National Prescription Drug Utilization Information System Database—Plan Information Document, July 1, 2012

Types of Care

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

Our Vision

Better data. Better decisions. Healthier Canadians.

Our Mandate

To lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care.

Our Values

Respect, Integrity, Collaboration, Excellence, Innovation

Introduction

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

Summary of Major Changes

Plan/Program Information by Category and Jurisdiction

- Eligibility

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

Generic Pricing Policy Summary

Glossary of Terms

Summary of Major Changes

British Columbia

Effective September 30, 2011:
Smoking Cessation program implemented to provide coverage for prescription smoking cessation drugs under PharmaCare and eligible nicotine replacement therapy products at no cost.

Effective April 2, 2012:
The maximum allowable list price (MALP) that manufacturers can charge for generic low-cost alternative products is reduced to 35% of the equivalent brand product's list price.

Effective May 31, 2012:
Royal assent of the *Pharmaceutical Services Act*

Alberta

Effective July 1, 2012:
The price for both existing and new generic drugs is reduced to 35% of the brand price.

Saskatchewan

Effective March 21, 2012:
The maximum copay for the Seniors' Drug Plan and the Children's Drug Plan increased from $15 to $20.

Effective April 1, 2012:
Maximum dispensing fee increased to $10.25 from $9.85

Manitoba

Effective April 12, 2012:
The deductible rate increased from between 2.73% and 6.17% for 2011–2012 to between 2.81% and 6.36% for 2012–2013.

Ontario

Effective September 1, 2011:
A smoking cessation program was implemented.

Effective April 1, 2012:
Dispensing fees for non-rural pharmacies increased to $8.40 from $8.20; the range for rural pharmacies will be $9.45 to $12.61.

New Brunswick

Effective January 1, 2012:
The maximum annual co-pay contribution for seniors receiving the Guaranteed Income Supplement (GIS) was increased to $500 from $250.

Effective June 1, 2012:
The dispensing fee for each prescription of an interchangeable drug is $10.40, with a markup of 4% of the drug cost to a maximum of $50.00.

The dispensing fee for non-interchangeable drugs (including compounded methadone oral solution and Metadol™ oral solution) and extemporaneous preparations has been increased. No markup on drug costs will be paid to pharmacies.

The New Brunswick Prescription Drug Program (NBPDP) rural pharmacy incentive pays an additional $2 dispensing fee to qualifying pharmacies for each of the first 10,000 NBPDP prescriptions filled per fiscal year.

Nova Scotia

Effective September 1, 2011:
Three new professional services are now offered through the Pharmacare Programs and the Medication Review service has been renamed; it is now known as the Advanced Medication Review Service.

Effective April 1, 2012:
Dispensing fees have increased to $16.35 from $16.10 for compounded extemporaneous products (except methadone and injectables); for all other prescriptions, dispensing fees have increased to $10.90 from $10.73.

Newfoundland and Labrador

Effective April 1, 2012:
The professional fee for each of the Foundation Plan, Access Plan and Assurance Plan increased to $8.25 from $7.15, retroactive to April 1, 2011.

Effective April 16, 2012:

The professional fee for each of the Foundation Plan, Access Plan and Assurance Plan changed as follows:

- $10.90—for drug costs between $0 and $49.99
- $21.95—for drug costs between $50.00 and $249.99
- $49.85—for drug costs $250.00+

These fees will remain in effect until March 31, 2013.

The professional fee for the 65Plus Plan changed to:

- $10.90—for drug costs between $0 and $249.99
- $39.59—for drug costs $250.00+

No surcharge can be applied to the prescription cost under any NLPDP Plan (that is, neither NLPDP nor the client can be billed or charged a surcharge).

Seniors will pay a copay not to exceed $6 per prescription. Pharmacies with fees of less than $6 per prescription can charge seniors the full amount of their fee.

Cognitive Services:

- Refusal to fill
  - Pharmacies may bill up to the maximum dispensing fee of $21.80 (double the base dispensing fee of $10.90).
- Medication management
  - Pharmacies may bill up to the maximum dispensing fee of $10.90 (the base dispensing fee).
- Medication review
  - The new agreement allows for payment for medication review as a cognitive service.
  - Pharmacies may bill $52.50 (48 times per year).

Eligibility (British Columbia, Alberta, Saskatchewan, Manitoba and Ontario)

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
Plan/Program	• Fair PharmaCare (Plan I) • Permanent Residents of Licensed Residential Care Facilities (Plan B) • Recipients of Income Assistance (Plan C) • Cystic Fibrosis (Plan D) • Children in the At Home Program (Plan F) • No-Charge Psychiatric Medication Plan (Plan G) • Medication Management (Plan M) • Palliative Care (Plan P) • British Columbia Centre for Excellence in HIV/AIDS (Plan X) • Smoking Cessation Program (Plan S) • HPV Vaccine One-Time Program	• Seniors • Widows • Palliative • Non-Group • Rare Diseases Drug Program • Alberta Human Services Drug Benefit Supplement	• Family Health Benefits • Income Supplement • Seniors Drug Plan • Special Support Program • Palliative Care Program • Emergency Assistance • Saskatchewan Aids to Independent Living (SAIL) • Supplementary Health Coverage • Children's Drug Program • Saskatchewan Insulin Pump Program	• Pharmacare (PC01) • Employment and Income Assistance Program (FS03) • Personal Care Home/Nursing Homes (NH02) • Palliative Care Drug Access Program (PA04)	• Ontario Drug Benefit Program (ODB) • Trillium Drug Program • Special Drugs Program (SDP) • New Drug Funding Program for Cancer Care (NDFP) • Inherited Metabolic Diseases Program (IMD) • Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program (RSV) • Pharmacy Smoking Cessation Program

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
General Beneficiary Information	For any plan, beneficiaries must be permanent residents of British Columbia for at least three months • **Fair PharmaCare:** – Regular Assistance: Residents born in 1940 or later – Enhanced Assistance: Residents born in 1939 or earlier • **Permanent Residents of Licensed Residential Care Facilities:** Permanent Resident of a licensed residential care facility • **Recipients of Income Assistance:** Recipients of B.C. income assistance • **Cystic Fibrosis:** Individuals with cystic fibrosis and registered with a provincial cystic fibrosis clinic • **Children in the At Home Program:** Non-institutionalized severely handicapped children, age 18 years and under, receiving full benefits or medical benefits through the "At Home" program of the Ministry of Children and Family Development • **No-Charge Psychiatric Medication Plan:** Individuals of any age who are registered with a mental health services centre, who have demonstrated clinical and financial need	• **Seniors:** Residents age 65 or older and eligible dependents. • **Widows:** Residents age 55 to 64 who qualified for Alberta Widows Pension up until 2004 and eligible dependents. • **Palliative:** Palliative residents treated at home. • **Non-Group:** residents younger than age 65 and eligible dependents. • **Rare Diseases Drug Program:** Residents who have government-sponsored drug coverage, whose physician has applied for coverage; and the individual or family have resided in Alberta for five years or have moved from another province in Canada where they were covered by that province's program for these drugs. • **Specialized High-Cost Drugs Program:** Some high-cost drugs used in relation to solid organ and bone marrow transplant; HIV; cystic fibrosis; human growth hormone; primary pulmonary hypertension; macular degeneration; multiple sclerosis; Gaucher's disease; Fabry disease; Hurler/Hurler–Scheie syndrome; Hunter syndrome; and Pompe disease. • **Alberta Human Services Drug Benefit Supplement:** Alberta Employment and Immigration prescription drugs for the following client groups: – **Income Support**, for Albertans who don't have the resources to meet their basic needs.	• **Family Health Benefits:** Low-income working families or families receiving the Saskatchewan Employment Supplement or the Saskatchewan Rental Housing Supplement with at least one child under the age of 18. • **Income Supplement:** Residents qualifying for the GIS and the Seniors' Income Plan (SIP) in Saskatchewan. • **Seniors Drug Plan:** Income-tested; seniors age 65 or older who have applied and qualified based on income. • **Special Support Program:** Income-tested; designed to help those whose drug costs are high in relation to their income. • **Palliative Care Program:** Persons approved for the drug plan's palliative care coverage (residents who are in the late stages of a terminal illness). • **Emergency Assistance:** Residents who require immediate treatment with covered prescription drugs and are unable to cover their share of the cost may access a one-time Emergency Assistance. The level of assistance provided will be in accordance with the consumer's ability to pay. The resident is then required to submit a completed Special Support Application to the Drug Plan in order to receive future assistance. • **Saskatchewan Aids to Independent Living (SAIL):** beneficiaries (paraplegics, cystic fibrosis and chronic renal disease)	• **Pharmacare:** All residents who are eligible for benefits under *The Prescription Drugs Cost Assistance Act* • **Employment and Income Assistance Program:** Individuals who are receiving drug benefits pursuant to the Employment and Income Assistance Program • **Personal Care Home/Nursing Homes:** Residents of personal care homes • **Palliative Care Drug Access Program:** Residents who are terminally ill and wish to remain at home	• **Ontario Drug Benefit Program:** Residents age 65 or older, residents of long-term care homes and homes for special care, recipients of professional home services and social assistance, and recipients of the Trillium Drug Program. • **Trillium Drug Program:** Residents who have high drug costs in relation to their household income; any resident who does not qualify under any of the other public drug plan or if their private insurance does not cover 100% of the prescription drug costs and they are not eligible for ODB coverage. • **Special Drugs Program:** Residents who require certain expensive outpatient drugs used to treat cystic fibrosis; HIV infection; end-stage renal disease; solid organ or bone marrow transplant; human growth hormone; schizophrenia; Gaucher's disease; and thalassemia. • **Inherited Metabolic Diseases Program:** Benefits for Ontarians with a valid health card for certain outpatient drugs, supplements and specialty foods used in the treatment of specific metabolic disorders. • **Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program:** Funds a drug for Ontario-resident infants who are at high risk for hospitalization and complications from RSV infection.

