Bulletin #991

January 31, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective January 31, 2019.
  - The original brand product will be reimbursed at the new category MAP effective February 21, 2019. Prior to February 21, 2019, the original brand product will be reimbursed up to the higher MAP indicated on the attached list.

- Drug price changes
  - Products listed on the NB Drug Plans Formulary prior to January 31, 2019 will be reimbursed up to the new category MAP effective February 21, 2019. Prior to February 21, 2019, products in the category will be reimbursed up to the previous MAP.

- Delisted drug products
  - Manufacturers who did not confirm prices to the new lower MAP will have impacted products removed from the NB Drug Plans Formulary effective February 21, 2019.

If you have any questions, please contact our office at 1-800-332-3691.

The Formulary Updates are available online: www.gnb.ca/0212/BenefitUpdates-e.asp. To unsubscribe from the NB Drug Plans emailed announcements, please send a message to info@nbdrugs-medicamentsnb.ca.

Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Ambrisentan							
Tab	Orl	5 mg	Volibris	2307065	GSK	(SA)	125.0927
			Apo-Ambrisentan	2475375	APX		106.3288
		10 mg	Volibris	2307073	GSK	(SA)	125.0927
			Apo-Ambrisentan	2475383	APX		106.3288
Cephalexin							
Tab	Orl	250 mg	Apo-Cephalex	768723	APX	ABDEFGVW	0.0866
		500 mg	Apo-Cephalex	768715	APX	ABDEFGVW	0.1731
Furosemide							
Tab	Orl	20 mg	Apo-Furosemide	396788	APX	ADEFGVW	0.0218
		40 mg	Apo-Furosemide	362166	APX	ADEFGVW	0.0327
Hydrochlorothiazide							
Tab	Orl	12.5 mg	Mint-Hydrochlorothiazide	2425947	MNT	ADEFGV	0.0322
		25 mg	Mint-Hydrochlorothiazide	2426196	MNT	ADEFGV	0.0157
Moxifloxacin							
Tab	Orl	400 mg	M-Moxifloxacin	2472791	MRA	VW (SA)	1.5230
Pantoprazole Sodium							
ECT	Orl	40 mg	M-Pantoprazole	2467372	MRA	ADEFGV	0.2016
Travoprost / Timolol							
Liq	Oph	0.004% / 0.5%	Duo Trav PQ	2278251	NVR	ADEFGV	11.7900
			Apo-Travoprost-Timop	2415305	APX		8.8425

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Furosemide							
Tab	Orl	20 mg	Mint-Furosemide	2466759	MNT	ADEFGVW	0.0218
			Teva-Furosemide	337730	TEV		
Trifluridine							
Liq	Oph	1%	Viroptic	687456	VLN	ADEFGV	3.3851
Vancomycin							
Cap	Orl	125 mg	Jamp-Vancomycin	2407744	JPC	ADEFGVW	5.1800
Voriconazole							
Tab	Orl	50 mg	Sandoz Voriconazole	2399245	SDZ	(SA)	3.1958
			Teva-Voriconazole	2396866	TEV		
		200 mg	Sandoz Voriconazole	2399253	SDZ	(SA)	12.7777
			Teva-Voriconazole	2396874	TEV		

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Vancomycin						
Cap	Orl	125 mg	Vancomycin Hydrochloride	2377470	FKB	ADEFGVW
Voriconazole						
Tab	Orl	50 mg	Apo-Voriconazole	2409674	APX	(SA)
		200 mg	Apo-Voriconazole	2409682	APX	(SA)

Bulletin # 992

February 7, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective February 7, 2019.

Included in this bulletin:

- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits
- Drugs Reviewed and Not Listed

If you have any questions, please contact our office at 1-800-332-3691.

The Formulary Updates are available online: http://www.gnb.ca/0212/BenefitUpdates-e.asp. To unsubscribe from the NB Drug Plans email announcements, please send a message to info@nbdrugs-medicamentsnb.ca.

Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Brivaracetam (Brivlera™)	10 mg tablet 25 mg tablet 50 mg tablet 75 mg tablet 100 mg tablet	02452936 02452944 02452952 02452960 02452979	UCB	(SA)	MLP

For the adjunctive treatment of refractory partial-onset seizures (POS) in patients who are currently receiving two or more antiepileptic drugs, and who have had an inadequate response or intolerance to at least three other antiepileptic drugs.

Claim Notes:

- The patient must be under the care of a physician experienced in the treatment of epilepsy.
- Any combination of lacosamide, perampanel, eslicarbazepine, levetiracetam or brivaracetam will not be reimbursed.

Infliximab (Renflexis™)	100 mg vial	02470373	FRS	(SA)	MLP

Ankylosing Spondylitis

- For the treatment of patients with moderate to severe ankylosing spondylitis (e.g. Bath AS Disease Activity Index (BASDAI) score ≥ 4 on 10 point scale) who:
  - Have axial symptoms and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months or in whom NSAIDs are contraindicated, or
  - Have peripheral symptoms and who have failed to respond, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum period of 3 months and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.
- Requests for renewal must include information demonstrating the beneficial effects of the treatment, specifically:
  - A decrease of at least 2 points on the BASDAI scale, compared with the pre-treatment score, or
  - Patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as HAQ or "ability to return to work").

Clinical Note:

- Patients with recurrent uveitis (2 or more episodes within 12 months) as a complication to axial disease do not require a trial of NSAIDs alone.

Claim Notes:

- Must be prescribed by a rheumatologist or internist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- All new requests for coverage of infliximab will be approved for the biosimilar versions only.
- Initial Approval: 6 months.

- Renewal Approval: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Crohn's Disease

- For the treatment of patients with moderately to severely active Crohn's disease who have contraindications, or are refractory, to therapy with corticosteroids and other immunosuppressants.

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Combined use of more than one biologic DMARD will not be reimbursed.
- All new requests for coverage of infliximab will be approved for the biosimilar versions only.
- Initial Approval: 12 weeks.
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Plaque Psoriasis

- Requests will be considered for treatment of patients with severe, debilitating chronic plaque psoriasis who meet all of the following criteria:
  - Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genital region;
  - Failure to respond to, contraindications to or intolerance to methotrexate and cyclosporine;
  - Failure to respond to, intolerance to or unable to access phototherapy.
- Requests for renewal must include information demonstrating an adequate response, defined as:
  - ≥75% reduction in the Psoriasis Area and Severity Index (PASI) score from when treatment started (PASI 75), or
  - ≥50% reduction in the PASI score (PASI 50) with a ≥5 point improvement in the Dermatology Life Quality Index (DLQI) from when treatment started, or
  - A quantitative reduction in BSA affected with qualitative consideration of specific regions such as face, hands, feet, or genital region.

Claim Notes:

- Must be prescribed by a dermatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- All new requests for coverage of infliximab will be approved for the biosimilar versions only.
- Initial Approval: 12 weeks.
- Renewal Approval: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Psoriatic Arthritis

- For the treatment of patients with predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs at maximal tolerated dose for a minimum of two weeks each.
- For the treatment of patients with predominantly peripheral psoriatic arthritis who are

refractory, intolerant or have contraindications to:

- the sequential use of at least two NSAIDs at maximal tolerated dose for a minimum of two weeks each; and
- methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥15 mg if patient is ≥65 years of age) for a minimum of 8 weeks; and
- leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months

Clinical Notes:

1. For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
2. Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
3. Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- All new requests for coverage of infliximab will be approved for the biosimilar versions only.
- Initial Approval: 16 weeks.
- Renewal Approval: 1 year. Confirmation of continued response is required
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Rheumatoid Arthritis

- For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:
  - Methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥20 mg weekly (≥15 mg if patient is ≥65 years of age) for a minimum of 12 weeks; and
  - Methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks.

Clinical Notes:

1. For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
2. Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.
3. For patients who have intolerances preventing the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
4. Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
5. Intolerant is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- All new requests for coverage of infliximab will be approved for the biosimilar versions only.
- Initial Approval: 6 months.
- Renewal Approval: 1 year. Confirmation of continued response is required.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Ulcerative Colitis

- For the treatment of patients with moderately to severely active ulcerative colitis who have a partial Mayo score > 4, and a rectal bleeding subscore ≥ 2 and are:
  - refractory or intolerant to conventional therapy (i.e. aminosalicylates for a minimum of four weeks, and prednisone ≥ 40 mg daily for two weeks or IV equivalent for one week); or
  - corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year).
- Renewal requests must include information demonstrating the beneficial effects of the treatment, specifically:
  - a decrease in the partial Mayo score ≥ 2 from baseline, and
  - a decrease in the rectal bleeding subscore ≥1.

Clinical Notes:

1. Consideration will be given for patients who have not received a four week trial of aminosalicylates if disease is severe (partial Mayo score > 6).
2. Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
3. Intolerant is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs. The nature of the intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Combined use of more than one biologic DMARD will not be reimbursed.
- All new requests for coverage of infliximab will be approved for the biosimilar versions only.
- Initial Approval: 12 weeks.
- Renewal Approval: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Itraconazole (Sporanox®)	10 mg/mL oral solution	02231347	JAN	(SA)	MLP

For the treatment of immunocompromised adult patients with oral and/or esophageal candidiasis.

Clinical Note:

- Itraconazole oral solution is not interchangeable with itraconazole capsules due to differences in bioavailability.

Nusinersen (Spinraza™)	2.4 mg/mL intrathecal injection	02465663	BIG	(SA)	MLP

For the treatment of 5q spinal muscular atrophy (SMA), if the following criteria are met:

- Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygous mutation
- Genetic documentation of two copies of the survival motor neuron 2 (SMN2) gene
- Disease duration less than 26 weeks with onset of clinical signs and symptoms consistent with SMA after the first week of birth and on or before 7 months of age
- Patient is not requiring permanent invasive ventilation

Discontinuation Criteria:
Prior to the fifth dose or every subsequent dose:

- There is failure to demonstrate maintenance of motor milestone function as assessed using the Hammersmith Infant Neurological Examination [HINE] Section 2; or
- There is failure to demonstrate improvement in motor milestone function as assessed using the HINE Section 2; or
- Permanent invasive ventilation is required.

Clinical Note:

- Permanent invasive ventilation is defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Claim Notes:

- The patient must be under the care of a physician experienced in the treatment of SMA.
- Initial Approval: 6 months.
- Renewal Approval: 1 year.

Velaglucerase alfa (VPRIV®)	400 units per vial	02357119	SHI	(SA)	MLP

For the treatment of patients with symptomatic Gaucher disease type 1 (GD1).

Clinical Note:

- Requests for coverage must meet the criteria for diagnosis of GD1, indication for therapy and expected response to enzyme replacement therapy. These criteria are consistent with the Ontario Guidelines for the Treatment of Gaucher Disease. Please contact the NB Drug Plans at 1-800-332-3691 for the criteria.

Claim Notes:

- Approvals will be for a maximum of 60 units/kg every 2 weeks.
- Initial Approval: 6 months.
- Renewal Approval: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria					
Plerixafor (Mozobil®)	24 mg/1.2 mL solution for injection	02377225	SAV	(SA)	MLP

For use in combination with filgrastim to mobilize hematopoietic stem cells for subsequent autologous transplantation in patients who meet one of the following criteria:

- PBCD34+ count of less than 10 cells/μL after 4 days of filgrastim, or
- Less than 50% of the target CD34+ yield is achieved on the first day of apheresis (after being mobilized with filgrastim alone or following chemotherapy), or
- Failed a previous attempt for stem cell mobilization with filgrastim alone or following chemotherapy.

Claim Note:

- Reimbursement is limited to a maximum of 4 doses (0.24 mg/kg given daily) for a single mobilization attempt and to prescriptions written by an oncologist or hematologist.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Eluxadoline (Viberzi®)	75 mg tablet 100 mg tablet	02460890 02460904	ALL	Irritable Bowel Syndrome

Bulletin # 993

February 27, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective February 27, 2019.

Included in this bulletin:

- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits
- Drugs Reviewed and Not Listed

If you have any questions, please contact our office at 1-800-332-3691.

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Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Empagliflozin/Metformin (Synjardy™)	5 mg / 500 mg tablet 5 mg / 850 mg tablet 5 mg / 1000 mg tablet 12.5 mg / 500 mg tablet 12.5 mg / 850 mg tablet 12.5 mg / 1000 mg tablet	02456575 02456583 02456591 02456605 02456613 02456621	BOE	(SA)	MLP
	For the treatment of type 2 diabetes mellitus in patients who are already stabilized on therapy with empagliflozin and metformin, to replace the individual components of empagliflozin and metformin.				
Osimertinib (Tagrisso®)	40 mg tablet 80 mg tablet	02456214 02456222	AZE	(SA)	MLP
	For the treatment of patients with locally advanced (not amenable to curative therapy) or metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC) who have progressed on EGFR tyrosine kinase inhibitor (TKI) therapy. Renewal Criteria: • Written confirmation that the patient is responding to treatment. <u>Clinical Notes:</u> 1. Treatment should be discontinued upon clinically meaningful disease progression or unacceptable toxicity. 2. Prior treatment with EGFR TKI therapy is not required in patients with *de novo* T790M mutation-positive NSCLC. <u>Claim Notes:</u> • Initial approval period: 1 year. • Renewal approval period: 1 year.				

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria – Dipeptidyl peptidase 4 (DPP-4) inhibitors					
Linagliptin (Trajenta®)	5 mg tablet	02370921	BOE	(SA)	MLP
Saxagliptin (Onglyza®)	2.5 mg tablet 5 mg tablet	02375842 02333554	AZE	(SA)	MLP
Sitagliptin (Januvia®)	25 mg tablet 50 mg tablet 100 mg tablet	02388839 02388847 02303922	FRS	(SA)	MLP

For the treatment of type 2 diabetes as a third drug added to metformin and a sulfonylurea for patients with inadequate glycemic control on metformin and a sulfonylurea and in whom insulin is not an option.

Clinical Note:

- For patients who cannot take metformin and/or a sulfonylurea due to contraindications or intolerances, details must be provided.

New Indication and Revised Criteria

Empagliflozin (Jardiance®)	10 mg tablet 25 mg tablet	02443937 02443945	BOE	(SA)	MLP

1. For the treatment of type 2 diabetes mellitus in combination with metformin and a sulfonylurea in patients who have:
   - inadequate glycemic control on metformin and a sulfonylurea, or
   - a contraindication or intolerance to metformin and/or a sulfonylurea; and
   - insulin is not an option.

2. As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular death in patients with type 2 diabetes mellitus who have:
   - inadequate glycemic control despite an adequate trial of metformin, or a contraindication or intolerance to metformin; and
   - established cardiovascular disease.

Clinical Notes:

1. Intolerance is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.
2. Established cardiovascular disease is defined as one of the following (details must be provided):
   - History of myocardial infarction (MI).
   - Multi-vessel coronary artery disease in two or more major coronary arteries (irrespective of revascularization status).
   - Single-vessel coronary artery disease with significant stenosis and a positive non-invasive stress test.
   - Unstable angina with either coronary multi-vessel or single-vessel disease.
   - History of ischemic or hemorrhagic stroke.
   - Occlusive peripheral artery disease.

Revised Criteria

Fidaxomicin (Dificid®)	200 mg film-coated tablet	02387174	FRS	(SA)	MLP

For the treatment of patients with Clostridium difficile infection (CDI), where the patient has:

- a second or subsequent recurrence following treatment with oral vancomycin; or
- treatment failure with oral vancomycin for the current CDI episode; or
- an intolerance or contraindication to oral vancomycin.

Re-treatment criteria:

- Re-treatment with fidaxomicin will only be considered for an early relapse occurring

within 8 weeks of the start of the most recent fidaxomicin course.

Clinical Notes:

1. Treatment failure is defined as 14 days of vancomycin therapy without acceptable clinical improvement.
2. Intolerance is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Should be prescribed by, or in consultation with, an infectious disease specialist or gastroenterologist.
- Requests will be approved for 200 mg twice a day for 10 days.

New Indication

Ixekizumab (Taltz®)

80 mg/mL prefilled autoinjector 80 mg/mL prefilled syringe	02455102 02455110	LIL	(SA)	MLP

Psoriatic Arthritis

- For the treatment of patients with predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs at maximal tolerated dose for a minimum of two weeks each.
- For the treatment of patients with predominantly peripheral psoriatic arthritis who are refractory, intolerant or have contraindications to:
  - The sequential use of at least two NSAIDs at maximal tolerated dose for a minimum of two weeks each; and
  - Methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥15 mg if patient is ≥65 years of age) for a minimum of 8 weeks; and
  - Leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months.

Clinical Notes:

1. For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
2. Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
3. Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Approvals will be for 160 mg at week 0, followed by 80 mg every four weeks.
- Initial Approval: 6 months.
- Renewal Approval: 1 year. Confirmation of continued response is required.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Dexamethasone (Ozurdex®)	0.7 mg intravitreal implant	02363445	ALL	For the treatment of adult patients with diabetic macular edema who are pseudophakic.
Ozenoxacin (Ozanex™)	1% cream	02463504	CIP	For the treatment of impetigo in patients aged two months and older.

