National Prescription Drug Utilization Information System (NPDUIS)

Plan Information Document

September 1st, 2006

Canadian Institute for Health Information
Institut canadien d'information sur la santé

Canadian Institute for Health Information
495 Richmond Road
Suite 600
Ottawa, Ontario
K2A 4H6

Telephone: 613-241-7860
Fax: 613-241-8120
www.cihi.ca

Introduction

This document provides contextual information regarding public federal/provincial/territorial drug benefit plans/programs across Canada. Users can click on the links below to view:

Summary of Major Changes

Plan/Program Information by Category:

- Eligibility
- Cost Sharing Mechanism
- Policy related information

Plan/Program Information by Category and by Jurisdiction:

- **Eligibility**

British Columbia	Alberta	Saskatchewan
Manitoba	Ontario	New Brunswick
Nova Scotia	Prince Edward Island	Newfoundland and Labrador
Yukon	First Nations and Inuit Health Branch	

- **Cost Sharing Mechanism**

British Columbia	Alberta	Saskatchewan
Manitoba	Ontario	New Brunswick
Nova Scotia	Prince Edward Island	Newfoundland and Labrador
Yukon	First Nations and Inuit Health Branch	

- **Policy Related Information**

British Columbia	Alberta	Saskatchewan
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Summary of Major Changes

Saskatchewan:

The maximum dispensing fee has increased to $8.21 (was $7.97), effective December 1, 2005.

Manitoba:

2006/07 Pharmacare deductible ranges from 2.56% to 5.51% (was 2.44% to 5.25%) based on total adjusted family income.

Ontario:

The impact of Bill 102 on the Ontario Drug Benefit Program is not known at this time. Once the information is available and confirmed by the Ontario Drug Benefit Program, a new version of this document will be released.

Nova Scotia:

For all programs:

For prescriptions with a drug ingredient cost of up to $145 (was $140), the maximum fee is $10.42 (was $10.12).
For prescriptions with a drug ingredient cost of more than $145 (was $140), the maximum fee is $15.64 (was $15.18).

Senior's Pharmacare program:

For people who do not receive the GIS, the premium is now up to $400 a year (was $390).
The annual maximum co-payment increased to $360 (was $350).

Eligibility (B.C., Alta., Sask., Man., Ont.)

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
Plan/Program	• **Fair PharmaCare** • **Plan B**—Permanent Residents of Licensed Long-Term Care Facilities • **Plan C**—Recipients of British Columbia Income Assistance Benefits • **Plan D**—Cystic Fibrosis • **Plan F**—Children in the At Home program • **Plan G**—No-Charge Psychiatric Medication Program • **Plan P**—Palliative Care	• **Seniors** • **Widows** • **Palliative** • **Non-Group**	• Universal Program	• **FS03**—Employment and Income Assistance Program • **NH02**—Personal Home Care/ Nursing Homes • **PA04**—Palliative Care • **PC01**—Pharmacare	• **ODB**—Ontario Drug Benefit Program
Beneficiary Group	• Residents of British Columbia for at least three months	• **Seniors** Alberta residents aged 65 or older and their eligible dependants. • **Widows** Alberta residents aged 55 to 64 who qualify for Alberta Widows' Pension and eligible dependants • **Palliative** Palliative residents treated at home • **Non-Group** Alberta residents under the age of 65	• Families/Individuals applying for and approved for the Drug Plan's Special Support program (income tested); • Supplementary Health Program; – People nominated for coverage by Saskatchewan Community Resources and Employment. • Guaranteed Income Supplement recipients;	• **FS03** Individual Manitobans that are receiving drug benefits pursuant to the Employment and Income Assistance Program. • **NH02** Manitoba residents of Personal Care Homes • **PA04** Residents who are terminally ill and wish to remain at home • **PC01** All provincial residents who are	• ODB – People 65 years of age and older; – Residents of long-term care facilities; – Residents of Homes for Special Care; – People receiving professional services under the Home Care program; – Trillium Drug Program recipients;

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
			– Government of Canada program for low-income seniors. • Saskatchewan Income Plan recipients; – Provincial program to provide a monthly supplement to low-income seniors. • Families/Individuals approved for Family Health Benefits (eligibility is established by Saskatchewan Community Resources and Employment, based on the number of children in the family and the family's annual income) • Saskatchewan Aids to Independent Living (SAIL) beneficiaries (Paraplegics, Cystic Fibrosis, and Chronic Renal Disease); • Persons approved for the Drug Plan's Palliative Care coverage (residents who are in the late stages of a terminal illness);	eligible for benefits under *The Prescription Drug Cost Assistance Act.* Persons who meet the following qualifications are designated as an eligible individual to receive benefits under the Act: • a person must be a resident as defined in *The Health Services Insurance Act* and be registered and eligible for benefits under that Act; • a person must be a member of a family unit whose members have, in a benefit year, collectively spent more on specified drugs than the deductible amount determined. • an application to become eligible must be made to the minister by the person's family unit, and the minister must be satisfied that the members of the family unit have, in a benefit year, collectively spent	– People receiving social assistance under the Ontario Works and Ontario Disability Support programs

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
			• Government Wards; • Inmates of provincial correctional institutions; • Families granted Emergency Assistance (residents who require immediate treatment with covered prescription drugs and are unable to cover their share of the cost. This is a one-time benefit, and individuals are encouraged to apply for income-tested coverage for future assistance) • Not eligible: Citizens whose health services are covered under First Nations & Inuit Health, Health Canada, Department of Veteran Affairs, Royal Canadian Mounted Police, Canadian Forces, Worker's Compensation or Federal Penitentiaries are not eligible for Drug Plan benefits under Saskatchewan Health	more on specified drugs than the deductible amount determined. Not eligible are: Citizens whose health services are covered under First Nations & Inuit Health, Health Canada, Veteran Affairs, Royal Canadian Mounted Police, Canadian Forces, Worker's Compensation, Federal Penitentiaries or Private Drug Benefit plans are not eligible for Provincial Drug Plan benefits as per section 2(2) (a) & (b) in *The Prescription Drug Cost Assistance Act*.	

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
Income Range	• **Plan C** BC residents in receipt of Income assistance through the Ministry of Employment and Income Assistance. • **Plan G** Low-income residents. An Application for Psychiatric Medication Coverage to a mental health service centre is required for approval	• **Widows** Recipients of the Alberta Widows' Pension • **Non-Group** Subsidized premiums available for low-income Albertans (singles less than $15,970, family with no children less than $28,240, family with children less than $34,250)	N/A	N/A	N/A
Age Range	• **Fair Pharmacare** Fair PharmaCare— – Residents born 1940 or later (varies yearly) • Fair PharmaCare Enhanced Assistance— – Residents born 1939 or earlier (varies yearly) • **Plan F** Less than 18 years old	• **Seniors** 65 or older, or their spouse/partner, or their eligible dependent(s) • **Widows** 55 to 64 • **Non-Group** Under 65	N/A	N/A	N/A
Disease-Specific	• Individuals with Cystic Fibrosis (Plan D) • Severely handicapped children—At-home program (Plan F)	• Alberta has special drug programs for cancer drugs, select high cost drugs funded through Province Wide Services, and public	N/A	N/A	N/A

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
	• Clients of Mental Health Service Centre (Plan G) (meeting low income criterion)	health drugs such as vaccines, TB and STDs. Drug use data for these special drug programs are not included in NPDUIS			
Other eligibility criteria	• **Fair PharmaCare**— Criteria for Fair PharmaCare financial assistance, an individual must: – Have effective British Columbia Medical Services Plan (MSP) coverage; – Have filed an income tax return for the relevant taxation year Criteria for Fair PharmaCare Enhanced Assistance, an individual must: – Have been born in 1939 or earlier; – Have effective British Columbia Medical Services Plan (MSP) coverage; and – Have filed an income tax return for the relevant taxation year	• **Seniors** Be registered with the Alberta Health Care Insurance Plan (AHCIP) and have not opted out of the plan • **Widows** Recipients of the Alberta Widows' Pension • **Palliative** Be registered with the AHCIP and have not opted out of the plan. Be diagnosed by a physician as being palliative. Be receiving treatments at home • **Non-Group** Be registered with AHCIP and have not opted out of the plan. Not be in arrears for AHCIP	N/A	N/A	N/A

