

EXCEPTION DRUG STATUS (EDS)

Certain drugs or other items are approved for coverage under the Exception Drug Status (EDS) Program when they meet specific criteria and upon review and recommendation of the Manitoba Drug Standards and Therapeutics Committee (MDSTC). The drugs or other items usually fall into one of the following categories:

- The drug or other item is ordinarily administered only to an in-patient of a hospital but is being administered outside of a hospital because of exceptional circumstances.
- The drug or other item is not ordinarily prescribed or administered in Manitoba, but is being prescribed because it is required in the treatment of a patient who has an illness, disability, or condition rarely found in Manitoba.
- Evidence, including therapeutic and economic evidence, provided to the minister in accordance with the criteria established by the minister, supports a specific treatment regime that includes use of the drug or other item.

Over-the-counter (OTC) products are generally not included as benefits of the Drug Plan. Exception Drug Status is not granted for appetite suppressants, drugs for the treatment of erectile dysfunction and vaccines normally provided by Public Health.

When an EDS drug is approved as a benefit, the cost will be covered through the Pharmacare Program during the time period authorized by the EDS Program and after the client's Pharmacare deductible has been met.

Effective October 18, 2021, “Part 3 Exception Drug Status” or “Part 3 benefits” will be referred to as “Exception Drug Status” or “EDS benefits”.

CHANGES TO APPROVAL PROCESS AND EXPIRY DATES - EFFECTIVE OCTOBER 2017

Effective October 1, 2017 many drugs will no longer require EDS renewal for coverage under Manitoba's Provincial Drug Programs (PDP) and the Employment and Income Assistance Drug Program (EIA). All EDS drugs will still require initial approval, but for many drugs, if coverage approval is granted, this approval will be indefinite and prescribers will no longer need to reapply for extending or renewing this coverage. Any patient that has an active EDS approval (as of October 1, 2017) for any of the drugs affected by this change will automatically have the approval extended indefinitely. This change will affect only products identified on the List of Designated Drugs and may be updated from time to time. Details can be found online at:

<https://www.gov.mb.ca/health/pharmacare/healthprofessionals.html>

INFORMATION REQUIRED WHEN MAKING A REQUEST FOR COVERAGE:

- Prescriber Information - Name (including first initial), Address, Phone Number and Prescriber Number.
- Client Information - Client Name, Address, Manitoba Health Registration Number (MHRN), Personal Health Identification Number (PHIN) and Date of Birth.
- Drug Information - Drug Name (trade and/or generic name), Dosage Form, Strength, Expected Dosing and Expected Therapy Duration.
- Justification - Diagnosis and/or Indications for Use.

EDS request forms are now available online, please visit:

<http://www.gov.mb.ca/health/pharmacare/healthprofessionals.html#b>

NOTES REGARDING THE EXCEPTION DRUG STATUS (EDS) PROGRAM:

- Duly licensed practitioners prescribing within their scope of practice may apply for EDS.
 - Requests can be submitted by mail or by fax.
The fax number is (204) 942-2030 or 1-877-208-3588. These numbers are for health professionals only.
 - To ensure eligible benefit coverage, approval must take place prior to purchase or dispensing of a prescription drug. Retroactive coverage is not provided, no exceptions.
 - EDS requests are prioritized by date received and the urgency of the request.
 - To ensure continuity of coverage, requests for renewal should be forwarded prior to the expiry date. Please allow at least one to two business days.
- Urgent requests received during regular business hours will usually be processed within 24 hours.
- Patients are notified by letter if a request for coverage has been approved or denied.
 - If a drug is approved for coverage under EDS, coverage is valid from the date of application to date of expiration.
 - If denied, payment for the medication is the responsibility of the patient.
 - For NEW requests - If a client meets EDS criteria for one of the products identified in the List of Designated Drugs with Indefinite EDS Approval, benefit coverage will be granted indefinitely. The client will receive an initial approval letter which confirms indefinite EDS approval.
 - For RENEWAL requests - If a client has an active EDS approval for a product identified in the List of Designated Drugs with Indefinite EDS Approval – as of October 1, 2017, this coverage will be grandfathered indefinitely; no renewal will be required. The client will not be sent a letter to confirm their continued EDS approval.
 - If the request for benefit coverage is not approved, payment for the medication is the responsibility of the patient.

NOTE: Not all medications currently available on the market in Canada are benefits under the Manitoba Drug Benefits Formulary or under the EDS Program.

NOTE: Some private and extended health insurance providers require their clients to have the EDS approval before they agree to cover any part of the prescription cost. It is the clients' responsibility to contact their private drug plan directly for further information.

PRODUCT SELECTION:

In September 2001, F/P/T Health Ministers agreed to establish a single Common Drug Review (CDR) for new drugs (chemical entities) submitted in Canada for coverage by F/P/T drug plans. Beginning September 2003, all new drugs are reviewed nationally through the CDR process, with expert advice and recommendations being provided by the Canadian Agency for Drugs and Technologies in Health (CADTH). The recommendations of CADTH are taken into consideration by each jurisdiction when making a listing decision.

CADTH recommendations are taken into account by the Manitoba Drug Standards and Therapeutics Committee who makes recommendations to the Minister of Health on drug products to be considered for benefit under the Pharmacare Drug Benefit Program.

Committee members provide recommendations on drug interchangeability and on the therapeutic and economic value of drug benefits.

For more information on the Manitoba Drug Formulary Review Process, please visit:

<http://www.gov.mb.ca/health/mdbif/review.html>

For more information on the Manitoba Drug Benefits Formulary and the Manitoba Drug Interchangeability Form

<http://www.gov.mb.ca/health/mdbif/>

PROVINCIAL DRUG PROGRAMS REVIEW PROCESS (SPECIAL CIRCUMSTANCES):

Should a prescriber wish to obtain EDS status for a drug not normally eligible for EDS status, the prescriber may apply in writing and include the information listed below.

Please address request to:

Provincial Drug Programs Review Committee
300 Carlton Street – Room 1070
Winnipeg MB R3B 3M9
Fax (204) 942-2030 or 1-877-208-3588

Please include all of the information required for an EDS request (see page 1) as well as:

- Information and background on the original EDS request.
- Previous therapies tried and response to those therapies.
- Additional Information such as supporting literature to support the review.

CRITERIA:

Following are the criteria for coverage of **common** drugs requested under Exception Drug Status. Further information can be provided by professional staff at the Exception Drug Status program.

CARDIOVASCULAR

02273233 02273284 02273241 02273292 02273268 02273306 02273276 02273314	Caduet	amlodipine/atorvastatin	5/10 mg 10/10 mg 5/20 mg 10/20 mg 5/40 mg 10/40 mg 5/80 mg 10/80 mg	Tablet
02411253 02411261 02411288 02411296 02411318 02411326 02411334 02411342	Apo-Amlodipine/ Atorvastatin	amlodipine/atorvastatin	5/10 mg 5/20 mg 5/40 mg 5/80 mg 10/10 mg 10/20 mg 10/40 mg 10/80 mg	Tablet
02362759 02362767 02362775 02362783 02362791 02362805 02362813 02362821	GD-Amlodipine/ Atorvastatin	amlodipine/atorvastatin	5/10 mg 5/20 mg 5/40 mg 5/80 mg 10/10 mg 10/20 mg 10/40 mg 10/80 mg	Tablet

For patients who have been titrated to a stable combination, for a minimum of at least 3 months, of the separate components, amlodipine besylate and atorvastatin.

02495244	Vascepa	icosapent ethyl	1 G	Capsule
----------	----------------	-----------------	-----	---------

To reduce the risk of cardiovascular events in statin-treated patients with elevated triglycerides, who meet all of the following criteria:

- Aged 45 years or older; AND
- Established cardiovascular disease (CVD) ¹ (secondary prevention); AND
- Baseline fasting triglyceride level greater than or equal to 1.7 mmol/L and lower than 5.6 mmol/L, measured within the preceding 3 months before starting treatment with icosapent ethyl, AND
- Receiving a maximally tolerated statin dose for a minimum of 4 weeks, targeted to achieve an LDL-C lower than 2.0 mmol/L.

¹ Established CVD is defined as: history of coronary artery disease (eg. Myocardial infarction, angina, coronary procedure, abdominal aortic aneurysm), cerebrovascular disease (eg. stroke, transient ischemic attack, carotid obstruction), or peripheral artery disease.

Note: Approval will be for a maximum of 4g daily.

02531917 02531925	Kerendia	finerenone	10mg 20mg	Tablet
----------------------	-----------------	------------	--------------	--------

For use as an adjunct to standard of care¹ therapy to reduce the risk of end-stage kidney disease and a sustained decrease in estimated glomerular filtration rate (eGFR), cardiovascular death, nonfatal myocardial infarction, and hospitalization for heart failure, in adult patients with BOTH chronic kidney disease AND type 2 diabetes who meet all of the following criteria:

- eGFR level greater than or equal to 25 mL/min/1.73 m²; AND
- Urine albumin-creatinine ratio (UACR) greater than or equal to 30 mg/g (or 3 mg/ mmol); AND
- Patient does not have New York Heart Association (NYHA) class II to IV heart failure; AND
- Patient is not using finerenone in combination with another mineralocorticoid receptor antagonist.

¹Standard of care is defined as maximally tolerated doses of an angiotensin- converting enzyme (ACE) inhibitor or angiotensin-receptor blocker (ARB) therapy in combination with a sodium-glucose cotransporter 2 (SGLT2) inhibitor, unless SGLT2 inhibitors are contraindicated or not tolerated.

Treatment with finerenone should be discontinued if:

- eGFR level is less than 15 mL/min/1.73 m²; OR
- UACR has increased from baseline

Finerenone must be prescribed in consultation with a nephrologist, or by a prescriber with experience in the diagnosis and management of patients with CKD and T2D.

AUTONOMIC DRUGS

02242115 02242116 02242117 02242118	Exelon	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02245240	Exelon	rivastigmine	2 mg/mL	Oral Liquid
02336715 02336723 02336731 02336758	Apo-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02485362 02485370 02485389 02485397	Jamp-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02401614 02401622 02401630 02401649	Med-Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule
02324563 02324571 02324598 02324601	Sandoz Rivastigmine	rivastigmine	1.5 mg 3 mg 4.5 mg 6 mg	Capsule

Confirmed diagnosis of Alzheimer's Disease with DSMIV criteria with:

- (a) Memory impairment (impaired ability to learn new information or to recall previously learned information); plus
- (b) at least one of the following:
- Aphasia; problems with language (receptive and expressive)
 - Apraxia; impaired ability to carry out motor activities despite intact motor function
 - Agnosia; failure of recognition - especially people
 - Disturbance in executive functioning

The above deficits must have:

- Caused significant decline in previous levels; and
- A gradual onset and continued cognitive decline; and
- The absence of other causative conditions; and
- The deficits do not occur exclusively during the course of delirium; and
- Normal test results for all of the following values: CBC, TSH, Electrolytes, Vitamin B12, and Glucose; and
- The initial MMSE score must be between 10 and 26 and measured within 30 days of the application.

02518058	Breztri Aerosphere	budesonide/glycopyrronium/ fomoterol	160/7.2/5.0 mcg	Metered Dose Inhaler
----------	---------------------------	---	-----------------	-------------------------

For the long-term maintenance treatment of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema according to the following:

- Patients should not be started on triple inhaled therapy as initial therapy for COPD
- For use in patients who are not controlled on optimal dual-inhaled therapy for COPD

02501244	Enerzair Breezhaler	glycopyrronium/indacaterol/ mometasone furoate	50/150/160 mcg	Capsule
----------	----------------------------	---	----------------	---------

For the treatment of asthma in adult patients inadequately controlled with a maintenance combination of a long-acting beta-2 agonist (LABA) and a medium or high dose of an inhaled corticosteroid (ICS), who have experienced one or more asthma exacerbations in the previous 12 months.

02474522	Trelegy Ellipta	fluticasone furoate/ umeclidinium/vilanterol	100 mcg/ 62.5 mcg/25 mg	Powder for Inhalation
----------	------------------------	---	----------------------------	--------------------------

For the long-term, once daily, maintenance treatment of COPD, including chronic bronchitis and/or emphysema according to the following:

- Patients should not be started on triple inhaled therapy as initial therapy for COPD
- For use in patients who are not controlled on optimal dual inhaled therapy for COPD

BLOOD FORMING AND COAGULATION

02532247 02532255 02532263 02533271 02532298	Elonox	enoxaparin sodium	30 mg/0.3 mL 40 mg/0.4 mL 60 mg/0.6 mL 80 mg/0.8 mL 100 mg/mL	Injection
02532301 02532328	Elonox HP	enoxaparin sodium	120 mg/0.8 mL 150 mg/mL	Injection
02132621 02430789 02132648 02132664 02231171 02352680 02352648 02352672 02352656 02352664	Fragmin	dalteparin	2500 IU/0.2 mL 3500 IU/0.28 mL 5000 IU/0.2 mL 10000 IU/mL 25000 IU/mL 18000 IU/0.72 mL 7500 IU/0.3 mL 15000 IU/0.6 mL 10000 IU/0.4 mL 12500 IU/0.5 mL	Injection
02236913 02240114	Fraxiparine	nadroparin	9500 IU/mL 19000 IU/mL	Injection
02229755 02167840 02231478 02229515 02358182 02358158 02358166 02358174 02429462 02429470 02429489	Innohep	tinzaparin	2500 IU/0.25 mL 10000 IU/mL 10000 IU/0.5 mL 20000 IU/mL 18000 IU/0.9 mL 3500 IU/0.35 mL 4500 IU/0.45 mL 14000 IU/0.7 mL 8,000/0.4 mL 12,000/0.6 mL 16,000/0.8 mL	Injection

02507501 02507528 02507536 02507544 02507552 02507560 02507579	Inclunox (<i>biosimilar</i>)	enoxaparin sodium	30 mg/0.3 mL 40 mg/0.4 mL 60 mg/0.6 mL 80 mg/0.8 mL 100 mg/1 mL 120 mg/0.8 mL 150 mg/1 mL	Injection
02507560 02507579	Inclunox-HP (<i>biosimilar</i>)	enoxaparin sodium	120 mg/0.8 mL 150 mg/1 mL	Injection
02012472 02236883 02242692 02236564 02378426 02378434 02378442 02378469	Lovenox	enoxaparin	30 mg/0.3 mL 40 mg/0.4 mL 120 mg/0.8 mL 300 mg/3 mL 60 mg/0.6 mL 80 mg/0.8 mL 100 mg/mL 150 mg/mL	Injection
02506440 02506459 02506467 02506475 02506483 02506491	Noromby (<i>biosimilar</i>)	enoxaparin sodium	20 mg/0.2 mL 30 mg/0.3 mL 40 mg/0.4 mL 60 mg/0.6 mL 80 mg/0.8 mL 100 mg/mL	Injection
02506505 02506513	Noromby HP (<i>biosimilar</i>)	enoxaparin sodium	120 mg/0.8 mL 150 mg/mL	Injection
02509075 02509083 02509091 02509105 02509113 02509121	Redesca (<i>biosimilar</i>)	enoxaparin sodium	30 mg/0.3 mL 40 mg/0.4 mL 60 mg/0.6 mL 80 mg/0.8 mL 100 mg/mL 300 mg/3 mL	Injection
02509148 02509156	Redesca HP (<i>biosimilar</i>)	enoxaparin sodium	120 mg/0.8 mL 150 mg/mL	Injection

Please contact the EDS Program at Manitoba Health for specific criteria.

