET	APX PFR PMS TEV APX PFR PMS TEV APX PFR PMS TEV
1MG TABLET 02364115 APO-HYDROMORPHONE 00705438 DILAUDID 00885444 PMS-HYDROMORPHONE 02319403 TEVA-HYDROMORPHONE 2MG TABLET 02364123 APO-HYDROMORPHONE 00125083 DILAUDID 00885436 PMS-HYDROMORPHONE 02319411 TEVA-HYDROMORPHONE 4MG TABLET 02364131 APO-HYDROMORPHONE 00125121 DILAUDID 00885401 PMS-HYDROMORPHONE 02319438 TEVA-HYDROMORPHONE 02319438 TEVA-HYDROMORPHONE 8MG TABLET 02364158 APO-HYDROMORPHONE	APX PFR PMS TEV APX PFR PMS TEV APX PFR PMS TEV APX APX

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METHADONE HYDROCHLORIDE (METADOL)

Limited use benefit (prior approval required) with the following criteria:

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 patients that requires end of life care. 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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days)

1MG/ML SYRUP

00614491 DOLORAL 1 ATL

5MG/ML SYRUP

00614505 DOLORAL 5 ATL

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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 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

5MG SUPPOSITORY

00632228 STATEX PAL

10MG SUPPOSITORY

00632201 STATEX PAL

20MG SUPPOSITORY

00596965 STATEX PAL

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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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

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
02478897 SANDOZ MORPHINE SR	SDZ
02302802 TEVA-MORPHINE SR	TEV
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

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MAY

28:08.08 OPIATE AGONISTS

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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 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

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 200 mg morphine equivalents per day for chronic non-cancer 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. 6000 morphine equivalents over 30 days).

10MG SUPPOSITORY

09991313 KADIAN

00392480 SUPEUDOL	SDZ
20MG SUPPOSITORY	
00392472 SUPEUDOL	SDZ
5MG TABLET	
02231934 OXY-IR	PFR
02319977 PMS-OXYCODONE	PMS
00789739 SUPEUDOL	SDZ
10MG TABLET	
02240131 OXY-IR	PFR
02319985 PMS-OXYCODONE	PMS
00443948 SUPEUDOL	SDZ
20MG TABLET	
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 (BUTRANS)

Limited use benefit (prior approval required).

For the following medical conditions:

- pain due to cancer
- chronic non-cancer pain-causing limitations in activities of daily living.
- prevention of precipitated withdrawal during buprenorphine/naloxone induction (max 3 x 20 mcg patches are covered)
- patient requires end of life care (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less)

*Guidelines indicate little evidence for opioid use for fibromyalgia, headache or back or neck pain without a neuropathic component.

5MCG PATCH

20MCG PATCH

02341174 BUTRANS 5

10MCG PATCH

02341212 BUTRANS 10

PFR

15MCG PATCH

02450771 BUTRANS 15

PFR

02341220 BUTRANS 20

PFR

BUPRENORPHINE (SUBLOCADE)

Limited use benefit (prior approval required).

For the management of moderate to severe opioid use disorder in adult patients who have been inducted and clinically stabilized on a transmucosal buprenorphine-containing product; and

Patient must be induced and stabilized on an equivalent of 8 mg to 24 mg per day of transmucosal buprenorphine for a minimum of 7 days.

Note

- the prescriber has experience in the diagnosis and management of opioid use disorder and certified under Sublocade Certification Program.
- Sublocade must be administered subcutaneously in the abdominal region by a healthcare provider.
- · Sublocade should be used as part of a complete treatment plan that includes counselling and psychosocial support.
- · client will be added to the Client Safety Program (CSP).

100MG SOLUTION (EXTENDED RELEASE)

02483084 SUBLOCADE IND

BUPRENORPHINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the management of patients with opioid use disorder, in combination with psychosocial support:

- patient is stabilized on a dose of no more than 8 mg per day of sublingual buprenorphine/naloxone for the preceding 90 days; and
- patient is under the care of a health care provider with experience in the diagnosis and management of opioid use disorder; and
- the prescriber has been trained to implant the buprenorphine subdermal implant.

Approval is for a maximum of four lifetime doses. One package of 4 implants is approved at every 6 months (e.g. four times X package of 4 implants)

80MG IMPLANT

02474921 PROBUPHINE UNK

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 buprenorphine/naloxone administration. These supports include the safe daily witnessing, storage and handling of the buprenorphine/naloxone doses. After this confirmation, NIHB will approve the buprenorphine/naloxone for the client.

2MG & 0.5MG TABLET

02453908 ACT BUPRENORPHINE/NALOXONE	TEV
02424851 PMS-BUPRENORPHINE-NALOXONE	PMS
02295695 SUBOXONE	IND
8MG & 2MG TABLET	
02453916 ACT BUPRENORPHINE/NALOXONE	TEV
02424878 PMS-BUPRENORPHINE-NALOXONE	PMS
02295709 SUBOXONE	IND

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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 buprenorphine/naloxone administration. These supports include the safe daily witnessing, storage and handling of the buprenorphine/naloxone doses. After this confirmation, NIHB will approve the buprenorphine/naloxone for the client.

12MG & 3MG TABLET

02468085 SUBOXONE IND

16MG & 4MG TABLET

02468093 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.

rams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.	
ST 80MG/ML DROP	
01904140 ACETAMINOPHEN	TAN
01905864 ACETAMINOPHEN	TLI
02263793 PEDIAPHEN	EUR
02027801 PEDIATRIX	TEV
00875988 TEMPRA INFANT	PAL
02046059 TYLENOL	MCL
ST 16MG/ML LIQUID	
01905848 ACETAMINOPHEN	TLI
00792713 PDP-ACETAMINOPHEN	PED
02263807 PEDIAPHEN	EUR
00884553 TEMPRA CHILDREN'S	PAL
ST 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
325MG SUPPOSITORY	
01919393 ABENOL	PED
02230436 ACET 325	PED
02046687 PMS-ACETAMINOPHEN	PMS
650MG SUPPOSITORY	
02230437 ACET 650	PED
02046695 PMS-ACETAMINOPHEN	PMS
ST 80MG TABLET	
02015676 ACETAMINOPHEN	TAN
02263815 PEDIAPHEN	EUR
ST 160MG TABLET	
02230934 ACETAMINOPHEN	TAN
ST 325MG TABLET	
00605751 ACETAMINOPHEN	VTH
00743542 ACETAMINOPHEN	PMT

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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.

ST 325MG TABLET	
00789801 ACETAMINOPHEN	TLI
01938088 ACETAMINOPHEN	JMP
01977415 ACETAMINOPHEN	TLI
02022214 ACÉTAMINOPHÈNE	RIV
02362198 ACÉTAMINOPHÈNE	RIV
00544981 APO ACETAMINOPHEN	APX
02229873 APO-ACETAMINOPHEN	APX
00389218 NOVO-GESIC	TEV
00559393 TYLENOL	MCL
00723894 TYLENOL	MCL
ST 500MG TABLET	
00549703 ACETAMINOPHEN	PMT
00605778 ACETAMINOPHEN	VTH
00789798 ACETAMINOPHEN	TLI
01939122 ACETAMINOPHEN	JMP
01962353 ACETAMINOPHEN	TAN
02252813 ACETAMINOPHEN	PMT
02255251 ACETAMINOPHEN	PMT
02362368 ACETAMINOPHEN	APX
02022222 ACÉTAMINOPHÈNE	RIV
02362228 ACÉTAMINOPHÈNE	RIV
02362201 ACÉTAMINOPHÈNE BLASON SHIELD	RIV
00545007 APO ACETAMINOPHEN	APX
02229977 APO-ACETAMINOPHEN	APX
02285797 EXTRA STRENGTH ACETAMINOPHEN	VTH
02355299 JAMP ACETAMINOPHEN BLAZON	JMP
00482323 NOVO-GESIC FORTE	TEV
00892505 PMS-ACETAMINOPHEN	PMS
00723908 TYLENOL	MCL
00559407 TYLENOL EXTRA STRENGTH	MCL
ST 80MG TABLET (CHEWABLE)	
01905856 ACETAMINOPHEN	TLI
02017458 ACETAMINOPHEN	RIV
02129957 ACETAMINOPHEN	VTH
ST 160MG TABLET (CHEWABLE)	
02017431 ACETAMINOPHEN	RIV
02142805 ACETAMINOPHEN	VTH
02237562 ACETAMINOPHEN	TLI
02263823 PEDIAPHEN	EUR
02347792 TYLENOL JR STRENGTH FASTMELTS	MCL
02241361 TYLENOL JUNIOR STRENGTH	MCL

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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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 0.25MG TABLET	
02179660 PMS-CLONAZEPAM	PMS
ST 0.5MG TABLET	
02177889 APO-CLONAZEPAM	APX
02230366 CLONAPAM	VAE
02048701 PMS-CLONAZEPAM	PMS
02207818 PMS-CLONAZEPAM-R	PMS
02311593 PRO-CLONAZEPAM	PDL
02242077 RIVA-CLONAZEPAM	RIV
00382825 RIVOTRIL	HLR
02239024 TEVA-CLONAZEPAM	TEV
ST 1MG TABLET	
02230368 CLONAPAM	VAE
02048728 PMS-CLONAZEPAM	PMS
02311607 PRO-CLONAZEPAM	PDL
^{sτ} 2MG TABLET	
02177897 APO-CLONAZEPAM	APX
02230369 CLONAPAM	VAE
02048736 PMS-CLONAZEPAM	PMS
02311615 PRO-CLONAZEPAM	PDL
02242078 RIVA-CLONAZEPAM	RIV
00382841 RIVOTRIL	HLR
02239025 TEVA-CLONAZEPAM	TEV

28:12.92 MISCELLANEOUS ANTICONVULSANTS

BRIVARACETAM

Limited use benefit (prior approval required).

For adjunctive therapy in adult 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; and
- are not receiving concurrent therapy with levetiracetam.

02452936 BRIVLERA	UCB
25MG TABLET	
02452944 BRIVLERA	UCB
50MG TABLET	
02452952 BRIVLERA	UCB
75MG TABLET	
02452960 BRIVLERA	UCB
100MG TABLET	
02452979 BRIVLERA	UCB

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ANG

28:12.92 MISCELLANEOUS ANTICONVULSANTS

ESLICARBAZEPINE ACETATE

Limited use benefit (prior approval required).

For adjunctive therapy in adult 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.

$^{\text{ST}}$ 200MG TABLET

02426862 APTIOM SPC $^{\it ST}$ 400MG TABLET 02426870 APTIOM SPC $^{\it ST}$ 600MG TABLET 02426889 APTIOM SPC

 $^{\text{ST}}$ 800MG TABLET

02426897 APTIOM SPC

GABAPENTIN

Limited use benefit (prior approval is not required).

02477912 AG-GABAPENTIN

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 30-day period, for a total daily dose of 4000 mg/day.

The gabapentin dose limit will be further reduced to 3600 mg per day. The new limit will be implemented region-by-region.

100MG CAPSULE

02244304	APO-GABAPENTIN	APX
02321203	AURO-GABAPENTIN	AUR
02450143	BIO-GABAPENTIN	BMI
02243743	DOM-GABAPENTIN	DPC
02246314	GABAPENTIN	SIV
02353245	GABAPENTIN	SAN
02416840	GABAPENTIN	ACC
02285819	GD-GABAPENTIN	PFI
02361469	JAMP-GABAPENTIN	JMP
02391473	MAR-GABAPENTIN	MAR
02084260	NEURONTIN	UNK
02243446	PMS-GABAPENTIN	PMS
02310449	PRO-GABAPENTIN	PDL
02319055	RAN-GABAPENTIN	RBY
02251167	RIVA-GABAPENTIN	RIV
02244513	TEVA-GABAPENTIN	TEV
300MG CAP	SULE	
02477920	AG-GABAPENTIN	ANG
02244305	APO-GABAPENTIN	APX
02321211	AURO-GABAPENTIN	AUR
02450151	BIO-GABAPENTIN	BMI
02243744	DOM-GABAPENTIN	DPC
02246315	GABAPENTIN	SIV
02353253	GABAPENTIN	SAN
02416859	GABAPENTIN	ACC
02361485	JAMP-GABAPENTIN	JMP
02391481	MAR-GABAPENTIN	MAR
02084279	NEURONTIN	UNK
02243447	PMS-GABAPENTIN	PMS
02310457	PRO-GABAPENTIN	PDL
02319063	RAN-GABAPENTIN	RBY

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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 30-day period, for a total daily dose of 4000 mg/day.

The gabapentin dose limit will be further reduced to 3600 mg per day. The new limit will be implemented region-by-region.

300MG CAPSULE	
02251175 RIVA-GABAPENTIN	RIV
02244514 TEVA-GABAPENTIN	TEV
400MG CAPSULE	
02477939 AG-GABAPENTIN	ANG
02244306 APO-GABAPENTIN	APX
02321238 AURO-GABAPENTIN	AUR
02450178 BIO-GABAPENTIN	ВМІ
02243745 DOM-GABAPENTIN	DPC
02246316 GABAPENTIN	SIV
02353261 GABAPENTIN	SAN
02416867 GABAPENTIN	ACC
02361493 JAMP-GABAPENTIN	JMP
02391503 MAR-GABAPENTIN	MAR
02084287 NEURONTIN	UNK
02243448 PMS-GABAPENTIN	PMS
02310465 PRO-GABAPENTIN	PDL
02319071 RAN-GABAPENTIN	RBY
02251183 RIVA-GABAPENTIN	RIV
02244515 TEVA-GABAPENTIN	TEV
^{sτ} 600MG TABLET	
02293358 APO-GABAPENTIN	APX
02428334 AURO-GABAPENTIN	AUR
02450186 BIO-GABAPENTIN	BMI
02388200 GABAPENTIN	SIV
02392526 GABAPENTIN	ACC
02431289 GABAPENTIN	SAN
02285843 GD-GABAPENTIN	PFI
02402289 JAMP-GABAPENTIN	JMP
02239717 NEURONTIN	UNK
02255898 PMS-GABAPENTIN	PMS
02310473 PRO-GABAPENTIN	PDL
02259796 RIVA-GABAPENTIN	RIV
02248457 TEVA-GABAPENTIN	TEV
ST 800MG TABLET	
02293366 APO-GABAPENTIN	APX
02428342 AURO-GABAPENTIN	AUR
02450194 BIO-GABAPENTIN	BMI
02388219 GABAPENTIN	SIV
02392534 GABAPENTIN	ACC
02431297 GABAPENTIN	SAN
02402297 JAMP-GABAPENTIN	JMP
02239718 NEURONTIN	UNK
02255901 PMS-GABAPENTIN	PMS
02310481 PRO-GABAPENTIN	PDL
02259818 RIVA-GABAPENTIN	RIV
02247346 TEVA-GABAPENTIN	TEV

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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 30-day period, for a total daily dose of 4000 mg/day.

The gabapentin dose limit will be further reduced to 3600 mg per day. The new limit will be implemented region-by-region.

ST 600MG TABLET (IMMEDIATE RELEASE)

02410990 GLN-GABAPENTIN GLK

ST 800MG TABLET (IMMEDIATE RELEASE)

02411008 GLN-GABAPENTIN GLK

LACOSAMIDE

Limited use benefit (prior approval required).

For adjunctive therapy in adult 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.

ST 50MG TABLET

02475332 AURO-LACOSAMIDE	AUR
02487802 MAR-LACOSAMIDE	MAR
02490544 MINT-LACOSAMIDE	MIN
02478196 PHARMA-LACOSAMIDE	PMS
02474670 SANDOZ LACOSAMIDE	SDZ
02472902 TEVA-LACOSAMIDE	TEV
02357615 VIMPAT	UCB
ST 100MG TABLET	
02475340 AURO-LACOSAMIDE	AUR

02475340 AURO-LACOSAMIDE	AUR
02487810 MAR-LACOSAMIDE	MAR
02490552 MINT-LACOSAMIDE	MIN
02478218 PHARMA-LACOSAMIDE	PMS
02474689 SANDOZ LACOSAMIDE	SDZ
02472910 TEVA-LACOSAMIDE	TEV
02357623 VIMPAT	UCB

$^{\text{ST}}$ 150MG TABLET

02475359 AURO-LACOSAMIDE	AUR
02487829 MAR-LACOSAMIDE	MAR
02490560 MINT-LACOSAMIDE	MIN
02478226 PHARMA-LACOSAMIDE	PMS
02474697 SANDOZ LACOSAMIDE	SDZ
02472929 TEVA-LACOSAMIDE	TEV
02357631 VIMPAT	UCB

$^{\it ST}$ 200MG TABLET

02475367 AURO-LACOSAMIDE	AUR
02487837 MAR-LACOSAMIDE	MAR
02490579 MINT-LACOSAMIDE	MIN
02478234 PHARMA-LACOSAMIDE	PMS
02474700 SANDOZ LACOSAMIDE	SDZ
02472937 TEVA-LACOSAMIDE	TEV
02357658 VIMPAT	UCB

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EIS

28:12.92 MISCELLANEOUS ANTICONVULSANTS

OXCARBAZEPINE (SUSPENSION)

Limited use benefit (prior approval is not required).

For patients 19 years of age or over who are unable to swallow the tablet formulation due to:

- tube feeding; or
- severe dysphagia

Note: Trileptal (oxcarbazepine) suspension is an open benefit for patients 18 years of age and under and does not require prior approval for these patients.

Oxcarbazepine tablets are an open benefit for patients of all ages and do not require prior approval.

60MG SUSPENSION

02244673 TRILEPTAL NVR

PERAMPANEL

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures or primary generalized tonic-clonic (PGTC) 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.

ST 2MG TABLET	
02404516 FYCOMPA	EIS
ST 4MG TABLET	
02404524 FYCOMPA	EIS
ST 6MG TABLET	
02404532 FYCOMPA	EIS
ST 8MG TABLET	
02404540 FYCOMPA	EIS
ST 10MG TABLET	
02404559 FYCOMPA	EIS
ST 12MG TABLET	

PREGABALIN

Limited use benefit (prior approval required).

02404567 FYCOMPA

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.

25MG CAPSULE

02480727 AG-PREGABALIN	ANG
02394235 APO-PREGABALIN	APX
02433869 AURO-PREGABALIN	AUR
02402556 DOM-PREGABALIN	DPC
02435977 JAMP-PREGABALIN	JMP
02268418 LYRICA	UNK
02417529 MAR-PREGABALIN	MAR
02423804 MINT-PREGABALIN	MIN
02467291 M-PREGABALIN	MAN
02479117 NRA-PREGABALIN	UNK
02359596 PMS-PREGABALIN	PMS
02396483 PREGABALIN	PDL
02403692 PREGABALIN	SIV
02405539 PREGABALIN	SAN
02476304 PREGABALIN	RIV
02377039 RIVA-PREGABALIN	RIV
02390817 SANDOZ PREGABALIN	SDZ
02392801 TARO-PREGABALIN	SUN

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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.

25MG	CAPS	ULE
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25WIG CAP	SULE	
02361159	TEVA-PREGABALIN	TEV
50MG CAPS	SULE	
02480735	AG-PREGABALIN	ANG
02394243	APO-PREGABALIN	APX
02433877	AURO-PREGABALIN	AUR
02402564	DOM-PREGABALIN	DPC
02435985	JAMP-PREGABALIN	JMP
02268426	LYRICA	UNK
02417537	MAR-PREGABALIN	MAR
02423812	MINT-PREGABALIN	MIN
02467305	M-PREGABALIN	MAN
02479125	NRA-PREGABALIN	UNK
02359618	PMS-PREGABALIN	PMS
02396505	PREGABALIN	PDL
02403706	PREGABALIN	SIV
02405547	PREGABALIN	SAN
02476312	PREGABALIN	RIV
02377047	RIVA-PREGABALIN	RIV
02390825	SANDOZ PREGABALIN	SDZ
02392828	TARO-PREGABALIN	SUN
02361175	TEVA-PREGABALIN	TEV
75MG CAPS	SULE	
02480743	AG-PREGABALIN	ANG
02394251	APO-PREGABALIN	APX
02433885	AURO-PREGABALIN	AUR
02402572	DOM-PREGABALIN	DPC
02435993	JAMP-PREGABALIN	JMP
02268434	LYRICA	UNK
02417545	MAR-PREGABALIN	MAR
02424185	MINT-PREGABALIN	MIN
02467313	M-PREGABALIN	MAN
02479133	NRA-PREGABALIN	UNK
02359626	PMS-PREGABALIN	PMS
02396513	PREGABALIN	PDL
02403714	PREGABALIN	SIV
02405555	PREGABALIN	SAN
02476320	PREGABALIN	RIV
02377055	RIVA-PREGABALIN	RIV
02390833	SANDOZ PREGABALIN	SDZ
02392836	TARO-PREGABALIN	SUN
02361183	TEVA-PREGABALIN	TEV
150MG CAF	PSULE	
02480751	AG-PREGABALIN	ANG
02394278	APO-PREGABALIN	APX
02433907	AURO-PREGABALIN	AUR
02402580	DOM-PREGABALIN	DPC

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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.

150MG CAPSULE

02436000 JAMP-PREGABALIN	JMP
02268450 LYRICA	UNK
02417561 MAR-PREGABALIN	MAR
02424207 MINT-PREGABALIN	MIN
02467321 M-PREGABALIN	MAN
02479168 NRA-PREGABALIN	UNK
02359634 PMS-PREGABALIN	PMS
02396521 PREGABALIN	PDL
02403722 PREGABALIN	SIV
02405563 PREGABALIN	SAN
02476347 PREGABALIN	RIV
02377063 RIVA-PREGABALIN	RIV
02390841 SANDOZ PREGABALIN	SDZ
02392844 TARO-PREGABALIN	SUN
02361205 TEVA-PREGABALIN	TEV

ST 300MG CAPSULE

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	02394294 APO-PREGABALIN	APX
	02436019 JAMP-PREGABALIN	JMP
	02268485 LYRICA	UNK
	02359642 PMS-PREGABALIN	PMS
	02396548 PREGABALIN	PDL
	02403730 PREGABALIN	SIV
	02405598 PREGABALIN	SAN
	02476371 PREGABALIN	RIV
	02377071 RIVA-PREGABALIN	RIV
	02390868 SANDOZ PREGABALIN	SDZ
	02392860 TARO-PREGABALIN	SUN
	02361248 TEVA-PREGABALIN	TEV

RUFINAMIDE

Limited use benefit (prior approval required).

For the adjunctive treatment of seizures associated with Lennox-Gastaux 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.

ST 100MG TABLET

02369613 BANZEL EIS

ST 200MG TABLET

02369621 BANZEL EIS

$^{\it ST}$ 400MG TABLET

02369648 BANZEL EIS

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28:16.04 ANTIDEPRESSANTS

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.

ST 150MG TABLET (EXTENDED RELEASE)

02238441 ZYBAN VAE

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
 - ST 5MG TABLET

02374803 SAPHRIS FRS

ST 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.

ST 20MG TABLET

02422050 LATUDA SPC

ST 40MG TABLET

02387751 LATUDA SPC

ST 60MG TABLET

02413361 LATUDA SPC

ST 80MG TABLET

02387778 LATUDA SPC

ST 120MG TABLET

02387786 LATUDA SPC

28:20.04 AMPHETAMINES

AMPHETAMINE, DEXTROAMPHETAMINE

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 100 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

ST 5MG CAPSULE (EXTENDED RELEASE)

02439239 ACT AMPHETAMINE XR	TEV
02248808 ADDERALL XR	UNK
02445492 APO-AMPHETAMINE XR	APX
02440369 PMS-AMPHETAMINES XR	PMS
02457288 SANDOZ AMPHETAMINE XR	SDZ

ST 10MG CAPSULE (EXTENDED RELEASE)

02439247 ACT AMPHETAMINE XR	TEV
02248809 ADDERALL XR	UNK

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28:20.04 AMPHETAMINES

AMPHETAMINE, DEXTROAMPHETAMINE

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 100 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

ST 10MG CAPSULE (EXTENDED RELEASE)	
02445506 APO-AMPHETAMINE XR	APX
02440377 PMS-AMPHETAMINES XR	PMS
02457296 SANDOZ AMPHETAMINE XR	SDZ
ST 15MG CAPSULE (EXTENDED RELEASE)	
02439255 ACT AMPHETAMINE XR	TEV
02248810 ADDERALL XR	UNK
02445514 APO-AMPHETAMINE XR	APX
02440385 PMS-AMPHETAMINES XR	PMS
02457318 SANDOZ AMPHETAMINE XR	SDZ
ST 20MG CAPSULE (EXTENDED RELEASE)	
02439263 ACT AMPHETAMINE XR	TEV
02248811 ADDERALL XR	UNK
02445522 APO-AMPHETAMINE XR	APX
02440393 PMS-AMPHETAMINES XR	PMS
02457326 SANDOZ AMPHETAMINE XR	SDZ
ST 25MG CAPSULE (EXTENDED RELEASE)	
02439271 ACT AMPHETAMINE XR	TEV
02248812 ADDERALL XR	UNK
02445530 APO-AMPHETAMINE XR	APX
02440407 PMS-AMPHETAMINES XR	PMS
02457334 SANDOZ AMPHETAMINE XR	SDZ
ST 30MG CAPSULE (EXTENDED RELEASE)	
02439298 ACT AMPHETAMINE XR	TEV
02248813 ADDERALL XR	UNK
02445549 APO-AMPHETAMINE XR	APX
02440415 PMS-AMPHETAMINES XR	PMS
02457342 SANDOZ AMPHETAMINE XR	SDZ

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 100 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

ST 10MG CAPSULE (SUSTAINED RELEASE)	
02448319 ACT DEXTROAMPHETAMINE SR	TEV
01924559 DEXEDRINE SPANSULE	PAL
ST 15MG CAPSULE (SUSTAINED RELEASE)	
02448327 ACT DEXTROAMPHETAMINE SR	TEV
01924567 DEXEDRINE SPANSULE	PAL
ST 5MG TABLET	
01924516 DEXEDRINE	PAL
02443236 DEXTROAMPHETAMINE	AAP

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28:20.04 AMPHETAMINES

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 100 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

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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 100 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

s ^s 5MG TABLET	
02273950 APO-METHYLPHENIDATE	APX
02234749 PMS-METHYLPHENIDATE	PMS
ST 10MG TABLET	
02249324 APO-METHYLPHENIDATE	APX
00584991 PMS-METHYLPHENIDATE	PMS
ST 20MG TABLET	
02249332 APO-METHYLPHENIDATE	APX
00585009 PMS-METHYLPHENIDATE	PMS
ST 18MG TABLET (EXTENDED RELEASE)	
02441934 ACT METHYLPHENIDATE ER	TEV
02452731 APO-METHYLPHENIDATE ER	APX
02247732 CONCERTA	JSO
02315068 TEVA-METHYLPHENIDATE	TEV
ST 20MG TABLET (EXTENDED RELEASE)	
02266687 APO-METHYLPHENIDATE SR	APX
02320312 SANDOZ METHYLPHENIDATE SR	SDZ
ST 27MG TABLET (EXTENDED RELEASE)	
02441942 ACT METHYLPHENIDATE ER	TEV
02452758 APO-METHYLPHENIDATE ER	APX
02250241 CONCERTA	JSO
02315076 TEVA-METHYLPHENIDATE	TEV

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TEV

MDS

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 100 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

ST 36MG TABLET (EXTENDED RELEASE)

02441950 ACT METHYLPHENIDATE ER	TEV
02452766 APO-METHYLPHENIDATE ER	APX
02247733 CONCERTA	JSO
02315084 TEVA-METHYLPHENIDATE	TEV
ST 54MG TABLET (EXTENDED RELEASE)	
02441969 ACT METHYLPHENIDATE ER	TEV
02330377 APO-METHYLPHENIDATE ER	APX
02247734 CONCERTA	JSO

28:20.92 MISC ANOREXIGENIC AGENTS & RESPIRATORY & CEREBRAL STIMULANT

CAFFEINE CITRATE

Limited use benefit (prior approval not required).

02315092 TEVA-METHYLPHENIDATE

For children up to 1 year of age

POWDER

00972037 CAFFEINE CITRATE

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

01908189 ALPRAZOLAM	PDL
02349191 ALPRAZOLAM	SAN
00865397 APO-ALPRAZ	APX
01913484 TEVA-ALPRAZOLAM	TEV
00548359 XANAX	UNK
ST 0.5MG TABLET	
01908170 ALPRAZOLAM	PDL
02349205 ALPRAZOLAM	SAN
00865400 APO-ALPRAZ	APX
01913492 TEVA-ALPRAZOLAM	TEV
00548367 XANAX	UNK
ST 1MG TABLET	
02248706 ALPRAZOLAM	PDL
02243611 APO-ALPRAZ	APX
00723770 XANAX	UNK
ST 2MG TABLET	
02243612 APO-ALPRAZ	APX
00813958 XANAX TS	UNK

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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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 1.5MG TABLET

02177153 APO-BROMAZEPAM APX

ST 3MG TABLET

02177161 APO-BROMAZEPAM APX 02230584 TEVA-BROMAZEPAM TEV

ST 6MG TABLET

02177188 APO-BROMAZEPAM APX

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 1MG/ML SOLUTION

00891797 PMS-DIAZEPAM PMS

ST 2MG TABLET

00405329 DIAZEPAM AAP
02247490 PMS-DIAZEPAM PMS

ST 5MG TABLET

 00313580 DIAZEPAM
 PDL

 00362158 DIAZEPAM
 AAP

 02247491 PMS-DIAZEPAM
 PMS

 00013285 VALIUM
 HLR

ST 10MG TABLET

00405337 DIAZEPAM AAP 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 30 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. 3,000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 0.5MG TABLET

00655740 APO-LORAZEPAM	APX
02041413 ATIVAN	PFI
02041456 ATIVAN SUBLINGUAL	PFI
02351072 LORAZEPAM	SAN

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TEV

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 0.5MG TABLET 02410745 LORAZEPAM SUBLINGUAL AAP **PMS** 00728187 PMS-LORAZEPAM 00655643 PRO-LORAZEPAM PDL 00711101 TEVA-LORAZEPAM TEV ST 1MG TABLET 00655759 APO-LORAZEPAM APX 02041421 ATIVAN PFI 02041464 ATIVAN SUBLINGUAL PFI 02351080 LORAZEPAM SAN 02410753 LORAZEPAM SUBLINGUAL AAP **PMS** 00728195 PMS-LORAZEPAM 00655651 PRO-LORAZEPAM PDI 00637742 TEVA-LORAZEPAM TEV ST 2MG TABLET ΔΡΥ 00655767 APO-LORAZEPAM 02041448 ATIVAN PFI PFI 02041472 ATIVAN SUBLINGUAL 02351099 LORAZEPAM SAN 02410761 LORAZEPAM SUBLINGUAL AAP 00728209 PMS-LORAZEPAM **PMS** 00655678 PRO-LORAZEPAM **PDL**

NITRAZEPAM

Limited use benefit (prior approval is not required).

00637750 TEVA-LORAZEPAM

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 5MG TABLET

00511528 MOGADON AAP

ST 10MG TABLET

00511536 MOGADON AAP

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 10MG TABLET

00402680 APO OXAZEPAM	APX
00497754 OXAZEPAM	PDL
00414247 OXPAM	ВМІ
00568392 RIVA OXAZEPAM	RIV
ST 15MG TABLET	

00402745 APO OXAZEPAM	APX
00497762 OXAZEPAM	PDL
00568406 RIVA OXAZERAM	RIV

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PDL

TEV

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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 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 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 15MG CAPSULE

00604453 RESTORIL	AAP
02225964 TEMAZEPAM	APX
02229760 TEMAZEPAM	PDL
02230095 TEVA-TEMAZEPAM	TEV
ST 30MG CAPSULE	
00604461 RESTORIL	AAP
02225972 TEMAZEPAM	APX

TRIAZOLAM

Limited use benefit (prior approval is not required).

02229761 TEMAZEPAM 02230102 TEVA-TEMAZEPAM

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 30 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. 3 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 30 mg per day.

ST 0.25MG TABLET

00808571 TRIAZOLAM AAP

28:32.28 SELECTIVE SEROTONIN AGONISTS

ALMOTRIPTAN MALATE

Limited use benefit (prior approval is not required).

A total of 12 tablets are permitted in a 30-day period

6.25MG TABLET

02405792 APO-ALMOTRIPTAN	APX	
02248128 AXERT	MCL	
02398435 MYLAN-ALMOTRIPTAN	MYL	
12.5MG TABLET		
02424020 ALMOTRIDTANI	DDI	

 02424029
 ALMOTRIPTAN
 PDL

 02466821
 ALMOTRIPTAN
 SAN

 02405806
 APO-ALMOTRIPTAN
 APX

 02248129
 AXERT
 MCL

 02398443
 MYLAN-ALMOTRIPTAN
 MYL

 02405334
 SANDOZ ALMOTRIPTAN
 SDZ

 02434849
 TEVA-ALMOTRIPTAN
 TEV

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28:32.28 SELECTIVE SEROTONIN AGONISTS

NARATRIPTAN HYDROCHLORIDE

NARATRIPTAN HYDROCHLORIDE	
Limited use benefit (prior approval is not required).	
A total of 12 tablets 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 are permitted in a 30-day period.	
5MG TABLET	
02393468 APO-RIZATRIPTAN	APX
02380455 JAMP-RIZATRIPTAN	JMF
02429233 JAMP-RIZATRIPTAN IR	JMF
02379651 MAR-RIZATRIPTAN	MAR
10MG TABLET	
02381702 ACT RIZATRIPTAN	TEV
02393476 APO-RIZATRIPTAN	APX
02441144 AURO-RIZATRIPTAN	AUF
02380463 JAMP-RIZATRIPTAN	JMF
02429241 JAMP-RIZATRIPTAN IR	JMF
02379678 MAR-RIZATRIPTAN	MAR
02240521 MAXALT	FRS
5MG TABLET (ORALLY DISINTEGRATING)	
02483270 ACCEL-RIZATRIPTAN ODT	ACF
02393484 APO-RIZATRIPTAN RPD	APX
02465086 JAMP-RIZATRIPTAN ODT	JMF
02462788 MAR-RIZATRIPTAN ODT	MAR
02240518 MAXALT RPD	FRS
02379198 MYLAN-RIZATRIPTAN ODT	MYL
02436604 NAT-RIZATRIPTAN ODT	NPH
02393360 PMS-RIZATRIPTAN RDT	PMS
02442906 RIZATRIPTAN ODT 02446111 RIZATRIPTAN ODT	SAN SIV
02415798 RIZATRIPTAN ODT	PDL
02351870 SANDOZ RIZATRIPTAN ODT	SDZ
02396661 TEVA-RIZATRIPTAN ODT	TEV
10MG TABLET (ORALLY DISINTEGRATING)	12.
02483289 ACCEL-RIZATRIPTAN ODT	ACF
02393492 APO-RIZATRIPTAN RPD	APX
02396203 DOM-RIZATRIPTAN RDT	DPC
02465094 JAMP-RIZATRIPTAN ODT	JMF
02462796 MAR-RIZATRIPTAN ODT	MAR
02240519 MAXALT RPD	FRS
02379201 MYLAN-RIZATRIPTAN ODT	MYL
02436612 NAT-RIZATRIPTAN ODT	NPF
02489384 NRA-RIZATRIPTAN ODT	UNK
02393379 PMS-RIZATRIPTAN RDT	PMS

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28:32.28 SELECTIVE SEROTONIN AGONISTS

RIZATRIPTAN BENZOATE

RIZATRIPTAN BENZUATE	
Limited use benefit (prior approval is not required).	
A total of 12 tablets are permitted in a 30-day period.	
10MG TABLET (ORALLY DISINTEGRATING)	
02442914 RIZATRIPTAN ODT	SAN
02446138 RIZATRIPTAN ODT	SIV
02415801 RIZATRIPTAN RDT	PDL
02351889 SANDOZ RIZATRIPTAN ODT	SDZ
02396688 TEVA-RIZATRIPTAN ODT	TEV
SUMATRIPTAN SUCCINATE	
Limited use benefit with quantity and frequency limits (prior approval is not required).	
Coverage is granted for 2 spacer devices every 12 months.	
6MG/0.5ML INJECTION	
99000598 IMITREX STAT DOSE KIT	GSK
12MG/ML SOLUTION	
02212188 IMITREX	GSK
02361698 TARO-SUMATRIPTAN	TAR
25MG TABLET	
02270749 DOM-SUMATRIPTAN	DPC
02268906 MYLAN-SUMATRIPTAN	MYL
02256428 PMS-SUMATRIPTAN	PMS
02286815 TEVA-SUMATRIPTAN DF	TEV
50MG TABLET	
02268388 APO-SUMATRIPTAN	APX
02270757 DOM-SUMATRIPTAN	DPC
02212153 IMITREX DF	GSK
02268914 MYLAN-SUMATRIPTAN	MYL
02256436 PMS-SUMATRIPTAN	PMS
02263025 SANDOZ SUMATRIPTAN 02286521 SUMATRIPTAN	SDZ SAN
02324652 SUMATRIPTAN	PDL
02385570 SUMATRIPTAN DF	SIV
02286823 TEVA-SUMATRIPTAN DF	TEV
100MG TABLET	
02257904 ACT SUMATRIPTAN	TEV
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 DE	PDL
02385589 SUMATRIPTAN DF	SIV
02239367 TEVA-SUMATRIPTAN 02286831 TEVA-SUMATRIPTAN DF	TEV TEV
02200031 TEVA-30INMINIFIAN DI	IEV

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28:32.28 SELECTIVE SEROTONIN AGONISTS

ZOLMITRIPTAN

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

2.5MG TABLET

DPC
JMP
JMP
MAR
MIN
NPH
PMS
SDZ
TEV
PDL
AZC

2

02438453 AG-ZOLMITRIPTAN ODT	ANG
02381575 APO-ZOLMITRIPTAN RAPID	APX
02428237 JAMP-ZOLMITRIPTAN ODT	JMP
02324768 PMS-ZOLMITRIPTAN ODT	PMS
02362996 SANDOZ ZOLMITRIPTAN ODT	SDZ
02428474 SEPTA-ZOLMITRIPTAN-ODT	SPT
02342545 TEVA-ZOLMITRIPTAN OD	TEV
02379988 ZOLMITRIPTAN ODT	PDL
02442671 ZOLMITRIPTAN ODT	SAN
02243045 ZOMIG RAPIMELT	AZC

28:36.16 ANTIPARKINSONIAN AGENTS - DOPAMINE PRECURSORS LEVODOPA, CARBIDOPA (CARBIDOPA MONOHYDRATE)

Limited use benefit (prior approval required).

Initial coverage criteria (12 months):

For the treatment of patients with advanced levodopa-responsive Parkinson's disease; and

- patient has severe disability associated with at least 25% of the waking day in the off state*;and/or
- patient has ongoing, bothersome levodopa-induced dyskinesias, despite having tried frequent dosing of levodopa (at least five doses per day); and
- patient has failed an adequate trial of adjunctive medications if not contraindicated or contrary to judgement of prescriber; and
- patient is able to administer the medication and care for the administration port and infusion pump. Or alternatively, trained personnel or a care partner must be available to perform these tasks reliably; and
- patient does not have a contraindication to the insertion of a percutaneous endoscopic gastrostomy-jejunostomy (PEG-J tube); and
- patient does not have severe psychosis or dementia.

Criteria for renewal or for initial NIHB coverage in patients currently maintained on Duodopa (12 months):

- patient continues to demonstrate a significant reduction in the time spent in the off state; and/or
- patient has had a decrease in bothersome levodopa-induced dyskinesias.

20MG & 5MG GEL

02292165 DUODOPA **ABV**

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^{*} Time in the off state, frequency of motor fluctuations, and severity of associated disability should be assessed by a movement disorder subspecialist and be based on an adequate and reliable account from longitudinal specialist care, clinical interview of a patient and/or care partner, or motor symptom diary.

28:36.20 ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR AGONISTS APOMORPHINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the acute, intermittent treatment of hypomobility "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) in patients with advanced Parkinson's disease (PD);

and

Patient is under the care of a physician with experience in the diagnosis and management of PD;

and

Apomorphine (Movapo) is being used as adjunctive therapy in patients who are receiving optimized PD therapy (levodopa and derivatives and dopaminergic agonists) and still experiencing "off" episodes.

10MG SOLUTION

02459132 MOVAPO PAL

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

02455897 APO-CABERGOLINE APX
02242471 DOSTINEX PFI

ROTIGOTINE

Limited use benefit (prior approval required).

As an adjunct to levodopa for the treatment of patients with advanced stage Parkinson's disease; and Patient is currently receiving treatment with levodopa.

2MG PATCH

02403900 NEUPRO UCB

4MG PATCH

02403927 NEUPRO UCB

6MG PATCH

02403935 NEUPRO UCB

8MG PATCH

02403943 NEUPRO UCB

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
02467747 ATOMOXETINE	SAN
02471485 AURO-ATOMOXETINE	AUR
02390469 DOM-ATOMOXETINE	DPC
02381028 PMS-ATOMOXETINE	PMS
02405962 RIVA-ATOMOXETINE	RIV

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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

10MG CAPSULE	
02386410 SANDOZ ATOMOXETINE	SDZ
02262800 STRATTERA	LIL
02314541 TEVA-ATOMOXETINE	TEV
18MG CAPSULE	
02318032 APO-ATOMOXETINE	APX
02358204 ATOMOXETINE	AAP
02396912 ATOMOXETINE	PDL
02445905 ATOMOXETINE	SIV
02467755 ATOMOXETINE	SAN
02471493 AURO-ATOMOXETINE	AUR
02390477 DOM-ATOMOXETINE	DPC
02381036 PMS-ATOMOXETINE	PMS
02405970 RIVA-ATOMOXETINE	RIV
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
02467763 ATOMOXETINE	SAN
02471507 AURO-ATOMOXETINE	AUR
02390485 DOM-ATOMOXETINE	DPC
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
02467771 ATOMOXETINE	SAN
02471515 AURO-ATOMOXETINE	AUR
02390493 DOM-ATOMOXETINE	DPC
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

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LIL

TEV

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

02396947 ATOMOXETINE	PDL
02445956 ATOMOXETINE	SIV
02467798 ATOMOXETINE	SAN
02471523 AURO-ATOMOXETINE	AUR
02390515 DOM-ATOMOXETINE	DPC
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
02467801 ATOMOXETINE	SAN
02471531 AURO-ATOMOXETINE	AUR
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
02467828 ATOMOXETINE	SAN
02404672 PMS-ATOMOXETINE	PMS
02422832 RIVA-ATOMOXETINE	RIV
02386488 SANDOZ ATOMOXETINE	SDZ

DIMETHYL FUMARATE

Limited use benefit (prior approval required).

02279355 STRATTERA

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

02362538 TEVA-ATOMOXETINE

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

120MG CAPSULE (DELAYED RELEASE)

02404508 TECFIDERA UNK

240MG CAPSULE (DELAYED RELEASE)

02420201 TECFIDERA UNK

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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

99400482 NOVA-T BEX

36:00 DIAGNOSTIC AGENTS (DX)

36:00.00 DIAGNOSTIC AGENTS (DX)

COAGULATION MONITORS

Limited use benefit (prior approval required).

For monitoring the international normalized ratio (INR) in patients who require long-term oral anticoagulation.

· client has difficulty accessing laboratory-based INR testing.

Coverage is limited to 1 meter every 2 years.

DEVICE

97499983 COAGUCHEK INRANGE METER 97499986 COAGUCHEK XS KIT ROD

ROD

COAGULATION TEST

Limited use benefit (prior approval required).

For monitoring the international normalized ratio (INR) in patients who require long-term oral anticoagulation.

client has difficulty accessing laboratory-based INR testing.

STRIP

97499988 COAGUCHEK XS PT STRIPS 24 97499987 COAGUCHEK XS PT STRIPS 48 97499989 COAGUCHEK XS PT STRIPS 6

ROD

ROD

ROD

LANCET

Limited use benefit (prior approval not required).

The number of lancets that will be covered by the NIHB Program will depend on the client's medical treatment:

- clients managing diabetes with insulin will be allowed 800 lancets per 100 days.
- clients managing diabetes with high risk of causing hypoglycemia will be allowed 400 lancets per 365 days.
- clients managing diabetes medication with low risk of causing hypoglycemia will be allowed 200 lancets per 365 days.
- clients managing diabetes through diet/lifestyle therapy only (no insulin or anti-diabetes medications) will be allowed 200 lancets per 365 days.

Please note that the test strip limit is 800/100 days. Due to lancet pack sizes, 800 per 100 days will be reimbursed.

LANCET

97499991 COAGUCHEK LANCETS

ROD

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 800 test strips per 100 days. A client can test up to eight 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.
- non-diabetic clients with rare conditions leading to symptomatic hypo or hyperglycemia will be allowed 800 test strips per 100 days.

STRIP

 09857563 ACCU-CHEK GUIDE (ON)
 ROD

 97799177 ACCU-CHEK GUIDE (SK)
 ROD

ACCU-CHEK ADVANTAGE STRIP

09853626 ACCU-CHEK ADVANTAGE ROD

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36:26.00 DX - DIABETES MELLITUS

GLUCOSE OXIDASE, PEROXIDASE

Limited use benefit (prior approval not required).

ACCII CHEK ADVANTACE STRIP

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 800 test strips per 100 days. A client can test up to eight 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.
- non-diabetic clients with rare conditions leading to symptomatic hypo or hyperglycemia will be allowed 800 test strips per 100 days.

ACCU-CHEK ADVANTAGE STRIP	
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	
97799748 ASCENSIA BREEZE 2	BAY
09857293 BREEZE 2 BG (ON)	BAY
ASCENSIA CONTOUR STRIP	
97799702 ASCENCIA CONTOUR	BAY
09857127 CONTOUR BG (ON)	BAY
BG STAR STRIP	
97799465 BG STAR	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
09857525 GE200 (ON)	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 800 test strips per 100 days. A client can test up to eight 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
- 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.
- non-diabetic clients with rare conditions leading to symptomatic hypo or hyperglycemia will be allowed 800 test strips per 100 days.

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

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UNK

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:10.20

BENRALIZUMAB

Limited use benefit (prior approval required).

Initial coverage criteria (12 months):

For the adjunctive treatment of severe eosinophilic asthma in adults who are inadequately controlled with high-dose inhaled corticosteroids* plus one or more additional asthma controller(s) (e.g. long-acting beta-agonist); and

- patient has had a blood eosinophil count of ≥0.15x109/L before initiation of benralizumab; and
- patient is receiving maintenance treatment with oral corticosteroids (at a dose equivalent to ≥5mg prednisone per day) prior to starting benralizumab;
- or
- patient has had a blood eosinophil count of ≥0.3x109/L within the 12-month period prior to starting benralizumab; and
- patient has experienced two or more clinically significant asthma exacerbations** within the 12-month period prior to starting benralizumab;
- and
- a baseline assessment of asthma symptom control using a validated asthma control questionnaire has been completed prior to the initiation of benralizumab; and
- patient is managed by a physician with expertise in the treatment of asthma.

Coverage for benralizumab is provided for a maximum dose of 30 mg administered subcutaneously once every 4 weeks for the first 3 doses, then once every 8 weeks thereafter.

Fasenra will not be funded as a dual therapy with another biologic for the treatment of asthma.

Patients will be permitted to switch from one biologic agent to another following an adequate trial of the first biologic agent if unresponsive to therapy, or due to serious adverse effects or contraindications. An adequate trial is defined as at a minimum the completion of induction dosing (e.g. initial coverage period). Patients will not be permitted to switch back to a previously trialed biologic agent if they were deemed unresponsive to therapy.

Criteria for renewal or for initial NIHB coverage in patients currently maintained on Fasenra (12 months):

- patient has not experienced an increase in clinically significant asthma exacerbations** with benralizumab treatment; and
- for patients receiving maintenance oral corticosteroids, patient's oral corticosteroid maintenance dose has decreased from the pre-treatment dose. After the first 12 months, subsequent oral corticosteroid dose should be maintained; and
- the 12-month asthma control questionnaire score has improved from baseline, where baseline represents the initiation of treatment. After the first 12 months, subsequent scores should be maintained.
- * High-dose inhaled corticosteroid is defined as ≥ 500mcg of fluticasone propionate or equivalent daily.
- ** A clinically significant asthma exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized.

30MG SOLUTION

02473232 FASENRA AZC

40:18.19 PHOSPHATE - REMOVING AGENTS

IRON (SUCROFERRIC OXYHYDROXIDE)

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.

500MG TABLET (CHEWABLE)

02471574 VELPHORO UNK

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

500MG TABLET (CHEWABLE)

02287153 FOSRENOL UNK

750MG TABLET (CHEWABLE)

02287161 FOSRENOL UNK

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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.

1000MG TABLET (CHEWABLE)

02287188 FOSRENOL UNK

SEVELAMER CARBONATE

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

02461501 ACCEL-SEVELAMER
02354586 RENVELA
SAC

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 SOLUTION

02492105 ODAN LEVOCARNITINE ODN

100MG/ML SOLUTION

02144336 CARNITOR UNK

200MG/ML SOLUTION

02144344 CARNITOR UNK

330MG TABLET

02144328 CARNITOR UNK

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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:

- dagnosis 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 ≥ 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 ≥ 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 ≥ 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 ≥ 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

267MG TABLET

02464489 ESBRIET HLR

801MG TABLET

02464500 ESBRIET HLR

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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.

Montelukast is open benefit for children up to 17 years of age.	
ST 4MG GRANULES	
02358611 SANDOZ MONTELUKAST	SDZ
02247997 SINGULAIR	FRS
ST 10MG TABLET	
02374609 APO-MONTELUKAST	APX
02401274 AURO-MONTELUKAST	AUR
02445735 BIO-MONTELUKAST	UNK
02376695 DOM-MONTELUKAST	DPC
02391422 JAMP-MONTELUKAST	JMP
02399997 MAR-MONTELUKAST	MAR
02408643 MINT-MONTELUKAST	MIN
02379333 MONTELUKAST	SAN
02379856 MONTELUKAST	PDL
02382474 MONTELUKAST	SIV
02379236 MONTELUKAST SODIUM	ACC
02489821 NRA-MONTELUKAST	UNK
02373947 PMS-MONTELUKAST	PMS
02389517 RAN-MONTELUKAST	RBY
02398826 RIVA-MONTELUKAST	RIV
02328593 SANDOZ MONTELUKAST	SDZ FRS
02238217 SINGULAIR 02355523 TEVA-MONTELUKAST	TEV
4MG TABLET (CHEWABLE)	TEV
` ,	ARY
02377608 APO-MONTELUKAST 02422867 AURO-MONTELUKAST	APX AUR
02442353 JAMP-MONTELUKAST	JMP
02399865 MAR-MONTELUKAST	MAR
02408627 MINT-MONTELUKAST	MIN
02379821 MONTELUKAST	PDL
02382458 MONTELUKAST	SIV
02354977 PMS-MONTELUKAST	PMS
02402793 RAN-MONTELUKAST	RBY
02330385 SANDOZ MONTELUKAST	SDZ
02243602 SINGULAIR	FRS
02355507 TEVA-MONTELUKAST	TEV
ST 5MG TABLET (CHEWABLE)	
02377616 APO-MONTELUKAST	APX
02422875 AURO-MONTELUKAST	AUR
02442361 JAMP-MONTELUKAST	JMP
02399873 MAR-MONTELUKAST	MAR
02408635 MINT-MONTELUKAST	MIN
02379848 MONTELUKAST	PDL
02382466 MONTELUKAST	SIV
02354985 PMS-MONTELUKAST	PMS
02402807 RAN-MONTELUKAST	RBY
02330393 SANDOZ MONTELUKAST	SDZ

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BAY

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.

Montelukast is open benefit for children up to 17 years of age.

ST 5MG TABLET (CHEWABLE)

02238216 SINGULAIR FRS
02355515 TEVA-MONTELUKAST TEV

48:48.00 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.

ST 5MG TABLET

02475375 APO-AMBRISENTAN APX

ST 10MG TABLET

02475383 APO-AMBRISENTAN APX

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.

ST 125MG TABLET

02399210 APO-BOSENTAN APX

RIOCIGUAT

Limited use benefit (prior approval required).

For the treatment of patients 18 years of age or older with chronic thromboembolic pulmonary hypertension (CTEPH) with World Health Organization (WHO) Functional Class 2 or 3 pulmonary hypertension with:

- inoperable CTEPH, World Health Organization (WHO) Group 4;
- or
- persistent or recurrent CTEPH after surgical treatment; and
- prescriber experienced in the diagnosis and treatment of CTEPH.

0.5MG TABLET

02412810 ADEMPAS

 02412764 ADEMPAS
 BAY

 1MG TABLET
 02412772 ADEMPAS
 BAY

 1.5MG TABLET
 02412799 ADEMPAS
 BAY

 2MG TABLET
 02412802 ADEMPAS
 BAY

 2.5MG TABLET
 BAY

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JSO

48:48.00 VASODILATING AGENTS

SELEXIPAG

Limited use benefit (prior approval required).

For the treatment of adult patients with World Health Organization (WHO) functional class (FC) II to III pulmonary arterial hypertension (PAH), including idiopathic PAH, heritable PAH, PAH associated with connective tissue disorders or PAH associated with congenital heart disease:

- patient is under the care of a physician with experience in the diagnosis and treatment of PAH; and
- patient has failed to respond to first- and second-line PAH therapies; or
- patient has contraindications/intolerance to first- and second-line PAH therapies.

200MCG	TABLET
--------	--------

02451158 UPTRAVI	JSO
400MCG TABLET	
02451166 UPTRAVI	JSO
600MCG TABLET	
02451174 UPTRAVI	JSO
800MCG TABLET	
02451182 UPTRAVI	JSO
1000MCG TABLET	
02451190 UPTRAVI	JSO
1200MCG TABLET	
02451204 UPTRAVI	JSO
1400MCG TABLET	
02451212 UPTRAVI	JSO
1600MCG TABLET	

48:92.00 MISCELLANEOUS RESPIRATORY TRACT AGENTS

OMALIZUMAB

Limited use benefit (prior approval required).

02451220 UPTRAVI

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).

1. 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).

- 2. 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 ≥ 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; or For use in immunocompromised patients who are at risk of mucosal breakdown.

0.15% MOUTHWASH

02239044 APO-BENZYDAMINE APX
02229777 PHARIXIA PED

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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; or For use in immunocompromised patients who are at risk of mucosal breakdown.

0.15% MOUTHWASH

02239537 PMS-BENZYDAMINE

PMS

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

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NVR

NVR

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 02425629 LUCENTIS PFS

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 CHE

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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 SUSPENSION

02097079 PEPTO-BISMOL PGI

262MG TABLET

02326582 BISMUTH SUBSALICYLATE UNK
02177994 PEPTO BISMOL PGI

56:22.00 ANTIEMETICS

NETUPITANT, PALONOSETRON (PALONOSETRON HYDROCHLORIDE)

Limited use benefit (prior approval required).

When used in combination with dexamethasone for the prevention of acute and delayed nausea and vomiting due to highly emetogenic cancer chemotherapy (eg. cisplatin > 70mg/m2).

ST 300MG & 0.5MG CAPSULE

02468735 AKYNZEO PFR

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 TABLET

02241532 ANTI-NAUSEANT	VTH
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).

80MG CAPSULE

02298791 EMEND FRS

ST 125MG CAPSULE

02298805 EMEND FRS

ST 125MG & 80MG CAPSULE

02298813 EMEND TRI-PACK FRS

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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 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.

ST 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
02422808 RIVA-LANSOPRAZOLE	RIV
02385643 SANDOZ LANSOPRAZOLE	SDZ
02402610 TARO-LANSOPRAZOLE	SUN
02280515 TEVA-LANSOPRAZOLE	TEV
ST 30MG CAPSULE (DELAYED RELEASE)	
02293838 APO-LANSOPRAZOLE	APX
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
02422816 RIVA-LANSOPRAZOLE	RIV
02402629 TARO-LANSOPRAZOLE	SUN
02280523 TEVA-LANSOPRAZOLE	TEV
ST 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.

ST 15MG TABLET (DELAYED RELEASE)

02249464 PREVACID FASTAB

TAK

ST 30MG TABLET (DELAYED RELEASE)

02249472 PREVACID FASTAB

TAK

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
- 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 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.

ST 20MG CAPSULE (DELAYED RELEASE)

02	2245058	APO-OMEPRAZOLE	APX
00	0846503	LOSEC	AZC
02	2339927	OMEPRAZOLE	PDL
02	2348691	OMEPRAZOLE	SAN
02	2411857	OMEPRAZOLE-20	SIV
02	2320851	PMS-OMEPRAZOLE	PMS
02	2403617	RAN-OMEPRAZOLE	RBY
02	2296446	SANDOZ OMEPRAZOLE	SDZ
20N	IG TABL	LET (DELAYED RELEASE)	
02	2449927	BIO-OMEPRAZOLE	BMI
02	2420198	JAMP-OMEPRAZOLE DR	JMP
02	2190915	LOSEC	AZC

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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
- 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 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.

20MG TABLET (DELAYED RELEASE)

02439549 NAT-OMEPRAZOLE DR	NPH
02416549 OMEPRAZOLE	ACC
02374870 RAN-OMEPRAZOLE	RBY
02402416 RIVA-OMEPRAZOLE DR	RIV
02295415 TEVA-OMEPRAZOLE	TEV

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 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.

ST 40MG TABLET (DELAYED RELEASE)

02466147 PANTOPRAZOLE T

\$7
40MG TABLET (ENTERIC COATED)

02408570 MYLAN-PANTOPRAZOLE T

02441853 PANTOPRAZOLE MAGNESIUM

02267233 TECTA

02440628 TEVA-PANTOPRAZOLE MAGNESIUM

TEV

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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.

All proton pump inhibitors (open benefit and limited use 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.

40MG TABLET (DELAYED RELEASE)

02478781 AG-PANTOPRAZOLE	ANG
02292920 APO-PANTOPRAZOLE	APX
02415208 AURO-PANTOPRAZOLE	AUR
02445867 BIO-PANTOPRAZOLE	ВМІ
02357054 JAMP-PANTOPRAZOLE	JMP
02416565 MAR-PANTOPRAZOLE	MAR
02417448 MINT-PANTOPRAZOLE	MIN
02467372 M-PANTOPRAZOLE	MAN
02229453 PANTOLOC	TAK
02318695 PANTOPRAZOLE	PDL
02370808 PANTOPRAZOLE	SAN
02431327 PANTOPRAZOLE	RIV
02437945 PANTOPRAZOLE	PMS
02439107 PANTOPRAZOLE	DPC
02428180 PANTOPRAZOLE-40	SIV
02307871 PMS-PANTOPRAZOLE	PMS
02425378 PRIVA-PANTOPRAZOLE	PHA
02305046 RAN-PANTOPRAZOLE	RBY
02316463 RIVA-PANTOPRAZOLE	RIV
02301083 SANDOZ PANTOPRAZOLE	SDZ
02285487 TEVA-PANTOPRAZOLE	TEV

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RBY

SDZ 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
- double dose PPI is not necessary for initial therapy

02298082 RAN-RABEPRAZOLE

02296640 TEVA-RABEPRAZOLE

02314185 SANDOZ RABEPRAZOLE

• 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 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.

