

### IFHP Benefit Grid – Prescription Drug Coverage

Benefit Description	Pre-authorization Requirements
<b>Regular Drug Benefit List</b> (by province or territory)	See NOTES 1, 2, 3, 5, 6 & 7
NOTE 1 -	Interchangeable program applies to pay low cost generic available.
NOTE 2 -	Prescription is required.
NOTE 3 -	Prior approval is required for prescriptions bearing a notification that no substitution is allowed if the drug prescribed is not a low-cost generic.
NOTE 5 -	In British Columbia and Alberta, IFHP covers anti-retroviral medications provided through the BC Center for Excellence in HIV HIV/AIDS and Alberta Province Wide Services (PWS) Anti-retroviral Medications for IFHP beneficiaries who meet the therapeutic requirements for anti-retroviral therapy. No prior approval is required.
NOTE 6 -	For drug lists per Province/Territory use the following P/T Formulary links. Please note that certain products are excluded under the IFHP.
NOTE 7 -	In Saskatchewan, Alberta, Ontario, British Columbia, and New Brunswick, IFHP covers anti-tubercular agents provided by the Saskatchewan TB Program, the Alberta TB Program, the Ontario TB Program, the British Columbia TB Program and the New Brunswick TB Drug Plan respectfully.
<b>Alberta:</b>	<a href="#">Alberta Prescription Drug Coverage</a>
<b>British Columbia:</b>	<a href="#">British Columbia Prescription Drug Coverage</a>
<b>Manitoba:</b>	<a href="#">Manitoba Prescription Drug Coverage</a>
<b>New Brunswick:</b>	<a href="#">New Brunswick Prescription Drug Coverage</a>
<b>Newfoundland:</b>	<a href="#">Newfoundland Prescription Drug Coverage</a>
<b>Northwest Territories - NIHB formulary:</b>	<a href="#">NT Prescription Drug Coverage</a>
<b>Nova Scotia:</b>	<a href="#">Nova Scotia Prescription Drug Coverage</a>
<b>Nunavut - NIHB formulary:</b>	<a href="#">Nunavut Prescription Drug Coverage</a>
<b>Ontario:</b>	<a href="#">Ontario Prescription Drug Coverage</a>
<b>Prince Edward Island:</b>	<a href="#">PEI Prescription Drug Coverage</a>
<b>Quebec:</b>	<a href="#">Quebec Prescription Drug Coverage</a>
<b>Saskatchewan:</b>	<a href="#">Saskatchewan Prescription Drug Coverage</a>
<b>Yukon:</b>	<a href="#">Yukon Prescription Drug Coverage</a>

Benefit Description	Pre-authorization Requirements
<b>Limited Use, Exceptional Status, Special Authorization or Restricted Use Medications</b>	<b>YES</b> - See NOTES 2, 4 & 6
<p><b>Alberta:</b> <a href="#">Alberta Prescription Drug Coverage</a></p> <p><b>British Columbia:</b> <a href="#">British Columbia Prescription Drug Coverage</a></p> <p><b>Manitoba:</b> <a href="#">Manitoba Prescription Drug Coverage</a></p> <p><b>New Brunswick:</b> <a href="#">New Brunswick Prescription Drug Coverage</a></p> <p><b>Newfoundland:</b> <a href="#">Newfoundland Prescription Drug Coverage</a></p> <p><b>Northwest Territories - NIHB formulary:</b> <a href="#">NT Prescription Drug Coverage</a></p> <p><b>Nova Scotia:</b> <a href="#">Nova Scotia Prescription Drug Coverage</a></p> <p><b>Nunavut - NIHB formulary:</b> <a href="#">Nunavut Prescription Drug Coverage</a></p> <p><b>Ontario:</b> <a href="#">Ontario Prescription Drug Coverage</a></p> <p><b>Prince Edward Island:</b> <a href="#">PEI Prescription Drug Coverage</a></p> <p><b>Quebec:</b> <a href="#">Quebec Prescription Drug Coverage</a></p> <p><b>Saskatchewan:</b> <a href="#">Saskatchewan Prescription Drug Coverage</a></p> <p><b>Yukon:</b> <a href="#">Yukon Prescription Drug Coverage</a></p>	
NOTE 2 - Prescription is required.	
NOTE 4 - Prior approval is required for the drug listed as Restricted Use, Limited Use, Exceptional Status or Special Authorization unless the same drug is listed in the IFHP additional drug benefit list. IFHP will use the same recognition criteria for prior approval and payment as provided in the provincial/territorial public prescription drug insurance plan.	
NOTE 6 - For drug lists per Province/Territory use the following P/T Formulary links. Please note that certain products are excluded under the IFHP.	

**IFHP ADDITIONAL DRUG BENEFITS**

Benefit Description	Pre-authorization Requirements
<b>SCABICIDES and PEDICULICIDES</b>	<b>See NOTES 1 &amp; 2</b>
Gamma-Benzene Hexachloride 1% lot	No
Gamma-Benzene Hexachloride 1% Shampoo	
Permethrin 5% lot	
Permethrin 1% Cr Rinse	
Permethrin Dermal Cream 5% Cr	
NOTE 1 - Interchangeable program applies to pay low cost generic available.	
NOTE 2 - Prescription is required.	

