NON-INSURED HEALTH BENEFITS

First Nations and Inuit Health Branch

DRUG BENEFIT LIST

January 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 January 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 (DBL)

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

3. DRUG REVIEW PROCESS

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

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

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

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

Canadian Agency for Drugs and Technologies in Health 865 Carling Avenue, Suite 600 Ottawa, Ontario K1S 5S8 Telephone: (613) 226-2553

Website: 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
- 5. an improvement in compliance, resulting in an increase in clinical effectiveness, is demonstrated.

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

- 1. clinical studies have demonstrated the safety and efficacy of the active ingredient when administered in the long acting form; and
- 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-Parkinsonian Drugs
Anti-Parkinsonian Drugs
Cardiovascular Drugs
Anti-platelet aggregation Drugs
Enzyme Preparations
Drugs for Diabetes
Drugs for Treatment of Bone Diseases
GI Anti-inflammatory Drugs
Thyroid Therapy

Proton Pump Inhibitors Urinary Anti-Spasmotics NSAIDs

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. PALLIATIVE CARE FORMULARY

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

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

The client:

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

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

8. ADJUNCT CANCER 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: Palliative 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

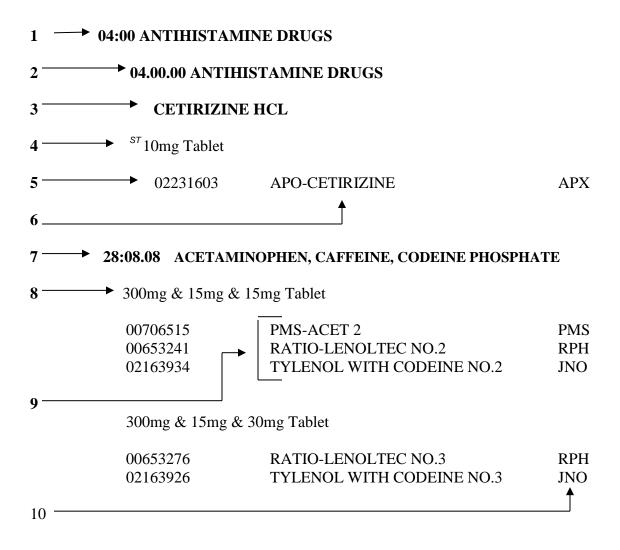
The drugs in the NIHB DBL are classified according to the AHFS Pharmacologic-Therapeutic classification developed by the American Society of Health-System Pharmacists for the purposes of the AHFS Drug Information.

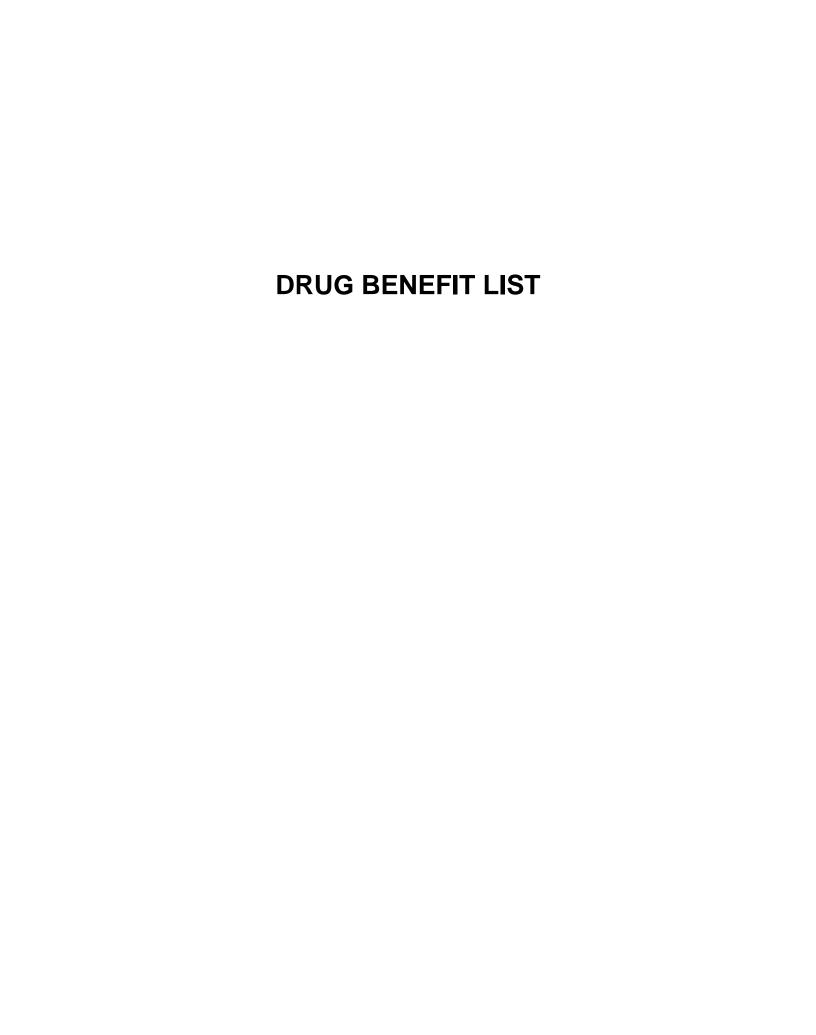
Permission to use this system has been granted by the American Society of Health-System Pharmacists. The Society is not responsible for the accuracy of transpositions from the original context.

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





4:00 ANTIHISTAMINE DRUGS		04:08.00 ANTIHISTAMINE DRUGS	
04.04.04 ANTHUSTAMINE DRUCS		CETIRIZINE HYDROCHLORIDE	
04:04.04 ANTIHISTAMINE DRUGS			
DIPHENHYDRAMINE HYDROCHLORIDE		ST 20MG TABLET 02315963 PMS-CETIRIZINE	PMS
ST 25MG CAPSULE		02427192 PRIVA-CETIRIZINE	PIVIS
00757683 PDP-DIPHENHYDRAMINE	PMS	01900978 REACTINE	MCL
ST 50MG CAPSULE		DESLORATADINE	IVICL
00757691 PDP-DIPHENHYDRAMINE	PMS		
ST 2.5MG/ML ELIXIR		ST 0.5MG/ML SYRUP	
00833266 ALLERGY ELIXIR	TAN	02247193 AERIUS KIDS	BAY
00804193 ALLERNIX ELIXIR	TEV	ST 5MG TABLET	5.43
02019736 BENADRYL	MCL	02243919 AERIUS	BAY
00792705 PMS-DIPHENHYDRAMINE	PMS	02369656 ALLERNIX MULTI SYMPTOM	TEV APX
ST 12.5MG/5ML ELIXIR	11.45	02338424 DESLORATADINE 02298155 DESLORATADINE ALLERGY	PMS
02298503 DIPHENHYDRAMINE	JMP	CONTROL	PIVIS
ST 1.25MG/ML LIQUID	MOL	FEXOFENADINE HYDROCHLORIDE	
02019698 BENADRYL CHILDRENS 50MG/ML LIQUID	MCL		
	CD7	ST 60MG TABLET	
00596612 DIPHENHYDRAMINE 02219336 DIPHENIST	SDZ OMG	02231462 ALLEGRA 12 HOUR	SAC
00878200 PMS-DIPHENHYDRAMINE	PMS	ST 120MG TABLET	
ST 25MG TABLET	FIVIO	02242819 ALLEGRA 24 HOUR	SAC
02176483 ALLER-AIDE	TEV	LORATADINE	
01949454 ALLERGY	TAN	ST 1MG/ML SYRUP	
02229492 ALLERGY FORMULA	VTH	02241523 CLARITIN KIDS	BAY
02097583 ALLERNIX	TEV	ST 10MG TABLET	
02017849 BENADRYL	MCL	02280159 24 HOUR ALLERGY REMEDY	VTH
02257548 DIPHENHYDRAMINE	JMP	02375990 ALLERGY REMEDY	APX
02239029 NADRYL	RIV	02418959 ALLERTIN	APX
ST 50MG TABLET		02243880 APO-LORATADINE	APX
02230398 ALLERGY EXTRA STRENGTH	TAN	00782696 CLARITIN ALLERGY	BAY
02097575 ALLERNIX EXTRA STRENGTH	TEV	02366444 LORATADINE	APX
02257556 DIPHENHYDRAMINE	JMP	04:92.00 ANTIHISTAMINE DRUGS	
4:04.20 ANTIHISTAMINE DRUGS		KETOTIFEN FUMARATE	
CHLORPHENIRAMINE MALEATE		ST 0.2MG/ML SYRUP	
		00600784 ZADITEN	TEV
ST 4MG TABLET	DAY	ST 1MG TABLET	
00738972 CHLOR-TRIPOLON	BAY	00577308 ZADITEN	TEV
00021288 TEVA-PHENIRAM	TEV	3337.333	
ST 12MG TABLET (EXTENDED RELEASE) 00738964 CHLOR-TRIPOLON	BAY		
	DAT		
04:08.00 ANTIHISTAMINE DRUGS			
CETIRIZINE HYDROCHLORIDE			
ST 1MG/ML SYRUP			
02238337 REACTINE	MCL		
ST 10MG TABLET			
02315955 ALLERGY RELIEF	PMS		
02231603 APO-CETIRIZINE	APX		
02375095 CETIRIZINE	APX		
02451778 JAMP-CETIRIZINE	JMP		
02427133 MAR-CETIRIZINE	MAR		
02223554 REACTINE	MCL		
ST 20MG TABLET			
02453363 APO-CETIRIZINE	APX		
02450526 CETIRIZINE	PDL		
02427141 MAR-CETIRIZINE	MAR		

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		Non-insured Health Ber	ietits
08:00 ANTI-INFECTIVE AGENTS		08:12.06 CEPHALOSPORINS	
08:08.00 ANTHELMINTICS		CEFACLOR	
IVERMECTIN		250MG CAPSULE	
		02230263 APO-CEFACLOR	APX
3MG TABLET		500MG CAPSULE	
02480557 STROMECTOL	FRS	02230264 APO-CEFACLOR	APX
MEBENDAZOLE		CEFADROXIL	
100MG TABLET		500MG CAPSULE	
00556734 VERMOX	JSO	02240774 APO-CEFADROXIL	APX
PYRANTEL PAMOATE		02311062 PRO-CEFADROXIL	PDL
50MG SUSPENSION		02235134 TEVA-CEFADROXIL	TEV
02412470 JAMP-PYRANTEL PAMOATE	JMP	CEFAZOLIN SODIUM	
125MG TABLET		500MG POWDER FOR SOLUTION	
01944363 COMBANTRIN	MCL	02108119 CEFAZOLIN	TEV
08:12.02 AMINOGLYCOSIDES		02237137 CEFAZOLIN	FKD
AMIKACIN SULFATE		02308932 CEFAZOLIN	SDZ
		1G POWDER FOR SOLUTION	
Limited use benefit (prior approval required).		02108127 CEFAZOLIN	TEV
250MG LIQUID	007	02237138 CEFAZOLIN	FKD
02242971 AMIKACIN SULFATE	SDZ	02308959 CEFAZOLIN	SDZ
GENTAMICIN SULFATE		02437112 CEFAZOLIN	RAX
1MG/ML SOLUTION		10G POWDER FOR SOLUTION	
02082136 GENTAMICIN IV	BAX	02108135 CEFAZOLIN	TEV
1.6MG/ML SOLUTION		02237140 CEFAZOLIN	FKD
02082152 GENTAMICIN IV	BAX	02308967 CEFAZOLIN	SDZ
10MG/ML SOLUTION		02437120 CEFAZOLIN	RAX
02268531 GENTAMICIN	SDZ	PDIN FOR EXTEMPORANEOUS MIXTURE	LINUZ
40MG/ML SOLUTION	1.15.11.2	99506000 CEFAZOLIN STERILE INFUSION	UNK
02225131 CIDOMYCIN	UNK	CEFIXIME	
02242652 GENTAMICIN	SDZ	20MG/ML POWDER FOR SUSPENSION	
PDIN FOR EXTEMPORANEOUS MIXTURE 99506004 GENTAMYCIN STERILE INFUSION	UNK	00868965 SUPRAX	ODN
TOBRAMYCIN	UNK	100MG POWDER FOR SUSPENSION	
		02468689 AURO-CEFIXIME	AUR
Limited use benefit (prior approval required).		400MG TABLET	
28MG CAPSULE		02432773 AURO-CEFIXIME	AUR
02365154 TOBI PODHALER	BGP	00868981 SUPRAX	ODN
1.2G POWDER FOR SOLUTION	EKD	CEFPROZIL	
00533688 TOBRAMYCIN 02285150 TOBRAMYCIN	FKD RAX	25MG/ML POWDER FOR SUSPENSION	
10MG/ML SOLUTION	KAA	02329204 TARO-CEFPROZIL	SUN
02230639 TOBRAMYCIN	FKD	50MG/ML POWDER FOR SUSPENSION	
02241209 TOBRAMYCIN	SDZ	02293579 TARO-CEFPROZIL	SUN
40MG/ML SOLUTION	ODL	250MG TABLET	
02420287 JAMP-TOBRAMYCIN	JMP	02292998 APO-CEFPROZIL	APX
02230640 TOBRAMYCIN	FKD	02347245 AURO-CEFPROZIL	AUR
02241210 TOBRAMYCIN	SDZ	02293528 RAN-CEFPROZIL	RBY
02382814 TOBRAMYCIN	MYL	02302179 SANDOZ CEFPROZIL 500MG TABLET	SDZ
99005069 TOBRAMYCINE	UNK	02293005 APO-CEFPROZIL	APX
60MG SOLUTION		02347253 AURO-CEFPROZIL	AUR
02389622 TEVA-TOBRAMYCIN	TEV	02293536 RAN-CEFPROZIL	RBY
300MG SOLUTION		02302187 SANDOZ CEFPROZIL	SDZ
02443368 TOBRAMYCIN INHALATION	SDZ		

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08:12.06 CEPHAL	OSPORINS		08:12.06 CE	PHALOSPORINS	
CEFTAZIDIME			CEPHALEXIN	I	
Limited use benefit (prior	approval required).		25MG/ML PC	OWDER FOR SUSPENSION	
1G POWDER FOR S	OLUTION		00015547		PED
00886971 CEFTA	AZIDIME	FKD	00342106	TEVA-CEPHALEXIN	TEV
02437848 CEFTA	AZIDIME	RAX	50MG/ML PC	OWDER FOR SUSPENSION	
02212218 FORTA	AZ 1G	GSK	02177870	DOM-CEPHALEXIN	DPC
2G POWDER FOR S	OLUTION		00035645	KEFLEX	PED
00886955 CEFTA	AZIDIME	FKD	00342092	TEVA-CEPHALEXIN	TEV
02437856 CEFTA	AZIDIME	RAX	125MG POW	DER FOR SUSPENSION	
02212226 FORTA	AZ 2G	GSK	02469170	LUPIN-CEPHALEXIN	LUP
3G POWDER FOR S	OLUTION		250MG POW	DER FOR SUSPENSION	
02439522 CEFTA		RAX	02469189	LUPIN-CEPHALEXIN	LUP
6G POWDER FOR S			250MG TABI		
00886963 CEFTA		FKD		APO-CEPHALEX	APX
	AZIDIME	RAX	02470578	AURO-CEPHALEXIN	AUR
02212234 FORTA		GSK	02177846	DOM-CEPHALEXIN	DPC
CEFTRIAXONE SO	DIUM		02177781	PMS-CEPHALEXIN	PMS
250MG POWDER FO	OR SOLUTION			TEVA-CEPHALEXIN	TEV
02250276 CEFTF	RIAXONE	PFI	500MG TABI	LE I APO-CEPHALEX	APX
02289679 CEFTF	RIAXONE	FKD	02470586	AURO-CEPHALEXIN	AUR
02292262 CEFTF	RIAXONE	SDZ	00828866		PDL
02325594 CEFTF	RIAXONE	RAX	02177854		DPC
1G POWDER FOR S	OLUTION			PMS-CEPHALEXIN	PMS
02250292 CEFTF		PFI	00583421	TEVA-CEPHALEXIN	TEV
	RIAXONE	TEV		SCELLANEOUS B-LACTAM	
	RIAXONE	SDZ		TIBIOTICS	
	RIAXONE	RAX			
2G POWDER FOR S		DEI	AZTREONAM		
	RIAXONE	PFI SDZ	Limited use bene	fit (prior approval required).	
02325624 CEFTR	RIAXONE	RAX	For the managen	nent of cystic fibrosis (CF) in patients if the	
10G POWDER FOR		NAX	following criteria	are met:	
	RIAXONE SODIUM FOR BP	RAX		with chronic pulmonary Pseudomonas	
	ORANEOUS MIXTURE	1000	aeruginosa infect	ions; AND clinician with experience in the diagnosis	
	RIAXONE STERILE INFUSION	UNK	and treatment of		
CEFUROXIME AXE				DER FOR SOLUTION	
				CAYSTON	GIL
25MG/ML POWDER		0014	ERTAPENEN		O.L
02212307 CEFTII	N	GSK		fit (prior approval required).	
250MG TABLET 02244393 APO-C	EELIBOVIME	APX		. ,	
02344823 AURO-		APL		R FOR SOLUTION	EDC.
02212277 CEFTII		GSK	02247437		FRS
500MG TABLET	•	OOK	MEROPENE		
02244394 APO-C	EFUROXIME	APX	Limited use bene	fit (prior approval required).	
02344831 AURO-		APL	500MG POW	DER FOR SOLUTION	
02212285 CEFTII	N	GSK	02378787	MEROPENEM	SDZ
02311453 PRO-C	EFUROXIM	PDL		R FOR SOLUTION	
CEPHALEXIN				MEROPENEM	SDZ
			02436507		RAX
250MG CAPSULE 00342084 TEVA-	CEDHAI EYIN	TEV	08:12.12 MA	CROLIDES	
500MG CAPSULE	OLI HALLAIN	ΙĽV	AZITHROMY	CIN	
00342114 TEVA-	CEPHALEXIN	TEV	20MG/ML D	OWDER FOR SUSPENSION	
25MG/ML POWDER		1 L V		GD-AZITHROMYCIN	PFI
02177862 DOM-0		DPC		PMS-AZITHROMYCIN	PMS
2=11.002 25			-2		

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08:12.12 MA	CROLIDES		08:12.12 MACROLIDES	
AZITHROMY			CLARITHROMYCIN	
	OWDER FOR SUSPENSION	0.0.7	500MG TABLET	DI) (
	SANDOZ AZITHROMYCIN	SDZ	02346532 RIVA-CLARITHROMYCIN	RIV
	ZITHROMAX	PFI	02266547 SANDOZ CLARITHROMYCIN	SDZ
	OWDER FOR SUSPENSION	DMO	02248805 TEVA-CLARITHROMYCIN	TEV
	PMS-AZITHROMYCIN	PMS	500MG TABLET (EXTENDED RELEASE)	400
02332396	SANDOZ AZITHROMYCIN ZITHROMAX	SDZ PFI	02403196 ACT CLARITHROMYCIN XL	ACG APX
250MG TAB		PFI	02413345 APO-CLARITHROMYCIN XL 02244756 BIAXIN XL	BGP
	AG-AZITHROMYCIN	ANG	ERYTHROMYCIN	БОІ
	APO-AZITHROMYCIN	APX	ERTTHROWITCH	
	AZITHROMYCIN	SAN	250MG CAPSULE (ENTERIC COATED)	
	AZITHROMYCIN	SIV	00607142 ERYC	PFI
02278499	DOM-AZITHROMYCIN	DPC	333MG CAPSULE (ENTERIC COATED)	
02452308	JAMP-AZITHROMYCIN	JMP	00873454 ERYC	PFI
02452324	MAR-AZITHROMYCIN	MAR	250MG TABLET	
02479680	NRA-AZITHROMYCIN	UNK	00682020 ERYTHRO BASE	AAP
02261634	PMS-AZITHROMYCIN	PMS	ERYTHROMYCIN STEARATE	
02310600	PRO-AZITHROMYCINE	PDL	250MG TABLET	
02275309	RIVA-AZITHROMYCIN	RIV	00545678 ERYTHRO-S	AAP
02265826	SANDOZ AZITHROMYCIN	SDZ	FIDAXOMICIN	, , , ,
02267845	TEVA-AZITHROMYCIN	TEV		
02212021	ZITHROMAX	PFI	Limited use benefit (prior approval required).	
600MG TAB			For the treatment of confirmed severea Clostridium Difficile	
02261642	PMS-AZITHROMYCIN	PMS	Infection (CDI); AND	
	ZITHROMAX	PFI	Fidaxomicin has been prescribed or recommended by an	
CLARITHRO			infectious disease specialist or gastroenterologist; AND There is a documented allergy (immune-mediated reaction)	0.5
			severe intolerance to oral vancomycin resulting in	JI
	RANULES FOR SUSPENSION	202	discontinuation of vancomycin.	
02146908		BGP	OR	
	CLARITHROMYCIN	SAN	 After an unsuccessful but adequateb trial of oral vancomycin; AND 	
	TARO-CLARITHROMYCIN	TAR	- Retreatment with vancomycin is not an optionc; AND	
	RANULES FOR SUSPENSION	B0B	- The patient is at a high risk of hospitalization due to severe	
02244641	BIAXIN	BGP	complications; AND	
02408996	CLARITHROMYCIN	SAN	- Fidaxomicin is being used as monotherapy.	
02390450	TARO-CLARITHROMYCIN	TAR	Notes:	
250MG TAB		ADV	a. Severe infection is defined as having any of the following	
02274744	APO-CLARITHROMYCIN	APX	symptoms: white blood cell count > 15,000 mm3 and fever;	
01984853	BIAXIN CLARITHROMYCIN	BGP PDL	acute kidney injury with rising serum creatinine ≥ 1.5 times premorbid level or ≥ 175 micromoles/L; pseudomembranous	
02324482		SIV	colitis, hypotension, shock or megacolon.	
02442469 02466120	CLARITHROMYCIN CLARITHROMYCIN	SAN	b. An adequate trial of oral vancomycin is considered to be a	ıt
02471388	M-CLARITHROMYCIN	MAN	least 10 days of therapy with a dose of at least 125mg four	
02247573	PMS-CLARITHROMYCIN	PMS	times daily. c. Retreatment with fidaxomicin in recurrent CDI will be	
02361426	RAN-CLARITHROMYCIN	RBY	considered in symptomatic patients who require treatment of	
02266539	SANDOZ CLARITHROMYCIN	SDZ	a previously resolved CDI episode. This is defined as a	
02248804	TEVA-CLARITHROMYCIN	TEV	subsequent CDI episode occurring within 2 to 8 weeks of a	
500MG TAB		124	previous episode from the date of diagnosis.	
	APO-CLARITHROMYCIN	APX	200MG TABLET	
02126710	BIAXIN	BGP	02387174 DIFICID	FRS
02324490	CLARITHROMYCIN	PDL	08:12.16 PENICILLINS	
02442485	CLARITHROMYCIN	SIV	AMOXICILLIN	
02351005	DOM-CLARITHROMYCIN	DPC		
02471396	M-CLARITHROMYCIN	MAN	250MG CAPSULE	0.4
02247574	PMS-CLARITHROMYCIN	PMS	02352710 AMOXICILLIN	SAN
02361434	RAN-CLARITHROMYCIN	RBY	00628115 APO-AMOXI	APX
			02388073 AURO-AMOXICILLIN	AUR

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08:12.16 PE	NICH LINE		08:12.16 PENICILLINS	
AMOXICILLII	N		AMOXICILLIN, CLAVULANIC ACID	
250MG CAP	SULE		875MG & 125MG TABLET	
02433060	JAMP-AMOXICILLIN	JMP	02482584 SANDOZ AMOXI-CLAV	SDZ
00406724	NOVAMOXIN	TEV	AMPICILLIN	
02230243	PMS-AMOXICILLIN	PMS	250MG CAPSULE	
500MG CAP	SULE		00020877 TEVA-AMPICILLIN	TEV
	AG-AMOXICILLIN	ANG	500MG CAPSULE	
	AMOXICILLIN	SAN	00020885 TEVA-AMPICILLIN	TEV
	AMOXICILLIN	SIV	1G POWDER FOR SOLUTION	
******	APO-AMOXI	APX	01933345 AMPICILLIN SODIUM	TEV
	AURO-AMOXICILLIN	AUR	2G POWDER FOR SOLUTION	
	JAMP-AMOXICILLIN	JMP	02226995 AMPICILLIN	FKD
	NOVAMOXIN	TEV	01933353 AMPICILLIN SODIUM	TEV
	PMS-AMOXICILLIN	PMS	02462346 AMPICILLIN SODIUM FOR BP	AUR
	PRO AMOX	PDL	PDIN FOR EXTEMPORANEOUS MIXTURE	
	RANULES FOR SUSPENSION	TE\ /	99506005 AMPICILLIN STERILE INFUSION	UNK
	NOVAMOXIN	TEV	CLOXACILLIN SODIUM	
	NOVAMOXIN	TEV		
	RANULES FOR SUSPENSION	0.441	250MG CAPSULE	
	AMOXICILLIN	SAN	00337765 TEVA-CLOXACILLIN	TEV
	AMOXICILLIN	SIV	500MG CAPSULE	
	AMOXICILLIN (SUGAR REDUCED)	SAN	00337773 TEVA-CLOXACILLIN	TEV
	NOVAMOVIN	TEV	25MG/ML GRANULES FOR SOLUTION	
	NOVAMOXIN	TEV	00337757 TEVA-CLOXACILLIN	TEV
	OWDER FOR SUSPENSION	APX	PENICILLIN G BENZATHINE	
	APO-AMOXI	PMS	600,000U/ML SUSPENSION	
	PMS-AMOXICILLIN	PIVIS	02291924 BICILLIN	PFI
	OWDER FOR SUSPENSION	APX	PENICILLIN G POTASSIUM	
	APO-AMOXI APO-AMOXI SUGAR FREE	APX		
		PMS	1MU INJECTION	
	PMS-AMOXICILLIN PRO-AMOX	PDL	00773727 NOVO-PENICILLIN G POTASSIUM	NOP
	LET (CHEWABLE)	PDL	PENICILLIN G SODIUM	
	NOVAMOXIN	TEV	10MU POWDER FOR SOLUTION	
	LET (CHEWABLE)	I L V	02220296 PENICILLIN G	FKD
	NOVAMOXIN	TEV	1000000U POWDER FOR SOLUTION	
		ILV	02220261 PENICILLIN G SODIUM	FKD
AWOXICILLII	N, CLAVULANIC ACID		5000000U POWDER FOR SOLUTION	
25MG & 6.25	MG/ML POWDER FOR SUSPENSION		02220288 PENICILLIN G SODIUM	FKD
01916882	CLAVULIN 125 F	GSK	PDIN FOR EXTEMPORANEOUS MIXTURE	
40MG & 5.7I	MG/ML POWDER FOR SUSPENSION		99506003 PENICILLIN G STERILE INFUSION	UNK
02288559	APO-AMOXI CLAV	APX	PENICILLIN V POTASSIUM	
02238831	CLAVULIN 200	GSK		
50MG & 12.5	MG/ML POWDER FOR SUSPENSION		25MG/ML POWDER FOR SOLUTION	ADV
01916874	CLAVULIN 250 F	GSK	00642223 APO PEN VK	APX
80MG & 11.4	MG/ML POWDER FOR SUSPENSION		60MG/ML POWDER FOR SOLUTION	4 D)/
02238830	CLAVULIN 400	GSK	00642231 APO PEN VK	APX
250MG & 12	5MG TABLET		300MG TABLET	A A D
02243350	APO-AMOXI CLAV	APX	00642215 PEN-VK	AAP
500MG & 12	5MG TABLET		PIPERACILLIN, TAZOBACTAM	
02243351	APO-AMOXI CLAV	APX	Limited use benefit (prior approval required).	
01916858	CLAVULIN 500 F	GSK	2G & 0.25G POWDER FOR SOLUTION	
02482576	SANDOZ AMOXI-CLAV	SDZ	02401312 PIPERACILLIN AND TAZOBACTAM	ALV
	5MG TABLET		02299623 PIPERACILLIN	SDZ
	APO-AMOXI CLAV	APX	SODIUM/TAZOBACTAM SODIUM	
02238829	CLAVULIN 875	GSK	02370158 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

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08:12.16 PENICILLINS 08:12.18 QUINOLONES PIPERACILLIN, TAZOBACTAM CIPROFLOXACIN HYDROCHLORIDE Limited use benefit (prior approval required). **500MG TABLET** 3G & 0.375G POWDER FOR SOLUTION SIV 02386127 **CIPROFLOXACIN** DPC 02401320 PIPERACILLIN AND TAZOBACTAM AI V 02251280 DOM-CIPROFI OXACIN 02299631 **PIPERACILLIN** SDZ 02380366 JAMP-CIPROFLOXACIN **JMP** SODIUM/TAZOBACTAM SODIUM 02379694 MAR-CIPROFI OXACIN MAR **PIPERACILLIN** APX 02308452 02423561 MINT-CIPROFLOX MIN SODIUM/TAZOBACTAM SODIUM **PMS** 02248438 PMS-CIPROFLOXACIN 02362627 **PIPERACILLIN** RAX 02317818 PRO-CIPROFLOXACIN **PDL** SODIUM/TAZOBACTAM SODIUM 02303736 RAN-CIPROFLOX **RBY** 02370166 **PIPFRACII I IN** TEV 02251248 RIVA-CIPROFLOXACIN RIV SODIUM/TAZOBACTAM SODIUM 02248757 SANDOZ CIPROFLOXACIN SDZ 4G & 0.5G POWDER FOR SOLUTION 02379635 SEPTA-CIPROFLOXACIN SPT 02401339 PIPERACILLIN AND TAZOBACTAM AI V 02266970 TARO-CIPROFLOXACIN TAR 02299658 **PIPERACILLIN** SDZ **750MG TABLET** SODIUM/TAZOBACTAM SODIUM 02308460 **PIPERACILLIN** APX 02247341 **ACT CIPROFLOXACIN TEV** SODIUM/TAZOBACTAM SODIUM ΔPX 02229523 APO-CIPROFI OX 02362635 **PIPERACILLIN** RAX 02380374 JAMP-CIPROFLOXACIN **JMP** SODIUM/TAZOBACTAM SODIUM 02379708 MAR-CIPROFLOXACIN MAR 02370174 **PIPERACILLIN** TEV 02423588 MINT-CIPROFLOX MIN SODIUM/TAZOBACTAM SODIUM 02248439 PMS-CIPROFLOXACIN **PMS** 12G & 1.5G POWDER FOR SOLUTION 02303744 RAN-CIPROFLOX **RBY** 02330547 **PIPERACILLIN** SDZ 02251256 RIVA-CIPROFLOXACIN RIV SODIUM/TAZOBACTAM SODIUM 02248758 SANDOZ CIPROFLOXACIN SD7 02377748 **PIPFRACII I IN** RAX 02379643 SEPTA-CIPROFLOXACIN SPT SODIUM/TAZOBACTAM SODIUM 36G & 4.5G POWDER FOR SOLUTION LEVOFLOXACIN HEMIHYDRATE **PIPERACILLIN** RAX 02439131 Limited use benefit (prior approval not required). SODIUM/TAZOBACTAM SODIUM Coverage will be limited to 14 tablets every 14 days, followed **08:12.18 QUINOLONES** by a 14 day lockout. CIPROFLOXACIN HYDROCHLORIDE 250MG TABLET 100MG/ML SUSPENSION 02315424 **ACT LEVOFLOXACIN** TEV 02237514 CIPRO BAY 02284707 APO-LEVOFLOXACIN APX 250MG TABLET **PMS** 02284677 PMS-LEVOEL OXACIN 02247339 ACT CIPROFLOXACIN **TEV** 02298635 SANDOZ LEVOFLOXACIN SDZ APX 02229521 APO-CIPROFLOX **500MG TABLET** 02381907 **AURO-CIPROFLOXACIN AUR** 02315432 **ACT LEVOFLOXACIN** TFV 02353318 **CIPROFLOXACIN** SAN 02284715 APO-LEVOFLOXACIN **APX** 02386119 CIPROFI OXACIN SIV 02415879 LEVOFI OXACIN PDL 02380358 JAMP-CIPROFLOXACIN **JMP** 02284685 PMS-LEVOFLOXACIN **PMS** 02379686 MAR-CIPROFLOXACIN MAR 02298643 SANDOZ LEVOFLOXACIN SDZ MINT-CIPROFLOX 02423553 MIN 750MG TABLET PMS-CIPROFLOXACIN 02248437 **PMS** 02315440 **ACT LEVOFLOXACIN** TEV PRO-CIPROFLOXACIN **PDL** 02317796 02325942 APX APO-LEVOFLOXACIN 02303728 **RAN-CIPROFLOX RBY** 02305585 PMS-LEVOFLOXACIN **PMS** 02251221 RIVA-CIPROFLOXACIN RIV 02298651 SANDOZ LEVOFLOXACIN SDZ 02248756 SANDOZ CIPROFLOXACIN SDZ SPT 02379627 SEPTA-CIPROFLOXACIN 02266962 TARO-CIPROFLOXACIN TAR **500MG TABLET** 02247340 **ACT CIPROFLOXACIN** TEV 02229522 APO-CIPROFI OX APX 02381923 **AURO-CIPROFLOXACIN AUR** 02444887 **BIO-CIPROFLOXACIN** BMI **CIPRO** BAY 02155966 02353326 CIPROFLOXACIN SAN

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APX

TEV

APX

AUR

UNK

08:12.18 QUINOLONES 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

UNK 02442302 QUINSAIR

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
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
DEI OVAC	NINI .	

NORFLOXACIN

400MG TABLET

02229524 NORFLOXACIN

08:12.20 SULFONAMIDES

SULFAMETHOXAZOLE, TRIMETHOPRIM

40MG & 8MG	S/ML SUSPENSION	
00726540	TEVA-TRIMFI	

100MG & 20MG TABLET			
00445266 SULFATRIM PEDIATRIC			
400MG & 80MG TABLET			
00445274	SULFATRIM		

00510637 TEVA-TRIMEL **800MG & 160MG TABLET**

00512524 PROTRIN DF 00445282 SULFATRIM DS 00510645 TEVA-TRIMEL DS

08:12.20 SULFONAMIDES

SULFASALAZINE 500MG TABLET

00598461	PMS-SULFASALAZINE	PMS
02064480	SALAZOPYRIN	PFI
500MG TAB	LET (ENTERIC COATED)	
00598488	PMS-SULFASALAZINE	PMS
02064472	SALAZOPYRIN EN	PFI

08:12.24 TETRACYCLINES

DOXYCYCLINE HYCLATE

00740713 APO-DOXY

100MG CAPSULE

00817120	DOXYCIN	RIV
02351234	DOXYCYCLINE	SAN
00725250	TEVA-DOXYCYCLINE	TEV
100MG TABI	LET	
00874256	APO-DOXY	APX
00860751	DOXYCIN	RIV
02351242	DOXYCYCLINE	SAN
00887064	DOXYTAB	PDL

02158574 TEVA-DOXYCYCLINE MINOCYCLINE HYDROCHLORIDE

50MG CAPSULE

AAP

TEV

APX

APX

TEV

PDL

APX

TEV

02084090	MINOCYCLINE	AAP
02108143	TEVA-MINOCYCLINE	TEV
100MG CAP	SULE	
02084104	MINOCYCLINE	AAP
02108151	TEVA-MINOCYCLINE	TEV

TETRACYCLINE HYDROCHLORIDE

02245232 APO-CLINDAMYCIN

02436906 AURO-CLINDAMYCIN

250MG CAPSULE

00580929 TETRACYCLINE AAP

08:12.28 MISCELLANEOUS ANTIBIOTICS **CLINDAMYCIN HYDROCHLORIDE**

150MG CAPSULE

02248525	CLINDAMYCINE	PDL		
00030570	DALACIN C	PFI		
02483734	JAMP CLINDAMYCIN	JMP		
02479923	M-CLINDAMYCIN	MAN		
02468476	RIVA-CLINDAMYCIN	RIV		
02241709	TEVA-CLINDAMYCIN	TEV		
300MG CAP	SULE			
02245233	APO-CLINDAMYCIN	APX		
02436914	AURO-CLINDAMYCIN	AUR		
02248526	CLINDAMYCINE	PDL		
02182866	DALACIN C	PFI		
02483742	JAMP CLINDAMYCIN	JMP		
02479931	M-CLINDAMYCIN	MAN		
02241710	TEVA-CLINDAMYCIN	TEV		
PDIN FOR EXTEMPORANEOUS MIXTURE				

99506008 CLINDAMYCIN STERILE INFUSION

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08:12.28 MISCELLANEOUS ANTIBIOTICS CLINDAMYCIN PALMITATE HYDROCHLORIDE

15MG/ML POWDER FOR SOLUTION

00225851 DALACIN C PFI

CLINDAMYCIN PHOSPHATE

150MG/ML INJECTION

100MO/ME II	100011011				
02139286	CLINDAMYCIN	FKD			
02230535	CLINDAMYCIN	SDZ			
02230540	CLINDAMYCIN	SDZ			
00260436	DALACIN C PHOSPHATE	PFI			
02215683	NOVO-CLINDAMYCIN	NOP			
12MG SOLUTION					
02408511	CLINDAMYCIN IV INFUSION	SDZ			
18MG SOLUTION					
02408538	CLINDAMYCIN IV INFUSION	SDZ			

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.

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:

cannot tolerate vancomycin.

02243686 ZYVOXAM

- For treatment of proven vancomycin-resistant enterococci (VRE) infections
- For the treatment of proven methicillin-resistant staphylococcus aureus (MRSA) infections in patients who

100MG POWDER FOR SUSPENSION

2MG/ML SOLUTION				
02243685	ZYVOXAM	PFI		
600MG TAB	LET			
02426552	APO-LINEZOLID	APX		
02422689	SANDOZ LINEZOLID	SDZ		
02243684	ZYVOXAM	PFI		

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.

$^{\rm ST}$ 550MG TABLET

02410702 ZAXINE SLX

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 CAP	SULE	
02407752	JAMP-VANCOMYCIN	JMP
00788716	VANCOCIN	SEA
02377489	VANCOMYCIN	FKD
02380552	VANCOMYCIN	UNK

MDS

VANCOMYCIN HYDROCHLORIDE (INJECTION)

Limited use benefit (prior approval required).

500MG POWDER FOR SOLUTION

99100176 VANCOMYCIN

POWDER

JAMP-VANCOMYCIN	JMP
MYLAN-VANCOMYCIN	MYL
VANCOMYCIN	FKD
VANCOMYCIN	PFI
VANCOMYCIN	SDZ
VANCOMYCIN	RAX
VANCOMYCIN	GMP
VANCOMYCIN HYDROCHLORIDE	RAX
WDER FOR SOLUTION	
VANCOMYCIN	PFI
VANCOMYCIN	RAX
VANCOMYCIN	GMP
R FOR SOLUTION	
JAMP-VANCOMYCIN	JMP
MYLAN-VANCOMYCIN	MYL
PMS-VANCOMYCIN 1 G	PMS
VANCOMYCIN	FKD
VANCOMYCIN	SDZ
VANCOMYCIN HYDROCHLORIDE	RAX
R FOR SOLUTION	
JAMP-VANCOMYCIN	JMP
MYLAN-VANCOMYCIN	MYL
	MYLAN-VANCOMYCIN VANCOMYCIN AFOR SOLUTION JAMP-VANCOMYCIN PMS-VANCOMYCIN PMS-VANCOMYCIN VANCOMYCIN JAMP-VANCOMYCIN

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PFI

VANCOMYCIN HYDROCHLORIDE (INJECTION)	08:12.28 MISCELLANEOUS ANTIBIOTICS 08:14.08 AZOLES				
Commons Comm					
1	,				
02138243					
02376337					
0239462					
108 POWDER FOR SOLUTION JMP ITRACONAZOLE TEV 102429325 JAMP-VANCOMYCIN MYL 02241897 VANCOMYCIN PFI 02462598 MINT-ITRACONAZOLE MIN 02394680 VANCOMYCIN PFI 02047454 SPORANOX JSO JSO 0249480 VANCOMYCIN RAX 09991094 ITRACONAZOLE DRIVEN MIN 02405839 VANCOMYCIN PFI 02047454 SPORANOX JSO MINT-ITRACONAZOLE DRIVEN MIN 02405839 VANCOMYCIN PFI 02405939 MINT-ITRACONAZOLE DRIVEN MIN 02405839 VANCOMYCIN HYDROCHLORIDE RAX 09991094 ITRACONAZOLE DRIVEN MIN 02405839 VANCOMYCIN HYDROCHLORIDE RAX 09991094 ITRACONAZOLE DRIVEN MIN 02464315 JAMP ITRACONAZOLE DIM MIN 04464315 JAMP ITRACONAZOLE DIM					
			SDZ		
02406578 MYLAN-VANCOMYCIN FKD 02462559 MINI-TITRACONAZOLE MIN					TEV
100MG CAPSULE				ITRACONAZOLE	
02378345				100MG CAPSULE	
0.2394650 VANCOMYCIN RAX POWDER 0.2496850 VANCOMYCIN HYDROCHLORIDE RAX POWDER 0.2496850 VANCOMYCIN HYDROCHLORIDE RAX 0.9991094 ITRACONAZOLE PDR MDS M				02462559 MINT-ITRACONAZOLE	MIN
Q2411940				02047454 SPORANOX	JSO
08:14.04 ALLYLAMINES 08:14.04 ALLYLAMINES TERBINAFINE HYDROCHLORIDE 250MG TABLET 02254727 ACT TERBINAFINE 02239893 APO-TERBINAFINE 02239134 AURO-TERBINAFINE 02239134 AURO-TERBINAFINE 02239134 AURO-TERBINAFINE 02239275 DOM-TERBINAFINE 02239275 DOM-TERBINAFINE 02239277 JAMP-TERBINAFINE 0223116 LAMISL 022404773 PMS-TERBINAFINE 022624727 TERBINAFINE 02365279 TERBINAFINE 02365279 TERBINAFINE 02365279 TERBINAFINE 0241895 APO-FLUCONAZOLE 150MG CAPSULE 02426792 MAR-FLUCONAZOLE 150MG CAPSULE 02426793 APO-FLUCONAZOLE 150MG CAPSULE 02426793 ATO FLUCONAZOLE 150MG CAPSULE 02426793 ATO FLUCONAZOLE 150MG CAPSULE 02426794 APO-FULCONAZOLE 150MG CAPSULE 02426795 ATO FLUCONAZOLE 150MG CAPSULE 150MG				POWDER	
10MG 8 D.LUTION JAMP ITRACONAZOLE JAMP				09991094 ITRACONAZOLE PDR	MDS
TERBINAFINE HYDROCHLORIDE 250MG TABLET 10MG/ML SOL UTION 02231347 SPORANOX JSO JSO 22231347 SPORANOX JSO 22231347 SPORANOX JSO SPORANOX JSO SPORANOX JSO 22231347 JAMP-TERBINAFINE APX 220MG TABLET 220MG TABLET 220MG TABLET 220MG TABLET 220MG TABLET 22231031 AURO-TERBINAFINE DPC 02231031 TEVALED			RAX	10MG SOLUTION	
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Commonstration	TERBINAFIN	E HYDROCHLORIDE		10MG/ML SOLUTION	
O2254727	250MC TAD	ET		02231347 SPORANOX	JSO
02299993		 -	TEV	KETOCONAZOLE	
02320134					
02299275 DOM-TERBINAFINE DPC 02231061 TEVA-KETOCONAZOLE TEV 02357070 JAMP-TERBINAFINE JMP VORICONAZOLE					
O2357070					
O2031116					TEV
02294273 PMS-TERBINAFINE PMS Limited use benefit (prior approval required). 02262924 RIVA-TERBINAFINE RIV For the treatment of patients with invasive aspergillosis; OR 02242735 TERBINAFINE SAN countered to culture proven invasive candidiasis with documented resistance to fluconazole. 02385279 TERBINAFINE SIV 50MG TABLET 08:14.08 AZOLES 02490674 APO-VORICONAZOLE APX FLUCONAZOLE 023998868 TEVA-VORICONAZOLE SDZ 150MG CAPSULE 02241895 APO-FLUCONAZOLE BMI 02409682 APO-VORICONAZOLE TEV 02421895 APO-FLUCONAZOLE BMI 02409682 APO-VORICONAZOLE APX 024311690 CANESORAL BMI 02409682 APO-VORICONAZOLE APX 02432471 JAMP-FLUCONAZOLE JMP 02256479 VFEND PFI 02433720 PRIS-FLUCONAZOLE MAR 08:14.28 POLYENES NOP 02245020 PRIS-FLUCONAZOLE PIA 100,0000/mL sUspension DPC 022451520				VORICONAZOLE	
02262924 RIVA-TERBINAFINE PDL For the treatment of patients with invasive aspergillosis; OR 02242735 TERBINAFINE PDL For the treatment of culture proven invasive candidiasis with documented resistence to fluctonazole.				Limited use benefit (prior approval required).	
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02353121 TERBINAFINE SAN 0235279 documented resistance to flüconazole. 02385279 TERBINAFINE SIV 50MG TABLET 08:14.08 AZOLES 02409674 APO-VORICONAZOLE APX FLUCONAZOLE 02399245 SANDOZ VORICONAZOLE SDZ 150MG CAPSULE 02256460 VFEND PFI 02241895 APO-FLUCONAZOLE BMI 02409682 APO-VORICONAZOLE APX 02311690 CANESORAL BAY 02399253 SANDOZ VORICONAZOLE SDZ 02432471 JAMP-FLUCONAZOLE JMP 02396874 TEVA-VORICONAZOLE TEV 02432471 JAMP-FLUCONAZOLE JMP 02396874 TEVA-VORICONAZOLE TEV 0243272 MAR-FLUCONAZOLE MAR 08:14.28 POLYENES NYSTATIN PFI 02433702 PRIVA-FLUCONAZOLE PMS NYSTATIN DPC 10MG/ML POWDER FOR SOLUTION 0243343 JAMP-NYSTATIN DPC 10MG/ML POWDER FOR SOLUTION PFI 00792667 PMS-NYSTATIN PMS 02245292				For the treatment of patients with invasive aspergillosis; OR	
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Page			OIV		APX
TEVA-VORICONAZOLE TEV 150MG CAPSULE 02256460 VFEND VFEND PFI 02241895 APO-FLUCONAZOLE APX 200MG TABLET					
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02243645 NOVO-FLUCONAZOLE NOP NYSTATIN 02246620 PMS-FLUCONAZOLE PMS NYSTATIN 02433702 PRIVA-FLUCONAZOLE PHA 100,000U/ML SUSPENSION 02255510 RIVA-FLUCONAZOLE RIV 02125145 DOM-NYSTATIN DPC 10MG/ML POWDER FOR SOLUTION 02433443 JAMP-NYSTATIN JMP 02024152 DIFLUCAN PFI 00792667 PMS-NYSTATIN PMS 50MG TABLET 02194201 TEVA-NYSTATIN TEV 02281260 ACT FLUCONAZOLE APX 08:16.04 ANTITUBERCULOSIS AGENTS 02237370 APO-FLUCONAZOLE MYL ETHAMBUTOL HYDROCHLORIDE 02245292 MYLAN-FLUCONAZOLE MYL 100MG TABLET 00247960 ETIBI BSH 02249294 TARO-FLUCONAZOLE TEV 400MG TABLET 00247979 ETIBI BSH 10281279 ACT FLUCONAZOLE ACG ISONIAZID 10MG/ML SOLUTION 10MG/ML SOLUTION	02428792	MAR-FLUCONAZOLE	MAR	08:14 28 POLYENES	
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10MG/ML POWDER FOR SOLUTION 02433443 JAMP-NYSTATIN JMP 02024152 DIFLUCAN PFI 00792667 PMS-NYSTATIN PMS 50MG TABLET 02194201 TEVA-NYSTATIN TEV 02281260 ACT FLUCONAZOLE ACG 08:16.04 ANTITUBERCULOSIS AGENTS 02237370 APO-FLUCONAZOLE MYL ETHAMBUTOL HYDROCHLORIDE 02245292 MYLAN-FLUCONAZOLE MYL 100MG TABLET 02249294 TARO-FLUCONAZOLE TAR 00247960 ETIBI BSH 02236978 TEVA-FLUCONAZOLE TEV 400MG TABLET 00247979 ETIBI BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID ISONIAZID 10MG/ML SOLUTION	02433702	PRIVA-FLUCONAZOLE	PHA	100,000U/ML SUSPENSION	
02024152 DIFLUCAN PFI 00792667 PMS-NYSTATIN PMS 50MG TABLET 02194201 TEVA-NYSTATIN TEV 02281260 ACT FLUCONAZOLE ACG 08:16.04 ANTITUBERCULOSIS AGENTS 02237370 APO-FLUCONAZOLE APX ETHAMBUTOL HYDROCHLORIDE 02245292 MYLAN-FLUCONAZOLE MYL 100MG TABLET 02249294 TARO-FLUCONAZOLE TAR 00247960 ETIBI BSH 02236978 TEVA-FLUCONAZOLE TEV 400MG TABLET 00247979 ETIBI BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID 02237371 APO-FLUCONAZOLE APX 02246109 DOM-FLUCONAZOLE DPC	02255510	RIVA-FLUCONAZOLE	RIV	02125145 DOM-NYSTATIN	DPC
50MG TABLET 02194201 TEVA-NYSTATIN TEV 02281260 ACT FLUCONAZOLE ACG O8:16.04 ANTITUBERCULOSIS AGENTS 02237370 APO-FLUCONAZOLE APX O2245292 MYLAN-FLUCONAZOLE MYL MYL ETHAMBUTOL HYDROCHLORIDE 02245643 PMS-FLUCONAZOLE PMS PMS O2247960 ETIBI BSH 02249294 TARO-FLUCONAZOLE TAR O0247960 ETIBI BSH 02236978 TEVA-FLUCONAZOLE TEV PV 400MG TABLET BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID ISONIAZID BSH 02237371 APO-FLUCONAZOLE APX APX APX O2246109 DOM-FLUCONAZOLE APX DPC 10MG/ML SOLUTION	10MG/ML PC	OWDER FOR SOLUTION		02433443 JAMP-NYSTATIN	JMP
02281260 ACT FLUCONAZOLE ACG 08:16.04 ANTITUBERCULOSIS AGENTS 02237370 APO-FLUCONAZOLE APX ETHAMBUTOL HYDROCHLORIDE 02245292 MYLAN-FLUCONAZOLE MYL 100MG TABLET 02249294 TARO-FLUCONAZOLE TAR 00247960 ETIBI BSH 02236978 TEVA-FLUCONAZOLE TEV 400MG TABLET BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID 02237371 APO-FLUCONAZOLE APX 02246109 DOM-FLUCONAZOLE APX 02246109 DOM-FLUCONAZOLE APX 02000 TOMG/ML SOLUTION	02024152	DIFLUCAN	PFI	00792667 PMS-NYSTATIN	PMS
02237370 APO-FLUCONAZOLE APX 02245292 MYLAN-FLUCONAZOLE MYL 02245643 PMS-FLUCONAZOLE PMS 100MG TABLET 02249294 TARO-FLUCONAZOLE TAR 00247960 ETIBL BSH 02236978 TEVA-FLUCONAZOLE TEV 400MG TABLET BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID 02237371 APO-FLUCONAZOLE APX 02246109 DOM-FLUCONAZOLE APX 02246109 DOM-FLUCONAZOLE DPC 10MG/ML SOLUTION	50MG TABL	ET		02194201 TEVA-NYSTATIN	TEV
02245292 MYLAN-FLUCONAZOLE MYL ETHAMBUTOL HYDROCHLORIDE 02245643 PMS-FLUCONAZOLE PMS 100MG TABLET 02249294 TARO-FLUCONAZOLE TAR 00247960 ETIBI BSH 02236978 TEVA-FLUCONAZOLE TEV 400MG TABLET BSH 100MG TABLET 00247979 ETIBI BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID 02237371 APO-FLUCONAZOLE APX 02246109 DOM-FLUCONAZOLE APX 02246109 DOM-FLUCONAZOLE DPC	02281260	ACT FLUCONAZOLE	ACG	08:16.04 ANTITUBERCULOSIS AGENTS	
02245292 MYLAN-FLUCONAZOLE MYL 02245643 PMS-FLUCONAZOLE PMS 100MG TABLET 02249294 TARO-FLUCONAZOLE TAR 00247960 ETIBL BSH 02236978 TEVA-FLUCONAZOLE TEV 400MG TABLET 00247979 ETIBL BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID 02237371 APO-FLUCONAZOLE APX 10MG/ML SOLUTION	02237370	APO-FLUCONAZOLE	APX	ETHAMBLITOL HYDROCHLORIDE	
02249294 TARO-FLUCONAZOLE TAR 00247960 ETIBI BSH 02236978 TEVA-FLUCONAZOLE TEV 400MG TABLET BSH 100MG TABLET 00247979 ETIBI BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID 02237371 APO-FLUCONAZOLE APX 10MG/ML SOLUTION 02246109 DOM-FLUCONAZOLE DPC					
02236978 TEVA-FLUCONAZOLE TEV 400MG TABLET 100MG TABLET 00247979 ETIBI BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID 02237371 APO-FLUCONAZOLE APX 10MG/ML SOLUTION 02246109 DOM-FLUCONAZOLE DPC	02245643	PMS-FLUCONAZOLE			
100MG TABLET 00247979 ETIBI BSH 02281279 ACT FLUCONAZOLE ACG ISONIAZID 02237371 APO-FLUCONAZOLE APX 10MG/ML SOLUTION 02246109 DOM-FLUCONAZOLE DPC					BSH
02281279 ACT FLUCONAZOLE ACG ISONIAZID 02237371 APO-FLUCONAZOLE APX 02246109 DOM-FLUCONAZOLE DPC			TEV		
02237371 APO-FLUCONAZOLE APX 02246109 DOM-FLUCONAZOLE DPC					BSH
02246109 DOM-FLUCONAZOLE DPC				ISONIAZID	
02246109 DOM-FLUCONAZOLE DPC				10MG/ML SOLUTION	
	02246109	DOM-FLUCONAZOLE	DPC	00265500 ISOTAMINE	VAE

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08:16.04 ANTITUBERCULOSIS AGENTS		08:18.08 ANTIRETROVIRALS
ISONIAZID		ABACAVIR SULFATE, LAMIVUDINE
10MG/ML SOLUTION		600MG & 300MG TABLET
00577812 PDP-ISONIAZID	PED	02399539 APO-ABACAVIR-LAMIVUDINE APX
100MG TABLET		02454513 AURO-ABACAVIR/LAMIVUDINE AUR
00261270 ISOTAMINE	VAE	02269341 KIVEXA VII
00577790 PDP-ISONIAZID	PED	02450682 MYLAN-ABACAVIR/LAMIVUDINE MYL
300MG TABLET		02416662 TEVA-ABACAVIR/LAMIVUDINE TEV
00272655 ISOTAMINE	VAE	ABACAVIR SULFATE, LAMIVUDINE,
00577804 PDP-ISONIAZID	PED	DOLUTEGRAVIR SODIUM
PDIN FOR EXTEMPORANEOUS MIXTURE		
99503031 ISONIAZID ORAL LIQUID	UNK	600MG & 300MG & 50MG TABLET
PYRAZINAMIDE		02430932 TRIUMEQ VII
		ABACAVIR SULFATE, LAMIVUDINE, ZIDOVUDINE
500MG TABLET	PED	300MG & 150MG & 300MG TABLET
00618810 PDP-PYRAZINAMIDE		02416255 APO-ABACAVIR-LAMIVUDINE- APX
00283991 TEBRAZID	VAE	ZIDOVUDINE
RIFABUTIN		ATAZANAVIR SULFATE
150MG CAPSULE		150MG CAPSULE
02063786 MYCOBUTIN	PFI	02456877 MYLAN-ATAZANAVIR MYL
RIFAMPIN		02248610 REYATAZ BMS
150MG CAPSULE		02443791 TEVA-ATAZANAVIR TEV
02091887 RIFADIN	SAC	200MG CAPSULE
00393444 ROFACT	UNK	02456885 MYLAN-ATAZANAVIR MYL
300MG CAPSULE	ONIC	02248611 REYATAZ BMS
02092808 RIFADIN	SAC	02443813 TEVA-ATAZANAVIR TEV
00343617 ROFACT	UNK	300MG CAPSULE
PDIN FOR EXTEMPORANEOUS MIXTURE	Orac	02456893 MYLAN-ATAZANAVIR MYL
99503022 RIFAMPIN ORAL LIQUID	UNK	02294176 REYATAZ BMS
08:16.92 MISCELLANEOUS	•	02443821 TEVA-ATAZANAVIR TEV
ANTIMYCOBACTERIALS		DARUNAVIR ETHANOLATE
		75MG TABLET
DAPSONE		02338432 PREZISTA JSO
100MG TABLET		150MG TABLET
02041510 DAPSONE	JAC	02369753 PREZISTA JSO
02481227 MAR-DAPSONE	MAR	400MG TABLET
02489058 RIVA-DAPSONE	RIV	02324016 PREZISTA JSO
08:18.04 ADAMANTANES		600MG TABLET
AMANTADINE HYDROCHLORIDE		02324024 PREZISTA JSO
AWAN I ADINE III DROCI LORIDE		800MG TABLET
100MG CAPSULE		02393050 PREZISTA JSO
01990403 PMS-AMANTADINE	PED	DARUNAVIR ETHANOLATE, COBICISTAT
10MG/ML SYRUP		,
02022826 PMS-AMANTADINE	PED	150MG & 800MG TABLET
08:18.08 ANTIRETROVIRALS		02426501 PREZCOBIX JSO
ABACAVIR SUFLATE, LAMIVUDINE		DIDANOSINE
600MG & 300MG TABLET		125MG CAPSULE (ENTERIC COATED)
02458381 PMS-ABACAVIR/LAMIVUDINE	PMS	02244596 VIDEX EC BMS
ABACAVIR SULFATE	1 1010	200MG CAPSULE (ENTERIC COATED)
		02244597 VIDEX EC BMS
20MG/ML SOLUTION		250MG CAPSULE (ENTERIC COATED)
02240358 ZIAGEN	VII	02244598 VIDEX EC BMS
300MG TABLET		400MG CAPSULE (ENTERIC COATED)
02396769 APO-ABACAVIR	APX	02244599 VIDEX EC BMS
02480956 MINT-ABACAVIR	MIN	
02240357 ZIAGEN	VII	

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08:18.08 AN	08:18.08 ANTIRETROVIRALS 08:18.08 ANTIRETROVIRALS				
DOLUTEGRAVIR SODIUM		LAMIVUDINE			
50MG TABLI	=T		5MG SOLUTION		
02414945		VII	02239194 HEPTOVIR	GSK	
	AVIR SODIUM, RILPIVIRINE	٧	10MG/ML SOLUTION	00.1	
HYDROCHLO	•		02192691 3TC	VII	
			100MG TABLET		
50MG & 25M			02393239 APO-LAMIVUDINE HBV	APX	
02475774	JULUCA	VII	02239193 HEPTOVIR	GSK	
EFAVIRENZ			150MG TABLET		
50MG CAPS	ULE		02192683 3TC	VII	
02239886	SUSTIVA	BMS	02369052 APO-LAMIVUDINE	APX	
200MG CAPS			300MG TABLET		
02239888	SUSTIVA	BMS	02247825 3TC	VII	
600MG TABI	_ET		02369060 APO-LAMIVUDINE	APX	
02418428	AURO-EFAVIRENZ	AUR	LAMIVUDINE, ZIDOVUDINE		
02458233	JAMP-EFAVIRENZ	JMP	150MG & 300MG TABLET		
	MYLAN-EFAVIRENZ	MYL	02375540 APO-LAMIVUDINE-ZIDOVUDINE	APX	
02246045		BMS	02414414 AURO-LAMIVUDINE/ZIDOVUDINE	AUR	
	TEVA-EFAVIRENZ	TEV	02239213 COMBIVIR	VII	
	EMTRICITABINE, TENOFOVIR		02387247 TEVA-LAMIVUDINE/ZIDOVUDINE	TEV	
DISOPROXIL	FUMARATE		LOPINAVIR, RITONAVIR		
600MG & 20	OMG & 300MG TABLET				
02468247	APO-EFAVIRENZ-EMTRICITABINE-	APX	80MG & 20MG/ML SOLUTION	ABV	
	TENOFOVIR		02243644 KALETRA 100MG & 25MG TABLET	Abv	
02300699		GIL	02312301 KALETRA	ABV	
02461412		MYL	200MG & 50MG TABLET	ADV	
	EFAVIRENZ/EMTRICITABINE/TENO FOVIR DISOPROXIL FUMARATE		02285533 KALETRA	ABV	
02393549	TEVA-	TEV	MARAVIROC	ADV	
020000.0	EFAVIRENZ/EMTRICITABINE/TENO				
	FOVIR		150MG TABLET		
EMTRICITAB	INE, BICTEGRAVIR (BICTEGRA	VIR	02299844 CELSENTRI	VII	
SODIUM), TE	NOFOVIR ALAFENAMIDE		300MG TABLET		
200MG & 50	MG & 25MG TABLET		02299852 CELSENTRI	VII	
02478579	BIKTARVY	GIL	NELFINAVIR MESYLATE		
EMTRICITAR	INE, COBICISTAT, ELVITEGRA	/IR	50MG/G POWDER		
	ALAFENAMIDE	, . ,	02238618 VIRACEPT	PFI	
			250MG TABLET		
	OMG & 150MG & 10MG TABLET	OII	02238617 VIRACEPT	PFI	
	GENVOYA	GIL	625MG TABLET		
	INE, RILPIVIRINE	.DE	02248761 VIRACEPT	PFI	
HYDROCHLO	ORIDE, TENOFOVIR ALAFENAM	IDE	NEVIRAPINE		
200MG & 25	MG & 25MG TABLET		200MG TABLET		
02461463	ODEFSEY	GIL	02318601 AURO-NEVIRAPINE	APL	
ETRAVIRINE			02405776 JAMP NEVIRAPINE	JMP	
100MG TABI	FT		02387727 MYLAN-NEVIRAPINE	MYL	
	INTELENCE	JSO	400MG TABLET (EXTENDED RELEASE)		
200MG TABI			02427931 APO-NEVIRAPINE XR	APX	
	INTELENCE	JSO	RALTEGRAVIR POTASSIUM		
	NAVIR CALCIUM				
00004004 JOENTDEO0		FRS			
50MG/ML SU		170	RILPIVIRINE HYDROCHLORIDE	1110	
02261553		VII	MILTIVININE HTUNUCHLURIUE		
700MG TABI 02261545		VII	25MG TABLET		
02201343		VII	02370603 EDURANT	JSO	

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08:18.08 ANTIRETROVIRALS 08:18.08 ANTIRETROVIRALS **RITONAVIR** TENOFOVIR DISOPROXIL FUMARATE. EMTRICITABINE. RILPIVIRINE HYDROCHLORIDE **100MG TABLET** 02357593 NORVIR ABV 200MG & 25MG & 300MG TABLET 02374129 COMPLERA GIL SAQUINAVIR MESYLATE **TIPRANAVIR 500MG TABLET** 02279320 INVIRASE HLR 250MG CAPSULE STAVUDINE 02273322 APTIVUS BOE **ZIDOVUDINE** 15MG CAPSULE 02216086 ZERIT **BMS** 100MG CAPSULE 20MG CAPSULE 01946323 APO-ZIDOVUDINE **APX** 02216094 ZERIT BMS 01902660 RETROVIR VII **30MG CAPSULE** 10MG/ML SYRUP 02216108 ZERIT **BMS** 01902652 RETROVIR VII **40MG CAPSULE 08:18.20 INTERFERONS** 02216116 ZERIT **BMS INTERFERON ALFA-2B** TENOFOVIR DISOPROXIL FUMARATE 6,000,000IU/ML SOLUTION Limited use benefit (prior approval required). 02238674 INTRON A **FRS** 10,000,000IU/ML SOLUTION For the treatment of patients with HIV-1 infection who have failed or have experienced adverse events to an alternative 02238675 INTRON A **FRS** agent. 10.000.000IU/VIAL SOLUTION For the treatment of patients with chronic hepatitis B infection 02223406 INTRON A **FRS** who have cirrhosis documented on radiologic or histologic grounds and a HBV concentration above 2.000 IU/mL. **PEGINTERFERON ALFA-2A** 245MG TABLET Limited use benefit (prior approval required). GIL 02247128 VIREAD For the treatment of patients with chronic hepatitis B infection **300MG TABLET** who have a HBV DNA concentration above 2,000 IU/mL 02451980 APO-TENOFOVIR APX without decompensated cirrhosis, upon the written request of **AURO-TENOFOVIR** AUR 02460173 a hepatologist or other specialist in this area. 02479087 JAMP-TENOFOVIR **JMP** 180MCG/0.5ML SOLUTION 02452634 MYLAN-TENOFOVIR DISOPROXIL MYL HLR 02248077 PEGASYS 02472511 NAT-TENOFOVIR NPH PEGINTERFERON ALFA-2B, RIBAVIRIN 02453940 PMS-TENOFOVIR **PMS** Limited use benefit (prior approval required). 02403889 TEVA-TENOFOVIR **TEV** TENOFOVIR DISOPROXIL FUMARATE. For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or **EMTRICITABINE** other specialist in this area. **200MG & 300MG TABLET** • For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if 02274906 TRUVADA GIL patient has a viral reduction of at least 2 logs or HCV is **300MG & 200MG TABLET** undetectable at 12 weeks (48 weeks total). 02452006 APO-EMTRICITABINE-TENOFOVIR APX • For genotypes 2 or 3, initial coverage for a maximum of 24 02487012 **JMP** weeks will be approved. Renewals will not be covered. EMTRICITABINE/TENOFOVIR 50MCG/0.5ML & 200MG KIT **DISOPROXIL FUMARATE** 02254573 PEGETRON KIT FRS 02443902 MYI AN-MYL EMTRICITABINE/TENOFOVIR DISOPROXIL 02461110 PMS-EMTRICITABINE-TENOFOVIR **PMS** 02399059 TEVA-EMTRICITABINE/TENOFOVIR TFV TENOFOVIR DISOPROXIL FUMARATE, **EMTRICITABINE, COBICISTAT, ELVITEGRAVIR** 150MG & 200MG & 150MG & 300MG TABLET

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GIL

02397137 STRIBILD

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

125MCG LIQUID

02444399 PLEGRIDY UNK

08:18.28 NEURAMINIDASE INHIBITORS

OSELTAMIVIR

30MG CAPSULE

02472635 NAT-OSELTAMIVIR NPH

45MG CAPSULE

02472643 NAT-OSELTAMIVIR NPH

08:18.32 NUCLEOSIDES AND NUCLEOTIDES

ACYCLOVIR

40MG/ML SUSPENSION

 00886157
 ZOVIRAX
 GSK

 200MG TABLET
 02207621
 APO-ACYCLOVIR
 APX

 02207621
 APO-ACYCLOVIR
 APX

 02242784
 MYLAN-ACYCLOVIR
 MYL

 02285959
 TEVA-ACYCLOVIR
 TEV

400MG TABLET

 02207648
 APO-ACYCLOVIR
 APX

 02242463
 MYLAN-ACYCLOVIR
 MYL

 02285967
 TEVA-ACYCLOVIR
 TEV

800MG TABLET

 02207656
 APO-ACYCLOVIR
 APX

 02242464
 MYLAN-ACYCLOVIR
 MYL

 02285975
 TEVA-ACYCLOVIR
 TEV

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	GIL

08:18.32 NUCLEOSIDES AND NUCLEOTIDES

ENTECAVIR MONOHYDRATE

Limited use benefit (prior approval required).

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

0.5MG TABLET

02396955	APO-ENTECAVIR	APX
02448777	AURO-ENTECAVIR	AUR
02282224	BARACLUDE	BMS
02467232	JAMP ENTECAVIR	JMP
02430576	PMS-ENTECAVIR	PMS

FAMCICLOVIR

UNK

125MG TABLET

ATAMA TARI ET				
02278634	SANDOZ FAMCICLOVIR	SDZ		
02278081	PMS-FAMCICLOVIR	PMS		
02229110	FAMVIR	NVR		
02292025	APO-FAMCICLOVIR	APX		
02305682	ACT FAMCICLOVIR	ACG		

A OT E A A A O I O I O I I I I

250MG TABLET

02305690	ACT FAMCICLOVIR	ACG
02292041	APO-FAMCICLOVIR	APX
02229129	FAMVIR	NVR
02278103	PMS-FAMCICLOVIR	PMS
02278642	SANDOZ FAMCICLOVIR	SDZ

500MG TABLET

•	JOONIG TABLET			
	02305704	ACT FAMCICLOVIR	ACG	
	02292068	APO-FAMCICLOVIR	APX	
	02177102	FAMVIR	NVR	
	02278111	PMS-FAMCICLOVIR	PMS	
	02278650	SANDOZ FAMCICLOVIR	SDZ	

GANCICLOVIR SODIUM

500MG POWDER FOR SOLUTION

02162695 CYTOVENE CHE

VALACYCLOVIR HYDROCHLORIDE

500MG TABLET

SUUNG TAB	LC I	
02295822	APO-VALACYCLOVIR	APX
02405040	AURO-VALACYCLOVIR	AUR
02444860	BIO-VALACYCLOVIR	BMI
02307936	DOM-VALACYCLOVIR	DPC
02441454	JAMP-VALACYCLOVIR	JMP
02441586	MAR-VALACYCLOVIR	MAR
02351579	MYLAN-VALACYCLOVIR	MYL
02298457	PMS-VALACYCLOVIR	PMS
02441861	PRIVA-VALACYCLOVIR	PHA
02315173	PRO-VALACYCLOVIR	PDL
02316447	RIVA-VALACYCLOVIR	RIV
02347091	SANDOZ VALACYCLOVIR	SDZ
02357534	TEVA-VALACYCLOVIR	TEV
02442000	VALACYCLOVIR	SIV
02454645	VALACYCLOVIR	SAN
02219492	VALTREX	GSK

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08:18.32 NUCLEOSIDES AND **NUCLEOTIDES**

VALGANCICLOVIR HYDROCHLORIDE

50MG POWDER FOR SOLUTION

02306085	VALCYTE	HLR
450MG TAB	LET	
02393824	APO-VALGANCICLOVIR	APX
02435179	AURO-VALGANCICLOVIR	AUR
02413825	TEVA-VALGANCICLOVIR	TEV
02245777	VALCYTE	HLR

08:18.40 HCV ANTIVIRALS **DACLATASVIR**

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.

60MG TABLET

02444755 DAKLINZA

BMS

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

08:18.40 HCV ANTIVIRALS **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

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** PED 02425890 IBAVYR **600MG TABLET**

02425904 IBAVYR PFD

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

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08:18.40 HCV ANTIVIRALS 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

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

08:30.04 AMEBICIDES

PAROMOMYCIN SULFATE

250MG CAPSULE

02078759 HUMATIN

08:30.08 ANTIMALARIALS

CHLOROQUINE PHOSPHATE

250MG TABLET

00021261 TEVA-CHLOROQUINE

HYDROXYCHLOROQUINE SULFATE

200MG TABLET

02246691 APO-HYDROXYQUINE

08:30.08 ANTIMALARIALS

HYDROXYCHLOROQUINE SULFATE

200MG TABLET

02424991 MINT-HYDROXYCHLOROQUINE MIN 02017709 PLAQUENIL SAC

PRIMAQUINE PHOSPHATE

26.3MG TABLET

SAC 02017776 PRIMAQUINE

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

99503012 METRONIDAZOLE ORAL LIQUID UNK

08:36.00 URINARY ANTI-INFECTIVES **FOSFOMYCIN TROMETHAMINE**

Limited use benefit (prior approval required).

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

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

3G/PK POWDER FOR SOLUTION

02240335 MONUROL PAL **3G POWDER FOR SOLUTION**

JMP

TEV

02473801 JAMP-FOSFOMYCIN

NITROFURANTOIN

100MG CAPSULE

02063662 MACROBID AΠ 02455676 PMS-NITROFURANTOIN **PMS 50MG CAPSULE (DELAYED RELEASE)**

02231015 TEVA-NITROFURANTOIN

100MG CAPSULE (DELAYED RELEASE)

02231016 TEVA-NITROFURANTOIN

TEV **50MG TABLET** 00319511 NITROFURANTOIN AAP

100MG TABLET

00312738 NITROFURANTOIN AAP

PDIN FOR EXTEMPORANEOUS MIXTURE

99503004 NITRO-FURANTOIN ORAL LIQUID UNK

TRIMETHOPRIM

100MG TABLET

02243116 TRIMETHOPRIM AAP 200MG TABLET

02243117 TRIMETHOPRIM AAP

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ERF

TEV

APX

GIL

08:36.00 URINARY ANTI-INFECTIVES TRIMETHOPRIM

PDIN FOR EXTEMPORANEOUS MIXTURE

99503017 TRIMETHOPRIM ORAL LIQUID

UNK

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

Limited use benefit (prior approval required).

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	JSO

500MG TABLET02457113 ZYTIGA

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.

AND

JSO

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
02394898	ACT ANASTROZOLE	TEV
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

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 riska of developing metastases; AND
- Have no risk factors for seizures; AND
- Have a good ECOG performance status (0 or 1)

a 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 TABLE	Т	
02389630	INLYTA	PFI
5MG TABLE	Т	
02389649	INLYTA	PFI
BICALUTAM	IDE	
50MG TABLET		

ACH-BICALUTAMIDE	ACC
APO-BICALUTAMIDE	APX
BICALUTAMIDE	SIV
CASODEX	AZC
JAMP-BICALUTAMIDE	JMP
PMS-BICALUTAMIDE	PMS
PRO-BICALUTAMIDE	PDL
RAN-BICALUTAMIDE	RBY
TEVA-BICALUTAMIDE	TEV
	APO-BICALUTAMIDE BICALUTAMIDE CASODEX JAMP-BICALUTAMIDE PMS-BICALUTAMIDE PRO-BICALUTAMIDE RAN-BICALUTAMIDE

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 TAB	LET		
02419149	BOSULIF	PFI	
500MG TAB	LET		
02419157	BOSULIF	PFI	
BUSERELIN	ACETATE		
6.3MG/IMPL	ANT IMPLANT		
02228955	SUPREFACT DEPOT 2 MONTHS	SAC	
9.45MG/IMP	LANT IMPLANT		
02240749	SUPREFACT DEPOT 3 MONTHS	SAC	
1MG/ML SOLUTION			
02225166	SUPREFACT	SAC	

10:00.00 ANTINEOPLASTIC AGENTS **BUSERELIN ACETATE**

1MG/ML SOLUTION

02225158 SUPREFACT (NASAL) SAC

BUSULFAN

2MG TABLET

00004618 MYLERAN ASP

CAPECITABINE

150MG TABLET

02426757	ACH-CAPECITABINE	ACC
02421917	SANDOZ CAPECITABINE	SDZ
02457490	TARO-CAPECITABINE	TAR
02400022	TEVA-CAPECITABINE	TEV
02238453	XELODA	HLR
500MG TAB	LET	
02426765	ACH-CAPECITABINE	ACC
00404005	OANDOZ OADEOITADINE	007

02421925 SANDOZ CAPECITABINE SDZ 02457504 TARO-CAPECITABINE TAR 02400030 TEVA-CAPECITABINE TEV 02238454 XELODA HI R

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**

CHLORAMBUCIL

2MG TABLET

00004626 LEUKERAN ASP

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 HI R

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10:00.00 ANTINEOPLASTIC AGENTS 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.*

- · 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

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.

PFI

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; 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.

40MG CAPSULE

02407329 XTANDI AST

ERLOTINIB HYDROCHLORIDE

Limited use benefit (prior approval required).

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

25MG TABLET

ETOPOSIDE		
02377713	TEVA-ERLOTINIB	TEV
02269023	TARCEVA	HLR
02454394	PMS-ERLOTINIB	PMS
02461889	APO-ERLOTINIB	APX
150MG TABL	_ET	
02377705	TEVA-ERLOTINIB	TEV
02269015	TARCEVA	HLR
02454386	PMS-ERLOTINIB	PMS
02461870	APO-ERLOTINIB	APX
100MG TABL	_ET	
02377691	TEVA-ERLOTINIB	TEV
02269007	TARCEVA	HLR
02483912	NAT-ERLOTINIB	NPH
02461862	APO-ERLOTINIB	APX

50MG CAPSULE

00616192 VEPESID **BMS**

10:00.00 ANTINEOPLASTIC AGENTS **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).			
.ET			
AFINITOR	NVF		
Т			
AFINITOR	NVR		
ET			
AFINITOR	NVF		
T FOR SUSPENSION			
AFINITOR DISPERZ	NVF		
T FOR SUSPENSION			
AFINITOR DISPERZ	NVF		
T FOR SUSPENSION			
AFINITOR DISPERZ	NVF		
IE			
ET			
ACT EXEMESTANE	ACG		
APO-EXEMESTANE	APX		
AROMASIN	PF		
֡֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜֜	AFINITOR T AFINITOR ET AFINITOR FOR SUSPENSION AFINITOR DISPERZ T FOR SUSPENSION AFINITOR DISPERZ T FOR SUSPENSION AFINITOR DISPERZ I FOR SUSPENSION AFINITOR DISPERZ ET ACT EXEMESTANE APO-EXEMESTANE		

02419726	APO-EXEMESTANE	APX
02242705	AROMASIN	PF
02407841	MED-EXEMESTANE	GMF
02408473	TEVA-EXEMESTANE	TEV

FLUDARABINE PHOSPHATE

OMG TABLE	Т

SAC 02246226 FLUDARA

FLUTAMIDE

250MG TABLET

02238560 FLUTAMIDE AAP 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

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10:00.00 ANTINEOPLASTIC AGENTS HYDROXYUREA

500MG CAPSULE

02247937	APO-HYDROXYUREA	APX
00465283	HYDREA	BMS
02242920	MYLAN-HYDROXYUREA	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

GIL

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

Limited use benefit (prior approval required).

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

10:00.00 ANTINEOPLASTIC AGENTS 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 CAPSULE** 02304899 REVLIMID UNK 10MG CAPSULF 02304902 REVLIMID UNK 15MG CAPSULE 02317699 REVLIMID UNK 20MG CAPSULE 02440601 REVLIMID UNK 25MG CAPSULE 02317710 REVLIMID UNK

LENVATINIB

Limited use benefit (prior approval required).

Criteria for initial 4-month coverage:

- Used as monotherapy for treatment of patients with locally recurrent or metastatic, progressive differentiated thyroid cancer (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

here is no objective evidence of disease progression.					
10MG CAPSULE					
02450321	LENVIMA		EIS		
14MG CAPSULE					
02450313	LENVIMA		EIS		

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BMS

UNK

10:00.00 ANTINEOPLASTIC AGENTS LENVATINIB

Limited use benefit (prior approval required).

Criteria for initial 4-month coverage:

- Used as monotherapy for treatment of patients with locally recurrent or metastatic, progressive differentiated thyroid cancer (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.

20MG CAPS	ULE		
02450305	LENVIMA	EIS	S
24MG CAPS	ULE		
02450291	LENVIMA	EIS	S

LETROZOLE

ST 2.5MG TABLET

02338459	ACH-LETROZOLE
02358514	APO-LETROZOLE
02392496	BIO-LETROZOLE
02231384	FEMARA

02373009 JAMP-LETROZOLE **JMP** 02402025 | FTROZOLF PDI 02373424 MAR-LETROZOLE MAR 02322315 MED-LETROZOLE **GMP** 02421585 NAT-LETROZOLE NPH 02309114 PMS-LETROZOLE **PMS** 02372282 RAN-LETROZOLE **RBY** 02398656 RIVA-LETROZOLE RIV SDZ 02344815 SANDOZ LETROZOLE

02378213 ZINDA-LETROZOLE **LEUPROLIDE ACETATE**

02248999 ELIGARD

02343657

10.5MG/VIAL POWDER FOR SUSPENSION
02248239 ELIGARD

22.5MG/VIAL POWDER FOR SUSPENSION
02248240 ELIGARD

30MG/VIAL POWDER FOR SUSPENSION

TEVA-LETROZOLE

10:00.00 ANTINEOPLASTIC AGENTS LEUPROLIDE ACETATE

45MG/VIAL POWDER FOR SUSPENSION
02268892 ELIGARD SAC
LOMUSTINE
10MG CAPSULE

40MG CAPSULE

00360422 CEENU BMS

MEGESTROL ACETATE

00360430 CEENU

40MG TABLET
02195917 MEGESTROL AAP
160MG TABLET

02195925 MEGESTROL AAP

MELPHALAN

2MG TABLET00004715 ALKERAN ASP

MERCAPTOPURINE

 50MG TABLET

 02415275
 MERCAPTOPURINE
 RAX

 00004723
 PURINETHOL
 TEV

METHOTREXATE SODIUM

7.5MG SOLUTION

02320029 METOJECT UNK

02454823 METOJECT SUBCUTANEOUS UNK

10MG SOLUTION

02320037 METOJECT UNK

02454831 METOJECT SUBCUTANEOUS UNK

10MG/0.4ML SOLUTION

02422174 METHOTREXATE PMS

10MG/ML SOLUTION

02182947 METHOTREXATE PFI

12.5MG SOLUTION

02454750 METOJECT SUBCUTANEOUS UNK

15MG SOLUTION

02454858 METOJECT SUBCUTANEOUS UNK

15MG/0.6ML SOLUTION

02422182 METHOTREXATE PMS

17.5MG SOLUTION
02454769 METOJECT SUBCUTANEOUS
20MG SOLUTION

02454866 METOJECT SUBCUTANEOUS UNK
20MG/0.8ML SOLUTION
02422190 METHOTREXATE PMS

22.5MG SOLUTION

02454777 METOJECT SUBCUTANEOUS UNK

25MG SOLUTION
02454874 METOJECT SUBCUTANEOUS UNK
25MG/ML SOLUTION

 02419173
 JAMP-METHOTREXATE
 JMP

 02099705
 METHOTREXATE
 TEV

 02182777
 METHOTREXATE
 PFI

 02182955
 METHOTREXATE
 PFI

 02398427
 METHOTREXATE
 SDZ

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ACC

APX

BMI

NVR

TEV

UNK

SAC

SAC

SAC

10:00.00 ANTINEOPLASTIC AGENTS METHOTREXATE SODIUM

25MG/ML SOLUTION

02417626	METHOTREXATE	MYL		
02422166	METHOTREXATE	PMS		
02422204	METHOTREXATE	PMS		
02122201	WETTIOTILE OTTE	1 1010		
2.5MG TABLET				
LIGHTO TABL	· - ·			
02182963	APO-METHOTREXATE	APX		
02102000	AL O METHOTICE VITE	711 73		
02170608	PMS-METHOTREXATE	PMS		
02170030	I MO-ME I I O I NEXA I E	I IVIO		

02170698 PMS-METHOTREXATE

10MG TABLET

02182750 METHOTREXATE

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

MITOTANE

500MG TABLET

00463221 LYSODREN LAP

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

NILUTAMIDE

50MG TABLET

02221861 ANANDRON SAC

10:00.00 ANTINEOPLASTIC AGENTS 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

PFI

- 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;
 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).

Criteria for initial 12-month coverage:

Patient with locally advanced or metastatic non-small cell lung cancer (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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10:00.00 ANTINEOPLASTIC AGENTS **PALBOCICLIB**

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of post-menopausal women 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.

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:

02419610 POMALYST

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 CAPSU	ILE	
02419599	POMALYST	UNK
3MG CAPSULE		
02419602	POMALYST	UNK
4MG CAPSU	ILE	

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;
- 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:

02437333 ICLUSIG

• There is no objective evidence of disease progression.

15MG TABLET

45MG TABLET

02437341 ICLUSIG ARI

PROCARBAZINE HYDROCHLORIDE

50MG CAPSULE

00012750 MATULANE

UNK

ARI

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 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; 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

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UNK

10:00.00 ANTINEOPLASTIC AGENTS RIBOCICLIB (RIBOCICLIB SUCCINATE)

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of post-menopausal women 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
- 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

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

10:00.00 ANTINEOPLASTIC AGENTS 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.

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 \leq 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 TABLET

02434814 JAKAVI NVR

15MG TABLET

02388014 JAKAVI NVR

20MG TABLET

02388022 JAKAVI NVR

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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.

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:

02312794 TEMODAL

02241096 TEMODAL

02395312 ACT TEMOZOLOMIDE

02443554 TARO-TEMOZOLOMIDE

250MG CAPSULE

THIOGUANINE 40MG TABLET 00282081 LANVIS

There is no objective evidence of disease progression.			
12.5MG CAP	SULE		
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	LE		
02441160	ACT TEMOZOLOMIDE	ACG	
02443473	TARO-TEMOZOLOMIDE	TAR	
02241093	TEMODAL	FRS	
20MG CAPSULE			
02395274	ACT TEMOZOLOMIDE	ACG	
02443481	TARO-TEMOZOLOMIDE	TAR	
02241094	TEMODAL	FRS	
100MG CAP	SULE		
02395282	ACT TEMOZOLOMIDE	ACG	
02443511	TARO-TEMOZOLOMIDE	TAR	
02241095	TEMODAL	FRS	
140MG CAPSULE			
	ACT TEMOZOLOMIDE	ACG	
	APO-TEMOZOLOMIDE	APX	
02443538	TARO-TEMOZOLOMIDE	TAR	

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.

0.5MG TABLET

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

U.SWIG TABL	. 드 I	
02409623	MEKINIST	NVR
2MG TABLE	Т	
02409658	MEKINIST	NVR
TRETINOIN		
10MG CAPS	ULE	
02145839	VESANOID	CHE
TRIPTORELI	N PAMOATE	
3.75MG/VIAL	POWDER FOR SUSPENSION	
02240000	TRELSTAR	ALL
11.25MG/VIA	AL POWDER FOR SUSPENSION	
02243856	TRELSTAR	ALL
22.5MG POV	VDER FOR SUSPENSION	
02412322	TRELSTAR	ALL

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FRS

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

VENETOCLAX

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of chronic lymphocytic leukemia (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.

Coverage is for a maximum duration of two years

10MG TABLET

02458039 VENCLEXTA ABV

50MG TABLET

02458047 VENCLEXTA ABV

100MG TABLET

 02458055
 VENCLEXTA
 ABV

 02458063
 VENCLEXTA
 ABV

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12:00 AUTONOMIC DRUGS

12:04.00 PARASYMPATHOMIMETIC AGENTS

BETHANECHOL CHLORIDE

10MG TABL	ET	
01947958	DUVOID	PAL
25MG TABL	ET	
01947931	DUVOID	PAL
50MG TABL		
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:

02400588 AURO-DONEPEZIL

02420600 DONEPEZIL

BIO-DONEPEZIL

DONEPEZIL

DONEPEZIL

02412861

02402653

02416425

- 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
02381508	RAN-DONEPEZIL	RBY
02412918	RIVA-DONEPEZIL	RIV
02328666	SANDOZ DONEPEZIL	SDZ
02428482	SEPTA DONEPEZIL	SPT
02340607	TEVA-DONEPEZIL	TEV
10MG TABLE	ĒΤ	
02362279	APO-DONEPEZIL	APX
02232044	ARICEPT	PFI

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 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
02381516	RAN-DONEPEZIL	RBY
02412934	RIVA-DONEPEZIL	RIV
02328682	SANDOZ DONEPEZIL	SDZ
02428490	SEPTA DONEPEZIL	SPT
02340615	TEVA-DONEPEZIL	TEV

GALANTAMINE HYDROBROMIDE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

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

Criteria for coverage at every 12 month interval:

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

ST 8MG CAPSULE (EXTENDED RELEASE)

	,	
02425157	AURO-GALANTAMINE ER	AUR
02443015	GALANTAMINE	SAN
02416573	GALANTAMINE ER	PDL
02420821	MAR-GALANTAMINE ER	MAR
02339439	MYLAN-GALANTAMINE ER	MYL
02316943	PAT-GALANTAMINE ER	JSO

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AUR

BMI

ACC

PDL

SIV

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) 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) 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 00869945 PROSTIGMIN VAE PILOCARPINE HYDROCHLORIDE ST 5MG TABLET 02402483 PILOCARPINE HYDROCHLORIDE **RAX** 02216345 SALAGEN PFI PYRIDOSTIGMINE BROMIDE ST 60MG TABLET 00869961 MESTINON **BSH** ST 180MG TABLET (EXTENDED RELEASE) 00869953 MESTINON-SR **BSH**

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 1.5MG CAPS	SULE	
02336715	APO-RIVASTIGMINE	APX
02242115	EXELON	NVR
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
02401622	MED-RIVASTIGMINE	GMP
02306042	PMS-RIVASTIGMINE	PMS
02417006	RIVASTIGMINE	PDL
02324571	SANDOZ RIVASTIGMINE	SDZ
ST 4.5MG CAPS	SULE	
02336731	APO-RIVASTIGMINE	APX
02242117	EXELON	NVR
02401630	MED-RIVASTIGMINE	GMP
02306050	PMS-RIVASTIGMINE	PMS
02417014	RIVASTIGMINE	PDL
02324598	SANDOZ RIVASTIGMINE	SDZ
ST 6MG CAPSU	JLE	
02336758	APO-RIVASTIGMINE	APX
02242118	EXELON	NVR
02401649	MED-RIVASTIGMINE	GMP
02306069	PMS-RIVASTIGMINE	PMS
02417022	RIVASTIGMINE	PDL
02324601	SANDOZ RIVASTIGMINE	SDZ
ST 2MG/ML SO	LUTION	
02245240	EXELON	NVR
12:08.08 ANTIMUSCARINICS / ANTISPASMODICS		

ACLIDINIUM BROMIDE

400MCG POWDER

02409720 TUDORZA GENUAIR AZC

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12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

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

02240508DOM-IPRATROPIUMDPC02239627PMS-IPRATROPIUMPMS

21MCG NASAL SPRAY

02246083 IPRAVENT AAP
42MCG NASAL SPRAY

02246084 IPRAVENT

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

 02231675
 COMBIVENT
 BOE

 02243789
 RATIO-IPRA SAL
 TEV

 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.

ÓR

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

02245386 SYMBICORT 200 TURBUHALER

AZC

6MCG & 200MCG/INHALATION POWDER

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

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
200MCG PO	WDER	

02243115 VENTOLIN DISKUS

GSK 0.5MG/ML SOLUTION

02208245 PMS-SALBUTAMOL 1MG/ML SOLUTION

INIONIE GOLOTION		
02216949	DOM-SALBUTAMOL	DPC
02208229	PMS-SALBUTAMOL	PMS
01926934	TEVA-SALBUTAMOL	TEV
02213419	VENTOLIN P.F	GSK

2MG/ML SOLUTION

LINIO/INIE OO		
02208237	PMS-SALBUTAMOL	PMS
02173360	TEVA-SALBUTAMOL	TEV
02213427	VENTOLIN P.F	GSK

5MG/ML SOLUTION

02139324	DOM-SALBUTAMOL	DPC
02213486	VENTOLIN RESPIRATOR	GSK

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**

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

Limited use benefit (prior approval required).

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

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

· moderate to severe COPD, as defined by spirometry; OR

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

25MCG	&	125MCG	AEROSOL
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02245126	ADVAIR 125	GSK
25MCG & 25	OMCG AEROSOL	
02245127	ADVAIR 250	GSK
50MCG & 10	OMCG POWDER	
02240835	ADVAIR 100 DISKUS	GSK
50MCG & 25	OMCG POWDER	
02240836	ADVAIR 250 DISKUS	GSK
50MCG & 50	OMCG POWDER	
02240837	ADVAIR 500 DISKUS	GSK

TERBUTALINE SULFATE

500MCG/INHALATION POWDER

00786616 BRICANYL TURBUHALER AZC

12:12.12 ALPHA AND BETA ADRENERGIC **AGONISTS**

EPINEPHRINE

AAP

PMS

0.15MG SOL	UTION		
02382059	ALLERJECT	K	ΆL
0.3MG SOLU	JTION		
02382067	ALLERJECT	K	ΆL
0.5MG/ML S	OLUTION		
00578657	EPIPEN JR	M	IYL
1MG/ML SO	LUTION		
00155357	ADRENALIN	E	RF
00721891	EPINEPHRINE	į	PFI
00509558	EPIPEN	M	IYL

12:16.00 SYMPATHOLYTIC AGENTS DIHYDROERGOTAMINE MESYLATE

1MG/ML LIQUID

IIII O/IVIE EIG	CID	
00027243	DIHYDROERGOTAMINE	RAX
4MG/ML LIQ	UID	
02228947	MIGRANAL	RAX

12:16.04 ALPHA-ADRENERGIC BLOCKING **AGENTS**

ALFUZOSIN HYDROCHLORIDE

ST 10MG TABLET (EXTENDED RELEASE)

02447576	ALFUZOSIN	SIV
02315866	APO-ALFUZOSIN	APX

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12:16.04 ALPHA-ADRENERGIC BLOCKING AGENTS

ALFUZOSIN HYDROCHLORIDE

ST AGAIN TO THE CONTRACT OF TH

" 10MG TABLI	ET (EXTENDED RELEASE)		
02443201	AURO-ALFUZOSIN	AUR	
02304678	SANDOZ ALFUZOSIN	SDZ	
02245565	XATRAL	SAC	
TAMSULOSIN HYDROCHLORIDE			
ST 0.4MG CAPSULE (SUSTAINED RELEASE)			
02294265	RATIO-TAMSULOSIN	TEV	
09857334	RATIO-TAMSULOSIN	RPH	

02319217 SANDOZ TAMSULOSIN 02281392 TEVA-TAMSULOSIN ST 0.4MG TABLET (EXTENDED RELEASE)

J.4IVIG TADL	EI (EXIENDED RELEASE)	
02362406	APO-TAMSULOSIN	APX
02270102	FLOMAX	BOE
02340208	SANDOZ TAMSULOSIN	SDZ
02413612	TAMSULOSIN	PDL
02427117	TAMSULOSIN	SAN
02429667	TAMSULOSIN	SIV
02368242	TEVA-TAMSULOSIN	TEV

12:20.04 CENTRALL ACTING SKELETAL MUSCLE RELAXANTS

CYCLOBENZAPRINE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

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

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

02259893 TIZANIDINE AAP

12:20.08 DIRECT-ACTING SKELETAL MUSCLE RELAXANTS

DANTROLENE SODIUM

25MG CAPSULE

01997602 DANTRIUM PPH

12:20.12 GABA-DERIVATIVE SKELETAL MUSCLE RELAXANTS

BACLOFEN

SDZ

TEV

ST 10MG TABLET				
02139332	APO-BACLOFEN	APX		
02152584	BACLOFEN	PDL		
02287021	BACLOFEN	SAN		
02138271	DOM-BACLOFEN	DPC		
00455881	LIORESAL	NVR		
02088398	MYLAN-BACLOFEN	MYL		
02063735	PMS-BACLOFEN	PMS		
02242150	RIVA-BACLOFEN	RIV		
ST 20MG TABL	ET			
02139391	APO-BACLOFEN	APX		
02152592	BACLOFEN	PDL		
02287048	BACLOFEN	SAN		
02138298	DOM-BACLOFEN	DPC		
00636576	LIORESAL	NVR		
02088401	MYLAN-BACLOFEN	MYL		
02063743	PMS-BACLOFEN	PMS		
02242151	RIVA-BACLOFEN	RIV		
PDIN FOR EXTEMPORANEOUS MIXTURE				
99503011	BACLOFEN ORAL LIQUID	UNK		

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

NICOTINE (GUM)

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

For smoking cessation:

Coverage is limited to 945 pieces during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for nicotine gum or lozenges when one year has elapsed from the day the initial prescription was filled.

NUCCEETTE OUR

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

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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 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 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.

ST 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 PATCH			
01943065	HABITROL	NVC	
80051600	NICOTINE TRANSDERMAL	APX	
80013549	NICOTINE TRANSDERMAL SYSTEM	ADD	
80044392	TRANSDERMAL NICOTINE	ACG	
ST 16MG PATC	Н		
80014321	NICOTINE TRANSDERMAL SYSTEM	ADD	
ST 18MG PATCH			
02241227	TRANSDERMAL NICOTINE PATCHDAY	NVC	

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 21MG PATCH

01943073	HABITROL	NVC
80051603	NICOTINE TRANSDERMAL	APX
80014250	NICOTINE TRANSDERMAL SYSTEM	ADD
80044389	TRANSDERMAL NICOTINE	ACG
$^{\it ST}$ 36MG PATC	Н	
02093111	NICODERM	KIM

ST 53MG PATCH

02241228 TRANSDERMAL NICOTINE NVC PATCHDAY

ST 78MG PATCH

02093138 NICODERM KIM

ST 114MG PATCH

02093146 NICODERM KIM

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-VARENICI INF	TEV

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12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

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 & 1MG TABLET

0.5MG & 1MG TABLET			
02435675	APO-VARENICLINE	APX	
02298309	CHAMPIX STARTER PACK	PFI	
02426781	TEVA-VARENICLINE	TEV	
ST 1MG TABLE	Т		
02419890	APO-VARENICLINE	APX	
02291185	CHAMPIX	PFI	
02426234	TEVA-VARENICLINE	TEV	

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00.00 DI 00D E0DIATION		00.04.04 IDON DDEDADATIONS	
20:00 BLOOD FORMATION		20:04.04 IRON PREPARATIONS	
COAGULATION AND		FERROUS SULFATE	
THROMBOSIS		ST 300MG TABLET	
		02246733 EURO-FERROUS SULFATE	EUR
20:04.04 IRON PREPARATIONS		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	1717 (14	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	JIVIF
ST 60MG/ML SUSPENSION	01411	02243333 FERRLECIT	SAC
01923439 PALAFER	VAE		SAC
ST 300MG/5ML SUSPENSION	V/ \L	IRON (IRON ISOMALTOSIDE 1000)	
02246590 FERRATE	EUR	100MG SOLUTION	
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	JDZ
		02205963 DEXIRON	UNK
sr 300MG TABLET			ONIX
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	
80000435 FERROUS GLUCONATE	NUR	99506015 IRON SUCROSE STERILE	UNK
80002426 FERROUS GLUCONATE	WNP	INFUSION	
80006316 FERROUS GLUCONATE	UNK	POLYSACCHARIDE IRON COMPLEX	
80009681 WAMPOLE FERROUS GLUCONATE	WAM	Limited use benefit (prior approval not required).	
ST 324MG TABLET	\	Far shildren 10 waste of are an under	
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 IRON COMPLEX	
ST 75MG/ML LIQUID		20:12.04 ANTICOAGULANTS	
00762954 ENFAMIL FERINSOL	MJO		
80008309 JAMP FERROUS SULFATE	JMP	ACENOCOUMAROL	
ST 6MG/ML SOLUTION		ST 1MG TABLET	
00017884 ENFAMIL FERINSOL	MJO	00010383 SINTROM	PAL
02242863 PEDIAFER	EUR	ST 4MG TABLET	
ST 15MG/ML SOLUTION		00010391 SINTROM	PAL
02237385 FERODAN INFANT DROPS	ODN		
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).

OR

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

ST 2.5MG TABLET

02377233 ELIQUIS BMS $^{\rm sr}$ 5MG TABLET

02397714 ELIQUIS

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

- 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).

02312441 PRADAXA 150MG CAPSULE

02468905 APO-DABIGATRAN

110MG CAPSULE

02468913 APO-DABIGATRAN 02358808 PRADAXA

DALTEPARIN SODIUM

02352680 FRAGMIN

2,500IU/0.2N	IL SOLUTION		
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/0.5ML SOLUTION			
02352664	FRAGMIN	PFI	
15,000IU/0.6ML SOLUTION			
02352672	FRAGMIN	PFI	
18,000IU/0.72ML SOLUTION			

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

BMS

APX BOE

APX

BOE

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

15MG TABL	ET		
02458640	LIXIANA	SEV	
30MG TABL	ET		
02458659	LIXIANA	SEV	
60MG TABL	ET		
02458667	LIXIANA	SEV	
ENOXAPARI	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		
02378442	LOVENOX	SAC	
150MG/1.0M	IL SOLUTION		
02242692	LOVENOX HP	SAC	
150MG/ML S	SOLUTION		
02378469	LOVENOX HP	SAC	
300MG/3ML	SOLUTION		
02236564	LOVENOX	SAC	
HEPARIN SC	DDIUM		
100U/ML LIC	QUID		
00727520	HEPARIN LEO	LEO	
1,000U/ML L	LIQUID		
00453811	HEPARIN LEO	LEO	
1,000 U/ML	SOLUTION		
	HEPARIN SODIUM (MULTIDOSE VIAL-WITH PRESERVATIVE)	SDZ	
10,000 U/ML SOLUTION			
02303108	HEPARIN SODIUM (MULTIDOSE VIAL-WITH PRESERVATIVE)	SDZ	
02303094	HEPARIN SODIUM (SINGLE USE VIAL-PRESERVATIVE FREE)	SDZ	

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PFI

20:12.04 ANTICOAGULANTS		20:12.04 ANTICOAGULANTS	
HEPARIN SODIUM		TINZAPARIN SODIUM	
5000U SOLUTION		14,000IU/0.7ML SOLUTION	
02456958 HEPARIN SODIUM	UNK	02358174 INNOHEP	LEO
10,000U SOLUTION	UNIX	16,000IU/0.8ML SOLUTION	LLO
02392453 HEPARIN SODIUM	FKD	02429489 INNOHEP	LEO
NADROPARIN CALCIUM	TRD	18,000IU/0.9ML SOLUTION	LLO
NADROPARIN CALCIUM		02358182 INNOHEP	LEO
9,500IU/ML SOLUTION		20,000IU/ML SOLUTION	220
02236913 FRAXIPARINE	ASP	02229515 INNOHEP	LEO
19,000IU/ML SOLUTION		WARFARIN SODIUM	
02240114 FRAXIPARINE FORTE	ASP		
RIVAROXABAN		ST 1MG TABLET	
Limited use benefit (prior approval required).		02242924 APO-WARFARIN	APX
Criteria for riversus han 45 may 200ma tableta (Varalta) for		01918311 COUMADIN	BMS
Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto) for Stroke Prevention in Atrial Fibrillation (SPAF)		02242680 TARO-WARFARIN ST 2MG TABLET	TAR
For at-risk patients (CHADS2 score ≥1) with non-valvular			ADV
atrial fibrillation who require rivaroxaban for the prevention of		02242925 APO-WARFARIN 01918338 COUMADIN	APX BMS
stroke and systemic embolism AND in whom: • Anticoagulation is inadequate (outside the desired INR		01918338 COUMADIN 02242681 TARO-WARFARIN	TAR
range for at least 35% of the tests) with a two-month trial of		ST 2.5MG TABLET	IAN
warfarin; OR		02242926 APO-WARFARIN	APX
Anticoagulation with warfarin is contraindicated; OR		01918346 COUMADIN	BMS
 Anticoagulation is not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e., 		02242682 TARO-WARFARIN	TAR
no access to INR testing service at a laboratory, clinic,		ST 3MG TABLET	1741
pharmacy, and at home)		02245618 APO-WARFARIN	APX
Critoria for rivarovohan 15 mg, 20mg tablata (Varalta)		02240205 COUMADIN	BMS
Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto) For the treatment of venous thromboembolism: Deep Vein		02242683 TARO-WARFARIN	TAR
Thrombosis (DVT) or Pulmonary Embolism (PE).		ST 4MG TABLET	
ST 15MG TABLET		02242927 APO-WARFARIN	APX
02378604 XARELTO	BAY	02007959 COUMADIN	BMS
ST 20MG TABLET		02242684 TARO-WARFARIN	TAR
02378612 XARELTO	BAY	ST 5MG TABLET	
RIVAROXABAN (10)		02242928 APO-WARFARIN	APX
Limited use benefit (prior approval not required).		01918354 COUMADIN	BMS
Emiliad doo borion (prior approval not required).		02242685 TARO-WARFARIN	TAR
For the prevention of venous thromboembolism following total	ıl	6MG TABLET	
knee replacement or total hip replacement surgery, for up to 35 days.		02240206 COUMADIN	BMS
•		02242686 TARO-WARFARIN	TAR
ST 10MG TABLET	DAY	ST 7.5MG TABLET	
02316986 XARELTO	BAY	02242697 TARO-WARFARIN	TAR
TINZAPARIN SODIUM		ST 10MG TABLET	4.537
2,500IU/0.25ML SOLUTION		02242929 APO-WARFARIN	APX
02229755 INNOHEP	LEO	01918362 COUMADIN	BMS
3,500IU/0.35ML SOLUTION		02242687 TARO-WARFARIN	TAR
02358158 INNOHEP	LEO	20:12.14 PLATELET AGGREGATION	
4,500IU/0.45ML SOLUTION		INHIBITORS	
02358166 INNOHEP	LEO	ANAGRELIDE HYDROCHLORIDE	
8,000IU/0.4ML SOLUTION		ST 0.5MG CAPSULE	
02429462 INNOHEP	LEO	02236859 AGRYLIN	SHI
10,000IU/0.5ML SOLUTION	. = 6	02274949 PMS-ANAGRELIDE	PMS
02231478 INNOHEP	LEO	02260107 SANDOZ ANAGRELIDE	SDZ
10,000IU/ML SOLUTION	150		
02167840 INNOHEP	LEO		
12,000IU/0.6ML SOLUTION	150		
02429470 INNOHEP	LEO		

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20:12.18 PLATELET AGGREGATION INHIBITORS

CLOPIDOGREL BISULFATE

ST 75MG TABLET

02303027	ACT CLOPIDOGREL	ACG
02252767	APO-CLOPIDOGREL	APX
02416387	AURO-CLOPIDOGREL	AUR
02385813	CLOPIDOGREL	SIV
02394820	CLOPIDOGREL	PDL
02400553	CLOPIDOGREL	SAN
02378507	DOM-CLOPIDOGREL	DPC
02415550	JAMP-CLOPIDOGREL	JMP
02422255	MAR-CLOPIDOGREL	MAR
02238682	PLAVIX	SAC
02348004	PMS-CLOPIDOGREL	PMS
02379813	RAN-CLOPIDOGREL	RBY
02388529	RIVA-CLOPIDOGREL	RIV
02359316	SANDOZ CLOPIDOGREL	SDZ
02293161	TEVA-CLOPIDOGREL	TEV

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
ST 90MG TABL	ET	
02368544	BRILINTA	AZC
TICLOPIDINE	HYDROCHLORIDE	

02237701 TICLOPIDINE 20:16.00 HEMATOPOIETIC AGENTS

FILGRASTIM

ST 250MG TABLET

300MCG/ML	INJECTION	
09853464	NEUPOGEN (ON)	AMG
99001454	NEUPOGEN (QC)	AMG
300MCG SO	LUTION	
02441489	GRASTOFIL	APX
300MCG/ML	SOLUTION	
01968017	NEUPOGEN	AMG
480MCG SO	LUTION	
02454548	GRASTOFIL	APX

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

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);

AND

AAP

· Prescribed by an oncologist or hematologist.

AND if one of the following are met

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

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

20MG SOLUTION

02377225 MOZOBIL

SAC

20:24.00 HEMORRHEOLOGIC AGENTS PENTOXIFYLLINE

ST 400MG TABLET (EXTENDED RELEASE)

02230090 PENTOXIFYLLINE

AAP

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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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24:00 CARDIOVASCULAR DRUGS		24:04.08 CARDIOTONIC AGENTS	
24:04.04 ANTIARRHYTHMIC AGENTS		DIGOXIN	
		ST 0.05MG/ML SOLUTION	
AMIODARONE HYDROCHLORIDE		02242320 TOLOXIN	PED
ST 100MG TABLET		ST 0.0625MG TABLET	
02292173 PMS-AMIODARONE	PMS	02335700 TOLOXIN	PED
ST 200MG TABLET		ST 0.125MG TABLET	
02364336 AMIODARONE	SAN	02335719 TOLOXIN	PED
02385465 AMIODARONE	SIV	ST 0.250MG TABLET	
02246194 APO-AMIODARONE	APX	02335727 TOLOXIN	PED
02246331 DOM-AMIODARONE	DPC	24:04.92 MISCELLANEOUS CARDIAC	
02242472 PMS-AMIODARONE	PMS	DRUGS	
02309661 PRO-AMIODARONE	PDL		·-·
02247217 RIVA-AMIODARONE 02243836 SANDOZ AMIODARONE	RIV SDZ	IVABRADINE (IVABRADINE HYDROCHLORID) L)
02243836 SANDOZ AMIODARONE 02239835 TEVA-AMIODARONE	TEV	Limited use benefit (prior approval required).	
ST PDIN FOR EXTEMPORANEOUS MIXTURE	IEV	For the treatment of stable chronic heart failure with New Yo	ork
99503016 AMIODARONE ORAL LIQUID	UNK	Heart Association (NYHA) class II or III symptoms in adult	, i.c
DISOPYRAMIDE	ONIX	patients if the following criteria are met:	
		 Left ventricular ejection fraction ≤ 35%; AND Resting heart rate must be documented as ≥ 77 bpm on 	
ST 100MG CAPSULE		average using either an ECG on at least three separate visit	s
02224801 RYTHMODAN	SAC	or by continuous monitoring; AND	
FLECAINIDE ACETATE		Patient has had at least one hospitalization due to heart failure in the least years AND.	
ST 50MG TABLET		failure in the last year; AND • NYHA class II to III symptoms despite at least four weeks	of
02275538 APO-FLECAINIDE	APX	treatment with an angiotensin converting enzyme inhibitor	01
02459957 AURO-FLECAINIDE	AUR	(ACEI) or an angiotensin II receptor antagonist (ARB) in	
ST 100MG TABLET		combination with a beta blocker and, if tolerated, a mineralocorticoid receptor antagonist (MRA).	
02275546 APO-FLECAINIDE	APX	· · · · · · · · · · · · · · · · · · ·	
02459965 AURO-FLECAINIDE	AUR	5MG TABLET	051
MEXILETINE HYDROCHLORIDE		02459973 LANCORA	SEV
sr 100MG CAPSULE		7.5MG TABLET 02459981 LANCORA	SEV
02230359 TEVA-MEXILETINE	TEV		SEV
ST 200MG CAPSULE	IEV	24:06.04 BILE ACID SEQUESTRANTS	
02230360 TEVA-MEXILETINE	TEV	CHOLESTYRAMINE RESIN	
PROCAINAMIDE HYDROCHLORIDE	1 L V	ST 4G POWDER FOR SUSPENSION	
		02455609 CHOLESTYRAMINE-ODAN	ODN
ST 250MG CAPSULE		02478595 JAMP-CHOLESTYRAMINE	JMP
00713325 APO-PROCAINAMIDE	APX	00890960 OLESTYR	PMS
ST 250MG TABLET (EXTENDED RELEASE)		02210320 OLESTYR	PMS
00638692 PROCAN SR	ERF	COLESEVELAM HYDROCHLORIDE	
PROPAFENONE HYDROCHLORIDE		ST 3.75G POWDER FOR SUSPENSION	
ST 150MG TABLET		02432463 LODALIS	VAE
02243324 APO-PROPAFENONE	APX	ST 625MG TABLET	VAL
02457172 MYLAN-PROPAFENONE	MYL	02373955 LODALIS	VAE
02294559 PMS-PROPAFENONE	PMS		VAL
02343053 PROPAFENONE	SAN	COLESTIPOL HYDROCHLORIDE	
00603708 RYTHMOL	BGP	ST 5G GRANULES	
ST 300MG TABLET		00642975 COLESTID	PFI
02243325 APO-PROPAFENONE	APX	02132699 COLESTID ORANGE	PFI
02457164 MYLAN-PROPAFENONE	MYL	ST 1G TABLET	
02294575 PMS-PROPAFENONE	PMS	02132680 COLESTID	PFI
02343061 PROPAFENONE	SAN	24:06.05 CHOLESTEROL ABSORPTION	
00603716 RYTHMOL	BGP	INHIBITORS	
		EZETIMIBE	
		ST 10MG TABLET	
		02425610 ACH-EZETIMIBE	ACC

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24:06.05 CHOLESTEROL ABSORPTION		24:06.06 FIBRIC ACID DERIVATIVES	
INHIBITORS		GEMFIBROZIL	
EZETIMIBE		ST 300MG CAPSULE	
ST 10MG TABLET		01979574 APO-GEMFIBROZIL	APX
02475898 AG-EZETIMIBE	ANG	02241608 DOM-GEMFIBROZIL	DPC
02427826 APO-EZETIMIBE	APX	02239951 PMS-GEMFIBROZIL	PMS
02469286 AURO-EZETIMIBE	AUR	02241704 TEVA-GEMFIBROZIL	TEV
02422549 EZETIMIBE	PDL	ST 600MG TABLET	
02429659 EZETIMIBE	SIV	01979582 APO-GEMFIBROZIL	APX
02431300 EZETIMIBE	SAN	02142074 TEVA-GEMFIBROZIL	TEV
02478544 EZETIMIBE	RIV	24:06.08 HMG-COA REDUCTASE	
02247521 EZETROL	FRS	INHIBITORS	
02423235 JAMP-EZETIMIBE	JMP		
02422662 MAR-EZETIMIBE	MAR	ATORVASTATIN CALCIUM	
02467437 M-EZETIMIBE	MAN	10MG TABLET	
02423243 MINT-EZETIMIBE	MIN	02478145 AG-ATORVASTATIN	ANG
02481669 NRA-EZETIMIBE	UNK	02295261 APO-ATORVASTATIN	APX
02416409 PMS-EZETIMIBE	PMS	02346486 ATORVASTATIN	PDL
02425238 PRIVA-EZETIMIBE	PHA	02348705 ATORVASTATIN	SAN
02419548 RAN-EZETIMIBE	RBY	02396424 ATORVASTATIN	APX
02424436 RIVA-EZETIMIBE	RIV	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
		02399482 DOM-ATORVASTATIN	DPC
BEZAFIBRATE		02391058 JAMP-ATORVASTATIN	JMP
ST 200MG TABLET		02230711 LIPITOR	PFI
02240331 PMS-BEZAFIBRATE	PMS	02454017 MAR-ATORVASTATIN	MAR
ST 400MG TABLET (EXTENDED RELEASE)		02471167 M-ATORVASTATIN	MAN
02083523 BEZALIP SR	ALL	02392933 MYLAN-ATORVASTATIN	MYL
02453312 JAMP-BEZAFIBRATE	JMP	02476517 NRA-ATORVASTATIN	UNK
FENOFIBRATE		02313707 RAN-ATORVASTATIN	RBY
		02417936 REDDY-ATORVASTATIN	REC
ST 67MG CAPSULE	4.45	02422751 RIVA-ATORVASTATIN	RIV
02243180 AA-FENO-MICRO	AAP	02324946 SANDOZ ATORVASTATIN	SDZ
ST 100MG CAPSULE	445	02310899 TEVA-ATORVASTATIN	TEV
02225980 FENOFIBRATE	AAP	20MG TABLET	
ST 160MG CAPSULE	OID	02478153 AG-ATORVASTATIN	ANG
02250004 FENOMAX	CIP	02295288 APO-ATORVASTATIN	APX
ST 200MG CAPSULE	4.45	02346494 ATORVASTATIN	PDL
02239864 AA-FENO-MICRO	AAP	02348713 ATORVASTATIN	SAN
02240360 FENO-MICRO	PDL	02396432 ATORVASTATIN	APX
ST 48MG TABLET		02399385 ATORVASTATIN	PMS
02269074 LIPIDIL EZ	BGP	02475030 ATORVASTATIN	RIV
02390698 SANDOZ FENOFIBRATE E	SDZ	02411369 ATORVASTATIN-20	SIV
ST 100MG TABLET	4.504	02407264 AURO-ATORVASTATIN	AUR
02246859 APO-FENO-SUPER	APX	02399490 DOM-ATORVASTATIN	DPC
02288044 SANDOZ FENOFIBRATE S	SDZ	02391066 JAMP-ATORVASTATIN	JMP
ST 145MG TABLET	DOD	02230713 LIPITOR	PFI
02269082 LIPIDIL EZ	BGP	02454025 MAR-ATORVASTATIN	MAR
02465167 MINT-FENOFIBRATE E	MIN	02471175 M-ATORVASTATIN	MAN
02390701 SANDOZ FENOFIBRATE E	SDZ	02392941 MYLAN-ATORVASTATIN	MYL
ST 160MG TABLET	A DV	02476525 NRA-ATORVASTATIN	UNK
02246860 APO-FENO-SUPER	APX	02313715 RAN-ATORVASTATIN	RBY
02241602 LIPIDIL SUPRA	BGP	02417944 REDDY-ATORVASTATIN	REC
02310236 PRO-FENO-SUPER	PDL	02422778 RIVA-ATORVASTATIN	RIV
02288052 SANDOZ FENOFIBRATE S	SDZ	02324954 SANDOZ ATORVASTATIN	SDZ

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24:06.08 HMG-COA REDUCTASE INHIBITORS		24:06.08 HMG-COA REDUCTASE INHIBITORS	
ATORVASTATIN CALCIUM		LOVASTATIN	
20MG TABLET	TC\	ST 20MG TABLET	400
02310902 TEVA-ATORVASTATIN	TEV	02248572 ACT LOVASTATIN 02220172 APO-LOVASTATIN	ACG APX
40MG TABLET 02478161 AG-ATORVASTATIN	ANG	02353229 LOVASTATIN	SAN
02295296 APO-ATORVASTATIN	APX	02246013 PMS-LOVASTATIN	PMS
02346508 ATORVASTATIN	PDL	st 40MG TABLET	FIVIS
02348721 ATORVASTATIN	SAN	02248573 ACT LOVASTATIN	ACG
02396440 ATORVASTATIN	APX	02220180 APO-LOVASTATIN	APX
02399393 ATORVASTATIN	PMS	02353237 LOVASTATIN	SAN
02411377 ATORVASTATIN-40	SIV	02246014 PMS-LOVASTATIN	PMS
02407272 AURO-ATORVASTATIN	AUR	PRAVASTATIN SODIUM	1 1010
02399504 DOM-ATORVASTATIN	DPC		
02391074 JAMP-ATORVASTATIN	JMP	ST 10MG TABLET	
02230714 LIPITOR	PFI	02243506 APO-PRAVASTATIN	APX
02454033 MAR-ATORVASTATIN	MAR	02458977 AURO-PRAVASTATIN	AUR
02471183 M-ATORVASTATIN	MAN	02446251 BIO-PRAVASTATIN	BMI
02392968 MYLAN-ATORVASTATIN	MYL	02249723 DOM-PRAVASTATIN	DPC
02476533 NRA-ATORVASTATIN	UNK	02330954 JAMP-PRAVASTATIN	JMP
02313723 RAN-ATORVASTATIN	RBY	02432048 MAR-PRAVASTATIN	MAR
02417952 REDDY-ATORVASTATIN	REC	02317451 MINT-PRAVASTATIN	MIN
02422786 RIVA-ATORVASTATIN	RIV	02476274 M-PRAVASTATIN	MAN
02324962 SANDOZ ATORVASTATIN	SDZ	02247655 PMS-PRAVASTATIN	PMS
02310910 TEVA-ATORVASTATIN	TEV	02356546 PRAVASTATIN	SAN
80MG TABLET		02389703 PRAVASTATIN	SIV
02478188 AG-ATORVASTATIN	ANG	02243824 PRAVASTATIN-10	PDL
02295318 APO-ATORVASTATIN	APX	02284421 RAN-PRAVASTATIN	RBY
02346516 ATORVASTATIN	PDL	02468700 SANDOZ PRAVASTATIN	SDZ
02348748 ATORVASTATIN	SAN	02247008 TEVA-PRAVASTATIN	TEV
02396459 ATORVASTATIN	APX	ST 20MG TABLET	
02399407 ATORVASTATIN	PMS	02243507 APO-PRAVASTATIN	APX
02475057 ATORVASTATIN	RIV	02458985 AURO-PRAVASTATIN	AUR
02411385 ATORVASTATIN-80	SIV	02446278 BIO-PRAVASTATIN	BMI
02407280 AURO-ATORVASTATIN	AUR	02249731 DOM-PRAVASTATIN	DPC
02391082 JAMP-ATORVASTATIN	JMP	02330962 JAMP-PRAVASTATIN	JMP
02243097 LIPITOR	PFI	02432056 MAR-PRAVASTATIN	MAR
02454041 MAR-ATORVASTATIN	MAR	02317478 MINT-PRAVASTATIN	MIN
02471191 M-ATORVASTATIN	MAN	02476282 M-PRAVASTATIN	MAN
02392976 MYLAN-ATORVASTATIN	MYL	02247656 PMS-PRAVASTATIN	PMS
02476541 NRA-ATORVASTATIN	UNK	00893757 PRAVACHOL	BMS
02313758 RAN-ATORVASTATIN	RBY	02356554 PRAVASTATIN 02389738 PRAVASTATIN	SAN
02417960 REDDY-ATORVASTATIN	REC		SIV
02422794 RIVA-ATORVASTATIN	RIV	02243825 PRAVASTATIN-20 02284448 RAN-PRAVASTATIN	PDL RBY
02324970 SANDOZ ATORVASTATIN	SDZ		
02310929 TEVA-ATORVASTATIN	TEV	02468719 SANDOZ PRAVASTATIN 02247009 TEVA-PRAVASTATIN	SDZ TEV
FLUVASTATIN SODIUM		st 40MG TABLET	Ι⊏V
ST 20MG CAPSULE		02243508 APO-PRAVASTATIN	APX
02299224 TEVA-FLUVASTATIN	TEV	02458993 AURO-PRAVASTATIN	AUR
ST 40MG CAPSULE	I L V	02446286 BIO-PRAVASTATIN	BMI
02299232 TEVA-FLUVASTATIN	TEV	02249758 DOM-PRAVASTATIN	DPC
ST 80MG TABLET (EXTENDED RELEASE)	I L V	02330970 JAMP-PRAVASTATIN	JMP
02250527 LESCOL XL	NVR	02432064 MAR-PRAVASTATIN	MAR
VZZVVVZI LLOVOL AL	INVIX	02317486 MINT-PRAVASTATIN	MIN
		02476290 M-PRAVASTATIN	MAN
		0217 0200 111 1 1 W W 1 O 1 / 1 1 1 W	1717 11 1

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	-COA REDUCTASE BITORS			IG-COA REDUCTASE	
PRAVASTATIN	SODION			ATIN CALCIUM	
ST 40MG TABLET			ST 20MG TABL		
	MS-PRAVASTATIN	PMS	02337991	APO-ROSUVASTATIN	APX
	RAVACHOL	BMS	02442590	AURO-ROSUVASTATIN	AUR
	RAVASTATIN	SAN	02444984	BIO-ROSUVASTATIN	BMI
	RAVASTATIN	SIV	02247163	CRESTOR	AZC
	RAVASTATIN-40	PDL	02386720	DOM-ROSUVASTATIN	DPC
	AN-PRAVASTATIN	RBY	02391279	JAMP-ROSUVASTATIN	JMP
	ANDOZ PRAVASTATIN	SDZ	02413086	MAR-ROSUVASTATIN	MAR
	EVA-PRAVASTATIN	TEV	02399180	MED-ROSUVASTATIN	GMP
ROSUVASTATI	N CALCIUM		02477505	NRA-ROSUVASTATIN	UNK
ST 5MG TABLET			02378558	PMS-ROSUVASTATIN	PMS
02438917 A	CH-ROSUVASTATIN	ACC	02380064	RIVA-ROSUVASTATIN	RIV
02477033 A	G-ROSUVASTATIN	ANG	02381192	ROSUVASTATIN	PDL
02337975 A	PO-ROSUVASTATIN	APX	02405644	ROSUVASTATIN	SAN
02442574 A	URO-ROSUVASTATIN	AUR	02411644	ROSUVASTATIN	SIV
02444968 B	IO-ROSUVASTATIN	BMI	02338742	SANDOZ ROSUVASTATIN	SDZ
02265540 C	RESTOR	AZC	02382660	TARO-ROSUVASTATIN	SUN
02386704 D	OM-ROSUVASTATIN	DPC	02354624 ^{sr} 40MG TABL	TEVA-ROSUVASTATIN	TEV
02391252 J	AMP-ROSUVASTATIN	JMP			ACC
02413051 N	IAR-ROSUVASTATIN	MAR	02438941	ACH-ROSUVASTATIN	ACC
02399164 N	IED-ROSUVASTATIN	GMP	02477076 02338009	AG-ROSUVASTATIN APO-ROSUVASTATIN	ANG APX
02477483 N	RA-ROSUVASTATIN	UNK	02442604	AURO-ROSUVASTATIN	AUR
02378523 P	MS-ROSUVASTATIN	PMS	02444992	BIO-ROSUVASTATIN	BMI
02380013 R	IVA-ROSUVASTATIN	RIV	02247164	CRESTOR	AZC
02381176 R	OSUVASTATIN	PDL	02391287	JAMP-ROSUVASTATIN	JMP
02405628 R	OSUVASTATIN	SAN	02413108	MAR-ROSUVASTATIN	MAR
02411628 R	OSUVASTATIN	SIV	02399199	MED-ROSUVASTATIN	GMP
02338726 S	ANDOZ ROSUVASTATIN	SDZ	02477513	NRA-ROSUVASTATIN	UNK
02382644 T	ARO-ROSUVASTATIN	SUN	02378566	PMS-ROSUVASTATIN	PMS
02354608 T	EVA-ROSUVASTATIN	TEV	02380102	RIVA-ROSUVASTATIN	RIV
ST 10MG TABLET			02381206	ROSUVASTATIN	PDL
02438925 A	CH-ROSUVASTATIN	ACC	02405652	ROSUVASTATIN	SAN
02477041 A	G-ROSUVASTATIN	ANG	02411652	ROSUVASTATIN	SIV
02337983 A	PO-ROSUVASTATIN	APX	02338750	SANDOZ ROSUVASTATIN	SDZ
02442582 A	URO-ROSUVASTATIN	AUR	02382679	TARO-ROSUVASTATIN	SUN
	IO-ROSUVASTATIN	BMI	02354632	TEVA-ROSUVASTATIN	TEV
	RESTOR	AZC	SIMVASTATI		
	OM-ROSUVASTATIN	DPC			
	AMP-ROSUVASTATIN	JMP	5MG TABLE		
	IAR-ROSUVASTATIN	MAR	02480050	AG-SIMVASTATIN	ANG
	IED-ROSUVASTATIN	GMP	02247011	APO-SIMVASTATIN	APX
	RA-ROSUVASTATIN	UNK	02405148	AURO-SIMVASTATIN	AUR
	MS-ROSUVASTATIN	PMS	02253747	DOM-SIMVASTATIN	DPC
	IVA-ROSUVASTATIN	RIV	02281619	DOM-SIMVASTATIN	DPC
	OSUVASTATIN	PDL	02375591	JAMP-SIMVASTATIN	JMP
	OSUVASTATIN	SAN	02375036	MAR-SIMVASTATIN	MAR
	OSUVASTATIN	SIV	02372932	MINT-SIMVASTATIN	MIN
	ANDOZ ROSUVASTATIN	SDZ	02469979	PHARMA-SIMVASTATIN	PMS
	ARO-ROSUVASTATIN	SUN	02269252	PMS-SIMVASTATIN	PMS
	EVA-ROSUVASTATIN	TEV	02329131	RAN-SIMVASTATIN	RBY
ST 20MG TABLET		400	02247827 02386291	SANDOZ SIMVASTATIN SIMVASTATIN	SDZ SIV
	CH-ROSUVASTATIN	ACC	02250144	TEVA-SIMVASTATIN	TEV
02477068 A	G-ROSUVASTATIN	ANG	02230144	ILVA-SIIVIVASTATIIV	I⊏V

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24:06.08 HMG-COA REDUCTASE 24:06.08 HMG-COA REDUCTASE **INHIBITORS INHIBITORS SIMVASTATIN SIMVASTATIN 10MG TABLET 80MG TABLET** 02480069 AG-SIMVASTATIN **ANG** 02480093 AG-SIMVASTATIN **ANG** 02247012 APO-SIMVASTATIN APX 02247015 APO-SIMVASTATIN **APX** 02405156 **AURO-SIMVASTATIN AUR** 02405180 **AURO-SIMVASTATIN AUR** 02484455 **BIO-SIMVASTATIN** BMI 02253798 DOM-SIMVASTATIN DPC DPC 02253755 DOM-SIMVASTATIN DPC 02281651 DOM-SIMVASTATIN DPC 02281627 DOM-SIMVASTATIN 02375648 JAMP-SIMVASTATIN **JMP** 02375605 JAMP-SIMVASTATIN **JMP** 02375079 MAR-SIMVASTATIN MAR 02375044 MAR-SIMVASTATIN MAR 02372975 MINT-SIMVASTATIN MIN 02372940 MINT-SIMVASTATIN MIN 02470012 PHARMA-SIMVASTATIN **PMS** 02469987 PHARMA-SIMVASTATIN **PMS** 02269295 PMS-SIMVASTATIN **PMS** 02269260 PMS-SIMVASTATIN **PMS** 02329182 RAN-SIMVASTATIN **RBY** 02329158 **RAN-SIMVASTATIN RBY** 02247833 SANDOZ SIMVASTATIN SDZ SDZ SIV 02247828 SANDOZ SIMVASTATIN 02386348 **SIMVASTATIN** 02386305 **SIMVASTATIN** SIV 02247224 SIMVASTATIN-80 **PDL** PDL 02247221 SIMVASTATIN-10 02250187 **TEVA-SIMVASTATIN TEV TEVA-SIMVASTATIN** TEV 02250152 00884332 **70COR FRS 20MG TABLET** AG-SIMVASTATIN 02480077 ANG 02247013 APO-SIMVASTATIN **APX** 02405164 **AURO-SIMVASTATIN AUR** 02484463 **BIO-SIMVASTATIN** BMI DPC 02253763 DOM-SIMVASTATIN 02281635 DOM-SIMVASTATIN DPC 02375613 JAMP-SIMVASTATIN **JMP** 02375052 MAR-SIMVASTATIN MAR 02372959 MINT-SIMVASTATIN MIN 02469995 PHARMA-SIMVASTATIN **PMS** PMS-SIMVASTATIN **PMS** 02269279 02329166 **RAN-SIMVASTATIN RBY** 02247830 SANDOZ SIMVASTATIN SDZ 02386313 SIMVASTATIN SIV PDL 02247222 SIMVASTATIN-20 02250160 **TEVA-SIMVASTATIN** TEV 00884340 **ZOCOR FRS 40MG TABLET** AG-SIMVASTATIN 02480085 **ANG** 02247014 APO-SIMVASTATIN **APX AUR** 02405172 **AURO-SIMVASTATIN** 02484471 **BIO-SIMVASTATIN** BMI 02253771 DOM-SIMVASTATIN DPC DPC 02281643 DOM-SIMVASTATIN 02375621 JAMP-SIMVASTATIN **JMP** 02375060 MAR-SIMVASTATIN MAR MINT-SIMVASTATIN 02372967 MIN 02470004 PHARMA-SIMVASTATIN **PMS** 02269287 PMS-SIMVASTATIN **PMS** 02329174 **RAN-SIMVASTATIN RBY** SDZ 02247831 SANDOZ SIMVASTATIN 02386321 **SIMVASTATIN** SIV 02247223 SIMVASTATIN-40 **PDL** 02250179 TEVA-SIMVASTATIN TEV 00884359 **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:

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

75MG SOLUTION

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

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; 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.