ST 10MG TABLET (ENTERIC COATED) 02345579 APO-RABEPRAZOLE APX 02243796 PARIET JSO 02310805 PMS-RABEPRAZOLE **PMS** 02315181 PRO-RABEPRAZOLE PDL 02385449 RABEPRAZOLE SIV 02356511 RABEPRAZOLE EC SAN 02298074 RAN-RABEPRAZOLE **RBY** 02314177 SANDOZ RABEPRAZOLE SD7 02296632 TEVA-RABEPRAZOLE TEV ST 20MG TABLET (ENTERIC COATED) 02320460 DOM-RABEPRAZOLE EC DPC JSO 02243797 PARIFT 02310813 PMS-RABEPRAZOLE **PMS** 02315203 PRO-RABEPRAZOLE **PDL** 02385457 RABEPRAZOLE SIV 02356538 RABEPRAZOLE EC SAN

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56:92.00 MISCELLANEOUS GI DRUGS

OBETICHOLIC ACID

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

The patient has a confirmed diagnosis of primary biliary cholangitis (PBC), defined as:

- positive antimitochondrial antibodies (AMA); or
- liver biopsy results consistent with PBC.
- $\bullet \text{ and }$

The patient is under the care of a gastroenterologist, hepatologist or internal medicine specialist with experience in the treatment of PBC.

The patient has received ursodeoxycholic acid (UDCA) for a minimum of 12 months and has experienced an inadequate response to UDCA and can benefit from the addition of obeticholic acid. An inadequate response is defined as:

- alkaline phosphatase (ALP) ≥ 1.67 x upper limit of normal (ULN); and/or
- bilirubin > ULN and < 2 x ULN; and/or
- evidence of compensated cirrhosis by fibroscan or biopsy.
- or

The patient has experienced documented and unmanageable intolerance to UDCA.

Criteria for renewal every 12 months:

The patient continues to benefit from treatment with obeticholic acid as evidenced by:

- a reduction in the ALP level to less than 1.67 x ULN; or
- a 15% reduction in the ALP level compared with values before beginning treatment with obeticholic acid.

5MG TABLET

02463121 OCALIVA UNK

10MG TABLET

02463148 OCALIVA UNK

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

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56:92.00 MISCELLANEOUS GI DRUGS

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; and
- 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 ≥ 2 points.

300MG POWDER FOR SOLUTION

02436841 ENTYVIO TAK

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04.00 ADRENALS

FLUTICASONE FUROATE, UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE

Limited use benefit (prior approval required).

For the maintenance treatment of chronic obstructive pulmonary disease (COPD) including chronic bronchitis and/or emphysema who meet the following criteria:

- patients are not started on triple inhaled therapy as initial therapy for COPD; and
- patients have had an inadequate response to optimal dual-inhaled therapy* for COPD.

*Dual-inhaled therapy refers to any combination of a long-acting muscarinic antagonist (LAMA), long-acting beta-2 agonist (LABA) or an inhaled corticosteroid (ICS).

100MCG & 62.5MCG & 25MCG POWDER

02474522 TRELEGY ELLIPTA

GSK

68:08.00 ANDROGENS

TESTOSTERONE (TOPICAL)

Limited use benefit (prior approval required).

The NIHB Program covers topical testosterone for the treatment of the following:

- orchiectomy, undescended testes, Klinefelter's; or
- pituitary tumour or post-pituitary surgery with low testosterone; or
- AIDS-wasting syndrome with low testosterone; or
- gender affirming hormone therapy.

Note: Older individuals with non-specific symptoms such as, but not limited to, fatigue, malaise, or depression who have a low random testosterone level do not meet coverage criteria.

1% GEL

12 FMC GEI	
02280248 TESTIM	PAL
02463806 TARO-TESTOSTERONE	TAR
02463792 TARO-TESTOSTERONE	TAR
02245346 ANDROGEL	BGP
02245345 ANDROGEL	BGP

12.5MG GEL

02249499 ANDROGEL BGP

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68:08.00 ANDROGENS

TESTOSTERONE (TOPICAL)

Limited use benefit (prior approval required).

The NIHB Program covers topical testosterone for the treatment of the following:

- orchiectomy, undescended testes, Klinefelter's; or
- pituitary tumour or post-pituitary surgery with low testosterone; or
- · AIDS-wasting syndrome with low testosterone; or
- gender affirming hormone therapy.

Note: Older individuals with non-specific symptoms such as, but not limited to, fatigue, malaise, or depression who have a low random testosterone level do not meet coverage criteria.

2.5MG PATCH

02239653 ANDRODERM ALL

5MG PATCH

02245972 ANDRODERM ALL

68:12.00 CONTRACEPTIVES

ULIPRISTAL ACETATE

Limited use benefit (prior approval not required).

For the preoperative treatment of moderate-to-severe signs and symptoms of uterine fibroids in adult clients of reproductive age; and for the intermittent treatment of moderate-to-severe signs and symptoms of uterine fibroids in adult clients of reproductive age who are not eligible for surgery, with the duration of each treatment course being three months, if the following conditions are met:

- the patient is under the care of an obstetrician/gynecologist.
- patients receiving ulipristal acetate should have their liver function tests monitored before, during, and after treatment.

Coverage will be limited to a maximum of four courses of therapy for clients aged 18 to 60 years.

ST 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 clients who experience failure on bisphosphonates; or

For secondary prevention of osteoporosis in clients who have a personal history or a first degree relative with a history of breast cancer.

60MG TABLET

 02358840 ACT RALOXIFENE
 TEV

 02279215 APO-RALOXIFENE
 APX

 02239028 EVISTA
 LIL

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.

ST 25MG TABLET

02388839 JANUVIA FRS

ST 50MG TABLET

02388847 JANUVIA FRS

ST 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.

50MG & 1000MG TABLET 50MG & 1000MG TABLET

02333872 JANUMET FRS

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68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

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.

ST 50MG & 500MG TABLET

02333856 JANUMET FRS

50MG & 850MG TABLET

02333864 JANUMET FRS

ST 50MG & 1000MG TABLET (EXTENDED RELEASE)

02416794 JANUMET XR FRS

ST 50MG & 500MG TABLET (EXTENDED RELEASE)

02416786 JANUMET XR FRS

ST 100MG & 1000MG TABLET (EXTENDED RELEASE)

02416808 JANUMET XR FRS

68:20.06 INCRETIN MIMETICS

SEMAGLUTIDE

Open benefit.

For the treatment of type 2 diabetes in combination with metformin alone, when diet and exercise plus maximal tolerated dose of metformin do not achieve adequate glycemic control.

1MG SOLUTION

02471469 OZEMPIC NOO

1.34MG SOLUTION

02471477 OZEMPIC NOO

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.

ST 100MG TABLET

02425483 INVOKANA JSO

ST 300MG TABLET

02425491 INVOKANA JSO

EMPAGLIFLOZIN

Open benefit.

For the treatment of type 2 diabetes mellitus:

- in patients who did not achieve glycemic control with an adequate trial of metformin and a sulfonylurea; or
- to reduce the incidence of cardiovascular death in patients with established cardiovascular disease who did not achieve adequate glycemic control despite an appropriate trial of metformin

Established cardiovascular disease is defined as one of the following:

- history of myocardial infarction
- multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status)
- single-vessel coronary artery disease with significant stenosis and either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina
- unstable angina with confirmed evidence of coronary multi-vessel or single-vessel disease
- history of ischemic or hemorrhagic stroke
- occlusive peripheral artery disease.

ST 10MG TABLET

02443937 JARDIANCE BOE

ST 25MG TABLET

02443945 JARDIANCE BOE

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68:20.18 SODIUM-GLUCOSE CONTRANSPORTER 2 (SGLT2) INHIBITORS METFORMIN HYDROCHLORIDE, EMPAGLIFLOZIN

Open benefit. For the treatment of patients with type 2 diabetes mellitus in patients who are eligible to receive metformin and empagliflozin, to replace the individual components. **500MG & 12.5MG TABLET** 02456605 SYNJARDY BOE **500MG & 5MG TABLET** 02456575 SYNJARDY BOE 850MG & 12.5MG TABLET 02456613 SYNJARDY BOE 850MG & 5MG TABLET 02456583 SYNJARDY BOE 1000MG & 12.5MG TABLET 02456621 SYNJARDY BOE 1000MG & 5MG TABLET 02456591 SYNJARDY BOE **68:32.00 PROGESTINS DIENOGEST** Limited use benefit (prior approval required). For the management of pelvic pain associated with endometriosis. $^{\it ST}$ 2MG TABLET 02493055 ASPEN-DIENOGEST UNK 02374900 VISANNE **BAY PROGESTERONE**

Limited use benefit (prior approval required).

For the treatment of clients:

- 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.

In adults

• for use as Gender Affirming Hormone Therapy.

100MG CAPSULE

PMS
FRS
REC
TEV

84:00 SKIN AND MUCOUS MEMBRANE AGENTS (SMMA)

84:08.00 SMMA - ANTIPRURITICS AND LOCAL ANESTHETICS

LIDOCAINE

Limited use benefit (prior approval not required).

Coverage will be limited to 35 grams every 30 days.

5% OINTMENT

02386836 JAMPOCAINE	JMP
01963988 LIDODAN	ODN
02083795 LIDODAN	ODN
00001961 XYLOCAINE	UNK

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84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS BRODALUMAB

Limited use benefit (prior approval required).

For psoriasis, coverage is provided for an initial period of 12 weeks at a dose of 210 mg at week 0, 1, and 2, followed by 210 mg every 2 weeks.

• 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 to16 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.

210MG SOLUTION

02473623 SILIQ VAE

DUPILUMAB

Limited use benefit (prior approval required).

Initial coverage criteria (4 months):

For adult patient with chronic moderate to severe atopic dermatitis who meet all the following criteria:

- patient has a score greater than or equal to 16 on the Eczema Area and Severity Index (EASI); and
- patient has a score greater than or equal to 8 on the Dermatology Life Quality Index (DLQI); and
- body surface area (BSA) of 10% or more is affected; and
- the disease is insufficiently controlled despite the use of topical treatments including at least two medium or high-potency topical corticosteroids and one topical calcineurin inhibitor; and
- intolerance or lack of response to phototherapy or inability to access phototherapy.

Criteria for renewal or for initial coverage in patients currently maintained on Dupixent (12 months):

- patient has an improvement of at least 75% in the EASI score compared to the baseline level; or
- patient has an improvement of at least 50% in the EASI score; and
- patient has had a decrease of at least five points on the DLQI questionnaire compared to the baseline.

150MG SOLUTION

02470365 DUPIXENT SAC

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84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

IXEKIZUMAB

Limited use benefit (prior approval required).

1. For the treatment of moderate to severe psoriatic arthritis

Coverage is provided for an initial period of one year at a dose of 160 mg at Week 0, followed by 80 mg every 4weeks. For psoriatic arthritis patients with coexistent moderate-to-severe psoriasis, coverage is provided for psoriasis dosing: 160 mg at week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks. For psoriatic arthritis patients with coexistent mild plaque psoriasis, coverage is provided for psoriatic arthritis dosing: 160 mg at Week 0, followed by 80 mg 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 (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) ≥ 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 in at least 2 of 4 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 ≥ 30%. A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.
- 2. For psoriasis only, coverage is provided for an initial period of 12 weeks at a dose of 160mg at week 0, followed by 80mg at weeks 2, 4, 6, 8, 10, and 12, then 80mg every 4 weeks.
- 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.

80MG SOLUTION

02455102 TALTZ LIL 02455110 TALTZ LIL LIL

PIMECROLIMUS

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

1% CREAM

02247238 ELIDEL VAE

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84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS **RISANKIZUMAB**

Limited use benefit (prior approval required).

For the treatment of patients with moderate to severe psoriasis

Coverage is provided for an initial period of 16 weeks at a dose of 150 mg at week 0 and 4, followed by 150 mg every 12 weeks.

- 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.

90MG SOLUTION

02487454 SKYRIZI ABV

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84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

Limited use benefit (prior approval required).

1. For the treatment of moderate to severe psoriasis

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

SECUKINUMAB

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.
- 2. For the treatment of moderate to severe psoriatic arthritis

Coverage is provided for an initial period of one year at a dose of 150 mg at weeks 0, 1, 2 and 3, followed by 150 mg per month starting at week 4. If patient is an anti-TNF inadequate responder and continues to have active psoriatic arthritis or has co-existent severe plaque psoriasis, 300 mg per month will be considered.

• 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) ≥ 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 ≥ 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 150 mg at weeks 0, 1, 2 and 3, followed by 150 mg per month starting at week 4.

- 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.

150MG/ML INJECTION

99101215 COSENTYX (STYLO) 09857548 COSENTYX PEN (ON) NVC NVC

150MG SOLUTION

02438070 COSENTYX NVR

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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

86:12.04 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 UNK

15MG TABLET (EXTENDED RELEASE)

02273225 ENABLEX UNK

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.

ST 4MG TABLET (EXTENDED RELEASE)

02380021 TOVIAZ PFI

ST 8MG TABLET (EXTENDED RELEASE)

02380048 TOVIAZ PFI

TROSPIUM 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.

ST 20MG TABLET

02488353 MAR-TROSPIUM MAR
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.

ST 25MG TABLET (EXTENDED RELEASE)

02402874 MYRBETRIQ AST

50MG TABLET (EXTENDED RELEASE)

02402882 MYRBETRIQ AST

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80039441 STRESSTABS FOR WOMEN

80011134 CENTRUM JUNIOR COMPLETE

80020794 CENTRUM JUNIOR COMPLETE

02247995 FLINTSTONES MULTIPLE VITAMINS PLUS IRON

02247975 FLINTSTONES MULTIPLE VITAMINS WITH EXTRA C

ST TABLET (CHEWABLE)

PFI

PFI

PFI

BAY

BAY

88:00 VITAMINS

88:20.00 VITAMIN E

VITAMIN E

Limited use benefit (prior approval required).	
For use in malabsorption	
ST 100IU CAPSULE (SOFTGEL)	
00122823 VITAMIN E	JAM
ST 200IU CAPSULE (SOFTGEL)	
00122831 VITAMIN E	JAM
ST 400IU CAPSULE (SOFTGEL)	
00122858 VITAMIN E	JAM
ST 800IU CAPSULE (SOFTGEL)	
00330191 VITAMIN E	JAM
ST 20U/ML LIQUID	
09991656 AQUA-E/ML	UNK
ST 75U/ML LIQUID	
09991652 AQUA-E	UNK
ST 50IU ORAL LIQUID	
00480215 AQUASOL E	NVC
ST 50IU/ML ORAL LIQUID	
02162075 AQUASOL E VITAMIN E	CLC
88:28.00 MULTIVITAMIN PREPARATIONS	
MULTIVITAMINS (CHILDREN AND YOUTH)	
Limited use benefit (prior approval is not required).	
Multivitamins are benefits for children up to 19 years of age.	
ST DROP	
00762946 ENFAMIL POLYVISOL	MJO
ST 450MG & 10MG & 30MG LIQUID	
80008471 JAMP VITAMIN A, D AND C	JMP
ST 2,500IU & 666.67IU & 50MG/ML LIQUID	
00762903 ENFAMIL TRIVISOL	MJO
02229790 PEDIAVIT	EUR
0MG TABLET	
02246362 CENTRUM	PFI
80021452 CENTRUM	PFI
80024482 CENTRUM FOR WOMEN	PFI
2MG TABLET	
80045908 ONE A DAY WOMEN	BAY

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88:28.00 MULTIVITAMIN PREPARATIONS

MULTIVITAMINS (PRENATAL)

_	- (,		
Limited use benefit	(prior approval is not rec	quired.).		
Prenatal and postna	atal vitamins are benefits	s only for clients of childbearing age (12 to 50 years).	
ST CAPSULE				
80042704	CENTRUM DHA			PFI
ST TABLET				
80045822	CENTRUM PRENA	TAL		PFI
80080882	MATERNA			NES
80082297	MATERNA			NES
80001842	NESTL MATERNA			NES
02241235	PRENATAL AND P	OSTPARTUM VITAMINS AND	MINERALS	VTH
80005770	PRENATAL AND PO	OSTPARTUM VITAMINS AND	MINERALS	PMT
02229535	WAMPOLE COMPL	ETE MULT-PRE AND POST N	ATAL WITH FOLIC ACID	WAM
2MG TABLE	ΕΤ			
80004919	NATURES BOUNT	Y PRENATAL VITAMINS		VTH

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS

EVTEMPODANICALIS MIVTURE (CENTER ACCIDMING)

EXTEMPORANEOUS MIXTURE (GENDER AFFIRMING)	
Limited use benefit (prior approval required).	
For gender affirming hormone therapy.	
INJECTION	
00915312 GENDER AFFIRMING HORMONES	UNK
LIQUID	
00915311 GENDER AFFIRMING TOPICAL HORMONES	UNK
EXTEMPORANEOUS MIXTURE (LU)	
Limited use benefit (prior approval required).	
INJECTION	
99506021 MISCELLANEOUS COMPOUNDED INJECTION/INFUSION	UNK
MISCELLANEOUS	
99504001 MISC LIMITED USE EXTERNAL COMPOUND MIXTURE	UNK
OPHTHALMIC AND OTIC SOLUTION	
99507000 MISCELLANEOUS COMPOUNDED EYE/EAR DROP	UNK
ORAL LIQUID	
99503033 MISC LIMITED USE COMPOUND INTERNAL	UNK
99503032 OPIOID COMPOUNDED	UNK
POWDER	
99504000 MISCELLANEOUS COMPOUNDED EXTERNAL POWDER	UNK
SUPPOSITORY	
99508000 MISCELLANEOUS COMPOUNDED SUPPOSITORY	UNK
EXTEMPORANEOUS MIXTURE (NSAID)	
Limited use benefit (prior approval not required).	

Limited use benefit (prior approval not required). Coverage will be limited to 100 grams every 30 days.

99501007 NSAID IN TRANSDERMAL BASE UNK **OINTMENT**

99501009 TRANSDERMAL LIDOCAINE W/NSAID UNK

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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 ≤ 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 PASI score; or
- a ≥ 50% reduction in the PASI score with a ≥ 5-point improvement in the DLQI; or
- a significant reduction in 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

92:01.28

MULTIVITAMINS (PRENATAL)

Limited use benefit (prior approval is not required.).

Prenatal and postnatal vitamins are benefits only for clients of childbearing age (12 to 50 years).

ST CAPSULE

80081007 MATERNA PRENATAL DHA

NES

92:16.00 ANTIGOUT AGENTS

FEBUXOSTAT

Limited use benefit (prior approval required).

For patients with symptomatic gout who have documented hypersensitivity to allopurinol.

80MG TABLET

 02490870 JAMP FEBUXOSTAT
 JMP

 02473607 MAR-FEBUXOSTAT
 MAR

 02466198 TEVA-FEBUXOSTAT
 TEV

 02357380 ULORIC
 TAK

92:20.00 IMMUNOMODULAROTY AGENTS

FINGOLIMOD (FINGOLIMOD HYDROCHLORIDE)

Limited use benefit (prior approval required).

Initial Coverage (one year):

For the treatment of patients with Relapsing Remitting Multiple Sclerosis (RRMS) who meet all of the following criteria:

- failure to respond to full and adequate courses of at least one initial disease-modifying therapy (an interferon, glatiramer acetate, dimethyl fumarate, ocrelizumab or teriflunomide) or documented intolerance to at least 2 therapies; and
- one or more clinically disabling relapses in the previous year; and
- significant increase in T2 lesion load compared with that from a previous MRI scan or at least one gadolinium-enhancing lesion; and
- requested and followed by a neurologist experienced in the management of RRMS; and
- recent Expanded Disability Status Scale (EDSS) score.

Renewal Coverage (two years):

- EDSS scores must be provided (exam must have occurred within that last 90 days).
- patients must be stable or have experienced no more than 1 disabling attack/relapse in the past year.

0.5MG CAPSULE

02475669 ACH-FINGOLIMOD ACC
02469936 APO-FINGOLIMOD APX

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92:20.00 IMMUNOMODULAROTY AGENTS

FINGOLIMOD (FINGOLIMOD HYDROCHLORIDE)

Limited use benefit (prior approval required).

Initial Coverage (one year):

For the treatment of patients with Relapsing Remitting Multiple Sclerosis (RRMS) who meet all of the following criteria:

- failure to respond to full and adequate courses of at least one initial disease-modifying therapy (an interferon, glatiramer acetate, dimethyl fumarate, ocrelizumab or teriflunomide) or documented intolerance to at least 2 therapies; and
- one or more clinically disabling relapses in the previous year; and
- significant increase in T2 lesion load compared with that from a previous MRI scan or at least one gadolinium-enhancing lesion; and
- requested and followed by a neurologist experienced in the management of RRMS; and
- recent Expanded Disability Status Scale (EDSS) score.

Renewal Coverage (two years):

- EDSS scores must be provided (exam must have occurred within that last 90 days).
- patients must be stable or have experienced no more than 1 disabling attack/relapse in the past year.

0.5MG CAPSULE

02365480 GILENYA	NVR
02487772 JAMP FINGOLIMOD	JMP
02474743 MAR-FINGOLIMOD	MAR
02469715 MYLAN-FINGOLIMOD	MYL
02469782 PMS-FINGOLIMOD	PMS
02482606 SANDOZ FINGOLIMOD	SDZ
02469618 TARO-FINGOLIMOD	TAR
02469561 TEVA-FINGOLIMOD	TEV

GLATIRAMER ACETATE

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

20MG SOLUTION

02245619 COPAXONE TEV 02460661 GLATECT PMS

INTERFERON BETA-1A

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

30MCG INJECTION

09857395 AVONEX PEN 99100763 AVONEX PEN	UNK UNK
60MCG POWDER FOR SOLUTION	
02267594 AVONEX	UNK
22MCG SOLUTION	
02237319 REBIF	SRO
30MCG SOLUTION	
02269201 AVONEX	UNK
44MCG SOLUTION	
02237318 REBIF	SRO
02237320 REBIF	SRO

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92:20.00 IMMUNOMODULAROTY AGENTS

INTERFERON BETA-1A

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

66MCG SOLUTION

SRO 02318253 REBIE

132MCG SOLUTION

02318261 REBIF SRO 02318288 REBIF SRO

INTERFERON BETA-1B

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

0.3MG INJECTION

99100555 BETASERON INITIATION KIT BAY 0.3MG POWDER FOR SOLUTION

02169649 BETASERON BAY 02337819 EXTAVIA **NVR**

OCRELIZUMAB

Limited use benefit (prior approval required).

- 1. For the treatment of relapsing-remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence who meet all of the following criteria:
- prescribed by a neurologist experienced in the management of RRMS; and
- patient has had a clinical relapse* and/or new MRI activity** in the last two years; and
 patient is fully ambulatory for 100 meters without aids. Expanded Disability Status Scale score (EDSS) of 5.5 or less.
- patient is 18 years of age or older.
- *. A clinical relapse is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 24 hours in the absence of fever, preceded by stability for at least one month
- **. MRI activity is defined as any new multiple sclerosis lesion/s, expanding lesion/s, and/or enhancing lesion/s.

- 2. For the treatment of primary progressive multiple sclerosis (PPMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence who meet all of the following criteria: Initial Coverage (one year)
- prescribed by a neurologist experienced in the management of PPMS; and
- expanded Disability Status Scale (EDSS) between 3.0 and 6.5; and
- score of at least 2.0 on the Functional Systems scale (FSS) for the pyramidal system due to lower extremity findings; and
- disease duration of less than 15 years for those with an EDSS greater than 5.0 or less than 10 years for those with an EDSS of 5.0 of less; and
- patient is 18 years of age or older.

Renewal Coverage for PPMS (one year):

• EDSS of less than 7.0.

30MG SOLUTION

02467224 OCREVUS HI R

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92:20.00 IMMUNOMODULAROTY AGENTS

TERIFLUNOMIDE

Limited use benefit (prior approval required).

As a first-line therapy for the treatment of relapsing remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist experienced in the management of RRMS.

And for patients who meet all of the following criteria:

- patient has had a clinical relapse and/or new MRI activity in the last two years; and
- patient is fully ambulatory for 100 meters without aids; and
- patient is 18 years of age or older.

14MG TABLET

02416328 AUBAGIO GEE

92:24.00 BONE RESORPTION INHIBITORS

DENOSUMAB (PROLIA)

Limited use benefit (prior approval required).

For the treatment of osteoporosis in patients who have a significant fracture risk defined as either:

- moderate 10-year fracture risk (10% to 20%) with a prior fragility fracture; or
- high 10-year fracture risk (≥ 20%);
- and
- have a contraindication to oral bisphosphonates (e.g. hypersensitivity, esophageal abnormality, renal impairment); or
- have failed or have an intolerance to oral bisphosphonates (e.g. hypersensitivity, esophageal abnormality, renal impairment).

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).

Maximum dose covered is 5mg per 12-month period

For the treatment of Paget's disease; or

For the treatment of osteoporosis in patients who have a significant fracture risk defined as either:

- moderate 10-year fracture risk (10% to 20%) with a prior fragility fracture; or
- high 10-year fracture risk (≥ 20%); and
- have a contraindication to oral bisphosphonates (e.g. hypersensitivity, esophageal abnormality, renal impairment);or
- have failed or have an intolerance to oral bisphosphonates (e.g. hypersensitivity, esophageal abnormality, renal impairment)

5MG/100ML SOLUTION

 02269198 ACLASTA
 NVR

 02415100 TARO-ZOLEDRONIC ACID
 TAR

 02422433 ZOLEDRONIC ACID
 REC

92:32.00

ICATIBANT

Limited use benefit (prior approval required).

For the treatment of acute attacks of hereditary angioedema (HAE) in adults with lab-confirmed C1-esterase inhibitor deficiency (type I or type II); and

- treatment of acute non-laryngeal attacks of at least moderate severity; or
- treatment of acute laryngeal attacks; and
- is prescribed by physician with experience in the treatment of HAE.

Note: Limited to two (2) doses of prefilled syringes per dispense.

10MG SOLUTION

02425696 FIRAZYR UNK

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ABATACEPT

Limited use benefit (prior approval required).

1. For the treatment of severely active rheumatoid arthritis (RA)

Coverage is provided for an initial period of one year at a dose of 500mg IV for patients weighing <60kg; 750mg IV for patients weighing 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 ≥ 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, or cyclosporine, 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) or Renflexis (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:

- ≥ 5 swollen joints; and
- ≥ 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

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ADALIMUMAB

Limited use benefit (prior approval required).

- 1. For the treatment of severely active rheumatoid arthritis (RA)
- 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 ≥ 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 hydroxychloroguine, 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, or cyclosporine, 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 Bath Ankylosing Spondylitis Disease Activity Index (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:
- BASDAI ≥ 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 ≥ 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:
- 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 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

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• intolerance or lack of response to 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 BSA involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI):

- a 75% reduction in PASI score; or
- a \geq 50% reduction in the PASI score with a \geq 5-point improvement in the DLQI; or
- a significant reduction in 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 Crohn's Disease Activity Index (CDAI) or Harvey Bradshaw Index (HBI) scores

- at least a 100-point reduction in the CDAI or at least a 3-point reduction in the 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/m2 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:

- ≥ 5 swollen joints; and
- ≥ 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

- >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
- \bullet 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 ≥ 2 points.

8. For the treatment of adult patients with active moderate to severe hidradenitis suppurativa (HS)

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 week beginning 4 weeks after the initial dose.

• prescribed by a dermatologist

For the treatment of adult patients with active moderate to severe HS who meet all of the following criteria:

- total inflammatory lesion (abscess and nodule) count of 3 or greater; and
- lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III*; and
- inadequate response to a 90-day trial of oral antibiotics.
- * Hurley Stage II and III defined as:

Stage II: One or more widely separated recurrent abscesses with tract formation and scars

Stage III: Multiple interconnected tracts and abscesses throughout an entire area

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Coverage beyond the initial 12-week period will be based on decreases in inflammatory nodule and abscess counts:

• at least a 50% reduction in abscesses and inflammatory nodule count from baseline; and

- no increase in abscess count; and
- no increase in draining fistula count.

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).

1. For the treatment of severely active rheumatoid arthritis (RA)

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 ≥ 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 hydroxychloroguine, 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, or cyclosporine, 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:
- BASDAI ≥ 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 ≥ 30%. A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.
- 3. For the treatment of anklosing 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:
- 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 BASDAI score.

200MG SOLUTION

02465574 CIMZIA UCB

200MG/ML SOLUTION

02331675 CIMZIA UCB

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ETANERCEPT

Limited use benefit (prior approval required).

1. For the treatment of severely active rheumatoid arthritis (RA)

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 ≥ 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 hydroxychloroguine, 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, or cyclosporine, 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 Bath Ankylosing Spondylitis Disease Activity Index (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:
- BASDAI ≥ 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 ≥ 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:
- 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 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:

• ≥ 5 swollen joints; and

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- ≥ 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%

25MG/VIAL INJECTION

02242903 ENBREL PED

50MG/ML INJECTION

02274728 ENBREL
99100373 ENBREL SURECLICK
AMG

ETANERCEPT (BRENZYS)

Limited use benefit (prior approval required).

Coverage for Brenzys will be approved indefinitely.

- 1. For the treatment of severely active rheumatoid arthritis (RA)
- · 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, or cyclosporine, for a minimum of 12 weeks of continuous treatment.
- 2. 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 (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.

50MG SOLUTION

 02455323 BRENZYS
 UNK

 02455331 BRENZYS
 UNK

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ETANERCEPT (ERELZI)

Limited use benefit (prior approval required).

Coverage for Erelzi will be approved indefinitely.

- 1. For the treatment of severely active rheumatoid arthritis (RA)
- 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 hydroxychloroguine, 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, or cyclosporine, 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 (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:
- ullet 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 ≥ 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
- 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.

- 4. For the treatment of severely active polyarticular juvenile idiopathic arthritis (pJIA)
- prescribed by a rheumatologist

In children 4 years or older who meet the following criteria:

- ≥ 5 swollen joints; and
- ≥ 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.

25MG SOLUTION

 02462877 ERELZI
 SDZ

 50MG SOLUTION
 SDZ

 02462850 ERELZI
 SDZ

 02462869 ERELZI
 SDZ

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GOLIMUMAB

Limited use benefit (prior approval required).

1. For the treatment of severely active rheumatoid arthritis (RA)

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 ≥ 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, or cyclosporine, 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) ≥ 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 ≥ 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

• 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 ≥ 2 points.

50MG/0	EMI	COL	LITION
SUIVIG/U	. DIVI L	SUL	U I I U I

 02324776 SIMPONI
 JSO

 02324784 SIMPONI
 JSO

100MG/ML SOLUTION

02413175 SIMPONI JSO 02413183 SIMPONI JSO

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INFLIXIMAB (INFLECTRA)

Limited use benefit (prior approval required).

Coverage for Inflectra or Renflexis will be approved indefinitely.

- 1. For the treatment of severely active rheumatoid arthritis (RA)
- · 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 hydroxychloroguine, 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, or cyclosporine, 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) ≥ 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;
- ullet 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
- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks.
- 6. For the treatment of fistulising 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 02470373 RENFLEXIS HOS

INFLIXIMAB (REMICADE)

Limited use benefit (prior approval required).

1. For the treatment of severely active rheumatoid arthritis (RA)

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 ≥ 18 years who have failed:

- with the 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, or cyclosporine, 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 Crohn's Disease Activity Index (CDAI) or Harvey Bradshaw Index (HBI) scores.

- at least a 100-point reduction in the CDAI or at least a 3-point reduction in the 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 drainling 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

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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 maximum dose of 200 mg s/c once every two weeks. A reduced dose of 150 mg once every two weeks is recommended for patients with neutropenia, thrombocytopenia or with elevated liver enzymes. See product monograph for further prescribing information.

· prescribed by a rheumatologist

SARILUMAB

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 or cyclosporine, 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.

150MG SOLUTION

02460521 KEVZARA	SAC
02472961 KEVZARA	SAC
200MG SOLUTION	
02460548 KEVZARA	SAC
02472988 KEVZARA	SAC

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TOCILIZUMAB (IV)

Limited use benefit (prior approval required).

1. For the treatment of severely active rheumatoid arthritis (RA)

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 ≥ 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, or cyclosporine, 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 ≥ 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 ≥ 30 kg.

• prescribed by a rheumatologist

In patients two years of age and older who meet the following criteria:

- ≥ 5 swollen joints; and
- ullet \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

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HLR

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 (RA)

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, or cyclosporine, 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 giant cel arteritis in adults

Coverage is limited to 52 weeks per treatment course at a dose of 162 mg s/c weekly. Treatment can be repeated if relapse occurs.

- patient has been diagnosed with new-onset or relapsing active giant cell arteritis; and
- patient is receiving moderate to high-dose oral corticosteroids (equivalent to prednisone 20 mg to 60 mg daily).

162MG SOLUTION

02424770 ACTEMRA 02483327 ACTEMRA

TOFACITINIB CITRATE

Limited use benefit (prior approval required).

1. For the treatment of severely active rheumatoid arthritis (RA)

Coverage of tofacitinib in adult patients ≥ 18 years is provided at a maximum dose of 10mg daily for an initial period of one year. Coverage of Xeljanz XR in adult patients ≥ 18 years is provided at a maximum dose of 11mg 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;
- 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, or cyclosporine, 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

PFI 02423898 XFLJANZ

11MG TABLET (EXTENDED RELEASE)

02470608 XELJANZ XR PFI

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92:44.00 IMMUNOSUPPRESSIVE AGENTS

ALEMTUZUMAB

Limited use benefit (prior approval required).

Coverage is provided for two years (i.e. two treatment courses/ total of eight doses) for adult patients who meet all of the following criteria:

For the treatment of relapsing-remitting multiple sclerosis (RRMS) diagnosed according to the 2017 McDonald clinical criteria and magnetic resonance imaging (MRI) evidence; and

- prescribed by a specialist with experience in the treatment of multiple sclerosis; and
- highly active disease defined by clinical and imaging features (i.e. significant increase in T2 lesion load compared with that from a previous MRI scan or at least one gadolinium-enhancing lesion) MRI report does not need to be submitted with the request; and
- failure to respond to full and adequate courses of at least two trials of disease-modifying therapies (DMT) for at least six months each or where any other DMT is contraindicated or otherwise unsuitable; and
- at least one relapse while on at least six months of a DMT within the last 10 years, and
- at least two attacks (first episode or relapse) in the previous two years, with at least one attack in the previous year; and
- an Expanded Disability Status Scale (EDSS) score of five (5) or less.

12MG SOLUTION

02418320 LEMTRADA GEE

CLADRIBINE

Limited use benefit (prior approval required).

Initial Coverage (two years):

For the treatment of patients with Relapsing Remitting Multiple Sclerosis (RRMS) who meet all of the following criteria:

- failure to respond to full and adequate courses* of at least ONE initial disease-modifying therapy (DMT) (interferon, glatiramer, dimethyl fumarate, ocrelizumab or teriflunomide) or documented intolerance** to at least 2 DMTs; and
- one or more clinically disabling relapses in the previous year; and
- significant increase in T2 lesion load compared with that from a previous MRI scan or at least one gadolinium-enhancing lesion; and
- requested and followed by a neurologist experienced in the management of RRMS; and
- recent Expanded Disability Status Scale (EDSS) score***
- * failure to respond is defined as: a trial of at least 6 months and experienced at least one disabling relapse (attack) while on an initial DMT.
- ** intolerance is defined as: documented serious adverse effects or contraindications that are incompatible with further use of that class of drug.
- *** recent Expanded Disability Status Scale (EDSS) score less than or equal to 5.5 (i.e. patients must be able to ambulate at least 100 meters without assistance).

10MG TABLET

02470179 MAVENCLAD SRO

CYCLOSPORINE

Limited use benefit (prior approval required).

For transplant therapy.

ST 10MG CAPSULE	
02237671 NEORAL	NVR
ST 25MG CAPSULE	
02150689 NEORAL	NVR
02247073 SANDOZ CYCLOSPORINE	SDZ
ST 50MG CAPSULE	
02150662 NEORAL	NVR
02247074 SANDOZ CYCLOSPORINE	SDZ
ST 100MG CAPSULE	
02150670 NEORAL	NVR
02242821 SANDOZ CYCLOSPORINE	SDZ
ST 100MG/ML SOLUTION	
02244324 APO-CYCLOSPORINE	APX
02150697 NEORAL	NVR

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92:44.00 IMMUNOSUPPRESSIVE AGENTS

MEPOLIZUMAB

Limited use benefit (prior approval required).

For initial 12-month coverage:

For the adjunctive treatment of severe eosinophilic asthma in adults who are inadequately controlled with high-dose inhaled corticosteroids plus one or more additional asthma controller(s) (e.g. long-acting beta-agonist); and

- have had a blood eosinophil count of ≥0.15x109/L before initiation of Nucala (levels must have been drawn within 3 months of the start of treatment); or
- have had a blood eosinophil count of ≥0.3x109/L within the 12-month period prior to starting Nucala
- and
- show reversibility on spirometry (a rise in FEV1of at least 12% and at least 200 mL);
- and
- have experienced two or more clinically significant asthma exacerbations* in the past 12 months period prior to starting Nucala; or
- have received maintenance therapy with daily oral corticosteroids for at least 3 months prior to starting Nucala.

For 12-month renewal coverage:

For the adjunctive treatment of severe eosinophilic asthma in adult patients who have experienced a decrease in clinically significant exacerbations with mepolizumab treatment as demonstrated by:

- patient has experienced a decrease in clinically significant asthma exacerbations* with Nucala treatment; or
- patient's oral corticosteroid maintenance dose decreased by at least 25 % from the pre-treatment dose.

Coverage for Nucala is provided for a maximum dose of 100 mg every four weeks.

* A clinically significant asthma exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least three days or the patient visited an emergency department or was hospitalized.

100MG POWDER FOR SOLUTION

02449781 NUCALA GSK

100MG SOLUTION

02492989 NUCALA GSK
02492997 NUCALA GSK

MYCOPHENOLATE MOFETIL

Limited use benefit (prior approval required).

For transplant therapy.

ST 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

ST 200MG POWDER FOR SUSPENSION

02242145 CELLCEPT HLR

$^{\text{ST}}$ 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.

ST 180MG TABLET (ENTERIC COATED)

02372738 APO-MYCOPHENOLIC ACID APX 02264560 MYFORTIC NVR

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92:44.00 IMMUNOSUPPRESSIVE AGENTS

MYCOPHENOLATE SODIUM

Limited use benefit (prior approval required).

For transplant therapy.

ST 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.

ST 1MG/ML SOLUTION

02243237 RAPAMUNE PFI

 $^{\rm ST}$ 1MG TABLET

02247111 RAPAMUNE PFI

TACROLIMUS MONOHYDRATE

Limited use benefit (prior approval required).

For transplant therapy.

ST 0.5MG CAPSULE

02243144 PROGRAF AST 02416816 SANDOZ TACROLIMUS SDZ

ST 1MG CAPSULE

02175991 PROGRAF AST

02416824 SANDOZ TACROLIMUS

SDZ

5T **5MG CAPSULE** 02175983 PROGRAF

02175983 PROGRAF AST

 $^{\mathrm{s} au}$ 0.5MG CAPSULE (EXTENDED RELEASE)

02296462 ADVAGRAF AST

ST 1MG CAPSULE (EXTENDED RELEASE)

02296470 ADVAGRAF AST

ST 3MG CAPSULE (EXTENDED RELEASE)

02331667 ADVAGRAF AST

ST 5MG CAPSULE (EXTENDED RELEASE)

02296489 ADVAGRAF AST

 $^{\rm ST}$ 5MG CAPSULE (IMMEDIATE RELEASE)

02416832 SANDOZ TACROLIMUS SDZ

5MG/ML SOLUTION

02176009 PROGRAF AST

92:92.00 OTHER MISCELLANEOUS THERAPEUTIC AGENTS

ABOBOTULINUMTOXINA

Limited use benefit (prior approval required).

Treatment of cervical dystonia (spasmodic torticollis) in adults; or Symptomatic treatment of focal spasticity affecting upper limbs in adults; or Lower limb spasticity in patients 2 years of age and older.

300U POWDER FOR SOLUTION

02460203 DYSPORT THERAPEUTIC IPS

500U POWDER FOR SOLUTION

02456117 DYSPORT THERAPEUTIC IPS

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TRU

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; or
- overactive bladder.

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.

96899962 AFROCHAMBER AC BOYZ

DEVICE

90099902 AEROCHAWIBER AC BOTZ	IRU
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
00901012 INSPIRA CHAMBER W LARGE MASK	LUP
00900003 INSPIRA CHAMBER W MEDIUM MASK	LUP
00900001 INSPIRA CHAMBER W MOUTHPIECE	LUP
00900002 INSPIRA CHAMBER W SMALL MASK	LUP
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

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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

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)

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	Ov
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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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.

Insulin pump suppli	es are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.	
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
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 D	EVICE	
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 DE	VICE	
97799521	PARADIGM SURE-T 29G 6MMX18	MDT
97799520	PARADIGM SURE-T 29G 6MMX23	MDT
97799519	PARADIGM SURE-T 29G 8MMX23	MDT
TENDER D	EVICE	
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 "N	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
ULTRAFLE	X DEVICE	
97799665	ULTRAFLEX 1 10MM/110CM	ROD

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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.

nsulin 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	
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
643MMX" DEVICE	
09991616 INSET 6MMX43"	UNK
2360IN/CM DEVICE	
97799202 AUTOSOFT 30 13MM	UNK
97799198 AUTOSOFT 90 6MM	UNK
97799199 AUTOSOFT 90 6MM	UNK
97799200 AUTOSOFT 90 6MM	UNK
97799194 AUTOSOFT 90 9MM	UNK
97799195 AUTOSOFT 90 9MM	UNK
97799196 AUTOSOFT 90 9MM	UNK
97799192 TRUSTEEL 6MM	UNK
97799190 TRUSTEEL 8MM	UNK
97799188 VARISOFT 13MM	UNK
97799185 VARISOFT 17MM	UNK
3280IN/CM DEVICE	
97799191 TRUSTEEL 6MM	UNK
97799189 TRUSTEEL 8MM	UNK
97799187 VARISOFT 13MM	UNK
97799184 VARISOFT 17MM	UNK
43110IN/CM DEVICE	
97799201 AUTOSOFT 30 13MM	UNK
97799197 AUTOSOFT 90 6MM	UNK
97799193 AUTOSOFT 90 9MM	UNK
97799186 VARISOFT 13MM	UNK
DRESS	
09991615 IV3000 STANDARD	SMW
3ML NEEDLE	
00951417 T: SLIM X2 CARTRIDGE (SK)	UNK
PATCH	
09991614 MMT-174 ADHESIVE	UNK
SYRINGE	
97799707 RESERVOIR PARADIGM 5X1.8ML	MDT
97799706 RESERVOIR PARADIGM 7X3.0ML	MDT

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94:01.00 DEVICES (DIABETIC)

LANCET

Limited use benefit (prior approval not required).

The number of lancets that will be covered by the NIHB Program will depend on the client's medical treatment:

• clients managing diabetes with insulin will be allowed 800 lancets per 100 days.

• clients managing diabetes with high risk of causing hypoglycemia will be allowed 400 lancets per 365 days.

- clients managing diabetes medication with low risk of causing hypoglycemia will be allowed 200 lancets per 365 days.
- clients managing diabetes through diet/lifestyle therapy only (no insulin or anti-diabetes medications) will be allowed 200 lancets per 365 days.

Please note that the test strip limit is 800/100 days. Due to lancet pack sizes, 800 per 100 days will be reimbursed.

LANCET

97799494 ACCU-CHEK FASTCLIK LANCET	ROD
97799495 ACCU-CHEK FASTCLIK LANCET	ROD
97799817 ACCU-CHEK MULTICLIX LANCET	ROD
97799945 ACCU-CHEK SOFTCLIX LANCET	ROD
97799946 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
97799140 ONETOUCH DELICAPLUS 30G LANCET	UNK
97799139 ONETOUCH DELICAPLUS 33G LANCET	UNK
97799970 ONETOUCH ULTRASOFT LANCET	JAJ
97799348 ULTILET CLASSIC LANCET	UNK
21G LANCET	
97799804 MONOLET 21G LANCET	TYC
28G LANCET	
97799232 DROPLET PERSONAL LANCET 28G	SFA
97799253 FIRST CANHEALTH 28G LANCET	ARA
97799801 MONOLET THIN (MONOJECT) 28G	TYC
30G LANCET	
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
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

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96:00 PHARMACEUTICAL AIDS

96:00.00 PHARMACEUTICAL AIDS

ADULT

Limited use benefit (prior approval required).

- Criteria for nutritional supplement coverage for adults
 sole source nutrition (more than 75% of intake is from nutritional supplement)
- unintentional weight loss
- wound care
- pre or post-surgery (6 months before or after date of surgery)
- other medical conditions not listed

ORAL LIQUID

95900061 BOOST DIABETIC 237ML LIQ	NES
95999963 BOOST ORIGINAL 237ML LIQ	NES
95900050 ENSURE 235ML LIQ	ABB
95900139 ENSURE FIBRE 235ML LIQ	ABB
95900140 GLUCERNA 237ML LIQ	ABB
95900076 ISOSOURCE 1.0 HP 250ML LIQ	NES
95900072 ISOSOURCE 1.2 CAL 1500ML LIQ	NES
95900071 ISOSOURCE 1.2 CAL 250ML LIQ	NES
95900073 ISOSOURCE 1.5 CAL 250ML LIQ	NES
95900209 ISOSOURCE FIBRE 1.2 CAL 250ML LIQ	NES
95900075 ISOSOURCE FIBRE 1.5 CAL 1500ML LIQ	NES
95900074 ISOSOURCE FIBRE 1.5 CAL 250ML LIQ	NES
95900077 ISOSOURCE HN WITH FIBRE 250ML LIQ	NES
95900217 JEVITY 1.5 CAL	ABB
95900082 JEVITY 1.5 CAL 235ML LIQ	ABB
95900078 JEVITY 235ML LIQ	ABB
95900220 NUTREN 1.5	NES
95900088 PEPTAMEN 1.5 1000ML LIQ	NES
95900087 PEPTAMEN 1.5 250ML LIQ	NES
95900086 PEPTAMEN 250ML LIQ	NES
95900091 PEPTAMEN WITH PREBIO 1000ML LIQ	NES
95900090 PEPTAMEN WITH PREBIO 250ML LIQ	NES
95900058 RESOURCE 2.0 237ML LIQ	NES
95900207 RESOURCE DIABETIC 1.5L	NES
95900062 RESOURCE DIABETIC 250ML LIQ	NES
95900130 VITAL 1.5 CAL 1000ML LIQ	ABB
95900128 VITAL PEPTIDE 1 CAL 220ML LIQ	ABB
95900129 VITAL PEPTIDE 1.5 CAL 220ML LIQ	ABB

BASES-EMULSIONS

Limited use benefit (prior approval required).

For the treatment of atopic dermatitis in children 0 to 18 years old. Coverage is limited to 450 grams per month.

CREAM

09991668 EMOLLIENT FOR ADULTS	GSK
99000385 EMOLLIENT FOR CHILDREN	WPC

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96:00.00 PHARMACEUTICAL AIDS

CHILDREN AND YOUTH

Limited use benefit (prior approval required).

Criteria for nutritional supplement coverage for children and youth (19 years and under)

• sole source nutrition (more than 75% of intake is from nutrition supplement)

- failure to thrive/growth faltering
- pre or post-surgery (6 months before or after date of surgery)
- other medical conditions not listed

ORAL LIQUID

95900131 COMPLEAT PEDIATRIC 250ML LIQ	NES
95900133 NUTREN JR. 250ML LIQ	NES
95900177 PEDIASURE 235ML LIQ	ABB
95900142 PEDIASURE COM. GROW&GAIN 235ML LIQ	ABB
95900178 PEDIASURE FIBRE 235ML LIQ	ABB
95900179 PEDIASURE PLUS WITH FIBRE 235	ABB
95900135 PEPTAMEN JUNIOR 1.0 CAL 250ML LIQ	NES
95900136 PEPTAMEN JUNIOR 1.5 CAL 250ML LIQ	NES
95900137 RESOURCE JUST KIDS 1.5 CAL 237ML LIQ	NES
POWDER	
95900132 NEOCATE JR FIBER&IRON 400G PDR	UNK

DEVICE (METHADONE)

Limited use benefit (prior approval is not required).

Coverage is granted for 1 device.

MISCELLANEOUS

91500016 METHADONE LOCK BOX

95900007 ENFAMIL A+ 237ML LIQ

95900143 PEDIASURE GROW&GAIN 400G PDR

UNK

MJO

ABB

INFANT FORMULATION

Limited use benefit (prior approval required).

Criteria for infant formula coverage < 1 year of age (corrected gestational age for prematurity)

• contraindications for breastfeeding HIV, hepatitis C, active tuberculosis and herpetic lesions on breast. Please note, contraindications are in accordance with respective Health Canada and World Health Organization guidance.

- prematurity or low birth weight
- failure to thrive/growth faltering
- cow milk protein allergy
- other medical conditions not listed

ORAL LIQUID

95900003	ENFAMIL A+ 385ML LIQ	MJO
95900152	ENFAMIL A+ ENFACARE 385ML LIQ	MJO
95900012	ENFAMIL LOWER IRON 385ML LIQ	MJO
95900026	NUTRAMIGEN A+ 945ML LIQ	MJO
95900000	SIMILAC ALIMENTUM 237ML LIQ	ABB
95900001	SIMILAC ALIMENTUM 945ML LIQ	ABB
POWDER		
95900164	ENFAMIL A+ 663G PDR	MJO
95900009	ENFAMIL A+ ENFACARE 363G PDR	MJO
95900155	ENFAMIL LOWER IRON 900G PDR	MJO
95900023	NEOCATE 400G PDR	UNK
95900021	NEOCATE JUNIOR 400G PDR	UNK
95900022	NEOCATE ONE 400G	UNK
95900025	NEOCATE W/ DHA & ARA 400G PDR	UNK
95900027	NUTRAMIGEN A+ LGG 561G PDR	MJO
95900035	PURAMINO A+ 400G PDR	MJO
95900112	PURAMINO A+ JUNIOR 400G PDR	MJO
95900047	SIMILAC ALIMENTUM 400G PDR	ABB

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96:00.00 PHARMACEUTICAL AIDS

INFANT FORMULATION

Limited use benefit (prior approval required).

- Criteria for infant formula coverage < 1 year of age (corrected gestational age for prematurity)

 contraindications for breastfeeding HIV, hepatitis C, active tuberculosis and herpetic lesions on breast. Please note, contraindications are in accordance with respective Health Canada and World Health Organization guidance.
- prematurity or low birth weightfailure to thrive/growth faltering
- cow milk protein allergy
- other medical conditions not listed

POWDER

95900184 SIMILAC LOWER IRON 850G PDR ABB 95900036 SIMILAC NEOSURE 363G PDR ABB 95900044 SIMILAC PM 60/40 450G PDR ABB

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Non-Insured Health Benefits

Appendix A - Limited Use Be	enents ar	iu Criteria		Non-insured nearth be	anemo
AA-TRIMEBUTINE	26	AEROCHAMBER PLUS FLOWVU	120	APO-METHYLPHENIDATE ER	58
ABATACEPT	102	MOUTH		APO-METHYLPHENIDATE SR	58
ABENOL	47	AEROCHAMBER PLUS FLOWVU SMALL	120	APO-MONTELUKAST	75
ABIRATERONE ACETATE	7	AEROTRACH PLUS	120	APOMORPHINE HYDROCHLORIDE	66
ABOBOTULINUMTOXINA	119	AFATINIB DIMALEATE	7	APO-MOXIFLOXACIN	2
ACAMPROSATE CALCIUM	66	AFINITOR	11	APO-MYCOPHENOLATE	118
ACCEL-RIZATRIPTAN ODT	63	AFINITOR DISPERZ	12	APO-MYCOPHENOLIC ACID	118
ACCEL-SEVELAMER	73	AFLIBERCEPT	78	APO-OMEPRAZOLE	82
ACCU-CHEK ADVANTAGE	69	AG-GABAPENTIN	50	APO-OXYCODONE/ACET	39
ACCU-CHEK AVIVA	70	AG-MOXIFLOXACIN	2	APO-PANTOPRAZOLE	84
ACCU-CHEK COMPACT	70	AG-PANTOPRAZOLE	84	APO-PREGABALIN	53
ACCU-CHEK FASTCLIK LANCET	124	AG-PREGABALIN	53	APO-RABEPRAZOLE	85
ACCU-CHEK GUIDE (ON)	69	AG-ZOLMITRIPTAN ODT	65	APO-RALOXIFENE	88
ACCU-CHEK GUIDE (SK)	69	AKYNZEO	80	APO-RIVASTIGMINE	25
ACCU-CHEK MOBILE BG	70	ALECENSARO	7	APO-RIZATRIPTAN	63
ACCU-CHEK MOBILE CASSETT	70	ALECTINIB	7	APO-RIZATRIPTAN RPD	63
ACCU-CHEK MULTICLIX LANCET	124	ALEMTUZUMAB	117	APO-SILDENAFIL R	36
ACCU-CHEK SOFTCLIX LANCET	124	ALIROCUMAB	35	APO TARALASII RALI	64
ACCUTREND	70	ALMOTRIPTAN	62	APO VARENIOUNE	36
ACET 325	47	ALMOTRIPTAN MALATE	62	APO VODICONAZOLE	31 4
ACETAMINOPHEN	47 47	ALPRAZOLAM	59	APO-VORICONAZOLE APO-ZOLMITRIPTAN RAPID	65
ACETAMINOPHEN ACETAMINOPHEN	47 47	ALPRAZOLAM	59	APREPITANT	80
ACETAMINOPHEN ACETAMINOPHEN, CAFFEINE	47 39	AMBRISENTAN	37	APTIOM	50
CITRATE, CODEINE PHOSPHATE	39	AMERGE	63	AQUA-E	96
ACETAMINOPHEN, CODEINE	39	AMIKACIN SULFATE	1	AQUA-E/ML	96
PHOSPHATE		AMIKACIN SULFATE	1	AQUASOL E	96
ACETAMINOPHEN, OXYCODONE	39	AMPHETAMINE,	56	AQUASOL E VITAMIN E	96
HYDROCHLORIDE		DEXTROAMPHETAMINE		ARICEPT	23
ACÉTAMINOPHÈNE	48	ANDRODERM	88	ASA EC	38
ACÉTAMINOPHÈNE BLASON	48	ANDROGEL	87	ASAPHEN	38
SHIELD ACETYLSALICYLIC ACID	38	ANTI-NAUSEANT	80	ASATAB	38
ACETYLSALICYLIC ACID ACETYLSALICYLIC ACID	38	APALUTAMIDE	8	ASCENCIA CONTOUR	70
ACETYLSALICYLIC ACID	40	APIXABAN	31	ASCENSIA BREEZE 2	70
OXYCODONE HYDROCHLORIDE	40	APO ACETAMINOPHEN	48	ASENAPINE MALEATE	56
ACH-FINGOLIMOD	98	APO DIMENHYDRINATE	80	ASPEN-DIENOGEST	90
ACH-MYCOPHENOLATE	118	APO ACETAMINOPHEN	61	ATIVAN	60
ACLASTA	101	APO-ACETAMINOPHEN	48 5	ATIVAN SUBLINGUAL	60
ACT AMPHETAMINE XR	56	APO-ADEFOVIR APO-ALMOTRIPTAN	62	ATOMOXETINE	66
ACT BUPRENORPHINE/NALOXONE	46	APO-ALPRAZ	59	ATOMOXETINE HYDROCHLORIDE	66
ACT DEXTROAMPHETAMINE SR	57	APO-AMBRISENTAN	76	AUBAGIO	101
ACT LEVOFLOXACIN	2	APO-AMPHETAMINE XR	56	AURO-ATOMOXETINE	66
ACT METHYLPHENIDATE ER	58	APO-ATOMOXETINE	66	AURO-CYCLOBENZAPRINE	29
ACT RALOXIFENE	88	APO-BENZYDAMINE	77	AURO-DONEPEZIL	23
ACT RIZATRIPTAN	63	APO-BOSENTAN	37	AURO-GABAPENTIN	50
ACT SUMATRIPTAN	64	APO-BROMAZEPAM	60	AURO-GALANTAMINE ER	24
ACTEMRA	115	APO-CABERGOLINE	66	AURO-LACOSAMIDE	52
ADALIMUMAB	103	APO-CLONAZEPAM	49	AURO-MONTELUKAST	75
ADCIRCA	36	APO-CYCLOBENZAPRINE	29	AURO-MOXIFLOXACIN	3
ADDERALL XR	56	APO-CYCLOSPORINE	117	AURO-PANTOPRAZOLE	84
ADEFOVIR DIPIVOXIL	5	APO-DABIGATRAN	32	AURO-PREGABALIN AURO-RIZATRIPTAN	53 63
ADEMPAS	76	APO-DICLOFENAC	39	AUTOSOFT 30 13MM	123
ADULT	125	APO-DONEPEZIL	23	AUTOSOFT 90 6MM	123
ADVAIR 100 DISKUS	119	APO-ERLOTINIB	11	AUTOSOFT 90 9MM	123
ADVAIR 100 DISKUS	28	APO-FINGOLIMOD	98	AVONEX	99
ADVAIR 125 ADVAIR 250	28 28	APO-GABAPENTIN	50	AVONEX PEN	99
	28	APO-GEFITINIB	12	AXERT	62
ADVAIR 250 DISKUS ADVAIR 500 DISKUS	28	APO-HYDROMORPHONE	41	AXITINIB	8
AEROCHAMBER AC BOYZ	26 120	APO-IMATINIB	14	AZTREONAM	1
AEROCHAMBER AC GIRLZ	120	APO-LANSOPRAZOLE	81	BANZEL	55
AEROCHAMBER PLUS FLOWVU	120	APO-LEVOFLOXACIN	2	BASES-EMULSIONS	125
LARGE	120	APO-LINEZOLID	3	BD ULTRAFINE 33G LANCET	124
AEROCHAMBER PLUS FLOWVU	120	APO METHYLDHENIDATE	60 50	BENRALIZUMAB	72
MEDIUM		APO-METHYLPHENIDATE	58		

