Health Canada Santé Canada

Fall 2016

Non-Insured Health Benefits

First Nations and Inuit Health Branch

Updates to the Drug Benefit List

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

BENEFIT DEFINITIONS

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

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

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

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

ADDITIONS TO THE DRUG BENEFIT LIST

OPEN BENEFITS

Single-Source Drug Products

DIN	MFR	BRAND NAME	Effective Date
02435411	ALC	SIMBRINZA 1/0.2% OPHTHALMIC SOLUTION	18-07-2016
02439611	LIL	HUMALOG KWIKPEN 200U/ML INJECTION	28-07-2016
97799232	SFA	ST DROPLET PERSONAL LANCET 28G	20-09-2016
97799233	SFA	ST DROPLET PERSONAL LANCET 30G	20-09-2016
97799234	SFA	ST DROPLET PERSONAL LANCET 33G	20-09-2016
02213826	TEP	REVIA 50MG TABLET	04-11-2016
09991447	BDT	ST BD BLUNT 18GX1 1/2 FILTER	14-09-2016
09991387	BTD	ST BD PRECISIONGLIDE 25GX1 NEEDLE	13-10-2016
97799238	SFA	ST DROPLET PEN NEEDLE 10MM 29G	20-09-2016
97799235	SFA	ST DROPLET PEN NEEDLE 12MM 29G	20-09-2016
97799243	SFA	ST DROPLET PEN NEEDLE 4MM 32G	20-09-2016
97799239	SFA	ST DROPLET PEN NEEDLE 5MM 31G	20-09-2016
97799242	SFA	ST DROPLET PEN NEEDLE 5MM 32G	20-09-2016

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

Canada

DIN	MFR	BRAND NAME	Effective Date
97799237	SFA	[ST] DROPLET PEN NEEDLE 6MM 31G	20-09-2016
97799241	SFA	[ST] DROPLET PEN NEEDLE 6MM 32G	20-09-2016
97799236	SFA	[ST] DROPLET PEN NEEDLE 8MM 31G	20-09-2016
97799240	SFA	[ST] DROPLET PEN NEEDLE 8MM 32G	20-09-2016
09991341	BTD	[ST] BD LUER-LOK TIP 22GX1 1/2 SYRINGE	03-10-2016
80031157	WNP	[ST] VITAMIN D3 1000U CHEW TABLET	15-07-2016

Multi-Source Drug Products

DIN	MFR	BRAND NAME	Effective Date
02454467	APX	[ST] APO-ALENDR-CHOL 70MG/2800U TABLET	05-10-2016
02454475	APX	[ST] APO-ALENDR-CHOL 70MG/5600U TABLET	05-10-2016
02452308	JAP	JAMP-AZITHROMYCIN 250MG TABLET	29-08-2016
02449153	AUR	AURO-BETAHISTINE 16MG TABLET	14-07-2016
02449161	AUR	AURO-BETAHISTINE 24MG TABLET	14-07-2016
02449145	AUR	AURO-BETAHISTINE 8MG TABLET	14-07-2016
02453312	JAP	[ST] JAMP-BEZAFIBRATE SR 400MG TABLET	08-09-2016
02451778	JAP	[ST] JAMP-CETIRIZINE 10MG TABLET	29-08-2016
02219336	OMG	DIPHENIST 50MG/ML INJECTION	21-09-2016
02451913	JAP	[ST] JAMP-DULOXETINE 30MG CAPSULE	20-09-2016
02451921	JAP	[ST] JAMP-DULOXETINE 60MG CAPSULE	20-09-2016
02446081	MAR	[ST] MAR-DULOXETINE 30MG CAPSULE	20-09-2016
02446103	MAR	[ST] MAR-DULOXETINE 60MG CAPSULE	20-09-2016
02452359	NHP	[ST] NAT-GRANISETRON 1MG TABLET	14-07-2016
02425009	MYL	CONTINGENCY ONE 1.5MG TABLET	29-08-2016
02449811	SDZ	SANDOZ MOMETASONE 50MCG NASAL SPRAY	12-09-2016
02393042	OMG	NALOXONE 1MG/ML INJECTION	04-10-2016
02148714	SDZ	NALOXONE 1MG/ML INJECTION	04-10-2016
09991488	UNK	NALOXONE KIT 3 VIALS/AMPS	01-11-2016
02444275	APX	APO-NALTREXONE 50MG TABLET	04-11-2016
02447207	BMI	[ST] BIO-QUETIAPINE 100MG TABLET	25-10-2016
02447223	BMI	[ST] BIO-QUETIAPINE 200MG TABLET	25-10-2016
02447193	BMI	[ST] BIO-QUETIAPINE 25MG TABLET	25-10-2016
02447258	BMI	[ST] BIO-QUETIAPINE 300MG TABLET	25-10-2016
02446383	AUR	[ST] AURO-SOLIFENACIN 10MG TABLET	29-08-2016
02446375	AUR	[ST] AURO-SOLIFENACIN 5MG TABLET	29-08-2016
02428938	GMP	[ST] MED-SOLIFENACIN 10MG TABLET	14-07-2016
02428911	GMP	[ST] MED-SOLIFENACIN 5MG TABLET	14-07-2016
02443198	MIN	[ST] MINT-SOLIFENACIN 10MG TABLET	14-07-2016
02443171	MIN	[ST] MINT-SOLIFENACIN 5MG TABLET	14-07-2016
02437635	APX	APO-TRIAMCINOLONE AQ 55MCG NASAL SPRAY	08-09-2016
02426900	GLK	[ST] URSODIOL 250MG TABLET	14-07-2016
02426919	GLK	[ST] URSODIOL 500MG TABLET	14-07-2016

