This guide provides information on the Nova Scotia Pharmacare Programs, but it does not replace the *Fair Drug Pricing Act, Pharmacy Act, Prescription Monitoring Act*, or any of their associated regulations.
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To search for specific text and page content in the electronic version of the Pharmacists’ Guide:
Press “CTRL” + “F” to bring up the Quick Search bar
Pharmacy Claims
Inquiries regarding claims, benefits and eligibility
Local calls: 902-496-7001
Toll-free calls: 1-800-305-5026
Fax: 902-468-9402

Exception status drug requests for authorization
Fax: 902-496-4440
Toll-free fax: 1-888-594-4440

Our representatives are available Monday to Friday, 8:00 a.m. to 5:00 p.m.

Information related to the Nova Scotia Pharmacare Programs may also be found at: www.nspharmacare.ca

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<th>MSI Registration</th>
<th>Local calls: 902-496-7008</th>
<th>Toll-free: 1-800-563-8880</th>
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<tr>
<td>(Nova Scotia Health Cards, new residents)</td>
<td>P.O. Box 500, Halifax, NS B3J 2S1</td>
<td><a href="http://novascotia.ca/dhw/hsi/">http://novascotia.ca/dhw/hsi/</a></td>
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<tr>
<td>P.O. Box 9322, Halifax, NS B3K 6A1</td>
<td><a href="http://www.nspharmacare.ca">www.nspharmacare.ca</a></td>
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<td>Nova Scotia Pharmacare Programs</td>
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<td>P.O. Box 500, Halifax, NS B3J 2S1</td>
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<td><a href="http://www.nspharmacare.ca">www.nspharmacare.ca</a></td>
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<tr>
<td>P.O. Box 500, Halifax, NS B3J 2T7</td>
<td><a href="http://www.novascotia.ca/coms/employment/income_assistance/Pharmacare.html">http://www.novascotia.ca/coms/employment/income_assistance/Pharmacare.html</a></td>
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<td>Organization</td>
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<tr>
<td>Low Income Pharmacare for Children</td>
<td>Nova Scotia Department of Community Services</td>
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<td></td>
<td>P.O. Box 696, Halifax, NS B3J 2T7</td>
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<td></td>
<td><a href="http://www.novascotia.ca/coms/families/PharmacareforChildren.html">http://www.novascotia.ca/coms/families/PharmacareforChildren.html</a></td>
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<td>P.O. Box 500, Halifax, NS B3J 2S1</td>
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<tr>
<td>Nova Scotia Prescription Monitoring Program</td>
<td>P.O. Box 2200, Halifax, NS B3J 3C6</td>
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<td>General e-mail: <a href="mailto:pmp@medavie.bluecross.ca">pmp@medavie.bluecross.ca</a></td>
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<td>Website: <a href="http://www.nspmp.ca">www.nspmp.ca</a></td>
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<td>Pharmacare Audit</td>
<td>P.O. Box 500, Halifax, NS B3J 2S1</td>
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<tr>
<td>Dalhousie MS Research Unit</td>
<td>University Ave, Halifax, NS B3H 1B7</td>
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<td><a href="http://www.cdha.nshealth.ca/dmsru">http://www.cdha.nshealth.ca/dmsru</a></td>
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<td>Addiction Services</td>
<td>P.O. Box 896, Dartmouth, NS B2Y 3Z6</td>
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<td><a href="http://novascotia.ca/dhw/addictions/">http://novascotia.ca/dhw/addictions/</a></td>
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<tr>
<td>Nova Scotia College of Pharmacists</td>
<td>1559 Brunswick Street, Suite 220 Halifax, NS B3J 2G1 General e-mail: <a href="mailto:info@nspharmacists.ca">info@nspharmacists.ca</a> Website: <a href="http://www.nspharmacists.ca">www.nspharmacists.ca</a></td>
</tr>
<tr>
<td>Pharmacy Association of Nova Scotia</td>
<td>170 Cromarty Drive, Suite 225 Dartmouth, NS B3B 0G1 Website: <a href="http://www.pans.ns.ca">www.pans.ns.ca</a></td>
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<td>P.O. Box 488, Halifax NS B3J 2R8</td>
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<td><a href="http://novascotia.ca/dhw/CDPC/flu.asp">For information regarding the flu vaccine, please visit http://novascotia.ca/dhw/CDPC/flu.asp</a></td>
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ADMINISTRATION

Provider Registration

Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1
Local calls: 496-7001
Toll-free: 1-800-305-5026
Fax: 902-468-9402

A “Provider” means:

- a pharmacy licensed under the Pharmacy Act that has confirmed agreement with the tariff between the Minister and the Pharmacy Association of Nova Scotia and has been designated as a provider or in a class of providers; or,

- a supplier of drugs, devices or services that is not licensed as a pharmacy under the Pharmacy Act but is designated as a provider or in a class of providers; or,

- a pharmacy licensed under the Pharmacy Act that has entered into an agreement with the Minister respecting the tariff and has been designated as a provider or in a class of providers.

New non-pharmacy provider requests will not be considered for approval of designation. Existing non-pharmacy providers will remain designated unless notification of opting out of being a non-pharmacy provider is given to the Administrator.

Please note: all pharmacists who prescribe must be registered with Medavie Blue Cross in order to submit any claims. Registration information can be found at: https://www.medaviebc.ca/en/health-professionals/register

Pharmacy providers must be licensed with the Nova Scotia College of Pharmacists.

New providers and providers who have changed ownership are required to complete the following forms provided by Pharmacare:

- Registration of the Pharmacy form, providing information to establish the pharmacy as an authorized provider of pharmaceutical services under the Pharmacare Programs

- Confirmation of Agreement form, as acceptance of the Tariff Agreement

- MSI Provider Business Arrangement form, authorizing direct payment to the pharmacy’s account

- Provider Accreditation Application form, to request accreditation of the pharmacy’s software package and to accept the Terms and Conditions of MSI Provider Accreditation

- Certification of Responsibility for Electronic Claims Submission form, to accept legal responsible and liability for the accuracy and validity of all claims submitted to Medavie Blue Cross via telecommunications.

Pharmacy Closing or Transferring Ownership

As indicated in the Tariff Agreement between the Pharmacy Association of Nova Scotia and the Nova Scotia Department of Health and Wellness, if your pharmacy is closing or changing ownership, it is your responsibility to notify our office within 30 days in advance of transfer/closing.

This information will be retained in confidence. A close-out prescription audit is required. You may contact our office at msiproviders@medavie.bluecross.ca or (902) 496-7560, 496-7190, or 496-7107
Upon registration, a new pharmacy is provided with some key information, including:

- Pharmacy provider number
- Business arrangement number
- Nova Scotia Formulary with reimbursement levels
- Tariff Agreement
- Recent Pharmacare News Bulletins
- Requests for Adjustment forms
- Pharmacare Confirmation of Agreement Form
- Pharmacist Administered Publicly Funded Seasonal Influenza Vaccine Confirmation of Agreement
- Nova Scotia Pharmacare Programs Pharmacists’ Guide
- Nova Scotia Seniors’ Pharmacare Program Information Booklet
- Nova Scotia Family Pharmacare Program Information Booklet

**Conditions of Provider Participation**

A Provider shall:

- determine that the prescription is for the use of the eligible beneficiary,
- respect the Pharmacare Programs as the payer of last resort, which involves determining to the best of their knowledge that the beneficiary is not entitled to the benefit under any private plan, or the Workers’ Compensation Act, from the Royal Canadian Mounted Police, the Department of National Defence, Veterans Affairs Canada, under any other Act of the Legislature or the Parliament of Canada, or under any statute of any jurisdiction either within or outside of Canada,
- dispense all prescriptions in accordance with the directions of the prescriber, Pharmacare rules and regulations, and all applicable pharmacy legislation,
- submit claims to the Pharmacare Programs in an approved manner (CPhA Pharmacy Claims Standard),
- bill the Pharmacare Programs according to the current Tariff Agreement,
- collect all applicable copayments and/or deductibles, and
- be subject to audit, ensuring the Pharmacare Programs are being billed correctly and benefits are provided according to the rules and regulations of the Programs.

**Nova Scotia Pharmacare Payment Schedule**

See the following link: [https://novascotia.ca/dhw/pharmacare/documents/pharmacare-payment-schedule.pdf](https://novascotia.ca/dhw/pharmacare/documents/pharmacare-payment-schedule.pdf)
Nova Scotia Seniors’ Pharmacare Program

The Nova Scotia Seniors’ Pharmacare Program is a provincial drug insurance plan that assists seniors with the cost of their prescription drugs. Seniors are not obligated to join the Seniors’ Pharmacare Program, and not every senior is eligible to join.

The following general information applies to the Seniors’ Pharmacare Program and is subject to change at any time. The Pharmacare News Bulletins, which are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at www.nspharmacare.ca, provide pharmacies with information on changes to the Program.

Eligibility

The Seniors’ Pharmacare Program is offered to Nova Scotia residents who:

- have a valid Nova Scotia Health Card number;
- are at least 65 years of age; and
- do not already have prescription drug coverage through Veterans Affairs Canada, Non-insured Health Benefits, Nova Scotia Family Pharmacare, or any other public or private benefit plan that covers medication and supplies after age 65.

Enrolment

Pharmacare sends an information package approximately three months prior to the 65th birthday of an eligible resident of Nova Scotia. If a senior wishes to join the Seniors’ Pharmacare Program, they must return completed application forms within 90 days of the first day of the month of their 65th birthday to avoid being subject to the late entry penalty. Seniors become eligible for Seniors’ Pharmacare coverage on the first day of the month of their 65th birthday, but only if Pharmacare has received the proper documentation to register, and any required premium payment prior to this date.

Seniors Whose Private Drug Coverage Ceases

If a senior has continuous private prescription drug coverage since becoming 65 years of age but it ends for any reason, they can apply to join the Seniors’ Pharmacare Program. They must return completed application forms, along with proof of other drug coverage from age 65, within 90 days of the first day of the month that the other drug coverage was terminated to avoid being subject to the late entry penalty.

Seniors New to Nova Scotia

If a senior moves to Nova Scotia, they must first apply for and receive a Nova Scotia Health Card before they can apply to join the Seniors’ Pharmacare Program. They must return completed application forms within 90 days of the first day of the month they received their Nova Scotia Health Card to avoid being subject to the late entry penalty.
Late Entry Penalty

If a senior applies for Seniors’ Pharmacare Program coverage beyond the 90-day period in which they were first eligible to apply, or decides to leave the Program for any reason but later wants to rejoin; they may be subject to the late entry penalty, which means they will have to:

- wait 90 days for coverage to begin once accepted into the Program,
- pay one and a half times the assessed premium for the fiscal year in which enrolment begins, prorated from the date of acceptance into the Program, and
- pay one and a half times the assessed premium for each of the four fiscal years of coverage after the first fiscal year.

Benefits

The benefits for the Seniors’ Pharmacare Program are indicated in the Nova Scotia Formulary with an “S” in the benefit status column. Some medications are considered exception status drugs and require a prescriber’s request for approval. These exception status drugs are indicated by “E” next to the program covered in the benefit status column. Please refer to the “Exception Status Drugs” section of this guide for more information.

Identification Card

All individuals registered for MSI have a personalized Nova Scotia Health Card. This card is also used to identify beneficiaries in the Seniors’ Pharmacare Program. Seniors enrolled in the Program must present their Health Card to the provider at the time of prescription purchase to have their prescription processed under Pharmacare. The card can only be used by the person whose name appears on the card.

Public Service Health Care Plan (PSHCP) Members

The Public Service Health Care Plan (PSHCP) provides primary drug coverage to its Nova Scotia members who do not receive the Guaranteed Income Supplement (GIS). However, if a resident is a PSHCP member who meets the Seniors’ Pharmacare Program eligibility criteria and receives the GIS, the Program may provide their primary drug coverage. Residents must apply to the Seniors’ Pharmacare Program to confirm enrolment.

If you would like to learn more about the Guaranteed Income Supplement (GIS) from the federal government, please visit [http://www.servicecanada.gc.ca/eng/services/pensions/oas/gis/index.shtml](http://www.servicecanada.gc.ca/eng/services/pensions/oas/gis/index.shtml).

Reimbursement of Copayments for Seniors with Private Drug Coverage (including PSHCP)

Seniors who are not eligible to join Pharmacare because they have drug coverage through a private benefit plan (including PSHCP) may be eligible to have their drug copayments reimbursed.

If the copayment amount a senior pays to their private insurance (including PSHCP) exceeds the amount of annual maximum premium plus annual maximum copayment they would have paid if they were enrolled in the Seniors’ Pharmacare Program, they may request a reimbursement of the difference. The current maximum amount is $806 ($424 for premium plus $382 for copayment) but may be less if the senior would have qualified for a reduced premium.

Only drugs and supplies listed as benefits under the Seniors’ Pharmacare Program are included in the copayment reimbursement calculation.

Seniors who seek reimbursement should contact Pharmacare, providing the original receipts and the explanation of benefits from the private insurer and may be submitted to Pharmacare anytime during the fiscal year, but no later than June 30, which is 90 days after the end of that fiscal year. Submissions for consideration of reimbursement must also include the senior’s Nova Scotia Health Card number, name, phone number, and address. The private benefit plan continues to be primary insurer.
Premiums

The maximum premium to join the Seniors’ Pharmacare Program is $424. Seniors receiving the GIS from the federal government do not pay the premium.

Seniors not receiving the GIS must pay a premium for Seniors’ Pharmacare coverage. However, some lower income seniors who do not receive the GIS may qualify for reduced premiums. Eligibility for a reduced premium is automatically determined when the Seniors’ Pharmacare Program verifies seniors’ income with the Canada Revenue Agency.

Copayment

Beneficiaries in the Seniors’ Pharmacare Program are required to pay a copayment of 30% of the prescription cost up to an annual maximum copayment of $382. Beneficiaries have the option of paying the annual maximum copayment amount in monthly or annual instalments directly to the Seniors’ Pharmacare Program, similar to their premium payments. However, beneficiaries may choose to pay their copayment on every prescription to the pharmacy. Once the annual maximum copayment of $382 has been reached, Seniors’ Pharmacare will pay the full cost of prescriptions that are covered under the Program until the end of the Program year, March 31st. If the beneficiary chooses to pay the annual maximum copayment of $382 for the Program year, there will be no reimbursement for any portion of $382 that was not used within the year.

No beneficiary in the Seniors’ Pharmacare Program will pay more than $382 in copayments each year. The exception to this is when:

- The senior wants the brand name drug, which is more expensive than the generic; or
- The drug or supply costs more than the maximum amount Seniors’ Pharmacare will cover; or
- The drug prescribed is not covered by Seniors’ Pharmacare.

In these circumstances, the senior is responsible for the additional costs and the amounts paid do not go toward the annual maximum copayment.

Billing

Eligible prescription claims for Seniors’ Pharmacare beneficiaries are submitted online to Pharmacare, using the Nova Scotia Health Card number as the beneficiary’s identification number. Professional fees and mark-ups are paid according to the Pharmacare Tariff Agreement (Appendix I). If a senior chooses to pay their copayment at the pharmacy with each prescription, the Pharmacare online adjudication system calculates the amount of copayment to be billed for each prescription and automatically stops copayment requirements when the senior has reached the annual copayment maximum.

- Nova Scotia Family Pharmacare Program

The Nova Scotia Family Pharmacare Program is available to all Nova Scotia residents who are not currently enrolled in another Pharmacare Program (except Drug Assistance for Cancer Patients). Residents may also enrol in the Family Pharmacare Program as secondary insurance if they already have private insurance.

There are no upfront costs or premiums when enrolling in the Family Pharmacare Program. Annual copayment and deductible maximums are determined by family size and income.

The following general information applies to the Family Pharmacare Program and is subject to change at any time. The Pharmacare News Bulletins, which are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at www.nspharmacare.ca, provide pharmacies with information on changes to the Program.
Eligibility

To be eligible for the Family Pharmacare Program, an individual must be a Nova Scotia resident AND have a valid Nova Scotia Health Card number. The family members must also agree to provide family size information and annual family income verification through Canada Revenue Agency (CRA).

An individual is not eligible for the Family Pharmacare Program if currently receiving drug coverage through:

- The Nova Scotia Seniors’ Pharmacare Program;
- The Nova Scotia Diabetes Assistance Program;
- The Under 65 – Long Term Care Pharmacare Plan; or
- any Department of Community Services Pharmacare Benefits.

Enrolment

Enrolment in the Family Pharmacare Program is by family. Each family must complete and submit only one Family Pharmacare Program Registration Form, which can be found on the Nova Scotia Pharmacare Programs website: [www.nspharmacare.ca](http://www.nspharmacare.ca). Coverage starts on the first day of the month the family joins.

For the purposes of the Family Pharmacare Program, a family is:

- A single adult (age 18 years or older whether or not they are living with their parents)
- An adult and spouse (a spouse is a person who is married to the other adult or with whom they are living in a marriage-like relationship. A spouse may be of the same gender).
- An adult and all dependant children (a dependant child can only be registered with one family at any given time). A dependant child is defined as follows:
  - A child or a legal ward of the adult or by their spouse
  - Supported by the adult or their spouse
  - Younger than 18 years of age
  - Not married and not living in a marriage-like relationship
- An adult, spouse, and all dependant children

The Family Pharmacare Program has an annual renewal. Each year, families are required to re-register by April 1st, as Family Pharmacare coverage year runs from April 1st to March 31st of the following year. Pharmacare sends renewal packages to each family enrolled in the Program.