Bulletin #994

February 28, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective February 28, 2019.

- Drug price changes
  - Price decreases for products listed on the NB Drug Plans Formulary prior to February 28, 2019 will be reimbursed up to the new category MAP effective March 21, 2019. Prior to March 21, 2019, products in the category will be reimbursed up to the previous MAP.
  - Price increases for products listed on the NB Drug Plans Formulary prior to February 28, 2019 will be reimbursed up to the new category MAP effective February 28, 2019.

- Delisted drug products
  - Manufacturers who did not confirm prices to the new lower MAP or did not confirm prices with the pan-Canadian Pharmaceutical Alliance (pCPA) will have impacted products removed from the NB Drug Plans Formulary effective March 31, 2019.

If you have any questions, please contact our office at 1-800-332-3691.

The Formulary Updates are available online: www.gnb.ca/0212/BenefitUpdates-e.asp. To unsubscribe from the NB Drug Plans emailed announcements, please send a message to info@nbdrugs-medicamentsnb.ca.

Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Atenolol							
Tab	Orl	50 mg	Teva-Atenolol	2171791	TEV	ADEFGV	0.1107
		100 mg	Teva-Atenolol	2171805	TEV	ADEFGV	0.1821
Fluoxetine							
Cap	Orl	10 mg	Sandoz Fluoxetine	2479486	SDZ	ADEFGV	0.3404
		20 mg	Sandoz Fluoxetine	2479494	SDZ	ADEFGV	0.3311
Imiquimod							
Crm	Top	5%	Taro-Imiquimod Pump	2482983	TAR	(SA)	43.4350
Morphine							
SRT	Orl	100 mg	Sandoz Morphine SR	2478889	SDZ	ADEFGVW	1.5395
		200 mg	Sandoz Morphine SR	2478897	SDZ	ADEFGVW	2.7718
Simvastatin							
Tab	Orl	5 mg	pharma-Simvastatin	2469979	PMS	ADEFGV	0.1023
		80 mg	pharma-Simvastatin	2470012	PMS	ADEFGV	0.2501

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Amoxicillin / Clavulanate							
Tab	Orl	500 mg / 125 mg	Apo-Amoxi Clav	1916858	APX	ABDEFGVW	1.1333
Cimetidine							
Tab	Orl	300 mg	Apo-Cimetidine	487872	APX	ADEFGV	0.3423
Dexamethasone							
Tab	Orl	0.5 mg	Apo-Dexamethasone	2261081	APX	ADEFGVW	0.1564
			pms-Dexamethasone	1964976	PMS		
Morphine							
SRT	Orl	100 mg	Teva- Morphine SR	2302799	TEV	ADEFGVW	1.5395
		200 mg	Teva- Morphine SR	2302802	TEV	ADEFGVW	2.7718
Theophylline							
SRT	Orl	100 mg	Apo-Theo LA	692689	APX	ADEFGV	0.1624
		200 mg	Apo-Theo LA	692697	APX	ADEFGV	0.1805
		300 mg	Apo-Theo LA	692700	APX	ADEFGV	0.2186

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Alendronate						
Tab	Orl	70 mg	Mylan-Alendronate	2286335	MYL	ADEFGV
Amiodarone						
Tab	Orl	200 mg	Mylan-Amiodarone	2240604	MYL	ADEFGV
Amlodipine						
Tab	Orl	5 mg	pms-Amlodipine	2284065	PMS	ADEFGV
			Van-Amlodipine	2426986	VAN	
		10 mg	pms-Amlodipine	2284073	PMS	ADEFGV
			Van-Amlodipine	2426994	VAN	
Anastrozole						
Tab	Orl	1 mg	Med-Anastrozole	2379104	GMP	ADEFV
Atenolol						
Tab	Orl	25 mg	Mylan-Atenolol	2303647	MYL	ADEFGV
		50 mg	Mylan-Atenolol	2146894	MYL	ADEFGV
		100 mg	Mylan-Atenolol	2147432	MYL	ADEFGV
Atorvastatin						
Tab	Orl	10 mg	ratio-Atorvastatin	2350297	TEV	ADEFGV
		20 mg	ratio-Atorvastatin	2350319	TEV	ADEFGV
		40 mg	ratio-Atorvastatin	2350327	TEV	ADEFGV
Candesartan						
Tab	Orl	8 mg	Act Candesartan	2376539	TEV	ADEFGV
		16 mg	Act Candesartan	2376547	TEV	ADEFGV
Celecoxib						
Cap	Orl	100 mg	Mylan-Celecoxib	2423278	MYL	ADEFGV
		200 mg	Mylan-Celecoxib	2399881	MYL	ADEFGV
Ciprofloxacin						
Tab	Orl	250 mg	Mylan-Ciprofloxacin	2245647	MYL	BW (SA)
		500 mg	Mylan-Ciprofloxacin	2245648	MYL	BW (SA)
		750 mg	Auro-Ciprofloxacin	2381931	ARO	BW (SA)
Clonazepam						
Tab	Orl	0.5 mg	Teva-Clonazepam	2239024	TEV	ADEFGV
		2 mg	Mylan-Clonazepam	2230951	MYL	ADEFGV
			Teva-Clonazepam	2239025	TEV	
Cyclobenzaprine						
Tab	Orl	10 mg	Mylan-Cyclobenzaprine	2231353	MYL	ADEFGV

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Donepezil						
Tab	Orl	5 mg	Mylan-Donepezil	2359472	MYL	(SA)
Finasteride						
Tab	Orl	5 mg	Act Finasteride	2354462	TEV	ADEFGV
Fluoxetine						
Cap	Orl	20 mg	Act Fluoxetine	2242178	TEV	ADEFGV
			Mylan-Fluoxetine	2237814	MYL	
Gabapentin						
Cap	Orl	100 mg	Act Gabapentin	2256142	TEV	ADEFGVW
Imiquimod						
Crm	Top	5%	Apo-Imiquimod	2407825	APX	(SA)
Irbesartan / Hydrochlorothiazide						
Tab	Orl	150 mg / 12.5 mg	Act Irbesartan/HCT	2357399	TEV	ADEFGV
		300 mg / 12.5 mg	Apo-Irbesartan/HCTZ	2387654	APX	ADEFGV
		300 mg / 25 mg	Apo-Irbesartan/HCTZ	2387662	APX	ADEFGV
Metformin						
Tab	Orl	500 mg	Mylan-Metformin	2148765	MYL	ADEFGV
		850 mg	Mylan-Metformin	2229656	MYL	ADEFGV
Minocycline						
Cap	Orl	50 mg	Minocycline	2287226	SAS	ABDEFGVW
			pms-Minocycline	2294419	PMS	
		100 mg	Minocycline	2287234	SAS	ABDEFGVW
Montelukast						
TabC	Orl	4 mg	Auro-Montelukast Chewable	2422867	ARO	(SA)
		5 mg	Auro-Montelukast Chewable	2422875	ARO	(SA)
Mycophenolate						
Cap	Orl	250 mg	Van-Mycophenolate	2433680	VAN	ADEFGRV
Tab	Orl	500 mg	Van-Mycophenolate	2432625	VAN	ADEFGRV
Omeprazole						
SRT	Orl	20 mg	Van-Omeprazole	2432404	VAN	ABDEFGV
Pantoprazole						
ECT	Orl	20 mg	Ran-Pantoprazole	2305038	RAN	ADEFGV
		40 mg	Mylan-Pantoprazole	2299585	MYL	ADEFGV
Paroxetine						
Tab	Orl	10 mg	pms-Paroxetine	2247750	PMS	ADEFGV
		20 mg	Mylan-Paroxetine	2248013	MYL	ADEFGV

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Paroxetine						
Tab	Orl	30 mg	Mylan-Paroxetine	2248014	MYL	ADEFGV
Pramipexole						
Tab	Orl	0.25 mg	Pramipexole	2367602	SAS	ADEFV
		0.5 mg	Pramipexole	2367610	SAS	ADEFV
		1 mg	Pramipexole	2367629	SAS	ADEFV
Pregabalin						
Cap	Orl	25 mg	Act Pregabalin	2402912	TEV	ADEFGVW
		50 mg	Act Pregabalin	2402920	TEV	ADEFGVW
		75 mg	Act Pregabalin	2402939	TEV	ADEFGVW
		150 mg	Act Pregabalin	2402955	TEV	ADEFGVW
		300 mg	Act Pregabalin Mylan-Pregabalin	2402998 2382253	TEV MYL	ADEFGVW
Quetiapine						
Tab	Orl	25 mg	Teva-Quetiapine	2284235	TEV	ADEFGVW
		100 mg	Teva-Quetiapine	2284243	TEV	ADEFGVW
		200 mg	Teva-Quetiapine	2284278	TEV	ADEFGVW
		300 mg	Teva-Quetiapine	2284286	TEV	ADEFGVW
Ramipril						
Cap	Orl	1.25 mg	Act Ramipril	2295482	TEV	ADEFGV
		5 mg	Act Ramipril	2295504	TEV	ADEFGV
Risperidone						
Tab	Orl	0.25 mg	Act Risperidone	2282585	TEV	ADEFGV
		1 mg	Act Risperidone	2282607	TEV	ADEFGV
Rosuvastatin						
Tab	Orl	5 mg	Mylan-Rosuvastatin	2381265	MYL	ADEFGV
		10 mg	Mylan-Rosuvastatin Act Rosuvastatin	2381273 2339773	MYL TEV	ADEFGV
		20 mg	Mylan-Rosuvastatin Act Rosuvastatin	2381281 2339781	MYL TEV	ADEFGV
		40 mg	Mylan-Rosuvastatin Act Rosuvastatin	2381303 2339803	MYL TEV	ADEFGV
Sertraline						
Cap	Orl	100 mg	Ran-Sertraline	2374579	RAN	ADEFGV

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Simvastatin						
Tab	Orl	5 mg	pms-Simvastatin	2269252	PMS	ADEFGV
		20 mg	pms-Simvastatin	2269279	PMS	ADEFGV
		40 mg	pms-Simvastatin	2269287	PMS	ADEFGV
		80 mg	pms-Simvastatin	2269295	PMS	ADEFGV
Telmisartan						
Tab	Orl	40 mg	Apo-Telmisartan	2420082	APX	ADEFGV
			Mylan-Telmisartan	2376717	MYL	
		80 mg	Mylan-Telmisartan	2376725	MYL	ADEFGV
Telmisartan / Hydrochlorothiazide						
Tab	Orl	80 mg / 25 mg	Apo-Telmisartan/HCTZ	2420031	APX	ADEFGV
Valacyclovir						
Tab	Orl	500 mg	Co Valacyclovir	2331748	TEV	ADEFGV
Valsartan						
Tab	Orl	40 mg	Act Valsartan	2337487	TEV	ADEFGV
			Apo-Valsartan	2371510	APX	
		80 mg	Act Valsartan	2337495	TEV	ADEFGV
			Mylan-Valsartan	2383535	MYL	
		160 mg	Act Valsartan	2337509	TEV	ADEFGV
		320 mg	Act Valsartan	2337517	TEV	ADEFGV
Valsartan / Hydrochlorothiazide						
Tab	Orl	80 mg / 12.5 mg	Apo-Valsartan/HCTZ	2382547	APX	ADEFGV
		160 mg / 12.5mg	Apo-Valsartan/HCTZ	2382555	APX	ADEFGV
		160 mg / 25 mg	Apo-Valsartan/HCTZ	2382563	APX	ADEFGV
		320 mg / 12.5 mg	Apo-Valsartan/HCTZ	2382571	APX	ADEFGV
		320 mg / 25 mg	Apo-Valsartan/HCTZ	2382598	APX	ADEFGV
Venlafaxine						
SRC	Orl	75 mg	Act Venlafaxine XR	2304325	TEV	ADEFGV
Zopiclone						
Tab	Orl	5 mg	Act- Zopiclone	2271931	TEV	ADEFVW
			Mylan-Zopiclone	2296616	MYL	
		7.5 mg	Act- Zopiclone	2271958	TEV	ADEFVW
			Mylan-Zopiclone	2238596	MYL	

Bulletin # 995

March 27, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective March 27, 2019.

Included in this bulletin:

- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits
- Drugs Reviewed and Not Listed

If you have any questions, please contact our office at 1-800-332-3691.

The Formulary Updates are available online: http://www.gnb.ca/0212/BenefitUpdates-e.asp. To unsubscribe from the NB Drug Plans email announcements, please send a message to info@nbdrugs-medicamentsnb.ca.

Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Levofloxacin (Quinsair®)	240 mg / 2.4 mL solution for inhalation	02442302	HRZ	(SA)	MLP

For the treatment of chronic pulmonary *Pseudomonas aeruginosa* infections, when used as a cyclic treatment, in adult patients with cystic fibrosis who have experienced treatment failure with inhaled tobramycin.

Clinical Note:

- Cyclic treatment measured in 28-day cycles is defined as 28 days of treatment, followed by 28 days without treatment.

Claim Notes:

- Combined use of inhaled levofloxacin, either concurrently or for antibiotic cycling during off-treatment periods, with other inhaled antibiotics (e.g. tobramycin, aztreonam) will not be reimbursed.
- Requests will be considered for individuals in Plans ADEFGV.

Product	Strength	DIN	MFR	Plans	Cost Base
Taliglucerase alfa (Elelyso®)	200 unit/vial powder for injection	02425637	PFI	(SA)	MLP

For the treatment of patients with symptomatic Gaucher disease type 1 (GD1) for whom treatment with velaglucerase alfa is not tolerated or contraindicated.

Clinical Notes:

1. Velaglucerase alfa is the preferred reimbursed enzyme replacement therapy for GD1. Requests for patients currently using taliglucerase alfa who do not have a contraindication or intolerance to velaglucerase alfa will be considered for coverage of velaglucerase alfa only.
2. Requests for coverage must meet the criteria for diagnosis of GD1, indication for therapy and expected response to enzyme replacement therapy. These criteria are consistent with the Ontario Guidelines for the Treatment of Gaucher Disease. Please contact the NB Drug Plans at 1-800-332-3691 for the criteria.

Claim Notes:

- Approvals will be for a maximum of 60 units/kg every 2 weeks.
- Initial Approval: 6 months.
- Renewal Approval: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria – Biologic Disease-Modifying Antirheumatic Drugs for Plaque Psoriasis					
Adalimumab (Humira®)	40 mg / 0.8 mL pen and prefilled syringe	02258595	ABV	(SA)	MLP
Etanercept (Enbrel®)	25 mg/mL vial 50 mg/mL autoinjector and prefilled syringe	02242903 02274728	AGA	(SA)	MLP
Infliximab (Inflectra®)	100 mg vial	02419475	PFI	(SA)	MLP
Infliximab (Remicade®)	100 mg vial	02244016	JAN	(SA)	MLP
Infliximab (Renflexis™)	100 mg vial	02470373	FRS	(SA)	MLP
Ixekizumab (Taltz™)	80 mg/mL autoinjector 80 mg/mL prefilled syringe	02455102 02455110	LIL	(SA)	MLP
Secukinumab (Cosentyx®)	45 mg / 0.5 mL prefilled syringe and SensoReady pen	02438070	NVR	(SA)	MLP
Ustekinumab (Stelara®)	45 mg / 0.5 mL prefilled syringe 90 mg/mL prefilled syringe	02320673 02320681	JAN	(SA)	MLP

For the treatment of patients with chronic moderate to severe plaque psoriasis who meet all of the following criteria:

- Psoriasis Area Severity Index (PASI) > 10 and Dermatology Life Quality Index (DLQI) > 10, or major involvement of visible areas, scalp, genitals, or nails
- Refractory, intolerant or unable to access phototherapy
- Refractory, intolerant or have contraindications to one of the following:
  - Methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age) for a minimum of 12 weeks
  - Cyclosporine for a minimum of 6 weeks

Clinical Notes:

1. For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
2. Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
3. Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a dermatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.

- All new requests for coverage of infliximab will be approved for the biosimilar versions only.
- Maximum approved dosages as per existing criteria on the NB Drug Plans Formulary.
- Initial approval period: 12 weeks for secukinumab and ixekizumab, 16 weeks for others.
- Renewal approval period: 1 year. Confirmation of continued response is required.

Revised Criteria

Linagliptin / Metformin (Jentadueto®)	2.5 mg / 500 mg tablet 2.5 mg / 850 mg tablet 2.5 mg / 1000 mg tablet	02403250 02403269 02403277	BOE	(SA)	MLP

For the treatment of type 2 diabetes mellitus in patients who are already stabilized on therapy with linagliptin and metformin, to replace the individual components of linagliptin and metformin.

Revised Criteria

Saxagliptin / Metformin (Komboglyze®)	2.5 mg / 500 mg tablet 2.5 mg / 850 mg tablet 2.5 mg / 1000 mg tablet	02389169 02389177 02389185	AZE	(SA)	MLP

For the treatment of type 2 diabetes mellitus in patients who are already stabilized on therapy with saxagliptin and metformin, to replace the individual components of saxagliptin and metformin.