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

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 TFV

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04.00.40. 6=11=541. 41=114. 15	ONIOTO	04.40.00 1	FDATES AND MICHES	
24:08.16 CENTRAL ALPHA-AG	UNISTS		TRATES AND NITRITES	
CLONIDINE HYDROCHLORIDE		NITROGLYC	ERIN	
ST 0.2MG TABLET		^{s⊤} 0.2MG PATO	СН	
00868957 APO-CLONIDINE	APX	02162806	MINITRAN	VAE
02462206 MINT-CLONIDINE	MIN	02407442	MYLAN-NITRO	MYL
02046148 TEVA-CLONIDINE	TEV	01911910	NITRO-DUR	FRS
$^{s au}$ PDIN FOR EXTEMPORANEOUS MIXTU		00584223		NVR
99503021 CLONIDINE ORAL LIQUII	D UNK		TRINIPATCH	PAL
METHYLDOPA		ST 0.4MG PATO		
sr 125MG TABLET			MINITRAN	VAE
00360252 METHYLDOPA	AAP	02407450		MYL
ST 250MG TABLET			NITRO-DUR	FRS
00360260 METHYLDOPA	AAP		TRANSDERM-NITRO TRINIPATCH	NVR PAL
ST 500MG TABLET		02230733 ST 0.6MG PAT(PAL
00426830 METHYLDOPA	AAP	0.0MG PATO 02163535		VAE
24:08.20 DIRECT VASODILATO	RS	02407469		MYL
DIAZOXIDE		01911929	=	FRS
		02046156	TRANSDERM-NITRO	NVR
ST 100MG CAPSULE			TRINIPATCH	PAL
00503347 PROGLYCEM	FRS	ST 0.8MG PATO		
HYDRALAZINE HYDROCHLORIDE	E		MYLAN-NITRO	MYL
ST 10MG TABLET		02011271	NITRO-DUR	FRS
00441619 APO-HYDRALAZINE	APX	0.4MG PUM	P	
02457865 JAMP-HYDRALAZINE	JMP	02393433	APO-NITROGLYCERIN	APX
02468778 MINT-HYDRALAZINE	MIN	02243588	MYLAN-NITRO	MYL
ST 25MG TABLET		02231441	NITROLINGUAL PUMPSPRAY	SAC
00441627 APO-HYDRALAZINE	APX	02238998	RHO-NITRO PUMPSPRAY	SDZ
02457873 JAMP-HYDRALAZINE	JMP	ST 0.3MG TABL	_ET	
02468786 MINT-HYDRALAZINE	MIN		NITROSTAT	PFI
ST 50MG TABLET		ST 0.6MG TABL	_ET	
00441635 APO-HYDRALAZINE	APX	00037621	NITROSTAT	PFI
02457881 JAMP-HYDRALAZINE	JMP	24:12.12 PH	OSPHODIESTERASE	
02468794 MINT-HYDRALAZINE	MIN	INI	HIBITORS	
MINOXIDIL		SILDENAFIL	CITRATE	
ST 2.5MG TABLET		_	efit (prior approval required).	
00514497 LONITEN	PFI	Limited use bene	ent (prior approvar required).	
ST 10MG TABLET		Must be initiated	by a Pulmonary Hypertension specia	llist
00514500 LONITEN	PFI	Detients with Mr		
24:12.08 NITRATES AND NITRI	TES		orld Health Organization (WHO) class hypertension (PAH), either idiopathio	
ISOSORBIDE DINITRATE			ciated with a congenital or systemic c	
			tissue disease) and confirmed by righ	nt heart
ST 5MG TABLET		catheterization.		
00670944 ISDN	AAP	ST 20MG TABL		
ST 10MG TABLET	A A D		APO-SILDENAFIL R	APX
00441686 ISDN	AAP	02412179		PMS
00786667 PMS-ISOSORBIDE ST 30MG TABLET	PMS	02279401		PFI
00441694 ISDN	AAP	02319500	TEVA-SILDENAFIL R	TEV
	AAF			
ISOSORBIDE-5-MONONITRATE				
ST 60MG TABLET (EXTENDED RELEASE	•			
02272830 APO-ISMN	APX			
02126559 IMDUR	UNK			
02301288 PMS-ISMN	PMS			
02311321 PRO-ISMN	PDL			

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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

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.

02399202 APO-BOSENTAN

02386283 SANDOZ BOSENTAN

00571245 APO-DIPYRIDAMOLE

ST 62.5MG TABLET

02383012	PMS-BOSENTAN	PMS
02386275	SANDOZ BOSENTAN	SDZ
02398400	TEVA-BOSENTAN	TEV
02244981	TRACLEER	JSO
125MG TAB	LET	
02383020	PMS-BOSENTAN	PMS

02244982 TRACLEER

DIPYRIDAMO	JLE	
ST 25MG TABL	ET	
00895644	APO-DIPYRIDAMOLE	APX
ST 50MG TABL	ET	

24:12.92 MISCELLANEOUS VASODILATING AGENTS

DIPYRIDAMOLE

57 50MG TABLET

00895652 APO-DIPYRIDAMOLE APX

***75MG TABLET

00601845 APO-DIPYRIDAMOLE APX

00601845APO-DIPYRIDAMOLEAPX00895660APO-DIPYRIDAMOLEAPX

DIPYRIDAMOLE, ACETYLSALICYLIC ACID

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

02242119 AGGRENOX BOE 02471051 TARO-DIPYRIDAMOLE/ ASA TAR

24:20.00 ALPHA ADRENERGIC BLOCKING AGENTS

DOXAZOSIN MESYLATE

ST 1MG TABLET

INIO IADEL	•	
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	TEV
DDAZOSINI L	INDBUCHI UBIDE	•

PRAZOSIN HYDROCHLORIDE

ST 1MG	TABLET
--------	---------------

GSK

APX

SDZ

JSO

APX

00882801	APO-PRAZO	APX
01934198	TEVA-PRAZOSIN	TEV
$^{\mathtt{ST}}$ 2MG TABLE	T	
00882828	APO-PRAZO	APX
01934201	TEVA-PRAZOSIN	TEV
ST 5MG TABLE	T	
00882836	APO-PRAZO	APX
01934228	TEVA-PRAZOSIN	TEV

TERAZOSIN HYDROCHLORIDE

ST 1MG TABLET

INIO IADEL	•	
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

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24:20.00 AL	PHA ADRENERGIC BL	OCKING	24:24.00 BE	TA ADRENERGIC BLOCKI	NC
	ENTS	OCKING		ENTS	ING
TERAZOSIN	HYDROCHLORIDE		ATENOLOL		
ST 5MG TABLE			ST 50MG TABL	ET	
	APO-TERAZOSIN	APX		MAR-ATENOLOL	MAR
	DOM-TERAZOSIN	DPC		MINT-ATENOLOL	MIN
	PMS-TERAZOSIN	PMS		PMS-ATENOLOL	PMS
02237478	TERAZOSIN	PDL		RAN-ATENOLOL	RBY
02350491	TERAZOSIN	SAN		RIVA-ATENOLOL	RIV
	TEVA-TERAZOSIN	TEV	02368641		SPT
ST 10MG TABLI				TENORMIN	AZC
	APO-TERAZOSIN	APX		TEVA-ATENOLOL	TEV
02243749	DOM-TERAZOSIN	DPC	ST 100MG TAB		
02243521	PMS-TERAZOSIN	PMS	02255553	ACT ATENOLOL	ACG
02237479	TERAZOSIN	PDL	02369192	AG-ATENOLOL	ANG
02350505	TERAZOSIN	SAN	00773697	APO-ATENOL	APX
02230808	TEVA-TERAZOSIN	TEV	00828793	ATENOLOL	PDL
24:24 00 BE	TA ADRENERGIC BLO	CKING	02238318	ATENOLOL	SIV
	ENTS	O. C. I. C.	02466473	ATENOLOL	SAN
_	_		02392186	BIO-ATENOLOL	BMI
ACEBUTOLO	L HYDROCHLORIDE		02229468	DOM-ATENOLOL	DPC
ST 100MG TABI	LET		02367572	JAMP-ATENOLOL	JMP
02164396	ACEBUTOLOL	PDL	02371995	MAR-ATENOLOL	MAR
02147602	APO-ACEBUTOLOL	APX	02368048	MINT-ATENOL	MIN
02204517	TEVA-ACEBUTOLOL	TEV	02237601	PMS-ATENOLOL	PMS
ST 200MG TABI	LET		02267993	RAN-ATENOLOL	RBY
02164418	ACEBUTOLOL	PDL	02242093	RIVA-ATENOLOL	RIV
02147610	APO-ACEBUTOLOL	APX	02368668	SEPTA-ATENOLOL	SPT
02204525	TEVA-ACEBUTOLOL	TEV	02039540	TENORMIN	AZC
ST 400MG TABI	LET		02171805	TEVA-ATENOLOL	TEV
02164426	ACEBUTOLOL	PDL	ATENOLOL,	CHLORTHALIDONE	
02147629	APO-ACEBUTOLOL	APX	ST 50MG & 25M	IG TARI ET	
02204533	TEVA-ACEBUTOLOL	TEV		APO-ATENIDONE	APX
ATENOLOL				TENORETIC	AZC
25MG TABLI	FT		02302918	TEVA-	TEV
	AG-ATENOLOL	ANG	02002010	ATENOLOL/CHLORTHALIDONE	
	ATENOLOL	PDL	ST 100MG & 25	MG TABLET	
02392194	BIO-ATENOLOL	BMI	02248764	APO-ATENIDONE	APX
02367556	JAMP-ATENOLOL	JMP	02049988	TENORETIC	AZC
02371979	MAR-ATENOLOL	MAR	02302926	TEVA-	TEV
02368013	MINT-ATENOL	MIN		ATENOLOL/CHLORTHALIDONE	
02246581	PMS-ATENOLOL	PMS	BISOPROLO	L FUMARATE	
02373963	RAN-ATENOLOL	RBY	ST 5MG TABLE	т	
02277379	RIVA-ATENOLOL	RIV		APO-BISOPROLOL	APX
02368633	SEPTA-ATENOLOL	SPT		BISOPROLOL	SIV
02266660	TEVA-ATENOLOL	TEV		BISOPROLOL	SAN
ST 50MG TABLI	ET		02465612	MINT-BISOPROLOL	MIN
02255545	ACT ATENOLOL	ACG	02302632	PMS-BISOPROLOL	PMS
02369184	AG-ATENOLOL	ANG	02306999	PRO-BISOPROLOL	PDL
00773689	APO-ATENOL	APX	02471264		RIV
00828807	ATENOLOL	PDL	02247439		SDZ
02238316	ATENOLOL	SIV	02267470	TEVA-BISOPROLOL	TEV
02466465	ATENOLOL	SAN	$^{s au}$ 10MG TABL	ET	
02392178	BIO-ATENOLOL	BMI	02256177	APO-BISOPROLOL	APX
02229467	DOM-ATENOLOL	DPC	02383063	BISOPROLOL	SIV
02367564	JAMP-ATENOLOL	JMP	02391597	BISOPROLOL	SAN

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	BETA ADRENERGIC BLO	OCKING	24:24.00 BETA ADRENERGIC BLOCKII	NG
, and a	AGENTS		AGENTS	
BISOPROI	LOL FUMARATE		HYDROCHLOROTHIAZIDE, PINDOLOL	
^{sτ} 10MG TA	BI FT		ST 10MG & 25MG TABLET	
	20 MINT-BISOPROLOL	MIN	00568627 VISKAZIDE	UNK
	40 PMS-BISOPROLOL	PMS	ST 10MG & 50MG TABLET	
	06 PRO-BISOPROLOL	PDL	00568635 VISKAZIDE	UNK
0247127	72 RIVA-BISOPROLOL	RIV	LABETALOL HYDROCHLORIDE	
0224744	40 SANDOZ BISOPROLOL	SDZ		
0226748	39 TEVA-BISOPROLOL	TEV	ST 100MG TABLET	D0.4
CARVEDIL	.OL		02489406 RIVA-LABETALOL	RIV
ST 3.125MG	TABLET		02106272 TRANDATE ST 200MG TABLET	PAL
	33 APO-CARVEDILOL	APX		DIV
	95 AURO-CARVEDILOL	AUR	02489414 RIVA-LABETALOL	RIV PAL
	52 CARVEDILOL	SIV	02106280 TRANDATE	PAL
	04 CARVEDILOL	PDL	METOPROLOL TARTRATE	
	13 CARVEDILOL	SAN	ST 25MG TABLET	
	18 DOM-CARVEDILOL	DPC	02246010 APO-METOPROLOL	APX
0236889		JMP	02252252 DOM-METOPROLOL-L	DPC
0224591		PMS	02356813 JAMP-METOPROLOL-L	JMP
	27 RAN-CARVEDILOL	RBY	02296713 METOPROLOL	PDL
0225230		TEV	02442116 METOPROLOL-L	SIV
ST 6.25MG T			02248855 PMS-METOPROLOL-L	PMS
	34 APO-CARVEDILOL	APX	02315300 RIVA-METOPROLOL L	RIV
	09 AURO-CARVEDILOL	AUR	02261898 TEVA-METOPROLOL	TEV
	53 CARVEDILOL	SIV	ST 50MG TABLET	
	12 CARVEDILOL	PDL	00618632 APO METOPROLOL	APX
0236492		SAN	00749354 APO METOPROLOL (TYPE L)	APX
0224874		DPC	02172550 DOM-METOPROLOL-B	DPC
0236890		JMP	02231121 DOM-METOPROLOL-L	DPC
0224591		PMS	02356821 JAMP-METOPROLOL-L	JMP
0226803	35 RAN-CARVEDILOL	RBY	00648019 METOPROLOL	PDL
0225231	17 TEVA-CARVEDILOL	TEV	02350394 METOPROLOL	SAN
ST 12.5MG T	ABLET		02442124 METOPROLOL-L	SIV
0224793	35 APO-CARVEDILOL	APX	02145413 PMS-METOPROLOL-B	PMS
0241851	17 AURO-CARVEDILOL	AUR	02230803 PMS-METOPROLOL-L	PMS
0224875	54 CARVEDILOL	SIV	02315319 RIVA-METOPROLOL L	RIV
0232452	20 CARVEDILOL	PDL	00648035 TEVA-METOPROLOL	TEV
0236494	48 CARVEDILOL	SAN	00842648 TEVA-METOPROLOL	TEV
0224875	50 DOM-CARVEDILOL	DPC	ST 100MG TABLET	
0236891	19 JAMP-CARVEDILOL	JMP	00618640 APO METOPROLOL	APX
0224591	16 PMS-CARVEDILOL	PMS	00751170 APO-METOPROLOL (TYPE L)	APX
0226804	13 RAN-CARVEDILOL	RBY	02172569 DOM-METOPROLOL-B	DPC
0225232	25 TEVA-CARVEDILOL	TEV	02231122 DOM-METOPROLOL-L	DPC
ST 25MG TA	BLET		02356848 JAMP-METOPROLOL-L	JMP
0224793	36 APO-CARVEDILOL	APX	00648027 METOPROLOL	PDL
0241852	25 AURO-CARVEDILOL	AUR	02350408 METOPROLOL 02442422 METOPROLOL 1	SAN
0224875	55 CARVEDILOL	SIV	02442132 METOPROLOL-L	SIV
0232453	39 CARVEDILOL	PDL	02145421 PMS-METOPROLOL-B	PMS
0236495	56 CARVEDILOL	SAN	02230804 PMS-METOPROLOL-L 02315327 RIVA-METOPROLOL L	PMS RIV
0224875	51 DOM-CARVEDILOL	DPC		
0236892	27 JAMP-CARVEDILOL	JMP	00648043 TEVA-METOPROLOL 00842656 TEVA-METOPROLOL	TEV TEV
0224591	17 PMS-CARVEDILOL	PMS	st 100MG TABLET (EXTENDED RELEASE)	Ι⊏V
0226805	51 RAN-CARVEDILOL	RBY	02285169 APO-METOPROLOL SR	APX
0225233	33 TEVA-CARVEDILOL	TEV	00658855 LOPRESOR SR	NVR
			02351404 METOPROLOL SR	PDL
			UZUU ITUT IVIL I UF NULUL ON	FUL

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### TOPROLOL TARTRATE #*100MG TABLET (EXTENDED RELEASE) 0.02030376 SANDOZ METOPROLOL SR SDZ #*200MG TABLET (EXTENDED RELEASE) 0.0280377 APO-METOPROLOL SR NZ 0.0280377 APO-METOPROLOL SR NZ 0.0280377 APO-METOPROLOL SR NZ 0.0230373 SANDOZ METOPROLOL ORAL LIQUID UNK 0.0303273 METOPROLOL ORAL LIQUID UNK NADOLOL #*40MG TABLET 0.0762695 NADOLOL APA 1*00762675 NADOLOL APA 1*00762677 APO-PINDOL APA 0.0036277 APO-PINDOL 0.045677 APO-PINDOL 0.045677 APO-PINDOL 0.045677 APO-PINDOL 0.0566907 TEVA-PINDOLOL 1*00765686 APO-PINDOL 0.0869007 TEVA-PINDOLOL 0.0869007	24:24.00 BETA ADRENERGIC BLOCKI AGENTS	NG	24:24.00 BETA ADRENERGIC BLOCKING AGENTS	i
02933398 SANDOZ METOPROLOL SR APX 00740875 TEV-APROPRANOLOL TEV TEV 2008 TABLET TEXTENDED RELEASE 02285177 APO-METOPROLOL SR APX 00740875 TEV-APROPRANOLOL TEV TEV 0394590 LOPRESOR SR NVR 0394590 EVA-PROPRANOLOL TEV 0394590 TEV-A-PROPRANOLOL TEV 0394590 TEV-A-PROPRANOLOL TEV 03950315 METOPROLOL ORAL LIQUID UIK 03952317 MS-PROPRANOLOL PMS 03952315 METOPROLOL ORAL LIQUID UIK 03952317 MS-PROPRANOLOL PMS 03952317 MS-PROPRANOLOL APX 03952317 APO-PINDOL APX 03952317 APO-PINDOL APX 03953317 APO-PINDOL TEV TEV 03953317 APO-PINDOL TEV TEV 03953317 APO-PINDOL TEV TEV 03953317 APO-PINDOL TEV 03953317	METOPROLOL TARTRATE		PROPRANOLOL HYDROCHLORIDE	
02933398 SANDOZ METOPROLOL SR APX 00740875 TEV-APROPRANOLOL TEV TEV 2008 TABLET TEXTENDED RELEASE 02285177 APO-METOPROLOL SR APX 00740875 TEV-APROPRANOLOL TEV TEV 0394590 LOPRESOR SR NVR 0394590 EVA-PROPRANOLOL TEV 0394590 TEV-A-PROPRANOLOL TEV 0394590 TEV-A-PROPRANOLOL TEV 03950315 METOPROLOL ORAL LIQUID UIK 03952317 MS-PROPRANOLOL PMS 03952315 METOPROLOL ORAL LIQUID UIK 03952317 MS-PROPRANOLOL PMS 03952317 MS-PROPRANOLOL APX 03952317 APO-PINDOL APX 03952317 APO-PINDOL APX 03953317 APO-PINDOL TEV TEV 03953317 APO-PINDOL TEV TEV 03953317 APO-PINDOL TEV TEV 03953317 APO-PINDOL TEV 03953317	ST 100MG TABLET (EXTENDED RELEASE)		ST 10MG TARI FT	
**200MG TABLET (EXTENDED RELASE) **20MG TABLET **20MG TA	` ,	SDZ		TFV
December		322		
0.0303418 SANDOZ METOPROLOL SR SDZ 0.0498499 TEVA-PROPRANOLOL TEV		APX		TEV
"PIDIN FOR EXTEMPORANEOUS MIXTURE 98503015 METOPROLOL ORAL LIQUID UNK 00582271 PMS-PROPRANOLOL PMS NADOLOL 0049602 TEVA-PROPRANOLOL PMS 00782505 NADOLOL APX 00582278 PMS-PROPRANOLOL PMS 00782505 NADOLOL APX 00582278 PMS-PROPRANOLOL PMS 00782505 NADOLOL APX 00582278 PMS-PROPRANOLOL PMS 00782467 NADOLOL APX 00582278 PMS-PROPRANOLOL PMS 00782467 NADOLOL APX 00582278 PMS-PROPRANOLOL PMS 00782475 NADOLOL APX 99503014 PROPRANOLOL ORAL LIQUID UNK 99503014 PROPRANOLOL APX 00782475 NADOLOL APX 02238634 DOM-SOTALOL DPC 00782475 NADOLOL APX 02238634 DOM-SOTALOL DPC 00828464 PINDOLOL TEV 02238634 DOM-SOTALOL DPC 00828424 PINDOLOL TEV 02238632 PMS-SOTALOL PMS 00417270 VISKEN UNK 02316628 PRO-SOTALOL DPC 00828424 PINDOLOL PDL 02338635 DOM-SOTALOL DPC 00828424 PINDOLOL PDL 02338635 PRO-SOTALOL PMS 00443174 VISKEN UNK 02238637 PMS-SOTALOL PMS 00443174 VISKEN UNK 02338635 PRO-SOTALOL PMS 00434174 VISKEN UNK 02338635 PMS-SOTALOL PMS 00434184 VISKEN UNK 02338635 PMS-SOTALOL PMS 00434184 VISKEN	00534560 LOPRESOR SR	NVR	ST 40MG TABLET	
MADOLOL MADOLOL PMS	02303418 SANDOZ METOPROLOL SR	SDZ	00496499 TEVA-PROPRANOLOL	TEV
MADOLOL	ST PDIN FOR EXTEMPORANEOUS MIXTURE		ST 80MG TABLET	
### ### ### ### ### ### ### ### ### ##	99503015 METOPROLOL ORAL LIQUID	UNK	00582271 PMS-PROPRANOLOL	PMS
MONT TABLET	NADOLOL		00496502 TEVA-PROPRANOLOL	TEV
100782505	ST 40MG TARLET		ST 120MG TABLET	
## 80MG TABLET 00782467 NADOLOL 0782475 NADOLOL 0782476 NADOLOL 0782476 NADOLOL 0782476 NADOLOL 0782477 NADOLOL 0782476 NADOLOL 0782476 NADOLOL 0782477 NADOLOL 0782476 NADOLOL 0782477 NADOLOL 0782477 NADOLOL 0782477 NADOLOL 0782477 NADOLOL 0782476 PINDOLOL 0782477 NADOLOL 07824787 NADOLOL 0782478 NADOLOL 078248 NADOLOL 078248 NADOLOL 0782478 NADOLOL 078248 NADOLOL 07824		ΔΔΡ	00504335 APO PROPRANOLOL	APX
00782467		771	00582298 PMS-PROPRANOLOL	PMS
### 160MG TABLET		ΔΔΡ	$^{s au}$ PDIN FOR EXTEMPORANEOUS MIXTURE	
SOTALOL HYDROCHLORIDE		7741	99503014 PROPRANOLOL ORAL LIQUID	UNK
SMG TABLET		AAP	SOTALOL HYDROCHLORIDE	
### SMG TABLET ### O755877 APO-PINDOL APX O2238631 DOM-SOTALOL JMP ### O755877 APO-PINDOL PDL O2238631 JAMP-SOTALOL JMP ### O0828416 PINDOLOL PDL O2238236 PMS-SOTALOL JMP ### O0828416 PINDOLOL PDL O2238236 PMS-SOTALOL PMS ### O0417270 VISKEN UNK ### O0417270 VISKEN UNK ### O0417270 VISKEN UNK ### O045888 APO-PINDOL APX ### O055888 APO-PINDOL APX ### O05888424 PINDOLOL PDL O2368625 JAMP-SOTALOL DPC ### O0889015 TEVA-PINDOLOL TEV O2238637 DOM-SOTALOL JMP ### O04343174 VISKEN UNK ### O2336536 PRO-SOTALOL PMS ### O0443174 VISKEN UNK ### O2346536 PRO-SOTALOL PMS ### O2346536 PRO-SOTALOL JMP ### O0443174 VISKEN UNK ### O2346536 PRO-SOTALOL PMS ### O24316536 PRO-SOTALOL PMS ### O24316536 PRO-SOTALOL JMP ### O2316536 PRO-SOTALOL PMS ### O2		700	ST 80MG TABLET	
March Marc				APX
MO755847 APO-PINDOL				
00869007 TEVA-PINDOLOL TEV 02238326 bytes PMS-SOTALOL PMS (D0417270 bytes) 00417270 VISKEN UNK "160MG TABLET 02167794 bytes APO-SOTALOL APX (D2167794 bytes) APO-SOTALOL APX (D22386855 bytes) DOM-SOTALOL (DPC (DMS-SOTALOL) DPC (DMS-SOTALOL) JMP				JMP
0417270 VISKEN UNK			02238326 PMS-SOTALOL	PMS
### 10MG TABLET 00755885			02316528 PRO-SOTALOL	PDL
00755885 APO-PINDOL APX 00828424 PINDOLOL PDL 00869015 TEVA-PINDOLOL TEV 02388325 JAMP-SOTALOL JMP 00443174 VISKEN UNK 02316536 PRO-SOTALOL PDL 3**T15MG TABLET 00755893 APO-PINDOL APX 00233477 DOM-PINDOLOL DPC 02231539 PMS-PINDOLOL DPC 02231539 PMS-PINDOLOL PMS 00869023 TEVA-PINDOLOL PMS 00869023 TEVA-PINDOLOL TEV 99503023 SOTALOL ORAL LIQUID UNK 02231539 PMS-PINDOLOL PMS 00869023 TEVA-PINDOLOL TEV 3**SMG TABLET 00755893 APO-PINDOL PMS 00869023 TEVA-PINDOLOL PMS 00869023 TEVA-PINDOLOL TEV 3**SMG TABLET ***T1MOLOL MALEATE** ***T1MOLOL MALEATE** ***T1MOLOL MALEATE** ***T1MOLOL MALEATE** ***Unimited use benefit (prior approval required). ***Life or function-threatening hemangioma requiring systemic therapy and at least one of the following: **Life or function-threatening hemangioma, OR **Ulcerated hemangioma with a risk of permanent scarring or disfigurement. ***3.75MG SOLUTION** 02457857 HEMANGIOL PFD 02326795 AMLODIPINE BESYLATE ***G0MG CAPSULE (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02326825 DOM-SOLODIPINE BIM DOW-AMLODIPINE BIM APX ***T10MG TABLET** 00755869 TIMOLOL APX ***T2.SMG TABLET** 02297477 ACT AMLODIPINE BESYLATE ***G0MG CAPSULE (SUSTAINED RELEASE) 02326795 AMLODIPINE BESYLATE ***G0MG CAPSULE (SUSTAINED RELEASE) 02326795 AMLODIPINE BESYLATE ***G0MG CAPSULE (SUSTAINED RELEASE) 02357186 JAMP-AMLODIPINE BIM DOW-AMLODIPINE BIM APX ***T10MG TABLET** 0755869 TIMOLOL APX ***T10MG TABLET** 0755869 TIMOLOL APX ***T10MG TABLET** 0765869 TIMOLOL APX ***T10MG TABLET** 0765869 TIMOLOL APX ***T10MG TABLET** 0775869 TIMOLOL APX ***T10M		UNK	ST 160MG TABLET	
00828424 PINDOLOL PDL 02236835 DOM-SOTALOL JMP 00869015 TEVA-PINDOLOL TEV 02368625 JAMP-SOTALOL JMP 00443174 VISKEN UNK 02238327 PMS-SOTALOL PMS 3***ISMG*TABLE** DOM-PINDOL APX 02316533 PRO-SOTALOL PDL 00755893 APO-PINDOL DL DPC 99503023 SOTALOL ORAL LIQUID UNK 02231637 PMS-PINDOLOL PMS TIMOLOL MALEATE VIDED VIDED TIMOLOL MALEATE VIDED APX PMS-PINDOLOL APX TIMOLOL MALEATE VIDED APX PMS-PINDOLOL APX TIMOLOL MALEATE APX PMS-PINDOLOL APX PMS-PINDOLOL APX PMS-PINDOLOL MALEATE PMS-PINDOLOL MALEATE PMS-PINDOLOL MALEATE P		ADV	02167794 APO-SOTALOL	APX
00869015 TEVA-PINDOLOL TEV 02368625 JAMP-SOTALOL PMS			02238635 DOM-SOTALOL	DPC
0443174 VISKEN UNK 02238327 PMS-SOTALOL PMS 57 15MG TABLET 00755893 APO-PINDOL APX 99503023 SOTALOL ORAL LIQUID UNK 02238047 DOM-PINDOLOL DPC 02231539 PMS-PINDOLOL PMS 00869023 TEVA-PINDOLOL TEV 75 MG TABLET 00869023 TEVA-PINDOLOL TEV 0755842 TIMOLOL MALEATE 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 a risk of permanent scarring or disfigurement. 3.75MG SOLUTION 02457857 HEMANGIOL PFD 02326795 AMLODIPINE PROPRANOL OL HYDROCHLORIDE 57 60MG CAPSULE (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02326825 DOM-AMLODIPINE BMI 02042268 INDERAL LA PFI 020426705 NRA-AMLODIPINE MAR AND 02042261 INDERAL LA PFI 02468018 M-AMLODIPINE MAR AND 02042274 INDERAL LA PFI 02468018 M-AMLODIPINE MAR O2042274 INDERAL LA PFI 02468012 PMS-AMLODIPINE MAR AMLODIPINE MAR O2042274 INDERAL LA PFI 02468022 PHARMA-AMLODIPINE PMS PMS- 02042274 INDERAL LA PFI 02468022 PHARMA-AMLODIPINE PMS 02042274 INDERAL LA PFI 02468022 PHARMA-AMLODIPINE PMS 02042274 INDERAL LA PFI 02468022 PHARMA-AMLODIPINE PMS 02042274 INDERAL LA PFI 02295148 PMS-AMLODIPINE PMS			02368625 JAMP-SOTALOL	JMP
15MG TABLET			02238327 PMS-SOTALOL	PMS
00755893		ONK	02316536 PRO-SOTALOL	PDL
02238047 DOM-PINDOLOL 02231539 DPC PMS-PINDOLOL PMS-PINDOLOL 9MS PMS-PINDOLOL TIMOLOL MALEATE PROPRANOLOL (HEMANGIOL) TEV *** 5 MG TABLET 00755842 *** TIMOLOL APX 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. *** 20MG TABLET 00755880 TIMOLOL APX 3.75MG SOLUTION 0 2457857 *** 1 MEMANGIOL PFD 02326795 AMLODIPINE ACG PROPRANOLOL HYDROCHLORIDE PFD 023285783 AMLODIPINE SIV *** 60MG CAPSULE (SUSTAINED RELEASE) 023926825 DOM-AMLODIPINE BMI *** 02042258 INDERAL LA PFI 0236818 M-AMLODIPINE MAN *** 120MG CAPSULE (SUSTAINED RELEASE) 02371707 MAR-AMLODIPINE MAR *** 24:28.08 DIHYDROCHLORIDE *** 2.5 MG TABLET **** 2.5 MG TABLET </td <td></td> <td>APX</td> <td>ST PDIN FOR EXTEMPORANEOUS MIXTURE</td> <td></td>		APX	ST PDIN FOR EXTEMPORANEOUS MIXTURE	
Description			99503023 SOTALOL ORAL LIQUID	UNK
PROPRANOL OL (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 PROPRANOL OL HYDROCHLORIDE FOMOG CAPSULE (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02042258 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE NOT55842 TIMOLOL APX 1MOLOL APX 24:28.08 DIHYDROPYRIDINES AMLODIPINE BESYLATE 1MOLOL APX 24:28.08 DIHYDROPYRIDINES AMLODIPINE 02295777 ACT AMLODIPINE PO2326795 AMLODIPINE PO2326795 AMLODIPINE PDL PROPRANOL OL HYDROCHLORIDE 102385783 AMLODIPINE SIV 02419556 AMLODIPINE BMI 02042231 INDERAL LA PFI 02326825 DOM-AMLODIPINE DPC 102469022 PHARMA-AMLODIPINE MAR 120MG CAPSULE (SUSTAINED RELEASE) 02371707 MAR-AMLODIPINE MAR 120MG CAPSULE (SUSTAINED RELEASE) 02469022 PHARMA-AMLODIPINE PMS NS-AMLODIPINE PMS			TIMOLOL MALEATE	
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 PROPRANOLOL HYDROCHLORIDE **ToMMC CAPSULE** (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02042258 INDERAL LA PFI 02042256 INDERAL LA PFI 02042266 INDERAL LA PFI 02042274 INDERAL LA PFI 020422274 INDERAL LA PFI 02042274 INDERAL LA PFI 02042275 PHARMA-AMLODIPINE PMS			ST 5MG TABLET	
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 PROPRANOLOL HYDROCHLORIDE **T 60MG CAPSULE (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02042258 INDERAL LA PFI 02042258 INDERAL LA PFI 02042266 INDERAL LA PFI 02042274 INDERAL LA PFI 020422274 INDERAL LA PFI 02042274 INDERAL LA PFI 02042295148 PMS-AMLODIPINE PM				APX
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 PROPRANOLOL HYDROCHLORIDE *** 60MG CAPSULE (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02042258 INDERAL LA PFI 02042258 INDERAL LA PFI 02042258 INDERAL LA PFI 02042266 INDERAL LA PFI 02042261 INDERAL LA PFI 02042274 PPI 02042274 INDERAL LA PFI 02042274 INDERAL LA PFI 02042274 PPI	,			
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 PROPRANOLOL HYDROCHLORIDE **F 60MG CAPSULE (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02042258 INDERAL LA PFI 02042258 INDERAL LA PFI 02042266 INDERAL LA PFI 02042274 INDERAL LA PFI 020469022 PHARMA-AMLODIPINE PMS PMS-AMLODIPINE PMS	Limited use benefit (prior approval required).		00755850 TIMOLOL	APX
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 02326795 AMLODIPINE ACG PROPRANOLOL HYDROCHLORIDE *** 60MG CAPSULE (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02326825 DOM-AMLODIPINE BMI 02042258 INDERAL LA PFI 02468018 M-AMLODIPINE *** 120MG CAPSULE (SUSTAINED RELEASE) 02042266 INDERAL LA PFI 02468018 M-AMLODIPINE *** 120MG CAPSULE (SUSTAINED RELEASE) 02042266 INDERAL LA PFI 02468018 M-AMLODIPINE *** 120MG CAPSULE (SUSTAINED RELEASE) 02042266 INDERAL LA PFI 02468018 M-AMLODIPINE *** 120MG CAPSULE (SUSTAINED RELEASE) 02042266 INDERAL LA PFI 02466018 M-AMLODIPINE *** 140MG CAPSULE (SUSTAINED RELEASE) 02042266 INDERAL LA PFI 02466022 PHARMA-AMLODIPINE *** 140MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 150MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 150MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 150MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 160MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 160MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 160MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 160MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 160MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 160MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 160MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-AMLODIPINE *** 160MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 02469022 PHARMA-DIPINE *** 160MG CAPSULE (SUSTAI	For the treatment of proliferating infantile hemangioma		ST 20MG TABLET	
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** **PROPRANOLOL HYDROCHLORIDE** **5 60MG CAPSULE (SUSTAINED RELEASE)* **02042231** INDERAL LA** PFI** **02042258** INDERAL LA** **1 20MG CAPSULE (SUSTAINED RELEASE)* **02042258** INDERAL LA** **1 120MG CAPSULE (SUSTAINED RELEASE)* **02042266** INDERAL LA** **1 120MG CAPSULE (SUSTAINED RELEASE)* **1 2042266** INDERAL LA** **1 120MG CAPSULE (SUSTAINED RELEASE)* **1 2042266** INDERAL LA** **1 120MG CAPSULE (SUSTAINED RELEASE)* **1 2042266** INDERAL LA** **1 120MG CAPSULE (SUSTAINED RELEASE)* **1 120MG		ving:		APX
Simple wound care measures, OR • Hemangioma with a risk of permanent scarring or disfigurement. 3.75MG SOLUTION 02457857 HEMANGIOL PFD PROPRANOLOL HYDROCHLORIDE 5T 60MG CAPSULE (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02042258 INDERAL LA PFI 02042258 INDERAL LA PFI 02042266 INDERAL LA PFI 02042274 INDERAL LA PFI 020469022 PHARMA-AMLODIPINE ACC AMLODIPINE SIV 02385783 AMLODIPINE 02419556 AMLODIPINE 02419556 AMLODIPINE 02419556 AMLODIPINE BMI 02419556 AMLODIPINE BMI 02326825 DOM-AMLODIPINE DPC 02357186 JAMP-AMLODIPINE MAN M-AMLODIPINE MAN M-AMLODIPINE MAN PFI 02468018 M-AMLODIPINE MAN MR-AMLODIPINE MAN PFI 02469022 PHARMA-AMLODIPINE PMS 02469022 PHARMA-AMLODIPINE PMS		ise to	24:28.08 DIHYDROPYRIDINES	
**Hemangioma with a risk of permanent scarring of disfigurement. 3.75MG SOLUTION 02457857 HEMANGIOL PFD 02326795 AMLODIPINE 02385783 AMLODIPINE 02419556 AMLODIPINE \$1V PROPRANOLOL HYDROCHLORIDE **T 60MG CAPSULE (SUSTAINED RELEASE) 02042231 INDERAL LA PFI 02042231 INDERAL LA PFI 02042258 INDERAL LA PFI 02042258 INDERAL LA PFI 02042258 INDERAL LA PFI 02042266 INDERAL LA PFI 02042266 INDERAL LA PFI 02042266 INDERAL LA PFI 02042274 INDERAL LA PFI 020469018 M-AMLODIPINE MAR 020476452 NRA-AMLODIPINE UNK **T 160MG CAPSULE (SUSTAINED RELEASE) 02042274 INDERAL LA PFI 020469022 PHARMA-AMLODIPINE PMS 02042274 INDERAL LA PMS		100 10		
3.75MG SOLUTION				
02457857 HEMANGIOL PFD 02326795 AMLODIPINE PDL PROPRANOLOL HYDROCHLORIDE 02385783 AMLODIPINE SIV ST 60MG CAPSULE (SUSTAINED RELEASE) 02419556 AMLODIPINE BESYLATE ACC 02042231 INDERAL LA PFI 02326825 DOM-AMLODIPINE DPC ST 80MG CAPSULE (SUSTAINED RELEASE) 02357186 JAMP-AMLODIPINE JMP 02042258 INDERAL LA PFI 02468018 M-AMLODIPINE MAN ST 120MG CAPSULE (SUSTAINED RELEASE) 02371707 MAR-AMLODIPINE MAR 02042266 INDERAL LA PFI 02476452 NRA-AMLODIPINE UNK ST 160MG CAPSULE (SUSTAINED RELEASE) 02469022 PHARMA-AMLODIPINE PMS 02042274 INDERAL LA PFI 02295148 PMS-AMLODIPINE PMS	-			
PROPRANOLOL HYDROCHLORIDE 02385783 AMLODIPINE SIV ***********************************	3.75MG SOLUTION			
02419556 AMLODIPINE BESYLATE ACC		PFD		
ST 60MG CAPSULE (SUSTAINED RELEASE) 02392127 BIO-AMLODIPINE BMI 02042231 INDERAL LA PFI 02326825 DOM-AMLODIPINE DPC ST 80MG CAPSULE (SUSTAINED RELEASE) 02357186 JAMP-AMLODIPINE JMP 02042258 INDERAL LA PFI 02468018 M-AMLODIPINE MAN ST 120MG CAPSULE (SUSTAINED RELEASE) 02371707 MAR-AMLODIPINE MAR 02042266 INDERAL LA PFI 02476452 NRA-AMLODIPINE UNK ST 160MG CAPSULE (SUSTAINED RELEASE) 02469022 PHARMA-AMLODIPINE PMS 02042274 INDERAL LA PFI 02295148 PMS-AMLODIPINE PMS	PROPRANOLOL HYDROCHLORIDE			
02042231 INDERAL LA PFI 02326825 DOM-AMLODIPINE DPC 87 80MG CAPSULE (SUSTAINED RELEASE) 02357186 JAMP-AMLODIPINE JMP 02042258 INDERAL LA PFI 02468018 M-AMLODIPINE MAN 87 120MG CAPSULE (SUSTAINED RELEASE) 02371707 MAR-AMLODIPINE MAR 02042266 INDERAL LA PFI 02476452 NRA-AMLODIPINE UNK 87 160MG CAPSULE (SUSTAINED RELEASE) 02469022 PHARMA-AMLODIPINE PMS 02042274 INDERAL LA PFI 02295148 PMS-AMLODIPINE PMS	ST 60MG CAPSULE (SUSTAINED RELEASE)			
ST 80MG CAPSULE (SUSTAINED RELEASE) 02357186 JAMP-AMLODIPINE JMP 02042258 INDERAL LA PFI 02468018 M-AMLODIPINE MAN ST 120MG CAPSULE (SUSTAINED RELEASE) 02371707 MAR-AMLODIPINE MAR 02042266 INDERAL LA PFI 02476452 NRA-AMLODIPINE UNK ST 160MG CAPSULE (SUSTAINED RELEASE) 02469022 PHARMA-AMLODIPINE PMS 02042274 INDERAL LA PFI 02295148 PMS-AMLODIPINE PMS	` ,	PFI		
02042258 INDERAL LA PFI 02468018 M-AMLODIPINE MAN ST 120MG CAPSULE (SUSTAINED RELEASE) 02371707 MAR-AMLODIPINE MAR 02042266 INDERAL LA PFI 02476452 NRA-AMLODIPINE UNK ST 160MG CAPSULE (SUSTAINED RELEASE) 02469022 PHARMA-AMLODIPINE PMS 02042274 INDERAL LA PFI 02295148 PMS-AMLODIPINE PMS	ST 80MG CAPSULE (SUSTAINED RELEASE)			
O2042266 INDERAL LA PFI 02476452 NRA-AMLODIPINE UNK *** 160MG CAPSULE (SUSTAINED RELEASE) O2042274 INDERAL LA PFI 02295148 PMS-AMLODIPINE PMS	·	PFI		
02042266 INDERAL LA PFI 02371707 MAR-AMICODIPINE MAR *** 160MG CAPSULE (SUSTAINED RELEASE) 02476452 NRA-AMLODIPINE UNK 02042274 INDERAL LA PFI 02295148 PMS-AMLODIPINE PMS *** MRA-AMICODIPINE PMS PMS-AMLODIPINE PMS	ST 120MG CAPSULE (SUSTAINED RELEASE)			
ST 160MG CAPSULE (SUSTAINED RELEASE)02469022PHARMA-AMLODIPINEPMS02042274INDERAL LAPFI02295148PMS-AMLODIPINEPMS	02042266 INDERAL LA	PFI		
02042274 INDERAL LA PFI 02295148 PMS-AMLODIPINE PMS	ST 160MG CAPSULE (SUSTAINED RELEASE)			
	02042274 INDERAL LA	PFI		
02398877 RAN-AMLODIPINE RBY				

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24:28.08 DIHYDROPYRIDINES 24:28.08 DIHYDROPYRIDINES **AMLODIPINE BESYLATE AMLODIPINE BESYLATE** ST 2.5MG TABLET ST 10MG TABLET RIV TEV 02331489 RIVA-AMI ODIPINE 02250500 TEVA-AMLODIPINE SANDOZ AMLODIPINE SDZ **ST PDIN FOR EXTEMPORANEOUS MIXTURE** 02330474 02357704 SEPTA-AMLODIPINE SPT 99503003 AMLODIPINE ORAL LIQUID UNK $^{\text{ST}}$ 5MG TABLET AMLODIPINE BESYLATE. ATORVASTATIN 02297485 **ACT AMLODIPINE** ACG **CALCIUM** 02369230 **AG-AMLODIPINE** ANG ST 5MG & 10MG TABLET 02326809 **AMLODIPINE** PDL 02411253 APO-AMLODIPINE-ATORVASTATIN APX 02331284 AMI ODIPINE SAN 02273233 CADUET PFI 02385791 **AMLODIPINE** SIV 02362759 **GD-AMLODIPINE-ATORVASTATIN** PFI 02429217 **AMLODIPINE JMP** 02404222 PMS-AMLODIPINE-ATORVASTATIN **PMS** 02419564 AMLODIPINE BESYLATE ACC ST 5MG & 20MG TABLET 02273373 APO-AMI ODIPINE APX 02411261 APO-AMLODIPINE-ATORVASTATIN APX 02397072 **AURO-AMLODIPINE AUR** 02273241 CADUET PFI 02392135 **BIO-AMLODIPINE** BMI 02362767 **GD-AMLODIPINE-ATORVASTATIN** PFI DPC 02326833 DOM-AMLODIPINE PMS-AMLODIPINE-ATORVASTATIN 02404230 **PMS** 02357194 JAMP-AMLODIPINE **JMP** ST 5MG & 40MG TABLET 02468026 M-AMLODIPINE MAN 02411288 APO-AMLODIPINE-ATORVASTATIN APX 02371715 MAR-AMLODIPINE MAR 02273268 CADUFT PFI 02362651 MINT-AMI ODIPINE MIN **GD-AMLODIPINE-ATORVASTATIN** PFI 02362775 02272113 MYLAN-AMLODIPINE MYL $^{\rm s au}$ 5MG & 80MG TABLET 00878928 **NORVASC** PFI APO-AMLODIPINE-ATORVASTATIN APX 02411296 02476460 NRA-AMI ODIPINE UNK 02273276 CADUET PFI 02469030 PHARMA-AMLODIPINE **PMS** 02362783 GD-AMLODIPINE-ATORVASTATIN PFI 02284065 PMS-AMI ODIPINE **PMS** $^{\rm s7}$ 10MG & 10MG TABLET 02321858 RAN-AMI ODIPINE RRY 02411318 APO-AMLODIPINE-ATORVASTATIN APX 02331497 RIVA-AMLODIPINE RIV 02273284 CADUET PFI SDZ 02284383 SANDOZ AMLODIPINE 02362791 **GD-AMLODIPINE-ATORVASTATIN** PFI SEPTA-AMI ODIPINE SPT 02357712 02404249 PMS-AMLODIPINE-ATORVASTATIN **PMS** 02250497 TEVA-AMI ODIPINE TFV $^{s\tau}$ 10MG & 20MG TABLET ST 10MG TABLET 02411326 APO-AMLODIPINE-ATORVASTATIN **APX** 02297493 **ACT AMLODIPINE** ACG 02273292 CADUET PFI 02369249 AG-AMI ODIPINE ANG 02362805 **GD-AMLODIPINE-ATORVASTATIN** PFI 02326817 **AMLODIPINE** PDL 02404257 PMS-AMLODIPINE-ATORVASTATIN **PMS** 02331292 **AMLODIPINE** SAN ST 10MG & 40MG TABLET 02385805 **AMLODIPINE** SIV 02411334 APO-AMLODIPINE-ATORVASTATIN APX 02429225 **AMLODIPINE JMP** 02273306 CADUET PFI 02419572 AMLODIPINE BESYLATE ACC **GD-AMLODIPINE-ATORVASTATIN** 02362813 PFI 02273381 APO-AMI ODIPINE **APX** ST 10MG & 80MG TABLET 02397080 **AURO-AMLODIPINE AUR** 02411342 APO-AMLODIPINE-ATORVASTATIN **APX** 02392143 **BIO-AMLODIPINE** BMI 02273314 CADUET PFI 02326841 DPC DOM-AMI ODIPINE PFI 02362821 GD-AMLODIPINE-ATORVASTATIN 02357208 JAMP-AMLODIPINE **JMP** AMLODIPINE BESYLATE, TELMISARTAN 02468034 M-AMLODIPINE MAN 02371723 MAR-AMLODIPINE MAR ST 5MG & 40MG TABLET 02362678 MINT-AMLODIPINE MIN BOE 02371022 TWYNSTA 02272121 MYLAN-AMLODIPINE MYL ST 5MG & 80MG TABLET 00878936 NORVASC PFI 02371049 TWYNSTA BOE 02476479 NRA-AMI ODIPINE UNK $^{\rm s7}$ 10MG & 40MG TABLET 02469049 PHARMA-AMLODIPINE **PMS** BOE 02371030 TWYNSTA 02284073 PMS-AMI ODIPINE **PMS** ST 10MG & 80MG TABLET 02321866 RAN-AMI ODIPINE RRY 02371057 TWYNSTA BOE 02331500 **RIVA-AMLODIPINE** RIV SDZ 02284391 SANDOZ AMLODIPINE 02357720 SEPTA-AMLODIPINE SPT

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24:20 00 DILIVEDODVEIDINES		24.20 02 MI	CCELL ANEQUE CALCIUM	
24:28.08 DIHYDROPYRIDINES			SCELLANEOUS CALCIUM-	
FELODIPINE			IANNEL BLOCKING AGENTS	
ST 2.5MG TABLET (EXTENDED RELEASE)		DILTIAZEM I	HYDROCHLORIDE	
02452367 APO-FELODIPINE	APX	ST 300MG CAP	SULE (CONTROLLED DELIVERY)	
02057778 PLENDIL	AZC	02229526	APO-DILTIAZ CD	APX
ST 5MG TABLET (EXTENDED RELEASE)		02231057	DILTIAZEM CD	PDL
02452375 APO-FELODIPINE	APX	02400464	DILTIAZEM CD	SAN
00851779 PLENDIL	AZC		PMS-DILTIAZEM CD	PMS
02280264 SANDOZ FELODIPINE	SDZ		SULE (EXTENDED RELEASE)	
09857203 SANDOZ-FELODIPINE	SDZ	02370611	ACT DILTIAZEM CD	TEV
ST 10MG TABLET (EXTENDED RELEASE)			ACT DILTIAZEM T	ACG
02452383 APO-FELODIPINE	APX		CARDIZEM CD	VAE
00851787 PLENDIL	AZC		DILTIAZEM CD	SIV
02280272 SANDOZ FELODIPINE	SDZ		DILTIAZEM TZ	PDL
09857204 SANDOZ-FELODIPINE	SDZ		MAR-DILTIAZEM T	MAR
NIFEDIPINE			SANDOZ DILTIAZEM CD	SDZ
ST 5MG CAPSULE			SANDOZ DILTIAZEM T	SDZ
00725110 NIFEDIPINE	AAP		TEVA-DILTIAZEM	VAE
02235897 PMS-NIFEDIPINE	PMS		TEVA-DILTIAZEM CD	TEV
ST 10MG CAPSULE		02231150		VAE
00755907 NIFEDIPINE	AAP		SULE (EXTENDED RELEASE) ACT DILTIAZEM CD	TC\/
02235898 PMS-NIFEDIPINE	PMS			TEV
ST 20MG TABLET (EXTENDED RELEASE)			ACT DILTIAZEM T	ACG SIV
02237618 ADALAT XL	BAY		DILTIAZEM CD	PDL
ST 30MG TABLET (EXTENDED RELEASE)			DILTIAZEM TZ MAR-DILTIAZEM T	MAR
02155907 ADALAT XL	BAY		SANDOZ DILTIAZEM CD	SDZ
02349167 MYLAN-NIFEDIPINE	MYL		SANDOZ DILTIAZEM T	SDZ
02421631 NIFEDIPINE	PDL		TEVA-DILTIAZEM	VAE
02418630 PMS-NIFEDIPINE	PMS		TEVA-DILTIAZEM TEVA-DILTIAZEM CD	TEV
ST 60MG TABLET (EXTENDED RELEASE)		02231151		VAE
02155990 ADALAT XL	BAY		SULE (EXTENDED RELEASE)	VAL
02321149 MYLAN-NIFEDIPINE	MYL		ACT DILTIAZEM CD	TEV
02421658 NIFEDIPINE	PDL		ACT DILTIAZEM T	ACG
02416301 PMS-NIFEDIPINE	PMS		DILTIAZEM CD	SIV
NIMODIPINE			DILTIAZEM TZ	PDL
ST 30MG TABLET			MAR-DILTIAZEM T	MAR
02325926 NIMOTOP	BAY	02243340		SDZ
24:28.92 MISCELLANEOUS CALCIUM-	<i>D</i> , ()		SANDOZ DILTIAZEM T	SDZ
			TEVA-DILTIAZEM	VAE
CHANNEL BLOCKING AGENTS			TEVA-DILTIAZEM CD	TEV
DILTIAZEM HYDROCHLORIDE		02231152	TIAZAC	VAE
ST 120MG CAPSULE (CONTROLLED DELIVERY)			SULE (EXTENDED RELEASE)	
02230997 APO-DILTIAZ CD	APX		ACT DILTIAZEM CD	TEV
02231472 DILTIAZEM CD	PDL	02370514	ACT DILTIAZEM T	ACG
02400421 DILTIAZEM CD	SAN	02446022	DILTIAZEM CD	SIV
02355752 PMS-DILTIAZEM CD	PMS	02325330	DILTIAZEM TZ	PDL
ST 180MG CAPSULE (CONTROLLED DELIVERY)		02465396	MAR-DILTIAZEM T	MAR
02230998 APO-DILTIAZ CD	APX	02243341	SANDOZ DILTIAZEM CD	SDZ
02231474 DILTIAZEM CD	PDL	02245921	SANDOZ DILTIAZEM T	SDZ
02400448 DILTIAZEM CD	SAN	02271648	TEVA-DILTIAZEM	VAE
02355760 PMS-DILTIAZEM CD	PMS	02242541	TEVA-DILTIAZEM CD	TEV
ST 240MG CAPSULE (CONTROLLED DELIVERY)		02231154	TIAZAC	VAE
02230999 APO-DILTIAZ CD	APX	^{S7} 360MG CAP	SULE (EXTENDED RELEASE)	
02231475 DILTIAZEM CD	PDL	02370522	ACT DILTIAZEM T	ACG
02400456 DILTIAZEM CD	SAN	02325349	DILTIAZEM TZ	PDL
02355779 PMS-DILTIAZEM CD	PMS	02465418	MAR-DILTIAZEM T	MAR

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		Hon moured realth Ben	Ciito
24:28.92 MISCELLANEOUS CALCIUM- CHANNEL BLOCKING AGENTS		24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	
DILTIAZEM HYDROCHLORIDE		BENAZEPRIL HYDROCHLORIDE	
ST 360MG CAPSULE (EXTENDED RELEASE)		ST 10MG TABLET	
02245922 SANDOZ DILTIAZEM T	SDZ	02290340 BENAZEPRIL	AAP
02271656 TEVA-DILTIAZEM	VAE	ST 20MG TABLET	7771
02231155 TIAZAC	VAE	02273918 BENAZEPRIL	AAP
ST 30MG TABLET	V/\L	CAPTOPRIL	7771
00771376 APO-DILTIAZ	APX		
00862924 TEVA-DILTIAZEM	TEV	ST 6.25MG TABLET	
ST 60MG TABLET	1 L V	01999559 APO-CAPTO	APX
00771384 APO-DILTIAZ	APX	ST 12.5MG TABLET	
00862932 TEVA-DILTIAZEM	TEV	00893595 APO-CAPTO	APX
ST 120MG TABLET (EXTENDED RELEASE)	1	01942964 TEVA-CAPTOPRIL	TEV
02256738 TIAZAC XC	VAE	ST 25MG TABLET	
ST 180MG TABLET (EXTENDED RELEASE)	VAL	00893609 APO-CAPTO	APX
02256746 TIAZAC XC	VAE	01942972 TEVA-CAPTOPRIL	TEV
ST 240MG TABLET (EXTENDED RELEASE)	VAL	ST 50MG TABLET	
02256754 TIAZAC XC	VAE	00893617 APO-CAPTO	APX
ST 300MG TABLET (EXTENDED RELEASE)	VAL	01942980 TEVA-CAPTOPRIL	TEV
02256762 TIAZAC XC	VAE	ST 100MG TABLET	
	VAE	00893625 APO-CAPTO	APX
ST 360MG TABLET (EXTENDED RELEASE)	VAE	02230206 PMS-CAPTOPRIL	PMS
02256770 TIAZAC XC	VAE	01942999 TEVA-CAPTOPRIL	TEV
VERAPAMIL HYDROCHLORIDE		CILAZAPRIL	
120MG CAPSULE (SUSTAINED RELEASE)		ST 1MG TABLET	
02100479 VERELAN	RGL	02291134 APO-CILAZAPRIL	APX
ST 180MG CAPSULE (SUSTAINED RELEASE)		02283778 MYLAN-CILAZAPRIL	MYL
02100487 VERELAN	RGL	02280442 PMS-CILAZAPRIL	PMS
ST 240MG CAPSULE (SUSTAINED RELEASE)		st 2.5MG TABLET	PIVIS
02100495 VERELAN	RGL		APX
ST 80MG TABLET		02291142 APO-CILAZAPRIL	
00782483 APO-VERAP	APX	01911473 INHIBACE	CHE
02237921 MYLAN-VERAPAMIL	MYL	02283786 MYLAN-CILAZAPRIL	MYL
ST 120MG TABLET		02280450 PMS-CILAZAPRIL ST 5MG TABLET	PMS
00782491 APO-VERAP	APX		ADV
02237922 MYLAN-VERAPAMIL	MYL	02291150 APO-CILAZAPRIL	APX
ST 120MG TABLET (EXTENDED RELEASE)		01911481 INHIBACE	CHE
02246893 APO-VERAP SR	APX	02283794 MYLAN-CILAZAPRIL	MYL
01907123 ISOPTIN SR	BGP	02280469 PMS-CILAZAPRIL	PMS
02210347 MYLAN-VERAPAMIL SR	MYL	CILAZAPRIL, HYDROCHLOROTHIAZIDE	
ST 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
ST 240MG TABLET (EXTENDED RELEASE)		ENALAPRIL MALEATE	
02246895 APO-VERAP SR	APX		
02240321 DOM-VERAPAMIL SR	DPC	ST 2.5MG TABLET	
00742554 ISOPTIN SR	BGP	02291878 ACT ENALAPRIL	TEV
02450496 MYLAN-VERAPAMIL	MYL	02020025 APO-ENALAPRIL	APX
02237791 PMS-VERAPAMIL SR	PMS	02400650 ENALAPRIL	SAN
24:32.04 ANGIOTENSIN-CONVERTING		02442957 ENALAPRIL	SIV
		02459450 MAR-ENALAPRIL	MAR
ENZYME INHIBITORS		02300036 MYLAN-ENALAPRIL	MYL
BENAZEPRIL HYDROCHLORIDE		02311402 PRO-ENALAPRIL	PDL
ST 5MG TABLET		02352230 RAN-ENALAPRIL	RBY
02290332 BENAZEPRIL	AAP	02300796 RIVA-ENALAPRIL	RIV
		02299933 SANDOZ ENALAPRIL	SDZ

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	NGIOTENSIN-CONVERTING		24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	
ENALAPRIL MALEATE			FOSINOPRIL SODIUM	
ST 2.5MG TAB	LET		ST 10MG TABLET	
	TARO-ENALAPRIL	TAR	02303000 FOSINOPRIL	PDL
ST 5MG TABLE	ET		02332566 FOSINOPRIL	RBY
02291886	ACT ENALAPRIL	TEV	02459388 FOSINOPRIL	SAN
	APO-ENALAPRIL	APX	02331004 JAMP-FOSINOPRIL	JMP
02400669	ENALAPRIL	SAN	02255944 PMS-FOSINOPRIL	PMS
02442965	ENALAPRIL	SIV	02294524 RAN-FOSINOPRIL	RBY
02459469	MAR-ENALAPRIL	MAR	02247802 TEVA-FOSINOPRIL	TEV
02300044	MYLAN-ENALAPRIL	MYL	ST 20MG TABLET	
02311410	PRO-ENALAPRIL	PDL	02266016 APO-FOSINOPRIL	APX
02352249	RAN-ENALAPRIL	RBY	02303019 FOSINOPRIL	PDL
02300818	RIVA-ENALAPRIL	RIV	02332574 FOSINOPRIL	RBY
02299941	SANDOZ ENALAPRIL	SDZ	02459396 FOSINOPRIL	SAN
02300125	TARO-ENALAPRIL	TAR	02331012 JAMP-FOSINOPRIL	JMP
00708879	VASOTEC	FRS	02255952 PMS-FOSINOPRIL	PMS
ST 10MG TABI	_ET		02294532 RAN-FOSINOPRIL	RBY
02291894	ACT ENALAPRIL	TEV	02247803 TEVA-FOSINOPRIL	TEV
02019892	APO-ENALAPRIL	APX	LISINOPRIL	
02400677	ENALAPRIL	SAN		
02442973	ENALAPRIL	SIV	ST 5MG TABLET	ADV
02444771	MAR-ENALAPRIL	IDE	02217481 APO-LISINOPRIL	APX
02300052	MYLAN-ENALAPRIL	MYL	09853685 APO-LISINOPRIL	APX
02311429	PRO-ENALAPRIL	PDL	02394472 AURO-LISINOPRIL	AUR
02352257	RAN-ENALAPRIL	RBY	02361531 JAMP-LISINOPRIL	JMP
02300826	RIVA-ENALAPRIL	RIV	02386232 LISINOPRIL	SIV
02299968	SANDOZ ENALAPRIL	SDZ	02292203 PMS-LISINOPRIL	PMS
02300133	TARO-ENALAPRIL	TAR	02310961 PRO-LISINOPRIL	PDL
00670901	VASOTEC	FRS	02294230 RAN-LISINOPRIL	RBY
ST 20MG TABI	_ET		02289199 SANDOZ LISINOPRIL	SDZ
02291908	ACT ENALAPRIL	TEV	02285061 TEVA-LISINOPRIL (TYPE P)	TEV
02019906	APO-ENALAPRIL	APX	02285118 TEVA-LISINOPRIL (TYPE Z)	TEV
02400685	ENALAPRIL	SAN	02049333 ZESTRIL	AZC
02442981	ENALAPRIL	SIV	ST 10MG TABLET 02217503 APO-LISINOPRIL	ADV
02444798	MAR-ENALAPRIL	IDE		APX
02300060	MYLAN-ENALAPRIL	MYL	09853960 APO-LISINOPRIL	APX
02311437	PRO-ENALAPRIL	PDL	02394480 AURO-LISINOPRIL	AUR
02352265	RAN-ENALAPRIL	RBY	02361558 JAMP-LISINOPRIL	JMP
02300834	RIVA-ENALAPRIL	RIV	02386240 LISINOPRIL	SIV
02299976	SANDOZ ENALAPRIL	SDZ	02292211 PMS-LISINOPRIL	PMS
02300141	TARO-ENALAPRIL	TAR	00839396 PRINIVIL	FRS
00670928	VASOTEC	FRS	02310988 PRO-LISINOPRIL	PDL
ST PDIN FOR I	EXTEMPORANEOUS MIXTURE		02294249 RAN-LISINOPRIL	RBY
99503013	ENALAPRIL ORAL LIQUID	UNK	02289202 SANDOZ LISINOPRIL	SDZ
ENALAPRIL	MALEATE.		02285088 TEVA-LISINOPRIL (TYPE P)	TEV
	OROTHIAZIDE		02285126 TEVA-LISINOPRIL (TYPE Z)	TEV
ST ENG. 9. 40 E	MC TADI ET		02049376 ZESTRIL	AZC
ST 5MG & 12.5		A A D	ST 20MG TABLET	ADV
	ENALAPRIL MALEATE/HCTZ	AAP	02217511 APO-LISINOPRIL	APX
ST 10MG & 25		A A D	09854010 APO-LISINOPRIL	APX
	ENALAPRIL MALEATE/HCTZ	AAP	02394499 AURO-LISINOPRIL	AUR
	VASERETIC	FRS	02361566 JAMP-LISINOPRIL	JMP
FOSINOPRI	L SODIUM		02386259 LISINOPRIL 02292238 PMS-LISINOPRIL	SIV PMS
ST 10MG TABI	_ET		02292238 PMS-LISINOPRIL 00839418 PRINIVIL	FRS
02266008	APO-FOSINOPRIL	APX	OOOOOTIO I INIMIVIL	1110

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	IGIOTENSIN-CONVERTING		24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	
LISINOPRIL			PERINDOPRIL ERBUMINE	
ST 20MG TABL	ET		sr 4MG TABLET	
	PRO-LISINOPRIL	PDL	02472023 RIVA-PERINDOPRIL	RIV
02310990	RAN-LISINOPRIL	RBY	02470233 SANDOZ PERINDOPRIL ERBUMINE	SDZ
	SANDOZ LISINOPRIL	SDZ	02464993 TEVA-PERINDOPRIL	TEV
	TEVA-LISINOPRIL (TYPE P)	TEV	ST 8MG TABLET	1
	TEVA-LISINOPRIL (TYPE Z)	TEV	02289296 APO-PERINDOPRIL	APX
02049384	ZESTRIL	AZC	02459833 AURO-PERINDOPRIL	AUR
	HYDROCHLOROTHIAZIDE	ALO	02246624 COVERSYL	SEV
			02477025 JAMP PERINDOPRIL	JMP
^{sτ} 10MG & 12.5			02474840 MAR-PERINDOPRIL	MAR
	LISINOPRIL/HCTZ (TYPE Z)	SAN	02476789 MINT-PERINDOPRIL	MIN
	SANDOZ LISINOPRIL HCT	SDZ	02479893 PERINDOPRIL ERBUMINE	SIV
	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV	02481650 PERINDOPRIL ERBUMINE	SAN
	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV	02488965 PERINDOPRIL ERBUMINE	PDL
	ZESTORETIC	AZC	02470691 PMS-PERINDOPRIL	PMS
ST 20MG & 12.5			02472031 RIVA-PERINDOPRIL	RIV
	LISINOPRIL/HCTZ (TYPE Z)	SAN	02470241 SANDOZ PERINDOPRIL ERBUMINE	SDZ
	SANDOZ LISINOPRIL HCT	SDZ	02465000 TEVA-PERINDOPRIL	TEV
	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV	PERINDOPRIL ERBUMINE, INDAPAMIDE	
	TEVA-LISINOPRIL/HCTZ (TYPE Z) ZESTORETIC	TEV AZC	ς ST 4MG & 1.25MG TABLET	
ST 20MG & 25N		71.20	02246569 COVERSYL PLUS	SEV
02362961	LISINOPRIL/HCTZ (TYPE Z)	SAN	02470438 SANDOZ PERINDOPRIL	SDZ
02302381	SANDOZ LISINOPRIL HCT	SDZ	ERBUMINE/ INDAPAMIDE	022
	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV	02464020 TEVA-PERINDOPRIL/INDAPAMIDE	TEV
	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV	ST 8MG & 2.5MG TABLET	
	ZESTORETIC	AZC	02453061 APO-PERINDOPRIL-INDAPAMIDE	APX
	IL ERBUMINE	/ ==0	02321653 COVERSYL PLUS HD	SEV
2MG TABLE			02408201 MYLAN-	MYL
	AG-PERINDOPRIL	ANG	PERINDOPRIL/INDAPAMIDE	CDZ
	APO-PERINDOPRIL	APX	02470446 SANDOZ PERINDOPRIL ERBUMINE/ INDAPAMIDE HD	SDZ
	AURO-PERINDOPRIL	AUR	02464039 TEVA-PERINDOPRIL/INDAPAMIDE	TEV
	COVERSYL	SEV	QUINAPRIL	v
02123274	JAMP PERINDOPRIL	JMP		
02474824	MAR-PERINDOPRIL	MAR	ST 5MG TABLET	
02476762	MINT-PERINDOPRIL	MIN	01947664 ACCUPRIL	PFI
02479877	PERINDOPRIL ERBUMINE	SIV	02248499 APO-QUINAPRIL	APX
	PERINDOPRIL ERBUMINE	SAN	02340550 PMS-QUINAPRIL	PMS
	PERINDOPRIL ERBUMINE	PDL	ST 10MG TABLET	
	PMS-PERINDOPRIL	PMS	01947672 ACCUPRIL	PFI
02472015	RIVA-PERINDOPRIL	RIV	02248500 APO-QUINAPRIL	APX
02470225		SDZ	02340569 PMS-QUINAPRIL	PMS
	TEVA-PERINDOPRIL	TEV	ST 20MG TABLET	
ST 4MG TABLE			01947680 ACCUPRIL	PFI
	APO-PERINDOPRIL	APX	02248501 APO-QUINAPRIL	APX
	AURO-PERINDOPRIL	AUR	02340577 PMS-QUINAPRIL	PMS
02123282		SEV	ST 40MG TABLET	
02477017	JAMP PERINDOPRIL	JMP	01947699 ACCUPRIL	PFI
02474832		MAR	02248502 APO-QUINAPRIL	APX
02476770	MINT-PERINDOPRIL	MIN	02340585 PMS-QUINAPRIL	PMS
02479885	PERINDOPRIL ERBUMINE	SIV	QUINAPRIL, HYDROCHLOROTHIAZIDE	
02481642		SAN	ST 10MG & 12.5MG TABLET	
02488957	PERINDOPRIL ERBUMINE	PDL	02237367 ACCURETIC	PFI
02470683		PMS	02408767 APO-QUINAPRIL/HCTZ	APX

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24:32.04 ANGIOTENSIN-CONVERTING 24:32.04 ANGIOTENSIN-CONVERTING **ENZYME INHIBITORS ENZYME INHIBITORS RAMIPRIL** QUINAPRIL. HYDROCHLOROTHIAZIDE **ST 10MG & 12.5MG TABLET 5MG CAPSULE** 02473291 AURO-QUINAPRIL HCTZ **AUR** 02287935 **RAMIPRIL** SIV **ST 20MG & 12.5MG TABLET** 02374854 RAMIPRII SAN RBY PFI 02310538 RAN-RAMIPRII 02237368 ACCURETIC 02408775 APO-QUINAPRIL/HCTZ **APX** 02247946 TEVA-RAMIPRIL TEV 02473305 **AURO-QUINAPRIL HCTZ AUR** 10MG CAPSULE ST 20MG & 25MG TABLET AG-RAMIPRII 02477500 ANG 02237369 ACCURETIC PFI 02221853 ALTACE VAE 02408783 APO-QUINAPRIL/HCTZ APX 02251582 APO-RAMIPRIL APX 02473321 AURO-QUINAPRIL HCTZ **AUR** 02387417 ALIRO-RAMIPRII ALIR DPC 02287986 DOM-RAMIPRII **RAMIPRIL** 02331144 JAMP-RAMIPRIL JMP ST 1.25MG CAPSULE 02420481 MAR-RAMIPRIL MAR 02221829 ALTACE VAE 02421321 MINT-RAMIPRIL MIN 02251515 APO-RAMIPRIL **APX** 02469081 PHARMA-RAMIPRIL **PMS** 02387387 **AURO-RAMIPRIL AUR** 02247919 PMS-RAMIPRIL **PMS** JAMP-RAMIPRIL 02331101 **JMP** 02310104 PRO-RAMIPRIL PDI 02420457 MAR-RAMIPRIL MAR 02255332 **RAMIPRIL** RIV 02469057 PHARMA-RAMIPRIL **PMS** 02287943 SIV RAMIPRII PMS-RAMIPRIL **PMS** 02295369 RAMIPRIL 02374862 SAN 02310023 PRO-RAMIPRIL PDL 02310546 RAN-RAMIPRIL **RBY** 02299372 RAMIPRII RIV 02247947 TEVA-RAMIPRIL TEV RAMIPRII 02308363 SIV ST 15MG CAPSULE 02310503 RAN-RAMIPRIL **RBY APX** 02325381 APO-RAMIPRIL 2.5MG CAPSULE **JMP** 02440334 JAMP-RAMIPRII 02477572 AG-RAMIPRII ANG 02420503 MAR-RAMIPRIL MAR 02221837 ALTACE VAE 02421348 MINT-RAMIPRIL MIN APO-RAMIPRIL 02251531 **APX** 02343932 PMS-RAMIPRIL **PMS** 02387395 AURO-RAMIPRIL AUR 02425548 RAN-RAMIPRIL **RBY** DPC 02287951 DOM-RAMIPRIL **S**^T **1.25MG TABLET** 02331128 JAMP-RAMIPRIL **JMP** 02291398 SANDOZ RAMIPRIL SDZ 02420465 MAR-RAMIPRIL MAR ST 2.5MG TABLET 02421305 MINT-RAMIPRII MIN SANDOZ RAMIPRIL SD7 02291401 02469065 PHARMA-RAMIPRIL **PMS** ST 5MG TABLET 02247917 PMS-RAMIPRIL **PMS** 02291428 SANDOZ RAMIPRIL SDZ 02310066 PRO-RAMIPRIL PDI $^{\rm ST}$ 10MG TABLET **RAMIPRIL** 02255316 RIV 02291436 SANDOZ RAMIPRIL SDZ 02287927 RAMIPRII SIV RAMIPRIL, HYDROCHLOROTHIAZIDE 02374846 **RAMIPRIL** SAN RAN-RAMIPRIL RBY $^{\rm ST}$ 2.5MG & 12.5MG TABLET 02310511 02247945 TEVA-RAMIPRIL TEV 02283131 ALTACE HCT VAE **5MG CAPSULE** 02354004 APO-RAMIPRIL/HCTZ APX 02477580 AG-RAMIPRII ANG 02449439 **RAN-RAMIPRIL HCTZ RBY** 02221845 VAE ALTACE ST 5MG & 12.5MG TABLET 02251574 APO-RAMIPRIL APX 02283158 ALTACE HCT VAF 02387409 AURO-RAMIPRII **AUR** 02354012 APO-RAMIPRIL/HCTZ **APX** 02287978 DOM-RAMIPRIL DPC 02449447 **RAN-RAMIPRIL HCTZ RBY** 02331136 .IAMP-RAMIPRII **JMP** ST 5MG & 25MG TABLET 02420473 MAR-RAMIPRII MAR 02283174 ALTACE HCT VAF 02421313 MINT-RAMIPRIL MIN 02354020 APO-RAMIPRIL/HCTZ APX 02469073 PHARMA-RAMIPRIL **PMS** 02449463 **RAN-RAMIPRIL HCTZ RBY** 02247918 PMS-RAMIPRIL **PMS ST 10MG & 12.5MG TABLET** 02310074 PRO-RAMIPRIL **PDL** 02283166 ALTACE HCT VAE 02255324 RAMIPRIL RIV 02342154 PMS-RAMIPRIL-HCTZ **PMS**

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					Jononio
	IGIOTENSIN-CONVERTING IZYME INHIBITORS			IGIOTENSIN II RECEPTOR ITAGONISTS	
RAMIPRIL. H	IYDROCHLOROTHIAZIDE		CANDESARTAN CILEXETIL		
ŕ					
ST 10MG & 12.9		DDV	ST 4MG TABLE		0.07
	RAN-RAMIPRIL HCTZ	RBY	02326957 ST 8MG TABLE	SANDOZ CANDESARTAN	SDZ
ST 10MG & 25Ν		\/AF			A C D
	ALTACE HCT	VAE		ACCEL-CANDESARTAN	ACP
	APO-RAMIPRIL/HCTZ	APX		ACH-CANDESARTAN	ACC
	PMS-RAMIPRIL-HCTZ RAN-RAMIPRIL HCTZ	PMS		APO-CANDESARTAN	APX
		RBY		ALIDO CANDESARTAN	AZC
TRANDOLAF	RIL			AURO-CANDESARTAN CANDESARTAN	AUR PDL
ST 0.5MG CAPS	SULE			CANDESARTAN	SIV
02471868	AURO-TRANDOLAPRIL	AUR		CANDESARTAN	SAN
02231457	MAVIK	BGP	02386518		JMP
02357755	PMS-TRANDOLAPRIL	PMS		MINT-CANDESARTAN	MIN
02325721	SANDOZ TRANDOLAPRIL	SDZ		PMS-CANDESARTAN	PMS
02415429	TEVA-TRANDOLAPRIL	TEV		RAN-CANDESARTAN	RBY
ST 1MG CAPSU	JLE			SANDOZ CANDESARTAN	SDZ
02471876	AURO-TRANDOLAPRIL	AUR		TEVA-CANDESARTAN	TEV
02231459	MAVIK	BGP	^{S7} 16MG TABL		I⊏V
02357763	PMS-TRANDOLAPRIL	PMS		ACCEL-CANDESARTAN	ACP
02325748	SANDOZ TRANDOLAPRIL	SDZ		ACH-CANDESARTAN ACH-CANDESARTAN	ACC
02415437	TEVA-TRANDOLAPRIL	TEV			ACC
02488698	TRANDOLAPRIL	PDL		APO-CANDESARTAN ATACAND	AZC
ST 2MG CAPSU	JLE			AURO-CANDESARTAN	AUR
02471884	AURO-TRANDOLAPRIL	AUR		CANDESARTAN	PDL
02231460	MAVIK	BGP		CANDESARTAN	SIV
02357771	PMS-TRANDOLAPRIL	PMS		CANDESARTAN	SAN
02325756	SANDOZ TRANDOLAPRIL	SDZ	02386526		JMP
02415445	TEVA-TRANDOLAPRIL	TEV	02476924		MIN
02488701	TRANDOLAPRIL	PDL	02391201		PMS
ST 4MG CAPSU	JLE			RAN-CANDESARTAN	RBY
02471892	AURO-TRANDOLAPRIL	AUR		SANDOZ CANDESARTAN	SDZ
02239267	MAVIK	BGP		TEVA-CANDESARTAN	TEV
02357798	PMS-TRANDOLAPRIL	PMS	ST 32MG TABL		I L V
02325764	SANDOZ TRANDOLAPRIL	SDZ		ACCEL-CANDESARTAN	ACP
02415453	TEVA-TRANDOLAPRIL	TEV		ACH-CANDESARTAN ACH-CANDESARTAN	ACC
02488728	TRANDOLAPRIL	PDL		APO-CANDESARTAN	ACC
24:32.08 AN	IGIOTENSIN II RECEPTOR			ATACAND	AZC
	ITAGONISTS			AURO-CANDESARTAN	AUR
				CANDESARTAN	PDL
AZILSARTAN	N MEDOXOMIL			CANDESARTAN	SAN
ST 40MG TABL	ET		02386534		JMP
02381389	EDARBI	VAE		PMS-CANDESARTAN	PMS
ST 80MG TABL	ET			RAN-CANDESARTAN	RBY
02381397	EDARBI	VAE		SANDOZ CANDESARTAN	SDZ
CANDESART	TAN CILEXETIL			TEVA-CANDESARTAN	TEV
					I L V
ST 4MG TABLE		400		TAN CILEXETIL,	
	ACH-CANDESARTAN	ACC	HYDROCHLO	OROTHIAZIDE	
02365340	APO-CANDESARTAN	APX	^{S7} 16MG & 12.5	5MG TABLET	
02239090	ATACAND	AZC	02463865	ACCEL-CANDESARTAN/HCTZ	ACP
02445786	AURO-CANDESARTAN	AUR	02367866	APO-CANDESARTAN/HCTZ	APX
02388901	CANDESARTAN	SAN	02244021	ATACAND PLUS	AZC
02386496	JAMP-CANDESARTAN	JMP	02421038	AURO-CANDESARTAN HCT	AUR
02391171		PMS	02394812	CANDESARTAN-HCT	SIV
02380684	RAN-CANDESARTAN	RBY			

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	GIOTENSIN II RECEPTOR TAGONISTS			GIOTENSIN II RECEPTOR TAGONISTS	
	AN CILEXETIL,		IRBESARTAI		
	OROTHIAZIDE			· -	
			150MG TAB 02446154	LE I BIO-IRBESARTAN	ВМІ
^{sr} 16MG & 12.5 02392275	CANDESARTAN-HCTZ	PDL	02365200	IRBESARTAN	PDL
02392273	CANDESARTAN-HCTZ CANDESARTAN-HCTZ	SAN	02372371	IRBESARTAN	SAN
02394804	JAMP CANDESARTAN-HCT	JMP	02385295	IRBESARTAN	SIV
	PMS-CANDESARTAN HCTZ	PMS	02418207	JAMP-IRBESARTAN	JMP
	SANDOZ CANDESARTAN PLUS	SDZ	02422999	MINT-IRBESARTAN	MIN
02395541	TEVA-CANDESARTAN/HCTZ	TEV	02317079	PMS-IRBESARTAN	PMS
ST 32MG & 12.5			02406829	RAN-IRBESARTAN	RBY
	ACCEL-CANDESARTAN/HCTZ	ACP	02328488	SANDOZ IRBESARTAN	SDZ
	APO-CANDESARTAN/HCTZ	APX	02316404	TEVA-IRBESARTAN	TEV
02332922	ATACAND PLUS	AZC	300MG TAB	LET	
02421046	AURO-CANDESARTAN HCT	AUR	02474417	AG-IRBESARTAN	ANG
02420732	SANDOZ CANDESARTAN PLUS	SDZ	02386984	APO-IRBESARTAN	APX
02395568	TEVA-CANDESARTAN/HCTZ	TEV	02406128	AURO-IRBESARTAN	AUR
ST 32MG & 25N	IG TABLET		02237925	AVAPRO	SAC
02463857	ACCEL-CANDESARTAN/HCTZ	ACP	02446162	BIO-IRBESARTAN	BMI
02395134	APO-CANDESARTAN/HCTZ	APX	02365219	IRBESARTAN	PDL
02332957	ATACAND PLUS	AZC	02372398	IRBESARTAN	SAN
02421054	AURO-CANDESARTAN HCT	AUR	02385309	IRBESARTAN	SIV
02473267	JAMP CANDESARTAN-HCT	JMP	02418215	JAMP-IRBESARTAN	JMP
02420740	SANDOZ CANDESARTAN PLUS	SDZ	02423006	MINT-IRBESARTAN	MIN
EPOSARTAN	I MESYLATE		02317087	PMS-IRBESARTAN	PMS
ST 400MG TAB	-		02406837	RAN-IRBESARTAN	RBY
		DCD	02328496	SANDOZ IRBESARTAN	SDZ
02240432 ST 600MG TAB I	TEVETEN	BGP	02316412	TEVA-IRBESARTAN	TEV
	TEVETEN	BGP	IRBESARTAN, HYDROCHLOROTHIAZIDE		
	I MESYLATE,	ВО	^s 150MG & 12	.5MG TABLET	
	DROTHIAZIDE		02387646	APO-IRBESARTAN/HCTZ	APX
			02447878	AURO-IRBESARTAN HCT	AUR
	.5MG TABLET		02241818	AVALIDE	SAC
	TEVETEN PLUS	BGP	02385317	IRBESARTAN HCT	SIV
IRBESARTAI	N		02372886	IRBESARTAN/HCTZ	SAN
75MG TABL	ET		02365162	IRBESARTAN-HCTZ	PDL
02474395	AG-IRBESARTAN	ANG	02418223	JAMP-IRBESARTAN AND	JMP
02386968	APO-IRBESARTAN	APX		HYDROCHLOROTHIAZIDE	
02406098	AURO-IRBESARTAN	AUR	02392992	MINT-IRBESARTAN/HCTZ	MIN
02237923	AVAPRO	SAC	02328518	PMS-IRBESARTAN-HCTZ	PMS
02446146	BIO-IRBESARTAN	BMI	02363208	RAN-IRBESARTAN HCTZ	RBY
02365197	IRBESARTAN	PDL		SANDOZ IRBESARTAN HCT	SDZ
02372347	IRBESARTAN	SAN		TEVA-IRBESARTAN HCTZ	TEV
02385287	IRBESARTAN	SIV		.5MG TABLET	
02418193	JAMP-IRBESARTAN	JMP		APO-IRBESARTAN/HCTZ	APX
02422980	MINT-IRBESARTAN	MIN		AURO-IRBESARTAN HCT	AUR
02317060	PMS-IRBESARTAN	PMS	02241819		SAC
02406810	RAN-IRBESARTAN	RBY	02385325	IRBESARTAN HCT	SIV
02328461	SANDOZ IRBESARTAN	SDZ	02372894	IRBESARTAN/HCTZ	SAN
02316390	TEVA-IRBESARTAN	TEV	02365170	IRBESARTAN-HCTZ	PDL
150MG TAB	LET		02418231	JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	JMP
02474409	AG-IRBESARTAN	ANG	02393018	MINT-IRBESARTAN/HCTZ	MIN
02386976	APO-IRBESARTAN	APX	02328526	PMS-IRBESARTAN-HCTZ	PMS
02406101	AURO-IRBESARTAN	AUR	02363216	RAN-IRBESARTAN HCTZ	RBY
02237924	AVAPRO	SAC	02337436		SDZ

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	NGIOTENSIN II RECEPTOR NTAGONISTS		24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS	
IRBESARTA	N, HYDROCHLOROTHIAZIDE		LOSARTAN POTASSIUM	
ST 300MG & 1	2.5MG TABLET		100MG TABLET	
	TEVA-IRBESARTAN HCTZ	TEV	02398850 JAMP-LOSARTAN	JMP
	5MG TABLET	, <u>-</u> v	02388812 LOSARTAN	SIV
	APO-IRBESARTAN/HCTZ	APX	02388898 LOSARTAN	SAN
	AURO-IRBESARTAN HCT	AUR	02394383 LOSARTAN	PDL
02385333		SIV	02405768 MINT-LOSARTAN	MIN
02372908		SAN	02309777 PMS-LOSARTAN	PMS
02365189		PDL	02313359 SANDOZ LOSARTAN	SDZ
02418258		JMP	02424983 SEPTA-LOSARTAN	SPT
	HYDROCHLOROTHIAZIDE		02357976 TEVA-LOSARTAN	TEV
02393026	MINT-IRBESARTAN/HCTZ	MIN	LOSARTAN POTASSIUM,	
02328534	PMS-IRBESARTAN-HCTZ	PMS	HYDROCHLOROTHIAZIDE	
02363224	RAN-IRBESARTAN HCTZ	RBY		
02337444	SANDOZ IRBESARTAN HCT	SDZ	ST 50MG & 12.5MG TABLET	
02330539	TEVA-IRBESARTAN HCTZ	TEV	02371235 APO-LOSARTAN/HCTZ	APX
LOSARTAN	POTASSIUM		02423642 AURO-LOSARTAN HCT	AUR
100MG CAI	Delli E		02230047 HYZAAR	FRS
		LINIZ	02408244 JAMP-LOSARTAN HCTZ	JMP
	LOSARTAN (PQ)	UNK	02388960 LOSARTAN HCT	SIV
25MG TABI		ANIC	02427648 LOSARTAN/HCTZ	SAN
	AG-LOSARTAN	ANG	02394391 LOSARTAN-HCTZ	PDL
	APO-LOSARTAN	APX	02389657 MINT-LOSARTAN/HCTZ	MIN
	AURO-LOSARTAN	AUR	02392224 PMS-LOSARTAN-HCTZ	PMS
02445964		BMI	02313375 SANDOZ LOSARTAN HCT	SDZ
02182815		FRS	02428539 SEPTA-LOSARTAN HCTZ	SPT
02398834		JMP	02358263 TEVA-LOSARTAN/HCTZ	TEV
	LOSARTAN	SIV	ST 100MG & 12.5MG TABLET	
02388863		SAN	02371243 APO-LOSARTAN/HCTZ	APX
02394367		PDL	02423650 AURO-LOSARTAN HCT	AUR
02405733		MIN	02297841 HYZAAR	FRS
02309750		PMS	02388979 LOSARTAN HCT	SIV
02313332		SDZ	02427656 LOSARTAN/HCTZ	SAN
02424967		SPT	02394405 LOSARTAN-HCTZ	PDL
02380838		TEV	02389665 MINT-LOSARTAN/HCTZ	MIN
50MG TABI		ANIO	02392232 PMS-LOSARTAN-HCTZ	PMS
	AG-LOSARTAN	ANG	02362449 SANDOZ LOSARTAN HCT	SDZ
	APO-LOSARTAN	APX	02377144 TEVA-LOSARTAN/HCTZ	TEV
02403331		AUR	ST 100MG & 25MG TABLET	
02445972		BMI	02371251 APO-LOSARTAN/HCTZ	APX
02182874		FRS	02423669 AURO-LOSARTAN HCT	AUR
02398842		JMP	02241007 HYZAAR DS	FRS
02388804		SIV	02408252 JAMP-LOSARTAN HCTZ	JMP
02388871		SAN	02388987 LOSARTAN HCT	SIV
02394375		PDL	02427664 LOSARTAN/HCTZ	SAN
02405741		MIN	02394413 LOSARTAN-HCTZ	PDL
02309769		PMS	02389673 MINT-LOSARTAN/HCTZ	MIN
02313340		SDZ SPT	02392240 PMS-LOSARTAN-HCTZ	PMS
02424975			02313383 SANDOZ LOSARTAN HCT	SDZ
02357968		TEV	02428547 SEPTA-LOSARTAN HCTZ	SPT
100MG TAE		ANIC	02377152 TEVA-LOSARTAN/HCTZ	TEV
	AG-LOSARTAN	ANG	OLMESARTAN MEDOXOMIL	
02353512		APX	ST 20MG TABLET	
02403358		AUR	02442191 ACT OLMESARTAN	TEV
02445980		BMI	02475731 AG-OLMESARTAN	ANG
02182882	COZAAR	FRS		

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	GIOTENSIN II RECEPTOR TAGONISTS			IGIOTENSIN II RECEPTOF ITAGONISTS	₹
	AN MEDOXOMIL		TELMISART		
ST 20MG TABL			ST 40MG TABL		
	APO-OLMESARTAN	APX		TEVA-TELMISARTAN	TEV
	AURO-OLMESARTAN	AUR	ST 80MG TABL		
02469812		GLK		APO-TELMISARTAN	APX
02461641	JAMP-OLMESARTAN	JMP		AURO-TELMISARTAN	AUR
02318660	OLMETEC PMS-OLMESARTAN	FRS PMS	02240770	MICARDIS PMS-TELMISARTAN	BOE
	SANDOZ OLMESARTAN	SDZ	02391244		PMS SDZ
02443414 ST 40MG TABL	*: ":= * = * = ::= *: " ::: " :	SDZ		TELMISARTAN	SAN
	ACT OLMESARTAN	TEV		TELMISARTAN	SIV
02475758	AG-OLMESARTAN	ANG	02395231		PDL
02453460	APO-OLMESARTAN	APX		TELMISARTAN	ACC
		AUR	02432900		PMS
02469820	GLN-OLMESARTAN	GLK		TEVA-TELMISARTAN	TEV
02461668	JAMP-OLMESARTAN	JMP	TEL MISART	AN, HYDROCHLOROTHIAZII	DF
02318679	OLMETEC	FRS		•	-
02461315	PMS-OLMESARTAN	PMS	ST 80MG & 12.		
02443422	SANDOZ OLMESARTAN	SDZ		ACH-TELMISARTAN HCTZ	ACC
OLMESARTA	AN MEDOXOMIL,			APO-TELMISARTAN/HCTZ	APX
	OROTHIAZIDE (AURO-TELMISARTAN HCTZ	AUR BOE
ST 20MG & 12.5	EMC TABLET			MICARDIS PLUS PMS-TELMISARTAN-HCTZ	PMS
	ACH-OLMESARTAN HCTZ	ACC		SANDOZ TELMISARTAN HCT	SDZ
	ACT OLMESARTAN HCT	TEV		TELMISARTAN HCTZ	SIV
	APO-OLMESARTAN/HCTZ	APX	02395355		SAN
	AURO-OLMESARTAN HCTZ	AUR	02395525		PDL
ST 20MG/12.5M		AON	02433214		PMS
	OLMETEC PLUS	FRS		TEVA-TELMISARTAN HCTZ	TEV
ST 40MG & 12.5			ST 80MG & 25N		
	ACH-OLMESARTAN HCTZ	ACC	02419122	ACH-TELMISARTAN HCTZ	ACC
02443120	ACT OLMESARTAN HCT	TEV	02420031	APO-TELMISARTAN/HCTZ	APX
02453614	APO-OLMESARTAN/HCTZ	APX	02456397	AURO-TELMISARTAN HCTZ	AUR
02476495	AURO-OLMESARTAN HCTZ	AUR	02318709	MICARDIS PLUS	BOE
ST 40MG & 25M	IG TABLET		02393565	SANDOZ TELMISARTAN HCT	SDZ
02468964	ACH-OLMESARTAN HCTZ	ACC	02390310	TELMISARTAN HCTZ	SIV
02443139	ACT OLMESARTAN HCT	TEV	02395363	TELMISARTAN/HCTZ	SAN
02453622	APO-OLMESARTAN/HCTZ	APX	02395533	TELMISARTAN-HCTZ	PDL
02476509	AURO-OLMESARTAN HCTZ	AUR	02433222		PMS
ST 40MG/12.5M				TEVA-TELMISARTAN HCTZ	TEV
	OLMETEC PLUS	FRS	VALSARTAN		
st 40MG/25MG			ST 40MG TABL	ET	
	OLMETEC PLUS	FRS	02371510	APO-VALSARTAN	APX
TELMISARTA	AN		02414201	AURO-VALSARTAN	AUR
ST 40MG TABL	ET		02270528	DIOVAN	NVR
02420082	APO-TELMISARTAN	APX	02363062	RAN-VALSARTAN	RBY
02453568	AURO-TELMISARTAN	AUR	02356740	SANDOZ VALSARTAN	SDZ
02240769	MICARDIS	BOE	02356643	TEVA-VALSARTAN	TEV
02391236	PMS-TELMISARTAN	PMS	02366940		SAN
02375958	SANDOZ TELMISARTAN	SDZ		VALSARTAN	PDL
02388944	TELMISARTAN	SAN		VALSARTAN	SIV
02390345	TELMISARTAN	SIV	ST 80MG TABL		
02395223	TELMISARTAN	PDL		APO-VALSARTAN	APX
02407485	TELMISARTAN	ACC		AURO-VALSARTAN	AUR
02432897	TELMISARTAN	PMS	02244781	DIOVAN	NVR

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	GIOTENSIN II RECEPTOR		24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS	
VALSARTAN			VALSARTAN, HYDROCHLOROTHIAZIDE	
ST 80MG TABL			sr 160MG & 25MG TABLET	
02363100	RAN-VALSARTAN	RBY	02367785 VALSARTAN-HCTZ	PDL
02356759	SANDOZ VALSARTAN	SDZ	ST 320MG & 12.5MG TABLET	PDL
02356651		TEV		APX
02366959		SAN	02382571 APO-VALSARTAN/HCTZ 02408147 AURO-VALSARTAN HCT	AUR
02367734		PDL		
	VALSARTAN	SIV	02308908 DIOVAN-HCT 02356724 SANDOZ VALSARTAN HCT	NVR
ST 160MG TAB		Siv	02357038 TEVA-VALSARTAN/HCTZ	SDZ TEV
	APO-VALSARTAN	APX	02367033 VALSARTAN/HCTZ	SAN
	AURO-VALSARTAN	AUR	02384760 VALSARTAN HCT	SIV
02244782		NVR	st 320MG & 25MG TABLET	317
02363119		RBY	02382598 APO-VALSARTAN/HCTZ	APX
02356767		SDZ	02408155 AURO-VALSARTAN/HCTZ	AUR
02356678		TEV	02308916 DIOVAN-HCT	NVR
02366967		SAN	02356732 SANDOZ VALSARTAN HCT	SDZ
	VALSARTAN	PDL	02357046 TEVA-VALSARTAN/HCTZ	TEV
	VALSARTAN	SIV	02367040 TEVA-VALSARTAN/HCTZ	SAN
ST 320MG TAB		Siv	02384779 VALSARTAN HCT	SIV
	APO-VALSARTAN	APX		Siv
	AURO-VALSARTAN	AUR	24:32.20 MINERALOCORTICOIDE	
02289504		NVR	(ALDOSTERONE) RECEPTOR	
02356775		SDZ	ANTAGONISTS	
02356686		TEV	ENALAPRIL MALEATE	
02366975		SAN	ST O FAMO TARLET	
02367750	VALSARTAN	PDL	ST 2.5MG TABLET 02474786 JAMP ENALAPRIL	JMP
	VALSARTAN	SIV	st 5MG TABLET	JIVIP
	, HYDROCHLOROTHIAZIDE	0	02474794 JAMP ENALAPRIL	JMP
			ST 10MG TABLET	JIVIF
ST 80MG & 12.5			02474808 JAMP ENALAPRIL	JMP
	APO-VALSARTAN/HCTZ	APX	ST 20MG TABLET	JIVII
	AURO-VALSARTAN HCT	AUR	02474816 JAMP ENALAPRIL	JMP
02241900		NVR	EPLERENONE	JIVII
02356694	SANDOZ VALSARTAN HCT	SDZ		
02356996	TEVA-VALSARTAN/HCTZ	TEV	Limited use benefit (prior approval required).	
02367009	VALSARTAN HCT	SAN	For the treatment of patients with New York Heart Association	on
02384736	VALSARTAN HCT	SIV	(NYHA) class II chronic heart failure with left ventricular	
02367769	VALSARTAN-HCTZ .5MG TABLET	PDL	systolic dysfunction (with ejection fraction ≤ 35%), as an	
		ADV	adjunct to standard therapy.	
	APO-VALSARTAN/HCTZ AURO-VALSARTAN HCT	APX	Note: Patients must be on optimal therapy with an	
02408120		AUR	angiotensin-converting-enzyme (ACE) inhibitor or an	
02241901	DIOVAN-HCT	NVR SDZ	angiotensin-receptor blocker (ARB), and a beta-blocker	
02356708	SANDOZ VALSARTAN HCT	TEV	(unless contraindicated) at the recommended dose or	
02357003 02367017	TEVA-VALSARTAN/HCTZ VALSARTAN HCT	SAN	25MG TABLET	
02384744	VALSARTAN HCT	SIV	02323052 INSPRA	PFI
02367777		PDL	02471442 MINT-EPLERENONE	MIN
^{S™} 160MG & 25		FDL	50MG TABLET	
02382563	APO-VALSARTAN/HCTZ	APX	02323060 INSPRA	PFI
02408139	AURO-VALSARTAIVITCTZ AURO-VALSARTAN HCT	AUR	02471450 MINT-EPLERENONE	MIN
02246955	DIOVAN-HCT	NVR	HYDROCHLOROTHIAZIDE, SPIRONOLACTO	NE
02356716	SANDOZ VALSARTAN HCT	SDZ	ST PDIN FOR EXTEMPORANEOUS MIXTURE	
02357011	TEVA-VALSARTAN HCT	TEV	99503009 ALDACTAZIDE ORAL LIQUID	UNK
02367025	VALSARTAN/HOTZ	SAN	SSSSSSS / LES/ CITALIDE OF ALL LINGS	J. 11.
02384752		SIV		
020041 02	7, LO, 0.17, 0.4 110 1	OIV		

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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

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.

00010332 **ENTROPHEN** PED Kawasaki Syndrome). PED 02050161 **ENTROPHEN** 150MG SUPPOSITORY 00216666 NOVASEN TEV **PMS** 00785547 ASA ST 650MG TABLET (DELAYED RELEASE) **650MG SUPPOSITORY** 00794244 VTH ASA 00582867 ASA **PMS** 02352435 ASATAB EC ODN ST 80MG TABLET 00229296 NOVASEN TEV **PMS** ACETYLSALICYLIC ACID .IMP 02284537 PMS-ASA FC 02269139 ST 81MG TABLET (ENTERIC COATED) 02295563 LOWPRIN **EUR** 02202360 RIVASA RIV 02243896 ASA DAILY LOW DOSE **PMS** ST 325MG TABLET 02237726 ASPIRIN RAY APX 00472468 APO ASA 02243801 **EQUATE DAILY LOW-DOSE PMS** JAMP-ASA EC 00530336 ASA VTH 02427206 VTH ST 325MG TABLET (ENTERIC COATED) 02150328 ASPIRIN RAY $^{\text{ST}}$ 80MG TABLET (CHEWABLE) 00510696 ASA APX 02009013 **ASAPHEN PMS** 02285371 PMS-ASA FC **PMS** 02280167 **ASATAB** ODN ST 650MG TABLET (ENTERIC COATED) APX 02250675 **EURO-ASA EUR** 00472476 ASA 02296004 **LOWPRIN** SDZ 00010340 **ENTROPHEN** PFD 02429950 M-ASA MAN 01905392 **ENTROPHEN** PED 02311518 PRO-AAS PDL **CELECOXIB** 02202352 **RIVASA** RIV ST 100MG CAPSULE **81MG TABLET (CHEWABLE)** 02420155 ACT CELECOXIB ACG 02394790 ASA DAILY LOW DOSE **PMS** 02437570 AG-CELECOXIB **ANG** 02243974 ENTROPHEN PED 02418932 APO-CELECOXIB **APX** ST 80MG TABLET (DELAYED RELEASE) 02445670 AURO-CELECOXIR AHR 02427176 ASA FO SAN 02426382 **BIO-CELECOXIB** BMI 02238545 **ASAPHEN PMS** 02239941 **CFI FBRFX** PFI 02283905 JAMP-ASA **JMP** 02424371 **CELECOXIB** PDL PDI 02311496 PRO-AAS 02429675 **CELECOXIB** SIV 02485222 RIVASA EC RIV 02436299 **CELECOXIB** SAN **81MG TABLET (DELAYED RELEASE)** 02291975 **GD-CELECOXIB** PFI APX 02461471 APO-ASA LD 02424533 JAMP-CFI FCOXIB JMP 02244993 ASA **PMS** 02420058 MAR-CELECOXIB MAR 02372177 ASA VTH 02412497 MINT-CELECOXIB MIN 02433044 ASA **PMS** 02479737 **NRA-CELECOXIB** UNK 02449277 TLI ASA 02355442 PMS-CELECOXIB **PMS** 02243101 ASA DAILY LOW DOSE **PMS** 02426366 PRIVA-CELECOXIB PHA 02377683 ASA DAILY LOW DOSE **APX** RAN-CELECOXIB **RBY** 02412373 ASA EC 02426811 SAN 02425386 RIV RIVA-CELECOX 02242281 **ENTROPHEN** PED 02442639 SDZ CELECOXIB SDZ 02283700 PRAXIS ASA DAILY LOW DOSE **PMS** ST 200MG CAPSULE 02420279 RIVASA EC RIV 02420163 ACT CFL FCOXIB ACG ST 162MG TABLET (DELAYED RELEASE) 02437589 AG-CELECOXIB ANG 02247550 ASAPHEN EC **PMS** 02418940 APO-CELECOXIB **APX** ST 325MG TABLET (DELAYED RELEASE) **AUR** 02445689 **AURO-CELECOXIB** 02010526 **VTH** ASA 02426390 **BIO-CELECOXIB** BMI 02352427 **ASATAB EC** ODN 02239942 **CELEBREX** PFI 02150417 **ASPIRIN** BAY

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			Non-insured health belief	เอ
	NSTEROIDAL ANTI- FLAMMATORY AGENTS		28:08.04 NONSTEROIDAL ANTI- INFLAMMATORY AGENTS	
CELECOXIB			DICLOFENAC SODIUM	
ST 200MG CAP	SULE		ST 100MG TABLET (EXTENDED RELEASE)	
02424398	CELECOXIB	PDL	·	NVR
02429683	CELECOXIB	SIV	DICLOFENAC SODIUM (TOPICAL)	
02436302	CELECOXIB	SAN	Limited use benefit (prior approval required).	
02291983	GD-CELECOXIB	PFI	Limited use benefit (prior approval required).	
02424541	JAMP-CELECOXIB	JMP	For the treatment of osteoarthritis when:	
02420066	MAR-CELECOXIB	MAR	• pain is inadequately controlled with acetaminophen AND a	
02412500	MINT-CELECOXIB	MIN	non-steroidal anti-inflammatory (NSAID); OR • there is contraindication to acetaminophen and NSAID; OR	
02479745	NRA-CELECOXIB	UNK	• there is intolerance to acetaminophen and NSAID.	
02355450	PMS-CELECOXIB	PMS	ST 1.5% SOLUTION	
02426374	PRIVA-CELECOXIB	PHA		APX
	RAN-CELECOXIB	RBY		TEL
	RIVA-CELECOX	RIV		RAX
	SDZ CELECOXIB	SDZ	02472309 JAMP DICLOFENAC TOPICAL J	JMP
DICLOFENA	C SODIUM		02356783 PMS-DICLOFENAC P	PMS
50MG SUPP	POSITORY		02420988 TARO-DICLOFENAC T	TAR
02231506	PMS-DICLOFENAC	PMS	DIFLUNISAL	
02261928	SANDOZ-DICLOFENAC	SDZ	ST 250MG TABLET	
00632724	VOLTAREN	NVR		AAP
100MG SUP	POSITORY		sr 500MG TABLET	√ √\Γ
02231508	PMS-DICLOFENAC	PMS		AAP
02261936	SANDOZ-DICLOFENAC	SDZ	FLURBIPROFEN	VII
00632732	VOLTAREN	NVR		
ST 25MG TABL	ET (DELAYED RELEASE)		ST 50MG TABLET	
	DOM-DICLOFENAC	DPC		AAP
	PMS-DICLOFENAC	PMS	ST 100MG TABLET	
	ET (DELAYED RELEASE)			٩AP
	DOM-DICLOFENAC	DPC		TEV
	PMS-DICLOFENAC	PMS	IBUPROFEN	
02261960	SANDOZ-DICLOFENAC	SDZ	ST 40MG/ML DROP	
	VOLTAREN	NVR	02242522 ADVIL PEDIATRIC DROPS	PFI
	ET (ENTERIC COATED)		02238626 CHILDREN'S MOTRIN	ИCL
	APO-DICLO	APX	ST 20MG/ML SUSPENSION	
00808539	TEVA-DICLOFENAC	TEV	02232297 CHILDREN'S ADVIL	PFI
	ET (ENTERIC COATED)	ADV	02354799 CHILDREN'S EUROPROFEN F	PED
	APO-DICLO	APX	02242365 CHILDREN'S MOTRIN	ИCL
	DICLOFENACEC	PDL	ST 100MG TABLET	
02352397	DICLOFENAC EC PMS-DICLOFENAC	SAN PMS	02246403 ADVIL	PFI
	TEVA-DICLOFENAC	TEV	ST 200MG TABLET	
	ET (EXTENDED RELEASE)	ΙΕV	01933558 ADVIL	PFI
	APO-DICLO SR	APX	00441643 APO-IBUPROFEN A	٩PX
02224119	DICLOFENAC-SR	PDL		JMP
02231664	DOM-DICLOFENAC SR	DPC		PMS
	PMS-DICLOFENAC	PMS		PMS
02261901	SANDOZ-DICLOFENAC SR	SDZ		√TH
	TEVA-DICLOFENAC SR	TEV		√TH
	VOLTAREN	NVR		APX
	LET (EXTENDED RELEASE)			MCL.
	APO-DICLO SR	APX		TEV
02224127	DICLOFENAC-SR	PDL	ST 300MG TABLET	
02231505	PMS-DICLOFENAC	PMS		APX
	SANDOZ-DICLOFENAC SR	SDZ	00629332 NOVO-PROFEN 1	TEV

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28:08.04 NONSTERO	DIDAL ANTI- TORY AGENTS		ONSTEROIDAL ANTI- FLAMMATORY AGENTS	
IBUPROFEN		MELOXICAM		
ST 400MG TABLET		ST 7.5MG TAB	LET	
02244577 ADVIL EXT	RA STRENGTH PF	02353148	MELOXICAM	SAN
00506052 APO IBUPF	ROFEN AP)	02248267	PMS-MELOXICAM	PMS
00636533 IBUPROFE	N PDI	. 02258315	TEVA-MELOXICAM	TEV
02314770 IBUPROFE	N PMS	ST 15MG TABI	LET	
02317338 IBUPROFE	N JMF	02250020	ACT MELOXICAM	TEV
02401290 JAMP-IBUF	PROFEN JMF	02248974	APO-MELOXICAM	APX
00629340 NOVO-PRO	DFEN TE\	02390892	AURO-MELOXICAM	AUR
00836133 PMS-IBUPF	ROFEN PMS	02248606	DOM-MELOXICAM	DPC
ST 600MG TABLET			MELOXICAM	PDL
00585114 APO IBUPF			MELOXICAM	SAN
00629359 TEVA-PRO			PMS-MELOXICAM	PMS
600MG TABLET (EXTEN	•		TEVA-MELOXICAM	TEV
02443562 ADVIL 12 H	IOUR PF	MISOPROS	TOL, DICLOFENAC SODIUM	
INDOMETHACIN			50MG TABLET	
sr 25MG CAPSULE			SANDOZ DICLOFENAC	SDZ
00611158 APO INDOI		ST COOLIGO O	MISOPROSTOL 75MG TABLET	
02461811 MINT-INDO		2012212	SANDOZ DICLOFENAC	SDZ
00337420 TEVA-INDO	DMETHACIN TEN	02400018	MISOPROSTOL	SDZ
00611166 APO INDOI	METHACIN APX	ST 200MCG &	50MG TABLET (DELAYED RELEASE)	
02461536 MINT-INDO		01017056	ARTHROTEC	PFI
00337439 TEVA-INDO		023/1690	GD-DICLOFENAC/MISOPROSTOL	PFI
50MG SUPPOSITORY		02413469	PMS-DICLOFENAC-MISOPROSTOL	PMS
02231799 SANDOZ IN	NDOMETHACIN SDZ		75MG TABLET (DELAYED RELEASE)	
100MG SUPPOSITORY			ARTHROTEC	PFI
02231800 SANDOZ IN	NDOMETHACIN SDZ		GD-DICLOFENAC/MISOPROSTOL	PFI
KETOPROFEN		NAPROXEN	PMS-DICLOFENAC-MISOPROSTOL	PMS
ST 50MG CAPSULE				
00790427 KETOPROF	FEN AAF		PPOSITORY	
02150808 PMS-KETO	PROFEN PMS		PMS-NAPROXEN	PMS
100MG SUPPOSITORY		ST 25MG/ML S		PEI
02015951 PMS-KETO	PROFEN PMS	° 125MG TAE	NAPROXEN	PEI
ST 50MG TABLET (ENTERIO	C COATED)		APO NAPROXEN	APX
00790435 KETOPROF		ST 220MG TAE		AFA
02150816 PMS-KETO			NAPROXEN	PMS
$^{\rm ST}$ 100MG TABLET (ENTER	•	02385007	NAPROXEN SODIUM	APX
00842664 KETOPROF		ST 250MG TΔF		7 11 7 1
02150824 PMS-KETO			APO-NAPROXEN	APX
ST 200MG TABLET (EXTEN	•	00590762	NAPROXEN	PDL
02172577 KETOPROF	FEN SR AAF		NAPROXEN	SAN
MEFENAMIC ACID			TEVA-NAPROXEN	TEV
ST 250MG CAPSULE		ST 275MG TAE		
02237826 DOM-MEFE			ANAPROX	APU
02229452 MEFENAMI			APO-NAPRO-NA	APX
00155225 PONSTAN	AAF	0_00.0.0	NAPROXEN SODIUM	SAN
MELOXICAM			NAPROXEN-NA TEVA-NAPROXEN	PDL TEV
ST 7.5MG TABLET		ST 375MG TAE		1 L V
02250012 ACT MELO		00600806	APO-NAPROXEN	APX
02248973 APO-MELO		00655686	NAPROXEN	PDL
02390884 AURO-MEL		02350769	NAPROXEN	SAN
02248605 DOM-MELC	DXICAM DPC			

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28:08.04 NONSTEROIDAL ANTI-28:08.08 OPIATE AGONISTS **INFLAMMATORY AGENTS** ACETAMINOPHEN, CAFFEINE CITRATE, **CODEINE PHOSPHATE NAPROXEN** Limited use benefit (prior approval is not required). ST 375MG TABLET 00627097 TEVA-NAPROXEN TEV For safety reasons NIHB has implemented a dose limit on ST 500MG TABLET acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain APX 00592277 APO-NAPROXEN acetaminophen and/or acetaminophen in combination with 00618721 NAPROXEN **PDL** opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. 02350777 NAPROXEN SAN Percocet®). A total of 360 grams of acetaminophen is 00589861 TEVA-NAPROXEN TFV permitted in a 100-day period, for a total daily dose of ST 550MG TABLET 3600mg/day. 02162717 ANAPROX DS APU 300MG & 15MG & 15MG TABLET 01940309 APO-NAPRO-NA DS APX 00653241 RATIO-LENOLTEC NO 2 TEV 02351021 NAPROXEN SODIUM DS SAN 02163934 TYLENOL WITH CODEINE NO.2 JSO 02153386 NAPROXEN-NA DF PDL 300MG & 15MG & 30MG TABLET 02026600 TEVA-NAPROXEN DS TEV TEV 00653276 RATIO-LENOLTEC NO 3 ST 250MG TABLET (ENTERIC COATED) 02163926 TYLENOL WITH CODEINE NO.3 JSO. 02246699 APO-NAPROXEN EC APX 325MG & 30MG & 15MG TABLET 02350785 NAPROXEN EC SAN 00293504 ATASOL 15 CHU 02243312 TEVA-NAPROXEN TEV **ACETAMINOPHEN, CODEINE PHOSPHATE** ST 375MG TABLET (ENTERIC COATED) Limited use benefit (prior approval is not required). 02246700 APO-NAPROXEN EC APX 02162415 NAPROSYN APU For safety reasons NIHB has implemented a dose limit on 02350793 NAPROXEN EC SAN acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain 02294702 PMS-NAPROXEN EC **PMS** acetaminophen and/or acetaminophen in combination with 02310945 PRO-NAPROXEN PDL opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. 02243313 TEVA-NAPROXEN TEV Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 500MG TABLET (ENTERIC COATED) 02246701 APO-NAPROXEN EC APX 3600mg/day. 02162423 NAPROSYN APU 32MG & 1.6MG/ML ELIXIR 02350807 NAPROXEN EC SAN 00816027 PMS-ACETAMINOPHEN **PMS** 02294710 PMS-NAPROXEN EC PMS **300MG & 30MG TABLET** PDL 02310953 PRO-NAPROXEN 00608882 TEVA-EMTEC-30 **TEV** 02243314 TEVA-NAPROXEN TEV RIV 00789828 TRIATEC-30 ST 750MG TABLET (EXTENDED RELEASE) ACETAMINOPHEN, OXYCODONE APU 02162466 NAPROSYN **HYDROCHLORIDE PIROXICAM** Limited use benefit (prior approval is not required). ST 10MG CAPSULE For safety reasons NIHB has implemented a dose limit on 00642886 APO PIROXICAM APX acetaminophen. The limit accumulates against the amount of 00695718 TEVA-PIROXICAM **TEV** acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with ST 20MG CAPSULE opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. 00642894 APO PIROXICAM **APX** Percocet®). A total of 360 grams of acetaminophen is 00695696 TEVA-PIROXICAM **TEV** permitted in a 100-day period, for a total daily dose of **SULINDAC** . 3600mg/day. ST 150MG TABLET 325MG & 5MG TABLET 00745588 TEVA-SULINDAC TEV 02324628 APO-OXYCODONE/ACET **APX** ST 200MG TABLET 02361361 OXYCODONE/ACET SAN 02242468 RIVACOCET RIV 00745596 TEVA-SULINDAC TEV 02307898 SANDOZ SDZ **TIAPROFENIC ACID** OXYCODONE/ACETAMINOPHEN ST 200MG TABLET 00608165 TEVA-OXYCOCET TFV 02230827 PMS-TIAPROFENIC **PMS** 02179679 TEVA-TIAPROFENIC TEV ST 300MG TABLET 02231060 DOM-TIAPROFENIC DPC 02179687 TEVA-TIAPROFENIC TEV

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28:08.08 OPIATE AGONISTS 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 non-cancer, nonpalliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30day period (i.e. 6000 morphine equivalents over 30 days).

325MG & 5MG TABLET

00608157 TEVA-OXYCODAN

TFV

CODEINE MONOHYDRATE, CODEINE SULFATE TRIHYDRATE

Limited use benefit (prior approval required).

For treatment of:

- · chronic pain and palliative care patients as an alternative to products containing codeine in combination with acetaminophen or ASA with or without caffeine; OR
- · chronic pain and palliative care patients as an alternative to regular release codeine tablets when large doses are required.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, nonpalliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30day period (i.e. 6000 morphine equivalents over 30 days).

	50MG TABLI	ET (EXTENDED R	ELEASE)	
	02230302	CODEINE CONT	IN CR	PFR
	100MG TABI	ET (EXTENDED	RELEASE)	
	02163748	CODEINE CONT	IN CR	PFR
	150MG TABI	ET (EXTENDED	RELEASE)	
	02163780	CODEINE CONT	IN CR	PFR
:	200MG TABI	ET (EXTENDED	RELEASE)	
	02163799	CODEINE CONT	IN 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 non-cancer, nonpalliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30day period (i.e. 6000 morphine equivalents over 30 days).

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

28:08.08 OPIATE AGONISTS **FENTANYL**

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, nonpalliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30day period (i.e. 6000 morphine equivalents over 30 days).

12MCG/HR PATCH 02341379 PMS-FENTANYL MTX

PMS 02327112 SANDOZ FENTANYL SD7 02311925 TEV TEVA-FENTANYI 25MCG/HR PATCH

02341387 PMS-FENTANYL MTX **PMS** 02327120 SANDOZ FENTANYL SDZ 02282941 TEVA-FENTANYL TEV

50MCG/HR PATCH

02341395 PMS-FENTANYL MTX **PMS** SDZ 02327147 SANDOZ FENTANYL 02282968 TEVA-FENTANYL **TEV** 75MCG/HR PATCH

02341409 PMS-FENTANYL MTX **PMS** SANDOZ FENTANYL 02327155 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 non-cancer, nonpalliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30day period (i.e. 6000 morphine equivalents over 30 days).

3MG CAPSULE (EXTENDED RELEASE)

02476614 APO-HYDROMORPHONE **APX**

APX

4.5MG CAPSULE (EXTENDED RELEASE) 02476622 APO-HYDROMORPHONE

6MG CAPSULE (EXTENDED RELEASE) 02476630 APO-HYDROMORPHONE **APX**

9MG CAPSULE (EXTENDED RELEASE)

02476649 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 non-cancer, nonpalliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30day period (i.e. 6000 morphine equivalents over 30 days).

12MG CAPSULE (EXTENDED RELEASE) 0247665 18MG CAP 0247666 24MG CAF 0247667 30MG CAR 0247668 3MG CAPS 0212532 4.5MG CA 0235950 6MG CAPS 0212533 9MG CAPS 0235951 12MG CAF 0212536 18MG CAF 0224356 24MG CAF 0212538 30MG CAF 0212539 1MG/ML L 0191638 **3MG SUPI** 0191639 **1MG TABI** 0236411 0070543 0088544 0231940 2MG TABI 0236412 0012508 0088543 0231941 **4MG TABI** 0236413 00125121 DILAUDID 00885401 PMS-HYDROMORPHONE **PMS**

28:08.08 OPIATE AGONISTS HYDROMORPHONE HYDROCHLORIDE

Limited use benefit.

AMC TARLET

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 non-cancer, nonpalliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30day period (i.e. 6000 morphine equivalents over 30 days).

NPS	ULE (EXTENDED RELEASE)		4MG TABLE	T	
57	APO-HYDROMORPHONE	APX	02319438	TEVA-HYDROMORPHONE	TEV
APS	ULE (EXTENDED RELEASE)		8MG TABLE	т	
65	APO-HYDROMORPHONE	APX	02364158	APO-HYDROMORPHONE	APX
\PS	ULE (EXTENDED RELEASE)		00786543	DILAUDID	PFR
73	APO-HYDROMORPHONE	APX	00885428	PMS-HYDROMORPHONE	PMS
\PS	ULE (EXTENDED RELEASE)		02319446	TEVA-HYDROMORPHONE	TEV
81	APO-HYDROMORPHONE	APX	METHADON	E HYDROCHLORIDE	
PSU	LE (SUSTAINED RELEASE)		POWDER		
23	HYDROMORPH CONTIN	PFR		METHADONE BOWDER (OAT)	MDS
APS	SULE (SUSTAINED RELEASE)		10MG SOLU	METHADONE POWDER (OAT)	IVIDS
02	HYDROMORPH CONTIN	PFR	02481979	METHADONE HYDROCHLORIDE	UNK
PSU	LE (SUSTAINED RELEASE)		02401979	CONCENTRATE	UNK
31	HYDROMORPH CONTIN	PFR	10MG/ML S		
PSU	LE (SUSTAINED RELEASE)		02244290	METADOL-D	PAL
10	HYDROMORPH CONTIN	PFR	02394596	METHADOSE	MAT
\PS	ULE (SUSTAINED RELEASE)		02394618	METHADOSE	MAT
66	HYDROMORPH CONTIN	PFR	METHADON	E HYDROCHLORIDE (BC ONL	V)
\PS	ULE (SUSTAINED RELEASE)			,	',
62	HYDROMORPH CONTIN	PFR	10MG/ML O		
\PS	ULE (SUSTAINED RELEASE)		66999999	METHADOSE DEL. W DIRECT	UNK
82	HYDROMORPH CONTIN	PFR	0700000	INTER (OAT)	LINUZ
\PS	ULE (SUSTAINED RELEASE)		67000000	METHADOSE DEL. W/OUT DIR INTER (OAT)	UNK
90	HYDROMORPH CONTIN	PFR	66999997	METHADOSE W DIRECT	UNK
LIQ	UID		0000001	INTERACTION (OAT)	Ortic
86	PMS HYDROMORPHONE	PMS	66999998	METHADOSE W/OUT DIRECT	UNK
PPC	SITORY			INTER (OAT)	
94	PMS HYDROMORPHONE	PMS	METHADON	E HYDROCHLORIDE (METADO	DL)
BLE	т		Limited use bene	efit (prior approval required) with the follo	owina
15	APO-HYDROMORPHONE	APX	criteria:		3
38	DILAUDID	PFR			
44	PMS-HYDROMORPHONE	PMS		stered with Health Canada and is eligible done for the management of pain; AND	e to
03	TEVA-HYDROMORPHONE	TEV		nent of moderate to severe cancer pain	or
BLE	т			cer pain, as an alternative to other opioic	
23	APO-HYDROMORPHONE	APX	OR		
83	DILAUDID	PFR	0	nent of pain for palliative care patients.	,
36	PMS-HYDROMORPHONE	PMS	days at one time	y only dispense a maximum supply of 30	,
11	TEVA-HYDROMORPHONE	TEV	,		
BLE	т		1MG/ML SO		DAI
31	APO-HYDROMORPHONE	APX		METADOL	PAL
21	DILAUDID	PFR	10MG/ML S	METABOL	DAI

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02241377 METADOL

PAL

28:08.08 OPIATE AGONISTS METHADONE HYDROCHLORIDE (METADOL)

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

Prescriber is registered with Health Canada and is eligible to prescribe methadone for the management of pain; AND For the management of moderate to severe cancer pain or chronic non-cancer pain, as an alternative to other opioids; OR

For the management of pain for palliative care patients. Pharmacists may only dispense a maximum supply of 30 days at one time.

