Types of Care

Our Vision

Our Mandate
To lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care.

Our Values
Respect, Integrity, Collaboration, Excellence, Innovation
Introduction

This document provides contextual information regarding public federal/provincial/territorial drug benefit plans/programs across Canada. Users can click on the links below:

Summary of Major Changes

Plan/Program Information by Category and Jurisdiction

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  - Saskatchewan
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  - Ontario
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  - Nova Scotia
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  - Newfoundland and Labrador
  - Yukon
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Pan-Canadian Pricing Alliance

Generic Pricing Policy Summary

Glossary of Terms
Summary of Major Changes

Pan-Canadian Pricing Alliance

As of April 1, 2014:

- The Pan-Canadian Pricing Alliance (PCPA) decided to not negotiate collectively or individually at the provincial/territorial level for 12 drug products.
- The PCPA recommended that 6 brand-name drug products be considered by each province/territory individually: Fycompa (perampanel), Genotropin (somatropin), Humira (adalimumab), Jentadueto (linagliptin/saxagliptin), Latuda (lurasidone), and Trisenox (arsenic trioxide).
- There were 31 joint negotiations completed. As well, 2 negotiations were closed because agreements were not reached.
- There are 12 products currently under negotiation, 1 of which is new as of April 1, 2014: Lodalis (colesevelam).

Pan-Canadian Generic Price Initiative

Effective April 1, 2014:
The prices of the following generic medications have been limited to 18% of the equivalent brand-name price:

- Citalopram: used to treat depression and other mental health conditions
- Pantoprazole: used to treat a variety of gastrointestinal conditions
- Rosuvastatin: used to treat high cholesterol
- Simvastatin: used to treat high cholesterol

British Columbia

Effective October 1, 2013:
Health Canada transferred its role in the design, management and delivery of First Nations health programming in British Columbia to the new First Nations Health Authority (FNHA).

Effective January 1, 2014:
Manufacturers can submit price increases for brand-name and single-source generic drugs only once a year. Price decreases will continue to be accepted throughout the year.

Effective April 1, 2014:
Generic drug prices for oral solids were reduced to 20% of the brand-name list price. All other generic drug forms were priced at 35% of the brand-name list price.

Effective April 1, 2014:
Insulin pump coverage was extended to patients age 25 and younger (coverage was previously for those age 18 and younger).

i. Completed negotiations since last update of February 28, 2014.
Alberta

Effective June 1, 2013:
The Insulin Pump Therapy Program was launched.

Effective April 1, 2014:
The Actual Acquisition Cost was replaced with the Manufacturer’s List Price (MLP) or Base Price.

A three-tiered professional fee was replaced with a new dispensing fee of $12.30 for all products except compounds and diabetic supplies.

Two new allowable upcharges, referred to as Allowable Upcharge #1 and Allowable Upcharge #2, were added. Allowable Upcharge #1 is defined as 3% of the MLP, and Allowable Upcharge #2 is defined as a percentage of the combination of the MLP and the Allowable Upcharge #1, up to a maximum of $100. This percentage will change over time, starting at 5.5% on April 1, 2014, and increasing by 0.5% every year to 7% on April 1, 2017.

Previously administered Human Services Drug Benefit programs—including recipients being assisted under Income Support, Adult Health Benefit, Child Health Benefit, Assured Income for the Severely Handicapped, Child Intervention Services and Family Supports for Children With Disabilities—have been consolidated within the Ministry of Health.

Saskatchewan

Effective April 1, 2014:
The maximum dispensing fee increased to $11.25 from $10.75.

The CeRx (Pan-Canadian Electronic Drug Messaging) integration supplement fee increased to $0.20 for integrated pharmacies until March 31, 2015.

Manitoba

Effective April 12, 2012:
The Pediatric Insulin Pump Program was launched.

Effective April 1, 2014:
The deductible rate increased from between 2.85% and 6.47% for 2013–2014 to between 2.91% and 6.60% for 2014–2015.

Ontario

Effective April 1, 2014:
Dispensing fees for non-rural pharmacies increased from $8.62 to $8.83, and the range for rural pharmacies changed to $9.93 to $13.25.
New Brunswick

Effective July 2, 2013:
The New Brunswick Prescription Drug Program will pay for one dispensing fee every 28 days or more for drugs in solid oral dosage form taken on a continuous basis.

Effective September 1, 2013:
The New Brunswick Prescription Drug Program will pay for one transition fee, included in the dispensing fee, for each eligible claim. The transition fee for each eligible claim will be as follows:

$1.00: from September 1, 2013, to November 30, 2013
$0.75: from December 1, 2013, to January 31, 2014
$0.50: from February 1, 2014, to March 31, 2014

The transition fee will not apply to drugs for the treatment of opioid dependence, NB PharmaCheck, the Extra-Mural Program (Plan W), the influenza vaccine (Plan I) and tuberculosis drugs (Plan P).

Effective April 1, 2014:
NB PharmaCheck™ expanded to include Department of Social Development clients.

Effective May 1, 2014:
The New Brunswick Drug Plan was introduced for residents without another source of drug coverage.

Effective June 1, 2014:
The dispensing fees for eligible claims dispensed by pharmacies have been revised; see the section Policy-Related Information for more details.

Nova Scotia

Effective September 1, 2013:
The Insulin Pump Program was introduced for residents younger than age 25 with type 1 diabetes.

Prince Edward Island

Effective December 1, 2013:
Professional fees were introduced for the following pharmacy services: compliance packaging ($25 per 28-day period), catastrophic drug program application support ($5 per individual per year), therapeutic substitution (1.2 times the dispensing fee), refusal to fill (1.2 times the dispensing fee) and prescription adaptation (1.2 times the dispensing fee).

Effective April 1, 2014:
The professional fee is $12.18 and the extemporaneous fee is $18.27. Private nursing home capitation fees are $75.02.
All generic drug prices were reduced to 25% of the brand-name prices.
Newfoundland and Labrador

Effective July 1, 2013:
Generic drug prices are equal to or less than 25% of the brand-name prices.

Effective April 1, 2014:
The professional fees for the Foundation Plan, Access Plan and Assurance Plan changed to
- $11.50 for drug costs between $0 and $49.99
- $23.23 for drug costs between $50 and $249.99
- $49.77 for drug costs $250+

The professional fees for the 65Plus Plan changed to
- $11.50 for drug costs between $0 and $249.99
- $39.75 for drug costs $250+

Cognitive Services
- Refusal to Fill: Pharmacies may bill up to the maximum dispensing fee of double the base dispensing fee of $11.50.
- Medication Management: Pharmacies may bill up to the maximum dispensing fee of $11.50 (the base dispensing fee).

Yukon

Effective January 17, 2011:
The professional fee is $8.75 and the extemporaneous preparation fee is $13.30.

Health Canada—First Nations and Inuit Health Branch

Effective July 15, 2012:
The Non-Insured Health Benefits (NIHB) Short-Term Dispensing Policy was expanded to include anticonvulsants, antidepressants, antipsychotics, benzodiazepines and stimulant medications. When medically necessary, prescriptions can be dispensed daily and/or for periods shorter than 28 days. The NIHB will reduce the professional fee on most chronic medications that are dispensed less than 28 days apart.

Effective October 1, 2013:
Health Canada transferred its role in the design, management and delivery of First Nations health programming in British Columbia to the new First Nations Health Authority (FNHA).
## Eligibility (British Columbia, Alberta, Saskatchewan, Manitoba and Ontario)

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### General Beneficiary Information

For any plan, beneficiaries must be permanent residents of British Columbia for at least 3 months.

- **Fair PharmaCare**
  - Regular Assistance: Residents born in 1940 or later
  - Enhanced Assistance: Residents born in 1939 or earlier
- **Permanently Resident of Licensed Residential Care Facilities**: Permanent resident of a licensed residential care facility
- **Recipients of Income Assistance**: Recipients of B.C. income assistance and medical benefits
- **Cystic Fibrosis**: Individuals with cystic fibrosis and registered with a provincial cystic fibrosis clinic
- **Children in the At Home Program**: Non-institutionalized severely handicapped children, age 18 years and under, receiving economic benefits or medical benefits through the “At Home” program of the Ministry of Children and Family Development
- **No-Charge Psychiatric Medication Plan**: Individuals of any age who are registered with a mental health services centre, who have demonstrated clinical and financial need

### B.C.

- **Seniors**: Residents age 65 or older and eligible dependents.
- **Widows**: Residents age 55 to 64 who qualified for Alberta Widows Pension up until 2004 and eligible dependents.
- **Palliative**: Palliative residents treated at home.
- **Non-Group**: Residents younger than age 65 and eligible dependents.
- **Rare Diseases Drug Program**: Residents who have government-sponsored drug coverage, whose physician has applied for coverage, and the individual or family have resided in Alberta for 5 years or have moved from another province in Canada where they were covered by that province's program for these drugs.
- **Outpatient Cancer Therapy Drug Program**: Provides selected medications, used in the direct treatment of cancer, to patients at no cost.
- **Specialized High-Cost Drugs Program**: Provides funding to all Albertans for drugs used in highly specialized procedures and treatments, such as transplant, HIV, cystic fibrosis, human growth hormone, primary pulmonary hypertension and macular degeneration.
- **Diabetic Supply Coverage**: Covers up to $800 worth of supplies for Albertans using insulin to treat diabetes.
- **Insulin Pump Therapy Program**: Residents must be diagnosed with Type 1 diabetes

### Alta.

- **Family Health Benefits**: Low-income working families or families receiving the Saskatchewan Employment Supplement or the Saskatchewan Rental Housing Supplement with at least one child under the age of 18.
- **Income Supplement**: Residents qualifying for the Seniors’ Income Plan (SIP) in Saskatchewan.
- **Seniors Drug Plan**: Income-tested; seniors age 65 or older who have applied and qualified based on income.
- **Special Support Program**: Income-tested; designed to help those whose drug costs are high in relation to their income.
- **Palliative Care Program**: Persons approved for the drug plan’s palliative care coverage (residents who are in the late stages of a terminal illness). The level of assistance provided will be in accordance with the consumer’s ability to pay. The resident is then required to submit a completed Special Support Application to the Drug Plan in order to receive future assistance.
- **Saskatchewan Aids to Independent Living (SAIL)**: Persons with specific disabling conditions may be eligible for benefits under the various special

### Sask.

### Man.

- **Pharmacare**: All residents who are eligible for benefits under The Prescription Drugs Cost Assistance Act.
- **Employment and Income Assistance Program**: Individuals who are receiving drug benefits pursuant to the Employment and Income Assistance Program.
- **Personal Care Home/Nursing Homes**: Residents of personal care homes.
- **Palliative Care Drug Access Program**: Residents who are receiving drug benefits at home.
- **Home Cancer Drug Program**: Patients identified by CancerCare Manitoba as receiving or being scheduled to receive eligible outpatient oral cancer and specific supportive drugs, and who are registered with the Pharmacare program whose prescriptions for eligible outpatient oral cancer and specific supportive drugs are not being covered by other provincial or federal programs.
- **Saskatchewan Aids to Independent Living**: Persons with specific disabling conditions may be eligible for benefits under the various special

### Ont.

### Ontario Drug Benefit Program

- Residents age 65 or older, residents of long-term care homes and homes for special care, recipients of professional home services and social assistance, and recipients of the Trillium Drug Program.
- **Trillium Drug Program**: Residents who have high drug costs in relation to their household income; any resident who does not qualify under any of the other public drug plan or if their private insurance does not cover 100% of the prescription drug costs and they are not eligible for ODB coverage.
- **Special Drugs Program**: Residents who require certain expensive outpatient drugs used to treat cystic fibrosis; HIV infection; end-stage renal disease; solid organ or bone marrow transplant; human growth hormone; schizophrenia; Gaucher’s disease; and thalassemia.
- **Inherited Metabolic Diseases Program**: Benefits for Ontarians with a valid health card for certain outpatient drugs, supplements and specialty foods used in the treatment of specific metabolic disorders.
- **Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program**: Funds a drug for Ontario-resident infants who are at high risk for hospitalization and complications from RSV infection.
General Beneficiary Information (cont’d)

- **Medication Management:** Covers individuals for eligible medication management services (e.g., clinical services, medication review services and publicly funded vaccinations) provided by pharmacies.
- **Palliative Care:** Individuals who have reached the end stage of a life-threatening disease or illness who wish to receive palliative care at home.
- **British Columbia Centre for Excellence in HIV/AIDS:** HIV-positive individuals enrolled in the centre.
- **Smoking Cessation Program:** For prescription smoking cessation drugs for individuals who are registered in one of the following plans: Fair PharmaCare, Plan B, Plan C or Plan G. Nicotine replacement therapies are available to all smokers (and users of other tobacco products) who are B.C. residents with active Medical Services Plan (MSP) coverage. And be under the care of a physician or nurse practitioner for the condition.
- **Alberta Human Services Drug Benefit Programs With Supplement:** Defines the drugs and drug products that are covered for Alberta Human Services clients, including the following client groups:
  - **Income Support:** For Albertans who don’t have the resources to meet their basic needs.
  - **Alberta Adult Health Benefit:** For Albertans with low income.
  - **Assured Income for the Severely Handicapped (AISH):** For adults, under the age of 65 years, who have a permanent disability that severely affects their ability to earn a livelihood.
  - **Alberta Child Health Benefit:** For children of low-income families.
  - **Child Intervention Services:** Intervention services are provided when there are concerns that a child or youth is being neglected or abused by his or her parent or guardian.
  - **Family Supports for Children with Disabilities:** Provides a wide range of family-centred supports and services

benefit programs (Paraplegia Program, Cystic Fibrosis Program, End Stage Renal Disease Program, Ostomy Program and Aids to the Blind Program).