Revised Criteria

Sitagliptin / Metformin (Janumet®)	50 mg / 500 mg tablet 50 mg / 850 mg tablet 50 mg / 1000 mg tablet	02333856 02333864 02333872	FRS	(SA)	MLP
Sitagliptin / Metformin (Janumet XR®)	50 mg / 1000 mg extended release tablet	02416794	FRS	(SA)	MLP

For the treatment of type 2 diabetes mellitus in patients who are already stabilized on therapy with sitagliptin and metformin, to replace the individual components of sitagliptin and metformin.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Tapentadol (Nucynta® ER)	50 mg extended release tablet	02415577	PAL	For management of pain severe enough to require daily, continuous, long-term opioid treatment.
	100 mg extended release tablet	02415585		
	150 mg extended release tablet	02415593		
	200 mg extended release tablet	02415607		
	250 mg extended release tablet	02415615		

Bulletin #996

March 28, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective March 28, 2019.

- Drug price changes
  - Price decreases for products listed on the NB Drug Plans Formulary prior to March 28, 2019 will be reimbursed up to the new category MAP effective April 18, 2019. Prior to April 18, 2019, products in the category will be reimbursed up to the previous MAP.

- Delisted drug products
  - Manufacturers who did not confirm prices to the new lower MAP will have impacted products removed from the NB Drug Plans Formulary effective April 18, 2019.

If you have any questions, please contact our office at 1-800-332-3691.

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Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Amoxicillin							
Cap	Orl	250 mg	Jamp-Amoxicillin	2433060	JPC	ABDEFGVW	0.0672
		500 mg	Jamp-Amoxicillin	2433079	JPC	ABDEFGVW	0.1308
Bisoprolol							
Tab	Orl	5 mg	Mint-Bisoprolol	2465612	MNT	ADEFGV	0.0715
		10 mg	Mint-Bisoprolol	2465620	MNT	ADEFGV	0.1044
Fenofibrate							
Cap	Orl	67 mg	Apo-Feno-Micro	2243180	APX	ADEFGV	0.5479
Perindopril							
Tab	Orl	2 mg	Perindopril Erbumine	2479877	SIV	ADEFGV	0.1632
		4 mg	Jamp-Perindopril	2477017	JPC		
			Mint-Perindopril	2476770	MNT	ADEFGV	0.2042
			Perindopril Erbumine	2479885	SIV		
		8 mg	Jamp-Perindopril	2477025	JPC		
			Mint-Perindopril	2476789	MNT	ADEFGV	0.2831
			Perindopril Erbumine	2479893	SIV		
Quinapril / Hydrochlorothiazide							
Tab	Orl	10 mg / 12.5 mg	Auro-Quinapril HCTZ	2473291	ARO	ADEFGV	0.4786
		20 mg / 12.5 mg	Auro-Quinapril HCTZ	2473305	ARO	ADEFGV	0.4786
		20 mg / 25 mg	Auro-Quinapril HCTZ	2473321	ARO	ADEFGV	0.4602
Tenofovir							
Tab	Orl	300 mg	Jamp-Tenofovir	2479087	JPC	(SA)	4.8884

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Amoxicillin							
Cap	Orl	250 mg	Amoxicillin	2352710	SAS		
			Amoxicillin	2401495	SIV		
			Apo-Amoxi	628115	APX	ABDEFGVW	0.0672
			Auro-Amoxicillin	2388073	ARO		
			Novamoxin	406724	TEV		
		500 mg	Amoxicillin	2352729	SAS		
			Amoxicillin	2401509	SIV		
			Apo-Amoxi	628123	APX	ABDEFGVW	0.1308
			Auro-Amoxicillin	2388081	ARO		
			Novamoxin	406716	TEV		
Benzydamine							
Liq	Buc	0.15%	pms-Benzydamine	2239537	PMS	ADEFGV	0.0325

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Quinapril / Hydrochlorothiazide							
Tab	Orl	10 mg / 12.5 mg	Apo-Quinapril/HCTZ	2408767	APX	ADEFGV	0.4786
		20 mg / 12.5 mg	Apo-Quinapril/HCTZ	2408775	APX	ADEFGV	0.4786
		20 mg / 25 mg	Apo-Quinapril/HCTZ	2408783	APX	ADEFGV	0.4602

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Amoxicillin						
Cap	Orl	250 mg	Amoxicillin	2241826	NUM	ABDEFGVW
			pms-Amoxicillin	2230243	PMS	
		500 mg	Amoxicillin	2241827	NUM	ABDEFGVW
			pms-Amoxicillin	2230244	PMS	
Benzydamine						
Liq	Buc	0.15%	Odan-Benzydamine	2463105	ODN	ADEFGV

Bulletin # 997

April 29, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective April 29, 2019.

Included in this bulletin:

- Regular Benefit Additions
- Benefit Status Change
- Drugs Reviewed and Not Listed
- Update: Extemporaneous Preparations

If you have any questions, please contact our office at 1-800-332-3691.

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Regular Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Insulin glargine (Basaglar™)	100 units/mL KwikPen	02461528	LIL	ADEFGV	MLP
Listed on Additional Plans					
Lamivudine (3TC® and generics)	150 mg tablet 300 mg tablet	See NB Drug Plans Formulary or MAP List for Products		ADEFGUV	MAP
Special Authorization No Longer Required					
Montelukast (Singulair® and generics)	4 mg oral granules 4 mg chewable tablet 5 mg chewable tablet 10 mg tablet	See NB Drug Plans Formulary or MAP List for Products		ADEFGV	MAP
Tenofovir disoproxil (Viread® and generics)	300 mg tablet	See NB Drug Plans Formulary or MAP List for Products		ADEFGUV	MAP

Benefit Status Change

Product	Strength	DIN	MFR	Plans	Cost Base
Delisted					
Auranofin (Ridaura®)	3 mg capsule	01916823	XPI		

Effective April 29, 2019, auranofin (Ridaura) 3 mg capsules will be delisted as a benefit on the NB Drug Plans Formulary. Requests for special authorization will not be considered.

There are more effective and less costly agents for the treatment of rheumatoid arthritis listed as benefits.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Ustekinumab (Stelara®)	45 mg / 0.5 mL prefilled syringe 90 mg/mL prefilled syringe	02320673 02320681	JAN	For the treatment of adult patients with moderately to severely active Crohn's disease.

UPDATE: Extemporaneous Preparations

The policy for reimbursement of extemporaneous preparations (compounds) has been updated to clarify the intent of the policy regarding eligible benefits and submission of claims.

Changes are outlined below and the complete policy is in the NB Drug Plans Formulary (Appendix II). Please note that compounds that contain drugs listed as special authorization (SA) benefits must have SA approval prior to the claims being submitted.

Changes to Eligible Benefits Effective April 29, 2019

- **Anthralin weak ointment and soft pastes** (PINs 00902063, 00900907, 00900915 and 00901105) will be delisted as benefits. Compounds which contain anthralin for topical application remain eligible as regular benefit compounds and claims must be submitted using PIN 00901113.

- **Propylene glycol liquid for use in compounds for topical application** (PIN 00990884) will be delisted as a benefit. Claims for compounds which contain propylene glycol must be submitted using the DIN/PIN of the eligible main active ingredient.

- **Progesterone powder for use in compounds for topical application** (PIN 00990876) will be delisted as a benefit. For patients who have had a claim paid between October 29, 2018 and April 28, 2019, a special authorization request, documenting rationale for continued use, will be required for coverage to be considered. Requests for special authorization will not be considered for progesterone compounds that contain additional active ingredients or are not for topical application.

Non Benefits

- **Custom-compounded bioidentical hormone preparations** are not eligible benefits and special authorization requests are not considered.

  Bioidentical hormones such as estradiol, estrone, progesterone, testosterone and others are available commercially or can be compounded into different dosages and for different routes of administration. There is a lack of evidence that compounded preparations are safer or more effective than commercial products and their use is not supported by the Society of Obstetricians and Gynaecologists of Canada (SOGC).

Bulletin #998

April 30, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective April 30, 2019.
  - The original brand product will be reimbursed at the new category MAP effective May 21, 2019. Prior to May 21, 2019, the original brand product will be reimbursed up to the higher MAP indicated on the attached list.

- Drug price changes
  - Price decreases for products listed on the NB Drug Plans Formulary prior to April 30, 2019 will be reimbursed up to the new category MAP effective May 21, 2019. Prior to May 21, 2019, products in the category will be reimbursed up to the previous MAP.

- Delisted drug products
  - Manufacturers who did not confirm prices to the new lower MAP will have impacted products removed from the NB Drug Plans Formulary effective May 21, 2019.

If you have any questions, please contact our office at 1-800-332-3691.

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Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Abacavir							
Tab	Orl	300 mg	Mint-Abacavir	2480956	MNT	DU	3.4828
Acyclovir							
Ont	Top	5%	Zovirax	569771	VLN	ADEFGV	14.9170
			Apo-Acyclovir	2477130	APX		12.3114
Amoxicillin / Clavulanic Acid							
Tab	Orl	500 mg / 125 mg	Sandoz Amoxi-Clav	2482576	SDZ	ABDEFGVW	0.7555
		875 mg / 125 mg	Sandoz Amoxi-Clav	2482584	SDZ	ABDEFGVW	0.5551
Candesartan							
Tab	Orl	16 mg	Auro-Candesartan	2445808	ARO	ADEFGV	0.2281
		32 mg	Auro-Candesartan	2445816	ARO	ADEFGV	0.2281
Dabigatran Etexilate							
Cap	Orl	110 mg	Pradaxa	2312441	BOE	(SA)	1.6720
			Apo-Dabigatran	2468905	APX		1.2540
		150 mg	Pradaxa	2358808	BOE	(SA)	1.6720
			Apo-Dabigatran	2468913	APX		1.2540
Enalapril							
Tab	Orl	2.5 mg	Jamp-Enalapril	2474786	JPC	ADEFGV	0.1863
			Mar-Enalapril	2459450	MAR		
		5 mg	Jamp-Enalapril	2474794	JPC	ADEFGV	0.2203
			Mar-Enalapril	2459469	MAR		
		10 mg	Jamp-Enalapril	2474808	JPC	ADEFGV	0.2647
			Mar-Enalapril	2444771	MAR		
		20 mg	Jamp-Enalapril	2474816	JPC	ADEFGV	0.3195
			Mar-Enalapril	2444798	MAR		

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Abacavir							
Tab	Orl	300 mg	Apo-Abacavir	2396769	APX	DU	3.4828
Amoxicillin / Clavulanic Acid							
Tab	Orl	500 mg / 125 mg	Apo-Amoxi-Clav	2243351	APX	ABDEFGVW	0.7555
Clarithromycin							
Tab	Orl	500 mg	Apo-Clarithromycin	2274752	APX	ABDEFGVW	0.8318
			Ran Clarithromycin	2361434	RAN		
			Sandoz Clarithromycin	2266547	SDZ		
			Teva-Clarithromycin	2248805	TEV		

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Doxycycline							
Cap	Orl	100 mg	Apo-Doxy	740713	APX		
			Doxycycline	2351234	SAS	ABDEFGVW	0.5860
			Teva-Doxycycline	725250	TEV		

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	
Clarithromycin							
Tab	Orl	500 mg	Mylan-Clarithromycin	2248857	MYL	ABDEFGVW	0.8318
			pms-Clarithromycin	2247574	PMS		

Bulletin # 999

May 16, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective May 16, 2019.

Included in this bulletin:

- Special Authorization Benefit Additions
- Drugs Reviewed and Not Listed
- Field Change for Claim Submissions for Drugs on MLP List

If you have any questions, please contact our office at 1-800-332-3691.

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Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Alectinib (Alecensaro®)	150 mg capsule	02458136	HLR	(SA)	MLP

For the treatment of patients with anaplastic lymphoma kinase (ALK)-positive locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer when used:

- as first-line therapy, or
- following disease progression on, or intolerance to, crizotinib.

Renewal Criteria:

- Written confirmation that the patient is responding to treatment.

Clinical Note:

- Treatment should be discontinued upon clinically meaningful disease progression or unacceptable toxicity.

Claim Notes:

- Requests for alectinib will not be considered for patients who experience disease progression on any ALK inhibitor other than crizotinib.
- No further ALK inhibitor will be reimbursed following disease progression on alectinib.
- Initial approval period: 1 year.
- Renewal approval period: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Product	Strength	DIN	MFR	Plans	Cost Base
Brexpiprazole (Rexulti®)	0.25 mg tablet	02461749	OTS	(SA)	MLP
	0.5 mg tablet	02461757			
	1 mg tablet	02461765			
	2 mg tablet	02461773			
	3 mg tablet	02461781			
	4 mg tablet	02461803			

For the treatment of schizophrenia and related psychotic disorders (not dementia related) in adult patients with a history of intolerance or inadequate response to at least one less expensive antipsychotic agent, or who have a contraindication to less expensive agents.

Product	Strength	DIN	MFR	Plans	Cost Base
Glecaprevir/Pibrentasvir (Maviret™)	100 mg / 40 mg tablet	02467550	ABV	(SA)	MLP

For treatment-naïve or treatment-experienced adult patients with chronic hepatitis C virus (HCV) who meet the following criteria:

	Approval Period
Genotypes 1, 2, 3, 4, 5 or 6 • Treatment-naïve	8 weeks (12 weeks with cirrhosis)
Genotypes 1, 2, 4, 5 or 6 • Treatment-experienced with regimens containing peginterferon/ribavirin (PR) and/or sofosbuvir (SOF)	8 weeks (12 weeks with cirrhosis)
Genotype 1 • NS5A inhibitor treatment-naïve and treatment-experienced with regimens containing: – Boceprevir/PR; or – Simeprevir (SMV)/SOF; or – SMV/PR; or – Telaprevir/PR	12 weeks
Genotype 1 • NS3/4A inhibitor treatment-naïve and treatment-experienced with regimens containing: – Daclatasvir (DCV)/SOF; or – DCV/PR; or – Ledipasvir/SOF	16 weeks
Genotype 3 • Treatment-experienced with regimens containing PR and/or SOF	16 weeks

The following information is also required:

- Lab-confirmed hepatitis C genotype 1, 2, 3, 4, 5 or 6
- Quantitative HCV RNA value within the last 6 months
- Fibrosis stage

Clinical Note:

- Acceptable methods for the measurement of fibrosis score include Fibrotest, liver biopsy, transient elastography (FibroScan®), serum biomarker panels (such as AST-to-Platelet Ratio Index or Fibrosis-4 score) either alone or in combination.

Claim Notes:

- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other physician experienced in treating a patient with hepatitis C infection).
- Requests will be considered for individuals enrolled in Plans ADEFGV.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Framycetin sulfate/ Gramicidin/Phenylephrine hydrochloride (Soframycin® Nasal Spray)	12.5 mg/0.05 mg/2.5 mg/mL nasal spray	02224860	ERF	Nasal infections and/or congestion
Lenvatinib (Lenvima®)	8 mg/dose 10 mg/dose 14 mg/dose 18 mg/dose	02468220 02450321 02450313 02468239	EIS	In combination with everolimus for the treatment of patients with advanced or metastatic, clear-cell renal cell carcinoma following one prior vascular endothelial growth factor targeted therapy

Field Change for Claim Submissions for Drugs on MLP List

Currently, claims for drugs on the Manufacturer List Price (MLP) List are submitted with the drug cost and mark-up amounts in the drug cost field. Effective June 19, 2019, the drug cost and mark-up must be submitted in separate fields as indicated below.

Field	Information Required
Drug Cost	up to MLP
Mark-up	up to 8%

This change is being implemented to align with the format specified by the Canadian Pharmacists Association's Pharmacy Claim Standard. This is also how pharmacy claims are submitted for drugs on the Maximum Allowable Price (MAP) list.

Pharmacy software vendors have been notified of this change. More information on claim submissions is available on the NB Drug Plan Claims Submissions web page.

Bulletin #1000 May 30, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective May 30, 2019.
  - The original brand product will be reimbursed at the new category MAP effective June 20, 2019. Prior to June 20, 2019, the original brand product will be reimbursed up to the higher MAP indicated on the attached list.

- Drug price changes
  - Price decreases for products listed on the NB Drug Plans Formulary prior to May 30, 2019 will be reimbursed up to the new category MAP effective June 20, 2019. Prior to June 20, 2019, products in the category will be reimbursed up to the previous MAP.
  - Price increases for products listed on the NB Drug Plans Formulary prior to May 30, 2019 will be reimbursed up to the new category MAP effective May 30, 2019.

- Delisted drug products
  - Manufacturers who did not confirm prices to the new lower MAP will have impacted products removed from the NB Drug Plans Formulary effective June 20, 2019.

If you have any questions, please contact our office at 1-800-332-3691.

