Drug Formulary

November 1, 2020

Disclaimer: The Saskatchewan Cancer Agency Drug Formulary is an **information-only** resource that identifies the funding status of cancer treatment drugs and some supportive drugs used to care for cancer patients in Saskatchewan. This information is intended to be for informational purposes only and is current as of the date listed on the Drug Formulary. It is not intended to constitute medical advice.

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Abiraterone	Oral (tablet) 250 mg, 500 mg	Formulary --- STEP access	Approved for the following indications: Prostate – Metastatic, Castration-Resistant • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required prior to treatment initiation • Treatment of symptomatic metastatic castration-resistant prostate cancer (in combination with Prednisone) in patients who have received prior chemotherapy with Docetaxel or who are not candidates for treatment with Docetaxel • Treatment of metastatic castration-resistant prostate cancer (in combination with Prednisone) in patients who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy who have not received prior chemotherapy Notes: Patients are not eligible for Abiraterone if they have previously experienced disease progression on Enzalutamide used for treatment of metastatic castration-resistant prostate cancer (mCRPC) Patients are eligible for Abiraterone if they have previously experienced disease progression on Apalutamide or Enzalutamide used for treatment of non-metastatic castration-resistant prostate cancer (nmCRPC) Not funded for treatment of hormone naïve metastatic prostate cancer or for patients with castration-resistant prostate cancer without evidence of metastases (e.g., biochemical only recurrence/relapse)
Abraxane® Paclitaxel-nanoparticle albumin-bound (nab) (tradename used to minimize confusion with Paclitaxel)	Injection (vial) 100 mg	Formulary	Approved for the following indications: Breast Cancer - Metastatic • Patients who have experienced previous anaphylaxis or anaphylactoid reactions with standard Paclitaxel or Docetaxel infusions where further use of a taxane is desirable • Patients who have significant contraindications to the pre-medications for taxanes (e.g. uncontrolled diabetes) Pancreas Cancer – Locally Advanced or Metastatic • In combination with Gemcitabine as first or second-line (after FOLFIRINOX) treatment of patients with locally advanced unresectable or metastatic adenocarcinoma of the pancreas who have a good performance status
Acitretin	Oral (capsule) 10 mg, 25 mg	Formulary	Approved for the following indication: • Treatment of refractory cutaneous T-cell lymphoma (e.g. mycosis fungoides)
Afatinib	Oral (tablet) 20 mg, 30 mg 40 mg	Formulary	Non-Small Cell Lung Cancer (NSCLC) - Advanced • First line treatment of patients with EGFR mutation positive advanced or metastatic adenocarcinoma of the lung with an ECOG performance status of 0 or 1 Note: o Patients experiencing disease progression on Afatinib precludes the use of any other EGFR inhibitor as a subsequent line of therapy, with the exception of Osimertinib for tumors with identified T790M mutations

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Akynzeo® Netupitant/ Palonosetron	Oral (capsule) 300 mg Netupitant/ 0.5 mg Palonosetron	Formulary	Approved for the following indications: • Primary prevention of acute and delayed nausea and vomiting for patients receiving highly emetogenic chemotherapy (e.g. single day Cisplatin regimens ≥40 mg/m^2, women with breast cancer receiving an anthracycline and Cyclophosphamide [e.g., AC, FE$_{100}$C], and regimens containing Carmustine, Mechlorethamine, Streptozocin or high dose single day Dacarbazine [e.g., ≥850 mg/m^2]) in combination with Dexamethasone • Secondary prevention of acute nausea and vomiting for patients receiving moderately emetogenic chemotherapy (e.g., multi-day Cisplatin-based chemotherapy [BEP], ABVD and CHOP like regimens) where emesis (vomiting) is experienced despite treatment with a combination of a 5-HT3 antiemetic (e.g. Ondansetron) and Dexamethasone in a previous cycle
Aldesleukin Interleukin-2, IL-2	Injection (vial) 22 MU	Formulary	Approved for the following indication: • Intralesional treatment of unresectable in-transit metastatic melanoma (e.g., in patients with rapidly developing in-transit metastases after surgery or patients who present with multiple in-transit metastases unsuitable for surgical resection)
Alectinib	Oral (capsule) 150 mg	Formulary	Approved for the following indications: Non-Small Cell Lung Cancer (NSCLC) - Advanced • First-line treatment of patients with anaplastic lymphoma kinase (ALK)-positive, locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer (NSCLC) • Treatment of patients with anaplastic lymphoma kinase (ALK)-positive, locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer (NSCLC) who have disease progression on or intolerance to Crizotinib • Eligible patients should have a good performance status and treatment should continue until disease progression or unacceptable toxicity Notes: o If Alectinib is chosen as first-line therapy, Ceritinib is not funded as a subsequent line of therapy o Alectinib is not funded following two prior ALK inhibitor therapies (e.g., Crizotinib followed by Ceritinib)
All-trans Retinoic Acid ATRA, Tretinoin,	Oral (capsule) 10 mg	Formulary	See Tretinoin
Amsacrine	Injection (ampoule) 75 mg/1.5 mL	Formulary	Approved for the following indication: • Induction of remission in adult acute leukemia refractory to conventional therapy Note: Amsacrine is not routinely stocked by the Cancer Centre Pharmacies and sufficient notice for purchase must be provided
Anagrelide	Oral (capsule) 0.5 mg	Formulary	Approved for the following indication: • Treatment of essential thrombyotosis or polycythemia vera with elevated platelets after failure or intolerance of Hydroxyurea Note: Anagrelide also has full listing on the Saskatchewan Prescription Drug Plan (SPDP) Formulary

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Anastrozole	Oral (tablet) 1 mg	Formulary	Approved for the following indications: <u>Breast Cancer - Metastatic</u> • Endocrine therapy in post-menopausal women with hormone-receptor positive breast cancer. Not approved after failure with Letrozole <u>Breast Cancer - Adjuvant</u> • Endocrine therapy in post-menopausal women with hormone-receptor positive disease either initially for 5 to 10 years (upfront strategy), for 2 to 3 years following 2 to 3 years of treatment with Tamoxifen for a total of 5 years (switch strategy), or for up to 5 years following 5 years of treatment with Tamoxifen (extended strategy) • Endocrine therapy in post-menopausal women with hormone-receptor positive ductal carcinoma in-situ (DCIS) for up to 5 years <u>Breast Cancer – Neoadjuvant</u> • Endocrine therapy in post-menopausal women with hormone receptor positive, locally advanced disease, not eligible for chemotherapy

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Apalutamide	Oral (tablet) 60 mg	Formulary --- STEP access	Approved for the following indication: Prostate – Non-metastatic, Castrate-Resistant • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required prior to treatment initiation • In combination with androgen deprivation therapy (ADT) for the treatment of patients with castration-resistant prostate cancer (CRPC) who have no detectable distant metastases by either CT, MRI or technetium-99m bone scan and who are at high risk of developing metastases • High risk is defined as a prostate-specific antigen doubling time (PSADT) of ≤ 10 months during continuous ADT • Patients should have good performance status and no risk factors for seizures; treatment may continue until unacceptable toxicity or radiographic disease progression Notes: o Patients should have histologically or cytologically confirmed adenocarcinoma of the prostate without neuroendocrine differentiation or small cell features o Patients with presence of any distant metastases, including CNS and vertebral or meningeal involvement, are not eligible for Apalutamide; however, patients with pelvic lymph nodes <2 cm in short axis (N1) located below the common iliac vessels are eligible for Apalutamide o Castrate levels of testosterone (<1.7 nmol/L) must be demonstrated prior to treatment initiation with Apalutamide o Castration-resistant prostate cancer must be demonstrated during continuous ADT, and is defined as 3 PSA rises, at least 1 week apart, with the last PSA >2 mcg/L o Patients who are receiving a first generation anti-androgen (e.g., Bicalutamide) must show a further rise in PSA measured at least 6 weeks after discontinuing the anti-androgen to be eligible for Apalutamide o In case of biochemical progression (rising PSA) while on Apalutamide, appropriate clinical evaluation and/or investigations for metastatic disease should be conducted in a timely manner o Patients receiving Apalutamide for treatment of non-metastatic castration-resistant prostate cancer (nmCRPC) will be eligible for SCA funded Abiraterone at the time of disease progression to metastatic castration-resistant prostate cancer (mCRPC) for patients unable to tolerate or who are not candidates for other therapeutic choices (e.g., chemotherapy); Enzalutamide is not funded for patients who experience disease progression to mCRPC while on Apalutamide o Either Abiraterone or Enzalutamide may be used to treat mCRPC in patients who discontinued Apalutamide in the non-metastatic setting due to intolerance without disease progression to the metastatic setting

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Aprepitant (also see Fosaprepitant)	Oral (tablet) 125 mg 80 mg	Formulary	Approved for the following indications: • Primary prevention of acute and delayed nausea and vomiting for patients receiving highly emetogenic chemotherapy [e.g. single day Cisplatin regimens ≥40 mg/m^2, women with breast cancer receiving an anthracycline and Cyclophosphamide (e.g., AC, FE$_{100}$C), and regimens containing Carmustine, Mechlorethamine, Streptozocin or high dose single day Dacarbazine (e.g., ≥850 mg/m^2)] in combination with a 5-HT$_3$ antiemetic (e.g., Ondansetron) and Dexamethasone • Secondary prevention of acute and delayed nausea and vomiting for patients receiving multi-day Cisplatin-based chemotherapy (e.g., BEP), ABVD and CHOP like regimens where emesis (vomiting) is experienced despite treatment with a combination of a 5-HT$_3$ antiemetic (e.g. Ondansetron) and Dexamethasone in a previous cycle • Pediatric patients ≥6 months old receiving highly emetogenic chemotherapy
Arsenic Trioxide	Injection (ampoule) 10 mg/10 mL	Formulary	Approved for the following indications: • As part of first-line induction and/or consolidation therapy in patients with low, intermediate or high-risk acute promyelocytic leukemia (APL) characterized by t(15;17) translocation and/or promyelocytic leukemia-retinoic-acid-receptor alpha (PML-RARα) gene expression • In the relapsed/refractory acute promyelocytic leukemia (APL) setting as part of induction and/or consolidation therapy in: a) patients who have relapsed after completion of first-line therapy, including prior therapy with arsenic trioxide b) patients with t(15;17) translocation and/or PML/RARα gene expression who are refractory to non-arsenic trioxide based treatment
Asparaginase (E.Coli) Kidrolase®	Injection (vial) 10,000 units	Formulary	Note: Kidrolase has been discontinued from the Canadian market as of March 2020
Asparaginase (Erwinia) Crisantaspase	Injection (vial) 10,000 units/1 mL	Formulary	Approved for use in the following indications: • Pediatric patients who are actively enrolled on a COG protocol • Pediatric patients where a COG protocol is being followed "off study" • Patients with acute lymphoblastic leukemia (ALL) who have experienced prior hypersensitivity to other forms of L-asparaginase
Asparaginase-PEG Pegaspargase Oncaspar®	Injection (vial) 3,750 units/5 mL	Formulary	Approved for use in the following indications: • As a component of a multi-agent chemotherapeutic regimen for the treatment of patients with acute lymphoblastic leukemia (ALL)

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Atezolizumab	Injection (vial) 840 mg/14 mL 1,200 mg/20 mL	Formulary --- STEP access	Approved for the following indications: <u>Non-Small Cell Lung Cancer (NSCLC) – Advanced (Stage IIIB or IV)</u> • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required • Treatment of patients with locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer and who have disease progression on or after cytotoxic chemotherapy • Patients with genomic tumor driver aberrations (e.g., epidermal growth factor receptor (EGFR),r anaplastic lymphoma kinase (ALK), or ROS1) should first be treated with targeted agents followed by cytotoxic chemotherapy prior to receiving Atezolizumab • Treatment with Atezolizumab should be discontinued upon loss of clinical benefit or unacceptable toxicity <u>Notes</u>: o Patients must have measurable disease to be considered eligible for funding o Imaging for disease assessment is required at least every 3 months during the first year of Atezolizumab therapy, then at a minimum every 6 months thereafter, or more frequently as clinically indicated o The definition of disease progression is an additional 10% in tumor burden and/or development of new lesions since the time of initial disease progression o If pseudo-progression is suspected (i.e. radiographic progression thought to be immune-related inflammation), a confirmatory radiologic scan must be done 6 to 8 weeks after initial progression to assess for true progression o If Atezolizumab is stopped in the setting of maximum response/stable disease or for intolerance without evidence of disease progression, Atezolizumab may be re-started at time of disease progression/relapse or toxicity resolution o Patients who have received prior treatment with any other PD-1/PD-L1 inhibitor (e.g., Nivolumab, Pembrolizumab) for advanced NSCLC will not be eligible for Atezolizumab o Cytotoxic chemotherapy options remain funded following Atezolizumab, when clinically appropriate o Patients will be eligible for Atezolizumab in the advanced setting only if there has been at least a 6 month progression-free interval between completion of Durvalumab if used for stage III NSCLC and confirmation of disease progression

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Avelumab	Injection (vial) 200 mg/10 mL	Formulary	Approved for the following indications: Merkel Cell Carcinoma – Metastatic (mMCC) • Treatment of metastatic Merkel Cell carcinoma (mMCC) in previously treated adults with good performance status who have had prior cytotoxic chemotherapy • Treatment of metastatic Merkel Cell carcinoma (mMCC) in adults with good performance status who are ineligible for treatment with cytotoxic chemotherapy (e.g., contraindications for treatment with cytotoxic chemotherapy) and who would not be able to receive first-line chemotherapy • Treatment may continue until confirmed disease progression or unacceptable toxicity; for patients who achieve a complete response (CR), treatment should continue for a maximum of 12 months after confirmation of CR Notes: o Patients must have measurable disease to be considered eligible for funding o Imaging for disease assessment is required at least every 3 months during the first year of Avelumab therapy, then at a minimum every 6 months thereafter, or more frequently as clinically indicated o The definition of disease progression is an additional 10% in tumor burden and/or development of new lesions since the time of initial disease progression o If pseudo-progression is suspected (e.g., radiographic progression thought to be immune-related inflammation), a confirmatory radiologic scan must be done 6 to 8 weeks after initial progression to assess for true progression o If Avelumab is stopped in the setting of maximum response/stable disease, or for intolerance without evidence of disease progression, treatment may be re-started at time of disease progression/relapse or toxicity resolution o Patients who have received prior treatment with any other PD-1/PD-L1 inhibitor for mMCC are not eligible for Avelumab
Axitinib	Oral (tablet) 1 mg, 5 mg	Formulary	Approved for use in the following indications: Renal Cell Carcinoma – Metastatic (mRCC) • As a second-line treatment option for patients with metastatic renal carcinoma (mRCC) in patients who experience disease progression after previous treatment with Sunitinib or Pazopanib • As a third-line treatment option for metastatic renal cell carcinoma (mRCC) in patients who experience disease progression after previous treatment with Nivolumab plus Ipilimumab first-line and a VEGF TKI (Sunitinib or Pazopanib) second-line Note: o Either Axitinib or Cabozantinib are funded for third-line treatment of advanced RCC for intermediate or poor risk patients previously treated with Nivolumab plus Ipilimumab first-line and a VEGF TKI (Sunitinib or Pazopanib) second-line

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Azacitidine	Injection (vial) 100 mg	Formulary	Approved for the following indications: <u>Myelodysplastic Syndromes (MDS)</u> • Treatment of myelodysplastic syndrome (MDS) of intermediate-2 or high risk type according to the International Prognostic Scoring System (IPSS) <u>Chronic Myelomonocytic Leukemia (CMML)</u> • Treatment of chronic myelomonocytic leukemia (CMML) with 10-29% blasts • Treatment of chronic myelomonocytic leukemia (CMML) of intermediate-2 or high risk type according to the CMML-specific prognostic scoring system (CPSS) • Treatment of relapsed chronic myelomonocytic leukemia (CMML) following an allogeneic stem cell transplant <u>Acute Myeloid Leukemia (AML)</u> • Treatment of patients with AML with 20-30% blasts • Treatment of patients with AML who are not candidates for induction chemotherapy • Treatment of patients with induction failure if they have MDS related changes or blasts <30%, if they are not candidates for salvage or re-induction chemotherapy • Treatment of patients who achieved a complete response (CR) after induction chemotherapy and are not candidates for any further consolidation chemotherapy or stem cell transplant (SCT) in patients with MDS related changes or poor risk cytogenetics • Treatment of relapsed AML following an alloegenic stem cell transplant
BCG Vaccine Bacillus Calmette-Guerin OncoTICE®	Intravesical (vial) 1 x 10^8 CFU's (colony forming units)	Formulary	

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Bendamustine	Injection (vial) 25 mg, 100 mg	Formulary	Approved for use in the following indications: <u>Indolent non-Hodgkin's lymphoma (NHL) and Mantle Cell Lymphoma (MCL)</u> • Treatment of patients with indolent non-Hodgkin's lymphoma (NHL) including follicular lymphoma, marginal zone lymphoma, lymphoplasmacytic lymphoma and mantle cell lymphoma, in combination with Rituximab (B-R) for a maximum of 6 cycles as a first line option or as one line of therapy in the relapsed setting in patients eligible for Rituximab re-treatment (e.g., in patients with progressive disease or relapse <u>≥</u> 6 months after last Rituximab dose) <u>Notes</u>: Maintenance Rituximab therapy following B-R given in the induction setting is approved for patients who achieve a partial response or greater; <u>Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)</u> • In combination with Rituximab (BR) for patients with CLL/SLL who are either previously untreated or previously treated with chemotherapy (excluding Bendamustine), but have not received any anti-CD20 therapy, or as repeat treatment in patients who have experienced a progression free interval of at least 1 year since the last BR cycle • First line treatment of patients with CLL/SLL as a single agent for a maximum of 6 cycles in patients medically unfit for chemotherapy in combination with anti-CD20 therapy <u>Note</u>: Bendamustine as a single agent is not approved for patients who have received previous treatment for CLL/SLL <u>Blood and Marrow Transplant (BMT)</u> • As part of the BeEAM conditioning regimen prior to autologous stem cell transplant
Bevacizumab (continued on next page)	Injection (vial) 100 mg/4 mL 400 mg/16 mL	Formulary --------- STEP Access	Approved for the following indications: <u>Colorectal Cancer – Metastatic (Unresectable Stage IV)</u> • First line treatment in combination with Irinotecan or Oxaliplatin-based chemotherapy (e.g., FOLFIRI, CAPIRI, FOLFOX, CAPOX~~)~~ • In combination with chemotherapy (e.g., FOLFIRI or FOLFOX) for borderline resectable disease and conversion therapy • In combination with a fluoropyrimidine (Capecitabine or Fluorouracil/Leucovorin) for the first-line treatment of patients with advanced or metastatic colorectal cancer for whom combination chemotherapy with Oxaliplatin or Irinotecan is unsuitable, and who have an ECOG performance status of <u>≤</u>2 <u>Carcinoma of the Cervix</u> • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • In combination with platinum and Paclitaxel for the treatment of patients with metastatic (Stage IVb), persistent, or recurrent carcinoma of the cervix of all histologic subtypes, except small cell, and who have an ECOG performance status of 0 or 1. Bevacizumab is approved at a dose of 15 mg/kg for treatment until disease progression, unacceptable toxicity or complete response.

