Ontario Drug Benefit Formulary/Comparative Drug Index

Edition 42

Summary of Changes - July 2015

Effective July 29, 2015

Ministry of Health and Long-Term Care

Ontario

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New Single Source Products

DIN/PIN	PRODUCT NAME, STRENGTH & DOSAGE FORM	GENERIC NAME	MFR	DBP
02415992	Eylea 40mg/mL Sol for Intravitreal Inj-0.05mL Vial Pk	AFLIBERCEPT	BAH	1418.0000

Reason For Use Code and Clinical Criteria

Code 463
For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD) in a verteporfin PDT (Visudyne)-naive eye. Initial diagnosis should be confirmed by an appropriate diagnostic procedure and administration should be done by a qualified ophthalmologist experienced in intravitreal injections.
Patients receiving concurrent administration of verteporfin PDT (Visudyne) or ranibizumab (Lucentis) are not eligible for reimbursement. Treatment should be initiated with a monthly intravitreal injection for the first 3 consecutive doses, followed by one injection every 2 months.
The interval between two doses should not be shorter than one month.
Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.
For clarity, coverage will be provided for patients responding to therapy with Lucentis who switch to Eylea.
Coverage will NOT be provided for patients who have failed to respond to Lucentis.

LU Authorization Period: 1 year.

Code 464
For the treatment of patients with clinically significant macular edema secondary to central retinal vein occlusion (CRVO).
Treatment should be initiated with an intravitreal injection once every month. The interval between two doses should not be shorter than one month. The treatment interval may be extended up to 3 months based on visual and anatomic outcomes.
Prescribers are advised to periodically assess the need for continued therapy.
Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.
For clarity, coverage will be provided for patients responding to therapy with Lucentis who switch to Eylea.
Coverage will NOT be provided for patients who have failed to respond to Lucentis.

LU Authorization Period: 1 year.

Code 465
For the treatment of patients with clinically significant diabetic macular edema (DME) for whom laser photocoagulation is also indicated; and a hemoglobin A1c of less than 12%.
Treatment should be initiated with a monthly intravitreal injection for the first 5 consecutive doses, followed by one injection every 2 months.
The interval between two doses should not be shorter than one month.
Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.
For clarity, coverage will be provided for patients responding to therapy with Lucentis who switch to Eylea.
Coverage will NOT be provided for patients who have failed to respond to Lucentis.

LU Authorization Period: 1 year.

New Single Source Products (Cont'd...)

DIN/PIN	PRODUCT NAME, STRENGTH & DOSAGE FORM	GENERIC NAME	MFR	DBP
02420864	Abilify Maintena 300mg/Vial Prolong-Rel Inj Pd-Vial Pk	ARIPIPRAZOLE	OTS	456.1800
02420872	Abilify Maintena 400mg/Vial Prolong-Rel Inj Pd-Vial Pk	ARIPIPRAZOLE	OTS	456.1800

Therapeutic Note:

For the maintenance treatment of schizophrenia in patients who are stabilized on oral aripiprazole who have:
A history of non-adherence; AND one of the following:

(a) Inadequate control or significant side-effects from two or more formulary oral antipsychotic medications, including at least one atypical agent; OR
(b) Inadequate control or significant side-effects from one or more conventional depot antipsychotic agents.

DIN/PIN	PRODUCT NAME, STRENGTH & DOSAGE FORM	GENERIC NAME	MFR	DBP
02425483	Invokana 100mg Tab	CANAGLIFLOZIN	JAN	2.6177
02425491	Invokana 300mg Tab	CANAGLIFLOZIN	JAN	2.6177

Therapeutic Note:

Treatment of Type 2 diabetes in patients on maximally tolerated doses of metformin who have:

- Inadequate glycemic control (defined as HbA1c greater than 0.07) and intolerance or contraindication to a sulfonylurea; OR
- Inadequate glycemic control (HbA1c greater than 0.07) and on maximal doses of sulfonylurea and for whom insulin is not an option.