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
General Beneficiary Information (cont'd)	• **Medication Management:** Covers individuals for eligible medication management services (for example, clinical services, medication review services and publicly funded vaccinations) provided by pharmacies. • **Palliative Care:** Individuals who have reached the end stage of a life-threatening disease or illness who wish to receive palliative care at home. • **British Columbia Centre for Excellence in HIV/AIDS:** HIV-positive individuals enrolled in the centre. • **Smoking Cessation Program:** For prescription smoking cessation drugs for individuals who are registered in one of the following plans: Fair PharmaCare, Plan B, Plan C or Plan G. Nicotine replacement therapies are available to all smokers (and users of other tobacco products) who are B.C. residents with active Medical Services Plan (MSP) coverage. • **HPV Vaccine One-Time Program:** For female residents born in 1991, 1992 and 1993.	– **Alberta Adult Health Benefit**, for Albertans with low income. – **Assured Income for the Severely Handicapped (AISH)**, for adults, under the age of 65 years, who have a permanent disability that severely affects their ability to earn a livelihood. – **Alberta Child Health Benefit**, for children of low-income families.	• **Supplementary Health Coverage:** Eligibility is determined by the Ministry of Social Services. There are four supplementary drug coverage programs: – **All Plans—**Individuals under age 18 will receive benefit prescriptions at no charge. – **Plan One—**Adults pay no more than $2 for each benefit prescription. – **Plan Two—**Plan One adults needing several different drugs on a long-term basis may be eligible for prescriptions at no charge. Physician or pharmacist may request coverage. – **Plan Three—**Benefit prescriptions received at no charge and is designed for people receiving the Seniors' Income Plan and residing in special-care homes. Individuals living in Approved Homes and Group Homes may also be eligible. • **Children's Drug Program:** Children age 14 or younger • **Saskatchewan Insulin Pump Program:** – Applicants must be age 25 or younger. – Applicants must have type 1 diabetes and require a pump to adequately stabilize blood sugar levels.		• **Pharmacy Smoking Cessation Program:** Currently, ODB recipients who smoke may enrol in the program once per year from the date of the patient's first meeting with the pharmacist, at which time the patient and pharmacist agree to work together on a stop smoking strategy. Note: The ODB Program benefit year runs from August 1 to July 31.

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
Other Eligibility Criteria	• **Fair PharmaCare:** An individual must – Have effective British Columbia Medical Services Plan (MSP) coverage; and – Have filed an income tax return for the relevant taxation year • **Permanent Residents of Licensed Residential Care Facilities:** Permanent resident of a licensed residential care facility who are enrolled and receive coverage through the care facility • **Recipients of Income Assistance:** Recipients must be registered in MSP and receiving medical benefits and income assistance through the Ministry of Social Development • **Cystic Fibrosis:** Individuals with cystic fibrosis are registered with a provincial cystic fibrosis clinic • **Children in the At Home Program:** Recipient must be – Younger than 19 years of age (that is, 18 or less); – A resident of B.C.; – Living at home with a parent or guardian; and – Assessed as dependent in at least three of four areas of daily living • **No-Charge Psychiatric Medication** – The patient's physician or psychiatrist must submit an application for psychiatric medication coverage to a mental health service centre for approval	• **Seniors:** In order to be registered, seniors must complete a proof-of-age declaration, which Alberta Health mails to them; registration with the Alberta Health Care Insurance Plan (AHCIP) is required • **Palliative:** A person must be – Registered with the AHCIP; and – Diagnosed by a physician as being palliative and receiving treatments at home • **Non-Group:** A person must be registered with AHCIP and not eligible to receive the Alberta Widows Pension or be in premium arrears for the plan	• Citizens whose health services are covered under First Nations and Inuit Health, Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers' Compensation or federal penitentiaries are not eligible for drug plan benefits under Saskatchewan Health • Residents may qualify and be covered under more than one program at the same time. The better benefit applies at the time a prescription is filled • Foreign skilled workers nominated through the Saskatchewan Immigrant Nominee Program (SINP) whose work permits have expired maintain Saskatchewan health coverage eligibility while awaiting permanent residency from CIC	• Persons who meet the following qualifications are designated as individuals eligible 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 more on specified drugs than the deductible amount determined	**Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program** Infants who are residents of Ontario and have a valid Ontario health card, as follows: • Infants born prematurely at less than 32 completed weeks gestation and those younger than 6 months at the start of, or during, the local RSV season; or • Infants of 33–35 completed weeks gestation and those younger than 6 months at the start of, or during the local RSV season, who do not live in isolated communities and have a Risk Assessment Tool Score of between 49 and 100; or • Infants of 33–35 completed weeks gestation and those younger than 6 months at the start of, or during the local RSV season, and who live in isolated communities where pediatric hospital care is not readily accessible and ambulance transportation for hospital admission is required; or • Infants younger than 24 months of age with Down syndrome/Trisomy 21 syndrome; or • Infants younger than 24 months of age with bronchopulmonary dysplasia/chronic lung disease and who required oxygen and/or medical therapy within the 6 months preceding the RSV season; or • Infants younger than 24 months of age with hemodynamically significant cyanotic or acyanotic congenital heart disease who require corrective surgery or are on cardiac medication for hemodynamic significant disease.

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
Other Eligibility Criteria (cont'd)	– Patient must qualify for premium assistance under the Medical Services Plan • **Palliative Care** – Recipients must be diagnosed as being in the terminal stage of a life-threatening illness or condition – Recipients must have a life expectancy of up to six months – Recipients wish to receive palliative care at home – Consent to the focus of care being palliative rather than treatment aimed at a cure – The physician submits an application, certifying that the individual meets the above criteria				Infants with other specific medical illnesses that place them at high risk of hospitalization and complications from an RSV infection may also be considered for prophylaxis, if they meet necessary requirements.
Sources	For more information: British Columbia PharmaCare	For more information: Alberta Health	For more information: Saskatchewan Health Drug Plan and Extended Benefits Branch	For more information: Manitoba Health	For more information: Ontario Drug Benefit Program

Back to Top

Eligibility (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Yukon and First Nations and Inuit Health Branch)

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
Plan/Program	• **Seniors Program (A)** • **Cystic Fibrosis (B)** • **Adults in Licensed Residential Facilities (E)** • **Department of Social Development (F)** • **Special Needs Children and Children in the Care of the Minister of Social Development (G)** • **Multiple Sclerosis (H)** • **Influenza (I)** • **Tuberculosis (TB) Drug Program (P)** • **Organ Transplant (R)** • **Human Growth Hormone Deficiency (T)** • **HIV/AIDS (U)** • **Nursing Home (V)**	• **Family Pharmacare Program (A)** • **Department of Community Services Pharmacare Benefits (F)** • **Seniors' Pharmacare Program (S)** • **Drug Assistance for Cancer Patients (C)** • **Diabetes Assistance Program (D)**	• **Family Health Benefit Program (F)** • **Seniors Drug Cost Assistance Plan (S)** • **High-Cost Drug Program (M)** • **AIDS/HIV Program (A)** • **Community Mental Health Program (B)** • **Cystic Fibrosis Program (C)** • **Diabetes Control Program (D)** • **Erythropoietin Program (E)** • **Growth Hormone (G)** • **Hepatitis Program (H)** • **Immunization Program (I)** • **Intron A (Interferon alfa-2b) Program (J)** • **Meningitis Program (K)** • **Institutional Pharmacy/ Nursing Home Program (N)** • **Nutrition Services Program (O)** • **Phenylketonuria (PKU) Program (P)** • **Rabies Program (R)** • **Transplant Program (T)** • **Rheumatic Fever Program (U)** • **Sexually Transmitted Diseases (STD) Program (V)** • **Children-In-Care/Financial Assistance Program (W)** • **Tuberculosis (TB) Drug Program (X)** • **Quit Smoking Program (Z)** • **Home Oxygen 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** (Plan H) • **The Select Needs Plan**	• **Pharmacare** • **Children's Drug and Optical Program** • **Chronic Disease Program**	• **Non-Insured Health Benefits (NIHB)**

