

Bulletin #789

June 15, 2010

## BENEFIT CHANGES TO NBPDP

This update to the New Brunswick Prescription Drug Program (NBPDP) Formulary is effective June 15, 2010.

**Included in this bulletin:**

- **Regular Benefit Additions**
- **Special Authorization Additions and Revised Criteria**
- **Drugs Reviewed and Not Listed**

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

Yours truly,



Debbie LeBlanc  
New Brunswick Prescription Drug Program

## REGULAR BENEFIT ADDITIONS

Drug/Form/Route/Strength	Brand Name	DIN	Manufacturer	Plans	\$
<b>Aprepitant</b>					
Cap Orl	80mg	Emend <sup>®</sup>	2298791		AAC
	125mg	Emend <sup>®</sup>	2298805	FRS	W
	Tri-Pack	Emend <sup>®</sup>	2298813		
<b>Brinzolamide/Timolol</b>					
Liq Sus	1%/0.5%	Azarga <sup>®</sup>	2331624	ALC	AEF+18VW
<b>Dolasetron</b>					
Tab Orl	100mg	Anzemet <sup>®</sup>	2231379	SAV	W
<b>Tacrolimus</b>					
ERC Orl	0.5mg	Advagraf <sup>®</sup>	2296462		
	1mg	Advagraf <sup>®</sup>	2296470	ASL	R
	5mg	Advagraf <sup>®</sup>	2296489		AAC

## SPECIAL AUTHORIZATION ADDITIONS

### Aprepitant

(Emend<sup>®</sup>)

80 mg and 125 mg capsule;  
Tri-Pack

For the prevention of acute and delayed nausea and vomiting due to highly emetogenic cancer chemotherapy (e.g. cisplatin >70 mg/m<sup>2</sup>) in patients who have experienced emesis despite treatment with a combination of a 5-HT<sub>3</sub> antagonist and dexamethasone in a previous cycle of highly emetogenic chemotherapy.

Note: Prescription claims for up to a maximum of 2 Tri-packs, or 6 capsules will be automatically reimbursed every 28 days when the prescription is written by an oncologist. If additional medication is required within a 28 day period subsequent to the initial prescription, a request should be made through special authorization.

### Lactulose

(various brands)

667 mg/mL

For the treatment of hepatic encephalopathy in patients with liver disease.

Please note requests for treatment of constipation will not be considered.

## SPECIAL AUTHORIZATION ADDITIONS

### Low Molecular Weight

#### Heparins:

**Dalteparin Sodium,**  
**Enoxaparin Sodium,**  
**Nadroparin Calcium,**  
**Tinzaparin Sodium,**  
(*Fragmin*<sup>®</sup>, *Lovenox*<sup>®</sup>,  
*Lovenox*<sup>®</sup> HP, *Fraxiparin*  
*Forte*<sup>®</sup>, *Innohep*<sup>®</sup>)

See NBPDP Formulary for  
complete product listings

### Golimumab

(*Simponi*<sup>™</sup>)

50mg/0.5mL

autoinjector/prefilled syringe

New indications added to criteria:

- For the prophylaxis of venous thromboembolism (VTE) up to 35 days following elective hip replacement or hip fracture surgery.
- For the prophylaxis of VTE up to 10 days following elective knee replacement surgery.

1. For the treatment of patients with moderate to severe ankylosing spondylitis (e.g. Bath AS Disease Activity Index (BASDAI) score  $\geq 4$  on 10 point scale) who:

- Have axial symptoms\* and who have failed to respond to the sequential use of at least 2 NSAIDs at the optimum dose for a minimum 3 month observation period or in whom NSAIDs are contraindicated OR
- Have peripheral symptoms and who have failed to respond to, or have contraindications to, the sequential use of at least 2 NSAIDs at the optimum dose for a minimum 3 month observation period and have had an inadequate response to an optimal dose or maximal tolerated dose of a DMARD.
- Must be prescribed by a rheumatologist or internist.
- Initial approval will be for 4 x 50 mg doses in a 4 month period.
- Requests for continuation of therapy must include information showing the clinical beneficial effects of the treatment, specifically:
  - a decrease of at least 2 points on the BASDAI scale, compared with the pre-treatment score OR
  - patient and expert opinion of an adequate clinical response as indicated by a significant functional improvement (measured by outcomes such as HAQ or "ability to return to work")
- Approvals for continuation of therapy will be for 12 x 50 mg doses annually with no dose escalation permitted.
- Golimumab will not be reimbursed in combination with other anti-TNF agents.

