



Pharmacy Guide

December 2020

Virtual Care Service Claim Eligibility

All provisions within this Guide pertaining to delivery of and claims submission for publicly funded pharmacy professional services are in effect until March 31, 2021. Any change to the effective date after publication of the Guide will be communicated through the Pharmacare News Bulletin.

This guide does not replace the *Fair Drug Pricing Act*, *Pharmacy Act*, *Prescription Monitoring Act*, or any of their associated regulations.

This guide is referred to as the “Pharmacists’ Guide” in the *Provider Appeals Regulations* under the *Fair Drug Pricing Act*.

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CONTACT INFORMATION

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

MSI Registration (Nova Scotia Health Cards, new residents)
P.O. Box 500, Halifax, NS B3J 2S1
<http://novascotia.ca/dhw/msi/>

Local calls: 902-496-7008
Toll-free: 1-800-563-8880

Nova Scotia Seniors' Pharmacare Program
P.O. Box 9322, Halifax, NS B3K 6A1
www.nspharmacare.ca

Local calls: 902-429-6565
902-496-7002
Toll-free: 1-800-544-6191

Nova Scotia Family Pharmacare Program
P.O. Box 500, Halifax, NS B3J 2S1
www.nspharmacare.ca

Local calls: 902-496-5667
Toll-free: 1-877-330-0323

Drug Assistance for Cancer Patients
Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2T7
www.nspharmacare.ca

Local calls: 902-496-7001
Toll-free: 1-800-305-5026

Nova Scotia Diabetes Assistance Program
P.O. Box 500, Halifax, NS B3J 2S1
www.nspharmacare.ca

Local calls: 902-496-7001
Toll-free: 1-800-305-5026

Palliative Care Drug Program
www.nspharmacare.ca

Local calls: 902-496-5680
Toll-free: 1-800-305-5026

Fax: 1-902-494-7423
Toll-free fax: 1-855-640-7423

Nova Scotia Department of Community Services Pharmacare Benefits P.O. Box 500, Halifax, NS B3J 2T7 http://www.novascotia.ca/coms/employment/income_assistance/Pharmacare.html	Toll-free: 1-877-424-1177
Low Income Pharmacare for Children Nova Scotia Department of Community Services P.O. Box 696, Halifax, NS B3J 2T7 http://www.novascotia.ca/coms/families/PharmacareforChildren.html	Local calls: 902-424-1269 Toll-free: 1-866-424-1269
Under 65 – LTC Pharmacare Plan Nova Scotia Pharmacare Programs P.O. Box 500, Halifax, NS B3J 2S1 http://novascotia.ca/dhw/ccs/long-term-care.asp	Local calls: 902-496-7001 Toll-free: 1-800-305-5026
Nova Scotia Prescription Monitoring Program P.O. Box 2200, Halifax, NS B3J 3C6 General e-mail: pmp@medavie.bluecross.ca Website: www.nspmp.ca	Local calls: 902-496-7123 Toll-free: 1-877-476-7767
Pharmacare Audit P.O. Box 500, Halifax, NS B3J 2S1	Toll-free: 1-800-305-5026
Dalhousie MS Research Unit University Ave, Halifax, NS B3H 1B7 http://www.cdha.nshealth.ca/dmsru	Phone: 902-473-5734
Addiction Services P.O. Box 896, Dartmouth, NS B2Y 3Z6 http://novascotia.ca/dhw/addictions/	Phone: 902-424-5623
Nova Scotia College of Pharmacists 800 - 1801 Hollis St, Halifax, NS B3J 3N4 General e-mail: info@nspharmacists.ca Website: www.nspharmacists.ca	Phone: 902-422-8528
Pharmacy Association of Nova Scotia 170 Cromarty Drive, Suite 225 Dartmouth, NS B3B 0G1 Website: www.pans.ns.ca	Phone: 902-422-9583
Public Health Nova Scotia Department of Health and Wellness P.O. Box 488, Halifax NS B3J 2R8 For information regarding the flu vaccine, please visit http://novascotia.ca/dhw/CDPC/flu.asp	Phone: 902-481-5800

DEFINITIONS

Authorized registrants: means either a

- a) pharmacy technician – a person registered and licensed under the Pharmacy Act of Nova Scotia as a pharmacy technician; or
- b) pharmacist – a person registered and licensed under the Pharmacy Act of Nova Scotia as a pharmacist.

Beneficiary: means a person who is enrolled as a member of a Pharmacare Program pursuant to Nova Scotia's Fair Drug Pricing Act and regulations or a person who receives services under the terms of the Pharmacy Service Agreement.

Benefit: means a drug, device, or service to which some level of coverage from the Nova Scotia Department of Health and Wellness (DHW) applies.

DIN: means drug identification number, a computer-generated eight-digit number assigned by Health Canada to a drug product prior to being marketed in Canada. It uniquely identifies all drug products sold in a dosage form in Canada and is located on the label of prescription and over-the-counter drug products that have been evaluated and authorized for sale in Canada.

NSCP: means the Nova Scotia College of Pharmacists.

Original Prescriber: means the prescriber who authorized the original prescription.

Original Prescription: means the first fill of a prescription, which may or may not be for a new drug therapy.

Pharmacy: means a pharmacy as licensed under the Pharmacy Act of Nova Scotia or licensed as a pharmacy by the licensing authority of the jurisdiction in which it operates.

PIN: means product identification number as assigned by OPINIONS (Online Product Identification Number Index of Nova Scotia) which was developed and is maintained by Atlantic Pharmaceutical Services, Inc.

Prescriber: means individual who is licensed to provide specific health care services to patients, including but not limited to, dentists, midwives, nurses, optometrists, pharmacists, and physicians.

Provider: means either a

- a) pharmacy licensed under the Pharmacy Act of Nova Scotia that has confirmed agreement with the Pharmacare Tariff Agreement and Pharmacy Service Agreement 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
- b) 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.

Resident: means a resident of the Province as defined in the *Hospital Insurance Regulations* or any successor legislation thereto.

Signature: is defined as proof of identity and intent. This can be a handwritten or electronic (i.e. e-signature) signature.

- a) A handwritten signature should be a person's usual or consistent signature and must clearly identify the person signing.
- b) An e-signature will be treated as functionally equivalent to a handwritten signature. Provincial e-commerce laws do not prescribe any particular form for an e-signature but define an e-signature as electronic information that a person creates or adopts in order to sign a record and that is attached to, or associated with, the record. In other words, e-signatures are technologically neutral and can be constituted and used in a number of ways, including typing a person's name, initials and a password or a code intended to be used uniquely as a signature.

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 Pharmacare Tariff Agreement and Pharmacy Service Agreement 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. ***Pharmacy providers must be licensed with the Nova Scotia College of Pharmacists.***

Pharmacist Registration with Medavie:

Pharmacists who prescribe in Nova Scotia must register with Medavie to be eligible as a prescriber on drug claims under the Pharmacare programs and to be eligible for public funding of pharmacy services. Registration can be completed online at <https://www.medaviebc.ca/en/health-professionals/register>.

Please note: the “Main Address” submitted with a pharmacist’s registration will be used for all patient correspondence that Medavie sends the pharmacist as the prescriber. **This address must be accurate and appropriate for receiving and handling private patient information.** Pharmacists are responsible under the *Personal Health Information Act* to ensure the patient information sent to their Main Address is protected from unauthorized disclosure or use. If a pharmacist needs to change their address after initial registration, updates can be submitted to Medavie through <https://www.medaviebc.ca/en/health-professionals/register>.

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
- **Pharmacy Provider Agreement Confirmation of Agreement form**, as acceptance of the Pharmacare Tariff Agreement and the Pharmacy Service 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

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 MSIProvidercoordinators@medavie.bluecross.ca or 1-866-553-0585

Upon registration, a new pharmacy is provided with links to some key information, including:

- Pharmacy provider number
- Business arrangement number
- Nova Scotia Formulary with reimbursement levels
- Recent Pharmacare News Bulletins
- Requests for Adjustment forms
- Pharmacy Provider Confirmation of Agreement Form
- Nova Scotia Pharmacy 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 and DHW 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 Pharmacare Tariff Agreement,
- bill DHW according to the current Pharmacy Service Agreement,
- collect all applicable copayments and/or deductibles, and
- be subject to audit, ensuring the Pharmacare Programs and DHW are being billed correctly and benefits are provided according to the rules and regulations of the Programs and Services.

■ 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

Please refer to the Formulary for more information.

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 (except for 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.

■ 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 link to the current Pharmacare Tariff Agreement is provided in [Appendix I](#) of this guide.

■ Pharmacy Service Agreement

The Nova Scotia Department of Health and Wellness negotiates with the Pharmacy Association of Nova Scotia to determine compensation to pharmacies for services covered by DHW for all residents of Nova Scotia. A link to the current Pharmacy Service Agreement is provided in [Appendix I](#) of this guide.

