

Alberta Health and Wellness Drug Benefit List

Revised October 1, 2007



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

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

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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

5 MG / ML INJECTION

00000870420 FLAGYL

00000649074 METRONIDAZOLE

10	●	APX	\$0.0575	\$	0.0575	●	12
	●	BAX	\$0.0176	\$	0.0189	●	14
		HSP	\$0.1421	\$	0.1421		

1 28:00 CENTRAL NERVOUS SYSTEM DRUGS

2 28:08:04 ANALGESICS & ANTIPYRETICS (NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)

3 NAPROXEN

4 750 MG ORAL SUSTAINED-RELEASE TABLET

00002177072 APO-NAPROXEN SR

5 00002231327 NOVO-NAPROX

00002162466 NAPROSYN SR

APX \$ 0.7604 \$ 0.7604

NOP \$ 0.7604 \$ 0.7604

HLR \$ 1.2698 \$ 1.3650

MAC pricing has been applied based on the LCA price for 2 x 375 mg oral tablets, \$0.2916. 16

68:00 HORMONES & SYNTHETIC SUBSTITUTES

68:16 ESTROGENS

CONJUGATED ESTROGENS

0.625 MG ORAL TABLET

00000265470 C.E.S. 13

00002043408 PREMARIN

VCL \$ 0.0972 \$ 0.1045

WAY \$ 0.1215 \$ 0.1215

84:00 SKIN & MUCOUS MEMBRANE PREPARATIONS

84:06 ANTI-INFLAMMATORY AGENTS 17

7 HYDROCORTISONE ACETATE/ UREA

8 1% * 10% TOPICAL CREAM

00000503134 UREMOL-HC 9

TCD \$ 0.6110 \$ 0.1730

HYDROCORTISONE

1% TOPICAL CREAM

00000192597 EMO-CORT

6 00002086034 BARRIERE-HC

TCD \$ 0.1582 \$ 0.1700

SHB \$ 0.3980 \$ 0.3980

1% TOPICAL LOTION

6 00000578541 SARNA HC

00000192600 EMO-CORT

STI \$ 0.0863 \$ 0.0928

TCD \$ 0.1462 \$ 0.1572 11

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00

15 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 (ECDT), 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.

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
POLICIES AND GUIDELINES**

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 (NCRP). 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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
POLICIES AND GUIDELINES**

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

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- 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

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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

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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

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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*,

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- 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 products¹ and product line extensions - if the product price offers savings to government-sponsored drug programs² 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 programs² of \$500,000 per year over the least cost alternative (LCA) price.

¹For 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.

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

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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 II, 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.

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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 equivalent¹ as defined by the *AHWDBL* criteria.
3. The drug product has been demonstrated to be bioequivalent¹ 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.

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- 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*,

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- 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.

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
POLICIES AND GUIDELINES**

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 Informationagree 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**

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-source¹ 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 <i>AHWDBL</i>
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 nebulas
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), Pegatron/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.
- *Pegatron/Pegasys RBV Special Authorization Request Form (ABC 30932)* - All requests for Pegatron (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.

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
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- *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.



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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> 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
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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, used 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.

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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.

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		<input type="checkbox"/> Alberta Blue Cross
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			<input type="checkbox"/> Alberta Employment, Immigration and Industry
				<input type="checkbox"/> Alberta Children's Services
				<input type="checkbox"/> Alberta Seniors and Community Supports
				<input type="checkbox"/> Other
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: <input type="checkbox"/> Aricept <input type="checkbox"/> Exelon <input type="checkbox"/> Reminyl ER	Please confirm the diagnosis for which this drug is requested: For the treatment of: <input type="checkbox"/> Dementia of the Alzheimer's Type <input type="checkbox"/> other, please specify: _____
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Please provide a recent MMSE score and the date the exam was administered: MMSE Score: _____ Date of exam: _____	Please confirm request type: <input type="checkbox"/> request for Aricept, Exelon or Reminyl ER for a new* patient, (i.e. a patient who has either: never taken the <u>requested</u> drug before, <u>or</u> , has taken it for 60 days or less). <input type="checkbox"/> request for an existing Aricept, Exelon or Reminyl ER patient (i.e. a patient who has already been on the <u>requested</u> 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
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

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.

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

PATIENT INFORMATION					COVERAGE TYPE:
PATIENT SURNAME	FIRST NAME	INITIAL			<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> 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: <input type="checkbox"/> stroke <input type="checkbox"/> TIA <input type="checkbox"/> other (specify): _____

Criteria for Post-Stent Coverage of PLAVIX	Section II (Must complete for requests for post-stent coverage of Plavix)
<p>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. *</p> <p>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. *</p> <p>* 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.</p>	<p>Please indicate the type and date of the stent:</p> <p>Date of stenting procedure: _____</p> <p><input type="checkbox"/> bare metal stent (1 month of coverage)</p> <p><input type="checkbox"/> drug eluting stent (12 months of coverage)</p> <p>For additional coverage, please proceed to Section III below</p>

Other Criteria for Coverage of PLAVIX
<p>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.</p> <p>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.</p> <p>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.</p>

Section III (For Plavix requests, complete ALL that apply)
Does this patient have a contraindication/intolerance to ASA? <input type="checkbox"/> YES <input type="checkbox"/> NO

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

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		<input type="checkbox"/> Alberta Blue Cross
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			<input type="checkbox"/> Alberta Employment, Immigration and Industry
				<input type="checkbox"/> Alberta Children's Services
				<input type="checkbox"/> Alberta Seniors and Community Supports
				<input type="checkbox"/> Other
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: <ul style="list-style-type: none"> • 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
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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.
ABC 30888 (R2007/10) ©The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan.

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



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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> Other		
DATE OF BIRTH: Year / Month / Day		ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS		CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:	PATIENT CONSENT:
<p>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 <i>Alberta Post-Marketing Study Addressing REMICADE ("Study")</i>. 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.</p>	<p>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.</p> <p>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.</p> <p>Signature/Effective Date _____ Patient's Signature _____</p>

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: <input type="checkbox"/> Severe Active Crohn's <input type="checkbox"/> Fistulizing Crohn's <input type="checkbox"/> Other (specify)	Patient's current weight (kg):	Dosage of Remicade requested (mg/kg):
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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: _____
Identify if surgery has been <input type="checkbox"/> tried <input type="checkbox"/> contemplated <input type="checkbox"/> not indicated (specify why not)	Previous medications utilized (For ALL requests): dose, duration & response is required for BOTH of the following : Glucocorticoid(s) (specify drug name) : 5-ASA :	

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: <ul style="list-style-type: none"> ▪ 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
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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, used 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. ABC 30901 (R04/2007) ©The Blue Cross symbol and name are registered marks of the Canadian Association of Blue Cross Plans, an association of independent Blue Cross plans. Licensed to ABC Benefits Corporation for use in operating the Alberta Blue Cross Plan.

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.



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 table with fields: PATIENT SURNAME, FIRST NAME, INITIAL, DATE OF BIRTH, ALBERTA PERSONAL HEALTH NUMBER, STREET ADDRESS, CITY, PROV, POSTAL CODE, COVERAGE TYPE, IDENTIFICATION/CLIENT/COVERAGE No.

NOTIFICATION and PATIENT CONSENT sections. Includes text about eligibility and consent, and signature lines for Patient's Signature and Signature/Effective Date.

PHYSICIAN INFORMATION table with fields: RHEUMATOLOGY SPECIALIST SURNAME, FIRST NAME, INITIAL, PHONE, FAX, COLLEGE OF PHYSICIANS AND SURGEONS REGISTRATION NO., STREET ADDRESS, CITY, PROVINCE, POSTAL CODE.

Please provide the following information for ALL requests: Diagnosis, Patient's current weight, Indicate requested drug, Dosage, Scores, and Will the patient be maintained on methotrexate...

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, 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, used 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.

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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> 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 EZETROL

<p><i>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;</i></p> <p><i>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*</i></p>	<p>*High cardiovascular risk is as defined by possessing one of the following:</p> <ol style="list-style-type: none"> 1) <i>pre-existing cardiovascular disease and/or cerebrovascular disease, or</i> 2) <i>diabetes, or</i> 3) <i>familial hypercholesterolemia, or</i> 4) <i>three or more of the following risk factors:</i> <ul style="list-style-type: none"> • <i>family history of premature cardiovascular disease</i> • <i>smoking</i> • <i>hypertension</i> • <i>obesity</i> • <i>glucose intolerance</i> • <i>renal disease.</i>
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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
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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.

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	
DATE OF BIRTH: Year / Month / Day		ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS		CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:
<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> Other					

NOTIFICATION:	PATIENT CONSENT:
<p>You may be eligible to receive Pegatron 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.</p>	<p>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.</p>
	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:	Diagnosis of chronic hepatitis C:	Evidence of active liver disease:
<input type="checkbox"/> Pegatron <input type="checkbox"/> Pegasys RBV	<p>Both:</p> <p>a) is the patient anti-HCV positive, pre-treatment..... <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Tested</p> <p>AND:</p> <p>b) is the patient serum HCV RNA positive (by PCR), pre treatment..... <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Tested</p> <p>If the patient is anti-HCV negative but serum HCV RNA positive, please explain: _____</p>	<p>Either:</p> <p>a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Tested</p> <p>OR:</p> <p>b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Tested</p> <p>If patient is currently on Pegatron or Pegasys RBV Year / Month / Day indicate start date: _____</p>

INITIAL REQUEST:	EXTENSION REQUEST:
<p>Initial length of approval:</p> <input type="checkbox"/> Advanced fibrosis or cirrhosis (regardless of genotype)..... 48 weeks <input type="checkbox"/> Genotype 1 14 weeks Is a baseline serum sample stored for future testing? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Genotype 2 or 3 with HIV co-infection 14 weeks Is a baseline serum sample stored for future testing? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Genotype 1, 2 or 3 post-liver transplant ... 26 weeks <hr/> <p>Initial and maximum length of approval:</p> <input type="checkbox"/> Genotype 2 or 3 (not co-infected with HIV) ... 24 weeks <input type="checkbox"/> Genotype 4, 5 or 6 48 weeks	<p>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? <input type="checkbox"/> YES Patient may be eligible for additional 34 weeks of coverage (total 48 wks) <input type="checkbox"/> NO → Has the patient achieved a reduction of viral load by at least 2 logs (100 fold)? <input type="checkbox"/> 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 <input type="checkbox"/> NO </p> <p>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? <input type="checkbox"/> YES <input type="checkbox"/> NO The patient may be eligible for a total of 48 weeks of therapy. </p>

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.

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	
DATE OF BIRTH: Year / Month / Day		ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS		CITY	PROV	POSTAL CODE	
<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> Other					
IDENTIFICATION/CLIENT/COVERAGE No:					
NOTIFICATION:			PATIENT CONSENT:		
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.			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			CRITERIA 2		
Diagnosis of chronic hepatitis C: a) is the patient anti-HCV positive, pre-treatment..... YES NO Not Tested <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AND: b) is the patient serum HCV RNA positive (by PCR), pre treatment..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If the patient is anti-HCV negative but serum HCV RNA positive, please explain:			Evidence of active liver disease, either: a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment YES NO Not Tested <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> OR: b) does the patient have an abnormal liver biopsy (inflammation and/or fibrosis) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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: <input type="checkbox"/> patient has contraindication to use of ribavirin <input type="checkbox"/> patient experienced intolerance to ribavirin <input type="checkbox"/> 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 <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 3 <input type="checkbox"/> Other <input type="checkbox"/> _____	Please confirm whether previous therapy has been tried: <input type="checkbox"/> No previous treatment with interferon alfa monotherapy or ribavirin/interferon alfa (naive patient). <input type="checkbox"/> Previous treatment with interferon alfa monotherapy and the patient: <input type="checkbox"/> has since relapsed <input type="checkbox"/> did not respond <input type="checkbox"/> Previous treatment with ribavirin / interferon alfa combination therapy, and the patient: <input type="checkbox"/> has since relapsed <input type="checkbox"/> 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.					

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.



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: PATIENT SURNAME, FIRST NAME, INITIAL, DATE OF BIRTH, 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 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. 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

SECTION 1: Diagnosis of chronic hepatitis C: a) is the patient anti-HCV positive, pre-treatment... YES NO Not Tested; AND: b) is the patient serum HCV RNA positive (by PCR), pre-treatment... Evidence of active liver disease, either: a) does the patient have elevated liver enzymes (ALT and/or AST), pre-treatment... YES NO Not Tested; OR: 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.



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	
DATE OF BIRTH: Year / Month / Day		ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS		CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:
<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> Other					

NOTIFICATION:			PATIENT CONSENT:		
<p>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 <i>Alberta Post-Marketing Study Addressing ENBREL ("Study")</i>. 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.</p> <p>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.</p>			<p>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.</p> <p>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.</p>		
			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:			Date of assessment for the following JRA30 criteria:		
<input type="checkbox"/> Polyarticular Juvenile Rheumatoid Arthritis <input type="checkbox"/> Other (specify) _____			MD global assessment (0-10)	Patient global assessment (0-10)	
Patient's current weight (kg): _____			No. of joints with active RA	CHAQ (1-4)	
Enbrel dosage requested (mg/kg): _____			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:	
				<ul style="list-style-type: none"> 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 	
<input type="checkbox"/> 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.					

The information collected, used and disclosed by this Request Form is collected, used 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.
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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.



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	
DATE OF BIRTH: Year / Month / Day		ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS		CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:
<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> Other					

NOTIFICATION:		PATIENT CONSENT:	
<p>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 <i>Alberta Post-Marketing Study Addressing ENBREL/HUMIRA/KINERET/REMICADE</i> ("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.</p> <p>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.</p>		<p>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.</p> <p>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.</p>	
		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:		Indicate requested drug:	Dosage:
<input type="checkbox"/> Polyarticular Psoriatic Arthritis <input type="checkbox"/> Pauciarticular Psoriatic Arthritis → Joints affected: <input type="checkbox"/> Knee joint(s) <input type="checkbox"/> Hip joint(s) <input type="checkbox"/> Other (specify) <input type="checkbox"/> Other (specify)		<input type="checkbox"/> Enbrel <input type="checkbox"/> Humira	Dosing Frequency:
Scores: * DAS28 Score ____ OR <input type="checkbox"/> ACR20 (renewals only) Date: ____ AND HAQ Score ____ Date: ____		Please provide reason if a switch to a different biologic agent is requested:	
* 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.			
Will the patient be maintained on methotrexate in combination with the requested biologic? <input type="checkbox"/> YES <input type="checkbox"/> 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
<input type="checkbox"/> 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, used 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.

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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.

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		<input type="checkbox"/> Alberta Blue Cross
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			<input type="checkbox"/> Alberta Employment, Immigration and Industry
				<input type="checkbox"/> Alberta Children's Services
				<input type="checkbox"/> Alberta Seniors and Community Supports
				<input type="checkbox"/> Other
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.