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Bevacizumab (continued from previous page)	Injection (vial) 100 mg/4 mL 400 mg/16 mL	---------- STEP Access ---------- STEP access	Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Cancer (Front-Line) • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • In combination with platinum and Paclitaxel for the front-line treatment of patients with epithelial ovarian, fallopian tube or primary peritoneal cancer who are at high risk of relapse [Stage III suboptimally debulked (≥1 cm residual disease), Stage III unresectable or Stage IV] and who have an ECOG performance status of ≤ 2. Bevacizumab is approved at a dose of 7.5 mg/kg for 5 cycles (if chemotherapy is initiated ≤ 4 weeks from surgery) or for 6 cycles (if chemotherapy is initiated > 4 weeks from surgery), then for up to 12 additional cycles, or until disease progression Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Cancer (Platinum-Resistant) • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • In combination with Paclitaxel, Topotecan, or pegylated liposomal Doxorubicin for the treatment of patients with platinum-resistant recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (PROC) who have received no more than two prior anticancer regimens; AND who have good performance status, no contraindications to bevacizumab and whose disease is not primary platinum refractory Notes: ○ Eligible patients must have measurable/assessable ovarian cancer that has progressed less than 6 months after completing at least 4 cycles of platinum-based therapy and be carefully reviewed for risk of GI perforation ○ Patients remain eligible for Bevacizumab for PROC if they have received more than two lines of platinum-based treatments, where all treatments were in the setting of platinum-sensitive disease ○ Patients who were previously treated with Bevacizumab in the front-line setting for high risk Stage III disease are not eligible to receive Bevacizumab again in the platinum-resistant setting ○ Patients who are currently receiving treatment with pegylated liposomal Doxorubicin, Paclitaxel or Topotecan for platinum-resistant ovarian cancer, and would have met the criteria for Bevacizumab eligibility at the start of treatment, may have Bevacizumab added to their therapy provided they are still responding to their therapy, or Bevacizumab may be initiated with their next line of therapy for PROC, providing they have not shown resistance to all the chemotherapy options that may be used with Bevacizumab ○ Patients with PROC who have been previously treated and experienced disease progression on all approved chemotherapy options with Bevacizumab (pegylated liposomal Doxorubicin, Paclitaxel and Topotecan) are not eligible to receive Bevacizumab with another chemotherapy treatment ○ Treatment should continue until disease progression or unacceptable toxicity. Bevacizumab is not funded as a single agent if chemotherapy is interrupted or held for any reason
Bicalutamide	Oral (tablet) 50 mg	Formulary	
Bleomycin	Injection (vial) 15 units	Formulary	

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Blinatumomab	Injection (vial) 35 mcg	Formulary	Approved for the following indications: <u>Acute Lymphoblastic Leukemia (ALL)</u> • Treatment of *pediatric* patients with Philadelphia chromosome-negative (Ph-) relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL) who are in second or later relapse, or who relapsed after allogeneic hematopoietic stem cell transplant (alloHSCT), or who have refractory disease; treatment should be for patients with a good performance status and no active central nervous system disease • Treatment of *adult* patients with Philadelphia chromosome-negative (Ph-) relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL); treatment should be for patients with a good performance status and patients may be treated for up to 2 cycles of induction and 3 cycles of consolidation • Treatment of *adult* patients with Philadelphia chromosome-positive (Ph+) relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL); treatment should be for patients with a good performance status and patients may be treated for up to 2 cycles of induction and 3 cycles of consolidation <u>Notes (Adult BCP-ALL)</u>: • Patients must have CD19 positive B-cell precursor ALL to be eligible for Blinatumomab • In (Ph)-positive B-cell precursor ALL with an overt relapse, defined as the need for repeat induction chemotherapy, physicians may choose Blinatumomab after failure of a first-line tyrosine kinase inhibitor (TKI); in all other (Ph)-positive patients there is a requirement for a trial of a second-line TKI prior to accessing Blinatumomab

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Bortezomib (cont'd on next page)	Injection (vial) 3.5 mg	Formulary	Approved for the following indications: <u>Multiple Myeloma</u> • Treatment of multiple myeloma in patients who are refractory to or have relapsed after at least one prior line of therapy, <u>or</u> have completed at least one full treatment regimen and are experiencing intolerance to their current therapy • First line treatment for multiple myeloma as part of an approved regimen (e.g., CyBorD, CyBorP, VMP, Bortezomib/Dexamethasone) • For patients eligible for their first autologous stem cell transplant (ASCT) as part of the RVd regimen (Lenalidomide, Bortezomib, Dexamethasone) for the following indications: o 2 to 4 cycles as first-line induction therapy for patients with plasma cell leukemia and high risk multiple myeloma, defined as del 17p, t(4:14), or t(14:16) o 2 cycles as salvage induction therapy in patients who did not achieve an adequate response (i.e. did not achieve a ≥ 50% disease response) after 3 or 4 cycles of CyBorD induction therapy; if a response after 2 cycles of RVd was achieved, but a deeper response is still required, an additional 1 or 2 cycles may be separately requested o 2 cycles as post-transplant consolidation therapy in patients with multiple myeloma who achieve a VGPR or better when an upfront tandem transplant is not planned <u>Note</u>: RVd is not funded as salvage therapy in the relapsed/refractory setting, or as induction or consolidation therapy in conjunction with a second transplant • Step-down maintenance for up to 2 years in patients not proceeding to transplant who have only achieved stable disease after use of a Bortezomib containing protocol in the first line setting • Maintenance treatment for patients with newly diagnosed multiple myeloma with 17p deletion, t(4:14), or t(14:16) following autologous stem cell transplant (ASCT), in patients with stable disease or better, with no evidence of disease progression; treatment may be continued for up to 2 years, unless discontinued due to patient intolerance <u>Note</u>: Maintenance Bortezomib is not funded after a second ASCT; patients that start maintenance Bortezomib in this setting are not eligible for treatment with maintenance Lenalidomide • Maintenance treatment for patients with newly diagnosed multiple myeloma without a 17p deletion, t(4:14), or t(14:16) following autologous stem cell transplant (ASCT)n patients who develop intolerance to Lenalidomide maintenance in this setting • In combination with Daratumumab as part of the DVd regimen for relapsed/refractory multiple myeloma according to Daratumumab eligibility criteria • In combination with Lenalidomide and low-dose Dexamethasone (RVd) for treatment of newly diagnosed patients with multiple myeloma in whom stem cell transplantation is not intended • Patients should have good performance status, and treatment in the maintenance phase (with Lenalidomide and low-dose Dexamethasone alone) may continue until unacceptable toxicity or disease progression <u>Notes (RVd for first-line treatment of transplant-ineligible myeloma)</u> o Good performance status is interpreted as ECOG 0-2 o Patients with newly diagnosed transplant-ineligible myeloma who recently initiated first-line Lenalidomide and Dexamethasone prior to September 1, 2020 may have Bortezomib added to their treatment regimen provided there has been no disease progression experienced on Lenalidomide o Patients with myeloma and complications of amyloidosis as a consequence of the disease are eligible

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Bortezomib (cont'd from previous page)	Injection (vial) 3.5 mg	Formulary	Mantle Cell Lymphoma • Monotherapy for treatment of patients with relapsed or refractory mantle cell lymphoma after failure of at least 1 prior therapy
Bosutinib	Oral (tablet) 100 mg, 500 mg	Formulary	Approved for the following indication: Chronic Myelogenous Leukemia (CML) - Philadephia Chromosome Positive (Ph+) • Treatment of patients with chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) who have resistance/disease progression or intolerance to prior tyrosine kinase inhibitor (TKI) therapy Note: Second generation TKI's (Dasatinib, Nilotinib, Bosutinib) are not funded as options after Ponatinib
Brentuximab vedotin	Injection (vial) 50 mg	Formulary	Approved for the following indications: Hodgkin lymphoma (HL) • Treatment of patients with CD30 positive Hodgkin lymphoma who have relapsed disease following autologous stem cell transplant and who have an ECOG performance status of 0 or 1 • For the post-autologous stem cell transplant (ASCT) consolidation treatment of patients with CD30 positive Hodgkin lymphoma (HL) at increased risk of progression. Consolidation treatment should be initiated within four to six weeks post-ASCT or upon recovery from ASCT and continued until a maximum of 16 cycles, disease progression or unacceptable toxicity, whichever comes first. Notes: o High-risk of progression is defined below: ▪ Refractory to frontline therapy (e.g., progressed during, or no response to frontline therapy), or ▪ Relapsed less than 12 months from completion of frontline therapy, or ▪ Relapsed 12 months or later after completion of frontline therapy with extranodal disease o Re-treatment with Brentuximab vedotin is allowed in patients who are not considered refractory to Brentuximab vedotin (e.g., no evidence of disease progression during consolidation Brentuximab vedotin, and a minimum of 6 months since the last dose of consolidation Brentuximab vedotin) Systemic Anaplastic Large Cell Lymphoma (sALCL) • Treatment of patients with CD30 positive systemic anaplastic large cell lymphoma who have failed at least one prior multi-agent chemotherapy regimen and who have an ECOG performance status of 0 or 1
Busulfan	Injection (vial) 60 mg/10 mL Oral (tablet) 2 mg	Formulary	Injection approved for the following indication: • Use in the Blood and Marrow Transplant (BMT) program as part of the conditioning regimen prior to allogeneic transplant Oral approved for the following indication: • Treatment of chronic myelogenous leukemia (CML) when alternative treatments are not suitable
Cabazitaxel	Injection (vial) 60 mg/1.5 mL	Formulary	Approved for the following indication: Prostate – Advanced, Castration-Resistant • Treatment of metastatic castration-resistant prostate cancer in combination with Prednisone in patients who have received prior chemotherapy with Docetaxel

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Cabozantinib	Oral (tablet) 20 mg, 40 mg, 60 mg	Formulary	Approved for the following indication: Renal Cell Carcinoma – Metastatic (mRCC) • Treatment of patients with advanced renal cell carcinoma (RCC) who have received at least one prior vascular endothelial growth factor receptor (VEGFR) tyrosine kinase inhibitor (TKI) therapy • Treatment may continue until clinically meaningful disease progression or unacceptable toxicity Notes: • Patients with both clear cell and non-clear cell histologies are eligible • For patients treated with a VEGF TKI (e.g., Sunitinib, Pazopanib) in the first-line setting, Cabozantinib is funded as an option either second-line before Nivolumab or third-line after Nivolumab • Either Axitinib or Cabozantinib are funded for third-line treatment of advanced RCC for intermediate or poor risk patients previously treated with Nivolumab plus Ipilimumab first-line and a VEGF TKI (Sunitinib or Pazopanib) second-line
Capecitabine	Oral (tablet) 150 mg 500 mg	Formulary	
Carboplatin	Injection (vial) 50 mg/5 mL 150 mg/15 mL 450 mg/450 mL 600 mg/60 mL	Formulary	
Carfilzomib	Injection (vial) 10 mg, 30 mg, 60 mg	Formulary --- STEP Access	Approved for the following indications: Multiple Myeloma • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • Only one of the following two regimens is funded for any one patient: 1. In combination with Lenalidomide and Dexamethasone (KRd regimen) for patients with multiple myeloma who have received at least one prior treatment KRd funding notes: • Patients must not have had disease progression during treatment with Bortezomib or Lenalidomide • Treatment should be in patients who have good performance status and are deemed to have adequate renal function • Treatment with Carfilzomib should continue until disease progression or unacceptable toxicity, to a maximum of 18 cycles • Re-treatment with Carfilzomib will not be permitted for patients whose disease relapsed after completing 18 cycles of the KRd regimen 2. In combination with Dexamethasone (Kd regimen) for patients with relapsed multiple myeloma with a good performance status who have received one to three prior treatments, and whose disease is refractory to either Lenalidomide or Bortezomib or both

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Ceritinib	Oral (capsule) 150 mg	Formulary	Approved for the following indication: Non-Small Cell Lung Cancer (NSCLC) - Advanced • Treatment as monotherapy in patients with anaplastic lymphoma kinase (ALK)-positive locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer (NSCLC) who have disease progression on or intolerance to Crizotinib Note: • Use of any other ALK inhibitors in the second-line setting after Crizotinib precludes the use of Ceritinib as a subsequent line of therapy • If Alectinib is chosen as first-line therapy, Ceritinib is not funded as a subsequent line of therapy
Cetuximab	Injection (vial) 100 mg/50 mL 200 mg/100 mL	Formulary	Approved for the following indications: Colorectal Cancer - Metastatic • As monotherapy or in combination with Irinotecan for treatment of patients with non-mutated (wild type) RAS (KRAS or NRAS) after failure, intolerance or contraindication of prior therapy containing a fluoropyrimidine, Oxaliplatin and Irinotecan Head and Neck Cancer - Locally or Regionally Advanced • First line treatment in combination with radiation therapy for patients with locally or regionally advanced squamous cell head and neck cancer without distant metastases who are deemed unsuitable for Cisplatin
Chlorambucil	Oral (tablet) 2 mg	Formulary	
Cisplatin	Injection (vial) 50 mg/50mL 100 mg /100mL	Formulary	
Cladribine 2-CDA	Injection (vial) 10 mg/10 mL	Formulary	Approved for the following indication: • Treatment of hairy cell leukemia
Clodronate	Oral (capsule) 400 mg	Formulary	Approved for the following indication: • Treatment of symptomatic, lytic bony lesions in advanced breast cancer as an oral alternative to Pamidronate

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Cobimetinib	Oral (tablet) 20 mg	Formulary	Approved for the following indication: Melanoma - Advanced (Unresectable or Metastatic) • In combination with Vemurafenib, for the treatment of patients with previously untreated BRAF V600 mutation-positive unresectable stage III or stage IV melanoma who have a good performance status Notes: o Previously untreated patients will be interpreted as BRAF-targeted therapy naïve. Patients who received prior checkpoint inhibitor immunotherapy will be eligible for combination BRAF-MEK inhibitor therapy. Previous use of any other BRAF-targeted therapy precludes the use of the combination of Cobimetinib and Vemurafenib. o If brain metastases are present, patients should be asymptomatic or have stable symptoms. o Treatment should continue until unacceptable toxicity or disease progression. o In the clinical setting of toxicity to the combination of Cobimetinib and Vemurafenib, but without disease progression, treatment may be continued, as clinically appropriate, with Vemurafenib monotherapy, or switched to alternate BRAF-targeted therapy with the combination of Dabrafenib and Trametinib, or monotherapy with either Dabrafenib or Trametinib. o Use of the combination of Cobimetinib and Vemurafenib precludes the use of any other BRAF targeted therapy as a subsequent line of therapy following disease progression.
Cortisone acetate	Oral (tablet) 5 mg, 25 mg	Formulary	Approved only for the following indication: • Replacement therapy when required for patients treated with Mitotane
Crisantaspase Asparaginase Erwinia Erwinase®	Injection (vial) 10,000 units/1 mL	Formulary	See Asparaginase Erwinia
Crizotinib	Oral (capsule) 200 mg, 250 mg	Formulary	Approved for the following indication: • Second line treatment of patients with anaplastic lymphoma kinase (ALK) positive advanced non-small cell lung cancer (NSCLC) with an ECOG performance status ≤2 who have received one prior chemotherapy regimen, until disease progression or unacceptable toxicity • First line treatment of patients with anaplastic lymphoma kinase (ALK) positive advanced non-small cell lung cancer (NSCLC) with an ECOG performance status of ≤2, until disease progression or unacceptable toxicity Notes (ALK positive): o If Alectinib is chosen as first-line therapy, Crizotinib is not funded as a subsequent line of therapy • First-line single agent treatment for patients with ROS1-positive advanced non-small cell lung cancer (NSCLC) • Patients should have good performance status in the judgement of the physician; treatment may continue until unacceptable toxicity or disease progression Notes (ROS1 positive): o Good performance status is usually interpreted as ECOG 0-2 o Patients with stable brain metastases are eligible o Any patients who are currently receiving alternate first-line therapy or who have been previously treated with other therapies are eligible for Crizotinib on a time-limited basis if it is subsequently determined the tumor is ROS1-positive and they otherwise meet the funded eligibility criteria; these patients may be switched to Crizotinib immediately or at the time of experiencing disease progression on their current therapy

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Cyclophosphamide	Injection (vial) 1 g, 2 g Oral (tablet) 25 mg, 50 mg	Formulary	
Cyproterone acetate CPA	Oral (tablet) 50 mg	Formulary	
Cytarabine Cytosine Arabinoside, ARA-C	Injection (vial) 100 mg/1 mL 500 mg/5 mL 1 g/10 mL 2 g/20 mL	Formulary	
Dabrafenib (continued on next page)	Oral (capsule) 50 mg, 75 mg	Formulary	Approved for the following indications: <u>Melanoma – Advanced (Unresectable or Metastatic)</u> • First line BRAF targeted therapy (i.e. patients may be treatment naïve or previously treated with checkpoint inhibitor immunotherapy and/or chemotherapy) as a single agent in patients with BRAF V600 mutation positive unresectable or metastatic melanoma who have an ECOG performance status of 0 or 1 and stable brain metastases (if present) • First line BRAF targeted therapy (i.e. patients may be treatment naïve or previously treated with checkpoint inhibitor immunotherapy and/or chemotherapy) with the combination of Dabrafenib and Trametinib in patients with BRAF V600 mutation positive unresectable or metastatic melanoma who have an ECOG performance status of 0 or 1 and stable brain metastases (if present). <u>Notes</u>: o Dabrafenib or the combination of Dabrafenib and Trametinib is not approved in patients who have progressed on prior BRAF targeted therapy o Use of the combination of Dabrafenib and Trametinib precludes the use of any other BRAF targeted therapy as a subsequent line of therapy following disease progression (e.g., combination of Vemurafenib and Cobimetinib, or monotherapy with either Dabrafenib, Trametinib, or Vemurafenib) o In the clinical setting of toxicity to combination therapy, but without disease progression, treatment may be continued with either Dabrafenib or Trametinib as monotherapy if clinically appropriate, or switched to other BRAF targeted agents (e.g. Vemurafenib monotherapy or the combination of Vemurafenib and Cobimetinib

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Dabrafenib (continued from previous page)	Oral (capsule) 50 mg, 75 mg	Formulary	Melanoma – Stage III Resected • Adjuvant treatment of patients with stage IIIA (limited to lymph node metastases of > 1 mm) to stage IIID BRAF-mutated (all BRAF V600 mutations) cutaneous melanoma (based on 8th edition of the American Joint Committee on Cancer [AJCC] staging system) • Disease must be completely resected including in-transit metastases; however, presence of regional lymph nodes with micrometastases after sentinel lymph node biopsy alone is allowed • Patients must have a good performance status Notes: o Patients with mucosal or ocular melanoma are not eligible for the combination of Dabrafenib and Trametinib o Treatment should start within 12 weeks from surgery o Treatment should continue until disease recurrence, unacceptable toxicity, or a maximum duration of 12 months from treatment initiation o For patients who have dose interruptions and subsequently resume therapy, Dabrafenib and Trametinib may continue up to a maximum of 12 months from the time of treatment initiation o Treatment should be discontinued prior to 12 months if there is confirmation of local disease progression or development of metastatic disease o Patients should be assessed for disease recurrence at least every 3 months, or more frequently as clinically indicated o Patients currently receiving adjuvant Interferon who are BRAF mutation positive may be switched to the combination of Dabrafenib and Trametinib for up to 12 months of BRAF targeted therapy provided they meet all other funding criteria o A one-time switch to adjuvant Nivolumab is allowed within the first 3 months of combination Dabrafenib and Trametinib treatment; the total duration of adjuvant therapy that is funded is 12 months of BRAF targeted therapy and immunotherapy combined o Switching to the combination of Vemurafenib and Cobimetinib is not funded for patients who experience intolerance or disease progression on the combination of Dabrafenib and Trametinib used for adjuvant treatment of melanoma o Retreatment with BRAF targeted therapy for recurrent or metastatic disease is allowed if the progression-free interval from the completion of adjuvant Dabrafenib and Trametinib is >6 months o All immunotherapy treatment options are available for patients relapsing on or any time after completion of combination Dabrafenib and Trametinib
Dacarbazine DTIC	Injection (vial) 200 mg 600 mg	Formulary	
Dactinomycin Actinomycin D	Injection (vial) 0.5 mg vial	Formulary	Approved for the following indications: Gynecology • As single agent therapy, or part of combination chemotherapy treatment for gestational trophoblastic neoplasia Soft Tissue Sarcomas (STS) • As part of combination chemotherapy and/or multi-modality treatment for Wilms tumor, rhabdomyosarcoma and Ewing's sarcoma