■ Pharmacy Provider Confirmation of Agreement

The Pharmacy Provider Confirmation of Agreement Form ([link in Appendix I](#)) 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 PROGRAMS AND BENEFITS

■ 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. The annual coverage period for Seniors' Pharmacare is from April 1 to March 31 of the following year.

Seniors Whose Private Drug Coverage Ceases

If a senior had 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 one-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 one-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" 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>.

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 to provide an official prescription receipt and an explanation of benefits from their insurer. This information must be submitted to Pharmacare by June 30th for the preceding year (April 1st–March 31st). 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 annual premium to join the Seniors' Pharmacare Program is \$424. Seniors receiving the GIS from the federal government do not pay the premium. 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 three options for paying the annual maximum copayment amount:

1. In monthly instalments directly to the Seniors' Pharmacare Program;
2. In annual instalments directly to the Senior's Pharmacare Program; or
3. Pay their copayment on every prescription to the pharmacy.

When 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 ([link in 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 enroll 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. 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 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 of 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. The coverage period is from April 1 to March 31 of the following year. Families are required to re-register each year by April 1st. 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” 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 portion 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's annual maximum copayment and annual maximum deductible. Beneficiaries can determine their initial out of pocket expense using the online calculator at: www.nspharmacare.ca.

Under Family Pharmacare, the first 20 percent of the prescription cost of prescriptions that are covered under the program is applied toward the family's annual maximum copayment. The remaining 80 percent of the prescription cost will be applied against the family's annual maximum deductible.

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.

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 ([link in 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, provide pharmacies with information on changes to the Program.

Eligibility

Effective **April 1, 2010**, the Diabetes Assistance Program is no longer 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 the first 20 percent of the prescription cost. The remaining 80 percent of the prescription cost will be applied against the annual maximum deductible. The annual family deductible resets on April 1st of each year. When 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.nsparmacare.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 are mailed to pharmacies and can be accessed on the Nova Scotia Pharmacare Programs website at www.nspharmacare.ca. The bulletins 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 when 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.

Department of Community Services Pharmacare Benefits

Program	Who Is Eligible	Premium	Deductible	Copayment
Income Assistance	As determined by the Department of Community Services Assessment	NO	NO	\$5.00
Income Assistance: Copayment Exempt	Clients on Income Assistance who: <ul style="list-style-type: none"> ▪ receive more than 3 prescriptions per month ▪ have a permanent disability ▪ take small dosage amounts on a regular basis 	NO	NO	NO
Income Assistance: Special Needs Pharmacare	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 #	NO	NO	Variable
Income Assistance: Transitional Pharmacare	Clients who are no longer eligible for Income Assistance because of employment income may be eligible to receive transitional benefits for 1 year	NO	NO	\$5.00
Low Income Pharmacare For Children (LIPC)	Children of families who receive the NS Child Benefit	NO	NO	\$5.00
Disability Support Program	Clients with intellectual and physical disabilities and long term mental illness who qualify for support and services under the program.	NO	NO	NO
Children in Care	Children who are placed outside their parent's home.	NO	NO	NO

■ 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 follow 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

■ Exception Status Drugs

Certain drugs are only eligible for coverage under the Pharmacare Programs when an individual meets criterion 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 must 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. Forms may be added or changed at any time. To ensure up to date information, please refer to the website.

Pharmacists may complete and sign exception status forms as prescribers on behalf of beneficiaries when prescribing for a drug within the approved scope of practice for pharmacists as per the Nova Scotia College of Pharmacists *Standards of Practice: Prescribing Drugs*. For products prescribed by another prescribers, 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

When 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 for Exception Status Drugs

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.

- A pharmacist who is affixing a criteria code not provided by the prescriber must have the required expertise and information to be reasonably able to determine the code is appropriate.
- When submitting criteria codes for drugs to treat Hepatitis C, the criteria code must be provided by the prescriber and not based on information obtained by the pharmacist from the beneficiary.
- 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 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 of Nova Scotia. Exceptions for prescriptions filled in a pharmacy out-of-province but within Canada may be considered on a case-by-case basis. However, there is no reimbursement for prescriptions filled outside of Canada, 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/>
 - College of Registered Nurses of Nova Scotia – Nurse Practitioner Licensing Roster
<http://www.crnns.ca/>
 - Nova Scotia College of Optometrists
<http://www.nasco.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 Pharmacist-Prescribed Claims

Virtual Care Service Claim Eligibility

All provisions within this Guide pertaining to delivery of and claims submission for publicly funded pharmacy professional services are in effect until March 31, 2021. Any change to the effective date after publication of the Guide will be communicated through the Pharmacare News Bulletin.

The Nova Scotia College of Pharmacists maintains the *Standards of Practice: Prescribing Drugs*, which establish the responsibilities of pharmacists when they prescribe drugs under the authority of the *Pharmacist Drug Prescribing Regulation*. Claims for prescriptions written by pharmacists that comply with the requirements as detailed in the Standards are eligible for benefit under the applicable Pharmacare Program. These include the following categories of prescriptions pursuant to the Standards:

- Conditions approved by Council
- Prescribing in an emergency
- Prescribing renewals
- Prescribing adaptations
- Prescribing therapeutic substitutions
- Prescribing Schedule II, III and unscheduled drugs

Claims Submission

Claims for pharmacist-prescribed drugs 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 prescription.
- 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.

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 the following criteria are met:

- The patient is a beneficiary of a Nova Scotia Pharmacare Program, except the Under 65 – LTC Program.
- The BMRS is conducted by a pharmacist licensed with the Nova Scotia College of Pharmacists.
- The patient agrees with their pharmacist that they are a suitable candidate for the service and provides consent to authorize the pharmacist to provide this service. All documentation related to the Basic Medication Review Service is to be kept on file as per NSCP's guidelines for patient record retention.
- If the review was initiated by the pharmacist and delivered as a virtual service (telephone or video), the beneficiary must meet one of the criteria defined in the section Virtual Care Delivery of Medication Reviews and this must be documented on the file.
- 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 unless eligible for a virtual service.

- 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 signature. The patient's signature is also required for reviews completed in person.

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 code ED must be entered in the Intervention Code field and one of the following codes must be entered in the Special Authorization Code field for all claims:
 - 91 = In-person
 - 92 = Telephone
 - 93 = Video
- 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:

CPhA Claims Standard – Basic Medication Review Services		
Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899995
D.57.03	Special Service Code	003 (pharmacist consultation)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	The physician, nurse practitioner or pharmacist who initiates the review
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	5250 (\$52.50) *

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

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 the following criteria are met:

- The patient is a beneficiary of the Nova Scotia Seniors' Pharmacare Program.
- The AMRS is conducted by a pharmacist licensed with the Nova Scotia College of Pharmacists.

- The patient agrees with their pharmacist that they are a suitable candidate for the service and provides consent to authorize the pharmacist to provide this service. All documentation related to the Advanced Medication Review Service is to be kept on file in the pharmacy as per NSCP's guidelines for patient record retention. The patient must not reside in a nursing home or home for special care.
- If the review was initiated by the pharmacist and delivered as a virtual service (telephone or video), the beneficiary must meet one of the criteria defined in the section Virtual Care Delivery of Medication Reviews and this must be documented on the file.
- The patient must be provided with a comprehensive drug review list that is dated and authorized with the pharmacist's signature. The patient's signature is also required for reviews completed in person.
- The patient is taking 4 or more prescription medications; OR taking one of the following:
 - methyldopa
 - 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 code ED must be entered in the Intervention Code field and one of the following codes must be entered in the Special Authorization Code field for all claims:
 - 91 = In-person
 - 92 = Telephone
 - 93 = Video
- 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:

CPHA Claims Standard – Advanced Medication Review Services

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899999
D.57.03	Special Service Code	006 (Drug utilization review)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	The physician, nurse practitioner or pharmacist who initiates the review
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	15000 (\$150.00) *

*The copayment **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 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 signature. The patient's signature is also required for reviews completed in person.
- 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, or if the Advanced or Basic review for the patient was eligible for a virtual 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 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 as per NSCP's guidelines for patient record retention.
- Claims for Medication Review Service Follow-Ups must be submitted electronically to the Pharmacare Programs for reimbursement, provided all the criteria above are met, with the following claim field content:

CPHA Claims Standard – Medication Review Service Follow-Ups

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899909
D.57.03	Special Service Code	003 (pharmacist consultation)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	The physician, nurse practitioner or pharmacist who initiates the review
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2000 (\$20.00) *

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

Virtual Care Delivery of Medication Reviews

In addition to meeting all existing eligibility requirements as per the Pharmacy Guide, pharmacists may initiate a virtual **Basic** or **Advanced Medication Review** with a client only when the individual meets one of the following conditions, which must be documented in the patient file and available for audit:

- Recently discharged from hospital.
- No primary care provider for at least four to six months.
- Has a primary care provider but regularly brings in prescriptions from other prescribers (e.g. walk-in clinics or duty doctors).
- Recent change in medications, specifically tapering up or down or switching between medications.
- Taking new medications that have a high likelihood of side effects in the first few months of use that may lead to adherence or efficacy issues (e.g. antidepressants).
- Experiencing renal or hepatic function decline.