Elonox, Elonox HP, Inclunox, Inclunox HP, Noromby, Noromby HP, Redesca or Redesca HP will be the preferred enoxaparin option for all enoxaparin-naïve patients prescribed enoxaparin.

Preferred means the first enoxaparin product to be considered for reimbursement for enoxaparin-naïve patients. Patients will not be permitted to switch from Elonox, Elonox HP, Inclunox, Inclunox HP, Lovenox, Noromby, Noromby HP, Redesca or Redesca HP to another

02458640 02458659 02458667	Lixiana	edoxaban	15 mg 30 mg 60 mg	Tablet
02312441 02358808	Pradaxa	dabigatran	110 mg 150 mg	Capsule
02468905 02468913	Apo-Dabigatran	dabigatran	110 mg 150 mg	Capsule

For patients with non-valvular atrial fibrillation (AF) for the prevention of stroke and systemic embolism AND in whom:

- (a) Anticoagulation is inadequate following a reasonable trial on warfarin; **OR**
- (b) Anticoagulation with warfarin is contraindicated or not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e. no access to INR testing services at a laboratory, clinic, pharmacy, and at home).

02458640 02458659 02458667	Lixiana	edoxaban	15 mg 30 mg 60 mg	Tablet
----------------------------------	----------------	----------	-------------------------	--------

For the treatment of venous thromboembolic events (VTE) (deep vein thrombosis [DVT] and pulmonary embolism [PE]), and the prevention of recurrent DVT and PE for a duration of up to six months.

IRON PREPARATIONS

02477777	Monoferic	iron	100 mg/mL	Injection
----------	------------------	------	-----------	-----------

For the treatment of iron deficiency anemia (IDA) in patients who meet the following criteria:

- Patient has a documented diagnosis of IDA based on laboratory test results (i.e. hemoglobin, ferritin); AND
- Patient has failed to respond or is intolerant to an adequate trial (at least 4 weeks) of oral iron therapy; OR
- Patient has a contraindication to oral iron therapy.
- Monoferic is administered in a setting where appropriate monitoring and management of hypersensitivity reactions can be provided to the patient.

02243716	Venofer	iron sucrose	20 mg/mL	Injectable Solution
02502917	pms-Iron Sucrose	iron sucrose	20 mg/mL	Injectable Solution

For the treatment of iron deficiency anemia (IDA) in patients who meet the following criteria:

- Patient has a documented diagnosis of IDA based on laboratory test results (i.e. hemoglobin, ferritin); AND
- Patient has failed to respond or is intolerant to an adequate trial (at least 4 weeks) of oral iron therapy; OR
- Patient has a contraindication to oral iron therapy.
- Iron sucrose is administered in a setting where appropriate monitoring and management of hypersensitivity reactions can be provided to the patient.

CENTRAL NERVOUS SYSTEM AGENTS

Anorexigenic Agents and Respiratory and Cerebral Stimulants

02239665	Alertec	modafinil	100 mg	Tablet
02285398	Apo-Modafinil	modafinil	100 mg	Tablet
02430487	Auro-Modafinil	modafinil	100 mg	Tablet
02503727	Jamp Modafinil	modafinil	100 mg	Tablet
02432560	Mar-Modafinil	modafinil	100 mg	Tablet
02530244	Modafinil	modafinil	100 mg	Tablet
02420260	Teva-Modafinil	modafinil	100 mg	Tablet

1. To treat narcolepsy where:

(a) Amphetamines are contraindicated; OR

(b) Patients over 40 years old who have underlying cardiovascular disease or history of the disease; OR

(c) Patients have Parkinson's Disease or are unresponsive to methylphenidate (Ritalin) or dexamphetamine.

2. To treat patients with sleep lab confirmed diagnosis of narcolepsy, or idiopathic CNS hypersomnia.

3. To treat Multiple Sclerosis fatigue not responding to amantadine.

02262800 02262819 02262827 02262835 02262843	Strattera	atomoxetine	10 mg 18 mg 25 mg 40 mg 60 mg	Capsule
02318024 02318032 02318040 02318059 02318067	Apo-Atomoxetine	atomoxetine	10 mg 18 mg 25 mg 40 mg 60 mg	Capsule
02445883 02445905 02445913 02445948 02445956	Atomoxetine	atomoxetine	10 mg 18 mg 25 mg 40 mg 60 mg	Capsule
02506807 02506815 02506823 02506831 02506858	Jamp Atomoxetine	atomoxetine	10 mg 18 mg 25 mg 40 mg 60 mg	Capsule

02386410 02386429 02386437 02386445 02386453	Sandoz Atomoxetine	atomoxetine	10 mg 18 mg 25 mg 40 mg 60 mg	Capsule
02314541 02314568 02314576 02314584 02314592 02362511	Teva-Atomoxetine	atomoxetine	10 mg 18 mg 25 mg 40 mg 60 mg 80 mg	Capsule

For treatment of Attention-Deficit Hyperactivity Disorder (ADHD) and must meet the following criteria:

- Patient has a contraindication or intolerance to, or has previously failed treatment with both of the following:

- one methylphenidate-based long-acting psychostimulant AND
- one amphetamine-based long-acting psychostimulant

Anticonvulsants				
02284294 02284308 02284316	Apo-Oxcarbazepine	oxcarbazepine	150 mg 300 mg 600 mg	Tablet
02242068 02242069	Trileptal	oxcarbazepine	300 mg 600 mg	Tablet
02244673	Trileptal	oxcarbazepine	60 mg/mL	Liquid

For the treatment of patients with refractory partial epilepsy;

(a) when intolerant to other anticonvulsant therapy;

(b) adjunct therapy when current anticonvulsant therapies are not providing adequate seizure control.

02426862 02426870 02426889 02426897	Aptiom	eslicarbazepine	200 mg 400 mg 600 mg 800 mg	Tablet
02452936 02452944 02452952 02452960 02452979	Brivlera	brivaracetam	10 mg 25 mg 50 mg 75 mg 100 mg	Tablet
02357615 02357623 02357631 02357658	Vimpat	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet

02475332 02475340 02475359 02475367	Auro-Lacosamide	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet
02489287 02489295 02489309 02489317	ACH-Lacosamide	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet
02488388 02488396 02488418 02488426	Jamp-Lacosamide	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet
02512874 02512882 02512890 02512904	Lacosamide (Sanis)	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet
02487802 02487810 02487829 02487837	Mar-Lacosamide	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet
02490544 02490552 02490560 02490579	Mint-Lacosamide	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet
02499568 02499576 02499584 02499592	NRA-Lacosamide	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet
02478196 02478218 02478226 02478234	Pharma-Lacosamide	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet
02474670 02474689 02474697 02474700	Sandoz Lacosamide	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet
02472902 02472910 02472929 02472937	Teva-Lacosamide	lacosamide	50 mg 100 mg 150 mg 200 mg	Tablet

For use as an adjunctive therapy in patients in the management of refractory partial-onset seizures (POS) in adult patients with epilepsy who are not satisfactorily controlled with conventional therapy and who meet all of the following criteria:

- (a) are under the care of a physician experienced in the treatment of epilepsy,
- (b) are currently receiving two or more antiepileptic drugs, and
- (c) in whom all other antiepileptic drugs are ineffective or not appropriate

02404516	Fycompa	perampanel	2 mg	Tablet
02404524			4 mg	
02404532			6 mg	
02404540			8 mg	
02404559			10 mg	
02404567			12 mg	

For use as an adjunctive therapy in patients in the management of refractory partial-onset seizures (POS) in adult patients with epilepsy who are not satisfactorily controlled with conventional therapy and who meet all of the following criteria:

- (a) are under the care of a physician experienced in the treatment of epilepsy,
- (b) are currently receiving two or more antiepileptic drugs, and
- (c) in whom all other antiepileptic drugs are ineffective or not appropriate

For use as an adjunctive therapy in the management of primary generalized tonic-clonic (PGTC) seizures in adult patients with epilepsy who are not satisfactorily controlled with conventional therapy and who meet all of the following criteria:

- (a) are under the care of a physician experienced in the treatment of epilepsy,
- (b) are currently receiving two or more antiepileptic drugs, and
- (c) in whom all other antiepileptic drugs are ineffective or not appropriate

Calcitonin Gene-related Peptide (CGRP) Antagonists				
02497859 02509474	Ajovy	fremanezumab	225 mg/1.5 mL	Injection

For the prevention of migraine in patients who have a confirmed diagnosis of either:

1. Episodic migraine: headaches for less than 15 days per month for more than 3 months of which at least 4 days per month are with migraine; OR
2. Chronic migraine: headaches for at least 15 days per month for more than 3 months of which at least 8 days per month are with migraine.

Initiation criteria:

- The patient must have experienced an inadequate response¹, intolerance, or contraindication to at least two oral prophylactic migraine medications² of different classes; AND
- The patient must be under the care of a physician who has appropriate experience in the management of migraine headaches; AND
- The physician must provide the number of headache and migraine days per month at the time of initial request for reimbursement.

Initial approval duration: 6 months

Initial Renewal criteria:

- Reduction of at least 50% in the average number of migraine days per month compared with baseline.

Renewal duration: 6 months

Subsequent Renewal criteria:

- Maintenance of 50% reduction in the average number of migraine days per month from baseline.

¹ Inadequate response to oral prophylactic therapies is defined as less than a 30% reduction in frequency of headache days to an adequate dose and duration of at least two prophylactic medications, which must be of a different class.

² Oral prophylactic medication alternatives include:

- beta blockers
- tricyclic antidepressants
- verapamil or flunarizine
- sodium valproate or divalproex sodium
- topiramate
- gabapentin

02491087 02491060	Emgality	galcanezumab	120 mg/mL	Injection
----------------------	-----------------	--------------	-----------	-----------

For the prevention of migraine in patients who have a confirmed diagnosis of either:

1. Episodic migraine: headaches for less than 15 days per month for more than 3 months of which at least 4 days per month are with migraine; OR
2. Chronic migraine: headaches for at least 15 days per month for more than 3 months of which at least 8 days per month are with migraine.

Initiation criteria:

- The patient must have experienced an inadequate response¹, intolerance, or contraindication to at least two oral prophylactic migraine medications² of different classes; AND
- The patient must be under the care of a physician who has appropriate experience in the management of migraine headaches; AND
- The physician must provide the number of headache and migraine days per month at the time of initial request for reimbursement.

Initial approval duration: 6 months

Initial Renewal criteria:

- Reduction of at least 50% in the average number of migraine days per month compared with baseline.

Renewal duration: 6 months

Subsequent Renewal criteria:

- Maintenance of 50% reduction in the average number of migraine days per month from baseline.

¹Inadequate response to oral prophylactic therapies is defined as less than a 30% reduction in frequency of headache days to an adequate dose and duration of at least two prophylactic medications, which must be of a different class.

² Oral prophylactic medication alternatives include:

- beta blockers
- tricyclic antidepressants
- verapamil or flunarizine
- sodium valproate or divalproex sodium
- topiramate

- *gabapentin*

02510839	Vyepti	eptinezumab	100 mg/ mL	Solution
02542269	Vyepti	eptinezumab	300 mg/3 mL	Solution

For the prevention of migraine in patients who have a confirmed diagnosis of either:

1. Episodic migraine: headaches for less than 15 days per month for more than 3 months of which at least 4 days per month are with migraine; OR
2. Chronic migraine: headaches for at least 15 days per month for more than 3 months of which at least 8 days per month are with migraine.

Initiation criteria:

- The patient must have experienced an inadequate response¹, intolerance, or contraindication to at least two oral prophylactic migraine medications² of different classes; AND
- The patient must be under the care of a physician who has appropriate experience in the management of migraine headaches; AND
- The physician must provide the number of headache and migraine days per month at the time of initial request for reimbursement.

Initial approval duration: 6 months

Initial Renewal criteria:

- Reduction of at least 50% in the average number of migraine days per month compared with baseline.

Renewal duration: 6 months

Subsequent Renewal criteria:

- Maintenance of 50% reduction in the average number of migraine days per month from baseline.

¹Inadequate response to oral prophylactic therapies is defined as less than a 30% reduction in frequency of headache days to an adequate dose and duration of at least two prophylactic medications, which must be of a different class.

²Oral prophylactic medication alternatives include:

- beta blockers
- tricyclic antidepressants
- verapamil or flunarizine
- sodium valproate or divalproex sodium
- topiramate
- gabapentin

02533979	Qulipta	atogepant	10 mg	Tablet
02533987			30 mg	
02533995			60 mg	

For the prevention of migraine in patients who have a confirmed diagnosis of episodic migraine: headaches for less than 15 days per month for more than 3 months of which at least 4 days per month are with migraine.

Initiation criteria:

- The patient must have experienced an inadequate response¹, intolerance, or contraindication to at least two oral prophylactic migraine medications² of different classes; AND
- The patient must be under the care of a physician who has appropriate experience in the management of migraine headaches; AND
- The physician must provide the number of headache and migraine days per month at the time of initial request for reimbursement.

Initial approval duration: 6 months

Initial Renewal criteria:

- Reduction of at least 50% in the average number of migraine days per month compared with baseline.

Subsequent Renewal criteria:

- Maintenance of 50% reduction in the average number of migraine days per month from baseline.

¹Inadequate response to oral prophylactic therapies is defined as less than a 30% reduction in frequency of headache days to an adequate dose and duration of at least two prophylactic medications, which must be of a different class.

²Oral prophylactic medication alternatives include:

- beta blockers
- tricyclic antidepressants
- verapamil or flunarizine
- sodium valproate or divalproex sodium
- topiramate
- gabapentin

Combined use with other calcitonin gene-related peptide (CGRP) inhibitors will not be reimbursed.

Opiate Agonists				
02230302	Codeine Contin	codeine	50 mg	Sustained Release Tablet
02163748			100 mg	
02163780			150 mg	
02163799			200 mg	

For the treatment of:

- Palliative and chronic pain** in patients where hepatotoxicity is a concern due to high doses of acetaminophen (e.g. taking over 12 tablets of acetaminophen compound with codeine 30 mg per day).
- Codeine addiction** using tapering doses.