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Daratumumab	Injection (vial) 400 mg/20 mL 100 mg/5 mL	Formulary --- STEP access	Approved for the following indication: Multiple Myeloma • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • In combination with Lenalidomide and Dexamethasone (DRd regimen) or Bortezomib and Dexamethasone (DVd regimen) for the treatment of patients with multiple myeloma with good performance status who have received at least one prior therapy Notes: • Daratumumab containing regimens are not funded when the disease is considered refractory to both Lenalidomide and Bortezomib • Patients are considered to be refractory to Lenalidomide and/or Bortezomib if they are receiving or previously received Lenalidomide (any dose) or Bortezomib, including maintenance therapy post-ASCT, and have experienced disease progression during or within 60 days of stopping therapy • Daratumumab will only be funded as a triplet in combination with either Lenalidomide-Dexamethasone (DRd) or Bortezomib-Dexamethasone (DVd); no other anti-myeloma treatment regimens will be funded in combination with Daratumumab • Either DRd or DVd can be chosen depending on drug sensitivities • Only one of the following triplet regimens will be funded per patient – either Daratumumab (DRd, DVd) or Carfilzomib-based (KRd) triplet therapy • Patients currently receiving either Lenalidomide-Dexamethasone (Rd) or Bortezomib-based therapy (e.g., CyBor-D) in the second-line setting will be eligible to have Daratumumab added to their second-line regimen provided there has been no disease progression, and all other funding eligibility criteria is met at the time of Daratumumab addition • Patients who continue to receive a Bortezomib-based regimen in the second-line setting without the addition of Daratumumab will be eligible to receive either DRd in the third-line setting provided the disease is not refractory to Lenalidomide, and all other funding eligibility criteria is met at the time of Daratumumab addition • Patients who continue to receive a Lenalidomide-based regimen in the second-line setting without the addition of Daratumumab will be eligible to receive DVd in the third-line setting provided the disease is not refractory to Bortezomib, and all other funding eligibility criteria is met at the time of Daratumumab addition • Daratumumab triplet therapy may be continued until disease progression or unacceptable toxicity Daratumumab is not funded in the following situations: • As a treatment switch in patients intolerant of first-line therapy without evidence of disease progression • As single agent salvage monotherapy • As part of re-induction prior to a second hematopoietic stem cell transplant (SCT), or as consolidation or maintenance following a SCT • Treatment of patients with monoclonal gammopathy of undetermined significance (MGUS), smoldering myeloma, or amyloidosis without evidence of concomitant myeloma

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Darbepoetin alfa	Injection (prefilled syringe) 100 mcg/1 mL 200 mcg/1 mL 500 mcg/1 mL	Formulary	Approved for the following indication: Myelodysplastic Syndrome (MDS): • Management of patients with IPSS low-risk or intermediate-1 myelodysplastic syndrome (MDS) with symptomatic anemia for a therapeutic trial of 12 weeks if the serum erythropoietin level < 500 units/L and/or receiving < 2 units of RBC transfusions per month
Dasatinib	Oral (tablet) 20 mg, 50 mg 70 mg, 80 mg 100 mg, 140 mg	Formulary	Approved for the following indications: Chronic Myelogenous Leukemia (CML) - Philadephia Chromosome Positive (Ph+) • Second line treatment in chronic phase, accelerated phase or blast crisis with primary or acquired resistance to Imatinib • First line treatment 'switch' in patients with chronic phase, accelerated phase or blast crisis who were initiated on Imatinib, but are experiencing a suboptimal response by not meeting established therapeutic milestones according to the Canadian Hematology Society (CHS) or European LeukemiaNet (ELN) guidelines, or who are experiencing unacceptable toxicity to Imatinib • Subsequent line of treatment in patients who are resistant to or experiencing toxicity to other second generation TKI therapies (e.g. Nilotinib or Bosutinib) • First line treatment in patients with accelerated phase or blast crisis Note: Second generation TKI's (Dasatinib, Nilotinib, Bosutinib) are not funded as options after Ponatinib Acute Lymphoblastic Leukemia (ALL) - Philadephia Chromosome Positive (Ph+) • First or second line treatment for induction and maintenance therapy in patients with Ph+ ALL
Daunorubicin Daunomycin	Injection (vial) 20 mg	Formulary	
Defibrotide	Injection (vial) 200 mg/2.5 mL	Formulary	Exception drug coverage (EDC) approved for the following indication: • Treatment of adult patients with severe or very severe (as defined by EBMT diagnostic and grading criteria) hepatic veno-occlusive disease (VOD), also known as sinusoidal obstruction syndrome (SOS), following allogeneic hematopoietic stem-cell transplantation (HSCT) therapy
Degarelix	Injection (vial) 240 mg (as 2 x 120 mg) 80 mg	Formulary	Approved for the following indications: Prostate Cancer • Treatment of patients with prostate adenocarcinoma who are suitable candidates for an every 4 week administration schedule in whom androgen deprivation therapy is warranted for testosterone suppression Note: Degarelix is a gonadotrophin-releasing hormone (also known as a luteinizing hormone- releasing hormone or LHRH) antagonist There is no role for the use of a GnRH (LHRH) antagonist in patients who have had a bilateral orchiectomy
Dexamethasone	Injection (vial) 20 mg/5 mL Oral (tablet) 0.5 mg, 2 mg 4 mg	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Dexrazoxane	Injection (vial) 250 mg 500 mg	Formulary	Approved for the following indications: • Reducing (preventing) the incidence and severity of cardiotoxicity associated with the use of Doxorubicin for the treatment of metastatic breast cancer • Reducing (preventing) the incidence and severity of cardiotoxicity associated with the use of Doxorubicin in combination with Olaratumab for the treatment of soft tissue sarcoma • Reducing (preventing) the incidence and severity of cardiotoxicity associated with the use of Doxorubicin or other anthracyclines in pediatric patients (or adults if following a COG protocol) as specified in COG protocols • Treatment of extravasation resulting from IV anthracycline chemotherapy
Dinutuximab	Injection (vial) 17.5 mg/5 mL	Formulary	Approved for the following indication: <u>Neuroblastoma – High-Risk</u> • In combination with granulocyte-macrophage colony-stimulating factor (GM-CSF), interleukin-2 (IL-2) and retinoic acid (RA) for the treatment of pediatric patients with high-risk neuroblastoma who achieve a response to prior pediatric protocol first-line multi-agent, multimodal therapy • Treatment may be continued until unacceptable toxicity or disease progression to a maximum of six cycles of Dinutuximab in combination with GM-CSF, IL-2 and RA; for clarification, a maximum of five cycles of Dinutuximab are administered - the sixth treatment cycle only includes RA <u>Notes</u>: o High-risk neuroblastoma is defined as those patients treated for high-risk disease (e.g., with induction chemotherapy, consideration of surgical resection, and high-dose chemotherapy with autologous stem cell transplant +/- radiotherapy) o Patients initially diagnosed as non-high-risk who later progress or relapse and are treated as high-risk are eligible o Patients are not eligible for funded Dinutuximab for treatment of relapsed/refractory neuroblastoma following upfront therapy for high-risk disease o Interleukin-2 may be omitted from post-consolidation therapy with Dinutuximab as currently recommended by the Children's Oncology Group o GM-CSF is not commercially available in Canada and requires Health Canada Special Access Programme (SAP) approval
Docetaxel	Injection (vial) 20 mg 80 mg 160 mg	Formulary	
Doxorubicin	Injection (vial) 10 mg/5 mL 50 mg/25 mL 200 mg/100 mL	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Doxorubicin, pegylated liposomal	Injection (vial) 20 mg/10 mL 50 mg/25 mL	Formulary	Approved for the following indications: • Second or subsequent line treatment as a single agent for advanced epithelial ovarian cancer, fallopian tube carcinoma, and primary peritoneal neoplasms in patients with platinum intolerance, resistant disease or refractory disease • Second line treatment in combination with Carboplatin for advanced epithelial ovarian cancer, fallopian tube carcinoma, and primary peritoneal neoplasms in patients with platinum sensitive disease • In combination with Bevacizumab for the treatment of patients with platinum-resistant recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer (PROC) • First line treatment of advanced AIDS-related Kaposi's sarcoma (KS) in patients with extensive mucocutaneous or visceral disease
Durvalumab	Injection (vial) 120 mg/2.4 mL 500 mg/10 mL	Formulary --- STEP access	Approved for the following indication: <u>Non-Small Cell Lung Cancer (NSCLC) – Locally Advanced</u> • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required prior to treatment initiation • Treatment of patients with locally advanced, unresectable stage III non-small cell lung cancer (NSCLC) following curative intent platinum-based concurrent chemoradiation therapy. • Eligible patients include those with good performance status who are deemed fit following curative intent platinum-based concurrent chemoradiation therapy • Treatment may continue until unacceptable toxicity or disease progression to a maximum of 12 months <u>Notes</u>: o Patients must have received at least 2 cycles of platinum-based chemotherapy concurrently with definitive radiation therapy (defined as a target dose of 54 to 66 Gy in the PACIFIC trial) o Durvalumab is not approved following sequential chemoradiation therapy o Durvalumab should start within 6 weeks following completion of concurrent chemoradiation therapy, and after confirmation there has been no disease progression; initiation of Durvalumab after the 6 week interval will be considered on a case-by-case basis if additional time is required for patients recovering from unresolved toxicities o For patients who have dose interruptions and subsequently resume therapy, Durvalumab may continue for up to a maximum of 12 months from the time of treatment initiation o Therapy should be discontinued prior to 12 months if there is confirmation of local disease progression or development of metastatic disease o Imaging for disease assessment is required at least every 3 months, or more frequently as clinically indicated o Patients will be eligible for PD-1/PD-L1 inhibitor therapy in the metastatic setting only if there has been at least a 6 month progression-free interval between completion of Durvalumab and confirmation of disease progression

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Enzalutamide	Oral (capsule) 40 mg	Formulary --- STEP Access --- STEP Access	<u>Prostate – Metastatic, Castration-Resistant (mCRPC)</u> • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required prior to treatment initiation • Treatment of symptomatic metastatic castration-resistant prostate cancer in patients with good performance status (ECOG <u>≤</u>2) who have progressed on Docetaxel based chemotherapy or who are not candidates for treatment with Docetaxel • Treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy who have not received prior chemotherapy <u>Prostate – Non-Metastatic, Castration-Resistant (nmCRPC)</u> • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required prior to treatment initiation • In combination with androgen deprivation therapy (ADT) for the treatment of patients with non-metastatic castration-resistant prostate cancer (nmCRPC) who are at high risk of developing metastases • High risk is defined as a prostate-specific antigen doubling time (PSADT) of ≤ 10 months during continuous ADT • Patients should have good performance status and no risk factors for seizures; treatment may continue until unacceptable toxicity or radiographic disease progression <u>Notes (nmCRPC):</u> o Patients should have histologically or cytologically confirmed adenocarcinoma of the prostate without neuroendocrine differentiation, signet cell features, or small cell features o Patients should have no detectable distant metastases by either CT, MRI or technetium-99m bone scan o Patients with presence of CNS, vertebral or meningeal involvement are not eligible; however, patients with pelvic lymph nodes <2 cm in short axis (N1) located below the common iliac vessels are eligible o Castrate levels of testosterone (<1.7 nmol/L) must be demonstrated prior to treatment initiation o Castration-resistant prostate cancer must be demonstrated during continuous ADT, and is defined as 3 PSA rises, at least 1 week apart, with the last PSA >2 mcg/L o Patients who are receiving a first generation anti-androgen (e.g., Bicalutamide) must show a further rise in PSA measured at least 6 weeks after discontinuing the anti-androgen to be eligible o In case of biochemical progression (rising PSA) while on Enzalutamide, appropriate clinical evaluation and/or investigations for metastatic disease should be conducted in a timely manner o Patients receiving Enzalutamide for treatment of non-metastatic castration-resistant prostate cancer (nmCRPC) will be eligible for SCA funded Abiraterone at the time of disease progression to metastatic castration-resistant prostate cancer (mCRPC) for patients unable to tolerate or who are not candidates for other therapeutic choices (e.g., chemotherapy)
Epirubicin	Injection (vial) 10 mg/5 mL 50 mg/25 mL 200 mg/100 mL	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Eribulin	Injection (vial) 1 mg/2 mL	Formulary	Approved for the following indication: Breast Cancer - Metastatic • Treatment of metastatic or incurable locally advanced breast cancer in patients with a good performance status (ECOG ≤2) who have had previous treatment with a taxane and an anthracycline, who have had at least two chemotherapy regimens for metastatic or locally recurrent disease, and who have progressed after their last therapy
Erlotinib	Oral (tablet) 25 mg,100 mg 150 mg	Formulary	Approved for the following indication: Non-Small Cell Lung Cancer (NSCLC) - Advanced • Monotherapy for treatment of patients with locally advanced or metastatic non-small cell lung cancer after failure of at least one prior chemotherapy regimen in patients who have not received prior EGFR inhibitor therapy, and whose EGFR mutation status is positive • Monotherapy for first line treatment of patients with locally advanced (stage IIIB, not amenable to curative therapy) or metastatic (stage IV) non-small cell lung cancer (NSCLC) with EGFR activating mutations Note: • Patients experiencing disease progression on Erlotinib precludes the use of any other EGFR inhibitor as a subsequent line of therapy, with the exception of Osimertinib for tumors with identified T790M mutations
Etoposide VP-16	Injection (vial) 100 mg/5 mL 1 g/50 mL Oral (capsule) 50 mg	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Everolimus	Oral (tablet) 2.5 mg, 5 mg, 10 mg	Formulary	Approved for the following indications: <u>Renal Cell Carcinoma – Metastatic (mRCC)</u> • Treatment of patients with metastatic renal cell carcinoma (mRCC) after failure of initial treatment with either of the VEGF-receptor TKI's Sunitinib or Pazopanib <u>Note</u>: Patients are only eligible for treatment with either Everolimus <u>or</u> Axitinib in the second line setting Patients are not eligible for Everolimus after disease progression on Nivolumab
		---------- STEP Access	<u>Gastrointestinal – Pancreatic Neuroendocrine (pNET)</u> • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • Treatment of patients with progressive, unresectable, well or moderately differentiated, locally advanced or metastatic pancreatic neuroendocrine tumors (pNET) with good performance status (ECOG 0-2) <u>Note</u>: Patients whose disease progresses on Everolimus are not eligible for SCA funded treatment with Sunitinib for pNET
		---------- STEP Access	<u>Neuroendocrine Tumors – Gastrointestinal or Lung Origin (NET GIL)</u> • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • Treatment of unresectable, locally advanced or metastatic, well-differentiated, non-functional neuroendocrine tumours (NETs) of gastrointestinal or lung origin (GIL) in adults with documented radiological disease progression within six months and with a good performance status; treatment should continue until confirmed disease progression or unacceptable toxicity
		Formulary	<u>Breast Cancer - Metastatic</u> • In combination with Exemestane for treatment of hormone-receptor positive, HER2 negative, advanced breast cancer in post-menopausal women with good performance status (ECOG <2) after recurrence or progression following a non-steroidal aromatase inhibitor (Anastrozole or Letrozole) <u>Notes</u>: o Patients that had breast cancer progression while previously receiving Exemestane will not be eligible for Everolimus o Patients will be eligible for EITHER Palbociclib or Ribociclib with Anastrozole or Letrozole in the first line setting OR Everolimus with Exemestane as a subsequent line of therapy, not both therapies

