Alberta Health and Wellness Drug Benefit List

Revised October 1, 2007

Alberta
HEALTH AND WELLNESS

Inquiries

Inquiries should be directed to:

Pharmacy Services
Alberta Blue Cross
10009 108 Street NW
Edmonton AB T5J 3C5

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(403) 294-4041 (Calgary)
1-800-361-9632 (Toll Free)

FAX Number: (780) 498-8384
1-877-828-4106 (Toll Free)

Website: www.health.alberta.ca/ahcip/ahcip_list.html

Administered by Alberta Blue Cross
on behalf of Alberta Health and Wellness.

Additional copies of the *Alberta Health and Wellness Drug Benefit List* Publication CD are available from Pharmacy Services, Alberta Blue Cross at the address shown above.

Binder and contents: **$42.80** ($40.00 + $2.80 G.S.T.)
Contents only: **$37.45** ($35.00 + $2.45 G.S.T.)

A cheque or money order must accompany the request for additional copies.

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PART 1

SECTION 1

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INTRODUCTION

Eligibility

The *Alberta Health and Wellness Drug Benefit List* defines the drugs and drug products that are covered by Alberta government-sponsored drug programs. These programs are for Albertans and their dependents who are covered by:

1. the Alberta Blue Cross *Non-Group Coverage (Group 1)* offered by the Alberta Health Care Insurance Plan,
2. the Alberta Blue Cross *Coverage for Seniors (Group 66)* provided to all Alberta senior citizens and those on the Alberta Widows' Pension Plan *(Group 66A)*, or
3. the drug coverage provided to individuals approved by Alberta Health and Wellness for *Palliative Care Drug Coverage.* (For these individuals the *Palliative Care Drug Benefit Supplement* must also be considered), or
4. the drug coverage provided to Alberta Employment, Immigration and Industry Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients. (For these clients the *Alberta Employment, Immigration and Industry Drug Benefit Supplement* must also be considered.)

Additional Notes Regarding Application of the List

1. The *List* is not intended to be used as a scientific reference or prescribing guide.
2. Formularies used by hospitals and continuing care facilities are developed independently of the *List.*
3. Drugs are classified according to the Pharmacologic–Therapeutic classifications (PTC) developed by the American Society of Health-System Pharmacists for the purpose of the American Hospital Formulary Service.

   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 or excerpts from the original content.

   Where necessary, additional PTCs may have been assigned by Alberta Health and Wellness to facilitate product location in the *List*.
4. Where appropriate, the *Compendium of Pharmaceuticals and Specialties*, published by the Canadian Pharmacist's Association, was used as a reference source for the trade name, generic name, manufacturer, strength and dosage form.

   The Canadian Pharmacist's Association is not responsible for the accuracy of transpositions or excerpts from the original content.
5. Other reference sources used for the trade name, generic name, manufacturer, strength and dosage form are:
   - completed Drug Identification Number (DIN) notification form
   - Notice of Compliance (NOC)
   - Product Monograph
6. DINs listed reflect current manufacturer information available as of March 31, 2006.
7. Alberta Health and Wellness reserves the right to make changes, without notice, to the *List* through the on-line interactive *List*, and any such changes to the on-line interactive *List* are effective the date of the change (unless otherwise stated) and regardless of the date of publication in the paper/CD Rom version or updates.

Legend

1. Pharmacologic–Therapeutic classification.

2. Pharmacologic–Therapeutic sub-classification.

3. Nonproprietary or generic ingredient name of the drug.

4. Drug strength and dosage form.

5. The Drug Identification Number (DIN), assigned by the Therapeutic Products Programme, Health Protection Branch, Health Canada.

6. A box containing an X ☒ to the left of the DIN indicates that the product is not interchangeable with other products or interchangeability has not been assessed within the category.

7. All active ingredients of combination products are listed.

8. Strengths of active ingredients are listed in the same order as the ingredients. This example indicates that the topical cream contains 1% hydrocortisone acetate and 10% urea.

9. Brand name of the drug.

10. Three letter identification code assigned to each manufacturer. The codes are listed in Appendix 2 at the end of the List.

11. For products which are marked as non-interchangeable, the price is indicated in regular type (not bold type). These prices are supplied by the manufacturer and are expressed in decimal dollars.

12. For those products which are single source, the price is indicated in regular type (not bold type). These prices are supplied by the manufacturer and are expressed in decimal dollars.

13. Interchangeable grouping where the Least Cost Alternative (LCA) Price Policy has not been applied. This example indicates these two products are deemed interchangeable. These prices are supplied by the manufacturer and are expressed in decimal dollars.

14. The LCA Price for the selected interchangeable category appears in bold type. Pharmacists may dispense any brand listed in a category that is interchangeable, but the LCA price is the maximum price which will be paid. The prices listed are expressed as decimal dollars.

15. Products or devices designated as restricted benefits and limited restricted benefits are identified by a comment after the generic name. The comment indicates “RESTRICTED BENEFIT” or “LIMITED RESTRICTED BENEFIT” along with an explanation of the limits and/or restrictions. In this example, coverage of Proscar is restricted to the treatment of benign prostatic hyperplasia in patients 65 years of age and older. For more information about products or devices designated as restricted benefits, refer to the restricted benefits section of the List.

16. The Maximum Allowable Cost (MAC) is indicated for a specific drug product or a selected group of interchangeable drug products. The MAC price appears in bold italic type, and is displayed in the second column from the right (after the manufacturer code) where two price columns are listed. The MAC price is the maximum unit cost established for the selected product(s). In this example the LCA price for the two products matches the established MAC price. Where the MAC price policy has been applied, a comment in bold italic type explaining the basis for establishing the MAC price follows the specific drug product or selected group of interchangeable drug products. For more information about MAC pricing, refer to the price policy section of the List.

Example of Drug Product Listings

08:00 ANTI-INFECTIVE AGENTS

08:40 MISCELLANEOUS ANTI-INFECTIVES

METRONIDAZOLE

250 MG ORAL TABLET

00000545066	APO-METRONIDAZOLE	APX	$0.0575	$	0.0575

5 MG / ML INJECTION

00000870420	**FLAGYL**	**BAX**	$0.0176	$	**0.0189**
00000649074	METRONIDAZOLE	HSP	$0.1421	$	0.1421

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:04 ANALGESICS & ANTIPYRETICS
(NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

NAPROXEN

750 MG ORAL SUSTAINED-RELEASE TABLET

00002177072	APO-NAPROXEN SR	APX	$ 0.7604	$	0.7604
00002231327	NOVO-NAPROX	NOP	$ 0.7604	$	0.7604
00002162466	NAPROSYN SR	HLR	$ 1.2698	$	1.3650

MAC pricing has been applied based on the LCA price for 2 x 375 mg oral tablets, $0.2916.

68:00 HORMONES & SYNTHETIC SUBSTITUTES

68:16 ESTROGENS

CONJUGATED ESTROGENS

0.625 MG ORAL TABLET

00000265470	C.E.S.	VCL	$ 0.0972	$	0.1045
00002043408	PREMARIN	WAY	$ 0.1215	$	0.1215

84:00 SKIN & MUCOUS MEMBRANE PREPARATIONS

84:06 ANTI-INFLAMMATORY AGENTS

HYDROCORTISONE ACETATE/ UREA

1 % * 10 % TOPICAL CREAM

00000503134	UREMOL-HC	TCD	$ 0.6110	$	0.1730

HYDROCORTISONE

1 % TOPICAL CREAM

00000192597	EMO-CORT	TCD	$ 0.1582	$	0.1700
☒ 00002086034	BARRIERE-HC	SHB	$ 0.3980	$	0.3980

1 % TOPICAL LOTION

☒ 00000578541	SARNA HC	STI	$ 0.0863	$	0.0928
☒ 00000192600	EMO-CORT	TCD	$ 0.1462	$	0.1572

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00

FINASTERIDE

RESTRICTED BENEFIT - This product is a benefit for patients 65 years of age and older for the treatment of benign prostatic hyperplasia. (For eligibility in patients less than 65 years of age refer to the Criteria for Special Authorization of Select Drug Products of the List and Criteria for Special Authorization of Select Drug Products of the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

5 MG ORAL TABLET

00002010909	PROSCAR	MFC		$	1.7463

Acknowledgments

Alberta Health and Wellness acknowledges the important role Alberta Blue Cross continues to play in the production of the *List* and in the development of an overall strategy and initiatives to better manage Alberta Health and Wellness sponsored drug programs.

Drug Review Procedure

The Minister of Health and Wellness makes the final decisions on changes to the *Alberta Health and Wellness Drug Benefit List (List)* after reviewing the recommendations of the Expert Committee on Drug Evaluation and Therapeutics (ECDET), and/or the Notice of Final Recommendation issued by the CDR Directorate, and/or the recommendations of Alberta Health and Wellness. Further information is outlined in the following sections.

Common Drug Review Procedure

Alberta is a participant in the national Common Drug Review Procedure (CDR Procedure).* Submissions relating to the New Chemical Entities and New Combination Products that have received a Health Canada Notice of Compliance (NOC) should be directed to the CDR Directorate for consideration.

- **New Chemical Entity** is an active moiety that has not been previously approved for sale in Canada by Health Canada and marketed in Canada.
- **New Combination Product** consists of two or more active moieties that have not previously been approved for sale in Canada and marketed in Canada in that combination. It may consist of either two or more new active moieties or two or more old active moieties or a combination of new and old active moieties.

Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics

The Minister of Health and Wellness has established an Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics to refine and maintain the *List* on an ongoing basis.

All drug products not eligible for review under the CDR Procedure must be reviewed by the Expert Committee prior to their determination as benefits on the *List*. As part of this procedure, drug manufacturers are required to make submissions to the Senior Manager, Scientific and Research Services, Alberta Blue Cross. Alberta Health and Wellness reserves the right to refer any submission to the CDR Directorate for review and/or comment.

If requested, the manufacturer must provide written confirmation from the CDR Directorate that the drug product is not eligible for review under the CDR Procedure.

The Expert Committee considers the scientific, therapeutic, clinical and socio-economic merits of drug products. The Committee receives advice and assistance from external consultants and agencies when needed. The Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics makes recommendations on the *List* to Alberta Health and Wellness through the Director, Pharmaceutical Policy and Programs Branch, Strategic Directions Division. Alberta Health and Wellness reserves the right to refer drug products reviewed under the CDR Procedure to the Expert Committee for additional review or comment. The Expert Committee is permitted to request any additional information it requires in order to complete its review or provide comments.

*Information regarding the CDR Procedure may be obtained through the Canadian Agency for Drugs and Technologies in Health.

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SUBMISSION AND DRUG REVIEW PROCESS

Submission Requirements and Criteria

Manufacturers should note that only complete submissions, satisfying all of the submission requirements of the applicable category of drug product, will be put forward for consideration by the Expert Committee. There is no obligation or guarantee that every completed submission will be reviewed, and/or a recommendation made, at the next scheduled meeting of the Expert Committee. Pre-NOC submissions may be made; however, the submission will only be reviewed by the Expert Committee once it is complete. **Any request by a manufacturer to hold a submission will result in a submission being deemed incomplete as of the date of the request. A submission on hold will only be considered complete once correspondence is received from a manufacturer to proceed with the submission.** Only one (1) copy of a submission for a drug product is required. A determination by Alberta Blue Cross that a submission is complete is preliminary and made only for the purposes of forwarding the Submission to the Expert Committee for review.

IMPORTANT NOTES:

1. **The Expert Committee reserves the right to request any additional information it may require in order to conduct its review and prepare recommendations.**

2. **From time to time, new and novel issues are raised by drug submissions that require additional time and/or research before the Expert Committee is able to appropriately assess the submission and make a recommendation. The Expert Committee reserves the right in these situations to defer any submission it deems appropriate in order to ensure that it may complete its duties and functions as required, and in a manner that protects patient safety and maintains the integrity of the AHWDBL.**

In addition, drug manufacturers are invited to provide other information they feel may be important to the review of a submission e.g. selected references or additional studies completed after a drug product had been submitted to the Therapeutic Products Directorate, Health Canada. Comparative studies with other listed drug products or studies in sub-groups such as the elderly are most relevant. If questions or concerns are raised about a product by the Expert Committee during the review process the Senior Manager, Scientific and Research Services will contact the manufacturer involved for further information.

All submissions should be sent to the attention of:

Senior Manager
Scientific and Research Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5

To ensure continued listing of drug products, manufacturers are required to notify the Senior Manager, Scientific and Research Services of any significant change to listed drug products. Significant changes are considered to be changes in NOC, DIN, product name, manufacturer or distributor, indication, product monograph, packaging, formulation, manufacturing specifications or any change that could potentially affect the bioavailability or bioequivalence of a drug product.

For clarification of submission requirements, additional information on the submission and drug review process, or for copies of forms referenced in the Submission Requirements section (e.g. Budget Impact Assessment, Resubmissions), all inquiries should be directed to:

Coordinator
Scientific and Research Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5
Phone: (780) 498-8098
Fax: (780) 498-8040

Each year manufacturers are notified of the submission deadlines for the upcoming year by Alberta Blue Cross. Information on submission deadlines can also be found on the *Alberta Health and Wellness Drug Benefit List* website which can be accessed at http://www.ab.bluecross.ca/dbl/manufacturers.html

Interpretation Notices

From time to time, or as circumstances warrant, certain practices or procedures may be adopted by the Committee pertaining to the interpretation of the procedures and criteria published in the *AHWDBL Policies and Guidelines*. In order to assist manufacturers in preparing and submitting effective drug review submissions, the Expert Committee has determined that, where it deems appropriate, notice of these practices will be provided to manufacturers through "Interpretation Notices".

The Notices are intended to be a guide to assist manufacturers, but in situations where the Notices lead to inconsistencies or conflicts, the criteria in the Drug Review Procedure and Submission Requirements and Criteria, will apply.

Notices will be published electronically and it continues to be the responsibility of manufacturers to monitor amendments to the *AHWDBL*. For convenience only, hard copies of Notices may be provided with the *AHWDBL Quarterly Updates* where deemed appropriate by Alberta Blue Cross.

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST

INTERPRETATION NOTICE #1

INTERCHANGEABILITY and NON-CANADIAN REFERENCE PRODUCTS

The *Submission Requirements and Criteria* of the AHWDBL require manufacturers to provide the *Expert Committee on Drug Evaluation and Therapeutics* ("Expert Committee") with data comparing the submitted drug product to the reference drug product. Under the *Interchangeable Drug Products Criteria*, manufacturers are also required to demonstrate bioequivalence with the reference drug product in accordance with the Criteria.

At various times, some manufacturers have submitted interchangeability submissions using a Non-Canadian Reference Product (NRCP). After reviewing several submissions, the Expert Committee has adopted the practice of permitting manufacturers to demonstrate bioequivalency by providing data comparing the submitted drug product to a NCRP that meets the *Criteria for use of a Non-Canadian Reference Product* as set out in Health Canada's *Drugs Directorate Policy regarding the use of a Non-Canadian Reference Product under the provisions of Section C.08.002.1(c) of the* Food and Drug Regulations (the "NCRP Criteria").

Important Note: Health Canada does not determine interchangeability and therefore, a determination by Health Canada that a product meets the NCRP Criteria *is not sufficient proof* for the Expert Committee's purposes. The Expert Committee will continue to consider and assess all of the submission materials, and make its own determination whether the NCRP Criteria, the Submission Requirements and the Criteria are met, and whether the product may be designated as interchangeable.

The practice in these situations is that, after receipt of the submission, Alberta Blue Cross makes a request to Health Canada for a copy of the Therapeutic Products Directorate's review (TPD File) for the submitted product(s). Manufacturers are advised that, in order to avoid a possible deferral, they may include a full copy of the TPD File in their submission. If necessary, submissions may be deferred until the TPD File is received. Product submissions may, at the discretion of Alberta Blue Cross, be scheduled for review if the TPD File is received 7 days prior to the meeting date.

As with all submissions, the Expert Committee retains the right to request additional materials from the manufacturer, Health Canada or any other entity it determines appropriate in order to conduct its review.

Issue Date: November 9, 2006

SUBMISSION REQUIREMENTS

The following Submission Requirements pertain to submissions not eligible for review under the CDR Procedure.

A) New Chemical Entities/Single Source Drug Products

The following submission requirements pertain to New Chemical Entities, New Combination Products where one or more of the active moieties have never been listed on the *List*, and other single source drug products that have never been listed on the *List*; and are not eligible for review under the Common Drug Review (CDR) Procedure. Submissions for drug products in this category should first be directed to the CDR Directorate.

1. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR procedure, the Patented Medicine Price Review Board (PMPRB), the Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada
2. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
3. Complete Bibliography
   - in the form of a medical literature database search (i.e., Medline, EMBASE, Cochrane, etc.)using the generic name of the drug as a search term and the time period from the year of inception of the database to the current year
4. Copy of Comprehensive Summary
   - the 'Clinical Studies' section is sufficient; the 'Pre-Clinical' section is appreciated
   - in addition to a hard copy, an electronic (diskette/CD) copy of the Comprehensive Summary compatible with Microsoft Word 2000 (version for PC) is appreciated
5. Copy of completed Drug Identification Number (DIN) notification form
6. Copy of Notice of Compliance (NOC)
7. Current Patent Status
   - a signed statement from the manufacturer stating that the submitted product does not infringe any patents
   - expiry date(s) of all Canadian patent(s)
8. Copy of completed and approved Certified Product Information Document (CPID)
   - in lieu of the CPID, a Master Formula and Final Product Specifications must be provided
9. Certificates of Analyses from two (2) batches of each strength and/or dosage form of finished submitted product; if only one (1) batch is available, the manufacturer must indicate so in writing
10. Price Information
    - proposed price in Alberta and lowest price in Canada

11. Product Monograph
    - in addition to a hard copy, an electronic (diskette/CD) copy of the TPD-approved Product Monograph compatible with Microsoft Word 2000 (version for PC) is required
12. Economic Information
    - a comprehensive pharmacoeconomic analysis prepared in accordance with the Canadian Coordinating Office for Health Technology Assessment (CCOHTA): "Guidelines for Economic Evaluation of Pharmaceuticals: Canada", 2nd edition, November 1997; cost-effectiveness and cost-utility data and the impact on "direct" healthcare costs are most useful
    - a completed *Budget Impact Assessment for the Alberta Health and Wellness Drug Benefit List* form. Note: copies of this form can be obtained by accessing the *Alberta Health and Wellness Drug Benefit List* website which can be accessed at www.ab.bluecross.ca/dbl/manufacturers.html, or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross at Phone: (780) 498-8098 or Fax: (780) 498-8040.
13. If requested, the manufacturer must provide written confirmation from the CDR Directorate that the drug product is not eligible for review under the CDR Procedure.

B) Changes to Special Authorization or Restricted Benefit Status of Listed Single Source Drug Products Due to a New Indication

The following submission requirements pertain to single source drug products currently listed via special authorization or as restricted benefits that have received a new indication from Health Canada, where the manufacturer wishes to request expansion of the coverage criteria or change in benefit status due to the new indication and that are not eligible for review under the CDR Procedure. Submissions for drug products in this category that have been previously reviewed under the CDR Procedure should first be directed to the CDR Directorate.

1. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR procedure, the Patented Medicine Price Review Board (PMPRB), the Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada
2. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
3. Justification for the Expanded Coverage Criteria or Change in Benefit Status
   - a separate document indicating the reason for and evidence to justify the need for the expanded coverage criteria or change in benefit status due to the new indication
4. Complete Bibliography
   - in the form of a medical literature database search (i.e., Medline, EMBASE, Cochrane, etc.) using the generic name of the drug and terms relevant to the new indication as search terms and the time period from the year of inception of the database to the current year
5. Copy of Comprehensive Summary
   - the 'Clinical Studies' section is sufficient; the 'Pre-Clinical' section is appreciated.
   - in addition to a hard copy, an electronic (diskette/CD) copy of the Comprehensive Summary compatible with Microsoft Word 2000 (version for PC) is appreciated
6. Copy of Notice of Compliance (NOC) for the new indication
7. Current Patent Status
   - a signed statement from the manufacturer stating that the submitted product does not infringe any patents
   - expiry date(s) of all Canadian patent(s)
8. Price Information
   - proposed price in Alberta and lowest price in Canada
9. Product Monograph (revised to include the new indication)
   - in addition to a hard copy, an electronic (diskette/CD) copy of the TPD-approved Product Monograph compatible with Microsoft Word 2000 (version for PC) is required
10. Economic Information
    - a comprehensive pharmacoeconomic analysis (**prepared with respect to the new indication only**) in accordance with the Canadian Coordinating Office for Health Technology Assessment (CCOHTA): *"Guidelines for Economic Evaluation of Pharmaceuticals: Canada",* 2nd edition, November 1997; cost-effectiveness and cost-utility data and the impact on "direct" healthcare costs are most useful

- a completed Budget Impact Assessment for the *Alberta Health and Wellness Drug Benefit List* form **prepared with respect to the new indication only**. Note: copies of this form can be obtained by accessing the *Alberta Health and Wellness Drug Benefit List* website which can be accessed at www.ab.bluecross.ca/dbl/manufacturers.html, or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross at Phone: (780) 498-8098 or Fax: (780) 498-8040.

11. If requested, the manufacturer must provide written confirmation from the CDR Directorate that the drug product is not eligible for review under the CDR Procedure.

C) Line Extension Drug Products

The following submission requirements pertain to new strengths and formulations or reformulations of drug products that are currently listed or are under consideration for listing on the *List* and where products are not eligible for review under the CDR Procedure. Submissions for drug products in this category that have previously been reviewed under the CDR Procedure should first be directed to the CDR Directorate.

1. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR procedure, the Patented Medicine Price Review Board (PMPRB), the Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada
2. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
3. Justification for the Line Extension
   - a separate document indicating the reason for and evidence to justify the need for the new strength, formulation or reformulation of the drug product
4. Condensed Bibliography
   - in the form of a medical literature database search (i.e., Medline, EMBASE, Cochrane, etc.) using the generic name of the drug as a search term and the time period from the most recent two (2) years prior to the submission to the current year
5. Copy of Comprehensive Summary
   - the 'Clinical Studies' section is sufficient
   - in addition to a hard copy, an electronic (diskette/CD) copy of the Comprehensive Summary compatible with Microsoft Word 2000 (version for PC) is appreciated
   - if a Comprehensive Summary is not available (i.e. clinical studies have not been conducted on the new strength, formulation or reformulation) then the manufacturer must provide evidence establishing a clear linkage between the submitted product(s) and a currently listed product(s). This can be in the form of:
     - bioequivalence data; or
     - evidence of formulation proportionality (i.e. a comparison of master formulae for all strengths) and evidence of a similar dissolution profile
6. Copy of completed Drug Identification Number (DIN) notification form
7. Copy of Notice of Compliance (NOC)
8. Current Patent Status
   - a signed statement from the manufacturer stating that the submitted product does not infringe any patents
   - expiry date(s) of all Canadian patent(s)
9. Copy of completed and approved Certified Product Information Document (CPID)
   - in lieu of the CPID, a Master Formula and Final Product Specifications must be provided
10. Certificates of Analyses from two (2) batches of each strength and/or dosage form of finished submitted product; if only one (1) batch is available, the manufacturer must indicate so in writing
11. Price Information
    - proposed price in Alberta and lowest price in Canada

12. Product Monograph (revised to include the line extension)
    - in addition to a hard copy, an electronic (diskette/CD) copy of the TPD-approved Product Monograph compatible with Microsoft Word 2000 (version for PC) is required
13. Economic Information
    - a completed *Budget Impact Assessment for the Alberta Health and Wellness Drug Benefit List* form. Note: copies of this form can be obtained by accessing the *Alberta Health and Wellness Drug Benefit List* website which can be accessed at www.ab.bluecross.ca/dbl/manufacturers.html, or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross at Phone: (780) 498-8098 or Fax: (780) 498-8040.
14. If requested, the manufacturer must provide written confirmation from the CDR Directorate that the drug product is not eligible for review under the CDR Procedure.

D) Interchangeable Drug Products

The following submission requirements pertain to multisource drug products submitted for listing in an interchangeable grouping in the *Alberta Health and Wellness Drug Benefit List*.

1. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR procedure, the Patented Medicine Price Review Board (PMPRB), the Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada
2. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
3. Condensed Bibliography
   - in the form of a medical literature database search (i.e., Medline, EMBASE, Cochrane, etc.) using the generic name of the drug as a search term and the time period from the most recent two (2) years prior to the submission to the current year
4. Interchangeability/bioequivalence data comparing the submitted drug product to the reference drug product:
   - all products submitted as interchangeable products must provide sufficient evidence that the criteria set forth in the *Criteria for Recommendations on the Interchangeability of Multisource Drug Products by the Expert Committee on Drug Evaluation and Therapeutics* have been met, and please note as follows:
     - drug products in solid oral dosage forms will require a comparative bioavailability study or a comparative pharmacodynamic study or studies with the reference drug product conducted in accordance with the TPD *guidances 'Conduct and Analysis of Bioavailability and Bioequivalence Studies - Parts A and B and Report C'*
     - drug products not in solid oral dosage forms will require surrogate comparisons with the reference drug product using *in vivo* or *in vitro* test methods or a pharmacodynamic or therapeutic equivalence study
     - drug products that are pseudo-generics will require letters from both the manufacturer of the submission drug product and the manufacturer of the innovator brand or a currently listed drug product within the submission product's interchangeable grouping, stating that the submission drug product is manufactured under the identical master formula and manufacturing and quality control specifications, as the innovator brand or the currently listed drug product
5. Copy of completed Drug Identification Number (DIN) notification form
6. Copy of Notice of Compliance (NOC)
7. Current Patent Status
   - a signed statement from the manufacturer stating that the submitted product does not infringe any patents
8. Copy of completed and approved Certified Product Information Document (CPID)
   - in lieu of the CPID, a Master Formula and Final Product Specifications must be provided

9. Certificates of Analyses from two (2) batches of each strength and/or dosage form of finished submitted product; if only one (1) batch is available, the manufacturer must indicate so in writing
10. Price Information
    - proposed price in Alberta and lowest price in Canada
11. Product Monograph
    - in addition to a hard copy, an electronic (diskette/CD) copy of the TPD-approved Product Monograph compatible with Microsoft Word 2000 (version for PC) is required

E) Old Drug Products (as designated by the Therapeutic Products Directorate, Health Canada)

The following submission requirements pertain to those drug products submitted for listing in an interchangeable grouping in the *Alberta Health and Wellness Drug Benefit List* where the active ingredient is designated as an "old drug" by Health Canada and the drug product is approved on the basis of a DIN application (i.e. an NOC is not issued by Health Canada).

1. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR procedure, the Patented Medicine Price Review Board (PMPRB), the Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada
2. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.
3. Condensed Bibliography
   - in the form of a medical literature database search (i.e., Medline, EMBASE, Cochrane, etc.) using the generic name of the drug as a search term and the time period from the most recent two (2) years prior to the submission to the current year
4. Copy of completed Drug Identification Number (DIN) notification form
5. Interchangeability/bioequivalence data comparing the submitted drug product to the reference drug product:
   - all products submitted as interchangeable products must provide sufficient evidence that the criteria set forth in the *Criteria for Recommendations on the Interchangeability of Multisource Drug Products by the Expert Committee on Drug Evaluation and Therapeutics* have been met and please note as follows:
     - drug products in solid oral dosage forms will require a comparative bioavailability study or a comparative pharmacodynamic study or studies with the reference drug product conducted in accordance with the TPD guidances *'Conduct and Analysis of Bioavailability and Bioequivalence Studies - Parts A and B and Report C'*
     - drug products not in solid oral dosage forms will require surrogate comparisons with the reference drug product using in vivo or in vitro test methods or a pharmacodynamic or therapeutic equivalence study
     - drug products that are pseudo-generics will require letters from both the manufacturer of the submission drug product and the manufacturer of the innovator brand or a currently listed drug product within the submission product's interchangeable grouping, stating that the submission drug product is manufactured under the identical master formula and manufacturing and quality control specifications, as the innovator brand or the currently listed drug product
6. Copy of completed and approved Certified Product Information Document (CPID)
   - in lieu of the CPID, a Master Formula and Final Product Specifications must be provided
7. Certificates of Analyses from two (2) batches of each strength and/or dosage form of finished submitted product; if only one (1) batch is available, the manufacturer must indicate so in writing

8. Price Information
   - proposed price in Alberta and lowest price in Canada
9. Product Monograph or Prescribing Information
   - in addition to a hard copy, an electronic (diskette/CD) copy of the TPD-approved Product Monograph or Prescribing Information compatible with Microsoft Word 2000 (version for PC) is required

F) Resubmissions

The following resubmission requirements apply to those drug products that have been reviewed by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics and a decision has been made by the Minister of Health and Wellness to:

- not add the drug product to the *Alberta Health and Wellness Drug Benefit List*
- add the drug product to the *Alberta Health and Wellness Drug Benefit List* as a special authorization or restricted benefit, or
- maintain the criteria for coverage of a special authorization or restricted benefit drug product despite the manufacturer's request for a change

1. Resubmission Form
   - if a manufacturer wishes to request reconsideration of a previously submitted drug product, the manufacturer must complete and submit the *Resubmission for the Alberta Health and Wellness Drug Benefit List* form. This form can be obtained by accessing the *Alberta Health and Wellness Drug Benefit List* website which can be accessed at www.ab.bluecross.ca/dbl/manufacturers.html, or by contacting the Coordinator, Scientific and Research Services, Alberta Blue Cross at Phone: (780) 498-8098 or Fax: (780) 498-8040. Whether a request for reconsideration is granted is in the sole discretion of the Expert Committee.
2. Consent Letter
   - an unrestricted letter authorizing Alberta Health and Wellness and its agent/designate to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR procedure, the Patented Medicine Price Review Board (PMPRB), the Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada, all submission information and information in the possession of Health Canada, CADTH, PMPRB, Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada
3. Letter Confirming Ability to Supply
   - a letter signed by a senior official providing assurance that the manufacturer is able to supply the specific drug product and strength from the time of listing in a quantity sufficient to meet the anticipated demand in Alberta for a minimum of 6 months.

Please note: Resubmissions will not be accepted for products prior to a decision being rendered on the product in question.

Criteria for Listing Drug Products

1. The following criteria apply to drug product submissions reviewed by the Expert Committee. They are general criteria only and are intended to be applied flexibly, having regard to each individual case. They may be modified or adapted as the situation may require. Not all criteria will apply to each case. The criteria are:
    - Clinical studies must have demonstrated the safety and efficacy of the product in appropriate populations.
    - The product must:
        i. possess demonstrated therapeutic advantage over other presently accepted therapies or treatments of the disease entity for which the product is indicated, or
        ii. be significantly more cost-effective than present accepted therapy.
    - Assessment of therapeutic advantage may include consideration of:
        i. clinical efficacy,
        ii. risk/benefit ratio,
        iii. toxicity,
        iv. compliance,
        v. clinical outcomes,
        vi. Health Canada advisories,
        vii. population health issues,
        viii. any other factor which affects the therapeutic value of the product
    - Limitations may be placed on reimbursement for certain products.
    - Products expected to have high cost implications may not be listed or may be restricted by special authorization procedures.
    - For line extensions (i.e., different dosages or formats for products already listed), the product must be at least cost-neutral.
2. For all drug products, the Expert Committee, Alberta Health and Wellness and/or the Minister may, in addition to all of the factors listed above, also consider any factors that they consider appropriate, including but not limited to any or all of the following:
    - the recommendations from the CDR review,
    - failure by a manufacturer to meet previous product supply assurances,
    - failure by a manufacturer to provide a Request for Quotation (RFQ),
    - type of drug, drug product, class or category and indications for use,
    - other available alternative products, treatments or therapies,
    - whether the product is interchangeable,
    - unit cost,
    - volume of use and amounts paid out for similar products, classes or categories,
    - potential cost savings (percentage and dollar amounts)
    - expenditure management and resources,
    - patent issues,
    - coverage provided by other programs,
    - for interchangeable products, safety concerns that have been identified subsequent to the initial designation of interchangeability on the *AHWDBL*,

- issues, concerns, objectives, goals and/or mandates related to any government policies, plans or programs, and
- patient care concerns related to factors external to the drug product.

3. For interchangeability of multisource drug products, see additional criteria under "Interchangeable Drug Products".
4. As a general policy, first entry interchangeable products will be initially screened to determine whether they provide at least a 25% savings over the brand name product:
   - those that meet the initial screen will normally be added, subject to interchangeability or other factors and considerations outlined in the criteria.
   - those that do not meet the initial screen will be subject to more detailed review. The manufacturer may present additional information on the question of cost.
   - this is a general policy only and may be varied in the circumstances of any particular case having regard to the facts. Examples of cases where a product might be added even though it does not provide a 25% saving include:
     i. where the product would provide a significant cost saving
     ii. where a product is designated as an old drug by Health Protection Branch and there is limited market potential
     iii. where the cost of manufacturing the product is too high to allow a 25% savings based on evidence submitted by the manufacturer
     iv. where the product is primarily dispensed by hospital outpatient pharmacies in which contracts with major regional health authorities indicate there will be at least a 25% saving realized because of the tenders and the actual acquisition cost used to determine drug material costs when pricing prescriptions
     v. these are examples only, and not an exhaustive list.
5. Second, third, or subsequent interchangeable entries will normally be added (subject to interchangeability issues).
6. As a general policy, interchangeable products and product line extensions may, at the sole option and discretion of Alberta Health and Wellness, be considered for review and possible addition to the *List* on a **"fast-track"** basis", if the product submission is otherwise complete, and:
   - For first-entry interchangeable products[1] and product line extensions - if the product price offers savings to government-sponsored drug programs[2] of either:
     - more than 30% over the brand-name product and at least $250,000 per year; or
     - at least $1 million per year.
   - For subsequent-entry interchangeable products – if the product price offers savings to government-sponsored programs[2] of $500,000 per year over the least cost alternative (LCA) price.

[1]For consideration on a "fast-track" basis, the following may be considered first entry interchangeable products:

- All submissions for a given multisource drug that achieve "complete" status (i.e., satisfying all of the submission requirements) on the same business day that Alberta Blue Cross receives the first "complete" submission; and
- A subsequent entry interchangeable product where one or all of the interchangeable products already listed on the List are not supplying a sufficient quantity of drug product to meet the demand in Alberta, as determined by Alberta Health and Wellness at its sole option and discretion, and based on any information that Alberta Health and Wellness deems appropriate.

[2]Government-sponsored drug programs are defined under Eligibility in the Introduction section of the *List*.

7. New Chemical Entities, New Combination Products and other single source products not eligible for review under the CDR Procedure may, at the sole option and discretion of Alberta Health and Wellness, be considered for review and possible addition to the *List* on a **"fast-track"** basis, if the product submission is otherwise complete, and the product has been granted "Priority Review" status by the Therapeutic Products Directorate, Health Canada. A copy of documentation from the Therapeutic Products Directorate granting 'Priority Review' status is required.
8. The onus is on the manufacturer to formally request, in writing, consideration on a 'fast-track' basis if, in the opinion of the manufacturer, the product meets any of the above 'fast-track' criteria.
    - Request for 'fast-track' review does not automatically mean that the submission will be considered on that basis. The decision whether to 'fast-track' a submission will be made by Alberta Health and Wellness at its sole option and discretion.
9. Where a manufacturer has not supplied, or is not supplying, a sufficient quantity of drug product to meet the demand in Alberta (as determined by Alberta Health and Wellness at its sole option and discretion, and based on any information it deems appropriate), Alberta Health and Wellness may:
    - refuse to list any product of the manufacturer,
    - refuse to "fast-track" any product submission of the manufacturer; or,
    - discontinue listing the product that is not meeting the supply demand.

Interchangeable Drug Products

Criteria for Recommendations on the Interchangeability of Multisource Drug Products by the Expert Committee on Drug Evaluation and Therapeutics

Principle:
Decisions respecting interchangeability and drug lists remain in the domain of the institution responsible for the costs of the product which includes hospitals, provincial governments and other third party payers (*6/9/95 Canada Gazette Part ll, Vol. 129, No. 18)*

Preface:
The *Alberta Health and Wellness Drug Benefit List (AHWDBL*) contains designations of interchangeability for approved multisource drug products. The Expert Committee on Drug Evaluation and Therapeutics makes recommendations on interchangeability to Alberta Health and Wellness through the Director, Pharmaceuticals and Life Sciences Branch, Population Health. The Minister of Health and Wellness makes the final decisions on interchangeability after reviewing the recommendations of the Expert Committee and Alberta Health and Wellness.

Definitions:

Bioavailability: This term means the rate and extent to which the active ingredient or active moiety is absorbed from a drug product and becomes available at the site of action. Bioavailability is most frequently assessed by serial measurements of the drug, or its metabolites, or both, in the systemic circulation.

Bioequivalent: This term describes pharmaceutically equivalent drug products that display comparable bioavailability when studied under similar experimental conditions. A test (submission) drug product and reference drug product shall be considered bioequivalent when the rate and extent of absorption of the test drug product is not significantly different from the rate and extent of absorption of the reference drug product when administered at the same molar dose of the active ingredient under similar experimental conditions after a single dose or multiple doses as appropriate. Where these methods are not applicable (e.g. for simple solutions, elixirs, syrups, aerosols, injectables, topicals, suppositories, non-systemic oral products), other *in vivo* or *in vitro* test methods, comparative clinical trials or pharmacodynamic studies may be used to demonstrate bioequivalence; however, the final determination of bioequivalence in these circumstances is at the sole discretion of the Expert Committee.

Pseudo-Generic Drug Product: A pseudo-generic drug product is a drug product that is manufactured under the identical master formulae and manufacturing and quality control specifications as a) the innovator brand of the drug; or b) any drug product that is currently listed on the *AHWDBL* within the submission product's interchangeable grouping.

Interchangeable Drug Product: An interchangeable drug product is a drug product that has been designated as interchangeable by the Minister of Health and Wellness after reviewing the recommendations of the Expert Committee and Alberta Health and Wellness. Recommendations regarding interchangeability are made taking into consideration the scientific, therapeutic, clinical and socio-economic merits of drug products. Drug products designated as interchangeable are expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling. The designation of interchangeability is made only for the purpose of funding of drug benefits covered under the Alberta government-sponsored drug benefit programs and is not to be used as a scientific reference or prescribing guide.

Multisource Drug Product: Drug products are considered to be multisource drug products when they are manufactured and/or distributed by more than one manufacturer.

Pharmaceutical Alternative: Drug products are considered to be pharmaceutical alternatives if they contain the same therapeutic moiety, but are different salts, esters or complexes of that moiety, or are different dosage forms or strengths.

Pharmaceutical Equivalent: Drug products are considered to be pharmaceutical equivalents if they contain the same active ingredient(s), are of comparable dosage form(s), route of administration and are identical in strength or concentration.

Criteria:

The Expert Committee on Drug Evaluation and Therapeutics may recommend as interchangeable, multisource drug products that meet all of the following criteria:

1. The drug product has been approved as safe and efficacious by the Therapeutic Products Directorate (TPD). *Issuance of a Notice of Compliance by the TPD as stated in subsection C.08.002.1 of the Food and Drug Regulations which provides for a Declaration of Equivalence does not mean the drug product will automatically be designated as interchangeable.*
2. The drug product is a pharmaceutical equivalent[1] as defined by the *AHWDBL* criteria.
3. The drug product has been demonstrated to be bioequivalent[1] as follows:
   a) if the submission drug product is a pseudo-generic drug product, letters from both the manufacturer of the submission drug product and the manufacturer of the innovator brand or a currently listed drug product within the submission product's interchangeable grouping, stating that the submission drug product is manufactured under the identical master formula and manufacturing and quality control specifications, as the innovator brand or the currently listed drug product are required.
   b) if the drug has uncomplicated or non-variable pharmacokinetics and is in a conventional (immediate release) formulation or a modified release formulation, the drug product must meet, without deviation, the study design requirements and standards for bioequivalence as per Section 7.1 of *Part A: Oral Dosage Formulations Used for Systemic Effects* or Section 4.0 of *Part B: Oral Modified Release Formulations* of the *Drugs Directorate Guidelines: Conduct and Analysis of Bioavailability and Bioequivalence Studies.* For purposes of recommendations of interchangeability, AUC (area under the curve) is interpreted to mean AUC_T which is the AUC to the time of the last quantifiable concentration.
   c) if the drug has complicated or variable pharmacokinetics as defined by the *Expert Advisory Committee on Bioavailability - Report C: Report on Bioavailability of Oral Dosage Formulations, not in Modified-Release Form, of Drugs Used for Systemic Effects, Having Complicated or Variable Pharmacokinetics (Draft 1992)* which includes the individual drug categories:
      1. drugs for which pharmacodynamic studies are appropriate alternatives to bioavailability and bioequivalence studies of oral dosage formulations
      2. highly toxic drugs
      3. drugs with non-linear kinetics
      4. drugs with an effective half-life > 12 hours
      5. drugs for which an early time of onset or rapid rate of absorption is important
      6. drugs with a narrow therapeutic range
      7. combination drug products

   The drug product would be expected to meet the study design requirements and standards for bioequivalence as they apply to each individual drug category within Report C. To date, Report C and all study design requirements and standards for bioequivalence contained therein are in draft stage. As a result, a manufacturer submitting a drug with complicated or variable pharmacokinetics does so with full realization that a recommendation of interchangeability by the Expert Committee may be deferred until final study design requirements and standards for bioequivalence for the individual drug category are published by the TPD. If a recommendation of interchangeability is deferred, the Expert Committee will initiate a process for an investigation and review of the appropriate study design requirements and standards for bioequivalence for such drug products on a case by case basis. This process may involve consultation with the TPD, the manufacturer of the drug product, other provinces and experts as deemed necessary.

d) if the drug product cannot be demonstrated to be bioequivalent by serial measurements of the drug, or its metabolites, or both, in the systemic circulation, other *in vivo* or *in vitro* test methods, comparative clinical trials or pharmacodynamic studies may be considered in the assessment of bioequivalence; however, the final determination of bioequivalence in these circumstances is at the sole discretion of the Expert Committee.

[1] Alternatively, pharmaceutical alternatives may, at the sole discretion of the Expert Committee, be recommended as interchangeable if supported by evidence of comparative therapeutic efficacy

Considerations:

1. Multisource drug products may be recommended as interchangeable and still differ in characteristics such as shape, scoring configuration, packaging, labeling aspects and excipient content.
2. Excipients and non-medicinal ingredients such as sugar, sodium, gluten, tartrazine, sulfites, colouring agents and preservatives are generally not considered in the recommendation of interchangeability. Excipients that may affect absorption of a drug may be considered in the recommendation of interchangeability.
3. Powders for reconstitution for administration as oral or injectable liquids may vary with respect to their expiration time or storage conditions after reconstitution. A recommendation of interchangeability is applicable only when each product is reconstituted, stored and used under the conditions specified in the labeling of the product.

Review of Benefit Status (ROBS) Criteria

The Expert Committee and/or Alberta Health and Wellness may at any time review the benefit status of a drug product, a group of drug products, a class or classes of drug products, or a category or categories of drug products listed or being considered for listing on the *AHWDBL* (collectively "Products"). The Expert Committee and/or Alberta Health and Wellness may, at their sole option and discretion, recommend altering or discontinuing the benefit status for Products if one or more of the following criteria are met. These are general criteria only, which are intended to be applied flexibly, having regard to each individual case. The criteria may be modified or adapted as the situation may require, and not all criteria will apply to each case:

1. There has been a significant change to the Product(s). Significant changes may include changes in NOC, DIN, product name, manufacturer or distributor, indication, product monograph, packaging, formulation, or any change that could potentially affect the bioavailability or bioequivalence of a product.
2. The Product(s), no longer possesses demonstrated therapeutic advantage compared to other presently accepted therapies or treatments of the disease entity for which the Product(s) is/are indicated. Assessment of therapeutic advantage may include consideration of clinical efficacy, risk/benefit ratio, toxicity, compliance, clinical outcomes, Health Canada advisories, population health issues, and any factor which affects the therapeutic value of the product, class or category.
3. The Product(s) is/are no longer cost-effective compared to other presently accepted therapies or treatments of the disease entity for which the Product(s) is/are indicated.
4. To enable broader coverage of higher priority Product(s).
5. When a product has been discontinued by the manufacturer.
6. When Product(s) is/are changed from prescription to non-prescription status, the Expert Committee may recommend continuing, altering or discontinuing benefit status of the Product(s) based upon scientific, therapeutic, clinical and socio-economic merits of the Product(s).
7. For all ROBS reviews, the Expert Committee, Alberta Health and Wellness and/or the Minister may, in addition to all of the factors listed above, also consider any factors that they consider appropriate, including but not limited to any of the following:
   - failure by a manufacturer to meet previous product supply assurances,
   - failure by a manufacturer to provide a Request for Quotation (RFQ),
   - type of drug, drug product, class or category and indications for use,
   - other available or alternative products, treatments or therapies,
   - whether the product is interchangeable,
   - unit cost,
   - volume of use and amounts paid out for similar products, classes or categories,
   - potential cost savings (percentage and dollar amounts),
   - expenditure management and resources,
   - patent issues,
   - coverage provided by other programs,
   - for interchangeable products, safety concerns that have been identified subsequent to the initial designation of interchangeability on the *AHWDBL,*

- issues, concerns, objectives, goals and/or mandates related to any government policies, plans or programs, and
- patient care concerns related to factors external to the drug product.

Unsolicited information from manufacturers relating to ROBS Reviews will not be put before the Expert Committee. However, if the Expert Committee determines that a change in benefit status may be warranted, manufacturers of the affected Product(s) will be notified and provided with an opportunity to make submissions to the Expert Committee prior to the final recommendation being made. Notification will include advice regarding the form of submission that will be accepted, the deadline for filing the submission and any other relevant advice. Any submissions that do not comply with the notification advice will not be put before the Expert Committee.

Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics: Policy for Administering Interchangeability Challenges

From time-to-time, the Expert Committee on Drug Evaluation and Therapeutics receives unsolicited information ("Challenge Information") from a manufacturer (the "Challenger") suggesting that additional information should be taken into account when a submission for interchangeability for a multisource product is being considered by the Expert Committee. Alberta Health and Wellness is not prepared to have any Challenge Information considered by the Expert Committee unless the manufacturer whose product is being challenged (the "Applicant") is provided with a full copy of the Challenge Information and is given an opportunity to respond to it.

As a result, Alberta Health & Wellness has developed and approved the following process for the handling of Challenge Information:

1. Challenge Information must comply with the following conditions.
2. Challenge information must be received by Alberta Blue Cross:
   - For first-entry interchangeable product submissions – Within 15 days of the date of issuance of the NOC for the Applicant's product.
   - For all other submissions, by the submission deadline date.
3. All Challenge Information must include an unconditional Written Consent, signed by the Challenger, authorizing Alberta Health and Wellness and its agent/designate to (a) disclose to the Applicant all Challenge Information; and (b) to access, discuss, use, collect from, and disclose to its agents, consultants, Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH) and all persons, parties or entities involved in the CDR Procedure, the Patented Medicine Price Review Board (PMPRB), the Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada, all submission information and Challenge Information and any information in the possession of Health Canada, the Canadian Agency for Drugs and Technologies in Health (CADTH), the Patented Medicine Price Review Board (PMPRB), the Alberta Cancer Board, regional health authorities and the government of any province or territory in Canada.
4. If the above unconditional Written Consent is not submitted as required, the Challenge Information will not be considered by the Expert Committee.
5. If Written Consent is submitted as required, the Challenge Information will be duplicated in its entirety and forwarded by Alberta Blue Cross to the Applicant, inviting a response ("Applicant Response"). The Applicant Response must be received by Alberta Blue Cross no later than 15 days after the date of the letter from Alberta Blue Cross.
6. If an Applicant Response is not received by Alberta Blue Cross within the time provided, only the Challenge Information will be provided to the Expert Committee for consideration. If an Applicant Response is received within the time provided, both the Applicant Response and the Challenge Information will be provided to the Expert Committee for consideration.
7. No further information may be submitted to the Expert Committee for consideration.
8. The Applicant Response should only address information contained in the Challenge Information. Anything in the Applicant Response that does not relate to information contained in the Challenge Information may, at the sole discretion of the Expert Committee, be disregarded.

9. It is a condition of each and every Submission and Challenge that the terms, conditions, criteria and time limitations contained in this policy will apply and that:

    a) Applicants, by filing a Submission and Applicant Response; and,
    b) Challengers, by submitting Challenge Information

    agree to and are bound by this policy.

10. In the event the anticipated Applicant submission is not received, Challenge Information will be destroyed 6 months after receipt.

Inquiries may be made to:

Senior Manager
Scientific and Research Services
Alberta Blue Cross
10009 - 108 Street NW
Edmonton AB T5J 3C5
Phone: (780) 498-5978
Fax: (780) 498-8040

Your Comments are Important to Us

To improve the high standards established for this publication, the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics would like to offer you an opportunity for input. Should you have any concerns and/or suggestions concerning product listings or criteria for coverage of products available via special authorization, etc. please let us know. If you are writing in support of a product listing change or a revision to the special authorization criteria for coverage, you must provide evidence in support of your comments from the peer-reviewed scientific literature. In order to meet the expectations of stakeholders relative to objectivity and transparency, all individuals providing comments are required to advise the Expert Committee of any potential conflicts of interest below (please check appropriate box):

Please note: this is not a mechanism for an appeal for a specific patient.

Conflict of Interest: ☐ **Yes** ☐ **No**

If Yes, please indicate the nature of the potential conflict of interest below:

_____

_____

Please provide your comments in the space provided below:

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_____

Contact Information:

Name and Address: _____

Phone/Fax: _____

Please print form and mail/fax to:

Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics
c/o Senior Manager
Scientific and Research Services
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5
FAX to: (780) 498-8040 in Edmonton area

PRICE POLICY

Price Policy

Prices printed in the *Alberta Health and Wellness Drug Benefit List* are based on a Request for Quotation (RFQ) process undertaken with manufacturers. It is the manufacturer's/vendor's responsibility to ensure supply of all products for which price quotes have been submitted.

When a manufacturer fails to provide a RFQ as required, or fails to comply with any price quoted under the RFQ process, Alberta Health and Wellness may, at its sole discretion and without the advice of the Expert Committee:

a. refuse to list;

b. refuse to fast-track a submission of; or

c. recommend a change in benefit status (including being removed as a benefit from the *AHWDBL*); or

d. change or not change the listed price of;

any one or more of the manufacturer's products listed or being considered for listing on the *AHWDBL*. Despite this provision, Alberta Health and Wellness reserves the right to pursue any other remedy available to it.

Three types of pricing appear on the *List.* For examples, refer to the Legend in the Introduction section of the *List.*

Least Cost Alternative (LCA) Pricing

- appears in **bold** type where it is the lowest unit cost established for a drug product within a set of interchangeable drug products.
- is shown in the far right price column.

Where the LCA price policy has been applied, the Alberta government-sponsored drug programs will pay the Actual Acquisition Cost (AAC) of the drug material to a maximum of the LCA price.

The LCA price policy may or may not be applied to selected interchangeable groupings identified in the *List*. In determining whether to apply the LCA price policy, the Expert Committee and/or the Minister may take into consideration any factor set out in the listing criteria for the drug product, as well as one or more of the following:

- compliance issues,
- failure by a manufacturer to meet previous product supply assurances,
- patient care concerns related to factors external to the drug product,
- population health issues, and
- issues, concerns, objectives, goals and/or mandates related to any government policies, plans or programs.

Where a physician prescribes or a patient chooses a higher priced interchangeable product subject to the LCA price policy, the patient will be responsible for any additional costs associated with the selection.

A physician may request special authorization if a particular brand is essential in the care of a patient where the LCA price policy would otherwise apply. If special authorization is granted, the program will pay the AAC of the brand prescribed. For further information refer to the Special Authorization Guidelines section of the *List.*

Maximum Allowable Cost (MAC) Pricing

- appears in ***bold italic*** type, and
- is shown in the second column from the right (after the manufacturer code) where two price columns are listed.
- a comment in ***bold italic*** type appears following a specific drug product or a selected group of drug products where MAC pricing has been applied. The comment explains the basis for establishing the MAC price.

The MAC price is the maximum unit cost established for a specific drug product or a selected group of drug products. The Alberta government-sponsored drug programs, which follow the MAC price policy, will pay the AAC of the drug material to a maximum of the MAC price. Where a physician prescribes a specific product subject to the MAC price policy, patients will be responsible for any additional cost(s).

A physician may request special authorization if a particular drug product or dosage form of a drug is essential in the care of a patient where the MAC price policy would otherwise apply. Exceptions may occur at the product level. Coverage may be considered only where a patient has experienced significant allergic reactions to the drug product which establishes the MAC pricing. If special authorization is granted, the program will pay the AAC of the product prescribed. For further information refer to the Special Authorization Guidelines section of the *List.*

Categories Where MAC Pricing Has Been Applied

MAC pricing has been applied to the following categories on the *List*:

- **PTC 28:08:04**
  Selected Oral Modified-Release Dosage Forms of Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)
- **PTC 40:12**
  Potassium Chloride (K+) 8 mEq Oral Sustained-Release Tablets

Pricing Which Appears in Regular Type

- Includes:
  - all products which have not been identified as an LCA product,
  - non-interchangeable products,
  - single-source[1] products,
  - products where the LCA price policy has not been applied, and
  - products where the MAC price policy has been applied and the quoted price are greater than the MAC price.

[1] Products are considered single source in situations where there is only one product in a category.

Supply Shortage Policy for Drug Products

1. If a confirmed supply shortage exists and the unavailable product is a single-source product on the *List*, products not otherwise allowed as benefits may be added temporarily or temporarily reimbursed under Alberta government-sponsored drug programs.
2. Confirmation that the product is not reasonably available via wholesalers and/or direct from the manufacturer is required.
3. Products added or reimbursed under this policy may remain as temporary benefits until the supply shortage is rectified.
4. In order to remain as benefits after the shortage is rectified, these products must be subjected to the usual review process.
5. An attempt to recover any cost difference from the manufacturer unable to supply a drug product may be considered and made by Alberta Health and Wellness.
6. Failure to ensure product supply may result in the product being removed from the list.
7. Alberta Health and Wellness may at its sole discretion, take any other steps or require any information from a manufacturer or other person, that is reasonably required to manage a supply shortage.

Units of Issue for Pricing

These units of issue are used for presenting prices in the *List*.

Dosage Form	Unit of Issue Priced in *AHWDBL*
Ampoules	Millilitre
Bladder Irrigation Solutions	Millilitre
Dental Pastes	Gram
Devices	Device
Inhalation Capsules	Capsule
Inhalation Cartridges	Cartridge
Inhalation Disks	Disk
Inhalation Solutions or Suspensions	Millilitre – all preparations including nebules
Inhalation Unit Dose Solution	Millilitre
Injections	Vial – where reconstitution is required (or Millilitre where indicated)
	Millilitre – where no reconstitution is required
Injections – Cartridges	Millilitre
Injections – Emulsion	Millilitre
Injections – Syringes	Syringe (or Millilitre where indicated)
Injection – Implant	System
Injection Syringe/Oral Capsule	Kit
Injection Vial/Oral Capsule	Kit
Injection Vial/Oral Tablet	Kit
Injection Syringe/Oral Tablet	Kit
Intrauterine Insert	System
Irrigating Solutions	Millilitre
Lock Flush	Millilitre
Metered Dose Aerosols	Dose
Metered Inhalation Powder	Dose
Nasal Metered Dose Aerosols	Dose
Nasal Metered or Unit Dose Sprays	Dose
Nasal Solutions	Millilitre
Nasal Sprays	Millilitre
Ophthalmic Solutions or Suspensions or Drops	Millilitre
Ophthalmic Gels or Ointment	Gram
Ophthalmic Long Acting Gellan Solutions	Millilitre
Oral Caplets	Caplet
Oral Capsules – all formulations	Capsule
Oral Drops	Millilitre
Oral Granules	Bulk size – Gram
	Individual Packet – Packet
Oral Liquids – all formulations	Millilitre
Oral Powders	Gram (or Dose where indicated)
Oral Powder Packets	Individual Packet
Oral Rinses	Millilitre
Oral Tablets – all formulations	Tablet

Units of Issue for Pricing, continued

Dosage Form	Unit of Issue Priced in AHWDBL
Oral Tablets – oral contraceptives	Tablet
Oral Tablet/Capsule	Kit
Oral Wafer	Wafer
Otic Ointments or Gels	Gram
Otic Solutions or Suspensions or Drops	Millilitre (or Vial where indicated)
Rectal Enemas	Enema
Rectal Foams	Gram
Rectal Ointments	Gram
Rectal Retention Enemas	Enema
Rectal Suppositories - all formulations	Suppository
Scalp Lotions	Millilitre
Scalp Solutions	Millilitre
Sublingual Metered Dose Spray	Dose
Topical Bars	Gram
Topical Cleansers	Millilitre
Topical Creams/Ointments - all formulations	Gram
Topical Gauzes	Dressing
Topical Gels - all formulations	Gram
Topical Jellies	Millilitre
Topical Lotions	Millilitre or Gram
Topical Powders	Gram
Topical Solutions	Millilitre
Topical Washes	Millilitre or Gram
Transdermal Gel	Gram
Transdermal Patches	Patch
Vaginal Capsules or Ovules or Tablets	Capsule or Ovule or Tablet
Vaginal Creams or Ointments or Gels	Gram
Vaginal Douches	Millilitre
Vaginal Ovule/Topical Cream	Kit
Vaginal Slow Release Rings	Ring
Vaginal Suppositories	Suppository

RESTRICTED BENEFITS

Restricted Benefits

Selected devices or drug products are eligible benefits with restrictions in the *Alberta Health and Wellness Drug Benefit List*. For these products a comment is displayed in the *List* after the ingredient name. The comment initially states "RESTRICTED BENEFIT" and is followed by an explanation of the restriction. For an example, refer to the Legend in the Introduction section of the *List*.

Products Designated as Restricted Benefits

The products listed below are restricted benefits in the *List.*

PTC 28:16

- **Risperidone (Apo-Risperidone, pms-Risperidone, Risperdal)** 1 mg/ml oral solution

PTC 28:92

- **Almotriptan Malate (Axert)** 6.25 mg and 12.5 mg oral tablet
- **Naratriptan HCL (Amerge)** 1 mg and 2.5 mg oral tablet
- **Rizatriptan Benzoate (Maxalt)** 5 mg oral tablet, 10 mg oral tablet and **(Maxalt RPD)** 5 mg oral wafer, 10 mg oral wafer
- **Sumatriptan Hemisulfate (Imitrex)** 5 mg/dose and 20 mg/dose unit dose nasal spray
- **Sumatriptan Succinate (Apo-Sumatriptan, Co Sumatriptan, Gen Sumatriptan, Imitrex DF, Novo-Sumatriptan DF, pms-Sumatriptan, ratio-Sumatriptan, Sandoz Sumatriptan)** 50 mg oral tablet, **(Apo-Sumatriptan, Co Sumatriptan, Imitrex DF, Novo-Sumatriptan DF, pms-Sumatriptan, ratio-Sumatriptan, Sandoz Sumatriptan)** 100 mg oral tablet and **(Imitrex)** 6 mg/syr injection syringe
- **Zolmitriptan (Zomig)** 2.5 mg oral tablet, **(Zomig Rapimelt)** 2.5 mg oral dispersible tablet and **(Zomig)** 5 mg/dose unit dose nasal spray

PTC 52:08

- **Mometasone Furoate (Nasonex)** 50 mcg/dose aqueous nasal spray

PTC 92:00

- **Dutasteride (Avodart)** 0.5 mg capsule
- **Finasteride (Proscar)** 5 mg oral tablet
- **Montelukast Sodium (Singulair)** 4 mg oral chewable tablet, 5 mg oral chewable tablet, 10 mg oral tablet, and 4 mg oral granule
- **Zafirlukast (Accolate)** 20 mg oral tablet

PTC 94:00

- **Aerosol Holding Chamber** (Aerochamber, Aerochamber Max Device, Optichamber, Space Chamber, Vortex)
- **Aerosol Holding Chamber/Mask - Infant** (Infant Aerochamber with Mask, Infant Aerochamber Max with Mask Device, Optichamber Small Mask, Space Chamber Infant Mask, Vortex Baby Whirl Infant Mask)

- **Aerosol Holding Chamber/Mask - Pediatric** (Child Aerochamber Max with Mask, Optichamber Medium Mask, Pediatric Aerochamber with Mask, Space Chamber Pediatric Mask, Vortex Spinner Pediatric Mask)
- **Aerosol Holding Chamber Mask - Adult** (Adult Aerochamber with Mask, Adult Aerochamber Max with Mask, Optichamber Large Mask, Space Chamber Adult Mask, Space Chamber Adult Large Mask)

Limited Restricted Benefits

Selected drug products are eligible benefits with limits and restrictions in the *Alberta Health and Wellness Drug Benefit List*. For these products a comment is displayed in the *List* after the ingredient name. The comment initially states “LIMITED RESTRICTED BENEFIT” and is followed by an explanation of the limits and restrictions. For an example, refer to the Legend in the Introduction of the *List*.

Product(s) Designated as Limited Restricted Benefits

The product(s) listed below are limited restricted benefits in the *List*.

PTC 92:00

- **Clopidogrel Bisulfate (Plavix)** 75 mg oral tablet

SPECIAL AUTHORIZATION GUIDELINES

Special Authorization Policy

Drug Products Eligible for Consideration by Special Authorization

Drug products may be considered for coverage by special authorization under one or more of the following circumstances (unless a specific product falls under the criteria for drug products **not** eligible):

1. The drug is covered by Alberta Health and Wellness under specified criteria (listed in the following sections). Drug Products and indications other than those specified are not eligible for consideration by special authorization.
2. The drug is normally covered by another government program or agency for a specific clinical condition, but is needed for the treatment of a clinical condition that is not covered by that government program or agency.
3. The drug is required because other preparations listed in the *Alberta Health and Wellness Drug Benefit List* are contraindicated or inappropriate because of the clinical condition of the patient.
4. The particular brand of drug is considered essential in the care of a patient, where the LCA price policy would otherwise apply. Coverage of a specific brand may be considered where a patient has experienced significant allergic reactions or documented untoward therapeutic effects with alternate brands in an interchangeable grouping. Coverage of a brand name product will not be considered in situations where the interchangeable grouping includes a cross-licensed / pseudo-generic / ultra-generic to the brand name drug.
5. A particular drug product or dosage form of a drug is essential in the care of a patient where the MAC price policy would otherwise apply. Exceptions may occur at the product level. Coverage may be considered only where a patient has experienced significant allergic reactions to the drug product which establishes the MAC pricing.

Prior approval must be granted by Alberta Blue Cross to ensure coverage by special authorization. For those special authorization requests that are approved, the effective date for authorization is the beginning of the month in which the physician's request is received by Alberta Blue Cross.

Special authorization is granted for a specific period, to a maximum of 12 months unless otherwise indicated. If continued treatment is necessary, it is the responsibility of the patient and physician to re-apply for coverage prior to the expiration date of the authorization period.

Drug Products *Not Eligible* for Consideration by Special Authorization

The following categories of drug products are **not** eligible for special authorization:

1. Drug products **deleted** from the *List*.
2. Drug products **not yet reviewed** by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics. This applies to:
   - products where a complete submission has been received from the manufacturer and the product is under review,
   - products where an incomplete submission has been received from the manufacturer, and
   - products where the manufacturer has not made a submission for review.

   Drug products not yet reviewed may encompass new pharmaceutical products, new strengths of products already listed, reformulated products and new interchangeable (generic) products.
3. Drug products that have **completed the review** process and are **not included** on the *List.*
4. Most drugs available through Health Canada's Special Access Program.
5. Drug products when prescribed for cosmetic indications.
6. Nonprescription or over-the-counter drug products are generally not eligible.

Special Authorization Procedures

A prescriber's request for special authorization should be directed by mail or FAX to:

Clinical Drug Services and Evaluation
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5

FAX: (780) 498-8384 in Edmonton and area
1-877-828-4106 toll-free fax for all other areas

1. For most drug products, written requests from a prescriber may be submitted on the general *Drug Special Authorization Request* (form number ABC 20061).

   Select drug products such as Aricept/Exelon/Reminyl ER (form number ABC 30776), Aggrenox/Plavix (form number ABC 30786), Aranesp/Eprex for chronic renal failure (form number ABC 30888), Remicade for Crohn's/Fistulizing Crohn's Disease (form number ABC 30901), Enbrel/Humira/Kineret/Remicade for Rheumatoid Arthritis (form number ABC 30902), Ezetrol (form number ABC 30925), Pegetron/Pegasys RBV (form number ABC 30932), Unitron-PEG (form number ABC 30933), Pegasys for Chronic Hepatitis C (form number ABC 30944), Enbrel for Juvenile Rheumatoid Arthritis (form number ABC 30948), and Enbrel/Humira for Psoriatic Arthritis (form number ABC 30964), Select Quinolones (form number 30966), Alendronate/Raloxifene/ Risedronate/Synthetic Calcitonin Salmon for Osteoporosis (form number ABC 31086), Pegasys for Chronic Hepatitis B (form number ABC 31095), Celebrex (form number ABC 31140) and Neulasta/Neupogen (form number ABC 31150) have a unique special authorization request form. All requests for these drug products must be submitted using the applicable form.

   Special authorization request forms can be found on the following pages.

2. A separate request is required for each patient.

3. For a request for special authorization to be considered, the prescriber (an individual authorized by law to prescribe) must contact Alberta Blue Cross and provide the following information:

   Patient Identification
   - patient's name, address and card holder's name (if different than the patient's),
   - Alberta Blue Cross identification number or coverage number/client number of any other applicable coverage (e.g. Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Services (AISH) or Alberta Personal Health number, and
   - date of birth.

   Prescriber Identification
   - name of prescriber (e.g. physician, dentist, or optometrist),
   - address,
   - telephone number and FAX number (if applicable), and
   - professional association registration number (e.g. College of Physicians and Surgeons, Alberta Dental Association, or Alberta College of Optometrists registration number).

   Drug Requested
   - name, strength and dosage form,
   - dosage schedule, and
   - proposed duration of therapy.

Reason for the Request

- diagnosis and/or indication for which the drug is being used,
- information regarding previous medications which have been used and the patient's response to therapy where appropriate,
- proposed results of therapy, and
- any additional information that may assist in making a decision on the request for special authorization.

Special Authorization Forms

Special Authorization forms can be found on the following pages:

- *Drug Special Authorization Request Form* (ABC 20061)
- *Aricept/Exelon/Reminyl ER Special Authorization Request Form* (ABC 30776) - All requests for Aricept (donepezil HCl), Exelon (rivastigmine hydrogen tartrate) and Reminyl ER (galantamine hydrobromide) must be submitted using this form only.
- *Aggrenox/Plavix Special Authorization Request Form* (ABC 30786) - All requests for Aggrenox (dipyridamole/ASA) or Plavix (clopidogrel bisulfate) must be submitted using this form only.
- *Aranesp/Eprex for chronic renal failure Special Authorization Request Form* (ABC 30888) - All requests for Aranesp (darbepoetin) or Eprex (epoetin alfa) must be submitted using this form only.
- *Remicade for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* (ABC 30901) - All requests for Remicade (infliximab) for Crohn's/Fistulizing Crohn's must be submitted using this form only.
- *Enbrel/Humira/Kineret/Remicade for Rheumatoid Arthritis Special Authorization Request Form* (ABC 30902) - All requests for Enbrel (etanercept), Humira (adalimumab), Kineret (anakinra), or Remicade (infliximab) for Rheumatoid Arthritis must be submitted using this form only.
- *Ezetrol Special Authorization Request Form* (ABC 30925) - All requests for Ezetrol (ezetimibe) must be submitted using this form only.
- *Pegetron/Pegasys RBV Special Authorization Request Form* (ABC 30932) - All requests for Pegetron (peginterferon alfa-2b/ribavirin) and Pegasys RBV (peginterferon alfa-2a/ribavirin) must be submitted using this form only.
- *Unitron-PEG Special Authorization Request Form* (ABC 30933) - All requests for Unitron-PEG (peginterferon alfa-2b) must be submitted using this form only.
- *Pegasys for Chronic Hepatitis C Special Authorization Request Form* (ABC 30944) - All requests for Pegasys (peginterferon alfa-2a) must be submitted using this form only.
- *Enbrel for Juvenile Rheumatoid Arthritis Special Authorization Request Form* (ABC 30948) - All requests for Enbrel (etanercept) for Juvenile Rheumatoid Arthritis must be submitted using this form only.
- *Enbrel/Humira for Psoriatic Arthritis Special Authorization Request Form* (ABC 30964) - All requests for Enbrel (etanercept) or Humira (adalimumab) for Psoriatic Arthritis must be submitted using this form only.
- *Select Quinolones Special Authorization Request Form* (ABC 30966) - All requests for ciprofloxacin, gatifloxacin, levofloxacin, moxifloxacin and ofloxacin must be submitted using this form only.
- *Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form* (ABC 31086) - All requests for alendronate, raloxifene, risedronate, and synthetic calcitonin salmon for Osteoporosis must be submitted using this form only.
- *Pegasys for Chronic Hepatitis B Special Authorization Request Form* (ABC 31095) - All requests for Pegasys (peginterferon alfa-2a) must be submitted using this form only.

- *Celebrex Special Authorization Request Form (ABC 31140)* – All requests for Celebrex (celecoxib) must be submitted using this form only.
- *Neulasta/Neupogen Special Authorization Request Form* (form number ABC 31150) – All request for Neulasta (pegfilgrastim) and Neupogen (filgrastim) must be submitted using this form only.

The following official forms are provided for your convenience to photocopy and use as required.

Submit completed forms by FAX to Alberta Blue Cross:

(780) 498-8384 in Edmonton and area

1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please DO NOT mail or re-fax your request

Drug Special Authorization Request Form

On the reverse is the official *Drug Special Authorization Request Form* (ABC 20061).

- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

DRUG SPECIAL AUTHORIZATION REQUEST

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PHYSICIAN INFORMATION			
PHYSICIAN SURNAME / FIRST NAME / INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

☐ **NEW** ☐ **RENEWAL DRUG REQUEST** **Note: Request may or may not be approved by Alberta Blue Cross**

Drug(s), Dosage(s) and Duration Requested:

Diagnosis and / or Indication which drug is being used to treat:
(Include applicable information regarding previous medications, patient response to therapy and proposed results of therapy.)

Additional information relating to request:

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to:
		▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Aricept/Exelon/Reminyl ER Special Authorization Request Form

On the reverse is the official *Aricept/Exelon/Reminyl ER Special Authorization Request Form* (ABC 30776).

- All requests for Aricept (donepezil HCl), Exelon (rivastigmine hydrogen tartrate) and Reminyl ER (galantamine hydrobromide) must be submitted using the *Aricept/Exelon/Reminyl ER Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ARICEPT/EXELON/REMINYL ER SPECIAL AUTHORIZATION REQUEST FORM

Please complete ALL sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PHYSICIAN INFORMATION				
PHYSICIAN SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	

Criteria for Coverage of ARICEPT, EXELON, REMINYL ER

For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26.

This drug must be initiated by a designated prescriber for new patients (individuals who have never taken the requested drug before or who have taken the drug for 60 days or less) with an MMSE score between 10-13 inclusive.

Specialists in Geriatric Medicine, Neurology, and Psychiatry are deemed designated prescribers by virtue of their specialty in medical practice. All other practitioners will be added to the list of designated prescribers if they have successfully completed MAINPRO-C credits through the College of Family Practice (Physicians) [prior to March 31, 2006], the Care of the Elderly Six-month/One-year Fellowship Program through the Department of Family Medicine or the MAINPRO-M1 course entitled, "Module 2: Advanced Alzheimer's Disease."

Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, rivastigmine, galantamine) when these medications are intended for use in combination.

PLEASE COMPLETE ALL SECTIONS TO ALLOW YOUR REQUEST TO BE PROCESSED

Indicate which drug is requested:

- ☐ **Aricept**
- ☐ **Exelon**
- ☐ **Reminyl ER**

Please confirm the diagnosis for which this drug is requested:

For the treatment of: ☐ Dementia of the Alzheimer's Type

☐ other, please specify: _____

Please provide a **recent MMSE score** and the **date** the exam was administered:

MMSE Score: _____

Date of exam: _____

Please confirm request type:

- ☐ request for Aricept, Exelon or Reminyl ER for a **new*** patient, (i.e. a patient who has either: never taken the requested drug before, or, has taken it for 60 days or less).
- ☐ request for an **existing** Aricept, Exelon or Reminyl ER patient (i.e. a patient who has already been on the requested drug for more than 60 days).

*** For new patients only with an MMSE score between 10-13, this drug must be initiated by a designated prescriber.**

Designated prescriber who recommended the drug for this patient: _____

Note:

- a recent MMSE score is that which is within 3 months from the time of this application, or from the date of expiration of the current authorization.
- new patients (those who have never taken the requested drug before or who have taken the drug for 60 days or less) will be approved for an initial 12 week authorization. Subsequent renewals, and approvals for existing patients (those who have already been on the requested drug for more than 60 days) will be for 12 months.
- for those patients approved for the initial 12 week authorization, a drop by more than 3 points in their MMSE score during the 12 week period will result in discontinuation of coverage.
- an MMSE score below 10 at any time will also result in discontinuation of coverage.

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: • **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information provided on this application is collected pursuant to section 41 of the Alberta Health Care Insurance Act and sections 20(a) and (b) of the Health Information Act, pursuant to section 27. If you have any questions regarding the collection of this information, please contact Alberta Blue Cross Clinical Drug Services and Evaluation at (780)498-8480.

Aggrenox/Plavix Special Authorization Request Form

On the reverse is the official *Aggrenox/Plavix Special Authorization Request Form* (ABC 30786).

- All requests for Aggrenox (dipyridamole/ASA) or Plavix (clopidogrel bisulfate) must be submitted using the *Aggrenox/Plavix Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

AGGRENOX/PLAVIX
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PHYSICIAN INFORMATION				
PHYSICIAN SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY		PROVINCE	POSTAL CODE

Indicate which drug is being requested (check ONE box): ☐ **AGGRENOX (complete Section I)** ☐ **PLAVIX (complete Sections II and/or III)**

Criteria for Coverage of AGGRENOX	**Section I (Must complete for all Aggrenox requests)**
For use in patients who have experienced a cerebrovascular ischemic event (e.g. stroke, TIA).	**Cerebrovascular** ischemic event: ☐ stroke ☐ TIA ☐ other (specify):

Criteria for Post-Stent Coverage of PLAVIX	**Section II (Must complete for requests for post-stent coverage of Plavix)**
For the prevention of thrombosis, for one month, when prescribed following intravascular bare metal stent placement. Patients who have received one month of coverage via the Limited Restricted Benefit will not be eligible for additional coverage under this criterion. *	**Please indicate the type and date of the stent:**
For the prevention of thrombosis, for up to 12 months, when prescribed following intravascular drug eluting stent (DES) placement. Patients who have received one month of coverage via the Limited Restricted Benefit may be eligible for an additional 11 months of coverage (i.e., up to 12 months of coverage) following the submission of a special authorization request. *	Date of stenting procedure: _____ ☐ bare metal stent (1 month of coverage) ☐ drug eluting stent (12 months of coverage)
**** Special Authorization for post-stent coverage is required when the physician prescribing the medication is not a designated prescriber, for treatment after repeat stents, or for continued coverage of up to 12 months following intravascular drug eluting stent (DES) placement.***	*For additional coverage, please proceed to Section III below*

Other Criteria for Coverage of PLAVIX

For the prevention of cerebrovascular (e.g. stroke, TIA) and non-cerebrovascular ischemic events in patients who have a contraindication to ASA. Special Authorization for this criterion may be granted for 24 months.

For use in patients who have experienced a non-cerebrovascular ischemic event while on ASA. Special Authorization for this criterion may be granted for 24 months.

For use in patients who have experienced a cerebrovascular ischemic event (e.g. stroke, TIA) while on dipyridamole/ASA (Aggrenox) or for whom dipyridamole/ASA (Aggrenox) is contraindicated. Special Authorization for this criterion may be granted for 24 months.

Section III (For Plavix requests, complete ALL that apply)

Does this patient have a contraindication/intolerance to ASA? ☐ YES ☐ NO

Please indicate the **cerebrovascular** ischemic event experienced: ☐ stroke ☐ TIA	Please specify the **non-cerebrovascular** ischemic event experienced:
Did the **cerebrovascular** event occur while this patient was on dipyridamole/ASA (Aggrenox)? ☐ YES ☐ NO	Please indicate which anti-platelet therapy this patient was on when the **non-cerebrovascular** event occurred: ☐ ASA ☐ other (specify):_____ ☐ Patient was not on anti-platelet therapy
If applicable, please indicate which product this patient has a contraindication/intolerance to: ☐ dipyridamole/ASA (Aggrenox) ☐ dipyridamole	

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Aranesp/Eprex for chronic renal failure Special Authorization Request Form

On the reverse is the official *Aranesp/Eprex for chronic renal failure Special Authorization Request Form* (ABC 30888).

