Ontario

Ontario Drug Benefit Formulary/Comparative Drug Index

Edition 43

Summary of Changes – August 2025
Effective August 29, 2025

Drug Programs Policy and Strategy Branch
Health Programs and Delivery Division
Ministry of Health

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New Single Source Products

Generic Name: BIMEKIZUMAB

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02553627	Bimzelx	320mg/2mL	Inj Sol-2mL Pref Autoinj (Preservative-Free)	UCB	3250.0000/Pref Autoinj Pk
02553619	Bimzelx	320mg/2mL	Inj Sol-2mL Pref Syr (Preservative-Free)	UCB	3250.0000/Pref Syr Pk

The LU code 641 and clinical criteria are the same as the currently listed bimekizumab (Bimzelx) products.

Generic Name: OMALIZUMAB

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02553805	Omlyclo	75mg/0.5mL	Inj Sol-0.5mL Pref Syr Pk	CEI	168.7440/ Pref Syr Pk
02553813	Omlyclo	150mg/mL	Inj Sol-1mL Pref Syr Pk	CEI	384.9600/ Pref Syr Pk

Reason For Use Code and Clinical Criteria

LU Code: 726

For the treatment of adults with severe uncontrolled asthma who meet the following criteria:

1. Patient is 12 years of age or older; AND

New Single Source Products (Continued)

2. Diagnosed with severe asthma that is not controlled despite treatment with a high-dose inhaled corticosteroid, defined as greater than or equal to 500mcg of fluticasone propionate or equivalent daily*, in addition to a long-acting inhaled beta 2-agonist;

*Note: Check dose comparison tables for high-dose inhaled corticosteroid equivalency comparisons for various inhaled corticosteroids.

Omalizumab will not be funded as a first line treatment for uncontrolled asthma and patients must try other conventional therapies for asthma that include a corticosteroid inhaler before being prescribed a biologic treatment.

Proper inhaler technique (with a spacer if required/appropriate) and adherence to prescribed treatment should be confirmed. Patients may also be on other concomitant therapies.

AND

3. In the past 12 months, inadequately controlled asthma has resulted in at least one of the following:
   - Hospitalization for asthma
   - Two or more urgent care visits to a physician/nurse practitioner or emergency department for asthma exacerbations.
   - Use of two or more courses of high-dose oral corticosteroids (e.g. prednisone) or increase in the dose of chronic prednisone treatment to manage asthma exacerbations; AND

4. Patient has demonstrated a positive skin test or in vitro reactivity to a perennial aeroallergen (e.g. positive allergy testing by skin prick test or IgE RAST);

Note: Removal or reduction of allergic and environmental triggers of asthma to the fullest extent possible should be attempted.

AND

5. Has a baseline Immunoglobulin E (IgE) level between 30IU/mL and 700IU/mL inclusive prior to start of omalizumab;

Note: Serum total IgE levels increase following administration of omalizumab due to formation of omalizumab:IgE complexes. Elevated serum total IgE levels may persist for up to 1 year following discontinuation of omalizumab. Serum total IgE levels obtained less than 1 year following discontinuation may not reflect steady state free IgE levels and should not be used to reassess the dosing regimen in asthma patients.

New Single Source Products (Continued)

AND

6. Has an actual body weight between 20 to 150kg inclusive (Refer to Omlyclo product monograph for dosing in individuals 12 years of age and older by IgE level and weight); AND

7. Prescribed by or in consultation with a specialist in respirology or allergy/clinical immunology.

8. Omalizumab is not being used in combination with another biologic drug used for the treatment of asthma.

Renewal of omalizumab is provided for patients who have responded to treatment by improving asthma control compared to baseline before omalizumab was initiated. Depending on the baseline parameters, this may be evidenced by clinical improvements of one or more of the following;

- Decreased utilization of rescue medications [as determined by reduction in nighttime awakenings or reduction in average number of puffs/day of short-acting beta-agonists (SABA)]; OR
- Decreased frequency of asthma exacerbations (as determined by reduction in exacerbations that require hospitalization and/or urgent care visits to a hospital emergency department or physician/nurse practitioner clinic.); OR
- Reduction in asthma exacerbations that require adding or increasing doses of corticosteroids; OR
- Increase in percent predicted FEV-1 from pre-treatment baselines.

