NOVA SCOTIA

Pharmacy Guide

July 2024

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: 1-888-894-5353
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
Sensor-based Glucose Monitoring Program https://beta.novascotia.ca/register-sensor-based-glucose-monitoring-program	Local calls: 902-496-5667 Toll Free: 1-877-330-0323

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: Toll-free:	902-424-1269 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: Toll-free:	902-496-7001 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: Toll-free:	902-496-7123 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* https://novascotia.ca/flu/	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.

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.

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 at least 30 days in advance of transfer/closing.

This information will be retained in confidence. A close-out audit is required. You may contact our office at MSIProvidercoordinators@medavie.bluecross.ca or 1-866-553-0585.

If your pharmacy is issued a new licence number, you must update the licence number in CANImmunize Clinic Flow to ensure payments for vaccinations can be processed. Incorrect or inactive license numbers will result in payments not being processed. To update your license in Clinic Flow, please contact the Vaccination Information Technology Team at Cathy.M.McPhee@novascotia.ca and Glenn.Bartlett@novascotia.ca.

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 and any amending agreements,
- bill DHW according to the current Pharmacy Service Agreement and any amending agreements,
- 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 Reimbursement 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 and process.

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 https://novascotia.ca/dhw/pharmacare/formulary-review-pathways.asp.

Generic Drugs

The **Nova Scotia Department of Health and Wellness** 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. Links to the current Pharmacare Tariff Agreement and any amending agreements are 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. Links to the current Pharmacy Service Agreement and any amending agreements are 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 unless that change is in response to an increase in the maximum dispensing fee as specified in the tariff agreement.

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 decides 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 decides 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 though:

- 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, Seniors' Pharmacare or the Palliative Care Drug Program;
- have a diagnosis of cancer;
- have a gross family income of no more than $35,000;
- 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 the 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: https://novascotia.ca/dhw/pharmacare/cancer-assistance.asp. The application form allows residents to enrol in the **Boarding, Transportation and Ostomy Program** and **Wig Program** (see below) at the same time.

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, and ostomy 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. 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.

Boarding, Transportation and Ostomy Program

The Boarding, Transportation, and Ostomy (BTO) Program is a provincial program that helps eligible Nova Scotia residents undergoing cancer treatment with assistance for costs related to boarding, transportation, and ostomy supply needs.

Benefits

Boarding cost assistance is considered for residents who must travel more than 50 km one-way from their home to the treatment centre.

Transportation cost assistance is considered, at the applicable provincial government mileage reimbursement rate adjusted each year effective the first of April, for residents who use a personal vehicle to travel between their home and the treatment centre. The Program will also cover the cost for patients using a bus, shuttle or community transportation service.

The program may cover the boarding and/or transportation costs for a travel escort, who, in the opinion of the patient’s physician and verified by the Program Administrator, is considered essential. Travel escort costs must be pre-approved by the Program Administrator.

Claims for ostomy supplies are covered through the Drug Assistance for Cancer Patients program and direct billed by pharmacies following usual Pharmacare claims submission procedures. Ostomy supplies must be listed in the Ostomy Supplies Benefit List in the NS Formulary to be eligible. All BTO program beneficiaries are automatically enrolled in the Drug Assistance for Cancer Patients program.

Eligibility

- You may apply if you are actively receiving treatment for cancer at a treatment centre and:
- are a resident of Nova Scotia with a valid Nova Scotia Health Card,
- have a gross family income no greater than $35,000 per year, and

- do not have private insurance that covers the cost of transportation or accommodation.

Enrolment

Residents of Nova Scotia wishing to apply for coverage should contact the Boarding, Transportation, and Ostomy Program 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: https://novascotia.ca/dhw/pharmacare/cancer-assistance.asp. The application form allows residents to enrol in the **Drug Assistance for Cancer Patients Program** and the **Wig Program** (see above and below) at the same time.

Wig Program

The Wig Program helps Nova Scotians with the purchase of a wig. The program is designed to assist low-income Nova Scotians who do not have existing coverage for a wig.

Benefits

Residents will be reimbursed up to $300 for the one-time purchase of a wig. If the first wig was less than $300, residents cannot apply the difference towards another wig. Wig accessories (like caps and adhesives) are not eligible for reimbursement.

The wig can be purchased from anywhere, including online and does not need to be through a specific provider or physical store. Residents do not need to be assessed by a proper wig fitter.

The original receipt with purchase details is required. A credit and debit card statements are not sufficient for reimbursement.

Patients must submit your original receipt (cash register receipts are not acceptable) along with the Wig Claim Form (PDF) to make sure there are no delays in your reimbursement. They can submit claim via mail, email, and fax. There is no direct deposit option, and they will be mailed a cheque.

Eligibility

Patients may apply if they have been diagnosed with cancer, and:

- are a resident of Nova Scotia with a valid Nova Scotia Health Card,
- have a gross family income no greater than $35,000 per year,
- have enrolled in the Assistance for Cancer Patients programs, and
- do not have private insurance coverage that covers the cost of a wig.

Enrolment

Residents of Nova Scotia wishing to apply for coverage should contact the Wig Program 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: https://novascotia.ca/dhw/pharmacare/cancer-assistance.asp. The application form allows residents to enrol in the Drug Assistance for Cancer Patients Program and the Boarding, Transportation and Ostomy Program (see above) at the same time.

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.

Sensor-based Glucose Monitor Program

The Sensor-based Glucose Monitoring (SBGM) Program is an income-based program that covers supplies for Nova Scotia residents who have Type 1 or Type 2 diabetes who meet specific criteria. Patients can choose to apply for coverage through this program or access the products as benefits through other Pharmacare programs (Family, Seniors' or DCS).

Enrolment

Patients must complete an enrolment form and forward it to the SBGM Program office. A portion of the form must be completed by a physician, nurse practitioner, or pharmacist. This signature sign-off serves as verification the patient meets the clinical criteria for the glucose monitoring product, including being on the required daily injections of insulin. Enrolment forms are available on the program website at: https://beta.novascotia.ca/register-sensor-based-glucose-monitoring-program.

Billing/Copayment

There is an annual maximum deductible based on family size and income.

Benefits

See the **Quantitative Limits** section of the Guide for product-specific frequency limits.

PRODUCT	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Dexcom G6 Sensor	97799136	DNP	E(SFD), G[1]	DEX
Dexcom G6 Transmitter	97799135	DNP	E(SFD), G[1]	DEX
Dexcom G7 Sensor	97798972	DNP	E(SFD), G[1]	DEX
Dexcom G7 Receiver	97798973	DNP	E(SFD), G[1]	DEX
FreeStyle Libre 2 Sensor	97799075	DNP	E(SFD), G[1]	MID
Guardian 3 Sensor	97799158	DNP	E(SFD), G[1]	MDT
Guardian 4 Sensor	97798971	DNP	E(SFD), G[1]	MDT
Criteria	• For patients 2 years of age or older with Diabetes Mellitus (DM) AND who require multiple daily injections of insulin or insulin pump			

	therapy as part of intensive insulin therapy. Multiple daily injections of insulin are defined as 1 (or more) injection(s) of basal insulin and 3 (or more) injections of bolus insulin, with a minimum of at least of 4 total insulin injections per day.

[1] Benefit Status code G represents the income-based SBGM program

- If a sensor must be replaced early (stops working or falls off), users must contact the manufacturer directly to request a replacement. Depending on the manufacturer and product, a replacement sensor may be shipped at no cost or an email voucher provided to redeem for a sensor at the pharmacy.
- Patients will need to use any other sources of insurance that are available to them first (e.g. private insurance). This includes situations in which the patient must submit manual receipts. Portions unpaid by the private insurance would then be sent to the SBGM program for reimbursement consideration.

More information and application forms can be found on the website: https://beta.novascotia.ca/register-sensor-based-glucose-monitoring-program.

Multiple Sclerosis Copayment Assistance

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

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

Eligibility

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

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

Enrolment

When eligibility is confirmed, the DMSRU sends a written notification of eligibility to Pharmacare. The DMSRU also sends written notification and information on billing processes to the provider that will be filling eligible prescriptions.

Benefits

For a prescription to be eligible for copayment assistance, it must be for the following:

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

and be:

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

Billing

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

Copayment

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

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

Under 65 – Long Term Care (LTC) Pharmacare Plan

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

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

Eligibility

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

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

Enrolment

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

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

- Facility name and address
- Name and number for facility contact
- Name of resident
- Resident’s date of birth
- Resident’s Nova Scotia Health Card number
- Date of admission
- Date of discharge (where applicable)
- Accommodation charges form that is completed by an Eligibility Review Officer

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 webpage 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: ▪ 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

Provincial Clozapine Program: Adjudication of Claims

The Nova Scotia Department of Health & Wellness funds clozapine for patients who are approved through the Nova Scotia Clozapine Program. All patients on clozapine in Canada must be registered with a monitoring and distribution system through a drug manufacturer. In Nova Scotia, monitoring is currently with the Clozaril® Support and Assistance Network (CSAN). All physicians and pharmacies involved in patient care must be registered with CSAN.