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
General Beneficiary Information	• **Seniors Program—** Residents age 65 and older who receive the GIS or who qualify for benefits based on an annual income • **Cystic Fibrosis—**Cystic fibrosis patients or patients with juvenile or infant sclerosis of the pancreas • **Adults in Licensed Residential Facilities—** Individuals residing in a licensed adult residential facility who hold a valid health card for prescription drugs issued by the Department of Social Development • **Department of Social Development—**Individuals holding a valid health card for prescription drugs issued by the Department of Social Development • **Special Needs Children and Children in the Care of the Minister of Social Development—**Children with special needs and children under the care of the Minister of Social Development • **Multiple Sclerosis—** Residents in possession of a prescriptions written by a neurologist for eligible MS medications • **Influenza—**Residents and children with selected chronic health conditions significant enough to require regular medical follow-up or hospital care; or residents of	• **Family Pharmacare Program—**Families, including families of one, who apply for the program; any permanent Nova Scotia resident (age 18 or older) with a valid Nova Scotia health card number is eligible to enrol; must not have coverage through Department of Community Services Programs, Seniors' Pharmacare Program, Diabetes Assistance Program or Under 65–Long-Term Care Pharmacare Plan • **Drug Assistance for Cancer Patients—** Permanent Nova Scotia residents with a valid Nova Scotia health card number who have a gross family income no greater than $15,720 per year and are not eligible for coverage under other drug programs, except Family Pharmacare • **Nova Scotia Diabetes Assistance Program—** Permanent Nova Scotia residents with a valid Nova Scotia health card number younger than age 65 who have a confirmed diagnosis of diabetes and who do not have drug coverage through Veterans Affairs Canada, First Nations and Inuit Health, Nova Scotia Family Pharmacare or any other drug insurance plan for diabetes medications and supplies	• **AIDS/HIV Program—**Persons registered with the program through the chief health officer • **Community Mental Health Program—**Approved long-term psychiatric patients living in the community • **Erythropoietin Program—** Persons diagnosed with chronic renal failure or receiving kidney dialysis • **Family Health Benefit Program—**Families (parents, guardians and children younger than 18 or younger than 25 and in full-time attendance at a post-secondary educational institution), with a total net family income less than the threshold (see Income Range section below); coverage must be applied for on an annual basis • **Growth Hormone—**Children (younger than age 18) with a proven growth hormone deficiency or Turner syndrome • **Hepatitis Program—**Persons diagnosed with hepatitis, in close contact with a person diagnosed with hepatitis, or are at risk of infection; persons with an occupational risk of infection • **Immunization Program—** Children and persons at risk for exposure to various communicable diseases • **Intron A (Interferon alfa-2b) Program—**For the treatment of patients diagnosed with hairy cell leukemia, AIDS-related Kaposi's sarcoma and basal cell carcinoma; the person's	• **The Foundation Plan—** 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 get 100% coverage of eligible prescription drugs • **The Access Plan—** Individuals and families with low income. The amount of coverage is determined by family net income level and family status (see Income Range section) • **The 65Plus Plan—** Residents age 65 or older who receive Old Age Security benefits and the GIS • **The Assurance Plan—** Individuals and families with the financial burden of eligible high drug costs • **The Select Needs Plan** Residents who have been diagnosed with cystic fibrosis and residents age 18 years or younger with growth hormone deficiency	• **Children's Drug and Optical Program—**Children younger than age 19 from low-income families • **Chronic Disease Program—**Residents who have a chronic disease or a serious functional disability as provided under the *Chronic Disease and Disability Benefits Regulations* and not having coverage through First Nations and Inuit Health; program may also include clients receiving palliative care • **Pharmacare—**Seniors age 65 or older (and seniors' spouses age 60 or older) registered with Yukon Health Care Insurance Plan (YHCIP) and not having coverage through First Nations and Inuit Health; program may also include clients receiving palliative care • **For all programs—**Benefits are not covered if they are already available through a federal or territorial drug program, such as First Nations and Inuit Health and Veterans Affairs Canada. Residents with private or group insurance plans must submit claims to those plans first and will then be eligible for top-up benefits. The Pharmacare program is the insurer of last resort	**Non-Insured Health Benefits Program** • Registered Indian according to the Indian Act; or • Inuk recognized by one of the Inuit Land Claim organizations; or • An Innu member of one of the two Innu communities in Labrador (Davis Inlet and Sheshatshiu); or • An infant younger than age one whose parent is an eligible recipient; and • Is currently registered or eligible for registration under a provincial or territorial health insurance plan; and • Is not covered under a separate agreement with federal, provincial or territorial governments.

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
General Beneficiary Information (cont'd)	nursing homes and other chronic-care facilities; or residents older than 65; or pregnant women; or healthy children 6 months to 18 years old; or residents capable of transmitting influenza to those at high risk • **Tuberculosis (TB) Drug Program—**Individuals with tuberculosis prescribed by prescriber regardless of permanent residence • **Organ Transplant—** Recipients of an organ or bone marrow transplant who are registered with New Brunswick Medicare and are not entitled to receive similar benefits from any other source • **Human Growth Hormone Deficiency—**Residents under the age of 18 years with growth hormone deficiency or hypopituitarism who are registered on the plan by an endocrinologist • **HIV/AIDS—**Individuals diagnosed with HIV/AIDS and who are registered with the NBPDP through a provincial infectious disease specialist • **Nursing Home—**Individuals who reside in a registered nursing home	• **Department of Community Services Pharmacare Benefits—**Residents younger than age 65 years 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 • **Seniors Pharmacare Program—**Permanent Nova Scotia residents who are age 65 or older with a valid Nova Scotia health card number and who do not have drug coverage through Veterans Affairs Canada, Non-Insured Health Benefits, Nova Scotia Family Pharmacare or any other public or private plan that covers most medications and supplies after age 65	physician must request coverage from the chief health officer of the Department of Health and Social Services • **Meningitis Program—**Persons who have been in close contact with a person diagnosed with meningitis or are at risk of infection • **High-Cost Drug Program—** Persons approved for coverage of one or more of the medications for: Ankylosing Spondylitis, Cancer, Crohn's Disease, Diabetes, Multiple Sclerosis, Pulmonary Hypertension, Psoriatic Arthritis Rheumatoid Arthritis, and Wet Age-Related Macular Degeneration included in the program; coverage must be applied for on an annual basis • **Institutional Pharmacy/ Nursing Home Program—** Residents in government manors or private nursing homes eligible for coverage under the *Long-Term Care Subsidization Act* • **Nutrition Services Program—** High-risk pregnant women diagnosed with a nutritional deficiency • **Phenylketonuria (PKU) Program—**Persons diagnosed with phenylketonuria • **Rabies Program—**Persons with exposure to or at risk for exposure to rabies through an animal bite • **Seniors Drug Cost Assistance Plan—**Persons age 65 or older			

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
General Beneficiary Information (cont'd)			• **Transplant Program—**Persons who have had an organ or bone marrow transplant • **Rheumatic Fever Program—** Persons who have a well-documented history of rheumatic fever or rheumatic heart disease • **Sexually Transmitted Diseases (STD) Program—** Persons diagnosed with a sexually transmitted disease or identified contacts of a person diagnosed with a sexually transmitted disease • **Children-In-Care/Financial Assistance Program—** Persons eligible under the *Social Assistance Act* and persons in the temporary or permanent care of the director of child welfare • **Tuberculosis (TB) Drug Program—**Patients must have a diagnosis of tuberculosis confirmed by the chief health officer of the Department of Health and Social Services • **Home Oxygen Program—** Persons prescribed oxygen by a specialist and who meet clinical criteria			

<table>
<tr><th>Eligibility</th><th>N.B.</th><th>N.S.</th><th>P.E.I.</th><th>N.L.</th><th>Y.T.</th><th>Health Canada—FNIHB</th></tr>
<tr><td>Income Range (completed only if actual dollar amounts are known)</td><td>Seniors Program—For those not receiving the GIS:
Single with an annual income of $17,198 or less;
Senior couple (both age 65 or older) with a combined annual income of $26,955 or less; or
Senior couple with one spouse younger than 65 with a combined annual income of $32,390 or less</td><td>Drug Assistance for Cancer Patients—Gross family income no greater than $15,720</td><td>Family Health Benefit Program<table><tr><th>Number of Children</th><th>Net Annual Family Income</th></tr><tr><td>1</td><td><$24,800</td></tr><tr><td>2</td><td><$27,800</td></tr><tr><td>3</td><td><$30,800</td></tr><tr><td>4</td><td><$33,800</td></tr><tr><td>More Than 4</td><td>Add $3,000 per additional child</td></tr></table></td><td>The Access Plan
Families with children, including single parents: net annual incomes of $42,870 or less
Couples without children with net annual incomes of $30,009 or less
Single individuals with net annual incomes of $27,151 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</td><td>Family income and family size are used to determine deductibles for Chronic Disease and Children’s Drug and Optical programs; the table for Children’s Drug and Optical indicates income ranges that would not be eligible for the program</td><td>N/A</td></tr>
<tr><td>Other Eligibility Criteria or Comments</td><td></td><td>Family Pharmacare Program and Nova Scotia Diabetes Assistance Program—Residents must agree to provide family size information and annual family income verification through Canada Revenue Agency (CRA)

Nova Scotia Diabetes Assistance Program—The enrolment under this program ceased March 31, 2010. New patients can choose to register in the Family Pharmacare Program.</td><td></td><td></td><td>Absence from the territory for more than 183 consecutive days (six months) results in suspension of drug and benefit cost reimbursement starting the date of departure. A one-month extension will be considered on application to the director of health care insurance where Yukon is the location of the applicant’s only principal residence. On return to the territory, the resident may reapply for coverage under the respective program.</td><td>Recipients with chronic renal failure are eligible to receive a list of supplemental benefits that are not included on the NIHB Drug Benefit List. New patients, requiring drugs on the special formulary will be identified for coverage through the usual prior approval process. Once the patient has been confirmed as eligible, coverage will automatically be extended to all drugs in the special formulary for as long as needed.