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Appendix A - Limited Use B	enems an	iu Criteria		Non-insured nearth B	enents
BENZYDAMINE HYDROCHLORIDE	77	CIMZIA	106	DIAZEPAM	60
BETASERON	100	CLADRIBINE	117	DIAZEPAM (DIASTAT)	60
BETASERON INITIATION KIT	100	CLONAPAM	49	DICETEL	86
BG STAR	70	CLONAZEPAM	49	DICLOFENAC DIETHYLAMINE	38
BG STAR LANCET	124	COAGUCHEK INRANGE METER	69	DICLOFENAC SODIUM	39
BIO-DONEPEZIL	23	COAGUCHEK LANCETS	69	DICLOFENAC SODIUM (TOPICAL)	39
BIO-GABAPENTIN	50	COAGUCHEK XS KIT	69	DICLOFENAC TOPICAL	39
BIO-MONTELUKAST	75	COAGUCHEK XS PT STRIPS 24	69	DIENOGEST	90
BIO-MOXIFLOXACIN	3	COAGUCHEK XS PT STRIPS 48	69	DIFICID	1
BIO-OMEPRAZOLE	82	COAGUCHEK XS PT STRIPS 6	69	DILAUDID	42
BIO-PANTOPRAZOLE	84	COAGULATION MONITORS	69	DIMENHYDRINATE	80
BISMUTH	80	COAGULATION TEST	69	DIMETHYL FUMARATE	68
BISMUTH SUBSALICYLATE	80	COBIMETINIB	9	DOLORAL 1	43
BISMUTH SUBSALICYLATE	80	CODEINE	40	DOLORAL 5	43
BOOST DIABETIC 237ML LIQ	125	CODEINE CONTIN CR	40	DOM-ATOMOXETINE	66
BOOST ORIGINAL 237ML LIQ	125	CODEINE MONOHYDRATE,	40	DOM-CYCLOBENZAPRINE	29
BOSENTAN MONOHYDRATE	37	CODEINE SULFATE TRIHYDRATE	40	DOM-GABAPENTIN	50
BOSULIF	8	CODEINE PHOSPHATE	40	DOM-LANSOPRAZOLE	81
BOSUTINIB	8	CODEINE PHOSPHATE	40	DOM-MONTELUKAST	75
BOTOX	120	COLISTIMETHATE FOR U.S.P	3	DOM-PREGABALIN	53
BREEZE 2 BG (ON)	70	COLISTIN	3	DOM-RABEPRAZOLE EC	85
BRENZYS	108	COLY-MYCIN M PARENTERAL	3	DOM-RIZATRIPTAN RDT	63
BREO ELLIPTA	27	COMFORT ANGLED INFSET 17MM	121		64
BRILINTA	33	COMFORT SRT ANGLED INFSET 13	121	DOM-SUMATRIPTAN	
BRIVARACETAM	49	COMPACT SPACE PLUS LARGE	120	DOM-ZOLMITRIPTAN	65 23
	49 49	MASK	120	DONEPEZIL LIVERGOLII GRIPE	
BRIVLERA		COMPACT SPACE PLUS MEDIUM	120	DONEPEZIL HYDROCHLORIDE	23
BRODALUMAB	91	MASK		DOSTINEX	66
BROMAZEPAM	60	COMPACT SPACE PLUS NO MASK	120	DROPLET PERSONAL LANCET 28G	124
BUPRENORPHINE (BUTRANS)	46	COMPACT SPACE PLUS SMALL	120	DROPLET PERSONAL LANCET 33G	124
BUPRENORPHINE (SUBLOCADE)	40	MASK		DUODOPA	65
BUPRENORPHINE	46	COMPLEAT PEDIATRIC 250ML LIQ	126	DUPILUMAB	91
HYDROCHLORIDE	40	CONCERTA	58	DUPIXENT	91
BUPRENORPHINE HYDROCHLORIDE, NALOXONE	46	CONTACT DETACH 90 DEGREE	121	DYSPORT THERAPEUTIC	119
HYDROCHLORIDE		6MMX60CM		EDOXABAN (EDOXABAN	32
BUPROPION HYDROCHLORIDE	56	CONTACT DETACH 90 DEGREE	121	TOSYLATE MONOHYDRATE)	_
(ZYBAN)		8MMX60CM	70	ELBASVIR, GRAZOPREVIR	5
BUTRANS 10	46	CONTOUR BG (ON)	70	ELIDEL	92
BUTRANS 15	46	CONTOUR NEXT	70	ELIQUIS	31
BUTRANS 20	46	CONTOUR NEXT (ON)	70	EMEND	80
BUTRANS 5	46	COPAXONE	99	EMEND TRI-PACK	80
CABERGOLINE	66	COSENTYX	94	EMOLLIENT FOR ADULTS	125
CABOMETYX	8	COSENTYX (STYLO)	94	EMOLLIENT FOR CHILDREN	125
CABOZANTINIB (CABOZANTINIB	8	COSENTYX PEN (ON)	94	EMPAGLIFLOZIN	89
MALATE)		COTELLIC	9	ENABLEX	95
CAFFEINE CITRATE	59	CRESEMBA	4	ENBREL	108
CAFFEINE CITRATE	59	CRIZOTINIB	9	ENBREL SURECLICK	108
CAMPRAL	66	CYCLOBENZAPRINE	29	ENFAMIL A+ 237ML LIQ	126
CANAGLIFLOZIN	89	CYCLOBENZAPRINE	29	ENFAMIL A+ 385ML LIQ	126
CAPRELSA	22	HYDROCHLORIDE		ENFAMIL A+ 663G PDR	126
CARNITOR	73	CYCLOSPORINE	117	ENFAMIL A+ ENFACARE 363G PDR	126
CARTRIDGE FOR IR200	121	DABIGATRAN ETEXILATE MESILATE	32	ENFAMIL A+ ENFACARE 385ML LIQ	126
CAYSTON	1	DABRAFENIB	10	ENFAMIL LOWER IRON 385ML LIQ	126
CELLCEPT	118			ENFAMIL LOWER IRON 900G PDR	126
CENTRUM	96	DARIFENACIN HYDROBROMIDE	95 404	ENFAMIL POLYVISOL	96
CENTRUM DHA	97	DENOSUMAB (PROLIA)	101	ENFAMIL TRIVISOL	96
CENTRUM FOR WOMEN	96	DENOSUMAB (XGEVA)	101	ENSURE 235ML LIQ	125
CENTRUM JUNIOR COMPLETE	96	DEVICE (METHADONE)	126	ENSURE FIBRE 235ML LIQ	125
CENTRUM PRENATAL	97	DEXEDRINE ORANGUI E	57	ENTRESTO	38
CERITINIB	9	DEXEDRINE SPANSULE	57	ENTYVIO	87
CERTOLIZUMAB PEGOL	106	DEXTROAMPHETAMINE	57	ENZALUTAMIDE	10
CHAMPIX	31	DEXTROAMPHETAMINE SULFATE	57	EPCLUSA	6
CHAMPIX STARTER PACK	31	DIASTAT	60	EPLERENONE	37
CHILDREN AND YOUTH	126	DIASTAT 2X10MG RECTAL PACK	60	ERELZI	109
CHU NICOTINE ANTI SMOKING AID	30	DIASTAT 2X15MG RECTAL PACK	60	ERLEADA	8
		DIAZEPAM	60		

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Non-Insured Health Benefits

Appendix A - Limited Use Be	enemis ai	iu Criteria		Non-insured nearth b	enents
ERLOTINIB HYDROCHLORIDE	11	FREESTYLE LANCET	124	INSPIRA CHAMBER W MEDIUM	120
ESBRIET ESLICARBAZEPINE ACETATE	74 50	FREESTYLE LITE FREESTYLE LITE (ON)	70 70	MASK INSPIRA CHAMBER W	120
ETANERCEPT	107	FREESTYLE PRECISION	70	MOUTHPIECE	
ETANERCEPT (BRENZYS)	107	FREESTYLE PRECISION (ON)	70	INSPIRA CHAMBER W SMALL	120
ETANERCEPT (ERELZI)	109	FYCOMPA	53	MASK	
EURO-ASA	38	GABAPENTIN	50	INSPRA	37
EVEROLIMUS	11	GABAPENTIN	50	INSULIN PUMP BATTERY	121
EVISTA	88	GALANTAMINE	24	INSULIN PUMP SUPPLIES	121
EVOLOCUMAB	36	GALANTAMINE ER	24	INTERFERON BETA-1A	99
EXELON	25	GALANTAMINE HYDROBROMIDE	24	INTERFERON BETA-1B	100
EXTAVIA	100	GD-GABAPENTIN	50	INTRAUTERINE DEVICE INVOKANA	69
EXTEMPORANEOUS MIXTURE	97	GE200	70	IRESSA	89 13
(GENDER AFFIRMING)		GE200 (ON)	70	IRON (SUCROFERRIC	72
EXTEMPORANEOUS MIXTURE (LU)	97	GEFITINIB	12	OXYHYDROXIDE)	12
EXTEMPORANEOUS MIXTURE	97	GENDER AFFIRMING HORMONES	97	ISAVUCONAZOLE	4
(NSAID)		GENDER AFFIRMING TOPICAL	97	(ISAVUCONAZONIUM SULFATE)	
EXTRA STRENGTH ACETAMINOPHEN	48	HORMONES		ISOSOURCE 1.0 HP 250ML LIQ	125
EYLEA	78	GILENYA	99	ISOSOURCE 1.2 CAL 1500ML LIQ	125
EZ HEALTH ORACLE	70 70	GIOTRIF	7	ISOSOURCE 1.2 CAL 250ML LIQ	125
EZ HEALTH ORACLE LANCET	124	GLATECT	99	ISOSOURCE 1.5 CAL 250ML LIQ	125
E-Z SPACER	124	GLATIRAMER ACETATE	99	ISOSOURCE FIBRE 1.2 CAL 250ML	125
E-Z SPACER (MASK ONLY)	120	GLECAPREVIR, PIBRENTASVIR	5	LIQ	
E-Z SPACER WITH SMALL MASK	120	GLEEVEC	14	ISOSOURCE FIBRE 1.5 CAL 1500ML LIQ	125
FASENRA	72	GLN-GABAPENTIN	52	ISOSOURCE FIBRE 1.5 CAL 250ML	125
FEBUXOSTAT	98	GLUCERNA 237ML LIQ	125	LIQ	123
FENTANYL	41	GLUCOSE OXIDASE, PEROXIDASE	69	ISOSOURCE HN WITH FIBRE	125
FERAMAX POWDER WATER	31	GOLIMUMAB	110	250ML LIQ	
SOLUBLE POLYSACCHARIDE IRON	٠.	GRAVOL	80	ITEST	71
COMPLEX		HABITROL	30	ITEST ULTRA-THIN 33G LANCET	124
FESOTERODINE FUMARATE	95	HARVONI	6	IV3000	121
FIBRISTAL	88	HEMANGIOL	37	IV3000 STANDARD	123
FIDAXOMICIN	1	HEPSERA	5	IVABRADINE (IVABRADINE	34
FINGERSTIX LANCET	124	HUMIRA	105 42	HYDROCHLORIDE)	
FINGOLIMOD (FINGOLIMOD	98	HYDROMORPH CONTIN HYDROMORPHONE		IXEKIZUMAB	92
HYDROCHLORIDE)	404	HYDROCHLORIDE	41	JAKAVI	20
FIRAZYR	101	HYDROMORPHONE	42	JAMP ACETAMINOPHEN BLAZON	48
FIRST CANADIAN HEALTH LANCETS	124	HYDROCHLORIDE HP 50		JAMP DICLOFENAC TOPICAL	39
FIRST CANHEALTH 28G LANCET	124	IBAVYR	5	JAMP FEBUXOSTAT	98
FIRST CANHEALTH 30G LANCET	124	IBRANCE	18	JAMP FINGOLIMOD	99
FIRST CANHEALTH 33G LANCET	124	IBRUTINIB	13	JAMP VITAMIN A D AND C	25 96
FIRST CANHEALTH SPIRIT	71	ICATIBANT	101	JAMP VITAMIN A, D AND C JAMP ZOLMITRIPTAN	96 65
FLINTSTONES MULTIPLE	96	ICLUSIG	19	JAMP-ASA	
VITAMINS PLUS IRON		IDELALISIB	13	JAMP-CYCLOBENZAPRINE	38 29
FLINTSTONES MULTIPLE	96	IMATINIB MESYLATE	14	JAMP-DIMENHYDRINATE	80
VITAMINS WITH EXTRA C		IMBRUVICA	13	JAMP-DONEPEZIL	23
FLUTICASONE FUROATE,	87	IMITREX	64	JAMP-GABAPENTIN	50
UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE		IMITREX DF	64	JAMP-MONTELUKAST	75
FLUTICASONE FUROATE,	27	IMITREX STAT DOSE KIT	64	JAMP-MOXIFLOXACIN	3
VILANTEROL TRIFENATATE		INCOBOTULINUMTOXINA	120	JAMP-MYCOPHENOLATE	118
FLUTICASONE FUROATE,	27	INDACATEROL MALEATE	28	JAMPOCAINE	90
VILANTEROL TRIFENATATE		INFANT FORMULATION	126	JAMP-OMEPRAZOLE DR	82
(ASTHMA)	07	INFLECTRA	113	JAMP-PANTOPRAZOLE	84
FORADIL	27	INFLIXIMAB (INFLECTRA)	112	JAMP-PREGABALIN	53
FORMOTEROL FUMARATE	27	INFLIXIMAB (REMICADE)	113	JAMP-RIZATRIPTAN	63
FORMOTEROL FUMARATE DIHYDRATE	27	INLYTA	8	JAMP-RIZATRIPTAN IR	63
FORMOTEROL FUMARATE	27	INSET 30 INFUSION SETS	121	JAMP-RIZATRIPTAN ODT	63
DIHYDRATE, BUDESONIDE		INSET 6MMX43"	123	JAMP-ZOLMITRIPTAN	65
FORMOTEROL FUMARATE	27	INSET II 90 DEGREE 6MMX110CM	121	JAMP-ZOLMITRIPTAN ODT	65
DIHYDRATE, MOMETASONE		INSET II 90 DEGREE 6MMX60CM	121	JANUMET	88
FUROATE		INSET II 90 DEGREE 9MMX110CM	121	JANUMET XR	89
FOSRENOL	72	INSET II 90 DEGREE 9MMX60CM	121	JANUVIA	88
FREESTYLE	70	INSPIRA CHAMBER W LARGE MASK	120	JARDIANCE	89
FREESTYLE (ON)	70				

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Non-Insured	Health	Benefits
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EMPTY 15 CAL 235M.LIQ	Appendix A - Limited Use Be	enemis an	u Criteria		Non-insured nearth be	enents
METHY ASSMALLIQ	JEVITY 1.5 CAL	125	MEDI+SURE	71	MPD ULTRA THIN LANCET (100)	124
KEYZARA 114 MED HOMER SOFT 33G T YINST 124 MS CONTIN SR 44 KEYAZARA 114 MED HOMOREDOXACO 3 MS 18	JEVITY 1.5 CAL 235ML LIQ	125	MEDI+SURE (ON)	71	MPD ULTRA THIN LANCET (200)	124
KEYARA KISOALI 19 MED-MOJELONACIN KISOALI 14 MED-MOJELONACIN 22 MULTUTTAMINS (CHILDREN AND 48 KISOALI 14 MED-MOJELONACIN 24 MEROPENSIS 25 MULTUTTAMINS (CHILDREN AND 48 KANCOPALORIA 34 MEROPENSIS 27 MOJETY LANCORA 34 MEROPENSIS 37 MEROPENSIS 38 MEROPENSIS 38 MEROPENSIS 39 MEROPENSIS 39 MEROPENSIS 30 MEROPENSIS 30 MEROPENSIS 30 MEROPENSIS 30 MEROPENSIS 30 MEROPENSIS 31 MEROPENSIS 32 MEROPENSIS 33 MEROPENSIS 34 MEROPENSIS 35 MEROPENSIS 35 MEROPENSIS 36 MEROPENSIS 36 MEROPENSIS 36 MEROPENSIS 37 MEROPENSIS 38 MEROPENSIS 38 MEROPENSIS 38 MEROPENSIS 39 MEROPENSIS 39 MEROPENSIS 30 MEROPENSIS 30 MEROPENSIS 31 MEROPENSIS 32 MEROPENSIS 33 MEROPENSIS 34 MEROPENSIS 34 MEROPENSIS 35 MEROPENSIS 35 MEROPENSIS 36 MEROPENSIS 36 MEROPENSIS 37 MEROPENSIS 37 MEROPENSIS 38 MEROPENSIS 38 MEROPENSIS 39 MEROPENSIS	JEVITY 235ML LIQ	125	MEDI+SURE SOFT 30G TWIST	124	M-PREGABALIN	53
INCOMENDATE 19	KADIAN	45	MEDI+SURE SOFT 33G TWIST	124	MS CONTIN SR	44
LANCET	KEVZARA	114	MED-MOXIFLOXACIN	3	MS IR	44
LANCORTA 34 MEDOLIZIMAS 119 MULTIVITAMINS PRENATAL) 97 LANCORA 34 MEROPERIOL 1 MCOPHEROLATE 118 LANSOPRAZOLE 81 MEROPERIOL 1 MCOPHEROLATE MOFETIL 118 LANSOPRAZOLE 01 82 MESOPENEN 1 MCOPHEROLATE MOFETIL 118 LANSOPRAZOLE 07 82 METADOL 35 METADOL 1 MESOPENEN 1	KISQALI	19	MED-RIVASTIGMINE	25		96
MEROPENEM	LACOSAMIDE	52	MEKINIST	22	,	
MEROPENIM	LANCET	69	MEPOLIZUMAB	118		
M-SELON	LANCORA	34	MEROPENEM	1		
LANTHANUM CABONATE 12 METFORMIN YOROCHLORIDE 13 METFORMIN YOROCHLORIDE 14 METFORMIN YOROCHLORIDE 15 EMPAGUILOZIN 16 METHADONE HYDROCHLORIDE 16 METHADONE HYDROCHLORIDE 17 (METADON) 18 METHADONE HYDROCHLORIDE 18 METHADONE HYDROCHLORIDE 18 METHADONE HYDROCHLORIDE 18 METHADONE HYDROCHLORIDE 18 METHADONE LOCK BOX 18 MITADONE LOCK BOX 18	LANSOPRAZOLE	81	MEROPENEM	1		
MATTORITIC	LANSOPRAZOLE	81	M-ESLON	43		
HYDRATE	LANSOPRAZOLE ODT	82	METADOL	43		
LENTRADA		72		90		
LENALIDOMIDE						
METHADONE LOCK BOX 126				43		
LEWYATNIB 19 METRYLPHENIDATE LEVOVARYTHIB 10 MERCHET LANCET 11 MICROLET LANCET 12 MYLAN-RANTOPRAZOLET 13 MICROLET LANCET 14 MYLAN-RANTOPRAZOLET 15 MICROLET LANCET 16 MYLAN-RANTOPRAZOLET 17 MICROLET LANCET 18 MYLAN-RANTOPRAZOLET 18 MYLAN-RANTOPRAZOLED 19 MINT-DONEPEZIL 19 MINT-DONEPEZIL 10 MINT-DONEPEZ			,	106		
LEVORARITIME 16 MYLAN-PARTOPRAZOLE 83 LEVOCARRITIME 73 MIGROLET LANCET 124 MYLAN-PARTOPRAZOLE 83 LEVOCARRITIME 73 MIGROLET LANCET 124 MYLAN-RAZTRIPTAN 064 MYLAN-RAZTRIPTAN 065 MYLAN-SUMARTPAN 064 MYLAN-RAZTRIPTAN 067 MYLAN-SUMARTPAN 064 MYLAN-RAZTRIPTAN 067 MARATRIPTAN 167 MART-PANTOPRAZOLE 84 MAT-AMATRIP 114 MAT-PANTOPRAZOLE 84 MAT-AMATRIP 114 MAT-PANTOPRAZOLE 85 MAT-COMPARAZOLE 167 MAT-ZOLANTRIPTAN 167 MART-PANTOPRAZOLE 167 MAT-ZOLANTRIPTAN 167 MARCOLEAN 167 MARCOLEAN 167 MAT-ZOLANTRIPTAN 167 MARCOLEAN						
LEVOCARNTINE 73 LEVODOPA, CARBIDOPA 65 LEVOPE, CARBIDOPA 65 LEVOPE, CARBIDOPA 65 LEVOPE, CARBIDOPA 65 LEVOPE, CARBIDOPA 66 LEVOPE, CARBIDOPA 66 LEVOPE, CARBIDOPA 67 LEVOPE, CARBIDOPA 67 LEVOPE, CARBIDOPA 68 LEVOPE, CARBIDOPA 69 LINTERDATO, CARB	LENVATINIB			58		
LEVOLOZARNI INC. 15				124		
CARBIDUPA (ANDIOUPRATE)						
LEVOFLOXICIN 2	,	65				
LEVOFLOXACIN HEMIHYDRATE						
EVOFLOXACIN HEMIHYDRATE 2						
MINT-PANTOPRAZOLE						
IDDOCANE		2				
LIDODAN	,	90				
INCTUS CODEINE						
INEZOLID 3						
LINEZOLID 3 MIO CLEAR 6MMX32 121 NAT-ZOLMITRIPTAN 65						97
LISDEXAMFETAMINE DIMESYLATE 58 MIO CLEAR 9MMX32 121 NEOCATE 400G PDR 126 LIXIANA 32 MIO PINK 6MMX18 121 NEOCATE 400G PDR 126 LORAZEPAM 60 MIO PINK 6MMX18 121 PDR LORAZEPAM 60 MIO PINK 6MMX18 121 PDR LORAZEPAM 60 MIO PINK 6MMX18 121 PDR LORAZEPAM 60 MIRABEGRON 95 NEOCATE JUNIOR 400G PDR 126 LORAZEPAM SUBLINGUAL 61 MISC LIMITED USE COMPOUND 97 NEOCATE JUNIOR 400G PDR 126 LORAZEPAM SUBLINGUAL 61 MISC LIMITED USE COMPOUND 97 NEOCATE W/ DHA & ARA 400G 126 LORAZEPAM SUBLINGUAL 61 MISC LIMITED USE EXTERNAL 97 PDR LORAZEPAM SUBLINGUAL 61 MISC LIMITED USE EXTERNAL 97 PDR LORAZEPAM SUBLINGUAL 61 MISC LIMITED USE EXTERNAL 97 PDR LORAZEPAM SUBLINGUAL 61 MISC LIMITED USE EXTERNAL 97 PDR LUCENTIS 79 MISC LIANEOUS COMPOUNDED 97 NEOCATE W/ DHA & ARA 400G 126 LUCENTIS PFS 79 MISC LIANEOUS COMPOUNDED 97 NESTL MATERNA 97 NETUPITANT, PALONOSETRON 97 NEURONOSETRON 97 NEUROSTRON 97 NEURONOSETRON 97						e e
LIXIANA 32 MIO PINK 6MMX18 121 NEOCATE JR FIBERRIRON 400G 126 LORAZEPAM 60 MIO PINK 6MMX23 121 POR LORAZEPAM 60 MIO PINK 6MMX23 121 POR LORAZEPAM 60 MINEABEGRON 95 NEOCATE JUNIOR 400G PDR 126 LORAZEPAM SUBLINGUAL 61 MISC LIMITED USE COMPOUND 97 NEOCATE ONE 400G 126 LOSEC 82 INTERNAL 97 POR LOWPRIN 38 MISC LIMITED USE EXTERNAL 97 POR LUCENTIS 79 MISCELLANEOUS COMPOUNDED 97 NEOCATE W/ DHA & ARA 400G 126 LUCENTIS PFS 79 MISCELLANEOUS COMPOUNDED 97 NEOCATE W/ DHA & ARA 400G 126 LURASIBONE HYDROCHLORIDE 56 MISCELLANEOUS COMPOUNDED 97 NEURASIBONE HYDROCHLORIDE 170 EYE/EAR DROP 170 EXTERNAL POWDER 170 EYE/EAR DROP 170 EYE/EAR						
LORAZEPAM 60 MIO PINK 6MMX23 121 PDR 121 LORAZEPAM 126 MIRABEGRON 95 NEOCATE JUNIOR 400G PDR 126 127 127 126 127						
LORAZEPAM 60 MIRABEGRON 95 NEOCATE JUNIOR 400G PDR 126 LORAZEPAM SUBLINGUAL 61 MISC LIMITED USE COMPOUND 97 NEOCATE ONE 400G 126 LOSEC 82 INTERNAL NEOCATE W/ DHA & ARA 400G 126 LOWPRIN 38 MISC LIANTED USE EXTERNAL 97 PDR LUCENTIS 79 MISCELLANEOUS COMPOUNDED 97 NESTL MATERNA 97 LUCENTIS PFS 79 MISCELLANEOUS COMPOUNDED 97 NESTL MATERNA 97 LYRAZA 17 EYEFAR DROP 97 NEULASTA 80 LYRICA 53 MISCELLANEOUS COMPOUNDED 97 NEURONOSETRON 80 MAR-FEBUXOSTAT 98 MISCELLANEOUS COMPOUNDED 97 NEURONTIN 50 MAR-GABAPENTIN 50 M-MOXIFLOXACIN 3 NICHIT 30 MAR-GASAMIDE 52 MOGADON 61 NICODERM 29 MAR-MONTELUKAST 75 MONOLET 21G LANCET 124 NICOTINE (INHALER 29						120
LORAZEPAM SUBLINGUAL 61 MISC LIMITED USE COMPOUND 97 NEOCATE ONE 400G 126 LOSEC 82 INTERNAL NEOCATE W/ DHA & ARA 400G 126 LOWPRIN 38 MISC LIMITED USE EXTERNAL 97 PDR LUCENTIS 79 MISC LIMITED USE EXTERNAL 97 PDR LUCENTIS 79 MISCELLANEOUS COMPOUNDED 97 NESTL MATERNA 97 LUCENTIS PFS 79 MISCELLANEOUS COMPOUNDED 97 NESTL MATERNA 97 LURASIDONE HYDROCHLORIDE 56 MISCELLANEOUS COMPOUNDED 97 NEURASTA 80 LYRICA 53 MISCELLANEOUS COMPOUNDED 97 NEURASTA 33 MAR-PONEPEZIL 23 MISCELLANEOUS COMPOUNDED 97 NEUROSTIN 50 MAR-FINGOLIMOD 99 SUPPOSTIORY NEUROSTIN 50 NEUROSTIN 50 MAR-GALANTAIMIE ER 24 MOSALANTAIMIE ER 24 MISCELLANEOUS COMPOUNDED 97 NEUROSTIN 50 MAR-MONTELUKAST 75						126
LOSEC						
LOWPRIN 38				0.		
LUCENTIS 79			MISC LIMITED USE EXTERNAL	97		0
LUCENTIS PFS 79			COMPOUND MIXTURE		NEORAL	117
LURASIDONE HYDROCHLORIDE 56 MISCELLANEOUS COMPOUNDED 97 NETUPITANT, PALONOSETRON 80 LYNPARZA 17 EYE/EAR DROP 17 EYE/EAR DROP HYDROCHLORIDE) 17 LYRICA 53 MISCELLANEOUS COMPOUNDED 97 NEULASTA 33 MAR-DONEPEZIL 23 INJECTION/INFUSION NEUPRO 66 MAR-FEBUXOSTAT 98 MISCELLANEOUS COMPOUNDED 97 NEURONTIN 50 MAR-FINGOLIMOD 99 SUPPOSITORY NICHIT 30 MAR-GABAPENTIN 50 M-MOXIFLOXACIN 3 NICODERM 30 MAR-GABAPENTIN 50 M-MOXIFLOXACIN 3 NICORETTE GUM 29 MAR-LACOSAMIDE 52 MOGADON 61 NICORETTE INHALER 29 MAR-MONTELUKAST 75 MONLET 71G LANCET 124 NICORETTE LOZENGE 30 MAR-PREGABALIN 3 MONTELUKAST SODIUM 75 NICORETTE CUICKMIST 31 MAR-RIZATRIPTAN ODT 63 MORPHINE SULFATE (KADIAN) <t< td=""><td></td><td></td><td></td><td>97</td><td>NESTL MATERNA</td><td>97</td></t<>				97	NESTL MATERNA	97
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MAR-MOXIFLOXACIN 3 MONOLET THIN (MONOJECT) 28G 124 NICORETTE LOZENGE 30 MAR-PANTOPRAZOLE 84 MONTELUKAST 75 NICORETTE QUICKMIST 31 MAR-PREGABALIN 53 MONTELUKAST SODIUM 75 NICOTINE (GUM) 29 MAR-RIZATRIPTAN 63 MONTELUKAST SODIUM 75 NICOTINE (INHALER) 29 MAR-RIZATRIPTAN ODT 63 MORPHINE HYDROCHLORIDE 43 NICOTINE (LOZENGE) 29 MAR-TROSPIUM 95 MORPHINE SR 44 NICOTINE (PATCH) 30 MAR-ZOLMITRIPTAN 65 MORPHINE SULFATE 43 NICOTINE (PATCH) 30 M-ASA 38 MORPHINE SULFATE (KADIAN) 45 NICOTINE (BUM 29 M-ASA 38 MORPHINE SULFATE (KADIAN) 45 NICOTINE (BUM 29 MATERNA 97 MOTION SICKNESS 80 NICOTINE TRANSDERMAL 30 MAYENCLAD 117 MOXIFLOXACIN HYDROCHLORIDE 2 NITOTINIB 17 MAYENCLAD 117			MONOLET 21G LANCET	124		
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MAVIRET 5 MOZIFEDAACIN HYDROCHLORIDE 2 NITRAZEPAM 61 MAXALT 63 MOZOBIL 34 NOVA MAX 71 MAXALT RPD 63 M-PANTOPRAZOLE 84 NOVA MAX 71 MAXALT RPD 69 M-PANTOPRAZOLE 124 NOVA-T 69	MAVENCLAD	117				
MAXALT 63 MOZOBIL 34 NOVA MAX 71 MAXALT RPD 63 M-PANTOPRAZOLE 84 NOVA-T 69 MAXALT RPD 100 <t< td=""><td>MAVIRET</td><td>5</td><td></td><td></td><td></td><td></td></t<>	MAVIRET	5				
MAXALT RPD 63 M-PANTOPRAZULE 84 MDD TUINL ANCET (NC) 424 NOVA-T 69	MAXALT	63				
M-DONEPEZIL 23 MPD THIN LANCET (NS) 124 NOVA-1	MAXALT RPD	63				
	M-DONEPEZIL	23	MPD THIN LANCET (NS)	124		09

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Non-Insured Health Benefits

Appendix A - Limited 03c L	ochenico un	ia Officia		Non-insured ricaltif B	CHCHLO
NOVO-GESIC	48	PANTOPRAZOLE MAGNESIUM	83	PMS-AMPHETAMINES XR	56
NOVO-GESIC FORTE	48	PANTOPRAZOLE SODIUM	84	PMS-ATOMOXETINE	66
NRA-MONTELUKAST	75	PANTOPRAZOLE T	83	PMS-BENZYDAMINE	78
NRA-PREGABALIN	53	PANTOPRAZOLE-40	84	PMS-BOSENTAN	37
NRA-RIZATRIPTAN ODT	63	PARADIGM SILHOUETTE 13MMX 43	122	PMS-BUPRENORPHINE-NALOXONE	46
NSAID IN TRANSDERMAL BASE	97	PARADIGM SILHOUETTE 13MMX18"	122	PMS-CLONAZEPAM	49
NUCALA	118	PARADIGM SILHOUETTE 13MMX23	122	PMS-CLONAZEPAM-R	49
NUTRAMIGEN A+ 945ML LIQ	126	PARADIGM SILHOUETTE 13MMX32"	122	PMS-CYCLOBENZAPRINE	29
NUTRAMIGEN A+ LGG 561G PDR	126	PARADIGM SILHOUETTE 17MMX23	122	PMS-DIAZEPAM	60
NUTREN 1.5	125	PARADIGM SILHOUETTE 17MMX32"	122	PMS-DICLOFENAC	39
NUTREN JR. 250ML LIQ	126	PARADIGM SILHOUETTE 17MMX43	122	PMS-DIMENHYDRINATE	80
OBETICHOLIC ACID	86	PARADIGM SILHOUETTE	122	PMS-DONEPEZIL	24
OCALIVA	86	CANNULA 13MM		PMS-ERLOTINIB	11
OCRELIZUMAB	100	PARADIGM SILHOUETTE	122	PMS-FENTANYL MTX	41
OCREVUS	100	CANNULA 17MM		PMS-FINGOLIMOD	99
ODAN LEVOCARNITINE	73	PARADIGM SURE-T 29G 6MMX18	122	PMS-FLUTICASONE	28
OFEV	74	PARADIGM SURE-T 29G 6MMX23	122	PROPIONATE/SALMETEROL DPI	
OLAPARIB	17	PARADIGM SURE-T 29G 8MMX23	122	PMS-GABAPENTIN	50
OMALIZUMAB	77	PARIET	85	PMS-GALANTAMINE ER	25
OMEPRAZOLE	82	PAT-GALANTAMINE ER	25	PMS-HYDROMORPHONE	42
OMEPRAZOLE MAGNESIUM	82	PAZOPANIB	18	PMS-IMATINIB	14
OMEPRAZOLE-20	82	PDP-ACETAMINOPHEN	47	PMS-LANSOPRAZOLE	81
ONABOTULINUMTOXINA	120	PEDIAPHEN	47	PMS-LEVOFLOXACIN	2
ONBREZ BREEZHALER	28	PEDIASURE 235ML LIQ	126	PMS-LORAZEPAM	61
ONE A DAY WOMEN	96	PEDIASURE COM. GROW&GAIN	126	PMS-METHYLPHENIDATE	58
ONE TOUCH DELICA 30G LANCET	124	235ML LIQ		PMS-MONTELUKAST	75
ONE TOUCH DELICA 30G LANCET	71	PEDIASURE FIBRE 235ML LIQ	126	PMS-OMEPRAZOLE	82
	124	PEDIASURE GROW&GAIN 400G	126	PMS-OXYCODONE	45
ONETOLICH DELICA 33G LANCET		PDR	400	PMS-PANTOPRAZOLE	84
ONETOUCH DELICAPLUS 30G LANCET	124	PEDIASURE PLUS WITH FIBRE 235	126	PMS-PREGABALIN	53
ONETOUCH DELICAPLUS 33G	124	PEDIATRIX	47	PMS-PROGESTERONE	90
LANCET	124	PEDIAVIT	96	PMS-RABEPRAZOLE	85
ONETOUCH ULTRASOFT LANCET	124	PEGASYS	4	PMS-RIVASTIGMINE	25
ONETOUCH VERIO	71	PEGETRON KIT	4	PMS-RIZATRIPTAN RDT	63
ONETOUCH VERIO (ON)	71	PEGFILGRASTIM	33	PMS-SILDENAFIL R	36
OPIOID COMPOUNDED	97	PEGINTERFERON ALFA-2A	4	PMS-SUMATRIPTAN	64
OPTICHAMBER	120	PEGINTERFERON ALFA-2B,	4	PMS-ZOLMITRIPTAN	65
OPTICHAMBER DIAMOND	120	RIBAVIRIN	_	PMS-ZOLMITRIPTAN ODT	65
(CHAMBER)		PEGINTERFERON BETA-1A	5	POCKET CHAMBER	121
OPTICHAMBER DIAMOND LARGE	120	PEPTAMEN 1.5 1000ML LIQ	125	POCKET CHAMBER WITH ADULT	121
MASK		PEPTAMEN 1.5 250ML LIQ	125	MASK	121
OPTICHAMBER DIAMOND MEDIUM	120	PEPTAMEN 250ML LIQ	125	POCKET CHAMBER WITH INFANT	121
MASK		PEPTAMEN JUNIOR 1.0 CAL 250ML	126	MASK	
OPTICHAMBER DIAMOND SMALL	120	LIQ	400	POCKET CHAMBER WITH MEDIUM	121
MASK	404	PEPTAMEN JUNIOR 1.5 CAL 250ML LIQ	126	MASK	
OPTICHAMBER LARGE MASK	121	PEPTAMEN WITH PREBIO 1000ML	125	POCKET CHAMBER WITH SMALL	121
OPTICHAMBER MEDIUM MASK	121 121	LIQ	120	MASK	
OPTICHAMBER SMALL MASK		PEPTAMEN WITH PREBIO 250ML	125	PODS	121
OPTIHALER	121	LIQ		POLYSACCHARIDE IRON COMPLEX	31
ORENCIA	102	PEPTO BISMOL	80		40
OSIMERTINIB	17	PEPTO-BISMOL	80	POMALYOT	18
OXAZEPAM	61	PERAMPANEL	53	POMALYST	18
OXAZEPAM	61	PHARIXIA	77	PONATINIB HYDROCHLORIDE	19
OXCARBAZEPINE (SUSPENSION)	53	PHARMA-LACOSAMIDE	52	PRADAXA	32
OXEZE TURBUHALER	27	PIMECROLIMUS	92	PRALUENT	35
OXPAM	61	PINAVERIUM BROMIDE	86	PRECISION XTRA	71
OXYCODONE HYDROCHLORIDE	45	PIPERACILLIN AND TAZOBACTAM	1	PREGABALIN	53
OXYCODONE/ACET	39	PIPERACILLIN	1	PREGABALIN	53
OXY-IR	45	SODIUM/TAZOBACTAM SODIUM		PRENATAL AND POSTPARTUM	97
OZEMPIC	89	PIPERACILLIN, TAZOBACTAM	1	VITAMINS AND MINERALS	0.4
PALBOCICLIB	18	PIRFENIDONE	74	PREVACID FASTAR	81 82
PAL-TIZANIDINE	29	PLEGRIDY	5	PREVACID FASTAB	
PANTOLOC	84	PLERIXAFOR	34	PRIVA-PANTOPRAZOLE	84
PANTOPRAZOLE	84	PMS HYDROMORPHONE	42	PRO-AAS	38
PANTOPRAZOLE MAGNESIUM	83	PMS-ACETAMINOPHEN	39	PROBUPHINE	46
				PRO-CLONAZEPAM	49

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Non-Insured	Health	Benefits
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Appendix A - Limited 03c D	criciito ai	ia Officia		Non-moured meaning	Jenenes
PRO-GABAPENTIN	50	RIBAVIRIN	5	SANDOZ RABEPRAZOLE	85
PROGESTERONE	90	RIBOCICLIB (RIBOCICLIB	19	SANDOZ RIVASTIGMINE	25
PROGRAF	119	SUCCINATE)		SANDOZ RIZATRIPTAN ODT	63
PROLIA	101	RIFAXIMIN	4	SANDOZ SUMATRIPTAN	64
PRO-LORAZEPAM	61	RIOCIGUAT	76	SANDOZ TACROLIMUS	119
PROMETRIUM	90	RISANKIZUMAB	93	SANDOZ VORICONAZOLE	4
PROPRANOLOL (HEMANGIOL)	37	RITUXAN	20	SANDOZ ZOLMITRIPTAN	65
PRO-RABEPRAZOLE	85	RITUXIMAB	20	SANDOZ ZOLMITRIPTAN ODT	65
PROTOPIC	95	RIVA OXAZEPAM	61	SAPHRIS	56
PURAMINO A+ 400G PDR	126	RIVA-ATOMOXETINE	66	SARILUMAB	114
PURAMINO A+ JUNIOR 400G PDR	126	RIVA-CLONAZEPAM	49	SECUKINUMAB	94
QUICK-SET 6MMX18	122	RIVACOCET	39	SELEXIPAG	77
QUICK-SET 6MMX23 TUBING	122	RIVA-CYCLOBENZAPRINE	29	SEMAGLUTIDE	89
QUICK-SET 6MMX32	122	RIVA-GABAPENTIN	50	SEPTA DONEPEZIL	24
QUICK-SET 6MMX43 TUBING	122	RIVA-LANSOPRAZOLE	81	SEPTA DONEFEZIL SEPTA-ZOLMITRIPTAN-ODT	65
	122	RIVA-MONTELUKAST	75		
QUICK-SET 9MMX23 TUBING		RIVA-MOXIFLOXACIN	3	SEREVENT DISKUS	28
QUICK-SET 9MMX32	122	RIVA-MEPRAZOLE DR	83	SEVELAMER CARBONATE	73
QUICK-SET 9MMX43 TUBING	122	RIVA-OMERICAZOLE DIX	84	SEVELAMER HYDROCHLORIDE	73
QUINSAIR	2			SIDEKICK	71
RABEPRAZOLE	85	RIVA-PREGABALIN	53	SILDENAFIL CITRATE	36
RABEPRAZOLE EC	85	RIVAROXABAN	32	SILIQ	91
RABEPRAZOLE SODIUM	85	RIVAROXABAN (10)	32	SIMILAC ALIMENTUM 237ML LIQ	126
RALOXIFENE HYDROCHLORIDE	88	RIVAROXABAN (CAD,PAD)	33	SIMILAC ALIMENTUM 400G PDR	126
RAN-GABAPENTIN	50	RIVASA	38	SIMILAC ALIMENTUM 945ML LIQ	126
RANIBIZUMAB	79	RIVASA EC	38	SIMILAC LOWER IRON 850G PDR	127
RAN-MONTELUKAST	75	RIVASTIGMINE	25	SIMILAC NEOSURE 363G PDR	127
RAN-OMEPRAZOLE	82	RIVASTIGMINE HYDROGEN	25	SIMILAC PM 60/40 450G PDR	127
RAN-PANTOPRAZOLE	84	TARTRATE		SIMPONI	111
RAN-RABEPRAZOLE	85	RIVOTRIL	49	SINGULAIR	75
RAPAMUNE	119	RIZATRIPTAN BENZOATE	63	SIROLIMUS	119
RAPID-D 10MM/110CM	122	RIZATRIPTAN ODT	63	SITAGLIPTIN PHOSPHATE	88
RAPID-D 10MM/60CM	122	RIZATRIPTAN RDT	63	MONOHYDRATE	
RAPID-D 10MM/80CM	122	ROTIGOTINE	66	SITAGLIPTIN PHOSPHATE	88
RAPID-D 6MM/110CM	122	RUFINAMIDE	55	MONOHYDRATE, METFORMIN	
RAPID-D 6MM/60CM	122	RUGBY NICOTINE POLACRILEX	29	HYDROCHLORIDE	
RAPID-D 6MM/80CM	122	GUM		SKYRIZI	93
RAPID-D 8MM/110CM	122	RUXOLITINIB	20	SOFOSBUVIR	6
RAPID-D 8MM/60CM	122	RYDAPT	16	SOFOSBUVIR, LEDIPASVIR	6
RAPID-D 8MM/80CM	122	SALMETEROL XINAFOATE	28	SOFOSBUVIR, VELPATASVIR	6
RATIO-LENOLTEC NO 2	39	SALMETEROL XINAFOATE,	28	SOFOSBUVIR, VELPATASVIR,	6
RATIO-LENOLTEC NO 3	39	FLUTICASONE PROPIONATE		VOXILAPREVIR	
REBIF	99	SANDOZ ALMOTRIPTAN	62	SOVALDI	6
REDDY-PROGESTERONE	90	SANDOZ AMPHETAMINE XR	56	SPACER DEVICE	120
		SANDOZ ATOMOXETINE	67	SPIRIT TEST STRIP (ON)	71
REGORAFENIB REMICADE	19	SANDOZ BOSENTAN	37	STATEX	43
	113	SANDOZ CYCLOSPORINE	117	STELARA	98
RENAGEL	73	SANDOZ DONEPEZIL	24	STIVARGA	19
RENFLEXIS	113	SANDOZ FENTANYL	41	STRATTERA	67
RENVELA	73	SANDOZ FINGOLIMOD	99	STRESSTABS FOR WOMEN	96
REPATHA	36	SANDOZ GEFITINIB	13	SUBLOCADE	40
RESERVOIR PARADIGM 5X1.8ML	123	SANDOZ LACOSAMIDE	52	SUBOXONE	46
RESERVOIR PARADIGM 7X3.0ML	123	SANDOZ LANSOPRAZOLE	81	SUMATRIPTAN	64
RESOURCE 2.0 237ML LIQ	125	SANDOZ LEVOFLOXACIN	2	SUMATRIPTAN DF	64
RESOURCE DIABETIC 1.5L	125	SANDOZ LINEZOLID	3	SUMATRIPTAN SUCCINATE	64
RESOURCE DIABETIC 250ML LIQ	125	SANDOZ METHYLPHENIDATE SR	58	SUNITINIB MALATE	21
RESOURCE JUST KIDS 1.5 CAL	126	SANDOZ MONTELUKAST	75	SUPEUDOL	45
237ML LIQ		SANDOZ MORPHINE SR	44	SURE STEP	71
RESPICHAMBER SILICONE	121	SANDOZ MOXIFLOXACIN	3	SURETEST (ON)	71
MEDIUM MASK	404	SANDOZ MYCOPHENOLATE	118	SUTENT	21
RESPICHAMBER SILICONE SMALL MASK	121	SANDOZ NARATRIPTAN	63	SYMBICORT 100 TURBUHALER	27
RESPICHAMBER VHC W	121	SANDOZ MARATRIFTAN SANDOZ OMEPRAZOLE	82	SYMBICORT 200 TURBUHALER	27
MOUTHPIECE	14.1	SANDOZ OMEFRAZOLE SANDOZ	39	SYNJARDY	90
RESTORIL	62	OXYCODONE/ACETAMINOPHEN	39		123
REVATIO	36	SANDOZ PANTOPRAZOLE	84	T : SLIM X2 CARTRIDGE (SK)	
REVLIMID	14	SANDOZ PREGABALIN	53	TACROLIMUS (PROTOPIC)	95 110
				TACROLIMUS MONOHYDRATE	119

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Non-Insured	Health	Benefits
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Appendix A - Limited Use Be	nents an	u Ontena		Non-insured nearth E	Denenia
TADALAFIL	36	TEVA-MYCOPHENOLATE	118	ULTRAFLEX 1 8MM/60CM	123
TAFINLAR	10	TEVA-NARATRIPTAN	63	ULTRAFLEX 1 8MM/80CM	123
TAGRISSO	17	TEVA-OMEPRAZOLE	83	UPTRAVI	77
TALTZ	92	TEVA-OXYCOCET	39	USTEKINUMAB	98
TARCEVA	11	TEVA-OXYCODAN	40	VALIUM	60
TARO-DICLOFENAC	39	TEVA-PANTOPRAZOLE	84	VALSARTAN, SACUBITRIL	38
TARO-DONEPEZIL	24	TEVA-PANTOPRAZOLE	83	VANDETANIB	22
TARO-FINGOLIMOD	99	MAGNESIUM		VARENICLINE TARTRATE	31
TARO-LANSOPRAZOLE	81	TEVA-PREGABALIN	54	VARISOFT 13MM	123
TARO-PREGABALIN	53	TEVA-PROGESTERONE	90	VARISOFT 17MM	123
TARO-SUMATRIPTAN	64	TEVA-RABEPRAZOLE	85	VEDOLIZUMAB	87
TARO-SOMATRIFTAN TARO-TESTOSTERONE	87	TEVA-RIZATRIPTAN ODT	63	VELPHORO	72
TARO-TESTOSTERONE TARO-ZOLEDRONIC ACID	101	TEVA-SILDENAFIL R	36		
	17	TEVA-SUMATRIPTAN	64	VEMURAFENIB	22
TASIGNA	68	TEVA-SUMATRIPTAN DF	64	VENCLEXTA	23
TECFIDERA		TEVA-TEMAZEPAM	62	VENETOCLAX	23
TECTA	83	TEVA-VARENICLINE	31	VERTEPORFIN	79
TEMAZEPAM	62	TEVA-VARICUINE TEVA-VORICONAZOLE	4	VFEND	4
TEMAZEPAM	62	TEVA-VORICONAZOLL TEVA-ZOLMITRIPTAN	65	VIMPAT	52
TEMPRA CHILDREN'S	47	TEVA-ZOLMITRIPTAN OD	65	VISANNE	90
TEMPRA CHILDREN'S DOUBLE	47			VISUDYNE	79
STRENGTH	47	THRIVE GUM (NS)	30	VITAL 1.5 CAL 1000ML LIQ	125
TEMPRA INFANT	47	THRIVE NICOTINE LOZENGES	29	VITAL PEPTIDE 1 CAL 220ML LIQ	125
TENDER-1 17MM/110CM	122	THRIVE NICOTINELL GUM	29	VITAL PEPTIDE 1.5 CAL 220ML LIQ	125
TENDER-1 17MM/60CM	122	TICAGRELOR	33	VITAMIN E	96
TENDER-1 17MM/80CM	122	TIZANIDINE	29	VITAMIN E	96
TENDER-1 MINI INF SET	122	TIZANIDINE HYDROCHLORIDE	29	VOLIBRIS	37
13MM/110CM	100	TOCILIZUMAB (IV)	115	VOLTAREN EMULGEL	38
TENDER-1 MINI INFSET 13MM/60CM	122	TOCILIZUMAB (SC)	116	VOLTAREN EMULGEL EXTRA	38
TENDER-1 MINI INFSET 13MM/80CM	122	TOFACITINIB CITRATE	116	STRENGTH	
TENDER-2 17MM/110CM	122	TOVIAZ	95	VOLTAREN EMULGEL JOINT PAIN	38
TENDER-2 17MM/60CM	122	TRACLEER	37	REGULAR STRENGTH	
TENDER-2 17MM/80CM	122	TRAMETINIB	22	VORICONAZOLE	4
TENDER-2 MINI INF SET	122	TRANSDERMAL LIDOCAINE	97	VOSEVI	6
13MM/110CM		W/NSAID		VOTRIENT	18
TENDER-2 MINI INFSET 13MM/60CM	122	TRANSDERMAL NICOTINE	30	VYVANSE	58
TENDER-2 MINI INFSET 13MM/80CM	122	TRANSDERMAL NICOTINE	30	WAMPOLE COMPLETE MULT-PRE	97
TERIFLUNOMIDE	101	PATCHDAY		AND POST NATAL WITH FOLIC	
TESTIM	87	TRAVEL	80	ACID	
TESTOSTERONE (TOPICAL)	87	TRELEGY ELLIPTA	87	WIXELA INHUB	28
TEVA-ALMOTRIPTAN	62	TRIATEC-30	39	XALKORI	9
TEVA-ALPRAZOLAM	59	TRIAZOLAM	62	XANAX	59
TEVA-ATOMOXETINE	67	TRIAZOLAM	62	XANAX TS	59
TEVA-BOSENTAN	37	TRILEPTAL	53	XARELTO	32
TEVA-BROMAZEPAM	60	TRIMEBUTINE	26	XELJANZ	116
TEVA-CLONAZEPAM	49	TRIMEBUTINE MALEATE	26	XELJANZ XR	116
TEVA-CODEINE	40	TROSEC	95	XEOMIN	120
TEVA-CYCLOBENZAPRINE	29	TROSPIUM CHLORIDE	95	XGEVA	101
TEVA-DIMENATE	80	TRUE TRACK	71	XOLAIR	77
TEVA-DONEPEZIL	24	TRUETEST	71	XTANDI	10
TEVA-EMTEC-30	39	TRUSTEEL 6MM	123	XYLOCAINE	90
TEVA-ERLOTINIB	11	TRUSTEEL 8MM	123	ZAXINE	4
TEVA-EVEROLIMUS	11	TYLENOL	47	ZELBORAF	22
TEVA-FEBUXOSTAT	98	TYLENOL EXTRA STRENGTH	48	ZENHALE	27
TEVA-FENTANYL	41	TYLENOL JR STRENGTH	48	ZEPATIER	5
TEVA-FINGOLIMOD	99	FASTMELTS	10	ZOLEDRONIC ACID	101
TEVA-GABAPENTIN	50	TYLENOL JUNIOR STRENGTH	48	ZOLEDRONIC ACID	101
TEVA-HYDROMORPHONE	42	TYLENOL WITH CODEINE NO.2	39	MONOHYDRATE	
TEVA-IMATINIB	14	TYLENOL WITH CODEINE NO.3	39	ZOLMITRIPTAN	65
	52	ULIPRISTAL ACETATE	88	ZOLMITRIPTAN	65
TEVA LANSOPRAZOLE		ULORIC	98	ZOLMITRIPTAN ODT	65
TEVA-LANSOPRAZOLE	81 61	ULTILET CLASSIC LANCET	124	ZOMIG	65
TEVA-LORAZEPAM	61 50	ULTRAFLEX 1 10MM/110CM	124	ZOMIG RAPIMELT	65
TEVA MONTELLICACE	58 75	ULTRAFLEX 1 10MM/60CM	122	ZYBAN	56
TEVA-MORRUNE OR	75			ZYDELIG	13
TEVA-MORPHINE SR	44	ULTRAFLEX 1 10MM/80CM ULTRAFLEX 1 8MM/110CM	123 123	ZYKADIA	9
TEVA-MOXIFLOXACIN	3	SETTAL LEX TOWNWITHOUN	123	 -	

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ZYTIGA 7 ZYVOXAM 3

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Appendix B

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 supplements 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		20:16.00 HEMATOPOIETIC AGENTS	
08:12.02 AMINOGLYCOSIDES		DARBEPOETIN ALFA	
GENTAMICIN SULFATE		500MCG/ML SOLUTION	
		02391805 ARANESP	AMG
10MG/ML INJECTION 02225123 CIDOMYCIN	UNK	02391821 ARANESP	AMG
10MG SOLUTION	UNK	02392364 ARANESP	AMG
02470462 GENTAMICIN	TEL	09857185 ARANESP	AMG
40MG SOLUTION	ILL	EPOETIN ALFA	
02457008 GENTAMICIN	TEL	1,000U/0.5ML SOLUTION	
08:12.06 CEPHALOSPORINS	122	02231583 EPREX	JSO
CEFAZOLIN SODIUM		2,000U/0.5ML SOLUTION	JSO
500MG POWDER FOR SOLUTION		02231584 EPREX 3,000U/0.3ML SOLUTION	350
02437104 CEFAZOLIN	RAX	02231585 EPREX	JSO
1G POWDER FOR SOLUTION	NAX	4,000U/0.4ML SOLUTION	330
02465469 CEFAZOLIN	UNK	02231586 EPREX	JSO
10G POWDER FOR SOLUTION	ONIC	5000U/0.5ML SOLUTION	000
02452162 CEFAZOLIN	FKD	02243400 EPREX	JSO
02465477 CEFAZOLIN	UNK	6000U/0.6ML SOLUTION	
20G POWDER FOR SOLUTION		02243401 EPREX	JSO
02237141 CEFAZOLIN	FKD	8000U/0.8ML SOLUTION	
100G POWDER FOR SOLUTION		02243403 EPREX	JSO
02401029 CEFAZOLIN	FKD	10,000/ML SOLUTION	
20:00 BLOOD FORMATION		02231587 EPREX	JSO
COAGULATION AND		20,000U/0.5ML SOLUTION	
		02243239 EPREX	JSO
THROMBOSIS		30,000U/0.75ML SOLUTION	
20:16.00 HEMATOPOIETIC AGENTS		02288680 EPREX	JSO
DARBEPOETIN ALFA		40,000U/ML SOLUTION 02240722 EPREX	JSO
25MCG/ML SOLUTION			330
02392313 ARANESP	AMG	40:00 ELECTROLYTIC, CALORIC,	
40MCG/ML SOLUTION	7	AND WATER BALANCE	
02392321 ARANESP	AMG	40:12.00 REPLACEMENT PREPARATION	าพร
60MCG/ML SOLUTION			,,,,
02246348 ARANESP	AMG	CALCIUM	
100MCG/ML SOLUTION		250MG TABLET	
02391740 ARANESP	AMG	00645958 CALCIUM	NOP
02391759 ARANESP	AMG	625MG TABLET (COATED)	451/
02392348 ARANESP	AMG	00682047 APOCAL	APX
99004917 ARANESP	AMG	CALCIUM CARB-GLUCONOLACTATE	
99004925 ARANESP	AMG	500MG TABLET	
200MCG/ML SOLUTION		02232482 CALCIUMSANDOZ FORTE	GSK
02391767 ARANESP	AMG	1,000MG TABLET	
02391775 ARANESP	AMG	02232483 GRAMCAL	GSK
02391783 ARANESP	AMG	SODIUM PHOSPHATE	
02392356 ARANESP	AMG	123MG POWDER FOR SOLUTION	
99004909 ARANESP 99004933 ARANESP	AMG AMG	80027202 PHOSPHATE NOVARTIS	NVR
500MCG/ML SOLUTION	AIVIG	500MG TABLET	
02391791 ARANESP	AMG	00225819 PHOSPHATE-NOVARTIS	NVC
32301101 74044201	,		

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The Special Formulary for Chronic Renal Failure Patients defines selected drugs (for example: darbepoetin alfa, calcium products, water-soluble multivitamin products and selected nutritional supplements 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.

40:12.00 REPLACEMENT PREPARATION	NS	84:00 SKIN AND MUCOUS	
ZINC GLUCONATE		MEMBRANE AGENTS (SMMA)	
50MG TABLET		•	•)
00503169 ZINC	VTH	84:04.04 SMMA - ANTIBIOTICS	
00505463 ZINC	JAM	GENTAMICIN SULFATE	
40:28.08 LOOP DIURETICS		1MG OINTMENT	
FUROSEMIDE		00872881 PMS-GENTAMICIN	PMS
		84:92.00 MISCELLANEOUS SKIN AND	
10MG/ML INJECTION 01987550 LASIX SPECIAL	UNK	MUCOUS MEMBRANE AGENTS	}
10MG LIQUID	UNK	MENTHOL,CAMPHOR	
00527033 FUROSEMIDE	SDZ	OINTMENT	
02360365 FUROSEMIDE	OMG	09991675 ANTIPRURITIC (PRA) CREAM	UNK
10MG SOLUTION		88:00 VITAMINS	0
02461404 FUROSEMIDE	RAX	00.00 VITAIVIINS	
02480530 FUROSEMIDE	MAR	88:28.00 MULTIVITAMIN PREPARATIONS	3
02488868 FUROSEMIDE	BAX	MULTIVITAMINS	
10MG/ML SOLUTION		TABLET/CAPLET	
02382539 FUROSEMIDE	SDZ	00123803 B COMPLEX PLUS C	JAM
02384094 FUROSEMIDE	ALV	80007498 BC VITAMINS	WNP
250MG SOLUTION	DAY	02245391 DIAMINE	EUR
02466945 FUROSEMIDE	RAX	80063438 M-PLAVITE	MAN
56:00 GASTROINTESTINAL DRUGS	5	80001432 RENAVITE	MAC
56:04.00 ANTACIDS AND ADSORBENTS	;	00558796 STRESS PLEX	JAM
ALUMINUM HYDROXIDE		96:00 PHARMACEUTICAL AIDS	
500MG CAPSULE		96:00.00 PHARMACEUTICAL AIDS	
02135620 BASALJEL	AUP	NUTRITIONAL SUPPLEMENT	
320MG/ML SUSPENSION		ORAL LIQUID	
00572527 ALUGEL	ATL	95900049 BOOST 1.0 STANDARD 237ML LIQ	NES
325MG/5ML SUSPENSION		95900053 BOOST 1.5	NES
02125862 AMPHOJEL	AUP	95900051 BOOST FRUIT BEVERAGE 235ML	NES
600MG TABLET		LIQ	
02124971 AMPHOJEL	AUP	95900054 BOOST HIPROTEIN 237ML LIQ	NES
CALCIUM		95999950 ENSURE 235ML LIQ	ABB
500MG TABLET		95900061 BOOST DIABETIC 237ML LIQ	NES
01970240 TUMS	GSK	95900052 BOOST PLUS 237ML LIQ	NES
750MG TABLET		95999975 BOOST PLUS CALORIES 237ML LIQ	NES
01967932 TUMS EXTRA STRENGTH	GSK	95900056 ENSURE HIGH PROTEIN 235ML LIQ	ABB ABB
1,000MG TABLET	CCK	95900057 ENSURE PLUS 235ML LIQ 95900181 ENSURE PLUS CALORIES 235ML	ABB
02151138 TUMS ULTRA STRENGTH	GSK	LIQ	ADD
SODIUM BICARBONATE		95900204 ENSURE PROTEIN MAX 235ML LIQ	ABB
500MG TABLET	13.45	95900140 GLUCERNA 237ML LIQ	ABB
80030520 JAMP-SODIUM BICARBONATE	JMP	95900063 NEPRO 237ML LIQ	ABB
80022194 SANDOZ SODIUM BICARBONATE	SDZ	95900064 NOVASOURCE RENAL 237ML LIQ	NVC
		95900067 SUPLENA 235ML LIQ	ABB
		POWDER	
		95900055 BOOST JUST PROTEIN 588G PDR	NES
		95900215 NEPHEA KID 400G PDR	UNK
		95900182 RESOURCE BENEPROTEIN 227G	NES
		PDR	

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Appendix B - Formulary for C	JIIIOIIIC	Renai Fanure Fanents		Non-insured Health Bellents
ALUGEL	2	ZINC GLUCONATE	2	
ALUMINUM HYDROXIDE	2	2.110 0200010112	-	
AMPHOJEL	2			
ANTIPRURITIC (PRA) CREAM	2			
APOCAL	1			
ARANESP	1			
B COMPLEX PLUS C	2			
BASALJEL	2			
BC VITAMINS	2			
BOOST 1.0 STANDARD 237ML LIQ	2			
BOOST 1.5	2			
BOOST FRUIT BEVERAGE 235ML	2			
LIQ				
BOOST HIPROTEIN 237ML LIQ	2			
BOOST JUST PROTEIN 588G PDR	2			
BOOST PLUS 237ML LIQ	2			
BOOST PLUS CALORIES 237ML LIQ	2			
CALCIUM	1			
CALCIUM	1			
CALCIUM CARB-	1			
GLUCONOLACTATE	•			
	1			
CALCIUMSANDOZ FORTE				
CEFAZOLIN	1			
CEFAZOLIN SODIUM	1			
CIDOMYCIN	1			
DARBEPOETIN ALFA	1			
DIAMINE	2			
ENSURE HIGH PROTEIN 235ML LIQ	2			
ENSURE PLUS 235ML LIQ ENSURE	2			
PLUS CALORIES 235ML LIQ	2			
ENSURE PROTEIN MAX 235ML LIQ	2			
EPOETIN ALFA	1			
EPREX	1			
FUROSEMIDE	2			
FUROSEMIDE	2			
GENTAMICIN	1			
GENTAMICIN SULFATE	1			
GLUCERNA 237ML LIQ	2			
GRAMCAL	1			
JAMP-SODIUM BICARBONATE	2			
LASIX SPECIAL	2			
MENTHOL, CAMPHOR	2			
M-PLAVITE	2			
MULTIVITAMINS	2			
NEPHEA KID 400G PDR	2			
NEPRO 237ML LIQ	2			
NOVASOURCE RENAL 237ML LIQ	2			
NUTRITIONAL SUPPLEMENT	2			
PHOSPHATE NOVARTIS	1			
PHOSPHATE-NOVARTIS	1			
PMS-GENTAMICIN	2			
RENAVITE	2			
RESOURCE BENEPROTEIN 227G	2			
PDR				
SANDOZ SODIUM BICARBONATE	2			
SODIUM BICARBONATE	2			
SODIUM PHOSPHATE	1			
STRESS PLEX	2			
SUPLENA 235ML LIQ	2			
TUMS	2			
TUMS EXTRA STRENGTH	2			
TUMS ULTRA STRENGTH	2			
ZINC				
· •	2			

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Appendix C

End of life care formulary

Requests for any of the DINs below will generate a End of Life Care Application Form, faxed to the prescribing physician. Once completed and submitted, the recipient will be eligible for all medications on the End of Life Care Formulary if the following criteria are met:

The recipient:

- 1. is not receiving care in a provincially funded hospital or provincially funded 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

Once approved, the recipient will be eligible for all medications on the End of Life Care Formulary for six months without the need for further prior approval. If coverage is required beyond the initial six months, an additional six months may be granted upon receipt of another End of Life Care Application Form completed. Please note: During the six month coverage period, a maximum 30 day supply will be reimbursed at any one time.

