National Prescription Drug Utilization Information System (NPDUIS)

Plan Information Document

July 1, 2008

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Introduction

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- **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
Manitoba	Ontario	New Brunswick
Nova Scotia	Prince Edward Island	Newfoundland and Labrador
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Summary of Major Changes

Saskatchewan
As of July 1, 2008, the Seniors' Drug Plan will require an application, and eligibility will be based on an individual net income less than $64,044 (Line 236) from the annual income tax. Under the Seniors' Drug Plan, eligible seniors 65 years and older will pay a maximum of $15 per prescription for drugs listed on the Saskatchewan Formulary and those approved under Exception Drug Status (MAC and LCA policies apply).

Effective July 1, 2008: The Children's Drug Plan is available to all Saskatchewan children 14 and under. The Children's Drug Plan will ensure families will pay a maximum of $15 for drugs listed on the Saskatchewan Formulary and those approved under Exception Drug Status (MAC and LCA policies apply).

As of March 19, 2008, the Saskatchewan Workers' Health Benefits program was discontinued. Working adults without children who are currently enrolled and receiving benefits will maintain coverage until June 2010, if they continue to meet the original criteria.

Nova Scotia
Effective April 1, 2008: Under the Seniors' Pharmacare program, the $30 per prescription copayment maximum has been eliminated.

Prince Edward Island
Effective November 1st, 2007: The income range to qualify for the Family Health Benefit Program is as follows:
For families with one child under 18 years of age or under 25 years of age and in full-time attendance at a post-secondary educational institution (e.g. university or community college), the net annual family income must be less than $24,800. Add $3,000 for each additional child

Manitoba
In 2006, Manitoba introduced The Deductible Installment Payment Program for Pharmacare (DIPPP). The DIPPP program is a financing program which provides Pharmacare participants with high prescription drug costs (relative to average monthly income) the opportunity to pay the annual deductible in monthly instalments.

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 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 and eligible dependants	• 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 Social Services. • Guaranteed Income Supplement recipients; – Government of Canada program for low-income seniors. • Saskatchewan Income Plan recipients; – Provincial program to provide a monthly supplement to low-income seniors. • Seniors' Drug Plan (income tested); – All residents 65 years of age and older not already covered by another plan. • Families/Individuals approved for Family Health Benefits (eligibility is established	• **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 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:	• **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; – People receiving social assistance under the Ontario Works and Ontario Disability Support programs

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
			by Saskatchewan Social Services, 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); • 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) • **Workers' Health Benefits Program (Note:** As of March 19, 2008, the Saskatchewan Workers' Health Benefits program was discontinued. Working adults without children who are currently enrolled and receiving benefits will maintain coverage until June 2010, if they continue to meet the original criteria.) – Single: income less than $21,000 or Married or common law: income less than $26,000 – In addition applicant must be: o A Saskatchewan resident with a valid Saskatchewan Health card o Single or a couple, without dependent children	• 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 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.
			○ Under 65 years of age ○ Employed or self-employed. and not be; ○ Receiving benefits under a private or employer sponsored health plan, or the federal government's Non-Insured Health Benefits program ○ Not be attending a post-secondary education institution on a full-time basis (university or technical school) • **Children's Insulin Pump Program:** – Applicants must be 17 years of age or less – Applicants must have Type 1 diabetes, and require a pump to adequately stabilize blood sugar levels. • **Children's Drug Program:** – Children 14 years of age or less • 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		
Income Range	• **Plan C** B.C. residents in receipt of Income assistance through the Ministry of Employment and Income Assistance. • **Plan G** Low-income residents.	• **Widows** Recipients of the Alberta Widows' Pension • **Non-Group** Subsidized premiums available for low-income	• **Seniors' Program** Individual annual net income reported in 2006 must be less than $64,044	N/A	N/A