02231934 02240131 02240132	Oxy-IR	oxycodone HCl	5 mg 10 mg 20 mg	Tablet
02319977 02319985 02319993	pms-Oxycodone	oxycondone HCl	5 mg 10 mg 20 mg	Tablet
00789739 00443948 02262983	Supeudol	oxycodone HCl	5 mg 10 mg 20 mg	Tablet
00392480 00392472	Supeudol	oxycodone HCl	10 mg 20 mg	Suppositories

Patients who have tried the combination products (e.g. Percocet) and have maximized the acetaminophen dose or have contraindications to acetaminophen.

02372525 02372533 02372797 02372541 02372568 02372576 02372584	OxyNeo	oxycodone	10 mg 15 mg 20 mg 30 mg 40 mg 60 mg 80 mg	Controlled Released Tablet
--	---------------	-----------	---	-------------------------------

For the diagnosis of:

1. Cancer related pain; PLUS

Patients who are unable to tolerate or receive an adequate response to either the regular release dosage forms of oxycodone or the sustained release preparations of morphine or hydromorphone; OR

2. Pain management in a specified chronic pain diagnosis (details regarding patient's condition and previous medication history are required); PLUS

Patients who are unable to tolerate or receive an adequate response to either the regular release dosage forms of oxycodone or the sustained release preparations of morphine or hydromorphone.

Selective Serotonin and Norepinephrine Reuptake Inhibitors				
02420864 02420872	Abilify Maintena	aripiprazole	300 mg/vL 400 mg/vL	Injection
02354217 02354225 02354233 02354241	Invega Sustenna	paliperidone	50 mg/0.5 mL 75 mg/0.75 mL 100 mg/mL 150 mg/1.5 mL	Injection
02455943 02455986 02455994 02456001	Invega Trinza	paliperidone	175 mg/0.875 mL 263 mg/1.315 mL 350 mg/1.75 mL 525 mg/2.625 mL	Injection
02298465 02255707 02255723 02255758	Risperdal Consta	risperidone	12.5mg 25 mg 37.5 mg 50 mg	Injection

For patients with schizophrenia:

- (a) With a history of non-adherence, as evidenced by outcomes such as repeated hospitalizations, or
- (b) Who have tried one or more antipsychotic agents, and who continue to be inadequately controlled, or are experiencing significant side effects such as EPS.

***NOTE:** *Invega Trinza to be used only after Invega Sustenna has been established as adequate treatment for at least four months.*

ELECTROLYTIC, CALORIC AND WATER BALANCE				
02242814	Apo-Lactulose	lactulose	667 mg/mL	Oral Liquid
02295881	Jamp-Lactulose	lactulose	667 mg/mL	Oral Solution
02412268	Lactulose	lactulose	667 mg/mL	Oral Solution
02247383	Pharma-Lactulose	lactulose	667 mg/mL	Oral Liquid
00703486 02469391	pms-Lactulose	lactulose	667 mg/mL	Oral Liquid
00854409	ratio-Lactulose	lactulose	667 mg/mL	Oral Liquid

Portal systemic encephalopathy.

02410702	Zaxine	rifaximin	550 mg	Tablet
----------	---------------	-----------	--------	--------

For reducing the risk of overt hepatic encephalopathy (HE) recurrence (i.e. 2 or more episodes), if the following clinical criteria are met:

- (a) Patients are unable to achieve adequate control of HE recurrence with maximal tolerated dose of lactulose alone;
- (b) Must be used in combination with a maximal tolerated dose of lactulose;
- (c) For patients not maintained on lactulose, information is required regarding the nature of the patient's intolerance to lactulose.

EYE, EAR, NOSE AND THROAT PREPARATIONS

02248151	Alphagan P	brimonidine tartrate	0.15%	Ophthalmic Solution
02301334	Apo-Brimonidine P	brimonidine tartrate	0.15%	Ophthalmic Solution

Intolerance to brimonidine 0.2%.

02484137	Verkazia	cyclosporine	0.1%	Emulsion
----------	-----------------	--------------	------	----------

For the treatment of severe vernal keratoconjunctivitis (VKC) in patients who meet ALL of the following criteria:

- Patient is between 4 and 18 years of age inclusive; AND
- Diagnosis of severe VKC defined as either:
 - o Grade 3 (severe) or 4 (very severe) on the Bonini scale, OR
 - o Grade 4 (marked) or 5 (severe) on the modified Oxford scale; AND
- Documentation of the baseline severity of signs and symptoms of VKC prior to treatment initiation is provided; AND
- Patient is under the care of a specialist physician with experience in the diagnosis and management of VKC.

Note: Patients previously treated with cyclosporine 0.1% but who discontinued treatment upon resolution of VKC signs and symptoms are eligible to reinstate treatment if signs and symptoms of severe VKC recur and they meet the initiation criteria.

Initial approval period: 6 months

Discontinuation Criteria:

- Treatment should be discontinued if no improvement in signs and symptoms of VKC is observed; OR
- Treatment should be discontinued once signs and symptoms of VKC have resolved.

GASTROINTESTINAL DRUGS

02470780	Apo-Lansoprazole-Amoxicillin-Clarithromycin	amoxicillin/clarithromycin/ lansoprazole	500 mg 500 mg 30 mg	Tablet
----------	--	---	---------------------------	--------

For H. pylori Eradication (approved for a 7-14 day treatment course).

02256452	Jamp-Loperamide	loperamide	2 mg	Tablet
02132591	Novo-Loperamide	loperamide	2 mg	Tablet
02228351	pms-Loperamide	loperamide	2 mg	Tablet

For the treatment of:

- Ileostomy or a colostomy;
- Bowel resection, including short bowel syndrome;
- Inflammatory bowel diseases, e.g. Crohn's Disease, Ulcerative Colitis;
- Cancer including chemotherapy and radiation therapy;
- HIV/AIDS;
- Fecal incontinence.

HORMONES AND SYNTHETIC SUBSTITUTES

02229293	Entocort	budesonide	3 mg	Capsule
----------	-----------------	------------	------	---------

Crohn's Disease of ileum, ascending colon (right-sided disease).

02391600 02339587 02339595	ACH-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02302861 02302888 02302896	ACT Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02302942 02302950 02302977	Apo-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02397307 02365529 02365537	Jamp-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02326477 02326485 02326493	Mint-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02303124 02303132 02303140	pms-Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet
02297906 02297914 02297922	Sandoz Pioglitazone	pioglitazone	15 mg 30 mg 45 mg	Tablet

For use in patients who are not optimally controlled on maximal doses of metformin and either a sulfonylurea (glyburide, gliclazide) or repaglinide or with contraindications to these agents.

Type 2 diabetics on high doses of insulin (over 2 U/kg) and on maximally tolerated metformin who are not achieving optimal control.

NOTE: *Pioglitazone should be used as an add-on to pre-existing therapy not a substitution.*

02269589 02269597 02269619	Sandoz Glimepiride	glimepiride	1 mg 2 mg 4 mg	Tablet
----------------------------------	---------------------------	-------------	----------------------	--------

For patients poorly controlled on maximum doses of glyburide or gliclazide and metformin and diet (unless metformin is contraindicated because of renal/hepatic dysfunction or G.I. intolerance.)

02321475 02321483 02321491	ACT Repaglinide	repaglinide	0.5 mg 1 mg 2 mg	Tablet
02424258 02424266 02424274	Auro-Repaglinide	repaglinide	0.5 mg 1 mg 2 mg	Tablet
02239924 02239925 02239926	Gluconorm	repaglinide	0.5 mg 1 mg 2 mg	Tablet
02354926 02354934 02354942	Jamp-Repaglinide	repaglinide	0.5 mg 1 mg 2 mg	Tablet
02357453 02357461 02357488	Sandoz Repaglinide	repaglinide	0.5 mg 1 mg 2 mg	Tablet

(a) Inadequate control on maximum doses of glyburide and metformin.

(b) Frequent or severe hypoglycemic events despite dosage adjustments of glyburide or gliclazide.

02425483 02425491	Invokana	canagliflozin	100 mg 300 mg	Tablet
02388839 02388847 02303922	Januvia	sitagliptin	25 mg 50 mg 100 mg	Tablet
02508656 02508664 02508672	Apo-Sitagliptin	sitagliptin	25 mg 50 mg 100 mg	Tablet
02529866 02529874 02529882	Auro-Sitagliptin	sitagliptin	25 mg 50 mg 100 mg	Tablet
02534134 02534142 02534150	Jamp Sitagliptin	sitagliptin	25 mg 50 mg 100 mg	Tablet
02504049 02504057 02504065	Sandoz Sitagliptin	sitagliptin	25 mg 50 mg 100 mg	Tablet
02529033 02529041 02529068	Sitagliptin	sitagliptin	25 mg 50 mg 100 mg	Tablet
02531631 02531658 02531666	Taro-Sitagliptin Fumarate	sitagliptin	25 mg 50 mg 100 mg	Tablet
02443937 02443945	Jardiance	empagliflozin	10 mg 25 mg	Tablet

02375842 02333554	Onglyza	saxagliptin	2.5 mg 5 mg	Tablet
02507471 02507498	Apo-Saxagliptin	saxagliptin	2.5 mg 5 mg	Tablet
02468603 02468611	Sandoz Saxagliptin	saxagliptin	2.5 mg 5 mg	Tablet
02370921	Trajenta	linagliptin	5 mg	Tablet

For the treatment of patients with type 2 diabetes who have previously been treated with metformin and a sulfonylurea. Should be used in patients with diabetes who are not adequately controlled on or are intolerant to metformin and a sulfonylurea, and for whom insulin is not an option.

02443937 02443945	Jardiance	empagliflozin	10 mg 25 mg	Tablet
----------------------	------------------	---------------	----------------	--------

As an adjunct to diet, exercise, and standard care therapy to reduce the incidence of cardiovascular (CV) death in patients with type 2 diabetes mellitus (T2DM) and established cardiovascular disease who have inadequate glycemic control, if the following criteria are met:

- Patients have inadequate glycemic control despite an adequate trial of metformin
- Patients have established cardiovascular disease as defined* in the EMPA-REG OUTCOME trial.

***NOTE:** Established CV disease is defined on the basis of one of the following:

- 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 either a positive non-invasive stress test or discharged from hospital with a documented diagnosis of unstable angina within 12 months prior to selection.
- Last episode of unstable angina > 2 months prior with confirmed evidence of coronary multi-vessel or single-vessel disease.
- History of ischemic or hemorrhagic stroke.
- Occlusive peripheral artery disease.

02456575 02456583 02456591 02456605 02456613 02456621	Synjardy	empagliflozin/metformin	5/500 mg 5/850 mg 5/1000 mg 12.5/500 mg 12.5/850 mg 12.5/1000 mg	Tablet
--	-----------------	-------------------------	---	--------

For type 2 diabetic patients who have been titrated to a stable combination, for a minimum of 3 months, of the separate components, metformin and empagliflozin.

NOTE: Patients must meet EDS criteria for empagliflozin.

02333856 02333864 02333872	Janumet	sitagliptin/metformin	50/500 mg 50/850 mg 50/1000 mg	Tablet
02509415 02509423 02509431	Apo-Sitagliptin Malate/ Metformin	sitagliptin/metformin	50/500 mg 50/850 mg 50/1000 mg	Tablet
02503956 02503964 02503972	Sandoz Sitagliptin- Meformin	sitagliptin/metformin	50/500 mg 50/850 mg 50/1000 mg	Tablet
02416794	Janumet XR	sitagliptin/metformin	50/1000 mg	Tablet
02506270 02506289 02506297	Apo- Sitagliptin/Metformin XR	sitagliptin/metformin	50/500 mg 50/1000 mg 100/1000 mg	Tablet
02529106 02529114 02529122	Sandoz Sitagliptin- Meformin XR	sitagliptin/metformin	50/500 mg 50/1000 mg 100/1000 mg	Tablet
02403250 02403269 02403277	Jentadueto	linagliptin/metformin	2.5/500 mg 2.5/850 mg 2.5/1000 mg	Tablet
02389169 02389177 02389185	Komboglyze	saxagliptin/metformin	2.5/500 mg 2.5/850 mg 2.5/1000 mg	Tablet

For type 2 diabetic patients who have been titrated to a stable combination, for a minimum of at least 3 months, of the separate components, Metformin and Linagliptin/Saxagliptin/Sitagliptin/Dapagliflozin, and for whom insulin is not an option.

02471469 02471477 02540258	Ozempic	semaglutide	1.34 mg/mL 1.34 mg/mL 0.68mg/mL	Injection
----------------------------------	----------------	-------------	---------------------------------------	-----------

For the treatment of type 2 diabetes in combination with metformin and a sulfonylurea, when diet and exercise plus dual therapy with metformin and a sulfonylurea do not achieve adequate glycemic control.

02478293	Soliqua	insulin glargine/lixisenatide	100 U/33 mcg	Injection
----------	----------------	-------------------------------	--------------	-----------

For treatment of patients with type 2 diabetes who would be eligible for Adlyxine but will also be treated with a basal insulin (less than 60U/day) to achieve adequate glycemic control.

MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

02244148 02244149	Protopic	tacrolimus	0.1% 0.03%	Ointment
----------------------	-----------------	------------	---------------	----------

Second-line therapy for short and long-term intermittent-treatment of moderate to severe atopic dermatitis in non-immunocompromised patients, in whom the use of conventional topical corticosteroid therapies are deemed inadvisable because of potential risks, or who are not adequately responsive to or intolerant of conventional therapies.

Note: Both 0.03% and 0.1% for adults and only 0.03% for children aged 2 to 15 years.

02528363 02528371 02528398	Cibinqo	abrocitinib	50 mg 100 mg 200 mg	Tablet
----------------------------------	----------------	-------------	---------------------------	--------

For the treatment of refractory moderate to severe¹ atopic dermatitis (AD), in patients aged 12 years and older, only if the following criteria are met:

Initiation criteria:

- Patient has had an adequate trial² (with a documented refractory disease), or was intolerant (with documented intolerance), or is ineligible for each of the following therapies:
 - o maximally tolerated medical topical therapies for AD combined with phototherapy (where available); AND
 - o maximally tolerated medical topical therapies for AD combined with at least 1 of the 4 systemic immunomodulators (methotrexate, cyclosporine, mycophenolate mofetil, or azathioprine).
- The physician must provide the Eczema Area and Severity Index (EASI) score at the time of initial request for reimbursement.

Initial approval: 6 months

Renewal Criteria:

- The physician must provide proof of beneficial clinical effect when requesting continuation of reimbursement, defined as a 75% or greater improvement from baseline in the EASI score (EASI-75) 6 months after treatment initiation.
- The physician must provide proof of maintenance of EASI-75 response from baseline for subsequent authorizations.

Renewal approval: 1 year

Request for coverage must be made by, or in consultation with, a dermatologist, allergist, clinical immunologist, or pediatrician who has expertise in the management of moderate to severe AD.

Abrocitinib should not be used in combination with phototherapy, any immunomodulatory agents (including biologics) or other Janus kinase [JAK] inhibitor treatment for moderate to severe AD.