Recipients who are diagnosed with a terminal illness and are near the end of life will be eligible to receive a list of supplemental benefits that are not included in the NIHB Drug Benefit List.</td></tr>
</table>

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
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 and Social Services	For more information: Non-Insured Health Benefits

Back to Top

Cost-Sharing Mechanism (British Columbia, Alberta, Saskatchewan, Manitoba and Ontario)

Cost-Sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
Premium	None	**Non-Group, as of July 2010** Single: $63.50/month Family: $118.00/month Subsidized rates available based on information reported on the prior year's income tax return Subsidized rates: Single: $44.45/month Family: $82.60/month	None	None	None
Copayment/ Co-Insurance	• **Fair PharmaCare—**After annual deductible has been met, 30% of the eligible prescription drug costs up to the annual maximum • **Fair PharmaCare Enhanced Assistance—**After annual deductible has been met, 25% of the eligible prescription drug costs up to the annual maximum • **"Full Payment" (no copayment) Policy—**As of October 15, 2010, if a patient is receiving full PharmaCare coverage, a pharmacy will not be permitted to collect directly from that patient any amount above the maximum drug price and maximum dispensing fee set by PharmaCare. This will apply to patients covered under plans B, C, D, F, G and P and those that have reached the Fair PharmaCare family maximum	• **Seniors—**30% per prescription to a maximum of $25 • **Widows—**30% per prescription to a maximum of $25 • **Palliative—**30% per prescription to a maximum of $25 • **Non-Group—**30% per prescription to a maximum of $25	• **Special Support Program—** The copayment is determined by the amount that the family drug costs exceed 3.4% of the adjusted combined family income. The family pays a portion of each prescription to reduce their share of drug costs and spread the cost over the six-month benefit period. • **Seniors Drug Plan—**Up to $20 per benefit prescription; no charge for seniors who have SAIL or Palliative Care coverage • **Seniors Income Plan Supplement or GIS Recipients—** After deductible is met, 35% copayment, may apply for income-tested coverage • **Family Health Benefits—**After deductible is met, 35% however no copay on benefits for children younger than 18 years • **Supplementary Health Program** – Under 18—None	None	• ODB recipients pay up to $2 per prescription if – 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; or – Eligible under the Trillium Drug Program • ODB recipients pay up to $6.11 toward the ODB dispensing fee per prescription if: – A senior single person with an annual net income *equal to or greater than* $16,018; or

<table>
<tr><th>Cost-Sharing Mechanism</th><th>B.C.</th><th>Alta.</th><th>Sask.</th><th>Man.</th><th>Ont.</th></tr>
<tr><td>Copayment/ Co-Insurance (cont'd)</td><td></td><td></td><td>– Plan One—Adults maximum $2 per benefit prescription
– Plan Two—May be eligible for prescriptions at no charge
– Plan Three—None
• Children's Drug Plan—Up to $20 per benefit prescription</td><td></td><td>– A senior couple with a combined annual net income equal to or greater than $24,175
• $2.83 for each prescription dispensed from an outpatient hospital pharmacy.</td></tr>
<tr><td>Deductible</td><td>• Fair PharmaCare<table><tr><th>Net Family Income</th><th>Approximate Deductible (as a percentage of net income)</th></tr><tr><td><$15,000</td><td>0%</td></tr><tr><td>$15,000–$30,000</td><td>2%</td></tr><tr><td>>$30,000</td><td>3%</td></tr></table>• Fair PharmaCare Enhanced Assistance<table><tr><th>Net Family Income</th><th>Approximate Deductible (as a percentage of net income)</th></tr><tr><td><$33,000</td><td>0%</td></tr><tr><td>$33,000–$50,000</td><td>1%</td></tr><tr><td>>$50,000</td><td>2%</td></tr></table>For a family registered for Fair PharmaCare whose income cannot be verified or for a person actively enrolled in the Medical Services Plan but not registered for Fair PharmaCare, the deductible is $10,000.

No deductible is applied to the remaining plans/programs.</td><td>None</td><td>• GIS Recipients
– If living in the community, the semi-annual deductible for prescription drugs is $200
– If living in a special care home, the semi-annual deductible is $100
• SIP Recipients
– If receiving SIP, the semi-annual deductible is $100
• Family Health Benefits
– $100 semi-annual family deductible
Deductibles may be reduced if eligible for additional drug coverage through the Special Support Program</td><td>• Pharmacare
– Annual threshold based on total adjusted family income
– Minimum deductible is $100.
Deductible rates for adjusted family incomes for 2012–2013<table><tr><th>Lower Limit</th><th>Upper Limit</th><th>Deductible</th></tr><tr><td></td><td>≤$15,000</td><td>2.81%</td></tr><tr><td>>$15,000</td><td>≤$21,000</td><td>3.99%</td></tr><tr><td>>$21,000</td><td>≤$22,000</td><td>4.03%</td></tr><tr><td>>$22,000</td><td>≤$23,000</td><td>4.10%</td></tr><tr><td>>$23,000</td><td>≤$24,000</td><td>4.16%</td></tr><tr><td>>$24,000</td><td>≤$25,000</td><td>4.20%</td></tr><tr><td>>$25,000</td><td>≤$26,000</td><td>4.25%</td></tr><tr><td>>$26,000</td><td>≤$27,000</td><td>4.30%</td></tr><tr><td>>$27,000</td><td>≤$28,000</td><td>4.34%</td></tr><tr><td>>$28,000</td><td>≤$29,00</td><td>4.38%</td></tr><tr><td>>$29,000</td><td>≤$40,000</td><td>4.41%</td></tr><tr><td>>$40,000</td><td>≤$42,500</td><td>4.79%</td></tr><tr><td>>$42,500</td><td>≤$45,000</td><td>4.91%</td></tr><tr><td>>$45,000</td><td>≤$47,500</td><td>5.01%</td></tr><tr><td>>$47,500</td><td>≤$75,000</td><td>5.08%</td></tr><tr><td>>$75,000</td><td>—</td><td>6.36%</td></tr></table></td><td>• ODB—$100 deductible for
– Single seniors with annual income equal to or greater than $16,018; and
– Senior couples with a combined annual income equal to or greater than $24,175
Trillium Drug Program applicants must pay a quarterly or pro-rated deductible that is based on income.</td></tr>
</table>

<table>
<tr><th>Cost-Sharing Mechanism</th><th>B.C.</th><th>Alta.</th><th>Sask.</th><th>Man.</th><th>Ont.</th></tr>
<tr><td>Maximum Beneficiary Contribution</td><td>

Fair PharmaCare

<table>
<tr><th>Net Family Income</th><th>Approximate Maximum (as a percentage of net income)</th></tr>
<tr><td><$15,000</td><td>2%</td></tr>
<tr><td>$15,000–$30,000</td><td>3%</td></tr>
<tr><td>>$30,000</td><td>4%</td></tr>
</table>

Fair PharmaCare Enhanced Assistance

<table>
<tr><th>Net Family Income</th><th>Approximate Maximum (as a percentage of net income)</th></tr>
<tr><td><$33,000</td><td>1.25%</td></tr>
<tr><td>$33,000–$50,000</td><td>2.0%</td></tr>
<tr><td>>$50,000</td><td>3.0%</td></tr>
</table>
</td><td>

Palliative—The lifetime maximum amount paid is $1,000

</td><td></td><td>The maximum beneficiary contribution is the calculated deductible.</td><td>N/A</td></tr>
<tr><td>Sources</td><td>For more information: British Columbia PharmaCare</td><td>For more information: Alberta Health</td><td>For more information: Saskatchewan Health Drug and Extended Benefits Branch</td><td>For more information: Manitoba Health</td><td>For more information: Ontario Drug Benefit Program</td></tr>
</table>

Back to Top

Cost-Sharing Mechanism (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Yukon and First Nations and Inuit Health Branch)

<table>
<tr><th>Cost-Sharing Mechanism</th><th>N.B.</th><th>N.S.</th><th>P.E.I.</th><th>N.L.</th><th>Y.T.</th><th>Health Canada—FNIHB</th></tr>
<tr><td>Premium</td><td>Cystic Fibrosis, Multiple Sclerosis, Organ Transplant, Human Growth Hormone Deficiency, HIV/AIDS—
$50/year for each plan</td><td>Seniors Pharmacare—
Maximum $424/year
• No Premium
– Single and income <$18,000
– Married and joint income <$21,000
• Reduced Premium
– Single and income between $18,000 and $24,000
– Married and joint income between $21,000 and $28,000</td><td>None</td><td>None</td><td>None</td><td>None</td></tr>
<tr><td>Copayment/ Co-Insurance</td><td>• Seniors
– GIS: $9.05/prescription
– Non-GIS: $15/prescription
• Adults in Licensed Residential Facilities
– $4/prescription
• Department of Social Development
– $4/prescription for adults 18 and older
– $2/prescription for children younger than 18
• Multiple Sclerosis
– Income-tested annually
• Cystic Fibrosis, Organ Transplant, Human Growth Hormone Deficiency and HIV/AIDS
– 20%/prescription to a maximum of $20</td><td>• Family Pharmacare
– 20%/prescription
• Diabetes Assistance Program
– 20%/prescription
• Department of Community Services Pharmacare Benefits
– $5 per prescription unless eligible for copayment exemption
• Seniors' Pharmacare
– 30%</td><td>• Diabetes
– Insulin: $10 per 10 mL or box of 1.5 mL cartridges or $20 per box of 3 mL cartridges
– Blood glucose test strips: $11 per prescription to a maximum of 100 strips every 30 days
– Oral medications and urine testing materials: $11 per prescription
– High-cost diabetes medications: an income-based portion of the drug cost plus the professional fee
• Family Health Benefit Program
– Professional fee for each prescription</td><td>• The 65Plus Plan
– Up to $6 per prescription
• The Access Plan Families (With Children)
<table><tr><th>Income</th><th>Copay</th></tr><tr><td><$30,009</td><td>20.0%</td></tr><tr><td>$31,000</td><td>23.9%</td></tr><tr><td>$32,000</td><td>27.7%</td></tr><tr><td>$33,000</td><td>31.6%</td></tr><tr><td>$34,000</td><td>35.5%</td></tr><tr><td>$35,000</td><td>39.4%</td></tr><tr><td>$36,000</td><td>43.3%</td></tr><tr><td>$37,000</td><td>47.2%</td></tr><tr><td>$38,000</td><td>51.1%</td></tr><tr><td>$39,000</td><td>55.0%</td></tr><tr><td>$40,000</td><td>58.8%</td></tr><tr><td>$41,000</td><td>62.7%</td></tr><tr><td>$42,000</td><td>66.6%</td></tr><tr><td>$42,870</td><td>70.0%</td></tr></table></td><td>None</td><td>None</td></tr>
</table>

<table>
<tr><th>Cost-Sharing Mechanism</th><th>N.B.</th><th>N.S.</th><th>P.E.I.</th><th>N.L.</th><th>Y.T.</th><th>Health Canada—FNIHB</th></tr>
<tr><td>Copayment/ Co-Insurance (Cont’d)</td><td></td><td></td><td>