Recommended dose: Omalizumab 75 to 375mg administered SC every 2 to 4 weeks.

LU Authorization Period: 1 Year

New Single Source Products (Continued)

Code 727

For the treatment of moderate to severe chronic idiopathic urticaria (CIU) in patients who meet all the following criteria:

1. Patient is 12 years of age or older; AND
2. Diagnosed with moderate to severe CIU [Weekly urticaria activity score (UAS7) of 16 or greater]; AND
3. Remains symptomatic despite management with optimal doses of standard oral therapies for CIU (e.g. histamine H1 receptor antagonists [e.g. cetirizine, desloratadine, loratadine, fexofenadine]); AND
4. Omalizumab is not being used in combination with another biologic drug used for the treatment of CIU; AND
5. Prescribed by a specialist (e.g. allergist, immunologist, dermatologist, etc.).

Recommended dose: 300mg SC every 4 weeks

Note the following guidance:

Severe urticaria - UAS7 of 28 to 42
Moderate urticaria - UAS7 of 16 to 27
Mild urticaria – UAS7 of 7 to 15
Well-controlled urticaria – UAS7 of 1 to 6
Urticaria-free – UAS7 of 0 (zero)

Patients who achieve symptom control for at least 12 weeks while on therapy should have a trial of stopping treatment.

LU Authorization Period: 6 months

New Single Source Products (Continued)

Code 728

All patients new to the Ontario Drug Benefit (ODB) Program should meet the RFU Code for initiation.

Renewal of funding of omalizumab will be provided for the treatment of chronic idiopathic urticaria (CIU) in patients who meet the following criteria:

1. Patient is 12 years of age or older; AND
2. Omalizumab is prescribed by a specialist (e.g. allergist, immunologist, dermatologist, etc.); AND
3. Omalizumab is not being used in combination with another biologic drug used for the treatment of CIU; AND
4. Patient's response to omalizumab previously funded under the ODB program meets at least ONE of the following criteria:
    i. Has achieved symptom control on omalizumab and tried stopping therapy but experienced symptom relapse of their urticaria while off treatment.
    ii. Has experienced a partial improvement in response with omalizumab treatment by demonstrating a reduction of the weekly urticaria activity score (UAS7) by 9.5 points or more but patient has not been able to achieve complete symptom control for more than 12 consecutive weeks.
    iii. Has responded to omalizumab in the past but has been rediagnosed with moderate to severe CIU with UAS7 of 16 or higher.

Notes:

1. Patients who achieve complete symptom control for at least 12 weeks while on therapy should have a trial of stopping treatment to establish whether the condition has gone into spontaneous remission.
2. Patients must demonstrate a minimum response to omalizumab for CIU by reducing the UAS7 score by at least 9.5 points from baseline before initiation of omalizumab for CIU.

Note the following guidance:

Urticaria-free – UAS7 of 0 (zero)

Well-controlled urticaria – UAS7 of 1 to 6

Mild urticaria – UAS7 of 7 to 15

Moderate urticaria - UAS7 of 16 to 27

Severe urticaria - UAS7 of 28 to 42

Recommended dose: 300mg every 4 weeks

LU Authorization Period: 1 year

New Single Source Products (Continued)

Generic Name: USTEKINUMAB

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02558270	Steqeyma	45mg/0.5mL	Inj Sol-0.5mL Vial Pk (Preservative-Free)	CEH	2755.8840/Vial Pk

