M.O., 2006-002

Order of the Minister of Health and Social Services making the Regulation to amend the Regulation respecting the List of medications covered by the basic prescription drug insurance plan dated 18 January 2006

An Act respecting prescription drug insurance (R.S.Q., c. A-29.01; 2002, c. 27)

THE MINISTER OF HEALTH AND SOCIAL SERVICES,

CONSIDERING section 60 of the Act respecting prescription drug insurance (R.S.Q., c. A-29.01; 2002, c. 27, s. 22, par. 3);

CONSIDERING Order 1999-014 dated 15 September 1999 of the Minister of State for Health and Social Services and Minister of Health and Social Services making the Regulation respecting the List of medications covered by the basic prescription drug insurance plan;

CONSIDERING that it is necessary to amend the List of medications attached to that Regulation;

CONSIDERING that the Conseil du médicament has been consulted on the draft regulation;

MAKES the Regulation to amend the Regulation respecting the List of medications covered by the basic prescription drug insurance plan, the text of which is attached hereto.

Québec, 18 January 2006

PHILIPPE COUILLARD,
Minister of Health and Social Services

Regulation to amend the Regulation respecting the List of medications covered by the basic prescription drug insurance plan *

An Act respecting prescription drug insurance (R.S.Q., c. A-29.01, s. 60; 2002, c. 27. s. 22, par. 3)

1. The Regulation respecting the List of medications covered by the basic prescription drug insurance plan is amended, in the List of medications attached thereto, in Appendix I entitled "Manufacturers That Have Submitted Different Guaranteed Selling Prices for Wholesalers and Pharmacists":

(1) by inserting the following after the line concerning the manufacturer "Odan":

"* Oméga Laboratoires Oméga Ltée 5%";

(2) by replacing the line concerning the manufacturer "Prempharm" by the following:

"* Prempharm Prempharm Inc. 5%".

2. The List of medications, attached to the Regulation, is amended in Appendix III entitled "Products for Which the Wholesaler's Mark-up is Limited to a Maximum Amount":

(1) by deleting the line concerning the medication "Selegiline Tab. 5 mg";

* The Regulation respecting the List of medications covered by the basic prescription drug insurance plan, made by Minister's Order 1999-014 dated 15 September 1999 (1999, *G.O.* 2, 3197) of the Minister of State for Health and Social Services and Minister of Health and Social Services, was last amended by Minister's Orders 2003-010 dated 10 September 2003 (2003, *G.O.* 2, 2915A), 2003-012 dated 28 October 2003 (2003, *G.O.* 2, 3288), 2003-013 dated 2 December 2003 (2003, *G.O.* 2, 3472), 2004-002 dated 19 January 2004 (2004, *G.O.* 2, 828), 2004-006 dated 15 April 2004 (2004, *G.O.* 2, 1376), 2004-008 dated 17 June 2004 (2004, *G.O.* 2, 2028), 2004-013 dated 21 September 2004 (2004, *G.O.* 2, 2864), 2004-015 dated 15 November 2004 (2004, *G.O.* 2, 3157), 2004-019 dated 13 December 2004 (2004, *G.O.* 2, 3613), 2005-001 dated 20 January 2005 (2005, *G.O.* 2, 491), 2005-06 dated 13 May 2005 (2005, *G.O.* 2, 1381), 2005-011 dated 28 July 2005 (2005, *G.O.* 2, 3273), 2005-015 dated 14 September 2005 (2005, *G.O.* 2, 4409) and 2005-016 dated 7 October 2005 (2005, *G.O.* 2, 4512) of that Minister. For previous amendments, refer to the *Tableau des modifications et Index sommaire*, Éditeur officiel du Québec, 2005, updated to 1 September 2005.

(2) by inserting the following after the line concerning the medication "Avonex I.M. Inj. Pd 30 mcg (6 MUI)":

"Biogen	Avonex PS I.M. Inj. Sol. 30 mcg (6 MUI)	4";

(3) by inserting the following after the line concerning the medication "Eprex Syringe 10 000 UI/1,0 mL":

"J.O.I.	Eprex Syringe 40 000 UI/mL (1 mL)	1";

(4) by inserting the following after the medication "Fuzeon S.C. Inj. Pd 108 mg":

"Genpharm	Gen-Pravastatin Tab. 10 mg	1 000
Genpharm	Gen-Pravastatin Tab. 20 mg	1 000";

(5) by inserting the following after the line concerning the medication "Kaletra Caps. 133,3 mg-33,3 mg":

"GSK	Kivexa Tab. 600 mg-300 mg	30";

(6) by inserting the following after the line concerning the medication "Suprefact Depot 3 mois Implant 9,45 mg":

"Roche	Tarceva Tab. 100 mg	30
Roche	Tarceva Tab. 150 mg	30";

(7) by inserting the following after the line concerning the medication "Vesanoid Caps. 10 mg":

"AllergiLab	Vespides combines Inj. Pd 3,3 mg	1".

3. The List of medications is amended in Appendix IV entitled "Exceptional Medications, With Recognized Indications for Payment Purposes":

(1) by deleting the following:

"TENOFOVIR DISOPROXIL FUMARATE:

♦ for treatment of HIV-infected persons who have used two NRTIs that proved either ineffective, or intolerable to the point of raising doubts regarding continuation of the treatment;";

(2) by inserting, in alphabetical order of the exceptional medications, the following medications and the accompanying indications:

"DRESSING – INTERFACE:

♦ to facilitate the treatment of persons suffering from very painful severe burns;

DRESSING – SILVER:

♦ for treatment of persons suffering from severe burns or severe chronic wounds (affecting the subcutaneous tissue) with critical colonization by at least one pathogen, documented by a bacterial culture from the debrided wound base. The request is authorized for a maximum of 12 weeks.

Critical colonization is defined by the presence of at least one pathogen, documented by a culture, in a severe wound, showing the following clinical signs: increased exudate, friable granulation tissue, stagnation in the scarring process, accentuated odour, accentuated pain and inflammation less than two cm from the edge. Critical colonization of a chronic wound, if it persists, may lead to infection of the chronic wound with systemic signs or symptoms;

ERLOTINIB HYDROCHLORIDE:

♦ for treatment of locally advanced or metastatic non-small-cell lung cancer in persons;

• for whom a first-line therapy has failed and who are not eligible for other chemotherapy, or for whom a second-line therapy has failed and

• who do not have cerebral metastases and

• whose ECOG performance status is = 3.