Benefits

Family Pharmacare Program benefits are indicated with an “F” in the benefit status column of the Nova Scotia Formulary. Some medications are considered exception status drugs and require a prescriber’s request for approval. These exception status drugs are indicated by “E” next to the program covered in the benefit status column. Please refer to the “Exception Status Drugs” section of this guide for more information.

Identification Card

All individuals registered for MSI have a Nova Scotia Health Card. This card is also used to identify beneficiaries in the Family Pharmacare Program. Individuals enrolled in the Program must present their Nova Scotia Health Card to the provider at the time of prescription purchase to have their prescriptions processed under Pharmacare. The card can only be used by the person whose name appears on the card.
Billing

Eligible prescription claims for Family Pharmacare beneficiaries are submitted online to Pharmacare and are adjudicated according to the beneficiary’s deductible and copayment level. An electronic response is returned to the pharmacy. The beneficiary pays the copayment and deductible component to the pharmacy and Pharmacare reimburses the pharmacy for any portion covered by Family Pharmacare.

Copayment and Deductible

All beneficiaries who are enrolled in the Family Pharmacare Program will be required to pay a part of the cost of medications or supplies covered under the Program.

The annual maximum copayment and deductible amounts are specific to each family and depend on family size and income. Each family will receive a letter with their family annual maximum copayment and annual maximum deductible. Beneficiaries can determine their initial out of pocket expense using the online calculator at: www.nspharmacare.ca.

The first 20 percent of every prescription that is covered by the Family Pharmacare Program is applied towards the family’s maximum annual copayment amount. The remaining 80 percent of the total will be applied towards the family’s maximum annual deductible amount.

When the maximum annual deductible amount is paid, the family will continue to pay 20 percent per prescription until their maximum annual copayment amount is also paid in full.

When the family has paid both the maximum annual deductible and copayment amounts in full, Family Pharmacare will pay the approved cost of their medications that are covered under the Program until the end of the Program year, which is March 31st. Families can contact Pharmacare for their deductible and copayment balance at any time.

No family in the Family Pharmacare Program will pay more than their maximum annual family deductible or copayment amounts each year. The exception to this is when:

- the family wants the brand name drug, which is more expensive than the generic; or
- the drug or supply costs more than the maximum amount that Family Pharmacare will cover; or
- the drug prescribed is not covered by the Family Pharmacare Program.

In these circumstances, families are responsible for the additional costs and the amounts paid are not applied towards their maximum annual family deductible or copayment amounts under the Family Pharmacare Program.

Drug Assistance for Cancer Patients

Drug Assistance for Cancer Patients provides income-based assistance to Nova Scotia residents to help defray the cost of approved cancer-related benefits.

The following general information applies to Drug Assistance for Cancer Patients and is subject to change at any time. The Pharmacare News Bulletins, which are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at www.nspharmacare.ca, provide pharmacies with information on changes to the Program.

Eligibility

To be eligible for Drug Assistance for Cancer Patients, an individual must:

- be a resident of Nova Scotia and have a valid Nova Scotia Health Card number;
- not be eligible for any other drug coverage, except Nova Scotia Family Pharmacare or Seniors’ Pharmacare;
- have a diagnosis of cancer;
- have a gross family income of no more than $25,500;
- provide a copy of the most recent Income Tax Notice of Assessment or Reassessment from Canada Revenue Agency (CRA) for the cancer patient, their parent(s) or guardian(s), spouse or common-law partner; and
- agree to family income verification from the CRA Notice of Assessment or Reassessment.

**Enrolment**

Residents of Nova Scotia wishing to apply for coverage should contact Drug Assistance for Cancer Patients using the numbers provided at the beginning of this document. An application form and other information can be found on the Nova Scotia Pharmacare Programs website at: [www.nspharmacare.ca](http://www.nspharmacare.ca).

Once approved, patients do not pay for the drugs and devices which are benefits of Drug Assistance for Cancer Patients.

**Benefits**

A "C" in the benefit status column of the Nova Scotia Formulary indicates benefits covered under Drug Assistance for Cancer Patients. Benefits include categories such as chemotherapeutic agents, pain medications, antiemetic agents, laxatives for use with chronic opioid therapy. Some medications are considered exception status drugs and require a prescriber’s request for approval. These exception status drugs are indicated by "E" next to the program covered in the benefit status column. Please refer to the “Exception Status Drugs” section of this guide for more information. Other agents that are directly related to the beneficiary’s cancer therapy can be considered by Pharmacare upon receipt of a written request from the prescriber.

**Identification Card**

All individuals registered for MSI have a Nova Scotia Health Card. This card is also used for the Drug Assistance for Cancer Patients Program. Individuals enrolled in the Program must present their Nova Scotia Health Card to the provider at the time of prescription purchase to have their prescriptions processed under Pharmacare. The card can only be used by the person whose name appears on the card.

**Billing/Copayment**

Claims are submitted online to Pharmacare using the Nova Scotia Health Card number as the beneficiary’s identification number. Professional fees and mark-ups are paid according to the Pharmacare Tariff Agreement (Appendix I). Beneficiaries do not pay a copayment.

- **Nova Scotia Diabetes Assistance Program**

The Nova Scotia Diabetes Assistance Program is a provincial drug plan that helps to pay for certain prescribed medications and supplies used to manage diabetes.

The following general information applies to the Diabetes Assistance Program and is subject to change at any time. The Pharmacare News Bulletins, which are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at [www.nspharmacare.ca](http://www.nspharmacare.ca), provide pharmacies with information on changes to the Program.
Eligibility

Effective April 1, 2010, the Diabetes Assistance Program will no longer be accepting new beneficiaries.

The Diabetes Assistance Program is offered to eligible residents of Nova Scotia who:

- are existing beneficiaries of the Program;
- have a valid Nova Scotia Health Card number;
- are under age 65;
- have a confirmed diagnosis of diabetes;
- agree to provide family size information;
- agree to family income verification through Canada Revenue Agency (CRA); and
- do not already have coverage through Veterans Affairs Canada, Nova Scotia Family Pharmacare, or any other drug insurance plan for medications and supplies for diabetes.

Re-Enrolment

Re-enrolment packages for the Diabetes Assistance Program will be sent out to families, who must re-enrol by April 1st of each year to remain in the Program. Upon re-enrolment, families are provided with a letter confirming their enrolment and family deductible.

Benefits

A “D” in the benefit status column of the Nova Scotia Formulary indicates benefits available under the Diabetes Assistance Program.

Standard benefits include:

- insulin and analogues, oral blood glucose lowering drugs
- blood glucose test strips, needles, syringes, and lancets.

The program does not cover:

- medications - or supplies taken or used for other medical conditions, such as blood pressure or heart problems
- blood glucose monitors, insulin pumps, and pump supplies.

Some medications are considered exception status drugs and require a prescriber’s request for approval. These exception status drugs are indicated by “E” next to the program covered in the benefit status column. Please refer to the “Exception Status Drugs” section of this guide for more information.

Identification Card

All individuals registered for MSI have a Nova Scotia Health Card. This card is also used for the Diabetes Assistance Program. Individuals enrolled in the Program must present their Nova Scotia Health Card to the provider at the time of prescription purchase to have their prescriptions processed under Pharmacare. The card can be used only by the person whose name appears on the card.
Copayment and Deductible

All beneficiaries who are enrolled in the Diabetes Assistance Program will be required to pay a portion of the cost of prescriptions for medications or supplies covered under the Program.

Beneficiaries are required to pay 20% of the total cost of each prescription as a copayment. The balance of the total prescription cost will also be paid by the beneficiary but will be applied against the annual family deductible. The annual family deductible resets on April 1st of each year. Once a beneficiary pays the deductible portion of the prescription cost they will only be required to pay the 20% copayment. Note: There is no copayment maximum in the Diabetes Assistance Program.

The deductible is specific to each family and depends on family size and income. Each family will receive a letter with their family copayment and deductible requirements.

Billing

Eligible prescription claims for Diabetes Assistance Program clients are submitted online to Pharmacare and are adjudicated according to the beneficiary’s copayment and deductible level. An electronic response is returned to the pharmacy. The beneficiary pays the copayment and deductible component to the pharmacy and Pharmacare reimburses the pharmacy for any portion covered by the Program. Beneficiaries can determine their initial out of pocket expense using the online calculator at: www.nspharmacare.ca.

Multiple Sclerosis Copayment Assistance

The Multiple Sclerosis Copayment Assistance Program provides copayment assistance for select multiple sclerosis (MS) drugs to eligible residents who meet the established disease state criteria, have private insurance coverage for these drugs, and are required to pay a copayment as part of their drug coverage.

The following general information applies to the Multiple Sclerosis Copayment Assistance Program and is subject to change at any time. The Pharmacare News Bulletins, which are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at www.nspharmacare.ca, provide pharmacies with information on changes to the Program.

Eligibility

To be eligible for the Multiple Sclerosis Copayment Assistance Program, an individual must:

- be a resident of Nova Scotia with a valid Nova Scotia Health Card number;
- have drug coverage for the specified MS drugs, but be required to pay a copayment as part of the coverage;
- be managed by the Dalhousie Multiple Sclerosis Research Unit (DMSRU); and
- meet the DMSRU guidelines for MS disease-modifying therapy.

Enrolment

When eligibility is confirmed, the DMSRU sends a written notification of eligibility to Pharmacare. The DMSRU also sends written notification and information on billing processes to the provider that will be filling eligible prescriptions.
Benefits
For a prescription to be eligible for copayment assistance, it must be for the following:

- Glatiramer acetate, or
- Interferon-beta-1a, or
- Interferon-beta-1b

and be:

- written by a neurologist/nurse practitioner at the DMSRU or the MS satellite clinic in Sydney; and
- dispensed by a Pharmacare provider

Billing
Pharmacare reimburses either the eligible beneficiary or the provider. An eligible beneficiary or the provider must submit their receipt for the copayment, along with the completed MS Copayment Reimbursement Form (available from Pharmacare) to Pharmacare.

Copayment
Pharmacare reimburses the eligible resident or provider for the copayment minus a user fee per prescription equal to the maximum professional fee negotiated in the Tariff Agreement between the Department of Health and Wellness and the Pharmacy Association of Nova Scotia (PANS).

Where the eligible resident has reached the annual maximum under their drug insurance plan and is required to pay the full amount of the prescription, Pharmacare reimburses the full amount of the prescription minus the applicable user fee for the remainder of the year.

Under 65 – Long Term Care (LTC) Pharmacare Plan
The Under 65 – Long Term Care (LTC) Pharmacare Plan provides drug coverage for long-term care residents under age 65 who have no drug insurance.

The following general information applies to the Under 65 – LTC Pharmacare Plan and is subject to change at any time. The Pharmacare News Bulletins, which are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at www.nspharmacare.ca, provide pharmacies with information on changes to the Program.

Eligibility
To be eligible for the Under 65 – LTC Pharmacare Plan, an individual must:

- be a resident of Nova Scotia with a valid Nova Scotia Health Card number;
- be under age 65;
- be a regular bed resident of a long-term care facility; and
- not have access to, or coverage under, another public or private drug plan.
Enrolment

Upon admission of a resident, the long-term care facility shall provide written notification to the Program Administrator for the Pharmacare Programs to enrol the resident in the Under 65 – LTC Pharmacare Plan. Facsimile notification is acceptable.

The following information must be provided by the long-term care facility:

- Facility name and address
- Name and number for facility contact
- Name of resident
- Resident’s date of birth
- Resident’s Nova Scotia Health Card number
- Date of admission
- Date of discharge (where applicable)

The Program Administrator for the Pharmacare Programs will confirm that the resident has a valid Nova Scotia Health Card number and set up the resident as a beneficiary of the Under 65 – LTC Pharmacare Plan.

Benefits

The Under 65 – LTC Pharmacare Plan benefits are indicated with an “F” in the benefit status column of the Nova Scotia Formulary. Some medications are considered exception status drugs and require a prescriber’s request for approval. These exception status drugs are indicated by “E” next to the program covered in the benefit status column. Please refer to the “Exception Status Drugs” section of this guide for more information.

Billing/Copayment

Eligible prescription claims for Under 65 – LTC Pharmacare Plan beneficiaries are submitted online to Pharmacare. The long-term care facilities notify their respective pharmacy providers when eligible individuals have been enrolled as beneficiaries in the Under 65 – LTC Pharmacare Plan. The resident identification number for the plan is the resident’s Nova Scotia Health Card number. Beneficiaries of the Under 65 – LTC Pharmacare Plan are not charged a premium, copayment, or deductible.

Department of Community Services Pharmacare Benefits

The Department of Community Services provides prescription drug coverage to eligible beneficiaries.

The following general information applies to Department of Community Services Pharmacare Benefits and is subject to change at any time. The Pharmacare News Bulletins, which are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at www.nspharmacare.ca, provide pharmacies with information on changes to the Program.

Eligibility

Please refer to the table below for information on eligibility for programs.

Enrolment

Low Income Pharmacare for Children Program:

Application forms are available by calling toll-free 1-866-424-1269 or on the Community Services web-page at https://www.novascotia.ca/coms/families/PharmacareforChildren.html.
For all other Programs:

Pharmacare is considered a benefit that is available to individuals/families once they meet the specific program eligibility criteria. If an individual does not have prescription coverage and requires assistance with the cost of drugs, they can be referred to the Department of Community Services’ toll-free number at 1-877-424-1177 or access information on their website at: https://www.novascotia.ca/coms/index.html.

Benefits

Department of Community Services Pharmacare Benefits are indicated with an “F” in the benefit status column of the Nova Scotia Formulary. Some medications are considered exception status drugs and require a prescriber’s request for approval. These exception status drugs are indicated by “E” next to the program covered in the benefit status column. Please refer to the “Exception Status Drugs” section of this guide for more information.

Drugs not listed as benefits in the Formulary or not approved for exception status coverage are not covered.

Identification Card

All beneficiaries and their dependants with Pharmacare coverage through the Department of Community Services must present their Nova Scotia Health Card to the provider at the time of prescription purchase to have their prescriptions processed under Pharmacare. The card can only be used by the person whose name appears on the card.

Billing/Copayment

Please refer to the table below for copayment arrangements by program.

<table>
<thead>
<tr>
<th>Program</th>
<th>Who Is Eligible</th>
<th>Premium</th>
<th>Deductible</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Assistance</td>
<td>As determined by the Department of Community Services Assessment</td>
<td>NO</td>
<td>NO</td>
<td>$5.00</td>
</tr>
<tr>
<td>Income Assistance: Copayment Exempt</td>
<td>Clients on Income Assistance who:</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>▪ receive more than 3 prescriptions per month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ have a permanent disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ take small dosage amounts on a regular basis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income Assistance: Special Needs Pharmacare</td>
<td>Clients who do not qualify for Pharmacare under Income Assistance but have significant drug costs may qualify for payment and if deemed eligible, payment can only be made through a PO #</td>
<td>NO</td>
<td>NO</td>
<td>Variable</td>
</tr>
<tr>
<td>Income Assistance: Transitional Pharmacare</td>
<td>Clients who are no longer eligible for Income Assistance because of employment income may be eligible to receive transitional benefits for 1 year</td>
<td>NO</td>
<td>NO</td>
<td>$5.00</td>
</tr>
<tr>
<td>Low Income Pharmacare For Children (LIPC)</td>
<td>Children of families who receive the NS Child Benefit</td>
<td>NO</td>
<td>NO</td>
<td>$5.00</td>
</tr>
<tr>
<td>Disability Support Program</td>
<td>Clients with intellectual and physical disabilities and long term mental illness who qualify for support and services under the program.</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Children in Care</td>
<td>Children who are placed outside their parent's home.</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>
Palliative Care Drug Program

The Palliative Care Drug Program helps cover the cost of drugs needed for end-of-life care at home. The goals of the Program are to ensure the cost of palliative care medications is not a barrier to symptom control and to help minimize financial burden for those who choose end-of-life care at home.

Many existing drug coverage programs cover medications to help manage symptoms associated with palliative and end-of-life care. This program is for situations where additional coverage is required for home-based end-of-life care.

The following general information applies to the Palliative Care Drug Program and is subject to change at any time. The Pharmacare News Bulletins, which are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at www.nspharmacare.ca, provide pharmacies with information on changes to the Program.

Eligibility

To qualify, patients must meet the following eligibility criteria:

- Reside in Nova Scotia and have a valid Nova Scotia Health Card number
- Be 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
- Wish 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

Enrolment

If eligible, the patient’s local specialist palliative care team completes a Palliative Care Drug Program Application Form available on the www.nspharmacare.ca website and sends it to the Pharmacare office. Coverage is effective for 6 months from the enrolment date. If a patient does not meet eligibility criteria, other Pharmacare programs should be considered, as appropriate.

The pharmacy will submit the claims with the Nova Scotia Health Card number as the patient identification number and a carrier ID of NS.

Note: It may take up to two business days to have system eligibility set up for new clients in the program. If a new client’s eligibility is not in the system, claims may be rejected with the message “CLIENT ID ERROR. If you are having claims rejected and you have the patient’s Palliative Care Drug Program Application Form, you can fax it to 1-902-494-7423 or 1-855-640-7423.

