BULLETIN # 137

Manitoba Drug Benefits and Manitoba Drug Interchangeability Formulary Amendments

The following amendments will take effect on January 31, 2025

The amended Manitoba Drug Benefits Formulary and Manitoba Drug Interchangeability Formulary will be available on the Manitoba Health website http://www.gov.mb.ca/health/mdbif on the effective date of January 31, 2025

Bulletin 137 is currently available for download:
https://www.gov.mb.ca/health/mdbif/bulletins.html

Inside This Issue

The following changes will take effect on January 31, 2025

Exception Drug Status Additions

02511061	**Abrilada** *(updated criteria)*	adalimumab	20 mg/0.4 mL	Pre-filled Syringe	PFI
02511053	**Abrilada** *(updated criteria)*	adalimumab	40 mg/0.8 mL	Pre-filled Syringe	PFI
02511045	**Abrilada** *(updated criteria)*	adalimumab	40 mg/0.8 mL	Pre-filled Pen	PFI
02459302	**Amgevita** *(updated criteria)*	adalimumab	50 mg/mL	Pre-filled Autoinjector	AGA
02459299	**Amgevita** *(updated criteria)*	adalimumab	50 mg/mL	Pre-filled Syringe	AGA
02459310	**Amgevita** *(updated criteria)*	adalimumab	50 mg/mL	Pre-filled Syringe	AGA
02473097	**Hadlima** *(updated criteria)*	adalimumab	40 mg / 0.8 mL	Pre-filled Syringe	SBC
02533472	**Hadlima** *(updated criteria)*	adalimumab	40 mg / 0.4 mL	Pre-filled Syringe	SBC
02473100	**Hadlima Pushtouch** *(updated criteria)*	adalimumab	40 mg / 0.8 mL	Auto-Injector	SBC
02533480	**Hadlima Pushtouch** *(updated criteria)*	adalimumab	40 mg / 0.4 mL	Auto-Injector	SBC
02502402	**Hulio** *(updated criteria)*	adalimumab	40 mg / 0.8 mL	Pre-filled Pen	BGP
02502399	**Hulio** *(updated criteria)*	adalimumab	40 mg / 0.8 mL	Pre-filled Syringe	BGP
02502380	**Hulio** *(updated criteria)*	adalimumab	20 mg / 0.4 mL	Pre-filled Syringe	BGP
02505258	**Hyrimoz** *(updated criteria)*	adalimumab	20 mg / 0.4 mL	Pre-filled Syringe	SDZ
02492156	**Hyrimoz** *(updated criteria)*	adalimumab	40 mg / 0.8 mL	Pre-filled Autoinjector	SDZ
02492164	**Hyrimoz** *(updated criteria)*	adalimumab	40 mg / 0.8 mL	Pre-filled Syringe	SDZ
02542358	**Hyrimoz** *(updated criteria)*	adalimumab	80 mg/0.8 mL	Pre-filled Syringe	SDZ
02542366	**Hyrimoz** *(updated criteria)*	adalimumab	80 mg/0.8 mL	Pre-filled Autoinjector	SDZ
02542323	**Hyrimoz** *(updated criteria)*	adalimumab	40 mg/0.4 mL	Pre-filled Syringe	SDZ
02542331	**Hyrimoz** *(updated criteria)*	adalimumab	40 mg/0.4 mL	Pre-filled Autoinjector	SDZ
02542315	**Hyrimoz** *(updated criteria)*	adalimumab	20 mg/0.2 mL	Pre-filled Syringe	SDZ

02502674	**Idacio** *(updated criteria)*	adalimumab	40 mg/0.8 mL	Pre-filled Pen	FKC
02502682	**Idacio** *(updated criteria)*	adalimumab	40 mg/0.8 mL	Pre-filled Syringe	FKC
02523949	**Simlandi** *(updated criteria)*	adalimumab	40 mg/0.4 mL	Pre-filled Syringe	JPC
02523965	**Simlandi** *(updated criteria)*	adalimumab	80 mg/0.8 mL	Pre-filled Syringe	JPC
02523957	**Simlandi** *(updated criteria)*	adalimumab	40 mg/0.4 mL	Auto-Injector	JPC
02523760	**Yuflyma** *(updated criteria)*	adalimumab	40 mg/0.4 mL	Pre-filled Syringe	CHC
02523779	**Yuflyma** *(updated criteria)*	adalimumab	40 mg/0.4 mL	Pre-filled Pen	CHC
02535084	**Yuflyma** *(updated criteria)*	adalimumab	80 mg/0.8 mL	Pre-filled Pen	CHC
02535076	**Yuflyma** *(updated criteria)*	adalimumab	80 mg/0.8 mL	Pre-filled Syringe	CHC

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.