The maximum duration of each authorization is three months. Upon subsequent requests, the physician must provide evidence of a beneficial clinical effect (absence of disease progression);

ROSIGLITAZONE MALEATE / METFORMIN HYDROCHLORIDE:

♦ in type-2 diabetic persons under treatment with metformin and a thiazolidinedione and whose daily doses have been stable for at least three months. These persons must also fulfill the requirements of the recognized payment indication for thiazolidinediones;";

(3) by replacing the indication accompanying the medication "ADALIMUMAB" by the following:

"♦ for treatment of moderate or severe rheumatoid arthritis;

Upon initiation of treatment or if the person has been receiving the drug for less than five months:

• the person must, prior to the beginning of treatment, have eight or more joints with active synovitis and one of the following five elements must be present:

— a positive rheumatoid factor;

— radiologically measured erosions;

— a score of more than 1 on the health assessment questionnaire (HAQ);

— an elevated C-reactive protein level;

— an elevated sedimentation rate;

and

• the disease must still be active despite treatment with two disease-modifying anti-rheumatic drugs, used either concomitantly or not, for at least three months each. Unless there is a significant intolerance or contraindication, one of the two drugs must be methotrexate at a dose of 20 mg or more per week.

The initial request is authorized for a maximum of five months.

When requesting continuation of treatment, the physician must provide information establishing the treatment's beneficial effects, specifically:

• a decrease of at least 20% in the number of joints with active synovitis and one of the following four elements:

— a decrease of 20% or more in the C-reactive protein level;

— a decrease of 20% or more in the sedimentation rate;

— a decrease of 0.20 in the HAQ score;

— a return to work.

Requests for continuation of treatment are authorized for a period of 12 months.

Authorizations for adalimumab are given for a dose of 40 mg every two weeks;";

(4) by replacing the first indication accompanying the medication "CAPECITABINE" by the following:

"♦ for treatment of advanced or metastatic breast cancer that has not responded to first-line chemotherapy administered during the advanced or metastatic phase, unless such chemotherapy is contraindicated;";

(5) concerning the medication "ETANERCEPT":

(a) by replacing the first indication accompanying it by the following:

"♦ for treatment of moderate or severe rheumatoid arthritis and moderate or severe psoriasic arthritis of the rheumatoid type;

Upon initiation of treatment or if the person has been receiving the drug for less than five months:

• the person must, prior to the beginning of treatment, have eight or more joints with active synovitis and one of the following five elements must be present:

— a positive rheumatoid factor for rheumatoid arthritis only;

— radiologically measured erosions;

— a score of more than 1 on the health assessment questionnaire (HAQ);

— an elevated C-reactive protein level;

— an elevated sedimentation rate;

and

• the disease must still be active despite treatment with two disease-modifying anti-rheumatic drugs, used either concomitantly or not, for at least three months each. Unless there is a significant intolerance or contraindication, one of the two drugs must be:

for rheumatoid arthritis: methotrexate at a dose of 20 mg or more per week;

for psoriasic arthritis of the rheumatoid type:

— methotrexate at a dose of 20 mg or more per week;

or

— sulfasalazine at a dose of 2 000 mg per day.

The initial request is authorized for a maximum of five months.

When requesting continuation of treatment, the physician must provide information making it possible to establish the treatment's beneficial effects, specifically:

• a decrease of at least 20% in the number of joints with active synovitis and one of the following four elements:

— a decrease of 20% or more in the C-reactive protein level;

— a decrease of 20% or more in the sedimentation rate;

— a decrease of 0.20 in the HAQ score;

— a return to work.

Requests for continuation of treatment are authorized for a period of 12 months.

Authorizations for etanercept are given for a dose of 50 mg per week;";

(b) by adding the following indication after the indications accompanying it:

"♦ for treatment of persons suffering from moderate or severe ankylosing spondylitis whose BASDAI score is ≥ 4 on a scale of 0 to 10 and in whom the sequential use of two non-steroidal anti-inflammatories at the optimum dose for a period of three months each did not adequately control the disease;

• Upon the initial request, the physician must provide the following information:

— the BASDAI score;

— the degree of functional injury, according to the BASFI (scale of 0 to 10);

The initial request will be authorized for a maximum of five months.

• When requesting a continuation of treatment, the physician must provide information showing the beneficial effects of the treatment, specifically:

— a decrease of 2.2 points or 50% on the BASDAI scale, compared with the pre-treatment score;

or

— a decrease of 1.5 points or 43% on the BASFI scale;

or

a return to work.

Requests for continuation of treatment will be authorized for maximum periods of 12 months.

Authorizations for etanercept are given for a maximum of 50 mg per week;";

(6) by replacing the second indication accompanying the medication "NUTRITIONAL FORMULAS – MONOMERIC" by the following:

"♦ for total oral feeding of persons requiring monomeric nutritional formulas as their source of nutrition in presence of severe maldigestion or malabsorption disorders and for whom polymeric formulas are not recommended or not tolerated;";

(7) by adding the following after the indication accompanying the medication "GLATIRAMER ACETATE":

"For persons who previously received an interferon beta-1a for treatment of the first acute clinical episode with documented demyelinization, the interval between the two episodes may exceed two years;";

(8) by adding the following indication after the indications accompanying the medication "IMATINIB MESYLATE":

"♦ in adults suffering from refractary or recidivant acute lymphoblastic leukemia with a positive Philadelphia chromosome and for whom a stem cell transplant is foreseeable.

The maximum duration of each authorization is three months. Upon subsequent requests, the physician must provide evidence of a beneficial clinical effect (absence of disease progession);";

(9) concerning the medication "INFLIXIMAB":

(a) by striking out the losange preceding the third paragraph of the first indication accompanying it, in the French version of the List;

(b) by replacing the third indication accompanying it by the following:

"♦ for treatment of moderate or severe rheumatoid arthritis;

Upon initiation of treatment or if the person has been receiving the medication for less than five months :

• the person must, prior to the beginning of treatment, have eight or more joints with active synovitis and one of the following five elements must be present :

— a positive rheumatoid factor ;

— radiologically measured erosions ;

— a score of more than 1 on the health assessment questionnaire (HAQ) ;

— an elevated C-reactive protein level ;

— an elevated sedimentation rate ;

and

• the disease must still be active despite treatment with two disease-modifying anti-rheumatic medications, used either concomitantly or not, for at least three months each. Unless there is a significant intolerance or contraindication, one of the two drugs must be methotrexate at a dose of 20 mg or more per week.

The initial request is authorized for a maximum of five months.

When requesting continuation of treatment, the physician must provide information establishing the treatment's beneficial effects, specifically :

• a decrease of at least 20% in the number of joints with active synovitis and one of the following four elements :

— a decrease of 20% or more in the C-reactive protein level ;

— a decrease of 20% or more in the sedimentation rate ;

— a decrease of 0.20 in the HAQ score ;

— a return to work.

Requests for continuation of treatment are authorized for a period of 12 months.

Authorizations for infliximab are given for three doses of 3 mg/kg, with the possibility of increasing the dose to 5 mg/kg after three doses or in the 14th week ;" ;

(c) by adding the following indication after the indications accompanying it :

"♦ for treatment of persons suffering from moderate or severe ankylosing spondylitis whose BASDAI score is ≥ 4 on a scale of 0 to 10 and in whom the sequential use of two non-steroidal anti-inflammatories at the optimum dose for a period of three months each did not adequately control the disease ;

• Upon the initial request, the physician must provide the following information :

— the BASDAI score ;

— the degree of functional injury, according to the BASFI (scale of 0 to 10) ;

The initial request will be authorized for a maximum of five months.