DIN/PIN	PRODUCT NAME, STRENGTH & DOSAGE FORM	GENERIC NAME	MFR	DBP
02240335	Monurol Sachet-3g Pk	FOSFOMYCIN TROMETHAMINE	PAL	17.0000

Therapeutic Note:

The recommended dosage for women over 18 years with acute uncomplicated urinary tract infections (acute cystitis) is one sachet containing the equivalent of 3 grams of fosfomycin.

A single dose of fosfomycin should be used to treat an episode of acute cystitis.

New Single Source Products (Cont'd...)

DIN/PIN	PRODUCT NAME, STRENGTH & DOSAGE FORM	GENERIC NAME	MFR	DBP
02425629	Lucentis 10mg/mL Inj Sol-Pref Syr 0.165mL Pk	RANIBIZUMAB	NOV	1575.0000

Reason For Use Code and Clinical Criteria

Code 422

For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD) in a verteporfin PDT (Visudyne)-naive eye.
Initial diagnosis should be confirmed by an appropriate diagnostic procedure and administration should be done by a qualified ophthalmologist experienced in Intravitreal injections.
Patients receiving concurrent administration of verteporfin PDT (Visudyne) or aflibercept (Eylea) are not eligible for reimbursement.
Treatment should be initiated with a loading phase of one injection per month for three consecutive months, followed by a maintenance phase.
During the maintenance phase, patients should be monitored for best corrected visual acuity or continued disease activity. If there is clinical or diagnostic evidence of disease activity such as a loss of greater than 5 letters in visual acuity (Early Treatment Diabetic Retinopathy Score (ETDRS) chart or one Snellen line equivalent), Lucentis may be administered.
The interval between two doses should not be shorter than one month.
Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.
For clarity, coverage will be provided for patients responding to therapy with Eylea who switch to Lucentis.
Coverage will NOT be provided for patients who have failed to respond to Eylea.

LU Authorization Period: 1 year.

Code 439

For the treatment of patients with clinically significant diabetic macular edema (DME) for whom laser photocoagulation is also indicated; and a hemoglobin A1c of less than 11%.
Treatment to be given monthly and continued until maximum visual acuity is achieved, confirmed by stable visual acuity for three consecutive monthly assessments performed while on Lucentis treatment. Thereafter patients should be monitored monthly for visual acuity.
Treatment is resumed with monthly injections when monitoring indicates a loss of visual acuity due to DME and continued until stable visual acuity is reached again for three consecutive monthly assessments.Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.
For clarity, coverage will be provided for patients responding to therapy with Eylea who switch to Lucentis.
Coverage will NOT be provided for patients who have failed to respond to Eylea.

LU Authorization Period: 1 year.

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Code 445

For the treatment of patients with clinically significant macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO).
Treatment to be given monthly and continued until maximum visual acuity is achieved, confirmed by stable visual acuity for three consecutive monthly assessments performed while on Lucentis treatment. Thereafter patients should be monitored monthly for visual acuity.
Treatment is resumed with monthly injections when monitoring indicates a loss of visual acuity due to macular edema secondary to retinal vein occlusion and continued until stable visual acuity is reached again for three consecutive monthly assessments.
Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.
For clarity, coverage will be provided for patients responding to therapy with Eylea who switch to Lucentis. Coverage will NOT be provided for patients who have failed to respond to Eylea.

LU Authorization Period: 1 year.

Code 462

For the treatment of patients with visual impairment due to choroidal neovascularization secondary to pathologic myopia.
Treatment is initiated with a single intravitreal injection. Monitoring is recommended monthly for the first 2 months and at least every 3 months thereafter during the first year. If monitoring reveals signs of disease activity (e.g. reduced visual acuity and/or signs of lesion activity), further treatment is recommended at a frequency of 1 injection per month until no disease activity is seen.

LU Authorization Period: 1 year.

New Multi-Source Products

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	DBP
02426978	Van-Ciprofloxacin	250mg	Tab	VAN	0.6186
02427001	Van-Ciprofloxacin	500mg	Tab	VAN	0.6979
02427028	Van-Ciprofloxacin	750mg	Tab	VAN	1.2780

(Interchangeable with Cipro)

Reason For Use Code and Clinical Criteria

For the treatment of patients with:

Code 332
SST/BJ (Gram negative bacteria):
Skin/soft tissue and bone/joint infection due to gram negative bacteria; severe diabetic foot infection; severe otitis externa; decubitus ulcers.