High-Cost Drug Program
Income-based portion of the drug plus the professional fee for each prescription
Seniors Drug Cost Assistance Plan
First $8.25 of the medication cost plus the professional fee for each prescription
Quit Smoking Program
Patients are responsible for all medication costs approved, except for the first $75 per year, which will be paid by the program
Home Oxygen Program
PEI Medicare program pays 50% of the eligible expenses up to $200 per month

</td><td>
Couples (With No Children)
<table>
<tr><th>Income</th><th>Copay</th></tr>
<tr><td><$21,435</td><td>20.0%</td></tr>
<tr><td>$22,000</td><td>23.3%</td></tr>
<tr><td>$23,000</td><td>29.1%</td></tr>
<tr><td>$24,000</td><td>35.0%</td></tr>
<tr><td>$25,000</td><td>40.8%</td></tr>
<tr><td>$26,000</td><td>46.6%</td></tr>
<tr><td>$27,000</td><td>52.4%</td></tr>
<tr><td>$28,000</td><td>58.3%</td></tr>
<tr><td>$29,000</td><td>64.1%</td></tr>
<tr><td>$30,000</td><td>69.9%</td></tr>
<tr><td>$30,009</td><td>70.0%</td></tr>
</table>
Single Individuals
<table>
<tr><th>Income</th><th>Copay</th></tr>
<tr><td><$18,577</td><td>20.0%</td></tr>
<tr><td>$19,000</td><td>22.5%</td></tr>
<tr><td>$20,000</td><td>28.3%</td></tr>
<tr><td>$21,000</td><td>34.1%</td></tr>
<tr><td>$22,000</td><td>40.0%</td></tr>
<tr><td>$23,000</td><td>45.8%</td></tr>
<tr><td>$24,000</td><td>51.6%</td></tr>
<tr><td>$25,000</td><td>57.5%</td></tr>
<tr><td>$26,000</td><td>63.3%</td></tr>
<tr><td>$27,000</td><td>69.1%</td></tr>
<tr><td>$27,151</td><td>70.0%</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>Deductible</td><td>None</td><td>

Family Pharmacare— Annual family deductible is a sliding scale percentage based on adjusted family income
Diabetes Assistance— Percentage based on adjusted family income

</td><td>None</td><td>None</td><td>

Children’s Drug and Optical Program—$250 per child per year
May be waived or reduced depending on income
Chronic Disease Program—$250 per person per year
May be waived for palliative care recipients
May be waived or reduced depending on income

</td><td>None</td></tr>
</table>

<table>
<tr><th>Cost-Sharing Mechanism</th><th>N.B.</th><th>N.S.</th><th>P.E.I.</th><th>N.L.</th><th>Y.T.</th><th>Health Canada—FNIHB</th></tr>
<tr><td>Maximum Beneficiary Contribution</td><td>Seniors Receiving GIS: $500 per calendar year
Cystic Fibrosis, Organ Transplant, Human Growth Hormone Deficiency and HIV/AIDS: $500 maximum copayment + premium per family unit per fiscal year
Adults in Licensed Residential Facilities: $250 per person in a fiscal year
Department of Social Development: $250 per family unit per fiscal year</td><td>Family Pharmacare: Annual family copayment plus annual family deductible both based on income
Seniors Pharmacare: Annual maximum copayment $382 + premium</td><td>N/A</td><td>Assurance Plan based on net income:
<table><tr><th>Net Income</th><th>Max.</th></tr><tr><td>Up to $39,999</td><td>5.0%</td></tr><tr><td>$40,000 to $74,999</td><td>7.5%</td></tr><tr><td>$75,000 to $149,999</td><td>10.0%</td></tr></table>For example, family income of $35,000 with annual drug costs of $6,000. This income requires a maximum contribution per year of 5% of the family's income, which is $1,750 (5% x $35,000) towards the annual drug costs of $6,000. The program will use the following calculation to determine copay:
(35,000 x 5%) / $6,000 = 29.17%
Each time a prescription for an eligible benefit is filled, the family will pay 29.17% of the total cost of the prescription</td><td>Children's Drug and Optical Program—$500 per family per year
Chronic Disease Program—$500 per family per year</td><td>N/A</td></tr>
<tr><td>Sources</td><td>For more information: New Brunswick Prescription Drug Program</td><td>For more information: Nova Scotia Pharmacare Drug Programs and Funding</td><td>For more information: Prince Edward Island Drug Programs</td><td>For more information: Newfoundland and Labrador Prescription Drug Program</td><td>For more information: Yukon Health and Social Services</td><td>For more information: Non-Insured Health Benefits</td></tr>
</table>

Back to Top

Policy-Related Information (British Columbia, Alberta, Saskatchewan, Manitoba and Ontario)

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Ingredient Price	**Low-Cost Alternative (LCA) Program—**The LCA price is based on the least expensive product in a group of generic drugs that are the same in chemical, strength and form. **Maximum Allowable List Price (MALP)** for products within an LCA category is the LCA plus 8%. **Reference Drug Program—**If there is more than one drug in a therapeutic class, full coverage is provided for only those drugs considered as being the most medically effective and the most cost effective in that category; this is the reference drug. Insulin, insulin needles and syringes, and ostomy supplies are reimbursed at the regular retail price.	**Least-Cost Alternative (LCA)—**The LCA price is the lowest unit cost established for a drug product within a set of interchangeable drug products. **Maximum Allowable Cost (MAC)—** The MAC price is the maximum unit cost established for a specific drug product or group of drug products. **Actual Acquisition Cost (AAC)—** Pharmacists are expected to charge the AAC of a drug product, including any discounts received towards a product purchased. For interchangeable drug products, pharmacists can charge only the AAC to a maximum of the lowest LCA or MAC price.	**Low-Cost Alternative (LCA)—**Benefits are based on the lowest-priced interchangeable brand as listed in the formulary. **Maximum Allowable Cost (MAC) —** Maximum price that the drug plan will cover for similar drugs used to treat the same condition. **Actual Acquisition Cost (AAC)—** Ingredient cost, unless otherwise determined (that is, LCA, MAC), is based on the actual cost of the material of a drug product, including any discounts received towards a product purchased. **Saskatchewan Insulin Pump Program—** AAC up to the maximum formulary list price for insulin pump supplies. Brand name manufacturers complete a price quotation process and are required to guarantee the prices of their listed products during the fiscal year (April to March).	**Lowest Cost Pricing—** 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)—**The DBP for a drug in a particular dosage form and strength reflects the amount, calculated per gram, millilitre, tablet, capsule or other appropriate unit, for which a listed drug product in that dosage form and strength will be reimbursed by the ministry. Drug products are reimbursed at the listed DBP (or lowest DBP for an interchangeable category) plus a markup plus the lesser of a pharmacy’s posted usual and customary fee or the ODB dispensing fee, minus the applicable copayment amount.
Generic Pricing Policy (percentage of brand-name drug)	Effective April 2, 2012, generic price is equal to or less than 35% of the brand price listed as of January 1, 2010.	New generics as of October 2009—45% Existing generics as of April 2010—56% New and existing generics as of July 2012—35% Price policy applies to both public and private plans.	All generics as of April 1, 2012—35% Price policy applies to both public and private sectors.		All generics as of April 1, 2012—25% Applies to public and private sectors.

<table>
<tr><th>Policy-Related Information</th><th>B.C.</th><th>Alta.</th><th>Sask.</th><th>Man.</th><th>Ont.</th></tr>
<tr>
<td>Professional Fees—Product-Related Fees/ Services</td>
<td>
Dispense Fee: $10.00, maximum

Methadone (Maintenance) Interaction Fee: $7.70
Frequency of Dispensing Policy
For drugs dispensed in less than a 28-day supply:

Maximum of three dispensing fees per patient for drugs dispensed daily.
Maximum of five dispensing fees per patient for drugs dispensed in 2- to 27-day supplies.

Capitation Rate

Pharmacies providing services to long-term care facilities receive $43.75 per bed serviced.
Rural Incentive Program—A per-claim subsidy ($3.00 to $10.50) to rural pharmacies with monthly claims volumes of less than 1,700.
Vaccination administration—$10 for each publicly funded vaccination provided.

No dispensing fee is charged for insulins (except Humalog), and needles and syringes for insulin therapy.
</td>
<td>
Alberta has two types of professional fees: dispensing fees and additional inventory allowance.

The fees from April 1, 2012, to March 31, 2013, are as follows:
<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>$1.71</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>
</table>

Insulin and Oral Contraceptives—The prescription charge must not exceed the acquisition cost of the drug product multiplied by 5/3.
Injectable Drugs Other Than Insulin—The prescription charge must not exceed the acquisition cost multiplied by 5/3, to a maximum of $100 more than the acquisition cost of the injectable drug.
Compounded Prescriptions—An additional charge of up to 75 cents per each minute in excess of seven minutes.
Transitional Allowance—The inventory allowance for prescriptions with an AAC of between $0.00 and $74.99 (except for insulin, oral contraceptives, injectables, diabetic supplies, Alberta Public Health Activities Program drugs and Pharmacy Practice Models Initiative drugs) as follows:
<table>
<tr><th>Effective Date</th><th>Inventory Allowance</th></tr>
<tr><td>April 1, 2012—March 31, 2013</td><td>$1.71</td></tr>
<tr><td>April 1, 2013—March 31, 2014</td><td>$0.71</td></tr>
</table>

</td>
<td>
Effective April 1, 2012, the maximum dispensing fee is $10.25.

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 $10.25) 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—Methadone fee is $3.50 per day ($24.50 per week) and is paid only for face-to-face interactions with the pharmacist.
Compliance Packaging—$6.25 for each 7-day supply ($25 for a 28-day supply or $31.25 for a 35-day supply).
Extemporaneous Compounding Fee—$0.75/minute to a maximum of 60 minutes; maximum of 20 minutes applies to most methadone compounds
Urine-Testing Agents—No fee allowed
Saskatchewan Insulin Pump Program—No fee allowed

</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.