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
	• **Plan B** Enrol in and receive coverage under Plan B through the care facility • **Plan C** Must be registered in MSP and be enrolled either through the Ministry of Children and Family Development or the Ministry of Employment and Income Assistance • **Plan D** Individuals with Cystic Fibrosis who are registered with a provincial cystic fibrosis clinic • **Plan F** – Age 17 or younger – A resident of BC – Living at home with a parent or guardian – Assessed as dependent in at least three of four areas of daily living • **Plan G** – Patient's physician or psychiatrist must submit an				

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
	Application for Psychiatric Medication Coverage to a mental health service centre for approval – Patient must qualify for premium assistance under the B.C. Medical Services Plan. • **Plan P** – Enrolled in MSP, living at home – Diagnosed as being in the terminal stage of a life-threatening illness – Have a life expectancy of up to six months – The physician submits an application, certifying the individual meets the criteria				
Sources	Validated by British Columbia PharmaCare July 2006	Validated by Alberta Health and Wellness December 2005	Validated by Saskatchewan Health Drug and Extended Benefits Branch December 2005	Validated by Manitoba Health August 2006	Validated by Ontario Drug Benefit Program January 2006

Eligibility (N.B., N.S., P.E.I., N.L., Y.T., FNIHB)

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
Plan/Program	• **A**—Seniors' Program • **B**—Cystic Fibrosis • **E**—Individuals in Licensed Residential Facilities • **F**—Family and Community Services • **G**—Children in the Care of the Minister of Family and Community Services • **H**—Multiple Sclerosis • **R**—Organ Transplant • **T**—Human Growth Hormone • **U**—HIV • **V**—Nursing Home	• **C**—Drug Assistance for Cancer patients • **D**—Nova Scotia Diabetes Assistance Program • **F**—Department of Community Services Programs • **S**—Seniors' Pharmacare Program	• **A**—AIDS/HIV Program • **B**—Community Mental Health Program • **C**—Cystic Fibrosis Program • **D**—Diabetes Control Program • **E**—Erythropoietin Program • **F**—Family Health Benefit Program • **G**—Growth Hormone • **H**—Hepatitis Program • **I**—Immunization Program • **J**—Intron A (Interferon alfa-2b) Program • **K**—Meningitis Program • **M**—High Cost Drug Program • **N**—Institutional Pharmacy/Nursing Home Program • **O**—Nutrition Services Program • **P**—Phenylketonuria (PKU) Program	• **E**—Social Services Drug Program • **N**—Senior Citizens Drug Subsidy Program	• Children's Drug & Optical Program • Chronic Disease Program • Pharmacare	▪ **NIHB**—Non-Insured Health Benefits

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
			• **R**—Rabies Program • **S**—Seniors Drug Cost Assistance Plan • **T**—Transplant Program • **U**—Rheumatic Fever Program • **V**—Sexually Transmitted Diseases (STD) Program • **W**—Children-In-Care/Financial Assistance Program • **X**—Tuberculosis (TB) Drug Program • **Z**—Quit Smoking Program			
Beneficiary Group	• **A**—Seniors who receive the Guaranteed Income Supplement (GIS) or who qualify for benefits based on an annual income as follows: – a single senior with an annual income of	• **C**—Residents having a gross family income no greater than $15,720 per year, and not eligible for coverage under other drug programs • **D**—Residents aged under 65 with a valid Nova Scotia Health Card and	• **A**—Persons diagnosed as HIV positive with AIDS, or with a needle stick injury and registered with the program through the Chief Health Officer • **B**—Approved long-term psychiatric patients living	• **E**—Residents who qualify for full benefit coverage under the Department of Human Resources and Employment. Residents who, due to the high cost of their medications, may qualify for drug card only benefits	• **Children's Drug and Optical Program** Children under the age of 19 years from low-income families and not having coverage through First Nations and Inuit Health Program	Registered Indian or recognized Inuit (regardless of province or territory of residency)

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
	$17,198 or less; – a senior couple (both age ≥ 65) with a combined annual income of $26,955 or less; – a senior couple with one spouse under 65, with a combined annual income of $32,390 or less • **B**—Cystic fibrosis patients or patients with juvenile or infant sclerosis of the pancreas • **E**—Individuals residing in a licensed residential facility who hold a valid health card for prescription drugs issued by the Department of Family and	who do not have drug coverage through Veterans Affairs Canada, First Nations and Inuit Health, or any private drug plans that cover diabetes supplies, that have a confirmed diagnosis of diabetes • **F**—Eligible clients and their dependents in receipt of Income Assistance who do not have access to another drug plan, be it from a public or private entity • **S**—Residents aged 65 or older with a valid Nova Scotia Health Card and who do not have drug coverage through Veterans Affairs Canada, First Nations and Inuit	in the community • **C**—Persons eligible for PEI Medicare, diagnosed with cystic fibrosis and who are registered with the program • **D**—Persons with diabetes eligible for PEI Medicare and whom their Physician registers in the program • **E**—Persons eligible for PEI Medicare who have been diagnosed with chronic renal failure or are receiving kidney dialysis & who do not have any other drug insurance • **F**—Only parents/guardians and children under 18 years of age who are eligible for PEI Medicare, in the following income ranges:	**N**—Residents 65 years of age and over who are registered with the Old Age Security Division of Health and Welfare Canada, and who are in receipt of the Guaranteed Income Supplement	• **Chronic Disease Program** Residents who have a chronic disease or a serious functional disability as provided under the Chronic Disease and Disability Benefits Regulations. Program may also include clients receiving Palliative Care • **Pharmacare** Seniors 65 years of age or older (and seniors' spouses aged 60 years and older) registered with Yukon Health Care Insurance Plan (YCHCIP) and not having coverage through First Nations and Inuit Health Program. Program may also include clients receiving Palliative Care	

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
	Community Services • **F**—Individuals holding a valid health card for prescription drugs issued by the Department of Family and Community Services • **G**—Special needs children and children under the care of the Minister of Family and Community Services • **H**—Residents in possession of a prescription written by a neurologist for the medications Avonex, Rebif, Betaseron or Copaxone are eligible to apply for assistance • **R**—Organ transplant recipients who are registered and qualify with the NBPDP • **T**—Individuals with growth	Health, or a private drug plan	– 1 child with a net annual family income less than $22,000; – 2 children with a net annual family income of less than $24,000; – For each additional child, add $2,000 • **G**—Children eligible for PEI Medicare with a proven growth deficiency or Turners Syndrome, and who are registered with the program • **H**—Persons diagnosed with hepatitis; Persons who have been in close contact with a person diagnosed with hepatitis or are at risk of infection; Persons with an occupational risk of infection			

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
	hormone deficiency who are registered and qualify with the NBPDP • **U**—Individuals who are HIV positive and are registered with the NBPDP through a provincial infectious disease specialist • **V**—Individuals who reside in a registered nursing home		• **I**—Children and persons at risk for exposure to various communicable diseases • **J**—For the treatment of patients diagnosed with hairy Cell Leukemia, AIDS-related Kaposi's Sarcoma, and Basal Cell Carcinoma. The person's Physician must request coverage from the Chief Health Officer of the Department of Health and Social Services • **K**—Persons who have been in close contact with a person diagnosed with meningitis or are at risk of infection • **M**—Persons eligible for PEI Medicare, and approved for coverage of one or more of the			