• When requesting a continuation of treatment, the physician must provide information showing the beneficial effects of the treatment, specifically :

— a decrease of 2.2 points or 50% on the BASDAI scale, compared with the pre-treatment score ;

or

— a decrease of 1.5 points or 43% on the BASFI scale ;

or

a return to work.

Requests for continuation of treatment will be authorized for maximum periods of 12 months.

Authorizations for infliximab are given for a maximum of 5 mg/kg in weeks 0, 2 and 6 and then every 6 to 8 weeks ;" ;

(10) by replacing, in both indications accompanying the medication "INTERFERON ALFA-2B (PEGYLATED)", the sentence "The authorization will be renewed if the decrease in the HCV-RNA is greater than or equal to 2 log after 12 weeks of treatment." by the sentence "The authorization will be renewed if the decrease in the HCV-RNA is greater than or equal to 1.8 log after 12 weeks of treatment." ;

(11) by replacing the medication "INTERFERON BETA-1A, i.m. inj. pd." and the accompanying indications by the following medication and the accompanying indications:

"INTERFERON BETA-1A, i.m. inj. pd. and i.m. inj. sol.:

♦ for treatment of persons who have had a documented first acute clinical episode of demyelinization.

The physician must provide, at the beginning of treatment, the results of an MRI showing:

• the presence of four or more lesions of the white substance, including a lesion located in the cerebellum, the corpus callosum or the periventricular region;

and

• one such lesion having a diameter of 6 mm or more.

Authorizations are given for 30 mcg once per week.

The maximum duration of the initial authorization is 12 months. When submitting subsequent requests, the physician must provide evidence of a beneficial effect (absence of new clinical episodes);

♦ for treatment of persons suffering from remitting multiple sclerosis who have had two or more episodes of the disease within the last two years and whose EDSS scale result is less than 7.

The physician must provide, at the beginning of treatment and with each subsequent request, the following information: number of attacks per year and EDSS scale result.

The maximum duration of the initial authorization is six months. When submitting subsequent requests, the physician must provide evidence of a beneficial effect (absence of deterioration);

For persons who previously received an interferon beta-1a for treatment of the first acute clinical episode with documented demyelinization, the interval between the two episodes may exceed two years;

♦ for treatment of persons suffering from secondary progressive multiple sclerosis who have had clinical episodes of the disease and whose EDSS scale result is less than 7.

The physician must provide, at the beginning of treatment and with each subsequent request, the following information: number of attacks per year and EDSS scale result.

The maximum duration of the initial authorization is 12 months. When submitting subsequent requests, the physician must provide evidence of a beneficial effect (absence of deterioration).

Authorizations are given for 30 mcg once per week;";

(12) by replacing the second indication accompanying the medication "INTERFERON BETA-1A, s.c. inj. sol. (syr.)" by the following:

"♦ for treatment of persons suffering from remitting multiple sclerosis who have had two or more episodes of the disease within the last two years and whose EDSS scale result is less than 7.

The physician must provide, at the beginning of treatment and with each subsequent request, the following information: number of attacks per year and EDSS scale result.

The maximum duration of the initial authorization is six months. When submitting subsequent requests, the physician must provide evidence of a beneficial effect (absence of deterioration).

For persons who previously received an interferon beta-1a for treatment of the first acute clinical episode with documented demyelinization, the interval between the two episodes may exceed two years;";

(13) by replacing the first indication accompanying the medication "INTERFERON BETA-1B" by the following:

"♦ for treatment of persons suffering from remitting multiple sclerosis who have had two or more episodes of the disease within the last two years and whose EDSS scale result is less than 7.

The physician must provide, at the beginning of treatment and with each subsequent request, the following information: number of attacks per year and EDSS scale result.

The maximum duration of the initial authorization is six months. When submitting subsequent requests, the physician must provide evidence of a beneficial effect (absence of deterioration).

For persons who previously received an interferon beta-1a for treatment of the first acute clinical episode with documented demyelinization, the interval between the two episodes may exceed two years;";

(14) by adding the following indication after the indication accompanying the medication "MODAFINIL":

"♦ for adjunctive treatment of diurnal hypersomnolence secondary to sleep apnea or hypopnea that persists despite the use of a nasal continuous positive airway pressure device;";

(15) by replacing the indication accompanying the medication "DRESSING – IODINE CADEXOMER" by the following:

"♦ for treatment of persons suffering from severe burns or severe chronic wounds (affecting the subcutaneous tissue) with critical colonization by at least one pathogen, documented by a bacterial culture from the debrided wound base. The request is authorized for a maximum of 12 weeks.

Critical colonization is defined by the presence of at least one pathogen, documented by a culture, in a severe wound, showing the following clinical signs: increased exudate, friable granulation tissue, stagnation in the scarring process, accentuated odour, accentuated pain and inflammation less than two cm from the edge. Critical colonization of a chronic wound, if it persists, may lead to infection of the chronic wound with systemic signs or symptoms;";

(16) by replacing, in both indications accompanying the medication "PEGINTERFERON ALFA-2A", the sentence "The authorization will be renewed if the decrease in the HCV-RNA is greater than or equal to 2 log after 12 weeks of treatment." by the sentence "The authorization will be renewed if the decrease in the HCV-RNA is greater than or equal to 1.8 log after 12 weeks of treatment.";

(17) by replacing the second indication accompanying the medication "RIBAVIRIN / INTERFERON ALFA-2B (PEGYLATED)" by the following:

"♦ for treatment of persons suffering from chronic hepatitis C of a genotype other than 2 or 3

and

for treatment of chronic hepatitis C in persons infected with HIV of any genotype.

The total duration of the authorization is a maximum of 48 weeks. Authorizations will be granted under different conditions based on the type of test conducted for the purpose of evaluating response to the treatment after the first 12 weeks of treatment.

The initial request is authorized for a maximum of 20 weeks. A quantitative or qualitative HCV-RNA screening test 12 weeks from the beginning of the treatment is necessary to determine response to the treatment.

• In the case of a qualitative test, another authorization, for a maximum of 28 weeks, will be granted for treatment termination purposes, only if the test result is negative.

• In the case of a quantitative test, another authorization, for an additional maximum of 12 weeks, will be granted only if the test result shows a decrease in viremia greater than or equal to 1.8 log compared with pre-treatment viremia.

Thereafter, an authorization will be granted, for a maximum of 16 weeks for treatment termination purposes, only if the qualitative HCV-RNA result is negative after 24 weeks of treatment.

However, persons who, during a previous treatment with an association of ribavirin/interferon alfa-2b (pegylated),

— did not obtain a 1.8-log decrease in viremia after 12 weeks compared to the pre-treatment value;

— did not obtain a negativation of their viremia after a minimum of 24 weeks of treatment;

— did not obtain a sustained virological response 24 weeks after the end of the treatment;
are not eligible for a second treatment;";

(18) by replacing the second indication accompanying the medication "RIBAVIRIN / PEGINTERFERON ALFA-2A" by the following:

"♦ for treatment of persons suffering from chronic hepatitis C of a genotype other than 2 or 3
and
for treatment of chronic hepatitis C in persons infected with HIV of any genotype.