- All requests for Aranesp (darbepoetin) or Eprex (epoetin alfa) must be submitted using the *Aranesp/Eprex for chronic renal failure Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

Aranesp/Eprex
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PHYSICIAN INFORMATION			
PHYSICIAN SURNAME / FIRST NAME / INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Indicate which drug is requested (check one box): ☐ Aranesp ☐ Eprex

PLEASE COMPLETE ALL APPLICABLE SECTIONS TO ALLOW YOUR REQUEST TO BE PROCESSED

ANEMIA OF CHRONIC RENAL FAILURE (does not apply to Eprex 40,000 IU/mL strength)

☐ anemia of chronic renal failure

☐ other, please specify: _____

This section applies only to patients who received a renal transplant:
Please indicate if the renal transplant is failing or has failed:
☐ Yes ☐ No

Hemoglobin level:
For new patients: pre-treatment hemoglobin level (g/L):

For patients with prior special authorization for Aranesp or Eprex with Alberta Blue Cross: current hemoglobin level (g/L):

Please provide the current iron status:
Serum ferritin is >100 mcg/L: ☐ Yes ☐ No AND Transferrin saturation is >20%: ☐ Yes ☐ No

CHEMOTHERAPY-INDUCED ANEMIA (includes Eprex 40,000 IU/mL strength)

Please specify the type of cancer:
_____

☐ other, please specify: _____

For the treatment of anemia:
Please indicate if the anemia is chemotherapy-induced:
☐ Yes ☐ No, please specify: _____

Please provide the patient's hemoglobin level (g/L):

Please specify the reason why blood transfusions are not an option:
☐ Transfusion reactions in the past ☐ Difficulty cross-matching the patient
☐ Iron overload ☐ Other, please specify:_____

ANEMIA IN AZT-TREATED/HIV INFECTED PATIENTS (does not apply to Aranesp nor the Eprex 40,000 IU/mL strength)

☐ anemia in AZT-treated/HIV infected patients

☐ other, please specify: _____

Additional information relating to request:

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to:
		• **Alberta Blue Cross, Clinical Drug Services & Evaluation 10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **(780) 498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information provided on this application is collected pursuant to section 41 of the Alberta Health Care Insurance Act and sections 20(a) and (b) of the Health Information Act, pursuant to section 27. If you have any questions regarding the collection of this information, please contact Alberta Blue Cross Clinical Drug Services and Evaluation at (780) 498-8480.

ALBERTA BLUE CROSS®

Aranesp/Eprex
SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Criteria for Coverage:

ARANESP

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (<100 g/L). Hemoglobin levels should be maintained within 100 – 110 g/L. According to current practice guidelines patients' iron status should be monitored regularly, and wherever possible patients should be iron replete as demonstrated by serum ferritin >100 mcg/L and transferrin saturation >20%."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Aranesp should be reduced by about 25%."

In order to comply with the second criterion: if the patient has iron overload the physician must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with results of liver function tests if applicable.

For the first and second criteria, renewal requests may be considered if the patient's hemoglobin is <110 g/L while on Aranesp.

EPREX (ALL strengths except 40,000 IU/mL strength)

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (< 100 g/L). Hemoglobin levels should be maintained within 100 - 110 g/L. According to current practice guidelines patients' iron status should be monitored regularly, and wherever possible patients should be iron replete as demonstrated by serum ferritin >100 mcg/L and transferrin saturation >20%."

"For the treatment of anemia in AZT-treated/HIV infected patients."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Eprex should be reduced by about 25%."

In order to comply with the third criterion: if the patient has iron overload the physician must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the first and third criteria, renewal requests may be considered if the patient's hemoglobin is <110 g/L while on Eprex.

EPREX 40,000 IU/mL strength

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Eprex should be reduced by about 25%. Patients may be granted a maximum allowable dose of 40,000 IU per week."

In order to comply with this criterion, if the patient has iron overload the physician must state this in the request, or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests, if applicable. Renewal requests may be considered if the patient's hemoglobin is <110 g/L while on Eprex.

Remicade for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form

On the reverse is the official *Remicade for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* (ABC 30901).

- All requests for Remicade (infliximab) for Crohn's/Fistulizing Crohn's Disease must be submitted using the *Remicade for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request

ALBERTA BLUE CROSS®

REMICADE for Crohn's / Fistulizing Crohn's Disease
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:	**PATIENT CONSENT:**
You may be eligible to receive Remicade drug benefits. Personal and health Information is required in order to determine eligibility and, in the event you are approved to receive drug benefits, to maintain eligibility, process payments and conduct the *Alberta Post-Marketing Study Addressing REMICADE ("Study")*. The *Study* will assist Alberta Health and Wellness to monitor, plan, evaluate and manage the cost-effectiveness of providing Remicade as a benefit under the AHWDBL. Therefore, your consent is required as set out herein. **Important:** In order to be eligible for, and to maintain eligibility for, REMICADE drug benefits both you and your physician(s) must agree to and continue to actively and consistently participate in the *Study* as required by Alberta Blue Cross, Alberta Health and Wellness, its affiliates and agents throughout the special authorization period. **Refusal to provide the requested consent will result in benefits being denied, and withdrawal of consent will result in benefits being revoked.**	**I hereby authorize:** (A)The below physician(s) to disclose to Alberta Blue Cross, Alberta Health and Wellness, Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports (the "Designated Recipients") any of my personal or health information contained on this Request Form or requested by the Designated Recipients (collectively "My Information"); and (B) The Designated Recipients to use and collect My Information for the purposes stated on this form; and (C) The Designated Recipients to disclose My Information to any affiliates or agents of the Designated Recipients for the purposes stated on this form. **I acknowledge that:** I have been made aware of the reasons why my health information is needed, and the risks and benefits of consenting or refusing to consent to disclosure of my health information; and (2) I am aware that I may revoke this consent (in writing) at anytime. Signature/Effective Date Patient's Signature

PHYSICIAN INFORMATION			
GASTROENTEROLOGY SPECIALIST SURNAME FIRST NAME INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:	Patient's current weight (kg):	Dosage of Remicade requested (mg/kg):
☐ Severe Active Crohn's ☐ Fistulizing Crohn's ☐ Other (specify)		

Please provide the following information for ALL requests:

Previous medications utilized: Dose, duration and response is required for ONE of the following medications:

Azathioprine:

6-mercaptopurine:

Methotrexate:

For Fistulizing Crohn's Disease:	**For Severe Active Crohn's Disease:**	
Previous medications utilized: dose, duration & response to antibiotics: Antibiotic (specify drug name) :	**For all requests:** CDAI Score: _____ Date: _____	**For request for repeat treatment:** CDAI Score after most recent treatment:_____ Date: _____
	Previous medications utilized (For ALL requests): dose, duration & response is required for BOTH of the following : Glucocorticoid(s) (specify drug name) : 5-ASA :	
Identify if surgery has been ☐ tried ☐ contemplated ☐ not indicated (specify why not)		

Additional information relating to request (e.g. reasons why any of the above therapies were not tried):

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

☐ **I am currently an active participant in the Alberta Post-Marketing Study addressing Remicade**

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information collected, used and disclosed by this Request Form is collected, use and disclosed pursuant to section 41 of the Alberta Health Care Insurance Act, sections 17, 33, 34, 39 and 40 of the Freedom of Information and Protection of Privacy Act, and sections 20, 21, 22, 27 and 34 of the Health Information Act. If you have any questions regarding the collection of this information, please contact Alberta Blue Cross Clinical Drug Services and Evaluation at (780) 498-8480.

Enbrel/Humira/Kineret/Remicade for Rheumatoid Arthritis Special Authorization Request Form

On the reverse is the official *Enbrel/Humira/Kineret/Remicade for Rheumatoid Arthritis Special Authorization Request Form* (ABC 30902).

- All requests for Enbrel (etanercept), Humira (adalimumab), Kineret (anakinra), or Remicade (infliximab) for Rheumatoid Arthritis must be submitted using the *Enbrel/Humira/Kineret/Remicade for Rheumatoid Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ENBREL/HUMIRA/KINERET/REMICADE for Rheumatoid Arthritis

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT SURNAME	FIRST NAME	INITIAL

DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Employment, Immigration and Industry
- ☐ Alberta Children's Services
- ☐ Alberta Seniors and Community Supports
- ☐ Other

IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:

You may be eligible to receive Enbrel, Humira, Kineret or Remicade drug benefits. Personal and health information is required in order to determine eligibility and, in the event you are approved to receive drug benefits, to maintain eligibility, process payments and conduct the *Alberta Post-Marketing Study Addressing ENBREL/HUMIRA/KINERET/REMICADE ("Study")*. The *Study* will assist Alberta Health and Wellness to monitor, plan, evaluate and manage the cost-effectiveness of providing Enbrel, Humira, Kineret or Remicade as a benefit under the AHWDBL. Therefore, your consent is required as set out herein. **Important:** In order to be eligible for, and to maintain eligibility for, Enbrel, Humira, Kineret or Remicade drug benefit both you and your physician(s) must agree to and continue to actively and consistently participate in the *Study* as required by Alberta Blue Cross, Alberta Health and Wellness, its affiliates and agents throughout the special authorization period. **Refusal to provide the requested consent will result in benefits being denied, and withdrawal of consent will result in benefits being revoked.**

PATIENT CONSENT:

I hereby authorize:
(A)The below physician(s) to disclose to Alberta Blue Cross, Alberta Health and Wellness, and Alberta Employment, Immigration and Industry (the "Designated Recipients") any of my personal or health information contained on this Request Form or requested by the Designated Recipients (collectively "My Information"); and (B) The Designated Recipients to use and collect My Information for the purposes stated on this form; and (C) The Designated Recipients to disclose My Information to any affiliates or agents of the Designated Recipients for the purposes stated on this form.

I acknowledge that:
I have been made aware of the reasons why my health information is needed, and the risks and benefits of consenting or refusing to consent to disclosure of my health information; and (2) I am aware that I may revoke this consent (in writing) at anytime.

Signature/Effective Date

Patient's Signature

PHYSICIAN INFORMATION

RHEUMATOLOGY SPECIALIST SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:
☐ Rheumatoid Arthritis ☐ Other (specify)

Patient's current weight (kg):

Indicate requested drug:
☐ Enbrel ☐ Remicade
☐ Humira ☐ Kineret

Dosage:
Dosing Frequency:

Scores: * DAS28 Score ___.___ **OR** ☐ ACR20 (renewals only) Date: _____

AND HAQ Score ___.___ ___ Date: _____

* New requests for patients currently maintained on the requested biologics require pre-treatment scores. Scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places, as indicated above.

Please provide reason if a switch to a different biologic agent is requested: (If switching to Kineret, complete last section)

Will the patient be maintained on methotrexate in combination with the requested biologic?
☐ YES ☐ NO (If not, please specify reason):

Please provide the following information for all NEW requests:

Previous medications utilized: Dose, duration and response is required for ALL FOUR of the following:

- ☐ Methotrexate PO:
- ☐ Methotrexate SC or IM:
- ☐ Methotrexate with another DMARD other than leflunomide (specify agent) :
- ☐ Leflunomide:

Additional information relating to request (e.g. reasons why any of the above therapies were not tried):

Please provide the following information for all NEW Kineret requests:

Previous medications utilized: Indicate the contraindication or adverse effects related to ALL of the following:

- ☐ Enbrel:
- ☐ Remicade:
- ☐ Humira:

PHYSICIAN'S SIGNATURE	DATE

Please forward this request to:
- **Alberta Blue Cross, Clinical Drug Services & Evaluation**
  10009-108 Street NW, Edmonton, Alberta T5J 3C5
- **FAX**: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

☐ **I am currently an active participant in the Alberta Post-Marketing Study addressing Enbrel / Humira / Kineret / Remicade**

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED. PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information collected, used and disclosed by this Request Form is collected, use and disclosed pursuant to section 41 of the Alberta Health Care Insurance Act, sections 17, 33, 34, 39 and 40 of the Freedom of Information and Protection of Privacy Act, and sections 20, 21, 22, 27 and 34 of the Health Information Act. If you have any questions regarding the collection of this information, please contact Alberta Blue Cross Clinical Drug Services and Evaluation at (780) 498-8480.

Ezetrol Special Authorization Request Form

On the reverse is the official *Ezetrol Special Authorization Request Form* (ABC 30925).

- All requests for Ezetrol (ezetimibe) must be submitted using the *Ezetrol Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

EZETROL
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT SURNAME	FIRST NAME	INITIAL

DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Employment, Immigration and Industry
- ☐ Alberta Children's Services
- ☐ Alberta Seniors and Community Supports
- ☐ Other

IDENTIFICATION/CLIENT/COVERAGE No:

PHYSICIAN INFORMATION

PHYSICIAN SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Criteria for Coverage of EZETROL

For the treatment of hypercholesterolemia in patients who are intolerant to statins or in whom a statin is contraindicated and who are at high cardiovascular risk*, or;
For the treatment of hypercholesterolemia when used in combination with a statin in patients failing to achieve target LDL with a statin at maximum tolerable dose or maximum recommended dose as per respective product monograph and who are at high cardiovascular risk*

****High cardiovascular risk is as defined by possessing one of the following:***

1) ***pre-existing cardiovascular disease and/or cerebrovascular disease, or***
2) ***diabetes, or***
3) ***familial hypercholesterolemia, or***
4) ***three or more of the following risk factors:***

- ***family history of premature cardiovascular disease***
- ***smoking***
- ***hypertension***
- ***obesity***
- ***glucose intolerance***
- ***renal disease.***

Please provide the following information for all NEW requests:

A. Diagnosis: ☐ hypercholesterolemia ☐ other, please specify _____

B. Information regarding previous STATIN use:

☐ Statin(s) HAS been utilized. Please specify which statin has been utilized (including dose and duration): _____

Nature of response to STATIN: ☐ Intolerance ☐ Failure to achieve target LDL ☐ Other _____

☐ Statin(s) has NOT been utilized. Contraindication? ☐ Yes ☐ No Please elaborate: _____

C. Presence of CARDIOVASCULAR risk factors (CHECK ALL THAT APPLY):

*In order to comply with the above criteria check **at least three** of the following:*

☐ family history of premature cardiovascular disease ☐ smoking ☐ hypertension ☐ obesity ☐ glucose intolerance ☐ renal disease

AND/OR

*In order to comply with the above criteria check **at least one** of the following:*

☐ pre-existing cardiovascular disease and/or cerebrovascular disease ☐ diabetes ☐ familial hypercholesterolemia

D. Additional information relating to request:

Please provide the following information for all RENEWAL requests:

Response to EZETROL therapy:

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: • **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Pegetron/Pegasys RBV Special Authorization Request Form

On the reverse is the official *Pegetron/Pegasys RBV Special Authorization Request Form* (ABC 30932).

- All requests for Pegetron (peginterferon alfa-2b/ribavirin) and Pegasys RBV (peginterferon alfa-2a/ribavirin) must be submitted using the *Pegetron/Pegasys RBV Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

PEGETRON/PEGASYS RBV
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION			**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER		
STREET ADDRESS	CITY / PROV / POSTAL CODE		IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:

You may be eligible to receive Pegetron or Pegasys RBV drug benefits. Information from your physician is required to determine eligibility. Your consent is required: (A) for your physician to release necessary and relevant information to Alberta Blue Cross, Alberta Health and Wellness and, if requested, to Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports; and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health and Wellness.

PATIENT CONSENT:

I hereby authorize: (A) my physician to release to Alberta Blue Cross, Alberta Health and Wellness, and (if they request it) to Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health and Wellness the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information.

Date Patient's Signature

PHYSICIAN INFORMATION

PHYSICIAN SURNAME / FIRST NAME / INITIAL	PHONE: FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED
STREET ADDRESS / CITY / PROVINCE / POSTAL CODE	

Indicate which drug is requested:

☐ **Pegetron**

☐ **Pegasys RBV**

Diagnosis of chronic hepatitis C:

Both:

	YES	NO	Not Tested
a) is the patient anti-HCV positive, pre-treatment.....	☐	☐	☐
AND;			
b) is the patient serum HCV RNA positive (by PCR), pre treatment.....	☐	☐	☐

If the patient is anti-HCV negative but serum HCV RNA positive, please explain:

Evidence of active liver disease:

Either:

	YES	NO	Not Tested
a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment ……	☐	☐	☐
OR;			
b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis)	☐	☐	☐

If patient is currently on Pegetron or Pegasys RBV indicate start date: Year / Month / Day

INITIAL REQUEST:

Initial length of approval:

☐ **Advanced fibrosis or cirrhosis** (regardless of genotype)…….... 48 weeks

☐ **Genotype 1** ……. 14 weeks

Is a baseline serum sample stored for future testing?

☐ YES ☐ NO

☐ **Genotype 2 or 3 with HIV co-infection**…… 14 weeks

Is a baseline serum sample stored for future testing?

☐ YES ☐ NO

☐ **Genotype 1, 2 or 3 post-liver transplant** … 26 weeks

Initial **and maximum** length of approval:

☐ **Genotype 2 or 3** (not co-infected with HIV) … 24 weeks

☐ **Genotype 4, 5 or 6** …….. 48 weeks

EXTENSION REQUEST:

Request for treatment extension at 14 weeks:

For Genotype 1 (non-liver transplant) patients and Genotype 2 or 3 patients with HIV co-infection:

Is the patient serum HCV RNA negative at 12 weeks?

☐ YES Patient may be eligible for additional 34 weeks of coverage (total 48 wks)

☐ NO → Has the patient achieved a reduction of viral load by at least 2 logs (100 fold)?

☐ YES The patient may be eligible for an additional 14 weeks of therapy to confirm response. Additional serum HCV RNA test results are required at 24 weeks

☐ NO

Request for treatment extension at 26 weeks:

For Genotype 1, 2 or 3 post-liver transplant patients and for patients from the above section that achieved a 2-log drop but were not serum HCV negative at 12 weeks:

Is the patient serum HCV RNA negative at 24 weeks?

☐ YES ☐ NO The patient may be eligible for a total of 48 weeks of therapy.

PREVIOUS THERAPY: Consideration may be given in patients who have previously received therapy who meet at least one of the following criteria:

☐ Advanced fibrosis or cirrhosis.

☐ Patient relapsed following non-pegylated interferon/ribavirin combination therapy.

☐ Patient failed to respond to or relapsed following interferon monotherapy

Additional information relating to request:

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: • **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

Unitron-PEG Special Authorization Request Form

On the reverse is the official *Unitron-PEG Special Authorization Request Form* (ABC 30933).

- All requests for Unitron-PEG (peginterferon alfa-2b) must be submitted using the *Unitron-PEG Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

UNITRON-PEG
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION

PATIENT SURNAME	FIRST NAME	INITIAL

DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER

STREET ADDRESS	CITY	PROV	POSTAL CODE

COVERAGE TYPE:

- ☐ Alberta Blue Cross
- ☐ Alberta Employment, Immigration and Industry
- ☐ Alberta Children's Services
- ☐ Alberta Seniors and Community Supports
- ☐ Other

IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:

You may be eligible to receive Unitron-PEG drug benefits. Information from your physician is required to determine eligibility. Your consent is required: (A) for your physician to release necessary and relevant information to Alberta Blue Cross, Alberta Health and Wellness and, if requested, to Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports; and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health and Wellness.

PATIENT CONSENT:

I hereby authorize: (A) my physician to release to Alberta Blue Cross, Alberta Health and Wellness, and (if they request it) to Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health and Wellness the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information.

Date Patient's Signature

PHYSICIAN INFORMATION

PHYSICIAN SURNAME	FIRST NAME	INITIAL	PHONE: FAX:

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

CRITERIA 1

Diagnosis of chronic hepatitis C:

	YES	NO	Not Tested
a) is the patient anti-HCV positive, pre-treatment.....	☐	☐	☐
AND;			
b) is the patient serum HCV RNA positive (by PCR), pre treatment.....	☐	☐	☐

If the patient is anti-HCV negative but serum HCV RNA positive, please explain:

CRITERIA 2

Evidence of active liver disease, either:

	YES	NO	Not Tested
a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment	☐	☐	☐
OR;			
b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis)	☐	☐	☐

If patient is currently receiving Unitron-PEG indicate start date: Year / Month / Day

CRITERIA 3 : Contraindication/ intolerance to ribavirin

Please indicate why Unitron-PEG is requested: ☐ patient has contraindication to use of ribavirin ☐ patient experienced intolerance to ribavirin
☐ other (specify) _____

Additional information relating to request: _____

The personal information collected in this section is for quality monitoring purposes only. It will be used to review the current provision of Unitron-PEG This personal information will not be used to make any program decisions about the patient named above.

Genotype:
- **Type 1** ☐
- **Type 2** ☐
- **Type 3** ☐
- **Other** ☐

_____

Please confirm whether previous therapy has been tried:

- ☐ No previous treatment with interferon alfa monotherapy or ribavirin/interferon alfa (naive patient).
- ☐ Previous treatment with interferon alfa monotherapy and the patient:
  - ☐ has since relapsed ☐ did not respond
- ☐ Previous treatment with ribavirin / interferon alfa combination therapy, and the patient:
  - ☐ has since relapsed ☐ did not respond

PHYSICIAN'S SIGNATURE	DATE

Please forward this request to:
- **Alberta Blue Cross, Clinical Drug Services & Evaluation**
  10009-108 Street NW, Edmonton, Alberta T5J 3C5
- FAX: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information collected, used and disclosed by this Request Form is collected, use and disclosed pursuant to section 41 of the Alberta Health Care Insurance Act, sections 17, 33, 34, 39 and 40 of the Freedom of Information and Protection of Privacy Act, and sections 20, 21, 22, 27 and 34 of the Health Information Act. If you have any questions regarding the collection of this information, please contact Alberta Blue Cross Clinical Drug Services and Evaluation at (780) 498-8480.

Pegasys for Chronic Hepatitis C Special Authorization Request Form

On the reverse is the official *Pegasys for Chronic Hepatitis C Special Authorization Request Form* (ABC 30944).

- All requests for Pegasys (peginterferon alfa-2a) must be submitted using the *Pegasys for Chronic Hepatitis C Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

PEGASYS for Chronic Hepatitis C
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:	PATIENT CONSENT:
You may be eligible to receive Pegasys drug benefits. Information from your physician is required to determine eligibility. Your consent is required: (A) for your physician to release necessary and relevant information to Alberta Blue Cross, Alberta Health and Wellness and, if requested, to Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports; and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health and Wellness.	I hereby authorize: (A) my physician to release to Alberta Blue Cross, Alberta Health and Wellness, and (if they request it) to Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health and Wellness the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information. Date Patient's Signature

PHYSICIAN INFORMATION				
PHYSICIAN SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	

SECTION 1 :

Diagnosis of chronic hepatitis C:	**Evidence of active liver disease, either:**
a) is the patient anti-HCV positive, pre-treatment…..... …..... **YES** ☐ **NO** ☐ **Not Tested** ☐	a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment …..... **YES** ☐ **NO** ☐ **Not Tested** ☐
AND;	**OR**;
b) is the patient serum HCV RNA positive (by PCR), pre-treatment…..... ☐ ☐ ☐	b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis) …..... ☐ ☐ ☐
If the patient is anti-HCV negative but serum HCV RNA positive, please explain:	If patient is currently on Pegasys, indicate start date: Year / Month / Day

SECTION 2 : HCV Genotype *

Is a baseline serum sample stored for future testing? ☐ YES ☐ NO

Indicate which genotype the patient is infected with (check ONE box):

☐ Genotype 1 ☐ Genotype 2 or 3 ☐ Genotype 4, 5 or 6

*** Please note: Initial approval is for 14 weeks of coverage**

Requests for treatment extension beyond initial 14 weeks:

Patients authorized for 14 weeks therapy may be eligible for an additional 34 weeks of coverage (total 48 weeks)	**YES**	**NO**
Is the patient serum HCV RNA negative at 12 weeks	☐	☐
If serum HCV RNA positive, has the patient responded to therapy, as measured by a reduction of viral load by at least 2 logs (100 fold)	☐	☐

Additional information relating to request:

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: • **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Enbrel for Juvenile Rheumatoid Arthritis Special Authorization Request Form

On the reverse is the official *Enbrel for Juvenile Rheumatoid Arthritis Special Authorization Request Form* (ABC 30948).

- All requests for Enbrel (etanercept) for Juvenile Rheumatoid Arthritis must be submitted using the *Enbrel for Juvenile Rheumatoid Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ENBREL for Juvenile Rheumatoid Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:

You may be eligible to receive Enbrel drug benefits. Personal and health information is required in order to determine eligibility and, in the event you are approved to receive drug benefits, to maintain eligibility, process payments and conduct the *Alberta Post-Marketing Study Addressing ENBREL ("Study")*. The *Study* will assist Alberta Health and Wellness to monitor, plan, evaluate and manage the cost-effectiveness of providing Enbrel as a benefit under the AHWDBL.

Therefore, your consent is required as set out herein. **Important:** In order to be eligible for, and to maintain eligibility for Enbrel drug benefit both you and your physician(s) must agree to and continue to actively and consistently participate in the *Study* as required by Alberta Blue Cross, Alberta Health and Wellness, its affiliates and agents throughout the special authorization period. **Refusal to provide the requested consent will result in benefits being denied, and withdrawal of consent will result in benefits being revoked.**

PATIENT CONSENT:

I hereby authorize:
(A)The below physician(s) to disclose to Alberta Blue Cross, Alberta Health and Wellness, Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports (the "Designated Recipients") any of my personal or health information contained on this Request Form or requested by the Designated Recipients (collectively "My Information"); and (B) The Designated Recipients to use and collect My Information for the purposes stated on this form; and (C) The Designated Recipients to disclose My Information to any affiliates or agents of the Designated Recipients for the purposes stated on this form.

I acknowledge that:
I have been made aware of the reasons why my health information is needed, and the risks and benefits of consenting or refusing to consent to disclosure of my health information; and (2) I am aware that I may revoke this consent (in writing) at anytime.

_____ Signature Effective Date

_____ Patient or Guardian Signature:

_____ Print Name of Guardian

PHYSICIAN INFORMATION

RHEUMATOLOGY SPECIALIST SURNAME FIRST NAME INITIAL	PHONE: FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests: (initial, 12 week and 6 month renewals)

Diagnosis:

☐ Polyarticular Juvenile Rheumatoid Arthritis
☐ Other (specify)

Patient's current weight (kg): _____

Enbrel dosage requested (mg/kg): _____

Date of assessment for the following JRA30 criteria: _____

MD global assessment (0-10)		Patient global assessment (0-10)	
No. of joints with active RA		CHAQ (1-4)	
No. of joints with LROM + P/T		ESR (mm/hr)	

Please provide the following information for ALL new requests:

Previous disease modifying anti-rheumatic agents utilized: Dose, duration and response is required:

Additional information relating to request

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: ▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

☐ **I am currently an active participant in the Alberta Post-Marketing Study addressing Enbrel**

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

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Enbrel/Humira for Psoriatic Arthritis Special Authorization Request Form

On the reverse is the official *Enbrel/Humira for Psoriatic Arthritis Special Authorization Request Form* (ABC 30964).

- All requests for Enbrel (etanercept) or Humira (adalimumab) for Psoriatic Arthritis must be submitted using the *Enbrel/Humira for Psoriatic Arthritis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ENBREL/HUMIRA for Psoriatic Arthritis
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:	**PATIENT CONSENT:**
You may be eligible to receive Enbrel or Humira drug benefits. Personal and health information is required in order to determine eligibility and, in the event you are approved to receive drug benefits, to maintain eligibility, process payments and conduct the *Alberta Post-Marketing Study Addressing ENBREL/ HUMIRA /KINERET/ REMICADE ("Study")*. The *Study* will assist Alberta Health and Wellness to monitor, plan, evaluate and manage the cost-effectiveness of providing Enbrel or Humira as a benefit under the AHWDBL. Therefore, your consent is required as set out herein. **Important:** In order to be eligible for, and to maintain eligibility for, Enbrel or Humira drug benefit both you and your physician(s) must agree to and continue to actively and consistently participate in the *Study* as required by Alberta Blue Cross, Alberta Health and Wellness, its affiliates and agents throughout the special authorization period. **Refusal to provide the requested consent will result in benefits being denied, and withdrawal of consent will result in benefits being revoked.**	**I hereby authorize:** (A)The below physician(s) to disclose to Alberta Blue Cross, Alberta Health and Wellness, Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports (the "Designated Recipients") any of my personal or health information contained on this Request Form or requested by the Designated Recipients (collectively "My Information"); and (B) The Designated Recipients to use and collect My Information for the purposes stated on this form; and (C) The Designated Recipients to disclose My Information to any affiliates or agents of the Designated Recipients for the purposes stated on this form. **I acknowledge that:** I have been made aware of the reasons why my health information is needed, and the risks and benefits of consenting or refusing to consent to disclosure of my health information; and (2) I am aware that I may revoke this consent (in writing) at anytime. Signature/Effective Date Patient's Signature

PHYSICIAN INFORMATION			
RHEUMATOLOGY SPECIALIST SURNAME FIRST NAME INITIAL	PHONE:	FAX:	
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Diagnosis:

☐ Polyarticular Psoriatic Arthritis

☐ Pauciarticular Psoriatic Arthritis→Joints affected: ☐ Knee joint(s) ☐ Hip joint(s) ☐ Other (specify)

☐ Other (specify)

Indicate requested drug:
☐ Enbrel
☐ Humira

Dosage:

Dosing Frequency:

Scores: * DAS28 Score ___.___ **OR** ☐ ACR20 (renewals only) Date: _____

AND

HAQ Score ___.___ ___ Date: _____

* New requests for patients currently maintained on the requested biologic require pre-treatment scores. Scores must be provided to the correct number of decimal places. DAS28 should be reported to one decimal place and HAQ should be reported to two decimal places, as indicated above.

Please provide reason if a switch to a different biologic agent is requested:

Will the patient be maintained on methotrexate in combination with the requested biologic?

☐ YES ☐ NO (If not, please specify reason):

Please provide the following information for all NEW requests:

Previous medications utilized: Dose, duration and response is required for ALL THREE of the following:

☐ Methotrexate PO:

☐ Methotrexate SC or IM:

☐ DMARD other than MTX (specify agent):

Additional information relating to request (e.g. reasons why any of the above therapies were not tried):

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to:
		▪ **Alberta Blue Cross, Clinical Drug Services & Evaluation 10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

☐ **I am currently an active participant in the Alberta Post-Marketing Study addressing Enbrel / Humira / Kineret / Remicade**

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information collected, used and disclosed by this Request Form is collected, use and disclosed pursuant to section 41 of the Alberta Health Care Insurance Act, sections 17, 33, 34, 39 and 40 of the Freedom of Information and Protection of Privacy Act, and sections 20, 21, 22, 27 and 34 of the Health Information Act. If you have any questions regarding the collection of this information, please contact Alberta Blue Cross Clinical Drug Services and Evaluation at (780) 498-8480.

Select Quinolones Special Authorization Request Form

On the reverse is the official *Select Quinolones Special Authorization Request Form* (ABC 30966).

- All requests for ciprofloxacin, gatifloxacin, levofloxacin, moxifloxacin and ofloxacin must be submitted using the *Select Quinolones Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

SELECT QUINOLONES*

*ciprofloxacin/levofloxacin/moxifloxacin/ofloxacin

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed. Incomplete requests CANNOT BE EXPEDITED.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION:			
PRESCRIBER SURNAME / FIRST NAME / INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO. OR PROFESSIONAL REGISTRATION NO.		**YOUR FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED**	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Only the following conditions may be authorized for coverage.
Drug Requested and Condition requiring quinolone treatment: Please check the boxes that apply to your patient.

☐ CIPROFLOXACIN

Respiratory Tract Infection:
- ☐ End stage COPD with or without bronchiectasis, where there has been documentation of previous *Pseudomonas aeruginosa* colonization/infection
- ☐ Pneumonic illness in cystic fibrosis

Genitourinary Tract Infection:
- ☐ Urinary Tract Infection
- ☐ Prostatitis
- ☐ Prophylaxis of urinary tract surgical procedures
- ☐ Gonococcal infection

Skin & Soft Tissue / Bone & Joint Infection:
- ☐ Malignant / invasive otitis externa
- ☐ Bone / joint infection due to gram-negative organism(s)
- ☐ Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole, e.g. diabetic foot infection, decubitus ulcers

Gastrointestinal Tract Infection:
- ☐ Bacterial gastroenteritis where antimicrobial therapy is indicated
- ☐ Typhoid fever (enteric fever)
- ☐ Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole, e.g. intra-abdominal infections

Other:
- ☐ Prophylaxis of adult contacts of cases of invasive meningococcal disease
- ☐ Therapy / step-down therapy of hospital acquired gram-negative infections
- ☐ Empiric therapy of febrile neutropenia in combination with other appropriate agents
- ☐ Exception case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references, i.e. AMA CPGs or Bugs & Drugs

⬇

Please specify details: _____

- ☐ For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases

☐ LEVOFLOXACIN* ☐ MOXIFLOXACIN

- ☐ Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy
- ☐ Community acquired pneumonia in patients with co morbidities (asthma, lung cancer, COPD, diabetes, alcoholism, chronic renal or liver failure, CHF, chronic corticosteroid use, malnutrition or acute weight loss, hospitalization within previous 3 months, HIV/AIDS, smoking)
- ☐ Acute exacerbation of chronic bronchitis after failure of first and second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy
- ☐ Acute sinusitis after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy, in patients with β–lactam (penicillin & cephalosporin) allergy
- ☐ For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases

***only Levofloxacin 250 mg and 500 mg may be considered for coverage.**

☐ OFLOXACIN

- ☐ Pelvic inflammatory disease
- ☐ Epididymo-orchitis/epididymitis most likely due to enteric organisms
- ☐ For the treatment of Chlamydial infection
- ☐ For the treatment of Gonococcal infection
- ☐ For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5**	**FAX**: **498-8384** in Edmonton **1-877-828-4106** toll-free all other areas

ONCE YOU HAVE CONFIRMED YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form

On the reverse is the official *Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form* (ABC 31086).

- All requests for alendronate, raloxifene, risedronate, and synthetic calcitonin salmon must be submitted using the *Alendronate/Raloxifene/Risedronate/Synthetic Calcitonin Salmon for Osteoporosis Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

ALENDRONATE / RALOXIFENE / RISEDRONATE / SYNTHETIC CALCITONIN SALMON FOR OSTEOPOROSIS

SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PHYSICIAN INFORMATION			
PHYSICIAN SURNAME / FIRST NAME / INITIAL		PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.		FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

Please provide the following information for ALL requests:

Indicate which drug is requested (check ONE box)*:

- ☐ Alendronate (10mg, 70mg oral tablets)
- ☐ Raloxifene
- ☐ Risedronate
- ☐ Synthetic Calcitonin Salmon

*Coverage **cannot** be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when intended **for use as combination therapy**.

Diagnosis:

- ☐ For the treatment of Osteoporosis
- ☐ Osteopenia
- ☐ Bone pain secondary to: _____
- ☐ Other, please specify: _____

Please provide the following information for all NEW requests:

Has the patient experienced FRACTURES related to the diagnosis? ☐ NO ☐ YES

Information regarding previous etidronate (Didronel or Didrocal) use:

☐ Etidronate HAS been utilized.

Nature of response to etidronate:
- ☐ Lack of response (i.e. demonstrated as a > 2% loss in bone mineral density in one year)
- ☐ Intolerance
- ☐ Other (please specify):_____

☐ Etidronate has NOT been utilized:
- ☐ Contraindication. Please elaborate:_____
- ☐ Other reason(s) etidronate was NOT tried (please specify):_____

Additional information relating to request:

Please provide the following information for all RENEWAL requests:

Response to requested therapy:

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: • **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

ALBERTA BLUE CROSS®

ALENDRONATE / RALOXIFENE / RISEDRONATE / SYNTHETIC CALCITONIN SALMON FOR OSTEOPOROSIS

SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Criteria for Coverage:

ALENDRONATE (10mg, 70mg oral tablets)**
RALOXIFENE
RISEDRONATE Special Authorization Criteria for OSTEOPOROSIS**

"For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures. Special authorization for may be granted for 24 months."

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a > 2 % loss in bone mineral density in one year). Special authorization for this criteria may be granted for 24 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

**Please note: alendronate and risedronate also have Special Authorization criteria for Paget's disease. Please refer to the Alberta Health and Wellness Drug Benefit List for alendronate and risedronate's other criteria for the indication of Paget's disease.

www.health.gov.ab.ca/ahcip/ahcip_list.html

SYNTHETIC CALCITONIN SALMON Nasal Spray Special Authorization Criteria:

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a >2% loss in bone mineral density in one year). Special authorization may be granted for 24 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

ABC 31086 (07/2006)

Pegasys for Chronic Hepatitis B Special Authorization Request Form

On the reverse is the official *Pegasys for Chronic Hepatitis B Special Authorization Request Form* (ABC 31095).

- All requests for Pegasys (peginterferon alfa-2a) must be submitted using the *Pegasys for Chronic Hepatitis B Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

PEGASYS for Chronic Hepatitis B
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION			**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL	☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER		

STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:	PATIENT CONSENT:
You may be eligible to receive Pegasys drug benefits. Information from your physician is required to determine eligibility. Your consent is required: (A) for your physician to release necessary and relevant information to Alberta Blue Cross, Alberta Health and Wellness and, if requested, to Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports and (B) for Alberta Blue Cross to release that and related usage information to Alberta Health and Wellness.	I hereby authorize: (A) my physician to release to Alberta Blue Cross, Alberta Health and Wellness, and (if they request it) to Alberta Employment, Immigration and Industry, Alberta Children's Services, and Alberta Seniors and Community Supports (the aforesaid being the "designated recipients"); and (B) Alberta Blue Cross to release to Alberta Health and Wellness the information on this form and information relating to my usage of and experience with the drug and treatment results, and I consent to the designated recipients collecting such information. Date Patient's Signature

PHYSICIAN INFORMATION

PHYSICIAN SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.	FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

STREET ADDRESS	CITY	PROVINCE	POSTAL CODE

SECTION 1 :

Please provide the indication/diagnosis:		If patient is currently on Pegasys, indicate start date:
☐ For the treatment of chronic hepatitis B: Does the patient have decompensated liver disease? ☐ Yes ☐ No	☐ Other (please specify):	Year / Month / Day

SECTION 2 :

a) Hepatits B surface antigen (HBsAg):

	YES	NO	Not Tested
Is the patient hepatitis B surface antigen (HBsAg) positive?	☐	☐	☐
Has the patient been (HBsAg) positive > 6 months?	☐	☐	
Other (please specify): _____			

b) ALT Levels / Liver Biopsy:

	YES	NO	Not Tested
Does the patient have elevated **pre-treatment serum ALT levels?**.....	☐	☐	☐
Are the levels **≥2 times** the upper limit of normal?	☐	☐	
Other (please explain):_____			
OR;			
Does the patient have a liver biopsy showing grade 1 or worse inflammation consistent with chronic hepatitis B?.....	☐	☐	☐

SECTION 3:

a) HEPATITIS B e antigen (HBeAg):

What are the results of testing? ☐ Positive ☐ Negative ☐ Not Tested ☐ Other (Specify):

b) HBV DNA:

What are the results of testing?	**YES**	**NO**	**Not Tested**
HBV DNA >100,000 copies/mL (>20,000 IU/mL)?	☐	☐	☐
HBV DNA >500,000 copies/mL (>100,000 IU/mL)?	☐	☐	☐

Other (Please specify):_____

*Special Authorization may be granted for a total of 48 weeks.

*Requests for retreatment will not be considered.

*Patients who have decompensated liver disease will not be considered for coverage

*Coverage will not be considered when Pegasys and lamivudine are intended for use in combination

Additional information relating to request:

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: • **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** • FAX: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

Celebrex Special Authorization Request Form

On the reverse is the official *Celebrex Special Authorization Request Form* (ABC 31140).

- All requests for Celebrex (celecoxib) must be submitted using the *Celebrex Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

CELEBREX
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PHYSICIAN INFORMATION				
PHYSICIAN SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	

Criteria for Coverage of Celebrex

For patients who are at high risk of upper gastrointestinal (GI) complications due to a proven history of prior complicated GI events (e.g. GI perforation, obstruction or major bleeding), OR

For patients who have a documented history of ulcers proven radiographically and/or endoscopically.

Please provide the following information for ALL requests (check ALL that apply):

1) a) Is this patient at high risk of upper GI complications?	☐ Yes; (If Yes, proceed to 1b)	☐ No
b) Does this patient have a proven history of prior complicated GI events (e.g. GI perforation, obstruction, or major bleeding)?	☐ Yes	☐ No
2) a) Does this patient have a documented history of ulcers?	☐ Yes; (If Yes, proceed to 2b)	☐ No
b) Have the ulcers been proven radiographically and/or endoscopically?	☐ Yes	☐ No

Additional information relating to request:

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to:
		• **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** **FOR CELEBREX REQUESTS ONLY:** • FAX: **401-1150** in Edmonton • **1-888-401-1150** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

THIS SECTION IS FOR ALBERTA BLUE CROSS USE ONLY

Neulasta/Neupogen Special Authorization Request Form

On the reverse is the official *Neulasta/Neupogen Special Authorization Request Form* (ABC 31150**)**

- All requests for *Neulasta* (pegfilgrastim) and *Neupogen* (filgrastim) must be submitted using the *Neulasta/Neupogen Special Authorization Request Form* only.
- **Photocopy this form and use as required.**
- Submit completed forms by FAX to Alberta Blue Cross:
  (780) 498-8384 in Edmonton and area
  1-877-828-4106 toll-free for all other areas

Once your request has successfully transmitted, please do not mail or re-fax your request.

ALBERTA BLUE CROSS®

NEULASTA/NEUPOGEN
SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta Government sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE:**
PATIENT SURNAME	FIRST NAME	INITIAL		☐ Alberta Blue Cross ☐ Alberta Employment, Immigration and Industry ☐ Alberta Children's Services ☐ Alberta Seniors and Community Supports ☐ Other
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PHYSICIAN INFORMATION				
PHYSICIAN SURNAME	FIRST NAME	INITIAL	PHONE:	FAX:
COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	
STREET ADDRESS	CITY	PROVINCE	POSTAL CODE	

Indicate which drug is requested (check ONE box):

☐ **NEULASTA** **(complete Section I only)**

☐ **NEUPOGEN** **(complete Section I or II)**

Criteria for Coverage of Neulasta	**Criteria for Coverage of Neupogen**
To decrease the incidence of infection, as manifested by febrile neutropenia, in patients 18 years of age and older with non-myeloid malignancies receiving myelosuppressive anti-neoplastic drugs with curative intent. This drug product must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates). *Please note:* ***Coverage cannot be considered for palliative patients.***	To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-neoplastic drugs with curative intent. This drug must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates). For the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization, following induction and consolidation treatment for acute myeloid leukemia. This drug must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates). To increase neutrophil counts and to reduce the incidence and duration of infection in patients with a diagnosis of congenital, cyclic or idiopathic neutropenia. This drug must be prescribed by the Directors of Divisions of Hematology in tertiary care centres (or their designates). For the treatment of patients undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy when prescribed by a designated prescriber. *Please note for the first criterion:* ***Coverage cannot be considered for palliative patients.***

Section I (all Neulasta requests and Neupogen requests for the first criterion, check ALL that apply)

Please **SPECIFY** the type of cancer being treated with chemotherapy for curative intent: _____

AND

Please provide the indication for which the drug is requested:

☐ patient has febrile neutropenia

☐ patient had febrile neutropenia from a previous cycle of the same chemotherapy

☐ patient will be undergoing a *high dose* or *aggressive* chemotherapy where febrile neutropenia is very likely to occur

☐ other, please **SPECIFY**: _____

Section II (Neupogen requests for other criteria, check ALL that apply)

Please provide the indication for which Neupogen is requested:

☐ patient has neutropenia AND a diagnosis of ☐ congenital, cyclic or idiopathic neutropenia OR ☐ acute myeloid leukemia

☐ other, please **SPECIFY**: _____

☐ patient is undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy

Additional information relating to request:

PHYSICIAN'S SIGNATURE	DATE	Please forward this request to: **Alberta Blue Cross, Clinical Drug Services & Evaluation** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** FAX: **498-8384** in Edmonton • **1-877-828-4106** toll-free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

SECTION 2

Multiple Sclerosis (MS) Drug Coverage

MULTIPLE SCLEROSIS (MS) DRUG COVERAGE

Selected drug products used in the treatment of relapsing multiple sclerosis (MS) may be considered for coverage for patients covered under Alberta government-sponsored drug programs. For further information regarding eligibility for Alberta government-sponsored drug programs, refer to the Introduction section of the *List*.

In order to be eligible for *Multiple Sclerosis (MS) Drug Coverage*, an individual must:

- have valid Alberta government-sponsored drug coverage;
- meet specific clinical criteria according to *Multiple Sclerosis (MS) Drug Coverage* program requirements;
- have an *Multiple Sclerosis (MS) Drug Coverage Application* form submitted on their behalf to Alberta Blue Cross by any "MS Neurologist" identified by the Alberta Multiple Sclerosis (MS) Drug Review Panel, and
- have their Application approved by the Review Panel.

Clinical Criteria for Coverage

Patients must be assessed for coverage by an "MS Neurologist" and meet the following clinical criteria:

- have a diagnosis of clinically definite relapsing-remitting multiple sclerosis:
    - have had at least two attacks/exacerbations of MS during the previous two years. (An attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 48 hours in the absence of fever, not associated with withdrawal from steroids. Attacks must be separated by a period of at least one month.)
    - are ambulatory with or without aid (i.e. a cane or walker).

OR

- have a diagnosis of secondary progressive multiple sclerosis with relapses:
    - have had at least two attacks/exacerbations of MS during the previous two years. (An attack is defined as the appearance of new symptoms or worsening of old symptoms, lasting at least 72 hours in the absence of fever, not associated with withdrawal from steroids, and preceded by stability for at least one month. Attacks must be separated by a period of at least one month.)
    - have an EDSS score of less than or equal to 5.5.

Contraindications to Coverage

In addition to meeting the above clinical criteria, the patient must have none of the following contraindications:

- Significant illness likely to alter compliance or substantially reduce life expectancy.
- Active, severe depression: as part of the process for *Multiple Sclerosis (MS) Drug Coverage* each patient is required to undergo testing for depression, using the CES-D depression rating scale. If the patient obtains a score above 15 on the CES-D, a depression waiver is required from a psychologist or psychiatrist. The depression waiver must accompany the *Multiple Sclerosis (MS) Drug Coverage Application* form.
- Planned or current pregnancy, nursing women.

Alberta Multiple Sclerosis (MS) Drug Review Panel

The Alberta Multiple Sclerosis (MS) Drug Review Panel is an external review panel composed of neurologists and other health professionals with expertise in MS, appointed by the Minister of Health and Wellness.

The Review Panel's functions include:

- making recommendations to Alberta Health and Wellness on *Multiple Sclerosis (MS) Drug Coverage* program requirements, including maintenance of the eligibility criteria;
- identifying "MS Neurologists" for the purposes of this program, and;
- reviewing applications for *Multiple Sclerosis (MS) Drug Coverage*.

Process for Multiple Sclerosis (MS) Drug Coverage

Participating "MS Neurologists" must complete a separate *Multiple Sclerosis (MS) Drug Coverage Application* form for each patient. The completed application may be forwarded to Alberta Blue Cross by mail or by facsimile.

Alberta Blue Cross, in providing administrative support to the Review Panel, receives and screens each application for completeness, then forwards it to the Review Panel for assessment. Alberta Blue Cross responds to applicants on the Review Panel's behalf. After an application is assessed by the Review Panel, Alberta Blue Cross notifies the "MS Neurologist" and the patient by letter of the Review Panel's decision.

If the patient is approved for *Multiple Sclerosis (MS) Drug Coverage* an MS Nurse (a nurse with extensive knowledge of MS and MS therapies) will ensure that the patient receives education regarding: (i) potential benefits and limitations of therapy, (ii) side-effects, (iii) how drug administration will be taught, (iv) how the patient will be followed, (v) how the patient can access help or information, (vi) how the treatment will be reimbursed, (vii) indications that treatment may be discontinued, and (viii) what should be reported and to whom. The MS Nurse will ensure that every patient is receiving the necessary ongoing follow-up to ensure safe and appropriate ongoing use of therapies. This will include providing educational materials to each patient's primary care physician and ensuring that the physician knows how to access further information if necessary.

A new *Multiple Sclerosis (MS) Drug Coverage Application* form must be completed by an "MS Neurologist" to review coverage if the patient requires a different Multiple Sclerosis (MS) Drug and for renewal requests.

To be eligible for *Multiple Sclerosis (MS) Drug Coverage*, prescriptions must be written by an "MS Neurologist" identified by the Review Panel. Regular monitoring of patients during the first year of therapy is needed in order to ensure the appropriate treatment option and dose, and to minimize the potential for wastage. Therefore, prescription quantities are limited to a one-month supply for the first year of therapy. This also applies to drug changes and to patients new or transferring to this program. Once the patient has been stabilized on a drug and dosage for one year and received program renewal authorization, up to 100 days' supply may be dispensed at a time.

Government will not be responsible for reimbursement of costs associated with wastage or improper storage of the drug.

Prior approval must be granted to ensure coverage. Approval is granted for a specific period, to a maximum of 12 months unless otherwise indicated. If continued treatment is necessary, it is the responsibility of the patient and "MS Neurologist" to re-apply for drug coverage prior to the expiry date of the authorization period.

Drug Products Under *Multiple Sclerosis (MS) Drug Coverage* Program

The following drug products may be considered for coverage under the *Multiple Sclerosis (MS) Drug Coverage* program for patients who have a diagnosis of **relapsing-remitting multiple sclerosis**, and who participate in Alberta government-sponsored drug programs.

GLATIRAMER ACETATE

20 MG/SYR	**INJECTION**			
00002245619	COPAXONE	TMP	$	46.4400

INTERFERON BETA-1A

8.8 MCG/SYR * 22 MCG/SYR	**INJECTION SYRINGE**			
00002281708	REBIF (INITIATION PACK)	SRO	$	115.0000
22 MCG/SYR	**INJECTION SYRINGE**			
00002237319	REBIF(0.5 ML SYRINGE)	SRO	$	115.0000
44 MCG/SYR	**INJECTION SYRINGE**			
00002237320	REBIF (0.5 ML SYRINGE)	SRO	$	140.0000
6 MILLION IU/VIAL	**INJECTION**			
00002237770	AVONEX (30 MCG)	BIO	$	380.7005
6 MILLION IU/SYR	**INJECTION SYRINGE**			
00002269201	AVONEX PS (30 MCG/ 0.5 ML SYR)	BIO	$	380.7005

The following drug product may be considered for coverage under the *Multiple Sclerosis (MS) Drug Coverage* program for patients who have a diagnosis of **relapsing-remitting multiple sclerosis** OR **secondary progressive multiple sclerosis with relapses**, and who participate in Alberta government-sponsored drug programs.

INTERFERON BETA-1B

9.6 MILLION IU/VIAL	**INJECTION**			
00002169649	BETASERON (0.3 MG)	BEX	$	109.6621

Completed *Multiple Sclerosis (MS) Drug Coverage Application* forms should be directed by mail or FAX to:

Clinical Drug Services and Evaluation
Alberta Blue Cross
10009 108 Street NW
Edmonton, Alberta T5J 3C5

(780) 498-8384 in Edmonton and area
1-877-828-4106 toll-free for all other areas

SECTION 3

Criteria for Special Authorization of Select Drug Products

CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

The drug products listed in this section may be considered for coverage by special authorization for patients covered under Alberta Health and Wellness-sponsored drug programs. (For Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Support (AISH) clients, the special authorization criteria for coverage can be found in the Criteria for Special Authorization of Select Drug Products section of the *Alberta Employment, Immigration and Industry Drug Benefit Supplement.)*

Criteria for Coverage

Wording that appears within quotation marks (" ") in this section is the official special authorization criteria, as recommended by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics, and approved by the Minister of Health and Wellness. Wording that is not enclosed in quotation marks outlines specific information required to interpret criteria, guidelines for submitting requests and/or information regarding conditions under which coverage cannot be provided.

Products Available Through Health Canada's Special Access Program

PEMOLINE

"For the treatment of attention deficit hyperactivity disorder where approval has been provided by Health Canada's Special Access Program."

37.5 MG	**ORAL TABLET**	
DIN N/A*	CYLERT	ABB
75 MG	**ORAL TABLET**	
DIN N/A*	CYLERT	ABB

**As Cylert has been withdrawn from market, the DINs are no longer valid. Where authorizations for Cylert have been granted, coverage for this product will be provided under PIN 00000999917.*

Other Products

The remaining drug products in this section are listed alphabetically according to the generic ingredient name of the drug. These products can be found on the following pages.

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Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in the signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory to:

- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial) [e.g. methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily)

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as one or more of the following: lack of effect at doses and for duration of treatments specified above, serious adverse effects (e.g. leukopenia, hepatitis) or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.

- Coverage will not be approved when another anti-TNF agent or an interleukin-2 agent is intended for use in combination.
- Patients will be permitted to switch from one biologic to another (with the exception of anakinra) following an adequate trial of the first biologic, if unresponsive to therapy or due to serious adverse effects or contraindications.
- Patients will not be permitted to switch from anakinra to other biologics except under exceptional circumstances.
- Initial coverage may be approved for five doses as follows: An initial 40 mg dose, followed by additional 40 mg doses at 2, 4, 6 and 8 weeks after the first dose.
- Patients will be limited to receiving a one-month supply of Humira per prescription at their pharmacy.

For continued coverage of this biologic agent beyond five doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial five doses of this biologic agent to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in the HAQ score [reported to two (2) decimal places].
- It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one 40 mg dose every other week, for a maximum of 6 months. After 6 months, in order to be considered for continued coverage of 40 mg every other week, the patient must be re-assessed every 6 months by an RA

ADALIMUMAB

Specialist and must meet the following criteria:
1) The patient has been assessed by an RA Specialist to determine response; and
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- confirmation of maintenance of ACR20, or
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

The maximum amount of Humira approved for coverage will not exceed a total of twenty-six 40 mg doses per year".

All requests (including renewal requests) for Humira must be completed using the Enbrel/Humira/Kineret/Remicade for Rheumatoid Arthritis Special Authorization Request Form (ABC 30902).

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as one or more of the following: lack of effect at doses and for duration of treatments specified above, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.

- Coverage will not be approved when another anti-TNF agent is intended for use in combination.
- Patients will be permitted to switch from one biologic to another following an adequate trial of the first biologic, if unresponsive to therapy or due to serious adverse effects or contraindications.
- Initial coverage may be approved for 40 mg administered every other week for 8 weeks.
- Patients will be limited to receiving a one-month supply of Humira per prescription at their pharmacy.

For continued coverage of this biologic agent beyond 8 weeks, the patient must meet the

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following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 weeks after, treatment with this biologic agent to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one (1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for doses of 40 mg doses administered every other week, for a maximum of 6 months. After 6 months, in order to be considered for continued coverage, the patient must be re-assessed every 6 months by an RA Specialist and must meet the following criteria:
1) The patient has been assessed by an RA Specialist to determine response; and
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests."
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

The maximum amount of Humira approved for coverage will not exceed a total of twenty-six 40 mg doses per year".

All requests (including renewal requests) for Humira for Psoriatic Arthritis must be completed using the Enbrel/Humira for Psoriatic Arthritis Special Authorization Request Form (ABC 30964).

40 MG / SYR INJECTION SYRINGE			
00002258595	HUMIRA	ABB	$ 743.2013

ALENDRONATE SODIUM

"For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures. Special authorization may be granted for 24 months."

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a > 2% loss in bone mineral density in one year). Special authorization for this criteria may be granted for 24 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

"For the treatment of Paget's disease. Special Authorization for this criteria may be granted to a maximum of 6 months."

"Coverage cannot be provided for two or more medications used in the treatment of Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

10 MG ORAL TABLET				
00002248728	**APO-ALENDRONATE**	**APX**	$	**1.1057**
00002270129	**GEN-ALENDRONATE**	**GPM**	$	**1.1057**
00002247373	**NOVO-ALENDRONATE**	**NOP**	$	**1.1057**
00002288087	**SANDOZ ALENDRONATE**	**SDZ**	$	**1.1057**
00002201011	FOSAMAX	MFC	$	1.8800
40 MG ORAL TABLET				
00002258102	CO ALENDRONATE	COB	$	2.6097
00002201038	FOSAMAX	MFC	$	3.8403
70 MG ORAL TABLET				
00002248730	**APO-ALENDRONATE**	**APX**	$	**5.5750**
00002258110	**CO ALENDRONATE**	**COB**	$	**5.5750**
00002286335	**GEN-ALENDRONATE**	**GPM**	$	**5.5750**
00002261715	**NOVO-ALENDRONATE**	**NOP**	$	**5.5750**
00002273179	**PMS-ALENDRONATE**	**PMS**	$	**5.5750**
00002284006	**PMS-ALENDRONATE-FC**	**PMS**	$	**5.5750**
00002275279	**RATIO-ALENDRONATE**	**RPH**	$	**5.5750**
00002288109	**SANDOZ ALENDRONATE**	**SDZ**	$	**5.5750**
00002245329	FOSAMAX	MFC	$	9.4800

ALFUZOSIN HCL

"For the treatment of the symptoms of benign prostatic hyperplasia (BPH) in patients who are unresponsive to a six-week trial with a non-selective alpha-blocker (e.g., terazosin) or in whom non-selective alpha-blockers are not tolerated or are contraindicated."

"Special authorization may be granted for 24 months"

10 MG ORAL SUSTAINED-RELEASE TABLET				
00002245565	XATRAL	SAV	$	1.0468

ALMOTRIPTAN MALATE

(Refer to 28:92 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using almotriptan malate prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

6.25 MG (BASE) ORAL TABLET				
00002248128	AXERT	MCL	$	13.9217
12.5 MG (BASE) ORAL TABLET				
00002248129	AXERT	MCL	$	13.9217

AMPICILLIN

"For the treatment of infections caused by susceptible Shigella and Salmonella."

250 MG ORAL CAPSULE				
00000020877	NOVO-AMPICILLIN	NOP	$	0.3071
500 MG ORAL CAPSULE				
00000020885	NOVO-AMPICILLIN	NOP	$	0.5955

ANAKINRA

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) in whom other biologics are contraindicated or in patients who have experienced serious adverse events while on other biologics and who are refractory to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4-month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as one or more of the following: lack of effect at doses and for duration of treatments specified above, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.
- Coverage will not be approved when another anti-TNF agent or an interleukin-2 agent is intended for use in combination.
- Patients will not be permitted to switch from anakinra to other biologics except under exceptional circumstances.
- Initial coverage may be approved for 100 mg doses administered daily for 8 weeks.
- Patients will be limited to receiving a one-month supply of Kineret per prescription at their pharmacy.

For continued coverage of this biologic agent beyond 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks but no longer than 12 weeks after treatment with this biologic agent to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one(1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for 100 mg doses administered once daily for a maximum of 6 months. After 6 months, in order to be considered for continued coverage, the patient must be re-assessed every 6 months by an RA Specialist and must meet the following criteria:
1) The patient has been assessed by an RA Specialist to determine response; and
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one(1) decimal place] from baseline.

ANAKINRA

3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests."
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

All requests (including renewal requests) for Kineret must be completed using the Enbrel/Humira/Kineret/Remicade for Rheumatoid Arthritis Special Authorization Request Form (ABC 30902).

100 MG / SYR INJECTION SYRINGE

00002245913	KINERET	AMG	$	49.7989

ATOVAQUONE

"For the treatment of mild to moderate Pneumocystis carinii pneumonia in patients who are intolerant to trimethoprim-sulfamethoxazole treatment."

150 MG / ML ORAL SUSPENSION

00002217422	MEPRON	GSK	$	2.4999

AZITHROMYCIN

"For the prevention of disseminated Mycobacterium avium complex disease in patients with advanced HIV infection or other immunocompromised conditions."

600 MG ORAL TABLET

00002256088	CO AZITHROMYCIN	COB	$	7.6250
00002261642	PMS-AZITHROMYCIN	PMS	$	7.6250
00002231143	ZITHROMAX	PFI	$	12.7073

BENZOYL PEROXIDE

"For the treatment of severe acne as define by scarring acne."

10 % TOPICAL LOTION

00000370568	BENOXYL	STI	$	0.1892

20 % TOPICAL LOTION

00000187585	BENOXYL	STI	$	0.2102

10 % TOPICAL (ALCOHOL) GEL

00000263699	PANOXYL 10	STI	$	0.1478

15 % TOPICAL (ALCOHOL) GEL

00000403571	PANOXYL 15	STI	$	0.1788

20 % TOPICAL (ALCOHOL) GEL

00000373036	PANOXYL 20	STI	$	0.1926

10 % TOPICAL (WATER) GEL

00001908871	DESQUAM-X	WSD	$	0.1515

10 % TOPICAL BAR

00000527661	PANOXYL	STI	$	0.0905

BIMATOPROST

"For the reduction of intraocular pressure in patients with open angle glaucoma or ocular hypertension who are intolerant of, or insufficiently responsive to travoprost."

Special authorization for this criterion may be granted for 24 months.

0.03 % OPHTHALMIC SOLUTION

00002245860	LUMIGAN	ALL	$	11.6233

BUDESONIDE

"For the treatment of inflammatory bowel disease (e.g. Crohn's, ulcerative colitis, ulcerative ileitis, etc.). This drug product must be prescribed by a specialist in Gastroenterology, Internal Medicine or Pediatrics (or by a specialist in General Surgery on a case-by-case basis, in geographic areas where access to these specialties is not available)."

3 MG ORAL CONTROLLED-RELEASE CAPSULE

00002229293	ENTOCORT	AZC	$	1.5240

BUSERELIN ACETATE

"When prescribed for non-cancer, non-cosmetic or non-fertility indications."

Information is required regarding the patient's diagnosis/indication for use of this medication.

1 MG / ML (BASE) NASAL SOLUTION

00002225158	SUPREFACT INTRANASAL	SAV	$	7.4433

1 MG / ML (BASE) INJECTION

00002225166	SUPREFACT	SAV	$	10.6064

6.3 MG (BASE) INJECTION IMPLANT

00002228955	SUPREFACT DEPOT	SAV	$	720.2500

CABERGOLINE

"For the treatment of hyperprolactinemia in patients who are intolerant to or who have failed bromocriptine. Special authorization may be granted for 24 months."

0.5 MG ORAL TABLET

00002242471	DOSTINEX	PAL	$	12.6500

CASPOFUNGIN

"For esophageal candidiasis in patients who are intolerant to fluconazole and itraconazole, or who have failed both agents as evidenced by significant clinical deterioration due to the fungal infection during a course of therapy or no resolution after a full course of therapy."

50 MG / VIAL INJECTION

00002244265	CANCIDAS	MFC	$	440.0000

70 MG / VIAL INJECTION

00002244266	CANCIDAS	MFC	$	567.0000

CEFADROXIL

"For the treatment of skin and skin structure infections."

500 MG ORAL CAPSULE

00002240774	**APO-CEFADROXIL**	**APX**	$	**0.8421**
00000507245	**DURICEF**	**BMS**	$	**0.8421**
00002235134	**NOVO-CEFADROXIL**	**NOP**	$	**0.8421**

CELECOXIB

1) "For patients who are at high risk of upper gastrointestinal (GI) complications due to a proven history of prior complicated GI events (e.g. GI perforation, obstruction or major bleeding) or

2) For patients who have a documented history of ulcers proven radiographically and/or endoscopically."

Special authorization for both criteria may be granted for 12 months.

100 MG ORAL CAPSULE				
00002239941	CELEBREX	PFI	$	0.6988
200 MG ORAL CAPSULE				
00002239942	CELEBREX	PFI	$	1.3975

CLINDAMYCIN PHOSPHATE/ BENZOYL PEROXIDE

"For the treatment of severe acne as defined by scarring acne."

1 % (BASE) * 5 % TOPICAL GEL				
☒ 00002248472	BENZACLIN	SAV	$	0.9180
☒ 00002243158	CLINDOXYL	STI	$	0.9267

CLOPIDOGREL BISULFATE

(Refer to 92:00 of the Alberta Health and Wellness Drug Benefit List for one month of coverage, following the first intravascular stent placement, when prescribed by a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, or General Surgery.)

"For the prevention of thrombosis, for one month, when prescribed following intravascular bare metal stent placement. Patients who have received one month of coverage via the Limited Restricted Benefit will not be eligible for additional coverage under this criterion." **

"For the prevention of thrombosis, for up to 12 months, when prescribed following intravascular drug eluting stent (DES) placement. Patients who have received one month of coverage via the Limited Restricted Benefit may be eligible for an additional 11 months of coverage (i.e., up to 12 months of coverage) following the submission of a special authorization request." **

"For the prevention of cerebrovascular (e.g. stroke, TIA) and non-cerebrovascular ischemic events in patients who have a contraindication to ASA. Special authorization for this criterion may be granted for 24 months."

"For use in patients who have experienced a non-cerebrovascular ischemic event while on ASA. Special authorization for this criterion may be granted for 24 months."

"For use in patients who have experienced a cerebrovascular ischemic event (e.g. stroke, TIA) while on dipyridamole/ASA (Aggrenox) or for whom dipyridamole/ASA (Aggrenox) is contraindicated. Special authorization for this criterion may be granted for 24 months."

** Special Authorization for post-stent coverage is required when the physician prescribing the medication is not a designated prescriber, for treatment after repeat stents, or for continued coverage of up to 12 months following intravascular drug eluting stent (DES) placement.

In order to comply with the first and second criteria, information is required regarding the date, type of stent, and stenting procedure. In order to comply with the third criterion, information is required as to why ASA cannot be used. In order to comply with the fourth criterion, information is required regarding the type of ischemic event experienced while on ASA. In order to comply with the fifth criterion, information is required regarding the type of ischemic event experienced while on dipyridamole/ASA (Aggrenox) and/or why dipyridamole/ASA (Aggrenox) cannot be used. All requests for Plavix must be completed using the Aggrenox/Plavix Special Authorization Request Form (ABC 30786).

75 MG (BASE) ORAL TABLET				
00002238682	PLAVIX	BMS	$	2.4698

CYCLOSPORINE

"For the treatment of severe psoriasis in those patients where other standard therapy has failed. This drug product must be prescribed by a specialist in Dermatology."

"For the treatment of severe rheumatoid arthritis in patients who are unable to tolerate or have failed an adequate trial of methotrexate. This drug product must be prescribed by a specialist in Rheumatology (or by a Specialist in Internal Medicine with an interest in Rheumatology on a case-by-case basis, in geographic areas where access to this specialty is not available)."

"For the treatment of steroid dependent and steroid resistant nephrotic syndrome. Consideration will be given where cyclosporine is used for the induction and maintenance of remissions or for the maintenance of steroid induced remissions. This drug product must be prescribed by a specialist in Pediatrics or Nephrology."

"Special authorization for all criteria may be granted for 24 months."

10 MG ORAL CAPSULE				
00002237671	NEORAL	NOV	$	0.6706
25 MG ORAL CAPSULE				
00002247073	SANDOZ CYCLOSPORINE	SDZ	$	1.1690
00002150689	NEORAL	NOV	$	1.5588
50 MG ORAL CAPSULE				
00002247074	SANDOZ CYCLOSPORINE	SDZ	$	2.2793
00002150662	NEORAL	NOV	$	3.0390
100 MG ORAL CAPSULE				
00002242821	SANDOZ CYCLOSPORINE	SDZ	$	4.5603
00002150670	NEORAL	NOV	$	6.0802
100 MG / ML ORAL LIQUID				
00002150697	NEORAL	NOV	$	5.4047

CYPROTERONE ACETATE

"When prescribed for non-cancer, non-cosmetic indications."

Information is required regarding the patient's diagnosis/indication for use of this medication.

50 MG ORAL TABLET				
00000704431	**ANDROCUR**	**PMS**	$	**1.4085**
00002245898	**APO-CYPROTERONE**	**APX**	$	**1.4085**
00002229723	**GEN-CYPROTERONE**	**GPM**	$	**1.4085**
00002232872	**NOVO-CYPROTERONE**	**NOP**	$	**1.4085**
100 MG / ML INJECTION				
00000704423	ANDROCUR DEPOT	PMS	$	24.3033

DANAPAROID SODIUM

"For the treatment of patients with heparin-induced thrombocytopenia."

1,250 UNIT / ML INJECTION				
00002129043	ORGARAN	ORG	$	32.2417

DARBEPOETIN

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (< 100 g/L). Hemoglobin levels should be maintained within 100 - 110 g/L. According to current practice guidelines patients' iron status should be monitored regularly, and wherever possible patients should be iron replete as demonstrated by serum ferritin > 100 mcg/L and transferrin saturation > 20%."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Aranesp should be reduced by about 25%."

In order to comply with the second criterion: if the patient has iron overload the physician must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the first and second criteria, renewal requests may be considered if the patient's hemoglobin is <110 g/L while on Aranesp.

All requests for Aranesp must be completed using the Aranesp/Eprex Special Authorization Request Form (ABC 30888).

10 MCG / SYR INJECTION SYRINGE			
00002246354	ARANESP (0.4 ML SYRINGE)	AMG	$ 28.8100
20 MCG / SYR INJECTION SYRINGE			
00002246355	ARANESP (0.5 ML SYRINGE)	AMG	$ 57.6200
100 MCG / ML INJECTION SYRINGE			
00002246357	ARANESP (0.3/ 0.4/ 0.5 ML SYR)	AMG	$ 288.1000
For this product - pricing has been established on a per millilitre basis.			
200 MCG / ML INJECTION SYRINGE			
00002246358	ARANESP (0.3/ 0.4/ 0.5/ 0.65 ML SYR)	AMG	$ 576.2000
For this product - pricing has been established on a per millilitre basis.			
500 MCG / ML INJECTION SYRINGE			
00002246360	ARANESP (0.3/0.4/0.6/1.0 ML SYR)	AMG	$ 1483.5000
For this product - pricing has been established on a per millilitre basis.			

DILTIAZEM HCL

"Consideration may be given on an exception basis, to those patients who experience clinically significant difficulties with the controlled-delivery (CD) formulation of diltiazem. Special authorization may be granted for 24 months."

Information is required regarding the patient's response to the CD formulation.

60 MG ORAL SUSTAINED-RELEASE CAPSULE			
00002222957	APO-DILTIAZ SR	APX	$ 0.3635
90 MG ORAL SUSTAINED-RELEASE CAPSULE			
00002222965	APO-DILTIAZ SR	APX	$ 0.5455
120 MG ORAL SUSTAINED-RELEASE CAPSULE			
00002222973	APO-DILTIAZ SR	APX	$ 0.7270

DIPYRIDAMOLE/ ASA

"For use in patients who have experienced a cerebrovascular ischemic event (e.g. stroke, TIA)."

Information is required regarding the type of ischemic event experienced. All requests for Aggrenox must be completed using the Aggrenox/Plavix Special Authorization Request Form (ABC 30786).

200 MG * 25 MG ORAL CAPSULE

00002242119	AGGRENOX	BOE	$	0.8230

DONEPEZIL HCL

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26."

"This drug must be initiated by a designated prescriber for new patients (individuals who have never taken the requested drug before or who have taken the drug for 60 days or less) with an MMSE score between 10-13 inclusive."

"Specialists in Geriatric Medicine, Neurology, and Psychiatry are deemed designated prescribers by virtue of their specialty in medical practice. All other practitioners will be added to the list of designated prescribers if they have successfully completed MAINPRO-C credits through the College of Family Practice (Physicians) [prior to March 31, 2006], the Care of the Elderly Six-month/One-year Fellowship Program through the Department of Family Medicine or the MAINPRO-M1 course entitled, "Module 2: Advanced Alzheimer's Disease."

"Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination."

All requests (including renewal requests) for Aricept must be completed using the Aricept/Exelon/Reminyl ER Special Authorization Request Form (ABC 30776).

For each request, an updated MMSE score and the date on which the exam was administered must be provided. The MMSE score must be within 3 months of the time of the application (including renewal requests).

Renewal requests for patients where the updated MMSE score is greater than 26 while on this drug, may also be considered.

Initial special authorization for new patients may be granted for a maximum of 12 weeks. Continued special authorization coverage may be granted for a maximum of 12 months.

In order to be considered for coverage beyond the initial 12-week authorization, those patients with an MMSE score of 10 or higher may be eligible for continued coverage provided their MMSE score has not dropped by more than 3 points during the 12-week period.

5 MG ORAL TABLET

00002232043	ARICEPT	PFI	$	4.9303

10 MG ORAL TABLET

00002232044	ARICEPT	PFI	$	4.9303

DORZOLAMIDE HCL

"For the treatment of elevated intraocular pressure in patients who have a documented sensitivity to preservatives."

2 % (BASE) OPHTHALMIC SOLUTION

00002269090	TRUSOPT (PRESERVATIVE-FREE)	MFC	$	3.6458

DORZOLAMIDE HCL/ TIMOLOL MALEATE

"For the treatment of elevated intraocular pressure in patients who have a documented sensitivity to preservatives."

2 % (BASE) * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002258692	COSOPT PRESERVATIVE-FREE	MFC	$	4.5992

DUTASTERIDE

(Refer to 92:00 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 65 years of age and older.)

"For the treatment of benign prostatic hyperplasia in patients less than 65 years of age who are poor surgical risks. Special authorization may be granted for the period of time from the approval of the request until the patient turns 65 years of age (at which time the drug becomes an unrestricted benefit, no longer requiring authorization)."

Information is required regarding the medical condition(s) or circumstances by which this patient would be deemed a poor surgical risk.

0.5 MG ORAL CAPSULE

00002247813	AVODART	GSK	$	1.5793

EPOETIN ALFA

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Eprex should be reduced by about 25%. Patients may be granted a maximum allowable dose of 40,000 IU per week."

In order to comply with this criterion, if the patient has iron overload the physician must state this in the request, or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests, if applicable.

Renewal requests may be considered if the patient's hemoglobin is <110 g/L while on Eprex."

All requests for Eprex must be completed using the Aranesp/Eprex Special Authorization Request Form (ABC 30888).

40,000 UNIT / SYR INJECTION SYRINGE

00002240722	EPREX	JOI	$	431.9888

EPOETIN ALFA

"For the treatment of anemia of chronic renal failure in patients with low hemoglobin (< 100 g/L). Hemoglobin levels should be maintained within 100 - 110 g/L. According to current practice guidelines patients' iron status should be monitored regularly, and wherever possible patients should be iron replete as demonstrated by serum ferritin > 100 mcg/L and transferrin saturation > 20%."

"For the treatment of anemia in AZT-treated/HIV infected patients."

"For the treatment of chemotherapy-induced anemia in patients with non-myeloid malignancies with low hemoglobin (<100 g/L) in whom blood transfusions are not possible due to transfusion reactions, cross-matching difficulties or iron overload. If hemoglobin is rising by more than 20 g/L per month, the dose of Eprex should be reduced by about 25%."

In order to comply with the third criterion: if the patient has iron overload the physician must state this in the request or alternatively, information is required regarding the patient's transferrin saturation, along with the results of liver function tests if applicable.

For the first and third criteria, renewal requests may be considered if the patient's hemoglobin is <110 g/L while on Eprex.

All requests for Eprex must be completed using the Aranesp/Eprex Special Authorization Request Form (ABC 30888).

20,000 UNIT / ML INJECTION			
00002206072	EPREX	JOI	$ 287.9925
1,000 UNIT / SYR INJECTION SYRINGE			
00002231583	EPREX (0.5 ML SYRINGE)	JOI	$ 15.3188
2,000 UNIT / SYR INJECTION SYRINGE			
00002231584	EPREX (0.5 ML SYRINGE)	JOI	$ 30.6375
3,000 UNIT / SYR INJECTION SYRINGE			
00002231585	EPREX (0.3 ML SYRINGE)	JOI	$ 45.9563
4,000 UNIT / SYR INJECTION SYRINGE			
00002231586	EPREX (0.4 ML SYRINGE)	JOI	$ 61.2750
5,000 UNIT / SYR INJECTION SYRINGE			
00002243400	EPREX (0.5 ML SYRINGE)	JOI	$ 76.5938
6,000 UNIT / SYR INJECTION SYRINGE			
00002243401	EPREX (0.6 ML SYRINGE)	JOI	$ 91.9125
8,000 UNIT / SYR INJECTION SYRINGE			
00002243403	EPREX (0.8 ML SYRINGE)	JOI	$ 122.5500
10,000 UNIT / SYR INJECTION SYRINGE			
00002231587	EPREX (1 ML SYRINGE)	JOI	$ 153.1875

ERTAPENEM

"For therapy of complicated polymicrobial skin and skin structure infections."