LU Authorization Period: 1 year.

Code 333
GU Tract:
Urinary tract infection/prostatitis/epididymitis caused by (suspected or documented) Pseudomonas; sexually transmitted diseases.

LU Authorization Period: 1 year.

Code 334
COPD with risk:
Acute bacterial exacerbation of chronic obstructive pulmonary disease (COPD) with risk factors*; bronchiectasis; pneumonic illness with cystic fibrosis. *Risk factors include: poor pulmonary lung function (FEV1 below 50% predicted level), age over 65 years, co-morbid medical illness (congestive heart failure, diabetes, chronic renal failure, chronic liver disease), chronic corticosteroid use, malnutrition, prolonged duration of disease or 4 or more exacerbations per year.

LU Authorization Period: 1 year.

Code 336
Step-Down:
Step-down therapy after parenteral therapy or hospital/emergency department discharge; febrile neutropenia.

LU Authorization Period: 1 year.

Code 350
GI:
Traveller's diarrhea; enteric fever syndromes; Crohn's disease.

LU Authorization Period: 1 year.

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Code 353
For the prophylaxis or treatment of B. anthracis exposure.

LU Authorization Period: 1 year.

Code 977
Exceptional cases of allergy or intolerance to all other appropriate therapies.

LU Authorization Period: 1 year.

New Multi-Source Products (Cont'd...)

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	DBP
02426943	Van-Donepezil	5mg	Tab	VAN	1.2340
02426951	Van-Donepezil	10mg	Tab	VAN	1.2340

(Interchangeable with Aricept)

Reason For Use Code and Clinical Criteria

Code 347
Initial Trial: For patients with mild to moderate Alzheimer's Disease (Mini-Mental State Exam [MMSE] 10-26). Patients will be reimbursed for a period of up to 3 months after which continued treatment must be reassessed. Network note: Maximum duration 3 months.

LU Authorization Period: 1 year.

Code 348
Continuation: Further reimbursement will be made available to those patients whose disease has not progressed/deteriorated while on this drug. Patients must continue to have a MMSE score of 10-26.

LU Authorization Period: 1 year.

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	DBP
02431114	PMS-Imatinib	100mg	Tab	PMS	6.8186
02431122	PMS-Imatinib	400mg	Tab	PMS	27.2743

(Interchangeable with Gleevec)

Therapeutic Note:

These products must be prescribed based on the following criteria:

1) For treatment of Philadelphia chromosome-positive Chronic Myelogenous Leukemia (CML) in chronic phase. The initial dose is 400mg/day. The dose may be increased up to a maximum of 800mg/day in patients who do not have an adequate hematologic response at 3 months or cytogenetic response at 1 year; or if there has been loss of a previously achieved hematologic and/or cytogenetic response.
Note: The ministry will only reimburse, in a patient's lifetime, any two (2) of the oral Tyrosine Kinase Inhibitors (TKIs)* used for chronic phase CML. (* TKIs: Imatinib, Nilotinib, or Dasatinib).

2) For treatment of Philadelphia chromosome-positive Chronic Myelogenous Leukemia (CML) in blast phase or accelerated phase. The initial dose is 600mg/day. The dose may be increased to a maximum of 800mg/day in patients who do not have an adequate hematologic response at 3 months or cytogenetic response at 1 year; or loss of a previously achieved hematologic and/or cytogenetic response.

New Multi-Source Products (Cont'd...)

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	DBP
02438275	Auro-Metformin	500mg	Tab	AUR	0.0444
	(Interchangeable with Glucophage)				

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	DBP
02436965	Mint-Olanzapine ODT	5mg	Rapid Dissolve Tab	MIN	0.6434
02436973	Mint-Olanzapine ODT	10mg	Rapid Dissolve Tab	MIN	1.2857
02436981	Mint-Olanzapine ODT	15mg	Rapid Dissolve Tab	MIN	1.9280
	(Interchangeable with Zyprexa Zydis)				

New Multi-Source Products (Cont'd...)