Eligibility

All residents enrolled in the Nova Scotia Clozapine Program are eligible for public funding of clozapine dispensed by providers, pursuant to a valid prescription, appropriate blood work, and provided the patient meets the specified eligibility criteria for clozapine. The patient's clinician will work with the Pharmacy team members at the Dartmouth General Hospital (DGH) involved in the Clozapine Program to enroll the patient in the provincial program.

Adjudication

For new patients, providers will need to confirm eligibility of the patient in the Clozapine Program and verify setup in CSAN. Please contact the Pharmacy team members at DGH involved in the Clozapine Program for assistance at **902-465-8556.**

The prescriber will send the prescription to the community pharmacy. The community pharmacy will complete CSAN monitoring prior to dispensing. Prescriptions will be adjudicated online, using a Nova Scotia Health Card Number, at zero drug cost, with no markup applied, only allowing a dispensing fee (outlined by the *Pharmacare Tariff Agreement*) to be reimbursed to the pharmacy.

Beneficiaries of the Clozapine Program should **not** be charged a copay. In the case that adjudication indicates a copay is to be paid, please 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
- medication (DIN) to be dispensed
- dispense date

Supply

Dispensing pharmacies must order from the provincial clozapine supply, direct from the Provincial Drug Distribution Program (PDDP) and hold stock separate from regular pharmacy inventory. Clozapine will be supplied at zero cost to the pharmacy. An internal inventory audit will be conducted periodically.

Pharmacies will need to be set up with PDDP as a vendor to order from the provincial supply. Pharmacies will be responsible for letting PDDP know the quantities they need, maintaining that inventory, and the PDDP will be responsible for couriering the medication to the pharmacies. To connect with PDDP regarding clozapine, please email ClozapineOPP@nshealth.ca.

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 provider must mail or fax a completed Exception Status Drug (ESD) 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. The Department of Health and Wellness continually reviews exception status drug requirements and is continuing to explore improvements to make the ESD process as effective and efficient as possible for all providers.

Criteria for Exception Status Drugs: https://novascotia.ca/dhw/pharmacare/documents/Criteria-for-Exception-Status-Coverage.pdf

Please note that pharmacists are among the health care providers who can complete and submit ESD forms for beneficiaries of the Pharmacare Programs, provided they have the information that is required to determine whether the patient meets the established coverage criteria. The pharmacist does not have to be the prescriber of the medication.

Many products require a specialist request (biologic therapies, MS therapies, hepatitis C therapies etc.) and in those cases, only pharmacists who work directly with that specialty group such as in a hospital or clinic setting, would be permitted to submit a coverage request. If there are extenuating circumstances, please contact the Pharmacare Office.

IMPORTANT REMINDER: Pharmacists who prescribe and/or submit ESD forms in Nova Scotia must register with Medavie to be eligible as a prescriber under the Pharmacare programs. The "Main Address" submitted with your registration will be used for all patient correspondence that Medavie sends you. **This address must be accurate and appropriate for receiving and handling private patient information. You are responsible under the Personal Health Information Act to ensure the patient information sent to your Main Address is protected from unauthorized disclosure or use.** If you need to change your address, please visit the following site to update your profile information and click on 'Edit your profile': https://www.medaviebc.ca/en/health-professionals/register

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

Every effort is made to process requests within 6 business 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 provider 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
- Arazlo 0.045% Lotion will not require prior approval for beneficiaries under the age of 30
- Desmopressin (DDAVP Tab, MELT Tab and generic brands) will not require prior approval for beneficiaries under the age of 16
- 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:

- Calcipotriol (Dovonex 50mcg/g Ointment)
- Entacapone (Comtan 200mg Tablet & generic brands)
- Fluconazole (Diflucan POS 10mg/mL)
- Levodopa and carbidopa and entacapone (Stalevo 50mg, 75mg, 100mg, 125mg, 150mg Tablet)
- Vigabatrin (Sabril Sachet & Tablet)
- COPD and Asthma inhalers

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 provider 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.nsco.ca/
- The two-digit prescriber ID Reference Code for each prescriber type follows:

  31 = Nova Scotia College of Physicians and Surgeons

  35 = Provincial Dental Board of Nova Scotia

  36 = Nova Scotia College of Pharmacists

  37 = College of Registered Nurses of Nova Scotia

  38 = Nova Scotia College of Optometrists
- The following default prescriber license numbers can be used only when a valid license number cannot be obtained:

  9999 = Physician

  3333 = Out of Province Physician

  8888 = Dentist

  71113 = Midwife
- If the Prescriber ID is submitted with an invalid value, the claim submission will reject with CPhA3 response code **D3 "PRESCRIBER IS NOT AUTHORIZED"**. Note that a claim submission will also reject with this response code if a pharmacist submits a valid Prescriber ID but has not registered their Prescriber ID with Medavie Blue Cross.
- If the Prescriber ID is submitted with a blank value, the claim submission will reject with CPhA3 response code **61 "PRESCRIBER ID ERROR"**.
- If the Prescriber ID Reference Code is submitted with an invalid value, the claim submission will reject with CPhA3 response code **60 "INVALID PRESCRIBER ID REFERENCE CODE"**.
- If the Prescriber ID Reference Code is submitted with a blank value, the claim submission will reject with CPhA3 response code **LF "PRESCRIBER ID REFERENCE IS MISSING"**.
- If a claim is submitted for a benefit that is not eligible to be prescribed by a particular prescriber type, the claim submission will reject with CPhA3 response code **CD "DRUG IS NOT A BENEFIT"**.

Coverage of Pharmacist-Prescribed Claims

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 and other benefits 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.

Additionally, prescription documentation must adhere to the requirements for pharmacist prescriptions as identified in the Pharmacare Prescription Audits section of this Guide.

Additional Funded Clinical Services for Pharmacare Beneficiaries

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 and is eligible for coverage provided all the following criteria are met:

- The patient is a beneficiary of a Nova Scotia Pharmacare 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 BMRS 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.
- For both in-person and virtual services, the patient must bring their medications (prescription and non-prescription) for review by the pharmacist for discussion and visual verification. If completed as a virtual service, the review must be completed in a manner that allows viewing by the pharmacist (e.g. by video conference). If this does not occur, there must be a documented reason on the patient's file.
- 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.
- For patients who do not reside in a nursing home, home for special care, or are not insured through the Under 65 -LTC Program, a BMRS cannot be completed on the same day as an Advanced Medication Review Service for the same patient.
- For patients who reside in a nursing home, home for special care, or are insured through the Under 65 - LTC Program, only one Medication Review Service (BMRS or AMRS, if applicable) will be eligible for

coverage upon admission to a long-term care facility. If the patient has multiple admissions within a benefit year, only one Medication Review Service will be covered.

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.

- 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.
- For both in-person and virtual services, the patient must bring their medications (prescription and non-prescription) for review by the pharmacist for discussion and visual verification. If completed as a virtual service, the review must be completed in a manner that allows viewing by the pharmacist (e.g. by video conference). If this does not occur, there must be a documented reason on the patient's 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.
- For patients who do not reside in a nursing home, home for special care, or are not insured through the Under 65 -LTC Program, an AMRS cannot be completed on the same day as a BMRS for the same patient.
- For patients who reside in a nursing home, home for special care, or are insured through the Under 65 - LTC Program, only one Medication Review Service (BMRS or AMRS, if applicable) will be eligible for coverage upon admission to a long-term care facility. If the patient has multiple admissions within a benefit year, only one Medication Review Service will be covered.
- 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 not reside in a nursing home, a home for special needs, or be insured through the Under 65 – LTC Program.
- 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.

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. A Medication Review Service Follow-up cannot be completed on the same day as a 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.

In addition to meeting the above requirement(s), the patient must bring their medications (prescription and non-prescription) for review by the pharmacist for discussion and visual verification. The review must be completed in a manner that allows viewing by the pharmacist (e.g. by video conference). If this does not occur, there must be a documented reason on the patient's file.

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.

Administration of Publicly Funded Influenza Vaccinations Provided by a Pharmacy

Eligibility

All individuals 6 months of age and over can have publicly funded influenza vaccine provided by a pharmacy. Eligibility for publicly funded influenza vaccine is defined in the document Publicly-Funded-Seasonal-Inactivated-Influenza-Vaccine-Information.pdf (novascotia.ca), and pharmacy claims must be submitted in compliance with the eligibility, dosage and frequency criteria.

High Dose Vaccine

Everyone in Nova Scotia who is 65 years and older is eligible to receive High Dose influenza vaccine. High Dose influenza vaccine has four times the amount of antigen and offers better protection for this age group.

Coadministration of COVID-19 and Influenza Vaccines

Administration of COVID-19 vaccines may occur concurrently with (i.e., same day), or at any time before or after seasonal influenza immunization for those aged 6 months and older. Health care providers should consult the Canadian Immunization Guide COVID-19 chapter for updated NACI guidance on the concurrent administration of influenza and COVID-19: https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/page-26-covid-19-vaccine.html

Billing and Payment Process

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 or when administered by any self-regulated health professional under a pharmacist's direction and supervision, when performed in compliance with the regulations and standards of practice. Pharmacies are to use Clinic Flow for appointment booking and to document administration of influenza vaccine. As the publicly funded influenza vaccine is available free of charge, no individual is to be charged for the vaccine.

