Health Canada Santé Canada

Spring 2016

Non-Insured Health Benefits

First Nations and Inuit Health Branch

Updates to the Drug Benefit List

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

BENEFIT DEFINITIONS

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

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

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

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

ADDITIONS TO THE DRUG BENEFIT LIST

OPEN BENEFITS

Single-Source Drug Products

DIN	MFR	BRAND NAME	Effective Date
09857398	ALL	LUMIGAN RC 0.01% 7.5ML (ON)	25-04-2016
80061575	RIV	[ST] CALCITE + D 400 O/L	22-04-2016
02269090	FRS	TRUSOPT 20MG/ML OPHTHALMIC SOLUTION	30-03-2016
02444062	ALC	SYSTANE OP OINTMENT	19-05-2016
09991319	NOV	SOURCE THICKEN UP 227G POWDER	27-05-2016
97799280	ALI	[ST] SURECOMFORT 29GX1/2 NEEDLE	11-03-2016
97799269	ALI	[ST] SURECOMFORT 30GX5/16 NEEDLE	11-03-2016
97799279	ALI	[ST] SURECOMFORT 31GX3/16 NEEDLE	11-03-2016
97799268	ALI	[ST] SURECOMFORT 31GX5/16 NEEDLE	11-03-2016
97799278	ALI	[ST] SURECOMFORT 32GX1/4 NEEDLE	11-03-2016
97799267	ALI	[ST] SURECOMFORT 32GX5/32 NEEDLE	11-03-2016
02354551	PED	RHINARIS NASAL MIST SPRAY	09-05-2016
97799257	ALI	[ST] SURECOMFORT 1/2 IN 28GX0.5CC	11-03-2016
97799275	ALI	[ST] SURECOMFORT 1/2 IN 28GX1CC SYRINGE	11-03-2016

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

Canada

DIN	MFR	BRAND NAME	Effective Date
97799260	ALI	[ST] SURECOMFORT 1/2 IN 29GX0.3CC	11-03-2016
97799259	ALI	[ST] SURECOMFORT 1/2 IN 29GX0.5CC	11-03-2016
97799258	ALI	[ST] SURECOMFORT 1/2 IN 29GX1CC	11-03-2016
97799264	ALI	[ST] SURECOMFORT 1/2 IN 30GX0.3CC	11-03-2016
97799270	ALI	[ST] SURECOMFORT 1/2 IN 30GX0.5CC	11-03-2016
97799271	ALI	[ST] SURECOMFORT 1/2 IN 30GX1CC	11-03-2016
97799261	ALI	[ST] SURECOMFORT 5/16 IN 30GX0.3CC	11-03-2016
97799272	ALI	[ST] SURECOMFORT 5/16 IN 30GX0.5CC	11-03-2016
97799265	ALI	[ST] SURECOMFORT 5/16 IN 30GX1CC	11-03-2016
97799273	ALI	[ST] SURECOMFORT 5/16 IN 31GX0.3CC	11-03-2016
97799274	ALI	[ST] SURECOMFORT 5/16 IN 31GX0.3CC	11-03-2016
97799263	ALI	[ST] SURECOMFORT 5/16 IN 31GX0.5CC	11-03-2016
97799262	ALI	[ST] SURECOMFORT 5/16 IN 31GX1CC	11-03-2016
80000352	WNP	[ST] VITAMIN B1 100MG TABLET	12-04-2016
12137029	NOV	RESOURCE THICKEN CLEAR POWDER	27-05-2016
00038202	HOS	STERILE WATER FOR INJECTION	13-06-2016