"For the therapy of community-acquired intra-abdominal infections."

"For culture & susceptibility directed therapy against infections with Enterobacteriaceae producing AmpC or extended-spectrum beta-lactamases (ESBLs) where there is resistance to first line agents."

"For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."

In order to comply with all of the above criteria, information is required regarding the type of infection and organisms involved. Also, where the criteria restrict coverage of the requested drug to non-first line therapy, information is required regarding previous first-line antibiotic therapy that has been utilized, the patient's response to therapy, and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. Also, where applicable, the specialist in Infectious Diseases that recommended this drug is required.

1 G / VIAL INJECTION

00002247437	INVANZ	MFC	$	49.9500

ERYTHROMYCIN/ TRETINOIN

"For the treatment of severe acne as defined by scarring acne."

4 % * 0.01 % TOPICAL GEL

00002015994	STIEVAMYCIN MILD	STI	$	0.5590

4 % * 0.025 % TOPICAL GEL

00001905112	STIEVAMYCIN REGULAR	STI	$	0.5590

4 % * 0.05 % TOPICAL GEL

00001945262	STIEVAMYCIN FORTE	STI	$	0.6428

ETANERCEPT

Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4-month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as one or more of the following: lack of effect at doses and for duration of treatments specified above, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.

- Coverage will not be approved when another anti-TNF agent or an interleukin-2 agent is intended for use in combination.
- Patients will be permitted to switch from one biologic to another (with the exception of anakinra) following an adequate trial of the first biologic, if unresponsive to therapy or due to serious adverse effects or contraindications.
- Patients will not be permitted to switch from anakinra to another biologic except under exceptional circumstances.
- Initial coverage may be approved for doses of 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of Enbrel per prescription at their pharmacy.

For continued coverage of this biologic agent beyond 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12 weeks after treatment with this biologic agent to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one(1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for doses of 50 mg per week, for a maximum of 6 months. After 6 months, in order to be considered for continued coverage, the patient must be re-assessed every 6 months by an RA Specialist and must meet the following criteria:
1) The patient has been assessed by an RA Specialist to determine response; and

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2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one (1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests."
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

All requests (including renewal requests) for Enbrel for Rheumatoid Arthritis must be completed using the Enbrel/Humira/Kineret/Remicade for Rheumatoid Arthritis Special Authorization Request Form (ABC 30902).

Juvenile Rheumatoid Arthritis:

"Special authorization coverage may be provided for the reduction in signs and symptoms of severely active polyarticular juvenile rheumatoid arthritis (JRA) in patients 4 years of age and older who:
- Possess five or more swollen joints, AND
- Three or more joints with limitation of motion, pain or tenderness, AND
- Are refractory to one or more disease modifying anti-rheumatic agents (DMARDS) conventionally used in children (minimum three month trial).

"Refractory" is defined as one or more of the following: lack of effect, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in the product monographs.

For coverage, this drug must be prescribed by a designated prescriber affiliated with a Pediatric Rheumatology Clinic in Edmonton or Calgary who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness and its agent, throughout the special authorization approval period (Pediatric RA Specialist). The patient or patient's guardian must also provide all consents and authorizations required to permit the Pediatric RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the Pediatric RA Specialist does not continually, actively and consistently participate in the Study.
- Coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly for 12 weeks.
- Patients will be limited to receiving a one-month supply of Enbrel per prescription at their pharmacy.

For continued coverage of this agent beyond 12 weeks, the patient must meet the following criteria:
1) The patient must be assessed by a Pediatric RA Specialist after 12 weeks, but no longer than 16 weeks after, treatment with this biologic agent to determine response.
2) The Pediatric RA Specialist must confirm in writing that the patient is a responder that meets the following criteria (JRA30):
- 30% improvement from baseline in at least three of the following six response variables, with worsening of 30% or more in no more than one of the six variables. The variables include:
  i. global assessment of the severity of the disease by the Pediatric RA Specialist,
  ii. global assessment of overall well-being by the patient or parent,
  iii. number of active joints (joints with swelling not due to deformity or joints with limitation of motion with pain tenderness or both),
  iv. number of joints with limitation of motion,
  v. functional ability based on CHAQ scores,
  vi. ESR
3) Data from all of the six variables comprising the JRA30 and the CHAQ scores must be reported in each request

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Following this assessment, continued coverage may be approved for 0.8 mg/kg/dose (maximum dose 50 mg) weekly, for a maximum of six months. After six months, in order to be considered for continued coverage, the patient must be re-assessed every six months by a Pediatric RA Specialist and must meet the following criteria:
1) The patient has been assessed by a Pediatric RA Specialist to determine response, and
2) The Pediatric RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by maintenance of the JRA30,
3) Data from all of the six variables comprising the JRA30 and the CHAQ scores must be reported in each request.

Once a child with JRA has had two disease-free years, it is common clinical practice for drug treatment to be stopped."

All requests (including renewal requests) for Enbrel for Juvenile Rheumatoid Arthritis must be completed using the Enbrel for Juvenile Rheumatoid Arthritis Special Authorization Request Form (ABC 30948).

Psoriatic Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for reducing signs and symptoms and inhibiting the progression of structural damage of active arthritis in adult patients (18 years of age or older) with moderate to severe polyarticular psoriatic arthritis (PsA) or pauciarticular PsA with involvement of knee or hip joint who are refractory to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- An adequate trial of another disease modifying anti-rheumatic agent(s) (minimum 4 month trial).

Special authorization coverage of this agent may be provided for use as monotherapy in adult patients for whom methotrexate is contraindicated and/or for those patients who have experienced serious adverse effects.

'Refractory' is defined as one or more of the following: lack of effect at doses and for duration of treatments specified above, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.

- Coverage will not be approved when another anti-TNF agent is intended for use in combination.
- Patients will be permitted to switch from one biologic to another following an adequate trial of the first biologic, if unresponsive to therapy or due to serious adverse effects or contraindications.
- Initial coverage may be approved for doses of 50 mg per week for 8 weeks.
- Patients will be limited to receiving a one-month supply of Enbrel per prescription at their pharmacy.

For continued coverage of this biologic agent beyond 8 weeks, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after 8 weeks, but no longer than 12

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weeks after, treatment with this biologic agent to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one(1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for doses of 50 mg per week, for a maximum of 6 months. After 6 months, in order to be considered for continued coverage, the patient must be re-assessed every 6 months by an RA Specialist and must meet the following criteria:
1) The patient has been assessed by an RA Specialist to determine response; and
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- Confirmation of maintenance of ACR20, or
- Maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one(1) decimal place] from baseline.
3) A current HAQ score [reported to two (2) decimal places] must be included with all renewal requests."
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

All requests (including renewal requests) for Enbrel for Psoriatic Arthritis must be completed using the Enbrel for Psoriatic Arthritis Special Authorization Request Form (ABC 30964).

25 MG / VIAL INJECTION

00002242903	ENBREL	AMG	$ 200.6307

50 MG / SYR INJECTION SYRINGE

00002274728	ENBREL	AMG	$ 401.2614

Note: 1 x 50 mg syringe is interchangeable with 2 x 25 mg vials

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ETIDRONATE DISODIUM

"For the treatment of Paget's Disease."

"Coverage cannot be provided for two or more medications used in the treatment of Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

"For maintenance therapy in the treatment of hypercalcemia."

Requests for the treatment of osteoporosis will not be considered.

200 MG ORAL TABLET

00002248686	CO ETIDRONATE	COB	$ 0.8257
00002245330	GEN-ETIDRONATE	GPM	$ 0.8257
00001997629	DIDRONEL	PGA	$ 1.4900

EZETIMIBE

"For the treatment of hypercholesterolemia in patients who are intolerant to statins or in whom a statin is contraindicated and who are at high cardiovascular risk as defined by possessing one of the following:
1) Pre-existing cardiovascular disease and/or cerebrovascular disease, or
2) Diabetes, or
3) Familial hypercholesterolemia, or
4)Three or more of the following risk factors:
- Family history of premature cardiovascular disease
- Smoking
- Hypertension
- Obesity
- Glucose intolerance
- Renal disease.

Special authorization for these criteria may be granted for 24 months."

"For the treatment of hypercholesterolemia when used in combination with a statin in patients failing to achieve target LDL with a statin at maximum tolerable dose or maximum recommended dose as per respective product monograph and who are at high cardiovascular risk as defined by possessing one of the following:
1) Pre-existing cardiovascular disease and/or cerebrovascular disease, or
2) Diabetes, or
3) Familial hypercholesterolemia, or
4)Three or more of the following risk factors:
- Family history of premature cardiovascular disease
- Smoking
- Hypertension
- Obesity
- Glucose intolerance
- Renal disease.

Special authorization for these criteria may be granted for 24 months."

All requests for Ezetrol must be completed using the Ezetrol Special Authorization Request Form (ABC 30925).

10 MG ORAL TABLET

00002247521	EZETROL	MFC	$	1.6747

FENTANYL

"For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who cannot swallow. Special authorization may be granted for 24 months."

"For the treatment of persistent, severe chronic pain in those patients who require continuous around-the-clock analgesia for an extended period of time in those patients who require opioid therapy at a total daily dose of at least 60 mg/day oral morphine equivalents. Patients must have tried and not been able to tolerate at least two discrete courses of therapy with two of the following agents: morphine, hydromorphone and oxycodone, if not contraindicated. Special authorization may be granted for 24 months."

Information is required regarding previous medications utilized and the patient's response to therapy. Also, information regarding the number of discrete (separate) courses of these medications is required. A discrete course is defined as a separate treatment course, which may involve more than 1 agent, used at one time to manage the patient's condition.

(Please note: The following fentanyl products are benefits not requiring special authorization for individuals approved by Alberta Health and Wellness for Palliative Care Drug Coverage. Refer to the Palliative Care Drug Benefit Supplement for additional information on this coverage.)

12 MCGHR TRANSDERMAL PATCH				
00002280345	DURAGESIC 12	JOI	$	4.5688
25 MCGHR TRANSDERMAL PATCH				
00002249391	**RAN-FENTANYL**	**RAN**	$	**5.9500**
00002282941	**RATIO-FENTANYL**	**RPH**	$	**5.9500**
00001937383	DURAGESIC 25	JOI	$	10.1910
50 MCGHR TRANSDERMAL PATCH				
00002249413	**RAN-FENTANYL**	**RAN**	$	**11.2000**
00002282968	**RATIO-FENTANYL**	**RPH**	$	**11.2000**
00001937391	DURAGESIC 50	JOI	$	19.1780
75 MCGHR TRANSDERMAL PATCH				
00002249421	**RAN-FENTANYL**	**RAN**	$	**15.7500**
00002282976	**RATIO-FENTANYL**	**RPH**	$	**15.7500**
00001937405	DURAGESIC 75	JOI	$	26.9718
100 MCGHR TRANSDERMAL PATCH				
00002249448	**RAN-FENTANYL**	**RAN**	$	**19.6000**
00002282984	**RATIO-FENTANYL**	**RPH**	$	**19.6000**
00001937413	DURAGESIC 100	JOI	$	33.5723

FENTANYL CITRATE

"For the management of pain in those patients who cannot swallow, or who are intolerant of, morphine and/or hydromorphone, if not contraindicated. Special authorization may be granted for 24 months."

Information is required regarding previous medications utilized and the patient's response to therapy. Information should include the use of agents such as morphine and/or hydromorphone, if not contraindicated for the patient.

(Please note: The following fentanyl citrate product is a benefit not requiring special authorization for individuals approved by Alberta Health and Wellness for Palliative Care Drug Coverage. Refer to the Palliative Care Drug Benefit Supplement for additional information on this coverage.)

0.05 MG / ML (BASE) INJECTION				
00000888346	FENTANYL CITRATE	HSP	$	1.7250

FILGRASTIM

"To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppresive anti-neoplastic drugs with curative intent. This drug product must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates)."

"For the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization following induction and consolidation treatment for acute myeloid leukemia. This drug product must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates)."

"To increase neutrophil counts and to reduce the incidence and duration of infection in patients with a diagnosis of congenital, cyclic or idiopathic neutropenia. This drug product must be prescribed by the Directors of Divisions of Hematology in tertiary care centres (or their designates)."

"For the treatment of patients undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy when prescribed by a designated prescriber."

Please note for the first criterion: Coverage cannot be considered for palliative patients.

0.3 MG / ML INJECTION

00001968017	NEUPOGEN	AMG	$	196.8372

FINASTERIDE

(Refer to 92:00 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 65 years of age and older.)

"For the treatment of benign prostatic hyperplasia in patients less than 65 years of age who are poor surgical risks. Special authorization may be granted for the period of time from the approval of the request until the patient turns 65 years of age (at which time the drug becomes an unrestricted benefit, no longer requiring authorization)."

Information is required regarding the medical condition(s) or circumstances by which this patient would be deemed a poor surgical risk.

5 MG ORAL TABLET

00002010909	PROSCAR	MFC	$	1.7463

FLUCONAZOLE

"For susceptible infections in immunocompromised patients (e.g. patients with AIDS, cancer, or transplant patients)."

10 MG / ML ORAL SUSPENSION

00002024152	DIFLUCAN	PFI	$	1.0434

FLUTAMIDE

"When prescribed for non-cancer, non-cosmetic indications."

Information is required regarding the patient's diagnosis/indication for use of this medication.

250 MG ORAL TABLET

00002238560	**APO-FLUTAMIDE**	**APX**	$	**1.3530**
00000637726	**EUFLEX**	**SCH**	$	**1.3530**
00002230089	**NOVO-FLUTAMIDE**	**NOP**	$	**1.3530**
00002230104	**PMS-FLUTAMIDE**	**PMS**	$	**1.3530**

FLUTICASONE PROPIONATE

"For the prophylactic management of steroid-responsive bronchial asthma in patients who are unable to use the Turbuhaler dosage form of budesonide. Special authorization may be granted for 24 months."

Information is required regarding the patient's response to the Turbuhaler dosage form of budesonide.

50 MCG / DOSE METERED DOSE AEROSOL

00002244291	FLOVENT HFA	GSK	$	0.1994

FUSIDIC ACID

"For the treatment of ophthalmic infections in patients with documented sensitivity to preservatives."

1 % OPHTHALMIC GEL

00002243861	FUCITHALMIC (UNPRESERVED)	LEO	$	4.0542

GALANTAMINE HYDROBROMIDE

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26."

"This drug must be initiated by a designated prescriber for new patients (individuals who have never taken the requested drug before or who have taken the drug for 60 days or less) with an MMSE score between 10-13 inclusive."

"Specialists in Geriatric Medicine, Neurology, and Psychiatry are deemed designated prescribers by virtue of their specialty in medical practice. All other practitioners will be added to the list of designated prescribers if they have successfully completed MAINPRO-C credits through the College of Family Practice (Physicians) [prior to March 31, 2006], the Care of the Elderly Six-month/One-year Fellowship Program through the Department of Family Medicine or the MAINPRO-M1 course entitled, "Module 2: Advanced Alzheimer's Disease."

"Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination."

All requests (including renewal requests) for Reminyl ER must be completed using the Aricept/Exelon/Reminyl ER Special Authorization Request Form (ABC 30776).

For each request, an updated MMSE score and the date on which the exam was administered must be provided. The MMSE score must be within 3 months of the time of the application (including renewal requests).

Renewal requests for patients where the updated MMSE score is greater than 26 while on this drug, may also be considered.

Initial special authorization for new patients may be granted for a maximum of 12 weeks. Continued special authorization coverage may be granted for a maximum of 12 months.

In order to be considered for coverage beyond the initial 12-week authorization, those patients with an MMSE score of 10 or higher may be eligible for continued coverage provided their MMSE score has not dropped by more than 3 points during the 12-week period.

8 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002266717	REMINYL ER	JOI	$	4.9343
16 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002266725	REMINYL ER	JOI	$	4.9343
24 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002266733	REMINYL ER	JOI	$	4.9343

GOSERELIN ACETATE

"When prescribed for non-cancer, non-cosmetic or non-fertility indications."

Information is required regarding the patient's diagnosis/indication for use of this medication.

3.6 MG / SYR (BASE) INJECTION SYRINGE				
00002049325	ZOLADEX	AZC	$	381.7500
10.8 MG / SYR (BASE) INJECTION SYRINGE				
00002225905	ZOLADEX LA	AZC	$	1087.9800

IMIPENEM MONOHYDRATE/ CILASTATIN SODIUM

"For the treatment of:

1) "Second-line therapy of intra-abdominal sepsis where there is failure of first-line therapy (e.g. ampicillin + gentamicin + metronidazole), as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy or

2) Second-line therapy of severe polymicrobial skin and skin structure infections (e.g. limb threatening diabetic foot) or

3) Empiric therapy of mixed synergistic necrotizing gangrene (Fournier's gangrene) or

4) Therapy of severe ventilator-associated pneumonia where Pseudomonas and Staphylococcus aureus coverage is needed or

5) Second-line therapy of infections due to gram-negative organisms producing inducible beta-lactamases (i.e. Enterobacter spp., Citrobacter freundii complex, Serratia spp., Morganella spp., Providencia spp., Proteus vulgaris, Proteus penneri and some Hafnia spp.) or extended spectrum beta-lactamases where there is resistance to first-line agents (trimethoprim/sulfamethoxazole, ciprofloxacin and aminoglycosides) or

6) For use in other Health Canada approved indications in consultation with a specialist in Infectious Diseases."

In order to comply with all of the above criteria, information is required regarding the type of infection and organisms involved. Also, where the criteria restrict coverage of the requested drug to non-first line therapy, information is required regarding previous first-line antibiotic therapy that has been utilized, the patient's response to therapy, and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. Also, where applicable, the specialist in Infectious Diseases that recommended this drug is required.

250 MG / VIAL (BASE)	*** 250 MG / VIAL (BASE)**	**INJECTION**			
00000717274	PRIMAXIN		MFC	$	13.0400
500 MG / VIAL (BASE)	*** 500 MG / VIAL (BASE)**	**INJECTION**			
00000717282	PRIMAXIN		MFC	$	24.3800

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Rheumatoid Arthritis:

"Special authorization coverage may be provided for use in combination with methotrexate for the reduction in signs and symptoms of severely active Rheumatoid Arthritis (RA) in adult patients (18 years of age or older) who are refractory to:
- Methotrexate at 20 mg (PO, SC or IM) or greater total weekly dosage (15 mg or greater if patient is 65 years of age or older) for more than 12 weeks. Patients who do not exhibit a clinical response to PO methotrexate or experience gastrointestinal intolerance to PO methotrexate must have a trial of parenteral methotrexate before being accepted as refractory; AND
- Methotrexate with other disease modifying anti-rheumatic agent(s) (minimum 4 month trial). [e.g., methotrexate with hydroxychloroquine or methotrexate with sulfasalazine]; AND
- Leflunomide (minimum 10 week trial at 20 mg daily)

'Refractory' is defined as one or more of the following: lack of effect at doses and for duration of treatments specified above, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Rheumatology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("RA Specialist"). The patient must also provide all consents and authorizations required to permit the RA Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the RA Specialist does not continually, actively and consistently participate in the Study.

- Coverage will not be approved when another anti-TNF agent or an interleukin-2 agent is intended for use in combination.
- Patients will be permitted to switch from one biologic to another (with the exception of anakinra) following an adequate trial of the first biologic if unresponsive to therapy or due to serious adverse effects or contraindications.
- Patients will not be permitted to switch from anakinra to other biologics except under exceptional circumstances.
- Initial coverage may be approved for three doses as follows: An initial dose of 3 mg/kg, followed by additional 3 mg/kg doses at 2 and 6 weeks after the first infusion.
- Patients will be limited to receiving one dose of Remicade per prescription at their pharmacy.

For continued coverage of this biologic agent beyond three doses, the patient must meet the following criteria:
1) The patient must be assessed by an RA Specialist after the initial three doses of this biologic agent to determine response.
2) The RA Specialist must confirm in writing that the patient is a 'responder' that meets the following criteria:
- ACR20 OR an improvement of 1.2 units in the DAS28 score [reported to one(1) decimal place]; AND
- An improvement of 0.22 in HAQ score [reported to two (2) decimal places].
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

Following this assessment, continued coverage may be approved for one 3 mg/kg dose every 8 weeks, for a maximum of 6 months. After 6 months, in order to be considered for continued coverage, the patient must be re-assessed every 6 months by an RA Specialist and must meet the following criteria:
1) The patient has been assessed by an RA Specialist to determine response; and
2) The RA Specialist must confirm in writing that the patient has maintained a response to therapy as indicated by:
- confirmation of maintenance of ACR20, or
- maintenance of a minimum improvement of 1.2 units in DAS28 score [reported to one(1)

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decimal place] from baseline.
3) a current HAQ score [reported to two (2) decimal places] must be included with all renewal requests.
It should be noted that the initial score for the DAS28 or HAQ score on record will be rounded to the correct number of decimal places as indicated above.

All requests (including renewal requests) for Remicade for Rheumatoid Arthritis must be completed using the Enbrel/Humira/Kineret/Remicade for Rheumatoid Arthritis Special Authorization Request Form (ABC 30902).

Severe, Active Crohn's Disease:

"Special authorization coverage may be provided for the treatment of a single flare of severe, active Crohn's Disease in adult patients (18 years of age and older) who meet the following criteria for each flare:
- Possess a Crohn's Disease Activity Index (CDAI) score of >220 for each flare, AND are refractory to the following medications for each flare:
- 5-ASA (minimum trial of 3 grams per day for a minimum of 6 weeks or treatment discontinued at less than 6 weeks due to serious adverse reactions), AND
- Glucocorticoids (inadequate response to initial therapy for each flare with high dose prednisone at least 40 mg/day for at least 6 weeks or treatment discontinued due to serious adverse reactions or contraindications), AND
[Note: Patients who have used the above agents in combination will not be required to be challenged with individual agents as monotherapy].
- Immunosuppressive therapy:
- Azathioprine - at least 2 mg/kg/day for a minimum of 3 months or treatment discontinued at less than 3 months due to serious adverse reactions; OR
- 6-mercaptopurine - at least 1 mg/kg/day for a minimum of 3 months or treatment is discontinued due to serious adverse effects; OR
- Methotrexate - at least 15 mg/week for a minimum of 3 months or treatment discontinued due to serious adverse effects.

Applications for coverage must include information regarding the dosages of each agent that the patient received.

'Refractory' is defined as one or more of the following: lack of effect at doses and for duration of treatments specified above, serious adverse effects (e.g., leukopenia, hepatitis) or contraindications to treatments as defined in product monographs.

For coverage, this drug must be initiated by a Specialist in Gastroenterology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its agent, throughout the special authorization approval period ("Specialist"). The patient must also provide all consents and authorizations required to permit the Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the Specialist does not continually, actively and consistently participate in the Study.
- Coverage may only be approved for a single dose of 5 mg/kg per flare.
- Patient must meet the above criteria for each flare in order to be considered for potential coverage.
- Patients will be limited to receiving one dose per prescription at their pharmacy.

In order to be considered for coverage for a subsequent flare, the patient must meet the following criteria:
1) The patient has been assessed by the Specialist after the previous single dose treatment.
2) The Specialist must confirm in writing that the patient has shown a 25% reduction in CDAI score AND a decrease of 70 points in CDAI score from the baseline score provided at the time of the INITIAL request for treatment of the first flare.

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3) In addition to a current baseline score to indicate that the patient is experiencing a flare, the specialist must confirm in writing that the patient has shown a 25% reduction in the CDAI score and a decrease of 70 points in CDAI score from the baseline score provided at the time of the most recent previous request.
- patients who fail to respond to two consecutive renewal doses will not be eligible for additional doses.

Patients are only eligible for four doses per year."

All requests (including renewal requests) for Remicade for Crohn's/Fistulizing Crohn's Disease must be completed using the Remicade for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 30901).

Fistulizing Crohn's Disease:

"Special authorization coverage may be approved for the treatment of Fistulizing Crohn's Disease in adults patients (18 years of age and older) with actively draining perianal or enterocutaneous fistula(e) that have recurred or persisted despite:
- a course of appropriate antibiotic therapy (e.g. ciprofloxacin or metronidazole) for a minimum of 3 weeks (drug, dose and duration of treatment must be specified), AND
- Immunosupressive Therapy:
- Azathioprine - at least 2 mg/kg/day for a minimum of 6 weeks or treatment discontinued at less than 6 weeks due to serious adverse reactions, OR
- 6-mercaptopurine - at least 1 mg/kg/day for a minimum of 6 weeks or treatment discontinued due to serious adverse effects, OR
- Methotrexate - at least 15 mg/week for a minimum of 6 weeks or less if patient experiences serious adverse effects

Requests for immediate coverage may be considered for patients who have severe disease and no response to drug therapy within 3 weeks, and are being considered for immediate surgery. These patients may be approved for infliximab treatment without a trial of azathioprine, 6-mercaptopurine or methotrexate as they may require more rapid onset of response.

Requests for immediate coverage may be considered for patients who are very ill, and are not candidates for surgery (e.g., multiple prior surgeries, high surgical risk due to comorbid disease). These patients may be approved for infliximab treatment without a trial of antibiotic therapy, azathioprine, 6-mercaptopurine or
methotrexate as they may require more rapid onset of response.

Physician must indicate whether surgery has been tried, contemplated or is not indicated.

For coverage, this drug must be initiated by a Specialist in Gastroenterology who agrees to and continues to actively and consistently participate in the Alberta Post-Marketing Study ("Study") as required by Alberta Health and Wellness or its
agent, throughout the special authorization approval period ("Specialist"). The patient must also provide all consents and authorizations required to permit the Specialist to actively and consistently participate in the Study. Special authorization approval for the patient may be revoked if the Specialist does not
continually, actively and consistently participate in the Study.

- Coverage may be approved for 3 doses of 5 mg/kg/dose, administered at 0, 2 and 6 weeks.
- Patients will be limited to receiving one dose of Remicade per prescription at their pharmacy.
- Patients who experience a complete response as defined by closure of individual fistulas as evidenced by no fistula drainage despite gentle finger compression and maintain the closure of all fistulas that were draining at baseline for at least four weeks, but who subsequently develop new fistula or re-opening of fistula may be eligible to receive subsequent dosing at intervals no less than 12 weeks apart as long as complete response is experienced after each dose. In the

INFLIXIMAB

absence of a complete response, patients are only eligible for four doses per year.

All requests (including renewal requests) for Remicade for Crohn's/Fistulizing Crohn's Disease must be completed using the Remicade for Crohn's/Fistulizing Crohn's Disease Special Authorization Request Form (ABC 30901).

"These criteria are transitional pending the receipt and review of data from the Alberta Post-Marketing Study evaluating the first year of coverage of this agent."

100 MG / VIAL INJECTION

00002244016	REMICADE	SCH	$	940.0000

IPRATROPIUM BROMIDE

"For use in patients with manual dexterity problems or visual limitations who are unable to prepare a dose of the drug using the multi-dose solution."

"For use in patients who are hypersensitive to preservatives contained in multi-dose solutions."

"Special authorization for both criteria may be granted for 24 months."

Information is required regarding the nature of the difficulties experienced by the patient in preparing a dose using the multi-dose preparation; or the nature of the patient's hypersensitivity to the preservatives contained in the multi-dose solution.

125 MCG / ML INHALATION UNIT DOSE SOLUTION

00002231135	PMS-IPRATROPIUM	PMS	$	0.3775
00002097176	RATIO-IPRATROPIUM UDV	RPH	$	0.3775

250 MCG / ML INHALATION UNIT DOSE SOLUTION

00002216221	**GEN-IPRATROPIUM STERINEBS**	**GPM**	$	**0.7550**
00002231244	**PMS-IPRATROPIUM (1ML)**	**PMS**	$	**0.7550**
00002231245	**PMS-IPRATROPIUM (2ML)**	**PMS**	$	**0.7550**
00002097168	**RATIO-IPRATROPIUM UDV**	**RPH**	$	**0.7550**

IPRATROPIUM BROMIDE/ FENOTEROL HYDROBROMIDE

"For use in patients with manual dexterity problems or visual limitations who are unable to prepare a dose of the drug using the multi-dose solution."

"For use in patients who are hypersensitive to preservatives contained in multi-dose solutions."

"Special authorization for both criteria may be granted for 24 months."

Information is required regarding the nature of the difficulties experienced by the patient in preparing a dose using the multi-dose preparation; or the nature of the patient's hypersensitivity to the preservatives contained in the multi-dose solution.

0.125 MG / ML * 0.3125 MG / ML INHALATION SOLUTION

00002148633	DUOVENT UDV	BOE	$	0.8264

ITRACONAZOLE

"For the treatment of oral and/or esophageal candidiasis in immunocompromised patients who are intolerant to fluconazole, or who have failed fluconazole as evidenced by significant clinical deterioration due to the fungal infection during a course of therapy or no resolution after a full course of therapy."

10 MG / ML ORAL SOLUTION

00002231347	SPORANOX	JOI	$	0.8612

LAMIVUDINE

"For the treatment of patients with chronic hepatitis B and evidence of hepatitis B viral replication. Special authorization for this criteria may be granted for 12 months."

"To prevent hepatitis B re-infection in post-liver transplant patients. Special authorization for this criteria may be granted for 12 months."

"For the prevention of hepatitis B re-infection in patients who are Hepatitis B surface antigen positive and are undergoing high dose, short-term cytotoxic chemotherapy with curative intent or stem cell transplant procedures. Coverage may be granted for up to 8 weeks following the completion of treatment. Special authorization for this criteria may be granted for up to 8 weeks post-treatment."

In order to comply with the first criteria: to confirm the diagnosis of chronic hepatitis B and evidence of hepatitis B viral replication, information is required regarding the patient's hepatitis B surface antigen (HBsAg) and hepatitis Be antigen (HBeAg) status, and whether the serum ALT levels are elevated.
Renewals for continued therapy beyond 12 months will be considered if durable seroconversion has not occurred (i.e. durable seroconversion is defined as loss of HBeAg and development of anti-HeBe).

Please note for the third criteria: Coverage cannot be considered for palliative patients.

100 MG ORAL TABLET

00002239193	HEPTOVIR	GSK	$	4.4880

LATANOPROST

"For the reduction of intraocular pressure in patients with open angle glaucoma or ocular hypertension who are intolerant of, or insufficiently responsive to travoprost."

"For the reduction of intraocular pressure in patients with chronic angle-closure glaucoma."

Special authorization for both criteria may be granted for 24 months.

0.005 % OPHTHALMIC SOLUTION

00002231493	XALATAN	PFI	$	11.6272

LATANOPROST/ TIMOLOL MALEATE

"For the reduction of intraocular pressure in patients with open angle glaucoma or ocular hypertension who are intolerant of, or insufficiently responsive to travoprost."

Special authorization for this criterion may be granted for 24 months.

0.005 % * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002246619	XALACOM	PFI	$	13.1580

LEFLUNOMIDE

"For the treatment of refractory rheumatoid arthritis in patients who have failed an adequate trial of methotrexate. For patients who are unable to tolerate or with a contraindication to methotrexate. This drug product must be prescribed by a specialist in Rheumatology or Internal Medicine. Special authorization may be granted for 24 months."

"Note: In order to qualify for coverage of biologic agents for the treatment of rheumatoid arthritis (e.g., etanercept, infliximab), patients must be refractory to: 1) methotrexate, AND 2) methotrexate in combination with DMARD(s) other than leflunomide, AND 3) leflunomide. For additional detail, please refer to the special authorization criteria for these agents."

10 MG ORAL TABLET				
00002256495	APO-LEFLUNOMIDE	APX	$	6.0417
00002261251	NOVO-LEFLUNOMIDE	NOP	$	6.0417
00002283964	SANDOZ LEFLUNOMIDE	SDZ	$	6.0417
00002241888	ARAVA	SAV	$	11.3660
20 MG ORAL TABLET				
00002256509	**APO-LEFLUNOMIDE**	**APX**	$	**6.0417**
00002261278	**NOVO-LEFLUNOMIDE**	**NOP**	$	**6.0417**
00002283972	**SANDOZ LEFLUNOMIDE**	**SDZ**	$	**6.0417**
00002241889	ARAVA	SAV	$	11.3660

LEUPROLIDE ACETATE

"When prescribed for non-cancer, non-cosmetic or non-fertility indications."

Information is required regarding the patient's diagnosis/indication for use of this medication.

3.75 MG / VIAL INJECTION				
00000884502	LUPRON DEPOT	ABB	$	325.2600
5 MG / ML INJECTION				
00000727695	LUPRON	ABB	$	67.6464
7.5 MG / VIAL INJECTION				
00000836273	LUPRON DEPOT	ABB	$	387.9700
11.25 MG / VIAL INJECTION				
00002239834	LUPRON DEPOT	ABB	$	975.8000
22.5 MG / VIAL INJECTION				
00002230248	LUPRON DEPOT	ABB	$	1071.0000

LEVETIRACETAM

"For use in combination with other anti-epileptic medication(s) in the treatment of partial seizures in patients who are refractory to adequate trials of three anti-epileptic medications used either as monotherapy or in combination. This product must be prescribed in consultation with a specialist in Neurology."

"Special authorization may be granted for 24 months"

250 MG ORAL TABLET				
00002285924	**APO-LEVETIRACETAM**	**APX**	$	**1.1175**
00002274183	**CO LEVETIRACETAM**	**COB**	$	**1.1175**
00002247027	KEPPRA	LBC	$	1.6482
500 MG ORAL TABLET				
00002285932	**APO-LEVETIRACETAM**	**APX**	$	**1.3650**
00002274191	**CO LEVETIRACETAM**	**COB**	$	**1.3650**
00002247028	KEPPRA	LBC	$	2.0132
750 MG ORAL TABLET				
00002285940	APO-LEVETIRACETAM	APX	$	1.9425
00002274205	CO LEVETIRACETAM	COB	$	1.9425
00002247029	KEPPRA	LBC	$	2.8650

LEVOCARNITINE

"For the treatment of primary carnitine deficiency. Information is required regarding the ratio of acyl:free carnitine and total plasma carnitine levels."

"For the treatment of patients with an inborn error of metabolism that results in secondary carnitine deficiency. Information is required regarding the patient's diagnosis."

In order to comply with the first criteria: Information is required regarding pre-treatment acyl:free carnitine and total plasma carnitine levels.

330 MG ORAL TABLET				
00002144328	CARNITOR	PPC	$	1.2583
100 MG / ML ORAL SOLUTION				
00002144336	CARNITOR	PPC	$	0.3811
200 MG / ML INJECTION				
00002144344	CARNITOR	PPC	$	12.0480

LINEZOLID

"For the treatment of:

1) Vancomycin-resistant enterococcus infections or

2) Methicillin-resistant Staphylococcus aureus (MRSA)/methicillin-resistant coagulase-negative Staphylococcus infections in patients who are unresponsive to or intolerant of vancomycin or

3) Susceptible organisms in patients severely intolerant or allergic to all other appropriate alternatives (e.g. beta-lactam antibiotics, clindamycin, trimethoprim/sulfamethoxazole and vancomycin) or to facilitate patient discharge from hospital where it otherwise would not be possible.

This product must be prescribed in consultation with a specialist in Infectious Diseases in all instances."

In order to comply with the above criteria, information is required regarding the type of infection and organisms involved. Information is also required regarding previous antibiotic therapy that has been utilized and the patient's response to therapy and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. The specialist in Infectious Diseases that recommended this drug is also required.

600 MG ORAL TABLET				
00002243684	ZYVOXAM	PFI	$	75.9370

MEGESTROL ACETATE

"For the treatment of non-cancer indications (e.g. cachexia in HIV/AIDS patients and cancer patients) in patients who cannot swallow tablets."

(Please note: The above megestrol acetate product is a benefit not requiring special authorization for individuals approved by Alberta Health and Wellness for Palliative Care Drug Coverage. Refer to the Palliative Care Drug Benefit Supplement for additional information on this coverage.)

40 MG / ML ORAL SUSPENSION				
00002168979	MEGACE OS	BMS	$	1.4860

MEGESTROL ACETATE

"For the treatment of non-cancer indications (e.g. cachexia in HIV/AIDS patients and cancer patients)."

(Please note: The above megestrol acetate products are benefits not requiring special authorization for individuals approved by Alberta Health and Wellness for Palliative Care Drug Coverage. Refer to the Palliative Care Drug Benefit Supplement for additional information on this coverage.)

40 MG ORAL TABLET				
00002195917	**APO-MEGESTROL**	**APX**	$	**0.9054**
00002185415	**NU-MEGESTROL**	**NXP**	$	**0.9054**
160 MG ORAL TABLET				
00002195925	APO-MEGESTROL	APX	$	3.6267
00002185423	NU-MEGESTROL	NXP	$	3.6267
00000731323	MEGACE	BMS	$	5.6840

MEROPENEM

1) "As an alternative to imipenem for severe polymicrobial infections involving gram-negative organisms resistant to first-line agents in patients with documented seizure disorder/CNS abnormality or

2) As an alternative agent for severe polymicrobial infections involving gram-negative organisms resistant to first-line agents and to imipenem but susceptible to meropenem or

3) Therapy of meningitis due to gram-negative organisms producing inducible beta-lactamases (i.e. Enterobacter spp., Citrobacter freundii complex, Serratia spp., Morganella spp., Providencia spp., Proteus vulgaris, Proteus penneri and some Hafnia spp.) or

4) For treatment of CNS infections due to gram-negative organisms that are resistant to third-generation cephalosporins but are susceptible to meropenem or

5) Therapy for infections involving multi-resistant Pseudomonas aeruginosa, where there is documented susceptibility to meropenem (i.e. cannot assume meropenem susceptibility from imipenem susceptibility), in patients with documented seizure disorder/CNS abnormality or

6) For use in other Health Canada approved indications, in consultation with a specialist in Infectious Diseases."

In order to comply with all of the above criteria, information is required regarding the type of infection and organisms involved. Also, where the criteria restrict coverage of the requested drug to non-first line therapy, information is required regarding previous first-line antibiotic therapy that has been utilized, the patient's response to therapy, and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient. Also, where applicable, the specialist in Infectious Diseases that recommended this drug is required.

500 MG / VIAL INJECTION				
00002218488	MERREM	AZC	$	24.3500
1 G / VIAL INJECTION				
00002218496	MERREM	AZC	$	48.7000

METHYLPREDNISOLONE ACETATE/ ALUMINUM CHLORHYDROXIDE COMPLEX/ SULFUR

"For the treatment of acne rosacea and seborrheic dermatitis."

2.5 MG / ML * 100 MG / ML * 50 MG / ML TOPICAL LOTION				
00000252395	MEDROL ACNE	PFI	$	0.1909

METHYLPREDNISOLONE ACETATE/ NEOMYCIN SULFATE/ ALUMINUM CHLORHYDROXIDE COMPLEX/ SULFUR

"For the treatment of severe acne as defined by scarring acne."

"For the treatment of acne rosacea and seborrheic dermatitis."

2.5 MG / ML * 2.5 MG / ML * 100 MG / ML * 50 MG / ML TOPICAL LOTION

00000195057	NEO-MEDROL ACNE	PFI	$	0.2748

MIDODRINE HCL

"For the treatment of neurogenic types of idiopathic hypotension where the response to standard therapy is inadequate. Special authorization may be granted for 24 months."

Information is required regarding previous medications utilized and the patient's response to therapy.

2.5 MG ORAL TABLET

00002278677	APO-MIDODRINE	APX	$	0.2999
00001934392	AMATINE	SHB	$	0.4997

5 MG ORAL TABLET

00002278685	APO-MIDODRINE	APX	$	0.4998
00001934406	AMATINE	SHB	$	0.8441

MODAFINIL

"For the treatment of documented narcolepsy. This drug product must be prescribed by a specialist in Neurology or Psychiatry, or a sleep specialist affiliated with a recognized level 1 lab."

100 MG ORAL TABLET

00002239665	ALERTEC	SHB	$	1.2243

MONTELUKAST SODIUM

(Refer to 92:00 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 6 to 18 years of age inclusive).

"For the prophylaxis and chronic treatment of asthma in patients over the age of 18 who meet one of the following criteria:

a) when used as adjunctive therapy in patients who do not respond adequately to high doses of inhaled glucocorticosteroids and long-acting beta 2 agonists. Patients must be unable to use long-acting beta 2 agonists or have demonstrated persistent symptoms while on long-acting beta 2 agonists, or

b) cannot operate inhaler devices."

"For the prophylaxis of exercise-induced bronchoconstriction in patients over the age of 18 where tachyphylaxis exists for long-acting beta 2 agonists."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information should indicate either a) current use of inhaled steroids and contraindications or poor response to long-acting beta 2 agonists (e.g. salmeterol or formoterol) or b) the nature of the patient's difficulties with using inhaler devices. In order to comply with the second criteria, information should include the nature of the patient's response to long-acting beta 2 agonists (e.g. salmeterol or formoterol).

10 MG (BASE) ORAL TABLET				
00002238217	SINGULAIR	MFC	$	2.2067
5 MG (BASE) ORAL CHEWABLE TABLET				
00002238216	SINGULAIR	MFC	$	1.4997

NARATRIPTAN HCL

(Refer to 28:92 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using naratriptan hydrochloride prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

1 MG (BASE) ORAL TABLET				
00002237820	AMERGE	GSK	$	13.2307
2.5 MG (BASE) ORAL TABLET				
00002237821	AMERGE	GSK	$	13.9417

OCTREOTIDE ACETATE

"For control of symptoms in patients with metastatic carcinoid and vasoactive intestinal peptide-secreting tumors (VIPomas) and for the treatment of acromegaly."

"For the treatment of intractable diarrhea which has not responded to less costly therapy [e.g. associated with (secondary to) AIDS, intra-abdominal fistulas, short bowel syndrome]. Treatment for these indications must be initiated by a specialist in Gastroenterology, General Surgery, Internal Medicine, or Palliative Care."

In order to comply with the second criteria, information is required regarding previous medications utilized and the patient's response to therapy.

50 MCG / ML (BASE) INJECTION			
00002248639	OCTREOTIDE ACETATE OMEGA	OMG	$ 3.9920
00000839191	SANDOSTATIN	NOV	$ 5.3643
100 MCG / ML (BASE) INJECTION			
00002248640	OCTREOTIDE ACETATE OMEGA	OMG	$ 7.5360
00000839205	SANDOSTATIN	NOV	$ 10.1265
200 MCG / ML (BASE) INJECTION			
00002248642	**OCTREOTIDE ACETATE OMEGA**	**OMG**	**$ 14.4960**
00002049392	SANDOSTATIN	NOV	$ 19.4790
500 MCG / ML (BASE) INJECTION			
00002248641	OCTREOTIDE ACETATE OMEGA	OMG	$ 35.4160
00000839213	SANDOSTATIN	NOV	$ 47.5903
10 MG / VIAL (BASE) INJECTION			
00002239323	SANDOSTATIN LAR	NOV	$ 1272.0583
20 MG / VIAL (BASE) INJECTION			
00002239324	SANDOSTATIN LAR	NOV	$ 1696.8445
30 MG / VIAL (BASE) INJECTION			
00002239325	SANDOSTATIN LAR	NOV	$ 2123.9420

OMEPRAZOLE

"For the treatment of patients who are unable to tolerate omeprazole 20 mg. Special authorization may be granted for 24 months."

10 MG ORAL SUSTAINED-RELEASE TABLET			
00002230737	LOSEC	AZC	$ 1.7500

PAPAVERINE HCL

"For the relief of cerebral or peripheral ischemia with arterial spasm."

32.5 MG / ML INJECTION			
00000009881	PAPAVERINE HCL	SDZ	$ 1.3540

PEGFILGRASTIM

"To decrease the incidence of infection, as manifested by febrile neutropenia, in patients 18 years of age and older with non-myeloid malignancies receiving myelosuppressive anti-neoplastic drugs with curative intent. This drug product must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates)."

Please note: Coverage cannot be considered for palliative patients.

6 MG / SYR INJECTION SYRINGE			
00002249790	NEULASTA (0.6 ML SYRINGE)	AMG	$ 2655.5071

PEGINTERFERON ALFA-2A

"For the treatment of chronic hepatitis C in patients with evidence of active liver disease.

Prior to initiation of therapy

- To determine treatment duration and prognosis, HCV genotype testing is required for all patients.
- Patients must have a baseline serum sample stored for future viral load testing in the event that the week 12 HCV RNA test is positive.
- At least three weeks before anticipated start date of therapy, please submit to Alberta Blue Cross a Pegasys Special Authorization Request Form (ABC 30944), along with appropriate lab results. In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

Initial Alberta Blue Cross approval periods (for patients meeting criteria)

- Patients may receive an initial approval for 14 weeks of coverage.

After 12 weeks of treatment

- HCV RNA testing is required for all patients at the 12th week of treatment.
- If the HCV RNA test is positive, viral load testing is required on the previously stored baseline serum sample, and the 12 week serum sample, for evaluation of continued coverage.

Renewal approval period (for patients meeting criteria)

- Patients who respond to therapy, as measured by a reduction of viral load by at least 2 logs (100 fold) or HCV RNA not detected at 12 weeks, may be approved for an additional 34 weeks of coverage (total 48 weeks)."

"For the treatment of patients with chronic hepatitis B as evidenced by positive hepatitis B s antigen (HBsAg) for more than six months and:

- Elevated serum ALT values = 2 times the upper limit of normal, or
- A liver biopsy showing grade 1 or worse inflammation consistent with chronic hepatitis B.

Patients who are HBeAg positive require HBV DNA >500,000 copies/ml (>100,000 IU/mL).
Patients who are HBeAg negative require HBV DNA >100,000 copies/ml (>20,000 IU/mL).

Special authorization may be granted for a total of 48 weeks. Requests for retreatment will not be considered.
Patients who have decompensated liver disease will not be considered for coverage.
Coverage will not be considered when Pegasys and lamivudine are intended for use in combination."

In order to comply with the first criteria: Confirmation of the diagnosis of chronic hepatitis C and presence of active liver disease is required. Information must include the patient's pre-treatment anti-HCV and serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of a liver biopsy. All requests must be completed using the Pegasys for treatment of Chronic Hepatitis C Special Authorization Request Form (ABC 30944 form). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

In order to comply with the second criteria: Confirmation of the diagnosis of chronic hepatitis B and the patient's hepatitis B surface antigen (HBsAg) status is required. Information must indicate whether liver enzymes (ALT/AST) are elevated, or the results of a liver biopsy.

PEGINTERFERON ALFA-2A

Information is also required regarding evidence of hepatitis B viral replication and must indicate Be antigen (HBeAg), and hepatitis B viral DNA (HBV-DNA) status. All requests must be completed using the Pegasys for treatment of Chronic Hepatitis B Special Authorization Request Form (ABC 31095 form). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

180 MCG / ML INJECTION			
00002248078	PEGASYS	HLR	$ 425.5300
180 MCG / SYR INJECTION SYRINGE			
00002248077	PEGASYS (0.5 ML SYRINGE)	HLR	$ 425.5300

PEGINTERFERON ALFA-2A/ RIBAVIRIN

"For the treatment of chronic hepatitis C in patients with evidence of active liver disease.

Prior to initiation of Pegasys RBV therapy:

- To determine treatment duration and prognosis, HCV genotype testing is required for all patients.
- At least three (3) weeks before anticipated start date of therapy, please submit a Pegetron/Pegasys RBV Special Authorization Request Form (ABC 30932) along with appropriate lab results to Alberta Blue Cross.

All Patients (with the Exception of Post-Liver Transplant Patients and Advanced Fibrosis or Cirrhosis Patients):

Prior to initiation of Pegasys RBV therapy:

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection must have a baseline serum sample stored for future viral load testing in the event that the week 12 HCV RNA test is positive.

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection, may receive an initial approval for 14 weeks of coverage.
- Genotype 2 or 3 patients may receive initial and maximal approval for 24 weeks of coverage. These patients will not be eligible for continued approval.
- Genotype 4, 5 and 6 patients may receive initial and maximal approval for 48 weeks of coverage. These patients will not be eligible for continued approval.

At 12 weeks of treatment:

- HCV RNA testing is required for all Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection at the 12th week of treatment.
- If the HCV RNA test is positive, viral load testing is required on the previously stored baseline serum sample and the 12th week serum sample for evaluation of continued coverage.

Renewal approval period (for patients meeting criteria):

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection who respond to therapy as measured by a negative HCV RNA status at 12 weeks, may be approved for an additional 34 weeks of coverage (i.e. total 48 weeks).
- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection who achieve a reduction in viral load by at least 2 logs (100 fold) but do not possess negative HCV RNA status at week 12 may be approved for an additional 14 weeks of coverage. Patients should be retested for HCV RNA status at 24 weeks:
- Patients who respond to therapy, as measured by a negative HCV RNA status at 24 weeks, may be approved for an additional 20 weeks of coverage (i.e. total 48 weeks).
- Those who fail to demonstrate negative HCV RNA status at 24 weeks will not be eligible for continued approval.

Post-Liver Transplant Patients:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Genotype 1 and Genotype 2 or 3 patients may receive an initial approval for 26 weeks of coverage.
- Genotype 4, 5 and 6 patients may receive initial and maximal approval for 48 weeks of

PEGINTERFERON ALFA-2A/ RIBAVIRIN

coverage. These patients will not be eligible for continued approval.

At 24 weeks of treatment:

- HCV RNA testing is required for all Genotype 1 and Genotype 2 or 3 patients at the 24th week of treatment.

Renewal approval period (for patients meeting criteria):

- Genotype 1 and Genotype 2 or 3 patients who respond to therapy as measured by a negative HCV RNA status at 24 weeks, may be approved for an additional 22 weeks of coverage (i.e. total 48 weeks).
- Those who fail to demonstrate negative HCV RNA status at 24 weeks will not be eligible for continued approval.

Advanced Fibrosis or Cirrhosis Patients:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Patients with advanced fibrosis or cirrhosis may receive approval for 48 weeks of coverage.

Consideration for therapy in ALL patients (including post-liver transplant patients) who have previously received therapy:

- Consideration for therapy in patients who have previously received therapy may be given for patients who meet at least one of the following criteria:
- Advanced fibrosis or cirrhosis.
- Patients who have relapsed following non-pegylated interferon/ribavarin combination therapy.
- Patients who have failed to respond to or relapsed following interferon monotherapy."

Confirmation of the diagnosis of chronic hepatitis C and presence of active liver disease is required. Information must include the patient's pre-treatment anti-HCV and serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of liver biopsy. All requests for Pegasys RBV must be completed using the Pegetron/Pegasys RBV Special Authorization Request Form (ABC 30932). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

180 MCG * 200 MG	**INJECTION SYRINGE/TABLET**		
00002253429	PEGASYS RBV (KIT)	HLR	$ 425.5300
180 MCG * 200 MG	**INJECTION VIAL/TABLET**		
00002253410	PEGASYS RBV (KIT)	HLR	$ 425.5300

PEGINTERFERON ALFA-2B

"For the treatment of chronic hepatitis C in patients with evidence of active liver disease who are 18 years of age or older with documented evidence of intolerance or contraindication to ribavirin."

Confirmation of the diagnosis of chronic hepatitis C and presence of active liver disease is required. Information must include the patient's pre-treatment anti-HCV and serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of liver biopsy. Specific information is required regarding why ribavirin cannot be used. All requests for Unitron-PEG must be completed using the Unitron-PEG Special Authorization Request Form (ABC 30933). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to the completed form.

74 MCG / VIAL INJECTION			
00002242966	UNITRON-PEG	SCH	$ 395.8500
118.4 MCG / VIAL INJECTION			
00002242967	UNITRON-PEG	SCH	$ 395.8500
177.6 MCG / VIAL INJECTION			
00002242968	UNITRON-PEG	SCH	$ 395.8500
222 MCG / VIAL INJECTION			
00002242969	UNITRON-PEG	SCH	$ 395.8500

PEGINTERFERON ALFA-2B/ RIBAVIRIN

"For the treatment of chronic hepatitis C in patients with evidence of active liver disease.

Prior to initiation of Pegetron therapy:

- To determine treatment duration and prognosis, HCV genotype testing is required for all patients.
- At least three (3) weeks before anticipated start date of therapy, please submit a Pegetron/Pegasys RBV Special Authorization Request Form (ABC 30932) along with appropriate lab results to Alberta Blue Cross.

All Patients (with the Exception of Post-Liver Transplant Patients and Advanced Fibrosis or Cirrhosis Patients):

Prior to initiation of Pegetron therapy:

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection must have a baseline serum sample stored for future viral load testing in the event that the week 12 HCV RNA test is positive.

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection, may receive an initial approval for 14 weeks of coverage.
- Genotype 2 or 3 patients may receive initial and maximal approval for 24 weeks of coverage. These patients will not be eligible for continued approval.
- Genotype 4, 5 and 6 patients may receive initial and maximal approval for 48 weeks of coverage. These patients will not be eligible for continued approval.

At 12 weeks of treatment:

- HCV RNA testing is required for all Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection at the 12th week of treatment.
- If the HCV RNA test is positive, viral load testing is required on the previously stored baseline serum sample and the 12th week serum sample for evaluation of continued coverage.

Renewal approval period (for patients meeting criteria):

- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection who respond to therapy as measured by a negative HCV RNA status at 12 weeks, may be approved for an additional 34 weeks of coverage (i.e. total 48 weeks).
- Genotype 1 patients and Genotype 2 or 3 patients with HIV co-infection who achieve a reduction in viral load by at least 2 logs (100 fold) but do not possess negative HCV RNA status at week 12 may be approved for an additional 14 weeks of coverage. Patients should be retested for HCV RNA status at 24 weeks:
- Patients who respond to therapy, as measured by a negative HCV RNA status at 24 weeks, may be approved for an additional 20 weeks of coverage (i.e. total 48 weeks).
- Those who fail to demonstrate negative HCV RNA status at 24 weeks will not be eligible for continued approval.

Post-Liver Transplant Patients:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Genotype 1 and Genotype 2 or 3 patients may receive an initial approval for 26 weeks of coverage.
- Genotype 4, 5 and 6 patients may receive initial and maximal approval for 48 weeks of coverage. These patients will not be eligible for continued approval.

PEGINTERFERON ALFA-2B/ RIBAVIRIN

At 24 weeks of treatment:

- HCV RNA testing is required for all Genotype 1 and Genotype 2 or 3 patients at the 24th week of treatment.

Renewal approval period (for patients meeting criteria):

- Genotype 1 and Genotype 2 or 3 patients who respond to therapy as measured by a negative HCV RNA status at 24 weeks, may be approved for an additional 22 weeks of coverage (i.e. total 48 weeks).
- Those who fail to demonstrate negative HCV RNA status at 24 weeks will not be eligible for continued approval.

Advanced Fibrosis or Cirrhosis Patients:

Initial Alberta Blue Cross approval periods (for patients meeting criteria):

- Patients with advanced fibrosis or cirrhosis may receive approval for 48 weeks of coverage.

Consideration for therapy in ALL patients (including post-liver transplant patients) who have previously received therapy:

- Consideration for therapy in patients who have previously received therapy may be given for patients who meet at least one of the following criteria:
- Advanced fibrosis or cirrhosis.
- Patients who have relapsed following non-pegylated interferon/ribavarin combination therapy.
- Patients who have failed to respond to or relapsed following interferon monotherapy."

Confirmation of the diagnosis of chronic hepatitis C and presence of active liver disease is required. Information must include the patient's pre-treatment anti-HCV and serum HCV RNA (by PCR) status. Information is also required regarding whether liver enzymes (ALT/AST) are elevated, or the results of liver biopsy. All requests for Pegasys RBV must be completed using the Pegetron/Pegasys RBV Special Authorization Request Form (ABC 30932). In order to meet the requirements of provincial privacy legislation, the patient's signature must be affixed to each completed form.

50 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246026	PEGETRON (KIT)	SCH	$ 752.2000
80 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246027	PEGETRON (KIT)	SCH	$ 752.2000
100 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246028	PEGETRON (KIT)	SCH	$ 752.2000
120 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246029	PEGETRON (KIT)	SCH	$ 831.1800
150 MCG * 200 MG INJECTION VIAL/CAPSULE			
00002246030	PEGETRON (KIT)	SCH	$ 831.1800
80 MCG * 200 MG INJECTION SYRINGE/CAPSULE			
00002254581	PEGETRON REDIPEN (KIT)	SCH	$ 752.2000
100 MCG * 200 MG INJECTION SYRINGE/CAPSULE			
00002254603	PEGETRON REDIPEN (KIT)	SCH	$ 752.2000
120 MCG * 200 MG INJECTION SYRINGE/CAPSULE			
00002254638	PEGETRON REDIPEN (KIT)	SCH	$ 831.1800
150 MCG * 200 MG INJECTION SYRINGE/CAPSULE			
00002254646	PEGETRON REDIPEN (KIT)	SCH	$ 831.1800

PIPERACILLIN SODIUM/ TAZOBACTAM SODIUM

For the treatment of:

1) "Second-line therapy of intra-abdominal sepsis where there are serious adverse events due to first-line therapy or documented failure of first-line therapy (e.g. ampicillin + gentamicin + metronidazole), as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy or

2) Second-line therapy of severe polymicrobial skin and skin structure infections (e.g. limb threatening diabetic foot) or

3) Therapy of severe ventilator-associated pneumonia where Pseudomonas and Staphylococcus aureus coverage is needed."

In order to comply with all of the above criteria, information is required regarding the type of infection and organisms involved. Also, where the criteria restrict coverage of the requested drug to non-first line therapy, information is required regarding previous first-line antibiotic therapy that has been utilized, the patient's response to therapy, and the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient.

2 G / VIAL (BASE) * 250 MG / VIAL (BASE) INJECTION				
00002170817	TAZOCIN	WAY	$	12.8162
3 G / VIAL (BASE) * 375 MG / VIAL (BASE) INJECTION				
00002170795	TAZOCIN	WAY	$	19.2242
4 G / VIAL (BASE) * 500 MG / VIAL (BASE) INJECTION				
00002170809	TAZOCIN	WAY	$	25.6334

QUINAGOLIDE

"For the treatment of hyperprolactinemia in patients who are intolerant to or who have failed bromocriptine. Special authorization may be granted for 24 months."

0.075 MG ORAL TABLET				
00002223767	NORPROLAC	FEI	$	1.1718
0.15 MG ORAL TABLET				
00002223775	NORPROLAC	FEI	$	1.7523

RALOXIFENE HCL

"For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures. Special authorization for this criteria may be granted for 24 months."

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a > 2% loss in bone mineral density in one year). Special authorization for this criteria may be granted for 24 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

60 MG ORAL TABLET				
00002239028	EVISTA	LIL	$	1.8724

RIFABUTIN

"For the prevention of disseminated Mycobacterium avium complex disease in patients with advanced HIV infection or other immunocompromised conditions."

150 MG ORAL CAPSULE				
00002063786	MYCOBUTIN	PFI	$	4.1925

RILUZOLE

"For use in patients who have probable or definite amyotrophic lateral sclerosis (ALS) as defined by World Federation of Neurology (WFN) criteria who have a vital capacity of >60% predicted and do not have a tracheostomy for invasive ventilation. This drug must be prescribed by a physician in the ALS Consortium."

"Patients who previously received Rilutek and were not eligible for the Phase IV study can also be considered for coverage if they meet the special authorization criteria."

"This listing is transitional pending the product receiving full Notice of Compliance (NOC) from Health Canada."

Coverage cannot be renewed once the patient has a tracheostomy for the purpose of invasive ventilation or has a vital capacity of <60% predicted.

50 MG ORAL TABLET				
00002242763	RILUTEK	SAV	$	9.8255

RISEDRONATE SODIUM

"For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures. Special authorization may be granted for 24 months."

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a > 2% loss in bone mineral density in one year). Special authorization for this criteria may be granted for 24 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

"For the treatment of Paget's disease. Special Authorization for this criteria may be granted to a maximum of 2 months. Renewal requests may be considered following an observation period of at least 2 months."

"Coverage cannot be provided for two or more medications used in the treatment of Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

5 MG ORAL TABLET				
00002242518	ACTONEL	PGA	$	1.8866
30 MG ORAL TABLET				
00002239146	ACTONEL	PGA	$	12.2227
35 MG ORAL TABLET				
00002246896	ACTONEL	PGA	$	10.0620

RIVASTIGMINE HYDROGEN TARTRATE

"For the treatment of Alzheimer's disease in patients with an MMSE (Mini Mental State Exam) score between 10-26."

"This drug must be initiated by a designated prescriber for new patients (individuals who have never taken the requested drug before or who have taken the drug for 60 days or less) with an MMSE score between 10-13 inclusive."

"Specialists in Geriatric Medicine, Neurology, and Psychiatry are deemed designated prescribers by virtue of their specialty in medical practice. All other practitioners will be added to the list of designated prescribers if they have successfully completed MAINPRO-C credits through the College of Family Practice (Physicians) [prior to March 31, 2006], the Care of the Elderly Six-month/One-year Fellowship Program through the Department of Family Medicine or the MAINPRO-M1 course entitled, "Module 2: Advanced Alzheimer's Disease."

"Coverage cannot be provided for two or more medications used in the treatment of Alzheimer's disease (donepezil, galantamine, rivastigmine) when these medications are intended for use in combination."

All requests (including renewal requests) for Exelon must be completed using the Aricept/Exelon/Reminyl ER Special Authorization Request Form (ABC 30776).

For each request, an updated MMSE score and the date on which the exam was administered must be provided. The MMSE score must be within 3 months of the time of the application (including renewal requests).

Renewal requests for patients where the updated MMSE score is greater than 26 while on this drug, may also be considered.

Initial special authorization for new patients may be granted for a maximum of 12 weeks. Continued special authorization coverage may be granted for a maximum of 12 months.

In order to be considered for coverage beyond the initial 12-week authorization, those patients with an MMSE score of 10 or higher may be eligible for continued coverage provided their MMSE score has not dropped by more than 3 points during the 12-week period.

1.5 MG (BASE) ORAL CAPSULE				
00002242115	EXELON	NOV	$	2.6278
3 MG (BASE) ORAL CAPSULE				
00002242116	EXELON	NOV	$	2.6278
4.5 MG (BASE) ORAL CAPSULE				
00002242117	EXELON	NOV	$	2.6278
6 MG (BASE) ORAL CAPSULE				
00002242118	EXELON	NOV	$	2.6278
2 MG / ML (BASE) ORAL SOLUTION				
00002245240	EXELON	NOV	$	1.4027

RIZATRIPTAN BENZOATE

(Refer to 28:92 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using rizatriptan benzoate prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

5 MG (BASE) ORAL TABLET				
00002240520	MAXALT	MFC	$	13.8717
10 MG (BASE) ORAL TABLET				
00002240521	MAXALT	MFC	$	13.8717
5 MG (BASE) ORAL WAFER				
00002240518	MAXALT RPD	MFC	$	13.8717
10 MG (BASE) ORAL WAFER				
00002240519	MAXALT RPD	MFC	$	13.8717

SOMATROPIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of a diagnostic insulin tolerance test. Growth hormone values less than 3 mcg/litre during hypoglycemia are indicative of severe growth hormone deficiency."

6 MG / VIAL INJECTION				
00002243077	HUMATROPE	LIL	$	301.0215
12 MG / VIAL INJECTION				
00002243078	HUMATROPE	LIL	$	602.0430

SOMATROPIN R-DNA ORIGIN

"For replacement of endogenous growth hormone in adults with severe growth hormone deficiency. Information is required regarding the results of a diagnostic insulin tolerance test. Growth hormone values less than 3 mcg/litre during hypoglycemia are indicative of severe growth hormone deficiency."

3.3 MG / VIAL INJECTION				
00002215136	SAIZEN	SRO	$	144.9000
5 MG / VIAL INJECTION				
00002237971	SAIZEN	SRO	$	217.5200
8.8 MG / VIAL INJECTION				
00002272083	SAIZEN	SRO	$	348.0300

SULFUR/ SULFACETAMIDE SODIUM

"For the treatment seborrheic dermatitis and bacterial folliculitis."

5 % * 10 % TOPICAL LOTION				
00002220407	SULFACET-R	DER	$	0.8987

SUMATRIPTAN HEMISULFATE

(Refer to 28:92 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using sumatriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

5 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230418	IMITREX	GSK	$	13.4283
20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230420	IMITREX	GSK	$	14.1474

SUMATRIPTAN SUCCINATE

(Refer to 28:92 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using sumatriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

50 MG (BASE) ORAL TABLET				
00002268388	**APO-SUMATRIPTAN**	**APX**	$	**9.0650**
00002257890	**CO SUMATRIPTAN**	**COB**	$	**9.0650**
00002268914	**GEN-SUMATRIPTAN**	**GPM**	$	**9.0650**
00002286823	**NOVO-SUMATRIPTAN DF**	**NOP**	$	**9.0650**
00002256436	**PMS-SUMATRIPTAN**	**PMS**	$	**9.0650**
00002271583	**RATIO-SUMATRIPTAN**	**RPH**	$	**9.0650**
00002263025	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**9.0650**
00002212153	IMITREX DF	GSK	$	14.1487
100 MG (BASE) ORAL TABLET				
00002268396	**APO-SUMATRIPTAN**	**APX**	$	**9.9867**
00002257904	**CO SUMATRIPTAN**	**COB**	$	**9.9867**
00002268922	**GEN-SUMATRIPTAN**	**GPM**	$	**9.9867**
00002239367	**NOVO-SUMATRIPTAN**	**NOP**	$	**9.9867**
00002286831	**NOVO-SUMATRIPTAN DF**	**NOP**	$	**9.9867**
00002256444	**PMS-SUMATRIPTAN**	**PMS**	$	**9.9867**
00002271591	**RATIO-SUMATRIPTAN**	**RPH**	$	**9.9867**
00002263033	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**9.9867**
00002212161	IMITREX DF	GSK	$	15.5860
6 MG / SYR (BASE) INJECTION SYRINGE				
00002212188	IMITREX (0.5 ML)	GSK	$	75.7044

SYNTHETIC CALCITONIN SALMON (SALCATONIN)

"For the treatment of osteoporosis in patients with documented evidence of intolerance or lack of response to etidronate (i.e. demonstrated as a >2% loss in bone mineral density in one year). Special authorization may be granted for 24 months."

"Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when these medications are intended for use as combination therapy."

200 IU / DOSE NASAL METERED DOSE SPRAY

00002247585	**APO-CALCITONIN**	**APX**	$	**1.7254**
00002261766	**SANDOZ CALCITONIN NS**	**SDZ**	$	**1.7254**
00002240775	MIACALCIN	NOV	$	1.9765

TACROLIMUS

"For use in patients 16 years of age and older with atopic dermatitis affecting face and flexures who are unable to tolerate or have failed topical steroid therapy."

"For use in patients 16 years of age and older with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids over greater than 30 % of body surface area."

"Special authorization for all criteria may be granted for 24 months."

Information is required regarding the patient's diagnosis, previous medications utilized (including specific topical steroids) and the patient's response to therapy. In order to comply with the first criteria, information is also required regarding the area(s) affected. In order to comply with the second criteria, information is also required regarding the percentage body surface area affected.

0.1 % TOPICAL OINTMENT

00002244148	PROTOPIC	ASP	$	2.4730

TACROLIMUS

"For use in patients 2 to 15 years of age inclusive with atopic dermatitis who are unable to tolerate or have failed topical steroid therapy."

"For use in patients 2 to 15 years of age inclusive with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids."

"For use in patients 16 years of age and older with atopic dermatitis affecting face and flexures who are unable to tolerate or have failed topical steroid therapy."

"For use in patients 16 years of age and older with atopic dermatitis who require ongoing use of potent (Class 3 or higher) topical steroids over greater than 30 % of body surface area."

"Special authorization for all criteria may be granted for 24 months."

Information is required regarding the patient's diagnosis, previous medications utilized (including specific topical steroids) and the patient's response to therapy. In order to comply with the third criteria, information is also required regarding the area(s) affected. In order to comply with the fourth criteria, information is also required regarding the percentage body surface area affected.

0.03 % TOPICAL OINTMENT

00002244149	PROTOPIC	ASP	$	2.3110

TELITHROMYCIN

"For the treatment of:

1) Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy or

2) Acute exacerbation of chronic bronchitis after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy."

In order to comply with the above criteria, information is required regarding the type of infection and organisms involved, previous antibiotic therapy that has been utilized and the patient's response to therapy. Information is also required regarding the first line agents the organism is resistant to or why other first-line therapies cannot be used in this patient.

400 MG ORAL TABLET

00002247520	KETEK	SAV	$	3.4217

TESTOSTERONE

"For use in males for the treatment of congenital and acquired primary and secondary hypogonadism."

"Coverage cannot be considered when used for the treatment of androgen decline in the aging male (ADAM)."

"Special authorization may be granted for 12 months."

12.2 MG TRANSDERMAL PATCH

00002239653	ANDRODERM (2.5 MG/DAY)	PAL	$	1.8800

24.3 MG TRANSDERMAL PATCH

00002245972	ANDRODERM (5 MG/DAY)	PAL	$	3.7600

TESTOSTERONE UNDECANOATE

"For use in males for the treatment of congenital and acquired primary and secondary hypogonadism."

"Coverage cannot be considered when used for the treatment of androgen decline in the aging male (ADAM)."

"Special authorization may be granted for 12 months."

40 MG ORAL CAPSULE

00000782327	ANDRIOL	ORG	$	0.9400

TETRABENAZINE

"For the treatment of hyperkinetic movement disorders when prescribed by specialists in Neurology, Psychiatry, or Geriatric Medicine."

25 MG ORAL TABLET

00002199270	NITOMAN	PRW	$	6.4500

TIZANIDINE HCL

"For the treatment of spasticity in patients with documented evidence of intolerance or lack of response to diazepam or baclofen. Special authorization is granted for 24 months."

4 MG (BASE) ORAL TABLET

00002259893	**APO-TIZANIDINE**	**APX**	$	**0.5106**
00002272059	**GEN-TIZANIDINE**	**GPM**	$	**0.5106**
00002239170	ZANAFLEX	SHB	$	0.6946

TOLTERODINE L-TARTRATE

"For patients who are intolerant to oxybutynin."

"Special authorization may be granted for 24 months."

2 MG ORAL EXTENDED-RELEASE CAPSULE

00002244612	DETROL LA	PFI	$	1.9567

4 MG ORAL EXTENDED-RELEASE CAPSULE

00002244613	DETROL LA	PFI	$	1.9567

TRETINOIN

"For the treatment of severe acne as defined by scarring acne."

0.01 % TOPICAL CREAM

00000657204	STIEVA-A	STI	$	0.3053
00001926497	VITAMIN A ACID	SAV	$	0.3053
00000897329	RETIN-A	JOI	$	0.3827

0.025 % TOPICAL CREAM

00000578576	STIEVA-A	STI	$	0.3053
00001926500	VITAMIN A ACID	SAV	$	0.3053
00000897310	RETIN-A	JOI	$	0.3827

0.05 % TOPICAL CREAM

✉ 00000518182	STIEVA-A	STI	$	0.3053
00001926519	VITAMIN A ACID	SAV	$	0.3053
00000443794	RETIN-A	JOI	$	0.3712

0.1 % TOPICAL CREAM

00000662348	STIEVA-A FORTE	STI	$	0.3053
00001926527	VITAMIN A ACID	SAV	$	0.3053
00000870021	RETIN-A	JOI	$	0.3827

0.025 % TOPICAL SOLUTION

00000578568	STIEVA-A	STI	$	0.1914

TRETINOIN

0.01 % TOPICAL GEL

00001926462	VITAMIN A ACID	SAV	$	0.3053
00000870013	RETIN-A	JOI	$	0.3712

0.025 % TOPICAL GEL

00000587966	STIEVA-A	STI	$	0.3053
00001926470	VITAMIN A ACID	SAV	$	0.3053
00000443816	RETIN-A	JOI	$	0.3712

0.05 % TOPICAL GEL

00000641863	**STIEVA-A**	**STI**	$	**0.3053**
00001926489	**VITAMIN A ACID**	**SAV**	$	**0.3053**

TROSPIUM CHLORIDE

"For patients who are intolerant to oxybutynin."

"Special authorization may be granted for 24 months."

20 MG ORAL TABLET

00002275066	TROSEC	ORY	$	0.8063

VALGANCICLOVIR

"For the treatment of cytomegalovirus (CMV) retinitis in patients with acquired immunodeficiency syndrome (AIDS)."
"Special authorization may be granted for 12 months."

"For the prevention of CMV disease in solid organ transplant patients at risk (i.e. risk is defined as donor +ve/recipient -ve for CMV or recipient +ve post-active treatment of CMV disease with IV ganciclovir)."
"Special authorization may be granted for 100 days."

450 MG ORAL TABLET

00002245777	VALCYTE	HLR	$	24.0908

VANCOMYCIN HCL

"For the treatment of:

1) Clostridium difficile enteritis if there is clinical deterioration or documented failure on metronidazole therapy. Documented failure is defined as no clinical improvement after 5 days of therapy or

2) Laboratory confirmed relapse of Clostridium difficile enteritis with symptoms after 2 courses of metronidazole therapy or

3) Clostridium difficile enteritis if there is documented or impending toxic megacolon or

4) Clostridium difficile enteritis if there is intolerance or side effects to metronidazole therapy."

125 MG (BASE) ORAL CAPSULE

00000800430	VANCOCIN	LIL	$	7.6341

250 MG (BASE) ORAL CAPSULE

00000788716	VANCOCIN	LIL	$	15.2677

VORICONAZOLE

"For the treatment of invasive aspergillosis for post-hospital discharge only."

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

"This medication must be prescribed in consultation with a specialist in Infectious Diseases."

50 MG ORAL TABLET				
00002256460	VFEND	PFI	$	12.7710
200 MG ORAL TABLET				
00002256479	VFEND	PFI	$	51.0627
200 MG / VIAL INJECTION				
00002256487	VFEND	PFI	$	150.5000

ZAFIRLUKAST

(Refer to 92:00 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 12 to 18 years of age inclusive).

"For the prophylaxis and chronic treatment of asthma in patients over the age of 18 who meet one of the following criteria:

a) when used as adjunctive therapy in patients who do not respond adequately to high doses of inhaled glucocorticosteroids and long-acting beta 2 agonists. Patients must be unable to use long-acting beta 2 agonists or have demonstrated persistent symptoms while on long-acting beta 2 agonists, or

b) cannot operate inhaler devices."

"For the prophylaxis of exercise-induced bronchoconstriction in patients over the age of 18 where tachyphylaxis exists for long-acting beta 2 agonists."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information should indicate either a) current use of inhaled steroids and contraindications or poor response to long-acting beta 2 agonists (e.g. salmeterol or formoterol) or b) the nature of the patient's difficulties with using inhaler devices. In order to comply with the second criteria, information should include the nature of the patient's response to long-acting beta 2 agonists (e.g. salmeterol or formoterol).

20 MG ORAL TABLET				
00002236606	ACCOLATE	AZC	$	0.7208

ZOLEDRONIC ACID

"For the treatment of Paget's disease. Special Authorization for this criterion may be granted for one dose per 12 month period."

"Coverage cannot be provided for two or more medications used in the treatment of Paget's disease when these medications are intended for use in combination or when therapy with two or more medications overlap."

0.05 MG / ML INJECTION				
00002269198	ACLASTA	NOV	$	6.9338

ZOLEDRONIC ACID

"For the treatment of tumor-induced hypercalcemia in patients with documented evidence of intolerance or lack of response to clodronate or pamidronate. Special authorization may be granted for 24 months."

0.8 MG / ML INJECTION				
00002248296	ZOMETA CONCENTRATE	NOV	$	558.7313

ZOLMITRIPTAN

(Refer to 28:92 of the Alberta Health and Wellness Drug Benefit List for coverage of patients 18 to 64 years of age inclusive.)

"For the treatment of acute migraine attacks in patients 65 years of age and older where other standard therapy has failed."

"For the treatment of acute migraine attacks in patients 65 years of age and older who have been using zolmitriptan prior to turning 65."

"Special authorization for both criteria may be granted for 24 months."

In order to comply with the first criteria, information is required regarding previous medications utilized and the patient's response to therapy.

2.5 MG ORAL TABLET				
00002238660	ZOMIG	AZC	$	13.3333
2.5 MG ORAL DISPERSIBLE TABLET				
00002243045	ZOMIG RAPIMELT	AZC	$	13.3400
5 MG / DOSE NASAL UNIT DOSE SPRAY				
00002248993	ZOMIG	AZC	$	13.3333

SECTION 3A

Criteria for Optional Special Authorization of Select Drug Products

ALBERTA GOVERNMENT SPONSORED DRUG BENEFIT PROGRAMS
OPTIONAL SPECIAL AUTHORIZATION

REGISTRATION FOR DESIGNATED PRESCRIBER STATUS
for *Alberta Health and Wellness Drug Benefit List* Claim Coverage

Select Quinolone Antibiotics
ciprofloxacin, gatifloxacin, levofloxacin, moxifloxacin, ofloxacin

Please complete all sections of this form
and return it by fax to Alberta Blue Cross

Registrations will be accepted on an ongoing basis

PRESCRIBER SURNAME	FIRST NAME	INITIAL	OFFICE PHONE:	FAX:

OFFICE ADDRESS	CITY	PROVINCE	POSTAL CODE

COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO.
OR PROFESSIONAL REGISTRATION NO.

