National Prescription Drug Utilization Information System

Plan Information Document

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Introduction

This document provides contextual information regarding public federal/provincial/territorial drug benefit plans/programs across Canada.

Summary of major changes (January 2018 to December 2019)

Pan-Canadian Generic Price Initiative

Effective April 1, 2018: Nearly 70 of the most commonly prescribed drugs in Canada are priced at either 10% or 18% of the equivalent brand-name product:

- **10% oral solid:** amlodipine, atorvastatin, citalopram, clopidogrel, donepezil, ezetimibe, gabapentin, metformin, olanzapine, olanzapine ODT, omeprazole, pantoprazole, quetiapine, rabeprazole EC, ramipril, ranitidine, rosuvastatin, simvastatin, venlafaxine XR and zopiclone
- **18% oral solid:** alendronate, almotriptan, amiodarone, anastrozole, atenolol, atomoxetine, azithromycin, bicalutamide, bisoprolol, candesartan, candesartan HCTZ, carvedilol, celecoxib, ciprofloxacin, clonazepam, cyclobenzaprine, domperidone, dutasteride, eletriptan, escitalopram, famciclovir, finasteride, fluoxetine, imatinib, irbesartan, irbesartan HCTZ, lamotrigine, levetiracetam, memantine, minocycline, montelukast, mycophenolate, paroxetine, pramipexole, pravastatin, pregabalin, risedronate, risperidone, sertraline, solifenacin, sumatriptan DF, telmisartan, telmisartan HCTZ, terbinafine, topiramate, valacyclovir, valsartan and valsartan HCTZ

Information on all pan-Canadian selected molecules and their established price points can be found on the pCPA website.

British Columbia

Effective January 15, 2018: PharmaCare provides 100% coverage of the medical abortion drugs mifepristone and misoprostol (Mifegymiso) for all B.C. residents.

Effective July 3, 2018: The coverage of insulin pumps — previously with an age restriction of age 25 and younger — is expanded to include all individuals living with diabetes, regardless of age.

Effective January 1, 2019: Families with net annual incomes between $15,000 and $30,000 are no longer required to pay a deductible. Copayments have been eliminated for families covered under enhanced assistance with a net income up to $14,000 and for regular assistance families with a net income up to $13,750. The maximum copayment contribution has also been lowered for regular assistance families with net incomes up to $45,000.

Effective April 1, 2019: The Maximum Accepted List Price (MALP) of the brand-name drug price for oral solids increases from 20% to 25%.

Effective May 27, 2019: The Biosimilar Initiative, which is to expand the use of biosimilar drugs, is implemented. This initiative is to switch patients who use the affected biologic drugs to biosimilar versions by November 25, 2019.

Alberta

Effective May 17, 2018: A new pharmacy funding framework comes into effect. Changes include a lowered dispensing fee; limitations on reimbursement for daily and frequent dispensing; the elimination of tiered fees for Comprehensive Annual Care Plans and Standard Medication Management Assessments and a cap on the number of follow-up assessments; the introduction of a new assessment to provide continuity of care in the event of an emergency; and the reduction of the fee for administering a publicly funded vaccine.

Effective October 1, 2018: Alberta launches the Alberta HIV PrEP Program, which provides the generic versions of tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) for HIV pre-exposure prophylaxis (PrEP) medication for all eligible Albertans at high and ongoing risk of HIV infection. Medications are covered at no cost, for a maximum 100-day supply, when prescribed by a designated prescriber.

Effective April 1, 2019: The Holdback Policy is implemented — a new concept to share the risk associated with ensuring that Alberta Health meets its projected budget for Pharmacy Compensation Expenditures related to the payment of dispensing fees, upcharges and pharmacy services/public health in 2019–2020.

Saskatchewan

Effective April 11, 2018: The deductible and copay have been waived for drugs used to treat HIV.

Effective July 1, 2018: The Saskatchewan Rental Housing Supplement (SRHS) — previously 1 of 3 methods used to determine eligibility for the Family Health Benefits drug plan — suspends intake of new applications. Current SRHS clients will continue to receive benefits as long as they remain eligible, but applications received on or after July 1, 2018, are not accepted.

Effective November 1, 2018: Prescription dispensing fees increase from $11.40 to $11.60.

Manitoba

Effective April 1, 2018: The deductible rate increases from between 3.05% and 6.90% for 2017–2018 to between 3.09% and 6.98% for 2018–2019.

Effective August 15, 2018: The Tiered Biologics Reimbursement Policy is implemented. This policy will apply only to new patients (biologic naive) and existing patients who have previously been trialled and deemed unresponsive to biologic therapy.

Effective April 1, 2019: The deductible rate increases from between 3.09% and 6.98% for 2018–2019 to between 3.17% and 7.15% for 2019–2020.

Ontario

Effective January 1, 2018: Ontario implements a new eligibility stream (OHIP+) extending the Ontario Drug Benefit (ODB) Program to cover OHIP-insured children and youth age 24 and younger.

Effective February 9, 2018: The Palliative Care Facilitated Access Drug Products mechanism is expanded to include certain nurse practitioners who are authorized to prescribe controlled drugs and substances.

Effective August 1, 2018: The 35-day supply limit for Ontario Works recipients eligible for ODB Program benefits is removed. In most cases, persons who are eligible for the ODB Program could receive up to a 100-day supply of medication, regardless of eligibility stream.

Effective April 1, 2019: OHIP+ coverage for individuals age 24 and younger has changed to cover only those who do not have a private plan.

Quebec

No major public drug benefit plan/program changes were identified in 2018 and 2019.

New Brunswick

No major public drug benefit plan/program changes were identified in 2018 and 2019.

Nova Scotia

Effective February 14, 2018: The Take-Home Cancer Drug Fund is launched to help patients who face high costs for take-home cancer drugs. The program is retroactive for patients who took take-home cancer drugs after April 1, 2017.

Effective April 1, 2018: Dispensing fees increase from $11.85 to $11.95 for ostomy supplies, from $17.77 to $17.92 for compounded extemporaneous products (excluding methadone and injectables) and from $11.85 to $11.95 for all other prescriptions (including methadone).

Effective April 1, 2019: Dispensing fees increase from $11.95 to $12.10 for ostomy supplies, from $17.92 to $18.15 for compounded extemporaneous products (excluding methadone and injectables) and from $11.95 to $12.10 for all other prescriptions (including methadone).

Prince Edward Island

Effective January 1, 2019: A new Ostomy Supplies Program is introduced to provide financial assistance for those living with a permanent ostomy. Coverage will range from 60% to 90% of eligible expenses, dependent on income.

Newfoundland and Labrador

Effective September 1, 2018: Mifegymiso, the medication used for medical abortion, is made available at no cost to eligible individuals.

Yukon

Effective October 31, 2018: Mifegymiso, the medication used for medical abortions, is made available at no cost to eligible individuals.

Indigenous Services Canada

Effective March 1, 2018: Coverage of unregistered infants is extended up to 18 months of age in order to allow parents time to register their infant children.

Effective April 9, 2018: A maximum 30-day dispensing policy is implemented for stimulants with a dose limit of 100 mg methylphenidate equivalents (MEQ) per day, previously 150 mg MEQ per day.

Effective May 14, 2018: The eligible quantity of nicotine patches increases to 252 patches of any listed brand within a 12-month period.

Effective August 1, 2018: Maximum compensation for the dispensation of methadone for the treatment of opioid use disorder increases from (dispensing fee ÷ 7) plus $5.17 to $5.25.

Effective October 9, 2018: The quantity limit for lancets is changed to depend on a client's diabetes medications in order to better align reimbursements with those for blood glucose test strips.

Plan/program information by jurisdiction and category

British Columbia

Eligibility

Plans/programs

- Fair PharmaCare (Plan I)
- Residential Care (Plan B)
- Income Assistance (Plan C)
- Cystic Fibrosis (Plan D)
- Children in the At Home Program (Plan F)
- Psychiatric Medications (Plan G)
- Medication Management (Plan M)*
- Palliative Care (Plan P)
- HIV/AIDS (Plan X)*
- Nicotine Replacement Therapies (Plan S)
- First Nations Health Benefits (Plan W)*

Note
* Data is currently not submitted to NPDUIS.

General beneficiary information

For any plan, beneficiaries must be residents of British Columbia. For plans I, D, F, G, P, S and W, beneficiaries must have Medical Services Plan (MSP) coverage.

Fair PharmaCare: Regular assistance: residents born in 1940 or later; enhanced assistance: residents born in 1939 or earlier.

Residential Care: Permanent residents of licensed residential care facilities that are on the list of approved Plan B facilities.

Income Assistance: Recipients of B.C. income assistance and medical benefits through the Ministry of Social Development and Poverty Reduction.

Cystic Fibrosis: Individuals with cystic fibrosis who are registered with a provincial cystic fibrosis clinic.

Children in the At Home Program: Non-institutionalized severely handicapped children, age 18 and younger, who would otherwise become reliant on institutional care.

Psychiatric Medications: Individuals who have demonstrated clinical and financial need for certain psychiatric drugs as determined by their physician or nurse practitioner.

Medication Management: Individuals who require eligible medication management services (e.g., clinical services, medication review services, 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. “Home” is defined as wherever individuals are living, whether in their own home, with family or friends, in a supportive-/assisted-living residence or in a hospice unit at a residential care facility.

HIV/AIDS: Individuals with documented HIV infection who meet the British Columbia Centre for Excellence in HIV/AIDS’ clinical criteria for treatment.

Nicotine Replacement Therapies: B.C. residents who wish to stop smoking and are registered for Fair PharmaCare, Plan B, Plan C or Plan G are eligible for coverage of specific smoking cessation prescription drugs. Nicotine replacement therapy (NRT) products are fully covered for all B.C. residents. Both the patient and pharmacist must sign a declaration form.

First Nations Health Benefits: Recipients must be a registered Indian under the *Indian Act* or a child younger than 1 year who has at least one parent who is a registered Indian under the act. This program covers 100% of eligible benefits for clients who were previously covered by Health Canada’s Non‑Insured Health Benefits program under the First Nations Health Authority (FNHA).

Other eligibility criteria

Fair PharmaCare: An individual must have effective British Columbia MSP coverage, have a social insurance number and have filed an income tax return for the relevant taxation year (2 years ago). Coverage is based on income. Families with lower net incomes receive more coverage than families with higher net incomes.

Residential Care: Recipients must be permanent residents of a licensed residential care facility that is registered as a Plan B facility.

Income Assistance: Recipients must be receiving medical benefits and income or disability assistance through the Ministry of Social Development and Poverty Reduction or be certain persons defined in the *Child, Family and Community Services Act* (per the Drug Plans Regulation under the *Pharmaceutical Services Act*).

Children in the At Home Program: Recipients must be age 18 or younger, residents of B.C., living at home with a parent or guardian and assessed as dependent in at least 3 of 4 areas of daily living.

Psychiatric Medications: Patients must be prescribed a psychiatric drug that is a benefit under the plan, must qualify for premium assistance under the MSP, and must declare that they lack other insurance and that cost is a barrier to obtaining the drug. Prescribers must certify that without the drug, patients will be hospitalized or suffer serious harm.

Palliative Care: Recipients must be diagnosed as having an illness or condition that will likely result in death within 6 months. Recipients wish to receive palliative care at home and consent to the focus of care being palliative rather than treatment aimed at a cure. The medical or nurse practitioner submits an application, certifying that the individual meets the above criteria. Persons enrolled in the Residential Care plan are not eligible for the Palliative Care plan.

First Nations Health Benefits: Eligibility is determined by the FNHA. Recipients must have active MSP coverage and must not be eligible for comprehensive drug coverage through a treaty and land claims agreement under the *Constitution Act, 1982* or a written arrangement between a First Nations organization and the federal or a provincial government of Canada.

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

Fair PharmaCare: After annual deductible has been met, 30% of the eligible prescription drug costs up to the annual maximum. No copayment for families with a net income up to $13,750.

Fair PharmaCare enhanced assistance: After annual deductible has been met, 25% of the eligible prescription drug costs up to the annual maximum. No copayment for families with a net income up to $14,000.

Full Payment (no copayment) Policy: If a patient is receiving full PharmaCare coverage and the drug/product being claimed is eligible for full PharmaCare reimbursement, 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, W and P and those who have reached the Fair PharmaCare family maximum.

Deductible

Fair PharmaCare regular assistance

Net family income	Approximate deductible in 2019 (as a percentage of net income)
<$30,000	0%
>$30,000	2–3%

Fair PharmaCare enhanced assistance

Net family income	Approximate deductible in 2019 (as a percentage of net income)
<$33,000	0%
$33,000–$50,000	1%
>$50,000	2%

For a family registered for Fair PharmaCare whose income cannot be verified or for a person actively enrolled in the MSP but not registered for Fair PharmaCare, the deductible is $10,000.

Maximum beneficiary contribution

Fair PharmaCare regular assistance

Net family income	Approximate maximum in 2019 (as a percentage of net income)
<$13,750	0%
$13,750–$30,000	1–2%
$30,000–$40,000	3%
>$40,000	4%

Fair PharmaCare enhanced assistance

Net family income	Approximate maximum in 2019 (as a percentage of net income)
<$14,000	0%
$14,000–$33,000	1%
$33,000–$50,000	2%
>$50,000	3%

Policy information

Ingredient price

Maximum Pricing: Drugs are reimbursed to a maximum price based on the manufacturer's list price, plus 8% (5% or less for drugs subject to the High-Cost Drugs Policy; 2% for oral hepatitis C medications).

Low-Cost Alternative (LCA) Program: LCA prices are set at the maximum accepted list price for generic drugs in an LCA category, plus 8% (5% or less for drugs subject to the High-Cost Drugs Policy). When the same drug is made and sold by 2 or more manufacturers, PharmaCare covers the less-expensive version — the low-cost alternative.

Reference Drug Program (RDP): Reimbursement for certain drugs in designated therapeutic categories is limited to a maximum daily amount payable. The reference drug is fully covered. Other drugs within the category are only partially covered, up to a maximum daily cost based on the cost of the reference drug. The RDP applies to the following classes of drugs: H2 blockers, nitrates, ACE (angiotensin converting enzyme) inhibitors, dihydropyridine calcium channel blockers, nonsteroidal anti-inflammatory drugs, angiotensin receptor blockers, proton pump inhibitors and statins. If an RDP drug is also an LCA drug, the reimbursement limit for drugs in that RDP category is the lower of the RDP or LCA price.

Retail price: Certain products (such as insulin, insulin needles and syringes, insulin pump supplies and ostomy supplies) are reimbursed at the regular retail price with no dispensing fee.

Actual acquisition cost (AAC): Certain products (such as blood glucose test strips and cystic fibrosis vitamin and nutritional supplements) are reimbursed at their AAC, not to exceed the manufacturer's list price plus a 7% markup.

