BULLETIN # 147

Manitoba Drug Benefits and Manitoba Drug Interchangeability Formulary Amendments

The following amendments will take effect on June1, 2026

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 June 1, 2026

Bulletin 147 is currently available for download:
https://www.gov.mb.ca/health/mdbif/bulletins.html

Please also refer to the psv/excel files* found on the Manitoba Health website under "Notices" here:
https://www.gov.mb.ca/health/pharmacare/healthprofessionals.html

***The psv/excel files contain the following information: DIN, PRODUCT NAME, UNIT PRICE (List Price + Allowable Markup) & LOWEST GENERIC PRICE (List Price + Allowable Markup).**
Information on allowable markup can be found here:
https://www.gov.mb.ca/health/pharmacare/profdocs/csp_pdrc.pdf

Inside This Issue

Drugs Provided at No Cost - Exception Drug Status Updates

02560445 02560453 02560461	**Sitagliptin/Metformin**	sitagliptin/metformin hydrochloride	50/500 mg 50/850 mg 50/1000 mg	Tablet	SAH

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 Sitagliptin, and for whom insulin is not an option.

Part 1 Additions

DIN	TRADE NAME	GENERIC	STRENGTH	FORM	MFR*
02545497	**Atorvastatin**	atorvastatin	80 mg	Tablets	TEV
02556618	**Auro-Atovaquone**	atovaquone	750 mg/5 mL	Oral Suspension	AUP
02529580	**Bimatoprost RC**	bimatoprost	0.01%	Ophthalmic Solution	JUP
02565773	**Jamp Bimatoprost Solution RC**	bimatoprost	0.01%	Ophthalmic Solution	JPC
02554372	**Jamp Doxycycline Tablets**	doxycycline	100 mg	Tablets	JPC
80023817	**Jamp-K-Citrate**	potassium citrate	1080 mg	Tablets	JPC
02525186 02525194 02525208	**Lisinopril (Type Z)**	lisinopril	5 mg 10 mg 20 mg	Tablets	SAH

* Abbreviation of Manufacturers' Name

Exception Drug Status Additions

02562677	**Apo-Enzalutamide**	enzalutamide	40 mg	Capsule	APX
02494736	**Auro-Enzalutamide**	enzalutamide	40 mg	Capsule	AUP
02515229	**Jamp Enzalutamide**	enzalutamide	40 mg	Capsule	JPC
02558424	**Reddy-Enzalutamide**	enzalutamide	40 mg	Capsule	DRL

Metastatic castration-sensitive prostate cancer:

- In combination with androgen deprivation therapy (ADT) for the treatment of patients with metastatic castration-sensitive prostate cancer (mCSPC).
- Patients must be castration sensitive (i.e., no prior ADT in the metastatic setting or within six months of beginning ADT), with good performance status and no risk factors for seizures.
- Treatment should be continued until unacceptable toxicity or disease progression.

Non-metastatic castration-resistant prostate cancer:

- In combination with androgen deprivation therapy (ADT) for the treatment of patients with non-metastatic castration-resistant prostate cancer (nmCRPC) who are at high risk of developing metastases.
- High risk is defined as a prostate-specific antigen doubling time (PSADT) of ≤10 months during continuous ADT. Patients should have good performance status and no risk factors for seizures. Treatment should continue until unacceptable toxicity or radiographic disease progression.

Metastatic castration-resistant prostate cancer:

- For the treatment of histologically confirmed metastatic castrate-resistant prostate cancer with disease progression after prior chemotherapy with Docetaxel.
- For the treatment of histologically confirmed metastatic castrate-resistant prostate cancer with disease progression after prior androgen deprivation therapy and no prior chemotherapy.

02545985 02545993	**Auro-Rufinamide**	rufinamide	200 mg 400 mg	Tablet	AUP

For the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome for patients who meet all of the following criteria:
• Are under the care of a physician experienced in treating Lennox-Gastaut syndrome associated seizures, AND
• Are currently receiving two or more antiepileptic drugs, AND
• In whom less costly antiepileptic drugs are ineffective or not appropriate.

Note: Rufinamide is not indicated for the treatment of any other type of seizure disorder.

02562022 02562030 02562049	**Avtozma**	tocilizumab	80 mg/4 mL 200 mg/10 mL 400 mg/20 mL	Vial	CHC
02562057	**Avtozma**	tocilizumab	162 mg/0.9 mL	Pre-Filled Syringe	CHC
02562065	**Avtozma**	tocilizumab	162 mg/0.9 mL	Autoinjector	CHC

Giant Cell Arteritis
For the 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.

Avtozma will be a preferred tocilizumab option for all tocilizumab-naïve patients prescribed a tocilizumab product for GCA. Preferred means the first tocilizumab product to be considered for reimbursement for tocilizumab-naïve patients. Patients will not be permitted to switch from Avtozma to another tocilizumab product or vice versa, if:
• Previously trialed and deemed unresponsive to tocilizumab.