- Starting compliance-packed medications.
- Communicates that they think they are on too many medications or that they have financial concerns about their drug costs.
- Consistently early or late filling prescriptions.
- Appears to be confused about their medications.

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 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 as per NSCP's guidelines for patient record retention.

Therapeutic Substitution for Other Products

Therapeutic substitution services for products or drug classes other than PPIs may be deemed eligible for coverage through the Pharmacare Programs in specific circumstances. Any such changes and the process for submitting claims for those products will be communicated to pharmacies through the Pharmacare Bulletin.

Claims Submission

Pharmacists must submit electronic claims for therapeutic substitution services to the Pharmacare Programs for reimbursement provided all 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:

- 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

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899912
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2625 (\$26.25)*

* 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.

Criteria for Coverage: Prescription adaptation services provided by a pharmacist are insured when performed as a refusal to fill a full, partial fill or refill of a prescription for a drug monitored by the NSPMP, provided all 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 polypharmacy/multi-doctoring
 - Falsified or altered prescription

- Risk of harm if drug provided to patient (e.g. methadone for a patient who appears to be impaired or if patient has recently been non-compliant with therapy)
- 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 as per NSCP's guidelines for patient record retention.

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.
- 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

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899986
D.57.03	Special Service Code	001 (refusal to fill)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	NSCP licence number
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	1400 (\$14.00) *

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

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 subsequent completion of a prescription element through interaction with the original prescriber is not an insured prescription adaptation service.

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 the following conditions are met:

- The patient is a beneficiary of a Nova Scotia Pharmacare Program.
- The prescription adaptation service is conducted by a pharmacist licensed with the NSCP.
- The pharmacist must comply with all applicable NSCP policies and standards.
- The patient provides informed 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 the following: 1) consent, 2) assessment (e.g. patient-specific factors to support prescription adaptation), 3) monitoring and follow-up plan appropriate to each prescription adaptation, and 4) notification to the prescriber of the adapted prescription must be kept on file in the pharmacy as per NSCP's guidelines for patient record retention.

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 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.
- 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

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

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

Uninsured Services

Uninsured services are any services for which a Pharmacare tariff level has not been established. Examples include compliance packaging or special charges for sterile compounding.

BENEFITS FOR ALL RESIDENTS

■ Administration of Publicly Funded Influenza Vaccinations Provided by a Pharmacy

Eligibility

All individuals 2 years of age and over can have publicly funded influenza vaccine provided by a pharmacy. 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 DHW. There are no copayments or deductibles associated with the administration of the influenza vaccine for residents with a valid Nova Scotia Health Card Number. 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 last year are already set up. However, all pharmacies are still required to contact their local Nova Scotia Health Authority public health office to confirm their email, dispensary telephone number, and preferred method for being contacted by public health.

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* certifying agreement with the *Pharmacy Service Agreement* (link in Appendix I) 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 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 public health office. The supply and distribution of Fluzone High-Dose will be coordinated by the Provincial Bio-Depot.

All providers are responsible for any transportation costs to obtain publicly funded vaccine. Pharmacies should contact their local public health office to place their order for vaccine and to arrange pick-up. Please review the Immunization Toolkit (located at <http://www.cdha.nshealth.ca/immunization-forms>) for information on transporting biologicals to ensure you have all the required equipment when you pick up your vaccine. Public health can only release vaccine in accordance with this protocol.

Annual Influenza Vaccine Launch Date

Pharmacies 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 DHW 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.

In line with the *Pharmacy Practice Regulations* effective October 5, 2020, claims for seasonal influenza vaccine will be accepted when the technical aspect of the administration has been delegated to a pharmacy technician, when performed in compliance with the regulations and standards of practice. Claims for such services should be billed as usual under the supervising pharmacist's prescriber ID up to the maximum special service fee for Flu Vaccine Administration as per the *Pharmacy Service Agreement*.

Claims are submitted with the administration fee in the professional fee field. Please note: fees for the administration of publicly-funded influenza vaccines are for the service of administering the influenza vaccine, not the amount of vaccine administered. Therefore, all influenza claims **must be** adjudicated using a quantity of 1. 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

CPhA Claim Standard Field #	CPhA Claim Standard Field Name	Content
D.56.03	DIN/GP#/PIN	<p>DINs</p> <ul style="list-style-type: none"> ▪ Fluzone Quadrivalent MDV 02432730 ▪ Fluzone Quadrivalent PFS 2420643 ▪ FluLaval Tetra 02420783 ▪ Fluzone High-Dose 02445646* <p>* Only for residents of Long Term Care Facilities (nursing homes and residential care facilities) ≥65 years of age</p> <ul style="list-style-type: none"> ▪ Afluria Tetra Quadrivalent MDV 02473313** ▪ Afluria Tetra Quadrivalent PFS 02473283** <p>** Age indication of 5 years of age or older</p> <p>PIN for pregnant women</p> <ul style="list-style-type: none"> ▪ Fluzone Quadrivalent 93899895 ▪ FluLaval Tetra 93899893 ▪ Afluria Tetra Quadrivalent 6599953 <p>PIN for second dose for children</p> <ul style="list-style-type: none"> ▪ Fluzone Quadrivalent 93899896 ▪ FluLaval Tetra 93899894 ▪ Afluria Tetra Quadrivalent 96599952* <p>PIN for Influsplit Tetra (German)</p> <ul style="list-style-type: none"> ▪ Single dose prefilled syringe (German) 96599948 ▪ Single dose prefilled syringe – second dose for children (German) 96599946 ▪ Single dose prefilled syringe – for pregnant women 96599947 <p>*Age indication of 5 years of age or older</p>
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Pharmacists prescriber ID

Claims Submission Fields for Pharmacist-Administered Publicly Funded Influenza Vaccines

CPhA Claim Standard Field #	CPhA Claim Standard Field Name	Content
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D 67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	<ul style="list-style-type: none">April 1, 2020: \$12.40 per vaccineApril 1, 2021: \$12.55 per vaccineApril 1, 2022: \$12.70 per vaccineApril 1, 2023: \$12.85 per vaccineApril 1, 2024: \$13.00 per vaccine

Documentation

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 Nova Scotia Health Authority public health office for the appropriate follow-up.* For information of what adverse events to report, please review “It’s the Law: Reporting Notifiable Diseases and Conditions” (located at <https://novascotia.ca/dhw/CDPC/info-for-professionals.asp>).

Providers should document an adverse event following immunization (AEFI) using the Public Health Agency of Canada AEFI form (located at: <https://canada.ca/en/public-health/services/immunization/reporting-adverse-events-following-immunization/form.html>) and *forward the form to the local public health office.* The local public health office reviews these reports and facilitates with Department of Health and Wellness the reporting of AEFIs 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. A break in the cold chain occurs when vaccines are exposed to temperatures of less than 2°C or more than 8°C. 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 public health office to determine whether the vaccines 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 provides 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

As per recognized protocols, benefits 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 must 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 **902-496-7001** 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 must 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 may 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 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.

CPhA Claim Standard Field	CPhA Claim Standard Field Name	Content
D56.03	DIN/GP#/PIN	02444038
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Prescriber ID
D.66.03	Drug Cost/Product Value	DDDDD (MLP dollar value)
D 67.03	Cost Upcharge	DDDDD (usual Pharmacare upcharge)
D.68.03	Professional Fee	DDDDD (usual Pharmacare dispensing fee)

■ Assessment and Prescribing for Uncomplicated Cystitis, Herpes Zoster and Contraception Management

Virtual Care Service Claim Eligibility

All provisions within this Guide pertaining to delivery of and claims submission for publicly funded pharmacy professional services are in effect until March 31, 2021. Any change to the effective date after publication of the Guide will be communicated through the Pharmacare News Bulletin.

Assessment and prescribing by a pharmacist for uncomplicated cystitis, herpes zoster and contraception management is eligible for coverage by DHW **effective January 1, 2020**, provided all the following criteria are met:

- The service is conducted by a pharmacist licensed with the Nova Scotia College of Pharmacists (NSCP) and registered with Medavie as a prescriber.
- Pharmacists must comply with all applicable NSCP policies and standards.
- Pharmacists are reminded to make their best effort to ensure the service is appropriate for the patient, prior to offering.
- The patient must have a valid Nova Scotia Health Card and not reside in a nursing home.
- The patient must meet with the pharmacist for an in-person assessment unless the service is provided virtually in compliance with DHW's policy on *Provision of Publicly Funded Virtual Health Services*.
- If the service does not result in a prescription by the pharmacist, the pharmacist has documented the reason(s) for not prescribing and retained a copy of documentation related to referral of the patient to another health care provider or the reason why a referral was not appropriate.
- The patient agrees with their pharmacist that they are a suitable candidate for the service and provides verbal consent to authorize the pharmacist to provide this service. Patients should also be made aware that the service will be billed to the DHW and there is a per patient limit on the number of times the service can be billed.
- All documentation related to the service is to be kept on file in the pharmacy as per NSCP's guidelines for patient record retention.
- For assessment and prescribing for uncomplicated cystitis services, claims will not be accepted if the patient is under 16 years old.
- For contraception management services:
 - The assessment is not eligible if the primary purpose was prescribing and/or dispensing emergency contraception and a full contraception management assessment was not completed.