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	DBP
02437945	Pantoprazole	40mg	Ent Tab	PMS	0.3628
	(Interchangeable with Pantoloc)				

Reason For Use Code and Clinical Criteria

Code 293
Gastroesophageal Reflux Disease (GERD)
For the treatment of erosive GERD or upper GI malignancy;
OR For the treatment of non-erosive GERD after failure of H2-receptor antagonist therapy.
Patients with GERD should be reassessed within 6 months after initial treatment with a PPI. The reassessment could include confirmation of need for PPI with endoscopy, a trial of PPI withdrawal, or step-down therapy to H2-receptor antagonist therapy.
Note: There is a lack of published evidence to support double-dose PPI therapy in this setting.

LU Authorization Period: 1 year.

Code 295
H. pylori-positive Peptic Ulcers
For the treatment of H. pylori-positive peptic ulcers where H. pylori is documented, by serology, urea breath test or endoscopy, for a one-week course in combination with antimicrobial therapy. Retreatment of H. pylori-positive peptic ulcers must be documented by persistent H. pylori infection on urea breath test or endoscopy.
Maximum duration: 7 days (for retreatment, a four-week period must elapse since the end of the previous treatment).

LU Authorization Period: 1 year.

Code 297
Confirmed Peptic Ulcers or NSAID-induced Ulcer Prophylaxis:
For the treatment of confirmed peptic ulcers and NSAID-induced ulcers;
OR For the prophylaxis of NSAID-induced ulcers for patients at increased risk of GI bleeding.
Note: There is a lack of published evidence to support double-dose PPI therapy in this setting.

LU Authorization Period: 1 year.

Code 401
Other Gastrointestinal Disorders
For the treatment of gastroduodenal Crohns disease, short-gut syndrome, scleroderma, or pancreatitis.
Note: There is a lack of published evidence to support double-dose PPI therapy in these settings.

LU Authorization Period: 1 year.

Code 402
Severe Conditions:
For the treatment of severe esophagitis, Zollinger-Ellison syndrome, esophageal stricture, persistent symptoms of GERD or persistent erosive esophagitis, or upon hospital discharge following a gastrointestinal bleed.
For patients receiving double-dose therapy, the need to continue treatment at higher doses should be reassessed after eight weeks. For re-treatment at higher doses, a four-week period should have elapsed from the end of the previous treatment. Reassessment could include a procedural assessment of the condition or step-down therapy to lower-dose proton pump inhibitor (PPI) therapy.

LU Authorization Period: 1 year.

New Off-Formulary Interchangeable (OFI) Products

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	UNIT COST
02437007	Mint-Olanzapine ODT	20mg	Rapid Dissolve Tab	MIN	7.5977
(Interchangeable with Zyprexa Zydis)					

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	UNIT COST
02439913	Teva-Progesterone	100mg	Cap	TEV	1.4358
(Interchangeable with Prometrium)					

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	UNIT COST
02409097	Gd-Tranexamic Acid	500mg	Tab	GEM	0.8071
(Interchangeable with Cyklokapron)					

New Diabetic Testing Agent

PIN	PRODUCT	MFR	COST/ UNIT	AMT MOH PAYS	AMT PATIENT PAYS
09857526	CareSens N Blood Glucose Test Strip	ISE	0.6912	0.6912	0.0000

Drug Benefit Price (DBP) Changes

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR	DBP
09857523	PediaSure Peptide 1 Cal	1.0kcal/mL	Liq-237mL Pk Reclosable Plastic Bottle	ABB	2.6892
02248499	Apo-Quinapril	5mg	Tab	APX	0.2321
02248500	Apo-Quinapril	10mg	Tab	APX	0.2321
02248501	Apo-Quinapril	20mg	Tab	APX	0.2321
02248502	Apo-Quinapril	40mg	Tab	APX	0.2321
02381524	Mylan-Efavirenz	600mg	Tab	MYL	3.8030
02421917	Sandoz Capecitabine	150mg	Tab	SDZ	0.4575
02421925	Sandoz Capecitabine	500mg	Tab	SDZ	1.5250
02403641	Teva-Alendronate/Cholecalciferol	70mg/140mcg	Tab	TEV	2.3312
02400022	Teva-Capecitabine	150mg	Tab	TEV	0.4575
02400030	Teva-Capecitabine	500mg	Tab	TEV	1.5250
02389762	Teva-Efavirenz	600mg	Tab	TEV	3.8030