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.

Avtozma will be a preferred tocilizumab option for all tocilizumab-naïve patients prescribed a tocilizumab product for pJIA. Preferred means the first tocilizumab product to be considered for reimbursement for tocilizumab-naïve patients. Patients will not be permitted to switch from Avtozma to another tocilizumab product or vice versa, if:
• Previously trialed and deemed unresponsive to tocilizumab.

Rheumatoid Arthritis
For the treatment of adult patients who have moderate to severe active rheumatoid arthritis (RA) and who:

i. Failed treatment with at least 3 DMARD therapies, one of which 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.

Tocilizumab can be given as monotherapy in cases of intolerance to methotrexate or where continued treatment with methotrexate is inappropriate.

<u>Avtozma IV:</u>
Approval will be provided for a maximum dose of up to 8mg per kg of body weight every 4 weeks, not to exceed 800mg in total in such 4-week period.

<u>Avtozma SC:</u>
For patients weighing less than 100kg, initial coverage may be approved for one 162mg dose of tocilizumab administered every other week. Dose may be increased up to weekly based on clinical response. For patients weighing 100kg or more, initial coverage may be approved for one 162mg dose of tocilizumab administered every week.

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

Avtozma will be a preferred tocilizumab option for all tocilizumab-naïve patients prescribed a tocilizumab product for RA. Preferred means the first tocilizumab product to be considered for reimbursement for tocilizumab-naïve patients. Patients will not be permitted to switch from Avtozma to another tocilizumab product or vice versa, if:
• Previously trialed and deemed unresponsive to tocilizumab.

Systemic Juvenile Idiopathic Arthritis
For the treatment of active systemic juvenile idiopathic arthritis (sJIA) in patients 2 years of age or older who have responded inadequately to previous therapy with:
i. One or more non-steroidal anti-inflammatory drugs; and
ii. One or more systemic corticosteroids.

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

Avtozma will be a preferred tocilizumab option for all tocilizumab-naïve patients prescribed a tocilizumab product for sJIA. Preferred means the first tocilizumab product to be considered for reimbursement for tocilizumab-naïve patients. Patients will not be permitted to switch from Avtozma to another tocilizumab product or vice versa, if:
• Previously trialed and deemed unresponsive to tocilizumab.

02541769	**Evkeeza**	evinacumab	150 mg/mL	Solution	UGX

For the treatment of adult and pediatric patients aged 5 years and older with homozygous familial hypercholesterolemia (HoFH) who meet all of the following conditions:

Initiation Criteria:
1. Clinically or genetically confirmed diagnosis of HoFH, defined as:

   (a) Clinical Criteria:
   i. Untreated total cholesterol (TC) > 12.93 mmol/L and triglycerides (TGs) < 3.39 mmol/L; AND
   ii. Both parents have documented TC > 6.47 mmol/L, indicative of heterozygous familial hypercholesterolemia (HeFH); OR
   History of cutaneous or tendinous xanthoma before 10 years of age.

   OR

   (b) Genetic Criteria:
   i. Documented functional mutation(s) in both low-density lipoprotein receptor (LDLR) alleles; OR
   ii. Documented homozygous or compound heterozygous mutations in apolipoprotein B (Apo B) or proprotein convertase subtilisin/kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1), or at least 2 such variants at different loci;

2. Elevated low-density lipoprotein cholesterol (LDL-C) despite an adequate trial of other accessible lipid-lowering therapies for at least 3 months, defined as LDL-C > 1.8 mmol/L for adults and > 3.4 mmol/L for children.
3. The physician must provide the pre-treatment baseline LDL-C when the initial request for reimbursement occurs after all other treatment options of lipid-lowering therapies have been exhausted.

   Pre-treatment baseline refers to the LDL-C level taken prior to initiation of evinacumab, rather than the untreated LDL-C level.
4. Evinacumab is used as an adjunct to diet and other LDL-C lowering therapies.

Initial approval duration: 6 months

Renewal Criteria:
For renewal after initial authorization and for subsequent renewals, the physician must provide proof of beneficial clinical effect, defined as a reduction in LDL-C from baseline that is considered clinically beneficial by the treating physician.

Renewal duration: 12 months

Prescribing Condition:
Evinacumab must be prescribed by, or in consultation with, specialists with qualifications and experience in the diagnosis and management of HoFH (e.g., [pediatric] endocrinologists, cardiologists, lipidologists).