The LU codes 668, 669, 671, 672 and clinical criteria are the same as the currently listed ustekinumab (Steqeyma DIN 02550245)

Generic Name: AFLIBERCEPT

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02554178	Aflivu	2mg/0.05mL	Inj Sol-0.05mL Pref Syr (Preservative-Free)	APX	850.8000/Pref Syr
02554194	Aflivu	2mg/0.05mL	Sol for Intravitreal Inj-0.05mL Vial Pk (Preservative-Free)	APX	850.8000/Vial Pk
02558238	Yesafili	2mg/0.05mL	Inj Sol-0.05mL Pref Syr (Preservative-Free)	BCL	850.8000/Pref Syr
02535858	Yesafili	2mg/0.05mL	Sol for Intravitreal Inj-0.05mL Vial Pk (Preservative-Free)	BCL	850.8000/Vial Pk

Reason For Use Code and Clinical Criteria

LU Code: 729

For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD) in a treatment-naive eye.

Initial diagnosis should be confirmed by an appropriate diagnostic procedure and administration should be done by a qualified ophthalmologist experienced in intravitreal injections.

Patients receiving concurrent administration of other anti-VEGF intravitreal injections are not eligible for reimbursement.

Treatment should be initiated with a monthly intravitreal injection for the first 3 consecutive doses, followed by one injection every 2 months.

The interval between two doses should not be shorter than one month.

Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.

New Single Source Products (Continued)

Coverage will be provided for patients responding to therapy with another anti-VEGF agent who switch to this product. Coverage will NOT be provided for patients who have failed to respond to other anti-VEGF agents.

LU Authorization: 1 Year

Code: 730

For the treatment of patients with clinically significant macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO).

Patients receiving concurrent administration of other anti-VEGF intravitreal injections are not eligible for reimbursement.

Treatment should be initiated with an intravitreal injection once every month. The interval between two doses should not be shorter than one month. The treatment interval may be extended up to 3 months based on visual and anatomic outcomes.

Prescribers are advised to periodically assess the need for continued therapy.

Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.

Coverage will be provided for patients responding to therapy with another anti-VEGF agent who switch to this product. Coverage will NOT be provided for patients who have failed to respond to other anti-VEGF agents.

LU Authorization: 1 Year

Code: 731

For the treatment of patients with clinically significant diabetic macular edema (DME) for whom laser photocoagulation is also indicated; and a hemoglobin A1c of less than 12 percent.

Patients receiving concurrent administration of other anti-VEGF intravitreal injections are not eligible for reimbursement.

Treatment should be initiated with a monthly intravitreal injection for the first 5 consecutive doses, followed by one injection every 2 months.

The interval between two doses should not be shorter than one month.

Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.

Coverage will be provided for patients responding to therapy with another anti-VEGF agent who switch to this product. Coverage will NOT be provided for patients who have failed to respond to other anti-VEGF agents.

LU Authorization: 1 Year

New Multi-Source Products

Where applicable, please consult the respective brand reference product's drug profile on the ODB e-Formulary for the details of the Limited Use (LU) code and criteria, and/or any associated Therapeutic Notes (TN).

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02547805	Auro-Sitagliptin Hydrochloride and Metformin Hydrochloride	50mg & 500mg	Tab	AUR	0.4446
02547813	Auro-Sitagliptin Hydrochloride and Metformin Hydrochloride	50mg & 850mg	Tab	AUR	0.4446
02547821	Auro-Sitagliptin Hydrochloride and Metformin Hydrochloride	50mg & 1000mg	Tab	AUR	0.4446

(Interchangeable with Janumet – GB)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02553368	Jamp Rivaroxaban	2.5mg	Tab	JPC	0.3550

(Interchangeable with Xarelto – GB)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02552256	Jamp Rivastigmine Capsules	1.5mg	Cap	JPC	0.6514
02552264	Jamp Rivastigmine Capsules	3mg	Cap	JPC	0.6514
02552272	Jamp Rivastigmine Capsules	4.5mg	Cap	JPC	0.6514
02552280	Jamp Rivastigmine Capsules	6mg	Cap	JPC	0.6514