Benefits

The Palliative Care Drug Program covers the cost of drugs required to manage symptoms associated with end-of-life care beyond the patient’s regular coverage. The list of drugs covered under the Program is based on the pan-Canadian Gold Standards for Palliative Care. Coverage is also provided for the following insured professional services, in the same manner as other Pharmacare Programs: Basic Medication Review, Therapeutic Substitution, and Prescription Adaptation.

All drugs eligible under the program will be regular benefits and do not require prior authorization. Please see the Palliative Care Drug Program Formulary available on the www.nspharmacare.ca website for a list of insured medication categories.
Other Coverage

Patients are eligible for the Palliative Care Drug Program if they are enrolled in another Pharmacare Program. The adjudication system will automatically coordinate amongst the Pharmacare plans as claims are submitted using the patient’s Nova Scotia Health Card number. For patients with private insurance, the Program shall be payer of last resort. All claims are to be submitted to private insurance first before being submitted to the Program.

Billing/Copayment

Eligible prescription claims for the Palliative Care Drug Program are submitted online to Pharmacare. There are no copayments, deductibles, or premiums associated with this program. There is no cost to the patient for medications approved under the Program.

Pricing

All claims will be subject to the Tariff Agreement between the Department of Health and Wellness and the Pharmacy Association of Nova Scotia. Claims should be submitted following Pharmacare pricing policies as set out in the Pharmacists’ Guide and Pharmacare News Bulletins.

Contact Information

For further information, including documents and the application form, please visit:

http://novascotia.ca/dhw/pharmacare/palliative-drug-program.asp

For other questions regarding the Palliative Care Drug Program:

- Phone: (902) 496-5680
- Toll-free 1-800-305-5026
Administration of Publicly Funded Influenza Vaccinations by Pharmacists

Eligibility

All individuals 5 years of age and over are eligible to have the publicly-funded influenza vaccine administered by a pharmacist. As the publicly-funded influenza vaccine is available free of charge, no individual is to be charged for the vaccine.

Only residents with a valid Nova Scotia Health Card Number are eligible to have the influenza vaccine administration fee billed to Pharmacare with no copayment or deductible. All other individuals are responsible for paying the applicable administration fee.

Providers

Pharmacies set up as providers to bill publicly-funded influenza vaccine administration fees the previous year are already set up. However, all pharmacies are still required to contact their local Nova Scotia Health Authority (NSHA) public health office to confirm their email, dispensary telephone number, and preferred method of contact.

Pharmacies that have not yet been set up as a provider to bill publicly-funded influenza vaccine administration must:

1. Comply with the required training and application expectations set out by the Pharmacist Extended Practice Regulations and the NSCP’s Standards of Practice: Drug Administration.

2. Sign the Confirmation of Agreement Form for Pharmacist Administered Publicly Funded Seasonal Influenza Vaccine (Appendix II) and submit it to Medavie Blue Cross. Medavie Blue Cross will confirm by email or facsimile that the pharmacy has been set up as a provider to bill influenza vaccine administration fees.

3. Provide their local NSHA public health office with their provider confirmation and any other information the public health office requires to issue influenza vaccine to the pharmacy.

Vaccine Supply

All publicly-funded influenza vaccine must be obtained from the local NSHA public health office. All providers are responsible for any transportation costs to obtain publicly-funded vaccine. Pharmacies should contact their local NSHA public health office to place their order for vaccine and to arrange pick-up. Review the packing protocol for transporting biologicals in the Nova Scotia Immunization Manual (located at: http://novascotia.ca/dhw/cdpc/documents/Immunization-Manual.pdf) to ensure you have all the required equipment when you pick up your vaccine. NSHA public health offices can only release vaccine in accordance with this protocol.

Annual Influenza Vaccine Launch Date

Pharmacists may begin administering publicly-funded influenza vaccine as soon as they receive it.

Billing for Vaccine Administration

Fees for the administration of publicly-funded influenza vaccine to Nova Scotia residents with a valid Nova Scotia Health Card Number must be billed to Pharmacare online. The electronic claim must contain the following in the patient’s insurance field:

- Patient ID – the patient’s Nova Scotia Health Card Number
- Carrier ID – NS

If a patient is already set up in the pharmacy system with Pharmacare coverage (e.g., Seniors’ Pharmacare, Family Pharmacare), a separate patient file does not need to be created.
Claims must be submitted using the DIN of the vaccine administered to the patient, unless the patient is pregnant or is a child receiving a second vaccine dose. See the following Table for direction related to submitting claims using a PIN for pregnant women or children receiving a second dose.

Claims are submitted with the administration fee in the professional fee field. Providers are not reimbursed for ingredient costs or markups for these claims as they are able to access publicly-funded vaccine at no charge.

### Claims Submission Fields for Pharmacist-Administered Publicly Funded Influenza Vaccines

<table>
<thead>
<tr>
<th>CPhA Claim Standard Field #</th>
<th>CPhA Claim Standard Field Name</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.56.03</td>
<td>DIN/GP#/PIN</td>
<td>DINS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ FluLaval® Tetra 02420783</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Fluzone® Quadrivalent MDV 02432730</td>
</tr>
<tr>
<td></td>
<td>PIN for pregnant women</td>
<td>▪ FluLaval® Tetra 93899893</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Fluzone® Quadrivalent 93899895</td>
</tr>
<tr>
<td></td>
<td>PIN for second dose for children</td>
<td>▪ FluLaval® Tetra 93899894</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Fluzone® Quadrivalent 93899896</td>
</tr>
<tr>
<td>D.58.03</td>
<td>Quantity</td>
<td>000001 (one)</td>
</tr>
<tr>
<td>D.61.03</td>
<td>Prescriber ID</td>
<td>Pharmacists prescriber ID</td>
</tr>
<tr>
<td>D.66.03</td>
<td>Drug Cost/Product Value</td>
<td>DDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.67.03</td>
<td>Cost Upcharge</td>
<td>DDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.68.03</td>
<td>Professional Fee</td>
<td>$12.00</td>
</tr>
</tbody>
</table>

### Audit

Pharmacies must retain a signed patient Consent and Disclosure form for each claim reimbursed by Pharmacare.

Pharmacies are advised to maintain a record of the quantity of influenza vaccine administered to individuals who do not have a valid Nova Scotia Health Card Number, as this information may be requested by public health.

### Reporting Adverse Events

It is possible that reactions may occur after administration of influenza vaccine, without a causal association to the vaccine. These reactions must be reported to the local NSHA public health office for the appropriate follow-up. Providers should document an adverse event following immunization (AEFI) using the Public Health Agency of Canada AEFI form (located at: http://www.phac-aspc.gc.ca/im/pdf/raefi-dmcisi-eng.pdf) and forward the form to the local NSHA public health office. The local NSHA public health office reviews these reports and enters them in their local database before forwarding them to the Public Health Agency of Canada.
Breaks in the Cold Chain

Cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines, starting with the manufacturer and ending with the administration of the vaccine. When vaccines are exposed to temperatures of less than 2°C or more than 8°C, the result is a break in the cold chain. Vaccines affected by a break in the cold chain must be packaged separately, identified with a sticker reading “DO NOT USE,” and stored in a refrigerator at between 2°C and 8°C separately from vaccines in current use. Contact your local NSHA public health office to determine whether or not they can be used.

Medical Assistance in Dying: Adjudication of Claims

In June of 2016 amendments to the Criminal Code of Canada enabled access to medical assistance in dying (MAiD) in Canada. The Nova Scotia Department of Health and Wellness will provide coverage for eligible Nova Scotia residents for medications related to the provision of MAiD.

Eligibility

All residents are eligible for public funding of MAiD benefits dispensed by providers, pursuant to a valid prescription and provided the patient meets the specified eligibility criteria for MAiD, including assessments by the prescriber and informed consent from the patient.

Public funding of MAiD benefits dispensed by providers is restricted to patients on an outpatient and community-based level.

Benefits

Benefits, as per recognized protocols, provided in the MAiD kits shall be reimbursed and dispensed as 1 primary MAiD kit and 1 back-up MAiD kit.

MAiD benefits are funded with no premiums, copayments, or deductibles for all residents who meet the eligibility criteria.

Adjudication

All claims shall be submitted for adjudication online only, as per other programs, using the identification number and a carrier ID of NS.

Contact the Pharmacare office to ensure coverage is in place and the claims are submitted correctly. The Pharmacare office can be reached by phone at 496-7001 or 1-800-305-5026, please choose Option 4 and have the following information ready to provide:

- patient’s Nova Scotia Health Card Number
- patient’s date of birth
- provider number
- prescriber
- medications (DINs) and supplies to be dispensed
- dispense date

Providers shall use the DINs of the individual drugs in each kit as part of the claim. Each drug can be billed separately according to the mark-up and dispensing fee outlined in the Pharmacare Tariff Agreement.

If supplies are required to be dispensed, a PIN will be used to adjudicate the claim. This PIN will allow adjudication of the total cost of all supplies dispensed (Primary and Back-up kit combined), as well as the Pharmacare dispensing fee.
Reimbursement for Unreturnable Products: MAiD Benefits

Pharmacies can be compensated for excess and unusable drug and supplies that cannot be returned to the wholesaler/manufacturer and kits that are ultimately not dispensed, if:

- the drugs are not eligible for return for credit as per the policies of the wholesaler or manufacturer from which they are purchased; and
- the provider had no opportunity to dispense the benefit to another patient; and
- the drugs cannot reasonably be provided to another pharmacy for use; and
- the original claim was submitted via the online claims adjudication system; and
- pharmacies contact the Pharmacare office for a Request for Credit Form which must be submitted within six months of the date of claim submission

**Mifegymiso**

Effective **November 1, 2017**, coverage is available for Mifegymiso for women in Nova Scotia with a valid health card number. Any other sources of insurance, such as a private plan, must be billed first. The method for claims submission is outlined below. Should you have any questions, please contact the Pharmacare Office.

<table>
<thead>
<tr>
<th>CPhA Claim Standard Field</th>
<th>CPhA Claim Standard Field Name</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>D56.03</td>
<td>DIN/GP#/PIN</td>
<td>02444038</td>
</tr>
<tr>
<td>D.58.03</td>
<td>Quantity</td>
<td>000001 (one)</td>
</tr>
<tr>
<td>D.61.03</td>
<td>Prescriber ID</td>
<td>Prescriber ID</td>
</tr>
<tr>
<td>D.66.03</td>
<td>Drug Cost/Product Value</td>
<td>DDDDD (MLP dollar value)</td>
</tr>
<tr>
<td>D 67.03</td>
<td>Cost Upcharge</td>
<td>DDDDD (usual Pharmacare upcharge)</td>
</tr>
<tr>
<td>D.68.03</td>
<td>Professional Fee</td>
<td>DDDDD (usual Pharmacare dispensing fee)</td>
</tr>
</tbody>
</table>
**Benefits and Exclusions**

**Seniors’ Pharmacare, Family Pharmacare, Drug Assistance for Cancer Patients, Diabetes Assistance Program, and Community Services Pharmacare Benefits Only**

**Benefits**

Benefits generally include:

- Drugs requiring a prescription by law under Schedule F of the *Food and Drugs Act*, the *Controlled Drug Substances Act*, or Schedule I of the Drug Schedules Regulations to the Nova Scotia *Pharmacy Act* and that have been specifically included as a benefit for recipients of these Pharmacare Programs.
- Non-prescription products specifically included on the benefit list (e.g., enteric coated ASA).
- Selected diabetic supplies including insulin, needles, lancets, and testing strips but not including glucose testing meters, lancet devices, alcohol swabs, insulin pump, or pump supplies.
- Selected ostomy products for use by beneficiaries with ileostomy, colostomy, or urostomy.

Note: A complete list of benefits is available in the Nova Scotia Formulary which details the benefit status of each medication.

Pharmacare News Bulletins are also an important source of information as they provide timely information on recent changes to the benefit list. Bulletins are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at [www.nspharmacare.ca](http://www.nspharmacare.ca).

ALL benefits require a prescription and must be dispensed as a prescription by an approved provider. The Nova Scotia Formulary provides “Prescriber Codes” which indicate the health care provider (physicians/dentists, nurse practitioners, pharmacists, midwives and prescribing optometrists) who is authorized to prescribe a specific drug product for payment under the Nova Scotia Pharmacare Programs.

**Benefit Exclusions**

Exclusions include, but are not limited to:

- prescriptions filled outside Nova Scotia;
- proprietary medicines and household remedies;
- non-prescription products unless otherwise listed;
- artificial sweetening agents;
- dietary supplements and food products;
- soaps, cleansers, and shampoos, medicated or otherwise;
- supportive or physical aids/devices, mechanical or otherwise;
- prescription accessories, convalescent aids or other non-drug items of a similar nature;
- cosmetic, health and beauty aids;
- blood derivatives (Immune Serum Globulin for prophylaxis against infectious hepatitis or measles for treatment of immune deficiency disease available from Public Health);
- vaccines and sera (most are available from Public Health);
- smoking cessation therapies;
- anti-obesity therapies;
- erectile dysfunction therapies;
- infertility therapies;
- therapies for environmental illness;
- drug products identified by trade names deemed to be inappropriate, confusing, and/or misleading;
- wound care products.
## Exception Status Drugs

Certain drugs are only eligible for coverage under the Pharmacare Programs when an individual meets criteria developed by the Atlantic or Canadian Expert Advisory Committees. A list of these drugs is included in the Nova Scotia Formulary (Appendix III – Criteria for Coverage of Exception Status Drugs) and they are indicated by “E” in the benefit status column of the Formulary. For Drug Assistance for Cancer Patients, the exception status drugs which can be considered for coverage are indicated by an asterisk (*).

### Requests for Coverage

To request coverage, the prescriber should mail or fax a completed Standard Exception Status Drug Request Form or a letter to Pharmacare. A copy of this form, as well as other specialized forms, is available on the Nova Scotia Pharmacare Programs website at: [www.nspharmacare.ca](http://www.nspharmacare.ca). Forms may be added or changed at any time. To ensure up to date information, please refer to the website.

Pharmacists may complete an exception status form on behalf of the beneficiary; however, the form must be signed by the prescriber. Prescribers may also contact Pharmacare and speak directly to a drug exception analyst or a pharmacist consultant to request coverage. The prescriber must provide the following information as part of the request:

- beneficiary identification, including Nova Scotia Health Card number;
- diagnosis;
- drug requested;
- criteria met; and
- other pertinent information.

Coverage for non-benefit drugs may also be considered for coverage in exceptional circumstances following a written request from the prescriber. Prescribers may also contact Pharmacare and speak directly to a pharmacist consultant to request coverage.

---

**Every effort is made to process requests within 7 days. Requests of a more urgent nature are processed more quickly. Requests that do not meet defined criteria but warrant further review may take longer.**

### Notification

Beneficiaries are notified by a letter if the request is approved. Beneficiaries 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. The prescriber is notified if coverage is authorized, if the request is refused because the criterion for coverage is not met, or if more information is required.

### Billing

Once authorization is approved, the claim for the exception status drug is billed online to Pharmacare. Usual copayment and deductible rules apply. If the beneficiary has received the drug while awaiting authorization and the request is eventually approved, the beneficiary can seek reimbursement if the receipt is forwarded to Pharmacare within six months of the date purchased. Likewise, coverage may also be backdated to a maximum of three months, or the first of the month of registration (whichever is less).
## Online Adjudication of Exception Status Drugs

Requests will be adjudicated online based on the age of the patient as follows:

- Asmanex 100mcg/act Twisthaler will not require prior approval for beneficiaries aged 4 to 11
- Desmopressin (DDAVP Tab, MELT Tab and generic brands) will not require prior approval for beneficiaries under the age of 16
- Insulin Lispro (Humalog Cartridges, Humalog Insulin and Humalog Kwik Pen) will not require prior approval for beneficiaries under the age of 18
- Mometasone nasal spray (Nasonex) will not require prior approval for beneficiaries aged 3 to 11
- Tretinoin topical preparations will not require prior approval for beneficiaries under the age of 30

The following drugs will be adjudicated online based on the beneficiary’s history:

- Cabergoline (Dostinex 0.5mg Tablet & generic brands)
- Calcipotriol (Dovonex 50mcg/g Ointment, Cream and 50mcg/mL Scalp Solution)
- Entacapone (Comtan 200mg Tablet)
- Fluconazole (Diflucan POS 10mg/mL)
- Levodopa and carbidopa and entacapone (Stalevo 50mg, 75mg, 100mg, 125mg, 150mg Tablet)
- Quinagolide (Norprolac 0.025mg, 0.05mg, 0.075mg 0.15mg Tablet)
- Vigabatrin (Sabril Sachet & Tablet)

Claims submitted that meet these criteria will be accepted; claims submitted that do not meet the criteria will be rejected with the message “CP” (Eligible for special authorization). If the claim is rejected, the prescriber can still submit a request to Pharmacare for consideration.

## Use of Criteria Codes

Selected exception status drugs can be billed online without prior approval if criteria codes are provided during the billing process. The exception status drugs that have been assigned criteria codes are noted in the Nova Scotia Formulary (Appendix III – Criteria for Coverage of Exception Status Drugs).