Biosimilar Initiative: As of November 26, 2019, PharmaCare covers only the biosimilar versions of the selected originator drugs for the affected indications. During the transition period from May 27 to November 25, 2019, both originator and biosimilar versions of the affected drugs are covered by PharmaCare.

Generic pricing policy (percentage of brand-name drug)

Effective April 1, 2019, generic drugs are priced as follows:

- 25% of the equivalent brand-name product's list price for oral solids
- 35% of the equivalent brand-name product's list price for drugs available in other forms
- 18% or 10% of the equivalent brand-name product's list price for drugs subject to pan-Canadian pricing

Professional fees: Product-related fees/services

Dispensing fee: $10 maximum.

Trial Prescription Program: $10 maximum. The pharmacy can claim a second dispensing fee for filling the balance of the prescription, once it has been established that the patient can tolerate the medication (following a 14-day trial period).

Methadone Maintenance Program: Effective February 1, 2014, pharmacists are reimbursed for methadone for maintenance at a maximum of $0.162/mL, plus the usual dispensing fee, plus an interaction fee of $7.70 for each dispensation involving direct interaction with the patient.

Frequency of Dispensing Policy: Methadone dispensed under the Methadone Maintenance Payment Program is subject to a maximum of 1 dispensing fee and 1 interaction fee per patient per day (in cases where the interaction fee is applicable), regardless of physician administration instructions on the prescription.

For drugs that are dispensed daily, PharmaCare covers 1 dispensing fee per drug per day, up to a maximum of 3 dispensing fees. For 2- to 27-day supplies, PharmaCare covers 1 dispensing fee per drug per day, up to a maximum of 5 dispensing fees.

Capitation rate: Pharmacies providing services to long-term care facilities receive $43.75 per month per bed serviced.

Rural Incentive Program: A per-claim subsidy (from $3.00 to $10.50) is provided to rural pharmacies that have applied for the program where the pharmacy is the only pharmacy in the community, where the next-nearest pharmacy is at least 25 km away and where the number of PharmaCare claims submitted by the pharmacy does not exceed 1,700 per month.

Vaccination administration: $10 is paid for each publicly funded vaccination provided to eligible B.C. residents, provided that it is administered by injection by an authorized pharmacist.

Smoking cessation: $10 per dispensing of nicotine replacement therapy (maximum 3 annually).

Refusal to fill (special services fee): Up to twice the maximum dispensing fee ($10 per service).

Compounded prescriptions: Flat fee maximum per type of compound:

- Oral solutions: $20
- Oral suspensions: $20
- Capsules: $0.30 per capsule
- Suppositories: $40 (may be pro-rated during special authority adjudication)
- Oral lozenges: $40 (may be pro-rated during special authority adjudication)
- CADD (continuous ambulatory delivery device) injections: $20
- Sterile intravenous (IV), intramuscular (IM) and subcutaneous (SC) injections: $20
- Intrathecal injections: $40
- Creams/ointments/lotions less than or equal to 250 g/mL: $15
- Creams/ointments/lotions greater than or equal to 251 g/mL: $20
- Sterile eye drops, preservative-free: $30

No dispensing fee is paid for products reimbursed at retail cost (such as insulin and insulin pump supplies).

Professional fees: Clinical services

Clinical pharmacy services fees

- Prescription renewal: $10
- Prescription change: $10
- Therapeutic substitution: $17.20
- Maximum 2 clinical services fees per drug, per person during a 6-month period

PharmaCare pays a pharmacy a clinical services fee when a pharmacist renews or adapts a prescription for a B.C. resident. There is no charge to B.C. residents for these services.

Medication review services

- Standard: $60 (maximum 2 annually, at least 6 months apart)
- Pharmacist consultation: $70 (maximum 2 annually, at least 6 months apart)
- Follow-up: $15 (maximum 4 annually)
- 1 standard or 1 pharmacist consultation fee per 6 months
- Recipients who have at least 5 different qualifying medications that have been entered into PharmaNet within the last 6 months and have a clinical need for service
- Only 1 fee can be claimed for each service appointment

The maximum reimbursement for a combination of medication review services, clinical services or administration of vaccines for the same patient, on the same day, from the same pharmacy is $70.

Pharmacy markup

- Most drugs maximum: 8%
- Most high-cost drugs[i] maximum: 5%
- Products subject to AAC pricing maximum: 7%

Effective March 1, 2017, the maximum markup on certain hepatitis C drugs covered by PharmaCare was reduced from 5% to 2%.

Coordination of benefits (public/private)

PharmaCare does not provide coverage for B.C. residents who are covered under other acts or programs as listed in Part 2, Section 6 of the Drug Plans Regulation 73/2015. These include Veterans Affairs Canada, Canadian Forces, Workers' Compensation and the Federal Non-Insured Health Benefits Program.

PharmaCare is considered the first payer and private insurance is the second payer.

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.

Reimbursement policy

PharmaCare will reimburse a provider any amounts payable not more than 30 days after the adjudication of a claim submitted on behalf of a beneficiary.

The province does not reimburse for most out-of-province claims.

i. 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).

Miscellaneous

Prescription quantities: PharmaCare limits coverage of all prescription drugs to a maximum 30-day supply (for short-term prescriptions and for first-time prescriptions for longer-term maintenance drugs) or a 100-day supply (when refilling a prescription for a drug intended for longer-term use).

Exemptions to the 30-day supply limit are available for Plan B patients, consumers in rural or remote areas and prescriptions under the Trial Prescription Program (where a 14-day trial has been dispensed).

Quantity limits for blood glucose test strips: Annual limits will depend on the beneficiary's diabetes treatment category:

- Insulin dependent: 3,000 strips per year
- Managed with medications that have a high risk of causing hypoglycemia: 400 strips per year
- Managed with medications that have a low risk of causing hypoglycemia: 200 strips per year
- Managed through diet/lifestyle: 200 strips per year

Insulin pumps and insulin pump supplies: Effective July 3, 2018, insulin pumps and insulin pump supplies are covered for individuals living with diabetes, regardless of age.

- PharmaCare provides 100% coverage for the Omnipod Insulin Management System, regardless of the PharmaCare plan.
- If the Omnipod system is clinically unsuitable for the patient, the following exceptional coverage may be granted for a MiniMed Insulin Pump System:
  - 100% of the cost under Plan C, Plan F or Plan W; and
  - 70% of costs above the deductible and 100% of costs above the family maximum under the Fair PharmaCare plan.

Travel supply: PharmaCare covers out-of-province travel supplies of medication up to the PharmaCare maximum allowable days' supply. Once every 6 months (180 days), a patient can ask for an out-of-province travel supply. Patients are required to sign a PharmaCare travel declaration form and the pharmacy is required to retain this form on file for the normal record retention periods specified by the College of Pharmacists of British Columbia.

Smoking cessation: Eligible B.C. residents who wish to stop smoking or using other tobacco products can be covered for **1** of 2 treatment options. Each calendar year, individuals can receive up to 12 continuous weeks or 84 days in a row of coverage for **either** 1 prescription smoking cessation drug — bupropion or varenicline (available to individuals registered with Fair PharmaCare, Plan B, Plan C, Plan G or Plan W only) — **or** non-prescription nicotine replacement therapy (NRT) products — gum, lozenges, inhalers and patches (available to all B.C. residents, without a prescription or being registered with PharmaCare).

Source: For more information, visit British Columbia PharmaCare.

Alberta

Eligibility

Plans/programs

- Seniors (Plan 66)
- Palliative (Plan P)
- Non-Group (Plan I)
- Rare Diseases Drug Program*
- Outpatient Cancer Drug Benefit Program*
- Specialized High Cost Drug Program*
- Disease Control and Prevention*
- Diabetic Supply Coverage*
- Insulin Pump Therapy Program*
- Low-income health benefits programs*
- Retina Anti-Vascular Endothelial Growth Factor Program for Intraocular Disease (RAPID)*
- Women's Choice Program*
- Alberta HIV PrEP Program*

Note
* Data is currently not submitted to NPDUIS.

General beneficiary information

Seniors: Residents age 65 and older and eligible dependents

Palliative: Palliative residents treated at home or in a hospice where access to publicly funded drugs is not included

Non-Group: Residents younger than 65 and eligible dependents

Rare Diseases Drug Program: Residents who meet the clinical criteria for a rare disease drug product published on the list and who must not have an additional significant illness (i.e., not including the rare disease) likely to affect life expectancy

Outpatient Cancer Drug Benefit Program: Residents who require selected medications used in the direct treatment of cancer

Specialized High Cost Drug Program: Residents who require drugs used in highly specialized procedures and treatments, such as transplant, HIV, cystic fibrosis, human growth hormone, primary pulmonary hypertension and age-related macular degeneration

Disease Control and Prevention: Residents who require prescription drugs for the treatment of tuberculosis and sexually transmitted diseases

Diabetic Supply Coverage: Residents who use insulin to treat diabetes

Insulin Pump Therapy Program: Residents who are diagnosed with type 1 diabetes and under the care of a physician or nurse practitioner for the condition

Low-income health benefits programs

- **Income Support:** Residents who do not have the resources to meet their basic needs
- **Alberta Adult Health Benefit:** Residents with low income
- **Assured Income for the Severely Handicapped:** Residents age 18 to 64 who have a permanent disability that severely affects their ability to earn a livelihood
- **Alberta Child Health Benefit:** Children of low-income families

RAPID: Covers 3 drugs to treat patients with certain eye conditions

Women's Choice Program: Women residing in Alberta who are registered with the Alberta Health Care Insurance Plan (AHCIP), have a valid Personal Health Number and have a valid prescription for Mifegymiso

Alberta HIV PrEP Program: Albertans who are registered with AHCIP and have a valid Personal Health Number, with a high and ongoing risk of HIV infection, who meet eligibility criteria and have a valid prescription from a designated prescriber

Other eligibility criteria

Seniors: In order to be registered, seniors must complete a proof-of-age declaration, which Alberta Health mails to them; registration with AHCIP is required.

Palliative: A person must be registered with AHCIP and diagnosed by a physician as being palliative and receiving treatments at home or in a hospice where access to publicly funded drugs is not included.

Non-Group: A person must be registered with AHCIP, be younger than age 65 and not be in premium arrears for the plan.

Rare Diseases Drug Program: Residents must have government-sponsored drug coverage and

- Have been continuously registered in the AHCIP for at least 5 continuous years; or
- If younger than age 5, parents/guardians have been registered in the AHCIP for at least 5 continuous years; or
- Have moved from another province in Canada where they were covered by that province's program for these drugs.

Outpatient Cancer Drug Benefit Program: A person must be a resident of Alberta, registered with AHCIP, registered in the Cancer Registry and require drugs to treat cancer.

Specialized High Cost Drug Program: A person must be a resident of Alberta, registered with AHCIP and require a high-cost drug to treat an eligible medical condition specified in the program.

Diabetic Supply Coverage: A person must be treated with insulin for diabetes and be registered with one of Alberta's supplementary health benefit plans.

Cost-sharing mechanism

Premium

Non-Group

- Single: $63.50/month
- Family: $118.00/month

Subsidized rates are available for lower-income Albertans based on the combined taxable income of the registrant and his or her spouse/partner (if applicable), as follows:

- Single: income less than $20,970: $44.45/month
- Family (no children): income less than $33,240: $82.60/month
- Family (with children): income less than $39,250: $82.60/month

Copayment/co-insurance

Seniors, Palliative and Non-Group drug plans: 30% copayment per prescription, to a maximum $25. Possible exceptions to this maximum include if the drug is not listed on the Alberta Drug Benefit List; if a more expensive brand of drug than the least-cost alternative or generic product is requested; or if the brand of drug requested costs more than the maximum cost set by Alberta Health for that drug.

Deductible

None

Maximum beneficiary contribution

Palliative: The lifetime maximum amount paid out of pocket by eligible Albertans enrolled in the program is $1,000.

Policy information

Ingredient price

Least-cost alternative (LCA) price: The lowest unit cost established for a drug product within a set of interchangeable drug products. Beneficiaries who choose higher-cost alternatives are responsible for paying the difference in price.

Maximum allowable cost (MAC) price: The maximum unit cost Alberta's supplementary health plans will pay for a specific drug product within a grouping of interchangeable groups subject to MAC pricing. A small number of products are subject to MAC pricing.

Manufacturer's list price (MLP): The maximum unit cost established for a drug product within a specific grouping of drugs used to treat a common condition. Beneficiaries who choose higher-cost alternatives are responsible for paying the difference in price.

Base price: The price per unit of a drug, a drug product or a product. This is published by Alberta Blue Cross and listed in the Alberta Blue Cross Drug Price List. The base price applies to drugs not listed on the Alberta Drug Benefit List (ADBL).

Fixed pricing rules: Applies to any drug product, other than a brand-name drug, that is listed or is under consideration for listing on the ADBL.

- Fixed-price drug products listed or under consideration for listing that are not subject to the pan-Canadian Select Molecule Price Initiative must be priced less than or equal to the LCA price of the most recently published ADBL, the price established through the pan-Canadian Generic Initiative or the price published in the February ADBL, whichever is lower.
- Fixed-price drug products subject to the pan-Canadian Select Molecule Price Initiative must be priced equal to the price established by the pan-Canadian Select Molecule Price Initiative.

Non-fixed pricing rules: The confirmed price for a brand-name drug or other drug must be the lowest of

- The price less than or equal to the previous price of that drug product listed on the February ADBL; or
- The previous price of the drug product listed on the February ADBL, plus an increase that is less than or equal to the current Patented Medicine Prices Review Board Guidelines, which will be used to determine acceptable price increases, up to a maximum of 5%.

Transitional Period Price Policy: The minister may establish a transitional period of up to 30 days to provide for a temporary benefit or payment for a drug product under defined circumstances, which may include but are not limited to

- The listing of a new interchangeable drug that results in the establishment of a new interchangeable grouping; or
- The discontinuation or removal of a drug product from the ADBL.

Generic pricing policy (percentage of brand-name drug)

Effective April 2010, generic drugs are reduced to 56% of the brand-name price for existing drugs covered on the ADBL and to 45% for new generic drugs.

Effective July 1, 2012, generic drugs are further reduced to 35% of the brand-name price for both existing and new generic drugs.

Effective May 1, 2013, the pCPA Generics Initiative reduced the price of 6 of the most commonly prescribed medications to 18% of the brand-name price.

Effective April 1, 2014, generic drugs are priced at the lowest available price for existing generics, with tiered pricing for new generics:

- 70% for 1 generic
- 50% for 2 generics
- 25% for 3 generics
- 18% for 4 or more generics

Effective April 1, 2015, present generic drugs are priced based on the pan-Canadian Tiered Pricing Framework, with the tiers set as follows:

- Tier 1: Priced at 75% of brand-name drug price if product-listing agreement (PLA) or pricing agreement for brand-name drug exists in any jurisdiction; if there is no PLA or pricing agreement, priced at 85% of brand-name drug price
- Tier 2: 50%
- Tier 3: 25% oral solid, 35% all dosage forms other than oral solids (liquids, patches, injectable, inhalers, etc.)