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
			medications included in the program. Patients must apply for coverage on an annual basis and provide income information to the program • **N**—Residents in private nursing homes eligible for coverage under the Welfare Assistance Act. • **O**—Children and high risk pregnant women diagnosed with a nutritional deficiency • **P**—Island children under 18 years and diagnosed with Phenylketonuria • **R**—Persons with exposure to or at risk for exposure to rabies through an animal bite • **S**—Persons eligible for PEI Medicare and 65 years of age or more			

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
			• **T**—Residents who have had an organ or bone marrow transplant. A letter from a Physician confirming the transplant is required • U—Persons eligible for PEI Medicare and who have a well documented history of rheumatic fever or rheumatic heart disease and are registered with the program • **V**—Persons diagnosed with a sexually transmitted disease or identified contacts of a person diagnosed with a sexually transmitted disease • **W**—Persons eligible under the Welfare Assistance Act			

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
			and persons in the temporary or permanent care of the Director of Child Welfare • **X**—Patients must have a diagnosis of tuberculosis confirmed by the Chief Health Officer of the Department of Health and Social Services • **Z**—Persons eligible for PEI Medicare and who have registered with the program			
Income Range	• **A**—For seniors without GIS: Single senior with an annual income of $17,198 or less; Senior couple (both age ≥ 65) with a combined annual income of $26,955 or less; Senior couple with one spouse under 65 with a combined annual income of $32,390 or less	• **C**—Gross family income no greater than $15,720 • **D**—No income based criteria for eligibility however, deductible is based on income—See section of deductible • **F**—As determined by Department of Community Services	N/A	• **E**—Residents who qualify for full benefit coverage under the Departments of Human Resources and Employment. Residents who, due to the high cost of their medications, may qualify for drug card only benefits	• Tables with family income and family size are used to determine deductibles for Chronic Disease and Children's Drug & Optical programs. The table for Children's Drug and Optical indicates income ranges that would not be eligible for program	N/A

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
		• **S**—No income based criteria for eligibility however, premium is based on income—See section on premium		• **N**—Seniors in receipt of the Guaranteed Income Supplement and who are registered for Old Age Security benefits		
Age Range	• **A**—65 and older	• **C**—Under 65 • **D**—Under 65 • **F**—Under 65 • **S**—65 and older	• **G**—Under 18 years • **P**—Under 18 years • **S**—65 years and older	• **N**—65 or older	• **Children's Drug and Optical Program** Children 0 to 18 years of age • **Pharmacare** Seniors 65 years of age or older (and seniors' spouses aged 60 years and older)	N/A
Disease-Specific	• **B**—Cystic fibrosis or juvenile or infant sclerosis of the pancreas • **H**—Multiple sclerosis • **R**—Organ transplant • **T**—Human growth hormone • **U**—HIV	• **C**—Cancer • **D**—Diabetes	• **A**—AIDS/HIV • **B**—Mental Health • **C**—Cystic Fibrosis • **D**—Diabetes • **G**—Growth Hormone • **H**—Hepatitis • **I**—Immunization • **J**—Intron A (Interferon alfa-2b) • **K**—Meningitis • **M**—High Cost Drugs	N/A	• **Chronic Disease Program**—Residents who have a chronic disease or a serious functional disability as provided under the Chronic Disease and Disability Benefits Regulations (Residents must use private insurance plans first)	• Special formulary for Chronic Renal Failure patients within NIHB

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
			• **P**—Phenylketonuria (PKU) • **R**—Rabies • **T**—Transplant • **U**—Rheumatic • **V**—Sexually Transmitted Diseases (STD) • **X**—Tuberculosis (TB)			
Other eligibility criteria	N/A	• **C**—Not be eligible for coverage under another drug plan • **D**—Do not have coverage through Veterans Affairs Canada, First Nations and Inuit Health, or a private drug plan that covers diabetes supplies • **S**—Do not have coverage through Veterans Affairs Canada, First Nations and Inuit Health, or a private drug plan	N/A	N/A	• Absence from the Territory for more than 183 (six months) consecutive days will result in suspension of drug and benefit costs reimbursement starting the date of departure. A one-month extension will be considered on application to the Director of Health Care Insurance where the Yukon is the location of the applicant's only principal residence. On return to the Territory, the resident may	NIHB Program is that it is the payer of last resort i.e. resident must use private, provincial or territorial health plan first if eligible for any of those.

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
					re-apply for coverage under the respective program	
Sources	Validated by New Brunswick Prescription Drug Program August 2006	Validated by Nova Scotia Programs and Funding—Pharmacare September 2006	Validated by Prince Edward Island Drug Program August 2006	Validated by Newfoundland and Labrador Prescription Drug Program January 2006	Validated by Yukon Health Services July 2006	Validated by Non-Insured Health Benefits July 2006

Cost-Sharing Mechanism (B.C., Alta., Sask., Man., Ont.)

Cost-sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
Premium	None	• **Non-Group** $61.50 per quarter for individuals, $123 per quarter for families. If the individual/family qualifies for Alberta Health Care Insurance Premium Subsidy (based on previous years' taxable income), then $43.05 per quarter for individuals, $86.10 per quarter for families	None	None	None
Co-Payment/ Co-insurance	• **Fair PharmaCare** Fair PharmaCare – After meeting their annual deductible, families pay 30% for eligible prescription drug costs for the remainder of the calendar year (or until reaching their annual maximum— whichever comes first)	• **Seniors** 30% per prescription up to a maximum of $25 • **Widows** 30% per prescription up to a maximum of $25 • **Palliative** 30% per prescription up to a maximum of $25 • **Non-Group** 30% per prescription up to a maximum of $25	• Income-tested (based on benefit drug costs, to help spread cost out evenly over the year) • 35% for seniors receiving the Saskatchewan Income Plan supplement or receiving the federal Guaranteed Income Supplement (automatically receive this co-pay but may also apply for income-tested coverage) • 35% for Family Health Benefits;	None	• ODB recipients pay up to $2 per prescription (i.e. co-payment) if they are: – A senior single person with an annual net income of *less than* $16,018 – A senior couple with a combined annual net income of *less than* $24,175 – Receiving benefits under the Ontario Works Act or the Ontario Disability

Cost-sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
	Fair PharmaCare Enhanced Assistance – After meeting their annual deductible, families pay 25% for eligible prescription drug costs for the remainder of the calendar year (or until reaching their annual maximum—whichever comes first)		no charge for benefit prescriptions for FHB children under 18 • Up to $2.00 per prescription for Supplementary Health (Persons nominated by Saskatchewan Community Resources and Employment for special coverage, including persons on Social Assistance, wards, inmates, etc.); some drugs covered at no charge; individuals under 18 and certain other categories receive benefit prescriptions at no charge • For the Emergency Assistance Program, the level of assistance provided is in accordance with the consumer's ability to pay		Support Program Act – Receiving professional services under the Home Care Program – Residents of Long-Term Care facilities and Homes for Special Care – Eligible under the Trillium Drug Program • ODB recipients each pay their first annual $100 (i.e. prorated deductible based on number of months) in prescription costs each year. After that, they pay up to $6.11 (i.e. co-payment) toward the ODB dispensing fee on each prescription if they are: – A senior single person with an annual net income *equal to or greater than* $16,018 – A senior couple with a combined annual net income *equal to or greater than* $24,175