Crohn's Disease
For the 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.

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.

Plaque 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 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.

Polyarticular Juvenile Idiopathic Arthritis
For the treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 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.

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 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.

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.

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.

02532247 02532255 02532263 02532271 02532298	**Elonox** *(updated criteria)*	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	Pre-filled Syringe	FKC
02532301 02532328	**Elonox HP** *(updated criteria)*	enoxaparin sodium	120 mg/0.8 mL 150 mg/mL	Pre-filled Syringe	FKC
02507501 02507528 02507536 02507544 02507552	**Inclunox** *(updated criteria)*	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	Pre-filled syringe	SDZ
02507560 02507579	**Inclunox HP** *(updated criteria)*	enoxaparin sodium	120 mg/0.8 mL 150 mg/mL	Pre-filled syringe	SDZ
02506440 02506459 02506467 02506475 02506483 02506491	**Noromby** *(updated criteria)*	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	Pre-filled syringe	JUP

02506505 02506513	**Noromby HP** *(updated criteria)*	enoxaparin sodium	120 mg/0.8 mL 150 mg/mL	Pre-filled syringe	JUP
02509075 02509083 02509091 02509105 02509113 02509121	**Redesca** *(updated criteria)*	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	Pre-filled syringe	VPI
02509148 02509156	**Redesca HP** *(updated criteria)*	enoxaparin sodium	120 mg/0.8 mL 150 mg/mL	Pre-filled syringe	VPI

1. For prophylaxis of thromboembolic disorders (DVT) in patients undergoing orthopedic surgery of the hip or knee.
2. For treatment of deep venous thrombosis (DVT).
3. Peri-operatively if a high risk of thromboembolism exists (i.e., requiring anticoagulation where warfarin is withheld).
4. For treatment of recurrent DVT or pulmonary embolism occurring on therapeutic warfarin.
5. For antithrombotic therapy in pediatrics.
6. For antithrombotic therapy during pregnancy (extend coverage for 2 weeks past due date).
7. For prophylaxis of thromboembolic disorders in spinal cord injury for a maximum of 8 to 12 weeks.
8. For the prevention of venous thromboembolism in patients undergoing pelvic or abdominal surgery for cancer (4 week duration).
9. For the prevention of venous thromboembolism in patients undergoing pelvic or abdominal surgery for inflammatory bowel disease (4 week duration).

02455331	**Brenzys** *(updated criteria)*	etanercept	50 mg/mL	Pre-filled Auto-Injector	SBC
02455323	**Brenzys** *(updated criteria)*	etanercept	50 mg/mL	Pre-filled Syringe	SBC
02462869	**Erelzi** *(updated criteria)*	etanercept	50 mg/mL	Pre-filled Syringe	SDZ
02462877	**Erelzi** *(updated criteria)*	etanercept	25 mg/0.5 mL	Pre-filled Syringe	SDZ
02462850	**Erelzi** *(updated criteria)*	etanercept	50 mg/mL	Auto-Injector Pen	SDZ
02530295	**Rymti** *(updated criteria)*	etanercept	50 mg/mL	Pre-filled Syringe	LPC
02530309	**Rymti** *(updated criteria)*	etanercept	50 mg/mL	Pre-filled Auto-Injector	LPC

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.

Plaque 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:

• ≥ 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.

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.

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 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.

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.

02454548	**Grastofil** *(updated criteria)*	filgrastim	480 mcg/0.8 mL	Pre-filled Syringe	APX
02441489	**Grastofil** *(updated criteria)*	filgrastim	300 mcg/0.5 mL	Pre-filled Syringe	APX
02485656	**Nivestym** *(updated criteria)*	filgrastim	480 mcg / 1.6 mL	Solution for Injection	PFI
02485583	**Nivestym** *(updated criteria)*	filgrastim	480 mcg / 0.8 mL	Pre-filled Syringe	PFI
02485575	**Nivestym** *(updated criteria)*	filgrastim	300 mcg/0.5 mL	Pre-filled Syringe	PFI
02485591	**Nivestym** *(updated criteria)*	filgrastim	300 mcg/mL	Solution for Injection	PFI
02520990	**Nypozi** *(updated criteria)*	filgrastim	300 mcg/0.5 mL	Pre-filled Syringe	TBP
02521008	**Nypozi** *(updated criteria)*	filgrastim	480 mcg/0.8 mL	Pre-filled Syringe	TBP

For use in patients with HIV infection for the prevention and treatment of neutropenia, to maintain a normal absolute neutrophil count.

