BULLETIN # 150

Manitoba Drug Benefits and Manitoba Drug Interchangeability Formulary Amendments

The following amendments will take effect on September 1, 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 September 1, 2026

Bulletin 150 is currently available for download:
https://www.gov.mb.ca/health/mdbif/bulletins.html

Pharmacies are responsible for confirming product availability and any applicable procurement requirements for listed products.

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

Part 1 Additions	Page 1
Exception Drug Status Additions	Page 1-4
New Interchangeable Categories	Page 4-5
New interchangeable Products	Page 5-6
Interchangeable Product Price Changes	Page 6
Product Deletions	Page 6-7
Discontinued Products	Page 7

Part 1 Additions

DIN	TRADE NAME	GENERIC	STRENGTH	FORM	MFR*
02564955	**Auro-Mirabegron**	mirabegron	50 mg	Extended Release Tablet	AUP
02550423	**Cabtreo**	adapalene/ benzoyl peroxide/ clindamycin phosphate	0.15%/ 3.1%/ 1.2%	Gel	BHC
02540584	**Jamp Anastrozole Tablets**	anastrozole	1 mg	Tablet	JPC
02543435	**Jamp Domperidone Tablets**	domperidone	10 mg	Tablet	JPC
02558084 02558092 02558106	**Jamp Pravastatin Tablets**	pravastatin sodium	10 mg 20 mg 40 mg	Tablet	JPC
02561417	**NRA-Amoxicillin**	amoxicillin	500 mg	Capsule	NRA
02567776 02567784 02567792	**Octreotide Depot**	octreotide	10 mg/vial 20 mg/vial 30 mg/vial	Powder for Injection	SMI
02565587	**Taro-Sodium Fusidate**	sodium fusidate	2%	Ointment	SUN

* Abbreviation of Manufacturers' Name

Exception Drug Status Additions

02525267 02553619	**Bimzelx** *(new DIN, new indications)*	bimekizumab	160 mg/mL 320 mg/2 mL	Prefilled Syringe	UCB
02525275 02553627	**Bimzelx** *(new DIN, new indications)*	bimekizumab	160 mg/mL 320 mg/2 mL	Auto-Injector	UCB

Plaque Psoriasis

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

- Psoriasis Area and 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.

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.

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.

02559323 02559331	**Lupin-Letermovir**	letermovir	240 mg 480 mg	Tablet	LPC

For the prophylaxis therapy of cytomegalovirus (CMV) infection in adult CMV seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT), AND meeting the following criteria:

- Umbilical cord blood as stem cell source or
- Patient is a haploidentical recipient, or
- Recipients of T-cell depleted grafts, or
- Recipients treated with antithymocyte globulin (ATG) for conditioning, or
- Recipients requiring high-dose steroids (defined as the use of greater than or equal to 1 mg/kg/day of prednisone or equivalent dose of another corticosteroid) or other immunosuppression for acute graft versus host disease (GVHD), OR
- Recipients treated with ATG for steroid-refractory acute - GVHD treatment, or
- Recipients with documented history of CMV disease prior to transplantation.

AND

- Patients must have undetectable CMV viremia at baseline
- Treatment is being prescribed by clinicians with expertise in the management of HSCT such as medical oncologists, hematologists, or infectious disease specialists.
- The maximum dosage will not exceed 480 mg administered orally or intravenously per day.
- The duration of treatment will not exceed 100 days, per patient, per HSCT procedure.

02544555 02544563 02544571	**Myalepta**	metreleptin	3 mg/ vial 5.8 mg/ vial 11.3 mg/ vial	Injection	CHI

As an adjunct to diet as a replacement therapy to treat the complications of leptin deficiency in lipodystrophy (LD) patients:
• with confirmed congenital generalised LD (Berardinelli-Seip syndrome) or acquired generalised LD (Lawrence syndrome) in adults and children 2 years of age and above.
• with confirmed familial partial LD (PL) or acquired PL (Barraquer-Simons syndrome), in adults and children 12 years of age and above with persistent significant metabolic disease for whom standard treatments* have failed to achieve adequate metabolic control only if the following conditions are met:

Initiation Criteria
In patients with either of the following:
• Confirmed congenital generalized lipodystrophy (GL) (Berardinelli-Seip syndrome) or acquired GL (Lawrence syndrome) in adults and children aged 2 years and older with at least 1 metabolic abnormality (diabetes mellitus, insulin resistance, or hypertriglyceridemia).
• Confirmed familial PL or acquired PL in adults and children aged 12 years and older with persistent significant metabolic abnormalities (as defined by baseline hemoglobin A1C ≥ 6.5% and/or fasting TGs ≥ 5.65 mmol/L), for whom standard treatments* have failed to achieve adequate metabolic control after at least 12 months since initiating standard treatments*.