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Exemestane	Oral (tablet) 25 mg	Formulary	Approved for the following indications: <u>Breast Cancer - Metastatic</u> • Endocrine therapy in post-menopausal women with hormone-receptor positive breast cancer. May be used after failure of a non-steroidal aromatase inhibitor (either Anastrozole or Letrozole) • In combination with Everolimus for treatment of hormone-receptor positive, HER2 negative, advanced breast cancer in post-menopausal women with good performance status (ECOG ≤2) after recurrence or progression following a non-steroidal aromatase inhibitor (Anastrozole or Letrozole) <u>Breast Cancer - Adjuvant</u> • Endocrine therapy in post-menopausal women with hormone-receptor positive disease either initially for 5 to 10 years (upfront strategy), for 2 to 3 years following 2 to 3 years of treatment with Tamoxifen for a total of 5 years (switch strategy), or for up to 5 years following 5 years of treatment with Tamoxifen (extended strategy) • Endocrine therapy in post-menopausal women with hormone-receptor positive ductal carcinoma in-situ (DCIS) for up to 5 years <u>Breast Cancer – Neoadjuvant</u> • Endocrine therapy in post-menopausal women with hormone receptor positive, locally advanced disease, not eligible for chemotherapy
Filgrastim G-CSF (Granulocyte Colony Stimulating Factor)	Injection (vial) 300 mcg /1 mL 480 mcg /1.6 mL Injection (pre-filled syringe) 300 mcg/0.5 mL 480 mcg/0.8 mL	Formulary	Filgrastim (G-CSF) is approved to prevent or mitigate neutropenic complications resulting from cancer treatment according to the following indications: • Primary prophylaxis in patients receiving an SCA approved regimen where the documented or expected incidence of febrile neutropenia has been identified as 20% or higher. • Secondary prophylaxis in patients receiving curative intent therapy following at least a 1 week dose delay due to neutropenia or an episode of febrile neutropenia <u>and</u> where further treatment delays and/or dose reductions may result in inferior outcomes • Acute Myelogenous Leukemia (AML): following induction therapy in patients age 55 or older to reduce the duration of antibiotic administration and hospital admission; after completion of consolidation therapy in patients of any age with AML in remission to reduce the duration of neutropenia • As required by protocol in pediatric patients and within the Blood and Marrow Transplant program • As primary prophylaxis with each AC (doxorubicin/cyclophosphamide) treatment as part of dose-dense chemotherapy for adjuvant or neoadjuvant treatment of early stage breast cancer in patients who are candidates for a regimen containing both anthracyclines and taxanes <u>Not</u> approved in the following clinical scenarios: • In afebrile patients during neutropenia in an attempt to more quickly increase granulocyte counts • As adjunct therapy for the treatment of uncomplicated fever and neutropenia defined as: fever of less than or equal to 10 days in duration; no evidence of pneumonia, cellulitis, abscess, sinusitis, hypotension, multi-organ dysfunction (sepsis syndrome) or invasive fungal infection; and no uncontrolled malignancies • In patients with aplastic anemia
Fludarabine	Injection (vial) 50 mg Oral (tablet) 10 mg	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Fludrocortisone acetate	Oral (tablet) 0.1 mg	Formulary	Approved only for the following indication: • Replacement therapy when required for patients treated with Mitotane
Fluorouracil 5-FU	Injection (vial) 5 g/100 mL	Formulary	
Flutamide	Oral (tablet) 250 mg	Formulary	
Fosaprepitant (also see Aprepitant)	Injection (vial) 150 mg	Formulary	Approved for the following indications: • Primary prevention of acute and delayed nausea and vomiting for patients receiving highly emetogenic chemotherapy [e.g. single day Cisplatin regimens $\geq$40 mg/m^2, women with breast cancer receiving an anthracycline and Cyclophosphamide (e.g., AC, FE$_{100}$C), and regimens containing Carmustine, Mechlorethamine, Streptozocin or high dose single day Dacarbazine (e.g., $\geq$850 mg/m^2)] in combination with a 5-HT$_3$ antiemetic (e.g., Ondansetron) and Dexamethasone • Secondary prevention of acute and delayed nausea and vomiting for patients receiving multi-day Cisplatin-based chemotherapy (e.g., BEP), ABVD and CHOP like regimens where emesis (vomiting) is experienced despite treatment with a combination of a 5-HT3 antiemetic (e.g. Ondansetron) and Dexamethasone in a previous cycle
Fulvestrant	Injection (pre-filled syringe) 250 mg/5 mL	Formulary	Approved for the following indications: <u>Breast Cancer - Metastatic</u> • Monotherapy treatment of estrogen-receptor positive, HER2-negative, non-visceral locally advanced or metastatic breast cancer in post-menopausal women not previously treated with endocrine therapy (including in the adjuvant setting) • Monotherapy treatment of locally advanced or metastatic breast cancer in post-menopausal women who have disease progression following prior anti-estrogen therapy • In combination with Palbociclib or Ribociclib for treatment of hormone receptor-positive, HER2-negative advanced or metastatic breast cancer (ABC), either as initial therapy, or following disease progression in previously treated patients who have not previously experienced disease progression on either a CDK 4/6 inhibitor or Fulvestrant
Gefitinib	Oral (tablet) 250 mg	Formulary	<u>Non-Small Cell Lung Cancer (NSCLC) - Advanced</u> • First line treatment of patients with locally advanced (not amenable to curative therapy) or metastatic non-small cell lung cancer (NSCLC) of non-squamous histology who have activating mutations of the epidermal growth factor receptor (EGFR) – tyrosine kinase (TK) <u>Note</u>: • Patients experiencing disease progression on Gefitinib precludes the use of any other EGFR inhibitor as a subsequent line of therapy, with the exception of Osimertinib for tumors with identified T790M mutations
Gemcitabine	Injection (vial) 200 mg 1 g, 2 g	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Gemtuzumab ozogamicin	Injection (vial) 4.5 mg	Formulary	Approved for the following indication: • In combination with Daunorubicin (or Idarubicin) and Cytarabine for the treatment of adult patients with previously untreated, de novo CD33-positive acute myeloid leukemia (AML) • Eligible patients include those who have good performance status and favourable, intermediate, or unknown cytogenetics (using the European LeukemiaNet [ELN] 2017 risk classification); should a patient's unknown cytogenetic status become known as adverse, Gemtuzumab ozogamicin must be discontinued Notes: • Good performance status is interpreted as ECOG 0-2 • Patients with acute promyelocytic leukemia (APL) are not eligible • Patients with FLT3-mutated AML receiving Midostaurin are not eligible • Patients with therapy related AML (t-AML) who received previous systemic chemotherapy are not eligible • Patients receiving alternate induction chemotherapy regimens (e.g., FLAG-Ida, anthracycline combined with high dose Cytarabine [e.g., "super 7+3"], Azacitidine) are not eligible • Gemtuzumab ozogamicin in combination with Daunorubicin (or Idarubicin) and Cytarabine should consist of one induction cycle; if a second induction cycle is required, Gemtuzumab ozogamicin should not be administered during the second induction cycle • For patients with complete remission following induction, Gemtuzumab ozogamicin in combination with standard Cytarabine consolidation or Cytarabine and Daunorubicin consolidation, a maximum of two cycles may be administered • Re-challenging with Gemtuzumab ozogamicin in patients undergoing re-induction and consolidation is not permitted
Glucarpidase	Injection (vial) 1,000 units	Formulary	Glucarpidase is not marketed in Canada and drug supply is only available through Health Canada's Special Access program (SAP) and BTG International Inc. for the following indication: • Emergency treatment of toxic plasma Methotrexate concentrations (>1 micromol/L) in patients with delayed Methotrexate clearance due to impaired renal function as recommended in a COG protocol Note: Glucarpidase is not indicated for use in patients who exhibit expected clearance of Methotrexate (plasma concentrations of Methotrexate within 2 standard deviations of the mean Methotrexate excretion curve specific for the last dose of Methotrexate administered) or those with normal or mildly impaired renal function because of the potential risk of subtherapeutic exposure to Methotrexate Glucarpidase is not routinely stocked in the cancer centre pharmacies or hospitals; once an emergency SAP request is initiated, drug can be shipped for on-site delivery within 24 hours

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Goserelin acetate	Injection (depot syringe) 3.6 mg (1 month) 10.8 mg (3 month)	Formulary --- STEP access	Approved for the following indications: <u>Prostate Cancer</u> • Neoadjuvant and/or adjuvant therapy for prostate cancer with a maximum therapy duration of 3 years • Treatment of metastatic prostate cancer <u>Note</u>: There is no role for the use of a GnRH (LHRH) analog in patients who have had a bilateral orchiectomy <u>Breast Cancer - Metastatic</u> • Endocrine therapy for pre-menopausal patients with hormone-receptor positive disease after failure of Tamoxifen <u>Breast Cancer – Adjuvant</u> • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • In combination with an aromatase inhibitor for up to 5 years of adjuvant endocrine therapy for pre-menopausal women with early stage (I-III), high risk, lymph node negative or lymph node positive, endocrine receptor positive breast cancer to achieve ovarian suppression in women where use of GnRH agonist therapy would be the preferred choice over surgical oophorectomy (e.g., younger age, preservation of fertility, not a surgical candidate) o The results of subgroup analyses suggest that patients with sufficiently higher risk breast cancer that warranted chemotherapy administration <u>and</u> were less than 35 years of age derived the most benefit from the combination of ovarian suppression and an aromatase inhibitor o If adjuvant or neo-adjuvant chemotherapy is prescribed, Goserelin may be initiated at any time in relation to chemotherapy (e.g., at the start, during or after), but within 8 months following completion of chemotherapy o Aromatase inhibitor therapy should start after completion of chemotherapy, and at least 6 to 8 weeks after initiation of Goserelin to allow time for ovarian suppression to occur <u>Notes</u>: o For high-risk, pre-menopausal breast cancer patients that are intolerant of an aromatase inhibitor, Tamoxifen may be combined with Goserelin
Hydrocortisone	Injection (vial) 100 mg	Formulary	
Hydroxyurea	Oral (capsule) 500 mg	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Ibritumomab tiuxetan (Zevalin®) (Note: Zevalin can only be ordered and administered in a nuclear medicine department)	Injection (vial)	Formulary --- STEP access	Approved for the following indication: Indolent (Low Grade) Lymphoma • Treatment of relapsed CD20-positive indolent lymphoma, including follicular, small lymphocytic, lymphoplasmacytic, marginal zone and transformed lymphoma arising from one of these specified indolent histologies, excluding chronic lymphocytic leukemia (CLL) • Patients must also meet the following conditions: o Third line or greater treatment o Less than 25% bone marrow involvement o Less than 25% of bone marrow previously irradiated o Platelet count greater than 100 x 10^9/L Note: only intravenous Rituximab is approved for use with Ibritumomab tiuxetan
Ibrutinib	Oral (capsule) 140 mg	Formulary	Approved for the following indications: Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) Second-Line • Treatment of patients with CLL/SLL who have relapsed after at least one prior therapy Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) First-Line • For patients with previously untreated chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) for whom Fludarabine-based treatment is considered inappropriate Notes: • Patients for whom Ibrutinib may be considered over a Fludarabine or other anti-CD20-based treatment as a first-line option include: o High risk for relapse and likelihood of resistance to anti-CD20 based therapy (e.g., del17p/TP53, del11q, unmutated IGHV) o Preferred oral therapy option for those who live a significant distance from a treatment centre where IV anti-CD20 therapy in combination with chemotherapy may not be suitable, or if IV therapy is declined • Ibrutinib may be continued until disease progression • Ibrutinib is not funded as a sequential treatment option for patients who have progressed on Idelalisib • treatment • Anti-CD20 therapy in combination with chemotherapy is not funded after Ibrutinib failure • Ibrutinib may be used as a third-line treatment option if Venetoclax plus Rituximab is chosen as a second-line therapy provided all other funding eligibility criteria is met; conversely, Venetoclax plus Rituximab may be used as a third-line treatment option if Ibrutinib is chosen as a second-line therapy provided all other funding eligibility criteria is met Mantle Cell Lymphoma (MCL) • For the treatment of patients with relapsed/refractory mantle cell lymphoma (MCL)
Idarubicin	Injection (vial) 5 mg/5 mL 10 mg/10 mL	Formulary	Approved for the following indication: • Treatment of acute myeloid leukemia (AML)

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Idelalisib	Oral (tablet) 100 mg, 150 mg	Formulary	Approved for the following indications: <u>Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)</u> • In combination with Rituximab for the treatment of patients with relapsed chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • For responding patients receiving Ibrutinib, but who are experiencing toxicity with no disease progression, Idelalisib may be used as monotherapy without requirement for Rituximab <u>Note</u>: Idelalisib may be continued until unacceptable toxicity or disease progression Idelalisib is not funded as a sequential treatment option for patients who have progressed on Ibrutinib treatment, except in the clinical setting where Idelalisib with Rituximab may be used as a bridge to allogeneic transplant Chemotherapy in combination with anti-CD20 therapy is not funded after Idelalisib failure
Ifosfamide	Injection (vial) 1 g, 3 g	Formulary	
Imatinib	Oral (tablet) 100 mg 400 mg	Formulary	Approved for the following indications: <u>Chronic Myelogenous Leukemia (CML) - Philadelphia Chromosome positive</u> • First line treatment for blast crisis, accelerated phase, or chronic phase <u>Acute Lymphoblastic Leukemia (ALL) - Philadephia Chromosome positive</u> • First line treatment for induction and maintenance therapy <u>Gastrointestinal Stromal Tumor (GIST)</u> • Treatment of surgically unresectable or metastatic *c-kit* (CD117) positive GIST • Adjuvant treatment of high risk, surgically resected (R0 or R1) *c-kit* (CD117) positive GIST for a maximum duration of 3 years with any of the following criteria: o Tumor mass greater than 10 cm in diameter, OR o Greater than 10 mitoses per 50 high power field (HPF), OR o Tumor mass greater than 5 cm in diameter with greater than 5 mitoses per 50 HPF, OR o Tumor rupture • Neoadjuvant treatment of non-metastatic, locally advanced, potentially resectable c-kit (CD117) positive GIST <u>Melanoma – Advanced (Unresectable or Metastatic)</u> • Treatment of advanced acral or mucosal melanoma harboring a *KIT* mutation
Infliximab	Injection (vial) 100 mg	Formulary	Approved for use by the Blood and Marrow Transplant (BMT) Program for the following indication: • Management of graft versus host disease refractory to standard therapy

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Inotuzumab ozogamicin	Injection (vial) 0.9 mg	Formulary	Approved for the following indications: Acute Lymphoblastic Leukemia (ALL) • Treatment of relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL) • Eligible patients include Philadelphia chromosome (Ph)-positive and (Ph)-negative relapsed or refractory B-cell precursor ALL • Treatment may be continued until unacceptable toxicity or disease progression, up to a maximum of 3 cycles for patients proceeding to hematopoietic stem cell transplant (HSCT); for patients not proceeding to HSCT who achieve a complete response or complete response with incomplete count recovery (CR/CRi) and minimal residual disease negativity, treatment may be continued for a maximum of 6 cycles Notes: • Patients must have CD22 positive B-cell precursor ALL to be eligible for Inotuzumab ozogamicin • In (Ph)-positive B-cell precursor ALL with an overt relapse, defined as the need for repeat induction chemotherapy, physicians may choose Inotuzumab ozogamicin after failure of a first-line tyrosine kinase inhibitor (TKI); in all other (Ph)-positive patients there is a requirement for a trial of a second-line TKI prior to accessing Inotuzumab ozogamicin
Interferon Alpha 2b IFNα2b, Intron A®	Injection (vial) 10 MU PF 10 MU /1mL (penfill syringe) 18 million units 30 million units 60 million units	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Ipilimumab (cont'd on next page)	Injection (vial) 50 mg/10 mL 200 mg/40 mL	Formulary --- STEP access (combination use)	Melanoma – Advanced (Unresectable or Metastatic) • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required for treatment approval • Combination use of Nivolumab plus Ipilimumab followed by Nivolumab maintenance for patients with unresectable or metastatic melanoma regardless of BRAF status who are treatment naïve, or may have received treatment with BRAF-targeted therapy, with ECOG performance status of 0-1 and with stable brain metastases, if present. Treatment should continue until unacceptable toxicity or disease progression. Notes: o Repeat treatment with combination Nivolumab and Ipilimumab is not funded o Patients receiving Nivolumab monotherapy initiated as maintenance therapy following combination Ipilimumab and Nivolumab who experience disease progression are not eligible for Ipilimumab as a subsequent line of therapy o Patients receiving anti-PD-1 monotherapy initiated without the combination of Ipilimumab who experience disease progression are eligible for Ipilimumab monotherapy as a subsequent line of therapy, but are not eligible to continue anti-PD-1 therapy with the addition of Ipilimumab o Patients who have completed (e.g., after 2 years of therapy) or stopped anti-PD-1 monotherapy, initiated as either a single agent or maintenance after combination immunotherapy, without disease progression, are eligible to re-initiate anti-PD-1 monotherapy at time of subsequent disease progression o Patients who experience disease progression while receiving anti-PD-1 immunotherapy or BRAF-targeted therapy initiated in the adjuvant setting are not eligible for further anti-PD-1 immunotherapy or BRAF-targeted therapy o Combination dosing for melanoma is Nivolumab 1 mg/kg plus Ipilimumab 3 mg/kg every 3 weeks for up to 4 doses, followed by Nivolumab maintenance 3 mg/kg (up to a maximum of 240 mg) every 2 weeks or 6 mg/kg (up to a maximum of 480 mg) every 4 weeks o Patients must have measurable disease to be considered eligible for funding o Imaging for disease assessment is required at least every 3 months during the first year of immunotherapy therapy, then at a minimum every 6 months thereafter, or more frequently as clinically indicated o The definition of disease progression is an additional 10% in tumor burden and/or development of new lesions since the time of initial disease progression o If pseudo-progression is suspected (e.g., radiographic progression thought to be immune-related inflammation), a confirmatory radiologic scan must be done 6 to 8 weeks after initial progression to assess for true progression o Patients will be eligible for Nivolumab plus Ipilimumab in the advanced setting only if there has been at least a 6 month progression-free interval between completion of Nivolumab if used for adjuvant treatment of melanoma and confirmation of disease progression o Patients will be eligible for single agent Ipilimumab in the advanced setting if they experience disease progression while receiving, or within 6 months of receiving Nivolumab if used for adjuvant treatment of melanoma

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Ipilimumab (cont'd from previous page)	Injection (vial) 50 mg/10 mL 200 mg/40 mL	Formulary --- STEP access	Renal Cell Carcinoma – Metastatic (mRCC) • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required • Combination use of Nivolumab plus Ipilimumab followed by Nivolumab maintenance for previously untreated patients with intermediate or poor-risk advanced renal cell carcinoma based on International Metastatic Renal Cell Carcinoma Database Consortium (IMDC) criteria Notes: o Patients should have good performance status, as the clinical trial required patients to have a Karnofsky PS ≥70 (equivalent to ECOG PS of 0 or 1) o Treatment may continue until unacceptable toxicity or disease progression; for patients who have responded and whose disease is well controlled, consider stopping maintenance Nivolumab for a treatment break, especially after 2 years of therapy o Patients who have stopped Nivolumab maintenance therapy without disease progression (e.g., on a treatment break) are eligible to re-initiate Nivolumab monotherapy at time of subsequent disease progression (Note: repeat treatment with combination Nivolumab and Ipilimumab is not funded) o Combination dosing for renal cell carcinoma is Nivolumab 3 mg/kg plus Ipilimumab 1 mg/kg every 3 weeks for up to 4 doses, followed by Nivolumab maintenance 3 mg/kg (up to a maximum of 240 mg) every 2 weeks or 6 mg/kg (up to a maximum of 480 mg) every 4 weeks o Patients must have measurable disease to be considered eligible for funding o Imaging for disease assessment is required at least every 3 months during the first year of immunotherapy therapy, then at a minimum every 6 months thereafter, or more frequently as clinically indicated o The definition of disease progression is an additional 10% in tumor burden and/or development of new lesions since the time of initial disease progression o If pseudo-progression is suspected (e.g., radiographic progression thought to be immune-related inflammation), a confirmatory radiologic scan must be done 6 to 8 weeks after initial progression to assess for true progression
Irinotecan CPT-11	Injection (vial) 40 mg/2 mL 100 mg/5 mL 500 mg/25 mL	Formulary	
Kadcyla® Trastuzumab Emtansine (T-DM1) (tradename used to minimize confusion with Trastuzumab)	Injectable (vial) 100 mg 160 mg	Formulary	Approved for the following indications in HER2 positive disease (IHC 3+ or FISH positive): Breast Cancer - Metastatic • Second line treatment of patients with HER2 positive, unresectable locally advanced or metastatic breast cancer, with an ECOG performance status of 0 or 1, who have received prior treatment with Trastuzumab plus chemotherapy in the metastatic setting, or have disease recurrence during or within 6 months of completing adjuvant therapy with Trastuzumab plus chemotherapy

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Lapatinib	Oral (tablet) 250 mg	Formulary	Approved for the following indications: • In combination with Capecitabine as a second anti-HER2 therapy option for patients with advanced or metastatic breast cancer whose tumors over express HER2 after systemic disease progression while receiving Trastuzumab +/- Pertuzumab • Maintenance single agent Lapatinib after maximum response to combination therapy with Capecitabine, continued until disease progression Notes: • Lapatinib with Capecitabine is not approved as a first line option for patients with HER2 positive metastatic breast cancer • Lapatinib with Capecitabine may be given to patients as a second line option if they experience disease relapse either during or within 6 months of completing adjuvant Trastuzumab +/- Pertuzumab • Lapatinib in combination with Letrozole as a Health Canada approved indication for the treatment of post-menopausal patients with HER2 positive, hormone receptor positive metastatic breast cancer is not approved
Lanreotide Somatuline Autogel®	Injection (prefilled syringe) 60 mg/unit 90 mg/unit 120 mg/unit	Formulary	Approved for the following indication: Neuroendocrine Tumours • Treatment of patients with well to moderately differentiated, low to intermediate grade, unresectable, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NET) • Treatment of patients with carcinoid syndrome or symptoms from hypersecretion of hormones from a gastrointestinal neuroendocrine tumor (GI NET) who have unresectable disease

Lenalidomide (cont'd on next page)	Oral (capsule) 2.5mg, 5 mg, 10 mg, 15 mg 20 mg25 mg	Formulary	Approved for the following indications:
			Multiple Myeloma:
			• In combination with Dexamethasone in patients who are not candidates for autologous stem cell transplant, and are refractory to or have relapsed after at least one prior line of therapy including Bortezomib, or are intolerant of a Bortezomib containing regimen
			• For patients eligible for their first autologous stem cell transplant (ASCT) as part of the RVd regimen (Lenalidomide, Bortezomib, Dexamethasone) for the following indications:
			  • 2 to 4 cycles as first-line induction therapy for patients with plasma cell leukemia and high risk multiple myeloma, defined as del 17p, t(4:14), or t(14:16)
			  • 2 cycles as salvage induction therapy in patients who did not achieve an adequate response (i.e. did not achieve a ≥ 50% disease response) after 3 or 4 cycles of CyBorD induction therapy; if a response after 2 cycles of RVd was achieved, but a deeper response is still required, an additional 1 or 2 cycles may be separately requested
			Note: RVd is not funded as salvage therapy in the relapsed/refractory setting, or as induction or consolidation therapy in conjunction with a second transplant
			• As part of the RVd regimen (Lenalidomide, Bortezomib, Dexamethasone) for 2 cycles as post-transplant consolidation therapy in patients with multiple myeloma who achieve a VGPR or better when an upfront tandem transplant is not planned
			• Maintenance treatment for patients with newly diagnosed multiple myeloma following autologous stem cell transplant (ASCT), optimally initiated at Day 100 post-transplant, in patients with stable disease or better, with no evidence of disease progression; treatment is continued until disease progression, unless discontinued due to patient intolerance
			• Maintenance treatment may be provided to patients after a second autologous stem cell transplant (ASCT) if they have not had maintenance Lenalidomide with a previous transplant
			• As an option for first line treatment of patients with multiple myeloma who are not eligible for autologous stem cell transplantation. Treatment is in combination with dexamethasone for patients with an ECOG performance status of less than or equal to 2 and continued until disease progression.