- **Supplementary Health Coverage:** Eligibility is determined by the Ministry of Social Services. There are 4 supplementary drug coverage programs:
  - **All Plans—**Individuals under age 18 will receive benefit prescriptions at no charge.
  - **Plan One—**Adults pay no more than $2 for each benefit prescription.
  - **Plan Two—**Plan One adults needing several different drugs on a long-term basis may be eligible for prescriptions at no charge. Physician or pharmacist may request coverage.
  - **Plan Three—**Benefit prescriptions received at no charge and is designed for people receiving the Seniors’ Income Plan and residing in special-care homes. Individuals living in Approved Homes and Group Homes may also be eligible.

- **Children’s Drug Program:** Children age 14 or younger.

- **Saskatchewan Insulin Pump Program:**
  - Applicants must be age 25 or younger.
  - Applicants must have type 1 diabetes and require a pump to adequately stabilize blood sugar levels.

- **Pharmacy Smoking Cessation Program:** Currently, ODB recipients who smoke may enrol in the program once per year from the date of the patient’s first meeting with the pharmacist, at which time the patient and pharmacist agree to work together on a stop-smoking strategy.

Note: The ODB Program benefit year runs from August 1 to July 31.
Other Eligibility Criteria

- **Fair PharmaCare:** An individual must
  - Have effective British Columbia Medical Services Plan (MSP) coverage; and
  - Have filed an income tax return for the relevant taxation year
- **Permanent Residents of Licensed Residential Care Facilities:** Permanent residents of a licensed residential care facility who are enrolled and receive coverage through the care facility
- **Recipients of Income Assistance:** Recipients must be registered in MSP and receiving medical benefits and income assistance through the Ministry of Social Development
- **Cystic Fibrosis:** Individuals with cystic fibrosis who are registered with a provincial cystic fibrosis clinic
- **Children in the At Home Program:** Recipient must be
  - Younger than 19 years of age (i.e., 18 or less);
  - A resident of B.C.;
  - Living at home with a parent or guardian; and
  - Assessed as dependent in at least 3 of 4 areas of daily living
- **No-Charge Psychiatric Medication:** The patient’s physician or psychiatrist must submit an application for
- **Seniors:** In order to be registered, seniors must complete a proof-of-age declaration, which Alberta Health mails to them; registration with the Alberta Health Care Insurance Plan (AHCIP) is required
- **Palliative:** A person must be
  - Registered with the AHCIP; and
  - Diagnosed by a physician as being palliative and receiving treatments at home
- **Non-Group:** A person must be registered with AHCIP and not eligible to receive the Alberta Widows Pension or be in premium arrears for the plan
- **Citizens whose health services are covered under First Nations and Inuit Health, Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers’ Compensation or federal penitentiaries are not eligible for drug plan benefits under Saskatchewan Health.
- **Residents may qualify and be covered under more than one program at the same time. The better benefit applies at the time the prescription is filled.**
- **Foreign skilled workers nominated through the Saskatchewan Immigrant Nominee Program (SINP) whose work permits have expired maintain Saskatchewan Health coverage under First Nations and Inuit Health, Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers’ Compensation or federal penitentiaries are not eligible for drug plan benefits under Saskatchewan Health.
- **A person must be a member of a family unit whose members have, in a benefit year, collectively spent more on specified drugs than the deductible amount determined.**
- **An application to become eligible must be made to the minister by the person’s family unit, and the minister must be satisfied that the members of the family unit have, in a benefit year, collectively spent more on specified drugs than the deductible amount determined.**
- **Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program**
  - Infants who are residents of Ontario and have a valid Ontario health card, as follows:
    - Infants born prematurely at less than 32 completed weeks gestation and those younger than 6 months at the start of, or during, the local RSV season; or
    - Infants of 33–35 completed weeks gestation and those younger than 6 months at the start of, or during, the local RSV season, who do not live in isolated communities and have a Risk Assessment Tool Score of between 49 and 100; or
    - Infants of 33–35 completed weeks gestation and those younger than 6 months at the start of, or during, the local RSV season, who do not live in isolated communities where pediatric hospital care is not readily accessible and ambulance transportation for hospital admission is required; or
    - Infants younger than 24 months of age with Down syndrome/Trisomy 21 syndrome; or
    - Infants younger than 24 months of age with bronchopulmonary dysplasia/chronic lung disease and who required oxygen and/or medical therapy within the 6 months preceding the RSV season; or
    - Infants younger than 24 months of age with hemodynamically significant cyanotic or acyanotic congenital heart disease who require corrective surgery or are on cardiac mediation for hemodynamic significant disease.
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<td>Other Eligibility Criteria</td>
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<td>– Patient must qualify for premium assistance under the MSP</td>
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<td>• Palliative Care</td>
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<td>– Recipients must be diagnosed as being in the terminal stage of a</td>
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<td>life-threatening illness or condition</td>
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<td>– Recipients must have a life expectancy of up to six months</td>
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<td>– Recipients wish to receive palliative care at home</td>
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<td>– Recipients consent to the focus of care being palliative rather</td>
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<td>than treatment aimed at a cure</td>
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<td>– The physician submits an application, certifying that the</td>
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<td>individual meets the above criteria</td>
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**Sources**

- For more information: [British Columbia PharmaCare](#)
- For more information: [Alberta Health](#)
- For more information: [Saskatchewan Health Drug Plan and Extended Benefits Branch](#)
- For more information: [Manitoba Health](#)
- For more information: [Ontario Drug Benefit Program](#)
Eligibility (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Yukon and First Nations and Inuit Health Branch)

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<td>• HIV/AIDS (U)</td>
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<td>• Nursing Home (V)</td>
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<td>• New Brunswick Drug Plan</td>
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<td>• Family Pharmacare Program (A)</td>
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<td>• Department of Community Services Pharmacare Benefits (F)</td>
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<td>• Palliative Home Care Drug Coverage (PHCDC) Program</td>
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<td>• Insulin Pump Program</td>
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<td>• Intron A (Interferon alfa-2b) Program (J)</td>
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<td>• Institutional Pharmacy/ Nursing Home Program (N)</td>
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<td>• Catastrophic Drug Program (Q)</td>
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<td>• Seniors Drug Cost Assistance Plan (S)</td>
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<td>• Sexually Transmitted Diseases (STD) Program/ Opioid Replacement Therapy Program (V)</td>
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<td>• Children’s Drug and Optical Program (CDOP)</td>
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<td>• The Foundation Plan (previously Income Support Drug Program or Plan E)</td>
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<td>• The 65Plus Plan (previously Senior Citizen’s Drug Subsidy Plan or Plan N)</td>
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<td>• The Select Needs Plan</td>
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<td>• Non-Insured Health Benefits (NIHB)</td>
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<td>General Beneficiary Information</td>
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<tr>
<td>- Seniors Program—Residents age 65 and older who receive the GIS or who qualify for benefits based on an annual income</td>
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<td>- Cystic Fibrosis—Cystic fibrosis patients or patients with juvenile or infant sclerosis of the pancreas</td>
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<td>- Adults in Licensed Residential Facilities—Individuals residing in a licensed adult residential facility who hold a valid health card for prescription drugs issued by the Department of Social Development</td>
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<tr>
<td>- Department of Social Development—Individuals holding a valid health card for prescription drugs issued by the Department of Social Development</td>
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<td>- Special Needs Children and Children in the Care of the Minister of Social Development—Children with special needs and children under the care of the Minister of Social Development</td>
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<td>- Multiple Sclerosis—Residents diagnosed with MS who are in possession of a prescription written by a neurologist for eligible medications</td>
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<td>- Influenza—Residents and children with selected chronic health conditions significant enough to</td>
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<tr>
<td>- Family Pharmacare Program—Families, including families of one, who apply for the program; any permanent Nova Scotia resident (age 18 or older) with a valid Nova Scotia health card number is eligible to enroll; must not have coverage through other programs, except Family Pharmacare</td>
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<tr>
<td>- Nova Scotia Diabetes Assistance Program—Permanent Nova Scotia residents with a valid Nova Scotia health card number younger than age 65 who have a confirmed diagnosis of diabetes and who do not have drug coverage through other programs, except Family Pharmacare</td>
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<td>- AIDs/HIV Program—Persons who test positive for the human immunodeficiency virus (HIV) or who are diagnosed with acquired immune deficiency syndrome (AIDS) or who have a needle stick injury</td>
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<td>- Community Mental Health Program—Approved long-term psychiatric patients living in the community</td>
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<tr>
<td>- Cystic Fibrosis Program—Persons diagnosed with cystic fibrosis</td>
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<tr>
<td>- Diabetes Control Program—Persons diagnosed with diabetes and registered with the provincial Diabetes Program</td>
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<td>- Drug Assistance for Cancer Patients—Permanent Nova Scotia residents with a valid Nova Scotia health card number who have a gross family income no greater than $15,720 per year and are not eligible for coverage under other drug programs, except Family Pharmacare</td>
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<tr>
<td>- Family Health Benefit Program—Families (parents, guardians and children) younger than 18 or younger than 25 and in full-time attendance at a post-secondary educational institution, with a total net family income less than the threshold (see Income Range section below); coverage must be applied for on an annual basis</td>
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<td>- Growth Hormone—Children (younger than age 18) with a proven growth hormone deficiency or Turner syndrome</td>
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<td>- Hepatitis Program—Persons diagnosed with hepatitis, in close contact with a person diagnosed with hepatitis, or at risk of infection; persons with an occupational risk of infection</td>
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<tr>
<td>- The Foundation Plan—Persons and families in receipt of income support benefits through the Department of Human Resources, Labour and Employment, and certain individuals receiving services through the regional health authorities, including children in the care of Child, Youth and Family Services and individuals in supervised care get 100% coverage of eligible prescription drugs</td>
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<td>- The Access Plan—Individuals and families with low income. The amount of coverage is determined by family net income level and family status (see Income Range section)</td>
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<td>- The 65Plus Plan—Residents age 65 or older who receive Old Age Security benefits and the GIS</td>
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<td>- The Assurance Plan—Individuals and families with the financial burden of eligible high drug costs</td>
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<tr>
<td>- The Select Needs Plan—Residents who have been diagnosed with cystic fibrosis and residents age 18 years or younger with growth hormone deficiency</td>
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<td>- The Foundation Plan—Persons and families in receipt of income support benefits through the Department of Human Resources, Labour and Employment, and certain individuals receiving services through the regional health authorities, including children in the care of Child, Youth and Family Services and individuals in supervised care get 100% coverage of eligible prescription drugs</td>
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<tr>
<td>- Children’s Drug and Optical Program—Children younger than age 19 from low-income families</td>
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<tr>
<td>- Chronic Disease Program—Residents who have a chronic disease or a serious functional disability as provided under the Chronic Disease and Disability Benefits Regulations and not having coverage through First Nations and Inuit Health; program may also include clients receiving palliative care</td>
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<tr>
<td>- Pharmacare—Seniors age 65 or older (and seniors’ spouses age 60 or older) registered with Yukon Health Care Insurance Plan (YHCIP) and not having coverage through First Nations and Inuit Health; program may also include clients receiving palliative care</td>
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<td>- Palliative Care —For people who are living with or dying from advanced illness. Palliative care patients access benefits through either Pharmacare or the Chronic Disease Program and must be registered with one of these 2 plans in order to be eligible for the palliative care expanded coverage</td>
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*Note: The table above contains information related to the National Prescription Drug Utilization Information System Database Plan Information Document, July 1, 2014.*
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<th>Health Canada—FNIHB</th>
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<tbody>
<tr>
<td>General Beneficiary Information (cont’d)</td>
<td>require regular medical follow-up or hospital care; or residents of nursing homes and other chronic-care facilities; or residents older than 65; or pregnant women; or healthy children 6 months to 18 years old; or Aboriginal people; or residents capable of transmitting influenza to those at high risk</td>
<td></td>
<td>• Tuberculosis (TB) Drug Program—Individuals with tuberculosis prescribed by prescriber regardless of permanent residence</td>
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<td></td>
<td>• Organ Transplant—Recipients of an organ or bone marrow transplant who are registered with New Brunswick Medicare and are not entitled to receive similar benefits from any other source</td>
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<td>• Human Growth Hormone Deficiency—Residents under the age of 18 years with growth hormone deficiency or hypopituitarism who are registered on the plan by an endocrinologist</td>
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<td></td>
<td>• HIV/AIDS—Individuals diagnosed with HIV/AIDS and who are registered with the NBPD through a provincial infectious disease specialist</td>
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<td>• Nursing Home—Individuals who reside in a registered nursing home and supplies. This program closed for new enrollment as of April 1, 2010.</td>
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<td></td>
<td>• Palliative Home Care Drug Coverage Program—Residents diagnosed as palliative and receiving treatments at home</td>
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<td>• Immunization Program—Children and persons at risk for exposure to various communicable diseases</td>
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<td></td>
<td>• Insulin Pump Program—Covers the cost of insulin and supplies for children/youth (younger than age 19) with type 1 diabetes; covers the cost of pump supplies for young adult residents (age 19 to 24) with type 1 diabetes</td>
<td></td>
<td>• Intron A (Interferon alfa-2b) Program—For the treatment of patients diagnosed with hairy cell leukemia, AIDS-related Kaposi’s sarcoma and basal cell carcinoma; the person’s physician must request coverage from the chief health officer of the Department of Health and Social Services</td>
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<td></td>
<td>• Methadone Maintenance—Persons approved for coverage through the provincial Methadone Maintenance Program.</td>
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<td>• High-Cost Drug Program—Persons approved for coverage of one or more of the medications for ankylosing spondylitis, cancer, Crohn’s disease, diabetes, multiple sclerosis, pulmonary hypertension, psoriatic arthritis rheumatoid arthritis, and wet age-related macular degeneration included in the program; coverage must be applied for on an annual basis</td>
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<td></td>
<td>• Institutional Pharmacy/Nursing Home Program—Residents in government manors or private nursing homes eligible for coverage under the Long-Term Care Subsidization Act</td>
<td></td>
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</table>