NEW LIMITED USE BENEFITS

DIN	MFR	BRAND NAME	Effective Date
02426862	SPC	APTIOM 200MG TABLET	01-11-2016
02426870	SPC	APTIOM 400MG TABLET	01-11-2016
02426889	SPC	APTIOM 600MG TABLET	01-11-2016
02426897	SPC	APTIOM 800MG TABLET	01-11-2016

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are under the care of a physician experienced in the treatment of epilepsy; AND
- Are currently receiving two or more antiepileptic medications; AND
- Have failed or demonstrated intolerance to at least two other antiepileptic medications.

DIN	MFR	BRAND NAME	Effective Date
97799291	ARA	FIRST CANADIAN HEALTH SPIRIT STRIP	30-08-2016
09857547	ARA	SPIRIT TEST STRIP	30-08-2016

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:
- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

02439654	ATP	[ST] ACT BUPROPION XL 150MG TABLET	29-08-2016
02439662	ATP	[ST] ACT BUPROPION XL 300MG TABLET	29-08-2016

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

Coverage of Wellbutrin XL and Bupropion SR is limited to 300mg per day.
(Note: this product will not be approved for coverage for smoking cessation).

02445670	AUR	[ST] AURO-CELECOXIB 100MG CAPSULE	26-09-2016

Limited use benefit (prior approval required).

For patients who have:
- A history of serious gastrointestinal complications (e.g. ulcer, bleeding, perforation);
OR
- Multiple (at least two) risk factors for serious gastrointestinal complications (e.g. age >60, concurrent use of ASA, SSRIs, corticosteroids, anticoagulants or antiplatelet agents).

02407329	AST	XTANDI 40MG CAPSULE	11-07-2016

Limited use benefit (prior approval required).

For the treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) who are/have:
- Asymptomatic or mildly symptomatic after failure of androgen deprivation therapy (ADT) who have not received prior chemotherapy; AND
- Have an ECOG performance status of 0 or 1 with no risk factors for seizures.
OR
- Progressed on docetaxel-based chemotherapy with an ECOG performance status ≤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.

02454386	PMS	PMS-ERLOTINIB 100MG TABLET	06-10-2016
02454394	PMS	PMS-ERLOTINIB 150MG TABLET	06-10-2016

Limited use benefit (prior approval required).

For the 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.

02445077	SAN	[ST] FINASTERIDE 5MG TABLET	29-08-2016

Limited use benefit (prior approval required).

- For treatment of Benign Prostatic Hyperplasia (BPH) in patients who do not tolerate or have not responded to an alpha-adrenergic blocker; OR
- For use in combination therapy when monotherapy with an alpha-adrenergic blocker is not sufficient.