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		STEP Access (KRd)
			• Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for KRd treatment approval
			• In combination with Carfilzomib and Dexamethasone (KRd regimen) for patients with multiple myeloma who have received at least one prior treatment
			• In combination with Daratumumab as part of the DRd regimen for relapsed/refractory multiple myeloma according to Daratumumab eligibility criteria
			• In combination with Bortezomib and low-dose Dexamethasone (RVd) for treatment of newly diagnosed patients with multiple myeloma in whom stem cell transplantation is not intended
			• Patients should have good performance status, and treatment in the maintenance phase (with Lenalidomide and low-dose Dexamethasone alone) may continue until unacceptable toxicity or disease progression
			Notes (RVd for first-line treatment of transplant-ineligible myeloma)
			  • Good performance status is interpreted as ECOG 0-2
			  • Patients with newly diagnosed transplant-ineligible myeloma who recently initiated first-line Lenalidomide and Dexamethasone prior to September 1, 2020 may have Bortezomib added to their treatment regimen provided there has been no disease progression experienced on Lenalidomide
			  • Patients with myeloma and complications of amyloidosis as a consequence of the disease are eligible

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Lenalidomide (cont'd from previous page)	Oral (capsule) 2.5mg, 5 mg, 10 mg, 15 mg 20 mg, 25 mg	Formulary	Myelodysplastic Syndrome (MDS): • Management of transfusion dependent anemia in patients with International Prognostic Scoring System (IPSS) low or intermediate-1 risk category myleodysplastic syndrome (MDS) associated with deletion [5q] cytogenetic abnormality. Pre and post therapy transfusion records are required with demonstration of at least a 50% reduction in transfusion requirements at 6 months to support continued Lenolidomide therapy Note: Only RevAid approved physicians and pharmacists can prescribe and dispense Revlimid® for any indication through a mandated Health Canada safety program

Lenvatinib	Oral (capsule) 4 mg, 10 mg	Formulary --- STEP Access	Approved for the following indications: <u>Thyroid Cancer, Differentiated</u> • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • Treatment of patients with locally recurrent or metastatic, progressive, radioactive-iodine-refractory differentiated thyroid cancer (DTC). Treatment should be for patients with good performance status and who otherwise meet the eligibility criteria of the SELECT trial and should continue until treatment progression or unacceptable toxicity. <u>Note</u>: Eligibility for the SELECT trial is as follows: • Pathologically confirmed differentiated thyroid cancer (patients with anaplastic or medullary thyroid cancer are not eligible) • Evidence of iodine-131 refractory disease according to at least one of the following criteria: ▪ At least one measurable lesion without iodine uptake on any iodine-131 scan ▪ At least one measurable lesion that had progressed according to RECIST criteria within 12 months after iodine-131 therapy despite iodine-131 avidity at the time of treatment ▪ Total lifetime radioactive iodine dose greater than 600 mCi (millicurie) • Radiologic evidence of progression within the previous 13 months • No prior therapy with a tyrosine kinase inhibitor or have received one prior treatment regimen with a tyrosine kinase inhibitor
		Formulary	<u>Hepatocellular Carcinoma (HCC) - Advanced</u> • First-line treatment of adult patients with unresectable hepatocellular carcinoma (HCC) with Child-Pugh A liver function who have an ECOG performance status of 0-1 and who would otherwise meet the inclusion criteria of the REFLECT trial • Treatment may continue until confirmed disease progression or unacceptable toxicity <u>Notes</u>: • Diagnosis of HCC should be confirmed histologically or cytologically, or confirmed clinically in accordance with the American Association for the Study of Liver Diseases criteria • Patients must have one or more measurable target lesions (lesions previously treated with radiotherapy or locoregional therapy must show radiographic evidence of disease progression to be deemed target lesions) based on mRECIST criteria • Patients must have Barcelona Clinic Liver Cancer (BCLC) stage B or C category • Patients must have <50% liver involvement with no invasion of the bile duct or main portal vein • Patients with prior liver transplantation, brain or leptomeningeal involvement are not eligible • Lenvatinib is not approved for maintenance therapy or as a bridge to transplant • Patients coinfected with hepatitis and patients with intermediate-stage HCC who are unable to receive TACE (provided they have Child-Pugh A liver function) are eligible • Patients should have controlled blood pressure and adequate organ function before treatment initiation • Lenvatinib may be used in patients unable to tolerate Sorafenib, but who have not experienced disease progression, provided all other funding criteria are met; conversely, patients unable to tolerate Lenvatinib may be switched to Sorafenib if there is no disease progression and all other funding criteria for Sorafenib are met • Regorafenib is funded as a second-line option after treatment failure with either Lenvatinib or Sorafenib, provided all funding criteria for Regorafenib are met

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Letrozole	Oral (tablet) 2.5 mg	Formulary	Approved for the following indications: <u>Breast Cancer - Metastatic</u> • Endocrine therapy in post-menopausal women with hormone-receptor positive breast cancer. Not approved after failure with Anastrozole <u>Breast Cancer - Adjuvant</u> • Endocrine therapy in post-menopausal women with hormone-receptor positive disease either initially for 5 to 10 years (upfront strategy), for 2 to 3 years following 2 to 3 years of treatment with Tamoxifen for a total of 5 years (switch strategy), or for up to 5 years following 5 years of treatment with Tamoxifen (extended strategy) • Endocrine therapy in post-menopausal women with hormone-receptor positive ductal carcinoma in-situ (DCIS) for up to 5 years <u>Breast Cancer – Neoadjuvant</u> • Endocrine therapy in post-menopausal women with hormone receptor positive, locally advanced disease, not eligible for chemotherapy <u>Uterine Sarcoma - Advanced</u> • Endocrine therapy in post-menopausal women with hormone receptor positive advanced uterine sarcoma
Leucovorin calcium Folinic acid, Citrovorum factor	Injection (vial) 50 mg/5 mL 500 mg/50 mL Oral (tablet) 5 mg	Formulary	
Leuprolide acetate Lupron® Eligard®	Injection (depot syringe) 7.5 mg (1 month) 22.5 mg (3 month) 30 mg (4 month) 7.5 mg (1 month) 22.5 mg (3 month) 30 mg (4 month) 45 mg (6 month)	Formulary Formulary	Approved for the following indications: <u>Prostate Cancer</u> • Neoadjuvant and/or adjuvant therapy for prostate cancer with a maximum therapy duration of 3 years • Treatment of metastatic prostate cancer <u>Note</u>: There is no role for the use of a GnRH (LHRH) analog in patients who have had a bilateral orchiectomy
Liothyronine	Oral (tablet) 5 mcg, 25 mcg	Formulary	Approved for the following indication: • Use following thyroidectomy or a period of thyroid hormone withdrawal to ameliorate the symptoms of hypothyroidism while waiting for thyroid scan or possible ablation therapy
Lomustine CCNU	Oral (capsule) 10 mg, 40 mg, 100 mg	Formulary	
Mechlorethamine Nitrogen Mustard,	Injection (vial) 10 mg	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Medroxyprogesterone	Oral (tablet) 5 mg, 10 mg 100 mg	Formulary	Approved for the following indication: Endometrial Cancer • Treatment option for recurrent, inoperable or metastatic endometrial cancer Note: Depo-Provera® is not funded by the SCA
Megestrol acetate	Oral (tablet) 40 mg, 160 mg	Formulary	Approved for the following indications: Breast Cancer - Metastatic • Hormonal treatment in women with progesterone-receptor positive breast cancer Endometrial Cancer • Treatment option for recurrent, inoperable or metastatic endometrial cancer Prostate Cancer • Treatment option for androgen-dependent advanced prostate cancer Uterine Sarcoma - Advanced • Endocrine therapy in women with hormone receptor positive advanced uterine sarcoma
	Oral (suspension) 240 mg/1 mL	Non-formulary	
Melphalan	Injection (vial) 50 mg Oral (tablet) 2 mg	Formulary	
Mercaptopurine 6-MP	Oral (tablet) 50 mg	Formulary	
Mesna	Injection (vial) 1 g/10 mL	Formulary	Approved for the following indication: • As a uro-protector with and following Ifosfamide or high dose Cyclophosphamide
Methotrexate	Intrathecal (vial) 20 mg/2 mL Injection (vial) 50 mg/2 mL 500 mg/20 mL 2.5 g/100 mL Oral (tablet) 2.5 mg	Formulary	
Methoxsalen	Oral or in bath	Formulary	Approved for the following indication: • Use with PUVA light therapy for the treatment of cutaneous T-cell lymphoma (e.g. mycosis fungoides) Note: There are no commercially available capsules of Methoxsalen available for sale in Canada. Prescriptions are prepared by retail compounding pharmacies.

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Methylprednisolone	Injection (vial) 500 mg	Formulary	
Midostaurin	Oral (capsule) 25 mg	Formulary	Approved for the following indication: Acute Myeloid Leukemia (AML) • In combination with standard Cytarabine and Daunorubicin (or Idarubicin) induction and Cytarabine consolidation chemotherapy for the treatment of adult patients with newly diagnosed FMS-like tyrosine kinase 3 (FLT3)-mutated acute myeloid leukemia (AML). Patients should be deemed fit to receive standard induction and consolidation chemotherapy. Midostaurin is not funded in the following situations: o In combination with alternate induction chemotherapy regimens, such as FLAG-Ida or NOVE-HiDAC o As part of re-induction or re-consolidation chemotherapy treatment in relapsed or refractory AML o As part of induction or consolidation chemotherapy treatment for therapy-induced AML after prior radiation therapy or chemotherapy for another cancer or disorder o As part of maintenance therapy following completing of Cytarabine consolidation chemotherapy
Mitomycin Mitomycin C	Intravesical or Injection (vial) 20 mg	Formulary	Approved for the following indications: Anal Cancer • As part of combined modality therapy for carcinoma of the anal canal Bladder Cancer • Intravesical therapy for non-muscle invasive transitional cell bladder cancer Ocular Malignancies • Topical treatment of conjuctival melanoma • Topical treatment of ocular surface squamous neoplasia (also known as conjuctival-corneal intraepithelial neoplasia (CCIN))
Mitotane	Oral (tablet) 500 mg	Formulary	Approved for the following indication: • Treatment of unresectable adrenal cortical carcinoma for both functional and nonfunctional types Note: Mitotane is not routinely stocked by the Cancer Centre Pharmacies and sufficient notice for purchase must be provided.
Mitoxantrone	Injection (vial) 20 mg/10 mL	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Nilotinib	Oral (capsule) 200 mg	Formulary	Approved for the following indications: <u>Chronic Myelogenous Leukemia (CML) - Philadephia Chromosome Positive (Ph+)</u> • Second line treatment in patients with chronic phase or accelerated phase CML with primary or acquired resistance to first line therapy with Imatinib • First line treatment 'switch' in patients with chronic or accelerated phase CML who were initiated on Imatinib, but are experiencing a suboptimal response by not meeting established therapeutic milestones according to the Canadian Hematology Society or European Leukemia Net (ELN) guidelines, or who are experiencing unacceptable toxicity to Imatinib • Subsequent line of treatment in patients who are resistant to or experiencing toxicity to other second generation TKI therapies (e.g. Dasatinib or Bosutinib) • First line treatment in patients with accelerated phase CML <u>Note</u>: Second generation TKI's (Dasatinib, Nilotinib, Bosutinib) are not funded as options after Ponatinib
Nivolumab (cont'd on next page)	Injection (vial) 40 mg/4 mL 100mg/10 mL	Formulary ---------- STEP Access	Approved for the following indications: <u>Non-Small Cell Lung Cancer (NSCLC)</u> • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required • As a treatment for adult patients with advanced or metastatic non-small cell lung cancer (NSCLC) with disease progression on or after cytotoxic chemotherapy for advanced disease and have a good performance status. <u>Notes</u>: o Patients with driver mutations (e.g., ALK, EGFR, ROS1) are eligible for Nivolumab, but only after treatment with both targeted agents <u>and</u> cytotoxic chemotherapy o Nivolumab is not funded for patients previously treated with Atezolizumab or Pembrolizumab o Cytotoxic chemotherapy options remain funded following Nivolumab therapy, when clinically appropriate o Patients will be eligible for Nivolumab in the advanced setting only if there has been at least a 6 month progression-free interval between completion of Durvalumab if used for stage III NSCLC and confirmation of disease progression

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Nivolumab (cont'd on next page)	Injection (vial) 40 mg/4 mL 100mg/10 mL	---------- STEP Access	Melanoma – Advanced (Unresectable or Metastatic) • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required • As monotherapy treatment for patients with advanced (unresectable or metastatic) melanoma until disease progression in patients with good performance status and who have stable brain metastases (if present) Melanoma funding notes: o Nivolumab may be used as the first-line of checkpoint inhibitor immunotherapy (patients with BRAF-mutation positive tumors may or may not have received BRAF-targeted therapy) o Nivolumab is not funded in the following settings: ▪ For patients who have had disease progression on, or after, receiving Pembrolizumab ▪ For patients who have had intolerance/toxicity to Pembrolizumab o Patients who experience disease progression while receiving anti-PD-1 immunotherapy in the advanced setting are not eligible for Nivolumab o Patients who experience disease progression while receiving anti-PD-1 immunotherapy in the adjuvant setting are not eligible for Nivolumab in the advanced setting • Combination use of Nivolumab plus Ipilimumab followed by Nivolumab maintenance for patients with unresectable or metastatic melanoma regardless of BRAF status who are treatment naïve, or may have received treatment with BRAF-targeted therapy, with ECOG performance status of 0-1 and with stable brain metastases, if present. Treatment should continue until unacceptable toxicity or disease progression. Notes: o Repeat treatment with combination Nivolumab and Ipilimumab is not funded o Patients receiving Nivolumab monotherapy initiated as maintenance therapy following combination Ipilimumab and Nivolumab who experience disease progression are not eligible for Ipilimumab as a subsequent line of therapy o Patients receiving anti-PD-1 monotherapy initiated without the combination of Ipilimumab who experience disease progression are eligible for Ipilimumab monotherapy as a subsequent line of therapy, but are not eligible to continue anti-PD-1 therapy with the addition of Ipilimumab o Patients who have completed or stopped anti-PD-1 monotherapy, initiated as either a single agent or maintenance after combination immunotherapy, without disease progression, are eligible to re-initiate anti-PD-1 monotherapy at time of subsequent disease progression o Patients who experience disease progression while receiving anti-PD-1 immunotherapy initiated in the adjuvant setting are not eligible for further anti-PD-1 therapy o Combination dosing for melanoma is Nivolumab 1 mg/kg plus Ipilimumab 3 mg/kg every 3 weeks for up to 4 doses, followed by Nivolumab maintenance 3 mg/kg (up to a maximum of 240 mg) every 2 weeks or 6 mg/kg (up to a maximum of 480 mg) every 4 weeks

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Nivolumab (cont'd on next page)	Injection (vial) 40 mg/4 mL 100mg/10 mL	Formulary	Melanoma – Adjuvant • Adjuvant treatment of patients with stage IIIA (limited to lymph node metastases of >1 mm) to stage IIID, and stage IV melanoma (based on 8th edition of the American Joint Committee on Cancer [AJCC] melanoma staging system) • Disease must be completely resected including in-transit metastases; however, presence of regional lymph nodes with micrometastases after sentinel lymph node biopsy alone is allowed' • Eligible patients may continue treatment until disease progression or a maximum of one year, whichever comes first Notes: o Patients with either cutaneous or mucosal melanoma are included in the eligibility criteria; patients with ocular melanoma are not eligible for SCA funded Nivolumab as adjuvant treatment o Treatment should start within 12 weeks from surgery o For patients who have dose interruptions and subsequently resume therapy, Nivolumab may continue up to a maximum of 12 months from the time of treatment initiation o Therapy should be discontinued prior to 12 months if there is confirmation of local disease progression or development of metastatic disease o Patients should be assessed for disease recurrence at least every 3 months, or more frequently as clinically indicated o Patients currently receiving adjuvant Interferon may be switched to Nivolumab for up to 12 months of Nivolumab treatment provided they meet all other funding criteria o If a patient is BRAF mutation positive, a one-time switch to the combination of Dabrafenib and Trametinib is allowed within the first 3 months of Nivolumab treatment; the total duration of adjuvant therapy that is funded is 12 months of immunotherapy and BRAF targeted therapy combined o Patients will be eligible for all immunotherapy options in the advanced or metastatic setting only if there has been at least a 6 month progression-free interval between completion of Nivolumab or Pembrolizumab and confirmation of disease progression

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Nivolumab (cont'd from previous page)	Injection (vial) 40 mg/4 mL 100mg/10 mL	---------- STEP Access	Renal Cell Carcinoma – Metastatic (mRCC) • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required • As monotherapy treatment for patients with advanced or metastatic renal cell carcinoma with disease progression after at least one prior anti-angiogenic systemic treatment and who have good performance status • Combination use of Nivolumab plus Ipilimumab followed by Nivolumab maintenance for previously untreated patients with intermediate or poor-risk advanced renal cell carcinoma based on International Metastatic Renal Cell Carcinoma Database Consortium (IMDC) criteria Notes: o Patients should have good performance status, as the clinical trial required patients to have a Karnofsky PS ≥70 (equivalent to ECOG PS of 0 or 1) o Treatment may continue until unacceptable toxicity or disease progression; for patients who have responded and whose disease is well controlled, consider stopping maintenance Nivolumab for a treatment break, especially after 2 years of therapy o Patients who have stopped Nivolumab maintenance therapy without disease progression (e.g., on a treatment break) are eligible to re-initiate Nivolumab monotherapy at time of subsequent disease progression (Note: repeat treatment with combination Nivolumab and Ipilimumab is not funded) o Combination dosing for renal cell carcinoma is Nivolumab 3 mg/kg plus Ipilimumab 1 mg/kg every 3 weeks for up to 4 doses, followed by Nivolumab maintenance 3 mg/kg (up to a maximum of 240 mg) every 2 weeks or 6 mg/kg (up to a maximum of 480 mg) every 4 weeks o Patients must have measurable disease to be considered eligible for funding o Imaging for disease assessment is required at least every 3 months during the first year of immunotherapy therapy, then at a minimum every 6 months thereafter, or more frequently as clinically indicated o The definition of disease progression is an additional 10% in tumor burden and/or development of new lesions since the time of initial disease progression o If pseudo-progression is suspected (e.g., radiographic progression thought to be immune-related inflammation), a confirmatory radiologic scan must be done 6 to 8 weeks after initial progression to assess for true progression
		---------- STEP Access	Squamous Cell Head and Neck Cancer (SCCHN) – Advanced • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required • Treatment of patients with squamous cell cancer of the head and neck (SCCHN) who either have a recurrence within six months of potentially curative neoadjuvant/adjuvant platinum-based therapy, or recurrence after receiving platinum-based therapy in a non-curative setting, and who have a good performance status. Treatment should continue until unacceptable toxicity or disease progression.
		Formulary	Hodgkin Lymphoma • Treatment of patients with classical Hodgkin lymphoma (cHL) that has relapsed or progressed after autologous stem cell transplantation (ASCT) and Brentuximab vedotin • Treatment may continue until confirmed disease progression or unacceptable toxicity Notes: o cHL subtypes include: nodular sclerosis, mixed cellularity, lymphocyte-rich and lymphocyte-depleted o Patients with central nervous system lymphoma or nodular lymphocyte-predominant Hodgkin lymphoma are not eligible