### Criteria Codes Provided by Authorized Prescribers

For most of the drugs that can be billed using criteria codes, the criteria codes are supplied directly by an authorized prescriber. By supplying a code, the prescriber is verifying that he or she is prescribing the drug for an indication approved under the Pharmacare Programs. The prescriber may provide the criteria code or diagnostic information on the prescription (instead of the actual code). If the criteria code or diagnostic information is not provided by the prescriber on the prescription, the pharmacist may obtain the necessary information from the patient, nurse or other caregiver. The Pharmacist is responsible for clearly documenting on the prescription the information required to support the use of the code as well as the source of this information.

Any situation that falls outside the criteria identified by the codes requires pre-approval and the procedure mentioned previously under “Requests for Coverage” must be followed.
RULES FOR USING CRITERIA CODES

- Criteria codes or diagnostic information may be provided by the prescriber or the code may be added by the pharmacist. It is expected that the prescriber and/or the pharmacist affixing the code will obtain the information necessary to determine if the beneficiary meets the criteria and document this clearly on the prescription as outlined above.

- When a criteria code is part of a verbally received prescription, the criteria code must be documented on the hard copy.

- If diagnostic information is provided, it must be specific enough that the code is clearly identified (e.g., "patient had stroke on ASA" for ticlopidine therapy").

- If the therapy is long term and the code has been supplied correctly on the original prescription but not on the subsequent prescriptions, please reference the original prescription number on subsequent prescriptions. The original code must be easily located upon audit.

If appropriate information is not evident upon audit, monies will be recovered.

BILLING

To allow payment when using a criteria code, two codes are required:

1. The code ‘ED’ must be entered in the Intervention Code field when prescribed by a physician, nurse practitioner, pharmacist, midwife, or optometrist.

2. The code ‘EA’ must be entered in the Intervention Code field when a continuing care prescription is written by a pharmacist.

3. The specific criteria code (01, 02, etc.) is entered in the Special Authorization Code field.

Please continue to refer to the Pharmacare News Bulletins (www.nspharmacare.ca) for updated information regarding the use of criteria codes.

Prescriptions Filled Outside Nova Scotia

The Pharmacare Programs will not pay for prescriptions filled in a pharmacy outside Nova Scotia. However, exceptions may be considered for prescriptions filled in a pharmacy out-of-province but within Canada on a case-by-case basis. For prescriptions filled outside of Canada, there is no reimbursement, emergency or otherwise. Beneficiaries traveling out of the province are advised to take adequate supplies of medications with them and to have adequate travel insurance.

Prescriber Validation

The Nova Scotia formulary lists benefits insured when prescribed by a specific prescriber type. Eligibility by prescriber type is indicated by the prescriber code in the prescriber code column for each benefit. The following prescriber codes are used in the Formulary:

D: Physicians and Dentists
N: Nurse practitioners
P: Pharmacists
M: Midwives
O: Prescribing Optometrists
Claims Submission

- The prescriber for each prescription is validated based on:
  1. Prescriber ID, which is the provincial license number (with or without leading zeros);
  2. Licensing province; and
  3. Prescriber type (indicated by the Prescriber ID Reference Code)

- If a prescriber's license number is not known, it is readily available online from respective licensing authorities:
  - College of Physicians and Surgeons – Physician Search
    [http://www.cpsns.ns.ca/](http://www.cpsns.ns.ca/)
  - College of Registered Nurses of Nova Scotia – Nurse Practitioner Licensing Roster
    [http://www.crnns.ca/](http://www.crnns.ca/)
  - Nova Scotia College of Optometrists
    [http://www.nsco.ca/](http://www.nsco.ca/)

- The two-digit prescriber ID Reference Code for each prescriber type follows:
  - 31 = Nova Scotia College of Physicians and Surgeons
  - 35 = Provincial Dental Board of Nova Scotia
  - 36 = Nova Scotia College of Pharmacists
  - 37 = College of Registered Nurses of Nova Scotia
  - 38 = Nova Scotia College of Optometrists

- The following default prescriber license numbers can be used only when a valid license number cannot be obtained:
  - 9999 = Physician
  - 3333 = Out of Province Physician
  - 8888 = Dentist
  - 71113 = Midwife

- If the Prescriber ID is submitted with an invalid value, the claim submission will reject with CPhA3 response code **D3 "PRESCRIBER IS NOT AUTHORIZED"**. Note that a claim submission will also reject with this response code if a pharmacist submits a valid Prescriber ID but has not registered their Prescriber ID with Medavie Blue Cross.

- If the Prescriber ID is submitted with a blank value, the claim submission will reject with CPhA3 response code **61 "PRESCRIBER ID ERROR"**.

- If the Prescriber ID Reference Code is submitted with an invalid value, the claim submission will reject with CPhA3 response code **60 "INVALID PRESCRIBER ID REFERENCE CODE"**.

- If the Prescriber ID Reference Code is submitted with a blank value, the claim submission will reject with CPhA3 response code **LF "PRESCRIBER ID REFERENCE IS MISSING"**.

- If a claim is submitted for a benefit that is not eligible to be prescribed by a particular prescriber type, the claim submission will reject with CPhA3 response code **CD "DRUG IS NOT A BENEFIT"**.
Coverage of Continued Care Prescriptions

The Nova Scotia College of Pharmacists (NSCP) have established Conditional Authority Agreements with the College of Physicians and Surgeons of Nova Scotia (CPSNS) as well as the College of Registered Nurses of Nova Scotia (CRNNS), allowing pharmacists to extend existing prescriptions as continued care prescriptions (CCPs), provided certain conditions are met.

Pharmacists may submit claims for CCPs to the Nova Scotia Pharmacare Programs for reimbursement, provided:

- The medication being continued is not benzodiazepine or a drug monitored by the Nova Scotia Prescription Monitoring Program.
- The CCP is for an eligible benefit under the applicable Pharmacare Program.
- The pharmacist prescribing the CCP is licensed with the NSCP.
- The physician who prescribed the original prescription being extended is licensed with the CPSNS, or the nurse practitioner who prescribed the original prescription being extended is licensed with the CRNNS.
- The patient is a beneficiary of a Nova Scotia Pharmacare Program and has an immediate need for a prescription extension, but their physician or nurse practitioner is unavailable to provide refill authorization.
- The pharmacist is reasonably satisfied that the physician or nurse practitioner, if available, would provide the authorization.
- The medication to be continued is for a chronic or long-term condition.
- The patient has established a stable history with the medication (no recent changes to dosage/drug therapy).
- The prescription is being extended in the same pharmacy where it originated, and the patient is under the current care of that pharmacy.
- The prescription has not previously been extended through a CCP.
- The amount of the medication provided does not exceed the previous amount prescribed or one month (30 days), whichever is lesser.
- The CCP is documented in a manner that complies with all applicable legislation. It is assigned its own prescription number and the prescription number of the prescription being extended must be noted on the CCP.
- The pharmacist signs the CCP as the prescriber, thereby assuming full responsibility for the CCP.
- CCPs are retained by the pharmacy in compliance with all applicable legislation and are available for Pharmacare audit (refer to the Audit Section for the prescription audit procedures that apply).
- As with any other prescription, the CCP should be documented on the patient’s medication profile.
- The primary care physician or nurse practitioner (or physician/nurse practitioner providing overall care to the patient), if different from the prescriber, should be notified of the CCP as soon as reasonably possible. Documentation of such contact is not required for audit purposes.

Claims Submission

CCPs are to be billed to the Pharmacare Programs for real-time electronic adjudication as follows:

- All claims must have the NSCP licence number in the Prescriber ID field.
- All claims must include the prescription number assigned to the CCP and have an “N” in the New/Refill code field.
• Claims must be submitted in accordance with the terms and conditions of the Nova Scotia Pharmacare Tariff Agreement. Reimbursement will be in accordance with the payment rules of this agreement.

## Insured Professional Services

### Advanced Medication Review Service

Advanced Medication Review Service (AMRS) – approximately one and one-half hours to complete - is an insured service under the Nova Scotia Seniors’ Pharmacare Program and is eligible for coverage provided all of the following criteria are met:

- The AMRS is conducted by a pharmacist licensed with the Nova Scotia College of Pharmacists
- The patient is a beneficiary of the Nova Scotia Seniors’ Pharmacare Program.
- The patient agrees with their pharmacist that they are a suitable candidate for the service. A signed consent form with the pharmacist’s and patient’s signatures and all documentation must be kept on file in the pharmacy for at least three years for audit purposes.
- The patient must not reside in a nursing home or home for special care.
- The patient must be provided with a comprehensive drug review list that is dated and authorized with the pharmacist’s and patient’s signatures.
- The patient is taking 4 or more prescription medications; OR taking one of the following:
  - methylldopa
  - indomethacin
  - cyclobenzaprine
  - diazepam
  - chlordiazepoxide
  - clorazepate
  - amitriptyline
- The patient has at least one of the following diseases:
  - asthma
  - diabetes
  - hypertension
  - hyperlipidemia
  - congestive heart failure
  - chronic obstructive pulmonary disease
  - arthritis
Claims Submission

Claims for AMRS must be submitted electronically to the Nova Scotia Pharmacare Programs for reimbursement, provided the beneficiaries qualify according to the criteria above, and:

- One AMRS per beneficiary using PIN 93899999 in each benefit year, April 1st to March 31st.
- The service fee for AMRS (Special Service Code 006) will be subject to a PRP of $150.00. The copayment will be applicable to this claim.
- The special service code 006 is only applicable to the Nova Scotia Seniors’ Pharmacare Program.

The following CPhA Claims Standard field content is required on the claim:

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Name</th>
<th>Content</th>
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<tbody>
<tr>
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<td>DIN/GP#/PIN</td>
<td>93899999</td>
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<td>D.57.03</td>
<td>Special Service Code</td>
<td>006 (Drug utilization review)</td>
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<td>D.58.03</td>
<td>Quantity</td>
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<td>D.61.03</td>
<td>Prescriber ID</td>
<td>The physician, nurse practitioner or pharmacist who initiates the review</td>
</tr>
<tr>
<td>D.66.03</td>
<td>Drug Cost/Product Value</td>
<td>DDddd (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.67.03</td>
<td>Cost Upcharge</td>
<td>DDddd (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.68.03</td>
<td>Professional Fee</td>
<td>DDddd (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.72.03</td>
<td>Special Services Fee(s)</td>
<td>15000 ($150.00)*</td>
</tr>
</tbody>
</table>

*The copayment will be applicable to this claim.

Pharmacies are required to complete the Pharmacy sign-up form and fax it to the Pharmacy Association of Nova Scotia (PANS) prior to offering the service to their patients. It is important for the pharmacy to be registered for billing and audit purposes. For more information, please contact the Pharmacy Association of Nova Scotia (PANS) at (902) 422-9583 or visit the PANS website for the Medication Review Forms under Membership.

Basic Medication Review Service

Basic Medication Review Service (BMRS) – approximately 20 to 30 minutes to complete - is an insured service under all the Pharmacare Programs, except the Under 65 – LTC Program, and is eligible for coverage provided all of the following criteria are met:

- The BMRS is conducted by a pharmacist licensed with the Nova Scotia College of Pharmacists
- The patient is a beneficiary of a Nova Scotia Pharmacare Program, except the Under 65 – LTC Program.
- The patient must agree with their pharmacist that they are a suitable candidate for the service and sign a consent form which, along with all other documentation, is to be kept on file in the pharmacy for at least three years for audit purposes.
- The patient must not reside in a nursing home, or home for special care.
- The patient must meet with the pharmacist for an in-person consultation.
The patient must be taking 3 (three) or more prescription medications that are used for the treatment of chronic conditions and are covered by the Pharmacare Programs.

The patient must be provided with a comprehensive drug review list that is dated and authorized with the pharmacist's and the patient's signatures.

**CLAIMS SUBMISSION**

Claims for BMRS must be submitted electronically to the Nova Scotia Pharmacare Programs for reimbursement, provided all the above criteria are met, and:

- One BMRS per beneficiary using PIN 93899995 in each benefit year, April 1st to March 31st.
- The service fee for BMRS (Special Service Code 003) is subject to a PRP of $52.50. The copayment and/or deductible will be applicable to this claim.

The following CPhA Claims Standard field content is required on the claim:

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Name</th>
<th>Content</th>
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<td>D.57.03</td>
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<td>D.61.03</td>
<td>Prescriber ID</td>
<td>The physician, nurse practitioner or pharmacist who initiates the review</td>
</tr>
<tr>
<td>D.66.03</td>
<td>Drug Cost/Product Value</td>
<td>DDDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.67.03</td>
<td>Cost Upcharge</td>
<td>DDDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.68.03</td>
<td>Professional Fee</td>
<td>DDDDDD (dollar value - not adjudicated)</td>
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<tr>
<td>D.72.03</td>
<td>Special Services Fee(s)</td>
<td>5250 ($52.50)*</td>
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</tbody>
</table>

*The copayment and/or deductible will be applicable to this claim.

**Medication Review Service Follow-Up**

A Medication Review Service Follow-Up is a supplementary service to the Basic or Advanced Medication Review Service and is eligible for coverage provided all of the following criteria are met:

- The patient must meet the eligibility criteria set out for the corresponding Basic or Advanced Medication Review Service.
- The patient must have had a Basic or Advanced Medication Review Service in the last 12 months.
- The patient must have had **one** of the following:
  - Documented evidence of patient non-adherence;
  - A drug therapy problem identified in the previous Basic or Advanced Medication Review Service that documented the need for pharmacist monitoring/follow-up in the care plan;
  - Hospital discharge if medication changes were made while admitted;
Planned hospital admission; or

- Physician or nurse practitioner request

- The patient must be provided with a personal medication record that is dated and authorized with the pharmacist’s and the patient’s signatures.

- The Medication Review Service Follow-Up must be completed in-person unless the patient is non-ambulatory and the follow-up does not result in any change to the comprehensive drug review list provided as part of the Basic or Advanced Medication Review Service.

- Pharmacists are permitted, if they deem appropriate, to conduct a Medication Review Service Follow-Up outside of the pharmacy (such as in the patient’s home).

- Medication Review Service Follow-Ups may be claimed by a pharmacist employed by a provider that did not complete the original Basic or Advanced Medication Review Service only if the pharmacist providing the Medication Review Service Follow-Up has made every effort to obtain a copy of the original Basic or Advanced Medication Review Service. If the pharmacist is not able to obtain a copy, the reason must be documented and subject to audit.

- Provided all of the criteria are met, the Pharmacare Programs shall reimburse a maximum of two (2) Medication Review Service Follow-Ups per beneficiary within one year of the original Basic or Advanced Medication Review Service.

- Copayments and/or deductibles shall not be applied to claims for Medication Review Service Follow-Ups.

- All documentation related to the Medication Review Service Follow-Ups is to be kept on file in the pharmacy for at least three (3) years for audit purposes.

- Claims for Medication Review Service Follow-Ups must be submitted electronically to the Pharmacare Programs for reimbursement, provided all of the criteria above are met, with the following claim field content:

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Name</th>
<th>Content</th>
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</thead>
<tbody>
<tr>
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<td>Quantity</td>
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</tr>
<tr>
<td>D.61.03</td>
<td>Prescriber ID</td>
<td>The physician, nurse practitioner or pharmacist who initiates the review</td>
</tr>
<tr>
<td>D.66.03</td>
<td>Drug Cost/Product Value</td>
<td>DDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.67.03</td>
<td>Cost Upcharge</td>
<td>DDDDD (dollar value - not adjudicated)</td>
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<td>Professional Fee</td>
<td>DDDDD (dollar value - not adjudicated)</td>
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<tr>
<td>D.72.03</td>
<td>Special Services Fee(s)</td>
<td>2000 ($20.00)*</td>
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</tbody>
</table>

*The copayment and/or deductible will not be applicable to this claim.

**Therapeutic Substitution Service - Proton Pump Inhibitors (PPIs)**

Under the authority of the Pharmacist Drug Prescribing Regulations of the *Pharmacy Act*, pharmacists are able to adapt existing prescriptions to maintain or enhance patient care. Therapeutic substitution within the ATC Code A02BC (Proton Pump Inhibitors-PPIs) is an insured service for beneficiaries of the Pharmacare Programs.
Therapeutic substitution services for PPIs are eligible for coverage provided all the following criteria are met:

- To allow a beneficiary of a Pharmacare Program access to an open benefit PPI in situations where the beneficiary has been prescribed a non-benefit product and/or one requiring special authorization for payment. Reimbursement is restricted to one payment per beneficiary per year.
- Pharmacists are responsible for determining the appropriateness of the therapeutic substitution before performing the service.
- The therapeutic substitution service is conducted by a pharmacist licensed with the Nova Scotia College of Pharmacists (NSCP).
- The patient is a beneficiary of a Nova Scotia Pharmacare Program.
- Pharmacists must comply with all applicable NSCP policies and standards.
- The beneficiary provides written consent to authorize the pharmacist to make the therapeutic substitution. Documentation of consent and notification to the prescriber of the benefit being substituted is to be kept on file in the pharmacy for at least three (3) years for audit purposes.