For all programs—Benefits are not covered if they are already available through a federal or territorial drug program, such as First Nations and Inuit Health and Veterans Affairs Canada. Residents with private or group insurance plans must submit claims to those plans first and will then be eligible for top-up benefits. The Pharmacare program is the insurer of last resort.
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<thead>
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<th>Eligibility</th>
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<td>• New Brunswick Drug Plan</td>
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<td>Residents who do not have existing drug coverage (through a private plan or a government program) or who have existing drug coverage that does not cover a specific drug that is included in the drug plan formulary or who have reached their yearly or lifetime maximum for drug coverage</td>
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<td>• Nutrition Services Program</td>
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<td>High-risk pregnant women diagnosed with a nutritional deficiency; or low-income pregnant women who are receiving Financial Assistance or determined to be in need of financial assistance by a community nutritionist</td>
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<td>• Phenylketonuria (PKU) Program</td>
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<tr>
<td>Persons diagnosed with phenylketonuria</td>
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<tr>
<td>• Catastrophic Drug Program</td>
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<td>Permanent residents of PEI, with valid PEI Health card and with the financial burden of eligible high prescription drug costs</td>
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<td>• Rabies Program</td>
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<td>Persons with exposure to or at risk for exposure to rabies through an animal bite</td>
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<td>• Seniors Drug Cost Assistance Plan</td>
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<td>Persons age 65 or older</td>
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<tr>
<td>• Transplant Drug Program</td>
<td></td>
<td></td>
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<tr>
<td>Persons who have had an organ or bone marrow transplant</td>
<td></td>
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<tr>
<td>• Rheumatic Fever Program</td>
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<tr>
<td>Persons who have a well-documented history of rheumatic fever or rheumatic heart disease</td>
<td></td>
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</tr>
<tr>
<td>• Sexually Transmitted Diseases (STD) Program/Opioid Replacement Therapy Program</td>
<td></td>
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</tr>
<tr>
<td>Persons diagnosed with a sexually transmitted disease or identified contacts of a person diagnosed with a sexually transmitted disease/persons approved for coverage through the provincial Methadone Maintenance Program</td>
<td></td>
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</tr>
<tr>
<td>Eligibility</td>
<td>N.B.</td>
<td>N.S.</td>
<td>P.E.I.</td>
<td>N.L.</td>
<td>Y.T.</td>
<td>Health Canada—FNIHB</td>
</tr>
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</tr>
<tr>
<td>General Beneficiary Information (cont'd)</td>
<td></td>
<td></td>
<td>• Children in Care/Financial Assistance Program—Persons eligible under the <em>Social Assistance Act</em> and persons in the temporary or permanent care of the director of child welfare</td>
<td></td>
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</tr>
<tr>
<td></td>
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<td></td>
<td>• Tuberculosis (TB) Drug Program—Patients must have a diagnosis of tuberculosis confirmed by the chief health officer of the Department of Health and Social Services</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Quit Smoking Drug Program—Persons participating in the Smoking Cessation program through Addiction Services</td>
<td></td>
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<td></td>
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<td></td>
<td>• Home Oxygen Program—Persons prescribed oxygen by a specialist and who meet clinical criteria</td>
<td></td>
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</tr>
</tbody>
</table>
### Eligibility

**Income Range**

(Completed only if actual dollar amounts are known)

**Seniors Program**—For those not receiving the GIS:
- Single with an annual income of $17,198 or less;
- Senior couple (both age 65 or older) with a combined annual income of $26,955 or less; or
- Senior couple with one spouse younger than 65 with a combined annual income of $32,390 or less

**Drug Assistance for Cancer Patients**—Gross family income no greater than $15,720

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>N.B.</th>
<th>N.S.</th>
<th>P.E.I.</th>
<th>N.L.</th>
<th>Y.T.</th>
<th>Health Canada—FNIHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seniors Program</td>
<td></td>
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<tr>
<td>Drug Assistance for Cancer Patients</td>
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</tbody>
</table>

### Family Health Benefit Program

**Number of Children**

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Net Annual Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt;$24,800</td>
</tr>
<tr>
<td>2</td>
<td>&lt;$27,800</td>
</tr>
<tr>
<td>3</td>
<td>&lt;$30,800</td>
</tr>
<tr>
<td>4</td>
<td>&lt;$33,800</td>
</tr>
<tr>
<td>More Than 4</td>
<td>Add $3,000 per additional child</td>
</tr>
</tbody>
</table>

### Catastrophic Drug Program

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

<table>
<thead>
<tr>
<th>Total Household Income Ranges</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0–&lt;$20,000</td>
<td>3%</td>
</tr>
<tr>
<td>&gt;$20,000–$50,000</td>
<td>5%</td>
</tr>
<tr>
<td>&gt;$50,000–$100,000</td>
<td>8%</td>
</tr>
<tr>
<td>&gt;$100,000</td>
<td>12%</td>
</tr>
</tbody>
</table>

### The Access Plan

- Families with children, including single parents: net annual incomes of $42,870 or less
- Couples without children with net annual incomes of $30,009 or less
- Single individuals with net annual incomes of $27,151 or less

### The Assurance Plan

- Maximum out of pocket is based on the following net income ranges:
  - Up to $39,999
  - $40,000 to $74,999
  - $75,000 to $149,999

Family income and family size are used to determine deductibles for the Chronic Disease and the Children’s Drug and Optical programs; the table for Children’s Drug and Optical indicates income ranges that would not be eligible for the program.

<table>
<thead>
<tr>
<th>Family Income and Family Size are Used to Determine Deductibles for the Chronic Disease and the Children's Drug and Optical Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

---

**N.B.**

**N.S.**

**P.E.I.**

**N.L.**

**Y.T.**
<table>
<thead>
<tr>
<th>Eligibility</th>
<th>N.B.</th>
<th>N.S.</th>
<th>P.E.I.</th>
<th>N.L.</th>
<th>Y.T.</th>
<th>Health Canada—FNHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Eligibility Criteria or Comments</td>
<td>New Brunswick Drug Plan—Children age 18 and younger do not pay premiums; however, a parent must be enrolled in the plan to be eligible for coverage.</td>
<td>Family Pharmacare Program and Nova Scotia Diabetes Assistance Program—Residents must agree to provide family size information and annual family income verification through Canada Revenue Agency (CRA)</td>
<td>Nova Scotia Diabetes Assistance Program—The enrolment under this program ceased March 31, 2010. New patients can choose to register in the Family Pharmacare Program.</td>
<td>Abortion from the territory for more than 183 consecutive days (6 months) results in suspension of drug and benefit cost reimbursement starting the date of departure. A 1-month extension will be considered on application to the director of health care insurance where Yukon is the location of the applicant’s only principal residence. On return to the territory, the resident may reapply for coverage under the respective program.</td>
<td>Recipients with chronic renal failure are eligible to receive a list of supplemental benefits that are not included on the NIHB Drug Benefit List. New patients requiring drugs on the special formulary will be identified for coverage through the usual prior approval process. Once the patient has been confirmed as eligible, coverage will automatically be extended to all drugs in the special formulary for as long as needed.</td>
<td>Recipients who are diagnosed with a terminal illness and are near the end of life will be eligible to receive a list of supplemental benefits that are not included in the NIHB Drug Benefit List.</td>
</tr>
<tr>
<td>Sources</td>
<td>For more information: New Brunswick Prescription Drug Program and New Brunswick Drug Plan</td>
<td>For more information: Nova Scotia Pharmacare Drug Programs and Funding</td>
<td>For more information: Prince Edward Island Drug Programs</td>
<td>For more information: Newfoundland and Labrador Prescription Drug Program</td>
<td>For more information: Yukon Health and Social Services</td>
<td>For more information: Non-Insured Health Benefits</td>
</tr>
</tbody>
</table>

Back to Top
Cost-Sharing Mechanism (British Columbia, Alberta, Saskatchewan, Manitoba and Ontario)

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Copayment/Co-Insurance</strong></td>
<td></td>
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<tr>
<td>- Fair PharmaCare—After annual deductible has been met, 30% of the eligible prescription drug costs up to the annual maximum</td>
<td></td>
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<tr>
<td>- Fair PharmaCare Enhanced Assistance—After annual deductible has been met, 25% of the eligible prescription drug costs up to the annual maximum</td>
<td></td>
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</tr>
<tr>
<td>- “Full Payment” (no copayment) Policy—As of October 15, 2010, if a patient is receiving full PharmaCare coverage, a pharmacy will not be permitted to collect directly from that patient any amount above the maximum drug price and maximum dispensing fee set by PharmaCare. This will apply to patients covered under plans B, C, D, F, G and P and those who have reached the Fair PharmaCare family maximum</td>
<td></td>
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</tr>
<tr>
<td>- Seniors, Widows, Palliative and Non-Group drug plans are all subject to a 30% per prescription, to a maximum $25, copay.</td>
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</tr>
<tr>
<td>- Special Support Program—The copayment is determined by the amount that the family drug costs exceed 3.4% of the adjusted combined family income. The family pays a portion of each prescription to reduce its share of drug costs and spread the cost over the 6-month benefit period.</td>
<td></td>
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</tr>
<tr>
<td>- Seniors Drug Plan—Up to $20 per benefit prescription; no charge for seniors who have SAIL or Palliative Care coverage</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>- Seniors Income Plan Supplement or GIS Recipients—After deductible is met, 35% copayment, may apply for income-tested coverage</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Family Health Benefits—After deductible is met, 35%; however no copay on benefits for children younger than 18 years</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>- Supplementary Health Program</td>
<td>Under 18—None</td>
<td></td>
<td></td>
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<tr>
<td>- Plan One—Adults maximum $2 per benefit prescription</td>
<td></td>
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</tr>
<tr>
<td>- ODB recipients pay up to $2 per prescription if</td>
<td>All of the above:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- A senior single person with an annual net income of less than $16,018;</td>
<td></td>
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</tr>
<tr>
<td>- A senior couple with a combined annual net income of less than $24,175;</td>
<td></td>
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<tr>
<td>- Receiving benefits under the Ontario Works Act or the Ontario Disability Support Program Act;</td>
<td></td>
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<tr>
<td>- Receiving professional services under the Home Care Program;</td>
<td></td>
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<tr>
<td>- Residents of long-term care facilities and homes for special care; or</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- ODB recipients pay up to $6.11 toward the ODB dispensing fee per prescription if:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- A senior single person with an annual net income equal to or greater than $16,018; or</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- A senior couple with a combined annual net income equal to or greater than $24,175</td>
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</tr>
<tr>
<td><strong>Copayment/Co-Insurance (cont’d)</strong></td>
<td></td>
<td></td>
<td>Plan Two—May be eligible for prescriptions at no charge</td>
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<td></td>
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<td></td>
<td>Plan Three—None</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Children’s Drug Plan—Up to $20 per benefit prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fair PharmaCare</td>
<td></td>
<td></td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Net Family Income</strong></td>
<td>Approximate Deductible</td>
<td></td>
<td>Pharmacare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(as a percentage of net income)</td>
<td></td>
<td>• Annual threshold based on total adjusted family income</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Minimum deductible is $100.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$15,000</td>
<td>0%</td>
<td></td>
<td>Deductible rates for adjusted family incomes for 2014–2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$15,000–$30,000</td>
<td>2%</td>
<td></td>
<td>Lower Limit</td>
<td>Upper Limit</td>
<td>Deductible</td>
</tr>
<tr>
<td>&gt;$30,000</td>
<td>3%</td>
<td></td>
<td>≤$15,000</td>
<td>≤$21,000</td>
<td>2.91%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$15,000</td>
<td>≤$22,000</td>
<td>4.14%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$21,000</td>
<td>≤$23,000</td>
<td>4.18%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$22,000</td>
<td>≤$24,000</td>
<td>4.26%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$23,000</td>
<td>≤$25,000</td>
<td>4.32%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$24,000</td>
<td>≤$26,000</td>
<td>4.36%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$25,000</td>
<td>≤$27,000</td>
<td>4.42%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$26,000</td>
<td>≤$28,000</td>
<td>4.47%</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>&gt;$27,000</td>
<td>≤$29,000</td>
<td>4.51%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$28,000</td>
<td>≤$40,000</td>
<td>4.58%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$29,000</td>
<td>≤$42,500</td>
<td>4.68%</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>&gt;$40,000</td>
<td>≤$45,000</td>
<td>5.19%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$42,500</td>
<td>≤$47,500</td>
<td>5.20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$45,000</td>
<td>≤$75,000</td>
<td>5.27%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;$75,000</td>
<td>—</td>
<td>6.00%</td>
</tr>
<tr>
<td>• GIS Recipients</td>
<td></td>
<td></td>
<td>Trillium Drug Program recipients pay up to $2 for each prescription.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• SIF Recipients</td>
<td></td>
<td></td>
<td>For a family registered for Fair PharmaCare whose income cannot be verified or for a person actively enrolled in the Medical Services Plan but not registered for Fair PharmaCare, the deductible is $10,000.</td>
<td></td>
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<tr>
<td>• Family Health Benefits</td>
<td></td>
<td></td>
<td>Deductibles may be reduced if eligible for additional drug coverage through the Special Support Program.</td>
<td></td>
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<td></td>
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<td></td>
<td>Manitoba Pediatric Insulin Pump Program: While the insulin pump is fully funded, supplies designated as benefits may be eligible for coverage under provincial drug programs,</td>
<td></td>
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</tr>
<tr>
<td>• ODB—$100 deductible</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Single seniors with annual income equal to or greater than $16,018, and</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Senior couples with a combined annual income equal to or greater than $24,175</td>
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<td></td>
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<td></td>
<td>Trillium Drug Program applicants must pay a quarterly or pro-rated deductible that is based on income.</td>
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</tbody>
</table>

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

No deductible is applied to the remaining plans/programs.
### Deductible (cont’d)

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Deductible (cont’d)</td>
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</tbody>
</table>

### Maximum Beneficiary Contribution

<table>
<thead>
<tr>
<th>Net Family Income</th>
<th>Approximate Maximum (as a percentage of net income)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$15,000</td>
<td>2%</td>
</tr>
<tr>
<td>$15,000–$30,000</td>
<td>3%</td>
</tr>
<tr>
<td>&gt;$30,000</td>
<td>4%</td>
</tr>
</tbody>
</table>

- **Fair PharmaCare**

- **Palliative**—The lifetime maximum amount paid out-of-pocket by eligible Albertans enrolled in the Program is $1,000.