The Department of Health and Wellness (DHW) uses the Clinic Flow system to generate reports indicating the immunization volumes for each pharmacy based on the pharmacy's active license number. DHW submits these reports to Medavie and payments are processed on a bi-weekly basis within two pay periods of report submission. The payments appear as a bottom-line adjustment on each pharmacy's pay statement, labelled as "FLU" with a date range for when the immunizations occurred. Any questions about payment can be directed to Medavie Blue Cross through the Pharmacare phone line at 1-800-305-5026.

Coverage of Service Fee for Non-Residents: The pharmacy professional fee will be covered for all persons receiving a pharmacy-administered influenza vaccine when recorded in CANImmunize, including those who do not have a valid Nova Scotia health card. This is consistent with the policy for COVID-19 vaccinations.

To ensure accurate and timely payment, all vaccines must be recorded in CANImmunize on the same day as administration. A delay in data entry may result in missed payments.

If your pharmacy is issued a new licence number, you must update the licence number in CANImmunize Clinic Flow to ensure payments for vaccinations can be processed. Incorrect or inactive license numbers will result in payments not being processed. To update your license in Clinic Flow, please contact the Vaccination Information Technology Team at Cathy.M.McPhee@novascotia.ca and Glenn.Bartlett@novascotia.ca.

Administration of Publicly Funded COVID-19 Vaccinations Provided by a Pharmacy

Effective April 1, 2022 the maximum special service fee for each dose of the COVID-19 vaccine is $18.00. The fee applies to COVID-19 vaccines administered by licensed pharmacists and any self-regulated health professional administering the vaccine under a pharmacist's direction and supervision.

Billing and Payment Process

Pharmacies that are providing COVID-19 immunizations through pharmacy-led clinics do not have to submit service claims to Pharmacare. DHW uses the Clinic Flow system to generate reports indicating the immunization volumes for each pharmacy based on the pharmacy's active license number. DHW submits these reports to Medavie and payments are processed on a bi-weekly basis within two pay periods of report submission. The payments appear as a bottom-line adjustment on each pharmacy's pay statement, labelled as "COVID" with a date range for when the immunizations occurred. Any questions about payment can be directed to Medavie Blue Cross through the Pharmacare phone line for initial review.

If your pharmacy is issued a new licence number, you must update the licence number in CANImmunize Clinic Flow to ensure payments for vaccinations can be processed. Incorrect or inactive license numbers will result in payments not being processed. To update your license in Clinic Flow, please contact the Vaccination Information Technology Team at Cathy.M.McPhee@novascotia.ca and Glenn.Bartlett@novascotia.ca.

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 all persons 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 Services

Assessment and prescribing by a pharmacist for uncomplicated cystitis, herpes zoster, contraception management, Lyme disease chemoprophylaxis, and antibiotics (chemoprophylaxis) for select infectious diseases is eligible for coverage by DHW 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 except for assessing and prescribing for antibiotics (chemoprophylaxis) for select infectious diseases.
- The patient must not reside in a nursing home with the exception of assessing and prescribing for herpes zoster.
- 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 if applicable to the service that 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:
    - Claims will not be accepted if the patient is 65 years of age or older.
    - 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.
- For assessment and prescribing for antibiotics (chemoprophylaxis) in response to a Public Health request:
    - The service must be provided based on the information provided by Public Health in a letter to the pharmacy, including the recommendation for an antibiotic to be prescribed following direction from the NSH Medical Officer of Health.

- The appropriate drug, dose, and formulation is prescribed by the community pharmacy based on the patient's age, weight, allergies, and any health conditions that may be relevant for prescribing.
- The service is completed in compliance with the Public Health Protocols for prescribing, available through the PANS Member Lounge Portal (https://pans.memberlounge.app).

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.
4. Assessment and prescribing service by a pharmacist for **Lyme disease chemoprophylaxis** that:
    a. Results in a prescription for chemoprophylaxis, or
    b. Does not result in a prescription for chemoprophylaxis.
5. Assessment and prescribing of **antibiotics (chemoprophylaxis)** to prevent invasive group A streptococcus (iGAS), pertussis, or invasive meningococcal disease (IMD) infections in response to a request for chemoprophylaxis for the patient from Public Nova Scotia Health (NSH), Public Health division.

Claims Submission

Fees for assessment and prescribing services must be billed to DHW online, with the exception of claims for non-residents for assessment and prescribing for antibiotics (chemoprophylaxis). Manual claims for any other services 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	▪ 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	▪ 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	▪ 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-monthperiod (from first date of claim) for a subsequent assessment that does not result in a change in therapy.
Assessment and prescribing for Lyme disease chemoprophylaxis	▪ No limit
Assessment and prescribing for antibiotics (chemoprophylaxis)	▪ No limit

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.

CPhA Claims Standard – Assessment and Prescribing for Lyme Disease Chemoprophylaxis Resulting in a Prescription

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899840
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 Lyme Disease Chemoprophylaxis That Does Not Result in a Prescription

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899839
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 – CPhA Claims Standard – Fee to Prescribe antibiotic prophylaxis to prevent Invasive group A streptococcus (iGAS)		
Field #	**Field Name**	**Content**
D.56.03	DIN/GP#/PIN	93899732
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	License 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)	2000 ($20.00)

CPhA Claims Standard – Fee to Prescribe antibiotic prophylaxis to prevent pertussis		
Field #	**Field Name**	**Content**
D.56.03	DIN/GP#/PIN	93899731
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	License 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)	2000 ($20.00)

CPhA Claims Standard – Fee to Prescribe antibiotic prophylaxis to prevent invasive meningococcal disease (IMD) infection		
Field #	**Field Name**	**Content**
D.56.03	DIN/GP#/PIN	93899730
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	License 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)	2000 ($20.00)

Non-Resident Claims for Assessment and Prescribing for Antibiotic Prophylaxis

If a non-resident has been referred for antibiotic prophylaxis by Public Health and the assessment and prescribing service is completed at a pharmacy, a claim for the service fee cannot be submitted electronically. Pharmacies receiving a referral for a non-resident should contact PANS or Public Health for information on the claims process.

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.
- 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 three refills for a total of 360 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**.

  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

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	93899860
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	93899859
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.

Prescription Renewals for Emergency Pharmacy Closures

For Nova Scotia residents unable to access their usual pharmacy because it is closed due to emergencies, effective June 1, 2023, until September 30, 2024, pharmacies may bill DHW for prescription renewal services when required to ensure the continuity of care for patients during an emergency pharmacy closure. Emergency pharmacy closure prescription renewal services must be performed in compliance with the Nova Scotia College of Pharmacists' *Standards of Practice: Prescribing Drugs* (April 2023 update, section 4.3 Pharmacy Closures). A special service fee of $12 is in effect for renewal of three prescriptions or less and $20 for renewals of four prescriptions or more. There is no maximum number of services for which a resident is eligible for coverage and claims will not affect the resident's annual maximum of regular prescription renewal services.

Pharmacy closure prescription renewals will be subject to audit and must comply with the requirements in Pharmacy Guide for prescription renewals except for the following:

- Pharmacists must comply with all applicable NSCP policies and standards.
- Duration of therapy prescribed must be consistent with the number of refills remaining on the patient's prescription unless a documented clinical reason is provided.
- Documentation must include the name and license number of the pharmacy that was closed and the reason why the prescription had to be refilled prior to the pharmacy reopening.

Claims must be submitted electronically using the following CPhA Claims Standard field content:

CPhA Claims Standard – Pharmacy Closure Prescription Renewal for 3 or Less Prescriptions Renewed		
Field #	**Field Name**	**Content**
D.56.03	DIN/GP#/PIN	93899831
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)

D.61.03	Prescriber ID	License 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)	1200($12.00) *

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

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

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899830
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	License 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)	2000 ($20.00) *

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

Therapeutic Substitution and Prescription Adaptation

Therapeutic substitution involves substituting one drug for another and is funded for the following situations:

- drug shortages,
- better patient outcomes,
- intolerance or allergy, or
- to reduce the financial impact on patients (e.g. formulary coverage).

Prescription adaptation involves adapting a prescription written by another provider and is funded for the following situations only when done to improve clinical effectiveness/outcomes:

- changes in dose and duration, or
- refusal to fill a drug monitored by the Prescription Monitoring Program.

All the following criteria must be met:

- Pharmacists are responsible for determining the appropriateness of the therapeutic substitution or prescription adaptation before performing the service.
- The service is conducted by a pharmacist licensed with the Nova Scotia College of Pharmacists (NSCP).
- The resident has a valid Nova Scotia health card number.

- Pharmacists must comply with all applicable NSCP policies and standards.
- A record must be available that references the original written or scanned prescription and the new or modified prescription resulting from the service. The resulting prescription may be either dispensed or logged. A service that does not result in a new or modified prescription is not eligible for the service fee.
- Verbal consent is provided to authorize the pharmacist to do the therapeutic substitution or prescription adaptation.