3 · · · · · · · · · · · · · · · · · · ·	,	, 11,	
12:00 AUTONOMIC DRUGS 12:08.08 ANTIMUSCARINICS /		28:00 CENTRAL NERVOUS SYST AGENTS	EM
ANTISPASMODICS		28:04.92 GENERAL ANESTHETICS, M	IISC.
ATROPINE SULFATE		KETAMINE HYDROCHLORIDE	
0.4MG/ML SOLUTION		10MG/ML SOLUTION	
02094681 ATROPINE	ALV	00224391 KETALAR	ERF
00960624 ATROPINE SULFATE	UNK	02246795 KETAMINE	SDZ
0.6MG/ML SOLUTION		02387301 KETAMINE	SDZ
00012076 ATROPINE SULFATE	GSK	50MG/ML SOLUTION	ODZ
00392693 ATROPINE SULFATE	SDZ	00224405 KETALAR	ERF
00392782 ATROPINE SULFATE	SDZ	02246796 KETAMINE	SDZ
GLYCOPYRROLATE		02387328 KETAMINE	SDZ
0.2MG/ML LIQUID		02387336 KETAMINE	SDZ
02382857 GLYCOPYRROLATE	OMG	28:08.08 OPIATE AGONISTS	
0.2MG SOLUTION			
02382849 GLYCOPYRROLATE MULTIDOSE	OMG	EXTEMPORANEOUS MIXTURE	
0.2MG/ML SOLUTION		INJECTION	
02039508 GLYCOPYRROLATE	SDZ	99506019 FENTANYL STERILE INFUSION	UNK
1MG SOLUTION		99506017 HYDROMORPHONE HP STERILE INFUSION	UNK
02469332 CUVPOSA	PEI	99506018 MORPHINE HP STERILE INFUSION	UNK
HYOSCINE BUTYLBROMIDE		FENTANYL	Orac
20MG/ML SOLUTION		12MCG/HR PATCH	
00363839 BUSCOPAN	SAC	02454440 APO-FENTANYL MATRIX	APX
02229868 HYOSCINE BUTYLBROMIDE	SDZ	02334186 DURAGESIC	JSO
SCOPOLAMINE HYDROBROMIDE		99100480 FENTANYL	JNO
0.4MG/ML SOLUTION		02376768 PAT-FENTANYL MATRIX	KLA
00541869 SCOPOLAMINE	PFI	25MCG/HR PATCH	KLA
02242810 SCOPOLAMINE	OMG	02304120 FENTANYL TRANSDERMAL	ACG
0.6MG/ML SOLUTION		SYSTEM	7.00
00541877 SCOPOLAMINE	PFI	02376776 PAT-FENTANYL MATRIX	KLA
02242811 SCOPOLAMINE	OMG	02325403 RAN-FENTANYL MATRIX	RBY
		37MCG/HR PATCH	
		02386860 CO FENTANYL	OBT
		02327139 SANDOZ FENTANYL	SDZ
		50MCG/HR PATCH	
		02304139 FENTANYL TRANSDERMAL SYSTEM	ACG

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Requests for any of the DINs below will generate a End of Life Care Application Form, faxed to the prescribing physician. Once completed and submitted, the recipient will be eligible for all medications on the End of Life Care Formulary if the following criteria are met:

The recipient:

- 1. is not receiving care in a provincially funded hospital or provincially funded long-term care facility and
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28:08.08 OPIATE AGONISTS		28:08.08 OPIATE AGONISTS	
FENTANYL		METHADONE HYDROCHLORIDE (BC ONLY)	
50MCG/HR PATCH		POWDER	
02376784 PAT-FENTANYL MATRIX	KLA	09991180 METHADONE PDR (PAIN)	UNK
02325411 RAN-FENTANYL MATRIX	RBY	09991552 METHADONE PDR (END OF LIFE)	UNK
75MCG/HR PATCH		METHADONE HYDROCHLORIDE (METADOL	_)
02304147 FENTANYL TRANSDERMAL SYSTEM	ACG	1MG/ML SOLUTION 02247694 METADOL	PAL
02376792 PAT-FENTANYL MATRIX	KLA	1MG TABLET	IAL
02325438 RAN-FENTANYL MATRIX	RBY	02247698 METADOL	PAL
100MCG/HR PATCH		5MG TABLET	FAL
02304155 FENTANYL TRANSDERMAL	ACG	02247699 METADOL	PAL
SYSTEM		10MG TABLET	IAL
02376806 PAT-FENTANYL MATRIX	KLA	02247700 METADOL	PAL
02325446 RAN-FENTANYL MATRIX	RBY	25MG TABLET	IAL
FENTANYL CITRATE		02247701 METADOL	PAL
50MCG LIQUID		MORPHINE SULFATE	FAL
02384124 FENTANYL CITRATE SDZ	SDZ		
50MCG/ML SOLUTION		2MG/ML LIQUID	
00888346 FENTANYL CITRATE	PFI	02242484 MORPHINE SULFATE	SDZ
02240434 FENTANYL CITRATE	SDZ	10MG LIQUID	
HYDROMORPHONE HYDROCHLORIDE		00392588 MORPHINE SULFATE	SDZ
2MG/ML SOLUTION		15MG LIQUID	0.0.7
02145901 HYDROMORPHONE	SDZ	00392561 MORPHINE SULFATE	SDZ
10MG SOLUTION		50MG/ML LIQUID	
02460610 HYDROMORPHONE	RAX	02137267 MORPHINE SULPHATE	HOS
HYDROCHLORIDE HP 10		0.5MG/ML SOLUTION	
10MG/ML SOLUTION		02021056 MORPHINE LP EPIDURAL	SDZ
02145928 HYDROMORPHONE HP	SDZ	01949047 MORPHINE-EPD	PFI
20MG/ML SOLUTION		1MG/ML SOLUTION	0.0.7
02145936 HYDROMORPHONE HP	SDZ	02021048 MORPHINE LP	SDZ
50MG/ML SOLUTION		01980696 MORPHINE SULFATE	SDZ
02146126 HYDROMORPHONE HP	SDZ	01949055 MORPHINE-EPD	PFI
99003163 HYDROMORPHONE HP	UNK	2MG/ML SOLUTION	DEI
100MG/ML SOLUTION		00850314 MORPHINE SULFATE	PFI
02244797 HYDROMORPHONE HP FORTE	SDZ	01964437 MORPHINE SULFATE	SDZ
		5MG/ML SOLUTION	0.0.7
		01964429 MORPHINE SULFATE	SDZ

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28:08.08 OPIATE AGONISTS MORPHINE SULFATE		28:24.08 ANXIOLYTICS, SEDATIVE HYPNOTICS - BENZODIA	
10MG/ML SOLUTION		LORAZEPAM	
00850322 MORPHINE SULFATE	PFI	4MG/ML LIQUID	
25MG/ML SOLUTION		02243278 LORAZEPAM	SDZ
00676411 MORPHINE HP	SDZ	2MG/ML SOLUTION	
50MG/ML SOLUTION		02438704 LORAZEPAM	SDZ
00617288 MORPHINE HP	SDZ	MIDAZOLAM	
28:12.04 ANTICONVULSANTS -		1MG/ML SOLUTION	
BARBITURATES		02240285 MIDAZOLAM	SDZ
PHENOBARBITAL		02242904 MIDAZOLAM	FKD
30MG SOLUTION		02243934 MIDAZOLAM	NOP
02304082 PHENOBARBITAL SODIUM	SDZ	5MG SOLUTION	
120MG SOLUTION		02423766 MIDAZOLAM	PFI
02304090 PHENOBARBITAL SODIUM	SDZ	5MG/ML SOLUTION	
28:12.12 ANTICONVULSANTS -		02240286 MIDAZOLAM	SDZ
HYDANTOINS		02242905 MIDAZOLAM	FKD
		02243935 MIDAZOLAM	NOP
PHENYTOIN		02382903 MIDAZOLAM	SDZ
50MG LIQUID	0.0.7	40:00 ELECTROLYTIC, CALOF	RIC,
00780626 PHENYTOIN SODIUM	SDZ	AND WATER BALANCE	
28:16.08 ANTIPSYCHOTIC AGENTS		40:28.08 LOOP DIURETICS	
METHOTRIMEPRAZINE HYDROCHLORIDE			
25MG/ML SOLUTION		FUROSEMIDE	
01927698 NOZINAN	SAC	10MG LIQUID	
28:24.08 ANXIOLYTICS, SEDATIVES AN	ID	00527033 FUROSEMIDE	SDZ
HYPNOTICS - BENZODIAZEPII	NES	10MG/ML SOLUTION	
DIAZEPAM		02382539 FUROSEMIDE	SDZ
5MG/ML SOLUTION		02384094 FUROSEMIDE	ALV
00399728 DIAZEPAM	SDZ	52:00 EYE, EAR, NOSE AND T	HROAT
02386143 DIAZEPAM	SDZ	(EENT) PREPARATIONS	
DIAZEPAM (DIASTAT)	ODZ	52:92.00 MISCELLANEOUS EENT	
5MG/ML GEL			DRUGS
02238162 DIASTAT	VAE	ARTIFICIAL SALIVA	
09853340 DIASTAT 2X10MG RECTAL PACK	FIN	0.05MG SPRAY	
09853430 DIASTAT 2X15MG RECTAL PACK	ELN	02238696 MOISTIR	PMS
55500 100 BING INTERNIOR INCOME INTOR	,		

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Requests for any of the DINs below will generate a End of Life Care Application Form, faxed to the prescribing physician. Once completed and submitted, the recipient will be eligible for all medications on the End of Life Care Formulary if the following criteria are met:

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56:00 GASTROINTESTINAL DRUG	GS	56:22.20 5-HT3 RECEPTOR ANTAGONI	STS
	ONDANSETRON HYDROCHLORIDE		
56:08.00 ANTIDIARRHEA AGENTS		2MG/ML SOLUTION	
DIPHENOXYLATE HYDROCHLORIDE, ATR	OPINE	02390051 ONDANSETRON	MYL
SULFATE		56:22.92 MISCELLANEOUS ANTIEMETI	ICS
2.5MG & 0.025MG TABLET			
00036323 LOMOTIL	PFI	NABILONE	
56:22.20 5-HT3 RECEPTOR ANTAGON	NISTS	0.25MG CAPSULE	ADV
GRANISETRON HYDROCHLORIDE		02441497 APO-NABILONE	APX
1MG LIQUID		02345897 APP-NABILONE 02380897 PMS-NABILONE	UNK PMS
02322765 GRANISETRON HYDROCHLORIDE	OMG	0.5MG CAPSULE	FIVIS
1MG/ML SOLUTION		02441500 APO-NABILONE	APX
02385414 GRANISETRON	SDZ	02345927 APP-NABILONE	UNK
ONDANSETRON HYDROCHLORIDE		1MG CAPSULE	Ortic
2MG/ML INJECTION		02441519 APO-NABILONE	APX
02291703 ONDANSETRON W/P	APX	02345935 APP-NABILONE	UNK
09857324 ZOFRAN (ON)	GSK	SCOPOLAMINE	
09857325 ZOFRAN (ON)	GSK	1.5MG PATCH	
2MG LIQUID		00550094 TRANSDERM-V	NVC
02271761 ONDANSETRON OMEGA -	OMG	80024336 TRANSDERM-V	NVR
(PRESERVATIVE FREE SINGLE DOSE VIALS)		56:28.12 HISTAMINE H2-ANTAGONISTS	
02271788 ONDANSETRON OMEGA -(WITH PRESERVATIVE MULTIDOSE VIAL)	OMG	FAMOTIDINE	
2MG SOLUTION		10MG SOLUTION	
02420414 JAMP-ONDANSETRON	JMP	02247735 FAMOTIDINE OMEGA -(WITHOUT PRESERVATIVE)	OMG
02420422 JAMP-ONDANSETRON	JMP	,	
02462257 ONDANSETRON	RAX	RANITIDINE HYDROCHLORIDE	
02464578 ONDANSETRON	RAX	25MG/ML SOLUTION	CDZ
02279436 ONDANSETRON -(WITH	SDZ	02256711 RANITIDINE	SDZ
PRESERVATIVE)		56:32.00 PROKINETIC AGENTS	
02461420 ONDANSETRON BP	AUR	METOCLOPRAMIDE HYDROCHLORIDE	
02213745 ZOFRAN	NVR	5MG/ML LIQUID	
2MG/ML SOLUTION		02185431 METOCLOPRAMIDE	SDZ
02265524 ONDANSETRON	TEV	02243563 METOCLOPRAMIDE OMEGA	OMG
02274418 ONDANSETRON	SDZ		
02279428 ONDANSETRON	SDZ		
02390019 ONDANSETRON	MYL		

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NES

56:92.00 MISCELLANEOUS GI DRUGS

METHYLNALTREXONE BROMIDE

20MG SOLUTION

02308215	RELISTOR	SLX
02356481	RELISTOR	SLX
02356503	RELISTOR	SLX

96:00 PHARMACEUTICAL AIDS

96:00.00 PHARMACEUTICAL AIDS

95900049 BOOST 1.0 STANDARD 237ML LIQ

95900055 BOOST JUST PROTEIN 588G PDR

ADMINISTRATION DIN

MISCELLANEOUS

91500004 STERILE PREPERATION FEE UNK

NUTRITIONAL SUPPLEMENT

ORAL LIQUID

95900053	BOOST 1.5	NES
95900051	BOOST FRUIT BEVERAGE 235ML	NES
	LIQ	
95900054	BOOST HIPROTEIN 237ML LIQ	NES
95999950	ENSURE 235ML LIQ	ABB
95900061	BOOST DIABETIC 237ML LIQ	NES
95900052	BOOST PLUS 237ML LIQ	NES
95999975	BOOST PLUS CALORIES 237ML LIQ	NES
95900056	ENSURE HIGH PROTEIN 235ML LIQ	ABB
95900057	ENSURE PLUS 235ML LIQ	ABB
95900181	ENSURE PLUS CALORIES 235ML	ABB
	LIQ	
95900204	ENSURE PROTEIN MAX 235ML LIQ	ABB
95900141	GLUCERNA TUBE FEEDING 235ML	ABB
	LIQ	
POWDER		

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NES

Appendix C - End of Life Car	e Form	ulary	i
ADMINISTRATION DIN	5	HYOSCINE BUTYLBROMIDE	1
APO-FENTANYL MATRIX	1	JAMP-ONDANSETRON	4
APO-NABILONE	4	KETALAR	1
APP-NABILONE	4	KETAMINE	1
ARTIFICIAL SALIVA	3	KETAMINE HYDROCHLORIDE	1
ATROPINE	1	LOMOTIL	4
ATROPINE SULFATE	1	LORAZEPAM	3
ATROPINE SULFATE	1	LORAZEPAM	3
BOOST 1.0 STANDARD 237ML LIQ	5	METADOL	2
BOOST 1.0 STANDARD 237WIL LIQ	5	METHADONE HYDROCHLORIDE	2
BOOST FRUIT BEVERAGE 235ML	5	(BC ONLY)	2
LIQ	5	METHADONE HYDROCHLORIDE	2
BOOST HIPROTEIN 237ML LIQ	5	(METADOL)	-
BOOST JUST PROTEIN 588G PDR	5	METHADONE PDR (PAIN)	2
BOOST PLUS 237ML LIQ	5	METHADONE PDR (END OF LIFE)	2
BOOST PLUS CALORIES 237ML LIQ	5	METHOTRIMEPRAZINE	3
	5 1	HYDROCHLORIDE	J
BUSCOPAN	•	METHYLNALTREXONE BROMIDE	5
CO FENTANYL	1	METOCLOPRAMIDE	4
CUVPOSA	1	METOCLOPRAMIDE	4
DIASTAT	3	HYDROCHLORIDE	7
DIASTAT 2X10MG RECTAL PACK	3	METOCLOPRAMIDE OMEGA	4
DIASTAT 2X15MG RECTAL PACK	3	MIDAZOLAM	3
DIAZEPAM	3		3
DIAZEPAM	3	MIDAZOLAM	3
DIAZEPAM (DIASTAT)	3	MOISTIR	3
DIPHENOXYLATE	4	MORPHINE HP	
HYDROCHLORIDE, ATROPINE		MORPHINE HP STERILE INFUSION	1
SULFATE		MORPHINE LP	2
DURAGESIC	1	MORPHINE LP EPIDURAL	2
ENSURE HIGH PROTEIN 235ML LIQ	5	MORPHINE SULFATE	2
ENSURE PLUS 235ML LIQ	5	MORPHINE SULFATE	2
ENSURE PLUS CALORIES 235ML	5	MORPHINE SULPHATE	2
LIQ		MORPHINE-EPD	2
ENSURE PROTEIN MAX 235ML LIQ	5	NABILONE	4
EXTEMPORANEOUS MIXTURE	1	NOZINAN	3
FAMOTIDINE	4	NUTRITIONAL SUPPLEMENT	5
FAMOTIDINE OMEGA -(WITHOUT	4	ONDANSETRON	4
PRESERVATIVE)		ONDANSETRON -(WITH	4
FENTANYL	1	PRESERVATIVE)	
FENTANYL	1	ONDANSETRON HYDROCHI ORIDE	4
FENTANYL CITRATE	2	ONDANGETRON ONE CA	4
FENTANYL CITRATE	2	ONDANSETRON OMEGA -	4
FENTANYL CITRATE SDZ	2	(PRESERVATIVE FREE SINGLE	
FENTANYL STERILE INFUSION	1	DOSE VIALS)	
FENTANYL TRANSDERMAL	1	ONDANSETRON OMEGA -(WITH	4
SYSTEM		PRESERVATIVE MULTIDOSE VIAL)	4
FUROSEMIDE	3	ONDANSETRON W/P	1
FUROSEMIDE	3	PAT-FENTANYL MATRIX	-
GLUCERNA TUBE FEEDING 235ML	5	PHENOBARBITAL	3
LIQ		PHENOBARBITAL SODIUM	3
GLYCOPYRROLATE	1	PHENYTOIN	3
GLYCOPYRROLATE	1	PHENYTOIN SODIUM	3
GLYCOPYRROLATE MULTIDOSE	1	PMS-NABILONE	4
GRANISETRON	4	RAN-FENTANYL MATRIX	1
GRANISETRON HYDROCHLORIDE	4	RANITIDINE	4
GRANISETRON HYDROCHLORIDE	4	RANITIDINE HYDROCHLORIDE	4
HYDROMORPHONE	2	RELISTOR	5
HYDROMORPHONE HP	2	SANDOZ FENTANYL	1
HYDROMORPHONE HP FORTE	2	SCOPOLAMINE	1
HYDROMORPHONE HP STERILE	1	SCOPOLAMINE	4
INFUSION		SCOPOLAMINE HYDROBROMIDE	1
HYDROMORPHONE	2	STERILE PREPERATION FEE	5
HYDROCHLORIDE		TRANSDERM-V	4
HYDROMORPHONE	2	ZOFRAN	4
HYDROCHLORIDE HP 10		ZOFRAN (ON)	4
HYOSCINE BUTYLBROMIDE	1		•

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Appendix D

Formulary for adjunct medications used during active cancer treatment

The NIHB Program has established a new formulary to streamline access to adjunctive (non-chemotherapy) medications frequently used by clients undergoing active cancer treatment.

Clients who are approved for oral chemotherapy drugs are given access to all of the medications and nutritional supplements in the formulary. Additionally, clients who request, and are approved, for one of the medications on the formulary for a cancer-related indication are also granted access.

Clients are automatically enrolled for a period of six months. If cancer treatment is of a longer duration, access to the formulary will be granted to align with the treatment duration. In the event that treatment duration is not known and the treatment plan extends beyond six months, access to this formulary may be extended upon request.

08:00 ANTI-INFECTIVE AGENTS		20:16.00 HEMATOPOIETIC AGENTS	
08:12.24 TETRACYCLINES		DARBEPOETIN ALFA	
		200MCG/ML SOLUTION	
MINOCYCLINE HYDROCHLORIDE		02391775 ARANESP	AMG
50MG CAPSULE		02391783 ARANESP	AMG
02084090 MINOCYCLINE	AAP	02392356 ARANESP	AMG
02108143 TEVA-MINOCYCLINE	TEV	99004909 ARANESP	AMG
100MG CAPSULE	445	99004933 ARANESP	AMG
02084104 MINOCYCLINE	AAP	500MCG/ML SOLUTION	
02108151 TEVA-MINOCYCLINE	TEV	02391791 ARANESP	AMG
12:00 AUTONOMIC DRUGS		02391805 ARANESP	AMG
12:12.08 BETA ADRENERGIC AGON	ISTS	02391821 ARANESP	AMG
		02392364 ARANESP	AMG
SALMETEROL XINAFOATE, FLUTICASOI	NE	09857185 ARANESP	AMG
PROPIONATE		EPOETIN ALFA	
25MCG & 125MCG AEROSOL		1,000U/0.5ML SOLUTION	
02245126 ADVAIR 125	GSK	02231583 EPREX	JSO
25MCG & 250MCG AEROSOL		2,000U/0.5ML SOLUTION	
02245127 ADVAIR 250	GSK	02231584 EPREX	JSO
50MCG & 100MCG POWDER		3,000U/0.3ML SOLUTION	
02240835 ADVAIR 100 DISKUS	GSK	02231585 EPREX	JSO
50MCG & 250MCG POWDER		4,000U/0.4ML SOLUTION	
02240836 ADVAIR 250 DISKUS	GSK	02231586 EPREX	JSO
50MCG & 500MCG POWDER		5000U/0.5ML SOLUTION	
02240837 ADVAIR 500 DISKUS	GSK	02243400 EPREX	JSO
20:00 BLOOD FORMATION		6000U/0.6ML SOLUTION	
COAGULATION AND		02243401 EPREX	JSO
THROMBOSIS		8000U/0.8ML SOLUTION	
INCINIDUSIS		02243403 EPREX	JSO
20:16.00 HEMATOPOIETIC AGENTS		10,000/ML SOLUTION	
DARBEPOETIN ALFA		02231587 EPREX	JSO
25MCG/ML SOLUTION		20,000U/0.5ML SOLUTION	
02392313 ARANESP	AMG	02243239 EPREX	JSO
40MCG/ML SOLUTION	71110	30,000U/0.75ML SOLUTION	
02392321 ARANESP	AMG	02288680 EPREX	JSO
60MCG/ML SOLUTION	7 11 11 0	40,000U/ML SOLUTION	
02246348 ARANESP	AMG	02240722 EPREX	JSO
100MCG/ML SOLUTION	7	PEGFILGRASTIM	
02391740 ARANESP	AMG	10MG/ML SOLUTION	
02391759 ARANESP	AMG	02249790 NEULASTA	AMG
02392348 ARANESP	AMG		
99004917 ARANESP	AMG		
99004925 ARANESP	AMG		
200MCG/ML SOLUTION			
02391767 ARANESP	AMG		

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28:00 CENTRAL NERVOUS SY	/STEM	28:12.92 MISCELLANEOUS ANTICONVULSANTS	
AGENTS		PREGABALIN	
28:08.12 OPIATE PARTIAL AGONI	STS	50MG CAPSULE	
BUPRENORPHINE (BUTRANS)		02359618 PMS-PREGABALIN	PMS
5MCG PATCH		0239610 PRIGABALIN	PDL
02341174 BUTRANS 5	PFR	02403706 PREGABALIN	SIV
10MCG PATCH		02405547 PREGABALIN	SAN
02341212 BUTRANS 10	PFR	02476312 PREGABALIN	RIV
15MCG PATCH		02392828 RAN-PREGABALIN	RBY
02450771 BUTRANS 15	PFR	02377047 RIVA-PREGABALIN	RIV
20MCG PATCH		02390825 SANDOZ PREGABALIN	SDZ
02341220 BUTRANS 20	PFR	02361175 TEVA-PREGABALIN	TEV
28:12.92 MISCELLANEOUS		75MG CAPSULE	
ANTICONVULSANTS		02480743 AG-PREGABALIN	ANG
		02394251 APO-PREGABALIN	APX
PREGABALIN		02433885 AURO-PREGABALIN	AUR
25MG CAPSULE		02402572 DOM-PREGABALIN	DPC
02480727 AG-PREGABALIN	ANG	02435993 JAMP-PREGABALIN	JMP
02394235 APO-PREGABALIN	APX	02268434 LYRICA	PFI
02433869 AURO-PREGABALIN	AUR	02417545 MAR-PREGABALIN	MAR
02402556 DOM-PREGABALIN	DPC	02424185 MINT-PREGABALIN	MIN
02435977 JAMP-PREGABALIN	JMP	02479133 NRA-PREGABALIN	UNK
02268418 LYRICA	PFI	02359626 PMS-PREGABALIN	PMS
02417529 MAR-PREGABALIN	MAR	02396513 PREGABALIN	PDL
02423804 MINT-PREGABALIN	MIN	02403714 PREGABALIN	SIV
02479117 NRA-PREGABALIN	UNK	02405555 PREGABALIN	SAN
02359596 PMS-PREGABALIN	PMS	02476320 PREGABALIN	RIV
02396483 PREGABALIN	PDL	02392836 RAN-PREGABALIN	RBY
02403692 PREGABALIN	SIV	02377055 RIVA-PREGABALIN	RIV
02405539 PREGABALIN	SAN	02390833 SANDOZ PREGABALIN	SDZ
02476304 PREGABALIN	RIV	02361183 TEVA-PREGABALIN	TEV
02392801 RAN-PREGABALIN	RBY	150MG CAPSULE	
02377039 RIVA-PREGABALIN	RIV	02480751 AG-PREGABALIN	ANG
02390817 SANDOZ PREGABALIN	SDZ	02394278 APO-PREGABALIN	APX
02361159 TEVA-PREGABALIN	TEV	02433907 AURO-PREGABALIN	AUR
50MG CAPSULE		02402580 DOM-PREGABALIN	DPC
02480735 AG-PREGABALIN	ANG	02436000 JAMP-PREGABALIN	JMP
02394243 APO-PREGABALIN	APX	02268450 LYRICA	PFI
02433877 AURO-PREGABALIN	AUR	02417561 MAR-PREGABALIN	MAR
02402564 DOM-PREGABALIN	DPC	02424207 MINT-PREGABALIN	MIN
02435985 JAMP-PREGABALIN	JMP	02479168 NRA-PREGABALIN	UNK
02268426 LYRICA	PFI	02359634 PMS-PREGABALIN	PMS
02417537 MAR-PREGABALIN	MAR	02396521 PREGABALIN	PDL
02423812 MINT-PREGABALIN	MIN	02403722 PREGABALIN	SIV
02479125 NRA-PREGABALIN	UNK	02405563 PREGABALIN	SAN

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28:12.92 MISCELLANEOUS		48:10.24 LEUKOTRIENE MODIFIERS	
ANTICONVULSANTS		MONTELUKAST SODIUM	
PREGABALIN		10MG TABLET	
150MG CAPSULE		02328593 SANDOZ MONTELUKAST	SDZ
02476347 PREGABALIN	RIV	02238217 SINGULAIR	FRS
02392844 RAN-PREGABALIN	RBY	02355523 TEVA-MONTELUKAST	TEV
02377063 RIVA-PREGABALIN	RIV	4MG TABLET (CHEWABLE)	
02390841 SANDOZ PREGABALIN	SDZ	02377608 APO-MONTELUKAST	APX
02361205 TEVA-PREGABALIN	TEV	02422867 AURO-MONTELUKAST	AUR
300MG CAPSULE		02442353 JAMP-MONTELUKAST	JMP
02394294 APO-PREGABALIN	APX	02399865 MAR-MONTELUKAST	MAR
02436019 JAMP-PREGABALIN	JMP	02408627 MINT-MONTELUKAST	MIN
02268485 LYRICA	PFI	02379821 MONTELUKAST	PDL
02359642 PMS-PREGABALIN	PMS	02382458 MONTELUKAST	SIV
02396548 PREGABALIN	PDL	02354977 PMS-MONTELUKAST	PMS
02403730 PREGABALIN	SIV	02402793 RAN-MONTELUKAST	RBY
02405598 PREGABALIN	SAN	02330385 SANDOZ MONTELUKAST 02243602 SINGULAIR	SDZ FRS
02476371 PREGABALIN	RIV	02355507 TEVA-MONTELUKAST	TEV
02392860 RAN-PREGABALIN 02377071 RIVA-PREGABALIN	RBY RIV	5MG TABLET (CHEWABLE)	I L V
02377071 RIVA-FREGABALIN 02390868 SANDOZ PREGABALIN	SDZ	02377616 APO-MONTELUKAST	APX
02361248 TEVA-PREGABALIN	TEV	02422875 AURO-MONTELUKAST	AUR
	1 = V	02442361 JAMP-MONTELUKAST	JMP
48:00 RESPIRATORY TRACT		02399873 MAR-MONTELUKAST	MAR
AGENTS		02408635 MINT-MONTELUKAST	MIN
48:10.24 LEUKOTRIENE MODIFIERS		02379848 MONTELUKAST	PDL
		02382466 MONTELUKAST	SIV
MONTELUKAST SODIUM		02354985 PMS-MONTELUKAST	PMS
4MG GRANULES 02358611 SANDOZ MONTELUKAST	SDZ	02402807 RAN-MONTELUKAST	RBY
02247997 SINGULAIR	FRS	02330393 SANDOZ MONTELUKAST	SDZ
10MG TABLET	110	02238216 SINGULAIR	FRS
02374609 APO-MONTELUKAST	APX	02355515 TEVA-MONTELUKAST	TEV
02401274 AURO-MONTELUKAST	AUR	52:00 EYE, EAR, NOSE AND THRO	AT
02445735 BIO-MONTELUKAST	UNK	(EENT) PREPARATIONS	
02376695 DOM-MONTELUKAST	DPC		
02391422 JAMP-MONTELUKAST	JMP	52:28.00 EENT - MOUTHWASHES AND	
02399997 MAR-MONTELUKAST	MAR	GARGLES	
02408643 MINT-MONTELUKAST	MIN	BENZYDAMINE HYDROCHLORIDE	
02379333 MONTELUKAST	SAN	0.15% MOUTHWASH	
02379856 MONTELUKAST	PDL	02239044 APO-BENZYDAMINE	APX
02382474 MONTELUKAST	SIV	02229777 PHARIXIA	PED
02379236 MONTELUKAST SODIUM	ACC	02239537 PMS-BENZYDAMINE	PMS
02373947 PMS-MONTELUKAST	PMS		
02389517 RAN-MONTELUKAST	RBY		
02398826 RIVA-MONTELUKAST	RIV		

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52:92.00 MISCELLANEOUS EENT DR	UGS	56:22.32 MISCELLANEOUS ANTIEMETICS		
ARTIFICIAL SALIVA		APREPITANT		
0.05MG SPRAY		80MG CAPSULE		
02238696 MOISTIR	PMS	02298791 EMEND	FRS	
56:00 GASTROINTESTINAL DRU	GS	125MG CAPSULE		
		02298805 EMEND	FRS	
56:08.00 ANTIDIARRHEA AGENTS		125MG & 80MG CAPSULE		
DIPHENOXYLATE HYDROCHLORIDE, ATF	ROPINE	02298813 EMEND TRI-PACK	FRS	
SULFATE		56:22.92 MISCELLANEOUS ANTIEME	TICS	
2.5MG & 0.025MG TABLET		NABILONE		
00036323 LOMOTIL	PFI	0.25MG CAPSULE		
56:22.00 ANTIEMETICS		02441497 APO-NABILONE	APX	
NETUPITANT, PALONOSETRON		02312263 CESAMET	UNK	
(PALONOSETRON HYDROCHLORIDE)		02380897 PMS-NABILONE	PMS	
300MG & 0.5MG CAPSULE		02358077 RAN-NABILONE	RBY	
02468735 AKYNZEO	PFR	02392925 TEVA-NABILONE	TEV	
56:22.20 5-HT3 RECEPTOR ANTAGO	NISTS	0.5MG CAPSULE		
	141010	02393581 ACT NABILONE	ACG	
ONDANSETRON HYDROCHLORIDE		02441500 APO-NABILONE	APX	
2MG/ML INJECTION	4.507	02256193 CESAMET	UNK	
02291703 ONDANSETRON W/P	APX	02380900 PMS-NABILONE	PMS	
09857324 ZOFRAN (ON)	GSK	02358085 RAN-NABILONE	RBY	
09857325 ZOFRAN (ON)	GSK	02384884 TEVA-NABILONE	TEV	
2MG LIQUID 02271761 ONDANSETRON OMEGA -	OMG	1MG CAPSULE	400	
(PRESERVATIVE FREE SINGLE	OIVIG	02393603 ACT NABILONE 02441519 APO-NABILONE	ACG APX	
DOSE VIALS)		00548375 CESAMET	UNK	
02271788 ONDANSETRON OMEGA -(WITH	OMG	02380919 PMS-NABILONE	PMS	
PRESERVATIVE MULTIDOSE VIAL)		02358093 RAN-NABILONE	RBY	
2MG SOLUTION	11.45	02384892 TEVA-NABILONE	TEV	
02420414 JAMP-ONDANSETRON	JMP	92:00 UNCLASSIFIED THERAPEU		
02420422 JAMP-ONDANSETRON 02462257 ONDANSETRON	JMP RAX			
02464578 ONDANSETRON	RAX	AGENTS		
02279436 ONDANSETRON -(WITH	SDZ	92:24.00 BONE RESORPTION INHIBIT	rors	
PRESERVATIVE)	052	DENOSUMAB (XGEVA)		
02461420 ONDANSETRON BP	AUR	120MG/1.7ML SOLUTION		
02213745 ZOFRAN	NVR	02368153 XGEVA	AMG	
2MG/ML SOLUTION			AIVIO	
02265524 ONDANSETRON	TEV	96:00 PHARMACEUTICAL AIDS		
02274418 ONDANSETRON	SDZ	96:00.00 PHARMACEUTICAL AIDS		
02279428 ONDANSETRON	SDZ	ADULT		
02390019 ONDANSETRON	MYL	ORAL LIQUID		
02390051 ONDANSETRON	MYL	95900061 BOOST DIABETIC 237ML LIQ	NES	
		95999963 BOOST ORIGINAL 237ML LIQ	NES	
			0	

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96:00.00	PHARMACEUTICAL AIDS	
ADULT		
ORAL LIQU	IID	
95900050	ENSURE 235ML LIQ	ABB
95900139	ENSURE FIBRE 235ML LIQ	ABB
95900140	GLUCERNA 237ML LIQ	ABB
95900058	RESOURCE 2.0 237ML LIQ	NES
CHILDREN	AND YOUTH	
ORAL LIQU	IID	
95900142	PEDIASURE COM. GROW&GAIN 235ML LIQ	ABB
POWDER		
95900143	PEDIASURE GROW&GAIN 400G PDR	ABB
NUTRITION	NAL SUPPLEMENT	
ORAL LIQU	IID	
95900049	BOOST 1.0 STANDARD 237ML LIQ	NVC
95900051	BOOST FRUIT BEVERAGE 235ML LIQ	NES
95900054	BOOST HIPROTEIN 237ML LIQ	NES
95900052	BOOST PLUS 237ML LIQ	NES
95999975	BOOST PLUS CALORIES 237ML LIQ	NES
95900070	COMPLEAT MODIFIED 1000ML LIQ	NES
95900069	COMPLEAT MODIFIED 250ML LIQ	NES
95900056	ENSURE HIGH PROTEIN 235ML LIQ	ABB
	ENSURE PLUS 235ML LIQ 95900181	ABB
ENSURE I	PLUS CALORIES 235ML LIQ	ABB
95900204	ENSURE PROTEIN MAX 235ML LIQ	ABB
95900141	GLUCERNA TUBE FEEDING 235ML	ABB
	LIQ	
POWDER		
95900055	BOOST JUST PROTEIN 588G PDR	NES

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ACT NABILONE	4	MAR-MONTELUKAST	3
ADULT	4	MAR-PREGABALIN	2
ADVAIR 100 DISKUS	1	MINOCYCLINE	1
ADVAIR 125	1	MINOCYCLINE HYDROCHLORIDE	1
ADVAIR 250	1	MINT-MONTELUKAST	3
ADVAIR 250 DISKUS	1	MINT-PREGABALIN	2
ADVAIR 500 DISKUS	1	MOISTIR	4
AG-PREGABALIN	2	MONTELUKAST	3
AKYNZEO	4	MONTELUKAST SODIUM	3
APO-BENZYDAMINE	3	MONTELUKAST SODIUM	3
APO-MONTELUKAST	3	NABILONE	4
	4		4
APO-NABILONE		NETUPITANT, PALONOSETRON (PALONOSETRON	4
APO-PREGABALIN	2	HYDROCHLORIDE)	
APREPITANT	4	NEULASTA	1
ARANESP	1	NRA-PREGABALIN	2
ARTIFICIAL SALIVA	4	NUTRITIONAL SUPPLEMENT	5
AURO-MONTELUKAST	3	ONDANSETRON	4
AURO-PREGABALIN	2	ONDANSETRON -(WITH	4
BENZYDAMINE HYDROCHLORIDE	3	PRESERVATIVE)	4
BIO-MONTELUKAST	3	ONDANSETRON BP	4
BOOST 1.0 STANDARD 237ML LIQ	5	ONDANSETRON HYDROCHLORIDE	4
BOOST DIABETIC 237ML LIQ	4	ONDANSETRON OMEGA -	4
BOOST FRUIT BEVERAGE 235ML	5	(PRESERVATIVE FREE SINGLE	7
LIQ		DOSE VIALS)	
BOOST HIPROTEIN 237ML LIQ	5	ONDANSETRON OMEGA -(WITH	4
BOOST JUST PROTEIN 588G PDR	5	PRESERVATIVE MULTIDOSE VIAL)	
BOOST ORIGINAL 237ML LIQ	4	ONDANSETRON W/P	4
BOOST PLUS 237ML LIQ	5	PEDIASURE COM. GROW&GAIN	5
BOOST PLUS CALORIES 237ML LIQ	5	235ML LIQ	
BUPRENORPHINE (BUTRANS)	2	PEDIASURE GROW&GAIN 400G	5
BUTRANS 10	2	PDR	
BUTRANS 15	2	PEGFILGRASTIM	1
BUTRANS 20	2	PHARIXIA	3
BUTRANS 5	2	PMS-BENZYDAMINE	3
CESAMET	4	PMS-MONTELUKAST	3
CHILDREN AND YOUTH	5	PMS-NABILONE	4
COMPLEAT MODIFIED 1000ML LIQ	5	PMS-PREGABALIN	2
COMPLEAT MODIFIED 250ML LIQ	5	PREGABALIN	2
DARBEPOETIN ALFA	1	PREGABALIN	2
	=	RAN-MONTELUKAST	3
DENOSUMAB (XGEVA)	4	RAN-NABILONE	4
DIPHENOXYLATE	4	RAN-PREGABALIN	2
HYDROCHLORIDE, ATROPINE SULFATE		RESOURCE 2.0 237ML LIQ	5
DOM-MONTELUKAST	3	RIVA-MONTELUKAST	3
DOM-PREGABALIN	2	RIVA-PREGABALIN	2
EMEND	4	SALMETEROL XINAFOATE,	1
EMEND TRI-PACK	4	FLUTICASONE PROPIONATE	•
ENSURE 235ML LIQ	5	SANDOZ MONTELUKAST	3
ENSURE FIBRE 235ML LIQ	5	SANDOZ PREGABALIN	2
ENSURE FIBRE 235ML LIQ ENSURE HIGH PROTEIN 235ML LIQ	5 5	SINGULAIR	3
ENSURE PLUS 235ML LIQ	5 5	TEVA-MINOCYCLINE	1
		TEVA-MONTELUKAST	3
ENSURE PLUS CALORIES 235ML LIQ	5	TEVA-NABILONE	4
ENSURE PROTEIN MAX 235ML LIQ	5	TEVA-PREGABALIN	2
EPOETIN ALFA	1	XGEVA	4
EPREX	1	ZOFRAN	4
GLUCERNA 237ML LIQ	5	ZOFRAN (ON)	4
		ZOI IMIN (ON)	7
GLUCERNA TUBE FEEDING 235ML LIQ	5		
JAMP-MONTELUKAST	3		
JAMP-ONDANSETRON	4		
JAMP-PREGABALIN	2		
LOMOTIL	4		
LYRICA	2		

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Appendix E

Extemporaneous mixtures

Appendix E - Extemporaneous Mixtures

Non-Insured Health Benefits

To be eligible under the NIHB Program, extemporaneous mixtures (compounds) must have at least one ingredient listed on the DBL and must not duplicate the formulation of commercially manufactured drug products. Mixtures that contain exception or limited use drugs must receive prior approval by the DEC. Mixtures that contain ingredients excluded from the Program will not be eligible for coverage.

All extemporaneous mixtures must be submitted with the corresponding pseudo-DIN to be reimbursed appropriately. Pharmaceutical powders of eligible ingredients may be used in lieu of tablets/capsules. These powders must be billed at AAC and must not exceed the maximum allowable AAC which is based on the price of the DIN of the comparable listed tablet or capsule.

Back Order Items and Compounding:

Providers who are preparing a compound to replace a commercially available product which is on back-order do not require a PA. The claim must be submitted using the corresponding miscellaneous pseudo-DIN. Providers are required to maintain documentation demonstrating that the commercially available product was on back-order at the time of dispense.

99501007 NSAID IN TRANSDERMAL BASE 99501009 TRANSDERMAL LIDOCAINE W/NSAID

9900 1009 TRANSDERIVIAL LIDOCAINE W

99505005 H2RA SOLID

COMPOUNDED EXTERNAL LOTION

99502001 MENTHOL & CAMPHOR IN CORTICOSTEROID LOTION

99502002 MISCELLANEOUS COMPOUNDED EXTERNAL LOTION

COMPOUNDED EXTERNAL POWDER

99504000 MISCELLANEOUS COMPOUNDED EXTERNAL POWDER

COMPOUNDED EYE/EAR DROP

99507000 MISCELLANEOUS COMPOUNDED EYE/EAR DROP

99507001 ANTIFUNGAL DROPS

99507002 ANTIBIOTIC DROPS

99507003 ANTIVIRAL DROPS

COMPOUNDED INJECTION OR INFUSION

99506000 CEFAZOLIN STERILE INFUSION

99506001 CEFTRIAXONE STERILE INFUSION

99506003 PENICILLIN G STERILE INFUSION

99506004 GENTAMYCIN STERILE INFUSION

99506005 AMPICILLIN STERILE INFUSION

99506008 CLINDAMYCIN STERILE INFUSION

99506015 IRON SUCROSE STERILE INFUSION

99506021 MISCELLANEOUS COMPOUNDED

INJECTION/INFUSION

COMPOUNDED INTERNAL POWDER

99505000 MISCELLANEOUS COMPOUNDED INTERNAL POWDER

99505003 PHENAZOPYRIDINE COMPOUNDED

COMPOUNDED INTERNAL POWDER

99505004 BACKORDER INTERNAL POWDER

COMPOUNDED INTERNAL USE LIQUID

99503000 HYDROCHLOROTHIAZIDE ORAL LIQUID

99503001 SPIRONOLACTONE ORAL LIQUID

99503002 OMEPRAZOLE ORAL LIQUID

99503003 AMLODIPINE ORAL LIQUID

99503004 NITRO-FURANTOIN ORAL LIQUID

99503005 DOMPERIDONE ORAL LIQUID

99503006 TRANEXAMIC DENTAL MOUTHWASH

99503007 DEXAMETHASONE ORAL LIQUID

99503008 PREDNISONE ORAL LIQUID

99503009 ALDACTAZIDE ORAL LIQUID

99503010 LANSOPRAZOLE ORAL LIQUID

99503011 BACLOFEN ORAL LIQUID

99503012 METRONIDAZOLE ORAL LIQUID

99503013 ENALAPRIL ORAL LIQUID

99503014 PROPRANOLOL ORAL LIQUID

99503015 METOPROLOL ORAL LIQUID

99503016 AMIODARONE ORAL LIQUID 99503017 TRIMETHOPRIM ORAL LIQUID

99503018 ALLOPURINOL ORAL LIQUID

99503019 AZATHIOPRINE ORAL LIQUID

99503020 BENZODIAZEPINE ORAL LIQUID

99503021 CLONIDINE ORAL LIQUID

99503022 RIFAMPIN ORAL LIQUID

99503023 SOTALOL ORAL LIQUID

99503024 UROSODIOL ORAL LIQUID

99503025 MISCELLANEOUS COMPOUNDED INTERNAL LIQUID

99503026 LEVETIRACETAM ORAL LIQUID

99503027 TOPIRAMATE ORAL LIQUID

99503028 ANTACID AND LIDOCAINE ORAL LIQUID

99503029 MAGIC MOUTHWASH

99503031 ISONIAZID ORAL LIQUID

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COMPOUNDED INTERNAL USE LIQUID

99503032 OPIOID COMPOUNDED 99503033 MISC LIMITED USE COMPOUND INTERNAL

COMPOUNDED SUPPOSITORY

99508000 MISCELLANEOUS COMPOUNDED SUPPOSITORY

COMPOUNDED TOPICAL CREAM

99500000 HYDROCORTISONE POWDER AND

CLOTRIMAZOLE CREAM

99500001 STEROID AND ANTIFUNGAL CREAM

99500002 MENTHOL &/OR CAMPHOR IN STEROID

99500003 SALICYLIC ACID IN CORTICOSTEROID CREAM

99500004 MISCELLANEOUS COMPOUNDED TOPICAL

CREAM

99500006 SULFUR IN NON-MEDICATED CREAM

99500008 MOMETASONE CREAM

99500009 LCD IN NON-MEDICATED CREAM

99500010 LCD IN CORTICOSTEROID CREAM

99504001 MISC LIMITED USE EXTERNAL COMPOUND

MIXTURE

COMPOUNDED TOPICAL OINTMENT

99501000 LCD IN CORTICOSTEROID OINTMENT

99501001 SALICYLIC ACID IN NON-MEDICATED

OINTMENT

99501002 SULFUR IN NON-MEDICATED OINTMENT

99501003 CALCIUM CHANNEL BLOCKER IN OINTMENT

99501004 MISCELLANEOUS COMPOUNDED TOPICAL

OINTMENT

99501005 LCD IN NON-MEDICATED OINTMENT

99501006 ALL PURPOSE NIPPLE OINTMENT

99501008 DILTIAZEM IN OINTMENT

99502000 CLINDAMYCIN IN DILUSOL OR DUONALC

GENDER AFFIRMING THERAPY

00915311 GENDER AFFIRMING TOPICAL HORMONES 00915312 GENDER AFFIRMING HORMONES

STERILE EXTEMPORANEOUS MIXTURE

00915000 STERILE EXTEMPORANEOUS MIXTURE (QC)

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Appendix F

List of drug manufacturers

леропал і	- List of Drug Manufacturers		Hon-insured Health Delients
MFR	Manufacturer Name	MFR	Manufacturer Name
		DOR	DORMER LABORATORIES INCORPORATED
AAP	AA PHARMA INCORPORATED	DPC	DOMINION PHARMACAL
ABB	ABBOTT LABORATORIES LIMITED	DPI	DOMREX PHARMA INCORPORATED
ABV	ABBVIE CORPORATION	DPT	DERMTEK PHARMA INCORPORATED
ACC	ACCORD HEALTHCARE INCORPORATED	DUI	DUCHESNAY INCORPORATED
ACG	ACTAVIS GROUP PTC EHF	EIS	EISAI LIMITED
ACP	ACCEL PHARMA INCORPORATED	ELN	ELAN PHARMACEUTICALS INCORPORATED
ADA	ADAMS LABS LIMITED	ERF	ERFA CANADA INCORPORATED
ADD	AVEVA DRUG DELIVERY SYSTEMS	ETH	ETHYPHARM INCORPORATED
ABB	INCORPORATED	EUR	EURO-PHARM INTERNATIONAL CANADA
ALC	ALCON CANADA INCORPORATED	2011	INCORPORATED
ALK	ALK ABELLO A/S	FEI	FERRING INCORPORATED
ALL	ALLERGAN INCORPORATED	FKD	FRESENIUS KABI CANADA LIMITED
ALV	ALVEDA PHARMACEUTICALS INCORPORATED	FMC	FRESENIUS MEDICAL CARE NORTH AMERICA
AMD	AMDIPHARM LIMITED	FRS	MERCK FROSST CANADA LIMITED
AMG	AMGEN CANADA INCORPORATED	GAC	GALDERMA CANADA INCORPORATED
ANG	ANGITA PHARMA INCORPORATED	GEE	GENZYME CANADA INCORPORATED
APC	APTALIS PHARMA CANADA ULC	GIL	GILEAD SCIENCES INCORPORATED
APL	AUROBINDO PHARMA LIMITED	GLK	GLENMARK PHARMACEUTICALS CANADA
APU	ATNAHS PHARMA UK LIMITED		INCORPORATED
APX	APOTEX INCORPORATED	GMP	GENERIC MEDICAL PARTNERS
ARA	ARA PHARMACUETICALS INCORPORATED		INCORPORATED
ARI	ARIAD PHARMACEUTICALS INCORPORATED	GPB	G POHL-BOSKAMP GMBH & CO KG
ASP	ASPEN PHARMA TRADING LIMITED	GSK	GLAXOSMITHKLINE INCORPORATED
AST	ASTELLAS PHARMA CANADA INCORPORATED	HIL	HILL DERMACEUTICALS INCORPORATED
ATL	LABORATORIE ATLAS INCORPORATED	HJS	H.J. SUTTON INDUSTRIES LIMITED
ATO	ATON PHARMA INCORPORATED, A DIVISION	HLR	HOFFMAN-LAROCHE LIMITED
	OF VALEANT PHARMACEUTICALS NORTH	HLS	HLS THERAPEUTICS INC
	AMERICA LLC	HOD	NIPRO DIAGNOSTICS CANADA LIMITED
AUC	AUTO CONTROL	HOS	HOSPIRA HEALTHCARE CORPORATION
AUP	AURIUM PHARMA INCORPORATED	HRA	HRA PHARMA
AUR	AURO PHARMA INCORPORATED	HYD	HYDRATION PHARMACEUTICALS CANADA INCORPORATED
AXX	AXXESS PHARMA INCORPORATED	ICN	ICN CANADA LIMITED
AZC	ASTRAZENECA CANADA INCORPORATED	IDE	INTERNATIONAL DERMATOLOGICALS
BAX BAY	BAXTER CORPORATION BAYER INCORPORATED.	IDE	INCORPORATED
DAT	HEALTHCARE/DIAGNOSTICS	IND	INDIVIOR UK LIMITED
BEN	BENCARD ALLERGY LABORATORIES	INS	INSIGHT PHARMACEUTICALS LLC
BEX	BERLEX CANADA INCORPORATED	IPS	IPSEN LIMITED
BGP	BGP PHARMA ULC	JAC	JACOBUS PHARMACEUTICAL COMPANY
BIO	BIONICHE PHARMA (CANADA) LIMITED		INCORPORATED
BMI	BIOMED 2002 INCORPORATED	JAJ	JOHNSON & JOHNSON
BMS	BRISTOL-MYERS SQUIBB CANADA	JAM	C.E. JAMIESON COMPANY LIMITED
BOE	BOEHRINGER INGELHEIM (CANADA) LIMITED	JMP	JAMP PHARMA CORPORATION
BSH	BAUSCH & LOMB CANADA INCORPORATED	JNO	JANSSEN-ORTHO INCORPORATED
BSY	BIOSYENT PHARMA INCORPORATED	JSO	JANSSEN INCORPORATED
BTD	WEB PACK INTERNATIONAL INCORPORATED	JUB	JUBILANT HOLLISTERSTIER LLC
BTU	BRAINTREE LABORATORIES INCORPORATED	KAL	KALEO INCORPORATED
CHE	CHEPLAPHARM ARZNEIMITTEL GMBH GERMANY	KIM	MCNEIL CONSUMER HEALTHCARE, A DIVISION OF JOHNSON & JOHNSON INCORPORATED
CHU	CHURCH & DWIGHT CANADA CORP	KLA	PATRIOT A DIVISION OF JANSSEN INCORPORATED
CIP	CIPHER PHARMACEUTICALS INCORPORATED	LAL	LABORATOIRE LALCO INCORPORATED
CLC	COLUMBIA LABORATORIES CANADA INCORPORATED	LAP	LABORATOIRE HRA PHARMA
COV	COVIDIEN CANADA	LEO	LEO PHARMA INCORPORATED
DCM	D & C MOBILITY	LIL	ELI LILLY CANADA INCORPORATED
DDP	THE D DROPS COMPANY INCORPORATED	LIP	LINEPHARMA INTERNATIONAL LIMITED
וטט	THE D DIVOLO GOING ANT INCOME OF ATEL	LUD	LUNDBECK CANADA INCORPORATED

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пррешата т	- List of Drug Manufacturers		Non-insured ficallit Beliefits
MFR	Manufacturer Name	MFR	Manufacturer Name
LUK	LUNDBECK LLC	RBW	R.W. PACKAGING LIMITED
LUP	LUPIN PHARMA CANADA LIMITED	RBY	RANBAXY PHARMACEUTICALS CANADA
MAC	MACDONALD'S PRESCRIPTION LAB LIMITED	INDI	INCORPORATED
		REC	DR REDDYS LABORATORIES INCORPORATED
MAK	3M CANADA COMPANY	RGL	RECRO GAINESVILLE LLC
MAN	MANTRA PHARMA INCORPORATED	RIV	LABORATORIE RIVA INCORPORATED
MAR	MARCAN PHARMACEUTICALS INCORPORATED		
MAT	MALLINCKRODT CANADA ULC	RLI	RED LEAF MEDICAL INCORPORATED
MAY	MAYNE PHARMA (CANADA) INCORPORATED	ROD	ROCHE DIAGNOSTICS
MCA	MCARTHUR MEDICAL SALES INCORPORATED	RPH	RATIOPHARM INCORPORATED
MCL	MCNEIL CONSUMER PRODUCTS COMPANY	SAC	SANOFI-AVENTIS CANADA
MDF	MEDICAL FUTURES INCORPORATED	SAN	SANIS HEALTH INCORPORATED
MDS	MEDISCA PHARMACEUTIQUE INCORPORATED	SCN	SCHEIN PHARMACEUTICAL CANADA
MDT	MEDTRONIC OF CANADA LIMITED	007	INCORPORATED
MEC	MEDI+SURE CANADA INCORPORATED	SDZ	SANDOZ CANADA INCORPORATED
MEZ	MERZ PHARMACEUTICALS GMBH	SEA	SEARCHLIGHT PHARMA INCORPORATED
MIN	MINT PHARMACEUTICALS INCORPORATED	SEV	SERVIER CANADA INCORPORATED
MJO	MEAD JOHNSON CANADA INCORPORATED	SFA	HTL STREFA
MPD	MEDICAL PLASTIC DEVICES INCORPORATED	SHI	SHIRE CANADA INCORPORATED
MSF	MEDISAFE DISTRIBUTION INCORPORATED	SIV	SIVEM PHARMACEUTICALS ULC
MTC	MEDTECH PRODUCTS INCORPORATED	SKY	LIFESCAN INCORPORATED, PART OF THE
MYL	MYLAN PHARMACEUTICALS ULC		JOHNSON & JOHNSON
NCA	NOVA DIABETES CARE	SLX	SALIX PHARMACEUTICALS INCORPORATED
NEB	NEOBOURNE PHARMA LP	SMW	SMITH & NEPHEW CANADA
		SNE	SMITH & NEPHEW INCORPORATED
NES	NESTLÉ CANADA INCORPORATED	SPC	SUNOVION PHARMACEUTICALS CANADA
NOO	NOVO NORDISK CANADA INCORPORATED		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
NVC	NOVARTIS CONSUMER HEALTH CANADA INCORPORATED	STE	INCORPORATED CANADA STERIMAX INCORPORATED
NVR	NOVARTIS PHARMACEUTICALS CANADA		
	INCORPORATED	STG	LABORATOIRES STERIGEN INCORPORATED
OBT	COBALT PHARMACEUTICALS COMPANY	STS	STRIDES ARCOLAB LIMITED
ODN	ODAN LABORATORIES LIMITED	SUN	SUN PHARMA GLOBAL FZE
OMG	OMEGA LABORATORIES LIMITED	SUS	SUNSTAR AMERICAS INCORPORATED
OPU	OPUS PHARMA	SWS	SWISS HERBAL REMEDIES LIMITED
ORM	ORIMED PHARMA INCORPORATED	TAK	TAKEDA PHARMACEUTICALS AMERICA INCORPORATED
OTS	OTSUKA PHARMACEUTICAL CORPORATION	TAN	TANTA PHARMACEUTICALS INCORPORATED
	LIMITED	TAR	TARO PHARMACEUTICALS INCORPORATED
PAL	PALADIN LABS INCORPORATED	TEL	TELIGENT OU
PDI	PROFESSIONAL DISPOSABLES	TEV	TEVA CANADA LIMITED
	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	TPT	TAROPHARMA, A DIVISION OF TARO
PER	PERRIGO INTERNATIONAL	IFI	PHARMACEUTICALS INCORPORATED
PFD	PROFESSIONAL DISPOSABLES	TRE	TREMBLAY HARRISON INCORPORATED
PFI	PFIZER CANADA INCORPORATED	TRI	TRIANON LABORATORIES INCORPORATED
PFR	PURDUE PHARMA	TRM	ACERUS PHARMACEUTICALS CORPORATION
PGI	PROCTOR & GAMBLE INCORPORATED	TRU	TRUDELL MEDICAL INTERNATIONAL
PHA	PHARMAPAR INCORPORATED		
PMS	PHARMASCIENCE INCORPORATED	TSN	TRIMEDIC SUPPLY NETWORK LIMITED
PMT	PHARMETICS INCORPORATED	TYC	KENDALL HEALTHCARE
PPH	PAR PHARMACEUTICAL COMPANIES	UCB	UBC PHARMA INCORPORATED
PPI	PRESTIGE PHARMA INCORPORATED	UMI	ULTIMED, INCORPORATED
RAX	STERIMAX INC	UNK	
RBP	RB PHARMACEUTICALS LIMITED	VAE	VALEANT CANADA LIMITED

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MFR	Manufacturer Name	MFR	Manufacturer Name
VAN	VANC PHARMACEUTICALS INCORPORATED		
VII	VIIV HEALTHCARE ULC		
VTH	VITA HEALTH PRODUCTS INCORPORATED		
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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Appendix G

List of exclusions

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.