DIN	MFR	BRAND NAME	Effective Date
02452731	APX	[ST] APO-METHYLPHENIDATE ER 18MG TABLET	06-10-2016
02452758	APX	[ST] APO-METHYLPHENIDATE ER 27MG TABLET	06-10-2016
02452766	APX	[ST] APO-METHYLPHENIDATE ER 36MG TABLET	06-10-2016

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

02437333	ARI	ICLUSIG 15MG TABLET	05-10-2016
02437341	ARI	ICLUSIG 45MG TABLET	05-10-2016

Limited use benefit (prior approval required).

Criteria for initial six (6) month coverage:
- For the treatment of patients who have confirmed T315i mutation positive disease, independent of previous TKI therapy; OR
- Treatment of last resort for patients with intolerances or contraindications to imatinib and all other second generation TKI's (dasatinib, nilotinib, bosutinib); OR
- For the treatment of patients with chronic phase chronic myeloid leukemia (CML) who have resistance/disease progression after at least two prior lines of TKI therapy where Iclusig would be available as third-line TKI option; OR
- For the treatment of patients with accelerated phase or blast phase CML or Ph+ ALL who have resistance or disease progression after at least one second generation TKI therapy.
AND
- An ECOG performance status of 0 to 2.
Note: Second generation TKI's (dasatinib, nilotinib, bosutinib) are not covered as options after ponatinib

Criteria for assessment every six (6) month:
- There is no objective evidence of disease progression.

02439530	AZE	DUAKLIR GENUAIR 12/400MCG INHALER	01-11-2016

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- Moderate to severe COPD, as defined by spirometry; AND
- Inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

02438070	NOV	COSENTYX 150MG/ML INJECTION	21-10-2016

Limited use benefit (prior approval required).

Coverage is provided for PSORIASIS ONLY, 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.

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 (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.

DIN	MFR	BRAND NAME	Effective Date
02424770	HLR	ACTEMRA 162MG/0.9ML SC INJECTION	26-10-2016

Limited use benefit (prior approval required).

Prescribed by a rheumatologist
For RHEUMATOID ARTHRITIS, coverage is provided for an initial period of one year.
Initial approvals for patients < 100 kg will be for a dose of 162 mg every other week up to a maximum dose of 162 mg every week (Maximum 51 doses).
For patients weighing 100 kg or more, coverage is provided at a dose of 162 mg weekly (Maximum 52 doses).

For the treatment of severely active RHEUMATOID ARTHRITIS
Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment.
Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX.
AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment.
OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

02423898	PFI	XELJANZ 5MG TABLET	13-09-2016

Limited use benefit (prior approval required).

Prescribed by a rheumatologist
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 beyond one year will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

For the treatment of severely active RHEUMATOID ARTHRITIS:
Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment.
Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;
AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;
OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

02415666	BOE	GIOTRIF 20MG TABLET	01-11-2016
02415674	BOE	GIOTRIF 30MG TABLET	01-11-2016
02415682	BOE	GIOTRIF 40MG TABLET	01-11-2016

Limited use benefit (prior approval required).

For the treatment of patients with advanced Non-Small Cell Lung Cancer (NSCLC) who meet ALL of the following criteria:
- First line treatment of patients; AND
- EGFR mutation positive; AND
- Advanced or metastatic adenocarcinoma of the lung; AND
- An ECOG performance status of 0 or 1.

Criteria for assessment every six (6) month:
- There is no objective evidence of disease progression.

DIN	MFR	BRAND NAME	Effective Date
80033717	BSY	FERAMAX 83G POWDER	17-08-2016

Limited use benefit (prior approval not required).

For children 12 years of age or under.

02402475	BMS	ORENCIA 125MG/ML INJECTION	19-03-2014
02282097	BMS	ORENCIA 250MG/VIAL INJECTION	01-12-2007

Limited use benefit (prior approval required).

For RHEUMATOID ARTHRITIS ONLY, coverage is provided for an initial period of one year at a dose of 500mg IV for patients weighting <60kg; 750mg IV for patients weighting 60kg to 100kg; and 1000mg IV for patients weighing >100kg. Initial IV doses are given at 0, 2, and 4 weeks, then every 4 weeks. Alternatively, a single weight-based IV loading dose is covered (if required), followed by 125mg SC weekly.

