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PHARMACISTS' EDITION

NOVA SCOTIA

PharmacareNEWS

inside

Nova Scotia Formulary Updates

New Exception Status Benefits

The following product has been reviewed by the pCODR Expert Review Committee (pERC) and will be listed with the following criteria, effective **December 1, 2016.**

Product	Strength	DIN	Prescriber	Benefit Status	MFR
Iclusig (ponatinib)	15mg Tab	02437333	DNP	E (SFC)	PAL
	45mg Tab	02437341	DNP	E (SFC)	PAL
Criteria	• For the treatment of patients with chronic phase, accelerated phase or blast phase chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) for whom other tyrosine kinase inhibitor (TKI) therapy is not appropriate, including CML or Ph+ ALL that is T315i mutation positive or where there is resistance or intolerance to prior TKI therapy. Funding should be for ECOG performance status 0-2. Treatment should continue until unacceptable toxicity or disease progression.				

The following product has been reviewed by the Atlantic Common Drug Review (ACDR) and will be listed with the following criteria, effective **December 1, 2016.**

Product	Strength	DIN	Prescriber	Benefit Status	MFR
Sodium Bicarbonate	500mg Tab	80030520	DNP	E (SF)	JPC
	500mg Tab	80022194	DNP	E (SF)	SDZ
Criteria	• For patients with chronic kidney disease with a serum bicarbonate (CO2) <22 mmol/L.				

New Exception Status Benefits Continued…

The following products have been reviewed by the Common Drug Review (CDR) and will be listed with the following criteria, effective **December 1, 2016.**

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Ferriprox	100mg/mL Sol	02436523	DNP	E (SF)	APO
(deferiprone)	1000mg Tab	02436558	DNP	E (SF)	APO
Criteria	• For the treatment of patients with transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate.				

In order to allow for online adjudication the claim must be divided and processed as separate transactions. The following PINs are to be used to bill drug cost in excess of $9,999.99:

100mg/mL Sol

- 00904194 and 00904195

1000mg Tab

- 00904192 and 00904193

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Xolair	150mg sterile powder for reconstitution vials	02260565	DNP	E (SF)	NVR
(omalizumab)					

Criteria	For the treatment of adults and adolescents (12 years of age or older) with moderate to severe chronic idiopathic urticaria (CIU) who remain symptomatic (presence of hives and/or associated itching) despite optimum management with available oral therapies.
	
	Criteria Notes:
	• Prescribed by a specialist (allergist, immunologist, dermatologist, etc.) or other authorized prescriber with knowledge of CIU treatment.
	• Initial approval period of 24 weeks at a maximum dose of 300mg every 4 weeks.
	• Treatment cessation could be considered for patients who experience complete symptom control for at least 12 consecutive weeks at the end of a 24 week treatment period.
	• Continued coverage will be authorized if the patient has achieved:
	  ○ complete symptom control for less than 12 consecutive weeks; or
	  ○ partial response to treatment, defined as at least a ≥ 9.5 point reduction in baseline urticaria activity score over 7 days (UAS7)				

New Exception Status Benefits Continued…

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Cosentyx (secukinumab)	300mg dose kits (two subcutaneous injections of 150mg/1mL)	02438070	DNP	E (SF)	NVR
Criteria	For patients with severe, debilitating chronic plaque psoriasis who meet all of the following: • Body surface area (BSA) involvement of >10% and/or significant involvement of the face, hands, feet or genitals; • Failure to, contraindication to or intolerant of methotrexate and cyclosporine; • Failure to, intolerant of or unable to access phototherapy; • Written request of a dermatologist or prescriber with a specialty in dermatology. Continued coverage is dependent on evidence of improvement, specifically: • A >75% reduction in the Psoriasis Area and Severity Index (PASI) score; or • A >50% reduction in PASI with a > 5 point improvement in DLQI (Dermatology Life Quality Index); or • Significant reduction in BSA involved, with consideration of important regions such as the face, hands, feet or genitals. Concurrent use of biologics not approved. Initial approval for a maximum of 12 weeks. Coverage may be approved as follows: initial dosing of 300 mg doses at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing of 300 mg doses starting at Week 4.				