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	UNK	RELPAX	20MG TABLET
02256304	UNK	RELPAX	40MG TABLET

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Appendix H

New listings

Updated as of October 26, 2020

DIN	MFR	Brand Name	Strength and Dosage Form	Date Added
02478935	ACP	ACCEL-ONDANSETRON	8MG TABLET	2020-05-01
02483270	ACP	ACCEL-RIZATRIPTAN ODT	5MG TABLET (ORALLY DISINTEGRATING)	2020-05-01
01977415	TLI	ACETAMINOPHEN	325MG TABLET	2020-04-09
02362368	APX	ACETAMINOPHEN	500MG TABLET	2020-04-09
02237562	TLI	ACETAMINOPHEN	160MG TABLET (CHEWABLE)	2020-04-08
02440644	ACC	ACH-PRAVASTATIN	10MG TABLET	2020-05-01
02440660	ACC	ACH-PRAVASTATIN	40MG TABLET	2020-05-01
02440652	ACC	ACH-PRAVASTATIN	20MG TABLET	2020-05-01
02328445	PFI	ADVIL PEDIATRIC DROPS FEVER	40MG DROP	2020-04-15
		FROM COLDS OR FLU		
02487241	APX	APO-DARUNAVIR	600MG TABLET	2020-05-27
02487268	APX	APO-DARUNAVIR	800MG TABLET	2020-03-31
02493055	UNK	ASPEN-DIENOGEST	2MG TABLET	2020-06-01
02486121	AUR	AURO-DARUNAVIR	600MG TABLET	2020-05-27
97799201	UNK	AUTOSOFT 30 13MM	43110IN/CM DEVICE	2020-04-15
97799202	UNK	AUTOSOFT 30 13MM	2360IN/CM DEVICE	2020-04-15
97799197	UNK	AUTOSOFT 90 6MM	43110IN/CM DEVICE	2020-04-15
97799200	UNK	AUTOSOFT 90 6MM	2360IN/CM DEVICE	2020-04-15
97799199	UNK	AUTOSOFT 90 6MM	2360IN/CM DEVICE	2020-04-15
97799198	UNK	AUTOSOFT 90 6MM	2360IN/CM DEVICE	2020-04-15
97799194	UNK	AUTOSOFT 90 9MM	2360IN/CM DEVICE	2020-04-15
97799195	UNK	AUTOSOFT 90 9MM	2360IN/CM DEVICE	2020-04-06
97799196	UNK	AUTOSOFT 90 9MM	2360IN/CM DEVICE	2020-04-15
97799193	UNK	AUTOSOFT 90 9MM	43110IN/CM DEVICE	2020-04-14
09991391	BTD	BD PRECISIONGLIDE 23GX1 1/4	NEEDLE	2020-03-01
02481219	BMI	BIO-ATORVASTATIN	80MG TABLET	2020-04-07
02481189	BMI	BIO-ATORVASTATIN	10MG TABLET	2020-04-07
02481200	BMI	BIO-ATORVASTATIN	40MG TABLET	2020-04-07
02481197	BMI	BIO-ATORVASTATIN	20MG TABLET	2020-04-07
02495899	STS	CALCITRIOL	0.25MCG CAPSULE	2020-05-27
02495902	STS	CALCITRIOL	0.5MCG CAPSULE	2020-05-27
02328437	PFI	CHILDREN'S ADVIL FEVER FROM COLDS OR FLU	100MG SUSPENSION	2020-04-15
02280175	PER	CHILDREN'S IBUPROFEN	100MG SUSPENSION	2020-03-27
97499983	ROD	COAGUCHEK INRANGE METER	DEVICE	2020-04-06
97499991	ROD	COAGUCHEK LANCETS	LANCET	2020-04-06
97499986	ROD	COAGUCHEK XS KIT	DEVICE	2020-04-06
97499988	ROD	COAGUCHEK XS PT STRIPS 24	STRIP	2020-04-06
97499987	ROD	COAGUCHEK XS PT STRIPS 48	STRIP	2020-04-06
97499989	ROD	COAGUCHEK XS PT STRIPS 6	STRIP	2020-04-06
02483998	UNK	CRESEMBA	200MG POWDER FOR SOLUTION	2020-02-11
02483971	UNK	CRESEMBA	100MG CAPSULE	2020-02-11
02475065	UNK	DICLOFENAC	0.1% SOLUTION	2020-03-01
02285797	VTH	EXTRA STRENGTH	500MG TABLET	2020-04-09
02484153	BGP	ACETAMINOPHEN	10MG SOLUTION	2020-04-01
02439735	APX	FULPHILA		
02439735	APX	IBUPROFEN	400MG TABLET	2020-04-15
UZ4381Z1	AFA	IBUPROFEN	200MG TABLET	2020-04-15

DIN	MFR	Brand Name	Strength and Dosage Form	Date Added
02473259	JMP	JAMP CANDESARTAN-HCT	32MG & 12.5MG TABLET	2020-03-16
02490870	JMP	JAMP FEBUXOSTAT	80MG TABLET	2020-06-01
02491427	JMP	JAMP HYDROXYCHLOROQUINE	200MG TABLET	2020-04-07
02453355	JMP	SULFATE	50MCG SOLUTION	2020-04-30
02490617	JMP	JAMP CARANGETRON	4MG SOLUTION	2020-05-01
02477106	JMP	JAMP ONDANSETRON JAMP ZOLMITRIPTAN	2.5MG TABLET	2020-04-01
02453770	JMP	JAMP-LATANOPROST/TIMOLOL	50MCG & 5MG SOLUTION	2020-05-15
95900217	ABB	JEVITY 1.5 CAL	ORAL LIQUID	2020-03-12
02481278	JMP	LINEZOLID	2MG SOLUTION	2020-04-01
02481278	UNK	LORIS ALCOHOL SWABS	70% PAD	2020-04-03
80081007	NES			2020-05-01
02470179	SRO	MATERNA PRENATAL DHA	CAPSULE	2020-03-01
	MDS	MAVENCLAD	10MG TABLET	2020-02-09
80074942	ACC	MEDISURE ALCOHOL WIPES	70% WIPE, MEDICATED	2020-04-00
02491362		METHOTREXATE SUBCUTANEOUS	25MG SOLUTION	
02491125	MIN	MINT-CETIRIZINE	20MG TABLET	2020-02-19
02487330	MIN	MINT-ONDANSETRON ODT	4MG TABLET (ORALLY DISINTEGRATING)	2020-03-25
02486369	MIN	MINT-TELMISARTAN MUCOCLEAR	40MG TABLET	2020-06-01
02492989	GSK	NUCALA	100MG SOLUTION	2020-05-08
02492997	GSK	NUCALA	100MG SOLUTION	2020-05-08
95900220	NES	NUTREN 1.5	ORAL LIQUID	2020-05-21
99113755	UNK	NYSTATIN 100,000U SUSP (QC)	100000U/ML ORAL LIQUID	2020-04-01
02481065	SAN	OLMESARTAN	40MG TABLET	2020-04-23
02481057	SAN	OLMESARTAN	20MG TABLET	2020-04-01
99113716	UNK	OLMESARTAN (QC)	40MG CAPSULE	2020-03-01
02247755	OMG	OMEGA ALLERGENIC EXTRACTS	40000U LIQUID	2020-04-06
		POLLENS (SUSPAL)		
02494507	PMS	PMS-FLUTICASONE	50MCG & 100MCG POWDER	2020-04-30
02494523	PMS	PROPIONATE/SALMETEROL DPI PMS-FLUTICASONE	50MCG & 500MCG POWDER	2020-04-30
02494515	PMS	PROPIONATE/SALMETEROL DPI	50M00 0 050M00 D0M/D5D	0000 04 00
02494313	i WO	PMS-FLUTICASONE PROPIONATE/SALMETEROL DPI	50MCG & 250MCG POWDER	2020-04-08
02490110	PHA	PRIVA-AMITRIPTYLINE	10MG TABLET	2020-05-27
02490129	PHA	PRIVA-AMITRIPTYLINE	25MG TABLET	2020-05-27
02490137	PHA	PRIVA-AMITRIPTYLINE	50MG TABLET	2020-05-27
02444445	PHA	PRIVA-AMLODIPINE	2.5MG TABLET	2020-04-29
02444453	PHA	PRIVA-AMLODIPINE	5MG TABLET	2020-04-29
02444461	PHA	PRIVA-AMLODIPINE	10MG TABLET	2020-04-29
02482916	PHA	PRIVA-ATORVASTATIN	80MG TABLET	2020-04-29
02482894	PHA	PRIVA-ATORVASTATIN	20MG TABLET	2020-04-29
02482886	PHA	PRIVA-ATORVASTATIN	10MG TABLET	2020-04-29
02482908	PHA	PRIVA-ATORVASTATIN	40MG TABLET	2020-04-29
02445344	PHA	PRIVA-CIPROFLOXACIN	500MG TABLET	2020-04-29
02445328	PHA	PRIVA-DOMPERIDONE	10MG TABLET	2020-04-29
02448416	PHA	PRIVA-FLUOXETINE	10MG CAPSULE	2020-04-29
02448408	PHA	PRIVA-FLUOXETINE	20MG CAPSULE	2020-04-29
02450119	PHA	PRIVA-GABAPENTIN	400MG CAPSULE	2020-04-29
02450100	PHA	PRIVA-GABAPENTIN	300MG CAPSULE	2020-04-29
02450097	PHA	PRIVA-GABAPENTIN	100MG CAPSULE	2020-04-29

DIN	MFR	Brand Name	Strength and Dosage Form	Date Added
02440350	PHA	PRIVA-MONTELUKAST	10MG TABLET	2020-04-29
02444321	PHA	PRIVA-PAROXETINE	20MG TABLET	2020-04-29
02444313	PHA	PRIVA-PAROXETINE	10MG TABLET	2020-04-29
02444348	PHA	PRIVA-PAROXETINE	30MG TABLET	2020-04-29
02483238	PHA	PRIVA-PERINDOPRIL ERBUMINE	2MG TABLET	2020-04-29
02483254	PHA	PRIVA-PERINDOPRIL ERBUMINE	8MG TABLET	2020-04-29
02483246	PHA	PRIVA-PERINDOPRIL ERBUMINE	4MG TABLET	2020-04-29
02445379	PHA	PRIVA-PRAVASTATIN	10MG TABLET	2020-04-29
02445395	PHA	PRIVA-PRAVASTATIN	20MG TABLET	2020-04-29
02445409	PHA	PRIVA-PRAVASTATIN	40MG TABLET	2020-04-29
02447088	PHA	PRIVA-QUETIAPINE	25MG TABLET	2020-04-29
02483424	PHA	PRIVA-RAMIPRIL	5MG CAPSULE	2020-04-29
02483432	PHA	PRIVA-RAMIPRIL	10MG CAPSULE	2020-04-29
02483416	PHA	PRIVA-RAMIPRIL	2.5MG CAPSULE	2020-04-29
02445417	PHA	PRIVA-ROSUVASTATIN	5MG TABLET	2020-04-29
02445425	PHA	PRIVA-ROSUVASTATIN	10MG TABLET	2020-04-29
02445433	PHA	PRIVA-ROSUVASTATIN	20MG TABLET	2020-04-29
02445352	PHA	PRIVA-SERTRALINE	25MG CAPSULE	2020-04-29
02445360	PHA	PRIVA-SERTRALINE	50MG CAPSULE	2020-04-29
02445387	PHA	PRIVA-SERTRALINE	100MG CAPSULE	2020-04-29
02485745	PHA	PRIVA-SIMVASTATIN	10MG TABLET	2020-04-29
02485761	PHA	PRIVA-SIMVASTATIN	40MG TABLET	2020-04-29
02485753	PHA	PRIVA-SIMVASTATIN	20MG TABLET	2020-04-29
80069578	UNK	SALINEX	100% SPRAY	2020-04-01
02478889	SDZ	SANDOZ MORPHINE SR	100MG TABLET (EXTENDED RELEASE)	2020-03-01
02483092	IND	SUBLOCADE	300MG SOLUTION (EXTENDED RELEASE)	2020-03-18
02483084	IND	SUBLOCADE	100MG SOLUTION (EXTENDED RELEASE)	2020-03-18
02496410	TAR	TARO-	0.05% & 1% CREAM	2020-06-12
		CLOTRIMAZOLE/BETAMETHASONE DIPROPIONATE		
99113746	UNK	TELMISARTAN (QC)	80MG CAPSULE	2020-03-26
02463253	TEV	TEVA-EVEROLIMUS	10MG TABLET	2020-03-06
02463229	TEV	TEVA-EVEROLIMOS TEVA-EVEROLIMOS	2.5MG TABLET	2020-03-06
02463237	TEV	TEVA-EVEROLIMUS	5MG TABLET	2020-03-06
02470632	UNK	TRIAMCINOLONE HEXACETONIDE	20MG SUSPENSION	2020-06-10
		INJECTABLE		
02486318	GLK	TRI-JORDYNA 28	0.25MG & 0.035MG TABLET	2020-04-28
97799192	UNK	TRUSTEEL 6MM	2360IN/CM DEVICE	2020-04-15
97799191	UNK	TRUSTEEL 6MM	3280IN/CM DEVICE	2020-04-15
97799190	UNK	TRUSTEEL 8MM	2360IN/CM DEVICE	2020-04-15
97799189	UNK	TRUSTEEL 8MM	3280IN/CM DEVICE	2020-04-15
97799188	UNK	VARISOFT 13MM	2360IN/CM DEVICE	2020-04-15
97799187	UNK	VARISOFT 13MM	3280IN/CM DEVICE	2020-04-15
97799186	UNK	VARISOFT 13MM	43110IN/CM DEVICE	2020-04-15
97799185	UNK	VARISOFT 17MM	2360IN/CM DEVICE	2020-04-15
97799184	UNK	VARISOFT 17MM	3280IN/CM DEVICE	2020-04-15
80092665	JAM	VITAMIN C	500MG TABLET	2020-06-01

DIN	MFR	Brand Name	Strength and Dosage Form	Date Added
02290375	GSK	VOLTAREN EMULGEL VOLTAREN	1.16% GEL	2020-06-09
02393190	GSK	EMULGEL EXTRA STRENGTH	2.32% GEL	2020-06-09
02338580	GSK	VOLTAREN EMULGEL JOINT PAIN REGULAR STRENGTH	1.16% GEL	2020-06-09
80034595	PED	WAMPOLE CALCIUM FOR CHILDREN	100MG ORAL LIQUID	2020-04-20
02495619	MYL	WIXELA INHUB	50MCG & 500MCG POWDER	2020-04-09
02495600	MYL	WIXELA INHUB	50MCG & 250MCG POWDER	2020-04-09
02495597	MYL	WIXELA INHUB	50MCG & 100MCG POWDER	2020-04-17

Appendix I

Nutritional products formulary

The Non-Insured Health Benefits (NIHB) program has established a nutritional product formulary for clients who require medically necessary nutritional products.

Clients who request and obtain approval will be granted access based on their condition. The length of approval and type of benefit will vary by nutritional product and/or life stage.

Select nutritional products are also included in the following special formularies: End of Life Care Formulary, Formulary for Chronic Renal Patients and Formulary for Adjunct Medications Used During Active Cancer Treatment.

INFANT FORMULA

Limited use benefit (prior approval required).

- Criteria for Infant Formula Coverage < 1 year of age (Corrected Gestational Age for Prematurity)

 Contraindications for breastfeeding HIV, active tuberculosis and herpetic lesions on breast. Please note, contraindications are in accordance with respective Health Canada and World Health Organization guidance.
- Prematurity or low birth weight
- · Failure to thrive/growth faltering
- · Cow milk protein allergy
- Other medical conditions not listed

ORAL	П	OI	IID

95900007	ENFAMIL A+ 237ML LIQ	MJO
95900003	ENFAMIL A+ 385ML LIQ	MJO
95900152	ENFAMIL A+ ENFACARE 385ML LIQ	MJO
95900012	ENFAMIL LOWER IRON 385ML LIQ	MJO
95900026	NUTRAMIGEN A+ 945ML LIQ	MJO
95900000	SIMILAC ALIMENTUM 237ML LIQ	ABB
95900001	SIMILAC ALIMENTUM 945ML LIQ	ABB
POWDER		
95900164	ENFAMIL A+ 663G PDR	MJO
95900009	ENFAMIL A+ ENFACARE 363G PDR	MJO
95900155	ENFAMIL LOW IRON FORMULA 900GM	MJO
95900022	NEOCATE ONE 400G	UNK
95900023	NEOCATE 400G PDR	UNK
95900025	NEOCATE W/ DHA & ARA 400G PDR	MJO
95900027	NUTRAMIGEN A+ LGG 561G PDR	MJO
95900035	PURAMINO A+ 400G PDR	ABB
95900036	SIMILAC ADVANCE NEOSURE 363G	ABB
95900047	SIMILAC ALIMENTUM 400G PDR	ABB
95900184	SIMILAC LOWER IRON 850G PDR	UNK
95900044	SIMILAC PM 60/40 450G PDR	UNK

September 2020 Page I-1 of 3 The Non-Insured Health Benefits (NIHB) program has established a nutritional product formulary for clients who require medically necessary nutritional products.

Clients who request and obtain approval will be granted access based on their condition. The length of approval and type of benefit will vary by nutritional product and/or life stage.

Select nutritional products are also included in the following special formularies: End of Life Care Formulary, Formulary for Chronic Renal Patients and Formulary for Adjunct Medications Used During Active Cancer Treatment.

CHILDREN AND YOUTH

Limited use benefit (prior approval required).

Criteria for Nutritional Supplement Coverage for Children and Youth (19 years and under)

- Sole source nutrition (more than 75% of intake is from nutrition supplement)
- · Failure to thrive/growth faltering
- Pre or post-surgery (6 months before or after date of surgery)
- · Other medical conditions not listed

ORAL LIQUID

95900131 COMPLEAT PEDIATRIC 250ML LIQ	NES
95900083 NEOCATE SPLASH 237ML LIQ	UNK
95900133 NUTREN JR. 250ML LIQ	NES
95900177 PEDIASURE 235ML LIQ	ABB
95900142 PEDIASURE COM. GROW&GAIN 235ML LIQ	ABB
95900178 PEDIASURE FIBRE 235ML LIQ	ABB
95900179 PEDIASURE PLUS WITH FIBRE 235	ABB
95900135 PEPTAMEN JUNIOR 1.0 CAL 250ML LIQ	NES
95900136 PEPTAMEN JUNIOR 1.5 CAL 250ML LIQ	NES
95900137 RESOURCE JUST KIDS 1.5 CAL 237ML LIQ	NES
POWDER	
95900132 NEOCATE JR FIBER&IRON 400G PDR	UNK
95900021 NEOCATE JUNIOR 400G PDR	UNK
95900143 PEDIASURE GROW&GAIN 400G PDR	ABB
95900112 PURAMINO A+ JUNIOR 400G PDR	MJO

ADULT

Limited use benefit (prior approval required).

Criteria for Nutritional Supplement Coverage for Adults

- Sole source nutrition (more than 75% of intake is from nutritional supplement)
- Unintentional weight loss
- Wound care
- Pre or post-surgery (6 months before or after date of surgery)
- Other medical conditions not listed

ORAL LIQUID

95900061 BOOST DIABETIC 237ML LIQ	NES
95999963 BOOST ORIGINAL 237ML LIQ	NES
95900070 COMPLEAT MODIFIED 1000ML LIQ	NES
95900069 COMPLEAT MODIFIED 250ML LIQ	NES
95900050 ENSURE 235ML LIQ	ABB
95900194 ENSURE COMPACT MILK 118ML LIQ	ABB
95900139 ENSURE FIBRE 235ML LIQ	ABB
95900181 ENSURE PLUS CALORIES 235ML LIQ	ABB

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The Non-Insured Health Benefits (NIHB) program has established a nutritional product formulary for clients who require medically necessary nutritional products.

Clients who request and obtain approval will be granted access based on their condition. The length of approval and type of benefit will vary by nutritional product and/or life stage.

Select nutritional products are also included in the following special formularies: End of Life Care Formulary, Formulary for Chronic Renal Patients and Formulary for Adjunct Medications Used During Active Cancer Treatment.

ORAL LIQUID	
95900204 ENSURE PROTEIN MAX 235ML LIQ	ABB
95900140 GLUCERNA 237ML LIQ	ABB
95900076 ISOSOURCE 1.0 HP 250ML LIQ	NES
95900072 ISOSOURCE 1.2 CAL 1500ML LIQ	NES
95900071 ISOSOURCE 1.2 CAL 250ML LIQ	NES
95900073 ISOSOURCE 1.5 CAL 250ML LIQ	NES
95900075 ISOSOURCE FIBRE 1.5 CAL 1500ML LIQ	NES
95900074 ISOSOURCE FIBRE 1.5 CAL 250ML LIQ	NES
95900077 ISOSOURCE HN WITH FIBRE 250ML LIQ	NES
95900082 JEVITY 1.5 CAL 235ML LIQ	ABB
95900078 JEVITY 235ML LIQ	ABB
95900088 PEPTAMEN 1.5 1000ML LIQ	NES
95900087 PEPTAMEN 1.5 250ML LIQ	NES
95900086 PEPTAMEN 250ML LIQ	NES
95900091 PEPTAMEN WITH PREBIO 1000ML LIQ	NES
95900090 PEPTAMEN WITH PREBIO 250ML LIQ	NES
95900058 RESOURCE 2.0 237ML LIQ	NES
95900207 RESOURCE DIABETIC 1.5L	NES
95900062 RESOURCE DIABETIC 250ML LIQ	NES
95900130 VITAL 1.5 CAL 1000ML LIQ	ABB
95900128 VITAL PEPTIDE 1 CAL 220ML LIQ	ABB
95900129 VITAL PEPTIDE 1.5 CAL 220ML LIQ	ABB
95900209 ISOSOURCE FIBRE 1.2CAL 250ML LIQ	NES
POWDER	
95900182 RESOURCE BENEPROTEIN 227G PDR	NVC
THICKENING AGENTS	
Open benefit	
THICKENING AGENT (KIT)	
95900118 SIMPLY THICK 64OZ BOTTLE PUMP	UNK
THICKENING AGENT (POWDER)	
95900113 RESOURCE THICKEN CLEAR 125G	NES
95900114 RESOURCE THICKEN UP 6.4G	NES
95900185 SIMPLY THICK HONEY 12G PDR	UNK
95900119 SIMPLY THICK HONEY 200G	UNK
95900120 SIMPLY THICK NECTAR 200G	UNK
95900186 SIMPLY THICK NECTAR 6G PDR	UNK
95900123 SOURCE THICKEN UP 227G PDR	NES
95900190 GELMIX JAR 125G PDR	UNK

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Alphabetical index of drug products

				Non-insured nearth ben	CIILO
24 HOUR ALLERGY REMEDY	1	ACETYLSALICYLIC ACID,	68	ACT QUETIAPINE	90
3TC	11	OXYCODONE HYDROCHLORIDE		ACT RALOXIFENE	134
AA-AMILZIDE	110	ACH-ALENDRONATE	159	ACT RANITIDINE	124
AA-ATENIDONE	49	ACH-ANASTROZOLE	16	ACT REPAGLINIDE	137
AA-CLOZAPINE	87	ACH-ATORVASTATIN CALCIUM	42	ACT RIZATRIPTAN	97
AA-DILTIAZ	54	ACH-BICALUTAMIDE	17	ACT SUMATRIPTAN	97
AA-FENO-MICRO	42	ACH-CANDESARTAN	58	ACT TEMOZOLOMIDE	26
AA-LEVOCARB	98	ACH-CAPECITABINE	17	ACT TERBINAFINE	8
AA-TRIMEBUTINE	30	ACH-ESCITALOPRAM	82	ACT VENLAFAXINE XR	86
ABACAVIR SUFLATE, LAMIVUDINE	10	ACH-EZETIMIBE	41	ACTEMRA	162
ABACAVIR SULFATE	10	ACH-FINASTERIDE	157	ACTIKERALL	149
ABACAVIR SULFATE, LAMIVUDINE	10	ACH-FINGOLIMOD	158	ACTONEL	160
ABACAVIR SULFATE, LAMIVUDINE,	10	ACH-FLUOXETINE	83	ACULAR	116
DOLUTEGRAVIR SODIUM	10	ACH-LETROZOLE	21	ACUVAIL	116
ABACAVIR SULFATE, LAMIVUDINE,	10	ACH-MYCOPHENOLATE	164	ACYCLOVIR	13
ZIDOVUDINE		ACH-OLMESARTAN HCTZ	61	ADALAT XL	53
ABATACEPT	161	ACH-PIOGLITAZONE	138	ADALIMUMAB	161
ABENOL	73	ACH-PRAVASTATIN	43	ADAPALENE	148
ABILIFY	86	ACH-ROSUVASTATIN	44	ADCIRCA	48
ABILIFY MAINTENA	87	ACH-TELMISARTAN HCTZ	61		
ABIRATERONE ACETATE	16	ACH-TOPIRAMATE	79	ADDERALL XR	92
ABOBOTULINUMTOXINA	165	ACITRETIN	147	ADEFOVIR DIPIVOXIL	13
ACAMPROSATE CALCIUM	100	ACLASTA	161	ADEMPAS	112
ACARBOSE	134	ACLIDINIUM BROMIDE	30	ADHESHIVE WIPES	167
ACCEL-LEFLUNOMIDE	162			ADLYXINE	135
ACCEL-ONDANSETRON	122	ACLIDINIUM BROMIDE, FORMOTEROL FUMARATE DIHYDRATE	31	ADMINISTRATION DIN	173
ACCEL-RIZATRIPTAN ODT	97	ACT AMLODIPINE	51	ADRENALIN	33
ACCEL-SEVELAMER		ACT AMPHETAMINE XR	92	ADULT	173
	109	ACT ATENOLOL	49	ADVAGRAF	165
ACCEL-TOPIRAMATE	79	ACT BUPRENORPHINE/NALOXONE	72	ADVAIR 100 DISKUS	32
ACCU-CHEK ADVANTAGE	104			ADVAIR 125	32
ACCU-CHEK AVIVA	104	ACT CELECOXIB	64	ADVAIR 250	32
ACCU-CHEK COMPACT	104	ACT CITAL ORDAM	6	ADVAIR 250 DISKUS	32
ACCU-CHEK FASTCLIK LANCET	169	ACT CITALOPRAM	81	ADVAIR 500 DISKUS	32
ACCU-CHEK GUIDE (ON)	104	ACT CLARITHROMYCIN XL	4	ADVIL	65
ACCU-CHEK GUIDE (SK)	104	ACT CLOPIDOGREL	39	ADVIL 12 HOUR	66
ACCU-CHEK MOBILE BG	104	ACT DEXTROAMPHETAMINE SR	93	ADVIL EXTRA STRENGTH	66
ACCU-CHEK MOBILE CASSETT	104	ACT DILTIAZEM CD	53	ADVIL PEDIATRIC DROPS	65
ACCU-CHEK MULTICLIX LANCET	169	ACT DILTIAZEM T	53	ADVIL PEDIATRIC DROPS FEVER	65
ACCU-CHEK SOFTCLIX LANCET	169	ACT DORZOTIMOLOL	117	FROM COLDS OR FLU	
ACCUPRIL	56	ACT DUTASTERIDE	157	AERIUS	1
ACCURETIC	57	ACT ENALAPRIL	54	AERIUS KIDS	1
ACCUTANE ROCHE	148	ACT ESCITALOPRAM ODT	83	AEROCHAMBER AC BOYZ	167
ACCUTREND	104	ACT ETIDRONATE	160	AEROCHAMBER AC GIRLZ	167
ACEBUTOLOL	49	ACT EXEMESTANE	19	AEROCHAMBER PLUS FLOWVU	167
ACEBUTOLOL HYDROCHLORIDE	49	ACT FAMCICLOVIR	13	LARGE	
ACENOCOUMAROL	36	ACT FLUCONAZOLE	9	AEROCHAMBER PLUS FLOWVU	167
ACET	73	ACT FLUOXETINE	83	MEDIUM	
ACET 120	73	ACT FLUVOXAMINE	83	AEROCHAMBER PLUS FLOWVU	167
ACET 325	73	ACT LATANOPROST/TIMOLOL	117	MOUTH	
ACET 650	73	ACT LEVETIRACETAM	77	AEROCHAMBER PLUS FLOWVU SMALL	167
ACETAMINOPHEN	72	ACT LEVOFLOXACIN	6	AEROTRACH PLUS	167
ACETAMINOPHEN	72	ACT LOVASTATIN	43	AFATINIB DIMALEATE	16
ACETAMINOPHEN, CAFFEINE	67	ACT MELOXICAM	66	AFINITOR	19
CITRATE, CODEINE PHOSPHATE	Ŭ,	ACT METFORMIN	134	AFINITOR DISPERZ	19
ACETAMINOPHEN, CODEINE	67	ACT METHYLPHENIDATE ER	93	AFLIBERCEPT	118
PHOSPHATE		ACT MOXIFLOXACIN	114	AG-ALLOPURINOL	157
ACETAMINOPHEN, OXYCODONE	68	ACT NABILONE	123	AG-AMITRIPTYLINE	80
HYDROCHLORIDE		ACT OLANZAPINE ODT	89	AG-AMLODIPINE	52
ACÉTAMINOPHÈNE	73	ACT OLMESARTAN	60	AG-AMOXICILLIN	4
ACÉTAMINOPHÈNE BLASON SHIELD	73	ACT OLMESARTAN HCT	61	AG-ATENOLOL	49
ACETAZOLAMIDE	117	ACT OLOPATADINE	114	AG-ATORVASTATIN	42
ACETAZOLAMIDE	117	ACT OLOPATADINE ACT ONDANSETRON	114	AG-AZITHROMYCIN	3
ACETYLSALICYLIC ACID	64	ACT PAROXETINE	84	AG-CELECOXIB	64
ACETYLSALICYLIC ACID	64	ACT PIOGLITAZONE	138	AG-CITALOPRAM	81
				AG-DULOXETINE	82
		ACT PRAMIPEXOLE	99		

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				Non-insured Health Be	nems
AG-ESCITALOPRAM	82	ALLERNIX ELIXIR	1	ANORO ELLIPTA	30
AG-EZETIMIBE	41	ALLERNIX EXTRA STRENGTH	1	ANTACID AND LIDOCAINE ORAL	155
AG-GABAPENTIN	75	ALLERTIN	1	LIQUID	
AG-IRBESARTAN	59	ALLOPURINOL	157	ANTIBIOTIC DROPS	155
AG-LOSARTAN	60	ALLOPURINOL	157	ANTIBIOTIC OINT	142
AG-MOXIFLOXACIN	7	ALLOPURINOL ORAL LIQUID	158	ANTIFUNGAL DROPS	155
AG-OLMESARTAN	60	ALMOTRIPTAN	96	ANTI-NAUSEANT	122
AG-PANTOPRAZOLE	125		96	ANTIVIRAL DROPS	155
		ALMOTRIPTAN MALATE ALOMIDE		ANUGESIC HC	145
AG-PANTOPRAZOLE SODIUM	125		114	ANUSOL HC	145
AG-PAROXETINE	84	ALPHAGAN	116	APALUTAMIDE	16
AG-PERINDOPRIL	56	ALPHAGAN P	116	APIDRA CARTRIDGE	136
AG-PREGABALIN	78	ALPRAZOLAM	94		
AG-QUETIAPINE	91	ALPRAZOLAM	94	APIDRA SOLOSTAR	136
AG-RAMIPRIL	57	ALTACE	57	APIDRA VIAL	136
AG-RISPERIDONE	91	ALTACE HCT	57	APIS MELLIFERA VENOM PROTEIN	156
AG-ROSUVASTATIN	44	ALVESCO	130	EXTRACT	
AGRYLIN	39	ALYSENA 21	132	APIXABAN	37
AG-SERTRALINE	85	ALYSENA 28	132	APO ACETAMINOPHEN	73
AG-SIMVASTATIN	45	AMANTADINE HYDROCHLORIDE	10	APO ASA	64
AG-TOPIRAMATE	79	AMBRISENTAN	48	APO CARBAMAZEPINE	75
AG-ZOLMITRIPTAN ODT	98	AMCINONIDE	144	APO DIMENHYDRINATE	122
AIROMIR	32	AMERGE	96	APO FUROSEMIDE	109
AKYNZEO	122	AMI-HYDRO	110	APO GLYBURIDE	138
ALBALON	116			APO HALOPERIDOL	87
ALCOHOL PREP	168	AMIKACIN SULFATE	2	APO HYDRO	110
		AMIKACIN SULFATE	2	APO IBUPROFEN	66
ALCOHOL SWABS	168	AMILORIDE	110	APO INDOMETHACIN	66
ALCOHOL SWABS 6893 BUTTERFLY	168	AMILORIDE, HYDROCHLOROTHIAZIDE	110	APO METOPROLOL	50
ALCOHOL SWABS 6896 (150)	169	AMIODARONE	41	APO METOPROLOL (TYPE L)	50
ALCOHOL SWABS ANTISEPTIC SKIN	169	AMIODARONE HYDROCHLORIDE	41	APO NAPROXEN	66
CLEANERS	400	AMIODARONE ORAL LIQUID	41	APO OXAZEPAM	95
ALCOHOL SWABS BD REGULAR	169	AMITRIPTYLINE	80		95 5
ALDACTAZIDE ORAL LIQUID	62	AMITRIPTYLINE HYDROCHLORIDE	80	APO PEN VK	
ALDACTONE	63	AMLODIPINE	51	APO PIROXICAM	67
ALDARA P	148	AMLODIPINE BESYLATE	51	APO PREDNISONE	131
ALECENSARO	16	AMLODIPINE BESYLATE	51	APO PROPRANOLOL	51
ALECTINIB	16	AMLODIPINE BESYLATE,	52	APO TRIAZIDE	110
ALEMTUZUMAB	163	ATORVASTATIN CALCIUM		APO-ABACAVIR	10
ALENDRONATE	160	AMLODIPINE BESYLATE,	52	APO-ABACAVIR-LAMIVUDINE	10
ALENDRONATE SODIUM	159	TELMISARTAN		APO-ABACAVIR-LAMIVUDINE-	10
ALENDRONATE SODIUM,	160	AMLODIPINE ORAL LIQUID	52	ZIDOVUDINE	
CHOLECALCIFEROL		AMOXICILLIN	4	APO-ACEBUTOLOL	49
ALENDRONATE-70	160	AMOXICILLIN	4	APO-ACETAMINOPHEN	73
ALERTEC	93	AMOXICILLIN (SUGAR REDUCED)	5	APO-ACYCLOVIR	13
ALESSE 21	132	AMOXICILLIN, CLARITHROMYCIN,	124	APO-ADEFOVIR	13
ALESSE 28	132	LANSOPRAZOLE		APO-ALENDRONATE	160
ALFACALCIDOL	153	AMOXICILLIN, CLAVULANIC ACID	5	APO-ALENDRONATE/VITAMIN D3	160
ALFUZOSIN	33	AMPHETAMINE,	92	APO-ALFUZOSIN	33
ALFUZOSIN HYDROCHLORIDE	33	DEXTROAMPHETAMINE	-	APO-ALLOPURINOL	157
ALIROCUMAB	46	AMPICILLIN	5	APO-ALMOTRIPTAN	96
ALKERAN		AMPICILLIN	5	APO-ALPRAZ	94
	21	AMPICILLIN SODIUM	5	APO-AMBRISENTAN	112
ALL PURPOSE NIPPLE OINTMENT	155	AMPICILLIN SODIUM FOR BP	5	APO-AMIODARONE	41
ALLEGRA 12 HOUR	1	AMPICILLIN STERILE INFUSION	5	APO-AMITRIPTYLINE	80
ALLEGRA 24 HOUR	1			APO-AMLODIPINE	52
ALLER-AIDE	1	ANAFRANIL	82		
ALLERGENIC EXTRACT NON POLLENS	156	ANAGRELIDE HYDROCHLORIDE	39	APO-AMOVI	52
ALLERGENIC EXTRACT POLLENS	157	ANANDRON	22	APO-AMOXI	4
ALLERGENIC EXTRACTS POLLENS	156	ANAPROX	67	APO-AMOXI CLAV	5
ALLERGY	1	ANAPROX DS	67	APO-AMOXI SUGAR FREE	5
ALLERGY ELIXIR	1	ANASTROZOLE	16	APO-AMPHETAMINE XR	92
ALLERGY EXTRA STRENGTH	1	ANASTROZOLE	16	APO-ANASTROZOLE	16
ALLERGY FORMULA	1	ANDROCUR	165	APO-ARIPIPRAZOLE	86
ALLERGY RELIEF	1	ANDRODERM	132	APO-ASA LD	64
ALLERGY REMEDY	1	ANDROGEL	131	APO-ATENOL	49
ALLERJECT	32	ANETHOLE TRITHIONE	118	APO-ATOMOXETINE	100
ALLERNIX	1	ANODAN-HC	145	APO-ATORVASTATIN	42
	'				

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				Non-insured Health B	enents
APO-AZATHIOPRINE	163	APO-FAMOTIDINE	123	APO-METHYLPHENIDATE	93
APO-AZITHROMYCIN	4	APO-FELODIPINE	52	APO-METHYLPHENIDATE ER	93
APO-BACLOFEN	33	APO-FENO-SUPER	42	APO-METHYLPHENIDATE SR	93
APO-BECLOMETHASONE	115	APO-FERROUS GLUCONATE	36	APO-METOCLOP	126
APO-BENZYDAMINE	116	APO-FINASTERIDE	157	APO-METOPROLOL	50
APO-BICALUTAMIDE	17	APO-FINGOLIMOD	158	APO-METOPROLOL (TYPE L)	50
APO-BISACODYL	120	APO-FLECAINIDE	41	APO-METOPROLOL SR	50
APO-BISOPROLOL	49	APO-FLUCONAZOLE	9	APO-METRONIDAZOLE	15
APO-BOSENTAN	48	APO-FLUOXETINE	83	APO-MIDODRINE	30
APO-BRIMONIDINE	116	APO-FLURBIPROFEN	65	APO-MIRTAZAPINE	84
APO-BROMAZEPAM	94	APO-FLUTICASONE	115	APO-MODAFINIL	93
APO-BUSPIRONE	96	APO-FLUVOXAMINE	83	APO-MOMETASONE	115
APO-CABERGOLINE	99	APO-FOSINOPRIL	55	APO-MONTELUKAST	111
APO-CANDESARTAN	58	APO-GABAPENTIN	75	APOMORPHINE HYDROCHLORIDE	99
APO-CAPTO	54	APO-GATIFLOXACIN	114	APO-MOXIFLOXACIN	7
APO-CARVEDILOL	50	APO-GEFITINIB	20	APO-MYCOPHENOLATE	164
APO-CEFADROXIL	2	APO-GEMFIBROZIL	42	APO-MYCOPHENOLIC ACID	165
APO-CEFPROZIL	2	APO-GLICLAZIDE	138	APO-NALTREXONE	74
APO-CEFUROXIME	3	APO-GLICLAZIDE MR	138	APO-NAPRO-NA	67
APO-CELECOXIB	64	APO-GRANISETRON	122	APO-NAPRO-NA DS	67
APO-CEPHALEX	3	APO-HALOPERIDOL	87	APO-NAPROXEN	67
APO-CETIRIZINE	1	APO-HYDRALAZINE	47	APO-NAPROXEN EC	67
APO-CILAZAPRIL	54	APO-HYDRO	110	APO-NEVIRAPINE XR	11
APO-CILAZAPRIL/HCTZ	54	APO-HYDROMORPHONE	69	APO-OFLOXACIN	114
APO-CINACALCET	165	APO-HYDROXYQUINE	15	APO-OLANZAPINE	88
APO-CIPROFLOX	6	APO-HYDROXYUREA	20	APO-OLANZAPINE ODT	89
APO-CITALOPRAM	81	APO-IBUPROFEN	66	APO-OLMESARTAN	60
APO-CLARITHROMYCIN	4	APO-IMATINIB	20	APO-OLMESARTAN/HCTZ	61
APO-CLARITHROMYCIN XL	4	APO-IMIQUIMOD	148	APO-OLOPATADINE	114
APO-CLINDAMYCIN	7	APO-INDAPAMIDE	110	APO-OMEPRAZOLE	125
APO-CLOBAZAM	74	APO-IPRAVENT	30	APO-ONDANSETRON	123
APO-CLONAZEPAM	74	APO-IRBESARTAN	59	APO-OXCARBAZEPINE	78
APO-CLONIDINE	47	APO-IRBESARTAN/HCTZ	59	APO-OXYBUTYNIN	150
APO-CLOPIDOGREL	39	APO-ISMN	47	APO-OXYCODONE/ACET	68
APO-CROMOLYN	112	APO-KETOCONAZOLE	9	APO-PANTOPRAZOLE	125
APO-CYCLOBENZAPRINE	33	APO-KETOROLAC	116	APO-PAROXETINE	84
APO-CYCLOSPORINE	164	APO-LACTULOSE	106	APO-PERINDOPRIL	56
APO-DABIGATRAN	37	APO-LAMIVUDINE	11	APO-PERINDOPRIL-INDAPAMIDE	56
APO-DARUNAVIR	10	APO-LAMIVUDINE HBV	11	APO-PHENYTOIN SODIUM	74
APO-DEXAMETHASONE	130	APO-LAMIVUDINE-ZIDOVUDINE	11	APO-PINAVERIUM	126
APO-DICLO	65	APO-LAMOTRIGINE	77	APO-PINDOL	51
APO-DICLO SR	65	APO-LANSOPRAZOLE	124	APO-PIOGLITAZONE	138
APO-DICLOFENAC	65	APO-LANSOPRAZOLE-AMOXICILLIN-	124	APO-PRAMIPEXOLE	99
APO-DILTIAZ CD	53	CLARITHROMYCIN		APO-PRAVASTATIN	43
APO-DIPIVEFRIN	116	APO-LATANOPROST	117	APO-PRAZO	48
APO-DIPYRIDAMOLE	48	APO-LATANOPROST-TIMOP	117	APO-PREGABALIN	78
APO-DIVALPROEX	80	APO-LEFLUNOMIDE	162	APO-PROCAINAMIDE	41
APO-DOMPERIDONE	125	APO-LETROZOLE	21	APO-PROPAFENONE	41
APO-DONEPEZIL	28	APO-LEVETIRACETAM	77	APO-QUETIAPINE	90
APO-DORZO-TIMOP	117	APO-LEVOBUNOLOL	116	APO-QUETIAPINE XR	90
APO-DOXAZOSIN	48	APO-LEVOCARB	98	APO-QUINAPRIL	56
APO-DOXY	7	APO-LEVOFLOXACIN	6	APO-QUINAPRIL/HCTZ	57
APO-DOXYLAMINE/B6	123	APO-LINEZOLID	8	APO-RABEPRAZOLE	125
APO-DULOXETINE	82	APO-LISINOPRIL	55	APO-RALOXIFENE	134
APO-DUTASTERIDE	157	APO-LITHIUM CARBONATE	96	APO-RAMIPRIL	57
APO-EFAVIRENZ-EMTRICITABINE-	11	APO-LOPERAMIDE	120	APO-RAMIPRIL/HCTZ	57
TENOFOVIR	40	APO-LORATADINE	1	APO-RANITIDINE	124
APO-EMTRICITABINE-TENOFOVIR	12	APO-LORAZEPAM	95	APO-REPAGLINIDE	137
APO-ENALAPRIL	54	APO LOSABTANILICTZ	60	APO-RISEDRONATE	161
APO-ENTECAVIR	13	APO-LOSARTAN/HCTZ	60	APO-RISPERIDONE	91
APO-ERLOTINIB	19	APO MEDDOXY	43	APO-RIVASTIGMINE	29
APO-ESCITALOPRAM	82	APO-MELOVICAM	139	APO-RIZATRIPTAN	96
APO-EXEMESTANE	19	APO METEODAIN	66	APO-RIZATRIPTAN RPD	97
APO-EZETIMIBE	41	APO METHOTREYATE	134	APO-ROPINIROLE	100
APO-FAMCICLOVIR	13	APO-METHOTREXATE	22		

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				Non-insured Health	Denenis
APO-ROSUVASTATIN	44	ARTIFICIAL TEARS	118	AURO-CYCLOBENZAPRINE	33
APO-SALBUTAMOL HFA	32	ASA	64	AURO-DARUNAVIR	10
APO-SELEGILINE	100	ASA DAILY LOW DOSE	64	AURO-DONEPEZIL	28
APO-SERTRALINE	85	ASA EC	64	AURO-DULOXETINE	82
APO-SILDENAFIL R	47	ASACOL	126	AURO-DUTASTERIDE	157
APO-SIMVASTATIN	45	ASAPHEN	64	AURO-EFAVIRENZ	11
APO-SOLIFENACIN	150	ASAPHEN EC	64	AURO-ENTECAVIR	13
APO-SOTALOL	51	ASATAB	64	AURO-ESCITALOPRAM	82
APO-SUCRALFATE	124	ASATAB EC	64	AURO-EZETIMIBE	41
APO-SUMATRIPTAN	97	ASCENCIA CONTOUR	104	AURO-FINASTERIDE	157
APO-TADALAFIL PAH	48	ASCENSIA BREEZE 2	104	AURO-FLECAINIDE	41
APO-TAMOX	26	ASCORBIC ACID	152	AURO-FLUOXETINE	83
APO-TAMSULOSIN	33	ASCORBIC ACID	152	AURO-GABAPENTIN	75
APO-TELMISARTAN	61	ASENAPINE MALEATE	87	AURO-GALANTAMINE ER	28
APO-TELMISARTAN/HCTZ	61	ASMANEX TWISTHALER	131	AURO-IRBESARTAN	59
APO-TEMOZOLOMIDE	26	ASPEN-DIENOGEST	139	AURO-IRBESARTAN HCT	59
APO-TENOFOVIR	12	ASPIRIN	64	AURO-LACOSAMIDE	76
APO-TERAZOSIN	48	ATACAND	58	AURO-LAMIVUDINE/ZIDOVUDINE	11
APO-TERBINAFINE	8	ATACAND PLUS	58	AURO-LAMOTRIGINE	77
APO-TETRABENAZINE	101	ATARAX	96	AURO-LEVETIRACETAM	77
APO-THEO-LA	151	ATAZANAVIR SULFATE	10	AURO-LISINOPRIL	55
APO-TIMOP	117	ATENOLOL	49	AURO-LOSARTAN	60
APO-TOLTERODINE	150	ATENOLOL	49	AURO-LOSARTAN HCT	60
APO-TOPIRAMATE	79	ATENOLOL, CHLORTHALIDONE	49	AURO-MELOXICAM	66
APO-TRAVOPROST Z	118	ATIVAN	95	AURO-METFORMIN	134
APO-TRAVOPROST-TIMOP PQ	118	ATIVAN SUBLINGUAL	95	AURO-METRONIDAZOLE	15
APO-TRAZODONE	85	ATOMOXETINE	100	AURO-MIRTAZAPINE	84
APO-TRAZODONE D	85	ATOMOXETINE HYDROCHLORIDE	100	AURO-MIRTAZAPINE OD	84
APO-TRIAMCINOLONE AQ	115	ATORVASTATIN	42	AURO-MODAFINIL	93
APO-VALACYCLOVIR	13	ATORVASTATIN CALCIUM	42	AURO-MONTELUKAST	111
APO-VALGANCICLOVIR	13	ATORVASTATIN-10	42	AURO-MOXIFLOXACIN	7
APO-VALPROIC	80	ATORVASTATIN-20	42	AURO-NEVIRAPINE	11
APO-VALSARTAN	61	ATORVASTATIN-40	43	AURO-OLANZAPINE ODT	89
APO-VALSARTAN/HCTZ	62	ATORVASTATIN-80	43	AURO-OLMESARTAN	61
APO-VARENICLINE	35	ATOVAQUONE	15	AURO-OLMESARTAN HCTZ	61
APO-VENLAFAXINE XR	86	ATRIPLA	11	AURO-PANTOPRAZOLE	125
APO-VERAP	54	ATROPINE	116	AURO-PAROXETINE	84
APO-VERAP SR	54	ATROPINE SULFATE	116	AURO-PERINDOPRIL	56
APO-VORICONAZOLE	9	ATROVENT HFA	30	AURO-PRAMIPEXOLE	99
APO-WARFARIN	39	AUBAGIO	159	AURO-PRAVASTATIN	43
APO-ZIDOVUDINE	12	AURANOFIN	128	AURO-PREGABALIN	78
APO-ZOLMITRIPTAN RAPID	98	AURO-ABACAVIR/LAMIVUDINE	10	AURO-QUETIAPINE	90
APRACLONIDINE HYDROCHLORIDE	118	AURO-ALENDRONATE	160	AURO-QUINAPRIL HCTZ	57
APREPITANT	123	AURO-ALFUZOSIN	33	AURO-RAMIPRIL	57
APRI 21	132	AURO-AMLODIPINE	52	AURO-REPAGLINIDE	137
APRI 28	132	AURO-AMOXICILLIN	4	AURO-RISEDRONATE	161
APTIOM	75	AURO-ARIPIPRAZOLE	86	AURO-RIZATRIPTAN	97
APTIVUS	12	AURO-ATOMOXETINE	100	AURO-ROSUVASTATIN	44
APX-OXCARBAZEPINE	78	AURO-ATORVASTATIN	42	AURO-SERTRALINE	85
AQUA-E	154	AURO-AZITHROMYCIN	3	AURO-SIMVASTATIN	45
AQUA-E/ML	154	AURO-BETAHISTINE	101	AURO-SOLIFENACIN	150
AQUASOL E	154	AURO-CANDESARTAN	58	AURO-TELMISARTAN	61
AQUASOL E VITAMIN E	154	AURO-CANDESARTAN HCT	59	AURO-TELMISARTAN HCTZ	61
ARAVA	162	AURO-CARVEDILOL	50	AURO-TENOFOVIR	12
ARICEPT	28	AURO-CEFIXIME	2	AURO-TERBINAFINE	8
ARIMIDEX	16	AURO-CEFPROZIL	2	AURO-TOPIRAMATE	79
ARIPIPRAZOLE	86	AURO-CEFUROXIME	3	AURO-TRANDOLAPRIL	58
ARIPIPRAZOLE	86	AURO-CELECOXIB	64	AURO-VALACYCLOVIR	13
ARIPIPRAZOLE (MAINTENA)	87	AURO-CEPHALEXIN	3	AURO-VALGANCICLOVIR	13
ARISTOCORT C	146	AURO-CINACALCET	165	AURO-VALSARTAN	61
ARISTOCORT R	146	AURO-CIPROFLOXACIN	6	AURO-VALSARTAN HCT	62
ARNUITY ELLIPTA	115	AURO-CITALOPRAM	81	AURO-VENLAFAXINE XR	86
AROMASIN	19	AURO-CLINDAMYCIN	7	AURO-ZIPRASIDONE	92
ARTHROTEC	66	AURO-CLOPIDOGREL	39	AUTOSOFT 30 13MM	168

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AUTOSOFT 90 6MM AUTOSOFT 90 9MM AVALIDE AVAPRO AVENTYL AVIANE 21 AVIANE 28 AVODART AVONEX	168 168 59 59 84 132	BD MICRO-FINE 28GX1CC SYRINGE BD NANO PRO 32GX4MM PEN NEEDLE BD POSIFLUSH SP BD PRECISIONGLIDE 18GX1 1/2	171 170 170 170	BETAMETHASONE SODIUM PHOSPHATE BETAMETHASONE VALERATE BETASERON	126 144
AVALIDE AVAPRO AVENTYL AVIANE 21 AVIANE 28 AVODART	59 59 84	BD POSIFLUSH SP	170	BETAMETHASONE VALERATE	
AVAPRO AVENTYL AVIANE 21 AVIANE 28 AVODART	59 84				
AVENTYL AVIANE 21 AVIANE 28 AVODART	84	BD FRECISIONGLIDE 10GAT 1/2			159
AVIANE 21 AVIANE 28 AVODART		BD PRECISIONGLIDE 18GX1 NEEDLE	170	BETASERON INITIATION KIT	159
AVIANE 28 AVODART	1.37	BD PRECISIONGLIDE 23GX1 1/4	169	BETAXOLOL HYDROCHLORIDE	116
AVODART	132	BD PRECISIONGLIDE 25GX1 NEEDLE	169	BETHANECHOL CHLORIDE	28
	157	BD PRECISIONGLIDE 25GX5/8	170	BETNESOL	126
AT OTTER	159	BD PRECISIONGLIDE 25GX7/8	170	BETOPTIC S	116
AVONEX PEN	159	BD PRECISIONGLIDE 26GX1/2	170	BEZAFIBRATE	42
AXERT	96	BD PRECISIONGLIDE 26GX3/8	170	BEZALIP SR	42
AXID	123	BD PRECISIONGLIDE 27GX1 1/4	170	BG STAR	104
AXITINIB	17	BD PRECISIONGLIDE 27GX1/2	170	BG STAR LANCET	169
AZARGA	117	BD SHARPS CONTAINER 3.1L	170	BIACNA TOPICAL	147
AZATHIOPRINE	163	BD SHARPS CONTAINER 3L	170	BIAXIN	4
AZATHIOPRINE ORAL LIQUID	163	BD SLIP TIP 10ML SYRINGE	171	BIAXIN XL	4
AZATHIOPRINE-50	163	BD SLIP TIP 1ML SYRINGE	171	BICALUTAMIDE	17
AZELAIC ACID	148	BD SLIP TIP 20ML SYRINGE	171	BICILLIN	5
AZILSARTAN MEDOXOMIL	58	BD SLIP TIP 30ML SYRINGE	172	BIKTARVY	11
AZITHROMYCIN	3	BD SLIP TIP 3ML SYRINGE	171	BIMATOPROST	117
AZITHROMYCIN	4	BD SLIP TIP 5ML SYRINGE	171	BIO CAL-D3	156
AZOPT	117	BD SLIP TIP 60ML SYRINGE	172	BIO K-20 POTASSIUM	108
AZTREONAM	3	BD SLIP TIP SUB Q 26G SYRINGE	171	BIO-AMLODIPINE	51
B-12	152	BD SYRINGE + NEEDLE	172	BIO-ANASTROZOLE	16
B6	152	BD SYRINGE WITH ULTRA-FINE	172	BIO-ATENOLOL	49
BABY DDROPS	153	NEEDLE		BIO-ATORVASTATIN	42
BACIMYXIN ONGUENT	142	BD TUBERCULIN 21GX1 SYRINGE	171	BIO-CAL DR FORTE	154
BACITIN	142	BD TUBERCULIN 25GX5/8 SYRINGE	171	BIOCALCIUM	107
BACITRACIN ZINC	142	BD TUBERCULIN 26GX3/8 SYRINGE	171	BIOCALCIUMD	107
BACKORDER INTERNAL POWDER	155	BD TUBERCULIN 27GX1/2 SYRINGE	171	BIOCALD FORTE	107
BACKUP PLAN ONESTEP	133	BD ULTRA 29G.1/2CC SYRINGE	171	BIO-CELECOXIB	64
BACLOFEN	33	BD ULTRA 29G.1CC SYRINGE	171	BIO-CIPROFLOXACIN	6
BACLOFEN	33	BD ULTRAFINE 31G 5MM PEN NEEDLE	170	BIO-CITALOPRAM	81
BACLOFEN ORAL LIQUID	33	BD ULTRAFINE 31G 8MM PEN NEEDLE	170	BIODERM	142
BACTERIOSTATIC SODIUM CHLORIDE	108	BD ULTRAFINE 33G LANCET	169	BIO-DOMPERIDONE	125
BACTERIOSTATIC WATER	110	BD ULTRA-FINE II 30GX0.5CC SYRINGE	171	BIO-DONEPEZIL	28
BACTROBAN	142	BD ULTRA-FINE III PEN NEEDLE	169	BIO-ESCITALOPRAM	82
BANZEL	79	BD ULTRA-FINE NANO PEN NEEDLE	170	BIO-FLUCONAZOLE	9
BARACLUDE	13	BD ULTRA-FINE PEN NEEDLE 29G BECLOMETHASONE DIPROPIONATE	170	BIO-FLUOXETINE	83
BARRIERE	147		115	BIO-FUROSEMIDE	109
BASAGLAR	136	BEDUZIL BENADRYL	152 1	BIO-GABAPENTIN	75
BASES-EMULSIONS	173	BENADRYL ALLERGY	1	BIO-HYDROCHLOROTHIAZIDE	110
BC SHARPS CONTAINER 1.4L	170		54	BIO-IRBESARTAN	59
BD ALCOHOL SWABS	169	BENAZEPRIL BENAZEPRIL HYDROCHLORIDE	54 54	BIO-LETROZOLE	21
BD AUTOSHIELD DUO SAFETY PEN	169	BENRALIZUMAB	106	BIO-LEVETIRACETAM	77
NEEDLE	170	BENZACLIN	142	BIO-LOSARTAN	60
BD AUTOSHIELD PEN NEEDLES BD BLUNT 18GX1 1/2 FILTER	170 169	BENZAGEL	147	BIO-MODAFINIL BIO-MONTELUKAST	93 111
BD BUTTERFLY NEEDLE 21G	170	BENZAGEL 5	147	BIO-MOXIFLOXACIN	7
BD GLUCOSE	109	BENZAMYCIN	142	BIO-OMEPRAZOLE	125
BD LUER-LOK TIP 10ML SYRINGE	171	BENZODIAZEPINE ORAL LIQUID	74	BIO-PANTOPRAZOLE	125
BD LUER-LOK TIP 18GX1 1/2 SYRINGE	171	BENZOYL PEROXIDE	147	BIO-PAROXETINE	84
BD LUER-LOK TIP 1ML SYRINGE	171	BENZTROPINE MESYLATE	98	BIO-PRAVASTATIN	43
BD LUER-LOK TIP 20ML SYRINGE	171	BENZTROPINE OMEGA	98	BIO-QUETIAPINE	90
BD LUER-LOK TIP 22GX1 1/2 SYRINGE	171	BENZYDAMINE HYDROCHLORIDE	116	BIO-ROSUVASTATIN	44
BD LUER-LOK TIP 25GX1 SYRINGE	171	BETADERM	144	BIOSENNOSIDES	121
BD LUER-LOK TIP 25GX1 1/2 SYRINGE	171	BETADINE	143	BIO-SERTRALINE	85
BD LUER-LOK TIP 25GX5/8 SYRINGE	171	BETAHISTINE	101	BIO-SIMVASTATIN	45
BD LUER-LOK TIP 30ML SYRINGE	172	BETAHISTINE HYDROCHLORIDE	101	BIO-VITAMIN D3	153
BD LUER-LOK TIP 3ML SYRINGE	171	BETAMETHASONE DIPROPIONATE	144	BIO-VITAMINE D3	156
BD LUER-LOK TIP 5ML SYRINGE	171	BETAMETHASONE DIPROPIONATE,	142	BI-PEGLYTE	121
BD LUER-LOK TIP 60ML SYRINGE	172	CLOTRIMAZOLE	-	BISACODYL	120
	171	BETAMETHASONE DIPROPIONATE,	144	BISACODYL	120
BD MICRO-FINE 0.3CC SYRINGE	17.1	SALICYLIC ACID			120