¹Moderate to severe atopic dermatitis is defined as an EASI score of 16 points or higher.

² Adequate trials are defined as:

- Phototherapy – 3 times a week for 12 weeks.
- Methotrexate – 10 to 20mg per week for 12 weeks.
- Cyclosporine – 2.5 to 5mg/kg/day for 12 weeks.
- Mycophenolate mofetil – 1g twice daily for 12 weeks.
- Azathioprine – 1.5 to 2.5mg/kg/day for 12 weeks.

02470365 02492504 02510049 02524252	Dupixent	dupilumab	150 mg/mL 200 mg/1.14 mL 150 mg/mL 200 mg/1.14 mL	Injection
--	-----------------	-----------	--	-----------

For the treatment of moderate-to-severe¹ atopic dermatitis (AD) in patients aged 12 years and older, whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable, only if the following criteria are

met:

Initiation Criteria

- Patient has had an adequate trial²(with a documented refractory disease), or was intolerant (with documented intolerance), or is ineligible for each of the following therapies:
 - o maximally tolerated medical topical therapies for AD combined with phototherapy (where available); AND
 - o maximally tolerated medical topical therapies for AD combined with at least 1 of the 4 systemic immunomodulators (methotrexate, cyclosporine, mycophenolate mofetil, or azathioprine).
- The physician must provide the Eczema Area and Severity Index (EASI) score at the time of initial request for reimbursement.

Initial approval: 6 months

Renewal Criteria

- The physician must provide proof of beneficial clinical effect when requesting continuation of reimbursement, defined as a 75% or greater improvement from baseline in the EASI score (EASI-75) six months after treatment initiation.
- The physician must provide proof of maintenance of EASI-75 response from baseline every six months for subsequent authorizations.

Request for coverage must be made by, or in consultation with, a dermatologist, allergist, clinical immunologist, or pediatrician who has expertise in the management of moderate-to-severe AD.

Dupilumab should not be used in combination with phototherapy, any immunomodulatory drugs (including biologics or a Janus kinase [JAK] inhibitor treatment) for moderate-to-severe AD.

¹ Moderate-to-severe atopic dermatitis is defined as an EASI score of 16 points or higher

² Adequate trials are defined as:

- Phototherapy – 3 times a week for 12 weeks.
- Methotrexate – 10 to 20mg per week for 12 weeks.
- Cyclosporine – 2.5 to 5mg/kg/day for 12 weeks.
- Mycophenolate mofetil – 1g twice daily for 12 weeks.
- Azathioprine – 1.5 to 2.5mg/kg/day for 12 weeks.

02495155 02520893	Rinvoq	upadacitinib	15 mg 30 mg	Tablet
----------------------	---------------	--------------	----------------	--------

Atopic Dermatitis

For the treatment of refractory moderate to severe¹ atopic dermatitis (AD), in patients aged 12 years and older, only if the following criteria are met:

Initiation Criteria:

- Patient has had an adequate trial² (with a documented refractory disease), or was intolerant (with documented intolerance), or is ineligible for each of the following therapies:
 - o maximally tolerated medical topical therapies for AD combined with phototherapy (where available); AND
 - o maximally tolerated medical topical therapies for AD combined with at least 1 of the 4 systemic immunomodulators (methotrexate, cyclosporine, mycophenolate mofetil, or azathioprine).
- The physician must provide the Eczema Area and Severity Index (EASI) score at the time of initial request for reimbursement.

Initial approval: 6 months

Renewal Criteria:

- The physician must provide proof of beneficial clinical effect when requesting continuation of reimbursement, defined as a 75% or greater improvement from baseline in the EASI score (EASI-75) 6 months after treatment initiation.
- The physician must provide proof of maintenance of EASI-75 response from baseline for subsequent authorizations.

Renewal approval: 1 year

Request for coverage must be made by, or in consultation with, a dermatologist, allergist, clinical immunologist, or pediatrician who has expertise in the management of moderate to severe AD.

Upadacitinib should not be used in combination with phototherapy, any immunomodulatory agents (including biologics) or other Janus kinase [JAK] inhibitor treatment for moderate to severe AD.

¹ Moderate to severe atopic dermatitis is defined as an EASI score of 16 points or higher.

² Adequate trials are defined as:

- Phototherapy – 3 times a week for 12 weeks.
- Methotrexate – 10 to 20mg per week for 12 weeks.
- Cyclosporine – 2.5 to 5mg/kg/day for 12 weeks.
- Mycophenolate mofetil – 1g twice daily for 12 weeks.
- Azathioprine – 1.5 to 2.5mg/kg/day for 12 weeks.

SMOOTH MUSCLE RELAXANTS

02275066	Trosec	trospium	20 mg	Tablet
02488353	Mar-Trospium	trospium	20 mg	Tablet
02506661	JampTrospium	trospium	20 mg	Tablet

Urinary incontinence in patients unable to tolerate or failing immediate release oxybutynin e.g. headache, dry mouth, dyspepsia.

MISCELLANEOUS THERAPEUTIC AGENTS

02298384	Teva-Risedronate	risedronate	30 mg	Tablet
----------	-------------------------	-------------	-------	--------

For the treatment of **Paget's Disease**.

02489597	Evenity	romosozumab	105 mg/1.17 mL	Pre-filled syringe
----------	----------------	-------------	----------------	--------------------

For the treatment of osteoporosis in postmenopausal women only if the following criteria are met:

- History of osteoporotic fracture; AND
- High risk for future fracture, defined as a 10-year fracture risk > 20% as defined by the Fracture Risk Assessment (FRAX) tool; AND
- Treatment naive to osteoporosis medications, except calcium and/or vitamin D.

Maximum duration of reimbursement is 12 months.

Note: Romosozumab will not be reimbursed if prescribed concurrently with other osteoporosis medications, except calcium and/or vitamin D.

02343541	Prolia	denosumab	60 mg/mL	Injection
----------	---------------	-----------	----------	-----------

To increase bone mass in men or postmenopausal women with osteoporosis who are at a high risk for fracture or who have failed or are intolerant to other available osteoporosis therapy, where the following clinical criteria are met:

High fracture risk defined as either:

- moderate 10-year fracture risk (10% to 20%) as defined by either the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) tool or the World Health Organization's Fracture Risk Assessment (FRAX) tool with a prior fragility fracture;

OR

- high 10-year fracture risk ($\geq 20\%$) as defined by either the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) tool or the World Health Organization's Fracture Risk Assessment (FRAX) tool.

AND

Contraindication to oral bisphosphonates.

Notes:

- Bisphosphonate failure will be defined as a fragility fracture and/or evidence of a decline in bone mineral density below pre-treatment baseline levels, despite adherence for one year.
- Contraindication to oral bisphosphonates will be considered. Contraindications include renal impairment, hypersensitivity, and abnormalities of the esophagus (e.g. esophageal stricture or achalasia).

Jubbonti will be the preferred denosumab option for all denosumab-naïve patients prescribed a denosumab product for osteoporosis. Preferred means the first denosumab product to be considered for reimbursement for denosumab-naïve patients. Patients will not be permitted to switch from Prolia or Jubbonti to another denosumab product or vice versa, if previously trialed and deemed unresponsive to denosumab.

02545411	Jubbonti (biosimilar)	denosumab	60mg/mL	Injection
----------	---------------------------------	-----------	---------	-----------

To increase bone mass in men or postmenopausal women with osteoporosis who are at a high risk for fracture or who have failed or are intolerant to other available osteoporosis therapy, where the following clinical criteria are met:

- High fracture risk defined as either:

- o moderate 10-year fracture risk (10% to 20%) as defined by either the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) tool or the World Health Organization's Fracture Risk Assessment (FRAX) tool with a prior fragility fracture;

OR

- o high 10-year fracture risk ($\geq 20\%$) as defined by either the Canadian Association of Radiologists and Osteoporosis Canada (CAROC) tool or the World Health Organization's Fracture Risk Assessment (FRAX) tool.

AND

- Contraindication to oral bisphosphonates.

Notes:

- Bisphosphonate failure will be defined as a fragility fracture and/or evidence of a decline in bone mineral density below pre-treatment baseline levels, despite adherence for one year.
- Contraindication to oral bisphosphonates will be considered. Contraindications include renal impairment, hypersensitivity, and abnormalities of the esophagus (e.g. esophageal stricture or achalasia).

02269198	Aclasta	zoledronic acid	5 mg/100 mL	Injection
02415100	Taro-Zoledronic Acid	zoledronic acid	5 mg/100 mL	Injection
02422433	Zoledronic Acid	zoledronic acid	5 mg/100 mL	Injection

1. Paget's disease.
2. a) For female patients with post-menopausal osteoporosis (PMO) at high risk for fracture and satisfy at least two of the following three criteria:
 - (i) Age > 75 years;
 - (ii) A prior fragility fracture;
 - (iii) A bone mineral density (BMD) T-score ≤ -2.5 ; OR
 b) Female patients with PMO with a serious intolerance to oral bisphosphonates or for whom oral bisphosphonates are contraindicated.

02368153	Xgeva	denosumab	120 mg	Injection
----------	--------------	-----------	--------	-----------

For the prevention of skeletal-related events (SREs) in patients with castrate-resistant prostate cancer with one or more documented bony metastases and good performance status (ECOG performance status score of 0, 1 or 2).

2545764	Wyost	denosumab	120 mg/1.7 mL	Injection
---------	--------------	-----------	---------------	-----------

For the prevention of skeletal-related events (SREs) in patients with castrate-resistant prostate cancer with one or more documented bony metastases and good performance status (ECOG performance status score of 0, 1 or 2).

02237671 02150689 02150662 02150670	Neoral	cyclosporine	10 mg 25 mg 50 mg 100 mg	Capsule
02150697	Neoral	cyclosporine	100 mg/mL	Solution
02495805 02495821 02495813	Cyclosporine (Strides)	cyclosporine	25 mg 50 mg 100 mg	Capsule
02247073 02247074 02242821	Sandoz Cyclosporine	cyclosporine	25 mg 50 mg 100 mg	Capsule

- (a) Psoriasis resistant to topical treatments (steroids, coal tar), systemic retinoids, MTX, hydroxyurea, PUVA, UVB treatment.
- (b) Rheumatoid arthritis.
- (c) Pediatric nephrotic syndrome.
- (d) Vasculitis failing other therapies such as steroids, Imuran.

- (e) Aplastic anemia.
- (f) Inflammatory bowel disease.
- (g) Where prescribed by a neurologist for the treatment of myasthenia gravis refractory to azathioprine, with or without steroids or where azathioprine is contraindicated.

NOTE: TRANSPLANT patients are covered under the WRHA Hospital Insured Program at Health Sciences Centre Pharmacy, phone number (204) 787-7440.

02436841	Entyvio	vedolizumab	300 mg/vL	Injection
02497875 02497867	Entyvio SC	vedolizumab	108 mg 108 mg	Pre-filled syringe Pre-filled pen

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

02402475 02282097	Orencia	abatacept	125 mg/mL 250 mg/vial	Injection
----------------------	----------------	-----------	--------------------------	-----------

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis and who have failed treatment with at least 3 DMARDs (disease-modifying antirheumatic drugs) therapies one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented.

One combination therapy of DMARDs must also be tried.

Request for coverage must be made by a specialist in rheumatology.

02496933	Avsola	infliximab	100 mg/vial	Powder for Solution
----------	---------------	------------	-------------	---------------------

Avsola will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Rheumatoid Arthritis, Ankylosing Spondylitis, Crohn's Disease, Ulcerative Colitis, Psoriatic Arthritis, and Psoriasis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Avsola will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Ankylosing Spondylitis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Avsola, Renflexis or Inflectra will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Crohn's Disease.

For Pediatrics: Avsola will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Crohn's Disease.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole)
- AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Avsola will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Fistulizing Crohn's Disease.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Psoriasis

For the treatment of adult patients with severe plaque psoriasis with one or more of the following:

- Psoriasis Area and Severity Index (PASI) ≥ 10 ;
- Body Surface Area (BSA) > 10 percent;
- Dermatology Life Quality Index (DLQI) > 10 ;
- Significant involvement of the face, hands, feet or genital region; AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

The initial request is approved for a maximum of 4 months. For continued coverage the physician must

confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- ≥ 50 percent reduction in the PASI score with ≥ 5 point improvement in the DLQI; OR
- ≥ 75 percent reduction in the PASI score; OR
- ≥ 50 percent reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Avsola will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Psoriasis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindication to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Avsola will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Psoriatic Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Rheumatoid Arthritis

For the treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Avsola will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Rheumatoid Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Ulcerative Colitis

For the treatment of patients with moderate to severely active ulcerative colitis who have had an inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Avsola will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Ulcerative Colitis.

For Pediatrics: Avsola will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Ulcerative Colitis.

Preferred means the first infliximab product to be considered for reimbursement for

infliximab-naive patients. Patients will not be permitted to switch from Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

02274728	Enbrel	etanercept	50 mg/mL	Injection
----------	--------	------------	----------	-----------

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Brenzys, Erelzi or Rymti will be the preferred etanercept option for all etanercept-naïve patients prescribes an etanercept product for Ankylosing Spondylitis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Enbrel, Brenzys, Erelzi or Rymti to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Brenzys, Erelzi or Rymti will be the preferred etanercept option for all etanercept-naïve patients prescribes an etanercept product for Psoriasis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Enbrel, Brenzys, Erelzi or Rymti to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Brenzys, Erelzi or Rymti will be the preferred etanercept option for all etanercept-naïve patients prescribes an etanercept product for Psoriatic Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Enbrel, Brenzys, Erelzi or Rymti to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Brenzys, Erelzi or Rymti will be the preferred etanercept option for all etanercept-naïve patients prescribes an etanercept product for Rheumatoid Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Enbrel, Brenzys, Erelzi or Rymti to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

02455323 02455331	Brenzys	etanercept	50 mg/mL	Injection
----------------------	----------------	------------	----------	-----------

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Brenzys will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Ankylosing Spondylitis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Brenzys to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 years of age or older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Brenzys will be a preferred etanercept option for all etanercept-naïve patients weighing 63kg (138 pounds) or more who are prescribed an etanercept product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Brenzys to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Psoriasis

For the treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region

Request for coverage must be made by a specialist in dermatology.