The total duration of the authorization is a maximum of 48 weeks. Authorizations will be granted under different conditions based on the type of test conducted for the purpose of evaluating response to the treatment after the first 12 weeks of treatment.

The initial request is authorized for a maximum of 20 weeks. A quantitative or qualitative HCV-RNA screening test 12 weeks from the beginning of the treatment is necessary to determine response to the treatment.

• In the case of a qualitative test, another authorization, for a maximum of 28 weeks, will be granted for treatment termination purposes, only if the test result is negative.

• In the case of a quantitative test, another authorization, for an additional maximum of 12 weeks, will be granted only if the test result shows a decrease in viremia greater than or equal to 1.8 log compared with pre-treatment viremia.

Thereafter, an authorization will be granted, for a maximum of 16 weeks for treatment termination purposes, only if the qualitative HCV-RNA result is negative after 24 weeks of treatment.

However, persons who, during a previous treatment with an association of ribavirin/peginterferon alfa-2a,

— did not obtain a 1.8-log decrease in viremia after 12 weeks compared to the pre-treatment value ;

— did not obtain a negativation of their viremia after a minimum of 24 weeks of treatment ;

— did not obtain a sustained virological response 24 weeks after the end of the treatment ;

are not eligible for a second treatment ;".

4. The List of medications is amended:

(1) by inserting, in the order of classification of the medications, the following medications and the accompanying information:

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
8:18.08					
ANTIRETROVIRAL AGENTS					
ABACAVIR/LAMIVUDINE P					
Tab.				600 mg - 300 mg	
02269341	*Kivexa*	GSK	30	639.00	21.3000
8:22					
QUINOLONES					
CIPROFLOXACIN HYDROCHLORIDE P					
Tab.				250 mg **LPM**	
02267934	*Ran-Ciprofloxacin*	Ranbaxy	100	155.47	➡ 1.5547
Tab.				500 mg **LPM**	
02267942	*Ran-Ciprofloxacin*	Ranbaxy	100	175.40	➡ 1.7540
Tab.				750 mg **LPM**	
02267950	*Ran-Ciprofloxacin*	Ranbaxy	50	165.41	➡ 3.3082
12:12					
SYMPATHOMIMETIC AGENTS					
EPINEPHRINE					
Inj. Sol. (App.)				0.15 mg	
02268205	*Twinject 0.15 mg Auto-Injector*	Paladin	1	79.00	
Inj. Sol. (App.)				0.3 mg	
02247310	*Twinject 0.3 mg Auto-Injector*	Paladin	1	79.00	
20:04.04					
IRON PREPARATIONS					
IRON (FERRIC GLUCONATE/SUCROSE COMPLEX) P					
I.V. Inj. Sol.				12.5 mg (Ir)/mL (5 mL)	
02243333	*Ferrlecit*	J.O.I.	10	234.38	23.4380
24:04.04					
ANTIARRHYTHMIC AGENTS					
AMIODARONE HYDROCHLORIDE P					
Tab.				200 mg	
02245781	*Phl-Amiodarone*	Pharmel	100	129.71	1.2971

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
24:06.08					
HMG-COA REDUCTASE INHIBITORS					
LOVASTATINE P					
Tab.				20 mg **LPM**	
02267969	*Ran-Lovastatin*	Ranbaxy	500	545.35	➡ 1.0907
Tab.				40 mg **LPM**	
02267977	*Ran-Lovastatin*	Ranbaxy	100	201.17	➡ 2.0117
PRAVASTATINE SODIUM P					
Tab.				10 mg **LPM**	
02257092	*Gen-Pravastatin*	Genpharm	1000	953.00	➡ 0.9530
02270234	*Riva-Pravastatin*	Riva	100	95.30	➡ 0.9530
Tab.				20 mg **LPM**	
02257106	*Gen-Pravastatin*	Genpharm	1000	1124.30	➡ 1.1243
02270242	*Riva-Pravastatin*	Riva	100	112.43	➡ 1.1243
Tab.				40 mg **LPM**	
02257114	*Gen-Pravastatin*	Genpharm	1000	1354.30	➡ 1.3543
02270250	*Riva-Pravastatin*	Riva	100	135.43	➡ 1.3543
SIMVASTATIN P					
Tab.				10 mg **LPM**	
02265885	*Taro-Simvastatin*	Taro	100	112.13	➡ 1.1213
Tab.				20 mg **LPM**	
02265893	*Taro-Simvastatin*	Taro	100	138.60	➡ 1.3860
Tab.				40 mg **LPM**	
02265907	*Taro-Simvastatin*	Taro	100	138.60	➡ 1.3860
24:24					
BÊTA-ADRENERGICS BLOCKING AGENTS					
ATENOLOL P					
Tab.				25 mg **LPM**	
02266660	*Novo-Atenol*	Novopharm	100	17.58	➡ 0.1758

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
Tab.				50 mg **LPM**	
02267985	*Ran-Atenolol*	Ranbaxy	500	175.65	➡ 0.3513
Tab.				100 mg **LPM**	
02267993	*Ran-Atenolol*	Ranbaxy	500	288.85	➡ 0.5777
BISOPROLOL FUMARATE P					
Tab.				5 mg	
02267470	*Novo-Bisoprolol*	Novopharm	500	110.25	0.2205
Tab.				10 mg	
02267489	*Novo-Bisoprolol*	Novopharm	100	36.54	0.3654
CARVEDILOL P					
Tab.				3.125 mg	
02268027	*Ran-Carvedilol*	Ranbaxy	100	80.01	0.8001
Tab.				6.25 mg	
02268035	*Ran-Carvedilol*	Ranbaxy	100	80.01	0.8001
Tab.				12.5 mg	
02268043	*Ran-Carvedilol*	Ranbaxy	100	80.01	0.8001
Tab.				25 mg	
02268051	*Ran-Carvedilol*	Ranbaxy	100	80.01	0.8001
24:32.04					
ANGIOTENSIN-CONVERTING ENZYME INHIBITORS (ACEI)					
SODIUM FOSINOPRIL P					
Tab.				10 mg	
02266008	*Apo-Fosinopril*	Apotex	100	49.77	0.4977
02265923	*Riva-Fosinopril*	Riva	100	49.77	0.4977
Tab.				20 mg	
02266016	*Apo-Fosinopril*	Apotex	100	59.85	0.5985
02265931	*Riva-Fosinopril*	Riva	100	59.85	0.5985