Multi-Source Drug Products

DIN	MFR	BRAND NAME	Effective Date
02396769	APX	APO-ABACAVIR 300MG TABLET	22-04-2016
02399539	APX	APO-ABACAV/LAMIVUD 600/300MG	22-04-2016
02450682	MYL	MYLAN-ABACAV/LAMIVUD 600/300MG	10-05-2016
02416662	TEP	TEVA-ABACAV/LAMIVUD 600/300MG	06-04-2016
02428725	VAN	[ST] VAN-ALENDRONATE 10MG TABLET	13-05-2016
02428717	VAN	[ST] VAN-ALENDRONATE 5MG TABLET	13-05-2016
02428733	VAN	[ST] VAN-ALENDRONATE 70MG TABLET	13-05-2016
02426994	VAN	[ST] VAN-AMLODIPINE 10MG TABLET	13-05-2016
02426986	VAN	[ST] VAN-AMLODIPINE 5MG TABLET	13-05-2016
01933353	TEP	AMPICILLIN SOD 2G INJECTION	23-06-2016
02427818	VAN	VAN-ANASTROZOLE 1MG TABLET	13-05-2016
02391082	JAP	[ST] JAMP-ATORVASTATIN 80MG TABLET	11-05-2016
02428709	VAN	VAN-BICALUTAMIDE 50MG TABLET	13-05-2016
02431645	ODN	[ST] CALCITRIOL-ODAN 0.5MCG CAPSULE	18-05-2016
80062015	SAN	[ST] CALCIUM CARBONATE 500MG TABLET	24-06-2016
02421038	AUR	[ST] AURO-CANDESARTAN-HCTZ 16/12.5MG	07-04-2016
02421046	AUR	[ST] AURO-CANDESARTAN-HCTZ 32/12.5MG	07-04-2016
02421054	AUR	[ST] AURO-CANDESARTAN-HCTZ 32/25MG	07-04-2016
02453363	APX	[ST] APO-CETIRIZINE 20MG TABLET	29-06-2016
02449099	JAP	[ST] JAMP-VITAMIN D 10,000U CAPSULE	29-06-2016
02437686	GMP	MED-DORZOLAMIDE-TIMOLOL 20MG/5	18-04-2016
02449048	LUP	[ST] LUPIN-ESTRADIOL 0.5MG TABLET	18-05-2016
02449056	LUP	[ST] LUPIN-ESTRADIOL 1MG TABLET	18-05-2016
02449064	LUP	[ST] LUPIN-ESTRADIOL 2MG TABLET	18-05-2016
02452383	APX	[ST] APO-FELODIPINE 10MG TABLET	27-04-2016
02452367	APX	[ST] APO-FELODIPINE 2.5MG TABLET	27-04-2016
02452375	APX	[ST] APO-FELODIPINE 5MG TABLET	27-04-2016
02427095	VAN	[ST] VAN-IRBESARTAN 150MG TABLET	13-05-2016
02427109	VAN	[ST] VAN-IRBESARTAN 300MG TABLET	13-05-2016
02427087	VAN	[ST] VAN-IRBESARTAN 75MG TABLET	13-05-2016
02433532	APX	BACKUP PLAN ONESTEP 1.5MG TABLET	29-03-2016
02426617	VAN	[ST] VAN-LOSARTAN 100MG TABLET	13-05-2016
02426595	VAN	[ST] VAN-LOSARTAN 25MG TABLET	13-05-2016
02426609	VAN	[ST] VAN-LOSARTAN 50MG TABLET	13-05-2016
80041590	JAP	JAMP-MAGNESIUM 100MG TABLET	09-06-2016
02438275	AUR	[ST] AURO-METFORMIN 500MG TABLET	22-04-2016
02438283	AUR	[ST] AURO-METFORMIN 850MG TABLET	22-04-2016

DIN	MFR	BRAND NAME	Effective Date
02422174	PMS	METHOTREXATE 10MG/0.4ML INJECTION	14-04-2016
02422182	PMS	METHOTREXATE 15MG/0.6ML INJECTION	14-04-2016
02422190	PMS	METHOTREXATE 20MG/0.8ML INJECTION	14-04-2016
02422166	PMS	METHOTREXATE 7.5MG/0.3ML INJECTION	14-04-2016
02422204	PMS	PMS-METHOTREXATE 25MG/ML INJECTION	21-04-2016
02148706	SDZ	NALOXONE 0.4MG/ML INJECTION	08-04-2016
02382601	SDZ	NALOXONE 0.4MG/ML INJECTION	08-04-2016
02382482	ALV	NALOXONE 0.4MG/ML INJECTION	08-04-2016
02453258	SDZ	S.O.S. NALOXONE HYDROCHLORIDE	23-06-2016
02441306	LUP	[ST] JENCYCLA 0.35MG 28 TABLET	13-05-2016
02374137	JAP	EMOLAX 1G/G POWDER	18-04-2016
02434032	VAN	[ST] VAN-QUETIAPINE 100MG TABLET	13-05-2016
02434040	VAN	[ST] VAN-QUETIAPINE 200MG TABLET	13-05-2016
02434024	VAN	[ST] VAN-QUETIAPINE 25MG TABLET	13-05-2016
02434059	VAN	[ST] VAN-QUETIAPINE 300MG TABLET	13-05-2016
02438860	VAN	[ST] VAN-RAMIPRIL 1.25MG CAPSULE	13-05-2016
02438895	VAN	[ST] VAN-RAMIPRIL 10MG CAPSULE	13-05-2016
02438909	VAN	[ST] VAN-RAMIPRIL 15MG CAPSULE	13-05-2016
02438879	VAN	[ST] VAN-RAMIPRIL 2.5MG CAPSULE	13-05-2016
02438887	VAN	[ST] VAN-RAMIPRIL 5MG CAPSULE	13-05-2016
02405628	SAN	[ST] ROSUVASTATIN 5MG TABLET	24-06-2016
02417731	PMS	[ST] PMS-SOLIFENACIN 10MG TABLET	13-05-2016
02417723	PMS	[ST] PMS-SOLIFENACIN 5MG TABLET	13-05-2016