As with previous Pharmacare coverage, **prescription adaptation is not a funded service** in the following types of situations:

- A change in prescription quantity unrelated to a dose change or duration change, for example:
    - Replacing a 5mg tablet with one-half of a 10mg tablet, or using multiples of a lower strength (e.g., Synthroid® 0.2mg changed to 2 Synthroid® 0.1mg).
    - 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.
    - Any change in formulation (e.g., tablet to liquid).
    - Any change in regimen (e.g., changing therapy from morning to bedtime dosing).
- Verification and completion of a prescription element is not an insured prescription adaptation service.

Claim submission information is included below:

- There is no annual frequency limit for any individual with a valid Nova Scotia health card number.
- Three PINS are assigned to each service for situations when an individual requires more than one service on the same day. Only one PIN can be used per prescription.
- All PINS associated with coverage that was provided for Pharmacare beneficiaries were terminated on August 7, 2023.

Claims must be submitted electronically using the following CPhA Claims Standard field content:

CPhA Claims Standard – Therapeutic Substitutions (All NS)

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899773 93899737 93899738
D.57.03	Special Service Code	002 (pharmacist consultation)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	License Number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
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) *

CPhA Claims Standard – Refusal to Fill (Adaptation) (All NS): Refusal to Fill a Prescription for a Drug Monitored by the NSPMP

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899772 93899735 93899736
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	License Number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
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)

CPhA Claims Standard – Prescription Adaptation (All NS): 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	93899771 93899733 93899734
D.57.03	Special Service Code	002 (pharmacist intervention)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	License Number
D.64.03	Special Authorization Code	91 (In Person), 92 (Telephone) or 93 (Video)
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)

Pharmacist Assessment for COVID-19 Therapies

Through an amendment to the Pharmacy Service Agreement, effective May 9, 2022, pharmacies may bill DHW a special service fee of $20 for completing assessment and, if appropriate, prescribing services for select COVID-19 therapies. There is no maximum number of services for which a resident is eligible for coverage.

At this time, only assessment for inhaled budesonide for patients with COVID-19 symptoms is eligible for coverage, with services performed based on the Inhaled Budesonide (Pulmicort Turbuhaler®) Prescribing Protocol. The services must also be performed in compliance with the Nova Scotia College of Pharmacists' Standards of Practice: Prescribing Drugs (Appendix G – Prescribing for a Diagnosis Supported by a Protocol, SARS-CoV-2) to be eligible for coverage.

All residents with a valid Nova Scotia health card are eligible for coverage, except residents of nursing homes. DHW is the "payer of last resort" for all services under the Pharmacy Service Agreement, meaning residents must first use their available insurance coverage before any portion of the professional fee can be billed to DHW. Further, the agreement covers only the pharmacist professional fees associated with the service. Residents will continue to access their usual drug coverage or method of payment for any prescriptions they have filled.

When the service does not result in a prescription, pharmacists are expected to provide supporting documentation for why a prescription was not written by the pharmacist. All other audit requirements pertaining to existing assessment and prescribing services apply to these new services.

Claims must be submitted electronically using the following CPhA Claims Standard field content:

CPhA Claims Standard – Assessment for COVID-19 Therapies – Prescription Provided

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899825
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 for COVID-19 Therapies – Prescription Not Appropriate

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	93899824

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.

Community Pharmacy Anticoagulation Management Services (CPAMS)

Pharmacies may bill DHW a maximum of one special fee of $50 per calendar month per patient for those who are provided Community Pharmacy-led Anticoagulation Management Services (CPAMS), inclusive of all costs associated with providing the service. The monthly fee may be billed for any resident of Nova Scotia and is not limited to Pharmacare beneficiaries. Pharmacies must be approved by Pharmacy Association of Nova Scotia (PANS) to be eligible for the fee and pharmacy enrollment in providing the service will be gradual over the next couple of years. **Interested pharmacies must contact PANS at info@pans.ns.ca for additional information.**

The services must be performed in compliance with the Nova Scotia College of *Pharmacists' Standards of Practice: Prescribing Drugs* and the Nova Scotia College of Pharmacists' *Standards of Practice: Testing* to be eligible for coverage. In addition, eligible residents enrolled in the service must meet the following criteria:

- Have a valid Nova Scotia Health Card
- Must not have factors that based on the pharmacist's professional judgement would deem them inappropriate for the service

Service Overview

As part of this service, the pharmacist takes responsibility for appropriate testing, dosage adjustments, and communication with the patient's primary care provider, as per applicable Nova Scotia College of Pharmacists' (NSCP) Standards of Practice.

When a patient or healthcare provider requests that a pharmacy provide the CPAMS Service for a patient, the pharmacist will liaise as appropriate with the patient's primary prescriber and provide an initial assessment. The pharmacist will prescribe dosage adjustments and recommend the next test interval as per clinical guidelines, and using their clinical judgement based on the information collected during the assessment. Pharmacies will notify the patient's primary care provider of test results and pharmacist prescribing decisions, as per standards of practice. If the patient does not have a primary care provider, the patient is provided the record in addition to the one maintained at the pharmacy.

Pharmacies may bill a maximum of one monthly service fee per calendar month per patient regardless of the number of tests and/or clinical assessments provided in that month. Tests may be provided as part of the recommended routine monitoring for warfarin. Additional testing may be clinically appropriate when new medications are added, doses are modified, the patient has signs of bleeding, when the most recent test result suggests more frequent monitoring is warranted and/or other clinical reasons.

If the patient has a current prescription, the pharmacist will maintain or adapt the dose as appropriate and as per the NSCP's *Standards of Practice: Prescribing Drugs*. If the patient requires a renewal of their warfarin

prescription, they may obtain it from any prescriber. If a pharmacist chooses to do a renewal of a warfarin prescription, this is conducted as per standards of practice and additional requirements as identified in the Pharmacy Guide and can be billed to DHW as a separate service.

DHW is the “payer of last resort” for all services under the *Pharmacy Service Agreement*, meaning residents must first use their available insurance coverage before any portion of the professional fee can be billed to DHW. Further, the agreement covers only the pharmacist professional fees associated with the service. Residents will continue to access their usual drug coverage or method of payment for any prescriptions they have filled.

Claims must be submitted electronically using the following CPhA Claims Standard field content:

CPhA Claim Standard Field #	CPhA Claim Standard Field Name	Content
D.56.03	DIN/GP#/PIN	93899872 INR Management Fee
D.57.03	Special Service Code	003 (Pharmacist consultation)
D.58.03	Quantity	000001 (one)
D.61.03	Prescriber ID	Pharmacists Prescriber ID
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 Service Fee	5000 ($50.00)

Take Home Naloxone Kits

To support improved monitoring of naloxone kit usage, effective April 1, 2022, two PINs will be in effect for billing of naloxone kits:

- Naloxone Kit – Initial or Regular Replacement: 96599960
- Naloxone Kit – Replacement when kit used: 96599961

The PIN 96599961 for “replacement when kit used” can be submitted by pharmacies when the customer voluntarily discloses that their previous kit was used. This PIN will replace the kit usage reporting form. All PINs have the same eligible fee of $25 and all other claims submission requirements remain the same.

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

CPhA Claims Standard – Naloxone Kit – Initial or Regular Replacement

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	96599960
D.57.03	Special Service Code	003 (pharmacist consultation)
D.58.03	Quantity	# of kit(s) dispensed
D.61.03	Prescriber ID	License 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)	2500 ($25.00)

CPhA Claims Standard – Naloxone Kit – Replacement when Kit Used

Field #	Field Name	Content
D.56.03	DIN/GP#/PIN	96599961
D.57.03	Special Service Code	003 (pharmacist consultation)
D.58.03	Quantity	# of kit(s) dispensed
D.61.03	Prescriber ID	License 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)	2500 ($25.00)

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.

Special Access Program Drugs

Effective starting in 2020, Health Canada authorized community pharmacies to receive and distribute or dispense drugs approved under the *Special Access Program*. Claims for drugs approved for special access are not covered under the Pharmacare Tariff Agreement and do not follow the standard electronic claim submission process**. If a pharmacy is asked to order or dispense a Special Access Program drug to a Pharmacare client, please contact Pharmacare for further direction on eligibility and the claims process including level of reimbursement that will be provided.**

Pharmacare Reimbursement

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

- Manufacturer's List Price (MLP)
- Maximum Reimbursement 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 Reimbursement Price (MRP)

MRP is the maximum reimbursement 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% to a maximum mark-up of $325. 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.