<input type="checkbox"/> CIPROFLOXACIN Respiratory Tract Infection: <input type="checkbox"/> End stage COPD with or without bronchiectasis, where there has been documentation of previous <i>Pseudomonas aeruginosa</i> colonization/infection <input type="checkbox"/> Pneumonic illness in cystic fibrosis Genitourinary Tract Infection: <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Prostatitis <input type="checkbox"/> Prophylaxis of urinary tract surgical procedures <input type="checkbox"/> Gonococcal infection Skin & Soft Tissue / Bone & Joint Infection: <input type="checkbox"/> Malignant / invasive otitis externa <input type="checkbox"/> Bone / joint infection due to gram-negative organism(s) <input type="checkbox"/> Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole, e.g. diabetic foot infection, decubitus ulcers Gastrointestinal Tract Infection: <input type="checkbox"/> Bacterial gastroenteritis where antimicrobial therapy is indicated <input type="checkbox"/> Typhoid fever (enteric fever) <input type="checkbox"/> Therapy / step-down therapy of polymicrobial infection in combination with clindamycin or metronidazole, e.g. intra-abdominal infections Other: <input type="checkbox"/> Prophylaxis of adult contacts of cases of invasive meningococcal disease <input type="checkbox"/> Therapy / step-down therapy of hospital acquired gram-negative infections <input type="checkbox"/> Empiric therapy of febrile neutropenia in combination with other appropriate agents <input type="checkbox"/> Exception case of allergy or intolerance to all other appropriate therapies as defined by relevant guidelines/references, i.e. AMA CPGs or Bugs & Drugs <p align="center">↓</p> <i>Please specify details:</i> _____ <input type="checkbox"/> For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases	<input type="checkbox"/> LEVOFLOXACIN* <input type="checkbox"/> MOXIFLOXACIN <input type="checkbox"/> 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 <input type="checkbox"/> 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) <input type="checkbox"/> Acute exacerbation of chronic bronchitis after failure of first <u>and</u> second line therapy, as defined by clinical deterioration after 72 hours of antibiotic therapy or lack of improvement after completion of antibiotic therapy <input type="checkbox"/> 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 <input type="checkbox"/> For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases <p>*only Levofloxacin 250 mg and 500 mg may be considered for coverage.</p> <input type="checkbox"/> OFLOXACIN <input type="checkbox"/> Pelvic inflammatory disease <input type="checkbox"/> Epididymo-orchitis/epididymitis most likely due to enteric organisms <input type="checkbox"/> For the treatment of Chlamydial infection <input type="checkbox"/> For the treatment of Gonococcal infection <input type="checkbox"/> For use in other current Health Canada approved indications when prescribed by a specialist in Infectious Diseases
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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
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ONCE YOU HAVE CONFIRMED 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, used 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.
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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.



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	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> 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:

<p>Indicate which drug is requested (check ONE box)*:</p> <input type="checkbox"/> Alendronate (10mg, 70mg oral tablets) <input type="checkbox"/> Raloxifene <input type="checkbox"/> Risedronate <input type="checkbox"/> Synthetic Calcitonin Salmon <p>*Coverage cannot be provided for two or more osteoporosis medications (alendronate, calcitonin, etidronate, raloxifene, risedronate) when intended for use as combination therapy.</p>	<p>Diagnosis:</p> <input type="checkbox"/> For the treatment of Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Bone pain secondary to: _____ <input type="checkbox"/> 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
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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, used 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.
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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."

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.

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		<input type="checkbox"/> Alberta Blue Cross
DATE OF BIRTH: Year / Month / Day	ALBERTA PERSONAL HEALTH NUMBER			<input type="checkbox"/> Alberta Employment, Immigration and Industry
				<input type="checkbox"/> Alberta Children's Services
				<input type="checkbox"/> Alberta Seniors and Community Supports
				<input type="checkbox"/> Other
STREET ADDRESS	CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

NOTIFICATION:	PATIENT CONSENT:
<p>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.</p>	<p>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.</p>
	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 :

<p>Please provide the indication/diagnosis:</p> <p><input type="checkbox"/> For the treatment of chronic hepatitis B: Does the patient have decompensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Other (please specify): _____</p>	<p>If patient is currently on Pegasys, indicate start date: Year / Month / Day</p>
--	---	--

SECTION 2 :

a) Hepatitis B surface antigen (HBsAg):

Is the patient hepatitis B surface antigen (HBsAg) positive?	YES	NO	Not Tested
Has the patient been (HBsAg) positive > 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	

b) ALT Levels / Liver Biopsy:

Does the patient have elevated pre-treatment serum ALT levels?	YES	NO	Not Tested
Are the levels ≥ 2 times the upper limit of normal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please explain): _____	<input type="checkbox"/>	<input type="checkbox"/>	

OR:

Does the patient have a liver biopsy showing grade 1 or worse inflammation consistent with chronic hepatitis B?.....

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HBV DNA >500,000 copies/mL (>100,000 IU/mL)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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
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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.

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			<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> 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
<p>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</p> <p>For patients who have a documented history of ulcers proven radiographically and/or endoscopically.</p>

Please provide the following information for ALL requests (check ALL that apply):			
1) a) Is this patient at high risk of upper GI complications?	<input type="checkbox"/> Yes; (If Yes, proceed to 1b)	<input type="checkbox"/> No	
b) Does this patient have a proven history of prior complicated GI events (e.g. GI perforation, obstruction, or major bleeding)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2) a) Does this patient have a documented history of ulcers?	<input type="checkbox"/> Yes; (If Yes, proceed to 2b)	<input type="checkbox"/> No	
b) Have the ulcers been proven radiographically and/or endoscopically?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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
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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.

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

PATIENT INFORMATION				COVERAGE TYPE:	
PATIENT SURNAME	FIRST NAME	INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Employment, Immigration and Industry <input type="checkbox"/> Alberta Children's Services <input type="checkbox"/> Alberta Seniors and Community Supports <input type="checkbox"/> 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
<p>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).</p> <p><i>Please note: Coverage cannot be considered for palliative patients.</i></p>	<p>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).</p> <p>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).</p> <p>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).</p> <p>For the treatment of patients undergoing Peripheral Blood Progenitor Cell (PBPC) collection and therapy when prescribed by a designated prescriber.</p> <p><i>Please note for the first criterion: Coverage cannot be considered for palliative patients.</i></p>

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
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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.

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

ADALIMUMAB

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

ADALIMUMAB

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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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.

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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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
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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
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20 % TOPICAL LOTION

00000187585	BENOXYL	STI	\$	0.2102
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10 % TOPICAL (ALCOHOL) GEL

00000263699	PANOXYL 10	STI	\$	0.1478
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15 % TOPICAL (ALCOHOL) GEL

00000403571	PANOXYL 15	STI	\$	0.1788
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20 % TOPICAL (ALCOHOL) GEL

00000373036	PANOXYL 20	STI	\$	0.1926
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10 % TOPICAL (WATER) GEL

00001908871	DESQUAM-X	WSD	\$	0.1515
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10 % TOPICAL BAR

00000527661	PANOXYL	STI	\$	0.0905
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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
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**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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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
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1 MG / ML (BASE) INJECTION

00002225166	SUPREFACT	SAV	\$	10.6064
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6.3 MG (BASE) INJECTION IMPLANT

00002228955	SUPREFACT DEPOT	SAV	\$	720.2500
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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
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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
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70 MG / VIAL INJECTION

00002244266	CANCIDAS	MFC	\$	567.0000
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CEFADROXIL

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

500 MG ORAL CAPSULE

00002240774	APO-CEFADROXIL	APX	\$	0.8421
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00000507245	DURICEF	BMS	\$	0.8421
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00002235134	NOVO-CEFADROXIL	NOP	\$	0.8421
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ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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				
<input checked="" type="checkbox"/> 00002248472	BENZACLIN	SAV	\$	0.9180
<input checked="" type="checkbox"/> 00002243158	CLINDOXYL	STI	\$	0.9267

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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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
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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
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DANAPAROID SODIUM

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

1,250 UNIT / ML INJECTION

00002129043	ORGARAN	ORG	\$	32.2417
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**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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/Epex 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
<i>For this product - pricing has been established on a per millilitre basis.</i>			
200 MCG / ML INJECTION SYRINGE			
00002246358	ARANESP (0.3/ 0.4/ 0.5/ 0.65 ML SYR)	AMG	\$ 576.2000
<i>For this product - pricing has been established on a per millilitre basis.</i>			
500 MCG / ML INJECTION SYRINGE			
00002246360	ARANESP (0.3/0.4/0.6/1.0 ML SYR)	AMG	\$ 1483.5000
<i>For this product - pricing has been established on a per millilitre basis.</i>			

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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) OPTHALMIC 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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
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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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
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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
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ERYTHROMYCIN/ TRETINOIN

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

4 % * 0.01 % TOPICAL GEL

00002015994	STIEVAMYCIN MILD	STI	\$	0.5590
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4 % * 0.025 % TOPICAL GEL

00001905112	STIEVAMYCIN REGULAR	STI	\$	0.5590
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4 % * 0.05 % TOPICAL GEL

00001945262	STIEVAMYCIN FORTE	STI	\$	0.6428
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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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
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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:

- global assessment of the severity of the disease by the Pediatric RA Specialist,
- global assessment of overall well-being by the patient or parent,
- number of active joints (joints with swelling not due to deformity or joints with limitation of motion with pain tenderness or both),
- number of joints with limitation of motion,
- functional ability based on CHAQ scores,
- 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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
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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
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50 MG / SYR INJECTION SYRINGE

00002274728	ENBREL	AMG	\$	401.2614
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Note: 1 x 50 mg syringe is interchangeable with 2 x 25 mg vials

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

FILGRASTIM

"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 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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
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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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

INFLIXIMAB

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

- Immunosuppressive 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

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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
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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
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ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
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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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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5 MG / ML INJECTION

00000727695	LUPRON	ABB	\$	67.6464
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7.5 MG / VIAL INJECTION

00000836273	LUPRON DEPOT	ABB	\$	387.9700
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11.25 MG / VIAL INJECTION

00002239834	LUPRON DEPOT	ABB	\$	975.8000
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22.5 MG / VIAL INJECTION

00002230248	LUPRON DEPOT	ABB	\$	1071.0000
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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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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1 G / VIAL INJECTION

00002218496	MERREM	AZC	\$	48.7000
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**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
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ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

**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
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ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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.

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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180 MCG / SYR INJECTION SYRINGE

00002248077	PEGASYS (0.5 ML SYRINGE)	HLR	\$ 425.5300
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ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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 Pegatron/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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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/ribavirin 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 Pegatron/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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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118.4 MCG / VIAL INJECTION

00002242967	UNITRON-PEG	SCH	\$ 395.8500
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177.6 MCG / VIAL INJECTION

00002242968	UNITRON-PEG	SCH	\$ 395.8500
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222 MCG / VIAL INJECTION

00002242969	UNITRON-PEG	SCH	\$ 395.8500
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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.

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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/ribavirin 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 Pegatron/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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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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
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30 MG ORAL TABLET

00002239146	ACTONEL	PGA	\$	12.2227
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35 MG ORAL TABLET

00002246896	ACTONEL	PGA	\$	10.0620
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ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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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
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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
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4 MG ORAL EXTENDED-RELEASE CAPSULE

00002244613	DETROL LA	PFI	\$	1.9567
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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

<input checked="" type="checkbox"/> 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
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**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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	VANCOGIN	LIL	\$	7.6341
250 MG (BASE) ORAL CAPSULE				
00000788716	VANCOGIN	LIL	\$	15.2677

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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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
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2.5 MG ORAL DISPERSIBLE TABLET

00002243045	ZOMIG RAPIMELT	AZC	\$ 13.3400
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5 MG / DOSE NASAL UNIT DOSE SPRAY

00002248993	ZOMIG	AZC	\$ 13.3333
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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 <i>Alberta Health and Wellness Drug Benefit List</i> .				
SIGNATURE OF PRESCRIBER (required): <input checked="" type="checkbox"/>			DATE:	
This information is collected and will be used pursuant to Sections 22 and 27 of the Health Information Act, for coverage under the <i>Alberta Health and Wellness Drug Benefit List</i> , program evaluation; research and management; and monitoring compliance with coverage criteria.				

PLEASE RETURN YOUR COMPLETED REGISTRATION BY FAX TO 1-877-305-9911

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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS

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
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500 MG ORAL TABLET

00002236842	LEVAQUIN	JOI	\$	5.5743
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**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
CRITERIA FOR OPTIONAL SPECIAL AUTHORIZATION OF SELECT DRUG PRODUCTS**

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
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TRIMEPRAZINE TARTRATE**2.5 MG (BASE) ORAL TABLET**

00001926306	PANECTYL	ERF	\$	0.2580
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5 MG (BASE) ORAL TABLET

00001926292	PANECTYL	ERF	\$	0.3225
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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
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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
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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
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1 G / VIAL (BASE) INJECTION

00002108127	STERILE CEFAZOLIN SODIUM	NOP	\$	6.0000
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10 G / VIAL (BASE) INJECTION

00002108135	STERILE CEFAZOLIN SODIUM	NOP	\$	56.0000
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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 CEZIL BMS \$ 1.6491

500 MG ORAL TABLET

00002293005 APO-CEFPROZIL APX \$ 2.2214

00002293536 RAN-CEFPROZIL RAN \$ 2.2214

00002163667 CEZIL BMS \$ 3.2337

25 MG / ML ORAL SUSPENSION

00002293943 APO-CEFPROZIL APX \$ 0.1107

00002163675 CEZIL BMS \$ 0.1611

50 MG / ML ORAL SUSPENSION

00002293951 APO-CEFPROZIL APX \$ 0.2213

00002293579 RAN-CEFPROZIL RAN \$ 0.2213

00002163683 CEZIL 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

CEFTRIAZONE SODIUM**0.25 G / VIAL (BASE) INJECTION**

00000657387 ROCEPHIN HLR \$ 11.8950

1 G / VIAL (BASE) INJECTION

00002292270 CEFTRIAZONE FOR INJECTION USP SDZ \$ 23.8000

00000657417 ROCEPHIN HLR \$ 37.6250

2 G / VIAL (BASE) INJECTION

00002292289 CEFTRIAZONE FOR INJECTION USP SDZ \$ 46.9000

10 G / VIAL (BASE) INJECTION

00000851957 ROCEPHIN HLR \$ 328.9500

08:00 ANTI-INFECTIVE AGENTS08:12:06 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
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500 MG ORAL CAPSULE

00000342114	NOVO-LEXIN	NOP	\$	0.2986
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25 MG / ML ORAL SUSPENSION

00000342106	NOVO-LEXIN	NOP	\$	0.0323
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50 MG / ML ORAL SUSPENSION

00000342092	NOVO-LEXIN	NOP	\$	0.0655
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08:00 ANTI-INFECTIVE AGENTS08:12:08 ANTIBIOTICS
(CHLORAMPHENICOL)**CHLORAMPHENICOL SODIUM SUCCINATE**

1 G / VIAL (BASE) INJECTION

00000312363	CHLOROMYCETIN	ERF	\$	13.3750
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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
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500 MG ORAL TABLET

00002126710	BIAXIN BID	ABB	\$	3.1819
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500 MG ORAL EXTENDED-RELEASE TABLET