NEW LIMITED USE BENEFITS

DIN	MFR	BRAND NAME	Effective Date
02269198	NOV	ACLASTA 5MG/100ML INJECTION	22-04-2016

Limited use benefit (prior approval required).

a- For the treatment of Paget's disease. Coverage will be granted for one dose per 12 month period. OR
b- For women with postmenopausal osteoporosis who would otherwise be eligible for coverage of oral bisphosphonates, but who have a contraindication to bisphosphonates due to hypersensitivity or abnormalities of the esophagus (e.g, esophageal stricture or achalasia);
AND who have at least two of the following:
i) age >70 years
ii) a prior fragility fracture
iii) a bone mineral density (BMD) T-score ≤ - 2.5.

09857313	NCA	NOVA MAX TEST STRIP	20-06-2016

Limited use benefit (prior approval not required).

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

DIN	MFR	BRAND NAME	Effective Date
02440423	APX	[ST] APO-DULOXETINE 30MG CAPSULE	29-06-2016
02440431	APX	[ST] APO-DULOXETINE 60MG CAPSULE	29-06-2016
02436647	AUR	[ST] AURO-DULOXETINE 30MG CAPSULE	29-06-2016
02436655	AUR	[ST] AURO-DULOXETINE 60MG CAPSULE	29-06-2016
02437082	TEP	[ST] DULOXETINE DR 30MG CAPSULE	29-06-2016
02437090	TEP	[ST] DULOXETINE DR 60MG CAPSULE	29-06-2016
02438984	MIN	[ST] MINT-DULOXETINE 30MG CAPSULE	29-06-2016
02438992	MIN	[ST] MINT-DULOXETINE 60MG CAPSULE	29-06-2016
02429446	PMS	[ST] PMS-DULOXETINE 30MG CAPSULE	29-06-2016
02429454	PMS	[ST] PMS-DULOXETINE 60MG CAPSULE	29-06-2016
02438259	RBY	[ST] RAN-DULOXETINE 30MG CAPSULE	29-06-2016
02438267	RBY	[ST] RAN-DULOXETINE 60MG CAPSULE	29-06-2016
02439948	SDZ	[ST] SANDOZ DULOXETINE 30MG CAPSULE	29-06-2016
02439956	SDZ	[ST] SANDOZ DULOXETINE 60MG CAPSULE	29-06-2016

Limited use benefit (prior approval is not required).

The dose of duloxetine is limited to a maximum of 60 mg per day

02443937	BOE	[ST] JARDIANCE 10MG TABLET	28-06-2016
02443945	BOE	[ST] JARDIANCE 25MG TABLET	28-06-2016

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea

02428741	VAN	[ST] VAN-FINASTERIDE 5MG TABLET	11-05-2016

Limited use benefit (prior approval required).

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

02408872	GSK	BREO ELLIPTA 100/25MCG	28-06-2016

Limited use benefit (prior approval required).

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

02425165	AUR	[ST] AURO-GALANTAMINE ER 16MG CAPSULE	07-04-2016
02425173	AUR	[ST] AURO-GALANTAMINE ER 24MG CAPSULE	07-04-2016
02425157	AUR	[ST] AURO-GALANTAMINE ER 8MG CAPSULE	07-04-2016

Limited use benefit (prior approval required).

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

Criteria for coverage at every 12 month interval:
f- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
g- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10

DIN	MFR	BRAND NAME	Effective Date
02413175	JNO	SIMPONI 100MG SYRINGE	04-03-2016
02413183	JNO	SIMPONI 100MG/ML INJECTION	04-03-2016

Limited use benefit (prior approval required).

The coverage of golimumab in adult patients ≥ 18 years is set at a MAXIMUM dose of 50mg every month for the 3 indications.