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
	An Application for Psychiatric Medication Coverage to a mental health service centre is required for approval	Albertans (singles less than $17,450, family with no children less than $26,200, family with children less than $32,210)			
Age Range	• **Fair Pharmacare** Fair PharmaCare – Residents born 1940 or later • Fair PharmaCare Enhanced Assistance – Residents born 1939 or earlier • **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	• **Children's Drug Program:** Children 14 years of age or less • **Seniors' Program :** 65 or older	N/A	N/A
Disease-Specific	• Individuals with Cystic Fibrosis (Plan D) • Severely handicapped children—At-home program (Plan F) • Clients of Mental Health Service Centre (Plan G) (meeting low income criterion)	• Alberta has special drug programs for cancer drugs, select high cost drugs funded through Province Wide Services, and public health drugs such as vaccines, TB and STDs. Drug use data for these special drug programs are not included in NPDUIS	N/A	N/A	N/A
Other eligibility criteria	• Fair PharmaCare: an individual must: – Have effective British Columbia Medical Services Plan (MSP) coverage; – 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	N/A	N/A	N/A

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
	• 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 • Plan B recipients are enrolled in and receive coverage under through the care facility • Plan C recipients 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 recipients must be: – Age 17 or younger – A resident of B.C. – Living at home with a parent or guardian – Assessed as dependent in at least three of four areas of daily living • Plan G – The patient's physician or psychiatrist must submit	• **Palliative** Be registered with the AHCIP and have not opted out of the plan. Diagnosed by a physician as being palliative and receiving treatments at home • **Non-Group** Be registered with AHCIP and have not opted out of the plan or in arrears for the plan.			

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
	an Application for Psychiatric Medication Coverage to a mental health service centre for approval, and – Patient must qualify for premium assistance under the Medical Services Plan. • Plan P recipients must be: – 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	For more information: British Columbia PharmaCare	For more information: Alberta Health and Wellness	For more information: Saskatchewan Health Drug and Extended Benefits Branch	For more information: Manitoba Health	For more information: Ontario Drug Benefit Program

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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**—Department of Social Development • **G**—Children in the Care of the Minister of Social Development • **H**—Multiple Sclerosis • **R**—Organ Transplant • **T**—Human Growth Hormone • **U**—HIV • **V**—Nursing Home	• **A**—Family Pharmacare Program • **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 • **R**—Rabies Program • **S**—Seniors Drug Cost Assistance Plan • **T**—Transplant Program • **U**—Rheumatic Fever Program • **V**—Sexually Transmitted Diseases (STD) Program	• **The Foundation Plan** (previously Income Support Drug Program or plan E) • **The Access Plan** (previously Low Income Drug Program or plan L) • **The 65Plus Plan** (previously Senior Citizen's Drug Subsidy Plan or plan N) • **The Assurance Plan** (new plan)	• 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
			• **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 $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	• **A**—Families, including families of one, who apply for the program. Any Nova Scotian with a valid Health Card is eligible to enrol. • **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 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	• **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 in the community • **C**—Persons eligible for P.E.I. Medicare, diagnosed with cystic fibrosis and who are registered with the program • **D**—Persons with diabetes eligible for P.E.I. Medicare and whom their Physician registers in the program • **E**—Persons eligible for P.E.I. Medicare who have been diagnosed with chronic renal failure or are receiving kidney dialysis & who do not have any other drug insurance	• **The Foundation Plan** provides 100 per cent coverage of eligible prescription drugs for those who need the greatest support. This includes persons and families in receipt of income support benefits through the Department of Human Resources, Labour and Employment, and certain individuals receiving services through the Regional Health Authorities, including children in the care of Child, Youth and Family Services, and individuals in supervised care. • **The Access Plan** offers individuals and families with low incomes access to eligible prescription medications. The amount of coverage is determined by net income level and family status. (see Income Range section)	• **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 • **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	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
	issued by the Department of Social Development • **F**—Individuals holding a valid health card for prescription drugs issued by the Department of Social Development • **G**—Special needs children and children under the care of the Minister of Social Development • **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 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	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 Health, or a private drug plan	• **F**—Only parents/ guardians and children under 18 years of age or under 25 years of age and in full-time attendance at a post-secondary educational institution (e.g. university or community college) who are eligible for P.E.I. Medicare, based on net annual family income (see Income Range section below) • **G**—Children eligible for P.E.I. 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 occu-pational risk of infection • **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	• **The 65Plus Plan** provides coverage for eligible prescription drugs to residents 65 years of age and older who receive Old Age Security benefits and the Guaranteed Income Supplement (GIS). • **The Assurance Plan** offers protection for individuals and families against the financial burden of eligible high drug costs, whether it be from the cost of one extremely high cost drug or the combined cost of different drugs.	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
	• **V**—Individuals who reside in a registered nursing home		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 P.E.I. Medicare, and approved for coverage of one or more of the 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 Social 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			