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Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Candesartan / Hydrochlorothiazide							
Tab	Orl	16 mg / 12.5 mg	Jamp-Candesartan HCT	2473240	JPC	ADEFGV	0.2156
		32 mg / 12.5 mg	Jamp-Candesartan HCT	2473259	JPC	ADEFGV	0.2156
		32 mg / 25 mg	Jamp-Candesartan HCT	2473267	JPC	ADEFGV	0.3008
Cefixime							
Pws	Orl	20 mg	Suprax	868965	ODN	ABDEFGVW	0.5198
			Auro-Cefixime	2468689	ARO		0.3899
Clozapine							
Tab	Orl	50 mg	AA-Clozapine	2458748	AAP	ADEFGV	1.3188
		200 mg	AA-Clozapine	2458756	AAP	ADEFGV	5.2892
Diclofenac / Misoprostol							
Tab	Orl	50 mg / 200 mcg	pms-Diclofenac-Misoprostol	2413469	PMS	ADEFGV	0.3027
		75 mg / 200mcg	pms-Diclofenac-Misoprostol	2413477	PMS	ADEFGV	0.4120
Gabapentin							
Cap	Orl	100 mg	Gabapentin	2416840	AHI	ADEFGVW	0.0416
		300 mg	Gabapentin	2416859	AHI	ADEFGVW	0.1012
		400 mg	Gabapentin	2416867	AHI	ADEFGVW	0.1206
Tab	Orl	600 mg	Auro-Gabapentin	2428334	ARO	ADEFGVW	0.1809
		800 mg	Auro-Gabapentin	2428342	ARO	ADEFGVW	0.2412
Mixed Salts Amphetamine							
ERC	Orl	5 mg	Apo-Amphetamine XR	2445492	APX	ADEFG	0.5372
		10 mg	Apo-Amphetamine XR	2445506	APX	ADEFG	0.6105
		15 mg	Apo-Amphetamine XR	2445514	APX	ADEFG	0.6838
		20 mg	Apo-Amphetamine XR	2445522	APX	ADEFG	0.7572
		25 mg	Apo-Amphetamine XR	2445530	APX	ADEFG	0.8305
		30 mg	Apo-Amphetamine XR	2445549	APX	ADEFG	0.9038
Pantoprazole Sodium							
ECT	Orl	40 mg	pms-Pantoprazole	2307871	PMS	ADEFGV	0.2016
Perindopril							
Tab	Orl	2 mg	Mar-Perindopril	2474824	MAR		
			Mint-Perindopril	2476762	MNT	ADEFGV	0.1632
			Perindopril Erbumine	2481634	SAS		
		4 mg	Mar-Perindopril	2474832	MAR	ADEFGV	0.2042
			Perindopril Erbumine	2481642	SAS		

Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Perindopril							
Tab	Orl	8 mg	Mar-Perindopril	2474840	MAR	ADEFGV	0.2831
			Perindopril Erbumine	2481650	SAS		
Sucralfate							
Tab	Orl	1 g	Apo-Sucralfate	2125250	APX	ADEFGV	0.3089

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Felodipine							
ERT	Orl	2.5 mg	Apo-Felodipine	2452367	APX	ADEFGV	0.3815
Fentanyl							
Pth	Trd	12 mcg	pms-Fentanyl MTX	2341379	PMS	W (SA)	2.2280
			Ran-Fentanyl matrix	2330105	RAN		
			Sandoz Fentanyl MTX	2327112	SDZ		
			Teva-Fentanyl	2311925	TEV		
		25 mcg	pms-Fentanyl MTX	2341387	PMS	W (SA)	3.6560
			Ran-Fentanyl matrix	2330113	RAN		
			Sandoz Fentanyl MTX	2327120	SDZ		
			Teva-Fentanyl	2282941	TEV		
		50 mcg	pms-Fentanyl MTX	2341395	PMS	W (SA)	6.8820
			Ran-Fentanyl matrix	2330121	RAN		
			Sandoz Fentanyl MTX	2327147	SDZ		
			Teva-Fentanyl	2282968	TEV		
		75 mcg	pms-Fentanyl MTX	2341409	PMS	W (SA)	9.6800
			Ran-Fentanyl matrix	2330148	RAN		
			Sandoz Fentanyl MTX	2327155	SDZ		
			Teva-Fentanyl	2282976	TEV		
		100 mcg	pms-Fentanyl MTX	2341417	PMS	W (SA)	12.0500
			Ran-Fentanyl matrix	2330156	RAN		
			Sandoz Fentanyl MTX	2327163	SDZ		
			Teva-Fentanyl	2282984	TEV		
Ferrous Fumarate							
Cap	Orl	300 mg	Euro-Fer	2237556	SDZ	AEFGV	0.1050
			Jamp-Fer	80024232	JPC		
Fluphenazine							
Tab	Orl	1 mg	Fluphenazine	405345	AAP	ADEFGV	0.1739
		2 mg	Fluphenazine	410632	AAP	ADEFGV	0.2252
		5 mg	Fluphenazine	405361	AAP	ADEFGV	0.1720

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Moclobemide							
Tab	Orl	100 mg	Moclobemide	2232148	AAP	ADEFGV	0.3400
		300 mg	Moclobemide	2240456	AAP	ADEFGV	1.0399
Sucralfate							
Tab	Orl	1 g	Teva-Sucralfate	2045702	TEV	ADEFGV	0.3089

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Fentanyl						
Pth	Trd	12 mcg	Mylan-Fentanyl matrix	2396696	MYL	W (SA)
		25 mcg	Mylan-Fentanyl matrix	2396718	MYL	W (SA)
		50 mcg	Mylan-Fentanyl matrix	2396726	MYL	W (SA)
		75 mcg	Mylan-Fentanyl matrix	2396734	MYL	W (SA)
		100 mcg	Mylan-Fentanyl matrix	2396742	MYL	W (SA)

Bulletin # 1001

June 6, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective June 6, 2019.

Included in this bulletin:

- Regular Benefit Additions
- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits

If you have any questions, please contact our office at 1-800-332-3691.

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Regular Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Micafungin sodium (Mycamine®)	50 mg vial 100 mg vial	02294222 02311054	ASL	ADEFGVW	MLP

Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Canakinumab (Ilaris®)	150 mg/mL powder for solution for injection 150 mg/mL solution for injection	02344939 02460351	NVR	(SA)	MLP

For the treatment of active systemic juvenile idiopathic arthritis, in patients 2 years of age or older, who have an inadequate response or intolerance to systemic corticosteroids (with or without methotrexate) and tocilizumab.

Clinical Note:

- Intolerance is defined as a serious adverse effect as described in the product monograph. The nature of the intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by, or in consultation with, a rheumatologist, who is familiar with the use of biologic DMARDs in children.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Approvals will be for 4 mg/kg for patients weighing more than 9 kg, to a maximum of 300 mg, administered every four weeks.
- Initial approval period: 16 weeks.
- Renewal approval period: 1 year. Confirmation of continued response is required.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Migalastat (Galafold®)	123 mg capsule	02468042	AMT	(SA)	MLP

For the treatment of Fabry Disease in adults with a lab-confirmed alpha-galactosidase (alpha-Gal A) mutation, determined to be amenable by an in vitro assay.

Clinical Note:

- Must be eligible for disease specific therapy for the treatment of Fabry Disease as determined through the Canadian Fabry Disease Initiative. Please contact the NB Drug Plans at 1-800-332-3691 for the request form.

Claim Notes:

- Combined use of more than one disease specific therapy (i.e., enzyme replacement therapy or chaperone therapy) will not be reimbursed.
- Initial approval period: 1 year.
- Renewal approval period: 1 year. Confirmation of continued response is required.

- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
New Indication					
Etanercept (Erelzi™)	25 mg / 0.5 mL prefilled syringe 50 mg/mL prefilled syringe 50 mg/mL prefilled auto-injector	02462877 02462869 02462850	SDZ	(SA)	MLP

Psoriatic Arthritis

- For the treatment of patients with predominantly axial psoriatic arthritis who are refractory, intolerant or have contraindications to the sequential use of at least two NSAIDs at maximal tolerated dose for a minimum of two weeks each.
- For the treatment of patients with predominantly peripheral psoriatic arthritis who are refractory, intolerant or have contraindications to:
  - the sequential use of at least two NSAIDs at maximal tolerated dose for a minimum of two weeks each; and
  - methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥15 mg if patient is ≥65 years of age) for a minimum of 8 weeks; and
  - leflunomide for a minimum of 10 weeks or sulfasalazine for a minimum of 3 months.

Clinical Notes:

1. For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
2. Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
3. Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- All new requests for coverage of etanercept will be approved for the biosimilar versions only.
- Approvals will be for a maximum of 50 mg once a week.
- Initial approval period: 16 weeks.
- Renewal approval period: 1 year. Confirmation of continued response is required.

Bulletin # 1002

June 24, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective June 24, 2019.

Included in this bulletin:

- Special Authorization Benefit Additions
- Reviewed and Not Listed

If you have any questions, please contact our office at 1-800-332-3691.

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Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Brodalumab (Siliq™)	210 mg / 1.5 mL prefilled syringe	02473623	BSL	(SA)	MLP

For the treatment of patients with chronic moderate to severe plaque psoriasis who meet all of the following criteria:

- Psoriasis Area Severity Index (PASI) > 10 and Dermatology Life Quality Index (DLQI) > 10, or major involvement of visible areas, scalp, genitals, or nails
- Refractory, intolerant or unable to access phototherapy
- Refractory, intolerant or have contraindications to one of the following:
  - Methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥ 15 mg if patient is ≥ 65 years of age) for a minimum of 12 weeks
  - Cyclosporine for a minimum of 6 weeks

Clinical Notes:

1. For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
2. Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
3. Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a dermatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Approvals will be for 210 mg at week 0, 1 and 2, then 210 mg every two weeks thereafter.
- Initial approval period: 16 weeks.
- Renewal approval period: 1 year. Confirmation of continued response is required.

Midostaurin (Rydapt™)	25 mg capsule	02466236	NVR	(SA)	MLP

For the treatment of adult patients with newly diagnosed FMS-like tyrosine kinase 3 (FLT3)-mutated acute myeloid leukemia (AML) when used in combination with standard cytarabine and daunorubicin (7+3) induction and cytarabine consolidation chemotherapy.

Claim Notes:

- Requests for midostaurin will not be considered when used as maintenance therapy, or as part of re-induction and/or re-consolidation.
- Requests for midostaurin in combination with idarubicin containing 7+3 induction and cytarabine consolidation chemotherapy will be considered.
- Approval period: Up to 6 cycles (maximum of 2 cycles of induction and 4 cycles of consolidation).
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Sandoz Opium & Belladonna®	65 mg / 15 mg suppository	01901869	SDZ	For the relief of moderate to severe pain associated with ureteral spasm not responsive to non-narcotic analgesics.
Darunavir / cobicistat / emtricitabine / tenofovir alafenamide (Symtuza™)	800 mg / 150 mg / 200 mg / 10 mg film-coated tablet	02473720	JAN	Treatment of HIV type 1 (HIV-1) infection.

Bulletin #1003 June 26, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective June 26, 2019.
  - The original brand product will be reimbursed at the new category MAP effective July 17, 2019. Prior to July 17, 2019, the original brand product will be reimbursed up to the higher MAP indicated on the attached list.

- Drug price changes
  - Price decreases for products listed on the NB Drug Plans Formulary prior to June 26, 2019 will be reimbursed up to the new category MAP effective July 17, 2019. Prior to July 17, 2019, products in the category will be reimbursed up to the previous MAP.
  - Price increases for products listed on the NB Drug Plans Formulary prior to June 26, 2019 will be reimbursed up to the new category MAP effective June 26, 2019.

- Delisted drug products
  - Products will be removed from the NB Drug Plans Formulary effective July 17, 2019.

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Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Atomoxetine							
Cap	Orl	10 mg	Auro-Atomoxetine	2471485	ARO	ADEFG	0.5106
		18 mg	Auro-Atomoxetine	2471493	ARO	ADEFG	0.5748
		25 mg	Auro-Atomoxetine	2471507	ARO	ADEFG	0.6420
		40 mg	Auro-Atomoxetine	2471515	ARO	ADEFG	0.7369
		60 mg	Auro-Atomoxetine	2471523	ARO	ADEFG	0.8092
		80 mg	Auro-Atomoxetine	2471531	ARO	ADEFG	1.2193
		100 mg	Auro-Atomoxetine	2471558	ARO	ADEFG	1.3382
Bupropion							
ERT	Orl	150 mg	Ran-Bupropion XL	2475804	RAN	ADEFGV	0.1463
		300 mg	Ran-Bupropion XL	2475812	RAN	ADEFGV	0.2927
Clarithromycin							
Tab	Orl	500 mg	Clarithromycin	2442485	SIV	ABDEFGVW	0.8318
Deferasirox							
Tab	Orl	90 mg	Jadenu	2452219	NVR	(SA)	10.7410
			Apo-Deferasirox (Type J)	2485265	APX		7.8909
		180 mg	Jadenu	2452227	NVR	(SA)	21.4830
			Apo-Deferasirox (Type J)	2485273	APX		15.7830
		360 mg	Jadenu	2452235	NVR	(SA)	42.9680
			Apo-Deferasirox (Type J)	2485281	APX		31.5683
Erlotinib							
Tab	Orl	25 mg	Nat-Erlotinib	2483912	NAT	ADEFGV	3.4615
		100 mg	Nat-Erlotinib	2483920	NAT	ADEFGV	13.2000
		150 mg	Nat-Erlotinib	2483939	NAT	ADEFGV	19.8000
Febuxostat							
Tab	Orl	80 mg	Uloric	2357380	TAK	(SA)	1.5900
			Mar-Febuxostat	2473607	MAR		1.1925
Ondansetron							
ODT	Orl	4 mg	Ondansetron ODT	2481723	SDZ	(SA)	3.2720
		8 mg	Ondansetron ODT	2481731	SDZ	(SA)	4.9930
Sodium Acid Phosphate / Sodium Bicarbonate / Potassium							
Evt	Orl	500 mg / 469 mg / 123 mg	Jamp-Sodium Phosphate	80047562	NVR	ADEFGV	1.4010

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Bupropion							
ERT	Orl	150 mg	Act Bupropion XL	2439654	ATV	ADEFGV	0.1463
			Mylan-Bupropion XL	2382075	MYL		
		300 mg	Act Bupropion XL	2439662	ATV	ADEFGV	0.2927
			Mylan-Bupropion XL	2382083	MYL		
Diazepam							
Tab	Orl	2 mg	Diazepam	405329	AAP	ADEFGV	0.0532
Doxazosin							
Tab	Orl	1 mg	Apo-Doxazosin	2240588	APX	ADEFGV	0.3437
			Teva-Doxazosin	2242728	TEV		
		2 mg	Apo-Doxazosin	2240589	APX	ADEFGV	0.4123
			Teva-Doxazosin	2242729	TEV		
		4 mg	Apo-Doxazosin	2240590	APX	ADEFGV	0.5361
			Teva-Doxazosin	2242730	TEV		
Erlotinib							
Tab	Orl	25 mg	Apo-Erlotinib	2461862	APX	ADEFGV	3.4615
			Teva-Erlotinib	2377691	TEV		
Hydrocortisone / Cinchocaine / Framycetin / Esculin							
Ont	Rt	5 mg / 5 mg / 10 mg / 10 mg	Proctol Ointment	2247322	ODN	ADEFGV	0.4000
			Sandoz Proctomyxin HC	2242527	SDZ		
Sup	Rt	5 mg / 5 mg / 10 mg / 10 mg	Proctol Suppositories	2247882	ODN	ADEFGV	0.6000
			Sandoz Proctomyxin HC Supp	2242528	SDZ		
Isosorbide Dinitrate							
Slt	Slg	5 mg	ISDN S/L	670944	AAP	ADEFGV	0.0633
Ketoprofen							
ECT	Orl	50 mg	Keto-E	790435	AAP	ADEFGV	0.3379
Nabumetone							
Tab	Orl	500 mg	Nabumetone	2238639	AAP	ADEFGV	0.6130
Norfloxacin							
Tab	Orl	400 mg	Norfloxacin	2229524	AAP	ADEFGVW	1.0933
Tryptophan							
Cap	Orl	500 mg	Apo-Tryptophan	2248540	APX	ADEFGV	0.3955
			Teva-Tryptophan	2240334	TEV		
Valganciclovir							
Tab	Orl	450 mg	Auro-Valganciclovir	2435179	ARO	ADEFGV	11.7106
			Teva-Valganciclovir	2413825	TEV		

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Product No Longer Marketed						
Diazepam						
Tab	Orl	2 mg	pms-Diazepam	2247490	PMS	ADEFGV
Norfloxacin						
Tab	Orl	400 mg	Teva-Norfloxacin	2237682	TEV	ADEFGVW
Valganciclovir						
Tab	Orl	450 mg	Apo-Valganciclovir	2393824	APX	ADEFGV

Bulletin # 1004

July 4, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective July 4, 2019.