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Ofev (nintedanib)	100mg Cap 150mg Cap	02443066 02443074	DNP DNP	E (SF) E (SF)	BOE BOE
Criteria	**Initial approval criteria:** Adult patients who have a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF)* confirmed by a respirologist and a high-resolution CT scan within the previous 24 months. • All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded. • Patient is under the care of a physician with experience in IPF				

New Exception Status Benefits Continued…

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Ofev	100mg Cap	02443066	DNP	E (SF)	BOE
(nintedanib)	150mg Cap	02443074	DNP	E (SF)	BOE
Criteria	• Initial approval period: 7 months (allow 4 weeks for repeat pulmonary function tests) *Mild-moderate IPF is defined as: a forced vital capacity (FVC) ≥ 50% of predicted. **Initial renewal criteria:** Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later. • Approval period: 6 months **Second and Subsequent renewal criteria (at 12 months after initiation and thereafter):** Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later. • Approval period: 12 months **Exclusion Criteria:** Combination use of Ofev (nintedanib) and Esbriet (pirfenidone) will not be funded. **Note:** • Patients who have experienced intolerance or failure to Ofev (nintedanib) or Esbriet (pirfenidone) will be considered for the alternate agent provided that the patient continues to meet the above coverage criteria.				
Decision Highlights	• The Manufacturer's Patient Access Program is called HeadStart™ and can be reached by phone at 1-844-473-6338.				

In order to allow for online adjudication the claim must be divided and processed as separate transactions. The following PIN is to be used to bill drug cost in excess of $9,999.99:

- 00904198

New Exception Status Benefits Continued…

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Lemtrada (alemtuzumab)	12 mg/1.2 mL (10mg/mL) concentrated solution for IV infusion in single-use vials	02418320	DNP	E (SF)	GZM
Criteria	For the management of adult patients with relapsing-remitting multiple sclerosis (RRMS), with active disease defined by clinical and imaging features, who have had an inadequate response to interferon beta or other disease-modifying therapies, if the following clinical criteria are met: • At least two attacks (first episode or relapse) in the previous two years, with at least one attack in the previous year; • At least one relapse while on at least six months of a disease modifying therapy within the last 10 years; • An Expanded Disability Status Scale (EDSS) score of five (5) or less; • Prescribed by a specialist with experience in the treatment of multiple sclerosis. **Claim Note:** A maximum of two years of therapy (i.e. two treatment courses; 8 vials) will be reimbursed.				

In order to allow for online adjudication the claim must be divided and processed as separate transactions. The following PIN is to be used to bill drug cost in excess of $9,999.99:

- 00904161

Please call the Nova Scotia Pharmacare Programs if additional PINs are required.

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Orencia (abatacept)	125mg/mL pre-filled syringe	02402475	DNP	E (SF)	BRI
Criteria	**Rheumatoid Arthritis (250mg/15mL vial and 125mg/mL pre-filled syringe):** For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to: • methotrexate (oral or parenteral) at a dose of ≥ 20 mg weekly (≥15mg if patient is ≥65 years of age), or use in combination with another DMARD, for a minimum of 12 weeks; AND • methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks				

New Exception Status Benefits Continued…

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Orencia (abatacept)	125mg/mL pre-filled syringe	02402475	DNP	E (SF)	BRI
Criteria	**Clinical Notes:** • For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered. • Optimal treatment response to DMARDs may take up to 24 weeks, however coverage of a biologic therapy can be considered if no improvement is seen after 12 weeks of triple DMARD use. • If patient factors (e.g. intolerance) prevent the use of triple DMARD therapy, these must be described and dual therapy with DMARDs must be tried. • Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above. • Intolerant is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs. The nature of intolerance(s) must be clearly documented. **Claim Notes:** • Must be prescribed by a rheumatologist. • Combined use of more than one biologic DMARD will not be reimbursed. • Initial Approval: 6 months • Renewal Approval: 1 year. Confirmation of continued response is required. **Maximum Dosage Approved:** • Abatacept Intravenous infusion: 500mg for patients <60 kg, 750mg for patients 60-100 kg and 1000mg for patients >100 kg, given at 0, 2, and 4 weeks then every 4 weeks thereafter. • Subcutaneous injection: a single IV loading dose of up to 1,000mg may be given, followed by 125mg subcutaneous injection within a day, then once-weekly 125mg subcutaneous injections.				