Brenzys will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Psoriasis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients. Patients will not be permitted to switch from Brenzys to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Brenzys will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Psoriatic Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients. Patients will not be permitted to switch from Brenzys to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Brenzys will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Rheumatoid Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients. Patients will not be permitted to switch from Brenzys to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

02462869 02462877 02462850	Erelzi	etanercept	50 mg/mL 25mg/0.5mL 50mg/mL	Injection
----------------------------------	---------------	------------	-----------------------------------	-----------

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Erelzi will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Ankylosing Spondylitis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients. Patients will not be permitted to switch from Erelzi to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 years of age or older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Erelzi will be a preferred etanercept option for all etanercept-naïve patients weighing 63kg (138 pounds) or more who are prescribed an etanercept product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients. Patients will not be permitted to switch from Erelzi to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Erelzi will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Psoriasis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients. Patients will not be permitted to switch from Erelzi to another etanercept product or vice versa.

versa, if previously trialed and deemed unresponsive to etanercept.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Erelzi will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Psoriatic Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Erelzi to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Erelzi will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Rheumatoid Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients. Patients will not be permitted to switch from Erelzi to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

2530295	Rymti	etanercept	50 mg/mL	Pre-filled Syringe
2530309	Rymti	etanercept	50 mg/mL	Pre-filled Auto-Injector

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Rymti will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Rheumatoid Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Rymti to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 4 years of age or older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Rymti will be a preferred etanercept option for all etanercept-naïve patients weighing 63kg (138 pounds) or more who are prescribed an etanercept product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Rymti to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Rymti will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Psoriatic Arthritis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Rymti to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Rymti will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Ankylosing Spondylitis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Rymti to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

Psoriasis

For the treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $>10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region

Request for coverage must be made by a specialist in dermatology.

Rymti will be a preferred etanercept option for all etanercept-naïve patients prescribed an etanercept product for Psoriasis. Preferred means the first etanercept product to be considered for reimbursement for etanercept-naïve patients.

Patients will not be permitted to switch from Rymti to another etanercept product or vice versa, if previously trialed and deemed unresponsive to etanercept.

02474263	Humira	adalimumab	20 mg/0.2 mL	Injection
----------	--------	------------	--------------	-----------

Pediatric Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

02258595	Humira	adalimumab	40 mg/0.8 mL	Injection
----------	--------	------------	--------------	-----------

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for

Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Humira, Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults:

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

For Pediatrics:

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz or Idacio will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Humira, Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Humira, Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics
- Prescribed by a practitioner with expertise in the management of patients with HS

Note: *Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment*

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Humira, Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Humira, Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Humira, Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented.

One combination therapy of DMARD's must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Humira, Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Humira, Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma will be the preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Humira, Abrilada, Amgevita, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi or Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02511061	Abrilada	adalimumab	20 mg/0.4 mL	Injection
02511053 02511045	Abrilada	adalimumab	40 mg/0.8 mL	Injection

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Abrilada to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

For Pediatrics: Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Abrilada to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Abrilada to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics
- Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Abrilada to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Abrilada to another adalimumab product or vice versa, if:

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Abrilada to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Abrilada to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Abrilada to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Abrilada will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Abrilada to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02459310 02459299 02459302	Amgevita	adalimumab	50 mg/mL	Injection
----------------------------------	-----------------	------------	----------	-----------

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

For Pediatrics: Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics
- Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented.

One combination therapy of DMARDs must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Amgevita will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Amgevita to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02473097 02473100	Hadlima	adalimumab	40 mg/0.8 mL	Injection
02533472 02533480	Hadlima	adalimumab	40 mg/0.4 mL	Injection

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients

prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics
- Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Hadlima will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hadlima to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02502380	Hulio	adalimumab	20 mg/0.4 mL	Injection
02502399 02502402	Hulio	adalimumab	40 mg/0.8 mL	Injection

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

For Pediatrics: Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hulio to another adalimumab

product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics
- Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$

- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- ≥ 50% reduction in the PASI score with ≥ 5 point improvement in the DLQI
- ≥ 75 % reduction in the PASI score
- ≥ 50% reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented.

One combination therapy of DMARDs must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Hulio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hulio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02492156	Hyrimoz	adalimumab	40 mg/0.8 mL	Injection
02492164			40 mg/0.8 mL	
02505258			20 mg/0.4 mL	
02542358			80mg/0.8 mL	
02542366			80mg/0.8 mL	
02542323			40mg/0.4mL	
02542331			40mg/0.4mL	
02542315			20mg/0.2mL	

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

For Pediatrics: Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics
- Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented.

One combination therapy of DMARDs must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Hyrimoz will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Hyrimoz to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02502674	Idacio	adalimumab	40 mg/0.8 mL	Injection
02502682	Idacio	adalimumab	40 mg/0.8 mL	Pre-filled Syringe

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

For Pediatrics: Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics
- Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to

switch from Idacio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Idacio will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Idacio to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02523949 02523957	Simlandi	adalimumab	40 mg/0.4 mL	Injection
02523965	Simlandi	adalimumab	80 mg/0.8 mL	Injection

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or

sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Simlandi will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Simlandi to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Simlandi will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Simlandi to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Simlandi will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Simlandi to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics
- Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Simlandi will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Simlandi to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Simlandi will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Simlandi to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Simlandi will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Simlandi to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Simlandi will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Simlandi to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented.

One combination therapy of DMARDs must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Simlandi will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Simlandi to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Simlandi will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Simlandi to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02523760 02523779	Yuflyma	adalimumab	40 mg/0.8 mL	Injection
02535084 02535076	Yuflyma	adalimumab	80 mg/0.8 mL	Injection

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, who have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Yuflyma will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ankylosing Spondylitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Yuflyma will be a preferred adalimumab option for all adalimumab-naïve patients.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Yuflyma will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Fistulizing Crohn's Disease.

Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Hidradenitis Suppurativa

For the treatment of adult patients with active moderate to severe hidradenitis suppurativa who have not responded to conventional therapy (including systemic antibiotics) and who meet all of the following:

- A total abscess and nodule count of 3 or greater
- Lesions in at least two distinct anatomic areas, one of which must be Hurley Stage II or III
- An inadequate response to a 90-day trial of oral antibiotics
- Prescribed by a practitioner with expertise in the management of patients with HS

Note: Treatment with adalimumab should be discontinued if there is no improvement after 12 weeks of treatment.

Yuflyma will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Hidradenitis Suppurativa. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Yuflyma will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Polyarticular Juvenile Idiopathic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Yuflyma will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriasis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Yuflyma will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Psoriatic Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented.

One combination therapy of DMARDs must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Yuflyma will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Rheumatoid Arthritis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Yuflyma will be a preferred adalimumab option for all adalimumab-naïve patients prescribed an adalimumab product for Ulcerative Colitis. Preferred means the first adalimumab product to be considered for reimbursement for adalimumab-naïve patients. Patients will not be permitted to switch from Yuflyma to another adalimumab product or vice versa, if:

- Previously trialed and deemed unresponsive to adalimumab.

02460521 02460548 02472961 02472988	Kevzara	sarilumab	150 mg/1.14 mL 200 mg/1.14 mL 150 mg/1.14 mL 200 mg/1.14 mL	Injection
--	----------------	-----------	--	-----------

For the treatment of patients over 18 years of age who have moderate to severe active **rheumatoid arthritis** who have failed treatment with at least 3 DMARD (disease modifying antirheumatic drug) therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

02245913	Kineret	anakinra	150 mg/mL	Injection
----------	----------------	----------	-----------	-----------

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARD's must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

02470373	Renflexis	infliximab	100 mg	Injection
----------	------------------	------------	--------	-----------

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Renflexis will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Ankylosing Spondylitis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Renflexis to another infliximab

product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Renflexis will be a preferred infliximab option for all infliximab-naive adult patients prescribed an infliximab product for Crohn's Disease.

For Pediatrics: Renflexis will be a preferred infliximab option for all infliximab-naive pediatric patients prescribed an infliximab product for Crohn's Disease.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Renflexis to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

For Adults : Renflexis will be a preferred infliximab option for all infliximab-naive adult patients prescribed an infliximab product for Fistulizing Crohn's Disease.

For Pediatrics: Renflexis will be a preferred infliximab option for all infliximab-naive pediatric patients prescribed an infliximab product for Fistulizing Crohn's Disease.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naive patients.

Patients will not be permitted to switch from Renflexis to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Psoriasis

For the treatment of adult patients with severe plaque psoriasis with one or more of the following:

- Psoriasis Area and Severity Index (PASI) ≥ 10 ;
- Body Surface Area (BSA) > 10 percent;
- Dermatology Life Quality Index (DLQI) > 10 ;
- Significant involvement of the face, hands, feet or genital region; AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

The initial request is approved for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- ≥ 50 percent reduction in the PASI score with ≥ 5 point improvement in the DLQI; OR
- ≥ 75 percent reduction in the PASI score; OR
- ≥ 50 percent reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Renflexis will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Psoriasis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Renflexis to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindication to these agents is documented. One combination therapy of DMARD must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Renflexis will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Psoriatic Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Renflexis to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Rheumatoid Arthritis

For the treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Renflexis will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Rheumatoid Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Renflexis to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

Ulcerative Colitis

For the treatment of patients with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Renflexis will be a preferred infliximab option for all infliximab-naïve adult patients prescribed an infliximab product for Ulcerative Colitis.

For Pediatrics: Renflexis will be a preferred infliximab option for all infliximab-naïve pediatric patients prescribed an infliximab product for Ulcerative Colitis.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Renflexis to another infliximab product or vice versa, if previously trialed and deemed unresponsive to infliximab.

02419475	Inflectra	infliximab	100 mg/vL	Injection
----------	------------------	------------	-----------	-----------

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Inflectra will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Ankylosing Spondylitis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Inflectra will be a preferred infliximab option for all infliximab-naïve adult patients prescribed an infliximab product for Crohn's Disease.

For Pediatrics: Inflectra will be a preferred infliximab option for all infliximab-naïve pediatric patients prescribed an infliximab product for Crohn's Disease.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Inflectra will be a preferred infliximab option for all infliximab-naïve adult patients prescribed an infliximab product for Fistulizing Crohn's Disease.

For Pediatrics: Inflectra will be a preferred infliximab option for all infliximab-naïve pediatric patients prescribed an infliximab product for Fistulizing Crohn's Disease.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Psoriasis

For the treatment of adult patients with severe plaque psoriasis with one or more of the following:

- Psoriasis Area and Severity Index (PASI) ≥ 10 ;
- Body Surface Area (BSA) > 10 percent;
- Dermatology Life Quality Index (DLQI) > 10 ;
- Significant involvement of the face, hands, feet or genital region; AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

The initial request is approved for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

≥ 50 percent reduction in the PASI score with \geq point improvement in the DLQI; OR

≥ 75 percent reduction in the PASI score; OR

≥ 50 percent reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Inflectra will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Psoriasis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindication to these agents is documented. One combination therapy of DMARD must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Inflectra will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Psoriatic Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Rheumatoid Arthritis

For the treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Inflectra will be a preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Rheumatoid Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients. Patients will not be permitted to switch from Inflectra to another infliximab

product or vice versa, if previously trialed and deemed unresponsive to therapy.

Ulcerative Colitis

For the treatment of patients with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

For Adults : Inflectra will be a preferred infliximab option for all infliximab-naïve adult patients prescribed an infliximab product for Ulcerative Colitis.

For Pediatrics : Inflectra will be a preferred infliximab option for all infliximab-naïve pediatric patients prescribed an infliximab product for Ulcerative Colitis.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Inflectra to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

02244016	Remicade	infliximab	100 mg/10 mL	Injection
----------	-----------------	------------	--------------	-----------

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Ankylosing Spondylitis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Remicade, Renflexis, Inflectra or Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve adult patients prescribed an infliximab product for Crohn's Disease.

For Pediatrics: Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve pediatric patients prescribed an infliximab product for Crohn's Disease.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Remicade, Renflexis, Inflectra or Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND

- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

For Adults: Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve adult patients prescribed an infliximab product for Fistulizing Crohn's Disease.

For Pediatrics: Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve pediatric patients prescribed an infliximab product for Fistulizing Crohn's Disease.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Remicade, Renflexis, Inflectra or Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Psoriasis

For the treatment of adult patients with severe plaque psoriasis with one or more of the following:

- Psoriasis Area and Severity Index (PASI) ≥ 10 ;
- Body Surface Area (BSA) > 10 percent;
- Dermatology Life Quality Index (DLQI) > 10 ;
- Significant involvement of the face, hands, feet or genital region; AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

The initial request is approved for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

≥ 50 percent reduction in the PASI score with ≥ 5 point improvement in the DLQI; OR

≥ 75 percent reduction in the PASI score; OR

≥ 50 percent reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Psoriasis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Remicade, Renflexis, Inflectra or Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindication to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Psoriatic Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Remicade, Renflexis, Inflectra or Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Rheumatoid Arthritis

For the treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve patients prescribed an infliximab product for Rheumatoid Arthritis. Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Remicade, Renflexis, Inflectra or Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Ulcerative Colitis

For the treatment of patients with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

For Adults : Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve adult patients prescribed an infliximab product for Ulcerative Colitis.

For Pediatrics : Renflexis, Inflectra or Avsola will be the preferred infliximab option for all infliximab-naïve pediatric patients prescribed an infliximab product for Ulcerative Colitis.

Preferred means the first infliximab product to be considered for reimbursement for infliximab-naïve patients.

Patients will not be permitted to switch from Remicade, Renflexis, Inflectra or Avsola to another infliximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

02506009	Zeposia	ozanimod	0.23mg & 0.46mg	Capsules (initiation pack)
02505991	Zeposia	ozanimod	0.92mg	Capsule

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

02495155	Rinvoq	upadacitinib	15 mg	Tablet
----------	---------------	--------------	-------	--------

Ankylosing Spondylitis

For the treatment of adults with active ankylosing spondylitis (AS) who have had an inadequate response to a biologic disease-modifying antirheumatic drug (bDMARD) or when use of those therapies is inadvisable¹, only if the following criteria are met:

Patients have previously failed to respond to an adequate trial of at least three different non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Combined use with other biologic drugs or janus kinase (JAK) inhibitors will not be reimbursed.

¹Scenarios of patients for whom use of bDMARDS are inadvisable include patients who were intolerant to, or who have contraindications to, bDMARDS for AS.

Rheumatoid Arthritis

For the treatment of patients 18 years of age or older who have moderate to severe active rheumatoid arthritis and have:

- (a) failed treatment with at least 3 DMARD therapies, one of which is methotrexate or leflunomide or both, unless intolerance or contraindications to these agents is documented;
- (b) tried one combination therapy of DMARDs; and
- (c) documented disease activity (such as the number of tender joints, the number of swollen joints, the erythrocyte sedimentation rate or C-reactive protein value).

NOTE: Coverage will be provided only if prescribed by a specialist in rheumatology.

Combined use with other biologic drugs or Janus kinase (JAK) inhibitors will not be reimbursed.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented.

One combination therapy of DMARD's must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Combined use with other biologic drugs or Janus kinase (JAK) inhibitors will not be reimbursed.

02495155	Rinvoq	upadacitinib	15 mg	Tablet
02520893			30 mg	
02539721			45 mg	

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

Combined use with other biologic drugs or janus kinase (JAK) inhibitors will not be reimbursed.