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
28:12.12					
HYDANTOINS					
PHENYTOIN P					
Oral Susp.			125 mg/5 mL	**LPM**	
02250896	*Taro-Phenytoin*	Taro	237 ml	7.37	➧ 0.0311
28:12.92					
MISCELLANEOUS ANTICONVULSANTS					
PREGABALIN P					
Caps.				25 mg	
02268418	*Lyrica*	Pfizer	60	44.86	0.7477
Caps.				50 mg	
02268426	*Lyrica*	Pfizer	60	70.39	1.1732
Caps.				75 mg	
02268434	*Lyrica*	Pfizer	60	91.07	1.5178
Caps.				150 mg	
02268450	*Lyrica*	Pfizer	60	139.31	2.3218
Caps.				300 mg	
02268485	*Lyrica*	Pfizer	60	139.31	2.3218
28:16.04					
ANTIDEPRESSANTS					
CITALOPRAM HYDROMIDE P					
Tab.				20 mg	
02268000	*Ran-Citalopram*	Ranbaxy	500	437.50	0.8750
Tab.				40 mg	
02268019	*Ran-Citalopram*	Ranbaxy	100	87.50	0.8750
MIRTAZAPINE P					
Tab. or oral disint.				15 mg	
02256096	*Gen-Mirtazapine*	Genpharm	100	37.50	0.3750
Tab. or oral disint.				30 mg	
02267292	*Rhoxal-Mirtazapine FC*	Rhoxal	100	78.00	0.7800

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
Tab. or oral disint.				45 mg	
02256126	*Gen-Mirtazapine*	Genpharm	100	112.50	1.1250

28:16.08
ANTIPSYCHOTIC AGENTS
RISPERIDONE P

Oral Diss. tab.				3 mg	
02268086	*Risperdal M-Tab*	J.O.I.	28	80.50	2.8750
Oral Diss. tab.				4 mg	
02268094	*Risperdal M-Tab*	J.O.I.	28	107.33	3.8332

40:12
REPLACEMENT PREPARATIONS
CALCIUM CARBONATE/VITAMIN D

Tab.				500 mg -400 UI **LPM**	
80000159	*Calcia 400*	Medexus	60	7.20	➡ 0.1200

52:36
MISCELLANEOUS EENT DRUGS
BRIMONIDINE TARTRATE P

Oph. Sol.				0.2 %	
02260077	*Apo-Brimonidine*	Apotex	10 ml	20.79	

56:40
MISCELLANEOUS GI DRUGS
5-AMINOSALICYLIC ACID P

Ent. Tab.				800 mg	
02267217	*Asacol*	P&G Pharma	180	178.20	0.9900

DOMPERIDONE MALEATE P

Tab.				10 mg **LPM**	
02268078	*Ran-Domperidone*	Ranbaxy	500	74.80	➡ 0.1496

68:20.92
MISCELLANEOUS ANTIDIABETIC AGENTS
METFORMIN HYDROCHLORIDE P

Tab.				500 mg **LPM**	
02269031	*Ran-Metformin*	Ranbaxy	500	60.80	➡ 0.1216
Tab.				850 mg **LPM**	
02269058	*Ran-Metformin*	Ranbaxy	100	20.90	➡ 0.2090

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
68:32					
PROGESTINS					
MEDROXYPROGESTERONE ACETATE P					
Tab.				100 mg **LPM**	
02267640	*Apo-Medroxy*	Apotex	100	85.43	➡ 0.8543
84:06					
ANTI-INFLAMMATORY AGENTS					
MOMETASON FUROATE P					
Top. Oint.				0.1 %	
02264749	*Taro-Mometasone*	Taro	50 g	17.46	0.3492
92:00					
UNCLASSIFIED THERAPEUTIC AGENTS					
HYMENOPTERA VENOM PROTEIN					
Inj. Pd				1.1 mg	
99100226	*Frelon a tete blanche*	AllergiLab	1	173.00	173.0000
99100227	*Frelon Jaune*	AllergiLab	1	173.00	173.0000
99100225	*Honey Bee Venom*	AllergiLab	1	173.00	173.0000
99100229	*Wasp Venon*	AllergiLab	1	173.00	173.0000
99100228	*Yellow Jacket Venom*	AllergiLab	1	173.00	173.0000
Inj. Pd				3.3 mg	
99100230	*Vespides combines*	AllergiLab	1	401.00	401.0000
92:00.02					
OTHER MISCELLANEOUS					
ALENDRONATE MONOSODIUM P					
Tab.				40 mg	
02258102	*Co Alendronate*	Cobalt	30	78.29	2.6097
Tab.				70 mg	
02248730	*Apo-Alendronate*	Apotex	4	22.30	5.5750
02258110	*Co Alendronate*	Cobalt	4	22.30	5.5750
02261715	*Novo-Alendronate*	Novopharm	4	22.30	5.5750
ANAGRELIDE HYDROCHLORIDE P					
Caps.				0.5 mg	
02253054	*Gen-Anagrelide*	Genpharm	100	334.91	3.3491

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
ISOTRETINOIN P					
Caps.				10 mg **LPM**	
02257955	*Clarus*	Prempharm	30	40.98	➡ 1.3660
Caps.				40 mg **LPM**	
02257963	*Clarus*	Prempharm	30	83.63	➡ 2.7877
PAMIDRONATE DISODIUM P					
I.V. inf. pd/sol.				90 mg	
02249685	*Pamidronate Disodium Omega*	Oméga	1	265.05	

(2) by inserting, in alphabetical order of the exceptional medications, the following medications and the accompanying information:

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
EXCEPTIONAL MEDICATIONS					
DRESSING - HYDROPHILIC FOAM					
Dressing				5 cm X 6 cm	
99100241	*Allevyn Compression*	S. & N.	1	2.10	
Dressing				10 cm X 10 cm	
99100052	*Allevyn Compression*	S. & N.	1	5.22	5.2200
EPOETIN ALFA P					
Syringe				40 000 U.I./mL (1 mL)	
02240722	*Eprex*	J.O.I.	1	401.85	
ERLOTINIB (HYDROCHLORIDE) P					
Tab.				100 mg	
02269015	*Tarceva*	Roche	30	1600.00	53.3333
Tab.				150 mg	
02269023	*Tarceva*	Roche	30	2400.00	80.0000

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
GLIMEPIRIDE P					
Tab.				1 mg	
02269589	*Rhoxal-Glimepiride*	Rhoxal	30	14.70	0.4900
Tab.				2 mg	
02269597	*Rhoxal-Glimepiride*	Rhoxal	30	14.70	0.4900
Tab.				4 mg	
02269619	*Rhoxal-Glimepiride*	Rhoxal	30	14.70	0.4900
INTERFERON BETA-1A P					
I.M. Inj. Sol.				30 mcg (6 MUI)	
02269201	*Avonex PS*	Biogen	4	1292.30	323.0750
METHYLPHENIDATE HYDROCHLORIDE ⊜					
L.A. Tab.				27 mg	
02250241	*Concerta*	J.O.I.	100	228.50	2.2850
MULTIVITAMINS [5]					
Oral Sol.		Vit A 1500 UI - Beta Carotène 1 mg - Vit D 400 UI and others			
02139650	*Adeks*	Axcan	60 ml	18.00	0.3000
Tab.		Vit A 4000 UI -Bêta Carotene 3 mg - Vit D 400 UI and others			
02031388	*Adeks*	Axcan	60	18.00	0.3000

5- Pharmacists may purchase the product of their choice. The product thus obtained is considered insured and the price payable by the Régie is the pharmacist's cost price.