(Interchangeable with Exelon – LU)

New Multi-Source Products (Continued)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02556189	Jamp Sitagliptin Hydrochloride / Metformin	50mg & 500mg	Tab	JPC	0.4446
02556197	Jamp Sitagliptin Hydrochloride / Metformin	50mg & 850mg	Tab	JPC	0.4446
02556200	Jamp Sitagliptin Hydrochloride / Metformin	50mg & 1000mg	Tab	JPC	0.4446

(Interchangeable with Janumet – GB)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02551683	Mar-Dienogest	2mg	Tab	MAR	0.5115

(Interchangeable with Visanne – LU)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02548461	MyStep	1.5mg	Tab	JPC	4.3000

(Interchangeable with Plan B – GB)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02431327	Pantoprazole	40mg	DR Tab	RIA	0.2016

(Interchangeable with Pantoloc – LU)

New Multi-Source Products (Continued)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02552736	PMS-Methadone Hydrochloride Oral Concentrate	10mg/mL	Oral Concentrate (Cherry Flavoured)	PMS	0.0525

(Interchangeable with Methadose DIN 02394596 – GB)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02552728	PMS-Methadone Hydrochloride Oral Concentrate	10mg/mL	Oral Concentrate (Unflavoured)	PMS	0.0525

(Interchangeable with Methadose DIN 02394618 – GB)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02548747	PRZ-Metoclopramide	5mg	Tab	PRZ	0.0257

(Interchangeable with Maxeran – GB)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP
02316447	Riva-Valacyclovir	500mg	Tab	RIA	0.6198

(Interchangeable with Valtrex – GB)

New Off-Formulary Interchangeable (OFI) Products

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	Unit Cost
02496127	Ertapenem for Injection	1g/Vial	Pd for Sol-1g Vial Pk	FKC	52.2650/Vial Pk

(Interchangeable with Invanz)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	Unit Cost
02552957	Eugia-Pazopanib	200mg	Tab	EUP	30.9655

(Interchangeable with Votrient)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	Unit Cost
02415216	Meropenem for Injection, USP	500mg/Vial	Pd for Sol-500mg Vial Pk	FKC	23.9950/Vial/Pk
02415224	Meropenem for Injection, USP	1g/Vial	Pd for Sol-1g Vial Pk	FKC	47.9900/Vial/Pk

(Interchangeable with Merrem)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	Unit Cost
02237140	Cefazolin for Injection, USP	10g/Vial	Pd for Sol-10g Vial Pk (Preservative-Free)	FKC	56.0000/Vial Pk

(Interchangeable with Ancef DIN 01919628)

New Off-Formulary Interchangeable (OFI) Products (Continued)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	Unit Cost
02553740	Jamp Methotrexate Tablets	10mg	Tab	JPC	2.6588

(Interchangeable with Methotrexate Tablets, USP)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	Unit Cost
02534673	PRZ-Metformin	1000mg	Tab	PRZ	0.0399

(Interchangeable with Glucophage)

Transition from Limited Use to General Benefit

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
02213826	Revia	50mg	Tab	TEV
02444275	Apo-Naltrexone	50mg	Tab	APX
02451883	Naltrexone Hydrochloride Tablets USP	50mg	Tab	STN

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Additional Limited Use Code & Clinical Criteria

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
02527618	Vabysmo	6mg/0.05mL	Inj Sol-0.24mL Vial Pk (Preservative-Free)	HLR

Reason For Use Code and Clinical Criteria

LU Code: 725

For the treatment of patients with clinically significant macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO).

Treatment should be initiated with an intravitreal injection every 4 weeks until stable visual acuity improvement and disease control are achieved.