Monthly Capitation Fee—For personal care homes: $37.50 per bed per month for Winnipeg and $38.20 per bed per month for rural areas
</td>
<td>
Dispensing fees for non-rural pharmacies are $8.40; for rural pharmacies, the fees range from $9.45 to $12.61 for 2012–2013.

Effective April 1, 2012, the transition fee payment of $0.35 for each eligible claim will be processed and added to the pharmacy’s regular payment cycle.

Dispensing fees paid by the Ontario government will increase annually on April 1, until April 1, 2014, when the dispensing fees payable under the Ontario Drug Benefit Program will be between $8.83 and $13.25.

Dispensing fees are set at a maximum of two fees per medication per patient per month; exceptions are for patients in long-term care homes and/or drugs in exemption medication list.
</td>
</tr>
</table>

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Professional Fees—Clinical Services	• **Clinical Pharmacy Services Fees—**Effective April 1, 2011, PharmaCare reimburses pharmacies for Medication Review Services: – Standard ($60.00) – Pharmacist Consultation ($70.00) – Follow-Up ($15.00)—maximum four per year One Standard or one Pharmacist Consultation fee per six months. • **Special Services Fee:** – Refusal to fill up to twice the professional fee – Prescription renewal: $10.00 – Change fee: $10.00. – Therapeutic substitution fee: $17.20. Maximum two clinical services fees per drug, per person during a six-month period • **Medication Management Program—**Medication Review Services: – Recipients who have at least five different qualifying medications that have been entered into PharmaNet within the last six months and have a clinical need for service – Recipients must meet time frame requirements regarding previous medication review appointments – Recipients must give expressed verbal consent to receive the service, and, if applicable, give written consent to sharing the information gathered therein with a patient representative		• **Emergency Contraception Prescribing—**Prescribing fee equal to two times the usual dispensing fee above and beyond the cost for 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—**Medication reconciliation for clients transferred from an institution to a community setting; 1.5 times the pharmacy's usual and customary dispensing fee. • **Medication Assessment—**Maximum $60 once per calendar year. • **Patient Assessments** (maximum amount per 28 days per patient) – Continuing Existing Prescription: $6.00—maximum four – Insufficient Information: $6.00—maximum one – Continuing Existing Prescription: $10.00—maximum one – Continuing Drug Reconciliation: $25.00—maximum one		• **MedsCheck Program—**Those eligible to receive an annual review and follow-up reviews: – Residents with three or more chronic conditions; or – Residents of licensed long-term care homes; or – People with diabetes; or – Those who are home-bound and not able to attend their community pharmacy for the service

<table>
<tr><th>Policy-Related Information</th><th>B.C.</th><th>Alta.</th><th>Sask.</th><th>Man.</th><th>Ont.</th></tr>
<tr><td>Pharmacy Markup</td><td>• Maximum Allowable List Price (MALP)
– For high-cost* drugs, the MALP = manufacturer list price plus 5%.
– For all other drugs, the MALP = manufacturer list price plus 8%.

* High-cost drugs are defined as those for which the expected daily cost of the typical dose is equal to or greater than $40 ($14,600 annual cost).</td><td>Prices listed in the Alberta Health Drug Benefit List include a wholesaler markup, but only if the drug manufacturer distributes through a wholesaler. In such cases, the drug manufacturer is asked to include a distribution allowance of up to 7.5%. This includes both single-source and interchangeable products</td><td>Maximum markup allowance calculated on the prescription drug cost:
<table><tr><th>Drug Cost</th><th>Markup</th></tr><tr><td>$0.01–$6.30</td><td>30%</td></tr><tr><td>$6.31–$15.80</td><td>15%</td></tr><tr><td>$15.81–$200.00</td><td>10%</td></tr><tr><td>>$200.01</td><td>$20 max.</td></tr></table>
Urine-Testing Agents—Markup as above plus 50%.

Insulin—A negotiated markup.

Saskatchewan Insulin Pump Program—No markup allowed.</td><td></td><td>Maximum 8% where permitted</td></tr>
<tr><td>Coordination of Benefits (Public/Private)</td><td>PharmaCare does not provide coverage for B.C. residents covered by Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers’ Compensation or the Federal Non-Insured Health Benefits Program.

PharmaCare is considered the first payer and private insurance is the second payer</td><td>Alberta Health 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 rules regarding coordination of benefits.</td><td>The drug plan is the first payer on eligible claims for eligible beneficiaries.</td><td></td><td>ODB is considered the first payer and private insurance is the second payer for seniors with both forms of coverage.</td></tr>
</table>

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Restricted/ Exception Drug Coverage Process	Special authority forms are completed by practitioners and evaluated on an individual basis, according to established criteria. Retroactive coverage is not provided.	Special authorization request forms are completed by providers and evaluated on an individual basis. Retroactive coverage is not provided. Special authorization is granted for a maximum of 12 months; if continued treatment is necessary, the providers must reapply for coverage before the expiry date of the previous coverage.	Eligible prescribers, authorized office staff or pharmacists may apply for Exception Drug Status (EDS) on behalf of a patient. Patients are notified of approvals while both the patient and the prescriber are notified of denials. For pharmacist-initiated requests, the diagnosis, obtained from the physician, is to be documented consistently within the pharmacy.	The prescriber must contact Manitoba Health to request eligibility for prescription; eligibility is from date of approval.	A physician must send a written request to the Drug Programs Branch, which obtains a recommendation from the Committee to Evaluate Drugs (CED). Decisions on requests are communicated 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 the pharmacy. Telephone Request Service (TRS) is available for select drugs and assessed in real time.
Reimbursement Policy	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 Drug Benefit List* at the time of service and received within 12 months of the service date.	Beneficiaries can submit claims if they have had to pay out of pocket for various reasons (system down, EDS coverage not in place at time of dispensing, etc.). Beneficiaries who are temporarily out of province are eligible for drug benefits, in accordance with their coverage level and Saskatchewan drug prices, upon submission of original receipts to the drug plan.	The original receipts for prescriptions purchased in another province or territory of Canada can be submitted to the drug plan for reimbursement, up to a maximum amount that is considered reasonable by the minister.	Claims can be reimbursed only for eligible drugs, when written by a physician licensed in Ontario and dispensed in Ontario.
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) Exemptions to the 30-day supply limit are available for • Plan B patients; • Consumers in rural or remote areas; and	**Prescription Quantities** • No limitation on the quantities of drugs that may be prescribed • In most cases, Alberta Health will not pay benefits for more than a 100-day supply of a drug at one time • Drugs considered 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	**Prescription Quantities** With some exceptions, 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 three-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 the duration of one month or more, the pharmacist is entitled to charge a dispensing	**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	**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 • 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

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Miscellaneous (cont'd)	• Prescriptions under the Trial Prescription Program (where a 14-day trial has been dispensed) **Travel Supply** PharmaCare covers out-of-province travel supplies of medication up to the PharmaCare maximum allowable days' supply. Under the new policy, once every six 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. **Smoking Cessation** Effective September 30, 2011, Pharmacare covers prescribed smoking cessation drugs or a free supply of nicotine gum or patches up to 12 weeks per year to help quit tobacco use.	– Oral contraceptives – Antihypertensive agents – Conjugated estrogens – Anti-arthritics The Seniors and Widows, Non-Group and Palliative programs do not cover prescription costs exceeding $25,000 per beneficiary per year. On an exception basis, this amount can be modified by Alberta Health	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 2-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 to be dispensed	– The person will be outside of Canada for more than 90 consecutive days	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 (that is, 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	For more information: Saskatchewan Health Drug Plan and Extended Benefits Branch	For more information: Manitoba Health	For more information: Ontario Drug Benefit Program

Back to Top

Policy-Related Information (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Yukon and First Nations and Inuit Health Branch)

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
Ingredient Pricing Policy	**Actual Acquisition Cost (AAC)** Ingredient cost, unless otherwise determined, that is, LCA, MAC, is based on the actual cost of the material of a drug product, including any discounts received towards a product purchased. This applies to non-interchangeable drugs.	**Manufacturer's List Price (MLP)** is the published price at which a drug or device is sold to a provider or wholesaler and does not include any markup for distribution. **Maximum Reimbursable Price (MRP)** is the maximum cost established by the Pharmacare Programs at which a benefit is reimbursed to a provider or beneficiary for a category of interchangeable products. **Pharmacare Reimbursement Price (PRP)** is the maximum amount the Program reimburses providers for one unit of a drug, supply or service as assigned by the minister to each of the following: • Certain groups of drugs that are similar in therapeutic effect; • Specific services for which coverage is established; • Certain unit dose and special delivery formats that are also available in less expensive bulk formats; and • Certain different supplies that are used for the same function. **Actual acquisition cost (AAC)** means the net cost to the provider after deducting all rebates, allowances, free products, etc. Net cost is the drug ingredient (or supply) costs based on date of purchase. Incentives for prompt payment are not included in the calculation.	**Maximum Allowable Cost (MAC)** the ingredient cost is based on the manufacturer's net catalogue price of the lowest-priced product within an interchangeable category plus 5%. When no MAC exists, price is based on type of manufacturer: • Direct manufacturer—The cost is the manufacturer's net catalogue price. • Non-direct manufacturer—The cost is the manufacturer's net catalogue price plus 13%.	**Defined cost—**The current published manufacturer's list price plus 8.5%. **Interchangeable Unit Price—**The lowest unit price of all drugs within a NIDPF category. Innovator price is the price for a drug established for a single-sourced ingredient as recorded by the pharmaceutical department at the time the drug submission is received, minus 8.5%. Inventory adjustment fee is a percentage set by the minister which may be included in the price that may be charged for a drug listed in the formulary. Maximum price listed for a drug shall not exceed the price listed for the same drug as published in the Ontario Drug Program formulary, plus an inventory adjustment fee set by the minister.	Yukon Drug Programs formulary benefits will be based on the lowest-priced interchangeable brand available. Prices listed in the formulary are based on wholesale prices.	**Best Price (lowest cost) Alternative—**A product in a group of interchangeable drug products. Provincial/territorial pharmacy legislation/policies are followed to identify interchangeable products and to select the lowest-priced brand. However, NIHB pays the amount identified on the price file. In general, the price is the same as the respective provincial formulary if listed, otherwise the price paid will be the price list of a national wholesaler. Exceptions may exist; contact NIHB for region-specific information.