I have reviewed the criteria for coverage of select quinolone products, and I agree to abide by and only prescribe in accordance with such criteria as updated from time to time in the Optional Special Authorization section of the *Alberta Health and Wellness Drug Benefit List*.

SIGNATURE OF PRESCRIBER (required): ✗ _____ **DATE:** _____

This information is collected and will be used pursuant to Sections 22 and 27 of the Health Information Act, for coverage under the *Alberta Health and Wellness Drug Benefit List*; program evaluation; research and management; and monitoring compliance with coverage criteria.

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-305-9911

ABC 81897 Reg Form RVSD (2006/01)

CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

The drug products listed in this section may be considered for coverage by optional special authorization for patients covered under Alberta Health and Wellness-sponsored drug programs. (For Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients, the optional special authorization criteria for coverage can be found in the Criteria for Optional Special Authorization of Select Drug Products section of the *Alberta Employment, Immigration and Industry Drug Benefit Supplement*.)

Criteria for Coverage

Wording that appears within quotation marks (" ") in this section is the official optional special authorization criteria, as recommended by the Alberta Health and Wellness Expert Committee on Drug Evaluation and Therapeutics, and approved by the Minister of Health and Wellness. Wording that is not enclosed in quotation marks outlines specific information required to interpret criteria, guidelines for submitting requests and/or information regarding conditions under which coverage cannot be provided.

Role of the Prescribers

In conjunction with the criteria, prescribers have two options by which patients may be eligible for coverage of these select optional special authorization drug products.

1) Prescribers can register to be a *designated prescriber*. Registration allows for patients to receive coverage of select drug products **without special authorization** as long as the prescription is written for one of the criteria for coverage set out in this section. Should a designated prescriber wish to prescribe one of the select drug products outside the coverage criteria, they may do so but must indicate this on the prescription; however, patients will not be eligible for payment under the Alberta government-sponsored program for such prescription and the patient may choose to receive the product at their expense. The registration form may be found on the previous page.

2) Prescribers who choose not to register will be considered *non-designated prescribers*. Such prescribers **will be required to apply for special authorization** on the patient's behalf.

Select Quinolones

Patient claims for select quinolone prescriptions written by a non-designated prescriber will be subject to a first forgiveness rule, meaning the first claim will be paid. Subsequent claims for the same product (irrespective of strength, route and form) within a 90-day period would require the prescriber to apply for special authorization for coverage on the patient's behalf.

CIPROFLOXACIN

"To be prescribed according to ONE of the following criteria:

For the treatment of:

1) Respiratory Tract Infections:
- end stage COPD with or without bronchiectasis, where there has been documentation of previous Pseudomonas aeruginosa colonization/infection; or
- pneumonic illness in cystic fibrosis; or

2) Genitourinary Tract Infections:
- urinary tract infections; or
- prostatitis; or
- prophylaxis of urinary tract surgical procedures; or
- gonococcal infections; or

3) Skin and Soft Tissue/Bone and Joint Infections:
- malignant/invasive otitis externa; or
- bone/joint infections due to gram negative organisms or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. diabetic foot infection, decubitus ulcers; or

4) Gastrointestinal Tract Infections:
- bacterial gastroenteritis where antimicrobial therapy is indicated; or
- typhoid fever (enteric fever), or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. intra-abdominal infections; or

5) Other:
- prophylaxis of adult contacts of cases of invasive meningococcal disease; or
- therapy/step-down therapy of hospital acquired gram negative infections; or
- empiric therapy of febrile neutropenia in combination with other appropriate agents; or
- exceptional case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references i.e. AMA CPGs or Bugs and Drugs; or
- for use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for ciprofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

100 MG / ML ORAL SUSPENSION				
00002237514	CIPRO	BAI	$	0.5827
2 MG / ML INJECTION				
00002237334	CIPRO IV MINIBAGS	BAI	$	0.1774

CIPROFLOXACIN HCL

"To be prescribed according to ONE of the following criteria:

For the treatment of:

1) Respiratory Tract Infections:
- end stage COPD with or without bronchiectasis, where there has been documentation of previous Pseudomonas aeruginosa colonization/infection or
- pneumonic illness in cystic fibrosis; or

2) Genitourinary Tract Infections:
- urinary tract infections; or
- prostatitis;or
- prophylaxis of urinary tract surgical procedures or
- gonococcal infections; or

3) Skin and Soft Tissue/Bone and Joint Infections:
- malignant/invasive otitis externa; or
- bone/joint infections due to gram negative organisms; or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. diabetic foot infection, decubitus ulcers; or

4) Gastrointestinal Tract Infections:
- bacterial gastroenteritis where antimicrobial therapy is indicated; or
- typhoid fever (enteric fever), or
- therapy/step-down therapy of polymicrobial infections in combination with clindamycin or metronidazole e.g. intra-abdominal infections; or

5) Other:
- prophylaxis of adult contacts of cases of invasive meningococcal disease,
- therapy/step-down therapy of hospital acquired gram negative infections,
- empiric therapy of febrile neutropenia in combination with other appropriate agents or
- exceptional case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references i.e. AMA CPGs or Bugs and Drugs; or
- for use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for ciprofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

250 MG (BASE) ORAL TABLET

00002229521	**APO-CIPROFLOX**	**APX**	**$**	**1.3992**
00002245647	**GEN-CIPROFLOXACIN**	**GPM**	**$**	**1.3992**
00002161737	**NOVO-CIPROFLOXACIN**	**NOP**	**$**	**1.3992**
00002248437	**PMS-CIPROFLOXACIN**	**PMS**	**$**	**1.3992**
00002267934	**RAN-CIPROFLOXACIN**	**RAN**	**$**	**1.3992**
00002246825	**RATIO-CIPROFLOXACIN**	**RPH**	**$**	**1.3992**
00002248756	**SANDOZ CIPROFLOXACIN**	**SDZ**	**$**	**1.3992**
00002266962	**TARO-CIPROFLOXACIN**	**TAR**	**$**	**1.3992**
00002247339	CO CIPROFLOXACIN	COB	$	1.5547
00002155958	CIPRO	BAI	$	2.5824

CIPROFLOXACIN HCL

500 MG (BASE) ORAL TABLET				
00002229522	**APO-CIPROFLOX**	**APX**	**$**	**1.5786**
00002245648	**GEN-CIPROFLOXACIN**	**GPM**	**$**	**1.5786**
00002161745	**NOVO-CIPROFLOXACIN**	**NOP**	**$**	**1.5786**
00002248438	**PMS-CIPROFLOXACIN**	**PMS**	**$**	**1.5786**
00002267942	**RAN-CIPROFLOXACIN**	**RAN**	**$**	**1.5786**
00002246826	**RATIO-CIPROFLOXACIN**	**RPH**	**$**	**1.5786**
00002248757	**SANDOZ CIPROFLOXACIN**	**SDZ**	**$**	**1.5786**
00002266970	**TARO-CIPROFLOXACIN**	**TAR**	**$**	**1.5786**
00002247340	CO CIPROFLOXACIN	COB	$	1.7540
00002155966	CIPRO	BAI	$	2.9135
750 MG (BASE) ORAL TABLET				
00002229523	**APO-CIPROFLOX**	**APX**	**$**	**2.9774**
00002245649	**GEN-CIPROFLOXACIN**	**GPM**	**$**	**2.9774**
00002161753	**NOVO-CIPROFLOXACIN**	**NOP**	**$**	**2.9774**
00002248439	**PMS-CIPROFLOXACIN**	**PMS**	**$**	**2.9774**
00002267950	**RAN-CIPROFLOXACIN**	**RAN**	**$**	**2.9774**
00002246827	**RATIO-CIPROFLOXACIN**	**RPH**	**$**	**2.9774**
00002248758	**SANDOZ CIPROFLOXACIN**	**SDZ**	**$**	**2.9774**
00002247341	CO CIPROFLOXACIN	COB	$	3.3082
00002155974	CIPRO	BAI	$	5.4952

LEVOFLOXACIN

"To be prescribed according to ONE of the following criteria:

For the treatment of:

1) Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

2) Community acquired pneumonia in patients with co-morbidities (asthma, lung cancer, COPD, diabetes, alcoholism, chronic renal or liver failure, CHF, chronic corticosteroid use, malnutrition or acute weight loss, hospitalization within previous 3 months, HIV/AIDS, smoking); or

3) Acute exacerbation of chronic bronchitis after failure of first and second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

4) Acute sinusitis after failure of first line therapy, as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy, in patients with beta-lactam (penicillin and cephalosporin) allergy.

5) For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for levofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

250 MG ORAL TABLET				
00002236841	LEVAQUIN	JOI	$	4.9401
500 MG ORAL TABLET				
00002236842	LEVAQUIN	JOI	$	5.5743

MOXIFLOXACIN HCL

"To be prescribed according to ONE of the following criteria:

For the treatment of:

1) Community acquired pneumonia after failure of first line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

2) Community acquired pneumonia in patients with co-morbidities (asthma, lung cancer, COPD, diabetes, alcoholism, chronic renal or liver failure, CHF, chronic corticosteroid use, malnutrition or acute weight loss, hospitalization within previous 3 months, HIV/AIDS, smoking); or

3) Acute exacerbation of chronic bronchitis after failure of first and second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy; or

4) Acute sinusitis after failure of first line therapy, as defined by clinical deterioration after 72 h of antibiotic therapy or lack of improvement after completion of antibiotic therapy, in patients with beta-lactam (penicillin and cephalosporin) allergy.

5) For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for moxifloxacin HCl must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

400 MG ORAL TABLET				
00002242965	AVELOX	BAI	$	5.8280

OFLOXACIN

"To be prescribed according to ONE of the following criteria:

For the treatment of:

1) Pelvic inflammatory disease; or

2) Epididymo-orchitis/epididymitis most likely due to enteric organisms; or

3) Chlamydia infection; or

4) Gonococcal infection."

5) For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases."

All requests for ofloxacin must be completed using the Select Quinolones Special Authorization Request Form (ABC 30966).

200 MG ORAL TABLET				
00002231529	**APO-OFLOX**	**APX**	**$**	**1.3041**
00002243474	**NOVO-OFLOXACIN**	**NOP**	**$**	**1.3041**
300 MG ORAL TABLET				
00002231531	**APO-OFLOX**	**APX**	**$**	**1.5323**
00002243475	**NOVO-OFLOXACIN**	**NOP**	**$**	**1.5323**
400 MG ORAL TABLET				
00002231532	**APO-OFLOX**	**APX**	**$**	**1.5323**
00002243476	**NOVO-OFLOXACIN**	**NOP**	**$**	**1.5323**

PART 2

Pharmacologic – Therapeutic Classification of Drugs

04:00 ANTIHISTAMINES

04:00

DIPHENHYDRAMINE HCL

50 MG / ML INJECTION

00000878200	PMS-DIPHENHYDRAMINE	PMS	$	1.1500
00000596612	DIPHENHYDRAMINE	SDZ	$	3.3230

PROMETHAZINE HCL

25 MG / ML (BASE) INJECTION

00000567434	PROMETHAZINE	SDZ	$	0.8410

TRIMEPRAZINE TARTRATE

2.5 MG (BASE) ORAL TABLET

00001926306	PANECTYL	ERF	$	0.2580

5 MG (BASE) ORAL TABLET

00001926292	PANECTYL	ERF	$	0.3225

08:00 ANTI-INFECTIVE AGENTS

08:04 AMEBICIDES

IODOQUINOL

210 MG ORAL TABLET				
00001997769	DIODOQUIN	GLE	$	0.6732
650 MG ORAL TABLET				
00001997750	DIODOQUIN	GLE	$	0.8355

08:00 ANTI-INFECTIVE AGENTS

08:08 ANTHELMINTICS

MEBENDAZOLE

100 MG ORAL CHEWABLE TABLET				
00000556734	VERMOX	JOI	$	3.4185

08:00 ANTI-INFECTIVE AGENTS

08:12:02 ANTIBIOTICS (AMINOGLYCOSIDES)

GENTAMICIN SULFATE

40 MG / ML (BASE) INJECTION				
00002242652	GENTAMICIN	SDZ	$	2.3485

TOBRAMYCIN SULFATE

60 MG / ML (BASE) INHALATION SOLUTION				
00002239630	TOBI	NOV	$	10.8844
10 MG / ML (BASE) INJECTION				
00002241209	TOBRAMYCIN	SDZ	$	1.7850
40 MG / ML (BASE) INJECTION				
00002241210	TOBRAMYCIN	SDZ	$	2.5300

08:00 ANTI-INFECTIVE AGENTS

08:12:04 ANTIBIOTICS (ANTIFUNGAL ANTIBIOTICS)

AMPHOTERICIN B

50 MG / VIAL INJECTION				
00000029149	FUNGIZONE IV	BMS	$	66.6720

FLUCONAZOLE

50 MG ORAL TABLET				
00002237370	**APO-FLUCONAZOLE**	**APX**	$	**3.1266**
00002245292	**GEN-FLUCONAZOLE**	**GPM**	$	**3.1266**
00002236978	**NOVO-FLUCONAZOLE**	**NOP**	$	**3.1266**
00002245643	**PMS-FLUCONAZOLE**	**PMS**	$	**3.1266**
100 MG ORAL TABLET				
00002237371	**APO-FLUCONAZOLE**	**APX**	$	**5.5466**
00002245293	**GEN-FLUCONAZOLE**	**GPM**	$	**5.5466**
00002236979	**NOVO-FLUCONAZOLE**	**NOP**	$	**5.5466**
00002245644	**PMS-FLUCONAZOLE**	**PMS**	$	**5.5466**

08:00 ANTI-INFECTIVE AGENTS

08:12:04 ANTIBIOTICS
(ANTIFUNGAL ANTIBIOTICS)

FLUCONAZOLE				
150 MG ORAL CAPSULE				
00002241895	**APO-FLUCONAZOLE-150**	**APX**	$	**9.1850**
00002245697	GEN-FLUCONAZOLE	GPM	$	9.1900
00002243645	NOVO-FLUCONAZOLE-150	NOP	$	9.1900
00002282348	PMS-FLUCONAZOLE	PMS	$	9.1900
00002141442	DIFLUCAN	PFI	$	15.6485
2 MG / ML INJECTION				
00002247749	**FLUCONAZOLE OMEGA**	**OMG**	$	**0.3977**
00002247922	FLUCONAZOLE	NOP	$	0.4630
00000891835	DIFLUCAN	PFI	$	0.5691
ITRACONAZOLE				
100 MG ORAL CAPSULE				
00002047454	SPORANOX	JOI	$	4.0501
KETOCONAZOLE				
200 MG ORAL TABLET				
00002237235	**APO-KETOCONAZOLE**	**APX**	$	**1.1835**
00002231061	**NOVO-KETOCONAZOLE**	**NOP**	$	**1.1835**
00002122197	**NU-KETOCON**	**NXP**	$	**1.1835**
NYSTATIN				
500,000 UNIT ORAL TABLET				
00002194198	RATIO-NYSTATIN	RPH	$	0.2400
100,000 UNIT / ML ORAL SUSPENSION				
00000792667	**PMS-NYSTATIN**	**PMS**	$	**0.0521**
00002194201	**RATIO-NYSTATIN**	**RPH**	$	**0.0521**
TERBINAFINE HCL				
250 MG (BASE) ORAL TABLET				
00002239893	**APO-TERBINAFINE**	**APX**	$	**2.5243**
00002254727	**CO TERBINAFINE**	**COB**	$	**2.5243**
00002240346	**NOVO-TERBINAFINE**	**NOP**	$	**2.5243**
00002262177	**SANDOZ TERBINAFINE**	**SDZ**	$	**2.5243**
00002242503	GEN-TERBINAFINE	GPM	$	2.5245
00002240807	PMS-TERBINAFINE	PMS	$	2.5245
00002031116	LAMISIL	NOV	$	4.5734

08:00 ANTI-INFECTIVE AGENTS

08:12:06 ANTIBIOTICS
(CEPHALOSPORINS)

CEFAZOLIN SODIUM				
500 MG / VIAL (BASE) INJECTION				
00002108119	STERILE CEFAZOLIN SODIUM	NOP	$	4.0000
1 G / VIAL (BASE) INJECTION				
00002108127	STERILE CEFAZOLIN SODIUM	NOP	$	6.0000
10 G / VIAL (BASE) INJECTION				
00002108135	STERILE CEFAZOLIN SODIUM	NOP	$	56.0000

08:00 ANTI-INFECTIVE AGENTS

08:12:06 ANTIBIOTICS (CEPHALOSPORINS)

CEFIXIME

400 MG ORAL TABLET				
00000868981	SUPRAX	AVE	$	3.7657
20 MG / ML ORAL SUSPENSION				
00000868965	SUPRAX	AVE	$	0.4036

CEFOTAXIME SODIUM

500 MG / VIAL (BASE) INJECTION				
00002225085	CLAFORAN	SAV	$	6.4500
1 G / VIAL (BASE) INJECTION				
00002225093	CLAFORAN	SAV	$	9.8900
2 G / VIAL (BASE) INJECTION				
00002225107	CLAFORAN	SAV	$	19.7800

CEFPROZIL

250 MG ORAL TABLET				
00002292998	**APO-CEFPROZIL**	**APX**	$	**1.1329**
00002293528	**RAN-CEFPROZIL**	**RAN**	$	**1.1329**
00002163659	CEFZIL	BMS	$	1.6491
500 MG ORAL TABLET				
00002293005	**APO-CEFPROZIL**	**APX**	$	**2.2214**
00002293536	**RAN-CEFPROZIL**	**RAN**	$	**2.2214**
00002163667	CEFZIL	BMS	$	3.2337
25 MG / ML ORAL SUSPENSION				
00002293943	**APO-CEFPROZIL**	**APX**	$	**0.1107**
00002163675	CEFZIL	BMS	$	0.1611
50 MG / ML ORAL SUSPENSION				
00002293951	**APO-CEFPROZIL**	**APX**	$	**0.2213**
00002293579	**RAN-CEFPROZIL**	**RAN**	$	**0.2213**
00002163683	CEFZIL	BMS	$	0.3222

CEFTAZIDIME

1 G / VIAL INJECTION				
00002212218	FORTAZ	GSK	$	21.5291
2 G / VIAL INJECTION				
00002212226	FORTAZ	GSK	$	42.3290
6 G / VIAL INJECTION				
00002212234	FORTAZ	GSK	$	127.0490

CEFTRIAXONE SODIUM

0.25 G / VIAL (BASE) INJECTION				
00000657387	ROCEPHIN	HLR	$	11.8950
1 G / VIAL (BASE) INJECTION				
00002292270	**CEFTRIAXONE FOR INJECTION USP**	**SDZ**	$	**23.8000**
00000657417	ROCEPHIN	HLR	$	37.6250
2 G / VIAL (BASE) INJECTION				
00002292289	CEFTRIAXONE FOR INJECTION USP	SDZ	$	46.9000
10 G / VIAL (BASE) INJECTION				
00000851957	ROCEPHIN	HLR	$	328.9500

08:00 ANTI-INFECTIVE AGENTS

08:12:06 ANTIBIOTICS
(CEPHALOSPORINS)

CEFUROXIME AXETIL

250 MG (BASE) ORAL TABLET				
00002244393	**APO-CEFUROXIME**	**APX**	$	**1.0131**
00002242656	RATIO-CEFUROXIME	RPH	$	1.0132
00002212277	CEFTIN	GSK	$	1.5428
500 MG (BASE) ORAL TABLET				
00002244394	**APO-CEFUROXIME**	**APX**	$	**2.0071**
00002242657	RATIO-CEFUROXIME	RPH	$	2.0072
00002212285	CEFTIN	GSK	$	3.0563

CEPHALEXIN

250 MG ORAL TABLET				
00000768723	**APO-CEPHALEX**	**APX**	$	**0.1493**
00000583413	**NOVO-LEXIN**	**NOP**	$	**0.1493**
00000865877	**NU-CEPHALEX**	**NXP**	$	**0.1493**
500 MG ORAL TABLET				
00000768715	**APO-CEPHALEX**	**APX**	$	**0.2986**
00000583421	**NOVO-LEXIN**	**NOP**	$	**0.2986**
00000865885	**NU-CEPHALEX**	**NXP**	$	**0.2986**
250 MG ORAL CAPSULE				
00000342084	NOVO-LEXIN	NOP	$	0.1493
500 MG ORAL CAPSULE				
00000342114	NOVO-LEXIN	NOP	$	0.2986
25 MG / ML ORAL SUSPENSION				
00000342106	NOVO-LEXIN	NOP	$	0.0323
50 MG / ML ORAL SUSPENSION				
00000342092	NOVO-LEXIN	NOP	$	0.0655

08:00 ANTI-INFECTIVE AGENTS

08:12:08 ANTIBIOTICS
(CHLORAMPHENICOL)

CHLORAMPHENICOL SODIUM SUCCINATE

1 G / VIAL (BASE) INJECTION				
00000312363	CHLOROMYCETIN	ERF	$	13.3750

08:00 ANTI-INFECTIVE AGENTS

08:12:12 ANTIBIOTICS (MACROLIDES)

AZITHROMYCIN

250 MG ORAL TABLET				
00002247423	**APO-AZITHROMYCIN**	**APX**	$	**3.1083**
00002255340	**CO AZITHROMYCIN**	**COB**	$	**3.1083**
00002278359	**GEN-AZITHROMYCIN**	**GPM**	$	**3.1083**
00002267845	**NOVO-AZITHROMYCIN**	**NOP**	$	**3.1083**
00002261634	**PMS-AZITHROMYCIN**	**PMS**	$	**3.1083**
00002275287	**RATIO-AZITHROMYCIN**	**RPH**	$	**3.1083**
00002265826	**SANDOZ AZITHROMYCIN**	**SDZ**	$	**3.1083**
00002212021	ZITHROMAX	PFI	$	5.2947
20 MG / ML ORAL SUSPENSION				
00002274388	**PMS-AZITHROMYCIN**	**PMS**	$	**0.7467**
00002223716	ZITHROMAX	PFI	$	1.1447
40 MG / ML ORAL SUSPENSION				
00002274396	**PMS-AZITHROMYCIN**	**PMS**	$	**1.0580**
00002223724	ZITHROMAX	PFI	$	1.6220

CLARITHROMYCIN

250 MG ORAL TABLET				
00001984853	BIAXIN BID	ABB	$	1.6035
500 MG ORAL TABLET				
00002126710	BIAXIN BID	ABB	$	3.1819
500 MG ORAL EXTENDED-RELEASE TABLET				
00002244756	BIAXIN XL	ABB	$	2.5144
25 MG / ML ORAL SUSPENSION				
00002146908	BIAXIN	ABB	$	0.2786
50 MG / ML ORAL SUSPENSION				
00002244641	BIAXIN	ABB	$	0.5572

ERYTHROMYCIN

250 MG ORAL TABLET				
00000682020	APO-ERYTHRO BASE	APX	$	0.1786
250 MG ORAL CAPSULE (ENTERIC-COATED PELLET)				
00000726672	**APO-ERYTHRO E-C**	**APX**	$	**0.3810**
00000607142	ERYC	PFI	$	0.5176
333 MG ORAL CAPSULE (ENTERIC-COATED PELLET)				
00001925938	**APO-ERYTHRO E-C**	**APX**	$	**0.4232**
00000873454	ERYC	PFI	$	0.5750

ERYTHROMYCIN ESTOLATE

25 MG / ML (BASE) ORAL SUSPENSION				
00000021172	NOVO-RYTHRO ESTOLATE	NOP	$	0.0368
50 MG / ML (BASE) ORAL SUSPENSION				
00000262595	NOVO-RYTHRO ESTOLATE	NOP	$	0.0713

ERYTHROMYCIN ETHYLSUCCINATE

600 MG (BASE) ORAL TABLET				
00000637416	APO-ERYTHRO-ES	APX	$	0.3248
40 MG / ML (BASE) ORAL SUSPENSION				
00000605859	NOVO-RYTHRO EES	NOP	$	0.0674
80 MG / ML (BASE) ORAL SUSPENSION				
00000652318	NOVO-RYTHRO EES	NOP	$	0.1044

08:00 ANTI-INFECTIVE AGENTS

08:12:12 ANTIBIOTICS (MACROLIDES)

ERYTHROMYCIN STEARATE

250 MG ORAL TABLET				
00000545678	APO-ERYTHRO-S	APX	$	0.2069
500 MG ORAL TABLET				
00000688568	APO-ERYTHRO-S	APX	$	0.5300

08:00 ANTI-INFECTIVE AGENTS

08:12:16 ANTIBIOTICS (PENICILLINS)

AMOXICILLIN TRIHYDRATE

125 MG (BASE) ORAL CHEWABLE TABLET				
00002036347	NOVAMOXIN	NOP	$	0.2315
250 MG (BASE) ORAL CHEWABLE TABLET				
00002036355	NOVAMOXIN	NOP	$	0.3410
250 MG (BASE) ORAL CAPSULE				
00000628115	**APO-AMOXI**	**APX**	$	**0.1032**
00002238171	**GEN-AMOXILLIN**	**GPM**	$	**0.1032**
00000406724	**NOVAMOXIN**	**NOP**	$	**0.1032**
00000865567	**NU-AMOXI**	**NXP**	$	**0.1032**
00002230243	**PMS-AMOXICILLIN**	**PMS**	$	**0.1032**
500 MG (BASE) ORAL CAPSULE				
00000628123	**APO-AMOXI**	**APX**	$	**0.2010**
00002238172	**GEN-AMOXILLIN**	**GPM**	$	**0.2010**
00000406716	**NOVAMOXIN**	**NOP**	$	**0.2010**
00000865575	**NU-AMOXI**	**NXP**	$	**0.2010**
00002230244	**PMS-AMOXICILLIN**	**PMS**	$	**0.2010**
25 MG / ML (BASE) ORAL SUSPENSION				
00000628131	**APO-AMOXI**	**APX**	$	**0.0200**
00000452149	**NOVAMOXIN**	**NOP**	$	**0.0200**
00001934171	**NOVAMOXIN SUGAR-REDUCED**	**NOP**	$	**0.0200**
00000865540	**NU-AMOXI**	**NXP**	$	**0.0200**
00002230245	**PMS-AMOXICILLIN**	**PMS**	$	**0.0200**
50 MG / ML (BASE) ORAL SUSPENSION				
00000628158	**APO-AMOXI**	**APX**	$	**0.0300**
00000452130	**NOVAMOXIN**	**NOP**	$	**0.0300**
00001934163	**NOVAMOXIN SUGAR-REDUCED**	**NOP**	$	**0.0300**
00000865559	**NU-AMOXI**	**NXP**	$	**0.0300**
00002230246	**PMS-AMOXICILLIN**	**PMS**	$	**0.0300**

AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM

250 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002243350	**APO-AMOXI CLAV**	**APX**	$	**0.6111**
00002243770	RATIO-ACLAVULANATE	RPH	$	0.6112
500 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002243351	**APO-AMOXI CLAV**	**APX**	$	**0.9342**
00002243771	**RATIO-ACLAVULANATE**	**RPH**	$	**0.9342**
00001916858	CLAVULIN-500F	GSK	$	1.4441

08:00 ANTI-INFECTIVE AGENTS

08:12:16 ANTIBIOTICS
(PENICILLINS)

AMOXICILLIN TRIHYDRATE/ CLAVULANATE POTASSIUM

875 MG (BASE) * 125 MG (BASE) ORAL TABLET				
00002245623	**APO-AMOXI CLAV**	**APX**	$	**1.2610**
00002248138	**NOVO-CLAVAMOXIN**	**NOP**	$	**1.2610**
00002247021	**RATIO-ACLAVULANATE**	**RPH**	$	**1.2610**
00002238829	CLAVULIN-875	GSK	$	2.1661
25 MG / ML (BASE) * 6.25 MG / ML (BASE) ORAL SUSPENSION				
00002243986	**APO-AMOXI CLAV**	**APX**	$	**0.0724**
00002244646	**RATIO-ACLAVULANATE 125F**	**RPH**	$	**0.0724**
00001916882	CLAVULIN-125F	GSK	$	0.1141
40 MG / ML (BASE) * 5.7 MG / ML (BASE) ORAL SUSPENSION				
00002238831	CLAVULIN-200	GSK	$	0.1405
50 MG / ML (BASE) * 12.5 MG / ML (BASE) ORAL SUSPENSION				
00002243987	**APO-AMOXI CLAV**	**APX**	$	**0.1217**
00002244647	**RATIO-ACLAVULANATE 250F**	**RPH**	$	**0.1217**
00001916874	CLAVULIN-250F	GSK	$	0.1917
80 MG / ML (BASE) * 11.4 MG / ML (BASE) ORAL SUSPENSION				
00002238830	CLAVULIN-400	GSK	$	0.2624

AMPICILLIN SODIUM

250 MG / VIAL (BASE) INJECTION				
00000872644	AMPICILLIN SODIUM	NOP	$	2.0500
500 MG / VIAL (BASE) INJECTION				
00000872652	AMPICILLIN SODIUM	NOP	$	2.1500
1 G / VIAL (BASE) INJECTION				
00001933345	AMPICILLIN SODIUM	NOP	$	3.6000
2 G / VIAL (BASE) INJECTION				
00001933353	AMPICILLIN SODIUM	NOP	$	7.2000

CLOXACILLIN SODIUM

250 MG (BASE) ORAL CAPSULE				
00000618292	**APO-CLOXI**	**APX**	$	**0.0993**
00000337765	**NOVO-CLOXIN**	**NOP**	$	**0.0993**
00000717584	**NU-CLOXI**	**NXP**	$	**0.0993**
500 MG (BASE) ORAL CAPSULE				
00000618284	**APO-CLOXI**	**APX**	$	**0.1946**
00000337773	**NOVO-CLOXIN**	**NOP**	$	**0.1946**
00000717592	**NU-CLOXI**	**NXP**	$	**0.1946**
25 MG / ML (BASE) ORAL LIQUID				
00000644633	**APO-CLOXI**	**APX**	$	**0.0238**
00000337757	**NOVO-CLOXIN**	**NOP**	$	**0.0238**
00000717630	**NU-CLOXI**	**NXP**	$	**0.0238**
500 MG / VIAL (BASE) INJECTION				
00001912429	CLOXACILLIN SODIUM	NOP	$	2.4000
1 G / VIAL (BASE) INJECTION				
00001975447	CLOXACILLIN SODIUM	NOP	$	2.9500
2 G / VIAL (BASE) INJECTION				
00001912410	CLOXACILLIN SODIUM	NOP	$	3.8500

08:00 ANTI-INFECTIVE AGENTS

08:12:16 ANTIBIOTICS
(PENICILLINS)

PENICILLIN G SODIUM

1,000,000 IU / VIAL INJECTION				
00001930672	PENICILLIN G SODIUM	NOP	$	2.4000
5,000,000 IU / VIAL INJECTION				
00000883751	PENICILLIN G SODIUM	NOP	$	5.1000
10,000,000 IU / VIAL INJECTION				
00001930680	PENICILLIN G SODIUM	NOP	$	8.9000

PENICILLIN V BENZATHINE

36 MG / ML ORAL SUSPENSION				
00002229618	PEN-VEE	PPH	$	0.0474

PENICILLIN V POTASSIUM

300 MG ORAL TABLET				
00000642215	**APO-PEN-VK**	**APX**	$	**0.0375**
00000021202	**NOVO-PEN-VK**	**NOP**	$	**0.0375**
00000717568	**NU-PEN-VK**	**NXP**	$	**0.0375**
25 MG / ML ORAL LIQUID				
00000642223	APO-PEN-VK	APX	$	0.0446
60 MG / ML ORAL LIQUID				
00000642231	**APO-PEN-VK**	**APX**	$	**0.0325**
00000391603	**NOVO-PEN-VK**	**NOP**	$	**0.0325**

08:00 ANTI-INFECTIVE AGENTS

08:12:24 ANTIBIOTICS
(TETRACYCLINES)

DOXYCYCLINE HYCLATE

100 MG (BASE) ORAL TABLET				
00000874256	**APO-DOXY**	**APX**	$	**0.5860**
00000860751	**DOXYCIN**	**GPM**	$	**0.5860**
00002158574	**NOVO-DOXYLIN**	**NOP**	$	**0.5860**
00000578452	VIBRA-TABS	PFI	$	1.8241
100 MG (BASE) ORAL CAPSULE				
00000740713	**APO-DOXY**	**APX**	$	**0.5860**
00000817120	**DOXYCIN**	**GPM**	$	**0.5860**
00000725250	**NOVO-DOXYLIN**	**NOP**	$	**0.5860**
00002044668	**NU-DOXYCYCLINE**	**NXP**	$	**0.5860**
00000024368	VIBRAMYCIN	PFI	$	1.8220

08:00 ANTI-INFECTIVE AGENTS

08:12:24 ANTIBIOTICS
(TETRACYCLINES)

MINOCYCLINE HCL

50 MG (BASE) ORAL CAPSULE				
00002084090	**APO-MINOCYCLINE**	**APX**	$	**0.5350**
00002230735	**GEN-MINOCYCLINE**	**GPM**	$	**0.5350**
00002108143	**NOVO-MINOCYCLINE**	**NOP**	$	**0.5350**
00002239238	**PMS-MINOCYCLINE**	**PMS**	$	**0.5350**
00001914138	**RATIO-MINOCYCLINE**	**RPH**	$	**0.5350**
00002237313	**SANDOZ MINOCYCLINE**	**SDZ**	$	**0.5350**
00002173514	MINOCIN	STI	$	0.5950
100 MG (BASE) ORAL CAPSULE				
00002084104	**APO-MINOCYCLINE**	**APX**	$	**1.0332**
00002230736	**GEN-MINOCYCLINE**	**GPM**	$	**1.0332**
00002108151	**NOVO-MINOCYCLINE**	**NOP**	$	**1.0332**
00002239239	**PMS-MINOCYCLINE**	**PMS**	$	**1.0332**
00001914146	**RATIO-MINOCYCLINE**	**RPH**	$	**1.0332**
00002237314	**SANDOZ MINOCYCLINE**	**SDZ**	$	**1.0332**
00002173506	MINOCIN	STI	$	1.1480

TETRACYCLINE HCL

250 MG ORAL CAPSULE				
00000580929	**APO-TETRA**	**APX**	$	**0.0635**
00000717606	**NU-TETRA**	**NXP**	$	**0.0635**

08:00 ANTI-INFECTIVE AGENTS

08:12:28 ANTIBIOTICS
(MISCELLANEOUS ANTIBIOTICS)

CLINDAMYCIN HCL

150 MG (BASE) ORAL CAPSULE				
00002245232	**APO-CLINDAMYCIN**	**APX**	$	**0.4890**
00002258331	**GEN-CLINDAMYCIN**	**GPM**	$	**0.4890**
00002241709	**NOVO-CLINDAMYCIN**	**NOP**	$	**0.4890**
00002130033	**RATIO-CLINDAMYCIN**	**RPH**	$	**0.4890**
00000030570	DALACIN C	PFI	$	1.0088
300 MG (BASE) ORAL CAPSULE				
00002245233	**APO-CLINDAMYCIN**	**APX**	$	**0.9780**
00002258358	**GEN-CLINDAMYCIN**	**GPM**	$	**0.9780**
00002241710	**NOVO-CLINDAMYCIN**	**NOP**	$	**0.9780**
00002192659	**RATIO-CLINDAMYCIN**	**RPH**	$	**0.9780**
00002182866	DALACIN C	PFI	$	2.0175

CLINDAMYCIN PALMITATE HCL

15 MG / ML (BASE) ORAL SOLUTION				
00000225851	DALACIN C PALMITATE	PFI	$	0.1332

CLINDAMYCIN PHOSPHATE

150 MG / ML (BASE) INJECTION				
☒ 00002230535	CLINDAMYCIN (60 & 120 ML)	SDZ	$	3.2585
00002230540	CLINDAMYCIN	SDZ	$	3.3250
00000260436	DALACIN C PHOSPHATE	PFI	$	4.3162

08:00 ANTI-INFECTIVE AGENTS

08:12:28 ANTIBIOTICS
(MISCELLANEOUS ANTIBIOTICS)

COLISTIMETHATE SODIUM

150 MG / VIAL INJECTION

00002244849	COLISTIMETHATE FOR INJECTION	STM	$	33.8088

SODIUM FUSIDATE

250 MG ORAL TABLET

00001934252	FUCIDIN (FC)	LEO	$	1.2094

VANCOMYCIN HCL

500 MG / VIAL (BASE) INJECTION

00002241820	PMS-VANCOMYCIN	PMS	$	31.0500

1 G / VIAL (BASE) INJECTION

00002241821	PMS-VANCOMYCIN	PMS	$	58.9500

08:00 ANTI-INFECTIVE AGENTS

08:18 ANTIVIRALS

ACYCLOVIR

200 MG ORAL TABLET

00002207621	**APO-ACYCLOVIR**	**APX**	$	**0.8783**
00002242784	**GEN-ACYCLOVIR**	**GPM**	$	**0.8783**
00002285959	**NOVO-ACYCLOVIR**	**NOP**	$	**0.8783**
00002197405	**NU-ACYCLOVIR**	**NXP**	$	**0.8783**
00002078627	**RATIO-ACYCLOVIR**	**RPH**	$	**0.8783**
00000634506	ZOVIRAX	GSK	$	1.3687

400 MG ORAL TABLET

00002207648	**APO-ACYCLOVIR**	**APX**	$	**1.7288**
00002242463	**GEN-ACYCLOVIR**	**GPM**	$	**1.7288**
00002285967	**NOVO-ACYCLOVIR**	**NOP**	$	**1.7288**
00002197413	**NU-ACYCLOVIR**	**NXP**	$	**1.7288**
00002078635	**RATIO-ACYCLOVIR**	**RPH**	$	**1.7288**
00001911627	ZOVIRAX	GSK	$	2.6943

800 MG ORAL TABLET

00002207656	**APO-ACYCLOVIR**	**APX**	$	**2.8557**
00002242464	**GEN-ACYCLOVIR**	**GPM**	$	**2.8557**
00002285975	**NOVO-ACYCLOVIR**	**NOP**	$	**2.8557**
00002197421	**NU-ACYCLOVIR**	**NXP**	$	**2.8557**
00002078651	**RATIO-ACYCLOVIR**	**RPH**	$	**2.8557**
00001911635	ZOVIRAX	GSK	$	5.2980

40 MG / ML ORAL SUSPENSION

00000886157	ZOVIRAX	GSK	$	0.2387

GANCICLOVIR SODIUM

500 MG / VIAL (BASE) INJECTION

00002162695	CYTOVENE	HLR	$	44.3060

VALACYCLOVIR

500 MG ORAL TABLET

00002219492	VALTREX (CAPLET)	GSK	$	3.3097

08:00 ANTI-INFECTIVE AGENTS

08:20 ANTIMALARIAL AGENTS

CHLOROQUINE PHOSPHATE

250 MG ORAL TABLET

00000021261	NOVO-CHLOROQUINE	NOP	$	0.3208

HYDROXYCHLOROQUINE SULFATE

200 MG ORAL TABLET

00002246691	**APO-HYDROXYQUINE**	**APX**	$	**0.3301**
00002252600	**GEN-HYDROXYCHLOROQUINE**	**GPM**	$	**0.3301**
00002017709	PLAQUENIL SULFATE	SAV	$	0.6210

PRIMAQUINE PHOSPHATE

15 MG (BASE) ORAL TABLET

00002017776	PRIMAQUINE	SAV	$	0.3724

PYRIMETHAMINE

25 MG ORAL TABLET

00000004774	DARAPRIM	GSK	$	1.2654

QUININE SULFATE

200 MG ORAL CAPSULE

00002254514	**APO-QUININE**	**APX**	$	**0.2390**
00000021008	**NOVO-QUININE**	**NOP**	$	**0.2390**

300 MG ORAL CAPSULE

00002254522	**APO-QUININE**	**APX**	$	**0.3750**
00000021016	**NOVO-QUININE**	**NOP**	$	**0.3750**

08:00 ANTI-INFECTIVE AGENTS

08:22 QUINOLONES

NORFLOXACIN

400 MG ORAL TABLET

00002229524	**APO-NORFLOX**	**APX**	$	**1.3716**
00002269627	**CO NORFLOXACIN**	**COB**	$	**1.3716**
00002237682	**NOVO-NORFLOXACIN**	**NOP**	$	**1.3716**
00002246596	**PMS-NORFLOXACIN**	**PMS**	$	**1.3716**

08:00 ANTI-INFECTIVE AGENTS

08:24 SULFONAMIDES

SULFAMETHOXAZOLE/ TRIMETHOPRIM

100 MG * 20 MG ORAL TABLET

00000445266	APO-SULFATRIM	APX	$	0.0880

400 MG * 80 MG ORAL TABLET

00000445274	**APO-SULFATRIM**	**APX**	$	**0.0482**
00000510637	**NOVO-TRIMEL**	**NOP**	$	**0.0482**
00000865710	**NU-COTRIMOX**	**NXP**	$	**0.0482**

800 MG * 160 MG ORAL TABLET

00000445282	**APO-SULFATRIM DS**	**APX**	$	**0.1221**
00000510645	**NOVO-TRIMEL DS**	**NOP**	$	**0.1221**
00000865729	**NU-COTRIMOX DS**	**NXP**	$	**0.1221**
00000512524	PROTRIN DF	PDL	$	0.1313

08:00 ANTI-INFECTIVE AGENTS

08:24 SULFONAMIDES

SULFAMETHOXAZOLE/ TRIMETHOPRIM

40 MG / ML * 8 MG / ML ORAL SUSPENSION				
00000726540	**NOVO-TRIMEL**	**NOP**	$	**0.0198**
00000865753	**NU-COTRIMOX**	**NXP**	$	**0.0198**
80 MG / ML * 16 MG / ML INJECTION				
00000550086	SEPTRA	GSK	$	6.1312

SULFASALAZINE

500 MG ORAL TABLET				
00000598461	**PMS-SULFASALAZINE**	**PMS**	$	**0.2101**
00002064480	SALAZOPYRIN	PFI	$	0.2692
500 MG ORAL ENTERIC-COATED TABLET				
00000598488	**PMS-SULFASALAZINE**	**PMS**	$	**0.3200**
00002064472	SALAZOPYRIN EN-TABS	PFI	$	0.4240

08:00 ANTI-INFECTIVE AGENTS

08:26 SULFONES

DAPSONE

100 MG ORAL TABLET				
00002041510	DAPSONE	NTI	$	0.4373

08:00 ANTI-INFECTIVE AGENTS

08:36 URINARY ANTI-INFECTIVES

NITROFURANTOIN

50 MG ORAL TABLET				
00000319511	APO-NITROFURANTOIN	APX	$	0.1440
100 MG ORAL TABLET				
00000312738	APO-NITROFURANTOIN	APX	$	0.1920
50 MG ORAL CAPSULE (MACROCRYSTALS)				
00002231015	NOVO-FURANTOIN	NOP	$	0.3187
100 MG ORAL CAPSULE (MACROCRYSTALS)				
00002231016	NOVO-FURANTOIN	NOP	$	0.6110
100 MG ORAL CAPSULE (MACROCRYSTALS/MONOHYDRATE)				
00002063662	MACROBID	PGA	$	0.7022

TRIMETHOPRIM

100 MG ORAL TABLET				
00002243116	APO-TRIMETHOPRIM	APX	$	0.1891
200 MG ORAL TABLET				
00002243117	APO-TRIMETHOPRIM	APX	$	0.3885

08:00 ANTI-INFECTIVE AGENTS

08:40 MISCELLANEOUS ANTI-INFECTIVES

METRONIDAZOLE

250 MG ORAL TABLET				
00000545066	APO-METRONIDAZOLE	APX	$	0.0575
5 MG / ML INJECTION				
00000870420	**FLAGYL**	**BAX**	$	**0.0219**
00000649074	METRONIDAZOLE	HSP	$	0.1421

10:00 ANTINEOPLASTIC AGENTS

10:00

METHOTREXATE

2.5 MG ORAL TABLET

00002182963	**APO-METHOTREXATE**	**APX**	$	**0.6325**
00002244798	**RATIO-METHOTREXATE SODIUM**	**RPH**	$	**0.6325**
00002170698	METHOTREXATE	WAY	$	0.6799

10 MG ORAL TABLET

00002182750	METHOTREXATE	HSP	$	2.7197

METHOTREXATE SODIUM

25 MG / ML (BASE) INJECTION

00002182955	METHOTREXATE SOD.(UNPRESERVED)	HSP	$	5.5650
00002099705	METHOTREXATE SOD.(UNPRESERVED)	NOP	$	6.2500
00002182777	METHOTREXATE SOD. (PRESERVED)	HSP	$	6.4500

12:00 AUTONOMIC DRUGS

12:04 PARASYMPATHOMIMETIC AGENTS

NEOSTIGMINE BROMIDE

15 MG ORAL TABLET				
00000869945	PROSTIGMIN	VCL	$	0.4698

PILOCARPINE HCL

5 MG ORAL TABLET				
00002216345	SALAGEN	PFI	$	1.1739

PYRIDOSTIGMINE BROMIDE

60 MG ORAL TABLET				
00000869961	MESTINON	VCL	$	0.4617
180 MG ORAL SUSTAINED-RELEASE TABLET				
00000869953	MESTINON-SR	VCL	$	1.0102

12:00 AUTONOMIC DRUGS

12:08:04 ANTICHOLINERGIC AGENTS (ANTIPARKINSONIAN AGENTS)

BENZTROPINE MESYLATE

1 MG ORAL TABLET				
00000706531	PMS-BENZTROPINE	PMS	$	0.0207
2 MG ORAL TABLET				
00000587265	**PMS-BENZTROPINE**	**PMS**	$	**0.0450**
00000426857	APO-BENZTROPINE	APX	$	0.0540

ETHOPROPAZINE HCL

50 MG (BASE) ORAL TABLET				
00001927744	PARSITAN	ERF	$	0.2150

PROCYCLIDINE HCL

2.5 MG ORAL TABLET				
00000649392	PMS-PROCYCLIDINE	PMS	$	0.0555
5 MG ORAL TABLET				
00000587354	PMS-PROCYCLIDINE	PMS	$	0.0255
0.5 MG / ML ORAL ELIXIR				
00000587362	PMS-PROCYCLIDINE	PMS	$	0.0313

TRIHEXYPHENIDYL HCL

2 MG ORAL TABLET				
00000545058	APO-TRIHEX	APX	$	0.0300
5 MG ORAL TABLET				
00000545074	APO-TRIHEX	APX	$	0.0540

12:00 AUTONOMIC DRUGS

12:08:08 ANTICHOLINERGIC AGENTS (ANTIMUSCARINICS/ANTISPASMODICS)

ATROPINE SULFATE

0.4 MG / ML INJECTION				
00000392782	ATROPINE SULFATE	SDZ	$	1.3250
0.6 MG / ML INJECTION				
00000392693	ATROPINE SULFATE	SDZ	$	1.3250

12:00 AUTONOMIC DRUGS

12:08:08 ANTICHOLINERGIC AGENTS (ANTIMUSCARINICS/ANTISPASMODICS)

BELLADONNA/ ERGOTAMINE TARTRATE/ PHENOBARBITAL

0.2 MG * 0.6 MG * 40 MG ORAL SUSTAINED-RELEASE TABLET

00000176141	BELLERGAL SPACETABS	TPI	$	1.2801

CHLORDIAZEPOXIDE HCL/ CLIDINIUM BROMIDE

5 MG * 2.5 MG ORAL CAPSULE

00000618454	**APO-CHLORAX**	**APX**	$	**0.2020**
00000115630	LIBRAX	VCL	$	0.3166

DICYCLOMINE HCL

10 MG ORAL TABLET

00002103087	BENTYLOL	AXC	$	0.1138

20 MG ORAL TABLET

00000513059	**PROTYLOL**	**PDL**	$	**0.1817**
00002103095	BENTYLOL	AXC	$	0.2137

10 MG ORAL CAPSULE

00000287709	**PROTYLOL**	**PDL**	$	**0.0655**
00000361933	FORMULEX	VCL	$	0.0983

2 MG / ML ORAL SYRUP

00002102978	BENTYLOL	AXC	$	0.0605

10 MG / ML INJECTION

00000392812	DICYCLOMINE HYDROCHLORIDE	SDZ	$	2.8175

GLYCOPYRROLATE

0.2 MG / ML INJECTION

00002039508	GLYCOPYRROLATE	SDZ	$	3.0560

HYOSCINE BUTYLBROMIDE

10 MG ORAL TABLET

00000363812	BUSCOPAN	BOE	$	0.3071

20 MG / ML INJECTION

00000363839	BUSCOPAN	BOE	$	4.3000

IPRATROPIUM BROMIDE

20 MCG / DOSE METERED DOSE AEROSOL

00002247686	ATROVENT HFA	BOE	$	0.0917

250 MCG / ML INHALATION SOLUTION

00002126222	**APO-IPRAVENT**	**APX**	$	**0.5530**
00002239131	**GEN-IPRATROPIUM**	**GPM**	$	**0.5530**
00002210479	**NOVO-IPRAMIDE**	**NOP**	$	**0.5530**
00002231136	**PMS-IPRATROPIUM**	**PMS**	$	**0.5530**
00002097141	**RATIO-IPRATROPIUM**	**RPH**	$	**0.5530**

0.03 % NASAL SPRAY

00002246083	**APO-IPRAVENT**	**APX**	$	**0.5847**
00002239627	**PMS-IPRATROPIUM**	**PMS**	$	**0.5847**
00002163705	ATROVENT	BOE	$	0.9930

IPRATROPIUM BROMIDE/ SALBUTAMOL SULFATE

0.2 MG / ML * 1 MG / ML (BASE) INHALATION SOLUTION

00002266393	**APO-SALVENT IPRAVENT STERULES**	**APX**	$	**0.3700**
00002272695	**GEN-COMBO STERINEBS**	**GPM**	$	**0.3700**
00002243789	**RATIO-IPRA SAL UDV**	**RPH**	$	**0.3700**
00002231675	COMBIVENT UDV	BOE	$	0.6030

12:00 AUTONOMIC DRUGS

12:08:08 ANTICHOLINERGIC AGENTS (ANTIMUSCARINICS/ANTISPASMODICS)

TIOTROPIUM BROMIDE MONOHYDRATE

18 MCG INHALATION CAPSULE				
00002246793	SPIRIVA	BOE	$	2.1000

12:00 AUTONOMIC DRUGS

12:12 SYMPATHOMIMETIC AGENTS

BUDESONIDE/ FORMOTEROL FUMARATE DIHYDRATE

100 MCG / DOSE * 6 MCG / DOSE METERED INHALATION POWDER				
00002245385	SYMBICORT 100 TURBUHALER	AZC	$	0.5000
200 MCG / DOSE * 6 MCG / DOSE METERED INHALATION POWDER				
00002245386	SYMBICORT 200 TURBUHALER	AZC	$	0.6500

EPINEPHRINE

0.15 MG / SYR INJECTION SYRINGE				
☒ 00002268205	TWINJECT AUTO INJECTOR	PAL	$	79.0000
☒ 00000578657	EPIPEN JR	KNG	$	81.0000
0.3 MG / SYR INJECTION SYRINGE				
☒ 00002247310	TWINJECT AUTO INJECTOR	PAL	$	79.0000
☒ 00000509558	EPIPEN	KNG	$	81.0000

EPINEPHRINE HCL

1 MG / ML TOPICAL SOLUTION				
00000155365	ADRENALIN	ERF	$	0.5770
1 MG / ML INJECTION				
00000155357	ADRENALIN	ERF	$	0.5770

FORMOTEROL FUMARATE

12 MCG INHALATION CAPSULE				
00002230898	FORADIL	NOV	$	0.8003

FORMOTEROL FUMARATE DIHYDRATE

6 MCG / DOSE METERED INHALATION POWDER				
00002237225	OXEZE TURBUHALER	AZC	$	0.5450
12 MCG / DOSE METERED INHALATION POWDER				
00002237224	OXEZE TURBUHALER	AZC	$	0.7258

ORCIPRENALINE SULFATE

2 MG / ML ORAL SYRUP				
00002236783	APO-ORCIPRENALINE	APX	$	0.0381

SALBUTAMOL

100 MCG / DOSE METERED DOSE AEROSOL				
00002245669	**APO-SALVENT CFC FREE**	**APX**	$	**0.0387**
00002244914	**RATIO-SALBUTAMOL HFA**	**RPH**	$	**0.0387**
00002232570	AIROMIR CFC-FREE	GRC	$	0.0416

12:00 AUTONOMIC DRUGS

12:12 SYMPATHOMIMETIC AGENTS

SALBUTAMOL SULFATE

2 MG (BASE) ORAL TABLET				
00002146843	**APO-SALVENT**	**APX**	$	**0.0990**
00002165368	**NU-SALBUTAMOL**	**NXP**	$	**0.0990**
4 MG (BASE) ORAL TABLET				
00002146851	**APO-SALVENT**	**APX**	$	**0.1655**
00002165376	**NU-SALBUTAMOL**	**NXP**	$	**0.1655**
400 MCG / ML (BASE) ORAL LIQUID				
00002091186	**PMS-SALBUTAMOL**	**PMS**	$	**0.0476**
00002212390	VENTOLIN	GSK	$	0.0710
0.5 MG / ML (BASE) INHALATION SOLUTION				
00002243828	**APO-SALVENT STERULES**	**APX**	$	**0.1492**
00002208245	**PMS-SALBUTAMOL**	**PMS**	$	**0.1492**
00002239365	**RATIO-SALBUTAMOL UNIT DOSE P.F**	**RPH**	$	**0.1492**
1 MG / ML (BASE) INHALATION SOLUTION				
00002231488	**APO-SALVENT STERULES**	**APX**	$	**0.2434**
00001926934	**GEN-SALBUTAMOL STERINEBS P.F.**	**GPM**	$	**0.2434**
00002231783	**NU-SALBUTAMOL**	**NXP**	$	**0.2434**
00002208229	**PMS-SALBUTAMOL**	**PMS**	$	**0.2434**
00001986864	**RATIO-SALBUTAMOL SULF U.D.P.F.**	**RPH**	$	**0.2434**
00002213419	VENTOLIN NEBULES P.F.	GSK	$	0.9848
5 MG / ML (BASE) INHALATION SOLUTION				
00002232987	**GEN-SALBUTAMOL**	**GPM**	$	**0.5900**
00002069571	**PMS-SALBUTAMOL**	**PMS**	$	**0.5900**
00000860808	**RATIO-SALBUTAMOL**	**RPH**	$	**0.5900**
00002154412	**SANDOZ SALBUTAMOL**	**SDZ**	$	**0.5900**
00002213486	VENTOLIN	GSK	$	0.9790
2 MG / ML (BASE) INHALATION UNIT DOSE SOLUTION				
00002231678	**APO-SALVENT STERULES**	**APX**	$	**0.4622**
00002173360	**GEN-SALBUTAMOL STERINEBS P.F.**	**GPM**	$	**0.4622**
00002231784	**NU-SALBUTAMOL PLASTIC AMPULES**	**NXP**	$	**0.4622**
00002208237	**PMS-SALBUTAMOL POLYNEB**	**PMS**	$	**0.4622**
00002239366	**RATIO-SALBUTAMOL UNI DOSE P.F.**	**RPH**	$	**0.4622**
00002213427	VENTOLIN NEBULES P.F.	GSK	$	1.8712

SALMETEROL XINAFOATE

50 MCG / DOSE (BASE) METERED INHALATION POWDER				
00002231129	SEREVENT DISKUS	GSK	$	0.8911
50 MCG / DOSE (BASE) INHALATION DISK				
00002214261	SEREVENT	GSK	$	0.8911

SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE

25 MCG / DOSE (BASE) * 125 MCG / DOSE METERED DOSE AEROSOL				
00002245126	ADVAIR 125	GSK	$	0.7625
25 MCG / DOSE (BASE) * 250 MCG / DOSE METERED DOSE AEROSOL				
00002245127	ADVAIR 250	GSK	$	1.0823
50 MCG / DOSE (BASE) * 100 MCG / DOSE METERED INHALATION POWDER				
00002240835	ADVAIR 100 DISKUS	GSK	$	1.2739
50 MCG / DOSE (BASE) * 250 MCG / DOSE METERED INHALATION POWDER				
00002240836	ADVAIR 250 DISKUS	GSK	$	1.5249
50 MCG / DOSE (BASE) * 500 MCG / DOSE METERED INHALATION POWDER				
00002240837	ADVAIR 500 DISKUS	GSK	$	2.1650

12:00 AUTONOMIC DRUGS

12:12 SYMPATHOMIMETIC AGENTS

TERBUTALINE SULFATE

0.5 MG / DOSE METERED INHALATION POWDER				
00000786616	BRICANYL TURBUHALER	AZC	$	0.0735

12:00 AUTONOMIC DRUGS

12:16 SYMPATHOLYTIC AGENTS

DIHYDROERGOTAMINE MESYLATE

4 MG / ML NASAL SPRAY				
00002228947	MIGRANAL	STM	$	10.6605
1 MG / ML INJECTION				
00002241163	DIHYDROERGOTAMINE MESYLATE	SDZ	$	3.7133
00000027243	DIHYDROERGOTAMINE (DHE)	STM	$	4.5365

ERGOLOID MESYLATES

1 MG ORAL TABLET				
00000176176	HYDERGINE	STM	$	0.7229

ERGOTAMINE TARTRATE/ CAFFEINE

1 MG * 100 MG ORAL TABLET				
00000176095	CAFERGOT	NOV	$	0.7005

ERGOTAMINE TARTRATE/ CAFFEINE/ DIMENHYDRINATE

1 MG * 100 MG * 50 MG ORAL CAPSULE				
00000116858	GRAVERGOL	AXS	$	0.6550

METHYSERGIDE MALEATE

2 MG ORAL TABLET				
00000027499	SANSERT	NOV	$	0.8949

PIZOTIFEN MALATE

0.5 MG (BASE) ORAL TABLET				
00000329320	SANDOMIGRAN	SQP	$	0.3475
1 MG (BASE) ORAL TABLET				
00000511552	SANDOMIGRAN DS	SQP	$	0.5770

12:00 AUTONOMIC DRUGS

12:20 SKELETAL MUSCLE RELAXANTS

BACLOFEN

10 MG ORAL TABLET				
00002139332	**APO-BACLOFEN**	**APX**	$	**0.2911**
00002138271	**DOM-BACLOFEN**	**DPC**	$	**0.2911**
00002088398	**GEN-BACLOFEN**	**GPM**	$	**0.2911**
00002136090	**NU-BACLO**	**NXP**	$	**0.2911**
00002063735	**PMS-BACLOFEN**	**PMS**	$	**0.2911**
00002236507	**RATIO-BACLOFEN**	**RPH**	$	**0.2911**
00000455881	LIORESAL	NOV	$	0.5923
20 MG ORAL TABLET				
00002139391	**APO-BACLOFEN**	**APX**	$	**0.5667**
00002138298	**DOM-BACLOFEN**	**DPC**	$	**0.5667**
00002088401	**GEN-BACLOFEN**	**GPM**	$	**0.5667**
00002136104	**NU-BACLO**	**NXP**	$	**0.5667**
00002063743	**PMS-BACLOFEN**	**PMS**	$	**0.5667**
00002236508	**RATIO-BACLOFEN**	**RPH**	$	**0.5667**
00000636576	LIORESAL D.S.	NOV	$	1.1529
0.05 MG / ML INJECTION				
00002131048	LIORESAL INTRATHECAL	NOV	$	12.2464
0.5 MG / ML INJECTION				
00002131056	LIORESAL INTRATHECAL	NOV	$	9.1757
2 MG / ML INJECTION				
00002131064	LIORESAL INTRATHECAL	NOV	$	36.7027

CYCLOBENZAPRINE HCL

10 MG ORAL TABLET				
00002177145	**APO-CYCLOBENZAPRINE**	**APX**	$	**0.3765**
00002238633	**DOM-CYCLOBENZAPRINE**	**DPC**	$	**0.3765**
00002231353	**GEN-CYCLOBENZAPRINE**	**GPM**	$	**0.3765**
00002080052	**NOVO-CYCLOPRINE**	**NOP**	$	**0.3765**
00002171848	**NU-CYCLOBENZAPRINE**	**NXP**	$	**0.3765**
00002212048	**PMS-CYCLOBENZAPRINE**	**PMS**	$	**0.3765**
00002236506	**RATIO-CYCLOBENZAPRINE**	**RPH**	$	**0.3765**

DANTROLENE SODIUM

25 MG ORAL CAPSULE				
00001997602	DANTRIUM	PGA	$	0.3945
100 MG ORAL CAPSULE				
00001997653	DANTRIUM	PGA	$	0.8020

ORPHENADRINE CITRATE

30 MG / ML INJECTION				
00001966162	NORFLEX	GRC	$	4.6125

20:00 BLOOD FORMATION AND COAGULATION

20:04:04 ANTIANEMIA DRUGS
(IRON PREPARATIONS)

IRON DEXTRAN COMPLEX

50 MG / ML INJECTION

☒ 00002221780	INFUFER	SDZ	$	13.7500
☒ 00002205963	DEXIRON	GPM	$	14.9500

20:00 BLOOD FORMATION AND COAGULATION

20:12:04 COAGULANTS & ANTICOAGULANTS
(ANTICOAGULANTS)

DALTEPARIN SODIUM

10,000 IU / ML INJECTION

00002132664	FRAGMIN	PFI	$	16.7700

25,000 IU / ML INJECTION

00002231171	FRAGMIN	PFI	$	41.9263

2,500 IU / SYR INJECTION SYRINGE

00002132621	FRAGMIN (0.2 ML SYRINGE)	PFI	$	5.3110

25,000 IU / ML INJECTION SYRINGE

00002132648	FRAGMIN (0.2-0.72 ML SYR)	PFI	$	52.8250

For this product - pricing has been established on a per millilitre basis.

ENOXAPARIN SODIUM

100 MG / ML INJECTION

00002236564	LOVENOX	SAV	$	22.0375

30 MG / SYR INJECTION SYRINGE

00002012472	LOVENOX (0.3 ML SYRINGE)	SAV	$	6.6543

100 MG / ML INJECTION SYRINGE

00002236883	LOVENOX (0.4 - 1 ML SYRINGE)	SAV	$	22.0375

For this product - pricing has been established on a per millilitre basis.

150 MG / ML INJECTION SYRINGE

00002242692	LOVENOX HP (0.8ML/1ML SYRINGE)	SAV	$	33.0025

For this product - pricing has been established on a per millilitre basis.

FONDAPARINUX SODIUM

2.5 MG / SYR INJECTION SYRINGE

00002245531	ARIXTRA (0.5 ML SYRINGE)	GSK	$	14.7084

HEPARIN SODIUM

1,000 UNIT / ML INJECTION

00000453811	HEPARIN LEO	LEO	$	0.4064
00000740519	HEPALEAN	ORG	$	0.9340

10,000 UNIT / ML INJECTION

00000579718	HEPARIN LEO	LEO	$	1.9362
00000740497	HEPALEAN	ORG	$	2.2050

25,000 UNIT / ML INJECTION

00000453781	HEPARIN LEO	LEO	$	8.0140

10 UNIT / ML LOCK FLUSH

00000725323	HEPARIN LOCK FLUSH	HSP	$	0.2750

100 UNIT / ML LOCK FLUSH

00000725315	HEPARIN LOCK FLUSH	HSP	$	0.2800
00000727520	HEPARIN LEO	LEO	$	0.3456

20:00 BLOOD FORMATION AND COAGULATION

20:12:04 COAGULANTS & ANTICOAGULANTS (ANTICOAGULANTS)

NADROPARIN CALCIUM

9,500 IU / ML INJECTION SYRINGE

00002236913	FRAXIPARINE (.3-1ML SYR)	GSK	$	9.1290

For this product - pricing has been established on a per millilitre basis.

19,000 IU / ML INJECTION SYRINGE

00002240114	FRAXIPARINE FORTE (.6-1ML SYR)	GSK	$	18.2580

For this product - pricing has been established on a per millilitre basis.

NICOUMALONE

1 MG ORAL TABLET

00000010383	SINTROM	SQP	$	0.4701

4 MG ORAL TABLET

00000010391	SINTROM	SQP	$	1.4782

TINZAPARIN SODIUM

10,000 IU / ML INJECTION

00002167840	INNOHEP	LEO	$	17.2000

20,000 IU / ML INJECTION

00002229515	INNOHEP	LEO	$	34.4000

10,000 IU / ML INJECTION SYRINGE

00002229755	INNOHEP (0.35/0.45 ML SYR)	LEO	$	17.3444

For this product - pricing has been established on a per millilitre basis.

20,000 IU / ML INJECTION SYRINGE

00002231478	INNOHEP (0.5/0.7/0.9 ML SYR)	LEO	$	34.4000

For this product - pricing has been established on a per millilitre basis.

WARFARIN SODIUM

1 MG ORAL TABLET

00002242924	**APO-WARFARIN**	**APX**	$	**0.1782**
00002244462	**GEN-WARFARIN**	**GPM**	$	**0.1782**
00002265273	**NOVO-WARFARIN**	**NOP**	$	**0.1782**
00002242680	**TARO-WARFARIN**	**TAR**	$	**0.1782**
00001918311	COUMADIN	BMS	$	0.2969

2 MG ORAL TABLET

00002242925	**APO-WARFARIN**	**APX**	$	**0.1885**
00002244463	**GEN-WARFARIN**	**GPM**	$	**0.1885**
00002265281	**NOVO-WARFARIN**	**NOP**	$	**0.1885**
00002242681	**TARO-WARFARIN**	**TAR**	$	**0.1885**
00001918338	COUMADIN	BMS	$	0.3141

2.5 MG ORAL TABLET

00002242926	**APO-WARFARIN**	**APX**	$	**0.1509**
00002244464	**GEN-WARFARIN**	**GPM**	$	**0.1509**
00002265303	**NOVO-WARFARIN**	**NOP**	$	**0.1509**
00002242682	**TARO-WARFARIN**	**TAR**	$	**0.1509**
00001918346	COUMADIN	BMS	$	0.2514

3 MG ORAL TABLET

00002245618	**APO-WARFARIN**	**APX**	$	**0.2337**
00002287498	**GEN-WARFARIN**	**GPM**	$	**0.2337**
00002265311	**NOVO-WARFARIN**	**NOP**	$	**0.2337**
00002242683	**TARO-WARFARIN**	**TAR**	$	**0.2337**
00002240205	COUMADIN	BMS	$	0.3893

20:00 BLOOD FORMATION AND COAGULATION

20:12:04 COAGULANTS & ANTICOAGULANTS (ANTICOAGULANTS)

WARFARIN SODIUM

4 MG ORAL TABLET				
00002242927	**APO-WARFARIN**	**APX**	$	**0.2337**
00002244465	**GEN-WARFARIN**	**GPM**	$	**0.2337**
00002265338	**NOVO-WARFARIN**	**NOP**	$	**0.2337**
00002242684	**TARO-WARFARIN**	**TAR**	$	**0.2337**
00002007959	COUMADIN	BMS	$	0.3893
5 MG ORAL TABLET				
00002242928	**APO-WARFARIN**	**APX**	$	**0.1512**
00002244466	**GEN-WARFARIN**	**GPM**	$	**0.1512**
00002265346	**NOVO-WARFARIN**	**NOP**	$	**0.1512**
00002242685	**TARO-WARFARIN**	**TAR**	$	**0.1512**
00001918354	COUMADIN	BMS	$	0.2519
6 MG ORAL TABLET				
00002242686	TARO-WARFARIN	TAR	$	0.2805
7.5 MG ORAL TABLET				
00002242697	TARO-WARFARIN	TAR	$	0.3014
10 MG ORAL TABLET				
00002242929	**APO-WARFARIN**	**APX**	$	**0.2713**
00002244467	**GEN-WARFARIN**	**GPM**	$	**0.2713**
00002242687	**TARO-WARFARIN**	**TAR**	$	**0.2713**
00001918362	COUMADIN	BMS	$	0.4519

20:00 BLOOD FORMATION AND COAGULATION

20:12:16 COAGULANTS & ANTICOAGULANTS (HEMOSTATICS)

TRANEXAMIC ACID

500 MG ORAL TABLET				
00002064405	CYKLOKAPRON	PFI	$	1.2358

20:00 BLOOD FORMATION AND COAGULATION

20:24 HEMORRHEOLOGIC AGENTS

PENTOXIFYLLINE

400 MG ORAL SUSTAINED-RELEASE TABLET				
00002230090	**APO-PENTOXIFYLLINE SR**	**APX**	$	**0.3837**
00002230401	**NU-PENTOXIFYLLINE-SR**	**NXP**	$	**0.3837**
00001968432	**RATIO-PENTOXIFYLLINE**	**RPH**	$	**0.3837**
00002221977	TRENTAL	SAV	$	0.7600

24:00 CARDIOVASCULAR DRUGS

24:04 CARDIAC DRUGS

ACEBUTOLOL HCL

100 MG (BASE) ORAL TABLET

00002147602	**APO-ACEBUTOLOL**	**APX**	$	**0.1630**
00002237721	**GEN-ACEBUTOLOL**	**GPM**	$	**0.1630**
00002237885	**GEN-ACEBUTOLOL (TYPE S)**	**GPM**	$	**0.1630**
00002204517	**NOVO-ACEBUTOLOL**	**NOP**	$	**0.1630**
00002165546	**NU-ACEBUTOLOL**	**NXP**	$	**0.1630**
00001910140	**RHOTRAL**	**SDZ**	$	**0.1630**
00002257599	**SANDOZ ACEBUTOLOL**	**SDZ**	$	**0.1630**
00001926543	SECTRAL	SAV	$	0.3222

200 MG (BASE) ORAL TABLET

00002147610	**APO-ACEBUTOLOL**	**APX**	$	**0.2440**
00002237722	**GEN-ACEBUTOLOL**	**GPM**	$	**0.2440**
00002237886	**GEN-ACEBUTOLOL (TYPE S)**	**GPM**	$	**0.2440**
00002204525	**NOVO-ACEBUTOLOL**	**NOP**	$	**0.2440**
00002165554	**NU-ACEBUTOLOL**	**NXP**	$	**0.2440**
00001910159	**RHOTRAL**	**SDZ**	$	**0.2440**
00002257602	**SANDOZ ACEBUTOLOL**	**SDZ**	$	**0.2440**
00001926551	SECTRAL	SAV	$	0.4832

400 MG (BASE) ORAL TABLET

00002147629	**APO-ACEBUTOLOL**	**APX**	$	**0.4848**
00002237723	**GEN-ACEBUTOLOL**	**GPM**	$	**0.4848**
00002237887	**GEN-ACEBUTOLOL (TYPE S)**	**GPM**	$	**0.4848**
00002204533	**NOVO-ACEBUTOLOL**	**NOP**	$	**0.4848**
00002165562	**NU-ACEBUTOLOL**	**NXP**	$	**0.4848**
00001910167	**RHOTRAL**	**SDZ**	$	**0.4848**
00002257610	**SANDOZ ACEBUTOLOL**	**SDZ**	$	**0.4848**
00001926578	SECTRAL	SAV	$	0.9616

AMIODARONE HCL

200 MG ORAL TABLET

00002246194	**APO-AMIODARONE**	**APX**	$	**1.2971**
00002240604	**GEN-AMIODARONE**	**GPM**	$	**1.2971**
00002239835	**NOVO-AMIODARONE**	**NOP**	$	**1.2971**
00002242472	**PMS-AMIODARONE**	**PMS**	$	**1.2971**
00002240071	**RATIO-AMIODARONE**	**RPH**	$	**1.2971**
00002243836	**SANDOZ AMIODARONE**	**SDZ**	$	**1.2971**
00002036282	CORDARONE	WAY	$	2.2133

AMLODIPINE BESYLATE

5 MG (BASE) ORAL TABLET

00000878928	NORVASC	PFI	$	1.3738

10 MG (BASE) ORAL TABLET

00000878936	NORVASC	PFI	$	2.0392

24:00 CARDIOVASCULAR DRUGS

24:04 CARDIAC DRUGS

ATENOLOL

25 MG ORAL TABLET

00002266660	**NOVO-ATENOL**	**NOP**	$	**0.1758**
00002246581	**PMS-ATENOLOL**	**PMS**	$	**0.1758**

50 MG ORAL TABLET

00000773689	**APO-ATENOL**	**APX**	$	**0.3513**
00002255545	**CO ATENOLOL**	**COB**	$	**0.3513**
00002146894	**GEN-ATENOLOL**	**GPM**	$	**0.3513**
00001912062	**NOVO-ATENOL**	**NOP**	$	**0.3513**
00000886114	**NU-ATENOL**	**NXP**	$	**0.3513**
00002237600	**PMS-ATENOLOL**	**PMS**	$	**0.3513**
00002267985	**RAN-ATENOLOL**	**RAN**	$	**0.3513**
00002171791	**RATIO-ATENOLOL**	**RPH**	$	**0.3513**
00002229467	DOM-ATENOLOL	DPC	$	0.3515
00002231731	SANDOZ ATENOLOL	SDZ	$	0.3515
00002039532	TENORMIN	AZC	$	0.5746

100 MG ORAL TABLET

00000773697	**APO-ATENOL**	**APX**	$	**0.5777**
00002255553	**CO ATENOLOL**	**COB**	$	**0.5777**
00002229468	**DOM-ATENOLOL**	**DPC**	$	**0.5777**
00002147432	**GEN-ATENOLOL**	**GPM**	$	**0.5777**
00001912054	**NOVO-ATENOL**	**NOP**	$	**0.5777**
00000886122	**NU-ATENOL**	**NXP**	$	**0.5777**
00002237601	**PMS-ATENOLOL**	**PMS**	$	**0.5777**
00002267993	**RAN-ATENOLOL**	**RAN**	$	**0.5777**
00002171805	**RATIO-ATENOLOL**	**RPH**	$	**0.5777**
00002231733	**SANDOZ ATENOLOL**	**SDZ**	$	**0.5777**
00002039540	TENORMIN	AZC	$	0.9446

BISOPROLOL FUMARATE

5 MG ORAL TABLET

00002256134	**APO-BISOPROLOL**	**APX**	$	**0.2205**
00002267470	**NOVO-BISOPROLOL**	**NOP**	$	**0.2205**
00002247439	**SANDOZ BISOPROLOL**	**SDZ**	$	**0.2205**
00002241148	MONOCOR	BOV	$	0.3785

10 MG ORAL TABLET

00002256177	**APO-BISOPROLOL**	**APX**	$	**0.3654**
00002267489	**NOVO-BISOPROLOL**	**NOP**	$	**0.3654**
00002247440	**SANDOZ BISOPROLOL**	**SDZ**	$	**0.3654**

24:00 CARDIOVASCULAR DRUGS

24:04 CARDIAC DRUGS

CAPTOPRIL

12.5 MG ORAL TABLET

00000893595	**APO-CAPTO**	**APX**	$	**0.2120**
00002242788	**CAPTOPRIL**	**ZMC**	$	**0.2120**
00002238551	**DOM-CAPTOPRIL**	**DPC**	$	**0.2120**
00002163551	**GEN-CAPTOPRIL**	**GPM**	$	**0.2120**
00001942964	**NOVO-CAPTORIL**	**NOP**	$	**0.2120**
00001913824	**NU-CAPTO**	**NXP**	$	**0.2120**
00002230203	**PMS-CAPTOPRIL**	**PMS**	$	**0.2120**
00000695661	CAPOTEN	BMS	$	0.2160

25 MG ORAL TABLET

00000893609	**APO-CAPTO**	**APX**	$	**0.3000**
00002242789	**CAPTOPRIL**	**ZMC**	$	**0.3000**
00002238552	**DOM-CAPTOPRIL**	**DPC**	$	**0.3000**
00002163578	**GEN-CAPTOPRIL**	**GPM**	$	**0.3000**
00001942972	**NOVO-CAPTORIL**	**NOP**	$	**0.3000**
00001913832	**NU-CAPTO**	**NXP**	$	**0.3000**
00002230204	**PMS-CAPTOPRIL**	**PMS**	$	**0.3000**
00000546283	CAPOTEN	BMS	$	0.3057

50 MG ORAL TABLET

00000893617	**APO-CAPTO**	**APX**	$	**0.5590**
00002242790	**CAPTOPRIL**	**ZMC**	$	**0.5590**
00002238553	**DOM-CAPTOPRIL**	**DPC**	$	**0.5590**
00002163586	**GEN-CAPTOPRIL**	**GPM**	$	**0.5590**
00001942980	**NOVO-CAPTORIL**	**NOP**	$	**0.5590**
00001913840	**NU-CAPTO**	**NXP**	$	**0.5590**
00002230205	**PMS-CAPTOPRIL**	**PMS**	$	**0.5590**
00000546291	CAPOTEN	BMS	$	0.5696