*For Clarity, standard treatments are defined as optimized regimens of diet and exercise, antihyperglycemics and and lipid-lowering medications.

Genetic testing must be conducted:
• If genetic testing is positive, then diagnosis is confirmed and treatment with metreleptin can be initiated.
• If after conducting genetic testing, LD is not confirmed, treatment can be initiated in patients with confirmed clinical diagnosis based on a comprehensive clinician assessment and who have fasting leptin levels of <12.0 ng/mL in females and < 8.0 ng/mL in males older than 5 years of age or < 6 ng/mL in children ages 6 months to 5 years.

Patients should not be pregnant or lactating or have HIV-associated LD.

The maximum duration of initial authorization is 12 months.

Renewal
For renewal after initial authorization, the physician must provide proof of beneficial metabolic effect when requesting continuation of reimbursement, defined as 1 or both of the following:
• Actual hemoglobin A1C reduction of at least 0.5% from baseline,
• Percent fasting TG reduction of at least 15% from baseline.

The physician must provide proof of maintenance of reduction in HbA1C and/or fasting TG from baseline every 12 months for subsequent authorizations.

Prescribing
Prescribing should be limited to endocrinologists or pediatric endocrinologists with expertise in treating LD.

02528592 02528606 02528622 02528630	**Sandoz Tacrolimus XR**	tacrolimus	0.5 mg 1 mg 3 mg 5 mg	Extended Release Capsule	SDZ

• For prophylaxis of organ rejection in adult patients receiving allogeneic kidney transplants.
• For prophylaxis of organ rejection in patients receiving allogeneic liver transplants.

02548909	**Wainua**	eplontersen	45 mg/0.8 mL	Pre-Filled Autoinjector	AZC

Initiation Criteria
For the treatment of polyneuropathy in patients with hereditary transthyretin-mediated amyloidosis (hATTR), meeting all the following criteria:
1. Age 18 years of age or older; AND
2. Has a confirmed genetic diagnosis of hereditary transthyretin-mediated amyloidosis; AND
3. Symptomatic with polyneuropathy disability (PND) stage I to less than or equal to IIIB or with familial amyloidotic polyneuropathy (FAP) stage I or II; AND
4. Under the care of a specialist with experience in the diagnosis and management of hATTR.

Exclusion Criteria
• Pre-symptomatic patients
• Patients diagnosed with severe heart failure symptoms (defined as New York Heart Association class III or IV)
• Patients who are recipients of a liver transplant
• Patients who will be using eplontersen in combination with other interfering ribonucleic acid drugs or transthyretin stabilizers used to treat hATTR.

Discontinuation Criteria
Treatment with eplontersen will be discontinued for patients who are:
• Permanently bedridden and dependent on assistance for basic activities of daily living, or
• Receiving end-of-life/palliative care where survival of less than one year is expected.

Renewal Criteria
Renewal of funding will be considered if patients do not meet the discontinuation criteria.

Patients should be assessed after 9 months of treatment and then every six months thereafter.

Duration of Approval of initiation requests: 10 months
Duration of Approval of first renewal: 6 months
Duration of Approval of 2nd and subsequent renewals: 1 year

Notes to Prescribers:
• Laboratory documentation for genetic mutation for hATTR must be included with the application.
• Signs and symptoms of polyneuropathy should be listed.
• In your application, please list all drugs that the patient is using including whether they are using any of the following: diflunisal, inotersen, tafamidis, patisiran, vutrisiran.
• Confirmation that the patient does not meet each of the listed exclusions must be provided on the request.

Definitions
Familial Amyloid Polyneuropathy (FAP) stage: Clinical staging system for the neuropathy symptoms of hATTR (formerly termed familial amyloid neuropathy).

- FAP Stage 1: Walking without assistance, mild neuropathy (sensory, autonomic, and motor) in lower limbs
- FAP Stage 2: Walking with assistance, moderate impairment in lower limbs, trunk, and upper limbs
- FAP Stage 3: Wheelchair or bed-ridden, severe neuropathy

Polyneuropathy disability score (PND): A five-stage measure of neuropathy impairment ranging from 0 (no impairment) to 4 (confined to a wheelchair or bedridden).