New Exception Status Benefits Continued…

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Xeljanz (tofacitinib)	5mg Tab	02423898	DNP	E (SF)	PFI

Criteria

Rheumatoid Arthritis:

For the treatment of severely active rheumatoid arthritis, in combination with methotrexate or other disease-modifying antirheumatic drugs (DMARDs), in adult patients who are refractory or intolerant to:

- Methotrexate (oral or parenteral) at a dose of ≥ 20mg weekly (≥15mg if patient is ≥ 65 years of age) for a minimum of 12 weeks, followed by methotrexate in combination with at least two other DMARDs, such as hydroxychloroquine and sulfasalazine, for a minimum of 12 weeks; OR
- Initial use of triple DMARD therapy with methotrexate in combination with at least two other DMARDs such as hydroxychloroquine and sulfasalazine, for a minimum of 24 weeks.

Notes:

- For patients who do not demonstrate a clinical response to oral methotrexate, or who experience gastrointestinal intolerance, a trial of parenteral methotrexate must be considered.
- Optimal treatment response may take up to 24 weeks; however coverage of tofacitinib can be considered if no improvement is seen after 12 weeks of triple DMARD use.
- If the patient is intolerant to triple DMARD therapy, then dual therapy with DMARDs (methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) must be considered.
- Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Intolerant is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs. The nature of intolerance(s) must be clearly documented.
- Must be prescribed by a rheumatologist.
- Combined use with biologic DMARD will not be reimbursed.

Criteria Updates

The following products were reviewed by the Common Drug Review (CDR) and will be listed with the following new criteria effective **December 1, 2016.**

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Esbriet (pirfenidone)	267mg Cap	02393751	DNP	E (SF)	HLR
Criteria	**Initial approval criteria:** Adult patients who have a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF)* confirmed by a respirologist and a high-resolution CT scan within the previous 24 months. • All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded. • Patient is under the case of a physician with experience in IPF • Initial approval period: 7 months (allow 4 weeks for repeat pulmonary function tests) *Mild-moderate IPF is defined as: a forced vital capacity (FVC) ≥ 50% of predicted. **Initial renewal criteria:** Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later. • Approval period: 6 months **Second and Subsequent renewal criteria (at 12 months after initiation and thereafter):** Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later. • Approval period: 12 months **Exclusion Criteria:** Combination use of Esbriet (pirfenidone) and Ofev (nintedanib) will not be funded.				
Decision Highlights	• The Manufacturer's Patient Access Program is called the Inspiration™ Program and can be reached by phone at 1-855-547-3227.				

In order to allow for online adjudication the claim must be divided and processed as separate transactions. The following PIN is to be used to bill drug cost in excess of $9,999.99:

- 00904113

Criteria Updates Continued…

The following product was reviewed by the Common Drug Review (CDR) and will be listed with the following additional criteria effective **December 1, 2016.**

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Inflectra (infliximab)	100mg/vial, sterile, lyophilized powder for solution	02419475	DNP	E (SF)	HOS

Criteria

For infliximab-naïve patients whose infliximab therapy is initiated after December 1, 2016, Inflectra will be the product approved for the following indications:

Ulcerative Colitis:

For the treatment of adult patients with moderately to severely active ulcerative colitis who have a partial Mayo score > 4, and a rectal bleeding subscore ≥ 2 and are:

- refractory or intolerant to conventional therapy (i.e. 5-ASA for a minimum of 4 weeks, and prednisone ≥ 40mg daily for two weeks or IV equivalent for one week); or
- corticosteroid dependent (i.e. cannot be tapered from corticosteroids without disease recurrence; or have relapsed within three months of stopping corticosteroids; or require two or more courses of corticosteroids within one year.)

Renewal requests must include information demonstrating the beneficial effects of the treatment, specifically:

- a decrease in the partial Mayo score ≥ 2 from baseline, and
- a decrease in the rectal bleeding subscore ≥1.

Clinical Notes:

- Refractory is defined as lack of effect at the recommended doses and for duration of treatments specified above.
- Intolerant is defined as demonstrating serious adverse effects or contraindications to treatments as defined in product monographs. The nature of intolerance(s) must be clearly documented.
- Patients with severe disease do not require a trial of 5-ASA

Claim Notes:

- Must be prescribed by a gastroenterologist or physician with a specialty in gastroenterology.
- Combined use of more than one biologic DMARD will not be reimbursed.
- Initial Approval: 16 weeks.
- Renewal Approval: 1 year.