1MG TABLE	Т	
02247698	METADOL	PAL
5MG TABLE	Т	
02247699	METADOL	PAL
10MG TABLE	ET	
02247700	METADOL	PAL
25MG TABLE	ET	
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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

1MG/ML SYI	RUP		
00614491	DOLORAL 1		ATL
5MG/ML SYI	RUP		
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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG CAPS	ULE (EXTENDED RELE	EASE)	
02019930	M-ESLON		ETH
15MG CAPS	ULE (EXTENDED RELE	EASE)	
02177749	M-ESLON		ETH
30MG CAPS	ULE (EXTENDED RELE	EASE)	
02019949	M-ESLON		ETH
60MG CAPS	ULE (EXTENDED RELE	EASE)	
02019957	M-ESLON		ETH
100MG CAPS	SULE (EXTENDED REL	.EASE)	
02019965	M-ESLON		ETH
200MG CAPS	SULE (EXTENDED REL	.EASE)	
02177757	M-ESLON		ETH
5MG SUPPO	SITORY		
00632228	STATEX		PAL
10MG SUPPOSITORY			
00632201	STATEX		PAL

28:08.08 OPIATE AGONISTS MORPHINE SULFATE

20MG SUPPOSITORY

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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

20MG SUPP	OSITORY	
00596965	STATEX	PAL
5MG TABLE	т	
00594652	STATEX	PAL
10MG TABL	ET	
00594644	STATEX	PAL
25MG TABL	ET	
00594636	STATEX	PAL
50MG TABL	ET	
00675962	STATEX	PAL
	ET (EXTENDED RELEASE)	
02350815	MORPHINE SR	SAN
02015439	MS CONTIN SR	PFR
	SANDOZ MORPHINE SR	SDZ
02302764	TEVA-MORPHINE SR	TEV
30MG TABL	ET (EXTENDED RELEASE)	
	MORPHINE SR	SAN
02014297	MS CONTIN SR	PFR
02244791	SANDOZ MORPHINE SR	SDZ
02302772	TEVA-MORPHINE SR	TEV
60MG TABL	ET (EXTENDED RELEASE)	
02350912	MORPHINE SR	SAN
02014300	MS CONTIN SR SANDOZ MORPHINE SR	PFR
02244792	SANDOZ MORPHINE SR	SDZ
02302780	TEVA-MORPHINE SR	TEV
100MG TAB	LET (EXTENDED RELEASE)	
02014319	MS CONTIN SR	PFR
02302799	TEVA-MORPHINE SR	TEV
200MG TAB	LET (EXTENDED RELEASE)	
	MS CONTIN SR	PFR
02478897	SANDOZ MORPHINE SR	SDZ
02302802	TEVA-MORPHINE SR	TEV
5MG TABLE	T (IMMEDIATE RELEASE)	
02014203	MS IR	PFR
10MG TABL	ET (IMMEDIATE RELEASE)	
02014211		PFR
20MG TABL	ET (IMMEDIATE RELEASE)	
02014238	MS IR	PFR
30MG TABL	ET (IMMEDIATE RELEASE)	
02014254	MS IR	PFR

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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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG CAPSULE (SUSTAINED RELEASE)

	- ,			
KADIAN		BGP		
KADIAN		MAY		
ULE (SUS1	ΓAINED RELEASE)			
KADIAN		BGP		
KADIAN		MAY		
ULE (SUST	TAINED RELEASE)			
KADIAN		BGP		
KADIAN		MAY		
100MG CAPSULE (SUSTAINED RELEASE)				
KADIAN		BGP		
KADIAN		MAY		
	KADIAN KADIAN ULE (SUS KADIAN KADIAN	KADIAN ULE (SUSTAINED RELEASE) KADIAN KADIAN ULE (SUSTAINED RELEASE) KADIAN KADIAN KADIAN SULE (SUSTAINED RELEASE) KADIAN		

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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG SUPPOSITORY 00392480 SUPEUDOL SDZ **20MG SUPPOSITORY** 00392472 SUPEUDOL SDZ **5MG TABLET PFR** 02231934 OXY-IR PMS-OXYCODONE 02319977 **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**

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.
- Patient is palliative (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less)

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

5MCG PATCH 02341174 BUTRANS 5 PFR 10MCG PATCH 02341212 BUTRANS 10 PFR 15MCG PATCH 02450771 BUTRANS 15 PFR 20MCG PATCH 02341220 BUTRANS 20 PFR

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	ACG
02424851	PMS-BUPRENORPHINE-	PMS
	NALOXONE	
02295695	SUBOXONE	IND
8MG & 2MG	TABLET	
02453916	ACT BUPRENORPHINE/NALOXONE	ACG

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PED

MCL

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.

8MG & 2MG TABLET

02424878	PMS-BUPRENORPHINE- NALOXONE	- PMS		
02295709	SUBOXONE	IND		
12MG & 3MG	G 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).

01904140 ACETAMINOPHEN

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

01304140	ACLIAMINOI HEN	IAN			
01905864	ACETAMINOPHEN	TLI			
02263793	PEDIAPHEN	EUR			
02027801	PEDIATRIX	TEV			
00875988	TEMPRA INFANT	PAL			
02046059	TYLENOL	MCL			
ST 16MG/ML LI	QUID				
01905848	ACETAMINOPHEN	TLI			
00792713	PDP-ACETAMINOPHEN	PED			
02263807	PEDIAPHEN	EUR			
00884553	TEMPRA CHILDREN'S	PAL			
ST 32MG/ML LI	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			
120MG SUPPOSITORY					
00553328	ABENOL	GSK			
02230434	ACET 120	PED			

02046660 PMS-ACETAMINOPHEN

28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

ACETAMINOPHEN

160MG SUPPOSITORY

02230435 ACET
325MG SUPPOSITORY

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.

01919393	ABENOL	PED		
02230436	ACET 325	PED		
02046687	PMS-ACETAMINOPHEN	PMS		
650MG SUPPOSITORY				
02230437	ACET 650	PED		
02046695	PMS-ACETAMINOPHEN	PMS		
ST 80MG TABLE	ĒΤ			
02015676	ACETAMINOPHEN	TAN		
02263815	PEDIAPHEN	EUR		
ST 160MG TABL	_ET			
02230934	ACETAMINOPHEN	TAN		
ST 325MG TABL	_ET			
00605751	ACETAMINOPHEN	VTH		
00743542	ACETAMINOPHEN	PMT		
00789801	ACETAMINOPHEN	TLI		
01938088	ACETAMINOPHEN	JMP		
02022214	ACÉTAMINOPHÈNE	RIV		
02362198	ACÉTAMINOPHÈNE	RIV		
00544981	APO ACETAMINOPHEN	APX		
02229873	APO-ACETAMINOPHEN	APX		
00389218	NOVO-GESIC	TEV		
00559393	TYLENOL	MCL		
00723894	TYLENOL	MCL		
ST 500MG TABL				
00549703	ACETAMINOPHEN	PMT		
00605778	ACETAMINOPHEN	VTH		
00789798	ACETAMINOPHEN	TLI		
01939122	ACETAMINOPHEN	JMP		
01962353	ACETAMINOPHEN	TAN		
02252813	ACETAMINOPHEN	PMT		
02255251	ACETAMINOPHEN	PMT		
02022222	ACÉTAMINOPHÈNE	RIV		
02362228	ACÉTAMINOPHÈNE	RIV		
02362201	ACÉTAMINOPHÈNE BLASON SHIELD	RIV		
00545007	APO ACETAMINOPHEN	APX		
02229977	APO-ACETAMINOPHEN	APX		
02355299	JAMP ACETAMINOPHEN BLAZON	JMP		
00482323	NOVO-GESIC FORTE	TEV		
00892505	PMS-ACETAMINOPHEN	PMS		
00723908	TYLENOL	MCL		

00559407 TYLENOL EXTRA STRENGTH

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PMS

TAN

PMS

TEV

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 TABL	ET (CHEWABLE)		
01905856	ACETAMINOPHEN	TLI	
02017458	ACETAMINOPHEN	RIV	
02129957	ACETAMINOPHEN	VTH	
ST 160MG TAB	LET (CHEWABLE)		
02017431	ACETAMINOPHEN	RIV	
02142805	ACETAMINOPHEN	VTH	
02263823	PEDIAPHEN	EUR	
02347792	TYLENOL JR STRENGTH FASTMELTS	MCL	
02241361	TYLENOL JUNIOR STRENGTH	MCL	
I OCTAFENINE			

FLOCTAFENINE

ST 200MG TABLET			
02244680	FLOCTAFENINE	AAP	
ST 400MG TABLET			
02244681	FLOCTAFENINE	AAP	

28 N

28:10.00 OP	IATE ANTAGONISTS	
NALOXONE	HYDROCHLORIDE	
INJECTION		
09991488	NALOXONE KIT	UNK
0.4MG/ML IN	JECTION	
09991460	NALOXONE KIT	UNK
0.4MG SOLU	JTION	
02453258	S.O.S NALOXONE HYDROCHLORIDE	SDZ
0.4MG/ML S	OLUTION	
02148706	NALOXONE	SDZ
02382482	NALOXONE	TEL
02393034	NALOXONE	OMG
1MG/ML SO	LUTION	
02148714	NALOXONE	SDZ
02393042	NALOXONE	OMG
4MG SPRAY	•	
02458187	NARCAN	UNK
NALTREXON	IE HYDROCHLORIDE	
50MG TABL	ET	
02444275	APO-NALTREXONE	APX
02451883	NALTREXONE HYDROCHLORIDE	UNK
02213826	REVIA	TEV

28:12.04 ANTICONVULSANTS -**BARBITURATES**

PHENOBARBITAL

5MG/ML EL	IXIR	
00645575	PHENOBARB	PED
100MG TAB	LET	
00178829	PHENOBARB	PED
PRIMIDONE		
ST 125MG TAB	LET	
00399310	PRIMIDONE	AAP
ST 250MG TAB	LET	
00396761	PRIMIDONE	AAP
28:12.08 AN	TICONVULSANTS -	
BE	NZODIAZEPINES	
CLOBAZAM		
ST 10MG TABL	ET	
02244638	APO-CLOBAZAM	APX

CLONAZEPAM

Limited use benefit (prior approval is not required).

02244474 PMS-CLOBAZAM

02238334 TEVA-CLOBAZAM

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.

$^{\text{ST}}$ 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 TABLE	т			
02230368	CLONAPAM	VAE		
02048728	PMS-CLONAZEPAM	PMS		
02311607	PRO-CLONAZEPAM	PDL		
ST 2MG TABLE	т			
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		
$^{\rm s au}$ PDIN FOR E	XTEMPORANEOUS MIXTURE			
99503020	BENZODIAZEPINE ORAL LIQUID	UNK		

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28:12.12 ANTICONVULSANTS -28:12.92 MISCELLANEOUS **HYDANTOINS ANTICONVULSANTS PHENYTOIN CARBAMAZEPINE** ST 30MG CAPSULE ST 100MG TABLET (CHEWABLE) 00022772 DILANTIN PFI 02244403 TARO-CARBAMAZEPINE TAR ST 100MG CAPSULE ST 200MG TABLET (CHEWABLE) 02460912 APO-PHENYTOIN SODIUM APX 02244404 TARO-CARBAMAZEPINE TAR 00022780 DILANTIN PFI ST 200MG TABLET (EXTENDED RELEASE) ST 6MG/ML SUSPENSION 02413590 CARBAMAZEPINE **PDL** 02238222 DOM-CARBAMAZEPINE 00023442 DILANTIN PFI DPC ST 25MG/ML SUSPENSION 02231543 PMS-CARBAMAZEPINE **PMS** 00023450 DILANTIN PFI 02261839 SANDOZ-CARBAMAZEPINE SDZ 02250896 TARO-PHENYTOIN TAR 02237907 TARO-CARBAMAZEPINE TAR ST 50MG TABLET 00773611 **TEGRETOL NVR** ST 400MG TABLET (EXTENDED RELEASE) 00023698 DILANTIN INFATABS PFI PDI 02413604 CARBAMAZEPINE 28:12.20 ANTICONVULSANTS-DPC 02238223 DOM-CARBAMAZEPINE SUCCINIMIDES 02231544 PMS-CARBAMAZEPINE **PMS ETHOSUXIMIDE** SANDOZ-CARBAMAZEPINE SDZ 02261847 ST 250MG CAPSULE 02237908 TARO-CARBAMAZEPINE TAR 00022799 ZARONTIN FRF 00755583 **TEGRETOL NVR** ST 50MG/ML SYRUP ESLICARBAZEPINE ACETATE 00023485 ZARONTIN **ERF** Limited use benefit (prior approval required). 28:12.92 MISCELLANEOUS For adjunctive therapy in adult patients with refractory partial-**ANTICONVULSANTS** onset seizures who meet all of the following criteria: · Are under the care of a physician experienced in the **BRIVARACETAM** treatment of epilepsy; AND Limited use benefit (prior approval required). · Are currently receiving two or more antiepileptic medications; AND For adjunctive therapy in adult patients with refractory partial-Have failed or demonstrated intolerance to at least two other onset seizures who meet all of the following criteria: antiepileptic medications. · Are under the care of a physician experienced in the ST 200MG TABLET treatment of epilepsy; AND · Are currently receiving two or more antiepileptic 02426862 APTIOM SPC medications; AND ST 400MG TABLET · Have failed or demonstrated intolerance to at least two other 02426870 APTIOM SPC antiepileptic medications: AND ST 600MG TABLET · Are not receiving concurrent therapy with levetiracetam. 02426889 APTIOM SPC **10MG TABLET** ST 800MG TABLET 02452936 BRIVLERA **UCB** SPC 02426897 APTIOM 25MG TABLET **GABAPENTIN** 02452944 BRIVLERA **UCB** Limited use benefit (prior approval is not required). **50MG TABLET** UCB 02452952 BRIVLERA For safety reasons NIHB has implemented a dose limit on 75MG TABLET gabapentin. The limit accumulates against the amount of 02452960 BRIVLERA **UCB** gabapentin claimed to the program. A total of 400 grams of **100MG TABLET** gabapentin is permitted in a 30-day period, for a total daily dose of 4000 mg/day. 02452979 BRIVLERA **UCB CARBAMAZEPINE** The gabapentin dose limit will be further reduced to 3600 mg per day. The new limit will be implemented region-by-region. ST 20MG/ML SUSPENSION **100MG CAPSULE** 02367394 TARO-CARBAMAZEPINE TAR 02477912 AG-GABAPENTIN ANG **NVR** 02194333 TEGRETOL 02244304 APO-GABAPENTIN APX ST 200MG TABLET 00402699 APO CARBAMAZEPINE APX 02321203 AURO-GABAPENTIN **AUR** 02450143 **BIO-GABAPENTIN** BMI MAZEPINE 00504742 BMI 02243743 DOM-GABAPENTIN DPC 02407515 TARO-CARBAMAZEPINE **TAR** 02246314 **GABAPENTIN** SIV 00010405 **TEGRETOL NVR** 02353245 **GABAPENTIN** SAN 00782718 TEVA-CARBAMAZEPINE 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.

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.

ci day. The new	v iii iii viiii be ii iipiei iietitea regior	i-by-region.	per day. The nev	v illinit will be implemented region-by	y-region.
100MG CAPSULE		ST 600MG TAB	LET		
02416840	GABAPENTIN	ACC	02293358	APO-GABAPENTIN	APX
02285819	GD-GABAPENTIN	PFI	02428334	AURO-GABAPENTIN	AUR
02361469	JAMP-GABAPENTIN	JMP	02450186	BIO-GABAPENTIN	BMI
02391473	MAR-GABAPENTIN	MAR	02388200	GABAPENTIN	SIV
02084260	NEURONTIN	PFI	02392526	GABAPENTIN	ACC
02243446	PMS-GABAPENTIN	PMS	02431289	GABAPENTIN	SAN
02310449	PRO-GABAPENTIN	PDL	02285843	GD-GABAPENTIN	PFI
02319055	RAN-GABAPENTIN	RBY	02402289	JAMP-GABAPENTIN	JMP
02251167	RIVA-GABAPENTIN	RIV	02239717	NEURONTIN	PFI
02244513	TEVA-GABAPENTIN	TEV	02255898	PMS-GABAPENTIN	PMS
300MG CAP	SULE		02310473	PRO-GABAPENTIN	PDL
02477920	AG-GABAPENTIN	ANG	02259796	RIVA-GABAPENTIN	RIV
02244305	APO-GABAPENTIN	APX	02248457	TEVA-GABAPENTIN	TEV
02321211	AURO-GABAPENTIN	AUR	ST 800MG TAB	LET	
02450151	BIO-GABAPENTIN	BMI	02293366	APO-GABAPENTIN	APX
02243744	DOM-GABAPENTIN	DPC	02428342	AURO-GABAPENTIN	AUR
02246315	GABAPENTIN	SIV	02450194	BIO-GABAPENTIN	BMI
02353253	GABAPENTIN	SAN	02388219	GABAPENTIN	SIV
02416859	GABAPENTIN	ACC	02392534	GABAPENTIN	ACC
02285827	GD-GABAPENTIN	PFI	02431297	GABAPENTIN	SAN
02361485	JAMP-GABAPENTIN	JMP	02402297	JAMP-GABAPENTIN	JMP
02391481	MAR-GABAPENTIN	MAR	02239718	NEURONTIN	PFI
02084279	NEURONTIN	PFI	02255901	PMS-GABAPENTIN	PMS
02243447	PMS-GABAPENTIN	PMS	02310481	PRO-GABAPENTIN	PDL
02310457	PRO-GABAPENTIN	PDL	02259818	RIVA-GABAPENTIN	RIV
02319063	RAN-GABAPENTIN	RBY	02247346	TEVA-GABAPENTIN	TEV
02251175	RIVA-GABAPENTIN	RIV	ST 600MG TAB	LET (IMMEDIATE RELEASE)	
02244514	TEVA-GABAPENTIN	TEV	02410990	GLN-GABAPENTIN	GLK
400MG CAP	SULE		ST 800MG TAB	LET (IMMEDIATE RELEASE)	
02477939	AG-GABAPENTIN	ANG	02411008	GLN-GABAPENTIN	GLK
02244306	APO-GABAPENTIN	APX	LACOSAMID)E	
02321238	AURO-GABAPENTIN	AUR		efit (prior approval required).	
02450178	BIO-GABAPENTIN	BMI	Limited use bene	sin (prior approvar required).	
02243745	DOM-GABAPENTIN	DPC		erapy in adult patients with refracto	
02246316	GABAPENTIN	SIV		ho meet all of the following criteria:	
02353261	GABAPENTIN	SAN	 Are under the determined treatment of epile 	care of a physician experienced in the	ne
02416867	GABAPENTIN	ACC	Are currently re	eceiving two or more antiepileptic	
02361493	JAMP-GABAPENTIN	JMP	medications; AN	D	
02391503	MAR-GABAPENTIN	MAR	 Have failed or or 	demonstrated intolerance to at least	two other
02084287	NEURONTIN	PFI	antiepileptic med	lications.	
02243448	PMS-GABAPENTIN	PMS	ST 50MG TABL	ET	
02310465	PRO-GABAPENTIN	PDL	02475332	AURO-LACOSAMIDE	AUR
02319071	RAN-GABAPENTIN	RBY	02487802	MAR-LACOSAMIDE	MAR
02251183	RIVA-GABAPENTIN	RIV	02478196	PHARMA-LACOSAMIDE	PMS
02244515	TEVA-GABAPENTIN	TEV	02474670	SANDOZ LACOSAMIDE	SDZ

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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 tre
- m
- ar

reatment of epilepsy; AND Are currently receiving two or more antiepileptic nedications; AND Have failed or demonstrated intolerance to at least two other ntiepileptic medications.				
ST 50MG TABLE				
	TEVA-LACOSAMIDE	TEV		
02357615	VIMPAT	UCB		
ST 100MG TABI	LET			
02475340	AURO-LACOSAMIDE	AUR		
02487810	MAR-LACOSAMIDE	MAR		
02478218	PHARMA-LACOSAMIDE	PMS		
02474689	SANDOZ LACOSAMIDE	SDZ		
02472910	TEVA-LACOSAMIDE	TEV		
02357623	VIMPAT	UCB		
ST 150MG TABLET				
02475359	AURO-LACOSAMIDE	AUR		
02487829	MAR-LACOSAMIDE	MAR		
02478226	PHARMA-LACOSAMIDE	PMS		
02474697	SANDOZ LACOSAMIDE	SDZ		
02472929	TEVA-LACOSAMIDE	TEV		
02357631 VIMPAT UCB				
ST 200MG TABLET				

02472937 TEVA-LACOSAMIDE 02357658 VIMPAT **LAMOTRIGINE**

ST 2MG TABLET

02302969

02381362

02142104

02302985

02487837

02243803	LAMICTAL			
ST 5MG TABLET				
02240115	LAMICTAL			
ST 25MG TABLET				
02245208	APO-LAMOTRIGINE			
02381354	AURO-LAMOTRIGINE			

02142082 LAMICTAL

LAMOTRIGINE

02475367 AURO-LACOSAMIDE

02478234 PHARMA-LACOSAMIDE

02474700 SANDOZ LACOSAMIDE

MAR-LACOSAMIDE

02343010 LAMOTRIGINE SAN 02428202 **LAMOTRIGINE** SIV 02265494 MYLAN-LAMOTRIGINE MYL 02246897 **PMS-LAMOTRIGINE PMS** 02248232 TEVA-LAMOTRIGINE TEV ST 100MG TABLET 02245209 APO-LAMOTRIGINE APX

AURO-LAMOTRIGINE

LAMICTAL

02343029 LAMOTRIGINE

LAMOTRIGINE

January 2020

28:12.92 MISCELLANEOUS **ANTICONVULSANTS**

LAMOTRIGINE

ST 100MG TABLET				
02428210	LAMOTRIGINE	SIV		
02265508	MYLAN-LAMOTRIGINE	MYL		
02246898	PMS-LAMOTRIGINE	PMS		
02248233	TEVA-LAMOTRIGINE	TEV		
ST 150MG TABL	_ET			
02245210	APO-LAMOTRIGINE	APX		
02381370	AURO-LAMOTRIGINE	AUR		
02142112	LAMICTAL	GSK		
02302993	LAMOTRIGINE	PDL		
02343037	LAMOTRIGINE	SAN		
02428229	LAMOTRIGINE	SIV		
02265516	MYLAN-LAMOTRIGINE	MYL		
02246899	PMS-LAMOTRIGINE	PMS		
02248234	TEVA-LAMOTRIGINE	TEV		

LEVETIRACETAM

02247027 KEPPRA

02353342

AUR

MAR

PMS

SDZ

TEV

UCB

GSK

GSK

APX

AUR

GSK

PDL

AUR

GSK

PDL

SAN

ST 250MG TABLET			
02274183	ACT LEVETIRACETAM	TEV	
02285924	APO-LEVETIRACETAM	APX	
02375249	AURO-LEVETIRACETAM	AUR	
02450348	BIO-LEVETIRACETAM	BMI	
02403005	JAMP-LEVETIRACETAM	JMP	

02399776	LEVETIRACETAM	ACC
02442531	LEVETIRACETAM	SIV
02454653	LEVETIRACETAM	PMS
02474468	LEVETIRACETAM	RIV
02440202	NAT-LEVETIRACETAM	NPH
02296101	PMS-LEVETIRACETAM	PMS
02396106	RAN-LEVETIRACETAM	RBY
02482274	RIVA-LEVETIRACETAM	RIV

LEVETIRACETAM

02461986	SANDOZ LEVETIRACETAM	SDZ	
57 500MG TABLET			
02274191	ACT LEVETIRACETAM	TEV	
02285932	APO-LEVETIRACETAM	APX	
02375257	AURO-LEVETIRACETAM	AUR	
02450356	BIO-LEVETIRACETAM	BMI	

02297418 DOM-LEVETIRACETAM

02403021 JAMP-LEVETIRACETAM

02247020 KEDDDA

02247020	NEFFRA	UCB
02353350	LEVETIRACETAM	SAN
02399784	LEVETIRACETAM	ACC
02442558	LEVETIRACETAM	SIV
02454661	LEVETIRACETAM	PMS
02474476	LEVETIRACETAM	RIV
02440210	NAT-LEVETIRACETAM	NPH
02296128	PMS-LEVETIRACETAM	PMS
02311380	PRO-LEVETIRACETAM	PDL

02396114 **RAN-LEVETIRACETAM RBY** 02482282 RIVA-LEVETIRACETAM RIV SANDOZ LEVETIRACETAM 02461994 SDZ

UCB

SAN

DPC

JMP

LICD

28:12.92 MISCELLANEOUS ANTICONVULSANTS

LEVETIRACETAM

750MG TABLET			
02274205	ACT LEVETIRACETAM	TEV	
02285940	APO-LEVETIRACETAM	APX	
02375265	AURO-LEVETIRACETAM	AUR	
02450364	BIO-LEVETIRACETAM	BMI	
02403048	JAMP-LEVETIRACETAM	JMP	
02247029	KEPPRA	UCB	
02353369	LEVETIRACETAM	SAN	
02399792	LEVETIRACETAM	ACC	
02442566	LEVETIRACETAM	SIV	
02454688	LEVETIRACETAM	PMS	
02474484	LEVETIRACETAM	RIV	
02440229	NAT-LEVETIRACETAM	NPH	
02296136	PMS-LEVETIRACETAM	PMS	
02311399	PRO-LEVETIRACETAM	PDL	
02396122	RAN-LEVETIRACETAM	RBY	
02482290	RIVA-LEVETIRACETAM	RIV	
02462001	SANDOZ LEVETIRACETAM	SDZ	
PDIN FOR EXTEMPORANEOUS MIXTURE			
99503026	LEVETIRACETAM ORAL LIQUID	UNK	
VC ADD AZEDINE			

OXCARBAZEPINE

150MG	TABLET
-------	---------------

02348381	APX-OXCARBAZEPINE	APX
02440717	JAMP-OXCARBAZEPINE	JMP
300MG TABL	.ET	
02284308	APO-OXCARBAZEPINE	APX
02348403	APX-OXCARBAZEPINE	APX
02440725	JAMP-OXCARBAZEPINE	JMP

600MG TABLET

02242068 TRILEPTAL

	·	
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).

02284294 APO-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	NV	R
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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	21	١G	TΑ	BL	.ET
----	----	----	----	----	-----

02404516	FYCOMPA	EIS
ST 4MG TABLE	Т	
02404524	FYCOMPA	EIS
ST 6MG TABLE	Т	
02404532	FYCOMPA	EIS
ST 8MG TABLE	Т	
02404540	FYCOMPA	EIS
ST 10MG TABLE	ET	
02404559	FYCOMPA	EIS
ST 12MG TABLE	ET	

EIS

ANG

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

APX

NVR

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.

02480735 AG-PREGABALIN

25MG CAPSULE

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

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PFI

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);

For the treatment of neuropathic pain in patients who have a contraindication or intolerance to a tricyclic antidepressant

Coverage is limited to a maximum of 600mg per day.

02394243 APO-PREGABALIN

50MG CAPSULE

02433877	AURO-PREGABALIN	AUR
02402564	DOM-PREGABALIN	DPC
02435985	JAMP-PREGABALIN	JMP
02268426	LYRICA	PFI
02417537	MAR-PREGABALIN	MAR
02423812	MINT-PREGABALIN	MIN
02467305	M-PREGABALIN	MAN
02479125	NRA-PREGABALIN	UNK
02359618	PMS-PREGABALIN	PMS
02396505	PREGABALIN	PDL
02403706	PREGABALIN	SIV
02405547	PREGABALIN	SAN
02476312	PREGABALIN	RIV
02392828	RAN-PREGABALIN	RBY
02377047	RIVA-PREGABALIN	RIV
02390825	SANDOZ PREGABALIN	SDZ
02361175	TEVA-PREGABALIN	TEV
75MG CAPS	ULE	
02480743	AG-PREGABALIN	ANG
02394251	APO-PREGABALIN	APX
02433885	AURO-PREGABALIN	AUR
02402572	DOM-PREGABALIN	DPC
02435993	JAMP-PREGABALIN	JMP
02268434	LYRICA	PFI
02417545	MAR-PREGABALIN	MAR
02424185	MINT-PREGABALIN	MIN
02467313	M-PREGABALIN	MAN
02479133	NRA-PREGABALIN	UNK
02359626	PMS-PREGABALIN	PMS
02396513	PREGABALIN	PDL
02403714	PREGABALIN	SIV
02405555	PREGABALIN	SAN
02476320	PREGABALIN	RIV
02392836	RAN-PREGABALIN	RBY
02377055	RIVA-PREGABALIN	RIV
02390833	SANDOZ PREGABALIN	SDZ
02361183	TEVA-PREGABALIN	TEV
150MG CAP	SULE	
02480751	AG-PREGABALIN	ANG
02394278	APO-PREGABALIN	APX
02433907	AURO-PREGABALIN	AUR
02402580	DOM-PREGABALIN	DPC
02436000	JAMP-PREGABALIN	JMP

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

APX

For the treatment of neuropathic pain in patients who have a contraindication or intolerance to a tricyclic antidepressant

Coverage is limited to a maximum of 600mg per day.

150MG CAPSULE

02268450 LYRICA

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
02392844	RAN-PREGABALIN	RBY
02377063	RIVA-PREGABALIN	RIV
02390841	SANDOZ PREGABALIN	SDZ
02361205	TEVA-PREGABALIN	TEV
ST 300MG CAPS	SULE	
02394294	APO-PREGABALIN	APX
02436019	JAMP-PREGABALIN	JMP
02268485	LYRICA	PFI
02359642	PMS-PREGABALIN	PMS
02396548	PREGABALIN	PDL
02403730	PREGABALIN	SIV
02405598	PREGABALIN	SAN
02476371	PREGABALIN	RIV
02392860	RAN-PREGABALIN	RBY
02377071	RIVA-PREGABALIN	RIV
02390868	SANDOZ PREGABALIN	SDZ
02361248	TEVA-PREGABALIN	TEV
RUFINAMIDE		

F

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 $^{\text{ST}}$ 200MG TABLET 02369621 BANZEL EIS

ST 400MG TABLET

02369648 BANZEL **EIS**

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28:12.92 MISCELLANEOUS 28:12.92 MISCELLANEOUS **ANTICONVULSANTS ANTICONVULSANTS TOPIRAMATE TOPIRAMATE** ST 15MG CAPSULE ST 200MG TABLET 02239907 TOPAMAX JSO 02315661 MINT-TOPIRAMATE MIN ST 25MG CAPSULE 02263386 MYLAN-TOPIRAMATE MYI **PMS** 02263017 PMS-TOPIRAMATE 02239908 TOPAMAX JSO ST 25MG TABLET 02313677 PRO-TOPIRAMATE **PDL** 02351307 ACCEL-TOPIRAMATE **ACP** 02396092 **RAN-TOPIRAMATE** RBY AG-TOPIRAMATE 02431823 SANDOZ TOPIRAMATE SD7 02475936 ANG 02279614 APO-TOPIRAMATE APX 02248862 **TEVA-TOPIRAMATE** TFV 02345803 **AURO-TOPIRAMATE** APL 02230896 **TOPAMAX** JSO 02356872 **TOPIRAMATE** SAN DOM-TOPIRAMATE DPC 02271141 **TOPIRAMATE** 02395754 ACC 02287765 **GLN-TOPIRAMATE GLK** PDIN FOR EXTEMPORANEOUS MIXTURE 02435608 JAMP-TOPIRAMATE **JMP** MAR-TOPIRAMATE MAR 99503027 TOPIRAMATE ORAL LIQUID UNK 02432099 02315645 MINT-TOPIRAMATE MIN VALPROIC ACID (DIVALPROEX SODIUM) 02263351 MYLAN-TOPIRAMATE MYI ST 125MG TABLET (ENTERIC COATED) 02262991 PMS-TOPIRAMATE **PMS** APX 02239698 APO-DIVALPROEX 02313650 **PRO-TOPIRAMATE** PDI 02400499 **DIVALPROEX** SAN 02396076 **RAN-TOPIRAMATE RBY** 00596418 FPIVAL **BGP** 02431807 SANDOZ TOPIRAMATE SDZ MYLAN-DIVALPROEX 02458926 MYI 02248860 **TEVA-TOPIRAMATE** TFV 02244138 PMS-DIVALPROEX **PMS** 02230893 **TOPAMAX** JSO TEVA-DIVALPROEX 02239701 TEV 02356856 **TOPIRAMATE** SAN ST 250MG TABLET (ENTERIC COATED) 02389460 **TOPIRAMATE** SIV 02239699 APO-DIVALPROEX **APX** 02395738 **TOPIRAMATE** ACC 02400502 DIVAL PROFX SAN ST 50MG TABLET 00596426 **EPIVAL BGP** 02312085 PMS-TOPIRAMATE **PMS** 02458934 MYLAN-DIVALPROEX MYL $^{\text{ST}}$ 100MG TABLET PMS-DIVALPROEX 02244139 **PMS** ACP 02351315 **ACCEL-TOPIRAMATE** 02239702 TEVA-DIVALPROEX TEV AG-TOPIRAMATE 02475944 ANG ST 500MG TABLET (ENTERIC COATED) 02279630 **APO-TOPIRAMATE** APX 02239700 APO-DIVALPROEX APX **AURO-TOPIRAMATE** 02345838 API 02400510 **DIVALPROEX** SAN 02271168 DOM-TOPIRAMATE DPC 00596434 FPIVAI **BGP GLN-TOPIRAMATE** 02287773 **GLK** 02459019 MYLAN-DIVALPROEX MYL 02435616 JAMP-TOPIRAMATE **JMP** 02244140 PMS-DIVALPROEX **PMS** 02432102 MAR-TOPIRAMATE MAR 02239703 TEVA-DIVALPROEX **TEV** MINT-TOPIRAMATE 02315653 MIN VALPROIC ACID (SODIUM VALPROATE) 02263378 **MYLAN-TOPIRAMATE** MYL 02263009 PMS-TOPIRAMATE **PMS** ST 250MG CAPSULE PDL 02313669 PRO-TOPIRAMATE 02238048 APO-VALPROIC **APX** 02396084 RAN-TOPIRAMATE **RBY** 02231030 DOM-VALPROIC ACID DPC 02431815 SANDOZ TOPIRAMATE SDZ 02230768 PMS-VALPROIC ACID **PMS TEVA-TOPIRAMATE TEV** ST 500MG CAPSULE (ENTERIC COATED) 02248861 02230894 **TOPAMAX** JSO 02231031 DOM-VALPROIC ACID DPC 02356864 **TOPIRAMATE** SAN 02229628 PMS-VALPROIC ACID **PMS** 02389487 **TOPIRAMATE** SIV $^{\rm s au}$ 50MG/ML SOLUTION **TOPIRAMATE** ACC 02395746 02238817 DOM-VALPROIC ACID DPC ST 200MG TABLET 02236807 PMS-VALPROIC ACID **PMS** 02351323 ACCEL-TOPIRAMATE ACP ST 50MG/ML SYRUP 02279649 APO-TOPIRAMATE **APX** APO-VALPROIC **APX** 02238370 02345846 **AURO-TOPIRAMATE** APL 00443832 **DEPAKENE BGP** 02271176 DOM-TOPIRAMATE DPC **VIGABATRIN** 02287781 **GLN-TOPIRAMATE GLK** ST 500MG POWDER FOR SOLUTION 02435624 JAMP-TOPIRAMATE **JMP** 02068036 SABRII LUK 02432110 MAR-TOPIRAMATE MAR

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				Non-insured field	an Bononco
	SCELLANEOUS		28:16.04 AN	TIDEPRESSANTS	
AN	TICONVULSANTS		BUPROPION HYDROCHLORIDE (WELLBUTRIN)		
VIGABATRIN	l		ST 150MG TAB	LET (EXTENDED RELEASE)	
ST 500MG TABI	LET			SANDOZ BUPROPION SR	SDZ
02065819		LUK	02237825	WELLBUTRIN SR	VAE
28:16 04 AN	TIDEPRESSANTS		02275090	WELLBUTRIN XL	VAE
			ST 300MG TAB	LET (EXTENDED RELEASE)	
AMITRIPIYL	INE HYDROCHLORIDE		02439662	ACT BUPROPION XL	ACG
10MG TABLI	ET		02382083	MYLAN-BUPROPION XL	MYL
02477963	AG-AMITRIPTYLINE	ANG	02475812	RAN-BUPROPION XL	RBY
00370991	AMITRIPTYLINE	PDL	02275104	WELLBUTRIN XL	VAE
02403137	APO-AMITRIPTYLINE	APX	BUPROPION	HYDROCHLORIDE (ZYB)	AN)
00335053	ELAVIL	AAP	Limited use bene	fit with quantity and frequency lim	its (prior
02435527	JAMP-AMITRIPTYLINE	JMP	approval is not re	equired).	
00293911	LEVATE	BMI	Can amaldan asa		
02429861	MAR-AMITRIPTYLINE	MAR	For smoking cess	sation:	
00654523	PMS-AMITRIPTYLINE	PMS	Coverage is limit	ed to 180 tablets during a one-yea	r period.
02326043	TEVA-AMITRIPTYLINE	TEV		n the date the first prescription is	
25MG TABLI				been reached the client is eligible ropion hydrochloride when one ye	
02477971	AG-AMITRIPTYLINE	ANG		day the initial prescription was fill	
00371009	AMITRIPTYLINE	PDL	•	LET (EXTENDED RELEASE)	ou.
02403145	APO-AMITRIPTYLINE	APX	02238441	•	VAE
00335061	ELAVIL	AAP			VAL
02435535	JAMP-AMITRIPTYLINE	JMP	CITALOPRAI	M HYDROBROMIDE	
02429888	MAR-AMITRIPTYLINE	MAR	$^{s au}$ 10MG TABL	ET	
00654515	PMS-AMITRIPTYLINE	PMS	02355248	ACCEL-CITALOPRAM	ACP
02326051	TEVA-AMITRIPTYLINE	TEV	02374617	AG-CITALOPRAM	ANG
50MG TABLI		ANIC	02448475	BIO-CITALOPRAM	BMI
02477998	AG-AMITRIPTYLINE AMITRIPTYLINE	ANG PDL	02325047	CITALOPRAM	PDL
00456349	APO-AMITRIPTYLINE	APX	02387948	CITALOPRAM	SIV
02403153 00335088	ELAVIL	AAP	02430517	CITALOPRAM	JMP
02435543	JAMP-AMITRIPTYLINE	JMP	02445719	CITALOPRAM	SAN
02435543	LEVATE	BMI	02273055	DOM-CITALOPRAM	DPC
02429896	MAR-AMITRIPTYLINE	MAR	02370085	JAMP-CITALOPRAM	JMP
00654507	PMS-AMITRIPTYLINE	PMS	02371871	MAR-CITALOPRAM	MAR
02326078	TEVA-AMITRIPTYLINE	TEV	02429691	MINT-CITALOPRAM	MIN
S [™] 75MG TABLI		ı L v	02409003	NAT-CITALOPRAM	NPH
02403161	APO-AMITRIPTYLINE	APX		NRA-CITALOPRAM	UNK
00754129	ELAVIL	AAP	02270609		PMS
02435551	JAMP-AMITRIPTYLINE	JMP	02303256	RIVA-CITALOPRAM	RIV
00405612		BMI	02431629		SPT
	MAR-AMITRIPTYLINE	MAR		TEVA-CITALOPRAM	TEV
	HYDROCHLORIDE (WEI		ST 20MG TABL		4.00
	•	LLDOTTKIII)		ACCEL-CITALOPRAM ACT CITALOPRAM	ACP
	LET (EXTENDED RELEASE)		02248050 02339390	AG-CITALOPRAM	SPC
	BUPROPION SR	PDL	02246056	APO-CITALOPRAM	ANG APX
02391562	BUPROPION SR	SAN		AURO-CITALOPRAM	AUR
02325373	PMS-BUPROPION SR	PMS	02448491		BMI
	SANDOZ BUPROPION SR	SDZ	02239607	CELEXA	LUD
	LET (EXTENDED RELEASE)	400	02257513	CITALOPRAM	PDL
02439654	ACT BUPROPION XL	ACG	02257515	CITALOPRAM	SAN
02325357	BUPROPION SR	PDL	02387956	CITALOPRAM	SIV
02391570	BUPROPION SR	SAN	02430541	CITALOPRAM	JMP
02382075	MYLAN-BUPROPION XL	MYL	02248942		DPC
02313421 02475804	PMS-BUPROPION SR RAN-BUPROPION XL	PMS RBY	02313405	JAMP-CITALOPRAM	JMP
0247 3004	IVAIN-DOLUOLION VE	KDI		MAR-CITALOPRAM	MAR

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28:16.04 AN	TIDEPRESSANTS		28:16.04 ANTIDEPRESSANTS	
	M HYDROBROMIDE		DESIPRAMINE HYDROCHLORIDE	
ST 20MG TABL		NAIN!	ST 100MG TABLET	4 A D
	MINT-CITALOPRAM	MIN	02216280 DESIPRAMINE	AAP
02409011	NAT-CITALOPRAM	NPH	DOXEPIN HYDROCHLORIDE	
02477645 02248010	NRA-CITALOPRAM PMS-CITALOPRAM	UNK PMS	ST 10MG CAPSULE	
	RAN-CITALO	RBY	02049996 DOXEPIN	APX
	RIVA-CITALOPRAM	RIV	00024325 SINEQUAN	AAP
	SANDOZ CITALOPRAM	SDZ	ST 25MG CAPSULE	
	SEPTA-CITALOPRAM	SPT	02050005 DOXEPIN	APX
02293218	TEVA-CITALOPRAM	TEV	00024333 SINEQUAN	AAP
ST 30MG TABL			ST 50MG CAPSULE	
02296152	CTP 30	SPC	02050013 DOXEPIN	APX
ST 40MG TABL	ET		00024341 SINEQUAN	AAP
02355264	ACCEL-CITALOPRAM	ACP	ST 75MG CAPSULE	ADV
02248051	ACT CITALOPRAM	SPC	02050021 DOXEPIN 00400750 SINEQUAN	APX AAP
02339404	AG-CITALOPRAM	ANG	ST 100MG CAPSULE	AAP
02246057	APO-CITALOPRAM	APX	02050048 DOXEPIN	APX
02275570	AURO-CITALOPRAM	AUR	00326925 SINEQUAN	AAP
02448513	BIO-CITALOPRAM	BMI	ST 150MG CAPSULE	AAF
02239608	CELEXA	LUD	02050056 DOXEPIN	APX
02257521	CITALOPRAM	PDL	DULOXETINE HYDROCHLORIDE	AIX
02353679	CITALOPRAM	SAN		
02387964	CITALOPRAM	SIV	30MG CAPSULE (DELAYED RELEASE)	
02430568	CITALOPRAM	JMP	02475308 AG-DULOXETINE	ANG
02248943	DOM-CITALOPRAM	DPC	02440423 APO-DULOXETINE	APX
02313413 02371901	JAMP-CITALOPRAM	JMP MAR	02436647 AURO-DULOXETINE	AUR
02429713	MAR-CITALOPRAM MINT-CITALOPRAM	MIN	02301482 CYMBALTA	LIL
02409038	NAT-CITALOPRAM	NPH	02452650 DULOXETINE	PDL
02477653	NRA-CITALOPRAM	UNK	02453630 DULOXETINE	SIV TEV
02248011	PMS-CITALOPRAM	PMS	02437082 DULOXETINE DR 02451913 JAMP-DULOXETINE	JMP
02285630	RAN-CITALO	RBY	02446081 MAR-DULOXETINE	MAR
02303272	RIVA-CITALOPRAM	RIV	02473208 M-DULOXETINE	MAN
02248171	SANDOZ CITALOPRAM	SDZ	02438984 MINT-DULOXETINE	MIN
02355280	SEPTA-CITALOPRAM	SPT	02482126 NRA-DULOXETINE	UNK
02293226	TEVA-CITALOPRAM	TEV	02429446 PMS-DULOXETINE	PMS
CLOMIPRAM	IINE HYDROCHLORIDE		02438259 RAN-DULOXETINE	RBY
^{S7} 10MG TABL			02451077 RIVA-DULOXETINE	RIV
	ANAFRANIL	AAP	02439948 SANDOZ DULOXETINE	SDZ
ST 25MG TABL		AAF	60MG CAPSULE (DELAYED RELEASE)	
	ANAFRANIL	AAP	02475316 AG-DULOXETINE	ANG
ST 50MG TABL		7731	02440431 APO-DULOXETINE	APX
	ANAFRANIL	AAP	02436655 AURO-DULOXETINE	AUR
	IE HYDROCHLORIDE	, , , ,	02301490 CYMBALTA	LIL
_			02452669 DULOXETINE	PDL
ST 10MG TABL			02453649 DULOXETINE	SIV
	DESIPRAMINE	AAP	02437090 DULOXETINE DR	TEV
ST 25MG TABL			02451921 JAMP-DULOXETINE	JMP
	DESIPRAMINE	AAP	02446103 MAR-DULOXETINE	MAR
57 50MG TABL		445	02473216 M-DULOXETINE	MAN
	DESIPRAMINE DMS DESIDRAMINE	AAP	02438992 MINT-DULOXETINE	MIN
	PMS DESIPRAMINE	PMS	02482134 NRA-DULOXETINE	UNK
ST 75MG TABL		^ ^ D	02429454 PMS-DULOXETINE	PMS
	DESIPRAMINE DMS DESIDRAMINE	AAP	02438267 RAN-DULOXETINE 02451085 RIVA-DULOXETINE	RBY RIV
01940242	PMS DESIPRAMINE	PMS	0270 1000 NIVA-DULUAETINE	ri v

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28:16.04 AN	TIDEPRESSANTS		28:16.04 AN	TIDEPRESSANTS	
	HYDROCHLORIDE			HYDROCHLORIDE	
	JLE (DELAYED RELEASE)		ST 10MG CAPS		
	SANDOZ DULOXETINE	SDZ		ACH-FLUOXETINE	ACC
ESCITALOPR	RAM OXALATE			ACT FLUOXETINE	REC
ST 10MG TABLE	ΞΤ			APO-FLUOXETINE	APX
02434652	ACH-ESCITALOPRAM	ACC		AURO-FLUOXETINE BIO-FLUOXETINE	AUR BMI
02477742	AG-ESCITALOPRAM	ANG		DOM-FLUOXETINE	DPC
02295016	APO-ESCITALOPRAM	APX		FLUOXETINE	SAN
02397358	AURO-ESCITALOPRAM	AUR		FLUOXETINE	SIV
02481154	BIO-ESCITALOPRAM	BMI	02401894		JMP
02263238	CIPRALEX	LUD	02380560		MIN
02424401	ESCITALOPRAM	PDL	02177579		PMS
02429039	ESCITALOPRAM	SIV	02314991		PDL
02430118	ESCITALOPRAM	SAN	02018985		LIL
02429780	JAMP-ESCITALOPRAM	JMP		RAN-FLUOXETINE	RBY
02423480	MAR-ESCITALOPRAM	MAR	02479486	SANDOZ FLUOXETINE	SDZ
02471418	M-ESCITALOPRAM	MAN	02216582	TEVA-FLUOXETINE	TEV
02407418	MINT-ESCITALOPRAM	MIN	ST 20MG CAPS	ULE	
02309467	MYLAN-ESCITALOPRAM	MYL	02383241	ACH-FLUOXETINE	ACC
02440296	NAT-ESCITALOPRAM	NPH	02242178	ACT FLUOXETINE	REC
02476851	NRA-ESCITALOPRAM	UNK	02216361	APO-FLUOXETINE	APX
02469243	PHARMA-ESCITALOPRAM	PMS	02385635	AURO-FLUOXETINE	AUR
02303949	PMS-ESCITAL OPPAN	PMS	02448432	BIO-FLUOXETINE	BMI
02426331	PRIVA-ESCITALOPRAM	PHA	02177625	DOM-FLUOXETINE	DPC
02385481	RAN-ESCITAL OPPAM	RBY	02286076	FLUOXETINE	SAN
	RIVA-ESCITAL OPPAM	RIV	02374455	FLUOXETINE	SIV
02364077 02318180	SANDOZ ESCITALOPRAM TEVA-ESCITALOPRAM	SDZ TEV	02386402	JAMP-FLUOXETINE	JMP
57 20MG TABLE		ΙCV	02380579	MINT-FLUOXETINE	MIN
	ACH-ESCITALOPRAM	ACC	02177587	PMS-FLUOXETINE	PMS
02477769	AG-ESCITALOPRAM	ANG	02315009		PDL
	APO-ESCITALOPRAM	APX	00636622	PROZAC	LIL
02397374	AURO-ESCITALOPRAM	AUR		RAN-FLUOXETINE	RBY
02481170	BIO-ESCITALOPRAM	BMI	02305488		RIV
02263254	CIPRALEX	LUD		SANDOZ FLUOXETINE	SDZ
	ESCITALOPRAM	PDL		TEVA-FLUOXETINE	TEV
	ESCITALOPRAM	SIV	ST 40MG CAPS		
02430126	ESCITALOPRAM	SAN		PMS-FLUOXETINE	PMS
02429799	JAMP-ESCITALOPRAM	JMP	ST 60MG CAPS		
02423502	MAR-ESCITALOPRAM	MAR		PMS-FLUOXETINE	PMS
02407434	MINT-ESCITALOPRAM	MIN	ST 4MG/ML SO		457
02309475	MYLAN-ESCITALOPRAM	MYL		APO-FLUOXETINE	APX
02440318	NAT-ESCITALOPRAM	NPH	20MG SOLU		ODN
02476878	NRA-ESCITALOPRAM	UNK		ODAN-FLUOXETINE	ODN
02469251	PHARMA-ESCITALOPRAM	PMS	FLUVOXAMI	NE MALEATE	
02303965	PMS-ESCITALOPRAM	PMS	ST 50MG TABL	ET	
02426358	PRIVA-ESCITALOPRAM	PHA	02255529	ACT FLUVOXAMINE	ACG
02385503	RAN-ESCITALOPRAM	RBY	02231329	APO-FLUVOXAMINE	APX
02428857	RIVA-ESCITALOPRAM	RIV	02236753	FLUVOXAMINE	PDL
02364085	SANDOZ ESCITALOPRAM	SDZ	01919342	LUVOX	BGP
02318202	TEVA-ESCITALOPRAM	TEV	02303345	RIVA-FLUVOX	RIV
	ET (ORALLY DISINTEGRATING)		ST 100MG TAB	LET	
	ACT ESCITALOPRAM ODT	ACG	02255537	ACT FLUVOXAMINE	ACG
$^{s au}$ 20MG TABLE	ET (ORALLY DISINTEGRATING)		02231330	APO-FLUVOXAMINE	APX
02454300	ACT ESCITALOPRAM ODT	ACG	02236754	FLUVOXAMINE	PDL

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				Non-insured Healti	Denents
28:16.04 AN	TIDEPRESSANTS		28:16.04 AN	TIDEPRESSANTS	
FLUVOXAMII	NE MALEATE		MOCLOBEMIDE		
ST 100MG TABI	CT		ST 300MG TAB	CT	
01919369		BGP		MOCLOBEMIDE	AAP
	RIVA-FLUVOX	RIV		PMS-MOCLOBEMIDE	PMS
		KIV			FIVIS
IMIPRAMINE	HYDROCHLORIDE		NORTRIPTY	LINE HYDROCHLORIDE	
ST 10MG TABLI	ET		ST 10MG CAPS	ULE	
00360201	IMIPRAMINE	AAP	00015229	AVENTYL	AAP
ST 25MG TABLI	ET		ST 25MG CAPS	ULE	
00312797	IMIPRAMINE	AAP	00015237	AVENTYL	AAP
ST 50MG TABLE	ET		PAROXETINI	E HYDROCHLORIDE	
00326852	IMIPRAMINE	AAP	ST 10MG TABL		
ST 75MG TABLI	ET				400
00644579	IMIPRAMINE	AAP		ACT PAROXETINE	ACG
MIRTAZAPIN	E			AG-PAROXETINE	ANG
ST 45MO TABLE				APO-PAROXETINE	APX
ST 15MG TABLI		ABY		AURO-PAROXETINE	AUR
	APO-MIRTAZAPINE	APX		BIO-PAROXETINE	BMI
02411695	AURO-MIRTAZAPINE	AUR	02248447		DPC
02256096	MYLAN-MIRTAZAPINE	MYL	02368862	JAMP-PAROXETINE	JMP
02273942	PMS-MIRTAZAPINE	PMS	02411946	MAR-PAROXETINE	MAR
02312778	PRO-MIRTAZAPINE	PDL	02421372		MIN
02250594	SANDOZ MIRTAZAPINE	SDZ	02467402		MAN
ST 30MG TABLI			02479753	NRA-PAROXETINE	UNK
02286629	APO-MIRTAZAPINE	APX		PAROXETINE	PDL
02411709	AURO-MIRTAZAPINE	AUR		PAROXETINE	SAN
02252287	DOM-MIRTAZAPINE	DPC	02388227		SIV
02370689	MIRTAZAPINE	SAN	02027887		GSK
02256118	MYLAN-MIRTAZAPINE	MYL	02247750		PMS
02248762	PMS-MIRTAZAPINE	PMS	02248559	RIVA-PAROXETINE	RIV
02312786	PRO-MIRTAZAPINE	PDL	02248556	TEVA-PAROXETINE	TEV
02243910	REMERON	FRS	ST 20MG TABL	ET	
02250608	SANDOZ MIRTAZAPINE	SDZ	02262754	ACT PAROXETINE	ACG
02259354	TEVA-MIRTAZAPINE	TEV	02475545	AG-PAROXETINE	ANG
ST 45MG TABLI	ET		02240908	APO-PAROXETINE	APX
02286637	APO-MIRTAZAPINE	APX	02383284	AURO-PAROXETINE	AUR
02411717	AURO-MIRTAZAPINE	AUR	02444917	BIO-PAROXETINE	BMI
02256126	MYLAN-MIRTAZAPINE	MYL	02248448	DOM-PAROXETINE	DPC
ST 15MG TABLI	ET (ORALLY DISINTEGRATING)		02368870	JAMP-PAROXETINE	JMP
02299801	AURO-MIRTAZAPINE OD	AUR	02411954	MAR-PAROXETINE	MAR
02248542	REMERON RD	FRS	02421380	MINT-PAROXETINE	MIN
ST 30MG TABLI	ET (ORALLY DISINTEGRATING)		02467410	M-PAROXETINE	MAN
02299828	AURO-MIRTAZAPINE OD	AUR	02479761	NRA-PAROXETINE	UNK
02248543	REMERON RD	FRS	02248914	PAROXETINE	PDL
ST 45MG TABLI	ET (ORALLY DISINTEGRATING)		02282852	PAROXETINE	SAN
	AURO-MIRTAZAPINE OD	AUR	02388235	PAROXETINE	SIV
	REMERON RD	FRS	01940481	PAXIL	GSK
MOCLOBEM			02247751	PMS-PAROXETINE	PMS
			02248560	RIVA-PAROXETINE	RIV
ST 100MG TABI			02248557	TEVA-PAROXETINE	TEV
	MOCLOBEMIDE	AAP	ST 30MG TABL	ET	
⁵ [™] 150MG TABI			02262762	ACT PAROXETINE	ACG
	MANERIX	VAE	02475553	AG-PAROXETINE	ANG
02232150	MOCLOBEMIDE	AAP		APO-PAROXETINE	APX
	PMS-MOCLOBEMIDE	PMS		AURO-PAROXETINE	AUR
ST 300MG TABI	LET			BIO-PAROXETINE	BMI
02166747	MANERIX	VAE		DOM-PAROXETINE	DPC

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28:16.04 AN	TIDEPRESSANTS		28:16.04 ANTIDEPRESSANTS	
PAROXETINI	E HYDROCHLORIDE		SERTRALINE HYDROCHLORIDE	
ST 30MG TABL	ET		50MG CAPSULE	
02368889	JAMP-PAROXETINE	JMP	02241303 SERTRALINE-50	PDL
02411962	MAR-PAROXETINE	MAR	02240484 TEVA-SERTRALINE	TEV
02421399	MINT-PAROXETINE	MIN	01962817 ZOLOFT	PFI
02467429	M-PAROXETINE	MAN	100MG CAPSULE	
02479788	NRA-PAROXETINE	UNK	02477904 AG-SERTRALINE	ANG
02248915	PAROXETINE	PDL	02238282 APO-SERTRALINE	APX
02282860	PAROXETINE	SAN	02390922 AURO-SERTRALINE	AUR
02388243	PAROXETINE	SIV	02445069 BIO-SERTRALINE	BMI
01940473	PAXIL	GSK	02245750 DOM-SERTRALINE	DPC
02247752	PMS-PAROXETINE	PMS	02357178 JAMP-SERTRALINE	JMP
02248561	RIVA-PAROXETINE	RIV	02399431 MAR-SERTRALINE	MAR
02248558	TEVA-PAROXETINE	TEV	02402408 MINT-SERTRALINE	MIN
ST 40MG TABL	ET		02244840 PMS-SERTRALINE	PMS
02293749	PMS-PAROXETINE	PMS	02374579 RAN-SERTRALINE	RBY
PHENELZINE	SULFATE		02248498 RIVA-SERTRALINE	RIV
ST 15MG TABL	ET		02245161 SANDOZ SERTRALINE	SDZ
00476552		ERF	02353547 SERTRALINE	SAN
	HYDROCHLORIDE		02386097 SERTRALINE	SIV
			02469642 SERTRALINE	JMP
25MG CAPS			02241304 SERTRALINE-100	PDL
	AG-SERTRALINE	ANG	02240481 TEVA-SERTRALINE	TEV
02238280	APO-SERTRALINE	APX	01962779 ZOLOFT	PFI
	AURO-SERTRALINE	AUR	TRANYLCYPROMINE SULFATE	
	BIO-SERTRALINE	BMI	ST 10MG TABLET	
	DOM-SERTRALINE	DPC	01919598 PARNATE	GSK
02357143	JAMP-SERTRALINE	JMP	TRAZODONE HYDROCHLORIDE	
02399415	MAR-SERTRALINE	MAR		
02402378	MINT-SERTRALINE	MIN	ST 50MG TABLET	451/
02244838	PMS-SERTRALINE	PMS	02147637 APO-TRAZODONE	APX
02374552	RAN-SERTRALINE	RBY	02128950 DOM-TRAZODONE	DPC
02248496	RIVA-SERTRALINE	RIV	01937227 PMS TRAZODONE	PMS
02245159	SANDOZ SERTRALINE	SDZ	02144263 TEVA-TRAZODONE	TEV
02353520	SERTRALINE	SAN	02164353 TRAZODONE	PDL
02386070	SERTRALINE	SIV	02348772 TRAZODONE	SAN
02469626	SERTRALINE SERTRALINE 25	JMP	ST 75MG TABLET	DMC
02241302	SERTRALINE-25	PDL	02237339 PMS-TRAZODONE	PMS
02240485 02132702	TEVA-SERTRALINE	TEV PFI	ST 100MG TABLET	ADV
50MG CAPS		FFI	02147645 APO-TRAZODONE 02128969 DOM-TRAZODONE	APX DPC
	AG-SERTRALINE	ANG	01937235 PMS TRAZODONE	PMS
02238281	APO-SERTRALINE	APX	02144271 TEVA-TRAZODONE	TEV
02390914	AURO-SERTRALINE	AUR	02164361 TRAZODONE	PDL
02445050	BIO-SERTRALINE	BMI	02348780 TRAZODONE	SAN
02245749	DOM-SERTRALINE	DPC	ST 150MG TABLET	JAN
02357151	JAMP-SERTRALINE	JMP	02147653 APO-TRAZODONE D	APX
02399423	MAR-SERTRALINE	MAR	02144298 TEVA-TRAZODONE	TEV
02402394	MINT-SERTRALINE	MIN	02164388 TRAZODONE	PDL
02244839	PMS-SERTRALINE	PMS	02348799 TRAZODONE	SAN
02374560	RAN-SERTRALINE	RBY	TRIMIPRAMINE MALEATE	0/114
02248497	RIVA-SERTRALINE	RIV		
02245160	SANDOZ SERTRALINE	SDZ	ST 75MG CAPSULE	
02353539	SERTRALINE	SAN	02070987 TRIMIPRAMINE	AAP
02386089	SERTRALINE	SIV	ST 12.5MG TABLET	
02469634	SERTRALINE	JMP	00740799 TRIMIPRAMINE	AAP

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28·16 04 AN	TIDEPRESSANTS		28·16 08 AN	TIPSYCHOTIC AGENTS	
	NE MALEATE		ARIPIPRAZOLE		
ST 25MG TABL			ST 2MG TABLE	т	
	TRIMIPRAMINE	AAP	02322374		OTS
ST 50MG TABL			02471086	APO-ARIPIPRAZOLE	APX
	TRIMIPRAMINE	AAP	02488000	ARIPIPRAZOLE	PDL
ST 100MG TAB			02460025		PMS
	TRIMIPRAMINE	AAP	02466635		PMS
VENLAFAXIN	NE HYDROCHLORIDE		02479346		RIV
ST 37.5MG CAP	SULE (EXTENDED RELEASE)		02473658		SDZ
02304317	ACT VENLAFAXINE XR	TEV	02464144 ST 5MG TABLE	TEVA-ARIPIPRAZOLE	TEV
02331683	APO-VENLAFAXINE XR	APX	02322382		OTS
02452839	AURO-VENLAFAXINE XR	AUR		APO-ARIPIPRAZOLE	APX
02299291	DOM-VENLAFAXINE XR	DPC	02488019		PDL
02237279	EFFEXOR XR	PFI	02460033		PMS
02471280	M-VENLAFAXINE XR	MAN	02466643		PMS
02278545	PMS-VENLAFAXINE XR	PMS	02479354	RIVA-ARIPIPRAZOLE	RIV
02380072	RAN-VENLAFAXINE XR	RBY	02473666	SANDOZ ARIPIPRAZOLE	SDZ
02307774	RIVA-VENLAFAXINE XR	RIV		TEVA-ARIPIPRAZOLE	TEV
02310317	SANDOZ VENLAFAXINE XR	SDZ	ST 10MG TABL		124
02275023		TEV	02322390		OTS
02339242	VENLAFAXINE XR	PDL		APO-ARIPIPRAZOLE	APX
02354713		SAN	02488027		PDL
	VENLAFAXINE XR	SIV	02460041		PMS
	ULE (EXTENDED RELEASE)		02466651	PMS-ARIPIPRAZOLE	PMS
	ACT VENLAFAXINE XR	TEV	02479362		RIV
02331691	APO-VENLAFAXINE XR	APX	02473674	SANDOZ ARIPIPRAZOLE	SDZ
02452847		AUR	02464160	TEVA-ARIPIPRAZOLE	TEV
02299305	DOM-VENLAFAXINE XR	DPC	ST 15MG TABL	ET	
02237280	EFFEXOR XR	PFI	02322404	ABILIFY	OTS
02471299	M-VENLAFAXINE XR	MAN	02471116	APO-ARIPIPRAZOLE	APX
02278553	PMS-VENLAFAXINE XR	PMS	02488035	ARIPIPRAZOLE	PDL
02380080	RAN-VENLAFAXINE XR	RBY	02460068	AURO-ARIPIPRAZOLE	PMS
02307782	RIVA-VENLAFAXINE XR	RIV	02466678	PMS-ARIPIPRAZOLE	PMS
02310325	SANDOZ VENLAFAXINE XR	SDZ	02479370	RIVA-ARIPIPRAZOLE	RIV
02275031	TEVA-VENLAFAXINE XR	TEV PDL	02473682	SANDOZ ARIPIPRAZOLE	SDZ
02339250	VENLAFAXINE XR VENLAFAXINE XR	SAN	02464179	TEVA-ARIPIPRAZOLE	TEV
	VENLAFAXINE XR	SIV	$^{s au}$ 20MG TABL	ET	
	VENLAFAXINE XR	RIV	02322412	ABILIFY	OTS
	SULE (EXTENDED RELEASE)	KIV	02471124	APO-ARIPIPRAZOLE	APX
	ACT VENLAFAXINE XR	TEV	02488043	ARIPIPRAZOLE	PDL
	APO-VENLAFAXINE XR	APX	02460076	AURO-ARIPIPRAZOLE	PMS
02452855		AUR	02466686	PMS-ARIPIPRAZOLE	PMS
02299313	DOM-VENLAFAXINE XR	DPC	02479389	RIVA-ARIPIPRAZOLE	RIV
02237282	EFFEXOR XR	PFI	02473690	SANDOZ ARIPIPRAZOLE	SDZ
02471302	M-VENLAFAXINE XR	MAN		TEVA-ARIPIPRAZOLE	TEV
02278561	PMS-VENLAFAXINE XR	PMS	ST 30MG TABL		
02380099	RAN-VENLAFAXINE XR	RBY	02322455		OTS
02307790	RIVA-VENLAFAXINE XR	RIV		APO-ARIPIPRAZOLE	APX
02310333	SANDOZ VENLAFAXINE XR	SDZ	02488051	ARIPIPRAZOLE	PDL
02275058	TEVA-VENLAFAXINE XR	TEV	02460084	AURO-ARIPIPRAZOLE	PMS
02339269	VENLAFAXINE XR	PDL	02466694	PMS-ARIPIPRAZOLE	PMS
02354748	VENLAFAXINE XR	SAN	02479397	RIVA-ARIPIPRAZOLE	RIV
02385945	VENLAFAXINE XR	SIV	02473704	SANDOZ ARIPIPRAZOLE	SDZ
			02464195	TEVA-ARIPIPRAZOLE	TEV

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28:16.08 ANTIPSYCHOTIC AGENTS ARIPIPRAZOLE (MAINTENA) 300MG NUSCTION 02420564 ABILET MAINTENA 0TS 400MG NUSCTION 02420572 ABILET MAINTENA 0TS ASENAPINE MALEATE Limited use benefit (prior approval required). For the acute treatment of manior emixed pisodes associated with bipolar il disorder as either. **Monorherapy, after a trial of limitum or divaloprox sodium has failed or is continuational case), and time of invaloprox sodium has failed or is continuation of the polar disorder as either. **Monorherapy, after a trial of limitum or divaloprox sodium has failed or is continuation of vivaloprox sodium has failed or is continuation of vivaloprox sodium. Alter of response. **Monorherapy, after a trial of limitum or divaloprox sodium has failed or is post-marked or low shypical antibipsycholic agents have failed due to imbolarance or lack of response. **Monorherapy after a trial of limitum or divaloprox sodium, after trials of two shypical antibipsycholic agents have failed due to imbolarance or lack of response. **Monorherapy after a trial of limitum or divaloprox sodium has failed or incommance or lack of response. **Monorherapy after a trial of limitum or divaloprox sodium has failed or incommance or lack of response. **Monorherapy after a trial of limitum or divaloprox sodium has failed or incommance or lack of response. **Monorherapy after a trial of limitum or divaloprox sodium has failed or incommance or lack of or response. **Monorherapy after a trial of limitum or divaloprox sodium has failed or incommance or lack of response. **Monorherapy after a trial of limitum or divaloprox sodium has failed or incommance or lack of response. **Monorherapy after a trial of limitum or divaloprox sodium has failed or lo minorherapy after a trial of limitum or divaloprox sodium has failed at the long and the limitum or divaloprox sodium has failed and to minorherapy after a trial of limitum or divaloprox sodium has failed and to minorherapy after a trial of limitum or divaloprox sodium has failed and to m			Non-insured nearth benefit	13
300MG INJECTION	28:16.08 ANTIPSYCHOTIC AGENTS		28:16.08 ANTIPSYCHOTIC AGENTS	
300MG INJECTION	ARIPIPRAZOI F (MAINTENA)		FI UPENTHIXOL DIHYDROCHI ORIDE	
02420864 ABILIPY MINTENA 0TS 02158008 FLUANXOL LUD A00MG INJECTION 02420872 ABILIPY MINTENA 0TS 02158016 FLUANXOL LUD A00MG INJECTION C2420872 ABILIPY MINTENA 0TS 02158016 FLUANXOL DEPOT LUD A00MG INJECTION C2420872 ABILIPY MINTENA OTS 02158018 FLUANXOL DEPOT LUD A00MG INJECTION C2420873 FLUANXOL DEPOT LUD C2420875 FLUANXOL DEPOT LU	• • •			
## AGE TABLET ## ALEATE		0.70		
ASENAPINE MALEATE Limited use benefit (prior approval required). For the acute treatment of manic or mixed episodes associated with blood in tisoler as either. For the acute treatment of manic or mixed episodes associated with blood in tisoler as either. For the acute treatment of manic or mixed episodes associated with blood in tisoler as either. For the acute treatment of manic or mixed episodes associated with blood in tisoler as either. For the acute treatment of manic or mixed episodes associated with blood in tisoler as either. For the acute treatment of manic or mixed episodes associated with blood in tisoler as either. For the acute treatment of manic or mixed episodes associated with blood inticoler as either. For the acute treatment of manic or mixed episodes associated with blood in tisoler as either. For the acute treatment of manic or mixed episodes associated with blood inticoler as either. For the acute treatment of manic or mixed episodes associated with blood inticoler as either. For the acute treatment of manic or mixed episodes associated with blood inticoler as either. For the acute treatment of manic or mixed episodes associated with blood inticoler as either. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the pole of the treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of manic or mixed episodes. For the acute treatment of mani		OIS		LUD
ASENAPINE MALEATE FLUPENTIXOL DECANOATE		0.70	*****	
Limited use benefit (prior approval required). 20MG/ML SOLUTION 02156032 FLUANXOL DEPOT LUD 100MG/ML SOLUTION 02156032 FLUANXOL DEPOT LUD 100MG/ML SOLUTION 02156040 FLUANXOL DEPOT LUD 100MG/ML SOLUTION 0216020 FMS-FLUPHENAZINE PMS PMS FLUPHENAZINE PMS 100MG/ML LIQUID 02241028 PMS-FLUPHENAZINE PMS 04041032 FLUPHENAZINE PMS 04041032 F		OIS		בטט
For the acute treatment of manic or mixed episodes associated with bipolar I disorder as either. **Monotherapy, after at laid of littlinum or diveloprex sodium has failed or is contraindicated, and thisle of two atypical agents have failed due to intolerance or lack of response. **General State of the State of the State of Intelligent Contraindicated, and thisle of two atypical agents have failed due to intolerance or lack of response. **General State of the State of Tesponse of Intelligent Contraindicated, and thisle of two atypical and this of two atypical and the state of response. **General State of Tesponse of Intelligent Contraindicated, and this of two atypical and the state of the State of Tesponse of Intelligent Contraindicated, and this of the State of Tesponse of Intelligent Contraindicated, and this of the State of Tesponse of Intelligent Contraindicated, and this of the State of Tesponse of Intelligent Contraindicated, and this of the State of Intelligent Contraindicated, and this of Intelligent Contraindicated, and this of the State of Intelligent Contraindicated, and this of the State of Intelligent Contraindicated, and this of the State of Intelligent Contraint Contraindicated, and this of the State of Intelligent Contraint Contraints Contra	ASENAPINE MALEATE		FLUPENTIXOL DECANOATE	
Sesociated with pipolar i disorder as either: * Monothreapy, after a field of lithous of divalproex sodium has associated with pipolar i disorder as either: * Monothreapy, after a field of lithous of divalproex sodium has antibogy-hold pipolar and pipolar i disorder as either: * Monothreapy, after a field of lithous of divalproex sodium has antibogy-hold pipolar and pipola	Limited use benefit (prior approval required).		20MG/ML SOLUTION	
Monotherapy, after altial of lithium or divalproex sodium has failed or is contraindicated, and trials of two atypical analyse/choica agents have failed due to inclorance or lack of response; OR	For the acute treatment of manic or mixed enisodes		02156032 FLUANXOL DEPOT L	_UD
Monotherapy, after a trial of thibum or divalproex sodium has failed or its contraindicated, and trials of two atypical analysychotic agents have failed due to intolerance or lack of response; Of two atypical analysychotic agents have failed due to intolerance or lack of response.			100MG/ML SOLUTION	
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. Formal	· Monotherapy, after a trial of lithium or divalproex sodium ha	s	02156040 FLUANXOL DEPOT L	_UD
Pesponse OR			FLUPHENAZINE DECANOATE	
Ocherapy with lithium or divalprozex sodium, after trials of two atypical antibosychotic agents have failed due to intolerance or lack of response.			25MG/MLLIQUID	
Transpired antipsychotic agents have failed due to intolerance or lack of response. 100MG/mL LIQUID 100MG/mL LIQUI				PMS
### 1985 1985	two atypical antipsychotic agents have failed due to			IVIO
***SMG*TABLET	intolerance or lack of response.			PMS
### 1006 TABLET ### 2374811 SAPHRIS ### 2374811 SAPHRIS ### 2374811 SAPHRIS ### 2786 TABLET ### 02461749 REXULTI ### 02461745 REXULTI ### 02461745 REXULTI ### 02461745 REXULTI ### 02461745 REXULTI ### 02461773 REXULTI ### 035603 PAS HALOPERIDOL ### 0366010 HALOPERIDOL ### 036	^{sτ} 5MG TABLET			IVIO
Description		FRS		
Description	ST 10MG TABLET			
Q.25MG TABLET	02374811 SAPHRIS	FRS		λΑΡ
0.25MG TABLET	BREXPIPRAZOLE			
0.2461749 REXULTI	0.25MG TABLET			ΑAP
0.5MG TABLET		OTS		
OTS		0.0		
MALOPERIDOL 02461765 REXULTI OTS \$"2MG/ML SOLUTION 2MG TABLET 00759503 PMS-HALOPERIDOL PMS 02461773 REXULTI OTS \$\$MG/ML SOLUTION SDZ 02461781 REXULTI OTS 02366010 HALOPERIDOL OMG 4MG TABLET 0036652 HALOPERIDOL OMG 4MG TABLET 00366780 APO HALOPERIDOL APX CHLORPROMAZINE HYDROCHLORIDE 00363685 TEVA-HALOPERIDOL TEV 00232823 TEVA-CHLORPROMAZINE TEV 00363685 TEVA-HALOPERIDOL TEV 00232823 TEVA-CHLORPROMAZINE TEV 00363677 TEVA-HALOPERIDOL TEV 00232823 TEVA-CHLORPROMAZINE TEV 00363699 TEVA-HALOPERIDOL TEV 00232821 TEVA-CHLORPROMAZINE TEV 00363699 TEVA-HALOPERIDOL TEV 00236381 TEVA-CHLORPROMAZINE TEV 00363699 TEVA-HALOPERIDOL TEV 00236362 TEVA-HALOPERIDOL TEV		OTS		MS
02461765 REXULTI OTS 5" 2MG/ML SOLUTION PMS 2MG TABLET 00759503 PMS-HALOPERIDOL PMS 02461781 REXULTI OTS 5MG/ML SOLUTION SDZ 02461781 REXULTI OTS 02366010 HALOPERIDOL OMG 4MG TABLET 02461881 REXULTI OTS 02366010 HALOPERIDOL APX CHLORPROMAZINE HYDROCHLORIDE **05MG TABLET 00363685 TEVA-HALOPERIDOL TEV 00232823 TEVA-CHLORPROMAZINE TEV 0036685 TEVA-HALOPERIDOL TEV *** 55MG TABLET 0036865 TEVA-HALOPERIDOL TEV *** 003232837 TEVA-CHLORPROMAZINE TEV 00363669 TEVA-HALOPERIDOL TEV *** 100MG TABLET *** 00363669 TEVA-HALOPERIDOL TEV *** 00232831 TEVA-CHLORPROMAZINE TEV 00363650 TEVA-HALOPERIDOL TEV *** 100MG TABLET *** 00463698 APO-HALOPERIDOL TEV *** 02248034 AA-CLOZAPINE AAP		0.0	HALOPERIDOL	
2MG TABLET 00759503 PMS-HALOPERIDOL PMS 02461773 REXULTI OTS 5MC/ML SU-LITION SDZ 3MG TABLET 00808652 HALOPERIDOL OMG 02461781 REXULTI OTS 02366010 HALOPERIDOL OMG 4MG TABLET 02461803 REXULTI OTS 00396796 APO HALOPERIDOL APX CHLORPROMAZINE HYDROCHLORIDE 57 1MG TABLET 0036818 APO HALOPERIDOL APX 25MG TABLET 00396818 APO HALOPERIDOL APX 25MG TABLET 00396818 APO HALOPERIDOL APX 25MG TABLET 00396818 APO HALOPERIDOL TEV 25MG TABLET 0036369 TEVA-HALOPERIDOL TEV 25MG TABLET 0036369 TEVA-HALOPERIDOL TEV 25MG TABLET 00463698 APO-HALOPERIDOL APX 25MG TABLET 00463698 APO-HALOPERIDOL TEV 002248034 AA-CLO		OTS	ST 2MG/ML SOLUTION	
3MG TABLET				2M°
02461781 REXULTI OTS 02366010 HALOPERIDOL OMG 4MG TABLET 02461803 REXULTI OTS 0.5MG TABLET CHLORPROMAZINE HYDROCHLORIDE 1MG TABLET 1 FVA-HALOPERIDOL APX 25MG TABLET 00396818 APO HALOPERIDOL APX 00232803 TEVA-CHLORPROMAZINE TEV 00363677 TEVA-HALOPERIDOL TEV 1000432831 TEVA-CHLORPROMAZINE TEV 00363650 TEVA-HALOPERIDOL TEV 100436869 TEVA-HALOPERIDOL TEV CLOZAPINE TEV 00363650 TEVA-HALOPERIDOL TEV TEVA-HALOPERIDOL APX 02248034 AA-CLOZAPINE AAP 00713449 TEVA-HALOPERIDOL TEVA-HALOPERIDOL TEVA-HAL		OTS	5MG/ML SOLUTION	
AMG TABLET	3MG TABLET		00808652 HALOPERIDOL S	SDZ
02461803 REXULTI OTS 00396796 APO HALOPERIDOL APX CHLORPROMAZINE HYDROCHLORIDE 00363685 TEVA-HALOPERIDOL TEV " 25MG TABLET 003968818 APO HALOPERIDOL APX 00322823 TEVA-CHLORPROMAZINE TEV 00363677 TEVA-HALOPERIDOL TEV " 2MG TABLET 00363669 TEVA-HALOPERIDOL TEV CLOZAPINE TEV 00363669 TEVA-HALOPERIDOL TEV " 25MG TABLET 00463698 APO-HALOPERIDOL APX 02247243 AA-CLOZAPINE AAP 00713449 TEVA-HALOPERIDOL TEV " 20MG TABLET " 20MG TABLET " 20MG TABLET " 20MG/ML LIQUID " 20MG/ML LIQUID " 20MG/ML LIQUID " 20MG/ML LIQUID	02461781 REXULTI	OTS	02366010 HALOPERIDOL O	MG
CHLORPROMAZINE HYDROCHLORIDE 00363685 TEV-A-HALOPERIDOL TEV-A-HALOPERIDOL APX 57 25MG TABLET 003232823 TEVA-CHLORPROMAZINE TEV 003636697 TEVA-HALOPERIDOL TEVA-HALOPERIDOL TEV 50 MG TABLET 003636699 TEVA-HALOPERIDOL TEV TOMG TABLET 00463698 APO-HALOPERIDOL TEV TOMG TABLET 00463698 APO-HALOPERIDOL TEV TOMG TABLET 00463698 APO-HALOPERIDOL TEV 00463698	4MG TABLET		ST 0.5MG TABLET	
ST 25MG TABLET	02461803 REXULTI	OTS	00396796 APO HALOPERIDOL A	٩РХ
5" 25MG TABL=T 5" 1MG TABL=T 00336818 APO HALOPERIDOL APX 00232823 TEVA-CHLORPROMAZINE TEV 00363677 TEVA-HALOPERIDOL TEV 5" 5MG TABL=T 00232807 TEVA-CHLORPROMAZINE TEV 00363669 TEVA-HALOPERIDOL TEV 1 TEVA-CHLORPROMAZINE TEV 00363650 TEVA-HALOPERIDOL TEV 00232831 TEVA-CHLORPROMAZINE TEV 00363650 TEVA-HALOPERIDOL TEV CLOZAPINE TEV 00363650 TEVA-HALOPERIDOL TEV 00363650 TEVA-HALOPERIDOL APX 00448034 AA-CLOZAPINE AAP 00713449 TEVA-HALOPERIDOL TEV 00894737 CLOZAPINE MYL 00768820 TEVA-HALOPERIDOL TEV 00894737 CLOZAPINE MYL 00768820 TEVA-HALOPERIDOL TEV ***********************************	CHLORPROMAZINE HYDROCHLORIDE		00363685 TEVA-HALOPERIDOL 1	ΓΕV
TEV 00398818 APO HALOPERIDOL TEV			ST 1MG TABLET	
ST 50MG TABLET ST 2MG TABLET ST 5MG TABLET ST 10MG TABLET ST 10MG TABLET ST 10MG TABLET ST 10MG TABLET ST 25MG TABLET ST 25MG TABLET ST 25MG TABLET ST 25MG TABLET ST 20MG TABLET		TE\ (00396818 APO HALOPERIDOL	λPX
00232807 TEVA-CHLORPROMAZINE TEV 2MG TABLET 7 (0006 TABLET) TEV 200363669 TEVA-HALOPERIDOL TEV 00232831 TEVA-CHLORPROMAZINE TEV 00363650 TEVA-HALOPERIDOL TEV CLOZAPINE TOMG TABLET 00463698 APO-HALOPERIDOL APX 02248034 AA-CLOZAPINE AAP 00713449 TEVA-HALOPERIDOL TEV 0894737 CLOZARIL HLS ST 20MG TABLET TOMG TABLET TOMG TABLET TOMG TABLET TOMG TABLET HALOPERIDOL DECANOATE 02458748 AA-CLOZAPINE AAP 50MG/ML LIQUID DOMG TABLET DOMG TABLET 02130297 HALOPERIDOL LA SDZ 00894745 CLOZAPINE AAP 100MG/ML LIQUID PMS-HALOPERIDOL PMS 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 00894745 CLOZARIL <td></td> <td>IEV</td> <td>00363677 TEVA-HALOPERIDOL 1</td> <td>ΓΕV</td>		IEV	00363677 TEVA-HALOPERIDOL 1	ΓΕV
TeV		TE\ (ST 2MG TABLET	
SMG TABLE CLOZAPINE TEV **SMG TABLE** TEVA-CHLORPROMAZINE TEV **CLOZAPINE **AAP **O0463698 APO-HALOPERIDOL APX 02248034 AA-CLOZAPINE AAP 00713449 TEVA-HALOPERIDOL TEV 00894737 CLOZARIL HLS **ZOMG TABLE** **TABLOPERIDOL TEVA-HALOPERIDOL TEV ***50MG TABLE** **HALOPERIDOL DECANOATE 02458748 AA-CLOZAPINE AAP **50MG/ML LIQUID 02305003 GEN-CLOZAPINE MYL **02130297 HALOPERIDOL LA SDZ ***100MG TABLE** **02230707 PMS-HALOPERIDOL LA SDZ **02458756 AA-CLOZAPINE MYL **02230708 PMS-HALOPERIDOL LA SDZ **02458756 AA-CLOZAPINE MYL **02230708 PMS-HALOPERIDO		IEV	00363669 TEVA-HALOPERIDOL 1	ΓEV
CLOZAPINE 00363650 TEVA-HALOPERIDOL TEVA-HALOPERIDOL TEVA-HALOPERIDOL APX 2248034 AA-CLOZAPINE AAP 00713449 TEVA-HALOPERIDOL		TC\/	ST 5MG TABLET	
ST 25MG TABLET		IEV	00363650 TEVA-HALOPERIDOL 1	ΓEV
02248034 AA-CLOZAPINE AAP 00713449 TEVA-HALOPERIDOL TEV 00894737 CLOZARIL HLS ST 20MG TABLET O0768820 TEVA-HALOPERIDOL TEV 02247243 GEN-CLOZAPINE MYL 00768820 TEVA-HALOPERIDOL TEV *** 50MG TABLET *** HALOPERIDOL DECANOATE 02305003 GEN-CLOZAPINE MYL 02130297 HALOPERIDOL LA SDZ 02230707 PMS-HALOPERIDOL PMS 02230707 PMS-HALOPERIDOL PMS 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 00247244 GEN-CLOZAPINE MYL 02239640 HALOPERIDOL LA OMG 5** 200MG TABLET 02239640 HALOPERIDOL LA OMG OMG 02458756 AA-CLOZAPINE AAP 02230708 PMS-HALOPERIDOL PMS	CLOZAPINE		ST 10MG TABLET	
00894737 CLOZARIL HLS 5T 20MG TABLET 02247243 GEN-CLOZAPINE MYL 00768820 TEVA-HALOPERIDOL TEV ST 50MG TABLET HALOPERIDOL DECANOATE 02458748 AA-CLOZAPINE AAP 02305003 GEN-CLOZAPINE MYL 02130297 HALOPERIDOL LA SDZ ST 100MG TABLET 02248035 AA-CLOZAPINE AAP 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 02247244 GEN-CLOZAPINE MYL 02130300 HALOPERIDOL LA SDZ ST 200MG TABLET 02239640 HALOPERIDOL LA SDZ 02230707 PMS-HALOPERIDOL LA SDZ 02230708 PMS-HALOPERIDOL LA OMG MYL 02239640 HALOPERIDOL LA OMG MYL 02239640 HALOPERIDOL LA PMS 02458756 AA-CLOZAPINE AAP	ST 25MG TABLET		00463698 APO-HALOPERIDOL A	۱PX
02247243 GEN-CLOZAPINE MYL 00768820 TEVA-HALOPERIDOL TEV st 50MG TABLET HALOPERIDOL DECANOATE 02458748 AA-CLOZAPINE AAP 50MG/ML LIQUID SDZ 02305003 GEN-CLOZAPINE MYL 02130297 HALOPERIDOL LA SDZ 5t 100MG TABLET 02248035 AA-CLOZAPINE AAP 100MG/ML LIQUID PMS-HALOPERIDOL PMS 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 02247244 GEN-CLOZAPINE MYL 02239640 HALOPERIDOL LA OMG 5t 200MG TABLET 02230708 PMS-HALOPERIDOL PMS 02458756 AA-CLOZAPINE AAP 02230708 PMS-HALOPERIDOL PMS	02248034 AA-CLOZAPINE	AAP	00713449 TEVA-HALOPERIDOL 1	ΓEV
ST 50MG TABLET HALOPERIDOL DECANOATE 02458748 AA-CLOZAPINE AAP 50MG/ML LIQUID 02305003 GEN-CLOZAPINE MYL 02130297 HALOPERIDOL LA SDZ 5T 100MG TABLET 02248035 AA-CLOZAPINE AAP 100MG/ML LIQUID PMS-HALOPERIDOL LA PMS 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 02247244 GEN-CLOZAPINE MYL 02239640 HALOPERIDOL LA OMG 5T 200MG TABLET 02458756 AA-CLOZAPINE AAP PMS-HALOPERIDOL PMS	00894737 CLOZARIL	HLS	ST 20MG TABLET	
02458748 AA-CLOZAPINE AAP 02305003 GEN-CLOZAPINE MYL 50MG/ML LIQUID 8T 100MG TABLET 02230707 PMS-HALOPERIDOL LA SDZ 02248035 AA-CLOZAPINE AAP 02230707 PMS-HALOPERIDOL PMS 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 02247244 GEN-CLOZAPINE MYL 02239640 HALOPERIDOL LA OMG 8T 200MG TABLET 02458756 AA-CLOZAPINE AAP	02247243 GEN-CLOZAPINE	MYL	00768820 TEVA-HALOPERIDOL 1	ſΕV
02305003 GEN-CLOZAPINE MYL 50MG/ML LIQUID 87 100MG TABLET 02130297 HALOPERIDOL LA SDZ 02248035 AA-CLOZAPINE AAP 100MG/ML LIQUID 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 02247244 GEN-CLOZAPINE MYL 02239640 HALOPERIDOL LA OMG 87 200MG TABLET 02230708 PMS-HALOPERIDOL PMS 02458756 AA-CLOZAPINE AAP 02230708 PMS-HALOPERIDOL PMS	ST 50MG TABLET		HALOPERIDOL DECANOATE	
02305003 GEN-CLOZAPINE MYL 02130297 HALOPERIDOL LA SDZ *** 100MG TABLET 02248035 AA-CLOZAPINE AAP 100MG/ML LIQUID PMS-HALOPERIDOL PMS 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 02247244 GEN-CLOZAPINE MYL 02239640 HALOPERIDOL LA OMG *** 200MG TABLET 02230708 PMS-HALOPERIDOL PMS 02458756 AA-CLOZAPINE AAP PMS	02458748 AA-CLOZAPINE		50MG/ML LIQUID	
** 100MG TABLET 02230707 PMS-HALOPERIDOL PMS 02248035 AA-CLOZAPINE AAP 100MG/ML LIQUID *** 100MG/ML LIQUID 02247244 GEN-CLOZAPINE MYL 02130300 HALOPERIDOL LA SDZ 02458756 AA-CLOZAPINE AAP 02230708 PMS-HALOPERIDOL PMS		MYL		SD7
02248035 AA-CLOZAPINE AAP 100MG/ML LIQUID 00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 02247244 GEN-CLOZAPINE MYL 02239640 HALOPERIDOL LA OMG st 200MG TABLET 02458756 AA-CLOZAPINE AAP PMS-HALOPERIDOL PMS	ST 100MG TABLET			
00894745 CLOZARIL HLS 02130300 HALOPERIDOL LA SDZ 02247244 GEN-CLOZAPINE MYL 02239640 HALOPERIDOL LA OMG s ⁷ 200MG TABLET 02458756 AA-CLOZAPINE AAP PMS-HALOPERIDOL PMS	02248035 AA-CLOZAPINE	AAP		
02247244 GEN-CLOZAPINE MYL 02239640 HALOPERIDOL LA OMG *** 200MG TABLET 02230708 PMS-HALOPERIDOL PMS 02458756 AA-CLOZAPINE AAP	00894745 CLOZARIL	HLS		3D7
*' 200MG TABLET02230708PMS-HALOPERIDOLPMS02458756AA-CLOZAPINEAAP		MYL		
02458756 AA-CLOZAPINE AAP	$^{s au}$ 200MG TABLET			
02305011 GEN-CLOZAPINE MYL				
	02305011 GEN-CLOZAPINE	MYL		

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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 AN	TIPSYCHOTIC AGENTS		28:16.08 ANTIPSYCHOTIC AGENTS	
OLANZAPINE			PALIPERIDONE PALMITATE	
ST 15MG TABLE	ET		150MG/1.5ML SUSPENSION (EXTENDED RELEASE)	
02276755	TEVA-OLANZAPINE	TEV	02354241 INVEGA SUSTENNA	JSO
	ZYPREXA	LIL	175MG SUSPENSION (EXTENDED RELEASE)	
ST 20MG TABLE			02455943 INVEGA TRINZA	JSO
	JAMP-OLANZAPINE	JMP	263MG SUSPENSION (EXTENDED RELEASE)	
	T (ORALLY DISINTEGRATING)		02455986 INVEGA TRINZA	JSO
	ACT OLANZAPINE ODT	TEV	350MG SUSPENSION (EXTENDED RELEASE)	
	APO-OLANZAPINE ODT	APX	02455994 INVEGA TRINZA	JSO
	AURO-OLANZAPINE ODT	AUR	525MG SUSPENSION (EXTENDED RELEASE)	
02406624		JMP	02456001 INVEGA TRINZA	JSO
02389088		MAR	PERICYAZINE	
02436965	MINT-OLANZAPINE ODT	MIN	ST 5MG CAPSULE	
02338645		PDL	01926780 NEULEPTIL	ERF
02343665	OLANZAPINE ODT	SIV	ST 10MG CAPSULE	
02352974		SAN	01926772 NEULEPTIL	ERF
02303191		PMS	ST 20MG CAPSULE	
02414090		RBY	01926764 NEULEPTIL	ERF
02327775		SDZ	ST 10MG/ML DROP	
	ZYPREXA ZYDIS	LIL	01926756 NEULEPTIL	ERF
	ET (ORALLY DISINTEGRATING)		PERPHENAZINE	
	ACT OLANZAPINE ODT	TEV		
	APO-OLANZAPINE ODT	APX	ST 3.2MG/ML LIQUID	
02448734		AUR	00751898 PMS PERPHENAZINE	PMS
02406632	JAMP OLANZAPINE ODT	JMP	ST 2MG TABLET	
02389096	MAR-OLANZAPINE ODT	MAR	00335134 PERPHENAZINE	AAP
02436973	MINT-OLANZAPINE ODT	MIN	ST 4MG TABLET	
02338653	OLANZAPINE ODT	PDL	00335126 PERPHENAZINE	AAP
02343673		SIV	ST 8MG TABLET	
02352982		SAN	00335118 PERPHENAZINE	AAP
02303205		PMS	ST 16MG TABLET	
02414104	RAN-OLANZAPINE ODT	RBY	00335096 PERPHENAZINE	AAP
02327783	SANDOZ OLANZAPINE ODT	SDZ	00726206 PMS PERPHENAZINE	PMS
02243087		LIL	PIMOZIDE	
	ET (ORALLY DISINTEGRATING)	TC\/	ST 2MG TABLET	
	ACT OLANZAPINE ODT	TEV	02245432 PIMOZIDE	AAP
	APO-OLANZAPINE ODT	APX	st 4MG TABLET	7 V II
02448742		AUR	02245433 PIMOZIDE	AAP
02406640	JAMP OLANZAPINE ODT	JMP	PIPOTIAZINE PALMITATE	7 V II
02389118	MAR-OLANZAPINE ODT	MAR	PIPOTIAZINE PALIVITATE	
02436981	MINT-OLANZAPINE ODT OLANZAPINE ODT	MIN	50MG/ML INJECTION	
02338661 02343681	OLANZAPINE ODT	PDL SIV	00894672 PIPORTIL L4	SAC
			PROCHLORPERAZINE	
02352990	OLANZAPINE ODT	SAN	10MG SUPPOSITORY	
02303213 02414112		PMS RBY	00753688 PMS-PROCHLORPERAZINE	PMS
			00789720 SANDOZ PROCHLORPERAZINE	SDZ
02327791	SANDOZ OLANZAPINE ODT ZYPREXA ZYDIS	SDZ LIL	PROCHLORPERAZINE MALEATE	ODZ
		LIL	FROOTLONFENAZINE MALLATE	
PALIPERIDO	NE PALMITATE		ST 5MG TABLET	
50MG/0.5ML	SUSPENSION (EXTENDED RELEASE)		00753661 PMS-PROCHLORPERAZINE	PMS
02354217	INVEGA SUSTENNA	JSO	00886440 PROCHLORAZINE	AAP
75MG/0.75M	L SUSPENSION (EXTENDED RELEASE)		ST 10MG TABLET	
02354225	INVEGA SUSTENNA	JSO	00753637 PMS-PROCHLORPERAZINE	PMS
100MG/ML S	SUSPENSION (EXTENDED RELEASE)		00886432 PROCHLORAZINE	AAP
02354233	INVEGA SUSTENNA	JSO		

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28·16 08 ANT	IPSYCHOTIC AGENTS		28·16 08 AN	TIPSYCHOTIC AGENTS	
PROCHLORPERAZINE MESYLATE		QUETIAPINE			
			•		
5MG/ML SOLU		DMO	ST 200MG TAΒ		DMO
	PMS PROCHLORPERAZINE	PMS	02296594 02317362	PMS-QUETIAPINE	PMS PDL
QUETIAPINE F	-UMARATE		02317362	PRO-QUETIAPINE QUETIAPINE	SIV
ST 25MG TABLE	Γ		02353199	QUETIAPINE	SAN
02316080	ACT QUETIAPINE	ACG	02387824		ACC
02313901	APO-QUETIAPINE	APX	02397110		RBY
02390205	AURO-QUETIAPINE	AUR	02316722		RIV
	BIO-QUETIAPINE	BMI	02314010		SDZ
	DOM-QUETIAPINE	DPC	02236953		AZC
	JAMP-QUETIAPINE	JMP	02284278	TEVA-QUETIAPINE	TEV
	MAR-QUETIAPINE	MAR	ST 300MG TAB	LET	
	MINT-QUETIAPINE	MIN	02316129	ACT QUETIAPINE	ACG
	NAT-QUETIAPINE	NPH	02313944	APO-QUETIAPINE	APX
	PMS-QUETIAPINE	PMS PDL	02390256	AURO-QUETIAPINE	AUR
	PRO-QUETIAPINE QUETIAPINE	SIV	02447258	BIO-QUETIAPINE	BMI
	QUETIAPINE QUETIAPINE	SAN	02299046	DOM-QUETIAPINE	DPC
	QUETIAPINE	ACC	02330466	JAMP-QUETIAPINE	JMP
	RAN-QUETIAPINE	RBY	02399857	MAR-QUETIAPINE	MAR
	RIVA-QUETIAPINE	RIV	02438054	MINT-QUETIAPINE	MIN
	SANDOZ QUETIAPINE	SDZ	02439190	NAT-QUETIAPINE	NPH
	SEROQUEL	AZC	02296608	PMS-QUETIAPINE	PMS
	TEVA-QUETIAPINE	TEV	02317370	PRO-QUETIAPINE	PDL
ST 50MG TABLE		124	02317931	QUETIAPINE	SIV
	PMS-QUETIAPINE	PMS	02353202	QUETIAPINE	SAN
ST 100MG TABLE		· inic	02387832		ACC
	ACT QUETIAPINE	ACG	02397129	RAN-QUETIAPINE	RBY
	APO-QUETIAPINE	APX	02316730		RIV
	AURO-QUETIAPINE	AUR	02314029	SANDOZ QUETIAPINE	SDZ
	BIO-QUETIAPINE	BMI	02244107		AZC
02299003 I	DOM-QUETIAPINE	DPC	02284286	TEVA-QUETIAPINE	TEV
02330423	JAMP-QUETIAPINE	JMP		ET (EXTENDED RELEASE)	4 D.V
02399830 I	MAR-QUETIAPINE	MAR		APO-QUETIAPINE XR	APX
02438011 I	MINT-QUETIAPINE	MIN	02417359 02417782	QUETIADINE XR	SIV PDL
02439166 I	NAT-QUETIAPINE	NPH	02417762	QUETIAPINE XR SANDOZ QUETIAPINE XRT	SDZ
02296578 I	PMS-QUETIAPINE	PMS		SEROQUEL XR	AZC
02317354 I	PRO-QUETIAPINE	PDL	02395444		TEV
02317907	QUETIAPINE	SIV		LET (EXTENDED RELEASE)	ı L v
02353172	QUETIAPINE	SAN		APO-QUETIAPINE XR	APX
02387808	QUETIAPINE	ACC	02417367		SIV
02397102 I	RAN-QUETIAPINE	RBY	02417790		PDL
	RIVA-QUETIAPINE	RIV	02407698		SDZ
	SANDOZ QUETIAPINE	SDZ	02321513		AZC
	SEROQUEL	AZC		TEVA-QUETIAPINE XR	TEV
	TEVA-QUETIAPINE	TEV		LET (EXTENDED RELEASE)	
ST 200MG TABLE				APO-QUETIAPINE XR	APX
	ACT QUETIAPINE	ACG	02417375		SIV
	APO-QUETIAPINE	APX	02417804	QUETIAPINE XR	PDL
	AURO-QUETIAPINE	AUR	02407701	SANDOZ QUETIAPINE XRT	SDZ
	BIO-QUETIAPINE	BMI	02300192	SEROQUEL XR	AZC
	DOM-QUETIAPINE	DPC	02395460	TEVA-QUETIAPINE XR	TEV
	JAMP-QUETIAPINE	JMP	300MG TAB	LET (EXTENDED RELEASE)	
	MAR-QUETIAPINE	MAR	02457253	APO-QUETIAPINE XR	APX
	MINT-QUETIAPINE	MIN	02417383	QUETIAPINE XR	SIV
02439182 I	NAT-QUETIAPINE	NPH			

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28:16.08 ANTIPSYCHOTIC AGENTS		28:16.08 ANTIPSYCHOTIC AGENTS	
QUETIAPINE FUMARATE		RISPERIDONE	
300MG TABLET (EXTENDED RELEASE)		1MG TABLET	
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 TABLET (EXTENDED RELEASE)		02279800 SANDOZ RISPERIDONE	SDZ
02457261 APO-QUETIAPINE XR	APX	02264196 TEVA-RISPERIDONE	TEV
02417391 QUETIAPINE XR	SIV	2MG TABLET	
02417820 QUETIAPINE XR	PDL	02369117 AG-RISPERIDONE	ANG
02407736 SANDOZ QUETIAPINE XRT	SDZ	02282143 APO-RISPERIDONE	APX
02300214 SEROQUEL XR	AZC	02359553 JAMP-RISPERIDONE	JMP
02395487 TEVA-QUETIAPINE XR	TEV	02371790 MAR-RISPERIDONE	MAR
25MG TABLET (IMMEDIATE RELEASE)		02359820 MINT-RISPERIDON	MIN
02475979 AG-QUETIAPINE	ANG	02252031 PMS-RISPERIDONE	PMS
RISPERIDONE		02312735 PRO-RISPERIDONE	PDL
		02328348 RAN-RISPERIDONE	RBY
ST 1MG SOLUTION		02356910 RISPERIDONE	SAN
02454319 JAMP-RISPERIDONE	JMP	02283603 RIVA-RISPERIDONE	RIV
ST 1MG/ML SOLUTION		02279819 SANDOZ RISPERIDONE	SDZ
02280396 APO-RISPERIDONE	APX	02264218 TEVA-RISPERIDONE	TEV
02279266 PMS-RISPERIDONE	PMS	3MG TABLET	
02236950 RISPERDAL	JSO	02369125 AG-RISPERIDONE	ANG
0.25MG TABLET		02282151 APO-RISPERIDONE	APX
02369079 AG-RISPERIDONE	ANG	02359561 JAMP-RISPERIDONE	JMP
02282119 APO-RISPERIDONE	APX	02371804 MAR-RISPERIDONE	MAR
02359529 JAMP-RISPERIDONE	JMP	02359839 MINT-RISPERIDON	MIN
02371766 MAR-RISPERIDONE	MAR	02252058 PMS-RISPERIDONE	PMS
02359790 MINT-RISPERIDON	MIN	02312743 PRO-RISPERIDONE	PDL
02252007 PMS-RISPERIDONE	PMS	02328364 RAN-RISPERIDONE	RBY
02312700 PRO-RISPERIDONE	PDL	02356929 RISPERIDONE	SAN
02328305 RAN-RISPERIDONE	RBY	02283611 RIVA-RISPERIDONE	RIV
02356880 RISPERIDONE	SAN	02279827 SANDOZ RISPERIDONE	SDZ
02283565 RIVA-RISPERIDONE	RIV	02264226 TEVA-RISPERIDONE	TEV
02303655 SANDOZ RISPERIDONE	SDZ	4MG TABLET	
02282690 TEVA-RISPERIDONE	TEV	02369133 AG-RISPERIDONE	ANG
0.5MG TABLET		02282178 APO-RISPERIDONE	APX
02369087 AG-RISPERIDONE	ANG	02359588 JAMP-RISPERIDONE	JMP
02282127 APO-RISPERIDONE	APX	02371812 MAR-RISPERIDONE	MAR
02359537 JAMP-RISPERIDONE	JMP	02359847 MINT-RISPERIDON	MIN
02371774 MAR-RISPERIDONE	MAR	02252066 PMS-RISPERIDONE	PMS
02359804 MINT-RISPERIDON	MIN	02312751 PRO-RISPERIDONE	PDL
02252015 PMS-RISPERIDONE	PMS	02328372 RAN-RISPERIDONE	RBY
02312719 PRO-RISPERIDONE	PDL	02356937 RISPERIDONE	SAN
02328313 RAN-RISPERIDONE	RBY	02283638 RIVA-RISPERIDONE	RIV
02356899 RISPERIDONE	SAN	02279835 SANDOZ RISPERIDONE	SDZ
02283573 RIVA-RISPERIDONE	RIV	02264234 TEVA-RISPERIDONE	TEV
02303663 SANDOZ RISPERIDONE	SDZ	ST 0.5MG TABLET (ORALLY DISINTEGRATING)	ILV
02264188 TEVA-RISPERIDONE	TEV	02413485 MYLAN-RISPERIDONE ODT	MYL
1MG TABLET		ST 1MG TABLET (ORALLY DISINTEGRATING)	IVI T L
02369095 AG-RISPERIDONE	ANG	•	MAXI
02282135 APO-RISPERIDONE	APX	02413493 MYLAN-RISPERIDONE ODT	MYL
02359545 JAMP-RISPERIDONE	JMP	ST 2MG TABLET (ORALLY DISINTEGRATING)	B 45 //
02371782 MAR-RISPERIDONE	MAR	02413507 MYLAN-RISPERIDONE ODT	MYL
02359812 MINT-RISPERIDON	MIN	ST 3MG TABLET (ORALLY DISINTEGRATING)	
02252023 PMS-RISPERIDONE	PMS	02413515 MYLAN-RISPERIDONE ODT	MYL

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		Non-insured Health Dener	113
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		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			
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		with the potential misuse and abuse of these medications.	
02255723 RISPERDAL CONSTA	JSO	The stimulant dose coverage limit is set at 100 mg of	
ST 50MG INJECTION		methylphenidate equivalents* per day for adults and children. This limit is calculated based on the total dose of all	
02255758 RISPERDAL CONSTA	JSO	stimulants that patients are receiving from NIHB. The	
THIOPROPERAZINE MESYLATE		Program will continue to monitor the utilization of stimulants	
ST 10MG TABLET		and adjust the eligible dose limit as required.	
01927639 MAJEPTIL	ERF	* To convert to methylphenidate equivalents, 1 mg of	
THIOTHIXENE		METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to	
ST 5MG CAPSULE		0.5 mg DEXTROAMPHETAMINE	
00024449 NAVANE	ERF	ST 5MG CAPSULE (EXTENDED RELEASE)	
TRIFLUOPERAZINE HYDROCHLORIDE			TEV
ST 1MG TABLET			UNK
00345539 TRIFLUOPERAZINE	AAP		APX
ST 2MG TABLET	AAF		PMS SDZ
00312754 TRIFLUOPERAZINE	AAP	ST 10MG CAPSULE (EXTENDED RELEASE)	SDZ
ST 5MG TABLET		•	TEV
00312746 TRIFLUOPERAZINE	AAP		UNK
ST 10MG TABLET			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)	
ZIPRASIDONE HYDROCHLORIDE		02439255 ACT AMPHETAMINE XR	TEV
MONOHYDRATE			UNK
ST 20MG CAPSULE			APX
02449544 AURO-ZIPRASIDONE	AUR		PMS
02298597 ZELDOX	PFI	02457318 SANDOZ AMPHETAMINE XR ST 20MG CAPSULE (EXTENDED RELEASE)	SDZ
ST 40MG CAPSULE			TEV
02449552 AURO-ZIPRASIDONE	AUR		UNK
02298600 ZELDOX	PFI		APX
ST 60MG CAPSULE			PMS
02449560 AURO-ZIPRASIDONE	AUR		SDZ
02298619 ZELDOX	PFI	ST 25MG CAPSULE (EXTENDED RELEASE)	
ST 80MG CAPSULE 02449579 AURO-ZIPRASIDONE	AUR	02439271 ACT AMPHETAMINE XR	TEV
02298627 ZELDOX	PFI	02248812 ADDERALL XR	UNK
ZUCLOPENTHIXOL ACETATE	FII		APX
			PMS
50MG/ML SOLUTION			SDZ
02230405 CLOPIXOL-ACUPHASE	LUD	ST 30MG CAPSULE (EXTENDED RELEASE)	TC\/
ZUCLOPENTHIXOL DIHYDROCHLORIDE			TEV UNK
200MG/ML SOLUTION			APX
02230406 CLOPIXOL DEPOT	LUD		PMS
ST 10MG TABLET			SDZ
02230402 CLOPIXOL	LUD	32.0.0.12	

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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	ACG
01924559	DEXEDRINE SPANSULE	PAL
ST 15MG CAPS	ULE (SUSTAINED RELEASE)	
02448327	ACT DEXTROAMPHETAMINE SR	ACG
01924567	DEXEDRINE SPANSULE	PAL
ST 5MG TABLE	т	
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 CAPS	ULE	
02439603	VYVANSE	SHI
ST 20MG CAPS	ULE	
02347156	VYVANSE	SHI
ST 30MG CAPS	ULE	
02322951	VYVANSE	SHI
ST 40MG CAPS	ULE	
02347164	VYVANSE	SHI
ST 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 TABLET

SWIG TABLE		
02273950	APO-METHYLPHENIDATE	APX
02234749	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	ACG
02452731	APO-METHYLPHENIDATE ER	APX
02247732	CONCERTA	JSO
02413728	PMS-METHYLPHENIDATE ER	PMS
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	ACG
02452758	APO-METHYLPHENIDATE ER	APX
02250241	CONCERTA	JSO
02413736	PMS-METHYLPHENIDATE ER	PMS
02315076	TEVA-METHYLPHENIDATE	TEV
ST 36MG TABL	ET (EXTENDED RELEASE)	
02441950	ACT METHYLPHENIDATE ER	ACG
02452766	APO-METHYLPHENIDATE ER	APX
02247733	CONCERTA	JSO
02413744	PMS-METHYLPHENIDATE ER	PMS
02315084	TEVA-METHYLPHENIDATE	TEV
ST 54MG TABL	ET (EXTENDED RELEASE)	
02441969	ACT METHYLPHENIDATE ER	ACG
02330377	APO-METHYLPHENIDATE ER	APX
02247734	CONCERTA	JSO
02413752	PMS-METHYLPHENIDATE ER	PMS
02315092	TEVA-METHYLPHENIDATE	TEV

28:20.80 WAKEFULNESS-PROMOTING AGENTS

MODAFINIL

ST 100MG TABLET

 02239665
 ALERTEC
 TEV

 02285398
 APO-MODAFINIL
 APX

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28:20.80 WAKEFULNESS-PROMOTING AGENTS

MODAFINIL

ST 100MG TABLET

02430487	AURO-MODAFINIL	AUR
02442078	BIO-MODAFINIL	BMI
02432560	MAR-MODAFINIL	MAR
02420260	TEVA-MODAFINIL	TEV

28:20.92 MISC ANOREXIGENIC AGENTS & RESPIRATORY & CEREBRAL STIMULANT

CAFFEINE CITRATE

Limited use benefit (prior approval not required).

For children up to 1 year of age

POWDER

00972037 CAFFEINE CITRATE MDS

28:24.04 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BARBITURATES

PHENOBARBITAL

15MG TABLET

00178799 PHENOBARB PED

30MG TABLET

00178802 PHENOBARB PED

60MG TABLET

00178810 PHENOBARB PED

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

01908189	ALPRAZOLAM	PDL
02349191	ALPRAZOLAM	SAN
00865397	APO-ALPRAZ	APX
02400111	JAMP-ALPRAZOLAM	JMP
01913484	TEVA-ALPRAZOLAM	TEV
00548359	XANAX	PFI
ST 0.5MG TABL	.ET	
01908170	ALPRAZOLAM	PDL
02349205	ALPRAZOLAM	SAN
00865400	APO-ALPRAZ	APX
02400138	JAMP-ALPRAZOLAM	JMP
01913492	TEVA-ALPRAZOLAM	TEV
00548367	XANAX	PFI
ST 1MG TABLE	Т	
02248706	ALPRAZOLAM	PDL
02243611	APO-ALPRAZ	APX

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 1MG TABLET

02400146	JAMP-ALPRAZOLAM	JMP
00723770	XANAX	PFI
ST 2MG TABLE	T	
02243612	APO-ALPRAZ	APX
02400154	JAMP-ALPRAZOLAM	JMP
00813958	XANAX TS	PFI

BROMAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 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

PMS-DIAZEPAM	PMS			
ST 2MG TABLET				
DIAZEPAM	AAP			
PMS-DIAZEPAM	PMS			
ST 5MG TABLET				
DIAZEPAM	PDL			
DIAZEPAM	AAP			
PMS-DIAZEPAM	PMS			
VALIUM	HLR			
	T DIAZEPAM PMS-DIAZEPAM T DIAZEPAM DIAZEPAM PMS-DIAZEPAM			

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28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

DIAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 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

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	FIN

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
02410745	LORAZEPAM SUBLINGUAL	AAP
00728187	PMS-LORAZEPAM	PMS
00655643	PRO-LORAZEPAM	PDL
00711101	TEVA-LORAZEPAM	TEV
$^{ exttt{S}^{ au}}$ 1MG TABLE	ΕT	
00655759	APO-LORAZEPAM	APX
02041421	ATIVAN	PFI
02041464	ATIVAN SUBLINGUAL	PFI
02351080	LORAZEPAM	SAN
02410753	LORAZEPAM SUBLINGUAL	AAP
00728195	PMS-LORAZEPAM	PMS
00655651	PRO-LORAZEPAM	PDL

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 1MG TABLET

00637742	TEVA-LORAZEPAM	TEV	
ST 2MG TABLET			
00655767	APO-LORAZEPAM	APX	
02041448	ATIVAN	PFI	
02041472	ATIVAN SUBLINGUAL	PFI	
02351099	LORAZEPAM	SAN	
02410761	LORAZEPAM SUBLINGUAL	AAP	
00728209	PMS-LORAZEPAM	PMS	
00655678	PRO-LORAZEPAM	PDL	
00637750	TEVA-LORAZEPAM	TEV	

NITRAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 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
T10MG TABL	ET	
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	BMI
	00568392	RIVA OXAZEPAM	RIV
ST 15MG TABLET			
	00402745	APO OXAZEPAM	APX
	00497762	OXAZEPAM	PDL
	00568406	RIVA OXAZEPAM	RIV
ST 30MG TABLET			
	00402737	APO OXAZEPAM	APX

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28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

OXAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 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

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	
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

00808571 TRIAZOLAM AAP

28:24.92 MISCELLANEOUS ANXIOLYTICS, SEDATIVES, AND HYPNOTICS

BUSPIRONE HYDROCHLORIDE

ST 10MG TABLET

			02400021	ALIVIOTATETAIN
02211076	APO-BUSPIRONE	APX	02405806	APO-ALMOTRIPTAN
02223163	BUSPIRONE	PDL	02248129	AXERT
02447851	BUSPIRONE	SAN	02398443	MYLAN-ALMOTRIPTAN
02230942	PMS-BUSPIRONE	PMS	02405334	SANDOZ ALMOTRIPTA
02231492	TEVA-BUSPIRONE	TEV	02434849	TEVA-ALMOTRIPTAN

28:24.92 MISCELLANEOUS ANXIOLYTICS, SEDATIVES, AND HYPNOTICS

HYDROXYZINE HYDROCHLORIDE

ST 10MG CAPS	ULE	
00646059	HYDROXYZINE	APX
00738824	NOVO-HYDROXYZIN	TEV
ST 25MG CAPS	ULE	
00646024	HYDROXYZINE	APX
00738832	NOVO-HYDROXYZIN	TEV
ST 50MG CAPS	ULE	
00646016	HYDROXYZINE	APX
00738840	NOVO-HYDROXYZIN	TEV
ST 2MG/ML SY	RUP	
00024694	ATARAX	ERF
00741817	PMS HYDROXYZINE	PMS
0.20 00 41	TIMANIC ACENTS	2

28:28.00 ANTIMANIC AGENTS

LITHIUM CARBONATE

ST 150MG CAPSULE			
02242837	APO-LITHIUM CARBONATE	APX	
09857532	APO-LITHIUM CARBONATE	APX	
00461733	CARBOLITH	BSH	
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 TABLET (EXTENDED RELEASE)			

LITHIUM CITRATE

02266695 LITHMAX

ST 60MG/ML SYRUP

02074834 PMS-LITHIUM CITRATE PMS

AAP

APX

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.