Professional fees: Product-related fees/services

Dispensing fee: Effective May 17, 2018, a dispensing fee of $12.15 is allowed for each prescription, except for compounded prescriptions prepared in store, diabetic supplies or nutritional products.

Dispensing fees for daily medication dispensing are limited to 3 fees per day per patient. Dispensing fees for recurrent medication dispensing between 2 and 27 days are limited to 2 fees per medication per 28-day period per patient.

Exemptions to these rules exist for opioid dependence treatments, acute/short-term dispensing and drugs under the Women’s Choice Program, Naloxone Program and Alberta Public Health Activities Program.

Compounding fee: Effective May 17, 2018, for compound prescriptions prepared in a pharmacy, the cost of the prescription is the aggregate cost of all the ingredients plus an upcharge of 7.5%, plus a dispensing fee of $18.45. For compound prescriptions purchased from a compounding and repackaging pharmacy, the cost is the purchased compound price, plus an allowable upcharge (7% to a maximum of $100 as of May 17, 2018), plus a dispensing fee of $12.15.

Medication assessment fees

- Trial prescription: $20
- Therapeutic substitutions: $20
- Refusal to fill: $20
- Administration of injected medication: $20
- Prescription adaptation: $20
- Prescription renewal: $20
- Medication-related emergency: $20
- Initiation of medication therapy: $25
- Continuity of care during declared state of emergency: $20

Vaccine administration: $13, includes pneumococcal and diphtheria–tetanus–acellular pertussis (dTaP) vaccines, effective January 1, 2019

Professional fees: Clinical services

Comprehensive Annual Care Plans (CACPs)

- Patient has to have “complex needs.”
- Patient has to have 2 or more chronic conditions from Group A or 1 condition from Group A and 1 or more risk factors from Group B.
- Follow-up: Based on the pharmacist’s professional assessment, patient is within 14 days of hospital admission or discharge or there is a referral from a physician. Follow-up can be claimed by another pharmacist/pharmacy that did not complete the assessment if pharmacist has a copy of the CACP.

Group A (chronic disease): hypertensive disease, diabetes, chronic obstructive pulmonary disease (COPD), asthma, heart failure, ischemic heart disease and chronic renal failure

Group B (risk factors): mental health disorders, tobacco, obesity and addictions

CACP fees

Effective May 17, 2018,

- $100/medication review once per 365 days and $20/follow-up for an assessment by any pharmacist (no additional fee for clinical pharmacists with additional prescribing authorization)
- The number of CACP follow-ups is capped at 12 follow-ups annually per patient

Standard Medication Management Assessment (SMMA): Patients who do not meet the CACP criteria. Patients must have a chronic disease and be taking 3 or more of any Schedule 1 drug; have a chronic disease that is diabetes mellitus and currently taking at least one Schedule 1 drug or insulin; or use a tobacco product daily and be willing to receive tobacco cessation services. Medication review can be done once per year. Follow-ups can be to update the SMMA and Best Possible Medication History if substantiated by a referral from a physician, a hospital admission or discharge within 14 calendar days, or a pharmacist's documented decision.

SMMA fees

Effective May 17, 2018,

- $60/medication review once per 365 days and $20/follow-up for an assessment by any clinical pharmacist (no additional fee for clinical pharmacists with additional prescribing authorization)
- The number of SMMA follow-ups will be capped at 12 follow-ups annually per patient

Continuity of care: As of May 17, 2018, a fee of $20 may be charged for an assessment to ensure continuity of care in the event of a declaration of a state of emergency.

Pharmacy markup

Effective up to March 31, 2020

Allowable upcharge	2014	2015	2016	2017	2018	2019
#1	3%	3%	3%	3%	3%	3%
#2*	5.5%	6%	6.5%	7%	7%	7%

Note
* Upcharge #2 to a maximum of $100.

Coordination of benefits (public/private)

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.

Restricted/exception drug coverage process

Prior approval must be granted by Alberta Blue Cross to ensure coverage by special authorization. For those special authorization requests that are approved, the effective date for authorization is the beginning of the month in which the physician's request is received by Alberta Blue Cross.

Special authorization is granted for a defined period, as indicated in each applicable special authorization drug product's criteria (the approval period). If continued treatment is necessary beyond the approval period, it is the responsibility of the patient and physician to reapply for coverage prior to the expiration date of the approval period, unless the Auto-Renewal Process or Step Therapy Approval Process applies.

For a drug to be approved for special authorization, the drug must be covered by Alberta Health under specified criteria and must be required because other drug products listed in the ADBL are contraindicated or inappropriate because of the clinical condition of the patient.

Reimbursement policy

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 ADBL at the time of service. Claims must be received within 12 months of the service date.

Miscellaneous

Prescription quantities: Seniors, Non-Group and Palliative programs: There is 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
- Oral contraceptives
- Antihypertensive agents
- Conjugated estrogens
- Anti-arthritics

Diabetic Supply Coverage: Up to $600 per year available for diabetic supplies, including blood glucose test strips, urine test strips, lancets, syringes and needles.

RAPID: On October 1, 2015, Alberta Health launched the RAPID pilot project in partnership with the Retina Society of Alberta. RAPID allows patients with certain eye conditions to be treated with Avastin or Lucentis to prevent vision loss. Effective August 1, 2017, another drug, Eylea, was added to RAPID.

Alberta HIV PrEP Program: Effective October 1, 2018, the generic versions of tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) for HIV pre-exposure prophylaxis (PrEP) will be covered at no cost for all eligible Albertans at high and ongoing risk of HIV infection when prescribed by a designated prescriber. A designated prescriber is a physician or other prescribing health care provider with the knowledge to assess an individual's medical need and readiness for pre-exposure prophylaxis as part of an individualized comprehensive HIV prevention plan and who is named on the Alberta Health Services Designated PrEP Prescriber List.

Source: For more information, visit Alberta Health.

Saskatchewan

Eligibility

Plans/programs

- Family Health Benefits
- Income Supplements
- Seniors' Drug Plan
- Special Support Program
- Palliative Care Program
- Emergency Assistance for Prescription Drugs
- Saskatchewan Aids to Independent Living (SAIL)
- Supplementary Health Benefits
- Children's Drug Program
- Saskatchewan Insulin Pump Program

General beneficiary information

Family Health Benefits: Low-income working families with at least one child younger than 18 living with parents or guardians. Eligible families must meet the standards of an income test administered by the Canada Revenue Agency or be receiving benefits from the Ministry of Social Services' Saskatchewan Employment Supplement or the Saskatchewan Rental Housing Supplement (SRHS). (Note: Effective July 1, 2018, the SRHS suspended intake of new applications; however, current SRHS clients will continue to receive benefits as long as they remain eligible.)

Number of children younger than 18	Previous year's family net income as reported to Canada Revenue Agency
1–3	<$29,291
4–10	Add $1,391 per additional child
11–15	Up to $51,314

Income Supplements: Residents qualifying for the federal Guaranteed Income Supplement (GIS) and the Saskatchewan Seniors' Income Plan (SIP).

Seniors' Drug Plan: Residents age 65 and older who have applied and qualified based on income.

Special Support Program: Residents who have high drug costs in relation to their income and who have qualified based on income. The program is available to those whose annual covered prescription drug costs exceed 3.4% of their annual adjusted income. The drug plan adjusts family income by deducting $3,500 for each dependent child younger than age 18.

Palliative Care Program: Residents who are in the late stages of a terminal illness with a life expectancy measured in months, who have no appropriate treatment options to cure the illness or prolong life and who require care to maintain quality of life.

Emergency Assistance for Prescription Drugs: 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 individual may obtain up to 1 month's supply of covered drug products and 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): Residents with specific disabling conditions, physical disabilities and chronic health conditions may be eligible for benefits under the various universal and special benefit programs (e.g., Paraplegia Program, Cystic Fibrosis Program, Chronic End-Stage Renal Disease Program, Ostomy Program, Haemophilia Program, Aids to the Blind, Saskatchewan Insulin Pump Program). A resident must be referred for the service by an authorized health care professional. Unless preauthorized by Saskatchewan Health, the service must be obtained in Saskatchewan and the person must not be eligible to receive the service from any other government agency.

Supplementary Health Benefits: Residents who are government wards, inmates of provincial correctional institutions, Seniors' Income Plan beneficiaries who reside in care facilities and persons enrolled in certain income-support programs. Beneficiaries are eligible for coverage of a range of health services, including hearing, dental, optical, podiatry and road ambulance services, as well as certain medical supplies and full- or reduced-cost prescription drug coverage.

Children's Drug Program: Residents age 14 and younger are automatically eligible for coverage.

Other eligibility criteria

Residents whose health services are covered under First Nations and Inuit Health, Health Canada, Veterans Affairs Canada, Canadian Forces, Workers' Compensation or federal penitentiaries are not eligible for drug plan benefits under Saskatchewan Health.

Residents may qualify for and be covered under more than one program at the same time. The better benefit applies at the time a prescription is filled.

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

Special Support Program: The copayment is determined by the amount that the family's drug costs exceed 3.4% of its adjusted combined family income; the family pays a portion of each prescription to reduce its share of drug costs and spread the cost over the 6-month benefit period

Seniors' Drug Plan: Eligible seniors pay a maximum of $25 per benefit prescription; no charge for seniors who have SAIL or Palliative Care coverage

SIP supplement or GIS recipients: After deductible is met, 35% copayment; may apply for income-tested coverage

Family Health Benefits: After deductible is met, 35% copayment; however, no copayment on benefits for children younger than age 18

Supplementary Health Benefits

- Younger than 18: none
- Plan One: maximum $2 per benefit prescription
- Plan Two: may be eligible for prescriptions at no charge
- Plan Three: none

Children's Drug Plan: Families pay a maximum of $25 per benefit prescription

Deductible

GIS recipients

- If living in the community: $200 semi-annual deductible
- If living in a special care home: $100 semi-annual deductible

SIP recipients

- $100 semi-annual deductible

Family Health Benefits

- $100 semi-annual family deductible

Deductibles may be reduced if recipients are eligible for additional drug coverage through the Special Support Program.

Policy information

Ingredient price

Low-cost alternative (LCA): Benefits are based on the lowest-priced interchangeable brand-name drug, as listed in the formulary.

Maximum allowable cost (MAC): This is the 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 (i.e., LCA, MAC), is based on the actual cost of the material of a drug product, including any discounts received toward a product purchased.

Saskatchewan Insulin Pump Program: The program will pay the 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).

Generic pricing policy (percentage of brand-name drug)

Generic drugs (with certain exceptions, including pan-Canadian molecules) are priced based on the pan-Canadian Tiered Pricing Framework, as follows:

- New single source (i.e., only 1 manufacturer of a generic drug): Priced at 75% of brand-name drug price if product-listing agreement (PLA) or pricing agreement for brand-name drug exists in any jurisdiction
- Other single source: 85%
- 2 generics: 50%
- 3 or more generics: 25% oral solids, 35% all dosage forms other than oral solids (liquids, patches, injectables, inhalers, etc.)

Professional fees: Product-related fees/services

Dispensing fee: Effective November 1, 2018, the maximum dispensing fee is $11.60.

Trial prescriptions: A specific list of drugs is eligible for a 7- or 10-day trial. Follow-up by a pharmacist is required. The usual and customary professional fee (to a maximum of $11.60) is paid for the trial quantity; if the medication is continued, no fee may be claimed on the remainder of the 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: The methadone fee is $3.50 per day ($24.50 per week) and is paid only for face-to-face interactions with the pharmacist.

Direct observed therapy (DOT): A DOT fee of $3.50 per day ($24.50 per week) is paid when pharmacists observe the administration of approved hepatitis C drugs. Approved medications effective April 1, 2015: Sovaldi plus Ibavyr, Harvoni. Approved medications effective April 1, 2017: Daklinza, Epclusa, Sunvepra, Zepatier.

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.

Vaccine administration: $13

Injection administration fee: $13 for injecting approved medications (e.g., medroxyprogesterone acetate 150 mg/mL) to a maximum of 5 fees/year.

Urine testing agents: No fee allowed.

Saskatchewan Insulin Pump Program: No fee allowed.

The CeRx integration supplement of $0.10 per prescription for integrated pharmacies was eliminated as of January 1, 2017.

Professional fees: Clinical services

Emergency contraception prescribing: Prescribing fee equal to 2 times the usual dispensing fee above and beyond the cost of the dispensed product

Refusal to dispense: Specific list of drugs; may charge 1.5 times the pharmacy's usual and customary dispensing fee to a maximum of $17.40 for a single claim

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 for a maximum of $17.40

Saskatchewan Medication Assessment Program

- Medication assessment: 1 annual medication assessment fee to a maximum of $60 per year per person
- Up to 2 follow-up assessment fees per year at a rate of $20 each, to a maximum of $40 per person per year

Medication Assessment and Compliance Packaging Program

- Medication assessment: 1 annual fee of $60 per year per person

Patient assessments (maximum amount per 28 days per patient)

- Continuing existing prescription (interim supply and unable to access): $6 (maximum 4)
- Insufficient information: $6 (maximum 1)
- Continuing existing prescription (emergency situation): $10 (maximum 1)

- Drug reconciliation: $25 (maximum 1)
- Increasing suitability of a drug: $6 (maximum 4)
- Minor ailments and self care: A patient assessment fee of $18 will be paid where an assessment results in a pharmacist prescribing an eligible prescription medication. Authority to assess and prescribe for 25 minor ailments and self-care conditions, including uncomplicated urinary tract infections in women, shingles, conjunctivitis, obesity, hormonal contraception, emergency contraception, onychomycosis, influenza, erectile dysfunction and smoking cessation.

Smoking cessation

- Bronze level (identification of tobacco users in practice site and assessing stage of change): maximum $5 per person per year
- Bronze Plus level (identification of tobacco users in practice site, assessing stage of change and level of conviction and confidence): maximum $10 per person per year
- Silver/Gold level (tobacco user previously indicates quitting tobacco within 6 months or ready to quit): maximum $180 per person per year
- Follow-up: $10 per follow-up (maximum $100 per person per year)
- Group sessions: maximum $150 per person per year
- Up to $300 annually ($2 per minute) for Partnership to Assist with Cessation of Tobacco

Pharmacy markup

Maximum markup allowance calculated on the prescription drug cost:

Drug cost	Markup
$0.01–$6.30	30%
$6.31–$15.80	15%
$15.81–$200.00	10%
>$200.01	$20 maximum

Urine testing agents: Acquisition cost along with the markup as above, plus 50% markup in place of the dispensing fee

Insulin: Acquisition cost plus a negotiated markup

Saskatchewan Insulin Pump Program: No markup allowed

Coordination of benefits (public/private)

The drug plan is the first payer on eligible claims for eligible beneficiaries.

Restricted/exception drug coverage process

Eligible prescribers, authorized office staff or pharmacists may apply for Exception Drug Status (EDS) on behalf of a patient.