02539888	**Livmarli**	maralixibat	9.5 mg/mL	Solution	MIR

For the treatment of cholestatic pruritus in patients 12 months of age and older with Alagille syndrome (ALGS) who meet all of the following criteria:

- Have moderate to severe itch defined as an average daily score of 2 or more on the Itch Reported Outcome (ItchRO) or Clinician Scratch Scale (CSS) for 2 consecutive weeks; AND
- Are currently treated with, or have received an adequate trial with, a systemic treatment for pruritus[1] prior to initiating maralixibat; AND
- Have evidence of cholestasis, with at least one of the following:
  - Total serum bile acids (sBA) > 3 × upper limit of normal (ULN) for age; OR
  - Conjugated bilirubin > 1 mg/dL; OR
  - Fat-soluble vitamin deficiency otherwise unexplainable; OR
  - gamma glutamyltransferase (GGT) > 3 × ULN for age; OR
  - Intractable pruritus explainable only by liver disease.

The patient must be under the care of a hepatologist or gastroenterologist with experience in the diagnosis and management of ALGS.

Exclusion Criteria:
Patients with ANY of the following will not be eligible for initiation of maralixibat coverage: biliary diversion, previous liver translplant, decompensated cirrhosis, or history or presence of other concomitant liver disease.

[1]Systemic treatment for pruritis may include a trial of at least one month with one of the following: ursodeoxycholic acid (UDCA), rifampin, sertraline, naltrexone, cholestyramine.

Initial Approval: 6 months

Initial Renewal Criteria:
Renewal of maralixibat coverage will be considered in patients who:
- Remain under the care of a hepatologist or gastroenterologist with experience in the diagnosis and management of ALGS; AND
- Have not received a liver transplant or biliary diversion surgery; AND
- Have experienced either:
  - An improvement in pruritus to minimal or no itch (a score of 1 or less on the ItchRO or CSS); OR
  - For patients who initiated treatment with severe itch (equivalent to an ItchRO or CSS score of 4), an improvement (decrease) in pruritis by a score of 1 point.

Initial Renewal Approval: 6 months

Subsequent Renewal Criteria:
Ongoing coverage of maralixibat will be considered in patients who:
- Remain under the care of a hepatologist or gastroenterologist with experience in the diagnosis and management of ALGS; AND
- Have not received a liver transplant or biliary diversion surgery; AND
- Have maintained the improvement in ItchRO or CSS demonstrated at the initial renewal.

Subsequent Renewal Approval: 6 months

Note:
- The ItchRO or CSS score must be provided at baseline and with each renewal request. The same measurement tool should be used on all renewals.

New Interchangeable Categories

BIMATOPROST — 0.01 % — Ophthalmic Solution			**$**	**$ + 5%**
02324997	Lumigan RC	ABV	12.4248	13.0460
02529580	Bimatoprost RC	JUP	6.0189	6.3198
02565773	Jamp Bimatoprost Solution RC	JPC	6.0189	6.3198

ENZALUTAMIDE — 40 mg — Capsules			$	$ + 5%
02407329	Xtandi	ASP	28.3450	29.7623
02562677	Apo-Enzalutamide	APX	7.2989	7.6638
02494736	Auro-Enzalutamide	AUP	7.2989	7.6638
02515229	Jamp Enzalutamide	JPC	7.2989	7.6638
02558424	Reddy-Enzalutamide	DRL	7.2989	7.6638

RUFINAMIDE — 200 mg — Tablets			$	$ + 5%
02369621	Banzel	EIS	1.8928	1.9874
02545985	Auro-Rufinamide	AUP	1.3749	1.4436

RUFINAMIDE — 400 mg — Tablets			$	$ + 5%
02369648	Banzel	EIS	4.1245	4.3307
02545993	Auro-Rufinamide	AUP	2.9959	3.1457

New Interchangeable Products

The following products have been added to existing interchangeable drug categories:

ATOVAQUONE — 750 mg/5 mL — Oral Suspension			$	$ + 5%
02556618	Auro-Atovaquone	AUP	1.5857	**1.6650

ATORVASTATIN — 80 mg — Tablets			$	$ + 5%
02545497	Atorvastatin	TEV	0.2342	0.2459

DOXYCYCLINE — 100 mg — Tablets			$	$ + 5%
02554372	Jamp Doxycycline Tablets	JPC	0.4560	0.4788

LISINOPRIL — 5 mg — Tablets			$	$ + 5%
02525186	Lisinopril (Type Z)	SAH	0.1347	**0.1414

LISINOPRIL — 10 mg — Tablets			$	$ + 5%
02525194	Lisinopril (Type Z)	SAH	0.1619	**0.1700

LISINOPRIL — 20 mg — Tablets			$	$ + 5%
02525208	Lisinopril (Type Z)	SAH	0.1945	**0.2042

SITAGLIPTIN/METFORMIN HYDROCHLORIDE — 50/500 mg — Tablets			$	$ + 5%
02560445	Sitagliptin/Metformin	SAH	0.4446	0.4668