02405792 APO-ALMOTRIPTAN

6.25MG TABLET

02248128	AXERT	MCL
02398435	MYLAN-ALMOTRIPTAN	MYL
12.5MG TAB	SLET	
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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APX

DPC

28:32.28 SELECTIVE SEROTONIN 28:32.28 SELECTIVE SEROTONIN **AGONISTS AGONISTS** NARATRIPTAN HYDROCHLORIDE **SUMATRIPTAN HEMISULFATE** Limited use benefit (prior approval is not required). **5MG SPRAY** 02230418 IMITREX **GSK** A total of 12 tablets are permitted in a 30-day period 20MG SPRAY **1MG TABLET** 02230420 IMITREX **GSK** 02237820 AMERGE **GSK SUMATRIPTAN SUCCINATE** TEVA-NARATRIPTAN TEV 02314290 Limited use benefit (prior approval is not required). 2.5MG TABLET 02237821 **AMERGE GSK** A total of 12 tablets (or injections) are permitted in a 30-day SANDOZ NARATRIPTAN SDZ 02322323 02314304 TEVA-NARATRIPTAN TEV 6MG/0.5ML INJECTION **RIZATRIPTAN BENZOATE** 99000598 IMITREX STAT DOSE KIT **GSK** Limited use benefit (prior approval is not required). 12MG/ML SOLUTION 02212188 GSK IMITREX A total of 12 tablets are permitted in a 30-day period TARO-SUMATRIPTAN TAR 02361698 **5MG TABLET** 25MG TABLET 02393468 APO-RIZATRIPTAN APX 02270749 DOM-SUMATRIPTAN DPC 02380455 JAMP-RIZATRIPTAN .IMP 02268906 MYLAN-SUMATRIPTAN MYL JAMP-RIZATRIPTAN IR **JMP** 02429233 02256428 PMS-SUMATRIPTAN **PMS** 02379651 MAR-RIZATRIPTAN MAR 02286815 TEVA-SUMATRIPTAN DF **TEV 10MG TABLET 50MG TABLET** 02381702 ACT RIZATRIPTAN ACG 02268388 APO-SUMATRIPTAN **APX** 02393476 APO-RIZATRIPTAN **APX** 02270757 DOM-SUMATRIPTAN DPC 02441144 AURO-RIZATRIPTAN **AUR** IMITREX DE 02212153 GSK 02380463 JAMP-RIZATRIPTAN **JMP** 02268914 MYLAN-SUMATRIPTAN MYL 02429241 JAMP-RIZATRIPTAN IR **JMP** 02256436 PMS-SUMATRIPTAN **PMS** 02379678 MAR-RIZATRIPTAN MAR 02263025 SANDOZ SUMATRIPTAN SDZ 02240521 MAXALT **FRS** 02286521 **SUMATRIPTAN** SAN **5MG TABLET (ORALLY DISINTEGRATING)** PDL 02324652 SUMATRIPTAN APX 02393484 APO-RIZATRIPTAN RPD 02385570 SUMATRIPTAN DF SIV 02465086 JAMP-RIZATRIPTAN ODT **JMP** TEVA-SUMATRIPTAN DF **TEV** 02286823 02462788 MAR-RIZATRIPTAN ODT MAR **100MG TABLET** 02240518 MAXALT RPD **FRS** 02257904 **ACT SUMATRIPTAN** ACG 02379198 MYLAN-RIZATRIPTAN ODT MYL APX 02268396 **APO-SUMATRIPTAN** 02436604 NAT-RIZATRIPTAN ODT NPH 02270765 DOM-SUMATRIPTAN DPC 02393360 PMS-RIZATRIPTAN RDT **PMS** 02212161 **IMITREX DF GSK** 02442906 **RIZATRIPTAN ODT** SAN 02268922 MYLAN-SUMATRIPTAN MYL 02446111 **RIZATRIPTAN ODT** SIV 02256444 PMS-SUMATRIPTAN **PMS** 02415798 RIZATRIPTAN RDT **PDL** 02263033 SANDOZ SUMATRIPTAN SD7 02351870 SANDOZ RIZATRIPTAN ODT SD7 02286548 SUMATRIPTAN SAN 02396661 TEVA-RIZATRIPTAN ODT TEV PDI 02324660 **SUMATRIPTAN** 10MG TABLET (ORALLY DISINTEGRATING) 02385589 SUMATRIPTAN DF SIV 02393492 APO-RIZATRIPTAN RPD APX 02239367 **TEVA-SUMATRIPTAN** TEV DPC 02396203 DOM-RIZATRIPTAN RDT 02286831 TEVA-SUMATRIPTAN DF TFV JAMP-RIZATRIPTAN ODT 02465094 **JMP ZOLMITRIPTAN** 02462796 MAR-RIZATRIPTAN ODT MAR Limited use benefit (prior approval is not required). **FRS** 02240519 MAXALT RPD 02379201 MYLAN-RIZATRIPTAN ODT MYL A total of 12 tablets are permitted in a 30-day period. 02436612 NAT-RIZATRIPTAN ODT NPH 2.5MG SPRAY 02393379 PMS-RIZATRIPTAN RDT **PMS** AZC 02248992 ZOMIG 02442914 **RIZATRIPTAN ODT** SAN **5MG SPRAY** 02446138 **RIZATRIPTAN ODT** SIV 02248993 ZOMIG AZC 02415801 RIZATRIPTAN RDT PDI 2.5MG TABLET 02351889 SANDOZ RIZATRIPTAN ODT SD7

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TEV

02396688

TEVA-RIZATRIPTAN ODT

02380951

02389525

APO-ZOLMITRIPTAN

DOM-ZOLMITRIPTAN

	ELECTIVE SEROTONIN GONISTS		28:36.08 ANTIPARKINSONIAN AGENTS - ANTICHOLINERGIC AGENTS	
ZOLMITRIP	TAN		PROCYCLIDINE HYDROCHLORIDE	
Limited use be	nefit (prior approval is not required).		0.5MG/ML ELIXIR	
A total of 12 tal	plets are permitted in a 30-day period.		00587362 PDP-PROCYCLIDINE PE	ED
2.5MG TAE	, , , , , , , , , , , , , , , , , , , ,		2.5MG TABLET	
	B JAMP-ZOLMITRIPTAN	JMP		ED
	B MAR-ZOLMITRIPTAN	MAR	5MG TABLET	
02419521		MIN		ED
02421534		NPH	TRIHEXYPHENIDYL HYDROCHLORIDE	
02324229	PMS-ZOLMITRIPTAN	PMS	0.4MG/ML ELIXIR	
02362988	SANDOZ ZOLMITRIPTAN	SDZ	00885398 PMS-TRIHEXYPHENIDYL PN	MS
02313960) TEVA-ZOLMITRIPTAN	TEV	2MG TABLET	
02379929	O ZOLMITRIPTAN	PDL	00545058 TRIHEXYPHENIDYL AA	ΑP
02238660		AZC	5MG TABLET	
	BLET (ORALLY DISINTEGRATING)		00545074 TRIHEXYPHENIDYL AA	AP
	B AG-ZOLMITRIPTAN ODT	ANG	28:36.12 ANTIPARKINSONIAN AGENTS -	
02381575		APX	CATECHOL-O-	
02428237		JMP	METHYLTRANSFERASE (COMT)	
02324768		PMS	INHIBITORS	
02362996		SDZ	33 33 33 33 33 33 33 33 33 33 33 33 33	
	SEPTA-ZOLMITRIPTAN-ODT	SPT	ENTACAPONE	
02342545		TEV	ST 200MG TABLET	
	3 ZOLMITRIPTAN ODT I ZOLMITRIPTAN ODT	PDL SAN		VR
	5 ZOMIG RAPIMELT	AZC		DΖ
			02375559 TEVA-ENTACAPONE TE	ΕV
	IISCELLANEOUS ANTIMIGRAN	NE	28:36.16 ANTIPARKINSONIAN AGENTS -	
	GENTS		DOPAMINE PRECURSORS	
FLUNARIZI	NE HYDROCHLORIDE		LEVODOPA, BENSERAZIDE HYDROCHLORIDE	
ST 5MG CAPS	BULE		ST 50MG & 12.5MG CAPSULE	
	2 FLUNARIZINE	AAP	00522597 PROLOPA HI	LR
PIZOTIFEN	MALATE		ST 100MG & 25MG CAPSULE	
0.5MG TAE	BLET		00386464 PROLOPA HI	LR
00329320	SANDOMIGRAN	PAL	ST 200MG & 50MG CAPSULE	
1MG TABL	.ET		00386472 PROLOPA HI	LR
00511552	SANDOMIGRAN DS	PAL	LEVODOPA, CARBIDOPA	
28:36.08 A	NTIPARKINSONIAN AGENTS -	•	ST 100MG & 10MG TABLET	
	NTICHOLINERGIC AGENTS			РХ
	PINE MESYLATE			1IN
DENZIKUF	TINE WESTLATE			ΕV
1MG/ML L	IQUID		ST 100MG & 25MG TABLET	
	B BENZTROPINE OMEGA	OMG	02195941 APO-LEVOCARB AF	РХ
ST 1MG TABL			02457962 MINT-LEVOCARB M	/IN
	PDP-BENZTROPINE	PED	02421488 PMS-LEVOCARB PM	MS
ST 2MG TABL			02311178 PRO-LEVOCARB PI	DL
	7 PDP-BENZTROPINE	PED	00513997 SINEMET FF	RS
	5 PMS-BENZTROPINE	PMS		ΕV
ETHOPROF	PAZINE HYDROCHLORIDE		ST 250MG & 25MG TABLET	
50MG TAB	LET		02195968 APO-LEVOCARB AF	PX
01927744	PARSITAN	ERF		lΙΝ
PROCYCLI	DINE HCL			RS
5MG CAPS				ΕV
	5 PROCYCLIDINE (PQ)	UNK	ST 100MG & 25MG TABLET (EXTENDED RELEASE)	D) (
33101400	THOUSEIDHAL (I W)	ONIX	02272873 APO-LEVOCARB AF	PX

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28:36.16 ANTIPARKINSONIAN AGENTS DOPAMINE PRECURSORS LEVODOPA. CARBIDOPA

ST 200MG & 50MG TABLET (EXTENDED RELEASE)

 02245211
 APO-LEVOCARB
 APX

 02421496
 PMS-LEVOCARB
 PMS

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 & 12.5	5MG & 200MC	TABLET
02305933	STALEVO	NVR
ST 75MG & 18.7	75MG & 200N	G 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	G 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

02230454	BROMOCRIPTINE	AAP
02238637	DOM-BROMOCRIPTINE	DPC
02236949	PMS-BROMOCRIPTINE	PMS
2.5MG TABL	.ET	
02087324	BROMOCRIPTINE	AAP
02238636	DOM-BROMOCRIPTINE	DPC

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

ST 0.25MG TABLET

02424096

02297302	ACT PRAMIPEXOLE	ACG
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	ACG
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	ACG
02292394	APO-PRAMIPEXOLE	APX

AURO-PRAMIPEXOLE

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### SELEGILINE HYDROCHLORIDE ### TMG TABLET 02391649 PRAMIPEXOLE SIV 02239641 APO-SELEGILINE APX 02239629 PRAMIPEXOLE PDL 02068087 TEV-A-SELEGILINE TEV 02391689 SANDOZ PRAMIPEXOLE SIV 02290487 APO-SELEGILINE APX 0239048 APO-SELEGILINE APX 0229048 APO-PRAMIPEXOLE APX 0229048 APO-PRAMIPEXOLE APX 0229048 APO-PRAMIPEXOLE APX 0229048 APO-PRAMIPEXOLE APX 02290487 PRAMIPEXOLE APX 02290487 PRAMIPEXOLE SIV 02335687 PRAMIPEXOLE PDL 02315687 SANDOZ PRAMIPEXOLE SIV O2335687 PRAMIPEXOLE SIV O2335687 PRAMIPEXOLE SIV O2335687 PRAMIPEXOLE SIV O2335687 APO-ROPINIROLE APX O2304686 ACT ROPINIROLE APX O2335680 APO-ROPINIROLE APX O2335680 APO-ROPINIROLE APX O2335680 APO-ROPINIROLE APX O2335680 APO-ROPINIROLE APX O2336884 ACT ROPINIROLE APX O2336884 ACT ROPINIROLE APX O2336884 ACT ROPINIROLE APX O2336884 APO-ROPINIROLE APX O2336884 ACT ROPINIROLE APX O2368884 ACT ROPINIROLE APX O2368894 APO-ROPINIROLE APX O2368897 APO-ROPINIROLE APX O2368897 APO-ROPINIROLE APX O2368897 APO-ROPINIROLE APX O2368897 APO-ROPINIROLE APX O2368897		ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR		28:36.32 ANTIPARKINSONIAN AGENTS - MONOAMINE OXIDASE B	
**1MG TABLET	AGONISTS			INHIBITORS	
02309149 PRAMIPEXOLE PDL 0200887 TEVA-SELEGILINE TEV 02315289 SANDOZ PRAMIPEXOLE PDL 0200887 TEVA-SELEGILINE TEV 02315289 SANDOZ PRAMIPEXOLE APX CO293373 ACT PRAMIPEXOLE PDL CO200877 SANDOZ PRAMIPEXOLE PDL CO200877 CO20087 C	PRAMIPE	XOLE DIHYDROCHLORIDE		SELEGILINE HYDROCHLORIDE	
02325829 PRAMIPEXOLE PDL 02088087 TEVA-SELEGILINE TEV 28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS N	ST 1MG TAE	BLET		ST 5MG TABLET	
02315289 SANDOZ PRAMIPEXOLE ACG 02292408 ACT PRAMIPEXOLE APX 02392377 ACT PRAMIPEXOLE APX 02392408 APX 02392539 APP APRAMIPEXOLE SIV 02392539 SANDOZ PRAMIPEXOLE SIV 0239259 SAND	023091	49 PRAMIPEXOLE			
### 1.5MG TABLET O2297337	023258	29 PRAMIPEXOLE		02068087 TEVA-SELEGILINE	TEV
COLOR COLO			SDZ	28:92.00 MISCELLANEOUS CENTRAL	
02292408 APO_PRAMIPEXOLE AUR 02494118 AURO_PRAMIPEXOLE SIV 0236587 PRAMIPEXOLE SIV 0236587 PRAMIPEXOLE SDZ ROPINIROLE HYDROCHLORIDE ***OLESMO TABLET** 0231686 ACT ROPINIROLE MPS 0231690 PMS-ROPINIROLE MPS 0231697 PRAMIPEXOLE MPS 0231698 APO_ROPINIROLE MPS 0231698 APO_ROPINIROLE MPS 0231698 ACT ROPINIROLE MPS 0231698 APO_ROPINIROLE MPS 0231699 APO_ROPI				NERVOUS SYSTEM AGENTS	
0.224218				ACAMPROSATE CALCIUM	
02399157 PRAMIPEXOLE SIV 02326837 PRAMIPEXOLE PDL 02316837 PRAMIPEXOLE SD2 alcohol addiction treatment program. **ROPINIROLE HYDROCHLORIDE** **JOJEMO TABLET** 0231848 ACT ROPINIROLE TEV 0231848 ACT ROPINIROLE APX 0235238 JAMP-ROPINIROLE PMS 023237740 APO-ROPINIROLE PMS 023237340 APO-ROPINIROLE PMS 023233740 APO-ROPINIROLE PMS 0235233 AMP-ROPINIROLE PMS 02352340 AVAR-ROPINIROLE PMS 02354037 AVAR-ROPINIROLE SAN 02352340 AVAR-ROPINIROLE APX 0236230 AVAR-ROPINI					
D23125377 AND PRAMIPEXOLE SDZ SDZ SDZ SDZ SDZ SANDOZ PRAMIPEXOLE SDZ SDZ SDZ SDZ SDZ SANDOZ PRAMIPEXOLE SDZ SDZ SDZ SDZ SDZ SANDOZ PRAMIPEXOLE SDZ				Elittled use betieft (prior approval required).	
## ROPINIROLE HYDROCHLORIDE **7 0.25MG TABLET **0.25MG TABLET **0.2316846** **ACT ROPINIROLE **0.2337746** **APC-ROPINIROLE **0.2337746** **APC-ROPINIROLE **0.2337746** **APC-ROPINIROLE **O.2337746** **APC-ROPINIROLE **O.2337746** **APC-ROPINIROLE **O.2337746** **APC-ROPINIROLE **O.2326590** **PAS-ROPINIROLE **O.2326590** **PAS-ROPINIROLE **O.2337804** **APC-ROPINIROLE **O.2337762** **APC-ROPINIROLE **O.2337763** **APC-ROPINIROLE **O.2337760** **APC-ROPINIROLE **O.2334633** **APC-ROPINIROLE **O.2334635** **APC-ROPINIROLE **O.2334635** **APC-ROPINIROLE **O.2334635** **APC-ROPINIROLE **O.2334635** **APC-ROPINIROLE **O.2334635** **APC-ROPINIROLE **O.2334635** **APC-ROPINIROLE **O.2334640** **APC-ROPINIROLE **O.2334605** **APC-ROPINIROLE **O.2334605** **APC-ROPINIROLE **O.2334605** **APC-ROPINIROLE **O.2334605** **APC-ROPINIROLE **O.2334606** **APC-ROPINIROLE **O.23467747* **APC-ROPINIROLE **O.23467747* **APC-ROPINIROLE **O.23467474* **O.23467474* **APC-ROPINIROLE **O.23467474* **O.					st
## Copinion of the composition o					
### 0.25MG TABLET 0.2316846 ACT ROPINIROLE 0.2337746 APO-ROPINIROLE 0.2337746 APO-ROPINIROLE 0.234037 APO-ROPINIROLE 0.234037 APO-ROPINIROLE 0.234037 RAN-ROPINIROLE 0.235040 ROPINIROLE 0.2316870 ACT ROPINIROLE 0.2317762 APO-ROPINIROLE 0.2337762 APO-ROPINIROLE 0.2337762 APO-ROPINIROLE 0.2337762 APO-ROPINIROLE 0.2336246 JAMP-ROPINIROLE 0.2336246 JAMP-ROPINIROLE 0.2314053 RAN-ROPINIROLE 0.2314053 RAN-ROPINIROLE 0.2316802 ROPINIROLE 0.2316802 ACT ROPINIROLE 0.2316802 ACT ROPINIROLE 0.2316802 ACT ROPINIROLE 0.2316802 ACT ROPINIROLE 0.2316803 RAN-ROPINIROLE 0.2316804 ACT ROPINIROLE 0.2316805 ROPINIROLE 0.2316806 ACT ROPINIROLE 0.2316806 RAN-ROPINIROLE 0.2316807 APO-ROPINIROLE 0.231804 RAN-ROPINIROLE 0.231804 RAN-ROPINIROLE 0.231804 RAN-ROPINIROLE 0.231804 RAN-ROPINIROLE 0.231805 RAN-ROPINIROLE 0.231805 RAN-ROPINIROLE 0.231805 RAN-ROPINIROLE 0.231805 RAN-ROPINIROLE 0.231805 RAN-ROPINIROLE 0.231806 ACT ROPINIROLE 0.231807 APO-ROPINIROLE 0.231808 APO-			SDZ	·	
O2316846 ACT ROPINIROLE TEV O2337746 APO-ROPINIROLE APX O2352349 JAMP-ROPINIROLE PMS POSITION PROPERTIES AND CONTRIBUTION OF THE APPX O236591 PMS-ROPINIROLE PMS PMS-ROPINIROLE PMS PMS-ROPINIROLE RBY O236594 RAN-ROPINIROLE SAN PMS-ROPINIROLE APX O236594 ACT ROPINIROLE APX O236684 ACT ROPINIROLE APX O236682 ACT ROPINIROLE APX O236683 ACT ROPINIR	ROPINIRO	DLE HTDROCHLORIDE		· · · · · · · · · · · · · · · · · · ·	
D2337746 APO-ROPINIROLE JMP D2336334 JAMP-ROPINIROLE JMP D234037 RAN-ROPINIROLE PMS D234037 RAN-ROPINIROLE SAN D234037 RAN-ROPINIROLE SAN D23404 ROPINIROLE SAN D23405 ACT ROPINIROLE PMS D23405 RAN-ROPINIROLE APX D23405 RAN-ROPINIROLE APX D23405 RAN-ROPINIROLE PMS D23405 RAN-ROPINIROLE RBY D23406 RAN-ROPINIROLE PMS D23406 RAN-ROPINIROLE RBY D23406 RAN-ROPINIROLE RBY D23406 RAN-ROPINIROLE RBY D23406 RAN-ROPINIROLE PMS D23406 RAN-ROPINIROLE RBY D23406 RAN-ROP					MYL
02326599 MbS-ROPINIROLE JMP For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria: Contraindication to stimulant medication; OR Potential risk of stimulant misuse or diversion; OR Po				ATOMOXETINE HYDROCHLORIDE	
PMS-ROPINIROLE				Limited use benefit (prior approval required).	
December Part Par				For the treatment of natients with Attention Deficit	
0233503040 ROPINIROLE RBY criteria:					1
OR				criteria:	
02316854 ACT ROPINIROLE TEV Contraindication to stimulant medication; OR Prescribed or recommended by a pediatrician or a psychiatrist.			SAN		
Potential risk of stimulant misuse or diversion; OR			TE\/		
02352346					
02326612					
02314053				psychiatrist.	
02353059 ROPINIROLE SAN 02358190 ATOMOXETINE AAP				10MG CAPSULE	
1				02318024 APO-ATOMOXETINE	APX
D2316862			SAN		
02337777			TEV		
02352354 JAMP-ROPINIROLE JMP 02471485 AURO-ATOMOXETINE AUR 0236620 PMS-ROPINIROLE PMS 02390469 DOM-ATOMOXETINE DPC 02314061 RAN-ROPINIROLE RBY 02381028 PMS-ATOMOXETINE PMS 02316078 PMS-ATOMOXETINE PMS 02316078 PMS-ATOMOXETINE PMS PMS-ROPINIROLE PMS PMS-ATOMOXETINE PMS PMS-ROPINIROLE PMS PMS-ATOMOXETINE PMS PMS-ATOMOXETINE PMS PMS-ROPINIROLE PMS PMS-ATOMOXETINE PMS PMS-ROPINIROLE PMS PMS-ATOMOXETINE PMS PMS-ROPINIROLE PMS PMS-ATOMOXETINE PMS PMS-ROPINIROLE PMS PMS-ATOMOXETINE PMS PM					_
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02314061 RAN-ROPINIROLE RBY 0239469 DOM-ATOMOXETINE DPC 57 5MG TABLET 02381028 PMS-ATOMOXETINE PMS 02316870 ACT ROPINIROLE TEV 02386410 SANDOZ ATOMOXETINE SDZ 02337800 APO-ROPINIROLE JMP 02314541 TEVA-ATOMOXETINE TEV 02326639 PMS-ROPINIROLE JMP 02314541 TEVA-ATOMOXETINE TEV 02314088 RAN-ROPINIROLE PMS 18MG CAPSULE TEV ROTIGOTINE RBY 02318032 APO-ATOMOXETINE APX ROTIGOTINE 02358204 ATOMOXETINE APX As an adjunct to levodopa for the treatment of patients with advanced stage Parkinson's disease; AND 02369912 ATOMOXETINE SIV As an adjunct to levodopa for the treatment with levodopa. 02467755 ATOMOXETINE SIV As an adjunct to levodopa for the treatment of patients with advanced stage Parkinson's disease; AND 02445905 ATOMOXETINE SIV Abayanced stage Parkinson's disease; AND 02467755 ATOMOXETINE AUR 0240393					
ST 5MG TABLET					
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2MG PATCH					
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8MG PATCH 25MG CAPSULE 02318040 APQ-ATOMOXETINE APX			LICE		
$02318040 \Delta PO_{-}\Delta TOMOXETINE \qquad \Delta PX$			OCB		
			UCB	02318040 APO-ATOMOXETINE	APX
02403943 NEUPRO UCB 02358212 ATOMOXETINE AAP	024039	TO INCOLLO	OOD	02358212 ATOMOXETINE	AAP

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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.

25MG CAPSULE

25MG CAPS	ULE	
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 CAPS	ULE	
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 CAPS	ULE	
02318067	APO-ATOMOXETINE	APX
02358239	ATOMOXETINE	AAP
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 CAPS	ULE	
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

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.

80MG CAPSULE

02279347	STRATTERA	LIL
02362511	TEVA-ATOMOXETINE	TEV
100MG CAP	SULE	
02318083	APO-ATOMOXETINE	APX
02358255	ATOMOXETINE	AAP
02467828	ATOMOXETINE	SAN
02404672	PMS-ATOMOXETINE	PMS
02422832	RIVA-ATOMOXETINE	RIV
02386488	SANDOZ ATOMOXETINE	SDZ
02279355	STRATTERA	LIL
02362538	TEVA-ATOMOXETINE	TEV

BETAHISTINE HYDROCHLORIDE

8MG TABLET

02449145	AURO-BETAHISTINE	AUR
02280183	TEVA-BETAHISTINE	TEV
16MG TABL	ET	
02449153	AURO-BETAHISTINE	AUR
02466449	BETAHISTINE	SAN
02330210	PMS-BETAHISTINE	PMS
02243878	SERC	BGP
02280191	TEVA-BETAHISTINE	TEV
24MG TABL	ET	
02449161	AURO-BETAHISTINE	AUR
02466457	BETAHISTINE	SAN
02330237	PMS-BETAHISTINE	PMS
02247998	SERC	BGP

TEV

DIMETHYL FUMARATE

Limited use benefit (prior approval required).

02280205 TEVA-BETAHISTINE

 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.

120MG CAPSULE (DELAYED RELEASE)

02404508 TECFIDERA UNK

240MG CAPSULE (DELAYED RELEASE)

02420201 TECFIDERA UNK

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28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

TETRABENAZINE

25MG TABLET

02407590	APO-TETRABENAZINE	APX
02199270	NITOMAN	VAE
02402424	PMS-TETRABENAZINE	PMS
02410338	TETRABENAZINE	RAX

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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) 36:26.00 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	(0.1)	ROD
	CADVANTAGE STRIP	
09853626	ACCU-CHEK ADVANTAGE	ROD
97799824		ROD
ACCU-CHE	(AVIVA STRIP	
09857178	ACCU-CHEK AVIVA	ROD
97799814		ROD
	COMPACT STRIP	
09854282	ACCU-CHEK COMPACT	ROD
97799962	ACCU-CHEK COMPACT	ROD
ACCU-CHE	(MOBILE STRIP	
09857452	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
09857422	BG STAR (ON)	SAC
CONTOUR N	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

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 LITE STRIP

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 STRI	P	
97799373	GE200	AUC
09857525	GE200 (ON)	AUC
ITEST STRIE	•	
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	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 STR	IP	
	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

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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-diabétic clients with rare conditions leading to symptomatic hypo or hyperglycemia will be allowed 800 test strips per 100 days.

TRUETRACK STRIP

 09857283
 TRUE TRACK
 AUC

 97799602
 TRUE TRACK
 HOD

36:60.00 DX - THYROID FUNCTION

THYROTROPIN ALFA

0.9MG/ML POWDER FOR SOLUTION

02246016 THYROGEN GEE

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);

- 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

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40:12.00 REPLACEMENT PREPARATIONS		40:12.00 RE	PLACEMENT PREPARATION	NS	
CALCIUM			CALCIUM, V	ITAMIN D	
ST 500MG CAPI	.ET		500MG & 1,0	000IU TABLET	
80001408	OYSTER SHELL CALCIUM	NUR	80066093	CALCIUM 500 VITAMINE D1000	UNK
80001122	PHARMA-CAL	PED	80018540	JAMP CALCIUM CARBONATE	JMP
ST 5ML LIQUID				VITAMIN D	
80004123	CARBOCAL	EUR	80019536	M CALCIUM VITAMINE D	MAN
ST 20MG/ML LIC	QUID		ST 500MG & 40	OIU TABLET	
80054754	M-CAL	MAN		CALCITE 500 D 400	RIV
80002626	SOLUCAL	JMP	80004969	CALCIUM 500 D 400	TRI
80006877	WAMPOLE MINERAL CALCIUM	WAM		CALCIUM 500 VITAMINE D400	UNK
ST 100MG LIQU	ID		80066089		UNK
80043628	NU-CAL	ODN	80002623		JMP
80025527	SOLUCAL GREEN APPLE	JMP	00047400	FLAVOUR	חחו
80025523	SOLUCAL RASPBERRY	JMP	80017190	CALODAN D 400	PDL
ST 500MG TABL	.ET			CALODAN D 400	ODN
00682039	APOCAL	APX		CARBOCAL D	EUR
80017732	CAL500	PDL	80002901		EUR
02240240	CALCIUM	PMT	99100832		JMP
02246040	CALCIUM	JMP	80002122	* * –	JMP
80003658	CALCIUM	WNP	80025360		JMP
80076097	CALCIUM	UNK	80013329		MAN
80003773	CALCIUM 500	TRI	80002703		ODN
80062015	CALCIUM CARBONATE	SAN		OPUS CAL D	OPU
02237352	EUROCAL	EUR	80065914		RIV
80055526	M-CAL	MAN		WAMPOLE CALCIUM VITAMIN D	WAM
00618098	NU-CAL	ODN	sτ 500MG & 80		
00622443	O-CALCIUM	VTH		M CALCIUM VITAMINE D	MAN
80079608	PROCAL 500	PDL		000IU TABLET (CHEWABLE)	
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)	IVIZALV
500MG TABL	LET (FILM COATED)			CALCIUM CARBONATE VITAMINE D	MAN
80066648	BIOCALCIUM	BMI		OIU TABLET (CHEWABLE)	1717 (14
CALCIUM GL	UCONATE,VIT D			WAMPOLE CALCIUM AND D	WAM
ST 25MCG LIQU	un.			0IU TABLET (FILM COATED)	
	SOLUCAL D FORT CITRUS	JMP		BIOCALCIUMD	ВМІ
	SOLUCAL D FORT GREEN APPLE	JMP	ELECTROLY		D.V.II
		JIVII			
CALCIUM, VI	I AIVIIN D		ST 5G/L LIQUID		
^{S™} 10MG CAPLI	ĒT			PEDIALYTE	ABB
80008566	PROCALD 400	PDL	ST MISCELLAN		
ST 500MG & 400	DIU CAPLET			HYDRALYTE ELECTROLYTE	HYD
80012594	BIOCALD FORTE	BMI	ST 3.56G & 300	MG & 470MG & 530MG POWDER	
ST 500MG LIQU	ID			GASTROLYTE REGULAR	SAC
80025543	SOLUCAL D CITRUS	JMP		OR SOLUTION	
80025541	SOLUCAL D RASPBERRY	JMP		HYDRALYTE ELECTROLYTE	HYD
^{S7} 500MG & 1,0	00IU LIQUID			JAMP REHYDRALYTE	JMP
	SOLUCAL D FORT	JMP	ST 0.856MG/ML		
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
	SOLUCAL D	JMP	02219883	PEDIATRIC ELECTROLYTE	PMS
ST 500MG& 800	IU LIQUID				
80025722	JAMP CALCIUM LACTOGLUCONATE VITAMIN D	JMP			

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40.40.00 DEDI ACEMENT DDEDADATIO	NO	40-40 00 DEDI ACEMENT DEEDADATIO	10
40:12.00 REPLACEMENT PREPARATIO	NS	40:12.00 REPLACEMENT PREPARATION	NS
MAGNESIUM		POTASSIUM CITRATE	
25MG CAPLET		1080MG LIQUID	
80005079 MAGNESIUM COMPLEX	JAM	80011529 POTASSIUM CITRATE	UNK
100MG TABLET		10MEQ TABLET	
80041590 JAMP-MAGNESIUM	JMP	80023817 JAMPKCITRATE	JMP
02068400 MAGNESIUM	JAM	ST 10MMOL TABLET	
MAGNESIUM GLUCOHEPTONATE		80026332 MK 10	MAN
ST 25MG LIQUID		ST 25MEQ TABLET (EFFERVESCENT)	
80009357 MAGNESIUM	JMP	80033602 JAMP-K EFFERVESCENT	JMP
ST 100MG/ML ORAL LIQUID	JIVIE	02085992 K LYTE	WPC
00026697 ROUGIER-MAGNESIUM	TEV	ST 25MMOL TABLET (EFFERVESCENT)	
ST 100MG/ML SOLUTION	Ι⊑V	80011428 EURO K	EUR
80004109 MAGNESIUM-ODAN	ODN	SODIUM CHLORIDE	
	ODIN	1G CAPSULE	
MAGNESIUM GLUCONATE		90726364 SODIUM CHLORIDE 1G	MDS
29MG TABLET		0.9% INJECTION	IVIDO
80062929 MMAGNESIUM GLUCONATE	MAN	99002329 SODIUM CHLORIDE (SMALL VOL.)	UNK
ST 500MG TABLET		0.9% SOLUTION	ONIX
80009539 JAMP MAGNESIUM GLUCONATE	JMP	00037818 BACTERIOSTATIC SODIUM	PFI
00555126 MAGLUCATE	PED	CHLORIDE	
POTASSIUM CHLORIDE		00037796 SODIUM CHLORIDE	PFI
ST 600MG CAPSULE		00060208 SODIUM CHLORIDE	BAX
80062704 JAMP POTASSIUM CHLORIDE ER	JMP	00402249 SODIUM CHLORIDE	OMG
02042304 MICRO K	PAL	02150204 SODIUM CHLORIDE	OMG
ST 1,500MG LIQUID	IAL	SYRINGE	
80024835 JAMP-POTASSIUM CHLORIDE	JMP	09991564 NACL SALINE PF	UNK
ST 1.33MEQ/ML SOLUTION	OWN	40:18.00 ION-REMOVING AGENTS	
02238604 PMS-POTASSIUM	PMS		
ST 8MMOL TABLET		SODIUM POLYSTYRENE SULFONATE	
00602884 APO-K	APX	ORAL LIQUID	
02246734 EURO K	EUR	01902776 KAYEXALATE	SAC
80035346 MK 8	MAN	40:18.18 POTASSIUM - REMOVING	
02244068 RIVA-K 8	RIV	AGENTS	
ST 20MMOL TABLET		CALCIUM POLYSTYRENE SULFONATE	
80026265 BIO K-20 POTASSIUM	BMI	CALCIUM FOLTST TREME SULFONATE	
02242261 EURO K	EUR	1G POWDER FOR SOLUTION	
80013007 JAMP K	JMP	02017741 RESONIUM CALCIUM	SAC
80004415 ODAN K20	ODN	SODIUM POLYSTYRENE SULFONATE	
02243975 RIVA-K 20	RIV	1G POWDER	
ST 780MG TABLET		02026961 KAYEXALATE	SAC
80025624 MK 20	MAN	00765252 K-EXIT	OMG
ST 8MMOL TABLET (EXTENDED RELEASE)		00755338 SOLYSTAT	PED
80013005 JAMP-K 8	JMP	1G POWDER FOR SUSPENSION	
ST 600MG TABLET (EXTENDED RELEASE)		02473941 ODAN-SODIUM POLYSTYRENE	ODN
80008214 ODAN K8	ODN	SULFONATE	
20MEQ TABLET (FILM COATED), EXTENDED REL	EASE	250MG SUSPENSION	
80071412 MK20 SOLUBLE	MAN	02473968 ODAN-SODIUM POLYSTYRENE	ODN
ST 600MG TABLET (SUGAR COATED)		SULFONATE	
80040226 SLOWK	NVR	250MG/ML SUSPENSION	
ST 780MG TABLET (TIME RELEASE)		00769541 SOLYSTAT	PED
80040412 K20 POTASSIUM	UNK		
ST 1,500MG TABLET (TIME RELEASE)			
80040416 PHARMA-K20	PMS		
80053887 PRO-K 20	PDL		

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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

500MG TABLET (CHEWABLE)

02471574 VELPHORO

UNK

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 advnamic 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	UNK
500MG TAB	LET (CHEWABL	.E)
02287153	FOSRENOL	UNK
750MG TAB	LET (CHEWABL	.E)
02287161	FOSRENOL	UNK

02287161 FOSRENOL

1000MG TABLET (CHEWABLE)

02287188 FOSRENOL

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

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

800MG TABLET

02244310 RENAGEL

SAC

MIN

40:20.00 CALORIC AGENTS **GLUCOSE**

TABLET

BTD 97799899 BD GLUCOSE

4G TABLET

UNK 09991092 DEX-4 GLUCOSE

LEVOCARNITINE

Limited use benefit (prior approval required).

For treatment of carnitine deficiency.

100MG/ML SOLUTION

02144336 CARNITOR UNK

200MG/ML SOLUTION

02144344 CARNITOR UNK

330MG TABLET

02144328 CARNITOR UNK

40:28.08 LOOP DIURETICS

ETHACRYNIC ACID

ST 25MG TABLET

02258528 EDECRIN VAE

FUROSEMIDE

ST 10MG/ML SOLUTION

02224720 LASIX SAC ST 20MG TABLET

APO FUROSEMIDE 00396788 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 TABLET

02466767

00362166 APO FUROSEMIDE **APX** 02247372 **BIO-FUROSEMIDE** BMI 00397792 **FUROSEMIDE PDL** 02351439 **FUROSEMIDE** SAN

MINT-FUROSEMIDE

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40:28.08 LO	OP DIURETICS		40:28.20 TIAZIDE DIURETICS	
FUROSEMIDE		SPIRONOLACTONE, HYDROCHLOROTHIA	ZIDE	
ST 40MG TABL	ET		ST 50MG & 50MG TABLET	
	PMS-FUROSEMIDE	PMS	00594377 ALDACTAZIDE	PFI
	TEVA-FUROSEMIDE	TEV	00657182 TEVA-SPIRONOLACTONE/HCTZ	TEV
ST 80MG TABL	ET		40:28.24 THIAZIDE LIKE DIURETICS	
00707570	APO FUROSEMIDE	APX		
00667080	FUROSEMIDE	PDL	CHLORTHALIDONE	
02351447	FUROSEMIDE	SAN	ST 50MG TABLET	
02466775	MINT-FUROSEMIDE	MIN	00360279 CHLORTHALIDONE	AAP
	TEVA-FUROSEMIDE	TEV	INDAPAMIDE	
ST 500MG TAB			ST 1.25MG TABLET	
	LASIX SPECIAL	SAC	02245246 APO-INDAPAMIDE	APX
40:28.16 PO	TASSIUM SPARING DIURE	TICS .	02373904 JAMP-INDAPAMIDE	JMP
AMILORIDE			02179709 LOZIDE	SEV
ST 5MG TABLE	т		02240067 MYLAN-INDAPAMIDE	MYL
	MIDAMOR	AAP	sr 2.5MG TABLET	
AMILORIDE.	HYDROCHLOROTHIAZIDE		02223678 APO-INDAPAMIDE	APX
ŕ			02373912 JAMP-INDAPAMIDE	JMP
ST 5MG & 50MC		APX	00564966 LOZIDE 02153483 MYLAN-INDAPAMIDE	SEV MYL
	AA-AMILZIDE AMI-HYDRO	PDL	02312549 PRO-INDAPAMIDE	PDL
	NOVAMILOR	TEV	METOLAZONE	PDL
	NE, HYDROCHLOROTHIAZIDE	I L V		
	•		ST 2.5MG TABLET	
ST 50MG & 25Ν			00888400 ZAROXOLYN	SAC
	APO TRIAZIDE	APX	40:36.00 IRRIGATING SOLUTIONS	
	TEVA-TRIAMTERENE/HCTZ	TEV	SODIUM CHLORIDE	
40:28.20 TIA	ZIDE DIURETICS		0.9% SOLUTION	
HYDROCHLO	DROTHIAZIDE		00801267 SODIUM CHLORIDE	UNK
ST 12.5MG TAB	LET		40:40.00 URICOSURIC AGENTS	• • • • • • • • • • • • • • • • • • • •
02327856	APO-HYDRO	APX		
02425947	MINT-HYDROCHLOROTHIAZIDE	MIN	SULFINPYRAZONE	
02274086	PMS-HYDROCHLOROTHIAZIDE	PMS	200MG TABLET	
ST 25MG TABL	ET		00441767 SULFINPYRAZONE	AAP
00326844	APO HYDRO	APX	40:50.00 IRRIGATING SOLUTIONS	
	BIO-HYDROCHLOROTHIAZIDE	BMI	WATER	
02360594	HYDROCHLOROTHIAZIDE	SAN	100% SOLUTION	
02426196	MINT-HYDROCHLOROTHIAZIDE	MIN	00038202 BACTERIOSTATIC WATER	PFI
02247386	PMS-HYDROCHLOROTHIAZIDE	PMS TEV	00402257 STERILE WATER	OMG
ουο2 1474 ST 50MG TABL I	TEVA-HYDROCHLOROTHIAZIDE	IEV	02142546 STERILE WATER	PFI
	APO HYDRO	APX		
02247171	BIO-HYDROCHLOROTHIAZIDE	BMI		
	HYDROCHLOROTHIAZIDE	SAN		
	PMS-HYDROCHLOROTHIAZIDE	PMS		
00021482	TEVA-HYDROCHLOROTHIAZIDE	TEV		
ST 100MG TAB	LET			
00644552	APO HYDRO	APX		
$^{s\tau}$ PDIN FOR E	XTEMPORANEOUS MIXTURE			
99503000	HYDROCHLOROTHIAZIDE ORAL LIQUID	UNK		
	CTONE, HYDROCHLOROTHIA	ZIDE		
s [™] 25MG & 25N				
	ALDACTAZIDE	PFI		
00613231	TEVA-SPIRONOLACTONE/HCTZ	TEV		

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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:

- 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.

100MG CAPSULE 02443066 OFEV **150MG CAPSULE**

02443074 OFEV

BOE

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;
- · 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 02376695 DOM-MONTELUKAST

IUNG IADL	- !	
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
02373947	PMS-MONTELUKAST	PMS
02389517	RAN-MONTELUKAST	RBY
02398826	RIVA-MONTELUKAST	RIV
02328593	SANDOZ MONTELUKAST	SDZ
02238217	SINGULAIR	FRS
02355523	TEVA-MONTELUKAST	TEV
4MG TABLE	T (CHEWABLE)	
02377608	APO-MONTELUKAST	APX
02422867	AURO-MONTELUKAST	AUR
02442353	JAMP-MONTELUKAST	JMP
02399865	MAR-MONTELUKAST	MAR
02408627	MINT-MONTELUKAST	MIN
02379317	MONTELUKAST	SAN
02379821	MONTELUKAST	PDL
02382458	MONTELUKAST	SIV
02354977	PMS-MONTELUKAST	PMS
02402793	RAN-MONTELUKAST	RBY
02330385	SANDOZ MONTELUKAST	SDZ
02243602	SINGULAIR	FRS
02355507	TEVA-MONTELUKAST	TEV
5MG TABLE	T (CHEWABLE)	
02377616	APO-MONTELUKAST	APX
02422875	AURO-MONTELUKAST	AUR
02442361	JAMP-MONTELUKAST	JMP
02399873	MAR-MONTELUKAST	MAR
02408635	MINT-MONTELUKAST	MIN
02379325	MONTELUKAST	SAN
02379848	MONTELUKAST	PDL
02382466	MONTELUKAST	SIV
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

100MG CAPSULE 00500895 NALCROM

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

2% NASAL SPRAY

APX 02231390 APO-CROMOLYN 01950541 RHINARIS-CS PED 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

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

0.5MG TABLET

02412764 ADEMPAS

02412810 ADEMPAS

1MG TABLE	Т	
02412772	ADEMPAS	BAY
1.5MG TABL	.ET	
02412799	ADEMPAS	BAY
2MG TABLE	Т	
02412802	ADEMPAS	BAY
2.5MG TABL	.ET	

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.

200MCG TABLET 02451158 UPTRAVI JSO **400MCG TABLET** JSO 02451166 UPTRAVI **600MCG TABLET** 02451174 UPTRAVI JSO **800MCG TABLET** 02451182 UPTRAVI JSO 1000MCG TABLET 02451190 UPTRAVI JSO 1200MCG TABLET 02451204 UPTRAVI JSO 1400MCG TABLET JSO 02451212 UPTRAVI **1600MCG TABLET** 02451220 UPTRAVI JSO

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).

 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

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 THROAT (EENT)		52:04.04 EENT - ANTIBACTERIALS GATIFLOXACIN	
52:02.00 EENT - ANTIALLERGIC AGEN	ITS	0.3% SOLUTION	
CROMOLYN SODIUM		02257270 ZYMAR	ALL
		MOXIFLOXACIN HYDROCHLORIDE	
2% OPHTHALMIC SOLUTION 02009277 CROMOLYN	PED	Limited use benefit (prior approval not required).	
02230621 OPTICROM	ALL	Coverage will be limited to 14 tablets every 14 days, follower	d
KETOTIFEN FUMARATE	ALL	by a 14 day lockout.	
		0.5% SOLUTION	
0.25MG SOLUTION	JMP	02472120 JAMP-MOXIFLOXACIN	JMP
02489651 JAMP-KETOTIFEN 02400871 KETOTIFEN	RAX	MOXIFLOXACIN HYDROCHLORIDE	
LEVOCABASTINE HYDROCHLORIDE	TVV	(OPHTHALMIC)	
		0.5% SOLUTION	
0.05% NASAL SPRAY 02020017 LIVOSTIN	180	02404656 ACT MOXIFLOXACIN	ACG
LODOXAMIDE TROMETHAMINE	JSO	02406373 APO-MOXIFLOXACIN	APX
		02432218 PMS-MOXIFLOXACIN	PMS
0.1% SOLUTION		02411520 SANDOZ MOXIFLOXACIN	SDZ
00893560 ALOMIDE	NVR	02252260 VIGAMOX	NVR
OLOPATADINE HYDROCHLORIDE		OFLOXACIN	
0.1% OPHTHALMIC SOLUTION		0.3% SOLUTION	
02403986 ACT OLOPATADINE	ACG	02248398 APO-OFLOXACIN	APX
02305054 APO-OLOPATADINE	APX	02143291 OCUFLOX	ALL
02422727 MINT-OLOPATADINE	MIN NVR	POLYMYXIN B SULFATE, BACITRACIN ZINC	
02233143 PATANOL 02358913 SANDOZ OLOPATADINE	SDZ	500IU & 10,000IU/G OINTMENT	
0.2% OPHTHALMIC SOLUTION	SDZ	02160889 OPTIMYXIN	SDZ
02404095 ACT OLOPATADINE	ACG	02239157 POLYSPORIN	JAJ
02402823 APO-OLOPATADINE	APX	POLYMYXIN B SULFATE, GRAMICIDIN	
02420171 SANDOZ OLOPATADINE	SDZ	0.025MG & 10,000U/ML DROP	
0.1% SOLUTION		00701785 OPTIMYXIN	SDZ
02458411 JAMP-OLOPATADINE	JMP	02239156 POLYSPORIN EYE AND EAR	JAJ
52:04.04 EENT - ANTIBACTERIALS		POLYMYXIN B SULFATE, TRIMETHOPRIM	
CIPROFLOXACIN HYDROCHLORIDE		SULFATE	
0.3% OINTMENT		10,000U & 1MG/ML SOLUTION	
02200864 CILOXAN	NVR	02240363 PMS-POLYTRIMETHOPRIM	PMS
0.3% SOLUTION		02011956 POLYTRIM	ALL
02263130 APO-CIPROFLOX	APX	02239234 SANDOZ POLYTRIMETHOPRIM	SDZ
01945270 CILOXAN	NVR	TOBRAMYCIN (OPHTHALMIC)	
02387131 SANDOZ CIPROFLOXACIN	SDZ	0.3% OINTMENT	
CIPROFLOXACIN HYDROCHLORIDE,		00614254 TOBREX	NVR
DEXAMETHASONE		0.3% SOLUTION	007
0.3%/0.1% SUSPENSION		02241755 SANDOZ TOBRAMYCIN 00513962 TOBREX	SDZ NVR
02252716 CIPRODEX	NVR	52:04.20 EENT - ANTIVIRALS	INVIX
ERYTHROMYCIN			
5MG OINTMENT		TRIFLURIDINE	
00641324 ODAN-ERYTHROMYCIN	ODN	1% SOLUTION	
5MG/G OINTMENT		00687456 VIROPTIC	VAE
02326663 ERYTHROMYCIN	STG	52:04.92 EENT - MISCELLANEOUS ANTI-	
01912755 PDP-ERYTHROMYCIN	PED	INFECTIVES	
FUSIDIC ACID		CHLORHEXIDINE GLUCONATE	
1% DROP		0.12% MOUTHWASH	
02243862 FUCITHALMIC	AMD	02462842 CHLORHEXIDINE	EUR

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			-
52:04.92 EENT - MISCELLANEOUS ANTI-	52:08.08 EENT - CORTICOSTEROIDS		
INFECTIVES	FLUTICASONE FUROATE		
CHLORHEXIDINE GLUCONATE		200MCG POWDER	
0.12% MOUTHWASH		02446588 ARNUITY ELLIPTA	GSK
02384272 GUM PAROEX	SUS	FLUTICASONE PROPIONATE	
02240433 PERICHLOR	PED	50MCG PUMP	
02237452 PERIDEX	MAK	02453738 TEVA-FLUTICASONE	TEV
52:08.00		50MCG/DOSE SPRAY	
FLUTICASONE PROPIONATE		02294745 APO-FLUTICASONE	APX
50MCG SPRAY		02296071 RATIO-FLUTICASONE	TEV
02248307 FLONASE ALLERGY RELIEF	GSK	FRAMYCETIN SULFATE, GRAMICIDIN,	
52:08.08 EENT - CORTICOSTEROIDS	OOK	DEXAMETHASONE	
		5MG & 0.05MG/ML & 0.5MG DROP	
BECLOMETHASONE DIPROPIONATE		02224623 SOFRACORT EAR/EYE	SAC
50MCG/DOSE NASAL SPRAY		MOMETASONE FUROATE	
02238796 APO-BECLOMETHASONE	APX		
02172712 MYLAN-BECLO AQ	MYL	50MCG SPRAY	ADV
BUDESONIDE		02403587 APO-MOMETASONE 02238465 NASONEX	APX FRS
100MCG/DOSE POWDER		02475863 TEVA-MOMETASONE	TEV
02035324 RHINOCORT TURBUHALER	AZC	500MCG/ML SPRAY	1_1
64MCG/DOSE SPRAY		02449811 SANDOZ MOMETASONE	SDZ
02241003 MYLAN-BUDESONIDE AQ	MYL	PREDNISOLONE ACETATE	
02231923 RHINOCORT AQUA	MCL		
100MCG/DOSE SPRAY		0.12% DROP	
02230648 MYLAN-BUDESONIDE AQ	MYL	00299405 PRED MILD	ALL
DEXAMETHASONE		1% DROP 00301175 PRED FORTE	ALL
0.1% OINTMENT		1% SUSPENSION	ALL
00042579 MAXIDEX	NVR	01916203 SANDOZ PREDNISOLONE	SDZ
0.1% SUSPENSION		00700401 TEVA-PREDNISOLONE	TEV
00042560 MAXIDEX	NVR	PREDNISOLONE ACETATE, SULFACETAMID	E
DEXAMETHASONE PHOSPHATE		SODIUM	_
0.1% SOLUTION		0.2% & 10% DROP	
02023865 DEXAMETHASONE	UNK	0.2% & 10% DROP 00807788 BLEPHAMIDE	ALL
00785261 PMS-DEXAMETHASONE	PMS	0.5% & 10% SUSPENSION	ALL
DEXAMETHASONE, TOBRAMYCIN		02023814 PREDNISOLONE/SULFACETAMIDE	UNK
0.1% & 0.3% OINTMENT		PREDNISOLONE SODIUM PHOSPHATE	O. u.
0.1% & 0.3% CINTMENT 00778915 TOBRADEX	NVR		
0.1% & 0.3% SUSPENSION	INVIX	0.5% DROP	\
00778907 TOBRADEX	NVR	02148498 MINIMS PREDNISOLONE	VAE
FLUMETHASONE PIVALATE, CLIOQUINOL		TRIAMCINOLONE ACETONIDE	
		55MCG SPRAY	
0.02% & 1% DROP	DAI	02437635 APO-TRIAMCINOLONE AQ	APX
00074454 LOCACORTEN VIOFORM	PAL	55MCG/DOSE SPRAY	
FLUOROMETHOLONE		02213834 NASACORT AQ	SAC
0.1% DROP		52:08.20 EENT - NONSTEROIDAL ANTI-	
00247855 FML	ALL	INFLAMMATORY AGENTS	
0.1% SUSPENSION		DICLOFENAC SODIUM	
00756784 FLAREX	NVR	0.1% SOLUTION	
00432814 SANDOZ FLUOROMETHOLONE	SDZ	01940414 VOLTAREN OPHTHA	NVR
FLUTICASONE FUROATE		5.5.5 152EN 01.11111	
100MCG POWDER			
02446561 ARNUITY ELLIPTA	GSK		

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	NT - NONSTEROIDAL ANTI-			EENT - MYDRIATICS	
	FLAMMATORY AGENTS		PHENYLE	EPHRINE HYDROCHLORIDE	
	C SODIUM (TOPICAL)		2.5% DF	ROP	
Limited use bene	fit (prior approval required).			100 PHENYLEPHRINE	UNK
	t of osteoarthritis when:		10% DR	OP 455 MINIMS PHENYLEPHRINE	VAE
	ately controlled with acetaminophen AND a i-inflammatory (NSAID); OR		TROPICA		VAL
· there is contrain	ndication to acetaminophen and NSAID; OR				
 there is intolera 	nce to acetaminophen and NSAID.			DLUTION 981 MYDRIACYL	ALC
0.1% SOLUT			1% SOL	•••	ALC
	APO-DICLOFENAC SANDOZ DICLOFENAC OPHTHA	APX SDZ		007 MYDRIACYL	ALC
	C TROMETHAMINE	SDZ	52:28.00	EENT - MOUTHWASHES AND	
				GARGLES	
0.45% SOLU 02369362		ALL	BENZYD	AMINE HYDROCHLORIDE	
0.5% SOLUT		ALL		benefit (prior approval required).	
01968300		ALL			
02245821	APO-KETOROLAC	AAP		atment of radiation mucositis and oral ulcerative as of chemotherapy.	
NEPAFENAC			• For use in	immunocompromised patients who are at risk of	
0.1% SUSPE	NSION		mucosal bre		
02308983	NEVANAC	NVR		MOUTHWASH 044 APO-BENZYDAMINE	APX
0.3% SUSPE				777 PHARIXIA	PED
02411393		NVR		537 PMS-BENZYDAMINE	PMS
	NT - CONTACT LENS		52:32.00	EENT - VASOCONSTRICTORS	
	LUTION		EPINEPH	RINE	
HYDROXYPE	ROPYLMETHYLCELLULOSE			_ SOLUTION	
3MG SOLUT				365 ADRENALIN	ERF
	GENTEAL	ALC	NAPHAZO	OLINE HYDROCHLORIDE	
	NT - LOCAL ANESTHETICS		0.1% DF	ROP	
LIDOCAINE I	HYDROCHLORIDE			147 ALBALON	ALL
2% SOLUTIO			52:40.04	EENT - ALPHA-ADRENERGIC	
	XYLOCAINE VISCOUS	UNK		AGONISTS	
52:24.00 EE	NT - MYDRIATICS		BRIMONI	DINE TARTRATE	
ATROPINE S	ULFATE		0 15% S	SOLUTION	
1% SOLUTIO	ON			151 ALPHAGAN P	ALL
	ATROPINE	UNK	023013	334 BRIMONIDINE P	AAP
	ISOPTO ATROPINE	ALC		DLUTION	
	MINIMS ATROPINE OLATE HYDROCHLORIDE	VAE		876 ALPHAGAN	ALL
	OLATE HTDROCHLORIDE			077 APO-BRIMONIDINE 284 PMS-BRIMONIDINE	APX PMS
0.5% DROP	MINIMO OVOLODENTOLATE	\/A.E		429 SANDOZ BRIMONIDINE	SDZ
02148331 1% DROP	MINIMS CYCLOPENTOLATE	VAE	TIMOLOL	MALEATE, BRIMONIDINE TARTRAT	ΓΕ
	CYCLOGYL	ALC		0.5% SOLUTION	
02023644	CYCLOPENTOLATE	UNK		347 COMBIGAN	ALL
02148382	MINIMS CYCLOPENTOLATE	VAE	52:40.08	EENT - BETA-ADRENERGIC	
DIPIVEFRIN	HYDROCHLORIDE			BLOCKING AGENTS	
0.1% LIQUID)		BETAXO	LOL HYDROCHLORIDE	
	APO-DIPIVEFRIN	APX		OPHTHALMIC SOLUTION	
PHENYLEPH	RINE HYDROCHLORIDE			448 BETOPTIC S	NVR
2.5% DROP					
	MINIMS PHENYLEPHRINE	VAE			
00465763	MYDFRIN	ALC			

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		Non modred riculti Benen	10
52:40.08 EENT - BETA-ADRENERGIC BLOCKING AGENTS	52:40.12 EENT - CARBONIC ANHYDRASE INHIBITORS		
LEVOBUNOLOL HYDROCHLORIDE	DORZOLAMIDE HYDROCHLORIDE, TIMOLOL		
		MALEATE	
0.25% OPHTHALMIC SOLUTION	ADV	AND A THOUSE ADULTION	
02241575 APO-LEVOBUNOLOL	APX	20MG & 5MG/ML OPHTHALMIC SOLUTION	DN 40
0.5% OPHTHALMIC SOLUTION	A 1 1		PMS
00637661 BETAGAN	ALL		RIV
TIMOLOL MALEATE			SDZ
0.25% OPHTHALMIC GEL SOLUTION		METHAZOLAMIDE	
02242275 TIMOLOL MALEATE-EX	SDZ	50MG TABLET	
0.5% OPHTHALMIC GEL SOLUTION		02245882 METHAZOLAMIDE	AAP
02242276 TIMOLOL MALEATE-EX	SDZ	52:40.20 EENT - MIOTICS	
00451207 TIMOPTIC	PFR	CARBACHOL	
0.25% OPHTHALMIC SOLUTION		CARBACTIOE	
00755826 APO-TIMOP	APX	0.01% OPHTHALMIC SOLUTION	
02238770 DOM-TIMOLOL	DPC		ALC
02083353 PMS-TIMOLOL	PMS	PILOCARPINE HYDROCHLORIDE	
0.5% OPHTHALMIC SOLUTION		2% OPHTHALMIC SOLUTION	
00755834 APO-TIMOP	APX		NVR
02238771 DOM-TIMOLOL	DPC	4% OPHTHALMIC SOLUTION	
02447800 JAMP-TIMOLOL	JMP	00000884 ISOPTO CARPINE	NVR
02083345 PMS-TIMOLOL	PMS	02023733 PILOCARPINE	UNK
02166720 SANDOZ TIMOLOL	SDZ	PILOCARPINE NITRATE	
0.5% SOLUTION (EXTENDED RELEASE)	DED		
02171899 TIMOPTIC-XE	PFR -	2% DROP	VAE
52:40.12 EENT - CARBONIC ANHYDRASE	Ξ.		VAE
INHIBITORS		52:40.28 EENT - PROSTAGLANDIN	
ACETAZOLAMIDE		AGENTS	
250MG TABLET		BIMATOPROST	
00545015 ACETAZOLAMIDE	AAP	0.01% OPHTHALMIC SOLUTION	
BRINZOLAMIDE	, , , ,		ALL
			ALL
1% SUSPENSION			ALL
02238873 AZOPT	NVR	0.03% OPHTHALMIC SOLUTION	
BRINZOLAMIDE, BRIMONIDINE TARTRATE		02429063 VISTITAN	SDZ
1% & 0.2% SUSPENSION		LATANOPROST	
02435411 SIMBRINZA	NVR	0.0050/ 0.01 1.1710.11	
BRINZOLAMIDE, TIMOLOL MALEATE		0.005% SOLUTION	A DV
1%/0.5% SUSPENSION		02296527 APO-LATANOPROST 02373041 GD-LATANOPROST	APX PFI
.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	NIV/D		3MP
02331624 AZARGA	NVR		PMS
DORZOLAMIDE HYDROCHLORIDE			RIV
2% OPHTHALMIC SOLUTION			SDZ
02216205 TRUSOPT	FRS		TEV
02269090 TRUSOPT	FRS	02231493 XALATAN	PFI
20MG/ML OPHTHALMIC SOLUTION		LATANOPROST, TIMOLOL MALEATE	
02316307 SANDOZ DORZOLAMIDE	SDZ	·	
DORZOLAMIDE HYDROCHLORIDE, TIMOLOI	_	0.005% & 0.5% SOLUTION	
MALEATE			ACG
20MG & 5MG OPHTHALMIC SOLUTION			APX
02437686 MED-DORZOLAMIDE-TIMOLOL	GMP	02373068 GD-LATANOPROST/TIMOLOL	PFI
			≥MS
	GIVIF		
20MG & 5MG/ML OPHTHALMIC SOLUTION		02394685 SANDOZ LATANOPROST/TIMOLOL	SDZ
20MG & 5MG/ML OPHTHALMIC SOLUTION 02404389 ACT DORZOTIMOLOL	TEV		
20MG & 5MG/ML OPHTHALMIC SOLUTION 02404389 ACT DORZOTIMOLOL		02394685 SANDOZ LATANOPROST/TIMOLOL	SDZ

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52:40.28 EENT - PROSTAGLANDIN AGENTS		52:92.00 MISCELLANEOUS EENT DRUGS MACROGOL, PROPYLENE GLYCOL
TIMOLOL MALEATE, TRAVOPROST		15% & 20% GEL
0.5% & 0.004% SOLUTION		02352699 RHINARIS NASAL PEI
02415305 APO-TRAVOPROST-TIMOP	APX	00551805 SECARIS PEI
02278251 DUOTRAV PQ	NVR	15% & 20% SPRAY
02413817 SANDOZ TRAVOPROST / TIMOLOL	SDZ	00732230 LUBRICATING NASAL MIST PMS
PQ		02354551 RHINARIS NASAL MIST PEI
TRAVOPROST		MINERAL OIL, WHITE PETROLATUM
0.003% SOLUTION		55.5% & 42.5% OINTMENT
02457997 IZBA	NVR	00210889 REFRESH LACRI-LUBE ALI
0.004% SOLUTION	ADV	PETROLATUM, MINERAL OIL
02415739 APO-TRAVOPROST Z 02413167 SANDOZ TRAVOPROST	APX SDZ	80% & 20% OINTMENT
02412063 TEVA-TRAVOPROST Z	TEV	02125706 SOOTHE NIGHT TIME BSH
02318008 TRAVATAN Z	NVR	POLYVINYL ALCOHOL
TRAVOPROST-TIMOLOL		1.4% OPHTHALMIC SOLUTION
0.0040.5/% OPHTHALMIC SOLUTION		02229570 ARTIFICIAL TEARS PEI
09857513 DUOTRAV PQ OP	ALC	00579408 TEARS PLUS ALI
52:92.00 MISCELLANEOUS EENT DRUGS		RANIBIZUMAB
AFLIBERCEPT		Limited use benefit (prior approval required).
Limited use benefit (prior approval required).		For the treatment of: Diabetic Macular Edema (DME)
For the treatment of:		Wet Age-Related Macular Degeneration (w-AMD)
Diabetic Macular Edema (DME)		Retinal Vein Occlusion (RVO) Choroidal Neovascularization secondary to pathologic myopia
Wet Age-Related Macular Degeneration (w-AMD) Retinal Vein Occlusion (RVO)		(mCNV)
(Please refer to Appendix A).		(Please refer to Appendix A).
40MG SOLUTION		10MG/ML SOLUTION
02415992 EYLEA	BAY	02296810 LUCENTIS NVF
ANETHOLE TRITHIONE		02425629 LUCENTIS PFS NVF
ST 25MG TABLET		SODIUM CARBOXYMETHYL CELLULOSE
02240344 SIALOR	PMS	0.5% DROP
APRACLONIDINE HYDROCHLORIDE		02049260 REFRESH PLUS ALI
0.5% OPHTHALMIC SOLUTION		02231008 REFRESH TEARS ALI
02076306 IOPIDINE	NVR	1% DROP 00870153 REFRESH CELLUVISC ALI
DEXTRAN 70,		00870153 REFRESH CELLUVISC ALI 10MG/ML SOLUTION
HYDROXYPROPYLMETHYLCELLULOSE		02244650 REFRESH LIQUIGEL ALI
0.1% & 0.3% DROP		SODIUM CHLORIDE
01943308 TEARS NATURALE FREE	ALC	
00743445 TEARS NATURALE II	ALC	9MG/ML NASAL DROPS 80024901 SALINEX SD2
HYDROXYPROPYL CELLULOSE		5% OINTMENT
5MG INSERT		00750816 MURO 128 BSF
02250624 LACRISERT	ATO	5% OPHTHALMIC OINTMENT
HYDROXYPROPYLMETHYLCELLULOSE	70	80046696 ODAN SODIUM CHLORIDE ODN
0.5% SOLUTION		5% SOLUTION
00000809 ISOPTO TEARS	ALC	00750824 MURO 128 BSH
1% SOLUTION		80046737 ODAN-SODIUM CHLORIDE ODN
00000817 ISOPTO TEARS	ALC	9MG/ML SPRAY 80024381 SALINEX SD2
MACROGOL, PROPYLENE GLYCOL		SDZ
•		
15% & 20% GEL		

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52:92.00 MISCELLANEOUS EENT DRUGS VERTEPORFIN

Limited use benefit (prior approval required).

For treatment of age related macular degeneration for patients with this diagnosis who are being treated by a certified ophthalmologist.

15MG/VIAL POWDER FOR SOLUTION

02242367 VISUDYNE

VAE

WHITE PETROLATUM, LANOLIN, MINERAL OIL

94% & 3% & 3% OINTMENT

02444062 SYSTANE

ALC

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56:00 GASTROINTESTINAL DRUGS		56:12.00 CATHARTICS AND LAXATIVES	<u> </u>
		BISACODYL	
56:04.00 ANTACIDS AND ADSORBENTS		2.0.1.0 02 . 2	
BISMUTH SUBSALICYLATE		ST 5MG TABLET (DELAYED RELEASE)	
Limited use benefit (prior approval not required).			APX DN
Coverage will be limited to 8 tablets a day every 14 days,			אטי
followed by a 28 day lockout; OR		CITRIC ACID, MAGNESIUM OXIDE, SODIUM PICOSULFATE	
Coverage will be limited to 120mL a day every 14 days, followed by a 28 day lockout.		ST 12G & 3.5G & 10MG POWDER FOR SOLUTION	
262MG CAPLET			FEI
00245730 BISMUTH	JMP	GLYCERINE	אטי
17.6MG/ML SUSPENSION	• • • • • • • • • • • • • • • • • • • •		
02097079 PEPTO-BISMOL	PGI	ADULT SUPPOSITORY	
262MG TABLET			TEV
02326582 BISMUTH SUBSALICYLATE	UNK		/PC TEV
02177994 PEPTO BISMOL	PGI		JMP
MAGNESIUM OXIDE		PEDIATRIC SUPPOSITORY	IVII
420MG TABLET			ΤΕV
00299448 MAGNESIUM OXIDE	VAE		/PC
80082915 MAGNESIUM OXIDE	JMP	CHILDREN	
835MG TABLET		MACROGOL, POTASSIUM CHLORIDE, SODIUM	1
00689785 HI POTENCY MAGNESIUM OXIDE	SWS	BICARBONATE, SODIUM CHLORIDE, SODIUM	
80082435 MAGNESIUM OXIDE	JMP	SULFATE	
SODIUM BICARBONATE		ST 60G & 750MG & 1.68G & 1.46G & 5.68G/L SOLUTION	
325MG TABLET		00652512 GOLYTELY E	3TU
80072247 SODIUM BICARBONATE	MDS	00777838 PEGLYTE F	PED
56:08.00 ANTIDIARRHEA AGENTS		MAGNESIUM CITRATE	
LOPERAMIDE HYDROCHLORIDE		ST 5.40% SOLUTION	
			ΓEV
0.2MG/ML SOLUTION	DMC	ST 50MG/ML SOLUTION	
02016095 PMS-LOPERAMIDE ST 2MG/15ML SOLUTION	PMS	80001809 CITRODAN O	DN
02291800 IMODIUM CALMING	MCL	MAGNESIUM HYDROXIDE	
ST 2MG TABLET	WICL	ST 80MG/ML LIQUID	
02212005 APO-LOPERAMIDE	APX		PMS
02248994 DIARRHEA RELIEF	PMS		BAY
02256452 DIARRHEA RELIEF	VTH	ST 311MG TABLET (CHEWABLE)	
02225182 LOPERAMIDE	PDL		BAY
02228351 PMS-LOPERAMIDE	PMS	MINERAL OIL	
02238211 RIVA-LOPERAMIDE	RIV	ST 78% GEL	
02132591 TEVA-LOPERAMIDE	TEV		AUP
56:12.00 CATHARTICS AND LAXATIVES			\UP
BISACODYL		st 100% LIQUID	.0.
5MG SUPPOSITORY			BW
02410893 BISACODYL	JMP	POLYETHYLENE GLYCOL 3350	
02458845 BISACODYL	UNK		
10MG SUPPOSITORY	Ortic	POWDER 09991007 POLYETHYLENE GLYCOL N	/IDS
02361450 BISACODYL	JMP		/IDS
00003875 DULCOLAX	BOE	ST 100% POWDER FOR SOLUTION	iDO
00582883 PMS-BISACODYL	PMS		PER
02241091 THE MAGIC BULLET	DCM		JNK
ST 5MG TABLET			JMP
00254142 DULCOLAX	BOE		ΙΑΝ
02246039 JAMP-BISACODYL	JMP		
00587273 PMS-BISACODYL	PMS		

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56:12.00 CA	THARTICS AND LAXATIV	'ES	56:12.00 CATHARTICS AND LAXATIVES	
POLYETHYLENE GLYCOL 3350			SENNOSIDES	
ST 1G DOWNER	R FOR SOLUTION		ST 12MG TABLET	
	LAX-A-DAY	PED		PMS
	LAX-A-DAY PHARMA	PMS		JMP
02358034		MDS	ST 15MG TABLET	וועונ
02336672		RLI		NVC
	RESTORALAX	BAY	43MG TABLET	NVC
				/AN
	ENE GLYCOL 3350, SODIUI			VAIN
•	ODIUM BICARBONATE, SOI	NUN	8.6MG TABLET (FILM COATED) 80064362 SENNA SENNOSIDES NATURALS L	INIIZ
CHLORIDE, F	POTASSIUM CHLORIDE			JNK
ST 60G & 750M	G & 1.68G & 1.46G & 5.68G/L POW	DER .	15MG TABLET (FILM COATED) 80054167 SENNOSIDES	JNK
00677442	COLYTE	PED		אאוכ
POLYETHYL	ENE GLYCOL 3350, SODIUI	М	SODIUM PHOSPHATE	
SULFATE, SO	ODIUM BICARBONATE, SOI	DIUM	^{S7} 0.9G ORAL SOLUTION	
•	POTASSIUM CHLORIDÉ, BIS		80000689 PHOSLAX C	DDN
•	'4G & 1.69G & 1.46G & 0.76G & 5M		ST 60MG & 160MG/ML RECTAL LIQUID	
			02096900 ENEMOL SODIUM PHOSPHATE	OPC
	BI-PEGLYTE	PED	00009911 FLEET ENEMA	KIM
PSYLLIUM M	IUCILLOID		00108065 FLEET ENEMA PEDIATRIC	KIM
ST 50% POWDE	ER .		ST 180MG & 480MG/ML SOLUTION	
00599875	MUCILLIUM	PMS	02230399 PHOSPHATES F	PMS
ST 680MG/G PC	OWDER		^{S7} 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	PGI	123MG TABLET (EFFERVESCENT)	
	SMOOTH TEXTURE ORANGE FLAVOUR		80047562 JAMP-SODIUM PHOSPHATE	JMP
02174782	METAMUCIL FIBRE THERAPY	PGI	SORBITOL, SODIUM CITRATE, SODIUM LAURY	YL
02111102	SMOOTH TEXTURE ORANGE	. 0.	SULFOACETATE	
	FLAVOUR (SUGAR-FREE)			
02174804	METAMUCIL FIBRE THERAPY	PGI	ST 90MG & 9MG & 625MG ENEMA	401
	SMOOTH TEXTURE			MCL
	UNFLAVOURED		56:14.00 CHOLELITHOLYTIC AGENTS	
SENNOSIDES	S		URSODIOL	
ST 1.7MG/ML LI	IQUID		ST 250MG TABLET	
80024394	JAMP SENNAQUIL	JMP		JMP
02144379	SENNALAX	PMS		PMS
02084651	SENNAPREP	PMS		APC
00367729	SENOKOT	PFR		GLK
ST 8.6MG TABL	ET .		ST 500MG TABLET	OLIV
80043280	M SENNOSIDES	MAN		JMP
80047592	OPUS SENNOSIDES	OPU		PMS
01949292	RIVA SENNA	RIV		APC
ST 9MG TABLE	Т			GLK
80019511	BIOSENNOSIDES	BMI	ST PDIN FOR EXTEMPORANEOUS MIXTURE	OLIX
02247389	EURO SENNA	EUR		JNK
80054498	M SENNOSIDES	MAN		אווע
00896411	PMS-SENNOSIDES	PMS	56:16.00 DIGESTANTS	
80009595	SENNA	JMP	LACTASE	
02237105	SENNA LAXATIVE	VTH	^{S7} 3,000U CAPLET	
02068109	SENNA SENNOSIDES	PMS		√TH
80009182	SENNOSIDES	JMP	** 4,500U CAPLET	v 111
00026158	SENOKOT	PFR	•	√TH
ST 12MG TABLI	ET		ST ORAL LIQUID	V III
	M-SENNOSIDES	MAN		AUP
			BETUUTET LACTEEZE DROFS	702

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APX

JMP

		Non-insured Health B	CHEHLS
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 NIUID Decrease involvement of a decrease with the	
ST 3,000U TABLET		The NIHB Program implemented a dose coverage limit for DIMENHYDRINATE in June 2017 as part of a strategy to	
01951637 DAIRYAID	TAN	address safety concerns and potential misuse.	
02230653 LACTAID	KIM		
02017512 LACTOMAX	STE	The dimenhydrinate dose limit is currently 400 mg per data a total of 12,000 mg of dimenhydrinate in a 30-day perio	
ST 4,500U TABLET		a total of 12,000 mg of difficulty diffiate in a 30-day pend	u.
02230654 LACTAID EXTRA STRENGTH	KIM	This limit applies only to the 15 mg and 50 mg tablets.	
02224909 LACTOMAX EXTRA	STE	Dimenhydrinate in liquid, suppository and injectable form not included in this limit.	ns are
ST 9,000U TABLET			
02231507 LACTAID ULTRA	KIM	50MG/ML INJECTION	SDZ
LIPASE, AMYLASE, PROTEASE		00392537 DIMENHYDRINATE 00013579 GRAVOL	CHU
ST 8,000U & 30,000U & 30,000U CAPSULE		10MG LIQUID	СПО
00263818 COTAZYM	FRS	00392731 DIMENHYDRINATE	SDZ
00502790 COTAZYM ECS 8	FRS	25MG SUPPOSITORY	JDZ
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	022
02200104 CREON MINIMICROSPHERES 10	ABB	00013609 GRAVOL	CHU
ST 25000U & 25500U & 1600U CAPSULE (DELAYED RELEASE)		ST 3MG/ML SYRUP	
01985205 CREON MINIMICROSPHERES 25	ABB	00230197 GRAVOL	CHU
ST 5000U & 5100U & 320U GRANULES FOR SUSPEN		50MG TABLET	
(DELAYED RELEASE)	SION	02241532 ANTI-NAUSEANT	VTH
02445158 CREON MINIMICROSPHERES	BGP	00363766 APO DIMENHYDRINATE	APX
MICRO		00013803 GRAVOL	CHU
56:20.00 EMETICS		02245416 JAMP-DIMENHYDRINATE	JMP
IPECAC		02377179 MOTION SICKNESS	APX
		00586331 PMS-DIMENHYDRINATE	PMS
14MG/ML LIQUID	VEN	00605786 TRAVEL	VTH
00378801 XENEX IPECAC	XEN	00021423 TRAVEL ON	NOP
56:22.00 ANTIEMETICS		DOXYLAMINE SUCCINATE, PYRIDOXINE	
NETUPITANT, PALONOSETRON		HYDROCHLORIDE	
(PALONOSETRON HYDROCHLORIDE)		ST 10MG & 10MG TABLET (DELAYED RELEASE)	
Limited use benefit (prior approval required).		00609129 DICLECTIN	DUI
VAII		56:22.20 5-HT3 RECEPTOR ANTAGON	ISTS
When used in combination with dexamethasone for the prevention of acute and delayed nausea and vomiting during the prevention of acute and delayed nausea.	e to	GRANISETRON HYDROCHLORIDE	
highly emetogenic cancer chemotherapy (eg. cisplatin >			
70mg/m2).		ST 1MG TABLET	
ST 300MG & 0.5MG CAPSULE		02308894 APO-GRANISETRON	APX
02468735 AKYNZEO	PFR	02452359 NAT-GRANISETRON	NPH
		ONDANSETRON HYDROCHLORIDE	
		ST 4MG FILM	
		02389983 ONDISSOLVE ODF	TAK
		ST 8MG FILM	
		02389991 ONDISSOLVE ODF	TAK
		$^{\rm ST}$ 0.8MG/ML SOLUTION	
		02291967 ONDANSETRON	AAP
		02229639 ZOFRAN	NVR
		ST 4MG TABLET	
		02296349 ACT ONDANSETRON	ACG
		02288184 ADO ONDANSETDON	۸DV

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02288184 APO-ONDANSETRON02313685 JAMP-ONDANSETRON

Non-Insured Health Benefits 56:22.20 5-HT3 RECEPTOR ANTAGONISTS 56:22.92 MISCELLANEOUS ANTIEMETICS **ONDANSETRON HYDROCHLORIDE NABILONE** Limited use benefit (prior approval required). ST 4MG TABLET MAR-ONDANSETRON MAR 02371731 For patients who are experiencing nausea and vomiting due MINT-ONDANSETRON MIN 02305259 to cancer chemotherapy or radiation; 02297868 MYLAN-ONDANSETRON MYL OR Patient is palliative (diagnosed with a terminal illness or 02417839 NAT-ONDANSETRON NPH disease which is expected to be the primary cause of death 02421402 **ONDANSETRON** SAN within six months or less). 02258188 PMS-ONDANSETRON **PMS** 0.25MG CAPSULE 02312247 RAN-ONDANSETRON **RBY** 02312263 CESAMET UNK 02274310 SANDOZ ONDANSETRON SDZ 02358077 **RAN-NABILONE RBY** 02376091 SEPTA-ONDANSETRON SPT **TEVA-NABILONE** TEV 02392925 02213567 ZOFRAN **NVR** 0.5MG CAPSULE ST 8MG TABLET 02393581 **ACT NABILONE** ACG **ACT ONDANSETRON** 02296357 ACG 02256193 CESAMET UNK 02288192 APO-ONDANSETRON **APX** 02380900 PMS-NABILONE **PMS** 02313693 JAMP-ONDANSETRON **JMP** 02358085 **RAN-NABILONE RBY** MAR 02371758 MAR-ONDANSETRON TEVA-NABILONE 02384884 TFV 02305267 MINT-ONDANSETRON MIN **1MG CAPSULE** MYLAN-ONDANSETRON 02297876 MYL 02393603 **ACT NABILONE** ACG 02417847 NAT-ONDANSETRON NPH 00548375 UNK CESAMET PDL 02325160 ONDANSETRON 02380919 PMS-NABILONE **PMS** 02421410 **ONDANSETRON** SAN 02358093 **RAN-NABILONE RBY** 02258196 PMS-ONDANSETRON PMS 02384892 TEVA-NABILONE **TEV** 02312255 RAN-ONDANSETRON **RBY** 56:28.12 HISTAMINE H2-ANTAGONISTS 02274329 SANDOZ ONDANSETRON SDZ SPT 02376105 SEPTA-ONDANSETRON **CIMETIDINE** 02213575 **ZOFRAN NVR** ST 200MG TABLET ST 4MG TABLET (ORALLY DISINTEGRATING) 00584215 CIMETIDINE APX 02481723 ONDANSETRON ODT SDZ ST 300MG TABLET UNK 02444674 VPI-ONDANSETRON ODT 00487872 CIMETIDINE APX 02239372 ZOFRAN ODT **NVR** MYLAN-CIMETIDINE 02227444 MYI **ST 8MG TABLET (ORALLY DISINTEGRATING)** ST 400MG TABLET 02481731 ONDANSETRON ODT SD7 00600059 CIMETIDINE **APX** 02444682 VPI-ONDANSETRON ODT UNK ST 600MG TABLET 02239373 **ZOFRAN ODT NVR** 00600067 CIMETIDINE **APX** 56:22.32 MISCELLANEOUS ANTIEMETICS ST 800MG TABLET **APREPITANT** 00749494 CIMETIDINE APX Limited use benefit (prior approval required). **FAMOTIDINE** When used in combination with a 5-HT3 antagonist and ST 20MG TABLET dexamethasone for the prevention of acute and delayed 01953842 APO-FAMOTIDINE **APX**

nausea and vomiting due to highly emetogenic cancer chemotherapy (e.g. Cisplatin > 70mg/m2).

ST SOME CARSIII E

OUNG CAPS	OLE	
02298791	EMEND	FRS
ST 125MG CAPS	SULE	
02298805	EMEND	FRS
ST 125MG & 80	MG CAPSULE	
02298813	EMEND TRI-PACK	FRS

02351102 **FAMOTIDINE** SAN 02273357 MAXIMUM STRENGTH PEPCID AC MCI 02022133 **TEVA-FAMOTIDINE** TEV ST 40MG TABLET 01953834 APO-FAMOTIDINE APX 02351110 **FAMOTIDINE** SAN 02022141 **TEVA-FAMOTIDINE** TFV

NIZATIDINE

MEATIDINE		
ST 150MG CAPS	SULE	
00778338	AXID	PED
02177714	PMS-NIZATIDINE	PMS
ST 300MG CAPS	SULE	
00778346	AXID	PED
02177722	PMS-NIZATIDINE	PMS

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56:28.12 HISTAMINE H2-ANTAGONISTS	56:28.36 PROTON-PUMP INHIBITORS			
RANITIDINE HYDROCHLORIDE		LANSOPRAZOLE		
ST 15MG/ML SOLUTION	Limited use benefit (prior approval not required).			
02280833 APO-RANITIDINE	APX	Coverage will be limited to 400 tehlete/gangular every 190		
02242940 TEVA-RANITIDINE		Coverage will be limited to 400 tablets/capsules every 180 days.		
ST 150MG TABLET				
02248570 ACT RANITIDINE	TEV	(Please refer to Appendix A).		
00733059 APO-RANITIDINE	APX	ST 15MG CAPSULE (DELAYED RELEASE)		
02463717 JAMP-RANITIDINE	JMP	02293811 APO-LANSOPRAZOLE	APX	
02443708 MAR-RANITIDINE	MAR	02357682 LANSOPRAZOLE	SAN	
02293471 MAXIMUM STRENGTH ACID	PMS	02385767 LANSOPRAZOLE	SIV	
REDUCER		02433001 LANSOPRAZOLE	PMS	
02473534 M-RANITIDINE 02242453 PMS-RANITIDINE	MAN PMS	02353830 MYLAN-LANSOPRAZOLE	MYL	
00740748 RANITIDINE	PDL	02395258 PMS-LANSOPRAZOLE	PMS	
02353016 RANITIDINE	SAN	02165503 PREVACID	TAK	
02385953 RANITIDINE	SIV	02402610 RAN-LANSOPRAZOLE	RBY	
02336480 RAN-RANITIDINE	RBY	02422808 RIVA-LANSOPRAZOLE	RIV	
02247814 RIVA-RANITIDINE	RIV	02385643 SANDOZ LANSOPRAZOLE	SDZ	
02243229 SANDOZ RANITIDINE	SDZ	02280515 TEVA-LANSOPRAZOLE ST 30MG CAPSULE (DELAYED RELEASE)	TEV	
ST 300MG TABLET	022	02293838 APO-LANSOPRAZOLE	APX	
02248571 ACT RANITIDINE	TEV	02414775 DOM-LANSOPRAZOLE	DPC	
00733067 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	
00740756 RANITIDINE	PDL	02395266 PMS-LANSOPRAZOLE	PMS	
02353024 RANITIDINE	SAN	02165511 PREVACID	TAK	
02385961 RANITIDINE	SIV	02402629 RAN-LANSOPRAZOLE	RBY	
02336502 RAN-RANITIDINE	RBY	02422816 RIVA-LANSOPRAZOLE	RIV	
02247815 RIVA-RANITIDINE	RIV	02280523 TEVA-LANSOPRAZOLE	TEV	
02243230 SANDOZ RANITIDINE	SDZ	ST 30MG TABLET (DELAYED RELEASE)		
56:28.28 PROSTAGLANDINS		02385651 SANDOZ LANSOPRAZOLE	SDZ	
MISOPROSTOL		PDIN FOR EXTEMPORANEOUS MIXTURE		
		99503010 LANSOPRAZOLE ORAL LIQUID	UNK	
ST 100MCG TABLET	445	LANSOPRAZOLE ODT		
02244022 MISOPROSTOL	AAP	Limited use benefit (prior approval not required).		
ST 200MCG TABLET	A A D			
02244023 MISOPROSTOL	AAP	Coverage will be limited to 400 tablets/capsules every 180		
56:28.32 PROTECTANTS		days.		
SUCRALFATE		For children 12 years of age or under who are unable to		
ST 200MG/ML SUSPENSION		swallow the capsule formulation; OR		
02103567 SULCRATE PLUS	APC	For patients with dysphagia or a feeding tube when the use	of	
ST 1G TABLET		the capsule formulation is not possible.		
02125250 APO-SUCRALFATE	APX	(Please refer to Appendix A).		
02100622 SULCRATE	APC	ST 15MG TABLET (DELAYED RELEASE)		
02045702 TEVA-SUCRALFATE	TEV	02249464 PREVACID FASTAB	TAK	
56:28.36 PROTON-PUMP INHIBITORS		ST 30MG TABLET (DELAYED RELEASE)		
AMOXICILLIN, CLARITHROMYCIN, LANSOPRAZOLE		02249472 PREVACID FASTAB	TAK	
ST 500MG & 500MG & 30MG KIT				
02470780 APO-LANSOPRAZOLE- AMOXICILLIN-CLARITHROMYCIN	APX			
02238525 HP-PAC	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).

ST 20MG CAPSULE (DELAYED RELEASE)					
02245058	APO-OMEPRAZOLE	APX			
00846503	LOSEC	AZC			
02339927	OMEPRAZOLE	PDL			
02348691	OMEPRAZOLE	SAN			
02411857	OMEPRAZOLE-20	SIV			
02320851	PMS-OMEPRAZOLE	PMS			
02403617	RAN-OMEPRAZOLE	RBY			
02296446	SANDOZ OMEPRAZOLE	SDZ			
20MG TABL	ET (DELAYED RELEASE)				
02449927	BIO-OMEPRAZOLE	BMI			
02420198	JAMP-OMEPRAZOLE DR	JMP			
02190915	LOSEC	AZC			
02439549	NAT-OMEPRAZOLE DR	NPH			
02416549	OMEPRAZOLE	ACC			
02374870	RAN-OMEPRAZOLE	RBY			
02402416	RIVA-OMEPRAZOLE DR	RIV			
02295415	TEVA-OMEPRAZOLE	TEV			
PDIN FOR EXTEMPORANEOUS MIXTURE					
99503002	OMEPRAZOLE ORAL LIQUID	UNK			

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).

ST 10MG TABLET (ENTERIC COATED)

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

02243796	PARIET	JSO
02310805	PMS-RABEPRAZOLE	PMS
02315181	PRO-RABEPRAZOLE	PDL
02385449	RABEPRAZOLE	SIV
02356511	RABEPRAZOLE EC	SAN
02298074	RAN-RABEPRAZOLE	RBY
02330083	RIVA-RABEPRAZOLE EC	RIV
02314177	SANDOZ RABEPRAZOLE	SDZ
02296632	TEVA-RABEPRAZOLE	TEV
ST 20MG TABL	ET (ENTERIC COATED)	
02345587	APO-RABEPRAZOLE	APX
02320460	DOM-RABEPRAZOLE EC	DPC
02243797	PARIET	JSO
02310813	PMS-RABEPRAZOLE	PMS
02315203	PRO-RABEPRAZOLE	PDL
02385457	RABEPRAZOLE	SIV
02356538	RABEPRAZOLE EC	SAN
02298082	RAN-RABEPRAZOLE	RBY
02330091	RIVA-RABEPRAZOLE	RIV
02314185	SANDOZ RABEPRAZOLE	SDZ
02296640	TEVA-RABEPRAZOLE	TEV
56:32.00 PR	OKINETIC AGENTS	
	NIE MAI EATE	

DOMPERIDONE MALEATE

ST 10MG TABLET

02103613 APO-DOMPERIDONE **APX**

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56:32.00 PROKINETIC AGENTS		56:36.00 ANTI-INFLAMMATORY AGENTS	
DOMPERIDONE MALEATE		MESALAZINE	
sr 10MG TABLET		ST 400MG TABLET (ENTERIC COATED)	
02445034 BIO-DOMPERIDONE	ВМІ	02171929 TEVA-5 ASA	TEV
02238315 DOM-DOMPERIDONE	DPC	ST 500MG TABLET (EXTENDED RELEASE)	1 L V
02236857 DOMPERIDONE	PDL	02099683 PENTASA	FEI
02238341 DOMPERIDONE	SIV	ST 1G TABLET (EXTENDED RELEASE)	
02350440 DOMPERIDONE	SAN	02399466 PENTASA	FEI
02369206 JAMP-DOMPERIDONE	JMP	ST 1.2G TABLET (EXTENDED RELEASE)	
02403870 MAR-DOMPERIDONE	MAR	02297558 MEZAVANT	SHI
02236466 PMS-DOMPERIDONE	PMS	OLSALAZINE SODIUM	
02268078 RAN-DOMPERIDONE	RBY		
01912070 TEVA-DOMPERIDONE	TEV	ST 250MG CAPSULE	APU
PDIN FOR EXTEMPORANEOUS MIXTURE		02063808 DIPENTUM	APU
99503005 DOMPERIDONE ORAL LIQUID	UNK	56:92.00 MISCELLANEOUS GI DRUGS	
METOCLOPRAMIDE HYDROCHLORIDE		OBETICHOLIC ACID	
ST 1MG/ML SOLUTION		Limited use benefit (prior approval required).	
02230433 METONIA	PED	Criteria for initial 12-month coverage:	
ST 5MG TABLET		The patient has a confirmed diagnosis of primary biliary	
00842826 APO-METOCLOP	APX	cholangitis (PBC), defined as:	
02230431 METONIA	PED	Positive antimitochondrial antibodies (AMA); OR Liver bigger results consistent with DRC.	
ST 10MG TABLET		 Liver biopsy results consistent with PBC. AND 	
00842834 APO-METOCLOP	APX	The patient is under the care of a gastroenterologist,	
02230432 METONIA	PED	hepatologist or internal medicine specialist with experience in	า
56:36.00 ANTI-INFLAMMATORY AGENTS		the treatment of PBC. AND	
BETAMETHASONE SODIUM PHOSPHATE		The patient has received ursodeoxycholic acid (UDCA) for a	
0.05MG/ML ENEMA		minimum of 12 months and has experienced an inadequate	
02060884 BETNESOL	PAL	response to UDCA and can benefit from the addition of obeticholic acid. An inadequate response is defined as:	
	IAL	 Alkaline phosphatase (ALP) ≥ 1.67 x upper limit of normal 	
HYDROCORTISONE ACETATE		(ULN); AND/OR	
10% AEROSOL		Bilirubin > ULN and < 2 x ULN; AND/OR Findance of componented simbooic by fibrocoop or bigger	
00579335 CORTIFOAM	PAL	 Evidence of compensated cirrhosis by fibroscan or biopsy. OR 	
100MG/60ML ENEMA		The patient has experienced documented and unmanageable	е
02112736 CORTENEMA	APC	intolerance to UDCA.	
MESALAZINE		Criteria for renewal every 12 months:	
500MG SUPPOSITORY		The patient continues to benefit from treatment with	
02112760 SALOFALK	APC	obeticholic acid as evidenced by:	
1G SUPPOSITORY		• 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 before beginning treatment with obeticholic acid. 	
02153564 PENTASA	FEI	5MG TABLET	
02242146 SALOFALK	APC	02463121 OCALIVA	UNK
1G/100ML SUSPENSION		10MG TABLET	OIVIN
02153521 PENTASA	FEI	02463148 OCALIVA	UNK
2G/60G SUSPENSION			OIVIX
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	е
02112809 SALOFALK	APC	(IBS), spastic colon, spastic colitis and mucous colitis; OR	
$^{s au}$ 500MG TABLET (DELAYED RELEASE)		In postoperative paralytic ileus in order to accelerate the	
02112787 SALOFALK	APC	resumption of the intestinal transit following abdominal surgery.	
$^{s au}$ 800MG TABLET (DELAYED RELEASE)		50MG CAPSULE	
02267217 ASACOL	ALL	00465240 DICETEL	SPH
ST 400MG TABLET (ENTERIC COATED)		50MG TABLET	0, 11
01997580 ASACOL	ALL	02469677 APO-PINAVERIUM	APX
		OZTOGOTT THE OTHER VEHICLER	, u , ∧

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56:92.00 MISCELLANEOUS GI DRUGS PINAVERIUM BROMIDE

Limited use benefit (prior approval required).

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

50MG TABLET

 01950592
 DICETEL
 BGP

 100MG TABLET

 02469685
 APO-PINAVERIUM
 APX

 02230684
 DICETEL
 BGP

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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

VAE

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8:00 HORMONES AND SYNTHETI		68:04.00 ADRENALS	
SUBSTITUTES	C	DEXAMETHASONE PHOSPHATE	
68:04.00 ADRENALS		4MG/ML LIQUID 01977547 DEXAMETHASONE	RAX
BECLOMETHASONE DIPROPIONATE		02204266 DEXAMETHASONE-OMEGA	OMG
50MCG AEROSOL		10MG/ML LIQUID	OWIO
02242029 QVAR	VAE	00874582 DEXAMETHASONE	SDZ
100MCG AEROSOL		02204274 DEXAMETHASONE-OMEGA	OMG
02242030 QVAR	VAE	00783900 PMS-DEXAMETHASONE	PMS
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		·	
00851752 PULMICORT TURBUHALER	AZC	Limited use benefit (prior approval required).	
400MCG POWDER		For the maintenance treatment of chronic obstructive	
00851760 PULMICORT TURBUHALER	AZC	pulmonary disease (COPD) including chronic bronchitis	
0.125MG SUSPENSION		and/or emphysema who meet the following criteria:	
02465949 TEVA-BUDESONIDE	TEV	 Patients are not started on triple inhaled therapy as initial therapy for COPD; AND 	
0.125MG/ML SUSPENSION		 Patients have had an inadequate response to optimal dua 	I-
02229099 PULMICORT NEBUAMP	AZC	inhaled therapy* for COPD.	
0.25MG/ML SUSPENSION		*Dual inhalad therapy refers to any combination of a long	
01978918 PULMICORT NEBUAMP	AZC	*Dual-inhaled therapy refers to any combination of a long- acting muscarinic antagonist (LAMA), long-acting beta-2	
0.5MG SUSPENSION		agonist (LABA) or an inhaled corticosteroid (ICS).	
02465957 TEVA-BUDESONIDE	TEV	100MCG & 62.5MCG & 25MCG POWDER	
0.5MG/ML SUSPENSION		02474522 TRELEGY ELLIPTA	GSK
01978926 PULMICORT NEBUAMP	AZC	FLUTICASONE PROPIONATE	
CICLESONIDE		50MCG/INHALATION AEROSOL	
100MG/INHALATION AEROSOL		02244291 FLOVENT HFA	GSK
02285606 ALVESCO	AZC	125MCG/INHALATION AEROSOL	OOK
200MG/INHALATION AEROSOL		02244292 FLOVENT HFA	GSK
02285614 ALVESCO	AZC	250MCG/INHALATION AEROSOL	OOK
CORTISONE ACETATE		02244293 FLOVENT HFA	GSK
		100MCG/DOSE POWDER	OOK
25MG TABLET	\/A.E	02237245 FLOVENT DISKUS	GSK
00280437 CORTISONE	VAE	250MCG/DOSE POWDER	0011
DEXAMETHASONE		02237246 FLOVENT DISKUS	GSK
0.1MG/ML LIQUID		500MCG/DOSE POWDER	0011
01946897 PMS DEXAMETHASONE	PMS	02237247 FLOVENT DISKUS	GSK
0.5MG TABLET		HYDROCORTISONE (HYDROCORTISONE	00.1
02261081 APO-DEXAMETHASONE	APX	SODIUM SUCCINATE)	
01964976 PMS DEXAMETHASONE	PMS	,	
0.75MG TABLET		100MG POWDER FOR SOLUTION	
01964968 PMS DEXAMETHASONE	PMS	00030600 SOLU-CORTEF ACT-O-VIAL	PFI
2MG TABLET		250MG POWDER FOR SOLUTION	
02279363 PMS-DEXAMETHASONE	PMS	00030619 SOLU-CORTEF ACT-O-VIAL	PFI
4MG TABLET		1G POWDER FOR SOLUTION	5
02250055 APO-DEXAMETHASONE	APX	00030635 SOLU-CORTEF ACT-O-VIAL	PFI
01964070 PMS DEXAMETHASONE	PMS	HYDROCORTISONE ACETATE	
PDIN FOR EXTEMPORANEOUS MIXTURE		10MG TABLET	
99503007 DEXAMETHASONE ORAL LIQUID	UNK	00030910 CORTEF	PFI
DEXAMETHASONE PHOSPHATE		20MG TABLET	
		00030929 CORTEF	PFI
4MG/ML LIQUID		00000025	

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68:04.00 ADRENALS	68:04.00 ADRENALS			
METHYLPREDNISOLONE		PREDNISONE		
4MG TABLET		5MG TABLET		
00030988 MEDROL	PFI		APX	
16MG TABLET			TEV	
00036129 MEDROL	PFI	50MG TABLET		
METHYLPREDNISOLONE			APX	
(METHYLPREDNISOLONE SODIUM SUCCI	JATF)		TEV	
•	1 A1L)	PDIN FOR EXTEMPORANEOUS MIXTURE		
40MG INJECTION	DEL	99503008 PREDNISONE ORAL LIQUID	UNK	
02367947 SOLU-MEDROL	PFI	TRIAMCINOLONE ACETONIDE		
125MG INJECTION	PFI	40MG/ML INJECTION		
02367955 SOLU-MEDROL 500MG INJECTION	PFI		BMS	
00030678 SOLU-MEDROL	PFI	10MG/ML SUSPENSION	DIVIO	
1G INJECTION	FFI		BMS	
00036137 SOLU-MEDROL	PFI		SDZ	
02367971 SOLU-MEDROL	PFI	40MG/ML SUSPENSION	022	
500MG POWDER FOR SOLUTION			BMS	
02231895 METHYLPREDNISOLONE SODIUM	TEV		RAX	
SUCCINATE		02229550 TRIAMCINOLONE	SDZ	
1G POWDER FOR SOLUTION		TRIAMCINOLONE DIACETATE		
02241229 METHYLPREDNISOLONE SODIUM	TEV			
SUCCINATE		40MG/ML SUSPENSION 01977555 TRIAMCINOLONE	RAX	
METHYLPREDNISOLONE ACETATE			KAX	
20MG/ML SUSPENSION		68:08.00 ANDROGENS		
01934325 DEPO-MEDROL	PFI	DANAZOL		
40MG/ML SUSPENSION		50MG CAPSULE		
00030759 DEPO-MEDROL	PFI		SAC	
01934333 DEPO-MEDROL	PFI	100MG CAPSULE		
02245400 METHYLPREDNISOLONE	SDZ	02018152 CYCLOMEN	SAC	
02245407 METHYLPREDNISOLONE	SDZ	200MG CAPSULE		
80MG/ML SUSPENSION		02018160 CYCLOMEN	SAC	
00030767 DEPO-MEDROL	PFI	TESTOSTERONE (TOPICAL)		
01934341 DEPO-MEDROL	PFI	Limited use benefit (prior approval required).		
02245406 METHYLPREDNISOLONE	SDZ			
02245408 METHYLPREDNISOLONE	SDZ	The NIHB Program covers topical testosterone for the		
METHYLPREDNISOLONE ACETATE, LIDOO	CAINE	treatment of the following in adult males above 18 years old Orchiectomy, undescended testes, Klinefelter's; OR		
HYDROCHLORIDE		- Pituitary tumour or post-pituitary surgery with low		
40MG & 10MG SUSPENSION		testosterone; OR		
00260428 DEPO-MEDROL WITH LIDOCAINE	PFI	 AIDS-wasting syndrome with low testosterone; OR Gender affirming hormone therapy. 		
MOMETASONE FUROATE		- Gerider aniiming normone therapy.		
200MCG POWDER		Note: Older males with non-specific symptoms such as, but		
02243595 ASMANEX TWISTHALER	FRS	not limited to, fatigue, malaise, or depression who have a low random testosterone level do not meet coverage criteria.		
400MCG POWDER		Ü		
02243596 ASMANEX TWISTHALER	FRS	1% GEL	DOD	
PREDNISOLONE SODIUM PHOSPHATE			BGP	
			BGP TAR	
1MG/ML SOLUTION	040		TAR	
02230619 PEDIAPRED	SAC		PAL	
02245532 PMS-PREDNISOLONE	PMS	12.5MG GEL	IAL	
PREDNISONE			BGP	
1MG TABLET		2.5MG PATCH	201	
00598194 APO PREDNISONE	APX		ALL	
00271373 WINPRED	AAP	5MG PATCH		
			ALL	

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68:08.00 ANDROGENS		68:12.00 CONTRACEPTIVES	
TESTOSTERONE CYPIONATE		ETHINYL ESTRADIOL, LEVONORGESTREL	
100MG/ML SOLUTION		ST 30MCG & 0.05MG, 40MCG & 0.075MG, 30MCG &	
00030783 DEPO-TESTOSTERONE	PFI	0.125MG TABLET 00707600 TRIQUILAR 21	BAY
02246063 TESTOSTERONE CYPIONATE	SDZ	00707503 TRIQUILAR 28	BAY
TESTOSTERONE ENANTHATE		ST 30MCG & 150MCG TABLET	ואס
200MG/ML SOLUTION		02042320 MIN-OVRAL 21	PFI
00029246 DELATESTRYL	VAE	02042339 MIN-OVRAL 28	PFI
TESTOSTERONE UNDECANOATE		02387085 OVIMA 21	APX
40MG CAPSULE		02387093 OVIMA 28	APX
02322498 PMS-TESTOSTERONE	PMS	02295946 PORTIA 21	TEV
02421186 TARO-TESTOSTERONE	TAR	02295954 PORTIA 28	TEV
68:12.00 CONTRACEPTIVES		ETHINYL ESTRADIOL, NORELGESTROMIN	
DESOGESTREL, ETHINYL ESTRADIOL		$^{s au}$ 6MG & 0.6MG PATCH (EXTENDED RELEASE)	
ST 25MCG & 150MCG, 125MCG, 100MCG TABLET		02248297 EVRA	JSO
02272903 LINESSA 21	ASP	ETHINYL ESTRADIOL, NORETHINDRONE	
02257238 LINESSA 28	ASP	35MCG & 0.5MG TABLET	
ETHINYL ESTRADIOL, DESOGESTREL		02187086 BREVICON 0.5/35 (21-DAY PACK)	PFI
ST 30MCG & 150MCG TABLET		02187094 BREVICON 0.5/35 (28-DAY PACK)	PFI
02317192 APRI 21	TEV	ST 35MCG & 1MG TABLET	
02317206 APRI 28	TEV	02189054 BREVICON 1/35 (21-DAY PACK)	PFI
02396491 FREYA 21	MYL	02189062 BREVICON 1/35 (28-DAY PACK)	PFI
02396610 FREYA 28	MYL	02197502 SELECT 1/35 (21-DAY) 02199297 SELECT 1/35 (28-DAY)	PFI PFI
02042487 MARVELON 21	FRS		FFI
02042479 MARVELON 28	FRS	ETHINYL ESTRADIOL, NORETHINDRONE ACETATE	
02410249 MIRVALA 21	APX		
02410257 MIRVALA 28	APX	ST 10MCG & 1MG TABLET	
ETHINYL ESTRADIOL, DROSPIRENONE		02417456 LOLO	ALL
ST 0.02MG & 3MG TABLET		ST 20MCG & 1MG TABLET	A 1 1
02415380 MYA	APX	00315966 MINESTRIN 1/20 (21-DAY) 00343838 MINESTRIN 1/20 (28-DAY)	ALL ALL
02321157 YAZ	BAY	ST 30MCG & 1.5MG TABLET	ALL
ST 0.03MG & 3MG TABLET		00297143 LOESTRIN	ALL
02261723 YASMIN 21	BAY	00353027 LOESTRIN	ALL
02261731 YASMIN 28	BAY	ETHINYL ESTRADIOL, NORGESTIMATE	
02410788 ZAMINE 21 02410796 ZAMINE 28	APX APX	ST 35MCG & 0.25MG TABLET	
	AFA	01968440 CYCLEN (21 DAY)	JSO
ETHINYL ESTRADIOL, ETONOGESTREL		01992872 CYCLEN (21 DAY)	JSO
ST 2.6MG & 11.4MG RING (SLOW-RELEASE)	ED0	LEVONORGESTREL	
02253186 NUVARING	FRS	19.5MG INSERT (EXTENDED-RELEASE)	
ETHINYL ESTRADIOL, LEVONORGESTRE	iL	02459523 KYLEENA	BAY
⁵⁷ 0.03MG & 0.15MG TABLET		0.75MG TABLET	
02398869 INDAYO	MYL	02371189 OPTION 2	PER
ST 0.15MG & 0.03MG TABLET	TE\/	1.5MG TABLET	
02296659 SEASONALE ST 20MCG & 100MCG TABLET	TEV	02433532 BACKUP PLAN ONESTEP	APX
02236974 ALESSE 21	PFI	02425009 CONTINGENCY ONE	MYL
02236974 ALESSE 28	PFI	02293854 PLAN B	UNK
02387875 ALYSENA 21	APX		
02387883 ALYSENA 28	APX		
02298538 AVIANE 21	TEV		
02298546 AVIANE 28	TEV		

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		Non-insured nearth ben	ents
68:12.00 CONTRACEPTIVES		68:16.04 ESTROGENS	
LEVONORGESTREL INTRAUTERINE INSERT		CONJUGATED ESTROGENS	
Limited use benefit with quantity and frequency limits (prior approval is not required).		ST 1.25MG TABLET (EXTENDED RELEASE) 02414694 PREMARIN	PFI
Coverage is granted for 1 device every 2 years.		ESTRADIOL	
52MG INSERT (EXTENDED-RELEASE) 02243005 MIRENA	BAY	ST 0.25MG GEL 02424924 DIVIGEL	SEA
LEVONORGESTREL, ETHINYL ESTRADIOL		ST 0.5MG GEL	OLA
° 0.15MG & 0.03MG & 0.01MG TABLET		02424835 DIVIGEL	SEA
	TEV	ST 1MG GEL	
NORETHINDRONE		02424843 DIVIGEL ST 25MCG PATCH	SEA
ST 0.35MG TABLET		02245676 ESTRADOT 25	NVR
	LUP	02243722 OESCLIM	SEA
00037605 MICRONOR 28-DAY	JSO	ST 37.5MCG PATCH	
02410303 MOVISSE	MYL	02243999 ESTRADOT 37.5	NVR
NORETHINDRONE, ETHINYL ESTRADIOL		ST 50MCG PATCH	
35MCG & 0.5MG, 35MCG & 1MG TABLET		02244000 ESTRADOT 50	NVR
02187108 SYNPHASIC 21	PFI	02243724 OESCLIM	SEA
02187116 SYNPHASIC 28	PFI	ST 75MCG PATCH	NI) (D
NORGESTIMATE, ETHINYL ESTRADIOL		02244001 ESTRADOT 75 ST 100MCG PATCH	NVR
ST 25MCG & 0.180MG, 25MCG & 0.215MG, 25MCG &		02244002 ESTRADOT 100	NVR
0.25MG TABLET		ST 2MG RING (SLOW-RELEASE)	
	APX	02168898 ESTRING	PFI
	APX	ST 0.5MG TABLET	
,	JSO	02225190 ESTRACE	TRM
02258587 TRI-CYCLEN LO (28 DAY) ST 35MCG & 0.180MG, 35MCG & 0.215MG, 35MCG &	JSO	ST 1MG TABLET	
0.25MG TABLET		02148587 ESTRACE	TRM
02028700 TRI-CYCLEN 21-DAY	JSO	ST 2MG TABLET 02148595 ESTRACE	TRM
02029421 TRI-CYCLEN 28-DAY	JSO	ESTRADIOL HEMIHYDRATE	I IXIVI
ULIPRISTAL ACETATE			
Limited use benefit (prior approval not required).		ST 0.06% GEL 02238704 ESTROGEL	EDC
For the preoperative treatment of moderate-to-severe signs		st 25MCG PATCH	FRS
and symptoms of uterine fibroids in adult women of		02247499 CLIMARA 25	BAY
reproductive age; and for the intermittent treatment of		ST 50MCG PATCH	2,
moderate-to-severe signs and symptoms of uterine fibroids in adult women of reproductive age who are not eligible for		02231509 CLIMARA 50	BAY
surgery, with the duration of each treatment course being		02246967 SANDOZ ESTRADIOL DERM	SDZ
three months, if the following conditions are met: • The patient is under the care of an obstetrician/gynecologist.		ST 75MCG PATCH	
Patients receiving ulipristal acetate should have their liver		02247500 CLIMARA 75	BAY
function tests monitored before, during, and after treatment.		02246968 SANDOZ ESTRADIOL DERM ST 100MCG PATCH	SDZ
Coverage will be limited to a maximum of four courses of		02246969 SANDOZ ESTRADIOL DERM	SDZ
therapy for women aged 18 to 60 years.		ST 0.5MG TABLET	ODZ
ST 5MG TABLET		02449048 LUPIN-ESTRADIOL	LUP
02408163 FIBRISTAL	ALL	ST 1MG TABLET	
68:16.04 ESTROGENS		02449056 LUPIN-ESTRADIOL	LUP
CONJUGATED ESTROGENS		ST 2MG TABLET	
ST 0.625MG/G CREAM		02449064 LUPIN-ESTRADIOL ST 10MCG VAGINAL TABLET	LUP
02043440 PREMARIN	PFI	02325462 VAGIFEM 10	NOO
ST 0.3MG TABLET (EXTENDED RELEASE)		ESTRADIOL, NORETHINDRONE ACETATE	.400
02414678 PREMARIN	PFI	•	
ST 0.625MG TABLET (EXTENDED RELEASE)	DEI	87 50MCG & 140MCG PATCH 02241835 ESTALIS	NVR
02414686 PREMARIN	PFI	02241000 LOTALIO	INVE

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00.40.04 FOTDOOFNO		00 00 00 11	DUA OLUGOODAGE	
68:16.04 ESTROGENS			PHA-GLUCOSIDASE	
ESTRADIOL, NORETHINDRONE ACETATE		INI	HIBITORS	
ST 50MCG & 250MCG PATCH		ACARBOSE		
02241837 ESTALIS	NVR	ST 50MG TABL	ET	
ESTRONE		02190885	GLUCOBAY	BAY
ST 1MG/G CREAM		ST 100MG TAB	LET	
00727369 ESTRAGYN	SEA	02190893	GLUCOBAY	BAY
68:16.12 ESTROGEN AGONISTS-	OLA	68:20.04 BIG	GUANIDES	
ANTAGONISTS		METFORMIN	HYDROCHLORIDE	
RALOXIFENE HYDROCHLORIDE		ST 500MG TAB	ACT METFORMIN	TEV
Limited use benefit (prior approval required).			APO-METFORMIN	APX
For secondary prevention of osteoporosis in women who			AURO-METFORMIN	AUR
experience failure on bisphosphonates.		02229994		DPC
For secondary prevention of osteoporosis in women who ha	ve	02099233	GLUCOPHAGE	SAC
a personal history or a first degree relative with a history of breast cancer.		02229516	GLYCON	VAE
		02380196	JAMP-METFORMIN	JMP
60MG TABLET 02358840 ACT RALOXIFENE	400	02353377	METFORMIN	SAN
02279215 APO-RALOXIFENE	ACG APX	02378841	METFORMIN	MAR
	LIL	02385341	METFORMIN FC	SIV
02239028 EVISTA 02358921 PMS-RALOXIFENE	PMS	02223562	PMS-METFORMIN	PMS
	FIVIO	02314908	PRO-METFORMIN	PDL
TAMOXIFEN CITRATE		02269031	RAN-METFORMIN	RBY
10MG CAPSULE		02242974	RATIO-METFORMIN	TEV
99113709 TAMOXIFEN (QC)	UNK	02239081	RIVA-METFORMIN	RIV
68:18.00 GONADOTROPINS		02246820	SANDOZ METFORMIN FC	SDZ
GOSERELIN ACETATE		02379767	SEPTA-METFORMIN	SPT
		ST 850MG TAB		
3.6MG/DEPOT IMPLANT	LINUZ		ACT METFORMIN	TEV
02049325 ZOLADEX	UNK	02229785	APO-METFORMIN	APX
NAFARELIN ACETATE			AURO-METFORMIN	AUR
2MG/ML AEROSOL		02242726 02162849	DOM-METFORMIN GLUCOPHAGE	DPC SAC
02188783 SYNAREL	PFI	02102849	GLYCON	VAE
68:18.04		02380218	JAMP-METFORMIN	JMP
DEGARELIX ACETATE		02353385	METFORMIN	SAN
		02378868	METFORMIN	MAR
80MG POWDER FOR SOLUTION		02385368	METFORMIN FC	SIV
02337029 FIRMAGON	FEI	02388774	MINT-METFORMIN	MIN
120MG POWDER FOR SOLUTION 02337037 FIRMAGON	FEI	02242589	PMS-METFORMIN	PMS
	FEI	02314894	PRO-METFORMIN	PDL
68:18.08		02269058	RAN-METFORMIN	RBY
LEUPROLIDE ACETATE		02242931	RATIO-METFORMIN	TEV
3.75MG/VIAL POWDER FOR SUSPENSION		02242783	RIVA-METFORMIN	RIV
00884502 LUPRON DEPOT	ABV	02246821	SANDOZ METFORMIN	SDZ
7.5MG/VIAL POWDER FOR SUSPENSION		02379775	SEPTA-METFORMIN	SPT
00836273 LUPRON DEPOT	ABV			
11.25MG/VIAL POWDER FOR SUSPENSION				
02239834 LUPRON DEPOT	ABV			
22.5MG/VIAL POWDER FOR SUSPENSION				
02230248 LUPRON DEPOT	ABV			
30MG/VIAL POWDER FOR SUSPENSION				
02239833 LUPRON DEPOT	ABV			

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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

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 & 1000MG TABLET

02403277 JENTADUETO

ST 2.5MG & 500MG TABLET

02403250 JENTADUETO BOE

 $^{\rm s7}$ 2.5MG & 850MG 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 sulfonylurea.

ST 2.5MG TABLET

02375842 ONGLYZA AZC

ST 5MG TABLET

02333554 ONGLYZA AZC

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.

 $^{\mathrm{s} au}$ 2.5MG & 1000MG TABLET

02389185 KOMBOGLYZE AZC

 $^{\rm s au}$ 2.5MG & 500MG TABLET

02389169 KOMBOGLYZE AZC

ST 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

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 50MG TABLET

BOF

BOE

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.

ST 50MG & 1000MG TABLET

02333872 JANUMET FRS

ST 50MG & 500MG TABLET

02333856 JANUMET FRS

⁵⁷ 50MG & 850MG TABLET

02333864 JANUMET FRS

57 50MG & 1000MG TABLET (EXTENDED RELEASE)

02416794 JANUMET XR FRS

ST 50MG & 500MG TABLET (EXTENDED RELEASE)

02416786 JANUMET XR FRS

sr 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

68:20.08 INSULINS

INSULIN (30% NEUTRAL & 70% ISOPHANE) HUMAN BIOSYNTHETIC

100U/ML INJECTION

00705970	HUMULIN 30/70	1.11
00793079	HOWOLIN 30/70	LIL
01959212	HUMULIN 30/70 CARTRIDGE	LIL
09853855	HUMULIN 30/70 CARTRIDGE	LIL
02024217	NOVOLIN GE 30/70	NOO
02025248	NOVOLIN GE 30/70 PENFILL	NOO
09853812	NOVOLIN GE 30/70 PENFILL	NOO

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CO.20 00 INC	NIII INC		CO.20 00 ING	NIII INC	
68:20.08 INS			68:20.08 INS		
	% NEUTRAL & 60% ISOPHANE)		INSULIN GLU	JLISINE	
HUMAN BIOS	SYNTHETIC		100U/ML IN	JECTION	
100U/ML INJ	IECTION		02279479	APIDRA CARTRIDGE	SAC
02024314	NOVOLIN GE 40/60 PENFILL	NOO	02294346	APIDRA SOLOSTAR	SAC
INSULIN (50%	% NEUTRAL & 50% ISOPHANE)		02279460	APIDRA VIAL	SAC
HUMAN BIOS	•		INSULIN HUI	MAN BIOSYNTHETIC	
100U/ML INJ	IECTION		100U/ML IN.	JECTION	
02024322	NOVOLIN GE 50/50 PENFILL	NOO	02024233	NOVOLIN GE TORONTO	NOO
INSULIN (ISC	PHANE) HUMAN BIOSYNTHET	С	02024284	NOVOLIN GE TORONTO PENFILL	NOO
100U/ML INJ	,		09853774	NOVOLIN GE TORONTO PENFILL	NOO
	HUMULIN N	LIL	INSULIN LIS	PRO	
	HUMULIN N (CARTRIDGE)	LIL	100U/ML IN.	JECTION	
	HUMULIN N (KWIKPEN)	LIL		HUMALOG	LIL
	HUMULIN N 100U/ML (CARTRIDGE)	LIL		HUMALOG (CARTRIDGE)	LIL
	NOVOLIN GE NPH	NOO		HUMALOG (KWIKPEN)	LIL
	NOVOLIN GE NPH 100U/ML	NOO		HUMALOG 100U/ML CARTRIDGE	LIL
	PENFILL		200U/ML IN.	JECTION	
02024268	NOVOLIN GE NPH PENFILL	NOO	02439611	HUMALOG 200U/ML KWIKPEN	LIL
INSULIN (ZIN	IC CRYSTALLINE) HUMAN		100U SOLU	TION	
BIOSYNTHE	ΓΙC (RDNA ORIGIN)		02470152	HUMALOG	LIL
100U/ML INJ	IECTION		INSULIN LIS	PRO, INSULIN LISPRO PROTA	MINE
	HUMULIN R	LIL	100U/ML IN.	•	
	HUMULIN R 100U/ML (CARTRIDGE)	LIL		HUMALOG MIX 25 (CARTRIDGE)	LIL
	HUMULIN R CARTRIDGE	LIL		HUMALOG MIX 25 (KWIKPEN)	LIL
INSULIN ASF				HUMALOG MIX 50 (CARTRIDGE)	LIL
				HUMALOG MIX 50 (KWIKPEN)	LIL
100U/ML INJ		NOO	68:20.16 ME	,	
	NOVORAPID	NOO			
	NOVORAPID	NOO	REPAGLINID	DE .	
	NOVORAPID	NOO	ST 0.5MG TABL	.ET	
INSULIN BIO	SYNTHETIC HUMAN BR		02321475	ACT REPAGLINIDE	ACG
100U SOLUT	TION		02355663	APO-REPAGLINIDE	APX
02415089	HUMULIN R (KWIKPEN)	LIL	02424258	AURO-REPAGLINIDE	AUR
INSULIN DEC	SLUDEC		02239924	GLUCONORM	NOO
100U SOLUT	TION		02354926	JAMP REPAGLINIDE	JMP
02467879		NOO	02415968	REPAGLINIDE	PDL
200U SOLUT		1100		SANDOZ REPAGLINIDE	SDZ
02467887		NOO	ST 1MG TABLE		
INSULIN DET		1100		ACT REPAGLINIDE	ACG
				AURO-REPAGLINIDE	AUR
100U/ML INJ				GLUCONORM	NOO
	LEVEMIR FLEXTOUCH	NOO		JAMP REPAGLINIDE	JMP
	LEVEMIR PENFILL	NOO		REPAGLINIDE	PDL
INSULIN GLA	ARGINE		02357461 ST 2MG TABLE	SANDOZ REPAGLINIDE	SDZ
100U/ML INJ	IECTION			ACT REPAGLINIDE	ACG
02245689	LANTUS	SAC	02355698	APO-REPAGLINIDE	APX
02251930	LANTUS	SAC		AURO-REPAGLINIDE	AUR
02294338	LANTUS SOLOSTAR	SAC		GLUCONORM	NOO
100U SOLUT	TION			JAMP REPAGLINIDE	JMP
02444844	BASAGLAR	LIL		REPAGLINIDE	PDL
02461528	BASAGLAR	LIL		SANDOZ REPAGLINIDE	SDZ
300U SOLUT	TION		323300		
02441829	TOUJEO SOLOSTAR	SAC			

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AZC

AZC

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

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

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
- 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.

02443937 JARDIANCE

ST 10MG TABLET

" 25MG TABL	ET	
02443945	JARDIANCE	BOE

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

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.

ST **850MG & 5MG TABLET** 02449935 XIGDUO

⁵⁷ **1000MG & 5MG TABLET** 02449943 XIGDUO

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.