Patients are notified of approvals; 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.

Reimbursement policy

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.

Miscellaneous

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 3-month supply of a drug at a time.

A pharmacist may charge 1 dispensing fee for each prescription for most drugs listed in the formulary. If a prescription is for the duration of 1 month or more, the pharmacist is entitled to charge a dispensing fee for each 34-day supply; however, the contract that the drug plan has with pharmacies does not prohibit the pharmacist from dispensing more than a 34-day supply for 1 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.

Wholesale markup is allowed on specific products:

- Insulin: 5%
- Standing offer contract products: 6%
- Generic drugs: 6.5%
- Most other drugs: 8.5%

Wholesale markup is capped at $50 per package size.

Saskatchewan Insulin Pump Program: Eligible beneficiaries will receive an insulin pump (covered up to a maximum of $6,300) through SAIL and financial assistance with the cost of the pump supplies through the Saskatchewan Drug Plan (based on income/expenses under the Special Support Program).

Influenza Immunization Program: Pharmacists are permitted to administer publicly funded influenza vaccines to clients age 5 and older during home visits and in congregate living settings.

Source: For more information, visit Saskatchewan Health Drug Plan and Extended Benefits Branch.

Manitoba

Eligibility

Plans/programs

- Pharmacare
- Employment and Income Assistance Program
- Personal Care Home Drug Program
- Palliative Care Drug Access Program
- Home Cancer Drug Program
- Pediatric Insulin Pump Program

General beneficiary information

Pharmacare: Residents whose income is seriously affected by high prescription drug costs, regardless of disease or age

Employment and Income Assistance Program: Residents between 18 and 65 years of age who do not have a disability and are in financial need

Personal Care Home Drug Program: Residents of personal care homes

Palliative Care Drug Access Program: Residents who are terminally ill and wish to remain at home or in another residence

Home Cancer Drug Program: Patients identified by CancerCare Manitoba as receiving or being scheduled to receive eligible outpatient oral cancer and specific supportive drugs, **and** who are registered with the Pharmacare Program **and** whose prescriptions for eligible outpatient oral cancer and specific supportive drugs are not being covered by other provincial or federal programs

Pediatric Insulin Pump Program: Residents younger than age 18 diagnosed with type 1 diabetes and for whom a pediatric insulin pump is medically appropriate, as determined by Diabetes Education Resource for Children and Adolescents (DER-CA) physicians and who agree to be regularly monitored by DER-CA

Other eligibility criteria

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.

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

None

Deductible

Pharmacare

- Annual threshold based on total adjusted family income
- Minimum deductible is $100

Deductible rates for adjusted family incomes, 2019–2020

Lower limit	Upper limit	Deductible
$0	≤$15,000	3.17%
>$15,000	≤$21,000	4.49%
>$21,000	≤$22,000	4.53%
>$22,000	≤$23,000	4.61%
>$23,000	≤$24,000	4.67%
>$24,000	≤$25,000	4.72%
>$25,000	≤$26,000	4.79%
>$26,000	≤$27,000	4.84%
>$27,000	≤$28,000	4.91%
>$28,000	≤$29,000	4.94%
>$29,000	≤$40,000	4.97%
>$40,000	≤$42,500	5.39%
>$42,500	≤$45,000	5.52%
>$45,000	≤$47,500	5.64%
>$47,500	≤$75,000	5.71%
>$75,000	—	7.15%

Pediatric Insulin Pump Program: While the insulin pump is fully funded, supplies designated as benefits may be eligible for coverage under provincial drug programs, including the Manitoba Pharmacare Program. To have the cost of eligible insulin pump supplies covered by Manitoba Health, the patient and family must be enrolled in a provincial drug program.

Maximum beneficiary contribution

The maximum beneficiary contribution is the calculated deductible.

Policy information

Ingredient price

Lowest-cost pricing: Benefits are based on the lowest-priced interchangeable brand-name drug as listed in the formulary, whether or not the specified drug is prescribed with a “no sub” or “no substitution” instruction.

Tiered Biologics Reimbursement Policy

Patients are required to try 2 Tier 1 products before being reimbursed for a Tier 2 product. Tier 1 biologic products have been determined to be the most cost-effective.

Generic pricing policy (percentage of brand-name drug)

Manitoba has established a policy/contractual approach for multisource generic pharmaceutical products. The policy/contractual framework for multisource generic pharmaceutical products includes submission criteria requiring pricing equal to that of other jurisdictions, a price guarantee for a minimum of 365 days and supply commitments by the manufacturer.

Professional fees: Product-related fees/services

Effective August 18, 2017, Manitoba is introducing a cap on dispensing fees. Pharmacies are able to charge provincial drug programs up to $30 per prescription, regardless of the base cost of a drug or how a drug is packaged.

In addition, pharmacies are able to charge Pharmacare up to $30 for compounding services in a pharmacy.

Immunization fees are set at $7 per service.

In cases where drugs need to be compounded in sterile conditions, pharmacies are able to charge Pharmacare up to $60. Pharmacare considers a compounded drug an eligible benefit only if the main ingredient in the preparation is a Pharmacare benefit.

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 per prescription.

Monthly capitation fee for personal care homes: $47.80 per bed per month for Winnipeg; $48.70 per bed per month for rural areas.

Restricted/exception drug coverage process

The prescriber must contact the Exception Drug Status (EDS) office of Provincial Drug Programs to request eligibility for a prescription; eligibility is from the date of approval.

Effective October 1, 2017, Part 3 drugs identified on the List of Designated Drugs no longer require EDS renewal for coverage under Manitoba’s provincial drug programs and the Employment and Income Assistance Drug Program. All Part 3 EDS drugs still require initial approval; however, for many drugs, if coverage approval is granted, this approval is indefinite and prescribers no longer need to reapply to extend or renew this coverage.

Reimbursement policy

The original receipts for prescriptions purchased in another province or territory of Canada can be submitted to the drug plan for reimbursement, up to the lowest cost for the drug(s) listed in Manitoba.

Miscellaneous

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 days
- Up to an additional 100 days, if the prior approval of the minister has been obtained and the person will be outside of Canada for more than 90 consecutive days

Blood glucose test strips: Effective June 15, 2017, the Manitoba government is making changes to Pharmacare and Employment and Income Assistance coverage for blood glucose test strips. The new coverage levels include

- 3,650 test strips a year if a patient uses insulin;
- 400 test strips a year if a patient uses an oral diabetes agent with higher risk of hypoglycemia; and
- 200 test strips a year if a patient uses an oral diabetes agent with lower risk of hypoglycemia or manages diabetes with diet and exercise alone.

Patients will also be eligible to access additional test strips if medically necessary.

Source: For more information, visit Manitoba Health, Seniors and Active Living.

Ontario

Eligibility

Plans/programs

- Ontario Drug Benefit Program (ODB)
  - Trillium Drug Program (TDP)
- Special Drugs Program (SDP)
- Visudyne Program
- Inherited Metabolic Diseases Program (IMD)*
- Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program (RSV)*

Note
* Data is currently not submitted to NPDUIS.

General beneficiary information

Ontario Drug Benefit Program: Residents age 65 and older; children and youth age 24 and younger who are not covered by a private plan; residents of long-term care homes, homes for special care and Community Homes for Opportunity; recipients of professional home services and social assistance; and recipients of the TDP.

Note: The ODB Program benefit year runs from August 1 to July 31 for the purposes of calculating deductibles and copayments.

Trillium Drug Program: Residents who have high prescription drug costs in relation to their household income (approximately 3% to 4% or more of their after-tax household income); any residents who do not qualify under any of the other public drug plans or whose private insurance does not cover 100% of the prescription drug costs and who are not eligible for ODB coverage.

Special Drugs Program: Residents who require certain outpatient drugs used to treat cystic fibrosis, thalassemia, HIV infection, anemia, treatment-resistant schizophrenia and Gaucher's disease; residents who require drugs after organ or bone marrow transplant; and children with a lack or shortage of growth hormone. Patients must be under the care of an Ontario doctor at a designated treatment centre for the disease or condition.

Inherited Metabolic Diseases Program: Residents who require certain outpatient drugs, supplements and specialty foods used in the treatment of specific inherited metabolic disorders. Patients must be under the care of a doctor from a designated treatment centre.

Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program: Residents who are younger than age 2 at the start of the RSV season and who are at high risk for hospitalization and complications from RSV infection.

Visudyne Program: Residents who require treatment for age-related macular degeneration, pathologic myopia or presumed ocular histoplasmosis. This program funds the full cost of the drug verteporfin when examination by an ophthalmologist participating in the program confirms the need for treatment.

New Drugs Funding Program (NDFP) (Cancer Care Ontario): The NDFP covers certain approved intravenous cancer drugs administered in hospitals. Patients must live in Ontario, have valid Ontario Health Insurance Plan (OHIP) coverage and have the type of cancer for which the drug is approved.

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

ODB: A recipient pays up to $2 per prescription if he or she is

- A single senior with an annual net income of $19,300 or less;
- Part of a senior couple with a combined annual net income of $32,300 or less;
- Enrolled in Ontario Works, the Ontario Disability Support Program or the Home Care Program;
- Enrolled in the TDP and has met the annual deductible requirement; or
- A resident of a long-term care facility or home for special care.

ODB: A recipient pays up to $6.11 toward the ODB dispensing fee per prescription if he or she is

- A senior single person with an annual net income above $19,300; or
- Part of a senior couple with a combined annual net income above $32,300.

$2.83 for each prescription dispensed from an outpatient hospital pharmacy.

ODB: Recipients age 24 and younger who do not have a private plan have no copayments.

TDP: Recipients pay up to $2 for each prescription.

Deductible

ODB: $100 deductible per person for

- Single seniors with annual income above $19,300; and
- Senior couples with a combined annual income above $32,300.

For the first year of ODB eligibility, this deductible may be pro-rated depending on the month the recipient turns 65 within the ODB Program cycle.

ODB: Recipients age 24 and younger who do not have a private plan have no deductible.

TDP: Applicants must pay a quarterly or pro-rated deductible that is based on income.

Policy information

Ingredient price

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 1, 2014, generic drug prices are subject to the pan-Canadian Tiered Pricing Framework. The price policy applies to both public and private sectors.

Effective November 1, 2016, to increase the use of safe and effective generic alternatives to brand-name products, pharmacists must dispense an off-formulary interchangeable generic product in the pharmacy's inventory to ODB recipients with an Exceptional Access Program (EAP) approval from the ministry. Pharmacists will be reimbursed the cost of the generic product that is dispensed.

Professional fees: Product-related fees/services

Dispensing fee: Effective April 1, 2014, the dispensing fee is between $8.83 and $13.25 depending on the location of the pharmacy. Higher fees are paid to pharmacies in rural areas.

Effective October 1, 2015, the dispensing fee for claims for long-term care home residents is between $7.57 and $11.99.

A maximum of 2 dispensing fees is permitted per 28 days, even if the prescription directs more frequent dispensing. The 2-dispensing-fees-per-28-days rule does not apply to medications subject to the chronic-use policy below or to residents of long-term care homes. Other exceptions are permitted in special circumstances.

Effective October 1, 2015, the number of dispensing fees paid to pharmacies for 15 categories of chronic-use medications is limited to a maximum of 5 dispensing fees per recipient, per drug (by drug identification number), per 365-day period. Exceptions exist for patients in long-term care homes and Ontario Works recipients.

Professional fees: Clinical services

MedsCheck Program: Residents are eligible to receive an annual review and follow-up reviews if they are

- Taking 3 or more prescriptions for a chronic condition; or
- Living in a licensed long-term care home; or
- Diagnosed with type 1 or 2 diabetes and taking medication; or
- Eligible for MedsCheck but homebound and not able to attend their community pharmacy for the service.

MedsCheck Program fees

- $60/MedsCheck and $25/follow-up
- $75/MedsCheck Diabetes and $25/follow-up
- $150/MedsCheck at Home
- $90/initial consultation for MedsCheck Long-Term Care and $50/quarterly review

Immunization

- $7.50 per service

Pharmaceutical Opinion Program fee (ODB recipients only)

Pharmacist clinical intervention (identification of a potential drug-related problem) at the time of dispensing a new/repeat prescription or when conducting a MedsCheck. Includes refusals to fill.

- $15 per intervention in collaboration with prescriber

Pharmacy Smoking Cessation Program fee (ODB recipients only)

- $40 for first consultation (once per year)
- $15 for primary follow-up counselling sessions (3 times per year = $45 total)
- $10 for secondary follow-up counselling sessions (4 times per year = $40 total)
- Up to $125 annually

Pharmacy markup

Claims for prescriptions with total drug costs less than $1,000 are reimbursed with an 8% markup.

Effective October 1, 2015, the markup for all claims for high-cost drugs (total drug cost equal to or greater than $1,000) will be 6%.

Coordination of benefits (public/private)

ODB is considered the first payer and private insurance is the second payer, except for the TDP. For the TDP, during the deductible period, private insurance is the first payer and the TDP is the second payer. Once the household's quarterly deductible is paid, the TDP becomes first payer.

Restricted/exception drug coverage process

The EAP facilitates patient access to drugs not funded on the ODB formulary, or where no listed alternative is available.

To apply for ODB funding for an EAP drug, the patient's physician or nurse practitioner must submit a request to the EAP documenting complete and relevant medical information that explicitly addresses the relevant, approved clinical criteria for the drug requested. This may include providing the rationale for why formulary-listed drugs are not suitable and addressing the clinical circumstances for which the drug is required. All requests are reviewed according to the listing criteria for the drug product that have been established through the national and provincial drug review process, which may involve the Canadian Agency for Drugs and Technologies in Health's Common Drug Review (CDR) or its pan-Canadian Oncology Drug Review (pCODR) or Ontario-specific submissions that involve the ministry's expert advisory committee (the Committee to Evaluate Drugs) and approved by the executive officer for the Ontario Public Drug Programs. If EAP reimbursement criteria are met and an approval is granted, the coverage period begins as of the effective date and extends only to the specified date. 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 is available for certain drugs and assessed in real time.

Reimbursement policy

Claims can be reimbursed for eligible drugs only, when the prescription is written by a physician licensed in Ontario and the drug is dispensed in Ontario.

Miscellaneous

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 subject to a 30-day maximum prescription limit if they have not been taken in the preceding 12 months. If the newly prescribed drug helps the patient after the initial 30-day supply and the patient is not having any problems with it, the remainder of the prescription can be dispensed up to the maximum 100-day supply. Some recipients are exempt from this program (i.e., travel out of province for extended periods, samples from physician, insulin prescriptions).
- For recipients covered under the *Ontario Works Act*, the maximum quantity of medication claimed under the ODB Program must not exceed that required for a 35-day course of treatment. Effective January 1, 2018, Ontario Works (OW) recipients age 24 and younger are, in most cases, able to receive up to a 100-day supply of medication per pharmacy visit under the ODB Program as part of the new eligibility stream for those age 24 and younger. Effective August 1, 2018, OW recipients age 25 and older, in most cases, could receive up to a 100-day supply of medication.