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
NUTRITIONAL FORMULAS - POLYMERIC LOW-RESIDUE					
Liq.				1 L **suppl.**	
99100244	*Novasource Renal*	Novartis-N	1	14.07	
ROSIGLITAZONE MALEATE / METFORMIN HYDROCHLORIDE P					
Tab.				1 mg - 500 mg	
02247085	*Avandamet*	GSK	100	60.00	0.6000
Tab.				2 mg - 500 mg	
02247086	*Avandamet*	GSK	100	108.50	1.0850
Tab.				2 mg - 1000 mg	
02248440	*Avandamet*	GSK	100	118.50	1.1850
Tab.				4 mg - 500 mg	
02247087	*Avandamet*	GSK	100	148.00	1.4800
Tab.				4 mg - 1000 mg	
02248441	*Avandamet*	GSK	100	161.50	1.6150
SILVER DRESSING					
Dressing				5 cm X 5 cm	
99100231	*Acticoat Burn*	S. & N.	1	5.68	
Dressing				10 cm X 10 cm	
99100232	*Acticoat Burn*	S. & N.	1	12.11	
Dressing				10 cm X 20 cm	
99100233	*Acticoat Burn*	S. & N.	1	18.82	
Dressing				10 cm x 120 cm,	
99100234	*Acticoat Burn*	S. & N.	1	146.17	
Dressing				12.5 cm x 12.5 cm	
99100245	*Contreet Foam Adhesive*	Coloplast	5	73.27	14.6540
Dressing				18 cm x 18 cm	
99100246	*Contreet Foam Adhesive*	Coloplast	5	154.65	30.9300

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
Dressing				20 cm x 40 cm	
99100235	*Acticoat Burn*	S. & N.	1	66.28	
Dressing				23 cm x 23 cm (sacrum)	
99100247	*Contreet Foam Adhesive*	Coloplast	5	163.56	32.7120
Dressing				40 cm x 40 cm	
99100236	*Acticoat Burn*	S. & N.	1	130.27	
WOUND CONTACT LAYER					
Dressing				5 cm x 7.5 cm	
99100237	*Mepitel*	Mölnlycke	1	3.48	
Dressing				7.5 cm X 10 cm	
99100238	*Mepitel*	Mölnlycke	1	4.52	
Dressing				10 cm X 18 cm	
99100239	*Mepitel*	Mölnlycke	1	7.40	
Dressing				20 cm X 30 cm	
99100240	*Mepitel*	Mölnlycke	1	21.36	

(3) by inserting, in alphabetical order of the vehicles, solvents or adjuvants, the following product and the accompanying information:

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
VEHICLES, SOLVENTS OR ADJUVANTS [6]					
MAGNESIUM HYDROXIDE/ ALUMINIUM HYDROXIDE/ SIMETHICONE					
Oral Susp.				400 mg - 400 mg - 40 mg/5 mL	
99100243			350 ml		

6- Where no price is indicated, pharmacists may purchase the product of their choice. The product thus obtained is considered insured and the price payable by the Régie is the pharmacist's cost price.

5. The List of medications is amended by replacing the information concerning the following medications by the following information:

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
8:12.04					
ANTIFUNGAL ANTIBIOTICS					
FLUCONAZOLE P					
Caps.				150 mg **LPM**	
02241895	*Apo-Fluconazole-150*	Apotex	1	➡ 9.19	
02245697	*Gen-Fluconazole*	Genpharm	1	➡ 9.19	
02243645	*Novo-Fluconazole-150*	Novopharm	1	➡ 9.19	
02246620	*pms-Fluconazole-150*	Phmscience	1	➡ 9.19	
02255510	*Riva-Fluconazole*	Riva	1	➡ 9.19	
02141442	*Diflucan-150*	Pfizer	1	13.41	
I.V. Perf. Sol.				2 mg/mL **LPM**	
02247922	*Fluconazole Injectable*	Novopharm	100 ml	36.59	➡ 0.3659
02248443	*Fluconazole Injection*	Sabex	100 ml	➡ 36.59	
02247749	*Fluconazole Omega*	Oméga	100 ml	36.59	➡ 0.3659
00891835	*Diflucan*	Pfizer	100 ml	48.78	
Tab.				50 mg **LPM**	
02237370	*Apo-Fluconazole*	Apotex	50	156.33	➡ 3.1266
02245292	*Gen-Fluconazole*	Genpharm	50	156.33	➡ 3.1266
02236978	*Novo-Fluconazole*	Novopharm	100	312.66	➡ 3.1266
02245643	*pms-Fluconazole*	Phmscience	50	156.33	➡ 3.1266
02249294	*Taro-Fluconazole*	Taro	50	156.33	➡ 3.1266
00891800	*Diflucan*	Pfizer	50	223.38	4.4676
Tab.				100 mg **LPM**	
02237371	*Apo-Fluconazole*	Apotex	50	277.33	➡ 5.5466
02245293	*Gen-Fluconazole*	Genpharm	50	277.33	➡ 5.5466
02236979	*Novo-Fluconazole*	Novopharm	50	277.33	➡ 5.5466
02245644	*pms-Fluconazole*	Phmscience	50	277.33	➡ 5.5466
02249308	*Taro-Fluconazole*	Taro	50	277.33	➡ 5.5466
00891819	*Diflucan*	Pfizer	100	792.53	7.9253
8:16					
ANTITUBERCULOSIS AGENTS					
ISONIAZID P					
Tab.				100 mg	
00577790	*pms-Isoniazid*	Phmscience	100	26.80	0.2680

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
24:06.06					
FIBRIC ACID DERIVATIVES					
FENOFIBRATE P					
Caps.				100 mg **LPM**	
02225980	*Apo-Fenofibrate*	Apotex	500	216.25	➡ 0.4325
02223600	*Nu-Fenofibrate*	Nu-Pharm	100	43.25	➡ 0.4325
MICRONIZED FENOFIBRATE P					
Caps.				67 mg **LPM**	
02243180	*Apo-Feno-Micro*	Apotex	100	43.25	➡ 0.4325
02243551	*Novo-Fenofibrate Micronise*	Novopharm	100	43.25	➡ 0.4325
02230283	*Lipidil Micro*	Fournier	60	34.60	0.5767
Caps.				200 mg **LPM**	
02239864	*Apo-Feno-Micro*	Apotex	100	108.90	➡ 1.0890
02240360	*Feno-Micro-200*	Pro Doc	100	108.90	➡ 1.0890
02240210	*Gen-Fenofibrate Micro*	Genpharm	100	108.90	➡ 1.0890
02146959	*Lipidil Micro*	Fournier	30	32.67	➡ 1.0890
02243552	*Novo-Fenofibrate Micronise*	Novopharm	100	108.90	➡ 1.0890
02247489	*Phl-Fenofibrate Micro*	Pharmel	250	272.25	➡ 1.0890
02231780	*pms-Fenofibrate Micro*	Phmscience	250	272.25	➡ 1.0890
02250039	*Ratio-Fenofibrate MC*	Ratiopharm	100	108.90	➡ 1.0890
02247306	*Riva-Fenofibrate Micro*	Riva	100	108.90	➡ 1.0890
24:06.08					
HMG-COA REDUCTASE INHIBITORS					
PRAVASTATINE SODIUM P					
Tab.				10 mg **LPM**	
02243506	*Apo-Pravastatin*	Apotex	100	95.30	➡ 0.9530
02248182	*Co Pravastatin*	Cobalt	100	95.30	➡ 0.9530
02237373	*Lin-Pravastatin*	Linson	30	28.59	➡ 0.9530
02247008	*Novo-Pravastatin*	Novopharm	100	95.30	➡ 0.9530
02249766	*Phl-Pravastatin*	Pharmel	100	95.30	➡ 0.9530
02247655	*pms-Pravastatin*	Phmscience	100	95.30	➡ 0.9530
00893749	*Pravachol*	Squibb	30	28.59	➡ 0.9530
02243824	*Pravastatin-10*	Pro Doc	100	95.30	➡ 0.9530
02246930	*Ratio-Pravastatin*	Ratiopharm	100	95.30	➡ 0.9530
02247856	*Rhoxal-Pravastatin*	Rhoxal	100	95.30	➡ 0.9530
02256851	*Riva-Pravastatin*	Riva	100	95.30	➡ 0.9530