1 0	•	•	
500MG & 12	.5MG TABLET		
02456605	SYNJARDY	BOE	=
500MG & 5M	IG TABLET		
02456575	SYNJARDY	BOE	Ξ
850MG & 12	.5MG TABLET		
02456613	SYNJARDY	BOE	Ξ
850MG & 5M	IG TABLET		
02456583	SYNJARDY	BOE	Ξ
1000MG & 1	2.5MG TABLE	Γ	
02456621	SYNJARDY	BOE	Ξ
1000MG & 5	MG TABLET		
02456591	SYNJARDY	BOE	Ξ

68:20.20 ANTIDIABETIC AGENTS - SULFONYLUREAS

GLICLAZIDE

ST 80MG TABL	ST 80MG TABLET						
02245247	APO-GLICLAZIDE	APX					
00765996	DIAMICRON	SEV					
02248453	GLICLAZIDE	PDL					
02287072	GLICLAZIDE	SAN					
02238103	TEVA-GLICLAZIDE	TEV					
ST 30MG TABL	ET (EXTENDED RELEASE)						
02297795	APO-GLICLAZIDE MR	APX					
02242987	DIAMICRON MR	SEV					
02429764	JAMP GLICLAZIDE-MR	JMP					
02423286	MINT-GLICLAZIDE MR	MIN					
02438658	MYLAN-GLICLAZIDE MR	MYL					
02463571	RAN-GLICLAZIDE MR	RBY					
02461323	SANDOZ GLICLAZIDE MR	SDZ					
ST 60MG TABL	ET (EXTENDED RELEASE)						
02407124	APO-GLICLAZIDE MR	APX					
02356422	DIAMICRON MR	SEV					
02423294	MINT-GLICLAZIDE MR	MIN					
02439328	RAN-GLICLAZIDE	RBY					
02461331	SANDOZ GLICLAZIDE MR	SDZ					

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BOE

68:20.20 ANT	IDIABETIC AGENTS -		68:22.12 GLYCOGENOLYTIC AGENTS	
SUL	FONYLUREAS		GLUCAGON RECOMBINANT DNA ORGIN	
GLYBURIDE			ANACAMI IN IECTION	
	_		1MG/ML INJECTION	NOO
ST 2.5MG TABLE			02333619 GLUCAGEN 02333627 GLUCAGEN HYPOKIT	NOO NOO
	APO GLYBURIDE	APX		
02224550 I		SAC	02243297 GLUCAGON	LIL
01959352		PDL	68:24.00 PARATHYROID	
02350459		SAN	CALCITONIN SALMON (SYNTHETIC)	
	TEVA-GLYBURIDE	TEV	200IU/ML SOLUTION	
ST 5MG TABLET			01926691 CALCIMAR	SAC
	APO GLYBURIDE	APX		SAC
	DIABETA	SAC	68:28.00 PITUITARY	
	DOM-GLYBURIDE	DPC	DESMOPRESSIN ACETATE	
00720941 I		PMS	4MCG/ML LIQUID	
02350467		SAN	00873993 DDAVP	FEI
	PMS-GLYBURIDE	PMS	0.1MG/ML NASAL SPRAY	
	TEVA-GLYBURIDE	TEV	00402516 DDAVP	FEI
68:20.28 THIA	AZOLIDINEDIONES		00836362 DDAVP	FEI
PIOGLITAZON	IE HYDROCHLORIDE		02242465 DESMOPRESSIN	AAP
ST 15MG TABLE	т		ST 0.1MG TABLET	
	ACCEL PIOGLITAZONE	ACP	00824305 DDAVP	FEI
	ACCLE PIOGLITAZONE ACH-PIOGLITAZONE	ACC	02284030 DESMOPRESSIN	APX
	ACT PIOGLITAZONE	ACG	02304368 PMS-DESMOPRESSIN	PMS
	APO-PIOGLITAZONE	APX	02287730 TEVA-DESMOPRESSIN	TEV
	JAMP-PIOGLITAZONE	JMP	ST 0.2MG TABLET	
	MINT-PIOGLITAZONE	MIN	00824143 DDAVP	FEI
	PMS-PIOGLITAZONE	PMS	02284049 DESMOPRESSIN	APX
	PRO-PIOGLITAZONE	PDL	02304376 PMS-DESMOPRESSIN	PMS
	RAN-PIOGLITAZONE	RBY	ST 60MCG TABLET (ORALLY DISINTEGRATING)	
	SANDOZ PIOGLITAZONE	SDZ	02284995 DDAVP MELT	FEI
57 30MG TABLE		SDZ	ST 120MCG TABLET (ORALLY DISINTEGRATING)	
	ACCEL PIOGLITAZONE	ACP	02285002 DDAVP MELT	FEI
	ACH-PIOGLITAZONE	ACC	ST 240MCG TABLET (ORALLY DISINTEGRATING)	
	ACT PIOGLITAZONE	ACG	02285010 DDAVP MELT	FEI
	APO-PIOGLITAZONE	APX	68:32.00 PROGESTINS	
	JAMP-PIOGLITAZONE	JMP		
	MINT-PIOGLITAZONE	MIN	DIENOGEST	
	PMS-PIOGLITAZONE	PMS	Limited use benefit (prior approval required).	
	PRO-PIOGLITAZONE	PDL		
	RAN-PIOGLITAZONE	RBY	For the management of pelvic pain associated with endometriosis.	
	SANDOZ PIOGLITAZONE	SDZ		
ST 45MG TABLE		052	ST 2MG TABLET	DAY
	ACCEL PIOGLITAZONE	ACP	02374900 VISANNE	BAY
	ACH-PIOGLITAZONE	ACC	MEDROXYPROGESTERONE ACETATE	
	ACT PIOGLITAZONE	ACG	150MG/ML SUSPENSION	
	APO-PIOGLITAZONE	APX	00585092 DEPO-PROVERA	PFI
	JAMP-PIOGLITAZONE	JMP	02322250 MEDROXYPROGESTERONE	SDZ
	MINT-PIOGLITAZONE	MIN	ST 2.5MG TABLET	
	PMS-PIOGLITAZONE	PMS	02244726 APO-MEDROXY	APX
	PRO-PIOGLITAZONE	PDL	02253550 MEDROXY	PDL
	RAN-PIOGLITAZONE	RBY	00708917 PROVERA	PFI
	SANDOZ PIOGLITAZONE	SDZ	02221284 TEVA-MEDROXYPROGESTERONE	TEV
			ST 5MG TABLET	
			02244727 APO-MEDROXY	APX
			02253577 MEDROXY	PDL
			00030937 PROVERA	PFI

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			Non-insured nealth be	enents
68:32.00 PR	OGESTINS		68:36.04 THYROID AGENTS	
MEDROXYPE	ROGESTERONE ACETATE		LIOTHYRONINE SODIUM	
ST 5MG TABLE	т		ST 5MCG TABLET	
	TEVA-MEDROXYPROGESTERONE	TEV	01919458 CYTOMEL	PFI
ST 10MG TABL	ET		ST 25MCG TABLET	
02277298	APO-MEDROXY	APX	01919466 CYTOMEL	PFI
00729973	PROVERA	PFI	THYROID	
02221306	TEVA-MEDROXYPROGESTERONE	TEV	ST 30MG TABLET	
ST 100MG TABI	LET		00023949 THYROID	ERF
02267640	APO-MEDROXY	APX	st 60MG TABLET	EKF
PROGESTER	RONE		00023957 THYROID	ERF
Limited use bene	fit (prior approval required).		ST 125MG TABLET	
For the treatment	t of women		00023965 THYROID	ERF
	pausal symptoms who are intolerant to		68:36.08 ANTITHYROID AGENTS	
medroxyprogeste	erone acetate (MPA); OR of preterm birth; OR		METHIMAZOLE	
	the medication to prevent miscarriage.		ST 5MG TABLET	
			02480107 MAR-METHIMAZOLE	MAR
In adults:	des Affinesis es Henrico Theorem		00015741 TAPAZOLE	PAL
	der Affirming Hormone Therapy.		ST 10MG TABLET	FAL
100MG CAP			02480115 MAR-METHIMAZOLE	MAR
	PMS-PROGESTERONE	PMS	02296039 TAPAZOLE	PAL
	PROMETRIUM	FRS	PROPYLTHIOURACIL	
	REDDY-PROGESTERONE TEVA-PROGESTERONE	REC TEV		
		Ι⊑V	57 50MG TABLET	DAI
	YROID AGENTS		00010200 PROPYL-THYRACIL ST 100MG TABLET	PAL
LEVOTHYRO	OXINE SODIUM		00010219 PROPYL-THYRACIL	PAL
ST 0.025MG TA	BLET		00010210 1110112 11111110012	1712
02172062	SYNTHROID	BGP		
$^{s au}$ 0.05MG TAB	LET			
	ELTROXIN	ASP		
	SYNTHROID	BGP		
^{S7} 0.075MG TA				
	SYNTHROID	BGP		
ST 0.088MG TA		DOD		
02172097 ST 0.1MG TABL	SYNTHROID	BGP		
	ELTROXIN	ASP		
	SYNTHROID	BGP		
ST 0.112MG TA		ВОГ		
***************************************	SYNTHROID	BGP		
ST 0.125MG TA				
02172119	SYNTHROID	BGP		
$^{s au}$ 0.137MG TA	BLET			
02233852	SYNTHROID	BGP		
ST 0.15MG TAB	LET			
02213214	ELTROXIN	ASP		
	SYNTHROID	BGP		
^{s⊤} 0.175MG TA				
	SYNTHROID	BGP		
ST 0.2MG TABL		204		
	ELTROXIN	ASP		
	SYNTHROID	BGP		
ST 0.3MG TABL	SYNTHROID	BGP		
021/2101	OTMITIMOID	מטט		

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72:00 LOCAL ANESTHETICS

72:00.00 LOCAL ANESTHETICS LIDOCAINE HYDROCHLORIDE

2% LIQUID

00811874 PMS-LIDOCAINE VISCOUS

2% SOLUTION

01968823 LIDODAN VISCOUS

PMS ODN

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76:00 OXYTOCICS 76:00.00 OXYTOCICS MISOPROSTOL, MIFEPRISTONE

200MCG & 200MG TABLET 02444038 MIFEGYMISO

LIP

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				Ť
84:00 SKIN	AND MUCOUS		84:04.04 SMMA - ANTIBIOTICS	
MEM	BRANE AGENTS (SMN	/IA)	METRONIDAZOLE, NYSTATIN	
84·04 04 SM	IMA - ANTIBIOTICS	-	500MG & 100,000IU SUPPOSITORY	
BACITRACIN			01926829 FLAGYSTATIN SA	AC
			MUPIROCIN	
500IU OINT			2% OINTMENT	
00584908		PED		SK
	JAMP-BACITRACINE	JMP		AR
CLINDAMYC	IN PHOSPHATE		MUPIROCIN CALCIUM	
2% CREAM			2% CREAM	
02060604		PFI		SK
1% SOLUTIO			POLYMYXIN B SULFATE, BACITRACIN ZINC	0.1
	CLINDA-T	VAE	·	
	DALACIN T	PFI	10,000IU & 500IU OINTMENT	
	TARO-CLINDAMYCIN XTEMPORANEOUS MIXTURE	TAR		MS
	CLINDAMYCIN IN DILUSOL OR	UNK		MS DN
33302000	DUONALC	ONIX		MP
CLINDAMYC	IN PHOSPHATE, BENZOYL			JAJ
PEROXIDE	.,			DZ
1% & 3% GE	:1		POLYMYXIN B SULFATE, BACITRACIN ZINC,	
	CLINDOXYL ADV	GSK	GRAMICIDIN	
1% & 5% GE		00.1	10,000U & 500U & 0.25MG OINTMENT	
	BENZACLIN	VAE	•	JAJ
02243158	CLINDOXYL	GSK	POLYMYXIN B SULFATE, GRAMICIDIN	7 10
02464519	TARO-BENZOYL PEROXIDE /	TAR	·	
00440400	CLINDAMYCIN KIT	T4.D	0.25MG & 10,000IU CREAM	1
02440180	TARO-CLINDAMYCIN/BENZOYL PEROXIDE	TAR		JAJ
ERYTHROM	YCIN, BENZOYL PEROXIDE		84:04.06 SMMA - ANTIVIRALS	
3% & 5% GE	,		ACYCLOVIR	
	BENZAMYCIN	VAE	5% CREAM	
FUSIDATE S		VAL	02039524 ZOVIRAX V	ΆE
			5% OINTMENT	
2% OINTME		. 50		PX
00586676		LEO		ΆE
FUSIDIC ACI	ט		SINECATECHINS	
2% CREAM			10% OINTMENT	
00586668		LEO		PAL
FUSIDIC ACI	D, HYDROCORTISONE ACET	TATE	84:04.08 SMMA - ANTIFUNGALS	
2% & 1% CR	REAM		BETAMETHASONE DIPROPIONATE,	
02238578	FUCIDIN H	LEO	CLOTRIMAZOLE	
METRONIDA	ZOLE		0.05% & 1% CREAM	
1% CREAM				RS
	NORITATE	BSH	CICLOPIROX OLAMINE	
0.75% GEL			1% CREAM	
02092832	METROGEL	GAC		ΆE
	NIDAGEL	VAE	1% LOTION	
1% GEL	METROOF			ΆE
	METROGEL	GAC	CLOTRIMAZOLE	
0.75% LOTIO	ON METROLOTION	GAC	1% CREAM	
02248206	IVIL I ROLUTION	GAU		AY
				AY
				AR

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04-04-00 CM	MA ANTIFUNCAL C		04-04-00 CMMA ANTICHNOALC	
	MA - ANTIFUNGALS		84:04.08 SMMA - ANTIFUNGALS	
CLOTRIMAZ	OLE		TOLNAFTATE	
1% CREAM			1% AEROSOL	
00812382	CLOTRIMADERM	TAR	00576050 TINACTIN AEROSOL	BAY
02229380	CLOTRIMAZOLE	TAR	1% CREAM	
00874043	NEO-ZOL	PPI	00576034 TINACTIN	BAY
00874051	NEO-ZOL	PPI	1% POWDER	
2% CREAM			01919245 DRSCHOLL'S ATHLETE'S FOOT	BAY
02150905	CANESTEN	BAY	SPRAY	
00812374	CLOTRIMADERM	TAR	00576042 TINACTIN	BAY
1% & 200MG	TABLET (CONTROLLED RELEASE)		84:04.12 SMMA - SCABICIDES AND	
	CANESTEN COMBI-PAK COMFORTAB 3	BAY	PEDICULICIDES CROTAMITON	
	TABLET (CONTROLLED RELEASE)		CROTAINITON	
02264102	CANESTEN COMBI-PAK	BAY	10% CREAM	
	COMFORTAB 1		00623377 EURAX	CLC
	INAL TABLET	DAY	DIMETHICONE	
	CANESTEN COMFORTAB 1	BAY	50% SOLUTION	
KETOCONAZ	OLE		02373785 NYDA	GPB
2% CREAM			ISOPROPYL MYRISTATE	
02245662	KETODERM	TPT		
2% SHAMPO	00		50% SOLUTION	
02182920	NIZORAL	UNK	02279592 RESULTZ	MDF
MICONAZOL	E NITRATE		PERMETHRIN	
2% CREAM			1% CREAM	
02085852	MICATIN	WPC	00771368 NIX	INS
	MICOZOLE	TAR	5% CREAM	
	MONISTAT 7	INS	02219905 NIX DERMAL	GSK
	MONISTAT DERM	INS	1% LIQUID	
	CREAM/VAGINAL SUPPOSITORY	1110	02231480 KWELLADA-P	MTC
	MONISTAT 7 DUAL-PAK	INS	5% LOTION	
	CREAM/VAGINAL SUPPOSITORY		02231348 KWELLADA-P	MTC
	MONISTAT 3 DUAL-PAK	INS	PIPERONYL BUTOXIDE, PYRETHRINS	
400MG OVU			3% & 0.3% SHAMPOO	
	MONISTAT 3	INS	02125447 R & C SHAMPOO WITH	MTC
400MG SUPI			CONDITIONER	WITC
02171775	MICONAZOLE 3 DAY OVULE	VTH	84:04.92 SMMA - MISCELLANEOUS	
	TREATMENT		LOCAL ANTI-INFECTIVES	
NYSTATIN				
25,000IU CR	FAM		ISOPROPYL ALCOHOL	
•	NYADERM	TAR	70% LIQUID	
100,000IU CI			00426539 DUONALC	ICN
•	NYADERM	TAR	METRONIDAZOLE	
02194236	RATIO-NYSTATIN	TEV	10% CREAM	
02194163	TEVA-NYSTATIN	TEV	01926861 FLAGYL	SAC
100,000IU OI	INTMENT			OAO
•	RATIO-NYSTATIN	TEV	POVIDONE-IODINE	
TERBINAFIN	E HYDROCHLORIDE		10% SOLUTION 00158348 BETADINE	PFR
1% CREAM			SELENIUM SULFIDE	
02031094		NVR	2.5% LOTION	
TERCONAZO			00594601 VERSEL	VAE
0.4% CREAN			2.5% SHAMPOO	
02247651	TARO-TERCONAZOLE	TAR	00243000 EXTRA STRENGTH SELSUN	SAC

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OA-OA OO OMMAA MIOOFI I ANFOLIO		04-00 00 OMMA ANTUNE AMMATORY	
84:04.92 SMMA - MISCELLANEOUS LOCAL ANTI-INFECTIVES		84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS	
SILVER SULFADIAZINE		BETAMETHASONE VALERATE	
1% CREAM		0.05% CREAM	
00323098 FLAMAZINE	SNE	02357860 CELESTODERM V	VAE
09854037 FLAMAZINE	SMW	00535427 RATIO-ECTOSONE	TEV
		0.1% CREAM	1
84:06.00 SMMA - ANTI-INFLAMMATO	JK I	00716626 BETADERM	TAR
AGENTS		02357844 CELESTODERM V	VAE
AMCINONIDE		00535435 RATIO-ECTOSONE	TEV
0.1% CREAM		0.05% LOTION	
02246714 TARO-AMCINONIDE	TAR	00653209 RATIO-ECTOSONE	TEV
0.1% LOTION		0.1% LOTION	
02247097 RATIO-AMCINONIDE	TEV	00716634 BETADERM	TAR
0.1% OINTMENT		00750050 RATIO-ECTOSONE	TEV
02247096 RATIO-AMCINONIDE	TEV	01940112 RIVASONE	RIV
BECLOMETHASONE DIPROPIONATE		00027944 VALISONE	VAE
0.025% CREAM		0.05% OINTMENT	
02089602 PROPADERM	VAE	00716642 BETADERM	TAR
	VAE	02357879 CELESTODERM V	VAE
BETAMETHASONE DIPROPIONATE		0.1% OINTMENT	
0.05% CREAM		00716650 BETADERM	TAR
00323071 DIPROSONE	FRS	02357852 CELESTODERM V	VAE
02122073 ROLENE	RIV	BUDESONIDE, SODIUM CHLORIDE	
02122049 ROSONE	RIV	0.02MG/ML ENEMA	
01925350 TARO-SONE	TAR	02052431 ENTOCORT	TIL
00849650 TEVA-TOPILENE	TEV	CALCIPOTRIOL, BETAMETHASONE	
00804991 TEVA-TOPISONE	TEV	DIPROPIONATE	
0.05% LOTION			
00417246 DIPROSONE	FRS	50MCG & 0.5MG AEROSOL (FOAM)	
02122065 ROLENE	RIV	02457393 ENSTILAR	LEO
02122030 ROSONE	RIV	0.5MG & 50MCG GEL	
01927914 TEVA-TOPILENE 00809187 TEVA-TOPISONE	TEV	02319012 DOVOBET	LEO
	TEV	0.5MG & 50MCG OINTMENT	
0.05% OINTMENT 00629367 DIPROLENE	FRS	02244126 DOVOBET	LEO
00029307 DIFROLENE 00344923 DIPROSONE	FRS	CLOBETASOL PROPIONATE	
02122081 ROLENE	RIV	0.05% CREAM	
02122081 ROLLINE 02122057 ROSONE	RIV	02213265 DERMOVATE	TPT
00849669 TEVA-TOPILENE	TEV	02024187 MYLAN-CLOBETASOL	MYL
00805009 TEVA-TOPISONE	TEV	02232191 PMS-CLOBETASOL	PMS
BETAMETHASONE DIPROPIONATE, SA		02309521 PMS-CLOBETASOL	PMS
ACID	LIGILIG	02245523 TARO-CLOBETASOL	TAR
		01910272 TEVA-CLOBETASOL	TEV
0.05% & 2% LOTION		0.05% LOTION	
00578428 DIPROSALIC	FRS	02213281 DERMOVATE	TPT
02245688 RATIO-TOPISALIC	TEV	02216213 MYLAN-CLOBETASOL	MYL
0.05% & 3% OINTMENT		02232195 PMS-CLOBETASOL	PMS
00578436 DIPROSALIC	FRS	02245522 TARO-CLOBETASOL	TAR
PDIN FOR EXTEMPORANEOUS MIXTURE	LINUZ	01910299 TEVA-CLOBETASOL	TEV
99500003 SALICYLIC ACID IN CORTICOSTEROID CREAM	UNK	0.05% OINTMENT	TDT
99501001 SALICYLIC ACID IN NON-	UNK	02213273 DERMOVATE	TPT
MEDICATED OINTMENT	ONIX	02026767 MYLAN-CLOBETASOL	MYL
BETAMETHASONE VALERATE		02309548 PMS-CLOBETASOL 02245524 TARO-CLOBETASOL	PMS TAR
		01910280 TEVA-CLOBETASOL	TEV
0.05% CREAM 00716618 BETADERM	TAR	31310200 TEVA-OLOBETAGOL	1 L V
OUT TOO TO DETADERIN	IAN		

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84:06.00 SMMA - ANTI-INFLAMMATORY	8	84:06.00 SMMA - ANTI-INFLAMMATORY
AGENTS		AGENTS
CLOBETASONE BUTYRATE		HALOBETASOL PROPIONATE
0.05% CREAM		0.05% CREAM
02214415 SPECTRO ECZEMACARE G	SSK	01962701 ULTRAVATE UNK
DESONIDE		0.05% OINTMENT
		01962728 ULTRAVATE UNK
0.05% CREAM		HYDROCORTISONE ACETATE
	PED	
	PER	2.5% CREAM
0.05% OINTMENT		02469421 SANDOZ HYDROCORTISONE SDZ
	PED	HYDROCORTISONE ACETATE, UREA
	PER	1% CREAM
DESOXIMETASONE		80073645 M-HC UREA MAN
0.05% CREAM		1% & 10% CREAM
02221918 TOPICORT MILD B	BSH	00681989 DERMAFLEX HC PAL
0.25% CREAM		1% LOTION
02221896 TOPICORT B	BSH	80073689 M-HC UREA MAN
0.05% GEL		1.00% LOTION
02221926 TOPICORT B	BSH	00681997 DERMAFLEX HC PAL
0.25% OINTMENT		HYDROCORTISONE ACETATE, ZINC SULFATE
02221934 TOPICORT B	BSH	·
ESCULIN, FRAMYCETIN SULFATE, DIBUCAINE		0.5% & 0.5% OINTMENT
HYDROCHLORIDE, HYDROCORTISONE	-	02128446 ANODAN-HC ODN
ACETATE		00505773 ANUSOL HC CHU
		02209764 EGOZINC-HC PMS
1% & 1% & 0.5% & 0.5% OINTMENT		00607789 RATIO-HEMCORT-HC TEV
	DDN	02179547 RIVA-HC RIV
02223252 PROCTOSEDYL A	APC	02247691 SANDOZ ANUZINC HC SDZ
02242527 SANDOZ PROCTOMYXIN HC S	SDZ	10MG & 10MG SUPPOSITORY
10MG & 10MG & 5MG & 5MG OINTMENT		02236399 ANODAN-HC ODN
02226383 TEVA-PROCTOSONE T	ΓΕV	00476285 ANUSOL HC CHU
10MG & 10MG & 5MG & 5MG SUPPOSITORY		02210517 EGOZINC-HC PMS
02247882 PROCTOL O	DDN	02240112 RIVASOL-HC RIV
02223260 PROCTOSEDYL A	APC	02242798 SANDOZ ANUZINC HC SDZ
02242528 SANDOZ PROCTOMYXIN HC S	SDZ	HYDROCORTISONE ACETATE, ZINC SULFATE
02226391 TEVA-PROCTOSONE T	ΓEV	MONOHYDRATE
FLUOCINONIDE		0.5% & 0.5% OINTMENT
0.05% CREAM		02387239 JAMP-ZINC-HC JMP
	/AE	HYDROCORTISONE ACETATE, ZINC SULFATE,
	/AE	PRAMOXINE HYDROCHLORIDE
	TPT	PRAINIONINE HT DROCHLORIDE
	TPT	0.5% & 0.5% & 1% OINTMENT
0.05% GEL		00505781 ANUGESIC HC MCL
	/AE	02234466 PROCTODAN-HC ODN
	TPT	10MG & 10MG & 20MG SUPPOSITORY
0.01% LOTION	IFI	00476242 ANUGESIC HC MCL
	HIL	02240851 PROCTODAN-HC ODN
0.025% OINTMENT	11111	02242797 SANDOZ ANUZINC HC PLUS SDZ
	/AE	HYDROCORTISONE ACETATE-UREA
0.05% OINTMENT	/ //L	1% CREAM
	/AE	80061501 JAMP-HYDROCORTISONE UREA MAN
	TPT	HYDROCORTISONE VALERATE
0.01% SOLUTION	/AE	0.2% CREAM
02162504 SYNALAR V	/ AL	02242984 HYDROVAL TPT

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	IMA - ANTI-INFLAMMATORY ENTS		84:08.00 SMMA - ANTIPRURITICS AND LOCAL ANESTHETICS	
HYDROCOR'	TISONE VALERATE		LIDOCAINE	
0.2% OINTM	ENT		Limited use benefit (prior approval not required).	
	HYDROVAL	TPT		
	NE FUROATE		Coverage will be limited to 35 grams every 30 days.	
WOWLETASO	NE FOROATE		5% OINTMENT	
0.1% CREAM	И		02386836 JAMPOCAINE	JMP
00851744	ELOCOM	FRS	01963988 LIDODAN	ODN
02367157	TARO-MOMETASONE	TAR	02083795 LIDODAN	ODN
0.1% LOTIO	N		00001961 XYLOCAINE	UNK
00871095	ELOCOM	FRS	LIDOCAINE HCL	
0.1% OINTM			5% OINTMENT	
00851736	ELOCOM	FRS	00811475 XYLOCAINE	UNK
02244769	PMS-MOMETASONE	PMS		ONIX
02270862	PMS-MOMETASONE	PMS	LIDOCAINE HYDROCHLORIDE	
02266385	TARO-MOMETASONE	TAR	2% SOLUTION	
02248130	TEVA-MOMETASONE	TEV	02427745 JAMPOCAINE VISCOUS	JMP
PDIN FOR E	XTEMPORANEOUS MIXTURE		LIDOCAINE, PRILOCAINE	
99500008	MOMETASONE CREAM	UNK	2.5% & 2.5% CREAM	
TRIAMCINOL	ONE ACETONIDE		00886858 EMLA	LINIZ
0.1% CREAM	А			UNK
	ARISTOCORT R	VAE	2.5% & 2.5% PATCH	LINUZ
	TRIADERM	TAR	02057794 EMLA	UNK
0.5% CREAN		IAN	PHENAZOPYRIDINE HYDROCHLORIDE	
	ARISTOCORT C	VAE	100MG TABLET	
		VAE	00476714 PYRIDIUM	ERF
0.1% OINTM	ARISTOCORT R	VAE	84:16.00 SMMA - CELL STIMULANTS ANI	ח
		VAE	PROLIFERANTS	
0.1% PASTE	: ORACORT DENTAL PASTE	TAR		
	ORACORI DENTAL PASTE	IAK	TRETINOIN	
84:06.08			0.01% CREAM	
HYDROCOR'	TISONE ACETATE		00897329 RETIN-A	VAE
0.5% CREA	Л		00657204 STIEVA-A	GSK
	 CORTATE	BAY	0.025% CREAM	
	HYDERM	TAR	00897310 RETIN-A	VAE
02242930	HYDROCORTISONE ACETATE	TAR	00578576 STIEVA-A	GSK
1% CREAM	THE ROCORTISONE ACETATE	IAIX	0.05% CREAM	
00192597	EMOCORT	GSK	00443794 RETIN-A	VAE
		EUR	00518182 STIEVA-A	GSK
02412926 00716839	EUROHYDROCORTISONE	TAR	0.01% GEL	
	HYDERM		00870013 RETIN-A	VAE
00564281	HYDROSONE	TEV	01926462 VITAMIN A ACID	VAE
80057178	JAMP-HC	JMP	0.025% GEL	V/ (L
80057189	JAMP-HYDROCORTISONE	JMP	00443816 RETIN-A	VAE
80066164	M-HC	MAN	01926470 VITAMIN A ACID	VAE
00804533	PREVEX HC	GSK	0.05% GEL	VAL
0.5% LOTIO		5414	01926489 VITAMIN A ACID	VAE
80021087	CORTATE	BAY		VAL
1% LOTION	IAMB LIVERGOODTIOONS	11.45	84:24.00 EMOLLIENTS, DEMULCENTS,	
80057191	JAMP-HYDROCORTISONE	JMP	AND PROTECTANTS	
80066168	M-HC	MAN	UREA	
00578541		GSK	10% CREAM	
0.5% OINTM		5 • • • •	80079497 UREMOL 10	ODN
	CORTATE	BAY	80005397 URISEC10	ODN
	CORTODERM	TAR	20% CREAM	ODIN
1% OINTME		-	80083394 UREMOL	ODN
00716693	CORTODERM	TAR	OUOOOOOT OI\LIVIOL	ODIN

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84:24.00 EMOLLIENTS, DEMULCENTS,		84:28.00 KERATOLYTIC AGENTS	
AND PROTECTANTS		SALICYLIC ACID	
UREA		20% LIQUID	
22% CREAM		00690333 SOLUVER	DPT
00396125 URISEC 22	ODN	26% LIQUID	
10% LOTION		00754951 OCCLUSAL HP	VAE
80079498 UREMOL 10	ODN	27% LIQUID	
12% LOTION		00837733 SOLUVER PLUS	DPT
00514896 URISEC 12	ODN	40% PLASTER	D 4) /
84:24.12 BASIC OINTMENTS AND		01967878 DR SCHOLLS CLEAR AWAY PLANTAR WART REMOVER	BAY
PROTECTANTS		SYSTEM	
DIMETHICONE		01974335 DR SCHOLLS CLEAR AWAY WART REMOVER SYSTEM	BAY
20% CREAM		4% SHAMPOO	
02060841 BARRIERE	WPC	00666106 SEBCUR	DPT
WHITE PETROLATUM		84:32.00 KERATOPLASTIC AGENTS	
71.5% OINTMENT		COAL TAR	
02277778 CRITIC-AID CLEAR	UNK		
ZINC OXIDE		10% GEL	0011
15% CREAM		00344508 TARGEL	ODN
02215799 ZINC OXIDE	HJS	0.5% SHAMPOO 02240645 NEUTROGENA	JAJ
25% PASTE		1% SHAMPOO	JAJ
00532576 PATE D'IHLE	TEV	02307146 T/ THERAPEUTIC SHAMPOO	JAJ
00886327 PÂTE D'IHLE	ATL	EXTRA STRENGTH	0, 10
ZINC OXIDE, WHITE PETROLATUM		20% SOLUTION	
15% & 80.3% CREAM		00358495 ODAN LIQUOR CARBONIS	ODN
02337452 DIAPER RASH	HJS	DETERGENT	
40% OINTMENT		COAL TAR, SALICYLIC ACID	
02239160 ZINCOFAX EXTRA STRENGTH	PAL	10% & 3% GEL	
84:28.00 KERATOLYTIC AGENTS		00510335 TARGEL SA	ODN
BENZOYL PEROXIDE		10% & 4% SHAMPOO	DDT
		00666114 SEBCUR-T	DPT
5% GEL 02162113 BENZAGEL	CLC	84:92.00 MISCELLANEOUS SKIN AND	
4% LOTION	CLC	MUCOUS MEMBRANE AGENTS	
02413353 SPECTRO ACNECARE WASH	GSK	ACITRETIN	
5% LOTION		Open benefit (prior approval not required).	
02166607 BENZAGEL 5	CLC	Soriatane should be used with caution in women of	
5% SOLUTION		childbearing potential due to its teratogenicity. Pregnancy	
02162121 BENZAGEL	CLC	must be excluded. Effective contraception must be used.	
CANTHARIDIN		Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or	
1% LIQUID		dispensing this drug.	
80028872 CANTHACUR 07	PAL	ST 10MG CAPSULE	
CANTHARIDIN, PODOPHYLLIN, SALICYLIC	ACID	02468840 MINT-ACITRETIN	MIN
1% & 2% & 30% LIQUID		02070847 SORIATANE	ALL
00772011 CANTHARONE PLUS	DOR	02466074 TARO-ACITRETIN	TAR
CLINDAMYCIN PHOSPHATE, TRETINOIN		ST 25MG CAPSULE	
,		02468859 MINT-ACITRETIN	MIN
1.2% & 0.025% GEL	DOLL	02070863 SORIATANE	ALL TAR
02359685 BIACNA TOPICAL	BSH	02466082 TARO-ACITRETIN	IAK
SALICYLIC ACID		ADAPALENE	
170MG/ML GEL	,	0.1% CREAM	
00614246 COMPOUND W GEL	UNK	02231592 DIFFERIN	GAC

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84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

ADAPALENE

0.1% GEL

02148749 DIFFERIN GAC

0.3% GEL

02274000 DIFFERIN XP GAC

AZELAIC ACID

15% GEL

02270811 FINACEA LEO

BRODALUMAB

Limited use benefit (prior approval required).

· 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

02157101	CAPSAICIN	VAE
02244952	ZODERM	EUR
00740306	ZOSTRIX	VAE
0.075% CRE	AM	
02157128	CAPSAISIN	VAE

COLLAGENASE

250U OINTMENT

02004240 ZOSTRIX HP

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 highpotency 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

VAF

Limited use benefit (prior approval required).

For the treatment of condylomata acuminate (genital warts) in patients who have failed:

- self-applied podophyllotoxin (podofilox 0.5% solution); OR
- provider-applied podophyllum resin (10%-25%).

5% CREAM

 02239505
 ALDARA P
 BSH

 02407825
 APO-IMIQUIMOD
 APX

 02482983
 TARO-IMIQUIMOD PUMP
 TAR

ISOTRETINOIN

Open benefit (prior approval not required).

Accutane should be used with caution in women of childbearing potential due to its teratogenicity. Pregnancy must be excluded. Effective contraception must be used. Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or dispensing this drug.

ST 10MG CAPSULE

 00582344
 ACCUTANE ROCHE
 HLR

 02257955
 CLARUS
 MYL

 02396971
 EPURIS
 CIP

 20MG CAPSULE
 CIP

 02396998
 EPURIS
 CIP

30MG CAPSULE

02397005 EPURIS CIP

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84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

ISOTRETINOIN

Open benefit (prior approval not required).

Accutane should be used with caution in women of childbearing potential due to its teratogenicity. Pregnancy must be excluded. Effective contraception must be used. Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or dispensing this drug.

ST 40MG CAPSULE

00582352	ACCUTANE ROCHE	HLR
02257963	CLARUS	MYL
02397013	EPURIS	CIP

IXEKIZUMAB

Limited use benefit (prior approval required).

- · Psoriatic Arthritis according to established criteria.
- · Psoriasis according to established criteria.

(Please refer to Appendix A).

80MG SOLUTION

02455102	TALTZ	LII
02455110	TALTZ	LII

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

SALICYLIC ACID, FLUOROURACIL

10% & 0.5% SOLUTION

02428946 ACTIKERALL CIP

SECUKINUMAB

Limited use benefit (prior approval required).

- · Psoriasis according to established criteria.
- · Psoriatic Arthritis according to established criteria.
- · Anklyosing Spondylitis according to established criteria.

(Please refer to Appendix A).

150MG/ML INJECTION

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

84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

SECUKINUMAB

Limited use benefit (prior approval required).

- · Psoriasis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Anklyosing Spondylitis according to established criteria.

(Please refer to Appendix A).

150MG SOLUTION

02438070 COSENTYX NVR

TACROLIMUS (PROTOPIC)

Limited use benefit (prior approval required).

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

Note: Contraindicated in children less than 2 years of age.

0.03% OINTMENT

02244149 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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SDZ

PDL

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

7.5MG TABLET (EXTENDED RELEASE)

UNK 02273217 ENABLEX

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

ST 4MG TABLET (EXTENDED RELEASE)

02380021 TOVIAZ PFI **ST 8MG TABLET (EXTENDED RELEASE)**

02380048 TOVIAZ PFI

FLAVOXATE HYDROCHLORIDE

ST 200MG TABLET

00728179 URISPAS PAL

OXYBUTYNIN CHLORIDE

ST 1MG/ML	SYRUP
-----------	--------------

02231089 APO-OXYBUTYNIN APX 02223376 PMS-OXYBUTYNIN **PMS**

ST 2.5MG TABLET

02240549 PMS-OXYBUTYNIN **PMS**

ST 5MG TABLET

02163543 APO-OXYBUTYNIN APX DPC 02241285 DOM-OXYBUTYNIN 02350238 **OXYBUTYNIN** SAN 02240550 PMS-OXYBUTYNIN **PMS** RIV 02299364 **RIVA-OXYBUTYNIN** 02230394 TEVA-OXYBUTYNIN TEV

PROPIVERINE HYDROCHLORIDE

5MG TABLET

02460289 MICTORYL PEDIATRIC DUI

SOLIFENACIN SUCCINATE

ST 5MG TABLET

1		-	
	02423375	APO-SOLIFENACIN	APX
	02446375	AURO-SOLIFENACIN	AUR
	02424339	JAMP-SOLIFENACIN	JMP
	02428911	MED-SOLIFENACIN	GMP
	02417723	PMS-SOLIFENACIN	PMS
	02437988	RAN-SOLIFENACIN	RBY

86:12.04 ANTIMUSCARINICS **SOLIFENACIN SUCCINATE**

ST 5MG TABLET

02399032	SANDOZ SOLIFENACIN	SDZ
02458144	SOLIFENACIN	PDL
02458241	SOLIFENACIN	SAN
02397900	TEVA-SOLIFENACIN	TEV
02277263	VESICARE	AST
ST 10MG TABL	ET	
02423383	APO-SOLIFENACIN	APX
02446383	AURO-SOLIFENACIN	AUR
02424347	JAMP-SOLIFENACIN	JMP
02428938	MED-SOLIFENACIN	GMP
02417731	PMS-SOLIFENACIN	PMS
02437996	RAN-SOLIFENACIN	RBY

02399040 02458152 **SOLIFENACIN**

SOLIFENACIN SAN 02458268 02397919 TEVA-SOLIFENACIN TFV 02277271 VESICARE AST

SANDOZ SOLIFENACIN

TOLTERODINE TARTRATE

ST 2MG CAPSULE (EXTENDED RELEASE)

02244612	DETROL LA	PFI		
02404184	MYLAN-TOLTERODINE ER	MYL		
02413140	SANDOZ TOLTERODINE LA	SDZ		
02412195	TEVA-TOLTERODINE LA	TEV		
4MG CAPSULE (EXTENDED RELEASE)				

02244613 DETROL LA PFI 02404192 MYLAN-TOLTERODINE ER MYL SANDOZ TOLTERODINE LA 02413159 SD7 02412209 TEVA-TOLTERODINE LA **TEV**

ST 1MG TABLET

02369680 APO-TOLTERODINE APX 02239064 DETROL PFI 02423308 MINT-TOLTERODINE MIN 02299593 TEVA-TOLTERODINE TEV ST 2MG TABLET

02369699 APO-TOLTERODINE APX 02239065 DETROL PFI 02423316 MINT-TOLTERODINE MIN 02299607 **TEVA-TOLTERODINE TEV**

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 FR

$^{\text{ST}}$ 20MG TABLET

02488353 MAR-TROSPIUM MAR 02275066 TROSEC SPC

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86:12.08 BETA-ADRENERGIC AGONISTS MIRABEGRON

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:

- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

STOFMO	TABLET	(EXTENDED	DELEASE)
25IVIG	IABLEI	(EXTENDED	KELEASE

02402874 MYRBETRIQ AST

 $^{\text{ST}}$ 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

300MG TABLET (EXTENDED RELEASE)

00692700 APO-THEO-LA AAP

ST 400MG TABLET (EXTENDED RELEASE)

02360101 THEO ER AAP 02014165 UNIPHYL PFR

 $^{\text{ST}}$ 600MG TABLET (EXTENDED RELEASE)

02360128 THEO ER AAP
02014181 UNIPHYL PFR

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88:00 VITAI	MINS		88:08.00 VI	TAMIN B COMPLEX	
88:04.00 VIT	AMIN A		NIACIN		
VITAMIN A	, umil 4 7 4		ST 50MG TABL	.ET	
	DO!!! 5		00041084	NIACIN	ADA
ST 10,000IU CA	PSULE JAMP-VITAMIN A	JMP	ST 500MG TAB	LET	
	VITAMIN A	JAM	00557412	NIACIN	VTH
	VITAMIN A	VTH	01939130	NIACIN	ODN
	AMIN B COMPLEX	V 111	02247004		PMT
			PYRIDOXINE	HYDROCHLORIDE	
CYANOCOB	ALAMIN		ST 25MG TABL	ET .	
100MCG/ML	LIQUID		80056458	M-B6	MAN
02241500	VITAMIN B12	SDZ	00122645	VITAMIN B6	JAM
ST 200MCG/ML	LIQUID		00232475	VITAMIN B6	ADA
80039903		ORM	01943200		ODN
	JAMP-VITAMIN B12	JMP	80002890	VITAMIN B6	JMP
1,000MCG/N	IL LIQUID		ST 50MG TABL		
00626112		OMG		VITAMIN B6	JAM
	CYANOCOBALAMIN	TAR		VITAMIN B6	ADA
	CYANOCOBALAMIN	MYL	ST 100MG TAB	 :	
	JAMP-CYANOCOBALAMIN	JMP	00450677		VTH
•	IL SOLUTION		00263958	VITAMIN B6	VAE
	CYANOCOBALAMIN	RAX	00329185		JAM
	VITAMIN B12	SDZ		VITAMIN B6	PMT
ST 250MCG TAI		IMP	THIAMINE H	YDROCHLORIDE	
	JAMP-VITAMIN B12	JMP	100MG/ML I	LIQUID	
80055743		MAN JAM	02193221	THIAMIJECT	OMG
	VITAMIN B12 VITAMIN B12	PMT	02243525	THIAMINE	RAX
	VITAMIN B12	WNP	100MG/ML \$	SOLUTION	
ST 1000MCG TA		VVINI		VITAMIN B1	SDZ
	JAMP VITAMIN B12	JMP	ST 50MG TABL	ET	
	JAMP-VITAMIN B12	JMP	02245506	EURO VITAMIN B1	EUR
	M-B12	MAN	80054199	M-B1	MAN
	VITAMIN B12	VAE	00268631	THIAMINE	VAE
	VITAMIN B12	PMT	80009633		JMP
80006939	VITAMIN B12	WNP	ST 100MG TAB		
80012952	VITAMIN B12 SUBLINGUAL	JAM	80054205		MAN
FOLIC ACID				VITAMIN B1	PED
ST 1MG TABLE	_			VITAMIN B1	JAM
		1004	02239350	VITAMIN B1	PMT
	FOLIC ACID FOLIC ACID	JAM	80000352		WNP JMP
00647039 02048841	FOLIC ACID	VTH PMT		VITAMIN B1	JIVIP
	FOLIC ACID	WNP	88:12.00 VI		
80053274	JAMP FOLIC ACID	JMP	ASCORBIC A	ACID	
	M-FOLIQUE	MAN	ST 500MG CAP	LET	
	WAMPOLE FOLIC ACID	WAM	02163268	VITAMIN C	JAM
ST 5MG TABLE			ST 250MG TAB	LET	
	FOLIC ACID	APX	00162515	VITAMIN C	PMT
02366061	JAMP-FOLIC ACID	JMP	00221244	VITAMIN C	ADA
02285673	SANDOZ FOLIC ACID	SDZ	00266051	VITAMIN C	PMT
ST 1000MCG TA	ABLET		00557811	VITAMIN C	VTH
	FOLIC ACID	UNK	ST 500MG TAB	LET	
NIACIN			00266086	ASCORBIC ACID	PMT
^{S7} 500MG CAP	ET		00041114	VITAMIN C	ADA
00309737		JAM	00322326	VITAMIN C	ADA
00309737	NIACIIN	JAIVI	00557838	VITAMIN C	VTH

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88:12.00 VIT	TAMIN C		88:16.00 VIT	TAMIN D	
ASCORBIC ACID			CHOLECALO	FEROL	
ST 500MG TAB			ST 400IU TABL		
	VITAMIN C	VTH		VITAMIN D	VTH
	VITAMIN C	VAE		VITAMIN D	PMT
	VITAMIN C	PMT		VITAMINE D	LAL
	VITAMIN C	PMT		WAMPOLE VITAMIN D	WAM
	VITAMIN C	WNP	ST 1,000IU TAB		DMT
	VITAMIN C	PMT		VITAMIN D3	PMT
	VITAMINE C WAMPOLE VITAMIN C	LAL WAM	ST 10,000IU TA		DIV
	WAMPOLE VITAMIN C	WAM	00821772		RIV PDL
VITAMIN C	WAINFOLL VITAININ C	VVAIVI	ERGOCALCI	VITAMINE D	PDL
ST 500MG TAB			^{S7} 50,000IU CA		
	VITAMIN C	WNP		SANDOZ D-FORTE	SDZ
88:16.00 VIT	TAMIN D		ST 8,288IU/ML S		
ALFACALCIE	OOL		80020776		JMP
ST 0.25MCG CA	ADSIII E		80003615	ERDOL	ODN
	ONE ALPHA	LEO	VITAMIN D		
ST 1MCG CAPS			ST 10MCG CAP	SULE	
	ONE ALPHA	LEO	80063895	VIT D 400	UNK
ST 2MCG/ML D		220	ST 25MCG CAP	SULE	
	ONE-ALPHA	LEO	80063899	VIT D 1000	UNK
CALCITRIOL				VITACELL VITAMIN D3 SOFTGELS	UNK
			ST 200U CAPSU	JLE	
ST 0.25MCG CA				VITAMIN D3	ORM
	CALCITRIOL-ODAN	ODN	ST 400IU CAPS		
	ROCALTROL	HLR	80055196		MAN
	TARO-CALCITRIOL	TAR		PHARMA-D	PED
ST 0.5MCG CAF		ODN		VITAMINE D	BMI
	CALCITRIOL-ODAN	ODN	ST 800IU CAPS		
	ROCALTROL TARO-CALCITRIOL	HLR TAR	80003010		EUR
		IAK		VITAMINE D	BMI
CHOLECALO			ST 1,000IU CAP		IMD
ST 400IU CAPS	ULE		80007766		JMP EUR
80006629	DGEL	JMP	80003707		
02242651	EURO D	EUR	80055204	PHARMA-D	MAN PMS
80005560	RIVA-D	RIV		VITAMINE D	BMI
ST 800IU CAPS			ST 10,000IU CA		DIVII
80007769		JMP	02371499		PMS
1,000IU CAP		0.711		JAMP-VITAMIN D	JMP
80027592		OPU	ST 15MCG LIQU		0
	VITAMIN D3	WAM		DDROPS BOOSTER	DDP
ST 10,000IU CA		0.0.7	ST 400IU LIQUI		
02253178		SDZ	80019649		JMP
ST 400IU LIQUI		DDD	80038155		ORM
	BABY DDROPS	DDP	80041145		ORM
80001792		DDP	ST 800IU LIQUI	D	
ST 400IU/ML LI	עוטט D VI INFANTS	MJO		PEDIAVIT D	EUR
			ST 1,000IU LIQI	JID	
	JAMP VITAMIN D PEDIAVIT D	JMP EUR	•	JAMP VITAMIN D	JMP
02231624 ST 1,000IU LIQI		EUK		JAMP VITAMIN D	JMP
80001791		DDP		JAMP VITAMIN D	JMP
00001791	טטרטרט	אטט	ST 25MCG TAB	LET	
			80031157	VITAMIN D	WNP

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88:16.00 VITAMIN D		88:28.00 MULTIVITAMIN PREPARATIONS
VITAMIN D		MULTIVITAMINS (CHILDREN AND YOUTH)
ST 400IU TABLET		Limited use benefit (prior approval is not required).
80002452 VITAMIN D	WNP	Multivitaming are handita for children up to 10 years of are
80009578 VITAMIN D	VAE	Multivitamins are benefits for children up to 19 years of age.
ST 1,000IU TABLET		ST 450MG & 10MG & 30MG LIQUID
80002169 PHARMA-D	PMS	80008471 JAMP VITAMIN A, D AND C JMF ST 2,500IU & 666.67IU & 50MG/ML LIQUID
80051562 RIVA-D	RIV	00762903 ENFAMIL TRIVISOL MJC
80000131 VITAMIN D	VTH	02229790 PEDIAVIT EUR
80000436 VITAMIN D	JAM	OMG TABLET
80003663 VITAMIN D	WNP	02246362 CENTRUM PF
80009580 VITAMIN D	VAE	80021452 CENTRUM PF
80015278 WAMPOLE VITAMIN D	WAM	80024482 CENTRUM FOR WOMEN PF
ST 10,000IU TABLET	IMD	2MG TABLET
02379007 JAMP-VITAMIN D	JMP ORM	80045908 ONE A DAY WOMEN BAY
02417685 VIDEXTRA	URIVI	10MG TABLET
88:20.00 VITAMIN E		80039441 STRESSTABS FOR WOMEN PF
VITAMIN E		ST TABLET (CHEWABLE)
Limited use benefit (prior approval required).		80011134 CENTRUM JUNIOR COMPLETE PF
		80020794 CENTRUM JUNIOR COMPLETE PF
For use in malabsorption		02247995 FLINTSTONES MULTIPLE BAY
ST 100IU CAPSULE (SOFTGEL)		VITAMINS PLUS IRON
00122823 VITAMIN E	JAM	02247975 FLINTSTONES MULTIPLE BAY VITAMINS WITH EXTRA C
ST 200IU CAPSULE (SOFTGEL)		
00122831 VITAMIN E	JAM	MULTIVITAMINS (PRENATAL)
ST 400IU CAPSULE (SOFTGEL) 00122858 VITAMIN E	JAM	Limited use benefit (prior approval is not required.).
ST 800IU CAPSULE (SOFTGEL)	JAW	Prenatal and postnatal vitamins are benefits only for women
00330191 VITAMIN E	JAM	of childbearing age (12 to 50 years).
ST 20U/ML LIQUID	JAW	ST CAPSULE
09991656 AQUA-E/ML	UNK	80042704 CENTRUM DHA PF
ST 75U/ML LIQUID	ONIX	ST TABLET
09991652 AQUA-E	UNK	80045822 CENTRUM PRENATAL PF
ST 50IU ORAL LIQUID	Orac	80080882 MATERNA NES
00480215 AQUASOL E	NVC	80082297 MATERNA NES
ST 50IU/ML ORAL LIQUID		80001842 NESTL MATERNA NES
02162075 AQUASOL E VITAMIN E	CLC	02241235 PRENATAL AND POSTPARTUM VTH VITAMINS AND MINERALS
88:24.00 VITAMIN K PHYTONADIONE		80005770 PRENATAL AND POSTPARTUM PMT VITAMINS AND MINERALS
2MG/ML EMULSION		02229535 WAMPOLE COMPLETE MULT-PRE WAM AND POST NATAL WITH FOLIC
00781878 VITAMIN K1	SDZ	ACID ACID
10MG/ML EMULSION		2MG TABLET
00804312 VITAMIN K1	SDZ	80004919 NATURES BOUNTY PRENATAL VTH
88:28.00 MULTIVITAMIN PREPARATIONS		VITAMINS
CALCIUM, VITAMIN D		THIAMINE HYDROCHLORIDE
·		50MG TABLET
ST 500-400MGU TABLET		80049777 OPUS VITAMINE B1 OPL
80088060 BIO-CAL DR FORTE	BIO	100MG TABLET
MULTIVITAMINS (CHILDREN AND YOUTH)		80049780 OPUS VITAMINE B1 OPU
Limited use benefit (prior approval is not required).		
Multivitamins are benefits for children up to 19 years of age.		
207000 (0. 51/51/1// 50/1//// 50/1		

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MJO

00762946 ENFAMIL POLYVISOL

UNK

UNK

UNK

UNK

NVR

92:00 UNCLASSIFIED THERAPEUTIC **AGENTS**

92:00.00 UNCLASSIFIED THERAPEUTIC **AGENTS**

EXTEMPORANEOUS MIXTURE

A I LIVIPORA	ANEOUS WILKTURE	
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
OPHTHALM	IC 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

GENDER AFFIRMING TOPICAL UNK 00915311 **HORMONES**

EXTEMPORANEOUS MIXTURE (LU)

Limited use benefit (prior approval required). INJECTION 99506021 MISCELLANEOUS COMPOUNDED UNK INJECTION/INFUSION **MISCELLANEOUS** 99504001 MISC LIMITED USE EXTERNAL LINK

COMPOUND MIXTURE OPHTHALMIC AND OTIC SOLUTION

99507000 MISCELLANEOUS COMPOUNDED UNK EYE/EAR DROP

ORAL LIQUID

99503033 MISC LIMITED USE COMPOUND UNK INTFRNAL OPIOID COMPOUNDED 99503032 UNK

POWDER

99504000 MISCELLANEOUS COMPOUNDED UNK **EXTERNAL POWDER**

SUPPOSITORY

OINTMENT

MISCELLANEOUS COMPOUNDED UNK 99508000 SUPPOSITORY

EXTEMPORANEOUS MIXTURE (NSAID)

Limited use benefit (prior approval not required).

Coverage will be limited to 100 grams every 30 days. **GEL** NSAID IN TRANSDERMAL BASE 99501007

TRANSDERMAL LIDOCAINE 99501009 W/NSAID **GOSERELIN ACETATE**

10.8MG/DEPOT IMPLANT 02225905 ZOLADEX LA

OCTREOTIDE ACETATE

10MG/VIAL POWDER FOR SUSPENSION (SUSTAINED RELEASE) NVR 02239323 SANDOSTATIN LAR 20MG/VIAL POWDER FOR SUSPENSION (SUSTAINED RELEASE) SANDOSTATIN LAR **NVR** 30MG/VIAL POWDER FOR SUSPENSION (SUSTAINED RELEASE)

02239325 SANDOSTATIN LAR **50MCG/ML SOLUTION**

02248639 OCTREOTIDE ACETATE OMEGA OMG

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92:00.00 UN	NCLASSIFIED THERAPEUTIC		92:01.88 VITAMIN B COMPLEX	
AC	GENTS		VITAMIN D	
OCTREOTIC	DE ACETATE		1000UI CAPSULE	
50MCG/ML	SOLUTION		80089250 BIO-VITAMINE D3	ВМІ
00839191	SANDOSTATIN	NVR	92:05.00 SERUMS	
	L SOLUTION		APIS MELLIFERA VENOM PROTEIN EXTRACT	
	OCTREOTIDE ACETATE OMEGA	OMG	1.1MG POWDER FOR SOLUTION	
	SANDOSTATIN L SOLUTION	NVR		ALK
	OCTREOTIDE ACETATE OMEGA	OMG	VENOM	
	SANDOSTATIN	NVR	120MCG POWDER FOR SOLUTION	
	L SOLUTION			ALK
02248641	OCTREOTIDE ACETATE OMEGA	OMG	VENOM DOLICHOVESPULA ARENARIA VENOM PROTE	=INI
PENTOSAN	POLYSULFATE SODIUM			ZIIN
100MG CAF	PSULE		120MCG POWDER FOR SOLUTION	A I 1/
02029448	ELMIRON	JSO	01948946 PHARMALGEN YELLOW HORNET VENOM PROTEIN	ALK
QUINAGOLI	DE (QUINAGOLIDE		DOLICHOVESPULA MACULATA VENOM	
HYDROCHL	ORIDE)		PROTEIN EXTRACT	
0.075MG TA	ABLET		120MCG POWDER FOR SOLUTION	
02223767	NORPROLAC	FEI		ALK
USTEKINUM	IAB		HORNET VENOM	
Limited use ben	efit (prior approval required).		HONEY BEE VENOM PROTEIN EXTRACT	
Penriasis acco	rding to established criteria.		120MCG POWDER FOR SOLUTION	
1 30110313 0000	rung to established criteria.			JUB
(Please refer to	Appendix A).		550MCG POWDER FOR SOLUTION	
45MG/0.5M	L SOLUTION		02220075 HYMENOPTERA VENOM PRODUCT HONEY BEE VENOM	JUB
	STELARA	JSO	NON POLLEN	
90MG/ML S		100		
	STELARA	JSO	100,000U LIQUID	A I 1/2
	ATURAL HEALTH PRODUCTS		00299979 ALLERGENIC EXTRACT NON POLLENS	ALK
CANTHARID			POLISTES SPP VENOM PROTEIN EXTRACT	
1%(W/V) LI			1.1MG POWDER FOR SOLUTION	
	CANTHARONE 07	DOR	01948970 PHARMALGEN WASP VENOM	ALK
LACTASE			PROTEIN	
s [⊤] 150MG TAE	BLET		POLLEN	
	LACTASE 4500 FCCLU	JAM	4,300U/ML LIQUID	
NATURAL H	EALTH PRODUCT			BEN
1% CREAM			100,000U LIQUID	
	CORTIVERA H	VAN		ALK
PSYLLIUM N	MUCILLOID		POLLEN AND NON POLLEN	
ST 3G POWDE	R		20,000U LIQUID	
80013276		PGI		ALK
80013287	SMOOTH TEXTURE METAMUCIL FIBRE THERAPY	PGI	VENOM PROTEIN EXTRACT	
80013287	SMOOTH TEXTURE SUGAR FREE	FGI	3,300MCG POWDER FOR SOLUTION	
80015505	METAMUCIL SMOOTH TEXTURE UNFLAVOURED UNSWEETENED	PGI	01948873 PHARMALGEN MIXED VESPID VENOM PROTEIN	ALK
92:01.88 VI	TAMIN B COMPLEX		VESPULA SPP VENOM PROTEIN EXTRACT	
CALCIUM, V	TITAMIN D		1.1MG POWDER FOR SOLUTION	
500-400MG				ALK
	BIO CAL-D3	BMI	VENOM PROTEIN	

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92:05.00 SE	RUMS		92:08.00 5 A	ALFA REDUCTASE INHIBI	TORS
VESPULA SP	PP VENOM PROTEIN EXTRACT	-	DUTASTERII	DE	
120MCG PO	WDER FOR SOLUTION		ST 0.5MG CAPS	SULE	
01948962	PHARMALGEN YELLOW JACKET	ALK		RIVA-DUTASTERIDE	RIV
	VENOM PROTEIN		02424444	SANDOZ DUTASTERIDE	SDZ
WASP VENO	M PROTEIN		02408287	TEVA-DUTASTERIDE	TEV
120MCG PO	WDER FOR SOLUTION		FINASTERID	E	
02226219	VENOMIL WASP VENOM PROTEIN	JUB	ST 5MG TABLE	т	
550MCG PO	WDER FOR SOLUTION			ACH-FINASTERIDE	ACC
02220091	HYMENOPTERA VENOM	JUB	02365383	APO-FINASTERIDE	APX
\4/1.UTE	PRODUCT WASP VENOM PROTEIN		02405814	AURO-FINASTERIDE	AUR
	D HORNET VENOM PROTEIN		02376709 02350270	DOM-FINASTERIDE FINASTERIDE	DPC PDL
	WDER FOR SOLUTION VENOMIL WHITE-FACED HORNET	JUB	02445077	FINASTERIDE	SAN
02226235	VENOMIL WHITE-PACED HORNET VENOM PROTEIN	JUB	02447541	FINASTERIDE	SIV
WHITE FACE	D HORNET VENOM PROTEIN,		02357224	JAMP-FINASTERIDE	JMP
	RNET VENOM PROTEIN, YELL		02389878	MINT-FINASTERIDE	MIN
	IOM PROTEIN		02310112	PMS-FINASTERIDE	PMS
420MCC DO	WDER FOR SOLUTION		02010909	PROSCAR	FRS
	WDER FOR SOLUTION PHARMALGEN MIXED VESPID	ALK	02371820	RAN-FINASTERIDE	RBY
01940001	VENOM PROTEIN	ALIX	02455013	RIVA-FINASTERIDE	RIV
02226294	VENOMIL MIXED VESPID VENOM	JUB	02322579		SDZ
	PROTEIN		02348500		TEV
	WDER FOR SOLUTION		92:12.00 AN	TIDOTES	
02221314	HYMENOPTERA VENOM PRODUCT MIXED VESPID VENOM	JUB	LEUCOVORI		
VELLOWIJO	PROTEIN RNET VENOM PROTEIN		5MG TABLE	LEDERLE LEUCOVORIN	PFI
				TIGOUT AGENTS	111
	POWDER FOR SOLUTION				
02226251	VENOMIL YELLOW HORNET VENOM PROTEIN	JUB	ALLOPURIN		
550MCG PO	WDER FOR SOLUTION		100MG TAB 02481863	AG-ALLOPURINOL	ANG
02220083	HYMENOPTERA VENOM	JUB	00555681	ALLOPURINOL	PDL
	PRODUCTS YELLOW HORNET VENOM PROTEIN			APO-ALLOPURINOL	APX
VELLOW IAC	CKET VENOM PROTEIN		02421593		JMP
			02396327		MAR
	WDER FOR SOLUTION		00402818	ZYLOPRIM	AAP
02226286	VENOMIL YELLOW JACKET VENOM PROTEIN	JUB	200MG TAB	LET	
550MCG PO	WDER FOR SOLUTION		02481871	AG-ALLOPURINOL	ANG
	HYMENOPTERA VENOM	JUB	02130157	ALLOPURINOL	PDL
00	PRODUCT YELLOW JACKET	002	02402777	APO-ALLOPURINOL	APX
	VENOM PROTEIN		02421607		JMP
92:08.00 5 A	LFA REDUCTASE INHIBITO	RS		MAR-ALLOPURINOL	MAR
DUTASTERIC	DE			ZYLOPRIM	AAP
^{s⊤} 0.5MG CAPS	SIII E		300MG TAB		4110
	ACT DUTASTERIDE	TEV		AG-ALLOPURINOL	ANG APX
02404206	APO-DUTASTERIDE	APX		ALLOPURINOL ALLOPURINOL	PDL
02469308	AURO-DUTASTERIDE	AUR		APO-ALLOPURINOL	APX
02247813	AVODART	GSK	02421615		JMP
02421712		PDL		MAR-ALLOPURINOL	MAR
02429012	DUTASTERIDE	SIV		ZYLOPRIM	AAP
02443058	DUTASTERIDE	SAN		XTEMPORANEOUS MIXTURE	, v u
02416298	MED-DUTASTERIDE	GMP		ALLOPURINOL ORAL LIQUID	UNK
02428873	MINT-DUTASTERIDE	MIN	,,,,,,,,,,,	 	-···•
02393220	PMS-DUTASTERIDE	PMS			

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92:16.00 ANTIGOUT AGENTS 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

02473607	MAR-FEBUXOSTAT	MAR
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 or teriflunomide) OR documented intolerance to at least 2 therapies; AND
- One or more clinically disabling relapses in the previous vear: 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.

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
02469782	PMS-FINGOLIMOD	PMS

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

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	I	UNK
99100763	AVONEX PEN	ı	UNK
60MCG POV	VDER FOR SOL	UTION	
02267594	AVONEX	· ·	UNK
22MCG SOL	UTION		
02237319	REBIF	5	SRO
30MCG SOL	UTION		
02269201	AVONEX	Į.	UNK
44MCG SOL	UTION		
02237318	REBIF	5	SRO
02237320	REBIF	5	SRO
66MCG SOL	UTION		
02318253	REBIF	5	SRO
132MCG SO	LUTION		
02318261	REBIF	5	SRO
02318288	REBIF	5	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 POW	DER FOR SOLUTION	
02169649	BETASERON	BAY
02337819	EXTAVIA	NVR

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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 relapsea and/or new MRI activityb 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. 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
- b. MRI activity is defined as any new multiple sclerosis lesion/s, expanding lesion/s, and/or enhancing lesion/s.

OR

- 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 02248727 APO-ALENDRONATE APX

92:24.00 BONE RESORPTION INHIBITORS ALENDRONATE SODIUM

ST 5MG TABLE	ST 5MG TABLET			
02384698	RAN-ALENDRONATE	RBY		
02248251	TEVA-ALENDRONATE	TEV		
ST 10MG TABL	ET			
02381486	ACH-ALENDRONATE	ACC		
02248728	APO-ALENDRONATE	APX		
02388545	AURO-ALENDRONATE	AUR		
02384701	RAN-ALENDRONATE	RBY		
02288087	SANDOZ ALENDRONATE	SDZ		
02247373	TEVA-ALENDRONATE	TEV		
ST 70MG TABL	ET			
02381494	ACH-ALENDRONATE	ACC		
02299712	ALENDRONATE	SIV		
02352966	ALENDRONATE	SAN		
02303078	ALENDRONATE-70	PDL		
02248730	APO-ALENDRONATE	APX		
02388553	AURO-ALENDRONATE	AUR		
02282763	DOM-ALENDRONATE	DPC		
02245329	FOSAMAX	FRS		
02385031	JAMP-ALENDRONATE	JMP		
02394871	MINT-ALENDRONATE	MIN		
02273179	PMS-ALENDRONATE	PMS		
02284006	PMS-ALENDRONATE	PMS		
02384728	RAN-ALENDRONATE	RBY		
02270889	RIVA-ALENDRONATE	RIV		
02288109	SANDOZ ALENDRONATE	SDZ		
02261715	TEVA-ALENDRONATE	TEV		

ALENDRONATE SODIUM, CHOLECALCIFEROL

ST 70MG & 2,800U TABLET

02454467	APO-ALENDRONATE/VITAMIN D3	APX
02276429	FOSAVANCE	FRS
02403633	TEVA-	TEV
	ALENDRONATE/CHOLECALCIFERO	
	1	

ST 70MG & 5,600U TABLET

02454475	APO-ALENDRONATE/VITAMIN D3	APX
02314940	FOSAVANCE	FRS
02429160	SANDOZ ALENDRONATE/CHOLECALCIFERO L	SDZ
02403641	TEVA- ALENDRONATE/CHOLECALCIFERO L	TEV

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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%); ANĎ
- Have a contraindication to oral bisphosphonates (e.g. hypersensitivity, esophageal abnormality, renal impairment);
- 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

AMG 02368153 XGEVA

ETIDRONATE DISODIUM

ST 200MG TABLET

ACG 02248686 ACT ETIDRONATE

PAMIDRONATE DISODIUM

02249677 PAMIDRONATE

6MG SOLUTION

9MG SOLUTION			
02246599	PAMIDRONATE	FKD	
02249685	PAMIDRONATE DISODIUM OMEGA	OMG	
30MG SOLUTION			
02244550	PAMIDRONATE DISODIUM	PFI	
60MG SOLUTION			
02244551	PAMIDRONATE DISODIUM	PFI	
90MG SOLUTION			
02244552	PAMIDRONATE DISODIUM	PFI	

RISEDRONATE SODIUM

02245999 PMS-PAMIDRONATE

02413809 TEVA-RISEDRONATE

ST 5MG TABLET	•
02298376	

02298376	TEVA-RISEDRONATE	TEV	
ST 30MG TABL	ET		
02298384	TEVA-RISEDRONATE	TEV	
ST 35MG TABLET			
02370255	RISEDRONATE	SAN	
02411407	RISEDRONATE-35	SIV	
02298392	TEVA-RISEDRONATE	TEV	
ST 150MG TABLET			

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

ST 35MG TABLET

02246896	ACTONEL	ALL
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
150MC TARLET		

ST 150MG TABLET

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%)

ANĎ

- · 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	NVF
02415100	TARO-ZOLEDRONIC ACID	TAF
02422433	ZOLEDRONIC ACID	REC

92:32.00

OMG

PMS

TEV

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;

• Is prescribed by physician with experience in the treatment

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

10MG SOLUTION

UNK 02425696 FIRAZYR

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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

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

UCB 02465574 CIMZIA

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**

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 SOLUTION**

02462850 ERELZI SDZ 02462869 ERELZI SDZ

GOLIMUMAB

ABV

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.
- Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

50MG/0.5ML SOLUTION

02324776 SIMPONI JSO 02324784 SIMPONI JSO 100MG/ML SOLUTION

02413175 SIMPONI JSO 02413183 SIMPONI JSO

INFLIXIMAB (INFLECTRA)

Limited use benefit (prior approval required).

For the treatment of:

- · Rheumatoid Arthritis according to established criteria.
- · Psoriatic Arthritis according to established criteria.
- · Ankylosing Spondylitis according to established criteria.
- · Psoriasis according to established criteria.
- · Crohn's disease according to established criteria.
- Fistulizing Crohn's disease according to established criteria.
- · Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

100MG POWDER FOR SOLUTION

02419475 INFLECTRA HOS 02470373 RENFLEXIS UNK

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92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

INFLIXIMAB (REMICADE)

Limited use benefit (prior approval required).

For the treatment of:

- · Rheumatoid Arthritis according to established criteria.
- · Crohn's disease according to established criteria.
- Fistulizing Crohn's disease according to established criteria.

(Please refer to Appendix A).

100MG/VIAL POWDER FOR SOLUTION

02244016 REMICADE JSO

LEFLUNOMIDE

ST 10MG TABLET

02256495	APO-LEFLUNOMIDE	APX		
02241888	ARAVA	SAC		
02351668	LEFLUNOMIDE	SAN		
02415828	LEFLUNOMIDE	PDL		
02288265	PMS-LEFLUNOMIDE	PMS		
02283964	SANDOZ LEFLUNOMIDE	SDZ		
02261251	TEVA-LEFLUNOMIDE	TEV		
ST 20MG TABLET				
02256509	APO-LEFLUNOMIDE	APX		
02241889	ARAVA	SAC		

SARILUMAB

Limited use benefit (prior approval required).

02288273 PMS-LEFLUNOMIDE

02261278 TEVA-LEFLUNOMIDE

02283972 SANDOZ LEFLUNOMIDE

02351676 LEFLUNOMIDE

02415836 LEFLUNOMIDE

For the treatment of:

· Rheumatoid Arthritis according to established criteria.

(Please refer to Appendix A)

150MG SOLUTION

02460521	KEVZARA	5	SAC
02472961	KEVZARA	\$	SAC
200MG SOLUTION			
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

02350106 ACTEMRA

CONTO, TIME C	CLUTION		
02350092	ACTEMRA	ŀ	HLR
200MG/10ML	SOLUTION		

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).

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

TOFACITINIB CITRATE

Limited use benefit (prior approval required).

For the treatment of:

SAN

PDL

PMS

SDZ

TEV

· Rheumatoid Arthritis according to established criteria.

(Please refer to Appendix A).

5MG TABLET

02423898 XELJANZ PFI

11MG TABLET (EXTENDED RELEASE)

02470608 XELJANZ XR PFI

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HLR

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

CYCLOSPORINE

Limited use benefit (prior approval required).

For transplant therapy.

ST 10MG CAPS	ST 10MG CAPSULE				
02237671	NEORAL	NVR			
ST 25MG CAPS	ULE				
02150689	NEORAL	NVR			
02247073	SANDOZ CYCLOSPORINE	SDZ			
ST 50MG CAPS	ULE				
02150662	NEORAL	NVR			
02247074	SANDOZ CYCLOSPORINE	SDZ			
ST 100MG CAP	ST 100MG CAPSULE				
02150670	NEORAL	NVR			
02242821	SANDOZ CYCLOSPORINE	SDZ			
ST 100MG/ML SOLUTION					
02244324	APO-CYCLOSPORINE	APX			
02150697	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:

- 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.

GSK

100MG POWDER FOR SOLUTION

02449781 NUCALA

MYCOPHENOLATE MOFETIL

Limited use benefit (prior approval required).

For transplant therapy.

ST 250MG CAPSULE ACC 02383780 ACH-MYCOPHENOLATE APO-MYCOPHENOLATE APX 02352559 02192748 CELLCEPT HLR 02386399 JAMP-MYCOPHENOLATE **JMP** 02457369 MYCOPHENOLATE MOFETIL SAN 02371154 MYLAN-MYCOPHENOLATE MYI 02320630 SANDOZ MYCOPHENOLATE SDZ 02364883 TEVA-MYCOPHENOLATE **TEV 200MG POWDER FOR SUSPENSION** 02242145 CELLCEPT HLR 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

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		Non-Insured Health Benefits	<u>`</u>
92:44.00 IMMUNOSUPPRESSIVE AGEN	TS	92:44.00 IMMUNOSUPPRESSIVE AGENTS	_
MYCOPHENOLATE MOFETIL		VEDOLIZUMAB	
Limited use benefit (prior approval required).		Limited use benefit (prior approval required).	
For transplant therapy.		For the treatment of:	
ST 500MG TABLET		Crohn's disease according to established criteria.	
02348675 TEVA-MYCOPHENOLATE	TEV	Ulcerative colitis according to established criteria.	
MYCOPHENOLATE SODIUM		(Please refer to Appendix A).	
Limited use benefit (prior approval required).		300MG POWDER FOR SOLUTION	
For transplant therapy.		02436841 ENTYVIO TA	١K
ST 180MG TABLET (ENTERIC COATED)		92:92.00 OTHER MISCELLANEOUS	
02372738 APO-MYCOPHENOLIC ACID	APX	THERAPEUTIC AGENTS	
02264560 MYFORTIC	NVR	ABOBOTULINUMTOXINA	
ST 360MG TABLET (ENTERIC COATED)	4 D)/	Limited use benefit (prior approval required).	
02372746 APO-MYCOPHENOLIC ACID 02264579 MYFORTIC	APX NVR	Treatment of cervical dystonia (spasmodic torticollis) in	
SIROLIMUS	INVIX	adults; OR Symptomatic treatment of focal spasticity affecting upper	
Limited use benefit (prior approval required).		limbs in adults; OR	
Limited use beliefit (prior approval required).		Lower limb spasticity in patients 2 years of age and older.	
Coverage will be provided as a second line therapy for patients failing mycophenolate mofetil.		300U POWDER FOR SOLUTION	
st 1MG/ML SOLUTION			PS
02243237 RAPAMUNE	PFI	500U POWDER FOR SOLUTION 02456117 DYSPORT THERAPEUTIC IP	PS
ST 1MG TABLET	111	CYPROTERONE ACETATE	3
02247111 RAPAMUNE	PFI		
TACROLIMUS MONOHYDRATE		50MG TABLET 00704431 ANDROCUR BA	
Limited use benefit (prior approval required).		02245898 CYPROTERONE AA	
Factorian last the same		02390760 MED-CYPROTERONE GM	
For transplant therapy.			IV
^{sr} 0.5MG CAPSULE 02243144 PROGRAF	AST	CYPROTERONE ACETATE, ETHINYL ESTRADIO	L
02416816 SANDOZ TACROLIMUS	SDZ	2MG & 35MCG TABLET	
ST 1MG CAPSULE		02290308 CYESTRA-35 PA	٩L
02175991 PROGRAF	AST	02233542 DIANE-35 BA	
02416824 SANDOZ TACROLIMUS ST 5MG CAPSULE	SDZ	02425017 RAN-CYPROTERONE/ETHINYL RB ESTRADIOL	3Y
02175983 PROGRAF	AST	02309556 TEVA-CYPROTERONE / ETHINYL TE ESTRADIOL	V
ST 0.5MG CAPSULE (EXTENDED RELEASE)		INCOBOTULINUMTOXINA	
02296462 ADVAGRAF	AST	Limited use benefit (prior approval required).	
97 1MG CAPSULE (EXTENDED RELEASE) 02296470 ADVAGRAF	AST	Elimited and beliefit (prior approval required).	
ST 3MG CAPSULE (EXTENDED RELEASE)	701	For the treatment of: • strabismus and blepharospasm associated with dystonia.	
02331667 ADVAGRAF	AST	including benign essential blepharospasm or VII nerve	
ST 5MG CAPSULE (EXTENDED RELEASE)		disorder in patients 12 years of age or older; OR	
02296489 ADVAGRAF	AST	cervical dystonia (spasmodic torticollis).	
5T 5MG CAPSULE (IMMEDIATE RELEASE)	0.07	50UNIT/VIAL POWDER FOR SOLUTION 02371081 XEOMIN ME	=7
02416832 SANDOZ TACROLIMUS 5MG/ML SOLUTION	SDZ	100U/VIAL POWDER FOR SOLUTION	-2
02176009 PROGRAF	AST	02324032 XEOMIN ME	ΞZ
		LANREOTIDE ACETATE	
		60MG/0.3ML SOLUTION (EXTENDED RELEASE)	
		,	PS
		90MG/0.3ML SOLUTION (EXTENDED RELEASE)	
			PS
		120MG/0.5ML SOLUTION (EXTENDED RELEASE)	_

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02283417 SOMATULINE AUTOGEL

IPS

92:92.00 OTHER MISCELLANEOUS THERAPEUTIC AGENTS

ONABOTULINUMTOXINA

Limited use benefit (prior approval required).

For the treatment of:

- strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder in patients 12 years of age or older; OR
 • cervical dystonia (spasmodic torticollis); OR
- urinary incontinence due to neurogenic detrusor over activity resulting from neurogenic bladder associated with MS or subcervical spinal cord injury; 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

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 TRU 96899970 AEROCHAMBER PLUS FLOWVU TRU 96899968 AEROCHAMBER PLUS FLOWVU TRU 96899971 AEROCHAMBER PLUS FLOWVU SMALL 96899971 AEROTRACH PLUS UNK 96899975 COMPACT SPACE PLUS MEDIUM MIN MASK 96899955 COMPACT SPACE PLUS MEDIUM MIN 96899954 COMPACT SPACE PLUS NO MASK MIN 99400507 E-Z SPACER WEP 99400507 E-Z SPACER WEP 99400501 E-Z SPACER (MASK ONLY) WEP 99400501 E-Z SPACER WITH SMALL MASK WEP 00901012 INSPIRA CHAMBER W LARGE LUP MASK DOPO0003 INSPIRA CHAMBER W SMALL LUP MASK OPTICHAMBER DIAMOND AUC 96899961 OPTICHAMBER DIAMOND MEDIUM AUC 96899958 OPTICHAMBER DIAMOND	verage is grain	ted for 2 opacer devices every 12 months.	
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MASK 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 TRU	96899959		AUC
99400503 OPTICHAMBER MEDIUM MASK AUC 99400502 OPTICHAMBER SMALL MASK AUC 99400505 OPTIHALER AUC 99400787 POCKET CHAMBER WITH ADULT MCA MASK 99400788 POCKET CHAMBER WITH INFANT MCA MASK 99400790 POCKET CHAMBER WITH MEDIUM MCA MASK 99400789 POCKET CHAMBER WITH SMALL MASK 99400789 POCKET CHAMBER WITH SMALL MASK 96899974 RESPICHAMBER SILICONE TRU	96899960		AUC
99400502 OPTICHAMBER SMALL MASK AUC 99400505 OPTIHALER AUC 99400787 POCKET CHAMBER MCA 99400791 POCKET CHAMBER WITH ADULT MASK MASK 99400788 POCKET CHAMBER WITH INFANT MASK MCA MASK 99400790 POCKET CHAMBER WITH MEDIUM MASK MCA MASK 99400789 POCKET CHAMBER WITH SMALL MASK MCA MASK 96899974 RESPICHAMBER SILICONE TRU	99400504	OPTICHAMBER LARGE 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 TRU	99400503	OPTICHAMBER MEDIUM MASK	AUC
99400787 POCKET CHAMBER MCA 99400791 POCKET CHAMBER WITH ADULT MCA MASK 99400788 POCKET CHAMBER WITH INFANT MCA MASK 99400790 POCKET CHAMBER WITH MEDIUM MCA MASK 99400789 POCKET CHAMBER WITH SMALL MCA MASK 96899974 RESPICHAMBER SILICONE TRU	99400502	OPTICHAMBER SMALL MASK	AUC
99400791 POCKET CHAMBER WITH ADULT MCA MASK 99400788 POCKET CHAMBER WITH INFANT MCA MASK 99400790 POCKET CHAMBER WITH MEDIUM MCA MASK 99400789 POCKET CHAMBER WITH SMALL MCA MASK 96899974 RESPICHAMBER SILICONE TRU	99400505	OPTIHALER	AUC
MASK 99400788 POCKET CHAMBER WITH INFANT MCA MASK 99400790 POCKET CHAMBER WITH MEDIUM MCA MASK 99400789 POCKET CHAMBER WITH SMALL MCA MASK 96899974 RESPICHAMBER SILICONE TRU	99400787	POCKET CHAMBER	MCA
MASK 99400790 POCKET CHAMBER WITH MEDIUM MCA MASK 99400789 POCKET CHAMBER WITH SMALL MCA MASK 96899974 RESPICHAMBER SILICONE TRU	99400791		MCA
MASK 99400789 POCKET CHAMBER WITH SMALL MCA MASK 96899974 RESPICHAMBER SILICONE TRU	99400788		MCA
MASK 96899974 RESPICHAMBER SILICONE TRU	99400790		MCA
	99400789		MCA
	96899974		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	TRU
	MASK	
96899972	RESPICHAMBER VHC W	TRU

94:01.00 DEVICES (DIABETIC)

MOUTHPIECE

ADHESHIVE WIPES

MISCELLANEOUS

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
09991458	IV3000	SMW
COMFORT A	ANGLED DEVICE	
97799682	COMFORT ANGLED INFSET 17MM	UNK
97799683	COMFORT ANGLED INFSET 17MM	UNK
COMFORTS	SHORT ANGLED DEVICE	
97799678	COMFORT SRT ANGLED INFSET 13	UNK
97799679	COMFORT SRT ANGLED INFSET 13	UNK
CONTACT D	ETACH DEVICE	
97799672	CONTACT DETACH 90 DEGREE 6MMX60CM	UNK
97799610	CONTACT DETACH 90 DEGREE 8MMX60CM	UNK
INSET II DEV	/ICE	
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	<u> </u>	
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 D	EVICE	
09991327	PODS	UNK

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94:01.00 DEVICES (DIABETIC) INSULIN PUMP SUPPLIES

97799521

97799520

97799519

97799646

97799645

97799638

97799640

97799639

97799647

97799649

97799648

TENDER "MINI" DEVICE

TENDER DEVICE

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 97799715 PARADIGM SILHOUETTE 13MMX 43 MDT PARADIGM SILHOUETTE 97799485 **MDT** 13MMX18' 97799716 PARADIGM SILHOUETTE 13MMX23 MDT PARADIGM SILHOUETTE 97799484 MDT 13MMX32' PARADIGM SILHOUETTE 17MMX23 97799718 MDT 97799483 PARADIGM SILHOUETTE MDT 17MMX32' 97799719 PARADIGM SILHOUETTE 17MMX43 MDT 97799529 PARADIGM SILHOUETTE MDT CANNULA 13MM 97799528 PARADIGM SILHOUETTE MDT **CANNULA 17MM QUICK-SET DEVICE** 97799486 QUICK-SET 6MMX18 MDT 97799744 QUICK-SET 6MMX23 TUBING **MDT** MDT 97799487 QUICK-SET 6MMX32 97799743 QUICK-SET 6MMX43 TUBING MDT 97799742 QUICK-SET 9MMX23 TUBING MDT 97799488 QUICK-SET 9MMX32 MDT MDT 97799741 QUICK-SET 9MMX43 TUBING **RAPID-D DEVICE** 97799650 ROD RAPID-D 10MM/110CM 97799652 ROD RAPID-D 10MM/60CM RAPID-D 10MM/80CM ROD 97799651 97799656 RAPID-D 6MM/110CM ROD 97799658 RAPID-D 6MM/60CM ROD 97799657 RAPID-D 6MM/80CM ROD 97799653 RAPID-D 8MM/110CM ROD 97799655 RAPID-D 8MM/60CM ROD 97799654 RAPID-D 8MM/80CM ROD **SURE-T DEVICE**

PARADIGM SURE-T 29G 6MMX18

PARADIGM SURE-T 29G 6MMX23

PARADIGM SURE-T 29G 8MMX23

97799644 TENDER-1 17MM/110CM

13MM/110CM

13MM/60CM

13MM/80CM

TENDER-1 17MM/60CM

TENDER-1 17MM/80CM

TENDER-2 17MM/110CM

TENDER-2 17MM/60CM

TENDER-2 17MM/80CM

TENDER-1 MINI INF SET

TENDER-1 MINI INFSET

TENDER-1 MINI INFSET

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.

97799670 ULTRAFLEX 1 8MM/60CM ROD 97799669 ULTRAFLEX 1 8MM/80CM ROD 643MMX" DEVICE 09991616 INSET 6MMX43" 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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV			
13MM/110CM	TENDER "M	INI" DEVICE	
13MM/60CM 97799642 TENDER-2 MINI INFSET 13MM/80CM 13MM/80CM 13MM/80CM 13MM/80CM ROD 97799665 ULTRAFLEX 1 10MM/110CM ROD 97799667 ULTRAFLEX 1 10MM/60CM ROD 97799668 ULTRAFLEX 1 10MM/80CM ROD 97799669 ULTRAFLEX 1 8MM/110CM ROD 97799669 ULTRAFLEX 1 8MM/60CM ROD 97799669 ULTRAFLEX 1 8MM/80CM ROD 643MMX" DEVICE 09991616 INSET 6MMX43" UNK UNK	97799641		ROD
13MM/80CM	97799643		ROD
97799665 ULTRAFLEX 1 10MM/110CM 97799667 ULTRAFLEX 1 10MM/60CM 97799666 ULTRAFLEX 1 10MM/80CM 97799668 ULTRAFLEX 1 8MM/110CM 97799670 ULTRAFLEX 1 8MM/60CM 97799669 ULTRAFLEX 1 8MM/80CM 643MMX" DEVICE 09991616 INSET 6MMX43" 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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS 99038349 ALCOHOL SWABS BTD 99038349 ALCOHOL SWABS BTD 99038349 BD ALCOHOL SWABS BTD 97799880 BD ALCOHOL SWABS BTD 990383402 MONOJECT ALCOHOL WIPES	97799642		ROD
97799667 ULTRAFLEX 1 10MM/60CM ROD 97799666 ULTRAFLEX 1 10MM/80CM ROD 97799668 ULTRAFLEX 1 8MM/110CM ROD 97799670 ULTRAFLEX 1 8MM/60CM ROD 97799669 ULTRAFLEX 1 8MM/80CM ROD 643MMX" DEVICE 09991616 INSET 6MMX43" 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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS BD REGULAR 97799880 BD ALCOHOL SWABS BTD 99038349 ALCOHOL SWABS BTD 997799880 BD ALCOHOL SWABS BTD	ULTRAFLEX	DEVICE	
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 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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	97799665	ULTRAFLEX 1 10MM/110CM	ROD
97799668 ULTRAFLEX 1 8MM/10CM ROD 97799670 ULTRAFLEX 1 8MM/60CM ROD 97799669 ULTRAFLEX 1 8MM/80CM ROD 643MMX" DEVICE 09991616 INSET 6MMX43" 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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	97799667	ULTRAFLEX 1 10MM/60CM	ROD
97799670 ULTRAFLEX 1 8MM/60CM ROD 97799669 ULTRAFLEX 1 8MM/80CM ROD 643MMX" DEVICE 09991616 INSET 6MMX43" 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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	97799666	ULTRAFLEX 1 10MM/80CM	ROD
97799669 ULTRAFLEX 1 8MM/80CM ROD 643MMX" DEVICE 09991616 INSET 6MMX43" 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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD 00977187 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	97799668	ULTRAFLEX 1 8MM/110CM	ROD
643MMX" DEVICE 09991616 INSET 6MMX43" 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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC TIP SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	97799670	ULTRAFLEX 1 8MM/60CM	ROD
09991616 INSET 6MMX43" 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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC TIP SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	97799669	ULTRAFLEX 1 8MM/80CM	ROD
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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC TIP SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	643MMX" D	EVICE	
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 SOPROPYL ALCOHOL 180PROPYL ALCOHOL VALCOHOL VALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6896 (150) BTD 00977195 ALCOHOL SWABS 6896 (150) BTD 00977195 ALCOHOL SWABS ANTISEPTIC TIP SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 99038349 ALCOHOL SWABS BTD 99038349 ALCOHOL SWABS BTD 99038349	09991616	INSET 6MMX43"	UNK
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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC TIP SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	DRESS		
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 ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS TIP 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	09991615	IV3000 STANDARD	SMW
PATCH 09991614 MMT-174 ADHESIVE UNK SYRINGE 97799707 RESERVOIR PARADIGM 5X1.8ML MDT 97799706 RESERVOIR PARADIGM 7X3.0ML MDT ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS TIP 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	3ML NEEDL	E	
09991614 MMT-174 ADHESIVE UNK SYRINGE 97799707 RESERVOIR PARADIGM 5X1.8ML MDT 97799706 RESERVOIR PARADIGM 7X3.0ML MDT ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC TIP SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	00951417	T : SLIM X2 CARTRIDGE (SK)	UNK
SYRINGE 97799707 RESERVOIR PARADIGM 5X1.8ML MDT 97799706 RESERVOIR PARADIGM 7X3.0ML MDT ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS TIP 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	PATCH		
97799707 RESERVOIR PARADIGM 5X1.8ML MDT 97799706 RESERVOIR PARADIGM 7X3.0ML MDT ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	09991614	MMT-174 ADHESIVE	UNK
97799706 RESERVOIR PARADIGM 7X3.0ML MDT ISOPROPYL ALCOHOL 70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	SYRINGE		
ISOPROPYL ALCOHOL	97799707	RESERVOIR PARADIGM 5X1.8ML	MDT
70% PAD 00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS TIP 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	97799706	RESERVOIR PARADIGM 7X3.0ML	MDT
00480452 ALCOHOL PREP PDI 00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS TIP 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	ISOPROPYL	ALCOHOL	
00809357 ALCOHOL SWABS BTD 00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS TIP 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	70% PAD		
00977187 ALCOHOL SWABS 6893 BTD BUTTERFLY BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS TIP 99038349 ALCOHOL SWABS BD REGULAR BTD BTD 97799880 BD ALCOHOL SWABS BTD BTD 99438102 MONOJECT ALCOHOL WIPES COV			
BUTTERFLY 00977195 ALCOHOL SWABS 6896 (150) BTD 02247809 ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV			PDI
02247809 ALCOHOL SWABS ANTISEPTIC TIP SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	00809357	ALCOHOL SWABS	BTD
SKIN CLEANERS 99038349 ALCOHOL SWABS BD REGULAR BTD 97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	00809357	ALCOHOL SWABS ALCOHOL SWABS 6893 BUTTERFLY	BTD BTD
97799880 BD ALCOHOL SWABS BTD 99438102 MONOJECT ALCOHOL WIPES COV	00809357 00977187 00977195	ALCOHOL SWABS ALCOHOL SWABS 6893 BUTTERFLY ALCOHOL SWABS 6896 (150)	BTD BTD
99438102 MONOJECT ALCOHOL WIPES COV	00809357 00977187 00977195	ALCOHOL SWABS ALCOHOL SWABS 6893 BUTTERFLY ALCOHOL SWABS 6896 (150) ALCOHOL SWABS ANTISEPTIC	BTD BTD
	00809357 00977187 00977195 02247809	ALCOHOL SWABS ALCOHOL SWABS 6893 BUTTERFLY ALCOHOL SWABS 6896 (150) ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS	BTD BTD
00795232 WEBCOL ALCOHOL PREP COV	00809357 00977187 00977195 02247809 99038349	ALCOHOL SWABS ALCOHOL SWABS 6893 BUTTERFLY ALCOHOL SWABS 6896 (150) ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS ALCOHOL SWABS BD REGULAR	BTD BTD BTD TIP
	00809357 00977187 00977195 02247809 99038349 97799880	ALCOHOL SWABS ALCOHOL SWABS 6893 BUTTERFLY ALCOHOL SWABS 6896 (150) ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS ALCOHOL SWABS BD REGULAR BD ALCOHOL SWABS	BTD BTD TIP BTD
	00809357 00977187 00977195 02247809 99038349 97799880 99438102	ALCOHOL SWABS ALCOHOL SWABS 6893 BUTTERFLY ALCOHOL SWABS 6896 (150) ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS ALCOHOL SWABS BD REGULAR BD ALCOHOL SWABS MONOJECT ALCOHOL WIPES	BTD BTD TIP BTD BTD

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MDT

MDT

MDT

ROD

ROD

ROD

ROD

ROD

ROD

ROD

ROD

ROD

PMS

BTD

AUC

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.

97799494 ACCU-CHEK FASTCLIK LANCET

97799495	ACCU-CHEK FASTCLIK LANCET	ROD
97799817	ACCU-CHEK MULTICLIX LANCET	ROD
97799946	ACCU-CHEK MULTICLIX LANCET	ROD
97799945	ACCU-CHEK SOFTCLIX LANCET	ROD
97799466	BG STAR LANCET	SAC
97799541	EZ HEALTH ORACLE LANCET	TRE
97799825	FINGERSTIX LANCET	BAY
97799292	FIRST CANADIAN HEALTH LANCETS	ARA
97799826	FREESTYLE LANCET	BAY
97799918	MICROLET LANCET	BAY
97799810	MPD THIN LANCET (NS)	MPD
97799811	MPD THIN LANCET (NS)	MPD
97799807	MPD ULTRA THIN LANCET (100)	MPD
97799808	MPD ULTRA THIN LANCET (200)	MPD
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
97799766	ITEST SAFETY 28G LANCET	AUC
97799801	MONOLET THIN (MONOJECT) 28G	TYC
30G LANCE	Г	
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 LANCE	Г	
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

94:01.00 DEVICES (DIABETIC) MAGNIFIER

DEVICE

99400550 SYRINGE SCALE MAGNIFIER UNK

PEN NEEDLE

ST	N	E	E	D	L	E

ROD

97799433	BD AUTOSHIELD DUO SAFETY PEN NEEDLE	BTD
09991447	BD BLUNT 18GX1 1/2 FILTER	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	NEEDLE	
97799238	DROPLET PEN NEEDLE 10MM 29G	SFA
ST 29GX12.7MN	M NEEDLE	

97799561 SUPER-FINE STANDARD 29G-

12.7MM *** **29GX12MM NEEDLE**

97799235	DROPLET PEN NEEDLE 12MM 29G	SFA			
97799566	INSUPEN 29GX12MM NEEDLE	DPI			
97799543	ULTICARE 29GX12MM PEN NEEDLE	UMI			
97799991	UNIFINE 29G 12MM NEEDLE	AUC			
29GX8MM N	EEDLE				
97799526	BD AUTOSHIELD PEN NEEDLES	BTD			
30GX6MM N	EEDLE				
97799911	NOVOFINE 30GX 6MM NEEDLE	NVC			
30GX8MM N	EEDLE				
97799567	INSUPEN 30GX8MM NEEDLE	DPI			
97799910	NOVOFINE 30GX 8MM NEEDLE	NVC			
B1GX4.5MM NEEDLE					
97799404	CLICKFINE PEN NEEDLE 31G	AUC			

4.5MM st 31GX5MM NEEDLE

97799282	BD ULTRAFINE 31G 5MM PEN NEEDLE	BTD
97799239	DROPLET PEN NEEDLE 5MM 31G	SFA
97799563	SUPER-FINE MICRO 31G-5MM NEEDLE	PMS
97799426	UNIFINE PENTIPS 31GX5MM	AUC

ST 31GX6MM NEEDLE

ST 31GX8MM NEEDLE					
97799993	UNIFINE 31G.6MM NEEDLE	AUC			
97799545	ULTICARE 31GX6MM PEN NEEDLE	UMI			
97799569	INSUPEN 31GX6MM NEEDLE	DPI			
97799364	INSULIN PEN NEEDLE 31GX6MM	MDT			
97799237	DROPLET PEN NEEDLE 6MM 31G	SFA			
97799405	CLICKFINE PEN NEEDLE 31G 6MM	AUC			

97799281 BD ULTRAFINE 31G 8MM PEN

97799406 CLICKFINE PEN NEEDLE 31G 8MM

NEEDLE

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94:01.00 DE	94:01.00 DEVICES (DIABETIC) 94:01.00 DEVICES (DIABETIC)					
PEN NEEDLE	` ,			PEN NEEDLE		
	_					
ST 31GX8MM N			ST 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			
97799562	8MM SUPER-FINE XTRA 31G-8MM	PMS	99401026	BC SHARPS CONTAINER 1.4L	BTD	
97799302	NEEDLE	FIVIS	99401027	BD SHARPS CONTAINER 3.1L	BTD	
97799544	ULTICARE 31GX8MM PEN NEEDLE	UMI	09991639	BD SHARPS CONTAINER 3L	BTD	
00963976	ULTRAFINE III NEEDLE 31G 8MM	BTD	99401033	SHARPS NESTABLE YELLOW	UNK	
	UNIFINE 31G.8MM NEEDLE	AUC		LARGE 22.7L		
ST 32GX4MM N			SYRINGE &	NEEDLE		
97799527	BD ULTRA-FINE NANO PEN	BTD	ST 27GX1/2 NE	EDLE		
	NEEDLE		09991381	BD PRECISIONGLIDE 27GX1/2	BTD	
97799243	DROPLET PEN NEEDLE 4MM 32G	SFA	ST 18G NEEDL		טוט	
97799367	INSULIN PEN NEEDLE 32GX4MM	MDT		BD PRECISIONGLIDE 18GX1 1/2	BTD	
97799399	INSUPEN 32GX4MM NEEDLE	DPI	09991401	BD PRECISIONGLIDE 18GX1 1/2 BD PRECISIONGLIDE 18GX1	BTD	
97799334	MONTKIDDY BLUE NEEDLE	MDT	09991401	NEEDLE	ыл	
	32GX4MM		ST 25G NEEDL			
97799337	MONTKIDDY GREEN NEEDLE	MDT	09991385	BD PRECISIONGLIDE 25GX5/8	BTD	
	32GX4MM		09991386	BD PRECISIONGLIDE 25GX7/8	BTD	
97799335	MONTKIDDY PINK NEEDLE 32GX4MM	MDT	ST 26G NEEDL		515	
97799336	MONTKIDDY YELLOW NEEDLE	MDT	09991384	BD PRECISIONGLIDE 26GX1/2	BTD	
97799330	32GX4MM	ו טועו	09991383	BD PRECISIONGLIDE 26GX3/8	BTD	
97799386	NOVOFINE PLUS 4MM NEEDLE	NOO	ST 27G NEEDL		010	
97799440	ULTICARE 32GX4MM PEN NEEDLE	DPI	09991382	BD PRECISIONGLIDE 27GX1 1/4	BTD	
ST 32GX5MM N			SYRINGE	BBT REGISTORIOLIBE 27 GXT 174	סוט	
	DROPLET PEN NEEDLE 5MM 32G	SFA	09991609	BD POSIFLUSH SP	BTD	
ST 32GX6MM N			09991659	BD POSIFLUSH SP	BTD	
97799241	DROPLET PEN NEEDLE 6MM 32G	SFA	00977020	PLASTIPAK MICRO	BTD	
97799363	INSULIN PEN NEEDLE 32GX6MM	MDT	97799510	ULTICARE LOW DEAD SPACE	UMI	
97799571	INSUPEN 32GX6MM NEEDLE	DPI	0000.0	SYRINGE	•	
ST 32GX8MM N	EEDLE		ST 0.25CC SYR	INGE		
97799240	DROPLET PEN NEEDLE 8MM 32G	SFA	99002132	INSULIN SYR W/NEEDL 0.25CC	UNK	
97799365	INSULIN PEN NEEDLE 32GX8MM	MDT	0.3CC SYRI	NGE		
97799570	INSUPEN 32GX8MM NEEDLE	DPI	00977961	BD MICRO-FINE 0.3CC SYRINGE	BTD	
ST 33GX4MM N	EEDLE		99002140	INSULIN SYR W/NEEDLE 0.3CC	UNK	
	INSUPEN 33GX4MM NEEDLE	DPI	ST 0.5CC SYRI	NGE		
ST 315GXMM N	EEDLE		00920096	E-Z JE	RIV	
97799149	ULTICARE 31GX5MM PEN NEEDLE	UNK	99002159	INSULIN SYR W/NEEDLE 0.5CC	UNK	
ST 318GXMM N	EEDLE		00977136	MONOJECT	BTD	
97799148	ULTICARE 31GX8MM PEN NEEDLE	UNK	ST 0.5CC/1CC	SYRINGE		
324GXMM N			00977128	MONOJECT	MDT	
97799160	BD NANO PRO 32GX4MM PEN	BTD	ST 1CC SYRING	GE		
	NEEDLE		00920061	E-Z JE	RIV	
97799147	ULTICARE 32GX4MM PEN NEEDLE	UNK	99002167	INSULIN SYR W/NEEDLE 1CC	UNK	
ST 326GXMM N	EEDLE		ST 1ML SYRING	GE		
97799150	ULTICARE 32GX6MM PEN NEEDLE	UMI	09991376	BD LUER-LOK TIP 1ML SYRINGE	BTD	
21G NEEDL	E		09991375	BD SLIP TIP 1ML SYRINGE	BTD	
09991504	BD BUTTERFLY NEEDLE 21G	BTD	ST 3ML SYRING	GE		
ST 29G NEEDLI	E		09991371	BD LUER-LOK TIP 3ML SYRINGE	BTD	
97799897	BD ULTRA-FINE PEN NEEDLE 29G	BTD	09991372	BD SLIP TIP 3ML SYRINGE	BTD	
ST 30G NEEDL	E		ST 5ML SYRING	GE		
97799467	NOVOTWIST TIP 30G NEEDLE	NOO	09991373	BD LUER-LOK TIP 5ML SYRINGE	BTD	
			09991374	BD SLIP TIP 5ML SYRINGE	BTD	

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94:01.00 DE	VICES (DIABETIC)		94:01.00 DE	VICES (DIABETIC)	
SYRINGE & I	NEEDLE		SYRINGE &	NEEDLE	
ST 8MM SYRING	GE		28GX0.5CC	SYRINGE	
97799261	SURECOMFORT 5/16 IN 30GX0.3CC	UNK	97799518	ULTICARE 1/2 IN 28GX0.5CC	UMI
97799272	SURECOMFORT 5/16 IN 30GX0.5CC	UNK		SYRINGE	
97799265	SURECOMFORT 5/16 IN 30GX1CC	UNK	28GX1CC S		
97799273	SURECOMFORT 5/16 IN 31GX0.3CC	UNK	00920185	BD MICRO-FINE 28GX1CC SYRINGE	BTD
	SURECOMFORT 5/16 IN 31GX0.3CC	UNK	97799517	ULTICARE 1/2 IN 28GX1CC	UMI
	SURECOMFORT 5/16 IN 31GX0.5CC	UNK	91199311	SYRINGE	Olvii
	SURECOMFORT 5/16 IN 31GX1CC	UNK	ST 29GX0.3CC		
ST 10ML SYRIN				ULTI SYG 1/2 IN 29GX0.3CC	UMI
09991363	BD LUER-LOK TIP 10ML SYRINGE	BTD		ULTICARE 29GX0.3CC	AUC
09991364	BD SLIP TIP 10ML SYRINGE	BTD	97799887		BTD
ST 12MM SYRIN			ST 29GX0.5CC		
97799275	SURECOMFORT 1/2 IN 28GX1CC	UNK	97799888		BTD
ST 40 =1414 0\/=	SYRINGE		97799508		UMI
ST 12.7MM SYR		LINUZ	97799998	ULTICARE 29GX0.5CC	AUC
97799257	SURECOMFORT 1/2 IN 28GX0.5CC	UNK	ST 29GX1CC S		
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	
	SURECOMFORT 1/2 IN 30GX0.3CC	UNK	97799997	ULTICARE 29GX0.1CC	AUC
97799270	SURECOMFORT 1/2 IN 30GX0.5CC	UNK	ST 30GX0.3CC	SYRINGE	
	SURECOMFORT 1/2 IN 30GX1CC	UNK	97799551	ULTI SYG 1/2 IN 30GX0.3CC	UMI
s ⁵⁷ 18GX1 1/2 S		DTD	97799506	ULTI SYG 5/16 IN 30GX0.3CC	UMI
09991349	BD LUER-LOK TIP 18GX1 1/2 SYRINGE	BTD	97799996	ULTICARE 30GX0.3CC	AUC
ST 20ML SYRIN			97799886	ULTRA-FINE II 30GX0.3 CC	BTD
09991368	BD LUER-LOK TIP 20ML SYRINGE	BTD		SYRINGE	
09991369	BD SLIP TIP 20ML SYRINGE	BTD	ST 30GX0.5CC		
ST 21GX1 SYRI		5.5	97799885	BD ULTRA-FINE II 30GX0.5CC	BTD
	BD TUBERCULIN 21GX1 SYRINGE	BTD	97799550	SYRINGE ULTI SYG 1/2 IN 30GX0.5CC	UMI
ST 22GX1 1/2 S		5.5	97799505	ULTI SYG 1/2 IN 30GX0.5CC	UMI
	BD LUER-LOK TIP 22GX1 1/2	BTD		ULTICARE 30GX0.5CC	AUC
00001011	SYRINGE	2.2	57799995 ST 30GX1CC S		AUC
ST 23GX5/8 SY	RINGE		97799549	ULTI SYG 1/2 IN 30GX1CC	UMI
09991339	BD LUER-LOK TIP 25GX5/8	BTD	91199549	SYRINGE	Olvii
	SYRINGE		97799504	ULTI SYG 5/16 IN 30GX1CC	UMI
ST 25GX1 SYRI	NGE			SYRINGE	
09991338	BD LUER-LOK TIP 25GX1 SYRINGE	BTD	97799994	ULTICARE 30GX0.1CC	AUC
ST 25GX1 1/2 S	YRINGE		97799890	ULTRA-FINE II 30G.1CC	BTD
09991337	BD LUER-LOK TIP 25GX1 1/2	BTD	ST 30ML SYRIN	IGE	
ST OF OVER OW	SYRINGE		09991377	BD LUER-LOK TIP 30ML SYRINGE	BTD
ST 25GX5/8 SY		DTD	09991378	BD SLIP TIP 30ML SYRINGE	BTD
09991359	BD TUBERCULIN 25GX5/8 SYRINGE	BTD	ST 31GX0.3CC	SYRINGE	
ST 26GX3/8 SY			97799369	INSULIN 31GX0.3CC	MDT
09991358	BD TUBERCULIN 26GX3/8	BTD	97799548	ULTI SYG 5/16 IN 31GX0.3CC	UMI
	SYRINGE	ыы	97799513	ULTICARE 5/16 IN 31GX0.3CC SYRINGE	UMI
ST 26GX5/8 SY	RINGE		ST 31GX0.5CC		
	BD SLIP TIP SUB Q 26G SYRINGE	BTD	97799370	INSULIN 31GX0.5CC	MDT
ST 27GX1/2 SY	RINGE		97799547		UMI
09991356	BD TUBERCULIN 27GX1/2 SYRINGE	BTD	97799512		UMI
09991357	BD TUBERCULIN 27GX1/2	BTD	ST 31GX1CC S		
20072 500	SYRINGE		97799371	INSULIN 31GX1CC	MDT
28GX0.5CC		DTD	97799546	ULTI SYG 5/16 IN 31GX1CC	UMI
00920177	BD MICRO-FINE 28GX0.5CC SYRINGE	BTD	37700040	SYRINGE	

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94:01.00 DEVICES (DIABETIC) SYRINGE & NEEDLE

ST 31GX1CC SYRINGE				
97799511	ULTICARE 5/16 IN 31GX1CC SYRINGE	UMI		
ST 31GX6MMX0	.3CC SYRINGE			
97799425	BD SYRINGE WITH ULTRA-FINE NEEDLE	BTD		
ST 31X6MMX0.5	SCC SYRINGE			
97799385	BD SYRINGE + NEEDLE	BTD		
ST 31X6MMX1C	C SYRINGE			
97799384	BD SYRINGE + NEEDLE	BTD		
ST 60ML SYRIN	GE			
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 UNK

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

۰	SIVAL LIQUI		
	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
	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

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.

ST CREAM

99000385 EMOLLIENT FOR CHILDREN **WPC**

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
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

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

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

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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 weight
- · Failure to thrive/growth faltering
- · Cow milk protein allergy
- Other medical conditions not listed

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95900009	ENFAMIL A+ ENFACARE 363G PDR	MJO
95900155	ENFAMIL LOW IRON FORMULA 900GM	MJO
95900021	NEOCATE JUNIOR 400G PDR	UNK
95900022	NEOCATE ONE 400G	UNK
95900023	NEOCATE 400G PDR	UNK
95900025	NEOCATE W/ DHA & ARA 400G	UNK
	PDR	
95900027	NUTRAMIGEN A+ LGG 561G PDR	MJO
95900035	PURAMINO A+ 400G PDR	MJO
95900112	PURAMINO A+ JUNIOR 400G PDR	MJO
95900036	SIMILAC ADVANCE NEOSURE	ABB
	363G	
95900047	SIMILAC ALIMENTUM 400G PDR	ABB
95900184	SIMILAC LOWER IRON 850G PDR	ABB
95900044	SIMILAC PM 60/40 450G PDR	UNK

NUTRITIONAL SUPPLEMENT

THICKENING AGENT (POWDER)

95900123 SOURCE THICKEN UP 227G PDR NES

THICKENING AGENT

KIT

09991194	SIMPLY THICK 640Z BOTTLE	UNK
	DLIMD	

POWDER

12137029 RESOURCE THICKEN CLEAR NVC 09991163 RESOURCE THICKEN UP 6.4G NVC

THICKENING AGENT (KIT)

95900118 SIMPLY THICK 64OZ BOTTLE UNK PUMP

THICKENING AGENT (POWDER)

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

THICKENING GEL

ORAL LIQUID

09991164	SIMPLY THICK HONEY	UNK
09991035	SIMPLY THICK NECTAR	UNK

THICKENING AGENT (POWDER)

95900119 SIMPLY THICK HONEY 200G UNK 95900120 SIMPLY THICK NECTAR 200G UNK

96:00.00 PHARMACEUTICAL AIDS WATER

SOLUTION

00905178 STERILE WATER UNK 99002264 STERILE WATER UNK SYRINGE

09991563 STERILE WATER PF UNK

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APPENDIX A

LIMITED USE BENEFITS AND CRITERIA

SDZ

08:00 ANTI-INFECTIVE AGENTS

08:12.02 AMINOGLYCOSIDES

AMIKACIN SULFATE

Limited use benefit (prior approval required).	
250MG LIQUID	
02242971 AMIKACIN SULFATE	SDZ
TOBRAMYCIN	
Limited use benefit (prior approval required).	
28MG CAPSULE	
02365154 TOBI PODHALER	BGP
1.2G POWDER FOR SOLUTION	
00533688 TOBRAMYCIN	FKD
02285150 TOBRAMYCIN	RAX
10MG/ML SOLUTION	
02230639 TOBRAMYCIN	FKD
02241209 TOBRAMYCIN	SDZ
40MG/ML SOLUTION	
02420287 JAMP-TOBRAMYCIN	JMP
02230640 TOBRAMYCIN	FKD
02241210 TOBRAMYCIN	SDZ
02382814 TOBRAMYCIN	MYL
99005069 TOBRAMYCINE	UNK
60MG SOLUTION	
02389622 TEVA-TOBRAMYCIN	TEV
300MG SOLUTION	

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

02443368 TOBRAMYCIN INHALATION

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

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TEV

08:12.12 MACROLIDES

FIDAXOMICIN

Limited use benefit (prior approval required).

For the treatment of confirmed severea 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 adequateb trial of oral vancomycin; AND
- Retreatment with vancomycin is not an optionc; AND
- The patient is at a high risk of hospitalization due to severe complications; AND
- Fidaxomicin is being used as monotherapy.

Notes

- a. 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.
- b. 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.
- c. 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	
	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
	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	RAX
	36G & 4.5G POWDER FOR SOLUTION	
	02439131 PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX
_		

08:12.18 QUINOLONES

LEVOFLOXACIN HEMIHYDRATE

02315432 ACT LEVOFLOXACIN

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	

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08:12.18 QUINOLONES

LEVOFLOXACIN HEMIHYDRATE

Limited use benefit (prior approval not required).

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

500MG TABLET

02284715 APO-LEVOFLOXACIN	APX
02415879 LEVOFLOXACIN	PDL
02284685 PMS-LEVOFLOXACIN	PMS
02298643 SANDOZ LEVOFLOXACIN	SDZ

750MG TABLET

TEV
APX
PMS
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
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

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PFI

08:12.28 MISCELLANEOUS ANTIBIOTICS

LINEZOLID

Limited use benefit (prior approval required).

Tablets

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

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

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/ML SOLUTION 02243685 ZYVOXAM PFI **600MG TABLET**

02426552 APO-LINEZOLID APX 02422689 SANDOZ LINEZOLID SDZ

02243684 ZYVOXAM

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

VANCOMYCIN HYDROCHLORIDE (INJECTION)

Limited use benefit (prior approval required). **POWDER** 99100176 VANCOMYCIN MDS **500MG POWDER FOR SOLUTION**

02420295 JAMP-VANCOMYCIN **JMP** 02406535 MYLAN-VANCOMYCIN MYL 02139375 VANCOMYCIN FKD 02230191 VANCOMYCIN PFI 02394626 VANCOMYCIN SDZ 02411032 VANCOMYCIN RAX 02435713 VANCOMYCIN **GMP** 02342855 VANCOMYCIN HYDROCHLORIDE RAX

1.000MG POWDER FOR SOLUTION

PFI 02230192 VANCOMYCIN 02396386 VANCOMYCIN **RAX** 02435721 VANCOMYCIN **GMP**

1G POWDER FOR SOLUTION 02420309 JAMP-VANCOMYCIN **JMP** 02406543 MYLAN-VANCOMYCIN MYL 02241821 PMS-VANCOMYCIN 1 G **PMS** 02139383 VANCOMYCIN FKD 02394634 VANCOMYCIN SDZ 02342863 VANCOMYCIN HYDROCHLORIDE RAX

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PFI

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08:12.28 MISCELLANEOUS ANTIBIOTICS

VANCOMYCIN HYDROCHLORIDE (INJECTION)

Limited use benefit (prior approval required). **5G POWDER FOR SOLUTION** 02420317 JAMP-VANCOMYCIN JMP 02406551 MYLAN-VANCOMYCIN MYL 02139243 VANCOMYCIN FKD 02378337 VANCOMYCIN PFI 02394642 VANCOMYCIN SDZ **10G POWDER FOR SOLUTION** 02420325 JAMP-VANCOMYCIN **JMP** 02406578 MYLAN-VANCOMYCIN MYL 02241807 VANCOMYCIN FKD PFI 02378345 VANCOMYCIN 02394650 VANCOMYCIN SDZ 02411040 VANCOMYCIN RAX 02405830 VANCOMYCIN HYDROCHLORIDE RAX 08:14.08 AZOLES

VORICONAZOLE

Limited use benefit (prior approval required).

For the treatment of patients with invasive aspergillosis; OR

For the treatment of culture proven invasive candidiasis with documented resistance to fluconazole.

50MG TABLET

02409674 APO-VORICONAZOLE	APX
02399245 SANDOZ VORICONAZOLE	SDZ
02396866 TEVA-VORICONAZOLE	TEV
02256460 VFEND	PFI
200MG TABLET	
02409682 APO-VORICONAZOLE	APX
02399253 SANDOZ VORICONAZOLE	SDZ
02396874 TEVA-VORICONAZOLE	TEV

08:18.08 ANTIRETROVIRALS

TENOFOVIR DISOPROXIL FUMARATE

Limited use benefit (prior approval required).

02256479 VFEND

For the treatment of patients with HIV-1 infection who have failed or have experienced adverse events to an alternative agent. For the treatment of patients with chronic hepatitis B infection who have cirrhosis documented on radiologic or histologic grounds and a HBV concentration above 2,000 IU/mL

245MG TABLET

00047400 \/\DEAD

02247128 VIREAD	GIL
300MG TABLET	
02451980 APO-TENOFOVIR	APX
02460173 AURO-TENOFOVIR	AUR
02479087 JAMP-TENOFOVIR	JMP
02452634 MYLAN-TENOFOVIR DISOPROXIL	MYL
02472511 NAT-TENOFOVIR	NPH
02453940 PMS-TENOFOVIR	PMS
02403889 TEVA-TENOFOVIR	TEV

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08:18.20 INTERFERONS

PEGINTERFERON ALFA-2A

Limited use benefit (prior approval required).

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

180MCG/0.5ML SOLUTION

02248077 PEGASYS HLR

PEGINTERFERON ALFA-2B. RIBAVIRIN

Limited use benefit (prior approval required).

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

• For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).

• For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

50MCG/0.5ML & 200MG KIT

02254573 PEGETRON KIT

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 GIL

ENTECAVIR MONOHYDRATE

Limited use benefit (prior approval required).

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

0.5MG TABLET

02396955 APO-ENTECAVIR	APX
02448777 AURO-ENTECAVIR	AUR
02282224 BARACLUDE	BMS
02467232 JAMP ENTECAVIR	JMP
02430576 PMS-ENTECAVIR	PMS

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08:18.40 HCV ANTIVIRALS

DACLATASVIR

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

60MG TABLET

BMS 02444755 DAKLINZA

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

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

50MG & 100MG TABLET

FRS 02451131 ZEPATIER

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

ABV 02467550 MAVIRET

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

PED 02425904 IBAVYR

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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

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

08:36.00 URINARY ANTI-INFECTIVES

FOSFOMYCIN TROMETHAMINE

Limited use benefit (prior approval required).

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

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

3G/PK POWDER FOR SOLUTION

02240335 MONUROL PAL

3G POWDER FOR SOLUTION

02473801 JAMP-FOSFOMYCIN JMP

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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 riska of developing metastases; AND
- · Have no risk factors for seizures; AND
- · Have a good ECOG performance status (0 or 1)

a 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

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

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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

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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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

40MG CAPSULE

02407329 XTANDI AST

ERLOTINIB HYDROCHLORIDE

Limited use benefit (prior approval required).

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

25MG TABLET

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

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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.

2.5MG TABLET

02369257 AFINITOR NVR

5MG TABLET

02339501 AFINITOR NVR

10MG TABLET

02339528 AFINITOR NVR

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 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

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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 idelalisib 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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TFV

10:00.00 ANTINEOPLASTIC AGENTS

IMATINIB MESYLATE

Limited use benefit (prior approval required).

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

LENALIDOMIDE

Limited use benefit (prior approval required).

02399814 TEVA-IMATINIB

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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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.

10MG CAPSULE

02304902 REVLIMID

15MG CAPSULE

02317699 REVLIMID

02440601 REVLIMID

025MG CAPSULE

02317710 REVLIMID

UNK

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LENVATINIB

Limited use benefit (prior approval required).

Criteria for initial 4-month coverage:

- · Used as monotherapy for treatment of patients with locally recurrent or metastatic, progressive differentiated thyroid cancer (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.

10MG CAPSULE

02450321 LENVIMA FIS

14MG CAPSULE

02450313 LENVIMA EIS

20MG CAPSULE

02450305 LENVIMA FIS

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**

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**

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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).

Criteria for initial 12-month coverage:

Patient with locally advanced or metastatic non-small cell lung cancer (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

PALBOCICLIB

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of post-menopausal women 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.

75MG CAPSULE

02453150 IBRANCE PFI

100MG CAPSULE

02453169 IBRANCE PFI

125MG CAPSULE

02453177 IBRANCE PFI

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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

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 ARI

45MG TABLET

02437341 ICLUSIG ARI

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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; 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

NVR

RIBOCICLIB (RIBOCICLIB SUCCINATE)

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of post-menopausal women 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.
- 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

RITUXIMAB

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Initial coverage is provided for 24 weeks at a dose of 1000 mg x 2 doses at 0 & 2 weeks.

Prescribed by a rheumatologist

For the treatment of adult patients with severely active rheumatoid arthritis who have failed to respond to a trial of an anti-TNF agent. Treatment should be combined with methotrexate. Rituximab should not be used in combination with anti-TNF agents.

For continued coverage for rituximab beyond twenty-four weeks, patient must meet all the following criteria:

Initially prescribed by a rheumatologist;

AND

Patient has been assessed after the twentieth to twenty-fourth week of rituximab therapy and meets the response criteria of:

- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.
- 2. For the treatment of GRANULOMATOSIS POLYANGIITIS OR MICROSCOPIC POLYANGIITIS

Coverage is provided at a dose of 375 mg/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 HLR

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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 < $1.0 \times 109/L$, or platelet < $100 \times 109/L$ 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 $\leq 400 \times 109/L$, wBC $\leq 10 \times 109/L$, 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 TABLET

02434814 JAKAVI NVR

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.

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;
- 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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APX

10:00.00 ANTINEOPLASTIC AGENTS

VENETOCLAX

Limited use benefit (prior approval required).

Criteria for initial 12-month coverage:

For the treatment of chronic lymphocytic leukemia (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.

Coverage is for a maximum duration of two years.

10MG TABLET

02458039 VENCLEXTA

50MG TABLET

02458047 VENCLEXTA

ABV

100MG TABLET

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:

02362279 APO-DONEPEZIL

- · 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	ВМІ
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
02381508 RAN-DONEPEZIL	RBY
02412918 RIVA-DONEPEZIL	RIV
02328666 SANDOZ DONEPEZIL	SDZ
02428482 SEPTA DONEPEZIL	SPT
02340607 TEVA-DONEPEZIL	TEV
ST 10MG TABLET	

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MYL

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 10MG TABLET

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
02381516 RAN-DONEPEZIL	RBY
02412934 RIVA-DONEPEZIL	RIV
02328682 SANDOZ DONEPEZIL	SDZ
02428490 SEPTA DONEPEZIL	SPT
02340615 TEVA-DONEPEZIL	TEV

GALANTAMINE HYDROBROMIDE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:

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

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

Criteria for coverage at every 12 month interval:

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

ST 8MG CAPSULE (EXTENDED RELEASE)

02339447 MYLAN-GALANTAMINE ER

C	02425157	AURO-GALANTAMINE ER	AUR
C	02443015	GALANTAMINE	SAN
C	02416573	GALANTAMINE ER	PDL
C	02420821	MAR-GALANTAMINE ER	MAR
C	02339439	MYLAN-GALANTAMINE ER	MYL
C	02316943	PAT-GALANTAMINE ER	JSO
C	02398370	PMS-GALANTAMINE ER	PMS
ST 16	MG CAPS	SULE (EXTENDED RELEASE)	
C	02425165	AURO-GALANTAMINE ER	AUR
C	02443023	GALANTAMINE	SAN
C	02416581	GALANTAMINE ER	PDL
C	02420848	MAR-GALANTAMINE ER	MAR

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۸DV

PDL

SDZ

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 16MG CAPSULE (EXTENDED RELEASE)

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

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:

02417014 RIVASTIGMINE

02324598 SANDOZ RIVASTIGMINE

02226715 ADO DIVASTICMINE

- 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-RIVAS TIGMINE	APX
02242115	EXELON	NVR
02401614	MED-RIVASTIGMINE	GMP
02306034	PMS-RIVASTIGMINE	PMS
02416999	RIVASTIGMINE	PDL
02324563	SANDOZ RIVASTIGMINE	SDZ
ST 3MG CAPSU	ULE	
02336723	APO-RIVASTIGMINE	APX
02242116	EXELON	NVR
02401622	MED-RIVASTIGMINE	GMP
02306042	PMS-RIVASTIGMINE	PMS
02417006	RIVASTIGMINE	PDL
02324571	SANDOZ RIVASTIGMINE	SDZ
ST 4.5MG CAPS	SULE	
02336731	APO-RIVASTIGMINE	APX
02242117	EXELON	NVR
02401630	MED-RIVASTIGMINE	GMP
02306050	PMS-RIVASTIGMINE	PMS

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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 6MG CAPSULE

2MG/ML SOLUTION	
02324601 SANDOZ RIVASTIGMINE	SDZ
02417022 RIVASTIGMINE	PDL
02306069 PMS-RIVASTIGMINE	PMS
02401649 MED-RIVASTIGMINE	GMP
02242118 EXELON	NVR
02336758 APO-RIVASTIGMINE	APX

$^{\rm ST}$ 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

02349027 AA-TRIMEBUTINE	AAP
02245663 TRIMEBUTINE	AAP
200MG TABLET	
02349035 AA-TRIMEBUTINE	AAP
02245664 TRIMEBUTINE	AAP

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.

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**

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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.

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

· moderate to severe COPD, as defined by spirometry; OR

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

6MCG & 100MCG/INHALATION POWDER

02245385 SYMBICORT 100 TURBUHALER

AZC

6MCG & 200MCG/INHALATION POWDER

02245386 SYMBICORT 200 TURBUHALER

AZC

FORMOTEROL FUMARATE DIHYDRATE, MOMETASONE FUROATE

Limited use benefit (prior approval required).

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

5MCG & 100MCG/INHALATION AEROSOL

02361752 ZENHALE

FRS

5MCG & 200MCG/INHALATION AEROSOL

02361760 ZENHALE

FRS

5MCG & 50MCG/INHALATION AEROSOL

02361744 ZENHALE

FRS

INDACATEROL MALEATE

Limited use benefit (prior approval required).

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

- 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

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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 rapidonset, short-duration bronchodilator.

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 long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

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

· moderate to severe COPD, as defined by spirometry; OR

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

25MCG & 125MCG AEROSOL

02245126 ADVAIR 125	GSK
25MCG & 250MCG AEROSOL	
02245127 ADVAIR 250	GSK
50MCG & 100MCG POWDER	
02240835 ADVAIR 100 DISKUS	GSK
50MCG & 250MCG POWDER	
02240836 ADVAIR 250 DISKUS	GSK
50MCG & 500MCG POWDER	
02240837 ADVAIR 500 DISKUS	GSK

12:20.04 CENTRALL ACTING SKELETAL MUSCLE RELAXANTS

CYCLOBENZAPRINE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

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

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

02259893 TIZANIDINE AAP

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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

80015240 RUGBY NICOTINE POLACRILEX GUM

80000396 THRIVE NICOTINELL GUM

GSK

ST 4MG GUM

02091941 NICORETTE GUM

80000118 NICOTINE GUM

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 LOZENGE

02247347 NICORETTE LOZENGE 80007464 THRIVE NICOTINE LOZENGES KIM 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.

ST 2MG GUM

80025660 CHU NICOTINE ANTI SMOKING AID
UNK
94799974 THRIVE GUM (NS)
NVC

 $^{\text{ST}}$ 1MG LOZENGE

80061161 NICHIT EUR

ST 2MG LOZENGE

80059877 NICHIT EUR

 $^{\rm ST}$ 7MG PATCH

01943057 HABITROL NVC

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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.

S' 7MG PATCH	
80051602 NICOTINE TRANSDERMAL	APX
80044393 TRANSDERMAL NICOTINE	ACG
ST 14MG PATCH	
01943065 HABITROL	NVC
80013549 NICOTINE TRANSDERMAL SYSTEM	ADD
80044392 TRANSDERMAL NICOTINE	ACG
ST 18MG PATCH	
02241227 TRANSDERMAL NICOTINE PATCHDAY	NVC
ST 21MG PATCH	
01943073 HABITROL	NVC
80051603 NICOTINE TRANSDERMAL	APX
80014250 NICOTINE TRANSDERMAL SYSTEM	ADD
80044389 TRANSDERMAL NICOTINE	ACG
ST 36MG PATCH	
02093111 NICODERM	KIM
ST 53MG PATCH	

ST 78MG PATCH

02093138 NICODERM KIM

ST 114MG PATCH

4WG PATCH

NICOTINE (SPRAY)

02093146 NICODERM

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

02241228 TRANSDERMAL NICOTINE PATCHDAY

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

NVC

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

$^{s\tau}$ 0.5MG & 1MG TABLET

02435675 APO-VARENICLINE	APX
02298309 CHAMPIX STARTER PACK	PFI

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12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

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 & 1MG TABLET

02426781 TEVA-VARENICLINE TEV

 ST 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

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

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20:12.04 ANTICOAGULANTS

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

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

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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)

Secondary Prophylaxis

For use in patients receiving myelosuppressive chemotherapy who have experienced an episode of febrile neutropenic sepsis or profound neutropenia in a previous cycle of chemotherapy; OR

For use in patients who have experienced a dose reduction or treatment delay longer than one week, due to neutropenia.

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

10MG/ML SOLUTION

02249790 NEULASTA AMG

PLERIXAFOR

Limited use benefit (prior approval 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
- 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;

- 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;

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;

)R

- 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.

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
02412179 PMS-SILDENAFIL R
02279401 REVATIO
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

02399202 APO-BOSENTAN	APX
02383012 PMS-BOSENTAN	PMS
02386275 SANDOZ BOSENTAN	SDZ
02398400 TEVA-BOSENTAN	TEV
02244981 TRACLEER	JSO
T	

ST 125MG TABLET

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 \leq 35%), as an adjunct to standard therapy.

Note: Patients must be on optimal therapy with an angiotensin-converting-enzyme (ACE) inhibitor or an angiotensin-receptor blocker (ARB), and a beta-blocker (unless contraindicated) at the recommended dose or maximal tolerated dose.

25MG TABLET

02323052 INSPRA	PFI
02471442 MINT-EPLERENONE	MIN
50MG TABLET	

02323060 INSPRA PFI
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;
- 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 80MG TABLET

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

ST 80MG TABLET (DELAYED RELEASE)

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

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

APX
TEL
RAX
JMP
PMS
TAR

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ACETAMINOPHEN, CAFFEINE CITRATE, CODEINE PHOSPHATE

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

300MG & 15MG & 15MG TABLET

00653241 RATIO-LENOLTEC NO 2	TEV
02163934 TYLENOL WITH CODEINE NO.2	JSO

300MG & 15MG & 30MG TABLET

00653276 RATIO-LENOLTEC NO 3 TEV
02163926 TYLENOL WITH CODEINE NO.3 JSO

325MG & 30MG & 15MG TABLET

00293504 ATASOL 15 CHU

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	TFV

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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

325MG & 5MG TABLET

00608157 TEVA-OXYCODAN TEV

CODEINE MONOHYDRATE, CODEINE SULFATE TRIHYDRATE

Limited use benefit (prior approval required).

For treatment of

chronic pain and palliative care patients as an alternative to products containing codeine in combination with acetaminophen or ASA with or without caffeine; OR
 chronic pain and palliative care patients as an alternative to regular release codeine tablets when large doses are required.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

50MG TABLET (EXTENDED RELEASE)

02230302 CODEINE CONTIN CR PFR

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28:08.08 OPIATE AGONISTS

CODEINE MONOHYDRATE. CODEINE SULFATE TRIHYDRATE

Limited use benefit (prior approval required).

For treatment of:

· chronic pain and palliative care patients as an alternative to products containing codeine in combination with acetaminophen or ASA with or without caffeine; OR · chronic pain and palliative care patients as an alternative to regular release codeine tablets when large doses are required.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

100MG TABLET (EXTENDED RELEASE)

PFR 02163748 CODEINE CONTIN CR

150MG TABLET (EXTENDED RELEASE)

PFR 02163780 CODEINE CONTIN CR

200MG TABLET (EXTENDED RELEASE)

02163799 CODEINE CONTIN CR PFR

CODEINE PHOSPHATE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 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

00593435 TEVA-CODEINE TEV

30MG TABLET

02009757 CODEINE RIV

00593451 TEVA-CODEINE TEV

FENTANYL

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 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	

2

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

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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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

75MCG/HR PATCH

02282976 TEVA-FENTANYL	TEV
100MCG/HR PATCH	
02341417 PMS-FENTANYL MTX	PMS
02327163 SANDOZ FENTANYL	SDZ
02282984 TEVA-FENTANYI	TFV

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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 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
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

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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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

24MG CAPSULE (SUSTAINED RELEASE)	
02125382 HYDROMORPH CONTIN	PFR
30MG CAPSULE (SUSTAINED RELEASE)	
02125390 HYDROMORPH CONTIN	PFR
1MG/ML LIQUID	
01916386 PMS HYDROMORPHONE	PMS
3MG SUPPOSITORY	
01916394 PMS HYDROMORPHONE	PMS
1MG TABLET	
02364115 APO-HYDROMORPHONE	APX
00705438 DILAUDID	PFR
00885444 PMS-HYDROMORPHONE	PMS
02319403 TEVA-HYDROMORPHONE	TEV
2MG TABLET	
02364123 APO-HYDROMORPHONE	APX
00125083 DILAUDID	PFR
00885436 PMS-HYDROMORPHONE	PMS
02319411 TEVA-HYDROMORPHONE	TEV
4MG TABLET	
02364131 APO-HYDROMORPHONE	APX
00125121 DILAUDID	PFR
00885401 PMS-HYDROMORPHONE	PMS
02319438 TEVA-HYDROMORPHONE	TEV
8MG TABLET	
02364158 APO-HYDROMORPHONE	APX
00786543 DILAUDID	PFR
00885428 PMS-HYDROMORPHONE	PMS
02319446 TEVA-HYDROMORPHONE	TEV

METHADONE HYDROCHLORIDE (METADOL)

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

Prescriber is registered with Health Canada and is eligible to prescribe methadone for the management of pain; AND For the management of moderate to severe cancer pain or chronic non-cancer pain, as an alternative to other opioids; OR For the management of pain for palliative care patients. Pharmacists may only dispense a maximum supply of 30 days at one time.

1MG/ML SOLUTION	
02247694 METADOL	PAL
10MG/ML SOLUTION	
02241377 METADOL	PAL
1MG TABLET	
02247698 METADOL	PAL
5MG TABLET	
02247699 METADOL	PAL
10MG TABLET	
02247700 METADOL	PAL

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METHADONE HYDROCHLORIDE (METADOL)

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

Prescriber is registered with Health Canada and is eligible to prescribe methadone for the management of pain; AND For the management of moderate to severe cancer pain or chronic non-cancer pain, as an alternative to other opioids; OR For the management of pain for palliative care patients. Pharmacists may only dispense a maximum supply of 30 days at one time.

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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 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
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

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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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

15MG TABLET (EXTENDED RELEASE)	
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
ODDIINE CIII 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

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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 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

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[•] For the treatment of chronic pain.

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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

100MG CAPSULE (SUSTAINED RELEASE)

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 non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG SUPPOSITORY	
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

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.
- · Patient is palliative (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less)

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

5MCG PATCH	
02341174 BUTRANS 5	PFR
10MCG PATCH	
02341212 BUTRANS 10	PFR
15MCG PATCH	
02450771 BUTRANS 15	PFR
20MCG PATCH	
02341220 BUTRANS 20	PFR

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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	ACG
02424851	PMS-BUPRENORPHINE-NALOXONE	PMS
02295695	SUBOXONE	IND
8MG & 2M	STABLET	
02453916	ACT BUPRENORPHINE/NALOXONE	ACG
02424878	PMS-BUPRENORPHINE-NALOXONE	PMS
02295709	SUBOXONE	IND
12MG & 3N	G TABLET	
02468085	SUBOXONE	IND
16MG & 4N	IG 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
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

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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.

grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.	
ST 32MG/ML LIQUID	
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	1 MO
	DED
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
00789801 ACETAMINOPHEN	TLI
01938088 ACETAMINOPHEN	JMP
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
02022222 ACÉTAMINOPHÈNE	RIV
02362228 ACÉTAMINOPHÈNE	RIV
02362201 ACÉTAMINOPHÈNE BLASON SHIELD	RIV
00545007 APO ACETAMINOPHEN	APX
02229977 APO-ACETAMINOPHEN	APX
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
	· - ·

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MCL

28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

ACETAMINOPHEN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

ST 80MG TABLET (CHEWABLE)

02017458 ACETAMINOPHEN	RIV
02129957 ACETAMINOPHEN	VTH
ST 160MG TABLET (CHEWABLE)	
02017431 ACETAMINOPHEN	RIV
02142805 ACETAMINOPHEN	VTH
02263823 PEDIAPHEN	EUR
02347792 TYLENOL JR STRENGTH FASTMELTS	MCL

28:12.08 ANTICONVULSANTS - BENZODIAZEPINES

CLONAZEPAM

Limited use benefit (prior approval is not required).

02241361 TYLENOL JUNIOR STRENGTH

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
ST 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

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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.

10MG TABLET

02452936 BRIVLERA UCB

25MG TABLET

02452944 BRIVLERA UCB

50MG TABLET

02452952 BRIVLERA UCB

75MG TABLET

02452960 BRIVLERA UCB

100MG TABLET

02452979 BRIVLERA UCB

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.

ST 200MG TABLET

 02426862 APTIOM
 SPC

 \$T 400MG TABLET
 02426870 APTIOM
 SPC

 \$T 600MG TABLET
 02426889 APTIOM
 SPC

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	PFI
02243446 PMS-GABAPENTIN	PMS
02310449 PRO-GABAPENTIN	PDL
02319055 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.

100MG CAPSULE	d region by region.
02251167 RIVA-GABAPENTIN	RIV
02244513 TEVA-GABAPENTIN	TEV
300MG CAPSULE	
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
02285827 GD-GABAPENTIN	PFI
02361485 JAMP-GABAPENTIN	JMP
02391481 MAR-GABAPENTIN	MAR
02084279 NEURONTIN	PFI
02243447 PMS-GABAPENTIN	PMS
02310457 PRO-GABAPENTIN	PDL
02319063 RAN-GABAPENTIN	RBY
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	BMI
02243745 DOM-GABAPENTIN	DPC
02246316 GABAPENTIN	SIV
02353261 GABAPENTIN	SAN
02416867 GABAPENTIN 02361493 JAMP-GABAPENTIN	ACC JMP
02391503 MAR-GABAPENTIN	MAR
02084287 NEURONTIN	PFI
02243448 PMS-GABAPENTIN	PMS
02310465 PRO-GABAPENTIN	PDL
02319071 RAN-GABAPENTIN	RBY
02251183 RIVA-GABAPENTIN	RIV
02244515 TEVA-GABAPENTIN	TEV
ST 600MG TABLET	
02293358 APO-GABAPENTIN	APX
02428334 AURO-GABAPENTIN	AUR
02450186 BIO-GABAPENTIN	ВМІ
02388200 GABAPENTIN	SIV
02392526 GABAPENTIN	ACC
02431289 GABAPENTIN	SAN
02285843 GD-GABAPENTIN	PFI
02402289 JAMP-GABAPENTIN	JMP

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AUR

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	
02239717 NEURONTIN	PFI
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	PFI
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 TABLET (IMMEDIATE RELEASE)	
02411008 GLN-GABAPENTIN	GLK

LACOSAMIDE

Limited use benefit (prior approval required).

02475332 AURO-LACOSAMIDE

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.

02487802 MAR-LACOSAMIDE	MAR
02478196 PHARMA-LACOSAMIDE	PMS
02474670 SANDOZ LACOSAMIDE	SDZ
02472902 TEVA-LACOSAMIDE	TEV
02357615 VIMPAT	UCB
ST 100MG TABLET	
02475340 AURO-LACOSAMIDE	AUR
02487810 MAR-LACOSAMIDE	MAR
02478218 PHARMA-LACOSAMIDE	PMS
02474689 SANDOZ LACOSAMIDE	SDZ
02472910 TEVA-LACOSAMIDE	TEV
02357623 VIMPAT	UCB
ST 150MG TABLET	
02475359 AURO-LACOSAMIDE	AUR
02487829 MAR-LACOSAMIDE	MAR
02478226 PHARMA-LACOSAMIDE	PMS

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SDZ

TEV

UCB

EIS

28:12.92 MISCELLANEOUS ANTICONVULSANTS

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 150MG TABLET

02474697 SANDOZ LACOSAMIDE	SDZ
02472929 TEVA-LACOSAMIDE	TEV
02357631 VIMPAT	UCB
ST 200MG TABLET	
02475367 AURO-LACOSAMIDE	AUR
02487837 MAR-LACOSAMIDE	MAR
02478234 PHARMA-LACOSAMIDE	PMS

OXCARBAZEPINE (SUSPENSION)

02357658 VIMPAT

02472937 TEVA-LACOSAMIDE

02474700 SANDOZ LACOSAMIDE

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).

02404567 FYCOMPA

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 ST 4MG TABLET	EIS
02404524 FYCOMPA ST 6MG TABLET	EIS
02404532 FYCOMPA ST 8MG TABLET	EIS
02404540 FYCOMPA ST 10MG TABLET	EIS
02404559 FYCOMPA ST 12MG TABLET	EIS

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JMP

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.

02435993 JAMP-PREGABALIN

25MG CAPSULE

ZUNIO OAI	5011	
02480727	AG-PREGABALIN	ANG
02394235	APO-PREGABALIN	APX
02433869	AURO-PREGABALIN	AUR
02402556	DOM-PREGABALIN	DPC
02435977	JAMP-PREGABALIN	JMP
02268418	LYRICA	PFI
02417529	MAR-PREGABALIN	MAR
02423804	MINT-PREGABALIN	MIN
02467291	M-PREGABALIN	MAN
02479117	NRA-PREGABALIN	UNK
02359596	PMS-PREGABALIN	PMS
02396483	PREGABALIN	PDL
02403692	PREGABALIN	SIV
02405539	PREGABALIN	SAN
02476304	PREGABALIN	RIV
02392801	RAN-PREGABALIN	RBY
02377039	RIVA-PREGABALIN	RIV
02390817	SANDOZ PREGABALIN	SDZ
02361159	TEVA-PREGABALIN	TEV
50MG CAP	SULE	
02480735	AG-PREGABALIN	ANG
02394243	APO-PREGABALIN	APX
02433877	AURO-PREGABALIN	AUR
02402564	DOM-PREGABALIN	DPC
02435985	JAMP-PREGABALIN	JMP
02268426	LYRICA	PFI
02417537	MAR-PREGABALIN	MAR
02423812	MINT-PREGABALIN	MIN
02467305	M-PREGABALIN	MAN
02479125	NRA-PREGABALIN	UNK
02359618	PMS-PREGABALIN	PMS
02396505	PREGABALIN	PDL
02403706	PREGABALIN	SIV
02405547	PREGABALIN	SAN
02476312	PREGABALIN	RIV
02392828	RAN-PREGABALIN	RBY
02377047	RIVA-PREGABALIN	RIV
02390825	SANDOZ PREGABALIN	SDZ
02361175	TEVA-PREGABALIN	TEV
75MG CAP	SULE	
02480743	AG-PREGABALIN	ANG
02394251	APO-PREGABALIN	APX
02433885	AURO-PREGABALIN	AUR
02402572	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.