100 MG ORAL TABLET

00000893625	APO-CAPTO	APX	$	1.0395
00002242791	CAPTOPRIL	ZMC	$	1.0395
00002238554	DOM-CAPTOPRIL	DPC	$	1.0395
00002163594	GEN-CAPTOPRIL	GPM	$	1.0395
00001942999	NOVO-CAPTORIL	NOP	$	1.0395
00001913859	NU-CAPTO	NXP	$	1.0395
00002230206	PMS-CAPTOPRIL	PMS	$	1.0395
00000546305	CAPOTEN	BMS	$	1.0593

CARVEDILOL

3.125 MG ORAL TABLET

00002247933	**APO-CARVEDILOL**	**APX**	$	**0.8001**
00002245914	**PMS-CARVEDILOL**	**PMS**	$	**0.8001**
00002268027	**RAN-CARVEDILOL**	**RAN**	$	**0.8001**
00002252309	**RATIO-CARVEDILOL**	**RPH**	$	**0.8001**

6.25 MG ORAL TABLET

00002247934	**APO-CARVEDILOL**	**APX**	$	**0.8001**
00002245915	**PMS-CARVEDILOL**	**PMS**	$	**0.8001**
00002268035	**RAN-CARVEDILOL**	**RAN**	$	**0.8001**
00002252317	**RATIO-CARVEDILOL**	**RPH**	$	**0.8001**

12.5 MG ORAL TABLET

00002247935	**APO-CARVEDILOL**	**APX**	$	**0.8001**
00002245916	**PMS-CARVEDILOL**	**PMS**	$	**0.8001**
00002268043	**RAN-CARVEDILOL**	**RAN**	$	**0.8001**
00002252325	**RATIO-CARVEDILOL**	**RPH**	$	**0.8001**

24:00 CARDIOVASCULAR DRUGS

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CARVEDILOL

25 MG ORAL TABLET				
00002247936	**APO-CARVEDILOL**	**APX**	$	**0.8001**
00002245917	**PMS-CARVEDILOL**	**PMS**	$	**0.8001**
00002268051	**RAN-CARVEDILOL**	**RAN**	$	**0.8001**
00002252333	**RATIO-CARVEDILOL**	**RPH**	$	**0.8001**

DIGOXIN

0.0625 MG ORAL TABLET				
00002281236	**APO-DIGOXIN**	**APX**	$	**0.1520**
00002242321	LANOXIN	VIR	$	0.2340
0.125 MG ORAL TABLET				
00002281228	**APO-DIGOXIN**	**APX**	$	**0.1412**
00002245427	**PMS-DIGOXIN**	**PMS**	$	**0.1412**
00002242322	LANOXIN	VIR	$	0.2340
0.25 MG ORAL TABLET				
00002281201	**APO-DIGOXIN**	**APX**	$	**0.1412**
00002245428	**PMS-DIGOXIN**	**PMS**	$	**0.1412**
00002242323	LANOXIN	VIR	$	0.2340
0.05 MG / ML ORAL ELIXIR				
00002242320	LANOXIN PEDIATRIC	VIR	$	0.3828
0.05 MG / ML INJECTION				
00002048272	DIGOXIN PEDIATRIC	SDZ	$	5.4500
0.25 MG / ML INJECTION				
00002048264	DIGOXIN	SDZ	$	2.3000

DILTIAZEM HCL

30 MG ORAL TABLET				
00000771376	**APO-DILTIAZ**	**APX**	$	**0.2075**
00002146916	**GEN-DILTIAZEM**	**GPM**	$	**0.2075**
00000862924	**NOVO-DILTAZEM**	**NOP**	$	**0.2075**
00000886068	**NU-DILTIAZ**	**NXP**	$	**0.2075**
00002097370	CARDIZEM	BOV	$	0.3715
60 MG ORAL TABLET				
00000771384	**APO-DILTIAZ**	**APX**	$	**0.3637**
00002146924	**GEN-DILTIAZEM**	**GPM**	$	**0.3637**
00000862932	**NOVO-DILTAZEM**	**NOP**	$	**0.3637**
00000886076	**NU-DILTIAZ**	**NXP**	$	**0.3637**
00002097389	CARDIZEM	BOV	$	0.6516
120 MG ORAL EXTENDED-RELEASE TABLET				
00002256738	TIAZAC XC	BOV	$	0.7681
180 MG ORAL EXTENDED-RELEASE TABLET				
00002256746	TIAZAC XC	BOV	$	1.0196
240 MG ORAL EXTENDED-RELEASE TABLET				
00002256754	TIAZAC XC	BOV	$	1.3523
300 MG ORAL EXTENDED-RELEASE TABLET				
00002256762	TIAZAC XC	BOV	$	1.3523
360 MG ORAL EXTENDED-RELEASE TABLET				
00002256770	TIAZAC XC	BOV	$	1.3523

24:00 CARDIOVASCULAR DRUGS

24:04 CARDIAC DRUGS

DILTIAZEM HCL

120 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002230997	**APO-DILTIAZ CD**	**APX**	$	**0.8021**
00002254808	**GEN-DILTIAZEM CD**	**GPM**	$	**0.8021**
00002242538	**NOVO-DILTAZEM CD**	**NOP**	$	**0.8021**
00002231052	**NU-DILTIAZ-CD**	**NXP**	$	**0.8021**
00002229781	**RATIO-DILTIAZEM CD**	**RPH**	$	**0.8021**
00002243338	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**0.8021**
00002097249	CARDIZEM CD	BOV	$	1.3050
180 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002230998	**APO-DILTIAZ CD**	**APX**	$	**1.0646**
00002254816	**GEN-DILTIAZEM CD**	**GPM**	$	**1.0646**
00002242539	**NOVO-DILTAZEM CD**	**NOP**	$	**1.0646**
00002231053	**NU-DILTIAZ-CD**	**NXP**	$	**1.0646**
00002229782	**RATIO-DILTIAZEM CD**	**RPH**	$	**1.0646**
00002243339	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**1.0646**
00002097257	CARDIZEM CD	BOV	$	1.7324
240 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002230999	**APO-DILTIAZ CD**	**APX**	$	**1.4121**
00002254824	**GEN-DILTIAZEM CD**	**GPM**	$	**1.4121**
00002242540	**NOVO-DILTAZEM CD**	**NOP**	$	**1.4121**
00002231054	**NU-DILTIAZ-CD**	**NXP**	$	**1.4121**
00002229783	**RATIO-DILTIAZEM CD**	**RPH**	$	**1.4121**
00002243340	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**1.4121**
00002097265	CARDIZEM CD	BOV	$	2.2978
300 MG ORAL CONTROLLED-DELIVERY CAPSULE				
00002229526	**APO-DILTIAZ CD**	**APX**	$	**1.7652**
00002254832	**GEN-DILTIAZEM CD**	**GPM**	$	**1.7652**
00002242541	**NOVO-DILTAZEM CD**	**NOP**	$	**1.7652**
00002229784	**RATIO-DILTIAZEM CD**	**RPH**	$	**1.7652**
00002243341	**SANDOZ DILTIAZEM CD**	**SDZ**	$	**1.7652**
00002097273	CARDIZEM CD	BOV	$	2.8723
120 MG ORAL EXTENDED-RELEASE CAPSULE				
00002271605	**NOVO-DILTIAZEM HCL ER**	**NOP**	$	**0.5094**
00002245918	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.5094**
00002231150	TIAZAC	BOV	$	0.8284
180 MG ORAL EXTENDED-RELEASE CAPSULE				
00002271613	**NOVO-DILTIAZEM HCL ER**	**NOP**	$	**0.6761**
00002245919	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.6761**
00002231151	TIAZAC	BOV	$	1.1054
240 MG ORAL EXTENDED-RELEASE CAPSULE				
00002271621	**NOVO-DILTIAZEM HCL ER**	**NOP**	$	**0.8968**
00002245920	**SANDOZ DILTIAZEM T**	**SDZ**	$	**0.8968**
00002231152	TIAZAC	BOV	$	1.4662
300 MG ORAL EXTENDED-RELEASE CAPSULE				
00002271648	**NOVO-DILTIAZEM HCL ER**	**NOP**	$	**1.1210**
00002245921	**SANDOZ DILTIAZEM T**	**SDZ**	$	**1.1210**
00002231154	TIAZAC	BOV	$	1.8328
360 MG ORAL EXTENDED-RELEASE CAPSULE				
00002271656	**NOVO-DILTIAZEM HCL ER**	**NOP**	$	**1.3522**
00002245922	**SANDOZ DILTIAZEM T**	**SDZ**	$	**1.3522**
00002231155	TIAZAC	BOV	$	2.2108

24:00 CARDIOVASCULAR DRUGS

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DISOPYRAMIDE

100 MG ORAL CAPSULE				
00002224801	RYTHMODAN	SAV	$	0.2606
150 MG ORAL CAPSULE				
00002224828	RYTHMODAN	AVE	$	0.3683

DISOPYRAMIDE PHOSPHATE

250 MG (BASE) ORAL SUSTAINED-RELEASE TABLET				
00002224836	RYTHMODAN-LA	AVE	$	0.8737

ENALAPRIL MALEATE

2.5 MG ORAL TABLET				
00000851795	VASOTEC	MFC	$	0.7233
5 MG ORAL TABLET				
00000708879	VASOTEC	MFC	$	0.8557
10 MG ORAL TABLET				
00000670901	VASOTEC	MFC	$	1.0283
20 MG ORAL TABLET				
00000670928	VASOTEC	MFC	$	1.2407

FLECAINIDE ACETATE

50 MG ORAL TABLET				
00002275538	**APO-FLECAINIDE**	**APX**	$	**0.3620**
00001966197	TAMBOCOR	GRC	$	0.5559
100 MG ORAL TABLET				
00002275546	**APO-FLECAINIDE**	**APX**	$	**0.7239**
00001966200	TAMBOCOR	GRC	$	1.1118

FOSINOPRIL SODIUM

10 MG ORAL TABLET				
00002266008	**APO-FOSINOPRIL**	**APX**	$	**0.4977**
00002262401	**GEN-FOSINOPRIL**	**GPM**	$	**0.4977**
00002247802	**NOVO-FOSINOPRIL**	**NOP**	$	**0.4977**
00002255944	**PMS-FOSINOPRIL**	**PMS**	$	**0.4977**
00001907107	MONOPRIL	BMS	$	0.8292
20 MG ORAL TABLET				
00002266016	**APO-FOSINOPRIL**	**APX**	$	**0.5985**
00002262428	**GEN-FOSINOPRIL**	**GPM**	$	**0.5985**
00002247803	**NOVO-FOSINOPRIL**	**NOP**	$	**0.5985**
00002255952	**PMS-FOSINOPRIL**	**PMS**	$	**0.5985**
00001907115	MONOPRIL	BMS	$	0.9971

LISINOPRIL

5 MG ORAL TABLET				
00002049333	**ZESTRIL**	**AZC**	$	**0.5387**
00000839388	PRINIVIL	MFC	$	0.5388
10 MG ORAL TABLET				
00000839396	**PRINIVIL**	**MFC**	$	**0.6471**
00002049376	ZESTRIL	AZC	$	0.6473
20 MG ORAL TABLET				
00000839418	**PRINIVIL**	**MFC**	$	**0.7779**
00002049384	ZESTRIL	AZC	$	0.7780

24:00 CARDIOVASCULAR DRUGS

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METOPROLOL TARTRATE

25 MG ORAL TABLET				
00002246010	**APO-METOPROLOL**	**APX**	$	**0.0643**
00002248855	**PMS-METOPROLOL-L**	**PMS**	$	**0.0643**
50 MG ORAL TABLET				
00000618632	**APO-METOPROLOL**	**APX**	$	**0.1225**
00000749354	**APO-METOPROLOL (TYPE L)**	**APX**	$	**0.1225**
00002231121	**DOM-METOPROLOL-L**	**DPC**	$	**0.1225**
00002174545	**GEN-METOPROLOL (TYPE L)**	**GPM**	$	**0.1225**
00000842648	**NOVO-METOPROL**	**NOP**	$	**0.1225**
00000648035	**NOVO-METOPROL (FC)**	**NOP**	$	**0.1225**
00000865605	**NU-METOP**	**NXP**	$	**0.1225**
00002230803	**PMS-METOPROLOL-L**	**PMS**	$	**0.1225**
00002247875	**SANDOZ METOPROLOL (TYPE L)**	**SDZ**	$	**0.1225**
00000402605	BETALOC	AZC	$	0.2315
00000397423	LOPRESOR	NOV	$	0.2464
100 MG ORAL TABLET				
00000618640	**APO-METOPROLOL**	**APX**	$	**0.2223**
00000751170	**APO-METOPROLOL (TYPE L)**	**APX**	$	**0.2223**
00002231122	**DOM-METOPROLOL-L**	**DPC**	$	**0.2223**
00002174553	**GEN-METOPROLOL (TYPE L)**	**GPM**	$	**0.2223**
00000842656	**NOVO-METOPROL**	**NOP**	$	**0.2223**
00000648043	**NOVO-METOPROL (FC)**	**NOP**	$	**0.2223**
00000865613	**NU-METOP**	**NXP**	$	**0.2223**
00002230804	**PMS-METOPROLOL-L**	**PMS**	$	**0.2223**
00002247876	**SANDOZ METOPROLOL (TYPE L)**	**SDZ**	$	**0.2223**
00000402540	BETALOC	AZC	$	0.3965
00000397431	LOPRESOR	NOV	$	0.5054
100 MG ORAL SUSTAINED-RELEASE TABLET				
00000658855	LOPRESOR SR	NOV	$	0.2634
200 MG (BASE) ORAL SUSTAINED-RELEASE TABLET				
☒ 00000497827	BETALOC DURULES	AZC	$	0.4575
☒ 00000534560	LOPRESOR SR	NOV	$	0.4779
1 MG / ML (BASE) INJECTION				
00000590819	LOPRESOR	NOV	$	1.1670

MEXILETINE HCL

100 MG ORAL CAPSULE				
00002230359	NOVO-MEXILETINE	NOP	$	0.8162
200 MG ORAL CAPSULE				
00002230360	NOVO-MEXILETINE	NOP	$	1.0930

NADOLOL

40 MG ORAL TABLET				
00000782505	**APO-NADOL**	**APX**	$	**0.2465**
00002126753	**NOVO-NADOLOL**	**NOP**	$	**0.2465**
80 MG ORAL TABLET				
00000782467	**APO-NADOL**	**APX**	$	**0.3515**
00002126761	**NOVO-NADOLOL**	**NOP**	$	**0.3515**
160 MG ORAL TABLET				
00000782475	APO-NADOL	APX	$	0.6595

24:00 CARDIOVASCULAR DRUGS

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NIFEDIPINE

10 MG ORAL SUSTAINED-RELEASE TABLET				
00002197448	**APO-NIFED PA**	**APX**	$	**0.2245**
00002212102	**NU-NIFEDIPINE-PA**	**NXP**	$	**0.2245**
20 MG ORAL SUSTAINED-RELEASE TABLET				
00002181525	**APO-NIFED PA**	**APX**	$	**0.3900**
00002200937	**NU-NIFEDIPINE-PA**	**NXP**	$	**0.3900**
20 MG ORAL EXTENDED-RELEASE TABLET				
00002237618	ADALAT XL	BAI	$	0.8470
30 MG ORAL EXTENDED-RELEASE TABLET				
00002155907	ADALAT XL	BAI	$	1.0819
60 MG ORAL EXTENDED-RELEASE TABLET				
00002155990	ADALAT XL	BAI	$	1.7022
5 MG ORAL CAPSULE				
00000725110	APO-NIFED	APX	$	0.2440
10 MG ORAL CAPSULE				
00000755907	**APO-NIFED**	**APX**	$	**0.1858**
00000865591	**NU-NIFED**	**NXP**	$	**0.1858**

PROCAINAMIDE HCL

250 MG ORAL SUSTAINED-RELEASE TABLET				
00000638692	PROCAN SR	ERF	$	0.3763
500 MG ORAL SUSTAINED-RELEASE TABLET				
00000638676	PROCAN SR	ERF	$	0.4838
750 MG ORAL SUSTAINED-RELEASE TABLET				
00000638684	PROCAN SR	ERF	$	0.7525

PROPAFENONE HCL

150 MG ORAL TABLET				
00002243324	**APO-PROPAFENONE**	**APX**	$	**0.4275**
00002243727	**PMS-PROPAFENONE**	**PMS**	$	**0.4275**
00000603708	RYTHMOL	ABB	$	1.0345
300 MG ORAL TABLET				
00002243325	**APO-PROPAFENONE**	**APX**	$	**0.7537**
00002243728	**PMS-PROPAFENONE**	**PMS**	$	**0.7537**
00000603716	RYTHMOL	ABB	$	1.8235

PROPRANOLOL HCL

10 MG ORAL TABLET				
00000402788	**APO-PROPRANOLOL**	**APX**	$	**0.0192**
00002137313	**DOM-PROPRANOLOL**	**DPC**	$	**0.0192**
00000582255	**PMS-PROPRANOLOL**	**PMS**	$	**0.0192**
00000496480	NOVO-PRANOL	NOP	$	0.0240
20 MG ORAL TABLET				
00000663719	**APO-PROPRANOLOL**	**APX**	$	**0.0346**
00000740675	**NOVO-PRANOL**	**NOP**	$	**0.0346**
40 MG ORAL TABLET				
00000402753	**APO-PROPRANOLOL**	**APX**	$	**0.0348**
00002137321	**DOM-PROPRANOLOL**	**DPC**	$	**0.0348**
00000496499	**NOVO-PRANOL**	**NOP**	$	**0.0348**
00000582263	**PMS-PROPRANOLOL**	**PMS**	$	**0.0348**

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PROPRANOLOL HCL

80 MG ORAL TABLET				
00000402761	**APO-PROPRANOLOL**	**APX**	$	**0.0585**
00000496502	**NOVO-PRANOL**	**NOP**	$	**0.0585**
00000582271	**PMS-PROPRANOLOL**	**PMS**	$	**0.0585**
120 MG ORAL TABLET				
00000504335	APO-PROPRANOLOL	APX	$	0.1059
60 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002042231	INDERAL-LA	WAY	$	0.5144
80 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002042258	INDERAL-LA	WAY	$	0.5801
120 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002042266	INDERAL-LA	WAY	$	0.8929
160 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002042274	INDERAL-LA	WAY	$	1.0561

QUINAPRIL HCL

5 MG (BASE) ORAL TABLET				
00001947664	ACCUPRIL	PFI	$	0.9184
10 MG (BASE) ORAL TABLET				
00001947672	ACCUPRIL	PFI	$	0.9184
20 MG (BASE) ORAL TABLET				
00001947680	ACCUPRIL	PFI	$	0.9184
40 MG (BASE) ORAL TABLET				
00001947699	ACCUPRIL	PFI	$	0.9184

RAMIPRIL

1.25 MG ORAL CAPSULE				
00002251515	**APO-RAMIPRIL**	**APX**	$	**0.4200**
00002287692	**RATIO-RAMIPRIL**	**RPH**	$	**0.4200**
00002283891	NOVO-RAMIPRIL	NOP	$	0.4550
00002221829	ALTACE	SAV	$	0.7163
2.5 MG ORAL CAPSULE				
00002251531	**APO-RAMIPRIL**	**APX**	$	**0.5000**
00002287706	**RATIO-RAMIPRIL**	**RPH**	$	**0.5000**
00002247945	NOVO-RAMIPRIL	NOP	$	0.5250
00002221837	ALTACE	SAV	$	0.8264
5 MG ORAL CAPSULE				
00002251574	**APO-RAMIPRIL**	**APX**	$	**0.5000**
00002287714	**RATIO-RAMIPRIL**	**RPH**	$	**0.5000**
00002247946	NOVO-RAMIPRIL	NOP	$	0.5250
00002221845	ALTACE	SAV	$	0.8264
10 MG ORAL CAPSULE				
00002251582	**APO-RAMIPRIL**	**APX**	$	**0.6300**
00002287722	**RATIO-RAMIPRIL**	**RPH**	$	**0.6300**
00002247947	NOVO-RAMIPRIL	NOP	$	0.6650
00002221853	ALTACE	SAV	$	1.0467

24:00 CARDIOVASCULAR DRUGS

24:04 CARDIAC DRUGS

SOTALOL HCL

80 MG ORAL TABLET

00002210428	**APO-SOTALOL**	**APX**	$	**0.5932**
00002270625	**CO SOTALOL**	**COB**	$	**0.5932**
00002229778	**GEN-SOTALOL**	**GPM**	$	**0.5932**
00002231181	**NOVO-SOTALOL**	**NOP**	$	**0.5932**
00002200996	**NU-SOTALOL**	**NXP**	$	**0.5932**
00002238326	**PMS-SOTALOL**	**PMS**	$	**0.5932**
00002084228	**RATIO-SOTALOL**	**RPH**	$	**0.5932**
00002257831	**SANDOZ SOTALOL**	**SDZ**	$	**0.5932**

160 MG ORAL TABLET

00002167794	**APO-SOTALOL**	**APX**	$	**0.6492**
00002270633	**CO SOTALOL**	**COB**	$	**0.6492**
00002238635	**DOM-SOTALOL**	**DPC**	$	**0.6492**
00002229779	**GEN-SOTALOL**	**GPM**	$	**0.6492**
00002231182	**NOVO-SOTALOL**	**NOP**	$	**0.6492**
00002163772	**NU-SOTALOL**	**NXP**	$	**0.6492**
00002238327	**PMS-SOTALOL**	**PMS**	$	**0.6492**
00002084236	**RATIO-SOTALOL**	**RPH**	$	**0.6492**
00002234013	**SANDOZ SOTALOL**	**SDZ**	$	**0.6492**
00002257858	**SANDOZ SOTALOL**	**SDZ**	$	**0.6492**

TIMOLOL MALEATE

5 MG ORAL TABLET

00000755842	**APO-TIMOL**	**APX**	$	**0.1817**
00001947796	**NOVO-TIMOL**	**NOP**	$	**0.1817**
00002044609	**NU-TIMOLOL**	**NXP**	$	**0.1817**

10 MG ORAL TABLET

00000755850	**APO-TIMOL**	**APX**	$	**0.2835**
00001947818	**NOVO-TIMOL**	**NOP**	$	**0.2835**
00002044617	**NU-TIMOLOL**	**NXP**	$	**0.2835**

20 MG ORAL TABLET

00000755869	**APO-TIMOL**	**APX**	$	**0.5670**
00001947826	**NOVO-TIMOL**	**NOP**	$	**0.5670**

TRANDOLAPRIL

0.5 MG ORAL CAPSULE

00002231457	MAVIK	ABB	$	0.6200

1 MG ORAL CAPSULE

00002231459	MAVIK	ABB	$	0.6700

2 MG ORAL CAPSULE

00002231460	MAVIK	ABB	$	0.7700

4 MG ORAL CAPSULE

00002239267	MAVIK	ABB	$	0.9500

VERAPAMIL HCL

80 MG ORAL TABLET

00000782483	**APO-VERAP**	**APX**	$	**0.2735**
00002237921	**GEN-VERAPAMIL**	**GPM**	$	**0.2735**
00000554316	**ISOPTIN**	**PMS**	$	**0.2735**
00000886033	**NU-VERAP**	**NXP**	$	**0.2735**

120 MG ORAL TABLET

00000782491	**APO-VERAP**	**APX**	$	**0.4250**
00002237922	**GEN-VERAPAMIL**	**GPM**	$	**0.4250**
00000886041	**NU-VERAP**	**NXP**	$	**0.4250**

24:00 CARDIOVASCULAR DRUGS

24:04 CARDIAC DRUGS

VERAPAMIL HCL

120 MG ORAL SUSTAINED-RELEASE TABLET				
00002246893	**APO-VERAP SR**	**APX**	$	**0.6900**
00002210347	**GEN-VERAPAMIL SR**	**GPM**	$	**0.6900**
00001907123	ISOPTIN SR	ABB	$	1.1756
180 MG ORAL SUSTAINED-RELEASE TABLET				
00002246894	**APO-VERAP SR**	**APX**	$	**0.6558**
00002210355	**GEN-VERAPAMIL SR**	**GPM**	$	**0.6558**
00001934317	ISOPTIN SR	ABB	$	1.3276
240 MG ORAL SUSTAINED-RELEASE TABLET				
00002246895	**APO-VERAP SR**	**APX**	$	**0.8720**
00002210363	**GEN-VERAPAMIL SR**	**GPM**	$	**0.8720**
00002211920	**NOVO-VERAMIL SR**	**NOP**	$	**0.8720**
00002237791	**PMS-VERAPAMIL SR**	**PMS**	$	**0.8720**
00000742554	ISOPTIN SR	ABB	$	1.7704
180 MG ORAL CONTROLLED-ONSET EXT.-RELEASE TABLET				
00002231676	COVERA-HS	PFI	$	0.8720
240 MG ORAL CONTROLLED-ONSET EXT.-RELEASE TABLET				
00002231677	COVERA-HS	PFI	$	0.9749

24:00 CARDIOVASCULAR DRUGS

24:06 ANTILIPEMIC AGENTS

ATORVASTATIN CALCIUM

10 MG (BASE) ORAL TABLET				
00002230711	LIPITOR	PFI	$	1.7888
20 MG (BASE) ORAL TABLET				
00002230713	LIPITOR	PFI	$	2.2360
40 MG (BASE) ORAL TABLET				
00002230714	LIPITOR	PFI	$	2.4037
80 MG (BASE) ORAL TABLET				
00002243097	LIPITOR	PFI	$	2.4037

BEZAFIBRATE

400 MG ORAL SUSTAINED-RELEASE TABLET				
00002083523	BEZALIP	HLR	$	1.7200

CHOLESTYRAMINE RESIN

4 G ORAL POWDER PACKET				
00000890960	**PMS-CHOLESTYRAMINE LIGHT**	**PMS**	$	**1.3167**
00002210320	**PMS-CHOLESTYRAMINE REGULAR**	**PMS**	$	**1.3167**

COLESTIPOL HCL

1 G ORAL TABLET				
00002132680	COLESTID	PFI	$	0.2761
5 G ORAL POWDER PACKET				
00000642975	**COLESTID**	**PFI**	$	**0.9873**
00002132699	**COLESTID ORANGE**	**PFI**	$	**0.9873**

24:00 CARDIOVASCULAR DRUGS

24:06 ANTILIPEMIC AGENTS

FENOFIBRATE

100 MG ORAL TABLET				
00002246859	**APO-FENO-SUPER**	**APX**	$	**0.7875**
00002288044	**SANDOZ FENOFIBRATE S**	**SDZ**	$	**0.7875**
00002289083	NOVO-FENOFIBRATE-S	NOP	$	0.7877
00002241601	LIPIDIL SUPRA	SLO	$	1.1627
67 MG ORAL CAPSULE				
00002243180	**APO-FENO-MICRO**	**APX**	$	**0.4325**
00002243551	**NOVO-FENOFIBRATE MICRONIZED**	**NOP**	$	**0.4325**
100 MG ORAL CAPSULE				
00002225980	**APO-FENOFIBRATE**	**APX**	$	**0.4325**
00002223600	**NU-FENOFIBRATE**	**NXP**	$	**0.4325**
200 MG ORAL CAPSULE				
00002239864	**APO-FENO-MICRO**	**APX**	$	**1.0890**
00002240210	**GEN-FENOFIBRATE MICRO**	**GPM**	$	**1.0890**
00002243552	**NOVO-FENOFIBRATE MICRONIZED**	**NOP**	$	**1.0890**
00002273551	**PMS-FENOFIBRATE MICRO**	**PMS**	$	**1.0890**
00002250039	**RATIO-FENOFIBRATE MC**	**RPH**	$	**1.0890**
00002146959	LIPIDIL MICRO	SLO	$	1.1707
160 MG ORAL CAPSULE/TABLET				
00002246860	**APO-FENO-SUPER (TABLET)**	**APX**	$	**0.8470**
00002289091	**NOVO-FENOFIBRATE-S (TABLET)**	**NOP**	$	**0.8470**
00002288052	**SANDOZ FENOFIBRATE S (TABLET)**	**SDZ**	$	**0.8470**
00002250004	FENOMAX (CAPSULE)	ORY	$	0.9105
00002241602	LIPIDIL SUPRA (TABLET)	SLO	$	1.3397

FLUVASTATIN SODIUM

80 MG (BASE) ORAL EXTENDED-RELEASE TABLET				
00002250527	LESCOL XL	NOV	$	1.4535
20 MG (BASE) ORAL CAPSULE				
00002061562	LESCOL	NOV	$	0.8597
40 MG (BASE) ORAL CAPSULE				
00002061570	LESCOL	NOV	$	1.2036

GEMFIBROZIL

600 MG ORAL TABLET				
00001979582	**APO-GEMFIBROZIL**	**APX**	$	**0.7520**
00002230580	**DOM-GEMFIBROZIL**	**DPC**	$	**0.7520**
00002230476	**GEN-GEMFIBROZIL**	**GPM**	$	**0.7520**
00002142074	**NOVO-GEMFIBROZIL**	**NOP**	$	**0.7520**
00002058464	**NU-GEMFIBROZIL**	**NXP**	$	**0.7520**
00002230183	**PMS-GEMFIBROZIL**	**PMS**	$	**0.7520**
00000659606	LOPID	PFI	$	1.1086
300 MG ORAL CAPSULE				
00001979574	**APO-GEMFIBROZIL**	**APX**	$	**0.2964**
00002185407	**GEN-GEMFIBROZIL**	**GPM**	$	**0.2964**
00002241704	**NOVO-GEMFIBROZIL**	**NOP**	$	**0.2964**
00002058456	**NU-GEMFIBROZIL**	**NXP**	$	**0.2964**
00002239951	**PMS-GEMFIBROZIL**	**PMS**	$	**0.2964**
00000599026	LOPID	PFI	$	0.5538

24:00 CARDIOVASCULAR DRUGS

24:06 ANTILIPEMIC AGENTS

LOVASTATIN

20 MG ORAL TABLET

00002220172	**APO-LOVASTATIN**	**APX**	$	**1.0907**
00002248572	**CO LOVASTATIN**	**COB**	$	**1.0907**
00002243127	**GEN-LOVASTATIN**	**GPM**	$	**1.0907**
00002246542	**NOVO-LOVASTATIN**	**NOP**	$	**1.0907**
00002246013	**PMS-LOVASTATIN**	**PMS**	$	**1.0907**
00002267969	**RAN-LOVASTATIN**	**RAN**	$	**1.0907**
00002245822	**RATIO-LOVASTATIN**	**RPH**	$	**1.0907**
00002247056	**SANDOZ LOVASTATIN**	**SDZ**	$	**1.0907**
00000795860	MEVACOR	MFC	$	1.8547

40 MG ORAL TABLET

00002220180	**APO-LOVASTATIN**	**APX**	$	**2.0117**
00002248573	**CO LOVASTATIN**	**COB**	$	**2.0117**
00002243129	**GEN-LOVASTATIN**	**GPM**	$	**2.0117**
00002246543	**NOVO-LOVASTATIN**	**NOP**	$	**2.0117**
00002246014	**PMS-LOVASTATIN**	**PMS**	$	**2.0117**
00002267977	**RAN-LOVASTATIN**	**RAN**	$	**2.0117**
00002245823	**RATIO-LOVASTATIN**	**RPH**	$	**2.0117**
00002247057	**SANDOZ LOVASTATIN**	**SDZ**	$	**2.0117**
00000795852	MEVACOR	MFC	$	3.4207

PRAVASTATIN SODIUM

10 MG ORAL TABLET

00002243506	**APO-PRAVASTATIN**	**APX**	$	**0.9530**
00002248182	**CO PRAVASTATIN**	**COB**	$	**0.9530**
00002257092	**GEN-PRAVASTATIN**	**GPM**	$	**0.9530**
00002247008	**NOVO-PRAVASTATIN**	**NOP**	$	**0.9530**
00002244350	**NU-PRAVASTATIN**	**NXP**	$	**0.9530**
00002247655	**PMS-PRAVASTATIN**	**PMS**	$	**0.9530**
00002284421	**RAN-PRAVASTATIN**	**RAN**	$	**0.9530**
00002246930	**RATIO-PRAVASTATIN**	**RPH**	$	**0.9530**
00002247856	**SANDOZ PRAVASTATIN**	**SDZ**	$	**0.9530**
00000893749	PRAVACHOL	BMS	$	1.5883

20 MG ORAL TABLET

00002243507	**APO-PRAVASTATIN**	**APX**	$	**1.1243**
00002248183	**CO PRAVASTATIN**	**COB**	$	**1.1243**
00002257106	**GEN-PRAVASTATIN**	**GPM**	$	**1.1243**
00002247009	**NOVO-PRAVASTATIN**	**NOP**	$	**1.1243**
00002244351	**NU-PRAVASTATIN**	**NXP**	$	**1.1243**
00002247656	**PMS-PRAVASTATIN**	**PMS**	$	**1.1243**
00002284448	**RAN-PRAVASTATIN**	**RAN**	$	**1.1243**
00002246931	**RATIO-PRAVASTATIN**	**RPH**	$	**1.1243**
00002247857	**SANDOZ PRAVASTATIN**	**SDZ**	$	**1.1243**
00000893757	PRAVACHOL	BMS	$	1.8736

24:00 CARDIOVASCULAR DRUGS

24:06 ANTILIPEMIC AGENTS

PRAVASTATIN SODIUM

40 MG ORAL TABLET

00002243508	**APO-PRAVASTATIN**	**APX**	$	**1.3543**
00002248184	**CO PRAVASTATIN**	**COB**	$	**1.3543**
00002257114	**GEN-PRAVASTATIN**	**GPM**	$	**1.3543**
00002247010	**NOVO-PRAVASTATIN**	**NOP**	$	**1.3543**
00002244352	**NU-PRAVASTATIN**	**NXP**	$	**1.3543**
00002247657	**PMS-PRAVASTATIN**	**PMS**	$	**1.3543**
00002284456	**RAN-PRAVASTATIN**	**RAN**	$	**1.3543**
00002246932	**RATIO-PRAVASTATIN**	**RPH**	$	**1.3543**
00002247858	**SANDOZ PRAVASTATIN**	**SDZ**	$	**1.3543**
00002222051	PRAVACHOL	BMS	$	2.2568

ROSUVASTATIN CALCIUM

5 MG (BASE) ORAL TABLET

00002265540	CRESTOR	AZC	$	1.2900

10 MG (BASE) ORAL TABLET

00002247162	CRESTOR	AZC	$	1.3600

20 MG (BASE) ORAL TABLET

00002247163	CRESTOR	AZC	$	1.7000

40 MG (BASE) ORAL TABLET

00002247164	CRESTOR	AZC	$	1.9900

SIMVASTATIN

5 MG ORAL TABLET

00002247011	**APO-SIMVASTATIN**	**APX**	$	**0.5670**
00002248103	**CO SIMVASTATIN**	**COB**	$	**0.5670**
00002246582	**GEN-SIMVASTATIN**	**GPM**	$	**0.5670**
00002250144	**NOVO-SIMVASTATIN**	**NOP**	$	**0.5670**
00002252619	**PMS-SIMVASTATIN**	**PMS**	$	**0.5670**
00002269252	**PMS-SIMVASTATIN**	**PMS**	$	**0.5670**
00000884324	ZOCOR	MFC	$	0.9640

10 MG ORAL TABLET

00002247012	**APO-SIMVASTATIN**	**APX**	$	**1.1214**
00002248104	**CO SIMVASTATIN**	**COB**	$	**1.1214**
00002246583	**GEN-SIMVASTATIN**	**GPM**	$	**1.1214**
00002250152	**NOVO-SIMVASTATIN**	**NOP**	$	**1.1214**
00002252635	**PMS-SIMVASTATIN**	**PMS**	$	**1.1214**
00002269260	**PMS-SIMVASTATIN**	**PMS**	$	**1.1214**
00002247068	**RATIO-SIMVASTATIN**	**RPH**	$	**1.1214**
00002247828	**SANDOZ SIMVASTATIN**	**SDZ**	$	**1.1214**
00002265885	**TARO-SIMVASTATIN**	**TAR**	$	**1.1214**
00000884332	ZOCOR	MFC	$	1.9070

20 MG ORAL TABLET

00002247013	**APO-SIMVASTATIN**	**APX**	$	**1.3860**
00002248105	**CO SIMVASTATIN**	**COB**	$	**1.3860**
00002246737	**GEN-SIMVASTATIN**	**GPM**	$	**1.3860**
00002250160	**NOVO-SIMVASTATIN**	**NOP**	$	**1.3860**
00002252643	**PMS-SIMVASTATIN**	**PMS**	$	**1.3860**
00002269279	**PMS-SIMVASTATIN**	**PMS**	$	**1.3860**
00002247069	**RATIO-SIMVASTATIN**	**RPH**	$	**1.3860**
00002247830	**SANDOZ SIMVASTATIN**	**SDZ**	$	**1.3860**
00002265893	**TARO-SIMVASTATIN**	**TAR**	$	**1.3860**
00000884340	ZOCOR	MFC	$	2.3566

24:00 CARDIOVASCULAR DRUGS

24:06 ANTILIPEMIC AGENTS

SIMVASTATIN

40 MG ORAL TABLET				
00002247014	**APO-SIMVASTATIN**	**APX**	$	**1.3860**
00002248106	**CO SIMVASTATIN**	**COB**	$	**1.3860**
00002246584	**GEN-SIMVASTATIN**	**GPM**	$	**1.3860**
00002250179	**NOVO-SIMVASTATIN**	**NOP**	$	**1.3860**
00002252651	**PMS-SIMVASTATIN**	**PMS**	$	**1.3860**
00002269287	**PMS-SIMVASTATIN**	**PMS**	$	**1.3860**
00002247070	**RATIO-SIMVASTATIN**	**RPH**	$	**1.3860**
00002247831	**SANDOZ SIMVASTATIN**	**SDZ**	$	**1.3860**
00002265907	**TARO-SIMVASTATIN**	**TAR**	$	**1.3860**
00000884359	ZOCOR	MFC	$	2.3567
80 MG ORAL TABLET				
00002247015	**APO-SIMVASTATIN**	**APX**	$	**1.3860**
00002248107	**CO SIMVASTATIN**	**COB**	$	**1.3860**
00002246585	**GEN-SIMVASTATIN**	**GPM**	$	**1.3860**
00002250187	**NOVO-SIMVASTATIN**	**NOP**	$	**1.3860**
00002252678	**PMS-SIMVASTATIN**	**PMS**	$	**1.3860**
00002269295	**PMS-SIMVASTATIN**	**PMS**	$	**1.3860**
00002247071	**RATIO-SIMVASTATIN**	**RPH**	$	**1.3860**
00002247833	**SANDOZ SIMVASTATIN**	**SDZ**	$	**1.3860**
00002240332	ZOCOR	MFC	$	2.3567

24:00 CARDIOVASCULAR DRUGS

24:08 HYPOTENSIVE AGENTS

ATENOLOL/ CHLORTHALIDONE

50 MG * 25 MG ORAL TABLET				
00002248763	**APO-ATENIDONE**	**APX**	$	**0.4343**
00002049961	TENORETIC 50/25	AZC	$	0.6389
100 MG * 25 MG ORAL TABLET				
00002248764	**APO-ATENIDONE**	**APX**	$	**0.7118**
00002049988	TENORETIC 100/25	AZC	$	1.0471

BENAZEPRIL HCL

5 MG ORAL TABLET				
00002290332	**APO-BENAZEPRIL**	**APX**	$	**0.5060**
00000885835	LOTENSIN	NOV	$	0.7252
10 MG ORAL TABLET				
00002290340	**APO-BENAZEPRIL**	**APX**	$	**0.5981**
00000885843	LOTENSIN	NOV	$	0.8573
20 MG ORAL TABLET				
00002273918	**APO-BENAZEPRIL**	**APX**	$	**0.5460**
00000885851	LOTENSIN	NOV	$	0.9368

CANDESARTAN CILEXETIL

8 MG ORAL TABLET				
00002239091	ATACAND	AZC	$	1.1123
16 MG ORAL TABLET				
00002239092	ATACAND	AZC	$	1.1123

CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE

16 MG * 12.5 MG ORAL TABLET				
00002244021	ATACAND PLUS	AZC	$	1.1117

24:00 CARDIOVASCULAR DRUGS

24:08 HYPOTENSIVE AGENTS

CILAZAPRIL

1 MG ORAL TABLET

00002291134	**APO-CILAZAPRIL**	**APX**	$	**0.3717**
00002283778	**GEN-CILAZAPRIL**	**GPM**	$	**0.3717**
00002266350	**NOVO-CILAZAPRIL**	**NOP**	$	**0.3717**
00002280442	**PMS-CILAZAPRIL**	**PMS**	$	**0.3717**
00001911465	INHIBACE	HLR	$	0.6565

2.5 MG ORAL TABLET

00002291142	**APO-CILAZAPRIL**	**APX**	$	**0.4284**
00002285215	**CO CILAZAPRIL**	**COB**	$	**0.4284**
00002283786	**GEN-CILAZAPRIL**	**GPM**	$	**0.4284**
00002266369	**NOVO-CILAZAPRIL**	**NOP**	$	**0.4284**
00002280450	**PMS-CILAZAPRIL**	**PMS**	$	**0.4284**
00001911473	INHIBACE	HLR	$	0.7566

5 MG ORAL TABLET

00002291150	**APO-CILAZAPRIL**	**APX**	$	**0.4977**
00002285223	**CO CILAZAPRIL**	**COB**	$	**0.4977**
00002283794	**GEN-CILAZAPRIL**	**GPM**	$	**0.4977**
00002266377	**NOVO-CILAZAPRIL**	**NOP**	$	**0.4977**
00002280469	**PMS-CILAZAPRIL**	**PMS**	$	**0.4977**
00001911481	INHIBACE	HLR	$	0.8790

CILAZAPRIL/ HYDROCHLOROTHIAZIDE

5 MG * 12.5 MG ORAL TABLET

00002284987	**APO-CILAZAPRIL/HCTZ**	**APX**	$	**0.5530**
00002181479	INHIBACE PLUS	HLR	$	0.8789

CLONIDINE HCL

0.1 MG ORAL TABLET

00000868949	**APO-CLONIDINE**	**APX**	$	**0.1765**
00002046121	**NOVO-CLONIDINE**	**NOP**	$	**0.1765**
00001913786	**NU-CLONIDINE**	**NXP**	$	**0.1765**
00000259527	CATAPRES	BOE	$	0.1853

0.2 MG ORAL TABLET

00000868957	**APO-CLONIDINE**	**APX**	$	**0.3149**
00002046148	**NOVO-CLONIDINE**	**NOP**	$	**0.3149**
00001913220	**NU-CLONIDINE**	**NXP**	$	**0.3149**
00000291889	CATAPRES	BOE	$	0.3306

DIAZOXIDE

100 MG ORAL CAPSULE

00000503347	PROGLYCEM	SCH	$	1.5723

DOXAZOSIN MESYLATE

1 MG (BASE) ORAL TABLET

00002240588	**APO-DOXAZOSIN**	**APX**	$	**0.3465**
00002240498	**GEN-DOXAZOSIN**	**GPM**	$	**0.3465**
00002242728	**NOVO-DOXAZOSIN**	**NOP**	$	**0.3465**
00002244527	**PMS-DOXAZOSIN**	**PMS**	$	**0.3465**
00001958100	CARDURA	AZC	$	0.5665

2 MG (BASE) ORAL TABLET

00002240589	**APO-DOXAZOSIN**	**APX**	$	**0.4158**
00002240499	**GEN-DOXAZOSIN**	**GPM**	$	**0.4158**
00002242729	**NOVO-DOXAZOSIN**	**NOP**	$	**0.4158**
00002244528	**PMS-DOXAZOSIN**	**PMS**	$	**0.4158**
00001958097	CARDURA	AZC	$	0.6795

24:00 CARDIOVASCULAR DRUGS

24:08 HYPOTENSIVE AGENTS

DOXAZOSIN MESYLATE

4 MG (BASE) ORAL TABLET

00002240590	**APO-DOXAZOSIN**	**APX**	$	**0.5405**
00002240500	**GEN-DOXAZOSIN**	**GPM**	$	**0.5405**
00002242730	**NOVO-DOXAZOSIN**	**NOP**	$	**0.5405**
00002244529	**PMS-DOXAZOSIN**	**PMS**	$	**0.5405**
00001958119	CARDURA	AZC	$	0.8835

ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE

5 MG * 12.5 MG ORAL TABLET

00002242826	VASERETIC	MFC	$	0.8557

10 MG * 25 MG ORAL TABLET

00000657298	VASERETIC	MFC	$	1.0283

EPROSARTAN MESYLATE

400 MG (BASE) ORAL TABLET

00002240432	TEVETEN	SLO	$	0.7310

600 MG (BASE) ORAL TABLET

00002243942	TEVETEN	SLO	$	1.0965

EPROSARTAN MESYLATE/ HYDROCHLOROTHIAZIDE

600 MG * 12.5 MG ORAL TABLET

00002253631	TEVETEN PLUS	SLO	$	1.0965

FELODIPINE

2.5 MG ORAL EXTENDED-RELEASE TABLET

00002057778	**PLENDIL**	**AZC**	$	**0.5087**
00002221985	RENEDIL	SAV	$	0.5587

5 MG ORAL EXTENDED-RELEASE TABLET

00002280264	**SANDOZ FELODIPINE**	**SDZ**	$	**0.4620**
00000851779	PLENDIL	AZC	$	0.6797
00002221993	RENEDIL	SAV	$	0.7468

10 MG ORAL EXTENDED-RELEASE TABLET

00002280272	**SANDOZ FELODIPINE**	**SDZ**	$	**0.6923**
00000851787	PLENDIL	AZC	$	1.0197
00002222000	RENEDIL	SAV	$	1.1194

HYDRALAZINE HCL

10 MG ORAL TABLET

00000441619	**APO-HYDRALAZINE**	**APX**	$	**0.1026**
00000759465	**NOVO-HYLAZIN**	**NOP**	$	**0.1026**
00001913204	**NU-HYDRAL**	**NXP**	$	**0.1026**

25 MG ORAL TABLET

00000441627	**APO-HYDRALAZINE**	**APX**	$	**0.1764**
00000759473	**NOVO-HYLAZIN**	**NOP**	$	**0.1764**
00002004828	**NU-HYDRAL**	**NXP**	$	**0.1764**

50 MG ORAL TABLET

00000441635	**APO-HYDRALAZINE**	**APX**	$	**0.2770**
00000759481	**NOVO-HYLAZIN**	**NOP**	$	**0.2770**
00002004836	**NU-HYDRAL**	**NXP**	$	**0.2770**

24:00 CARDIOVASCULAR DRUGS

24:08 HYPOTENSIVE AGENTS

IRBESARTAN

75 MG ORAL TABLET				
00002237923	AVAPRO	BMS	$	1.1641
150 MG ORAL TABLET				
00002237924	AVAPRO	BMS	$	1.1641
300 MG ORAL TABLET				
00002237925	AVAPRO	BMS	$	1.1641

IRBESARTAN/ HYDROCHLOROTHIAZIDE

150 MG * 12.5 MG ORAL TABLET				
00002241818	AVALIDE 150/12.5	BMS	$	1.1641
300 MG * 12.5 MG ORAL TABLET				
00002241819	AVALIDE 300/12.5	BMS	$	1.1641
300 MG * 25 MG ORAL TABLET				
00002280213	AVALIDE 300/25	BMS	$	1.1641

LABETALOL HCL

100 MG ORAL TABLET				
00002243538	**APO-LABETALOL**	**APX**	$	**0.1977**
00002106272	TRANDATE	SHB	$	0.2401
200 MG ORAL TABLET				
00002243539	**APO-LABETALOL**	**APX**	$	**0.3358**
00002106280	TRANDATE	SHB	$	0.4245
5 MG / ML INJECTION				
00002231689	LABETALOL HYDROCHLORIDE	SDZ	$	1.1235

LISINOPRIL/ HYDROCHLOROTHIAZIDE

10 MG * 12.5 MG ORAL TABLET				
⊠ 00002108194	PRINZIDE	MFC	$	0.6668
⊠ 00002103729	ZESTORETIC	AZC	$	0.8337
20 MG * 12.5 MG ORAL TABLET				
⊠ 00000884413	PRINZIDE	MFC	$	0.8012
⊠ 00002045737	ZESTORETIC	AZC	$	1.0016
20 MG * 25 MG ORAL TABLET				
⊠ 00000884421	PRINZIDE	MFC	$	0.8012
⊠ 00002045729	ZESTORETIC	AZC	$	1.0016

LOSARTAN POTASSIUM

25 MG ORAL TABLET				
00002182815	COZAAR	MFC	$	1.1783
50 MG ORAL TABLET				
00002182874	COZAAR	MFC	$	1.1783
100 MG ORAL TABLET				
00002182882	COZAAR	MFC	$	1.1783

LOSARTAN POTASSIUM/ HYDROCHLOROTHIAZIDE

50 MG * 12.5 MG ORAL TABLET				
00002230047	HYZAAR	MFC	$	1.1783
100 MG * 25 MG ORAL TABLET				
00002241007	HYZAAR DS	MFC	$	1.1783

24:00 CARDIOVASCULAR DRUGS

24:08 HYPOTENSIVE AGENTS

METHYLDOPA

125 MG ORAL TABLET				
00000360252	APO-METHYLDOPA	APX	$	0.0966
250 MG ORAL TABLET				
00000360260	APO-METHYLDOPA	APX	$	0.1400
500 MG ORAL TABLET				
00000426830	APO-METHYLDOPA	APX	$	0.2479

MINOXIDIL

2.5 MG ORAL TABLET				
00000514497	LONITEN	PFI	$	0.3679
10 MG ORAL TABLET				
00000514500	LONITEN	PFI	$	0.8108

OXPRENOLOL HCL

40 MG ORAL TABLET				
00000402575	TRASICOR	NOV	$	0.2948

PERINDOPRIL ERBUMINE

2 MG ORAL TABLET				
00002123274	COVERSYL	SEV	$	0.6450
4 MG ORAL TABLET				
00002123282	COVERSYL	SEV	$	0.8063
8 MG ORAL TABLET				
00002289296	**APO-PERINDOPRIL**	**APX**	$	**0.8927**
00002246624	COVERSYL	SEV	$	1.1288

PERINDOPRIL ERBUMINE/ INDAPAMIDE HEMIHYDRATE

4 MG * 1.25 MG ORAL TABLET				
00002246569	COVERSYL PLUS	SEV	$	1.0105

PINDOLOL

5 MG ORAL TABLET				
00000755877	**APO-PINDOL**	**APX**	$	**0.2283**
00002231650	**DOM-PINDOLOL**	**DPC**	$	**0.2283**
00002057808	**GEN-PINDOLOL**	**GPM**	$	**0.2283**
00000869007	**NOVO-PINDOL**	**NOP**	$	**0.2283**
00000886149	**NU-PINDOL**	**NXP**	$	**0.2283**
00002231536	**PMS-PINDOLOL**	**PMS**	$	**0.2283**
00002261782	**SANDOZ PINDOLOL**	**SDZ**	$	**0.2283**
00000417270	VISKEN	NOV	$	0.5054
10 MG ORAL TABLET				
00000755885	**APO-PINDOL**	**APX**	$	**0.3965**
00002238046	**DOM-PINDOLOL**	**DPC**	$	**0.3965**
00002057816	**GEN-PINDOLOL**	**GPM**	$	**0.3965**
00000869015	**NOVO-PINDOL**	**NOP**	$	**0.3965**
00000886009	**NU-PINDOL**	**NXP**	$	**0.3965**
00002231537	**PMS-PINDOLOL**	**PMS**	$	**0.3965**
00002261790	**SANDOZ PINDOLOL**	**SDZ**	$	**0.3965**
00000443174	VISKEN	NOV	$	0.8630

24:00 CARDIOVASCULAR DRUGS

24:08 HYPOTENSIVE AGENTS

PINDOLOL

15 MG ORAL TABLET

00000755893	**APO-PINDOL**	**APX**	$	**0.5825**
00002057824	**GEN-PINDOLOL**	**GPM**	$	**0.5825**
00000869023	**NOVO-PINDOL**	**NOP**	$	**0.5825**
00000886130	**NU-PINDOL**	**NXP**	$	**0.5825**
00002231539	**PMS-PINDOLOL**	**PMS**	$	**0.5825**
00002261804	**SANDOZ PINDOLOL**	**SDZ**	$	**0.5825**
00000417289	VISKEN	NOV	$	1.2519

PINDOLOL/ HYDROCHLOROTHIAZIDE

10 MG * 25 MG ORAL TABLET

00000568627	VISKAZIDE 10/25	NOV	$	0.7897

10 MG * 50 MG ORAL TABLET

00000568635	VISKAZIDE 10/50	NOV	$	0.7897

PRAZOSIN HCL

1 MG (BASE) ORAL TABLET

00000882801	**APO-PRAZO**	**APX**	$	**0.2055**
00001934198	**NOVO-PRAZIN**	**NOP**	$	**0.2055**
00001913794	**NU-PRAZO**	**NXP**	$	**0.2055**

2 MG (BASE) ORAL TABLET

00000882828	**APO-PRAZO**	**APX**	$	**0.2791**
00001934201	**NOVO-PRAZIN**	**NOP**	$	**0.2791**
00001913808	**NU-PRAZO**	**NXP**	$	**0.2791**

5 MG (BASE) ORAL TABLET

00000882836	**APO-PRAZO**	**APX**	$	**0.3806**
00001934228	**NOVO-PRAZIN**	**NOP**	$	**0.3806**
00001913816	**NU-PRAZO**	**NXP**	$	**0.3806**

QUINAPRIL HCL/ HYDROCHLOROTHIAZIDE

10 MG (BASE) * 12.5 MG ORAL TABLET

00002237367	ACCURETIC 10/12.5	PFI	$	0.9182

20 MG (BASE) * 12.5 MG ORAL TABLET

00002237368	ACCURETIC 20/12.5	PFI	$	0.9182

20 MG * 25 MG ORAL TABLET

00002237369	ACCURETIC 20/25	PFI	$	0.8832

TELMISARTAN

40 MG ORAL TABLET

00002240769	MICARDIS	BOE	$	1.1296

80 MG ORAL TABLET

00002240770	MICARDIS	BOE	$	1.1296

TELMISARTAN/ HYDROCHLOROTHIAZIDE

80 MG * 12.5 MG ORAL TABLET

00002244344	MICARDIS PLUS	BOE	$	1.1296

24:00 CARDIOVASCULAR DRUGS

24:08 HYPOTENSIVE AGENTS

TERAZOSIN HCL

1 MG (BASE) ORAL TABLET				
00002234502	**APO-TERAZOSIN**	**APX**	$	**0.3490**
00002230805	**NOVO-TERAZOSIN**	**NOP**	$	**0.3490**
00002233047	**NU-TERAZOSIN**	**NXP**	$	**0.3490**
00002243518	**PMS-TERAZOSIN**	**PMS**	$	**0.3490**
00002218941	**RATIO-TERAZOSIN**	**RPH**	$	**0.3490**
00000818658	HYTRIN	ABB	$	0.6402
2 MG (BASE) ORAL TABLET				
00002234503	**APO-TERAZOSIN**	**APX**	$	**0.4436**
00002230806	**NOVO-TERAZOSIN**	**NOP**	$	**0.4436**
00002233048	**NU-TERAZOSIN**	**NXP**	$	**0.4436**
00002243519	**PMS-TERAZOSIN**	**PMS**	$	**0.4436**
00002218968	**RATIO-TERAZOSIN**	**RPH**	$	**0.4436**
00000818682	HYTRIN	ABB	$	0.8138
5 MG (BASE) ORAL TABLET				
00002234504	**APO-TERAZOSIN**	**APX**	$	**0.6025**
00002230807	**NOVO-TERAZOSIN**	**NOP**	$	**0.6025**
00002233049	**NU-TERAZOSIN**	**NXP**	$	**0.6025**
00002243520	**PMS-TERAZOSIN**	**PMS**	$	**0.6025**
00002218976	**RATIO-TERAZOSIN**	**RPH**	$	**0.6025**
00000818666	HYTRIN	ABB	$	1.1052
10 MG (BASE) ORAL TABLET				
00002234505	**APO-TERAZOSIN**	**APX**	$	**0.8820**
00002230808	**NOVO-TERAZOSIN**	**NOP**	$	**0.8820**
00002233050	**NU-TERAZOSIN**	**NXP**	$	**0.8820**
00002243521	**PMS-TERAZOSIN**	**PMS**	$	**0.8820**
00002218984	**RATIO-TERAZOSIN**	**RPH**	$	**0.8820**
00000818674	HYTRIN	ABB	$	1.6178

VALSARTAN

80 MG ORAL TABLET				
00002244781	DIOVAN	NOV	$	1.1955
160 MG ORAL TABLET				
00002244782	DIOVAN	NOV	$	1.1955
320 MG ORAL TABLET				
00002289504	DIOVAN	NOV	$	1.1955

VALSARTAN/ HYDROCHLOROTHIAZIDE

80 MG * 12.5 MG ORAL TABLET				
00002241900	DIOVAN-HCT	NOV	$	1.1955
160 MG * 12.5 MG ORAL TABLET				
00002241901	DIOVAN-HCT	NOV	$	1.1955
160 MG * 25 MG ORAL TABLET				
00002246955	DIOVAN-HCT	NOV	$	1.1955

24:00 CARDIOVASCULAR DRUGS

24:12 VASODILATING AGENTS

ALPROSTADIL

500 MCG / ML INJECTION				
00000559253	PROSTIN VR	PFI	$	253.8540

24:00 CARDIOVASCULAR DRUGS

24:12 VASODILATING AGENTS

DIPYRIDAMOLE

25 MG ORAL TABLET

00000895644	APO-DIPYRIDAMOLE (FC)	APX	$	0.1432

50 MG ORAL TABLET

00000895652	**APO-DIPYRIDAMOLE (FC)**	**APX**	$	**0.2864**
00000067393	PERSANTINE	BOE	$	0.3879

75 MG ORAL TABLET

00000895660	**APO-DIPYRIDAMOLE (FC)**	**APX**	$	**0.4296**
00000452092	PERSANTINE	BOE	$	0.5224

ISOSORBIDE DINITRATE

10 MG ORAL TABLET

00000441686	APO-ISDN	APX	$	0.0357

30 MG ORAL TABLET

00000441694	APO-ISDN	APX	$	0.0837

5 MG ORAL SUBLINGUAL TABLET

00000670944	APO-ISDN	APX	$	0.0600

20 MG ORAL SUSTAINED-RELEASE TABLET

00000740721	CEDOCARD-SR	PAL	$	0.4195

ISOSORBIDE-5-MONONITRATE

60 MG ORAL EXTENDED-RELEASE TABLET

00002272830	**APO-ISMN**	**APX**	$	**0.4950**
00002126559	IMDUR	AZC	$	0.6590

NIMODIPINE

30 MG ORAL CAPSULE

00002155923	NIMOTOP	BAI	$	6.3650

NITROGLYCERIN

0.3 MG ORAL SUBLINGUAL TABLET

00000037613	NITROSTAT	PFI	$	0.0299

0.6 MG ORAL SUBLINGUAL TABLET

00000037621	NITROSTAT	PFI	$	0.0311

0.4 MG / DOSE SUBLINGUAL METERED DOSE SPRAY

00002243588	**GEN-NITRO**	**GPM**	$	**0.0423**
00002238998	**RHO-NITRO PUMPSPRAY**	**SDZ**	$	**0.0423**
00002231441	NITROLINGUAL PUMPSPRAY	SAV	$	0.0683

2 % TOPICAL OINTMENT

00001926454	NITROL	PAL	$	0.5905

0.2 MG/HR TRANSDERMAL PATCH

⊠ 00001911910	NITRO-DUR 0.2	SCH	$	0.5667
⊠ 00002230732	TRINIPATCH 0.2	NOV	$	0.6092
⊠ 00002162806	MINITRAN 0.2	GRC	$	0.6274
⊠ 00000584223	TRANSDERM-NITRO 0.2	NOV	$	0.6275

0.4 MG/HR TRANSDERMAL PATCH

⊠ 00001911902	NITRO-DUR 0.4	SCH	$	0.6400
⊠ 00002230733	TRINIPATCH 0.4	NOV	$	0.6880
⊠ 00002163527	MINITRAN 0.4	GRC	$	0.7087
⊠ 00000852384	TRANSDERM-NITRO 0.4	NOV	$	0.7087

24:00 CARDIOVASCULAR DRUGS

24:12 VASODILATING AGENTS

NITROGLYCERIN

0.6 MG/HR TRANSDERMAL PATCH

☒	00001911929	NITRO-DUR 0.6	SCH	$	0.6400
☒	00002230734	TRINIPATCH 0.6	NOV	$	0.6880
☒	00002046156	TRANSDERM-NITRO 0.6	NOV	$	0.7087
☒	00002163535	MINITRAN 0.6	GRC	$	0.7090

0.8 MG/HR TRANSDERMAL PATCH

	00002011271	NITRO-DUR 0.8	SCH	$	1.1100

24:00 CARDIOVASCULAR DRUGS

24:12:00 VASODILATING AGENTS
(VASODILATING AGENTS (PERIPHERAL))

NYLIDRIN HCL

6 MG ORAL TABLET

	00001926713	ARLIDIN	ERF	$	0.4703

24:00 CARDIOVASCULAR DRUGS

24:16 SCLEROSING AGENTS

SODIUM TETRADECYL SULFATE

1 % INJECTION

	00000511234	TROMBOJECT	OMG	$	3.2500

3 % INJECTION

	00000511226	TROMBOJECT	OMG	$	3.3750

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:04 ANALGESICS & ANTIPYRETICS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

ASA

650 MG ORAL ENTERIC-COATED TABLET

00000010340	**ENTROPHEN 10**	**PPH**	$	**0.0862**
00002284537	**PMS-ASA EC**	**PMS**	$	**0.0862**

BUTALBITAL/ CAFFEINE/ ASA

50 MG * 40 MG * 330 MG ORAL TABLET

00000608211	**RATIO-TECNAL**	**RPH**	$	**0.5038**
00000275328	FIORINAL	NOV	$	1.2015

50 MG * 40 MG * 330 MG ORAL CAPSULE

00000608238	**RATIO-TECNAL**	**RPH**	$	**0.5038**
00000226327	FIORINAL	NOV	$	1.2015

DICLOFENAC SODIUM

75 MG ORAL SUSTAINED-RELEASE TABLET

00002162814	**APO-DICLO SR**	**APX**	***$ 0.5706***	$	**0.5706**
00002231664	**DOM-DICLOFENAC-SR**	**DPC**	***$ 0.5706***	$	**0.5706**
00002158582	**NOVO-DIFENAC SR**	**NOP**	***$ 0.5706***	$	**0.5706**
00002228203	**NU-DICLO SR**	**NXP**	***$ 0.5706***	$	**0.5706**
00002231504	**PMS-DICLOFENAC-SR**	**PMS**	***$ 0.5706***	$	**0.5706**
00002261901	**SANDOZ DICLOFENAC SR**	**SDZ**	***$ 0.5706***	$	**0.5706**
00000782459	VOLTAREN SR	NOV	***$ 0.5706***	$	1.0774

MAC pricing has been applied based on the LCA Price for 1 x 75 mg oral sustained-release tablets.

100 MG ORAL SUSTAINED-RELEASE TABLET

00002091194	APO-DICLO SR	APX	***$ 0.7608***	$	0.7874
00002231665	DOM-DICLOFENAC-SR	DPC	***$ 0.7608***	$	0.7874
00002048698	NOVO-DIFENAC SR	NOP	***$ 0.7608***	$	0.7874
00002228211	NU-DICLO SR	NXP	***$ 0.7608***	$	0.7874
00002231505	PMS-DICLOFENAC-SR	PMS	***$ 0.7608***	$	0.7874
00002261944	SANDOZ DICLOFENAC SR	SDZ	***$ 0.7608***	$	0.7874
00000590827	VOLTAREN SR	NOV	***$ 0.7608***	$	1.5356

MAC pricing has been applied based on the LCA Price for 4 X 25 mg oral enteric-coated tablets.

25 MG ORAL ENTERIC-COATED TABLET

00000839175	**APO-DICLO**	**APX**	$	**0.1902**
00002231662	**DOM-DICLOFENAC**	**DPC**	$	**0.1902**
00000808539	**NOVO-DIFENAC**	**NOP**	$	**0.1902**
00000886017	**NU-DICLO**	**NXP**	$	**0.1902**
00002231502	**PMS-DICLOFENAC**	**PMS**	$	**0.1902**
00002261952	**SANDOZ DICLOFENAC**	**SDZ**	$	**0.1902**

50 MG ORAL ENTERIC-COATED TABLET

00000839183	APO-DICLO	APX	***$ 0.3804***	$	0.3937
00002231663	DOM-DICLOFENAC	DPC	***$ 0.3804***	$	0.3937
00000808547	NOVO-DIFENAC	NOP	***$ 0.3804***	$	0.3937
00000886025	NU-DICLO	NXP	***$ 0.3804***	$	0.3937
00002231503	PMS-DICLOFENAC	PMS	***$ 0.3804***	$	0.3937
00002261960	SANDOZ DICLOFENAC	SDZ	***$ 0.3804***	$	0.3937
00000514012	VOLTAREN	NOV	***$ 0.3804***	$	0.7667

MAC pricing has been applied based on the LCA Price for 2 x 25 mg oral enteric-coated tablets.

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:04 ANALGESICS & ANTIPYRETICS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

DICLOFENAC SODIUM

50 MG RECTAL SUPPOSITORY

00002231506	**PMS-DICLOFENAC**	**PMS**	$	**0.6237**
00002241224	**SAB-DICLOFENAC**	**SDZ**	$	**0.6237**
00000632724	VOLTAREN	NOV	$	1.1510

100 MG RECTAL SUPPOSITORY

00002231508	**PMS-DICLOFENAC**	**PMS**	$	**0.8397**
00002241225	**SAB-DICLOFENAC**	**SDZ**	$	**0.8397**
00000632732	VOLTAREN	NOV	$	1.5498

DICLOFENAC SODIUM/ MISOPROSTOL

50 MG * 200 MCG ORAL TABLET

00001917056	ARTHROTEC-50	PFI	$	0.6194

75 MG * 200 MCG ORAL TABLET

00002229837	ARTHROTEC-75	PFI	$	0.8430

DIFLUNISAL

250 MG ORAL TABLET

00002039486	APO-DIFLUNISAL	APX	$	0.5646
00002058405	NU-DIFLUNISAL	NXP	$	0.5646
00002048493	NOVO-DIFLUNISAL FC	NOP	$	0.5647

500 MG ORAL TABLET

00002039494	**APO-DIFLUNISAL**	**APX**	$	**0.6906**
00002058413	**NU-DIFLUNISAL**	**NXP**	$	**0.6906**

ETODOLAC

200 MG ORAL CAPSULE

00002232317	APO-ETODOLAC	APX	$	0.6000

300 MG ORAL CAPSULE

00002232318	APO-ETODOLAC	APX	$	0.6000

FLOCTAFENINE

200 MG ORAL TABLET

00002244680	APO-FLOCTAFENINE	APX	$	0.4032

400 MG ORAL TABLET

00002244681	APO-FLOCTAFENINE	APX	$	0.7845

FLURBIPROFEN

50 MG ORAL TABLET

00001912046	**APO-FLURBIPROFEN**	**APX**	$	**0.2564**
00002100509	**NOVO-FLURPROFEN**	**NOP**	$	**0.2564**
00002020661	**NU-FLURBIPROFEN**	**NXP**	$	**0.2564**
00000647942	ANSAID	PFI	$	0.5508

100 MG ORAL TABLET

00001912038	**APO-FLURBIPROFEN**	**APX**	$	**0.3508**
00002100517	**NOVO-FLURPROFEN**	**NOP**	$	**0.3508**
00002020688	**NU-FLURBIPROFEN**	**NXP**	$	**0.3508**
00000600792	ANSAID	PFI	$	0.7211

200 MG ORAL SUSTAINED-RELEASE CAPSULE

00002223082	FROBEN SR	ABB	***$ 0.7016***	$	1.5052

MAC pricing has been applied based on the LCA price for 2 x 100 mg oral tablets.

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:04 ANALGESICS & ANTIPYRETICS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

IBUPROFEN

300 MG ORAL TABLET

00000441651	**APO-IBUPROFEN**	**APX**	$	**0.0690**
00000327794	MOTRIN	MCL	$	0.1314

400 MG ORAL TABLET

00000629340	**NOVO-PROFEN**	**NOP**	$	**0.0372**
00000506052	APO-IBUPROFEN	APX	$	0.1010
00000364142	MOTRIN	MCL	$	0.1708

600 MG ORAL TABLET

00000585114	**APO-IBUPROFEN**	**APX**	$	**0.0465**
00000629359	**NOVO-PROFEN**	**NOP**	$	**0.0465**
00002020726	**NU-IBUPROFEN**	**NXP**	$	**0.0465**

INDOMETHACIN

25 MG ORAL CAPSULE

00000611158	**APO-INDOMETHACIN**	**APX**	$	**0.0871**
00000337420	**NOVO-METHACIN**	**NOP**	$	**0.0871**
00000865850	**NU-INDO**	**NXP**	$	**0.0871**

50 MG ORAL CAPSULE

00000611166	**APO-INDOMETHACIN**	**APX**	$	**0.1511**
00000337439	**NOVO-METHACIN**	**NOP**	$	**0.1511**
00000865869	**NU-INDO**	**NXP**	$	**0.1511**

50 MG RECTAL SUPPOSITORY

00002231799	SAB-INDOMETHACIN	SDZ	$	0.8020

100 MG RECTAL SUPPOSITORY

00001934139	**RATIO-INDOMETHACIN**	**RPH**	$	**0.8920**
00002231800	**SAB-INDOMETHACIN**	**SDZ**	$	**0.8920**

KETOPROFEN

200 MG ORAL SUSTAINED-RELEASE TABLET

00002172577	APO-KETO SR	APX	***$ 0.6156***	$	0.6156

MAC pricing has been applied based on the price for 2 x 100 mg oral enteric-coated tablets.

50 MG ORAL ENTERIC-COATED TABLET

00000790435	APO-KETO-E	APX	$	0.1662

100 MG ORAL ENTERIC-COATED TABLET

00000842664	APO-KETO-E	APX	$	0.3078

50 MG ORAL CAPSULE

00000790427	**APO-KETO**	**APX**	$	**0.1662**
00002044633	**NU-KETOPROFEN**	**NXP**	$	**0.1662**

100 MG RECTAL SUPPOSITORY

00002015951	PMS-KETOPROFEN	PMS	$	0.9930

KETOROLAC TROMETHAMINE

10 MG ORAL TABLET

00002229080	**APO-KETOROLAC**	**APX**	$	**0.4550**
00002230201	**NOVO-KETOROLAC**	**NOP**	$	**0.4550**
00002237910	**NU-KETOROLAC**	**NXP**	$	**0.4550**
00002162660	TORADOL	HLR	$	0.7152

10 MG / ML INJECTION

00002162644	TORADOL	HLR	$	2.3580

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:04 ANALGESICS & ANTIPYRETICS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

KETOROLAC TROMETHAMINE

30 MG / ML INJECTION

00002239944	**KETOROLAC TROMETHAMINE**	**SDZ**	$	**3.6300**
00002162652	TORADOL IM	HLR	$	4.5940

MEFENAMIC ACID

250 MG ORAL CAPSULE

00002229452	**APO-MEFENAMIC**	**APX**	$	**0.3308**
00002237826	**DOM-MEFENAMIC ACID**	**DPC**	$	**0.3308**
00002229569	**NU-MEFENAMIC**	**NXP**	$	**0.3308**
00002231208	**PMS-MEFENAMIC ACID**	**PMS**	$	**0.3308**

NABUMETONE

500 MG ORAL TABLET

00002238639	**APO-NABUMETONE**	**APX**	$	**0.5025**
00002244563	**GEN-NABUMETONE**	**GPM**	$	**0.5025**
00002240867	**NOVO-NABUMETONE**	**NOP**	$	**0.5025**
00002242912	**SANDOZ NABUMETONE**	**SDZ**	$	**0.5025**

NAPROXEN

125 MG ORAL TABLET

00000522678	APO-NAPROXEN	APX	$	0.0763

250 MG ORAL TABLET

00000522651	**APO-NAPROXEN**	**APX**	$	**0.1068**
00000565350	**NOVO-NAPROX**	**NOP**	$	**0.1068**
00000865648	**NU-NAPROX**	**NXP**	$	**0.1068**

375 MG ORAL TABLET

00000600806	**APO-NAPROXEN**	**APX**	$	**0.1458**
00000627097	**NOVO-NAPROX**	**NOP**	$	**0.1458**
00000865656	**NU-NAPROX**	**NXP**	$	**0.1458**

500 MG ORAL TABLET

00000592277	**APO-NAPROXEN**	**APX**	$	**0.2110**
00000589861	**NOVO-NAPROX**	**NOP**	$	**0.2110**
00000865664	**NU-NAPROX**	**NXP**	$	**0.2110**

750 MG ORAL SUSTAINED-RELEASE TABLET

00002177072	APO-NAPROXEN SR	APX	***$ 0.2916***	$	0.7604
00002162466	NAPROSYN SR	HLR	***$ 0.2916***	$	1.3650

MAC pricing has been applied based on the LCA price for 2 x 375 mg oral tablets.

250 MG ORAL ENTERIC-COATED TABLET

00002246699	APO-NAPROXEN EC	APX	***$ 0.1068***	$	0.2835
00002243312	NOVO-NAPROX EC	NOP	***$ 0.1068***	$	0.2835
00002162792	NAPROSYN E	HLR	***$ 0.1068***	$	0.4319

MAC pricing has been applied based on the LCA price for 1 x 250 mg oral tablet.

375 MG ORAL ENTERIC-COATED TABLET

00002246700	APO-NAPROXEN EC	APX	***$ 0.1458***	$	0.3675
00002243432	GEN-NAPROXEN EC	GPM	***$ 0.1458***	$	0.3675
00002243313	NOVO-NAPROX EC	NOP	***$ 0.1458***	$	0.3675
00002162415	NAPROSYN E	HLR	***$ 0.1458***	$	0.5662

MAC pricing has been applied based on the LCA price for 1 x 375 mg oral tablet.

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:04 ANALGESICS & ANTIPYRETICS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

NAPROXEN

500 MG ORAL ENTERIC-COATED TABLET

00002246701	APO-NAPROXEN EC	APX	***$ 0.2110***	$ 0.6894
00002241024	GEN-NAPROXEN EC	GPM	***$ 0.2110***	$ 0.6894
00002243314	NOVO-NAPROX EC	NOP	***$ 0.2110***	$ 0.6894
00002162423	NAPROSYN E	HLR	***$ 0.2110***	$ 1.0228

MAC pricing has been applied based on the LCA price for 1 x 500 mg oral tablet.