- **Palliative**—The maximum beneficiary contribution is the calculated deductible. N/A

### Sources

- For more information: British Columbia PharmaCare
- For more information: Alberta Health
- For more information: Saskatchewan Health Drug Plan and Extended Benefits Branch
- For more information: Manitoba Health
- For more information: Ontario Drug Benefit Program
Cost-Sharing Mechanism (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Yukon and First Nations and Inuit Health Branch)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Premium</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Cystic Fibrosis, Multiple Sclerosis, Organ Transplant, Human Growth Hormone Deficiency, HIV/AIDS— $50 per year for each plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Brunswick Drug Plan— Income-based premiums</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross Income (Individual)</td>
<td>Premiums</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Annual</td>
<td>Monthly</td>
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<tr>
<td>&lt;$26,360</td>
<td>$800</td>
<td>$67</td>
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<tr>
<td>$26,361–$50,000</td>
<td>$1,400</td>
<td>$117</td>
<td></td>
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<tr>
<td>$50,001–$75,000</td>
<td>$1,600</td>
<td>$133</td>
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<tr>
<td>&gt;$75,000</td>
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<td>Gross Income (Single With Children/ Couple Without Children)</td>
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<td>&lt;$49,389</td>
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<td>75,001–$100,000</td>
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<td>&gt;$100,000</td>
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Seniors Pharmacare— Maximum $424 year
- No Premium
  - Single and income < $18,000
  - Married and joint income < $21,000
- Reduced Premium
  - Single and income between $18,000 and $24,000
  - Married and joint income between $21,000 and $28,000

None
None
None
None

None
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<td>— GIS: $9.05 per prescription</td>
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<td>— Non-GIS: $15 per prescription</td>
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<td>— $4 per prescription</td>
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<td>Department of Social Development—Social Development Clients</td>
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<tr>
<td>— $4 per prescription for adults 18 and older</td>
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<td>— $2 per prescription for children younger than 18</td>
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<td>Multiple Sclerosis</td>
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<tr>
<td>— Income-tested annually</td>
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<td>Cystic Fibrosis, Organ Transplant, Human Growth Hormone Deficiency and HIV/AIDS</td>
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<tr>
<td>— 20% per prescription to a maximum of $20</td>
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<td>— 30% per prescription to a maximum of $30</td>
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<tr>
<td>Family Pharmacare</td>
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<tr>
<td>— 20% per prescription, with an annual maximum based on a sliding scale (percentage of adjusted family income)</td>
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<tr>
<td>Diabetes Assistance Program</td>
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<tr>
<td>— 20% per prescription</td>
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<td>Department of Community Services Pharmacare Benefits</td>
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<td>— $3 per prescription unless eligible for copayment exemption</td>
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<tr>
<td>Seniors’ Pharmacare</td>
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<tr>
<td>— 30% per prescription with an annual maximum</td>
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<tr>
<td>Insulin Pump Program</td>
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</tr>
<tr>
<td>Calculated based on family income and dependents</td>
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<tr>
<td>Diabetes</td>
<td></td>
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<tr>
<td>— Insulin: $10 per 10 mL or box of 1.5 mL cartridges or $20 per box of 3 mL cartridges</td>
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<tr>
<td>— Blood glucose test strips: $11 per prescription to a maximum of 100 strips every 30 days</td>
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<td>— Oral medications and urine testing materials: $11 per prescription</td>
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<tr>
<td>— High-cost diabetes medications: an income-based portion of the drug cost plus the professional fee</td>
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<tr>
<td>Family Health Benefit Program</td>
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<td></td>
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<tr>
<td>— Professional fee for each prescription</td>
<td></td>
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<tr>
<td>High-Cost Drug Program</td>
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<tr>
<td>— Income-based portion of the drug plus the professional fee for each prescription</td>
<td></td>
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</tr>
<tr>
<td>Seniors Drug Cost Assistance Plan</td>
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<td></td>
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<tr>
<td>— First $8.25 of the medication cost plus the professional fee for each prescription</td>
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<tr>
<td>Quit Smoking Program</td>
<td></td>
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<tr>
<td>— Patients are responsible for all medication costs approved, except for the first $75 per year, which will be paid by the program</td>
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<tr>
<th>Families (With Children)</th>
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<tbody>
<tr>
<td>Income</td>
<td>Copay</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>&lt;$30,009</td>
<td>20.0%</td>
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<tr>
<td>$31,000</td>
<td>23.9%</td>
<td></td>
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<td>$32,000</td>
<td>27.7%</td>
<td></td>
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<tr>
<td>$33,000</td>
<td>31.6%</td>
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<tr>
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<td>35.5%</td>
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<tr>
<td>$35,000</td>
<td>39.4%</td>
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<td>$36,000</td>
<td>43.3%</td>
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<td>$37,000</td>
<td>47.2%</td>
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<td>$38,000</td>
<td>51.1%</td>
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<tr>
<td>$39,000</td>
<td>55.0%</td>
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<tr>
<td>$40,000</td>
<td>58.8%</td>
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<tr>
<td>$41,000</td>
<td>62.7%</td>
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<tr>
<td>$42,000</td>
<td>66.6%</td>
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<tr>
<td>$42,870</td>
<td>70.0%</td>
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<table>
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<tr>
<th>Couples (With No Children)</th>
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<tbody>
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<td>Income</td>
<td>Copay</td>
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<tr>
<td>&lt;$21,435</td>
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<td>$22,000</td>
<td>23.3%</td>
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<tr>
<td>$23,000</td>
<td>26.1%</td>
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<tr>
<td>$24,000</td>
<td>30.0%</td>
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<tr>
<td>$25,000</td>
<td>40.8%</td>
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<tr>
<td>$26,000</td>
<td>46.6%</td>
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<tr>
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<td>32.4%</td>
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<tr>
<td>$28,000</td>
<td>58.3%</td>
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<tr>
<td>$29,000</td>
<td>61.1%</td>
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<td>65.9%</td>
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<tr>
<td>$30,009</td>
<td>70.0%</td>
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## Cost-Sharing Mechanism

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<tr>
<td><strong>Single Individuals</strong></td>
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<tr>
<td>Income</td>
<td>Copay</td>
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<tr>
<td>&lt;$18,577</td>
<td>20.0%</td>
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<tr>
<td>$19,000</td>
<td>22.5%</td>
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<tr>
<td>$20,000</td>
<td>28.3%</td>
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<tr>
<td>$21,000</td>
<td>34.1%</td>
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<tr>
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<td>40.5%</td>
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<td>45.8%</td>
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<tr>
<td>$25,000</td>
<td>57.5%</td>
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<td>$26,000</td>
<td>63.3%</td>
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<tr>
<td>$27,000</td>
<td>69.1%</td>
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<td>$27,151</td>
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### Deductible

- **Family Pharmacare**—Annual family deductible is a sliding scale percentage based on adjusted family income
- **Diabetes Assistance**—Percentage based on adjusted family income
- **Catastrophic Drug Program**

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<tr>
<th>Total Household Income Ranges</th>
<th>Rate</th>
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<tbody>
<tr>
<td>$0–$20,000</td>
<td>3%</td>
</tr>
<tr>
<td>&gt;$20,000–$50,000</td>
<td>5%</td>
</tr>
<tr>
<td>&gt;$50,000–$100,000</td>
<td>8%</td>
</tr>
<tr>
<td>&gt;$100,000</td>
<td>12%</td>
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</tbody>
</table>

- **Children’s Drug and Optical Program**—$250 per child per year
  - May be waived or reduced depending on income
- **Chronic Disease Program**—$250 per person per year
  - May be waived for palliative care recipients
  - May be waived or reduced depending on income
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<tbody>
<tr>
<td><strong>Maximum Beneficiary Contribution</strong></td>
<td>• Seniors Receiving GIS: $500 per calendar year</td>
<td>• Cystic Fibrosis, Organ Transplant, Human Growth Hormone Deficiency and HIV/AIDS: $500 maximum copayment + premium per family unit per fiscal year</td>
<td>• Department of Social Development—Adults in Licensed Residential Facilities: $250 per person in a fiscal year</td>
<td>• Department of Social Development—Social Development Clients: $250 per family unit in a fiscal year</td>
<td>• Family Pharmacare: Annual family copayment plus deductible based on income</td>
<td>•Seniors Pharmacare: Annual maximum copayment $382 + premium</td>
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<tr>
<td></td>
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<td></td>
<td>The maximum beneficiary contribution is the calculated deductible.</td>
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<td><strong>Assurance Plan based on net income:</strong></td>
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<td></td>
<td>Net Income</td>
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<td></td>
<td></td>
<td></td>
<td>Up to $39,999</td>
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<td></td>
<td>$40,000 to $74,999</td>
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<td></td>
<td>$75,000 to $149,999</td>
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<td>For example, family income of $35,000 with annual drug costs of $6,000. This income requires a maximum contribution per year of 5% of the family’s income, which is $1,750 (5% × $35,000) towards the annual drug costs of $6,000. The program will use the following calculation to determine copay: (35,000 × 5%) / $6,000 = 29.17% Each time a prescription for an eligible benefit is filled, the family will pay 29.17% of the total cost of the prescription.</td>
</tr>
<tr>
<td>Sources</td>
<td>For more information: New Brunswick Prescription Drug Program and New Brunswick Drug Plan</td>
<td>For more information: Nova Scotia Pharmacare Drug Programs and Funding</td>
<td>For more information: Prince Edward Island Drug Programs</td>
<td>For more information: Newfoundland and Labrador Prescription Drug Program</td>
<td>For more information: Yukon Health and Social Services</td>
<td>For more information: Non-Insured Health Benefits</td>
</tr>
</tbody>
</table>
Policy-Related Information (British Columbia, Alberta, Saskatchewan, Manitoba and Ontario)