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
			• **S**—Persons eligible for P.E.I. Medicare and 65 years of age or more • **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 P.E.I. 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 Social Assistance Act 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			

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
			• **Z**—Persons eligible for P.E.I. 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	• **A**—No income based criteria for eligibility however, family deductible is based on income. See section on deductible. • **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 • **S**—No income based criteria for eligibility however, premium is based on income—See section on premium	• **F**—Family Health Benefit Program: **# of Children** / **Net Annual Family Income** 1 < $24,800 2 < $27,800 3 < $30,800 4 < $33,800 More than 4: Add $3000 per additional child • **M**—Prescription copay is based upon total net family income.	• The Access Plan: – Families with children, including single parents: net annual incomes of $30,000 or less; – Couples without children with net annual incomes of $21,000 or less; – Single individuals with net annual incomes of $19,000 or less. • The Assurance Plan maximum out of pocket is based on the following net income ranges: – Up to $39,999 – $40,000 to $74,999 – $75,000 to $149,999	• 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
Age Range	• **A**—65 and older	• **A**—No age range criteria for eligibility. All adults (18 years of age or older) must register as their own family. • **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	• **The 65Plus Plan** for those **6**5 years of age and 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

Eligibility	N.B.	N.S.	P.E.I	N.L.	Y.T.	FNIHB
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 • **P**—Phenylketonuria (PKU) • **R**—Rabies • **T**—Transplant • **U**—Rheumatic • **V**—Sexually Transmitted Diseases (STD) • **X**—Tuberculosis (TB)	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
Other eligibility criteria	N/A	• **A**—Do not have coverage through Department of Community Services Programs, Seniors' Pharmacare or Diabetes Assistance Program. • **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	N/A	• **The Access Plan**—Individual not eligible for coverage under another drug plan	• 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,	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
		• **S**—Do not have coverage through Veterans Affairs Canada, First Nations and Inuit Health, or a private drug plan			the resident may re-apply for coverage under the respective program	
Sources	For more information: New Brunswick Prescription Drug Program	For more information: Nova Scotia Pharmacare Drug Programs and Funding	For more information: Prince Edward Island Drug Programs	For more information: Newfoundland and Labrador Prescription Drug Program	For more information: Yukon Health & Social Services	For more information: Non-Insured Health Benefits

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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** – After meeting their annual deductible, families pay 30% of the eligible prescription drug costs for the remainder of the calendar year (or until reaching their annual maximum—whichever comes first) • 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)	• **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; no charge for benefit prescriptions for FHB children under 18 • 35% for Workers' Health Benefits • Up to $2.00 per prescription for Supplementary Health (Persons nominated by Saskatchewan Social Services for special coverage, including persons on Social Assistance,	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 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