00002244756	BIAXIN XL	ABB	\$	2.5144
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25 MG / ML ORAL SUSPENSION

00002146908	BIAXIN	ABB	\$	0.2786
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50 MG / ML ORAL SUSPENSION

00002244641	BIAXIN	ABB	\$	0.5572
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ERYTHROMYCIN**250 MG ORAL TABLET**

00000682020	APO-ERYTHRO BASE	APX	\$	0.1786
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250 MG ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000726672	APO-ERYTHRO E-C	APX	\$	0.3810
00000607142	ERYC	PFI	\$	0.5176

333 MG ORAL CAPSULE (ENTERIC-COATED PELLETT)

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
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50 MG / ML (BASE) ORAL SUSPENSION

00000262595	NOVO-RYTHRO ESTOLATE	NOP	\$	0.0713
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ERYTHROMYCIN ETHYLSUCCINATE**600 MG (BASE) ORAL TABLET**

00000637416	APO-ERYTHRO-ES	APX	\$	0.3248
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40 MG / ML (BASE) ORAL SUSPENSION

00000605859	NOVO-RYTHRO EES	NOP	\$	0.0674
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80 MG / ML (BASE) ORAL SUSPENSION

00000652318	NOVO-RYTHRO EES	NOP	\$	0.1044
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08:00 ANTI-INFECTIVE AGENTS08:12:12 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 AGENTS08:12:16 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
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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
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AMPICILLIN SODIUM

250 MG / VIAL (BASE) INJECTION

00000872644	AMPICILLIN SODIUM	NOP	\$	2.0500
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500 MG / VIAL (BASE) INJECTION

00000872652	AMPICILLIN SODIUM	NOP	\$	2.1500
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1 G / VIAL (BASE) INJECTION

00001933345	AMPICILLIN SODIUM	NOP	\$	3.6000
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2 G / VIAL (BASE) INJECTION

00001933353	AMPICILLIN SODIUM	NOP	\$	7.2000
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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
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1 G / VIAL (BASE) INJECTION

00001975447	CLOXACILLIN SODIUM	NOP	\$	2.9500
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2 G / VIAL (BASE) INJECTION

00001912410	CLOXACILLIN SODIUM	NOP	\$	3.8500
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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 AGENTS08:12:24 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 AGENTS08:12:28 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
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CLINDAMYCIN PHOSPHATE

150 MG / ML (BASE) INJECTION

<input checked="" type="checkbox"/> 00002230535	CLINDAMYCIN (60 & 120 ML)	SDZ	\$	3.2585
00002230540	CLINDAMYCIN	SDZ	\$	3.3250
00000260436	DALACIN C PHOSPHATE	PFI	\$	4.3162

08:00 ANTI-INFECTIVE AGENTS08:12:28 ANTIBIOTICS
(MISCELLANEOUS ANTIBIOTICS)**COLISTIMETHATE SODIUM**

150 MG / VIAL INJECTION

00002244849	COLISTIMETHATE FOR INJECTION	STM	\$	33.8088
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SODIUM FUSIDATE

250 MG ORAL TABLET

00001934252	FUCIDIN (FC)	LEO	\$	1.2094
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VANCOMYCIN HCL

500 MG / VIAL (BASE) INJECTION

00002241820	PMS-VANCOMYCIN	PMS	\$	31.0500
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1 G / VIAL (BASE) INJECTION

00002241821	PMS-VANCOMYCIN	PMS	\$	58.9500
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08:00 ANTI-INFECTIVE AGENTS

08:18 ANTIVIRALS

ACYCLOVIR

200 MG ORAL TABLET

00002207621	APO-ACYCLOVIR	APX	\$	0.8783
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00002242784	GEN-ACYCLOVIR	GPM	\$	0.8783
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00002285959	NOVO-ACYCLOVIR	NOP	\$	0.8783
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00002197405	NU-ACYCLOVIR	NXP	\$	0.8783
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00002078627	RATIO-ACYCLOVIR	RPH	\$	0.8783
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00000634506	ZOVIRAX	GSK	\$	1.3687
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400 MG ORAL TABLET

00002207648	APO-ACYCLOVIR	APX	\$	1.7288
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00002242463	GEN-ACYCLOVIR	GPM	\$	1.7288
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00002285967	NOVO-ACYCLOVIR	NOP	\$	1.7288
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00002197413	NU-ACYCLOVIR	NXP	\$	1.7288
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00002078635	RATIO-ACYCLOVIR	RPH	\$	1.7288
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00001911627	ZOVIRAX	GSK	\$	2.6943
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800 MG ORAL TABLET

00002207656	APO-ACYCLOVIR	APX	\$	2.8557
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00002242464	GEN-ACYCLOVIR	GPM	\$	2.8557
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00002285975	NOVO-ACYCLOVIR	NOP	\$	2.8557
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00002197421	NU-ACYCLOVIR	NXP	\$	2.8557
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00002078651	RATIO-ACYCLOVIR	RPH	\$	2.8557
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00001911635	ZOVIRAX	GSK	\$	5.2980
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40 MG / ML ORAL SUSPENSION

00000886157	ZOVIRAX	GSK	\$	0.2387
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GANCICLOVIR SODIUM

500 MG / VIAL (BASE) INJECTION

00002162695	CYTOVENE	HLR	\$	44.3060
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VALACYCLOVIR

500 MG ORAL TABLET

00002219492	VALTREX (CAPLET)	GSK	\$	3.3097
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08:00 ANTI-INFECTIVE AGENTS**08:20 ANTIMALARIAL AGENTS****CHLOROQUINE PHOSPHATE**

250 MG ORAL TABLET

00000021261	NOVO-CHLOROQUINE	NOP	\$	0.3208
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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
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PYRIMETHAMINE

25 MG ORAL TABLET

00000004774	DARAPRIM	GSK	\$	1.2654
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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
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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
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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
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PILOCARPINE HCL

5 MG ORAL TABLET

00002216345	SALAGEN	PFI	\$	1.1739
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PYRIDOSTIGMINE BROMIDE

60 MG ORAL TABLET

00000869961	MESTINON	VCL	\$	0.4617
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180 MG ORAL SUSTAINED-RELEASE TABLET

00000869953	MESTINON-SR	VCL	\$	1.0102
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12:00 AUTONOMIC DRUGS12:08:04 ANTICHOLINERGIC AGENTS
(ANTIPARKINSONIAN AGENTS)**BENZTROPINE MESYLATE**

1 MG ORAL TABLET

00000706531	PMS-BENZTROPINE	PMS	\$	0.0207
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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
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PROCYCLIDINE HCL

2.5 MG ORAL TABLET

00000649392	PMS-PROCYCLIDINE	PMS	\$	0.0555
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5 MG ORAL TABLET

00000587354	PMS-PROCYCLIDINE	PMS	\$	0.0255
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0.5 MG / ML ORAL ELIXIR

00000587362	PMS-PROCYCLIDINE	PMS	\$	0.0313
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TRIHEXYPHENIDYL HCL

2 MG ORAL TABLET

00000545058	APO-TRIHEX	APX	\$	0.0300
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5 MG ORAL TABLET

00000545074	APO-TRIHEX	APX	\$	0.0540
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12:00 AUTONOMIC DRUGS12:08:08 ANTICHOLINERGIC AGENTS
(ANTIMUSCARINICS/ANTISPASMODICS)**ATROPINE SULFATE**

0.4 MG / ML INJECTION

00000392782	ATROPINE SULFATE	SDZ	\$	1.3250
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0.6 MG / ML INJECTION

00000392693	ATROPINE SULFATE	SDZ	\$	1.3250
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12:00 AUTONOMIC DRUGS12:08:08 ANTICHOLINERGIC AGENTS
(ANTIMUSCARINICS/ANTISPASMODICS)**BELLADONNA/ ERGOTAMINE TARTRATE/ PHENOBARBITAL**

0.2 MG * 0.6 MG * 40 MG ORAL SUSTAINED-RELEASE TABLET

0000176141 BELLERGA 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
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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
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200 MCG / DOSE * 6 MCG / DOSE METERED INHALATION POWDER

00002245386	SYMBICORT 200 TURBUHALER	AZC	\$	0.6500
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EPINEPHRINE

0.15 MG / SYR INJECTION SYRINGE

<input checked="" type="checkbox"/>	00002268205	TWINJECT AUTO INJECTOR	PAL	\$	79.0000
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<input checked="" type="checkbox"/>	00000578657	EPIPEN JR	KNG	\$	81.0000
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0.3 MG / SYR INJECTION SYRINGE

<input checked="" type="checkbox"/>	00002247310	TWINJECT AUTO INJECTOR	PAL	\$	79.0000
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<input checked="" type="checkbox"/>	00000509558	EPIPEN	KNG	\$	81.0000
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EPINEPHRINE HCL

1 MG / ML TOPICAL SOLUTION

00000155365	ADRENALIN	ERF	\$	0.5770
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1 MG / ML INJECTION

00000155357	ADRENALIN	ERF	\$	0.5770
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FORMOTEROL FUMARATE

12 MCG INHALATION CAPSULE

00002230898	FORADIL	NOV	\$	0.8003
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FORMOTEROL FUMARATE DIHYDRATE

6 MCG / DOSE METERED INHALATION POWDER

00002237225	OXEZE TURBUHALER	AZC	\$	0.5450
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12 MCG / DOSE METERED INHALATION POWDER

00002237224	OXEZE TURBUHALER	AZC	\$	0.7258
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ORCIPRENALINE SULFATE

2 MG / ML ORAL SYRUP

00002236783	APO-ORCIPRENALINE	APX	\$	0.0381
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SALBUTAMOL

100 MCG / DOSE METERED DOSE AEROSOL

00002245669	APO-SALVENT CFC FREE	APX	\$	0.0387
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00002244914	RATIO-SALBUTAMOL HFA	RPH	\$	0.0387
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00002232570	AIROMIR CFC-FREE	GRC	\$	0.0416
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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
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12:00 AUTONOMIC DRUGS

12:16 SYMPATHOLYTIC AGENTS

DIHYDROERGOTAMINE MESYLATE

4 MG / ML NASAL SPRAY

00002228947	MIGRANAL	STM	\$	10.6605
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1 MG / ML INJECTION

00002241163	DIHYDROERGOTAMINE MESYLATE	SDZ	\$	3.7133
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00000027243	DIHYDROERGOTAMINE (DHE)	STM	\$	4.5365
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ERGOLOID MESYLATES

1 MG ORAL TABLET

00000176176	HYDERGINE	STM	\$	0.7229
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ERGOTAMINE TARTRATE/ CAFFEINE

1 MG * 100 MG ORAL TABLET

00000176095	CAFERGOT	NOV	\$	0.7005
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ERGOTAMINE TARTRATE/ CAFFEINE/ DIMENHYDRINATE

1 MG * 100 MG * 50 MG ORAL CAPSULE

00000116858	GRAVERGOL	AXS	\$	0.6550
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METHYSERGIDE MALEATE

2 MG ORAL TABLET

00000027499	SANSERT	NOV	\$	0.8949
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PIZOTIFEN MALATE

0.5 MG (BASE) ORAL TABLET

00000329320	SANDOMIGRAN	SQP	\$	0.3475
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1 MG (BASE) ORAL TABLET

00000511552	SANDOMIGRAN DS	SQP	\$	0.5770
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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
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0.5 MG / ML INJECTION

00002131056	LIORESAL INTRATHECAL	NOV	\$	9.1757
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2 MG / ML INJECTION

00002131064	LIORESAL INTRATHECAL	NOV	\$	36.7027
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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
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100 MG ORAL CAPSULE

00001997653	DANTRIUM	PGA	\$	0.8020
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ORPHENADRINE CITRATE**30 MG / ML INJECTION**

00001966162	NORFLEX	GRC	\$	4.6125
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20:00 BLOOD FORMATION AND COAGULATION

20:04:04 ANTIANEMIA DRUGS
(IRON PREPARATIONS)

IRON DEXTRAN COMPLEX

50 MG / ML INJECTION

<input checked="" type="checkbox"/>	00002221780	INFUFER	SDZ	\$	13.7500
<input checked="" type="checkbox"/>	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
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25,000 IU / ML INJECTION

00002231171	FRAGMIN	PFI	\$	41.9263
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2,500 IU / SYR INJECTION SYRINGE

00002132621	FRAGMIN (0.2 ML SYRINGE)	PFI	\$	5.3110
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25,000 IU / ML INJECTION SYRINGE

00002132648	FRAGMIN (0.2-0.72 ML SYR)	PFI	\$	52.8250
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For this product - pricing has been established on a per millilitre basis.

ENOXAPARIN SODIUM

100 MG / ML INJECTION

00002236564	LOVENOX	SAV	\$	22.0375
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30 MG / SYR INJECTION SYRINGE

00002012472	LOVENOX (0.3 ML SYRINGE)	SAV	\$	6.6543
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100 MG / ML INJECTION SYRINGE

00002236883	LOVENOX (0.4 - 1 ML SYRINGE)	SAV	\$	22.0375
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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
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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
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HEPARIN SODIUM

1,000 UNIT / ML INJECTION

00000453811	HEPARIN LEO	LEO	\$	0.4064
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00000740519	HEPALEAN	ORG	\$	0.9340
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10,000 UNIT / ML INJECTION

00000579718	HEPARIN LEO	LEO	\$	1.9362
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00000740497	HEPALEAN	ORG	\$	2.2050
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25,000 UNIT / ML INJECTION

00000453781	HEPARIN LEO	LEO	\$	8.0140
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10 UNIT / ML LOCK FLUSH

00000725323	HEPARIN LOCK FLUSH	HSP	\$	0.2750
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100 UNIT / ML LOCK FLUSH

00000725315	HEPARIN LOCK FLUSH	HSP	\$	0.2800
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00000727520	HEPARIN LEO	LEO	\$	0.3456
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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
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*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
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*For this product - pricing has been established on a per millilitre basis.***NICOUMALONE****1 MG ORAL TABLET**

00000010383	SINTROM	SQP	\$	0.4701
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4 MG ORAL TABLET

00000010391	SINTROM	SQP	\$	1.4782
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TINZAPARIN SODIUM**10,000 IU / ML INJECTION**

00002167840	INNOHEP	LEO	\$	17.2000
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20,000 IU / ML INJECTION

00002229515	INNOHEP	LEO	\$	34.4000
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10,000 IU / ML INJECTION SYRINGE

00002229755	INNOHEP (0.35/0.45 ML SYR)	LEO	\$	17.3444
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*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
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*For this product - pricing has been established on a per millilitre basis.***WARFARIN SODIUM****1 MG ORAL TABLET**

00002242924	APO-WARFARIN	APX	\$	0.1782
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00002244462	GEN-WARFARIN	GPM	\$	0.1782
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00002265273	NOVO-WARFARIN	NOP	\$	0.1782
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00002242680	TARO-WARFARIN	TAR	\$	0.1782
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00001918311	COUMADIN	BMS	\$	0.2969
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2 MG ORAL TABLET