Criteria Updates Continued…

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Inflectra (infliximab)	100mg/vial, sterile, lyophilized powder for solution	02419475	DNP	E (SF)	HOS
Criteria	**Crohn's Disease:** As per current Crohn's Disease criteria. Please refer to the Anti-Tumor Necrosis Factor (TNF) Agents criteria in the Nova Scotia Formulary online at http://novascotia.ca/dhw/pharmacare/documents/Criteria-for-Exception-Status-Coverage.pdf Initial approval is for three infusions of infliximab of 5mg/kg/dose at 0, 2 and 6 week intervals. **Psoriatic Arthritis:** As per current Psoriatic Arthritis criteria. Please refer to the Anti-Tumor Necrosis Factor (TNF) Agents criteria in the Nova Scotia Formulary online at http://novascotia.ca/dhw/pharmacare/documents/Criteria-for-Exception-Status-Coverage.pdf Initial approval for a maximum of 3 months. Dosage restricted to infliximab 5mg/kg 0, 2 and 6 weeks then every 8 weeks.				

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Eliquis (apixaban)	2.5mg Tab 5mg Tab	02377233 02397714	DNP DNP	E (SF) E (SF)	BRI BRI
Criteria	**Deep Vein Thrombosis/Pulmonary Embolism:** **Inclusion Criteria:** • For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE) • Approval Period: Up to six (6) months **Notes:** • The recommended dose of apixaban for patients initiating DVT or PE treatment is 10mg twice daily for 7 days, followed by 5mg twice daily (for treatment up to 6 months). • Drug plan coverage for apixaban for the treatment of DVT or PE is an alternative to heparin/warfarin for up to six months. When used for greater than 6 months, apixaban is more costly than heparin/warfarin. As such, patients with an intended duration of therapy greater than 6 months should be considered for initiation on heparin/warfarin. • Since renal impairment can increase bleeding risk, it is important to monitor renal function regularly. Other factors that increase bleeding risks should also be assessed and monitored (see apixaban product monograph)				

Criteria Updates Continued…

The following product was reviewed by the pCODR Expert Review Committee (pERC) and will be listed with the following additional criteria effective **December 1, 2016.**

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Revlimid (lenalidomide)	Various	Various	DNP	E (SFC)	CEL
Criteria	• As a first-line treatment option for newly diagnosed patients with multiple myeloma who are not eligible for autologous stem cell transplantation. Treatment should be in combination with dexamethasone for patients with ECOG performance status 0-2, and until disease progression. **Notes:** Celgene will ensure that the Product will be prescribed and dispensed only by physicians and pharmacists, respectively, who are registered with and agree in writing to adhere to the guidelines of the Company's RevAid® Program, details of which Program are available at https://revaid.ca/revaid.				

The following products were reviewed by the Atlantic Common Drug Review (ACDR) and will be listed with the following new criteria effective **December 1, 2016.**

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Donepezil	Various	Various	DNP	E (SF)	VAR
Galantamine	Various	Various	DNP	E (SF)	VAR
Rivastigmine	Various	Various	DNP	E (SF)	VAR
Criteria	For the treatment of patients with mild to moderate dementia who meet the following criteria: • A Mini-Mental Statement Examination (MMSE) score of 10 to 30 AND • A Functional Assessment Staging Test (FAST) score of 4 to 5 • Initial requests for reimbursement will be considered for a 4 month approval; subsequent requests may be considered for a maximum 12 months approval.				
Decision Highlights	• The committee made this recommendation because the types of dementia are not clearly differentiated in the clinical setting; therefore, there is no need to specify the types in the criteria. Also, the criteria addressing switching within 4 months between cholinesterase inhibitors was removed, as switching may be required at various times during therapy.				

Criteria Updates Continued…

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Renagel (Sevelamer hydrochloride)	800mg Tab	02244310	DNP	E (SF)	SAV
Criteria	For the treatment of hyperphosphatemia (>1.8 mmol/L) in patients with end-stage renal disease (eGFR < 15 mL/min) who have: • Inadequate control of phosphate levels on a calcium based phosphate binder, or • Hypercalcemia (corrected for albumin), or • Calciphylaxis (calcific arteriolopathy) **Claim Notes:** • Must be prescribed by a nephrologist or other prescriber within the Provincial Dialysis Program. • Initial Approval: 6 months. • Renewal Approval: 1 year. Confirmation of improvement of phosphate levels is required (lab values must be provided).				