02460661	**Glatect** *(updated criteria)*	glatiramer	20 mg/mL	Pre-filled Syringe	PMS

For the treatment of patients who have relapsing-remitting multiple sclerosis (RRMS), when prescribed by a neurologist from the Manitoba Multiple Sclerosis (MS) Clinic, and:
• Patient must have met diagnostic criteria for MS, as per the revised McDonald criteria
• Patient must be 18 years or older
• The course of disease must include at least one recent clinical attack in the year prior to therapy or two attacks in the

previous two years
• The patient must still be ambulatory (with aids, if necessary).

02496933	**Avsola** *(updated criteria)*	infliximab	100 mg/vial	Powder for Solution	AGA
02419475	**Inflectra** *(updated criteria)*	infliximab	100 mg/vial	Powder for Solution	CHC
02470373	**Renflexis** *(updated criteria)*	infliximab	100 mg/vial	Powder for Solution	SBC

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.

Crohn's Disease
For the 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.

Plaque Psoriasis
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Psoriatic Arthritis
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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

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.

02498316	**Riximyo** *(updated criteria)*	rituximab	10 mg/mL	Solution for Injection	SDZ
02495724	**Ruxience** *(updated criteria)*	rituximab	10 mg/mL	Solution for Injection	PFI
02478390	**Truxima** *(updated criteria)*	rituximab	500 mg/50 mL	Solution for Injection	CHC
02478382	**Truxima** *(updated criteria)*	rituximab	100 mg/10 mL	Solution for Injection	CHC

Granulomatosis with Polyangiitis and Microscopic Polyangiitis
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.

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.

02251930	**Lantus** *(moved from Part 1)*	insulin glargine	100U/mL	Injection Cartridge	SAA

For pediatric patients who require a half-unit pen device to administer insulin glargine.

02245397	**NovoRapid** *(moved from Part 1)*	insulin aspart	100U/mL	Injection Vial	NOO

For patients requiring an insulin aspart vial for use with an insulin pump.

Product Deletions

The following products have been deleted.

02245619	Copaxone	glatiramer acetate	20 mg/mL	Pre-filled Syringe
02274728	Enbrel	etanercept	50 mg/mL	Pre-filled Syringe
02229704	Humalog	insulin lispro	100U/mL	Injection
02229705	Humalog (Cartridge)	insulin lispro	100U/mL	Injection
02403412	Humalog (Kwikpen)	insulin lispro	100U/mL	Pre-filled Pen
02258595	Humira	adalimumab	40 mg/0.8 mL	Solution for Injection

02474263	Humira	adalimumab	20 mg/0.2 mL	Pre-filled Syringe
02245689	Lantus (Vial)	insulin glargine	100U/mL	Solution for Injection
02294338	Lantus	insulin glargine	100U/mL	Solostar Pre-filled Pen
02012472	Lovenox	enoxaparin sodium	30 mg/0.3 mL	Pre-filled Syringe
02236883	Lovenox	enoxaparin sodium	40 mg/0.4 mL	Pre-filled Syringe
02378426	Lovenox	enoxaparin sodium	60 mg/0.6 mL	Pre-filled Syringe
02378434	Lovenox	enoxaparin sodium	80 mg/0.8 mL	Pre-filled Syringe
02378442	Lovenox	enoxaparin sodium	100 mg/mL	Pre-filled Syringe
02242692	Lovenox HP	enoxaparin sodium	120 mg/0.8mL	Pre-filled Syringe
02378469	Lovenox HP	enoxaparin sodium	150 mg/mL	Pre-filled Syringe
02236564	Lovenox with Preservative 300mg/3mL	enoxaparin sodium	300 mg/3 mL	Solution for Injection
01968017	Neupogen	filgrastim	300 mcg/mL	Solution for Injection
02244353	NovoRapid (Cartridge)	insulin aspart	100U/mL	Solution for Injection
02377209	NovoRapid (Flextouch)	insulin aspart	100U/mL	Pre-filled Pen
02244016	Remicade	infliximab	100 mg/10 mL	Powder for Solution
02241927	Rituxan	rituximab	10 mg/mL	Solution for Injection