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Programmes provinciaux de médicaments
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PEI Pharmacare Bulletin

Issue (2026-08) **July 14, 2026**

NEW PRODUCT(S) ADDED TO THE PEI PHARMACARE FORMULARY (EFFECTIVE DATE: JULY 28, 2026)

Product (Generic name)	Product (Brand name)	Strength	Dosage Form	DIN	MFR
Evinacumab	**Evkeeza**	**150mg/mL**	**Vial**	**02541769**	**UGX**
Criteria	For the treatment of homozygous familial hypercholesterolemia (HoFH) in adult and pediatric patients 5 years of age and older with a clinically or genetically confirmed diagnosis if the following criteria are met: Clinical criteria: • Untreated TC > 12.93 mmol/L and TGs < 3.39 mmol/L, AND • Both parents with documented TC > 6.47 mmol/L, indicative of HeFH, or patient with cutaneous or tendinous xanthoma before the age of 10 years Genetic criteria: • Documented functional mutation or mutations in both LDLR alleles, OR • Documented homozygous or compound heterozygous mutations in Apo B or PCSK9, or LDLRAP1, or at least 2 such variants at different loci • Elevated LDL-C despite an adequate trial of other accessible lipid-lowering therapies; “elevated LDL-C” is defined as LDL-C greater than 1.8 mmol/L at baseline for adult patients and greater than 3.4 mmol/L for children. Initial and Subsequent Renewals: • The prescriber must provide proof of beneficial clinical effect when requesting continuation of reimbursement, defined as reduction in LDL-C from baseline that is considered clinically beneficial by the treating prescriber. Claim Notes: • Initial approval: 24 weeks • Renewal approval: 1 year • Approvals will be for a maximum of 15 mg/kg every 4 weeks • The prescriber must provide the baseline LDL-C when the initial request for reimbursement occurs after all other treatment options of lipid-lowering therapies have been exhausted.				

	• Evinacumab must be prescribed by specialists with qualifications and experience in the diagnosis and management of HoFH (e.g., [pediatric] endocrinologists, cardiologists, lipidologists).
Program Eligibility	High Cost Drug Program, Financial Assistance Drug Program, Nursing Home Drug Program, Catastrophic Drug Program

Mirikizumab	**Omvoh**	**100mg/mL & 200mg/2mL 100mg/mL & 200mg/2mL**	**Pre-filled pen carton Pre-filled syringe carton**	**02559242 02559234**	**LIL**
Criteria	See online Formulary for mirikizumab criteria.				
Program Eligibility	High Cost Drug Program, Financial Assistance Drug Program, Nursing Home Drug Program, Catastrophic Drug Program				

Palovarotene	**Sohonos**	**1mg 1.5mg 2.5mg 5mg 10mg**	**Capsule**	**02524627 02524635 02524643 02524651 02524678**	**IPS**
Criteria	Coverage is for females aged 8 years and above and males aged 10 years and above with a clinical diagnosis of fibrodysplasia ossificans progressiva (FOP) and the R206H ACVR1 mutation as confirmed by genetic testing. Clinical Notes: • Patients must not have complete ankylosis of the whole body. • Palovarotene should be discontinued if it is agreed that the perceived balance of benefits and risks is no longer acceptable or if the patient progresses to complete ankylosis of the whole body. Claim Note: • Palovarotene must be prescribed by an expert in the diagnosis and management of FOP.				
Program Eligibility	High Cost Drug Program, Financial Assistance Drug Program, Nursing Home Drug Program, Catastrophic Drug Program				

Secukinumab	**Cosentyx**	**300mg/2mL**	**Pre-filled syringe Pre-filled pen**	**02529653 02529661**	**NVR**
Criteria	See online Formulary for secukinumab criteria.				
Program Eligibility	High Cost Drug Program, Financial Assistance Drug Program, Nursing Home Drug Program, Catastrophic Drug Program				

Setmelanotide	**Imcivree**	**10mg/mL**	**Vial**	**02537745**	**RYT**
Criteria	For weight management in adult and pediatric patients 6 years of age and older with obesity due to clinically or genetically confirmed Bardet-Biedl syndrome (BBS). Initial Renewal Criteria: • The physician must provide proof of beneficial clinical effect, including: o at least a 5% reduction in BMI or total body weight in patients who are at least 12 years of age, OR o a reduction in BMI Z score that is considered clinically beneficial by the treating physician as appropriate for patients who are 6 to 11 years of age.				

	Subsequent Renewal Criteria:
	• The physician must provide proof that the initial response achieved after the first 26 weeks of therapy with setmelanotide has been maintained, including:
	  o maintenance of BMI or total body weight, OR
	  o maintenance of BMI Z score.
	
	Clinical Notes:
	• Obesity is defined as BMI ≥ 30 for patients aged ≥ 16 years, or weight > 97th percentile for age and sex in patients aged < 16 years.
	• Clinical diagnosis of BBS is to be based on the Beales criteria.
	