**CLAIMS SUBMISSION**

Pharmacists must submit electronic claims for therapeutic substitution services to the Pharmacare Programs for reimbursement provided all of the criteria for coverage are met. The following steps must be completed on the same day in the following order for the pharmacy to be reimbursed for the service:

- The original claim for the prescription as written by the prescriber is submitted to Pharmacare and then reversed.
- A claim for therapeutic substitution is submitted using PIN 93899912. (This PIN is specific for therapeutic substitutions within the PPI category).
- All CPhA Claims Standard field content included in the table below is required on the claim.
- The record of therapeutic substitution must reference the prescription numbers for the original claim and modified claim.
- The claim for the new prescription with the changes made is submitted to Pharmacare.
- Copayments and/or deductibles shall not be applied to claims for therapeutic substitution services.

### CPhA Claims Standard – Therapeutic Substitution

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<thead>
<tr>
<th>Field #</th>
<th>Field Name</th>
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<tr>
<td>D.57.03</td>
<td>Special Service Code</td>
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<td>Professional Fee</td>
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<td>D.72.03</td>
<td>Special Services Fee(s)</td>
<td>2625 ($26.25)*</td>
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</tbody>
</table>

* The copayment and/or deductible will not be applied to this claim.
Prescription Adaptation

Prescription adaptation is an insured service under all the Pharmacare Programs when it is performed as follows:

1. Refusal to fill a prescription for a drug monitored by the NSPMP

   Note: Refusing to fill a prescription for a monitored drug because it a) has been requested early or b) has incomplete prescription information is not an insured prescription adaptation service.

2. Changing a prescription for a clinical reason to enhance patient outcomes related to a change in dose or duration.

   Note: A change in prescription quantity unrelated to a dose change or duration change is not an insured prescription adaptation service. For example:

   - Replacing a 5mg tablet with one-half of a 10mg tablet is not insured
   - Changing quantities for compliance packaging must be authorized by the original prescriber, so it is not a prescription adaptation service and is not insured
   - Changes made to match the quantity prescribed to a commercially available package size are not insured
   - Substituting a strength in the case of a manufacturer shortage (e.g., Synthroid® 0.2mg changed to 2 Synthroid® 0.1mg) is not insured
   - Any change in formulation (e.g., tablet to liquid) is not insured
   - Any change in regimen (e.g., changing therapy from morning to bedtime dosing) is not insured
   - Verification and completion of a prescription element is not an insured prescription adaptation service.

Refusal to fill a prescription for a drug monitored by the NSPMP

Criteria for Coverage: Prescription adaptation services provided by a pharmacist are insured when performed as a refusal to fill a prescription for a drug monitored by the NSPMP, provided all of the following conditions are met:

- The pharmacist who refuses to fill the prescription is licensed with the NSCP.
- The patient is a beneficiary of a Nova Scotia Pharmacare Program.
- The pharmacist must comply with all applicable NSCP policies and standards.
- The pharmacist must determine there is sufficient information provided on the prescription to meet the claim submission requirements (see below).
- The pharmacist refuses to fill the prescription for a drug monitored by the NSPMP when in their professional judgement it is deemed not to be in the patient’s best interest. Reasons may include (but are not limited to):
  - Significant drug interaction
  - Prior adverse reaction
  - Therapeutic duplication
  - Sub-therapeutic dose
  - Dangerously high dose
  - Previous treatment failure
  - Potential overuse/abuse
- Suspected poly-pharmacy/multi-doctoring
- Falsified or altered prescription

- After the assessment for refusing to fill a prescription for a drug monitored by the NSPMP, the pharmacist must take action necessary to comply with all applicable NSCP policies and standards, existing legislation, regulations, the Code of Ethics, agreements, other standards of practice, and policy directives relevant to pharmacy practice in Nova Scotia.

- Documentation of all information relevant to the assessment for refusing to fill a prescription for a drug monitored by the NSPMP, the action(s) taken, and the notification to the prescriber must be kept on file in the pharmacy for at least three (3) years for audit purposes.

Claims Submission: Pharmacists submit claims for prescription adaptation services to the Pharmacare Programs for reimbursement of refusal to fill a prescription for a drug monitored by the NSPMP, provided all of the criteria for coverage are met. The following steps must be completed on the same day in the following order for the provider to be reimbursed for the service:

- Claims for prescription adaptation services must be submitted electronically.
- All CPhA Claims Standard field content included in the table below is required on the claim.
- The original claim for the prescription as written by the prescriber is submitted to Pharmacare and then reversed.
- A claim for prescription adaptation is submitted using PIN 93899986.
- The claims adjudication system will only allow the submission of one PIN per beneficiary per day. If multiple services are required for the same beneficiary on the same day, manual claims shall be submitted to the Pharmacare Programs.
- The provider’s record of prescription adaptation must reference the prescription number for the original claim.
- Copayments and/or deductibles shall not be applied to claims for prescription adaptation services that reimburse for refusal to fill a prescription for a drug monitored by the NSPMP.

### CPhA Claims Standard – Prescription Adaptation: Refusal to Fill a Prescription for a Drug Monitored by the NSPMP

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Name</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.56.03</td>
<td>DIN/GP#/PIN</td>
<td>93899986</td>
</tr>
<tr>
<td>D.57.03</td>
<td>Special Service Code</td>
<td>1 (refusal to fill)</td>
</tr>
<tr>
<td>D.58.03</td>
<td>Quantity</td>
<td>000001 (one)</td>
</tr>
<tr>
<td>D.61.03</td>
<td>Prescriber ID</td>
<td>NSCP licence number</td>
</tr>
<tr>
<td>D.66.03</td>
<td>Drug Cost/Product Value</td>
<td>DDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.67.03</td>
<td>Cost Upcharge</td>
<td>DDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.68.03</td>
<td>Professional Fee</td>
<td>DDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.72.03</td>
<td>Special Services Fee(s)</td>
<td>1400 ($14.00)*</td>
</tr>
</tbody>
</table>

*The copayment and/or deductible will not be applied to this claim.
CHANGING A PRESCRIPTION FOR A CLINICAL REASON TO ENHANCE PATIENT OUTCOMES RELATED TO A CHANGE IN DOSE OR DURATION

Criteria for Coverage: Prescription adaptation services provided by a pharmacist are insured when performed for a clinical reason to enhance patient outcomes related to a change in dose or duration, provided all of the following conditions are met:

- The prescription adaptation service is conducted by a pharmacist licensed with the NSCP.
- The patient is a beneficiary of a Nova Scotia Pharmacare Program.
- The pharmacist must comply with all applicable NSCP policies and standards.
- The patient provides written consent to authorize the pharmacist to make the prescription adaptation.
- The original prescription must be a valid complete prescription.
  - The dispenser must verify and complete any incomplete or missing element.
- Documentation of consent, assessment, monitoring plan, and notification to the prescriber of the adapted prescription must be kept on file in the pharmacy for at least three (3) years for audit purposes.

Claims Submission: Pharmacists submit claims for prescription adaptation to the Pharmacare Programs for reimbursement of changes to a prescription for a clinical reason to enhance patient outcomes, provided all of the criteria for coverage are met. The following steps must be completed on the same day in the following order for the provider to be reimbursed for the service:

- Claims for prescription adaptation services must be submitted electronically.
- All CPhA Claims Standard field content included in the table below is required on the claim.
- The original claim for the prescription as written by the prescriber is submitted to Pharmacare and then reversed.
- A claim for prescription adaptation is submitted using PIN 93899985.
- The claims adjudication system will only allow the submission of one PIN per beneficiary per day. If multiple prescription adaptation services are required for the same beneficiary on the same day, the following PINS have been established:
  - Second adaptation: 93899983
  - Third adaptation: 93899984
- If more than three prescription adaptation services are required for the same beneficiary on the same day, manual claims shall be submitted to the Pharmacare Programs.
- The provider’s record of prescription adaptation must reference the prescription numbers for the original claim and the modified claim.
- The claim for the new prescription with the changes made is submitted to Pharmacare.
- Copayments and/or deductibles shall not be applied to claims for prescription adaptation services that reimburse for changing a prescription for a clinical reason to enhance patient outcomes related to a change in dose or duration.
CPhA Claims Standard – Prescription Adaptation: Changing a Prescription for a Clinical Reason to Enhance Patient Outcomes Related to a Change in Dose or Duration

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Name</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.56.03</td>
<td>DIN/GP#/PIN</td>
<td>93899985</td>
</tr>
<tr>
<td>D.57.03</td>
<td>Special Service Code</td>
<td>E (claiming professional care service)</td>
</tr>
<tr>
<td>D.58.03</td>
<td>Quantity</td>
<td>000001 (one)</td>
</tr>
<tr>
<td>D.61.03</td>
<td>Prescriber ID</td>
<td>NSCP licence number</td>
</tr>
<tr>
<td>D.66.03</td>
<td>Drug Cost/Product Value</td>
<td>DDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.67.03</td>
<td>Cost Upcharge</td>
<td>DDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.68.03</td>
<td>Professional Fee</td>
<td>DDDDD (dollar value - not adjudicated)</td>
</tr>
<tr>
<td>D.72.03</td>
<td>Special Services Fee(s)</td>
<td>1400 ($14.00)*</td>
</tr>
</tbody>
</table>

*The copayment and/or deductible will not be applied to this claim.

Uninsured Services

Any service, such as compliance packaging or special charges for sterile compounding, for which a tariff level has not been established, is an uninsured service.

The Nova Scotia Formulary

The Nova Scotia Formulary is a detailed list of drugs and devices, and indicates those that are benefits under Pharmacare. The Pharmacare News Bulletins provide pharmacies with recent changes to the Formulary. The Formulary and Bulletins may be accessed through the Nova Scotia Pharmacare Programs website at: www.nspharmacare.ca. The online Formulary (PDF) is updated monthly.

Drugs are listed according to the Anatomical Therapeutic Chemical (ATC) Classification System. Drugs which have been deemed non-benefits are also listed in the Formulary to indicate the entire range of agents available in a therapeutic class. The benefit column is blank for these agents.

The Formulary provides the following information for each drug:

- name of each product manufactured (including dosage form and/or route and strength)
- authorized prescribers for each benefit
- whether a Maximum Reimbursable Price (MRP) applies
- whether a Pharmacare Reimbursement Price (PRP) applies
- benefit status (programs for which the product is a benefit) and exception drug status
- drug identification number (DIN)
- manufacturer
- interchangeability information
- reimbursement levels
Benefit Review Process

The Nova Scotia Department of Health and Wellness relies on several different expert advisory committees to provide guidance regarding what drugs will be reimbursed under the public drug programs and under what conditions. To provide prescribers with information to better understand how benefit decisions are made, the following is a brief description of each committee.

NEW DRUGS TO THE CANADIAN MARKET

New drugs to market and drugs with new indications are assessed through one of the Health Technology Assessment (HTA) bodies: the Common Drug Review (CDR) or the Pan-Canadian Oncology Drug Review (PCODR). Through these processes, an expert advisory committee reviews the new drug and makes a listing recommendation to publicly funded drug programs across the country (with the exception of Quebec). Each jurisdiction, such as Nova Scotia, must then make the final benefit listing and coverage decision.

RE-LISTING OF PRODUCTS

From time to time, discontinued products may be re-listed in the Formulary at the request of a manufacturer. Processes are in place to ensure that changes to the product since its discontinuation from the Formulary are reviewed accordingly.

LINE EXTENSIONS

The four Atlantic Provinces collaborate through the Atlantic Common Drug Review (ACDR) to review line extensions (e.g., new formats of strengths), review old funding decisions, and conduct drug class reviews. The Atlantic Expert Advisory Committee (AEAC), with experts in the fields of medicine and pharmacy, is involved in making a recommendation to the Nova Scotia Department of Health and Wellness. More information is available at http://novascotia.ca/dhw/pharmacare/expert-committees.asp.

GENERIC DRUGS

The Nova Scotia Drugs and Therapeutics Committee (DTC) reviews submissions from generic manufacturers to determine whether a pharmacist in Nova Scotia can use a generic brand if the prescription is written for a brand name product (interchangeability). The primary consideration is whether products are bioequivalent (produce similar blood levels as dictated by Health Canada guidelines) but other issues such as safety are also considered.
Pricing Procedures

Pharmacare Tariff Agreement

The Nova Scotia Department of Health and Wellness negotiates with the Pharmacy Association of Nova Scotia to determine maximum professional fees, allowable mark-ups, and definitions of the costs that pharmacies can charge for prescriptions covered under the Pharmacare Programs. A copy of the current Pharmacare Tariff Agreement is provided in Appendix I of this guide.

Pharmacare Confirmation of Agreement

The Pharmacare Confirmation of Agreement Form (Appendix III) must be completed when a new pharmacy opens or when a pharmacy changes ownership, as well as when the usual and customary charge to cash customers changes.

Pharmacare Reimbursement

Drug costs billed to the Pharmacare Programs are reimbursed based on the following pricing categories:

- Manufacturer’s List Price (MLP)
- Maximum Reimbursable Price (MRP)
- Pharmacare Reimbursement Price (PRP)
- Actual Acquisition Cost (AAC)

The Nova Scotia Formulary provides reimbursement level information for each drug and can be accessed through the Nova Scotia Pharmacare Programs website at: www.nspharmacare.ca.

Manufacturer’s List Price (MLP)

MLP is the manufacturer’s published price at which a drug or device is sold to a provider or wholesaler that does not include any mark-up for distribution.

In all pricing categories, except AAC, the Pharmacare Programs will reimburse pharmacies the lesser of the amount submitted, or as applicable, MRP, MLP, or PRP.

Maximum Reimbursable Price (MRP)

MRP is the maximum reimbursable price established by the Pharmacare Programs for an interchangeable generic drug. MRP is applied to those drugs which are Pharmacare benefits, and have been deemed interchangeable (e.g., brand name drugs and their generic equivalents) The MRP is the maximum amount that the Pharmacare Programs will reimburse providers for one unit (tablet, capsule, millilitre, etc.) of a drug.

Exemptions to the MRP are available for beneficiaries who have experienced severe, life-threatening side effects with lower cost alternatives. A request must be received from the prescriber detailing the reaction.

Collection of Costs from Beneficiaries for MRP Drugs

Providers shall not charge any cost difference between the AAC of the drug and amount reimbursed by the Pharmacare Programs unless the beneficiary requests the higher priced drug. If the beneficiary requests the higher priced drug, the extra cost is not counted toward their annual maximum copayment or annual maximum deductible.
Pharmacare Reimbursement Price (PRP)

PRP is the ‘special’ maximum price assigned to:

- certain groups of drugs that are similar in therapeutic effect;
- specific services for which coverage is established;
- certain unit dose and special delivery formats that are also available in less expensive bulk formats; and
- certain supplies that are used for the same function;
- other products as determined by Pharmacare.

The PRP is the maximum amount the Pharmacare Program reimburses providers for one unit of a drug (tablet, capsule, millilitre, etc.) supply or service. In the case of methadone, one unit is a milligram.

Collection of Costs From Beneficiaries for PRP Drugs

Providers may charge the beneficiary the portion of their AAC that exceeds the PRP but are not permitted to charge the beneficiary any excess mark-up, or fee beyond what is set out in the Tariff Agreement. Any extra cost is not counted toward the beneficiary’s annual maximum copayment or annual maximum deductible.

Actual Acquisition Costs (AAC)

AAC are the net costs to the provider after deducting all rebates, allowances, free products, etc. No mark-up or buying profit is to be included in the calculation of the AAC.

The ‘net cost’ to the provider is defined as the drug ingredient (or supply) costs based on the date of purchase and inventory flow, even though the current prices available may be lower or higher when the product is dispensed.

Incentives for prompt payment (e.g., payment within 15 days up to a maximum of 2%) are not to be included in the calculation of the AAC.

Product Shortages

Interchangeable Products (non-PRP)

In the event of a shortage of generic products in the Formulary, the Pharmacare Programs can lift the MRP. This will allow for full reimbursement of the brand product at MLP + 10.5%. Before this can be done, the shortage must be due to complete unavailability of all generic products in the interchangeable category, and be confirmed by the manufacturer, not the wholesaler level. The manufacturer must confirm a shortage before any changes are made to the reimbursement.

Quantitative Limits

Maximum Days’ Supply

Pharmacies shall fill claims up to a maximum of 100 days’ supply if prescribed.

Vacation Supply for Pharmacare Recipients

The Department of Health and Wellness has extended the length of time Nova Scotia residents are eligible for Medical Services Insurance (MSI) while out of the province for vacation to a maximum of 7 months in each calendar year. Residents are required to inform MSI of their absence by telephoning 902-496-7008 (local) or 1-800-563-8880 (toll-free) or submitting an email to msi@medavie.ca.
In order to allow beneficiaries an adequate supply of medications while travelling outside the province for more than 100 days, the Nova Scotia Family and Senior’s Pharmacare Programs allow pharmacies to dispense up to three 90-day refills, billed on three consecutive days. This will allow for a 270-day maximum supply of medication for beneficiaries to take with them. This must be clearly documented on the prescription. The usual copayment and pricing rules will apply to each of the prescriptions.
Minimum Days’ Supply

The Pharmacare Programs will not pay multiple dispensing fees where the pharmacist dispenses a quantity less than the quantity prescribed. Therefore, more than one dispensing fee cannot be charged on a prescription when the original quantity is reduced and refills are generated, (even at the beneficiary’s request) unless the prescriber is contacted and the reduced quantity plus refills are authorized. For drugs that fall under the Minimum Days’ Supply policy, the prescriber may, for example, authorize a 90-day supply to be changed to a 30-day supply with 2 refills, or a 60-day supply changed to a 30-day supply with one refill.