- Stage 0: no impairment
- Stage I: sensory disturbances but preserved walking capability
- Stage II: impaired walking capability but ability to walk without a stick or crutches
- Stage IIIA: walking only with the help of one stick or crutch
- Stage IIIB: walking with the help of two sticks or crutches
- Stage IV: confined to a wheelchair or bedridden

New Interchangeable Categories

LETERMOVIR — 240 mg — Tablets			$	$ + 5%
02469375	Prevymis	MFX	238.7160	250.6518
02559323	Lupin-Letermovir	LPC	179.0370	187.9889

LETERMOVIR — 480 mg — Tablets			$	$ + 5%
02469383	Prevymis	MFX	238.7160	250.6518
02559331	Lupin-Letermovir	LPC	179.0370	187.9889

LEVOTHYROXINE SODIUM — 25 mcg — Tablets			$	$ + 5%
02172062	Synthroid	BGP	0.1135	0.1192
02550709	Apo-Levothyroxine	APX	0.0597	0.0627

LEVOTHYROXINE SODIUM — 50 mcg — Tablets			$	$ + 5%
02172070	Synthroid	BGP	0.0779	0.0818
02550717	Apo-Levothyroxine	APX	0.0373	0.0392
02213192	Eltroxin	ASH	0.0373	0.0392

LEVOTHYROXINE SODIUM — 75 mcg — Tablets			$	$ + 5%
02172089	Synthroid	BGP	0.1226	0.1287
02550725	Apo-Levothyroxine	APX	0.0646	0.0678

LEVOTHYROXINE SODIUM — 88 mcg — Tablets			$	$ + 5%
02172097	Synthroid	BGP	0.1226	0.1287
02550733	Apo-Levothyroxine	APX	0.0646	0.0678

LEVOTHYROXINE SODIUM — 100 mcg — Tablets			$	$ + 5%
02172100	Synthroid	BGP	0.0961	0.1009
02534681	Apo-Levothyroxine	APX	0.0460	0.0483
02213206	Eltroxin	ASH	0.0460	0.0483

LEVOTHYROXINE SODIUM — 112 mcg — Tablets			$	$ + 5%
02171228	Synthroid	BGP	0.1295	0.1360
02550741	Apo-Levothyroxine	APX	0.0682	0.0716

LEVOTHYROXINE SODIUM — 125 mcg — Tablets			$	$ + 5%
02172119	Synthroid	BGP	0.1309	0.1374
02550768	Apo-Levothyroxine	APX	0.0690	0.0725

LEVOTHYROXINE SODIUM — 137 mcg — Tablets			$	$ + 5%
02233852	Synthroid	BGP	0.2215	0.2326
02550776	Apo-Levothyroxine	APX	0.1801	0.1891

LEVOTHYROXINE SODIUM — 150 mcg — Tablets			$	$ + 5%
02172127	Synthroid	BGP	0.1029	0.1080
02550784	Apo-Levothyroxine	APX	0.0495	0.0520
02213214	Eltroxin	ASH	0.0495	0.0520

LEVOTHYROXINE SODIUM — 175 mcg — Tablets			$	$ + 5%
02172135	Synthroid	BGP	0.1406	0.1476
02550792	Apo-Levothyroxine	APX	0.0740	0.0777

LEVOTHYROXINE SODIUM — 200 mcg — Tablets			$	$ + 5%
02172143	Synthroid	BGP	0.1098	0.1153
02550806	Apo-Levothyroxine	APX	0.0526	0.0552
02213222	Eltroxin	ASH	0.0526	0.0552

LEVOTHYROXINE SODIUM — 300 mcg — Tablets			$	$ + 5%
02172151	Synthroid	BGP	0.1515	0.1591
02534703	Apo-Levothyroxine	APX	0.0797	0.0837

OCTREOTIDE — 10 mg — Powder for Injection			$	$ + 5%
02239323	Sandostatin LAR	NVT	660.4650	693.4883
02567776	Octreotide Depot	SMI	363.2558	381.4186

OCTREOTIDE — 20 mg — Powder for Injection			$	$ + 5%
02239324	Sandostatin LAR	NVT	853.2952	895.9600
02567784	Octreotide Depot	SMI	469.3095	492.7750

SODIUM FUSIDATE — 2% — Ointment			$	$ + 5%
00586676	Fucidin Ointment 2%	LEO	1.0236	1.0748
02565587	Taro-Sodium Fusidate Ointment	SUN	0.8402	0.8822

New Interchangeable Products

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

AMOXICILLIN — 500 mg — Capsules			$	$ + 5%
02561417	NRA-Amoxicillin	NRA	0.1308	0.1373

ANASTROZOLE — 1 mg — Tablets			$	$ + 5%
02540584	Jamp Anastrozole Tablets	JPC	0.9522	1.0000

DOMPERIDONE — 10 mg — Tablets			$	$ + 5%
02543435	Jamp Domperidone Tablets	JPC	0.0428	0.0449