25 MG / ML ORAL SUSPENSION

00002162431	NAPROSYN	HLR		$ 0.0647

500 MG RECTAL SUPPOSITORY

00002017237	PMS-NAPROXEN	PMS		$ 0.7927

NAPROXEN SODIUM

275 MG ORAL TABLET

00000784354	**APO-NAPRO-NA**	**APX**		$ **0.3422**
00000778389	**NOVO-NAPROX SODIUM**	**NOP**		$ **0.3422**
00002162725	ANAPROX	HLR		$ 0.6447

550 MG ORAL TABLET

00001940309	**APO-NAPRO-NA DS**	**APX**		$ **0.6667**
00002026600	**NOVO-NAPROX SODIUM DS**	**NOP**		$ **0.6667**
00002162717	ANAPROX DS	HLR		$ 1.2411

PIROXICAM

10 MG ORAL CAPSULE

00000642886	**APO-PIROXICAM**	**APX**		$ **0.4147**
00002171813	**GEN-PIROXICAM**	**GPM**		$ **0.4147**
00000695718	**NOVO-PIROCAM**	**NOP**		$ **0.4147**
00000865761	**NU-PIROX**	**NXP**		$ **0.4147**

20 MG ORAL CAPSULE

00000642894	**APO-PIROXICAM**	**APX**		$ **0.7158**
00002171821	**GEN-PIROXICAM**	**GPM**		$ **0.7158**
00000695696	**NOVO-PIROCAM**	**NOP**		$ **0.7158**
00000865788	**NU-PIROX**	**NXP**		$ **0.7158**

20 MG RECTAL SUPPOSITORY

00002154463	PMS-PIROXICAM	PMS		$ 1.6460

SULINDAC

150 MG ORAL TABLET

00000778354	**APO-SULIN**	**APX**		$ **0.3824**
00000745588	**NOVO-SUNDAC**	**NOP**		$ **0.3824**
00002042576	**NU-SULINDAC**	**NXP**		$ **0.3824**

200 MG ORAL TABLET

00000778362	**APO-SULIN**	**APX**		$ **0.4840**
00000745596	**NOVO-SUNDAC**	**NOP**		$ **0.4840**
00002042584	**NU-SULINDAC**	**NXP**		$ **0.4840**

TENOXICAM

20 MG ORAL TABLET

00002230661	APO-TENOXICAM	APX		$ 0.9120

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:04 ANALGESICS & ANTIPYRETICS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

TIAPROFENIC ACID

200 MG ORAL TABLET				
00002136112	**APO-TIAPROFENIC**	**APX**	$	**0.3437**
00002179679	**NOVO-TIAPROFENIC**	**NOP**	$	**0.3437**
300 MG ORAL TABLET				
00002136120	**APO-TIAPROFENIC**	**APX**	$	**0.4104**
00002179687	**NOVO-TIAPROFENIC**	**NOP**	$	**0.4104**
00002146886	**NU-TIAPROFENIC**	**NXP**	$	**0.4104**
00002221950	SURGAM	SAV	$	0.8108

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:08 ANALGESICS & ANTIPYRETICS (OPIATE AGONISTS)

ASA/ CAFFEINE CITRATE/ CODEINE PHOSPHATE

375 MG * 30 MG * 15 MG ORAL TABLET				
00002234510	282	PPH	$	0.0669

BUTALBITAL/ CODEINE PHOSPHATE/ ASA/ CAFFEINE

50 MG * 15 MG * 330 MG * 40 MG ORAL CAPSULE				
00000608203	**RATIO-TECNAL-C 1/4**	**RPH**	$	**0.5400**
00000176192	FIORINAL-C 1/4	NOV	$	1.2886
50 MG * 30 MG * 330 MG * 40 MG ORAL CAPSULE				
00000608181	**RATIO-TECNAL-C 1/2**	**RPH**	$	**0.6615**
00000176206	FIORINAL-C 1/2	NOV	$	1.5779

CODEINE PHOSPHATE

15 MG ORAL TABLET				
00000593435	RATIO-CODEINE	RPH	$	0.0689
30 MG ORAL TABLET				
00000593451	RATIO-CODEINE	RPH	$	0.0831
5 MG / ML ORAL SYRUP				
00000779474	RATIO-CODEINE	RPH	$	0.0289
30 MG / ML INJECTION				
00000544884	CODEINE PHOSPHATE	SDZ	$	1.0320

CODEINE PHOSPHATE/ ACETAMINOPHEN

30 MG * 300 MG ORAL TABLET				
00000608882	RATIO-EMTEC-30	RPH	$	0.1300
60 MG * 300 MG ORAL TABLET				
00000621463	**RATIO-LENOLTEC NO.4**	**RPH**	$	**0.1384**
00002163918	TYLENOL NO. 4	JOI	$	0.1754
1.6 MG / ML * 32 MG / ML ORAL ELIXIR				
00002163942	TYLENOL WITH CODEINE	JOI	$	0.0975

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:08 ANALGESICS & ANTIPYRETICS (OPIATE AGONISTS)

CODEINE PHOSPHATE/ ACETAMINOPHEN/ CAFFEINE

15 MG * 300 MG * 15 MG ORAL TABLET				
00000653241	**RATIO-LENOLTEC NO.2**	**RPH**	$	**0.0595**
00002163934	TYLENOL NO. 2	JOI	$	0.0755
30 MG * 300 MG * 15 MG ORAL TABLET				
00000653276	**RATIO-LENOLTEC NO.3**	**RPH**	$	**0.0655**
00002163926	TYLENOL NO. 3	JOI	$	0.0830

CODEINE PHOSPHATE/ ACETAMINOPHEN/ CAFFEINE CITRATE

15 MG * 325 MG * 30 MG ORAL TABLET				
00000293504	ATASOL-15	CHD	$	0.1236
30 MG * 325 MG * 30 MG ORAL TABLET				
00000293512	ATASOL-30	CHD	$	0.0656

CODEINE PHOSPHATE/ ASA/ CAFFEINE CITRATE

30 MG * 375 MG * 30 MG ORAL TABLET				
00002238645	292	PPH	$	0.1730

CODEINE PHOSPHATE/ ASA/ MEPROBAMATE/ CAFFEINE CITRATE

15 MG * 350 MG * 200 MG * 30 MG ORAL TABLET				
00002238646	282 MEP	PPH	$	0.2160

HYDROMORPHONE HCL

1 MG ORAL TABLET				
00000885444	**PMS-HYDROMORPHONE**	**PMS**	$	**0.0959**
00000705438	DILAUDID	ABB	$	0.1130
2 MG ORAL TABLET				
00000125083	**DILAUDID**	**ABB**	$	**0.1417**
00000885436	**PMS-HYDROMORPHONE**	**PMS**	$	**0.1417**
4 MG ORAL TABLET				
00000125121	**DILAUDID**	**ABB**	$	**0.2240**
00000885401	**PMS-HYDROMORPHONE**	**PMS**	$	**0.2240**
8 MG ORAL TABLET				
00000885428	**PMS-HYDROMORPHONE**	**PMS**	$	**0.3528**
00000786543	DILAUDID	ABB	$	0.4156
3 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125323	HYDROMORPH CONTIN	PUR	$	0.6724
6 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125331	HYDROMORPH CONTIN	PUR	$	1.0086
12 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125366	HYDROMORPH CONTIN	PUR	$	1.7482
18 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002243562	HYDROMORPH CONTIN	PUR	$	2.5214
24 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125382	HYDROMORPH CONTIN	PUR	$	3.2276
30 MG ORAL CONTROLLED-RELEASE CAPSULE				
00002125390	HYDROMORPH CONTIN	PUR	$	3.8662
1 MG / ML ORAL LIQUID				
00001916386	PMS-HYDROMORPHONE	PMS	$	0.0652
00000786535	DILAUDID	ABB	$	0.0792

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:08 ANALGESICS & ANTIPYRETICS (OPIATE AGONISTS)

HYDROMORPHONE HCL

2 MG / ML INJECTION				
00002145901	**HYDROMORPHONE**	**SDZ**	$	**1.1380**
00000627100	DILAUDID	ABB	$	1.1400
10 MG / ML INJECTION				
00002145928	**HYDROMORPHONE HP**	**SDZ**	$	**2.7860**
00000622133	DILAUDID-HP	ABB	$	2.7900
20 MG / ML INJECTION				
00002145936	HYDROMORPHONE HP 20	SDZ	$	4.5100
00002146118	DILAUDID-HP-PLUS	ABB	$	4.5150
50 MG / ML INJECTION				
00002145863	DILAUDID-XP	ABB	$	10.4951
00002146126	HYDROMORPHONE HP 50	SDZ	$	13.1500
250 MG / VIAL INJECTION				
00002085895	DILAUDID STERILE POWDER	ABB	$	70.1425
3 MG RECTAL SUPPOSITORY				
00001916394	PMS-HYDROMORPHONE	PMS	$	2.2100

MEPERIDINE HCL

50 MG ORAL TABLET				
00002138018	DEMEROL	AVE	$	0.1403
50 MG / ML INJECTION				
00000725765	MEPERIDINE HYDROCHLORIDE	SDZ	$	0.8650
75 MG / ML INJECTION				
00000725757	MEPERIDINE HYDROCHLORIDE	SDZ	$	0.9150
100 MG / ML INJECTION				
00000725749	MEPERIDINE HYDROCHLORIDE	SDZ	$	0.9650

METHADONE COMPOUND

ORAL LIQUID				
00000999995	METHADONE	XXX	$	0.0000

METHADONE HCL

1 MG ORAL TABLET				
00002247698	METADOL	PMS	$	0.1500
5 MG ORAL TABLET				
00002247699	METADOL	PMS	$	0.5000
10 MG ORAL TABLET				
00002247700	METADOL	PMS	$	0.8000
25 MG ORAL TABLET				
00002247701	METADOL	PMS	$	1.5000
1 MG / ML ORAL SOLUTION				
00002247694	METADOL	PMS	$	0.0840
10 MG / ML ORAL LIQUID				
00002241377	METADOL CONCENTRATE	PMS	$	0.3035

MORPHINE HCL

10 MG ORAL TABLET				
00000690198	M.O.S.-10	VCL	$	0.1828
20 MG ORAL TABLET				
00000690201	M.O.S.-20	VCL	$	0.3486

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:08 ANALGESICS & ANTIPYRETICS (OPIATE AGONISTS)

MORPHINE HCL

40 MG ORAL TABLET				
00000690228	M.O.S.-40	VCL	$	0.4530
60 MG ORAL TABLET				
00000690244	M.O.S.-60	VCL	$	0.6290
30 MG ORAL SUSTAINED-RELEASE TABLET				
00000776181	M.O.S.-SR	VCL	$	0.5897
60 MG ORAL SUSTAINED-RELEASE TABLET				
00000776203	M.O.S.-SR	VCL	$	1.0350
1 MG / ML ORAL SYRUP				
00000614491	**DOLORAL 1**	**ATL**	$	**0.0192**
00000607762	**RATIO-MORPHINE**	**RPH**	$	**0.0192**
00000486582	M.O.S.-1	VCL	$	0.0215
5 MG / ML ORAL SYRUP				
00000614505	**DOLORAL 5**	**ATL**	$	**0.0669**
00000607770	**RATIO-MORPHINE**	**RPH**	$	**0.0669**
00000514217	M.O.S.-5	VCL	$	0.0905
10 MG / ML ORAL SYRUP				
00000690783	RATIO-MORPHINE	RPH	$	0.1838
00000632503	M.O.S.-10	VCL	$	0.2137
20 MG / ML ORAL SYRUP				
00000690791	RATIO-MORPHINE	RPH	$	0.5240
00000632481	M.O.S.-20 CONCENTRATE	VCL	$	0.5633
50 MG / ML ORAL SYRUP				
00000690236	M.O.S.-50 CONCENTRATE	VCL	$	1.3358

MORPHINE SULFATE

5 MG ORAL TABLET				
00002009773	**M.O.S. SULFATE**	**VCL**	$	**0.1183**
00000594652	**STATEX**	**PMS**	$	**0.1183**
00002014203	MS.IR	PUR	$	0.1264
10 MG ORAL TABLET				
00002009765	**M.O.S. SULFATE**	**VCL**	$	**0.1828**
00000594644	**STATEX**	**PMS**	$	**0.1828**
00002014211	MS.IR	PUR	$	0.1966
20 MG ORAL TABLET				
00002014238	MS.IR	PUR	$	0.3468
25 MG ORAL TABLET				
00002009749	**M.O.S. SULFATE**	**VCL**	$	**0.2419**
00000594636	**STATEX**	**PMS**	$	**0.2419**
30 MG ORAL TABLET				
00002014254	MS.IR	PUR	$	0.4452
50 MG ORAL TABLET				
00002009706	**M.O.S. SULFATE**	**VCL**	$	**0.3709**
00000675962	**STATEX**	**PMS**	$	**0.3709**
15 MG ORAL SUSTAINED-RELEASE TABLET				
00002245284	**PMS-MORPHINE SULFATE SR**	**PMS**	$	**0.3550**
00002244790	**RATIO-MORPHINE SULFATE SR**	**RPH**	$	**0.3550**
00002015439	MS CONTIN	PUR	$	0.6839

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:08 ANALGESICS & ANTIPYRETICS (OPIATE AGONISTS)

MORPHINE SULFATE

30 MG ORAL SUSTAINED-RELEASE TABLET				
00002245285	**PMS-MORPHINE SULFATE SR**	**PMS**	$	**0.5486**
00002244791	**RATIO-MORPHINE SULFATE SR**	**RPH**	$	**0.5486**
00002014297	MS CONTIN	PUR	$	1.0326
60 MG ORAL SUSTAINED-RELEASE TABLET				
00002245286	**PMS-MORPHINE SULFATE SR**	**PMS**	$	**0.9628**
00002244792	**RATIO-MORPHINE SULFATE SR**	**RPH**	$	**0.9628**
00002014300	MS CONTIN	PUR	$	1.8204
100 MG ORAL SUSTAINED-RELEASE TABLET				
00002014319	MS CONTIN	PUR	$	2.7754
200 MG ORAL SUSTAINED-RELEASE TABLET				
00002014327	MS CONTIN	PUR	$	5.1598
10 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019930	M-ESLON	ETP	$	0.3120
15 MG ORAL EXTENDED-RELEASE CAPSULE				
00002177749	M-ESLON	ETP	$	0.3601
30 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019949	M-ESLON	ETP	$	0.5375
60 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019957	M-ESLON	ETP	$	0.9546
100 MG ORAL EXTENDED-RELEASE CAPSULE				
00002019965	M-ESLON	ETP	$	2.0535
200 MG ORAL EXTENDED-RELEASE CAPSULE				
00002177757	M-ESLON	ETP	$	4.1065
10 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002242163	KADIAN	ABB	$	0.4900
20 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184435	KADIAN	ABB	$	0.6800
50 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184443	KADIAN	ABB	$	1.2500
100 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002184451	KADIAN	ABB	$	2.1800
1 MG / ML ORAL SYRUP				
00000591467	STATEX	PMS	$	0.0200
5 MG / ML ORAL SYRUP				
00000591475	STATEX	PMS	$	0.0803
10 MG / ML ORAL SYRUP				
00000647217	STATEX	PMS	$	0.1838
20 MG / ML ORAL DROPS				
00000621935	STATEX	PMS	$	0.4980
50 MG / ML ORAL DROPS				
00000705799	STATEX	PMS	$	0.9464
0.5 MG / ML INJECTION				
00002021056	MORPHINE LP EPIDURAL	SDZ	$	0.9644
1 MG / ML INJECTION				
00002021048	MORPHINE LP EPIDURAL	SDZ	$	1.9288
10 MG / ML INJECTION				
00000392588	MORPHINE SULFATE	SDZ	$	0.8950

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:08 ANALGESICS & ANTIPYRETICS (OPIATE AGONISTS)

MORPHINE SULFATE

15 MG / ML INJECTION				
00000392561	MORPHINE SULFATE	SDZ	$	0.9150
25 MG / ML INJECTION				
00000676411	MORPHINE HP 25	SDZ	$	2.4500
50 MG / ML INJECTION				
00000617288	MORPHINE HP 50	SDZ	$	3.5490
5 MG RECTAL SUPPOSITORY				
00000632228	STATEX	PMS	$	1.6690
10 MG RECTAL SUPPOSITORY				
00000632201	STATEX	PMS	$	1.8640
20 MG RECTAL SUPPOSITORY				
00000596965	STATEX	PMS	$	2.2190
30 MG RECTAL SUPPOSITORY				
00000639389	STATEX	PMS	$	2.4340

OPIUM/ BELLADONNA

65 MG * 15 MG RECTAL SUPPOSITORY				
00000815349	PMS-OPIUM BELLADONNA	PMS	$	1.7900
00001901869	SAB-OPIUM & BELLADONNA	SDZ	$	2.0000

OXYCODONE HCL

5 MG ORAL TABLET				
00000789739	SUPEUDOL	SDZ	$	0.2368
10 MG ORAL TABLET				
☒ 00000443948	SUPEUDOL	SDZ	$	0.3680
☒ 00002240131	OXY-IR	PUR	$	0.3996
20 MG ORAL TABLET				
00002240132	OXY-IR	PUR	$	0.6940
5 MG ORAL SUSTAINED-RELEASE TABLET				
00002258129	OXYCONTIN	PUR	$	0.6450
10 MG ORAL SUSTAINED-RELEASE TABLET				
00002202441	OXYCONTIN	PUR	$	0.8966
20 MG ORAL SUSTAINED-RELEASE TABLET				
00002202468	OXYCONTIN	PUR	$	1.3446
40 MG ORAL SUSTAINED-RELEASE TABLET				
00002202476	OXYCONTIN	PUR	$	2.3308
80 MG ORAL SUSTAINED-RELEASE TABLET				
00002202484	OXYCONTIN	PUR	$	4.3030
10 MG RECTAL SUPPOSITORY				
00000392480	SUPEUDOL	SDZ	$	1.9217
20 MG RECTAL SUPPOSITORY				
00000392472	SUPEUDOL	SDZ	$	2.4342

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:08 ANALGESICS & ANTIPYRETICS (OPIATE AGONISTS)

OXYCODONE HCL/ ACETAMINOPHEN

2.5 MG * 325 MG ORAL TABLET				
00001916491	PERCOCET DEMI	BMS	$	0.5706
5 MG * 325 MG ORAL TABLET				
00001916548	**ENDOCET**	**BMS**	$	**0.1285**
00002245758	PMS-OXYCODONE-ACETAMINOPHEN	PMS	$	0.2850
00000608165	RATIO-OXYCOCET	RPH	$	0.2850
00001916475	PERCOCET	BMS	$	0.6981

OXYCODONE HCL/ ASA

5 MG * 325 MG ORAL TABLET				
00001916483	**ENDODAN**	**BMS**	$	**0.1116**
00000608157	RATIO-OXYCODAN	RPH	$	0.3220
00001916572	PERCODAN	BMS	$	0.8412

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:08:12 ANALGESICS & ANTIPYRETICS (OPIATE PARTIAL AGONISTS)

PENTAZOCINE HCL

50 MG (BASE) ORAL TABLET				
00002137984	TALWIN	SAV	$	0.4050

PENTAZOCINE LACTATE

30 MG / ML INJECTION				
00002241976	TALWIN	HSP	$	1.4300

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:04 ANTICONVULSANTS (BARBITURATES)

PHENOBARBITAL

15 MG ORAL TABLET				
00000178799	PMS-PHENOBARBITAL	PMS	$	0.0612
30 MG ORAL TABLET				
00000178802	PMS-PHENOBARBITAL	PMS	$	0.0728
60 MG ORAL TABLET				
00000178810	PMS-PHENOBARBITAL	PMS	$	0.0987
100 MG ORAL TABLET				
00000178829	PMS-PHENOBARBITAL	PMS	$	0.1351
5 MG / ML ORAL ELIXIR				
00000645575	PMS-PHENOBARBITAL	PMS	$	0.0816

PRIMIDONE

125 MG ORAL TABLET				
00000399310	APO-PRIMIDONE	APX	$	0.0475
250 MG ORAL TABLET				
00000396761	APO-PRIMIDONE	APX	$	0.0750

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:08 ANTICONVULSANTS (BENZODIAZEPINES)

CLOBAZAM

10 MG ORAL TABLET

00002244638	**APO-CLOBAZAM**	**APX**	$	**0.2153**
00002238334	**NOVO-CLOBAZAM**	**NOP**	$	**0.2153**
00002244474	**PMS-CLOBAZAM**	**PMS**	$	**0.2153**
00002238797	**RATIO-CLOBAZAM**	**RPH**	$	**0.2153**
00002221799	FRISIUM	PPH	$	0.4087

CLONAZEPAM

0.25 MG ORAL TABLET

00002179660	PMS-CLONAZEPAM	PMS	$	0.0638

0.5 MG ORAL TABLET

00002177889	**APO-CLONAZEPAM**	**APX**	$	**0.1166**
00002270641	**CO CLONAZEPAM**	**COB**	$	**0.1166**
00002224100	**DOM-CLONAZEPAM-R**	**DPC**	$	**0.1166**
00002230950	**GEN-CLONAZEPAM**	**GPM**	$	**0.1166**
00002239024	**NOVO-CLONAZEPAM**	**NOP**	$	**0.1166**
00002173344	**NU-CLONAZEPAM**	**NXP**	$	**0.1166**
00002048701	**PMS-CLONAZEPAM**	**PMS**	$	**0.1166**
00002207818	**PMS-CLONAZEPAM-R**	**PMS**	$	**0.1166**
00002103656	**RATIO-CLONAZEPAM**	**RPH**	$	**0.1166**
00002233960	**SANDOZ CLONAZEPAM**	**SDZ**	$	**0.1166**
00000382825	RIVOTRIL	HLR	$	0.2089

1 MG ORAL TABLET

00002270668	**CO CLONAZEPAM**	**COB**	$	**0.1860**
00002048728	**PMS-CLONAZEPAM**	**PMS**	$	**0.1860**
00002233982	**SANDOZ CLONAZEPAM**	**SDZ**	$	**0.1860**

2 MG ORAL TABLET

00002177897	**APO-CLONAZEPAM**	**APX**	$	**0.2010**
00002270676	**CO CLONAZEPAM**	**COB**	$	**0.2010**
00002131013	**DOM-CLONAZEPAM**	**DPC**	$	**0.2010**
00002230951	**GEN-CLONAZEPAM**	**GPM**	$	**0.2010**
00002239025	**NOVO-CLONAZEPAM**	**NOP**	$	**0.2010**
00002173352	**NU-CLONAZEPAM**	**NXP**	$	**0.2010**
00002048736	**PMS-CLONAZEPAM**	**PMS**	$	**0.2010**
00002103737	**RATIO-CLONAZEPAM**	**RPH**	$	**0.2010**
00002233985	**SANDOZ CLONAZEPAM**	**SDZ**	$	**0.2010**
00000382841	RIVOTRIL	HLR	$	0.3601

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:12 ANTICONVULSANTS (HYDANTOINS)

PHENYTOIN

50 MG ORAL CHEWABLE TABLET

00000023698	DILANTIN INFATABS	PFI	$	0.0762

6 MG / ML ORAL SUSPENSION

00000023442	DILANTIN-30	PFI	$	0.0420

25 MG / ML ORAL SUSPENSION

00002250896	**TARO-PHENYTOIN**	**TAR**	$	**0.0311**
00000023450	DILANTIN-125	PFI	$	0.0496

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:12 ANTICONVULSANTS (HYDANTOINS)

PHENYTOIN SODIUM

30 MG ORAL CAPSULE				
00000022772	DILANTIN	PFI	$	0.0556
100 MG ORAL CAPSULE				
00000022780	DILANTIN	PFI	$	0.0773
50 MG / ML INJECTION				
00000780626	PHENYTOIN SODIUM	SDZ	$	2.1885

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:20 ANTICONVULSANTS (SUCCINIMIDES)

ETHOSUXIMIDE

250 MG ORAL CAPSULE				
00000022799	ZARONTIN	ERF	$	0.3333
50 MG / ML ORAL SYRUP				
00000023485	ZARONTIN	ERF	$	0.0667

METHSUXIMIDE

300 MG ORAL CAPSULE				
00000022802	CELONTIN	ERF	$	0.4085

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:92 ANTICONVULSANTS (MISC. ANTICONVULSANTS)

CARBAMAZEPINE

200 MG ORAL TABLET				
00000402699	**APO-CARBAMAZEPINE**	**APX**	$	**0.0795**
00000782718	**NOVO-CARBAMAZ**	**NOP**	$	**0.0795**
00002042568	**NU-CARBAMAZEPINE**	**NXP**	$	**0.0795**
00000010405	TEGRETOL	NOV	$	0.3596
100 MG ORAL CHEWABLE TABLET				
00002231542	**PMS-CARBAMAZEPINE**	**PMS**	$	**0.0770**
00002261855	**SANDOZ CARBAMAZEPINE**	**SDZ**	$	**0.0770**
00002244403	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.0770**
00000369810	TEGRETOL	NOV	$	0.1437
200 MG ORAL CHEWABLE TABLET				
00002231540	**PMS-CARBAMAZEPINE**	**PMS**	$	**0.1520**
00002261863	**SANDOZ CARBAMAZEPINE**	**SDZ**	$	**0.1520**
00002244404	**TARO-CARBAMAZEPINE**	**TAR**	$	**0.1520**
00000665088	TEGRETOL	NOV	$	0.2835
200 MG ORAL SUSTAINED-RELEASE TABLET				
00002241882	**GEN-CARBAMAZEPINE CR**	**GPM**	$	**0.1887**
00002231543	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.1887**
00002261839	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.1887**
00000773611	TEGRETOL CR	NOV	$	0.3520

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:92 ANTICONVULSANTS
(MISC. ANTICONVULSANTS)

CARBAMAZEPINE

400 MG ORAL SUSTAINED-RELEASE TABLET

00002241883	**GEN-CARBAMAZEPINE CR**	**GPM**	$	**0.3774**
00002231544	**PMS-CARBAMAZEPINE-CR**	**PMS**	$	**0.3774**
00002261847	**SANDOZ CARBAMAZEPINE CR**	**SDZ**	$	**0.3774**
00000755583	TEGRETOL CR	NOV	$	0.7039

20 MG / ML ORAL SUSPENSION

00002194333	TEGRETOL	NOV	$	0.0678

DIVALPROEX SODIUM (VALPROIC ACID EQUIV.)

125 MG (BASE) ORAL ENTERIC-COATED TABLET

00002239698	**APO-DIVALPROEX**	**APX**	$	**0.1377**
00002265133	**GEN-DIVALPROEX**	**GPM**	$	**0.1377**
00002239701	**NOVO-DIVALPROEX**	**NOP**	$	**0.1377**
00002239517	**NU-DIVALPROEX**	**NXP**	$	**0.1377**
00002244138	**PMS-DIVALPROEX**	**PMS**	$	**0.1377**
00000596418	EPIVAL	ABB	$	0.2526

250 MG (BASE) ORAL ENTERIC-COATED TABLET

00002239699	**APO-DIVALPROEX**	**APX**	$	**0.2475**
00002265141	**GEN-DIVALPROEX**	**GPM**	$	**0.2475**
00002239702	**NOVO-DIVALPROEX**	**NOP**	$	**0.2475**
00002239518	**NU-DIVALPROEX**	**NXP**	$	**0.2475**
00002244139	**PMS-DIVALPROEX**	**PMS**	$	**0.2475**
00000596426	EPIVAL	ABB	$	0.4539

500 MG (BASE) ORAL ENTERIC-COATED TABLET

00002239700	**APO-DIVALPROEX**	**APX**	$	**0.4952**
00002265168	**GEN-DIVALPROEX**	**GPM**	$	**0.4952**
00002239703	**NOVO-DIVALPROEX**	**NOP**	$	**0.4952**
00002239519	**NU-DIVALPROEX**	**NXP**	$	**0.4952**
00002244140	**PMS-DIVALPROEX**	**PMS**	$	**0.4952**
00000596434	EPIVAL	ABB	$	0.9084

GABAPENTIN

100 MG ORAL CAPSULE

00002244304	**APO-GABAPENTIN**	**APX**	$	**0.2520**
00002256142	**CO GABAPENTIN**	**COB**	$	**0.2520**
00002248259	**GEN-GABAPENTIN**	**GPM**	$	**0.2520**
00002244513	**NOVO-GABAPENTIN**	**NOP**	$	**0.2520**
00002243446	**PMS-GABAPENTIN**	**PMS**	$	**0.2520**
00002260883	**RATIO-GABAPENTIN**	**RPH**	$	**0.2520**
00002084260	NEURONTIN	PFI	$	0.4472

300 MG ORAL CAPSULE

00002244305	**APO-GABAPENTIN**	**APX**	$	**0.6130**
00002256150	**CO GABAPENTIN**	**COB**	$	**0.6130**
00002248260	**GEN-GABAPENTIN**	**GPM**	$	**0.6130**
00002244514	**NOVO-GABAPENTIN**	**NOP**	$	**0.6130**
00002243447	**PMS-GABAPENTIN**	**PMS**	$	**0.6130**
00002260891	**RATIO-GABAPENTIN**	**RPH**	$	**0.6130**
00002084279	NEURONTIN	PFI	$	1.0878

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:92 ANTICONVULSANTS
(MISC. ANTICONVULSANTS)

GABAPENTIN

400 MG ORAL CAPSULE

00002244306	**APO-GABAPENTIN**	**APX**	$	**0.7305**
00002256169	**CO GABAPENTIN**	**COB**	$	**0.7305**
00002248261	**GEN-GABAPENTIN**	**GPM**	$	**0.7305**
00002244515	**NOVO-GABAPENTIN**	**NOP**	$	**0.7305**
00002243448	**PMS-GABAPENTIN**	**PMS**	$	**0.7305**
00002260905	**RATIO-GABAPENTIN**	**RPH**	$	**0.7305**
00002084287	NEURONTIN	PFI	$	1.2963

LAMOTRIGINE

25 MG ORAL TABLET

00002245208	**APO-LAMOTRIGINE**	**APX**	$	**0.2088**
00002265494	**GEN-LAMOTRIGINE**	**GPM**	$	**0.2088**
00002248232	**NOVO-LAMOTRIGINE**	**NOP**	$	**0.2088**
00002246897	**PMS-LAMOTRIGINE**	**PMS**	$	**0.2088**
00002243352	**RATIO-LAMOTRIGINE**	**RPH**	$	**0.2088**
00002142082	LAMICTAL	GSK	$	0.3567

100 MG ORAL TABLET

00002245209	**APO-LAMOTRIGINE**	**APX**	$	**0.8354**
00002265508	**GEN-LAMOTRIGINE**	**GPM**	$	**0.8354**
00002248233	**NOVO-LAMOTRIGINE**	**NOP**	$	**0.8354**
00002246898	**PMS-LAMOTRIGINE**	**PMS**	$	**0.8354**
00002243353	**RATIO-LAMOTRIGINE**	**RPH**	$	**0.8354**
00002142104	LAMICTAL	GSK	$	1.4239

150 MG ORAL TABLET

00002245210	**APO-LAMOTRIGINE**	**APX**	$	**1.2530**
00002265516	**GEN-LAMOTRIGINE**	**GPM**	$	**1.2530**
00002248234	**NOVO-LAMOTRIGINE**	**NOP**	$	**1.2530**
00002246899	**PMS-LAMOTRIGINE**	**PMS**	$	**1.2530**
00002246963	**RATIO-LAMOTRIGINE**	**RPH**	$	**1.2530**
00002142112	LAMICTAL	GSK	$	2.1481

5 MG ORAL CHEWABLE TABLET

00002240115	LAMICTAL	GSK	$	0.1523

TOPIRAMATE

25 MG ORAL TABLET

00002263351	**GEN-TOPIRAMATE**	**GPM**	$	**0.6615**
00002248860	**NOVO-TOPIRAMATE**	**NOP**	$	**0.6615**
00002262991	**PMS-TOPIRAMATE**	**PMS**	$	**0.6615**
00002256827	**RATIO-TOPIRAMATE**	**RPH**	$	**0.6615**
00002260050	**SANDOZ TOPIRAMATE**	**SDZ**	$	**0.6615**
00002230893	TOPAMAX	JOI	$	1.2879

100 MG ORAL TABLET

00002263378	**GEN-TOPIRAMATE**	**GPM**	$	**1.2537**
00002248861	**NOVO-TOPIRAMATE**	**NOP**	$	**1.2537**
00002263009	**PMS-TOPIRAMATE**	**PMS**	$	**1.2537**
00002256835	**RATIO-TOPIRAMATE**	**RPH**	$	**1.2537**
00002260069	**SANDOZ TOPIRAMATE**	**SDZ**	$	**1.2537**
00002230894	TOPAMAX	JOI	$	2.4410

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:92 ANTICONVULSANTS
(MISC. ANTICONVULSANTS)

TOPIRAMATE

200 MG ORAL TABLET				
00002263386	**GEN-TOPIRAMATE**	**GPM**	$	**1.9845**
00002248862	**NOVO-TOPIRAMATE**	**NOP**	$	**1.9845**
00002263017	**PMS-TOPIRAMATE**	**PMS**	$	**1.9845**
00002256843	**RATIO-TOPIRAMATE**	**RPH**	$	**1.9845**
00002267837	**SANDOZ TOPIRAMATE**	**SDZ**	$	**1.9845**
00002230896	TOPAMAX	JOI	$	3.6450
15 MG ORAL CAPSULE				
00002239907	TOPAMAX SPRINKLE	JOI	$	1.1570
25 MG ORAL CAPSULE				
00002239908	TOPAMAX SPRINKLE	JOI	$	1.2150

VALPROIC ACID

250 MG ORAL CAPSULE				
00002238048	**APO-VALPROIC**	**APX**	$	**0.2584**
00002231030	**DOM-VALPROIC ACID**	**DPC**	$	**0.2584**
00002184648	**GEN-VALPROIC**	**GPM**	$	**0.2584**
00002100630	**NOVO-VALPROIC**	**NOP**	$	**0.2584**
00002237830	**NU-VALPROIC**	**NXP**	$	**0.2584**
00002230768	**PMS-VALPROIC ACID**	**PMS**	$	**0.2584**
00002140047	**RATIO-VALPROIC**	**RPH**	$	**0.2584**
00002239714	**SANDOZ VALPROIC**	**SDZ**	$	**0.2584**
00000443840	DEPAKENE	ABB	$	0.4766
500 MG ORAL ENTERIC-COATED CAPSULE				
00002231031	**DOM-VALPROIC ACID E.C.**	**DPC**	$	**0.5197**
00002218321	**NOVO-VALPROIC**	**NOP**	$	**0.5197**
00002229628	**PMS-VALPROIC ACID E.C.**	**PMS**	$	**0.5197**
00002140055	**RATIO-VALPROIC**	**RPH**	$	**0.5197**
00000507989	DEPAKENE	ABB	$	0.9532
50 MG / ML ORAL SYRUP				
00002238370	**APO-VALPROIC**	**APX**	$	**0.0577**
00002236807	**PMS-VALPROIC ACID**	**PMS**	$	**0.0577**
00002140063	**RATIO-VALPROIC**	**RPH**	$	**0.0577**
00000443832	DEPAKENE	ABB	$	0.0993

VIGABATRIN

500 MG ORAL TABLET				
00002065819	SABRIL	PAL	$	0.9110
500 MG ORAL POWDER PACKET				
00002068036	SABRIL	PAL	$	0.9110

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS
(ANTIDEPRESSANTS)

AMITRIPTYLINE HCL

10 MG ORAL TABLET				
00000335053	APO-AMITRIPTYLINE	APX	$	0.0520
25 MG ORAL TABLET				
00000335061	APO-AMITRIPTYLINE	APX	$	0.0995

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

AMITRIPTYLINE HCL

50 MG ORAL TABLET				
00000335088	APO-AMITRIPTYLINE	APX	$	0.1850
75 MG ORAL TABLET				
00000405612	**LEVATE**	**VCL**	$	**0.1994**
00000754129	APO-AMITRIPTYLINE	APX	$	0.2190

BUPROPION HCL

100 MG ORAL SUSTAINED-RELEASE TABLET				
00002285657	**RATIO-BUPROPION SR**	**RPH**	$	**0.3733**
00002275074	**SANDOZ BUPROPION SR**	**SDZ**	$	**0.3733**
00002237824	WELLBUTRIN SR	BOV	$	0.5833
150 MG ORAL SUSTAINED-RELEASE TABLET				
⊠ 00002260239	NOVO-BUPROPION SR	NOP	$	0.5040
00002285665	**RATIO-BUPROPION SR**	**RPH**	$	**0.5040**
00002275082	**SANDOZ BUPROPION SR**	**SDZ**	$	**0.5040**
00002237825	WELLBUTRIN SR	BOV	$	0.8750
150 MG ORAL EXTENDED-RELEASE TABLET				
00002275090	WELLBUTRIN XL	BOV	$	0.5190
300 MG ORAL EXTENDED-RELEASE TABLET				
00002275104	WELLBUTRIN XL	BOV	$	1.0380

CITALOPRAM HYDROBROMIDE

10 MG (BASE) ORAL TABLET				
00002270609	PMS-CITALOPRAM	PMS	$	0.4464
20 MG (BASE) ORAL TABLET				
00002246056	**APO-CITALOPRAM**	**APX**	$	**0.8750**
00002248050	**CO CITALOPRAM**	**COB**	$	**0.8750**
00002246594	**GEN-CITALOPRAM**	**GPM**	$	**0.8750**
00002251558	**NOVO-CITALOPRAM**	**NOP**	$	**0.8750**
00002248010	**PMS-CITALOPRAM**	**PMS**	$	**0.8750**
00002285622	**RAN-CITALO**	**RAN**	$	**0.8750**
00002268000	**RAN-CITALOPRAM**	**RAN**	$	**0.8750**
00002252112	**RATIO-CITALOPRAM**	**RPH**	$	**0.8750**
00002248170	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.8750**
00002239607	CELEXA	LBC	$	1.3828
40 MG (BASE) ORAL TABLET				
00002246057	**APO-CITALOPRAM**	**APX**	$	**0.8750**
00002248051	**CO CITALOPRAM**	**COB**	$	**0.8750**
00002246595	**GEN-CITALOPRAM**	**GPM**	$	**0.8750**
00002251566	**NOVO- CITALOPRAM**	**NOP**	$	**0.8750**
00002248011	**PMS-CITALOPRAM**	**PMS**	$	**0.8750**
00002285630	**RAN-CITALO**	**RAN**	$	**0.8750**
00002268019	**RAN-CITALOPRAM**	**RAN**	$	**0.8750**
00002252120	**RATIO-CITALOPRAM**	**RPH**	$	**0.8750**
00002248171	**SANDOZ CITALOPRAM**	**SDZ**	$	**0.8750**
00002239608	CELEXA	LBC	$	1.3828

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

CLOMIPRAMINE HCL

10 MG ORAL TABLET

00002040786	**APO-CLOMIPRAMINE**	**APX**	$	**0.1626**
00002244816	**CO CLOMIPRAMINE**	**COB**	$	**0.1626**
00002139340	**GEN-CLOMIPRAMINE**	**GPM**	$	**0.1626**
00000330566	ANAFRANIL	ORY	$	0.2775

25 MG ORAL TABLET

00002040778	**APO-CLOMIPRAMINE**	**APX**	$	**0.2215**
00002244817	**CO CLOMIPRAMINE**	**COB**	$	**0.2215**
00002139359	**GEN-CLOMIPRAMINE**	**GPM**	$	**0.2215**
00000324019	ANAFRANIL	ORY	$	0.3780

50 MG ORAL TABLET

00002040751	**APO-CLOMIPRAMINE**	**APX**	$	**0.4078**
00002244818	**CO CLOMIPRAMINE**	**COB**	$	**0.4078**
00002139367	**GEN-CLOMIPRAMINE**	**GPM**	$	**0.4078**
00000402591	ANAFRANIL	ORY	$	0.6960

DESIPRAMINE HCL

10 MG ORAL TABLET

00002216248	**APO-DESIPRAMINE**	**APX**	$	**0.1905**
00002211939	**NU-DESIPRAMINE**	**NXP**	$	**0.1905**
00001946250	**PMS-DESIPRAMINE**	**PMS**	$	**0.1905**

25 MG ORAL TABLET

00002216256	**APO-DESIPRAMINE**	**APX**	$	**0.2544**
00002130092	**DOM-DESIPRAMINE**	**DPC**	$	**0.2544**
00002211947	**NU-DESIPRAMINE**	**NXP**	$	**0.2544**
00001946269	**PMS-DESIPRAMINE**	**PMS**	$	**0.2544**
00001948784	**RATIO-DESIPRAMINE HYDROCHLOR**	**RPH**	$	**0.2544**
00002099128	NORPRAMIN	AVE	$	0.4304

50 MG ORAL TABLET

00002216264	**APO-DESIPRAMINE**	**APX**	$	**0.4110**
00002130106	**DOM-DESIPRAMINE**	**DPC**	$	**0.4110**
00002211955	**NU-DESIPRAMINE**	**NXP**	$	**0.4110**
00001946277	**PMS-DESIPRAMINE**	**PMS**	$	**0.4110**
00001948792	**RATIO-DESIPRAMINE HYDROCHLOR**	**RPH**	$	**0.4110**
00002099136	NORPRAMIN	AVE	$	0.7586

75 MG ORAL TABLET

00002216272	**APO-DESIPRAMINE**	**APX**	$	**0.6334**
00002211963	**NU-DESIPRAMINE**	**NXP**	$	**0.6334**
00001946242	**PMS-DESIPRAMINE**	**PMS**	$	**0.6334**

DOXEPIN HCL

10 MG (BASE) ORAL CAPSULE

00002049996	**APO-DOXEPIN**	**APX**	$	**0.1745**
00000024325	SINEQUAN	ERF	$	0.2680

25 MG (BASE) ORAL CAPSULE

00002050005	**APO-DOXEPIN**	**APX**	$	**0.2140**
00001913425	**NOVO-DOXEPIN**	**NOP**	$	**0.2140**
00000024333	SINEQUAN	ERF	$	0.3287

50 MG (BASE) ORAL CAPSULE

00002050013	**APO-DOXEPIN**	**APX**	$	**0.3971**
00001913433	**NOVO-DOXEPIN**	**NOP**	$	**0.3971**
00000024341	SINEQUAN	ERF	$	0.6098

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

DOXEPIN HCL

75 MG (BASE) ORAL CAPSULE				
00002050021	**APO-DOXEPIN**	**APX**	$	**0.5702**
00001913441	**NOVO-DOXEPIN**	**NOP**	$	**0.5702**
00000400750	SINEQUAN	ERF	$	0.8757
100 MG (BASE) ORAL CAPSULE				
00002050048	**APO-DOXEPIN**	**APX**	$	**0.7513**
00001913468	**NOVO-DOXEPIN**	**NOP**	$	**0.7513**
00000326925	SINEQUAN	ERF	$	1.1538
150 MG (BASE) ORAL CAPSULE				
00001913476	NOVO-DOXEPIN	NOP	$	1.1270

FLUOXETINE HCL

10 MG (BASE) ORAL CAPSULE				
00002216353	**APO-FLUOXETINE**	**APX**	$	**1.1773**
00002242177	**CO FLUOXETINE**	**COB**	$	**1.1773**
00002177617	**DOM-FLUOXETINE**	**DPC**	$	**1.1773**
00002237813	**GEN-FLUOXETINE**	**GPM**	$	**1.1773**
00002216582	**NOVO-FLUOXETINE**	**NOP**	$	**1.1773**
00002192756	**NU-FLUOXETINE**	**NXP**	$	**1.1773**
00002177579	**PMS-FLUOXETINE**	**PMS**	$	**1.1773**
00002241371	**RATIO-FLUOXETINE HYDROCHLORIDE**	**RPH**	$	**1.1773**
00002243486	**SANDOZ FLUOXETINE**	**SDZ**	$	**1.1773**
00002018985	PROZAC	LIL	$	1.8706
20 MG (BASE) ORAL CAPSULE				
00002216361	**APO-FLUOXETINE**	**APX**	$	**1.0112**
00002242178	**CO FLUOXETINE**	**COB**	$	**1.0112**
00002237814	**GEN-FLUOXETINE**	**GPM**	$	**1.0112**
00002216590	**NOVO-FLUOXETINE**	**NOP**	$	**1.0112**
00002192764	**NU-FLUOXETINE**	**NXP**	$	**1.0112**
00002177587	**PMS-FLUOXETINE**	**PMS**	$	**1.0112**
00002241374	**RATIO-FLUOXETINE HYDROCHLORIDE**	**RPH**	$	**1.0112**
00002243487	**SANDOZ FLUOXETINE**	**SDZ**	$	**1.0112**
00000636622	PROZAC	LIL	$	1.9123
40 MG (BASE) ORAL CAPSULE				
00002245283	FXT 40	ORY	$	2.1285
4 MG / ML (BASE) ORAL LIQUID				
00002231328	APO-FLUOXETINE	APX	$	0.4625

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

FLUVOXAMINE MALEATE

50 MG ORAL TABLET				
00002231329	**APO-FLUVOXAMINE**	**APX**	$	**0.4952**
00002255529	**CO FLUVOXAMINE**	**COB**	$	**0.4952**
00002239953	**NOVO-FLUVOXAMINE**	**NOP**	$	**0.4952**
00002231192	**NU-FLUVOXAMINE**	**NXP**	$	**0.4952**
00002240682	**PMS-FLUVOXAMINE**	**PMS**	$	**0.4952**
00002218453	**RATIO-FLUVOXAMINE**	**RPH**	$	**0.4952**
00002247054	**SANDOZ FLUVOXAMINE**	**SDZ**	$	**0.4952**
00001919342	LUVOX	SLO	$	0.8872
100 MG ORAL TABLET				
00002231330	**APO-FLUVOXAMINE**	**APX**	$	**0.8902**
00002255537	**CO FLUVOXAMINE**	**COB**	$	**0.8902**
00002239954	**NOVO-FLUVOXAMINE**	**NOP**	$	**0.8902**
00002231193	**NU-FLUVOXAMINE**	**NXP**	$	**0.8902**
00002240683	**PMS-FLUVOXAMINE**	**PMS**	$	**0.8902**
00002218461	**RATIO-FLUVOXAMINE**	**RPH**	$	**0.8902**
00002247055	**SANDOZ FLUVOXAMINE**	**SDZ**	$	**0.8902**
00001919369	LUVOX	SLO	$	1.5950

IMIPRAMINE HCL

10 MG ORAL TABLET				
00000360201	APO-IMIPRAMINE	APX	$	0.1037
25 MG ORAL TABLET				
00000312797	**APO-IMIPRAMINE**	**APX**	$	**0.1650**
00000010472	TOFRANIL	NOV	$	0.2663
50 MG ORAL TABLET				
00000326852	**APO-IMIPRAMINE**	**APX**	$	**0.3065**
00000010480	TOFRANIL	NOV	$	0.4949
75 MG ORAL TABLET				
00000644579	**APO-IMIPRAMINE**	**APX**	$	**0.3685**
00000306487	TOFRANIL	NOV	$	0.6765

MAPROTILINE HCL

25 MG ORAL TABLET				
00002158612	NOVO-MAPROTILINE	NOP	$	0.5493
50 MG ORAL TABLET				
00002158620	NOVO-MAPROTILINE	NOP	$	1.0401
75 MG ORAL TABLET				
00002158639	NOVO-MAPROTILINE	NOP	$	1.4204

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

MIRTAZAPINE

15 MG ORAL TABLET

00002273942	PMS-MIRTAZAPINE	PMS	$	0.3750

30 MG ORAL TABLET

00002286629	**APO-MIRTAZAPINE**	**APX**	$	**0.7800**
00002274361	**CO MIRTAZAPINE**	**COB**	$	**0.7800**
00002256118	**GEN-MIRTAZAPINE**	**GPM**	$	**0.7800**
00002259354	**NOVO-MIRTAZAPINE**	**NOP**	$	**0.7800**
00002248762	**PMS-MIRTAZAPINE**	**PMS**	$	**0.7800**
00002270927	**RATIO-MIRTAZAPINE**	**RPH**	$	**0.7800**
00002250608	**SANDOZ MIRTAZAPINE**	**SDZ**	$	**0.7800**
00002267292	**SANDOZ MIRTAZAPINE FC**	**SDZ**	$	**0.7800**
00002243910	REMERON	ORG	$	1.2400

MOCLOBEMIDE

100 MG ORAL TABLET

00002232148	**APO-MOCLOBEMIDE**	**APX**	$	**0.2520**
00002239746	**NOVO-MOCLOBEMIDE**	**NOP**	$	**0.2520**
00002237111	**NU-MOCLOBEMIDE**	**NXP**	$	**0.2520**

150 MG ORAL TABLET

00002232150	**APO-MOCLOBEMIDE**	**APX**	$	**0.3654**
00002239747	**NOVO-MOCLOBEMIDE**	**NOP**	$	**0.3654**
00002237112	**NU-MOCLOBEMIDE**	**NXP**	$	**0.3654**
00002243218	**PMS-MOCLOBEMIDE**	**PMS**	$	**0.3654**
00000899356	MANERIX	HLR	$	0.6384

300 MG ORAL TABLET

00002240456	**APO-MOCLOBEMIDE**	**APX**	$	**0.7176**
00002239748	**NOVO-MOCLOBEMIDE**	**NOP**	$	**0.7176**
00002243219	**PMS-MOCLOBEMIDE**	**PMS**	$	**0.7176**
00002166747	MANERIX	HLR	$	1.2538

NORTRIPTYLINE HCL

10 MG (BASE) ORAL CAPSULE

00002223511	**APO-NORTRIPTYLINE**	**APX**	$	**0.1260**
00002231686	**GEN-NORTRIPTYLINE**	**GPM**	$	**0.1260**
00002231781	**NOVO-NORTRIPTYLINE**	**NOP**	$	**0.1260**
00002223139	**NU-NORTRIPTYLINE**	**NXP**	$	**0.1260**
00002177692	**PMS-NORTRIPTYLINE**	**PMS**	$	**0.1260**
00002240789	**RATIO-NORTRIPTYLINE HCL**	**RPH**	$	**0.1260**
00000015229	AVENTYL	PHH	$	0.2150

25 MG (BASE) ORAL CAPSULE

00002231782	**NOVO-NORTRIPTYLINE**	**NOP**	$	**0.2546**
00002240790	**RATIO-NORTRIPTYLINE HCL**	**RPH**	$	**0.2546**
00002223538	APO-NORTRIPTYLINE	APX	$	0.2547
00002231687	GEN-NORTRIPTYLINE	GPM	$	0.2547
00002223147	NU-NORTRIPTYLINE	NXP	$	0.2547
00002177706	PMS-NORTRIPTYLINE	PMS	$	0.2547
00000015237	AVENTYL	PHH	$	0.4346

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

PAROXETINE HCL

20 MG (BASE) ORAL TABLET

00002240908	**APO-PAROXETINE**	**APX**	$	**1.0017**
00002262754	**CO PAROXETINE**	**COB**	$	**1.0017**
00002248013	**GEN-PAROXETINE**	**GPM**	$	**1.0017**
00002248557	**NOVO-PAROXETINE**	**NOP**	$	**1.0017**
00002247751	**PMS-PAROXETINE**	**PMS**	$	**1.0017**
00002247811	**RATIO-PAROXETINE**	**RPH**	$	**1.0017**
00002254751	**SANDOZ PAROXETINE**	**SDZ**	$	**1.0017**
00001940481	PAXIL	GSK	$	1.7209

30 MG (BASE) ORAL TABLET

00002240909	**APO-PAROXETINE**	**APX**	$	**1.0647**
00002262762	**CO PAROXETINE**	**COB**	$	**1.0647**
00002248014	**GEN-PAROXETINE**	**GPM**	$	**1.0647**
00002248558	**NOVO-PAROXETINE**	**NOP**	$	**1.0647**
00002247752	**PMS-PAROXETINE**	**PMS**	$	**1.0647**
00002247812	**RATIO-PAROXETINE**	**RPH**	$	**1.0647**
00002254778	**SANDOZ PAROXETINE**	**SDZ**	$	**1.0647**
00001940473	PAXIL	GSK	$	1.8285

PHENELZINE SULFATE

15 MG (BASE) ORAL TABLET

00000476552	NARDIL	ERF	$	0.3743

SERTRALINE HCL

25 MG (BASE) ORAL CAPSULE

00002238280	**APO-SERTRALINE**	**APX**	$	**0.5040**
00002287390	**CO SERTRALINE**	**COB**	$	**0.5040**
00002242519	**GEN-SERTRALINE**	**GPM**	$	**0.5040**
00002240485	**NOVO-SERTRALINE**	**NOP**	$	**0.5040**
00002244838	**PMS-SERTRALINE**	**PMS**	$	**0.5040**
00002245787	**RATIO-SERTRALINE**	**RPH**	$	**0.5040**
00002245159	**SANDOZ SERTRALINE**	**SDZ**	$	**0.5040**
00002132702	ZOLOFT	PFI	$	0.8617

50 MG (BASE) ORAL CAPSULE

00002238281	**APO-SERTRALINE**	**APX**	$	**1.0080**
00002287404	**CO SERTRALINE**	**COB**	$	**1.0080**
00002242520	**GEN-SERTRALINE**	**GPM**	$	**1.0080**
00002240484	**NOVO-SERTRALINE**	**NOP**	$	**1.0080**
00002244839	**PMS-SERTRALINE**	**PMS**	$	**1.0080**
00002245788	**RATIO-SERTRALINE**	**RPH**	$	**1.0080**
00002245160	**SANDOZ SERTRALINE**	**SDZ**	$	**1.0080**
00001962817	ZOLOFT	PFI	$	1.7234

100 MG (BASE) ORAL CAPSULE

00002238282	**APO-SERTRALINE**	**APX**	$	**1.1025**
00002287412	**CO SERTRALINE**	**COB**	$	**1.1025**
00002242521	**GEN-SERTRALINE**	**GPM**	$	**1.1025**
00002240481	**NOVO-SERTRALINE**	**NOP**	$	**1.1025**
00002244840	**PMS-SERTRALINE**	**PMS**	$	**1.1025**
00002245789	**RATIO-SERTRALINE**	**RPH**	$	**1.1025**
00002245161	**SANDOZ SERTRALINE**	**SDZ**	$	**1.1025**
00001962779	ZOLOFT	PFI	$	1.8060

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

TRANYLCYPROMINE SULFATE

10 MG (BASE) ORAL TABLET				
00001919598	PARNATE	GSK	$	0.3510

TRAZODONE HCL

50 MG ORAL TABLET				
00002147637	**APO-TRAZODONE**	**APX**	$	**0.2214**
00000579351	**DESYREL**	**BMS**	$	**0.2214**
00002128950	**DOM-TRAZODONE**	**DPC**	$	**0.2214**
00002231683	**GEN-TRAZODONE**	**GPM**	$	**0.2214**
00002144263	**NOVO-TRAZODONE**	**NOP**	$	**0.2214**
00002165384	**NU-TRAZODONE**	**NXP**	$	**0.2214**
00001937227	**PMS-TRAZODONE**	**PMS**	$	**0.2214**
00002277344	**RATIO-TRAZODONE**	**RPH**	$	**0.2214**
75 MG ORAL TABLET				
00002237339	PMS-TRAZODONE	PMS	$	0.3113
100 MG ORAL TABLET				
00002147645	**APO-TRAZODONE**	**APX**	$	**0.3956**
00000579378	**DESYREL**	**BMS**	$	**0.3956**
00002128969	**DOM-TRAZODONE**	**DPC**	$	**0.3956**
00002231684	**GEN-TRAZODONE**	**GPM**	$	**0.3956**
00002144271	**NOVO-TRAZODONE**	**NOP**	$	**0.3956**
00002165392	**NU-TRAZODONE**	**NXP**	$	**0.3956**
00001937235	**PMS-TRAZODONE**	**PMS**	$	**0.3956**
00002277352	**RATIO-TRAZODONE**	**RPH**	$	**0.3956**
150 MG ORAL TABLET				
00002147653	**APO-TRAZODONE D**	**APX**	$	**0.5812**
00000702277	**DESYREL DIVIDOSE**	**BMS**	$	**0.5812**
00002144298	**NOVO-TRAZODONE**	**NOP**	$	**0.5812**
00002165406	**NU-TRAZODONE-D**	**NXP**	$	**0.5812**
00002277360	**RATIO-TRAZODONE**	**RPH**	$	**0.5812**

TRIMIPRAMINE MALEATE

12.5 MG (BASE) ORAL TABLET				
00000740799	APO-TRIMIP	APX	$	0.0820
25 MG (BASE) ORAL TABLET				
00000740802	**APO-TRIMIP**	**APX**	$	**0.1040**
00002020602	**NU-TRIMIPRAMINE**	**NXP**	$	**0.1040**
50 MG (BASE) ORAL TABLET				
00000740810	**APO-TRIMIP**	**APX**	$	**0.1999**
00002020610	**NU-TRIMIPRAMINE**	**NXP**	$	**0.1999**
100 MG (BASE) ORAL TABLET				
00000740829	**APO-TRIMIP**	**APX**	$	**0.3418**
00002020629	**NU-TRIMIPRAMINE**	**NXP**	$	**0.3418**
75 MG (BASE) ORAL CAPSULE				
00002070987	APO-TRIMIP	APX	$	0.5197

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS (ANTIDEPRESSANTS)

VENLAFAXINE HCL

37.5 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002275023	**NOVO-VENLAFAXINE XR**	**NOP**	$	**0.5879**
00002237279	EFFEXOR XR	WAY	$	0.9291
75 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002275031	**NOVO-VENLAFAXINE XR**	**NOP**	$	**1.1758**
00002237280	EFFEXOR XR	WAY	$	1.8582
150 MG (BASE) ORAL EXTENDED-RELEASE CAPSULE				
00002275058	**NOVO-VENLAFAXINE XR**	**NOP**	$	**1.2414**
00002237282	EFFEXOR XR	WAY	$	1.9618

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:08 PSYCHOTHERAPEUTIC AGENTS (ANTIPSYCHOTIC AGENTS)

CHLORPROMAZINE HCL

25 MG (BASE) ORAL TABLET				
00000232823	NOVO-CHLORPROMAZINE	NOP	$	0.1675
50 MG (BASE) ORAL TABLET				
00000232807	NOVO-CHLORPROMAZINE	NOP	$	0.1915
100 MG (BASE) ORAL TABLET				
00000232831	NOVO-CHLORPROMAZINE	NOP	$	0.3200
25 MG / ML (BASE) INJECTION				
00000743518	CHLORPROMAZINE HCL	SDZ	$	0.6625

CLOZAPINE

25 MG ORAL TABLET				
⊠ 00002248034	APO-CLOZAPINE	APX	$	0.6594
⊠ 00002247243	GEN-CLOZAPINE	GPM	$	0.6594
⊠ 00000894737	CLOZARIL	NOV	$	1.0127
100 MG ORAL TABLET				
⊠ 00002248035	APO-CLOZAPINE	APX	$	2.6446
⊠ 00002247244	GEN-CLOZAPINE	GPM	$	2.6446
⊠ 00000894745	CLOZARIL	NOV	$	4.0614

FLUPENTHIXOL DECANOATE

20 MG / ML INJECTION				
00002156032	FLUANXOL DEPOT	LBC	$	7.4616
100 MG / ML INJECTION				
00002156040	FLUANXOL DEPOT	LBC	$	37.3079

FLUPENTHIXOL DIHYDROCHLORIDE

0.5 MG ORAL TABLET				
00002156008	FLUANXOL	LBC	$	0.2578
3 MG ORAL TABLET				
00002156016	FLUANXOL	LBC	$	0.5567

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:08 PSYCHOTHERAPEUTIC AGENTS (ANTIPSYCHOTIC AGENTS)

FLUPHENAZINE DECANOATE

25 MG / ML INJECTION				
00002239636	FLUPHENAZINE OMEGA	OMG	$	4.6320
100 MG / ML INJECTION				
00002242570	**FLUPHENAZINE OMEGA**	**OMG**	$	**29.7800**
00000755575	**MODECATE CONCENTRATE**	**BMS**	$	**29.7800**
00002241928	**PMS-FLUPHENAZINE DECANOATE**	**PMS**	$	**29.7800**

FLUPHENAZINE HCL

1 MG ORAL TABLET				
00000405345	APO-FLUPHENAZINE	APX	$	0.1680
2 MG ORAL TABLET				
00000410632	APO-FLUPHENAZINE	APX	$	0.2040
5 MG ORAL TABLET				
00000405361	APO-FLUPHENAZINE	APX	$	0.1720

HALOPERIDOL

0.5 MG ORAL TABLET				
00000396796	**APO-HALOPERIDOL**	**APX**	$	**0.0360**
00000363685	**NOVO-PERIDOL**	**NOP**	$	**0.0360**
1 MG ORAL TABLET				
00000396818	**APO-HALOPERIDOL**	**APX**	$	**0.0614**
00000363677	**NOVO-PERIDOL**	**NOP**	$	**0.0614**
2 MG ORAL TABLET				
00000396826	**APO-HALOPERIDOL**	**APX**	$	**0.1050**
00000363669	**NOVO-PERIDOL**	**NOP**	$	**0.1050**
5 MG ORAL TABLET				
00000396834	**APO-HALOPERIDOL**	**APX**	$	**0.1487**
00000363650	**NOVO-PERIDOL**	**NOP**	$	**0.1487**
10 MG ORAL TABLET				
00000463698	**APO-HALOPERIDOL**	**APX**	$	**0.1330**
00000713449	**NOVO-PERIDOL**	**NOP**	$	**0.1330**
20 MG ORAL TABLET				
00000768820	NOVO-PERIDOL	NOP	$	0.6304
2 MG / ML ORAL SOLUTION				
00000759503	PMS-HALOPERIDOL	PMS	$	0.1073
5 MG / ML INJECTION				
00000808652	HALOPERIDOL	SDZ	$	3.9200

HALOPERIDOL DECANOATE

50 MG / ML (BASE) INJECTION				
00002130297	HALOPERIDOL LA	SDZ	$	6.5000
100 MG / ML (BASE) INJECTION				
00002130300	HALOPERIDOL LA	SDZ	$	13.0000

LOXAPINE HCL

50 MG / ML (BASE) INJECTION				
00002169991	LOXAPAC	SDZ	$	5.8250

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:08 PSYCHOTHERAPEUTIC AGENTS (ANTIPSYCHOTIC AGENTS)

LOXAPINE SUCCINATE

2.5 MG (BASE) ORAL TABLET				
00002242868	PMS-LOXAPINE	PMS	$	0.0765
5 MG (BASE) ORAL TABLET				
00002237651	**APO-LOXAPINE**	**APX**	$	**0.1500**
00002237534	**NU-LOXAPINE**	**NXP**	$	**0.1500**
00002230837	**PMS-LOXAPINE**	**PMS**	$	**0.1500**
10 MG (BASE) ORAL TABLET				
00002237652	**APO-LOXAPINE**	**APX**	$	**0.2498**
00002237535	**NU-LOXAPINE**	**NXP**	$	**0.2498**
00002230838	**PMS-LOXAPINE**	**PMS**	$	**0.2498**
25 MG (BASE) ORAL TABLET				
00002237653	**APO-LOXAPINE**	**APX**	$	**0.3872**
00002237536	**NU-LOXAPINE**	**NXP**	$	**0.3872**
00002230839	**PMS-LOXAPINE**	**PMS**	$	**0.3872**
50 MG (BASE) ORAL TABLET				
00002237654	**APO-LOXAPINE**	**APX**	$	**0.5162**
00002237537	**NU-LOXAPINE**	**NXP**	$	**0.5162**
00002230840	**PMS-LOXAPINE**	**PMS**	$	**0.5162**

OLANZAPINE

2.5 MG ORAL TABLET				
00002276712	**NOVO-OLANZAPINE**	**NOP**	$	**1.2656**
00002229250	ZYPREXA	LIL	$	1.8141
5 MG ORAL TABLET				
00002276720	**NOVO-OLANZAPINE**	**NOP**	$	**2.5313**
00002229269	ZYPREXA	LIL	$	3.6281
7.5 MG ORAL TABLET				
00002276739	**NOVO-OLANZAPINE**	**NOP**	$	**3.7969**
00002229277	ZYPREXA	LIL	$	5.4422
10 MG ORAL TABLET				
00002276747	**NOVO-OLANZAPINE**	**NOP**	$	**5.0625**
00002229285	ZYPREXA	LIL	$	7.2563
15 MG ORAL TABLET				
00002276755	**NOVO-OLANZAPINE**	**NOP**	$	**7.5938**
00002238850	ZYPREXA	LIL	$	10.8844
5 MG ORAL DISINTEGRATING TABLET				
00002243086	ZYPREXA ZYDIS	LIL	$	3.6281
10 MG ORAL DISINTEGRATING TABLET				
00002243087	ZYPREXA ZYDIS	LIL	$	7.2563

PERICYAZINE

5 MG ORAL CAPSULE				
00001926780	NEULEPTIL	ERF	$	0.1962
10 MG ORAL CAPSULE				
00001926772	NEULEPTIL	ERF	$	0.3150
20 MG ORAL CAPSULE				
00001926764	NEULEPTIL	ERF	$	0.4913
10 MG / ML ORAL DROPS				
00001926756	NEULEPTIL	ERF	$	0.3870

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:08 PSYCHOTHERAPEUTIC AGENTS (ANTIPSYCHOTIC AGENTS)

PERPHENAZINE

2 MG ORAL TABLET				
00000335134	APO-PERPHENAZINE	APX	$	0.0612
4 MG ORAL TABLET				
00000335126	APO-PERPHENAZINE	APX	$	0.0741
8 MG ORAL TABLET				
00000335118	APO-PERPHENAZINE	APX	$	0.0813
16 MG ORAL TABLET				
00000335096	APO-PERPHENAZINE	APX	$	0.1245

PERPHENAZINE/ AMITRIPTYLINE HCL

4 MG * 10 MG ORAL TABLET				
00000176958	ETRAFON-A (4-10)	SCH	$	0.2820

PIMOZIDE

2 MG ORAL TABLET				
00002245432	**APO-PIMOZIDE**	**APX**	$	**0.2279**
00000313815	ORAP	PHH	$	0.2450
4 MG ORAL TABLET				
00002245433	**APO-PIMOZIDE**	**APX**	$	**0.4136**
00000313823	ORAP	PHH	$	0.4446

PIPOTIAZINE PALMITATE

25 MG / ML INJECTION				
00001926667	PIPORTIL L4	SAV	$	15.1145
50 MG / ML INJECTION				
00001926675	PIPORTIL L4	SAV	$	25.6065

PROCHLORPERAZINE

5 MG ORAL TABLET				
00000886440	**APO-PROCHLORAZINE**	**APX**	$	**0.1055**
00001964399	**NU-PROCHLOR**	**NXP**	$	**0.1055**
00000753661	**PMS-PROCHLORPERAZINE**	**PMS**	$	**0.1055**
10 MG ORAL TABLET				
00000886432	**APO-PROCHLORAZINE**	**APX**	$	**0.1290**
00001964402	**NU-PROCHLOR**	**NXP**	$	**0.1290**
00000753637	**PMS-PROCHLORPERAZINE**	**PMS**	$	**0.1290**
5 MG / ML INJECTION				
00000789747	PROCHLORPERAZINE	SDZ	$	0.6825
10 MG RECTAL SUPPOSITORY				
00000753688	**PMS-PROCHLORPERAZINE**	**PMS**	$	**0.8300**
00000789720	**SAB PROCHLORPERAZINE**	**SDZ**	$	**0.8300**

QUETIAPINE FUMARATE

25 MG (BASE) ORAL TABLET				
00002236951	SEROQUEL	AZC	$	0.4942
100 MG (BASE) ORAL TABLET				
00002236952	SEROQUEL	AZC	$	1.3183
200 MG (BASE) ORAL TABLET				
00002236953	SEROQUEL	AZC	$	2.6470
300 MG (BASE) ORAL TABLET				
00002244107	SEROQUEL	AZC	$	3.8625

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:08 PSYCHOTHERAPEUTIC AGENTS (ANTIPSYCHOTIC AGENTS)

RISPERIDONE

0.25 MG ORAL TABLET

00002282119	**APO-RISPERIDONE**	**APX**	$	**0.2615**
00002282585	**CO RISPERIDONE**	**COB**	$	**0.2615**
00002282240	**GEN-RISPERIDONE**	**GPM**	$	**0.2615**
00002282690	**NOVO-RISPERIDONE**	**NOP**	$	**0.2615**
00002252007	**PMS-RISPERIDONE**	**PMS**	$	**0.2615**
00002280906	**RAN-RISPERIDONE**	**RAN**	$	**0.2615**
00002264757	**RATIO-RISPERIDONE**	**RPH**	$	**0.2615**
00002279509	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.2615**
00002292807	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.2615**
00002240551	RISPERDAL	JOI	$	0.5127

0.5 MG ORAL TABLET

00002282127	**APO-RISPERIDONE**	**APX**	$	**0.4379**
00002282593	**CO RISPERIDONE**	**COB**	$	**0.4379**
00002282259	**GEN-RISPERIDONE**	**GPM**	$	**0.4379**
00002264188	**NOVO-RISPERIDONE**	**NOP**	$	**0.4379**
00002252015	**PMS-RISPERIDONE**	**PMS**	$	**0.4379**
00002280914	**RAN-RISPERIDONE**	**RAN**	$	**0.4379**
00002264765	**RATIO-RISPERIDONE**	**RPH**	$	**0.4379**
00002279495	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.4379**
00002240552	RISPERDAL	JOI	$	0.8587

1 MG ORAL TABLET

00002282135	**APO-RISPERIDONE**	**APX**	$	**0.6048**
00002282607	**CO RISPERIDONE**	**COB**	$	**0.6048**
00002282267	**GEN-RISPERIDONE**	**GPM**	$	**0.6048**
00002264196	**NOVO-RISPERIDONE**	**NOP**	$	**0.6048**
00002252023	**PMS-RISPERIDONE**	**PMS**	$	**0.6048**
00002280922	**RAN-RISPERIDONE**	**RAN**	$	**0.6048**
00002264773	**RATIO-RISPERIDONE**	**RPH**	$	**0.6048**
00002279800	**SANDOZ RISPERIDONE**	**SDZ**	$	**0.6048**
00002025280	RISPERDAL	JOI	$	1.1861

2 MG ORAL TABLET

00002282143	**APO-RISPERIDONE**	**APX**	$	**1.2075**
00002282615	**CO RISPERIDONE**	**COB**	$	**1.2075**
00002282275	**GEN-RISPERIDONE**	**GPM**	$	**1.2075**
00002264218	**NOVO-RISPERIDONE**	**NOP**	$	**1.2075**
00002252031	**PMS-RISPERIDONE**	**PMS**	$	**1.2075**
00002280930	**RAN-RISPERIDONE**	**RAN**	$	**1.2075**
00002264781	**RATIO-RISPERIDONE**	**RPH**	$	**1.2075**
00002279819	**SANDOZ RISPERIDONE**	**SDZ**	$	**1.2075**
00002025299	RISPERDAL	JOI	$	2.3682

3 MG ORAL TABLET

00002282151	**APO-RISPERIDONE**	**APX**	$	**1.8113**
00002282623	**CO RISPERIDONE**	**COB**	$	**1.8113**
00002282283	**GEN-RISPERIDONE**	**GPM**	$	**1.8113**
00002264226	**NOVO-RISPERIDONE**	**NOP**	$	**1.8113**
00002252058	**PMS-RISPERIDONE**	**PMS**	$	**1.8113**
00002264803	**RATIO-RISPERIDONE**	**RPH**	$	**1.8113**
00002279827	**SANDOZ RISPERIDONE**	**SDZ**	$	**1.8113**
00002280949	RAN-RISPERIDONE	RAN	$	1.8120
00002025302	RISPERDAL	JOI	$	3.5521

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:08 PSYCHOTHERAPEUTIC AGENTS (ANTIPSYCHOTIC AGENTS)

RISPERIDONE

4 MG ORAL TABLET				
00002282178	**APO-RISPERIDONE**	**APX**	$	**2.4150**
00002282631	**CO RISPERIDONE**	**COB**	$	**2.4150**
00002282291	**GEN-RISPERIDONE**	**GPM**	$	**2.4150**
00002264234	**NOVO-RISPERIDONE**	**NOP**	$	**2.4150**
00002252066	**PMS-RISPERIDONE**	**PMS**	$	**2.4150**
00002280957	**RAN-RISPERIDONE**	**RAN**	$	**2.4150**
00002264811	**RATIO-RISPERIDONE**	**RPH**	$	**2.4150**
00002279835	**SANDOZ RISPERIDONE**	**SDZ**	$	**2.4150**
00002025310	RISPERDAL	JOI	$	4.7361
0.5 MG ORAL DISINTEGRATING TABLET				
00002247704	RISPERDAL M-TAB	JOI	$	0.7471
1 MG ORAL DISINTEGRATING TABLET				
00002247705	RISPERDAL M-TAB	JOI	$	1.0320
2 MG ORAL DISINTEGRATING TABLET				
00002247706	RISPERDAL M-TAB	JOI	$	2.0601
3 MG ORAL DISINTEGRATING TABLET				
00002268086	RISPERDAL M-TAB	JOI	$	3.0906
4 MG ORAL DISINTEGRATING TABLET				
00002268094	RISPERDAL M-TAB	JOI	$	4.1207

RISPERIDONE TARTRATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 years of age and older for the management of the manifestations of schizophrenia and related psychotic disorders, as well as in severe dementia for the short-term symptomatic management of inappropriate behavior due to aggression and/or psychosis.