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Obinutuzumab	Injection (vial) 100 mg/40 mL	Formulary --- STEP Access	Approved for the following indications: <u>Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)</u> • In combination with Chlorambucil for patients with CLL/SLL who have adequate renal function <u>and</u> for whom Fludarabine-based treatment is considered inappropriate who are previously untreated <u>Note</u>: • Patients are not eligible to receive Obinutuzumab-based chemotherapy for CLL/SLL if they have previously received targeted therapy with BCL-2 inhibitors (Ibrutinib, Idelalisib) or Venetoclax <u>Indolent (Low Grade) Lymphoma – Rituximab refractory</u> • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required • In combination with chemotherapy in adult patients with indolent lymphoma with disease that is refractory to a Rituximab containing regimen as defined in the GADOLIN trial, and with good performance status • As maintenance treatment for patients with disease response, or who have stable disease, to induction treatment with Obinutuzumab and chemotherapy <u>Notes</u>: • Rituximab refractory is defined as the following: o Failure to respond to, or progression during, any previous Rituximab-containing regimen o Progression within 6 months of the last Rituximab dose, in the induction or maintenance treatment settings • Obinutuzumab maintenance treatment should not be for patients who have progressive disease while on Obinutuzumab induction (e.g., Obinutuzumab plus chemotherapy) • Maintenance treatment should continue until disease progression or for up to 2 years (maximum 12 doses), whichever occurs first
Octreotide Sandostatin LAR®	Injection Per 1 mL ampoule: 0.05 mg, 0.1 mg 0.5 mg Per 5 mL vial 0.2 mg/1 mL LAR Depot (prefilled syringe) 10 mg, 20 mg 30 mg	Formulary	Approved for the following indications: <u>Neuroendocrine Tumours</u> • Short-acting: initial dose finding treatment and for breakthrough symptoms in patients stabilized on long-acting depot therapy • Treatment of patients with carcinoid syndrome or symptoms from hypersecretion of hormones from a gastrointestinal neuroendocrine tumor (GI NET) who have unresectable disease • Treatment of patients with well to moderately differentiated, low to intermediate grade, unresectable, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NET) <u>Supportive</u> *(SCA funded for outpatient use only)* • Short-acting: management of severe chemotherapy-induced diarrhea for short-term treatment durations of 5 days or less

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Olaparib	Oral (tablet) 100 mg, 150 mg	Formulary --- STEP Access	Approved for the following indication: Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Cancer (Platinum-Sensitive, Relapsed) • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • As monotherapy maintenance treatment of adult patients who have good performance status with platinum-sensitive relapsed BRCA-mutated (germline or somatic as detected by approved testing) high grade serous epithelial ovarian, fallopian tube, or primary peritoneal cancer who have completed at least 2 previous lines of platinum-based chemotherapy and are in radiologic response (complete or partial response) to their most recent platinum-based chemotherapy regimen as per the SOLO-2 trial Notes: ◦ Good performance status for Olaparib eligibility is interpreted as ECOG ≤2 ◦ BRCA-mutation includes a documented mutation in BRCA1 and/or BRCA2 ◦ Eligible patients should have platinum-sensitive disease, defined as disease progression having occurred at least 6 months or more after completion of platinum-based chemotherapy ◦ Patients must have received at least 4 cycles of their most recent platinum-based chemotherapy before starting treatment with Olaparib ◦ No evidence of a rising CA-125 following completion of the current chemotherapy course as defined below: ▪ First CA-125 assessment following the current chemotherapy course is within the upper limit of normal (ULN) ▪ If the first CA-125 assessment following the current chemotherapy course is >ULN, a second assessment must be performed at least 7 days after the first; if the second assessment is ≥15% more than the first, the patient is not eligible for Olaparib ◦ Maintenance therapy with Olaparib should begin within 8 weeks of the last dose of platinum-based chemotherapy ◦ Treatment should continue until unacceptable toxicity or disease progression
Ondansetron	Injection (vial) 4 mg/2 mL 8 mg/4 mL 40 mg/20 mL Oral (tablet) (dissolving tablet) 4 mg, 8 mg (syrup) 0.8 mg/1 mL	Formulary	Approved for the following indications: *(SCA funded for outpatient use only)* • Prevention of acute nausea and vomiting in patients receiving moderately or highly emetogenic chemotherapy in regimens and doses consistent with the Multinational Association of Supportive Care in Cancer (MASCC) and the American Society of Clinical Oncology (ASCO) • Prevention of nausea and vomiting associated with radiation therapy where recommended by MASCC and ASCO

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Osimertinib	Oral (tablet) 40 mg, 80 mg	Formulary	Approved for the following indications: <u>Advanced Non-Small Cell Lung Cancer (NSCLC)</u> • As monotherapy in patients with good performance status for the treatment of locally advanced or metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC) who have progressed on EGFR tyrosine kinase inhibitor (TKI) therapy, or as initial therapy in patients with a *de novo* EGFR T790M mutation • First-line treatment of patients with locally advanced (not amenable to curative intent therapy) or metastatic non-small cell lung cancer (NSCLC) whose tumors have the following epidermal growth factor receptor (EGFR) mutations - exon 19 deletions [exon 19 del] or exon 21 [L858R] mutations; eligible patients should be previously untreated in the locally advanced or metastatic setting and have a good performance status • Treatment may continue until clinically meaningful disease progression or unacceptable toxicity <u>Notes</u>: o Patients currently receiving alternate first-line EGFR TKI's (e.g., Erlotinib, Gefitinib, Afatanib) whose tumors have the noted EGFR mutations (exon 19 del or L858R) may be switched to Osimertinib provided they meet all other funding criteria and have not experienced disease progression o Patients in whom chemotherapy was initiated prior to receiving results of their tumor's EGFR mutation status may be switched to Osimertinib if eligible (exon 19 del, L858R, T790M mutations identified) o Patients that experience disease progression while receiving Osimertinib, either first or second-line, are not eligible for any funded subsequent treatment with alternate EGFR TKI's
Oxaliplatin	Injection (vial) 50 mg/10 mL 100 mg/20 mL Injection (vial) 50 mg/10 mL 100 mg/20 mL	Formulary	
Paclitaxel	Injection (vial) 30 mg/5 mL 100 mg/16.7 mL 300 mg/50 mL	Formulary	
Paclitaxel nanoparticle albumin-bound (nab) Abraxane®	Injection (vial) 100 mg	Formulary	See Abraxane®

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Palbociclib	Oral (capsule) 75 mg, 100 mg, 125 mg	Formulary	Approved for the following indication: <u>Breast Cancer - Metastatic</u> • In combination with an aromatase inhibitor (AI), for the treatment of post-menopausal women or men with estrogen receptor (ER) positive, human epidermal growth factor receptor 2 (HER2) negative advanced breast cancer who have not received any prior endocrine treatment for metastatic disease. Treatment should continue until unacceptable toxicity or disease progression. Patients should have a good performance status and not be resistant to prior (neo)adjuvant aromatase inhibitor therapy, nor have active or uncontrolled metastases to the central nervous system. <u>Notes (with AI)</u>: o Anastrozole or Letrozole are the approved aromatase inhibitors for use in combination with Palbociclib; other endocrine therapies (e.g. Tamoxifen, Exemestane) are not approved o Good performance status for Palbociclib eligibility is interpreted as ECOG ≤2 o For patients who received Anastrozole or Letrozole in the (neo)adjuvant setting, a minimum disease free interval of twelve (12) months after stopping therapy is required for Palbociclib eligibility; there is no time restriction for patients who relapse after receiving Tamoxifen or Exemestane in the (neo)adjuvant setting o Patients will be eligible for EITHER Palbociclib or Ribociclib with Anastrozole or Letrozole in the first line setting OR Everolimus with Exemestane as a subsequent line of therapy, not both therapies • In combination with Fulvestrant for treatment of hormone receptor-positive, HER2-negative advanced or metastatic breast cancer (ABC), either as initial therapy, or following disease progression in previously treated patients • Eligible patients include men and women independent of their menopausal status; pre and peri-menopausal women must be rendered postmenopausal, either chemically or surgically, and should be treated with a luteinizing hormone-releasing hormone (LHRH) agonist or bilateral salpingo-oophorectomy • Patients should have good performance status and not have active or uncontrolled metastases to the central nervous system • Treatment may continue until disease progression or unacceptable toxicity <u>Notes (with Fulvestrant)</u>: o Good performance status is usually interpreted as ECOG 0-2 o Patients who have received prior neo/adjuvant endocrine therapy are eligible for Palbociclib plus Fulvestrant, including those who progress to metastatic disease less than 12 months from completion o More than one hormone treatment can be given for advanced disease before utilizing Palbociclib plus Fulvestrant, excluding patients who experienced disease progression on a prior CDK 4/6 inhibitor or Fulvestrant o Patients who received chemotherapy as initial treatment for advanced breast cancer are eligible for Palbociclib plus Fulvestrant o Only one of a CDK 4/6 inhibitor plus AI or Fulvestrant, or Everolimus plus Exemestane are funded for each patient
Palonosetron	Oral (capsule) 0.5 mg Injection (vial) 0.25 mg/5 mL	Formulary	Approved for the following indications: • Prevention and treatment of chemotherapy induced nausea and vomiting in pediatric patients receiving moderately or highly emetogenic chemotherapy according to POGO guidelines when other options are deemed unsuitable

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Pamidronate	Injection (vial) 30 mg/10 mL 60 mg/10 mL 90 mg/10 mL	Formulary	Approved for the following indications: *(SCA funded for outpatient use only)* Breast Cancer - Metastatic • Use in patients with documented bone metastases in conjunction with standard care in order to prevent or delay potential complications from bone lesions Multiple Myeloma • For a maximum duration of 24 months Supportive • For acute management of hypercalcemia related to malignancy Not approved for the following indication: • Prevention or treatment of osteopenia or osteoporosis
Panitumumab	Injection (vial) 100 mg/5 mL 400 mg/20 mL	Formulary --- STEP Access	Approved for the following indications: Colorectal Cancer - Metastatic • As monotherapy or in combination with Irinotecan for treatment of patients with non-mutated (wild type) RAS (KRAS or NRAS) after failure, intolerance or contraindication of prior therapy containing a fluoropyrimidine, Oxaliplatin and Irinotecan • In addition to combination chemotherapy for the treatment of patients with wild-type RAS metastatic colorectal cancer in the first-line treatment setting who have a contraindication or intolerance to Bevacizumab, and who would otherwise be treated only with combination chemotherapy. Patients should have good performance status. Treatment should continue until unacceptable toxicity or disease progression. Note: A contraindication or intolerance to Bevacizumab is defined as: • A high risk of bleeding or wound healing issues due to temporal proximity to surgery (e.g., recently received or planned for resectable/potentially resectable liver metastases) • A history of cardiovascular disease, or established class-specific side effects to Bevacizumab, such as hypertension, thromboembolic events, atrial fibrillation, as well as, proteinuria, risk of or presence of fistulae, risk of or current GI perforation, primary tumour in place, active bleeding, non-healing wound, ulcer, recent trauma, etc. and who would otherwise be treated only with combination chemotherapy
Pazopanib	Oral (tablet) 200 mg	Formulary	Approved for the following indications: Renal Cell Carcinoma – Metastatic (mRCC) • First-line treatment in patients with metastatic renal cell carcinoma (mRCC) and ECOG performance status of 0-2 • Second-line treatment of patients with metastatic renal cell carcinoma (mRCC) who were previously treated with the combination of Nivolumab and Ipilimumab • Alternate treatment in patients who are unable to tolerate ongoing use of an effective dose of Sunitinib Note: Patients whose disease progresses on Pazopanib are not eligible for SCA funded treatment with Sunitinib or Temsirolimus

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Pegfilgrastim	Injection (pre-filled syringe) 6 mg/0.6 mL	Formulary	Approved for the following indications: • Alternative to daily Filgrastim (G-CSF) injections in specific chemotherapy regimens of greater than or equal to every 3 weeks frequency where primary or secondary growth factor prophylaxis has been approved Not approved in the following clinical scenarios: • In afebrile patients during neutropenia in an attempt to more quickly increase granulocyte counts • As adjunct therapy for the treatment of uncomplicated fever and neutropenia defined as: fever of less than or equal to 10 days in duration; no evidence of pneumonia, cellulitis, abscess, sinusitis, hypotension, multi-organ dysfunction (sepsis syndrome) or invasive fungal infection; and no uncontrolled malignancies • In patients with aplastic anemia
Pembrolizumab (continued on next page)	Injection (vial) 100 mg/4 mL	Formulary	Approved for the following indications: Hodgkin Lymphoma • Monotherapy in adult patients with refractory or relapsed classical Hodgkin lymphoma (cHL) who have failed autologous stem cell transplantation (ASCT) and Brentuximab vedotin (BV), or who are not candidates for ASCT • Treatment may continue until confirmed disease progression or unacceptable toxicity, or to a maximum of 2 years, whichever comes first Hodgkin Lymphoma Funding Notes: o Patients with central nervous system lymphoma or nodular lymphocyte-predominant Hodgkin lymphoma are not eligible o Patients should have good performance status o If Pembrolizumab is stopped in the setting of maximum response/stable disease or after completion of 2 years of therapy, it may be re-started at the time of disease progression for an additional 1 year of therapy

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Pembrolizumab (continued on next page)	Injection (vial) 100 mg/4 mL	Formulary	Advanced Non-Small Cell Lung Cancer (NSCLC) – **First Line** • Treatment of locally advanced (Stage IIIB, not eligible for potentially curative concurrent chemoradiotherapy) or previously untreated metastatic non-small cell lung cancer (NSCLC) in patients whose tumours express PD-L1 Tumour Proportion Score (TPS) ≥50% as determined by a validated test and who have a good performance status, and who do not harbour a sensitizing epidermal growth factor receptor (EGFR) mutation, anaplastic lymphoma kinase (ALK) translocation, or a ROS1 rearrangement • In combination with Pemetrexed and platinum chemotherapy, for the treatment of metastatic non-squamous, non-small cell lung cancer (NS-NSCLC), in adults with no EGFR, ALK or ROS1 genomic tumour aberrations, and no prior systemic chemotherapy treatment for metastatic NSCLC and who have good performance status • Treatment may continue until confirmed disease progression or unacceptable toxicity, or after completing a maximum of 2 years of Pembrolizumab therapy, whichever comes first • In combination with platinum-based chemotherapy for the treatment of metastatic squamous non-small cell lung cancer (SQ-NSCLC), in adults with no prior systemic chemotherapy treatment for metastatic NSCLC and who have good performance status • Treatment may continue until confirmed disease progression or unacceptable toxicity, or after completing a maximum of 2 years of Pembrolizumab therapy, whichever comes first Advanced NSCLC Funding Notes (First Line): ○ Patients with a TPS ≥50% have the option of initiating treatment with Pembrolizumab monotherapy or Pembrolizumab plus chemotherapy ○ Only patients who are candidates for Pemetrexed-platinum chemotherapy for NS-NSCLC and platinum-based chemotherapy (preferably Paclitaxel-Carboplatin) for SQ-NSCLC are eligible for first line treatment in combination with Pembrolizumab ○ In patients where Pemetrexed-platinum chemotherapy for NS-NSCLC is initiated while waiting for target mutation test results, Pembrolizumab may be added to chemotherapy at the time it is confirmed there are no driver mutations; however, Pembrolizumab is not approved to be added in patients who have already completed platinum chemotherapy and are receiving maintenance Pemetrexed ○ For patients with NS-NSCLC initiated on Pembrolizumab with Pemetrexed-platinum chemotherapy who cannot tolerate Pemetrexed maintenance, Pembrolizumab may be continued as monotherapy if clinically appropriate ○ Patients who received Durvalumab for stage III NSCLC are eligible for Pembrolizumab in the metastatic setting only if there has been at least a 6 month progression-free interval between completion of Durvalumab and confirmation of disease progression ○ If Pembrolizumab is stopped in the setting of maximum response/stable disease or after completion of 2 years of therapy, it may be re-started at the time of disease progression for an additional 1 year of therapy ○ Patients who received Pembrolizumab as part of first-line therapy and experienced disease progression on treatment are not eligible for any further immunotherapy options as a subsequent line of therapy

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Pembrolizumab (continued on next page)	Injection (vial) 100 mg/4 mL	Formulary ---------- STEP Access	Advanced Non-Small Cell Lung Cancer (NSCLC) – **Second or Subsequent Line** • Completion of the SCA Treatment Evaluation Program (STEP) request/registration form for each patient is required • Treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumours express PD-L1 Tumour Proportion Score (TPS) ≥1% as determined by a validated test and who have a good performance status, and who have disease progression on or after cytotoxic chemotherapy and targeted therapy for mutations of either epidermal growth factor receptor (EFGR), anaplastic lymphoma kinase (ALK), or ROS1 for those patients who tumours express these genomic aberrations Advanced NSCLC Funding Notes (Second Line): o Patients must have measurable disease to be eligible for funding o Good performance status for Pembrolizumab eligibility is interpreted as ECOG ≤2 o Pembrolizumab is funded at a dose of 2 mg/kg every 3 weeks, up to a maximum capped dose of 200 mg o Treatment should continue until confirmed disease progression or unacceptable toxicity or to a maximum of two years (35 cycles), whichever comes first o Pembrolizumab may be re-started and continued for up to 12 additional months at the time of confirmed radiographic disease progression (according to immune-related response criteria) after initial Pembrolizumab therapy was stopped due to either completion of two years of therapy (35 cycles) or at physician discretion before 2 years in the setting of maximum response; a new STEP request approval will be required at time of re-start o Imaging for disease assessment is required at least every 3 months during the first year of Pembrolizumab therapy, then at a minimum every 6 months thereafter, or more frequently as clinically indicated o Definition of disease progression will be an additional 10% in tumor burden and/or development of new lesions since initiation of Pembrolizumab; if pseudo-progression is suspected (i.e. radiographic progression thought to be immune-related inflammation), a confirmatory radiologic scan must be done 6 to 8 weeks after initial progression to assess for true progression o Funding for Pembrolizumab for monotherapy use in NSCLC will not be extended to patients in whom tissue biopsy is not feasible, or where the tissue specimen is inadequate to determine PD-L1 status o Patients who have received prior treatment with any other PD-1/PD-L1 inhibitor (e.g., Nivolumab, Atezolizumab) for advanced disease will not be eligible for Pembrolizumab. o Cytotoxic chemotherapy options remain funded following Pembrolizumab therapy, when clinically appropriate o Patients will be eligible for Pembrolizumab in the advanced setting only if there has been at least a 6 month progression-free interval between completion of Durvalumab if used for stage III NSCLC and confirmation of disease progression

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Pembrolizumab (continued on next page)	Injection (vial) 100 mg/4 mL	Formulary	Melanoma – Advanced (Unresectable or Metastatic) • Completion of the SCA Treatment Evaluation Program (STEP) request/registration form for each patient is required for treatment approval • Treatment of patients with advanced (unresectable or metastatic) melanoma as a single agent for up to 24 months or until disease progression, according to the following criteria: o First line checkpoint inhibitor immunotherapy in patients naïve to Ipilimumab treatment (patients with BRAF mutation positive tumors may or may not have received BRAF targeted therapy) o After failure of Ipilimumab (and may have also failed BRAF targeted therapy) only for patients who received Ipilimumab before the effective funding date of Pembrolizumab for advanced melanoma (May 2016) o Treatment in either setting is for patients with an ECOG performance status of 0 or 1, and who have stable brain metastases (if present) Melanoma - Advanced Funding Notes: o Patients must have measurable disease to be eligible for funding o Pembrolizumab is not funded for patients who have disease progression after Nivolumab used for advanced disease, ether as a single agent or in combination with Ipilimumab o Patients will be eligible for Pembrolizumab in the advanced setting only if there has been at least a 6 month progression-free interval between completion of Nivolumab or Pembrolizumab if used for adjuvant treatment of melanoma and confirmation of disease progression