Effective December 1, 2016: Social assistance clients are now able to use their Ontario health card to access the ODB Program to get their prescription medicine, rather than being issued a monthly paper drug card for this purpose. This change applies to social assistance clients who are recipients of the Ontario Disability Support Program, including Assistance for Children With Severe Disabilities and Ontario Works. Clients who are not eligible for an Ontario health card will continue to receive a paper card.

Diabetes test strips: Maximum number of strips (per year) covered are as follows:

- Patients managing diabetes with insulin: 3,000
- Patients managing diabetes using medication with higher risk of causing hypoglycemia (low blood sugar): 400
- Patients managing diabetes using medication with lower risk of causing hypoglycemia (low blood sugar): 200
- Patients managing diabetes through diet/lifestyle therapy only (no insulin or medications used): 200

Source: For more information, visit Ontario Public Drug Programs.

Quebec

Eligibility

Plans/programs

- Public Prescription Drug Insurance Plan

General beneficiary information

Public Prescription Drug Insurance Plan: Residents without access to a private plan through their employment or profession, spouse or parents if they are a student or child; persons age 65 and older who have not joined a private plan; recipients of last-resort financial assistance and certain other holders of claim slips (carnet de réclamation)

Other eligibility criteria

Residents age 65 and older are automatically registered for the public plan. If they remain eligible for a private plan offering basic prescription drug coverage, they may decide to be insured

- Only by the public plan, administered by the Régie de l’assurance maladie du Québec (RAMQ);
- By the public plan (first payer) and by a private plan offering supplemental coverage (second payer); or
- Only by a private plan offering at least the basic coverage.

Cost-sharing mechanism

Premium

Net family income–based premium, ranging from $0 to $616 per person. Rates are adjusted annually on July 1.

No premium, co-insurance or deductible for the following persons:

Persons	Conditions
Holders of a claim slip (carnet de réclamation)	Hold a valid claim slip
Children of persons covered under the public plan	**Younger than 18:** Not have access to a private plan through a student job or otherwise **Age 18 to 25:** • Attend an educational institution on a full-time basis • Be spouseless • Live with their parents or tutor • Not have access to a private plan

Persons	Conditions
Persons with a functional impairment	• Have an impairment specified in the Regulation respecting the basic prescription drug insurance plan, which occurred before age 18 • Not be receiving last-resort financial assistance • Be spouseless • Live with their parents or tutor • Not have access to a private plan
Persons age 65 or older	Receive 94% to 100% of the Guaranteed Income Supplement

Copayment/co-insurance

34.9% of the prescription cost minus the deductible, where applicable.

No co-insurance for certain persons. See Premium section for more information.

Deductible

$19.90 monthly deductible per person that must be paid through the first purchases of the month.

No deductible for certain persons. See Premium section for more information.

Maximum beneficiary contribution

$90.58 per month or $1,087 per year.

Exception for persons age 65 or older who receive less than 94% of the Guaranteed Income Supplement: $53.16 per month or $638 per year.

Policy Information

Ingredient price

Lowest price: The lowest unit price established for a drug product within a set of drug products for which 2 or more manufacturers have drugs appearing on the formulary (i.e., List of Medications) that have the same generic name, dosage form and strength. Certain exceptions apply, which is when the prescriber indicates to the pharmacist

1. Not to replace a brand-name drug that he or she has prescribed with a generic drug;
2. The reason, among the following, why there must not be any replacement, using for this purpose the Régie-supplied code corresponding to the reason given:
   - The patient suffers from a documented allergy or intolerance to a non-medicinal ingredient present in the makeup of the less costly generic drug, but absent in the brand-name drug;
   - The drug being prescribed is a brand-name drug whose dosage form is essential to obtain the expected clinical results, and this drug is the only one appearing on the formulary.

Maximum amount: The maximum payable amount for a drug, in which case the payable price may not exceed the maximum amount indicated on the formulary.

Actual purchase price: The price indicated on the formulary that is valid at the time the prescription is filled, taking into account the source of supply and the package size. Where the manufacturer's name does not appear on the formulary, the payable price is the pharmacist's cost price.

Accredited drug wholesaler's markup: The drug wholesaler's markup is payable only if the drug was actually purchased through an accredited wholesaler. The minister allows a maximum markup of 6.5% of the guaranteed selling price. The markup is limited to a maximum of $39.00, under certain terms and conditions, notably for certain expensive drugs.

Generic pricing policy (percentage of brand-name drug)

Quebec requires that generic manufacturers provide the province with the lowest price available in other provinces.

Professional fees: Product-related fees/services

Dispensing fee: Professional fees for the Quebec public plan (RAMQ administered) are determined by agreement with the pharmacy owners association, l'Association québécoise des pharmaciens propriétaires (AQPP)

Execution or renewal of a prescription for a health problem or medical condition requiring treatment for 90 days or more: $0.30 per day, maximum $27.00

Execution of a new prescription: $8.88 to $9.49

Renewal of a prescription: $8.50 to $9.10

Refusal to fill: $9.10

Substitution treatment for opioid dependence: $9.48 to $14.48

Compounding fee: $17.00 to $42.00

Therapeutic substitutions: $16.25 per substitution in case of drug supply disruption

Other services: $9.10 per transmission of patient medication profile; on-call service: $29.24; pharmaceutical opinions: $20.10

Professional fees: Clinical services

Adaptation/altering of prescriptions: $12.70 per renewal (30+ days), maximum 1 per person annually; $20.10 per dosage adjustment to ensure patient safety

Minor ailments: $16.25 per assessment for 9 conditions where no diagnosis is required and for 12 where diagnosis and treatment are known (see list of conditions; available only in French)

Initial access or to manage ongoing therapy (excluding minor ailments): To reach therapeutic target: $15.74 to $19.81 for initial evaluation (based on condition); $40.63 annually for a minimum of 2 follow-ups for certain conditions; $50.79 annually for a minimum of 3 follow-ups for insulin-dependent diabetes; $16.25 per month for anticoagulation.

Teaching naloxone usage: $18.30

Pharmaceutical consultation as part of the free universal access program in pharmacy for abortion: $18.59

Parenteral therapy: $2.85 to $19.98

Administration of drugs for demonstration purpose: $18.30

Pharmacy markup

Not applicable

Coordination of benefits (public/private)

Beneficiaries must be registered with the Public Prescription Drug Insurance Plan if their private plan provides supplemental coverage only. Supplemental coverage does not replace the mandatory basic coverage of the public plan; it only adds to it. In this case, the public plan is considered the first payer and the private plan is the second payer.

Restricted/exception drug coverage process

The public plan covers, under certain conditions, the prescription drugs indicated in the Exceptional medications section of the List of Medications. There are 2 types of exceptional medications:

- **Coded:** The health professional writes a code on the prescription so that it will be covered. The prescription drug can be obtained at the pharmacy without delay.
- **Uncoded:** The health professional must send the public plan an authorization request before the prescription drug can be covered. The beneficiary is able to obtain it at the pharmacy once authorization has been granted.

The public plan also covers certain prescription drugs not on the List of Medications for insured persons with an exceptional need. The health professional will send the public plan an authorization request so that the beneficiary may qualify for the program. If authorization is granted, the prescription drug will be covered and the patient can obtain it at the pharmacy.

Reimbursement policy

If a resident is eligible for the Public Prescription Drug Insurance Plan and has paid out of pocket for the cost of purchased medications that are usually covered, an application for reimbursement can be made with the pharmacist.

Miscellaneous

Blood glucose test strips: Effective April 21, 2017, the quantity of blood glucose test strips that are reimbursed under the Public Prescription Drug Insurance Plan is determined according to the insured person's clinical situation (i.e., adjusted according to the person's risk of hypoglycemia).

Maximum number	Clinical situations
200	• Diabetic persons treated by a change in lifestyle • Diabetic persons treated with an antidiabetic other than a sulfonylurea, repaglinide or insulin
400	• Diabetic persons treated with a sulfonylurea or repaglinide, but who are not receiving insulin
3,000	• Persons treated with insulin

In special clinical situations, the health professional in charge of a person's follow-up can allow for coverage of additional strips per 365-day period.

Effective November 15, 2017: The Public Prescription Drug Insurance Plan covers the cost of blood glucose test strips for non-diabetic persons who face certain rare clinical situations entailing a risk of potentially severe symptomatic hypoglycemia. This coverage is added to the existing measures aimed at optimizing the use of blood glucose test strips.

Smoking cessation products: Coverage is limited to a maximum of 12 consecutive weeks per 12-month period, starting on the purchase date. Maximum quantity covered per period (gum or lozenges): 840 pieces.

Proton pump inhibitors maximum price payable: Effective July 24, 2015, the maximum price payable for proton-pump inhibitor class drugs decreased from $0.55 to $0.3628 per tablet or capsule for those insured under the Public Prescription Drug Insurance Program.

Proton pump inhibitors reimbursement period limit: Effective April 21, 2017, the period during which proton pump inhibitors are reimbursed is limited to a maximum of 90 days per 365-day period for those age 18 and older. This applies to those insured under the Public Prescription Drug Insurance Program.

Source: For more information, visit Quebec Prescription Drug Insurance and Aid Programs.

New Brunswick

Eligibility

Plans/programs

- New Brunswick Prescription Drug Program
  - Seniors
  - Nursing Home Residents
  - Social Development Clients
  - Individuals in Licensed Residential Facilities
  - Children in Care of the Minister of Social Development and Children With Disabilities
  - Multiple Sclerosis
  - HIV/AIDS
  - Cystic Fibrosis
  - Organ Transplant Recipients
  - Growth Hormone Deficiency
- Medavie Blue Cross Seniors Prescription Drug Program
- New Brunswick Drug Plan
- New Brunswick Drugs for Rare Diseases Plan*
- Extra-Mural Program*
- Tuberculosis Drug Plan*
- Pharmacist Administered Publicly Funded Seasonal Influenza Vaccine*
- Medical Abortion Program

Note
* Data is currently not submitted to NPDUIS.

General beneficiary information

Seniors: Low-income individuals age 65 and older who are permanent residents of New Brunswick, who have a valid New Brunswick Medicare card and who do not have prescription drug coverage from another plan

GIS recipients: Seniors who receive the federal Guaranteed Income Supplement (GIS) from Employment and Social Development Canada are covered by the New Brunswick Prescription Drug Program (NBPDP)

Non-GIS recipients: Seniors who do not receive the federal GIS but whose income falls below the following amounts may be eligible for coverage:

- A single person with an annual income of $17,198 or less
- A couple in which both persons are age 65 and older with a combined annual income of $26,955 or less
- A couple in which 1 person is younger than age 65 with a combined annual income of $32,390 or less

Nursing Home Residents: Individuals who reside in a registered nursing home

Social Development Clients: Individuals who hold a valid health card for prescription drugs issued by the Department of Social Development

Individuals 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

Children in Care of the Minister of Social Development and Children With Disabilities: Children under the care of the minister of Social Development and children with disabilities

Multiple Sclerosis: Residents diagnosed with multiple sclerosis who have a valid New Brunswick Medicare card and a prescription written by a neurologist for eligible medications

HIV/AIDS: Individuals diagnosed with HIV/AIDS who are registered with the NBPDP through a provincial infectious disease specialist and who are not entitled to receive similar benefits from any other source

Cystic Fibrosis: Residents diagnosed with cystic fibrosis who have a valid New Brunswick Medicare card and who do not have coverage for any portion of the cost of cystic fibrosis drugs from any other drug plan

Organ Transplant Recipients: New Brunswick residents who have received (or are on the active waiting list to receive) a solid organ or bone marrow transplant, who have a valid New Brunswick Medicare card and do not have coverage for any portion of the cost of anti-rejection drugs from any other drug plan

Growth Hormone Deficiency: Residents younger than age 19 with growth hormone deficiency or who have a valid New Brunswick Medicare card and do not have coverage for any portion of the cost of growth hormone deficiency drugs from any other drug plan

Medavie Blue Cross Seniors Prescription Drug Program: Seniors who do not have prescription drug coverage from another drug plan

New Brunswick Drug Plan: Residents, including seniors, with a valid Medicare card who do not have existing drug coverage (through a private plan or a government program) or who have existing drug coverage that does not cover a specific drug that is included in the drug plan formulary or who have reached their early or lifetime maximum for drug coverage

New Brunswick Drugs for Rare Diseases Plan: Individual must have one of a specific list of rare diseases and must be a permanent resident of New Brunswick and have a valid Medicare card. A request form for a listed drug must be completed by the physician and the individual must meet the clinical criteria for the drug requested

Extra-Mural Program: Residents receiving extra-mural services who do not have drug coverage from any other drug plan and have been provided with a Prescription Drug Authorization Form

Tuberculosis Drug Plan: Any patient (regardless of permanent residence) who has active or latent tuberculosis infection

Pharmacist Administered Publicly Funded Seasonal Influenza Vaccine: Residents who are at high risk for influenza-related complications as well as members of their households, as defined by Public Health

Medical Abortion Program: New Brunswick residents who have a valid Medicare card

Cost-sharing mechanism

Premium

Medavie Blue Cross Seniors' Prescription program: $115 per month

Cystic Fibrosis, Multiple Sclerosis, Organ Transplant, Growth Hormone Deficiency, HIV/AIDS: $50 per year registration fee for each plan

New Brunswick Drug Plan: Income-based premiums

Effective April 1, 2015

Gross income (individual)	Annual premium	Monthly premium
<$17,884	$200	$16.67
$17,885–$22,346	$400	$33.33
$22,347–$26,360	$800	$66.67
$26,361–$50,000	$1,400	$116.67
$50,001–$75,000	$1,600	$133.33
>$75,000	$2,000	$166.67

Gross income (single with children/ couple without children)	Annual premium	Monthly premium
<$26,826	$200	$16.67
$26,827–$33,519	$400	$33.33
$33,520–$49,389	$800	$66.67
$49,390–$75,000	$1,400	$116.67
$75,001–$100,000	$1,600	$133.33
>$100,000	$2,000	$166.67

Children age 18 and younger do not pay premiums; however, a parent must be enrolled in the plan to be eligible for coverage.