The following is a list of ATC categories for which all claims for drugs and products must be for a minimum of 28 days’ supply. Note: Injectables and compounded oral liquids that have been approved for an individual beneficiary within these ATC categories are exempt from the 28-day minimum supply policy.

<table>
<thead>
<tr>
<th>ATC Code</th>
<th>Descriptor</th>
<th>ATC Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>A02A</td>
<td>Antacids</td>
<td>H03</td>
<td>Thyroid Therapy</td>
</tr>
<tr>
<td>A02B</td>
<td>Drugs for Peptic Ulcer and Gastroesophageal Reflex Disease (GERD)</td>
<td>M05</td>
<td>Drugs for Treatment of Bone Diseases</td>
</tr>
<tr>
<td>A06</td>
<td>Laxatives</td>
<td>N02BA01</td>
<td>Acetylsalicylic Acid</td>
</tr>
<tr>
<td>A07E</td>
<td>Intestinal Anti-inflammatory Agents</td>
<td>N02BA11</td>
<td>Diflunisal</td>
</tr>
<tr>
<td>A09</td>
<td>Digestives, Including Enzymes</td>
<td>N02BG04</td>
<td>Floctafenine</td>
</tr>
<tr>
<td>A10</td>
<td>Drugs Used for Diabetes</td>
<td>N03AD</td>
<td>Succinimide Derivatives</td>
</tr>
<tr>
<td>A11</td>
<td>Vitamins</td>
<td>N03AF</td>
<td>Carboxamide Derivatives</td>
</tr>
<tr>
<td>B01AC</td>
<td>Platelet Aggregation Inhibitors Excl. Heparin</td>
<td>N03AG</td>
<td>Fatty Acid Derivatives</td>
</tr>
<tr>
<td>B03</td>
<td>Antinaemic Preparations</td>
<td>N03AX09</td>
<td>Lamotrigine</td>
</tr>
<tr>
<td>C01</td>
<td>Cardiac Therapy</td>
<td>N03AX11</td>
<td>Topiramate</td>
</tr>
<tr>
<td>C02</td>
<td>Antihypertensives</td>
<td>N03AX14</td>
<td>Levetiracetam</td>
</tr>
<tr>
<td>C03</td>
<td>Diuretics</td>
<td>N03AX18</td>
<td>Lacosamide</td>
</tr>
<tr>
<td>C04</td>
<td>Peripheral Vasodilators</td>
<td>N04</td>
<td>Anti-Parkinson Drugs</td>
</tr>
<tr>
<td>C07</td>
<td>Beta Blocking Agents</td>
<td>N06D</td>
<td>Anti-Dementia Drugs</td>
</tr>
<tr>
<td>C08</td>
<td>Calcium Channel Blockers</td>
<td>N07C</td>
<td>Antivertigo Preparations</td>
</tr>
<tr>
<td>C09</td>
<td>Agents Acting on the Renin-Angiotensin System</td>
<td>S01X</td>
<td>Other Ophthalmologicals</td>
</tr>
<tr>
<td>C10</td>
<td>Lipid Modifying Agents</td>
<td>V07AY04</td>
<td>Insulin Syringes</td>
</tr>
<tr>
<td>G04BD</td>
<td>Urinary Antispasmodics</td>
<td>V07AY05</td>
<td>Insulin Pen Needles</td>
</tr>
<tr>
<td>G04CA</td>
<td>Alpha-Adrenoreceptor Antagonists</td>
<td>V07AY06</td>
<td>Diabetic Lancets</td>
</tr>
</tbody>
</table>

The Pharmacare adjudication system will reject applicable Pharmacare claims if the days’ supply is less than 28 days. The pharmacy will receive the message “DR” (Days’ supply lower than minimum allowable).

Note: If it is determined by audit that claims are not being submitted consistent with the Minimum Days’ Supply policy, excess professional fees will be recovered.
Quantity Limits

Quantity limits apply to certain Pharmacare benefits. Beneficiaries requiring quantities that exceed these limits must receive approval through the exception status request process. Applicable quantity limits:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Quantity Limit</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adempas</td>
<td>28 day supply</td>
<td>Every 28 days (with 7-day grace)</td>
</tr>
<tr>
<td>AeroChamber</td>
<td>1 device</td>
<td>Fixed 12-month period (Apr 1–Mar 31)</td>
</tr>
<tr>
<td>Brilinta</td>
<td>60 tablets</td>
<td>Rolling 12-month period (from first date of claim)</td>
</tr>
<tr>
<td>Clopidogrel</td>
<td>30 tablets</td>
<td>Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)</td>
</tr>
<tr>
<td>Daklinza</td>
<td>84 tablets</td>
<td>Fixed 12-week period</td>
</tr>
<tr>
<td>Epclusa</td>
<td>84 tablets</td>
<td>Fixed 12-week period</td>
</tr>
<tr>
<td>Epipen /Allerject</td>
<td>2 injections</td>
<td>Fixed 12-month period (Apr 1–Mar 31)</td>
</tr>
<tr>
<td>Esbriet</td>
<td>270 capsules</td>
<td>Every 28 days (with 7-day grace)</td>
</tr>
<tr>
<td>Etidrocal Kit</td>
<td>6 kits</td>
<td>Fixed 12-month period (Apr 1–Mar 31)</td>
</tr>
<tr>
<td>FluLaval Tetra or Fluzone Quadrivalent</td>
<td>▶ Adults ▶ 1 injection ▶ 56 tablets ▶ Fixed 8-week period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▶ Children ▶ 2 injections ▶ 84 tablets ▶ Fixed 12-week period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▶ 168 tablets ▶ Fixed 24-week period</td>
<td></td>
</tr>
<tr>
<td>Harvoni</td>
<td></td>
<td>Rolling 12-month period (from first date of claim)</td>
</tr>
<tr>
<td>HP Pac</td>
<td>1 kit</td>
<td>Rolling 12-month period (from first date of claim)</td>
</tr>
<tr>
<td>Imbruvica</td>
<td>28 day supply</td>
<td>Every 28 days (with 7-day grace)</td>
</tr>
<tr>
<td>Iclusig</td>
<td>30 tablets</td>
<td>Every 28 days (with 7-day grace)</td>
</tr>
<tr>
<td>Invokana</td>
<td>365 tablets</td>
<td>Fixed 12-month period (Apr 1–Mar 31)</td>
</tr>
<tr>
<td>Kalydeco</td>
<td>28 day supply</td>
<td>Every 28 days (with 7-day grace)</td>
</tr>
<tr>
<td>Medication Review Service</td>
<td></td>
<td>Fixed 12-month period (Apr 1–Mar 31)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Within 12 months of Basic/Advanced</td>
</tr>
<tr>
<td>Ofev</td>
<td>60 capsules</td>
<td>Every 28 days (with 7-day grace)</td>
</tr>
<tr>
<td>Pomalyst</td>
<td>28 day supply</td>
<td>Every 28 days (with 7-day grace)</td>
</tr>
<tr>
<td>Proton Pump Inhibitors (PPI)</td>
<td>425 tablets/capsules</td>
<td>Fixed 12-month period (Apr 1–Mar 31)</td>
</tr>
<tr>
<td>Benefit</td>
<td>Quantity Limit</td>
<td>Time Frame</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Sovaldi</td>
<td>84 tablets</td>
<td>Fixed 12-week period</td>
</tr>
<tr>
<td></td>
<td>168 tablets</td>
<td>Fixed 24-week period</td>
</tr>
<tr>
<td>Testosterone gel (e.g., Androgel 2.5g/pkt)</td>
<td>300 g</td>
<td>Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)</td>
</tr>
<tr>
<td>Testosterone gel (e.g., Androgel 5g/pkt and Testim® 1%)</td>
<td>600 g</td>
<td>Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)</td>
</tr>
<tr>
<td>Testosterone patches</td>
<td>120 patches</td>
<td>Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)</td>
</tr>
<tr>
<td>Thyrogen</td>
<td>1 kit (2 injections)</td>
<td>Fixed 6-month period starting April 1</td>
</tr>
<tr>
<td>Triptans</td>
<td>18 doses</td>
<td>Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)</td>
</tr>
<tr>
<td>Tysabri</td>
<td>28 day supply</td>
<td>Every 28 days (with 7-day grace)</td>
</tr>
<tr>
<td>Vyvanse</td>
<td>5400 mg</td>
<td>Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)</td>
</tr>
<tr>
<td>Xeljanz</td>
<td>730 doses</td>
<td>Fixed 12-month period (Apr 1–Mar 31)</td>
</tr>
<tr>
<td>Zepatier</td>
<td>56 tablets</td>
<td>Fixed 8-week period</td>
</tr>
<tr>
<td></td>
<td>84 tablets</td>
<td>Fixed 12-week period</td>
</tr>
<tr>
<td></td>
<td>112 tablets</td>
<td>Fixed 16-week period</td>
</tr>
</tbody>
</table>

- Pharmacies receive the response code “CM” (Patient is nearing quantity limit) when the benefit reaches 80% of the quantity limit.
- Pharmacies receive the response code “CN” (Patient has reached quantity limit) when the beneficiary reaches 100% of the quantity limit.
- Pharmacies receive the response code “CO” (Patient is over quantity limit) when the claim rejects due to the quantity limit being previously met.
# Standardization of Package Sizes

To ensure claims are paid correctly, please use the following guidelines when calculating quantities for each claim and ensure your cost per unit is correct in your system.

<table>
<thead>
<tr>
<th>Form</th>
<th>Quantity</th>
<th>Form</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerosols</td>
<td>Per dose</td>
<td>Nasal sprays</td>
<td>Per dose</td>
</tr>
<tr>
<td>Capsules</td>
<td>Per capsule</td>
<td>Nebules</td>
<td>Per ml</td>
</tr>
<tr>
<td>Creams*</td>
<td>Per gram</td>
<td>Ointments</td>
<td>Per gram</td>
</tr>
<tr>
<td>Enemas</td>
<td>Per ml</td>
<td>Oral contraceptives</td>
<td>As 21 or 28</td>
</tr>
<tr>
<td>Gels</td>
<td>Per gram</td>
<td>Ostomy supplies</td>
<td>Per item (e.g., 20 pouches)</td>
</tr>
<tr>
<td>Inhalers</td>
<td>Per actuation</td>
<td>Patches</td>
<td>Per patch</td>
</tr>
<tr>
<td>Insulins (vials, penfills, cartridges)</td>
<td>Per ml</td>
<td>Powders</td>
<td>Per gram</td>
</tr>
<tr>
<td>Kits</td>
<td>Per kit</td>
<td>Powder Injectables</td>
<td>Per vial</td>
</tr>
<tr>
<td>Lancets</td>
<td>Per lancet</td>
<td>Suppositories</td>
<td>Per suppository</td>
</tr>
<tr>
<td>Liquids Injectables ****</td>
<td>Per ml</td>
<td>Tablets</td>
<td>Per tablet</td>
</tr>
<tr>
<td>Liquids (except methadone)</td>
<td>Per ml</td>
<td>Testing strips</td>
<td>Per testing strip</td>
</tr>
<tr>
<td>Methadone oral compound solution**</td>
<td>Per mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other:**

<table>
<thead>
<tr>
<th>Form</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package/Kits of more than one drug</td>
<td>Per package</td>
</tr>
<tr>
<td>Packages of blood glucose testing strips</td>
<td>Per test strip</td>
</tr>
<tr>
<td>with built-in meter</td>
<td>(e.g., Sidekick® Blood Glucose Testing System)</td>
</tr>
<tr>
<td>Methadone Oral Compound Solution**</td>
<td>Per milligram methadone, regardless of the product used to prepare the oral liquid</td>
</tr>
</tbody>
</table>

* imiquimod 5% cream - Claims should be billed per mg and not by packet or gram.

** may be compounded from powder or commercially available liquids to be dispensed according to NSCP standards

*** Proctofoam HC Aer - Claims should be billed per gram and not per dose.

**** Somatuline Autogel should be billed as 0.5mL syringe

# Billing for Methadone Oral Compound Solution

All claims for methadone oral compound solution must be billed to the Nova Scotia Pharmacare Programs using the methadone compound solution PIN (00999734), regardless of the product you chose to use to prepare the oral compound solution. Claims billed using the DINs for Metadol® 1mg/mL or 10mg/mL or Methadose® 10mg/mL will be rejected. Beneficiaries who have been approved for Metadol® will automatically be approved for the methadone oral compound solution PIN (00999734).
Compounded Products

**Anthralin Soft Paste**
PIN 00902063 0.05%
PIN 00900907 0.1%
PIN 00900915 0.2%
Ingredients: Anthralin, Lassar’s paste (half strength)

**Anthralin Ointment**
PIN 00901105 0.2%
PIN 00901113 0.4%
Ingredients: Anthralin, emulsifying wax, mineral oil

**Disulfiram 250mg Capsule** - PIN 00903079
Ingredients: disulfiram powder, gelatin capsules, lactose powder

**Hydrocortisone Powder in Clotrimazole Cream (1% - 2.5%)** - PIN 00999474*
Ingredients: hydrocortisone powder, clotrimazole cream

*Mixing hydrocortisone 1% cream with clotrimazole cream in equal parts will create a product of hydrocortisone 0.5% in ½ strength clotrimazole cream. This concentration is not insured under the Nova Scotia Pharmacare Programs and, upon audit, any reimbursements for this compound will be recovered.

**Placebo Capsule** - PIN 00999008
Ingredients: gelatin capsules, lactose powder

**Probencid 250mg Capsule** - PIN 00903771
Ingredients: probencid powder, gelatin capsules, lactose powder

**Probencid 500mg Capsule** - PIN 00903772
Ingredients: probencid powder, gelatin capsules, lactose powder

**LCD (Coal Tar) Preparations**
PIN 00358494 (any strength)
PIN 00358495 (20% USP)
Ingredients: LCD, petrolatum or hydrophilic ointment (lanolin, Eucerin®, Dermabase® etc.)

**Magic Mouthwash** - PIN 00999022
Formulations:
- Diphenhydramine Syrup (Pediatric) 50mL
- Lidocaine Viscous 2% 25mL
- Attapulgite Suspension 25mL
- Diphenhydramine Syrup (Pediatric) 50mL
- Lidocaine Viscous 2% 25mL
- Magnesium/Aluminum Conc. Suspension 75mL
- Diphenhydramine Syrup (Pediatric) 50mL
- Attapulgite Suspension 50mL
- Diphenhydramine Syrup (Pediatric) 50mL
- Magnesium/Aluminum Suspension 50mL

**Methadone for Oral Compound Solution**
- PIN 00999734
Ingredients: methadone (any methadone product used), Tang® or similar product

**Salicylic Acid Ointment (any strength)**
- PIN 00900788
Ingredients: salicylic acid, white soft paraffin

**Tar Pomade** - PIN 00901121
Ingredients: salicylic acid, coal tar solution, emulsifying ointment
BILLING THE PHARMACARE PROGRAM

Claim Information for Online Adjudication

Claims to the Pharmacare Programs are transmitted in accordance with the Canadian Pharmacists Association (CPhA) Pharmacy Claim Standard, Version 03. Copies of the Standard can be obtained from:

The Canadian Pharmacists Association
1785 Alta Vista Drive
Ottawa, ON K1G 3Y6
Phone: (613) 523-7877
Fax: (613) 523-0445

The following are some important fields that are transmitted and adjudicated with each claim.

- Pharmacy ID: number assigned by Pharmacare,
- Client ID,
- Client date of birth,
- Patient first and last name,
- Gender,
- Prescription number,
- Transaction date,
- DIN or assigned PIN,
- Quantity,
- Days’ supply,
- New or Repeat code,
- Number of refills,
- Prescriber ID,
- Drug cost,
- Mark-up,
- Professional fee, and
- Intervention and exception codes, if applicable (e.g., for online authorization of selected agents).
Response Codes

The following response codes below are commonly utilized by the Pharmacare Programs as per the Pharmacy Claims Standard. Please refer to the Claims Standard for a listing of all CPhA response codes.

30 – Carrier ID error
31 – Group ID number error
32 – Client ID error
34 – Patient DOB error
35 – Cardholder identity error
36 – Relationship error
37 – Patient first name error
38 – Patient last name error
40 – Patient gender error
56 – DIN error
58 – Quantity error
59 – Days’ supply error
60 – Invalid Prescriber ID reference
61 – Prescriber ID error
62 – Product selection code error
A1 – Claim too old
A3 – Identical claim has been processed
A6 – Submit manual claim
A7 – Submit manual reversal
A8 – No reversal made – original claim missing
C2 – Services provided before effective date
C4 – Coverage terminated before service
C9 – Patient is not covered for drugs
CD – Drug is not a benefit
CM – Patient is nearing quantity limit
CN – Patient has reached quantity limit
CO – Patient is over quantity limit
CP – Eligible for special authorization
D1 – DIN is not a benefit
D3 – Prescriber is not authorized
DR – Days’ supply lower than minimum allowable
LF – Prescriber ID reference is missing
MT – Drug/gender conflict indicated

• Please note that the same DIN cannot be billed for a beneficiary twice on the same day. Payment will not be provided for the second prescription, generating a reject code of A3, “Identical claim has been processed”.