Ulcerative Colitis

For the treatment of patients 18 years of age or older with moderate to severe active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Note: Coverage will be provided only if prescribed by a specialist in gastroenterology.

Combined use with other biologic drugs or janus kinase (JAK) inhibitors will not be reimbursed.

2480018	Olumiant	baricitinib	2 mg	Tablet
---------	-----------------	-------------	------	--------

For the treatment of patients 18 years of age or older who have moderate to severe active rheumatoid arthritis and have:

- (a) failed treatment with at least 3 DMARD therapies, one of which is methotrexate or leflunomide or both, unless intolerance or contraindications to these agents is documented;
- (b) tried one combination therapy of DMARDs; and
- (c) documented disease activity (such as the number of tender joints, the number of swollen joints, the erythrocyte sedimentation rate or C-reactive protein value).

NOTE: Coverage will be provided only if prescribed by a specialist in rheumatology.

Combined use with other biologic drugs or Janus kinase (JAK) inhibitors will not be reimbursed.

02470608	Xeljanz XR	tofacitinib	11 mg	Tablet
----------	-------------------	-------------	-------	--------

For the treatment of patients 18 years of age or older who have moderate to severe active rheumatoid arthritis and have:

- (a) failed treatment with at least 3 DMARD therapies, one of which is methotrexate or leflunomide or both, unless intolerance or contraindications to these agents is documented;
- (b) tried one combination therapy of DMARDs; and
- (c) documented disease activity (such as the number of tender joints, the number of swollen joints, the erythrocyte sedimentation rate or C-reactive protein value).

NOTE: Coverage will be provided only if prescribed by a specialist in rheumatology.

Combined use with other biologic drugs or Janus kinase (JAK) inhibitors will not be reimbursed.

02241927	Rituxan	rituximab	10 mg/mL	Injection
----------	----------------	-----------	----------	-----------

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis (RA), in combination with methotrexate, for patients who have failed to respond to an adequate trial of one or more anti-tumor necrosis factor (anti-TNF) agents (monoclonal antibody OR fusion protein) OR who are contraindicated to anti-TNF agents.

Request for coverage must be made by a specialist in rheumatology.

Riximyo, Ruxience or Truxima will be the preferred rituximab option for all rituximab-naïve patients prescribed a rituximab product for Rheumatoid Arthritis. Preferred means the first rituximab product to be considered for reimbursement for rituximab-naïve patients.

Patients will not be permitted to switch from Rituxan, Riximyo, Ruxience or Truxima to another rituximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Granulomatosis with Polyangiitis (GPA) and Microscopic Polyangiitis (MPA)

As induction-remission therapy for patients with severely active granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA) in whom the cyclophosphamide has failed; or the use of cyclophosphamide is not appropriate.

Riximyo, Ruxience or Truxima will be the preferred rituximab option for all rituximab-naïve patients prescribed a rituximab product for GPA and MPA. Preferred means the first rituximab product to be considered for reimbursement for rituximab-naïve patients. Patients will not be permitted to switch from Rituxan, Riximyo, Ruxience or Truxima to another rituximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

02498316	Riximyo	rituximab	10 mg/mL	Injection
----------	---------	-----------	----------	-----------

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis (RA), in combination with methotrexate, for patients who have failed to respond to an adequate trial of one or more anti-tumor necrosis factor (anti-TNF) agents (monoclonal antibody OR fusion protein) OR who are contraindicated to anti-TNF agents.

Request for coverage must be made by a specialist in rheumatology.

Riximyo will be a preferred rituximab option for all rituximab-naïve patients prescribed a rituximab product for Rheumatoid Arthritis. Preferred means the first rituximab product to be considered for reimbursement for rituximab-naïve patients. Patients will not be permitted to switch from Riximyo to another rituximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Granulomatosis with Polyangiitis (GPA) and Microscopic Polyangiitis (MPA)

As Induction-remission therapy for patients with severely active Granulomatosis with Polyangiitis (GPA) and Microscopic Polyangiitis (MPA) in whom:

- the use of cyclophosphamide has failed; or
- the use of cyclophosphamide is not appropriate

Riximyo will be a preferred rituximab option for all rituximab-naïve patients prescribed a rituximab product for GPA and MPA. Preferred means the first rituximab product to be considered for reimbursement for rituximab-naïve patients. Patients will not be permitted to switch from Riximyo to another rituximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

02495724	Ruxience	rituximab	10 mg/mL	Injection
----------	----------	-----------	----------	-----------

Granulomatosis with Polyangiitis (GPA) and Microscopic Polyangiitis (MPA)

As Induction-remission therapy for patients with severely active Granulomatosis with Polyangiitis (GPA) and Microscopic Polyangiitis (MPA) in whom:

- the use of cyclophosphamide has failed; or
- the use of cyclophosphamide is not appropriate

Ruxience will be a preferred rituximab option for all rituximab-naïve patients prescribed a rituximab product for GPA and MPA. Preferred means the first rituximab product to be considered for reimbursement for rituximab-naïve patients. Patients will not be permitted to switch from Ruxience to another rituximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis (RA), in combination with methotrexate, for patients who have failed to respond to an adequate trial of one or more anti-tumor necrosis factor (anti-TNF) agents (monoclonal antibody OR fusion protein) OR who are contraindicated to anti-TNF agents.

Request for coverage must be made by a specialist in rheumatology.

Ruxience will be a preferred rituximab option for all rituximab-naïve patients prescribed a rituximab product for Rheumatoid Arthritis. Preferred means the first rituximab product to be considered for reimbursement for rituximab-naïve patients. Patients will not be permitted to switch from Ruxience to another rituximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

02478382 02478390	Truxima	rituximab	100 mg/10 mL 500 mg/50 mL	Injection
----------------------	----------------	-----------	------------------------------	-----------

Granulomatosis with Polyangiitis (GPA) and Microscopic Polyangiitis (MPA)

As induction-remission therapy for patients with severely active granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA) in whom:

- the use of cyclophosphamide has failed; or
- the use of cyclophosphamide is not appropriate

Truxima will be a preferred rituximab option for all rituximab-naïve patients prescribed a rituximab product for GPA and MPA. Preferred means the first rituximab product to be considered for reimbursement for rituximab-naïve patients. Patients will not be permitted to switch from Truxima to another rituximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

Rheumatoid Arthritis

For the treatment of severely active rheumatoid arthritis (RA), in combination with methotrexate, for patients who have failed to respond to an adequate trial of one or more anti-tumor necrosis factor (anti-TNF) agents (monoclonal antibody OR fusion protein) OR who are contraindicated to anti-TNF agents.

Request for coverage must be made by a specialist in rheumatology.

Truxima will be a preferred rituximab option for all rituximab-naïve patients prescribed a rituximab product for Rheumatoid Arthritis. Preferred means the first rituximab product to be considered for reimbursement for rituximab-naïve patients. Patients will not be permitted to switch from Truxima to another rituximab product or vice versa, if previously trialed and deemed unresponsive to therapy.

02424770 02483327	Actemra	tocilizumab	162 mg/0.9 mL 162 mg/0.9 mL	Injection
----------------------	----------------	-------------	--------------------------------	-----------

Giant Cell Arteritis

For treatment of Giant Cell Arteritis (GCA) in adult patients where the following criteria are met:

- At initiation of therapy, or with relapse, patients should be receiving prednisone.
- Duration of therapy with tocilizumab should be limited to 52 weeks per treatment course.

Patients should be under the care of a physician with the experience of diagnosis and management of GCA.

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Rheumatoid Arthritis

For the treatment of adult patients who have moderate to severe active rheumatoid arthritis and who:

- (i) failed treatment with at least 3 DMARD (disease-modifying antirheumatic drugs) therapies, one of which therapies must be either methotrexate or leflunomide, unless intolerance or contraindication to these therapies is documented; and
- (ii) previously tried at least one combination of DMARD therapies.

Request for coverage must be made by a specialist in rheumatology.

Systemic Juvenile Idiopathic Arthritis

For the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older who:

- (i) have responded inadequately to previous therapy with one or more non steroidal anti-inflammatory drugs; and
- (ii) who have responded inadequately to previous therapy with one or more systemic corticosteroids.

02350092 02350106 02350114	Actemra	tocilizumab	80 mg/4 mL 200 mg/10 mL 400 mg/20 mL	Injection
----------------------------------	----------------	-------------	--	-----------

Polyarticular Juvenile Idiopathic Arthritis

For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older who are intolerant to or have inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs).

Request for coverage must be made by a specialist in rheumatology.

Rheumatoid Arthritis

For the treatment of adult patients who have moderate to severe active rheumatoid arthritis and who:

- (i) failed treatment with at least 3 DMARD (disease-modifying antirheumatic drugs) therapies, one of which therapies must be either methotrexate or leflunomide, unless intolerance or contraindication to these therapies is documented; and
- (ii) previously tried at least one combination of DMARD therapies.

Request for coverage must be made by a specialist in rheumatology.

Systemic Juvenile Idiopathic Arthritis

For the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age and older who:

- (i) have responded inadequately to previous therapy with one or more non steroidal anti-inflammatory drugs; and
- (ii) who have responded inadequately to previous therapy with one or more systemic corticosteroids.

02324776 02324784 02413175 02413183	Simponi	golimumab	50 mcg/0.5 mL 50 mcg/0.5 mL 100 mg/1 mL 100 mg/1 mL	Injection
--	----------------	-----------	--	-----------

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least three different nonsteroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Psoriatic Arthritis

For the treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also have been tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

02417472	Simponi IV	golimumab	50 mg/4 mL	Injection
----------	-------------------	-----------	------------	-----------

Rheumatoid Arthritis

For treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

02331675	Cimzia	certolizumab	200 mg/mL	Injection
02465574	Cimzia	certolizumab	200 mg/mL	Autoinjector

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least 3 different non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Psoriatic Arthritis

For the treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindication to these agents is documented.

One combination therapy of DMARD must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Rheumatoid Arthritis

For the treatment of patients over 18 years of age who have moderate to severe active rheumatoid arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

02516098	Ilumya	tildrakizumab	100 mg/mL	Injection
----------	---------------	---------------	-----------	-----------

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

02320673 02320681	Stelara	ustekinumab	45 mg/0.5 mL 90 mg/mL	Injection
----------------------	----------------	-------------	--------------------------	-----------

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment

clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Jamteki or Wezlana will be the preferred ustekinumab option for all ustekinumab-naïve patients prescribed an ustekinumab product for Psoriasis. Preferred means the first ustekinumab product to be considered for reimbursement for ustekinumab-naïve patients. Patients will not be permitted to switch from Stelara, Jamteki or Wezlana to another ustekinumab product or vice versa, if previously trialed and deemed unresponsive to ustekinumab.

02543036 02543044	Jamteki	ustekinumab	45 mg/0.5 mL 90 mg/1 mL	Injection
----------------------	----------------	-------------	----------------------------	-----------

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Jamteki will be a preferred ustekinumab option for all ustekinumab-naïve patients prescribed an ustekinumab product for Psoriasis. Preferred means the first ustekinumab product to be considered for reimbursement for ustekinumab-naïve patients. Patients will not be permitted to switch from Jamteki to another ustekinumab product or vice versa, if:

- ***Previously trialed and deemed unresponsive to ustekinumab***

02544180	Wezlana	ustekinumab	45 mg/0.5 mL	Pre-filled Syringe
02544199	Wezlana	ustekinumab	90 mg/mL	Pre-filled Syringe
02544202	Wezlana	ustekinumab	45 mg/0.5 mL	Injection Single-use Vial

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in adult patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- ≥ 50% reduction in the PASI score with ≥ 5 point improvement in the DLQI
- ≥ 75 % reduction in the PASI score
- ≥ 50% reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Wezlana will be a preferred ustekinumab option for all ustekinumab-naïve patients prescribed an ustekinumab product for Psoriasis. Preferred means the first ustekinumab product to be considered for reimbursement for ustekinumab-naïve patients. Patients will not be permitted to switch from Wezlana to another ustekinumab product or vice versa, if:

- ***Previously trialed and deemed unresponsive to ustekinumab.***

02544210	Wezlana I.V.	ustekinumab	5 mg/mL	Intavenous Solution
----------	---------------------	-------------	---------	---------------------

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in adult patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

Fistulizing Crohn's Disease

For the treatment of Fistulizing Crohn's Disease in patients with actively draining perianal or enterocutaneous fistula who meet the following criteria:

- Presence of fistula that has persisted despite a course of antibiotic therapy (e.g. ciprofloxacin and/or metronidazole) AND
- Have had inadequate response, intolerance or contraindications to an immunosuppressive agent (e.g. azathioprine or 6 mercaptopurine).

Request for coverage must be made by a specialist in gastroenterology.

Ulcerative Colitis

For the treatment of patients over 18 years of age with moderate to severely active ulcerative colitis who have had inadequate response, intolerance or contraindications to conventional therapy including 5-aminosalicylate compounds AND corticosteroids.

Request for coverage must be made by a specialist in gastroenterology

02438070	Cosentyx	secukinumab	150 mg/mL	Injection
02525569	Cosentyx	secukinumab	75 mg/mL	Injection

Ankylosing Spondylitis

For the treatment of patients with active ankylosing spondylitis who have failed to respond to an adequate trial of at least 3 different non-steroidal anti-inflammatory drugs (NSAIDs) and, in patients with peripheral joint involvement, have failed to respond to methotrexate or sulfasalazine.

Request for coverage must be made by a specialist in rheumatology.

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Psoriatic Arthritis

For the treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

02525267	Bimzelx	bimekizumab	160 mg/mL	Prefilled Syringe
02525275	Bimzelx	bimekizumab	160 mg/mL	Autoinjector

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

02473623	Siliq	brodalumab	210 mg/1.5 mL	Injection
----------	--------------	------------	---------------	-----------

For treatment of adult patients with severe plaque psoriasis presently with one or more

of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology

02455102 02455110	Taltz	ixekizumab	80 mg/mL 80 mg/mL	Autoinjector Pre-filled Syringe
----------------------	--------------	------------	----------------------	------------------------------------

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 3 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented.

One combination therapy of DMARD's must also be tried.

Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology

02487314	Tremfya	guselkumab	100 mg/mL	Autoinjector
02469758	Tremfya	guselkumab	100 mg/mL	Pre-filled Syringe

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands, feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology

Psoriatic Arthritis

For treatment of patients over 18 years of age who have active psoriatic arthritis who have failed treatment with at least 3 DMARD therapies, one of which is methotrexate and/or leflunomide unless intolerance or contraindications to these agents is documented. One combination therapy of DMARDs must also be tried. Initial application information should include information on disease activity such as the number of tender joints, swollen joints, erythrocyte sedimentation rate and C-reactive protein value.

Request for coverage must be made by a specialist in rheumatology.