1. For the treatment of severely active RHEUMATOID ARTHRITIS:
Criteria for initial for one year:
a- Prescribed by a rheumatologist

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

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS
Criteria for initial for one year:
a- Prescribed by a rheumatologist

Client who meet all least 2 of the following criteria:
b- 5 or more swollen joints
c- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
d- more than one joint with erosion on imaging study
e- dactylitis of two or more digits
f- tenosynovitis refractory to oral NSAIDs and steroid injections
g- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
h- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
i- daily use of corticosteroids
j- use of opioids > 12 hours per day for pain resulting from inflammation

Patient is refractory to:
i) NSAIDs AND
ii) methotrexate weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks PLUS
a minimum of one of the following:
iii) leflunomide: 20mg daily for 10 weeks OR
iv) gold: weekly injections for 20 weeks OR
v) cyclosporine: 2-5 mg/kg/day for 12 weeks OR
vi) sulfasalazine at least 2g daily for 3 months.

3. For the treatment of ANKYLOSING SPONDYLITIS when the following criteria are met:
Criteria for initial for one year:
a- Prescribed by a rheumatologist

Client who meet all of the following criteria:
b- BASDAI > 4 AND
c- patient is refractory to a three month trial of at least 3 NSAIDs at maximum tolerated dose AND for peripheral joint involvement, patient is refractory to weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks AND sulfasalazine 2g/day for four months.
NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

4. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:
a- Prescribed by expert in gastroenterology
b- Partial Mayo score > 4
c- Inadequate response to conventional therapies: 5-ASA 4grams/day for 6 weeks PLUS Prednisone 40mg daily for 2 weeks PLUS Azathioprine 2mg/kg/day for 12 weeks OR 6-mercaptopurine 1mg/kg/day for 12 weeks (unless the use of immunosuppressants is contraindicated)

02419475 HOS INFLECTRA 100MG VIAL INJECTION 09-03-2016
Limited use benefit (prior approval required).

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

02439603 BCM [ST] VYVANSE 10MG CAPSULE 28-06-2016
Limited use benefit (prior approval is not required).

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

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

02422050 SPC [ST] LATUDA 20MG TABLET 01-04-2016
02413361 SPC [ST] LATUDA 60MG TABLET 01-04-2016
Limited use benefit (prior approval required).

For the treatment of schizophrenia and schizoaffective disorders in patients:
a- who have intolerance or lack of response to an adequate trial of another antipsychotic agent; OR
b- a contraindication to another antipsychotic agent

02442353 JAP [ST] JAMP-MONTELUKAST 4MG TABLET 10-05-2016
02442361 JAP [ST] JAMP-MONTELUKAST 5MG TABLET 10-05-2016
Limited use benefit (prior approval required).

For treatment of:
a- asthma when used in patients on concurrent steroid therapy. OR
b- asthma patients not well controlled with or intolerant to inhaled corticosteroids.

02441888 BOE INSPIOLTO RESPIMAT 28-06-2016
Limited use benefit (prior approval required).

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

DIN	MFR	BRAND NAME	Effective Date
02434121	VAN	[ST] VAN-PIOGLITAZONE 15MG TABLET	13-05-2016
02434148	VAN	[ST] VAN-PIOGLITAZONE 30MG TABLET	13-05-2016
02434156	VAN	[ST] VAN-PIOGLITAZONE 45MG TABLET	13-05-2016

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

02405563	SAN	[ST] PREGABALIN 150MG CAPSULE	24-06-2016
02405539	SAN	[ST] PREGABALIN 25MG CAPSULE	24-06-2016
02405598	SAN	[ST] PREGABALIN 300MG CAPSULE	24-06-2016
02405547	SAN	[ST] PREGABALIN 50MG CAPSULE	24-06-2016
02405555	SAN	[ST] PREGABALIN 75MG CAPSULE	24-06-2016

Limited use benefit (prior approval required).

a- For the treatment of neuropathic pain in patients who have failed to effectively treat their pain with a tricyclic antidepressant (TCA). OR
b- For the treatment of neuropathic pain in patients who have a contraindication or intolerance with a TCA.

The dose of pregabalin is limited to a maximum of 600 mg per day

96899956	MIN	COMPACT SPACE PLUS LARGE MASK	10-03-2016
96899955	MIN	COMPACT SPACE PLUS MEDIUM MASK	10-03-2016
96899953	MIN	COMPACT SPACE PLUS NO MASK	10-03-2016
96899954	MIN	COMPACT SPACE PLUS SMALL MASK	10-03-2016

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

Coverage is granted for 2 spacer device every 12 months.

02435381	BOE	SPIRIVA RESPIMAT 2.5MCG	28-06-2016

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
a- did not respond to a trial of ipratropium (Atrovent); OR
b- did not have a previous trial of ipratropium, but who have moderate to severe COPD, defined as <60% FEV1, FEV1/FVC<0.7 and MRC 3 to 5.