Billing of Claims with Cost Exceeding $9,999.99

Currently pharmacy software systems do not allow for the online transmission of claims over $9,999.99. With the addition of newer high cost drugs, routine claims will likely exceed this amount. In order to allow for online adjudication, claims that will exceed $9,999.99 must be divided and processed as separate transactions as follows:

• The first transaction should be submitted using the DIN for the product. The quantity should be adjusted to ensure the total cost of the claim, including ingredient cost, dispensing fee and mark up, does not exceed $9,999.99.

• A subsequent claim, if required, can be transmitted for the remaining quantity using the PIN’s assigned to the product. These PIN’s will pay ingredient cost and applicable markup. The applicable PINS can be found in the Nova Scotia Pharmacare Formulary.

• The copayment and deductible will be applied to the claims for beneficiaries enrolled in Seniors’ Pharmacare, Family Pharmacare, and Community Services Pharmacare Benefits.

• This process should only be used when the total claim, as written by the prescriber, will exceed $9,999.99.

• Patients will still require exception status approval prior to claims being paid online.
# Manual Claims

In very exceptional circumstances, or for providers who are not online, it may be necessary to bill the Pharmacare Programs utilizing a manual claim. Claims must be submitted within three months of the date of service.

A charge of $0.25 per claim is deducted for each manual claim. This appears as a bottom line deduction on the payment statement.

## Manual Claim Form Sample

The claim form is available on the website below. An explanation of the various fields follows. Pharmacies may wish to retain a copy of completed claim forms for their files. The claim form is available on the website.

<table>
<thead>
<tr>
<th>A</th>
<th>Nova Scotia Health Card Number entered as 5555-555-555</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Pharmacy Number as assigned by Pharmacare Program</td>
</tr>
<tr>
<td>C</td>
<td>Date entered numerically, e.g., 15.05.00 (= 15th of May 2000)</td>
</tr>
<tr>
<td>D</td>
<td>Prescriber number, e.g., 9999 for a medical resident, 8888 for a dentist</td>
</tr>
<tr>
<td>E</td>
<td>“O” for original or new prescription, “R” for refill</td>
</tr>
<tr>
<td>F</td>
<td>Refer to “Standardization of Package Sizes” in the guide</td>
</tr>
<tr>
<td>G</td>
<td>Drug cost (AAC, MRP or PRP)</td>
</tr>
<tr>
<td>H</td>
<td>Professional fee. Do not put any mark-up in this field</td>
</tr>
<tr>
<td>I</td>
<td>Mark up (as per the Nova Scotia Pharmacare Tariff Agreement)</td>
</tr>
<tr>
<td>J</td>
<td>Total cost of prescription</td>
</tr>
<tr>
<td>K</td>
<td>Amount of copayment charged to beneficiary, if applicable</td>
</tr>
<tr>
<td>LM</td>
<td>For Pharmacare use only</td>
</tr>
</tbody>
</table>
**Adjustments**

If a claim has been billed incorrectly online the pharmacist may, within 90 days of the original claim, reverse and resubmit the claim with the correct information.

It is expected that pharmacists will check the response screen when claims are submitted to determine if the appropriate amount has been paid, instead of waiting to identify problems when the payment statement arrives.

After 90 days, reversals and adjustments must be submitted on a [Request for Adjustments Form](#) (reference sample below). This form is also used for adjustments to manual claims. Adjustments to previously paid claims can be submitted up to a maximum of six months from the date of service.

Pharmacare staff will make the necessary adjustments and these will appear on the next pharmacy statement. Should there be a problem; the request for adjustment will be returned to the pharmacy with an explanation.
Medications Returned to Stock

1) Medication that has been previously billed to the Pharmacare Programs, dispensed, and has not left the security of the pharmacy can be returned to stock. Providers must reverse these Pharmacare claims.

2) Medication that has been previously billed to the Pharmacare Programs and is being returned to stock following the conditions of the Nova Scotia College of Pharmacists’ Return of Medication policy (see form below) must be credited back to the Pharmacare Programs.

- If Providers wish to claim the Pharmacare restocking fee for returning these medications to stock, they are required to complete and submit a Statement of Returned Benefits form. The benefit description, quantity, unit cost, and total drug cost (including markup) associated with each item must be provided. The total cost paid by Pharmacare, less a restocking fee of 20%, will be deducted from the provider’s payment statement as a bottom line adjustment.

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**NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS**

**Statement of Returned Benefits**

Pharmacare benefits dispensed to a beneficiary in a facility licensed pursuant to the Homes for Special Care Act can be returned to stock where, in the exercise of professional judgement, the pharmacist deems it appropriate to do so and where all of the conditions in the Nova Scotia College of Pharmacists’ “Return of Medication” policy are met.

- The beneficiary has not been in possession of the benefit.
- The lot numbers and expiry dates (where applicable) of the benefit are directly attached to the dispensed container.
- Each dose of the drug product is individually sealed and the seal is intact at the time of the return to the pharmacy.
- The pharmacist has sufficient knowledge of the medication administration and storage conditions/policies of the facility registered under the Homes for Special Care Act to permit the exercise of professional judgement.

---

**CLAIM INFORMATION**

<table>
<thead>
<tr>
<th>PROVIDER NUMBER</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
</tbody>
</table>

**BENEFIT INFORMATION**

<table>
<thead>
<tr>
<th>BENEFIT NAME</th>
<th>DIN/PRIN/PN</th>
<th>QUANTITY</th>
<th>UNIT COST</th>
<th>(QUANTITY x UNIT COST) + MARK-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**DECLARATION**

I CERTIFY THIS TO BE AN ACCURATE STATEMENT OF BENEFITS RETURNED TO THE PHARMACY.

---

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026.

Please return form to: Nova Scotia Pharmacare Programs
P.O. Box 550, Halifax, NS B3J 2S1
Fax: (902) 468-9402

07/2015
Reimbursement for Unreturnable Products: Injectables and Ostomy Supplies

Pharmacies can be reimbursed for the cost of injectable medications and ostomy supplies that cannot be returned to the point of purchase. This process is intended to remove the financial risk for pharmacies who stock injectable medications and ostomy supplies for Pharmacare beneficiaries that are subsequently not needed and cannot be returned to the point of purchase.

This process will apply when the injectable medication or ostomy supply has been ordered for and is an eligible benefit for a Pharmacare beneficiary. Pharmacies will be reimbursed for the AAC of the medication.

Each request must also be accompanied by a fully completed “Request for Reimbursement Form”, with all required documentation, and will only be considered under the following conditions:

- The provider is an approved Pharmacare provider and has been assigned a provider ID number.
- The benefit was ordered for a claimant who was an eligible resident and enrolled in a Pharmacare Program at the time the benefit was ordered.
- The provider must provide the total dollar amount claimed, DIN/PIN, trade name, lot number, expiry date, and manufacturer of the product, the health card number and the name of the Pharmacare beneficiary.
- The provider must submit a copy of the prescription.
- The provider must submit a copy of the invoice showing the AAC of the product.
- The injection or ostomy supply was an eligible benefit in the Nova Scotia Formulary for the Pharmacare Program under which the resident was a beneficiary at the time it was purchased. Note that exception status benefits are only eligible for reimbursement if the resident had been approved for them through the exception status approval process at the time the benefit was received.
- The benefit is not eligible for return according to the policies of the wholesaler or manufacturer from which it was purchased.
- The provider has no opportunity to dispense the benefit to another patient.
- The request for reimbursement is received within six (6) months of the date on the prescription.

If the request qualifies for reimbursement, an adjustment based on the AAC of the unreturnable benefit will be applied on the next pharmacy statement. If an adjustment cannot be made, the request for adjustment will be returned to the pharmacy with an explanation.

If the provider is reimbursed for an unreturnable injectable or ostomy benefit but dispenses that same benefit to another patient, the provider must submit a request to make a bottom-line adjustment.
## Payments and Statements

Payments to pharmacies are made every two weeks on a predetermined schedule and are deposited electronically. The cut-off date, for claims to be included in the payment, is three days prior to the payment date.

A payment statement is generated on the predetermined date and itemizes each claim paid.

- A double asterisk beside a claim indicates that the amount paid is different from the amount claimed.
- Rejected claims are not included on the payment statement.
- Reversed claims are indicated by a zero-amount claimed and a negative amount paid.
- Bottom line adjustments appear on the last page of the statement and are deducted from the total amount owed to the pharmacy. These adjustments include a $0.05 per claim deduction which is forwarded to the Pharmacy Association of Nova Scotia and may also include any charges recovered due to an audit, medications returned to stock, and deductions of $0.25 for each manual claim submitted.

Below is a sample of the Payment Statement Form:

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Reference Number</th>
<th>Adjustment Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>This number is in sequence.</td>
<td>This number should be quoted when you are corresponding with MSI — the number uniquely identifies each claim.</td>
<td>If the amount paid is less than the amount corresponding with MSI the number claimed an adjustment code will be entered. — below is a list of the codes.</td>
</tr>
</tbody>
</table>

### Adjustment Codes

- **22** – Provider transaction data error
- **32** – Patient Identification Information error
- **52** – New/refill code error
- **56** – DIN/PIN error
- **58** – Quantity error
- **59** – Days supply error
- **61** – Prescriber ID error
- **66** – Drug cost error
AUDIT

■ Pharmacare Audit

Pharmacare Audit
P.O. Box 500, Halifax, NS B3J 2S1

Local calls: 902-496-7030 or 484-1059
Toll-free: 1-800-563-8880

For more information, please see the Nova Scotia Pharmacare Program Audit Guide.
APPENDIX I

Pharmacare Tariff Agreement

AGREEMENT

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF NOVA SCOTIA
As represented by the Department of Health and Wellness
(Hereinafter referred to as “Department”)

and

THE PHARMACY ASSOCIATION OF NOVA SCOTIA
(hereinafter referred to as “PANS”)

Effective October 1, 2014 to September 30, 2019

1.0 Definitions

In this agreement,

(a) “Agreement” means this agreement.

(b) “AAC” means actual acquisition cost which is the net cost to the provider after deducting all rebates, allowances, free products, etc. No mark-up or buying profit is to be included in the calculation of AAC. The net cost to the provider is defined as the drug ingredient (or supply) cost based on date of purchase and inventory flow, even though the current price available may be lower or higher when the product is dispensed. Incentives for prompt payment (payment within 15 days up to a maximum of 2%) will not be included in the calculation of AAC.

(c) “Department” means the Nova Scotia Department of Health and Wellness.

(d) “MLP” means the manufacturer’s list price, which is the Nova Scotia Formulary published price at which a drug or device is sold to a provider or wholesaler and it does not include any mark-up for distribution.

(e) “MRP” means the maximum reimbursable price, which is the maximum drug cost established by the Minister under the Insured Prescription Drug Plan that is reimbursed to a provider or a beneficiary for a category of interchangeable products.

(f) “PANS” means the Pharmacy Association of Nova Scotia.

(g) “Pharmcare Dispensing Fee” is the LESSER of the usual and customary dispensing fee the provider charges to cash customers and the applicable maximum Pharmcare dispensing fee as described in 6.0 of this Agreement.

(h) “PRP” means Pharmcare reimbursement price. A PRP is assigned by the Minister to each of the following:

- Certain groups of drugs that are similar in therapeutic effect;
- Specific services for which coverage is established;
- Certain unit dose and special delivery formats that are also available in less expensive bulk formats; and
- Certain different supplies that are used for the same function.

The PRP is the maximum amount the Program reimburses providers or beneficiaries for one unit of a drug, supply or service.
(i) “Pharmacy” means a pharmacy as defined in the Pharmacy Act and licensed with the Nova Scotia College of Pharmacists.

(j) “Program” means any program established under the Insured Prescription Drug Plan.

(k) “Provider” means:
   i. A pharmacy licensed under the Pharmacy Act that has confirmed agreement with the tariff between the Minister and the Pharmacy Association of Nova Scotia and has been designated as a provider, or in a class of providers, and
   ii. A supplier of drugs, devices or services that is not licensed as a pharmacy under the Pharmacy Act but is designated as a provider or in a class of providers.

(l) “Usual and Customary Dispensing Fee” means the dispensing fee the provider charges customers who pay cash for their prescriptions.

2.0 Days’ Supply

2.1 Maximum Supply
   (a) Providers shall fill claims to a maximum of a 100 day supply, if prescribed.
   (b) The Program will not pay multiple fees where a quantity less than the quantity prescribed is dispensed.

Exception for Seniors’ and Family Pharmacare Program beneficiaries:
Beneficiaries traveling outside the province for more than 100 days will be allowed to obtain three prescriptions for the same medication before leaving Nova Scotia. None of the prescriptions shall exceed a 90 day supply (maximum 270 day supply for three prescriptions). The usual dispensing fee and copayment are to be applied to each of the prescriptions, as per the Pharmacist Guide.

2.2 Minimum Supply

The Program will reimburse a maximum of one Pharmacare dispensing fee per 28 day supply for all medication as determined by the Program, as per the Pharmacist Guide.

3.0 Uninsured Services

Any service for which a tariff level has not been established in 6.0 of this Agreement, is an uninsured service under this agreement.

4.0 Submission of Claims

4.1 Providers must electronically submit claims to the Program.

4.2 A claim submitted to the Program for payment of insured drugs, supplies and services shall be honoured by the Program, only if it is received by the Program within 90 days of the date upon which the insured drugs, supplies and services were supplied.

4.3 The Program shall pay the line charges for the electronic submission of Program claims.
5.0 Collection of Costs from Beneficiaries

Providers shall collect all required copayments and deductibles for insured drugs, supplies, or services for the Program, including any cost that exceeds the PRP. Providers shall not collect any other amount for insured drugs, supplies or services, including any cost that exceeds the MRP.

6.0 Tariff Levels

6.1. Prescriptions for drugs and supplies which are Pharmacare benefits will be reimbursed to providers as follows:

<table>
<thead>
<tr>
<th>Effective Dates</th>
<th>Ototomy Supplies - AAC plus 10.0% (to a maximum of $50 per prescription), plus a maximum Pharmacare dispensing fee of:</th>
<th>Compounded extemporaneous products (except methadone and injectables) - AAC plus 2.0% (to a maximum of $50 per prescription), plus a maximum Pharmacare dispensing fee of:</th>
<th>Methadone - MRP or PRP plus 8% plus a Pharmacare dispensing fee of:</th>
<th>All other prescriptions (MLP plus 10.5% (if the ingredient cost is $2,000 or less) or MLP plus 8% (if the ingredient cost is greater than $3,000) plus a maximum Pharmacare dispensing fee of:</th>
<th>MRP or PRP plus 8% plus a maximum Pharmacare dispensing fee of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2014 to March 31, 2015</td>
<td>$11.50</td>
<td>$17.25</td>
<td>$11.50</td>
<td>$11.50</td>
<td>$11.50</td>
</tr>
<tr>
<td>April 1, 2015 to March 31, 2016</td>
<td>$11.65</td>
<td>$17.47</td>
<td>$11.65</td>
<td>$11.65</td>
<td>$11.65</td>
</tr>
<tr>
<td>April 1, 2016 to March 31, 2017</td>
<td>$11.75</td>
<td>$17.62</td>
<td>$11.75</td>
<td>$11.75</td>
<td>$11.75</td>
</tr>
<tr>
<td>April 1, 2017 to March 31, 2018</td>
<td>$11.85</td>
<td>$17.77</td>
<td>$11.85</td>
<td>$11.85</td>
<td>$11.85</td>
</tr>
<tr>
<td>April 1, 2018 to March 31, 2019</td>
<td>$11.95</td>
<td>$17.92</td>
<td>$11.95</td>
<td>$11.95</td>
<td>$11.95</td>
</tr>
<tr>
<td>April 1, 2019 to September 30, 2019</td>
<td>$12.10</td>
<td>$18.15</td>
<td>$12.10</td>
<td>$12.10</td>
<td>$12.10</td>
</tr>
</tbody>
</table>

6.2 Restocking Fee

Pursuant to the guidelines set out in the ‘Return of Medication’ Policy of the Nova Scotia College of Pharmacists, subsection 7.1 “Return of Prescription Medication From Homes For Special Care / Nursing Homes”, the Program will pay a restocking fee of 20% when medications are returned to inventory by a provider.

6.3 Other services as approved by the Program or Department and subject to criteria as identified by Pharmaceutical Services Policy

6.3.1. Advanced Medication Review: maximum special services fee of $150

Basic Medication Review: maximum special services fee of $52.50

Medication Review Follow-up: maximum special services fee of $20.00

Prescription Adaptation: maximum special services fee of $14.00

Therapeutic Substitution: maximum special services fee of $26.25

Pharmacare Tariff Agreement October 1, 2014 – September 30, 2019
6.3.2 Such other services as may be agreed to by the Parties during the term of this Agreement.

6.3.3 The Parties agree that no loyalty points or similar program may be offered by a provider on any of the services listed under this Section.

6.4 Demonstration Projects

6.4.1 The Department shall provide funding to conduct demonstration projects for new services under consideration, in the following maximum amounts:

<table>
<thead>
<tr>
<th>Funding Allocation</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$500,000</td>
<td>$1,000,000</td>
<td>$500,000</td>
</tr>
</tbody>
</table>

6.4.2 The Department and PANS agree that if monies allocated are not spent on demonstration projects in the year in which they are allocated, the remaining monies will be carried over to the subsequent year to be used for demonstration projects.