- For prescriptions by a pharmacist to maintain a patient's existing therapy, the pharmacist should prescribe hormonal contraception for an expected duration of one-year. In cases where it is not appropriate to do so (e.g. patient experiencing a possible adverse event) the pharmacist must clearly document their rationale.
- For Pharmacare beneficiaries, the pharmacy must dispense hormonal contraception in a supply of not less than 84 days unless a shorter supply is required for patient-related reasons and that reason is documented.

Providers

To bill for service fees under the *Pharmacy Service Agreement*, pharmacies must:

1. Comply with the required training and application expectations set out by the *Pharmacist Drug Prescribing Regulations* and the NSCP's *Standards of Practice: Prescribing Drugs*.
2. Sign the *Confirmation of Agreement Form* certifying agreement with the *Pharmacy Service Agreement* (link in Appendix I) 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 pharmacy services administration fees.

Benefits

The following benefits are available to eligible residents pursuant to the NSCP's *Standards of Practice: Prescribing Drugs*:

1. Assessment and prescribing service by a pharmacist for **uncomplicated cystitis** that:
 - a. Results in a prescription for drug therapy, or
 - b. Does not result in a prescription for drug therapy.
2. Assessment and prescribing service by a pharmacist for **herpes zoster** that:
 - a. Results in a prescription for drug therapy, or
 - b. Does not result in a prescription for drug therapy.
3. The following services for contraception management assessment and prescribing:
 - a. **Initial assessment:** the first time a patient has a prescription by a pharmacist for hormonal contraception following a contraception management assessment by a pharmacist, including prescriptions that continue a patient's existing therapy originally prescribed by another type of health care provider (e.g. physician or nurse practitioner) or by a pharmacist practicing at a different pharmacy location.
 - b. **Subsequent assessment that results in a change in therapy:** a contraception management assessment by a pharmacist practicing at the same pharmacy as the initial assessment that results in a change in hormonal contraception therapy prescribed by the pharmacist.
 - c. **Subsequent assessment that does not result in a change in therapy:** a contraception management assessment by a pharmacist that results in hormonal contraception prescribed by a pharmacist for a continuation of the patient's existing therapy as previously prescribed by a pharmacist practicing within the same pharmacy.

Claims Submission

Fees for assessment and prescribing services must be billed to DHW online. Manual claims are not accepted for pharmacy services provided under the *Pharmacy Service Agreement*. 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.

The code ED must be entered in the Intervention Code field and one of the following codes must be entered in the Special Authorization Code field for all claims:

- 91 = In-person
- 92 = Telephone
- 93 = Video

The following claim limits apply to each service:

Service	Claim Limit
Assessment and prescribing for uncomplicated cystitis	<ul style="list-style-type: none"> ▪ A maximum of two (2) PINs of any combination per resident within a rolling 12-month period (from first date of claim).
Assessment and prescribing for herpes zoster	<ul style="list-style-type: none"> ▪ A maximum of two (2) PINs of any combination per resident within a rolling 12-month period (from first date of claim).
Contraception management assessment and prescribing	<ul style="list-style-type: none"> ▪ Maximum of one (1) PIN per resident within a rolling 12-month period (from first date of claim) for an initial assessment. ▪ Maximum of one (1) PIN per resident within a rolling 12-month period (from first date of claim) for a subsequent assessment that results in a change in therapy. ▪ Maximum of one (1) PIN per resident within a rolling 12-month period (from first date of claim) for a subsequent assessment that does not result in a change in therapy.

All CPhA Claims Standard field content included in the tables below is required on service claims.

CPhA Claims Standard – Assessment and Prescribing for Uncomplicated Cystitis Resulting in a Prescription

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899857
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2000 (\$20.00) *

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

CPHA Claims Standard – Assessment and Prescribing for Uncomplicated Cystitis That Does Not Result in a Prescription

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899852
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2000 (\$20.00) *

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

CPHA Claims Standard – Assessment and Prescribing for Herpes Zoster Resulting in a Prescription

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899858
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2000 (\$20.00) *

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

CPhA Claims Standard – Assessment and Prescribing for Herpes Zoster That Does Not Result in a Prescription

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899853
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2000 (\$20.00) *

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

CPhA Claims Standard – Contraception Management Initial Assessment Resulting in a Prescription

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899856
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2000 (\$20.00) *

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

CPhA Claims Standard – Contraception Management Initial Assessment That Does Not Result in a Prescription

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899851
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2000 (\$20.00)*

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

CPhA Claims Standard – Contraception Management Subsequent Assessment Resulting in a Change in Therapy

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899855
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2000 (\$20.00) *

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

CPhA Claims Standard – Contraception Management Subsequent Assessment That Does Not Result in a Change in Therapy

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899854
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	1200 (\$12.00) *

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

■ Prescription Renewals

Prescription renewals by a pharmacist for are eligible for coverage by DHW effective April 1, 2020, provided all the following criteria are met:

- The service is conducted by a pharmacist licensed with the Nova Scotia College of Pharmacists (NSCP) and registered with Medavie as a prescriber.
- Pharmacists must comply with all applicable NSCP policies and standards.
- Pharmacists are reminded to make their best effort to ensure the service is appropriate for the patient, prior to offering.
- The patient must have a valid Nova Scotia Health Card and not reside in a nursing home.
- The pharmacist must determine when completing the patient assessment if there are likely to be other prescriptions that will require renewal within a reasonable timeframe and provide those renewals at the same time understanding the patient has a maximum number of renewal services that can be billed per year.
- The patient agrees with their pharmacist that they are a suitable candidate for the service and provides verbal consent to authorize the pharmacist to provide this service. Patients should also be made aware that the service will be billed to the DHW and there is a per patient limit on the number of times the service can be billed.
- The pharmacist renews prescriptions for Schedule 1 prescription drugs, insulin, epinephrine or nitroglycerin. Prescription renewals are not limited to drugs listed on the Nova Scotia Formulary. Prescription renewals for over-the-counter products (e.g. vitamins, minerals, dry eye preparations, supplies including diabetic test strips and lancets and ostomy supplies, etc.) are not eligible.
- The pharmacist renews prescriptions for duration not less than the patient's usual duration of therapy, unless it is the professional judgement of the pharmacist that it would be unsafe or unwise to do so, as documented in the patient record.
 - Usual duration will include usual day supply dispensed plus authorized refills. Overall duration must not exceed requirements defined in the NSCP's *Standards of Practice: Prescribing Drugs*. For example, if the patient's last prescription was for 90 days with three refills for a total of 360 days, the renewal should be for 90 days with one refill for a total of 180 days.

- A scheduled appointment with another health care provider to renew the medication without other clinical concerns or need for further information/assessment is not justification in and of itself to shorten the duration of therapy (days supply of medication prescribed). If a pharmacist chooses to prescribe less than the usual duration of therapy to bridge the patient to their next appointment without a supporting clinical reason, the service **should not be billed to DHW**.
- Under the *Standards of Practice: Prescribing Drugs (Appendix H – Prescribing in a Public Health Emergency)*, the NSCP has temporarily suspended the 180 days prescribing limit for consecutive pharmacist prescribed renewals in circumstances where the patient is unable to be assessed by their primary care provider. In this circumstance, pharmacists may reassess the patient and bill for this service, provided the patient has not reached the maximum of four (4) prescription renewal PINs of any combination per resident within a one-year period.
- All documentation related to the service is to be kept on file in the pharmacy as per NSCP's guidelines for patient record retention.

Providers

To bill for service fees under the *Pharmacy Service Agreement*, pharmacies must:

1. Comply with the required training and application expectations set out by the *Pharmacist Drug Prescribing Regulations* and the NSCP's *Standards of Practice: Prescribing Drugs*.
2. Sign the *Confirmation of Agreement Form* certifying agreement with the *Pharmacy Service Agreement* (link in Appendix I) 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 pharmacy services administration fees.

Benefits

The following benefits are available to eligible residents pursuant to the NSCP's *Standards of Practice: Prescribing Drugs*:

1. Prescription renewal service by a pharmacist wherein 3 or less eligible prescriptions are renewed.
2. Prescription renewal service by a pharmacist wherein 4 or more eligible prescriptions are renewed.

Claims Submission

Fees for assessment and prescribing services must be billed to DHW online. Manual claims are not accepted for pharmacy services provided under the *Pharmacy Service Agreement*. 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.