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

## SPECIAL AUTHORIZATION ADDITIONS

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### **Golimumab**

(*Simponi*<sup>TM</sup>)

50mg/0.5mL

autoinjector/prefilled syringe

2. For the treatment of moderate to severe psoriatic arthritis in patients who:
    - Have at least three active and tender joints, and
    - Have not responded to an adequate trial of two DMARDs or have an intolerance or contraindication to DMARDs.
    - Must be prescribed by a rheumatologist or internist.
    - Initial approval will be for 4 x 50 mg doses in a 4 month period.
    - Requests for continuation of therapy must include information demonstrating clinical beneficial effects of the treatment.
    - Approvals for continuation of therapy will be for 12 x 50 mg doses annually with no dose escalation permitted.
    - Golimumab will not be reimbursed in combination with other anti-TNF agents.
  
  3. For patients with moderate to severe active rheumatoid arthritis who:
    - Have not responded to, or have had intolerable side-effects with, an adequate trial of combination therapy of at least two traditional DMARDs (disease modifying antirheumatic drugs). Combination DMARD therapy must include methotrexate unless contraindicated or not tolerated, OR
    - Are not candidates for combination DMARD therapy must have had adequate trial of at least three traditional DMARDs in sequence, one of which must have been methotrexate unless contraindicated. AND
    - Have had an adequate trial of leflunomide unless it is contraindicated or not tolerated.
    - Must be prescribed by a rheumatologist.
    - Initial approval will be for 4 x 50 mg doses in a 4 month period.
    - Requests for continuation of therapy must include information demonstrating clinical beneficial effects of the treatment.
    - Approvals for continuation of therapy will be for 12 x 50 mg doses annually with no dose escalation permitted.
    - Golimumab will not be reimbursed in combination with other anti-TNF agents.
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## SPECIAL AUTHORIZATION – REVISED CRITERIA

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### **Ondansetron**

(*Zofran<sup>®</sup>* and generics)

4 mg and 8 mg tablets; 4 mg  
and 8 mg ODT tablets

### **Granisetron**

(*Kytril<sup>®</sup>* and generic)

1 mg tablets

### **Dolasetron**

(*Anzemet<sup>®</sup>*)

100 mg tablets

For the treatment of emesis in patients who are:

- receiving moderately or severely emetogenic chemotherapy
- OR
- receiving intravenous chemotherapy or radiotherapy and who have not experienced adequate control with other available antiemetics
- OR
- receiving any intravenous chemotherapy or radiotherapy and have experienced emesis with a prior cycle of chemotherapy with intolerable side effects to other antiemetics, including steroids and anti-dopaminergic agents.

Only requests for the oral dosage forms are eligible for consideration. Usually a single oral dose pre-chemotherapy is sufficient to control symptoms.

Some patients may require additional therapy up to 48 hours after the last dose of chemotherapy or last radiation treatment. Benefit beyond 48 hours has not been established.

When used in combination with aprepitant, only a single oral dose pre-chemotherapy will be covered.

Note: Prescription claims for up to a maximum of 12 tablets of ondansetron or 2 tablets of either granisetron or dolasetron will be automatically reimbursed every 28 days when the prescription is written by an oncologist. If additional medication is required within a 28 day period subsequent to the initial prescription, a request should be made through special authorization.

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## SPECIAL AUTHORIZATION – REVISED CRITERIA

**Infliximab**  
(*Remicade*<sup>®</sup>)  
100 mg vial for injection

For moderately to severely active Crohn's disease in patients who are refractory or have contraindications to an adequate course of 5-aminosalicylic acid and corticosteroids and other immunosuppressive therapy. Initial approval will consist of 3 doses of 5 mg/kg given at weeks 0, 2 and 6.

Ongoing coverage for maintenance therapy will only be reimbursed for responders and for a dose not exceeding 5mg/kg every 8 weeks. Coverage must be reassessed annually and is dependent on evidence of continued response.

Must be prescribed by, or in consultation with, a gastroenterologist or physician with a specialty in gastroenterology.

Infliximab will not be reimbursed in combination with other anti-TNF agents.

## DRUGS REVIEWED AND NOT LISTED

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

<b>Teriparatide</b> – in severe osteoporosis in women (ACP submission)	( <i>Forteo</i> <sup>®</sup> )	250µg/mL prefilled pen
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