New Products

The following products are new listings to the Nova Scotia Formulary, effective **December 1, 2016**. The benefit status within the Nova Scotia Pharmacare Programs is indicated.

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Arnuity Ellipta	100mcg Pdr for Inh	02446561	DNP	SF	GSK
Arnuity Ellipta	200mcg Pdr for Inh	02446588	DNP	SF	GSK
Biltricide	600mg Tab	02230897	DNP	SF	BAY
Jamp-Nystatin	100,000iu/mL Oral Susp	02433443	DNP	SFC	JPC
Naropin	5mg/mL Inj	02229415	DNP	SFC	AZE
Naropin	10mg/mL Inj	02229418	DNP	SFC	AZE
Pms-Sennosides	8.6 mg Tab	00896411	DNP	C	PMS
Ropivacaine	5mg/mL Inj	02347822	DNP	SFC	HOS
Ropivacaine	10mg/mL Inj	02347830	DNP	SFC	HOS

Change of Benefit Status

Effective **December 1, 2016,** the following products will move to full benefit status and will no longer require special authorization.

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
NovoRapid (Insulin Aspart)	100iu/mL Penfill Ins	02244353	DNP	SFD	NNO
NovoRapid (Insulin Aspart)	100iu/mL Vial Ins	02245397	DNP	SFD	NNO
NovoRapid (Insulin Aspart)	100iu/mL Flextouch	02377209	DNP	SFD	NNO
Olanzapine	2.5mg Tab	Various	DNP	SF	VAR
Olanzapine	5mg Tab	Various	DNP	SF	VAR
Olanzapine	7.5mg Tab	Various	DNP	SF	VAR
Olanzapine	10mg Tab	Various	DNP	SF	VAR
Olanzapine	15mg Tab	Various	DNP	SF	VAR
Olanzapine	20mg Tab	Various	DNP	SF	VAR
Olanzapine ODT	5mg Tab	Various	DNP	SF	VAR
Olanzapine ODT	10mg Tab	Various	DNP	SF	VAR
Olanzapine ODT	15mg Tab	Various	DNP	SF	VAR
Olanzapine ODT	20mg Tab	Various	DNP	SF	VAR

Non Insured Product

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
LoLo (ethinyl estradiol/norethindrone)	10mcg/1mg Tab	02417456	N/A	**Non Insured**	WNC

Delisted Product

Effective **December 1, 2016**, Fosrenol will be delisted as a benefit under the Nova Scotia Pharmacare Programs. Those with coverage currently will be grandparented.

PRODUCT	STRENGTH	DIN	PRESCRIBER	BENEFIT STATUS	MFR
Fosrenol (lanthanum)	250mg Tab	02287145	N/A	**Delisted**	SHI
Fosrenol (lanthanum)	500mg Tab	02287153	N/A	**Delisted**	SHI
Fosrenol (lanthanum)	750mg Tab	02287161	N/A	**Delisted**	SHI
Fosrenol (lanthanum)	1000mg Tab	02287188	N/A	**Delisted**	SHI

New Ostomy Products

Effective **December 1, 2016** a number of Hollister ostomy products will be added as full benefits under the Nova Scotia Pharmacare Programs. The specific products and associated billing PINs (as per the OPINIONS website) can be found in the next update of the Nova Scotia Formulary, which will be available on the Nova Scotia Pharmacare website.

New Diabetic Products

The following products will be new listings to the Nova Scotia Formulary, effective **December 1, 2016**. The benefit status and reimbursement price within the Nova Scotia Pharmacare Programs is indicated.

PRODUCT	DIN/PIN	PRODUCT NUMBER	PRESCRIBER	BENEFIT STATUS	MFR
Droplet Lancet 28G	97799232	7106	DNP	SFD	SFA
Droplet Lancet 30G	97799233	7167	DNP	SFD	SFA
Droplet Lancet 33G	97799234	7206	DNP	SFD	SFA
Droplet Pen Needles 10mm/29G	97799238	8084	DNP	SFD	SFA
Droplet Pen Needles 12mm/29G	97799235	8085	DNP	SFD	SFA
Droplet Pen Needles 5mm/31G	97799239	8156	DNP	SFD	SFA
Droplet Pen Needles 6mm/31G	97799237	8082	DNP	SFD	SFA
Droplet Pen Needles 8mm/31G	97799236	8085	DNP	SFD	SFA
Droplet Pen Needles 4mm/32G	97799243	8081	DNP	SFD	SFA
Droplet Pen Needles 5mm/32G	97799242	8153	DNP	SFD	SFA
Droplet Pen Needles 6mm/32G	97799241	8154	DNP	SFD	SFA
Droplet Pen Needles 8mm/32G	97799240	8155	DNP	SFD	SFA