Cost-sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
			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		• 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 Co-payment of $2.83 for prescriptions dispensed in out-patient hospital pharmacies
Deductible	• 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	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	• 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.	• $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.
	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 percentages provided. **No deductible is applied to the remaining Plans/Programs.**		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 • $100.00 semi-annual deductible for Workers' Health Benefits • No deductible for people covered under the Palliative Care Drug Program	In fiscal year 2008/2009 the deductible rates for adjusted family incomes: <= $15,000 then 2.69%; > $15,000 & <= $40,000 then 4.02%; > $40,000 & <= $75,000 then 4.63%; > $75,000 then 5.79% No deductible for people covered under the Palliative Care Program.	
Maximum Beneficiary Contribution	• 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	• Palliative $1,000	• Seniors pay no more than $15 per prescription for drugs listed under the Saskatchewan Formulary and those approved under Exception Drug Status (MAC and LCA policies apply) • Children up to age 14 will pay no more than $15 per prescription for drugs listed under the Saskatchewan Formulary and those approved under Exception Drug Status (MAC and LCA policies apply)	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.
	• 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 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	For more information: British Columbia PharmaCare	For more information: Alberta Health and Wellness	For more information: Saskatchewan Health Drug and Extended Benefits Branch	For more information: Manitoba Health	For more information: Ontario Drug Benefit Program

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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	• **A**—No premium • **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 $424 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 • **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	• **A**—20% co-payment with annual co-payment maximum. Annual family co-payment maximum based on adjusted family income. • **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 (minimum of $3 per prescription). Maximum annual co-payment of $382.00	• **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: – $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.	• **The 65Plus Plan**—Mark-up and Professional Fee • **The Access Plan**—co-payments are based on income as follows: **Families (with children)**: Income / Copay < $21,000 — 20.0% $22,000 — 25.6% $23,000 — 31.1% $24,000 — 36.7% $25,000 — 42.2% $26,000 — 47.8% $27,000 — 53.3% $28,000 — 58.9% $29,000 — 64.4% $30,000 — 70.0%	None	None

Cost-Sharing Mechanism	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
	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		• **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	**Couples (with no children)**: Income — Copay <$15,000 — 20.0% $16,000 — 28.3% $17,000 — 36.7% $18,000 — 45.0% $19,000 — 53.3% $20,000 — 61.7% $21,000 — 70.0% **Single individuals**: Income — Copay <$13,000 — 20.0% $14,000 — 28.3% $15,000 — 36.7% $16,000 — 45.0% $17,000 — 53.3% $18,000 — 61.7% $19,000 — 70.0%		
Deductible	None	• **A**—Annual family deductible is a sliding scale percentage based on adjusted family income. • **C**—No deductible • **D**— Annual deductible is a sliding scale percentage based on adjusted family income. • **F**—No deductible	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	None

Cost-Sharing Mechanism	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
		• **S**—No deductible			and $500 per family, waived for Palliative Care recipients. Deductible may be waived or reduced depending on income.	
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 + premium (see above)	• **A**—annual family co-payment plus annual family deductible. • **S**—Annual maximum co-payment of $382 + premium (see above)	N/A	**The Assurance Plan** maximums are based on net income as follows: **Net Income** — **Max** up to $39,000 — 5% $40,000 to $74,999 — 7.50% $75,000 to $149,999 — 10%	N/A	N/A
Sources	For more information: New Brunswick Prescription Drug Program	For more information: Nova Scotia Pharmacare Drug Programs and Funding	For more information: Prince Edward Island Drug Programs	For more information: Newfoundland and Labrador Prescription Drug Program	For more information: Yukon Health & Social Services	For more information: Non-Insured Health Benefits

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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 group of drug products. A small 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 lowest LCA or MAC price.	**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 dispensing fee (up to a maximum). Extemporaneous preparations—add a "compounding fee" of $0.50/minute to $30.00 maximum; a $10.00 maximum for methadone.	**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.