The treatment interval may be extended up to 16 weeks (4 months) in up to 4-week increments at a time in patients without disease activity.

If anatomic and/or visual outcomes deteriorate, the treatment interval should be shortened accordingly. The interval between doses should not be shorter than one month.

Patients should be assessed regularly. Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.

For clarity, coverage will be provided for patients responding to therapy with another anti-VEGF agent who switch to this product. Coverage will NOT be provided for patients who have failed to respond to other anti-VEGF agents.

LU Authorization Period: 1 year

Limited Use Code & Clinical Criteria Changes

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
02245619	Copaxone	20mg/mL	Inj Sol Pref Syr-1mL Pk	TEI
02541440	Glatiramer Acetate Injection	20mg/mL	Inj Sol Pref Syr-1mL Pk	MYL

Code 535, 536, 537: LU codes and criteria added.

Code 691, 692, 693: LU codes and criteria ended as of the August 2025 formulary update.

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
02460661	Glatect	20mg/mL	Inj Sol-Pref Syr 1mL Pk	PMS

Code 535, 536: Replacement of word Glatect with glatiramer acetate in the LU criteria.

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
02343541	Prolia (Preservative Free)	60mg/mL	Inj Sol-Pref Syr	AMG

Code 428, 429, 515, 516: LU codes and criteria ended as of the August 2025 formulary update.

Limited Use Code & Clinical Criteria Changes (Continued)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
09858364	Jamteki	45mg/0.5mL	Inj Sol-0.5mL Vial Pk (Preservative-Free)	JPC
02543036	Jamteki	45mg/0.5mL	Inj Sol-0.5mL Pref Syr Pk	JPC
02543044	Jamteki	90mg/mL	Inj Sol-1mL Pref Syr Pk	JPC
02550245	Steqeyma	45mg/0.5mL	Inj Sol-0.5mL Pref Syr Pk (Preservative-Free)	CEH
02550253	Steqeyma	90mg/1.0mL	Inj Sol-1.0mL Pref Syr Pk (Preservative-Free)	CEH

Code 668: Addition of content to LU criteria

Refer to the appropriate product monograph for dosing in pediatric patients weighing less than 60kg.

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
02415992	Eylea	40mg/mL	Sol for Intravitreal Inj-0.05mL Vial Pk	BAH
02505355	Eylea	40mg/mL	Inj Sol-0.05mL Pref Syr (Preservative-Free)	BAH

Revisions only to the first paragraph of the LU criteria. The rest of the criteria remain the same.

Code 463

For the treatment of patients with neovascular (wet) age-related macular degeneration (AMD) in a verteporfin PDT (Visudyne)-naive eye, but only for patients established on Eylea (aflibercept) therapy prior to August 29, 2025.

Code 464

For the treatment of patients with clinically significant macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO), but only for patients established on Eylea (aflibercept) therapy prior to August 29, 2025.

Limited Use Code & Clinical Criteria Changes (Continued)

Code 465

For the treatment of patients with clinically significant diabetic macular edema (DME) for whom laser photocoagulation is also indicated; and a hemoglobin A1c of less than 12 percent, but only for patients established on Eylea (aflibercept) therapy prior to August 29, 2025.

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Drug Benefit Price (DBP) Changes