75MG CAPS	SULE	
02268434	LYRICA	PFI
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
02392836	RAN-PREGABALIN	RBY
02377055	RIVA-PREGABALIN	RIV
02390833	SANDOZ PREGABALIN	SDZ
02361183	TEVA-PREGABALIN	TEV
150MG CAP	SULE	
02480751	AG-PREGABALIN	ANG
02394278	APO-PREGABALIN	APX
02433907	AURO-PREGABALIN	AUR
02402580	DOM-PREGABALIN	DPC
02436000	JAMP-PREGABALIN	JMP
02268450	LYRICA	PFI
	MAR-PREGABALIN	MAR
	MINT-PREGABALIN	MIN
	M-PREGABALIN	MAN
	NRA-PREGABALIN	UNK
	PMS-PREGABALIN	PMS
	PREGABALIN	PDL
	PREGABALIN	SIV
	PREGABALIN	SAN
	PREGABALIN	RIV
	RAN-PREGABALIN	RBY
	RIVA-PREGABALIN	RIV
	SANDOZ PREGABALIN	SDZ
02361205 ST 300MG CAF	TEVA-PREGABALIN	TEV
		ADV
	APO-PREGABALIN	APX
	JAMP-PREGABALIN	JMP
02268485		PFI
	PMS-PREGABALIN	PMS
	PREGABALIN PREGABALIN	PDL
		SIV
	PREGABALIN PREGABALIN	SAN RIV
	RAN-PREGABALIN	RBY
	RIVA-PREGABALIN	RIV
023//0/1	MINATI NEOADALIIN	ΓNIV

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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);

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

ST 300MG CAPSULE

02390868 SANDOZ PREGABALIN SDZ
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

ST 400MG TABLET

02369648 BANZEL EIS

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

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28:16.08 ANTIPSYCHOTIC AGENTS

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 80MG TABLET

02387778 LATUDA SPC

 $^{\it ST}$ 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
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

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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 30MG CAPSULE (EXTENDED RELEASE)

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)

TOWIG CAPSOLE (SUSTAINED RELEASE)	
02448319 ACT DEXTROAMPHETAMINE SR	ACG
01924559 DEXEDRINE SPANSULE	PAL
ST 15MG CAPSULE (SUSTAINED RELEASE)	
02448327 ACT DEXTROAMPHETAMINE SR	ACG
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 CAPSULE	
02347156 VYVANSE	SHI
ST 30MG CAPSULE	
02322951 VYVANSE	SHI
ST 40MG CAPSULE	
02347164 VYVANSE	SHI
ST 50MG CAPSULE	
02322978 VYVANSE	SHI
ST 60MG CAPSULE	
02347172 VYVANSE	SHI

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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

ST 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	ACG
02452731 APO-METHYLPHENIDATE ER	APX
02247732 CONCERTA	JSO
02413728 PMS-METHYLPHENIDATE ER	PMS
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	ACG
02452758 APO-METHYLPHENIDATE ER	APX
02250241 CONCERTA	JSO PMS
02413736 PMS-METHYLPHENIDATE ER 02315076 TEVA-METHYLPHENIDATE	TEV
ST 36MG TABLET (EXTENDED RELEASE)	ILV
02441950 ACT METHYLPHENIDATE ER	ACG
02452766 APO-METHYLPHENIDATE ER	APX
02247733 CONCERTA	JSO
02413744 PMS-METHYLPHENIDATE ER	PMS
02315084 TEVA-METHYLPHENIDATE	TEV
ST 54MG TABLET (EXTENDED RELEASE)	
02441969 ACT METHYLPHENIDATE ER	ACG
02330377 APO-METHYLPHENIDATE ER	APX
02247734 CONCERTA	JSO
02413752 PMS-METHYLPHENIDATE ER	PMS
02315092 TEVA-METHYLPHENIDATE	TEV

28:20.92 MISC ANOREXIGENIC AGENTS & RESPIRATORY & CEREBRAL STIMULANT CAFFEINE CITRATE

Limited use benefit (prior approval not required).

For children up to 1 year of age

POWDER

00972037 CAFFEINE CITRATE MDS

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28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES ALPRAZOLAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 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	
01908189 ALPRAZOLAM	PDL
02349191 ALPRAZOLAM	SAN
00865397 APO-ALPRAZ	APX
02400111 JAMP-ALPRAZOLAM	JMP
01913484 TEVA-ALPRAZOLAM	TEV
00548359 XANAX	PFI
ST 0.5MG TABLET	
01908170 ALPRAZOLAM	PDL
02349205 ALPRAZOLAM	SAN
00865400 APO-ALPRAZ	APX
02400138 JAMP-ALPRAZOLAM	JMP
01913492 TEVA-ALPRAZOLAM	TEV
00548367 XANAX	PFI
ST 1MG TABLET	
02248706 ALPRAZOLAM	PDL
02243611 APO-ALPRAZ	APX
02400146 JAMP-ALPRAZOLAM	JMP
00723770 XANAX	PFI
^{sτ} 2MG TABLET	
02243612 APO-ALPRAZ	APX
02400154 JAMP-ALPRAZOLAM	JMP
00813958 XANAX TS	PFI

BROMAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 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

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

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 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

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

VAE 02238162 DIASTAT 09853340 DIASTAT 2X10MG RECTAL PACK **ELN** 09853430 DIASTAT 2X15MG RECTAL PACK FI N

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	3 ATIVAN	PFI
02041456	S ATIVAN SUBLINGUAL	PFI
02351072	2 LORAZEPAM	SAN
0241074	5 LORAZEPAM SUBLINGUAL	AAP
00728187	7 PMS-LORAZEPAM	PMS
00655643	B PRO-LORAZEPAM	PDL
0071110 ⁻	1 TEVA-LORAZEPAM	TEV
ST 1MG TABL	ET	
00655759	APO-LORAZEPAM	APX
0204142	1 ATIVAN	PFI
02041464	4 ATIVAN SUBLINGUAL	PFI
02351080	LORAZEPAM	SAN
02410753	B LORAZEPAM SUBLINGUAL	AAP
0072819	5 PMS-LORAZEPAM	PMS
0065565	I PRO-LORAZEPAM	PDL
00637742	2 TEVA-LORAZEPAM	TEV
ST 2MG TABL	ET	
00655767	7 APO-LORAZEPAM	APX
02041448	3 ATIVAN	PFI
02041472	2 ATIVAN SUBLINGUAL	PFI
02351099	O LORAZEPAM	SAN
0241076	I LORAZEPAM SUBLINGUAL	AAP

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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 2MG TABLET

 00728209 PMS-LORAZEPAM
 PMS

 00655678 PRO-LORAZEPAM
 PDL

 00637750 TEVA-LORAZEPAM
 TEV

NITRAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 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

 $^{\it ST}$ 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	BMI
00568392 RIVA OXAZEPAM	RIV

ST 15MG TABLET

00402745 APO OXAZEPAM	APX
00497762 OXAZEPAM	PDL
00568406 RIVA OXAZEPAM	RIV

ST 30MG TABLET

00402737 APO OXAZEPAM	APX
00497770 OXAZEPAM	PDL
00414263 OXPAM	ВМІ
00568414 RIVA OXAZEPAM	RIV

TEMAZEPAM

Limited use benefit (prior approval is not required).

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 15MG CAPSULE

00604453 RESTORIL	AAP
02225964 TEMAZEPAM	APX
02229760 TEMAZEPAM	PDL
02230095 TEVA-TEMAZEPAM	TEV
ST 30MG CAPSULE	
00604461 RESTORIL	AAP
02225972 TEMAZEPAM	APX
02229761 TEMAZEPAM	PDL

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GSK

TEV

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES 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

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	
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

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 02314290 TEVA-NARATRIPTAN

 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
 JMP

 02429233 JAMP-RIZATRIPTAN IR
 JMP

 02379651 MAR-RIZATRIPTAN
 MAR

 10MG TABLET
 C381702 ACT RIZATRIPTAN

 02393476 APO-RIZATRIPTAN
 APX

 02441144 AURO-RIZATRIPTAN
 AUR

 02380463 JAMP-RIZATRIPTAN
 JMP

 02429241 JAMP-RIZATRIPTAN IR
 JMP

 02379678 MAR-RIZATRIPTAN
 MAR

 02240521 MAXALT
 FRS

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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 (ORALLY DISINTEGRATING)** 02393484 APO-RIZATRIPTAN RPD APX 02465086 JAMP-RIZATRIPTAN ODT JMP 02462788 MAR-RIZATRIPTAN ODT MAR **FRS** 02240518 MAXALT RPD 02379198 MYLAN-RIZATRIPTAN ODT MYL 02436604 NAT-RIZATRIPTAN ODT NPH 02393360 PMS-RIZATRIPTAN RDT **PMS** 02442906 RIZATRIPTAN ODT SAN 02446111 RIZATRIPTAN ODT SIV 02415798 RIZATRIPTAN RDT **PDL** 02351870 SANDOZ RIZATRIPTAN ODT SDZ 02396661 TEVA-RIZATRIPTAN ODT **TEV 10MG TABLET (ORALLY DISINTEGRATING)** 02393492 APO-RIZATRIPTAN RPD **APX** DPC 02396203 DOM-RIZATRIPTAN RDT 02465094 JAMP-RIZATRIPTAN ODT **JMP** 02462796 MAR-RIZATRIPTAN ODT MAR 02240519 MAXALT RPD **FRS** 02379201 MYLAN-RIZATRIPTAN ODT MYL 02436612 NAT-RIZATRIPTAN ODT NPH 02393379 PMS-RIZATRIPTAN RDT **PMS** 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 (prior approval is not required). A total of 12 tablets (or injections) are permitted in a 30-day period. 6MG/0.5ML INJECTION 99000598 IMITREX STAT DOSE KIT **GSK** 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 SDZ 02286521 SUMATRIPTAN SAN

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02243045 ZOMIG RAPIMELT

AZC

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. **50MG TABLET** 02324652 SUMATRIPTAN PDL 02385570 SUMATRIPTAN DF SIV 02286823 TEVA-SUMATRIPTAN DF TEV **100MG TABLET** 02257904 ACT SUMATRIPTAN ACG 02268396 APO-SUMATRIPTAN APX 02270765 DOM-SUMATRIPTAN DPC 02212161 IMITREX DF **GSK** 02268922 MYLAN-SUMATRIPTAN MYL 02256444 PMS-SUMATRIPTAN **PMS** 02263033 SANDOZ SUMATRIPTAN SDZ 02286548 SUMATRIPTAN SAN 02324660 SUMATRIPTAN PDL 02385589 SUMATRIPTAN DF SIV TEV 02239367 TEVA-SUMATRIPTAN 02286831 TEVA-SUMATRIPTAN DF **TEV ZOLMITRIPTAN** Limited use benefit (prior approval is not required). A total of 12 tablets are permitted in a 30-day period. 2.5MG TABLET 02380951 APO-ZOLMITRIPTAN **APX** 02389525 DOM-ZOLMITRIPTAN DPC 02421623 JAMP-ZOLMITRIPTAN **JMP** 02399458 MAR-ZOLMITRIPTAN MAR 02419521 MINT-ZOLMITRIPTAN MIN NPH 02421534 NAT-ZOLMITRIPTAN 02324229 PMS-ZOLMITRIPTAN **PMS** 02362988 SANDOZ ZOLMITRIPTAN SDZ 02313960 TEVA-ZOLMITRIPTAN TEV 02379929 ZOLMITRIPTAN PDL 02238660 ZOMIG AZC 2.5MG TABLET (ORALLY DISINTEGRATING) 02438453 AG-ZOLMITRIPTAN ODT ANG 02381575 APO-ZOLMITRIPTAN RAPID **APX** 02428237 JAMP-ZOLMITRIPTAN ODT **JMP** 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

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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 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.
- * 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 levodopa-induced dyskinesias

20MG & 5MG GEL

02292165 DUODOPA ABV

28:36.20 ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR AGONISTS

Limited use benefit (prior approval required).

APOMORPHINE HYDROCHLORIDE

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

4MG PATCH

02403927 NEUPRO

6MG PATCH

02403935 NEUPRO

UCB

8MG PATCH

02403943 NEUPRO

UCB

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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
02386410	SANDOZ ATOMOXETINE	SDZ
02262800	STRATTERA	LIL
02314541	TEVA-ATOMOXETINE	TEV
18MG CAP	SULE	
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 CAP	SULE	
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

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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; ORContraindication to stimulant medication; OR

- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

40N	ΙG	CAF	SUI	LE
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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
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
02279355 STRATTERA	LIL
02362538 TEVA-ATOMOXETINE	TEV

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28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

DIMETHYL FUMARATE

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.

120MG CAPSULE (DELAYED RELEASE)

UNK 02404508 TECFIDERA

240MG CAPSULE (DELAYED RELEASE)

02420201 TECFIDERA UNK

32:00 CONTRACEPTIVES (NON-ORAL)

32:00.00 CONTRACEPTIVES (NON-ORAL)

INTRAUTERINE DEVICE

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

Coverage is granted for 1 device every 12 months.

DEVICE

00970328 FLEXI-T +300 IUD	TSN
00970336 FLEXI-T +380 IUD	TSN
98099999 FLEXI-TD	TSN
99401085 LIBERTE UT380 SHORT IUD	MSF
99401086 LIBERTE UT380 STANDARD IUD	MSF
99400482 NOVA-T	BEX

36:00 DIAGNOSTIC AGENTS (DX)

36:26.00 DX - DIABETES MELLITUS

GLUCOSE OXIDASE. PEROXIDASE

Limited use benefit (prior approval not required).

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

- Clients managing diabetes with insulin will be allowed 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
- 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	
09857452 ACCU-CHEK MOBILE BG	ROD

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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.

ACCU-CHEK MOBILE STRIP	
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
09857422 BG STAR (ON)	SAC
CONTOUR NEXT STRIP	
97799459 CONTOUR NEXT	BAY
09857453 CONTOUR NEXT (ON)	BAY
EZ HEALTH STRIP	
09857357 EZ HEALTH ORACLE	TRE
97799564 EZ HEALTH ORACLE	TRE
FREESTYLE STRIP	
97799829 FREESTYLE	ABB
09857141 FREESTYLE (ON)	ABB
FREESTYLE LITE STRIP	
97799597 FREESTYLE LITE	ABB
09857297 FREESTYLE LITE (ON)	ABB
FREESTYLE PRECISION STRIP	
97799346 FREESTYLE PRECISION	ABB
09857502 FREESTYLE PRECISION (ON)	ABB
GE200 STRIP	
97799373 GE200	AUC
09857525 GE200 (ON)	AUC
ITEST STRIP	
09857348 ITEST	AUC
97799692 ITEST	AUC
MEDI+SURE STRIP	
97799403 MEDI+SURE	MEC
09857432 MEDI+SURE (ON)	MEC
NOVA MAX STRIP	
09857313 NOVA MAX	NCA

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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.

09854290 ONE TOUCH ULTRA JAJ 97799985 ONE TOUCH ULTRA JAJ ONE TOUCH VERIO STRIP JAJ 97799475 ONETOUCH VERIO (ON) JAJ 9857392 ONETOUCH VERIO (ON) JAJ PRECISION XTRA STRIP ABB 99854070 PRECISION XTRA AUC SIDEKICK STRIP AUC 97799801 SIDEKICK HOD SPIRIT STRIP ARA 97799291 FIRST CANHEALTH SPIRIT ARA 09857547 SPIRIT TEST STRIP (ON) ARA SURE STEP STRIP SKY 97799355 SURE STEP SKY SURETEST STRIP O9857522 SURETEST (ON) SKY TRUETEST STRIP HOD 09857283 TRUE TEACK AUC 97799902 TRUE TRACK AUC 97799902 TRUE TRACK HOD	ONE TOUCH ULTRA STRIP	
ONE TOUCH VERIO STRIP 97799475 ONETOUCH VERIO (ON) JAJ (D857392 ONETOUCH VERIO (ON)) JAJ (D85749840 PRECISION XTRA) ABB (D8584070 PRECISION XTRA) ABB (D8584070 PRECISION XTRA) AUC AUC SIDEKICK STRIP AUC SIDEKICK STRIP TOUR CONTROLLED TO THE VERY OF TOUR CONTROLLED TO THE VERY OF TOUR CONTROLLED TO THE VERY OF TOUR CONTROLLED TOUR CONT	09854290 ONE TOUCH ULTRA	JAJ
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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 UNK

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/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:

- 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

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

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

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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.

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ST 4MG GRANULES			
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		
02373947 PMS-MONTELUKAST	PMS		
02389517 RAN-MONTELUKAST	RBY		
02398826 RIVA-MONTELUKAST	RIV		
02328593 SANDOZ MONTELUKAST	SDZ		
02238217 SINGULAIR	FRS		
02355523 TEVA-MONTELUKAST	TEV		
4MG TABLET (CHEWABLE)			
02377608 APO-MONTELUKAST	APX		
02422867 AURO-MONTELUKAST	AUR		
02442353 JAMP-MONTELUKAST	JMP		
02399865 MAR-MONTELUKAST	MAR		
02408627 MINT-MONTELUKAST	MIN		
02379317 MONTELUKAST	SAN		
02379821 MONTELUKAST	PDL		
02382458 MONTELUKAST	SIV		
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		
02379325 MONTELUKAST	SAN		
02379848 MONTELUKAST	PDL		
02382466 MONTELUKAST	SIV		
02354985 PMS-MONTELUKAST	PMS		
02402807 RAN-MONTELUKAST	RBY		
02330393 SANDOZ MONTELUKAST	SDZ		

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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 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

02412764 ADEMPAS BAY **1MG TABLET** 02412772 ADEMPAS **BAY** 1.5MG TABLET 02412799 ADEMPAS BAY **2MG TABLET** 02412802 ADEMPAS **BAY**

2.5MG TABLET

02412810 ADEMPAS 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 TABLE	ΞΤ
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(02451158 UPTRAVI	JSO
40	DOMCG TABLET	
	02451166 UPTRAVI	JSO
60	DOMCG TABLET	
(02451174 UPTRAVI	JSO
80	DOMCG TABLET	
	02451182 UPTRAVI	JSO
10	DOOMCG TABLET	
(02451190 UPTRAVI	JSO
12	200MCG TABLET	
(02451204 UPTRAVI	JSO
14	400MCG TABLET	
	02451212 UPTRAVI	JSO
16	SOOMCG 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).

resolved to experienced in the accument of one (vinergial, permutatorgial, immunologial, or votice activities experienced in the accument of one).

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.
- For use in immunocompromised patients who are at risk of mucosal breakdown.

0.15% MOUTHWASH

02239044 APO-BENZYDAMINE APX

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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.
- For use in immunocompromised patients who are at risk of mucosal breakdown.

0.15% MOUTHWASH

02229777 PHARIXIA PED 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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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 NVR

NVR

VERTEPORFIN

Limited use benefit (prior approval required).

For treatment of age related macular degeneration for patients with this diagnosis who are being treated by a certified ophthalmologist

15MG/VIAL POWDER FOR SOLUTION

02242367 VISUDYNE VAE

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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;

ΩR

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).

$^{\rm s7}$ 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
00605786 TRAVEL	VTH
00021423 TRAVEL ON	NOP

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).

ST 80MG CAPSULE

02298791 EMEND FRS

ST 125MG CAPSULE

02298805 EMEND FRS

ST 125MG & 80MG CAPSULE

02298813 EMEND TRI-PACK FRS

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RBY

TEV

56:22.92 MISCELLANEOUS ANTIEMETICS

NABILONE

Limited use benefit (prior approval required).

For patients who are experiencing nausea and vomiting due to cancer chemotherapy or radiation;

ΟR

Patient is palliative (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less).

0.25MG CAPSULE

02312263 CESAMET	UNK
02358077 RAN-NABILONE	RBY
02392925 TEVA-NABILONE	TEV
0.5MG CAPSULE	
02393581 ACT NABILONE	ACG
02256193 CESAMET	UNK
02380900 PMS-NABILONE	PMS
02358085 RAN-NABILONE	RBY
02384884 TEVA-NABILONE	TEV
1MG CAPSULE	
02393603 ACT NABILONE	ACG
00548375 CESAMET	UNK
02380919 PMS-NABILONE	PMS

56:28.36 PROTON-PUMP INHIBITORS

LANSOPRAZOLE

Limited use benefit (prior approval not required).

02358093 RAN-NABILONE

02384892 TEVA-NABILONE

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

- · All PPIs are equally efficacious
- Double dose PPI is not necessary for initial therapy
- Double dose PPI is effective in H. Pylori eradication; however, treatment is not needed beyond 14 days.

PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

All proton pump inhibitors (open benefit and limited use (LU) PPIs) have a maximum quantity limit of 400 tablets/capsules per 180 day period. This quantity limit will be in effect for the entire class of PPIs.

- For example, if a patient fills 30 tablets of rabeprazole, then switch to 30 tablets of omeprazole, then switch to 30 capsules of lansoprazole, this will count as 90 PPI tablets/capsules towards the quantity limit.
- Patients taking two rabeprazole 10mg tablets a day can be switched to one rabeprazole 20mg tablet a day to avoid reaching the quantity limit
- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

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	
02402610 RAN-LANSOPRAZOLE	RBY	
02422808 RIVA-LANSOPRAZOLE	RIV	
02385643 SANDOZ LANSOPRAZOLE	SDZ	
02280515 TEVA-LANSOPRAZOLE	TEV	

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TAK

56:28.36 PROTON-PUMP INHIBITORS

LANSOPRAZOLE

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:

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- 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 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
02402629 RAN-LANSOPRAZOLE	RBY
02422816 RIVA-LANSOPRAZOLE	RIV
02280523 TEVA-LANSOPRAZOLE	TEV
ST 30MG TABLET (DELAYED RELEASE)	
02385651 SANDOZ LANSOPRAZOLE	SDZ

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

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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
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- 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 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
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- 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.

^{S7} 20MG CAPSULE (DELAYED RELEASE)

02245058 APO-OMEPRAZOLE	APX
00846503 LOSEC	AZC
02339927 OMEPRAZOLE	PDL
02348691 OMEPRAZOLE	SAN
02411857 OMEPRAZOLE-20	SIV
02320851 PMS-OMEPRAZOLE	PMS
02403617 RAN-OMEPRAZOLE	RBY
02296446 SANDOZ OMEPRAZOLE	SDZ
20MG TABLET (DELAYED RELEASE)	
02449927 BIO-OMEPRAZOLE	ВМІ
02420198 JAMP-OMEPRAZOLE DR	JMP
02190915 LOSEC	AZC
02439549 NAT-OMEPRAZOLE DR	NPH
02416549 OMEPRAZOLE	ACC
02374870 RAN-OMEPRAZOLE	RBY

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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.

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- · Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

20MG TABLET (DELAYED RELEASE)

02402416 RIVA-OMEPRAZOLE DR 02295415 TEVA-OMEPRAZOLE

RIV

TEV

SAN

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.

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- 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 ST 40MG TABLET (ENTERIC COATED) 02408570 MYLAN-PANTOPRAZOLE T MYI 02441853 PANTOPRAZOLE MAGNESIUM UNK 02267233 TECTA TAK 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 (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.

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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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
- 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 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** 02330083 RIVA-RABEPRAZOLE EC RIV 02314177 SANDOZ RABEPRAZOLE SD7 02296632 TEVA-RABEPRAZOLE **TFV** ST 20MG TABLET (ENTERIC COATED) ΔPX 02345587 APO-RABEPRAZOLE 02320460 DOM-RABEPRAZOLE EC DPC 02243797 PARIET JSO 02310813 PMS-RABEPRAZOLE **PMS** PDL 02315203 PRO-RABEPRAZOLE 02385457 RABEPRAZOLE SIV 02356538 RABEPRAZOLE EC SAN **RBY** 02298082 RAN-RABEPRAZOLE 02330091 RIVA-RABEPRAZOLE RIV SDZ 02314185 SANDOZ RABEPRAZOLE 02296640 TEVA-RABEPRAZOLE **TEV**

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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.

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

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

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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 in adult males above 18 years old.

- 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 males 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**

02245345 ANDROGEL	BGP
02245346 ANDROGEL	BGP
02463792 TARO-TESTOSTERONE	TAR
02463806 TARO-TESTOSTERONE	TAR
02280248 TESTIM	PAL

12.5MG GEL

02249499 ANDROGEL BGP

2.5MG PATCH

02239653 ANDRODERM ALL

5MG PATCH

02245972 ANDRODERM ALL

68:12.00 CONTRACEPTIVES

LEVONORGESTREL INTRAUTERINE INSERT

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

Coverage is granted for 1 device every 2 years.

52MG INSERT (EXTENDED-RELEASE)

02243005 MIRENA BAY

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 women of reproductive age; and for the intermittent treatment of moderate-to-severe signs and symptoms of uterine fibroids in adult women 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 women 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 women who experience failure on bisphosphonates.

For secondary prevention of osteoporosis in women who have a personal history or a first degree relative with a history of breast cancer.

60MG TABLET

02358840 ACT RALOXIFENE	ACG
02279215 APO-RALOXIFENE	APX
02239028 EVISTA	LIL
02358921 PMS-RALOXIFENE	PMS

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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

02370921 TRAJENTA BOE

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.

2.5MG & 1000MG TABLET

02403277 JENTADUETO BOE

ST 2.5MG & 500MG TABLET

02403250 JENTADUETO BOE

 $^{s\tau}$ 2.5MG & 850MG 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 sulfonylurea.

ST 2.5MG TABLET

02375842 ONGLYZA AZC

ST 5MG TABLET

02333554 ONGLYZA AZC

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.

2.5MG & 1000MG TABLET

02389185 KOMBOGLYZE AZC

 $^{\it st}$ 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

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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.

 $^{\it st}$ 50MG & 1000MG TABLET

02333872 JANUMET FRS

ST 50MG & 500MG TABLET

02333856 JANUMET FRS

 $^{s\tau}$ 50MG & 850MG TABLET

02333864 JANUMET FRS

 $^{\text{ST}}$ 50MG & 1000MG TABLET (EXTENDED RELEASE)

02416794 JANUMET XR FRS

 $^{\text{ST}}$ 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

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

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BOE

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

- 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

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.

 $^{\rm ST}$ 850MG & 5MG TABLET

02449935 XIGDUO AZC

 $^{s\tau}$ 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

1000MG & 5MG TABLET 02456591 SYNJARDY

00MG & 5MG TABLET

68:32.00 PROGESTINS

DIENOGEST

Limited use benefit (prior approval required).

For the management of pelvic pain associated with endometriosis.

ST 2MG TABLET

02374900 VISANNE BAY

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68:32.00 PROGESTINS

PROGESTERONE

Limited use benefit (prior approval required).

For the treatment of women:

- With postmenopausal symptoms who are intolerant to medroxyprogesterone acetate (MPA); OR
- Who are at risk of preterm birth: OR
- · Who are using the medication to prevent miscarriage.

In adults

· For use as Gender Affirming Hormone Therapy.

100MG CAPSULE

02476576 PMS-PROGESTERONE	PMS
02166704 PROMETRIUM	FRS
02463113 REDDY-PROGESTERONE	REC
02439913 TEVA-PROGESTERONE	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

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
- Intoleránce 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 to 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI).

- A 75% reduction in Psoriasis Area Severity Index (PASI) score; OR
- A \geq 50% reduction in the Psoriasis Area Severity Index (PASI) score with a \geq 5-point improvement in the Dermatology Life Quality Index (DLQI); OR
- · A significant reduction in Body Surface Area (BSA) involved, with consideration of important areas such as the face, hands, feet or genital regions.

210MG SOLUTION

02473623 SILIQ VAE

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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

IMIQUIMOD

Limited use benefit (prior approval required).

For the treatment of condylomata acuminate (genital warts) in patients who have failed:

- self-applied podophyllotoxin (podofilox 0.5% solution); OR
- provider-applied podophyllum resin (10%-25%).

5% CREAM

02239505 ALDARA PBSH02407825 APO-IMIQUIMODAPX02482983 TARO-IMIQUIMOD PUMPTAR

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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 psonasis, coverage is provided for psonasis 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
- 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 H

PIMECROLIMUS

Limited use benefit (prior approval required).

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

1% CRFAM

02247238 ELIDEL VAE

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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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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)

January 2020

PFI

PFI

PFI

BAY

BAY

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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	МЈО
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
OMG TABLET	
02246362 CENTRUM	PFI
80021452 CENTRUM	PFI
80024482 CENTRUM FOR WOMEN	PFI
2MG TABLET	
80045908 ONE A DAY WOMEN	BAY
10MG TABLET	

88:28.00 MULTIVITAMIN PREPARATIONS

MULTIVITAMINS (PRENATAL)

mozilivii/ minto (i rezivii/tz)	
Limited use benefit (prior approval is not required.).	
Prenatal and postnatal vitamins are benefits only for women of childbearing age (12 to 50 years).	
ST CAPSULE	
80042704 CENTRUM DHA	PFI
ST TABLET	
80045822 CENTRUM PRENATAL	PFI
80080882 MATERNA	NES
80082297 MATERNA	NES
80001842 NESTL MATERNA	NES
02241235 PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	VTH
80005770 PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	PMT
02229535 WAMPOLE COMPLETE MULT-PRE AND POST NATAL WITH FOLIC ACID	WAM
2MG TABLET	
80004919 NATURES BOUNTY PRENATAL VITAMINS	VTH

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS

EVTEMBODANICOUS 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).	
Coverage will be limited to 100 grams every 30 days.	

GEL

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 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.

45MG/0.5ML SOLUTION

02320673 STELARA JSO

90MG/ML SOLUTION

02320681 STELARA JSO

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

02473607 MAR-FEBUXOSTAT MAR
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 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
02487772 JAMP FINGOLIMOD
02469782 PMS-FINGOLIMOD
PMS

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92:20.00 IMMUNOMODULAROTY AGENTS

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	UNK
99100763 AVONEX PEN	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
66MCG SOLUTION	
02318253 REBIF	SRO
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

0.3MG POWDER FOR SOLUTION

02169649 BETASERON

02337819 EXTAVIA

NVR

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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 relapsea and/or new MRI activityb 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. 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.
- b. MRI activity is defined as any new multiple sclerosis lesion/s, expanding lesion/s, and/or enhancing lesion/s.

OR

- 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

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

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92:24.00 BONE RESORPTION INHIBITORS

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%)

- · 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

NVR 02269198 ACLASTA 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

UNK 02425696 FIRAZYR

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ABATACEPT

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 500mg IV for patients weighting <60kg; 750mg IV for patients weighting 60kg to 100kg; and 1000mg IV for patients weighting >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

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 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 40 mg every two weeks.

Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:

- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- · more than one joint with erosion on imaging study
- · dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- · daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:

- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;
- PLUS a minimum of any two of the following:
- methotrexate weekly (weekly oral or parenteral)at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- · leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine
- OR Axial disease with both of the following:
- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) ≥ 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:

- Methotrexate (MTX) (weekly oral or parenteral) weekly at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond one year will be based on improvement in the BASDAI score.

- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.
- 4. For the treatment of patients with moderate to severe PSORIASIS who meet all of the following criteria:

Coverage is provided for an initial period of 16 weeks at a dose of 80 mg as an initial dose, followed by 40 mg every 2 weeks, starting one week after the initial dose.

- · Prescribed by a dermatologist
- Body surface area (BSA) involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region; AND
- · Intolerance or lack of response to phototherapy; OR
- Inability to access phototherapy; AND
- Intolerance or lack of response to methotrexate (MTX) (weekly oral or parenteral)at 20 mg or greater (15 mg or greater if patient is > 65 years of age) for more than 8 weeks; AND

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- Intolerance or lack of response to cyclosporine; OR
- · A contraindication to methotrexate or cyclosporine.

Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI):

- A 75% reduction in Psoriasis Area Severity Index (PASI) score; OR
- A ≥ 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.
- 5. For the treatment of moderately to severely active CROHN'S DISEASE

Coverage is provided for an initial period of 12 weeks at an induction dose of 160 mg, followed by 80 mg two weeks later. Maintenance therapy is provided at a dose not exceeding 40 mg every two weeks.

Prescribed by a gastroenterology specialist

Patient meets the following criteria:

- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication;
 PLUS
- · Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
- · 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR
- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks...

Coverage beyond the initial twelve-week period will be based on improvement in the CDAI or HBI scores.

- At least a 100-point reduction in the Crohn's Disease Activity Index (CDAI) OR at least a 3-point reduction in the Harvey Bradshaw Index (HBI).
- 6. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 24 mg/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

Patient has experienced 3 of 6 of the following variables:

- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR; AND
- No more than one of these variables has worsened by greater than 30%
- 7. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:

Coverage is provided for an initial period of 12 weeks at a dose of 160 mg at week 0, followed by 80 mg two weeks later and then 40 mg every two weeks thereafter.

- · Prescribed by expert in gastroenterology
- Partial Mayo score > 4
- · Inadequate response to conventional therapies:
- 5-ASA 4grams/day for 6 weeks; PLUS
- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication.

Coverage beyond the initial 12 week period will be based on improvement in the partial Mayo score of ≥ 2 points.

8. For the treatment of adult patients with active moderate to severe HIDRADENITIS SUPPURATIVA

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 HIDRADENITIS SUPPURATIVA 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

Coverage beyond the initial 12-week period will be based on decreases in inflammatory nodule and abscess counts:

- \bullet 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

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 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 moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 400mg at weeks 0, 2, and 4, followed by 200mg every other week or 400mg every 4 weeks.

Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:

- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- · more than one joint with erosion on imaging study
- · dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- · daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:

- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;
- PLUS a minimum of any two of the following:
- methotrexate weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- · leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine
- OR Axial disease with both of the following:
- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) ≥ 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 400mg at weeks 0, 2, and 4, followed by 200mg every other week or 400mg every 4 weeks.

- Prescribed by a rheumatologist
- · BASDAI > 4; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks;

AND for peripheral joint involvement, patient is refractory:

- Methotrexate (MTX) weekly at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond the initial three doses will be based on improvement in the BASDAI score.

• Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.

200MG 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

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 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 moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 50 mg weekly.

Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:

- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- · more than one joint with erosion on imaging study
- · dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- · daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:

- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;
- PLUS a minimum of any two of the following:
- · methotrexate (oral or parenteral) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- · leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine
- OR Axial disease with both of the following:
- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) ≥ 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:

- Methotrexate (MTX) weekly (oral or parenteral) at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond one year will be based on improvement in the BASDAI score.

- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.
- 4. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Coverage is provided for children age 4 to 17, for an initial period of one year at a dose of 0.8 mg/kg/week body surface area up to a maximum single dose of 50 mg/week.

Prescribed by a rheumatologist

In patients four to seventeen years of age and older who meet the following criteria:

- ≥ 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.

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

PED 02242903 ENBREL

50MG/ML INJECTION

02274728 ENBREL PED

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
- · 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
- · 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 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:

- 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
- · 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
- · 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

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

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 and patients should be off corticosteroids.

50MG/0.5ML SOLUTION

 02324776 SIMPONI
 JSO

 02324784 SIMPONI
 JSO

100MG/ML SOLUTION

02413175 SIMPONI JSO 02413183 SIMPONI JSO

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INFLIXIMAB (INFLECTRA)

Limited use benefit (prior approval required).

Coverage for INFLECTRA will be approved indefinitely.

- 1. For the treatment of severely active RHEUMATOID ARTHRITIS
- · Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 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 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;

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 FISTULIZING CROHN"S DISEASE
- · Prescribed by a gastroenterology specialist

Patient meets all the following criteria:

• Patients with actively draining perianal or enterocutaneous fistulae that are refractory to a course of appropriate antibiotic therapy (e.g. ciprofloxacin with or without metronidazole for a minimum of 3 weeks);

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.
- 6-mercaptopurine 50-70 mg/day for a minimum of 3 months or treatment discontinued at <3 months due to severe adverse reactions.
- 7. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:
- · Prescribed by expert in gastroenterology
- Partial Mayo score > 4
- · Inadequate response to conventional therapies:
- 5-ASA 4grams/day for 6 weeks; PLUS
- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication.

100MG POWDER FOR SOLUTION

02419475 INFLECTRA HOS 02470373 RENFLEXIS UNK

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92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS INFLIXIMAB (REMICADE)

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial three doses of 3 mg/kg, administered at 0, 2 and 6 weeks.

Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 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 moderately to severely active CROHN'S DISEASE

Coverage is provided for an initial three doses of 5 mg/kg, administered at 0, 2 and 6 weeks.

· Prescribed by a gastroenterology specialist

Patient meets the following criteria:

- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication; PLUS
- · Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
- 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR
- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks.

Coverage beyond the initial three doses will be based on improvement in the CDAI or HBI scores.

- At least a 100-point reduction in the Crohn's Disease Activity Index (CDAI) OR at least a 3-point reduction in the Harvey Bradshaw Index (HBI).
- 3. For the treatment of FISTULIZING CROHN"S DISEASE

Coverage is provided for an initial three doses of 5 mg/kg, administered at 0, 2 and 6 weeks.

Prescribed by a gastroenterology specialist

Patient meets all the following criteria:

• Patients with actively draining perianal or enterocutaneous fistulae that are refractory to a course of appropriate antibiotic therapy (e.g. ciprofloxacin with or without metronidazole for a minimum of 3 weeks);
PLUS

Patient has failed a trial of one (1) immunosuppressive agent:

- Azathioprine 2 to 2.5 mg/kg/day for a minimum of 3 months or treatment discontinued at < 3 months due to severe adverse: reactions. OR
- 6-mercaptopurine 50-70 mg/day for a minimum of 3 months or treatment discontinued at <3 months due to severe adverse reactions.

Coverage beyond the initial three doses will be based on improvement or closure of actively draining fistulae

· Closure of individual fistulae as evidenced by no, or minimal, fistulae drainage and bleeding.

100MG/VIAL POWDER FOR SOLUTION

02244016 REMICADE JSO

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Limited use benefit (prior approval required).

SARILUMAB

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

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 \geq 20 mg weekly (\geq 15 mg weekly if patient is \geq 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide 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

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;

- 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
- ≥ 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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TOCILIZUMAB (SC)

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

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

• Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:

- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

 AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment; OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, 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 CELL 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

HLR

TOFACITINIB CITRATE

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage of tofacitinib in adult patients ≥ 18 years is provided at a MAXIMUM dose of 10mg daily for an initial period of one year. 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;

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.

5MG TABLET

02423898 XELJANZ PFI

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

CYCLOSPORINE

Limited use benefit (prior approval required).

For transplant therapy.

ST	1	0	M	G	CA	P	S	U	LE
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02237671 NEORAL ST 25MG CAPSULE	NVR
02150689 NEORAL 02247073 SANDOZ CYCLOSPORINE ST 50MG CAPSULE	NVR SDZ
02150662 NEORAL 02247074 SANDOZ CYCLOSPORINE ST 100MG CAPSULE	NVR SDZ
02150670 NEORAL 02242821 SANDOZ CYCLOSPORINE ST 100MG/ML SOLUTION	NVR SDZ
02244324 APO-CYCLOSPORINE 02150697 NEORAL	APX NVR

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

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92:44.00 IMMUNOSUPPRESSIVE AGENTS

MYCOPHENOLATE MOFETIL

Limited use benefit (prior approval required). For transplant therapy. ST 250MG CAPSULE 02383780 ACH-MYCOPHENOLATE ACC APX 02352559 APO-MYCOPHENOLATE 02192748 CELLCEPT HLR JMP 02386399 JAMP-MYCOPHENOLATE 02457369 MYCOPHENOLATE MOFETIL SAN 02371154 MYLAN-MYCOPHENOLATE MYL 02320630 SANDOZ MYCOPHENOLATE SDZ 02364883 TEVA-MYCOPHENOLATE TEV ST 200MG POWDER FOR SUSPENSION 02242145 CELLCEPT **HLR** 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** 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 ST 1MG TABLET 02247111 RAPAMUNE PFI TACROLIMUS MONOHYDRATE Limited use benefit (prior approval required). For transplant therapy. $^{\text{ST}}$ 0.5MG CAPSULE 02243144 PROGRAF AST 02416816 SANDOZ TACROLIMUS SDZ ST 1MG CAPSULE 02175991 PROGRAF **AST** 02416824 SANDOZ TACROLIMUS SDZ

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92:44.00 IMMUNOSUPPRESSIVE AGENTS

TACROLIMUS MONOHYDRATE

Limited use benefit (prior approval required).

For transplant therapy.

ST 5MG CAPSULE

02175983 PROGRAF AST

ST 0.5MG CAPSULE (EXTENDED RELEASE)

02296462 ADVAGRAF AST

ST 1MG CAPSULE (EXTENDED RELEASE)

02296470 ADVAGRAF AST

ST 3MG CAPSULE (EXTENDED RELEASE)

02331667 ADVAGRAF AST

5T 5MG CAPSULE (EXTENDED RELEASE)

02296489 ADVAGRAF AST

ST 5MG CAPSULE (IMMEDIATE RELEASE)

02416832 SANDOZ TACROLIMUS SDZ

5MG/ML SOLUTION

02176009 PROGRAF AST

VEDOLIZUMAB

Limited use benefit (prior approval required).

1. For the treatment of moderately to severely active CROHN'S DISEASE

Coverage is provided for an initial period of 14 weeks at a dose of 300 mg weeks zero, two and six and then every eight weeks. Maintenance therapy is provided at a dose not exceeding 300 mg every eight weeks.

· Prescribed by a gastroenterology specialist

Patient meets the following criteria:

• Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication;

- 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

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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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.

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

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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

96899960 OPTICHAMBER DIAMOND SMALL MASK	AUC
99400504 OPTICHAMBER LARGE MASK	AUC
99400503 OPTICHAMBER MEDIUM MASK	AUC
99400502 OPTICHAMBER SMALL MASK	AUC
99400505 OPTIHALER	AUC
99400787 POCKET CHAMBER	MCA
99400791 POCKET CHAMBER WITH ADULT MASK	MCA
99400788 POCKET CHAMBER WITH INFANT MASK	MCA
99400790 POCKET CHAMBER WITH MEDIUM MASK	MCA
99400789 POCKET CHAMBER WITH SMALL MASK	MCA
96899974 RESPICHAMBER SILICONE MEDIUM MASK	TRU
96899973 RESPICHAMBER SILICONE SMALL MASK	TRU
96899972 RESPICHAMBER VHC W MOUTHPIECE	TRU

94:01.00 DEVICES (DIABETIC)

INSULIN PUMP SUPPLIES

Limited use benefit (prior approval required).

Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
 Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

DEVICE

97799674 CARTRIDGE FOR IR200	UNK
97799342 INSET 30 INFUSION SETS	UNK
99401038 INSULIN PUMP BATTERY	AUC
09991458 IV3000	SMW
COMFORT ANGLED DEVICE	
97799682 COMFORT ANGLED INFSET 17MM	UNK
97799683 COMFORT ANGLED INFSET 17MM	UNK
COMFORT SHORT ANGLED DEVICE	
97799678 COMFORT SRT ANGLED INFSET 13	UNK
97799679 COMFORT SRT ANGLED INFSET 13	UNK
CONTACT DETACH DEVICE	
97799672 CONTACT DETACH 90 DEGREE 6MMX60CM	UNK
97799610 CONTACT DETACH 90 DEGREE 8MMX60CM	UNK
INSET II DEVICE	
97799685 INSET II 90 DEGREE 6MMX110CM	UNK
97799687 INSET II 90 DEGREE 6MMX60CM	UNK
97799684 INSET II 90 DEGREE 9MMX110CM	UNK
97799686 INSET II 90 DEGREE 9MMX60CM	UNK
MIO DEVICE	
97799491 MIO BLUE 6MMX18	MDT
97799438 MIO BLUE 6MMX23	MDT
97799490 MIO CLEAR 6MMX32	MDT
97799489 MIO CLEAR 9MMX32	MDT
97799492 MIO PINK 6MMX18	MDT
97799437 MIO PINK 6MMX23	MDT
OMNIPOD DEVICE	
09991327 PODS	UNK

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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 supp	lies 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
	QUICK-SET 9MMX43 TUBING	MDT
RAPID-D DE	EVICE	
97799650	RAPID-D 10MM/110CM	ROD
	RAPID-D 10MM/60CM	ROD
97799651	RAPID-D 10MM/80CM	ROD
97799656	RAPID-D 6MM/110CM	ROD
	RAPID-D 6MM/60CM	ROD
	RAPID-D 6MM/80CM	ROD
	RAPID-D 8MM/110CM	ROD
	RAPID-D 8MM/60CM	ROD
	RAPID-D 8MM/80CM	ROD
SURE-T DE		
	PARADIGM SURE-T 29G 6MMX18	MDT
	PARADIGM SURE-T 29G 6MMX23	MDT
	PARADIGM SURE-T 29G 8MMX23	MDT
TENDER DE	EVICE	
97799644	TENDER-1 17MM/110CM	ROD
	TENDER-1 17MM/60CM	ROD
	TENDER-1 17MM/80CM	ROD
	TENDER-2 17MM/110CM	ROD
	TENDER-2 17MM/60CM	ROD
	TENDER-2 17MM/80CM	ROD
TENDER "N	IINI" DEVICE	
	TENDER-1 MINI INF SET 13MM/110CM	ROD
	TENDER-1 MINI INFSET 13MM/60CM	ROD
	TENDER-1 MINI INFSET 13MM/80CM	ROD
	TENDER-2 MINI INF SET 13MM/110CM	ROD
	TENDER-2 MINI INFSET 13MM/60CM	ROD
	TENDER-2 MINI INFSET 13MM/80CM	ROD
ULTRAFLE		_
97799665	ULTRAFLEX 1 10MM/110CM	ROD

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MDT

MDT

94:01.00 DEVICES (DIABETIC)

INSULIN PUMP SUPPLIES

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

ULTRAFLEX DEVICE

ROD
ROD
ROD
ROD
ROD
UNK
SMW
UNK
UNK

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.

97799707 RESERVOIR PARADIGM 5X1.8ML

97799706 RESERVOIR PARADIGM 7X3.0ML

- 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		
97799946	ACCU-CHEK MULTICLIX LANCET	ROD		
97799945	ACCU-CHEK SOFTCLIX LANCET	ROD		
97799466	BG STAR LANCET	SAC		
97799541	EZ HEALTH ORACLE LANCET	TRE		
97799825	FINGERSTIX LANCET	BAY		
97799292	FIRST CANADIAN HEALTH LANCETS	ARA		
97799826	FREESTYLE LANCET	BAY		
97799918	MICROLET LANCET	BAY		
97799810	MPD THIN LANCET (NS)	MPD		
97799811	MPD THIN LANCET (NS)	MPD		
97799807	MPD ULTRA THIN LANCET (100)	MPD		
97799808	MPD ULTRA THIN LANCET (200)	MPD		
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		

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JAJ

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.

28G LANCET

97799232 DROPLET PERSONAL LANCET 28G	SFA
97799253 FIRST CANHEALTH 28G LANCET	ARA
97799766 ITEST SAFETY 28G LANCET	AUC
97799801 MONOLET THIN (MONOJECT) 28G	TYC
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

96:00 PHARMACEUTICAL AIDS

97799501 ONETOUCH DELICA 33G LANCET

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
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

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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

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.

ST CREAM

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	

Р

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

UNK 91500016 METHADONE LOCK BOX

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UNK

96:00.00 PHARMACEUTICAL AIDS

95900023 NEOCATE 400G PDR

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

OIVAL LIQU	שו	
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
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
95900036	SIMILAC ADVANCE NEOSURE 363G	ABB
95900047	SIMILAC ALIMENTUM 400G PDR	ABB
95900184	SIMILAC LOWER IRON 850G PDR	ABB
95900044	SIMILAC PM 60/40 450G PDR	UNK

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Non-Insured	Health	Benefits
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Appendix A - Lillined 03c D	ononto ai	ia oritoria		Hon-insured ficaltif B	Ononto
AA-TRIMEBUTINE	26	AEROCHAMBER PLUS FLOWVU	119	APO-LORAZEPAM	59
ABATACEPT	101	MOUTH		APO-METHYLPHENIDATE	57
ABENOL	46	AEROCHAMBER PLUS FLOWVU SMALL	119	APO-METHYLPHENIDATE ER	57
ABIRATERONE ACETATE	9	AEROTRACH PLUS	119	APO-METHYLPHENIDATE SR	57
ABOBOTULINUMTOXINA	118	AFATINIB DIMALEATE	9	APO-MONTELUKAST	73
ACAMPROSATE CALCIUM	65	AFINITOR	13	APOMORPHINE HYDROCHLORIDE	64
ACCEL-SEVELAMER	71	AFINITOR DISPERZ	13	APO-MOXIFLOXACIN	3
ACCU-CHEK ADVANTAGE	67	AFLIBERCEPT	76	APO-MYCOPHENOLATE	117
ACCU-CHEK AVIVA	67	AG-GABAPENTIN	48	APO-MYCOPHENOLIC ACID	117
ACCU-CHEK COMPACT	67	AG-MOXIFLOXACIN	3	APO-OMEPRAZOLE	81
ACCU-CHEK FASTCLIK LANCET	122	AG-PANTOPRAZOLE	83	APO-OXYCODONE/ACET	38
ACCU-CHEK GUIDE (ON)	67	AG-PREGABALIN	52	APO-PANTOPRAZOLE	83
ACCU-CHEK GUIDE (SK)	67	AG-ZOLMITRIPTAN ODT	63	APO-PREGABALIN	52
ACCU-CHEK MOBILE BG	67	AKYNZEO	78	APO-RABEPRAZOLE	84
ACCU-CHEK MOBILE CASSETT	68	ALDARA P	91	APO-RALOXIFENE	86
ACCU-CHEK MULTICLIX LANCET	122	ALECENSARO	9	APO-RIVASTIGMINE	25
ACCU-CHEK SOFTCLIX LANCET	122	ALECTINIB	9	APO-RIZATRIPTAN	61
ACCUTREND	68	ALEMTUZUMAB	116	APO-RIZATRIPTAN RPD	62
ACET 325	46	ALIROCUMAB	34	APO-SILDENAFIL R	35
ACET 650	46			APO-SUMATRIPTAN	62
ACETAMINOPHEN	45	ALMOTRIPTAN	61	APO-TADALAFIL PAH	35
ACETAMINOPHEN	45	ALMOTRIPTAN MALATE	61	APO-TENOFOVIR	5
ACETAMINOPHEN, CAFFEINE	38	ALPRAZOLAM	58	APO-VARENICLINE	30
CITRATE, CODEINE PHOSPHATE		ALPRAZOLAM	58	APO-VORICONAZOLE	5
ACETAMINOPHEN, CODEINE	38	AMBRISENTAN	36	APO-ZOLMITRIPTAN	63
PHOSPHATE		AMERGE	61	APO-ZOLMITRIPTAN RAPID	63
ACETAMINOPHEN, OXYCODONE HYDROCHLORIDE	38	AMIKACIN SULFATE	1	APREPITANT	78
ACÉTAMINOPHÈNE	46	AMIKACIN SULFATE	1	APTIOM	48
ACÉTAMINOPHÈNE BLASON	46	AMPHETAMINE, DEXTROAMPHETAMINE	55	AQUA-E	95
SHIELD	40	ANDRODERM	86	AQUA-E/ML	95
ACETYLSALICYLIC ACID	37	ANDROGEL	86	AQUASOL E	95
ACETYLSALICYLIC ACID	37	ANTI-NAUSEANT	78	AQUASOL E VITAMIN E	95
ACETYLSALICYLIC ACID,	38	APALUTAMIDE	10	ARICEPT	23
OXYCODONE HYDROCHLORIDE		APIXABAN	31	ASA EC	37
ACH-MYCOPHENOLATE	117	APO ACETAMINOPHEN	46	ASAPHEN	37
ACLASTA	100	APO DIMENHYDRINATE	78	ASATAB	37
ACT AMPHETAMINE XR	55	APO OXAZEPAM	60	ASCENCIA CONTOUR	68
ACT BUPRENORPHINE/NALOXONE	45	APO-ACETAMINOPHEN	46	ASCENSIA BREEZE 2	68
ACT DEXTROAMPHETAMINE SR	56	APO-ADEFOVIR	6	ASENAPINE MALEATE	54
ACT LEVOFLOXACIN	2	APO-ALMOTRIPTAN	61	ATASOL 15	38
ACT METHYLPHENIDATE ER	57	APO-ALPRAZ	58	ATIVAN	59
ACT NABILONE	79	APO-AMBRISENTAN	74	ATIVAN SUBLINGUAL	59
ACT RALOXIFENE	86	APO-AMPHETAMINE XR	55	ATOMOXETINE	65
ACT RIZATRIPTAN	61	APO-ATOMOXETINE	65	ATOMOXETINE HYDROCHLORIDE	65
ACT SUMATRIPTAN	63	APO-BENZYDAMINE	75	AUBAGIO	99
ACTEMRA	114	APO-BOSENTAN	36	AURO-ATOMOXETINE	65
ADALIMUMAB	102	APO-BROMAZEPAM	58	AURO-CYCLOBENZAPRINE	28
ADCIRCA	35	APO-CABERGOLINE	64	AURO-DONEPEZIL	23
ADDERALL XR	55	APO-CLONAZEPAM	47	AURO-ENTECAVIR	6
ADEFOVIR DIPIVOXIL	6	APO-CYCLOBENZAPRINE	28	AURO-GABAPENTIN	48
ADEMPAS	74	APO-CYCLOSPORINE	116	AURO-GALANTAMINE ER	24
ADULT	123	APO-DABIGATRAN	31	AURO-LACOSAMIDE	50
ADVAGRAF	118	APO-DICLOFENAC	37	AURO-MONTELUKAST	73
ADVAIR 100 DISKUS	28	APO-DONEPEZIL	23	AURO-MOXIFLOXACIN	3
ADVAIR 125	28	APO-ENTECAVIR	6	AURO-PANTOPRAZOLE	83
ADVAIR 250	28	APO-ERLOTINIB	12	AURO-PREGABALIN	52
ADVAIR 250 DISKUS	28	APO-GABAPENTIN	48	AURO-RIZATRIPTAN	61
ADVAIR 500 DISKUS	28	APO-GEFITINIB	13	AURO-TENOFOVIR	5
AEROCHAMBER AC BOYZ	119	APO-HYDROMORPHONE	40	AVONEX	98
AEROCHAMBER AC GIRLZ	119	APO-IMATINIB	15	AVONEX PEN	98
AEROCHAMBER PLUS FLOWVU	119	APO-IMIQUIMOD	91	AXERT	61
LARGE		APO-LANSOPRAZOLE	79	AXITINIB	10
AEROCHAMBER PLUS FLOWVU	119	APO-LEVOFLOXACIN	2	AZTREONAM	1
MEDIUM		APO-LINEZOLID	4	BANZEL	54
		, O LINEZOLID	7		

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Appendix A - Limited Use B	enerits ar	na Criteria		Non-insured Health Be	enerits
BARACLUDE	6	CHILDREN AND YOUTH	124	DICLOFENAC SODIUM (TOPICAL)	37
BASES-EMULSIONS	124	CHU NICOTINE ANTI SMOKING AID	29	DICLOFENAC TOPICAL	37
BD ULTRAFINE 33G LANCET	123	CIMZIA	104	DIENOGEST	89
BENRALIZUMAB	70	CLONAPAM	47	DIFICID	2
BENZYDAMINE HYDROCHLORIDE	75	CLONAZEPAM	47	DILAUDID	41
BETASERON	98	COBIMETINIB	11	DIMENHYDRINATE	78
BETASERON INITIATION KIT	98	CODEINE	39	DIMETHYL FUMARATE	67
BG STAR	68	CODEINE CONTIN CR	38	DOLORAL 1	42
BG STAR (ON)	68	CODEINE MONOHYDRATE,	38	DOLORAL 5	42
BG STAR LANCET	122	CODEINE SULFATE TRIHYDRATE		DOM-ATOMOXETINE	65
BIO-DONEPEZIL	23	CODEINE PHOSPHATE	39	DOM-CYCLOBENZAPRINE	28
BIO-GABAPENTIN	48	CODEINE PHOSPHATE	39	DOM-GABAPENTIN	48
BIO-MONTELUKAST	73	COLISTIMETHATE FOR U.S.P	3	DOM-LANSOPRAZOLE	80
BIO-MOXIFLOXACIN	3	COLISTIN	3	DOM-MONTELUKAST	73
BIO-OMEPRAZOLE	81	COLY-MYCIN M PARENTERAL	3	DOM-PREGABALIN	52
BIO-PANTOPRAZOLE	83	COMFORT ANGLED INFSET 17MM	120	DOM-RABEPRAZOLE EC	84
BISMUTH	78	COMFORT SRT ANGLED INFSET 13	120	DOM-RIZATRIPTAN RDT	62
BISMUTH SUBSALICYLATE	78	COMPACT SPACE PLUS LARGE	119	DOM-SUMATRIPTAN	62
BISMUTH SUBSALICYLATE	78	MASK	440	DOM-ZOLMITRIPTAN	63
BOOST DIABETIC 237ML LIQ	123	COMPACT SPACE PLUS MEDIUM MASK	119	DONEPEZIL	23
BOOST ORIGINAL 237ML LIQ	123	COMPACT SPACE PLUS NO MASK	119	DONEPEZIL HYDROCHLORIDE	23
BOSENTAN MONOHYDRATE	36	COMPACT SPACE PLUS SMALL	119	DOSTINEX	64
BOSULIF	10	MASK	110	DROPLET PERSONAL LANCET 28G	123
BOSUTINIB	10	COMPLEAT PEDIATRIC 250ML LIQ	124	DROPLET PERSONAL LANCET 33G	123
BOTOX	119	CONCERTA	57	DUODOPA	64
BREEZE 2 BG (ON)	68	CONTACT DETACH 90 DEGREE	120	DUPILUMAB	91
BRENZYS	106	6MMX60CM		DUPIXENT	91
BREO ELLIPTA	26	CONTACT DETACH 90 DEGREE	120	DYSPORT THERAPEUTIC	118
BRILINTA	32	8MMX60CM		EDOXABAN (EDOXABAN	32
BRIVARACETAM	48	CONTOUR BG (ON)	68	TOSYLATE MONOHYDRATE)	
BRIVLERA	48	CONTOUR NEXT	68	ELBASVIR, GRAZOPREVIR	7
BRODALUMAB	90	CONTOUR NEXT (ON)	68	ELIDEL	92
BROMAZEPAM	58	COPAXONE	98	ELIQUIS	31
BUPRENORPHINE (BUTRANS)	44	COSENTYX	93	EMEND	78
BUPRENORPHINE	45	COSENTYX (STYLO)	93	EMEND TRI-PACK	78
HYDROCHLORIDE		COSENTYX PEN (ON)	93	EMOLLIENT FOR CHILDREN	124
BUPRENORPHINE	45	COTELLIC	11	EMPAGLIFLOZIN	89
HYDROCHLORIDE, NALOXONE HYDROCHLORIDE		CRIZOTINIB	11	ENABLEX	94
BUPROPION HYDROCHLORIDE	54	CYCLOBENZAPRINE	28	ENBREL CUREOUS	106
(ZYBAN)		CYCLOBENZAPRINE HYDROCHLORIDE	28	ENBREL SURECLICK	106
BUTRANS 10	44	CYCLOSPORINE	116	ENFAMIL A+ 237ML LIQ	125
BUTRANS 15	44	DABIGATRAN ETEXILATE	31	ENFAMIL A+ 385ML LIQ	125
BUTRANS 20	44	MESILATE	٠.	ENFAMIL A+ 663G PDR	125
BUTRANS 5	44	DABRAFENIB	11	ENFAMIL A+ ENFACARE 363G PDR ENFAMIL A+ ENFACARE 385ML LIQ	125
CABERGOLINE	64	DACLATASVIR	7	ENFAMIL LOW IRON FORMULA	125 125
CAFFEINE CITRATE	57	DAKLINZA	7	900GM	123
CAFFEINE CITRATE	57	DAPAGLIFLOZIN PROPANEDIOL	88	ENFAMIL LOWER IRON 385ML LIQ	125
CAMPRAL	65	MONOHYDRATE		ENFAMIL POLYVISOL	95
CANAGLIFLOZIN	88	DARIFENACIN HYDROBROMIDE	94	ENFAMIL TRIVISOL	95
CAPRELSA	22	DENOSUMAB (PROLIA)	99	ENSURE 235ML LIQ	123
CARNITOR	71	DENOSUMAB (XGEVA)	99	ENSURE FIBRE 235ML LIQ	123
CARTRIDGE FOR IR200	120	DEVICE (METHADONE)	124	ENTECAVIR MONOHYDRATE	6
CAYSTON	1	DEXEDRINE	56	ENTRESTO	37
CELLCEPT	117	DEXEDRINE SPANSULE	56	ENTYVIO	118
CENTRUM	95	DEXTROAMPHETAMINE	56	ENZALUTAMIDE	12
CENTRUM DHA	96	DEXTROAMPHETAMINE SULFATE	56	EPCLUSA	8
CENTRUM FOR WOMEN	95	DIASTAT	59	EPLERENONE	36
CENTRUM JUNIOR COMPLETE	95	DIASTAT 2X10MG RECTAL PACK	59	ERELZI	107
CENTRUM PRENATAL	96	DIASTAT 2X15MG RECTAL PACK	59	ERLEADA	10
CERITINIB	10	DIAZEPAM	58	ERLOTINIB HYDROCHLORIDE	12
CERTOLIZUMAB PEGOL	104	DIAZEPAM	58	ESBRIET	72
CESAMET	79	DIAZEPAM (DIASTAT)	59	ESLICARBAZEPINE ACETATE	48
CHAMPIX	30	DICETEL	85	ETANERCEPT	105
CHAMPIX STARTER PACK	30	DICLOFENAC SODIUM	37	ETANERCEPT (BRENZYS)	106
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Non-Insured	Health	Benefits
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Appendix A - Limited USE BE	FIIEIILS ai	iu Ciliteria		Non-insured nealth b	enents
ETANERCEPT (ERELZI)	107	FREESTYLE LITE	68	INSPIRA CHAMBER W	119
EURO-ASA	37	FREESTYLE LITE (ON)	68	MOUTHPIECE	110
EVEROLIMUS	13	FREESTYLE PRECISION	68	INSPIRA CHAMBER W SMALL MASK	119
EVISTA	86	FREESTYLE PRECISION (ON)	68	INSPRA	36
EVOLOCUMAB	35	FYCOMPA	51	INSULIN PUMP BATTERY	120
EXELON EXTAVIA	25 98	GABAPENTIN GABAPENTIN	48 48	INSULIN PUMP SUPPLIES	120
EXTEMPORANEOUS MIXTURE	96 96	GALANTAMINE	24	INTERFERON BETA-1A	98
(GENDER AFFIRMING)	30	GALANTAMINE ER	24	INTERFERON BETA-1B	98
EXTEMPORANEOUS MIXTURE (LU)	96	GALANTAMINE HYDROBROMIDE	24	INTRAUTERINE DEVICE	67
EXTEMPORANEOUS MIXTURE	96	GD-GABAPENTIN	48	INVOKANA	88
(NSAID)		GE200	68	IRESSA	14
EYLEA	76	GE200 (ON)	68	IRON (SUCROFERRIC OXYHYDROXIDE)	70
EZ HEALTH ORACLE	68	GEFITINIB	13	ISOSOURCE 1.0 HP 250ML LIQ	123
EZ HEALTH ORACLE LANCET	122	GENDER AFFIRMING HORMONES	96	ISOSOURCE 1.2 CAL 1500ML LIQ	123
E-Z SPACER	119	GENDER AFFIRMING TOPICAL	96	ISOSOURCE 1.2 CAL 250ML LIQ	123
E-Z SPACER (MASK ONLY) E-Z SPACER WITH SMALL MASK	119 119	HORMONES	0.7	ISOSOURCE 1.5 CAL 250ML LIQ	123
FASENRA	70	GILENYA	97	ISOSOURCE FIBRE 1.2 CAL 250ML	123
FEBUXOSTAT	97	GIOTRIF GLATECT	9 98	LIQ	
FENTANYL	39	GLATIRAMER ACETATE	96 98	ISOSOURCE FIBRE 1.5 CAL	123
FERAMAX POWDER WATER	31	GLECAPREVIR, PIBRENTASVIR	3 0 7	1500ML LIQ	400
SOLUBLE POLYSACCHARIDE IRON	-	GLEEVEC GLEEVEC	, 15	ISOSOURCE FIBRE 1.5 CAL 250ML LIQ	123
COMPLEX		GLN-GABAPENTIN	50	ISOSOURCE HN WITH FIBRE	123
FESOTERODINE FUMARATE	94	GLUCERNA 237ML LIQ	123	250ML LIQ	
FIBRISTAL	86	GLUCOSE OXIDASE, PEROXIDASE	67	ITEST	68
FIDAXOMICIN	2	GOLIMUMAB	108	ITEST SAFETY 28G LANCET	123
FINGERSTIX LANCET	122	GRAVOL	78	ITEST ULTRA-THIN 33G LANCET	123
FINGOLIMOD (FINGOLIMOD HYDROCHLORIDE)	97	HABITROL	29	IV3000	120
FIRAZYR	100	HARVONI	8	IV3000 STANDARD	122
FIRST CANADIAN HEALTH	122	HEMANGIOL	36	IVABRADINE (IVABRADINE HYDROCHLORIDE)	33
LANCETS		HEPSERA	6	IXEKIZUMAB	92
FIRST CANHEALTH 28G LANCET	123	HUMIRA	103	JAKAVI	21
FIRST CANHEALTH 30G LANCET	123	HYDROMORPH CONTIN	40	JAMP ACETAMINOPHEN BLAZON	46
FIRST CANHEALTH 33G LANCET	123	HYDROMORPHONE HYDROCHLORIDE	40	JAMP DICLOFENAC TOPICAL	37
FIRST CANHEALTH SPIRIT	69	IBAVYR	7	JAMP ENTECAVIR	6
FLEXI-T +300 IUD	67	IBRANCE	18	JAMP FINGOLIMOD	97
FLEXI-T +380 IUD FLEXI-TD	67 67	IBRUTINIB	14	JAMP VITAMIN A, D AND C	95
FLINTSTONES MULTIPLE	95	ICATIBANT	100	JAMP-ALPRAZOLAM	58
VITAMINS PLUS IRON	90	ICLUSIG	19	JAMP-ASA	37
FLINTSTONES MULTIPLE	95	IDELALISIB	14	JAMP-CYCLOBENZAPRINE	28
VITAMINS WITH EXTRA C		IMATINIB MESYLATE	15	JAMP-DIMENHYDRINATE	78
FLUTICASONE FUROATE,	85	IMBRUVICA	14	JAMP-DONEPEZIL	23
UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE		IMIQUIMOD	91	JAMP-FOSFOMYCIN	8
FLUTICASONE FUROATE.	26	IMITREX	62	JAMP-GABAPENTIN	48 73
VILANTEROL TRIFENATATE	-	IMITREX DF	62	JAMP-MONTELUKAST JAMP-MOXIFLOXACIN	3
FLUTICASONE FUROATE,	26	IMITREX STAT DOSE KIT	62	JAMP-MYCOPHENOLATE	117
VILANTEROL TRIFENATATE (ASTHMA)		INCOBOTULINUMTOXINA	119	JAMPOCAINE	90
FORADIL	27	INDACATEROL MALEATE INFANT FORMULATION	27 425	JAMP-OMEPRAZOLE DR	81
FORMOTEROL FUMARATE	27	INFLECTRA	125 111	JAMP-PANTOPRAZOLE	83
FORMOTEROL FUMARATE	27	INFLIXIMAB (INFLECTRA)	110	JAMP-PREGABALIN	52
DIHYDRATE		INFLIXIMAB (REMICADE)	112	JAMP-RIZATRIPTAN	61
FORMOTEROL FUMARATE	27	INLYTA	10	JAMP-RIZATRIPTAN IR	61
DIHYDRATE, BUDESONIDE		INSET 30 INFUSION SETS	120	JAMP-RIZATRIPTAN ODT	62
FORMOTEROL FUMARATE DIHYDRATE, MOMETASONE	27	INSET 6MMX43"	122	JAMP-TENOFOVIR	5
FUROATE		INSET II 90 DEGREE 6MMX110CM	120	JAMP-TOBRAMYCIN	1
FORXIGA	88	INSET II 90 DEGREE 6MMX60CM	120	JAMP-VANCOMYCIN	4
FOSFOMYCIN TROMETHAMINE	8	INSET II 90 DEGREE 9MMX110CM	120	JAMP-ZOLMITRIPTAN	63 63
FOSRENOL	70	INSET II 90 DEGREE 9MMX60CM	120	JAMP-ZOLMITRIPTAN ODT	63 88
FREESTYLE	68	INSPIRA CHAMBER W LARGE	119	JANUMET JANUMET XR	88
FREESTYLE (ON)	68	MASK INSPIRA CHAMBER W MEDIUM	119	JANUVIA	87
FREESTYLE LANCET	122	MASK	119	JARDIANCE	89

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Non-Insured	Health	Benefits
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Appendix A - Ellilited 03c B	chents an	id Officia		Non-insured fleatin B	CHCHIC
JENTADUETO	87	MAVIRET	7	MOTION SICKNESS	78
JEVITY 1.5 CAL 235ML LIQ	123	MAXALT	61	MOVAPO	64
JEVITY 235ML LIQ	123	MAXALT RPD	62	MOXIFLOXACIN	3
KADIAN	43	M-DONEPEZIL	23	MOXIFLOXACIN HYDROCHLORIDE	3
KEVZARA	113	MEDI+SURE	68	MOZOBIL	33
KISQALI	20	MEDI+SURE (ON)	68	M-PANTOPRAZOLE	83
KOMBOGLYZE	87	MEDI+SURE SOFT 30G TWIST	123	MPD THIN LANCET (NS)	122
LACOSAMIDE	50	MEDI+SURE SOFT 33G TWIST	123	MPD ULTRA THIN LANCET (100)	122
LANCET	122	MED-MOXIFLOXACIN	3	MPD ULTRA THIN LANCET (200)	122
LANCORA	33	MED-RIVASTIGMINE	25	M-PREGABALIN	52
LANSOPRAZOLE	79	MEKINIST	22	MS CONTIN SR	42
LANSOPRAZOLE	79	MEPOLIZUMAB	116	MS IR	43
LANSOPRAZOLE ODT	80	MEROPENEM	1	MULTIVITAMINS (CHILDREN AND	95
LANTHANUM CARBONATE	70	MEROPENEM	1	YOUTH)	
HYDRATE		M-ESLON	42	MULTIVITAMINS (PRENATAL)	96
LATUDA	54	METADOL	41	MYCOPHENOLATE	117
LEMTRADA	116	METFORMIN HYDROCHLORIDE,	89	MYCOPHENOLATE MOFETIL	117
LENALIDOMIDE	15	DAPAGLIFLOZIN		MYCOPHENOLATE MOFETIL	117
LENVATINIB	17	METFORMIN HYDROCHLORIDE,	89	MYCOPHENOLATE SODIUM	117
LENVIMA	17	EMPAGLIFLOZIN		MYFORTIC	117
LEVOCARNITINE	71	METHADONE HYDROCHLORIDE	41	MYLAN-ALMOTRIPTAN	61
LEVODOPA, CARBIDOPA	64	(METADOL)		MYLAN-GALANTAMINE ER	24
(CARBIDOPA MONOHYDRATE)	0-1	METHADONE LOCK BOX	124	MYLAN-LANSOPRAZOLE	79
LEVOFLOXACIN	3	METHYLPHENIDATE	57	MYLAN-MYCOPHENOLATE	117
LEVOFLOXACIN HEMIHYDRATE	2	HYDROCHLORIDE		MYLAN-PANTOPRAZOLE T	82
LEVOFLOXACIN HEMIHYDRATE	3	MICROLET LANCET	122	MYLAN-RIZATRIPTAN ODT	62
(QUINSAIR)		MIDOSTAURIN	17	MYLAN-SUMATRIPTAN	62
LEVONORGESTREL	86	MINT-DONEPEZIL	23	MYLAN-TENOFOVIR DISOPROXIL	5
INTRAUTERINE INSERT		MINT-EPLERENONE	36	MYLAN-VANCOMYCIN	4
LIBERTE UT380 SHORT IUD	67	MINT-MONTELUKAST	73	MYRBETRIQ	94
LIBERTE UT380 STANDARD IUD	67	MINT-PANTOPRAZOLE	83	NABILONE	79
LIDOCAINE	90	MINT-PREGABALIN	52		79 61
LIDODAN	90	MINT-ZOLMITRIPTAN	63	NARATRIPTAN HYDROCHLORIDE	
LINAGLIPTIN	87	MIO BLUE 6MMX18	120	NAT-DONEPEZIL	23
LINAGLIPTIN, METFORMIN	87	MIO BLUE 6MMX23	120	NAT-ERLOTINIB	12 15
HYDROCHLORIDE		MIO CLEAR 6MMX32	120	NAT-IMATINIB	
LINCTUS CODEINE	39	MIO CLEAR 9MMX32	120	NAT-OMEPRAZOLE DR	81
LINEZOLID	4	MIO PINK 6MMX18	120	NAT-RIZATRIPTAN ODT	62
LISDEXAMFETAMINE DIMESYLATE	56	MIO PINK 6MMX23	120	NAT-TENOFOVIR	5
LIXIANA	32	MIRABEGRON	94	NATURES BOUNTY PRENATAL VITAMINS	96
LORAZEPAM	59	MIRENA	86	NAT-ZOLMITRIPTAN	63
LORAZEPAM	59	MISC LIMITED USE COMPOUND	96	NEOCATE JR FIBER&IRON 400G	124
LORAZEPAM SUBLINGUAL	59	INTERNAL		PDR	124
LOSEC	81	MISC LIMITED USE EXTERNAL	96	NEOCATE JUNIOR 400G PDR	125
LOWPRIN	37	COMPOUND MIXTURE		NEOCATE ONE 400G	125
LUCENTIS	77	MISCELLANEOUS COMPOUNDED	96	NEOCATE W/ DHA & ARA 400G	125
LUCENTIS PFS	77	EXTERNAL POWDER	00	PDR	120
LURASIDONE HYDROCHLORIDE	54	MISCELLANEOUS COMPOUNDED EYE/EAR DROP	96	NEORAL	116
LYNPARZA	18	MISCELLANEOUS COMPOUNDED	96	NESTL MATERNA	96
LYRICA	52	INJECTION/INFUSION	30	NETUPITANT, PALONOSETRON	78
MAR-DONEPEZIL	23	MISCELLANEOUS COMPOUNDED	96	(PALONOSETRON	
MAR-FEBUXOSTAT	97	SUPPOSITORY		HYDROCHLORIDE)	
MAR-GABAPENTIN	48	M-MOXIFLOXACIN	3	NEULASTA	33
MAR-GALANTAMINE ER	24	MMT-174 ADHESIVE	122	NEUPRO	64
MAR-LACOSAMIDE	50	MOGADON	60	NEURONTIN	48
MAR-MONTELUKAST	73	MONOLET 21G LANCET	122	NICHIT	29
MAR-MOXIFLOXACIN	3	MONOLET THIN (MONOJECT) 28G	123	NICODERM	30
MAR-PANTOPRAZOLE	83	MONTELUKAST	73	NICORETTE GUM	29
MAR-PREGABALIN	52	MONTELUKAST SODIUM	72	NICORETTE INHALER	29
MAR-RIZATRIPTAN	61	MONTELUKAST SODIUM	73	NICORETTE LOZENGE	29
MAR-RIZATRIPTAN ODT	62	MONUROL	8	NICORETTE QUICKMIST	30
MAR-TROSPIUM	94	MORPHINE HYDROCHLORIDE	42	NICOTINE (GUM)	29
MAR-I ROSPIUM MAR-ZOLMITRIPTAN	94 63	MORPHINE SR	42	NICOTINE (INHALER)	29
	37	MORPHINE SULFATE	42	NICOTINE (LOZENGE)	29
M-ASA MATERNA	37 96	MORPHINE SULFATE (KADIAN)	43	NICOTINE (PATCH)	29
MATERNA	90		75	, ,	

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Non-Insured Health Benefits

Appendix A - Limited Use B	enents ar	iu Criteria		Non-insured nealth b	enents
NICOTINE (SPRAY)	30	OZEMPIC	88	PIRFENIDONE	72
NICOTINE GUM	29	PALBOCICLIB	18	PLEGRIDY	6
NICOTINE TRANSDERMAL	30	PANTOLOC	83	PLERIXAFOR	33
NICOTINE TRANSDERMAL SYSTEM	30	PANTOPRAZOLE	83	PMS HYDROMORPHONE	41
NILOTINIB	17	PANTOPRAZOLE MAGNESIUM	82	PMS-ACETAMINOPHEN	38
NINTEDANIB ESILATE	72	PANTOPRAZOLE MAGNESIUM	82	PMS-AMPHETAMINES XR	55
NITRAZEPAM	60	PANTOPRAZOLE SODIUM	83	PMS-ATOMOXETINE	65
NOVA MAX	68	PANTOPRAZOLE T	82	PMS-BENZYDAMINE	76
NOVA-T	67	PANTOPRAZOLE-40	83	PMS-BOSENTAN	36
NOVO-GESIC	46	PARADIGM SILHOUETTE 13MMX 43	121	PMS-BUPRENORPHINE-NALOXONE	45
NOVO-GESIC FORTE	46	PARADIGM SILHOUETTE 13MMX18"	121	PMS-CLONAZEPAM	47
NRA-PREGABALIN	52	PARADIGM SILHOUETTE 13MMX23	121	PMS-CLONAZEPAM-R	47
NSAID IN TRANSDERMAL BASE	96	PARADIGM SILHOUETTE 13MMX32"	121	PMS-CYCLOBENZAPRINE	28
NUCALA	116	PARADIGM SILHOUETTE 17MMX23	121	PMS-DIAZEPAM	58
NUTRAMIGEN A+ 945ML LIQ	125	PARADIGM SILHOUETTE 17MMX32"	121	PMS-DICLOFENAC	37
NUTRAMIGEN A+ LGG 561G PDR	125	PARADIGM SILHOUETTE 17MMX43	121	PMS-DIMENHYDRINATE	78
NUTREN JR. 250ML LIQ	124	PARADIGM SILHOUETTE	121	PMS-DONEPEZIL	23
OBETICHOLIC ACID	85	CANNULA 13MM		PMS-ENTECAVIR	6
OCALIVA	85	PARADIGM SILHOUETTE	121	PMS-ERLOTINIB	12
OCRELIZUMAB	99	CANNULA 17MM		PMS-FENTANYL MTX	39
	99	PARADIGM SURE-T 29G 6MMX18	121	PMS-FINGOLIMOD	97
OCREVUS		PARADIGM SURE-T 29G 6MMX23	121	PMS-GABAPENTIN	48
OFEV	72	PARADIGM SURE-T 29G 8MMX23	121		24
OLAPARIB	18	PARIET	84	PMS-GALANTAMINE ER	
OMALIZUMAB	75	PAT-GALANTAMINE ER	24	PMS-HYDROMORPHONE	41
OMEPRAZOLE	81	PAZOPANIB	19	PMS-IMATINIB	15
OMEPRAZOLE MAGNESIUM	81	PDP-ACETAMINOPHEN	45	PMS-LANSOPRAZOLE	79
OMEPRAZOLE-20	81	PEDIAPHEN	45	PMS-LEVOFLOXACIN	2
ONABOTULINUMTOXINA	119	PEDIASURE 235ML LIQ	124	PMS-LORAZEPAM	59
ONBREZ BREEZHALER	27	PEDIASURE COM. GROW&GAIN	124	PMS-METHYLPHENIDATE	57
ONE A DAY WOMEN	95	235ML LIQ		PMS-METHYLPHENIDATE ER	57
ONE TOUCH DELICA 30G LANCET	123	PEDIASURE FIBRE 235ML LIQ	124	PMS-MONTELUKAST	73
ONE TOUCH ULTRA	69	PEDIASURE GROW&GAIN 400G	124	PMS-NABILONE	79
ONETOUCH DELICA 33G LANCET	123	PDR		PMS-OMEPRAZOLE	81
ONETOUCH DELICAPLUS 30G	122	PEDIASURE PLUS WITH FIBRE 235	124	PMS-OXYCODONE	44
LANCET		PEDIATRIX	45	PMS-PANTOPRAZOLE	83
ONETOUCH DELICAPLUS 33G LANCET	122	PEDIAVIT	95	PMS-PREGABALIN	52
	122	PEGASYS	6	PMS-PROGESTERONE	90
ONETOUCH ULTRASOFT LANCET ONETOUCH VERIO	69	PEGETRON KIT	6	PMS-RABEPRAZOLE	84
	69	PEGFILGRASTIM	33	PMS-RALOXIFENE	86
ONETOUCH VERIO (ON)	87	PEGINTERFERON ALFA-2A	6	PMS-RIVASTIGMINE	25
ONGLYZA OPIOID COMPOUNDED		PEGINTERFERON ALFA-2B,	6	PMS-RIZATRIPTAN RDT	62
	96	RIBAVIRIN		PMS-SILDENAFIL R	35
OPTICHAMBER	119	PEGINTERFERON BETA-1A	6	PMS-SUMATRIPTAN	62
OPTICHAMBER DIAMOND (CHAMBER)	119	PEPTAMEN 1.5 1000ML LIQ	123	PMS-TENOFOVIR	5
OPTICHAMBER DIAMOND LARGE	119	PEPTAMEN 1.5 250ML LIQ	123	PMS-VANCOMYCIN 1 G	4
MASK	113	PEPTAMEN 250ML LIQ	123	PMS-ZOLMITRIPTAN	63
OPTICHAMBER DIAMOND MEDIUM	119	PEPTAMEN JUNIOR 1.0 CAL 250ML	124	PMS-ZOLMITRIPTAN ODT	63
MASK		LIQ		POCKET CHAMBER	120
OPTICHAMBER DIAMOND SMALL	120	PEPTAMEN JUNIOR 1.5 CAL 250ML	124	POCKET CHAMBER WITH ADULT	120
MASK		LIQ		MASK	
OPTICHAMBER LARGE MASK	120	PEPTAMEN WITH PREBIO 1000ML LIQ	124	POCKET CHAMBER WITH INFANT	120
OPTICHAMBER MEDIUM MASK	120	PEPTAMEN WITH PREBIO 250ML	124	MASK	400
OPTICHAMBER SMALL MASK	120	LIQ	124	POCKET CHAMBER WITH MEDIUM MASK	120
OPTIHALER	120	PEPTO BISMOL	78	POCKET CHAMBER WITH SMALL	120
ORENCIA	101	PEPTO-BISMOL	78	MASK	120
OSIMERTINIB	18	PERAMPANEL	51	PODS	120
OXAZEPAM	60	PHARIXIA	76	POLYSACCHARIDE IRON	31
OXAZEPAM	60	PHARMA-LACOSAMIDE	50	COMPLEX	01
OXCARBAZEPINE (SUSPENSION)	51	PIMECROLIMUS	92	POMALIDOMIDE	19
OXEZE TURBUHALER	27	PINAVERIUM BROMIDE	92 85	POMALYST	19
OXPAM	60	PIPERACILLIN AND TAZOBACTAM	85 2	PONATINIB HYDROCHLORIDE	19
OXYCODONE HYDROCHLORIDE	44		2	PRADAXA	31
OXYCODONE/ACET	38	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	2	PRALUENT	34
OXY-IR	44	PIPERACILLIN, TAZOBACTAM	2	PRECISION XTRA	69
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Non-Insured Health Benefits

Appendix A - Limited Use i	Denenics an	u Criteria		Non-insured nearth be	enents
PREGABALIN	52	RESERVOIR PARADIGM 7X3.0ML	122	SANDOZ LANSOPRAZOLE	79
PREGABALIN	52	RESOURCE 2.0 237ML LIQ	124	SANDOZ LEVOFLOXACIN	2
PRENATAL AND POSTPARTUM	96	RESOURCE DIABETIC 1.5L	124	SANDOZ LINEZOLID	4
VITAMINS AND MINERALS		RESOURCE DIABETIC 250ML LIQ	124	SANDOZ METHYLPHENIDATE SR	57
PREVACID FASTAR	79	RESOURCE JUST KIDS 1.5 CAL 237ML LIQ	124	SANDOZ MONTELUKAST	72
PREVACID FASTAB	80	RESPICHAMBER SILICONE	120	SANDOZ MORPHINE SR	43
PRIVA-PANTOPRAZOLE PRO-AAS	83 37	MEDIUM MASK	120	SANDOZ MOXIFLOXACIN	3
PROBUPHINE	3 <i>1</i> 45	RESPICHAMBER SILICONE SMALL	120	SANDOZ MYCOPHENOLATE SANDOZ NARATRIPTAN	117
PRO-CLONAZEPAM	47	MASK		SANDOZ MARATRIFTAN SANDOZ OMEPRAZOLE	61
PRO-GABAPENTIN	48	RESPICHAMBER VHC W	120	SANDOZ	81
PROGESTERONE	90	MOUTHPIECE		OXYCODONE/ACETAMINOPHEN	38
PROGRAF	117	RESTORIL	60	SANDOZ PANTOPRAZOLE	83
PROLIA	99	REVATIO	35	SANDOZ PREGABALIN	52
PRO-LORAZEPAM	59	REVLIMID	15 -	SANDOZ RABEPRAZOLE	84
PROMETRIUM	90	RIBAVIRIN	7	SANDOZ RIVASTIGMINE	25
PROPRANOLOL (HEMANGIOL)	36	RIBOCICLIB (RIBOCICLIB SUCCINATE)	20	SANDOZ RIZATRIPTAN ODT	62
PRO-RABEPRAZOLE	84	RIFAXIMIN	4	SANDOZ SUMATRIPTAN	62
PROTOPIC	94	RIOCIGUAT	74	SANDOZ TACROLIMUS	117
PURAMINO A+ 400G PDR	125	RITUXAN	20	SANDOZ VORICONAZOLE	5
PURAMINO A+ JUNIOR 400G PDR	125	RITUXIMAB	20	SANDOZ ZOLMITRIPTAN	63
QUICK-SET 6MMX18	121	RIVA OXAZEPAM	60	SANDOZ ZOLMITRIPTAN ODT	63
QUICK-SET 6MMX23 TUBING	121	RIVA-ATOMOXETINE	65	SAPHRIS	54
QUICK-SET 6MMX32	121	RIVA-CLONAZEPAM	47	SARILUMAB	113
QUICK-SET 6MMX43 TUBING	121	RIVACOCET	38	SAXAGLIPTIN HYDROCHLORIDE	87
QUICK-SET 9MMX23 TUBING	121	RIVA-CYCLOBENZAPRINE	28	SAXAGLIPTIN HYDROCHLORIDE,	87
QUICK-SET 9MMX32	121	RIVA-DONEPEZIL	23	METFORMIN HYDROCHLORIDE	
QUICK-SET 9MMX43 TUBING	121	RIVA-GABAPENTIN	49	SECUKINUMAB	93
QUINSAIR	3	RIVA-LANSOPRAZOLE	79	SELEXIPAG	75
RABEPRAZOLE	84	RIVA-MONTELUKAST	73	SEMAGLUTIDE	88
RABEPRAZOLE EC	84	RIVA-MOXIFLOXACIN	3	SEPTA DONEPEZIL SEPTA-ZOLMITRIPTAN-ODT	23
RABEPRAZOLE SODIUM	84	RIVA-OMEPRAZOLE DR	82	SEREVENT DISKUS	63 28
RALOXIFENE HYDROCHLORIDE	86	RIVA-PANTOPRAZOLE	83	SEVELAMER CARBONATE	20 71
RAN-DONEPEZIL	23	RIVA-PREGABALIN	52	SEVELAMER HYDROCHLORIDE	71 71
RAN-GABAPENTIN	48	RIVA-RABEPRAZOLE	84	SIDEKICK	69
RANIBIZUMAB	77	RIVA-RABEPRAZOLE EC	84	SILDENAFIL CITRATE	35
RAN-LANSOPRAZOLE RAN-MONTELUKAST	79	RIVAROXABAN	32	SILIQ	90
RAN-NABILONE	73 79	RIVAROXABAN (10)	32	SIMILAC ADVANCE NEOSURE 363G	125
RAN-OMEPRAZOLE	81	RIVASA	37	SIMILAC ALIMENTUM 237ML LIQ	125
RAN-PANTOPRAZOLE	83	RIVASA EC	37	SIMILAC ALIMENTUM 400G PDR	125
RAN-PREGABALIN	52	RIVASTIGMINE	25	SIMILAC ALIMENTUM 945ML LIQ	125
RAN-RABEPRAZOLE	84	RIVASTIGMINE HYDROGEN TARTRATE	25	SIMILAC LOWER IRON 850G PDR	125
RAPAMUNE	117	RIVOTRIL	47	SIMILAC PM 60/40 450G PDR	125
RAPID-D 10MM/110CM	121	RIZATRIPTAN BENZOATE	61	SIMPONI	109
RAPID-D 10MM/60CM	121	RIZATRIPTAN ODT	62	SINGULAIR	73
RAPID-D 10MM/80CM	121	RIZATRIPTAN RDT	62	SIROLIMUS	117
RAPID-D 6MM/110CM	121	ROTIGOTINE	64	SITAGLIPTIN PHOSPHATE	87
RAPID-D 6MM/60CM	121	RUFINAMIDE	54	MONOHYDRATE	00
RAPID-D 6MM/80CM	121	RUGBY NICOTINE POLACRILEX	29	SITAGLIPTIN PHOSPHATE MONOHYDRATE, METFORMIN	88
RAPID-D 8MM/110CM	121	GUM		HYDROCHLORIDE	
RAPID-D 8MM/60CM	121	RUXOLITINIB	21	SOFOSBUVIR	8
RAPID-D 8MM/80CM	121	RYDAPT	17	SOFOSBUVIR, LEDIPASVIR	8
RATIO-LENOLTEC NO 2	38	SALMETEROL XINAFOATE	28	SOFOSBUVIR, VELPATASVIR	8
RATIO-LENOLTEC NO 3	38	SALMETEROL XINAFOATE,	28	SOFOSBUVIR, VELPATASVIR,	8
REBIF	98	FLUTICASONE PROPIONATE	0.1	VOXILAPREVIR	
REDDY-PROGESTERONE	90	SANDOZ AMPHETAMINE YP	61 55	SOVALDI	8
REGORAFENIB	20	SANDOZ ATOMOYETINE	55 65	SPACER DEVICE	119
REMICADE	112	SANDOZ ATOMOXETINE SANDOZ BOSENTAN	65 36	SPIRIT TEST STRIP (ON)	69
RENAGEL	71	SANDOZ BOSENTAN SANDOZ CYCLOSPORINE	36 116	STATEX	42
RENFLEXIS	111	SANDOZ DONEPEZIL	23		
RENVELA	71	SANDOZ DONEPEZIL SANDOZ FENTANYL	39		
REPATHA	35	SANDOZ FENTANTE SANDOZ GEFITINIB	14		
RESERVOIR PARADIGM 5X1.8ML	122	SANDOZ LACOSAMIDE	50		
		5 15 02 E 10 00/ WIIDE	50		

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Non-Insured	Health	Benefits
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Appendix A - Limited Use Be	illellis all	iu Criteria		Non-insured nearth b	enents
STELARA	97	TEVA-DONEPEZIL	23	TRIAZOLAM	61
STIVARGA	20	TEVA-EMTEC-30	38	TRILEPTAL	51
STRATTERA	65	TEVA-ERLOTINIB	12	TRIMEBUTINE	26
STRESSTABS FOR WOMEN	95	TEVA-FENTANYL	39	TRIMEBUTINE MALEATE	26
SUBOXONE	45	TEVA-GABAPENTIN	49	TROSEC	94
SUMATRIPTAN	62	TEVA-HYDROMORPHONE	41	TROSPIUM CHLORIDE	94
SUMATRIPTAN DF	63	TEVA-IMATINIB	15	TRUE TRACK	69
SUMATRIPTAN SUCCINATE	62	TEVA-LACOSAMIDE	50	TRUETEST	69
SUNITINIB MALATE	21	TEVA-LANSOPRAZOLE	79	TYLENOL	45
SUPEUDOL	44	TEVA-LORAZEPAM	59	TYLENOL EXTRA STRENGTH	46
SURE STEP	69	TEVA-METHYLPHENIDATE	57	TYLENOL JR STRENGTH FASTMELTS	47
SURETEST (ON)	69	TEVA-MONTELUKAST	73		47
SUTENT	21	TEVA-MORPHINE SR	43	TYLENOL JUNIOR STRENGTH TYLENOL WITH CODEINE NO.2	38
SYMBICORT 100 TURBUHALER	27	TEVA-MOXIFLOXACIN	3	TYLENOL WITH CODEINE NO.3	38
SYMBICORT 200 TURBUHALER	27	TEVA NARIL ONE	117	ULIPRISTAL ACETATE	86
SYNJARDY	89 133	TEVA NABATRIDTAN	79 61	ULORIC	97
T : SLIM X2 CARTRIDGE (SK)	122 94	TEVA-NARATRIPTAN	82	ULTILET CLASSIC LANCET	122
TACROLIMUS (PROTOPIC)	94 117	TEVA-OMEPRAZOLE TEVA-OXYCOCET	62 38	ULTRAFLEX 1 10MM/110CM	121
TACROLIMUS MONOHYDRATE TADALAFIL	35	TEVA-OXYCODAN	38	ULTRAFLEX 1 10MM/60CM	122
TAFINLAR	35 11	TEVA-PANTOPRAZOLE	83	ULTRAFLEX 1 10MM/80CM	122
TAGRISSO	18	TEVA-PANTOPRAZOLE	82	ULTRAFLEX 1 8MM/110CM	122
TALTZ	92	MAGNESIUM	02	ULTRAFLEX 1 8MM/60CM	122
TARCEVA	12	TEVA-PREGABALIN	52	ULTRAFLEX 1 8MM/80CM	122
TARO-DICLOFENAC	37	TEVA-PROGESTERONE	90	UPTRAVI	75
TARO-IMIQUIMOD PUMP	91	TEVA-RABEPRAZOLE	84	USTEKINUMAB	97
TARO-SUMATRIPTAN	62	TEVA-RIZATRIPTAN ODT	62	VALIUM	59
TARO-TESTOSTERONE	86	TEVA-SILDENAFIL R	35	VALSARTAN, SACUBITRIL	37
TARO-ZOLEDRONIC ACID	100	TEVA-SUMATRIPTAN	63	VANCOMYCIN	4
TASIGNA	17	TEVA-SUMATRIPTAN DF	62	VANCOMYCIN HYDROCHLORIDE	4
TECFIDERA	67	TEVA-TEMAZEPAM	60	VANCOMYCIN HYDROCHLORIDE	4
TECTA	82	TEVA-TENOFOVIR	5	(INJECTION)	
TEMAZEPAM	60	TEVA-TOBRAMYCIN	1	VANDETANIB	22
TEMAZEPAM	60	TEVA-VARENICLINE	30	VARENICLINE TARTRATE	30
TEMPRA CHILDREN'S	45	TEVA-VORICONAZOLE	5	VELDUODO	118
TEMPRA CHILDREN'S DOUBLE	46	TEVA-ZOLMITRIPTAN	63	VELPHORO	70
STRENGTH		TEVA-ZOLMITRIPTAN OD	63	VENCLEYE	22 23
TEMPRA INFANT	45	THRIVE GUM (NS)	29 29	VENCLEXTA VENETOCLAX	23 23
TENDER-1 17MM/110CM	121 121	THRIVE NICOTINE LOZENGES THRIVE NICOTINELL GUM	29 29	VERTEPORFIN	77
TENDER-1 17MM/60CM TENDER-1 17MM/80CM	121	TICAGRELOR	32	VFEND	5
TENDER-1 MINI INF SET	121	TIZANIDINE	28	VIMPAT	50
13MM/110CM	121	TIZANIDINE HYDROCHLORIDE	28	VIREAD	5
TENDER-1 MINI INFSET 13MM/60CM	121	TOBI PODHALER	1	VISANNE	89
TENDER-1 MINI INFSET 13MM/80CM	121	TOBRAMYCIN	1	VISUDYNE	77
TENDER-2 17MM/110CM	121	TOBRAMYCIN	1	VITAL 1.5 CAL 1000ML LIQ	124
TENDER-2 17MM/60CM	121	TOBRAMYCIN INHALATION	1	VITAL PEPTIDE 1 CAL 220ML LIQ	124
TENDER-2 17MM/80CM	121	TOBRAMYCINE	1	VITAL PEPTIDE 1.5 CAL 220ML LIQ	124
TENDER-2 MINI INF SET	121	TOCILIZUMAB (IV)	114	VITAMIN E	95
13MM/110CM		TOCILIZUMAB (SC)	115	VITAMIN E	95
TENDER-2 MINI INFSET 13MM/60CM	121	TOFACITINIB CITRATE	115	VOLIBRIS	36
TENDER-2 MINI INFSET 13MM/80CM	121	TOVIAZ	94	VORICONAZOLE	5
TENOFOVIR DISOPROXIL FUMARATE	5	TRACLEER	36	VOSEVI	8
TERIFLUNOMIDE	99	TRAJENTA	87	VOTRIENT	19
TESTIM	86	TRAMETINIB	22	VYVANSE	56
TESTOSTERONE (TOPICAL)	86	TRANSDERMAL LIDOCAINE	96	WAMPOLE COMPLETE MULT-PRE	96
TEVA-ALMOTRIPTAN	61	W/NSAID		AND POST NATAL WITH FOLIC ACID	
TEVA-ALPRAZOLAM	58	TRANSDERMAL NICOTINE	30	XALKORI	11
TEVA-ATOMOXETINE	65	TRANSDERMAL NICOTINE PATCHDAY	30	XANAX	58
TEVA-BOSENTAN	36	TRAVEL	78	XANAX TS	58
TEVA-BROMAZEPAM	58	TRAVEL ON	78 78	XARELTO	32
TEVA-CLONAZEPAM	47	TRELEGY ELLIPTA	85	XELJANZ	115
TEVA-CODEINE	39	TRIATEC-30	38	XELJANZ XR	115
TEVA-CYCLOBENZAPRINE	28	TRIAZOLAM	61	XEOMIN	119
			.		

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XGEVA	99
XIGDUO	89
XOLAIR	75
XTANDI	12
XYLOCAINE	90
ZAXINE	4
ZELBORAF	22
ZENHALE	27
ZEPATIER	7
ZOLEDRONIC ACID	100
ZOLEDRONIC ACID MONOHYDRATE	100
MONOTTENATE	
ZOLMITRIPTAN	63
	63 63
ZOLMITRIPTAN	
ZOLMITRIPTAN ZOLMITRIPTAN	63
ZOLMITRIPTAN ZOLMITRIPTAN ZOLMITRIPTAN ODT	63 63
ZOLMITRIPTAN ZOLMITRIPTAN ZOLMITRIPTAN ODT ZOMIG	63 63 63
ZOLMITRIPTAN ZOLMITRIPTAN ZOLMITRIPTAN ODT ZOMIG ZOMIG RAPIMELT	63 63 63 63
ZOLMITRIPTAN ZOLMITRIPTAN ZOLMITRIPTAN ODT ZOMIG ZOMIG RAPIMELT ZYBAN	63 63 63 63 54
ZOLMITRIPTAN ZOLMITRIPTAN ZOLMITRIPTAN ODT ZOMIG ZOMIG RAPIMELT ZYBAN ZYDELIG	63 63 63 63 54
ZOLMITRIPTAN ZOLMITRIPTAN ZOLMITRIPTAN ODT ZOMIG ZOMIG RAPIMELT ZYBAN ZYDELIG ZYKADIA	63 63 63 63 54 14

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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 02231584 EPREX	JSO
500MG POWDER FOR SOLUTION		3,000U/0.3ML SOLUTION	330
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		40:00 ELECTROLYTIC, CALORIC,	
02392313 ARANESP	AMG	•	
40MCG/ML SOLUTION		AND WATER BALANCE	
02392321 ARANESP	AMG	40:12.00 REPLACEMENT PREPARATION	NS
60MCG/ML SOLUTION		CALCIUM	
02246348 ARANESP	AMG		
100MCG/ML SOLUTION		250MG TABLET 00645958 CALCIUM	NOD
02391740 ARANESP	AMG		NOP
02391759 ARANESP	AMG	625MG TABLET (COATED) 00682047 APOCAL	APX
02392348 ARANESP	AMG	CALCIUM CARB-GLUCONOLACTATE	AFA
99004917 ARANESP	AMG		
99004925 ARANESP	AMG	500MG TABLET	0011
200MCG/ML SOLUTION	4140	02232482 CALCIUMSANDOZ FORTE	GSK
02391767 ARANESP	AMG	1,000MG TABLET	001/
02391775 ARANESP 02391783 ARANESP	AMG AMG	02232483 GRAMCAL	GSK
02391763 ARANESP 02392356 ARANESP	AMG	SODIUM PHOSPHATE	
99004909 ARANESP	AMG	123MG POWDER FOR SOLUTION	
99004909 ARANESP 99004933 ARANESP	AMG	80027202 PHOSPHATE NOVARTIS	NVR
500MCG/ML SOLUTION	ANO	500MG TABLET	
02391791 ARANESP	AMG	00225819 PHOSPHATE-NOVARTIS	NVC

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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 PREPARATIONS		84:00 SKIN AND MUCOUS		
ZINC GLUCONATE		MEMBRANE AGENTS (SMMA)		
50MG TABLET		84:04.04 SMMA - ANTIBIOTICS	-,	
00503169 ZINC	VTH			
00505463 ZINC	JAM	GENTAMICIN SULFATE		
40:28.08 LOOP DIURETICS		1MG OINTMENT		
FUROSEMIDE		00872881 PMS-GENTAMICIN	PMS	
10MG/ML INJECTION		84:92.00 MISCELLANEOUS SKIN AND		
01987550 LASIX SPECIAL	UNK	MUCOUS MEMBRANE AGENTS	3	
10MG LIQUID		MENTHOL,CAMPHOR		
00527033 FUROSEMIDE	SDZ	OINTMENT		
02360365 FUROSEMIDE	OMG	09991675 ANTIPRURITIC (PRA) CREAM	UNK	
10MG SOLUTION		(MENTHOL/CAMPHOR IN NON-		
02461404 FUROSEMIDE	RAX	MEDICATED EMOLLIENT CREAM)		
02480530 FUROSEMIDE	MAR	88:00 VITAMINS		
02488868 FUROSEMIDE	BAX	OO:UU VIIAIVIIIVS		
10MG/ML SOLUTION		88:28.00 MULTIVITAMIN PREPARATION	S	
02382539 FUROSEMIDE	SDZ	MULTIVITAMINS		
02384094 FUROSEMIDE	ALV	TABLET/CAPLET		
250MG SOLUTION 02466945 FUROSEMIDE	RAX	00123803 B COMPLEX PLUS C	JAM	
		80007498 BC VITAMINS	WNP	
56:00 GASTROINTESTINAL DRUG	5	02245391 DIAMINE	EUR	
56:04.00 ANTACIDS AND ADSORBENT	S	80063438 M-PLAVITE	MAN	
ALUMINUM HYDROXIDE		80001432 RENAVITE	MAC	
500MG CAPSULE		00558796 STRESS PLEX	JAM	
02135620 BASALJEL	AUP	92:00 UNCLASSIFIED THERAPEUT	IC	
320MG/ML SUSPENSION	7101	AGENTS		
00572527 ALUGEL	ATL			
325MG/5ML SUSPENSION		92:92.00 OTHER MISCELLANEOUS		
02125862 AMPHOJEL	AUP	THERAPEUTIC AGENTS		
600MG TABLET		CINACALCET (CINACALCET HYDROCHLORI	DE)	
02124971 AMPHOJEL	AUP	30MG TABLET		
CALCIUM		02452693 APO-CINACALCET	APX	
500MG TABLET		02480298 MAR-CINACALCET	MAR	
01970240 TUMS	GSK	02481987 M-CINACALCET	MAN	
750MG TABLET		02434539 MYLAN-CINACALCET	MYL	
01967932 TUMS EXTRA STRENGTH	GSK	02257130 SENSIPAR	AMG	
1,000MG TABLET		02441624 TEVA-CINACALCET	TEV	
02151138 TUMS ULTRA STRENGTH	GSK	60MG TABLET	ADV	
SODIUM BICARBONATE		02452707 APO-CINACALCET 02481995 M-CINACALCET	APX MAN	
500MG TABLET		02257149 SENSIPAR	AMG	
80030520 JAMP-SODIUM BICARBONATE	JMP	02441632 TEVA-CINACALCET	TEV	
80022194 SANDOZ SODIUM BICARBONATE	SDZ	90MG TABLET	1 L V	
		02452715 APO-CINACALCET	APX	
		02482002 M-CINACALCET	MAN	
		02257157 SENSIPAR	AMG	
		02441640 TEVA-CINACALCET	TEV	

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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.

96:00 PHARMACEUTICAL AIDS

96:00.00 PHARMACEUTICAL AIDS NUTRITIONAL SUPPLEMENT

ORAL LIQUID

95900049	BOOST 1.0 STANDARD 237ML LIQ	NVC
95900051	BOOST FRUIT BEVERAGE 235ML LIQ	NES
95900054	BOOST HIPROTEIN 237ML LIQ	NES
95999970	BOOST HIPROTEIN 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 LIQ	ABB
95900204	ENSURE PROTEIN MAX 235ML LIQ	ABB
95900141	GLUCERNA TUBE FEEDING 235ML LIQ	ABB
95900063	NEPRO 237ML LIQ	ABB
95900064	NOVASOURCE RENAL 237ML LIQ	NVC
95900067	SUPLENA 235ML LIQ	ABB
POWDER		
95900055	BOOST JUST PROTEIN 588G PDR	NES
95900182	RESOURCE BENEPROTEIN 227G PDR	NVC

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Non-Insured Health Benefits

Appendix B - I officially for		renai i anaie i atiento		Non-insured Health Deficits
ALUGEL	2	SUPLENA 235ML LIQ	3	
ALUMINUM HYDROXIDE	2	TEVA-CINACALCET	2	
AMPHOJEL	2	TUMS	2	
APOCAL	1	TUMS EXTRA STRENGTH	2	
APO-CINACALCET	2	TUMS ULTRA STRENGTH	2	
ARANESP	1	ZINC	2	
B COMPLEX PLUS C	2	ZINC GLUCONATE	2	
BASALJEL		ZING GLOCONATE	2	
	2			
BC VITAMINS	2			
BOOST 1.0 STANDARD 237ML LIQ	3			
BOOST FRUIT BEVERAGE 235ML	3			
LIQ				
BOOST HIPROTEIN 237ML LIQ	3			
BOOST JUST PROTEIN 588G PDR	3			
BOOST PLUS 237ML LIQ	3			
BOOST PLUS CALORIES 237ML LIQ	3			
CALCIUM	1			
CALCIUM	1			
CALCIUM CARB-	1			
GLUCONOLACTATE	•			
	1			
CALCIUMSANDOZ FORTE				
CEFAZOLIN	1			
CEFAZOLIN SODIUM	1			
CIDOMYCIN	1			
CINACALCET (CINACALCET	2			
HYDROCHLORIDE)	_			
DARBEPOETIN ALFA	1			
DIAMINE	2			
ENSURE HIGH PROTEIN 235ML LIQ	3			
ENSURE PLUS 235ML LIQ	3			
ENSURE PLUS CALORIES 235ML	3			
LIQ				
ENSURE PROTEIN MAX 235ML LIQ	3			
	1			
EPOETIN ALFA				
EPREX	1			
FUROSEMIDE	2			
FUROSEMIDE	2			
GENTAMICIN	1			
GENTAMICIN SULFATE	1			
GLUCERNA TUBE FEEDING 235ML	3			
LIQ				
GRAMCAL	1			
JAMP-SODIUM BICARBONATE	2			
LASIX SPECIAL	2			
MAR-CINACALCET	2			
M-CINACALCET	2			
ANTIPRURITIC (PRA) CREAM	2			
EMOLLIENT				
MENTHOL,CAMPHOR	2			
M-PLAVITE	2			
MULTIVITAMINS	2			
MYLAN-CINACALCET	2			
NEPRO 237ML LIQ	3			
NOVASOURCE RENAL 237ML LIQ	3			
NUTRITIONAL SUPPLEMENT	3			
PHOSPHATE NOVARTIS	1			
PHOSPHATE-NOVARTIS	1			
PMS-GENTAMICIN	2			
RENAVITE	2			
RESOURCE BENEPROTEIN 227G	3			
PDR				
SANDOZ SODIUM BICARBONATE	2			
SENSIPAR	2			
	2			
SODIUM BICARBONATE				
SODIUM PHOSPHATE	1			
STRESS PLEX	2	<u> </u>		

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APPENDIX C PALLIATIVE CARE FORMULARY

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

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12:00 AUTONOMIC DRUGS 12:08.08 ANTIMUSCARINICS /		28:00 CENTRAL NERVOUS SYST AGENTS	EM
ANTISPASMODICS		28:04.92 GENERAL ANESTHETICS, MI	SC.
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	022
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	ONIX
20MG/ML SOLUTION			
00363839 BUSCOPAN	SAC	12MCG/HR PATCH	APX
02229868 HYOSCINE BUTYLBROMIDE	SDZ	02454440 APO-FENTANYL MATRIX 02334186 DURAGESIC	JSO
SCOPOLAMINE HYDROBROMIDE		99100480 FENTANYL	JNO
0.4MG/ML SOLUTION		02376768 PAT-FENTANYL MATRIX	KLA
00541869 SCOPOLAMINE	PFI	25MCG/HR PATCH	INLA
02242810 SCOPOLAMINE	OMG	02304120 FENTANYL TRANSDERMAL	ACG
0.6MG/ML SOLUTION		SYSTEM	700
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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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 (PALLIATIVE)	UNK
75MCG/HR PATCH	T(B)	METHADONE HYDROCHLORIDE (METADOL	
02304147 FENTANYL TRANSDERMAL	ACG	1MG/ML SOLUTION	-)
SYSTEM	7.00	02247694 METADOL	PAL
02376792 PAT-FENTANYL MATRIX	KLA	1MG TABLET	PAL
02325438 RAN-FENTANYL MATRIX	RBY	02247698 METADOL	PAL
100MCG/HR PATCH		5MG TABLET	FAL
02304155 FENTANYL TRANSDERMAL	ACG	02247699 METADOL	PAL
SYSTEM		10MG TABLET	FAL
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	IAL
02384124 FENTANYL CITRATE SDZ	SDZ	2MG/ML LIQUID	
50MCG/ML SOLUTION		02242484 MORPHINE SULFATE	SDZ
00888346 FENTANYL CITRATE	PFI		SDZ
02240434 FENTANYL CITRATE	SDZ	10MG LIQUID 00392588 MORPHINE SULFATE	SDZ
HYDROMORPHONE HYDROCHLORIDE		15MG LIQUID	SDZ
2MG/ML SOLUTION		00392561 MORPHINE SULFATE	SDZ
02145901 HYDROMORPHONE	SDZ	50MG/ML LIQUID	SDZ
10MG SOLUTION		02137267 MORPHINE SULPHATE	HOS
02460610 HYDROMORPHONE	RAX	0.5MG/ML SOLUTION	1103
HYDROCHLORIDE HP 10		02021056 MORPHINE LP EPIDURAL	SDZ
10MG/ML SOLUTION		01949047 MORPHINE-EPD	PFI
02145928 HYDROMORPHONE HP	SDZ	1MG/ML SOLUTION	
20MG/ML SOLUTION		02021048 MORPHINE LP	SDZ
02145936 HYDROMORPHONE HP	SDZ	01980696 MORPHINE SULFATE	SDZ
50MG/ML SOLUTION	0.5.7	01949055 MORPHINE-EPD	PFI
02146126 HYDROMORPHONE HP	SDZ	2MG/ML SOLUTION	
99003163 HYDROMORPHONE HP	UNK	00850314 MORPHINE SULFATE	PFI
100MG/ML SOLUTION	007	01964437 MORPHINE SULFATE	SDZ
02244797 HYDROMORPHONE HP FORTE	SDZ	5MG/ML SOLUTION	
		01964429 MORPHINE SULFATE	SDZ

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28:08.08 OPIATE AGONISTS MORPHINE SULFATE		28:24.08 ANXIOLYTICS, SEDATIVES A HYPNOTICS - BENZODIAZEP	
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	OBL	02423766 MIDAZOLAM	PFI
02304090 PHENOBARBITAL SODIUM	SDZ	5MG/ML SOLUTION	
28:12.12 ANTICONVULSANTS -	OBL	02240286 MIDAZOLAM	SDZ
		02242905 MIDAZOLAM	FKD
HYDANTOINS		02243935 MIDAZOLAM	NOP
PHENYTOIN		02382903 MIDAZOLAM	SDZ
50MG LIQUID		40:00 ELECTROLYTIC, CALORIC,	
00780626 PHENYTOIN SODIUM	SDZ	AND WATER BALANCE	
28:16.08 ANTIPSYCHOTIC AGENTS			
METHOTRIMEPRAZINE HYDROCHLORIDE		40:28.08 LOOP DIURETICS	
25MG/ML SOLUTION		FUROSEMIDE	
01927698 NOZINAN	SAC	10MG LIQUID	
28:24.08 ANXIOLYTICS, SEDATIVES AN	0, 10	00527033 FUROSEMIDE	SDZ
		10MG/ML SOLUTION	
HYPNOTICS - BENZODIAZEPI	NE2	02382539 FUROSEMIDE	SDZ
DIAZEPAM		02384094 FUROSEMIDE	ALV
5MG/ML SOLUTION		52:00 EYE, EAR, NOSE AND	
00399728 DIAZEPAM	SDZ	• •	
02386143 DIAZEPAM	SDZ	THROAT (EENT)	
DIAZEPAM (DIASTAT)		52:92.00 MISCELLANEOUS EENT DRU	GS
5MG/ML GEL		ARTIFICIAL SALIVA	
02238162 DIASTAT	VAE	0.05MG SPRAY	
09853340 DIASTAT 2X10MG RECTAL PACK	ELN	02238696 MOISTIR	PMS
09853430 DIASTAT 2X15MG RECTAL PACK	ELN	02200000 INICIOTIIX	I IVIO

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56:00 GASTROINTESTINAL DRUG	GS	56:22.20 5-HT3 RECEPTOR ANTAGONIS	STS
		ONDANSETRON HYDROCHLORIDE	
56:08.00 ANTIDIARRHEA AGENTS		2MG/ML SOLUTION	
DIPHENOXYLATE HYDROCHLORIDE, ATR	OPINE	02390051 ONDANSETRON	MYL
SULFATE		56:22.92 MISCELLANEOUS ANTIEMETIC	CS.
2.5MG & 0.025MG TABLET			
00036323 LOMOTIL	PFI	NABILONE	
56:22.20 5-HT3 RECEPTOR ANTAGON	NISTS	0.25MG CAPSULE 02441497 APO-NABILONE	APX
GRANISETRON HYDROCHLORIDE		02345897 APP-NABILONE	UNK
1MG LIQUID		02380897 PMS-NABILONE	PMS
02322765 GRANISETRON HYDROCHLORIDE	OMG	0.5MG CAPSULE	1 IVIO
1MG/ML SOLUTION		02441500 APO-NABILONE	APX
02385414 GRANISETRON	SDZ	02345927 APP-NABILONE	UNK
ONDANSETRON HYDROCHLORIDE		1MG CAPSULE	
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	RANITIDINE HYDROCHLORIDE 25MG/ML SOLUTION	
2MG SOLUTION		02256711 RANITIDINE	SDZ
02420414 JAMP-ONDANSETRON	JMP		SDZ
02420422 JAMP-ONDANSETRON	JMP	56:32.00 PROKINETIC AGENTS	
02462257 ONDANSETRON	RAX	METOCLOPRAMIDE HYDROCHLORIDE	
02464578 ONDANSETRON	RAX	5MG/ML LIQUID	
02279436 ONDANSETRON -(WITH PRESERVATIVE)	SDZ	02185431 METOCLOPRAMIDE 02243563 METOCLOPRAMIDE OMEGA	SDZ OMG
02461420 ONDANSETRON BP	AUR	56:92.00 MISCELLANEOUS GI DRUGS	00
02213745 ZOFRAN	NVR		
2MG/ML SOLUTION		METHYLNALTREXONE BROMIDE	
02265524 ONDANSETRON	TEV	20MG SOLUTION	
02274418 ONDANSETRON	SDZ	02308215 RELISTOR	SLX
02279428 ONDANSETRON	SDZ	02356481 RELISTOR	SLX
02390019 ONDANSETRON	MYL	02356503 RELISTOR	SLX

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- 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 Palliative 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 Palliative Care Application Form completed. Please note: During the six month coverage period, a maximum 30 day supply will be reimbursed at any one time.