00002242925	APO-WARFARIN	APX	\$	0.1885
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00002244463	GEN-WARFARIN	GPM	\$	0.1885
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00002265281	NOVO-WARFARIN	NOP	\$	0.1885
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00002242681	TARO-WARFARIN	TAR	\$	0.1885
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00001918338	COUMADIN	BMS	\$	0.3141
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2.5 MG ORAL TABLET

00002242926	APO-WARFARIN	APX	\$	0.1509
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00002244464	GEN-WARFARIN	GPM	\$	0.1509
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00002265303	NOVO-WARFARIN	NOP	\$	0.1509
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00002242682	TARO-WARFARIN	TAR	\$	0.1509
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00001918346	COUMADIN	BMS	\$	0.2514
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3 MG ORAL TABLET

00002245618	APO-WARFARIN	APX	\$	0.2337
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00002287498	GEN-WARFARIN	GPM	\$	0.2337
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00002265311	NOVO-WARFARIN	NOP	\$	0.2337
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00002242683	TARO-WARFARIN	TAR	\$	0.2337
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00002240205	COUMADIN	BMS	\$	0.3893
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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
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7.5 MG ORAL TABLET

00002242697	TARO-WARFARIN	TAR	\$	0.3014
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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
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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
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10 MG (BASE) ORAL TABLET

00000878936	NORVASC	PFI	\$	2.0392
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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**24:04 CARDIAC DRUGS****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
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0.05 MG / ML INJECTION

00002048272	DIGOXIN PEDIATRIC	SDZ	\$	5.4500
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0.25 MG / ML INJECTION

00002048264	DIGOXIN	SDZ	\$	2.3000
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DILTIAZEM HCL**30 MG ORAL TABLET**

00000771376	APO-DILTIAZ	APX	\$	0.2075
00002146916	GEN-DILTIAZEM	GPM	\$	0.2075
00000862924	NOVO-DILTIAZEM	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-DILTIAZEM	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
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180 MG ORAL EXTENDED-RELEASE TABLET

00002256746	TIAZAC XC	BOV	\$	1.0196
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240 MG ORAL EXTENDED-RELEASE TABLET

00002256754	TIAZAC XC	BOV	\$	1.3523
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300 MG ORAL EXTENDED-RELEASE TABLET

00002256762	TIAZAC XC	BOV	\$	1.3523
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360 MG ORAL EXTENDED-RELEASE TABLET

00002256770	TIAZAC XC	BOV	\$	1.3523
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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-DILTIAZEM 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-DILTIAZEM 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-DILTIAZEM 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-DILTIAZEM 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**24:04 CARDIAC DRUGS****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

LISINAPRIL

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**24:04 CARDIAC DRUGS****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
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200 MG (BASE) ORAL SUSTAINED-RELEASE TABLET

<input checked="" type="checkbox"/> 00000497827	BETALOC DURULES	AZC	\$	0.4575
<input checked="" type="checkbox"/> 00000534560	LOPRESOR SR	NOV	\$	0.4779

1 MG / ML (BASE) INJECTION

00000590819	LOPRESOR	NOV	\$	1.1670
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MEXILETINE HCL**100 MG ORAL CAPSULE**

00002230359	NOVO-MEXILETINE	NOP	\$	0.8162
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200 MG ORAL CAPSULE

00002230360	NOVO-MEXILETINE	NOP	\$	1.0930
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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
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24:00 CARDIOVASCULAR DRUGS**24:04 CARDIAC DRUGS****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

24:00 CARDIOVASCULAR DRUGS**24:04 CARDIAC DRUGS****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
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60 MG ORAL SUSTAINED-RELEASE CAPSULE

00002042231	INDERAL-LA	WAY	\$	0.5144
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80 MG ORAL SUSTAINED-RELEASE CAPSULE

00002042258	INDERAL-LA	WAY	\$	0.5801
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120 MG ORAL SUSTAINED-RELEASE CAPSULE

00002042266	INDERAL-LA	WAY	\$	0.8929
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160 MG ORAL SUSTAINED-RELEASE CAPSULE

00002042274	INDERAL-LA	WAY	\$	1.0561
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QUINAPRIL HCL**5 MG (BASE) ORAL TABLET**

00001947664	ACCUPRIL	PFI	\$	0.9184
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10 MG (BASE) ORAL TABLET

00001947672	ACCUPRIL	PFI	\$	0.9184
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20 MG (BASE) ORAL TABLET

00001947680	ACCUPRIL	PFI	\$	0.9184
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40 MG (BASE) ORAL TABLET

00001947699	ACCUPRIL	PFI	\$	0.9184
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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
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1 MG ORAL CAPSULE

00002231459	MAVIK	ABB	\$	0.6700
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2 MG ORAL CAPSULE

00002231460	MAVIK	ABB	\$	0.7700
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4 MG ORAL CAPSULE

00002239267	MAVIK	ABB	\$	0.9500
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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	NOF	\$ 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
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20 MG (BASE) ORAL CAPSULE

00002061562	LESCOL	NOV	\$	0.8597
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40 MG (BASE) ORAL CAPSULE

00002061570	LESCOL	NOV	\$	1.2036
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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
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10 MG (BASE) ORAL TABLET

00002247162	CRESTOR	AZC	\$	1.3600
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20 MG (BASE) ORAL TABLET

00002247163	CRESTOR	AZC	\$	1.7000
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40 MG (BASE) ORAL TABLET

00002247164	CRESTOR	AZC	\$	1.9900
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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
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16 MG ORAL TABLET

00002239092	ATACAND	AZC	\$	1.1123
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CANDESARTAN CILEXETIL/ HYDROCHLOROTHIAZIDE**16 MG * 12.5 MG ORAL TABLET**

00002244021	ATACAND PLUS	AZC	\$	1.1117
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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
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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

LISINAPRIL/ 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

OPRENOLOL 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
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10 MG * 50 MG ORAL TABLET

00000568635	VISKAZIDE 10/50	NOV	\$	0.7897
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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
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20 MG (BASE) * 12.5 MG ORAL TABLET

00002237368	ACCURETIC 20/12.5	PFI	\$	0.9182
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20 MG * 25 MG ORAL TABLET

00002237369	ACCURETIC 20/25	PFI	\$	0.8832
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TELMISARTAN**40 MG ORAL TABLET**

00002240769	MICARDIS	BOE	\$	1.1296
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80 MG ORAL TABLET

00002240770	MICARDIS	BOE	\$	1.1296
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TELMISARTAN/ HYDROCHLOROTHIAZIDE**80 MG * 12.5 MG ORAL TABLET**

00002244344	MICARDIS PLUS	BOE	\$	1.1296
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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
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160 MG ORAL TABLET

00002244782	DIOVAN	NOV	\$	1.1955
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320 MG ORAL TABLET

00002289504	DIOVAN	NOV	\$	1.1955
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VALSARTAN/ HYDROCHLOROTHIAZIDE**80 MG * 12.5 MG ORAL TABLET**

00002241900	DIOVAN-HCT	NOV	\$	1.1955
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160 MG * 12.5 MG ORAL TABLET

00002241901	DIOVAN-HCT	NOV	\$	1.1955
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160 MG * 25 MG ORAL TABLET

00002246955	DIOVAN-HCT	NOV	\$	1.1955
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24:00 CARDIOVASCULAR DRUGS**24:12 VASODILATING AGENTS****ALPROSTADIL****500 MCG / ML INJECTION**

00000559253	PROSTIN VR	PFI	\$	253.8540
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24:00 CARDIOVASCULAR DRUGS**24:12 VASODILATING AGENTS****DIPYRIDAMOLE****25 MG ORAL TABLET**

00000895644 APO-DIPYRIDAMOLE (FC) APX \$ 0.1432

50 MG ORAL TABLET00000895652 APO-DIPYRIDAMOLE (FC) APX \$ **0.2864**

00000067393 PERSANTINE BOE \$ 0.3879

75 MG ORAL TABLET00000895660 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 SPRAY00002243588 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**

<input checked="" type="checkbox"/>	00001911929	NITRO-DUR 0.6	SCH	\$	0.6400
<input checked="" type="checkbox"/>	00002230734	TRINIPATCH 0.6	NOV	\$	0.6880
<input checked="" type="checkbox"/>	00002046156	TRANSDERM-NITRO 0.6	NOV	\$	0.7087
<input checked="" type="checkbox"/>	00002163535	MINITRAN 0.6	GRC	\$	0.7090

0.8 MG/HR TRANSDERMAL PATCH

	00002011271	NITRO-DUR 0.8	SCH	\$	1.1100
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24:00 CARDIOVASCULAR DRUGS

24:12:00 VASODILATING AGENTS

(VASODILATING AGENTS (PERIPHERAL))

NYLIDRIN HCL**6 MG ORAL TABLET**

	00001926713	ARLIDIN	ERF	\$	0.4703
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24:00 CARDIOVASCULAR DRUGS

24:16 SCLEROSING AGENTS

SODIUM TETRADECYL SULFATE**1 % INJECTION**

	00000511234	TROMBOJECT	OMG	\$	3.2500
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3 % INJECTION

	00000511226	TROMBOJECT	OMG	\$	3.3750
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28:00 CENTRAL NERVOUS SYSTEM DRUGS**28:08:04 ANALGESICS & ANTIPYRETICS****(NONSTEROIDAL ANTI-INFLAMMATORY AGENTS)****ASA**

650 MG ORAL ENTERIC-COATED TABLET

0000010340	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
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75 MG * 200 MCG ORAL TABLET

00002229837	ARTHROTEC-75	PFI	\$	0.8430
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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
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300 MG ORAL CAPSULE

00002232318	APO-ETODOLAC	APX	\$	0.6000
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FLOCTAFENINE**200 MG ORAL TABLET**

00002244680	APO-FLOCTAFENINE	APX	\$	0.4032
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400 MG ORAL TABLET

00002244681	APO-FLOCTAFENINE	APX	\$	0.7845
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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
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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
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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
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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
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100 MG ORAL ENTERIC-COATED TABLET

00000842664	APO-KETO-E	APX	\$	0.3078
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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
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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
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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
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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
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500 MG RECTAL SUPPOSITORY

00002017237	PMS-NAPROXEN	PMS		\$	0.7927
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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
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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
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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
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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
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30 MG ORAL TABLET

00000593451	RATIO-CODEINE	RPH	\$	0.0831
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5 MG / ML ORAL SYRUP

00000779474	RATIO-CODEINE	RPH	\$	0.0289
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30 MG / ML INJECTION

00000544884	CODEINE PHOSPHATE	SDZ	\$	1.0320
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CODEINE PHOSPHATE/ ACETAMINOPHEN

30 MG * 300 MG ORAL TABLET

00000608882	RATIO-EMTEC-30	RPH	\$	0.1300
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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
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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
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30 MG * 325 MG * 30 MG ORAL TABLET

00000293512	ATASOL-30	CHD	\$	0.0656
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CODEINE PHOSPHATE/ ASA/ CAFFEINE CITRATE

30 MG * 375 MG * 30 MG ORAL TABLET

00002238645	292	PPH	\$	0.1730
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CODEINE PHOSPHATE/ ASA/ MEPROBAMATE/ CAFFEINE CITRATE

15 MG * 350 MG * 200 MG * 30 MG ORAL TABLET

00002238646	282 MEP	PPH	\$	0.2160
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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
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6 MG ORAL CONTROLLED-RELEASE CAPSULE

00002125331	HYDROMORPH CONTIN	PUR	\$	1.0086
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12 MG ORAL CONTROLLED-RELEASE CAPSULE

00002125366	HYDROMORPH CONTIN	PUR	\$	1.7482
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18 MG ORAL CONTROLLED-RELEASE CAPSULE

00002243562	HYDROMORPH CONTIN	PUR	\$	2.5214
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24 MG ORAL CONTROLLED-RELEASE CAPSULE

00002125382	HYDROMORPH CONTIN	PUR	\$	3.2276
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30 MG ORAL CONTROLLED-RELEASE CAPSULE

00002125390	HYDROMORPH CONTIN	PUR	\$	3.8662
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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
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3 MG RECTAL SUPPOSITORY

00001916394	PMS-HYDROMORPHONE	PMS	\$ 2.2100
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MEPERIDINE HCL**50 MG ORAL TABLET**

00002138018	DEMEROL	AVE	\$ 0.1403
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50 MG / ML INJECTION

00000725765	MEPERIDINE HYDROCHLORIDE	SDZ	\$ 0.8650
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75 MG / ML INJECTION

00000725757	MEPERIDINE HYDROCHLORIDE	SDZ	\$ 0.9150
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100 MG / ML INJECTION

00000725749	MEPERIDINE HYDROCHLORIDE	SDZ	\$ 0.9650
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METHADONE COMPOUND**ORAL LIQUID**

00000999995	METHADONE	XXX	\$ 0.0000
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METHADONE HCL**1 MG ORAL TABLET**

00002247698	METADOL	PMS	\$ 0.1500
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5 MG ORAL TABLET

00002247699	METADOL	PMS	\$ 0.5000
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10 MG ORAL TABLET

00002247700	METADOL	PMS	\$ 0.8000
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25 MG ORAL TABLET

00002247701	METADOL	PMS	\$ 1.5000
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1 MG / ML ORAL SOLUTION

00002247694	METADOL	PMS	\$ 0.0840
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10 MG / ML ORAL LIQUID

00002241377	METADOL CONCENTRATE	PMS	\$ 0.3035
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MORPHINE HCL**10 MG ORAL TABLET**

00000690198	M.O.S.-10	VCL	\$ 0.1828
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20 MG ORAL TABLET

00000690201	M.O.S.-20	VCL	\$ 0.3486
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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
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200 MG ORAL SUSTAINED-RELEASE TABLET

00002014327	MS CONTIN	PUR	\$	5.1598
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10 MG ORAL EXTENDED-RELEASE CAPSULE

00002019930	M-ESLON	ETP	\$	0.3120
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15 MG ORAL EXTENDED-RELEASE CAPSULE

00002177749	M-ESLON	ETP	\$	0.3601
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30 MG ORAL EXTENDED-RELEASE CAPSULE

00002019949	M-ESLON	ETP	\$	0.5375
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60 MG ORAL EXTENDED-RELEASE CAPSULE

00002019957	M-ESLON	ETP	\$	0.9546
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100 MG ORAL EXTENDED-RELEASE CAPSULE

00002019965	M-ESLON	ETP	\$	2.0535
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200 MG ORAL EXTENDED-RELEASE CAPSULE

00002177757	M-ESLON	ETP	\$	4.1065
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10 MG ORAL SUSTAINED-RELEASE CAPSULE

00002242163	KADIAN	ABB	\$	0.4900
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20 MG ORAL SUSTAINED-RELEASE CAPSULE

00002184435	KADIAN	ABB	\$	0.6800
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50 MG ORAL SUSTAINED-RELEASE CAPSULE

00002184443	KADIAN	ABB	\$	1.2500
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100 MG ORAL SUSTAINED-RELEASE CAPSULE