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<tbody>
<tr>
<td><strong>Ingredient Price</strong></td>
<td><strong>Maximum Pricing</strong>—Drugs are reimbursed to a maximum price based on the manufacturer’s list price plus 8% (5% for high-cost drugs).</td>
<td><strong>Least-Cost Alternative (LCA)</strong>—The LCA price is the lowest unit cost established for a drug product within a set of interchangeable drug products.</td>
<td><strong>Low-Cost Alternative (LCA)</strong>—Benefits are based on the lowest-priced interchangeable brand as listed in the formulary.</td>
<td><strong>Lowest Cost Pricing</strong>—Benefits are based on the lowest-priced interchangeable brand as listed in the formulary.</td>
<td><strong>Drug Benefit Price (DBP)</strong>—The DBP for a drug in a particular dosage form and strength reflects the amount, calculated per gram, millilitre, tablet, capsule or other appropriate unit, for which a listed drug product in that dosage form and strength will be reimbursed by the ministry.</td>
</tr>
<tr>
<td></td>
<td><strong>Low-Cost Alternative (LCA)</strong> Program—LCA prices are set at the maximum accepted list price for generic drugs in an LCA category plus 8% (5% for high-cost drugs).</td>
<td><strong>Maximum Allowable Cost (MAC)</strong>—The MAC price is the maximum unit cost established for a specific drug product or group of drug products.</td>
<td><strong>Maximum Allowable Cost (MAC)</strong>—Maximum price that the drug plan will cover for similar drugs used to treat the same condition.</td>
<td><strong>Drug Benefit Price (DBP)</strong> for a drug in a particular dosage form and strength reflects the amount, calculated per gram, millilitre, tablet, capsule or other appropriate unit, for which a listed drug product in that dosage form and strength will be reimbursed by the ministry.</td>
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<td><strong>Reference Drug Program</strong>—Limits reimbursement for certain drugs in designated therapeutic categories to a maximum daily amount payable.</td>
<td><strong>Manufacturer’s List Price (MLP)</strong>—The price per unit of drug, drug product or product that is published in the Alberta Drug Benefit List (ADBL). Prices in the ADBL include a wholesaler markup of up to 7.5% if the manufacturer distributes the drug through a wholesaler. This includes both single-source and interchangeable products.</td>
<td><strong>Actual Acquisition Cost (AAC)</strong>—Ingredient cost, unless otherwise determined (i.e., LCA, MAC), is based on the actual cost of the material of a drug product, including any discounts received toward a product purchased.</td>
<td><strong>Drug Benefit Price (DBP)</strong> for a drug in a particular dosage form and strength reflects the amount, calculated per gram, millilitre, tablet, capsule or other appropriate unit, for which a listed drug product in that dosage form and strength will be reimbursed by the ministry.</td>
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<td><strong>Retail Price</strong>—Certain products such as insulin, insulin needles and syringes, insulin pump supplies and ostomy supplies are reimbursed at the regular retail price.</td>
<td><strong>Fixed Pricing Rules</strong> A tiered pricing system is introduced for entry IC (interchangeable) drugs based on the number of products in its new IC grouping.</td>
<td><strong>Actual Acquisition Cost (AAC)</strong>—Ingredient cost, unless otherwise determined (i.e., LCA, MAC), is based on the actual cost of the material of a drug product, including any discounts received toward a product purchased.</td>
<td><strong>Drug Benefit Price (DBP)</strong> for a drug in a particular dosage form and strength reflects the amount, calculated per gram, millilitre, tablet, capsule or other appropriate unit, for which a listed drug product in that dosage form and strength will be reimbursed by the ministry.</td>
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<td><strong>Actual Acquisition Cost (AAC)</strong>—Certain products (such as blood glucose test strips) are reimbursed at their AAC, not to exceed the manufacturer’s list price plus a 7% markup.</td>
<td>For an IC drug listed or under consideration for listing in an established IC grouping, the fixed price must be the lowest of:</td>
<td><strong>Brand-name manufacturers complete a price quotation process and are required to guarantee the prices of their listed products during the fiscal year (April to March).</strong></td>
<td><strong>Drug Benefit Price (DBP)</strong> for a drug in a particular dosage form and strength reflects the amount, calculated per gram, millilitre, tablet, capsule or other appropriate unit, for which a listed drug product in that dosage form and strength will be reimbursed by the ministry.</td>
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<td><strong>Least-Cost Alternative (LCA)</strong>—Benefits are based on the lowest-priced interchangeable brand as listed in the formulary.</td>
<td>• The lowest published price in Canada;</td>
<td><strong>Drug Benefit Price (DBP)</strong> for a drug in a particular dosage form and strength reflects the amount, calculated per gram, millilitre, tablet, capsule or other appropriate unit, for which a listed drug product in that dosage form and strength will be reimbursed by the ministry.</td>
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<td><strong>Low-Cost Alternative (LCA)</strong> Program—LCA prices are set at the maximum accepted list price for generic drugs in an LCA category plus 8% (5% for high-cost drugs).</td>
<td>• The LCA (where the LCA price policy applies) or the submitted price (where the LCA price policy does not apply); or</td>
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<td><strong>Maximum Allowable Cost (MAC)</strong>—The MAC price is the maximum unit cost established for a specific drug product or group of drug products.</td>
<td>• The most recent ADBL list price.</td>
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<td><strong>Manufacturer’s List Price (MLP)</strong>—The price per unit of drug, drug product or product that is published in the Alberta Drug Benefit List (ADBL). Prices in the ADBL include a wholesaler markup of up to 7.5% if the manufacturer distributes the drug through a wholesaler. This includes both single-source and interchangeable products.</td>
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<td>Ingredient Price (cont’d)</td>
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<td>Non-Fixed Pricing Rules</td>
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<td>Confirmed price for a brand-name drug or other drug must be the lowest of</td>
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<td>• The price less than or equal to the previous price of that drug product listed on the most recent ADBL (may include an increase that is less than or equal to the annual average percentage change from the previous year of the Consumer Price Index of Canada); or</td>
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<td>• The submitted price where that drug product was not previously listed on the ADBL.</td>
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<tr>
<td>Non–Oral Solid Dosage Form Drug Pricing Rules</td>
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<td>Confirmed price for brand-name or IC or other drug must be lowest of</td>
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<td>• The lowest published price in Canada;</td>
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<td>• The submitted price;</td>
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<td>• The LCA price (if applicable); or</td>
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<td>• The most recent ADBL list price.</td>
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<td>Transitional Period Price Policy</td>
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<td>The minister may establish a transitional period of up to 30 days to provide for a temporary benefit or payment for a drug product under defined circumstances</td>
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<td>(percentage of brand-name drug)</td>
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<td>Effective April 1, 2014, generic drugs are priced as follows:</td>
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<td>• Oral solid products—20% of the equivalent brand-name product’s list price.</td>
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<td>• All other forms—35% of the equivalent brand-name product’s list price.</td>
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<td>Effective May 1, 2013, all generic drugs are priced at 18% of the brand-name price.</td>
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<td>Price policy applies to both public and private plans.</td>
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<td>All generics as of April 1, 2012—35%</td>
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<td>Price policy applies to both public and private sectors.</td>
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<td>All generics as of April 1, 2012—25%</td>
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<td>Price policy applies to both public and private sectors.</td>
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<tr>
<td><strong>Dispensing Fee:</strong></td>
<td>$10.05, maximum</td>
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<td><strong>Methadone Maintenance Program:</strong></td>
<td>Effective February 1, 2014, pharmacists are reimbursed for methadone for maintenance at</td>
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<td>Maximum of $0.162/mL; plus</td>
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<td>The usual dispensing fee; plus</td>
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<td></td>
<td>An interaction fee of $7.70 for each dispensation involving direct interaction with the patient.</td>
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<td><strong>Frequency of Dispensing Policy:</strong></td>
<td>For drugs dispensed in less than a 28-day supply:</td>
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<td>Maximum of 3 dispensing fees per patient per day.</td>
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<td>Maximum of 5 dispensing fees per patient for drugs dispensed in 2- to 27-day supplies.</td>
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<td><strong>Medication Assessment Fees:</strong></td>
<td>Trial Prescription: $20</td>
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<td></td>
<td>Refusal to Fill: $20</td>
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<td>Administration injected medication: $20</td>
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<td>Prescription Adaptation: $20</td>
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<td>Prescription Renewal: $20</td>
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<td>Medication Related Emergency: $20</td>
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<tr>
<td><strong>Initiating Medication Therapy:</strong></td>
<td>$25</td>
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<tr>
<td><strong>Compounding Fee:</strong></td>
<td>An additional charge of up to 75 cents per each minute in excess of seven minutes.</td>
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<tr>
<td><strong>Medication Assessment Fees:</strong></td>
<td>Trial Prescription: $20</td>
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<td>Medication Related Emergency: $20</td>
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<tr>
<td><strong>Initiating Medication Therapy:</strong></td>
<td>$25</td>
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Capitation Fee

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

Rural Incentive Program—

A per-claim subsidy ($3 to $10.50) to rural pharmacies with monthly claims volumes of less than 1,700.

Vaccination administration—

$10 for each publicly funded vaccination provided.

Compounded Prescriptions: Flat fee maximum per type of compound

- Oral solutions—$20
- Oral suspensions—$20
- Capsules—$0.30 per capsule
- Suppositories—$40
- Oral lozenges—$40
- CADD injections—$20
- Sterile IV, IM, SC injections—$20

Dispensing Fee: Effective April 1, 2014, to March 31, 2018: $12.30 for all drug products except compounds and diabetic supplies.

Compounding Fee—An additional charge of up to 75 cents per each minute in excess of seven minutes.

Medication Assessment Fees:

- Trial Prescription: $20
- Refusal to Fill: $20
- Administration injected medication: $20
- Prescription Adaptation: $20
- Prescription Renewal: $20
- Medication Related Emergency: $20
- Initiating Medication Therapy: $25

Dispensing Fee: Effective April 1, 2014, the maximum dispensing fee is $11.25.

- Trial Prescriptions—Specific list of drugs; trial for 7 or 10 days; follow-up by pharmacist required; the usual and customary professional fee (to a maximum of $11.25) is paid for the trial quantity; if the medication is continued, no fee may be claimed on the “remainder” prescription, but an alternative reimbursement fee of $7.50 is paid, even if the balance of the prescription is not dispensed; subsequent refills are subject to usual reimbursement.
- Methadone—Methadone fee is $3.50 per day ($24.50 per week) and is paid only for face-to-face interactions with the pharmacist.
- Compliance Packaging—$6.25 for each 7-day supply ($25 for a 28-day supply or $31.25 for a 35-day supply).
- Extemporaneous Compounding Fee—$0.75/minute to a maximum of 60 minutes; maximum of 20 minutes applies to most methadone compounds.
- Urine-Testing Agents—No fee allowed.
- Saskatchewan Insulin Pump Program—No fee allowed.

CeRx integration supplement increases from 10 cents to 20 cents per prescription for integrated pharmacies until March 31, 2015.

Dispensing Fee: Effective April 1, 2014, the dispensing fee is between $8.83 and $13.25.

Dispensing fees are set at a maximum of 2 fees per medication per patient per month; exceptions are for patients in long-term care homes and/or drugs in exemption medication list.

The monthly capitation fee—

For personal care homes: $37.50 per bed per month for Winnipeg and $38.20 per bed per month for rural areas.

The employment and income assistance program has a maximum professional fee of $6.95.

Dispensing Fee: Effective April 1, 2014, the dispensing fee is between $8.83 and $13.25.

Dispensing fees are set at a maximum of 2 fees per medication per patient per month; exceptions are for patients in long-term care homes and/or drugs in exemption medication list.
### Professional Fees—Product-Related Fees/Services (cont’d)

- Intrathecal injections—$40
- Creams/ointments/lotions less than or equal to 250 gm/mL—$15
- Creams/ointments/lotions greater than or equal to 251 gm/mL—$20
- Sterile eye drops, preservative-free—$30

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

### Professional Fees—Clinical Services

- **Clinical Pharmacy Services Fees:**
  - Prescription renewal: $10
  - Prescription change: $10
  - Therapeutic substitution: $17.20

  Maximum two clinical services fees per drug, per person during a 6-month period.

- **Medication Review Services:**
  - Standard ($60)
  - Pharmacist Consultation ($70)
  - Follow-Up ($15)—maximum 4 per year
  - 1 Standard or 1 Pharmacist Consultation fee per 6 months
  - Recipients who have at least 5 different qualifying medications that have been entered into PharmaNet within the last 6 months and have a clinical need for service

- **Special Services Fee:**
  - Refusal to Fill—up to twice the maximum dispensing fee

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

  **Group A (Chronic Disease):** Hypertensive disease, diabetes, COPD, asthma, HF, IHD and mental health disorder.

  **Group B (Risk Factors):** Tobacco, obesity and addiction.

- **Emergency Contraception Prescribing:** Prescribing fee equal to 2 times the usual dispensing fee above and beyond the cost for dispensed product.

- **Refusal to Dispense—Specific list of drugs; may charge 1.5 times the pharmacy’s usual and customary dispensing fee.

- **Seamless Care Fee—Medication reconciliation for clients transferred from an institution to a community setting; 1.5 times the pharmacy’s usual and customary dispensing fee.

- **Medication Assessment—Maximum $60 once per calendar year.

- **Patient Assessments (maximum amount per 28 days per patient):**
  - Continuing Existing Prescription: $6—maximum 4
  - Insufficient Information: $6—maximum 1
  - Continuing Existing Prescription: $10—maximum 1
  - Continuing Drug Reconciliation: $25—maximum 1

  Effective February 1, 2012, a patient assessment fee of $18.00 will be paid where an assessment results in a pharmacist prescribing an eligible prescription medication.

- **MedsCheck Program—** Residents eligible to receive an annual review and follow-up reviews:
  - Taking 3 or more prescriptions for a chronic condition; or
  - Living in a licensed long-term care home; or
  - Diagnosed with type 1 or 2 diabetes and taking medication; or
  - Eligible for MedsCheck but are home-bound and not able to attend their community pharmacy for the service.

  **MedsCheck Program Fees:**
  - $60/MedsCheck
  - $25/follow-up
  - $75/MC Diabetes and $25/follow-up
  - $150/MC at Home
  - $90/initial consultation for MC LTC and $50/quarterly review

- **Smoking Cessation Program Fee:**
  - $40 for first consultation (once per year)
  - $15 for primary follow-up counselling sessions (3 times per year = $45 total)
### Policy-Related Information

**Professional Fees—Clinical Services (cont’d)**

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<td>CACP Fees:</td>
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<td>$10 for secondary follow-up counselling sessions (4 times per year = $40 total)</td>
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<td>• $100/medication review and $20/follow-up</td>
<td>• $125/medication review and $25/follow-up, if pharmacist has prescribing authority</td>
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<td>Standard Medication Management Assessment (SMMA):</td>
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<td>Patients who do not meet the CACP criteria. Patients must have one chronic condition and be taking at least 4 different Schedule 1 medications or insulin (different strengths or forms of the same drug do not count). Medication review can be done once per year.</td>
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<td>• Follow-ups can be to update the SMMA and Best Possible Medication History (BPMH) if substantiated by a referral from a physician, a hospital admission or discharge within 14 calendar days, or a pharmacist's documented decision.</td>
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<td>SMMA Fees:</td>
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<td>• $60/medication review and $20/follow-up</td>
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<td>• $75/medication review and $25/follow-up if pharmacist has prescribing authority</td>
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<td>Pharmacy Markup</td>
<td>Most drugs maximum 8%.</td>
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<td>• High cost drugs maximum 5%.</td>
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<td>• Products subject to AAC pricing maximum 7%.</td>
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<td>* High-cost drugs are defined as those for which the expected daily cost of the typical dose is equal to or greater than $40 ($14,600 annual cost).</td>
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<td>Effective April 1, 2014:</td>
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<td>Year: April</td>
<td>Allowable Upcharge #1</td>
<td>Allowable Upcharge #2</td>
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<td>2014</td>
<td>3%</td>
<td>5.5%</td>
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<td>2015</td>
<td>3%</td>
<td>6%</td>
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<td>2016</td>
<td>3%</td>
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<tr>
<td>2017</td>
<td>3%</td>
<td>7%</td>
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<td>Maximum markup allowance calculated on the prescription drug cost:</td>
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<td>Drug Cost</td>
<td>Markup</td>
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<td>$0.01–$6.30</td>
<td>30%</td>
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<td>$6.31–$15.80</td>
<td>15%</td>
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<td>$15.81–$200</td>
<td>10%</td>
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<td>&gt;$200.01</td>
<td>$20 max</td>
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<td>Urine-Testing Agents—Markup as above plus 50%.</td>
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<tr>
<td>Saskatchewan Insulin Pump Program—No markup allowed.</td>
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<tr>
<td><strong>Coordination of Benefits (Public/Private)</strong></td>
<td>PharmaCare does not provide coverage for B.C. residents covered by Veterans Affairs Canada, Canadian Forces, Workers’ Compensation or the Federal Non-Insured Health Benefits Program. PharmaCare is considered the first payer and private insurance is the second payer.</td>
<td>Alberta Health allows coordination of benefits between its Alberta Blue Cross non-group plans and private plans. The payment is shared pursuant to the Canadian Life and Health Insurance Association rules regarding coordination of benefits.</td>
<td>The drug plan is the first payer on eligible claims for eligible beneficiaries.</td>
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</table>