Reminder: Claims Submission for Therapeutic Substitution Service - Proton Pump Inhibitors (PPIs)

Pharmacists must submit electronic claims for therapeutic substitution services to the Pharmacare Programs for reimbursement provided all of the criteria for coverage are met (this criteria can be found in the Pharmacists' Guide).

The following steps **must be** completed on the same day in the following order for the pharmacy to be reimbursed for the service:

- The original claim for the prescription as written by the prescriber is submitted to Pharmacare and then reversed.
- A claim for therapeutic substitution is submitted using PIN 93899912. (This PIN is specific for therapeutic substitutions within the PPI category).
- The record of therapeutic substitution must reference the prescription numbers for the original claim and modified claim.
- The claim for the new prescription with the changes made is submitted to Pharmacare.

*Please see the Pharmacists' Guide for a table depicting all CPhA Claims Standard field content.

Reminder: Publicly-Funded Influenza Vaccine by Pharmacist

Reminder: Claim Submissions for Publicly-Funded Influenza Vaccine by Pharmacist

The last Pharmacare News Bulletin (Volume 16-05) contained the table below, which indicated claim submission content, which must be included for adjudication of the influenza vaccine. To ensure claims are adjudicated correctly, all influenza claims must be adjudicated using a **quantity of 1**, as well as the correct DIN and/or PIN.

Effective **December 1, 2016** reports will be generated by Nova Scotia Pharmacare to identify claims adjudicated with an improper quantity (<1) and incorrect PINS (i.e. PIN for pregnant women, used to adjudicate claim for male). These reports will be provided to pharmacies and the indicated claims must be reversed and resubmitted correctly. Any claims that have been identified on these reports, which are not corrected, may be subject to audit and possible recovery of administration fees.

Claims Submission Field Content for Pharmacist-Administered Publicly Funded Influenza Vaccines

CPhA Claim Standard Field #	CPhA Claim Standard Field Name	Content
D.56.03	DIN/GP#/PIN	**DINs** Fluzone Quadrivalent MDV 02432730 FluLaval Tetra 02420783 **PIN for pregnant women** Fluzone Quadrivalent 93899895 FluLaval Tetra 93899893 **PIN for second dose for children** Fluzone Quadrivalent 93899896 FluLaval Tetra 93899894
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	$12.00

Reminder: How to adjudicate claims for individuals without a valid Nova Scotia Health Card Number?

Only residents with a valid Nova Scotia Health Card Number are eligible to have the influenza vaccine administration fee billed to Pharmacare. Individuals who do not have a valid Nova Scotia Health Card Number are responsible for paying the applicable administration fee.

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

Home Care Acute Care Drugs

The Department of Health, Risk Mitigation – Continuing Care Branch oversees the payment for Home Care Acute Care drugs. The process at this time is that each pharmacy receives an authorization form that has been completed by a care coordinator or referral assistant, fills the prescription and bills appropriately. Billing should be done first through private insurance (except Pharmacare) and any remaining co-pays are then submitted to the local Nova Scotia Health Authority, Continuing Care Zone financial office. Continuing Care in turn processes these invoices and submits them to the DHW. It has been noted that in some cases pharmacies are not sending the original prescription receipt. Please be advised that only the original receipt will be processed on a go forward basis.

Nova Scotia Insulin Pump Program Annual Renewal

The Nova Scotia Insulin Pump Program (NSIPP) offers financial assistance toward the cost of insulin pumps and supplies. Beneficiaries of this program are required to renew their enrollment each year.

Eligibility for renewal and enrolment:

- Must be a permanent resident of Nova Scotia with a valid Nova Scotia Health Card
- Must be 25 years of age or younger
- Must meet medical criteria as determined by the program

Currently the program year runs from January 01 to December 31. For more information to renew or apply visit: http://novascotia.ca/dhw/NSIPP/