00002184451	KADIAN	ABB	\$	2.1800
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1 MG / ML ORAL SYRUP

00000591467	STATEX	PMS	\$	0.0200
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5 MG / ML ORAL SYRUP

00000591475	STATEX	PMS	\$	0.0803
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10 MG / ML ORAL SYRUP

00000647217	STATEX	PMS	\$	0.1838
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20 MG / ML ORAL DROPS

00000621935	STATEX	PMS	\$	0.4980
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50 MG / ML ORAL DROPS

00000705799	STATEX	PMS	\$	0.9464
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0.5 MG / ML INJECTION

00002021056	MORPHINE LP EPIDURAL	SDZ	\$	0.9644
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1 MG / ML INJECTION

00002021048	MORPHINE LP EPIDURAL	SDZ	\$	1.9288
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10 MG / ML INJECTION

00000392588	MORPHINE SULFATE	SDZ	\$	0.8950
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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
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25 MG / ML INJECTION

00000676411	MORPHINE HP 25	SDZ	\$	2.4500
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50 MG / ML INJECTION

00000617288	MORPHINE HP 50	SDZ	\$	3.5490
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5 MG RECTAL SUPPOSITORY

00000632228	STATEX	PMS	\$	1.6690
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10 MG RECTAL SUPPOSITORY

00000632201	STATEX	PMS	\$	1.8640
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20 MG RECTAL SUPPOSITORY

00000596965	STATEX	PMS	\$	2.2190
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30 MG RECTAL SUPPOSITORY

00000639389	STATEX	PMS	\$	2.4340
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OPIUM/ BELLADONNA**65 MG * 15 MG RECTAL SUPPOSITORY**

00000815349	PMS-OPIUM BELLADONNA	PMS	\$	1.7900
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00001901869	SAB-OPIUM & BELLADONNA	SDZ	\$	2.0000
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OXYCODONE HCL**5 MG ORAL TABLET**

00000789739	SUPEUDOL	SDZ	\$	0.2368
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10 MG ORAL TABLET

<input checked="" type="checkbox"/> 00000443948	SUPEUDOL	SDZ	\$	0.3680
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<input checked="" type="checkbox"/> 00002240131	OXY-IR	PUR	\$	0.3996
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20 MG ORAL TABLET

00002240132	OXY-IR	PUR	\$	0.6940
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5 MG ORAL SUSTAINED-RELEASE TABLET

00002258129	OXYCONTIN	PUR	\$	0.6450
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10 MG ORAL SUSTAINED-RELEASE TABLET

00002202441	OXYCONTIN	PUR	\$	0.8966
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20 MG ORAL SUSTAINED-RELEASE TABLET

00002202468	OXYCONTIN	PUR	\$	1.3446
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40 MG ORAL SUSTAINED-RELEASE TABLET

00002202476	OXYCONTIN	PUR	\$	2.3308
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80 MG ORAL SUSTAINED-RELEASE TABLET

00002202484	OXYCONTIN	PUR	\$	4.3030
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10 MG RECTAL SUPPOSITORY

00000392480	SUPEUDOL	SDZ	\$	1.9217
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20 MG RECTAL SUPPOSITORY

00000392472	SUPEUDOL	SDZ	\$	2.4342
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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
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5 MG * 325 MG ORAL TABLET

00001916548	ENDOCET	BMS	\$	0.1285
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00002245758	PMS-OXYCODONE-ACETAMINOPHEN	PMS	\$	0.2850
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00000608165	RATIO-OXYCO CET	RPH	\$	0.2850
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00001916475	PERCOCET	BMS	\$	0.6981
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OXYCODONE HCL/ ASA

5 MG * 325 MG ORAL TABLET

00001916483	ENDODAN	BMS	\$	0.1116
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00000608157	RATIO-OXYCODAN	RPH	\$	0.3220
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00001916572	PERCODAN	BMS	\$	0.8412
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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
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PENTAZOCINE LACTATE

30 MG / ML INJECTION

00002241976	TALWIN	HSP	\$	1.4300
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28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:12:04 ANTICONVULSANTS

(BARBITURATES)

PHENOBARBITAL

15 MG ORAL TABLET

00000178799	PMS-PHENOBARBITAL	PMS	\$	0.0612
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30 MG ORAL TABLET

00000178802	PMS-PHENOBARBITAL	PMS	\$	0.0728
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60 MG ORAL TABLET

00000178810	PMS-PHENOBARBITAL	PMS	\$	0.0987
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100 MG ORAL TABLET

00000178829	PMS-PHENOBARBITAL	PMS	\$	0.1351
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5 MG / ML ORAL ELIXIR

00000645575	PMS-PHENOBARBITAL	PMS	\$	0.0816
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PRIMIDONE

125 MG ORAL TABLET

00000399310	APO-PRIMIDONE	APX	\$	0.0475
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250 MG ORAL TABLET

00000396761	APO-PRIMIDONE	APX	\$	0.0750
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28:00 CENTRAL NERVOUS SYSTEM DRUGS28:12:08 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
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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 DRUGS28:12:12 ANTICONVULSANTS
(HYDANTOINS)**PHENYTOIN****50 MG ORAL CHEWABLE TABLET**

00000023698	DILANTIN INFATABS	PFI	\$	0.0762
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6 MG / ML ORAL SUSPENSION

00000023442	DILANTIN-30	PFI	\$	0.0420
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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
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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
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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
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25 MG ORAL CAPSULE

00002239908	TOPAMAX SPRINKLE	JOI	\$	1.2150
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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
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500 MG ORAL POWDER PACKET

00002068036	SABRIL	PAL	\$	0.9110
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28:00 CENTRAL NERVOUS SYSTEM DRUGS

28:16:04 PSYCHOTHERAPEUTIC AGENTS

(ANTIDEPRESSANTS)

AMITRIPTYLINE HCL**10 MG ORAL TABLET**

00000335053	APO-AMITRIPTYLINE	APX	\$	0.0520
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25 MG ORAL TABLET

00000335061	APO-AMITRIPTYLINE	APX	\$	0.0995
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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
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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
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4 MG / ML (BASE) ORAL LIQUID

00002231328	APO-FLUOXETINE	APX	\$	0.4625
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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
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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
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50 MG ORAL TABLET

00002158620	NOVO-MAPROTILINE	NOP	\$	1.0401
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75 MG ORAL TABLET

00002158639	NOVO-MAPROTILINE	NOP	\$	1.4204
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28:00 CENTRAL NERVOUS SYSTEM DRUGS**28:16:04 PSYCHOTHERAPEUTIC AGENTS****(ANTIDEPRESSANTS)****MIRTAZAPINE****15 MG ORAL TABLET**

00002273942	PMS-MIRTAZAPINE	PMS	\$	0.3750
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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
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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)****TRANLYCYPROMINE SULFATE**

10 MG (BASE) ORAL TABLET

00001919598	PARNATE	GSK	\$	0.3510
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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
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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
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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
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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
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50 MG (BASE) ORAL TABLET

00000232807	NOVO-CHLORPROMAZINE	NOP	\$	0.1915
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100 MG (BASE) ORAL TABLET

00000232831	NOVO-CHLORPROMAZINE	NOP	\$	0.3200
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25 MG / ML (BASE) INJECTION

00000743518	CHLORPROMAZINE HCL	SDZ	\$	0.6625
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CLOZAPINE

25 MG ORAL TABLET

<input checked="" type="checkbox"/> 00002248034	APO-CLOZAPINE	APX	\$	0.6594
<input checked="" type="checkbox"/> 00002247243	GEN-CLOZAPINE	GPM	\$	0.6594
<input checked="" type="checkbox"/> 00000894737	CLOZARIL	NOV	\$	1.0127

100 MG ORAL TABLET

<input checked="" type="checkbox"/> 00002248035	APO-CLOZAPINE	APX	\$	2.6446
<input checked="" type="checkbox"/> 00002247244	GEN-CLOZAPINE	GPM	\$	2.6446
<input checked="" type="checkbox"/> 00000894745	CLOZARIL	NOV	\$	4.0614

FLUPENTHIXOL DECANOATE

20 MG / ML INJECTION

00002156032	FLUANXOL DEPOT	LBC	\$	7.4616
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100 MG / ML INJECTION

00002156040	FLUANXOL DEPOT	LBC	\$	37.3079
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FLUPENTHIXOL DIHYDROCHLORIDE

0.5 MG ORAL TABLET

00002156008	FLUANXOL	LBC	\$	0.2578
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3 MG ORAL TABLET

00002156016	FLUANXOL	LBC	\$	0.5567
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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
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100 MG / ML INJECTION

00002242570	FLUPHENAZINE OMEGA	OMG	\$	29.7800
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00000755575	MODECATE CONCENTRATE	BMS	\$	29.7800
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00002241928	PMS-FLUPHENAZINE DECANOATE	PMS	\$	29.7800
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FLUPHENAZINE HCL**1 MG ORAL TABLET**

00000405345	APO-FLUPHENAZINE	APX	\$	0.1680
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2 MG ORAL TABLET

00000410632	APO-FLUPHENAZINE	APX	\$	0.2040
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5 MG ORAL TABLET

00000405361	APO-FLUPHENAZINE	APX	\$	0.1720
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HALOPERIDOL**0.5 MG ORAL TABLET**

00000396796	APO-HALOPERIDOL	APX	\$	0.0360
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00000363685	NOVO-PERIDOL	NOF	\$	0.0360
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1 MG ORAL TABLET

00000396818	APO-HALOPERIDOL	APX	\$	0.0614
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00000363677	NOVO-PERIDOL	NOF	\$	0.0614
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2 MG ORAL TABLET

00000396826	APO-HALOPERIDOL	APX	\$	0.1050
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00000363669	NOVO-PERIDOL	NOF	\$	0.1050
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5 MG ORAL TABLET

00000396834	APO-HALOPERIDOL	APX	\$	0.1487
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00000363650	NOVO-PERIDOL	NOF	\$	0.1487
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10 MG ORAL TABLET

00000463698	APO-HALOPERIDOL	APX	\$	0.1330
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00000713449	NOVO-PERIDOL	NOF	\$	0.1330
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20 MG ORAL TABLET

00000768820	NOVO-PERIDOL	NOF	\$	0.6304
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2 MG / ML ORAL SOLUTION

00000759503	PMS-HALOPERIDOL	PMS	\$	0.1073
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5 MG / ML INJECTION

00000808652	HALOPERIDOL	SDZ	\$	3.9200
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HALOPERIDOL DECANOATE**50 MG / ML (BASE) INJECTION**

00002130297	HALOPERIDOL LA	SDZ	\$	6.5000
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100 MG / ML (BASE) INJECTION

00002130300	HALOPERIDOL LA	SDZ	\$	13.0000
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LOXAPINE HCL**50 MG / ML (BASE) INJECTION**

00002169991	LOXAPAC	SDZ	\$	5.8250
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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
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5 MG (BASE) ORAL TABLET

00002237651	APO-LOXAPINE	APX	\$	0.1500
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00002237534	NU-LOXAPINE	NXP	\$	0.1500
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00002230837	PMS-LOXAPINE	PMS	\$	0.1500
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10 MG (BASE) ORAL TABLET

00002237652	APO-LOXAPINE	APX	\$	0.2498
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00002237535	NU-LOXAPINE	NXP	\$	0.2498
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00002230838	PMS-LOXAPINE	PMS	\$	0.2498
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25 MG (BASE) ORAL TABLET

00002237653	APO-LOXAPINE	APX	\$	0.3872
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00002237536	NU-LOXAPINE	NXP	\$	0.3872
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00002230839	PMS-LOXAPINE	PMS	\$	0.3872
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50 MG (BASE) ORAL TABLET

00002237654	APO-LOXAPINE	APX	\$	0.5162
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00002237537	NU-LOXAPINE	NXP	\$	0.5162
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00002230840	PMS-LOXAPINE	PMS	\$	0.5162
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OLANZAPINE**2.5 MG ORAL TABLET**

00002276712	NOVO-OLANZAPINE	NOP	\$	1.2656
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00002229250	ZYPREXA	LIL	\$	1.8141
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5 MG ORAL TABLET

00002276720	NOVO-OLANZAPINE	NOP	\$	2.5313
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00002229269	ZYPREXA	LIL	\$	3.6281
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7.5 MG ORAL TABLET

00002276739	NOVO-OLANZAPINE	NOP	\$	3.7969
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00002229277	ZYPREXA	LIL	\$	5.4422
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10 MG ORAL TABLET

00002276747	NOVO-OLANZAPINE	NOP	\$	5.0625
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00002229285	ZYPREXA	LIL	\$	7.2563
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15 MG ORAL TABLET

00002276755	NOVO-OLANZAPINE	NOP	\$	7.5938
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00002238850	ZYPREXA	LIL	\$	10.8844
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5 MG ORAL DISINTEGRATING TABLET

00002243086	ZYPREXA ZYDIS	LIL	\$	3.6281
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10 MG ORAL DISINTEGRATING TABLET

00002243087	ZYPREXA ZYDIS	LIL	\$	7.2563
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PERICYAZINE**5 MG ORAL CAPSULE**

00001926780	NEULEPTIL	ERF	\$	0.1962
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10 MG ORAL CAPSULE

00001926772	NEULEPTIL	ERF	\$	0.3150
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20 MG ORAL CAPSULE

00001926764	NEULEPTIL	ERF	\$	0.4913
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10 MG / ML ORAL DROPS

00001926756	NEULEPTIL	ERF	\$	0.3870
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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
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1 MG ORAL DISINTEGRATING TABLET

00002247705	RISPERDAL M-TAB	JOI	\$	1.0320
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2 MG ORAL DISINTEGRATING TABLET

00002247706	RISPERDAL M-TAB	JOI	\$	2.0601
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3 MG ORAL DISINTEGRATING TABLET

00002268086	RISPERDAL M-TAB	JOI	\$	3.0906
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4 MG ORAL DISINTEGRATING TABLET

00002268094	RISPERDAL M-TAB	JOI	\$	4.1207
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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
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THIOTHIXENE**2 MG ORAL CAPSULE**

00000024430	NAVANE	ERF	\$	0.3225
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5 MG ORAL CAPSULE

00000024449	NAVANE	ERF	\$	0.3570
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10 MG ORAL CAPSULE

00000024457	NAVANE	ERF	\$	0.4596
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TRIFLUOPERAZINE HCL**1 MG (BASE) ORAL TABLET**

00000345539	APO-TRIFLUOPERAZINE	APX	\$	0.1015
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2 MG (BASE) ORAL TABLET

00000312754	APO-TRIFLUOPERAZINE	APX	\$	0.1330
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5 MG (BASE) ORAL TABLET

00000312746	APO-TRIFLUOPERAZINE	APX	\$	0.1765
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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
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10 MG ORAL CAPSULE

00000522988	APO-CHLORDIAZEPOXIDE	APX	\$	0.1045
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25 MG ORAL CAPSULE

00000522996	APO-CHLORDIAZEPOXIDE	APX	\$	0.1620
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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
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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
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5 MG / ML INJECTION EMULSION

00002065614	DIAZEMULS	PFI	\$	1.1695
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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
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15 MG ORAL TABLET

00000402745	APO-OXAZEPAM	APX	\$	0.0660
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30 MG ORAL TABLET

00000402737	APO-OXAZEPAM	APX	\$	0.0900
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TEMAZEPAM**15 MG ORAL CAPSULE**