02487454	Skyrizi	risankizumab	90 mg/mL	Injection
02519283 02519291	Skyrizi	risankizumab	150 mg/mL	Injection

Psoriasis

For treatment of adult patients with severe plaque psoriasis presently with one or more of the following:

- Psoriasis Area and the Severity Index (PASI) ≥ 10
- Body Surface Area (BSA) $> 10\%$
- Significant involvement of the face, hands feet or genital region
- Dermatology Life Quality Index (DLQI) > 10 AND
- Failure to respond to, contraindications to, intolerant of or unable to access methotrexate, cyclosporine and/or phototherapy.

Coverage will be approved initially for a maximum of 4 months. For continued coverage the physician must confirm the patient's response to treatment and demonstration of treatment clinical benefits:

- $\geq 50\%$ reduction in the PASI score with ≥ 5 point improvement in the DLQI
- $\geq 75\%$ reduction in the PASI score
- $\geq 50\%$ reduction in the BSA with significant improvement of the face, hands, feet or genital region.

Request for coverage must be made by a specialist in dermatology.

02532107	Skyrizi	risankizumab	60 mg/mL	Injection
02532093	Skyrizi	risankizumab	360 mg/2.4 mL	Pre-filled Cartridge with On-Body Injector

Crohn's Disease

For treatment of moderate to severely active Crohn's Disease in patients with inadequate response, intolerance or contraindications to an adequate course of corticosteroids AND an immunosuppressive agent.

Request for coverage must be made by a specialist in gastroenterology.

02522845	Saphnelo	anifrolumab	150mg/mL	Injection
----------	-----------------	-------------	----------	-----------

For the treatment of adult patients with moderate to severe autoantibody positive, systemic lupus erythematosus (SLE), only if the following criteria are met:

Initiation Criteria:

- Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) score of at least 6 prior to treatment initiation with anifrolumab; AND
- Inadequately controlled with oral corticosteroids (OCS) at a dose of at least 10 mg/day of prednisone or its equivalent, in addition to standard therapy¹.

The pre-treatment baseline SLEDAI-2K score must be provided. If the British Isles Lupus Activity Group (BILAG)-2004 will be used for assessment on renewal, then a pre-treatment baseline BILAG-2004 assessment of organ systems must also be provided. The same scale should be used both at baseline and all subsequent renewals.

Initial approval: 12 months

Exclusion Criteria:

- Severe or unstable neuropsychiatric SLE; OR
- Active severe SLE nephritis

Renewal Criteria:

- Decrease in OCS dose to ≤ 7.5 mg/day of prednisone or its equivalent²; AND
- Reduction in disease activity as measured by:
 - o Reduction in the SLEDAI-2K score to 5 or less; OR
 - o BILAG-2004 score improvement³ in organ systems and no new worsening⁴.

Subsequent Renewal Criteria:

Initial response achieved after the first 12 months of therapy with anifrolumab has been maintained.

Renewal approval: 12 months

¹Standard therapy includes using an immunosuppressive drug (e.g., azathioprine, hydroxychloroquine, methotrexate, mycophenolate) with or without non-steroidal anti-inflammatory drugs (NSAIDs).

²Patients whose OCS dose remains > 7.5 mg/day of prednisone or equivalent but has decreased by at least 50% from baseline could be considered to have achieved the OCS dose reduction.

³BILAG improvement in organ systems is defined as a reduction of all baseline severe (BILAG-2004 A) or moderately severe (BILAG-2004 B) to lower rating levels.

⁴BILAG worsening in organ systems is defined as ≥ 1 new BILAG-2004 A or ≥2 new BILAG-2004 B items.

Combined use with other biologics for the treatment of SLE will not be reimbursed.

Request for coverage must be made by a specialist in rheumatology.

02370050 02370069	Benlysta	belimumab	120mg/5mL 400mg/20mL	Injection
02470489	Benlysta	belimumab	200 mg/mL	Auto-Injector

For the treatment of active lupus nephritis (LN) in adult patients who meet all of the following criteria:

- Diagnosed with International Society of Nephrology/Renal Pathology Society class III (with or without class V), class IV (with or without class V), or class V (i.e., pure class V) LN;
- Have started standard induction therapy within the previous 60 days;
- Have not previously failed both cyclophosphamide and mycophenolate induction therapies;
- Have not had an estimated glomerular filtration rate (eGFR) that is less than 30 mL/min/1.73 m².

Initial approval: 12 months

Renewal Criteria:

Renewal requests must provide proof of beneficial clinical effect, including all of the following:

- Reduction in glucocorticoids to less than or equal to 7.5 mg/day of prednisone or its equivalent after 12 months of therapy (oral corticosteroid dose that remains higher than 7.5 mg/day of prednisone or its equivalent, but has decreased by at least 50% from baseline could be considered as having achieved the oral corticosteroid dose reduction); AND
- An eGFR that is greater than or equal to 60 mL/min/1.73 m², or that is no more than 20% below the value before the renal flare (pre-flare value); AND

- improvement in proteinuria defined as either:
 - o Proteinuria no greater than 0.7 g/24 hours after 12 months of therapy if baseline proteinuria is less than 3.5 g/24 hours; OR
 - o Proteinuria no greater than 0.7 g/24 hours after 18 to 24 months of therapy if baseline proteinuria is in the nephrotic range (i.e., greater than 3.5 g/24 hours); AND
- Have not had an eGFR decrease to less than 30 mL/min/1.73 m²; AND
- Have not had the addition of other immunosuppressant agents (other than as part of the induction and maintenance regimens), corticosteroid use outside of the limits, anti-tumour necrosis factor therapy (such as adalimumab, etanercept, infliximab) or other biologics (such as rituximab, abatacept).

Subsequent renewal requests will be considered if the initial response in the first 12 months of therapy has been maintained.

Renewal approval: 12 months

Request for coverage must be made by a specialist in rheumatology or nephrology with experience in the management of lupus nephritis.

02416328	Aubagio	teriflunomide	14 mg	Tablet
02500639	Apo-Teriflunomide	teriflunomide	14 mg	Tablet
02504170	Jamp Teriflunomide	teriflunomide	14 mg	Tablet
02523833	M-Teriflunomide	teriflunomide	14 mg	Tablet
02500469	Mar-Teriflunomide	teriflunomide	14 mg	Tablet
02500310	NAT-Teriflunomide	teriflunomide	14 mg	Tablet
02500434	pms-Teriflunomide	teriflunomide	14 mg	Tablet
02505843	Sandoz Teriflunomide	teriflunomide	14 mg	Tablet
02501090	Teva-Teriflunomide	teriflunomide	14 mg	Tablet
02269201	Avonex	interferon beta 1-a	30 mcg/0.5 mL	Injection
02418320	Lemtrada	alemtuzumab	12 mg/1.2 mL	Solution for IV Infusion
02237319	Rebif	interferon beta 1-a	22 mcg/0.5 mL	Injection
02237320	Rebif	interferon beta 1-a	44 mcg/0.5 mL	Injection
02169649	Betaseron	interferon beta 1-b	0.3 mg	Injection
02245619	Copaxone	glatiramer acetate	20 mg/mL	Pre-Filled Syringe
02460661	Glatect	glatiramer acetate	20 mg	Pre-Filled Syringe
02365480	Gilenya	fingolimod	0.5 mg	Capsule
02469936	Apo-Fingolimod	fingolimod	0.5 mg	Capsule
02487772	Jamp-Fingolimod	fingolimod	0.5 mg	Capsule

02474743	Mar-Fingolimod	fingolimod	0.5 mg	Capsule
02469715	Mylan-Fingolimod	fingolimod	0.5 mg	Capsule
02469782	pms-Fingolimod	fingolimod	0.5 mg	Capsule
02482606	Sandoz-Fingolimod	fingolimod	0.5 mg	Capsule
02469618	Taro-Fingolimod	fingolimod	0.5 mg	Capsule
02469561	Teva-Fingolimod	fingolimod	0.5 mg	Capsule
02467224	Ocrevus	ocrelizumab	30 mg/mL	Injection
02444399 02444402	Plegridy	peginterferon beta-1a	125 mcg/0.5 mL 63 mcg/0.5 mL	Injection
02404508 02420201	Tecfidera	dimethyl fumarate	120 mg 240 mg	Capsule
02495341 02495368	ACH-Dimethyl Fumarate	dimethyl fumarate	120 mg 240 mg	Capsule
02505762 02505770	Apo-Dimethyl Fumarate	dimethyl fumarate	120 mg 240 mg	Capsule
02494809 02494817	GLN-Dimethyl Fumarate	dimethyl fumarate	120 mg 240 mg	Capsule
02516047 02516055	Jamp Dimethyl Fumarate	dimethyl fumarate	120 mg 240 mg	Capsule
02502690 02502704	Mar-Dimethyl Fumarate	dimethyl fumarate	120 mg 240 mg	Capsule
02497026 02497034	pms-Dimethyl Fumarate	dimethyl fumarate	120 mg 240 mg	Capsule
02513781 02513803	Sandoz Dimethyl Fumarate	dimethyl fumarate	120 mg 240 mg	Capsule
02286386	Tysabri	natalizumab	300 mg/15 mL	Injection

Specialists from the MS Clinic may apply for EDS. Please contact the EDS Program at MB Health for specific criteria.

Glatect will be a preferred glatiramer acetate option for all glatiramer acetate-naïve patients prescribed a glatiramer acetate product for relapsing-remitting multiple sclerosis (MS). Patients will not be permitted to switch from Glatect to another glatiramer acetate product or vice versa, if previously trialed and deemed unresponsive to therapy.

02511355	Kesimpta	ofatumumab	20 mg/0.4 mL	Injection
----------	-----------------	------------	--------------	-----------

For the treatment of adult patients with an established diagnosis of relapsing-remitting multiple sclerosis (RRMS), when prescribed by a neurologist from the Manitoba Multiple Sclerosis (MS) Clinic.

02470179	Mavenclad	cladribine	10 mg	Tablet
----------	------------------	------------	-------	--------

Specialists from the MS Clinic may apply for EDS. Please contact the EDS Program at MB Health for specific criteria.

02244550 02244552	Pamidronate Disodium	pamidronate disodium	3 mg/mL 9 mg/mL	Injection
02249685	Pamidronate Disodium Omega	pamidronat+A1698:C1721 edisodium	9 mg/mL	Injection

Patients unable to absorb oral medications due to Crohn's Disease or other absorption problems (use for the treatment of osteoporosis).

02296462 02296470 02331667 02296489	Advagraf	tacrolimus	0.5 mg 1 mg 3 mg 5 mg	Capsule
--	-----------------	------------	--------------------------------	---------

For the prophylaxis of organ rejection in patients receiving allogeneic liver or kidney transplants.

02485877 02485885 02485893	Envarsus PA	tacrolimus	0.75 mg 1 mg 4 mg	Extended Release Tablet
----------------------------------	--------------------	------------	-------------------------	-------------------------

For the prophylaxis of organ rejection in patients receiving allogeneic liver or kidney transplants.

02243144 02175991 02175983	Prograf	tacrolimus	0.5 mg 1 mg 5 mg	Capsule
02176009	Prograf	tacrolimus	5 mg/mL	Injection
00960632	Prograf	tacrolimus	0.5 mg/ mL	Suspension
02416816 02416824 02416832	Sandoz Tacrolimus	tacrolimus	0.5 mg 1 mg 5 mg	Capsule

(a) For the prophylaxis of organ rejection in patients receiving allogeneic liver or kidney transplants.

(b) For use in atopic dermatitis resistant to potent steroids and oral cyclosporine.

02264560 02264579	Myfortic	mycophenolate sodium	180 mg 360 mg	Tablet
02372738 02372746	Apo-Mycophenolic Acid	mycophenolate sodium	180 mg 360 mg	Tablet
02511673 02511681	Mar-Mycophenolic Acid	mycophenolic sodium	180 mg 360 mg	Tablet

For the prophylaxis of organ rejection in patients receiving allogeneic renal transplants.

00718149	Tryptan	l-tryptophan	500 mg	Capsule
02029456 00654531	Tryptan	l-tryptophan	500 mg 1 g	Tablet
02248540	Apo-Tryptophan	l-tryptophan	500 mg	Capsule

02248538 02458721 02248539	Apo-Tryptophan	l-tryptophan	500 mg 750 mg 1 g	Tablet
02240334	TEVA-Tryptophan	l-tryptophan	500 mg	Capsule
02240333 02237250	TEVA-Tryptophan	l-tryptophan	500 mg 1 g	Tablet

Adjunct therapy for refractory depression. Must have tried at least 2 other antidepressants.

02241888 02241889	Arava	leflunomide	10 mg 20 mg	Tablet
02478862 02478870	Accel-Leflunomide	leflunomide	10 mg 20 mg	Tablet
02256495 02256509	Apo-Leflunomide	leflunomide	10 mg 20 mg	Tablet
02351668 02351676	Leflunomide	leflunomide	10 mg 20 mg	Tablet
02261251 02261278	Teva-Leflunomide	leflunomide	10 mg 20 mg	Tablet
02283964 02283972	Sandoz Leflunomide	leflunomide	10 mg 20 mg	Tablet

Rheumatoid arthritis failing at least 2 disease modifying antirheumatic drugs (DMARDs), eg. gold, methotrexate (MTX), plaquenil, sulfasalazine, minocycline and doxycycline.

02233542	Diane-35	cyproterone acetate/ ethinyl estradiol	2 mg/0.035 mg	Tablet
02290308	Cyestra-35	cyproterone acetate/ ethinyl estradiol	2 mg/0.035 mg	Tablet
02309556	Novo-Cyproterone/Ethinyl Estradiol	cyproterone acetate/ ethinyl estradiol	2 mg/0.035 mg	Tablet

(a) Treatment of severe acne - refractory to birth control pills, topicals (vitamin A/acid gel, tretinoin), Accutane and antibiotics.

(b) Hirsutism not responding to standard therapy (e.g. birth control pills, spironolactone, metformin).

01968017 02420104 02420112	Neupogen	filgrastim	300 mcg/mL 300 mcg/0.5 mL 480 mcg/0.8 mL	Injection
----------------------------------	-----------------	------------	--	-----------

For the use in patients with HIV infection for the prevention and treatment of neutropenia to maintain a normal absolute neutrophil count (ANC).

Grastofil, Nivestym, or Nypozi will be the preferred filgrastim option for all filgrastim-naïve patients. Preferred means the first filgrastim product to be considered for reimbursement for filgrastim-naïve patients.

02441489 02454548	Grastofil	filgrastim	300 mcg/0.5 mL 480 mcg/0.8 mL	Injection
----------------------	------------------	------------	----------------------------------	-----------

For the use in patients with HIV infection for the prevention and treatment of neutropenia to maintain a normal absolute neutrophil count (ANC).

Grastofil will be a preferred filgrastim option for all filgrastim-naïve patients. Preferred means the first filgrastim product to be considered for reimbursement for filgrastim-naïve patients.