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 Gastro-esophageal Reflex Disease (GORD)	**M05**	Drugs for Treatment of Bone Diseases
A06	Drugs for Constipation	**N02BA01**	Acetylsalicylic Acid
A07E	Intestinal Anti-inflammatory Agents	**N03AD**	Succinimide Derivatives
A09	Digestives, Including Enzymes	**N03AF**	Carboxamide Derivatives
A10	Drugs Used for Diabetes	**N03AG**	Fatty Acid Derivatives
A11	Vitamins	**N03AX09**	Lamotrigine
B01AC	Platelet Aggregation Inhibitors Excl. Heparin	**N03AX11**	Topiramate
B03	Antianemia Preparations	**N03AX14**	Levetiracetam
C01	Cardiac Therapy	**N03AX18**	Lacosamide
C02	Antihypertensives	**N04**	Anti-Parkinson Drugs
C03	Diuretics	**N06D**	Anti-Dementia Drugs
C04	Peripheral Vasodilators	**N07C**	Antivertigo Preparations
C07	Beta Blocking Agents	**S01X**	Other Ophthalmologicals
C08	Calcium Channel Blockers	**V07AY04**	Insulin Syringes
C09	Agents Acting on the Renin-Angiotensin System	**V07AY05**	Insulin Pen Needles
C10	Lipid Modifying Agents	**V07AY06**	Diabetic Lancets
G04BD	Drugs for Urinary Frequency and Incontinence		
G04CA	Alpha-Adrenoreceptor Antagonists		

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
Abbott FreeStyle Libre 2	7	Sensors	Within a 3-month period
Adempas	28	day supply	Every 28 days (with 7-day grace)
AeroChamber	1	device	Fixed 12-month period (Apr 1–Mar 31)
Baqsimi	2	Device	Fixed 12-month period (Apr 1–Mar 31)
Biphentin	7200	mg	Every 90 days (with 7-day grace)
Dexcom G6	9 1	sensors transmitter	Within a 3-month period Every 3 months
Dexcom G7	9 1	sensors receiver	Within a 3-month period Per lifetime
Epclusa	84	tablets	Fixed 12-week period
EpiPen /Allerject/Emerade	2	injections	Fixed 12-month period (Apr 1–Mar 31)
Foquest	9000	Mg	Rolling 90-day period from first date of claim (with 7-day grace)
Pirfenidone	270	capsules	Every 28 days (with 7-day grace)
Harvoni	▶ 56 ▶ 84 ▶ 168	tablets tablets tablets	▶ Fixed 8-week period ▶ Fixed 12-week period ▶ Fixed 24-week period
Lansoprazole-Amoxicillin-Clarithromycin Kit	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)
Kynmobi	90	mg	Fixed quarterly period (Jan-Mar, Apr-Jun, etc.)
Lenvima	90	tablets	Every 28 days (with 7-day grace)
Maviret	▶ 168 ▶ 252 ▶ 336	tablets tablets tablets	▶ Fixed 8-week period ▶ Fixed 12-week period ▶ Fixed 16-week period
Medication Review Service ▶ Basic ▶ Advanced ▶ Follow-up	▶ 1 ▶ 1 ▶ 2	service service services	▶ Fixed 12-month period (Apr 1–Mar 31) ▶ Fixed 12-month period (Apr 1–Mar 31) ▶ Within 12 months of Basic/Advanced
Medtronic Guardian 3 and 4	15	sensors	Within a 3-month period

Benefit	Quantity Limit		Time Frame
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)
Ozempic	3	pens	Every 84 days (with7-day grace)
Pomalidomide	28	day supply	Every 28 days (with 7-day grace)
Radicava (30mg/100ml)	2800	ml	Every 28 days
Rinvoq	365	tablets	Fixed 12-month period (Apr-Mar 31)
Rybelsus	90	tablets	Every 90 days (with 7-day grace)
Sovaldi	▶ 84 ▶ 168	tablets tablets	Fixed 12-week period Fixed 24-week period
Tagrisso	30	tablets	Every 28 days (with 7-day grace)
Ticagrelor	60	tablets	Rolling 12-month period (from first date of claim)
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	tablets	Fixed 12-month period (Apr 1-Mar 31)
Xeljanz XR	365	tablets	Fixed 12-month period (Apr 1-Mar 31)
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
Aerosols	Per dose
Capsules	Per capsule
Creams*	Per gram
Enemas	Per ml
Foam***	Per gram
Gels	Per gram
Inhalers	Per actuation
Insulins (vials, pen fills, cartridges)	Per ml
Kits	Per kit
Lancets	Per lancet
Liquids Injectables ****	Per ml
Liquids (except methadone)	Per ml

Form	Quantity
Methadone oral compound solution**	Per mg
Nasal sprays	Per dose
Nebules	Per ml
Ointments	Per gram
Oral contraceptives	As 21 or 28
Ostomy supplies	Per item (e.g., 20 pouches)
Patches	Per patch
Powders	Per gram
Powder Injectables	Per vial
Suppositories	Per suppository
Tablets	Per tablet
Testing strips	Per testing strip

Other:

Form	Quantity
Package/Kits of more than one drug	Per package (e.g., Invega Sustenna®, lansoprazole 30mg, amoxicillin 500mg & clarithromycin 500mg kit, Monistat 3 Dual-Pack®)
Packages of blood glucose testing strips with built-in meter	Per test strip
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
****	adalimumab biosimilars should be billed per pen/syringe/autoinjector; 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
Lidocaine Viscous 2%
Magnesium/Aluminum Conc. Suspension

Diphenhydramine Syrup
Hydrocortisone Tablet
Nystatin Suspension
Distilled Water

Diphenhydramine Syrup
Magnesium/Aluminum Suspension

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/

Billing for Pharmacy Services

All pharmacy services completed must be billed on the same day as the service was provided. This will protect the integrity of the patient's medical record. Services must not be billed in advance of the service date.

Claim Information for Online Adjudication of Pharmacare Claims

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

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

Billing of Claims with Cost Exceeding $9,999.99

Currently pharmacy software systems do not allow for the online transmission of claims over $9,999.99. With the addition of newer high cost drugs, routine claims will likely exceed this amount. 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

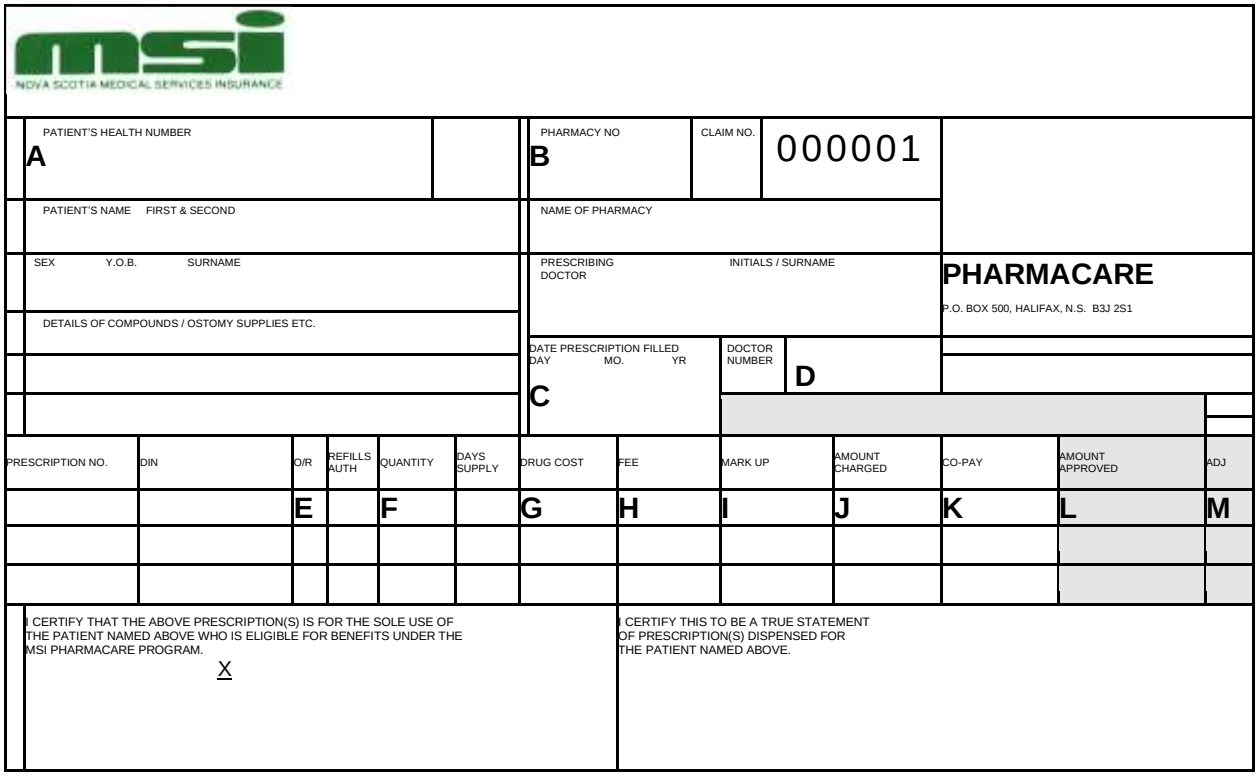
In very exceptional circumstances, or for providers who are not online, it may be necessary to bill the Pharmacare Programs utilizing a manual claim. Claims must be submitted within three months of the date of service.