Included in this bulletin:

- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits

If you have any questions, please contact our office at 1-800-332-3691.

The Formulary Updates are available online: http://www.gnb.ca/0212/BenefitUpdates-e.asp. To unsubscribe from the NB Drug Plans email announcements, please send a message to info@nbdrugs-medicamentsnb.ca.

Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Benralizumab (Fasenra®)	30 mg/mL prefilled syringe	02473232	AZE	(SA)	MLP

For the adjunctive treatment of severe eosinophilic asthma in adult patients who are inadequately controlled with high dose inhaled corticosteroids and one or more additional asthma controller(s) (e.g., long-acting beta-agonist), and meets one of the following criteria:

- blood eosinophil count of ≥ 0.3 x 10^9/L within the past 12 months and has experienced two or more clinically significant asthma exacerbations in the past 12 months, or
- blood eosinophil count of ≥ 0.15 x 10^9/L and is receiving maintenance treatment with oral corticosteroids (OCS).

Initial Discontinuation Criteria:

- Baseline asthma control questionnaire score has not improved at 12 months since the initiation of treatment, or
- No decrease in the daily maintenance OCS dose in the first 12 months of treatment, or
- Number of clinically significant asthma exacerbations has increased within the previous 12 months

Subsequent Discontinuation Criteria:

- Baseline asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
- Reduction in the daily maintenance OCS dose achieved after the first 12 months of treatment is not maintained subsequently, or
- Number of clinically significant asthma exacerbations has increased within the previous 12 months

Clinical Notes:

1. A baseline and annual assessment of asthma symptom control using a validated asthma control questionnaire must be provided.
2. High-dose inhaled corticosteroids is defined as greater than or equal to 500 mcg of fluticasone propionate or equivalent daily dose.
3. A significant clinical exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department or was hospitalized.

Claim Notes:

- Must be prescribed by a respirologist, clinical immunologist, allergist or internist experienced in the treatment of severe eosinophilic asthma.
- Combined use of benralizumab with other biologics used to treat asthma will not be reimbursed.
- Approvals will be for a maximum of 30 mg every four weeks for 12 weeks, then every eight weeks thereafter.
- Initial approval period: 1 year.
- Renewal approval period: 1 year.

Edoxaban (Lixiana®)	15 mg film-coated tablet 30 mg film-coated tablet 60 mg film-coated tablet	02458640 02458659 02458667	SEV	(SA)	MLP

Atrial fibrillation
For the prevention of stroke and systemic embolism in at-risk patients ($CHADS_2$ score ≥ 1) with non-valvular atrial fibrillation for whom:

- Anticoagulation is inadequate following at least a two month trial on warfarin; or
- Warfarin is contraindicated or not possible due to inability to regularly monitor through International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy and at home).

Clinical Note:

- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period.

Venous thromboembolic events treatment
For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

Clinical Note:

- When used for greater than 6 months, edoxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Claim Note:

- Approval period: 6 months.

Norethindrone acetate (Norlutate®)	5 mg tablet	00023760	ERF	(SA)	MLP

For the treatment of abnormal uterine bleeding in patients not able to be treated with other hormonal treatments.

Pegfilgrastim (Lapelga™)	6 mg / 0.6 mL prefilled syringe	02474565	APX	(SA)	MLP

For the prevention of febrile neutropenia in patients with non-myeloid malignancies receiving myelosuppressive chemotherapy with curative intent who:

- are at high risk of febrile neutropenia due to chemotherapy regimen, co-morbidities or pre-existing severe neutropenia; or
- have had an episode of febrile neutropenia, neutropenic sepsis or profound neutropenia in a previous cycle of chemotherapy; or
- have had a dose reduction, or treatment delay greater than one week due to neutropenia.

Clinical Note:

- Patients with non-curative cancer receiving chemotherapy with palliative intent are not eligible for coverage of pegfilgrastim for prevention of febrile neutropenia.

Teduglutide (Revestive®)	5 mg vial	02445727	SHI	(SA)	MLP

For the ongoing treatment of adult patients with Short Bowel Syndrome (SBS) who have all of the following:

- SBS as a result of major intestinal resection (e.g., volvulus, vascular disease, cancer, Crohn's disease, injury)
- dependency on parenteral nutrition (PN) for a least 12 months
- prior to initiating teduglutide, PN required at least three times weekly to meet caloric, fluid and electrolyte needs, due to ongoing malabsorption and stable PN frequency and volume for at least one month

A request for coverage for continued treatment will be considered if the patient has achieved at least a 20% reduction in PN volume compared to baseline, while on teduglutide therapy.

Renewal Criteria:

- Has maintained at least a 20% reduction in PN volume from baseline at 12 months.

Clinical Note:

- PN is defined as the parenteral delivery of lipids, protein and/or carbohydrates to address caloric needs, and intravenous fluids which addresses fluid and electrolyte needs of patients.

Claim Notes:

- Must be prescribed by a gastroenterologist or an internal medicine specialist with a specialty in gastroenterology.
- Approval period: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria					
Apixaban (Eliquis®)	2.5 mg tablet	02377233	BRI	(SA)	MLP

Venous thromboembolic event prophylaxis following total knee or total hip replacement surgery

For the prevention of venous thromboembolic events in patients who have undergone elective total knee replacement (TKR) surgery or total hip replacement (THR) surgery.

Clinical Note:

- The total duration of therapy includes the period during which doses are administered post-operatively in an acute care (hospital) setting, and the approval period is for the balance of the total duration after discharge.

Claim Notes:

- Maximum reimbursement without special authorization will be limited to 14 days of therapy (28 tablets) for TKR or 35 days of therapy (70 tablets) for THR, within a 6

month period.
- Subsequent reimbursement for prophylaxis within a 6 month period (i.e. second joint replacement procedure within the 6 month period) will require special authorization.

Revised Criteria

Apixaban (Eliquis®) 2.5 mg tablet 5 mg tablet	02377233 02397714	BRI	(SA)	MLP

Atrial fibrillation
For the prevention of stroke and systemic embolism in at-risk patients ($CHADS_2$ score ≥ 1) with non-valvular atrial fibrillation for whom:
- Anticoagulation is inadequate following at least a two month trial on warfarin; or
- Warfarin is contraindicated or not possible due to inability to regularly monitor through International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy and at home).

Clinical Note:
- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period.

Venous thromboembolic events treatment
For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

Clinical Note:
- When used for greater than 6 months, apixaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Claim Note:
- Approval Period: Up to 6 months.

Revised Criteria

Dabigatran Etexilate (Pradaxa® and generic brand) 110 mg capsule 150 mg capsule	See NB Drug Plans Formulary or MAP List for Products		(SA)	MAP

For the prevention of stroke and systemic embolism in at-risk patients ($CHADS_2$ score ≥ 1) with non-valvular atrial fibrillation for whom:
- Anticoagulation is inadequate following at least a two month trial on warfarin; or
- Warfarin is contraindicated or not possible due to inability to regularly monitor through International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy and at home).

Clinical Note:
- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period.

Revised Criteria

Mepolizumab (Nucala™)	100 mg/mL single-use vial	02449781	GSK	(SA)	MLP

For the adjunctive treatment of severe eosinophilic asthma in adult patients who are inadequately controlled with high-dose inhaled corticosteroids and one or more additional asthma controller(s) (e.g., a long-acting beta-agonist), and meets one of the following criteria:

- blood eosinophil count of ≥ 0.3 x 10^9/L and has experienced two or more clinically significant asthma exacerbations in the past 12 months, or
- blood eosinophil count of ≥ 0.15 x 10^9/L and is receiving treatment with daily oral corticosteroids (OCS).

Initial Discontinuation Criteria:

- Baseline asthma control questionnaire score has not improved at 12 months since the initiation of treatment, or
- No decrease in the daily maintenance OCS dose in the first 12 months of treatment, or
- Number of clinically significant asthma exacerbations has increased within the previous 12 months

Subsequent Discontinuation Criteria:

- Baseline asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
- Reduction in the daily maintenance OCS dose achieved after the first 12 months of treatment is not maintained subsequently, or
- Number of clinically significant asthma exacerbations has increased within the previous 12 months

Clinical Notes:

1. A baseline and annual assessment of asthma symptom control using a validated asthma control questionnaire must be provided.
2. High-dose inhaled corticosteroids is defined as greater than or equal to 500 mcg of fluticasone propionate or equivalent daily dose.
3. Significant clinical exacerbation is defined as worsening of asthma such that the treating physician elected to administer systemic glucocorticoids for at least 3 days or the patient visited an emergency department or was hospitalized.

Claim Notes:

- Must be prescribed by a respirologist, clinical immunologist, allergist or internist experienced in the treatment of severe eosinophilic asthma.
- Combined use of mepolizumab with other biologics used to treat asthma will not be reimbursed.
- Approvals will be for a maximum of 100 mg every four weeks.
- Initial approval period: 1 year.
- Renewal approval period: 1 year.

Revised Criteria

Rivaroxaban (Xarelto®)	10 mg tablet	02316986	BAY	(SA)	MLP

Venous thromboembolic event prophylaxis following total knee or total hip replacement surgery
For the prevention of venous thromboembolic events in patients who have undergone elective total knee replacement (TKR) surgery or total hip replacement (THR) surgery.

Clinical Note:

- The total duration of therapy includes the period during which doses are administered post-operatively in an acute care (hospital) setting, and the approval period is for the balance of the total duration after discharge.

Claim Notes:

- Maximum reimbursement without special authorization will be limited to 14 days of therapy (14 tablets) for TKR or 35 days of therapy (35 tablets) for THR, within a 6 month period.
- Subsequent reimbursement for prophylaxis within a 6 month period (i.e. second joint replacement procedure within the 6 month period) will require special authorization.

Revised Criteria

Rivaroxaban (Xarelto®)	15 mg tablet 20 mg tablet	02378604 02378612	BAY	(SA)	MLP

Atrial fibrillation
For the prevention of stroke and systemic embolism in at-risk patients ($CHADS_2$ score ≥ 1) with non-valvular atrial fibrillation for whom:

- Anticoagulation is inadequate following at least a two month trial on warfarin; or
- Warfarin is contraindicated or not possible due to inability to regularly monitor through International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy and at home).

Clinical Note:

- Inadequate anticoagulation is defined as INR testing results that are outside the desired INR range for at least 35% of the tests during the monitoring period.

Venous thromboembolic events treatment
For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE).

Clinical Note:

- When used for greater than 6 months, rivaroxaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin.

Claim Note:

- Approval Period: Up to 6 months.

Bulletin #1005 July 31, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective July 31, 2019.
  - The original brand product will be reimbursed at the new category MAP effective August 21, 2019. Prior to August 21, 2019, the original brand product will be reimbursed up to the higher MAP indicated on the attached list.

- Drug price changes
  - Price decreases for products listed on the NB Drug Plans Formulary prior to July 31, 2019 will be reimbursed up to the new category MAP effective August 21, 2019. Prior to August 21, 2019, products in the category will be reimbursed up to the previous MAP.
  - Price increases for products listed on the NB Drug Plans Formulary prior to July 31, 2019 will be reimbursed up to the new category MAP effective July 31, 2019.

- Drug category changes
  - Products in categories where there is no longer a generic brand will be moved to the Manufacturer List Price (MLP) List effective August 21, 2019.

- Delisted drug products
  - Products will be removed from the NB Drug Plans Formulary effective August 21, 2019.

If you have any questions, please contact our office at 1-800-332-3691.

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Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Calcitriol							
Cap	Orl	0.25 mcg	Taro-Calcitriol	2485710	TAR	ADEFGV	0.4682
		0.5 mcg	Taro-Calcitriol	2485729	TAR	ADEFGV	0.7446
Cholestyramine							
Pws	Orl	4 g	Jamp-Cholestyramine	2478595	JPC	ADEFGV	0.0923
Efavirenz							
Tab	Orl	600 mg	Jamp-Efavirenz	2458233	JPC	DU	3.8030
Eletriptan							
Tab	Orl	20 mg	Auro-Eletriptan	2479451	ARO	ADEFGV	2.6172
		40 mg	Auro-Eletriptan	2479478	ARO	ADEFGV	2.6172
Trospium							
Tab	Orl	20 mg	Trosec	2275066	SNV	(SA)	0.7635
			Mar-Trospium	2488353	MAR		0.6108
Varenicline							
Tab	Orl	0.5 mg	Teva-Varenicline	2426226	TEV	(SA)	0.9237
		1 mg	Teva-Varenicline	2426234	TEV	(SA)	0.9235

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Calcitriol							
Cap	Orl	0.25 mcg	Calcitriol-Odan	2431637	ODN	ADEFGV	0.4682
		0.5 mcg	Calcitriol-Odan	2431645	ODN	ADEFGV	0.7446
Cefprozil							
Pws	Orl	25 mg	Ran-Cefprozil	2329204	RAN	ADEFGVW	0.1649
		50 mg	Ran-Cefprozil	2293579	RAN	ADEFGVW	0.3294
Cholestyramine							
Pws	Orl	4 g	Cholestyramine-Odan	2455609	ODN		
			Olestyr	890960	PMS	ADEFGV	0.0923
			Olestyr	2210320	PMS		
Desmopressin							
Tab	Orl	0.1 mg	Desmopressin	2284030	AAP	DEF-18G (SA)	0.6609

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Mercaptopurine							
Tab	Orl	50 mg	Mercaptopurine	2415275	STR	ADEFGV	2.8372
			Purinethol	4723	TEV		
Meropenem							
Pws	Inj	1 g	Meropenem	2436507	STR	ADEFGVW	20.1051
Mirtazapine							
ODT	Orl	30 mg	Auro-Mirtazapine OD	2299828	ARO	ADEFGV	0.1950
Pindolol							
Tab	Orl	15 mg	Apo-Pindol	755893	APX	ADEFGV	0.8894
			Teva-Pindolol	869023	TEV		
Varenicline							
Tab	Orl	0.5 mg	Apo-Varenicline	2419882	APX	(SA)	0.9237
		1 mg	Apo-Varenicline	2419890	APX	(SA)	0.9235
Voriconazole							
Tab	Orl	200 mg	Sandoz Voriconazole	2399253	SDZ	(SA)	26.4807
			Teva-Voriconazole	2396874	TEV		

Drug Category Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Salbutamol							
Liq	Inh	5 mg/mL	Ventolin	2213486	GSK	BDEF-18GVW	
Sodium Aurothiomalate							
Liq	Inj	25 mg/mL	Myochrysine	1927612	SAV	ADEFGV	

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Product No Longer Marketed						
Cefprozil						
Pws	Orl	25 mg	Apo-Cefprozil	2293943	APX	ADEFGVW
		50 mg	Apo-Cefprozil	2293951	APX	ADEFGVW

Bulletin # 1006

August 26, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective August 26, 2019.

Included in this bulletin:

- Regular Benefit Additions
- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits
- Benefit Status Changes
- Drugs Reviewed and Not Listed

If you have any questions, please contact our office at 1-800-332-3691.

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Regular Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Alfacalcidol (One-Alpha®)	2 mcg/mL oral drops	02240329	LEO	ADEFGV	MLP
Sodium thiosulfate (Seacalphyx®)	250 mg/mL solution for injection	02386666	SFD	ADEFGVW	MLP
Special Authorization No Longer Required					
Repaglinide (GlucoNorm® and generic brands)	0.5 mg tablet 1 mg tablet 2 mg tablet	See NB Drug Plans Formulary or MAP List for products		ADEFGV	MAP

Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Apomorphine hydrochloride (Movapo™)	30 mg / 3 mL prefilled pen	02459132	PAL	(SA)	MLP

For the acute, intermittent treatment of hypomobility "off" episodes in patients with advanced Parkinson's Disease (PD) who are receiving optimized PD treatment (i.e. levodopa and derivatives and dopaminergic agonists).

Clinical Note:

- "Off" episodes are defined as "end of dose wearing off" and unpredictable "on/off" episodes.

Claim Notes:

- The patient must be under the care of a physician experienced in the diagnosis and treatment of PD.
- Approval period: 1 year.

Product	Strength	DIN	MFR	Plans	Cost Base
Buprenorphine hydrochloride (Probuphine™)	80 mg subdermal implant	02474921	KNI	(SA)	MAP

For the treatment of patients with opioid use disorder who have been stabilized on a dose of no more than 8 mg of sublingual buprenorphine for the preceding 90 days.

Clinical Note:

- Insertion of the subdermal implants should be performed by a healthcare provider who has completed the training program.

Claim Note:

- Approval period: 2 years.

Ceftolozane / Tazobactam (Zerbaxa®)	1 g / 0.5 g vial	02446901	FRS	W (SA)	MLP

For the treatment of patients with multidrug-resistant gram-negative infections, specifically caused by extended spectrum beta lactamase (ESBL)-producing *Enterobacteriaceae* and multidrug-resistant *Pseudomonas aeruginosa* when alternative agents are not an option.