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.
AND (FOR IV FORMULATION ONLY):
- Etanercept OR adalimumab OR golimumab OR certolizumab OR abatacept (SC): minimum of 12 weeks trial.
OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

For polyarticular JUVENILE IDIOPATHIC ARTHRITIS, coverage is provided for an initial period of 16 weeks at a dose of 10mg/kg for children weighing < 75kg; 750mg for children weighing 75kg to 100kg; and 1000mg for patients weighing > 100kg. Doses are given at 0, 2, and 4 weeks, then every 4 weeks.

Coverage is provided in children 6 to 17 years who meet ALL of 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 (MTX). An adequate trial is defined as at least 3 months of oral or parenteral MTX at 10 mg/m2 weekly (unless significant toxicity limits the dose tolerated).

CRITERIA CHANGES

CHANGE IN CRITERIA OF RHEUMATOID ARTHRITIS FOR ACTEMRA (TOCILIZUMAB) IV

Effective October 26, 2016, limited use criteria of Rheumatoid Arthritis for Actemra (tocilizumab) IV was changed to:

For the treatment of severely active RHEUMATOID ARTHRITIS
Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment.
Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX.
AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment.
OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

The following DINs were affected:
02350092 ACTEMRA 80MG/4ML IV INJECTION
02350106 ACTEMRA 200MG/10ML IV INJECTION
02350114 ACTEMRA 400MG/20ML IV INJECTION

CHANGE IN COVERAGE OF CLOPIDOGREL

Effective August 17, 2016, Plavix and generics (clopidogrel) became an open benefit.

The following DINs were affected:
02238682 PLAVIX 75MG TABLET
02252767 APO-CLOPIDOGREL 75MG TABLET
02293161 TEVA-CLOPIDOGREL 75MG TABLET
02303027 ACT-CLOPIDOGREL 75MG TABLET
02348004 PMS CLOPIDOGREL 75MG TABLET
02351536 MYLAN-CLOPIDOGREL 75MG TABLET
02359316 SANDOZ CLOPIDOGREL 75MG TABLET
02378507 DOM-CLOPIDOGREL 75MG TABLET
02379813 RAN-CLOPIDOGREL 75MG TABLET
02385813 CLOPIDOGREL 75MG TABLET
02388529 RIVA CLOPIDOGREL 75MG TABLET
02394820 CLOPIDOGREL 75MG TABLET
02400553 CLOPIDOGREL 75MG TABLET
02408910 MINT-CLOPIDOGREL 75MG TABLET
02412942 ABBOTT-CLOPIDOGREL 75MG TABLET
02415550 JAMP-CLOPIDOGREL 75MG TABLET
02416387 AURO-CLOPIDOGREL 75MG TABLET
02419963 ACCEL-CLOPIDOGREL 75MG TABLET
02422255 MAR-CLOPIDOGREL 75MG TABLET

CHANGE IN COVERAGE OF BRILINTA (TICAGRELOR)

Effective September 27, 2016, Brilinta (ticagrelor) became a Limited use benefit (with prior approval no longer required). Coverage is limited to 12 months. Continued coverage beyond one year upon receipt of rationale for continuation of therapy from the prescriber.

The following DIN was affected:
02368544 BRILINTA 90MG TABLET

CHANGE IN COVERAGE OF EZETIMIBE

Effective August 17, 2016, Ezetrol and generics (ezetimibe) became an open benefit.

The following DINs were affected:
02247521 EZETROL 10MG TABLET
02354101 TEVA-EZETIMIBE 10MG TABLET
02378035 MYLAN-EZETIMIBE 10MG TABLET
02414716 ACT-EZETIMIBE 10MG TABLET
02416409 PMS-EZETIMIBE 10MG TABLET
02416778 SANDOZ EZETIMIBE 10MG TABLET
02419548 RAN-EZETIMIBE 10MG TABLET
02422549 EZETIMIBE 10MG TABLET
02422662 MAR-EZETIMIBE 10MG TABLET
02423235 JAMP-EZETIMIBE 10MG TABLET
02423243 MINT-EZETIMIBE 10MG TABLET
02424436 RIVA-EZETIMIBE 10MG TABLET
02425238 PRIVA-EZETIMIBE 10MG TABLET
02427826 APO-EZETIMIBE 10MG TABLET
02429659 EZETIMIBE 10MG TABLET
02431300 EZETIMIBE 10MG TABLET

CHANGE IN COVERAGE OF DULOXETINE

Effective September 20, 2016, Cymbalta and generics (duloxetine) became an open benefit.