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 – Nova Scotia Health Card Number entered as follows 5555-555-555

B – Pharmacy Number as assigned by Pharmacare Program

C – Date entered numerically, e.g., 15.05.00 (= 15th of MAY 2000)

D – Prescriber number, e.g., 9999 for a medical resident, 8888 for a dentist

E – "O" for original or new prescription, "R" for refill

F – Refer to "Standardization of Package Sizes" in the guide

G – Drug cost (AAC, MRP or PRP)

H – Professional fee. Do not put any mark-up in this field

I – Mark up (as per the Nova Scotia Pharmacare Tariff Agreement)

J – Total cost of prescription

K – Amount of copayment charged to beneficiary, if applicable

LM – For Pharmacare use only

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: ____________

	REASON FOR ADJUSTMENT	PHARMACARE REPLY
CLAIM DATE ______	______	______
PRESCRIBER # ______	______	______
HEALTH CARD # ______	______	______
TRACE # ______	______	______
RX # ______	______	______
DIN ______	______	______
QTY ______	______	______
TOTAL BILLED ______	______	______
MARK UP ______	______	______
FEE ______	______	______

	REASON FOR ADJUSTMENT	PHARMACARE REPLY
CLAIM DATE ______	______	______
PRESCRIBER # ______	______	______
HEALTH CARD # ______	______	______
TRACE # ______	______	______
RX # ______	______	______
DIN ______	______	______
QTY ______	______	______
TOTAL BILLED ______	______	______
MARK UP ______	______	______
FEE ______	______	______

	REASON FOR ADJUSTMENT	PHARMACARE REPLY
CLAIM DATE ______	______	______
PRESCRIBER # ______	______	______
HEALTH CARD # ______	______	______
TRACE # ______	______	______
RX # ______	______	______
DIN ______	______	______
QTY ______	______	______
TOTAL BILLED ______	______	______
MARK UP ______	______	______
FEE ______	______	______

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Medications Returned to Stock

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

2) Medication that has been previously billed to the Pharmacare Programs and is being returned to stock following the conditions of the Nova Scotia College of Pharmacists' Return of Medication policy at http://www.nspharmacists.ca/wp-content/uploads/2018/10/Policy_ReturnOfMedication.pdf (see form below) **must** be credited back to the Pharmacare Programs.

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

NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS
Statement of Returned Benefits

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

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

CLAIM INFORMATION

PHARMACY NAME		FACILITY / FACILITIES
PROVIDER NUMBER	DATE	
ADDRESS		

BENEFIT NAME	DIN/PIN/NPN	QUANTITY	UNIT COST	(QUANTITY x UNIT COST) + MARK-UP
		TOTAL		
		LESS RESTOCKING FEE		
		NET AMOUNT DEDUCTED FROM PAYMENT STATEMENT		

DECLARATION

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

X _____

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026.
Please return form to: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1
Fax: (902) 468-9402

07/2015

NOVA SCOTIA

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

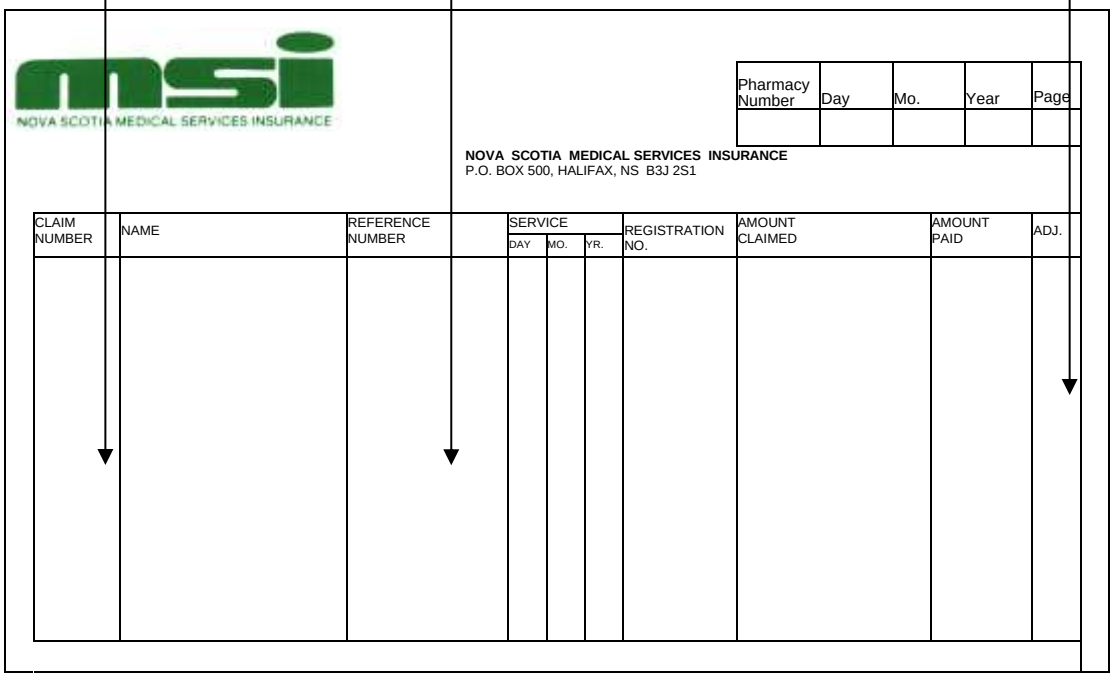
Pharmacy Association of Nova Scotia and may also include any charges recovered due to an audit, medications returned to stock, and deductions of $0.25 for each manual claim submitted.

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.



Adjustment Codes

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

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
- compounds
- ostomy supplies

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.

All prescriptions must include clear directions from the prescriber in terms of the total quantity and/or days supply that should be dispensed each time by the pharmacy. It is not acceptable for the directions to refer to another prescription (e.g. "Dispense with Methadone or Suboxone"). In this situation, dispensing requirements must be clarified with the prescriber and clearly documented for that prescription to avoid audit recovery.

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.

Prescriptions by pharmacists for Pharmacare benefits must include the following in addition to the above requirements:

- Prescribing pharmacist's license number
- Prescriber Notification Form (if applicable)

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, unless the change meets the criteria for an exception as noted below. 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.

Exceptions

Effective February 1, 2024, pharmacists may make changes to a prescription without authorization from the prescriber under the following conditions:

1. Pharmacists may change the quantity on a prescription for **creams, lotions and eye drops** if in their clinical judgement there is insufficient quantity noted to meet dosing directions. The reason for the change must be documented on the original prescription with a signature and license number for the pharmacist who made the change.

   If no quantity is available on a prescription, it is an incomplete prescription and may not be adjusted by a pharmacist. In these instances, the pharmacist may write a prescription or seek a verbal order from the prescriber.

2. Pharmacists may use their clinical judgement to change the quantity on a drug prescription for a product **sold by the manufacturer** in a blister pack, bottle, tube, or device to align with the pack size if the new quantity remains appropriate for patient care. For example, adjusting a quantity of 30 to 28, 60 to 56 and 90 to 84 (e.g. Ondansetron or Alendronate). ***NOTE:*** *this does not apply to internal blister/compliance packaging for safety or cost reasons.*

These changes will not be subject to the documentation requirements for changes made to an existing prescription.

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	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. If **no dosage directions** indicated, recover professional fee(s) for original and any refills. If **no quantity and no dosage directions** indicated, recover total amount paid for original and any refills.
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 * As defined by the Pharmacy Practice Regulations of Nova Scotia	General Documentation Requirements	Recover professional fee(s) for original and any refills.

Audit Findings	Section	Action
8. VERBAL ORDERS (INCLUDING NEW AND/OR CHANGES TO AN ORIGINAL PRESCRIPTION) REQUIRE ALL OF THE FOLLOWING: • Signature and license number of authorized registrant recording the change • Date received • Name of prescriber providing the order (see Section 4)	Documentation for verbal prescriptions AND Documentation for changes made to an existing prescription	Recover professional fee(s) for original and any refills.
9. REFILLS FOR DRUG PRESCRIBED (i) More refills claimed than authorized by prescriber (ii) Non-specific refill directions, e.g. "PRN", "Unlimited" and "1 Year"	Documentation for changes made to an existing prescription	(i) Recover total amount paid for excess refills. (ii) Recover total amount paid for any refills.
10. MISSING PRESCRIPTION(S) (i)One or two prescriptions (ii) Three or more prescriptions		(i) Recover the professional fee for original(s) and any refills, if the prescriptions cannot be located during the on-site audit. (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.
11. DIFFERENT DRUG CLAIMED THAN PRESCRIBED		Recover total amount paid for original and any refills. Only products indicated as interchangeable in the Nova Scotia Formulary may be selected for interchangeability.
12. UNINSURED PRODUCT CLAIMED UNDER AN INSURED DIN/PIN		Recover total amount paid for original and any refills.
13. CRITERIA CODE OR DIAGNOSIS SUPPORTING PAYMENT NOT INDICATED ON PLAN EXCEPTION PRESCRIPTION CLAIMED WITH CRITERIA CODE	Documentation for changes made to an existing prescription	Recover total amount paid for original and any refills.

Audit Findings	Section	Action
14. 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 (iii) For service delivered by telephone, missing documentation of reason the review was not completed in-person or by video.		Recover total amount paid for service.
15. 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 (iii) For service delivered by telephone, missing documentation of reason the review was not completed in-person or by video.		Recover total amount paid for service.
16. 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 (iii) For service delivered by telephone, missing documentation of reason the review was not completed in-person or by video.		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. At the discretion of the Administrator, pharmacies may be offered the option of accepting an automatic recovery payment in lieu of an extended on-site audit. Automatic recovery is only considered for audits with an error rate of less than 20% and is not available in concurrent years. The amount of payment offered is calculated based on error rate and claims volume.