Claim Notes:

- Must be prescribed by, or in consultation with, an infectious disease specialist or medical microbiologist.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Nitisinone (Orfadin®)	2 mg capsule 5 mg capsule 10 mg capsule 20 mg capsule	02459698 02459701 02459728 02459736	BVT	(SA)	MAP

For the treatment of adult and pediatric patients with hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine.

Claim Notes:

- Must be prescribed by, or in consultation with, a physician with experience in the diagnosis and management of HT-1.
- Approval period: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Sarilumab (Kevzara®)	150 mg / 1.14 mL prefilled syringe 200 mg / 1.14 mL prefilled syringe 150 mg / 1.14 mL prefilled pen 200 mg / 1.14 mL prefilled pen	02460521 02460548 02472961 02472988	SAV	(SA)	MLP

For the treatment of moderately to severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

- methotrexate (oral or parenteral), alone or in combination with another DMARD, at a dose of ≥ 20 mg weekly (≥15mg if patient is ≥65 years of age) for a minimum of 12 weeks; and
- methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks.

Clinical Notes:

1. For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
2. Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use.

3. For patients who have intolerances preventing the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried.
4. Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
5. Intolerant is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs. The nature of intolerance(s) must be clearly documented.

Claim Notes:

- Must be prescribed by a rheumatologist.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Approvals will be for a maximum of 200 mg every other week.
- Initial approval period: 16 weeks.
- Renewal approval period: 1 year. Confirmation of continued response is required.

Tigecycline (Tygacil®)	50 mg vial	02285401	PFI	W (SA)	MLP

For the treatment of patients with multi-drug resistant infections when alternative agents are not an option.

Claim Note:

- Must be prescribed by, or in consultation with, an infectious disease specialist or medical microbiologist.

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria					
Nusinersen (Spinraza™)	2.4 mg/mL intrathecal injection	02465663	BIG	(SA)	MLP

For the treatment of 5q spinal muscular atrophy (SMA), if the following criteria are met:

- Genetic documentation of 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygous mutation; and
- Patient is not requiring permanent invasive ventilation; and
- Patient who:
  - is pre-symptomatic with genetic documentation of two or three copies of the survival motor neuron 2 (SMN2) gene, or
  - has had disease duration less than 6 months, two copies of the SMN2 gene, and symptom onset after the first week of birth and on or before 7 months of age, or
  - is under the age of 18 with symptom onset after 6 months of age.

Discontinuation Criteria:

Prior to the fifth dose or every subsequent dose:

- There is failure to demonstrate achievement or maintenance of motor milestone function as assessed using age-appropriate scales since treatment initiation in patients who were pre-symptomatic at the time of treatment initiation; or

- There is failure to demonstrate maintenance in motor milestone function as assessed using age-appropriate scales since treatment initiation in patients who were symptomatic at the time of treatment initiation; or
- Permanent invasive ventilation is required.

Clinical Notes:

1. An age-appropriate scale is defined as the Hammersmith Infant Neurological Examination (HINE) Section 2, Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), or Hammersmith Functional Motor Scale-Expanded (HFMSE).
2. A baseline assessment using an age-appropriate scale must be completed prior to initiation of nusinersen treatment.
3. Permanent invasive ventilation is defined as the use of tracheostomy and a ventilator due to progression of SMA that is not due to an identifiable and reversible cause.

Claim Notes:

- The patient must be under the care of a specialist experienced in the treatment of SMA
- Approval period: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Requests for patients who do not meet the criteria may be considered on a case-by-case basis as outlined in the NB Drug Plans Special Authorization Policy.

Benefit Status Changes

Product	Strength	DIN	MFR	Plans	Cost Base
Delisted					
Ribavirin (Ibavyr™)	200 mg tablet 400 mg tablet 600 mg tablet	02439212 02425890 02425904	PDP		

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Guselkumab (Tremfya™)	100 mg/mL prefilled syringe	02469758	JAN	Treatment of moderate to severe plaque psoriasis.
Omalizumab (Xolair®)	75 mg / 0.5 mL prefilled syringe 150 mg/mL prefilled syringe 150 mg vial	02459787 02459795 02260565	NVR	Treatment of moderate to severe persistent asthma.

Bulletin #1007

August 29, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective August 29, 2019.

- Drug price changes
  - Price decreases for products listed on the NB Drug Plans Formulary prior to August 29, 2019 will be reimbursed up to the new category MAP effective September 19, 2019. Prior to September 19, 2019, products in the category will be reimbursed up to the previous MAP.

- Drug category changes
  - Products in categories where there is no longer a generic brand will be moved to the Manufacturer List Price (MLP) List effective September 19, 2019.

If you have any questions, please contact our office at 1-800-332-3691.

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Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Atomoxetine							
Cap	Orl	10 mg	Teva-Atomoxetine	2314541	TEV	ADEFG	0.5106
		18 mg	Teva-Atomoxetine	2314568	TEV	ADEFG	0.5748
		25 mg	Teva-Atomoxetine	2314576	TEV	ADEFG	0.6420
		40 mg	Teva-Atomoxetine	2314584	TEV	ADEFG	0.7369
		60 mg	Teva-Atomoxetine	2314592	TEV	ADEFG	0.8092
		80 mg	Teva-Atomoxetine	2362511	TEV	ADEFG	1.2193
Olmesartan / Hydrochlorothiazide							
Tab	Orl	20 mg / 12.5 mg	ACH-Olmesartan HCTZ	2468948	AHI	ADEFGV	0.3019
		40 mg / 12.5 mg	ACH-Olmesartan HCTZ	2468956	AHI	ADEFGV	0.3019
		40 mg / 25 mg	ACH-Olmesartan HCTZ	2468964	AHI	ADEFGV	0.3019
Paroxetine							
Tab	Orl	10 mg	pms-Paroxetine	2247750	PMS	ADEFGV	0.3046
Varenicline							
Kit	Orl	0.5 mg, 1 mg	Teva-Varenicline	2426781	TEV	(SA)	0.9203

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Mometasone							
Crm	Top	0.1%	Taro-Mometasone	2367157	TAR	ADEFGV	0.5542
Nitrofurantoin							
Cap	Orl	50 mg	Teva-Nitrofurantoin	2231015	TEV	ADEFGV	0.3252
Olmesartan / Hydrochlorothiazide							
Tab	Orl	20 mg / 12.5 mg	Act-Olmesartan HCT Apo-Olmesartan/HCTZ	2443112 2453606	TEV APX	ADEFGV	0.3019
		40 mg / 12.5 mg	Act-Olmesartan HCT Apo-Olmesartan/HCTZ	2443120 2453614	TEV APX	ADEFGV	0.3019
		40 mg / 25 mg	Act-Olmesartan HCT Apo-Olmesartan/HCTZ	2443139 2453622	TEV APX	ADEFGV	0.3019
Varenicline							
Kit	Orl	0.5 mg, 1 mg	Apo-Varenicline	2435675	APX	(SA)	0.9203

Drug Category Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Ofloxacin						
Liq	Oph	0.3%	Ocuflox	2143291	ALL	(SA)
Drospirenone / Ethinylestradiol						
Tab	Orl	3 mg / 0.03 mg	Yasmin (21)	2261723	BAY	DEFGV
		3 mg / 0.03 mg	Yasmin (28)	2261731	BAY	DEFGV

Bulletin # 1008

September 26, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective September 26, 2019.

Included in this bulletin:

- Regular Benefit Additions
- Changes to Existing Special Authorization Benefits
- Benefit Status Changes
- Drugs Reviewed and Not Listed

If you have any questions, please contact our office at 1-800-332-3691.

The Formulary Updates are available online: http://www.gnb.ca/0212/BenefitUpdates-e.asp. To unsubscribe from the NB Drug Plans email announcements, please send a message to info@nbdrugs-medicamentsnb.ca.

Regular Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Travoprost (Izba®)	0.003% ophthalmic solution	02457997	NVR	ADEFGV	MLP
Special Authorization No Longer Required					
Entecavir (Baraclude™ and generic brands)	0.5 mg tablet	See NB Drug Plans Formulary or MAP list for products		ADEFGV	MAP

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria					
Fentanyl (Duragesic® and generic brands)	12 mcg/hr transdermal patch 25 mcg/hr transdermal patch 50 mcg/hr transdermal patch 75 mcg/hr transdermal patch 100 mcg/hr transdermal patch	See NB Drug Plans Formulary or MAP list for products		W (SA)	MAP
	For the treatment of cancer-related or chronic non-cancer pain in adult patients who were previously receiving at least 60 mg per day of oral morphine equivalents and who: • had an inadequate response, intolerance, or contraindication to oral opioids; or • are unable to take oral therapy.				
New Indication					
Tocilizumab (Actemra®)	162 mg / 0.9 mL prefilled syringe	02424770	HLR	(SA)	MLP
	Giant Cell Arteritis • For the treatment of adult patients with new onset or relapsed giant cell arteritis (GCA) in combination with oral glucocorticoids. • Requests for renewal must include: – confirmation of response to treatment (e.g. absence of flares, normalization of C-reactive protein), and – description of attempts to taper or discontinue glucocorticoids, and – rationale for the need for ongoing treatment. <u>Clinical Note:</u> • A flare is defined as the recurrence of signs or symptoms and/or erythrocyte sedimentation rate ≥ 30 mm/hour. <u>Claim Notes:</u> • Must be prescribed by, or in consultation with, a rheumatologist or other physician experienced in the treatment of GCA. • Combined use of more than one biologic DMARD will not be reimbursed.				

- Subcutaneous injection: Approvals will be for up to 162 mg every week.
- Approval period: 1 year.

Benefit Status Changes

Product	Strength	DIN	MFR	Plans	Cost Base
Delisted Cromolyn sodium (pms-Sodium Cromoglycate)	1% w/v solution for inhalation	02046113	PMS		MAP

Effective September 26, 2019, pms-sodium cromoglycate 1% w/v inhalation solution will be delisted as a benefit under the New Brunswick Drug Plans Formulary.

There is insufficient evidence of efficacy for sodium cromoglycate inhalation solution and there are more effective agents for the treatment of asthma and cystic fibrosis listed as benefits in the New Brunswick Drug Plans Formulary.

Patients who had a claim paid for pms-sodium cromoglycate between March 26, 2019 and September 25, 2019, will continue to remain eligible for coverage if a special authorization request, documenting the rationale for continued use, is submitted on an annual basis. Requests for special authorization will not be considered for new patients.

Product	Strength	DIN	MFR	Plans	Cost Base
Delisted Sodium Cromoglycate (Nalcrom®)	100 mg capsule	00500895	SAV		MLP

Effective September 26, 2019, sodium cromoglycate (Nalcrom®) 100 mg capsules will be delisted as a benefit under the New Brunswick Drug Plans Formulary. Requests for special authorization will not be considered.

There is insufficient evidence of efficacy for Nalcrom® in the treatment of food allergies.

Patients who had a claim paid for Nalcrom® between March 26, 2019 and September 25, 2019, will continue to remain eligible for coverage if a special authorization request, documenting the rationale for continued use, is submitted on an annual basis. Requests for special authorization will not be considered for new patients.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Crisaborole (Eucrisa™)	2% topical ointment	02476991	PFI	For topical treatment of mild to moderate atopic dermatitis in patients 2 years of age and older.
Efinaconazole (Jublia™)	10% w/w topical solution	02413388	VLN	For the topical treatment of mild to moderate onychomycosis of toenails without lunula involvement.
Telotristat Ethyl (Xermelo™)	250 mg tablet	02481553	IPS	For the treatment of refractory carcinoid syndrome diarrhea, in combination with somatostatin analogue (SSA) therapy, in patients inadequately controlled by SSA therapy alone.

Bulletin #1009 September 30, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective September 30, 2019.
  - The original brand product will be reimbursed at the new category MAP effective October 21, 2019. Prior to October 21, 2019, the original brand product will be reimbursed up to the higher MAP indicated on the attached list.

- Drug price changes
  - Price decreases for products listed on the NB Drug Plans Formulary prior to September 30, 2019 will be reimbursed up to the new category MAP effective October 21, 2019. Prior to October 21, 2019, products in the category will be reimbursed up to the previous MAP.
  - Price increases for products listed on the NB Drug Plans Formulary prior to September 30, 2019 will be reimbursed up to the new category MAP effective September 30, 2019.

If you have any questions, please contact our office at 1-800-332-3691.

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Drug Product Additions

Drug/Form/Route/Strength	Tradename	DIN	MFR	Plans	MAP
Atropine					
Dps Oph 1%	Isopto Atropine	35017	ALC	ADEFGVW	0.7320
	Atropine	2023695	PST		0.5490
Cinacalcet					
Tab Orl 30 mg	Apo-Cinacalcet	2452693	APX		
	Auro-Cinacalcet	2478900	ARO	ADEFGV	2.7418
	Teva-Cinacalcet	2441624	TEV		
60 mg	Apo-Cinacalcet	2452707	APX		
	Auro-Cinacalcet	2478919	ARO	ADEFGV	4.9995
	Teva-Cinacalcet	2441632	TEV		
90 mg	Apo-Cinacalcet	2452715	APX		
	Auro-Cinacalcet	2478943	ARO	ADEFGV	7.2752
	Teva-Cinacalcet	2441640	TEV		
Clindamycin					
Cap Orl 150 mg	Jamp-Clindamycin	2483734	JPC	ABDEFGVW	0.2217
300 mg	Jamp-Clindamycin	2483742	JPC	ABDEFGVW	0.4434
Emtricitabine / Tenofovir					
Tab Orl 200 mg / 300 mg	Jamp-Emtricitabine/Tenofovir Disoproxil Fumarate	2487012	JPC	ADEFGUV	7.0582
Itraconazole					
Liq Orl 10 mg/mL	Sporanox	2231347	JAN	(SA)	0.8620
	Jamp-Itraconazole	2484315	JPC		0.6167
Perinodopril					
Tab Orl 2 mg	Jamp-Perindopril	2477009	JPC	ADEFGV	0.1632
Rizatriptan					
ODT Orl 5 mg	CCP-Rizatriptan ODT	2458764	CCM	ADEFGV	3.7050
10 mg	CCP-Rizatriptan ODT	2458772	CCM	ADEFGV	3.7050
Rosuvastatin					
Tab Orl 5 mg	ACH-Rosuvastatin	2438917	AHI	ADEFGV	0.1284
10 mg	ACH-Rosuvastatin	2438925	AHI	ADEFGV	0.1354
20 mg	ACH-Rosuvastatin	2438933	AHI	ADEFGV	0.1692
40 mg	ACH-Rosuvastatin	2438941	AHI	ADEFGV	0.1990
Zolmitriptan					
Tab Orl 2.5 mg	CCP-Zolmitriptan	2458780	CCM	ADEFGV	3.4292

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Cilazapril							
Tab	Orl	1 mg	Apo-Cilazapril	2291134	APX	ADEFGV	0.3115
			Mylan-Cilazapril	2283778	MYL		
		2.5 mg	Apo-Cilazapril	2291142	APX	ADEFGV	0.4295
			Mylan-Cilazapril	2283786	MYL		
		5 mg	Apo-Cilazapril	2291150	APX	ADEFGV	0.4989
			Mylan-Cilazapril	2283794	MYL		
Diclofenac							
Liq	Oph	0.1%	Apo-Diclofenac	2441020	APX	ADEFGV	1.2397
			Sandoz Diclofenac Ophtha	2454807	SDZ		
Oxazepam							
Tab	Orl	15 mg	Apo-Oxazepam	402745	APX	ADEFGV	0.0550
		30 mg	Apo-Oxazepam	402737	APX	ADEFGV	0.0750

Bulletin # 1010

October 1, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective October 1, 2019.

Included in this bulletin:

- Regular Benefit Additions
- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits
- Drugs Reviewed and Not Listed

If you have any questions, please contact our office at 1-800-332-3691.

The Formulary Updates are available online: http://www.gnb.ca/0212/BenefitUpdates-e.asp. To unsubscribe from the NB Drug Plans email announcements, please send a message to info@nbdrugs-medicamentsnb.ca.

Regular Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Cinacalcet (Sensipar® and generics)	30 mg tablet 60 mg tablet 90 mg tablet	See NB Drug Plans Formulary or MAP list for products		ADEFGV	MAP

Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Fluticasone furoate / umeclidinium / vilanterol (Trelegy® Ellipta®)	100 mcg / 62.5 mcg / 25 mcg dry powder for inhalation	02474522	GSK	(SA)	MLP

For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry, in patients who experience inadequate control while being treated with a long-acting beta-2 agonist/long-acting anticholinergic (LABA/LAAC).

Clinical Notes:

1. COPD is defined by spirometry as a post-bronchodilator FEV_1/FVC ratio of less than 0.70. Spirometry reports from any point in time will be accepted. If spirometry cannot be obtained, reasons must be clearly explained and other evidence of COPD severity provided (i.e. MRC Dyspnea Scale Score grade).
2. Inadequate control while being treated with a LABA/LAAC is defined as persistent symptoms for at least two months, or experiencing two or more exacerbations of COPD in the previous year requiring treatment with antibiotics and/or systemic corticosteroids or at least one exacerbation of COPD requiring hospitalization.
3. Patients should not be started on a LABA, LAAC and an inhaled corticosteroid (triple inhaled therapy) as initial therapy.