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
Tab.				20 mg **LPM**	
02237374	*Lin-Pravastatin*	Linson	30	33.72	➡ 1.1240
00893757	*Pravachol*	Squibb	30	33.72	➡ 1.1240
02243507	*Apo-Pravastatin*	Apotex	500	562.15	➡ 1.1243
02248183	*Co Pravastatin*	Cobalt	500	562.15	➡ 1.1243
02247009	*Novo-Pravastatin*	Novopharm	100	112.43	➡ 1.1243
02249774	*Phl-Pravastatin*	Pharmel	500	562.15	➡ 1.1243
02247656	*pms-Pravastatin*	Phmscience	500	562.15	➡ 1.1243
02243825	*Pravastatin-20*	Pro Doc	100	112.43	➡ 1.1243
02246931	*Ratio-Pravastatin*	Ratiopharm	500	562.15	➡ 1.1243
02247857	*Rhoxal-Pravastatin*	Rhoxal	100	112.43	➡ 1.1243
02256878	*Riva-Pravastatin*	Riva	100	112.43	➡ 1.1243
Tab.				40 mg **LPM**	
02237375	*Lin-Pravastatin*	Linson	30	40.62	➡ 1.3540
02222051	*Pravachol*	Squibb	30	40.62	➡ 1.3540
02243508	*Apo-Pravastatin*	Apotex	100	135.43	➡ 1.3543
02248184	*Co Pravastatin*	Cobalt	100	135.43	➡ 1.3543
02247010	*Novo-Pravastatin*	Novopharm	100	135.43	➡ 1.3543
02249782	*Phl-Pravastatin*	Pharmel	100	135.43	➡ 1.3543
02247657	*pms-Pravastatin*	Phmscience	100	135.43	➡ 1.3543
02243826	*Pravastatin-40*	Pro Doc	100	135.43	➡ 1.3543
02246932	*Ratio-Pravastatin*	Ratiopharm	100	135.43	➡ 1.3543
02247858	*Rhoxal-Pravastatin*	Rhoxal	100	135.43	➡ 1.3543
02256886	*Riva-Pravastatin*	Riva	100	135.43	➡ 1.3543

SIMVASTATIN P

Tab.				5 mg **LPM**	
02247011	*Apo-Simvastatin*	Apotex	100	56.70	➡ 0.5670
02248103	*Co Simvastatin*	Cobalt	100	56.70	➡ 0.5670
02246582	*Gen-Simvastatin*	Genpharm	100	56.70	➡ 0.5670
02250144	*Novo-Simvastatin*	Novopharm	100	56.70	➡ 0.5670
02253690	*Phl-Simvastatin*	Pharmel	100	56.70	➡ 0.5670
02252619	*pms-Simvastatin*	Phmscience	100	56.70	➡ 0.5670
02247067	*Ratio-Simvastatin*	Ratiopharm	100	56.70	➡ 0.5670
02247827	*Rhoxal-Simvastatin*	Rhoxal	100	56.70	➡ 0.5670
02247297	*Riva-Simvastatin*	Riva	100	56.70	➡ 0.5670
00884324	*Zocor*	Merck	30	27.00	0.9000

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
Tab.				10 mg **LPM**	
02247298	*Riva-Simvastatin*	Riva	100	112.13	➡ 1.1213
02247012	*Apo-Simvastatin*	Apotex	500	560.70	➡ 1.1214
02248104	*Co Simvastatin*	Cobalt	500	560.70	➡ 1.1214
02246583	*Gen-Simvastatin*	Genpharm	100	112.14	➡ 1.1214
02250152	*Novo-Simvastatin*	Novopharm	500	560.70	➡ 1.1214
02253704	*Phl-Simvastatin*	Pharmel	500	560.70	➡ 1.1214
02252635	*pms-Simvastatin*	Phmscience	100	112.14	➡ 1.1214
02247068	*Ratio-Simvastatin*	Ratiopharm	500	560.70	➡ 1.1214
02247828	*Rhoxal-Simvastatin*	Rhoxal	500	560.70	➡ 1.1214
02247221	*Simvastatin-10*	Pro Doc	500	560.70	➡ 1.1214
00884332	*Zocor*	Merck	500	890.00	1.7800
Tab.				20 mg **LPM**	
02247013	*Apo-Simvastatin*	Apotex	500	693.00	➡ 1.3860
02248105	*Co Simvastatin*	Cobalt	500	693.00	➡ 1.3860
02246737	*Gen-Simvastatin*	Genpharm	100	138.60	➡ 1.3860
02250160	*Novo-Simvastatin*	Novopharm	100	138.60	➡ 1.3860
02253712	*Phl-Simvastatin*	Pharmel	100	138.60	➡ 1.3860
02252643	*pms-Simvastatin*	Phmscience	100	138.60	➡ 1.3860
02247069	*Ratio-Simvastatin*	Ratiopharm	500	693.00	➡ 1.3860
02247830	*Rhoxal-Simvastatin*	Rhoxal	500	693.00	➡ 1.3860
02247299	*Riva-Simvastatin*	Riva	100	138.60	➡ 1.3860
02247222	*Simvastatin-20*	Pro Doc	100	138.60	➡ 1.3860
00884340	*Zocor*	Merck	100	220.00	2.2000
Tab.				40 mg **LPM**	
02247014	*Apo-Simvastatin*	Apotex	100	138.60	➡ 1.3860
02248106	*Co Simvastatin*	Cobalt	500	693.00	➡ 1.3860
02246584	*Gen-Simvastatin*	Genpharm	100	138.60	➡ 1.3860
02250179	*Novo-Simvastatin*	Novopharm	100	138.60	➡ 1.3860
02253720	*Phl-Simvastatin*	Pharmel	100	138.60	➡ 1.3860
02252651	*pms-Simvastatin*	Phmscience	100	138.60	➡ 1.3860
02247070	*Ratio-Simvastatin*	Ratiopharm	500	693.00	➡ 1.3860
02247831	*Rhoxal-Simvastatin*	Rhoxal	100	138.60	➡ 1.3860
02247300	*Riva-Simvastatin*	Riva	100	138.60	➡ 1.3860
02247223	*Simvastatin-40*	Pro Doc	100	138.60	➡ 1.3860
00884359	*Zocor*	Merck	30	66.00	2.2000