Cost-sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
Deductible	• Fair PharmaCare Fair PharmaCare— Net Family income < $15,000 Deductible = $0 Net Family income $15,000 to $30,000 Deductible = 2% of net income Net Family income > $30,000 Deductible = 3% of net income Fair PharmaCare Enhanced Assistance— Net Family income < $33,000 Deductible = $0 Net Family income $33,000 to $50,000 Deductible = 1% of net income Net Family income > $50,000 Deductible = 2% of net income Note: The deductible is based on income bands so it is not exact to the	None	• Income-tested (annual threshold based on 3.4% of adjusted family income) • $100 semi-annual family deductible for seniors receiving the Saskatchewan Income Plan supplement or receiving the federal Guaranteed Income Supplement and residing in a special care home (automatically receive this deductible but may also apply for income-tested coverage) • $200 semi-annual family deductible for seniors receiving the Guaranteed Income Supplement and living in the community (automatically receive this deductible but may also apply for income-tested coverage) • $100.00 semi-annual family deductible for Family Health Benefits	• Income tested—annual threshold based on total adjusted family income (total adjusted family income is total annual income on line 150 of income tax return less $3,000 for a spouse and each eligible dependent). • The deductible is the greater of: – $100 – Or the amount determined by multiplying the adjusted family income by the relevant percent. In fiscal year 2006/2007 the deductible rates for adjusted family incomes: < = $15,000 then 2.56%; > $15,000 & < = $40,000 then 3.83%; > $40,000 & < = $75,000 then 4.41%; > $75,000 then 5.51%	• $100 deductible for: – Single seniors (65 or older) with annual income of $16,018 or more – Senior couples with a combined annual income of $24,175 or more • Trillium Drug Program applicants must pay a quarterly or prorated deductible that is based on income • No deductible for other ODB eligible people

Cost-sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
	percentages provided. **No deductible is applied to the remaining Plans/Programs.**				
Maximum Beneficiary Contribution	• Fair PharmaCare Fair PharmaCare – Net Family income < $15,000 Maximum = 2% of net income Net Family income $15,000 to $30,000 Maximum = 3% of net income Net Family income > $30,000 Maximum = 4% of net income Fair PharmaCare Enhanced Assistance – Net Family income < $33,000 Maximum = 1.25% of net income Net Family income $33,000 to $50,000 Maximum = 2% of net income Net Family income > $50,000 Maximum = 3% of net income	• Palliative $1,000	N/A	The maximum beneficiary contribution is based on the beneficiary deductible. Once a person deductible has been met then all eligible drug costs are reimbursed.	N/A

Cost-sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
	Note: The maximum is based on income bands so it is not exact to the percentages provided. No maximum beneficiary contribution is applied to the remaining Plans/Programs.				
Sources	Validated by British Columbia PharmaCare July 2006	Validated by Alberta Health and Wellness December 2005	Validated by Saskatchewan Health Drug and Extended Benefits Branch December 2005	Validated by Manitoba Health August 2006	Validated by Ontario Drug Benefit Program January 2006

Cost-Sharing Mechanism (N.B., N.S., P.E.I., N.L., Y.T., FNIHB)

Cost-Sharing Mechanism	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Premium	• **B**—$50.00 yearly registration fee • **H**—$50.00 yearly registration fee • **R**—$50.00 yearly registration fee • **T**—$50.00 yearly registration fee • **U**—$50.00 yearly registration fee	• **C**—No premium • **D**—No premium • **F**—No premium • **S**—No premium for people who receive the GIS. For those who do not receive the GIS, they must pay a premium of up to $400 a year. Some low-income seniors who do not get the GIS may qualify for reduced premiums.	None	None	None	None
Co-Payment/ Co-insurance	• **A**—Seniors with GIS: $9.05 for each prescription, up to a maximum of $250 in one calendar year; Seniors without GIS: $15.00 per prescription • **B**—20% of the costs for each prescription up to a maximum of $20 • **E**—$4.00 for each prescription	• **C**—No co-payment • **D**—20% of the total prescription cost • **F**—$5.00 per prescription unless the client or dependent is eligible for co-pay exemption • **S**—33% of the total prescription cost to a maximum of $30 for each prescription	• **D**—Insulin: – $10.00 per 10 mL vial of insulin or box of 1.5 mL insulin cartridges; – $20.00 per box of 3.0 mL insulin cartridges Oral Medications and Urine Testing Materials:	• **N**—Any applied Mark-up and Professional Fee for identified benefits	None	None

Cost-Sharing Mechanism	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
	• **F**—$4.00 for each prescription for adults (18 and over) and $2.00 for children (under 18 years) • **H**—Ranges from zero to 100 per cent of the prescription cost, depends on discretionary income. The co-pay is determined annually during the re-qualification period • **R**—20% of the costs for each prescription up to a maximum of $20 • **T**—20% of the costs for each prescription up to a maximum of $20 • **U**—20% of the costs for each prescription up to a maximum of $20	(minimum of $3 per prescription)	– $11.00 per prescription High Cost Diabetes Medications: An income based portion of the medication plus the dispensing fee for each high cost medication obtained. • **F**—The pharmacy fee $7.50 per prescription • **M**—Income tested co-pay plus the pharmacy professional fee for each prescription • **S**—First $11.00 of the medication cost plus the pharmacy professional fee for each prescription • **Z**—Patients are responsible for all medication costs approved, except for the first $75.00 which will be paid by the program			

Cost-Sharing Mechanism	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Deductible	None	• **C**—No deductible • **D**—Deductible is based on adjusted annual family income (AAFI) (equal to annual family income less $3000 for a spouse and each family member under the age of 18 years) and is calculated as follows: AAFI less than $15,000: No deductible AAFI between $15,000 and $30,999: Deductible starts at $7.50 and increases by 0.05% for every $1,000 that AAFI exceeds $15,000 AAFI between $31,000 and $45,999: Deductible starts at $279.00 and increases by 0.1% for every $1,000 that AAFI exceeds $31,000	None	None	• Children's Drug & Optical Program Maximum $250.00 per child and $500.00 per family. Deductible may be waived or reduced depending on income. • Chronic Disease Program Maximum $250 per individual and $500 per family, waived for Palliative Care recipients. Deductible may be waived or reduced depending on income.	None

Cost-Sharing Mechanism	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
		AAFI $46,000 or over: Deductible starts at $1,115.50 and increases by 0.125% for every $1,000 that AAFI exceeds $46,000 • **F**—No deductible • **S**—No deductible				
Maximum Beneficiary Contribution	• **A**—Seniors with GIS: $250 in one calendar year • **B**—$500 per family unit in one fiscal year + premium (see above) • **E**—$250 per person in a fiscal year • **F**—$250 per family unit in a fiscal year • **R**—$500 per family unit in a fiscal year + premium (see above) • **T**—$500 per family unit in one fiscal year + premium (see above) • **U**—$500 per family unit in one fiscal year +	• **S**—Annual maximum co-payment of $360 + premium (see above)	N/A	N/A	N/A	N/A

Cost-Sharing Mechanism	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
	premium (see above)					
Sources	Validated by New Brunswick Prescription Drug Program August 2006	Validated by Nova Scotia Programs and Funding—Pharmacare September 2006	Validated by Prince Edward Island Drug Program August 2006	Validated by Newfoundland and Labrador Prescription Drug Program January 2006	Validated by Yukon Health Services July 2006	Validated by Non-Insured Health Benefits July 2006

Policy Related Information (B.C., Alta., Sask., Man., Ont.)

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Prescription Cost Components	PharmaCare will pay the pharmacy's Actual Acquisition Cost (AAC), including freight costs, up to a maximum of 7% above the manufacturer's list price for wholesaled drugs, plus the Professional/ dispensing Fee	Actual Acquisition Cost + Professional Fees + Inventory Allowance There are 3 drug price policies: least cost alternative (LCA), maximum allowable cost (MAC), and actual acquisition cost (AAC). The LCA price is the lowest unit cost established for a drug product within a set of interchangeable drug products. Alberta's supplemental health plans will only pay for the lowest-priced drug product where interchangeable (generic) products can be used to fill a prescription. Beneficiaries who choose higher cost alternatives are responsible for paying the difference. The MAC price is the maximum unit cost established for a specific drug product or a selected group of interchangeable drug products. A small	**Low Cost Alternative** Benefits are based on the lowest priced interchangeable brand as listed in the Formulary. **Maximum Allowable Cost** Classes of drugs are reviewed by the province's expert drug review committees to determine which products are equally safe, beneficial, and cost-effective. The price of the most cost-effective drugs are used as a guide to set the maximum price that the Drug Plan will cover for other similar drugs, used to treat the same condition. **Prescription Cost** The prescription cost is calculated by adding the actual acquisition cost of the drug material (which can include an allowable wholesale mark-up), the pharmacy mark-up (up to a maximum) and	**Prescription Cost** The prescription cost is equal to the cost of specified drug (the price of the specified drug to the pharmacist or holder of the pharmacy license), and a professional fee (the professional fee is equal to the amount regularly charged by a pharmacist to persons who are responsible for paying the fee without reimbursement). **Low Cost Alternative** Benefits are based on the lowest priced interchangeable brand as listed in the Formulary whether or not the specified drug is prescribed with a " no sub" or " no substitution" instruction.	Drug Benefit Price (DBP) + Mark-up + Professional Fee Where Actual Acquisition Cost exceeds DBP +10%, pharmacists may claim AAC. A mark-up is not paid on these claims.