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria – Long-acting anticholinergics for COPD					
Aclidinium bromide (Tudorza® Genuair®)	400 mcg powder for inhalation	02409720	ALM	(SA)	MLP
Glycopyrronium bromide (Seebri® Breezhaler®)	50 mcg powder for inhalation	02394936	NVR	(SA)	MLP
Tiotropium bromide (Spiriva®)	18 mcg powder for inhalation	02246793	BOE	(SA)	MLP

Tiotropium bromide (Spiriva® Respimat®)	2.5 mcg solution for inhalation	02435381	BOE	(SA)	MLP
Umeclidinium bromide (Incruse® Ellipta®)	62.5 mcg powder for inhalation	02423596	GSK	(SA)	MLP

- For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry, in patients who experience:
  - persistent symptoms, as defined by Medical Research Council (MRC) Dyspnea Scale of at least Grade 3 or a COPD Assessment test (CAT) score of at least 10 and have a post-bronchodilator FEV_1 less than 80% predicted; or
  - two or more moderate exacerbations of COPD in the previous year requiring treatment with antibiotics and/or systemic corticosteroids; or
  - at least one acute severe exacerbation of COPD requiring hospitalization.
- For the treatment of COPD, as defined by spirometry, in combination with a long-acting beta-2 agonist/inhaled corticosteroid (LABA/ICS), for patients who have inadequate control while being treated with a LABA/ICS or a long-acting beta-2 agonist/long-acting anticholinergic (LABA/LAAC).

Clinical Notes:

1. COPD is defined by spirometry as a post-bronchodilator FEV_1/FVC ratio less than 0.7 Spirometry reports from any point in time will be accepted.If spirometry cannot be obtained, reasons must be clearly explained, and other evidence of COPD severity provided (i.e. MRC Dyspnea Scale grade).
2. Inadequate control while being treated with a LABA/LAAC or LABA/ICS is defined as persistent symptoms for at least two months or experiencing two or more exacerbations of COPD in the previous year requiring treatment with antibiotics and/or systemic corticosteroids, or at least one exacerbation of COPD requiring hospitalization.

Claim Note:

- Requests for combination therapy of single agent long-acting bronchodilators, i.e. LABA and LAAC, will not be considered. Products which combine a LABA/LAAC in a single device are available as special authorization benefits with their own criteria.

Revised Criteria – Long-Acting Beta-2 Agonists for COPD

Formoterol (Foradil®)	12 mcg powder for inhalation	02230898	NVR	(SA)	MLP
Indacaterol (Onbrez® Breezhaler®)	75 mcg powder for inhalation	02376938	NVR	(SA)	MLP
Salmeterol (Serevent® Diskus®)	50 mcg diskus	02231129	GSK	(SA)	MLP

For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry, in patients who experience:

- persistent symptoms, as defined by Medical Research Council (MRC) Dyspnea Scale of at least Grade 3 or a COPD Assessment test (CAT) score of at least 10, and have a post-bronchodilator FEV_1 less than 80% predicted; or
- two or more moderate exacerbations of COPD in the previous year requiring treatment with

antibiotics and/or systemic corticosteroids; or
- at least one acute severe exacerbation of COPD requiring hospitalization.

Clinical Note:
- COPD is defined by spirometry as a post-bronchodilator FEV_1/FVC ratio less than 0.70. Spirometry reports from any point in time will be accepted. If spirometry cannot be obtained, reasons must be clearly explained, and other evidence of COPD severity provided (i.e. MRC Dyspnea Scale grade).

Claim Note:
- Requests for combination therapy of single agent long-acting bronchodilators, i.e. long-acting beta-2 agonist (LABA) and long-acting anticholinergic (LAAC), will not be considered. Products which combine a LABA/LAAC in a single device are available as special authorization benefits with their own criteria.

Revised Criteria – Long-Acting Beta-2 Agonists/Long-Acting Anticholinergic Combinations for COPD

Formoterol / aclidinium bromide (Duaklir® Genuair®)	12 mcg / 400 mcg powder for inhalation	02439530	AZE	(SA)	MLP
Indacaterol / glycopyrronium bromide (Ultibro® Breezhaler®)	110 mcg / 50 mcg powder for inhalation	02418282	NVR	(SA)	MLP
Olodaterol / tiotropium bromide (Inspiolto® Respimat®)	2.5 mcg / 2.5 mcg solution for inhalation	02441888	BOE	(SA)	MLP
Vilanterol / umeclidinum bromide (Anoro® Ellipta®)	25 mcg / 62.5 mcg powder for inhalation	02418401	GSK	(SA)	MLP

For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry, in patients who experience inadequate control while being treated with either a long-acting beta-2 agonist (LABA) or long-acting anticholinergic (LAAC).

Clinical Notes:
1. COPD is defined by spirometry as a post-bronchodilator FEV_1/FVC ratio less than 0.70. Spirometry reports from any point in time will be accepted. If spirometry cannot be obtained, reasons must be clearly explained, and other evidence of COPD severity provided (i.e. Medical Research Council (MRC) Dyspnea Scale grade).
2. Inadequate control is defined as persistent symptoms (e.g. MRC Dyspnea Scale of at least grade 3 or COPD Assessment test (CAT) score of at least 10) after at least one month of a LAAC or LABA.
3. LABA/LAAC combinations are not intended to be used with an inhaled corticosteroid (ICS) unless criteria for triple inhaled therapy (LABA/LAAC/ICS) is met.

Revised Criteria – Long-Acting Beta-2 Agonists/Inhaled Corticosteroid Combinations for COPD

Formoterol / budesonide (Symbicort® Turbuhaler®)	6 mcg / 100 mcg turbuhaler 6 mcg / 200 mcg turbuhaler	02245385 02245386	AZE	(SA)	MLP
Salmeterol / fluticasone (Advair®)	25 mcg / 125 mcg metered-dose inhaler 25 mcg / 250 mcg metered-dose inhaler	02245126 02245127			
Salmeterol / fluticasone (Advair® Diskus®)	50 mcg / 100 mcg diskus 50 mcg / 250 mcg diskus 50 mcg / 500 mcg diskus	02240835 02240836 02240837	GSK	(SA)	MLP
Vilanterol / fluticasone (Breo Ellipta®)	25 mcg / 100 mcg powder for inhalation	02408872	GSK	(SA)	MLP

- For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry, in combination with a long-acting anticholinergic (LAAC), in patients who experience inadequate control while being treated with a long-acting beta-2 agonist/long-acting anticholinergic (LABA/LAAC).
- For the treatment of patients with asthma / chronic obstructive pulmonary disease (ACO) overlap, based on patient history and lung function studies indicating an ACO diagnosis.

Clinical Notes:

1. COPD is defined by spirometry as a post-bronchodilator FEV_1/FVC ratio less than 0.70. Spirometry reports from any point in time will be accepted. If spirometry cannot be obtained, reasons must be clearly explained, and other evidence of COPD severity provided (i.e. MRC Dyspnea Scale grade).
2. Inadequate control while being treated with a LABA/LAAC is defined as persistent symptoms for at least two months or experiencing two or more exacerbations of COPD in the previous year requiring treatment with antibiotics and/or systemic corticosteroids or at least one exacerbation of COPD requiring hospitalization.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Latanoprost (Monoprost®)	50 ug/mL ophthalmic solution	02456230	LTH	For the reduction of intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

Bulletin # 1011

October 24, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective October 24, 2019.

Included in this bulletin:

- Regular Benefit Additions
- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits
- Drugs Reviewed and Not Listed

If you have any questions, please contact our office at 1-800-332-3691.

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Regular Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Fluoxetine (pms-Fluoxetine)	40 mg capsule 60 mg capsule	02464640 02464659	PMS	ADEFGV	MAP
Levetiracetam (Sandoz® Levetiracetam)	1000 mg tablet	02462028	SDZ	ADEFGV	MAP

Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Bictegravir / emtricitabine / tenofovir alafenamide (Biktarvy®)	50 mg / 200 mg / 25 mg tablet	02478579	GIL	(SA)	MLP

For the treatment of adult patients with HIV-1 infection with no known substitution associated with resistance to the individual components of Biktarvy.

Claim Note:

- Prescriptions written for beneficiaries of Plan U by infectious disease specialists and medical microbiologists who are licensed by the College of Physicians and Surgeons of New Brunswick, do not require special authorization.

Product	Strength	DIN	MFR	Plans	Cost Base
Levodopa / carbidopa (Duodopa®)	20 mg / 5 mg/mL intestinal gel	02292165	ABV	(SA)	MLP

For the treatment of adult patients with advanced levodopa-responsive Parkinson's disease who meet all of the following criteria:

- Experiences severe, debilitating motor fluctuations and dyskinesia, with at least 25% of the waking day in the "off" state and/or ongoing levodopa-induced dyskinesias, despite having tried frequent dosing of levodopa (at least five doses per day)
- Received an adequate trial of maximally tolerated doses of levodopa, with demonstrated clinical response
- Failed an adequate trial of each of the following adjunctive medications, if not contraindicated and/or contrary to the clinical judgment of the prescriber: amantadine, a dopamine agonist, entacapone, and a monoamine oxidase (MAO-B) inhibitor

Renewal Criteria:
The patient has a significant reduction in time spent in the "off" state and/or in ongoing levodopa-induced dyskinesias along with improvement in the related disability.

Clinical Note:

- Time in the "off" state, frequency of motor fluctuations, and severity of associated disability should be assessed by a movement disorder subspecialist and be based on an adequate and reliable account (e.g., clinical interview of a patient or care partner, motor symptom diary).

Claim Notes:

- Must be prescribed by a movement disorder subspecialist who has appropriate training in the use of Duodopa and are practising in a movement disorder clinic that provides ongoing management and support for patients receiving treatment with Duodopa.
- Approval period: 1 year.

Venetoclax (Venclexta®)	10 mg film-coated tablet 50 mg film-coated tablet 100 mg film-coated tablet	02458039 02458047 02458055	ABV	(SA)	MLP
Venetoclax (Venclexta®) starter kit	10 mg, 50 mg,100 mg film-coated tablets	02458063			

As monotherapy for the treatment of patients with chronic lymphocytic leukemia/small lymphocytic lymphoma who have received at least one prior therapy which must include disease progression on or intolerance to a B-cell receptor inhibitor.

Renewal criteria:
Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Notes:

1. Patient must have a good performance status.
2. Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Initial approval period: 1 year.
- Renewal approval period: 1 year.

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria					
Dimethyl fumarate (Tecfidera®)	120 mg delayed-release capsule 240 mg delayed-release capsule	02404508 02420201	BIG	(SA)	MLP

For the treatment of adult patients with relapsing-remitting multiple sclerosis (RRMS) who meet all of the following criteria:

- Confirmed diagnosis based on McDonald criteria
- Experienced one or more disabling relapses or new MRI activity in the past two years
- Ambulatory with or without aid (i.e. has a recent Expanded Disability Status Scale (EDSS) score of less than or equal to 6.5)

Clinical Note:

- Treatment should be discontinued for patients with an EDSS score of greater than or equal to 7.

Claim Notes:

- Prescriptions written by neurologists licensed by the College of Physicians and Surgeons of New Brunswick do not require special authorization.
- Combined use with other disease modifying therapies to treat RRMS will not be reimbursed.

Revised Criteria

Teriflunomide (Aubagio®)	14 mg film-coated tablet	02416328	GZM	(SA)	MLP

For the treatment of adult patients with relapsing-remitting multiple sclerosis (RRMS) who meet all of the following criteria:

- Confirmed diagnosis based on McDonald criteria
- Experienced one or more disabling relapses or new MRI activity in the past two years
- Ambulatory with or without aid (i.e. has a recent Expanded Disability Status Scale (EDSS) score of less than or equal to 6.5)

Clinical Note:

- Treatment should be discontinued for patients with an EDSS score of greater than or equal to 7.

Claim Notes:

- Prescriptions written by neurologists licensed by the College of Physicians and Surgeons of New Brunswick do not require special authorization.
- Combined use with other disease modifying therapies to treat RRMS will not be reimbursed.
- Requests will be considered for individuals enrolled in Plans ADEFGV.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Brigatinib (Alunbrig™)	30 mg tablet	02479206	TAK	For the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive locally advanced or metastatic non–small cell lung cancer (NSCLC) who have progressed on or who were intolerant to an ALK inhibitor (crizotinib).
	90 mg tablet	02479214		
	180 mg tablet	02479222		
Glatiramer (Copaxone®)	40 mg/mL prefilled syringe	02456915	TEV	For the treatment of ambulatory patients with relapsing remitting multiple sclerosis.

Bulletin #1012 October 31, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective October 31, 2019.
  - The original brand product will be reimbursed at the new category MAP effective November 21, 2019. Prior to November 21, 2019, the original brand product will be reimbursed up to the higher MAP indicated on the attached list.

If you have any questions, please contact our office at 1-800-332-3691.

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Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Almotriptan							
Tab	Orl	12.5 mg	Teva-Almotriptan	2434849	TEV	ADEFGV	2.3478
Donepezil							
Tab	Orl	5 mg	Mint-Donepezil	2408600	MNT	(SA)	0.4586
		10 mg	Mint-Donepezil	2408619	MNT	(SA)	0.4586
Emtricitabine / Tenofovir							
Tab	Orl	200 mg / 300 mg	pms-Emtricitabine-Tenofovir	2461110	PMS	ADEFGUV	7.0582
Methadone							
Liq	Orl	10 mg/mL	Metadol-D	2244290	PAL	(SA)	0.0146
			Methadone Hydrochloride	2481979	SDZ		0.0113
Pregabalin							
Cap	Orl	300 mg	Jamp-Pregabalin	2436019	JPC	ADEFGVW	0.4145

Bulletin # 1013

November 7, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective November 7, 2019.

Included in this bulletin:

- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits
- Benefit Status Changes
- Drugs Reviewed and Not Listed

If you have any questions, please contact our office at 1-800-332-3691.

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Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Dolutegravir / rilpivirine (Juluca®)	50 mg / 25 mg tablet	02475774	VIV	(SA)	MLP

As a complete regimen to replace the current antiretroviral regimen for the treatment of HIV-1 infection in adult patients who are virologically stable and suppressed (i.e., HIV-1 RNA less than 50 copies per mL).

Claim Note:

- Prescriptions written for beneficiaries of Plan U by infectious disease specialists and medical microbiologists who are licensed by the College of Physicians and Surgeons of New Brunswick, do not require special authorization.

Netupitant / palonosetron (Akynzeo™)	300 mg / 0.5 mg capsule	02468735	PFR	(SA)	MLP

In combination with dexamethasone for the prevention of acute and delayed nausea and vomiting in patients receiving:

- highly emetogenic chemotherapy, or
- moderately emetogenic chemotherapy who have had inadequate symptom control using a 5-HT_3 antagonist and dexamethasone in a previous cycle.

Claim Note:

- Prescription claims for up to a maximum of 2 capsules will be reimbursed every 28 days when the prescription is written by an oncologist, an oncology clinical associate, or a general practitioner in oncology.

Ocrelizumab (Ocrevus®)	30 mg/mL single-use vial	02467224	HLR	(SA)	MLP

Primary Progressive Multiple Sclerosis
For the treatment of adult patients with early primary progressive multiple sclerosis (PPMS) who meet all of the following criteria:

- Confirmed diagnosis based on McDonald criteria
- Recent Expanded Disability Status Scale (EDSS) score between 3.0 and 6.5
- Recent Functional Systems Scale (FSS) score of at least 2 for the pyramidal functions component due to lower extremity findings
- Disease duration of 10 years for those with an EDSS of less than or equal to 5 or disease duration less than 15 years for those with an EDSS greater than 5
- Diagnostic imaging features characteristic of inflammatory activity

Clinical Note:

- Treatment should be discontinued for patients with an EDSS score of greater than or equal to 7.

Claim Note:

- Requests will be considered for individuals enrolled in Plans ADEFGV.

Relapsing Remitting Multiple Sclerosis
For the treatment of adult patients with relapsing remitting multiple sclerosis (RRMS) who meet all of the following criteria:

- Confirmed diagnosis based on McDonald criteria
- Experienced one or more disabling relapses or new MRI activity in the last two years
- Ambulatory with or without aid (i.e., has a recent Expanded Disability Status Scale (EDSS) score of less than or equal to 6.5)

Clinical Note:

- Treatment should be discontinued for patients with an EDSS score of greater than or equal to 7.

Claim Notes:

- Combined use with other disease modifying therapies to treat RRMS will not be reimbursed.
- Requests will be considered for individuals enrolled in Plans ADEFGV.