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
Tab.				80 mg **LPM**	
02247015	*Apo-Simvastatin*	Apotex	100	138.60	➡ 1.3860
02248107	*Co Simvastatin*	Cobalt	100	138.60	➡ 1.3860
02246585	*Gen-Simvastatin*	Genpharm	100	138.60	➡ 1.3860
02250187	*Novo-Simvastatin*	Novopharm	100	138.60	➡ 1.3860
02253739	*Phl-Simvastatin*	Pharmel	100	138.60	➡ 1.3860
02252678	*pms-Simvastatin*	Phmscience	100	138.60	➡ 1.3860
02247071	*Ratio-Simvastatin*	Ratiopharm	100	138.60	➡ 1.3860
02247833	*Rhoxal-Simvastatin*	Rhoxal	100	138.60	➡ 1.3860
02247301	*Riva-Simvastatin*	Riva	100	138.60	➡ 1.3860
02240332	*Zocor*	Merck	30	66.00	2.2000

28:08.04
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS
ACETYLSALICYLIC ACID

Ent. Tab.				80 mg **LPM**	
02238545	*Asaphen E.C.*	Phmscience	1000	67.80	➡ 0.0678
02247355	*Phl-Asa*	Pharmel	500	33.90	➡ 0.0678

28:12.12
HYDANTOINS
PHENYTOIN P

Oral Susp.				125 mg/5 mL **LPM**	
00023450	*Dilantin-125*	Pfizer	250 ml	11.10	0.0444

28:12.92
MISCELLANEOUS ANTICONVULSANTS
VALPROATE SODIUM P

Syr.				250 mg/5 mL **LPM**	
00443832	*Depakene*	Abbott	480 ml	41.24	0.0859

28:16.04
ANTIDEPRESSANTS
MIRTAZAPINE P

Tab. or oral disint.				15 mg	
02250594	*Rhoxal-Mirtazapine*	Rhoxal	50	18.75	0.3750

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
40:12					
REPLACEMENT PREPARATIONS					
CALCIUM CARBONATE/VITAMIN D					
Tab.			500 mg -400 UI	**LPM**	
02244161	*Calcium 500 + D 400*	Trianon	100	12.00	➡ 0.1200
02246065	*Cal-D 400*	Pro Doc	100	12.00	➡ 0.1200
60:00					
GOLD COMPOUNDS					
SODIUM AUROTHIOMALATE P					
I.M. Inj. Sol.			10 mg/mL	**LPM**	
02245456	*Aurothiomalate de sodium*	Sabex	1 ml	➡ 6.31	
I.M. Inj. Sol.			25 mg/mL	**LPM**	
02245457	*Aurothiomalate de sodium*	Sabex	1 ml	➡ 7.66	
I.M. Inj. Sol.			50 mg/mL	**LPM**	
02245458	*Aurothiomalate de sodium*	Sabex	1 ml	➡ 11.89	
68:32					
PROGESTINS					
MEDROXYPROGESTERONE ACETATE P					
Tab.			100 mg	**LPM**	
00030945	*Provera*	Pfizer	100	122.04	1.2204
84:36					
MISCELLANEOUS					
FLUOROURACIL P					
Top. Cr.			5 %		
00330582	*Efudex*	ICN	40 g	32.00	0.8000
92:00.02					
OTHER MISCELLANEOUS					
DUTASTERIDE P					
Caps.			0.5 mg		
02247813	*Avodart*	GSK	30	46.45	1.5483
FLUNARIZINE HYDROCHLORIDE P					
Caps.			5 mg	**LPM**	
02246082	*Apo-Flunarizine*	Apotex	100	53.08	➡ 0.5308
00846341	*Sibelium*	Phmscience	60	31.85	➡ 0.5308

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
ISOTRETINOIN P					
Caps.				10 mg **LPM**	
00582344	*Accutane 10*	Roche	30	40.98	➡ 1.3660
Caps.				40 mg **LPM**	
00582352	*Accutane 40*	Roche	30	83.63	➡ 2.7877
KETOTIFENE FUMARATE P					
Syr.				1 mg/5 mL **LPM**	
02221330	*Apo-Ketotifen*	Apotex	250 ml	33.25	➡ 0.1330
02176084	*Novo-Ketotifen*	Novopharm	250 ml	33.25	➡ 0.1330
02218305	*Nu-Ketotifen*	Nu-Pharm	250 ml	33.25	➡ 0.1330
02231679	*pms-Ketotifen*	Phmscience	250 ml	33.25	➡ 0.1330
00600784	*Zaditen*	PanGeo	250 ml	33.25	➡ 0.1330
Tab.				1 mg **LPM**	
02230730	*Novo-Ketotifen*	Novopharm	100	63.35	➡ 0.6335
02231680	*pms-Ketotifen*	Phmscience	100	63.35	➡ 0.6335
00577308	*Zaditen*	PanGeo	56	35.48	➡ 0.6335

EXCEPTIONAL MEDICATIONS

FILGRASTIM P					
Inj. Sol.				300 mcg/mL (1.0 mL)	
01968017	*Neupogen*	Amgen	10	1645.71	164.5710
Inj. Sol.				300 mcg/mL (1.6mL)	
99001454	*Neupogen*	Amgen	10	2633.18	263.3180
LEVOFLOXACIN P					
I.V. Perf. Sol.				5 mg/mL	
02236839	*Levaquin*	J.O.I.	150 ml	44.24	0.2949
RISPERIDONE P					
I.M. Inj. Pd				25 mg	
02255707	*Risperdal Consta*	J.O.I.	1	184.48	
I.M. Inj. Pd				37.5 mg	
02255723	*Risperdal Consta*	J.O.I.	1	260.91	
I.M. Inj. Pd				50 mg	
02255758	*Risperdal Consta*	J.O.I.	1	330.46	

6. The List of medications is amended by inserting, in subsection 8:18:08, ANTIRETROVIRAL AGENTS, after the medication "STAVUDINE" and the accompanying information, the following medication and the accompanying information and by deleting them from the exceptional medications section:

CODE	BRAND NAME	MANUFACTURER	SIZE	COST OF PKG. SIZE	UNIT PRICE
8:18.08					
ANTIRETROVIRAL AGENTS					
TENOFOVIR DISOPROXIL FUMARATE P					
Tab.				300 mg	
02247128	*Viread*	Gilead	30	487.50	16.2500

7. This Regulation comes into force on 8 February 2006.

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