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Pembrolizumab (continued from previous page)	Injection (vial) 100 mg/4 mL	Formulary	Melanoma – Adjuvant • Adjuvant treatment of patients with stage IIIA (limited to lymph node metastases of >1 mm) to stage IIID, and stage IV melanoma (based on 8th edition of the American Joint Committee on Cancer [AJCC] melanoma staging system) • Disease must be completely resected including in-transit metastases; however, presence of regional lymph nodes with micrometastases after sentinel lymph node biopsy alone is allowed • Eligible patients may continue treatment until disease progression or a maximum of one year, whichever comes first Melanoma – Adjuvant Funding Notes o Patients with either cutaneous or mucosal melanoma are included in the eligibility criteria; patients with ocular melanoma are not eligible for SCA funded Pembrolizumab as adjuvant treatment o Patients should have good performance status o Treatment should start within 12 weeks from surgery o For patients who have dose interruptions and subsequently resume therapy, Pembrolizumab may continue up to a maximum of 12 months from the time of treatment initiation o Therapy should be discontinued prior to 12 months if there is confirmation of local disease progression or development of metastatic disease o Patients should be assessed for disease recurrence at least every 3 months, or more frequently as clinically indicated o Patients currently receiving adjuvant Interferon may be switched to Pembrolizumab for up to 12 months of Pembrolizumab treatment provided they meet all other funding criteria o If a patient is BRAF mutation positive, a one-time switch to the combination of Dabrafenib and Trametinib is allowed within the first 3 months of Pembrolizumab treatment; the total duration of adjuvant therapy that is funded is 12 months of immunotherapy and BRAF targeted therapy combined o Patients will be eligible for all immunotherapy options in the advanced or metastatic setting only if there has been at least a 6 month progression-free interval between completion of adjuvant Pembrolizumab (or Nivolumab) and confirmation of disease progression Urothelial Carcinoma - Advanced • Treatment of locally advanced or metastatic urothelial carcinoma (mUC) in patients who have disease progression during or following platinum-containing chemotherapy or within 12 months of completing neoadjuvant or adjuvant platinum-containing chemotherapy, and who have good performance status • Treatment may continue until confirmed disease progression or unacceptable toxicity, or after completing 2 years of Pembrolizumab therapy, whichever comes first Urothelial Carcinoma Funding Notes: o Eligible patients include those with urothelial carcinoma of the renal pelvis, ureter, bladder or urethra that display predominantly transitional-cell features on histologic testing o Patients that have disease suitable for local therapy with curative intent are not eligible o Patients with contraindications to platinum-containing chemotherapy who received alternate chemotherapy for mUC are eligible; patients who have not received any chemotherapy for mUC are not eligible o If Pembrolizumab is stopped in the setting of maximum response/stable disease or after completion of 2 years of therapy, it may be re-started at the time of disease progression for an additional 1 year of therapy

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Pemetrexed	Injection (vial) 100 mg 500 mg	Formulary	Approved for the following indications: Non-Small Cell Lung Cancer (NSCLC) – Advanced, Non-Squamous Histology • **First line (or Induction)** chemotherapy treatment option in combination with platinum for 4-6 cycles; patients who received either EGFR or ALK targeted therapy or Pembrolizumab as their initial treatment for advanced disease may be considered for this treatment as a next line chemotherapy option • **First line** treatment as a single agent in patients who are not candidates for platinum based combination chemotherapy; patients who received either EGFR or ALK targeted therapy or Pembrolizumab as their initial treatment for advanced disease may be considered for this treatment as a next line chemotherapy option • **Maintenance** single agent treatment following 4-6 cycles of platinum doublet induction treatment, which may include Pemetrexed, for patients who achieved stable disease or better and who have an ECOG performance status of 0 or 1; treatment may be continued until disease progression • **Second (or subsequent) line** single agent treatment for patients who have disease progression following any non-Pemetrexed treatment option; treatment may be continued until disease progression Malignant Mesothelioma • First line therapy in combination with platinum Note: Non-squamous histology must be confirmed to be eligible for any Pemetrexed treatment options
Pertuzumab	Injectable (vial) 420 mg/14 mL	Formulary	Approved for the following indication: Breast Cancer - Metastatic • In combination with a taxane and Trastuzumab (Herceptin) for the treatment of patients with HER-2 positive unresectable locally recurrent or metastatic (advanced) breast cancer who have not received prior anti-HER2 therapy or chemotherapy for advanced disease, or who have had a relapse-free interval of at least 6 months from anti-HER2 therapy given in the neoadjuvant or adjuvant setting • Patients must be fit for therapy with an ECOG performance status of 0 or 1 and no clinically significant cardiac disease with a LVEF of ≥50% • HER-2 over-expression defined as IHC 3+ or a FISH over-amplification ratio of ≥2 (double equivocal status of IHC 2+ and FISH ratio <2 are not eligible) • After 6 to 8 cycles of combination therapy with taxane, Trastuzumab and Pertuzumab and evidence of disease response, maintenance therapy with the combination of Trastuzumab and Pertuzumab may be continued until disease progression Note: On a one-time interim basis only, patients currently on treatment with a taxane and Trastuzumab in the first line setting, who have received < 8 cycles of taxane therapy, and who meet all eligibility criteria as defined above, will be eligible for addition of Pertuzumab to their therapy. Patients who have stopped taxane and Trastuzumab therapy due to intolerance or disease progression or who have received at least one dose of maintenance Trastuzumab are not eligible for Pertuzumab.
Plerixafor AMD-3100	Injectable (vial) 24 mg/1.2 mL	Formulary	Approved for the following indication: Blood and Marrow Transplant (BMT) Program • Hematopoietic stem cell mobilization as per the SCA Plerixafor Preemptive Algorithm in patients identified as failing the first harvest attempt with either Filgrastim/chemotherapy or Filgrastim alone

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Pomalidomide	Oral (capsules) 1 mg, 2 mg 3 mg, 4 mg	Formulary	Multiple Myeloma • Treatment of patients with relapsed and/or refractory multiple myeloma in combination with Dexamethasone (+/- Cyclophosphamide) who have previously failed at least 2 treatments, including both Bortezomib and Lenalidomide, and demonstrated disease progression on the last treatment • Treatment of patients in rare instances where Bortezomib is contraindicated or when patients are intolerant to Bortezomib, provided patients have failed Lenalidomide, which they may have received in the maintenance or relapsed/refractory setting Note: Only RevAid approved physicians and pharmacists can prescribe and dispense Pomalyst® through a mandated Health Canada safety program
Ponatinib	Oral (tablet) 15 mg, 45 mg	Formulary	Approved for the following indications: Chronic Myelogenous Leukemia (CML) and Acute Lymphoblastic Leukemia (ALL) - Philadelphia Chromosome (Ph+) positive • Treatment of patients with chronic phase CML who have resistance or disease progression after at least two prior lines of TKI therapy • Treatment of patients with accelerated phase or blast phase CML or Ph+ ALL who have resistance or disease progression after at least one second generation TKI therapy • Treatment of any patient with confirmed T315i mutation positive disease, independent of prior TKI therapy • Treatment of last resort for patients with intolerances or contraindications to Imatinib and all other second generation TKI's (Dasatinib, Nilotinib, Bosutinib) Note: Second generation TKI's (Dasatinib, Nilotinib, Bosutinib) are not funded as options after Ponatinib
Pralatrexate	Injection (vial) 20 mg/1 mL 40 mg/2 mL	Formulary	Approved for the following indication: • Treatment of relapsed or refractory peripheral T-cell lymphoma (PTCL) in patients who have undergone previous systemic therapy, none of which include Romidepsin Notes: • All subtypes of peripheral T-cell lymphomas (PTCL) are eligible, including: o Peripheral T-cell lymphoma, not otherwise specified (PTCL, NOS) o Anaplastic large cell lymphoma, primary systemic type (ALCL), ALK negative or positive o Angioimmunoblastic T-cell lymphoma (AITL) o Extranodal NK/T cell lymphoma, nasal type o Enteropathy associated T-cell lymphoma (EATL) o Hepatosplenic T-cell lymphoma o Subcutaneous panniculitis-like T-cell lymphoma o Cutaneous γ-δ T-cell lymphoma o Transformed mycosis fungoides (but not cutaneous T-cell mycosis fungoides)
Prednisolone	Oral (liquid) 1 mg/1 mL	Formulary	Approved for the following indication: • For pediatric patients unable to swallow oral Prednisone tablets
Prednisone	Oral (tablet) 1 mg, 5 mg 50 mg	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Procarbazine	Oral (capsule) 50 mg	Formulary	Approved for the following indications: Hematologic Cancers • Treatment of younger, fit patients with high risk Hodgkin's lymphoma according to the BEACOPP protocol • An alternative option to standard of care therapy for patients with Hodgkin's and non-Hodgkin's lymphoma • As part of multi-agent chemotherapy for treatment of primary CNS lymphoma Malignant Gliomas • Option for palliative treatment of brain tumors
Radium-223 Xofigo® (Note: Radium-223 can only be administered in a nuclear medicine department)	Injection (vial) 6,600 kBq/6 mL	---------- STEP access	Prostate – Metastatic, Castration-Resistant • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • Treatment of castration-resistant prostate cancer in patients with symptomatic bone metastases according to the following inclusion/exclusion criteria: o Inclusion Criteria ▪ ECOG performance status of 0, 1 or 2 ▪ Patient recently seen or discussed with medical oncologist regarding systemic therapy options ▪ Adequate hematologic parameters, defined as: • Initial bloodwork: Hemoglobin ≥100 g/L; Platelets ≥100 x 10^9/L; ANC ≥1.5 x 10^9/L • Subsequent doses: Platelets ≥50 x 10^9/L; ANC ≥1 x 10^9/L o Exclusion Criteria ▪ History of visceral metastases ▪ Current malignant lymphadenopathy >3 cm in diameter ▪ Active inflammatory bowel disease or significant fecal incontinence ▪ Untreated spinal cord compression or fracture requiring orthopedic stabilization
Raltitrexed	Injection (vial) 2 mg	Formulary	Approved for the following indications: Colorectal Cancer - Metastatic • Single agent treatment in patients with an intolerance or contraindication to fluoropyrimidine therapy (Fluorouracil or Capecitabine) Mesothelioma • First line treatment of malignant mesothelioma in combination with Cisplatin

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Ramucirumab	Injection (vial) 100 mg/10 mL 500 mg/50 mL	Formulary	Approved for the following indication: <u>Gastric and Gastro-esophageal Junction Cancer – Advanced</u> • In combination with Paclitaxel for the treatment of patients with advanced or metastatic gastric cancer or gastro-esophageal junction (GEJ) adenocarcinoma with an ECOG performance status of 0 or 1, and with disease progression following first-line chemotherapy <u>Notes</u>: o Ramucirumab is only approved in combination with Paclitaxel and is not funded as monotherapy o In the event Paclitaxel cannot be given due to significant toxicity, or toxicity that cannot be managed with appropriate dose reduction, Ramucirumab may be continued until Paclitaxel can be re-started o If serious, unmanageable toxicity to Paclitaxel requires permanent discontinuation, Ramucirumab may be continued as a single agent until disease progression o Ramucirumab is not approved as monotherapy when Paclitaxel is discontinued for reasons other than serious, unmanageable toxicity (e.g. in the clinical setting of maintenance therapy following response to combination therapy, patient refusal to receive Paclitaxel, etc.)
Regorafenib	Oral (tablet) 40 mg	Formulary	Approved for the following indications: <u>Gastrointestinal Stromal Tumors (GIST) - Advanced</u> • Treatment of patients with metastatic and/or unresectable GIST who have had disease progression on, or intolerance to, Imatinib and Sunitinib, and have an ECOG performance status of 0 or 1 <u>Hepatocellular Carcinoma (HCC) - Advanced</u> • Treatment of patients with unresectable hepatocellular carcinoma (HCC) who have been previously treated with Sorafenib or Lenvatinib; treatment may continue until disease progression • Eligible patients should have an ECOG performance status of 0 to 1, and a Child-Pugh class status of A; patients previously treated with Sorafenib should be able to tolerate Sorafenib as defined in the RESORCE trial criteria (>400 mg/day for >20 days of the last 28 days of treatment)

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Ribociclib	Oral (tablet) 200 mg	Formulary	Approved for the following indication: Breast Cancer - Metastatic • In combination with Anastrozole or Letrozole for the treatment of post-menopausal women or men with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer who have not received any prior endocrine treatment for advanced or metastatic disease • Treatment may continue until unacceptable toxicity or disease progression; patients should have good performance status and not be resistant to prior neoadjuvant or adjuvant non-steroidal aromatase inhibitor (NSAI) therapy (e.g., patients should be disease-free for at least one year from the completion of prior adjuvant NSAI therapy), nor have active or uncontrolled metastases to the central nervous system Notes (with AI): o Anastrozole or Letrozole are the approved aromatase inhibitors for use in combination with Ribociclib; other endocrine therapies (e.g., Tamoxifen, Exemestane) are not approved o For patients who received Anastrozole or Letrozole in the neoadjuvant or adjuvant setting, a minimum disease free interval of 12 months after stopping therapy is required for Ribociclib eligibility; there is no time restriction for patients who relapse after receiving Tamoxifen or Exemestane in the neoadjuvant or adjuvant setting o Patients will be eligible for EITHER Ribociclib or Palbociclib with Anastrozole or Letrozole in the first line setting OR Everolimus with Exemestane as a subsequent line of therapy, not both therapies • In combination with Fulvestrant for treatment of hormone receptor-positive, HER2-negative advanced or metastatic breast cancer (ABC), either as initial therapy, or following disease progression in previously treated patients • Eligible patients include men and women independent of their menopausal status; pre and peri-menopausal women must be rendered postmenopausal, either chemically or surgically, and should be treated with a luteinizing hormone-releasing hormone (LHRH) agonist or bilateral salpingo-oophorectomy • Patients should have good performance status and not have active or uncontrolled metastases to the central nervous system • Treatment may continue until disease progression or unacceptable toxicity Notes (with Fulvestrant): o Good performance status is usually interpreted as ECOG 0-2 o Patients who have received prior neo/adjuvant endocrine therapy are eligible for Ribociclib plus Fulvestrant, including those who progress to metastatic disease less than 12 months from completion o More than one hormone treatment can be given for advanced disease before utilizing Ribociclib plus Fulvestrant, excluding patients who experienced disease progression on a prior CDK 4/6 inhibitor or Fulvestrant o Patients who received chemotherapy as initial treatment for advanced breast cancer are eligible for Ribociclib plus Fulvestrant o Only one of a CDK 4/6 inhibitor plus AI or Fulvestrant, or Everolimus plus Exemestane are funded for each patient

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Rituximab (continued on next page)	Injection (vial) Intravenous 100 mg/10 mL 500 mg/50 mL Injection (vial) Subcutaneous 1,400 mg/11.7 mL 1,600 mg/13.4 mL	Formulary	Approved for the following indications in CD20 antigen positive patients: Burkitt's Lymphoma • Induction treatment in combination with standard chemotherapy Diffuse Large B-Cell Lymphoma (DLBCL) • Induction treatment in combination with chemotherapy for DLBCL or transformed lymphoma. Consolidation or maintenance therapy is not approved. • Re-treatment of patients with a Rituximab-containing regimen who have had a progression-free interval of greater than 6 months from last dose of Rituximab Indolent (Low Grade) Lymphoma and Mantle Cell Lymphoma (MCL) • Induction treatment in combination with chemotherapy for indolent low grade lymphomas (including follicular, marginal zone, and lymphoplasmocytic lymphoma) or mantle cell lymphoma • Re-treatment of patients with a Rituximab-containing regimen who have had a progression-free interval of greater than 6 months from last dose of Rituximab • Consolidation or maintenance therapy given every 3 months for 2 years (8 doses), initiated within 3 to 6 months of completing induction therapy, provided an adequate response to the induction Rituximab-chemotherapy treatment was achieved (defined as a 50% or greater reduction in total disease burden). Maintenance therapy is not approved for transformed lymphoma, or chronic lymphocytic leukemia/small lymphocytic lymphoma • A second consolidation or maintenance following a re-induction treatment is approved for patients who have a progression free interval ≥3 years from last Rituximab maintenance dose • Single agent weekly treatment (4 doses) in Rituximab naïve patients who have failed alkylator and purine analog based therapy and are not candidates for further chemotherapy • As maintenance therapy given every 3 months for up to 3 years in patients with mantle cell lymphoma who have responded to treatment with R-DHAP induction chemotherapy followed by autologous stem cell transplant Hodgkin's Lymphoma • In combination with chemotherapy for the treatment of patients with CD20+ve, lymphocyte predominant disease Primary CNS Lymphoma • As part of induction therapy for treatment of CD20 positive primary CNS lymphoma Blood and Marrow Transplant (BMT) • Patients with relapsed lymphoma who are transplant eligible may receive up to 4 cycles of Rituximab-based salvage therapy as a bridge prior to transplant, independent of prior Rituximab therapy

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Rituximab (continued from previous page)	Injection (vial) Intravenous 100 mg/10 mL 500 mg/50 mL Injection (vial) Subcutaneous 1,400 mg/11.7 mL 1,600 mg/13.4 mL		Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) • In combination with Fludarabine and Cyclophosphamide (FCR) for patients with CLL/SLL who are 70 years or less and have a creatinine clearance of 70 mL/min or greater and a CIRS score less than or equal to 6 and who are either previously untreated or as repeat treatment in patients who have experienced a progression free interval of at least 2-3 years since the last FCR cycle • In combination with Bendamustine (BR) for patients with CLL/SLL who are previously untreated or who have experienced a progression free interval of at least 1 year since the last BR cycle • In combination with Venetoclax for the treatment of adult patients with chronic lymphocytic leukemia (CLL) who have received at least one prior therapy, irrespective of their 17p deletion status Note: o Patients are not eligible to receive Rituximab-based chemotherapy for CLL/SLL if they have previously received targeted therapy with BCL-2 inhibitors (Ibrutinib, Idelalisib) or Venetoclax o Maintenance therapy is not approved for chronic lymphocytic leukemia/small lymphocytic lymphoma
Romidepsin	Injection (vial) 10 mg	Formulary	Approved for the following indication: Peripheral T-cell lymphoma (PTCL) • Treatment of patients with relapsed or refractory peripheral T-cell lymphoma (PTCL) who are ineligible for transplant and who have undergone previous systemic therapy and who have an ECOG performance status of 0 to 2