Copayment/co-insurance

Seniors

- GIS recipients: $9.05 per prescription
- Non-GIS recipients: $15 per prescription

Medavie Blue Cross Seniors' Prescription Drug Program

- $15 per prescription

Individuals in Licensed Residential Facilities

- $4 per prescription

Social Development Clients

- $4 per prescription for adults 18 and older
- $2 per prescription for children younger than 18

Multiple Sclerosis

- Income-tested annually, ranges from 0% to 100% for each prescription

Cystic Fibrosis, Organ Transplant, Growth Hormone Deficiency and HIV/AIDS

- 20% per prescription to a maximum of $20

Extra-Mural Program

- $9.05 per prescription

New Brunswick Drug Plan

- 30% per prescription to a maximum amount as outlined below:

Gross income (individual)	Maximum copay
<$17,884	$5
$17,885–$22,346	$10
$22,347–$26,360	$15
$26,361–$50,000	$20
$50,001–$75,000	$25
>$75,000	$30

Gross income (single with children/ couple without children)	Maximum copay
<$26,826	$5
$26,827–$33,519	$10
$33,520–$49,389	$15
$49,390–$75,000	$20
$75,001–$100,000	$25
>$100,000	$30

Deductible

None

Maximum beneficiary contribution

GIS recipients: $500 maximum copayment per fiscal year

Cystic Fibrosis, Organ Transplant, Growth Hormone Deficiency and HIV/AIDS:
$500 maximum copayment plus a registration fee per family unit per fiscal year

Individuals in Licensed Residential Facilities: $250 maximum copayment per person in a fiscal year

Social Development Clients: $250 maximum copayment per family unit in a fiscal year

Policy information

Ingredient price

Effective June 1, 2013, the drug cost for each eligible prescription is as below:

Drug category	Ingredient cost
Drugs on the MAP list	Up to MAP
Drugs on the MLP list	Up to MLP
Extemporaneous preparations (compounds)	AAC
Methadone oral solution	Up to MAP

Notes
MAP: Maximum allowable price.
MLP: Manufacturer's list price.
AAC: Actual acquisition cost.

Generic pricing policy (percentage of brand-name drug)

Effective June 1, 2013

- 25% for solid oral dosage forms
- 35% for non-solid oral dosage forms

In addition, some drugs are subject to the pan-Canadian competitive value price initiative for generic drugs.

Professional fees: Product-related fees/services

Effective June 1, 2014

- Drugs on the MAP list: up to $11
- Drugs on the MLP list: up to $11
- Extemporaneous preparations (compounds): up to $16.50
- Methadone for chronic pain: up to $11
- Drugs for opioid dependence (e.g., methadone, buprenorphine/naloxone): up to $9.50

Effective July 2, 2013, New Brunswick drug plans will pay for 1 dispensing fee every 28 days or more for drugs in solid oral dosage form taken on a continuous basis.

The 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.

Professional fees: Clinical services

New Brunswick PharmaCheck Program: $52.50

Limit of 1 medication checkup review per NBPDP beneficiary (Seniors, Social Development Clients and Individuals in Licensed Residential Facilities) who is taking 3 or more chronic prescription medications per year.

Pharmacist-administered publicly funded seasonal influenza vaccine: $12

Pharmacy markup

Effective June 1, 2013: Up to 8% markup allowed on drugs on the MAP list

Effective June 1, 2014: Up to 8% markup allowed on drugs on the MLP list

Coordination of benefits (public/private)

Coordination of benefits applies to the Multiple Sclerosis plan only.

Coordination of benefits (intrajurisdictional)

n/a

Restricted/exception drug coverage process

Drugs not listed as regular benefits may be eligible for reimbursement under New Brunswick drug plans 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 on a case-by-case basis 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 (e.g., drugs obtained through Health Canada's Special Access Programme)
- Products specifically excluded as benefits as identified on the exclusion list (New Brunswick drug plans formulary)

Special authorization requests must be submitted in writing by a prescriber to the New Brunswick drug plans Special Authorization Unit.

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.

Miscellaneous

Prescription quantities

- 100-day supply
- 35-day supply for narcotics, controlled drugs and benzodiazepines

Quantitative limits have been established for a number of products listed as benefits of the New Brunswick drug plans.

Travel supply: 1 travel supply of up to 100 days may be submitted in addition to a first fill/refill of up to 100 days. The total quantity of each drug that the senior has on hand cannot exceed a 200-day supply.

Source: For more information, visit New Brunswick Prescription Drug Program and New Brunswick Drug Plan.

Nova Scotia

Eligibility

Plans/programs

- Family Pharmacare Program (Plan F)
- Community Services Pharmacare Benefits (Plan F)*
- Seniors' Pharmacare Program (Plan S)
- Drug Assistance for Cancer Patients (Plan C)
- Take-Home Cancer Drug Fund*
- Diabetes Assistance Program (Plan D)
- Palliative Care Drug Program
- Insulin Pump Program*
- Under 65 — Long-Term Care (LTC) Pharmacare Plan (Plan F)
- Medical Assistance in Dying: Adjudication of Claims
- Mifegymiso*
- Multiple Sclerosis Copayment Assistance*

Note
* Data is currently not submitted to NPDUIS.

General beneficiary information

Family Pharmacare Program: Residents with a valid Nova Scotia health card who are not currently receiving drug benefits through any Department of Community Services pharmacare programs, Seniors' Pharmacare Program, Diabetes Assistance Program or Under 65 — Long-Term Care Pharmacare Plan. The program offers protection against drug costs for families without drug coverage or if the cost of the prescription drug becomes a financial burden.

Community Services Pharmacare Benefits: Residents who are income assistance clients, disability support clients, children in the care of child welfare or low-income Pharmacare children clients. Eligibility is determined by the Department of Community Services.

Seniors' Pharmacare Program: Residents age 65 and older with a valid Nova Scotia health card who do not have prescription drug coverage through any other plans or programs

Drug Assistance for Cancer Patients: Nova Scotia residents with a valid Nova Scotia health card number who are receiving cancer treatments, have a gross family income no greater than $25,500 per year and do not have drug coverage under any other public or private drug program other than Nova Scotia Family Pharmacare or Seniors' Pharmacare. The plan is designed to help with the cost of certain cancer-related drugs and supplies.

Take-Home Cancer Drug Fund: Residents with a valid Nova Scotia health card who have a prescription for take-home cancer drugs, have accessed all other sources of financial assistance available, including private, public and manufacturer assistance programs, and have out-of-pocket expenses for eligible take-home cancer drugs greater than 4% of net family income

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 (this program closed to new enrolments as of April 1, 2010)

Palliative Care Drug Program: Residents assessed by a palliative care team to be in the end stage of a terminal illness and anticipated to be in the last 6 months of life and wishing to receive end-of-life care at home for as long as possible, whether in their own home, with family or friends, or in a supportive-living residence

Insulin Pump Program: Residents age 25 or younger who have type 1 diabetes

Under 65 — Long-Term Care (LTC) Pharmacare Plan: Regular bed residents of a long-term care facility who are younger than 65, have a valid Nova Scotia health card and do not have access to, or coverage under, another public or private drug plan

Medical Assistance in Dying: Adjudication of claims: Residents with a valid prescription who meet the eligibility criteria, including assessments by the prescriber and informed consent from the patient. Coverage is restricted to patients on an outpatient basis and at the community level.

Mifegymiso: Women residing in Nova Scotia with a valid health card number; other sources of insurance must be billed first

Multiple Sclerosis Copayment Assistance: Residents who meet the established disease state criteria, have private insurance coverage for selected drugs, are required to pay a copayment as part of their drug coverage and are followed by the Multiple Sclerosis (MS) Clinic at the Nova Scotia Health Authority

Other eligibility criteria

Family Pharmacare Program, Drug Assistance for Cancer Patients, Diabetes Assistance Program and Insulin Pump Program: Residents must agree to provide family size information and annual family income verification through Canada Revenue Agency.

Diabetes Assistance Program: Enrolment for this program ceased as of April 1, 2010. New patients can choose to register in the Family Pharmacare Program.

Cost-sharing mechanism

Premium

Seniors' Pharmacare Program

Effective April 1, 2016

Gross income (individuals)	Annual premium
<$22,986	$0
$22,986–$35,000	<$424
≥$35,000	$424

Gross income (couples)	Annual premium
<$26,817	$0
$26,817–$40,000	<$424 each
≥$40,000	$424 each

Residents who receive the Guaranteed Income Supplement (GIS) do not have to pay a premium unless they have an outstanding balance from the previous year.

Copayment/co-insurance

Family Pharmacare Program: 20% copayment per prescription, to an annual maximum based on a sliding scale (percentage of adjusted family income)

Diabetes Assistance Program: 20% per prescription

Department of Community Services Pharmacare Benefits: $5 per prescription unless eligible for copayment exemption

Seniors' Pharmacare Program: 30% per prescription up to an annual maximum of $382

Insulin Pump Program: Calculated based on family income and size

Deductible

Family Pharmacare Program: Sliding scale percentage based on adjusted family income

Diabetes Assistance Program: Percentage based on adjusted family income and size

Maximum beneficiary contribution

Family Pharmacare Program: Annual family copayment plus deductible based on family income and size

Seniors' Pharmacare Program: Annual maximum copayment of $382 plus a premium

Policy information

Ingredient price

Manufacturer's list price (MLP): 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): The maximum cost established by the Pharmacare Program at which a benefit is reimbursed to a provider or beneficiary for a category of interchangeable products

Pharmacare reimbursement price (PRP): A special maximum amount the program reimburses providers for 1 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 doses 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): 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.

Generic pricing policy (percentage of brand-name drug)

Effective November 12, 2014

- 25%: solid oral form, multisource generics
- 35%: non-solid oral dosage forms

Professional fees: Product-related fees/services

April 1, 2019, to September 30, 2019

- Ostomy supplies: $12.10
- Compounded extemporaneous products (except methadone and injectables): $18.15
- All other prescriptions for drugs or supplies, including methadone: $12.10

Professional fees: Clinical services

The Pharmacare Program reimburses special services fees to the following maximums:

Advanced medication review (AMR): maximum special services fee of $150

- Only beneficiaries of the Seniors' Pharmacare Program are eligible
- Limit of 1 AMR per benefit year

Basic medication review (BMR): maximum special services fee of $52.50

- Beneficiaries of any Nova Scotia Pharmacare Program except the Under 65 — LTC program are eligible
- Limit of 1 BMR per benefit year

Medication review follow-up: maximum special services fee of $20

Prescription adaptation: maximum special services fee of $14

Therapeutic substitution: maximum special services fee of $26.25

Pharmacy markup

Effective October 1, 2014

- Ostomy supplies: AAC plus 10% (maximum $50)
- Compounded extemporaneous products (except methadone and injectables): AAC plus 2% (maximum $50)
- Methadone: MRP or PRP plus 8%

All other prescriptions

- MLP plus 10.5% (if the ingredient cost is $3,000 or less)
- MLP plus 8% (if the ingredient cost is greater than $3,000)
- MRP or PRP plus 8%

Coordination of benefits (public/private)

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.

Restricted/exception drug coverage process

Exception Status Drugs are those that are eligible for coverage under the Pharmacare Program only when an individual meets criteria developed by the Atlantic or Canadian Expert Advisory Committee.

To request coverage, the physician should mail or fax a completed standard request form or letter to the Pharmacare office. Physicians may also contact the Pharmacare office and speak directly to a pharmacist consultant to request coverage. Every effort is made to process requests within 7 days.

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 Pharmacare. 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.

Reimbursement policy

If a beneficiary paid cash at the pharmacy, he or she has up to 6 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.

Miscellaneous

Prescription quantities

- 100-day supply maximum, if prescribed
- A maximum of 1 dispensing fee per 28 days for maintenance medication

Travel supply: Seniors' Pharmacare Program beneficiaries travelling outside the province for more than 100 days are allowed to obtain 3 90-day refills, billed on 3 consecutive days, for the same medication before leaving Nova Scotia. This allows for a 270-day maximum supply of medication. The usual professional fee and copayment applies to each of the prescriptions.

Source: For more information, visit Nova Scotia Pharmacare Drug Programs.

Prince Edward Island

Eligibility

Plans/programs

- AIDS/HIV Program (Plan A)*
- Community Mental Health Program (Plan B)*
- Cystic Fibrosis Program (Plan C)*
- Diabetes Drug Program (Plan D)
- Erythropoietin Program (Plan E)*
- Family Health Benefit Drug Program (Plan F)
- Generic Drug Program (Plan G)
- Hepatitis Program (Plan H)*
- Immunization Program (Plan I)
- Meningitis Program (Plan K)*
- Opioid Replacement Therapy Program (Plan L)
- High Cost Drug Program (Plan M)

- Institutional Pharmacy Program (Plan N)*
- Nursing Home Drug Program (Plan N)
- Nutrition Services Program (Plan O)*
- Phenylketonuria (PKU) Program (Plan P)*
- Catastrophic Drug Program (Plan Q)
- Rabies Program (Plan R)*
- Seniors Drug Program (Plan S)
- Transplant Anti-Rejection Drug Program (Plan T)*
- Sexually Transmitted Diseases (STD) Program (Plan V)
- Children in Care Drug Program (Plan W)
- Financial Assistance Program (Plan W)
- Tuberculosis (TB) Drug Program (Plan X)*
- Growth Hormone Drug Program (Plan Y)*
- Quit Smoking Program (Plan Z)
- Home Oxygen Program*
- Insulin Pump Program*
- Ostomy Supplies Program*

Note
* Data is currently not submitted to NPDUIS.