	Claim Notes:
	• Initial approval: 26 weeks
	• Renewal approval: 1 year
	• The patient must be under the care of an endocrinologist, pediatric endocrinologist, and/or specialist in weight management or obesity.
	• Approvals will be for a maximum of 2.0 mg daily for patients aged 6 to 17 years old and up to 3.0 mg daily for patients aged 18 years and older.

Program Eligibility	High Cost Drug Program, Financial Assistance Drug Program, Nursing Home Drug Program, Catastrophic Drug Program

Tenofovir Alafenamide	**Vemlidy**	**25mg**	**Tablet**	**02464241**	**GIL**
Criteria	Open benefit				
Program Eligibility	Hepatitis Drug Program				

CRITERIA UPDATES

Effective immediately, special authorization criteria for currently listed febuxostat tablets have been amended to the following:

For the treatment of symptomatic gout in patients who are refractory, intolerant or have a contraindication to allopurinol.

Effective immediately, special authorization criteria for currently listed mirikizumab (Omvoh) products have been amended to include the following:

Crohn's Disease

For the treatment of patients with moderate to severe Crohn's disease who have active disease and are refractory, intolerant or have contraindications to:

- Prednisone 40mg (or equivalent) daily for ≥ 2 weeks (not required for treatment of Fistulizing Crohn's Disease), AND
- Azathioprine ≥ 2 mg/kg/day for ≥ 3 months, OR
- Mercaptopurine ≥ 1 mg/kg/day for ≥ 3 months, OR
- Methotrexate (SC or IM) ≥ 15 mg/week for ≥ 3 months

Clinical Notes:

- Refractory is defined as lack or loss of effect at the recommended doses and for duration of treatments specified above.
- Intolerant is defined as demonstrating serious adverse effects to treatments. The nature of intolerance(s) must be clearly documented.

- Consideration will be given for the approval of a biologic DMARD (disease modifying antirheumatic drug) without a trial of a traditional DMARD for patients who have an aggressive/severe disease course (e.g. extensive disease, a modified Harvey Bradshaw Index score > 16) and are refractory, intolerant or have contraindications to systemic corticosteroids.

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Combined use with other biologic drugs or janus kinase (JAK) inhibitors will not be reimbursed.
- Approvals will be for a maximum of 900mg intravenously at Weeks 0, 4 and 8, followed by a maintenance dose of 300mg subcutaneously at Week 12 and every 4 weeks thereafter.
- Initial Approval: 6 months
- Renewal Approval: 1 year

ORAL SEMAGLUTIDE (RYBELSUS) UPDATE

Pharmacare is aware of the discontinuation of Rybelsus 14mg and the anticipated discontinuation of Rybelsus 7mg and 3mg. In light of these supply issues, Pharmacare will not be approving new starts on Rybelsus at this time.

Although new strengths of Rybelsus have recently become available, they are not currently listed on the PEI Pharmacare Formulary. As a result, coverage will not be provided for these products at this time. Additionally, Pharmacare will not approve the use of multiple tablets to achieve a prescribed dose (e.g., two tablets of a lower strength), as this approach is not supported by the product monograph.

For patients currently receiving Rybelsus, switching to an injectable semaglutide product will be permitted without the need for a new Special Authorization request. Please contact the Pharmacare office to facilitate this switch.

BIOSIMILAR INITIATIVE REMINDER

Patients with existing coverage of Actemra® must switch to the biosimilar version by July 31, 2026, to maintain coverage through PEI Pharmacare. After July 31, 2026, Actemra® will be delisted as a benefit under the Pharmacare Programs.

PRESCRIBER BILLING NUMBER REMINDER

When creating a prescriber profile, ensure the prescriber's **billing number** is entered in the *"license"* field of the profile in your pharmacy system. This billing number is different from the prescriber's actual license number.

The billing number "**999**" should only be used if the prescriber is from outside Prince Edward Island and does not have a PEI billing number. It must **not** be used for prescribers licensed in PEI, as this does not comply with PEI Health Information Act Regulations. Entering an incorrect billing number will result in the wrong prescriber being identified in the Drug Information System (DIS). All pharmacies are responsible for routinely reviewing and verifying prescriber information during prescription processing and correcting any inaccuracies or incomplete entries.

If you require a billing number:

- You may contact the Help Desk for assistance.
- Alternatively, billing numbers can be found on the Resources for Community Pharmacies page: https://src.healthpei.ca/resources-community-pharmacies under the PEI Eligible Physicians List, which includes other authorized prescribers. It is password-protected, and PEI Pharmacare can provide the password upon request by phone or email. As this is a live document, we recommend bookmarking the page rather than downloading the PDF to ensure access to the most current information.

Note: Pharmacist prescribers are an exception. Their billing number is the same as their license number.