| **Restricted/Exception Drug Coverage Process** | Special authority forms are completed by practitioners and evaluated on an individual basis, according to established criteria. Retroactive coverage is not provided. | Prior approval must be granted by Alberta Blue Cross to ensure coverage by special authorization. For those special authorization requests that are approved, the effective date for authorization is the beginning of the month in which the physician’s request is received by Alberta Blue Cross. Special authorization is granted for a defined period, as indicated in each applicable special authorization drug product criteria (the “approval period”). If continued treatment is necessary beyond the approval period, it is the responsibility of the patient and physician to re-apply for coverage prior to the expiration date of the approval period, unless the Auto-Renewal Process or Step Therapy Approval Process applies. | Eligible prescribers, authorized office staff or pharmacists may apply for Exception Drug Status (EDS) on behalf of a patient. Patients are notified of approvals while both the patient and the prescriber are notified of denials. For pharmacist-initiated requests, the diagnosis, obtained from the physician, is to be documented consistently within the pharmacy. | The prescriber must contact Manitoba Health to request eligibility for prescription; eligibility is from date of approval. | | A physician must send a written request to the Drug Programs Branch, which obtains a recommendation from the Committee to Evaluate Drugs (CED). Decisions on requests are communicated to the physician making the request. If coverage is approved, the physician may provide a copy of the approval notice for the patient to take to the pharmacy. Telephone Request Service (TRS) is available for select drugs and assessed in real time. |

| **Reimbursement Policy** | The province does not reimburse for most out-of-province claims. | When beneficiaries pay out of pocket, reimbursement claims are permitted. Claims from out of province and out of country are permitted, but coverage is restricted to comparable benefits on the Alberta Health Drug Benefit List at the time of service and received within 12 months of the service date. | Beneficiaries can submit claims if they have had to pay out of pocket for various reasons (system down, EDS coverage not in place at time of dispensing, etc.). Beneficiaries who are temporarily out of province are eligible for drug benefits, in accordance with their coverage level and Saskatchewan drug prices, upon submission of original receipts to the drug plan. | The original receipts for prescriptions purchased in another province or territory of Canada can be submitted to the drug plan for reimbursement, up to a maximum amount that is considered reasonable by the minister. | | Claims can be reimbursed only for eligible drugs, when written by a physician licensed in Ontario and dispensed in Ontario. |
### Miscellaneous

#### Prescription Quantities

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<thead>
<tr>
<th>Province</th>
<th>Information</th>
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<tbody>
<tr>
<td>B.C.</td>
<td>• PharmaCare limits coverage of all prescription drugs to a maximum 30-day supply (for short-term medications and first-time prescriptions for maintenance drugs) or a 100-day supply (for repeat prescriptions of maintenance drugs). Exemptions to the 30-day supply limit are available for: Plan B patients; Consumers in rural or remote areas; and Prescriptions under the Trial Prescription Program (where a 14-day trial has been dispensed).</td>
</tr>
<tr>
<td>Alta.</td>
<td>• The Seniors and Widows, Non-Group and Palliative programs. No limitation on the quantities of drugs that may be prescribed. In most cases, Alberta Health will not pay benefits for more than a 100-day supply of a drug at 1 time. Drugs considered maintenance or long-term therapy in the following therapeutic classes should be dispensed for 100 days: Anticoagulants Anticonvulsants Digitalis and digitalis glycosides Hypoglycemic agents Thyroid drugs Vitamins Oral contraceptives Antihypertensive agents Conjugated estrogens Anti-arthritics</td>
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<tr>
<td>Sask.</td>
<td>• With some exceptions, the drug plan places no limitation on the quantities of drugs that may be prescribed. Prescribers shall exercise their professional judgment in determining the course and duration of treatment for their patients. However, in most cases, the drug plan will not pay benefits or credit deductibles for more than a 3-month supply of a drug at 1 time. A pharmacist may charge one dispensing fee for each prescription for most drugs listed in the formulary. If a prescription is for the duration of 1 month or more, the pharmacist is entitled to charge a dispensing fee for each 34-day supply; however, the contract the drug plan has with pharmacies does not prohibit the pharmacist from dispensing more than a 34-day supply for 1 fee. The contract also contains a list of 2-month and 34-day supplies for 1 fee. The contract also contains a list of 2-month and 100-day supplies. Prescribing and dispensing should be in these quantities once the medical therapy of a patient is in the maintenance stage, unless there are unusual circumstances that require these quantities not to be dispensed. Wholesale markup is allowed on specific products: Insulin: 5% Standing offer contract (SOC) products: 6% Generic drugs: 6% Most other drugs: 8.5% Wholesale markup is capped at $50 per package size.</td>
</tr>
<tr>
<td>Man.</td>
<td>• In any 90-day period, no benefit is payable for more than the following number of days’ supply (number of days’ supply of a specified drug is equal to the quantity of the specified drug dispensed divided by the person’s daily dosage requirements for that drug) of a specified drug: 100; and Up to an additional 100, if: The prior approval of the minister has been obtained; and The person will be outside of Canada for more than 90 consecutive days.</td>
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<tr>
<td>Ont.</td>
<td>• The normal quantity dispensed shall be the entire quantity of the drug prescribed. The maximum quantity that may be charged under the ODB program must not exceed that required for a 100-day course of treatment. All new prescriptions for ODB recipients are subject to a 30-day maximum prescription limit if they have not been taken in the preceding 12 months. If the newly prescribed drug helps a patient after the initial 30-day supply and the patient is not having any problems with it, the remainder of the prescription can be dispensed up to the maximum 100-day supply. Some recipients are exempt from this program (i.e., travel out of province for extended periods, samples from physician, insulin prescriptions). For recipients covered under the Ontario Works Act, the maximum quantity of medication claimed under the ODB Program must not exceed that required for a 35-day course of treatment.</td>
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</table>

#### Travel Supply

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

#### Smoking Cessation

Pharm care covers prescribed smoking cessation drugs or a free supply of nicotine gum or patches up to 12 weeks per year to help quit tobacco use.
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<tbody>
<tr>
<td>Sources</td>
<td>For more information: British Columbia PharmaCare</td>
<td>For more information: Alberta Health</td>
<td>For more information: Saskatchewan Health Drug Plan and Extended Benefits Branch</td>
<td>For more information: Manitoba Health</td>
<td>For more information: Ontario Drug Benefit Program</td>
</tr>
</tbody>
</table>

Back to Top
Policy-Related Information (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Yukon and First Nations and Inuit Health Branch)

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<tr>
<td><strong>Ingredient Pricing Policy</strong></td>
<td>• Effective June 1, 2013, the drug cost for each eligible prescription is as below:</td>
<td>• Manufacturer’s List Price (MLP) is the published price at which a drug or device is sold to a provider or wholesaler and does not include any markup for distribution.</td>
<td>• Maximum Reimbursable Price (MRP)—The ingredient cost is based on the manufacturer’s net catalogue price of the lowest-priced product within an interchangeable category plus 6% to a maximum of $250 per prescription.</td>
<td>• Defined cost—The current published manufacturer’s list price plus 8.5%.</td>
<td>• Yukon Drug Programs formulary benefits will be based on the lowest-priced interchangeable brand available.</td>
<td>• Best Price (lowest cost) Alternative—A product in a group of interchangeable drug products. Provincial/territorial pharmacy legislation/policies are followed to identify interchangeable products and to select the lowest-priced brand. However, NIHB pays the amount identified on the price file. In general, the price is the same as the respective provincial formulary if listed; otherwise the price paid will be the price list of a national wholesaler. Exceptions may exist; contact NIHB for region-specific information.</td>
</tr>
<tr>
<td>Drug Category</td>
<td>Ingredient Cost</td>
<td>Drug Category</td>
<td>Ingredient Cost</td>
<td>Drug Category</td>
<td>Ingredient Cost</td>
<td>Drug Category</td>
</tr>
<tr>
<td>Interchangeable</td>
<td>MAP</td>
<td>Non-Interchangeable</td>
<td>MLP + up to 8%</td>
<td>Extemporaneous Preparations (Compounds)</td>
<td>AAC</td>
<td>Methadone Oral Solution</td>
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</tbody>
</table>

MAP: maximum allowable price
MLP: manufacturer’s list price
AAC: actual acquisition cost
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<tbody>
<tr>
<td><strong>Ingredient Pricing Policy (cont’d)</strong></td>
<td>• Actual acquisition cost (AAC) means the net cost to the provider after deducting all rebates, allowances, free products, etc.</td>
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<td>• Net cost is the drug ingredient (or supply) costs based on date of purchase. Incentives for prompt payment are not included in the calculation.</td>
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<td><strong>Generic Pricing Policy (percentage of brand-name drug)</strong></td>
<td>Effective June 1, 2013: 25% for solid oral dosage forms 35% for non-solid oral dosage forms</td>
<td>July 1, 2012: 35%</td>
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<td>June 1, 2013: 25%</td>
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<td>Price policy applies to both public and private sectors for interchangeable drugs.</td>
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<td><strong>Professional Fees—Product-Related Fees/Services</strong></td>
<td>Effective June 1, 2014:</td>
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<td></td>
<td>• Pharmaceutical equivalent (interchangeable)—up to $11.00</td>
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<td></td>
<td>• Non-pharmaceutical equivalent (non-interchangeable)—up to $11.00</td>
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<td></td>
<td>• Extemporaneous preparations (compounds)—up to $16.50</td>
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<td></td>
<td>• Methadone for chronic pain—up to $11.00 (no change)</td>
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<td>• Drugs for opioid dependence (e.g., methadone, buprenorphine/ naloxone)—up to $9.50</td>
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<td>Effective July 2, 2013, the New Brunswick Prescription Drug Program will pay for 1 dispensing fee every 28 days or more for drugs in solid oral dosage form taken on a continuous basis.</td>
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<td></td>
<td>The New Brunswick Prescription Drug Program (NBPD) rural pharmacy incentive pays an additional $2 dispensing fee for each of the first 10,000 NBPD prescriptions filled</td>
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<td>June 1, 2013, to June 30, 2014:</td>
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<td></td>
<td>• Ostomy supplies: $11.05</td>
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<td></td>
<td>• Compound extemporaneous products (except methadone and injectables): $16.58</td>
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<td>• All other prescriptions for drugs or supplies, including methadone: $11.05.</td>
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<td>Effective April 1, 2013:</td>
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<td>• Dispensing fee is the usual and customary charge to a maximum of $12.</td>
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<td>• Compounding fee is the usual and customary charge times 1.2 to a maximum of $18.</td>
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<td>• Private nursing home capitation fee is $73.55.</td>
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<td>• Compliance packaging is $25.00 per 28 days.</td>
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<td>• Refusal to fill is 1.2 times current dispensing fee.</td>
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<td>• Therapeutic substitution is 1.2 times current dispensing fee.</td>
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<td>April 1, 2013, to March 31, 2015:</td>
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<td></td>
<td>The professional fees for the Foundation Plan, Access Plan and Assurance Plan have been increased to</td>
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<td></td>
<td>• $11.50 for drug costs between $0 and $49.99</td>
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<td>• $23.23 for drug costs between $50 and $249.99</td>
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<td>• $49.77 for drug costs of $250+</td>
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<td>The professional fees for the 65 Plus Plan have changed to</td>
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<td></td>
<td>• $11.50 for drug costs between $0 and $249.99</td>
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<td></td>
<td>• $39.75 for drug costs of $250+, effective April 1, 2013.</td>
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<td></td>
<td>The professional fee maximum is $8.75</td>
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<td></td>
<td>Extemporaneous Preparations Fee $13.13</td>
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<td>Fees are negotiated between NHB and pharmacists’ associations and therefore will differ by province/territory.</td>
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<td>The methadone dispensing fee will be paid by the dose, using the following formula: (usual and customary fee × 1.5 / 7 days + $3.80) per dose.</td>
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<td>Professional Fees—Product-Related Fees/Services (cont’d)</td>
<td>per fiscal year to the pharmacies in a community that are 25 kilometres or more apart from each other.</td>
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<td>Effective June 1, 2014: The dispensing fees for eligible claims are as follows:</td>
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<tr>
<td>Physician Dispensing Fees</td>
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<tr>
<td>Pharmaceutical equivalent (interchangeable)—up to $8.40 (no change)</td>
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<tr>
<td>Non-pharmaceutical equivalent (non-interchangeable)—up to $8.40 (no change)</td>
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<tr>
<td>Extemporaneous preparations (compounds)—up to $12.60 (no change)</td>
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<td>Effective September 1, 2011: The Pharmacare Program reimburses special services fees, to the following maximums:</td>
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<tr>
<td>Advanced Medication Review: $150</td>
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<tr>
<td>Basic Medication Review: $52.50</td>
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<td>Prescription Adaptation: $14</td>
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<td>Therapeutic Substitution: $26.25</td>
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<tr>
<td>Medication Review Service</td>
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<td>Effective April 1, 2013</td>
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<tr>
<td>Medication reviews are for clients who are eligible under 1 of the following programs: Seniors, Social Assistance, Private Nursing Homes or Diabetes.</td>
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<td>An eligible client may receive either 1 basic medication review (BMR) or diabetes medication review (DMR) every 365 days, and up to 4 follow-up reviews (BMRF, DMRF). If a client is eligible for and has received a DMR, that client may have a combination of basic and diabetic follow-up reviews, as long as the total does not exceed four in that 365-day period.</td>
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<tr>
<td>BMR: $52.50; BMRF: $20</td>
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<td>DMR: $65; DMRF: $25</td>
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<tr>
<td>Cognitive Services</td>
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<tr>
<td>• Refusal to Fill: Pharmacies may bill up to the maximum dispensing fee of double the base dispensing fee of $11.50</td>
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<tr>
<td>• Medication Management: Pharmacies may bill up to the maximum dispensing fee of $11.50 (the base dispensing fee amount)</td>
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<tr>
<td>• Medication Review: The new agreement allows for payment for medication review as a cognitive service; pharmacies may bill $52.50 (48 times per year)</td>
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<td>Special services fee</td>
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<tr>
<td>• Refusal to Fill: Pharmacies may bill up to their usual customary fee.</td>
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<td>• Trial drug dispensing fee: In British Columbia and Saskatchewan, the NIHB Program may cover the dispensing fee associated with the provision of a small initial quantity of a trial drug (7-day supply) that is included under the Trial Prescription Program.</td>
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<td>Professional—Clinical Services (cont’d)</td>
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<td></td>
<td>Catastrophic Drug Program application support: $5.00 per individual</td>
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<td>Markup</td>
<td>Effective June 1, 2013: Up to 8% markup on interchangeable drugs</td>
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<td></td>
<td>• April 1, 2013, to June 30, 2014:</td>
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<td></td>
<td>• Ostomy supplies—AAC plus 10.0% (maximum $50) plus a $1.05 transition fee</td>
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<td>• Compounded extemporaneous products (except methadone and injectables)—AAC plus 2.0% (maximum $50) plus $1.05 transition fee</td>
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<td></td>
<td>• All other prescriptions for drugs or supplies—MLP plus 10.5% (maximum $250), including methadone, or MRP or PRP plus 6.0% (maximum $250), plus $1.05 transition fee</td>
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<td></td>
<td>N/A</td>
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<td>No surcharge can be applied to the prescription cost under any NLPDP Plan (i.e., neither NLPDP nor client can be billed or charged a surcharge)</td>
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<td>• Pharmacies are allowed a 30% markup</td>
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<td>• In addition, if AAC includes a wholesale upcharge, this can be included up to a maximum of 14%.</td>
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<td>Markups, if applicable, are negotiated as part of the pharmacy agreements between NIHB and the pharmacists’ associations in the different jurisdictions.</td>
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<td>Coordination of Benefits (Public/Private)</td>
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<td>Family Pharmacare Program—Program is payer of last resort. Any out-of-pocket costs to client after private plans are used can be applied to Family Pharmacare.</td>
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<td>Seniors’ Pharmacare Program—If the copayments a senior pays to his or her private insurance exceed the amount of the annual maximum premium plus the annual maximum copayment he or she would have paid if enrolled in Seniors Pharmacare, he or she may request a reimbursement of the difference.</td>
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<td>Beneficiaries must first access private insurance plans before seeking reimbursement from the Newfoundland and Labrador Prescription Drug Program.</td>
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<td>For all Yukon government plans, residents must access private insurance plans first.</td>
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<td>When a beneficiary is covered by a private health care plan, claims must be submitted to it first.</td>
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### Restricted Benefit Process