General beneficiary information

AIDS/HIV Program: Persons who test positive for the human immunodeficiency virus (HIV) or who are diagnosed with acquired immune deficiency syndrome (AIDS) or who have a non–work related needle stick injury and do not have private insurance

Community Mental Health Program: Approved long-term psychiatric patients living in the community

Cystic Fibrosis Program: Persons diagnosed with cystic fibrosis

Diabetes Drug Program: Persons diagnosed with diabetes and registered with the provincial Diabetes Drug Program

Erythropoietin Program: Persons diagnosed with chronic renal failure or receiving kidney dialysis

Family Health Benefit Drug Program: Low-income families supporting at least one child younger than 19 or younger than 25 if the child is a full-time student, with a total net family income less than the threshold (see Other eligibility criteria below); coverage must be applied for on an annual basis

Generic Drug Program: Persons younger than 65 who do not have private drug insurance

Hepatitis Program: Persons diagnosed with hepatitis, persons who have been in close contact with a person diagnosed with hepatitis or persons with an occupational risk of infection

Immunization Program: Adults and children younger than 18 or who are still in high school

Meningitis Program: Persons diagnosed with meningitis or persons who have been in close contact with a person diagnosed with meningitis and are at an increased risk of infection

Opioid Replacement Therapy Program: Persons assessed by a clinical team and determined to require treatment for an opioid dependency who are registered in a program of opioid addiction therapy

High Cost Drug Program: Persons approved for coverage of 1 or more of the medications for ankylosing spondylitis, cancer, Crohn's disease, multiple sclerosis, pulmonary hypertension, plaque psoriasis, psoriatic arthritis, rheumatoid arthritis and wet age-related macular degeneration included in the program; coverage must be applied for annually and is based on household income

Institutional Pharmacy Program: Residents in government long-term care nursing homes or manors

Nursing Home Drug Program: Permanent residents in private nursing homes who qualify for financial assistance through the Social Assistance Program

Nutrition Services Program: High-risk pregnant women diagnosed with a nutritional deficiency who are receiving service from a community nutritionist or low-income pregnant women who are receiving or are in need of financial assistance

Phenylketonuria (PKU) Program: Persons diagnosed with phenylketonuria

Catastrophic Drug Program: Residents whose household members have up-to-date tax filings and are experiencing out-of-pocket eligible drug expenses that exceed their annual household limit

Rabies Program: Persons exposed to or at increased risk of exposure to rabies through an animal bite

Seniors Drug Program: Persons age 65 and older

Transplant Anti-Rejection Drug Program: Persons who have had a solid organ transplant or bone marrow transplant

Sexually Transmitted Diseases (STD) Program: Persons diagnosed with a sexually transmitted disease or in close contact with a person diagnosed with a sexually transmitted disease

Children in Care Drug Program: Persons in the temporary or permanent custody of the director of child protection; persons eligible for coverage through PEI Medicare

Financial Assistance Program: Persons eligible for financial assistance under the *Social Assistance Act* and its regulations

Tuberculosis (TB) Drug Program: Persons diagnosed with tuberculosis or who are at increased risk due to exposure to tuberculosis (confirmed by the chief health officer of the Department of Health and Wellness)

Growth Hormone Drug Program: Children (younger than age 18) with a proven growth hormone deficiency or Turner syndrome

Quit Smoking Drug Program: Persons participating in the smoking cessation program through Addiction Services

Home Oxygen Program: Persons prescribed oxygen by a specialist and who have been diagnosed with chronic obstructive pulmonary disease (COPD)

Insulin Pump Program: Children and youth younger than age 19 with type 1 diabetes who have been referred to the provincial Diabetes Program

Ostomy Supplies Program: Persons having a permanent ostomy and up-to-date tax filings

For all programs: Clients must be a permanent resident and have a valid P.E.I. health card

Other eligibility criteria

Family Health Benefit Drug Program

Number of children	Net annual family income
1	<$24,800
2	<$27,800
3	<$30,800
4	<$33,800
More than 4	Add $3,000 per additional child

Catastrophic Drug Program: Once a household has spent a certain percentage of its income on eligible drug costs, any further eligible prescription drug costs will be paid through the Catastrophic Drug Program for the remainder of the program year

Total household income	Rate
$0–$20,000	3%
>$20,000–$50,000	5%
>$50,000–$100,000	8%
>$100,000	12%

A household may consist of an

- Adult older than 18 (unless enrolled full time at a post-secondary institution and younger than 26);
- Adult and a spouse (married or common-law);
- Adult and any dependent children (younger than 19 or younger than 26 and attending a post-secondary institution full time); or
- Adult, a spouse and any dependent children.

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

Diabetes

- Insulin: $10/10 mL vial or $20/5 × 3 mL cartridges of insulin
- Blood glucose test strips: $11 per prescription to a maximum of 100 strips monthly, if the patient has used insulin within the last 5 months)
- Oral medications and urine testing materials: $11 per prescription

Family Health Benefit Drug Program: Professional fee for each prescription.

High Cost Drug Program: Income-based portion of the medication cost plus the professional fee for each prescription.

Seniors Drug Cost Assistance Plan: First $8.25 of the medication cost plus $7.69 of 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 is paid by the program.

Home Oxygen Program: PEI Medicare program pays up to 50% of the eligible expenses to a maximum of $200 per month.

Hepatitis Program: Vaccine may be purchased at cost by persons with an occupational risk of infection.

Insulin Pump Program: The program will calculate out-of-pocket copayment expenses based on family income, private insurance coverage and other considerations.

Estimated eligible coverage for recipients who do not have private medical insurance:

Yearly household income	Percentage of eligible coverage	Pump every 5 years	Pump supplies per year
$0–$20,000	90%	$630	$300
>$20,000–$50,000	80%	$1,260	$600
>$50,000–$100,000	70%	$1,890	$900
>$100,000	60%	$2,520	$1,200

Estimated eligible coverage for recipients who have private medical insurance with 80% coverage:

Yearly household income	Percentage of eligible coverage	Pump every 5 years	Pump supplies per year
$0–$20,000	90%	$126	$60
>$20,000–$50,000	80%	$252	$120
>$50,000–$100,000	70%	$378	$180
>$100,000	60%	$504	$240

Generic Drug Program: The beneficiary pays for each prescription out of pocket up to the program maximum cost of $19.95 per prescription.

Phenylketonuria (PKU) Program: For eligible special low-protein formulas, all costs are covered by the program. For specialty food items carried through the National Food Distribution Centre, costs are covered up to a maximum of $3,600 annually.

Ostomy Supplies Program: Copayment expenses are based on family income. The program covers up to 90% of out-of-pocket costs of eligible ostomy supplies to a maximum of $2,400 per full program year (July 1 to June 30).

Yearly household income	Eligible coverage
$0–$19,999	90%
$20,000–$49,999	80%
$50,000–$99,999	70%
>$100,000	60%

Deductible

Catastrophic Drug Program

Total household income range	Rate
$0–$20,000	3%
>$20,000–$50,000	5%
>$50,000–$100,000	8%
>$100,000	12%

Maximum beneficiary contribution

Catastrophic Drug Plan: The maximum beneficiary contribution is the calculated deductible.

Policy information

Ingredient price

Maximum reimbursable price (MRP): The ingredient cost is based on the manufacturer's net catalogue price of the lowest-priced product within an interchangeable category, plus 6%.

When no MRP exists, the price is 10% of the ingredient cost of all brand-name drugs for which the prescription cost is $2,702 or less and 9.25% of the ingredient cost of all brand-name drugs where the prescription cost is more than $2,702.

Generic pricing policy (percentage of brand-name drug)

December 2013: 25%

The price policy applies to both public and private sectors.

Professional fees: Product-related fees/services

Effective April 1, 2015

- Dispensing fee is the usual and customary charge to a maximum of $12.36.
- Compounding fee is the usual and customary charge times 1.5, to a maximum of $18.54.
- Private nursing home capitation fee is $76.52.
- Compliance packaging is $25 per 28 days.
- Prescription adaptation is 1.2 times current dispensing fee.
- Immunization fee is $12.36 per service.
- Refusal to fill is 1.2 times current dispensing fee.
- Therapeutic substitution is 1.2 times current dispensing fee.

Professional fees: Clinical services

Medication review service

Medication reviews are for clients who are eligible under one of the following programs:

- Seniors Drug Cost Assistance Program
- Financial Assistance Program
- Private Nursing Home Program
- Diabetes Drug Program

An eligible client may receive either 1 basic medication review (BMR) or diabetes medication review (DMR) every 365 days, and up to 4 follow-up reviews (BMRF, DMRF). If a client is eligible for and has received a DMR, that client may have a combination of basic and diabetic follow-up reviews, as long as the total does not exceed 4 in that 365-day period.

BMR: $52.50; BMRF: $20

DMR: $65; DMRF: $25

Pharmacy markup

n/a

Coordination of benefits (public/private)

Effective July 1, 2014

Public drug programs are the payer of last resort. Any residents using a public drug program who are also members of a private drug insurance program will have their private insurance billed first and Pharmacare second.

Pharmacare clients with private drug insurance will pay the lesser of

- 20% of the Pharmacare copayment as determined by those without private drug insurance; or
- The prescription balance after the insurance payment.

Pharmacare will cover the balance of the eligible prescription cost after the client and insurance payments are applied to the prescription.

Coordination of benefits (intrajurisdictional)

n/a

Restricted/exception drug coverage process

Prescribers may apply for special authorization coverage by mailing or faxing a completed special authorization form. For some drugs, a patient application is required in addition to the special authorization form.

Allow up to 3 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 1 fill of the prescription received during the assessment period after all of the requested information has been received.

Reimbursement policy

If a beneficiary paid cash at the pharmacy, he or she has 6 months to submit receipts for reimbursement.

Miscellaneous

Program maximum allowable days' supply

Nursing Home Drug Program: 35 days

Institutional Pharmacy Program: 35 days

AIDS/HIV Program: 60 days

Children in Care Drug Program

- 30 days: regular drugs
- 90 days: maintenance drugs
- Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills.

Cystic Fibrosis Program: 60 days

Diabetes Drug Program

- 30 days: insulin and test strips
- 90 days: oral medications
- 30 days: drugs requiring special authorization (SA)
- Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills.

Family Health Benefit Drug Program

- 30 days: regular drugs
- 90 days: maintenance drugs
- 30 days: drugs requiring SA coverage
- Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills.

Financial Assistance Program

- 30 days: regular drugs
- 90 days: maintenance drugs
- 30 days: drugs requiring SA coverage
- Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills.

Generic Drug Program

- 30 days: drugs requiring SA coverage
- 90 days: regular and maintenance drugs
- Prescriptions introducing a new medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills.

Growth Hormone Drug Program: 30 days

Hepatitis Program: 30 days

Multiple Sclerosis Drug Program: 30 days

Phenylketonuria Program: 60 days

Seniors Drug Program

- 30 days: regular drugs
- 90 days: maintenance drugs
- 30 days: drugs requiring SA coverage
- Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills.

Quit Smoking Program

- 7 days: over-the-counter drugs
- 14 days: prescription drugs

Transplant Anti-Rejection Drug Program: 60 days

Tuberculosis Drug Program: 60 days

Catastrophic Drug Program

- 30 days: regular drugs and SA drugs
- 90 days: maintenance drugs
- Prescriptions for a new medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills.

High Cost Drug Program: 30 days, unless otherwise specified in criteria for drug(s)

Insulin Pump Program

- 1 pump from an approved government vendor every 5 years
- 140 infusion sets per year
- 140 reservoirs per year
- 1 replacement site insert per device per year
- 150 skin adhesive wipes per year
- 200 sterile transparent dressings per year

Travel supply: PEI Pharmacare clients enrolled in the Seniors, Diabetes, Generic or Catastrophic Drug programs and travelling outside of the province may be allowed to obtain up to 180 days of their eligible medication prior to leaving the province.

Source: For more information, visit Prince Edward Island Pharmacare.

Newfoundland and Labrador

Eligibility

Plans/programs

- Foundation Plan
- Access Plan
- 65Plus Plan
  - Ostomy Subsidy Program
- Assurance Plan
- Select Needs Plan

General beneficiary information

Foundation Plan: Persons and families in receipt of income-support benefits through the Department of Advanced Education, Skills and Labour; certain individuals receiving services through the regional health authorities, including children in the care of the Department of Children, Seniors and Social Development; and individuals in supervised care.

Access Plan: Individuals and families with low income.

65Plus Plan: Residents age 65 and older who receive Old Age Security benefits and the Guaranteed Income Supplement. Residents covered under the 65Plus Plan also qualify for reimbursement under the Ostomy Subsidy Program.

Assurance Plan: Individuals and families with the financial burden of high eligible drug costs.

Select Needs Plan: Residents who have been diagnosed with cystic fibrosis and residents age 18 and younger with growth hormone deficiency.

Other eligibility criteria

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

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

65Plus Plan: Up to $6 per prescription. The plan covers up to 75% of the retail cost of benefit ostomy items under the Ostomy Subsidy Program.

Access Plan: The copayment is calculated based on family net income level and family status.

Families (with children)

Income	Copayment
<$30,009	20.0%
$31,000	23.9%
$32,000	27.7%
$33,000	31.6%
$34,000	35.5%
$35,000	39.4%
$36,000	43.3%
$37,000	47.2%
$38,000	51.1%
$39,000	55.0%
$40,000	58.8%
$41,000	62.7%
$42,000	66.6%
$42,870	70.0%

Couples (with no children)

Income	Copayment
<$21,435	20.0%
$22,000	23.3%
$23,000	29.1%
$24,000	35.0%
$25,000	40.8%
$26,000	46.6%
$27,000	52.4%
$28,000	58.3%
$29,000	64.1%
$30,000	69.9%
$30,009	70.0%

Single individuals

Income	Copayment
<$18,577	20.0%
$19,000	22.5%
$20,000	28.3%
$21,000	34.1%
$22,000	40.0%
$23,000	45.8%
$24,000	51.6%
$25,000	57.5%
$26,000	63.3%
$27,000	69.1%
$27,151	70.0%

Assurance Plan: Qualifying applicants will be responsible for a copayment depending on their income levels and drug costs:

- 5% of net income for those who earn less than $40,000
- 7.5% of net income for those who earn from $40,000 to less than $75,000
- 10% of net income for those who earn from $75,000 to less than $150,000

Deductible

None

Policy information

Ingredient price

Defined cost: The current published manufacturer's list price, plus 8.5%

Interchangeable unit price: The lowest unit price of all drugs within a Newfoundland and Labrador Interchangeable Drug Products Formulary category

Innovator price: 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: A percentage set by the minister that may be included in the price that may be charged for a drug listed in the formulary

The maximum price listed for a drug shall not exceed 25% of the brand-name price plus the inventory adjustment fee.

Generic pricing policy (percentage of brand-name drug)

July 1, 2013: 25%

The price policy applies to both public and private sectors.

Professional fees: Product-related fees/services

Effective April 1, 2015

The professional fees for the Foundation Plan, Access Plan and Assurance Plan are

- $11.96 for drug costs between $0 and $49.99
- $23.93 for drug costs between $50 and $249.99
- $50 for drug costs of $250+

The professional fees for the 65Plus Plan are

- $12 for drug costs between $0 and $249.99
- $40 for drug costs of $250+

Extemporaneous preparations fee: 1.5 times the base professional fee ($12 for the 65Plus Plan and $11.96 for all other plans) for non-compound products. This applies to compounds that contain 3 or more ingredients. Additionally, $0.10 per powder paper will be paid when compounded by the pharmacist.

Immunization: $13 per service

Mifegymiso: $50 per service

Professional fees: Clinical services

Cognitive services

- Refusal to fill: Pharmacies may bill up to $24 for a maximum of 2 claims.
- Medication management: Pharmacies may bill up to $12 per medication management adaptation.
- Prescribing for a minor ailment: Pharmacies may bill up to $12 for the regular dispensing fee.
- Medication review: Pharmacies may bill $52.50 up to 72 times per year per pharmacy for beneficiaries who have chronic illnesses and are taking 3 or more medications.
- SaferMedsNL: Pharmacists may bill $23 for an initial consult and $10 for a follow-up consult for claims for 3 years starting January 28, 2019, with a focus on 3 classes of drugs: proton pump inhibitors in year 1, sedative hypnotics in year 2 and opioids in year 3.

Pharmacy markup

No surcharge can be applied to the prescription cost under any Newfoundland and Labrador Prescription Drug Program (NLPDP) plan (i.e., neither NLPDP nor the client can be billed or charged a surcharge).

Coordination of benefits (public/private)

NLPDP is the payer of last resort. Beneficiaries must first access private insurance plans before seeking reimbursement from NLPDP.

Coordination of benefits (intrajurisdictional)

Federal public plans are to be used before the provincial drug plans.

Restricted/exception drug coverage process

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.

The following are required to process an out-of-province reimbursement request:

- Documentation of referral out of province by a physician of Newfoundland and Labrador, or documentation of hospitalization if not referred out of province;
- The original prescription receipts; and
- The beneficiary's NLPDP ID number as noted on the drug card.