The following DINs were affected:
02301482 CYMBALTA DR 30MG CAPSULE
02301490 CYMBALTA DR 60MG CAPSULE
02429446 PMS-DULOXETINE 30MG CAPSULE
02429454 PMS-DULOXETINE 60MG CAPSULE
02436647 AURO-DULOXETINE 30MG CAPSULE
02436655 AURO-DULOXETINE 60MG CAPSULE
02437082 DULOXETINE DR 30MG CAPSULE
02437090 DULOXETINE DR 60MG CAPSULE
02438259 RAN-DULOXETINE 30MG CAPSULE
02438267 RAN-DULOXETINE 60MG CAPSULE
02438984 MINT-DULOXETINE 30MG CAPSULE
02438992 MINT-DULOXETINE 60MG CAPSULE
02439948 SANDOZ DULOXETINE 30MG CAPSULE
02439956 SANDOZ DULOXETINE 60MG CAPSULE
02440423 APO-DULOXETINE 30MG CAPSULE
02440431 APO-DULOXETINE 60MG CAPSULE
02451077 RIVA-DULOXETINE 30MG CAPSULE
02451085 RIVA-DULOXETINE 60MG CAPSULE
02452650 DULOXETINE 30MG CAPSULE
02452669 DULOXETINE 60MG CAPSULE
02453630 DULOXETINE 30MG CAPSULE
02453649 DULOXETINE 60MG CAPSULE

CHANGE IN COVERAGE OF LEVETIRACETAM

Effective October 19, 2016, Keppra and generics (levetiracetam) became an open benefit.

The following DINs were affected:
02247027 KEPPRA 250MG TABLET
02247028 KEPPRA 500MG TABLET
02247029 KEPPRA 750MG TABLET
02274183 ACT-LEVETIRACETAM 250MG TABLET
02274191 ACT-LEVETIRACETAM 500MG TABLET
02274205 ACT-LEVETIRACETAM 750MG TABLET
02285924 APO-LEVETIRACETAM 250MG TABLET
02285932 APO-LEVETIRACETAM 500MG TABLET
02285940 APO-LEVETIRACETAM 750MG TABLET
02296101 PMS-LEVETIRACETAM 250MG TABLET
02296128 PMS-LEVETIRACETAM 500MG TABLET
02296136 PMS-LEVETIRACETAM 750MG TABLET
02297418 DOM-LEVETIRACETAM 500MG TABLET
02311380 PRO-LEVETIRACETAM 500MG TABLET
02311399 PRO-LEVETIRACETAM 750MG TABLET
02353342 LEVETIRACETAM 250MG TABLET
02353350 LEVETIRACETAM 500MG TABLET
02353369 LEVETIRACETAM 750MG TABLET
02375249 AURO-LEVETIRACETAM 250MG TABLET
02375257 AURO-LEVETIRACETAM 500MG TABLET
02375265 AURO-LEVETIRACETAM 750MG TABLET
02396106 RAN-LEVETIRACETAM 250MG TABLET
02396114 RAN-LEVETIRACETAM 500MG TABLET
02396122 RAN-LEVETIRACETAM 750MG TABLET
02399776 LEVETIRACETAM 250MG TABLET
02399784 LEVETIRACETAM 500MG TABLET
02399792 LEVETIRACETAM 750MG TABLET
02403005 JAMP-LEVETIRACETAM 250MG TABLET
02403021 JAMP-LEVETIRACETAM 500MG TABLET
02403048 JAMP-LEVETIRACETAM 750MG TABLET
02414783 ABBOTT-LEVETIRACETAM 750MG TABLET
02414791 ABBOTT-LEVETIRACETAM 500MG TABLET
02414805 ABBOTT-LEVETIRACETAM 250MG TABLET
02440202 NAT-LEVETIRACETAM 250MG TABLET
02440210 NAT-LEVETIRACETAM 500MG TABLET
02440229 NAT-LEVETIRACETAM 750MG TABLET
02442531 LEVETIRACETAM 250MG TABLET
02442558 LEVETIRACETAM 500MG TABLET
02442566 LEVETIRACETAM 750MG TABLET