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				Non-Insured Health Ben	etits
BISMUTH	120	CALCIPOTRIOL, BETAMETHASONE	144	CEFAZOLIN SODIUM	2
BISMUTH SUBSALICYLATE	120	DIPROPIONATE		CEFAZOLIN STERILE INFUSION	2
BISMUTH SUBSALICYLATE	120	CALCITE 500 D 400	107	CEFIXIME	2
BISOPROLOL	49	CALCITE LIQUIDE D 400	107	CEFPROZIL	2
BISOPROLOL FUMARATE	49	CALCITONIN SALMON (SYNTHETIC)	138	CEFTAZIDIME	2
BLEPHAMIDE	115	CALCITRIOL	153	CEFTAZIDIME	2
BOOST DIABETIC 237ML LIQ	173	CALCITRIOL	153	CEFTIN	3
BOOST ORIGINAL 237ML LIQ	173	CALCITRIOL-ODAN	153	CEFTRIAXONE	3
BOSENTAN MONOHYDRATE	48	CALCIUM	107	CEFTRIAXONE SODIUM	3
BOSULIF	17	CALCIUM	107	CEFTRIAXONE SODIUM FOR BP	3
BOSUTINIB	17	CALCIUM 500	107	CEFTRIAXONE STERILE INFUSION	3
вотох	166	CALCIUM 500 D 400	107	CEFUROXIME AXETIL	3
BREEZE 2 BG (ON)	104	CALCIUM 500 VITAMINE D1000	107	CELEBREX	64
BRENZYS	162	CALCIUM 500 VITAMINE D400	107	CELECOXIB	64
BREO ELLIPTA	31	CALCIUM CARBONATE	107	CELECOXIB	64
BREVICON 0.5/35 (21-DAY PACK)	132	CALCIUM CARBONATE VITAMINE D	107	CELESTODERM V	144
BREVICON 0.5/35 (28-DAY PACK)	132	CALCIUM CHANNEL BLOCKER IN	155	CELEXA	81
BREVICON 1/35 (21-DAY PACK)	132	OINTMENT		CELLCEPT	164
BREVICON 1/35 (28-DAY PACK)	132	CALCIUM GLUCONATE,VIT D	107	CELSENTRI	11
BREXPIPRAZOLE	87	CALCIUM POLYSTYRENE SULFONATE	108	CENTER-AL	157
BRICANYL TURBUHALER	32	CALCIUM VITAMIN D LEMON FLAVOUR	107	CENTRUM	154
BRILINTA	39	CALCIUM, VITAMIN D	107	CENTRUM DHA	154
BRIMONIDINE P	116	CALODAN D 400	107	CENTRUM FOR WOMEN	154
BRIMONIDINE TARTRATE	116	CAMPRAL	100	CENTRUM JUNIOR COMPLETE	154
BRINZOLAMIDE	117	CANAGLIFLOZIN	137	CENTRUM PRENATAL	154
BRINZOLAMIDE, BRIMONIDINE	117	CANDESARTAN	58	CEPHALEXIN	3
TARTRATE	• • • •	CANDESARTAN CILEXETIL	58	CEPHALEXIN-500	3
BRINZOLAMIDE, TIMOLOL MALEATE	117	CANDESARTAN CILEXETIL,	58	CERITINIB	17
BRIVARACETAM	75	HYDROCHLOROTHIAZIDE		CERTOLIZUMAB PEGOL	161
BRIVLERA	75	CANDESARTAN-HCT	59	CERVICAL	103
BRODALUMAB	148	CANDESARTAN-HCTZ	59	CESAMET	123
BROMAZEPAM	94	CANESORAL	9	CETIRIZINE	123
BROMOCRIPTINE	99	CANESTEN	142	CETIRIZINE HYDROCHLORIDE	1
BROMOCRIPTINE MESYLATE	99	CANESTEN COMBI-PAK COMFORTAB 1	143	CHAMPIX	35
BUDESONIDE	115	CANESTEN COMBI-PAK COMFORTAB 3	143	CHAMPIX STARTER PACK	35
BUDESONIDE, SODIUM CHLORIDE	144	CANESTEN COMFORTAB 1	143	CHILDREN AND YOUTH	173
BUPRENORPHINE (BUTRANS)	72	CANTHACUR 07	147	CHILDREN'S ADVIL	65
BUPRENORPHINE (SUBLOCADE)	68	CANTHARIDIN	147	CHILDREN'S ADVIL CHILDREN'S ADVIL FEVER FROM	65
BUPRENORPHINE HYDROCHLORIDE	72	CANTHARIDIN, PODOPHYLLIN,	147	COLDS OR FLU	00
BUPRENORPHINE HYDROCHLORIDE,	72	SALICYLIC ACID		CHILDREN'S BENADRYL ALLERGY	1
NALOXONE HYDROCHLORIDE		CANTHARONE 07	156	CHILDREN'S EUROPROFEN	65
BUPROPION HYDROCHLORIDE	81	CANTHARONE PLUS	147	CHILDREN'S IBUPROFEN	65
(WELLBUTRIN)		CAPECITABINE	17	CHILDREN'S MOTRIN	65
BUPROPION HYDROCHLORIDE	81	CAPRELSA	27	CHLORAMBUCIL	17
(ZYBAN)		CAPSAICIN	148	CHLORHEXIDINE	115
BUPROPION SR	81	CAPSAICIN	148	CHLORHEXIDINE GLUCONATE	115
BUSCOPAN	30	CAPSAISIN	148	CHLOROQUINE (PHOS.) (PQ)	15
BUSERELIN ACETATE	17	CAPTOPRIL	54	CHLOROQUINE PHOSPHATE	15
BUSPIRONE	96	CARBACHOL	117	CHLORPHENIRAMINE MALEATE	1
BUSPIRONE HYDROCHLORIDE	96	CARBAMAZEPINE	75	CHLORPROMAZINE HYDROCHLORIDE	87
BUSULFAN	17	CARBOCAL	107	CHLORTHALIDONE	110
BUTRANS 10	72	CARBOCAL D	107	CHLORTHALIDONE	110
BUTRANS 15	72	CARBOLITH	96	CHLOR-TRIPOLON	1
BUTRANS 20	72	CARDIZEM CD	53	CHOLECALCIFEROL	153
BUTRANS 5	72	CARNITOR	109	CHOLEDYL	151
CABERGOLINE	99	CARTRIDGE FOR IR200	167	CHOLESTYRAMINE RESIN	41
CABOMETYX	17	CARVEDILOL	50	CHOLESTYRAMINE-ODAN	41
CABOZANTINIB (CABOZANTINIB	17	CARVEDILOL	50	CHU NICOTINE ANTI SMOKING AID	34
MALATE)		CASODEX	17	CICLESONIDE	130
CADUET	52	CAYA CONTOURED DIAPHRAGM	103	CICLOPIROX OLAMINE	142
CAFFEINE CITRATE	94	CAYA DIAPHRAGM	149	CIDOMYCIN	2
CAFFEINE CITRATE	94	CAYSTON	3	CILAZAPRIL	54
CALCIMAR	107	CEENU	21	CILAZAPRIL,	54
CALCIMAR	138	CEFADROXIL	2	HYDROCHLOROTHIAZIDE	J
CALCIPOTRIOL	148	CEFAZOLIN	2		

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				Non-insured Health Ben	etits
CILOXAN	114	CLOPIDOGREL	39	CONTACT DETACH 90 DEGREE	167
CIMETIDINE	123	CLOPIDOGREL BISULFATE	39	8MMX60CM	
CIMETIDINE	123	CLOPIXOL	92	CONTINGENCY ONE	133
CIMZIA	161	CLOPIXOL DEPOT	92	CONTOUR BG (ON)	104
CINACALCET	165	CLOPIXOL-ACUPHASE	92	CONTOUR NEXT	104
CINACALCET (CINACALCET	165	CLOTRIMADERM	143	CONTOUR NEXT (ON)	104
HYDROCHLORIDE)		CLOTRIMADERM VAGINAL 3	143	CONTRACEPTIVE	103
CIPRALEX	82	CLOTRIMADERM VAGINAL 6	143	CONTRACEPTIVE DEVICE	103
CIPRO	6	CLOTRIMAZOLE	142	CONTRAGEL GREEN	149
CIPRODEX	114	CLOTRIMAZOLE	143	COPAXONE	158
CIPROFLOXACIN	6	CLOXACILLIN SODIUM	5	CORTATE	146
CIPROFLOXACIN HYDROCHLORIDE	6	CLOZAPINE	87	CORTEF	130
CIPROFLOXACIN HYDROCHLORIDE,	114	CLOZARIL	87	CORTENEMA	126
DEXAMETHASONE		COAGUCHEK INRANGE METER	104	CORTISONE	130
CITALOPRAM	81	COAGUCHEK LANCETS	104	CORTISONE ACETATE	130
CITALOPRAM HYDROBROMIDE	81	COAGUCHEK XS KIT	104	CORTIVERA H	156
CITRIC ACID, MAGNESIUM OXIDE,	120	COAGUCHEK XS PT STRIPS 24	104	CORTODERM	146
SODIUM PICOSULFATE	400	COAGUCHEK XS PT STRIPS 48	104	COSENTYX	149
CITRIC ACID, SODIUM CITRATE	106	COAGUCHEK XS PT STRIPS 6	104	COSENTYX (STYLO)	149
CITRO MAG	120	COAGULATION MONITORS	104	COSENTYX PEN (ON)	149
CITRODAN	120	COAGULATION TEST	104	COSOPT	117
CLADRIBINE	164	COAL TAR	147	COTAZYM	122
CLARITHROMYCIN	4	COAL TAR, SALICYLIC ACID	147	COTAZYM ECS 20	122
CLARITHROMYCIN	4	COBIMETINIB	18	COTAZYM ECS 8	122
CLARITIN ALLERGY CLARITIN KIDS	1	CODEINE	68	COTELLIC	18
	1	CODEINE CONTIN CR	68	COUMADIN	39
CLARUS	148	CODEINE MONOHYDRATE, CODEINE	68	COVERSYL	56
CLAVULIN 125 F	5	SULFATE TRIHYDRATE		COVERSYL PLUS	56
CLAVULIN 250 F	5 5	CODEINE PHOSPHATE	68	COVERSYL PLUS HD	56
CLAVULIN 250 F	5 5	CODEINE PHOSPHATE	68	COZAAR	60
CLAVULIN 400	5 5	COLCHICINE	158	CREON MINIMICROSPHERES 10	122
CLAVULIN 500 F	5 5	COLCHICINE	158	CREON MINIMICROSPHERES 25	122
CLAVULIN 875	120	COLESEVELAM HYDROCHLORIDE	41	CREON MINIMICROSPHERES MICRO	122
CLEARLAX CLICKFINE PEN NEEDLE 31G 4.5MM	170	COLESTID	41	CRESEMBA	9
CLICKFINE PEN NEEDLE 31G 4.5MM CLICKFINE PEN NEEDLE 31G 6MM	170	COLESTIPOL HYDROCHLORIDE	41	CRESTOR	44
CLICKFINE PEN NEEDLE 31G 8MM	170	COLISTIMETHATE FOR U.S.P	8	CRITIC-AID CLEAR	147
CLIMARA 25	134	COLISTIN	8	CRIZOTINIB	18
CLIMARA 50	134	COLLAGENASE	148	CROMOLYN	114
CLIMARA 75	134	COLY-MYCIN M PARENTERAL	8	CROMOLYN SODIUM	112
CLINDAMYCIN	7	COLYTE	121	CROTAMITON	143
CLINDAMYCIN HYDROCHLORIDE	7	COMBANTRIN	2	CTP 30	81
CLINDAMYCIN IN DILUSOL OR	142	COMBIGAN	116	CUPRIMINE	129
DUONALC	172	COMBIVENT RESPIMAT	30	CYANOCOBALAMIN	152
CLINDAMYCIN IV INFUSION	7	COMBIVIR	11	CYANOCOBALAMIN	152
CLINDAMYCIN PALMITATE	7	COMFILAX	120	CYCLEN (21 DAY)	132
HYDROCHLORIDE		COMFORT ANGLED INFSET 17MM	167	CYCLEN (28 DAY)	132
CLINDAMYCIN PHOSPHATE	7	COMFORT SRT ANGLED INFSET 13	167	CYCLOBENZAPRINE	33
CLINDAMYCIN PHOSPHATE TOPICAL	142	COMPACT SPACE PLUS LARGE MASK	167	CYCLOBENZAPRINE HYDROCHLORIDE	33
CLINDAMYCIN PHOSPHATE,	142	COMPACT SPACE PLUS MEDIUM	167	CYCLOGYL	116
BENZOYL PEROXIDE		COMPACT SPACE PLUS NO MASK	167	CYCLOMEN	131
CLINDAMYCIN PHOSPHATE,	147	COMPACT SPACE PLUS SMALL MASK	167	CYCLOPENTOLATE HYDROCHLORIDE	116
TRETINOIN	7	COMPLEAT PEDIATRIC 250ML LIQ	173	CYCLOPHOSPHAMIDE	18
CLINDAMYCIN STERILE INFUSION	7	COMPLERA	12	CYCLOSPORINE	164
CLINDA-T	142	COMPOUND W GEL	147	CYESTRA-35	166
CLINDOXYL ADV	142	COMTAN	98	CYKLOKAPRON	40
CLINDOXYL ADV CLOBAZAM	142 74	CONCERTA	93	CYMBALTA	82
		CONDOM	103	CYPROTERONE	165
CLOBETASONE BUTYBATE	144	CONDOM, LATEX, LUBRICATED	103	CYPROTERONE ACETATE	165
CLOBETASONE BUTYRATE	145	CONDOM, LATEX, NON-LUBRICATED	103	CYPROTERONE ACETATE CYPROTERONE ACETATE, ETHINYL	166
CLONARAM	82 74	CONDOM, NON-LATEX, LUBRICATED	103	ESTRADIOL	.00
CLONAZERAM	74 7 4	CONDYLINE	149	CYTOMEL	139
CLONAZEPAM	74 46	CONJUGATED ESTROGENS	133	CYTOVENE	13
CLONIDINE ORAL LIQUID	46 47	CONTACT DETACH 90 DEGREE 6MMX60CM	167	D VI INFANTS	153
CLONIDINE ORAL LIQUID	47	O. W. I. W.		D2-DOL	153

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				Non-insured nearth	Denenis
D3-DOL	153	DEXTRAN 70,	118	DISOPYRAMIDE	41
DABIGATRAN ETEXILATE MESILATE	37	HYDROXYPROPYLMETHYLCELLULOS		DIVALPROEX	80
DABRAFENIB	18	E		DIVIGEL	133
DAIRY DIGESTIVE	121	DEXTROAMPHETAMINE	93	DOLICHOVESPULA ARENARIA	156
DAIRYAID	122	DEXTROAMPHETAMINE SULFATE	93	VENOM PROTEIN	100
DALACIN	142	DGEL	153	DOLICHOVESPULA MACULATA	156
DALACIN C	7	DIAMICRON	138	VENOM PROTEIN EXTRACT	
DALACIN C DALACIN C PHOSPHATE	7	DIAMICRON MR	138	DOLORAL 1	70
DALACIN C PROSPRATE DALACIN T	142	DIANE-35	166	DOLORAL 5	70
	37	DIAPER RASH	147	DOLUTEGRAVIR SODIUM	10
DALTEPARIN SODIUM		DIARRHEA RELIEF	120	DOLUTEGRAVIR SODIUM,	10
DANAZOL	131	DIASTAT	94	RILPIVIRINE HYDROCHLORIDE	
DANTRIUM	33	DIASTAT 2X10MG RECTAL PACK	94	DOM-ALENDRONATE	160
DANTROLENE SODIUM	33	DIASTAT 2X15MG RECTAL PACK	95	DOM-AMIODARONE	41
DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE	137	DIASTIX	105	DOM-AMLODIPINE	51
DAPSONE	10	DIAZEPAM	94	DOM-ATENOLOL	49
		DIAZEPAM	94	DOM-ATOMOXETINE	100
DAPSONE	10	DIAZEPAM (DIASTAT)	94	DOM-ATORVASTATIN	42
DARIFENACIN HYDROBROMIDE	150	DIAZOXIDE	47	DOM-AZITHROMYCIN	4
DARUNAVIR	10	DICETEL	126	DOM-BACLOFEN	33
DARUNAVIR (DARUNAVIR PROPYLENE GLYCOLATE)	10	DICITRATE	106	DOM-BROMOCRIPTINE	99
DARUNAVIR ETHANOLATE	40	DICLECTIN	122	DOM-CARBAMAZEPINE	75
	10	DICLOFENAC	65	DOM-CARVEDILOL	50
DARUNAVIR ETHANOLATE, COBICISTAT	10		65	DOM-CIPROFLOXACIN	6
DDAVP	138	DICLOFENAC FO	65	DOM-CITALOPRAM	81
DDAVI DDAVP MELT	139	DICLOFENAC CODIUM		DOM-CLARITHROMYCIN	4
DDROPS	153	DICLOFENAC SODIUM	65	DOM-CLOPIDOGREL	39
DDROPS BOOSTER	153	DICLOFENAC SODIUM	65	DOM-CYCLOBENZAPRINE	33
DECAXIL	153	DICLOFENAC SODIUM (TOPICAL)	65	DOM-DICLOFENAC	65
		DICLOFENAC TOPICAL	65	DOM-DICLOFENAC SR	65
DEGARELIX ACETATE	134	DICLOFENAC-SR	65	DOM-DIOLOT ENAC GIV	125
DELATESTRYL	132	DIENOGEST	139	DOM-FINASTERIDE	157
DELSTRIGO	11	DIFFERIN	148	DOM-FLUCONAZOLE	9
DENOSUMAB (PROLIA)	160	DIFFERIN XP	148		
DENOSUMAB (XGEVA)	160	DIFICID	4	DOM-FLUOXETINE	83
DEPAKENE	80	DIFLUCAN	9	DOM-GABAPENTIN	75
DEPO-MEDROL	131	DIFLUNISAL	65	DOM-GEMFIBROZIL	42
DEPO-MEDROL WITH LIDOCAINE	131	DIFLUNISAL	65	DOM-GLYBURIDE	138
DEPO-PROVERA	139	DIGOXIN	41	DOM-IPRATROPIUM	30
DEPO-TESTOSTERONE	132	DIHYDROERGOTAMINE	33	DOM-LANSOPRAZOLE	124
DERMAFLEX HC	145	DIHYDROERGOTAMINE MESYLATE	33	DOM-LEVETIRACETAM	77
DERMA-SMOOTHE	145	DILANTIN	74	DOM-LOXAPINE	88
DERMOVATE	144	DILANTIN INFATABS	74	DOM-MEFENAMIC ACID	66
DESIPRAMINE	82	DILAUDID	69	DOM-MELOXICAM	66
DESIPRAMINE HYDROCHLORIDE	82	DILTIAZEM CD	53	DOM-METFORMIN	134
DESLORATADINE	1	DILTIAZEM HYDROCHLORIDE	53	DOM-METOPROLOL-B	50
DESLORATADINE	1	DILTIAZEM IN OINTMENT	155	DOM-METOPROLOL-L	50
DESLORATADINE ALLERGY CONTROL	1	DILTIAZEM TZ	53	DOM-MIRTAZAPINE	84
DESMOPRESSIN	138	DIMENHYDRINATE	122	DOM-MONTELUKAST	112
DESMOPRESSIN ACETATE	138	DIMENHYDRINATE	122	DOM-NYSTATIN	9
DESOGESTREL, ETHINYL ESTRADIOL	132	DIMETHICONE	143	DOM-OXYBUTYNIN	150
DESONIDE	145	DIMETHYL FUMARATE	101	DOM-PAROXETINE	84
DESOXIMETASONE	145	DIOVAN	61	DOMPERIDONE	125
DETROL	150	DIOVAN-HCT	62	DOMPERIDONE MALEATE	125
DETROL LA	150	DIPENTUM	126	DOMPERIDONE ORAL LIQUID	126
DEVICE (METHADONE)	173			DOM-PINDOLOL	51
DEX-4 GLUCOSE	109	DIPHENHYDRAMINE DIPHENHYDRAMINE	1 1	DOM-PRAVASTATIN	43
DEXAMETHASONE	115	HYDROCHLORIDE	1	DOM-PREGABALIN	78
		DIPHENIST	1	DOM-QUETIAPINE	90
DEXAMETHASONE ORAL LIQUID	115	DIPIVEFRIN HYDROCHLORIDE	116	DOM-RABEPRAZOLE EC	125
DEXAMETHASONE DRAL LIQUID	130	DIPROLENE	144	DOM-RAMIPRIL	57
DEXAMETHASONE PHOSPHATE	115			DOM-RISEDRONATE	161
DEXAMETHASONE, TOBRAMYCIN	115	DIPROSALIC	144	DOM-RIZATRIPTAN RDT	97
DEXAMETHASONE-OMEGA	130	DIPROSONE	144	DOM-ROSUVASTATIN	44
DEXEDRINE	93	DIPYRIDAMOLE	48	DOM-SALBUTAMOL	32
DEXEDRINE SPANSULE	93	DIPYRIDAMOLE, ACETYLSALICYLIC	48	POINI-OMEDO I MINIOL	32
DEXIRON	36	ACID		DOM-SERTRALINE	85

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				Non-insured nearth ben	ems
DOM-SIMVASTATIN	45	DYSPORT THERAPEUTIC	165	ENTRESTO	63
DOM-SOTALOL	51	EDARBI	58	ENTROPHEN	64
DOM-SUMATRIPTAN	97	EDECRIN	109	ENTYVIO	127
DOM-TERAZOSIN	48	EDOXABAN (EDOXABAN TOSYLATE	37	ENZALUTAMIDE	19
DOM-TERBINAFINE	8	MONOHYDRATE)		EPCLUSA	14
DOM-TIAPROFENIC	67	EDURANT	12	EPINEPHRINE	32
DOM-TIMOLOL	117	EFAVIRENZ	10	EPINEPHRINE	33
DOM-TOPIRAMATE	79	EFAVIRENZ, EMTRICITABINE,	11	EPIPEN	33
DOM-TRAZODONE	85	TENOFOVIR DISOPROXIL FUMARATE		EPIPEN JR	33
DOM-VALACYCLOVIR	13	EFFEXOR XR	86	EPIVAL	80
DOM-VALPROIC ACID	80	EFUDEX	148	EPLERENONE	62
DOM-VENLAFAXINE XR	86	EGOZINC-HC	145	EPOSARTAN MESYLATE	59
DOM-VERAPAMIL SR	54	ELAVIL	80	EPOSARTAN MESTLATE	59
DOM-ZOLMITRIPTAN	97	ELBASVIR, GRAZOPREVIR	14	HYDROCHLOROTHIAZIDE	39
DONEPEZIL	28	ELECTROLYTES	107	EPURIS	148
		ELIDEL	149	EQUATE DAILY LOW-DOSE	64
DONEPEZIL HYDROCHLORIDE	28	ELIGARD	21	ERDOL	153
DORAVIRINE	10	ELIQUIS	37	ERELZI	162
DORZOLAMIDE HYDROCHLORIDE	117	ELMIRON	156	ERGOCALCIFEROL	153
DORZOLAMIDE HYDROCHLORIDE,	117	ELOCOM	146		
TIMOLOL MALEATE	00	ELTROXIN	139	ERLEADA	16
DOSTINEX	99	EMEND	123	ERLOTINIB HYDROCHLORIDE	19
DOVATO	11	EMEND TRI-PACK	123	ERTAPENEM	3
DOVOBET	144	EMLA TRI-I AGR	146	ERYC	4
DOVONEX	148	EMOCORT	146	ERYTHRO BASE	4
DOXAZOSIN MESYLATE	48	EMOLAX	120	ERYTHROMYCIN	4
DOXEPIN	82			ERYTHROMYCIN	114
DOXEPIN HYDROCHLORIDE	82	EMOLLIENT FOR ADULTS	173	ERYTHROMYCIN STEARATE	4
DOXYCIN	7	EMOLLIENT FOR CHILDREN	173	ERYTHROMYCIN, BENZOYL PEROXIDE	142
DOXYCYCLINE	7	EMPAGLIFLOZIN	137	ERYTHRO-S	4
DOXYCYCLINE HYCLATE	7	EMTRICITABINE, BICTEGRAVIR	11	ESBRIET	111
DOXYLAMINE SUCCINATE,	122	(BICTEGRAVIR SODIUM), TENOFOVIR ALAFENAMIDE		ESCITALOPRAM	82
PYRIDOXINE HYDROCHLORIDE		EMTRICITABINE, COBICISTAT,	11	ESCITALOPRAM OXALATE	82
DOXYTAB	7	ELVITEGRAVIR, TENOFOVIR	• • • • • • • • • • • • • • • • • • • •	ESCULIN, FRAMYCETIN SULFATE,	145
DR SCHOLLS CLEAR AWAY PLANTAR	147	ALAFENAMIDE		DIBUCAINE HYDROCHLORIDE,	
WART REMOVER SYSTEM		EMTRICITABINE, RILPIVIRINE	11	HYDROCORTISONE ACETATE	
DR SCHOLLS CLEAR AWAY WART REMOVER SYSTEM	147	HYDROCHLORIDE, TENOFOVIR		ESLICARBAZEPINE ACETATE	75
DRESSING	407	ALAFENAMIDE		ESTALIS	134
	167	ENABLEX	150	ESTRACE	133
DROPLET PEN NEEDLE 10MM 29G	169	ENALAPRIL	54	ESTRADIOL	133
DROPLET PEN NEEDLE 12MM 29G	169	ENALAPRIL MALEATE	54	ESTRADIOL HEMIHYDRATE	134
DROPLET PEN NEEDLE 4MM 32G	170	ENALAPRIL MALEATE,	55	ESTRADIOL, NORETHINDRONE	134
DROPLET PEN NEEDLE 5MM 31G	170	HYDROCHLOROTHIAZIDE		ACETATE	
DROPLET PEN NEEDLE 5MM 32G	170	ENALAPRIL MALEATE/HCTZ	55	ESTRADOT 100	133
DROPLET PEN NEEDLE 6MM 31G	170	ENALAPRIL ORAL LIQUID	55	ESTRADOT 25	133
DROPLET PEN NEEDLE 6MM 32G	170	ENBREL	161	ESTRADOT 37.5	133
DROPLET PEN NEEDLE 8MM 31G	170	ENBREL SURECLICK	161	ESTRADOT 50	133
DROPLET PEN NEEDLE 8MM 32G	170	ENEMA	121	ESTRADOT 75	133
DROPLET PERSONAL LANCET 28G	169	ENEMOL SODIUM PHOSPHATE	121	ESTRAGYN	134
DROPLET PERSONAL LANCET 33G	169	ENFAMIL A+ 237ML LIQ	174	ESTRING	133
DRSCHOLL'S ATHLETE'S FOOT SPRAY	143	ENFAMIL A+ 385ML LIQ	174	ESTROGEL	134
D-TABS	153	ENFAMIL A+ 663G PDR	174	ESTRONE	134
DUAKLIR GENUAIR	31	ENFAMIL A+ ENFACARE 363G PDR	174	ETANERCEPT	161
DULCOLAX	120	ENFAMIL A+ ENFACARE 385ML LIQ	174	ETANERCEPT (BRENZYS)	162
DULOXETINE	82	ENFAMIL FERINSOL	36	ETANERCEPT (ERELZI)	162
DULOXETINE DR	82	ENFAMIL LOWER IRON 385ML LIQ	174	ETHACRYNIC ACID	109
DULOXETINE HYDROCHLORIDE	82	ENFAMIL LOWER IRON 900G PDR	174	ETHAMBUTOL HYDROCHLORIDE	9
DUODOPA	99	ENFAMIL POLYVISOL	154	ETHINYL ESTRADIOL, DESOGESTREL	132
DUONALC	143	ENFAMIL TRIVISOL	154	ETHINYL ESTRADIOL,	132
DUOTRAV PQ	118	ENOXAPARIN SODIUM	37	DROSPIRENONE	132
DUOTRAV PQ OP	118	ENSTILAR	144	ETHINYL ESTRADIOL,	132
DUPILUMAB	148	ENSURE 235ML LIQ	173	ETONOGESTREL	
DUPIXENT	148	ENSURE FIBRE 235ML LIQ	173	ETHINYL ESTRADIOL,	132
DUTASTERIDE	157		98	LEVONORGESTREL	
DUTASTERIDE	157	ENTACAPONE ENTECAVID MONOHYDBATE		ETHINYL ESTRADIOL,	132
DUVOID	28	ENTECAVIR MONOHYDRATE	13 120	NORELGESTROMIN	
201010	20	ENTOCORT	130		

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				Non-insured nealth ben	ents
ETHINYL ESTRADIOL, NORETHINDRONE	132	FERAMAX POWDER WATER SOLUBLE POLYSACCHARIDE IRON COMPLEX	36	FLUOROURACIL	148
ETHINYL ESTRADIOL,	132	FERODAN	36	FLUOXETINE FLUOXETINE HYDROCHLORIDE	83 83
NORETHINDRONE ACETATE		FERODAN INFANT DROPS	36	FLUPENTHIXOL DIHYDROCHLORIDE	87
ETHINYL ESTRADIOL, NORGESTIMATE	132	FERRATE	36	FLUPENTIXOL DECANOATE	87
ETHOPROPAZINE HYDROCHLORIDE	98	FERRLECIT	36	FLUPHENAZINE	87
ETHOSUXIMIDE	74	FERROUS FUMARATE	36	FLUPHENAZINE DECANOATE	87
ETIBI	9	FERROUS FUMARATE	36	FLUPHENAZINE HYDROCHLORIDE	87
ETIDRONATE DISODIUM	160	FERROUS GLUCONATE	36	FLURBIPROFEN	65
ETOPOSIDE	19	FERROUS GLUCONATE	36	FLUTAMIDE	19
ETRAVIRINE	11	FERROUS SULFATE	36	FLUTAMIDE	19
EUGLUCON	138	FERROUS SULFATE	36	FLUTICASONE FUROATE	115
EURAX	143	FERROUS SULPHATE	36	FLUTICASONE FUROATE,	130
EURO D	153	FESOTERODINE FUMARATE	150	UMECLIDINIUM BROMIDE,	130
EURO K	108	FEXOFENADINE HYDROCHLORIDE	1	VILANTEROL TRIFENATATE	
EURO SENNA	121	FIBRISTAL	133	FLUTICASONE FUROATE,	31
EURO VITAMIN B1	152	FIDAXOMICIN	4	VILANTEROL TRIFENATATE	
EURO-ASA	64	FILGRASTIM	39	FLUTICASONE FUROATE,	31
EUROCAL	107	FINACEA	148	VILANTEROL TRIFENATATE (ASTHMA)	
EURO-D	153	FINASTERIDE	157	FLUTICASONE PROPIONATE	115
EUROFER	36	FINASTERIDE	157	FLUVASTATIN SODIUM	43
EURO-FERROUS SULFATE	36	FINGERSTIX LANCET	169	FLUVOXAMINE	83
EUROHYDROCORTISONE	146	FINGOLIMOD (FINGOLIMOD	158	FLUVOXAMINE MALEATE	83
EVEROLIMUS	19	HYDROCHLORIDE)		FML	115
EVISTA	134	FIRAZYR	161	FOLIC ACID	152
EVOLOCUMAB	46	FIRMAGON	134	FOLIC ACID	152
EVRA	132	FIRST CANADIAN HEALTH LANCETS	169	FORADIL	31
EXELON	29	FIRST CANHEALTH 28G LANCET	169	FORMOTEROL FUMARATE	31
EXEMESTANE	19	FIRST CANHEALTH 30G LANCET	169	FORMOTEROL FUMARATE	31
EXLAX CHOCOLATED	121	FIRST CANHEALTH 33G LANCET	169	DIHYDRATE	24
EXTAVIA	159	FIRST CANHEALTH SPIRIT	105	FORMOTEROL FUMARATE DIHYDRATE, BUDESONIDE	31
EXTEMPORANEOUS MIXTURE	155	FLAGYL	15	FORMOTEROL FUMARATE	31
EXTEMPORANEOUS MIXTURE	155	FLAGYSTATIN	142	DIHYDRATE, MOMETASONE FUROATE	٠.
(GENDER AFFIRMING)		FLAMAZINE	144	FORTAZ 1G	2
EXTEMPORANEOUS MIXTURE (LU)	155	FLAREX	115	FORTAZ 2G	3
EXTEMPORANEOUS MIXTURE (NSAID)	155	FLAVOXATE HYDROCHLORIDE	150	FORTAZ 6G	3
EXTRA STRENGTH ACETAMINOPHEN	73	FLECAINIDE ACETATE	41	FORXIGA	137
EXTRA STRENGTH SELSUN	143	FLEET ENEMA	121	FOSAMAX	160
EYLEA	118	FLEET ENEMA PEDIATRIC	121	FOSAMPRENAVIR CALCIUM	11
EZ HEALTH ORACLE	104	FLEXI-T +300 IUD	103	FOSAVANCE	160
EZ HEALTH ORACLE LANCET	169	FLEXI-T +380 IUD	103	FOSFOMYCIN TROMETHAMINE	15
E-Z JE	171	FLEXI-TD	103	FOSINOPRIL	55
E-Z SPACER	167	FLINTSTONES MULTIPLE VITAMINS	154	FOSINOPRIL SODIUM	55
E-Z SPACER (MASK ONLY)	167	PLUS IRON		FOSRENOL	109
E-Z SPACER WITH SMALL MASK	167	FLINTSTONES MULTIPLE VITAMINS WITH EXTRA C	154	FRAGMIN	37
EZETIMIBE	41	FLOCTAFENINE	73	FRAMYCETIN SULFATE, GRAMICIDIN,	115
EZETIMIBE	42	FLOCTAFENINE	73	DEXAMETHASONE	
EZETROL	42	FLOMAX	33	FRAXIPARINE	38
FAMCICLOVIR	13	FLONASE ALLERGY RELIEF	115	FRAXIPARINE FORTE	38
FAMOTIDINE	123	FLORINEF	130	FREESTYLE	104
FAMOTIDINE	123	FLOVENT DISKUS	130	FREESTYLE (ON)	104
FAMOTIDINE (QC)	123	FLOVENT HFA	130	FREESTYLE LANCET	169
FAMVIR	13	FLUANXOL	87	FREESTYLE LITE	104
FASENRA	106	FLUANXOL DEPOT	87	FREESTYLE LITE (ON)	104
FC2 FEMALE CONDOMS	103	FLUCONAZOLE	9	FREESTYLE PRECISION	105
FEBUXOSTAT	158	FLUDARA	19	FREESTYLE PRECISION (ON)	105
FELODIPINE	52	FLUDARABINE PHOSPHATE	19	FREYA 21	132
FEMARA	21	FLUDROCORTISONE ACETATE	130	FREYA 28	132
FEMCAP	103	FLUMETHASONE PIVALATE,	115	FRUCTOSE	173
FENOFIBRATE	42	CLIOQUINOL		FRUCTOSE	173
FENOMAX	42	FLUNARIZINE	98	FUCIDIN	142
FENOMAX	42	FLUNARIZINE HYDROCHLORIDE	98	FUCIDIN H	142
FENTANY	42	FLUOCINONIDE	145	FUCITHALMIC	114
FENTANYL	69	FLUOROMETHOLONE	115	FULPHILA	40
				FUROSEMIDE	109

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FURBIGATE SOOIM					Non-insured nearth ben	ents
FUSIDIC ACID 144 COLLYPELY 150 SUCCIANTE 151	FUROSEMIDE	109	GLYCOPYRRONIUM BROMIDE	30		130
PISSINGLE, AUD, WYORCOCRTISONE 142 OSSERLIM, ACETATE 126	FUSIDATE SODIUM	142	GOLIMUMAB	162	`	
PACESTRIAN THYROCOURISIONE 145	FUSIDIC ACID	114	GOLYTELY	120	•	426
APPLICATION CARRESTORIL CARPORTISONE ACETATE, UREA 145		142	GOSERELIN ACETATE	134		
CABAPENTIN			GRANISETRON HYDROCHLORIDE			
CALANTAMINE 25 GIAVOLA 126 156 1					,	
GALANTAMNE 28					·	145
CALANTAMINE					HYDROCORTISONE ACETATE. ZINC	145
ALA JATAMINE HYDROROMIDE						
SASTROLYTE REGULAR 197						145
ABJORACORTISONE ACETATE-JIREA 146						
MALOPERIDOL DECANOATE 37 MYDROCORTISONE POWDER AND 155						446
MAYONACIN (GATIFLOXACIN 14 MALOPERIDOL LA 197 CLOTTMIAZOLE CREAM 146 MAYONA 146						
COMMINIORINE_ATORNASTATIN 14 ARREVONI 14 ARREVONI 14 ARREVONI 14 ARREVONI 15 ARREVONI						155
COLORIZATION 52		114				146
COLOCIO COLOR CO	•	52				
BOLATANOPROST						
GD-LATANOPROST 117						
GD-TRANE/MIC ACID	GD-LATANOPROST	117			HP 50	
GEZOO 105 HEPARIN SODIUM 38 HTTROVAL. 140 GEZOO (ON) 105 WITH PRESERVATIVE) 38 HYDROXYPENDYL CELLULOSE 118 GEZOO (ON) 105 WITH PRESERVATIVE) 38 HYDROXYPENDYL CELLULOSE 118 GEFITTINB 20 HEPARIN SODIUM (SINGLE USE VIAL- E CENTRAL 125G FDR 174 PRESERVATIVE) 38 HYDROXYPENDYL CELLULOSE 118 GERNALOZAPINE 174 PRESERVATIVE FREE 1 ST. 15 HYDROXYPENDYL CELLULOSE 118 GERNALOZAPINE 174 PRESERVATIVE FREE 1 ST. 15 HYDROXYPENDYL CELLULOSE 118 GERNALOZAPINE 175 HEPTOVIR 11 HYDROXYDREA 20 GENALOZAPINE 175 HEPTOVIR 11 HYDROXYDREA 20 GENALOZAPINE 175 HEPTOVIR 11 HYDROXYDREA 20 GENALOZAPINE 175 HEPTOVIR 11 HYDROXYDREA 175 HEPTOVIR 11 HYDROXYDREA 175 HEPTOVIR 11 HYDROXYDREA 175 HEPTOVIR 115 HORNONES 175 HORNONES 175 HEPTOVIR 115 HORNONES 175 HUMALOS (CARTRIDGE) 136 HYDRONECT 175 HUMALOS (CARTRIDGE) 136 HUMAL	GD-LATANOPROST/TIMOLOL	117			HYDROSONE	146
GE200 (ON)	GD-TRANEXAMIC ACID	40			HYDROVAL	146
GEFTINIB	GE200	105			HYDROXYCHLOROQUINE SULFATE	15
GEHINIA RA 126G PDR 174 PRESERVATIVE FREE) 8 HYDROXYPROPYLMETHYLCELLULOS 116 PROPERINGOUL 416 PRESERA 13 HYDROXYVIREA 20 GEMICALOZAPINE 42 HEPSERA 13 HYDROXYZINE 20 GEMICALOZAPINE 47 HEPTOVIR 11 HYDROXYZINE HYDROCHLORIDE 96 GENDER AFFIRMING HORIMONES 155 HIPOTENCY MAGNESIUM OXIDE 120 HYDROXYZINE HYDROCHLORIDE 96 GENDER AFFIRMING TOPICAL 155 HONEY BEE VENOM PROTEIN EXTRACT 166 HYDROXYZINE HYDROCHLORIDE 96 HYDROXYZINE HYDROCHLORIDE 96 GENTAMICIN CHARLES TOPICAL 150 HYDROXYZINE HYDROCHLORIDE 96 HYDROXYZINE 96 HYDROXYZINE 96 HYDROXYZINE HYDROCHLORIDE 96 HYDROXYZINE 97 HYDROXYZINE 97 HYDROXYZINE 96 H	GE200 (ON)	105		37	HYDROXYPROPYL CELLULOSE	118
GEMPIROZIL	GEFITINIB	20	•	38		116
CENTIFY CONTRIBUTION CONTRIBUTION CENTIFY CENT	GELMIX JAR 125G PDR	174			E	
SENDER AFFIRMING HORMONES 155	GEMFIBROZIL	42	HEPSERA	13		
CENDER AFFIRMING TOPICAL 156 HONEY BEE VENOM PROTEIN 156 HONEY BEE VENOM PROTEIN 156 HONEY BEE VENOM PROTEIN 157 HONEY BEE VENOM PROTEIN 157 HONEY BEE VENOM PRODUCT 157 HONEY BEE VENOM PROTEIN 156 HONEY BEE VENOM PROTEIN 156 HONEY BEE VENOM PROTEIN 157 HONEY BEE VENOM PROTEIN 156 HONEY BEE VENOM PROTEIN 157 HUMALOG (KWIKPEN) 136 HONEY BEE VENOM PROTEIN 157 HUMALOG (KWIKPEN) 136 HONEY BEE VENOM PROTEIN 157 HUMALOG (KWIKPEN) 136 HUMALOG MENTER BUT KWIKPEN 136 HUMALOG MENTER BUT KWIKPEN 136 HUMALOG MENTER BUT KWIKPEN 136 HONEY BUT KWIKPEN 136 HUMULIN SO/TO CARTRIDGE 136 BURNOTEN 136 HUMULIN SO/TO CARTRIDGE 136 HUMULIN SO/TO CARTRIDGE 136 HUMURO SO/TO CARTRIDGE 136 HUMU	GEN-CLOZAPINE	87	HEPTOVIR	11	HYDROXYZINE	
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GIOTRIF 16						107
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GLYBURIDE 138 HYDROCHLOROTHIAZIDE ORAL 110 IMODIUM CALMING 120 GLYBURIDE 138 LIQUID IMURAN 163 GLYCERIN 120 HYDROCHLOROTHIAZIDE, PINDOLOL 50 INCOBOTULINUMTOXINA 166 GLYCERIN FOR INFANTS CHILDREN 120 HYDROCHLOROTHIAZIDE, 62 INCRUSE ELLIPTA 30 GLYCERINE 120 SPIRONOLACTONE INDACATEROL MALEATE 32	GLUCOSE	109	HYDROCHLOROTHIAZIDE	110	IMITREX DF	97
GLYBURIDE138LÍQUIDIMURAN163GLYCERIN120HYDROCHLOROTHIAZIDE, PINDOLOL50INCOBOTULINUMTOXINA166GLYCERIN FOR INFANTS CHILDREN120HYDROCHLOROTHIAZIDE, SPIRONOLACTONE62INCRUSE ELLIPTA30GLYCERINE120SPIRONOLACTONEINDACATEROL MALEATE32	GLUCOSE OXIDASE, PEROXIDASE	104	HYDROCHLOROTHIAZIDE	110	IMITREX STAT DOSE KIT	97
GLYCERIN 120 HYDROCHLOROTHIAZIDE, PINDOLOL 50 INCOBOTULINUMTOXINA 166 GLYCERIN FOR INFANTS CHILDREN 120 HYDROCHLOROTHIAZIDE, 62 INCRUSE ELLIPTA 30 GLYCERINE 120 SPIRONOLACTONE INDACATEROL MALEATE 32	GLYBURIDE	138	HYDROCHLOROTHIAZIDE ORAL	110	IMODIUM CALMING	120
GLYCERIN FOR INFANTS CHILDREN 120 HYDROCHLOROTHIAZIDE, 5PIRONOLACTONE 1NDACATEROL MALEATE 30 SPIRONOLACTONE 1NDACATEROL MALEATE 32	GLYBURIDE	138	LIQUID		IMURAN	163
GLYCERINE 120 SPIRONOLACTONE INDACATEROL MALEATE 32	GLYCERIN	120	HYDROCHLOROTHIAZIDE, PINDOLOL	50	INCOBOTULINUMTOXINA	166
GLICERINE 120 INDACATEROL MALEATE 32	GLYCERIN FOR INFANTS CHILDREN	120		62	INCRUSE ELLIPTA	30
GLYCON 134	GLYCERINE	120	SPIRONOLACTONE		INDACATEROL MALEATE	32
	GLYCON	134				

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				Non-Insured Health Ben	ents
INDACATEROL MALEATE,	30	INSUPEN 32GX4MM NEEDLE	170	ITRACONAZOLE	9
GLYCOPYRRONIUM BROMIDE		INSUPEN 32GX6MM NEEDLE	170	ITRACONAZOLE PDR	9
INDAPAMIDE	110	INSUPEN 32GX8MM NEEDLE	170	IV3000 STANDARD	168
INDAYO	132	INSUPEN 33GX4MM NEEDLE	170	IVABRADINE (IVABRADINE	41
INDERAL LA	51	INTELENCE	11	HYDROCHLORIDE)	
INDOMETHACIN	66	INTERFERON ALFA-2B	12	IVERMECTIN	2
INFANT FORMULATION	174	INTERFERON BETA-1A	159	IXEKIZUMAB	149
INFLECTRA	162	INTERFERON BETA-1B	159	IZBA	118
INFLIXIMAB (INFLECTRA)	162	INTRAUTERINE DEVICE	103	JAKAVI	25
INFLIXIMAB (REMICADE)	162	INTRON A	12	JAMP ACETAMINOPHEN BLAZON	73
INFUFER	36	INVANZ	3	JAMP CALCIUM CARBONATE VITAMIN D	107
INHIBACE	54	INVEGA SUSTENNA	89	JAMP CALCIUM CITRATE VITAMIN D	107
INHIBACE PLUS	54	INVEGA TRINZA	89	JAMP CALCIUM LACTOGLUCONATE	107
INLYTA	17	INVIRASE	12	VITAMIN D	107
INNOHEP	38	INVOKANA	137	JAMP CANDESARTAN-HCT	59
INSET 30 INFUSION SETS	167 168	IOPIDINE	118	JAMP CINACALCET	165
INSET HOODECREE CAMAY 110 CM		IPECAC	122	JAMP CLINDAMYCIN	7
INSET II 90 DEGREE 6MMX110CM	167	IPRATROPIUM BROMIDE	30	JAMP DICLOFENAC TOPICAL	65
INSET II 90 DEGREE 6MMX60CM	167	IPRATROPIUM BROMIDE, SALBUTAMOL SULFATE	30	JAMP DORZOLAMIDE-TIMOLOL	117
INSET II 90 DEGREE 9MMX110CM	167		20	JAMP DUTASTERIDE	157
INSET II 90 DEGREE 9MMX60CM INSPIOLTO RESPIMAT	167 32	IPRAVENT	30 59	JAMP EMTRICITABINE/TENOFOVIR	12
INSPIRA CHAMBER W LARGE MASK	32 167	IRBESARTAN IRBESARTAN		DISOPROXIL FUMARATE	
INSPIRA CHAMBER W MEDIUM MASK	167		59	JAMP ENALAPRIL	62
INSPIRA CHAMBER W MOUTHPIECE	167	IRBESARTAN	59 59	JAMP ENTECAVIR	13
INSPIRA CHAMBER W SMALL MASK	167	IRBESARTAN, HYDROCHLOROTHIAZIDE	59	JAMP FEBUXOSTAT	158
INSPRA	62	IRBESARTAN/HCTZ	59	JAMP FERROUS FUMARATE	36
INSULIN (30% NEUTRAL & 70%	136	IRBESARTAN-HCTZ	59	JAMP FERROUS SULFATE	36
ISOPHANE) HUMAN BIOSYNTHETIC	130	IRESSA	20	JAMP FERROUS SULFATE LIQUID5	36
INSULIN (40% NEUTRAL & 60%	136	IRON	36	JAMP FINGOLIMOD	158
ISOPHANE) HUMAN BIOSYNTHETIC		IRON	36	JAMP FOLIC ACID	152
INSULIN (50% NEUTRAL & 50%	136	IRON (IRON ISOMALTOSIDE 1000)	36	JAMP GLICLAZIDE-MR	138
ISOPHANE) HUMAN BIOSYNTHETIC		IRON (SUCROFERRIC	109	JAMP GLYCERIN	120
INSULIN (ISOPHANE) HUMAN	136	OXYHYDROXIDE)		JAMP HYDROXYCHLOROQUINE SULFATE	15
BIOSYNTHETIC	400	IRON DEXTRAN	36	JAMP ITRACONAZOLE	9
INSULIN (ZINC CRYSTALLINE) HUMAN BIOSYNTHETIC (RDNA ORIGIN)	136	IRON FERROUS GLUCONATE	36	JAMP K	108
INSULIN 31GX0.3CC	172	IRON SUCROSE	36	JAMP LATANOPROST	117
INSULIN 31GX0.5CC	172	IRON SUCROSE STERILE INFUSION	36	JAMP MAGNESIUM GLUCONATE	108
INSULIN 31GX1CC	172	ISAVUCONAZOLE	9	JAMP NEVIRAPINE	11
INSULIN ASPART	136	(ISAVUCONAZONIUM SULFATE)		JAMP OLANZAPINE ODT	89
INSULIN BIOSYNTHETIC HUMAN BR	136	ISDN	47	JAMP ONDANSETRON	122
INSULIN DEGLUDEC	136	ISENTRESS	11	JAMP PERINDOPRIL	56
INSULIN DETEMIR	136	ISONIAZID	9	JAMP POTASSIUM CHLORIDE ER	108
INSULIN GLARGINE	136	ISONIAZID ORAL LIQUID	9	JAMP REHYDRALYTE	107
INSULIN GLULISINE	136	ISOPROPYL ALCOHOL	143	JAMP REPAGLINIDE	137
INSULIN HUMAN BIOSYNTHETIC	136	ISOPROPYL MYRISTATE	143	JAMP RIVASTIGMINE	29
INSULIN LISPRO	136	ISOPTIN SR	54	JAMP SENNAQUIL	121
INSULIN LISPRO, INSULIN LISPRO	136	ISOPTO ATROPINE ISOPTO CARPINE	116 117	JAMP VITAMIN A, D AND C	154
PROTAMINE		ISOPTO CARPINE	118	JAMP VITAMIN B12	152
INSULIN PEN NEEDLE 31GX6MM	170	ISOSORBIDE DINITRATE	47	JAMP VITAMIN D	153
INSULIN PEN NEEDLE 31GX8MM	170	ISOSORBIDE DINITRATE	47	JAMP ZOLMITRIPTAN	97
INSULIN PEN NEEDLE 32GX4MM	170	ISOSOURCE 1.0 HP 250ML LIQ	173	JAMP-ALENDRONATE	160
INSULIN PEN NEEDLE 32GX6MM	170	ISOSOURCE 1.2 CAL 1500ML LIQ	173	JAMP-ALLOPURINOL	157
INSULIN PEN NEEDLE 32GX8MM	170	ISOSOURCE 1.2 CAL 250ML LIQ	173	JAMP-AMITRIPTYLINE	80
INSULIN PUMP BATTERY	167	ISOSOURCE 1.5 CAL 250ML LIQ	173	JAMP-AMLODIPINE	51
INSULIN PUMP SUPPLIES	167	ISOSOURCE FIBRE 1.2 CAL 250ML LIQ	173	JAMP-AMOXICILLIN	4
INSULIN SYR W/NEEDL 0.25CC	171	ISOSOURCE FIBRE 1.5 CAL 1500ML LIQ	173	JAMP-ANASTROZOLE	16
INSULIN SYR W/NEEDLE 0.3CC	171	ISOSOURCE FIBRE 1.5 CAL 250ML LIQ	173	JAMP-ASA	64
INSULIN SYR W/NEEDLE 0.5CC	171	ISOSOURCE HN WITH FIBRE 250ML	173	JAMP-ASA EC	64
INSULIN SYR W/NEEDLE 1CC	171	LIQ		JAMP-ATENOLOL	49
INSUPEN 29GX12MM NEEDLE	169	ISOTAMINE	9	JAMP-ATORVASTATIN	42
INSUPEN 30GX8MM NEEDLE	170	ISOTRETINOIN	148	JAMP-AZITHROMYCIN	4
INSUPEN 31GX6MM NEEDLE	170	ITEST	105	JAMP-BACITRACINE	142
INSUPEN 31GX8MM NEEDLE	170	ITEST ULTRA-THIN 33G LANCET	169	JAMP-BEZAFIBRATE	42

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				Non-insured nealth ben	IEII13
JAMP-BICALUTAMIDE	17	JAMP-OLOPATADINE	114	KETOPROFEN	66
JAMP-BISACODYL	120	JAMPOLYCIN	142	KETOPROFEN	66
JAMP-CALCIUM + VITAMIN D	107	JAMP-OMEPRAZOLE DR	125	KETOPROFEN SR	66
JAMP-CALCIUM CARBONATE	107	JAMP-ONDANSETRON	123	KETOPROFEN-E	66
JAMP-CALCIUM VITAMIN D	107	JAMP-OXCARBAZEPINE	78	KETOROLAC TROMETHAMINE	116
JAMP-CANDESARTAN	58	JAMP-PANTOPRAZOLE	125	KETOSTIX	105
JAMP-CARVEDILOL	50	JAMP-PAROXETINE	84	KETOTIFEN	114
JAMP-CELECOXIB	64	JAMP-PIOGLITAZONE	138	KETOTIFEN FUMARATE	1
JAMP-CETIRIZINE	1	JAMP-POTASSIUM CHLORIDE	108	KEVZARA	162
JAMP-CHOLESTYRAMINE	41	JAMP-PRAVASTATIN	43	K-EXIT	108
JAMP-CIPROFLOXACIN	6	JAMP-PREGABALIN	78	KISQALI	24
JAMP-CITALOPRAM	81	JAMP-PYRANTEL PAMOATE	2	KIVEXA	10
JAMP-CLOPIDOGREL	39 450	JAMP-QUETIAPINE	90	KOMBOGLYZE	135
JAMP-COLCHICINE JAMP-CYANOCOBALAMIN	158 152	JAMP-RAMIPRIL JAMP-RANITIDINE	57 124	KWELLADA-P	143
JAMP-CYCLOBENZAPRINE	33	JAMP-RISEDRONATE	161	KYLEENA	133
JAMP-DIMENHYDRINATE	122	JAMP-RISPERIDONE	91	LABETALOL HYDROCHLORIDE LACOSAMIDE	50 76
JAMP-DOMPERIDONE	126	JAMP-RIZATRIPTAN	96	LACRISERT	118
JAMP-DONEPEZIL	28	JAMP-RIZATRIPTAN IR	96	LACTAID	122
JAMP-DULOXETINE	82	JAMP-RIZATRIPTAN ODT	97	LACTAID LACTAID EXTRA STRENGTH	122
JAMP-EFAVIRENZ	11	JAMP-ROPINIROLE	100	LACTAID LATTA OTTLENOTT	122
JAMP-ESCITALOPRAM	83	JAMP-ROSUVASTATIN	44	LACTASE	121
JAMP-EZETIMIBE	42	JAMP-SERTRALINE	85	LACTASE 4500 FCCLU	156
JAMP-FER	36	JAMP-SIMVASTATIN	45	LACTEEZE DROPS	121
JAMP-FERROUS FUMARATE	36	JAMP-SODIUM PHOSPHATE	121	LACTOMAX	122
JAMP-FINASTERIDE	157	JAMP-SOLIFENACIN	150	LACTOMAX EXTRA	122
JAMP-FLUCONAZOLE	9	JAMP-SOTALOL	51	LACTULOSE	106
JAMP-FLUOXETINE	83	JAMP-TENOFOVIR	12	LACTULOSE	106
JAMP-FOLIC ACID	152	JAMP-TERBINAFINE	8	LAMICTAL	77
JAMP-FOSFOMYCIN	15	JAMP-TIMOLOL	117	LAMISIL	8
JAMP-FOSINOPRIL	55	JAMP-TOBRAMYCIN	2	LAMIVUDINE	11
JAMP-GABAPENTIN	75	JAMP-TOPIRAMATE	79	LAMIVUDINE, DOLUTEGRAVIR	11
JAMP-HC	146	JAMP-URSODIOL	121	SODIUM	
JAMP-HYDRALAZINE	47	JAMP-VALACYCLOVIR	13	LAMIVUDINE, TENOFOVIR	11
JAMP-HYDROCORTISONE	146	JAMP-VANCOMYCIN	8	DISOPROXIL FUMARATE, DORAVIRINE	
JAMP-HYDROCORTISONE UREA	146	JAMP-VITAMIN A	152	LAMIVUDINE, ZIDOVUDINE	11
JAMP-IBUPROFEN	66	JAMP-VITAMIN B12	152	LAMOTRIGINE	77 77
JAMP-INDAPAMIDE	110	JAMP-VITAMIN D	153	LAMOTRIGINE	77
JAMP-IRBESARTAN	59	JAMP-ZINC-HC	145	LANCORA	104 41
JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	59	JAMP-ZOLMITRIPTAN	97	LANCORA LANREOTIDE ACETATE	166
JAMP-K 8	108	JAMP-ZOLMITRIPTAN ODT	98	LANSOPRAZOLE	124
JAMP-K EFFERVESCENT	108	JANUMET	135	LANSOPRAZOLE	124
JAMPKCITRATE	108	JANUMET XR	135	LANSOPRAZOLE ODT	124
JAMP-KETOTIFEN	114	JANUVIA JARDIANCE	135 137	LANSOPRAZOLE ORAL LIQUID	124
JAMPLACTASE ENZYME	122	J-CAL+D	107	LANSOYL	120
JAMP-LACTULOSE	106	JENCYCLA	133	LANSOYL SUGAR FREE	120
JAMP-LATANOPROST/TIMOLOL	118	JENTADUETO	135	LANTHANUM CARBONATE HYDRATE	109
JAMP-LETROZOLE	21	JEVITY 1.5 CAL	173	LANTUS	136
JAMP-LEVETIRACETAM	77	JEVITY 1.5 CAL 235ML LIQ	173	LANTUS SOLOSTAR	136
JAMP-LISINOPRIL	55	JEVITY 235ML LIQ	173	LANVIS	26
JAMP-LOSARTAN	60	JULUCA	10	LAPELGA	40
JAMP-LOSARTAN HCTZ	60	K LYTE	108	LASIX	109
JAMP-MAGNESIUM	108	K20 POTASSIUM	108	LASIX SPECIAL	110
JAMP-METFORMIN	134	KADIAN	71	LATANOPROST	117
JAMP-METHOTREXATE	22	KALETRA	11	LATANOPROST, TIMOLOL MALEATE	117
JAMP-METOPROLOL-L	50	KAYEXALATE	108	LATANOPROSTENE BUNOD	118
JAMP-MONTELUKAST	112	KCITRA 10	106	LATUDA	88
JAMP-MOXIFLOXACIN	7	KEFLEX	3	LAX-A-DAY	121
JAMP-MYCOPHENOLATE	164	KENALOG-10	131	LAX-A-DAY PHARMA	121
JAMP-NYSTATIN	9	KENALOG-40	131	LCD IN CORTICOSTEROID CREAM	155
JAMPOCAINE	146	KEPPRA	77	LCD IN CORTICOSTEROID OINTMENT	155
JAMPOCAINE VISCOUS	146	KETOCONAZOLE	9	LCD IN NON-MEDICATED CREAM	155
JAMP-OLANZAPINE	88	KETODERM	143	LCD IN NON-MEDICATED OINTMENT	155
JAMP-OLMESARTAN	61				