UNK

96:00 PHARMACEUTICAL AIDS

96:00.00 PHARMACEUTICAL AIDS

ADMINISTRATION DIN

MISCELLANEOUS

91500004 STERILE PREPERATION FEE
NUTRITIONAL SUPPLEMENT
ORAL LIQUID
05000040 D000T400TANDADD007M

95900049	BOOST 1.0 STANDARD 237ML LIQ	NVC
95900051	BOOST FRUIT BEVERAGE 235ML LIQ	NES
95900054	BOOST HIPROTEIN 237ML LIQ	NES
95999970	BOOST HIPROTEIN 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 LIQ	ABB
95900204	ENSURE PROTEIN MAX 235ML LIQ	ABB

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AOMISTRATION DIN 5 LORAZEPAM 3 APO-PASIBLONE 4 METHADOR 2 APO-ANGLONE 4 BOOST ION 2 APO-MARILONE 4 BOOST ION 4 BOOST ION ARTIFICIAL SALIVA 3 METHADONE PROPRIANI 2 ARTOPPIES SULFATE 1 METHADONE PROPRIANI 2 ARTOPPIES SULFATE 1 METHADONE PROPRIANI 2 BOOST I DI STAMORED 227ML IU 5 METHADONE PROPRIANI 3 BOOST PIUS SULFATE 4 METHADONE PROPRIANI 4 BOOST PIUS SULFARICA SALINA 5 METHADONE PROPRIANI 4 BOOST PIUS SULFARICA SALINA 6 METOCLOPRAMIDE 4 BOOST PIUS SULFARIA 1 MINOZOLAM 3 CO FENTANYL 1 MINOZOLAM 3 CO FENTANYL 3 MORPHINE PROPRIANI 3 DIASPAM JOANSTATI 3 MORPHINE PROPRIANI 3 DIASPAM JOANSTATI 3 MORPHINE SULFATE 2 <	Appendix C - Paillative Care	Formula	ary		Non-insured Health Benefits
APO-NABILONE 4 METHADOR HYDROCHLORIDE 2 APP-NABILONE 4 METHADOR HYDROCHLORIDE 4 METHADOR HYDROCHLORIDE 5 APP-NABILONE 4 METHADOR HYDROCHLORIDE 5 APP-NABILONE 5 METHADOR HYDROCHLORIDE 5 METHADOR HYDROCHLORIDE 6 METHADOR HYDROCHLORIDE 6 METHADOR HYDROCHLORIDE 7 ATROPHE SULFATE 7 METHADOR HYDROCHLORIDE 8 METHADOR HYDROCHLORIDE 9 METHADOR HYDROCHLO	ADMINISTRATION DIN	5	LORAZEPAM	3	
APP-MARLEONE 4 (BC ONLY) ATROPNE SULFATE 1 (METADONE POR (PAIN) 2 ATROPNE SULFATE 1 (METADONE POR (PAIN) 2 ATROPNE SULFATE 1 (METADONE POR (PAIN) 2 ATROPNE SULFATE 1 (METADONE POR (PAIN) 3 BOOST FULL STAME LIQ 5 (METADONE POR (PAIN) 4 BOOST FULL STAME	APO-FENTANYL MATRIX	1			
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METHADONE POR (PAIN) 2		1	(METADOL)		
ATROPINE SULFATE BOOST FLOY TRANSPERMAL BOOST FLOY TRANSPERMAL BOOST FLOY SATAML LIO BOOST FLOY SATAML LIO BOOST FLUS CALORIES 237ML LIO CO FENTANYL MIDAZOLAM BOOST RUS CALORIES 237ML LIO BOOST FLUS CALORIES		1	METHADONE PDR (PAIN)	2	
BOOST FINIT PEVERAGE 23ML LIQ			METHADONE PDR (PALLIATIVE)	2	
BOOST PLUS 277ML LIQ 6 METOCLOPRAMIDE 4			METHOTRIMEPRAZINE	3	
LIQ			HYDROCHLORIDE		
BOOST PLUS 237ML LIQ 5		3	METHYLNALTREXONE BROMIDE	4	
MOSOST PLUS 227ML LID 5		5	METOCLOPRAMIDE	4	
BOOST PLUS CALCRIES 237ML LIQ BUSCOPAN 1				4	
MIL TOCLOPRAMIDE OMEGA 4			HYDROCHLORIDE		
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DIASTAT		1	MIDAZOLAM	3	
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DIASTAT 2X15MG RECTAL PACK 3 MORPHINE IP'SITEMELE INFUSION 1 2 2 2 2 2 2 2 2 2			MORPHINE HP	3	
DIAZEPAM			MORPHINE HP STERILE INFUSION	1	
DIAZEPAM (DIASTAT) MORPHINE SULFATE 2			MORPHINE LP	2	
DIAZEPAM (DIASTAT) 3 MORPHINE SULFATE 2			MORPHINE LP EPIDURAL	2	
DIPHENOXYLATE			MORPHINE SULFATE	2	
DIPHENOXYLATE	DIAZEPAM (DIASTAT)	3		2	
MORPHINE_EPD		4			
DURAGESIC					
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ENSURE PLUS CALORIES 235ML 5					
ONDANSETRON - (WITH					
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FENTANYL			•	4	
FENTANYL 1					
PENTANYL CITRATE	FENTANYL				
PENTANYL CITRATE				4	
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GLYCOPYRROLATE MULTIDOSE 1	GLYCOPYRROLATE	1			
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HYDROMORPHONE				4	
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LOMOTIL 4		4			
		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	3	20:16.00 HEMATOPOIETIC AGE	NTS
08:12.24 TETRACYCLINES		DARBEPOETIN ALFA	
		200MCG/ML SOLUTION	
MINOCYCLINE HYDROCHLORIDE		02391775 ARANESP	AMG
50MG CAPSULE	440	02391783 ARANESP	AMG
02084090 MINOCYCLINE	AAP	02392356 ARANESP	AMG
02108143 TEVA-MINOCYCLINE	TEV	99004909 ARANESP	AMG
100MG CAPSULE		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	ІСТС	02391821 ARANESP	AMG
		02392364 ARANESP	AMG
SALMETEROL XINAFOATE, FLUTICASO	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	
INCOMPOSIS		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	AWO	30,000U/0.75ML SOLUTION	
02392321 ARANESP	AMG	02288680 EPREX	JSO
60MCG/ML SOLUTION	AWO	40,000U/ML SOLUTION	
02246348 ARANESP	AMG	02240722 EPREX	JSO
100MCG/ML SOLUTION	7 (IVIO	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 SYS	STEM	28:12.92 MISCELLANEOUS ANTICONVULSANTS	
AGENTS			
28:08.12 OPIATE PARTIAL AGONIS	TS	PREGABALIN	
BUPRENORPHINE (BUTRANS)		50MG CAPSULE	
` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `		02359618 PMS-PREGABALIN	PMS
5MCG PATCH	555	02396505 PREGABALIN	PDL
02341174 BUTRANS 5	PFR	02403706 PREGABALIN	SIV
10MCG PATCH	5-5	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
PREGABALIN		02394251 APO-PREGABALIN	APX
		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	024217301 MAR-FREGABALIN	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		
02479125 NRA-PREGABALIN	UNK	02403722 PREGABALIN	SIV
	•	02405563 PREGABALIN	SAN

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

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ANTICONVULSANTS MONTELUKAST SODIUM PREGABALIN 10MG TABLET 150MG CAPSULE 02328593 SANDOZ MONTELUKAST SE 02476347 PREGABALIN RIV 02238217 SINGULAIR FR 02392844 RAN-PREGABALIN RBY 02355523 TEVA-MONTELUKAST TE 02377063 RIVA-PREGABALIN RIV 4MG TABLET (CHEWABLE) 02390841 SANDOZ PREGABALIN SDZ 02377608 APO-MONTELUKAST AF 02361205 TEVA-PREGABALIN TEV 02422867 AURO-MONTELUKAST AL 300MG CAPSULE 02442353 JAMP-MONTELUKAST JM 02394294 APO-PREGABALIN APX 02399865 MAR-MONTELUKAST MA 02436019 JAMP-PREGABALIN JMP 02408627 MINT-MONTELUKAST M 02268485 LYRICA PFI 02379317 MONTELUKAST SA 02359642 PMS-PREGABALIN PMS 02379821 MONTELUKAST PE	RS EV PX JR JP AR JN AN
150MG CAPSULE 02328593 SANDOZ MONTELUKAST SE 02476347 PREGABALIN RIV 02238217 SINGULAIR FR 02392844 RAN-PREGABALIN RBY 02355523 TEVA-MONTELUKAST TE 02377063 RIVA-PREGABALIN RIV 4MG TABLET (CHEWABLE) TE 02390841 SANDOZ PREGABALIN SDZ 02377608 APO-MONTELUKAST AF 02361205 TEVA-PREGABALIN TEV 02422867 AURO-MONTELUKAST AU 300MG CAPSULE 02442353 JAMP-MONTELUKAST JM 02394294 APO-PREGABALIN APX 02399865 MAR-MONTELUKAST MAR 02436019 JAMP-PREGABALIN JMP 02408627 MINT-MONTELUKAST M 02268485 LYRICA PFI 02379317 MONTELUKAST SA	RS EV PX JR JP JR JN JN JN JN JN JN JN JN JN JN JN JN JN
02476347 PREGABALIN RIV 02238217 SINGULAIR FR 02392844 RAN-PREGABALIN RBY 02355523 TEVA-MONTELUKAST TE 02377063 RIVA-PREGABALIN RIV 4MG TABLET (CHEWABLE) 02390841 SANDOZ PREGABALIN SDZ 02377608 APO-MONTELUKAST AF 02361205 TEVA-PREGABALIN TEV 02422867 AURO-MONTELUKAST AU 300MG CAPSULE 02442353 JAMP-MONTELUKAST JM 02394294 APO-PREGABALIN APX 02399865 MAR-MONTELUKAST MA 02436019 JAMP-PREGABALIN JMP 02408627 MINT-MONTELUKAST M 02268485 LYRICA PFI 02379317 MONTELUKAST SA	RS EV PX JR JP JR JN JN JN JN JN JN JN JN JN JN JN JN JN
02392844 RAN-PREGABALIN RBY 02355523 TEVA-MONTELUKAST TE 02377063 RIVA-PREGABALIN RIV 4MG TABLET (CHEWABLE) 02390841 SANDOZ PREGABALIN SDZ 02377608 APO-MONTELUKAST AF 02361205 TEVA-PREGABALIN TEV 02422867 AURO-MONTELUKAST AL 300MG CAPSULE 02442353 JAMP-MONTELUKAST JM 02394294 APO-PREGABALIN APX 02399865 MAR-MONTELUKAST MA 02436019 JAMP-PREGABALIN JMP 02408627 MINT-MONTELUKAST M 02268485 LYRICA PFI 02379317 MONTELUKAST SA	PX JR JP JR JP JR JN JN JN JN JN JN JN JN JN JN JN JN JN
02377063 RIVA-PREGABALIN RIV 4MG TABLET (CHEWABLE) 02390841 SANDOZ PREGABALIN SDZ 02377608 APO-MONTELUKAST AF 02361205 TEVA-PREGABALIN TEV 02422867 AURO-MONTELUKAST AURO-MONTELUKAST JW 02394294 APO-PREGABALIN APX 02399865 MAR-MONTELUKAST M	PX JR JP JR JN JN JL JV JS
02390841 SANDOZ PREGABALIN SDZ 02377608 APO-MONTELUKAST AF 02361205 TEVA-PREGABALIN TEV 02422867 AURO-MONTELUKAST AL 300MG CAPSULE 02442353 JAMP-MONTELUKAST JN 02394294 APO-PREGABALIN APX 02399865 MAR-MONTELUKAST MA 02436019 JAMP-PREGABALIN JMP 02408627 MINT-MONTELUKAST M 02268485 LYRICA PFI 02379317 MONTELUKAST SA	IR IP IR IN IN DL IV
02361205 TEVA-PREGABALIN TEV 02422867 AURO-MONTELUKAST AL 300MG CAPSULE 02442353 JAMP-MONTELUKAST JM 02394294 APO-PREGABALIN APX 02399865 MAR-MONTELUKAST MA 02436019 JAMP-PREGABALIN JMP 02408627 MINT-MONTELUKAST M 02268485 LYRICA PFI 02379317 MONTELUKAST SA	IR IP IR IN IN DL IV
300MG CAPSULE 02442353 JAMP-MONTELUKAST JMP 02394294 APO-PREGABALIN APX 02399865 MAR-MONTELUKAST MA 02436019 JAMP-PREGABALIN JMP 02408627 MINT-MONTELUKAST M 02268485 LYRICA PFI 02379317 MONTELUKAST SA	IP AR IN AN DL IV
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02436019 JAMP-PREGABALIN JMP 02408627 MINT-MONTELUKAST M 02268485 LYRICA PFI 02379317 MONTELUKAST SA	IN N DL IV IS
02268485 LYRICA PFI 02379317 MONTELUKAST SA	N DL IV IS
	DL IV 1S
02359642 PMS-PREGABALIN PMS 02379821 MONTELUKAST PI	IV 1S
00000450 MONTELLIKA OT	1S
020001011120121111111111111111111111111	-
OT THE OTHER PROPERTY OF THE OTHER PROPERTY OTHER PROPERTY OTHER PROPERTY OF THE OTHER PROPERTY OF THE OTHER P	
ONIT	
0247 007 T TREO/ID/TEIN	
TEST TO THE PROPERTY OF THE PR	
02377071 RIVA-PREGABALIN RIV 02355507 TEVA-MONTELUKAST TE 02390868 SANDOZ PREGABALIN SDZ 5MG TABLET (CHEWABLE)	. v
02390808 SANDOZ FREGABALIN SDZ SING TABLET (STEWADLE) 02361248 TEVA-PREGABALIN TEV 02377616 APO-MONTELUKAST AF	×
48:00 RESPIRATORY TRACT 02442361 JAMP-MONTELUKAST JN	
AGENTS 02399873 MAR-MONTELUKAST MA	
48:10.24 LEUKOTRIENE MODIFIERS 02408635 MINT-MONTELUKAST M	IN
02379325 MONTELUKAST SA	ıN
MONTELUKAST SODIUM 02379848 MONTELUKAST PE)L
	IV
02358611 SANDOZ MONTELUKAST SDZ 02354985 PMS-MONTELUKAST PN	IS
02247997 SINGULAIR FRS 02402807 RAN-MONTELUKAST RE	Υ
10MG TABLET 02330393 SANDOZ MONTELUKAST SE)Z
02374609 APO-MONTELUKAST APX 02238216 SINGULAIR FF	lS
02401274 AURO-MONTELUKAST AUR 02355515 TEVA-MONTELUKAST TE 02445735 BIO-MONTELUKAST UNK - 0.0 -	V
02445735 BIO-MONTELUKAST UNK 02376695 DOM-MONTELUKAST DPC 52:00 EYE, EAR, NOSE AND	
02391422 JAMP-MONTELUKAST JMP THROAT (EENT)	
0000007 MAD MONTELLIKAGT MAD	
02408643 MINT-MONTELLIKAST MIN 52:28.00 EENT - MOUTHWASHES AND	
02379333 MONTELUKAST SAN GARGLES	
02379856 MONTELUKAST PDL BENZYDAMINE HYDROCHLORIDE	
02382474 MONTELUKAST SIV 0.15% MOUTHWASH	
02379236 MONTELUKAST SODIUM ACC 02239044 APO-BENZYDAMINE AF	χ
02373947 PMS-MONTELUKAST PMS 02229777 PHARIXIA PE	D
02389517 RAN-MONTELUKAST RBY 02239537 PMS-BENZYDAMINE PM	IS
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, ATI	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		
		02393581 ACT NABILONE	ACG	
ONDANSETRON HYDROCHLORIDE		02441500 APO-NABILONE	APX	
2MG/ML INJECTION	ADV	02256193 CESAMET	UNK	
02291703 ONDANSETRON W/P	APX GSK	02380900 PMS-NABILONE	PMS	
09857324 ZOFRAN (ON) 09857325 ZOFRAN (ON)	GSK	02358085 RAN-NABILONE	RBY TEV	
2MG LIQUID	GSK	02384884 TEVA-NABILONE TEV 1MG CAPSULE		
02271761 ONDANSETRON OMEGA -	OMG	02393603 ACT NABILONE	ACG	
(PRESERVATIVE FREE SINGLE	OMO	02441519 APO-NABILONE	APX	
DOSE VIALS)		00548375 CESAMET	UNK	
02271788 ONDANSETRON OMEGA -(WITH	OMG	02380919 PMS-NABILONE	PMS	
PRESERVATIVE MULTIDOSE VIAL)		02358093 RAN-NABILONE	RBY	
2MG SOLUTION 02420414 JAMP-ONDANSETRON	JMP	02384892 TEVA-NABILONE	TEV	
02420414 JAMP-ONDANSETRON	JMP	92:00 UNCLASSIFIED THERAPEL	ITIC	
02462257 ONDANSETRON	RAX		3110	
02464578 ONDANSETRON	RAX	AGENTS		
02279436 ONDANSETRON -(WITH	SDZ	92:24.00 BONE RESORPTION INHIBIT	rors	
PRESERVATIVE) 02461420 ONDANSETRON BP	AUR	DENOSUMAB (XGEVA)		
02213745 ZOFRAN	NVR	120MG/1.7ML SOLUTION		
2MG/ML SOLUTION	IVIX	02368153 XGEVA	AMG	
02265524 ONDANSETRON	TEV	96:00 PHARMACEUTICAL AIDS		
02274418 ONDANSETRON	SDZ	96:00.00 PHARMACEUTICAL AIDS		
02279428 ONDANSETRON	SDZ			
02390019 ONDANSETRON	MYL	ADULT		
02390051 ONDANSETRON	MYL	ORAL LIQUID		
		95900061 BOOST DIABETIC 237ML LIQ	NES	
		95999963 BOOST ORIGINAL 237ML LIQ	NES	

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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
95999970	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	ABB
95900181	ENSURE PLUS CALORIES 235ML LIQ	ABB
95900204	ENSURE PROTEIN MAX 235ML LIQ	ABB
POWDER		
95900055	BOOST JUST PROTEIN 588G PDR	NES

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ACT NABILONE	4	MINOCYCLINE	1
ADULT	4	MINOCYCLINE MINOCYCLINE HYDROCHLORIDE	1
ADVAIR 100 DISKUS	1	MINT-MONTELUKAST	3
ADVAIR 100 DISROS	1	MINT-PREGABALIN	2
ADVAIR 250	1	MOISTIR	4
ADVAIR 250 DISKUS	1	MONTELUKAST	3
ADVAIR 500 DISKUS	1	MONTELUKAST SODIUM	3
AG-PREGABALIN	2	MONTELUKAST SODIUM	3
AKYNZEO	4	NABILONE	4
APO-BENZYDAMINE	3	NETUPITANT, PALONOSETRON	4
APO-MONTELUKAST	3	(PALONOSETRON	•
APO-NABILONE	4	HYDROCHLORIDE)	
APO-PREGABALIN	2	NEULASTA	1
APREPITANT	4	NRA-PREGABALIN	2
ARANESP	1	NUTRITIONAL SUPPLEMENT	5
ARTIFICIAL SALIVA	4	ONDANSETRON	4
AURO-MONTELUKAST	3	ONDANSETRON -(WITH	4
AURO-PREGABALIN	2	PRESERVATIVE)	
BENZYDAMINE HYDROCHLORIDE	3	ONDANSETRON BP	4
BIO-MONTELUKAST	3	ONDANISETRON HYDROCHLORIDE	4
BOOST 1.0 STANDARD 237ML LIQ	5	ONDANSETRON OMEGA - (PRESERVATIVE FREE SINGLE	4
BOOST DIABETIC 237ML LIQ	4	DOSE VIALS)	
BOOST FRUIT BEVERAGE 235ML	5	ONDANSETRON OMEGA -(WITH	4
LIQ		PRESERVATIVE MULTIDOSE VIAL)	
BOOST HIPROTEIN 237ML LIQ	5	ONDANSETRON W/P	4
BOOST JUST PROTEIN 588G PDR	5	PEDIASURE COM. GROW&GAIN	5
BOOST ORIGINAL 237ML LIQ	4	235ML LIQ	
BOOST PLUS 237ML LIQ	5	PEDIASURE GROW&GAIN 400G	5
BOOST PLUS CALORIES 237ML LIQ	5	PDR	4
BUPRENORPHINE (BUTRANS)	2	PEGFILGRASTIM	1 3
BUTRANS 10	2	PHARIXIA	3
BUTRANS 15	2	PMS-BENZYDAMINE PMS-MONTELUKAST	3
BUTRANS 20	2		4
BUTRANS 5	2	PMS-NABILONE	2
CESAMET	4	PMS-PREGABALIN PREGABALIN	2
CHILDREN AND YOUTH	5	PREGABALIN PREGABALIN	2
COMPLEAT MODIFIED 1000ML LIQ	5	RAN-MONTELUKAST	3
COMPLEAT MODIFIED 250ML LIQ	5	RAN-NABILONE	4
DARBEPOETIN ALFA	1	RAN-PREGABALIN	2
DENOSUMAB (XGEVA)	4	RESOURCE 2.0 237ML LIQ	5
DIPHENOXYLATE	4	RIVA-MONTELUKAST	3
HYDROCHLORIDE, ATROPINE SULFATE		RIVA-PREGABALIN	2
DOM-MONTELUKAST	3	SALMETEROL XINAFOATE,	1
DOM-PREGABALIN	2	FLUTICASONE PROPIONATE	·
EMEND	4	SANDOZ MONTELUKAST	3
EMEND TRI-PACK	4	SANDOZ PREGABALIN	2
ENSURE 235ML LIQ	5	SINGULAIR	3
ENSURE FIBRE 235ML LIQ	5	TEVA-MINOCYCLINE	1
ENSURE HIGH PROTEIN 235ML LIQ	5	TEVA-MONTELUKAST	3
ENSURE PLUS 235ML LIQ	5	TEVA-NABILONE	4
ENSURE PLUS CALORIES 235ML	5	TEVA-PREGABALIN	2
LIQ		XGEVA	4
ENSURE PROTEIN MAX 235ML LIQ	5	ZOFRAN	4
EPOETIN ALFA	1	ZOFRAN (ON)	4
EPREX	1		
GLUCERNA 237ML LIQ	5		
JAMP-MONTELUKAST	3		
JAMP-ONDANSETRON	4		
JAMP-PREGABALIN	2		
LOMOTIL	4		
LYRICA	2		
MAR-MONTELUKAST	3		
MAR-PREGABALIN	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.

Compounds with Diclofenac:

Compounds with diclofenac as an ingredient require a PA and will be reviewed on a case-by-case basis

99501007 NSAID IN TRANSDERMAL BASE 99501009 TRANSDERMAL LIDOCAINE W/NSAID 99505005 H2RA SOLID

COMPOUNDED EXTERNAL LOTION

99502001 MENTHOL & CAMPHOR IN CORTICOSTEROID

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

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

прропал	- List of Drug Manufacturers		Non-insured ficultif Beliefits
MFR	Manufacturer Name	MFR	Manufacturer Name
AAP	AA PHARMA INCORPORATED	DPI	DOMREX PHARMA INCORPORATED
ABB	ABBOTT LABORATORIES LIMITED	DPT	DERMTEK PHARMA INCORPORATED
ABV	ABBVIE CORPORATION	DUI	DUCHESNAY INCORPORATED
ACC	ACCORD HEALTHCARE INCORPORATED	EIS	EISAI LIMITED
ACG	ACTAVIS GROUP PTC EHF	ELN	ELAN PHARMACEUTICALS INCORPORATED
ACP	ACCEL PHARMA INCORPORATED	ERF	ERFA CANADA INCORPORATED
ADA	ADAMS LABS LIMITED	ETH	ETHYPHARM INCORPORATED
ADD	AVEVA DRUG DELIVERY SYSTEMS INCORPORATED	EUR	EURO-PHARM INTERNATIONAL CANADA INCORPORATED
ALC	ALCON CANADA INCORPORATED	FEI	FERRING INCORPORATED
ALK	ALK ABELLO A/S	FKD	FRESENIUS KABI CANADA LIMITED
ALL	ALLERGAN INCORPORATED	FMC	FRESENIUS MEDICAL CARE NORTH AMERICA
ALV	ALVEDA PHARMACEUTICALS INCORPORATED	FRS	MERCK FROSST CANADA LIMITED
AMD	AMDIPHARM LIMITED	GAC	GALDERMA CANADA INCORPORATED
AMG	AMGEN CANADA INCORPORATED	GEE	GENZYME CANADA INCORPORATED
ANG	ANGITA PHARMA INCORPORATED	GIL	GILEAD SCIENCES INCORPORATED
APC	APTALIS PHARMA CANADA ULC	GLK	GLENMARK PHARMACEUTICALS CANADA
APL	AUROBINDO PHARMA LIMITED	OLIK	INCORPORATED
APU	ATNAHS PHARMA UK LIMITED	GMP	GENERIC MEDICAL PARTNERS
APX	APOTEX INCORPORATED	5	INCORPORATED
		GPB	G POHL-BOSKAMP GMBH & CO KG
ARA	ARA PHARMACUETICALS INCORPORATED	GSK	GLAXOSMITHKLINE INCORPORATED
ARI	ARIAD PHARMACEUTICALS INCORPORATED	HIL	HILL DERMACEUTICALS INCORPORATED
ASP	ASPEN PHARMA TRADING LIMITED	HJS	H.J. SUTTON INDUSTRIES LIMITED
AST	ASTELLAS PHARMA CANADA INCORPORATED	HLR	HOFFMAN-LAROCHE LIMITED
ATL	LABORATORIE ATLAS INCORPORATED	HLS	HLS THERAPEUTICS INC
ATO	ATON PHARMA INCORPORATED, A DIVISION	HOD	NIPRO DIAGNOSTICS CANADA LIMITED
	OF VALEANT PHARMACEUTICALS NORTH	HOS	HOSPIRA HEALTHCARE CORPORATION
4110	AMERICA LLC		
AUC	AUTO CONTROL	HYD	HYDRATION PHARMACEUTICALS CANADA INCORPORATED
AUP	AURIUM PHARMA INCORPORATED	ICN	ICN CANADA LIMITED
AUR	AURO PHARMA INCORPORATED		
AZC	ASTRAZENECA CANADA INCORPORATED	IDE	INTERNATIONAL DERMATOLOGICALS INCORPORATED
BAX	BAXTER CORPORATION	IND	INDIVIOR UK LIMITED
BAY	BAYER INCORPORATED,	INS	INSIGHT PHARMACEUTICALS LLC
	HEALTHCARE/DIAGNOSTICS	IPS	IPSEN LIMITED
BEN	BENCARD ALLERGY LABORATORIES		
BEX	BERLEX CANADA INCORPORATED	JAC	JACOBUS PHARMACEUTICAL COMPANY INCORPORATED
BGP	BGP PHARMA ULC	JAJ	JOHNSON & JOHNSON
BIO	BIONICHE PHARMA (CANADA) LIMITED		
BMI	BIOMED 2002 INCORPORATED	JAM	C.E. JAMIESON COMPANY LIMITED
BMS	BRISTOL-MYERS SQUIBB CANADA	JMP	JAMP PHARMA CORPORATION
BOE	BOEHRINGER INGELHEIM (CANADA) LIMITED	JNO	JANSSEN-ORTHO INCORPORATED
BSH	BAUSCH & LOMB CANADA INCORPORATED	JSO	JANSSEN INCORPORATED
BSY	BIOSYENT PHARMA INCORPORATED	JUB	JUBILANT HOLLISTERSTIER LLC
BTD	WEB PACK INTERNATIONAL INCORPORATED	KAL	KALEO INCORPORATED
BTU	BRAINTREE LABORATORIES INCORPORATED	KIM	MCNEIL CONSUMER HEALTHCARE, A DIVISION
CHE	CHEPLAPHARM ARZNEIMITTEL GMBH		OF JOHNSON & JOHNSON INCORPORATED
	GERMANY	KLA	PATRIOT A DIVISION OF JANSSEN INCORPORATED
CHU	CHURCH & DWIGHT CANADA CORP	LAL	LABORATOIRE LALCO INCORPORATED
CIP	CIPHER PHARMACEUTICALS INCORPORATED	LAP	LABORATOIRE HRA PHARMA
CLC	COLUMBIA LABORATORIES CANADA	LEO	LEO PHARMA INCORPORATED
0011	INCORPORATED	LIL	ELI LILLY CANADA INCORPORATED
COV	COVIDIEN CANADA	LIP	LINEPHARMA INTERNATIONAL LIMITED
DCM	D & C MOBILITY	LUD	LUNDBECK CANADA INCORPORATED
DDP	THE D DROPS COMPANY INCORPORATED	LUK	LUNDBECK LLC
DOR	DORMER LABORATORIES INCORPORATED	LUP	LUPIN PHARMA CANADA LIMITED
DPC	DOMINION PHARMACAL		
		MAC	MACDONALD'S PRESCRIPTION LAB LIMITED

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MFR Manufacturer Name MFR Manufacturer Name MAX MANUTAR PHARMA (CANDA) COMPANY MAN MANTAR PHARMA (CONDADA LINE NOCOPPORATED RIV LABORATORIER INCORPORATED RIV LABORATORIER INCORPORATED RIV LABORATORIER INVA INCORPORATED RIVE LABORATORIER INVA INCORPORATED SIZE SANDIA CANDA INCORPORATED SIZE SANDIA (CANDA INCORPORATED SIZE SANDIA (CANDA INCORPORATED SIZE SERVICE CANADA INCORPORATED SIZE SERVICE SERV	пррепаіх і	- List of Drug Manufacturers		Non-insured ficultif Deficilts
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MFR	Manufacturer Name	MFR	Manufacturer Name	
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	PFI	RELPAX	20MG TABLET
02256304	PFI	RELPAX	40MG TABLET

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APPENDIX H

NEW LISTINGS

The following items have been added to the NIHB Drug Benefit List since it was last published. Some of these items may have specific criteria for use. Please consult Appendix A for criteria.

DIN	MFR	Brand Name	Strength and Dosage Form	Date Adde
02468964	ACC	ACH-OLMESARTAN HCTZ	40MG & 25MG TABLET	2019-11-05
02438941	ACC	ACH-ROSUVASTATIN	40MG TABLET	2019-11-05
02438933	ACC	ACH-ROSUVASTATIN	20MG TABLET	2019-11-05
02438925	ACC	ACH-ROSUVASTATIN	10MG TABLET	2019-11-05
02438917	ACC	ACH-ROSUVASTATIN	5MG TABLET	2019-11-05
02481863	ANG	AG-ALLOPURINOL	100MG TABLET	2019-11-05
02481871	ANG	AG-ALLOPURINOL	200MG TABLET	2019-11-05
02481898	ANG	AG-ALLOPURINOL	300MG TABLET	2019-11-05
02481677	ANG	AG-PERINDOPRIL	2MG TABLET	2019-11-05
02488027	PDL	ARIPIPRAZOLE	10MG TABLET	2019-10-15
02488019	PDL	ARIPIPRAZOLE	5MG TABLET	2019-10-15
02488035	PDL	ARIPIPRAZOLE	15MG TABLET	2019-10-15
02488043	PDL	ARIPIPRAZOLE	20MG TABLET	2019-10-15
02488051	PDL	ARIPIPRAZOLE	30MG TABLET	2019-10-15
02488000	PDL	ARIPIPRAZOLE	2MG TABLET	2019-10-15
02428334	AUR	AURO-GABAPENTIN	600MG TABLET	2019-10-16
02428342	AUR	AURO-GABAPENTIN	800MG TABLET	2019-10-16
02476509	AUR	AURO-OLMESARTAN HCTZ	40MG & 25MG TABLET	2019-11-20
02476487	AUR	AURO-OLMESARTAN HCTZ	20MG & 12.5MG TABLET	2019-11-20
02476495	AUR	AURO-OLMESARTAN HCTZ	40MG & 12.5MG TABLET	2019-11-20
97799899	BTD	BD GLUCOSE	TABLET	2019-11-25
80090977	BMI	BIO CAL-D3	500-400MGU TABLET	2019-10-16
02481170	BMI	BIO-ESCITALOPRAM	20MG TABLET	2019-11-05
02481154	BMI	BIO-ESCITALOPRAM	10MG TABLET	2019-11-05
02462168	BMI	BIO-FLUCONAZOLE	150MG CAPSULE	2019-11-05
02450151	BMI	BIO-GABAPENTIN	300MG CAPSULE	2019-10-16
02450194	BMI	BIO-GABAPENTIN	800MG TABLET	2019-10-16
02450178	BMI	BIO-GABAPENTIN	400MG CAPSULE	2019-10-16
02450143	BMI	BIO-GABAPENTIN	100MG CAPSULE	2019-10-16
02450186	BMI	BIO-GABAPENTIN	600MG TABLET	2019-10-16
02484471	BMI	BIO-SIMVASTATIN	40MG TABLET	2019-10-30
02484463	BMI	BIO-SIMVASTATIN	20MG TABLET	2019-10-30
02484455	BMI	BIO-SIMVASTATIN	10MG TABLET	2019-10-30
80089250	BMI	BIO-VITAMINE D3	1000UI CAPSULE	2019-10-30
02458845	UNK	BISACODYL	5MG SUPPOSITORY	2019-11-05
02455005	AZC	BRILINTA	60MG TABLET	2019-09-27
02455005				
	PFR	BUTRANS 10	10MCG PATCH	2019-12-12
02450771	PFR	BUTRANS 15	15MCG PATCH	2019-12-12
02341220	PFR	BUTRANS 20	20MCG PATCH	2019-12-12
02341174	PFR	BUTRANS 5	5MCG PATCH	2019-12-12
02460297	UNK	COMFILAX	100% POWDER FOR SOLUTION	2019-11-20
09991092	UNK	DEX-4 GLUCOSE	4G TABLET	2019-11-25
02470365	SAC	DUPIXENT	150MG SOLUTION	2019-12-11
02478374	JSO	ERLEADA	60MG TABLET	2019-09-25
02404524	EIS	FYCOMPA	4MG TABLET	2019-09-18
02404532	EIS	FYCOMPA	6MG TABLET	2019-09-18
02404540	EIS	FYCOMPA	8MG TABLET	2019-09-18
02404559	EIS	FYCOMPA	10MG TABLET	2019-09-18
02404567	EIS	FYCOMPA	12MG TABLET	2019-09-18
02404516	EIS	FYCOMPA	2MG TABLET	2019-09-18
02469812	GLK	GLN-OLMESARTAN	20MG TABLET	2019-10-16

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The following items have been added to the NIHB Drug Benefit List since it was last published. Some of these items may have specific criteria for use. Please consult Appendix A for criteria.

DIN	MFR	Brand Name	Strength and Dosage Form	Date Added
02469820	GLK	GLN-OLMESARTAN	40MG TABLET	2019-10-16
99505005	UNK	H2RA SOLID	MISCELLANEOUS	2019-10-02
02470152	LIL	HUMALOG	100U SOLUTION	2019-10-18
02368080	VTH	IBUPROFEN	200MG TABLET	2019-10-01
95900209	NES	ISOSOURCE FIBRE 1.2 CAL 250ML LIQ	ORAL LIQUID	2019-11-13
02473240	JMP	JAMP CANDESARTAN-HCT	16MG & 12.5MG TABLET	2019-11-20
02483734	JMP	JAMP CLINDAMYCIN	150MG CAPSULE	2019-11-20
02483742	JMP	JAMP CLINDAMYCIN	300MG CAPSULE	2019-11-20
02487012	JMP	JAMP EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE	300MG & 200MG TABLET	2019-11-05
02487772	JMP	JAMP FINGOLIMOD	0.5MG CAPSULE	2019-12-09
02484315	JMP	JAMP ITRACONAZOLE	10MG SOLUTION	2019-11-05
02477009	JMP	JAMP PERINDOPRIL	2MG TABLET	2019-09-18
02458233	JMP	JAMP-EFAVIRENZ	600MG TABLET	2019-10-16
80018706	JAM	LACTASE 4500 FCCLU	150MG TABLET	2019-10-30
99113701	UNK	LOSARTAN (PQ)	100MG CAPSULE	2019-10-01
02469189	LUP	LUPIN-CEPHALEXIN	250MG POWDER FOR SUSPENSION	2019-10-16
02469170	LUP	LUPIN-CEPHALEXIN	125MG POWDER FOR SUSPENSION	2019-10-16
02487837	MAR	MAR-LACOSAMIDE	200MG TABLET	2019-11-05
02487802	MAR	MAR-LACOSAMIDE	50MG TABLET	2019-11-05
02487829	MAR	MAR-LACOSAMIDE	150MG TABLET	2019-11-05
02487810	MAR	MAR-LACOSAMIDE	100MG TABLET	2019-11-05
02273357	MCL	MAXIMUM STRENGTH PEPCID AC	20MG TABLET	2019-09-27
02479931	MAN	M-CLINDAMYCIN	300MG CAPSULE	2019-10-01
02479923	MAN	M-CLINDAMYCIN	150MG CAPSULE	2019-10-16
02481979	UNK	METHADONE HYDROCHLORIDE CONCENTRATE	10MG SOLUTION	2019-11-01
02408600	MIN	MINT-DONEPEZIL	5MG TABLET	2019-10-16
02408619	MIN	MINT-DONEPEZIL	10MG TABLET	2019-10-16
02410192	MIN	MINT-OLANZAPINE	15MG TABLET	2019-11-05
02410141	MIN	MINT-OLANZAPINE	2.5MG TABLET	2019-11-05
02410168	MIN	MINT-OLANZAPINE	5MG TABLET	2019-11-05
02410176	MIN	MINT-OLANZAPINE	7.5MG TABLET	2019-11-05
02410184	MIN	MINT-OLANZAPINE	10MG TABLET	2019-11-05
02477777	UNK	MONOFERRIC	100MG SOLUTION	2019-12-04
99501007	UNK	NSAID IN TRANSDERMAL BASE	GEL	2019-12-03
97799140	UNK	ONETOUCH DELICAPLUS 30G LANCET	LANCET	2019-11-01
80074173	ABB	PEDIALYTE	5G/L LIQUID	2019-10-01
02488949	PDL	PERINDOPRIL ERBUMINE	2MG TABLET	2019-10-15
02488957	PDL	PERINDOPRIL ERBUMINE	4MG TABLET	2019-10-15
02488965	PDL	PERINDOPRIL ERBUMINE	8MG TABLET	2019-10-15
02401312	ALV	PIPERACILLIN AND TAZOBACTAM	2G & 0.25G POWDER FOR SOLUTION	2019-11-05
02401339	ALV	PIPERACILLIN AND TAZOBACTAM	4G & 0.5G POWDER FOR SOLUTION	2019-11-05
02401320	ALV	PIPERACILLIN AND TAZOBACTAM	3G & 0.375G POWDER FOR SOLUTION	2019-11-05
02469782	PMS	PMS-FINGOLIMOD	0.5MG CAPSULE	2019-11-28
95900058	NES	RESOURCE 2.0 237ML LIQ		2019-09-26
95900030	NES	RESOURCE DIABETIC 1.5L	ORAL LIQUID	2019-11-04
02489058	RIV	RIVA-DAPSONE	ORAL LIQUID	2019-11-20
02703000	1317	1VI DIN CONE	100MG TABLET	2010-11-20

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The following items have been added to the NIHB Drug Benefit List since it was last published. Some of these items may have specific criteria for use. Please consult Appendix A for criteria.

DIN	MFR	Brand Name	Strength and Dosage Form	Date Added
02489414	RIV	RIVA-LABETALOL	200MG TABLET	2019-10-30
02489406	RIV	RIVA-LABETALOL	100MG TABLET	2019-10-30
99111294	UNK	SALBUTAMOL (QC)	2MG CAPSULE	2019-10-01
02487748	SDZ	SANDOZ GEFITINIB	250MG TABLET	2019-11-05
02478897	SDZ	SANDOZ MORPHINE SR	200MG TABLET (EXTENDED RELEASE)	2019-12-10
95900184	ABB	SIMILAC LOWER IRON 850G PDR	POWDER	2019-09-26
02480557	FRS	STROMECTOL	3MG TABLET	2019-12-11
99113709	UNK	TAMOXIFEN (QC)	10MG CAPSULE	2019-11-01
02488728	PDL	TRANDOLAPRIL	4MG CAPSULE	2019-11-20
02488698	PDL	TRANDOLAPRIL	1MG CAPSULE	2019-11-20
02488701	PDL	TRANDOLAPRIL	2MG CAPSULE	2019-11-20
99501009	UNK	TRANSDERMAL LIDOCAINE W/NSAID	OINTMENT	2019-12-03
02474522	GSK	TRELEGY ELLIPTA	100MCG & 62.5MCG & 25MCG POWDER	2019-12-11
02471574	UNK	VELPHORO	500MG TABLET (CHEWABLE)	2019-12-11
02489686	RIV	VENLAFAXINE XR	75MG CAPSULE (EXTENDED RELEASE)	2019-12-01
80068574	UNK	VITACELL VITAMIN D3 SOFTGELS	25MCG CAPSULE	2019-10-30
02442671	SAN	ZOLMITRIPTAN ODT	2.5MG TABLET (ORALLY DISINTEGRATING)	2019-11-20

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APPENDIX I

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: Palliative 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, 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

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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

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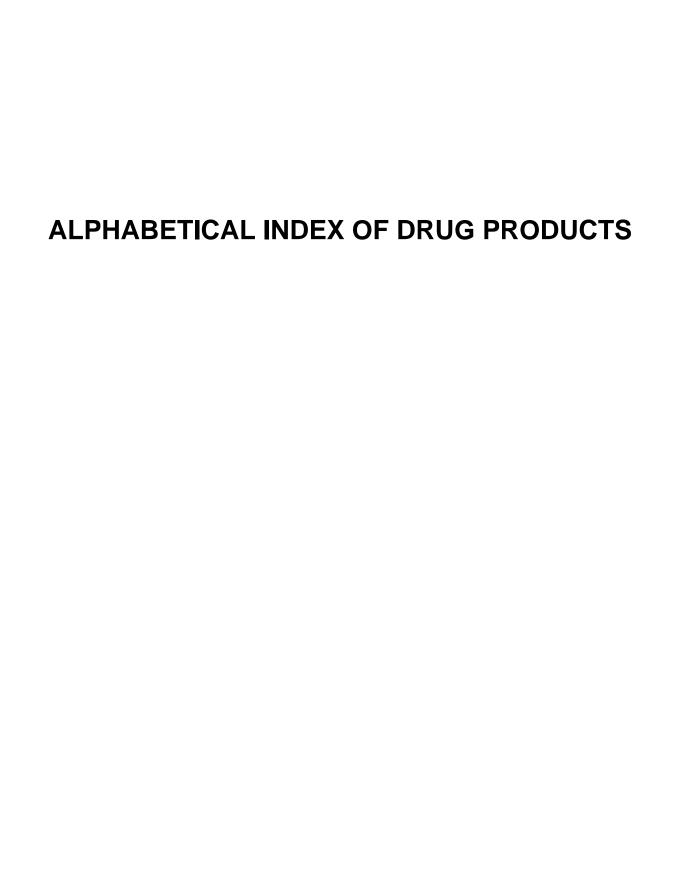
The Non-Insured Health Benefits (NIHB) program has established a nutrition product formulary for clients who require medically necessary nutrition products.

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: Palliative 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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Non-Insured Health Benefits

				Non-insured nearth	Denenia
24 HOUR ALLERGY REMEDY	1	ACH-ANASTROZOLE	17	ACT ROPINIROLE	99
3TC	11	ACH-BICALUTAMIDE	18	ACT SUMATRIPTAN	96
AA-AMILZIDE	109	ACH-CANDESARTAN	58	ACT TEMOZOLOMIDE	26
AA-CLOZAPINE	86	ACH-CAPECITABINE	18	ACT TERBINAFINE	9
AA-FENO-MICRO	42	ACH-ESCITALOPRAM	82	ACT VENLAFAXINE XR	85
AA-TRIMEBUTINE	30	ACH-EZETIMIBE	41	ACTEMRA	161
ABACAVIR SUFLATE, LAMIVUDINE	10	ACH-FINASTERIDE	156	ACTIKERALL	148
ABACAVIR SULFATE	10	ACH-FLUOXETINE	82	ACTONEL	159
ABACAVIR SULFATE, LAMIVUDINE	10	ACH-LETROZOLE	22	ACULAR	115
ABACAVIR SULFATE, LAMIVUDINE, DOLUTEGRAVIR SODIUM	10	ACH-MYCOPHENOLATE	162	ACUVAIL	115
ABACAVIR SULFATE, LAMIVUDINE,	10	ACH PIOCUTAZONE	61	ACYCLOVIR	13
ZIDOVUDINE	10	ACH POOLINA CTATIN	137	ADALAT XL	53
ABATACEPT	160	ACH-ROSUVASTATIN ACH-TELMISARTAN HCTZ	44 61	ADALIMUMAB	160 146
ABENOL	72	ACITRETIN	146	ADAPALENE ADCIRCA	48
ABILIFY	85	ACLASTA	159	ADDERALL XR	91
ABILIFY MAINTENA	86	ACLIDINIUM BROMIDE	29	ADEFOVIR DIPIVOXIL	13
ABIRATERONE ACETATE	17	ACLIDINIUM BROMIDE, FORMOTEROL	31	ADEMPAS	111
ABOBOTULINUMTOXINA	163	FUMARATE DIHYDRATE	31	ADHESHIVE WIPES	165
ACAMPROSATE CALCIUM	99	ACT AMLODIPINE	51	ADMINISTRATION DIN	171
ACARBOSE	133	ACT AMPHETAMINE XR	91	ADRENALIN	32
ACCEL PIOGLITAZONE	137	ACT ANASTROZOLE	17	ADULT	171
ACCEL-CANDESARTAN	58	ACT ATENOLOL	49	ADVAGRAF	163
ACCEL-CANDESARTAN/HCTZ	58	ACT BUPRENORPHINE/NALOXONE	71	ADVAIR 100 DISKUS	32
ACCEL-CITALOPRAM	80	ACT BUPROPION XL	80	ADVAIR 125	32
ACCEL-SEVELAMER	108	ACT CELECOXIB	64	ADVAIR 250	32
ACCEL-TOPIRAMATE	79	ACT CIPROFLOXACIN	6	ADVAIR 250 DISKUS	32
ACCU-CHEK ADVANTAGE	103	ACT CITALOPRAM	80	ADVAIR 500 DISKUS	32
ACCU-CHEK AVIVA	103	ACT CLARITHROMYCIN XL	4	ADVIL	65
ACCU-CHEK COMPACT	103	ACT CLOPIDOGREL	39	ADVIL 12 HOUR	66
ACCU-CHEK FASTCLIK LANCET	167	ACT DEXTROAMPHETAMINE SR	92	ADVIL EXTRA STRENGTH	66
ACCU-CHEK GUIDE (ON)	103	ACT DILTIAZEM CD	53	ADVIL PEDIATRIC DROPS	65
ACCU-CHEK GUIDE (SK)	103	ACT DILTIAZEM T	53	AERIUS	1
ACCU-CHEK MOBILE BG	103	ACT DORZOTIMOLOL	116	AERIUS KIDS	1
ACCU-CHEK MOBILE CASSETT	103	ACT DUTASTERIDE	156	AEROCHAMBER AC BOYZ	165
ACCU-CHEK MULTICLIX LANCET	167	ACT ENALAPRIL	54	AEROCHAMBER AC GIRLZ	165
ACCUPPI	167	ACT ESCITALOPRAM ODT	82	AEROCHAMBER PLUS FLOWVU	165
ACCUPETIC	56 56	ACT ETIDRONATE	159	LARGE	
ACCURETIC ACCUTANE ROCHE	56 147	ACT FAMOLOL OVER	20	AEROCHAMBER PLUS FLOWVU MEDIUM	165
ACCUTREND	103	ACT FLUCONAZOLE	13 9	AEROCHAMBER PLUS FLOWVU	165
ACEBUTOLOL	49	ACT FLUCONAZOLE ACT FLUOXETINE	9 82	MOUTH	100
ACEBUTOLOL HYDROCHLORIDE	49	ACT FLUVOXAMINE	82	AEROCHAMBER PLUS FLOWVU	165
ACENOCOUMAROL	36	ACT LATANOPROST/TIMOLOL	116	AEROTRACH PLUS	165
ACET	72	ACT LEVETIRACETAM	76	AFATINIB DIMALEATE	17
ACET 120	72	ACT LEVOFLOXACIN	6	AFINITOR	20
ACET 325	72	ACT LOVASTATIN	43	AFINITOR DISPERZ	20
ACET 650	72	ACT MELOXICAM	66	AFLIBERCEPT	117
ACETAMINOPHEN	72	ACT METFORMIN	133	AG-ALLOPURINOL	156
ACETAMINOPHEN	72	ACT METHYLPHENIDATE ER	92	AG-AMITRIPTYLINE	80
ACETAMINOPHEN, CAFFEINE	67	ACT MOXIFLOXACIN	113	AG-AMLODIPINE	52
CITRATE, CODEINE PHOSPHATE		ACT NABILONE	122	AG-AMOXICILLIN	5
ACETAMINOPHEN, CODEINE PHOSPHATE	67	ACT OLANZAPINE ODT	88	AG-ATENOLOL AG-ATORVASTATIN	49 42
ACETAMINOPHEN, OXYCODONE	67	ACT OLMESARTAN	60	AG-AZITHROMYCIN	42
HYDROCHLORIDE	01	ACT OLMESARTAN HCT	61	AG-AZITIROMTCIN AG-CELECOXIB	64
ACÉTAMINOPHÈNE	72	ACT OLOPATADINE	113	AG-CELECOXIB AG-CITALOPRAM	80
ACÉTAMINOPHÈNE BLASON SHIELD	72	ACT ONDANSETRON	121	AG-DULOXETINE	81
ACETAZOLAMIDE	116	ACT PAROXETINE	83	AG-ESCITALOPRAM	82
ACETAZOLAMIDE	116	ACT PIOGLITAZONE	137	AG-EZETIMIBE	42
ACETYLSALICYLIC ACID	64	ACT PRAMIPEXOLE	98	AG-GABAPENTIN	74
ACETYLSALICYLIC ACID	64	ACT DALOVIENE	89	AGGRENOX	48
ACETYLSALICYLIC ACID,	68	ACT PANITIONS	133	AG-IRBESARTAN	59
OXYCODONE HYDROCHLORIDE		ACT REPACTINIDE	123	AG-LOSARTAN	60
ACH-ALENDRONATE	158	ACT RIZATRIDIAN	135	AG-MOXIFLOXACIN	7
		ACT RIZATRIPTAN	96		

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Non-Insured Health Benefits

AGE-BARTOR					Non-insured nearth be	enents
AG-PARONER 150	AG-OLMESARTAN	60	ALLOPURINOL ORAL LIQUID	156	ANTIFUNGAL DROPS	154
AG PERINDOPRIL 55 ALPHAGAN 115 ANUGESIG NC 144 AG-PEREAGABAIN 77 ALPHAGAN 115 ANUGESIG NC 144 AG-PEREAGABAIN 77 ALPHAGAN 115 ANUGESIG NC 144 AG-PEREAGABAIN 77 ALPHAGAN 93 APRA CARTINDE 175 AG-AG-RISPERIONE 90 ALPHAGAN 93 APRA SOLOSTAR 135 AG-RISPERIONE 90 ALPHAGAN 93 APRA SOLOSTAR 135 AG-RISPERIONE 90 ALPHAGAN 93 APRA SOLOSTAR 135 AG-RISPERIONE 107 ALPHAGAN 135 AG-RISPERIONE 107 APRAZOLAM 93 APRA SOLOSTAR 135 AG-RISPERIONE 107 ARPAZOLAM 135 AG-SIRVARATIN 144 ALYSENO 21 131 APPOAGRAM 37 AG-SIRVARATIN 144 ALYSENO 21 131 APPOAGRAM 137 AG-SIRVARATIN 147 ARROSCO 127 AR	AG-PANTOPRAZOLE	124	ALMOTRIPTAN	95	ANTI-NAUSEANT	121
AG-PRECABALN 77 ALPHAGAN 15 ANUSOL HC 144 AG-ORDECABALN 77 ALPHAGAN 9 31 APIDRA CARTITIODE 157 AG-ORDECABALN 97 ALPHAGAN 93 APIDRA CARTITIODE 158 AG-RAMPRIL 57 ALPHAGAN 93 APIDRA CARTITIODE 158 AG-BAMPRIL 57 ALPHAGAN 93 APIDRA CARTITIODE 158 AG-BAMPRIL 37 ALPHAGAN 93 APIDRA CARTITIODE 158 AG-RAMPRIL 37 ALPHAGAN 93 APIDRA CARTITIODE 158 AGRINN 38 ALVESCO 129 AGRINN 38 ALVESCO 129 EXTRACT 1 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 AG-SERTALINE 84 ALYESNA 22 151 AGRINN 37 ALPHAGAN 172 ALPHAGAN 172 ALPHAGAN 172 ALCHOL SWABS SIB BUTTERFLY 166 AMILORIDE ALPHAGAN 172 ALCHOL SWABS ANTISEPID SINI 167 ALCHOL SWABS A	AG-PANTOPRAZOLE SODIUM	124	ALMOTRIPTAN MALATE	95	ANTIVIRAL DROPS	154
AG-REGABALIN 77 ALPHAGAIN P 115 APALUTAMIDE 177 AG-GOUETHAPINE 09 ALPAZOLAM 93 APRICA SACRITIDOSE 155 AG-RAMPRIL 57 ALPAZOLAM 93 APRICA SACRITIDOSE 155 AG-RISPERICONE 90 ALTACE 57 APRICA VIAL 135 AG-RISPERICONE 91 ALTACE 177 APRICA VIAL 135 AG-RISPERICONE 91 ALTACE 177 APRICA VIAL 135 AG-RISPERICONE 91 ALTACE 177 APRICA VIAL 135 AG-RISPERICONE 91 ARTACE 177 APRICA VIAL 135 AG-RISPERICONE 154 ALTACE 177 APRICA VIAL 135 AG-SIRMASTATIN 44 ALYSENA 22 151 APACAGAN 77 AG-SIRMASTATIN 44 ALYSENA 28 APACAGAN 77 AG-SIRMASTATIN 44 ALYSENA 28 APACAGAN 77 AG-COLMITERPAN DOT 97 AMARTISANIC HYDROCHLORIDE 101 APACAGAN 77 AG-COLMITERPAN DOT 97 AMARTISANIC HYDROCHLORIDE 101 APACAGAN 77 AG-COLMITERPAN DOT 97 AMARTISANIC HYDROCHLORIDE 101 APACAGAN 78 ARCHIR 32 AMCINONIDE 113 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULTERELY 101 AMARTISANIC SULFATE 101 APACAGAN 78 ALCOHOL SINAS SERVIS SULFATE 1	AG-PAROXETINE	83	ALOMIDE	113	ANUGESIC HC	144
AG CHETAPINE 89 ALPRAZOLAM 93 APIDRA CARTRIDICE 135 AG RAMPRIN 57 ALPRAZOLAM 93 APIDRA SCLOSTAR 135 AG RAMPRIN 36 ALTACE 57 APIDRA SCLOSTAR 135 AG ROSLIVASTATIN 44 ALTACE HOT 57 APIDRA SCLOSTAR 135 AGRIVAN 38 ALVESCO 120 EXTRACT 37 AG SERTRALINE 84 ALYSENA 21 131 APPACEAN PROPER 155 AGSERTRALINE 94 ALYSENA 21 131 APACACETAMINOPHEN 72 AG SERTRALINE 77 AMANTADINE HYDROCHLORIDE 100 APO ASA ACET MAINOPHEN 72 AG SERTRALINE 77 AMANTADINE HYDROCHLORIDE 100 APO ASA ACET MAINOPHEN 72 AG COLUMITED AND 197 AMBRISERTAN 48 APO CARBAMAZEPINE 74 AGROME 32 AMCINONIDE 101 AMENCE 100 APO GURBEN PURPINA 121 AKYNZEO 121 AMENCE 100 APO CHEMBER 108 ALCOHOL SWASS 808 INTERFLY 166 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 166 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 106 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 106 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 106 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 106 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 100 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 101 AMICORDE 101 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 101 AMICORDE 101 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 101 AMICORDE 101 APO GURBEN PURPINA 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 101 AMICORDE 101 APO GURBEN 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 101 AMICORDE 101 APO GURBEN 101 ALCOHOL SWASS 808 INTERFLY 101 AMILORIDE 101 AMICORDE 101 APO GURBEN 101 APO GURBEN 101 AND GURBEN 101 AMICORDE 101 AMICORDE 101 AMICORDE 101 AMICORDE 101 APO GURBEN 101 AMICORDE 101 AMICORDE 101 AMICORDE 101 APO GURBEN 101 AMICORDE 101 AMICORDE 101 AMICORDE 101 AMICORDE 10				115	ANUSOL HC	
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AGROSUNASTATIN 44 ALTACE HOTT 57 APIBRA VIAL 195 AGRIVIN 38 ALVESICO 129 EXTRACT AGS SERTRALINE 44 ALTACE HOTT 131 APPABAN 37 AGS SERTRALINE 44 ALTACE HOTT 131 APPABAN 62 AGS COLUMITIES TAND 1 97 AMBRISERTAN 48 APO CARBAMADE 124 AGS COLUMITIES TAND 1 97 AMBRISERTAN 48 APO CARBAMADE 124 AGS COLUMITIES TAND 1 197 AMBRISERTAN 184 APO CORBINDE 108 AGS COLUMITIES TAND 1 198 AMBRISERTAN 185 APO CARBAMADE 118 AGRICULUS SINGER 1 186 AMBRICAN SULFATE 2 APO HALD PERBIOL 187 ALCOHOL SIVARIS 888 BIS BIS 169 AMBRICAN SULFATE 2 APO HALD PERBIOL 187 ALCOHOL SIVARIS 888 BIS BIS 169 AMBRICAN SULFATE 2 APO HALD PERBIOL 186 ALCOHOL SIVARIS 888 FIS 169 AMBRICAN SULFATE 2 APO HALD PERBIOL 168 ALCOHOL SIVARIS 888 FIS 169 AMBRICAN SULFATE 2 APO HALD PERBIOL 168 ALCOHOL SIVARIS 888 FIS 169 AMBRICAN SULFATE 2 APO HALD PERBIOL 168 ALCOHOL SIVARIS 888 FIS 169 AMBRICAN SULFATE 2 APO HALD PERBIOL 168 ALCOHOL SIVARIS 888 FIS 169 AMBRICAN SULFATE 2 APO HALD PERBIOL 168 ALCOHOL SIVARIS SISS SULFATE 1 169 AMBRICAN SULFATE 2 APO HALD PERBIOL 168 ALCOHOL SIVARIS SISS FIS SULFATE 1 169 APO BUSINOS FIS APO METOPROLOL (TYPE L) 50 ALCOHOL SIVARIS SISS FIS SULFATE 1 169 APO BUSINOS FIS APO METOPROLOL (TYPE L) 50 ALCOHOL SIVARIS SISS FIS SULFATE 1 169 APO BUSINOS FIS APO METOPROLOL (TYPE L) 50 ALCOHOL SIVARIS SISS FIS SULFATE 1 169 APO BUSINOS FIS APO APO CONZETS AND SULFATE 1 169 APO BUSINOS FIS APO ABBRICAN SULFATE 1 169 APO BUSINOS FIS APO ABBRICAN SULFATE 1 169 APO APO CONZETS AND SULFATE 1 169 APO PERS VIX SULFATE 1 169 APO ABBRICAN SULFATE 1						
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AG SERTRAINE						
ACSERTRALINE 94 ALYSENA 21 131 APIXABAN 37 ACSEMASTATIN 44 PLYSENA 28 131 APIXABAN 7.72 ACSTOPRAMATE 77 AGATOPRAMATE 78 AGATOPRAMATE 79 AMANTADINE HYDROCHLORIDE 19 ACCORDINATION 19 AMANTADINE HYDROCHLORIDE 19 ACCORDINATION 11 A						155
ACSTOPHRAMTE 49 AMONTADINE HYDROCHLORIDE 10 AGACTOPHRAMTE 79 AMBRISENTAN 46 AMBRISENTAN 46 AGACTOPHRAMTE 79 AMBRISENTAN 46 AMBRISEN						27
AS-TOPIRAMATE 79 AMANTADNE HYDROCHLORIDE 10 APO CARBAMAZERNE 74 ARCOUNTRY AND 71 AMBRISHMENT 48 APO CARBAMAZERNE 74 ARROME 32 AMBRISHMENT 48 APO CARBAMAZERNE 74 ARROME 121 ARCHORD 122 ARCHORD 122 ARCHORD 123 ARCHORD 124 AR						
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ALLERJECT 32 ANDROGEL 130 APO-ATENIDONE 49 ALLERNIX 1 ANETHOLE TRITHIONE 117 APO-ATENOL 49 ALLERNIX ELIXIR 1 ANODAN-HC 144 APO-ATOMOXETINE 99 ALLERNIX EXTRA STRENGTH 1 ANORO ELLIPTA 30 APO-ATORVASTATIN 42 ALLERNIX MULTI SYMPTOM 1 ANTACID AND LIDOCAINE ORAL 154 APO-AZATHIOPRINE 162 ALLERTIN 1 LIQUID APO-AZITHROMYCIN 4 ALLOPURINOL 156 ANTIBIOTIC DROPS 154 APO-BACLOFEN 33	ALLERGY RELIEF	1	ANDROCUR	163	APO-ARIPIPRAZOLE	85
ALLERNIX	ALLERGY REMEDY	1	ANDRODERM	130	APO-ASA LD	64
ALLERNIX ELIXIR 1 ANODAN-HC 144 APO-ATOMOXETINE 99 ALLERNIX EXTRA STRENGTH 1 ANORO ELLIPTA 30 APO-ATORVASTATIN 42 ALLERNIX MULTI SYMPTOM 1 ANTACID AND LIDOCAINE ORAL 154 APO-AZATHIOPRINE 162 ALLERTIN 1 ANTIBIOTIC DROPS 154 APO-BACLOFEN 33 ALLOPURINOL 156 ANTIBIOTIC OINT	ALLERJECT	32	ANDROGEL	130	APO-ATENIDONE	49
ALLERNIX EXTRA STRENGTH 1 ANORO ELLIPTA 30 APO-ATORVASTATIN 42 ALLERNIX MULTI SYMPTOM 1 ANTACID AND LIDOCAINE ORAL 154 APO-AZATHIOPRINE 162 ALLERTIN 1 ANTIBIOTIC DROPS 154 APO-BACLOFEN 33	ALLERNIX	1	ANETHOLE TRITHIONE	117	APO-ATENOL	49
ALLERNIX MULTI SYMPTOM 1 ANTACID AND LIDOCAINE ORAL 154 APO-AZATHIOPRINE 162 ALLERTIN 1 LIQUID APO-AZITHROMYCIN 4 ALLOPURINOL 156 ANTIBIOTIC OINT 1414 ANTIBIOTIC OINT 1414	ALLERNIX ELIXIR	1	ANODAN-HC	144	APO-ATOMOXETINE	99
ALLERTIN 1 LIQUID APO-AZITHROMYCIN 4 ALLOPURINOL 156 ANTIBIOTIC OINT 1414 ANTIBIOTIC OINT 1414	ALLERNIX EXTRA STRENGTH	1	ANORO ELLIPTA	30	APO-ATORVASTATIN	42
ALLOPURINOL 156 ANTIBIOTIC DROPS 154 APO-BACLOFEN 33	ALLERNIX MULTI SYMPTOM	1		154	APO-AZATHIOPRINE	162
ALLOPURINOL 156 APO-DACLOFEN 53	ALLERTIN	1		45.	APO-AZITHROMYCIN	4
ALLOPURINOL 156 ANTIBIOTIC VINT 141 APO-BECLOMETHASONE 114	ALLOPURINOL	156			APO-BACLOFEN	33
	ALLOPURINOL	156	ANTIBIOTIC OINT	141	APO-BECLOMETHASONE	114

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				Non-insured nearth be	enents
APO-BENZYDAMINE	115	APO-FERROUS GLUCONATE	36	APO-METOPROLOL	50
APO-BICALUTAMIDE	18	APO-FINASTERIDE	156	APO-METOPROLOL (TYPE L)	50
APO-BISACODYL	119	APO-FLECAINIDE	41	APO-METOPROLOL SR	50
APO-BISOPROLOL	49	APO-FLUCONAZOLE	9	APO-METRONIDAZOLE	15
APO-BOSENTAN	48	APO-FLUOXETINE	82 65	APO-MIDODRINE	30
APO-BRIMONIDINE	115 93	APO-FLURBIPROFEN	65 114	APO MODAFINII	83 92
APO-BROMAZEPAM APO-BUSPIRONE	95 95	APO-FLUTICASONE APO-FLUVOXAMINE	114 82	APO-MODAFINIL APO-MOMETASONE	114
APO-CABERGOLINE	98	APO-FOSINOPRIL	55	APO-MONTELUKAST	110
APOCAL APOCAL	106	APO-GABAPENTIN	74	APOMORPHINE HYDROCHLORIDE	98
APO-CANDESARTAN	58	APO-GEFITINIB	20	APO-MOXIFLOXACIN	7
APO-CANDESARTAN/HCTZ	58	APO-GEMFIBROZIL	42	APO-MYCOPHENOLATE	162
APO-CAPTO	54	APO-GLICLAZIDE	136	APO-MYCOPHENOLIC ACID	163
APO-CARVEDILOL	50	APO-GLICLAZIDE MR	136	APO-NALTREXONE	73
APO-CEFACLOR	2	APO-GRANISETRON	121	APO-NAPRO-NA	66
APO-CEFADROXIL	2	APO-HALOPERIDOL	86	APO-NAPRO-NA DS	67
APO-CEFPROZIL	2	APO-HYDRALAZINE	47	APO-NAPROXEN	66
APO-CEFUROXIME	3	APO-HYDRO	109	APO-NAPROXEN EC	67
APO-CELECOXIB	64	APO-HYDROMORPHONE	68	APO-NEVIRAPINE XR	11
APO-CEPHALEX	3	APO-HYDROXYQUINE	15	APO-NITROGLYCERIN	47
APO-CETIRIZINE	1	APO-HYDROXYUREA	21	APO-OFLOXACIN	113
APO-CILAZAPRIL	54	APO-IBUPROFEN	65	APO-OLANZAPINE	87
APO-CILAZAPRIL/HCTZ	54	APO-IMATINIB	21	APO-OLANZAPINE ODT	88
APO-CIPROFLOX	6	APO-IMIQUIMOD	147	APO-OLMESARTAN	61
APO-CITALOPRAM	80	APO-INDAPAMIDE	109	APO-OLMESARTAN/HCTZ	61
APO-CLARITHROMYCIN	4	APO-IPRAVENT	30	APO-OLOPATADINE	113
APO-CLARITHROMYCIN XL	4	APO-IRBESARTAN	59	APO-OMEPRAZOLE	124
APO-CLINDAMYCIN	7	APO-IRBESARTAN/HCTZ	59	APO-ONDANSETRON	121
APO-CLOBAZAM	73	APO-ISMN	47	APO-OXCARBAZEPINE	77
APO-CLONAZEPAM	73	APO-K	107	APO-OXYBUTYNIN	149
APO-CLONIDINE	47	APO-KETOCONAZOLE	9	APO-OXYCODONE/ACET	67
APO-CLOPIDOGREL	39	APO-KETOROLAC	115	APO-PANTOPRAZOLE	124 83
APO-CROMOLYN APO-CYCLOBENZAPRINE	111 33	APO-LACTULOSE APO-LAMIVUDINE	105 11	APO-PAROXETINE APO-PERINDOPRIL	56
APO-CYCLOSPORINE	162	APO-LAMIVUDINE HBV	11	APO-PERINDOPRIL-INDAPAMIDE	56
APO-DABIGATRAN	37	APO-LAMIVUDINE-ZIDOVUDINE	11	APO-PHENYTOIN SODIUM	74
APO-DEXAMETHASONE	129	APO-LAMOTRIGINE	76	APO-PINAVERIUM	125
APO-DICLO	65	APO-LANSOPRAZOLE	123	APO-PINDOL	51
APO-DICLO SR	65	APO-LANSOPRAZOLE-AMOXICILLIN-	123	APO-PIOGLITAZONE	137
APO-DICLOFENAC	65	CLARITHROMYCIN		APO-PRAMIPEXOLE	98
APO-DILTIAZ	54	APO-LATANOPROST	116	APO-PRAVASTATIN	43
APO-DILTIAZ CD	53	APO-LATANOPROST-TIMOP	116	APO-PRAZO	48
APO-DIPIVEFRIN	115	APO-LEFLUNOMIDE	161	APO-PREGABALIN	77
APO-DIPYRIDAMOLE	48	APO-LETROZOLE	22	APO-PROCAINAMIDE	41
APO-DIVALPROEX	79	APO-LEVETIRACETAM	76	APO-PROPAFENONE	41
APO-DOMPERIDONE	124	APO-LEVOBUNOLOL	116	APO-QUETIAPINE	89
APO-DONEPEZIL	28	APO-LEVOCARB	97	APO-QUETIAPINE XR	89
APO-DORZO-TIMOP	116	APO-LEVOFLOXACIN	6	APO-QUINAPRIL	56
APO-DOXAZOSIN	48	APO-LINEZOLID	8	APO-QUINAPRIL/HCTZ	56
APO-DOXY	7	APO-LISINOPRIL	55	APO-RABEPRAZOLE	124
APO-DULOXETINE	81	APO-LITHIUM CARBONATE	95 110	APO-RALOXIFENE	133
APO-DUTASTERIDE	156	APO-LOPERAMIDE APO-LORATADINE	119	APO-RAMIPRIL	57
APO-EFAVIRENZ-EMTRICITABINE- TENOFOVIR	11	APO-LORAZEPAM	1 94	APO-RAMIPRIL/HCTZ	57
APO-EMTRICITABINE-TENOFOVIR	12	APO-LOSARTAN	60	APO-RANITIDINE	123
APO-ENALAPRIL	54	APO-LOSARTAN/HCTZ	60	APO-REPAGLINIDE	135
APO-ENTECAVIR	13	APO-LOVASTATIN	43	APO-RISEDRONATE	159
APO-ERLOTINIB	20	APO-MEDROXY	137	APO-RISPERIDONE APO-RIVASTIGMINE	90 29
APO-ESCITALOPRAM	82	APO-MELOXICAM	66	APO-RIZATRIPTAN	96
APO-EXEMESTANE	20	APO-METFORMIN	133	APO-RIZATRIFTAN APO-RIZATRIPTAN RPD	96
APO-EZETIMIBE	42	APO-METHOTREXATE	23	APO-ROPINIROLE	99
APO-FAMCICLOVIR	13	APO-METHYLPHENIDATE	92	APO-ROSUVASTATIN	44
APO-FAMOTIDINE	122	APO-METHYLPHENIDATE ER	92	APO-SALBUTAMOL HFA	32
APO-FELODIPINE	53	APO-METHYLPHENIDATE SR	92	APO-SELEGILINE	99
APO-FENO-SUPER	42	APO-METOCLOP	125		

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				Non-insured Health	benenis
APO-SERTRALINE	84	ASA DAILY LOW DOSE	64	AURO-EFAVIRENZ	11
APO-SILDENAFIL R	47	ASA EC	64	AURO-ENTECAVIR	13
APO-SIMVASTATIN	44	ASACOL	125	AURO-ESCITALOPRAM	82
APO-SOLIFENACIN	149	ASAPHEN	64	AURO-EZETIMIBE	42
APO-SOTALOL	51	ASAPHEN EC	64	AURO-FINASTERIDE	156
APO-SUCRALFATE	123	ASATAB	64	AURO-FLECAINIDE	41
APO-SUMATRIPTAN	96	ASATAB EC	64	AURO-FLUOXETINE	82
APO-TADALAFIL PAH	48	ASCENCIA CONTOUR	103	AURO-GABAPENTIN	74
APO-TAMOX	26	ASCENSIA BREEZE 2	103	AURO-GALANTAMINE ER	28
APO-TAMSULOSIN	33	ASCORBIC ACID	151	AURO-IRBESARTAN	59
APO-TELMISARTAN	61	ASCORBIC ACID	151	AURO-IRBESARTAN HCT	59
APO-TELMISARTAN/HCTZ	61	ASENAPINE MALEATE	86	AURO-LACOSAMIDE	75
APO-TEMOZOLOMIDE	26	ASMANEX TWISTHALER	130	AURO-LAMIVUDINE/ZIDOVUDINE	11
APO-TENOFOVIR	12	ASPIRIN	64	AURO-LAMOTRIGINE	76
APO-TERAZOSIN	48	ATACAND	58	AURO-LEVETIRACETAM	76
APO-TERBINAFINE	9	ATACAND PLUS	58	AURO-LISINOPRIL	55
APO-TETRABENAZINE	101	ATARAX	95	AURO-LOSARTAN	60
APO-THEO-LA	150	ATASOL 15	67	AURO-LOSARTAN HCT	60
APO-TIMOP	116	ATAZANAVIR SULFATE	10	AURO-MELOXICAM	66
APO-TOLTERODINE	149	ATENOLOL	49	AURO-METFORMIN	133
APO-TOPIRAMATE	79	ATENOLOL	49	AURO-METRONIDAZOLE	15
APO-TRAVOPROST Z	117	ATENOLOL, CHLORTHALIDONE	49	AURO-MIRTAZAPINE	83
APO-TRAVOPROST-TIMOP	117	ATIVAN	94	AURO-MIRTAZAPINE OD	83
APO-TRAZODONE	84	ATIVAN SUBLINGUAL	94	AURO-MODAFINIL	93
APO-TRAZODONE D	84	ATOMOXETINE	99	AURO-MONTELUKAST	110
APO-TRIAMCINOLONE AQ	114	ATOMOXETINE HYDROCHLORIDE	99	AURO-MOXIFLOXACIN	7
APO-VALACYCLOVIR	13	ATORVASTATIN	42	AURO-NEVIRAPINE	11
APO-VALGANCICLOVIR	14	ATORVASTATIN CALCIUM	42	AURO-OLANZAPINE ODT	88
APO-VALPROIC	79	ATORVASTATIN GALGIOM ATORVASTATIN-10	42	AURO-OLMESARTAN	61
APO-VALSARTAN	61	ATORVASTATIN-10 ATORVASTATIN-20	42	AURO-OLMESARTAN HCTZ	61
APO-VALSARTAN/HCTZ	62	ATORVASTATIN-20 ATORVASTATIN-40	42	AURO-PANTOPRAZOLE	124
APO-VARENICLINE	34	ATORVASTATIN-40 ATORVASTATIN-80	43	AURO-PAROXETINE	83
APO-VENLAFAXINE XR	85			AURO-PERINDOPRIL	56
APO-VERAP	54	ATOVAQUONE	15	AURO-PRAMIPEXOLE	98
APO-VERAP SR	54	ATROPINE	11	AURO-PRAVASTATIN	43
APO-VERAF SK APO-VORICONAZOLE	9	ATROPINE OU FATE	115	AURO-PRAVASTATIN AURO-PREGABALIN	43 77
APO-WARFARIN	38	ATROPINE SULFATE	115	AURO-QUETIAPINE	89
APO-ZIDOVUDINE	36 12	ATROVENT HFA	30	AURO-QUETIAPINE AURO-QUINAPRIL HCTZ	57
APO-ZOLMITRIPTAN	96	AUBAGIO	158	AURO-RAMIPRIL	57 57
APO-ZOLMITRIPTAN RAPID	97	AURANOFIN	127		135
APRACLONIDINE HYDROCHLORIDE	117	AURO-ABACAVIR/LAMIVUDINE	10	AURO-REPAGLINIDE AURO-RISEDRONATE	159
		AURO-ALENDRONATE	158	AURO-RISEDRONATE AURO-RIZATRIPTAN	
APREPITANT	122	AURO-ALFUZOSIN	33		96
APRI 21	131	AURO-AMLODIPINE	52	AURO-ROSUVASTATIN	44
APRI 28	131	AURO-AMOXICILLIN	4	AURO-SERTRALINE	84
APTIOM	74	AURO-ARIPIPRAZOLE	85	AURO-SIMVASTATIN	44
APTIVUS	12	AURO-ATOMOXETINE	99	AURO-SOLIFENACIN	149
APX-OXCARBAZEPINE	77	AURO-ATORVASTATIN	42	AURO-TELMISARTAN	61
AQUA-E	153	AURO-BETAHISTINE	100	AURO-TELMISARTAN HCTZ	61
AQUA-E/ML	153	AURO-CANDESARTAN	58	AURO-TENOFOVIR	12
AQUASOL E	153	AURO-CANDESARTAN HCT	58	AURO-TERBINAFINE	9
AQUASOL E VITAMIN E	153	AURO-CARVEDILOL	50	AURO-TOPIRAMATE	79
ARAVA	161	AURO-CEFIXIME	2	AURO-TRANDOLAPRIL	58
ARICEPT	28	AURO-CEFPROZIL	2	AURO-VALACYCLOVIR	13
ARIMIDEX	17	AURO-CEFUROXIME	3	AURO-VALGANCICLOVIR	14
ARIPIPRAZOLE	85	AURO-CELECOXIB	64	AURO-VALSARTAN	61
ARIPIPRAZOLE	85	AURO-CEPHALEXIN	3	AURO-VALSARTAN HCT	62
ARIPIPRAZOLE (MAINTENA)	86	AURO-CIPROFLOXACIN	6	AURO-VENLAFAXINE XR	85
ARISTOCORT C	145	AURO-CITALOPRAM	80	AURO-ZIPRASIDONE	91
ARISTOCORT R	145	AURO-CLINDAMYCIN	7	AVALIDE	59
ARNUITY ELLIPTA	114	AURO-CLOPIDOGREL	39	AVAPRO	59
AROMASIN	20	AURO-CYCLOBENZAPRINE	33	AVENTYL	83
ARTHROTEC	66	AURO-DONEPEZIL	28	AVIANE 21	131
ARTIFICIAL TEARS	117	AURO-DULOXETINE	81	AVIANE 28	131
ASA	64	AURO-DUTASTERIDE	156	AVODART	156

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				Non-Insured Healti	1 Benefits
AVONEX	157	BD PRECISIONGLIDE 26GX1/2	168	BEZAFIBRATE	42
AVONEX PEN	157	BD PRECISIONGLIDE 26GX3/8	168	BEZALIP SR	42
AXERT	95	BD PRECISIONGLIDE 27GX1 1/4	168	BG STAR	103
AXID	122	BD PRECISIONGLIDE 27GX1/2	168	BG STAR (ON)	103
AXITINIB	18	BD SHARPS CONTAINER 3.1L	168	BG STAR LANCET	167
AZARGA	116	BD SHARPS CONTAINER 3L	168	BIACNA TOPICAL	146
AZATHIOPRINE	162	BD SLIP TIP 10ML SYRINGE	169	BIAXIN	4
		BD SLIP TIP 10ML SYRINGE	168		4
AZATHIOPRINE ORAL LIQUID AZATHIOPRINE-50	162			BIAXIN XL	
	162	BD SLIP TIP 20ML SYRINGE	169	BICALLITAMIDE	18
AZELAIC ACID	147	BD SLIP TIP 30ML SYRINGE	169	BICALUTAMIDE	18
AZILSARTAN MEDOXOMIL	58	BD SLIP TIP 3ML SYRINGE	168	BICILLIN	5
AZITHROMYCIN	3	BD SLIP TIP 5ML SYRINGE	168	BIKTARVY	11
AZITHROMYCIN	4	BD SLIP TIP 60ML SYRINGE	170	BIMATOPROST	116
AZOPT	116	BD SLIP TIP SUB Q 26G SYRINGE	169	BIO CAL-D3	155
AZTREONAM	3	BD SYRINGE + NEEDLE	170	BIO K-20 POTASSIUM	107
B-12	151	BD SYRINGE WITH ULTRA-FINE	170	BIO-AMLODIPINE	51
B6	151	NEEDLE	400	BIO-ANASTROZOLE	17
BABY DDROPS	152	BD TUBERCULIN 21GX1 SYRINGE	169	BIO-ATENOLOL	49
BACIMYXIN ONGUENT	141	BD TUBERCULIN 25GX5/8 SYRINGE	169	BIO-CAL DR FORTE	153
BACITIN	141	BD TUBERCULIN 26GX3/8 SYRINGE	169	BIOCALCIUM	106
BACITRACIN ZINC	141	BD TUBERCULIN 27GX1/2 SYRINGE	169	BIOCALCIUMD	106
BACKORDER INTERNAL POWDER	154	BD ULTRA 29G.1/2CC SYRINGE	169	BIOCALD FORTE	106
BACKUP PLAN ONESTEP	131	BD ULTRA 29G.1CC SYRINGE	169	BIO-CELECOXIB	64
BACLOFEN	33	BD ULTRAFINE 31G 5MM PEN NEEDLE	167	BIO-CIPROFLOXACIN	6
BACLOFEN	33	BD ULTRAFINE 31G 8MM PEN NEEDLE	167	BIO-CITALOPRAM	80
BACLOFEN ORAL LIQUID	33	BD ULTRAFINE 33G LANCET	167	BIODERM	141
BACTERIOSTATIC SODIUM CHLORIDE	107	BD ULTRA-FINE II 30GX0.5CC SYRINGE	169	BIO-DOMPERIDONE	125
	107	BD ULTRA-FINE III PEN NEEDLE	167	BIO-DONEPEZIL	28
BACTERIOSTATIC WATER		BD ULTRA-FINE NANO PEN NEEDLE	168	BIO-ESCITALOPRAM	82
BACTROBAN	141	BD ULTRA-FINE PEN NEEDLE 29G	168		9
BANZEL	78	BECLOMETHASONE DIPROPIONATE	114	BIO-FLUCONAZOLE	
BARACLUDE	13	BEDUZIL	151	BIO-FLUOXETINE	82
BARRIERE	146	BENADRYL	1	BIO-FUROSEMIDE	108
BASAGLAR	135	BENADRYL CHILDRENS	1	BIO-GABAPENTIN	74
BASES-EMULSIONS	171	BENAZEPRIL	54	BIO-HYDROCHLOROTHIAZIDE	109
BC SHARPS CONTAINER 1.4L	168			BIO-IRBESARTAN	59
BD ALCOHOL SWABS	166	BENAZEPRIL HYDROCHLORIDE	54	BIO-LETROZOLE	22
BD AUTOSHIELD DUO SAFETY PEN	167	BENRALIZUMAB	105	BIO-LEVETIRACETAM	76
NEEDLE		BENZACLIN	141	BIO-LOSARTAN	60
BD AUTOSHIELD PEN NEEDLES	167	BENZAGEL	146	BIO-MODAFINIL	93
BD BLUNT 18GX1 1/2 FILTER	167	BENZAGEL 5	146	BIO-MONTELUKAST	110
BD BUTTERFLY NEEDLE 21G	168	BENZAMYCIN	141	BIO-MOXIFLOXACIN	7
BD GLUCOSE	108	BENZODIAZEPINE ORAL LIQUID	73	BIO-OMEPRAZOLE	124
BD LUER-LOK TIP 10ML SYRINGE	169	BENZOYL PEROXIDE	146	BIO-PANTOPRAZOLE	124
BD LUER-LOK TIP 18GX1 1/2 SYRINGE	169	BENZTROPINE MESYLATE	97	BIO-PAROXETINE	83
BD LUER-LOK TIP 1ML SYRINGE	168	BENZTROPINE OMEGA	97	BIO-PRAVASTATIN	43
BD LUER-LOK TIP 20ML SYRINGE	169	BENZYDAMINE HYDROCHLORIDE	115	BIO-QUETIAPINE	89
BD LUER-LOK TIP 22GX1 1/2 SYRINGE	169	BETADERM	143	BIO-ROSUVASTATIN	44
BD LUER-LOK TIP 25GX1 SYRINGE	169	BETADINE	142	BIOSENNOSIDES	120
BD LUER-LOK TIP 25GX1 1/2 SYRINGE	169	BETAGAN	116	BIO-SERTRALINE	84
BD LUER-LOK TIP 25GX5/8 SYRINGE	169	BETAHISTINE	100	BIO-SIMVASTATIN	45
BD LUER-LOK TIP 30ML SYRINGE	169	BETAHISTINE HYDROCHLORIDE	100	BIO-VALACYCLOVIR	13
BD LUER-LOK TIP 3ML SYRINGE	168	BETAMETHASONE DIPROPIONATE	143	BIO-VITAMINE D3	155
BD LUER-LOK TIP 5ML SYRINGE	168	BETAMETHASONE DIPROPIONATE,	141	BI-PEGLYTE	120
BD LUER-LOK TIP 60ML SYRINGE	170	CLOTRIMAZOLE		BISACODYL	119
BD MICRO-FINE 0.3CC SYRINGE	168	BETAMETHASONE DIPROPIONATE,	143	BISACODYL	119
BD MICRO-FINE 28GX0.5CC SYRINGE	169	SALICYLIC ACID			119
BD MICRO-FINE 28GX1CC SYRINGE	169	BETAMETHASONE SODIUM	125	BISACODYL-ODAN	
		PHOSPHATE		BISMUTH	119
BD NANO PRO 32GX4MM PEN NEEDLE	168 168	BETAMETHASONE VALERATE	143	BISMUTH SUBSALICYLATE	119
BD POSIFLUSH SP	168	BETASERON	157	BISMUTH SUBSALICYLATE	119
BD PRECISIONGLIDE 18GX1 1/2	168	BETASERON INITIATION KIT	157	BISOPROLOL	49
BD PRECISIONGLIDE 18GX1 NEEDLE	168	BETAXOLOL HYDROCHLORIDE	115	BISOPROLOL FUMARATE	49
BD PRECISIONGLIDE 25GX1 NEEDLE	167	BETHANECHOL CHLORIDE	28	BLEPHAMIDE	114
BD PRECISIONGLIDE 25GX5/8	168	BETNESOL	125	BOOST DIABETIC 237ML LIQ	171
BD PRECISIONGLIDE 25GX7/8	168	BETOPTIC S	115	BOOST ORIGINAL 237ML LIQ	171
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				Non-insured Health Ben	ents
BOSENTAN MONOHYDRATE	48	CALCIUM 500 VITAMINE D400	106	CEFTRIAXONE STERILE INFUSION	3
BOSULIF	18	CALCIUM CARBONATE	106	CEFUROXIME AXETIL	3
BOSUTINIB	18	CALCIUM CARBONATE VITAMINE D	106	CELEBREX	64
BOTOX	164	CALCIUM CHANNEL BLOCKER IN	154	CELECOXIB	64
BREEZE 2 BG (ON)	103	OINTMENT	101	CELECOXIB	64
BRENZYS	160	CALCIUM GLUCONATE, VIT D	106	CELESTODERM V	143
		CALCIUM POLYSTYRENE SULFONATE	107		
BREO ELLIPTA	31	CALCIUM VITAMIN D LEMON FLAVOUR	106	CELEXA	80
BREVICON 0.5/35 (21-DAY PACK)	131	CALCIUM, VITAMIN D	106	CELLCEPT	162
BREVICON 0.5/35 (28-DAY PACK)	131	CALD 400	106	CELSENTRI	11
BREVICON 1/35 (21-DAY PACK)	131			CENTER-AL	155
BREVICON 1/35 (28-DAY PACK)	131	CALODAN D 400	106	CENTRUM	153
BREXPIPRAZOLE	86	CAMPRAL	99	CENTRUM DHA	153
BRICANYL TURBUHALER	32	CANAGLIFLOZIN	136	CENTRUM FOR WOMEN	153
BRILINTA	39	CANDESARTAN	58	CENTRUM JUNIOR COMPLETE	153
BRIMONIDINE P	115	CANDESARTAN CILEXETIL	58	CENTRUM PRENATAL	153
BRIMONIDINE TARTRATE	115	CANDESARTAN CILEXETIL,	58	CEPHALEXIN	3
BRINZOLAMIDE	116	HYDROCHLOROTHIAZIDE		CEPHALEXIN-500	3
BRINZOLAMIDE, BRIMONIDINE	116	CANDESARTAN-HCT	58	CERITINIB	18
TARTRATE		CANDESARTAN-HCTZ	59	CERTOLIZUMAB PEGOL	160
BRINZOLAMIDE, TIMOLOL MALEATE	116	CANESORAL	9	CERVICAL	102
BRIVARACETAM	74	CANESTEN	141	CESAMET	122
BRIVLERA	74	CANESTEN COMBI-PAK COMFORTAB 1	142	CETIRIZINE	1
BRODALUMAB	147	CANESTEN COMBI-PAK COMFORTAB 3	142	CETIRIZINE HYDROCHLORIDE	1
BROMAZEPAM	93	CANESTEN COMFORTAB 1	142		
BROMOCRIPTINE	98	CANTHACUR 07	146	CHAMPIX	34
		CANTHARIDIN	146	CHAMPIX STARTER PACK	35
BROMOCRIPTINE MESYLATE	98	CANTHARIDIN, PODOPHYLLIN,	146	CHILDREN AND YOUTH	171
BUDESONIDE	114	SALICYLIC ACID	. 40	CHILDREN'S ADVIL	65
BUDESONIDE, SODIUM CHLORIDE	143	CANTHARONE 07	155	CHILDREN'S EUROPROFEN	65
BUPRENORPHINE (BUTRANS)	71	CANTHARONE PLUS	146	CHILDREN'S MOTRIN	65
BUPRENORPHINE HYDROCHLORIDE	71	CAPECITABINE	18	CHLORAMBUCIL	18
BUPRENORPHINE HYDROCHLORIDE,	71	CAPRELSA	27	CHLORHEXIDINE	113
NALOXONE HYDROCHLORIDE		CAPSAICIN	147	CHLORHEXIDINE GLUCONATE	113
BUPROPION HYDROCHLORIDE	80	CAPSAICIN		CHLOROQUINE PHOSPHATE	15
(WELLBUTRIN)			147	CHLORPHENIRAMINE MALEATE	1
BUPROPION HYDROCHLORIDE	80	CAPSAISIN	147	CHLORPROMAZINE HYDROCHLORIDE	86
(ZYBAN)	00	CAPTOPRIL	54	CHLORTHALIDONE	109
BUPROPION SR	80	CARBACHOL	116	CHLORTHALIDONE	109
BUSCOPAN	30	CARBAMAZEPINE	74	CHLOR-TRIPOLON	1
BUSERELIN ACETATE	18	CARBAMAZEPINE	74	CHOLECALCIFEROL	152
BUSPIRONE	95	CARBOCAL	106	CHOLEDYL	150
BUSPIRONE HYDROCHLORIDE	95	CARBOCAL D	106	CHOLESTYRAMINE RESIN	41
BUSULFAN	18	CARBOLITH	95	CHOLESTYRAMINE RESIN	41
BUTRANS 10	71	CARDIZEM CD	53		
BUTRANS 15	71	CARNITOR	108	CHU NICOTINE ANTI SMOKING AID	34
BUTRANS 20	71	CARTRIDGE FOR IR200	165	CICLESONIDE	129
BUTRANS 5	71	CARVEDILOL	50	CICLOPIROX OLAMINE	141
CABERGOLINE	98	CARVEDILOL	50	CIDOMYCIN	2
CADUET	52	CASODEX	18	CILAZAPRIL	54
CAFFEINE CITRATE	93	CAYA CONTOURED DIAPHRAGM	102	CILAZAPRIL,	54
CAFFEINE CITRATE	93	CAYA DIAPHRAGM	148	HYDROCHLOROTHIAZIDE	
CAL500	106	CAYSTON	3	CILOXAN	113
CALCIMAR	137	CEENU	22	CIMETIDINE	122
CALCIPOTRIOL	147	CEFACLOR	2	CIMETIDINE	122
CALCIPOTRIOL, BETAMETHASONE	143	CEFADROXIL	2	CIMZIA	160
DIPROPIONATE	0	CEFAZOLIN	2	CIPRALEX	82
CALCITE 500 D 400	106	CEFAZOLIN SODIUM	2	CIPRO	6
CALCITE LIQUIDE D 400	106			CIPRODEX	113
CALCITONIN SALMON (SYNTHETIC)	137	CEFAZOLIN STERILE INFUSION	2	CIPROFLOXACIN	6
CALCITRIOL	152	CEFIXIME	2	CIPROFLOXACIN HYDROCHLORIDE	6
CALCITRIOL CALCITRIOL-ODAN	152	CEFPROZIL	2	CIPROFLOXACIN HYDROCHLORIDE,	113
CALCIUM CALCIUM	106	CEFTAZIDIME	3	DEXAMETHASONE	
		CEFTAZIDIME	3	CITALOPRAM	80
CALCIUM	106	CEFTIN	3	CITALOPRAM HYDROBROMIDE	80
CALCIUM 500	106	CEFTRIAXONE	3	CITRIC ACID, MAGNESIUM OXIDE,	119
CALCIUM 500 D 400	106	CEFTRIAXONE SODIUM	3	SODIUM PICOSULFATE	
CALCIUM 500 VITAMINE D1000	106	CEFTRIAXONE SODIUM FOR BP	3	CITRIC ACID, SODIUM CITRATE	105

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				Non-insured nearth ben	CIILO
CITRO MAG	119	COLCHICINE	157	COVERSYL PLUS	56
CITRODAN	119	COLCHICINE	157	COVERSYL PLUS HD	56
CLARITHROMYCIN	4	COLESEVELAM HYDROCHLORIDE	41	COZAAR	60
CLARITHROMYCIN	4	COLESTID	41	CREON MINIMICROSPHERES 10	121
CLARITIN ALLERGY	1	COLESTID ORANGE	41	CREON MINIMICROSPHERES 25	121
CLARITIN KIDS	1	COLESTIPOL HYDROCHLORIDE	41	CREON MINIMICROSPHERES MICRO	121
CLARUS	147	COLISTIMETHATE FOR U.S.P	8	CRESTOR	44
CLAVULIN 125 F	5	COLISTIN	8	CRITIC-AID CLEAR	146
CLAVULIN 200	5	COLLAGENASE	147	CRIZOTINIB	19
CLAVULIN 250 F	5	COLY-MYCIN M PARENTERAL	8	CROMOLYN	113
CLAVULIN 400	5	COLYTE	120	CROMOLYN SODIUM	111
CLAVULIN 500 F	5 5	COMBANTRIN	2	CROTAMITON	142
CLAVULIN 875 CLEARLAX	119	COMBIGAN	115	CTP 30	81
CLICKFINE PEN NEEDLE 31G 4.5MM	167	COMBIVENT COMBIVENT RESPIMAT	30 30	CUPRIMINE CYANOCOBALAMIN	128 151
CLICKFINE PEN NEEDLE 31G 6MM	167	COMBIVIR	30 11	CYANOCOBALAMIN	151 151
CLICKFINE PEN NEEDLE 31G 8MM	167	COMFILAX	119	CYCLEN (21 DAY)	131
CLIMARA 25	132	COMFORT ANGLED INFSET 17MM	165	CYCLEN (28 DAY)	131
CLIMARA 50	132	COMFORT SRT ANGLED INFSET 13	165	CYCLOBENZAPRINE	33
CLIMARA 75	132	COMPACT SPACE PLUS LARGE MASK	165	CYCLOBENZAPRINE	33
CLINDAMYCIN	8	COMPACT SPACE PLUS MEDIUM	165	HYDROCHLORIDE	•
CLINDAMYCIN HYDROCHLORIDE	7	MASK	100	CYCLOGYL	115
CLINDAMYCIN IN DILUSOL OR	141	COMPACT SPACE PLUS NO MASK	165	CYCLOMEN	130
DUONALC		COMPACT SPACE PLUS SMALL MASK	165	CYCLOPENTOLATE	115
CLINDAMYCIN IV INFUSION	8	COMPLEAT PEDIATRIC 250ML LIQ	171	CYCLOPENTOLATE HYDROCHLORIDE	115
CLINDAMYCIN PALMITATE	8	COMPLERA	12	CYCLOPHOSPHAMIDE	19
HYDROCHLORIDE		COMPOUND W GEL	146	CYCLOSPORINE	162
CLINDAMYCIN PHOSPHATE	8	COMTAN	97	CYESTRA-35	163
CLINDAMYCIN PHOSPHATE, BENZOYL PEROXIDE	141	CONCERTA	92	CYKLOKAPRON	40
CLINDAMYCIN PHOSPHATE,	146	CONDOM	102	CYMBALTA	81
TRETINOIN	140	CONDOM, LATEX, LUBRICATED	102	CYPROTERONE	163
CLINDAMYCIN STERILE INFUSION	7	CONDOM, LATEX, NON-LUBRICATED	102	CYPROTERONE ACETATE	163
CLINDAMYCINE	7	CONDOM, NON-LATEX, LUBRICATED	102	CYPROTERONE ACETATE, ETHINYL	163
CLINDA-T	141	CONDYLINE	148	ESTRADIOL	400
CLINDOXYL	141	CONJUGATED ESTROGENS	132	CYTOMEL	138
CLINDOXYL ADV	141	CONTACT DETACH 90 DEGREE 6MMX60CM	165	CYTOVENE D VI INFANTS	13 152
CLOBAZAM	73	CONTACT DETACH 90 DEGREE	165	D2-DOL	152
CLOBETASOL PROPIONATE	143	8MMX60CM	103	D3-DOL	152
CLOBETASONE BUTYRATE	144	CONTINGENCY ONE	131	DABIGATRAN ETEXILATE MESILATE	37
CLOMIPRAMINE HYDROCHLORIDE	81	CONTOUR BG (ON)	103	DABRAFENIB	19
CLONAPAM	73	CONTOUR NEXT	103	DACLATASVIR	14
CLONAZEPAM	73	CONTOUR NEXT (ON)	103	DAIRY DIGESTIVE	120
CLONIDINE HYDROCHLORIDE	46	CONTRACEPTIVE	102	DAIRYAID	121
CLONIDINE ORAL LIQUID	47	CONTRACEPTIVE DEVICE	102	DAKLINZA	14
CLOPIDOGREL	39	CONTRAGEL GREEN	148	DALACIN	141
CLOPIDOGREL BISULFATE	39	COPAXONE	157	DALACIN C	7
CLOPIXOL	91	CORTATE	145	DALACIN C PHOSPHATE	8
CLOPIXOL DEPOT	91	CORTEF	129	DALACIN T	141
CLOPIXOL-ACUPHASE	91	CORTENEMA	125	DALTEPARIN SODIUM	37
CLOTRIMADERM	141	CORTIFOAM	125	DANAZOL	130
CLOTRIMAZOLE	141	CORTISONE	129	DANTRIUM	33
CLOTRIMAZOLE	142	CORTISONE ACETATE	129	DANTROLENE SODIUM	33
CLOXACILLIN SODIUM	5	CORTIVERA H	155	DAPAGLIFLOZIN PROPANEDIOL	136
CLOZAPINE	86	CORTODERM	145	MONOHYDRATE	
CLOZARIL	86	COSENTYX	148	DAPSONE	10
COAL TAR SALICYLIC ACID	146	COSENTYX (STYLO)	148	DAPSONE	10
COAL TAR, SALICYLIC ACID	146	COSENTYX PEN (ON)	148	DARIFENACIN HYDROBROMIDE	149
CODEINE	18 69	COSOPT	116	DARUNAVIR ETHANOLATE	10
CODEINE CONTIN CR	68 68	COTAZYM ECS 20	121	DARUNAVIR ETHANOLATE,	10
CODEINE CONTIN CR CODEINE MONOHYDRATE, CODEINE	68 68	COTAZYM ECS 8	121	COBICISTAT	127
SULFATE TRIHYDRATE	00	COTAZYM ECS 8 COTELLIC	121 18	DDAVP MELT	137 137
CODEINE PHOSPHATE	68	COUMADIN	38	DDAVP MELT DDROPS	152
CODEINE PHOSPHATE	68	COURADIN	56	DDROPS BOOSTER	152
		OUVEROIL .	50	DENOI O DOOOTEIX	102

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				Non-insured nearth b	enents
DECAXIL	152	DICLOFENAC TOPICAL	65	DOM-CLOPIDOGREL	39
DEGARELIX ACETATE	133	DICLOFENAC-SR	65	DOM-CYCLOBENZAPRINE	33
DELATESTRYL	131	DIDANOSINE	10	DOM-DICLOFENAC	65
DENOSUMAB (PROLIA)	159	DIENOGEST	137	DOM-DICLOFENAC SR	65
DENOSUMAB (XGEVA)	159	DIFFERIN	146	DOM-DOMPERIDONE	125
DEPAKENE	79	DIFFERIN XP	147	DOM-FINASTERIDE	156
DEPO-MEDROL	130	DIFICID	4	DOM-FLUCONAZOLE	9
DEPO-MEDROL WITH LIDOCAINE	130	DIFLUCAN	9	DOM-FLUOXETINE	82
DEPO-PROVERA	137	DIFLUNISAL	65	DOM-GABAPENTIN	74
DEPO-TESTOSTERONE	131	DIFLUNISAL	65	DOM-GEMFIBROZIL	42
DERMAFLEX HC	144	DIGOXIN	41	DOM-GLYBURIDE	137
DERMA-SMOOTHE	144	DIHYDROERGOTAMINE	32	DOM-IPRATROPIUM	30
DERMOVATE	143	DIHYDROERGOTAMINE MESYLATE	32	DOM-LANSOPRAZOLE	123
DESIPRAMINE	81	DILANTIN	74	DOM-LEVETIRACETAM	76
DESIPRAMINE HYDROCHLORIDE	81	DILANTIN INFATABS	74	DOM-LOXAPINE	87
DESLORATADINE	1	DILAUDID	69	DOM-MEFENAMIC ACID	66
DESLORATADINE	1	DILTIAZEM CD	53	DOM-MELOXICAM	66
DESLORATADINE ALLERGY CONTROL	1	DILTIAZEM HYDROCHLORIDE	53	DOM-METFORMIN	133
DESMOPRESSIN	137	DILTIAZEM IN OINTMENT	154	DOM-METOPROLOL-B	50
DESMOPRESSIN ACETATE	137	DILTIAZEM TZ	53	DOM-METOPROLOL-L	50
DESOGESTREL, ETHINYL ESTRADIOL	131	DIMENHYDRINATE	121	DOM-MIRTAZAPINE	83
DESONIDE	144	DIMENHYDRINATE	121	DOM-MONTELUKAST	111
DESOXIMETASONE	144	DIMETHICONE	142	DOM-NYSTATIN	9
DETROL	1 44 149	DIMETHICONE DIMETHYL FUMARATE	100	DOM-OXYBUTYNIN	149
DETROL LA	149	DIOVAN	61	DOM-PAROXETINE	83
			62	DOMPERIDONE	125
DEVICE (METHADONE)	171	DIOVAN-HCT		DOMPERIDONE MALEATE	124
DEX-4 GLUCOSE	108	DIPENTUM	125 1	DOMPERIDONE ORAL LIQUID	125
DEXAMETHASONE	114	DIPHENHYDRAMINE		DOM-PINDOLOL	51
DEXAMETHASONE ORAL HOUR	114	DIPHENHYDRAMINE HYDROCHLORIDE	1	DOM-PRAVASTATIN	43
DEXAMETHASONE ORAL LIQUID	129	DIPHENIST	1	DOM-PREGABALIN	43 77
DEXAMETHASONE PHOSPHATE	114	DIPIVEFRIN HYDROCHLORIDE	115	DOM-PREGABALIN DOM-QUETIAPINE	89
DEXAMETHASONE, TOBRAMYCIN	114	DIPROLENE	143	DOM-RABEPRAZOLE EC	124
DEXAMETHASONE-OMEGA	129	DIPROSALIC	143		57
DEXEDRINE	92	DIPROSONE	143	DOM-RAMIPRIL	159
DEXEDRINE SPANSULE	92		48	DOM-RISEDRONATE	96
DEXIRON	36	DIPYRIDAMOLE		DOM-RIZATRIPTAN RDT	
DEXTRAN 70,	117	DIPYRIDAMOLE, ACETYLSALICYLIC ACID	48	DOM-ROSUVASTATIN	44
HYDROXYPROPYLMETHYLCELLULOS E		DISOPYRAMIDE	41	DOM-SALBUTAMOL	32
DEXTROAMPHETAMINE	92	DIVALPROEX	79	DOM-SERTRALINE	84
DEXTROAMPHETAMINE SULFATE	92	DIVIGEL	132	DOM-SIMVASTATIN	44
DGEL DESTROAMFRETAMINE SOLFATE	152	DOLICHOVESPULA ARENARIA	155	DOM-SOTALOL	51
DIABETA	137	VENOM PROTEIN	100	DOM-SUMATRIPTAN	96
DIAMICRON	136	DOLICHOVESPULA MACULATA	155	DOM-TERAZOSIN	48
DIAMICRON MR	136	VENOM PROTEIN EXTRACT		DOM-TERBINAFINE	9
DIANE-35	163	DOLORAL 1	70	DOM-TIAPROFENIC	67
DIAPER RASH	146	DOLORAL 5	70	DOM-TIMOLOL	116
DIARRHEA RELIEF	119	DOLUTEGRAVIR SODIUM	11	DOM-TOPIRAMATE	79
DIASTAT	94	DOLUTEGRAVIR SODIUM,	11	DOM-TRAZODONE	84
DIASTAT DIASTAT		RILPIVIRINE HYDROCHLORIDE		DOM-VALACYCLOVIR	13
DIASTAT 2X10MG RECTAL PACK	94 94	DOM-ALENDRONATE	158	DOM-VALPROIC ACID	79
DIASTAT ZATSING RECTAL FACK		DOM-AMIODARONE	41	DOM-VENLAFAXINE XR	85
	104 93	DOM-AMLODIPINE	51	DOM-VERAPAMIL SR	54
DIAZEDAM		DOM-ATENOLOL	49	DOM-ZOLMITRIPTAN	96
DIAZEPAM (DIAGTAT)	93	DOM-ATOMOXETINE	99	DONEPEZIL	28
DIAZEPAM (DIASTAT)	94	DOM-ATORVASTATIN	42	DONEPEZIL HYDROCHLORIDE	28
DIAZOXIDE	47	DOM-AZITHROMYCIN	4	DORZOLAMIDE HYDROCHLORIDE	116
DICETEL	125	DOM-BACLOFEN	33	DORZOLAMIDE HYDROCHLORIDE,	116
DICITRATE	105	DOM-BROMOCRIPTINE	98	TIMOLOL MALEATE	
DICLECTIN	121	DOM-CARBAMAZEPINE	74	DOSTINEX	98
DICLOFENAC	65 05	DOM-CARVEDILOL	50	DOVONEY	143
DICLOFENAC EC	65	DOM-CEPHALEXIN	3	DOVONEX	147
DICLOFENAC SODIUM	65	DOM-CIPROFLOXACIN	6	DOXAZOSIN MESYLATE	48
DICLOFENAC SODIUM	65 65	DOM-CITALOPRAM	80	DOXEPIN	81
DICLOFENAC SODIUM (TOPICAL)	65	DOM-CLARITHROMYCIN	4	DOXEPIN HYDROCHLORIDE	81

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				Non-insured Health Ben	ents
DOXYCIN	7	EMPAGLIFLOZIN	136	ERYTHRO-S	4
DOXYCYCLINE	7	EMTRICITABINE, BICTEGRAVIR	11	ESBRIET	110
DOXYCYCLINE HYCLATE	7	(BICTEGRAVIR SODIUM), TENOFOVIR		ESCITALOPRAM	82
DOXYLAMINE SUCCINATE,	121	ALAFENAMIDE		ESCITALOPRAM OXALATE	82
PYRIDOXINE HYDROCHLORIDE		EMTRICITABINE, COBICISTAT,	11	ESCULIN, FRAMYCETIN SULFATE,	144
DOXYTAB	7	ELVITEGRAVIR, TENOFOVIR		DIBUCAINE HYDROCHLORIDE,	
DR SCHOLLS CLEAR AWAY PLANTAR	146	ALAFENAMIDE	4.4	HYDROCORTISONE ACETATE	
WART REMOVER SYSTEM		EMTRICITABINE, RILPIVIRINE HYDROCHLORIDE, TENOFOVIR	11	ESLICARBAZEPINE ACETATE	74
DR SCHOLLS CLEAR AWAY WART	146	ALAFENAMIDE		ESTALIS	132
REMOVER SYSTEM		ENABLEX	149	ESTRACE	132
DRESSING	165	ENALAPRIL	54	ESTRADIOL	132
DROPLET PEN NEEDLE 10MM 29G	167	ENALAPRIL MALEATE	54	ESTRADIOL HEMIHYDRATE	132
DROPLET PEN NEEDLE 12MM 29G	167	ENALAPRIL MALEATE.	55	ESTRADIOL, NORETHINDRONE	132
DROPLET PEN NEEDLE 4MM 32G	168	HYDROCHLOROTHIAZIDE	33	ACETATE	
DROPLET PEN NEEDLE 5MM 31G	167	ENALAPRIL MALEATE/HCTZ	55	ESTRADOT 100	132
DROPLET PEN NEEDLE 5MM 32G	168	ENALAPRIL ORAL LIQUID	55	ESTRADOT 25	132
DROPLET PEN NEEDLE 6MM 31G	167	ENBREL	160	ESTRADOT 37.5	132
DROPLET PEN NEEDLE 6MM 32G	168	ENBREL SURECLICK	160	ESTRADOT 50	132
DROPLET PEN NEEDLE 8MM 31G	168	ENEMA	120	ESTRADOT 75	132
DROPLET PEN NEEDLE 8MM 32G	168	ENEMOL SODIUM PHOSPHATE	120	ESTRAGYN	133
DROPLET PERSONAL LANCET 28G	167	ENFAMIL A+ 237ML LIQ	171	ESTRING	132
DROPLET PERSONAL LANCET 33G	167	ENFAMIL A+ 385ML LIQ	171	ESTROGEL	132
DRSCHOLL'S ATHLETE'S FOOT SPRAY	142	ENFAMIL A+ 663G PDR	171	ESTRONE	133
D-TABS	152	ENFAMIL A+ 663G PDR ENFAMIL A+ ENFACARE 363G PDR	171	ETANERCEPT	160
DUAKLIR GENUAIR	31			ETANERCEPT (BRENZYS)	160
DULCOLAX	119	ENFAMIL A+ ENFACARE 385ML LIQ	171	ETANERCEPT (ERELZI)	160
DULOXETINE	81	ENFAMIL FERINSOL	36	ETHACRYNIC ACID	108
DULOXETINE DR	81	ENFAMIL LOW IRON FORMULA 900GM	172		9
DULOXETINE HYDROCHLORIDE	81	ENFAMIL LOWER IRON 385ML LIQ	171	ETHAMBUTOL HYDROCHLORIDE	
DUODOPA	98	ENFAMIL POLYVISOL	153	ETHINYL ESTRADIOL, DESOGESTREL	131
DUONALC	142	ENFAMIL TRIVISOL	153	ETHINYL ESTRADIOL, DROSPIRENONE	131
DUOTRAV PQ	142	ENOXAPARIN SODIUM	37	ETHINYL ESTRADIOL,	131
DUOTRAV PQ DUOTRAV PQ OP	117	ENSTILAR	143	ETONOGESTREL	131
		ENSURE 235ML LIQ	171	ETHINYL ESTRADIOL,	131
DUPILUMAB	147	ENSURE FIBRE 235ML LIQ	171	LEVONORGESTREL	
DUPIXENT	147	ENTACAPONE	97	ETHINYL ESTRADIOL,	131
DUTASTERIDE	156	ENTECAVIR MONOHYDRATE	13	NORELGESTROMIN	
DUTASTERIDE	156	ENTOCORT	129	ETHINYL ESTRADIOL,	131
DUVOID	28	ENTRESTO	63	NORETHINDRONE	
DYSPORT THERAPEUTIC	163	ENTROPHEN	64	ETHINYL ESTRADIOL,	131
EDARBI	58	ENTYVIO	163	NORETHINDRONE ACETATE	
EDECRIN	108	ENZALUTAMIDE	20	ETHINYL ESTRADIOL, NORGESTIMATE	131
EDOXABAN (EDOXABAN TOSYLATE	37	EPCLUSA	15	ETHOPROPAZINE HYDROCHLORIDE	97
MONOHYDRATE)		EPINEPHRINE	32	ETHOSUXIMIDE	74
EDURANT	11	EPINEPHRINE	32	ETIBI	9
EFAVIRENZ	11	EPIPEN	32	ETIDRONATE DISODIUM	159
EFAVIRENZ, EMTRICITABINE,	11	EPIPEN JR	32	ETOPOSIDE	20
TENOFOVIR DISOPROXIL FUMARATE	0.5	EPIVAL	79	ETRAVIRINE	11
EFFEXOR XR	85	EPLERENONE	62	EUGLUCON	137
EFUDEX	147	EPOSARTAN MESYLATE	59	EURAX	142
EGOZINC-HC	144	EPOSARTAN MESYLATE,	59	EURO D	152
ELAVIL	80	HYDROCHLOROTHIAZIDE	33	EURO K	107
ELBASVIR, GRAZOPREVIR	14	EPURIS	147	EURO SENNA	120
ELECTROLYTES	106	EQUATE DAILY LOW-DOSE	64	EURO VITAMIN B1	151
ELIDEL	148	ERDOL BRIEF LOW BOOL	152	EURO-ASA	64
ELIGARD	22	ERELZI	160	EUROCAL	106
ELIQUIS	37	ERGOCALCIFEROL	152	EURO-D	152
ELMIRON	155	ERLEADA	17	EUROFER	36
ELOCOM	145				
ELTROXIN	138	ERLOTINIB HYDROCHLORIDE	20	EURO-FERROUS SULFATE	36 145
EMEND	122	ERTAPENEM	3	EVEROLIMIE	145
EMEND TRI-PACK	122	ERYC	4	EVEROLIMUS	20
EMLA	145	ERYTHRO BASE	4	EVISTA	133
EMOCORT	145	ERYTHROMYCIN	4	EVOLOCUMAB	46
EMOLAX	119	ERYTHROMYCIN	113	EVRA	131
EMOLLIENT FOR CHILDREN	171	ERYTHROMYCIN STEARATE	4	EXELON	29
		ERYTHROMYCIN, BENZOYL PEROXIDE	141	EXEMESTANE	20

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				Non-insured Health Bend	enits
EXLAX CHOCOLATED	120	FLAGYSTATIN	141	FORMOTEROL FUMARATE	31
EXTAVIA	157	FLAMAZINE	143	DIHYDRATE, MOMETASONE FUROATE	٠.
EXTEMPORANEOUS MIXTURE	154	FLAREX	114	FORTAZ 1G	3
		. ==	149	FORTAZ 2G	3
EXTEMPORANEOUS MIXTURE (GENDER AFFIRMING)	154	FLAVOXATE HYDROCHLORIDE		FORTAZ 6G	3
•	454	FLECAINIDE ACETATE	41		
EXTEMPORANEOUS MIXTURE (LU)	154	FLEET ENEMA	120	FORXIGA	136
EXTEMPORANEOUS MIXTURE (NSAID)	154	FLEET ENEMA PEDIATRIC	120	FOSAMAX	158
EXTRA STRENGTH SELSUN	142	FLEXI-T +300 IUD	102	FOSAMPRENAVIR CALCIUM	11
EYLEA	117	FLEXI-T +380 IUD	102	FOSAVANCE	158
EZ HEALTH ORACLE	103	FLEXI-TD	102	FOSFOMYCIN TROMETHAMINE	15
EZ HEALTH ORACLE LANCET	167	FLINTSTONES MULTIPLE VITAMINS	153	FOSINOPRIL	55
E-Z JE	168	PLUS IRON		FOSINOPRIL SODIUM	55
E-Z SPACER	165	FLINTSTONES MULTIPLE VITAMINS	153	FOSRENOL	108
E-Z SPACER (MASK ONLY)	165	WITH EXTRA C		FRAGMIN	37
E-Z SPACER WITH SMALL MASK	165	FLOCTAFENINE	73	FRAMYCETIN SULFATE, GRAMICIDIN,	114
EZETIMIBE	41	FLOCTAFENINE	73	DEXAMETHASONE	
EZETIMIBE	42	FLOMAX	33	FRAXIPARINE	38
		FLONASE ALLERGY RELIEF	114	FRAXIPARINE FORTE	38
EZETROL	42	FLORINEF	129	FREESTYLE	103
FAMCICLOVIR	13	FLOVENT DISKUS	129		
FAMOTIDINE	122			FREESTYLE (ON)	103
FAMOTIDINE	122	FLOVENT HFA	129	FREESTYLE LANCET	167
FAMVIR	13	FLUANXOL	86	FREESTYLE LITE	103
FASENRA	105	FLUANXOL DEPOT	86	FREESTYLE LITE (ON)	103
FC2 FEMALE CONDOMS	102	FLUCONAZOLE	9	FREESTYLE PRECISION	103
FEBUXOSTAT	157	FLUDARA	20	FREESTYLE PRECISION (ON)	103
FELODIPINE	53	FLUDARABINE PHOSPHATE	20	FREYA 21	131
FEMARA	22	FLUDROCORTISONE ACETATE	129	FREYA 28	131
FEMCAP	102	FLUMETHASONE PIVALATE.	114	FUCIDIN	141
		CLIOQUINOL		FUCIDIN H	141
FENOFIBRATE	42	FLUNARIZINE	97	FUCITHALMIC	113
FENOFIBRATE	42	FLUNARIZINE HYDROCHLORIDE	97	FUROSEMIDE	108
FENOMAX	42	FLUOCINONIDE	144		
FENO-MICRO	42		114	FUROSEMIDE	108
FENTANYL	68	FLUOROMETHOLONE		FUSIDATE SODIUM	141
FERAMAX POWDER WATER SOLUBLE	36	FLUOROURACIL	147	FUSIDIC ACID	113
POLYSACCHARIDE IRON COMPLEX		FLUOXETINE	82	FUSIDIC ACID, HYDROCORTISONE	141
FERODAN	36	FLUOXETINE HYDROCHLORIDE	82	ACETATE	
FERODAN INFANT DROPS	36	FLUPENTHIXOL DIHYDROCHLORIDE	86	FYCOMPA	77
FERRATE	36	FLUPENTIXOL DECANOATE	86	GABAPENTIN	74
FERRLECIT	36	FLUPHENAZINE	86	GABAPENTIN	74
FERROUS FUMARATE	36	FLUPHENAZINE DECANOATE	86	GALANTAMINE	28
FERROUS FUMARATE	36	FLUPHENAZINE HYDROCHLORIDE	86	GALANTAMINE ER	28
FERROUS GLUCONATE	36	FLURBIPROFEN	65	GALANTAMINE HYDROBROMIDE	28
		FLUTAMIDE	20	GANCICLOVIR SODIUM	13
FERROUS GLUCONATE	36	FLUTAMIDE	20	GASTROLYTE REGULAR	106
FERROUS SULFATE	36				
FERROUS SULFATE	36	FLUTICASONE FUROATE	114	GATIFLOXACIN	113
FERROUS SULPHATE	36	FLUTICASONE FUROATE,	129	GD-AMLODIPINE-ATORVASTATIN	52
FESOTERODINE FUMARATE	149	UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE		GD-AZITHROMYCIN	3
FEXOFENADINE HYDROCHLORIDE	1	FLUTICASONE FUROATE,	24	GD-CELECOXIB	64
FIBRISTAL	132	VILANTEROL TRIFENATATE	31	GD-DICLOFENAC/MISOPROSTOL	66
FIDAXOMICIN	4	FLUTICASONE FUROATE,	31	GD-GABAPENTIN	75
FILGRASTIM	39	VILANTEROL TRIFENATATE (ASTHMA)	31	GD-LATANOPROST	116
FINACEA	147	FLUTICASONE PROPIONATE	114	GD-LATANOPROST/TIMOLOL	116
FINASTERIDE	156	FLUVASTATIN SODIUM	43	GD-TRANEXAMIC ACID	40
FINASTERIDE	156			GE200	103
		FLUVOXAMINE	82	GE200 (ON)	103
FINGERSTIX LANCET	167	FLUVOXAMINE MALEATE	82	GEFITINIB	20
FINGOLIMOD (FINGOLIMOD	157	FML	114	GELMIX JAR 125G PDR	172
HYDROCHLORIDE)	450	FOLIC ACID	151		
FIRAZYR	159	FOLIC ACID	151	GEMFIBROZIL GEN GLOZADINE	42
FIRMAGON	133	FORADIL	31	GEN-CLOZAPINE	86
FIRST CANADIAN HEALTH LANCETS	167	FORMOTEROL FUMARATE	31	GENDER AFFIRMING HORMONES	154
FIRST CANHEALTH 28G LANCET	167	FORMOTEROL FUMARATE	31	GENDER AFFIRMING TOPICAL	154
FIRST CANHEALTH 30G LANCET	167	DIHYDRATE	٠.	HORMONES	
FIRST CANHEALTH 33G LANCET	167	FORMOTEROL FUMARATE	31	GENTAMICIN	2
FIRST CANHEALTH SPIRIT	103	DIHYDRATE, BUDESONIDE		GENTAMICIN IV	2
FLAGYL	15	·		GENTAMICIN SULFATE	2

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				Non-insured nealth ben	CIILO
GENTAMYCIN STERILE INFUSION	2	HUMALOG 200U/ML KWIKPEN	135	HYZAAR	60
GENTEAL	115	HUMALOG MIX 25 (CARTRIDGE)	135	HYZAAR DS	60
GENVOYA	11	HUMALOG MIX 25 (KWIKPEN)	135	IBAVYR	14
GILENYA	157	HUMALOG MIX 50 (CARTRIDGE)	135	IBRANCE	24
GIOTRIF	17	HUMALOG MIX 50 (KWIKPEN)	135	IBRUTINIB	21
GLATECT	157	HUMATIN	15	IBUPROFEN	65
GLATIRAMER ACETATE	157	HUMIRA	160	IBUPROFEN	65
GLECAPREVIR, PIBRENTASVIR	14	HUMULIN 30/70	134	ICATIBANT	159
GLEEVEC	21	HUMULIN 30/70 CARTRIDGE	134	ICLUSIG	24
GLICLAZIDE	136	HUMULIN N	135	IDELALISIB	21
GLICLAZIDE	136	HUMULIN N (CARTRIDGE)	135	ILEVRO	115
GLN-GABAPENTIN	75	HUMULIN N (KWIKPEN)	135	IMATINIB MESYLATE	21
GLN-OLMESARTAN	61	HUMULIN N 100U/ML (CARTRIDGE)	135	IMBRUVICA	21
GLN-OLINESARTAN GLN-TOPIRAMATE	79	HUMULIN R	135	IMDUR	47
GLUCAGEN	137	HUMULIN R (KWIKPEN)	135	IMIPRAMINE	83
GLUCAGEN HYPOKIT	137	HUMULIN R 100U/ML (CARTRIDGE)	135		83
GLUCAGON	137	HUMULIN R CARTRIDGE	135	IMIPRAMINE HYDROCHLORIDE	
GLUCAGON RECOMBINANT DNA	137	HYDERM	145	IMIQUIMOD	147 96
ORGIN	137	HYDRALAZINE HYDROCHLORIDE	47	IMITREX	
GLUCERNA 237ML LIQ	171	HYDRALYTE ELECTROLYTE		IMITREX DF	96
GLUCOBAY	133		106	IMITREX STAT DOSE KIT	96
GLUCONORM	135	HYDREA	21	IMODIUM CALMING	119
GLUCOPHAGE	133	HYDROCHLOROTHIAZIDE	109	IMURAN	162
GLUCOSE	108	HYDROCHLOROTHIAZIDE	109	INCOBOTULINUMTOXINA	163
		HYDROCHLOROTHIAZIDE ORAL LIQUID	109	INCRUSE ELLIPTA	30
GLUCOSE OXIDASE, PEROXIDASE	103		50	INDACATEROL MALEATE	32
GLYBURIDE	137	HYDROCHLOROTHIAZIDE, PINDOLOL	50	INDACATEROL MALEATE,	30
GLYBURIDE	137	HYDROCHLOROTHIAZIDE, SPIRONOLACTONE	62	GLYCOPYRRONIUM BROMIDE	
GLYCERIN	119	HYDROCORTISONE	129	INDAPAMIDE	109
GLYCERIN FOR INFANTS CHILDREN	119	(HYDROCORTISONE SODIUM	129	INDAYO	131
GLYCERINE	119	SUCCINATE)		INDERAL LA	51
GLYCON	133	HYDROCORTISONE ACETATE	125	INDOMETHACIN	66
GLYCOPYRRONIUM BROMIDE	30	HYDROCORTISONE ACETATE	145	INFANT FORMULATION	171
GOLIMUMAB	160	HYDROCORTISONE ACETATE, UREA	144	INFLECTRA	160
GOLYTELY	119	HYDROCORTISONE ACETATE, ZINC	144	INFLIXIMAB (INFLECTRA)	160
GOSERELIN ACETATE	133	SULFATE		INFLIXIMAB (REMICADE)	161
GRANISETRON HYDROCHLORIDE	121	HYDROCORTISONE ACETATE, ZINC	144	INFUFER	36
GRASTOFIL	39	SULFATE MONOHYDRATE		INHIBACE	54
GRAVOL	121	HYDROCORTISONE ACETATE, ZINC	144	INHIBACE PLUS	54
GUM PAROEX	114	SULFATE, PRAMOXINE		INLYTA	18
H2RA SOLID	154	HYDROCHLORIDE		INNOHEP	38
HABITROL	34	HYDROCORTISONE ACETATE-UREA	144	INSET 30 INFUSION SETS	165
HALOBETASOL PROPIONATE	144	HYDROCORTISONE POWDER AND	154	INSET 6MMX43"	166
HALOPERIDOL	86	CLOTRIMAZOLE CREAM	444	INSET II 90 DEGREE 6MMX110CM	165
HALOPERIDOL	86	HYDROCORTISONE VALERATE	144	INSET II 90 DEGREE 6MMX60CM	165
HALOPERIDOL DECANOATE	86	HYDROMORPH CONTIN	69	INSET II 90 DEGREE 9MMX110CM	165
HALOPERIDOL LA	86	HYDROMORPHONE HYDROCHLORIDE	68	INSET II 90 DEGREE 9MMX60CM	165
HARVONI	15	HYDROSONE	145	INSPIOLTO RESPIMAT	32
HEMANGIOL	51	HYDROVAL	144	INSPIRA CHAMBER W LARGE MASK	165
HEPARIN LEO	37	HYDROXYCHLOROQUINE SULFATE	15	INSPIRA CHAMBER W MEDIUM MASK	165
HEPARIN SODIUM	37	HYDROXYPROPYL CELLULOSE	117	INSPIRA CHAMBER W MOUTHPIECE	165
HEPARIN SODIUM	38	HYDROXYPROPYLMETHYLCELLULOS	115	INSPIRA CHAMBER W SMALL MASK	165
HEPARIN SODIUM (MULTIDOSE VIAL-	37	E	0.4	INSPRA	62
WITH PRESERVATIVE)	01	HYDROXYUREA	21	INSULIN (30% NEUTRAL & 70%	134
HEPARIN SODIUM (SINGLE USE VIAL-	37	HYDROXYZINE	95	ISOPHANE) HUMAN BIOSYNTHETIC	134
PRESERVATIVE FREE)		HYDROXYZINE HYDROCHLORIDE	95	INSULIN (40% NEUTRAL & 60%	135
HEPSERA	13	HYMENOPTERA VENOM PRODUCT	155	ISOPHANE) HUMAN BIOSYNTHETIC	
HEPTOVIR	11	HONEY BEE VENOM	156	INSULIN (50% NEUTRAL & 50%	135
HI POTENCY MAGNESIUM OXIDE	119	HYMENOPTERA VENOM PRODUCT MIXED VESPID VENOM PROTEIN	156	ISOPHANE) HUMAN BIOSYNTHETIC	
HONEY BEE VENOM PROTEIN	155	HYMENOPTERA VENOM PRODUCT	156	INSULIN (ISOPHANE) HUMAN	135
EXTRACT		WASP VENOM PROTEIN	.50	BIOSYNTHETIC	
HP-PAC	123	HYMENOPTERA VENOM PRODUCT	156	INSULIN (ZINC CRYSTALLINE) HUMAN	135
HUMALOG	135	YELLOW JACKET VENOM PROTEIN		BIOSYNTHETIC (RDNA ORIGIN)	
HUMALOG (CARTRIDGE)	135	HYMENOPTERA VENOM PRODUCTS	156	INSULIN 31GX0.3CC	169
HUMALOG (KWIKPEN)	135	YELLOW HORNET VENOM PROTEIN		INSULIN 31GX0.5CC	169
HUMALOG 100U/ML CARTRIDGE	135	HYOSCINE BUTYLBROMIDE	30	INSULIN 31GX1CC	169

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				Non-insured Health E	Jenenia
INSULIN ASPART	135	ISONIAZID	9	JAMP VITAMIN B12	151
INSULIN BIOSYNTHETIC HUMAN BR	135	ISONIAZID ORAL LIQUID	10	JAMP VITAMIN D	152
INSULIN DEGLUDEC	135	ISOPROPYL ALCOHOL	142	JAMP-ALENDRONATE	158
INSULIN DETEMIR	135	ISOPROPYL MYRISTATE	142	JAMP-ALLOPURINOL	156
INSULIN GLARGINE	135	ISOPTIN SR	54	JAMP-ALPRAZOLAM	93
INSULIN GLULISINE	135	ISOPTO ATROPINE	115	JAMP-AMITRIPTYLINE	80
INSULIN HUMAN BIOSYNTHETIC	135	ISOPTO CARPINE	116	JAMP AMOYICILLIN	51 5
INSULIN LISPRO	135	ISOPTO TEARS	117	JAMP-AMOXICILLIN	5 17
INSULIN LISPRO, INSULIN LISPRO PROTAMINE	135	ISOSORBIDE DINITRATE	47 47	JAMP-ANASTROZOLE JAMP-ASA	64
INSULIN PEN NEEDLE 31GX6MM	167	ISOSORBIDE-5-MONONITRATE ISOSOURCE 1.0 HP 250ML LIQ	47 171	JAMP-ASA EC	64
INSULIN PEN NEEDLE 31GX8MM	168	ISOSOURCE 1.2 CAL 1500ML LIQ	171	JAMP-ATENOLOL	49
INSULIN PEN NEEDLE 32GX4MM	168	ISOSOURCE 1.2 CAL 250ML LIQ	171	JAMP-ATORVASTATIN	42
INSULIN PEN NEEDLE 32GX6MM	168	ISOSOURCE 1.5 CAL 250ML LIQ	171	JAMP-AZITHROMYCIN	4
INSULIN PEN NEEDLE 32GX8MM	168	ISOSOURCE FIBRE 1.2 CAL 250ML LIQ	171	JAMP-BACITRACINE	141
INSULIN PUMP BATTERY	165	ISOSOURCE FIBRE 1.5 CAL 1500ML LIQ	171	JAMP-BEZAFIBRATE	42
INSULIN PUMP SUPPLIES	165	ISOSOURCE FIBRE 1.5 CAL 250ML LIQ	171	JAMP-BICALUTAMIDE	18
INSULIN SYR W/NEEDL 0.25CC	168	ISOSOURCE HN WITH FIBRE 250ML	171	JAMP-BISACODYL	119
INSULIN SYR W/NEEDLE 0.3CC	168	LIQ		JAMP-CALCIUM + VITAMIN D	106
INSULIN SYR W/NEEDLE 0.5CC	168	ISOTAMINE	9	JAMP-CALCIUM CARBONATE	106
INSULIN SYR W/NEEDLE 1CC	168	ISOTRETINOIN	147	JAMP-CALCIUM VITAMIN D	106
INSUPEN 29GX12MM NEEDLE	167	ITEST	103	JAMP-CANDESARTAN	58
INSUPEN 30GX8MM NEEDLE	167	ITEST SAFETY 28G LANCET	167	JAMP-CARVEDILOL	50
INSUPEN 31GX6MM NEEDLE	167	ITEST ULTRA-THIN 33G LANCET	167	JAMP-CELECOXIB	64
INSUPEN 31GX8MM NEEDLE	168	ITRACONAZOLE	9	JAMP-CETIRIZINE	1
INSUPEN 32GX4MM NEEDLE	168	ITRACONAZOLE PDR	9	JAMP-CHOLESTYRAMINE	41
INSUPEN 32GX6MM NEEDLE	168	IV3000	165	JAMP-CIPROFLOXACIN	6
INSUPEN 32GX8MM NEEDLE	168	IV3000 STANDARD	166	JAMP-CITALOPRAM	80
INSUPEN 33GX4MM NEEDLE	168	IVABRADINE (IVABRADINE HYDROCHLORIDE)	41	JAMP-CLOPIDOGREL	39
INTELENCE	11	IVERMECTIN	2	JAMP-COLCHICINE	157
INTERFERON ALFA-2B	12	IXEKIZUMAB	148	JAMP-CYANOCOBALAMIN	151
INTERFERON BETA-1A	157	IZBA	117	JAMP-CYCLOBENZAPRINE	33
INTERFERON BETA-1B	157	JAKAVI	25	JAMP-DIMENHYDRINATE	121
INTRAUTERINE DEVICE INTRON A	102 12	JAMP ACETAMINOPHEN BLAZON	72	JAMP-DOMPERIDONE JAMP-DONEPEZIL	125 28
INVANZ	3	JAMP CALCIUM CARBONATE VITAMIN	106	JAMP-DULOXETINE	26 81
INVEGA SUSTENNA	88	D		JAMP-EFAVIRENZ	11
INVEGA 303 TENNA INVEGA TRINZA	88	JAMP CALCIUM CITRATE VITAMIN D	106	JAMP-ESCITALOPRAM	82
INVIRASE	12	JAMP CALCIUM LACTOGLUCONATE	106	JAMP-EZETIMIBE	42
INVOKANA	136	VITAMIN D		JAMP-FER	36
IOPIDINE	117	JAMP CANDESARTAN-HCT	59	JAMP-FERROUS FUMARATE	36
IPECAC	121	JAMP CLINDAMYCIN	7	JAMP-FINASTERIDE	156
IPRATROPIUM BROMIDE	30	JAMP DICLOFENAC TOPICAL JAMP EMTRICITABINE/TENOFOVIR	65 12	JAMP-FLUCONAZOLE	9
IPRATROPIUM BROMIDE,	30	DISOPROXIL FUMARATE	12	JAMP-FLUOXETINE	82
SALBUTAMOL SULFATE		JAMP ENALAPRIL	62	JAMP-FOLIC ACID	151
IPRAVENT	30	JAMP ENTECAVIR	13	JAMP-FOSFOMYCIN	15
IRBESARTAN	59	JAMP FERROUS FUMARATE	36	JAMP-FOSINOPRIL	55
IRBESARTAN	59	JAMP FERROUS SULFATE	36	JAMP-GABAPENTIN	75
IRBESARTAN HCT	59	JAMP FERROUS SULFATE LIQUID5	36	JAMP-HC	145
IRBESARTAN,	59	JAMP FINGOLIMOD	157	JAMP-HYDRALAZINE	47
HYDROCHLOROTHIAZIDE	F 0	JAMP FOLIC ACID	151	JAMP-HYDROCORTISONE	145
IRBESARTAN/HCTZ	59	JAMP GLICLAZIDE-MR	136	JAMP-HYDROCORTISONE UREA	144
IRBESARTAN-HCTZ IRESSA	59 20	JAMP GLYCERIN	119	JAMP-IBUPROFEN	66
IRON	36	JAMP ITRACONAZOLE	9	JAMP-INDAPAMIDE	109
IRON	36	JAMP K	107	JAMP-IRBESARTAN	59
IRON (IRON ISOMALTOSIDE 1000)	36	JAMP MAGNESIUM GLUCONATE	107	JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	59
IRON (SUCROFERRIC	108	JAMP NEVIRAPINE	11	JAMP-K 8	107
OXYHYDROXIDE)	.00	JAMP OLANZAPINE ODT	88	JAMP-K EFFERVESCENT	107
IRON DEXTRAN	36	JAMP PERINDOPRIL	56	JAMPKCITRATE	107
IRON FERROUS GLUCONATE	36	JAMP POTASSIUM CHLORIDE ER	107	JAMP-KETOTIFEN	113
IRON SUCROSE	36	JAMP REHYDRALYTE	106	JAMPLACTASE ENZYME	121
IRON SUCROSE STERILE INFUSION	36	JAMP REPAGLINIDE	135	JAMP-LACTULOSE	105
ISDN	47	JAMP SENNAQUIL	120	JAMP-LETROZOLE	22
ISENTRESS	11	JAMP VITAMIN A, D AND C	153	JAMP-LEVETIRACETAM	76
				OTHER LEVELINGUE I AIVI	70