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria					
Aprepitant (Emend®)	80 mg capsule 125 mg capsule	02298791 02298805	FRS	(SA)	MLP
Aprepitant (Emend®) Tri-Pack	80 mg, 125 mg capsules	02298813			

In combination with a 5-HT_3 antagonist and dexamethasone for the prevention of acute and delayed nausea and vomiting in patients receiving:

- highly emetogenic chemotherapy, or
- moderately emetogenic chemotherapy who have had inadequate symptom control using a 5-HT_3 antagonist and dexamethasone in a previous cycle.

Claim Note:

- Prescription claims for up to a maximum of 2 Tri-packs, or 6 capsules will be reimbursed every 28 days when the prescription is written by an oncologist, an oncology clinical associate, or a general practitioner in oncology.

Revised Criteria					
Natalizumab (Tysabri®)	300 mg / 15 mL single-use vial	02286386	BIG	(SA)	MLP

For the treatment of adult patients with relapsing-remitting multiple sclerosis (RRMS) who meet all the following criteria:

- Confirmed diagnosis based on McDonald criteria
- Experienced one or more disabling relapses or new MRI activity in the past year
- Ambulatory with or without aid (i.e., has a recent Expanded Disability Status Scale (EDSS) score of less than or equal to 6.5)
- Refractory or intolerant to at least one disease modifying therapy (i.e., interferon, glatiramer, dimethyl fumarate, teriflunomide, ocrelizumab)

Renewal Criteria:

- Evidence of continued benefit must be provided (i.e., stability or reduction in the number of relapses in the past year or stability or improvement of EDSS score obtained within the previous 90 days).

Clinical Notes:

1. Treatment should be discontinued for patients with an EDSS score of greater than or equal to 7.
2. A relapse is defined as the appearance of new or worsening neurological symptoms in the absence of fever or infection, lasting at least 24 hours yet preceded by stability for at least one month and accompanied by new objective neurological findings observed through evaluation by a neurologist.

Claim Notes:

- Must be prescribed by a neurologist with experience in the treatment of multiple sclerosis
- Combined use with other disease modifying therapies to treat RRMS will not be reimbursed.
- Initial approval period: 1 year.
- Renewal approval period: 2 years.

New Indication and Revised Criteria

Regorafenib (Stivarga®)	40 mg film-coated tablet	02403390	BAY	(SA)	MLP

Advanced Hepatocellular Carcinoma

For the treatment of patients with unresectable hepatocellular carcinoma (HCC) who have had disease progression on sorafenib and meet all of the following criteria:

- ECOG performance status of 0 or 1
- Child-Pugh class status of A
- Tolerated sorafenib at a minimum dose of 400 mg per day for at least 20 of the last 28 days of treatment

Renewal Criteria:

- Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Note:

- Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Initial approval period: 4 months.
- Renewal approval period: 6 months.

Gastrointestinal Stromal Tumor

For the treatment of patients with metastatic and/or unresectable gastrointestinal stromal tumors (GIST) who have had disease progression on, or intolerance to, imatinib and sunitinib, and who have an ECOG performance status of 0 or 1.

Renewal Criteria:

- Written confirmation that the patient has responded to treatment and there is no evidence of disease progression.

Clinical Note:

- Treatment should be discontinued upon disease progression or unacceptable toxicity.

Claim Notes:

- Initial approval period: 6 months.
- Renewal approval period: 6 months.

Benefit Status Changes

Product	Strength	DIN	MFR	Plans	Cost Base
Delisted					
Granisetron (Apo-Granisetron)	1 mg tablet	02308894	APX	(SA)	MAP
Granisetron (Nat-Granisetron)	1 mg tablet	02452359	NAT		

Effective November 7, 2019, granisetron 1 mg tablets will be delisted as a benefit under the New Brunswick Drug Plans Formulary. Requests for special authorization will not be considered.

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Alirocumab (Praluent®)	75 mg/mL prefilled syringe 150 mg/mL prefilled syringe 75 mg/mL prefilled pen 150 mg/mL prefilled pen	02453754 02453762 02453819 02453835	SAV	For the treatment of clinical atherosclerotic cardiovascular disease.
Dulaglutide (Trulicity®)	0.75 mg / 0.5 mL prefilled syringe 1.5 mg / 0.5 mL prefilled syringe 0.75 mg / 0.5 mL prefilled pen 1.5 mg / 0.5 mL prefilled pen	02448572 02448580 02448599 02448602	LIL	For the treatment of adult patients with type 2 diabetes mellitus.
Evolocumab (Repatha®)	140 mg/mL prefilled syringe and autoinjector	02446057	AGA	For the treatment of clinical atherosclerotic cardiovascular disease.
Insulin glargine (Toujeo® SoloSTAR®)	300 units/mL prefilled pen	02441829	SAV	For the treatment of adult patients with type 1 or type 2 diabetes mellitus.

Bulletin #1014 November 28, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective November 28, 2019.
  - The original brand product will be reimbursed at the new category MAP effective December 19, 2019. Prior to December 19, 2019, the original brand product will be reimbursed up to the higher MAP indicated on the attached list.

- Drug price changes
  - Price decreases for products listed on the NB Drug Plans Formulary prior to November 28, 2019 will be reimbursed up to the new category MAP effective December 19, 2019. Prior to December 19, 2019, products in the category will be reimbursed up to the previous MAP.

- Delisted drug products
  - Products will be removed from the NB Drug Plans Formulary effective December 19, 2019.

If you have any questions, please contact our office at 1-800-332-3691.

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Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Cinacalcet							
Tab	Orl	30 mg	Mar-Cinacalcet	2480298	MAR	ADEFGV	2.7418
		60 mg	Mar-Cinacalcet	2480301	MAR	ADEFGV	4.9995
		90 mg	Mar-Cinacalcet	2480328	MAR	ADEFGV	7.2752
Clarithromycin							
Tab	Orl	500 mg	pms-Clarithromycin	2247574	PMS	ABDEFGVW	0.8318
Dapsone							
Tab	Orl	100 mg	Riva-Dapsone	2489058	RIV	ADEFGV	0.7031
Duloxetine							
CDR	Orl	30 mg	Duloxetine	2490889	SAS	(SA)	0.4814
		60 mg	Duloxetine	2490897	SAS	(SA)	0.9769
Fingolimod							
Cap	Orl	0.5 mg	Gilenya	2365480	NVR	(SA)	86.9525
			Apo-Fingolimod	2469936	APX		21.7381
			Jamp-Fingolimod	2487772	JPC		
			Mar-Fingolimod	2474743	MAR		
			Mylan-Fingolimod	2469715	MYL		
			pms-Fingolimod	2469782	PMS		
			Sandoz Fingolimod	2482606	SDZ		
			Teva-Fingolimod	2469561	TEV		
Labetalol							
Tab	Orl	100 mg	Trandate	2106272	PAL	ADEFGV	0.3970
			Riva-Labetalol	2489406	RIV		0.2974
		200 mg	Trandate	2106280	PAL	ADEFGV	0.7010
			Riva-Labetalol	2489414	RIV		0.5256
Lacosamide							
Tab	Orl	50 mg	Mar-Lacosamide	2487802	MAR	(SA)	0.6313
		100 mg	Mar-Lacosamide	2487810	MAR	(SA)	0.8750
		150 mg	Mar-Lacosamide	2487829	MAR	(SA)	1.1763
		200 mg	Mar-Lacosamide	2487837	MAR	(SA)	1.4500
Levetiracetam							
Tab	Orl	250 mg	Riva-Levetiracetam	2482274	RIV	ADEFGV	0.3210
		500 mg	Riva-Levetiracetam	2482282	RIV	ADEFGV	0.3911

Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Levetiracetam							
Tab	Orl	750 mg	Riva-Levetiracetam	2482290	RIV	ADEFGV	0.5416
Olanzapine							
Tab	Orl	2.5 mg	Mint-Olanzapine	2410141	MNT	ADEFGVW	0.1772
		5 mg	Mint-Olanzapine	2410168	MNT	ADEFGVW	0.3544
		7.5 mg	Mint-Olanzapine	2410176	MNT	ADEFGVW	0.5316
		10 mg	Mint-Olanzapine	2410184	MNT	ADEFGVW	0.7088
		15 mg	Mint-Olanzapine	2410192	MNT	ADEFGVW	1.0631
Quinapril							
Tab	Orl	5 mg	pms-Quinapril	2340550	PMS	ADEFGV	0.2278
		10 mg	pms-Quinapril	2340569	PMS	ADEFGV	0.2278
		20 mg	pms-Quinapril	2340577	PMS	ADEFGV	0.2278
		40 mg	pms-Quinapril	2340585	PMS	ADEFGV	0.2278

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Dapsone							
Tab	Orl	100 mg	Mar-Dapsone	2481227	MAR	ADEFGV	0.7031
Sildenafil							
Tab	Orl	20 mg	Teva-Sildenafil R	2319500	TEV	(SA)	5.7765
Theophylline							
SRT	Orl	400 mg	Theo ER	2360101	AAP	ADEFGV	0.3362
		600 mg	Theo ER	2360128	AAP	ADEFGV	0.4072
Tobramycin							
Liq	Inj	40 mg/mL	Tobramycin	2241210	SDZ	ABDEFGVW	3.3700
Trifluridine							
Liq	Oph	1%	Viroptic	687456	VLN	ADEFGV	3.4533
Trimipramine							
Tab	Orl	12.5 mg	Trimipramine	740799	AAP	ADEFGV	0.2156

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Price Not Confirmed by Manufacturer						
Sildenafil						
Tab	Orl	20 mg	Apo-Sildenafil R	2418118	APX	(SA)

Bulletin # 1015

December 5, 2019

NB Drug Plans Update

2019 Holiday Hours

Representatives of the New Brunswick Drug Plans will be available the following hours during the 2019 holiday season:

Date	Hours
Monday, December 23	8 a.m. to 5 p.m. (regular hours)
Tuesday, December 24	8 a.m. to 12 p.m.
Wednesday, December 25	Closed
Thursday, December 26	Closed
Friday, December 27	8 a.m. to 5 p.m. (regular hours)
Saturday, December 28	Closed
Sunday, December 29	Closed
Monday, December 30	8 a.m. to 5 p.m. (regular hours)
Tuesday, December 31	8 a.m. to 5 p.m. (regular hours)
Wednesday, January 1	Closed

Please refer to the New Brunswick Drug Plans' Pharmacy Provider Payment Schedule for the direct deposit dates during this time.

If you have any questions, please contact the New Brunswick Drug Plans at **1-800-332-3691**.

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Bulletin #1016 December 18, 2019

NB Drug Plans Formulary Update

Drug product updates included in this bulletin:

- Drug product additions
  - New generic products will be reimbursed up to the category Maximum Allowable Price (MAP) effective December 18, 2019.

- Drug price changes
  - Price increases for products listed on the NB Drug Plans Formulary prior to December 18, 2019 will be reimbursed up to the new category MAP effective December 18, 2019.

- Delisted drug products
  - Products will be removed from the NB Drug Plans Formulary effective January 8, 2020.

If you have any questions, please contact our office at 1-800-332-3691.

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Drug Product Additions

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Atorvastatin							
Tab	Orl	10 mg	ACH-Atorvastatin Calcium	2457741	AHI	ADEFGV	0.1743
		20 mg	ACH-Atorvastatin Calcium	2457768	AHI	ADEFGV	0.2179
		40 mg	ACH-Atorvastatin Calcium	2457776	AHI	ADEFGV	0.2342
		80 mg	ACH-Atorvastatin Calcium	2457784	AHI	ADEFGV	0.2342
Dutasteride							
Cap	Orl	0.5 mg	Jamp-Dutasteride	2484870	JPC	ADEFGV	0.3027
Fingolimod							
Cap	Orl	0.5 mg	Taro-Fingolimod	2469618	TAR	(SA)	21.7381
Lacosamide							
Tab	Orl	50 mg	Mint-Lacosamide	2490544	MNT	(SA)	0.6313
		100 mg	Mint-Lacosamide	2490552	MNT	(SA)	0.8750
		150 mg	Mint-Lacosamide	2490560	MNT	(SA)	1.1763
		200 mg	Mint-Lacosamide	2490579	MNT	(SA)	1.4500
Nevirapine							
Tab	Orl	200 mg	Jamp-Nevirapine	2405776	JPC	DU	1.2346
Rivastigmine							
Cap	Orl	1.5 mg	Jamp-Rivastigmine	2485362	JPC	(SA)	0.6515
		3 mg	Jamp-Rivastigmine	2485370	JPC	(SA)	0.6515
		4.5 mg	Jamp-Rivastigmine	2485389	JPC	(SA)	0.6515
		6 mg	Jamp-Rivastigmine	2485397	JPC	(SA)	0.6515
Valacyclovir							
Tab	Orl	1000 mg	Mylan-Valacyclovir	2351560	MYL	ADEFGV	1.7218
Zolmitriptan							
ODT	Orl	2.5 mg	Zolmitriptan ODT	2442671	SAS	ADEFGV	3.4313

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Azithromycin							
Tab	Orl	600 mg	pms-Azithromycin	2261642	PMS	(SA)	10.6652

Drug Price Changes

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans	MAP
Voriconazole							
Tab	Orl	50 mg	Sandoz Voriconazole	2399245	SDZ	(SA)	6.7818
			Teva-Voriconazole	2396866	TEV		

Delisted Drug Products

Drug/Form/Route/Strength			Tradename	DIN	MFR	Plans
Product No Longer Marketed						
Azithromycin						
Tab	Orl	600 mg	Act-Azithromycin	2256088	ATV	(SA)

Bulletin # 1017

December 19, 2019

NB Drug Plans Formulary Update

This update to the New Brunswick Drug Plans Formulary is effective December 19, 2019.

Included in this bulletin:

- Regular Benefit Additions
- Special Authorization Benefit Additions
- Changes to Existing Special Authorization Benefits
- Drugs Reviewed and Not Listed
- Medical Abortion Program Update

If you have any questions, please contact our office at 1-800-332-3691.

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Regular Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Methotrexate (Metoject® Subcutaneous)	10 mg / 0.2 mL prefilled syringe 12.5 mg / 0.25 mL prefilled syringe	02454831 02454750	MDX	ADEFGV	MLP

Special Authorization Benefit Additions

Product	Strength	DIN	MFR	Plans	Cost Base
Nitisinone (MDK-Nitisinone™)	2 mg capsule 5 mg capsule 10 mg capsule 20 mg capsule	02457717 02457725 02457733 02470055	MDK	(SA)	MAP

For the treatment of adult and pediatric patients with hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine.

Claim Notes:

- Must be prescribed by, or in consultation with, a physician with experience in the diagnosis and management of HT-1.
- Approval period: 1 year.
- Claims that exceed the maximum claim amount of $9,999.99 must be divided and submitted as separate transactions as outlined here.

Product	Strength	DIN	MFR	Plans	Cost Base
Semaglutide (Ozempic®)	2 mg / 1.5 mL prefilled pen 4 mg / 3 mL prefilled pen	02471477 02471469	NNO	(SA)	MLP

For the treatment of type 2 diabetes mellitus as a:

- second drug added to metformin for patients who have inadequate glycemic control on metformin; or
- third drug added to metformin and a sulfonylurea for patients who have inadequate glycemic control on metformin and a sulfonylurea.

Clinical Note:

- For patients who cannot take metformin due to contraindications or intolerances, details must be provided.

Changes to Existing Special Authorization Benefits

Product	Strength	DIN	MFR	Plans	Cost Base
Revised Criteria Febuxostat (Uloric® and generic brand)	80 mg tablet	02357380	TAK	(SA)	MAP
	For the treatment of symptomatic gout in patients who have documented hypersensitivity to allopurinol.				
New Indication Perampanel (Fycompa®)	2 mg tablet 4 mg tablet 6 mg tablet 8 mg tablet 10 mg tablet 12 mg tablet	02404516 02404524 02404532 02404540 02404559 02404567	EIS	(SA)	MLP
	For the adjunctive treatment of refractory partial-onset seizures or primary generalized tonic-clonic seizures in patients who are currently receiving two or more antiepileptic drugs, and who have had an inadequate response to at least three other antiepileptic drugs. Claim Note: • The patient must be under the care of a physician experienced in the treatment of epilepsy.				

Drugs Reviewed and Not Listed

The review of the following products found that they did not offer a significant therapeutic and/or cost advantage over existing therapies. Requests for special authorization will not be considered.

Product	Strength	DIN	MFR	Indication
Trifluridine / Tipiracil (Lonsurf®)	15 mg / 6.14 mg tablet 20 mg / 8.19 mg tablet	02472104 02472112	TAI	For the treatment of adult patients with metastatic colorectal cancer.

Medical Abortion Program Update

Effective December 19, 2019, the Medical Abortion Program will reimburse four tablets of misoprostol 200 mcg in the following instances:

- As a second dose if an incomplete abortion is confirmed on follow-up assessment; or
- As a replacement dose if the misoprostol from the Mifegymiso kit is lost, stolen or damaged.

For replacement doses, pharmacies must submit claims online using the CPhA Intervention Code “MR” (replacement, item lost or broken), and include the required information outlined on the Medical Abortion Program Claim Submissions webpage.