<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>Health Canada—FNIHB</th></tr>
<tr><td>Generic Pricing Policy (percentage of brand-name drug)</td><td>June 1, 2012: 40% (10-day washout period; prices effective June 11, 2012)
December 1, 2012: 35%

Price policy applies to both public and private sectors for interchangeable drugs</td><td>January 1, 2012: 40%
July 1, 2012: 35%</td><td>No policy or legislation currently in place</td><td>April 16, 2012: 45%
October 1, 2012: 40%
April 1, 2013: 35%

Price policy applies to both public and private sectors.</td><td></td><td></td></tr>
<tr><td>Professional Fees—Product-Related Fees/ Services</td><td>Effective June 1, 2012 :
$10.40 per prescription of an interchangeable drug product
<table><tr><th>Ingredient Cost/ Prescription</th><th>Dispensing Fee for Non-Interchan-geable Drugs</th><th>Dispensing Fee for Extempor-aneous Preparation</th></tr><tr><td>$0.00–$99.99</td><td>$10.40</td><td>$15.60</td></tr><tr><td>$100.00–$199.99</td><td>$12.90</td><td>$19.35</td></tr><tr><td>$200.00–$499.99</td><td>$18.00</td><td>$20.00</td></tr><tr><td>$500.00–$999.99</td><td>$23.00</td><td>$23.00</td></tr><tr><td>$1,000.00–$1,999.99</td><td>$63.00</td><td>$63.00</td></tr><tr><td>$2,000.00–$2,999.99</td><td>$83.00</td><td>$83.00</td></tr><tr><td>$3,000.00–$3,999.99</td><td>$103.00</td><td>$103.00</td></tr><tr><td>$4,000.00–$4,999.99</td><td>$123.00</td><td>$123.00</td></tr><tr><td>$5,000.00–$5,999.99</td><td>$143.00</td><td>$143.00</td></tr><tr><td>Greater Than or Equal to $6,000.00</td><td>$163.00</td><td>$163.00</td></tr></table>Dispensing physicians are reimbursed 80% of the applicable fee listed.

The dispensing fee for non-interchangeable drugs also applies to compounded methadone oral solution and Metadol™ oral solution.</td><td>April 1, 2012, to March 31, 2013:
• Ostomy supplies: $10.90
• Compounded extemporaneous products (except methadone and injectables): $16.35
• All other prescriptions for drugs or supplies including methadone: $10.90.

April 1, 2013, to June 30, 2014:
• Ostomy supplies: $11.05
• Compounded extemporaneous products (except methadone and injectables): $16.58
• All other prescriptions for drugs or supplies, including methadone: $11.05.</td><td></td><td>Professional Fee
The professional fee for the Foundation Plan, Access Plan and Assurance Plan has been increased to $8.25 effective April 1, 2012, retroactive to April 1, 2011. Subsequently, it was increased to
• $10.90—for drug costs between $0 and $49.99
• $21.95—for drug costs between $50.00 and $249.99
• $49.85—for drug costs of $250.00+ for the period between April 16, 2012, and March 31, 2013.
The professional fee for the 65 Plus Plan remained at $7.15. Subsequently, it was increased to
• $10.90—for drug costs between $0 and $249.99
• $39.59—for drug costs of $250.00+, effective April 16, 2012.

Extemporaneous Preparations Fee
1.5 times the professional fee for non-compound products. This applies to compounds that contain three or more ingredients.</td><td>The professional fee maximum is $8.75</td><td>Fees are negotiated between NIHB and pharmacists’ associations and therefore will differ by province/territory.

The methadone dispensing fee will be paid by the dose, using the following formula: (usual and customary fee) x 1.5) / 7 days + $3.80) per dose.</td></tr>
</table>

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
	The New Brunswick Prescription Drug Program (NBPDP) rural pharmacy incentive pays an additional $2 dispensing fee for each of the first 10,000 NBPDP prescriptions filled per fiscal year to the pharmacies in a community that are 25 kilometres or more apart from each other.			Additionally, 10 cents per powder paper will be paid when compounded by the pharmacist.		
Professional—Clinical Services	Med Check Review: $52.50 Limit of one review per year for plan beneficiaries.	Effective September 1, 2011: The Pharmacare Program reimburses special services fees, to the following maximums: • Advanced Medication Review: $150 • Basic Medication Review: $52.50 • Prescription Adaptation: $14.00 • Therapeutic Substitution: $26.25		**Cognitive Services** • Refusal to fill: Pharmacies may bill up to the maximum dispensing fee of double the base dispensing fee of $10.90 • Medication Management: Pharmacies may bill up to the maximum dispensing fee of $10.90 (the base dispensing fee amount) • Medication Review: The new agreement allows for payment for medication review as a cognitive service Pharmacies may bill $52.50 (48 times per year)		
Markup	Effective June 1, 2012: 4% markup to a maximum of $50.00 on interchangeable drugs	April 1, 2012, to March 31, 2013: • Ostomy supplies—AAC plus 10.0% (maximum $50) plus a $0.75 transition fee • Compounded extemporaneous products (except methadone and injectables)—AAC plus 2.0% (maximum $50) plus $0.75 transition fee • All other prescriptions for drugs or supplies—MLP plus 10.5% (maximum $250) including methadone, or MRP or PRP plus 6.0% (maximum $250) plus $0.75 transition fee	• Family Health Benefit, Nursing Home and Seniors programs: defined ingredient cost drugs equal to or greater than $45: 9.5%, maximum $60. • High-cost drugs: 7.5%, maximum $150.	*No surcharge* can be applied to the prescription cost under any NLPDP Plan (that is, neither NLPDP nor client can be billed or charged a surcharge)	• Pharmacies are allowed a 30% markup • In addition, if AAC includes a wholesale upcharge, this can be included up to a maximum of 14%	Markups, if applicable, are negotiated as part of the pharmacy agreements between NIHB and the pharmacists' associations in the different jurisdictions.

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
Markup (cont'd)		April 1, 2013, to June 30, 2014: • Ostomy supplies—AAC plus 10.0% (maximum $50) plus a $1.05 transition fee • Compounded extemporaneous products (except methadone and injectables)—AAC plus 2.0% (maximum $50) plus $1.05 transition fee • All other prescriptions for drugs or supplies—MLP plus 10.5% (maximum $250), including methadone, or MRP or PRP plus 6.0% (maximum $250), plus $1.05 transition fee				
Coordination of Benefits (Public/Private)	N/A	**Family Pharmacare Program—** Program is payer of last resort. Any out-of-pocket costs to client after private plans are used can be applied to Family Pharmacare **Seniors' Pharmacare Program—**If the copayments a senior pays to his or her private insurance exceed the amount of the annual maximum premium plus the annual maximum copayment he or she would have paid if enrolled in Seniors Pharmacare, he or she may request a reimbursement of the difference.	N/A		For all Yukon government plans, residents must access private insurance plans first	When a beneficiary is covered by a private health care plan, claims must be submitted to it first
Coordination of Benefits (Intra-Jurisdictional)	N/A	**Family Pharmacare Program—** Program is payer of last resort. Any out-of-pocket costs to client after private plans are used can be applied to Family Pharmacare	N/A	• Other federal public plans are to be used before the provincial drug plans.	• 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 a beneficiary is covered by another health care plan, claims must be submitted to it first

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
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 that 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. Drugs not eligible 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 (for example, drugs obtained through Health Canada's Special Access Programme) • Products specifically excluded as benefits as identified on the exclusion list (NBPDP formulary) Special authorization requests must be submitted in writing by a prescriber to the NB Prescription Drug Program Special Authorization Unit.	**Exception Status Drugs** are those which are eligible for coverage under the Pharmacare programs only when an individual meets criteria developed by the Atlantic or Canadian Expert Advisory Committees 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 seven days. If the request is approved, clients receive notification via letter. Clients may bring this letter to the pharmacy to verify that coverage has been approved or the pharmacist may simply bill the claim online 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 Selected Exception Status Drugs can be billed online without prior approval if criteria codes are provided during the billing process. For most of the drugs that can be billed using criteria codes, the criteria codes are supplied directly by an authorized prescriber. By supplying a code, the prescriber is verifying that he or she is prescribing the drug for an indication approved under the	• Prescribers may apply for special authorization coverage by mailing or faxing a completed special authorization form • Allow one to two weeks for the processing of special authorization 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 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 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, is encouraged to expedite the approval process.	Application process: • Only Yukon physicians may apply for Exception Drug Status • Applications must be submitted in writing When an exception drug is prescribed, the pharmacist may request an initial 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 provided that the drug is listed in the formulary. If the drug requires a specialist's recommendation according to the product's criteria, the 30-day coverage will not be granted unless the specialist's information is provided.	There are four types of limited-use benefits: • Limited-use benefits for which requests can be automatically adjudicated based on the client's prior drug history • Limited-use benefits that require prior approval (using the Limited-Use Drugs Request Form) • Benefits with an exception status, which require prior approval (using the Benefit Exception Questionnaire) • Benefits that 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.