00002225964	APO-TEMAZEPAM	APX	\$	0.1102
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00002244814	CO TEMAZEPAM	COB	\$	0.1102
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00002231615	GEN-TEMAZEPAM	GPM	\$	0.1102
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00002230095	NOVO-TEMAZEPAM	NOP	\$	0.1102
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00002223570	NU-TEMAZEPAM	NXP	\$	0.1102
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00002229455	PMS-TEMAZEPAM	PMS	\$	0.1102
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00002273039	PMS-TEMAZEPAM	PMS	\$	0.1102
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00002243023	RATIO-TEMAZEPAM	RPH	\$	0.1102
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00002229756	DOM-TEMAZEPAM	DPC	\$	0.1157
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00000604453	RESTORIL	ORY	\$	0.1881
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30 MG ORAL CAPSULE

00002225972	APO-TEMAZEPAM	APX	\$	0.1326
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00002244815	CO TEMAZEPAM	COB	\$	0.1326
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00002231616	GEN-TEMAZEPAM	GPM	\$	0.1326
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00002230102	NOVO-TEMAZEPAM	NOP	\$	0.1326
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00002223589	NU-TEMAZEPAM	NXP	\$	0.1326
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00002229456	PMS-TEMAZEPAM	PMS	\$	0.1326
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00002273047	PMS-TEMAZEPAM	PMS	\$	0.1326
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00002243024	RATIO-TEMAZEPAM	RPH	\$	0.1326
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00002229758	DOM-TEMAZEPAM	DPC	\$	0.1392
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00000604461	RESTORIL	ORY	\$	0.2263
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TRIAZOLAM**0.125 MG ORAL TABLET**

00000808563	APO-TRIAZO	APX	\$	0.1181
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00001995227	GEN-TRIAZOLAM	GPM	\$	0.1181
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0.25 MG ORAL TABLET

00000808571	APO-TRIAZO	APX	\$	0.2086
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00001913506	GEN-TRIAZOLAM	GPM	\$	0.2086
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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
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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
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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
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METHOTRIMEPRAZINE HCL**25 MG / ML (BASE) INJECTION**

00001927698	NOZINAN	AVE	\$	2.5488
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METHOTRIMEPRAZINE MALEATE**2 MG (BASE) ORAL TABLET**

00002238403	APO-METHOPRAZINE	APX	\$	0.0505
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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
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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
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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
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12.5 MG (BASE) ORAL TABLET

00002248129	AXERT	MCL	\$	13.9217
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AMANTADINE HCL**100 MG ORAL CAPSULE**

00002034468	ENDANTADINE	BMS	\$	0.5179
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00002139200	GEN-AMANTADINE	GPM	\$	0.5179
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00001990403	PMS-AMANTADINE HYDROCHLORIDE	PMS	\$	0.5179
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00001914006	SYMMETREL	BMS	\$	1.0850
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10 MG / ML ORAL SYRUP

00002022826	PMS-AMANTADINE HYDROCHLORIDE	PMS	\$	0.0810
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00001913999	SYMMETREL	BMS	\$	0.0810
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ENTACAPONE**200 MG ORAL TABLET**

00002243763	COMTAN	NOV	\$	1.6073
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LEVODOPA/ BENSERAZIDE HCL**50 MG * 12.5 MG (BASE) ORAL CAPSULE**

00000522597	PROLOPA 50-12.5	HLR	\$	0.2879
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100 MG * 25 MG (BASE) ORAL CAPSULE

00000386464	PROLOPA 100-25	HLR	\$	0.4741
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200 MG * 50 MG (BASE) ORAL CAPSULE

00000386472	PROLOPA 200-50	HLR	\$	0.7958
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LEVODOPA/ CARBIDOPA**100 MG * 10 MG ORAL TABLET**

00002195933	APO-LEVOCARB	APX	\$	0.2365
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00002244494	NOVO-LEVOCARBIDOPA	NOP	\$	0.2365
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00002182831	NU-LEVOCARB	NXP	\$	0.2365
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00000355658	SINEMET 100/10	BMS	\$	0.4221
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100 MG * 25 MG ORAL TABLET

00002195941	APO-LEVOCARB	APX	\$	0.3532
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00002244495	NOVO-LEVOCARBIDOPA	NOP	\$	0.3532
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00002182823	NU-LEVOCARB	NXP	\$	0.3532
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00000513997	SINEMET 100/25	BMS	\$	0.6303
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250 MG * 25 MG ORAL TABLET

00002195968	APO-LEVOCARB	APX	\$	0.3943
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00002244496	NOVO-LEVOCARBIDOPA	NOP	\$	0.3943
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00002182858	NU-LEVOCARB	NXP	\$	0.3943
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00000328219	SINEMET 250/25	BMS	\$	0.7036
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100 MG * 25 MG ORAL SUSTAINED-RELEASE TABLET

00002028786	SINEMET CR 100/25	BMS	\$	0.6701
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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
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2.5 MG (BASE) ORAL TABLET

00002237821	AMERGE	GSK	\$	13.9417
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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
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10 MG (BASE) ORAL TABLET

00002240521	MAXALT	MFC	\$	13.8717
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5 MG (BASE) ORAL WAFER

00002240518	MAXALT RPD	MFC	\$	13.8717
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10 MG (BASE) ORAL WAFER

00002240519	MAXALT RPD	MFC	\$	13.8717
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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
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1 MG (BASE) ORAL TABLET

00002232567	REQUIP	GSK	\$	1.0821
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2 MG (BASE) ORAL TABLET

00002232568	REQUIP	GSK	\$	1.1903
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5 MG (BASE) ORAL TABLET

00002232569	REQUIP	GSK	\$	3.3546
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SELEGILINE HCL**5 MG ORAL TABLET**

00002230641	APO-SELEGILINE	APX	\$	1.2650
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00002231036	GEN-SELEGILINE	GPM	\$	1.2650
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00002068087	NOVO-SELEGILINE	NOP	\$	1.2650
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00002230717	NU-SELEGILINE	NXP	\$	1.2650
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00002238102	PMS-SELEGILINE	PMS	\$	1.2650
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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
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20 MG / DOSE (BASE) NASAL UNIT DOSE SPRAY

00002230420	IMITREX	GSK	\$	14.1474
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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
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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
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2.5 MG ORAL DISPERSIBLE TABLET

00002243045	ZOMIG RAPIMELT	AZC	\$	13.3400
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5 MG / DOSE NASAL UNIT DOSE SPRAY

00002248993	ZOMIG	AZC	\$	13.3333
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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
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MAGNESIUM GLUCONATE

500 MG ORAL TABLET

00000555126	MAGLUCATE	PMS	\$	0.1088
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POTASSIUM CHLORIDE (K+)

8 MEQ ORAL SUSTAINED-RELEASE TABLET

<input checked="" type="checkbox"/>	00000602884	APO-K	APX	\$	0.0899
<input checked="" type="checkbox"/>	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
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8 MEQ ORAL SUSTAINED-RELEASE CAPSULE

00002042304	MICRO-K EXTENCAPS	WAY	\$	0.1000
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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
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POTASSIUM CITRATE (K+)

25 MEQ ORAL EFFERVESCENT TABLET

00002085992	K-LYTE	WSP	\$	0.5550
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**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
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40:00 ELECTROLYTIC, CALORIC, WATER BALANCE

40:18 POTASSIUM REMOVING RESINS

CALCIUM POLYSTYRENE SULPHONATE

ORAL POWDER

00002017741	RESONIUM CALCIUM	SAV	\$	0.3310
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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
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ORAL POWDER

00000755338	PMS-SODIUM POLYSTYRENE SULF.	PMS	\$	0.1432
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00002026961	KAYEXALATE	SAV	\$	0.1714
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30 G / ENM RECTAL RETENTION ENEMA

00000769533	PMS-SOD POLYSTYR SULF (120 ML)	PMS	\$	13.9200
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40:00 ELECTROLYTIC, CALORIC, WATER BALANCE**40:28 DIURETICS****CHLORTHALIDONE****50 MG ORAL TABLET**

00000360279	APO-CHLORTHALIDONE	APX	\$	0.0785
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FUROSEMIDE**20 MG ORAL TABLET**

00000396788	APO-FUROSEMIDE	APX	\$	0.0445
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00000337730	NOVO-SEMIDE	NOP	\$	0.0445
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00002224690	LASIX	SAV	\$	0.0817
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40 MG ORAL TABLET

00000362166	APO-FUROSEMIDE	APX	\$	0.0670
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00000337749	NOVO-SEMIDE	NOP	\$	0.0670
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00002224704	LASIX	SAV	\$	0.1255
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80 MG ORAL TABLET

00000707570	APO-FUROSEMIDE	APX	\$	0.1220
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00000765953	NOVO-SEMIDE	NOP	\$	0.1220
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500 MG ORAL TABLET

00002224755	LASIX SPECIAL	SAV	\$	2.8149
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10 MG / ML ORAL SOLUTION

00002224720	LASIX	SAV	\$	0.2572
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10 MG / ML INJECTION

00000527033	FUROSEMIDE	SDZ	\$	0.5850
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HYDROCHLOROTHIAZIDE**25 MG ORAL TABLET**

00000021474	NOVO-HYDRAZIDE	NOP	\$	0.0474
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00000326844	APO-HYDRO	APX	\$	0.0475
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50 MG ORAL TABLET

00000021482	NOVO-HYDRAZIDE	NOP	\$	0.0649
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00000312800	APO-HYDRO	APX	\$	0.0650
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100 MG ORAL TABLET

00000644552	APO-HYDRO	APX	\$	0.1190
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HYDROCHLOROTHIAZIDE/ AMILORIDE HCL**50 MG * 5 MG ORAL TABLET**

00000784400	APO-AMILZIDE	APX	\$	0.1917
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00002257378	GEN-AMILAZIDE	GPM	\$	0.1917
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00001937219	NOVAMILOR	NOP	\$	0.1917
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00000886106	NU-AMILZIDE	NXP	\$	0.1917
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00000487813	MODURET	PRP	\$	0.3517
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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
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GENTAMICIN SULFATE

0.3 % (BASE) OPHTHALMIC SOLUTION

00000512192	GARAMYCIN	SCH	\$	0.4060
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00002229440	SANDOZ GENTAMICIN SULFATE	SDZ	\$	0.4060
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0.3 % (BASE) OPHTHALMIC OINTMENT

00000028339	GARAMYCIN	SCH	\$	1.1429
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00002230888	SANDOZ GENTAMICIN SULFATE	SDZ	\$	1.1429
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0.3 % (BASE) OTIC SOLUTION

00000512184	GARAMYCIN	SCH	\$	1.0320
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00002230889	PMS-GENTAMICIN	PMS	\$	1.0320
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00002229441	SANDOZ GENTAMICIN SULFATE	SDZ	\$	1.0320
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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
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TOBRAMYCIN

0.3 % OPHTHALMIC SOLUTION

00002239577	PMS-TOBRAMYCIN	PMS	\$	1.0480
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00002241755	SANDOZ TOBRAMYCIN	SDZ	\$	1.0480
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00000513962	TOBEX	ALC	\$	1.7917
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0.3 % OPHTHALMIC OINTMENT

00000614254	TOBEX	ALC	\$	2.5400
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52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:04:06 ANTI-INFECTIVES

(ANTIVIRALS)

TRIFLURIDINE

1 % OPHTHALMIC SOLUTION

00002248529	SANDOZ TRIFLURIDINE	SDZ	\$	3.2520
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00000687456	VIROPTIC	TMD	\$	3.2667
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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
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00002253933	PMS-CIPROFLOXACIN	PMS	\$	1.1280
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00001945270	CILOXAN	ALC	\$	2.0860
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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-BECLMETHASONE	APX	\$	0.0613
00002172712	GEN-BECLO AQ.	GPM	\$	0.0613
00002238577	NU-BECLMETHASONE	NXP	\$	0.0613
00000872318	RATIO-BECLMETHASONE DIPROP AQ	RPH	\$	0.0613

BUDESONIDE

100 MCG / DOSE NASAL METERED DOSE AEROSOL

00002035324	RHINOCORT TURBUHALER	AZC	\$	0.1135
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100 MCG / DOSE NASAL METERED DOSE SPRAY

00002230648	GEN-BUDESONIDE AQ	GPM	\$	0.0772
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CIPROFLOXACIN HCL/ HYDROCORTISONE

2 MG / ML (BASE) * 10 MG / ML OTIC SUSPENSION

00002240035	CIPRO HC	ALC	\$	2.3180
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DEXAMETHASONE

0.1 % OPHTHALMIC SUSPENSION

00000042560	MAXIDEX	ALC	\$	1.6560
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0.1 % OPHTHALMIC OINTMENT

00000042579	MAXIDEX	ALC	\$	2.5657
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DEXAMETHASONE SODIUM PHOSPHATE

0.1 % OTIC/OPHTHALMIC SOLUTION

00000739839	SANDOZ DEXAMETHASONE SOD. PHOSPHATE	SDZ	\$	1.0000
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DICLOFENAC SODIUM

0.1 % OPHTHALMIC SOLUTION

00001940414	VOLTAREN OPHTHA	NVO	\$	2.3700
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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
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52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS**52:08 ANTI-INFLAMMATORY AGENTS****FLUOROMETHOLONE ACETATE**

0.1 % OPHTHALMIC SUSPENSION

00000756784	FLAREX	ALC	\$	1.8705
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HYDROCORTISONE ACETATE

2.5 % OPHTHALMIC OINTMENT

00001980661	CORTAMED	SDZ	\$	4.5543
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KETOROLAC TROMETHAMINE

0.5 % OPHTHALMIC SOLUTION

00002245821	APO-KETOROLAC	APX	\$	2.0160
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00002247461	RATIO-KETOROLAC	RPH	\$	2.0160
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00001968300	ACULAR	ALL	\$	3.6120
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MOMETASONE FUROATE

50 MCG / DOSE NASAL METERED DOSE SPRAY

00002238465	NASONEX	SCH	\$	0.1902
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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
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00000299405	PRED MILD	ALL	\$	1.6090
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1 % OPHTHALMIC SUSPENSION

00001916203	SANDOZ PREDNISOLONE ACETATE	SDZ	\$	1.7000
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00000700401	RATIO-PREDNISOLONE	RPH	\$	2.4400
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00000301175	PRED FORTE	ALL	\$	3.9480
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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
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00002244999	SANDOZ PENTASONE	SDZ	\$	1.2813
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DEXAMETHASONE/ FRAMYCETIN SULFATE/ GRAMICIDIN

0.5 MG / ML * 5 MG / ML * 0.05 MG / ML OTIC/OPHTHALMIC SOLUTION

00002247920	SANDOZ OPTICORT	SDZ	\$	1.2375
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00002224623	SOFRACORT	AVE	\$	1.7429
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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
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1 MG / G * 3.5 MG / G (BASE) * 6,000 UNIT / G OPHTHALMIC OINTMENT

00000358177	MAXITROL	ALC	\$	2.8543
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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 % OPTHALMIC SUSPENSION

00000778907 TOBRADEX ALC \$ 2.1160

0.1 % * 0.3 % OPTHALMIC 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 % OPTHALMIC SUSPENSION