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				Non-insured nearth ber	ients
JAMP-LISINOPRIL	55	JEVITY 235ML LIQ	171	LATANOPROST	116
JAMP-LOSARTAN	60	JULUCA	11	LATANOPROST, TIMOLOL MALEATE	116
JAMP-LOSARTAN HCTZ	60	K LYTE	107	LATUDA	87
JAMP-MAGNESIUM	107	K20 POTASSIUM	107	LAX-A-DAY	120
JAMP-METFORMIN	133	KADIAN	71	LAX-A-DAY PHARMA	120
JAMP-METHOTREXATE	22	KALETRA	11	LCD IN CORTICOSTEROID CREAM	154
JAMP-METOPROLOL-L	50	KAYEXALATE	107	LCD IN CORTICOSTEROID OINTMENT	154
JAMP-MONTELUKAST	111	KCITRA 10	105	LCD IN NON-MEDICATED CREAM	154
JAMP-MOXIFLOXACIN	7	KEFLEX	3	LCD IN NON-MEDICATED OINTMENT	154
JAMP-MYCOPHENOLATE	162	KENALOG-10	130	LEDERLE LEUCOVORIN	156
JAMP-NYSTATIN	9	KENALOG-40	130	LEFLUNOMIDE	161
JAMPOCAINE	145	KEPPRA	76	LEFLUNOMIDE	161
JAMPOCAINE VISCOUS	145	KETOCONAZOLE	9	LEMTRADA	162
JAMP-OLANZAPINE	87	KETODERM	142	LENALIDOMIDE	21
JAMP-OLMESARTAN	61	KETOPROFEN	66	LENVATINIB	21
JAMP-OLOPATADINE	113	KETOPROFEN	66	LENVIMA	21
JAMPOLYCIN	141	KETOPROFEN SR	66	LESCOL XL	43
JAMP-OMEPRAZOLE DR	124	KETOPROFEN-E	66	LETROZOLE	22
JAMP-ONDANSETRON	121	KETOROLAC TROMETHAMINE	115	LETROZOLE	22
JAMP-OXCARBAZEPINE	77	KETOSTIX	104	LEUCOVORIN CALCIUM	156
JAMP-PANTOPRAZOLE	124	KETOTIFEN	113	LEUKERAN	18
JAMP-PAROXETINE	83	KETOTIFEN FUMARATE	1	LEUPROLIDE ACETATE	22
JAMP-PIOGLITAZONE	137	KEVZARA	161	LEVATE	80
JAMP-POTASSIUM CHLORIDE	107	K-EXIT	107	LEVEMIR FLEXTOUCH	135
JAMP-PRAVASTATIN	43	KISQALI	25	LEVEMIR PENFILL	135
JAMP-PREGABALIN	77	KIVEXA	10	LEVETIRACETAM	76
JAMP-PYRANTEL PAMOATE	2	KOMBOGLYZE	134	LEVETIRACETAM	76
JAMP-QUETIAPINE	89	KWELLADA-P	142	LEVETIRACETAM ORAL LIQUID	77
JAMP-RAMIPRIL	57	KYLEENA	131	LEVOBUNOLOL HYDROCHLORIDE	116
JAMP-RANITIDINE	123	LABETALOL HYDROCHLORIDE	50	LEVOCABASTINE HYDROCHLORIDE	113
JAMP-RISEDRONATE	159	LACOSAMIDE	75	LEVOCARNITINE	108
JAMP-RISPERIDONE	90	LACRISERT	117	LEVODOPA, BENSERAZIDE	97
JAMP-RIZATRIPTAN	96	LACTAID	121	HYDROCHLORIDE	
JAMP-RIZATRIPTAN ORT	96	LACTAID EXTRA STRENGTH	121	LEVODOPA, CARBIDOPA	97
JAMP-RIZATRIPTAN ODT	96 99	LACTAID ULTRA	121	LEVODOPA, CARBIDOPA (CARBIDOPA MONOHYDRATE)	98
JAMP-ROPINIROLE	99 44	LACTASE	120	LEVODOPA, CARBIDOPA,	98
JAMP-ROSUVASTATIN JAMP-SERTRALINE	84	LACTASE 4500 FCCLU	155	ENTACAPONE	
JAMP-SIMVASTATIN	44	LACTEEZE DROPS LACTOMAX	120 121	LEVOFLOXACIN	6
JAMP-SODIUM PHOSPHATE	120			LEVOFLOXACIN HEMIHYDRATE	6
JAMP-SOLIFENACIN	149	LACTOMAX EXTRA LACTULOSE	121 105	LEVOFLOXACIN HEMIHYDRATE	7
JAMP-SOTALOL	51	LACTULOSE	105 105	(QUINSAIR)	
JAMP-TENOFOVIR	12	LAMICTAL	76	LEVONORGESTREL	131
JAMP-TERBINAFINE	9	LAMISIL	9	LEVONORGESTREL INTRAUTERINE	132
JAMP-TIMOLOL	116	LAMIVUDINE	11	INSERT	
JAMP-TOBRAMYCIN	2	LAMIVUDINE, ZIDOVUDINE	11	LEVONORGESTREL, ETHINYL ESTRADIOL	132
JAMP-TOPIRAMATE	- 79	LAMOTRIGINE	76	LEVOTHYROXINE SODIUM	138
JAMP-URSODIOL	120	LAMOTRIGINE	7 6	LIBERTE UT380 SHORT IUD	102
JAMP-VALACYCLOVIR	13	LANCET	167	LIBERTE UT380 STANDARD IUD	102
JAMP-VANCOMYCIN	8	LANCORA	41	LIDEMOL	144
JAMP-VITAMIN A	151	LANREOTIDE ACETATE	163	LIDEX	144
JAMP-VITAMIN B12	151	LANSOPRAZOLE	123	LIDOCAINE	145
JAMP-VITAMIN D	152	LANSOPRAZOLE	123	LIDOCAINE HCL	145
JAMP-ZINC-HC	144	LANSOPRAZOLE ODT	123	LIDOCAINE HYDROCHLORIDE	115
JAMP-ZOLMITRIPTAN	97	LANSOPRAZOLE ORAL LIQUID	123	LIDOCAINE, PRILOCAINE	145
JAMP-ZOLMITRIPTAN ODT	97	LANSOYL	119	LIDODAN	145
JANUMET	134	LANSOYL SUGAR FREE	119	LIDODAN VISCOUS	139
JANUMET XR	134	LANTHANUM CARBONATE HYDRATE	108	LIFE BRAND PEN NEEDLE 31G 8MM	168
JANUVIA	134	LANTUS	135	LINAGLIPTIN	134
JARDIANCE	136	LANTUS SOLOSTAR	135	LINAGLIPTIN, METFORMIN	134
J-CAL+D	106	LANVIS	26	HYDROCHLORIDE	134
JENCYCLA	132	LAPELGA	39	LINCTUS CODEINE	68
JENTADUETO	134	LASIX	108	LINESSA 21	131
JEVITY 1.5 CAL 235ML LIQ	171	LASIX SPECIAL	100	LINESSA 28	131
			.00		

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IMPORT					Non-insured nealth ben	ents
	LINEZOLID	8	LUVOX	82	MAR-PRAVASTATIN	43
PAPER	LIORESAL	33	LYDERM	144	MAR-PREGABALIN	77
IPPIDIE SUPRA	LIOTHYRONINE SODIUM	138	LYNPARZA	23	MAR-QUETIAPINE	89
Image	LIPASE, AMYLASE, PROTEASE	121	LYRICA	77	MAR-RAMIPRIL	57
LIPITOR	LIPIDIL EZ	42	LYSODREN	23	MAR-RANITIDINE	123
ISBNOPRIL ISBN	LIPIDIL SUPRA	42	M CALCIUM VITAMINE D	106	MAR-RISPERIDONE	90
ISBNOPRIL 55	LIPITOR	42	M SENNOSIDES	120	MAR-RIZATRIPTAN	96
ISBNOPRILL HYDROCHLOROTHIAZIDE 555 SOUND BICAREONATE, SODIUM MAR.SERTRALNE 34	LISDEXAMFETAMINE DIMESYLATE	92	MACROBID	15	MAR-RIZATRIPTAN ODT	96
CHARGE SOUIM SULFATE MAR.SBM.MSTATATN 44	LISINOPRIL	55		119	MAR-ROSUVASTATIN	44
LISINOPRILI, PUTWOCHLING INIAZIDE LISINOPRILI, PUTWOCHLING INIAZIDE LISINOPRILI, PUTWOCHLING INIAZIDE SS MAGIG MOLITHAME 95 MAGIG MOLITHAME 95 MAGIG MOLITHAME 96 MAGIG MOLITHAME 97 MAGIG MOLITHAME 98 MAGIG MOLITHAME 107 MARA-TORPRIAMATE 108 MAGIC MOLITHAME 109 MAGIC MOLITHAME 107 MARA-VALLACYCLOUR 108 MAGIC MOLITHAME 107 MARA-VALLACYCLOUR 108 MAGIC MOLITHAME 107 MARVELLON 22 108 MAGIC MOLITHAME 108 MAGIC MOLITHAME 109 MAGIC MOLITHAME 100 MAGIC MOLITHAME 100 MAGIC MOLITHAME 101 MAGIC MOLITHAME 101 MAGIC MOLITHAME 102 MAGIC MOLITHAME 103 MAGIC MOLITHAME 104 MAGIC MOLITHAME 105 MAGIC MOLITHAME 105 MAGIC MOLITHAME 106 MAGIC MOLITHAME 107 MAGIC MOLITHAME 107 MAGIC MOLITHAME 108 MAGIC MOLITHAME 108 MAGIC MOLITHAME 108 MAGIC MOLITHAME 109 MAGIC MOLITHAME 109 MAGIC MOLITHAME 100 MAGIC MOL	LISINOPRIL	55			MAR-SERTRALINE	84
LISHOPRICHICI (2 (1914) 558 MAGILCANTE 956 MAGILCATE 1077 MAGNESUM 1077 MARYELON 21 131 LITHIMM CARBONATE 955 MAGNESUM 1077 MARYELON 21 131 LITHIMM CARBONATE 955 MAGNESUM CHRATE 1197 MARYELON 21 131 LITHIMM CARBONATE 1197 MARYELON 21 131 MAGNESUM CHRATE 1197 MARYELON 21 131 LIDHIMA 1197 MAGNESUM CHRATE 1197 MARYELON 21 131 LIDHIMA 1197 MAGNESUM CHRATE 1197 MARYELON 21 137 MAGNESUM CHRATE 1197 MARYELON 21 131 LOESTRIN 131 LOESTRIN 131 LOESTRIN 131 LOESTRIN 131 LOESTRIN 131 MAGNESUM CHRATE 1197 MAG	LISINOPRIL, HYDROCHLOROTHIAZIDE	56	-	44=	MAR-SIMVASTATIN	44
LITHIUM CARBONATE 95 MAGUICATE 107 MAGNESUM 107 MARY-VALCA/CUO/R 13 LITHIUM CITRATE 95 MAGNESUM 107 MARY-VALCA/CUO/R 13 LITHIUM CITRATE 95 MAGNESUM 107 MARY-VALCA/CUO/R 13 LITHIUM CITRATE 105 MAGNESUM 107 MARY-VALCA/CUO/R 13 LITHIUM CITRATE 107 MAGNESUM 107 MARY-VALCA/CUO/R 13 LITHIUM CITRATE 107 MARY-VALCA/CUO/R 15 LITHIUM CITRATE 107 MARY-VALCA/CUO/R 15 LICOALIS IN MAGNESUM VADOR 107 MARY-VALCA/CUO/R 15 LICOALIS IN MAGNESUM VADOR 119 MARY-VALCA/CUO/R 15 LICOALIS IN MAGNESUM VADO	LISINOPRIL/HCTZ (TYPE Z)	56	,		MAR-TOPIRAMATE	79
LITHIMM CARBONALE 95 MAGNESIUM 107 MARVELON 21 131 LITHIMAX 95 MAGNESIUM CITRATE 19 MARVELON 21 131 LITHIMAX 95 MAGNESIUM CITRATE 19 MARVELON 21 131 LIVOSTIN 133 MAGNESIUM COMPIEX 197 MARZ COLMITRIPTAN 97 LIDIANA 37 MAGNESIUM COMPIEX 197 MASA 64 LODALIS 11 MAGNESIUM GULCOHATE 197 MASA 64 LODALIS 11 MAGNESIUM GULCOHATE 197 MATERNA 153 LOESTRIN 131 MAGNESIUM GULCOHATE 197 MATERNA 62 LODOXAMIDE TROMETHAMINE 131 MAGNESIUM GULCOHATE 197 MATERNA 153 LOESTRIN 131 MAGNESIUM COLDONALE 198 MAVIK 58 LOESTRIN 131 MAGNESIUM CONDE 199 MAVIK 58 LOUISTINE 22 MAGNESIUM CONDE 199 MAVIK 58 LOUISTINE 22 MAGNESIUM CONDE 199 MAVIK 58 LOUISTINE 27 MAGNESIUM CONDE 199 MAVIK 58 LOPERAMIDE 199 MARALICIPURINOL 195 MAXILITY 199 MARITE 199 MARIT	LITHANE	95			MAR-TROSPIUM	149
LITHIMAX	LITHIUM CARBONATE	95			MAR-VALACYCLOVIR	13
LITHIMAX 195 LIDNAX 196 LIDNAX 197 LIDNAX 198 AMAGRISHIM COMPLEX 197 AMACQUAITRIPTAN 197 LIDNAX 197	LITHIUM CITRATE	95			MARVELON 21	131
LIVIXIANA 37 MAGRISHIM COMPLEX 107 MASEA 64 LOCACORTEN VIOFORM 114 MAGRISHIM GLUCOHAPTONATE 107 MATERNA 153 LOCALIS 41 MAGRISHIM GLUCOHAPTONATE 107 MATERNA 153 LODALIS 41 MAGRISHIM GLUCOHAPTONATE 107 MATERNA 153 LOCACORTEN VIOFORM 113 MAGRISHIM GLUCOHAPTONATE 107 MATERNA 153 LOCACOMITICAL 113 MAGRISHIM GLUCOHAPTONATE 107 MATURAYSTATIN 122 LONDISTINE 22 MAGRISHIM-CODAN 107 MAVALT 96 LOPISTANIDE 121 MAGRISHIM OXIDE 119 MAVIRET 114 LOPISTANIDE 119 MAGRISHIM OXIDE 119 MAVIRET 114 LOPISTANIDE 119 MAGRISHIM OXIDE 119 MAVIRET 114 LOPISTANIDE 119 MAGRISHIM-ODAN 107 MAXALT RPD 96 LOPISTANIDE 119 MAGRISHIM OXIDE 119 MAXIBET 114 LOPISTANIDE 119 MAGRISHIM-ODAN 107 MAXALT RPD 96 LOPISTANIDE 119 MAMERICA 151 LOPISTANIDE 119 MAGRISHIM-ODAN 107 MAXALT RPD 96 LOPISTANIDE 119 MAMERICA 151 MAGRISHIM-ODAN 107 MAXALT RPD 96 LOPISTANIDE 119 MAMERICA 151 MAGRISHIM-ODAN 151 MAGRISHIM-ODAN 151 MAGRISHIM-ODAN 151 MAGRISHIM-ODAN 151 MARALOPURINOL 156 MARALOPURINOL 157 MAGRISHIM-ODAN 151 MAGRISHIM-ODAN 151 MAGRISHIM-ODAN 151 MAXIMUM STRENGTH ACID REDUCER 123 MAGRISHIM-ODAN 151 MAXIMUM STRENGTH ACID REDUCER 123 MAGRISHIM-ODAN 151 MAXIMUM STRENGTH ACID REDUCER 123 MARALOPURINOL 156 MARALOPURINOL 156 MARALOPURINOL 156 MARALOPURINOL 156 MARALOPURINOL 157 MARALOPURINOL 156 MARALOPURINOL 157 MARALOPURIN	LITHMAX	95			MARVELON 28	131
LOCACORTEN VIOFORM 1144 MAGNESIUM GLUCOMATE 1977 MATERNA 153 LODALIS 141 MAGNESIUM PYDROXIDE 119 MAYERNA 153 LODENAMIDE ROMETHAMINE 1131 MAGNESIUM PYDROXIDE 119 MAYUR 524 LODENAMIDE ROMETHAMINE 1131 MAGNESIUM PYDROXIDE 119 MAYUR 525 LODIESTRIN 1311 MAGNESIUM PYDROXIDE 119 MAYUR 525 LOUITEN 1311 MAGNESIUM DXIDE 119 MAYUR 525 LODIESTRIN 1311 MAGNESIUM DXIDE 119 MAYUR 525 LODIESTRIN 1311 MAGNESIUM DXIDE 119 MAYUR 525 LOPIERAMIDE 122 MAGNESIUM-DDAN 107 MAXALT 72 96 LOPERAMIDE HYDROCHLORIDE 119 MAGNESIUM-DDAN 107 MAXALT RDD 96 LOPERAMIDE HYDROCHLORIDE 119 MAGNESIUM-DDAN 107 MAXALT RDD 96 LOPERAMIDE HYDROCHLORIDE 119 MAGNESIUM-DDAN 156 LOPERAMIDE HYDROCHLORIDE 119 MAGNESIUM 156 LOPROX 1411 MARALITEN 151 LOPROX 1411 MARALITEN 151 LOPROX 1411 MARALITEN 151 LOPROX 1411 MARALITEN 151 LORATADINE 1 MARALITEN 151 LORATADINE 1 MARALITEN 151 LORATADINE 1 MARALITEN 151 LORATADINE 1 MARALITEN 151 LORAZEPAM 94 MARALITEN 151 LORAZEPAM 95 MARALITEN 151 LORAZEPAM 95 MARALITEN 151 LORAZEPAM 96 MARALITEN 151 LORAZEPAM 97 MARALITEN 151 LORAZEPAM 97 MARALITEN 151 LORAZEPAM 98 MARALITEN 151 LORAZEPAM 98 MARALITEN 151 LORAZEPAM 99 MARALI	LIVOSTIN	113			MAR-ZOLMITRIPTAN	97
LODALIS VIDORM	LIXIANA	37			M-ASA	64
LODIXAID	LOCACORTEN VIOFORM	114			MATERNA	153
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MICROLET LANCET 167 MINT-PANTOPRAZOLE	•	00				113 122
METHADONE LOCK BOX 171 MICRONOR 28-DAY 132 MINT-PAROXETINE METHADONE POWDER (OAT) 69 MICTORYL PEDIATRIC 149 MINT-PERINDOPRIL METHADOSE 69 MIDAMOR 109 MINT-PROJECTAZONE METHADOSE DEL. W DIRECT INTER (OAT) 69 MIDODRINE HYDROCHLORIDE MIDORIDE MINT-PREGABALIN 30 MINT-PREGABALIN METHADOSE DEL. W/OUT DIR INTER (OAT) 69 MIFEGYMISO 140 MINT-QUETIAPINE MINT-RAMIPRIL METHADOSE W DIRECT INTER (OAT) 69 MIGRANAL 32 MINT-RAMIPRIL METHADOSE W/OUT DIRECT INTER (OAT) 69 MINERAL OIL 119 MINT-SERTRALINE MINT-SERTRALINE MINT-SIMVASTATIN METHAZOLAMIDE 116 MINERAL OIL, WHITE PETROLATUM 117 MINT-TOLTERODINE METHIMAZOLE 116 MINESTRIN 1/20 (21-DAY) 131 MINT-TOPIRAMATE METHORAZINE 87 MINIMS ATROPINE 115 MIO BLUE 6MMX18 METHOREXATE 22 MINIMS CYCLOPENTOLATE 115 MIO BLUE 6MMX23		69				124
METHADONE POWDER (OAT) 69 MICTORYL PEDIATRIC 149 MINT-PERINDOPRIL METHADOSE 69 MIDAMOR 109 MINT-PIOGLITAZONE METHADOSE DEL. W DIRECT INTER (OAT) 69 MIDOSTAURIN 30 MINT-PRAVASTATIN METHADOSE DEL. W/OUT DIR INTER (OAT) 69 MIFEGYMISO 140 MINT-QUETIAPINE (OAT) MIGRANAL 32 MINT-RAMIPRIL METHADOSE W DIRECT INTER (OAT) 69 MINERAL OIL 119 MINT-SISPERIDON METHADOSE W/OUT DIRECT INTER (OAT) 69 MINERAL OIL (HEAVY) 119 MINT-SIMVASTATIN METHAZOLAMIDE 116 MINERAL OIL, WHITE PETROLATUM 117 MINT-TOLTERODINE METHAZOLAMIDE 116 MINESTRIN 1/20 (21-DAY) 131 MINT-TOPIRAMATE METHAZOLAMIDE 138 MINESTRIN 1/20 (28-DAY) 131 MINT-ZOLMITRIPTAN METHORAZINE 87 MINIMS ATROPINE 115 MIO BLUE 6MMX23 METHORAZINE 20 MINIMS CYCLOPENTOLATE 115 MIO BLUE 6MMX23		171				83
METHADOSE 69 MIDAMOR 109 MINT-PIOGLITAZONE METHADOSE DEL. W DIRECT INTER (OAT) 69 MIDODRINE HYDROCHLORIDE (OAT) 30 MINT-PRAVASTATIN (MINT-PREGABALIN (MINT-PREGABALIN MINT-PREGABALIN MINT-						56
METHADOSE DEL. W DIRECT INTER (OAT) 69 MIDODRINE HYDROCHLORIDE (DAT) 30 MINT-PRAVASTATIN (DAT) METHADOSE DEL. W/OUT DIR INTER (OAT) 69 MIFEGYMISO 140 MINT-QUETIAPINE (DAT) METHADOSE W DIRECT INTER (OAT) 69 MIGRANAL (DIL (DAT) 32 MINT-RAMIPRIL (DAT) METHADOSE W/OUT DIRECT INTER (OAT) 69 MINERAL OIL (DAT) 119 MINT-SERTRALINE (DAT) METHAZOLAMIDE (OAT) 116 MINERAL OIL, WHITE PETROLATUM (DAT) 117 MINT-TOLTERODINE (DAT) METHAZOLAMIDE (DAT) 116 MINESTRIN 1/20 (21-DAY) (DAT) 131 MINT-TOPIRAMATE (DAT) METHIMAZOLE (DAT) 138 MINESTRIN 1/20 (28-DAY) (DAT) 131 MINT-ZOLMITRIPTAN (DAT) METHOPRAZINE (DAT) 87 MINIMS ATROPINE (DAT) 115 MIO BLUE 6MMX18 (DAT) METHOTREXATE (DAT) 22 MINIMS CYCLOPENTOLATE (DAT) 115 MIO BLUE 6MMX23 (DAT)	• • •					137
METHADOSE DEL. W/OUT DIR INTER (OAT) METHADOSE W DIRECT (OAT) METHADOSE W DIRECT INTERACTION (OAT) METHADOSE W/OUT DIRECT INTER (OAT) METHADOSE W/OUT DIRECT INTER (OAT) METHADOSE W/OUT DIRECT INTER (OAT) MINERAL OIL MINERAL OIL MINERAL OIL (HEAVY) MINERAL OIL, WHITE PETROLATUM METHAZOLAMIDE METHOTAGE MINERAL OIL MINERAL OIL, WHITE PETROLATUM MINT-TOLTERODINE METHOPRAZINE METHOPRAZINE MINIMS ATROPINE MINIMS ATROPINE MINIMS ATROPINE MINIMS CYCLOPENTOLATE MINIMS CYCL						43
METHADOSE DEL. W/OUT DIR INTER (OAT) 69 MIFEGYMISO 140 MINT-QUETIAPINE (OAT) METHADOSE W DIRECT INTERACTION (OAT) 69 MILK OF MAGNESIA 119 MINT-RISPERIDON METHADOSE W/OUT DIRECT INTER (OAT) 69 MINERAL OIL 119 MINT-SERTRALINE (OAT) MINERAL OIL (HEAVY) 119 MINT-SIMVASTATIN METHAZOLAMIDE 116 MINERAL OIL, WHITE PETROLATUM 117 MINT-TOLTERODINE METHAZOLAMIDE 116 MINESTRIN 1/20 (21-DAY) 131 MINT-TOPIRAMATE METHIMAZOLE 138 MINESTRIN 1/20 (28-DAY) 131 MINT-ZOLMITRIPTAN METHOPRAZINE 87 MINIMS ATROPINE 115 MIO BLUE 6MMX18 METHOTREXATE 22 MINIMS CYCLOPENTOLATE 115 MIO BLUE 6MMX23		00				77
MIGRANAL 32 MINT-RAMIPRIL	METHADOSE DEL. W/OUT DIR INTER	69				89
METHADOSE W DIRECT 69 MILK OF MAGNESIA 119 MINT-RISPERIDON METHADOSE W/OUT DIRECT INTER (OAT) 69 MINERAL OIL (HEAVY) 119 MINT-SIMVASTATIN METHAZOLAMIDE 116 MINERAL OIL, WHITE PETROLATUM 117 MINT-TOLTERODINE METHIMAZOLE 138 MINESTRIN 1/20 (21-DAY) 131 MINT-ZOLMITENTAN METHOPRAZINE 87 MINIMS ATROPINE 115 MIO BLUE 6MMX18 METHOTREXATE 22 MINIMS CYCLOPENTOLATE 115 MIO BLUE 6MMX23	, ,					57
METHAZOLAMIDE 116 MINERAL OIL, WHITE PETROLATUM 117 MINT-SERTRALINE METHAZOLAMIDE 116 MINERAL OIL, WHITE PETROLATUM 117 MINT-TOLTERODINE METHAZOLAMIDE 116 MINESTRIN 1/20 (21-DAY) 131 MINT-TOPIRAMATE METHIMAZOLE 138 MINESTRIN 1/20 (28-DAY) 131 MINT-ZOLMITRIPTAN METHOPRAZINE 87 MINIMS ATROPINE 115 MIO BLUE 6MMX18 METHOTREXATE 22 MINIMS CYCLOPENTOLATE 115 MIO BLUE 6MX23		69				90
MINERAL OIL (HEAVY) 119 MINT-SIMVASTATIN	, ,	60				84
METHAZOLAMIDE116MINERAL OIL, WHITE PETROLATUM117MINT-TOLTERODINEMETHAZOLAMIDE116MINESTRIN 1/20 (21-DAY)131MINT-TOPIRAMATEMETHIMAZOLE138MINESTRIN 1/20 (28-DAY)131MINT-ZOLMITRIPTANMETHOPRAZINE87MINIMS ATROPINE115MIO BLUE 6MMX18METHOTREXATE22MINIMS CYCLOPENTOLATE115MIO BLUE 6MMX23		69				44
METHAZOLAMIDE 116 MINESTRIN 1/20 (21-DAY) 131 MINT-TOPIRAMATE METHIMAZOLE 138 MINESTRIN 1/20 (28-DAY) 131 MINT-ZOLMITRIPTAN METHOPRAZINE 87 MINIMS ATROPINE 115 MIO BLUE 6MMX18 METHOTREXATE 22 MINIMS CYCLOPENTOLATE 115 MIO BLUE 6MMX23		116	,			149
METHIMAZOLE138MINESTRIN 1/20 (28-DAY)131MINT-ZOLMITRIPTANMETHOPRAZINE87MINIMS ATROPINE115MIO BLUE 6MMX18METHOTREXATE22MINIMS CYCLOPENTOLATE115MIO BLUE 6MMX23			·			79
METHOPRAZINE 87 MINIMS ATROPINE 115 MIO BLUE 6MMX18 METHOTREXATE 22 MINIMS CYCLOPENTOLATE 115 MIO BLUE 6MMX23			, ,		MINT-ZOLMITRIPTAN	97
METHOTREXATE 22 MINIMS CYCLOPENTOLATE 115 MIO BLUE 6MMX23			• ,		MIO BLUE 6MMX18	165
AND CONTRACTOR OF THE CONTRACT			MINIMS CYCLOPENTOLATE	115	MIO BLUE 6MMX23	165
INETITOTICE/CVIE CODICIN	METHOTREXATE SODIUM	22	MINIMS PHENYLEPHRINE	115	MIO CLEAR 6MMX32	165
METHOTRIMEPRAZINE MALEATE 87 MINIMS PILOCARPINE 116 MIO CLEAR 9MMX32		87	MINIMS PILOCARPINE	116	MIO CLEAR 9MMX32	165

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				Non-insured nealth ben	ents
MIO PINK 6MMX18	165	MONTELUKAST SODIUM	111	MYLAN-CLOBETASOL	143
MIO PINK 6MMX23	165	MONTKIDDY BLUE NEEDLE 32GX4MM	168	MYLAN-DIVALPROEX	79
MIOSTAT	116	MONTKIDDY GREEN NEEDLE	168	MYLAN-EFAVIRENZ	11
MIRABEGRON	150	32GX4MM		MYLAN-	11
MIRAPEX	98	MONTKIDDY PINK NEEDLE 32GX4MM	168	EFAVIRENZ/EMTRICITABINE/TENOFOV IR DISOPROXIL FUMARATE	
MIRAPEX (ON)	98	MONTKIDDY YELLOW NEEDLE	168	MYLAN-EMTRICITABINE/TENOFOVIR	12
MIRENA	132	32GX4MM MONUROL	15	DISOPROXIL	12
MIRTAZAPINE	83	MORPHINE HYDROCHLORIDE	70	MYLAN-ENALAPRIL	54
MIRTAZAPINE	83	MORPHINE SR	70 70	MYLAN-ESCITALOPRAM	82
MIRVALA 21	131	MORPHINE SULFATE	70 70	MYLAN-FLUCONAZOLE	9
MIRVALA 28	131	MORPHINE SULFATE (KADIAN)	71	MYLAN-GALANTAMINE ER	28
MISC LIMITED USE COMPOUND INTERNAL	154	MOTION SICKNESS	121	MYLAN-GLICLAZIDE MR	136
MISC LIMITED USE EXTERNAL	154	MOTRIN	65	MYLAN-HYDROXYUREA	21
COMPOUND MIXTURE	134	MOVAPO	98	MYLAN-INDAPAMIDE	109
MISCELLANEOUS COMPOUNDED	154	MOVISSE	132	MYLAN-LAMOTRIGINE	76
EXTERNAL LOTION		MOXIFLOXACIN	7	MYLAN-LANSOPRAZOLE	123
MISCELLANEOUS COMPOUNDED	154	MOXIFLOXACIN HYDROCHLORIDE	7	MYLAN-MIRTAZAPINE	83
EXTERNAL POWDER	454	MOXIFLOXACIN HYDROCHLORIDE	113	MYLAN-MYCOPHENOLATE	162
MISCELLANEOUS COMPOUNDED EYE/EAR DROP	154	(OPHTHALMIC)		MYLAN-NEVIRAPINE	11
MISCELLANEOUS COMPOUNDED	154	MOZOBIL	39	MYLAN-NIFEDIPINE	53
INJECTION/INFUSION	101	M-PANTOPRAZOLE	124	MYLAN-NITRO	47
MISCELLANEOUS COMPOUNDED	154	M-PAROXETINE	83	MYLAN-ONDANSETRON	122
INTERNAL LIQUID		MPD THIN LANCET (NS)	167	MYLAN-PANTOPRAZOLE T	124
MISCELLANEOUS COMPOUNDED	154	MPD ULTRA THIN LANCET (100)	167	MYLAN-PERINDOPRIL/INDAPAMIDE	56
INTERNAL POWDER MISCELLANEOUS COMPOUNDED	151	MPD ULTRA THIN LANCET (200)	167	MYLAN PIEREPIPONE	41 90
SUPPOSITORY	154	M-PEG 3350	119	MYLAN-RISPERIDONE ODT MYLAN-RIZATRIPTAN ODT	90 96
MISCELLANEOUS COMPOUNDED	154	M-PRAVASTATIN	43 77	MYLAN-SUMATRIPTAN	96
TOPICAL CREAM		M-PREGABALIN	123	MYLAN-TENOFOVIR DISOPROXIL	12
MISCELLANEOUS COMPOUNDED	154	M-RANITIDINE MS CONTIN SR	70	MYLAN-TOLTERODINE ER	149
TOPICAL OINTMENT		MS IR	70 70	MYLAN-TOPIRAMATE	79
MISOPROSTOL	123	M-SENNOSIDES	120	MYLAN-VALACYCLOVIR	13
MISOPROSTOL	123	M-SULFATE FERREUX	36	MYLAN-VANCOMYCIN	8
MISOPROSTOL, DICLOFENAC SODIUM	66	MUCILLIUM	120	MYLAN-VERAPAMIL	54
MISOPROSTOL, MIFEPRISTONE	140	MULTIVITAMINS (CHILDREN AND	153	MYLAN-VERAPAMIL SR	54
MITOTANE	23	YOUTH)	.00	MYLERAN	18
MK 10	107	MULTIVITAMINS (PRENATAL)	153	MYRBETRIQ	150
MK 20	107	MUPIROCIN	141	NABILONE	122
MK 8 MK20 SOLUBLE	107 107	MUPIROCIN CALCIUM	141	NACL SALINE PF	107
MMAGNESIUM GLUCONATE	107	MURO 128	117	NADOLOL	51
M-MOXIFLOXACIN	7	M-VENLAFAXINE XR	85	NADOLOL	51
MMT-174 ADHESIVE	166	MYA	131	NADROPARIN CALCIUM	38
MOCLOBEMIDE	83	MYCOBUTIN	10	NADRYL	1
MOCLOBEMIDE	83	MYCOPHENOLATE	162	NAFARELIN ACETATE	133
MODAFINIL	92	MYCOPHENOLATE MOFETIL	162	NALCROM	111
MOGADON	94	MYCOPHENOLATE MOFETIL	162	NALOXONE	73
MOMETASONE CREAM	145	MYCOPHENOLATE SODIUM	163	NALOXONE HYDROCHLORIDE	73
MOMETASONE FUROATE	114	MYDFRIN	115	NALOXONE KIT	73
MONA LISA 10	102	MYDRIACYL	115	NALTREXONE HYDROCHLORIDE	73
MONA LISA 5	102	MYFORTIC	163	NALTREXONE HYDROCHLORIDE	73
MONA LISA N	102	MYHEALTH SYRINGE CASE-7	170	NAPHAZOLINE HYDROCHLORIDE	115
MONISTAT 3	142	MYHEALTH SYRINGE CASE-SINGLE	170	NAPROSYN	67
MONISTAT 3 DUAL-PAK	142	MYLAN-ABACAVIR/LAMIVUDINE	10	NAPROXEN	66
MONISTAT 7	142	MYLAN ALMOTRIDIAN	13	NAPROXEN	66
MONISTAT 7 DUAL-PAK	142	MYLAN AM ODIDINE	95 53	NAPROXEN EC	67
MONISTAT DERM	142	MYLAN-AMLODIPINE MYLAN-ATAZANAVIR	52 10	NAPROXEN SODIUM	66 67
MONOFERRIC	36	MYLAN-ATAZANAVIR MYLAN-ATORVASTATIN	42	NAPROXEN SODIUM DS	67 66
MONOJECT	168	MYLAN-BACLOFEN	33	NAPROXEN-NA	66 67
MONOJECT ALCOHOL WIPES	166	MYLAN-BECLO AQ	114	NAPATRIPTAN HYDROCHI OPIDE	67 96
MONOLET 21G LANCET	167	MYLAN-BUDESONIDE AQ	114	NARATRIPTAN HYDROCHLORIDE NARCAN	96 73
MONOLET THIN (MONOJECT) 28G	167	MYLAN-BUPROPION XL	80	NARDIL	73 84
MONTELUKAST	111	MYLAN-CILAZAPRIL	54	NASACORT AQ	0 4 114
MONTELUKAST SODIUM	110	MYLAN-CIMETIDINE	122	NASONEX	114
					. 17

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				Non-insured Health I	Benefits
NAT-ANASTROZOLE	17	NIMOTOP	53	NRA-EZETIMIBE	42
NAT-CITALOPRAM	80	NINTEDANIB ESILATE	110	NRA-PANTOPRAZOLE	124
NAT-DONEPEZIL	28	NITOMAN	101	NRA-PAROXETINE	83
NAT-ERLOTINIB	20	NITRAZEPAM		NRA-PREGABALIN	77
			94		
NAT-ESCITALOPRAM	82	NITRO-DUR	47	NRA-ROSUVASTATIN	44
NAT-GRANISETRON	121	NITROFURANTOIN	15	NSAID IN TRANSDERMAL BASE	154
NAT-IMATINIB	21	NITROFURANTOIN	15	NU-CAL	106
NAT-LETROZOLE	22	NITRO-FURANTOIN ORAL LIQUID	15	NU-CAL D	106
NAT-LEVETIRACETAM	76	NITROGLYCERIN	47	NUCALA	162
NAT-OMEPRAZOLE DR	124	NITROLINGUAL PUMPSPRAY	47	NUTRAMIGEN A+ 945ML LIQ	171
NAT-ONDANSETRON	122	NITROSTAT	47	NUTRAMIGEN A+ LGG 561G PDR	172
NAT-OSELTAMIVIR	13	NIX	142	NUTREN JR. 250ML LIQ	171
NAT-QUETIAPINE	89	NIX DERMAL	142	NUTRITIONAL SUPPLEMENT	172
NAT-RIZATRIPTAN ODT	96			NUVARING	
		NIZATIDINE	122		131
NAT-TENOFOVIR	12	NIZORAL	142	NYADERM	142
NATURAL HEALTH PRODUCT	155	NOLVADEX-D	26	NYDA	142
NATURES BOUNTY PRENATAL	153	NON POLLEN	155	NYSTATIN	9
VITAMINS		NORETHINDRONE	132	OBETICHOLIC ACID	125
NAT-ZOLMITRIPTAN	97	NORETHINDRONE, ETHINYL	132	O-CALCIUM	106
NAVANE	91	ESTRADIOL		OCALIVA	125
NELFINAVIR MESYLATE	11	NORFLOXACIN	7	OCCLUSAL HP	146
NEOCATE JR FIBER&IRON 400G PDR	171	NORFLOXACIN	7	OCRELIZUMAB	158
NEOCATE JUNIOR 400G PDR	172	NORGESTIMATE, ETHINYL ESTRADIOL	132	OCREVUS	158
NEOCATE ONE 400G	172	NORITATE	141		
NEOCATE W/ DHA & ARA 400G PDR	172			OCTREOTIDE ACETATE	154
		NORPROLAC	155	OCTREOTIDE ACETATE OMEGA	154
NEO-FER	36	NORTRIPTYLINE HYDROCHLORIDE	83	OCUFLOX	113
NEORAL	162	NORVASC	52	ODAN K20	107
NEOSTIGMINE BROMIDE	29	NORVIR	12	ODAN K8	107
NEO-ZOL	142	NOVA MAX	103	ODAN LIQUOR CARBONIS	146
NEPAFENAC	115	NOVAMILOR	109	DETERGENT	
NESTL MATERNA	153	NOVAMOXIN	5	ODAN SODIUM CHLORIDE	117
NETUPITANT, PALONOSETRON	121	NOVASEN	64	ODAN-ERYTHROMYCIN	113
(PALONOSETRON HYDROCHLORIDE)		NOVA-T	102	ODAN-FLUOXETINE	82
NEULASTA	39	NOVO-CLINDAMYCIN	8	ODAN-SODIUM CHLORIDE	117
NEULEPTIL	88			ODAN-SODIUM POLYSTYRENE	107
NEUPOGEN	39	NOVOFINE 30GX 6MM NEEDLE	167	SULFONATE	107
	39	NOVOFINE 30GX 8MM NEEDLE	167	ODEFSEY	11
NEUPOGEN (ON)		NOVOFINE 32G TIP PEN NEEDLE	168		
NEUPOGEN (QC)	39	NOVOFINE PLUS 4MM NEEDLE	168	OESCLIM	132
NEUPRO	99	NOVO-FLUCONAZOLE	9	OFEV	110
NEURONTIN	75	NOVO-GESIC	72	OFLOXACIN	113
NEUTROGENA	146	NOVO-GESIC FORTE	72	OLANZAPINE	87
NEVANAC	115	NOVO-HYDROXYZIN	95	OLANZAPINE	87
NEVIRAPINE	11	NOVOLIN GE 30/70	134	OLANZAPINE ODT	88
NIACIN	151			OLAPARIB	23
NIACIN	151	NOVOLIN GE 30/70 PENFILL	134	OLESTYR	41
NICHIT	34	NOVOLIN GE 40/60 PENFILL	135	OLMESARTAN MEDOXOMIL	60
NICODERM		NOVOLIN GE 50/50 PENFILL	135		
	34	NOVOLIN GE NPH	135	OLMESARTAN MEDOXOMIL, HYDROCHLOROTHIAZIDE	61
NICORETTE GUM	33	NOVOLIN GE NPH 100U/ML PENFILL	135	OLMETEC	61
NICORETTE INHALER	33	NOVOLIN GE NPH PENFILL	135		61
NICORETTE LOZENGE	34	NOVOLIN GE TORONTO	135	OLMETEC PLUS	61
NICORETTE QUICKMIST	34	NOVOLIN GE TORONTO PENFILL	135	OLODATEROL HYDROCHLORIDE,	32
NICOTINE (GUM)	33	NOVOLIN-PEN NEEDLE	167	TIOTROPIUM BROMIDE	
NICOTINE (INHALER)	33	NOVO-PENICILLIN G POTASSIUM	5	MONOHYDRATE	
NICOTINE (LOZENGE)	34			OLOPATADINE HYDROCHLORIDE	113
NICOTINE (PATCH)	34	NOVO-PROFEN	65	OLSALAZINE SODIUM	125
		NOVORAPID	135	OMALIZUMAB	112
NICOTINE (SPRAY)	34	NOVOTWIST TIP 30G NEEDLE	168	OMEPRAZOLE	124
NICOTINE GUM	33	NOVOTWIST TIP 32G NEEDLE	168	OMEPRAZOLE MAGNESIUM	124
NICOTINE TRANSDERMAL	34	NRA-AMLODIPINE	51	OMEPRAZOLE ORAL LIQUID	124
NICOTINE TRANSDERMAL SYSTEM	34	NRA-ATORVASTATIN	42	OMEPRAZOLE-20	124
NIDAGEL	141	NRA-AZITHROMYCIN	4		
NIFEDIPINE	53	NRA-CELECOXIB	64	ONABOTULINUMTOXINA	164
NIFEDIPINE	53	NRA-CITALOPRAM	80	ONBREZ BREEZHALER	32
NILOTINIB	23		81	ONDANSETRON	121
NILUTAMIDE	23	NRA-DULOXETINE		ONDANSETRON HYDROCHLORIDE	121
	23 53	NRA-ESCITALOPRAM	82	ONDANSETRON ODT	122
NIMODIPINE	อง				

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				Non-insured nearth ben	ent2
ONDISSOLVE ODF	121	PANTOPRAZOLE SODIUM	124	PENICILLIN G SODIUM	5
ONE A DAY WOMEN	153	PANTOPRAZOLE T	124	PENICILLIN G SODIUM	5
ONE ALPHA	152	PANTOPRAZOLE-40	124	PENICILLIN G STERILE INFUSION	5
ONE TOUCH DELICA 30G LANCET	167	PARADIGM SILHOUETTE 13MMX 43	166	PENICILLIN V POTASSIUM	5
ONE TOUCH ULTRA	103	PARADIGM SILHOUETTE 13MMX18"	166	PENTASA	125
ONE-ALPHA	152	PARADIGM SILHOUETTE 13MMX23	166		155
				PENTOSAN POLYSULFATE SODIUM	
ONETOUCH DELICA 33G LANCET	167	PARADIGM SILHOUETTE 13MMX32"	166	PENTOXIFYLLINE	39
ONETOUCH DELICAPLUS 30G LANCET	167	PARADIGM SILHOUETTE 17MMX23	166	PENTOXIFYLLINE	39
ONETOUCH DELICAPLUS 33G LANCET	167	PARADIGM SILHOUETTE 17MMX32"	166	PEN-VK	5
ONETOUCH ULTRASOFT LANCET	167	PARADIGM SILHOUETTE 17MMX43	166	PEPTAMEN 1.5 1000ML LIQ	171
ONETOUCH VERIO	103	PARADIGM SILHOUETTE CANNULA	166	PEPTAMEN 1.5 250ML LIQ	171
ONETOUCH VERIO (ON)	103	13MM		PEPTAMEN 250ML LIQ	171
ONGLYZA	134	PARADIGM SILHOUETTE CANNULA	166	PEPTAMEN JUNIOR 1.0 CAL 250ML LIQ	171
OPIOID COMPOUNDED	154	17MM	400	PEPTAMEN JUNIOR 1.5 CAL 250ML LIQ	171
OPTICHAMBER	165	PARADIGM SURE-T 29G 6MMX18	166	PEPTAMEN WITH PREBIO 1000ML LIQ	171
OPTICHAMBER DIAMOND (CHAMBER)	165	PARADIGM SURE-T 29G 6MMX23	166	PEPTAMEN WITH PREBIO 250ML LIQ	171
OPTICHAMBER DIAMOND LARGE	165	PARADIGM SURE-T 29G 8MMX23	166	PEPTO BISMOL	119
MASK		PARIET	124	PEPTO-BISMOL	119
OPTICHAMBER DIAMOND MEDIUM	165	PARNATE	84	PERAMPANEL	77
MASK		PAROMOMYCIN SULFATE	15	PERICHLOR	114
OPTICHAMBER DIAMOND SMALL	165	PAROXETINE	83		
MASK		PAROXETINE HYDROCHLORIDE	83	PERICYAZINE	88
OPTICHAMBER LARGE MASK	165	PARSITAN	97	PERIDEX	114
OPTICHAMBER MEDIUM MASK	165	PATANOL	113	PERINDOPRIL ERBUMINE	56
OPTICHAMBER SMALL MASK	165	PATE D'IHLE	146	PERINDOPRIL ERBUMINE	56
OPTICROM	113	PÂTE D'IHLE	146	PERINDOPRIL ERBUMINE,	56
OPTIHALER	165	PAT-GALANTAMINE ER	28	INDAPAMIDE	
OPTIMYXIN	113			PERMETHRIN	142
OPTION 2	131	PAXIL	83	PERPHENAZINE	88
OPUS CAL D	106	PAZOPANIB	24	PERPHENAZINE	88
OPUS SENNOSIDES	120	PDP-ACETAMINOPHEN	72	PETROLATUM, MINERAL OIL	117
		PDP-BENZTROPINE	97	PHARIXIA	115
OPUS VITAMINE B1	153	PDP-DESONIDE	144	PHARMA-AMLODIPINE	51
ORACORT DENTAL PASTE	145	PDP-DIPHENHYDRAMINE	1	PHARMA-CAL	106
ORCIPRENALINE	32	PDP-ERYTHROMYCIN	113	PHARMA-D	152
ORCIPRENALINE SULFATE	32	PDP-ISONIAZID	10	PHARMA-ESCITALOPRAM	82
ORENCIA	160	PDP-PROCYCLIDINE	97	PHARMA-K20	107
OSELTAMIVIR	13	PDP-PYRAZINAMIDE	10	PHARMA-LACOSAMIDE	75
OSIMERTINIB	23	PEDIAFER	36	PHARMA-LACTULOSE	105
OVIMA 21	131	PEDIALYTE	106	PHARMALGEN HONEY BEE VENOM	155
OVIMA 28	131	PEDIAPHEN	72		
OXAZEPAM	94	PEDIAPRED	130	PHARMALGEN MIXED VESPID VENOM PROTEIN	155
OXAZEPAM	94	PEDIASURE 235ML LIQ	171	PHARMALGEN WASP VENOM	155
OXCARBAZEPINE	77	PEDIASURE COM. GROW&GAIN 235ML	171	PROTEIN	100
OXCARBAZEPINE (SUSPENSION)	77	LIQ	171	PHARMALGEN WHITE FACED	155
OXEZE TURBUHALER	31	PEDIASURE FIBRE 235ML LIQ	171	HORNET VENOM	100
OXPAM	94	PEDIASURE GROW&GAIN 400G PDR	171	PHARMALGEN YELLOW HORNET	155
OXTRIPHYLLINE	150	PEDIASURE PLUS WITH FIBRE 235	171	VENOM PROTEIN	
OXYBUTYNIN		PEDIATRIC ELECTROLYTE	106	PHARMALGEN YELLOW JACKET	155
	149	PEDIATRIX	72	VENOM PROTEIN	
OXYBUTYNIN CHLORIDE	149			PHARMA-RAMIPRIL	57
OXYCODONE HYDROCHLORIDE	71	PEDIAVIT	153	PHARMA-SIMVASTATIN	44
OXYCODONE/ACET	67	PEDIAVIT D	152	PHENAZOPYRIDINE COMPOUNDED	154
OXY-IR	71	PEG 3350	120	PHENAZOPYRIDINE HYDROCHLORIDE	145
OYSTER SHELL CALCIUM	106	PEGASYS	12	PHENELZINE SULFATE	84
OZEMPIC	134	PEGETRON KIT	12	PHENOBARB	73
PALAFER	36	PEGFILGRASTIM	39	PHENOBARBITAL	73
PALBOCICLIB	24	PEGFILGRASTIM (LAPELGA)	39	PHENYLEPHRINE	115
PALIPERIDONE PALMITATE	88	PEGINTERFERON ALFA-2A	12		
PAMIDRONATE	159	PEGINTERFERON ALFA-2B, RIBAVIRIN	12	PHENYLEPHRINE HYDROCHLORIDE	115
PAMIDRONATE DISODIUM	159	PEGINTERFERON BETA-1A	13	PHENYTOIN	74
PAMIDRONATE DISODIUM	159	PEGLYTE	119	PHILIPS MAGNESIA	119
PAMIDRONATE DISODIUM OMEGA	159	PEN NEEDLE	167	PHILLIPS MILK OF MAGNESIA	119
PANTOLOC	124	PENICILLAMINE	128	PHOSLAX	120
PANTOPRAZOLE	124	PENICILLAMINE PENICILLIN G	5	PHOSPHATES	120
		PENICILLIN G PENICILLIN G BENZATHINE	5 5	PHYTONADIONE	153
PANTOPRAZOLE MAGNESIUM	124 124			PICO-SALAX	119
PANTOPRAZOLE MAGNESIUM	124	PENICILLIN G POTASSIUM	5		

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				Non-insured nearth	Denents
PILOCARPINE	116	PMS-BUPRENORPHINE-NALOXONE	71	PMS-IRBESARTAN-HCTZ	59
PILOCARPINE HYDROCHLORIDE	29	PMS-BUPROPION SR	80	PMS-ISMN	47
PILOCARPINE HYDROCHLORIDE	29	PMS-BUSPIRONE	95	PMS-ISOSORBIDE	47
PILOCARPINE NITRATE	116	PMS-CANDESARTAN	58	PMS-KETOPROFEN	66
PIMECROLIMUS	148	PMS-CANDESARTAN HCTZ	59	PMS-LACTULOSE	105
PIMOZIDE	88	PMS-CAPTOPRIL	54	PMS-LACTULOSE-PHARMA	105
PIMOZIDE	88	PMS-CARBAMAZEPINE	74	PMS-LAMOTRIGINE	76
PINAVERIUM BROMIDE	125	PMS-CARVEDILOL	50	PMS-LANSOPRAZOLE	123
PINDOLOL	51	PMS-CELECOXIB	64	PMS-LATANOPROST	116
PINDOLOL	51	PMS-CEPHALEXIN	3	PMS-LATANOPROST-TIMOLOL	116
PIOGLITAZONE HYDROCHLORIDE	137	PMS-CETIRIZINE	1	PMS-LEFLUNOMIDE	161 22
PIPERACILLIN AND TAZOBACTAM	5	PMS-CILAZAPRIL PMS-CIPROFLOXACIN	54 6	PMS-LETROZOLE PMS-LEVETIRACETAM	76
PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	5	PMS-CITALOPRAM	80	PMS-LEVOCARB	97
PIPERACILLIN, TAZOBACTAM	5	PMS-CLARITHROMYCIN	4	PMS-LEVOFLOXACIN	6
PIPERONYL BUTOXIDE, PYRETHRINS	142	PMS-CLOBAZAM	73	PMS-LIDOCAINE VISCOUS	139
PIPORTIL L4	88	PMS-CLOBETASOL	143	PMS-LISINOPRIL	55
PIPOTIAZINE PALMITATE	88	PMS-CLONAZEPAM	73	PMS-LITHIUM CARBONATE	95
PIRFENIDONE	110	PMS-CLONAZEPAM-R	73	PMS-LITHIUM CITRATE	95
PIROXICAM	67	PMS-CLOPIDOGREL	39	PMS-LOPERAMIDE	119
PIZOTIFEN MALATE	97	PMS-COLCHICINE	157	PMS-LORAZEPAM	94
PLAN B	131	PMS-CYCLOBENZAPRINE	33	PMS-LOSARTAN	60
PLAQUENIL	15	PMS-DESMOPRESSIN	137	PMS-LOSARTAN-HCTZ	60
PLASTIPAK MICRO	168	PMS-DEXAMETHASONE	114	PMS-LOVASTATIN	43
PLAVIX	39	PMS-DIAZEPAM	93	PMS-MELOXICAM	66
PLEGRIDY	13	PMS-DICLOFENAC	65	PMS-METFORMIN	133
PLENDIL	53	PMS-DICLOFENAC-MISOPROSTOL	66	PMS-METHOTREXATE	23
PLERIXAFOR	39	PMS-DILTIAZEM CD	53	PMS-METHYLPHENIDATE	92
PMS DESIPRAMINE	81	PMS-DIMENHYDRINATE	121	PMS-METHYLPHENIDATE ER	92
PMS DEXAMETHASONE	129	PMS-DIPHENHYDRAMINE	1	PMS-METOPROLOL-B	50
PMS FLUPHENAZINE	86	PMS-DIVALPROEX	79	PMS-METOPROLOL-L	50
PMS HYDROMORPHONE	69	PMS-DOMPERIDONE	125	PMS-MIRTAZAPINE	83
PMS HYDROXYZINE	95	PMS-DONEPEZIL	28	PMS-MOCLOBEMIDE	83
PMS PERPHENAZINE	88	PMS-DORZOLAMIDE-TIMOLOL	116	PMS-MOMETASONE	145
PMS PROCHLORPERAZINE	89	PMS-DOXAZOSIN	48	PMS-MONTELUKAST	111
PMS TRAZODONE	84	PMS-DULOXETINE	81	PMS-MOXIFLOXACIN	113
PMS-ABACAVIR/LAMIVUDINE	10	PMS-DUTASTERIDE	156	PMS-NABILONE	122
PMS-ACETAMINOPHEN	67	PMS-EMTRICITABINE-TENOFOVIR	12	PMS-NAPROXEN	66
PMS-ALENDRONATE	158	PMS-ENTECAVIR	13	PMS-NAPROXEN EC	67
PMS-AMANTADINE	10	PMS-ERLOTINIB	20	PMS-NIFEDIPINE	53
PMS-AMIODARONE	41	PMS-ESCITALOPRAM	82	PMS-NITROFURANTOIN	15
PMS-AMITRIPTYLINE	80	PMS-EZETIMIBE	42	PMS-NIZATIDINE	122 9
PMS-AMLODIPINE	51 52	PMS-FAMCICLOVIR	13	PMS-NYSTATIN	_
PMS-AMLODIPINE-ATORVASTATIN PMS-AMOXICILLIN	52 5	PMS-FENTANYL MTX PMS-FERROUS SULFATE	68 36	PMS-OLANZAPINE PMS-OLANZAPINE ODT	87 88
PMS-AMPHETAMINES XR	91	PMS-FINASTERIDE	156	PMS-OLMESARTAN	61
PMS-ANAGRELIDE	38	PMS-FINGOLIMOD	157	PMS-OLMESARTAN PMS-OMEPRAZOLE	124
PMS-ANASTROZOLE	17	PMS-FLUCONAZOLE	9	PMS-ONDANSETRON	122
PMS-ARIPIPRAZOLE	85	PMS-FLUOXETINE	82	PMS-OXYBUTYNIN	149
PMS-ASA EC	64	PMS-FLUPHENAZINE	86	PMS-OXYCODONE	71
PMS-ATENOLOL	49	PMS-FLUTAMIDE	20	PMS-PAMIDRONATE	159
PMS-ATOMOXETINE	99	PMS-FOSINOPRIL	55	PMS-PANTOPRAZOLE	124
PMS-AZITHROMYCIN	3	PMS-FUROSEMIDE	108	PMS-PAROXETINE	83
PMS-BACLOFEN	33	PMS-GABAPENTIN	75	PMS-PERINDOPRIL	56
PMS-BENZTROPINE	97	PMS-GALANTAMINE ER	29	PMS-PINDOLOL	51
PMS-BENZYDAMINE	115	PMS-GEMFIBROZIL	42	PMS-PIOGLITAZONE	137
PMS-BETAHISTINE	100	PMS-GLYBURIDE	137	PMS-POLYTRIMETHOPRIM	113
PMS-BEZAFIBRATE	42	PMS-HALOPERIDOL	86	PMS-POTASSIUM	107
PMS-BICALUTAMIDE	18	PMS-HYDROCHLOROTHIAZIDE	109	PMS-PRAVASTATIN	43
PMS-BISACODYL	119	PMS-HYDROMORPHONE	69	PMS-PREDNISOLONE	130
PMS-BISOPROLOL	49	PMS-IBUPROFEN	66	PMS-PREGABALIN	77
PMS-BOSENTAN	48	PMS-IMATINIB	21	PMS-PROCHLORPERAZINE	88
PMS-BRIMONIDINE	115	PMS-IPRATROPIUM	30	PMS-PROGESTERONE	138
PMS-BROMOCRIPTINE	98	PMS-IRBESARTAN	59	PMS-PROPAFENONE	41

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				Non-insured nearth be	ments
PMS-PROPRANOLOL	51	POLYETHYLENE GLYCOL 3350	119	PREZISTA	10
PMS-QUETIAPINE	89	POLYETHYLENE GLYCOL 3350	119	PRIMAQUINE	15
PMS-QUINAPRIL	56	POLYETHYLENE GLYCOL 3350,	120	PRIMAQUINE PHOSPHATE	15
PMS-RABEPRAZOLE	124	SODIUM SULFATE, SODIUM		PRIMIDONE	73
PMS-RALOXIFENE	133	BICARBONATE, SODIUM CHLORIDE, POTASSIUM CHLORIDE		PRIMIDONE	73
PMS-RAMIPRIL	57	POLYETHYLENE GLYCOL 3350,	120	PRINIVIL	55
PMS-RAMIPRIL-HCTZ	57	SODIUM SULFATE, SODIUM	120	PRIVA-CELECOXIB	64
PMS-RANITIDINE	123	BICARBONATE, SODIUM CHLORIDE,		PRIVA-CETIRIZINE	1
PMS-RISEDRONATE	159	POTASSIUM CHLORIDE, BISACODYL		PRIVA-ESCITALOPRAM	82
PMS-RISPERIDONE	90	POLYMYXIN B SULFATE, BACITRACIN	113	PRIVA-EZETIMIBE	42
PMS-RIVASTIGMINE	29	ZINC		PRIVA-FLUCONAZOLE	9
PMS-RIZATRIPTAN RDT	96	POLYMYXIN B SULFATE, BACITRACIN	141	PRIVA-PANTOPRAZOLE	124
PMS-ROPINIROLE	99	ZINC, GRAMICIDIN		PRIVA-VALACYCLOVIR	13
PMS-ROSUVASTATIN	44	POLYMYXIN B SULFATE, GRAMICIDIN	113	PRO AMOX	5
PMS-SALBUTAMOL	32	POLYMYXIN B SULFATE, TRIMETHOPRIM SULFATE	113	PRO-AAS	64
PMS-SENNOSIDES	120	POLYSACCHARIDE IRON COMPLEX	36	PRO-AMIODARONE	41
PMS-SERTRALINE	84	POLYSPORIN	113	PRO-AMOX	5
PMS-SILDENAFIL R	47	POLYSPORIN ANTIBIOTIC	141	PRO-AZITHROMYCINE	4
PMS-SIMVASTATIN	44	POLYSPORIN EYE AND EAR	113	PRO-BICALUTAMIDE	18
PMS-SODIUM CROMOGLYCATE	111	POLYSPORIN TRIPLE	141	PRO-BISOPROLOL	49
PMS-SOLIFENACIN	149	POLYTOPIC	141	PROBUPHINE	71
PMS-SOTALOL	51	POLYTRIM	113	PROCAINAMIDE HYDROCHLORIDE	41
PMS-SULFASALAZINE	7			PROCAL 500	106
PMS-SUMATRIPTAN	96	POLYVINYL ALCOHOL	117	PROCALD 400	106
PMS-TELMISARTAN	61	POMALYOT	24	PROCAN SR	41
PMS-TELMISARTAN-HCTZ	61	POMALYST	24	PROCARBAZINE HYDROCHLORIDE	24
PMS-TENOFOVIR	12	PONATINIB HYDROCHLORIDE	24	PRO-CEFADROXIL	2
PMS-TERAZOSIN	48	PONSTAN	66	PRO-CEFUROXIM	3
PMS-TERBINAFINE	9	PORTIA 21	131	PROCHLORAZINE	88
PMS-TESTOSTERONE	131	PORTIA 28	131	PROCHLORPERAZINE	88
PMS-TETRABENAZINE	101	POTASSIUM CHLORIDE	107	PROCHLORPERAZINE MALEATE	88
PMS-TIAPROFENIC	67	POTASSIUM CITRATE	105	PROCHLORPERAZINE MESYLATE	89
PMS-TIMOLOL	116	POTASSIUM CITRATE	107	PRO-CIPROFLOXACIN	6
PMS-TOPIRAMATE	79	POVIDONE-IODINE	142	PRO-CLONAZEPAM	73
PMS-TRANDOLAPRIL	58	PRADAXA	37	PROCTODAN-HC	144
PMS-TRAZODONE	84	PRALUENT	46	PROCTOL	144
PMS-TRIHEXYPHENIDYL	97	PRAMIPEXOLE BUILDINGS OF STREET	98	PROCTOSEDYL	144
PMS-URSODIOL	120	PRAMIPEXOLE DIHYDROCHLORIDE	98	PROCYCLIDINE (PQ)	97
PMS-VALACYCLOVIR	13	PRAVACHOL	43	PROCYCLIDINE HCL	97
PMS-VALPROIC ACID	79	PRAVASTATIN CORUM	43	PROCYCLIDINE HYDROCHLORIDE	97
PMS-VANCOMYCIN	8	PRAVASTATIN SODIUM	43	PROCYTOX	19
PMS-VANCOMYCIN 1 G	8	PRAVASTATIN 00	43	PRO-ENALAPRIL	54
PMS-VENLAFAXINE XR	85	PRAVASTATIN 40	43	PRO-FENO-SUPER	42
PMS-VERAPAMIL SR	54	PRAVASTATIN-40	44	PRO-FLUCONAZOLE	9
PMS-ZOLMITRIPTAN	97	PRAXIS ASA DAILY LOW DOSE	64	PRO-FLUOXETINE	82
PMS-ZOLMITRIPTAN ODT	97	PRAZOSIN HYDROCHLORIDE	48	PRO-GABAPENTIN	75
POCKET CHAMBER	165	PRECISION XTRA	103	PROGESTERONE	138
POCKET CHAMBER WITH ADULT	165	PRED FORTE	114	PROGLYCEM	47
MASK		PRED MILD	114	PROGRAF	163
POCKET CHAMBER WITH INFANT	165	PREDNISOLONE ACETATE	114	PRO-INDAPAMIDE	109
MASK	405	PREDNISOLONE ACETATE, SULFACETAMIDE SODIUM	114	PRO-ISMN	47
POCKET CHAMBER WITH MEDIUM MASK	165	PREDNISOLONE SODIUM PHOSPHATE	114	PRO-K 20	107
POCKET CHAMBER WITH SMALL	165	PREDNISOLONE/SULFACETAMIDE	114	PRO-LEVETIRACETAM	76
MASK	103	PREDNISONE	130	PRO-LEVOCARB	97
PODOFILM	148	PREDNISONE ORAL LIQUID	130	PROLIA	159
PODOFILOX	148	PREGABALIN	77	PRO-LISINOPRIL	55
PODOPHYLLIN	148	PREGABALIN PREGABALIN	77	PROLOPA	97
PODS	165	PREMARIN	132	PRO-LORAZEPAM	94
POLISTES SPP VENOM PROTEIN	155	PRENATAL AND POSTPARTUM	153	PRO-METFORMIN	133
EXTRACT		VITAMINS AND MINERALS	100	PROMETRIUM	138
POLLEN	155	PREVACID	123	PRO-MIRTAZAPINE	83
POLLEN AND NON POLLEN	155	PREVACID FASTAB	123	PRO-NAPROXEN	67
POLLINEX R	155	PREVEX HC	145	PROPADERM	143
POLYETHYLENE GLYCOL	119	PREZCOBIX	10	PROPAFENONE	41
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				Non-insured nearth ben	CIII
PROPAFENONE HYDROCHLORIDE	41	RAN-BICALUTAMIDE	18	RAPID-D 8MM/60CM	166
PRO-PIOGLITAZONE	137	RAN-BUPROPION XL	80	RAPID-D 8MM/80CM	166
PROPIVERINE HYDROCHLORIDE	149	RAN-CANDESARTAN	58	RATIO-AMCINONIDE	143
PROPRANOLOL (HEMANGIOL)	51	RAN-CARVEDILOL	50	RATIO-ECTOSONE	143
PROPRANOLOL HYDROCHLORIDE	51	RAN-CEFPROZIL	2	RATIO-FLUTICASONE	114
PROPRANOLOL ORAL LIQUID	51	RAN-CELECOXIB	64	RATIO-HEMCORT-HC	144
PROPYLTHIOURACIL	138	RAN-CIPROFLOX	6	RATIO-IPRA SAL	30
PROPYL-THYRACIL	138	RAN-CITALO	81	RATIO-IPRATROPIUM	30
PRO-QUETIAPINE	89	RAN-CLARITHROMYCIN	4	RATIO-LACTULOSE	105
PRO-RABEPRAZOLE	124	RAN-CLOPIDOGREL	39	RATIO-LENOLTEC NO 2	67
PRO-RAMIPRIL	57	RAN-CYPROTERONE/ETHINYL ESTRADIOL	163	RATIO-LENOLTEC NO 3 RATIO-METFORMIN	67
PRO-RISPERIDONE	90	RAN-DOMPERIDONE	125		133 142
PROSCAR	156	RAN-DONEPEZIL	28	RATIO-NYSTATIN RATIO-TAMSULOSIN	33
PRO-SOTALOL PROSTIGMIN	51 29	RAN-DULOXETINE	81	RATIO-TANISOLOGIN RATIO-TOPISALIC	143
PROTOPIC	29 148	RAN-ENALAPRIL	54	REACTINE	1
PRO-TOPIRAMATE	79	RAN-ESCITALOPRAM	82	REBIF	157
PROTRIN DF	7	RAN-EZETIMIBE	42	REDDY-ATORVASTATIN	42
PRO-VALACYCLOVIR	13	RAN-FINASTERIDE	156	REDDY-PROGESTERONE	138
PROVERA	137	RAN-FLUOXETINE	82	REFRESH CELLUVISC	117
PROZAC	82	RAN-FOSINOPRIL	55	REFRESH LACRI-LUBE	117
PSYLLIUM MUCILLOID	120	RAN-GABAPENTIN	75	REFRESH LIQUIGEL	117
PULMICORT NEBUAMP	129	RAN-GLICLAZIDE	136	REFRESH PLUS	117
PULMICORT TURBUHALER	129	RAN-GLICLAZIDE MR	136	REFRESH TEARS	117
PULMOPHYLLINE	150	RANIBIZUMAB	117	REFUSAL TO FILL	171
PURAMINO A+ 400G PDR	172	RAN-IRBESARTAN	59	REGORAFENIB	24
PURAMINO A+ JUNIOR 400G PDR	172	RAN-IRBESARTAN HCTZ	59	RELAXA	120
PURG-ODAN	119	RANITIDINE	123	REMERON	83
PURINETHOL	22	RANITIDINE HYDROCHLORIDE	123	REMERON RD	83
PYRANTEL PAMOATE	2	RAN-LANSOPRAZOLE	123	REMICADE	161
PYRAZINAMIDE	10	RAN-LETROZOLE	22	RENAGEL	108
PYRIDIUM	145	RAN-LEVETIRACETAM	76	RENFLEXIS	160
PYRIDOSTIGMINE BROMIDE	29	RAN-LISINOPRIL	55	RENVELA	108
PYRIDOXINE HYDROCHLORIDE	151	RAN-METFORMIN	133	REPAGLINIDE	135
QUETIAPINE	89	RAN-MONTELUKAST	111	REPAGLINIDE	135
QUETIAPINE FUMARATE	89	RAN-NABILONE	122	REPATHA	46
QUETIAPINE XR	89	RAN-OLANZAPINE ODT	87	RESERVOIR PARADIGM 5X1.8ML	166
QUICK-SET 6MMX18	166	RAN-OLANZAPINE ODT RAN-OMEPRAZOLE	88 124	RESERVOIR PARADIGM 7X3.0ML	166
QUICK-SET 6MMX23 TUBING	166	RAN-OMEFRAZULE RAN-ONDANSETRON	124	RESONIUM CALCIUM	107
QUICK-SET 6MMX32	166	RAN-PANTOPRAZOLE	124	RESOURCE 2.0 237ML LIQ	171
QUICK-SET 6MMX43 TUBING	166	RAN-PIOGLITAZONE	137	RESOURCE DIABETIC 1.5L	171
QUICK-SET 9MMX23 TUBING	166	RAN-PRAVASTATIN	43	RESOURCE DIABETIC 250ML LIQ	171
QUICK-SET 9MMX32	166	RAN-PREGABALIN	77	RESOURCE JUST KIDS 1.5 CAL 237ML LIQ	171
QUICK-SET 9MMX43 TUBING	166	RAN-QUETIAPINE	89	RESOURCE THICKEN CLEAR	172
QUINAGOLIDE (QUINAGOLIDE HYDROCHLORIDE)	155	RAN-RABEPRAZOLE	124	RESOURCE THICKEN CLEAR 125G	172
QUINAPRIL	56	RAN-RAMIPRIL	57	RESOURCE THICKEN UP 6.4G	172
QUINAPRIL, HYDROCHLOROTHIAZIDE	56	RAN-RAMIPRIL HCTZ	57	RESPICHAMBER SILICONE MEDIUM	165
QUINSAIR	7	RAN-RANITIDINE	123	MASK	
QVAR	129	RAN-RISPERIDONE	90	RESPICHAMBER SILICONE SMALL	165
R & C SHAMPOO WITH CONDITIONER	142	RAN-ROPINIROLE	99	MASK	
RABEPRAZOLE	124	RAN-SERTRALINE	84	RESPICHAMBER VHC W MOUTHPIECE	165
RABEPRAZOLE EC	124	RAN-SIMVASTATIN	44	RESTORALAX	120
RABEPRAZOLE SODIUM	124	RAN-SOLIFENACIN	149	RESTORIL	95
RALOXIFENE HYDROCHLORIDE	133	RAN-TOPIRAMATE	79	RESULTZ	142
RALTEGRAVIR POTASSIUM	11	RAN-VALSARTAN	61	RETIN-A	145
RAMIPRIL	57	RAN-VENLAFAXINE XR	85	RETROVIR REVATIO	12 47
RAMIPRIL	57	RAPAMUNE	163	REVATIO REVIA	73
RAMIPRIL, HYDROCHLOROTHIAZIDE	57	RAPID-D 10MM/110CM	166	REVIA REVLIMID	73 21
RAN-ALENDRONATE	158	RAPID-D 10MM/60CM	166	REXULTI	86
RAN-AMLODIPINE	51	RAPID-D 10MM/80CM	166	REYATAZ	10
RAN-ANASTROZOLE	17	RAPID-D 6MM/110CM	166	RHINARIS NASAL	117
RAN-ATENOLOL	49	RAPID-D 6MM/60CM	166	RHINARIS NASAL MIST	117
RAN-ATORVASTATIN	42	RAPID-D 6MM/80CM	166	RHINARIS-CS	111
		RAPID-D 8MM/110CM	166		

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				Non-insured nearth ben	CIIIO
RHINOCORT AQUA	114	RIVA-HC	144	SALBUTAMOL (QC)	32
RHINOCORT TURBUHALER	114	RIVA-K 20	107	SALBUTAMOL HFA	32
RHO-NITRO PUMPSPRAY	47	RIVA-K 8	107	SALBUTAMOL SULFATE	32
RIBAVIRIN	14	RIVA-LABETALOL	50	SALICYLIC ACID	146
RIBOCICLIB (RIBOCICLIB SUCCINATE)	25	RIVA-LANSOPRAZOLE	123	SALICYLIC ACID IN CORTICOSTEROID	143
RIDAURA	127	RIVA-LATANOPROST	116	CREAM	440
RIFABUTIN	10	RIVA-LETROZOLE	22	SALICYLIC ACID IN NON-MEDICATED OINTMENT	143
RIFADIN	10	RIVA-LEVETIRACETAM	76	SALICYLIC ACID, FLUOROURACIL	148
RIFAMPIN	10	RIVA-LOPERAMIDE	119	SALINEX	117
RIFAMPIN ORAL LIQUID	10	RIVA-METORDOLOLI	133	SALMETEROL XINAFOATE	32
RIFAXIMIN	8	RIVA-METOPROLOL L	50	SALMETEROL XINAFOATE,	32
RILPIVIRINE HYDROCHLORIDE	11	RIVA-MONTELUKAST	111 7	FLUTICASONE PROPIONATE	
RIOCIGUAT	111	RIVA-MOXIFLOXACIN RIVA-OLANZAPINE	87	SALOFALK	125
RISEDRONATE	159	RIVA-OLANZAFINE RIVA-OMEPRAZOLE DR	124	SANDOMIGRAN	97
RISEDRONATE SODIUM	159	RIVA-OXYBUTYNIN	149	SANDOMIGRAN DS	97
RISEDRONATE SODIUM (RISEDRONATE SODIUM	159	RIVA-PANTOPRAZOLE	124	SANDOSTATIN	155
HEMIPENTAHYDRATE)		RIVA-PAROXETINE	83	SANDOSTATIN LAR	154
RISEDRONATE-35	159	RIVA-PERINDOPRIL	56	SANDOZ ALENDRONATE	158
RISPERDAL	90	RIVA-PREGABALIN	77	SANDOZ	158
RISPERDAL CONSTA	91	RIVA-QUETIAPINE	89	ALENDRONATE/CHOLECALCIFEROL	33
RISPERIDONE	90	RIVA-RABEPRAZOLE	124	SANDOZ ALFUZOSIN SANDOZ ALMOTRIPTAN	95
RISPERIDONE	90	RIVA-RABEPRAZOLE EC	124	SANDOZ ALMOTRIFTAN SANDOZ AMIODARONE	41
RISPERIDONE (CONSTA)	91	RIVA-RANITIDINE	123	SANDOZ AMIODANONE SANDOZ AMLODIPINE	52
RITONAVIR	12	RIVA-RISEDRONATE	159	SANDOZ AMOXI-CLAV	5
RITUXAN	25	RIVA-RISPERIDONE	90	SANDOZ AMPHETAMINE XR	91
RITUXIMAB	25	RIVA-ROSUVASTATIN	44	SANDOZ ANAGRELIDE	38
RIVA OXAZEPAM	94	RIVAROXABAN	38	SANDOZ ANASTROZOLE	17
RIVA SENNA	120	RIVAROXABAN (10)	38	SANDOZ ANUZINC HC	144
RIVA-ALENDRONATE	158	RIVASA	64	SANDOZ ANUZINC HC PLUS	144
RIVA-AMIODARONE	41	RIVASA EC	64	SANDOZ ARIPIPRAZOLE	85
RIVA-AMAOTROZOLE	52	RIVA-SERTRALINE	84	SANDOZ ATOMOXETINE	99
RIVA-ANASTROZOLE	17	RIVASOL-HC	144	SANDOZ ATORVASTATIN	42
RIVA ATENOLOL	85 49	RIVASONE	143	SANDOZ AZITHROMYCIN	4
RIVA-ATENOLOL RIVA-ATOMOXETINE	49 99	RIVASTIGMINE	29	SANDOZ BISOPROLOL	49
RIVA-ATOMOXETINE RIVA-ATORVASTATIN	99 42	RIVASTIGMINE HYDROGEN TARTRATE	29	SANDOZ BOSENTAN	48
RIVA-AZITHROMYCIN	42	RIVA-TERBINAFINE	9	SANDOZ BRIMONIDINE	115
RIVA-BACLOFEN	33	RIVA-VALACYCLOVIR	13	SANDOZ BUPROPION SR	80
RIVA-BISOPROLOL	49	RIVA-VENLAFAXINE XR	85	SANDOZ CANDESARTAN	58
RIVA-CAL D	106	RIVOTRIL	73	SANDOZ CANDESARTAN PLUS	59
RIVA-CELECOX	64	RIZATRIPTAN BENZOATE RIZATRIPTAN ODT	96	SANDOZ CAPECITABINE	18
RIVA-CIPROFLOXACIN	6	RIZATRIPTAN ODT RIZATRIPTAN RDT	96 96	SANDOZ CEFPROZIL	2
RIVA-CITALOPRAM	80	ROCALTROL	152	SANDOZ CIPROFLOXACIN	6
RIVA-CLARITHROMYCIN	4	ROFACT	10	SANDOZ CITALOPRAM	81
RIVA-CLINDAMYCIN	7	ROLENE	143	SANDOZ CLARITHROMYCIN	4
RIVA-CLONAZEPAM	73	ROPINIROLE	99	SANDOZ COPIDOGREL	39
RIVA-CLOPIDOGREL	39	ROPINIROLE HYDROCHLORIDE	99	SANDOZ COLCHICINE SANDOZ CYCLOSPORINE	157 162
RIVACOCET	67	ROSONE	143	SANDOZ OTCLOSFORINE SANDOZ D-FORTE	152
RIVA-CYCLOBENZAPRINE	33	ROSUVASTATIN	44	SANDOZ DICLOFENAC MISOPROSTOL	66
RIVA-CYPROTERONE	163	ROSUVASTATIN CALCIUM	44	SANDOZ DICLOFENAC OPHTHA	115
RIVA-D	152	ROTIGOTINE	99	SANDOZ DICTOR ENAC OF TITTA SANDOZ DILTIAZEM CD	53
RIVA-DAPSONE	10	ROUGIER-MAGNESIUM	107	SANDOZ DILTIAZEM T	53
RIVA-DONEPEZIL	28	RUFINAMIDE	78	SANDOZ DIMENHYDRINATE	121
RIVA-DORZOLAMIDE/TIMOLOL	116	RUGBY NICOTINE POLACRILEX GUM	33	SANDOZ DONEPEZIL	28
RIVA-DULOXETINE	81	RUXOLITINIB	25	SANDOZ DORZOLAMIDE	116
RIVA-DUTASTERIDE	156	RYDAPT	23	SANDOZ DORZOLAMIDE/TIMOLOL	116
RIVA-ENALAPRIL	54	RYTHMODAN	41	SANDOZ DULOXETINE	81
RIVA-ESCITALOPRAM	82	RYTHMOL	41	SANDOZ DUTASTERIDE	156
RIVA-EZETIMIBE	42	S.O.S NALOXONE HYDROCHLORIDE	73	SANDOZ ENALAPRIL	54
RIVA-FINASTERIDE	156	SABRIL	79	SANDOZ ENTACAPONE	97
RIVA-FLUCONAZOLE	9	SALAGEN	29	SANDOZ ESCITALOPRAM	82
RIVA-FLUOXETINE RIVA-FLUVOX	82 82	SALAZOPYRIN	7	SANDOZ ESTRADIOL DERM	132
RIVA-FLUVOX RIVA-GABAPENTIN	6∠ 75	SALAZOPYRIN EN	7	SANDOZ EZETIMIBE	42
INVA-CADAL LIVIN	10				

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				Non-insured nearth be	nents
SANDOZ FAMCICLOVIR	13	SANDOZ RANITIDINE	123	SENOKOT	120
SANDOZ FELODIPINE	53	SANDOZ REPAGLINIDE	135	SEPTA DONEPEZIL	28
SANDOZ FENOFIBRATE E	42	SANDOZ RISEDRONATE	159	SEPTA-AMLODIPINE	52
SANDOZ FENOFIBRATE S	42	SANDOZ RISPERIDONE	90	SEPTA-ATENOLOL	49
SANDOZ FENTANYL	68	SANDOZ RIVASTIGMINE	29	SEPTA-CIPROFLOXACIN	6
SANDOZ FINASTERIDE	156	SANDOZ RIZATRIPTAN ODT	96	SEPTA-CITALOPRAM	80
SANDOZ FLUOROMETHOLONE	114	SANDOZ ROSUVASTATIN	44	SEPTA-LOSARTAN	60
SANDOZ FLUOXETINE	82	SANDOZ SERTRALINE	84	SEPTA-LOSARTAN HCTZ	60
SANDOZ FOLIC ACID	151	SANDOZ SIMVASTATIN	44	SEPTA-METFORMIN	133
SANDOZ GEFITINIB	20	SANDOZ SOLIFENACIN	149	SEPTA-ONDANSETRON	122
SANDOZ GLICLAZIDE MR	136	SANDOZ SUMATRIPTAN	96	SEPTA-ZOLMITRIPTAN-ODT	97
SANDOZ HYDROCORTISONE	144	SANDOZ TACROLIMUS	163	SERC	100
SANDOZ INDOMETHACIN	66	SANDOZ TAMSULOSIN	33	SEREVENT DISKUS	32
SANDOZ IRBESARTAN	59	SANDOZ TELMISARTAN	61	SEROQUEL	89
SANDOZ IRBESARTAN HCT	59	SANDOZ TELMISARTAN HCT	61	SEROQUEL XR	89
SANDOZ LACOSAMIDE	75	SANDOZ TIMOLOL	116	SERTRALINE	84
SANDOZ LANSOPRAZOLE	123	SANDOZ TOBRAMYCIN	113	SERTRALINE HYDROCHLORIDE	84
SANDOZ LATANOPROST	116	SANDOZ TOLTERODINE LA	149	SERTRALINE-100	84
SANDOZ LATANOPROST/TIMOLOL	116	SANDOZ TOPIRAMATE	79	SERTRALINE-25	84
SANDOZ LEFLUNOMIDE	161	SANDOZ TRANDOLAPRIL	58	SERTRALINE-50	84
SANDOZ LETROZOLE	22	SANDOZ TRAVOPROST	117	SEVELAMER CARBONATE	108
SANDOZ LEVETIRACETAM	76	SANDOZ TRAVOPROST / TIMOLOL PQ	117	SEVELAMER HYDROCHLORIDE	108
SANDOZ LEVOFLOXACIN	6	SANDOZ VALACYCLOVIR	13	SHARPS CONTAINER	168
SANDOZ LINEZOLID	8	SANDOZ VALSARTAN	61	SHARPS NESTABLE YELLOW LARGE	168
SANDOZ LISINOPRIL	55	SANDOZ VALSARTAN HCT	62	22.7L	
SANDOZ LISINOPRIL HCT	56	SANDOZ VENLAFAXINE XR	85	SIALOR	117
SANDOZ LOSARTAN	60	SANDOZ VORICONAZOLE	9	SIDEKICK	103
SANDOZ LOSARTAN HCT	60	SANDOZ ZOLMITRIPTAN	97	SILDENAFIL CITRATE	47
SANDOZ METFORMIN	133	SANDOZ ZOLMITRIPTAN ODT	97	SILIQ	147
SANDOZ METFORMIN FC	133	SANDOZ-CARBAMAZEPINE	74	SILVER SULFADIAZINE	143
SANDOZ METHYLPHENIDATE SR	92	SANDOZ-DICLOFENAC	65	SIMBRINZA	116
SANDOZ METOPROLOL SR	51	SANDOZ-DICLOFENAC SR	65	SIMILAC ADVANCE NEOSURE 363G	172
SANDOZ MIRTAZAPINE	83	SANDOZ-FELODIPINE	53	SIMILAC ALIMENTUM 237ML LIQ	171
SANDOZ MOMETASONE	114	SANTYL	147	SIMILAC ALIMENTUM 400G PDR	172
SANDOZ MONTELUKAST	110	SAPHRIS	86	SIMILAC ALIMENTUM 945ML LIQ	171
SANDOZ MORPHINE SR	70	SAQUINAVIR MESYLATE	12	SIMILAC LOWER IRON 850G PDR	172
SANDOZ MOXIFLOXACIN	7	SARILUMAB	161	SIMILAC PM 60/40 450G PDR	172
SANDOZ MYCOPHENOLATE	162	SARNA HC	145	SIMPLY THICK 64OZ BOTTLE PUMP	172
SANDOZ NARATRIPTAN	96	SAXAGLIPTIN HYDROCHLORIDE	134	SIMPLY THICK HONEY	172
SANDOZ OLANZAPINE	87	SAXAGLIPTIN HYDROCHLORIDE,	134	SIMPLY THICK HONEY 12G PDR	172
SANDOZ OLANZAPINE ODT	88	METFORMIN HYDROCHLORIDE		SIMPLY THICK HONEY 200G SIMPLY	172
SANDOZ OLMESARTAN	61	SDZ CELECOXIB	64	THICK NECTAR	172
SANDOZ OLOPATADINE	113	SEASONALE	131	SIMPLY THICK NECTAR 200G	172
SANDOZ OMEPRAZOLE	124	SEASONIQUE	132	SIMPLY THICK NECTAR 6G PDR	172
SANDOZ ONDANSETRON	122	SEBCUR	146	SIMPONI	160
SANDOZ	67	SEBCUR-T	146	SIMVASTATIN	44
OXYCODONE/ACETAMINOPHEN		SECARIS	117	SIMVASTATIN	44
SANDOZ PANTOPRAZOLE	124	SECUKINUMAB	148	SIMVASTATIN-10	45
SANDOZ PERINDOPRIL ERBUMINE	56	SEEBRI BREEZHALER	30	SIMVASTATIN-20	45
SANDOZ PERINDOPRIL ERBUMINE/	56	SELECT 1/35 (21-DAY)	131	SIMVASTATIN-40	45
INDAPAMIDE		SELECT 1/35 (28-DAY)	131	SIMVASTATIN-80	45
SANDOZ PERINDOPRIL ERBUMINE/ INDAPAMIDE HD	56	SELEGILINE HYDROCHLORIDE	99	SINECATECHINS	141
SANDOZ PIOGLITAZONE	137	SELENIUM SULFIDE	142	SINEMET	97
SANDOZ POLYTRIMETHOPRIM	113	SELEXIPAG	112	SINEQUAN	81
SANDOZ PRAMIPEXOLE	98	SEMAGLUTIDE	134	SINGULAIR	110
SANDOZ PRAVASTATIN	43	SENNA	120	SINTROM	36
SANDOZ PRAVASTATIN SANDOZ PREDNISOLONE	114	SENNA LAXATIVE	120	SIROLIMUS	163
SANDOZ PREGABALIN	77	SENNA SENNOSIDES	120	SITAGLIPTIN PHOSPHATE	134
SANDOZ PREGABALIN SANDOZ PROCHLORPERAZINE	7 7 88	SENNA SENNOSIDES NATURALS	120	MONOHYDRATE	
SANDOZ PROCHLORFERAZINE SANDOZ PROCTOMYXIN HC	144	SENNACE	120	SITAGLIPTIN PHOSPHATE	134
SANDOZ PROCTOMITAIN TIC SANDOZ QUETIAPINE	89	SENNALAX	120	MONOHYDRATE, METFORMIN HYDROCHLORIDE	
SANDOZ QUETIAPINE SANDOZ QUETIAPINE XRT	89	SENNAPREP	120	Brooneonde	
SANDOZ QOLTIAFINE XIXT	124	SENNOSIDES	120		
SANDOZ RABIER RAZOLE SANDOZ RAMIPRIL	57	SENNOSIDES	120		
O, II DOZ IV IVIII I III	31				

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				Non-insured nearth be	TEITE
SKIN PREP ADHESHIVE WIPES	165	STEROID AND ANTIFUNGAL CREAM	154	SYNAREL	133
SLOWK	107	STIEVA-A	145	SYNJARDY	136
SN IV3000 1-HAND TRANS	165	STIVARGA	24	SYNPHASIC 21	132
SODIUM AUROTHIOMALATE	127	STRATTERA	99	SYNPHASIC 28	132
SODIUM AUROTHIOMALATE	127	STRESSTABS FOR WOMEN	153	SYNTHROID	138
SODIUM BICARBONATE	105	STRIBILD	12	SYRINGE & NEEDLE	168
SODIUM BICARBONATE	119	STROMECTOL	2	SYRINGE CASE	170
SODIUM CARBOXYMETHYL	117	SUBOXONE	71	SYRINGE SCALE MAGNIFIER	167
CELLULOSE		SUCRALFATE	123	SYSTANE	118
SODIUM CHLORIDE	107	SULCRATE	123	T : SLIM X2 CARTRIDGE (SK)	166
SODIUM CHLORIDE	107	SULCRATE PLUS	123	T/ THERAPEUTIC SHAMPOO EXTRA	146
SODIUM CHLORIDE (SMALL VOL.)	107	SULFAMETHOXAZOLE,	7	STRENGTH	
SODIUM CHLORIDE 1G	107	TRIMETHOPRIM	_	TACROLIMUS (PROTOPIC)	148
SODIUM PHOSPHATE	120	SULFASALAZINE	7	TACROLIMUS MONOHYDRATE	163
SODIUM POLYSTYRENE SULFONATE	107	SULFATRIM	7	TADALAFIL	48
SOFOSBUVIR	14	SULFATRIM DS	7	TAFINLAR	19
SOFOSBUVIR, LEDIPASVIR	15	SULFATRIM PEDIATRIC	7	TAGRISSO	23
SOFOSBUVIR, VELPATASVIR	15	SULFINPYRAZONE	109	TALTZ	148
SOFOSBUVIR, VELPATASVIR, VOXILAPREVIR	15	SULFINPYRAZONE	109	TAMOXIFEN (QC)	133
SOFRACORT EAR/EYE	114	SULFUR IN NON-MEDICATED CREAM	154	TAMOXIFEN CITRATE	26
SOLIFENACIN	149	SULFUR IN NON-MEDICATED OINTMENT	154	TAMSULOSIN	33
SOLIFENACIN SUCCINATE	149	SULINDAC	67	TAMSULOSIN HYDROCHLORIDE	33
SOLUCAL	106	SUMATRIPTAN	96	TAPAZOLE	138
SOLUCAL D	106	SUMATRIPTAN DF	96	TARCEVA	20
SOLUCAL D CITRUS	106	SUMATRIPTAN HEMISULFATE	96	TARGEL	146
SOLUCAL D FORT	106	SUMATRIPTAN SUCCINATE	96	TARGEL SA	146
SOLUCAL D FORT CITRUS	106	SUNITINIB MALATE	26	TARO-AMCINONIDE	146 143
SOLUCAL D FORT GREEN APPLE	106	SUPER-FINE MICRO 31G-5MM NEEDLE	167	TARO-AMCINONIDE TARO-ANASTROZOLE	143
SOLUCAL D RASPBERRY	106	SUPER-FINE STANDARD 29G-12.7MM	167	TARO-ANASTROZOLE TARO-BENZOYL PEROXIDE /	141
SOLUCAL GREEN APPLE	106	SUPER-FINE XTRA 31G-8MM NEEDLE	168	CLINDAMYCIN KIT	141
SOLUCAL RASPBERRY	106	SUPEUDOL	71	TARO-CALCITRIOL	152
SOLU-CORTEF ACT-O-VIAL	129	SUPRAX	2	TARO-CAPECITABINE	18
SOLU-MEDROL	130	SUPREFACT	18	TARO-CARBAMAZEPINE	74
SOLUVER	146	SUPREFACT (NASAL)	18	TARO-CEFPROZIL	2
SOLUVER PLUS	146	SUPREFACT DEPOT 2 MONTHS	18	TARO-CIPROFLOXACIN	6
SOLYSTAT	107	SUPREFACT DEPOT 3 MONTHS	18	TARO-CLARITHROMYCIN	4
SOMATULINE AUTOGEL	163	SURE STEP	103	TARO-CLINDAMYCIN	141
SOOTHE NIGHT TIME	117	SURECOMFORT 1/2 IN 28GX0.5CC	169	TARO-CLINDAMYCIN/BENZOYL	141
SORBITOL, SODIUM CITRATE, SODIUM LAURYL SULFOACETATE	120	SURECOMFORT 1/2 IN 28GX1CC SYRINGE	169	PEROXIDE TARO-CLOBETASOL	143
SORIATANE	146	SURECOMFORT 1/2 IN 29GX0.3CC	169	TARO-DICLOFENAC	65
SOTALOL HYDROCHLORIDE	51	SURECOMFORT 1/2 IN 29GX0.5CC	169	TARO-DIPYRIDAMOLE/ ASA	48
SOTALOL ORAL LIQUID	51	SURECOMFORT 1/2 IN 29GX1CC	169	TARO-ENALAPRIL	55
SOURCE THICKEN UP 227G PDR	172	SURECOMFORT 1/2 IN 30GX0.3CC	169	TARO-FLUCONAZOLE	9
SOVALDI	14	SURECOMFORT 1/2 IN 30GX0.5CC	169	TARO-IMIQUIMOD PUMP	147
SPACER DEVICE	165	SURECOMFORT 1/2 IN 30GX1CC	169	TARO-MOMETASONE	145
SPECTRO ACNECARE WASH	146	SURECOMFORT 29GX1/2 NEEDLE	167	TARO-MUPIROCIN	141
SPECTRO ECZEMACARE	144	SURECOMFORT 30GX5/16 NEEDLE	167	TARO-PHENYTOIN	74
SPIRIT TEST STRIP (ON)	103	SURECOMFORT 31GX3/16 NEEDLE	167	TARO-ROSUVASTATIN	44
SPIRIVA	30	SURECOMFORT 31GX5/16 NEEDLE	167	TARO-SONE	143
SPIRIVA RESPIMAT	30	SURECOMFORT 32GX1/4 NEEDLE	167	TARO-SUMATRIPTAN	96
SPIRONOLACTONE	63	SURECOMFORT 32GX5/32 NEEDLE	167	TARO-TEMOZOLOMIDE	26
SPIRONOLACTONE ORAL LIQUID	63	SURECOMFORT 5/16 IN 30GX0.3CC	169	TARO-TERCONAZOLE	142
SPIRONOLACTONE,	109	SURECOMFORT 5/16 IN 30GX0.5CC	169	TARO-TESTOSTERONE	130
HYDROCHLOROTHIAZIDE		SURECOMFORT 5/16 IN 30GX1CC	169	TARO-WARFARIN	38
SPORANOX	9	SURECOMFORT 5/16 IN 31GX0.3CC	169	TARO-ZOLEDRONIC ACID	159
STALEVO	98	SURECOMFORT 5/16 IN 31GX0.5CC	169	TASIGNA	23
STATEX	70	SURECOMFORT 5/16 IN 31GX1CC	169	TAZAROTENE	148
STAVUDINE	12	SURETEST (ON)	103	TAZORAC	148
STELARA	155	SUSTIVA	11	TEARS NATURALE FREE	117
STERILE EXTEMPORANEOUS MIXTURE (QC)	154	SUTENT	26	TEARS NATURALE II	117
STERILE WATER	109	SYMBICORT 100 TURBUHALER	31	TERRAZIO	117
STERILE WATER STERILE WATER PF	172	SYMBICORT 200 TURBUHALER	31	TEBRAZID TECEIDERA	10
		SYNALAR	144	TECFIDERA	100

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				Non-insured Health B	enents
TECTA	124	TEVA-ALPRAZOLAM	93	TEVA-EXEMESTANE	20
TEGRETOL	74	TEVA-AMIODARONE	41	TEVA-EZETIMIBE	42
TELMISARTAN	61	TEVA-AMITRIPTYLINE	80	TEVA-FAMOTIDINE	122
TELMISARTAN	61	TEVA-AMLODIPINE	52	TEVA-FENTANYL	68
TELMISARTAN HCTZ	61	TEVA-AMPICILLIN	5	TEVA-FINASTERIDE	156
TELMISARTAN,	61	TEVA-ARIPIPRAZOLE	85	TEVA-FLUCONAZOLE	9
HYDROCHLOROTHIAZIDE		TEVA-ATAZANAVIR	10	TEVA-FLUOXETINE	82
TELMISARTAN/HCTZ	61	TEVA-ATENOLOL	49	TEVA-FLURBIPROFEN	65
TELMISARTAN-HCTZ	61	TEVA-ATENOLOL/CHLORTHALIDONE	49	TEVA-FLUTICASONE	114
TELZIR	11	TEVA-ATOMOXETINE	99	TEVA-FLUVASTATIN	43
TEMAZEPAM	95	TEVA-ATORVASTATIN	42	TEVA-FOSINOPRIL	55
TEMAZEPAM	95	TEVA-AZATHIOPRINE	162	TEVA-FUROSEMIDE	108
TEMODAL	26	TEVA-AZITHROMYCIN	4	TEVA-GABAPENTIN	75
TEMOZOLOMIDE	26	TEVA-BETAHISTINE	100	TEVA-GEMFIBROZIL	42
TEMPRA CHILDREN'S	72	TEVA-BICALUTAMIDE	18	TEVA-GLICLAZIDE	136
TEMPRA CHILDREN'S DOUBLE	72	TEVA-BISOPROLOL	49	TEVA-GLYBURIDE	137
STRENGTH		TEVA-BOSENTAN	48	TEVA-HALOPERIDOL	86
TEMPRA INFANT	72	TEVA-BROMAZEPAM	93	TEVA-HYDROCHLOROTHIAZIDE	109
TENDER-1 17MM/110CM	166	TEVA-BUDESONIDE	129	TEVA-HYDROMORPHONE	69
TENDER-1 17MM/60CM	166	TEVA-BUSPIRONE	95	TEVA-IMATINIB	21
TENDER-1 17MM/80CM	166	TEVA-CANDESARTAN	58	TEVA-INDOMETHACIN	66
TENDER-1 MINI INF SET 13MM/110CM	166	TEVA-CANDESARTAN/HCTZ	59	TEVA-IPRATROPIUM STERINEBS	30
TENDER-1 MINI INFSET 13MM/60CM	166	TEVA-CAPECITABINE	18	TEVA-IRBESARTAN	59
TENDER-1 MINI INFSET 13MM/80CM	166	TEVA-CAPTOPRIL	54	TEVA-IRBESARTAN HCTZ	59
TENDER-2 17MM/110CM	166	TEVA-CARBAMAZEPINE	74	TEVA-KETOCONAZOLE	9
TENDER-2 17MM/60CM	166	TEVA-CARVEDILOL	50	TEVA-LACOSAMIDE	76
TENDER-2 17MM/80CM	166	TEVA-CEFADROXIL	2	TEVA-LACTULOSE	105
TENDER-2 MINI INF SET 13MM/110CM	166	TEVA-CEPHALEXIN	3	TEVA-LAMIVUDINE/ZIDOVUDINE	11
TENDER-2 MINI INFSET 13MM/60CM	166	TEVA-CHLOROQUINE	15	TEVA-LAMOTRIGINE	76
TENDER-2 MINI INFSET 13MM/80CM	166	TEVA-CHLOROGOINE TEVA-CHLORPROMAZINE	86	TEVA-LANSOPRAZOLE	123
TENOFOVIR DISOPROXIL FUMARATE	12	TEVA-CILAZAPRIL/HCTZ	54	TEVA-LATANOPROST	116
TENOFOVIR DISOPROXIL FUMARATE,	12				
EMTRICITABINE		TEVA-CITALOPRAM	80 4	TEVA LETPOZOLE	161 22
TENOFOVIR DISOPROXIL FUMARATE,	12	TEVA-CLARITHROMYCIN	7	TEVALETROZOLE	97
EMTRICITABINE, COBICISTAT,		TEVA-CLINDAMYCIN		TEVA-LEVOCARBIDOPA	
ELVITEGRAVIR		TEVA-CLOBAZAM	73	TEVA-LISINOPRIL (TYPE P)	55 55
TENOFOVIR DISOPROXIL FUMARATE,	12	TEVA-CLOBETASOL	143	TEVA-LISINOPRIL (TYPE Z)	55 50
EMTRICITABINE, RILPIVIRINE HYDROCHLORIDE		TEVA-CLONAZEPAM	73	TEVA-LISINOPRIL/HCTZ (TYPE P)	56
TENORETIC	49	TEVA-CLONIDINE	46	TEVA-LISINOPRIL/HCTZ (TYPE Z)	56
TENORMIN	49	TEVA-CLOPIDOGREL	39	TEVA-LOPERAMIDE	119
TERAZOSIN	48	TEVA-CLOXACILLIN	5	TEVA-LORAZEPAM	94
TERAZOSIN HYDROCHLORIDE	48	TEVA-CODEINE	68	TEVA-LOSARTAN	60
TERBINAFINE	9	TEVA-COMBO STERINEBS	30	TEVA-LOSARTAN/HCTZ	60
TERBINAFINE HYDROCHLORIDE	9	TEVA-CYCLOBENZAPRINE	33	TEVA-MEDROXYPROGESTERONE	137
TERBUTALINE SULFATE	32	TEVA-CYPROTERONE / ETHINYL ESTRADIOL	163	TEVA-MELOXICAM	66
TERCONAZOLE	142	TEVA-DESMOPRESSIN	137	TEVA-METHYLPHENIDATE	92
	158	TEVA-DESMOFRESSIN TEVA-DICLOFENAC	65	TEVA-METOPROLOL	50
TERIFLUNOMIDE TESTIM	130	TEVA-DICLOFENAC SR	65	TEVA-MEXILETINE	41
		TEVA-DICLOFENAC SK TEVA-DILTIAZEM	53	TEVA-MINOCYCLINE	7
TESTOSTERONE (TOPICAL)	130	TEVA-DILTIAZEM CD	53	TEVA-MIRTAZAPINE	83
TESTOSTERONE CYPIONATE	131	TEVA-DIVALPROEX	79	TEVA-MODAFINIL	93
TESTOSTERONE CYPIONATE	131	TEVA-DIVALPROEX TEVA-DOMPERIDONE	125	TEVA-MOMETASONE	114
TESTOSTERONE ENANTHATE	131			TEVA-MONTELUKAST	111
TESTOSTERONE UNDECANOATE	131	TEVA-DONEPEZIL	28	TEVA-MORPHINE SR	70
TETRABENAZINE	101	TEVA DOMOVOUNE	48	TEVA-MOXIFLOXACIN	7
TETRABENAZINE	101	TEVA-DOXYCYCLINE	7	TEVA-MYCOPHENOLATE	162
TETRACYCLINE	7	TEVA-DUTASTERIDE	156	TEVA-NABILONE	122
TETRACYCLINE HYDROCHLORIDE	7	TEVA-EFAVIRENZ	11	TEVA-NAPROXEN	66
TEVA-5 ASA	125	TEVA- EFAVIRENZ/EMTRICITABINE/TENOFOV	11	TEVA-NAPROXEN DS	67
TEVA-ABACAVIR/LAMIVUDINE	10	IR		TEVA-NARATRIPTAN	96
TEVA-ACEBUTOLOL	49	TEVA-EMTEC-30	67	TEVA-NITROFURANTOIN	15
TEVA-ACYCLOVIR	13	TEVA-EMTRICITABINE/TENOFOVIR	12	TEVA-NYSTATIN	9
TEVA-ALENDRONATE	158	TEVA-ENTACAPONE	97	TEVA-OLANZAPINE	87
TEVA-	158	TEVA-ERLOTINIB	20	TEVA-OMEPRAZOLE	124
ALENDRONATE/CHOLECALCIFEROL	05	TEVA-ESCITALOPRAM	82	TEVA-OXYBUTYNIN	149
TEVA-ALMOTRIPTAN	95				

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TEVA-OXYCOCET 67 TEVA-VALSARTAN/HCTZ 62 TOLNAFTATE TEVA-OXYCODAN 68 TEVA-VARENICLINE 34 TOLOXIN TEVA-PANTOPRAZOLE 124 TEVA-VENLAFAXINE XR 85 TOLTERODINE TARTRATE TEVA-PANTOPRAZOLE MAGNESIUM 124 TEVA-VORICONAZOLE 9 TOPAMAX TEVA-PAROXETINE 83 TEVA-ZOLMITRIPTAN 97 TOPICORT TEVA-PERINDOPRIL 56 TEVA-ZOLMITRIPTAN 0D 97 TOPICORT MILD TEVA-PERINDOPRIL/INDAPAMIDE 56 TEVETEN 59 TOPIRAMATE TEVA-PHENIRAM 1 TEVETEN PLUS 59 TOPIRAMATE TEVA-PINDOLOL 51 THE MAGIC BULLET 119 TOPIRAMATE ORAL LIQUID TEVA-PIROXICAM 67 THEO ER 150 TOUJEO SOLOSTAR TEVA-PRAVASTATIN 43 THEOLAIR 150 TOVIAZ TEVA-PRAZOSIN 48 THEOPHYLLINE 150 TRACLEER	142 41 149 79 144 144 79 79 135 149 48 134 26
TEVA-PANTOPRAZOLE 124 TEVA-VENLAFAXINE XR 85 TOLTERODINE TARTRATE TEVA-PANTOPRAZOLE MAGNESIUM 124 TEVA-VORICONAZOLE 9 TOPAMAX TEVA-PAROXETINE 83 TEVA-ZOLMITRIPTAN 97 TOPICORT TEVA-PERINDOPRIL 56 TEVA-ZOLMITRIPTAN OD 97 TOPICORT MILD TEVA-PERINDOPRIL/INDAPAMIDE 56 TEVETEN 59 TOPIRAMATE TEVA-PHENIRAM 1 TEVETEN PLUS 59 TOPIRAMATE TEVA-PINDOLOL 51 THE MAGIC BULLET 119 TOPIRAMATE ORAL LIQUID TEVA-PIROXICAM 67 THEO ER 150 TOUJEO SOLOSTAR TEVA-PRAVASTATIN 43 THEOLAIR 150 TOVIAZ	149 79 144 144 79 79 135 149 48 134 26
TEVA-PANTOPRAZOLE MAGNESIUM 124 TEVA-VORICONAZOLE 9 TOPAMAX TEVA-PAROXETINE 83 TEVA-ZOLMITRIPTAN 97 TOPICORT TEVA-PERINDOPRIL 56 TEVA-ZOLMITRIPTAN OD 97 TOPICORT MILD TEVA-PERINDOPRIL/INDAPAMIDE 56 TEVETEN 59 TOPIRAMATE TEVA-PHENIRAM 1 TEVETEN PLUS 59 TOPIRAMATE TEVA-PINDOLOL 51 THE MAGIC BULLET 119 TOPIRAMATE ORAL LIQUID TEVA-PIROXICAM 67 THEO ER 150 TOUJEO SOLOSTAR TEVA-PRAVASTATIN 43 THEOLAIR 150 TOVIAZ	79 144 144 79 79 79 135 149 48 134 26
TEVA-PAROXETINE83TEVA-ZOLMITRIPTAN97TOPICORTTEVA-PERINDOPRIL56TEVA-ZOLMITRIPTAN OD97TOPICORT MILDTEVA-PERINDOPRIL/INDAPAMIDE56TEVETEN59TOPIRAMATETEVA-PHENIRAM1TEVETEN PLUS59TOPIRAMATETEVA-PINDOLOL51THE MAGIC BULLET119TOPIRAMATE ORAL LIQUIDTEVA-PIROXICAM67THEO ER150TOUJEO SOLOSTARTEVA-PRAVASTATIN43THEOLAIR150TOVIAZ	144 144 79 79 79 135 149 48 134 26
TEVA-PERINDOPRIL 56 TEVA-ZOLMITRIPTAN OD 97 TOPICORT MILD TEVA-PERINDOPRIL/INDAPAMIDE 56 TEVETEN 59 TOPIRAMATE TEVA-PHENIRAM 1 TEVETEN PLUS 59 TOPIRAMATE TEVA-PINDOLOL 51 THE MAGIC BULLET 119 TOPIRAMATE ORAL LIQUID TEVA-PIROXICAM 67 THEO ER 150 TOUJEO SOLOSTAR TEVA-PRAVASTATIN 43 THEOLAIR 150 TOVIAZ	144 79 79 79 135 149 48 134 26
TEVA-PERINDOPRIL/INDAPAMIDE 56 TEVETEN 59 TOPIRAMATE TEVA-PHENIRAM 1 TEVETEN PLUS 59 TOPIRAMATE TEVA-PINDOLOL 51 THE MAGIC BULLET 119 TOPIRAMATE ORAL LIQUID TEVA-PIROXICAM 67 THEO ER 150 TOUJEO SOLOSTAR TEVA-PRAVASTATIN 43 THEOLAIR 150 TOVIAZ	79 79 79 135 149 48 134 26
TEVA-PHENIRAM1TEVETEN PLUS59TOPIRAMATETEVA-PINDOLOL51THE MAGIC BULLET119TOPIRAMATE ORAL LIQUIDTEVA-PIROXICAM67THEO ER150TOUJEO SOLOSTARTEVA-PRAVASTATIN43THEOLAIR150TOVIAZ	79 79 135 149 48 134 26
TEVA-PINDOLOL 51 THE MAGIC BULLET 119 TOPIRAMATE ORAL LIQUID TEVA-PIROXICAM 67 THEO ER 150 TOUJEO SOLOSTAR TEVA-PRAVASTATIN 43 THEOLAIR 150 TOVIAZ	79 135 149 48 134 26
TEVA-PIROXICAM 67 THEO ER 150 TOUJEO SOLOSTAR TEVA-PRAVASTATIN 43 THEOLAIR 150 TOVIAZ	135 149 48 134 26
TEVA-PRAVASTATIN 43 THEOLAIR 150 TOVIAZ	149 48 134 26
	48 134 26
TEVA-FRAZOSIN 40 INEOFITELINE 150 TRACLEER	134 26
TEVA-PREDNISOLONE 114 THEOPHYLLINE 150 TRAJENTA	26
TEVA-PREDNISONE 130 THIAMIJECT 151 TRAMETINIB	
TEVA-PREGABALIN 77 THIAMINE 151 TRANDATE	00
TEVA-PROCTOSONE 144 THIAMINE HYDROCHLORIDE 151 TRANDOLAPRIL	58
TEVA-PROFEN 66 THICKENING AGENT 172 TRANDOLAPRIL	58
TEVA-PROGESTERONE 138 THICKENING GEL 172 TRANEXAMIC ACID	40
TEVA-PROPRANOLOL 51 THIOGUANINE 26 TRANEXAMIC ACID	40
TEVA-QUETIAPINE 89 THIOPROPERAZINE MESYLATE 91 TRANEXAMIC DENTAL MOUTHWASH	40
TEVA-QUETIAPINE XR 89 THIOTHIXENE 91 TRANSDERMAL LIDOCAINE W/NSAID	154
TEVA-RABEPRAZOLE 124 THRIVE GUM (NS) 34 TRANSDERMAL NICOTINE	34
TEVA-RAMIPRIL 57 THRIVE NICOTINE LOZENGES 34 TRANSDERMAL NICOTINE PATCHDAY	34
TEVA-RANITIDINE 123 THRIVE NICOTINELL GUM 33 TRANSDERM-NITRO	47
TEVA-RISEDRONATE 159 THYROGEN 104 TRANYLCYPROMINE SULFATE	84
TEVA-RISPERIDONE 90 THYROID 138 TRAVATAN Z	117
TEVA-RIZATRIPTAN ODT 96 THYROID 138 TRAVEL	121
TEVA-ROSUVASTATIN 44 THYROTROPIN ALFA 104 TRAVEL ON	121
TEVA-SALBUTAMOL 32 TIAMOL 144 TRAVOPROST	117
TEVA-SALBUTAMOL HFA 32 TIAPROFENIC ACID 67 TRAVOPROST-TIMOLOL	117
TEVA-SELEGILINE 99 TIAZAC 53 TRAZODONE	84
TEVA-SERTRALINE 84 TIAZAC XC 54 TRAZODONE HYDROCHLORIDE	84
TEVA-SILDENAFIL R 47 TICAGRELOR 39 TRELEGY ELLIPTA	129
TEVA-SIMVASTATIN 44 TICLOPIDINE 39 TRELSTAR	26
TEVA-SOLIFENACIN 149 TICLOPIDINE HYDROCHLORIDE 39 TRESIBA	135
TEVA-SPIRONOLACTONE 63 TIMOLOL 51 TRETINOIN TEVA-SPIRONOLACTONE/HCTZ 109 TIMOLOL MALEATE 51 TRIADERM	26
TEM CHORD LEATE	145
TEVA OURINDAO	130
TEVA-SULINDAC 67 TARTRATE TRIAMCINOLONE ACETONIDE TEVA-SUMATRIPTAN 96 TIMOLOL MALEATE, TRAVOPROST 117 TRIAMCINOLONE DIACETATE	114
TEVA-SUMATRIPTAN DF 96 TIMOLOL MALEATE, TRAVETROST 116 TRIAMICINOLONE DIACETATE	130 109
TEVA-TAMOXIFEN 26 TIMOPTIC 116 HYDROCHLOROTHIAZIDE	109
TEVA-TAMSULOSIN 33 TIMOPTIC-XE 116 TRIATEC-30	67
TEVA-TELMISARTAN 61 TINACTIN 142 TRIAZOLAM	95
TEVA-TELMISARTAN HCTZ 61 TINACTIN AEROSOL 142 TRIAZOLAM	95
TEVA-TEMAZEPAM 95 TINZAPARIN SODIUM 38 TRICIRA LO 21	132
TEVA-TENOFOVIR 12 TIOTROPIUM BROMIDE 30 TRICIRA LO 28	132
TEVA-TERAZOSIN 48 MONOHYDRATE TRI-CYCLEN 21-DAY	132
TEVA-TIAPROFENIC 67 TIPRANAVIR 12 TRI-CYCLEN 28-DAY	132
TEVA-TOBRAMYCIN 2 TIVICAY 11 TRI-CYCLEN LO (21 DAY)	132
TEVA-TOLTERODINE 149 TIZANIDINE 33 TRI-CYCLEN LO (28 DAY)	132
TEVA-TOLTERODINE LA 149 TIZANIDINE HYDROCHLORIDE 33 TRIDESILON	144
TEVA-TOPILENE 143 TOBI PODHALER 2 TRIFLUOPERAZINE	91
TEVA-TOPIRAMATE 79 TOBRADEX 114 TRIFLUOPERAZINE HYDROCHLORIDE	91
TEVA-TOPISONE 143 TOBRAMYCIN 2 TRIFLURIDINE	113
TEVA-TRANDOLAPRIL 58 TOBRAMYCIN 2 TRIHEXYPHENIDYL	97
TEVA-TRAVOPROST Z 117 TOBRAMYCIN (OPHTHALMIC) 113 TRIHEXYPHENIDYL HYDROCHLORIDE	97
TEVA-TRAZODONE 84 TOBRAMYCIN INHALATION 2 TRILEPTAL TEVA-TRIAMTERENE/HCTZ 109 TOBRAMYCINE 2 TRIMEBUTINE	77 20
TOPPEY	30
	30 45
	15 15
TEVA-VALACYCLOVIR 13 I OCILIZUMAB (SC) 161 TRIMETHOPRIM TEVA-VALGANCICLOVIR 14 TODAY SPONGE VAGINAL 102 TRIMETHOPRIM ORAL LIQUID	16
TEVA-VALSARTAN 61 CONTRACEPTIVE TRIMIPRAMINE	84
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				Non-insured ficaltif be	
TRIMIPRAMINE MALEATE	84	ULTRAFLEX 1 8MM/60CM	166	VENOM PROTEIN EXTRACT	155
TRINIPATCH	47	ULTRAFLEX 1 8MM/80CM	166	VENOMIL HONEY BEE VENOM	155
TRIPTORELIN PAMOATE	26	ULTRAVATE	144	VENOMIL MIXED VESPID VENOM	156
TRIQUILAR 21	131	UMECLIDINIUM BROMIDE	30	PROTEIN	
TRIQUILAR 28	131	UMECLIDINIUM BROMIDE,	30	VENOMIL WASP VENOM PROTEIN	156
TRIUMEQ	10	VILANTEROL TRIFENATATE		VENOMIL WHITE-FACED HORNET	156
TROPICAMIDE	115	UNIFINE 29G 12MM NEEDLE	167	VENOM PROTEIN	
TROSEC	149	UNIFINE 31G.6MM NEEDLE	167	VENOMIL YELLOW HORNET VENOM	156
TROSPIUM CHLORIDE	149	UNIFINE 31G.8MM NEEDLE	168	PROTEIN	
TRUE TRACK	104	UNIFINE PENTIPS 31GX5MM	167	VENOMIL YELLOW JACKET VENOM	156
	104	UNIPHYL	150	PROTEIN	
TRUETEST		UPTRAVI	112	VENTOLIN DISKUS	32
TRUSOPT	116	UREA	145	VENTOLIN HFA	32
TRUVADA	12	UREMOL	145	VENTOLIN P.F	32
TUDORZA GENUAIR	29	UREMOL 10	145	VENTOLIN RESPIRATOR	32
TWYNSTA	52	URINE TEST STRIP	104	VEPESID	20
TYLENOL	72			VERAPAMIL HYDROCHLORIDE	54
TYLENOL EXTRA STRENGTH	72	URISEC 12	146	VEREGEN	141
TYLENOL JR STRENGTH FASTMELTS	73	URISEC 22	146	VERELAN	54
TYLENOL JUNIOR STRENGTH	73	URISEC10	145	VERMOX	2
TYLENOL WITH CODEINE NO.2	67	URISPAS	149	VERSEL	142
TYLENOL WITH CODEINE NO.3	67	UROSODIOL ORAL LIQUID	120	VERTEPORFIN	118
ULIPRISTAL ACETATE	132	URSO	120	VESANOID	26
ULORIC	157	URSO DS	120	VESICARE	149
ULTI SYG 1/2 IN 29GX0.3CC	169	URSODIOL	120	VESPULA SPP VENOM PROTEIN	155
ULTI SYG 1/2 IN 29GX0.5CC	169	URSODIOL	120	EXTRACT	
ULTI SYG 1/2 IN 29GX1CC SYRINGE	169	USTEKINUMAB	155	VFEND	9
ULTI SYG 1/2 IN 30GX0.3CC	169	VAGIFEM 10	132	VIDEX EC	10
ULTI SYG 1/2 IN 30GX0.5CC	169	VALACYCLOVIR	13	VIDEXTRA	153
ULTI SYG 1/2 IN 30GX1CC SYRINGE	169	VALACYCLOVIR HYDROCHLORIDE	13	VIGABATRIN	79
ULTI SYG 5/16 IN 30GX0.3CC	169	VALCYTE	14	VIGAMOX	113
ULTI SYG 5/16 IN 30GX0.5CC	169	VALGANCICLOVIR HYDROCHLORIDE	14	VIMPAT	76
ULTI SYG 5/16 IN 30GX1CC SYRINGE	169	VALISONE	143	VIRACEPT	11
ULTI SYG 5/16 IN 31GX0.3CC	169	VALIUM	93	VIREAD	12
ULTI SYG 5/16 IN 31GX0.5CC	169	VALPROIC ACID (DIVALPROEX	79	VIROPTIC	113
ULTI SYG 5/16 IN 31GX1CC SYRINGE	169	SODIUM)		VISANNE	137
ULTIBRO BREEZHALER	30	VALPROIC ACID (SODIUM	79	VISKAZIDE	50
ULTICARE 1/2 IN 28GX0.5CC SYRINGE		VALPROATE)		VISKEN	50 51
	169 169	VALSARTAN	61	VISTITAN	116
ULTICARE 1/2 IN 28GX1CC SYRINGE		VALSARTAN	61		
ULTICARE 29GX0.1CC	169	VALSARTAN HCT	62	VISUDYNE	118
ULTICARE 29GX0.3CC	169	VALSARTAN,	62	VIT D 1000	152
ULTICARE 29GX0.5CC	169	HYDROCHLOROTHIAZIDE		VIT D 400	152
ULTICARE 29GX12MM PEN NEEDLE	167	VALSARTAN, SACUBITRIL	63	VITACELL VITAMIN D3 SOFTGELS	152
ULTICARE 30GX0.1CC	169	VALSARTAN-HCTZ	62	VITAL 1.5 CAL 1000ML LIQ	171
ULTICARE 30GX0.3CC	169	VALTREX	13	VITAL PEPTIDE 1 CAL 220ML LIQ	171
ULTICARE 30GX0.5CC	169	VANCOCIN	8	VITAL PEPTIDE 1.5 CAL 220ML LIQ	171
ULTICARE 31GX5MM PEN NEEDLE	168	VANCOMYCIN	8	VITAMIN A	151
ULTICARE 31GX6MM PEN NEEDLE	167	VANCOMYCIN HYDROCHLORIDE	8	VITAMIN A	151
ULTICARE 31GX8MM PEN NEEDLE	168	VANCOMYCIN HYDROCHLORIDE	8	VITAMIN A ACID	145
ULTICARE 32GX4MM PEN NEEDLE	168	VANCOMYCIN HYDROCHLORIDE	8	VITAMIN B1	151
ULTICARE 32GX6MM PEN NEEDLE	168	(INJECTION)	•	VITAMIN B12	151
ULTICARE 5/16 IN 31GX0.3CC SYRINGE	169	VANDETANIB	27	VITAMIN B12 SUBLINGUAL	151
ULTICARE 5/16 IN 31GX0.5CC SYRINGE	169	VARENICLINE TARTRATE	34	VITAMIN B6	151
ULTICARE 5/16 IN 31GX1CC SYRINGE	170	VASERETIC	55	VITAMIN C	151
ULTICARE LOW DEAD SPACE	168	VASOTEC	55	VITAMIN C	152
SYRINGE		VCF FOAM VAGINAL CONTRACEPTIVE	102	VITAMIN D	152
ULTILET CLASSIC LANCET	167	VCF VAGINAL CONTRACEPTIVE FILM	102	VITAMIN D	152
ULTRA 29G3/10CC	169	VEDOLIZUMAB	163	VITAMIN D3	152
ULTRA-FINE II 30G.1CC	169			VITAMIN E	153
ULTRA-FINE II 30GX0.3 CC SYRINGE	169	VELPHORO	108	VITAMIN E	153
ULTRAFINE III NEEDLE 31G 8MM	168	VEMURAFENIB	27	VITAMIN E VITAMIN K1	153
ULTRAFLEX 1 10MM/110CM	166	VENCLEXTA	27		
ULTRAFLEX 1 10MM/60CM	166	VENETOCLAX	27	VITAMINE C	152
ULTRAFLEX 1 10MM/80CM	166	VENLAFAXINE HYDROCHLORIDE	85	VITAMINE D	152
ULTRAFLEX 1 8MM/110CM	166	VENLAFAXINE XR	85	VOLIBRIS	48
SETTON LEX TOWNS TOOM	100	VENOFER	36	VOLTAREN	65

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				Non-insured Health Belletits
VOLTAREN OPHTHA	114	ZELDOX	91	
VOLTAREN SR	65	ZENHALE	31	
VORICONAZOLE	9	ZEPATIER	14	
VOSEVI	15	ZERIT	12	
VOTRIENT	24	ZESTORETIC	56	
VPI-ONDANSETRON ODT	122	ZESTRIL	55	
VYVANSE	92	ZIAGEN	10	
		ZIDOVUDINE	10 12	
WAMPOLE CALCIUM	106			
WAMPOLE CALCIUM AND D	106	ZINC OXIDE	146	
WAMPOLE CALCIUM VITAMIN D	106	ZINC OXIDE	146	
WAMPOLE COMPLETE MULT-PRE AND POST NATAL WITH FOLIC ACID	153	ZINC OXIDE, WHITE PETROLATUM	146	
WAMPOLE FERROUS GLUCONATE	36	ZINCOFAX EXTRA STRENGTH	146	
WAMPOLE FOLIC ACID		ZINDA-LETROZOLE	22	
	151	ZIPRASIDONE HYDROCHLORIDE	91	
WAMPOLE MINERAL CALCIUM	106	MONOHYDRATE		
WAMPOLE VITAMIN C	152	ZITHROMAX	4	
WAMPOLE VITAMIN D	152	ZOCOR	45	
WARFARIN SODIUM	38	ZODERM	147	
WASP VENOM PROTEIN	156	ZOFRAN	121	
WATER	109	ZOFRAN ODT	122	
WEBCOL ALCOHOL PREP	166	ZOLADEX	133	
WELLBUTRIN SR	80	ZOLADEX LA	154	
WELLBUTRIN XL	80	ZOLEDRONIC ACID	159	
WHITE FACED HORNET VENOM	156	ZOLEDRONIC ACID MONOHYDRATE	159	
PROTEIN		ZOLMITRIPTAN	96	
WHITE FACED HORNET VENOM	156	ZOLMITRIPTAN	97	
PROTEIN, YELLOW HORNET VENOM		ZOLMITRIPTAN ODT	97	
PROTEIN, YELLOW JACKET VENOM		ZOLOFT	84	
PROTEIN				
WHITE PETROLATUM	146	ZOMIG DADIMELT	96	
WHITE PETROLATUM, LANOLIN,	118	ZOMIG RAPIMELT	97	
MINERAL OIL		ZOSTRIX	147	
WINPRED	130	ZOSTRIX HP	147	
XALACOM	116	ZOVIRAX	13	
XALATAN	116	ZUCLOPENTHIXOL ACETATE	91	
XALKORI	19	ZUCLOPENTHIXOL	91	
XANAX	93	DIHYDROCHLORIDE		
XANAX TS	93	ZYBAN	80	
XARELTO	38	ZYDELIG	21	
XATRAL	33	ZYKADIA	18	
XELJANZ	161	ZYLOPRIM	156	
XELJANZ XR	161	ZYMAR	113	
XELODA	18	ZYPREXA	87	
XENEX IPECAC	121	ZYPREXA ZYDIS	88	
		ZYTIGA	17	
XENEX SODIUM BICARBONATE	105	ZYVOXAM	8	
XEOMIN	163	21 070 1101	Ü	
XGEVA	159			
XIGDUO	136			
XOLAIR	112			
XTANDI	20			
XYLAC	87			
XYLOCAINE	145			
XYLOCAINE VISCOUS	115			
YASMIN 21	131			
YASMIN 28	131			
YAZ	131			
YELLOW HORNET VENOM PROTEIN	156			
YELLOW JACKET VENOM PROTEIN	156			
ZADITEN	1			
ZAMINE 21	131			
ZAMINE 28	131			
ZARONTIN	74			
ZAROXOLYN	109			
ZAXINE	8			
ZELBORAF	27			

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