The code ED must be entered in the Intervention Code field and one of the following codes must be entered in the Special Authorization Code field for all claims:

- 91 = In-person
- 92 = Telephone
- 93 = Video

The following claim limits apply to each service:

Service	Claim Limit
Prescription renewal	<ul style="list-style-type: none"> A maximum of four (4) prescription renewal PINs of any combination per resident within a one-year period. For example, three claims for PIN 93899846 and one PIN for 93899845, or two claims for each PIN.

All CPhA Claims Standard field content included in the tables below is required on service claims.

CPhA Claims Standard – Prescription Renewal for 3 or Less Prescriptions Renewed

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899846
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	1200 (\$12.00) *

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

CPhA Claims Standard – Prescription Renewal for 4 or More Prescriptions Renewed

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899845
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Licence number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
D.65.03	Intervention Code	ED
D.66.03	Drug Cost/Product Value	DDDDD (dollar value - not adjudicated)
D.67.03	Cost Upcharge	DDDDD (dollar value - not adjudicated)
D.68.03	Professional Fee	DDDDD (dollar value - not adjudicated)
D.72.03	Special Services Fee(s)	2000 (\$20.00) *

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

PHARMACARE BENEFITS AND EXCLUSIONS

This section of the Guide applies to 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. The Formulary is available online at:
<https://novascotia.ca/dhw/pharmacare/documents/formulary.pdf>

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.

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);

- anti-obesity therapies;
- nicotine replacement 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.

PHARMACARE PRICING PROCEDURES

■ 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 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% until March 31, 2020, and at MLP + 10% to a maximum mark-up of \$325 effective April 1, 2020. 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

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.*

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

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:

Benefit	Quantity Limit	Time Frame	
Adempas	28 day supply	Every 28 days (with 7-day grace)	
AeroChamber	1 device	Fixed 12-month period (Apr 1–Mar 31)	
Brilinta	60 tablets	Rolling 12-month period (from first date of claim)	
Duloxetine	5400 mg	Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)	
Epclusa	84 tablets	Fixed 12-week period	
Epipen /Allerject	2 injections	Fixed 12-month period (Apr 1–Mar 31)	
Esbriet	270 capsules	Every 28 days (with 7-day grace)	
Influenza Vaccine	<ul style="list-style-type: none"> ▶ Adults ▶ Children 	<ul style="list-style-type: none"> ▶ 1 injection ▶ 2 injections 	Fixed 12-month period
Harvoni	<ul style="list-style-type: none"> ▶ 56 tablets ▶ 84 tablets ▶ 168 tablets 	<ul style="list-style-type: none"> ▶ Fixed 8-week period ▶ Fixed 12-week period ▶ Fixed 24-week period 	
HP Pac	1 kit	Rolling 12-month period (from first date of claim)	
Imbruvica	28 day supply	Every 28 days (with 7-day grace)	
Iclusig	30 tablets	Every 28 days (with 7-day grace)	
Invokana	365 tablets	Fixed 12-month period (Apr 1–Mar 31)	
Kalydeco	28 day supply	Every 28 days (with 7-day grace)	
Lenvima	90 tablets	Every 28 days (with 7-day grace)	
Lynparza	448 caps	Every 28 days	
Maviret	<ul style="list-style-type: none"> ▶ 168 tablets ▶ 252 tablets ▶ 336 tablets 	<ul style="list-style-type: none"> ▶ Fixed 8-week period ▶ Fixed 12-week period ▶ Fixed 16-week period 	
Medication Review Service	<ul style="list-style-type: none"> ▶ Basic ▶ Advanced ▶ Follow-up 	<ul style="list-style-type: none"> ▶ 1 service ▶ 1 service ▶ 2 services 	<ul style="list-style-type: none"> ▶ Fixed 12-month period (Apr 1–Mar 31) ▶ Fixed 12-month period (Apr 1–Mar 31) ▶ Within 12 months of Basic/Advanced
Nucala	1 vial	Every 28 days (with 7-day grace)	
Ocaliva	30 tablets	Every 28 days (with 7-day grace)	
Ofev	60 capsules	Every 28 days (with 7-day grace)	
Pomalyst	28 day supply	Every 28 days (with 7-day grace)	

Benefit	Quantity Limit	Time Frame
Proton Pump Inhibitors (PPI)	425 tablets/capsules	Fixed 12-month period (Apr 1–Mar 31)
Sovaldi	▶ 84 tablets ▶ 168 tablets	Fixed 12-week period Fixed 24-week period
Tagrisso	30 tablets	Every 28 days (with 7-day grace)
Testosterone gel (e.g., Androgel 2.5g/pkt)	300 g	Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)
Testosterone gel (e.g., Androgel 5g/pkt and Testim® 1%)	600 g	Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)
Testosterone patches	120 patches	Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)
Thyrogen	1 kit (2 injections)	Fixed 6-month period starting April 1
Triptans	18 doses	Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)
Tysabri	28 day supply	Every 28 days (with 7-day grace)
Varenicline	168 tablets	Fixed 12-month period (Apr 1–Mar 31)
Vosevi	84 tablets	Fixed 12-week period
Vyvanse	5400 mg	Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)
Xeljanz	730 doses	Fixed 12-month period (Apr 1–Mar 31)
Xeljanz XR	365 doses	Fixed 12-month period (Apr 1–Mar 31)
Zepatier	▶ 56 tablets ▶ 84 tablets ▶ 112 tablets	▶ Fixed 8-week period ▶ Fixed 12-week period ▶ Fixed 16-week period
Zyban	168 tablets	Fixed 12-month period (Apr 1–Mar 31)

- 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.

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

Other:

Form	Quantity
Package/Kits of more than one drug	Per package (e.g., Invega Sustenna®, HP-Pac®, Monistat 3 Dual-Pack®, Didrocal®)
Packages of blood glucose testing strips with built-in meter	Per test strip (e.g., Sidekick® Blood Glucose Testing System)
Methadone Oral Compound Solution**	Per milligram methadone, regardless of the product used to prepare the oral liquid

* imiquimod 5% cream – Effective April 15, 2019, claims should be billed per gram and not by packet or mg.

** compounded according to NSCP standards

*** claims for foam - 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-D® 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

Probenecid 250mg Capsule - PIN 000903771

Ingredients: probenecid powder, gelatin capsules, lactose powder

Probenecid 500mg Capsule - PIN 000903772

Ingredients: probenecid 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

Attapulgate Suspension 25mL

Diphenhydramine Syrup (Pediatric) 50mL

Lidocaine Viscous 2% 25mL

Magnesium/Aluminum Conc. Suspension 75mL

Diphenhydramine Syrup (Pediatric) 50mL

Attapulgate 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 DHW AND NOVA SCOTIA PHARMACARE

■ Nova Scotia Pharmacare Payment Schedule

The payment schedule is available on the Pharmacare website at: <https://novascotia.ca/dhw/pharmacare/>

■ Claim Information for Online Adjudication

Claims to DHW 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 drug or device claim for Pharmacare Programs.

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

- 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 claims are not accepted for pharmacy services provided under the *Pharmacy Service Agreement*.

Manual Claim Form Sample

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

													
A PATIENT'S HEALTH NUMBER				B PHARMACY NO		CLAIM NO.		000001					
PATIENT'S NAME FIRST & SECOND				NAME OF PHARMACY									
SEX Y.O.B. SURNAME			PRESCRIBING DOCTOR INITIALS / SURNAME					PHARMACARE					
DETAILS OF COMPOUNDS / OSTOMY SUPPLIES ETC.				DATE PRESCRIPTION FILLED DAY MO. YR					DOCTOR NUMBER		P.O. BOX 500, HALIFAX, N.S. B3J 2S1		
				C		D							
PRESCRIPTION NO.	DIN	O/R	REFILLS AUTH	QUANTITY	DAYS SUPPLY	DRUG COST	FEE	MARK UP	AMOUNT CHARGED	CO-PAY	AMOUNT APPROVED	ADJ	
			E	F		G	H	I	J	K	L	M	
I CERTIFY THAT THE ABOVE PRESCRIPTION(S) IS FOR THE SOLE USE OF THE PATIENT NAMED ABOVE WHO IS ELIGIBLE FOR BENEFITS UNDER THE MSI PHARMACARE PROGRAM.						I CERTIFY THIS TO BE A TRUE STATEMENT OF PRESCRIPTION(S) DISPENSED FOR THE PATIENT NAMED ABOVE.							
<input checked="" type="checkbox"/>													

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

■ 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 at <http://novascotia.ca/dhw/pharmacare/documents/forms/Request-for-Adjustments-Form.pdf> (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.

For claims under a Pharmacare Program, 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.

NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS Request for Adjustments																																																								
		DATE: _____																																																						
PHARMACY NAME: _____		PROVIDER NUMBER: _____																																																						
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■ 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" at <http://novascotia.ca/dhw/pharmacare/documents/forms/Injectable-Medication-Ostomy-Supplies-Credit-Form.pdf>, 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:

Claim Number Numbers are in sequence.	Reference Number This number should be quoted when you are corresponding with MSI — the number uniquely identifies each claim.	Adjustment Codes If the amount paid is less than the amount claimed an adjustment code will be entered. — below is a list of the codes.										
		<table border="1" style="margin-left: auto; margin-right: 0;"> <tr> <th>Pharmacy Number</th> <th>Day</th> <th>Mo.</th> <th>Year</th> <th>Page</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	Pharmacy Number	Day	Mo.	Year	Page					
Pharmacy Number	Day	Mo.	Year	Page								
NOVA SCOTIA MEDICAL SERVICES INSURANCE P.O. BOX 500, HALIFAX, NS B3J 2S1												
CLAIM NUMBER	NAME	REFERENCE NUMBER	SERVICE DAY	MO.	YR.	REGISTRATION NO.	AMOUNT CLAIMED	AMOUNT PAID	ADJ.			
↓		↓							↓			

Adjustment Codes

- | | |
|--|--|
| <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> A2 - Claim is post dated A3 - Identical claim has been processed C2 - Service provided before effective date C4 - Coverage terminated before service D1 - DIN/PIN not a benefit TS - Trial Prescription error ** - Payment reduced to comply with Tariff Agreement |
|--|--|

AUDIT

■ Pharmacare Prescription Audits

The purpose of a Pharmacare prescription audit is to confirm that the details of a prescription adjudicated under the Nova Scotia Pharmacare Programs comply with the corresponding prescription on file. All claims submitted through Pharmacare are subject to audit. Providers are audited on a regular basis, and specific audits may be conducted as warranted. Audits are conducted for the following reasons:

- to ensure consistent and accurate claims submissions by the provider
- to ensure system integrity
- to detect and report possible fraud issues and beneficiary abuse/misuse issues
- to clarify with the provider how to submit online claims in accordance with Pharmacare policies

Any potential falsification of prescription records identified during audit may be reported to the Nova Scotia College of Pharmacists.

Please note that successful adjudication of a claim on-line does not prohibit a future audit of that claim. If, during an audit, it is found that incorrect information or processes have resulted in a successful adjudication result, Pharmacare reserves the right to recover payments previously made. When the review portion of the pharmacy audit has been completed, the pharmacy will receive a letter outlining any issues that were discovered during the audit. The letter may also include a list of transactions for which payment is being fully or partially recovered due to non-compliance with Nova Scotia Pharmacare Program's policies and procedures as per the "Pharmacare Prescription Audit Recovery Procedures" section of this document.

Any inquiries regarding our audit policies and procedures should be referred to the audit department toll-free at 1-800-305-5026.

■ Types of Audits

There are several different types of audits conducted by Pharmacare:

a) On-site prescription audits:

- This type of audit is conducted regularly and is an in-depth investigation of a single pharmacy's submission practices to the Nova Scotia Pharmacare Programs.
- The auditor may contact the pharmacy in advance providing the pharmacy with a date and time for the audit as a professional courtesy. Rare instances may occur when advanced notification of the audit is not possible.
- On-site prescription audits may vary in duration, and are determined by the number of claims selected for review and the accessibility of the supporting documentation (prescriptions, scanned images, and computer generated hardcopies, etc.) for those claims.
- Compounded prescriptions, exception status drugs, and methadone prescriptions are included in an on-site prescription audit.
- Documentation to support the prescription claimed must be available for review during the on-site audit. Only the documentation available at the time of the audit will be considered.

b) Desk audits:

- This type of audit is conducted to identify:
 - excess refills

- day's supply issues
- pricing integrity
- prescription adaptations
- therapeutic substitutions
- pharmacist-prescribed claims
- basic, advanced, and medication review follow-up claims

c) Prescription verification:

- A percentage of prescriptions audited may be verified with beneficiaries to ensure the prescriptions were prescribed as claimed.

■ Required Documentation

Prescriptions must include the following information:

- Date
- Patient's full name - includes first name and surname
- Drug/product name, strength/unit/formulation, quantity, and directions for use
- Prescriber's name
- Prescriber's signature (please refer to the *Nova Scotia Pharmacy Practice Regulations* for details)
- Number of refills if applicable and interval between refills if applicable

Pharmacists or technicians can use reasonable methods to confirm the patient's name and prescription date on the prescription document, which may or may not include calling the prescriber to verbally verify and documenting the method of verification.

Pharmacare requires an authorized prescription for all claims submitted electronically. The above documentation includes all schedules (i.e. prescription, narcotics, controlled drugs, OTC, etc.). Pharmacare considers authorized prescribers to be as follows: physician, dentist, prescribing optometrist, nurse practitioner, pharmacist or midwife in good standing with their governing bodies. Provincial restrictions placed on prescribing practices are followed by Pharmacare. Please refer to the Nova Scotia Formulary for a comprehensive list of types of prescribers and what they are authorized to prescribe.

Documentation for verbally ordered initial prescriptions:

Nova Scotia provincial pharmacy regulations allow authorized registrants to take verbal orders from prescribers for both prescription-requiring claims and OTC claims. Verbal prescriptions must be received from an authorized prescriber and be clearly documented on the prescription by the authorized registrant. Subsequent information is to be recorded on this original prescription to ensure there is a reference to verify the prescription claim.

The documentation must include the following information:

- Date verbal prescription was received
- Patient's full name - includes first name and surname
- Drug/product name, strength/unit/formulation, quantity, and directions for use
- Number of refills if applicable and interval between refills if applicable
- Name of the prescriber from whom the information was received
- Signature and license number of authorized registrant receiving information

When the pharmacy uses a pre-printed refill form or other computer-generated form to document a verbal order, the pharmacist or technician must write out by hand the date, the prescriber's name and a notation that they have confirmed with the prescriber. For example, 'December 1st, 2020, confirmed with Dr. John Smith' followed by the signature and license number of the pharmacist or technician that received the verbal order.

Creating false verbal orders that were not authorized by the prescriber affects the accuracy of patient health records and may be considered fraud. Unauthorized verbal orders identified during audit may be reported to the Nova Scotia College of Pharmacists.

Documentation for changes made to an existing prescription:

Changes to an existing prescription must be received from an authorized prescriber and be clearly documented **on the original prescription** by the authorized registrant to ensure there is a reference to verify the prescription claim. A letter from a prescriber authorizing changes to a beneficiary's prescriptions is not acceptable as documentation. For example, a blanket letter from a prescriber stating all prescriptions should be dispensed weekly is not valid documentation to support dispensing for a prescription that was written for a 90-day supply.

Documentation for changes made to an existing prescription must include the following components:

- Date change was received
- Prescriber's name (even if it is from the original prescriber)
- The signature and license number of the authorized registrant receiving information

It is required that all documentation pertaining to claims processed be retained and available at the time of the audit. This includes any documentation on written, verbal, electronic, faxed prescriptions, and computer-generated hardcopies, etc.

Pharmacist-initiated prescriptions:

Nova Scotia provincial regulations allow for pharmacist extended scope of practice and pharmacist prescribing. Pharmacare will accept pharmacist-prescribed claims based on conditions set forth in the Nova Scotia College of Pharmacists *Standards of Practice: Prescribing Drugs*.

Any services covered by the Tariff Agreement (or related agreement) must be submitted in accordance with the claim submission instructions outlined in this Guide.

Documentation for each pharmacist- initiated prescription **must** include the following components:

- Date
- Patient's full name (includes first name and surname)
- Drug/product name, strength/unit/formulation, quantity, and directions for use
- Prescribing pharmacist's first name and surname, signature and license number
- Number of refills (if authorized)
- Prescriber Notification Form (if applicable)

■ Pharmacare Prescription Audit Recovery Procedures

Audit Findings	Section	Action
1. PATIENT'S FULL NAME NOT INDICATED (includes first name and surname)	General Documentation Requirements	Recover total amount paid for original and any refills.
2. DRUG NAME/PRODUCT NAME NOT INDICATED	General Documentation Requirements	Recover total amount paid for original and any refills.
3. NO DRUG STRENGTH/UNIT/FORMULATION INDICATED WHERE MULTIPLE STRENGTHS/UNITS/ FORMULATIONS EXIST	General Documentation Requirements	Recover total amount paid for original and any refills.
4. NO QUANTITY OR NO DOSAGE DIRECTIONS INDICATED FOR DRUG PRESCRIBED	General Documentation Requirements	<p>If no quantity indicated, unless the quantity claimed is the only size manufactured and the package format is such that it cannot be divided (e.g. inhalers, insulins, and ophthalmic/otic products) recover professional fee(s) for original and any refills.</p> <p>If no dosage directions indicated, recover professional fee(s) for original and any refills.</p> <p>If no quantity and no dosage directions indicated, recover total amount paid for original and any refills.</p>
5. SMALLER QUANTITY CLAIMED THAN PRESCRIBED	Documentation for changes made to an existing prescription	Recover excess professional fee(s).
6. LARGER QUANTITY CLAIMED THAN TOTAL QUANTITY PRESCRIBED	Documentation for changes made to an existing prescription	Unless the quantity claimed has been adjusted to comply with the minimum 28 days supply requirement regarding select products, recover excess drug cost for original and any refills.
7. AUTHORIZED SIGNATURE* OF PRESCRIBER NOT PRESENT ON WRITTEN PRESCRIPTION	General Documentation Requirements	Recover professional fee(s) for original and any refills.
* As defined by the Pharmacy Practice Regulations of Nova Scotia		