00000807788 BLEPHAMIDE ALL \$ 2.8620

0.2 % * 10 % OPTHALMIC 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 % OPTHALMIC SUSPENSION

00002238873 AZOPT ALC \$ 3.4620

DORZOLAMIDE HCL

2 % (BASE) OPTHALMIC 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 % OPTHALMIC SOLUTION

00000035076 ALCAINE ALC \$ 0.6453

52:00 EYE, EAR, NOSE AND THROAT PREPARATIONS

52:20 MIOTICS

CARBACHOL

1.5 % OPTHALMIC SOLUTION

00000000655 ISOPTO CARBACHOL ALC \$ 0.7240

3 % OPTHALMIC 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
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0.5 % (BASE) OPHTHALMIC LONG ACTING GELLAN SOLUTION

00002171899	TIMOPTIC-XE	MFC	\$	4.1780
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TRAVOPROST

0.004 % OPHTHALMIC SOLUTION

00002244896	TRAVATAN	ALC	\$	11.6280
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TRAVOPROST/ TIMOLOL MALEATE

0.004 % * 0.5 % (BASE) OPHTHALMIC SOLUTION

00002278251	DUO TRAV	ALC	\$	13.1580
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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 PELLETT)

00000789445 PANCREASE MT 4

JOI

\$

0.4039

4,500 UNIT * 20,000 UNIT * 25,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00002203324 ULTRASE MS4 MICROSPHERES

AXC

\$

0.2193

8,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000502790 COTAZYM ECS 8

ORG

\$

0.3475

10,000 UNIT * 30,000 UNIT * 30,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000789437 PANCREASE MT 10

JOI

\$

1.0093

10,000 UNIT * 33,200 UNIT * 37,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00002200104 CREON 10 MINIMICROSPHERES

SLO

\$

0.2870

12,000 UNIT * 39,000 UNIT * 39,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00002045834 ULTRASE MT12 MINITABLETS

AXC

\$

0.4289

16,000 UNIT * 48,000 UNIT * 48,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000789429 PANCREASE MT 16

JOI

\$

1.6147

20,000 UNIT * 55,000 UNIT * 55,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00000821373 COTAZYM ECS 20

ORG

\$

0.8975

20,000 UNIT * 65,000 UNIT * 65,000 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

00002045869 ULTRASE MT20 MINITABLETS

AXC

\$

0.7434

25,000 UNIT * 74,000 UNIT * 62,500 UNIT ORAL CAPSULE (ENTERIC-COATED PELLETT)

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
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50 MG / ML INJECTION

00000392537	DIMENHYDRINATE I.M.	SDZ	\$	1.0370
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DOLASETRON MESYLATE

50 MG ORAL TABLET

00002231378	ANZEMET	SAV	\$	14.7541
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100 MG ORAL TABLET

00002231379	ANZEMET	SAV	\$	29.5080
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20 MG / ML INJECTION

00002231380	ANZEMET	SAV	\$	2.4424
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DOXYLAMINE SUCCINATE/ PYRIDOXINE HCL

10 MG * 10 MG ORAL SUSTAINED-RELEASE TABLET

00000609129	DICLECTIN	DUI	\$	1.2900
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GRANISETRON HCL

1 MG (BASE) ORAL TABLET

00002185881	KYTRIL	HLR	\$	19.3500
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MECLIZINE HCL

25 MG ORAL CHEWABLE TABLET

00000220442	BONAMINE	JJM	\$	0.3138
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NABILONE

0.5 MG ORAL CAPSULE

00002256193	CESAMET	VCL	\$	3.3353
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1 MG ORAL CAPSULE

00000548375	CESAMET	VCL	\$	6.6704
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ONDANSETRON

4 MG ORAL DISINTEGRATING TABLET

00002239372	ZOFTRAN ODT	GSK	\$	12.7694
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8 MG ORAL DISINTEGRATING TABLET

00002239373	ZOFTRAN ODT	GSK	\$	19.4851
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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
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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
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400 MG ORAL ENTERIC-COATED TABLET

<input checked="" type="checkbox"/> 00002171929	NOVO-5 ASA	NOP	\$	0.3960
<input checked="" type="checkbox"/> 00001997580	ASACOL	PGA	\$	0.5590

500 MG ORAL ENTERIC-COATED TABLET

<input checked="" type="checkbox"/> 00002112787	SALOFALK	AXC	\$	0.5203
<input checked="" type="checkbox"/> 00001914030	MESASAL	GSK	\$	0.5857

800 MG ORAL ENTERIC-COATED TABLET

00002267217	ASACOL 800	PGA	\$	1.0643
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500 MG RECTAL SUPPOSITORY

00002112760	SALOFALK	AXC	\$	1.1710
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1 G RECTAL SUPPOSITORY

00002153564	PENTASA	FEI	\$	1.7523
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1,000 MG RECTAL SUPPOSITORY

00002242146	SALOFALK	AXC	\$	1.7200
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1 G / ENM RECTAL ENEMA

00002153521	PENTASA (1G/100ML)	FEI	\$	3.9775
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2 G / ENM RECTAL ENEMA

00002112795	SALOFALK (2G/60G)	AXC	\$	3.7729
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56:00 GASTROINTESTINAL DRUGS**56:40 MISCELLANEOUS GI DRUGS****5-AMINOSALICYLIC ACID**

4 G / ENM RECTAL ENEMA

<input checked="" type="checkbox"/>	00002153556	PENTASA (4G/100 ML)	FEI	\$	4.7945
<input checked="" type="checkbox"/>	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
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PINAVERIUM BROMIDE

50 MG ORAL TABLET

00001950592	DICETEL	SLO	\$	0.3720
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100 MG ORAL TABLET

00002230684	DICETEL	SLO	\$	0.6622
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RABEPRAZOLE SODIUM

10 MG ORAL ENTERIC-COATED TABLET

00002243796	PARIET	JOI	\$	0.6987
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20 MG ORAL ENTERIC-COATED TABLET

00002243797	PARIET	JOI	\$	1.3975
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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
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TRIMEBUTINE MALEATE**100 MG ORAL TABLET**

00002245663	APO-TRIMEBUTINE	APX	\$	0.2598
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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
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GOLD SODIUM THIOMALATE**10 MG / ML INJECTION**

00002245456	SODIUM AUROTHIOMALATE	SDZ	\$	8.1133
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00001927620	MYOCHRYSINE	AVE	\$	11.2230
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25 MG / ML INJECTION

00002245457	SODIUM AUROTHIOMALATE	SDZ	\$	9.8433
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50 MG / ML INJECTION

00002245458	SODIUM AUROTHIOMALATE	SDZ	\$	15.2867
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00001927604	MYOCHRYSINE	AVE	\$	21.1453
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64:00 HEAVY METAL ANTAGONISTS

64:00

DEFEROXAMINE MESYLATE

500 MG / VIAL INJECTION

00002241600	DEFERRIOXAMINE MESILATE	HSP	\$	8.1750
00002242055	PMS-DEFEROXAMINE	PMS	\$	8.1750
00001981242	DEFERLAL	NOV	\$	14.0503

2 G / VIAL INJECTION

00002247022	DEFERRIOXAMINE MESILATE	HSP	\$	35.1500
00002243450	PMS-DEFEROXAMINE	PMS	\$	35.1500
00001981250	DEFERLAL	NOV	\$	56.4375

PENICILLAMINE

250 MG ORAL CAPSULE

00000016055	CUPRIMINE	MFC	\$	0.7941
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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
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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
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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**

<input checked="" type="checkbox"/>	00002261731	YASMIN 28	BHP	\$	0.4143
<input checked="" type="checkbox"/>	00002261723	YASMIN 21	BHP	\$	0.5524

ETHYNODIOL DIACETATE/ ETHINYL ESTRADIOL**2 MG * 30 MCG ORAL TABLET**

<input checked="" type="checkbox"/>	00000471526	DEMULEN 30 (28 DAY)	PFI	\$	0.4982
<input checked="" type="checkbox"/>	00000469327	DEMULEN 30 (21 DAY)	PFI	\$	0.6210

LEVONORGESTREL**0.75 MG ORAL TABLET**

	00002241674	PLAN B	PAL	\$	7.9750
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52 MG INTRAUTERINE INSERT

	00002243005	MIRENA SYSTEM	BHP	\$	303.8000
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LEVONORGESTREL/ ETHINYL ESTRADIOL**100 MCG * 20 MCG ORAL TABLET**

<input checked="" type="checkbox"/>	00002236975	ALESSE (28 DAY)	WAY	\$	0.5229
<input checked="" type="checkbox"/>	00002236974	ALESSE (21 DAY)	WAY	\$	0.6972

150 MCG * 30 MCG ORAL TABLET

<input checked="" type="checkbox"/>	00002042339	MIN-OVRAL (28 DAY)	WAY	\$	0.5229
<input checked="" type="checkbox"/>	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**

<input checked="" type="checkbox"/>	00000707503	TRIQUILAR (28 DAY)	BHP	\$	0.4036
<input checked="" type="checkbox"/>	00002043734	TRIPHASIL (28 DAY)	WAY	\$	0.5229
<input checked="" type="checkbox"/>	00000707600	TRIQUILAR (21 DAY)	BHP	\$	0.5381
<input checked="" type="checkbox"/>	00002043726	TRIPHASIL (21 DAY)	WAY	\$	0.6972

NORETHINDRONE**0.35 MG ORAL TABLET**

	00000037605	MICRONOR (28 DAY)	JOI	\$	0.5064
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NORETHINDRONE ACETATE/ ETHINYL ESTRADIOL**1 MG * 20 MCG ORAL TABLET**

<input checked="" type="checkbox"/>	00000343838	MINISTRIN 1/20 (28 DAY)	PAL	\$	0.4172
<input checked="" type="checkbox"/>	00000315966	MINISTRIN 1/20 (21 DAY)	PAL	\$	0.5563

1.5 MG * 0.03 MG ORAL TABLET

<input checked="" type="checkbox"/>	00000353027	LOESTRIN 1.5/30 (28 DAY)	PAL	\$	0.4172
<input checked="" type="checkbox"/>	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**

<input checked="" type="checkbox"/>	00002187094	BREVICON 0.5/35 (28 DAY)	PFI	\$	0.4268
<input checked="" type="checkbox"/>	00000340731	ORTHO 0.5/35 (28 DAY)	JOI	\$	0.5064
<input checked="" type="checkbox"/>	00002187086	BREVICON 0.5/35 (21 DAY)	PFI	\$	0.5690
<input checked="" type="checkbox"/>	00000317047	ORTHO 0.5/35 (21 DAY)	JOI	\$	0.6752

1 MG * 0.035 MG ORAL TABLET

<input checked="" type="checkbox"/>	00002199297	SELECT 1/35 (28 DAY)	PFI	\$	0.2882
<input checked="" type="checkbox"/>	00002197502	SELECT 1/35 (21 DAY)	PFI	\$	0.3843
<input checked="" type="checkbox"/>	00002189062	BREVICON 1/35 (28 DAY)	PFI	\$	0.4268
<input checked="" type="checkbox"/>	00000372838	ORTHO 1/35 (28 DAY)	JOI	\$	0.5064
<input checked="" type="checkbox"/>	00002189054	BREVICON 1/35 (21 DAY)	PFI	\$	0.5690
<input checked="" type="checkbox"/>	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**

<input checked="" type="checkbox"/>	00002187116	SYNPHASIC (28 DAY)	PFI	\$	0.3925
<input checked="" type="checkbox"/>	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**

<input checked="" type="checkbox"/>	00000602965	ORTHO 7/7/7 (28 DAY)	JOI	\$	0.5064
<input checked="" type="checkbox"/>	00000602957	ORTHO 7/7/7 (21 DAY)	JOI	\$	0.6752

NORGESTIMATE/ ETHINYL ESTRADIOL**0.25 MG * 0.035 MG ORAL TABLET**

<input checked="" type="checkbox"/>	00001992872	CYCLEN (28 DAY)	JOI	\$	0.5064
<input checked="" type="checkbox"/>	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**

<input checked="" type="checkbox"/>	00002258587	TRI-CYCLEN LO 28	JOI	\$	0.4415
<input checked="" type="checkbox"/>	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

<input checked="" type="checkbox"/>	00002029421	TRI-CYCLEN (28 DAY)	JOI	\$	0.5064
<input checked="" type="checkbox"/>	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
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68:00 HORMONES AND SYNTHETIC SUBSTITUTES**68:16 ESTROGENS****CONJUGATED ESTROGENS****0.3 MG ORAL TABLET**

	00002043394	PREMARIN	WAY	\$	0.1333
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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**

0000265489 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 PREPLUS WAY \$ 0.1368

0.625 MG * 5 MG ORAL TABLET

00002242879 PREPLUS 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
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50 MCG / DAY * 250 MCG / DAY * 50 MCG / DAY TRANSDERMAL PATCH

<input checked="" type="checkbox"/> 00002243530	ESTALIS SEQUI (4.33+4.8*.51MG)	NOV	\$	2.9589
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<input checked="" type="checkbox"/> 00002108186	ESTRACOMB (4+30*10MG/PTH)	NOV	\$	3.0410
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ESTROPIPATE**0.625 MG ORAL TABLET**

00002089793	OGEN	PFI	\$	0.1918
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1.25 MG ORAL TABLET

00002089769	OGEN	PFI	\$	0.3424
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2.5 MG ORAL TABLET

00002089777	OGEN	PFI	\$	0.5414
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NORETHINDRONE ACETATE/ ESTRADIOL-17B**140 MCG / DAY * 50 MCG / DAY TRANSDERMAL PATCH**

00002241835	ESTALIS (2.7*.62 MG/PTH)	NOV	\$	3.1700
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250 MCG / DAY * 50 MCG / DAY TRANSDERMAL PATCH

00002241837	ESTALIS (4.8*.51 MG/PTH)	NOV	\$	3.1700
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68:00 HORMONES AND SYNTHETIC SUBSTITUTES**68:20:08 ANTIDIABETIC AGENTS****(INSULINS)****INSULIN ASPART****100 UNIT / ML INJECTION**

00002245397	NOVORAPID	NNA	\$	2.7870
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100 UNIT / ML INJECTION CARTRIDGE

00002244353	NOVORAPID	NNA	\$	3.7180
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INSULIN HUMAN BIOSYNTHETIC (ISOPHANE)**100 UNIT / ML INJECTION**

<input checked="" type="checkbox"/> 00000587737	HUMULIN N	LIL	\$	1.8060
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<input checked="" type="checkbox"/> 00002024225	NOVOLIN GE NPH	NNA	\$	1.9800
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100 UNIT / ML INJECTION CARTRIDGE

<input checked="" type="checkbox"/> 00001959239	HUMULIN N CARTRIDGE	LIL	\$	2.4976
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<input checked="" type="checkbox"/> 00002024268	NOVOLIN GE NPH PENFILL	NNA	\$	2.6120
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INSULIN HUMAN BIOSYNTHETIC (REGULAR)**100 UNIT / ML INJECTION**