SITAGLIPTIN/METFORMIN HYDROCHLORIDE — 50/850 mg — Tablets			$	$ + 5%
02560453	Sitagliptin/Metformin	SAH	0.4446	0.4668

SITAGLIPTIN/METFORMIN HYDROCHLORIDE— 50/1000 mg — Tablets			$	$ + 5%
02560461	Sitagliptin/Metformin	SAH	0.4446	0.4668

** The price has resulted in a change to the lowest price in the category.

Interchangeable Product Price Changes

The following changes in prices have occurred:

					($)	($ + 5%)
02240835	Advair 100 Diskus	fluticasone propionate/ salmeterol	100 mcg/50 mcg	Powder for Inhalation	1.6480	1.7304
02217481	Apo-Lisinopril	lisinopril	5 mg	Tablet	0.1347	**0.1414
02217503	Apo-Lisinopril	lisinopril	10 mg	Tablet	0.1619	**0.1700

02217511	Apo-Lisinopril	lisinopril	20 mg	Tablet	0.1945	**0.2042
02247813	Avodart	dutasteride	0.5 mg	Capsule	2.1613	2.6494
01916874	Clavulin 250 F	amoxicillin/clavulanic acid	250 mg/62.5 mg/ 5 mL	Oral Suspension	0.2600	0.2730
02238830	Clavulin 400	amoxicillin/clavulanic acid	400 mg/57 mg/ 5 mL	Oral Suspension	0.3664	0.3847
02238831	Clavulin 200	amoxicillin/clavulanic acid	200 mg/28.5mg/ 5 mL	Oral Suspension	0.1866	0.1959
02244291	Flovent HFA	fluticasone propionate	50 mcg/Dose	Metered Dose Inhaler	0.2707	0.2842
02244292	Flovent HFA	fluticasone propionate	125 mcg/Dose	Metered Dose Inhaler	0.4703	0.4938
02244293	Flovent HFA	fluticasone propionate	250 mcg/Dose	Metered Dose Inhaler	0.9407	0.9877
02528495	GLN-Atovaquone	atovaquone	750 mg/5 mL	Oral Suspension	1.5857	**1.6650
02212161	Imitrex DF	sumatriptan	100 mg	Tablet	21.1300	22.1865
02142082	Lamictal	lamotrigine	25 mg	Tablet	0.5238	0.5500
02142104	Lamictal	lamotrigine	100 mg	Tablet	2.0925	2.1971
02142112	Lamictal	lamotrigine	150 mg	Tablet	3.0837	3.2379
01940481	Paxil Tab 20mg	paroxetine	20 mg	Tablet	2.4240	2.5452
01940473	Paxil Tab 30mg	paroxetine	30 mg	Tablet	2.5770	2.7059
02560038	Reddy-Bosutinib	bosutinib	100 mg	Tablet	21.4383	**22.5102
02560046	Reddy-Bosutinib	bosutinib	500 mg	Tablet	83.7322	**87.9188
02285118	Teva-Lisinopril (Type Z)	lisinopril	5 mg	Tablet	0.1347	**0.1414
02285126	Teva-Lisinopril (Type Z)	lisinopril	10 mg	Tablet	0.1619	**0.1700
02285134	Teva-Lisinopril (Type Z)	lisinopril	20 mg	Tablet	0.1945	**0.2042
02219492	Valtrex	valacyclovir	500 mg	Tablet	4.4263	4.6476
02241497	Ventolin HFA	salbutamol	100 mcg/Dose	Metered Dose Inhaler	0.0402	0.0422

** The price has resulted in a change to the lowest price in the category.

Product Deletions

(as identified for discontinuation in Bulletin # 146)

The following products have been deleted.

02041448	Ativan	lorazepam	2 mg	Tablet
02459914	CCP-Citalopram	citalopram	20 mg	Tablet
00522724	Chlordiazepoxide	chlordiazepoxide hydrochloride	5 mg	Capsule
02301490	Cymbalta	duloxetine	60 mg	Capsule
02301482	Cymbalta	duloxetine	30 mg	Capsule
02241795	Procytox Tab 25mg	cyclophosphamide	25 mg	Tablet
02245688	Ratio-Topisalic	betamethasone/salicylic acid	0.5/20mg/g	Lotion
02415100	Taro-Zoledronic Acid	zoledronic acid	5mg/100mL	Solution

Interchangeable Category Deletions

PHENYTOIN — 25 mg/mL — Oral Liquid
TESTOSTERONE — 40 mg — Capsules

Discontinued Products

The following products will be deleted with the next Formulary amendments and will appear as "Product Deletions" on Bulletin # 148

02333864	Janumet	sitagliptin/metformin hydrochloride	50 mg/850 mg	Tablet
01940473	Paxil Tab 30mg	paroxetine	30 mg	Tablet
02322498	pms-Testosterone	testosterone	40 mg	Capsule