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				Non-insured nearth ber	ienta
LEDERLE LEUCOVORIN	157	LISINOPRIL	55	M CALCIUM VITAMINE D	107
LEFLUNOMIDE	162	LISINOPRIL	55	M SENNOSIDES	121
LEFLUNOMIDE	162	LISINOPRIL, HYDROCHLOROTHIAZIDE	56	MACROBID	15
LEMTRADA	163	LISINOPRIL/HCTZ (TYPE Z)	56	MACROGOL, POTASSIUM CHLORIDE,	120
LENALIDOMIDE	20	LITHANE	96	SODIUM BICARBONATE, SODIUM CHLORIDE, SODIUM SULFATE	
LENVATINIB	21	LITHIUM CARBONATE	96	MACROGOL, PROPYLENE GLYCOL	118
LENVIMA	21	LITHIUM CITRATE	96	MAGIC MOUTHWASH	155
LESCOL XL	43	LITHMAX	96	MAGLUCATE	108
LETROZOLE	21	LIVOSTIN	114	MAGNESIUM	108
LETROZOLE	21	LIXIANA	37	MAGNESIUM	108
LEUCOVORIN CALCIUM	157	LIXISENATIDE	135	MAGNESIUM CITRATE	120
LEUKERAN	17	LIXISENATIDE, INSULIN GLARGINE	136	MAGNESIUM COMPLEX	108
LEUPROLIDE ACETATE	21 80	LOCACORTEN VIOFORM LODALIS	115	MAGNESIUM GLUCOHEPTONATE	108
LEVATE LEVEMIR FLEXTOUCH	136	LODOXAMIDE TROMETHAMINE	41 114	MAGNESIUM GLUCONATE	108
LEVEMIR PENFILL	136	LOESTRIN	132	MAGNESIUM HYDROXIDE	120
LEVETIRACETAM	77	LOLO	132	MAGNESIUM OXIDE	120
LEVETIRACETAM	77	LOMUSTINE	21	MAGNESIUM OXIDE	120
LEVETIRACETAM ORAL LIQUID	78	LONITEN	47	MAGNESIUM-ODAN	108
LEVOBUNOLOL HYDROCHLORIDE	116	LOPERAMIDE	120	MAGNIFIER	169
LEVOCABASTINE HYDROCHLORIDE	114	LOPERAMIDE HYDROCHLORIDE	120	MAJEPTIL	92
LEVOCARNITINE	109	LOPINAVIR, RITONAVIR	11	M-AMLODIPINE	51
LEVODOPA, BENSERAZIDE	98	LOPRESOR SR	50	MANERIX	84
HYDROCHLORIDE		LOPROX	142	MAR-ACARBOSE	134
LEVODOPA, CARBIDOPA	98	LORATADINE	1	MAR-ALLOPURINOL	157
LEVODOPA, CARBIDOPA	99	LORATADINE	1	MAR-AMITRIPTYLINE	80
(CARBIDOPA MONOHYDRATE)		LORAZEPAM	95	MAR-AMLODIPINE	51
LEVODOPA, CARBIDOPA,	99	LORAZEPAM	95	MAR-ANASTROZOLE	16
ENTACAPONE	6	LORAZEPAM SUBLINGUAL	95	MAR-ATENOLOL	49
LEVOFLOXACIN HEMILYDDATE	6	LORIS ALCOHOL SWABS	169	MAR-ATORVASTATIN	42
LEVOFLOXACIN HEMIHYDRATE LEVOFLOXACIN HEMIHYDRATE	6	LOSARTAN	60	MARAVIROC	11
(QUINSAIR)	0	LOSARTAN (PQ)	60	MAR-AZITHROMYCIN	4
LEVONORGESTREL	133	LOSARTAN HCT	60	MAR-CELECOXIB	64
LEVONORGESTREL INTRAUTERINE	133	LOSARTAN POTASSIUM	60	MAR-CETIRIZINE	1 165
INSERT		LOSARTAN POTASSIUM,	60	MAR-CINACALCET MAR-CIPROFLOXACIN	6
LEVONORGESTREL, ETHINYL	133	HYDROCHLOROTHIAZIDE		MAR-CITALOPRAM	81
ESTRADIOL		LOSARTAN/HCTZ	60	MAR-CLOPIDOGREL	39
LEVOTHYROXINE SODIUM	139	LOSARTAN-HCTZ	60	MAR-DAPSONE	10
LIBERTE UT380 SHORT IUD	103	LOSEC	125	MAR-DILTIAZEM T	53
LIBERTE UT380 STANDARD IUD	103	LOTRIDERM LOVASTATIN	142 43	MAR-DOMPERIDONE	126
LIDEMOL	145	LOVASTATIN	43 43	MAR-DONEPEZIL	28
LIDEX	145	LOVENOX	43 37	MAR-DULOXETINE	82
LIDOCAINE	146	LOVENOX HP	37	MAR-ENALAPRIL	54
LIDOCAINE HCL	146	LOWPRIN	64	MAR-ESCITALOPRAM	83
LIDOCAINE PRILOCAINE	116	LOXAPINE HYDROCHLORIDE	88	MAR-EZETIMIBE	42
LIDOCAINE, PRILOCAINE LIDODAN	146 146	LOXAPINE SUCCINATE	88	MAR-FEBUXOSTAT	158
LIDODAN VISCOUS	140	LOZIDE	110	MAR-FINGOLIMOD	158
LIFE BRAND PEN NEEDLE 31G 8MM	170	LUBRICANT	149	MAR-FLUCONAZOLE	9
LINAGLIPTIN	135	LUBRICATING	118	MAR-GABAPENTIN	75
LINAGLIPTIN, METFORMIN	135	LUBRICATING NASAL MIST	118	MAR-GALANTAMINE ER	28
HYDROCHLORIDE	100	LUCENTIS	118	MAR-LACOSAMIDE	76
LINCTUS CODEINE	68	LUCENTIS PFS	118	MAR-LETROZOLE	21
LINESSA 21	132	LUMIGAN RC	117	MAR-METHIMAZOLE	139
LINESSA 28	132	LUMIGAN RC (ON)	117	MAR-MIDODRINE	30
LINEZOLID	8	LUPIN-CEPHALEXIN	3	MAR-MODAFINIL	93
LINEZOLID	8	LUPIN-ESTRADIOL	134	MAR-MONTELUKAST	112
LIORESAL	33	LUPRON DEPOT	134	MAR-MOXIFLOXACIN	7
LIOTHYRONINE SODIUM	139	LURASIDONE HYDROCHLORIDE	88	MAR-OLANZAPINE ODT	89
LIPASE, AMYLASE, PROTEASE	122	LUVOX	83	MAR-ONDANSETRON	123
LIPIDIL EZ	42	LYDERM	145	MAR-PANTOPRAZOLE	125
LIPIDIL SUPRA	42	LYNPARZA	22	MAR-PAROXETINE	84 56
LIPITOR	42	LYRICA	78	MAR-PERINDOPRIL MAR-PRAVASTATIN	56 43
LISDEXAMFETAMINE DIMESYLATE	93	LYSODREN	22	MAR-PREGABALIN	43 78
				WAN-FINE GADALIN	10

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MAR-QUETIAPINE 90 MEGESTROL ACETATE 21 METHYLDOPA MAR-RAMIPRIL 57 MEKINIST 26 METHYLPHENIDATE MAR-RAMIPRIL 124 MELOXICAM 66 METHYLPREDNISOLO MAR-RISATRIPTAN 97 MELPALLAN 21 METHYLPREDNISOLO MAR-RIZATRIPTAN ODT 97 MENTHOL & CAMPHOR IN 155 METHYLPREDNISOLO MAR-ROSUVASTATIN 44 CORTICOSTEROID LOTION 155 METHYLPREDNISOLO MAR-SERTRALINE 85 MENTHOL &/OR CAMPHOR IN 155 SUCCIMATE MAR-SIMVASTATIN 45 MEPRON 15 METHYLPREDNISOLO MARTOSPIUM 150 MEPRON 15 METHYLPREDNISOLO MARVELON 21 132 MERCAPTOPURINE 21 METHYLPREDNISOLO MARVELON 25 132 MERCAPTOPURINE 21 METHYLPREDNISOLO MARVELON 26 132 MERCAPTOPURINE 21 METOLOPRAMIDE H MARYELON 28 132 MERCAPTOPURINE 21 METOLOPRAMIDE H MATERNA	NE 131 NE 131 DNE SODIUM 131 NE ACETATE 131 NE ACETATE, ILORIDE 131 NE SODIUM 131 YDROCHLORIDE 126 21 NEOUS
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MAVENCLAD MAVIK MAVIK MAVIRET MAXALT MAXALT MAXALT MAXALT PD MAXIDEX MAXIMUM STRENGTH ACID REDUCER MAXIMUM STRENGTH PEPCID AC MAZEPINE MAZEPINE M-B1 M-B6 M-CAL METADOL METADOL METADOL-D METAMUCIL FIBRE THERAPY ORIGINAL TEXTURE UNFLAVOURED METAMUCIL FIBRE THERAPY ORIGINAL TEXTURE METAMUCIL FIBRE THERAPY METAMUCIL FIBRE TH	50
MAVIK 58 METADOL 70 METOPROLOL SR MAVIRET 14 METADOL-D 70 METOPROLOL TARTR MAXALT 97 METAMUCIL FIBRE THERAPY 121 METROGEL MAXALT PD 97 METAMUCIL FIBRE THERAPY 156 METROLOTION METRONIDAZOLE MAXIDEX MAXIMUM STRENGTH ACID REDUCER 124 METAMUCIL FIBRE THERAPY 156 METRONIDAZOLE MAXIMUM STRENGTH PEPCID AC 123 SMOOTH TEXTURE ORANGE MAZEPINE 75 METAMUCIL FIBRE THERAPY 121 METRONIDAZOLE ORAM M-B1 152 SMOOTH TEXTURE ORANGE M-B12 152 METAMUCIL FIBRE THERAPY 121 METRONIDAZOLE, NY M-B6 152 METAMUCIL FIBRE THERAPY 156 MEXILETINE HYDROC M-B6 152 METAMUCIL FIBRE THERAPY 156 MEZAVANT MEZAVANT MEZERA M-CAL MCAL D. METAMUCIL FIBRE THERAPY 121 MEZERA M-EZETIMIBE	
MAVIRET 14 METADOL-D 70 METOPROLOL TARTR MAVIRET 14 METADOL-D 70 METOPROLOL TARTR MAXALT 897 METAMUCIL FIBRE THERAPY 121 METROGEL MAXALT RPD 97 METAMUCIL FIBRE THERAPY 156 METROLOTION METRONIDAZOLE MAXIDEX 115 SMOOTH TEXTURE 156 METRONIDAZOLE MAXIMUM STRENGTH ACID REDUCER 124 METAMUCIL FIBRE THERAPY 121 METRONIDAZOLE MAXIMUM STRENGTH PEPCID AC 123 SMOOTH TEXTURE ORANGE METRONIDAZOLE ORAM MAZEPINE 75 METAMUCIL FIBRE THERAPY 121 METRONIDAZOLE, NY M-B1 152 SMOOTH TEXTURE ORANGE M-B12 152 FLAVOUR (SUGAR-FREE) M-B6 152 METAMUCIL FIBRE THERAPY 156 MEZAVANT M-B6 152 METAMUCIL FIBRE THERAPY 156 MEZAVANT MEZAVANT MEZERA M-CAL 107 METAMUCIL FIBRE THERAPY 121 MEZERA M-CAL 107 METAMUCIL FIBRE THERAPY 156 MEZAVANT MEZERA M-EZETIMIBE	50
MAXALT 97 METAMUCIL FIBRE THERAPY 121 METROGEL MAXALT RPD 97 ORIGINAL TEXTURE UNFLAVOURED MAXIDEX 115 SMOOTH TEXTURE MAXIMUM STRENGTH ACID REDUCER 124 METAMUCIL FIBRE THERAPY 156 METRONIDAZOLE MAXIMUM STRENGTH PEPCID AC 123 SMOOTH TEXTURE ORANGE METRONIDAZOLE ORA MAZEPINE 75 METAMUCIL FIBRE THERAPY 121 METRONIDAZOLE ORA M-B1 152 SMOOTH TEXTURE ORANGE M-B12 152 FLAVOUR (SUGAR-FREE) M-B6 152 METAMUCIL FIBRE THERAPY 156 MEZAVANT M-B6 152 METAMUCIL FIBRE THERAPY 156 MEZAVANT METAMUCIL FIBRE THERAPY 156 MEZAVANT METAMUCIL FIBRE THERAPY 157 MEZAVANT METAMUCIL FIBRE THERAPY 158 MEZAVANT METAMUCIL FIBRE THERAPY 158 MEZAVANT MEZERA M-EZETIMIBE	ATE 50
MAXALT RPD MAXALT RPD MAXIDEX MAXIDEX MAXIMUM STRENGTH ACID REDUCER MAXIMUM STRENGTH ACID REDUCER MAXIMUM STRENGTH PEPCID AC MAZEPINE MAZEPINE M-B1 M-B6 M-CAL M-CAL MAXIMUM STRENGTH METAMUCIL FIBRE THERAPY METAMUCIL FIBRE	50
MAXALT RPD MAXIDEX MAXIDEX MAXIMUM STRENGTH ACID REDUCER MAXIMUM STRENGTH PEPCID AC MAZEPINE M-B1 M-B1 M-B6 M-B6 M-CAL MAXIMUM STRENGTH SCID MAXIMUM STRENGTH SCID MAXIMUM STRENGTH PEPCID AC METAMUCIL FIBRE THERAPY METAMUCI	142
MAXIDEX MAXIMUM STRENGTH ACID REDUCER MAXIMUM STRENGTH PEPCID AC MAZEPINE M-B1 M-B1 M-B1 M-B6 M-CAL M-CAL MAXIMUM STRENGTH ACID REDUCER MAXIMUM STRENGTH PEPCID AC 123 METAMUCIL FIBRE THERAPY 121 METAONIDAZOLE METRONIDAZOLE M	142
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MAZEPINE 75 METAMUCIL FIBRE THERAPY 121 METRONIDAZOLE, NY M-B1 152 SMOOTH TEXTURE ORANGE MEXILETINE HYDROC M-B12 152 FLAVOUR (SUGAR-FREE) MEZAVANT M-B6 152 METAMUCIL FIBRE THERAPY 156 MEZAVANT M-CAL 107 METAMUCIL FIBRE THERAPY 121 M-EZETIMIBE	15
M-B1 152 SMOOTH TEXTURE ORANGE MEXILETINE HYDROC M-B12 152 FLAVOUR (SUGAR-FREE) MEZAVANT M-B6 152 METAMUCIL FIBRE THERAPY 156 MEZERA M-CAL 107 METAMUCIL FIBRE THERAPY 121 M-EZETIMIBE	AL LIQUID 15
M-B12 152 FLAVOUR (SUGAR-FREE) MEZAVANT M-B6 152 METAMUCIL FIBRE THERAPY 156 MEZAVANT M-CAL 107 SMOOTH TEXTURE SUGAR FREE MEZERA M-CAL 107 METAMUCIL FIBRE THERAPY 121 M-EZETIMIBE	STATIN 142
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M-CAL 107 METAMUCIL FIBRE THERAPY 121 M-EZETIMIBE	126
MICALID	42
	36
M-CINACALCET 165 METAMUCIL SMOOTH TEXTURE 156 M-FOLIQUE	152
M-CLARITHROMYCIN 4 UNFLAVOURED UNSWEETENED M-HC	146
M-CLINDAMYCIN 7 METFORMIN 134 M-HC UREA	145
M-D 153 METFORMIN FC 134 MICARDIS	61
M-DONEPEZIL 28 METFORMIN HYDROCHLORIDE 134 MICARDIS PLUS	61
M-DULOXETINE 82 METFORMIN HYDROCHLORIDE, 137 MICATIN MICONAZOLE	
MEBENDAZOLE 2 DAPAGLIFLOZIN MICONAZOLE 3 DAY O	
MED-ANASTROZOLE 16 METFORMIN HYDROCHLORIDE, 137 TREATMENT	VOLL 140
MED-CYPROTERONE 165 EMPAGLIFLOZIN MICONAZOLE NITRAT	E 143
MED-DORZOLAMIDE-TIMOLOL 117 METHADONE HYDROCHLORIDE 70 MICOZOLE	143
MED-DUTASTERIDE 157 METHADONE HYDROCHLORIDE (BC 70 MICRO K	108
MED-EXEMESTANE 19 ONLY) MICROLAX	121
MEDI+SURE 105 METHADONE HYDROCHLORIDE 70 MICROLET LANCET	169
(METADOL) MEDIASTIDE (ON) 105 MICRONOR 28-DAV	133
METHADONE LOCK BOX 1/3	
MEDI+SURE SOFT 30G TWIST 169 METHADONE POWDER (OAT) 70 MICTORYL PEDIATRIC 70 MIDAMOR	110
METHADOSE 70	
MEDISURE ALCOHOL WIPES 156 METHADOSE DEL. W DIRECT INTER 70 MIDODRINE HYDROCH	
MED-LATANOPROST 117 (OAT) MIDOSTAURIN	22
MED-LATANOPROST-TIMOLOL 118 METHADOSE DEL. W/OUT DIR INTER 70 MIFEGYMISO	141
MED-LETROZOLE 21 (OAT) MIGRANAL	33
MED-MOXIFLOXACIN 7 METHADOSE W DIRECT INTERACTION 70 MILK OF MAGNESIA MED-RIVASTIGMINE 20 (OAT)	120
METHADOSE WIGHT DIRECT INTED 70	120
(OAT)	
MED-ROSUVASTATIN 44 MINERAL OIL, WHITE I	
MEDROXY 139 MFTHAZOLAMIDE 117 MINESTRIN 1/20 (21-D/	,
MEDROXYPROGESTERONE 139 MINESTRIN 1/20 (28-D/	AY) 132
MEDROXYPROGESTERONE ACETATE 139 METHOPRAZINE 139 METHOPRAZINE 139 MINIMS ATROPINE 88	116
MED-SOLIFENACIN 150 METHOPRAZINE 00 MINIMS CYCLOPENTO METHOTREXATE 21 MINIMS CYCLOPENTO METHOTREXATE 21 MINIMS CYCLOPENTO	LATE 116
MEFENAMIC METHOTREXATE MINIMS PHENYLEPHR METHOTREXATE SODIUM 21 MINIMS PHENYLEPHR METHOTREXATE SODIUM 21 MINIMS PHENYLEPHR	INE 116
MEFENAMIC ACID METHOTREXATE SOCION MINIMS PILOCARPINE METHOTRIMEPRAZINE MALEATE 88 MINIMS PILOCARPINE	
MEGESTROL 21 METHOTRIMEPRAZINE MALEATE 88 MINIMS PREDNISOLON 47	117

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				Non-insured nealth bei	nents
MINITRAN	47	MIO CLEAR 6MMX32	167	MONTELUKAST	112
MINOCYCLINE	7	MIO CLEAR 9MMX32	167	MONTELUKAST SODIUM	111
MINOCYCLINE HYDROCHLORIDE	7	MIO PINK 6MMX18	167	MONTELUKAST SODIUM	112
MIN-OVRAL 21	132	MIO PINK 6MMX23	167	MONTKIDDY BLUE NEEDLE 32GX4MM	170
MIN-OVRAL 28	132	MIOSTAT	117	MONTKIDDY PINK NEEDLE 32GX4MM	170
MINOXIDIL	47	MIRABEGRON	151	MONTKIDDY YELLOW NEEDLE	170
MINT-ABACAVIR	10	MIRAPEX	99	32GX4MM	45
MINT-ACITRETIN	147	MIRAPEX (ON)	99	MONUROL	15
MINT-ALENDRONATE	160	MIRENA	133	MORPHINE HYDROCHLORIDE	70 71
MINT-AMLODIPINE	52	MIRTAZAPINE	84	MORPHINE SR MORPHINE SULFATE	71 70
MINT-ANASTROZOLE	16	MIRTAZAPINE	84	MORPHINE SULFATE (KADIAN)	70 71
MINT-ATENOL	49	MIRVALA 21	132	MOTION SICKNESS	122
MINT-ATORVASTATIN	42	MIRVALA 28	132	MOTRIN	66
MINT-BISOPROLOL	49 58	MISC LIMITED USE COMPOUND INTERNAL	155	MOVAPO	99
MINT-CANDESARTAN	56 64	MISC LIMITED USE EXTERNAL	155	MOVISSE	133
MINT-CELECOXIB MINT-CETIRIZINE	1	COMPOUND MIXTURE	.00	MOXIFLOXACIN	7
MINT-CIPROFLOX	6	MISCELLANEOUS COMPOUNDED	155	MOXIFLOXACIN HYDROCHLORIDE	7
MINT-CITALOPRAM	81	EXTERNAL LOTION		MOXIFLOXACIN HYDROCHLORIDE	114
MINT-CLONIDINE	46	MISCELLANEOUS COMPOUNDED	155	(OPHTHALMIC)	
MINT-DONEPEZIL	28	EXTERNAL POWDER	455	MOZOBIL	40
MINT-DULOXETINE	82	MISCELLANEOUS COMPOUNDED EYE/EAR DROP	155	M-PANTOPRAZOLE	125
MINT-DUTASTERIDE	157	MISCELLANEOUS COMPOUNDED	155	M-PAROXETINE	84
MINT-EPLERENONE	62	INJECTION/INFUSION		MPD THIN LANCET (NS)	169
MINT-ESCITALOPRAM	83	MISCELLANEOUS COMPOUNDED	155	MPD ULTRA THIN LANCET (100)	169
MINT-EZETIMIBE	42	INTERNAL LIQUID		MPD ULTRA THIN LANCET (200)	169
MINT-FINASTERIDE	157	MISCELLANEOUS COMPOUNDED	155	M-PEG 3350	120
MINT-FLUOXETINE	83	INTERNAL POWDER MISCELLANEOUS COMPOUNDED	155	M-PERINDOPRIL ERBUMINE	56
MINT-FUROSEMIDE	109	SUPPOSITORY	133	M-PRAVASTATIN	43
MINT-GLICLAZIDE MR	138	MISCELLANEOUS COMPOUNDED	155	M-PREGABALIN	78
MINT-HYDRALAZINE	47	TOPICAL CREAM		M-RANITIDINE	124
MINT-HYDROCHLOROTHIAZIDE	110	MISCELLANEOUS COMPOUNDED	155	MS CONTIN SR	71
MINT-HYDROXYCHLOROQUINE	15	TOPICAL OINTMENT		MS IR	71
MINT-INDOMETHACIN	66	MISOPROSTOL	124	M-SENNOSIDES	121
MINT-IRBESARTAN	59	MISOPROSTOL	124	M-SULFATE FERREUX	36
MINT-IRBESARTAN/HCTZ	59	MISOPROSTOL, DICLOFENAC SODIUM	66	MUCILLIUM	121 154
MINT-ITRACONAZOLE	9	MISOPROSTOL, MIFEPRISTONE	141	MULTIVITAMINS (CHILDREN AND YOUTH)	154
MINT-LACOSAMIDE	76	MITOTANE	22	MULTIVITAMINS (PRENATAL)	154
MINT-LEVOCARB	98	MK 10 MK 20	108 108	MUPIROCIN	142
MINT-LOSARTAN	60	MK 8	108	MUPIROCIN CALCIUM	142
MINT-LOSARTAN/HCTZ	60	MK20 SOLUBLE	108	MURO 128	118
MINT-MONTELUKAST	112	MMAGNESIUM GLUCONATE	108	M-VENLAFAXINE XR	86
MINT-OLANZAPINE	88	M-MOXIFLOXACIN	7	MYA	132
MINT-OLANZAPINE ODT MINT-OLOPATADINE	89	MMT-174 ADHESIVE	168	MYCOBUTIN	10
MINT-OLOPATADINE MINT-ONDANSETRON	114 123	MOCLOBEMIDE	84	MYCOPHENOLATE	165
MINT-ONDANSETRON MINT-ONDANSETRON ODT	123	MOCLOBEMIDE	84	MYCOPHENOLATE MOFETIL	164
MINT-PANTOPRAZOLE	125	MODAFINIL	93	MYCOPHENOLATE MOFETIL	164
MINT-PAROXETINE	84	MOGADON	95	MYCOPHENOLATE SODIUM	165
MINT-PERINDOPRIL	56	MOMETASONE CREAM	146	MYDFRIN	116
MINT-PIOGLITAZONE	138	MOMETASONE FUROATE	115	MYDRIACYL	116
MINT-PRAVASTATIN	43	MONA LISA 10	103	MYFORTIC	165
MINT-PREGABALIN	78	MONA LISA 5	103	MYHEALTH SYRINGE CASE-7	172
MINT-QUETIAPINE	90	MONA LISA N	103	MYHEALTH SYRINGE CASE-SINGLE	172
MINT-RAMIPRIL	57	MONISTAT 3	143	MYLAN-ABACAVIR/LAMIVUDINE	10
MINT-RISPERIDON	91	MONISTAT 3 DUAL-PAK	143	MYLAN-ACYCLOVIR	13
MINT-SERTRALINE	85	MONISTAT 7	143	MYLAN-ALMOTRIPTAN	96
MINT-SIMVASTATIN	45	MONISTAT 7 DUAL-PAK	143	MYLAN-AMLODIPINE	52
MINT-TELMISARTAN	61	MONISTAT DERM	143	MYLAN-ATAZANAVIR	10
MINT-TOLTERODINE	150	MONOFERRIC	36	MYLAN BACLOFFN	42
MINT-TOPIRAMATE	80	MONOJECT	171	MYLAN BECLOAG	33 115
MINT-ZOLMITRIPTAN	97	MONOJECT ALCOHOL WIPES	169	MYLAN BUDESONDE AO	115
MIO BLUE 6MMX18	167	MONOLET 21G LANCET	169	MYLAN-BUDESONIDE AQ MYLAN-BUPROPION XL	115 81
MIO BLUE 6MMX23	167	MONOLET THIN (MONOJECT) 28G	169	MYLAN-CILAZAPRIL	54
				IVI I LAIN-UILAZAF NIL	54

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MYLAN-CIMETIDINE123NASONEX115NILUTAMIDEMYLAN-CINACALCET165NAT-ANASTROZOLE16NIMODIPINEMYLAN-CLOBETASOL144NAT-CITALOPRAM81NIMOTOPMYLAN-DIVALPROEX80NAT-DONEPEZIL28NINTEDANIB ESILATEMYLAN-EFAVIRENZ11NAT-ERLOTINIB19NITOMAN	22 53 53 111
MYLAN-CLOBETASOL144NAT-CITALOPRAM81NIMOTOPMYLAN-DIVALPROEX80NAT-DONEPEZIL28NINTEDANIB ESILATEMYLAN-EFAVIRENZ11NAT-ERLOTINIB19NITOMAN	53
MYLAN-DIVALPROEX 80 NAT-DONEPEZIL 28 NINTEDANIB ESILATE MYLAN-EFAVIRENZ 11 NAT-ERLOTINIB 19 NITOMAN	
MYLAN-EFAVIRENZ 11 NAT-ERLOTINIB 19 NITOMAN	111
MYLAN-EFAVIRENZ 11 NAT-ERLOTINIB 19 NITOMAN	
	102
MYLAN- 11 NAT-ESCITALOPRAM 83 NITRAZEPAM	95
EFAVIRENZ/EMTRICITABINE/TENOFOVI NAT-GRANISETRON 122 NITRO-DUR	47
R DISOPROXIL FUMARATE NAT-IMATINIB 20 NITROFURANTOIN	15
MYLAN-EMTRICITABINE/TENOFOVIR 12 NAT LETPOZOLE 21 NITROELIRANITOIN	15
DISOPROAIL NAT LEVETIPACETAM 77 NITTO FURANTOIN ORAL LIQUID	15
MYLAN-ESCITALOPRAM 83	4 7
MYLAN-FINGOLIMOD 158 NAT-ONDANSETPON 123 NITROUNDULA PUMPERDAY	47 47
MYLAN-FLUCONAZOLE 9 NAT-ONDANSETRON 123 NITROLINGUAL PUMPSPRAY MYLAN-GALANTAMINE FR. 38 NAT-OSELTAMIVIR 13 NITROSTAT	
MYLAN-GALANTAMINE ER 28	47
MYLAN-GLICLAZIDE MR 138	143
MYLAN-HYDROXYUREA 20	143
MYLAN-INDAPAMIDE 110 NAT-TENOFOVIR 12 NIZATIDINE	123
MYLAN-LAMOTRIGINE 77 NATURAL HEALTH PRODUCT 118 NIZORAL	143
MYLAN-LANSOPRAZOLE 124 NATURES BOUNTY PRENATAL 154 NOLVADEX-D VITAMINS	26
MYLAN-MIRTAZAPINE 84 NAT ZOLMITRIDITAN 0.7	156
MYLAN-MYCOPHENOLATE 164 NORELITINDRONE	133
MYLAN-NEVIRAPINE 11 NEVERNAUE NAVANE 92 NORETHINDRONE, ETHINYL	133
MYLAN-NIFEDIPINE 53 NEGOTIE (200 DDD 47)	
MYLAN-NITRO NEOCATE 400G PDR 1/4 NORFLOXACIN	7
MYLAN-ONDANSETRON 123 NORFLOXACIN	7
MYLAN-PANTOPRAZOLE T 125 NEOCATE JUNIOR 400G PDR 174 NORGESTIMATE, ETHINYL ESTRA	DIOL 133
MYLAN-PERINDOPRII /INDAPAMIDE 56 NEOCATE ONE 400G 1/4 NORITATE	142
MYLAN-PROPAFENONE A1 NEOCATE W/ DHA & ARA 400G PDR 1/4 NORPROLAC	156
MYLAN-RISPERIDONE ODT 91 NEO-FER 36 NORTRIPTYLINE HYDROCHLORID	E 84
MYLAN-RIZATRIPTAN ODT 97 NEORAL 164 NORVASC	52
MYLAN-SUMATRIPTAN 97 NEO 701	12
MYLAN-TENOFOVIR DISOPROXIL 12	105
MYLAN-TOLTERODINE ER 150 NEPAFENAC 116 NOVAMILOR	110
NESTL MATERNA 154 NOVAMOVINI	4
MYLAN-TOPIRAMATE 80 NETUPITANT, PALONOSETRON 122 NOVASEN	64
MYLAN-VALACYCLOVIR 13 (PALONOSETRON HYDROCHLORIDE) NOVA-T	103
MYLAN-VERAPAMIL 54 NEULASTA 40 NOVO-CLINDAMYCIN	7
MYLAN-VERAPAMIL SR 54 NEULEPTIL 89 NOVOEINE 30CY 6MM NEEDLE	170
NEUPOGEN 39 NOVOEINE 30CX 8MM NEEDLE	170
MYRBETRIQ 151 NEUPOGEN (ON) 39 NOVOEINE 32G TIP PEN NEEDLE	170
NABILONE 123 NEUPOGEN (QC) 39 NOVOEINE PLUS 4MM NEEDLE	170
NACL SALINE PF 108 NEUPRO 100 NOVO-FLUCONAZOLE	9
NADOLOL 51 NEURONTIN 75 NOVO-GESIC	73
NADOLOL 51 NEUTROGENA 147 NOVO CESIC FORTE	73
NADROPARIN CALCIUM 38 NEVANAC 116 NOVO-GESIC FORTE 116 NOVO-UVDROVYZINI	
NADRYL 1 NEVIRAPINE 11 NOVO-HYDROXYZIN NOVOLIN GE 30/70	96 136
NAFARELIN ACETATE 134 NIACIN 152	136
NALCROM 112 NIACIN 153	136
NALOXONE 74 NICHIT 24	136
NALOXONE HYDROCHLORIDE 74 NICODERM 24	136
NALOXONE KIT 74 NICOPETTE CLIM 24	136
NALTREXONE HYDROCHI ORIDE 74 NICODETTE INITIALED NOVOLIN GENETI TOUD/INIE PENTIT	
NALTREXONE HYDROCHLORIDE 74 NICODETTE LOZENICE 24	136
NAPHAZOLINE HYDROCHLORIDE 116 NICODETTE OLUCIAMET 25	136
NAPROSYN 67 NICOTINE GUIDO	136
NAPPOVEN NOVOLIN-PEN NEEDLE	169
NAPPOVEN	5
NARDOVEN EC. 67	66
NAPPOVEN CODILINA	136
NAPPOVEN CODILIN DC 67	170
NADDOVENINA 67 NOVOTWIST TIP 32G NEEDLE	170
NAPPOVEN NA DE 67	51
NAPROXEN-NA DF 67 NICOTINE TRANSDERMAL SYSTEM 34 NRA-ATORVASTATIN	42
NARATRIPTAN HYDROCHLORIDE 96 NIDAGEL 142 NRA-AZITHROMYCIN	4
NARCAN 74 NIFEDIPINE 53 NRA-CELECOXIB	64
NARDIL 85 NIFEDIPINE 53 NRA-CITALOPRAM	81
NASACORT AQ 115 NILOTINIB 22	

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				Non-insured Health Ben	ents
NRA-DULOXETINE	82	OLOPATADINE HYDROCHLORIDE	114	OYSTER SHELL CALCIUM	107
NRA-ESCITALOPRAM	83	OLSALAZINE SODIUM	126	OZEMPIC	136
NRA-EZETIMIBE	42	OMALIZUMAB	113	PALAFER	36
NRA-MONTELUKAST	112	OMEGA ALLERGENIC EXTRACTS	156	PALBOCICLIB	23
NRA-PANTOPRAZOLE	125	POLLENS (SUSPAL)		PALIPERIDONE PALMITATE	89
NRA-PAROXETINE	84	OMEPRAZOLE	125	PAL-TIZANIDINE	33
NRA-PERINDOPRIL	56	OMEPRAZOLE MAGNESIUM	125	PAMIDRONATE	160
NRA-PREGABALIN	78	OMEPRAZOLE ORAL LIQUID	125	PAMIDRONATE DISODIUM	160
NRA-RAMIPRIL	57	OMEPRAZOLE-20	125	PAMIDRONATE DISODIUM	160
NRA-RIZATRIPTAN ODT	97	ONABOTULINUMTOXINA	166	PAMIDRONATE DISODIUM OMEGA	160
NRA-ROSUVASTATIN	44	ONBREZ BREEZHALER	32	PANTOLOC	125
NRA-SERTRALINE	85	ONDANSETRON	122	PANTOLOC PANTOPRAZOLE	125
	155	ONDANSETRON HYDROCHLORIDE	122		
NSAID IN TRANSDERMAL BASE NU-CAL	107	ONDANSETRON ODT	123	PANTOPRAZOLE MAGNESIUM	125
NU-CAL NU-CAL D	107	ONDISSOLVE ODF	122	PANTOPRAZOLE MAGNESIUM	125
		ONE A DAY WOMEN	154	PANTOPRAZOLE SODIUM	125
NUCALA	164	ONE ALPHA	153	PANTOPRAZOLE T	125
NUTRAMIGEN A+ 945ML LIQ	174	ONE TOUCH DELICA 30G LANCET	169	PANTOPRAZOLE-40	125
NUTRAMIGEN A+ LGG 561G PDR	174			PARADIGM SILHOUETTE 13MMX 43	167
NUTREN 1.5	173	ONE TOUCH ULTRA ONE-ALPHA	105	PARADIGM SILHOUETTE 13MMX18"	168
NUTREN JR. 250ML LIQ	173		153	PARADIGM SILHOUETTE 13MMX23	168
NUTRITIONAL SUPPLEMENT	174	ONETOUCH DELICA 33G LANCET	169	PARADIGM SILHOUETTE 13MMX32"	168
NUVARING	132	ONETOUCH DELICAPLUS 30G LANCET	169	PARADIGM SILHOUETTE 17MMX23	168
NYADERM	143	ONETOUCH DELICAPLUS 33G LANCET	169	PARADIGM SILHOUETTE 17MMX32"	168
NYDA	143	ONETOUCH ULTRASOFT LANCET	169	PARADIGM SILHOUETTE 17MMX43	168
NYSTATIN	9	ONETOUCH VERIO	105	PARADIGM SILHOUETTE CANNULA	168
NYSTATIN 100,000U SUSP (QC)	9	ONETOUCH VERIO (ON)	105	13MM	
OBETICHOLIC ACID	126	ONGLYZA	135	PARADIGM SILHOUETTE CANNULA	168
O-CALCIUM	107	OPIOID COMPOUNDED	155	17MM	400
OCALIVA	126	OPTICHAMBER	167	PARADIGM SURE-T 29G 6MMX18	168
OCCLUSAL HP	147	OPTICHAMBER DIAMOND (CHAMBER)	167	PARADIGM SURE-T 29G 6MMX23	168
OCRELIZUMAB	159	OPTICHAMBER DIAMOND LARGE	167	PARADIGM SURE-T 29G 8MMX23	168
OCREVUS	159	MASK		PARIET	125
OCTREOTIDE ACETATE	155	OPTICHAMBER DIAMOND MEDIUM	167	PARNATE	85
OCTREOTIDE ACETATE OMEGA	155	MASK	407	PAROMOMYCIN SULFATE	15
OCUFLOX	114	OPTICHAMBER DIAMOND SMALL MASK	167	PAROXETINE	84
ODAN K20	108	OPTICHAMBER LARGE MASK	167	PAROXETINE HYDROCHLORIDE	84
ODAN K8	108	OPTICHAMBER MEDIUM MASK	167	PARSITAN	98
ODAN LEVOCARNITINE	109	OPTICHAMBER SMALL MASK	167	PATANOL	114
ODAN LIQUOR CARBONIS	147	OPTICROM	114	PATE D'IHLE	147
DETERGENT		OPTIHALER	167	PÂTE D'IHLE	147
ODAN SODIUM CHLORIDE	119	OPTIMYXIN	114	PAT-GALANTAMINE ER	28
ODAN-ERYTHROMYCIN	114	OPTION 2	133	PAXIL	84
ODAN-FLUOXETINE	83	OPUS CAL D	107	PAZOPANIB	23
ODAN-SODIUM CHLORIDE	119	OPUS SENNOSIDES	121	PDP-ACETAMINOPHEN	73
ODAN-SODIUM POLYSTYRENE	108	OPUS VITAMINE B1	154	PDP-BENZTROPINE	98
SULFONATE		ORACORT DENTAL PASTE	146	PDP-DESONIDE	145
ODEFSEY	11	ORCIPRENALINE	32	PDP-DIPHENHYDRAMINE	1
OESCLIM	133	ORCIPRENALINE SULFATE	32	PDP-ERYTHROMYCIN	114
OFEV	111	ORENCIA	161	PDP-ISONIAZID	9
OFLOXACIN	114	OSELTAMIVIR	13	PDP-PROCYCLIDINE	98
OLANZAPINE	88	OSIMERTINIB	23	PDP-PYRAZINAMIDE	9
OLANZAPINE	88	OVIMA 21	132	PEDIAFER	36
OLANZAPINE ODT	89	OVIMA 28	132	PEDIALYTE	107
OLAPARIB	22	OXAZEPAM	95	PEDIAPHEN	73
OLESTYR	41	OXAZEPAM	95	PEDIAPRED	131
OLMESARTAN	61	OXCARBAZEPINE	78	PEDIASURE 235ML LIQ	173
OLMESARTAN (QC)	60	OXCARBAZEPINE (SUSPENSION)	78	PEDIASURE COM. GROW&GAIN 235ML	173
, ,		OXEZE TURBUHALER	31	LIQ	173
OLMESARTAN MEDOXOMIL	60 61	OXPAM	95	PEDIASURE FIBRE 235ML LIQ	173
OLMESARTAN MEDOXOMIL, HYDROCHLOROTHIAZIDE	61	OXTRIPHYLLINE	151	PEDIASURE GROW&GAIN 400G PDR	173
OLMETEC	61	OXYBUTYNIN	150	PEDIASURE PLUS WITH FIBRE 235	173
OLMETEC PLUS	61	OXYBUTYNIN CHLORIDE	150	PEDIATRIC ELECTROLYTE	107
OLODATEROL HYDROCHLORIDE, TIOTROPIUM BROMIDE	32	OXYCODONE HYDROCHLORIDE	71	PEDIAYIT	73 154
MONOHYDRATE		OXYCODONE/ACET	68	PEDIAVIT	154
-		OXY-IR	71	PEDIAVIT D	153

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				Non-insured nearth be	Henris
PEG 3350	121	PHENAZOPYRIDINE COMPOUNDED	155	PMS-ATENOLOL	49
PEGASYS	12	PHENAZOPYRIDINE HYDROCHLORIDE	146	PMS-ATOMOXETINE	100
PEGETRON KIT	12	PHENELZINE SULFATE	85	PMS-AZITHROMYCIN	3
PEGFILGRASTIM	40	PHENOBARB	74	PMS-BACLOFEN	33
PEGFILGRASTIM (LAPELGA)	40	PHENOBARBITAL	74	PMS-BENZTROPINE	98
PEGINTERFERON ALFA-2A	12	PHENYLEPHRINE	116	PMS-BENZYDAMINE	116
PEGINTERFERON ALFA-2B, RIBAVIRIN	12	PHENYLEPHRINE HYDROCHLORIDE	116	PMS-BETAHISTINE	101
PEGINTERFERON BETA-1A	12	PHENYTOIN	74	PMS-BEZAFIBRATE	42
PEGLYTE	120	PHILIPS MAGNESIA	120	PMS-BICALUTAMIDE	17
PEN NEEDLE	169	PHILLIPS MILK OF MAGNESIA	120	PMS-BISACODYL	120
PENICILLAMINE	129	PHOSLAX	121	PMS-BISOPROLOL	49
PENICILLIN G	5	PHOSPHATES	121	PMS-BOSENTAN	48 116
PENICILLIN G BENZATHINE	5	PHYTONADIONE	154	PMS-BRIMONIDINE PMS-BROMOCRIPTINE	99
PENICILLIN G POTASSIUM	5	PICO-SALAX PIFELTRO	120 10	PMS-BUPRENORPHINE-NALOXONE	72
PENICILLIN G SODIUM	5 -	PILOCARPINE	117	PMS-BUPROPION SR	81
PENICILLIN C STEPILE INFLISION	5		29	PMS-BUSPIRONE	96
PENICILLIN G STERILE INFUSION	5 -	PILOCARPINE HYDROCHLORIDE		PMS-CANDESARTAN	58
PENICILLIN V POTASSIUM	5	PILOCARPINE HYDROCHLORIDE PILOCARPINE NITRATE	29 117	PMS-CANDESARTAN HCTZ	59
PENTASA	126	PIMECROLIMUS	149	PMS-CAPTOPRIL	54
PENTOSAN POLYSULFATE SODIUM	156	PIMOZIDE	89	PMS-CARBAMAZEPINE	75
PENTOXIFYLLINE	40	PIMOZIDE	89	PMS-CARVEDILOL	50
PENTOXIFYLLINE PEN-VK	40 5	PINAVERIUM BROMIDE	126	PMS-CELECOXIB	64
PEPTAMEN 1.5 1000ML LIQ	5 173	PINDOLOL	51	PMS-CEPHALEXIN	3
PEPTAMEN 1.5 250ML LIQ	173	PIOGLITAZONE HYDROCHLORIDE	138	PMS-CETIRIZINE	1
PEPTAMEN 250ML LIQ	173	PIPERACILLIN AND TAZOBACTAM	5	PMS-CILAZAPRIL	54
PEPTAMEN JUNIOR 1.0 CAL 250ML LIQ	173	PIPERACILLIN SODIUM/TAZOBACTAM	5	PMS-CIPROFLOXACIN	6
PEPTAMEN JUNIOR 1.5 CAL 250ML LIQ	173	SODIUM	3	PMS-CITALOPRAM	81
PEPTAMEN WITH PREBIO 1000ML LIQ	173	PIPERACILLIN, TAZOBACTAM	5	PMS-CLARITHROMYCIN	4
PEPTAMEN WITH PREBIO 250ML LIQ	173	PIPERONYL BUTOXIDE, PYRETHRINS	143	PMS-CLOBAZAM	74
PEPTO BISMOL	120	PIPORTIL L4	89	PMS-CLOBETASOL	144
PEPTO-BISMOL	120	PIPOTIAZINE PALMITATE	89	PMS-CLONAZEPAM	74
PERAMPANEL	78	PIRFENIDONE	111	PMS-CLONAZEPAM-R	74
PERICHLOR	115	PIROXICAM	67	PMS-CLOPIDOGREL	39
PERICYAZINE	89	PIZOTIFEN MALATE	98	PMS-COLCHICINE	158
PERIDEX	115	PLAN B	133	PMS-CYCLOBENZAPRINE	33
PERINDOPRIL ERBUMINE	56	PLAQUENIL	15	PMS-DESMOPRESSIN	138
PERINDOPRIL ERBUMINE	56	PLASTIPAK MICRO	171	PMS-DEXAMETHASONE	115
PERINDOPRIL ERBUMINE,	56	PLAVIX	39	PMS-DIAZEPAM	94
INDAPAMIDE		PLEGRIDY	12	PMS-DICLOFENAC	65
PERMETHRIN	143	PLENDIL	52	PMS-DICLOFENAC-MISOPROSTOL	66
PERPHENAZINE	89	PLERIXAFOR	40	PMS-DILTIAZEM CD	53
PERPHENAZINE	89	PMS DESIPRAMINE	82	PMS-DIMENHYDRINATE	122
PETROLATUM, MINERAL OIL	118	PMS DEXAMETHASONE	130	PMS-DIPHENHYDRAMINE	1
PHARIXIA	116	PMS FLUPHENAZINE	87	PMS-DIVALPROEX	80
PHARMA-AMLODIPINE	51	PMS HYDROMORPHONE	69	PMS-DOMPERIDONE	126
PHARMA-CAL	107	PMS HYDROXYZINE	96	PMS-DONEPEZIL	28
PHARMA-D	153	PMS PERPHENAZINE	89	PMS-DORZOLAMIDE-TIMOLOL	117
PHARMA-ESCITALOPRAM	83	PMS PROCHLORPERAZINE	90	PMS-DOXAZOSIN	48
PHARMA-K20	108	PMS TRAZODONE	85	PMS-DOXYLAMINE-PYRIDOXINE	123
PHARMA-LACOSAMIDE	76	PMS-ABACAVIR/LAMIVUDINE	10	PMS-DULOXETINE	82
PHARMA-LACTULOSE	106	PMS-ACETAMINOPHEN	67	PMS-DUTASTERIDE	157
PHARMALGEN HONEY BEE VENOM	156	PMS-ALENDRONATE	160	PMS-EFAVIRENZ-EMTRICITABINE- TENOFOVIR	11
PHARMALGEN MIXED VESPID VENOM PROTEIN	157	PMS-AMANTADINE	10	PMS-EMTRICITABINE-TENOFOVIR	12
PHARMALGEN WASP VENOM PROTEIN	156	PMS-AMIODARONE	41	PMS-ENTECAVIR	13
PHARMALGEN WHITE FACED	156	PMS-AMITRIPTYLINE PMS-AMLODIPINE	80 51	PMS-ERLOTINIB	19
HORNET VENOM				PMS-EZETIMIBE	42
PHARMALGEN YELLOW HORNET	156	PMS-AMLODIPINE-ATORVASTATIN PMS-AMOXICILLIN	52 4	PMS-FAMCICLOVIR	13
VENOM PROTEIN		PMS-AMPHETAMINES XR	92	PMS-FENTANYL MTX	69
PHARMALGEN YELLOW JACKET	157	PMS-ANAGRELIDE	39	PMS-FERROUS SULFATE	36
VENOM PROTEIN	F7	PMS-ANASTROZOLE	16	PMS-FINASTERIDE	157
PHARMA-RAMIPRIL	57 45	PMS-ARIPIPRAZOLE	86	PMS-FINGOLIMOD	158
PHARMA-SIMVASTATIN PHARMA-TELMISARTAN	45 61	PMS-ASA EC	64	PMS-FLUCONAZOLE	9
I I II WANNE I ELIVIIOZIATEM	O I			PMS-FLUOXETINE	83

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				Non-insured nearth ben	CIILO
PMS-FLUPHENAZINE	87	PMS-OXYCODONE	71	PODOFILM	149
PMS-FLUTAMIDE	20	PMS-PAMIDRONATE	160	PODOFILOX	149
PMS-FLUTICASONE	32	PMS-PANTOPRAZOLE	125	PODOPHYLLIN	149
PROPIONATE/SALMETEROL DPI		PMS-PAROXETINE	84	PODS	167
PMS-FOSINOPRIL	55	PMS-PERINDOPRIL	56	POLISTES SPP VENOM PROTEIN	156
PMS-FUROSEMIDE	109	PMS-PINDOLOL	51	EXTRACT	
PMS-GABAPENTIN	75	PMS-PIOGLITAZONE	138	POLLEN	157
PMS-GALANTAMINE ER	29	PMS-POLYTRIMETHOPRIM	114	POLLEN AND NON POLLEN	157
PMS-GEMFIBROZIL	42	PMS-POTASSIUM	108	POLLINEX R	157
PMS-GLYBURIDE	138	PMS-PRAVASTATIN	43	POLYDERM	142
PMS-HALOPERIDOL	87	PMS-PREDNISOLONE	131	POLYETHYLENE GLYCOL	120
PMS-HYDROCHLOROTHIAZIDE PMS-HYDROMORPHONE	110	PMS-PREGABALIN	78	POLYETHYLENE GLYCOL 3350	120
	69 66	PMS-PROCHLORPERAZINE	89	POLYETHYLENE GLYCOL 3350	120
PMS-IBUPROFEN		PMS-PROGESTERONE	139	POLYETHYLENE GLYCOL 3350, SODIUM SULFATE, SODIUM	121
PMS-IMATINIB	20 30	PMS-PROPAFENONE	41	BICARBONATE, SODIUM CHLORIDE,	
PMS-IPRATROPIUM PMS-IRBESARTAN	59	PMS-PROPRANOLOL	51	POTASSIUM CHLORIDE	
PMS-IRBESARTAN-HCTZ	59 59	PMS-QUETIAPINE	90	POLYETHYLENE GLYCOL 3350,	121
PMS-ISMN	47	PMS-QUINAPRIL	56	SODIUM SULFATE, SODIUM	
PMS-ISOSORBIDE	47	PMS-RABEPRAZOLE	125	BICARBONATE, SODIUM CHLORIDE, POTASSIUM CHLORIDE, BISACODYL	
PMS-KETOPROFEN	66	PMS-RAMIPRIL	57	POLYMYXIN B SULFATE, BACITRACIN	114
PMS-LACTULOSE	106	PMS-RAMIPRIL-HCTZ	58	ZINC	114
PMS-LACTULOSE-PHARMA	106	PMS-RANITIDINE	124	POLYMYXIN B SULFATE, BACITRACIN	142
PMS-LAMOTRIGINE	77	PMS-RISEDRONATE	161	ZINC, GRAMICIDIN	
PMS-LANSOPRAZOLE	124	PMS-RISPERIDONE PMS-RIVASTIGMINE	91	POLYMYXIN B SULFATE, GRAMICIDIN	114
PMS-LATANOPROST	117		29	POLYMYXIN B SULFATE,	114
PMS-LATANOPROST-TIMOLOL	117	PMS-RIZATRIPTAN RDT PMS-ROPINIROLE	97 100	TRIMETHOPRIM SULFATE	
PMS-LEFLUNOMIDE	162	PMS-ROSUVASTATIN	44	POLYSACCHARIDE IRON COMPLEX	36
PMS-LETROZOLE	21	PMS-SALBUTAMOL	32	POLYSPORIN	114
PMS-LEVETIRACETAM	77	PMS-SENNOSIDES	32 121	POLYSPORIN ANTIBIOTIC	142
PMS-LEVOCARB	98	PMS-SERTRALINE	85	POLYSPORIN EYE AND EAR	114
PMS-LEVOFLOXACIN	6	PMS-SILDENAFIL R	47	POLYSPORIN TRIPLE	142
PMS-LIDOCAINE VISCOUS	140	PMS-SIMVASTATIN	45	POLYTOPIC	142
PMS-LISINOPRIL	55	PMS-SODIUM CROMOGLYCATE	112	POLYTRIM	114
PMS-LITHIUM CARBONATE	96	PMS-SOLIFENACIN	150	POLYVINYL ALCOHOL	118
PMS-LITHIUM CITRATE	96	PMS-SOTALOL	51	POMALIDOMIDE	24
PMS-LOPERAMIDE	120	PMS-SULFASALAZINE	7	POMALYST	24
PMS-LORAZEPAM	95	PMS-SUMATRIPTAN	97	PONATINIB HYDROCHLORIDE	24
PMS-LOSARTAN	60	PMS-TELMISARTAN-HCTZ	61	PONSTAN	66
PMS-LOSARTAN-HCTZ	60	PMS-TENOFOVIR	12	PORTIA 20	132
PMS-LOVASTATIN	43	PMS-TERAZOSIN	48	PORTIA 28	132
PMS-MELOXICAM	66	PMS-TERBINAFINE	8	POTASSIUM CHLORIDE	108
PMS-METFORMIN	134	PMS-TESTOSTERONE	132	POTASSIUM CITRATE POTASSIUM CITRATE	106 108
PMS-METHOTREXATE	22	PMS-TETRABENAZINE	102	POVIDONE-IODINE	143
PMS-METHYLPHENIDATE	93	PMS-TIAPROFENIC	67	PRADAXA	37
PMS-METOPROLOL-B	50	PMS-TIMOLOL	117	PRALUENT	46
PMS-METOPROLOL-L	50	PMS-TOPIRAMATE	80	PRAMIPEXOLE	99
PMS-MIRTAZAPINE	84	PMS-TRANDOLAPRIL	58	PRAMIPEXOLE DIHYDROCHLORIDE	99
PMS-MOCLOBEMIDE	84	PMS-TRAZODONE	85	PRAVACHOL	43
PMS-MOMETASONE	146	PMS-TRIHEXYPHENIDYL	98	PRAVASTATIN	43
PMS-MONTELUKAST	112	PMS-URSODIOL	121	PRAVASTATIN SODIUM	43
PMS-MOXIFLOXACIN	114	PMS-VALACYCLOVIR	13	PRAVASTATIN-10	43
PMS-NABILONE	123	PMS-VALPROIC ACID	80	PRAVASTATIN-20	43
PMS-NAPROXEN	66	PMS-VANCOMYCIN	8	PRAVASTATIN-40	44
PMS-NAPROXEN EC	67	PMS-VENLAFAXINE XR	86	PRAXIS ASA DAILY LOW DOSE	64
PMS-NIFEDIPINE	53	PMS-VERAPAMIL SR	54	PRAZOSIN HYDROCHLORIDE	48
PMS-NITROFURANTOIN	15	PMS-ZOLMITRIPTAN	97	PRECISION XTRA	105
PMS-NIZATIDINE	123	PMS-ZOLMITRIPTAN ODT	98	PRED FORTE	115
PMS-NYSTATIN	9	POCKET CHAMBER	167	PRED MILD	115
PMS-OLANZAPINE	88	POCKET CHAMBER WITH ADULT	167	PREDNISOLONE ACETATE	115
PMS-OLANZAPINE ODT	89 61	POCKET CHAMBER WITH INFANT	167	PREDNISOLONE ACETATE,	115
PMS-OLMESARTAN PMS-OMEPRAZOLE	61 125	MASK POCKET CHAMBER WITH MEDIUM	167	SULFACETAMIDE SODIUM	
PMS-ONDANSETRON	123	MASK	101	PREDNISOLONE SODIUM PHOSPHATE	115
PMS-OXYBUTYNIN	150	POCKET CHAMBER WITH SMALL MASK	167	PREDNISOLONE/SULFACETAMIDE	115
I WIO OXIDOTITIIII	130				