MIRABEGRON — 50 mg — Extended Release Tablets			$	$ + 5%
02564955	Auro-Mirabegron	AUP	0.7300	**0.7665

OCTREOTIDE — 30 mg — Powder for Injection			$	$ + 5%
02567792	Octreotide Depot	SMI	547.3800	**574.749

PRAVASTATIN SODIUM — 10 mg — Tablets			$	$ + 5%
02558084	Jamp Pravastatin Tablets	JPC	0.2916	0.3062

PRAVASTATIN SODIUM — 20 mg — Tablets			$	$ + 5%
02558092	Jamp Pravastatin Tablets	JPC	0.3440	0.3612

PRAVASTATIN SODIUM — 40 mg — Tablets				**$**	**$ + 5%**
	02558106	Jamp Pravastatin Tablets	JPC	0.4143	0.4351

** 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%)**
02441934	ACT Methylphenidate ER	methylphenidate hydrochloride	18 mg	Extended Release Tablet	0.5246	**0.5508
02441942	ACT Methylphenidate ER	methylphenidate hydrochloride	27 mg	Extended Release Tablet	0.6055	**0.6358
02441950	ACT Methylphenidate ER	methylphenidate hydrochloride	36 mg	Extended Release Tablet	0.6863	**0.7206
02441969	ACT Methylphenidate ER	methylphenidate hydrochloride	54 mg	Extended Release Tablet	0.8479	**0.8903
02475375	Apo-Ambrisentan	ambrisentan	5 mg	Tablet	62.5464	**65.6737
02452731	Apo-Methylphenidate ER	methylphenidate hydrochloride	18 mg	Extended Release Tablet	0.5246	**0.5508
02452758	Apo-Methylphenidate ER	methylphenidate hydrochloride	27 mg	Extended Release Tablet	0.6055	**0.6358
02452766	Apo-Methylphenidate ER	methylphenidate hydrochloride	36 mg	Extended Release Tablet	0.6863	**0.7206
02330377	Apo-Methylphenidate ER	methylphenidate hydrochloride	54 mg	Extended Release Tablet	0.8479	**0.8903
02564971	Apo-Mirabegron	mirabegron	50 mg	Extended Release Tablet	0.7300	**0.7665
02545985	Auro-Rufinamide	rufinamide	200 mg	Tablet	1.0083	**1.0587
02545993	Auro-Rufinamide	rufinamide	400 mg	Tablet	2.1970	**2.3069
02521938	Jamp Ambrisentan	ambrisentan	5 mg	Tablet	62.5464	**65.6737
02517450	Jamp-Quinapril	quinapril	10 mg	Tablet	0.4642	**0.4874
02340569	pms-Quinapril	quinapril	10 mg	Tablet	0.4642	**0.4874

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

Product Deletions

(as identified for discontinuation in Bulletin # 149)

The following products have been deleted.

02487608 02487616 02487632	AG-Olanzapine FC	olanzapine	2.5 mg 5 mg 10 mg	Tablet
01926691	Calcimar	calcitonin	200 U/mL	Injection
02458802	CCP-Ondansetron	ondansetron	8 mg	Tablet

02458810	CCP-Ondansetron	ondansetron	4 mg	Tablet
02503786	Octreotide For Injectable Suspension	octreotide	30 mg/Vial	Powder for Injection
00636622	Prozac Capsules 20mg	fluoxetine	20 mg	Capsule
02269023	Tarceva	erlotinib	150 mg	Tablet
02229639	Zofran	ondansetron	4 mg/5 mL	Oral Solution

Discontinued Products

The following products will be deleted with the next Formulary amendments and will appear as "Product Deletions" on Bulletin # 151

02350114 02350106 02350092 02424770 02483327	Actemra	tocilizumab	400 mg/20 mL 200 mg/10 mL 80 mg/4 mL 162 mg/0.9 mL 162 mg/0.9 mL	Injection
02248500	Apo-Quinapril	quinapril	10 mg	Tablet
02515377	Brimonidine Tartrate Ophthalmic Solution	brimonidine	0.02%	Ophthalmic Solution
-	Omnipod	reservoir	-	Pods
02526875	Sandoz Ambrisentan Tablets	ambrisentan	5 mg	Tablet
00432814	Sandoz Fluorometholone	fluorometholone	0.1%	Ophthalmic Solution
02487454	Skyrizi	risankizumab	90 mg/mL	Prefilled Syringe
02047454	Sporanox	itraconazole	10 mg	Capsule
02491559	Ultomiris	ravulizumab	10 mg/ml	Injection
02260565 02459795	Xolair	omalizumab	150 mg/vial 150 mg/1 mL	Injection