Drugs not listed as regular benefits may be eligible for reimbursement under New Brunswick Prescription Drug Program (NBPD) through special authorization.

**Drugs eligible for consideration through special authorization:**
- Drugs listed as special authorization benefits have specific criteria for coverage that must be met in order to be approved.
- Under exceptional circumstances, requests for drugs without specific criteria may be reviewed case-by-case and assessed based on the published medical evidence.

**Drugs not eligible through special authorization:**
- New drugs not yet reviewed by the expert advisory committee
- Drugs excluded as eligible benefits further to the expert advisory committee’s review and recommendation
- Drugs not licensed or marketed in Canada (e.g., drugs obtained through Health Canada’s Special Access Programme)

**Exception Status Drugs**

Drugs that are eligible for coverage under the Pharmacare programs only when an individual meets criteria developed by the Atlantic or Canadian Expert Advisory Committees. To request coverage, the physician should mail or fax a completed standard request form or letter to the Pharmacare office. Physicians may also contact the Pharmacare office and speak directly to a pharmacist consultant to request coverage. Every effort is made to process requests within 7 days. If the request is approved, clients receive notification via letter. Clients may bring this letter to the pharmacist to verify that coverage has been approved or the pharmacist may simply bill the claim online for immediate response for a limited list of products. The physician is notified if coverage is authorized, if the request is refused because the patient in these cases if the request is approved, patients may be reimbursed for one fill of the prescription received during the assessment period after all of the requested information has been received.

**Prescribers may apply for special authorization coverage by mailing or faxing a completed special authorization form**
- Allow 1 to 2 weeks for the processing of special authorization requests
- A letter will be sent notifying the patient and prescriber if coverage has been approved if the request is denied, letters are sent to the patient and prescriber notifying them of the reason for the denial; payment of the medication is the responsibility of the patient in these cases if the request is approved, patients may be reimbursed for one fill of the prescription received during the assessment period after all of the requested information has been received.

**A special authorization request form has been prepared at the request of pharmacists and physicians, which may be used to facilitate the approval process.**

While staff of the division try to accommodate verbal requests where possible, requests are assessed in the order received (fax, mail or verbal) and must be subject to a review of the patient’s medication claims summary. The use of the form, while not mandatory, is encouraged to expedite the approval process.

**Application process:**
- Only Yukon physicians may apply for Exception Drug Status
- Applications must be submitted in writing
- When an exception drug is prescribed, the pharmacist may request an initial 30-day approval. The pharmacist must phone the respective drug program advising that the patient is active; the exception drug will be covered for 30 days provided that the drug is listed in the formulary. If the drug requires a specialist’s recommendation according to the product’s criteria, the 30-day coverage will not be granted unless the specialist’s information is provided.

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<td>Coordination of Benefits (Intra-Jurisdictional)</td>
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| Restricted Benefit Process | Drugs not listed as regular benefits may be eligible for reimbursement under New Brunswick Prescription Drug Program (NBPD) through special authorization. **Drugs eligible for consideration through special authorization:**
- Drugs listed as special authorization benefits have specific criteria for coverage that must be met in order to be approved.
- Under exceptional circumstances, requests for drugs without specific criteria may be reviewed case-by-case and assessed based on the published medical evidence.

**Drugs not eligible through special authorization:**
- New drugs not yet reviewed by the expert advisory committee
- Drugs excluded as eligible benefits further to the expert advisory committee’s review and recommendation
- Drugs not licensed or marketed in Canada (e.g., drugs obtained through Health Canada’s Special Access Programme) | Exception Status Drugs are those which are eligible for coverage under the Pharmacare programs only when an individual meets criteria developed by the Atlantic or Canadian Expert Advisory Committees. To request coverage, the physician should mail or fax a completed standard request form or letter to the Pharmacare office. Physicians may also contact the Pharmacare office and speak directly to a pharmacist consultant to request coverage. Every effort is made to process requests within 7 days. If the request is approved, clients receive notification via letter. Clients may bring this letter to the pharmacist to verify that coverage has been approved or the pharmacist may simply bill the claim online for immediate response for a limited list of products. The physician is notified if coverage is authorized, if the request is refused because the patient in these cases if the request is approved, patients may be reimbursed for one fill of the prescription received during the assessment period after all of the requested information has been received. | Prescribers may apply for special authorization coverage by mailing or faxing a completed special authorization form
- Allow 1 to 2 weeks for the processing of special authorization requests
- A letter will be sent notifying the patient and prescriber if coverage has been approved if the request is denied, letters are sent to the patient and prescriber notifying them of the reason for the denial; payment of the medication is the responsibility of the patient in these cases if the request is approved, patients may be reimbursed for one fill of the prescription received during the assessment period after all of the requested information has been received. | A special authorization request form has been prepared at the request of pharmacists and physicians, which may be used to facilitate the approval process. While staff of the division try to accommodate verbal requests where possible, requests are assessed in the order received (fax, mail or verbal) and must be subject to a review of the patient’s medication claims summary. The use of the form, while not mandatory, is encouraged to expedite the approval process. | Application process:
- Only Yukon physicians may apply for Exception Drug Status
- Applications must be submitted in writing
- When an exception drug is prescribed, the pharmacist may request an initial 30-day approval. The pharmacist must phone the respective drug program advising that the patient is active; the exception drug will be covered for 30 days provided that the drug is listed in the formulary. If the drug requires a specialist’s recommendation according to the product’s criteria, the 30-day coverage will not be granted unless the specialist’s information is provided. | Application process:
- Only Yukon physicians may apply for Exception Drug Status
- Applications must be submitted in writing
- When an exception drug is prescribed, the pharmacist may request an initial 30-day approval. The pharmacist must phone the respective drug program advising that the patient is active; the exception drug will be covered for 30 days provided that the drug is listed in the formulary. If the drug requires a specialist’s recommendation according to the product’s criteria, the 30-day coverage will not be granted unless the specialist’s information is provided. | There are 4 types of limited-use benefits:
- Limited-use benefits for which requests can be automatically adjudicated based on the client’s prior drug history
- Limited-use benefits that require prior approval (using the Limited-Use Drugs Request Form)
- Benefits with an exception status, which require prior approval (using the Benefit Exception Questionnaire)
- Benefits that have a quantity and frequency limit.

Upon receipt of a prescription for a limited-use drug or a non-listed drug, the pharmacist must initiate the prior approval process by calling the Health Canada NIHB Drug Exception Centre.

N.B. = New Brunswick
N.S. = Newfoundland and Labrador
P.E.I. = Prince Edward Island
N.L. = Nova Scotia
Y.T. = Yukon
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<td><strong>Restricted Benefit Process (cont’d)</strong></td>
<td>• Products specifically excluded as benefits as identified on the exclusion list (NBPDP formulary)</td>
<td>Special authorization requests must be submitted in writing by a prescriber to the NB Prescription Drug Program Special Authorization Unit.</td>
<td>criteria for coverage are not met or if more information is required. Selected Exception Status Drugs can be billed online without prior approval if criteria codes are provided during the billing process. For most of the drugs that can be billed using criteria codes, the criteria codes are supplied directly by an authorized prescriber. By supplying a code, the prescriber is verifying that he or she is prescribing the drug for an indication approved under the Pharmacare programs. The prescriber may provide diagnostic information on the prescription (instead of the actual code), but it must clearly indicate to the pharmacist which code should be used.</td>
<td>• The Foundation Plan—Reimbursement can be considered under exceptional circumstances; out-of-province claims are considered only if a patient is referred out of province for medical reasons and approval is obtained prior to leaving the province. • The Access Plan—The program applies only to benefits obtained within the province of Newfoundland and Labrador.</td>
<td>• When beneficiaries pay out of pocket, receipts may be submitted for reimbursement if eligible under the program. Receipts will be assessed using formulary-listed prices. Exception drugs will require approval and these may be backdated.</td>
<td>A benefit analyst will request prescriber and client information. An electronically generated Exception or Limited-Use Drugs Request Form will be immediately faxed, if possible, to the prescribing physician. The physician will complete and return the form using the toll-free fax number indicated on the form. The Drug Exception Centre will review the information and the pharmacist will be notified of the decision by fax. If approved, the provider should retain this faxed confirmation for billing purposes.</td>
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<td><strong>Reimbursement Policy</strong></td>
<td>If a beneficiary pays out of pocket for a drug, the claim may be submitted for reimbursement consideration if the product is an eligible benefit, is prescribed by an authorized health care provider and is purchased at a New Brunswick pharmacy.</td>
<td>If a beneficiary paid cash at the pharmacy, he or she has up to 6 months from date of purchase to send original receipts to Pharmacare for reimbursement. Prescriptions filled at a pharmacy outside Nova Scotia, but inside Canada, will be reimbursed in medical emergencies only. There is no reimbursement, emergency or otherwise, for prescriptions filled outside Canada.</td>
<td>If a beneficiary paid cash at the pharmacy, he or she has 6 months to submit receipts for reimbursement.</td>
<td>• When beneficiaries pay out of pocket, receipts may be submitted for reimbursement if eligible under the program. Receipts will be assessed using formulary-listed prices. Exception drugs will require approval and these may be backdated.</td>
<td>• Claims older than 1 year will not be reimbursed.</td>
<td>Submissions for retroactive coverage must be received by FNIHB on an NIHB Client Reimbursement Request Form within 1 year from the date of service or date of purchase. The regional office assesses appropriateness of claims and acts accordingly. The vast majority of the claims are paid directly online to the pharmacist via electronic transactions. ESI Canada administers the Health Information and Claims Processing.</td>
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<td>Reimbursement Policy (cont’d)</td>
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<td>Services (HICPS) for pharmacy benefits covered by the NHB Program.</td>
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<td>Prescription Quantities</td>
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<td>• 100-day supply</td>
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<td>• 35-day supply for narcotics, controlled drugs and benzodiazepine</td>
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<td>Quantitative limits have been established for a number of products listed as benefits of the NBPDP.</td>
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<td>One travel supply of up to 100 days may be submitted in addition to a first fill/refill of up to 100 days. The total quantity of each drug that the senior has on hand cannot exceed a 200-day supply.</td>
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<td>Prescription Quantities</td>
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<td>• 90-day supply</td>
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<td>Program Maximum Allowable Days’ Supply</td>
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<td>• Nursing Home Program: 35 days</td>
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<td>• Institutional Pharmacy Program: 35 days</td>
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<td>• AIDS/HIV Program: 60 days</td>
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<td>• Children-In-Care Program: 30 days—regular drugs; 90 days—maintenance drugs (Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills)</td>
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<td>A maximum of one dispensing fee per 28 days for maintenance medication.</td>
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<td>Prescription Quantities</td>
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<td>• 90-day supply for narcotics</td>
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<td>• Test strips: Beneficiaries who are not on insulin or oral hypoglycemic medications but are being followed by a diabetes nurse educator, a dietitian, a nurse practitioner or a family physician (with a letter to confirm same) can apply for special authorization consideration. If approved, a special authorization will be entered into the system, with a limit of 2,500 test strips per 365-day period</td>
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<td>• Physicians shall exercise their professional judgment in determining the course and duration of treatment for their patients.</td>
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N.S. = Nova Scotia
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Y.T. = Yukon

Health Canada—FNIHB

Services (HICPS) for pharmacy benefits covered by the NHB Program.