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				Non-insured Health Ben	ents
PREDNISONE	131	PROCYCLIDINE HYDROCHLORIDE	98	QUICK-SET 9MMX23 TUBING	168
PREDNISONE ORAL LIQUID	131	PROCYTOX	18	QUICK-SET 9MMX32	168
PREGABALIN	78	PRO-ENALAPRIL	54	QUICK-SET 9MMX43 TUBING	168
PREGABALIN	78	PRO-FLUCONAZOLE	9	QUINAGOLIDE (QUINAGOLIDE	156
PREMARIN	133	PRO-FLUOXETINE	83	HYDROCHLORIDE)	
PRENATAL AND POSTPARTUM	154	PRO-GABAPENTIN	75	QUINAPRIL	56
VITAMINS AND MINERALS		PROGESTERONE	139	QUINAPRIL, HYDROCHLOROTHIAZIDE	57
PREVACID	124	PROGLYCEM	47	QUINSAIR	6
PREVACID FASTAB	124	PROGRAF	165	QVAR	130
PREVEX HC	146	PRO-INDAPAMIDE	110	R & C SHAMPOO WITH CONDITIONER	143
PREZIOTA	10	PRO-ISMN	47	RABEPRAZOLE	125
PREZISTA	10 15	PRO-LEVETIRACETAM	77	RABEPRAZOLE CODUM	125
PRIMAQUINE PRIMAQUINE PHOSPHATE	15 15	PRO-LEVETIRACETAM 250	77	RABEPRAZOLE SODIUM	125
PRIMAQUINE PROSPRATE PRIMIDONE	74	PRO-LEVOCARB	98	RALOXIFENE HYDROCHLORIDE	134
PRIMIDONE	74 74	PROLIA	160	RALTEGRAVIR POTASSIUM	11 57
PRINIVIL	55	PRO-LISINOPRIL	55	RAMIPRIL	57 57
PRIVA-AMITRIPTYLINE	80	PROLOPA	98	RAMIPRIL HYDROCHI ODOTHIAZIDE	57 57
PRIVA-AMLODIPINE	51	PRO-LORAZEPAM	95	RAMIPRIL, HYDROCHLOROTHIAZIDE RAN-ALENDRONATE	5 <i>1</i> 160
PRIVA-AMEODIFINE PRIVA-ATORVASTATIN	42	PRO-METFORMIN	134	RAN-AMLODIPINE	51
PRIVA-CELECOXIB	64	PROMETRIUM	139	RAN-ANASTROZOLE	16
PRIVA-CETIRIZINE	1	PRO-MIRTAZAPINE	84	RAN-BICALUTAMIDE	17
PRIVA-CIPROFLOXACIN	6	PRO-NAPROXEN	67 144	RAN-CARVEDILOL	50
PRIVA-DOMPERIDONE	126	PROPAGENONE		RAN-CELECOXIB	64
PRIVA-ESCITALOPRAM	83	PROPAGENONE LIVERGOUL ORIDE	41	RAN-CITALO	81
PRIVA-EZETIMIBE	42	PROPAFENONE HYDROCHLORIDE	41	RAN-CLARITHROMYCIN	4
PRIVA-FLUCONAZOLE	9	PRO-PIOGLITAZONE	138	RAN-CYPROTERONE/ETHINYL	166
PRIVA-FLUOXETINE	83	PROPIVERINE HYDROCHLORIDE	150	ESTRADIOL	100
PRIVA-GABAPENTIN	75	PROPRANCIAL LIVERSALL OF THE	51	RAN-DOMPERIDONE	126
PRIVA-MONTELUKAST	112	PROPRANOLOL OPAL LIGHT	51	RAN-DULOXETINE	82
PRIVA-PANTOPRAZOLE	125	PROPRANOLOL ORAL LIQUID	51	RAN-ENALAPRIL	54
PRIVA-PAROXETINE	84	PRO-QUETIAPINE PRO-RABEPRAZOLE	90 125	RAN-ESCITALOPRAM	83
PRIVA-PERINDOPRIL ERBUMINE	56	PRO-RAMIPRIL	125 57	RAN-EZETIMIBE	42
PRIVA-PRAVASTATIN	43	PRO-RISPERIDONE	91	RAN-FINASTERIDE	157
PRIVA-QUETIAPINE	90	PROSCAR	157	RAN-FLUOXETINE	83
PRIVA-RAMIPRIL	57	PRO-SOTALOL	51	RAN-FOSINOPRIL	55
PRIVA-ROSUVASTATIN	44	PROSTIGMIN	29	RAN-GABAPENTIN	75
PRIVA-SERTRALINE	85	PROTOPIC	149	RAN-GLICLAZIDE	138
PRIVA-SIMVASTATIN	45	PRO-TOPIRAMATE	80	RANIBIZUMAB	118
PRIVA-VALACYCLOVIR	13	PROTRIN DF	7	RAN-IRBESARTAN HCTZ	59
PRO AMOX	5	PRO-VALACYCLOVIR	13	RANITIDINE	124
PRO-AAS	64	PROVERA	139	RANITIDINE (QC)	124
PRO-AMIODARONE	41	PROZAC	83	RANITIDINE HCL	124
PRO-AMOX	5	PSYLLIUM MUCILLOID	121	RANITIDINE HYDROCHLORIDE	124
PRO-AZITHROMYCINE	4	PULMICORT NEBUAMP	130	RAN-LETROZOLE	21
PRO-BICALUTAMIDE	17	PULMICORT TURBUHALER	130	RAN-LEVETIRACETAM	77
PRO-BISOPROLOL	49	PULMOPHYLLINE	151	RAN-LISINOPRIL	55
PROBUPHINE	72	PURAMINO A+ 400G PDR	174	RAN-METFORMIN	134
PROCAINAMIDE HYDROCHLORIDE	41	PURAMINO A+ JUNIOR 400G PDR	174	RAN-MONTELUKAST	112
PROCAL 500	107	PURATHICK 125G PDR	174	RAN-NABILONE	123
PROCALD 400	107	PURG-ODAN	120	RAN-OLANZAPINE	88
PROCAN SR	41	PURINETHOL	21	RAN-OLANZAPINE ODT	89
PROCARBAZINE HYDROCHLORIDE	24	PYRANTEL PAMOATE	2	RAN-OMEPRAZOLE	125
PRO-CEFADROXIL	2	PYRAZINAMIDE	9	RAN-ONDANSETRON	123
PRO-CEFUROXIM	3	PYRIDIUM	146	RAN-PANTOPRAZOLE	125
PROCHLORAZINE	89	PYRIDOSTIGMINE BROMIDE	29	RAN-PIOGLITAZONE	138
PROCHLORPERAZINE	89	PYRIDOXINE HYDROCHLORIDE	152	RAN-PRAVASTATIN	43
PROCHLORPERAZINE MALEATE	89	QUETIAPINE	90	RAN-QUETIAPINE	90
PROCHLORPERAZINE MESYLATE	90	QUETIAPINE FUMARATE	90	RAN-RABEPRAZOLE	125
PRO-CIPROFLOXACIN	6	QUETIAPINE XR	90	RAN-RANITIDINE	124
PRO-CLONAZEPAM	74	QUICK-SET 6MMX18	168	RAN-RISPERIDONE	91
PROCTODAN-HC	145	QUICK-SET 6MMX23 TUBING	168	RAN-ROPINIROLE	100
PROCTOL	145	QUICK-SET 6MMX32	168	RAN-SERTRALINE	85
PROCTOSEDYL	145	QUICK-SET 6MMX43 TUBING	168	RAN-TOPIRAMATE	80
				RAPAMUNE	165

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				Non-insured nearth ben	CIILO
RAPID-D 10MM/110CM	168	REVIA	74	RIVA-FINASTERIDE	157
RAPID-D 10MM/60CM	168	REVLIMID	20	RIVA-FLUCONAZOLE	9
RAPID-D 10MM/80CM	168	REXULTI	87	RIVA-FLUOXETINE	83
RAPID-D 6MM/110CM	168	REYATAZ	10	RIVA-FLUVOX	83
RAPID-D 6MM/60CM	168	RHINARIS NASAL	118	RIVA-GABAPENTIN	75
RAPID-D 6MM/80CM	168	RHINARIS NASAL MIST	118	RIVA-HC	145
RAPID-D 8MM/110CM	168	RHINARIS-CS	112	RIVA-K 20	108
RAPID-D 8MM/60CM	168	RHINOCORT AQUA	115	RIVA-K 8	108
RAPID-D 8MM/80CM	168	RHO-NITRO PUMPSPRAY	47	RIVA-LABETALOL	50
RATIO-AMCINONIDE	144	RIBAVIRIN	14	RIVA-LANSOPRAZOLE	124
RATIO-ECTOSONE	144	RIBOCICLIB (RIBOCICLIB SUCCINATE)	24	RIVA-LATANOPROST	117
RATIO-FLUTICASONE	115	RIDAURA	128	RIVA-LETROZOLE	21
RATIO INDATEORIUM	145 30	RIFABUTIN	10	RIVA-LEVETIRACETAM	77 120
RATIO-IPRATROPIUM RATIO-LACTULOSE	106	RIFADIN RIFAMPIN	10 10	RIVA-LOPERAMIDE RIVA-METFORMIN	134
RATIO-LACTOLOGE RATIO-LENOLTEC NO 2	67	RIFAMPIN ORAL LIQUID	10	RIVA-METOPROLOL L	50
RATIO-LENOLTEC NO 2 RATIO-LENOLTEC NO 3	67	RIFAXIMIN RIFAXIMIN	8	RIVA-MONTELUKAST	112
RATIO-METFORMIN	134	RILPIVIRINE HYDROCHLORIDE	12	RIVA-MOXIFLOXACIN	7
RATIO-NYSTATIN	143	RIOCIGUAT	112	RIVA-OLANZAPINE	88
RATIO-TAMSULOSIN	33	RISANKIZUMAB	149	RIVA-OMEPRAZOLE DR	125
RATIO-TOPISALIC	144	RISEDRONATE	160	RIVA-OXYBUTYNIN	150
REACTINE	1	RISEDRONATE SODIUM	160	RIVA-PANTOPRAZOLE	125
REBIF	159	RISEDRONATE SODIUM	160	RIVA-PAROXETINE	84
REDDY-ATORVASTATIN	42	(RISEDRONATE SODIUM	100	RIVA-PERINDOPRIL	56
REDDY-CINACALCET	165	HEMIPENTAHYDRATE)		RIVA-PREGABALIN	78
REDDY-PROGESTERONE	139	RISEDRONATE-35	160	RIVA-QUETIAPINE	90
REFRESH CELLUVISC	118	RISPERDAL	91	RIVA-RANITIDINE	124
REFRESH LACRI-LUBE	118	RISPERDAL CONSTA	92	RIVA-RISEDRONATE	161
REFRESH LIQUIGEL	118	RISPERIDONE	91	RIVA-RISPERIDONE	91
REFRESH PLUS	118	RISPERIDONE	91	RIVA-ROSUVASTATIN	44
REFRESH TEARS	118	RISPERIDONE (CONSTA)	92	RIVAROXABAN	38
REFUSAL TO FILL	173	RITONAVIR	12	RIVAROXABAN (10)	38
REGORAFENIB	24	RITUXAN	25	RIVAROXABAN (CAD,PAD)	38
RELAXA	121	RITUXIMAB	25	RIVASA	64
REMERON	84	RIVA CENINA	95 121	RIVASA EC	64
REMERON RD	84	RIVA ALENDRONATE	121	RIVA-SERTRALINE	85
REMICADE	162	RIVA-ALENDRONATE RIVA-AMIODARONE	160 41	RIVASOL-HC	145
RENAGEL	109	RIVA-AMLODIPINE	51	RIVASONE	144
RENFLEXIS	162	RIVA-ANASTROZOLE	16	RIVA-SOTALOL	51
RENVELA	109 137	RIVA-ARIPIPRAZOLE	86	RIVASTIGMINE	29
REPAGLINIDE REPAGLINIDE	137 137	RIVA-ATENOLOL	49	RIVASTIGMINE HYDROGEN TARTRATE	29 8
REPATHA	46	RIVA-ATOMOXETINE	100	RIVA-TERBINAFINE RIVA-VALACYCLOVIR	o 13
RESERVOIR PARADIGM 5X1.8ML	168	RIVA-ATORVASTATIN	42	RIVA-VALACTOLOVIK RIVA-VENLAFAXINE XR	86
RESERVOIR PARADIGM 7X3.0ML	168	RIVA-AZITHROMYCIN	4	RIVOTRIL	74
RESONIUM CALCIUM	108	RIVA-BACLOFEN	33	RIZATRIPTAN BENZOATE	96
RESOURCE 2.0 237ML LIQ	173	RIVA-BISOPROLOL	49	RIZATRIPTAN ODT	97
RESOURCE DIABETIC 1.5L	173	RIVA-CAL D	107	RIZATRIPTAN RDT	97
RESOURCE DIABETIC 250ML LIQ	173	RIVA-CELECOX	64	ROCALTROL	153
RESOURCE JUST KIDS 1.5 CAL 237ML	173	RIVA-CIPROFLOXACIN	6	ROFACT	10
LIQ		RIVA-CITALOPRAM	81	ROLENE	144
RESOURCE THICKEN CLEAR	174	RIVA-CLARITHROMYCIN	4	ROPINIROLE	100
RESOURCE THICKEN CLEAR 125G	174	RIVA-CLINDAMYCIN	7	ROPINIROLE HYDROCHLORIDE	100
RESOURCE THICKEN UP 6.4G	174	RIVA-CLONAZEPAM	74	ROSONE	144
RESPICHAMBER SILICONE MEDIUM	167	RIVA-CLOPIDOGREL	39	ROSUVASTATIN	44
MASK	407	RIVACOCET	68	ROSUVASTATIN CALCIUM	44
RESPICHAMBER SILICONE SMALL MASK	167	RIVA-CYCLOBENZAPRINE	33	ROTIGOTINE	100
RESPICHAMBER VHC W MOUTHPIECE	167	RIVA-CYPROTERONE	165	ROUGIER-MAGNESIUM	108
RESTORALAX	121	RIVA-D	153	RUFINAMIDE	79
RESTORIL	95	RIVA-DAPSONE	10	RUGBY NICOTINE POLACRILEX GUM	34
RESULTZ	143	RIVA-DORZOLAMIDE/TIMOLOL	117	RUXOLITINIB	25
RETIN-A	146	RIVA-DULOXETINE	82	RYDAPT	22
RETROVIR	12	RIVA-DUTASTERIDE	157	RYTHMODAN	41
REVATIO	47	RIVA-ENALAPRIL	54	RYTHMOL	41
		RIVA-ESCITALOPRAM	83		

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				Non-insured nealth ber	ents
S.O.S NALOXONE HYDROCHLORIDE	74	SANDOZ DORZOLAMIDE/TIMOLOL	117	SANDOZ PERINDOPRIL ERBUMINE/	56
SABRIL	80	SANDOZ DULOXETINE	82	INDAPAMIDE HD SANDOZ PIOGLITAZONE	138
SALAGEN	29	SANDOZ DUTASTERIDE	157	SANDOZ PIOGLITAZONE SANDOZ POLYTRIMETHOPRIM	114
SALAMOL CFC-FREE	32 7	SANDOZ EFAVIRENZ/EMTRICITABINE/TENOFOVI	11	SANDOZ PRAMIPEXOLE	99
SALAZOPYRIN SALAZOPYRIN EN	7 7	R		SANDOZ PRAVASTATIN	43
SALBUTAMOL (QC)	32	SANDOZ ENALAPRIL	54	SANDOZ PREDNISOLONE	115
SALBUTAMOL (QC) SALBUTAMOL ALDO-UNION (ON)	32	SANDOZ ENTACAPONE	98	SANDOZ PREGABALIN	78
SALBUTAMOL HFA	32	SANDOZ ESCITALOPRAM	83	SANDOZ PROCHLORPERAZINE	89
SALBUTAMOL SULFATE	32	SANDOZ ESTRADIOL DERM	134	SANDOZ PROCTOMYXIN HC	145
SALICYLIC ACID	147	SANDOZ EZETIMIBE	42	SANDOZ QUETIAPINE	90
SALICYLIC ACID IN CORTICOSTEROID	144	SANDOZ FAMCICLOVIR	13	SANDOZ QUETIAPINE XRT	90
CREAM		SANDOZ FELODIPINE	53	SANDOZ RABEPRAZOLE	125
SALICYLIC ACID IN NON-MEDICATED	144	SANDOZ FENOFIBRATE S	42	SANDOZ RAMIPRIL	57
OINTMENT	440	SANDOZ FENOFIBRATE S SANDOZ FENTANYL	42 69	SANDOZ RANITIDINE	124
SALICYLIC ACID, FLUOROURACIL SALINEX	149 118	SANDOZ FENTANTL SANDOZ FINASTERIDE	157	SANDOZ REPAGLINIDE	137
SALMETEROL XINAFOATE	32	SANDOZ FINGOLIMOD	158	SANDOZ RISEDRONATE	161
SALMETEROL XINAFOATE.	32	SANDOZ FLUOROMETHOLONE	115	SANDOZ RIVASTICMINE	91
FLUTICASONE PROPIONATE	02	SANDOZ FLUOXETINE	83	SANDOZ RIVASTIGMINE SANDOZ RIZATRIPTAN ODT	29 97
SALOFALK	126	SANDOZ FOLIC ACID	152	SANDOZ ROSUVASTATIN	44
SANDOMIGRAN	98	SANDOZ GEFITINIB	20	SANDOZ ROGOVASTATIN SANDOZ SERTRALINE	85
SANDOMIGRAN DS	98	SANDOZ GLICLAZIDE MR	138	SANDOZ SIMVASTATIN	45
SANDOSTATIN	156	SANDOZ HYDROCORTISONE	145	SANDOZ SOLIFENACIN	150
SANDOSTATIN LAR	155	SANDOZ INDOMETHACIN	66	SANDOZ SUMATRIPTAN	97
SANDOZ ALENDRONATE	160	SANDOZ IRBESARTAN	59	SANDOZ TACROLIMUS	165
SANDOZ	160	SANDOZ IRBESARTAN HCT	59	SANDOZ TAMSULOSIN	33
ALENDRONATE/CHOLECALCIFEROL SANDOZ ALFUZOSIN	33	SANDOZ LACOSAMIDE	76	SANDOZ TELMISARTAN	61
SANDOZ ALFOZOSIN SANDOZ ALMOTRIPTAN	96	SANDOZ LANSOPRAZOLE	124	SANDOZ TELMISARTAN HCT	61
SANDOZ ALMOTKII TAN SANDOZ AMIODARONE	41	SANDOZ LATANOPROST	117	SANDOZ TIMOLOL	117
SANDOZ AMLODIPINE	51	SANDOZ LATANOPROST/TIMOLOL	117	SANDOZ TOBRAMYCIN	114
SANDOZ AMOXI-CLAV	5	SANDOZ LETROZOLE	162	SANDOZ TOLTERODINE LA	150
SANDOZ AMPHETAMINE XR	92	SANDOZ LETROZOLE SANDOZ LEVETIRACETAM	21 77	SANDOZ TOPIRAMATE	80
SANDOZ ANAGRELIDE	39	SANDOZ LEVOFLOXACIN	6	SANDOZ TRANDOLAPRIL	58
SANDOZ ANASTROZOLE	16	SANDOZ LINEZOLID	8	SANDOZ TRAVORROST / TIMOLOL RO	118
SANDOZ ANUZINC HC	145	SANDOZ LISINOPRIL	55	SANDOZ TRAVOPROST / TIMOLOL PQ SANDOZ VALACYCLOVIR	118 13
SANDOZ ANUZINC HC PLUS	145	SANDOZ LISINOPRIL HCT	56	SANDOZ VALACTOLOVIK SANDOZ VALSARTAN	61
SANDOZ ARIPIPRAZOLE	86	SANDOZ LOSARTAN	60	SANDOZ VALSARTAN HCT	62
SANDOZ ATOMOXETINE	100	SANDOZ LOSARTAN HCT	60	SANDOZ VENLAFAXINE XR	86
SANDOZ ATORVASTATIN	42	SANDOZ METFORMIN	135	SANDOZ VORICONAZOLE	9
SANDOZ AZITHROMYCIN	3	SANDOZ METFORMIN FC	134	SANDOZ ZOLMITRIPTAN	98
SANDOZ BOSENTAN	49 48	SANDOZ METHADONE	70	SANDOZ ZOLMITRIPTAN ODT	98
SANDOZ BOSENTAN SANDOZ BRIMONIDINE	116	SANDOZ METHYLPHENIDATE SR	93	SANDOZ-CARBAMAZEPINE	75
SANDOZ BUPROPION SR	81	SANDOZ METOPROLOL SR	50	SANDOZ-DICLOFENAC	65
SANDOZ CANDESARTAN	58	SANDOZ MIRTAZAPINE	84	SANDOZ-DICLOFENAC SR	65
SANDOZ CANDESARTAN PLUS	59	SANDOZ MONTELLIKACI	115	SANDOZ-FELODIPINE	53
SANDOZ CAPECITABINE	17	SANDOZ MONTELUKAST SANDOZ MORPHINE SR	111 71	SANTYL	148
SANDOZ CEFPROZIL	2	SANDOZ MORPHINE SK SANDOZ MOXIFLOXACIN	71	SAPHRIS	87
SANDOZ CINACALCET	165	SANDOZ MYCOPHENOLATE	164	SAQUINAVIR MESYLATE	12
SANDOZ CIPROFLOXACIN	6	SANDOZ NARATRIPTAN	96	SARILUMAB SARNA HC	162
SANDOZ CITALOPRAM	81	SANDOZ OLANZAPINE	88	SAXAGLIPTIN HYDROCHLORIDE	146 135
SANDOZ CLARITHROMYCIN	4	SANDOZ OLANZAPINE ODT	89	SAXAGLIPTIN HYDROCHLORIDE,	135
SANDOZ CLOPIDOGREL	39	SANDOZ OLMESARTAN	61	METFORMIN HYDROCHLORIDE	133
SANDOZ COLCHICINE	158	SANDOZ OLOPATADINE	114	SDZ CELECOXIB	64
SANDOZ CYCLOSPORINE	164	SANDOZ OMEPRAZOLE	125	SEASONALE	132
SANDOZ DICLOFENAC MISODROSTOL	153	SANDOZ ONDANSETRON	123	SEASONIQUE	133
SANDOZ DICLOFENAC OBJETIJA	66 116	SANDOZ	68	SEBCUR	147
SANDOZ DICLOFENAC OPHTHA SANDOZ DILTIAZEM CD	116 53	OXYCODONE/ACETAMINOPHEN	405	SEBCUR-T	147
SANDOZ DILTIAZEM CD SANDOZ DILTIAZEM T	53 53	SANDOZ PERINDORRII, ERRI IMINE	125	SECARIS	118
SANDOZ DIMENHYDRINATE	122	SANDOZ PERINDOPRIL ERBUMINE SANDOZ PERINDOPRIL ERBUMINE/	56 56	SECUKINUMAB	149
SANDOZ DONEPEZIL	28	INDAPAMIDE	30	SEEBRI BREEZHALER	30
SANDOZ DORZOLAMIDE	117			SELECT 1/35 (21-DAY)	132
				SELECT 1/35 (28-DAY)	132

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				Non-insured Health Ber	CIIC
SELEGILINE HYDROCHLORIDE	100	SIMVASTATIN-80	45	SPIRIT TEST STRIP (ON)	105
SELENIUM SULFIDE	143	SINECATECHINS	142	SPIRIVA	30
SELEXIPAG	113	SINEMET	98	SPIRIVA RESPIMAT	30
SEMAGLUTIDE	136	SINEQUAN	82	SPIRONOLACTONE	63
SENNA	121	SINGULAIR	111	SPIRONOLACTONE ORAL LIQUID	63
SENNA LAXATIVE	121	SINTROM	36	SPIRONOLACTONE,	110
SENNA SENNOSIDES	121	SIROLIMUS	165	HYDROCHLOROTHIAZIDE	•
SENNA SENNOSIDES NATURALS	121	SITAGLIPTIN PHOSPHATE	135	SPORANOX	9 99
SENNACE	121	MONOHYDRATE SITAGLIPTIN PHOSPHATE	135	STALEVO STATEX	99 70
SENNALAX	121	MONOHYDRATE, METFORMIN	135	STELARA	70 156
SENNAPREP	121	HYDROCHLORIDE		STERILE EXTEMPORANEOUS	155
SENNOSIDES	121	SiteSmart Coloured Pen Needles	170	MIXTURE (QC)	133
SENNOSIDES	121	32GX4MM		STERILE WATER	110
SENOKOT	121	SKIN PREP ADHESHIVE WIPES	167	STERILE WATER PF	174
SENSIPAR	165	SKYRIZI	149	STEROID AND ANTIFUNGAL CREAM	155
SEPTA AMI ODIDINE	28	SLOWK	108	STIEVA-A	146
SEPTA ATENOLOGY	51	SN IV3000 1-HAND TRANS	167	STIVARGA	24
SEPTA-ATENOLOL	49	SODIUM AUROTHIOMALATE	128	STRATTERA	100
SEPTA-CITAL ORDAM	6	SODIUM AUROTHIOMALATE	128	STRESSTABS FOR WOMEN	154
SEPTA-CITALOPRAM	81	SODIUM BICARBONATE	106	STRIBILD	12
SEPTA-LOSARTAN	60	SODIUM BICARBONATE	120	STROMECTOL	2
SEPTA-LOSARTAN HCTZ	60	SODIUM CARBOXYMETHYL	118	SUBLOCADE	68
SEPTA-METFORMIN	134	CELLULOSE		SUBOXONE	72
SEPTA-ONDANSETRON SEPTA-ZOLMITRIPTAN-ODT	123	SODIUM CHLORIDE	108	SUCRALFATE	124
	98	SODIUM CHLORIDE	108	SULCRATE	124
SERC	101	SODIUM CHLORIDE (SMALL VOL.)	108	SULCRATE PLUS	124
SEREVENT DISKUS	32	SODIUM CHLORIDE 1G	108	SULFAMETHOXAZOLE,	7
SEROQUEL VP	90	SODIUM PHOSPHATE	121	TRIMETHOPRIM	
SEROQUEL XR	90	SODIUM POLYSTYRENE SULFONATE	108	SULFASALAZINE	7
SERTRALINE	85 85	SOFOSBUVIR	14	SULFATRIM	7
SERTRALINE HYDROCHLORIDE	85 05	SOFOSBUVIR, LEDIPASVIR	14	SULFATRIM DS	7
SERTRALINE-100	85 05	SOFOSBUVIR, VELPATASVIR	14	SULFATRIM PEDIATRIC	7
SERTRALINE-25	85	SOFOSBUVIR, VELPATASVIR,	15	SULFINPYRAZONE	110
SERTRALINE-50	85	VOXILAPREVIR	115	SULFINPYRAZONE	110
SEVELAMER CARBONATE	109	SOFRACORT EAR/EYE SOLIFENACIN	115 150	SULFUR IN NON-MEDICATED CREAM	155
SEVELAMER HYDROCHLORIDE	109	SOLIFENACIN SUCCINATE	150 150	SULFUR IN NON-MEDICATED	155
SHARPS CONTAINER	170	SOLIQUA SOLIQUA	136	OINTMENT	
SHARPS NESTABLE YELLOW LARGE 22.7L	170	SOLUCAL	107	SULINDAC	67
SIALOR	118	SOLUCAL D	107	SUMATRIPTAN	97
SIDEKICK	105	SOLUCAL D CITRUS	107	SUMATRIPTAN DF	97
SILDENAFIL CITRATE	47	SOLUCAL DICTRUS SOLUCAL DIFORT	107	SUMATRIPTAN HEMISULFATE	97
SILIQ	148	SOLUCAL D FORT CITRUS	107	SUMATRIPTAN SUCCINATE	97
SILVER SULFADIAZINE	144	SOLUCAL D FORT GREEN APPLE	107	SUNITINIB MALATE	26
SIMBRINZA	117	SOLUCAL D RASPBERRY	107	SUPER-FINE MICRO 31G-5MM NEEDLE	170
SIMILAC ALIMENTUM 237ML LIQ	174	SOLUCAL GREEN APPLE	107	SUPER-FINE STANDARD 29G-12.7MM	169
SIMILAC ALIMENTUM 400G PDR	174	SOLUCAL RASPBERRY	107	SUPER-FINE XTRA 31G-8MM NEEDLE	170
SIMILAC ALIMENTUM 945ML LIQ	174	SOLU-CORTEF ACT-O-VIAL	130	SUPEUDOL	71
SIMILAC LOWER IRON 850G PDR	174	SOLU-MEDROL	131	SUPRAX	2
SIMILAC NEOSURE 363G PDR	174	SOLUVER	147	SUPREFACT	17
SIMILAC PM 60/40 450G PDR	174	SOLUVER PLUS	147	SUPREFACT (NASAL)	17
SIMPLY THICK 64OZ BOTTLE PUMP	174	SOLYSTAT	108	SUPREFACT DEPOT 2 MONTHS	17
SIMPLY THICK HONEY	174	SOMATULINE AUTOGEL	166	SUPREFACT DEPOT 3 MONTHS	17
SIMPLY THICK HONEY 12G PDR	174	SOOTHE NIGHT TIME	118	SURE STEP	105
SIMPLY THICK HONEY 200G	174	SORBITOL, SODIUM CITRATE,	121	SURECOMFORT 1/2 IN 28GX0.5CC	171
SIMPLY THICK NECTAR	174	SODIUM LAURYL SULFOACETATE	121	SURECOMFORT 1/2 IN 28GX1CC SYRINGE	171
SIMPLY THICK NECTAR 200G	174	SORIATANE	147	SURECOMFORT 1/2 IN 29GX0.3CC	171
SIMPLY THICK NECTAR 6G PDR	174	SOTALOL HYDROCHLORIDE	51	SURECOMFORT 1/2 IN 29GX0.3CC SURECOMFORT 1/2 IN 29GX0.5CC	171
SIMPONI	162	SOTALOL ORAL LIQUID	51	SURECOMFORT 1/2 IN 29GX0.5CC SURECOMFORT 1/2 IN 29GX1CC	
SIMVASTATIN	45	SOURCE THICKEN UP 227G PDR	174	SURECOMFORT 1/2 IN 29GX1CC SURECOMFORT 1/2 IN 30GX0.3CC	171 171
SIMVASTATIN	45	SOVALDI	14	SURECOMFORT 1/2 IN 30GX0.3CC SURECOMFORT 1/2 IN 30GX0.5CC	171
SIMVASTATIN-10	45	SPACER DEVICE	167	SURECOMFORT 1/2 IN 30GX0.5CC SURECOMFORT 1/2 IN 30GX1CC	
SIMVASTATIN-10 SIMVASTATIN-20	45	SPECTRO ACNECARE WASH	147		171 160
SIMVASTATIN-20 SIMVASTATIN-40	45	SPECTRO ECZEMACARE	145	SURECOMFORT 29GX1/2 NEEDLE SURECOMFORT 30GX5/16 NEEDLE	169 160
			• •	SUNECUMIFUR 1 SUGAS/ 10 NEEDLE	169

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				Non-insured nearth bei	ents
SURECOMFORT 31GX3/16 NEEDLE	169	TARO-	144	TENDER-2 17MM/60CM	168
SURECOMFORT 31GX5/16 NEEDLE	169	CLOTRIMAZOLE/BETAMETHASONE		TENDER-2 17MM/80CM	168
SURECOMFORT 32GX1/4 NEEDLE	169	DIPROPIONATE		TENDER-2 MINI INF SET 13MM/110CM	168
SURECOMFORT 32GX5/32 NEEDLE	169	TARO-DICLOFENAC	65	TENDER-2 MINI INFSET 13MM/60CM	168
SURECOMFORT 5/16 IN 30GX0.3CC	171	TARO-DIPYRIDAMOLE/ ASA	48	TENDER-2 MINI INFSET 13MM/80CM	168
SURECOMFORT 5/16 IN 30GX0.5CC	171	TARO-DONEPEZIL	28	TENOFOVIR DISOPROXIL FUMARATE	12
SURECOMFORT 5/16 IN 30GX1CC	171	TARO-ENALAPRIL	54	TENOFOVIR DISOPROXIL FUMARATE,	12
SURECOMFORT 5/16 IN 31GX0.3CC	171	TARO-FINGOLIMOD	158	EMTRICITABINE	•-
SURECOMFORT 5/16 IN 31GX0.5CC	171	TARO-FLUCONAZOLE	9	TENOFOVIR DISOPROXIL FUMARATE,	12
SURECOMFORT 5/16 IN 31GX1CC	171	TARO-GLICLAZIDE MR	138	EMTRICITABINE, COBICISTAT,	
SURETEST (ON)	105	TARO-IMIQUIMOD PUMP	148	ELVITEGRAVIR	
SUSTIVA	10	TARO-IRBESARTAN	59	TENOFOVIR DISOPROXIL FUMARATE,	12
SUTENT	26	TARO-LANSOPRAZOLE	124	EMTRICITABINE, RILPIVIRINE	
SYMBICORT 100 TURBUHALER	31	TARO-MOMETASONE	146	HYDROCHLORIDE TENORETIC	49
SYMBICORT 200 TURBUHALER	31	TARO-MUPIROCIN	142		
SYNALAR	145	TARO-PHENYTOIN	74	TENORMIN	49
SYNAREL	134	TARO-PREGABALIN	78	TERAZOSIN	48
		TARO-RAMIPRIL	57	TERAZOSIN HYDROCHLORIDE	48
SYNJARDY SYNJRUASIC 24	137	TARO-RAMIPRIL HCTZ	57	TERBINAFINE	8
SYNPHASIC 21	133	TARO-ROSUVASTATIN	44	TERBINAFINE HYDROCHLORIDE	8
SYNPHASIC 28	133	TARO-SIMVASTATIN	45	TERBUTALINE SULFATE	32
SYNTHROID	139	TARO-SOLIFENACIN	150	TERCONAZOLE	143
SYRINGE & NEEDLE	170	TARO-SONE	144	TERIFLUNOMIDE	159
SYRINGE CASE	172	TARO-SUMATRIPTAN	97	TESTIM	131
SYRINGE SCALE MAGNIFIER	169	TARO-TEMOZOLOMIDE	26	TESTOSTERONE (TOPICAL)	131
SYSTANE	119	TARO-TERCONAZOLE	143	TESTOSTERONE CYPIONATE	132
T : SLIM X2 CARTRIDGE (SK)	168	TARO-TESTOSTERONE	131	TESTOSTERONE CYPIONATE	132
T/ THERAPEUTIC SHAMPOO EXTRA	147	TARO-VALSARTAN	61	TESTOSTERONE ENANTHATE	132
STRENGTH		TARO-VALGARTAN TARO-VENLAFAXINE XR	86	TESTOSTERONE UNDECANOATE	132
TACROLIMUS (PROTOPIC)	149			TETRABENAZINE	101
TACROLIMUS MONOHYDRATE	165	TARO-WARFARIN	39	TETRABENAZINE	102
TADALAFIL	48	TARO-ZOLEDRONIC ACID	161	TETRACYCLINE	7
TAFINLAR	18	TASIGNA	22	TETRACYCLINE HYDROCHLORIDE	7
TAGRISSO	23	TAZAROTENE	149	TEVA-5 ASA	126
TALTZ	149	TAZORAC	149	TEVA-ABACAVIR/LAMIVUDINE	10
TAMIFLU	13	TEARS NATURALE FREE	118	TEVA-ACEBUTOLOL	49
TAMOXIFEN CITRATE	26	TEARS NATURALE II	118	TEVA-ACYCLOVIR	13
TAMSULOSIN	33	TEARS PLUS	118	TEVA-ACTOLOVIK TEVA-ALENDRONATE	160
TAMSULOSIN HYDROCHLORIDE	33	TEBRAZID	9	TEVA-	160
TAPAZOLE	139	TECFIDERA	101	ALENDRONATE/CHOLECALCIFEROL	100
TARCEVA	19	TECTA	125	TEVA-ALMOTRIPTAN	96
TARGEL	147	TEGRETOL	75	TEVA-ALPRAZOLAM	94
TARGEL SA	147	TELMISARTAN	61	TEVA-AMIODARONE	41
TARO-ACITRETIN	147	TELMISARTAN	61	TEVA-AMITRIPTYLINE	80
TARO-AMCINONIDE	144	TELMISARTAN (QC)	61	TEVA-AMLODIPINE	52
TARO-ANASTROZOLE	16	TELMISARTAN HCTZ	61	TEVA-AMPICILLIN	5
TARO-ATENOLOL	49	TELMISARTAN,	61	TEVA-ANASTROZOLE	16
TARO-ATORVASTATIN	42	HYDROCHLOROTHIAZIDE		TEVA-ANASTROZOLE TEVA-ARIPIPRAZOLE	86
TARO-BENZOYL PEROXIDE /	142	TELMISARTAN/HCTZ	61	TEVA-AKIFIF KAZOLL TEVA-ATAZANAVIR	10
CLINDAMYCIN KIT		TELMISARTAN-HCTZ	61		
TARO-BUPROPION XL	81	TELZIR	11	TEVA-ATENOLOL	49
TARO-CALCITRIOL	153	TEMAZEPAM	95	TEVA-ATOMOXETINE	100
TARO-CANDESARTAN	58	TEMAZEPAM	95	TEVA-ATORVASTATIN	42
TARO-CAPECITABINE	17	TEMODAL	26	TEVA-AZATHIOPRINE	163
TARO-CARBAMAZEPINE	75	TEMOZOLOMIDE	26	TEVA-AZITHROMYCIN	4
TARO-CEFPROZIL	2	TEMPRA CHILDREN'S	73	TEVA-BETAHISTINE	101
TARO-CIPROFLOX	6	TEMPRA CHILDREN'S DOUBLE	73	TEVA-BICALUTAMIDE	17
TARO-CIPROFLOXACIN	6	STRENGTH		TEVA-BISOPROLOL	49
		TEMPRA INFANT	73	TEVA-BOSENTAN	48
TARO-CLARITHROMYCIN	4	TENDER-1 17MM/110CM	168	TEVA-BROMAZEPAM	94
TARO-CLINDAMYCIN	142	TENDER-1 17MM/60CM	168	TEVA-BUDESONIDE	130
TARO-CLINDAMYCIN/BENZOYL PEROXIDE	142	TENDER-1 17MM/80CM	168	TEVA-BUPROPION XL	81
TARO-CLOBETASOL	144	TENDER-1 MINI INF SET 13MM/110CM	168	TEVA-BUSPIRONE	96
	39	TENDER-1 MINI INFSET 13MM/60CM	168	TEVA-CANDESARTAN	58
TARO-CLOPIDOGREL	39	TENDER-1 MINI INFSET 13MM/80CM	168	TEVA-CANDESARTAN/HCTZ	59
		TENDER-2 17MM/110CM	168	TEVA-CAPECITABINE	17
		NOEN E TANIMATTOOM	100		

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				Mon-insured ricaltin	Jenents
TEVA-CAPTOPRIL	54	TEVA-IMATINIB	20	TEVA-QUETIAPINE	90
TEVA-CARBAMAZEPINE	75	TEVA-INDOMETHACIN	66	TEVA-QUETIAPINE XR	90
TEVA-CARVEDILOL	50	TEVA-IPRATROPIUM STERINEBS	30	TEVA-RABEPRAZOLE	125
TEVA-CEFADROXIL	2	TEVA-IRBESARTAN	59	TEVA-RAMIPRIL	57
TEVA-CEPHALEXIN	3	TEVA-IRBESARTAN HCTZ	59	TEVA-RISEDRONATE	160
TEVA-CHLOROQUINE	15	TEVA-KETOCONAZOLE	9	TEVA-RISPERIDONE	91
TEVA-CHLORPROMAZINE	87	TEVA-LACOSAMIDE	76	TEVA-RIZATRIPTAN ODT	97
TEVA-CILAZAPRIL/HCTZ	54	TEVA-LACTULOSE	106	TEVA-ROPINIROLE	100
TEVA-CINACALCET	165	TEVA-LAMIVUDINE/ZIDOVUDINE	11	TEVA-ROSUVASTATIN	44
TEVA-CITALOPRAM	81	TEVA-LAMOTRIGINE	77	TEVA-SALBUTAMOL	32
TEVA-CLARITHROMYCIN	4	TEVA-LAMOTRIGINE TEVA-LANSOPRAZOLE	124	TEVA-SALBUTAMOL HFA	32
TEVA-CLINDAMYCIN	7	TEVA-LANSOF NAZOLL TEVA-LATANOPROST	117	TEVA-SELEGILINE	100
					85
TEVA CLOBETA COL	74	TEVA-LEFLUNOMIDE	162	TEVA-SERTRALINE	
TEVA CLONAZERAM	144	TEVA-LETROZOLE	21	TEVA-SILDENAFIL R	47
TEVA-CLONAZEPAM	74	TEVA-LEVOCARBIDOPA	98	TEVA-SIMVASTATIN	45
TEVA-CLONIDINE	46	TEVA-LISINOPRIL (TYPE P)	55	TEVA-SOLIFENACIN	150
TEVA-CLOPIDOGREL	39	TEVA-LISINOPRIL (TYPE Z)	55	TEVA-SPIRONOLACTONE	63
TEVA-CLOXACILLIN	5	TEVA-LISINOPRIL/HCTZ (TYPE P)	56	TEVA-SPIRONOLACTONE/HCTZ	110
TEVA-CODEINE	68	TEVA-LISINOPRIL/HCTZ (TYPE Z)	56	TEVA-SUCRALFATE	124
TEVA-COMBO STERINEBS	30	TEVA-LOPERAMIDE	120	TEVA-SULINDAC	67
TEVA-CYCLOBENZAPRINE	33	TEVA-LORAZEPAM	95	TEVA-SUMATRIPTAN	97
TEVA-CYPROTERONE / ETHINYL	166	TEVA-LOSARTAN	60	TEVA-SUMATRIPTAN DF	97
ESTRADIOL		TEVA-LOSARTAN/HCTZ	60	TEVA-TAMOXIFEN	26
TEVA-DESMOPRESSIN	138	TEVA-MEDROXYPROGESTERONE	139	TEVA-TAMSULOSIN	33
TEVA-DICLOFENAC	65	TEVA-MELOXICAM	66	TEVA-TELMISARTAN	61
TEVA-DICLOFENAC SR	65	TEVA-METHYLPHENIDATE	93	TEVA-TELMISARTAN HCTZ	61
TEVA-DILTIAZEM	53	TEVA-METOPROLOL	50	TEVA-TEMAZEPAM	95
TEVA-DILTIAZEM CD	53	TEVA-MEXILETINE	41	TEVA-TENOFOVIR	12
TEVA-DIMENATE	122	TEVA-MINOCYCLINE	7	TEVA-TERAZOSIN	48
TEVA-DOMPERIDONE	126	TEVA-MIRTAZAPINE	84	TEVA-TIAPROFENIC	67
TEVA-DONEPEZIL	28	TEVA-MODAFINIL	93	TEVA-TOBRAMYCIN	2
TEVA-DOXAZOSIN	48	TEVA-MOMETASONE	115	TEVA-TOLTERODINE	150
TEVA-DOXYCYCLINE	7	TEVA-MONTELUKAST	112	TEVA-TOLTERODINE LA	150
TEVA-DUTASTERIDE	157	TEVA-MORPHINE SR	71	TEVA-TOPILENE	144
TEVA-EFAVIRENZ	11	TEVA-MOXIFLOXACIN	7	TEVA-TOPIRAMATE	80
TEVA-	11	TEVA-MYCOPHENOLATE	164	TEVA-TOPISONE	144
EFAVIRENZ/EMTRICITABINE/TENOFOVI		TEVA-NABILONE	123	TEVA-TRANDOLAPRIL	58
R		TEVA-NAPROXEN	67	TEVA-TRAZODONE	85
TEVA-EMTEC-30	67	TEVA-NAPROXEN DS	67	TEVA-TRAZODONE TEVA-TRIAMTERENE/HCTZ	110
TEVA-EMTRICITABINE/TENOFOVIR	12				7
TEVA-ENTACAPONE	98	TEVA-NARATRIPTAN	96	TEVA-TRIMEL	
TEVA-ERLOTINIB	19	TEVA NICTATIN	15	TEVA-TRIMEL DS	7
TEVA-ESCITALOPRAM	83	TEVA-NYSTATIN	9	TEVA-VALACYCLOVIR	13
TEVA-EVEROLIMUS	19	TEVA-OLANZAPINE	88	TEVA-VALGANCICLOVIR	13
TEVA-EXEMESTANE	19	TEVA-OMEPRAZOLE	125	TEVA-VALSARTAN	61
TEVA-EZETIMIBE	42	TEVA-OXYBUTYNIN	150	TEVA-VALSARTAN/HCTZ	62
TEVA-FAMOTIDINE	123	TEVA-OXYCOCET	68	TEVA-VARENICLINE	35
TEVA-FEBUXOSTAT	158	TEVA-OXYCODAN	68	TEVA-VENLAFAXINE XR	86
TEVA-FENTANYL	69	TEVA-PANTOPRAZOLE	125	TEVA-VORICONAZOLE	9
TEVA-FINASTERIDE	157	TEVA-PANTOPRAZOLE MAGNESIUM	125	TEVA-ZOLMITRIPTAN	98
TEVA-FINGOLIMOD	158	TEVA-PAROXETINE	84	TEVA-ZOLMITRIPTAN OD	98
TEVA-FLUCONAZOLE	9	TEVA-PERINDOPRIL	56	TEVETEN	59
TEVA-FLUOXETINE	83	TEVA-PERINDOPRIL/INDAPAMIDE	56	TEVETEN PLUS	59
TEVA-FLURBIPROFEN	65	TEVA-PHENIRAM	1	THE MAGIC BULLET	120
TEVA-FLUTICASONE	115	TEVA-PINDOLOL	51	THEO ER	151
TEVA-FLUVASTATIN	43	TEVA-PIROXICAM	67	THEOLAIR	151
TEVA-FOSINOPRIL	5 5	TEVA-PRAVASTATIN	43	THEOPHYLLINE	151
TEVA-FUSEMIDE	109	TEVA-PRAZOSIN	48	THEOPHYLLINE	151
		TEVA-PREDNISOLONE	115	THIAMIJECT	152
TEVA CEMEIROZII	75	TEVA-PREDNISONE	131	THIAMINE	152
TEVA-GEMFIBROZIL	42	TEVA-PREGABALIN	78	THIAMINE HYDROCHLORIDE	152
TEVA-GLICLAZIDE	138	TEVA-PROCTOSONE	145	THICKENING AGENT	174
TEVA-GLYBURIDE	138	TEVA-PROFEN	66	THICKENING GEL	174
TEVA-HALOPERIDOL	87	TEVA-PROGESTERONE	139	THIOGUANINE	26
TEVA-HYDROCHLOROTHIAZIDE	110	TEVA-PROPRANOLOL	51	THIODOANINE THIOPROPERAZINE MESYLATE	92
TEVA-HYDROMORPHONE	69				

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				Non-insured nearth ben	ents
THIOTHIXENE	92	TRANEXAMIC DENTAL MOUTHWASH	40	TWYNSTA	52
THRIVE GUM (NS)	34	TRANSDERMAL LIDOCAINE W/NSAID	155	TYLENOL	73
THRIVE NICOTINE LOZENGES	34	TRANSDERMAL NICOTINE	34	TYLENOL EXTRA STRENGTH	73
THRIVE NICOTINELL GUM	34	TRANSDERMAL NICOTINE PATCHDAY	34	TYLENOL JR STRENGTH FASTMELTS	73
THYROGEN	105	TRANSDERM-NITRO	47	TYLENOL JUNIOR STRENGTH	73
THYROID	139	TRANYLCYPROMINE SULFATE	85	TYLENOL WITH CODEINE NO.2	67
THYROID	139	TRAVATAN Z	118	TYLENOL WITH CODEINE NO.3	67
THYROTROPIN ALFA	105	TRAVEL	122	ULIPRISTAL ACETATE	133
TIAMOL	145	TRAVOPROST	118	ULORIC	158
TIAPROFENIC ACID	67	TRAVOPROST-TIMOLOL	118	ULTI SYG 1/2 IN 29GX0.3CC	171
TIAZAC	53	TRAZODONE	85	ULTI SYG 1/2 IN 29GX0.5CC	171
TIAZAC XC	54	TRAZODONE HYDROCHLORIDE	85	ULTI SYG 1/2 IN 29GX1CC SYRINGE	171
TICAGRELOR	39	TRELEGY ELLIPTA	130	ULTI SYG 1/2 IN 30GX0.3CC	171
TICLOPIDINE	39	TRELSTAR	26	ULTI SYG 1/2 IN 30GX0.5CC	172
TICLOPIDINE HYDROCHLORIDE	39	TRESIBA	136	ULTI SYG 1/2 IN 30GX1CC SYRINGE	172
TIMOLOL	51	TRETINOIN	26	ULTI SYG 5/16 IN 30GX0.3CC	171
TIMOLOL MALEATE	51	TRIADERM	146	ULTI SYG 5/16 IN 30GX0.5CC	172
TIMOLOL MALEATE (QC)	117	TRIAMCINOLONE	131	ULTI SYG 5/16 IN 30GX1CC SYRINGE	172
TIMOLOL MALEATE, BRIMONIDINE	116	TRIAMCINOLONE ACETONIDE	115	ULTI SYG 5/16 IN 31GX0.3CC	172
TARTRATE		TRIAMCINOLONE DIACETATE	131	ULTI SYG 5/16 IN 31GX0.5CC	172
TIMOLOL MALEATE, TRAVOPROST	118	TRIAMCINOLONE HEXACETONIDE	131	ULTI SYG 5/16 IN 31GX1CC SYRINGE	172
TIMOLOL MALEATE-EX	117	TRIAMCINOLONE HEXACETONIDE	131	ULTIBRO BREEZHALER	30
TIMOPTIC	117	INJECTABLE		ULTICARE 1/2 IN 28GX0.5CC SYRINGE	171
TIMOPTIC-XE	117	TRIAMTERENE,	110	ULTICARE 1/2 IN 28GX1CC SYRINGE	171
TINACTIN	143	HYDROCHLOROTHIAZIDE		ULTICARE 29GX0.1CC	171
TINACTIN AEROSOL	143	TRIATEC-30	67	ULTICARE 29GX0.3CC	171
TINZAPARIN SODIUM	38	TRIAZOLAM	96	ULTICARE 29GX0.5CC	171
TIOTROPIUM BROMIDE	30	TRIAZOLAM	96	ULTICARE 29GX12MM PEN NEEDLE	169
MONOHYDRATE		TRICIRA LO 21	133	ULTICARE 30GX0.1CC	172
TIPRANAVIR	12	TRICIRA LO 28	133	ULTICARE 30GX0.3CC	171
TIVICAY	10	TRI-CYCLEN 21-DAY	133	ULTICARE 30GX0.5CC	172
TIZANIDINE	33	TRI-CYCLEN 28-DAY	133	ULTICARE 31GX5MM PEN NEEDLE	170
TIZANIDINE HYDROCHLORIDE	33	TRI-CYCLEN LO (21 DAY)	133	ULTICARE 31GX6MM PEN NEEDLE	170
TOBI PODHALER	2	TRI-CYCLEN LO (28 DAY)	133	ULTICARE 31GX8MM PEN NEEDLE	170
TOBRADEX	115	TRIDESILON	145	ULTICARE 32GX4MM PEN NEEDLE	170
TOBRAMYCIN	2	TRIFLUOPERAZINE	92	ULTICARE 32GX6MM PEN NEEDLE	170
TOBRAMYCIN	2	TRIFLUOPERAZINE HYDROCHLORIDE	92	ULTICARE 5/16 IN 31GX0.3CC SYRINGE	172
TOBRAMYCIN (OPHTHALMIC)	114	TRIFLURIDINE	115	ULTICARE 5/16 IN 31GX0.5CC SYRINGE	172
TOBRAMYCIN INHALATION	2	TRIHEXYPHENIDYL	98	ULTICARE 5/16 IN 31GX1CC SYRINGE	172
TOBRAMYCINE	2	TRIHEXYPHENIDYL HYDROCHLORIDE	98	ULTICARE LOW DEAD SPACE	171
TOBREX	114	TRI-JORDYNA 28	133	SYRINGE	
TOCILIZUMAB (IV)	162	TRILEPTAL	78	ULTILET CLASSIC LANCET	169
TOCILIZUMAB (SC)	163	TRIMEBUTINE	30	ULTRA 29G3/10CC	171
TODAY SPONGE VAGINAL	103	TRIMEBUTINE MALEATE	30	ULTRA-FINE II 30G.1CC	172
CONTRACEPTIVE		TRIMETHOPRIM	15	ULTRA-FINE II 30GX0.3 CC SYRINGE	171
TOFACITINIB CITRATE	163	TRIMETHOPRIM	15	ULTRAFINE III NEEDLE 31G 8MM	170
TOLNAFTATE	143	TRIMETHOPRIM ORAL LIQUID	15	ULTRAFLEX 1 10MM/110CM	168
TOLOXIN	41	TRIMIPRAMINE	85	ULTRAFLEX 1 10MM/60CM	168
TOLTERODINE TARTRATE	150	TRIMIPRAMINE MALEATE	85	ULTRAFLEX 1 10MM/80CM	168
TOPAMAX	79	TRINIPATCH	47	ULTRAFLEX 1 8MM/110CM	168
TOPICORT	145	TRIPTORELIN PAMOATE	26	ULTRAFLEX 1 8MM/60CM	168
TOPICORT MILD	145	TRIQUILAR 21	132	ULTRAFLEX 1 8MM/80CM	168
TOPIRAMATE	79	TRIQUILAR 28	132	ULTRAVATE	145
TOPIRAMATE	80	TRIUMEQ	10	UMECLIDINIUM BROMIDE	30
TOPIRAMATE ORAL LIQUID	80	TROPICAMIDE	116	UMECLIDINIUM BROMIDE,	30
TOUJEO SOLOSTAR	136	TROSEC	150	VILANTEROL TRIFENATATE	
TOVIAZ	150	TROSPIUM CHLORIDE	150	UNIFINE 29G 12MM NEEDLE	169
TRACLEER	48	TRUE TRACK	105	UNIFINE 31G.6MM NEEDLE	170
TRAJENTA	135	TRUETEST	105	UNIFINE 31G.8MM NEEDLE	170
TRAMETINIB	26	TRUSOPT	117	UNIFINE PENTIPS 31GX5MM	170
TRANDATE	50	TRUSTEEL 6MM	168	UNIPHYL	151
TRANDOLAPRIL	58	TRUSTEEL 8MM	168	UPTRAVI	113
TRANDOLAPRIL	58	TRUVADA	12	UREA	147
TRANEXAMIC ACID	40	TUDORZA GENUAIR	30	UREMOL	147
TRANEXAMIC ACID	40			UREMOL 10	147
					_

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				Non-insured nearth be	nents
URINE TEST STRIP	105	VENTOLIN RESPIRATOR	32	WAMPOLE CALCIUM FOR CHILDREN	107
URISEC 12	147	VEPESID	19	WAMPOLE CALCIUM VITAMIN D	107
URISEC 22	147	VERAPAMIL HYDROCHLORIDE	54	WAMPOLE COMPLETE MULT-PRE	154
URISEC10	147	VEREGEN	142	AND POST NATAL WITH FOLIC ACID	
URISPAS	150	VERELAN	54	WAMPOLE FERROUS GLUCONATE	36
UROSODIOL ORAL LIQUID	121	VERMOX	2	WAMPOLE FOLIC ACID	152
URSO	121	VERSEL	143	WAMPOLE MINERAL CALCIUM	107
URSO DS	121	VERTEPORFIN	119	WAMPOLE VITAMIN C	153
URSODIOL	121	VESANOID	26	WAMPOLE VITAMIN D	153
URSODIOL	121	VESICARE	150	WARFARIN SODIUM WASP VENOM PROTEIN	39 457
USTEKINUMAB	156	VESPULA SPP VENOM PROTEIN	157		157
VAGIFEM 10	134	EXTRACT VFEND	9	WATER WEBCOL ALCOHOL PREP	110 169
VALACYCLOVIR	13	VIDEXTRA	154	WELLBUTRIN SR	81
VALACYCLOVIR HYDROCHLORIDE	13	VIGABATRIN	80	WELLBUTRIN XL	81
VALCYTE	13	VIGAMOX	114	WHITE FACED HORNET VENOM	157
VALIGANCICLOVIR HYDROCHLORIDE	13 144	VIMPAT	76	PROTEIN	
VALISONE VALIUM	94	VIRACEPT	11	WHITE FACED HORNET VENOM	157
VALPROIC ACID (DIVALPROEX	9 4 80	VIREAD	12	PROTEIN, YELLOW HORNET VENOM	
SODIUM)	00	VIROPTIC	115	PROTEIN, YELLOW JACKET VENOM PROTEIN	
VALPROIC ACID (SODIUM	80	VISANNE	139	WHITE PETROLATUM	147
VALPROATE)		VISKAZIDE	50	WHITE PETROLATUM, LANOLIN,	119
VALSARTAN	61	VISKEN	51	MINERAL OIL	113
VALSARTAN	61	VISTITAN	117	WINPRED	131
VALSARTAN HCT	62	VISUDYNE	119	WIXELA INHUB	32
VALSARTAN,	62	VIT D 1000	153	XALACOM	117
HYDROCHLOROTHIAZIDE		VIT D 400	153	XALATAN	117
VALSARTAN, SACUBITRIL	63	VITACELL VITAMIN D3 SOFTGELS	153	XALKORI	18
VALSARTAN-HCTZ	62	VITAL 1.5 CAL 1000ML LIQ	173	XANAX	94
VALTREX	13	VITAL PEPTIDE 1 CAL 220ML LIQ	173	XANAX TS	94
VANCOCIN	8	VITAL PEPTIDE 1.5 CAL 220ML LIQ	173	XARELTO	38
VANCOMYCIN	8 8	VITAMIN A	152	XATRAL	33
VANCOMYCIN HYDROCHLORIDE VANCOMYCIN HYDROCHLORIDE	8 8	VITAMIN A	152	XELJANZ	163
VANCOMYCIN HYDROCHLORIDE VANCOMYCIN HYDROCHLORIDE	8	VITAMIN A ACID	146	XELJANZ XR	163
(INJECTION)	0	VITAMIN B1	152	XELODA	17
VANDETANIB	27	VITAMIN B12	152	XENEX IPECAC	122
VARENICLINE TARTRATE	35	VITAMIN B12 SUBLINGUAL	152	XENEX SODIUM BICARBONATE	106
VARISOFT 13MM	168	VITAMIN B6	152	XEOMIN	166
VARISOFT 17MM	168	VITAMIN C	152	XGEVA	160
VASERETIC	55	VITAMIN C	153	XIGDUO	137
VASOTEC	55	VITAMIN D	153	XOLAIR	113
VCF FOAM VAGINAL CONTRACEPTIVE	103	VITAMIN D	153 153	XTANDI	19
VCF VAGINAL CONTRACEPTIVE FILM	103	VITAMIN D3 VITAMIN E	153 154	XYLAC	88
VEDOLIZUMAB	127	VITAMIN E VITAMIN E	154	XYLOCAINE XYLOCAINE VISCOUS	146 116
VELPHORO	109	VITAMIN E VITAMIN K1	154	YASMIN 21	132
VEMURAFENIB	27	VITAMINE C	153	YASMIN 28	132
VENCLEXTA	27	VITAMINE D	153	YAZ	132
VENETOCLAX	27	VOLIBRIS	48	YELLOW HORNET VENOM PROTEIN	157
VENLAFAXINE HYDROCHLORIDE	86	VOLTAREN	65	YELLOW JACKET VENOM PROTEIN	157
VENLAFAXINE XR	86	VOLTAREN EMULGEL	65	ZADITEN	1
VENOFER	36	VOLTAREN EMULGEL EXTRA	65	ZAMINE 21	132
VENOM PROTEIN EXTRACT	157	STRENGTH		ZAMINE 28	132
VENOMIL HONEY BEE VENOM	156	VOLTAREN EMULGEL JOINT PAIN	65	ZARONTIN	74
VENOMIL MIXED VESPID VENOM	157	REGULAR STRENGTH		ZAROXOLYN	110
PROTEIN VENOMIL WASP VENOM PROTEIN	157	VOLTAREN OPHTHA	115	ZAXINE	8
VENOMIL WASP VENOM PROTEIN VENOMIL WHITE-FACED HORNET	157	VOLTAREN SR	65	ZELBORAF	27
VENOMIL WHITE-FACED HORNET VENOM PROTEIN	101	VORICONAZOLE	9	ZELDOX	92
VENOMIL YELLOW HORNET VENOM	157	VOSEVI	15	ZENHALE	31
PROTEIN		VOTRIENT	23	ZEPATIER	14
VENOMIL YELLOW JACKET VENOM	157	VPI-ONDANSETRON ODT	123	ZESTORETIC	56
PROTEIN		VYVANSE	93 119	ZESTRIL	55
VENTOLIN DISKUS	32	VYZULTA WAMPOLE CALCIUM	118 107	ZIAGEN	10
VENTOLIN HFA	32	WAMPOLE CALCIUM AND D	107	ZIDOVUDINE	12
VENTOLIN P.F	32	VVAIVIFULL CALCIUIVI AND D	107		

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ZINC OXIDE	147
ZINC OXIDE	147
ZINC OXIDE, WHITE PETROLATUM	147
ZINCOFAX EXTRA STRENGTH	147
ZINDA-LETROZOLE	21
ZIPRASIDONE HYDROCHLORIDE	92
MONOHYDRATE	
ZITHROMAX	3
ZOCOR	45
ZODERM	148
ZOFRAN	122
ZOFRAN ODT	123
ZOLADEX	134
ZOLADEX LA	155
ZOLEDRONIC ACID	161
ZOLEDRONIC ACID MONOHYDRATE	161
ZOLMITRIPTAN	97
ZOLMITRIPTAN	98
ZOLMITRIPTAN ODT	98
ZOLOFT	85
ZOMIG	97
ZOMIG RAPIMELT	98
ZOSTRIX	148
ZOSTRIX HP	148
ZOVIRAX	13
ZUCLOPENTHIXOL ACETATE	92
ZUCLOPENTHIXOL DIHYDROCHLORIDE	92
ZYBAN	81
ZYDELIG	20
ZYKADIA	17
ZYLOPRIM	157
ZYMAR	114
ZYPREXA	88
ZYPREXA ZYDIS	89
ZYTIGA	16
ZYVOXAM	8

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