Product Manufacturer Name Change

DIN	BRAND NAME	STRENGTH	DOSAGE FORM	CURRENT MFR	NEW MFR
00004626	Leukeran	2mg	Tab	TRT	ASN

Product Brand Name Change

DIN	CURRENT BRAND NAME	NEW BRAND NAME	STRENGTH	DOSAGE FORM	MFR
00367729	Senokot	Senokot Syrup	1.7mg/mL	Syrup	PFP

Addition of New Reason for Use Code and Changes to Reason For Use Contents

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR
02296810	Lucentis	10mg/mL	Inj Sol-0.23mL Vial Pk	NOV

New Reason For Use Code and Clinical Criteria in Addition to the Existing Codes

Code 462
For the treatment of patients with visual impairment due to choroidal neovascularization secondary to pathologic myopia.
Treatment is initiated with a single intravitreal injection. Monitoring is recommended monthly for the first 2 months and at least every 3 months thereafter during the first year. If monitoring reveals signs of disease activity (e.g. reduced visual acuity and/or signs of lesion activity), further treatment is recommended at a frequency of 1 injection per month until no disease activity is seen.

LU Authorization Period: 1 year.

Updated Reason For Use Codes

Code 422
For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD) in a verteporfin PDT (Visudyne)-naive eye.
Initial diagnosis should be confirmed by an appropriate diagnostic procedure and administration should be done by a qualified ophthalmologist experienced in Intravitreal injections.
Patients receiving concurrent administration of verteporfin PDT (Visudyne) or aflibercept (Eylea) are not eligible for reimbursement.
Treatment should be initiated with a loading phase of one injection per month for three consecutive months, followed by a maintenance phase.
During the maintenance phase, patients should be monitored for best corrected visual acuity or continued disease activity. If there is clinical or diagnostic evidence of disease activity such as a loss of greater than 5 letters in visual acuity (Early Treatment Diabetic Retinopathy Score (ETDRS) chart or one Snellen line equivalent), Lucentis may be administered.
The interval between two doses should not be shorter than one month.
Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.
For clarity, coverage will be provided for patients responding to therapy with Eylea who switch to Lucentis.
Coverage will NOT be provided for patients who have failed to respond to Eylea.

LU Authorization Period: 1 year.

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Code 439

For the treatment of patients with clinically significant diabetic macular edema (DME) for whom laser photocoagulation is also indicated; and a hemoglobin A1c of less than 11%.
Treatment to be given monthly and continued until maximum visual acuity is achieved, confirmed by stable visual acuity for three consecutive monthly assessments performed while on Lucentis treatment. Thereafter patients should be monitored monthly for visual acuity.
Treatment is resumed with monthly injections when monitoring indicates a loss of visual acuity due to DME and continued until stable visual acuity is reached again for three consecutive monthly assessments.Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.
For clarity, coverage will be provided for patients responding to therapy with Eylea who switch to Lucentis. Coverage will NOT be provided for patients who have failed to respond to Eylea.

LU Authorization Period: 1 year.

Code 445

For the treatment of patients with clinically significant macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO).
Treatment to be given monthly and continued until maximum visual acuity is achieved, confirmed by stable visual acuity for three consecutive monthly assessments performed while on Lucentis treatment. Thereafter patients should be monitored monthly for visual acuity.
Treatment is resumed with monthly injections when monitoring indicates a loss of visual acuity due to macular edema secondary to retinal vein occlusion and continued until stable visual acuity is reached again for three consecutive monthly assessments.
Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.
For clarity, coverage will be provided for patients responding to therapy with Eylea who switch to Lucentis. Coverage will NOT be provided for patients who have failed to respond to Eylea.

LU Authorization Period: 1 year.