6.4.3 Any monies allocated for demonstration projects that remain unspent upon expiry or termination of this Agreement may be used to fund demonstration projects under subsequent agreements.

7.0 Maximum Reimbursement

7.1 If the total reimbursement to the provider by the Department for the provision of a given product, service or both exceeds the amount contracted for or accepted as payment by the provider from any other payor or combination of payors for the same product, service or both, the Department will reclaim the difference as an adjustment to the bottom line payment to the provider.

8.0 Audit

Providers agree to permit the Department or its authorized agents, access to all provider records deemed necessary by the Department to verify pricing and billings under this Agreement.

9.0 Term and Termination

9.1 This Agreement is in effect from October 1, 2014 to September 30, 2019.

9.2 The Parties may agree to extend the agreement beyond the September 30, 2019 date subject, however, to the understanding that any extension may be terminated with a 30 day notice by either party.

9.3 This Agreement may be terminated by either party sending a written notice of termination by registered mail addressed to the other party at that party’s last known mailing address, in which case the Agreement will expire on the 90th day following the date of mailing.

9.4 Upon expiry of this Agreement on September 30, 2019, if the Parties have not extended the term of this Agreement in accordance with clause 9.2 or served notice of termination pursuant to clause 9.3, the provisions of this Agreement shall remain in effect until such
9.5 In the event that:

(a) The provider has its license or certificate of accreditation revoked or suspended, the provider’s rights under this Agreement, and the Pharmacare provider number are terminated without notice.

(b) There is a change in provider ownership, the provider will notify the Department 30 days in advance of the change in ownership, and the provider’s rights under this Agreement, and Pharmacare provider number, will automatically terminate on the date of transfer of ownership. (The Department will retain this information in confidence.)

(c) The provider is found to contravene or default on the obligations under this agreement, the provider’s rights under this Agreement and Pharmacare provider number will automatically terminate.

Upon termination, the rights of the provider hereunder automatically cease and terminate and the Department agrees to pay the provider all claims then properly due and owning pursuant to this Agreement, provided that such claims are submitted within 90 days of the date of the termination. Notwithstanding the termination of this Agreement, the Department may continue to exercise its audit rights pursuant to Section 8 of this Agreement.

10.0 Other

10.1. The Department agrees to deduct $0.05 per prescription from all claims and remit the amount to the PANS not less frequently than monthly.

10.2. The Department agrees to establish a Pharmacy Services Steering Committee to provide oversight for the management of this agreement. Refer to the Terms of Reference in Appendix A.
11.0 Amendment

11.1. This Agreement, including Appendix A, may be amended with the written consent of both Parties.

11.2. This Agreement is subject to approval by Governor in Council.

Witness

Honourable Leo A. Glavine
Minister of Health and Wellness

Sept 22, 2014

Date

Accepted on behalf of The Pharmacy Association of Nova Scotia subject to ratification by the Association’s Executive.

Witness

Allison Bodnar
Chief Executive Officer
Pharmacy Association of Nova Scotia

July 31, 2014

Date
Appendix A
PHARMACY SERVICES STEERING COMMITTEE

TERMS OF REFERENCE

1.0 PURPOSE

The Pharmacy Services Steering Committee (PSSC) is established, and is provided with these Terms of Reference, under the authority of the Minister of Health and Wellness (Minister).

The purpose of the PSSC is to provide a forum for senior management from the Nova Scotia Department of Health and Wellness (DHW), the Pharmacy Association of Nova Scotia (PANS) and as required, representatives from other stakeholder groups, to discuss and resolve issues of a strategic nature and to identify opportunities that support the ongoing relationship between community-based pharmacy and the Province of Nova Scotia.

2.0 MEMBERSHIP

The PSC consists of:

- Three members from the Department of Health and Wellness, as appointed by the Deputy Minister, including one member nominated to serve as co-chair.
- One member from the Department of Community Services, as appointed by the Deputy Minister.
- Three members from the Pharmacy Association of Nova Scotia, as appointed by the Board of Directors, including one member nominated to serve as co-chair.
- Representatives from other stakeholder groups may be invited to attend, as required.

3.0 MANDATE AND RESPONSIBILITIES

The PSSC is an oversight and advisory committee whose members are accountable to their respective organizations.

The PSC’s responsibilities include, but may not be limited to:

- The review, approval and ongoing revision of this Terms of Reference document.
- The establishment of reporting and communications processes, used to inform stakeholders of the objectives, activities, progress and accomplishments of the PSSC and any Working Group(s) or sub-committee(s) established by the PSSC.
- Development and implementation of an Information Sharing Agreement so that the PSSC has access to the data required to inform recommendations.
- Oversight for any agreement(s) (existing or new) between DHW and PANS.
- To provide a forum for discussion of issues related to the delivery of pharmacy services and new investments in pharmacy services.
- Identification, prioritization and development of recommendations to the Minister of Health and Wellness, for demonstration products and/or agreements for funded services that may be considered in the future.
- Direction for any Working Group(s) established to support the mandate identified.
4.0 MEETINGS

The PSSC will meet no less than three times per year and such additional times as necessary to efficiently carry out its mandate.

5.0 GENERAL PROVISIONS

5.1 Secretariat and Administrative Support

Secretariat and administrative support is provided by the PSSC co-chairs or their delegates.

5.2 Amendment to Terms of Reference

These Terms of Reference may be amended at any time with the agreement of the DHW and PANS and approval by the Minister.

5.3 Confidentiality

Committee members will be required to sign a Confidentiality Agreement.

5.4 Working Group(s) and Sub-Committees

Working Group(s) and/or sub-committee(s) can be created and disbanded on an “as-needed” basis by the PSSC to examine issues or opportunities on behalf of the PSSC.
APPENDIX II

Pharmacist Administered Publicly Funded Seasonal Influenza Vaccine
Confirmation of Agreement

NOVA SCOTIA

Pharmacist Administered Publicly Funded Seasonal Influenza Vaccine

Confirmation of Agreement

Name of Provider __________________________ Provider No. __________________________
Address
________________________________________________________
________________________________________________________
Email Address ______________________________
Effective Date ______________________________

This is to certify that the above provider accepts the terms and conditions of the compensation agreement (Schedule A) between the Nova Scotia Department of Health and Wellness and the Pharmacy Association of Nova Scotia for the provision/administration of the pharmacist-administered, publicly funded seasonal influenza vaccine.

Signed this ___________________ day of ___________________ 20 ____________

__________________________________________
Authorized Signature

Title

PROGRAMS ADMINISTERED BY MEDAVIE BLUE CROSS
P.O. Box 500, Halifax, Nova Scotia B3J 2S1   Tel. (902)496-7122   Fax (902)492-2921
APPENDIX III

Pharmacare Confirmation of Agreement Form

NOVA SCOTIA

Pharmacare Confirmation of Agreement

Name of Provider ___________________________ Provider No. __________________
Address ________________________________________________________________
Email Address ___________________________________________________________
Effective Date __________________________________________________________

This is to certify the above provider accepts the terms and conditions of the Pharmacare Tariff Agreement, effective October 1, 2014 to September 30, 2019, between the Nova Scotia Department of Health and Wellness and the Pharmacy Association of Nova Scotia. This provider confirms that all claims will be submitted on the basis of drug cost of either the actual acquisition cost (AAC) or the maximum allowable reimbursement level specified in the Nova Scotia Formulary. This provider further confirms that all claims will be submitted with the LESSER of the Usual and Customary Dispensing Fee charged to cash customers or the applicable maximum Pharmacare Dispensing Fee.

My Usual and Customary Dispensing Fees ($) charged to cash customers are:

- Ostomy Supplies
- Compounded Extemporaneous Products (except methadone & injectables)
- Methadone
- All Other Prescriptions

I certify the foregoing represents an accurate statement of the Usual and Customary Dispensing Fees in effect for the above provider. I understand that Usual and Customary Dispensing Fees mean the dispensing fees charged to customers who pay cash for their prescriptions. I agree to permit an examination by the Nova Scotia Department of Health and Wellness or its designated agent of those provider records deemed necessary by the Department of Health and Wellness to verify the accuracy of this declaration.

Signed this ___________________________ day of __________________________ 20_____

_________________________________________ ___________________________
Authorized Signature Title

PROGRAMS ADMINISTERED BY MEDAVIE BLUE CROSS
P.O. Box 500, Halifax, Nova Scotia B3J 2S1 Tel. (902)496-7122 Fax (902)492-2921
APPENDIX IV

Provider Appeals Regulations

Provider Appeals Regulations
made under subsections 17(2) and 31(3) of the

Fair Drug Pricing Act

S.N.S. 2011, c. 7


Citation
1 These regulations may be cited as the Provider Appeals Regulations.

Definitions
2 In these regulations,
   “Act” means the Fair Drug Pricing Act;
   “Pharmaceutical Services” means the Pharmaceutical Services Branch of the Department of Health and Wellness;
   “Executive Director” means the Executive Director of Pharmaceutical Services;
   “appeal panel” means the pharmacare appeals panel;
   “hearing” means a hearing before an appeal panel;
   “overpayment” means an overpayment made by the Administrator to a provider;
   “provider manual” means any billing instructions, including the pharmacare prescription audit recovery procedures, made available to providers by the Administrator in the Pharmacists’ Guide and Pharmacists’ Bulletins;
   “secretariat” means the secretariat to the appeal panel;
   “tariff agreement” means the current agreement on tariffs made under subsection 14(2) of the Act.

Patient and prescription records
3 (1) A provider must keep patient records or prescription records for all claims in accordance with the Act and its regulations, the provider manual and the tariff agreement.
(2) If requested by the Administrator, a provider making a claim must give the Administrator any particulars of the claim and documentation to support the claim in accordance with the Act and its regulations, the provider manual and the tariff agreement.

**Administrator’s determination of amounts payable**

4 In addition to being in accordance with the Act and regulations, as required by Section 23 of the Act, the Administrator’s determination of amounts payable for claims under Section 23 of the Act must also be in accordance with the provider manual and the tariff agreement.

**Administrator’s investigative determinations**

5 (1) The Administrator may make 1 or more of the investigative determinations set out in subsection (2) if the Administrator has reasonable grounds to believe that any of the following have occurred:

   (a) all or part of a benefit was not billed according to the billing instructions made available to the provider by the Administrator;

   (b) all or part of a benefit is not verifiable from the associated patient records or prescription records;

   (c) a patient record or prescription record has not been kept as required for the insured services;

   (d) the nature of a benefit is misrepresented;

   (e) all or part of a benefit was not provided to a beneficiary;

   (f) the Administrator has paid a claim or claims for a drug, device or service that is not a benefit.

(2) The following are the types of investigative determinations that the Administrator may make under subsection (1):

   (a) refuse or reduce payment of a claim;

   (b) order the provider to reimburse to the Plan any overpayment;

   (c) recover any overpayment by deducting the amount of the overpayment from any other amounts payable by the Administrator to the provider;

   (d) commence and maintain a civil proceeding in the Supreme Court of Nova Scotia for recovery of any overpayment;
(e) enter into an agreement with the provider in settlement of the matter upon any terms as may be agreed to;

(f) recommend to the Minister that the provider’s designation under the Plan be suspended, modified, restricted or terminated.

Pool of nominees for appeal panel

6 Every 3 years, the Pharmacy Association of Nova Scotia must create an appeal panel pool from the Association’s membership made up of 15 nominees that hold an active practice licence with the Nova Scotia College of Pharmacists.

Selecting appeal panel

7 (1) On receiving a notice of appeal, the Executive Director must select an appeal panel composed of 5 members chosen from the pool established in Section 6 to hear the appeal.

(2) Each appeal panel member must provide the Executive Director with all of the following, in the forms determined by the Minister:

(a) a signed form declaring that they have no conflict of interest in hearing the appeal;

(b) a signed confidentiality agreement.

(3) When appointing pool members to an appeal panel, the Executive Director may rotate the choice of appeal panel members from among the pool.

(4) A person who is party to an investigation must not be an appeal panel member for any appeal regarding the investigation.

(5) An appeal panel must designate 1 of its members as the panel’s chairperson and another member as the panel’s vice-chairperson.

(6) The chairperson or, in the absence of the chairperson, the vice-chairperson of the appeal panel must preside at each meeting of the panel.

Expense claim reimbursement for appeal panel members

8 Appeal panel members must be reimbursed for any expenses incurred as part of the appeals process, in accordance with the policy for public servants of the Province.
Appeal panel rules

9 (1) An appeal panel member must not communicate outside the hearing about the subject matter of the hearing with a party or the party’s representative, unless the opposing party has been given notice of the subject matter of the communication and has an opportunity to be present during the communication.

(2) A member of an appeal panel who ceases to be a member of the appeal panel after the hearing begins must not be replaced, and if there are not enough members to continue the hearing, the hearing must be discontinued and an appeal panel made up of different members must be selected to hear the appeal de novo.

(3) Only those members of an appeal panel who were present throughout a hearing may participate in making the appeal panel’s recommendation.

Scope of appeals

10 The scope of an appeal is limited to hearing evidence supporting a provider’s appeal that the Administrator’s investigation or investigative determination does not reflect the information provided in the provider manual or tariff agreement.

Powers of appeal panel

11 (1) The functions of an appeal panel are to hear appeals by providers from investigative determinations under Section 5 and to perform any other duties that may be necessary or incidental to hearing the appeals.

(2) Subject to subsections (3) and (4), an appeal panel may make decisions on any matter referred to it, including any of the following:

(a) confirming any action taken by the Administrator under Section 5 and dismissing the appeal;

(b) varying or rescinding any action taken by the Administrator under Section 5;

(c) directing that the Administrator take any action under Section 5.

(3) An appeal panel has no power or jurisdiction to amend, vary, change or add to the provider manual or the tariff agreement.

(4) A decision of the appeal panel must be in accordance with the Act, the regulations, the provider manual and the tariff agreement.
(5) The appeal panel may make any orders it considers necessary to avoid prejudice to any party or parties that might be caused by errors, omissions or amendments.

Initiating appeal of investigative determination

12 (1) A provider may appeal an investigative determination made under Section 5 by referring the determination to an appeal panel using the notice of appeal form determined by the Minister.

(2) A provider must serve the notice of appeal on the Executive Director no later than 30 days after the date that the provider received the investigative determination.

(3) An appeal to the appeal panel does not operate as a stay of any action taken or order made by the Administrator under the Act or these regulations.

Setting hearing

13 (1) The Executive Director must set the time, date and place for a hearing, at a date that is no later than 90 days after the notice of appeal is received.

(2) The Executive Director must assign staff of Pharmaceutical Services as the secretariat.

(3) The secretariat must give a provider at least 30 days’ notice of the date, time and place of their hearing, unless the notice is waived by the provider.

Closed hearings

14 A hearing is not open to the public.

Hearing procedures

15 (1) At the beginning of a hearing, the chairperson must be satisfied that the provider was given notice of the date, time and place of hearing in accordance with subsection 13(3).

(2) An appeal panel may consider all of information that was previously considered by the Administrator in making the investigative determination, and may consider any additional information, evidence or submissions that are placed before it for the appeal.
(3) The appellant and the Administrator may present evidence at a hearing through either written or oral submissions, or both, and both the provider and the Administrator may be represented by legal counsel.

(4) Oral evidence presented to an appeal panel at a hearing must be recorded in the minutes of the hearing.

(5) At the request of a party to a hearing, an appeal panel must give the party copies of the minutes of the hearing.

(6) An appeal panel may adjourn a hearing from time to time and place to place, as it considers necessary.

(7) After a hearing has been finally determined, an appeal panel must release documents and other evidence presented at the hearing to the person who produced them at the hearing, when requested, within a reasonable time.

Examination of evidence

16 (1) All parties must give the secretariat and any opposing parties an opportunity to examine all of the following, at least 7 days before the date of the hearing:

(a) any written or documentary evidence that will be produced at the hearing or any report the contents of which will be given in evidence at the hearing;

(b) the identity of any expert who will give evidence, and the expert’s written report or a written summary of the expert’s evidence if there is no written report;

(c) the identity of any witnesses who will give evidence.

(2) If a party fails to comply with subsection (1), the other party may request an adjournment from the appeal panel.

(3) An appeal panel may grant or deny a request for adjournment under subsection (2), and may take any further action or make any order it considers reasonable and necessary to fulfill the purpose of subsection (1).

Provider fails to appear at hearing

17 If a provider fails to appear at the time and place appointed for a hearing, the appeal panel may take any action or exercise any of its powers under Section 11.
Appendix V

Notice of Appeal by Provider

FORM A

NOTICE OF APPEAL BY PROVIDER

TO: Executive Director, Pharmaceutical Services and Extended Health Benefits
Nova Scotia Department of Health and Wellness

FROM: ____________________________________________
Pharmacist holding the pharmacy licence (Please print full name.)

TAKE NOTICE that I am referring the investigative determination of MSI, dated
_________________________ and a copy of which is attached to this notice, to
the Pharmacare appeal panel,

FURTHER TAKE NOTICE that the particulars of the investigative determination
being appealed are:

On the following grounds (Refer to section 10):

My address for correspondence regarding this appeal is:

_____________________________________

_____________________________________

DATED this ______ day of _____________, 20____.

_____________________________________

Signature of pharmacist holding the pharmacy licence

_____________________________________

Provider Name

_____________________________________

Provider Number