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<tr><th>Policy Related Information</th><th>B.C.</th><th>Alta.</th><th>Sask.</th><th>Man.</th><th>Ont.</th></tr>
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<td>Professional Fees</td>
<td>
• 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)
• Emergency Contraceptive honorarium ($15.00)
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• Alberta has two types of professional fees: dispensing fees and Additional Inventory Allowance. The Additional Inventory Allowance pricing component was implemented effective July 1, 2000.
• The fees from April 1, 2008 to March 31, 2009 are:
<table>
<tr><th>Acquisition Cost</th><th>Dispensing Fee</th><th>Additional Inventory Allowance</th></tr>
<tr><td>Up to $74.99</td><td>$10.22</td><td>$0.71</td></tr>
<tr><td>$75 to $149.99</td><td>$15.53</td><td>$2.00</td></tr>
<tr><td>$150 and more</td><td>$20.94</td><td>$5.03</td></tr>
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<td>
• The maximum dispensing fee is $8.63 (effective October 1, 2007).
• Trial Prescriptions—specific list of drugs; trial for 7 or 10 days; follow-up by pharmacist required. The usual and customary professional fee (to a maximum of $8.63) is paid for the trial quantity. If the medication is continued, no fee may be claimed on the “remainder” prescription, but an Alternative Reimbursement fee of $7.50 is paid even if the balance of the prescription is not dispensed. Subsequent refills are subject to usual reimbursement.
• Methadone managed care—pharmacists supply a “daily quantity” of methadone. The “managed care fee” is $3.50 per day ($24.50 per week) and is paid only for “face to face” interactions between the patient and the pharmacist.
• Emergency contraception prescribing—pharmacists who have the required training. May charge a prescribing fee equal to two times the usual “dispensing fee”. This is in addition to
</td>
<td>
• 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.
• Effective April 1, 2008 monthly capitation fee for personal care homes; $36.76 per bed/month for Winnipeg and $37.46 per bed/month for rural areas.
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<td>
• The maximum dispensing fee is $7.00.
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Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
			the usual cost plus fee for the dispensed product. • Refusal to Dispense—specific list of drugs. May charge 1.5 times the pharmacy's usual and customary dispensing fee. • Seamless Care Fee—for services related to medication reconciliation for clients who are transferred from an institution to a community setting. May charge 1.5 times the pharmacy's usual and customary dispensing fee.		
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. In such cases, they are asked to include a distribution allowance of up to 7.5%. This includes both single source and interchangeable products.	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	Maximum 8% where permitted
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 to all pharmaceutical manufacturers whose products are included in the *List* or were under review for possible addition to the *List*	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 wholesale mark-up. Pharmacies are required by contract to submit	• 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. • Or in any other case, the lowest usual price of	• 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 offset by

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
			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.	the specified drug as charged from time to time by wholesalers or manufacturers that supply pharmaceuticals to pharmacists or holders of pharmacy licenses.	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% mark up), payment of the acquisition cost to the pharmacy of the least

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
					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 B.C. 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. • 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.	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.
				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 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	Alberta Health and Wellness does not permit coordination of benefits across its public plans. It is intended that Albertans only be enrolled in one government plan at a time. As such, coordination of benefits is not necessary. Generally, Albertans eligible for coverage under federal plans do not seek coverage under another Alberta government plan.	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.	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.*	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.
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 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	• Special authorization request forms are completed by physicians and reviewed by clinical pharmacists of the program • 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, midwives, 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 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.	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 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.	**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. 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

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
				Part 3—The prescriber must contact Manitoba Health to request eligibility for prescription. Eligibility is from date of approval.	approval notice for the patient to take to their pharmacy.
Reimbursement Policy	Every time an enrolled Fair PharmaCare beneficiary purchases medication at a registered B.C. Pharmacy, a claim is automatically submitted for coverage. Starting January 1, 2008, PharmaCare will no longer reimburse prescription or medical supply costs paid before the date a family registers for Fair PharmaCare. Costs will continue to count towards the Fair PharmaCare deductible and annual family maximum but costs above the deductible that occurred before registration are not reimbursed. 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.	When beneficiaries pay out of pocket, reimbursement claims are permitted. 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.*	An on-line computer network transmits prescription information from the pharmacy to 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.	An on-line computer network transmits prescription information from the pharmacy to 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.	Claims are only reimbursed when dispensed from an Ontario pharmacy, 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) <u>Travel Supply</u> As of May 1, 2008, PharmaCare covers out-of-province travel supplies of medication up to the	**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 • Drugs considered as maintenance or long-term therapy in the following therapeutic classes should be dispensed for 100 days: – anticoagulants – anticonvulsants – digitalis and digitalis glycosides – hypoglycemic agents – thyroid drugs – vitamins – oral contraceptives – antihypertensive agents – conjugated estrogens – anti-arthritics	**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. A 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 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.	**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 100-day supply. Some recipients are exempt from this program