Audit Findings	Section	Action
<p>8. VERBAL ORDERS (INCLUDING NEW AND/OR CHANGES TO AN ORIGINAL PRESCRIPTION) REQUIRE ALL OF THE FOLLOWING:</p> <ul style="list-style-type: none"> • Signature and license number of authorized registrant recording the change • Date received • Name of prescriber providing the order (see Section 4) 	<p>Documentation for verbal prescriptions AND Documentation for changes made to an existing prescription</p>	<p>Recover professional fee(s) for original and any refills.</p>
<p>9. REFILLS FOR DRUG PRESCRIBED</p> <p>(i) More refills claimed than authorized by prescriber</p> <p>(ii) Non-specific refill directions, e.g. “PRN”, “Unlimited” and “1Year”</p>	<p>Documentation for changes made to an existing prescription</p>	<p>(i) Recover total amount paid for excess refills.</p> <p>(ii) Recover total amount paid for any refills.</p>
<p>10. MISSING PRESCRIPTION(S)</p> <p>(i) One or two prescriptions</p> <p>(ii) Three or more prescriptions</p>		<p>(i) Recover the professional fee for original(s) and any refills, if the prescriptions cannot be located during the on-site audit.</p> <p>(ii) Recover the total amount paid for original(s) and any refills associated with every missing prescription, if the prescriptions cannot be located during the on-site audit.</p>
<p>11. DIFFERENT DRUG CLAIMED THAN PRESCRIBED</p>		<p>Recover total amount paid for original and any refills.</p> <p>Only products indicated as interchangeable in the Nova Scotia Formulary may be selected for interchangeability.</p>
<p>12. UNINSURED PRODUCT CLAIMED UNDER AN INSURED DIN/PIN</p>		<p>Recover total amount paid for original and any refills.</p>
<p>13. CRITERIA CODE OR DIAGNOSIS SUPPORTING PAYMENT NOT INDICATED ON PLAN EXCEPTION PRESCRIPTION CLAIMED WITH CRITERIA CODE</p>	<p>Documentation for changes made to an existing prescription</p>	<p>Recover total amount paid for original and any refills.</p>
<p>14. PRESCRIPTION ADAPTATION Documentation of patient consent is missing</p>		<p>Recover total amount paid for service.</p>
<p>15. THERAPEUTIC SUBSTITUTION SERVICE Documentation of patient consent is missing</p>		<p>Recover total amount paid for service.</p>

Audit Findings	Section	Action
16. BASIC MEDICATION REVIEW SERVICE (i) Pharmacist signature is missing from the Comprehensive Drug Review List (ii) For service delivered in person, patient signature missing from the Comprehensive Drug Review List		Recover total amount paid for service.
17. ADVANCED MEDICATION REVIEW SERVICE (i) Pharmacist signature is missing from the Comprehensive Drug Review List (ii) For service delivered in person, patient signature missing from the Comprehensive Drug Review List		Recover total amount paid for service.
18. MEDICATION REVIEW SERVICE FOLLOW-UP (i) Pharmacist signature is missing from the Comprehensive Drug Review List (ii) For service delivered in person, patient signature missing from the Comprehensive Drug Review List		Recover total amount paid for service.

Based on the overall audit findings, the sample size and audit time period may be increased to further determine the extent of infractions. Sample audit results may be extrapolated over all the claims paid during the period from which the same was drawn for the purpose of calculating recovery.

For non-specific refill directions, the total quantity authorized in numerical value and the total number of refills (if applicable) is required. The following examples: "Refill Rx #6234567", "Refill Lanoxin® X 6", and "Refill all meds as before X 3" all lack some components of a valid prescription, i.e., drug name, strength, quantity, or dosage directions. In order to avoid recoveries for invalid prescriptions any missing or incomplete prescription information is to be verified prior to dispensing and added to the prescription. As well, any alteration of the original prescription is to be verified in a similar manner which includes the name of the prescriber the information was received from, the signature and licence number of the authorized registrant present on the prescription.

■ Pharmacy Service Audits

The purpose of a Pharmacy Service audit is to confirm that the details of a service adjudicated under the terms of the *Pharmacy Service Agreement* between DHW and the Pharmacy Association of Nova Scotia (PANS) comply with the corresponding service on file. All claims submitted to DHW are subject to audit. Providers are audited on a regular basis, and specific audits may be conducted as warranted. Audits are conducted for the following reasons:

- to ensure consistent and accurate claims submissions by the provider, including supporting documentation
- to ensure system integrity
- to detect and report possible fraud issues and beneficiary abuse/misuse issues
- to clarify with the provider how to submit online claims in accordance with DHW policies

Please note that successful adjudication of a claim on-line does not prohibit a future audit of that claim. If, during an audit, it is found that incorrect information or processes have resulted in a successful adjudication result, DHW reserves the right to recover payments previously made. When the review portion of the pharmacy audit has been completed, the pharmacy will receive a letter outlining any issues that were discovered during the audit. The letter may also include a list of transactions for which payment is being fully or partially recovered due to non-compliance DHW's policies and procedures as per the "Pharmacy Service Audit Recovery Procedures" section of this document.

Any inquiries regarding our audit policies and procedures should be referred to the audit department toll-free at 1-800-305-5026.

■ Types of Audits

There are several different types of audits conducted in relation to pharmacy services:

a) On-site service audits:

- This type of audit is conducted regularly and is an in-depth investigation of a single pharmacy's submission practices to the DHW.
- The auditor may contact the pharmacy in advance providing the pharmacy with a date and time for the audit as a professional courtesy. Rare instances may occur when advanced notification of the audit is not possible.
- On-site service audits may vary in duration and are determined by the number of claims selected for review and the accessibility of the supporting documentation (assessment forms, prescriptions, referrals, scanned images, and computer generated hardcopies, etc.) for those claims.
- Documentation to support the service claimed must be available for review during the on-site audit. Only the documentation available at the time of the audit will be considered.

b) Desk audits:

- This type of audit is performed remotely and requires pharmacies to submit supporting documentation.

c) Service verification:

- A percentage of services, as determined at the discretion of DHW, audited may be verified with beneficiaries to ensure the services were received as claimed.

■ Required Documentation

Documentation can be either electronic or paper-based, unless otherwise specified.

General documentation for all services:

All service documentation must include the following information:

- Date of service
- Patient's full name - includes first name and surname
- Pharmacist's full name – includes first initial and surname
- Pharmacist's license number
- Documentation of patient's verbal or written consent that clearly and directly indicates consent to provide the service was provided by the patient (e.g. missing check box or note on file).

Any additional documentation requirements for specific services are further defined in the sub-sections below.

Documentation for assessment and prescribing services:

The following applies to services for assessment and prescribing for uncomplicated cystitis, herpes zoster, and contraception management:

- **For all services that result in a prescription:**
 - Prescription by the pharmacist and either:
 - Documentation of notification of pharmacist prescribing to patient's primary care provider or specialist; or
 - Documentation that the prescription information was provided to the patient if the patient did not report having a primary care provider.
- **For all services that do not result in a prescription:**
 - Documentation of:
 - Reason(s) why the pharmacist could not prescribe to the patient; and
 - Referral to another health care provider (e.g. primary care provider or specialist, walk-in clinic or emergency department) including a copy of the referral form if the patient reported having a primary care provider.
 - Reasons why the pharmacist could not prescribe after completing an assessment may include but are not limited to:
 - Assessment uncovers clinical factors not readily apparent nor easily determined prior to commencing the assessment, such as:
 - Pregnancy or lactation status
 - Drug allergies or intolerances
 - Drug interactions
 - Complicated co-morbidities
 - Patient determined to already be receiving appropriate drug therapy or contraception.
 - Patient refuses prescription after completion of assessment.

Documentation for prescription renewals:

- Prescription by the pharmacist and either:
 - Documentation of notification of pharmacist prescribing to patient's primary care provider or specialist; or
 - Documentation that the prescription information was provided to the patient if the patient did not report having a primary care provider.