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Ruxolitinib	Oral (tablet) 5 mg, 10 mg 15 mg, 20 mg	Formulary --- STEP access --- STEP access	Approved for the following indication: <u>Myelofibrosis</u> • Completion of the SCA Treatment Evaluation Program (STEP) request form for each patient is required for treatment approval • Intermediate to high-risk symptomatic myelofibrosis (MF), including primary MF, post-polycythemia vera MF and post-essential thrombocythemia MF, as assessed using the Dynamic International Prognostic Scoring System-Plus (DIPSS-Plus) or symptomatic splenomegaly • ECOG performance status of ≤ 3 • Patients may be previously untreated or refractory to other treatments <u>Polycythemia Vera</u> • Patients must be referred to the SCA, and completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required prior to treatment initiation • For the treatment of patients with polycythemia vera who have disease resistant to Hydroxyurea or who are intolerant to Hydroxyurea according to the modified European LeukemiaNet Criteria used in the RESPONSE trial and have a good performance status Definition of <u>Resistance</u> to Hydroxyurea: • After three (3) months of at least 2 g/day of Hydroxyurea, or at the maximally tolerated Hydroxyurea dose if that dose is less than 2 g/day, the patient shows any one or more of the following: o Need for phlebotomy to keep the hematocrit less than 45% o Uncontrolled myeloproliferation (platelet count >400 x 10^9/L and WBC >10 x 10^9/L o Failure to reduce massive splenomegaly greater than 50% as measured by palpation Definition of <u>Intolerance</u> to Hydroxyurea: • During treatment with Hydroxyurea, at the lowest dose required to achieve a response*, the patient shows any one or more of the following: o ANC <1 x 10^9/L, or Platelets <100 x 10^9/L or Hemoglobin <100 g/L o Presence of leg ulcers o Non-hematologic toxicities related to hydroxyurea therapy (e.g., mucocutaneous manifestations, gastrointestinal symptoms, pneumonitis or fever) that are grade 3 to 4, or grade 2 for more than 1 week (CTCAE version 3.0) o Permanent discontinuation of Hydroxyurea, significant interruptions of therapy, or hospitalization due to Hydroxyurea toxicity **Response is defined as a hematocrit less than 45% without phlebotomy, and/or all of the following: platelets <400 x 10^9/L, WBC <10 x 10^9/L, and non-palpable spleen*
Siltuximab	Injection (vial) 100 mg, 400 mg	Formulary --- STEP access	Approved for the following indication: <u>Multicentric Castleman's Disease (MCD)</u> • Treatment of multicentric Castleman's disease (MCD) in patients who are human immunodeficiency virus (HIV) negative and human herpes virus-8 (HHV-8) negative, and who have an ECOG performance status ≤ 2

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Sorafenib	Oral (tablet) 200 mg	Formulary	Approved for the following indications: <u>Hepatocellular Carcinoma (HCC) - Advanced</u> • Treatment in patients with an ECOG performance status of 2 or less and Child-Pugh A status <u>Note</u>: o Sorafenib may be used in patients unable to tolerate Lenvatinib, but who have not experienced disease progression, provided all other funding criteria are met; conversely, patients unable to tolerate Sorafenib may be switched to Lenvatinib if there is no disease progression and all other funding criteria is met
Streptozocin	Injection (vial) 1 g	Formulary	<u>Note</u>: Streptozocin is not commercially available in Canada as of 2017, and is only available through the Health Canada Special Access Program on a case-by-case basis
Sunitinib	Oral (tablet) 12.5 mg, 25 mg, 50 mg	Formulary --- STEP access	Approved for the following indications: <u>Renal Cell Carcinoma - Metastatic (mRCC)</u> • First-line treatment of patients with metastatic renal cell carcinoma (mRCC) and ECOG performance status of 0-2 • Second-line treatment of patients with metastatic renal cell carcinoma (mRCC) who were previously treated with the combination of Nivolumab and Ipilimumab • Alternate treatment in patients who are unable to tolerate ongoing use of an effective dose of Pazopanib <u>Gastrointestinal Stromal Tumors (GIST) - Advanced</u> • Second line treatment in patients with *c-kit* (CD 117) positive GIST after Imatinib failure or intolerance <u>Gastrointestinal – Pancreatic Neuroendocrine (pNET)</u> • Treatment of patients with progressive, unresectable, well or moderately differentiated, locally advanced or metastatic pancreatic neuroendocrine tumors (pNET) with good performance status (ECOG 0-2) <u>Note</u>: Patients whose disease progresses on Sunitinib are not eligible for SCA funded treatment with Everolimus for pNET

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Tamoxifen	Oral (tablet) 10 mg, 20 mg	Formulary	Approved for the following indications: <u>Breast Cancer - Adjuvant</u> • Endocrine therapy in pre or post-menopausal women or men with hormone-receptor positive invasive disease either initially for 5 to 10 years (upfront strategy), or for 2 to 3 years prior to 2 to 3 years of treatment with an aromatase inhibitor for a total of 5 years (switch strategy) of hormonal therapy • Endocrine therapy in pre or post-menopausal women with hormone-receptor positive ductal carcinoma in-situ (DCIS) for up to 5 years <u>Breast Cancer - Metastatic</u> • Endocrine therapy in pre or post-menopausal women with hormone-receptor positive breast cancer <u>Gynecology</u> • Treatment of recurrent or progressive endometrial, epithelial ovarian, fallopian tube or primary peritoneal cancer as a single agent after failure or contraindication to standard therapy <u>Sarcoma</u> • Treatment of recurrent desmoid tumor or aggressive fibromatosis patients for whom other treatment modalities are not available
Temozolomide	Oral (capsule) 5 mg, 20 mg 100 mg, 140 mg 180 mg, 250 mg Injection (vial) 100 mg	Formulary Non-formulary	
Temsirolimus	Injection (vial) 25 mg	Formulary	Approved for the following indication: <u>Renal Cell Carcinoma - Metastatic (mRCC)</u> • First line treatment of patients with IMDC or MSKCC poor-risk metastatic renal cell carcinoma (mRCC) in patients with good performance status
Teniposide VM-26	Injection (ampoule) 50 mg/5 mL	Formulary	Approved for the following indications: <u>Acute Lymphocytic Leukemia (ALL)</u> • Second line treatment in combination with Cytarabine in patients refractory to other standard chemotherapy treatment <u>Neuroblastoma</u> • Second line treatment in patients refractory to other standard chemotherapy treatments <u>Non-Hodgkins Lymphoma (NHL)</u> • Second line treatment in patients refractory to other standard chemotherapy treatments As of June 27, 2016, worldwide production of Teniposide is discontinued due to unavailability of the active ingredient. Remaining Canadian inventory with Bristol will be distributed until exhausted, with last date for possible availability in May 2018 due to product expiry.

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Thioguanine 6-TG	Oral (tablet) 40 mg	Formulary	
Thiotepa	Injection (vial) 15 mg 100 mg	Formulary	Approved for the following indications: Primary CNS Lymphoma • As part of an approved chemotherapy regimen for the treatment of transplant-ineligible primary CNS lymphoma Blood and Marrow Transplant (BMT) Program • As part of an approved conditioning regimen prior to autologous hematopoietic stem cell transplantation for primary or secondary CNS lymphoma • As part of an approved conditioning regimen prior to haploidentical hematopoietic stem cell transplantation (haplo-HSCT)
rh-Thyrotropin alfa Thyrogen®	Injection (vial) 0.9 mg/1 mL	Formulary	Approved for the following indication: Thyroid Cancer • For use with radioiodine imaging follow-up in patients with thyroid cancer who have one of the following contraindications to thyroid hormone withdrawal: o Significant morbidity after previous thyroid hormone withdrawal o Significant medical contraindication to thyroid hormone withdrawal o In patients previously unable to produce an adequate endogenous TSH response to thyroid hormone withdrawal (e.g. hypopituitarism) • For newly diagnosed thyroid cancer patients prior to ablation therapy
Topotecan	Injection (vial) 4 mg	Formulary	
Trametinib (continued on next page)	Oral (tablet) 0.5 mg, 2 mg	Formulary	Approved for the following indication: Melanoma – Advanced (Unresectable or Metastatic) • First line BRAF targeted therapy (i.e. patients may be treatment naïve or previously treated with checkpoint inhibitor immunotherapy and/or chemotherapy) as a single agent in patients with BRAF V600 mutation positive unresectable or metastatic melanoma who have an ECOG performance status of 0 or 1 and stable brain metastases (if present) • First line BRAF targeted therapy (i.e. patients may be treatment naïve or previously treated with checkpoint inhibitor immunotherapy and/or chemotherapy) with the combination of Dabrafenib and Trametinib in patients with BRAF V600 mutation positive unresectable or metastatic melanoma who have an ECOG performance status of 0 or 1 and stable brain metastases (if present). Note: Trametinib, or the combination of Dabrafenib and Trametinib, is not approved in patients who have progressed on prior BRAF targeted therapy Use of the combination of Dabrafenib and Trametinib precludes the use of any other BRAF targeted therapy as a subsequent line of therapy following disease progression (e.g., combination of Vemurafenib and Cobimetinib, or monotherapy with either Dabrafenib, Trametinib, Vemurafenib or Cobimetinib) In the clinical setting of toxicity to combination therapy, but without disease progression, treatment may be continued with either Dabrafenib or Trametinib as monotherapy if clinically appropriate or switched to other BRAF targeted agents (e.g. Vemurafenib monotherapy or the combination of Vemurafenib and Cobimetinib)

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Trametinib (continued from previous page)	Oral (tablet) 0.5 mg, 2 mg	Formulary	Melanoma – Stage III Resected • Adjuvant treatment of patients with stage IIIA (limited to lymph node metastases of > 1 mm) to stage IIID BRAF-mutated (all BRAF V600 mutations) cutaneous melanoma (based on 8th edition of the American Joint Committee on Cancer [AJCC] staging system) • Disease must be completely resected including in-transit metastases; however, presence of regional lymph nodes with micrometastases after sentinel lymph node biopsy alone is allowed • Patients must have a good performance status Notes: o Patients with mucosal or ocular melanoma are not eligible for the combination of Dabrafenib and Trametinib o Treatment should start within 12 weeks from surgery o Treatment should continue until disease recurrence, unacceptable toxicity, or a maximum duration of 12 months from treatment initiation o For patients who have dose interruptions and subsequently resume therapy, Dabrafenib and Trametinib may continue up to a maximum of 12 months from the time of treatment initiation o Treatment should be discontinued prior to 12 months if there is confirmation of local disease progression or development of metastatic disease o Patients should be assessed for disease recurrence at least every 3 months, or more frequently as clinically indicated o Patients currently receiving adjuvant Interferon who are BRAF mutation positive may be switched to the combination of Dabrafenib and Trametinib for up to 12 months of BRAF targeted therapy provided they meet all other funding criteria o A one-time switch to adjuvant Nivolumab is allowed within the first 3 months of combination Dabrafenib and Trametinib treatment; the total duration of adjuvant therapy that is funded is 12 months of BRAF targeted therapy and immunotherapy combined o Switching to the combination of Vemurafenib and Cobimetinib is not funded for patients who experience intolerance or disease progression on the combination of Dabrafenib and Trametinib used for adjuvant treatment of melanoma o Retreatment with BRAF targeted therapy for recurrent or metastatic disease is allowed if the progression-free interval from the completion of adjuvant Dabrafenib and Trametinib is >6 months o All immunotherapy treatment options are available for patients relapsing on or any time after completion of combination Dabrafenib and Trametinib

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Trastuzumab	Injection (vial) 440 mg	Formulary	Approved for the following indications in HER2 positive disease (IHC 3+ or ISH positive assessed by a validated test): Breast Cancer - Adjuvant and Neoadjuvant • Treatment initiated in combination with or following adjuvant or neoadjuvant chemotherapy, for a total of 17 doses (every 3 week schedule) delivered within a time period not exceeding 14 months from initiation of therapy Breast Cancer - Metastatic • First line treatment in combination with chemotherapy (taxane preferred) +/- Pertuzumab in patients with de novo metastatic disease or for patients who relapse > 6 months after receiving adjuvant Trastuzumab therapy • Maintenance treatment (+/- Pertuzumab) after maximum response to initial combination chemotherapy and Trastuzumab (+/- Pertuzumab), continued until first disease progression • Second line treatment option in combination with synergistic chemotherapy in patients that progress after a first line Trastuzumab regimen Note: Trastuzumab in combination with chemotherapy is considered a second line option in patients who experience disease relapse either during or within 6 months of completing adjuvant Trastuzumab Gastroesophageal Cancer – Metastatic or Inoperable Locally Advanced • First line treatment in combination with Cisplatin and fluoropyrimidine for patients with HER2 positive metastatic or locally advanced (inoperable) adenocarcinoma of the stomach or gastroesophageal junction, followed by maintenance, single agent treatment until disease progression
Trastuzumab Emtansine (T-DM1) See Kadcyla® (tradename used to minimize confusion with Trastuzumab)			
Treosulfan	Injection (vial) 1 g, 5 g	Formulary	Treosulfan is not commercially available in Canada, but may be accessed through the Health Canada Special Access Program (SAP) and Medac UK. Approved for the following indication: Blood and Marrow Transplant (BMT) Program • In combination with Fludarabine as part of a conditioning regimen prior to allogeneic stem cell transplant in multiple myeloma
Tretinoin All trans retinoic acid, ATRA	Oral (capsule) 10 mg	Formulary	Approved for the following indications: • Induction and maintenance therapy for acute promyelocytic leukemia (APL)

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Vandetanib	Oral (tablet) 100 mg, 300 mg	Formulary --- STEP Access	Approved for the following indication: <u>Thyroid Cancer, Medullary</u> • Completion of the SCA Treatment Evaluation Program (STEP) registration form for each patient is required prior to treatment initiation • Treatment of patients who have symptomatic and/or progressive medullary thyroid cancer (MTC) with unresectable, locally advanced or metastatic disease and with a good performance status. Treatment should continue until disease progression or unacceptable toxicity. <u>Note</u>: • Vandetanib is only available through a controlled program referred to as the Caprelsa Restricted Distribution Program. Under this program, only prescribers and pharmacies that have completed the certification and are registered with the program are able to prescribe and dispense Vandetanib. Only patients who are enrolled and meet all of the requirements of the Caprelsa Restricted Distribution Program can receive Vandetanib. For further information about the program, visit www.caprelsa.ca/rdp.
Vemurafenib	Oral (tablet) 240 mg	Formulary	<u>Melanoma – Advanced (Unresectable or Metastatic)</u> • First line BRAF targeted therapy (i.e. patients may be treatment naïve or previously treated with checkpoint inhibitor immunotherapy and/or chemotherapy) as a single agent in patients with BRAF V600 mutation positive unresectable or metastatic melanoma who have an ECOG performance status of 0 or 1 and stable brain metastases (if present) • In combination with Cobimetinib, for the treatment of patients with previously untreated BRAF V600 mutation-positive unresectable stage III or stage IV melanoma who have a good performance status <u>Notes</u>: ○ Previously untreated patients will be interpreted as BRAF-targeted therapy naïve. Patients who received prior checkpoint inhibitor immunotherapy will be eligible for combination BRAF-MEK inhibitor therapy. Previous use of any other BRAF-targeted therapy precludes the use of the combination of Cobimetinib and Vemurafenib. ○ If brain metastases are present, patients should be asymptomatic or have stable symptoms. ○ Treatment should continue until unacceptable toxicity or disease progression. ○ In the clinical setting of toxicity to the combination of Cobimetinib and Vemurafenib, but without disease progression, treatment may be continued, as clinically appropriate, with Vemurafenib monotherapy, or switched to alternate BRAF-targeted therapy with the combination of Dabrafenib and Trametinib, or monotherapy with either Dabrafenib or Trametinib. ○ Use of the combination of Cobimetinib and Vemurafenib precludes the use of any other BRAF targeted therapy as a subsequent line of therapy following disease progression.

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Venetoclax	Oral (tablet) 10 mg, 50 mg, 100 mg	Formulary	Approved for the following indications: <u>Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL)</u> • Monotherapy treatment of patients with chronic lymphocytic leukemia (CLL) who have received at least one prior therapy and who have failed a B-cell receptor inhibitor (BCRi) • Patients should have good performance status and treatment may be continued until disease progression or unacceptable toxicity <u>Notes</u>: (Venetoclax monotherapy) o B-cell receptor inhibitors include: Ibrutinib and Idelalisib o Patients who are intolerant of Ibrutinib or Idelalisib as determined by the treating physician, but have not experienced disease progression, will be eligible for monotherapy treatment with Venetoclax • In combination with Rituximab for the treatment of adult patients with chronic lymphocytic leukemia (CLL) who have received at least one prior therapy, irrespective of their 17p deletion status • Patients may be continued on Venetoclax until disease progression or unacceptable toxicity up to a maximum of two years, whichever comes first <u>Notes</u>: (Venetoclax plus Rituximab): • Eligible patients should have good performance status, usually interpreted as ECOG 0-2 • Patients who were previously treated with and responded to an anti-CD20 containing therapy (e.g., FCR, BR, Chlorambucil-Obinutuzumab) must have had a progression-free interval of 12 months or longer since the last anti-CD20 therapy to be eligible for the combination of Venetoclax plus Rituximab; patients remain eligible for second-line Ibrutinib followed by third-line Venetoclax monotherapy in cases where the progression-free interval following anti-CD20 containing therapy is less than 12 months • Patients currently receiving and responding to Venetoclax monotherapy (initiated after at least one prior therapy and who have failed a B-cell receptor inhibitor [e.g., Ibrutinib, Idelalisib]), but who have not achieved an adequate response are eligible to have Rituximab added to Venetoclax; Venetoclax therapy is funded to a maximum of 2 years from the time when Rituximab is added • Addition of Rituximab to Venetoclax is not approved in patients who are experiencing disease progression on Venetoclax monotherapy • Re-treatment with Venetoclax plus Rituximab is funded as an option at the time of relapse if the progression-free interval was at least 12 months for patients who responded and completed 2 years of Venetoclax therapy • Venetoclax plus Rituximab may be used as a third-line treatment option if Ibrutinib is chosen as a second-line therapy provided all other funding eligibility criteria is met; conversely, Ibrutinib may be used as a third-line treatment option if Venetoclax plus Rituximab is chosen as a second-line therapy provided all other funding eligibility criteria is met
Vinblastine	Injection (vial) 10 mg/10 mL	Formulary	
Vincristine	Injection (vial) 1 mg/1 mL 2 mg/2 mL 5 mg/5 mL	Formulary	

DRUG	DOSAGE FORM	STATUS	FUNDED ELIGIBILITY GUIDELINES
Vinorelbine	Injection (vial) 10 mg/1 mL 50 mg/5 mL	Formulary	
Vismodegib	Oral (capsule) 150 mg	Formulary	Approved for the following indications: • Treatment of metastatic basal cell cancer (BCC) in patients with ECOG ≤2 • Treatment of locally advanced BCC (including basal cell nevus syndrome or Gorlin syndrome, 18 years of age or older) in patients with ECOG ≤2, who are inappropriate for surgery or radiotherapy, based on a multi-disciplinary team decision that included surgeons, dermatologists, radiation oncologists, and medical oncologists Note: Vismodegib is only available through a controlled distribution program called the Erivedge Pregnancy Prevention Program (EPPP). Under this program, only prescribers and pharmacies registered with the program are able to prescribe and dispense the product, respectively. In addition, Vismodegib can only be dispensed to patients who are registered and meet all the conditions of the EPPP.
Zevalin® (see Ibritumomab tiuxetan)			
Zoledronic acid	Injection (vial) 4 mg/5 mL	Formulary	Approved for the following indications: • Prevention of skeletal-related events in patients with metastatic castration-resistant prostate cancer with one or more documented bony metastases • Treatment of patients with documented bone metastases from solid tumors including breast cancer, lung cancer, renal cell carcinoma and other solid tumors Note: For prostate cancer, Zoledronic acid is only funded in cases that are metastatic castration-resistant with bone metastases • Tumor induced hypercalcemia in the outpatient setting • Treatment of patients with multiple myeloma Blood and Marrow Transplant (BMT) Program • Under the direction of an SCC hematologist for the prevention or treatment of osteoporosis in patients who have undergone an allogeneic blood or marrow transplant Breast Cancer – Adjuvant • As adjuvant therapy every 6 months for up to 3 years in high-risk, non-metastatic, post-menopausal patients (natural or induced by ovarian ablation or suppression) Notes: o High-risk is defined as patients who received adjuvant chemotherapy or are candidates for adjuvant chemotherapy, but did not receive due to other reasons o Treatment should begin within 1 year from diagnosis or completion of chemotherapy