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
		number of products are subject to MAC pricing. Pursuant to the Pharmacy Agreement, pharmacists are expected to charge the actual acquisition cost (AAC) of a drug product. For interchangeable drug products, pharmacists can only charge the AAC to a maximum of the LCA price.	dispensing fee (up to a maximum).		
Professional Fees	• PharmaCare reimburses up to $8.60 for dispensing fee • Plan B dispensing pharmacies are paid a capitation fee (per long-term care bed) • Methadone (maintenance) Interaction Fee: $7.70 • Special Services Fee: Remuneration to pharmacists if they choose not to fill a prescription based on their professional opinion (fee of twice the dispensing fee)	Alberta has two types of professional fees: dispensing fees and Additional Inventory Allowance. The new Additional Inventory Allowance pricing component was implemented effective July 1, 2000. DISPENSING FEES: • From April 1, 2005 to March 31, 2006, $10.22 to $20.94 depending on the acquisition cost of the drug	The maximum dispensing fee is $8.21 (effective December 1, 2005).	• The professional fee for Pharmacare is equal to the amount regularly charged by a pharmacist to persons who are responsible for paying the fee without reimbursement. • The Employment and Income Assistance program has a maximum professional fee of $6.95. • Monthly capitation fee for personal care homes; $31.74 per bed/month for Winnipeg and $32.34 per	$6.54

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	• Emergency Contraceptive honorarium ($15.00)	ADDITIONAL INVENTORY ALLOWANCE: • From April 1, 2004 to March 31, 2006, $0.71 to $5.03 depending on the acquisition cost of the drug		bed/month for rural areas.	
Mark-up	• Maximum 7% if bought from wholesalers • PharmaCare does not cover (pay for) retail mark-up • Mark-up is built into the ingredient cost, regardless of whom it is purchased from	Prices listed in the *Alberta Health and Wellness Drug Benefit List* include a wholesaler mark-up, but only if the drug manufacturer distributes through a wholesaler only. In such cases, they are asked to include a distribution allowance of up to 7.5%. This includes both single source and interchangeable products. In the April 2005 *List*, approximately 40% of the products included this distribution allowance.	The maximum pharmacy mark-up allowance calculated on the prescription drug cost is: • 30% for drug cost up to $6.30 • 15% for drug cost between $6.31 and $15.80 • 10% for drug cost of $15.81 to $200.00 • Maximum mark-up of $20.00 for drug cost over $200.00	N/A	10%
Ingredient Pricing Policy	AAC is adjusted to reflect the true cost to the pharmacy and is net of any cash discounts, volume discounts, rebates or performance allowances.	All prices printed in the *Alberta Health and Wellness Drug Benefit List* are based on responses to a Request for Quotation (RFQ) for the period of time during which the *List* is in effect. An RFQ was sent	Manufacturers are required to guarantee the prices of their listed products for a six-month period (January—June; July—December). The prices published in the Formulary include the maximum allowable	• The specified drug as listed in the Specified Drug Regulations is equal to the cost for the lowest priced interchangeable product prescribed in the formulary.	• Since January 1999, the Ministry will consider manufacturer requests for price increases that are cost neutral to the ODB in that any price increase needs to be

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
		to all pharmaceutical manufacturers whose products are included in the *List* or were under review for possible addition to the *List*	wholesale mark-up. Pharmacies are required by contract to submit their actual acquisition cost of the drug, which may be less than the published formulary price **Standing Offer Contract (SOC)** The Drug Plan tenders the drugs in certain interchangeable groups to obtain the lowest possible price. An accepted tender, called SOC requires the manufacturer to guarantee delivery of the specific drug to pharmacies through approved distributors at the contracted price. In return, the manufacturer's product will be used almost exclusively. Only the accepted tendered drug can be used to fill a prescription in an SOC interchangeable group.	Or in any other case, the lowest usual price of the specified drug as charged from time to time by wholesalers or manufacturers that supply pharmaceuticals to pharmacists or holders of pharmacy licenses.	offset by price decreases on other listed products. • Before a product is approved for listing, the Ministry and the manufacturer must agree on its Drug Benefit Price (DBP). • Prices of patented drugs must comply with the Price Guidelines set by the Patented Medicines Price Review Board (PMPRB). • Prices of multiple-source drugs must comply with the "70/90" price rule where the first generic is priced no greater than 70% of the DBP of the original product and subsequent generics are priced no more than 63% of the DBP (90% of the first generic price). • When a pharmacy is not able to purchase a Formulary listed drug at a price less than or equal to its ODB reimbursement amount (i.e. the drug benefit price + 10%

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
					mark up), payment of the acquisition cost to the pharmacy of the least expensive listed drug product in the pharmacy's inventory may be claimed. This is referred to as a "cost-to-operator" claim.
Coordination of benefits (Public/ Private)	With the exception of BC residents covered by Veteran Affairs Canada, Royal Canadian Mounted Police (RCMP), Canadian Forces, Worker's Compensation (WCB), or the federal Non-Insured Health Benefits (NIHB) program, PharmaCare covers every individual. PharmaCare will consider coverage first and private insurance will consider coverage second.	Alberta Health and Wellness allows coordination of benefits between its Alberta Blue Cross non-group plans and private plans. The payment is shared pursuant to the Canadian Life and Health Insurance Association (CLHIA) rules regarding Coordination of Benefits.	The Drug Plan is the first payor on eligible claims for eligible beneficiaries. Costs not covered by the Drug Plan are either sent electronically by the pharmacy or manually by the patient to their private insurance carrier (where applicable).	• For each benefit year beginning on or after April 1, 1996, the amount of the benefits payable to a family unit is the cost of specified drugs incurred collectively by the family unit in the benefit year that exceeds the deductible amount determined. A person is not considered to have spent an amount on the cost of a specified drug in the following cases: • The person is entitled to be reimbursed for the cost of the specified drug from a source other than the government to the extent of the reimbursement.	Claims for seniors with both Private Insurance and Public Provincial coverage are processed under their Provincial Plan first. Individuals or families can apply to the Trillium Drug Program if private insurance does not cover 100% of their prescription drug costs and if they are not eligible for drug coverage under the ODB Program.

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
				• The person is entitled to have the cost of the specified drug paid from a fund or pursuant to a program established under a law enacted by Parliament or a legislature in Canada or elsewhere. Citizens whose health services are covered under First Nations & Inuit Health, Health Canada, Veteran Affairs, Royal Canadian Mounted Police, Canadian Forces, Worker's Compensation, Federal Penitentiaries or Private Drug Benefit plans are not eligible for Provincial Drug Plan benefits as per section 2(2) (a) & (b) in *The Prescription Drug Cost Assistance Act*.	
Coordination of benefits (Intra-jurisdictionally)	For PharmaCare claims, the rules of Plan adjudication are as follows, by Plan priority. If a patient doesn't meet the criteria of one plan, they will move on to the next until a plan is selected. If one plan only offers partial coverage (e.g. based	Alberta Health and Wellness does not permit coordination of benefits across its public plans. As Albertans can only be enrolled in one of our plans, coordination of benefits would not be possible. Generally, Albertans eligible for coverage	Citizens whose health services are covered under First Nations & Inuit Health, Health Canada, Department of Veteran Affairs, Royal Canadian Mounted Police, Canadian Forces, Worker's Compensation or Federal Penitentiaries are not eligible for Drug	Citizens whose health services are covered under First Nations & Inuit Health, Health Canada, Veteran Affairs, Royal Canadian Mounted Police, Canadian Forces, Worker's Compensation, Federal Penitentiaries or Private Drug Benefit plans are not eligible	A person cannot be on more than one provincial public drug plan at the same time.