Policy Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	PharmaCare maximum allowable days' supply. Under the new policy, once every 6 months (180 days), a patient can ask for an out-of-province travel supply. Patients are required to sign a PharmaCare Travel Declaration form and the pharmacy is required to retain this form on file for the normal record retention periods specified by the College of Pharmacists of B.C.				(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	For more information: British Columbia PharmaCare	For more information: Alberta Health and Wellness	For more information: Saskatchewan Health Drug and Extended Benefits Branch	For more information: Manitoba Health	For more information: Ontario Drug Benefit Program

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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) or Actual Acquisition Cost (AAC) + 1.0% in 2008 and 2.0% in 2009 mark-up + applicable professional fees. In the case of injectable products and ostomy supplies; AAC + 10% mark-up + applicable 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.	Total Prescription Price = (Defined cost) + (up to the Maximum Professional Fee) + (up to the Maximum Surcharge) **Defined Cost**: Products listed in the NIDPF: Will be the published price Products specified under the Reasonable Based Pricing: Will be the lesser of the Reasonable Based Pricing published price or Manufacturer's List Price (MLP) plus 8.5%. Extemporaneous Preparations: Will be the MLP plus 8.5% for each covered product used in the Extemporaneous Preparation. All other cases (except methadone): Will be MLP plus 8.5% Methadone: When used for the purposes of addiction only, and billed under the specific PIN 967211, shall have a defined cost set at $1.50 per dose for the duration of the agreement (July 10, 2007—March 31, 2011).	AAC + mark-up + Professional Fee	Drug Benefit List Price + Professional Fee + Mark-up (if applicable)

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<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>
</table>
</td>
<td>For prescriptions the maximum fee is $10.42;

For compounded prescriptions (except methadone) the maximum fee is $15.63.</td>
<td>• Financial Assistance—$7.96 prescription drugs, $7.73 OTC drugs, $11.94 extemporaneous preparations
• Diabetes—$7.96 oral medications, $7.73 urine testing strips
• STD programs—$7.96
• Quit Smoking—$7.73
• There is no maximum fee on all the other programs</td>
<td>Professional Fee:
• $7.15 from January 1, 2008 to March 31, 2011

Extemporaneous Preparations Fee:
• $10.73 from January 1, 2008 to March 31, 2011</td>
<td>The professional fee maximum is $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>
</tr>
<tr>
<td>Mark-up</td>
<td>None</td>
<td>10% for injectable products and ostomy supplies and 1.0% in 2008 and 2.0% in 2009 for all other prescriptions.</td>
<td>See Prescription Cost Components and Ingredient Pricing Policy</td>
<td>Maximum Surcharge:
10% of the defined cost (chargeable only when the defined cost exceeds $30.00)</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 for interchangeable and certain single source drugs.</td>
<td>Actual Acquisition Cost (AAC) means the net cost to the provider after deducting all 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</td>
<td>P.E.I. Drug Programs creates a Maximum Allowable Cost (MAC) list which is published & distributed to Pharmacies on a monthly basis. For products with a MAC, the ingredient cost is based on the manufacturer's net</td>
<td>As of July 10, 2007, there are no longer three definitions for manufacturer up-charge: Direct, Wholesale and Tendered Wholesale Price. Reimbursement will be as noted under defined cost.</td>
<td>• Yukon Drug Programs Formulary benefits will be based on the lowest priced interchangeable brand available as negotiated with the Pharmacy</td>
<td>NIHB pays the amount identified on the price file that is created and maintained on NIHB's behalf by the claims processor—First Canadian Health Management Corporation Inc. (FCH).</td>
</tr>
</table>