1 MG / ML (BASE) ORAL SOLUTION				
00002280396	**APO-RISPERIDONE**	**APX**	$	**0.7727**
00002279266	**PMS-RISPERIDONE**	**PMS**	$	**0.7727**
00002236950	RISPERDAL	JOI	$	1.3639

THIOPROPERAZINE MESYLATE

10 MG (BASE) ORAL TABLET				
00001927639	MAJEPTIL	ERF	$	0.3548

THIOTHIXENE

2 MG ORAL CAPSULE				
00000024430	NAVANE	ERF	$	0.3225
5 MG ORAL CAPSULE				
00000024449	NAVANE	ERF	$	0.3570
10 MG ORAL CAPSULE				
00000024457	NAVANE	ERF	$	0.4596

TRIFLUOPERAZINE HCL

1 MG (BASE) ORAL TABLET				
00000345539	APO-TRIFLUOPERAZINE	APX	$	0.1015
2 MG (BASE) ORAL TABLET				
00000312754	APO-TRIFLUOPERAZINE	APX	$	0.1330
5 MG (BASE) ORAL TABLET				
00000312746	APO-TRIFLUOPERAZINE	APX	$	0.1765

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:08 PSYCHOTHERAPEUTIC AGENTS (ANTIPSYCHOTIC AGENTS)

TRIFLUOPERAZINE HCL

10 MG (BASE) ORAL TABLET				
00000326836	APO-TRIFLUOPERAZINE	APX	$	0.2115
20 MG (BASE) ORAL TABLET				
00000595942	APO-TRIFLUOPERAZINE	APX	$	0.3600
10 MG / ML (BASE) ORAL SYRUP				
00000751871	PMS-TRIFLUOPERAZINE	PMS	$	0.2488

ZUCLOPENTHIXOL ACETATE

50 MG / ML INJECTION				
00002230405	CLOPIXOL ACUPHASE	LBC	$	15.4865

ZUCLOPENTHIXOL DECANOATE

200 MG / ML INJECTION				
00002230406	CLOPIXOL DEPOT	LBC	$	15.4865

ZUCLOPENTHIXOL DIHYDROCHLORIDE

10 MG (BASE) ORAL TABLET				
00002230402	CLOPIXOL	LBC	$	0.3982
25 MG (BASE) ORAL TABLET				
00002230403	CLOPIXOL	LBC	$	0.9956

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:12 PSYCHOTHERAPEUTIC AGENTS (MISC. PSYCHOTHERAPEUTIC AGENTS)

L-TRYPTOPHAN

250 MG ORAL TABLET				
00002239326	TRYPTAN	VCL	$	0.3830
500 MG ORAL TABLET				
00002248538	**APO-TRYPTOPHAN**	**APX**	$	**0.4987**
00002240445	**PMS-TRYPTOPHAN**	**PMS**	$	**0.4987**
00002240333	**RATIO-TRYPTOPHAN**	**RPH**	$	**0.4987**
00002029456	TRYPTAN	VCL	$	0.7659
750 MG ORAL TABLET				
00002239327	TRYPTAN	VCL	$	1.1491
1 G ORAL TABLET				
00002248539	**APO-TRYPTOPHAN**	**APX**	$	**0.8978**
00002230202	**PMS-TRYPTOPHAN**	**PMS**	$	**0.8978**
00002237250	**RATIO-TRYPTOPHAN**	**RPH**	$	**0.8978**
00000654531	TRYPTAN	VCL	$	1.5320
500 MG ORAL CAPSULE				
00002248540	**APO-TRYPTOPHAN**	**APX**	$	**0.4987**
00002241023	**PMS-TRYPTOPHAN**	**PMS**	$	**0.4987**
00002240334	**RATIO-TRYPTOPHAN**	**RPH**	$	**0.4987**
00000718149	TRYPTAN	VCL	$	0.7659

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:20 ANOREXIGENIC AGENTS & RESP. & CEREBRAL STIMULANTS

DEXTROAMPHETAMINE SULFATE

5 MG ORAL TABLET				
00001924516	DEXEDRINE	GSK	$	0.5214
10 MG ORAL SUSTAINED-RELEASE CAPSULE				
00001924559	DEXEDRINE	GSK	$	0.7480
15 MG ORAL SUSTAINED-RELEASE CAPSULE				
00001924567	DEXEDRINE	GSK	$	0.9145

METHYLPHENIDATE HCL

5 MG ORAL TABLET				
00002234749	PMS-METHYLPHENIDATE	PMS	$	0.0947
10 MG ORAL TABLET				
00002249324	**APO-METHYLPHENIDATE**	**APX**	$	**0.1590**
00000584991	**PMS-METHYLPHENIDATE**	**PMS**	$	**0.1590**
00000005606	RITALIN	NOV	$	0.3134
20 MG ORAL TABLET				
00002249332	**APO-METHYLPHENIDATE**	**APX**	$	**0.3536**
00000585009	**PMS-METHYLPHENIDATE**	**PMS**	$	**0.3536**
00000005614	RITALIN	NOV	$	0.5476
20 MG ORAL EXTENDED-RELEASE TABLET				
00002266687	**APO-METHYLPHENIDATE SR**	**APX**	$	**0.3364**
00000632775	RITALIN SR	NOV	$	0.5498

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:24:04 ANXIOLYTICS,SEDATIVES & HYPNOTICS (BARBITURATES)

AMOBARBITAL SODIUM/ SECOBARBITAL SODIUM

50 MG * 50 MG ORAL CAPSULE				
00000128864	TUINAL	PMS	$	0.2042
100 MG * 100 MG ORAL CAPSULE				
00000128872	TUINAL	PMS	$	0.2785

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:24:08 ANXIOLYTICS,SEDATIVES & HYPNOTICS (BENZODIAZEPINES)

ALPRAZOLAM

0.25 MG ORAL TABLET				
00000865397	**APO-ALPRAZ**	**APX**	$	**0.0760**
00002137534	**GEN-ALPRAZOLAM**	**GPM**	$	**0.0760**
00001913484	**NOVO-ALPRAZOL**	**NOP**	$	**0.0760**
00001913239	**NU-ALPRAZ**	**NXP**	$	**0.0760**
00000548359	XANAX	PFI	$	0.2618
0.5 MG ORAL TABLET				
00000865400	**APO-ALPRAZ**	**APX**	$	**0.0920**
00002137542	**GEN-ALPRAZOLAM**	**GPM**	$	**0.0920**
00001913492	**NOVO-ALPRAZOL**	**NOP**	$	**0.0920**
00001913247	**NU-ALPRAZ**	**NXP**	$	**0.0920**
00000548367	XANAX	PFI	$	0.3129

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:24:08 ANXIOLYTICS,SEDATIVES & HYPNOTICS (BENZODIAZEPINES)

BROMAZEPAM

1.5 MG ORAL TABLET				
00002177153	**APO-BROMAZEPAM**	**APX**	$	**0.0693**
00002192705	**GEN-BROMAZEPAM**	**GPM**	$	**0.0693**
00002171856	**NU-BROMAZEPAM**	**NXP**	$	**0.0693**
3 MG ORAL TABLET				
00002177161	**APO-BROMAZEPAM**	**APX**	$	**0.0882**
00002192713	**GEN-BROMAZEPAM**	**GPM**	$	**0.0882**
00002230584	**NOVO-BROMAZEPAM**	**NOP**	$	**0.0882**
00002171864	**NU-BROMAZEPAM**	**NXP**	$	**0.0882**
00000518123	LECTOPAM	HLR	$	0.1580
6 MG ORAL TABLET				
00002177188	**APO-BROMAZEPAM**	**APX**	$	**0.1288**
00002192721	**GEN-BROMAZEPAM**	**GPM**	$	**0.1288**
00002230585	**NOVO-BROMAZEPAM**	**NOP**	$	**0.1288**
00002171872	**NU-BROMAZEPAM**	**NXP**	$	**0.1288**
00000518131	LECTOPAM	HLR	$	0.2308

CHLORDIAZEPOXIDE HCL

5 MG ORAL CAPSULE				
00000522724	APO-CHLORDIAZEPOXIDE	APX	$	0.0663
10 MG ORAL CAPSULE				
00000522988	APO-CHLORDIAZEPOXIDE	APX	$	0.1045
25 MG ORAL CAPSULE				
00000522996	APO-CHLORDIAZEPOXIDE	APX	$	0.1620

CLORAZEPATE DIPOTASSIUM

3.75 MG ORAL CAPSULE				
00000860689	**APO-CLORAZEPATE**	**APX**	$	**0.1067**
00000628190	**NOVO-CLOPATE**	**NOP**	$	**0.1067**
7.5 MG ORAL CAPSULE				
00000860700	**APO-CLORAZEPATE**	**APX**	$	**0.1926**
00000628204	**NOVO-CLOPATE**	**NOP**	$	**0.1926**
15 MG ORAL CAPSULE				
00000860697	**APO-CLORAZEPATE**	**APX**	$	**0.3856**
00000628212	**NOVO-CLOPATE**	**NOP**	$	**0.3856**

DIAZEPAM

2 MG ORAL TABLET				
00000405329	APO-DIAZEPAM	APX	$	0.0508
5 MG ORAL TABLET				
00000362158	**APO-DIAZEPAM**	**APX**	$	**0.0650**
00000013765	VIVOL	AXS	$	0.0877
00000013285	VALIUM	HLR	$	0.1615
10 MG ORAL TABLET				
00000405337	**APO-DIAZEPAM**	**APX**	$	**0.0867**
00000013773	VIVOL	AXS	$	0.1438
5 MG / ML INJECTION				
00000399728	DIAZEPAM	SDZ	$	0.5285
5 MG / ML INJECTION EMULSION				
00002065614	DIAZEMULS	PFI	$	1.1695

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:24:08 ANXIOLYTICS,SEDATIVES & HYPNOTICS (BENZODIAZEPINES)

FLURAZEPAM HCL

15 MG ORAL TABLET				
00000483826	SOMNOL	AXS	$	0.0841
30 MG ORAL TABLET				
00000483818	SOMNOL	AXS	$	0.0750
15 MG ORAL CAPSULE				
00000521698	APO-FLURAZEPAM	APX	$	0.0810
30 MG ORAL CAPSULE				
00000521701	APO-FLURAZEPAM	APX	$	0.0930

LORAZEPAM

0.5 MG ORAL TABLET				
00000655740	**APO-LORAZEPAM**	**APX**	$	**0.0359**
00000711101	**NOVO-LORAZEM**	**NOP**	$	**0.0359**
00000865672	**NU-LORAZ**	**NXP**	$	**0.0359**
00000728187	**PMS-LORAZEPAM**	**PMS**	$	**0.0359**
00002041413	ATIVAN	WAY	$	0.0806
1 MG ORAL TABLET				
00000655759	**APO-LORAZEPAM**	**APX**	$	**0.0447**
00000637742	**NOVO-LORAZEM**	**NOP**	$	**0.0447**
00000865680	**NU-LORAZ**	**NXP**	$	**0.0447**
00000728195	**PMS-LORAZEPAM**	**PMS**	$	**0.0447**
00002041421	ATIVAN	WAY	$	0.0481
2 MG ORAL TABLET				
00000655767	**APO-LORAZEPAM**	**APX**	$	**0.0699**
00000637750	**NOVO-LORAZEM**	**NOP**	$	**0.0699**
00000865699	**NU-LORAZ**	**NXP**	$	**0.0699**
00000728209	**PMS-LORAZEPAM**	**PMS**	$	**0.0699**
00002041448	ATIVAN	WAY	$	0.0751
0.5 MG ORAL SUBLINGUAL TABLET				
00002041456	ATIVAN	WAY	$	0.1051
1 MG ORAL SUBLINGUAL TABLET				
00002041464	ATIVAN	WAY	$	0.1321
2 MG ORAL SUBLINGUAL TABLET				
00002041472	ATIVAN	WAY	$	0.2054

MIDAZOLAM HCL

5 MG / ML (BASE) INJECTION				
00002240286	MIDAZOLAM	SDZ	$	3.2300

NITRAZEPAM

5 MG ORAL TABLET				
00002245230	**APO-NITRAZEPAM**	**APX**	$	**0.0857**
00002234003	**SANDOZ NITRAZEPAM**	**SDZ**	$	**0.0857**
00002229654	NITRAZADON	VCL	$	0.0921
00000511528	MOGADON	VCL	$	0.1535
10 MG ORAL TABLET				
00002245231	**APO-NITRAZEPAM**	**APX**	$	**0.1282**
00002234007	**SANDOZ NITRAZEPAM**	**SDZ**	$	**0.1282**
00002229655	NITRAZADON	VCL	$	0.1378
00000511536	MOGADON	VCL	$	0.2297

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:24:08 ANXIOLYTICS,SEDATIVES & HYPNOTICS (BENZODIAZEPINES)

OXAZEPAM

10 MG ORAL TABLET				
00000402680	APO-OXAZEPAM	APX	$	0.0420
15 MG ORAL TABLET				
00000402745	APO-OXAZEPAM	APX	$	0.0660
30 MG ORAL TABLET				
00000402737	APO-OXAZEPAM	APX	$	0.0900

TEMAZEPAM

15 MG ORAL CAPSULE				
00002225964	**APO-TEMAZEPAM**	**APX**	$	**0.1102**
00002244814	**CO TEMAZEPAM**	**COB**	$	**0.1102**
00002231615	**GEN-TEMAZEPAM**	**GPM**	$	**0.1102**
00002230095	**NOVO-TEMAZEPAM**	**NOP**	$	**0.1102**
00002223570	**NU-TEMAZEPAM**	**NXP**	$	**0.1102**
00002229455	**PMS-TEMAZEPAM**	**PMS**	$	**0.1102**
00002273039	**PMS-TEMAZEPAM**	**PMS**	$	**0.1102**
00002243023	**RATIO-TEMAZEPAM**	**RPH**	$	**0.1102**
00002229756	DOM-TEMAZEPAM	DPC	$	0.1157
00000604453	RESTORIL	ORY	$	0.1881
30 MG ORAL CAPSULE				
00002225972	**APO-TEMAZEPAM**	**APX**	$	**0.1326**
00002244815	**CO TEMAZEPAM**	**COB**	$	**0.1326**
00002231616	**GEN-TEMAZEPAM**	**GPM**	$	**0.1326**
00002230102	**NOVO-TEMAZEPAM**	**NOP**	$	**0.1326**
00002223589	**NU-TEMAZEPAM**	**NXP**	$	**0.1326**
00002229456	**PMS-TEMAZEPAM**	**PMS**	$	**0.1326**
00002273047	**PMS-TEMAZEPAM**	**PMS**	$	**0.1326**
00002243024	**RATIO-TEMAZEPAM**	**RPH**	$	**0.1326**
00002229758	DOM-TEMAZEPAM	DPC	$	0.1392
00000604461	RESTORIL	ORY	$	0.2263

TRIAZOLAM

0.125 MG ORAL TABLET				
00000808563	**APO-TRIAZO**	**APX**	$	**0.1181**
00001995227	**GEN-TRIAZOLAM**	**GPM**	$	**0.1181**
0.25 MG ORAL TABLET				
00000808571	**APO-TRIAZO**	**APX**	$	**0.2086**
00001913506	**GEN-TRIAZOLAM**	**GPM**	$	**0.2086**

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:24:92 ANXIOLYTICS,SEDATIVES & HYPNOTICS (MISC.ANXIOLYTICS,SEDATIVES&HYPNOTIC)

BUSPIRONE HCL

5 MG ORAL TABLET

00002230941	PMS-BUSPIRONE	PMS	$	0.3984

10 MG ORAL TABLET

00002211076	**APO-BUSPIRONE**	**APX**	$	**0.6521**
00002262916	**CO BUSPIRONE**	**COB**	$	**0.6521**
00002232564	**DOM-BUSPIRONE**	**DPC**	$	**0.6521**
00002230874	**GEN-BUSPIRONE**	**GPM**	$	**0.6521**
00002231492	**NOVO-BUSPIRONE**	**NOP**	$	**0.6521**
00002207672	**NU-BUSPIRONE**	**NXP**	$	**0.6521**
00002230942	**PMS-BUSPIRONE**	**PMS**	$	**0.6521**
00002237858	**RATIO-BUSPIRONE**	**RPH**	$	**0.6521**
00000603821	BUSPAR	BMS	$	0.9936

CHLORAL HYDRATE

100 MG / ML ORAL SYRUP

00000792659	PMS-CHLORAL HYDRATE	PMS	$	0.0433

HYDROXYZINE HCL

10 MG ORAL CAPSULE

00000646059	**APO-HYDROXYZINE**	**APX**	$	**0.1116**
00000738824	**NOVO-HYDROXYZIN**	**NOP**	$	**0.1116**

25 MG ORAL CAPSULE

00000646024	**APO-HYDROXYZINE**	**APX**	$	**0.1425**
00000738832	**NOVO-HYDROXYZIN**	**NOP**	$	**0.1425**

50 MG ORAL CAPSULE

00000646016	**APO-HYDROXYZINE**	**APX**	$	**0.2068**
00000738840	**NOVO-HYDROXYZIN**	**NOP**	$	**0.2068**

2 MG / ML ORAL SYRUP

00000741817	**PMS-HYDROXYZINE**	**PMS**	$	**0.0389**
00000024694	ATARAX	ERF	$	0.0530

50 MG / ML INJECTION

00000742813	HYDROXYZINE HCL	SDZ	$	3.5000

METHOTRIMEPRAZINE HCL

25 MG / ML (BASE) INJECTION

00001927698	NOZINAN	AVE	$	2.5488

METHOTRIMEPRAZINE MALEATE

2 MG (BASE) ORAL TABLET

00002238403	APO-METHOPRAZINE	APX	$	0.0505

5 MG (BASE) ORAL TABLET

00002238404	**APO-METHOPRAZINE**	**APX**	$	**0.0528**
00002232903	**PMS-METHOTRIMEPRAZINE**	**PMS**	$	**0.0528**
00001927655	NOZINAN	AVE	$	0.0568

25 MG (BASE) ORAL TABLET

00002238405	**APO-METHOPRAZINE**	**APX**	$	**0.1131**
00002232904	**PMS-METHOTRIMEPRAZINE**	**PMS**	$	**0.1131**
00001927663	NOZINAN	AVE	$	0.1216

50 MG (BASE) ORAL TABLET

00002238406	**APO-METHOPRAZINE**	**APX**	$	**0.1541**
00002232905	**PMS-METHOTRIMEPRAZINE**	**PMS**	$	**0.1541**
00001927671	NOZINAN	AVE	$	0.1657

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:24:92 ANXIOLYTICS,SEDATIVES & HYPNOTICS (MISC.ANXIOLYTICS,SEDATIVES&HYPNOTIC)

ZOPICLONE

5 MG ORAL TABLET				
00002245077	**APO-ZOPICLONE**	**APX**	$	**0.2231**
00002271931	**CO ZOPICLONE**	**COB**	$	**0.2231**
00002251450	**NOVO-ZOPICLONE**	**NOP**	$	**0.2231**
00002243426	**PMS-ZOPICLONE**	**PMS**	$	**0.2231**
00002267918	**RAN-ZOPICLONE**	**RAN**	$	**0.2231**
00002246534	**RATIO-ZOPICLONE**	**RPH**	$	**0.2231**
00002257572	**SANDOZ ZOPICLONE**	**SDZ**	$	**0.2231**
00002216167	IMOVANE	SAV	$	0.4051
7.5 MG ORAL TABLET				
00002218313	**APO-ZOPICLONE**	**APX**	$	**0.4685**
00002271958	**CO ZOPICLONE**	**COB**	$	**0.4685**
00002238596	**GEN-ZOPICLONE**	**GPM**	$	**0.4685**
00002251469	**NOVO-ZOPICLONE**	**NOP**	$	**0.4685**
00002228270	**NU-ZOPICLONE**	**NXP**	$	**0.4685**
00002240606	**PMS-ZOPICLONE**	**PMS**	$	**0.4685**
00002267926	**RAN-ZOPICLONE**	**RAN**	$	**0.4685**
00002242481	**RATIO-ZOPICLONE**	**RPH**	$	**0.4685**
00002008203	**RHOVANE**	**SDZ**	$	**0.4685**
00002257580	**SANDOZ ZOPICLONE**	**SDZ**	$	**0.4685**
00001926799	IMOVANE	SAV	$	0.9376

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:28 ANTIMANIC AGENTS

LITHIUM CARBONATE

300 MG ORAL SUSTAINED-RELEASE TABLET				
00002266695	APO-LITHIUM CARBONATE SR	APX	$	0.1334
150 MG ORAL CAPSULE				
00002242837	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0532**
00002216132	**PMS-LITHIUM CARBONATE**	**PMS**	$	**0.0532**
00000461733	CARBOLITH	VCL	$	0.1227
150 MG ORAL CAPSULE				
00002242837	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0532**
00002013231	LITHANE	ERF	$	0.1070
300 MG ORAL CAPSULE				
00002242838	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0558**
00002216140	**PMS-LITHIUM CARBONATE**	**PMS**	$	**0.0558**
00000236683	CARBOLITH	VCL	$	0.0953
300 MG ORAL CAPSULE				
00002242838	**APO-LITHIUM CARBONATE**	**APX**	$	**0.0558**
00000406775	LITHANE	ERF	$	0.1065
600 MG ORAL CAPSULE				
00002216159	PMS-LITHIUM CARBONATE	PMS	$	0.1360

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:92 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

ALMOTRIPTAN MALATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

6.25 MG (BASE) ORAL TABLET				
00002248128	AXERT	MCL	$	13.9217
12.5 MG (BASE) ORAL TABLET				
00002248129	AXERT	MCL	$	13.9217

AMANTADINE HCL

100 MG ORAL CAPSULE				
00002034468	**ENDANTADINE**	**BMS**	$	**0.5179**
00002139200	**GEN-AMANTADINE**	**GPM**	$	**0.5179**
00001990403	**PMS-AMANTADINE HYDROCHLORIDE**	**PMS**	$	**0.5179**
00001914006	SYMMETREL	BMS	$	1.0850
10 MG / ML ORAL SYRUP				
00002022826	**PMS-AMANTADINE HYDROCHLORIDE**	**PMS**	$	**0.0810**
00001913999	**SYMMETREL**	**BMS**	$	**0.0810**

ENTACAPONE

200 MG ORAL TABLET				
00002243763	COMTAN	NOV	$	1.6073

LEVODOPA/ BENSERAZIDE HCL

50 MG * 12.5 MG (BASE) ORAL CAPSULE				
00000522597	PROLOPA 50-12.5	HLR	$	0.2879
100 MG * 25 MG (BASE) ORAL CAPSULE				
00000386464	PROLOPA 100-25	HLR	$	0.4741
200 MG * 50 MG (BASE) ORAL CAPSULE				
00000386472	PROLOPA 200-50	HLR	$	0.7958

LEVODOPA/ CARBIDOPA

100 MG * 10 MG ORAL TABLET				
00002195933	**APO-LEVOCARB**	**APX**	$	**0.2365**
00002244494	**NOVO-LEVOCARBIDOPA**	**NOP**	$	**0.2365**
00002182831	**NU-LEVOCARB**	**NXP**	$	**0.2365**
00000355658	SINEMET 100/10	BMS	$	0.4221
100 MG * 25 MG ORAL TABLET				
00002195941	**APO-LEVOCARB**	**APX**	$	**0.3532**
00002244495	**NOVO-LEVOCARBIDOPA**	**NOP**	$	**0.3532**
00002182823	**NU-LEVOCARB**	**NXP**	$	**0.3532**
00000513997	SINEMET 100/25	BMS	$	0.6303
250 MG * 25 MG ORAL TABLET				
00002195968	**APO-LEVOCARB**	**APX**	$	**0.3943**
00002244496	**NOVO-LEVOCARBIDOPA**	**NOP**	$	**0.3943**
00002182858	**NU-LEVOCARB**	**NXP**	$	**0.3943**
00000328219	SINEMET 250/25	BMS	$	0.7036
100 MG * 25 MG ORAL SUSTAINED-RELEASE TABLET				
00002028786	SINEMET CR 100/25	BMS	$	0.6701

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:92 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

LEVODOPA/ CARBIDOPA

200 MG * 50 MG ORAL SUSTAINED-RELEASE TABLET

00002245211	**APO-LEVOCARB CR**	**APX**	$	**0.7385**
00000870935	SINEMET CR 200/50	BMS	$	1.2131

NARATRIPTAN HCL

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products in the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

1 MG (BASE) ORAL TABLET

00002237820	AMERGE	GSK	$	13.2307

2.5 MG (BASE) ORAL TABLET

00002237821	AMERGE	GSK	$	13.9417

PRAMIPEXOLE DIHYDROCHLORIDE

0.25 MG ORAL TABLET

00002292378	**APO-PRAMIPEXOLE**	**APX**	$	**0.6930**
00002269309	**NOVO-PRAMIPEXOLE**	**NOP**	$	**0.6930**
00002290111	**PMS-PRAMIPEXOLE**	**PMS**	$	**0.6930**
00002237145	MIRAPEX	BOE	$	1.0513

1 MG ORAL TABLET

00002292394	**APO-PRAMIPEXOLE**	**APX**	$	**1.3860**
00002269325	**NOVO-PRAMIPEXOLE**	**NOP**	$	**1.3860**
00002290146	**PMS-PRAMIPEXOLE**	**PMS**	$	**1.3860**
00002237146	MIRAPEX	BOE	$	2.1028

1.5 MG ORAL TABLET

00002292408	**APO-PRAMIPEXOLE**	**APX**	$	**1.3860**
00002269333	**NOVO-PRAMIPEXOLE**	**NOP**	$	**1.3860**
00002290154	**PMS-PRAMIPEXOLE**	**PMS**	$	**1.3860**
00002237147	MIRAPEX	BOE	$	2.1028

RIZATRIPTAN BENZOATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products of the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

5 MG (BASE) ORAL TABLET

00002240520	MAXALT	MFC	$	13.8717

10 MG (BASE) ORAL TABLET

00002240521	MAXALT	MFC	$	13.8717

5 MG (BASE) ORAL WAFER

00002240518	MAXALT RPD	MFC	$	13.8717

10 MG (BASE) ORAL WAFER

00002240519	MAXALT RPD	MFC	$	13.8717

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:92 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

ROPINIROLE HCL

0.25 MG (BASE) ORAL TABLET				
00002232565	REQUIP	GSK	$	0.2705
1 MG (BASE) ORAL TABLET				
00002232567	REQUIP	GSK	$	1.0821
2 MG (BASE) ORAL TABLET				
00002232568	REQUIP	GSK	$	1.1903
5 MG (BASE) ORAL TABLET				
00002232569	REQUIP	GSK	$	3.3546

SELEGILINE HCL

5 MG ORAL TABLET				
00002230641	**APO-SELEGILINE**	**APX**	$	**1.2650**
00002231036	**GEN-SELEGILINE**	**GPM**	$	**1.2650**
00002068087	**NOVO-SELEGILINE**	**NOP**	$	**1.2650**
00002230717	**NU-SELEGILINE**	**NXP**	$	**1.2650**
00002238102	**PMS-SELEGILINE**	**PMS**	$	**1.2650**

SUMATRIPTAN HEMISULFATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products of the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

5 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230418	IMITREX	GSK	$	13.4283
20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY				
00002230420	IMITREX	GSK	$	14.1474

28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:92 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

SUMATRIPTAN SUCCINATE

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

50 MG (BASE) ORAL TABLET				
00002268388	**APO-SUMATRIPTAN**	**APX**	$	**9.0650**
00002257890	**CO SUMATRIPTAN**	**COB**	$	**9.0650**
00002268914	**GEN-SUMATRIPTAN**	**GPM**	$	**9.0650**
00002286823	**NOVO-SUMATRIPTAN DF**	**NOP**	$	**9.0650**
00002256436	**PMS-SUMATRIPTAN**	**PMS**	$	**9.0650**
00002271583	**RATIO-SUMATRIPTAN**	**RPH**	$	**9.0650**
00002263025	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**9.0650**
00002212153	IMITREX DF	GSK	$	14.1487
100 MG (BASE) ORAL TABLET				
00002268396	**APO-SUMATRIPTAN**	**APX**	$	**9.9867**
00002257904	**CO SUMATRIPTAN**	**COB**	$	**9.9867**
00002268922	**GEN-SUMATRIPTAN**	**GPM**	$	**9.9867**
00002239367	**NOVO-SUMATRIPTAN**	**NOP**	$	**9.9867**
00002286831	**NOVO-SUMATRIPTAN DF**	**NOP**	$	**9.9867**
00002256444	**PMS-SUMATRIPTAN**	**PMS**	$	**9.9867**
00002271591	**RATIO-SUMATRIPTAN**	**RPH**	$	**9.9867**
00002263033	**SANDOZ SUMATRIPTAN**	**SDZ**	$	**9.9867**
00002212161	IMITREX DF	GSK	$	15.5860
6 MG / SYR (BASE) INJECTION SYRINGE				
00002212188	IMITREX (0.5 ML)	GSK	$	75.7044

ZOLMITRIPTAN

RESTRICTED BENEFIT - This product is a benefit for patients 18 to 64 years of age inclusive for the treatment of acute migraine attacks in patients where other standard therapy has failed. (Refer to Criteria for Special Authorization of Select Drug Products of the List for eligibility in patients 65 years of age and older; and Criteria for Special Authorization of Select Drug Products of the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

2.5 MG ORAL TABLET				
00002238660	ZOMIG	AZC	$	13.3333
2.5 MG ORAL DISPERSIBLE TABLET				
00002243045	ZOMIG RAPIMELT	AZC	$	13.3400
5 MG / DOSE NASAL UNIT DOSE SPRAY				
00002248993	ZOMIG	AZC	$	13.3333

40:00 ELECTROLYTIC, CALORIC, WATER BALANCE

40:10 AMMONIA DETOXICANTS

LACTULOSE

667 MG / ML ORAL SYRUP

00002242814	**APO-LACTULOSE**	**APX**	$	**0.0145**
00000703486	**PMS-LACTULOSE**	**PMS**	$	**0.0145**
00000854409	**RATIO-LACTULOSE**	**RPH**	$	**0.0145**

40:00 ELECTROLYTIC, CALORIC, WATER BALANCE

40:12 REPLACEMENT PREPARATIONS

MAGNESIUM GLUCOHEPTONATE

100 MG / ML ORAL SOLUTION

00000026697	ROUGIER MAGNESIUM	ROG	$	0.0210

MAGNESIUM GLUCONATE

500 MG ORAL TABLET

00000555126	MAGLUCATE	PMS	$	0.1088

POTASSIUM CHLORIDE (K+)

8 MEQ ORAL SUSTAINED-RELEASE TABLET

☒ 00000602884	APO-K	APX		$	0.0899
☒ 00000074225	SLOW K	NOV	***$ 0.0899***	$	0.1305

MAC pricing has been applied based on the lowest unit cost for an 8 mEq (K+) oral sustained-release tablet: APO-K.

20 MEQ ORAL SUSTAINED-RELEASE TABLET

00000713376	K-DUR	SCH	$	0.1995

8 MEQ ORAL SUSTAINED-RELEASE CAPSULE

00002042304	MICRO-K EXTENCAPS	WAY	$	0.1000

POTASSIUM CHLORIDE (K+)(CL-)

1.33 MEQ / ML ORAL LIQUID

00002238604	**PMS - POTASSIUM CHLORIDE**	**PMS**	$	**0.0128**
00001918303	K-10 ORAL LIQUID	GSK	$	0.0147

25 MEQ ORAL POWDER PACKET

00002089580	K-LYTE/CL	WSP	$	0.4783

POTASSIUM CITRATE (K+)

25 MEQ ORAL EFFERVESCENT TABLET

00002085992	K-LYTE	WSP	$	0.5550

SODIUM ACID PHOSPHATE/ SODIUM BICARBONATE/ POTASSIUM BICARBONATE

500 MG (BASE) * 469 MG (BASE) * 123 MG (BASE) ORAL EFFERVESCENT TABLET

00000225819	PHOSPHATE-NOVARTIS	NOV	$	0.6386

40:00 ELECTROLYTIC, CALORIC, WATER BALANCE

40:18 POTASSIUM REMOVING RESINS

CALCIUM POLYSTYRENE SULPHONATE

ORAL POWDER

00002017741	RESONIUM CALCIUM	SAV	$	0.3310

40:00 ELECTROLYTIC, CALORIC, WATER BALANCE

40:18 POTASSIUM REMOVING RESINS

SODIUM POLYSTYRENE SULFONATE

250 MG / ML ORAL SUSPENSION				
00000769541	PMS-SODIUM POLYSTYRENE SULF.	PMS	$	0.1183
ORAL POWDER				
00000755338	**PMS-SODIUM POLYSTYRENE SULF.**	**PMS**	$	**0.1432**
00002026961	KAYEXALATE	SAV	$	0.1714
30 G / ENM RECTAL RETENTION ENEMA				
00000769533	PMS-SOD POLYSTYR SULF (120 ML)	PMS	$	13.9200

40:00 ELECTROLYTIC, CALORIC, WATER BALANCE

40:28 DIURETICS

CHLORTHALIDONE

50 MG ORAL TABLET				
00000360279	APO-CHLORTHALIDONE	APX	$	0.0785

FUROSEMIDE

20 MG ORAL TABLET				
00000396788	**APO-FUROSEMIDE**	**APX**	$	**0.0445**
00000337730	**NOVO-SEMIDE**	**NOP**	$	**0.0445**
00002224690	LASIX	SAV	$	0.0817
40 MG ORAL TABLET				
00000362166	**APO-FUROSEMIDE**	**APX**	$	**0.0670**
00000337749	**NOVO-SEMIDE**	**NOP**	$	**0.0670**
00002224704	LASIX	SAV	$	0.1255
80 MG ORAL TABLET				
00000707570	**APO-FUROSEMIDE**	**APX**	$	**0.1220**
00000765953	**NOVO-SEMIDE**	**NOP**	$	**0.1220**
500 MG ORAL TABLET				
00002224755	LASIX SPECIAL	SAV	$	2.8149
10 MG / ML ORAL SOLUTION				
00002224720	LASIX	SAV	$	0.2572
10 MG / ML INJECTION				
00000527033	FUROSEMIDE	SDZ	$	0.5850

HYDROCHLOROTHIAZIDE

25 MG ORAL TABLET				
00000021474	**NOVO-HYDRAZIDE**	**NOP**	$	**0.0474**
00000326844	APO-HYDRO	APX	$	0.0475
50 MG ORAL TABLET				
00000021482	**NOVO-HYDRAZIDE**	**NOP**	$	**0.0649**
00000312800	APO-HYDRO	APX	$	0.0650
100 MG ORAL TABLET				
00000644552	APO-HYDRO	APX	$	0.1190

HYDROCHLOROTHIAZIDE/ AMILORIDE HCL

50 MG * 5 MG ORAL TABLET				
00000784400	**APO-AMILZIDE**	**APX**	$	**0.1917**
00002257378	**GEN-AMILAZIDE**	**GPM**	$	**0.1917**
00001937219	**NOVAMILOR**	**NOP**	$	**0.1917**
00000886106	**NU-AMILZIDE**	**NXP**	$	**0.1917**
00000487813	MODURET	PRP	$	0.3517

40:00 ELECTROLYTIC, CALORIC, WATER BALANCE

40:28 DIURETICS

HYDROCHLOROTHIAZIDE/ SPIRONOLACTONE

25 MG * 25 MG ORAL TABLET

00000613231	**NOVO-SPIROZINE**	**NOP**	$	**0.0859**
00000180408	ALDACTAZIDE 25	PFI	$	0.0960

50 MG * 50 MG ORAL TABLET

00000657182	NOVO-SPIROZINE	NOP	$	0.2236
00000594377	ALDACTAZIDE 50	PFI	$	0.2499

HYDROCHLOROTHIAZIDE/ TRIAMTERENE

25 MG * 50 MG ORAL TABLET

00000441775	**APO-TRIAZIDE**	**APX**	$	**0.0608**
00000532657	**NOVO-TRIAMZIDE**	**NOP**	$	**0.0608**
00000865532	**NU-TRIAZIDE**	**NXP**	$	**0.0608**

INDAPAMIDE HEMIHYDRATE

1.25 MG (BASE) ORAL TABLET

00002245246	**APO-INDAPAMIDE**	**APX**	$	**0.1877**
00002239913	**DOM-INDAPAMIDE**	**DPC**	$	**0.1877**
00002240067	**GEN-INDAPAMIDE**	**GPM**	$	**0.1877**
00002239619	**PMS-INDAPAMIDE**	**PMS**	$	**0.1877**
00002227339	**RATIO-INDAPAMIDE**	**RPH**	$	**0.1877**

2.5 MG (BASE) ORAL TABLET

00002223678	**APO-INDAPAMIDE**	**APX**	$	**0.2977**
00002239917	**DOM-INDAPAMIDE**	**DPC**	$	**0.2977**
00002153483	**GEN-INDAPAMIDE**	**GPM**	$	**0.2977**
00002231184	**NOVO-INDAPAMIDE**	**NOP**	$	**0.2977**
00002223597	**NU-INDAPAMIDE**	**NXP**	$	**0.2977**
00002239620	**PMS-INDAPAMIDE**	**PMS**	$	**0.2977**
00002049341	RATIO-INDAPAMIDE	RPH	$	0.2978
00000564966	LOZIDE	SEV	$	0.5238

METOLAZONE

2.5 MG ORAL TABLET

00000888400	ZAROXOLYN	AVE	$	0.1818

40:00 ELECTROLYTIC, CALORIC, WATER BALANCE

40:28:10 DIURETICS

(POTASSIUM-SPARING DIURETICS)

AMILORIDE HCL

5 MG ORAL TABLET

00002249510	APO-AMILORIDE	APX	$	0.2002

SPIRONOLACTONE

25 MG ORAL TABLET

00000613215	**NOVO-SPIROTON**	**NOP**	$	**0.0692**
00000028606	ALDACTONE	PFI	$	0.0774

100 MG ORAL TABLET

00000613223	**NOVO-SPIROTON**	**NOP**	$	**0.2120**
00000285455	ALDACTONE	PFI	$	0.2370

40:00 ELECTROLYTIC, CALORIC, WATER BALANCE

40:40 URICOSURIC AGENTS

PROBENECID

500 MG ORAL TABLET

00000294926	BENURYL	VCL	$	0.2025

SULFINPYRAZONE

200 MG ORAL TABLET

00000441767	**APO-SULFINPYRAZONE**	**APX**	$	**0.1980**
00002045699	**NU-SULFINPYRAZONE**	**NXP**	$	**0.1980**

48:00 ANTITUSSIVES, EXPECTORANTS, MUCOLYTIC AGENTS

48:24 MUCOLYTIC AGENTS

ACETYLCYSTEINE

20 % INHALATION SOLUTION

00002243098	**ACETYLCYSTEINE**	**SDZ**	$	**0.6450**
00002091526	MUCOMYST	WSP	$	0.7200

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:04:04 ANTI-INFECTIVES
(ANTIBIOTICS)

ERYTHROMYCIN

0.5 % OPHTHALMIC OINTMENT				
00001912755	PMS-ERYTHROMYCIN	PMS	$	1.1743

GENTAMICIN SULFATE

0.3 % (BASE) OPHTHALMIC SOLUTION				
00000512192	**GARAMYCIN**	**SCH**	$	**0.4060**
00002229440	**SANDOZ GENTAMICIN SULFATE**	**SDZ**	$	**0.4060**
0.3 % (BASE) OPHTHALMIC OINTMENT				
00000028339	**GARAMYCIN**	**SCH**	$	**1.1429**
00002230888	**SANDOZ GENTAMICIN SULFATE**	**SDZ**	$	**1.1429**
0.3 % (BASE) OTIC SOLUTION				
00000512184	**GARAMYCIN**	**SCH**	$	**1.0320**
00002230889	**PMS-GENTAMICIN**	**PMS**	$	**1.0320**
00002229441	**SANDOZ GENTAMICIN SULFATE**	**SDZ**	$	**1.0320**

NEOMYCIN SULFATE/ POLYMYXIN B SULFATE/ GRAMICIDIN

0.25 % * 10,000 UNIT / ML * 0.03 MG / ML OTIC/OPHTHALMIC SOLUTION				
00000807435	OPTIMYXIN PLUS	SDZ	$	0.7250

TOBRAMYCIN

0.3 % OPHTHALMIC SOLUTION				
00002239577	**PMS-TOBRAMYCIN**	**PMS**	$	**1.0480**
00002241755	**SANDOZ TOBRAMYCIN**	**SDZ**	$	**1.0480**
00000513962	TOBREX	ALC	$	1.7917
0.3 % OPHTHALMIC OINTMENT				
00000614254	TOBREX	ALC	$	2.5400

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:04:06 ANTI-INFECTIVES
(ANTIVIRALS)

TRIFLURIDINE

1 % OPHTHALMIC SOLUTION				
00002248529	**SANDOZ TRIFLURIDINE**	**SDZ**	$	**3.2520**
00000687456	VIROPTIC	TMD	$	3.2667

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:04:12 ANTI-INFECTIVES
(MISC. ANTI-INFECTIVES)

CIPROFLOXACIN HCL

0.3 % (BASE) OPHTHALMIC SOLUTION				
00002263130	**APO-CIPROFLOX**	**APX**	$	**1.1280**
00002253933	**PMS-CIPROFLOXACIN**	**PMS**	$	**1.1280**
00001945270	CILOXAN	ALC	$	2.0860

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:04:12 ANTI-INFECTIVES
(MISC. ANTI-INFECTIVES)

OFLOXACIN

0.3 % OPHTHALMIC SOLUTION				
00002248398	**APO-OFLOXACIN**	**APX**	$	**0.9920**
00002252570	**PMS-OFLOXACIN**	**PMS**	$	**0.9920**
00002143291	OCUFLOX	ALL	$	2.1900

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:08 ANTI-INFLAMMATORY AGENTS

BECLOMETHASONE DIPROPIONATE

50 MCG / DOSE NASAL METERED DOSE SPRAY				
00002238796	**APO-BECLOMETHASONE**	**APX**	$	**0.0613**
00002172712	**GEN-BECLO AQ.**	**GPM**	$	**0.0613**
00002238577	**NU-BECLOMETHASONE**	**NXP**	$	**0.0613**
00000872318	**RATIO-BECLOMETHASONE DIPROP AQ**	**RPH**	$	**0.0613**

BUDESONIDE

100 MCG / DOSE NASAL METERED DOSE AEROSOL				
00002035324	RHINOCORT TURBUHALER	AZC	$	0.1135
100 MCG / DOSE NASAL METERED DOSE SPRAY				
00002230648	GEN-BUDESONIDE AQ	GPM	$	0.0772

CIPROFLOXACIN HCL/ HYDROCORTISONE

2 MG / ML (BASE) * 10 MG / ML OTIC SUSPENSION				
00002240035	CIPRO HC	ALC	$	2.3180

DEXAMETHASONE

0.1 % OPHTHALMIC SUSPENSION				
00000042560	MAXIDEX	ALC	$	1.6560
0.1 % OPHTHALMIC OINTMENT				
00000042579	MAXIDEX	ALC	$	2.5657

DEXAMETHASONE SODIUM PHOSPHATE

0.1 % OTIC/OPHTHALMIC SOLUTION				
00000739839	SANDOZ DEXAMETHASONE SOD. PHOSPHATE	SDZ	$	1.0000

DICLOFENAC SODIUM

0.1 % OPHTHALMIC SOLUTION				
00001940414	VOLTAREN OPHTHA	NVO	$	2.3700

FLUNISOLIDE

0.025 % NASAL SPRAY				
00002239288	**APO-FLUNISOLIDE**	**APX**	$	**0.4988**
00000878790	**RATIO-FLUNISOLIDE**	**RPH**	$	**0.4988**
00002162687	RHINALAR	ORY	$	0.8516

FLUOROMETHOLONE

0.1 % OPHTHALMIC SUSPENSION				
00002238568	**PMS-FLUOROMETHOLONE**	**PMS**	$	**1.6180**
00000247855	FML LIQUIFILM	ALL	$	2.2840
0.25 % OPHTHALMIC SUSPENSION				
00000707511	FML FORTE	ALL	$	2.3520

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:08 ANTI-INFLAMMATORY AGENTS

FLUOROMETHOLONE ACETATE

0.1 % OPHTHALMIC SUSPENSION

00000756784	FLAREX	ALC	$	1.8705

HYDROCORTISONE ACETATE

2.5 % OPHTHALMIC OINTMENT

00001980661	CORTAMED	SDZ	$	4.5543

KETOROLAC TROMETHAMINE

0.5 % OPHTHALMIC SOLUTION

00002245821	**APO-KETOROLAC**	**APX**	$	**2.0160**
00002247461	**RATIO-KETOROLAC**	**RPH**	$	**2.0160**
00001968300	ACULAR	ALL	$	3.6120

MOMETASONE FUROATE

50 MCG / DOSE NASAL METERED DOSE SPRAY

00002238465	NASONEX	SCH	$	0.1902

RESTRICTED BENEFIT - This product is a benefit for patients 3 to 12 years of age inclusive for the treatment of seasonal allergic rhinitis or perennial allergic rhinitis.

PREDNISOLONE ACETATE

0.12 % OPHTHALMIC SUSPENSION

00001916181	**SANDOZ PREDNISOLONE ACETATE**	**SDZ**	$	**1.1500**
00000299405	PRED MILD	ALL	$	1.6090

1 % OPHTHALMIC SUSPENSION

00001916203	**SANDOZ PREDNISOLONE ACETATE**	**SDZ**	$	**1.7000**
00000700401	RATIO-PREDNISOLONE	RPH	$	2.4400
00000301175	PRED FORTE	ALL	$	3.9480

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:08:00 ANTI-INFLAMMATORY AGENTS

(COMBINATION ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENT)

BETAMETHASONE SODIUM PHOSPHATE/ GENTAMICIN SULFATE

0.1 % (BASE) * 0.3 % (BASE) OTIC/OPHTHALMIC SOLUTION

00000682217	**GARASONE**	**SCH**	$	**1.2813**
00002244999	**SANDOZ PENTASONE**	**SDZ**	$	**1.2813**

DEXAMETHASONE/ FRAMYCETIN SULFATE/ GRAMICIDIN

0.5 MG / ML * 5 MG / ML * 0.05 MG / ML OTIC/OPHTHALMIC SOLUTION

00002247920	**SANDOZ OPTICORT**	**SDZ**	$	**1.2375**
00002224623	SOFRACORT	AVE	$	1.7429

DEXAMETHASONE/ NEOMYCIN SULFATE/ POLYMYXIN B SULFATE

1 MG / ML * 3.5 MG / ML (BASE) * 6,000 UNIT / ML OPHTHALMIC SUSPENSION

00000042676	MAXITROL	ALC	$	2.0460

1 MG / G * 3.5 MG / G (BASE) * 6,000 UNIT / G OPHTHALMIC OINTMENT

00000358177	MAXITROL	ALC	$	2.8543

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:08:00 ANTI-INFLAMMATORY AGENTS (COMBINATION ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENT)

DEXAMETHASONE/ TOBRAMYCIN

0.1 % * 0.3 % OPHTHALMIC SUSPENSION				
00000778907	TOBRADEX	ALC	$	2.1160
0.1 % * 0.3 % OPHTHALMIC OINTMENT				
00000778915	TOBRADEX	ALC	$	3.1343

FLUMETHASONE PIVALATE/ CLIOQUINOL

0.02 % * 1 % OTIC SOLUTION				
00000074454	LOCACORTEN VIOFORM	PAL	$	1.3270

PREDNISOLONE ACETATE/ SULFACETAMIDE SODIUM

0.2 % * 10 % OPHTHALMIC SUSPENSION				
00000807788	BLEPHAMIDE	ALL	$	2.8620
0.2 % * 10 % OPHTHALMIC OINTMENT				
00000307246	BLEPHAMIDE S.O.P.	ALL	$	3.6600

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:10 CARBONIC ANHYDRASE INHIBITORS

ACETAZOLAMIDE

250 MG ORAL TABLET				
00000545015	APO-ACETAZOLAMIDE	APX	$	0.0935

BRINZOLAMIDE

1 % OPHTHALMIC SUSPENSION				
00002238873	AZOPT	ALC	$	3.4620

DORZOLAMIDE HCL

2 % (BASE) OPHTHALMIC SOLUTION				
00002216205	TRUSOPT	MFC	$	3.5340

METHAZOLAMIDE

50 MG ORAL TABLET				
00002245882	APO-METHAZOLAMIDE	APX	$	0.4706

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:16 LOCAL ANESTHETICS

PROPARACAINE HCL

0.5 % OPHTHALMIC SOLUTION				
00000035076	ALCAINE	ALC	$	0.6453

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:20 MIOTICS

CARBACHOL

1.5 % OPHTHALMIC SOLUTION				
00000000655	ISOPTO CARBACHOL	ALC	$	0.7240
3 % OPHTHALMIC SOLUTION				
00000000663	ISOPTO CARBACHOL	ALC	$	0.8707

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:20 MIOTICS

PILOCARPINE HCL

1 % OPHTHALMIC SOLUTION				
00000000841	ISOPTO CARPINE	ALC	$	0.2200
2 % OPHTHALMIC SOLUTION				
00000000868	ISOPTO CARPINE	ALC	$	0.2540
4 % OPHTHALMIC SOLUTION				
00000000884	ISOPTO CARPINE	ALC	$	0.2867
4 % OPHTHALMIC GEL				
00000575240	PILOPINE HS	ALC	$	2.6860

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:24 MYDRIATICS

ATROPINE SULFATE

1 % OPHTHALMIC SOLUTION				
00000035017	ISOPTO ATROPINE	ALC	$	0.6460
1 % OPHTHALMIC OINTMENT				
00000252484	ATROPINE	ALC	$	1.5514

CYCLOPENTOLATE HCL

1 % OPHTHALMIC SOLUTION				
00000252506	CYCLOGYL	ALC	$	0.8673

HOMATROPINE HYDROBROMIDE

2 % OPHTHALMIC SOLUTION				
00000000779	ISOPTO HOMATROPINE	ALC	$	0.6560
5 % OPHTHALMIC SOLUTION				
00000000787	ISOPTO HOMATROPINE	ALC	$	0.7813

TROPICAMIDE

0.5 % OPHTHALMIC SOLUTION				
00000000981	MYDRIACYL	ALC	$	0.8993
1 % OPHTHALMIC SOLUTION				
00000001007	MYDRIACYL	ALC	$	1.1573

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:28 MOUTHWASHES & GARGLES

BENZYDAMINE HCL

0.15 % ORAL RINSE				
00002239044	**APO-BENZYDAMINE**	**APX**	$	**0.0290**
00002239537	**DOM-BENZYDAMINE**	**DPC**	$	**0.0290**
00002229799	**NOVO-BENZYDAMINE**	**NOP**	$	**0.0290**
00002229777	**PMS-BENZYDAMINE**	**PMS**	$	**0.0290**
00002230170	**RATIO-BENZYDAMINE**	**RPH**	$	**0.0290**
00001966065	TANTUM	GRC	$	0.1096

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:32 VASOCONSTRICTORS

PHENYLEPHRINE HCL

2.5 % OPHTHALMIC SOLUTION

00000465763	MYDFRIN	ALC	$	1.0420

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:36 MISCELLANEOUS EENT DRUGS

APRACLONIDINE HCL

0.5 % OPHTHALMIC SOLUTION

00002076306	IOPIDINE	ALC	$	4.5740

BETAXOLOL HCL

0.5 % (BASE) OPHTHALMIC SOLUTION

00002235971	SANDOZ BETAXOLOL	SDZ	$	1.7860

0.25 % (BASE) OPHTHALMIC SUSPENSION

00001908448	BETOPTIC S	ALC	$	2.3950

BOTULINUM TOXIN TYPE A

100 UNIT / VIAL INJECTION

00001981501	BOTOX	ALL	$	357.0000

BRIMONIDINE TARTRATE

0.2 % OPHTHALMIC SOLUTION

00002260077	**APO-BRIMONIDINE**	**APX**	$	**2.0800**
00002246284	**PMS-BRIMONIDINE**	**PMS**	$	**2.0800**
00002243026	**RATIO-BRIMONIDINE**	**RPH**	$	**2.0800**
00002236876	ALPHAGAN	ALL	$	3.5480

BRIMONIDINE TARTRATE/ TIMOLOL MALEATE

0.2 % * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002248347	COMBIGAN	ALL	$	4.2360

DORZOLAMIDE HCL/ TIMOLOL MALEATE

2 % (BASE) * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002240113	COSOPT	MFC	$	5.3560

LEVOBUNOLOL HCL

0.25 % OPHTHALMIC SOLUTION

00002197456	**NOVO-LEVOBUNOLOL**	**NOP**	$	**1.1760**
00002031159	**RATIO-LEVOBUNOLOL**	**RPH**	$	**1.1760**
00002241715	**SANDOZ LEVOBUNOLOL**	**SDZ**	$	**1.1760**

0.5 % OPHTHALMIC SOLUTION

00002197464	**NOVO-LEVOBUNOLOL**	**NOP**	$	**1.5550**
00002237991	**PMS-LEVOBUNOLOL**	**PMS**	$	**1.5550**
00002031167	**RATIO-LEVOBUNOLOL**	**RPH**	$	**1.5550**
00002241716	**SANDOZ LEVOBUNOLOL**	**SDZ**	$	**1.5550**
00000637661	BETAGAN	ALL	$	2.9477

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:36 MISCELLANEOUS EENT DRUGS

TIMOLOL MALEATE

0.25 % (BASE) OPHTHALMIC SOLUTION				
00000755826	**APO-TIMOP**	**APX**	$	**1.5500**
00000893773	**GEN-TIMOLOL**	**GPM**	$	**1.5500**
00002083353	**PMS-TIMOLOL**	**PMS**	$	**1.5500**
00002166712	**SANDOZ TIMOLOL MALEATE**	**SDZ**	$	**1.5500**
0.5 % (BASE) OPHTHALMIC SOLUTION				
00000755834	**APO-TIMOP**	**APX**	$	**1.8600**
00000893781	**GEN-TIMOLOL**	**GPM**	$	**1.8600**
00002083345	**PMS-TIMOLOL**	**PMS**	$	**1.8600**
00002166720	**SANDOZ TIMOLOL MALEATE**	**SDZ**	$	**1.8600**
00000451207	TIMOPTIC	MFC	$	3.2710
0.25 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION				
00002171880	TIMOPTIC-XE	MFC	$	3.4920
0.5 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION				
00002171899	TIMOPTIC-XE	MFC	$	4.1780

TRAVOPROST

0.004 % OPHTHALMIC SOLUTION				
00002244896	TRAVATAN	ALC	$	11.6280

TRAVOPROST/ TIMOLOL MALEATE

0.004 % * 0.5 % (BASE) OPHTHALMIC SOLUTION				
00002278251	DUO TRAV	ALC	$	13.1580

56:00 GASTROINTESTINAL DRUGS

56:08 ANTIDIARRHEA AGENTS

DIPHENOXYLATE HCL/ ATROPINE SULFATE

2.5 MG * 0.025 MG ORAL TABLET

00000036323	LOMOTIL	PFI	$	0.4685

56:00 GASTROINTESTINAL DRUGS

56:14 CHOLELITHOLYTIC AGENTS

URSODIOL

250 MG ORAL TABLET

00002273497	**PMS-URSODIOL C**	**PMS**	$	**0.8635**
00002238984	URSO	AXC	$	1.3261

500 MG ORAL TABLET

00002273500	**PMS-URSODIOL C**	**PMS**	$	**1.6380**
00002245894	URSO DS	AXC	$	2.5155

56:00 GASTROINTESTINAL DRUGS

56:16 DIGESTANTS

LIPASE/ AMYLASE/ PROTEASE

8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL TABLET

00002230019	VIOKASE	AXC	$	0.2281

16,000 UNIT * 60,000 UNIT * 60,000 UNIT ORAL TABLET

00002241933	VIOKASE 16	AXC	$	0.3438

8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE

00000263818	COTAZYM	ORG	$	0.2530

4,000 UNIT * 12,000 UNIT * 12,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000789445	PANCREASE MT 4	JOI	$	0.4039

4,500 UNIT * 20,000 UNIT * 25,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00002203324	ULTRASE MS4 MICROSPHERES	AXC	$	0.2193

8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000502790	COTAZYM ECS 8	ORG	$	0.3475

10,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000789437	PANCREASE MT 10	JOI	$	1.0093

10,000 UNIT * 33,200 UNIT * 37,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00002200104	CREON 10 MINIMICROSPHERES	SLO	$	0.2870

12,000 UNIT * 39,000 UNIT * 39,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00002045834	ULTRASE MT12 MINITABLETS	AXC	$	0.4289

16,000 UNIT * 48,000 UNIT * 48,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000789429	PANCREASE MT 16	JOI	$	1.6147

20,000 UNIT * 55,000 UNIT * 55,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00000821373	COTAZYM ECS 20	ORG	$	0.8975

20,000 UNIT * 65,000 UNIT * 65,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00002045869	ULTRASE MT20 MINITABLETS	AXC	$	0.7434

25,000 UNIT * 74,000 UNIT * 62,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLET)

00001985205	CREON 25 MINIMICROSPHERES	SLO	$	0.8965

24,000 UNIT / G * 100,000 UNIT / G * 100,000 UNIT / G ORAL POWDER

00002230020	VIOKASE	AXC	$	0.4904

LIPASE/ AMYLASE/ PROTEASE/ BILE SALTS/ CELLULASE

8,000 UNIT * 30,000 UNIT * 30,000 UNIT * 65 MG * 2 MG ORAL CAPSULE

00000456233	COTAZYM-65 B	ORG	$	0.3300

56:00 GASTROINTESTINAL DRUGS

56:22 ANTIEMETICS

BETAHISTINE DIHYDROCHLORIDE

16 MG ORAL TABLET				
00002280191	**NOVO-BETAHISTINE**	**NOP**	$	**0.2940**
00002243878	SERC	SLO	$	0.4606

DIMENHYDRINATE

10 MG / ML INJECTION				
00000392731	DIMENHYDRINATE I.V.	SDZ	$	0.2840
50 MG / ML INJECTION				
00000392537	DIMENHYDRINATE I.M.	SDZ	$	1.0370

DOLASETRON MESYLATE

50 MG ORAL TABLET				
00002231378	ANZEMET	SAV	$	14.7541
100 MG ORAL TABLET				
00002231379	ANZEMET	SAV	$	29.5080
20 MG / ML INJECTION				
00002231380	ANZEMET	SAV	$	2.4424

DOXYLAMINE SUCCINATE/ PYRIDOXINE HCL

10 MG * 10 MG ORAL SUSTAINED-RELEASE TABLET				
00000609129	DICLECTIN	DUI	$	1.2900

GRANISETRON HCL

1 MG (BASE) ORAL TABLET				
00002185881	KYTRIL	HLR	$	19.3500

MECLIZINE HCL

25 MG ORAL CHEWABLE TABLET				
00000220442	BONAMINE	JJM	$	0.3138

NABILONE

0.5 MG ORAL CAPSULE				
00002256193	CESAMET	VCL	$	3.3353
1 MG ORAL CAPSULE				
00000548375	CESAMET	VCL	$	6.6704

ONDANSETRON

4 MG ORAL DISINTEGRATING TABLET				
00002239372	ZOFRAN ODT	GSK	$	12.7694
8 MG ORAL DISINTEGRATING TABLET				
00002239373	ZOFRAN ODT	GSK	$	19.4851

56:00 GASTROINTESTINAL DRUGS

56:22 ANTIEMETICS

ONDANSETRON HCL DIHYDRATE

4 MG (BASE) ORAL TABLET				
00002264056	**NOVO-ONDANSETRON**	**NOP**	$	**7.5450**
00002274310	**SANDOZ ONDANSETRON**	**SDZ**	$	**7.5450**
00002288184	APO-ONDANSETRON	APX	$	7.5453
00002258188	PMS-ONDANSETRON	PMS	$	7.5453
00002278529	RATIO-ONDANSETRON	RPH	$	7.5453
00002213567	ZOFRAN	GSK	$	12.7694
8 MG (BASE) ORAL TABLET				
00002264064	**NOVO-ONDANSETRON**	**NOP**	$	**11.5166**
00002278537	**RATIO-ONDANSETRON**	**RPH**	$	**11.5166**
00002274329	**SANDOZ ONDANSETRON**	**SDZ**	$	**11.5166**
00002288192	APO-ONDANSETRON	APX	$	11.5167
00002258196	PMS-ONDANSETRON	PMS	$	11.5170
00002213575	ZOFRAN	GSK	$	19.4851
0.8 MG / ML (BASE) ORAL SOLUTION				
00002229639	ZOFRAN	GSK	$	1.9484
2 MG / ML (BASE) INJECTION				
00002265524	ONDANSETRON (PRESERVATIVE FREE)	NOP	$	6.6090
00002265532	ONDANSETRON (WITH PRESERVATIVE)	NOP	$	6.6090
00002271788	ONDANSETRON OMEGA (WITH PRESERVATIVE)	OMG	$	8.1250
00002271761	ONDANSETRON OMEGA (PRESERVATIVE FREE)	OMG	$	8.1750
00002213745	ZOFRAN	GSK	$	9.6308

56:00 GASTROINTESTINAL DRUGS

56:40 MISCELLANEOUS GI DRUGS

5-AMINOSALICYLIC ACID

500 MG ORAL SUSTAINED-RELEASE TABLET				
00002099683	PENTASA	FEI	$	0.5987
400 MG ORAL ENTERIC-COATED TABLET				
☒ 00002171929	NOVO-5 ASA	NOP	$	0.3960
☒ 00001997580	ASACOL	PGA	$	0.5590
500 MG ORAL ENTERIC-COATED TABLET				
☒ 00002112787	SALOFALK	AXC	$	0.5203
☒ 00001914030	MESASAL	GSK	$	0.5857
800 MG ORAL ENTERIC-COATED TABLET				
00002267217	ASACOL 800	PGA	$	1.0643
500 MG RECTAL SUPPOSITORY				
00002112760	SALOFALK	AXC	$	1.1710
1 G RECTAL SUPPOSITORY				
00002153564	PENTASA	FEI	$	1.7523
1,000 MG RECTAL SUPPOSITORY				
00002242146	SALOFALK	AXC	$	1.7200
1 G / ENM RECTAL ENEMA				
00002153521	PENTASA (1G/100ML)	FEI	$	3.9775
2 G / ENM RECTAL ENEMA				
00002112795	SALOFALK (2G/60G)	AXC	$	3.7729

56:00 GASTROINTESTINAL DRUGS

56:40 MISCELLANEOUS GI DRUGS

5-AMINOSALICYLIC ACID

4 G / ENM RECTAL ENEMA

☒ 00002153556	PENTASA (4G/100 ML)	FEI	$	4.7945
☒ 00002112809	SALOFALK (4G/60G)	AXC	$	6.4071

CIMETIDINE

200 MG ORAL TABLET

00000584215	**APO-CIMETIDINE**	**APX**	$	**0.0737**
00000582409	**NOVO-CIMETINE**	**NOP**	$	**0.0737**
00000865796	**NU-CIMET**	**NXP**	$	**0.0737**

300 MG ORAL TABLET

00000487872	**APO-CIMETIDINE**	**APX**	$	**0.0860**
00002227444	**GEN-CIMETIDINE**	**GPM**	$	**0.0860**
00000582417	**NOVO-CIMETINE**	**NOP**	$	**0.0860**
00000865818	**NU-CIMET**	**NXP**	$	**0.0860**

400 MG ORAL TABLET

00000600059	**APO-CIMETIDINE**	**APX**	$	**0.1350**
00002227452	**GEN-CIMETIDINE**	**GPM**	$	**0.1350**
00000603678	**NOVO-CIMETINE**	**NOP**	$	**0.1350**
00000865826	**NU-CIMET**	**NXP**	$	**0.1350**

600 MG ORAL TABLET

00000600067	**APO-CIMETIDINE**	**APX**	$	**0.1720**
00002227460	**GEN-CIMETIDINE**	**GPM**	$	**0.1720**
00000603686	**NOVO-CIMETINE**	**NOP**	$	**0.1720**
00000865834	**NU-CIMET**	**NXP**	$	**0.1720**

800 MG ORAL TABLET

00000749494	**APO-CIMETIDINE**	**APX**	$	**0.2530**
00002227479	**GEN-CIMETIDINE**	**GPM**	$	**0.2530**
00000663727	**NOVO-CIMETINE**	**NOP**	$	**0.2530**

DOMPERIDONE MALEATE

10 MG (BASE) ORAL TABLET

00002103613	**APO-DOMPERIDONE**	**APX**	$	**0.1496**
00002278669	**GEN-DOMPERIDONE**	**GPM**	$	**0.1496**
00002157195	**NOVO-DOMPERIDONE**	**NOP**	$	**0.1496**
00002231477	**NU-DOMPERIDONE**	**NXP**	$	**0.1496**
00002236466	**PMS-DOMPERIDONE**	**PMS**	$	**0.1496**
00002268078	**RAN-DOMPERIDONE**	**RAN**	$	**0.1496**
00001912070	**RATIO-DOMPERIDONE MALEATE**	**RPH**	$	**0.1496**
00002238315	DOM-DOMPERIDONE	DPC	$	0.1571

FAMOTIDINE

20 MG ORAL TABLET

00001953842	**APO-FAMOTIDINE**	**APX**	$	**0.5896**
00002196018	**GEN-FAMOTIDINE**	**GPM**	$	**0.5896**
00002022133	**NOVO-FAMOTIDINE**	**NOP**	$	**0.5896**
00002024195	**NU-FAMOTIDINE**	**NXP**	$	**0.5896**
00000710121	PEPCID	MFC	$	1.0023

40 MG ORAL TABLET

00001953834	**APO-FAMOTIDINE**	**APX**	$	**1.0612**
00002196026	**GEN-FAMOTIDINE**	**GPM**	$	**1.0612**
00002022141	**NOVO-FAMOTIDINE**	**NOP**	$	**1.0612**
00002024209	**NU-FAMOTIDINE**	**NXP**	$	**1.0612**
00000710113	PEPCID	MFC	$	1.8223

56:00 GASTROINTESTINAL DRUGS

56:40 MISCELLANEOUS GI DRUGS

LANSOPRAZOLE

15 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002165503	PREVACID	ABB	$	2.0000
30 MG ORAL SUSTAINED-RELEASE CAPSULE				
00002165511	PREVACID	ABB	$	2.0000

LANSOPRAZOLE/ AMOXICILLIN TRIHYDRATE/ CLARITHROMYCIN

30 MG * 500 MG (BASE) * 500 MG ORAL TABLET/CAPSULE				
00002238525	HP-PAC (KIT)	ABB	$	78.2400

METOCLOPRAMIDE HCL

5 MG ORAL TABLET				
00000842826	**APO-METOCLOP**	**APX**	$	**0.0556**
00002143275	**NU-METOCLOPRAMIDE**	**NXP**	$	**0.0556**
00002230431	**PMS-METOCLOPRAMIDE**	**PMS**	$	**0.0556**
10 MG ORAL TABLET				
00000842834	**APO-METOCLOP**	**APX**	$	**0.0583**
00002143283	**NU-METOCLOPRAMIDE**	**NXP**	$	**0.0583**
00002230432	**PMS-METOCLOPRAMIDE**	**PMS**	$	**0.0583**
1 MG / ML ORAL LIQUID				
00002230433	PMS-METOCLOPRAMIDE	PMS	$	0.0365
5 MG / ML INJECTION				
00002185431	METOCLOPRAMIDE HYDROCHLORIDE	SDZ	$	1.1820

MISOPROSTOL

100 MCG ORAL TABLET				
00002244022	**APO-MISOPROSTOL**	**APX**	$	**0.1714**
00002240754	**NOVO-MISOPROSTOL**	**NOP**	$	**0.1714**
200 MCG ORAL TABLET				
00002244023	APO-MISOPROSTOL	APX	$	0.2853

NIZATIDINE

150 MG ORAL CAPSULE				
00002220156	**APO-NIZATIDINE**	**APX**	$	**0.5287**
00002246046	**GEN-NIZATIDINE**	**GPM**	$	**0.5287**
00002240457	**NOVO-NIZATIDINE**	**NOP**	$	**0.5287**
00002177714	**PMS-NIZATIDINE**	**PMS**	$	**0.5287**
00000778338	AXID	PHH	$	0.9021
300 MG ORAL CAPSULE				
00002220164	**APO-NIZATIDINE**	**APX**	$	**0.9580**
00002246047	**GEN-NIZATIDINE**	**GPM**	$	**0.9580**
00002240458	**NOVO-NIZATIDINE**	**NOP**	$	**0.9580**
00002177722	**PMS-NIZATIDINE**	**PMS**	$	**0.9580**
00000778346	AXID	PHH	$	1.6346

OLSALAZINE SODIUM

250 MG ORAL CAPSULE				
00002063808	DIPENTUM	LBC	$	0.5440

56:00 GASTROINTESTINAL DRUGS

56:40 MISCELLANEOUS GI DRUGS

OMEPRAZOLE

20 MG ORAL CAPSULE/SUSTAINED RELEASE TABLET

00002260867	**RATIO-OMEPRAZOLE (SUSTAINED RELEASE TABLET)**	**RPH**	$	**1.2000**
00002245058	APO-OMEPRAZOLE (CAPSULE)	APX	$	1.2500
00002190915	LOSEC (SUSTAINED RELEASE TABLET)	AZC	$	2.2000

PANTOPRAZOLE SODIUM SESQUIHYDRATE

40 MG (BASE) ORAL ENTERIC-COATED TABLET

00002229453	PANTOLOC	NYC	$	2.0425

PINAVERIUM BROMIDE

50 MG ORAL TABLET

00001950592	DICETEL	SLO	$	0.3720

100 MG ORAL TABLET

00002230684	DICETEL	SLO	$	0.6622

RABEPRAZOLE SODIUM

10 MG ORAL ENTERIC-COATED TABLET

00002243796	PARIET	JOI	$	0.6987

20 MG ORAL ENTERIC-COATED TABLET

00002243797	PARIET	JOI	$	1.3975

RANITIDINE HCL

150 MG (BASE) ORAL TABLET

00000733059	**APO-RANITIDINE**	**APX**	$	**0.4042**
00002248570	**CO RANITIDINE**	**COB**	$	**0.4042**
00002207761	**GEN-RANITIDINE**	**GPM**	$	**0.4042**
00000828564	**NOVO-RANIDINE**	**NOP**	$	**0.4042**
00000865737	**NU-RANIT**	**NXP**	$	**0.4042**
00002242453	**PMS-RANITIDINE**	**PMS**	$	**0.4042**
00000828823	**RATIO-RANITIDINE**	**RPH**	$	**0.4042**
00002243229	**SANDOZ RANITIDINE**	**SDZ**	$	**0.4042**
00002212331	ZANTAC	GSK	$	1.1676

300 MG (BASE) ORAL TABLET

00000733067	**APO-RANITIDINE**	**APX**	$	**0.7787**
00002248571	**CO RANITIDINE**	**COB**	$	**0.7787**
00002207788	**GEN-RANITIDINE**	**GPM**	$	**0.7787**
00000828556	**NOVO-RANIDINE**	**NOP**	$	**0.7787**
00000865745	**NU-RANIT**	**NXP**	$	**0.7787**
00002242454	**PMS-RANITIDINE**	**PMS**	$	**0.7787**
00000828688	**RATIO-RANITIDINE**	**RPH**	$	**0.7787**
00002243230	**SANDOZ RANITIDINE**	**SDZ**	$	**0.7787**
00002212358	ZANTAC	GSK	$	2.1978

15 MG / ML (BASE) ORAL SOLUTION

00002280833	**APO-RANITIDINE**	**APX**	$	**0.1174**
00002242940	**NOVO-RANIDINE**	**NOP**	$	**0.1174**
00002212374	ZANTAC	GSK	$	0.1987

25 MG / ML (BASE) INJECTION

00002256711	RANITIDINE	SDZ	$	1.1500
00002212366	ZANTAC	GSK	$	2.7305

56:00 GASTROINTESTINAL DRUGS

56:40 MISCELLANEOUS GI DRUGS

SUCRALFATE

1 G ORAL TABLET				
00002125250	**APO-SUCRALFATE**	**APX**	$	**0.2942**
00002045702	**NOVO-SUCRALATE**	**NOP**	$	**0.2942**
00002134829	**NU-SUCRALFATE**	**NXP**	$	**0.2942**
00002238209	**PMS-SUCRALFATE**	**PMS**	$	**0.2942**
00002100622	SULCRATE	AXC	$	0.5527
200 MG / ML ORAL SUSPENSION				
00002103567	SULCRATE SUSPENSION PLUS	AXC	$	0.1004

TRIMEBUTINE MALEATE

100 MG ORAL TABLET				
00002245663	APO-TRIMEBUTINE	APX	$	0.2598
200 MG ORAL TABLET				
00002245664	**APO-TRIMEBUTINE**	**APX**	$	**0.5056**
00000803499	MODULON	AXC	$	0.6794

60:00 GOLD COMPOUNDS

60:00

AURANOFIN

3 MG ORAL CAPSULE

00001916823	RIDAURA	PAL	$	1.9463

GOLD SODIUM THIOMALATE

10 MG / ML INJECTION

00002245456	SODIUM AUROTHIOMALATE	SDZ	$	8.1133
00001927620	MYOCHRYSINE	AVE	$	11.2230

25 MG / ML INJECTION

00002245457	SODIUM AUROTHIOMALATE	SDZ	$	9.8433

50 MG / ML INJECTION

00002245458	**SODIUM AUROTHIOMALATE**	**SDZ**	$	**15.2867**
00001927604	MYOCHRYSINE	AVE	$	21.1453

64:00 HEAVY METAL ANTAGONISTS

64:00

DEFEROXAMINE MESYLATE

500 MG / VIAL INJECTION

00002241600	**DESFERRIOXAMINE MESILATE**	**HSP**	$	**8.1750**
00002242055	**PMS-DEFEROXAMINE**	**PMS**	$	**8.1750**
00001981242	DESFERAL	NOV	$	14.0503

2 G / VIAL INJECTION

00002247022	**DESFERRIOXAMINE MESILATE**	**HSP**	$	**35.1500**
00002243450	**PMS-DEFEROXAMINE**	**PMS**	$	**35.1500**
00001981250	DESFERAL	NOV	$	56.4375

PENICILLAMINE

250 MG ORAL CAPSULE

00000016055	CUPRIMINE	MFC	$	0.7941

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

BECLOMETHASONE DIPROPIONATE

50 MCG / DOSE METERED DOSE AEROSOL				
00002242029	QVAR CFC-FREE	GRC	$	0.1570
100 MCG / DOSE METERED DOSE AEROSOL				
00002242030	QVAR CFC-FREE	GRC	$	0.3139

BETAMETHASONE SODIUM PHOSPHATE/ BETAMETHASONE ACETATE

3 MG / ML (BASE) * 3 MG / ML INJECTION				
00000028096	CELESTONE SOLUSPAN	SCH	$	4.5430

BUDESONIDE

100 MCG / DOSE METERED INHALATION POWDER				
00000852074	PULMICORT TURBUHALER	AZC	$	0.1520
200 MCG / DOSE METERED INHALATION POWDER				
00000851752	PULMICORT TURBUHALER	AZC	$	0.3043
400 MCG / DOSE METERED INHALATION POWDER				
00000851760	PULMICORT TURBUHALER	AZC	$	0.5475
0.125 MG / ML INHALATION SUSPENSION				
00002229099	PULMICORT NEBUAMP	AZC	$	0.2063
0.25 MG / ML INHALATION SUSPENSION				
00001978918	PULMICORT NEBUAMP	AZC	$	0.4125
0.5 MG / ML INHALATION SUSPENSION				
00001978926	PULMICORT NEBUAMP	AZC	$	0.8250

CICLESONIDE

100 MCG / DOSE METERED DOSE AEROSOL				
00002285606	ALVESCO	NYC	$	0.3709
200 MCG / DOSE METERED DOSE AEROSOL				
00002285614	ALVESCO	NYC	$	0.6128

CORTISONE ACETATE

25 MG ORAL TABLET				
00000280437	CORTISONE ACETATE	VCL	$	0.3296

DEXAMETHASONE

0.5 MG ORAL TABLET				
00002261081	**APO-DEXAMETHASONE**	**APX**	$	**0.1970**
00001964976	**PMS-DEXAMETHASONE**	**PMS**	$	**0.1970**
00002240684	**RATIO-DEXAMETHASONE**	**RPH**	$	**0.1970**
00000295094	DEXASONE	VCL	$	0.2118
0.75 MG ORAL TABLET				
00001964968	**PMS-DEXAMETHASONE**	**PMS**	$	**0.4500**
00002240685	**RATIO-DEXAMETHASONE**	**RPH**	$	**0.4500**
2 MG ORAL TABLET				
00002279363	PMS-DEXAMETHASONE	PMS	$	0.3916
4 MG ORAL TABLET				
00002250055	**APO-DEXAMETHASONE**	**APX**	$	**0.7673**
00001964070	**PMS-DEXAMETHASONE**	**PMS**	$	**0.7673**
00002240687	**RATIO-DEXAMETHASONE**	**RPH**	$	**0.7673**
00000489158	DEXASONE	VCL	$	0.8248

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

DEXAMETHASONE SODIUM PHOSPHATE

4 MG / ML (BASE) INJECTION				
00000664227	**DEXAMETHASONE SODIUM PHOSPHATE**	**SDZ**	$	**1.6900**
00001977547	**DEXAMETHASONE SODIUM PHOSPHATE**	**CYT**	$	**1.6900**
10 MG / ML (BASE) INJECTION				
00000783900	PMS-DEXAMETHASONE SODIUM PHOSP	PMS	$	1.2830
00000874582	DEXAMETHASONE SODIUM PHOSPHATE	SDZ	$	1.7360

FLUDROCORTISONE ACETATE

0.1 MG ORAL TABLET				
00002086026	FLORINEF	SHB	$	0.2214

FLUTICASONE PROPIONATE

125 MCG / DOSE METERED DOSE AEROSOL				
00002244292	FLOVENT HFA	GSK	$	0.3278
250 MCG / DOSE METERED DOSE AEROSOL				
00002244293	FLOVENT HFA	GSK	$	0.6557
250 MCG / DOSE METERED INHALATION POWDER				
00002237246	FLOVENT DISKUS	GSK	$	0.6557
500 MCG / DOSE METERED INHALATION POWDER				
00002237247	FLOVENT DISKUS	GSK	$	1.3112

HYDROCORTISONE

10 MG ORAL TABLET				
00000030910	CORTEF	PFI	$	0.1608
20 MG ORAL TABLET				
00000030929	CORTEF	PFI	$	0.2901

HYDROCORTISONE SODIUM SUCCINATE

100 MG / VIAL (BASE) INJECTION				
00000872520	**HYDROCORTISONE SOD. SUCCINATE**	**NOP**	$	**2.0000**
00000030600	SOLU-CORTEF	PFI	$	3.8810
250 MG / VIAL (BASE) INJECTION				
00000872539	**HYDROCORTISONE SOD. SUCCINATE**	**NOP**	$	**3.4000**
00000030619	SOLU-CORTEF	PFI	$	6.7340
500 MG / VIAL (BASE) INJECTION				
00000878618	**HYDROCORTISONE SOD. SUCCINATE**	**NOP**	$	**5.1000**
00000030627	SOLU-CORTEF	PFI	$	9.9980
1 G / VIAL (BASE) INJECTION				
00000878626	**HYDROCORTISONE SOD. SUCCINATE**	**NOP**	$	**8.6000**
00000030635	SOLU-CORTEF	PFI	$	16.7540

METHYLPREDNISOLONE

4 MG ORAL TABLET				
00000030988	MEDROL	PFI	$	0.3713
16 MG ORAL TABLET				
00000036129	MEDROL	PFI	$	1.0701

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

METHYLPREDNISOLONE ACETATE

20 MG / ML INJECTION				
00001934325	DEPO-MEDROL	PFI	$	2.5140
40 MG / ML INJECTION				
00002245407	METHYLPREDNISOLONE ACETATE (P)	SDZ	$	4.1010
00002245400	METHYLPREDNISOLONE ACETATE	SDZ	$	4.2860
00001934333	DEPO-MEDROL (PRESERVED)	PFI	$	5.4930
00000030759	DEPO-MEDROL	PFI	$	5.7410
80 MG / ML INJECTION				
00002245408	METHYLPREDNISOLONE ACETATE (P)	SDZ	$	6.3360
00002245406	METHYLPREDNISOLONE ACETATE	SDZ	$	8.2020
00001934341	DEPO-MEDROL (PRESERVED)	PFI	$	8.4880
00000030767	DEPO-MEDROL	PFI	$	10.9860

METHYLPREDNISOLONE ACETATE/ LIDOCAINE HCL

40 MG / ML * 10 MG / ML INJECTION				
00000260428	DEPO-MEDROL WITH LIDOCAINE	PFI	$	6.4300

METHYLPREDNISOLONE SODIUM SUCCINATE

40 MG / VIAL (BASE) INJECTION				
00002231893	**METHYLPREDNISOLONE SOD SUCCIN.**	**NOP**	$	**3.6000**
00002063719	SOLU-MEDROL ACT-O-VIAL	PFI	$	6.4110
125 MG / VIAL (BASE) INJECTION				
00002231894	**METHYLPREDNISOLONE SOD SUCCIN.**	**NOP**	$	**8.5000**
00002063727	SOLU-MEDROL ACT-O-VIAL	PFI	$	15.2200
500 MG / VIAL (BASE) INJECTION				
00002231895	**METHYLPREDNISOLONE SOD SUCCIN.**	**NOP**	$	**18.6000**
00000030678	SOLU-MEDROL	PFI	$	37.3940
00002063700	SOLU-MEDROL ACT-O-VIAL	PFI	$	38.1453
1 G / VIAL (BASE) INJECTION				
00002241229	**METHYLPREDNISOLONE SOD SUCCIN.**	**NOP**	$	**31.0000**
00000036137	SOLU-MEDROL	PFI	$	57.3200
00002063697	SOLU-MEDROL ACT-O-VIAL	PFI	$	58.4700