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	on medication) then a patient could have claims and payments for multiple plans. The order of adjudication is as follows: • Plan B • Plan P • Plan D • Plan G • Plan F • Plan C • Fair PharmaCare Enhanced Assistance • Fair PharmaCare	under federal plans do not seek coverage under one of the Alberta Health and Wellness non-group plans.	Plan benefits under Saskatchewan Health.	for Provincial Drug Plan benefits as per section 2(2) (a) & (b) in *The Prescription Drug Cost Assistance Act.*	
Restricted Benefit Process	• Special Authority forms are completed by practitioners on behalf of their patients • These forms can be forwarded to PharmaCare by mail, fax or telephone • The Special Authority requests are adjudicated on an individual basis, according to established criteria • Approved requests are entered into a patient's PharmaNet record. The Special Authority coverage is then available through any British Columbia pharmacy.	• Special authorization request forms are completed by physicians and reviewed by clinical pharmacists at Alberta Blue Cross • Prior approval must be granted to ensure coverage by special authorization • A small number of drugs are restricted to specific age groups	**Exception Drug Status** Criteria based coverage for drug products where regular benefit listing may not be appropriate or possible. • Physicians, dentists, duly qualified optometrists (or authorized office staff), nurse practitioners and pharmacists may apply for Exception Drug Status (EDS) • Requests can be submitted by telephone, by mail or by fax • Patients are notified by letter if coverage has been approved and the time period	A drug or other item not listed in Part 1, or a specified drug listed in Part 2 for use in a different condition, may be considered for eligibility if: • it is ordinarily administered only to hospital in-patients and is being administered outside of a hospital; • it is not ordinarily prescribed or administered in Manitoba but is being prescribed because it is required in the treatment of a patient having an illness, disability or condition rarely	**Limited Use Products**—A physician must complete a LU prescription form when prescribing LU products. The patient takes the prescription form to the pharmacy for dispensing. The LU prescription form is valid for one year from the initial date it was completed and signed by the physician. **Individual Clinical Review (Section 8)**—To apply for special coverage for drug products not listed on the Formulary, the physician must send a written request to the Drug Programs Branch.

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	Special authorities are valid from the effective date for various periods of time, depending on the medication and use • Information regarding requests is returned to the practitioner by fax or mail • If appropriate, expired Special Authority coverage may be renewed		for which coverage has been approved • If a request has been denied, letters are sent to the patient and prescriber notifying them of the reason for the denial For pharmacist-initiated EDS requests: The diagnosis, which must be obtained from the physician or physician's agent, is to be consistently documented within the pharmacy, whether the documentation is on the original prescription, computer file, or EDS fax form.	found in Manitoba; or • evidence, including therapeutic and economic evidence, provided to the minister in accordance with the criteria established by him or her, supports a specific treatment regime which includes use of the drug or other item. Process: Exception Drug Status Part 2—Adjudicated for payment by the DPIN system automatically if the pharmacist or prescriber indicates on the prescription that the patient meets the established Part 2 criteria. Part 3—The prescriber must contact Manitoba Health to request eligibility for prescription. Eligibility is from date of approval.	Ministry staff coordinates the review process, which includes obtaining a recommendation from the Drug Quality and Therapeutics Committee (DQTC). The DQTC requires full details of an individual's case in order to make a recommendation. The ministry's decision on individual coverage in a particular patient's case will be communicated via letter to the physician making the request. If coverage is approved, the physician may provide a copy of the approval notice for the patient to take to their pharmacy.
Reimburse-ment Policy	Every time an enrolled Fair PharmaCare beneficiary purchases medication at a	When beneficiaries pay out of pocket, reimbursement claims are permitted. Claims	An on-line computer network transmits prescription information from the pharmacy to	An on-line computer network transmits prescription information from the pharmacy to	Claims are only reimbursed when dispensed from an Ontario pharmacy,

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	registered BC Pharmacy, a claim is automatically submitted for coverage. If a patient enrols in Fair PharmaCare partway through the (calendar) year, but has paid out of pocket for eligible drugs before enrolling in the program in that year, PharmaCare will retroactively credit previous eligible drug purchases, and issue a reimbursement cheque where the beneficiary paid more than owing Special Authorities are prioritized by date received and the urgency of the request. On average, most requests are processed within two weeks. To ensure PharmaCare coverage, approval must take place prior to purchase or dispensing of a prescription drug. Retroactive coverage is not provided. The Province does not reimburse for most out of Province claims.	from out-of-province and out-of-country are permitted but coverage is restricted to comparable benefits on the *Alberta Health and Wellness Drug Benefit List.*	the central computer where it is checked against stored data to determine whether it can be approved for payment. The prescription claim is adjudicated and cost information is then transmitted back to the pharmacy, detailing the consumer share and Drug Plan share. Beneficiaries can submit claims if they have had to pay out of pocket for a various reasons (system down, EDS coverage not in place at time of dispensing, etc). Beneficiaries are eligible for the same drug benefits out–of-province as in Saskatchewan, according to Saskatchewan prices and an individual's coverage level. Original receipts for prescriptions purchased in another province or territory can be submitted to the Drug Plan.	the central computer where it is checked against stored data to determine whether the prescription can be approved for payment. The prescription information is then transmitted back to the pharmacy, detailing the customers cost share and the drug plan cost share. The cost of a specified drug when purchased in a province or territory of Canada other than Manitoba, the cost incurred to a maximum amount that is considered reasonable by the minister. The original receipts for prescriptions purchased in another province or territory can be submitted to the Drug Plan for reimbursement.	written by a physician licensed in Ontario and the recipient is an eligible Ontario resident. If a patient meets all the above criteria and pays cash at the pharmacy, they may submit receipt for reimbursement to the Ontario Drug Program.

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Miscellaneous	**Prescription Quantities** • PharmaCare limits coverage of all prescription drugs to a maximum 30-day supply (for short term medications and first-time prescriptions for maintenance drugs) or a 100-day supply (for repeat prescriptions of maintenance drugs) • Pharmacists are responsible for determining whether a prescription is a first fill (and subject to the maximum 30-day supply) or a refill (and eligible, in most cases, for 100-day supply) Exemptions to the 30-day supply limit are available for: • Plan B patients • Consumers in rural or remote areas • Prescriptions under the Trial Prescription Program (where a 14 day trial has been dispensed)	**Prescription Quantities** • No limitation on the quantities of drugs that may be prescribed • In most cases, Alberta Health and Wellness will not pay benefits for more than a 100-day supply of a drug at one time	**Prescription Quantities** The Drug Plan places no limitation on the quantities of drugs that may be prescribed. Prescribers shall exercise their professional judgment in determining the course and duration of treatment for their patients. However, in most cases, the Drug Plan will not pay benefits or credit deductibles for more than a 3-month supply of a drug at one time. The pharmacist may charge one dispensing fee for each prescription for most drugs listed in the Formulary. If a prescription is for a duration of one month or more, the pharmacist is entitled to charge a dispensing fee for each 34 day supply, however the contract the Drug Plan has with pharmacies does not prohibit the pharmacist from dispensing more than a 34 day supply for one fee. The contract also contains a list of Two-Month and	**Prescription Quantities** In any 90-day period, no benefit is payable for more than the following number of days' supply (Number of days' supply of a specified drug is equal to the quantity of the specified drug dispensed divided by the person's daily dosage requirements for that drug) of a specified drug: • 100; and • up to an additional 100, if – the prior approval of the minister has been obtained, and – the person will be outside of Canada for more than 90 consecutive days.	**Prescription Quantities** • The normal quantity dispensed shall be the entire quantity of the drug prescribed. The maximum quantity that may be charged under the ODB program must not exceed that required for a 100-day course of treatment • Beginning November 14, 2002, the 30-Day Prescription Program was implemented by ODB. All new prescriptions for ODB recipients are subjected to a 30-day maximum prescription limit if they have not been taken in the preceding 12 months. If the newly prescribed drug helps a patient after the initial 30-day supply and the patient is not having any problems with it, the remainder of the prescription can be dispensed up to the maximum