Status Changes from Discontinued Drug to Not-A-Benefit*

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR
02405040	Auro-Valacyclovir	500mg	Tab	AUR
02331748	Co Valacyclovir	500mg	Tab	COB
02357534	Novo-Valacyclovir	500mg	Tab	TEV

(*Due to supply depletion)

Removal of Therapeutic Note

The following Therapeutic Note is removed from Pharmacologic-Therapeutic Classification 12:08:00 PARASYMPATHOLYTIC (CHOLINERGIC BLOCKING) AGENTS

Therapeutic Note:

Anticholinergic agents should be used with extreme caution in the elderly due to age- related central nervous system adverse effects (e.g., confusion, paranoia, hallucinations). Avoid in patients with dementia as drug-induced memory impairment is common. (This does not apply to ipratropium bromide).

Discontinued Products

(Some products will remain on Formulary for six months to facilitate depletion of supply)

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR
02270641	Co Clonazepam	0.5mg	Tab	COB
02270676	Co Clonazepam	2mg	Tab	COB
02285215	Co Cilazapril	2.5mg	Tab	COB
02285223	Co Cilazapril	5mg	Tab	COB
02379996	Co Mycophenolate	500mg	Tab	COB
02244814	Co Temazepam	15mg	Cap	COB
02244815	Co Temazepam	30mg	Cap	COB
00860743	Imodium	2mg	Cap	JAN
02177722	PMS-Nizatidine	300mg	Cap	PMS
02391236	PMS-Telmisartan	40mg	Tab	PMS
02391244	PMS-Telmisartan	80mg	Tab	PMS
02401665	PMS-Telmisartan-HCTZ	80mg & 12.5mg	Tab	PMS
02401673	PMS-Telmisartan-HCTZ	80mg & 25mg	Tab	PMS
00400750	Sinequan	75mg	Cap	ERF
00326925	Sinequan	100mg	Cap	ERF

Delisted Products

DIN/PIN	BRAND NAME	STRENGTH	DOSAGE FORM	MFR
02291037	Apo-Diltiaz TZ	120mg	SR Cap	APX
02291045	Apo-Diltiaz TZ	180mg	SR Cap	APX
02291053	Apo-Diltiaz TZ	240mg	SR Cap	APX
02291061	Apo-Diltiaz TZ	300mg	SR Cap	APX
02291088	Apo-Diltiaz TZ	360mg	SR Cap	APX
02261979	Apo-Lisinopril/HCTZ	10mg & 12.5mg	Tab	APX
02261987	Apo-Lisinopril/HCTZ	20mg & 12.5mg	Tab	APX
02261995	Apo-Lisinopril/HCTZ	20mg & 25mg	Tab	APX
02150867*	Canesten 1% Topical Cream	10mg/g	Cr	BAY
02298309	Champix	0.5mg & 1.0mg	Tabs (Starter Pack)	PFI
02176017*	Didrocal	400mg/500mg	Tab-90 Tablets Kit	WAR
02201011*	Fosamax	10mg	Tab	MFC
01911465*	Inhibace	1mg	Tab	HLR
02247323	Mylan-Eti-Cal Carepac	400mg/500mg	Tab-90 Tablets Kit	MYL
00808733	Mylan-Glybe	2.5mg	Tab	MYL
02372169	Myl-Letrozole	2.5mg	Tab	MYL
02229654	Nitrazadon	5mg	Tab	VAL
02229655	Nitrazadon	10mg	Tab	VAL
00710121*	Pepcid	20mg	Tab	MFC
00710113*	Pepcid	40mg	Tab	MFC
02177714	PMS-Nizatidine	150mg	Cap	PMS
02108194*	Prinzide	10mg & 12.5mg	Tab	MFC
00884413*	Prinzide	20mg & 12.5mg	Tab	MFC
00657387*	Rocephin	0.25g/Vial	Inj Pd-1 Vial Pk	HLR
00657417*	Rocephin	1g/Vial	Inj Pd-1 Vial Pk	HLR
00657409*	Rocephin	2g/Vial	Inj Pd-1 Vial Pk	HLR

*Remain on Formulary as Not-a-Benefit to serve as reference product in interchangeable group.

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