Short-Term Dispensing Policy (STD)

For refills for medications requiring short-term dispensing for a shorter time than 28 days due to compliance concerns, the program will reimburse

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for a maximum of 30 days for the first 2 prescriptions or refills

- Family Health Benefit Program: 30 days—regular drugs; 90 days—maintenance drugs; 30 days—drugs under SA coverage (Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills)
- Financial Assistance Program: 30 days—regular drugs; 90 days—maintenance drugs; 30 days—drugs under SA coverage (Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills)
- Growth Hormone Program: 30 days
- Hepatitis Program: 30 days
- Intron A Program: 30 days
- Multiple Sclerosis Drug Program: 30 days
- Phenylketonuria Program: 60 days
- Rheumatic Fever Program: 60 days
- Seniors Drug Cost Assistance Plan: 30 days—regular drugs; 90 days—maintenance drugs; 30 days—drugs under SA coverage (Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills)

only a total of 1 dispensing fee per 28 days, except
- Refills for intermittent treatment of a chronic disorder (e.g., dosage change)
- Refills for drugs prescribed for as-required use (e.g., PRN)
- Refills of methadone
- Others as identified by the NIHB Program.

As of July 15, 2012, the STD policy was expanded to also include anticonvulsants, antidepressants, antipsychotics, benzodiazepines and stimulant medications. When short-term dispensing is medically necessary, the Program will compensate pharmacists up to one usual and customary dispensing fee every 7 days, up to the regional maximum of the Program, for the aforementioned medications. If these medications are dispensed daily, the Program will compensate 1/7th of the usual and customary dispensing fee, up to the Program’s regional maximum. When these medications are dispensed less frequently than every 7 days such as once a
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<td>strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills)</td>
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<td>month, the pharmacy will be entitled to 1 full dispensing fee, up to the regional maximum of the program.</td>
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<td>• Smoke Program: 7 days—OTC drugs; 14 days—prescription drugs</td>
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<td>Effective in phases from November 2013 to late 2014 Clients using insulin will be allowed 500 test strips per 100 days. Clients taking diabetes medications that have a high risk of causing low blood sugar will be allowed 400 test strips per 365 days; those taking medications that have a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. Diabetics not taking diabetic medication will be allowed 200 test strips per 365 days.</td>
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<td>• Transplant and Tuberculosis Drug Program: 60 days</td>
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<td>Effective February 25, 2014 A maximum 30-day supply for all opioids will be covered. 1 full fee will be paid per 30-day dispense (or less, if prescribed in a smaller quantity).</td>
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<td>• Catastrophic Drug Program: Regular drugs and special authorization drugs: 30-day supply; maintenance drugs: 90-day supply (Note: Prescriptions for a new medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first 2 prescriptions or refills)</td>
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<td>• High-Cost Drugs Program: 30 days, unless otherwise specified in criteria for drug(s)</td>
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<td>• High-Cost Drugs Program: 30 days, unless otherwise specified in criteria for drug(s)</td>
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### Policy-Related Information

<table>
<thead>
<tr>
<th>Miscellaneous (cont’d)</th>
<th>N.B.</th>
<th>N.S.</th>
<th>P.E.I.</th>
<th>N.L.</th>
<th>Y.T.</th>
<th>Health Canada—FNIHB</th>
</tr>
</thead>
</table>

First Nations Health Authority (FNHA)
Effective October 1, 2013, as part of the British Columbia Tripartite Framework Agreement on First Nation Health Governance, Health Canada transferred its role in the design, management and delivery of First Nations health programming in British Columbia to the First Nations Health Authority (FNHA).

### Sources

For more information:
- **New Brunswick Prescription Drug Program and New Brunswick Drug Plan**
- **Nova Scotia Pharmacare Drug Programs**
- **Prince Edward Island Drug Programs**
- **Newfoundland and Labrador Prescription Drug Program**
- **Yukon Health and Social Services**
- **Non-Insured Health Benefits**

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Pan-Canadian Pricing Alliance

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

As of April 1, 2014:

- The PCPA decided to not negotiate collectively or individually at the provincial/territorial level for 12 drug products.
- The PCPA recommended that 6 brand-name drug products be considered by each province/territory individually: Fycompa (perampanel), Genotropin (somatropin), Humira (adalimumab), Jentadueto (linagliptin/saxagliptin), Latuda (lurasidone)\textsuperscript{ii} and Trisenox (arsenic trioxide)\textsuperscript{ii}.
- There are 12 negotiations currently under way:
  - Erivedge (vismodegib)
  - Fibristral (ulipristal acetate)
  - Jetrea (ocriplasmin)
  - Kalydeco (ivacaftor)
  - Lodalis (colesevelam)\textsuperscript{iii}
  - Mekinist (trametinib)
  - Onglyza (saxagliptan)
  - Orencia (abatacept)
  - Rebif (interferon beta-1a)
  - Revlimid (lenalidomide)
  - Tafinlar (dabrafenib)
  - Tecfidera (dimethyl fumarate)

- 2 negotiations were closed because agreements were not reached: Byetta (exenatide) and Victoza (liraglutide).
- There were 31 joint negotiations completed (see list). As well, 2 negotiations were closed (Byetta [exenatide] and Victoza [liraglutide]) as agreements were not reached:
  - Adcetris (brentuximab)
  - Afinitor (everolimus)
  - Akiem (pemfexem)
  - Brillinta (ticagrelor)\textsuperscript{v}
  - Diflucan (fluconazole)
  - Effient (prasugrel)
  - Eliquis (apixaban)
  - Erivedge (vismodegib)\textsuperscript{v}
  - Gilena (minimodex)
  - Halaven (eribulin)
  - Inlyta
  - Jakavi (ruxolitinib)
  - Kadcyla (trastuzumab emtansine)\textsuperscript{v}
  - Kuvan (sapropterin)\textsuperscript{iv}
  - Mozobil (plerixafor)
  - Onbrez (indacaterol)\textsuperscript{v}
  - Oralair (grass pollen allergen extract)
  - Perjeta (pertuzumab)
  - Pradaxa (dabigatran)\textsuperscript{v}
  - Seebri Breezhaler (glycopyrronium bromide)
  - Soliris (eculizumab)\textsuperscript{v}
  - Strilb (elvitegravir/cobicistat/emtricitabine/tenofovir)

\textsuperscript{ii} Completed negotiations since last update of February 28, 2014.
\textsuperscript{iii} Completed negotiations since last update of February 28, 2014.
\textsuperscript{iv} The initial 9 products negotiated through the PCPA.
\textsuperscript{v} Completed negotiations since last update of February 28, 2014.
Generic Pricing Policy Summary

The following is a summary of the current generic drug-pricing policies. For implementation or specific drug product information, contact the individual drug program directly.

As of April 1, 2014, all provinces and territories, except Quebec, have set the price for the following 10 generic drugs at 18% of the equivalent brand-name drug: atorvastatin, rosvastatin, simvastatin, ramipril, venlafaxine, citalopram, amlodipine, omeprazole, rabeprazole and pantoprazole.

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Effective Date (Where Known)</th>
<th>Percentage of Brand</th>
<th>Generic Status</th>
<th>Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>April 2014</td>
<td>20</td>
<td>All oral solid generics</td>
<td>Applies to public sector</td>
</tr>
<tr>
<td></td>
<td></td>
<td>35</td>
<td>All other generics</td>
<td></td>
</tr>
<tr>
<td>Alberta</td>
<td>May 2013</td>
<td>18</td>
<td>All generics</td>
<td>Applies to public and private plans</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>—</td>
<td>35</td>
<td>All generics listed in the Saskatchewan formulary</td>
<td>Applies to public and private sectors</td>
</tr>
<tr>
<td>Manitoba</td>
<td>—</td>
<td>No generic pricing policy currently in place</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Ontario</td>
<td>July 2010 (Public)/April 2012 (Private)</td>
<td>25</td>
<td>All generics</td>
<td>Applies to public and private sectors</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>June 2013</td>
<td>25</td>
<td>All solid oral interchangeable generics</td>
<td>Applies to public and private sectors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>35</td>
<td>All non-solid interchangeable generics</td>
<td>Applies to public and private sectors</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>July 2012</td>
<td>35</td>
<td>All interchangeable generics</td>
<td>—</td>
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<tr>
<td>Prince Edward Island</td>
<td>April 2014</td>
<td>25</td>
<td>All generics</td>
<td>Applies to public and private sectors</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>July 2013</td>
<td>25</td>
<td>All generics</td>
<td>Applies to public and private sectors</td>
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<tr>
<td>Yukon</td>
<td>—</td>
<td>No generic pricing policy currently in place; however, pharmacies order from Alberta or B.C. wholesalers and therefore receive the prices listed in those provinces</td>
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</tbody>
</table>
Glossary of Terms

Please note that some of the terms in this glossary may have alternate definitions. The stated definitions are meant only to reflect how these terms were used in the context of this report and are not necessarily the sole definitions of these terms.

<table>
<thead>
<tr>
<th>Term/Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>age group</td>
<td>Age-specific requirements for beneficiaries to be eligible for coverage under a provincial, territorial or federal drug program</td>
</tr>
<tr>
<td>beneficiary group</td>
<td>Recipients of benefits under a specified provincial, territorial or federal plan/program</td>
</tr>
<tr>
<td>coordination of benefits</td>
<td>Coordination of benefits is a process whereby payments are coordinated through 2 or more drug plans (public/private, intra-jurisdictional). 1 plan is considered the primary insurer. The primary insurer is defined in the policies of the insurance plan/drug program. The portion of the drug cost not paid for by the primary insurer is claimed through the secondary insurer.</td>
</tr>
<tr>
<td>copayment/co-insurance</td>
<td>The portion of the drug cost that the beneficiary must pay each time a drug is dispensed. This may be a fixed amount or a percentage of the total cost. When calculated as a percentage of the total cost, this is also known as co-insurance</td>
</tr>
<tr>
<td>deductible</td>
<td>The amount of total drug spending a beneficiary must pay in a defined time period before any part of his or her drug costs will be paid by the drug benefit plan/program. A deductible may be a fixed amount or a percentage of income (income-based deductible)</td>
</tr>
<tr>
<td>disease specific</td>
<td>Disease-specific requirements for beneficiaries to be eligible for coverage under a provincial, territorial or federal drug program</td>
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<tr>
<td>GIS</td>
<td>Federal Guaranteed Income Supplement</td>
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<td>income range</td>
<td>Family or individual income-specific requirements for beneficiaries to be eligible for coverage under a specific provincial, territorial or federal drug program</td>
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<tr>
<td>ingredient pricing policy</td>
<td>A set of conditions related to the repayment of the ingredient cost portion of a prescription under a specific provincial, territorial or federal drug program</td>
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<tr>
<td>markup</td>
<td>An amount added to the cost price of a drug or ingredient, usually based on a percentage of the cost price</td>
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<tr>
<td>maximum beneficiary contribution</td>
<td>The maximum amount of drug spending a beneficiary is required to pay in a defined time period. Once the maximum contribution has been reached, the drug program will pay 100% of eligible drug costs for the remainder of the year or time period</td>
</tr>
<tr>
<td>plan/program</td>
<td>A provincial, territorial or federal program that provides coverage for drugs for a set population. Programs have defined rules for eligibility, payment, etc.</td>
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<tr>
<td>premium</td>
<td>The amount a beneficiary is required to pay to enroll in a provincial, territorial or federal drug plan/program</td>
</tr>
<tr>
<td>prescription cost components</td>
<td>The categories of costs that, when added together, make up the total cost of dispensing a prescription drug to a patient; usually includes the cost of the drug (or ingredients), a markup on the drug or ingredient cost and a professional fee</td>
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<tr>
<td>professional fees</td>
<td>The amount paid for the services provided by a service provider, such as a pharmacist; may also be referred to as a dispensing fee, compounding fee or any other special service fee</td>
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<td>reimbursement policy</td>
<td>A set of conditions regarding the repayment to a beneficiary of the incurred prescription drug cost under a specific provincial, territorial or federal drug program</td>
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<td>restricted benefit process</td>
<td>The steps by which prescribers request coverage for drug products where approval for coverage requires prior authorization by the specific provincial, territorial or federal drug program</td>
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<td>sector</td>
<td>Refers to the source of funding for drug expenses. “Public sector” refers to drugs covered by government-funded drug programs, while “private sector” refers to private drug plans (i.e., insurance and out-of-pocket or cash payment)</td>
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