PREDNISOLONE SODIUM PHOSPHATE

1 MG / ML (BASE) ORAL LIQUID				
00002245532	**PMS-PREDNISOLONE**	**PMS**	$	**0.0671**
00002230619	PEDIAPRED	SAV	$	0.1192

PREDNISONE

1 MG ORAL TABLET				
00000598194	**APO-PREDNISONE**	**APX**	$	**0.1035**
00000271373	WINPRED	VCL	$	0.1113
5 MG ORAL TABLET				
00000312770	**APO-PREDNISONE**	**APX**	$	**0.0260**
00000021695	**NOVO-PREDNISONE**	**NOP**	$	**0.0260**
50 MG ORAL TABLET				
00000550957	**APO-PREDNISONE**	**APX**	$	**0.1095**
00000232378	**NOVO-PREDNISONE**	**NOP**	$	**0.1095**

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04 ADRENALS

TRIAMCINOLONE ACETONIDE

10 MG / ML INJECTION				
00002229540	TRIAMCINOLONE ACETONIDE	SDZ	$	2.5860
00001999761	KENALOG-10	WSD	$	2.9380
40 MG / ML INJECTION				
00002229550	**TRIAMCINOLONE ACETONIDE**	**SDZ**	$	**5.5000**
00001977563	**TRIAMCINOLONE ACETONIDE USP**	**CYT**	$	**5.5000**
00001999869	KENALOG-40	WSD	$	6.8200

TRIAMCINOLONE DIACETATE

40 MG / ML INJECTION				
00001977555	TRIAMCINOLONE DIACETATE	CYT	$	5.5400

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:08 ANDROGENS

DANAZOL

50 MG ORAL CAPSULE				
00002018144	CYCLOMEN	SAV	$	0.8446
100 MG ORAL CAPSULE				
00002018152	CYCLOMEN	SAV	$	1.2533
200 MG ORAL CAPSULE				
00002018160	CYCLOMEN	SAV	$	2.0028

NANDROLONE DECANOATE

100 MG / ML INJECTION				
00000270687	DECA-DURABOLIN	ORG	$	92.7500

TESTOSTERONE CYPIONATE

100 MG / ML INJECTION				
00001977601	TESTOSTERONE CYPIONATE	CYT	$	1.2949
00002246063	TESTOSTERONE CYPIONATE	SDZ	$	1.7950
00000030783	DEPO-TESTOSTERONE CYPIONATE	PFI	$	2.8400

TESTOSTERONE ENANTHATE

200 MG / ML INJECTION				
00000029246	DELATESTRYL	TMD	$	5.2500

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

DESOGESTREL/ ETHINYL ESTRADIOL

0.15 MG * 0.03 MG ORAL TABLET				
☒ 00002042479	MARVELON (28 DAY)	ORG	$	0.4375
☒ 00002042533	ORTHO-CEPT (28 DAY)	JOI	$	0.5064
☒ 00002042487	MARVELON (21 DAY)	ORG	$	0.5833

DESOGESTREL/ ETHINYL ESTRADIOL/ DESOGESTREL/ ETHINYL ESTRADIOL/ DESOGESTREL/ ETHINYL ESTRADIOL

0.1 MG * 0.025 MG * 0.125 MG * 0.025 MG * 0.15 MG * 0.025 MG ORAL TABLET				
☒ 00002257238	LINESSA 28	ORG	$	0.4143
☒ 00002272903	LINESSA 21	ORG	$	0.5524

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

DROSPIRENONE/ ETHINYL ESTRADIOL

3 MG * 0.03 MG ORAL TABLET

☒ 00002261731	YASMIN 28	BHP	$	0.4143
☒ 00002261723	YASMIN 21	BHP	$	0.5524

ETHYNODIOL DIACETATE/ ETHINYL ESTRADIOL

2 MG * 30 MCG ORAL TABLET

☒ 00000471526	DEMULEN 30 (28 DAY)	PFI	$	0.4982
☒ 00000469327	DEMULEN 30 (21 DAY)	PFI	$	0.6210

LEVONORGESTREL

0.75 MG ORAL TABLET

00002241674	PLAN B	PAL	$	7.9750

52 MG INTRAUTERINE INSERT

00002243005	MIRENA SYSTEM	BHP	$	303.8000

LEVONORGESTREL/ ETHINYL ESTRADIOL

100 MCG * 20 MCG ORAL TABLET

☒ 00002236975	ALESSE (28 DAY)	WAY	$	0.5229
☒ 00002236974	ALESSE (21 DAY)	WAY	$	0.6972

150 MCG * 30 MCG ORAL TABLET

☒ 00002042339	MIN-OVRAL (28 DAY)	WAY	$	0.5229
☒ 00002042320	MIN-OVRAL (21 DAY)	WAY	$	0.6972

LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL/ LEVONORGESTREL/ ETHINYL ESTRADIOL

50 MCG * 30 MCG * 75 MCG * 40 MCG * 125 MCG * 40 MCG ORAL TABLET

☒ 00000707503	TRIQUILAR (28 DAY)	BHP	$	0.4036
☒ 00002043734	TRIPHASIL (28 DAY)	WAY	$	0.5229
☒ 00000707600	TRIQUILAR (21 DAY)	BHP	$	0.5381
☒ 00002043726	TRIPHASIL (21 DAY)	WAY	$	0.6972

NORETHINDRONE

0.35 MG ORAL TABLET

00000037605	MICRONOR (28 DAY)	JOI	$	0.5064

NORETHINDRONE ACETATE/ ETHINYL ESTRADIOL

1 MG * 20 MCG ORAL TABLET

☒ 00000343838	MINESTRIN 1/20 (28 DAY)	PAL	$	0.4172
☒ 00000315966	MINESTRIN 1/20 (21 DAY)	PAL	$	0.5563

1.5 MG * 0.03 MG ORAL TABLET

☒ 00000353027	LOESTRIN 1.5/30 (28 DAY)	PAL	$	0.4172
☒ 00000297143	LOESTRIN 1.5/30 (21 DAY)	PAL	$	0.5563

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12 CONTRACEPTIVES

NORETHINDRONE/ ETHINYL ESTRADIOL

0.5 MG * 0.035 MG ORAL TABLET

☒ 00002187094	BREVICON 0.5/35 (28 DAY)	PFI	$	0.4268
☒ 00000340731	ORTHO 0.5/35 (28 DAY)	JOI	$	0.5064
☒ 00002187086	BREVICON 0.5/35 (21 DAY)	PFI	$	0.5690
☒ 00000317047	ORTHO 0.5/35 (21 DAY)	JOI	$	0.6752

1 MG * 0.035 MG ORAL TABLET

☒ 00002199297	SELECT 1/35 (28 DAY)	PFI	$	0.2882
☒ 00002197502	SELECT 1/35 (21 DAY)	PFI	$	0.3843
☒ 00002189062	BREVICON 1/35 (28 DAY)	PFI	$	0.4268
☒ 00000372838	ORTHO 1/35 (28 DAY)	JOI	$	0.5064
☒ 00002189054	BREVICON 1/35 (21 DAY)	PFI	$	0.5690
☒ 00000372846	ORTHO 1/35 (21 DAY)	JOI	$	0.6752

NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL

0.5 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET

☒ 00002187116	SYNPHASIC (28 DAY)	PFI	$	0.3925
☒ 00002187108	SYNPHASIC (21 DAY)	PFI	$	0.5233

NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL/ NORETHINDRONE/ ETHINYL ESTRADIOL

0.5 MG * 0.035 MG * 0.75 MG * 0.035 MG * 1 MG * 0.035 MG ORAL TABLET

☒ 00000602965	ORTHO 7/7/7 (28 DAY)	JOI	$	0.5064
☒ 00000602957	ORTHO 7/7/7 (21 DAY)	JOI	$	0.6752

NORGESTIMATE/ ETHINYL ESTRADIOL

0.25 MG * 0.035 MG ORAL TABLET

☒ 00001992872	CYCLEN (28 DAY)	JOI	$	0.5064
☒ 00001968440	CYCLEN (21 DAY)	JOI	$	0.6752

NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL/ NORGESTIMATE/ ETHINYL ESTRADIOL

0.18 MG * 0.025 MG * 0.215 MG * 0.025 MG * 0.25 MG * 0.025 MG ORAL TABLET

☒ 00002258587	TRI-CYCLEN LO 28	JOI	$	0.4415
☒ 00002258560	TRI-CYCLEN LO 21	JOI	$	0.5887

0.18 MG * 0.035 MG * 0.215 MG * 0.035 MG * 0.25 MG * 0.035 MG ORAL TABLET

☒ 00002029421	TRI-CYCLEN (28 DAY)	JOI	$	0.5064
☒ 00002028700	TRI-CYCLEN (21 DAY)	JOI	$	0.6752

NORGESTREL/ ETHINYL ESTRADIOL

0.25 MG * 0.05 MG ORAL TABLET

00002043033	OVRAL (21 DAY)	WAY	$	0.6972

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16 ESTROGENS

CONJUGATED ESTROGENS

0.3 MG ORAL TABLET

00002043394	PREMARIN	WAY	$	0.1333

0.625 MG ORAL TABLET

00000265470	C.E.S.	VCL	$	0.1045
00002043408	PREMARIN	WAY	$	0.1333

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16 ESTROGENS

CONJUGATED ESTROGENS

1.25 MG ORAL TABLET				
00000265489	C.E.S.	VCL	$	0.1860
00002043424	PREMARIN	WAY	$	0.2369
0.625 MG / G VAGINAL CREAM				
00002043440	PREMARIN	WAY	$	0.6235

CONJUGATED ESTROGENS/ MEDROXYPROGESTERONE ACETATE

0.625 MG * 2.5 MG ORAL TABLET				
00002242878	PREMPLUS	WAY	$	0.1368
0.625 MG * 5 MG ORAL TABLET				
00002242879	PREMPLUS	WAY	$	0.1368

ESTRADIOL-17B

0.5 MG ORAL TABLET				
00002225190	ESTRACE	SHB	$	0.1128
1 MG ORAL TABLET				
00002148587	ESTRACE	SHB	$	0.2178
2 MG ORAL TABLET				
00002148595	ESTRACE	SHB	$	0.3845
0.06 % TRANSDERMAL GEL				
00002238704	ESTROGEL	SCH	$	0.2547
25 MCG / DAY TRANSDERMAL PATCH				
☒ 00002243722	OESCLIM 25 (5 MG/PTH)	PAL	$	2.4375
☒ 00002245676	ESTRADOT 25 (0.39 MG/PTH)	NOV	$	2.6540
☒ 00000756849	ESTRADERM-25 (2 MG/PTH)	NOV	$	3.2398
☒ 00002247499	CLIMARA 25 (2 MG/PTH)	BHP	$	4.7750
37.5 MCG / DAY TRANSDERMAL PATCH				
00002243999	ESTRADOT 37.5 (0.585 MG/PTH)	NOV	$	2.6540
50 MCG / DAY TRANSDERMAL PATCH				
00002246967	**SANDOZ ESTRADIOL DERM 50 (4 MG/PTH)**	**SDZ**	$	**2.0250**
☒ 00002243724	OESCLIM 50 (10 MG/PTH)	PAL	$	2.4375
00002244000	ESTRADOT 50 (0.78 MG/PTH)	NOV	$	2.8353
☒ 00000756857	ESTRADERM-50 (4 MG/PTH)	NOV	$	3.4642
☒ 00002231509	CLIMARA 50 (3.9 MG/PTH)	BHP	$	5.1000
75 MCG / DAY TRANSDERMAL PATCH				
00002246968	**SANDOZ ESTRADIOL DERM 75 (6 MG/PTH)**	**SDZ**	$	**2.1750**
00002244001	ESTRADOT 75 (1.17 MG/PTH)	NOV	$	3.0449
☒ 00002247500	CLIMARA 75 (5.7 MG/PTH)	BHP	$	5.4375
100 MCG / DAY TRANSDERMAL PATCH				
00002246969	**SANDOZ ESTRADIOL DERM 100 (8 MG/PTH)**	**SDZ**	$	**2.2875**
00002244002	ESTRADOT 100 (1.56 MG/PTH)	NOV	$	3.1995
☒ 00000756792	ESTRADERM-100 (8.0 MG/PTH)	NOV	$	3.9103
☒ 00002231510	CLIMARA 100 (7.8 MG/PTH)	BHP	$	5.7500
0.25 MG VAGINAL TABLET				
00002241332	VAGIFEM	NNA	$	2.7193
2 MG VAGINAL SLOW-RELEASE RING				
00002168898	ESTRING	PAL	$	62.2400

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:16 ESTROGENS

ESTRADIOL-17B/ NORETHINDRONE ACETATE/ ESTRADIOL-17B

50 MCG / DAY * 140 MCG / DAY * 50 MCG / DAY TRANSDERMAL PATCH				
00002243529	ESTALIS SEQUI (4.33+2.7*.62MG)	NOV	$	2.9442
50 MCG / DAY * 250 MCG / DAY * 50 MCG / DAY TRANSDERMAL PATCH				
⊠ 00002243530	ESTALIS SEQUI (4.33+4.8*.51MG)	NOV	$	2.9589
⊠ 00002108186	ESTRACOMB (4+30*10MG/PTH)	NOV	$	3.0410

ESTROPIPATE

0.625 MG ORAL TABLET				
00002089793	OGEN	PFI	$	0.1918
1.25 MG ORAL TABLET				
00002089769	OGEN	PFI	$	0.3424
2.5 MG ORAL TABLET				
00002089777	OGEN	PFI	$	0.5414

NORETHINDRONE ACETATE/ ESTRADIOL-17B

140 MCG / DAY * 50 MCG / DAY TRANSDERMAL PATCH				
00002241835	ESTALIS (2.7*.62 MG/PTH)	NOV	$	3.1700
250 MCG / DAY * 50 MCG / DAY TRANSDERMAL PATCH				
00002241837	ESTALIS (4.8*.51 MG/PTH)	NOV	$	3.1700

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20:08 ANTIDIABETIC AGENTS (INSULINS)

INSULIN ASPART

100 UNIT / ML INJECTION				
00002245397	NOVORAPID	NNA	$	2.7870
100 UNIT / ML INJECTION CARTRIDGE				
00002244353	NOVORAPID	NNA	$	3.7180

INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)

100 UNIT / ML INJECTION				
⊠ 00000587737	HUMULIN N	LIL	$	1.8060
⊠ 00002024225	NOVOLIN GE NPH	NNA	$	1.9800
100 UNIT / ML INJECTION CARTRIDGE				
⊠ 00001959239	HUMULIN N CARTRIDGE	LIL	$	2.4976
⊠ 00002024268	NOVOLIN GE NPH PENFILL	NNA	$	2.6120

INSULIN HUMAN BIOSYNTHETIC (REGULAR)

100 UNIT / ML INJECTION				
⊠ 00000586714	HUMULIN R	LIL	$	1.8060
⊠ 00002024233	NOVOLIN GE TORONTO	NNA	$	1.9800
100 UNIT / ML INJECTION CARTRIDGE				
⊠ 00001959220	HUMULIN R CARTRIDGE	LIL	$	2.4976
⊠ 00002024284	NOVOLIN GE TORONTO PENFILL	NNA	$	2.6120

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20:08 ANTIDIABETIC AGENTS (INSULINS)

INSULIN HUMAN BIOSYNTHETIC (REGULAR)/ INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)

30 UNIT / ML * 70 UNIT / ML INJECTION				
☒ 00000795879	HUMULIN 30/70	LIL	$	1.8060
☒ 00002024217	NOVOLIN GE 30/70	NNA	$	1.9800
30 UNIT / ML * 70 UNIT / ML INJECTION CARTRIDGE				
☒ 00001959212	HUMULIN 30/70 CARTRIDGE	LIL	$	2.4976
☒ 00002025248	NOVOLIN GE 30/70 PENFILL	NNA	$	2.6120
40 UNIT / ML * 60 UNIT / ML INJECTION CARTRIDGE				
00002024314	NOVOLIN GE 40/60 PENFILL	NNA	$	2.6400
50 UNIT / ML * 50 UNIT / ML INJECTION CARTRIDGE				
00002024322	NOVOLIN GE 50/50 PENFILL	NNA	$	2.6400

INSULIN LISPRO

100 UNIT / ML INJECTION				
00002229704	HUMALOG	LIL	$	2.7080
100 UNIT / ML INJECTION CARTRIDGE				
00002229705	HUMALOG	LIL	$	3.6113

INSULIN LISPRO/ INSULIN LISPRO PROTAMINE

25 % * 75 % INJECTION CARTRIDGE				
00002240294	HUMALOG MIX 25	LIL	$	3.6113

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20:20 ANTIDIABETIC AGENTS (SULFONYLUREAS)

CHLORPROPAMIDE

100 MG ORAL TABLET				
00000399302	APO-CHLORPROPAMIDE	APX	$	0.0720
250 MG ORAL TABLET				
00000312711	**APO-CHLORPROPAMIDE**	**APX**	$	**0.0418**
00000021350	**NOVO-PROPAMIDE**	**NOP**	$	**0.0418**

GLICLAZIDE

80 MG ORAL TABLET				
00002245247	**APO-GLICLAZIDE**	**APX**	$	**0.2790**
00002229519	**GEN-GLICLAZIDE**	**GPM**	$	**0.2790**
00002238103	**NOVO-GLICLAZIDE**	**NOP**	$	**0.2790**
00002155850	**RATIO-GLICLAZIDE**	**RPH**	$	**0.2790**
00002254719	**SANDOZ GLICLAZIDE**	**SDZ**	$	**0.2790**
00000765996	DIAMICRON	SEV	$	0.4004

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20:20 ANTIDIABETIC AGENTS (SULFONYLUREAS)

GLYBURIDE

2.5 MG ORAL TABLET

00001913654	**APO-GLYBURIDE**	**APX**	$	**0.0393**
00002234513	**DOM-GLYBURIDE**	**DPC**	$	**0.0393**
00000720933	**EUGLUCON**	**PMS**	$	**0.0393**
00000808733	**GEN-GLYBE**	**GPM**	$	**0.0393**
00001913670	**NOVO-GLYBURIDE**	**NOP**	$	**0.0393**
00002020734	**NU-GLYBURIDE**	**NXP**	$	**0.0393**
00002236733	**PMS-GLYBURIDE**	**PMS**	$	**0.0393**
00001900927	**RATIO-GLYBURIDE**	**RPH**	$	**0.0393**
00002248008	**SANDOZ GLYBURIDE**	**SDZ**	$	**0.0393**
00002224550	DIABETA	SAV	$	0.1250

5 MG ORAL TABLET

00001913662	**APO-GLYBURIDE**	**APX**	$	**0.0683**
00002234514	**DOM-GLYBURIDE**	**DPC**	$	**0.0683**
00000720941	**EUGLUCON**	**PMS**	$	**0.0683**
00000808741	**GEN-GLYBE**	**GPM**	$	**0.0683**
00001913689	**NOVO-GLYBURIDE**	**NOP**	$	**0.0683**
00002020742	**NU-GLYBURIDE**	**NXP**	$	**0.0683**
00002236734	**PMS-GLYBURIDE**	**PMS**	$	**0.0683**
00001900935	**RATIO-GLYBURIDE**	**RPH**	$	**0.0683**
00002248009	**SANDOZ GLYBURIDE**	**SDZ**	$	**0.0683**
00002224569	DIABETA	SAV	$	0.2239

TOLBUTAMIDE

500 MG ORAL TABLET

00000312762	APO-TOLBUTAMIDE	APX	$	0.0825

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20:92 ANTIDIABETIC AGENTS (MISCELLANEOUS ANTIDIABETIC AGENTS)

ACARBOSE

50 MG ORAL TABLET

00002190885	GLUCOBAY	BAI	$	0.2628

100 MG ORAL TABLET

00002190893	GLUCOBAY	BAI	$	0.3639

GLUCAGON, RDNA ORIGIN

1 MG / VIAL INJECTION

00002243297	GLUCAGON	LIL	$	88.3543

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20:92 ANTIDIABETIC AGENTS
(MISCELLANEOUS ANTIDIABETIC AGENTS)

METFORMIN HCL

500 MG ORAL TABLET

00002167786	**APO-METFORMIN**	**APX**	$	**0.1216**
00002257726	**CO METFORMIN**	**COB**	$	**0.1216**
00002148765	**GEN-METFORMIN**	**GPM**	$	**0.1216**
00002242794	**METFORMIN**	**ZMC**	$	**0.1216**
00002045710	**NOVO-METFORMIN**	**NOP**	$	**0.1216**
00002162822	**NU-METFORMIN**	**NXP**	$	**0.1216**
00002223562	**PMS-METFORMIN**	**PMS**	$	**0.1216**
00002269031	**RAN-METFORMIN**	**RAN**	$	**0.1216**
00002242974	**RATIO-METFORMIN HYDROCHLORIDE**	**RPH**	$	**0.1216**
00002246820	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.1216**
00002099233	GLUCOPHAGE	SAV	$	0.2608

850 MG ORAL TABLET

00002229785	**APO-METFORMIN**	**APX**	$	**0.2090**
00002257734	**CO METFORMIN**	**COB**	$	**0.2090**
00002229656	**GEN-METFORMIN**	**GPM**	$	**0.2090**
00002242793	**METFORMIN**	**ZMC**	$	**0.2090**
00002230475	**NOVO-METFORMIN**	**NOP**	$	**0.2090**
00002229517	**NU-METFORMIN**	**NXP**	$	**0.2090**
00002242589	**PMS-METFORMIN**	**PMS**	$	**0.2090**
00002242931	**RATIO-METFORMIN HYDROCHLORIDE**	**RPH**	$	**0.2090**
00002246821	**SANDOZ METFORMIN FC**	**SDZ**	$	**0.2090**
00002162849	GLUCOPHAGE	SAV	$	0.3303

PIOGLITAZONE HCL

15 MG (BASE) ORAL TABLET

00002242572	ACTOS	LIL	$	2.3073

30 MG (BASE) ORAL TABLET

00002242573	ACTOS	LIL	$	3.2325

45 MG (BASE) ORAL TABLET

00002242574	ACTOS	LIL	$	4.8604

REPAGLINIDE

0.5 MG ORAL TABLET

00002239924	GLUCONORM	NNA	$	0.2975

1 MG ORAL TABLET

00002239925	GLUCONORM	NNA	$	0.3093

2 MG ORAL TABLET

00002239926	GLUCONORM	NNA	$	0.3213

ROSIGLITAZONE MALEATE

2 MG (BASE) ORAL TABLET

00002241112	AVANDIA	GSK	$	1.3110

4 MG (BASE) ORAL TABLET

00002241113	AVANDIA	GSK	$	2.0572

8 MG (BASE) ORAL TABLET

00002241114	AVANDIA	GSK	$	2.9419

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:20:92 ANTIDIABETIC AGENTS
(MISCELLANEOUS ANTIDIABETIC AGENTS)

ROSIGLITAZONE MALEATE/ METFORMIN HCL

1 MG (BASE) * 500 MG ORAL TABLET				
00002247085	AVANDAMET	GSK	$	0.6120
2 MG (BASE) * 500 MG ORAL TABLET				
00002247086	AVANDAMET	GSK	$	1.1067
2 MG (BASE) * 1,000 MG ORAL TABLET				
00002248440	AVANDAMET	GSK	$	1.2087
4 MG (BASE) * 500 MG ORAL TABLET				
00002247087	AVANDAMET	GSK	$	1.9686
4 MG (BASE) * 1,000 MG ORAL TABLET				
00002248441	AVANDAMET	GSK	$	2.0910

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:24 PARATHYROID

SYNTHETIC CALCITONIN SALMON (SALCATONIN)

100 IU / ML INJECTION				
00002007134	CALTINE 100 (100 IU/ML)	FEI	$	8.4065
200 IU / ML INJECTION				
00001926691	CALCIMAR	SAV	$	25.9290

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:28 PITUITARY

COSYNTROPIN ZINC HYDROXIDE COMPLEX

1 MG / VIAL (BASE) INJECTION				
00000253952	SYNACTHEN DEPOT	NOV	$	28.5843

DESMOPRESSIN ACETATE

0.1 MG ORAL TABLET				
00002284030	**APO-DESMOPRESSIN**	**APX**	$	**0.9913**
00000824305	DDAVP	FEI	$	1.4208
0.2 MG ORAL TABLET				
00002284049	**APO-DESMOPRESSIN**	**APX**	$	**1.9826**
00000824143	DDAVP	FEI	$	2.8415
10 MCG / DOSE NASAL METERED DOSE SPRAY				
00002242465	**APO-DESMOPRESSIN**	**APX**	$	**1.3216**
00000836362	DDAVP	FEI	$	2.0296
150 MCG / DOSE NASAL METERED DOSE SPRAY				
00002237860	OCTOSTIM	FEI	$	16.5980
0.1 MG / ML NASAL SOLUTION				
00000402516	DDAVP	FEI	$	20.2960
4 MCG / ML INJECTION				
00000873993	DDAVP	FEI	$	10.8145

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:32 PROGESTINS

MEDROXYPROGESTERONE ACETATE

2.5 MG ORAL TABLET				
00002244726	**APO-MEDROXY**	**APX**	$	**0.0794**
00002229838	**GEN-MEDROXY**	**GPM**	$	**0.0794**
00002221284	**NOVO-MEDRONE**	**NOP**	$	**0.0794**
00002246627	**PMS-MEDROXYPROGESTERONE**	**PMS**	$	**0.0794**
00000708917	PROVERA	PFI	$	0.1719
5 MG ORAL TABLET				
00002244727	**APO-MEDROXY**	**APX**	$	**0.1569**
00002229839	**GEN-MEDROXY**	**GPM**	$	**0.1569**
00002221292	**NOVO-MEDRONE**	**NOP**	$	**0.1569**
00002246628	**PMS-MEDROXYPROGESTERONE**	**PMS**	$	**0.1569**
00000030937	PROVERA	PFI	$	0.3403
10 MG ORAL TABLET				
00002277298	**APO-MEDROXY**	**APX**	$	**0.3169**
00002229840	**GEN-MEDROXY**	**GPM**	$	**0.3169**
00002221306	**NOVO-MEDRONE**	**NOP**	$	**0.3169**
00002246629	**PMS-MEDROXYPROGESTERONE**	**PMS**	$	**0.3169**
00000729973	PROVERA	PFI	$	0.6906
100 MG ORAL TABLET				
00002267640	**APO-MEDROXY**	**APX**	$	**0.8543**
00000030945	PROVERA	PFI	$	1.3388
50 MG / ML INJECTION				
00000030848	DEPO-PROVERA	PFI	$	5.7220
150 MG / ML INJECTION				
00000585092	DEPO-PROVERA	PFI	$	29.5200

PROGESTERONE

100 MG ORAL CAPSULE				
00002166704	PROMETRIUM	SCH	$	0.8864
50 MG / ML INJECTION				
00001977652	PROGESTERONE	CYT	$	6.3000

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36:04 THYROID & ANTITHYROID AGENTS (THYROID AGENTS)

DESSICATED THYROID

30 MG ORAL TABLET				
00000023949	THYROID	ERF	$	0.0452
60 MG ORAL TABLET				
00000023957	THYROID	ERF	$	0.0534
125 MG ORAL TABLET				
00000023965	THYROID	ERF	$	0.0860

LEVOTHYROXINE SODIUM

0.025 MG ORAL TABLET				
00002172062	SYNTHROID	ABB	$	0.0785
0.05 MG ORAL TABLET				
00002213192	**ELTROXIN**	**GSK**	$	**0.0267**
00002172070	SYNTHROID	ABB	$	0.0539

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36:04 THYROID & ANTITHYROID AGENTS (THYROID AGENTS)

LEVOTHYROXINE SODIUM

0.075 MG ORAL TABLET				
00002172089	SYNTHROID	ABB	$	0.0848
0.088 MG ORAL TABLET				
00002172097	SYNTHROID	ABB	$	0.0848
0.1 MG ORAL TABLET				
00002213206	**ELTROXIN**	**GSK**	$	**0.0328**
00002172100	SYNTHROID	ABB	$	0.0664
0.112 MG ORAL TABLET				
00002171228	SYNTHROID	ABB	$	0.0895
0.125 MG ORAL TABLET				
00002172119	SYNTHROID	ABB	$	0.0906
0.137 MG ORAL TABLET				
00002233852	SYNTHROID	ABB	$	0.1530
0.15 MG ORAL TABLET				
00002213214	**ELTROXIN**	**GSK**	$	**0.0364**
00002172127	SYNTHROID	ABB	$	0.0711
0.175 MG ORAL TABLET				
00002172135	SYNTHROID	ABB	$	0.0971
0.2 MG ORAL TABLET				
00002213222	**ELTROXIN**	**GSK**	$	**0.0385**
00002172143	SYNTHROID	ABB	$	0.0759
0.3 MG ORAL TABLET				
00002213230	**ELTROXIN**	**GSK**	$	**0.0921**
00002172151	SYNTHROID	ABB	$	0.1047

LIOTHYRONINE SODIUM

5 MCG (BASE) ORAL TABLET				
00001919458	CYTOMEL	TMD	$	1.0554
25 MCG (BASE) ORAL TABLET				
00001919466	CYTOMEL	TMD	$	1.1473

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:36:08 THYROID & ANTITHYROID AGENTS (ANTITHYROID AGENTS)

METHIMAZOLE

5 MG ORAL TABLET				
00000015741	TAPAZOLE	PAL	$	0.2313

PROPYLTHIOURACIL

50 MG ORAL TABLET				
00000010200	PROPYL-THYRACIL	PAL	$	0.2056
100 MG ORAL TABLET				
00000010219	PROPYL-THYRACIL	PAL	$	0.3217

72:00 LOCAL ANESTHETICS

72:00

MEPIVACAINE HCL

10 MG / ML INJECTION

00002017563	CARBOCAINE	HSP	$	0.2240

80:00 SERUMS, TOXOIDS, AND VACCINES

80:04 SERUMS

ALLERGY SERUM

INJECTION

00000999981	ALLERGY SERUM	XXX	$	0.0000

80:00 SERUMS, TOXOIDS, AND VACCINES

80:12 VACCINES

HEPATITIS B VACCINE (RECOMBINANT)

10 MCG / ML INJECTION

00000749486	RECOMBIVAX-HB	MFC	$	21.3500

20 MCG / ML INJECTION

00001919431	ENGERIX-B	GSK	$	21.1650

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:04:04 ANTI-INFECTIVES (ANTIBIOTICS)

FUSIDIC ACID

2 % TOPICAL CREAM

00000586668	FUCIDIN	LEO	$	0.5989

GENTAMICIN SULFATE

0.1 % (BASE) TOPICAL CREAM

00000805386	RATIO-GENTAMICIN SULFATE	RPH	$	0.3560

0.1 % (BASE) TOPICAL OINTMENT

00000805025	RATIO-GENTAMICIN SULFATE	RPH	$	0.3560
00000872881	PMS-GENTAMICIN	PMS	$	0.3913

MUPIROCIN

2 % TOPICAL CREAM

00002239757	BACTROBAN	GKC	$	0.5080

2 % TOPICAL OINTMENT

00002279983	**TARO-MUPIROCIN**	**TAR**	$	**0.3453**
00001916947	BACTROBAN	GKC	$	0.5080

NEOMYCIN SULFATE/ POLYMYXIN B SULFATE

40 MG / ML (BASE) * 200,000 UNIT / ML IRRIGATION SOLUTION

00000666157	NEOSPORIN	GSK	$	2.0100

SODIUM FUSIDATE

2 % TOPICAL OINTMENT

00000586676	FUCIDIN	LEO	$	0.5989

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:04:08 ANTI-INFECTIVES (ANTIFUNGALS)

CICLOPIROX OLAMINE

1 % TOPICAL CREAM

00002221802	LOPROX	SAV	$	0.5088

KETOCONAZOLE

2 % TOPICAL CREAM

00002245662	**KETODERM**	**TPT**	$	**0.3167**
00000703974	NIZORAL	MCL	$	0.5113

TERBINAFINE HCL

1 % TOPICAL CREAM

00002031094	LAMISIL	NOV	$	0.5163

1 % TOPICAL SOLUTION

00002238703	LAMISIL	NOV	$	0.5343

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:04:16 ANTI-INFECTIVES
(MISC. LOCAL ANTI-INFECTIVES)

METRONIDAZOLE

0.75 % TOPICAL CREAM

00002226839	METROCREAM	GAL	$	0.4933

1 % TOPICAL CREAM

⊠ 00002156091	NORITATE	SAV	$	0.5304
⊠ 00002242919	ROSASOL	STI	$	0.5307

0.75 % TOPICAL LOTION

00002248206	METROLOTION	GAL	$	0.4933

0.75 % TOPICAL GEL

00002092832	METROGEL	GAL	$	0.6000

10 % VAGINAL CREAM

00001926861	FLAGYL	SAV	$	0.2168

METRONIDAZOLE/ NYSTATIN

100 MG / G * 20,000 UNIT / G VAGINAL CREAM

00001926845	FLAGYSTATIN	SAV	$	0.5303

500 MG * 100,000 UNIT VAGINAL OVULE

00001926829	FLAGYSTATIN	SAV	$	2.9165

SILVER SULFADIAZINE

1 % TOPICAL CREAM

00000323098	FLAMAZINE	SNE	$	0.2612

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:06 ANTI-INFLAMMATORY AGENTS

AMCINONIDE

0.1 % TOPICAL CREAM

00002247098	**RATIO-AMCINONIDE**	**RPH**	$	**0.2737**
00002246714	**TARO-AMCINONIDE**	**TAR**	$	**0.2737**
00002192284	CYCLOCORT	STI	$	0.5533

0.1 % TOPICAL OINTMENT

00002247096	**RATIO-AMCINONIDE**	**RPH**	$	**0.2737**
00002192268	CYCLOCORT	STI	$	0.5533

0.1 % TOPICAL LOTION

00002247097	**RATIO-AMCINONIDE**	**RPH**	$	**0.2272**
00002192276	CYCLOCORT	STI	$	0.4649

BECLOMETHASONE DIPROPIONATE

250 MCG / G TOPICAL CREAM

00002089602	PROPADERM	SHB	$	0.4120

BETAMETHASONE 17-VALERATE

0.05 % (BASE) TOPICAL CREAM

00000716618	**BETADERM MILD**	**TAR**	$	**0.0606**
00000535427	RATIO-ECTOSONE MILD	RPH	$	0.0611

0.1 % (BASE) TOPICAL CREAM

00000716626	**BETADERM REGULAR**	**TAR**	$	**0.0903**
00000535435	RATIO-ECTOSONE REGULAR	RPH	$	0.0911

0.1 % (BASE) TOPICAL OCCLUSIVE CREAM

00000804541	PREVEX B	TCD	$	0.3566

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:06 ANTI-INFLAMMATORY AGENTS

BETAMETHASONE 17-VALERATE

0.05 % (BASE) TOPICAL OINTMENT				
00000716642	BETADERM MILD	TAR	$	0.0606
0.1 % (BASE) TOPICAL OINTMENT				
00000716650	BETADERM REGULAR	TAR	$	0.0903
0.05 % (BASE) TOPICAL LOTION				
00000653209	RATIO-ECTOSONE MILD	RPH	$	0.1900
0.1 % (BASE) TOPICAL LOTION				
00000750050	RATIO-ECTOSONE REGULAR	RPH	$	0.2500
0.1 % (BASE) SCALP LOTION				
00000653217	**RATIO-ECTOSONE SCALP**	**RPH**	$	**0.0852**
00000027944	VALISONE SCALP	SCH	$	0.0853

BETAMETHASONE DIPROPIONATE

0.05 % (BASE) TOPICAL CREAM				
00000323071	**DIPROSONE**	**SCH**	$	**0.2046**
00000804991	RATIO-TOPISONE	RPH	$	0.2047
0.05 % (BASE) TOPICAL GLYCOL CREAM				
00000688622	**DIPROLENE GLYCOL**	**SCH**	$	**0.5187**
00000849650	**RATIO-TOPILENE**	**RPH**	$	**0.5187**
0.05 % (BASE) TOPICAL OINTMENT				
00000344923	**DIPROSONE**	**SCH**	$	**0.2153**
00000805009	**RATIO-TOPISONE**	**RPH**	$	**0.2153**
0.05 % (BASE) TOPICAL GLYCOL OINTMENT				
00000629367	**DIPROLENE GLYCOL**	**SCH**	$	**0.5187**
00000849669	**RATIO-TOPILENE**	**RPH**	$	**0.5187**
0.05 % (BASE) TOPICAL LOTION				
00000417246	**DIPROSONE**	**SCH**	$	**0.1980**
00000809187	**RATIO-TOPISONE**	**RPH**	$	**0.1980**
0.05 % (BASE) TOPICAL GLYCOL LOTION				
00000862975	**DIPROLENE GLYCOL**	**SCH**	$	**0.4683**
00001927914	**RATIO-TOPILENE**	**RPH**	$	**0.4683**

BETAMETHASONE DIPROPIONATE/ SALICYLIC ACID

0.5 MG / G (BASE) * 30 MG / G TOPICAL OINTMENT				
00000578436	DIPROSALIC	SCH	$	0.7413
0.5 MG / ML (BASE) * 20 MG / ML TOPICAL LOTION				
00002245688	**RATIO-TOPISALIC**	**RPH**	$	**0.3523**
00000578428	DIPROSALIC	SCH	$	0.3683

BETAMETHASONE SODIUM PHOSPHATE

5 MG / ENM (BASE) RECTAL ENEMA				
00002060884	BETNESOL (5MG/100ML)	SHB	$	8.5314

BUDESONIDE

2.3 MG / ENM RECTAL ENEMA				
00002052431	ENTOCORT (115 ML)	AZC	$	7.9286

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:06 ANTI-INFLAMMATORY AGENTS

CLOBETASOL 17-PROPIONATE

0.05 % TOPICAL CREAM				
00002024187	**GEN-CLOBETASOL**	**GPM**	$	**0.4068**
00002093162	**NOVO-CLOBETASOL**	**NOP**	$	**0.4068**
00002232191	**PMS-CLOBETASOL**	**PMS**	$	**0.4068**
00001910272	**RATIO-CLOBETASOL**	**RPH**	$	**0.4068**
00002245523	**TARO-CLOBETASOL**	**TAR**	$	**0.4068**
00002213265	DERMOVATE	TPT	$	0.6512
0.05 % TOPICAL OINTMENT				
00002026767	**GEN-CLOBETASOL**	**GPM**	$	**0.4068**
00002126192	**NOVO-CLOBETASOL**	**NOP**	$	**0.4068**
00002232193	**PMS-CLOBETASOL**	**PMS**	$	**0.4068**
00001910280	**RATIO-CLOBETASOL**	**RPH**	$	**0.4068**
00002245524	**TARO-CLOBETASOL**	**TAR**	$	**0.4068**
00002213273	DERMOVATE	TPT	$	0.6512
0.05 % SCALP LOTION				
00002216213	**GEN-CLOBETASOL**	**GPM**	$	**0.3565**
00002232195	**PMS-CLOBETASOL**	**PMS**	$	**0.3565**
00001910299	**RATIO-CLOBETASOL**	**RPH**	$	**0.3565**
00002245522	**TARO-CLOBETASOL**	**TAR**	$	**0.3565**
00002213281	DERMOVATE	TPT	$	0.5685

DESONIDE

0.05 % TOPICAL CREAM				
00002229315	**PMS-DESONIDE**	**PMS**	$	**0.2610**
0.05 % TOPICAL OINTMENT				
00002229323	**PMS-DESONIDE**	**PMS**	$	**0.2610**
00002115522	DESOCORT	GAL	$	0.2900
00002154870	TRIDESILON	PMS	$	0.3867
0.05 % TOPICAL LOTION				
00002115514	DESOCORT	GAL	$	0.1450

DESOXIMETASONE

0.05 % TOPICAL CREAM				
00002221918	TOPICORT MILD	AVE	$	0.4714
0.25 % TOPICAL CREAM				
00002221896	TOPICORT	AVE	$	0.6799

DIFLUCORTOLONE VALERATE

0.1 % TOPICAL CREAM				
⊠ 00000587826	NERISONE	STI	$	0.3905
⊠ 00000587818	NERISONE OILY	STI	$	0.3905
0.1 % TOPICAL OINTMENT				
00000587834	NERISONE	STI	$	0.3905

FLUOCINONIDE

0.05 % TOPICAL CREAM				
00000716863	LYDERM	TPT	$	0.2617
0.05 % TOPICAL EMOLLIENT CREAM				
00000598933	TIAMOL	TPT	$	0.2433
0.05 % TOPICAL OINTMENT				
00002236996	LYDERM	TPT	$	0.3370
0.05 % TOPICAL GEL				
00002236997	LYDERM	TPT	$	0.3418

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:06 ANTI-INFLAMMATORY AGENTS

HALCINONIDE

0.1 % TOPICAL CREAM

00002011921	HALOG	WSD	$	0.5303

0.1 % TOPICAL OINTMENT

00002010283	HALOG	WSD	$	0.5303

HALOBETASOL PROPIONATE

0.05 % TOPICAL CREAM

00001962701	ULTRAVATE	WSD	$	0.8176

0.05 % TOPICAL OINTMENT

00001962728	ULTRAVATE	WSD	$	0.8176

HYDROCORTISONE

1 % TOPICAL CREAM

00000192597	EMO-CORT	TCD	$	0.1701

2.5 % TOPICAL CREAM

00000595799	EMO-CORT	TCD	$	0.2322

1 % TOPICAL OCCLUSIVE CREAM

00000804533	PREVEX HC	TCD	$	0.2652

0.5 % TOPICAL OINTMENT

00000716685	CORTODERM MILD	TAR	$	0.1400

1 % TOPICAL OINTMENT

00000716693	CORTODERM REGULAR	TAR	$	0.0390

1 % TOPICAL LOTION

☒ 00000578541	SARNA HC	STI	$	0.0928
☒ 00000192600	EMO-CORT	TCD	$	0.1572

2.5 % TOPICAL LOTION

☒ 00000856711	SARNA HC	STI	$	0.1794
☒ 00000595802	EMO-CORT	TCD	$	0.2078

2.5 % SCALP LOTION

00000641154	EMO-CORT SCALP	TCD	$	0.1965

100 MG / ENM RECTAL ENEMA

00000230316	HYCORT (100MG/60ML)	VCL	$	5.5286
00002112736	CORTENEMA (100MG/60ML)	AXC	$	6.5043

HYDROCORTISONE 17-VALERATE

0.2 % TOPICAL CREAM

00002242984	HYDROVAL	TPT	$	0.1212

0.2 % TOPICAL OINTMENT

00002242985	**HYDROVAL**	**TPT**	$	**0.1212**
00001910132	WESTCORT	WSD	$	0.1667

HYDROCORTISONE ACETATE

0.5 % TOPICAL CREAM

00000716820	HYDERM	TAR	$	0.1667

1 % TOPICAL CREAM

00000716839	HYDERM	TAR	$	0.0364

10 % RECTAL FOAM

00000579335	CORTIFOAM	PAL	$	5.6707

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:06 ANTI-INFLAMMATORY AGENTS

HYDROCORTISONE ACETATE/ PRAMOXINE HCL

1 % * 1 % TOPICAL CREAM

00000770957	PRAMOX H.C.	DPT	$	0.2723

1 % * 1 % RECTAL FOAM

00000363014	PROCTOFOAM-HC	DUI	$	1.7139

HYDROCORTISONE ACETATE/ PRAMOXINE HCL/ ZINC SULFATE

10 MG * 20 MG * 10 MG RECTAL SUPPOSITORY

00002240851	**PROCTODAN-HC**	**ODN**	$	**1.0875**
00002242797	**SAB-ANUZINC HC PLUS**	**SDZ**	$	**1.0875**
00000476242	ANUGESIC-HC	JJM	$	1.3975

0.5 % * 1 % * 0.5 % RECTAL OINTMENT

00002234466	**PROCTODAN-HC**	**ODN**	$	**0.7317**
00002247692	**SANDOZ ANUZINC HC PLUS**	**SDZ**	$	**0.7317**
00000505781	ANUGESIC-HC	JJM	$	0.9317

HYDROCORTISONE ACETATE/ UREA

1 % * 10 % TOPICAL CREAM

00000503134	UREMOL-HC	TCD	$	0.1731

1 % * 10 % TOPICAL LOTION

00000560022	UREMOL-HC	TCD	$	0.0961

HYDROCORTISONE ACETATE/ ZINC SULFATE

10 MG * 10 MG RECTAL SUPPOSITORY

00002236399	**ANODAN-HC**	**ODN**	$	**0.6075**
00000607797	**RATIO-HEMCORT H.C.**	**RPH**	$	**0.6075**
00002242798	**SAB-ANUZINC HC**	**SDZ**	$	**0.6075**
00000476285	ANUSOL-HC	JJM	$	1.1183

0.5 % * 0.5 % RECTAL OINTMENT

00002128446	**ANODAN-HC**	**ODN**	$	**0.4130**
00000607789	**RATIO-HEMCORT H.C.**	**RPH**	$	**0.4130**
00002247691	**SANDOZ ANUZINC HC**	**SDZ**	$	**0.4130**
00000505773	ANUSOL-HC	JJM	$	0.7827

MOMETASONE FUROATE

0.1 % TOPICAL CREAM

00000851744	ELOCOM	SCH	$	0.5987

0.1 % TOPICAL OINTMENT

00002264749	**TARO-MOMETASONE**	**TAR**	$	**0.3492**
00002270862	PMS-MOMETASONE	PMS	$	0.3493
00002248130	RATIO-MOMETASONE	RPH	$	0.3493
00000851736	ELOCOM	SCH	$	0.5987

0.1 % TOPICAL LOTION

00000871095	ELOCOM	SCH	$	0.4320

TRIAMCINOLONE ACETONIDE

0.1 % TOPICAL CREAM

00000716960	TRIADERM REGULAR	TAR	$	0.0650
⊠ 00002194058	ARISTOCORT R	VLP	$	0.1397

0.5 % TOPICAL CREAM

00002194066	ARISTOCORT C	VLP	$	1.2387

0.1 % TOPICAL OINTMENT

00002194031	ARISTOCORT R	VLP	$	0.1397

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:06 ANTI-INFLAMMATORY AGENTS

TRIAMCINOLONE ACETONIDE

0.1 % DENTAL PASTE

00001964054	**ORACORT**	**TAR**	$	**1.0800**
00001999788	KENALOG IN ORABASE	WSD	$	1.2480

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:06:00 ANTI-INFLAMMATORY AGENTS (COMBINATION ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENT)

BETAMETHASONE DIPROPIONATE/ CLOTRIMAZOLE

0.05 % (BASE) * 1 % TOPICAL CREAM

00000611174	LOTRIDERM	SCH	$	0.6460

HYDROCORTISONE/ CINCHOCAINE HCL/ FRAMYCETIN SULFATE/ ESCULIN

5 MG * 5 MG * 10 MG * 10 MG RECTAL SUPPOSITORY

00002247882	**PROCTOL**	**ODN**	$	**0.7925**
00002226391	**RATIO-PROCTOSONE**	**RPH**	$	**0.7925**
00002242528	**SAB PROCTOMYXIN HC**	**SDZ**	$	**0.7925**
00002223260	PROCTOSEDYL	AXC	$	1.1375

5 MG / G * 5 MG / G * 10 MG / G * 10 MG / G RECTAL OINTMENT

00002247322	**PROCTOL**	**ODN**	$	**0.5960**
00002226383	**RATIO-PROCTOSONE**	**RPH**	$	**0.5960**
00002242527	**SANDOZ PROCTOMYXIN HC**	**SDZ**	$	**0.5960**
00002223252	PROCTOSEDYL	AXC	$	0.8027

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:08 ANTIPRURITICS & LOCAL ANESTHETICS

LIDOCAINE

5 % TOPICAL OINTMENT

00002083795	**LIDODAN**	**ODN**	$	**0.1986**
00000001961	XYLOCAINE	AZC	$	0.2571

LIDOCAINE HCL

2 % ORAL LIQUID

00001968823	**LIDODAN VISCOUS**	**ODN**	$	**0.0680**
00000811874	**PMS-LIDOCAINE VISCOUS**	**PMS**	$	**0.0680**
00000001686	XYLOCAINE VISCOUS	AZC	$	0.0900

2 % TOPICAL JELLY

00000001694	XYLOCAINE JELLY	AZC	$	0.3367

PHENAZOPYRIDINE HCL

100 MG ORAL TABLET

00000271489	PHENAZO	VCL	$	0.1269

200 MG ORAL TABLET

00000454583	PHENAZO	VCL	$	0.1582

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:28 KERATOLYTIC AGENTS

PODOFILOX

0.5 % TOPICAL SOLUTION

00002074788	WARTEC	PAL	$	12.7867

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:36 MISC. SKIN & MUCOUS MEMBRANE AGENTS

5-FLUOROURACIL

50 MG / G TOPICAL CREAM

00000330582	EFUDEX	VCL	$	0.8600

ACITRETIN

10 MG ORAL CAPSULE

00002070847	SORIATANE	HLR	$	1.7457

25 MG ORAL CAPSULE

00002070863	SORIATANE	HLR	$	3.0667

CALCIPOTRIOL

50 MCG / G TOPICAL CREAM

00002150956	DOVONEX	LEO	$	0.7498

50 MCG / G TOPICAL OINTMENT

00001976133	DOVONEX	LEO	$	0.7498

50 MCG / ML SCALP SOLUTION

00002194341	DOVONEX	LEO	$	0.7498

DIMETHYL SULFOXIDE

70 % TOPICAL SOLUTION

00000376167	KEMSOL	AXS	$	0.1808

ISOTRETINOIN

10 MG ORAL CAPSULE

00000582344	**ACCUTANE**	**HLR**	$	**1.0011**
00002257955	**CLARUS**	**PRP**	$	**1.0011**

40 MG ORAL CAPSULE

00000582352	**ACCUTANE**	**HLR**	$	**2.0428**
00002257963	**CLARUS**	**PRP**	$	**2.0428**

TAZAROTENE

0.05 % TOPICAL GEL

00002230784	TAZORAC	ALL	$	1.4203

0.1 % TOPICAL GEL

00002230785	TAZORAC	ALL	$	1.4203

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:50:04 DEPIGMENTING & PIGMENTING AGENTS (DEPIGMENTING AGENTS)

HYDROQUINONE

4 % TOPICAL CREAM				
☒ 00000626716	ULTRAQUIN	CDX	$	0.6833
☒ 00000632783	ULTRAQUIN PLAIN	CDX	$	0.6833
☒ 00001964534	ELDOPAQUE FORTE	VCL	$	1.3330
4 % TOPICAL GEL				
00000626724	ULTRAQUIN	CDX	$	0.6833

84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:50:06 DEPIGMENTING & PIGMENTING AGENTS (PIGMENTING AGENTS)

METHOXSALEN

10 MG ORAL CAPSULE				
☒ 00000252654	OXSORALEN ULTRA	VCL	$	0.4623
☒ 00000646237	ULTRAMOP	CDX	$	0.4755
☒ 00001946374	OXSORALEN	VCL	$	0.6206
10 MG / ML TOPICAL LOTION				
☒ 00000698059	ULTRAMOP	CDX	$	1.0320
☒ 00001907476	OXSORALEN	VCL	$	1.5792

86:00 SMOOTH MUSCLE RELAXANTS

86:12 GENITOURINARY SMOOTH MUSC RELAXANTS

FLAVOXATE HCL

200 MG ORAL TABLET				
00002244842	**APO-FLAVOXATE**	**APX**	$	**0.3112**
00002245480	**PMS-FLAVOXATE**	**PMS**	$	**0.3112**
00000728179	URISPAS	PAL	$	0.4940

OXYBUTYNIN CHLORIDE

2.5 MG ORAL TABLET				
00002240549	PMS-OXYBUTYNIN	PMS	$	0.1268
5 MG ORAL TABLET				
00002163543	**APO-OXYBUTYNIN**	**APX**	$	**0.2485**
00002230800	**GEN-OXYBUTYNIN**	**GPM**	$	**0.2485**
00002230394	**NOVO-OXYBUTYNIN**	**NOP**	$	**0.2485**
00002158590	**NU-OXYBUTYN**	**NXP**	$	**0.2485**
00002240550	**PMS-OXYBUTYNIN**	**PMS**	$	**0.2485**
00002220059	OXYBUTYN	VCL	$	0.2671
1 MG / ML ORAL SYRUP				
00002223376	PMS-OXYBUTYNIN	PMS	$	0.0714

86:00 SMOOTH MUSCLE RELAXANTS

86:16 RESPIRATORY SMOOTH MUSC RELAXANTS

AMINOPHYLLINE

225 MG ORAL SUSTAINED-RELEASE TABLET				
00002014270	PHYLLOCONTIN	PUR	$	0.2284
350 MG ORAL SUSTAINED-RELEASE TABLET				
00002014289	PHYLLOCONTIN-350	PUR	$	0.2911
25 MG / ML INJECTION				
00000497193	AMINOPHYLLINE	HSP	$	0.2840

OXTRIPHYLLINE

20 MG / ML ORAL ELIXIR				
00000792942	**PMS-OXTRIPHYLLINE**	**PMS**	$	**0.0229**
00000476366	CHOLEDYL	ERF	$	0.0373

OXTRIPHYLLINE/ GUAIFENESIN

20 MG / ML * 10 MG / ML ORAL ELIXIR				
00000476374	CHOLEDYL EXPECTORANT	ERF	$	0.0774

THEOPHYLLINE

100 MG ORAL SUSTAINED-RELEASE TABLET				
00000692689	APO-THEO LA	APX	$	0.1300
200 MG ORAL SUSTAINED-RELEASE TABLET				
00000692697	APO-THEO LA	APX	$	0.1350
300 MG ORAL SUSTAINED-RELEASE TABLET				
00000692700	APO-THEO LA	APX	$	0.1400
400 MG ORAL SUSTAINED-RELEASE TABLET				
00002014165	UNIPHYL	PUR	$	0.5248
600 MG ORAL SUSTAINED-RELEASE TABLET				
00002014181	UNIPHYL	PUR	$	0.6358
5.3 MG / ML ORAL LIQUID				
00001966219	THEOLAIR	GRC	$	0.0205

88:00 VITAMINS

88:08 VITAMIN B COMPLEX

CYANOCOBALAMIN

1,000 MCG / ML INJECTION

00001987003	**CYANOCOBALAMIN**	**CYT**	$	**0.4500**
00000521515	**VITAMIN B12**	**SDZ**	$	**0.4500**

FOLIC ACID

5 MG ORAL TABLET

00000426849	APO-FOLIC	APX	$	0.0404

5 MG / ML INJECTION

00000816086	FOLIC ACID	SDZ	$	1.7630

THIAMINE HCL

100 MG / ML INJECTION

00002193221	THIAMIJECT	OMG	$	1.1880
00002243525	THIAMINE HCL	CYT	$	1.1880
00000816078	VITAMIN B1	SDZ	$	1.5270

88:00 VITAMINS

88:16 VITAMIN D

ALFACALCIDOL

0.25 MCG ORAL CAPSULE

00000474517	ONE-ALPHA	LEO	$	0.4397

1 MCG ORAL CAPSULE

00000474525	ONE-ALPHA	LEO	$	1.3161

2 MCG / ML ORAL DROPS

00002240329	ONE-ALPHA	LEO	$	5.0280

2 MCG / ML INJECTION

00002242502	ONE-ALPHA	LEO	$	16.1260

CALCITRIOL

0.25 MCG ORAL CAPSULE

00000481823	ROCALTROL	HLR	$	0.9780

0.5 MCG ORAL CAPSULE

00000481815	ROCALTROL	HLR	$	1.5554

1 MCG / ML INJECTION

00000891738	CALCIJEX	ABB	$	10.2000

2 MCG / ML INJECTION

00000891746	CALCIJEX	ABB	$	18.5000

VITAMIN D2

50,000 UNIT ORAL CAPSULE

00000009830	OSTOFORTE	MFC	$	0.2169

8,288 UNIT / ML ORAL LIQUID

00002017598	DRISDOL	AVE	$	0.4588

88:00 VITAMINS

88:24 VITAMIN K ACTIVITY

PHYTONADIONE

2 MG / ML INJECTION

00000781878	VITAMIN K1 PEDIATRIC	SDZ	$	3.3970

10 MG / ML INJECTION

00000804312	VITAMIN K1	SDZ	$	2.3811

88:00 VITAMINS

88:28 MULTIVITAMIN PREPARATIONS

PIPRADROL HCL/ THIAMINE HCL/ RIBOFLAVIN/ PYRIDOXINE HCL/ NIACINAMIDE/ CHOLINE/ INOSITOL

0.04 MG / ML * 0.22 MG / ML * 0.11 MG / ML * 0.04 MG / ML * 1.11 MG / ML * 2.22 MG / ML * 2.22 MG / ML ORAL LIQUID

00002103052	ALERTONIC	ODN	$	0.0598

VITAMIN A PALMITATE/ VITAMIN D3/ TOCOPHEROL D-ALPHA/ PHYTONADIONE/ ASCORBIC ACID/ FOLIC ACID/ THIAMINE/ RIBOFLAVIN (VITAMIN B2)/ NIACIN/ PYRIDOXINE/ CYANOCOBALAMIN/ BIOTIN/ CALCIUM D-PANTOTHENATE/ ZINC GLUCONATE/ BETA CAROTENE

4,000 UNIT * 400 UNIT * 150 UNIT * 0.15 MG * 60 MG * 0.2 MG * 1.2 MG * 1.3 MG * 10 MG * 1.5 MG * 12 MCG * 50 MCG * 10 MG (BASE) * 7.5 MG (BASE) * 3 MG ORAL TABLET

00002031388	ADEKS	AXC	$	0.3225

VITAMIN A PALMITATE/ VITAMIN D/ TOCOPHEROL D-ALPHA/ PHYTONADIONE/ ASCORBIC ACID/ THIAMINE/ RIBOFLAVIN (VITAMIN B2)/ NIACINAMIDE/ PYRIDOXINE HCL/ CYANOCOBALAMIN/ BIOTIN/ D-PANTHENOL/ ZINC SULFATE/ BETA CAROTENE

1,500 UNIT / ML * 400 UNIT / ML * 40 UNIT / ML * 0.1 MG / ML * 45 MG / ML * 0.5 MG / ML * 0.6 MG / ML * 6 MG / ML * 0.6 MG / ML * 4 MCG / ML * 15 MCG / ML * 3 MG / ML (BASE) * 5 MG / ML (BASE) * 1 MG / ML ORAL DROPS

00002139650	ADEKS	AXC	$	0.3225

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00

ALLOPURINOL

100 MG ORAL TABLET				
00000402818	**APO-ALLOPURINOL**	**APX**	$	**0.0780**
00000364282	**NOVO-PUROL**	**NOP**	$	**0.0780**
200 MG ORAL TABLET				
00000479799	**APO-ALLOPURINOL**	**APX**	$	**0.1300**
00000565342	**NOVO-PUROL**	**NOP**	$	**0.1300**
300 MG ORAL TABLET				
00000402796	**APO-ALLOPURINOL**	**APX**	$	**0.2125**
00000363693	**NOVO-PUROL**	**NOP**	$	**0.2125**
00000294322	ZYLOPRIM	GSK	$	0.2936

AMINOBENZOATE POTASSIUM

500 MG ORAL TABLET				
00000550175	POTABA	GLE	$	0.3744
500 MG ORAL CAPSULE				
00000611271	POTABA	GLE	$	0.2854
2 G ORAL POWDER PACKET				
00000611298	POTABA	GLE	$	1.1524

AZATHIOPRINE

50 MG ORAL TABLET				
00002242907	**APO-AZATHIOPRINE**	**APX**	$	**0.5418**
00002231491	**GEN-AZATHIOPRINE**	**GPM**	$	**0.5418**
00002236819	**NOVO-AZATHIOPRINE**	**NOP**	$	**0.5418**
00000004596	IMURAN	GSK	$	0.9167

BROMOCRIPTINE MESYLATE

2.5 MG (BASE) ORAL TABLET				
00002087324	**APO-BROMOCRIPTINE**	**APX**	$	**0.5453**
00002238636	**DOM-BROMOCRIPTINE**	**DPC**	$	**0.5453**
00002231702	**PMS-BROMOCRIPTINE**	**PMS**	$	**0.5453**
5 MG (BASE) ORAL CAPSULE				
00002230454	**APO-BROMOCRIPTINE**	**APX**	$	**0.9711**
00002238637	**DOM-BROMOCRIPTINE**	**DPC**	$	**0.9711**
00002236949	**PMS-BROMOCRIPTINE**	**PMS**	$	**0.9711**

CLODRONATE DISODIUM

400 MG ORAL CAPSULE				
00002245828	CLASTEON	ORY	$	1.2989

CLODRONATE DISODIUM TETRAHYDRATE

400 MG ORAL CAPSULE				
00001984845	BONEFOS	BHP	$	1.7500
60 MG / ML INJECTION				
00001984837	BONEFOS	BHP	$	11.8000

CLOMIPHENE CITRATE

50 MG ORAL TABLET				
00000893722	SEROPHENE	SRO	$	4.9000
00002091879	CLOMID	SAV	$	5.2744

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00

CLONIDINE HCL

0.025 MG ORAL TABLET

00002248732	**APO-CLONIDINE**	**APX**	$	**0.1817**
00000519251	DIXARIT	BOE	$	0.2720

CLOPIDOGREL BISULFATE

LIMITED RESTRICTED BENEFIT - This product is a benefit for patients for the prevention of thrombosis, following intravascular stent placement, when prescribed by a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, or General Surgery. This benefit is limited to one month of coverage for the first stent placement only. (For eligibility for repeat stents, other indications, or continued coverage up to 12 months following intravascular drug eluting stent (DES) placement refer to Criteria for Special Authorization of Select Drug Products of the List and Criteria for Special Authorization of Select Drug Products of the Alberta Employment, Immigration and Industry Drug Benefit Supplement for Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

75 MG ORAL TABLET

00002238682	PLAVIX	BMS	$	2.4698

COLCHICINE

0.6 MG ORAL TABLET

00000572349	COLCHICINE	ODN	$	0.2490

1 MG ORAL TABLET

00000621374	COLCHICINE	ODN	$	0.4935

COMPOUND PRESCRIPTION

00000999999	COMPOUND	XXX	$	0.0000

DIMETHYL SULFOXIDE

50 % BLADDER IRRIGATION SOLUTION

00002243231	DIMETHYL SULFOXIDE IRRIGATION	SDZ	$	0.9990
00000493392	RIMSO-50	ALV	$	1.1900

DUTASTERIDE

RESTRICTED BENEFIT - This product is a benefit for patients 65 years of age and older for the treatment of benign prostatic hyperplasia. (For eligibility in patients less than 65 years of age refer to the Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

0.5 MG ORAL CAPSULE

00002247813	AVODART	GSK	$	1.5793

ETIDRONATE DISODIUM/ CALCIUM CARBONATE

400 MG * 500 MG ORAL TABLET

00002176017	DIDROCAL	PGA	$	0.4637

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00

FINASTERIDE

RESTRICTED BENEFIT - This product is a benefit for patients 65 years of age and older for the treatment of benign prostatic hyperplasia. (For eligibility in patients less than 65 years of age refer to the Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients.)

5 MG ORAL TABLET

00002010909	PROSCAR	MFC	$	1.7463

FLUNARIZINE HCL

5 MG (BASE) ORAL CAPSULE

00002246082	**APO-FLUNARIZINE**	**APX**	$	**0.5308**
00000846341	**SIBELIUM**	**PMS**	$	**0.5308**

KETOTIFEN FUMARATE

1 MG (BASE) ORAL TABLET

00002230730	**NOVO-KETOTIFEN**	**NOP**	$	**0.6335**
00000577308	ZADITEN	SQP	$	0.7920

0.2 MG / ML (BASE) ORAL SYRUP

00002176084	**NOVO-KETOTIFEN**	**NOP**	$	**0.1330**
00000600784	ZADITEN	SQP	$	0.1774

LEUCOVORIN CALCIUM

5 MG (BASE) ORAL TABLET

00002170493	LEDERLE LEUCOVORIN CALCIUM	WAY	$	6.2278

10 MG / ML INJECTION

00002087316	LEUCOVORIN CALCIUM	NOP	$	10.4000

MONTELUKAST SODIUM

10 MG (BASE) ORAL TABLET

00002238217	SINGULAIR	MFC	$	2.2067

RESTRICTED BENEFIT - This product is a benefit for patients 6 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients).

4 MG (BASE) ORAL CHEWABLE TABLET

00002243602	SINGULAIR	MFC	$	1.3583

RESTRICTED BENEFIT - This product is a benefit for patients 2 to 18 years of age inclusive for the prophylaxis and treatment of asthma.

5 MG (BASE) ORAL CHEWABLE TABLET

00002238216	SINGULAIR	MFC	$	1.4997

RESTRICTED BENEFIT - This product is a benefit for patients 6 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients).

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00

MONTELUKAST SODIUM

4 MG (BASE) ORAL GRANULE

00002247997	SINGULAIR	MFC	$	1.3583

RESTRICTED BENEFIT - This product is a benefit for patients 2 to 18 years of age inclusive for the prophylaxis and treatment of asthma.

NAFARELIN ACETATE

2 MG / ML (BASE) NASAL SOLUTION

00002188783	SYNAREL	FEI	$	37.6250

PAMIDRONATE DISODIUM

For the products within the following three groupings, pricing has been established on a per vial basis.

30 MG / VIAL INJECTION

00002244550	**PAMIDRONATE DISODIUM**	**HSP**	$	**88.3500**
00002264951	**PAMIDRONATE DISODIUM**	**SDZ**	$	**88.3500**
00002245998	PMS-PAMIDRONATE	PMS	$	93.0000
00002059762	AREDIA	NOV	$	174.3973

60 MG / VIAL INJECTION

00002244551	**PAMIDRONATE DISODIUM**	**HSP**	$	**176.7000**
00002264978	**PAMIDRONATE DISODIUM**	**SDZ**	$	**176.7000**

90 MG / VIAL INJECTION

00002244552	**PAMIDRONATE DISODIUM**	**HSP**	$	**265.0500**
00002264986	**PAMIDRONATE DISODIUM**	**SDZ**	$	**265.0500**
00002245999	PMS-PAMIDRONATE	PMS	$	279.0000
00002059789	AREDIA	NOV	$	523.1810

PENTOSAN POLYSULFATE SODIUM

100 MG ORAL CAPSULE

00002029448	ELMIRON	JOI	$	1.4668

PERGOLIDE MESYLATE

0.05 MG ORAL TABLET

00002123320	PERMAX	LIL	$	0.2723

0.25 MG ORAL TABLET

00002123339	PERMAX	LIL	$	0.9990

1 MG ORAL TABLET

00002123347	PERMAX	LIL	$	3.4056

SODIUM CROMOGLYCATE

100 MG ORAL CAPSULE

00000500895	NALCROM	SAV	$	1.3329

1 % INHALATION SOLUTION

00002231431	**APO-CROMOLYN STERULES**	**APX**	$	**0.2423**
00002231671	**NU-CROMOLYN**	**NXP**	$	**0.2423**
00002046113	**PMS-SODIUM CROMOGLYCATE**	**PMS**	$	**0.2423**

SODIUM FLUORIDE

2.21 MG ORAL CHEWABLE TABLET

00000575569	FLUOR-A-DAY	PMS	$	0.0498

5.56 MG / ML ORAL DROPS

00000610100	FLUOR-A-DAY	PMS	$	0.0975

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00

TAMSULOSIN HCL

0.4 MG ORAL EXTENDED-RELEASE TABLET

00002270102	FLOMAX CR	BOE	$	0.6000

0.4 MG ORAL SUSTAINED-RELEASE CAPSULE

00002281392	**NOVO-TAMSULOSIN**	**NOP**	$	**0.6000**
00002294265	**RATIO-TAMSULOSIN**	**RPH**	$	**0.6000**
00002295121	**SANDOZ TAMSULOSIN**	**SDZ**	$	**0.6000**

TICLOPIDINE HCL

250 MG ORAL TABLET

00002237701	**APO-TICLOPIDINE**	**APX**	$	**0.6885**
00002239744	**GEN-TICLOPIDINE**	**GPM**	$	**0.6885**
00002236848	**NOVO-TICLOPIDINE**	**NOP**	$	**0.6885**
00002237560	**NU-TICLOPIDINE**	**NXP**	$	**0.6885**
00002243587	**SANDOZ TICLOPIDINE**	**SDZ**	$	**0.6885**

ZAFIRLUKAST

RESTRICTED BENEFIT - This product is a benefit for patients 12 to 18 years of age inclusive for the prophylaxis and treatment of asthma. (For eligibility in patients over 18 years of age refer to the Criteria for Special Authorization of Select Drug Products of the List, and Criteria for Special Authorization of Select Drug Products in the Alberta Employment, Immigration and Industry Drug Benefit Supplement for eligibility in Alberta Employment, Immigration and Industry, Alberta Children's Services and Alberta Seniors and Community Supports (AISH) clients).

20 MG ORAL TABLET

00002236606	ACCOLATE	AZC	$	0.7208

94:00 DEVICES

94:00

AEROSOL HOLDING CHAMBER

RESTRICTED BENEFIT - Coverage is limited to one aerosol holding chamber per plan participant per year.

DEVICE

00000990014	SPACE CHAMBER	KGH	$	12.9000
00000990059	OPTICHAMBER	ACM	$	13.2000
00000990080	VORTEX	KGH	$	20.9600
00000999977	AEROCHAMBER PLUS	TMI	$	21.5400
00000990084	AEROCHAMBER MAX	TMI	$	23.5500

AEROSOL HOLDING CHAMBER/MASK

RESTRICTED BENEFIT - Coverage is limited to one of each size (infant, pediatric, adult) aerosol holding chamber mask or chamber w/ mask per plan participant per year.

INFANT DEVICE

00000990081	VORTEX BABY WHIRL INFANT MASK	KGH	$	9.1400
00000990063	OPTICHAMBER SMALL MASK	ACM	$	9.3000
00000990015	SPACE CHAMBER INFANT MASK	KGH	$	13.9800
00000999982	INFANT AEROCHAMBER PLUS W/ MASK	TMI	$	34.4600
00000990087	INFANT AEROCHAMBER MAX W/ MASK	TMI	$	37.6700

PEDIATRIC DEVICE

00000990082	VORTEX SPINNER PEDIATRIC MASK	KGH	$	9.1400
00000990062	OPTICHAMBER MEDIUM MASK	ACM	$	9.3000
00000990016	SPACE CHAMBER PEDIATRIC MASK	KGH	$	13.9800
00000999979	PEDIATRIC AEROCHAMBER PLUS W/ MASK	TMI	$	34.4600
00000990086	CHILD AEROCHAMBER MAX W/ MASK	TMI	$	37.6700

ADULT DEVICE

00000990061	OPTICHAMBER LARGE MASK	ACM	$	11.8000
00000990018	SPACE CHAMBER ADULT LARGE MASK	KGH	$	13.9800
00000990017	SPACE CHAMBER ADULT MASK	KGH	$	13.9800
00000999978	ADULT AEROCHAMBER PLUS W/ MASK	TMI	$	36.4600
00000990085	ADULT AEROCHAMBER MAX W/ MASK	TMI	$	39.8600

DEVICE

DEVICE

00000999949	SEREVENT DISKHALER	GSK	$	5.3300

Appendices

Abbreviations

Pharmaceutical Manufacturers

Appendix 1
Abbreviations

ASA ..... acetylsalicylic acid
ENM..... enema
FC ..... film coated
G ..... gram(s)
HCL ..... hydrochloride

HR..... hour
IU ..... international unit(s)
MCG ..... microgram
MEQ..... milliequivalent

MG ..... milligram
ML..... millilitre
PTH..... patch
SYR ..... syringe

W..... with
%..... percent

Appendix 2
Pharmaceutical Manufacturers

A

ABB Abbott Laboratories Limited
ACM Auto Control Medical Inc.
ALC Alcon Canada Inc.
ALL Allergan Inc.
ALV Alveda Pharmaceuticals Inc.
AMG Amgen Inc.
APX Apotex Inc.
ASP Astellas Pharma Canada, Inc.
ATL Atlas Laboratories Inc.
AVE Aventis Pharma Inc.
AXC Axcan Pharma Inc.
AXS Axxess Pharma Inc.
AZC AstraZeneca Canada Inc.

B

BAI Bayer Inc.
BAX Baxter Corporation
BHP Bayer Healthcare Pharmaceuticals
BIO Biogen Idec Canada Inc
BMS Bristol-Myers Squibb
BOE Boehringer Ingelheim (Canada) Ltd.
BOV Biovail Pharmaceuticals Canada

C

CDX Canderm Pharma Inc.
CHD Church & Dwight Canada
COB Cobalt Pharmaceuticals Inc.
CYT Cytex Pharmaceuticals Inc.

D

DER Dermik Laboratories Canada Inc.
DPC Dominion Pharmacal
DPT Dermtek Pharmaceuticals Ltd.
DUI Duchesnay Inc.

E

ERF ERFA Canada Inc.
ETP Ethypharm Inc.

F

FEI Ferring Inc.

G

GAL Galderma Canada Inc.
GKC GlaxoSmithKline Consumer Healthcare
GLE Glenwood Laboratories Canada Ltd.
GPM Genpharm Inc.
GRC Graceway Canada Company
GSK GlaxoSmithKline

H

HLR Hoffman-La Roche Limited
HSP Hospira Healthcare Corporation

J

JJM Johnson & Johnson - Merck
JOI Janssen-Ortho Inc.

K

KGH Kego Healthcare
KNG King Pharma Canada Ltd.

L

LBC Lundbeck Canada Inc.
LEO Leo Pharma Inc.
LIL Eli Lilly Canada Inc.

M

MCL McNeil Consumer Healthcare
MFC Merck Frosst Canada & Co.

N

NNA Novo Nordisk Canada Inc.
NOP Novopharm Limited
NOV Novartis Pharmaceuticals Canada Inc.
NTI Nucro-Technics Incorporated
NVO Novartis Ophthalmics, Div. of Novartis Pharmaceuticals
NXP Nu-Pharm Inc.
NYC Nycomed Company Inc.

O

ODN Odan Laboratories Ltd.
OMG Omega Laboratories Ltd.
ORG Organon Canada Ltd.
ORY Oryx Pharmaceutical Inc.

P

PAL Paladin Labs Inc.
PDL Pro Doc (Laboratories) Ltd.
PFI Pfizer Canada Inc.
PGA Procter & Gamble Pharmaceuticals Canada Inc.
PHH Pharmel Inc.
PMS Pharmascience Inc.
PPC Pharmaceutical Partners of Canada, a division of Abraxis Bioscience Inc.
PPH Pendopharm Inc.
PRP PremPharm
PRW Prestwick Pharmaceuticals
PUR Purdue Pharma

R

RAN Ranbaxy Pharmaceuticals Canada Inc
ROG Rougier Pharma Inc. (Div. of ratiopharm)
RPH ratiopharm

S

SAV Sanofi-Aventis
SCH Schering Canada Inc.
SDZ Sandoz Canada Inc.
SEV Servier Canada Inc.
SHB Shire Biochem Inc.
SLO Solvay Pharma Inc.
SNE Smith & Nephew Inc.
SQP Squire Pharmaceuticals Inc.
SRO Serono Canada Inc.
STI Stiefel Canada Inc.
STM Sterimax Inc.

T

TAR Taro Pharmaceuticals Inc.
TCD Trans Canaderm Inc. (Subsid. of Stiefel)
TMD Theramed Corporation
TMI Trudell Medical International
TMP Teva Neuroscience
TPI Triton Pharma Inc.
TPT Taropharma, A Div. of Taro Pharmaceuticals Inc.

V

VCL Valeant Canada Limittee/Limited
VIR Virco Pharmaceuticals (Canada) Co.
VLP Valeo Pharma Inc.

W

WAY Wyeth Pharmaceuticals
WSD Westwood Squibb (Div. Bristol-Myers Squibb Canada)
WSP Wellspring Pharmaceutical Canada Corp.

X

XXX Miscellaneous Manufacturers

Z

ZMC Zymcan Pharmaceuticals Inc.

Indices

Alphabetical List of Pharmaceutical Products

Numerical List by Drug Identification Number

ALPHABETICAL LIST OF PHARMACEUTICAL PRODUCTS

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DRUG IDENTIFICATION NUMBERS OF PHARMACEUTICAL PRODUCTS