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		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	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%.	Diabetic supplies and insulin will no longer be reimbursed at a 33 1/3% mark-up. Reimbursement will be as noted under defined cost. Birth Control fee will be reimbursed at the maximum professional fee as noted above, instead of the previous $4.10.	Society of Yukon. Prices listed in Formulary are based on McKesson wholesale prices.	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
Coordination of benefits (Public/ Private)	N/A	**A**—Program is payer of last resort. Any out of pocket costs to client after private plans are used can be applied to family Pharmacare. See **Eligibility—Beneficiary Group** above for co-ordination of benefits	N/A	• **The Access Plan**—Private insurers must be billed first. Government will pay the balance provided it does not exceed the cost Government would have paid if there was no private insurance. • **The 65Plus Plan**—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.

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Coordination of benefits (Intra-jurisdictionally)	N/A	**A**—Program is payer of last resort. Any out of pocket costs to client after private plans are used can be applied to family Pharmacare See **Eligibility—Beneficiary Group** above for co-ordination of benefits	N/A	• **The Foundation Plan** —Beneficiaries can not access this plan if they are eligible for a federal plan, or if they do, the card would be limited to only cover the %/$ not covered by the Federal Plan • **The Access Plan** — Residents who are already covered under the Foundation Plan or the 65Plus Plan are not eligible for coverage under this plan. • **The 65Plus Plan** — 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	Drugs not listed as regular benefits may be eligible for reimbursement under New Brunswick Prescription Drug Program (NBPDP) through special authorization. Drugs eligible for consideration through special authorization: • Drugs listed as special authorization benefits have specific criteria for coverage which must be met in order to be approved. • Under exceptional circumstances, requests for drugs without specific criteria may be reviewed case-by-case and assessed based on the published medical evidence.	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 clients if the request is approved. Clients may bring this letter to the pharmacy to verify that	• 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 and prescriber, if coverage has been approved • If the request is denied, letters are sent to the patient and prescriber	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 a review of the patient's medication claims summary. The use of the form, while not mandatory,	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 is prescribed the	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 Exception Questionnaire")

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	Drugs not eligible for consideration through special authorization: • New drugs not yet reviewed by the expert advisory committee • Drugs excluded as eligible benefits further to the expert advisory committee's review and recommendation • Drugs not licensed or marketed in Canada (e.g. drugs obtained through Health Canada's Special Access Programme) • Products specifically excluded as benefits as identified on the exclusion list (NB PDP Formulary). Special authorization requests must be submitted in writing by a prescriber to the NB Prescription Drug Program Special Authorization Unit.	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.	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	is encouraged to expedite the approval process.	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	• 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 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.

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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.	• If beneficiary paid cash at the pharmacy they have up to 90 days to send receipts to Pharmacare for reimbursement. In province claims only	• If a beneficiary has paid cash at a pharmacy they have 90 days to submit their receipts for reimbursement.	• **The Foundation Plan** Reimbursement can be considered under exceptional circumstances. Out of province claims are only considered if a patient is referred out of province for medical reasons and approval obtained prior to leaving the province • **The Access Plan**— The program only applies to benefits obtained within the province of Newfoundland and Labrador. • **The 65Plus Plan**— For medications 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.
Miscellaneous	Quantitative limits have been established for a number of products listed as benefits of the NBPDP.	**Prescription Quantities** 90 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		**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	**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

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			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 • 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 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		judgment in determining the course and duration of treatment for their patients	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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			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 • 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 • Tuberculosis Drug Program: 60 days			

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Sources	For more information: New Brunswick Prescription Drug Program	For more information: Nova Scotia Pharmacare Drug Programs and Funding	For more information: Prince Edward Island Drug Programs	For more information: Newfoundland and Labrador Prescription Drug Program	For more information: Yukon Health & Social Services	For more information: Non-Insured Health Benefits

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