DIN/PIN	Product Name	Strength	Dosage Form	Mfr	DBP/Unit Price
00771384	AA-Diltiaz	60mg	Tab	AAP	0.3802
02244727	AA-Medroxy	5mg	Tab	AAP	0.2602
02277298	AA-Medroxy	10mg	Tab	AAP	0.5649
02162814	Apo-Diclo SR	75mg	LA Tab	APX	0.7699
02292068	Apo-Famciclovir	500mg	Tab	APX	4.2591
02234504	Apo-Terazosin	5mg	Tab	APX	0.6797
02552744	Apo-Vortioxetine	5mg	Tab	APX	1.5853
02552752	Apo-Vortioxetine	10mg	Tab	APX	1.6606
02552779	Apo-Vortioxetine	20mg	Tab	APX	1.8028
02433532	Backup Plan Onestep	1.5mg	Tab-1 Tab Pk	APX	4.3000
02425009	Contingency One	1.5mg	Tab-1 Tab Pk	MYL	4.3000
02300273	Invega	3mg	ER Tab	JAN	4.5570
02300281	Invega	6mg	ER Tab	JAN	6.8160
02300303	Invega	9mg	ER Tab	JAN	9.0850
02496836	Jamp Tolterodine	1mg	Tab	JPC	0.4910
02517795	Mar-Metoclopramide	5mg	Tab	MAR	0.0257
02423308	Mint-Tolterodine	1mg	Tab	MIN	0.4910
09854215	Nutren Junior 1.0	1kcal/mL	Liq-250mL Pk	NES	2.6275
09854223	Nutren Junior Fibre 1.0	1kcal/mL	Liq-250mL Pk	NES	2.6275
02230431	PMS-Metoclopramide Tablets	5mg	Tab	PMS	0.0257
02243520	PMS-Terazosin	5mg	Tab	PMS	0.6797
09857142	Resource Kid Essentials 1.5	1.5kcal/mL	Liq-237mL Pk	NES	3.2978
02266938	Taro-Clindamycin	1%	Top Sol	TAR	0.5072
02496410	Taro-Clotrimazole / Betamethasone Dipropionate	1% w/w & 0.05% w/w	Top Cr	TAR	1.0832
02482983	Taro-Imiquimod Pump	5%	Top Cr	TAR	54.2147
02361698	Taro-Sumatriptan	6mg/0.5mL	Inj Sol-Pref Syr 0.5mL Pk	TAR	42.4650
02242686	Taro-Warfarin	6mg	Tab	TAR	0.5160
02462486	Teva-Cyclosporine	0.05% w/v	Oph Emuls-0.4mL Pk	TEV	4.1658

Discontinued Products

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

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
02483769	Clindamycin Phosphate Topical Solution	1%	Top Sol	TEP
02182866	Dalacin C	300mg	Cap	PFI
02476134	Diclofenac Sodium Solution	1.5% W/W	Top Sol	TEL
02489635	Dorzolamide and Timolol Eye Drops BP	2% & 0.5%	Oph Sol	TCI
02489570	Latanoprost Ophthalmic Solution	0.005%	Oph Sol-2.5mL Pk	TCI

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Delisted Products

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
02305682	Co Famciclovir	125mg	Tab	COB
02305690	Co Famciclovir	250mg	Tab	COB
02305704	Co Famciclovir	500mg	Tab	COB
02350459	Glyburide	2.5mg	Tab	SAI
02433001	Lansoprazole	15mg	DR Cap	PMS
02433028	Lansoprazole	30mg	DR Cap	PMS
02454653	Levetiracetam	250mg	Tab	PMS
02454661	Levetiracetam	500mg	Tab	PMS
02454688	Levetiracetam	750mg	Tab	PMS
02469030	Pharma-Amlodipine	5mg	Tab	PMS
02469049	Pharma-Amlodipine	10mg	Tab	PMS
02440369	PMS-Amphetamines XR	5mg	ER Cap	PMS
02440377	PMS-Amphetamines XR	10mg	ER Cap	PMS
02440385	PMS-Amphetamines XR	15mg	ER Cap	PMS
02440393	PMS-Amphetamines XR	20mg	ER Cap	PMS
02440415	PMS-Amphetamines XR	30mg	ER Cap	PMS
02246284	PMS-Brimonidine	0.2%	Oph Sol	PMS
02309521	PMS-Clobetasol	0.05%	Cr	PMS
02309548	PMS-Clobetasol	0.05%	Oint	PMS
02231508	PMS-Diclofenac	100mg	Sup	PMS
02239753	PMS-Diclofenac K	50mg	Tab	PMS
02335727	PMS-Digoxin	0.25mg	Tab	PMS
02355752	PMS-Diltiazem CD	120mg	LA Cap	PMS
02355760	PMS-Diltiazem CD	180mg	LA Cap	PMS
02355779	PMS-Diltiazem CD	240mg	LA Cap	PMS
02355787	PMS-Diltiazem CD	300mg	LA Cap	PMS
02236466	PMS-Domperidone	10mg	Tab	PMS
02442426	PMS-Dorzolamide-Timolol	2% & 0.5%	Oph Sol	PMS
02393220	PMS-Dutasteride	0.5mg	Cap	PMS
02434342	PMS-Eletriptan	20mg	Tab	PMS
02434350	PMS-Eletriptan	40mg	Tab	PMS
02255898	PMS-Gabapentin	600mg	Tab	PMS
02255901	PMS-Gabapentin	800mg	Tab	PMS
02398370	PMS-Galantamine ER	8mg	ER Cap	PMS
02398389	PMS-Galantamine ER	16mg	ER Cap	PMS
02398397	PMS-Galantamine ER	24mg	ER Cap	PMS
02236734	PMS-Glyburide	5mg	Tab	PMS