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
			100-day supply drugs. Prescribing and dispensing should be in these quantities once the medical therapy of a patient is in the maintenance stage, unless there are unusual circumstances that require these quantities not be dispensed.		100-day supply. Some recipients are exempt from this program (i.e. travel out-of-province for extended periods, samples from physician, insulin prescriptions). • For recipients covered under the Ontario Works Act, the maximum quantity of medication claimed under the ODB program must not exceed that required for a 35-day course of treatment
Sources	Validated by British Columbia PharmaCare July 2006	Validated by Alberta Health and Wellness December 2005	Validated by Saskatchewan Health Drug and Extended Benefits Branch December 2005	Validated by Manitoba Health August 2006	Validated by Ontario Drug Benefit Program January 2006

Policy related Information (N.B., N.S., P.E.I., N.L., Y.T., FNIHB)

Policy Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Prescription Cost Components	AAC (Actual Acquisition Cost) or MAP (Maximum Allowable Price) + Dispensing Fee	Maximum Allowable Cost (MAC) + Professional Fees; For drugs that are not assigned a MAC, the drug cost billed to the Pharmacare Programs shall be AAC, with no mark-up, plus the applicable professional fee. In the case of injectable products and ostomy supplies, a mark-up is allowed in addition to the AAC and professional fee.	Maximum Allowable Cost (MAC) plus professional fee. Where no MAC exists the cost is based upon the manufacturer's net catalogue price & professional fee for manufacturer's defined as direct. If the manufacturer is not defined as direct the cost is the manufacturer's net catalogue price plus a mark-up to a maximum of 13% plus the professional fee.	List Price + Allowable mark-up (see below) + Professional Fees	AAC + mark-up + Professional Fee	Drug Benefit List Price + Professional Fee + Mark-up (if applicable)

<table>
<tr><th>Policy Related Information</th><th>N.B.</th><th>N.S.</th><th>P.E.I.</th><th>N.L.</th><th>Y.T.</th><th>FNIHB</th></tr>
<tr>
<td>Professional Fees</td>
<td>
<table>
<tr><th>Ingredient Cost/ Prescription ($)</th><th>Dispensing Fee ($)</th><th>Dispensing Fee ($) for Compounds</th></tr>
<tr><td>0.00—99.99</td><td>8.40</td><td>12.60</td></tr>
<tr><td>100—199.99</td><td>10.90</td><td>16.35</td></tr>
<tr><td>200—499.99</td><td>16.00</td><td>17.00</td></tr>
<tr><td>500—999.99</td><td>21.00</td><td>21.00</td></tr>
<tr><td>1000—1999.99</td><td>61.00</td><td>61.00</td></tr>
<tr><td>2000—2999.99</td><td>81.00</td><td>81.00</td></tr>
<tr><td>3000—3999.99</td><td>101.00</td><td>101.00</td></tr>
<tr><td>4000—4999.99</td><td>121.00</td><td>121.00</td></tr>
<tr><td>5000—5999.99</td><td>141.00</td><td>141.00</td></tr>
<tr><td>Greater than or equal to 6,000</td><td>161.00</td><td>161.00</td></tr>
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</td>
<td>For prescriptions with a drug ingredient cost of up to $145, the maximum fee is $10.42;

For prescriptions with a drug ingredient cost of more than $145, the maximum fee is $15.64.</td>
<td>• Financial Assistance—$7.50
• Diabetes—$7.50
• STD programs—$7.50
• Quit Smoking—$7.50
• There is no maximum fee on all the other programs</td>
<td>• E—$6.50 + 10% mark-up on cost where cost exceeds $30
• N—None (See Co-pay section above)</td>
<td>$8.75</td>
<td>Pharmacists can charge dispensing fees. They are negotiated between NIHB and pharmacists' associations in a number of provinces/territories and will differ in each jurisdiction.</td>
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<tr>
<td>Mark-up</td>
<td>None</td>
<td>10% for injectable products and ostomy supplies only.</td>
<td>See Prescription Cost Components and Ingredient Pricing Policy</td>
<td>See professional fees above for plan E for mark-up allowance, it is really a component of the professional fee. The Wholesaler MU is dealt with under pricing policy section.</td>
<td>• Pharmacies are allowed a 30% mark-up
• In addition, if AAC includes a wholesale up charge, this can be included up to a maximum of 14%</td>
<td>Mark-ups, if applicable, are negotiated as part of the pharmacy agreements between NIHB and the pharmacists' associations in the different jurisdictions. If a mark-up exists, it will be submitted by the pharmacy in a separate field in the electronic claim document. The mark-ups are not built into the price file.</td>
</tr>
<tr>
<td>Ingredient Pricing Policy</td>
<td>The NB Prescription Drug Program MAP list establishes the maximum amount payable to pharmacies</td>
<td>Actual Acquisition Cost (AAC) means the net cost to the provider after deducting all</td>
<td>PEI Drug Programs creates a Maximum Allowable Cost (MAC) list which is published &</td>
<td>(a) List price for companies designated direct distributors;</td>
<td>• Yukon Drug Programs Formulary benefits will be based on the</td>
<td>NIHB pays the amount identified on the price file that is created and maintained on</td>
</tr>
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Policy Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
	for interchangeable and certain single source drugs.	rebates, allowances, free products, etc. No mark-up or buying profit is to be included in the calculation of AAC. The net cost to the provider is defined as the drug ingredient (or supply) costs based on date of purchase and inventory flow, even though the current prices available may be lower or higher when the product is dispensed. Incentives for prompt payment (payment within 15 days up to a maximum of 2%) will not be included in the calculation AAC is subject to the following conditions: • The provider shall make every effort to purchase each drug product	distributed to Pharmacies twice yearly. For products with a MAC, the ingredient cost is based on the manufacturer's net catalogue price of the lowest product within an interchangeable category plus a mark-up to a maximum of 5%. Where no MAC exists and the manufacturer is defined as being direct, the cost is based upon the manufacturer's net catalogue price. If there is no MAC & the manufacturer is not defined as direct, the cost is based upon the manufacturer's net catalogue price plus a mark-up to a maximum of 13,5 %.	(b) List price + set % mark-up for companies designated indirect distributors but who have provided a guaranteed maximum wholesale up charge (c) List price + 15% for all other indirect companies. (d) For generically interchangeable products the defined cost is published.	lowest priced interchangeable brand available **as negotiated with the Pharmacy Society of Yukon**. Prices listed in Formulary are based on McKesson wholesale prices.	NIHB's behalf by the claims processor—First Canadian Health Management Corporation Inc. (FCH). The principles guiding the price file are the following: • If an item is listed on both a provincial formulary and the NIHB benefits list (DBL), NIHB pays the same • If an item is unique to NIHB, the Program will pay according to the price list of a national wholesaler. Exceptions exist in Atlantic Canada and Quebec

Policy Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
		from the supplier providing the lowest AAC; and • The provider shall make every effort to purchase the drug most reasonably purchased to obtain the lowest AAC • The Department reserves the right to reduce the ingredient cost of claims if the average cost for any drug exceeds provincial weighted average cost				
Coordination of benefits (Public/ Private)	N/A	See **Eligibility—Beneficiary Group** above for co-ordination of benefits	N/A	• **N**—When beneficiaries are eligible for both plans they can bill NLPDP for what is not paid by their private insurance	• For all Yukon government plans: Residents must access private insurance plans first	When beneficiary is covered by another private health care plan, claims must be submitted to them first.