Benefit Description	Pre-authorization Requirements
<b>VITAMINS / MINERALS / ANTIANEMIA DRUGS</b>	<b>See NOTES 1 &amp; 2</b>
Calcium Carbonate 500 mg tab	No
Calcium Carbonate/Vitamin D 500 mg - 125 UI and 200 UI tab	
Calcium Carbonate/Vitamin D 500 mg - 400 UI tab; caps	
Vitamin D 10 000 UI caps; 10 000 UI tab	
Vitamin D 400 UI caps; 400 UI tab	
Pre-Natal Multivitamins - Materna	
Cyanocobalamin (B12) tab	
Folic Acid 5 mg tab	
Electrolyte & Dextrose Oral	
Ferrous Sulfate Tab 300 mg to 325 mg (Fe-60 mg to 65 mg)	
Ferrous Sulfate Oral Sol 75 mg/mL(Fe-15 mg/mL)	
<b>NOTE 1 -</b> Interchangeable program applies to pay low cost generic available.	
<b>NOTE 2 -</b> Prescription is required.	

Benefit Description	Pre-authorization Requirements
<b>ANALGESICS and ANTIPYRETICS</b>	<b>See NOTES 1 &amp; 2</b>
Acetaminophen	No
<b>NOTE 1 -</b> Interchangeable program applies to pay low cost generic available.	
<b>NOTE 2 -</b> Prescription is required.	

Benefit Description	Pre-authorization Requirements
<b>CATHARTICS and LAXATIVES</b>	<b>See NOTES 1 &amp; 2</b>
Docusate Sodium and Calcium	No
Sennosides	
<b>NOTE 1 -</b> Interchangeable program applies to pay low cost generic available.	
<b>NOTE 2 -</b> Prescription is required.	

Benefit Description	Pre-authorization Requirements
<b>NITRATES and NITRITES</b>	<b>See NOTES 1 &amp; 2</b>
Glyceryl Trinitrate patch 0.2 mg	No
Glyceryl Trinitrate patch 0.4 mg	
Glyceryl Trinitrate Patch 0.6 mg	
Glyceryl Trinitrate Patch 0.8 mg	
Glyceryl Trinitrate Top. Oint	
Glyceryl Trinitrate S. ling tab 0.3 mg	
Glyceryl Trinitrate S.ling tab 0.6 mg	
Glyceryl Trinitrate spray 0.4 mg	
<b>NOTE 1 -</b> Interchangeable program applies to pay low cost generic available.	
<b>NOTE 2 -</b> Prescription is required.	

Benefit Description	Pre-authorization Requirements
<b>PLASMODICIDES (ANTIPROTOZOALS)</b>	<b>See NOTES 1 &amp; 2</b>
Diiodohydroxyquin 210 mg tab; 650 mg tab	No
Atovaquone 150 mg/ml Oral Susp	
Atovaquone/Proguanil Hydrochloride 62.5 mg-25 mg tab; 250 mg-100 mg tab	
Paromomycine Sulfate 250 mg cap	
Isethionate Pentamidine 300 mg inj	
Chloroquine Phosphate 250 mg tab	
Hydroxychloroquine Sulfate 200 mg tab	
Primaquine Phosphate 15 mg tab; 26.3 mg tab	
Pyrimethamine 25 mg tab	
Quinine Sulphate 200 mg/300 mg caps	
Mefloquine Hydrochloride 250 mg tab	
Metronidazole 500 mg cap; 250 mg tab	
<b>NOTE 1 -</b> Interchangeable program applies to pay low cost generic available.	
<b>NOTE 2 -</b> Prescription is required.	

Benefit Description	Pre-authorization Requirements
<b>ANTIHELMINTICS</b>	<b>See NOTES 1 &amp; 2</b>
Mebendazole 100 mg tab	No
Thiabendazole 500 mg tab	
Praziquantel 600 mg tab	
Pyrantel Pamoate 50 mg oral susp; 125 mg tab	
Piperazine Adipate 2 g Pk	
Ivermectin	
<b>NOTE 1 -</b> Interchangeable program applies to pay low cost generic available.	
<b>NOTE 2 -</b> Prescription is required.	

Benefit Description	Pre-authorization Requirements
<b>TOXOIDS and VACCINES</b>	<b>See NOTE 2</b>
Tetanus - Diphtheria Toxoid (Absorbed) <b>(T,d)</b>	Yes
Diphtheria - Tetanus Toxoid - Poliomyelitis Vaccine (Inactivated, Absorbed) <b>(T,d, IPV)</b>	
Diphtheria - Tetanus Toxoid - Pertussis (Acellular) <b>T,d,ap</b>	
Diphtheria - Tetanus Toxoid - Pertussis (Acellular) <b>D,T,aP</b>	
Diphtheria - Tetanus Toxoid - Pertussis (Acellular) Poliomyelitis Vaccine (Inactivated) <b>D,T,aP, IPV</b>	
Diphtheria - Tetanus Toxoid - Acellular Pertussis Vaccine - Haemophilus B Conjugate <b>D,T,aP+(Hib)</b>	
Diphtheria - Tetanus Toxoid - Acellular Pertussis Vaccine – Inactivated Poliomyelitis Vaccine - Haemophilus B Conjugate <b>D,T,aP, IPV+(Hib)</b>	
Haemophilus Influenzae Type B Conjugate Vaccine <b>(Hib)</b>	
Hepatitis A Vaccine (Inactivated)	
Hepatitis B Vaccine (Recombinant)	
Hepatitis A & B Vaccine (Combination)	
Measles - Mumps - Rubella Virus Vaccine (Live, Attenuated)	
Meningococcal Polysaccharide Vaccine (Men-A-C-Y-W-135)	
Meningococcal Conjugate Vaccine (Men-C)	
Pneumococcal Conjugate (Pneu-C-10); (Pneu-C-13)	
Pneumococcal polysaccharide - 23 valent (Pneu-P-23)	
Poliomyelitis Vaccine (Inactivated)	
Varicella Virus Vaccine	
Influenzae Vaccine	
<b>NOTE 2 -</b> Prescription is required.	