Delisted Products (Continued)

DIN/PIN	Product Name	Strength	Dosage Form	Mfr
02288265	PMS-Leflunomide	10mg	Tab	PMS
02288273	PMS-Leflunomide	20mg	Tab	PMS
02017237	PMS-Naproxen	500mg	Sup	PMS
02294702	PMS-Naproxen EC	375mg	Ent Tab	PMS
02294710	PMS-Naproxen EC	500mg	Ent Tab	PMS
02367483	PMS-Olanzapine	20mg	Tab	PMS
02320851	PMS-Omeprazole	20mg	DR Cap	PMS
02303124	PMS-Pioglitazone	15mg	Tab	PMS
02303132	PMS-Pioglitazone	30mg	Tab	PMS
02303140	PMS-Pioglitazone	45mg	Tab	PMS
00583979	PMS-Promethazine	2mg/mL	O/L	PMS
02310805	PMS-Rabeprazole EC	10mg	Tab	PMS
02310813	PMS-Rabeprazole EC	20mg	Tab	PMS
02247917	PMS-Ramipril	2.5mg	Cap	PMS
02247918	PMS-Ramipril	5mg	Cap	PMS
02247919	PMS-Ramipril	10mg	Cap	PMS
02306034	PMS-Rivastigmine	1.5mg	Cap	PMS
02306050	PMS-Rivastigmine	4.5mg	Cap	PMS
02269252	PMS-Simvastatin	5mg	Tab	PMS
02269260	PMS-Simvastatin	10mg	Tab	PMS
02269279	PMS-Simvastatin	20mg	Tab	PMS
02269287	PMS-Simvastatin	40mg	Tab	PMS
02269295	PMS-Simvastatin	80mg	Tab	PMS
02230828	PMS-Tiaprofenic	300mg	Tab	PMS
02083345	PMS-Timolol	0.5%	Oph Sol	PMS
02324229	PMS-Zolmitriptan	2.5mg	Tab	PMS
02324768	PMS-Zolmitriptan ODT	2.5mg	Orally Disintegrating Tab	PMS
02432897	Telmisartan	40mg	Tab	PMS
02432900	Telmisartan	80mg	Tab	PMS
02158582	Teva-Diclofenac SR	75mg	LA Tab	TEV
00862932	Teva-Diltiazem	60mg	Tab	TEV
02221292	Teva-Medroxyprogesterone	5mg	Tab	TEV
02221306	Teva-Medroxyprogesterone	10mg	Tab	TEV
02230807	Teva-Terazosin	5mg	Tab	TEV
02299593	Teva-Tolterodine	1mg	Tab	TEV