Policy Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Coordination of benefits (Intra-jurisdictionally)	N/A	See **Eligibility—Beneficiary Group** above for co-ordination of benefits	N/A	• **E**—Beneficiaries can not access this plan if the are eligible for a federal plan, or if they do, the Plan E card would be limited to only cover the %/$ not covered by the Federal Plan • **N**—Other Federal public plans are to be used before this plan	• Residents must access all other drug insurance plans first • Coordination between Yukon government plans: Children who are eligible for Chronic Disease program will use that plan before Children's Drug and Optical plan	When beneficiary is covered by another public health care plan, claims must be submitted to them first.
Restricted Benefit Process	Written requests for individuals who are Program beneficiaries must be sent to the New Brunswick Prescription Drug Special Authorization (SA) Unit SA Part A: Requests for drugs not having defined criteria are reviewed on a case-by-case basis. SA Part B: Requests for drugs listed in the appendix are reviewed individually according to defined criteria.	To request coverage, the physician should mail or fax a completed Standard Request Form or letter to the Pharmacare office. Physicians may also contact the Pharmacare office and speak directly to a pharmacist consultant to request coverage. Every effort is made to process requests within 7 days. A letter notifies	• Prescribers may apply for EDS coverage by mailing or faxing a completed Exceptional Drug Request • Allow two to four weeks for the processing of Exceptional Drug Requests • A letter will be sent notifying the patient, prescriber, and the pharmacy authorized to provide the	A special authorization request form has been prepared at the request of pharmacists and physicians, which may be used to facilitate the approval process. While staff of the Division try to accommodate verbal requests where possible, requests are assessed in the order received (fax, mail or verbal) and must be subject to	Application Process • Yukon physicians only may apply for Exception Drug Status. • Applications must be submitted in writing • Criteria for Exception drugs: Refer to "Exception Drug Status Table" Initial 30 DAY Approval • When an Exception drug	There are four types of limited use benefits: • Limited use benefits, which do not require prior approval. • Limited use benefits, which require prior approval (using the "Limited Use Drugs Request Form"). • Benefits with an exception status, which require prior approval (using the "Benefit

Policy Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
		clients if the request is approved. Clients may bring this letter to the pharmacy to verify that coverage has been approved or the pharmacist may simply bill the claim on-line for immediate response for a limited list of products. The physician is notified if coverage is authorized, if the request is refused because the criteria for coverage are not met, or if more information is required.	requested medication, if coverage has been approved • If the request is denied, letters are sent to the patient and prescriber notifying them of the reason for the denial. Payment of the medication is the responsibility of the patient in these cases • If the request is approved, patients may be reimbursed for one fill of the prescription received during the assessment period, after all of the requested information has been received	a review of the patient's medication claims summary. The use of the form, while not mandatory, is encouraged to expedite the approval process.	is prescribed the pharmacist may request a 30-day approval. The pharmacist must phone the respective drug program advising that the patient is active the Exception drug will be covered for 30 days providing the drug is listed in the Formulary. If the drug requires a "specialist recommendation" according the products criteria, the 30-day coverage will not be granted unless the specialist information is provided	Exception Questionnaire") • Benefits, which have a quantity and frequency limit Upon receipt of a prescription for a Limited Use Drug or a non-listed drug, the pharmacist must initiate the prior approval process by calling the Health Canada NIHB Drug Exception Centre. A benefit analyst will request prescriber and client information. An electronically generated Exception or Limited Use Drugs Request Form will be immediately faxed, if possible, to the prescribing physician. The physician will complete and return the form using the toll-free fax number

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						indicated on the Form. The Drug Exception Centre will review the information and the pharmacist will be notified of the decision by fax. If approved, the provider should retain this faxed confirmation for billing purposes.
Reimbursement Policy	If a beneficiary pays out of pocket, he/she may submit the claim for coverage if it is a benefit product and was purchased at a pharmacy within New Brunswick.	• **D**—If beneficiary paid cash at the pharmacy they have up to 90 days to send receipts to Pharmacare for reimbursement. In province claims only • S—If beneficiary paid cash at the pharmacy they have up to 90 days to send receipts to Pharmacare for reimbursement. In province claims only, Seniors only	If a beneficiary has paid cash at a pharmacy they have 90 days to submit their receipts for reimbursement.	• **E**—Can only submit under exceptional circumstances. Out of province bills are only considered if the patient is referred out of province for medical reasons and approval must be obtained prior to leaving the province • **N**—For meds purchased in province only	• When beneficiaries pay out of pocket, receipts may be submitted for reimbursement if eligible under program. Receipts will be assessed using Formulary listed prices. Exception drugs will require approval and these may be backdated • Payment will not be made for any drug or supply receipt that is mailed from an address outside of the Yukon	Submissions for retroactive coverage must be received by FNIHB on an NIHB Client Reimbursement Request Form, within one year from the date of service or date of purchase. The regional office assesses appropriateness of claim and acts accordingly. The vast majority of the claims are paid directly on line to the pharmacist via electronic transactions.

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Miscellaneous	Quantitative limits have been established for a number of products listed as benefits of the NBPDP.	**Prescription Quantities** 100 days supply maximum, if prescribed.	**Program Maximum Allowable Days Supply** • Nursing Home Program: 35 days • Institutional Pharmacy Program: 35 days • AIDS/HIV Program: 60 days • Children-In-Care Program: 30 days—regular drugs, 60 days—maintenance drugs. Note: Prescriptions introducing a medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills • Cystic Fibrosis Program: 60 days		**Prescription Quantities** • The respective drug programs will not pay for more than a three-month supply of benefits at one time. There must be an interval of 75 days between dispensing 3-month supplies • Physicians shall exercise their professional judgment in determining the course and duration of treatment for their patients	**Prescription Quantities** The normal quantity dispensed shall be the entire quantity of the drug prescribed. A maximum 100- day supply should be considered for those circumstances where the patient has been stabilized on a medication and the prescriber feels that further adjustment during the prescribed period is unlikely. The physician may continue to prescribe a smaller quantity with repeats at certain intervals when it is in the patient's best interest

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			• Diabetes Control Program: 30 days—insulin, 90 days—oral medications and test strips. Note: Prescriptions introducing a medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills • Family Health Benefit Program: 30 days—regular drugs, 60 days—maintenance drugs, 30 days—drugs under EDS coverage. Note: Prescriptions introducing a medication, strength, dosage, or dosage form			

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			shall be filled for a maximum 30 days for the first two prescriptions or refills • Financial Assistance Program: 30 days—regular drugs, 60 days—maintenance drugs, 30 days—drugs under EDS coverage. Note: Prescriptions introducing a medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills • Growth Hormone Program: 30 days • Hepatitis Program: 30 days			

Policy Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
			• Intron A Program: 30 days • Multiple Sclerosis Drug Program: 30 days • Phenylkentonuria Program: 60 days • Rheumatic Fever Program: 60 days • Seniors Drug Cost Assistance Plan: 30 days—regular drugs, 90 days—maintenance drugs, 30 days—drugs under EDS coverage. Note: Prescriptions introducing a medication, strength, dosage, or dosage form shall be filled for a maximum 30 days for the first two prescriptions or refills • Transplant Drugs Program: 60 days			

Policy Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
			• Tuberculosis Drug Program: 60 days			
Sources	Validated by New Brunswick Prescription Drug Program August 2006	Validated by Nova Scotia Programs and Funding—Pharmacare September 2006	Validated by Prince Edward Island Drug Program August 2006	Validated by Newfoundland and Labrador Prescription Drug Program January 2006	Validated by Yukon Health Services July 2006	Validated by Non-Insured Health Benefits July 2006

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