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. 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. When electronic documentation is stored within a pharmacy's software, the auditor may request paper copies or PDF versions of the documentation for audit purposes (e.g. screen shots). If the documentation provided is not clearly demarcated (e.g. patient's name/service/date of claim/scan date) or the connection to the associated service is unclear, the auditors may request further information or deem the documentation to be unsupportive of the original service.

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

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 or documentation as to why a referral was not required.
    - 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.
- **For assessment and prescribing for antibiotic chemoprophylaxis in response to a Public Health request:**
    - Documentation of the request from Public Health for chemoprophylaxis for the specific disease

(e.g. copy of letter).

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.
- For prescriptions with a shorter overall duration (including refills) than the patient's usual duration of therapy, documentation of a clinical reason for the shorter duration being prescribed. The exception to this requirement is if the overall duration was prescribed to ensure compliance with requirements defined in the NSCP's *Standards of Practice: Prescribing Drugs*. Usual duration of therapy will be determined based on the patient's prior prescription history. 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 three refills for a total of 360 days.

Documentation for therapeutic substitution and prescription adaptation services:

- New or modified prescription by the pharmacist that was either dispensed or logged.

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. CLAIM SUBMITTED FOR AN INELIGIBLE RESIDENT (e.g. patient residing in a nursing home)	General Documentation Requirements	Recover total amount paid for service
6. CLAIM SUBMITTED FOR AN INELIGIBLE SERVICE (e.g. not pursuant to the *Standards of Practice: Prescribing Drugs* or the *Nova Scotia Department of Health and Wellness Pharmacy Guide*).	General Documentation Requirements	Recover total amount paid for service

Audit Findings	Section	Action
For all assessment and prescribing services:		
For services that result in a prescription: 7. MISSING PRESCRIPTION(S)	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.
For services that result in a prescription: 8. 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: 9. 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: 10. 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 select assessment and prescribing services:		
For contraception management billed as initial assessment or subsequent assessment resulting in change in therapy: 11. PRESCRIPTION WRITTEN FOR CONTINUATION OF EXISTING THERAPY	Assessment and Prescribing Documentation Requirements	Recover difference between higher fee PIN and lower fee PIN.
For assessment and prescribing for antibiotic chemoprophylaxis in response to a Public Health request: **12.** DOCUMENTATION OF THE REQUEST FROM PUBLIC HEALTH FOR CHEMOPROPHYLAXIS FOR THE SPECIFIC DISEASE.	Assessment and Prescribing Documentation Requirements	Recover total amount paid for service
For prescription renewals:		
13. MISSING PRESCRIPTION(S)	Prescription Renewal Documentation Requirements	Recover total amount paid for service

[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).

Audit Findings	Section	Action
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.
17. PRESCRIPTION FOR DURATION LESS THAN USUAL DURATION OF THERAPY AND MISSING DOCUMENTATION OF REASON(S)	Prescription Renewal Documentation Requirements	Recover total amount paid for service
For therapeutic substitution and prescription adaptation services		
18. MISSING RECORD OF NEW OR MODIFIED PRESCRIPTION RESULTING FROM THE SERVICE.	Therapeutic Substitution and Prescription Adaptation Documentation Requirements	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.

Pharmacy Close-out Audit

Pharmacy providers must notify Pharmacare at least 30 days in advance of a pharmacy transfer of ownership or closure to schedule a pharmacy close-out audit. Information about business transactions will be retained in confidence. You may contact Pharmacare at MSIProvidercoordinators@medavie.bluecross.ca or 1-866-553-0585.

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
July 9, 2024	• Under **Exception Status Drugs,** modified reference to Arazlo 0.045% lotion not requiring prior approval for beneficiaries to indicate only for those under the age of 30.

June 26, 2024	• From title page and subsequent sections of Guide, removed notice about virtual care eligibility.
	• In the **Administration** section:
	  ○ Provided updated information on updating your pharmacy's license number with CANImmunize.
	  ○ Removed reference to the Drugs and Therapeutics Committee.
	  ○ Clarified a new Provider Confirmation of Agreement form is not required due **to** usual and customary dispensing fee increases in line with the tariff agreement.
	• In the **Pharmacare Programs and Benefits** section:
	  ○ Added information on new programs offering a wig rebate for cancer patients and coverage for sensor-based glucose monitors.
	  ○ Clarified coverage and claims submission process for ostomy supplies under the Boarding, Transportation and Ostomy program.
	  ○ Added COPD and asthma inhalers to the list of exception status products that can be adjudicated online based on the beneficiary's history.
	  ○ Moved therapeutic substitution and prescription adaptation to the Benefits for All Residents section of the Guide.
	  ○ Under **Exception Status Drugs,** added reference to Arazlo 0.045% lotion not requiring prior approval for beneficiaries.
	• In the **Benefits for All Residents** section:
	  ○ In the **Administration of Publicly Funded Influenza Vaccinations Provided by a Pharmacy** section, updated the URL for the COVID chapter of the Canadian Immunization Guide. Updated the information on updating your pharmacy's license number with CANImmunize.
	  ○ In the **Assessment and Prescribing Services** section, noted exception that allows non-residents to receive assessing and prescribing services for antibiotics (chemoprophylaxis) for select infectious diseases. Moved content for assessment and prescribing for antibiotics (chemoprophylaxis) into this section of the Guide.
	  ○ In the **Prescription Renewals** section, removed the frequency limit and updated the service PINs.
	  ○ Added content on therapeutic substitution and prescription adaptation that was previously in the Pharmacare Programs and Benefits section, and clarified requirement that services must result in a modified or new prescription.
	  ○ Removed dispensing of oral anti-viral medications for COVID-19.
	• In the **Pharmacare Pricing Procedures** section:
	  ○ Added reference to vacation supply allowable under the Sensor-based Glucose Monitor Program.
	  ○ Under **Quantitative Limits**, added the frequency limits for sensor-based glucose monitoring products, Foquest, Ozempic, Radicava, and Rybelsus, and removed the limit for Lynparza.
	  ○ Under Compounded Products, updated information for Magic Mouthwash formulations.

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	• In the **Billing DHW and Nova Scotia Pharmacare** section, added the requirement that pharmacy services must be billed the same day service was provided.
	• In the **Audit** section:
	  ○ Added exceptions to documentation requirements for changes made to existing prescriptions.
	  ○ In the **Pharmacare Prescription Audit Recovery Procedures** section, added reference to pharmacies being offered the option of an automatic recovery payment.
	  ○ Under **Pharmacy Service Audits**, added the requirement that documentation of Public Health's request is required for assessment and prescribing for antibiotic chemoprophylaxis, and the requirement for a record of a new or modified prescription resulting from therapeutic substitution or prescription adaptation.

November 30, 2023	• Removed all references to an end date for virtual care on the cover page and throughout the Guide. • In the **Administration of Publicly Funded Influenza Vaccinations Provided by a Pharmacy** section replaced entire content with new information; pages 39-40. • Added a new section **Expansion of Chemoprophylaxis Coverage through Pharmacies for Close Contacts of Invasive Group A Streptococcus (iGAS), Pertussis or Invasive Meningococcal Disease (IMD) Infections;** pages 59-60
September 29, 2023	• In the **Online Adjudication of Exception Status Drugs** section, remove Cabergoline. • Remove Therapeutic Substitution Service for Biosimilar Insulins as it ended July 9, 2023. • In the **Quantity Limits Section**, changed Pomalyst to Pomalidomide. • In the **Therapeutic Substitution and Prescription Adaptation** section, replace entire content with new information; pages 36-42. • In the **Product Shortages** section, under **the Interchangeable Products (non-PRP)** header, removed references to the reimbursement structure pre-2020 (old tariff); page 71. • In the **Standardization of Package Sizes** section, added to the footnote: • **** adalimumab biosimilars should be billed per pen/syringe/autoinjector
June 30, 2023	• In the **Pharmacare Programs and Benefits** section, addition of Provincial Clozapine Program: Adjudication of Claims. • Under the **Prescription Renewals** section, inclusion of criteria that permits prescription renewals due to emergency pharmacy closures.
April 25, 2023	• Updated eligible date for virtual care services to September 30, 2023. • Addition of Rinvoq, Xeljanz and Xeljanz XR in the quantity limits table. • Amended mileage rate reimbursement for BTO Program and fixed a broken link.
March 17, 2023	• In the **Basic Medication Review Service** section, criteria that excludes patients in a nursing home, home for special care, or patients in the Under 65 – LTC Program has been removed. These patients may be eligible for the service based on new eligibility criteria. • In the **Advanced Medication Review Service** section, criteria that excludes patients in a nursing home, home for special care, or patients in the Under 65 – LTC Program have been removed. These patients may be eligible for the service based on new eligibility criteria.