<input checked="" type="checkbox"/> 00000586714	HUMULIN R	LIL	\$	1.8060
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<input checked="" type="checkbox"/> 00002024233	NOVOLIN GE TORONTO	NNA	\$	1.9800
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100 UNIT / ML INJECTION CARTRIDGE

<input checked="" type="checkbox"/> 00001959220	HUMULIN R CARTRIDGE	LIL	\$	2.4976
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<input checked="" type="checkbox"/> 00002024284	NOVOLIN GE TORONTO PENFILL	NNA	\$	2.6120
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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**

<input checked="" type="checkbox"/>	00000795879	HUMULIN 30/70	LIL	\$	1.8060
<input checked="" type="checkbox"/>	00002024217	NOVOLIN GE 30/70	NNA	\$	1.9800

30 UNIT / ML * 70 UNIT / ML INJECTION CARTRIDGE

<input checked="" type="checkbox"/>	00001959212	HUMULIN 30/70 CARTRIDGE	LIL	\$	2.4976
<input checked="" type="checkbox"/>	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
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50 UNIT / ML * 50 UNIT / ML INJECTION CARTRIDGE

	00002024322	NOVOLIN GE 50/50 PENFILL	NNA	\$	2.6400
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INSULIN LISPRO**100 UNIT / ML INJECTION**

	00002229704	HUMALOG	LIL	\$	2.7080
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100 UNIT / ML INJECTION CARTRIDGE

	00002229705	HUMALOG	LIL	\$	3.6113
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INSULIN LISPRO/ INSULIN LISPRO PROTAMINE**25 % * 75 % INJECTION CARTRIDGE**

	00002240294	HUMALOG MIX 25	LIL	\$	3.6113
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68:00 HORMONES AND SYNTHETIC SUBSTITUTES**68:20:20 ANTIDIABETIC AGENTS****(SULFONYLUREAS)****CHLORPROPAMIDE****100 MG ORAL TABLET**

	00000399302	APO-CHLORPROPAMIDE	APX	\$	0.0720
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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
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68:00 HORMONES AND SYNTHETIC SUBSTITUTES**68:20:92 ANTIDIABETIC AGENTS****(MISCELLANEOUS ANTIDIABETIC AGENTS)****ACARBOSE****50 MG ORAL TABLET**

00002190885	GLUCOBAY	BAI	\$	0.2628
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100 MG ORAL TABLET

00002190893	GLUCOBAY	BAI	\$	0.3639
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GLUCAGON, RDNA ORIGIN**1 MG / VIAL INJECTION**

00002243297	GLUCAGON	LIL	\$	88.3543
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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
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30 MG (BASE) ORAL TABLET

00002242573	ACTOS	LIL	\$	3.2325
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45 MG (BASE) ORAL TABLET

00002242574	ACTOS	LIL	\$	4.8604
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REPAGLINIDE**0.5 MG ORAL TABLET**

00002239924	GLUCONORM	NNA	\$	0.2975
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1 MG ORAL TABLET

00002239925	GLUCONORM	NNA	\$	0.3093
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2 MG ORAL TABLET

00002239926	GLUCONORM	NNA	\$	0.3213
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ROSIGLITAZONE MALEATE**2 MG (BASE) ORAL TABLET**

00002241112	AVANDIA	GSK	\$	1.3110
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4 MG (BASE) ORAL TABLET

00002241113	AVANDIA	GSK	\$	2.0572
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8 MG (BASE) ORAL TABLET

00002241114	AVANDIA	GSK	\$	2.9419
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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
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150 MG / ML INJECTION

00000585092	DEPO-PROVERA	PFI	\$	29.5200
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PROGESTERONE**100 MG ORAL CAPSULE**

00002166704	PROMETRIUM	SCH	\$	0.8864
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50 MG / ML INJECTION

00001977652	PROGESTERONE	CYT	\$	6.3000
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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
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60 MG ORAL TABLET

00000023957	THYROID	ERF	\$	0.0534
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125 MG ORAL TABLET

00000023965	THYROID	ERF	\$	0.0860
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LEVOTHYROXINE SODIUM**0.025 MG ORAL TABLET**

00002172062	SYNTHROID	ABB	\$	0.0785
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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
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80:00 SERUMS, TOXOIDS, AND VACCINES

80:04 SERUMS

ALLERGY SERUM

INJECTION

00000999981	ALLERGY SERUM	XXX	\$	0.0000
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80:00 SERUMS, TOXOIDS, AND VACCINES

80:12 VACCINES

HEPATITIS B VACCINE (RECOMBINANT)

10 MCG / ML INJECTION

00000749486	RECOMBIVAX-HB	MFC	\$	21.3500
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20 MCG / ML INJECTION

00001919431	ENGERIX-B	GSK	\$	21.1650
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84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS**84:04:04 ANTI-INFECTIVES****(ANTIBIOTICS)****FUSIDIC ACID****2% TOPICAL CREAM**

00000586668	FUCIDIN	LEO	\$	0.5989
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GENTAMICIN SULFATE**0.1% (BASE) TOPICAL CREAM**

00000805386	RATIO-GENTAMICIN SULFATE	RPH	\$	0.3560
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0.1% (BASE) TOPICAL OINTMENT

00000805025	RATIO-GENTAMICIN SULFATE	RPH	\$	0.3560
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00000872881	PMS-GENTAMICIN	PMS	\$	0.3913
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MUPIROCIN**2% TOPICAL CREAM**

00002239757	BACTROBAN	GKC	\$	0.5080
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2% TOPICAL OINTMENT

00002279983	TARO-MUPIROCIN	TAR	\$	0.3453
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00001916947	BACTROBAN	GKC	\$	0.5080
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NEOMYCIN SULFATE/ POLYMYXIN B SULFATE**40 MG / ML (BASE) * 200,000 UNIT / ML IRRIGATION SOLUTION**

00000666157	NEOSPORIN	GSK	\$	2.0100
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SODIUM FUSIDATE**2% TOPICAL OINTMENT**

00000586676	FUCIDIN	LEO	\$	0.5989
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84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS**84:04:08 ANTI-INFECTIVES****(ANTIFUNGALS)****CICLOPIROX OLAMINE****1% TOPICAL CREAM**

00002221802	LOPROX	SAV	\$	0.5088
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KETOCONAZOLE**2% TOPICAL CREAM**

00002245662	KETODERM	TPT	\$	0.3167
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00000703974	NIZORAL	MCL	\$	0.5113
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TERBINAFINE HCL**1% TOPICAL CREAM**

00002031094	LAMISIL	NOV	\$	0.5163
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1% TOPICAL SOLUTION

00002238703	LAMISIL	NOV	\$	0.5343
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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
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1 % TOPICAL CREAM

<input checked="" type="checkbox"/>	00002156091	NORITATE	SAV	\$	0.5304
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<input checked="" type="checkbox"/>	00002242919	ROSASOL	STI	\$	0.5307
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0.75 % TOPICAL LOTION

00002248206	METROLOTION	GAL	\$	0.4933
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0.75 % TOPICAL GEL

00002092832	METROGEL	GAL	\$	0.6000
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10 % VAGINAL CREAM

00001926861	FLAGYL	SAV	\$	0.2168
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METRONIDAZOLE/ NYSTATIN**100 MG / G * 20,000 UNIT / G VAGINAL CREAM**

00001926845	FLAGYSTATIN	SAV	\$	0.5303
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500 MG * 100,000 UNIT VAGINAL OVULE

00001926829	FLAGYSTATIN	SAV	\$	2.9165
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SILVER SULFADIAZINE**1 % TOPICAL CREAM**

00000323098	FLAMAZINE	SNE	\$	0.2612
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84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS

84:06 ANTI-INFLAMMATORY AGENTS

AMCINONIDE**0.1 % TOPICAL CREAM**

00002247098	RATIO-AMCINONIDE	RPH	\$	0.2737
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00002246714	TARO-AMCINONIDE	TAR	\$	0.2737
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00002192284	CYCLOCORT	STI	\$	0.5533
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0.1 % TOPICAL OINTMENT

00002247096	RATIO-AMCINONIDE	RPH	\$	0.2737
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00002192268	CYCLOCORT	STI	\$	0.5533
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0.1 % TOPICAL LOTION

00002247097	RATIO-AMCINONIDE	RPH	\$	0.2272
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00002192276	CYCLOCORT	STI	\$	0.4649
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BECLOMETHASONE DIPROPIONATE**250 MCG / G TOPICAL CREAM**

00002089602	PROPADERM	SHB	\$	0.4120
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BETAMETHASONE 17-VALERATE**0.05 % (BASE) TOPICAL CREAM**

00000716618	BETADERM MILD	TAR	\$	0.0606
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00000535427	RATIO-ECTOSONE MILD	RPH	\$	0.0611
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0.1 % (BASE) TOPICAL CREAM

00000716626	BETADERM REGULAR	TAR	\$	0.0903
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00000535435	RATIO-ECTOSONE REGULAR	RPH	\$	0.0911
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0.1 % (BASE) TOPICAL OCCLUSIVE CREAM

00000804541	PREVEX B	TCD	\$	0.3566
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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
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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
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DESOXIMETASONE**0.05 % TOPICAL CREAM**

00002221918	TOPICORT MILD	AVE	\$	0.4714
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0.25 % TOPICAL CREAM

00002221896	TOPICORT	AVE	\$	0.6799
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DIFLUCORTOLONE VALERATE**0.1 % TOPICAL CREAM**

<input checked="" type="checkbox"/> 00000587826	NERISONE	STI	\$	0.3905
<input checked="" type="checkbox"/> 00000587818	NERISONE OILY	STI	\$	0.3905

0.1 % TOPICAL OINTMENT

00000587834	NERISONE	STI	\$	0.3905
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FLUOCINONIDE**0.05 % TOPICAL CREAM**

00000716863	LYDERM	TPT	\$	0.2617
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0.05 % TOPICAL EMOLLIENT CREAM

00000598933	TIAMOL	TPT	\$	0.2433
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0.05 % TOPICAL OINTMENT

00002236996	LYDERM	TPT	\$	0.3370
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0.05 % TOPICAL GEL

00002236997	LYDERM	TPT	\$	0.3418
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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
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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
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PHENAZOPYRIDINE HCL

100 MG ORAL TABLET

00000271489	PHENAZO	VCL	\$	0.1269
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200 MG ORAL TABLET

00000454583	PHENAZO	VCL	\$	0.1582
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84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS**84:28 KERATOLYTIC AGENTS****PODOFILOX**

0.5 % TOPICAL SOLUTION

00002074788	WARTEC	PAL	\$	12.7867
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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
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ACITRETIN

10 MG ORAL CAPSULE

00002070847	SORIATANE	HLR	\$	1.7457
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25 MG ORAL CAPSULE

00002070863	SORIATANE	HLR	\$	3.0667
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CALCIPOTRIOL

50 MCG / G TOPICAL CREAM

00002150956	DOVONEX	LEO	\$	0.7498
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50 MCG / G TOPICAL OINTMENT

00001976133	DOVONEX	LEO	\$	0.7498
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50 MCG / ML SCALP SOLUTION

00002194341	DOVONEX	LEO	\$	0.7498
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DIMETHYL SULFOXIDE

70 % TOPICAL SOLUTION

00000376167	KEMSOL	AXS	\$	0.1808
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ISOTRETINOIN

10 MG ORAL CAPSULE

00000582344	ACCUTANE	HLR	\$	1.0011
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00002257955	CLARUS	PRP	\$	1.0011
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40 MG ORAL CAPSULE

00000582352	ACCUTANE	HLR	\$	2.0428
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00002257963	CLARUS	PRP	\$	2.0428
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TAZAROTENE

0.05 % TOPICAL GEL

00002230784	TAZORAC	ALL	\$	1.4203
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0.1 % TOPICAL GEL

00002230785	TAZORAC	ALL	\$	1.4203
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84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS**84:50:04 DEPIGMENTING & PIGMENTING AGENTS
(DEPIGMENTING AGENTS)****HYDROQUINONE****4 % TOPICAL CREAM**

<input checked="" type="checkbox"/>	00000626716	ULTRAQUIN	CDX	\$	0.6833
<input checked="" type="checkbox"/>	00000632783	ULTRAQUIN PLAIN	CDX	\$	0.6833
<input checked="" type="checkbox"/>	00001964534	ELDOPAQUE FORTE	VCL	\$	1.3330

4 % TOPICAL GEL

	00000626724	ULTRAQUIN	CDX	\$	0.6833
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84:00 SKIN AND MUCOUS MEMBRANE PREPARATIONS**84:50:06 DEPIGMENTING & PIGMENTING AGENTS
(PIGMENTING AGENTS)****METHOXSALLEN****10 MG ORAL CAPSULE**

<input checked="" type="checkbox"/>	00000252654	OXSORALEN ULTRA	VCL	\$	0.4623
<input checked="" type="checkbox"/>	00000646237	ULTRAMOP	CDX	\$	0.4755
<input checked="" type="checkbox"/>	00001946374	OXSORALEN	VCL	\$	0.6206

10 MG / ML TOPICAL LOTION

<input checked="" type="checkbox"/>	00000698059	ULTRAMOP	CDX	\$	1.0320
<input checked="" type="checkbox"/>	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
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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
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86:00 SMOOTH MUSCLE RELAXANTS**86:16 RESPIRATORY SMOOTH MUSC RELAXANTS****AMINOPHYLLINE****225 MG ORAL SUSTAINED-RELEASE TABLET**

00002014270	PHYLLOCONTIN	PUR	\$	0.2284
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350 MG ORAL SUSTAINED-RELEASE TABLET

00002014289	PHYLLOCONTIN-350	PUR	\$	0.2911
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25 MG / ML INJECTION

00000497193	AMINOPHYLLINE	HSP	\$	0.2840
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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
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THEOPHYLLINE**100 MG ORAL SUSTAINED-RELEASE TABLET**

00000692689	APO-THEO LA	APX	\$	0.1300
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200 MG ORAL SUSTAINED-RELEASE TABLET

00000692697	APO-THEO LA	APX	\$	0.1350
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300 MG ORAL SUSTAINED-RELEASE TABLET

00000692700	APO-THEO LA	APX	\$	0.1400
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400 MG ORAL SUSTAINED-RELEASE TABLET

00002014165	UNIPHYL	PUR	\$	0.5248
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600 MG ORAL SUSTAINED-RELEASE TABLET

00002014181	UNIPHYL	PUR	\$	0.6358
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5.3 MG / ML ORAL LIQUID

00001966219	THEOLAIR	GRC	\$	0.0205
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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

AMINO BENZOATE 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
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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
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10 MG / ML INJECTION

00002087316	LEUCOVORIN CALCIUM	NOP	\$	10.4000
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MONTELUKAST SODIUM**10 MG (BASE) ORAL TABLET**

00002238217	SINGULAIR	MFC	\$	2.2067
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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
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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
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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 ARELIA 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 ARELIA 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
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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

**ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
APPENDIX 1 - ABBREVIATIONS**

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.

ALBERTA HEALTH AND WELLNESS DRUG BENEFIT LIST REFRESHED
APPENDIX 2 - PHARMACEUTICAL MANUFACTURERS

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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