02369680	APX	[ST] APO-TOLTERODINE 1MG TABLET	06-04-2016
02369699	APX	[ST] APO-TOLTERODINE 2MG TABLET	06-04-2016

Limited use benefit (prior approval required).

For the symptomatic relief of patients with an overactive bladder with symptoms of urinary frequency urgency or urge incontinence or any combination of these in patients who have failed on or are intolerant of therapy with oxybutynin OR solifenacin OR tolterodine ER.

02423596	GSK	INCRUSE ELLIPTA 62.5MCG	28-06-2016

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
a- did not respond to a trial of ipratropium (Atrovent); OR
b- did not have a previous trial of ipratropium, but who have moderate to severe COPD, defined as <60% FEV1, FEV1/FVC<0.7 and MRC 3 to 5.

CRITERIA CHANGES

CHANGE IN COVERAGE OF ORAL BISPHOSPHONATES

Effective March 10, 2016, the following bisphosphonates became an open benefits:

- RISEDRONATE 5MG, 30MG, 35MG AND 150MG
- ALENDRONATE 5MG, 10MG, 40MG AND 70MG
- ALENDRONATE/VITAMIN D3

This change is intended to increase client access to medications for the treatment and prevention of osteoporosis and Paget disease.

CHANGE IN COVERAGE OF LONG ACTING TOLTERODINE

Effective May 9, 2016, Detrol LA and generics (tolterodine) became an open benefit.

The following DINs were affected:
02244612 DETROL LA 2MG CAPSULE
02244613 DETROL LA 4MG CAPSULE
02404184 MYLAN-TOLTERODINE ER 2MG CAPSULE
02404192 MYLAN-TOLTERODINE ER 4MG CAPSULE
02412195 TEVA-TOLTERODINE LA 2MG CAPSULE
02412209 TEVA-TOLTERODINE LA 4MG CAPSULE
02413140 SANDOZ TOLTERODINE LA 2MG CAPSULE
02413159 SANDOZ TOLTERODINE LA 4MG CAPSULE

CHANGE IN COVERAGE OF SOLIFENACIN

Effective May 9, 2016, Vesicare and generics (solifenacin) became an open benefit.

The following DINs were affected:
02277263 VESICARE 5MG TABLET
02277271 VESICARE 10MG TABLET
02397900 TEVA-SOLIFENACIN 5MG TABLET
02397919 TEVA-SOLIFENACIN 10MG TABLET
02399032 SANDOZ SOLIFENACIN 5MG TABLET
02399040 SANDOZ SOLIFENACIN 10MG TABLET
02417723 PMS-SOLIFENACIN 5MG TABLET
02417731 PMS-SOLIFENACIN 10MG TABLET
02422239 ACT SOLIFENACIN 5MG TABLET
02422247 ACT SOLIFENACIN 10MG TABLET
02424339 JAMP-SOLIFENACIN 5MG TABLET
02424347 JAMP-SOLIFENACIN 10MG TABLET
02437988 RAN-SOLIFENACIN 5MG TABLET
02437996 RAN-SOLIFENACIN 10MG TABLET

ADDITIONS TO THE PALLIATIVE CARE FORMULARY

NIHB has added the following medications to the palliative care formulary.

97904341 ENSURE
97904333 ENSURE PLUS
97904317 ENSURE WITH FIBRE
00801054 ENSURE HIGH PROTEIN
95999970 BOOST HIPROTEIN
95999963 BOOST ORIGINAL
09853154 BOOST FRUIT BEVERAGE 235ML
95999975 BOOST PLUS
02238696 MOI-STIR SPRAY
02256711 RANITIDINE 25MG/ML INJECTION
02265524 TEVA-ONDANSETRON P/F 2MG/ML
02274418 SDZ-ONDANSETRON HCL 2MG/ML INJECTION
02279428 SDZ-ONDANSETRON P/F 2MG/ML INJECTION
02390019 AJ-ONDANSETRON 2MG/ML INJECTION
02390051 AJ-ONDANSETRON 2MG/ML INJECTION
02382539 FUROSEMIDE 10MG/ML INJECTION
02384094 FUROSEMIDE 10MG/ML INJECTION
02385414 GRANISETRON HCL 1MG/ML INJECTION
02238162 DIASTAT 5MG/ML RECTAL GEL PACK
09853430 DIASTAT 2X15MG RECTAL GEL PACK
09853340 DIASTAT RECTAL GEL 2X10MG PACK
91500004 STERILE SYRINGE PREP FEE

The Palliative Care Formulary includes medications used to provide comfort to those near the end of life.
Please note: A maximum 30 day supply will be reimbursed at any one time.