Reimbursement policy

Reimbursement can be considered under exceptional circumstances; out-of-province claims are considered in cases where the beneficiary is referred out of province for medical reasons and approval is obtained prior to leaving the province or when the beneficiary, while out of province for travel or non-medical purposes, experienced a medical emergency requiring hospitalization and new medications.

Miscellaneous

Prescription quantities

- 90-day supply
- 30-day supply for narcotics, antidepressants and benzodiazepines

Vacation supply coverage

Beneficiaries travelling outside the province for **vacation only** for more than 100 days will be allowed to obtain up to 2 prescriptions (maximum 180-day supply) for the same medication before leaving Newfoundland and Labrador as approved by the prescriber.

Test strips

Effective July 1, 2016

- 2,500 per year maximum for beneficiaries receiving a short-acting insulin
- 700 per year maximum for beneficiaries receiving a long-acting insulin
- 100 per year maximum for beneficiaries receiving only non-insulin diabetes medications
- 50 per year maximum for beneficiaries newly diagnosed **not** receiving insulin or any other non-insulin diabetes medications

Source: For more information, visit Newfoundland and Labrador Prescription Drug Program.

Yukon

Eligibility

Plans/programs

- Pharmacare (PHRM)
- Children’s Drug and Optical Program (CDOP)
- Chronic Disease Program (CHRN)
- Palliative (PALL)

General beneficiary information

Pharmacare: Seniors age 65 and older (and seniors' spouses age 60 and older) registered with Yukon Health Care Insurance Plan; program may also include clients receiving palliative care.

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; program may also include clients receiving palliative care.

Palliative Care: For people who are living with or dying from advanced illness (life expectancy measured in months). Palliative care patients access benefits through either Pharmacare or the Chronic Disease Program and must be registered with 1 of these 2 plans in order to be eligible for the palliative care expanded coverage.

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.

Other eligibility criteria

Family income and family size are used to determine deductibles for the Chronic Disease and the Children's Drug and Optical programs.

Absence from the territory for more than 183 consecutive days (6 months) results in suspension of drug and benefit cost reimbursement, starting with the date of departure. A 1-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.

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

None

Deductible

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.

Maximum beneficiary contribution

Children's Drug and Optical Program: $500 per family per year

Chronic Disease Program: $500 per family per year

Policy information

Ingredient price

Lowest-cost alternative: Yukon Drug Programs formulary benefits will be based on the lowest-priced interchangeable brand available.

The actual acquisition cost (AAC) may include a wholesale upcharge of up to 14%.

A written exception drug application form is required with medical reason(s) for "no substitution." If multiple generics are available, a drug history is required. If approved, the respective program will be responsible for the full cost.

Generic pricing policy (percentage of brand-name drug)

n/a

Professional fees: Product-related fees/services

Professional fee: Up to $8.75

Extemporaneous preparations fee: $13.13

Professional fees: Clinical services

n/a

Pharmacy markup

Pharmacies are allowed a 30% markup on top of the AAC of a drug product.

Coordination of benefits (public/private)

For all Yukon government plans, residents must access private insurance plans first.

Coordination of benefits (intrajurisdictional)

Residents must access all other drug insurance plans first.

Coordination between Yukon government plans: Children who are eligible for the Chronic Disease Program will use that plan before the Children's Drug and Optical Plan.

Restricted/exception drug coverage 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 exception drug can be covered (in selected cases) 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.

Reimbursement policy

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; these may be backdated.

Claims older than 1 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.

Miscellaneous

Prescription quantities

The respective drug programs will not pay for more than a 3-month supply. There must be an interval of 75 days before a further 3-month supply can be given.

Physicians shall exercise their professional judgment in determining the course and duration of treatment for their patients.

Source: For more information, visit Yukon Health and Social Services.

Indigenous Services Canada

Eligibility

Plans/programs

- Non-Insured Health Benefits (NIHB)

General beneficiary information

Non-Insured Health Benefits Program: Recipients must be a Canadian citizen and have the following status:

- A registered Indian according to the *Indian Act*; or
- An Inuk recognized by one of the following Inuit land claim organizations: Nunavut Tunngavik Inc., Inuvialuit Regional Corporation or Makivik Corporation. For an Inuk residing outside of the land claim settlement area, a letter of recognition from one of the Inuit land claim organizations and a birth certificate are required; or
- An infant younger than 18 months 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.

Other eligibility criteria

For some recipients, an Indigenous government or First Nations or Inuit health authority may be responsible for providing health benefits.

As of October 1, 2017, First Nations (those who have a status number) who are residents of British Columbia (excluding persons who receive health benefits by way of a First Nations organization pursuant to self-government agreements with Canada) are eligible for First Nations Health Authority (FNHA) benefit coverage to receive the majority of their pharmacy benefits through B.C.'s PharmaCare Program. NIHB continues to provide claims adjudication and processing services only for a limited number of pharmacy items not available through PharmaCare.

Recipients with chronic renal failure are eligible to receive a list of supplemental benefits as specified in the Special Formulary for Chronic Renal Failure Patients. 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 as specified in the Palliative Care Formulary.

Recipients who are undergoing active cancer treatment are eligible to receive a list of supplemental benefits as specified in the Formulary for Adjunct Medications Used During Active Cancer Treatment.

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

None

Deductible

None

Maximum beneficiary contribution

n/a

Policy information

Ingredient price

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.

Generic pricing policy (percentage of brand-name drug)

Generic drug prices are subject to the pan-Canadian Tiered Pricing Framework.

Professional fees: Product-related fees/services

NIHB fees are set in response to provincial/territorial contexts and therefore vary across the country.

The methadone dispensing fee is paid by the dose, using the following formula:

(Dispensing fee ÷ 7) + $5.25

The program reimburses providers their full usual and customary dispensing fee for buprenorphine/naloxone or slow-release morphine up to the program's regional maximum, per dispense.

Professional fees: Clinical services

Refusal to fill fee: Pharmacies may bill up to their usual customary fee.

Trial drug dispensing fee: In British Columbia and Saskatchewan, the NIHB Program may cover the dispensing fee associated with the provision of a small initial quantity of a trial drug (7-day supply) that is included under the Trial Prescription Program.

Extemporaneous mixtures: NIHB considers reimbursement for extemporaneous mixtures when no suitable alternative is available commercially and when prescribed in accordance with NIHB's prescriber policy. The dispensing fee reimbursed is in accordance with the type of product submitted, per the following:

Category	Eligible NIHB dispensing fee
External creams, ointments, lotions, powders	Up to 1.5× dispensing fee
Internal liquids, powders	Up to 1.75× dispensing fee
Sterile injections, eye/ear mixtures, suppositories	Up to 2× dispensing fee

Pharmacy markup

Markups, if applicable, are set in response to provincial/territorial contexts and therefore vary across the country.

Coordination of benefits (public/private)

When a beneficiary is covered by a private health care plan, claims must be submitted to it first.

Coordination of benefits (intrajurisdictional)

When a beneficiary is covered by another health care plan, claims must be submitted to it first.

NIHB clients who are age 24 and younger and also eligible for OHIP+ in Ontario may access drug coverage from either NIHB or through the OHIP+ Program. Claims do not need to be coordinated.

Restricted/exception drug coverage process

There are 4 types of restricted/exception benefits:

- Limited-use benefits for which requests can be automatically adjudicated based on the client's drug history (prior approval not required)
- 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 Exception Drugs Request Form)
- Benefits that have a quantity and/or frequency limit

Upon receipt of a prescription for a limited-use drug (when not automatically adjudicated) or a non-listed drug, the pharmacist must initiate the prior approval process by calling the Indigenous Services Canada NIHB Drug Exception Centre.

A benefit analyst will request prescriber and client information. An electronically generated Exception or Limited-Use Drugs Request Form will be immediately faxed, if possible, to the prescribing physician. The physician will complete and return the form using the toll-free fax number indicated on the form.

The Drug Exception Centre will review the information and the pharmacist will be notified of the decision by fax. If approved, the provider should retain this faxed confirmation for billing purposes.

Reimbursement policy

Submissions for retroactive coverage must be received by Indigenous Services Canada on an NIHB Client Reimbursement Request Form within 1 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 for pharmacy benefits covered by the NIHB Program.

Miscellaneous

Prescription quantities: The program reimburses a 100-day supply of chronic medications unless otherwise indicated by the prescriber.

Short-Term Dispensing Policy (STD): For refills for medications requiring dispensing for a shorter time than 28 days due to compliance concerns, the program will reimburse only a total of 1 dispensing fee per 28 days up to the regional maximum of the program, except

- Refills for intermittent treatment of a chronic disorder (e.g., dosage change);
- Refills for drugs prescribed for "as required use" (e.g., PRN);
- Prescriptions for dose changes;
- Prescriptions for injectables and suppositories;
- Refills or new prescriptions when prescribed/dispensed in accordance with a court order; or
- Others as identified by the NIHB Program.

For certain medications for which short-term dispensing is deemed medically necessary, the program will compensate pharmacists up to 1 full dispensing fee every 7 days, up to the regional maximum of the program. If these medications are dispensed daily, the program will compensate one-seventh of this fee.

Drugs of concern dispensing: A maximum 30-day supply for all opioids, stimulants, nabilone and benzodiazepines will be covered. 1 full fee will be paid per 30-day dispense (or less, if prescribed in a smaller quantity).

Blood glucose test strips: Clients using insulin will be allowed 500 test strips per 100 days. A client can test up to 5 times per day.

Clients taking diabetes medications that have a high risk of causing low blood sugar will be allowed 400 test strips per 365 days and can test once daily; those taking medications that have a low risk of causing low blood sugar will be allowed 200 test strips per 365 days and can test 3 to 4 times per week.

Persons with diabetes not taking diabetic medication will be allowed 200 test strips per 365 days and can test 3 to 4 times per week.

Effective March 16, 2015, clients with a permanent medical condition can be approved for 2 years of ostomy supplies instead of 1.

Source: For more information, visit Non-Insured Health Benefits.

Appendix 1: Generic pricing policy summary

The following is a summary of the current generic drug pricing policies. Generic prices of 18%, 15% or 10% set by the pan-Canadian Pharmaceutical Alliance may apply over and above the provincial/territorial generic price policies. For implementation or specific drug product information, contact the individual drug program directly.

British Columbia

Covers 25% of the brand-name price of all oral solid generics and 35% of the brand-name price of all other generics. Applies to the public sector effective April 2019.

Alberta

Covers 18% of the brand-name price for all generics, with tiered pricing for new generics. Applies to public and private plans effective April 2014.

Saskatchewan

Covers 25% of the brand-name price of all solid oral generics and 35% of the brand-name price of all non-solid generics. Applies to public and private sectors effective April 1, 2015.

Manitoba

Manitoba has established a policy/contractual approach for generic/multisource pharmaceutical products. The policy/contractual framework for generic/multisource pharmaceutical products includes submission criteria requiring pricing equal to that of other jurisdictions, a price guarantee for a minimum of 365 days and supply commitments by the manufacturer.

Ontario

Covers 25% of the brand-name price for all solid dosage forms and 35% for all non-solid generics. Applies to the public and private sectors effective November 2014. Effective May 20, 2015, exemptions to the 25%/35% price requirements were applied for certain generics. Where there are 3 or more generic products available, the standard 25%/35% pricing would continue to apply. Changes will be retroactive to April 1, 2015.

Quebec

Requires that generic manufacturers provide the province with the lowest price available in other provinces.

New Brunswick

Covers 25% of the brand-name price of all solid oral interchangeable generics in the public and private sectors, and 35% of the brand-name price of all non-solid interchangeable generics in the public sector only, effective June 2013.

Nova Scotia

Covers 25% of the brand-name price of all solid oral interchangeable generics and 35% of the brand-name price of all non-solid interchangeable generics, effective November 2014.

Prince Edward Island

Covers 25% of the brand-name price for all generics. Applies to public and private sectors effective December 2013.

Newfoundland and Labrador

Covers 25% of the brand-name price for all generics. Applies to public and private sectors effective July 2013.

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.

Appendix 2: Pan-Canadian Pharmaceutical Alliance

Provinces and territories have been working together to achieve greater value for both brand-name and generic drugs for publicly funded drug programs. These initiatives, formerly known as the Pan-Canadian Pricing Alliance and the Generic Value Price Initiative, are now referenced collectively as the pan-Canadian Pharmaceutical Alliance (pCPA).

Established in August 2010, the pCPA is part of work under way by the Council of the Federation's Health Care Innovation Working Group. The pCPA conducts joint provincial/territorial negotiations for brand-name drugs in Canada. All brand-name drugs coming forward for funding through the national review processes — Common Drug Review (CDR) or pan-Canadian Oncology Drug Review (pCODR) — are now considered for negotiation through the pCPA.

Appendix 3: Pan-Canadian Tiered Pricing Framework

The first phase of the Pan-Canadian Generic Value Price Initiative Generic Pricing Framework,[ii] as outlined below, was implemented effective April 1, 2013.

Tiered Pricing Framework for new generic drugs

New generic drugs are priced according to category:[iii]

Tier 1: New single source (i.e., only 1 manufacturer of a generic drug): Priced at 75% of brand-name drug price if product-listing agreement (PLA) or pricing agreement for brand-name drug exists in any jurisdiction. Other single source: 85%. Products at this level will be reassessed after 2 years.[iv]

Tier 2: 2 generics: 50%

Tier 3: 3 or more generics: 25% oral solid;[v] 35% all dosage forms other than oral solids (liquids, patches, injectables, inhalers, etc.)

Progression: As soon as another manufacturer begins selling its version of the drug in any jurisdiction, the price of the drug will drop to the next tier (i.e., 75% to 50% to 25%).

Note: For products that fall into the "new single source" category, 1-year retro-activity exists on this section of the pricing framework. For all categories, the option exists for the province/territory to retain PLA or pricing agreement with the brand-name drug if it provides better value.

Pan-Canadian selected molecules

Category description: % of brand-name product

Pan-Canadian 18% group: 18% oral solid

Pan-Canadian 15% group: 15% oral solid

Pan-Canadian 10% group: 10% oral solid

For more information regarding the status of pan-Canadian Pharmaceutical Alliance negotiations for brand-name drugs, as well as the list of all pan-Canadian selected molecules and established price points, please visit the pan-Canadian Pharmaceutical Alliance website.

ii. This framework will be reassessed after 3 years.
iii. Price reduction to the next pricing tier is triggered by market entry of additional competitors.
iv. After 2 years, provinces/territories will reassess continued listing of the single-source product against international prices and the number of Notice of Compliance approvals that Health Canada has granted for the drug.
v. Modified release products will be treated the same as regular tablets and capsules.

Appendix 4: 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 document and are not necessarily the sole definitions of these terms.

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 2 or more drug plans (public/private, intrajurisdictional). 1 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 enrol 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 fee

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.

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 (i.e., insurance and out-of-pocket or cash payment).

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