02485575 02485583 02485591 02485656	Nivestym	filgrastim	300 mcg/0.5 mL 480 mcg/0.8 mL 300 mcg/mL 480 mcg/1.6 mL	Injection
--	-----------------	------------	--	-----------

For the use in patients with HIV infection for the prevention and treatment of neutropenia to maintain a normal absolute neutrophil count (ANC).

Nivestym will be a preferred filgrastim option for all filgrastim-naïve patients. Preferred means the first filgrastim product to be considered for reimbursement for filgrastim-naïve patients.

02520990 02521008	Nypozi	filgrastim	300 mcg/0.5 mL 480 mcg/0.8 mL	Injection
----------------------	---------------	------------	----------------------------------	-----------

For the use in patients with HIV infection for the prevention and treatment of neutropenia to maintain a normal absolute neutrophil count (ANC).

Nypozi will be a preferred filgrastim option for all filgrastim-naïve patients. Preferred means the first filgrastim product to be considered for reimbursement for filgrastim-naïve patients.

02387174	Dificid	fidaxomicin	200 mg	Tablet
----------	----------------	-------------	--------	--------

For the treatment of patients:

- (a) in place of vancomycin if there is a documented allergy to vancomycin; or
- (b) as an alternative to vancomycin if a patient experiences a “severe adverse reaction” to vancomycin therapy; or
- (c) treatment that results in the discontinuation of vancomycin;
- (d) as an alternative to vancomycin if a patient experiences a 'severe intolerance' to vancomycin treatment that results in the discontinuation of vancomycin therapy; or
- (e) for use in the event of vancomycin treatment failure.

In addition to the above, for use in prior Clostridium Difficile Infection (CDI) situations after other current CDI treatment options fail.

02393751	Esbriet	pirfenidone	267 mg	Capsule
02464489 02464500	Esbriet	pirfenidone	267 mg 801 mg	Tablet
02509938	Jamp Pirfenidone	pirfenidone	267 mg	Capsules
02514702 02514710	Jamp Pirfenidone	pirfenidone	267 mg 801 mg	Tablets
02531526 02531534	pms-Pirfenidone	pirfenidone	267 mg 801 mg	Tablets
02488833	Sandoz Pirfenidone	pirfenidone	267 mg	Capsules

02488507 02488515	Sandoz Pirfenidone	pirfenidone	267 mg 801 mg	Tablets
----------------------	---------------------------	-------------	------------------	---------

For the treatment of adult patients who have a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF)* confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.

*Mild-moderate IPF is defined as: forced vital capacity (FVC) greater than or equal to 50% of predicted.

02443066 02443074	Ofev	nintedanib	100 mg 150 mg	Capsule
----------------------	-------------	------------	------------------	---------

For the treatment of adult patients who have a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF)* confirmed by a respirologist and a high-resolution CT scan within the previous 24 months.

*Mild-moderate IPF is defined as: forced vital capacity (FVC) greater than or equal to 50% of predicted.

Chronic fibrosing interstitial lung diseases

Initiation criteria:

- The patient has a diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype confirmed by a specialist in interstitial lung diseases.
- The patient has a forced vital capacity greater than or equal to 45% of predicted.

Renewal criteria:

- The patient must not experience a more severe progression of disease, defined as an absolute decline in percent predicted forced vital capacity of 10% or greater over the preceding year of treatment with nintedanib.
- The patient's clinical status should be evaluated every 12 months.

Prescribing conditions:

- The patient's condition has been assessed by a specialist with experience in the diagnosis and management of interstitial lung diseases.
- Concurrent treatment of nintedanib with pirfenidone should not be reimbursed.

02470632	Trispan	triamcinolone hexacetonide	20 mg/mL	Injection
----------	----------------	----------------------------	----------	-----------

For the management of pediatric chronic inflammatory arthropathies.

02242471	Dostinex	cabergoline	0.5 mg	Tablet
02455897	Apo-Cabergoline	cabergoline	0.5 mg	Tablet

For treatment of:

- Hyperprolactinemic disorders in patients unresponsive to bromocriptine.
- Hyperprolactinemic disorders in patients intolerant to bromocriptine.

RESPIRATORY TRACT AGENTS

02470365 02492504 02510049 02524252	Dupixent	dupilumab	150 mg/mL 200 mg/1.14 mL 150 mg/mL 200 mg/1.14 mL	Injection
--	-----------------	-----------	--	-----------

As add-on maintenance treatment for patients 6 to 11 years of age with severe

asthma with a type 2/eosinophilic phenotype, if the following criteria are met:

Initiation criteria

- Patient must have a documented diagnosis of severe asthma with a type 2/eosinophilic phenotype; AND
- Symptoms not controlled despite optimal treatment, defined as daily use of medium- to high-dose inhaled corticosteroids (ICS)¹ plus one controller medication (e.g., long-acting beta-agonists (LABA)); AND
- Blood eosinophil count of ≥ 150 cells/ μ L within the past 12 months; AND
- Uncontrolled asthma with at least one clinically significant asthma exacerbation² in the past 12 months.

Administration criteria

- Dupilumab should not be used in combination with other biologics used to treat asthma.
- A baseline assessment of asthma symptom control using a validated asthma control questionnaire must be completed prior to initiation of dupilumab treatment.
- The initial prescription of dupilumab should be by a pediatric respirologist or allergist. Patients should be managed by a physician with expertise in treating asthma in pediatric patients.

¹High-dose ICS is defined as greater or equal to 400mcg of fluticasone propionate or equivalent daily. Medium-dose ICS is defined as greater than 100 mcg-400 mcg of fluticasone propionate or equivalent daily.

²Clinically significant asthma exacerbations are defined as worsening of asthma resulting in hospitalization, an emergency care visit, or treatment with systemic corticosteroids.

Renewal criteria

- The effects of treatment should be assessed every 12 months to determine whether reimbursement should continue.
- Reimbursement of treatment should be discontinued if:
 - o The 12 month asthma control questionnaire score has not improved from baseline, when baseline represents the initiation of treatment; OR
 - o The asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently; OR
 - o The number of clinically significant asthma exacerbations has increased within the previous 12 months.

As add-on maintenance treatment for patients aged 12 years and older with severe asthma with a type 2/eosinophilic phenotype if the following criteria are met:

Initiation Criteria:

- Patient must have a documented diagnosis of severe asthma with a type 2/eosinophilic phenotype.
- Patient is inadequately controlled with high-dose inhaled corticosteroids, defined as greater or equal to 500 mcg of fluticasone propionate or equivalent daily, and one or more additional asthma controller(s) (e.g., long-acting beta agonists).
- Patient has one of the following:
 - o Blood eosinophil count of ≥ 300 cells/ μ L within the past 12 months AND has experienced two or more clinically significant asthma exacerbations¹ in the past 12 months, OR
 - o Blood eosinophil count of ≥ 150 cells/ μ L AND is receiving maintenance treatment with oral corticosteroids (OCS)

Administration Criteria:

- Dupilumab should not be used in combination with other biologics used to treat asthma.
- A baseline assessment of asthma symptom control using a validated asthma control questionnaire must be completed prior to initiation of dupilumab treatment.
- Patients should be managed by a physician with expertise in treating asthma.

¹ Clinically significant asthma exacerbations are defined as worsening of asthma

resulting in administration of systemic corticosteroids for at least three days, or hospitalization.

Renewal Criteria:

- The effects of treatment should be assessed every 12 months to determine whether reimbursement should continue.
- Reimbursement of treatment should be discontinued if:
 - o The 12 month asthma control questionnaire score has not improved from baseline, when baseline represents the initiation of treatment; OR
 - o The asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently; OR
 - o The number of clinically significant exacerbations has increased within the previous 12 months; OR
 - o In patients on maintenance treatment with OCS, there has been no decrease in the OCS dose in the first 12 months of treatment; OR
 - o In patients on maintenance treatment with OCS, the reduction in the dose of OCS achieved after the first 12 months of treatment is not maintained subsequently.

02473232 02496135	Fasenra	benralizumab	30 mg/mL	Injection
----------------------	----------------	--------------	----------	-----------

As add-on maintenance treatment for adult patients with severe eosinophilic asthma, if the following criteria are met:

Initiation Criteria

1. Patient must have a documented diagnosis of asthma.
2. Patient is inadequately controlled with high-dose inhaled corticosteroids, defined as greater or equal to 500 mcg of fluticasone propionate or equivalent daily, and one or more additional asthma controller(s) (e.g., long-acting beta agonists).
3. Patient has one of the following:
 - 3.1 blood eosinophil count of ≥ 300 cells/ μ L AND has experienced two or more clinically significant asthma exacerbations in the past 12 months, OR
 - 3.2. blood eosinophil count of ≥ 150 cells/ μ L AND is receiving maintenance treatment with oral corticosteroids (OCS).

Administration Criteria

1. Benralizumab should not be used in combination with other biologics used to treat asthma.
2. A baseline assessment of asthma symptom control using a validated asthma control questionnaire must be completed prior to initiation of benralizumab treatment.
3. Patients should be managed by a physician with expertise in treating asthma.

Renewal Criteria

1. The effects of treatment should be assessed every 12 months to determine whether reimbursement should continue.
2. Reimbursement of treatment should be discontinued if:
 - 2.1. the 12 month asthma control questionnaire score has not improved from baseline, when baseline represents the initiation of treatment, or
 - 2.2. the asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
 - 2.3. the number of clinically significant exacerbations has increased within the previous 12 months, or
 - 2.4. in patients on maintenance treatment with OCS, there has been no decrease in the OCS dose in the first 12 months of treatment, or
 - 2.5. in patients on maintenance treatment with OCS, the reduction in the dose of OCS achieved after the first 12 months of treatment is not maintained subsequently.

02492989 02492997	Nucala	mepolizumab	100mg/ml	Injection
----------------------	---------------	-------------	----------	-----------

Eosinophilic Asthma

As add-on maintenance treatment for adult patients with severe eosinophilic asthma, if the following criteria are met:

Initiation Criteria

1. Patient must have a documented diagnosis of asthma.
2. Patient is inadequately controlled with high-dose inhaled corticosteroids, defined as greater or equal to 500 mcg of fluticasone propionate or equivalent daily, and one or more additional asthma controller(s) (e.g., long-acting beta agonists).
3. Patient has one of the following:
 - 3.1. blood eosinophil count of ≥ 300 cells/ μ L AND has experienced two or more clinically significant asthma exacerbations in the past 12 months, OR
 - 3.2. blood eosinophil count of ≥ 150 cells/ μ L AND is receiving maintenance treatment with oral corticosteroids (OCS).

Administration Criteria

1. Mepolizumab should not be used in combination with other biologics used to treat asthma.
2. A baseline assessment of asthma symptom control using a validated asthma control questionnaire must be completed prior to initiation of mepolizumab treatment.
3. Patients should be managed by a physician with expertise in treating asthma.

Renewal Criteria

1. The effects of treatment should be assessed every 12 months to determine whether reimbursement should continue.
2. Reimbursement of treatment should be discontinued if:
 - 2.1. the 12 month asthma control questionnaire score has not improved from baseline, when baseline represents the initiation of treatment, or
 - 2.2. the asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently, or
 - 2.3. the number of clinically significant exacerbations has increased within the previous 12 months, or
 - 2.4. in patients on maintenance treatment with OCS, there has been no decrease in the OCS dose in the first 12 months of treatment, or
 - 2.5. in patients on maintenance treatment with OCS, the reduction in the dose of OCS achieved after the first 12 months of treatment is not maintained subsequently.

Chronic rhinosinusitis with nasal polyps (CRSwNP)

For add-on maintenance treatment with intranasal corticosteroids in adult patients with severe chronic rhinosinusitis with nasal polyps (CRSwNP) inadequately controlled by intranasal corticosteroids alone, only if the following criteria are met:

Initiation Criteria

1. Patients must have ALL of the following:

- endoscopically or CT-documented bilateral nasal polyps
 - have undergone at least 1 prior surgical intervention for nasal polyps or have a contraindication to surgery
 - be tolerant and able to continue use of inhaled nasal corticosteroids but have refractory symptoms despite use of inhaled corticosteroids for 3 months at maximally tolerated doses.
2. A baseline Sino-nasal Outcome Test-22 (SNOT-22) or endoscopic nasal polyp score (NPS) must be provided with the initial request for coverage.

Initial approval: 1 year

Renewal Criteria

Patients must exhibit a clinically meaningful response* on the SNOT-22 or endoscopic NPS relative to their baseline score.

*A clinically meaningful response on the SNOT-22 is a decrease in score from baseline of 8.9 points or greater. A clinically meaningful response for NPS is a decrease in score from baseline of 1 point or greater.

Renewal approval: 1 year

Request for coverage must be made by a physician with expertise in managing severe CRSwNP (for example, otolaryngologist, allergist, respirologist).

02529548	Tezspire	ezepeumab	110mg/mL	Pre-filled Syringe
02529556	Tezspire	ezepeumab	110mg/mL	Pre-filled Pen

As an add-on maintenance treatment for patients aged 12 years and older with severe asthma, if all the following criteria are met:

Initiation criteria:

- Asthma inadequately controlled with high-dose inhaled corticosteroids (ICS), defined as greater or equal to 500 mcg of fluticasone propionate or equivalent daily, and one or more additional asthma controller(s) (e.g., long-acting beta agonists [LABA]).
- Patient has experienced two or more clinically significant asthma exacerbations¹ in the past 12 months.

Administration criteria:

- Tezepelumab should not be used in combination with other biologics used to treat asthma.
- A baseline assessment of asthma symptom control using a validated asthma control questionnaire must be completed prior to initiation of tezepelumab treatment.
- Tezepelumab should be initiated and monitored by an allergist or respirologist with experience managing severe asthma.

¹Clinically significant asthma exacerbations are defined as worsening of asthma resulting in administration of systemic corticosteroids for at least three days, or hospitalization.

Renewal criteria:

- The effects of treatment should be assessed every 12 months to determine whether reimbursement should continue.

- Reimbursement of treatment should be discontinued if:
 - o The 12-month asthma control questionnaire score has not improved from baseline, when baseline represents the initiation of treatment; OR
 - o The asthma control questionnaire score achieved after the first 12 months of therapy has not been maintained subsequently; OR
 - o The number of clinically significant asthma exacerbations has increased within the previous 12 months; OR
 - o In patients on maintenance treatment with oral corticosteroids (OCS), there has been no decrease in the OCS dose in the first 12 months of treatment; OR
 - o In patients on maintenance treatment with OCS, the reduction in the dose of OCS achieved after the first 12 months of treatment is not maintained or improved subsequently.

ANTI-INFECTIVE AGENTS

02239630	Tobi	tobramycin	60 mg/mL	Inhalation Solution
02389622	Teva-Tobramycin	tobramycin	60 mg/mL	Inhalation Solution

For the treatment of chronic pulmonary pseudomonas infections in patients with cystic fibrosis (CF).