Publication Date	Updates
	• In the **Medication Review Service Follow-Up** section, a sentence has been added to clarify that this service will not be funded for patients in a nursing home, a home for special needs, or for patients insured through the Under 65 – LTC Program. • In the **Assessment and Prescribing Services** section, patients who reside in a nursing home are eligible for coverage of assessment and prescribing for herpes zoster. • In the **Prescription Renewals** section, criteria that excludes patients in a nursing home has been removed. These patients are now eligible for the service. • In the **Community Pharmacy Anticoagulation Management Services (CPAMS)** section, criteria that excludes patients who reside in a nursing home or a home for special care has been removed. These patients may be eligible for the service. Additionally, criteria that stated eligible patients must be 18 years of age or older has been removed. • In the **Requests for Coverage** section, criteria updated to allow pharmacists to submit Exception Status Drug (ESD) request forms, without requiring signature from the prescriber, provided they have the information that is required to determine whether the patient meets the established criteria. • Under the **Compounded Products** list, volumes were removed from the Magic Mouthwash formulations. • In the section on **Quantity Limits,** Proton Pump Inhibitors (PPIs), duloxetine, influenza vaccines, Kalydeco and Zepatier were removed from the list; Baqsimi and Kynmobi were added to the list and Brilinta was changed to Ticagrelor to account for the generic formulations. • In the **Online Adjudication of Exception Status Drugs** section, Nasonex was removed from the list as it is a full benefit. • Under the section on **Dispensing of oral anti-viral medications for COVID-19**, the professional fee was updated to $12.69. • In the **Prescription Adaptation** and **Therapeutic Substitution** sections, the requirement to document the original prescription number was removed. • In the **Therapeutic Substitutions** section, pediatric antibiotics and biosimilar insulins were added as temporary services.
November 17, 2022	• In the section on **Administration of Publicly Funded Influenza Vaccinations Provided by a Pharmacy**, updated eligibility criteria and billing and payment process to reflect implementation of CANImmunize Clinic Flow. Reference to the Publicly Funded Seasonal Inactivated Influenza Vaccine Information for Health Care Providers 2022-23 document added for eligibility criteria and addition of reference to delegation of the technical aspect of administration as had appeared in prior versions of the Guide. • In the **Dispensing of oral anti-viral medications for COVID-19** section, a new DIN was added. • In the section on **Prescription Adaptations**, what is not insured was made more concise.
October 27, 2022	• Under **Administration of Publicly Funded Influenza Vaccinations Provided by a Pharmacy**, updated eligibility criteria and billing and payment process to reflect implementation of CANImmunize Clinic Flow. • Additional eligible DIN added under **Dispensing of oral anti-viral medications for COVID-19.**
June 8, 2022	• Updated eligible date for virtual care services to March 31, 2023.

Publication Date	Updates
	• In the **Administration** section, further emphasis that license numbers must be accurate in CANImmunize for COVID-19 vaccination payments to be processed. • In the **Pharmacare Programs and Benefits** section, addition of information about the Boarding, Transportation and Ostomy Program. • In the **Exception Status Drugs** section, under Online Adjudication of Exception Status Drugs, removal of reference to Humalog, which has been de-listed. • In the **Administration of Publicly Funded Influenza Vaccinations Provided by a Pharmacy** section, change to eligible age to six months. • In the **Administration of Publicly Funded COVID-19 Vaccinations Provided by a Pharmacy** section, update in fee, removal of reference to standalone Provider Confirmation of Agreement, update to labelling of bottom-line adjustment on the pharmacy pay statement, and further emphasis on license numbers being correct in CANImmunize. • In the **Prescription Renewals** section, update to reflect removal of 180-day prescribing limit. • In the **Benefits for All Residents** section, addition of new services: dispensing of oral anti-viral medications for COVID-19, pharmacist assessment for COVID-19 therapies, and Community Pharmacy Anticoagulation Management Services (CPAMS). • Under **Benefits for All Residents**, addition of new PINs for Take Home Naloxone Kits. • In the **Minimum Days' Supply** section, removal of de-listed ATC codes. • Under **Quantity Limits**, adjustment to timeframe for Biphentin. • In the **Standardization of Package Sizes** section, adjustments to product references for package kits of more than one drug. • In the **Adjustments** section, update to the Request for Adjustments Form. • In the **Pharmacare Prescription Audit Recovery Procedures**, removal of requirement to document patient consent for services; for medication reviews delivered by telephone, addition of requirement to document reason the review was not completed in-person or by video; update to types of desk audits. • Under **Pharmacy Service Audits**, removal of requirement to document patient consent.
November 29, 2021	• In the **Provider Registration** section, clarification that at least 30 days notice is required in advance of pharmacy closure or transfer of ownership and reminder to update pharmacy license number in CANImmunize Clinic Flow after any change to ensure payment for COVID-19 vaccinations can be processed. • In the **Drug Assistance for Cancer Patients** section under Pharmacare Programs and Benefits, updated the income limit from $25,500 to $35,000 and added hat residents can enrol in the Boarding, Transportation and Ostomy Program at the same time. • In the section **Coverage of Pharmacist-Prescribed Claims**, added reference to the prescription documentation requirements for pharmacist prescriptions. • In the section **Additional Funded Clinical Services for Pharmacare Beneficiaries**, new requirement for basic and advanced medication reviews that patients must bring their medications for review by the pharmacist for discussion and visual verification. If completed as a virtual service, the review must be completed in a manner that allows viewing by the pharmacist (e.g. by video conference). New requirement that no combination of a basic, advanced or follow-up medication review service can be completed on the same day for the same patient.

Publication Date	Updates
	• In the section **Administration of Publicly Funded Influenza Vaccinations Provided by a Pharmacy**, updates to ordering process, reference to vaccine administration by any self-regulated health professional, updates to PINs, and removal of content not related to the billing process. • In the section **Administration of Publicly Funded COVID-19 Vaccinations Provided by a Pharmacy**, reference to the requirement for pharmacy license number to be accurate in Clinic Flow. • In the section **Assessment and Prescribing Services**, addition of information on the Lyme disease chemoprophylaxis service. New requirement that contraception management services cannot be claimed for patients 65 years of age or older. • In the **Quantity Limits** section, limit added for Biphentin and limits for Xeljanz and Zeljanz XR removed. • In the **Compounded Products** section, removed reference to pediatric for Magic Mouthwash formulations. • In the section **Pharmacare Prescription Audits**, under **Required Documentation**, removal of sub-section on pharmacist-initiated prescriptions and incorporation of pharmacist prescription requirements in the same section as all other prescriptions. • In the section **Pharmacy Service Audits**, under **Required Documentation**, for documentation for prescription renewals, new requirement to document clinical reason when prescribing for an overall duration shorter than the patient's usual duration of therapy. New audit recovery specified for prescription renewals when the prescription was for a duration less than usual duration of therapy. • Under **Audit,** new section on Pharmacy Close-out Audit.
June 10, 2021	• All provisions related to virtual delivery of pharmacy services have been extended to March 31, 2022 and a link to the *Provision of Publicly Funded Virtual Health Services* policy has been added to the **Reference Documents** appendix. • In the **Provider Registration** section, removed reference to not considering new non-pharmacy provider requests. • In the **Pharmacare Benefits and Exclusions** section, new direction has been added on claims for Special Access Program drugs dispensed through community pharmacies. • In various places where the Pharmacare Tariff Agreement and Pharmacy Service Agreement are referenced, added reference to any amending agreements. • Updates to online adjudication of Exception Status Drugs, Quantity Limits, and Standardization of Package Sizes. • Clarification that Mifegymiso coverage is available to all persons. • New section on **Administration of Publicly Funded COVID-19 Vaccinations Provided by a Pharmacy**. • In the **Pharmacare Prescription Audits** section, under **Required Documentation**, clarification as per the January 2021 Pharmacare New Bulletin that all prescriptions must include clear directions from the prescriber in terms of the total quantity and days supply. • In the **Pharmacy Services Audits** section, under **Required Documentation**, clarification of expectations for electronic documentation.

Publication Date	Updates
	• In the **Pharmacy Services Audits** section, under **Required Documentation**, correction to the documentation requirement for consent that references a check box.
December 11, 2020	• 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 **Pharmacare Prescription Audits**: o 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. o Verbal order documentation requirements for computer-generated prescriptions have been clarified. o 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**: o 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**: o 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**: o Related to the clarification on documenting consent, audit recovery procedure 5 has been updated.

Publication Date	Updates
	○ 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.
October 6, 2020	• In the **Administration of Publicly Funded Influenza Vaccinations by Pharmacists** section, DINs and PINs updated for 2020-21 season.
July 31, 2020	• 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, new requirements for using criteria codes, and update to the processing time for exception status requests from 7 days to 6 business days. • 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 and Amendments	https://novascotia.ca/dhw/pharmacare/pharmacy-guide.asp
Pharmacy Provider Confirmation of Agreement	https://novascotia.ca/dhw/pharmacare/documents/Provider-Agreement.pdf
Pharmacy Provider Confirmation of Agreement for COVID-19 Immunizations	https://novascotia.ca/dhw/pharmacare/documents/Pharmacy-Provider-Confirmation-of%20Agreement-for-COVID-19%20Immunizations.pdf
Provision of Publicly Funded Virtual Health Services (Policy)	https://novascotia.ca/dhw/publications/Provision-of-Publicly-Funded-Virtual-Health-Services.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