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
Restricted Benefit Process (cont'd)		Pharmacare programs. The prescriber may provide diagnostic information on the prescription (instead of the actual code), but it must clearly indicate to the pharmacist which code should be used.				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 for a drug, the claim may be submitted for reimbursement consideration if the product is an eligible benefit, is prescribed by an authorized health care provider and is purchased at a New Brunswick pharmacy.	• If a beneficiary paid cash at the pharmacy, he or she has up to six months from date of purchase to send original receipts to Pharmacare for reimbursement. Prescriptions filled at a pharmacy outside Nova Scotia, but inside Canada, will be reimbursed in medical emergencies only. There is no reimbursement, emergency or otherwise, for prescriptions filled outside Canada.	• If a beneficiary paid cash at the pharmacy, he or she has six months to submit receipts for reimbursement.	• **The Foundation Plan—** Reimbursement can be considered under exceptional circumstances; out-of-province claims are considered only if a patient is referred out of province for medical reasons and approval is obtained prior to leaving the province. • **The Access Plan—**The program applies only to benefits obtained within the province of Newfoundland and Labrador. • **The 65Plus Plan—**For medications purchased in the province only. • **The Select Needs Plan—** The program applies only to benefits obtained through the Health Sciences Centre Pharmacy of the Eastern Regional Health Authority; out-of-province claims are considered only if a patient is referred out of province for medical reasons and approval is obtained prior to leaving the province.	• When beneficiaries pay out of pocket, receipts may be submitted for reimbursement if eligible under the program. Receipts will be assessed using formulary-listed prices. Exception drugs will require approval and these may be backdated. • Claims older than one year will not be reimbursed. • Payment will not be made for any drug or supply receipt that is mailed from an address outside of 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 claims and acts accordingly. The vast majority of the claims are paid directly online to the pharmacist via electronic transactions. ESI Canada administers the Health Information and Claims Processing Services (HICPS) for pharmacy benefits covered by the NIHB Program.

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
Miscellaneous	**Prescription Quantities** • 100-day supply • 35-day supply for narcotics, controlled drugs and benzodiazepines or the limit as set for specific medications by the NBPDP Quantitative limits have been established for a number of products listed as benefits of the NBPDP	**Prescription Quantities** 100-day supply maximum, if prescribed Seniors Pharmacare Program beneficiaries travelling outside the province for more than 100 days will be allowed to obtain two prescriptions for the same medication before leaving Nova Scotia. Neither prescription shall exceed a 90-day supply (maximum 180-day supply for the two prescriptions). The usual copayment and professional fee will apply to each of the prescriptions There is a 28-day minimum supply for maintenance medications	**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 of 30 days for the first two prescriptions or refills) • Cystic Fibrosis Program: 60 days • Diabetes Control Program: 30 days—insulin, 100 blood glucose test strips; 90 days—oral medications; 30 days for drugs requiring special authorization (SA) (Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 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 SA coverage (Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first two prescriptions or refills) • Financial Assistance Program: 30 days—regular drugs;	**Prescription Quantities** • 90-day supply • 30-day supply for narcotics • Test strips: Beneficiaries who are not on insulin or oral hypoglycemic medications but are being followed by a diabetes nurse educator, a dietitian, a nurse practitioner or a family physician (with a letter to confirm same) can apply for special authorization consideration. If approved, a special authorization will be entered into the system, with a limit of 2,500 test strips per 365-day period	**Prescription Quantities** • The respective drug programs will not pay for more than a three-month supply. There must be an interval of 75 days before a further three-month supply can be given • 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 However, effective September 9, 2008, prescriptions for most chronic medications should be refilled no sooner than 28 days. NIHB will reduce the professional fee on most chronic medications that are dispensed less than 28 days apart. Only 1/28th of the dispensing fee will be paid through the program for chronic-use drugs, if claims are submitted daily

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	Health Canada—FNIHB
Miscellaneous (cont'd)			60 days—maintenance drugs; 30 days—drugs under SA coverage (Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 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 • Phenylketonuria 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 SA coverage (Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first two prescriptions or refills) • Smoke Program: 7 days—OTC drugs; 14 days—prescription drugs • Transplant and Tuberculosis Drug Program: 60 days			
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 and Social Services	For more information: Non-Insured Health Benefits

Back to Top

Generic Pricing Policy Summary

The following is a summary of the current generic drug-pricing policies, as well as any future changes known as of June 1, 2012. For implementation or specific drug product information, contact the individual drug program directly.

Province/Territory	Effective Date (Where Known)	Percentage of Brand	Generic Status	Sector
British Columbia		35	All generics	Applies to public sector
Alberta	July 2012	35	All generics	Applies to public and private plans
Saskatchewan		35	All generics listed in the Saskatchewan formulary	Applies to public and private sectors
Manitoba	—	No generic pricing policy currently in place		—
Ontario		25	All generics	Applies to public and private sectors
New Brunswick	June 2012	40	All interchangeable (typically generic) drugs	Applies to public and private sectors
	December 2012	35		
Nova Scotia	July 2012	35	All interchangeable generics	Applies to public and private sectors
Prince Edward Island	July 2012	35	All generics	Applies to public and private sectors
Newfoundland and Labrador	April 2012	45	All generics	Applies to public and private sectors
	October 2012	40		
	April 2013	35		
Yukon	—	No generic pricing policy currently in place; however, pharmacies order from Alberta or B.C. wholesalers and therefore receive the prices listed in those provinces		—

Glossary of Terms

Please note that some of the terms in this glossary may have alternate definitions. The stated definitions are meant only to reflect how these terms were used in the context of this report and are not necessarily the sole definitions of these terms.

Term/Acronym	Definition
age group	Age-specific requirements for beneficiaries to be eligible for coverage under a provincial, territorial or federal drug program
beneficiary group	Recipients of benefits under a specified provincial, territorial or federal plan/program
coordination of benefits	Coordination of benefits is a process whereby payments are coordinated through two or more drug plans (public/private, intra-jurisdictional). One plan is considered the primary insurer. The primary insurer is defined in the policies of the insurance plan/drug program. The portion of the drug cost not paid for by the primary insurer is claimed through the secondary insurer
copayment/co-insurance	The portion of the drug cost that the beneficiary must pay each time a drug is dispensed. This may be a fixed amount or a percentage of the total cost. When calculated as a percentage of the total cost, this is also known as co-insurance
deductible	The amount of total drug spending a beneficiary must pay in a defined time period before any part of his or her drug costs will be paid by the drug benefit plan/program. A deductible may be a fixed amount or a percentage of income (income-based deductible)
disease specific	Disease-specific requirements for beneficiaries to be eligible for coverage under a provincial, territorial or federal drug program
GIS	Federal Guaranteed Income Supplement
income range	Family or individual income-specific requirements for beneficiaries to be eligible for coverage under a specific provincial, territorial or federal drug program
ingredient pricing policy	A set of conditions related to the repayment of the ingredient cost portion of a prescription under a specific provincial, territorial or federal drug program
markup	An amount added to the cost price of a drug or ingredient, usually based on a percentage of the cost price
maximum beneficiary contribution	The maximum amount of drug spending a beneficiary is required to pay in a defined time period. Once the maximum contribution has been reached, the drug program will pay 100% of eligible drug costs for the remainder of the year or time period
plan/program	A provincial, territorial or federal program that provides coverage for drugs for a set population. Programs have defined rules for eligibility, payment, etc.
premium	The amount a beneficiary is required to pay to enroll in a provincial, territorial or federal drug plan/program
prescription cost components	The categories of costs that, when added together, make up the total cost of dispensing a prescription drug to a patient; usually includes the cost of the drug (or ingredients), a markup on the drug or ingredient cost and a professional fee
professional fees	The amount paid for the services provided by a service provider, such as a pharmacist; may also be referred to as a dispensing fee, compounding fee or any other special service fee

Term/Acronym	Definition
reimbursement policy	A set of conditions regarding the repayment to a beneficiary of the incurred prescription drug cost under a specific provincial, territorial or federal drug program
restricted benefit process	The steps by which prescribers request coverage for drug products where approval for coverage requires prior authorization by the specific provincial, territorial or federal drug program
sector	Refers to the source of funding for drug expenses. “Public sector” refers to drugs covered by government-funded drug programs, while “private sector” refers to private drug plans (that is, insurance and out-of-pocket or cash payment)

Production of this report is made possible by financial contributions from Health Canada and provincial and territorial governments.
The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

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

Phone: 613-241-7860
Fax: 613-241-8120
www.cihi.ca
copyright@cihi.ca

ISBN 978-1-77109-073-5 (PDF)

How to cite this document:
Canadian Institute for Health Information, *National Prescription Drug Utilization Information System Database—Plan Information Document, July 1, 2012* (Ottawa, Ont.: CIHI, 2012).

Cette publication est aussi disponible en français sous le titre *Base de données sur le Système national d'information sur l'utilisation des médicaments prescrits — document d'information sur les régimes, 1er juillet 2012*.
ISBN 978-1-77109-074-2 (PDF)

Talk to Us

CIHI Ottawa
495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6
Phone: 613-241-7860

CIHI Toronto
4110 Yonge Street, Suite 300
Toronto, Ontario M2P 2B7
Phone: 416-481-2002

CIHI Victoria
880 Douglas Street, Suite 600
Victoria, British Columbia V8W 2B7
Phone: 250-220-4100

CIHI Montréal
1010 Sherbrooke Street West, Suite 300
Montréal, Quebec H3A 2R7
Phone: 514-842-2226

CIHI St. John's
140 Water Street, Suite 701
St. John's, Newfoundland and Labrador A1C 6H6
Phone: 709-576-7006

www.cihi.ca
At the heart of data

Canadian Institute for Health Information

Institut canadien d'information sur la santé