■ Pharmacy Service Audit Recovery Procedures

Audit Findings	Section	Action
For all services:		
1. DATE OF SERVICE NOT INDICATED	General Documentation Requirements	Recover total amount paid for service
2. PATIENT'S FULL NAME NOT INDICATED (includes first name and surname)	General Documentation Requirements	Recover total amount paid for service
3. PHARMACIST'S FULL NAME NOT INDICATED (includes initial of first name and full surname)	General Documentation Requirements	Recover total amount paid for service
4. PHARMACIST'S LICENSE NUMBER NOT INDICATED	General Documentation Requirements	Recover total amount paid for service
5. MISSING DOCUMENTATION OF PATIENT CONSENT Documentation of patient consent is missing (e.g. missing check box or note on file) or does not clearly and directly indicate consent to provide the service was provided by the patient.	General Documentation Requirements	Recover total amount paid for service
6. CLAIM SUBMITTED FOR AN INELIGIBLE RESIDENT (e.g. patient residing in a nursing home)	General Documentation Requirements	Recover total amount paid for service
7. CLAIM SUBMITTED FOR AN INELIGIBLE SERVICE (e.g. not pursuant to the <i>Standards of Practice: Prescribing Drugs</i> or the <i>Nova Scotia Department of Health and Wellness Pharmacy Guide</i>).	General Documentation Requirements	Recover total amount paid for service
For all assessment and prescribing services:		
For services that result in a prescription:	Assessment and Prescribing Documentation Requirements	If documentation indicates there was an assessment with no prescription, no recovery. If documentation indicates a prescription was written, recover total amount paid for service.
8. MISSING PRESCRIPTION(S)		

Audit Findings	Section	Action
For services that result in a prescription: 9. PRESCRIPTION PRESENT, MISSING PRESCRIBING NOTIFICATION ¹ OR DOCUMENTATION THAT PRESCRIBING INFORMATION PROVIDED TO PATIENT	Assessment and Prescribing Documentation Requirements	Recover total amount paid for service
For services that do not result in a prescription: 10. MISSING DOCUMENTATION OF REASON(S) PHARMACIST COULD NOT PRESCRIBE	Assessment and Prescribing Documentation Requirements	Recover total amount paid for service
For services that do not result in a prescription: 11. MISSING DOCUMENTATION OF REFERRAL TO ANOTHER HEALTH CARE PROVIDER OR REASON WHY A REFERRAL WAS NOT APPROPRIATE	Assessment and Prescribing Documentation Requirements	Recover total amount paid for service
For contraception management billed as initial assessment or subsequent assessment resulting in change in therapy: 12. PRESCRIPTION WRITTEN FOR CONTINUATION OF EXISTING THERAPY	Assessment and Prescribing Documentation Requirements	Recover difference between higher fee PIN and lower fee PIN.
For prescription renewals:		
13. MISSING PRESCRIPTION(S)	Prescription Renewal Documentation Requirements	Recover total amount paid for service
14. MISSING PRESCRIBER NOTIFICATION OR DOCUMENTATION THAT PRESCRIBING INFORMATION PROVIDED TO PATIENT	Prescription Renewal Documentation Requirements	Recover total amount paid for service
15. PRESCRIPTION FOR UNINSURED PRODUCT (e.g. over-the-counter medication, supplies)	Prescription Renewal Documentation Requirements	Recover total amount paid for service unless other eligible prescriptions were renewed as part of same service
For prescription renewals billed with PIN for 4 or more medications renewed: 16. QUANTITY OF PRESCRIPTIONS NOT MET (e.g. 3 or fewer prescriptions renewed)	Prescription Renewal Documentation Requirements	Recover difference between higher fee PIN and lower fee PIN.

Based on the overall audit findings, the sample size and audit time period may be increased to further determine the extent of infractions. Sample audit results may be extrapolated over all the claims paid during the period from which the same was drawn for the purpose of calculating recovery.

¹ Prescribing notification requirement waived until further notice in alignment with the Nova Scotia College of Pharmacists *Standards of Practice: Prescribing Drugs* (Appendix H – Prescribing in a Public Health Emergency/Crisis).

■ Appeal of Investigative Determination

A provider may appeal an investigative determination made under Section 5 of the *Provider Appeals Regulations* ([link in Appendix I](#)) by referring the determination to an appeal panel using the notice of appeal form ([link in Appendix I](#)). The notice of appeal is to be sent to the Executive Director of the Pharmaceutical Services and Extended Health Benefits branch of the Nova Scotia Department of Health and Wellness no later than 30 days after the date that the provider received the investigative determination.

■ Contact

Pharmacare Audit
P.O. Box 500, Halifax, NS B3J 2S1
Toll-free: 1-800-305-5026

PUBLICATION HISTORY

Publication Date	Updates
December 11, 2020	<ul style="list-style-type: none"> • Reference documents are no longer embedded in appendices. These previous appendices have been replaced by a new Appendix 1 that provides links to current versions of all documents. • A new Publication History section has been added at the end of the Guide to summarize the content changes in each version of the Guide. • In the sections on Advanced Medication Review Service, Basic Medication Review Service and Medication Follow-up Review Service, new claims submission and documentation requirements to support virtual care delivery have been incorporated. • A new section on Virtual Care Delivery of Medication Reviews has been added. • In the section Administration of Publicly Funded Influenza Vaccinations by Pharmacists, eligibility has been expanded to include administration of the vaccine by a pharmacy technician with instruction incorporated on how such claims should be billed to DHW. PINs have been added for Influsplit Tetra products. • In the section Assessment and Prescribing for Uncomplicated Cystitis, Herpes Zoster and Contraception Management, new claims submission requirements pertaining to virtual care delivery have been incorporated. • In the section on Prescription Renewals, additional information has been provided on expected duration of therapy for publicly funded services and new claims submission requirements pertaining to virtual care delivery have been incorporated. • In the Audit section of the Guide, in the section on Required Documentation for Pharmicare Prescription Audits: <ul style="list-style-type: none"> ○ Direction has been incorporated on acceptable practices for managing missing prescription dates, which is in line with the previous direction on handling incomplete patient names. ○ Verbal order documentation requirements for computer-generated prescriptions have been clarified. ○ Direction has been added that letters from prescribers authorizing changes to a patient's prescriptions are not accepted. • In the Audit section of the Guide, in the section on Pharmacare Prescription Audit Recovery Procedures: <ul style="list-style-type: none"> ○ Audit recovery procedures pertaining to medication review services have been updated to reflect new virtual care requirements. • In the Audit section of the Guide, in the section on Pharmacy Service Audits, in the section on Required Documentation: <ul style="list-style-type: none"> ○ The requirements for documenting a patient's consent for the service have been expanded to clarify that documentation must clearly and directly indicate consent was provided. • In the Audit section of the Guide, in the section on Pharmacy Service Audit Recovery Procedures: <ul style="list-style-type: none"> ○ Related to the clarification on documenting consent, audit recovery procedure 5 has been updated. ○ For audit recovery procedure 9 pertaining to services that result in a prescription, a footnote has been added to indicate the requirement for prescribing notification has been waived until further notice.

Publication Date	Updates
October 6, 2020	<ul style="list-style-type: none"> • In the Administration of Publicly Funded Influenza Vaccinations by Pharmacists section, DINs and PINs updated for 2020-21 season.
July 31, 2020	<ul style="list-style-type: none"> • In the Administration section, expanded information about the requirement for pharmacists to register with Medavie to be eligible as a prescriber for public drug and service claims. • In the Exception Status Drugs section, new reference to pharmacists submitting requests as prescribers and new requirements for using criteria codes. • In the Advanced Medication Review section, requirement for pharmacies to register with PANS removed. • In the Therapeutic Substitution and Prescription Adaptation sections, the requirement to submit and then reverse the original claim for the prescribed product removed. • In the section on Administration of Publicly Funded Influenza Vaccinations by Pharmacists, age requirement has been changed from 5 years to 2 years. • In the section on Assessment and Prescribing for Uncomplicated Cystitis, Herpes Zoster and Contraception Management, new reference to the requirement that pharmacists must register with Medavie as a prescriber before conducting services. New reference that claims will not be accepted for assessment and prescribing of uncomplicated cystitis services if the patient is under 16 years old. • In the Prescription Renewal section, new reference to the requirement that pharmacists must register with Medavie as a prescriber before conducting services and new PINs effective July 15, 2020. • In the Quantity Limits section, addition of Xeljanz XR. • In the Audit section, new reference that any potential falsification of prescription records identified during audit may be reported to the Nova Scotia College of Pharmacists and new reference to implications of creating false verbal orders.

APPENDIX I: REFERENCE DOCUMENTS

Document	URL
Pharmacare Tariff Agreement	https://novascotia.ca/dhw/pharmacare/documents/Pharmacare-Tariff-Agreement.pdf
Pharmacy Service Agreement	https://novascotia.ca/dhw/pharmacare/documents/Pharmacy-Service-Agreement.pdf
Pharmacy Provider Confirmation of Agreement	https://novascotia.ca/dhw/pharmacare/documents/Provider-Agreement.pdf
Provider Appeals Regulations	https://novascotia.ca/just/regulations/regs/fdappeals.htm
Notice of Appeal by Provider	https://novascotia.ca/dhw/pharmacare/documents/Notice-of-Appeal.pdf