# Table of contents

Introduction ................................................................................................................................. 5
Summary of major changes (January 2015 to December 2016) .................................................. 5
Pan-Canadian Generic Price Initiative ................................................................................... 5
British Columbia .................................................................................................................... 5
Alberta................................................................................................................................... 6
Saskatchewan ....................................................................................................................... 6
Manitoba .................................................................................................................................. 7
Ontario .................................................................................................................................. 7
New Brunswick .................................................................................................................. 7
Nova Scotia......................................................................................................................... 8
Prince Edward Island ............................................................................................................ 8
Newfoundland and Labrador ................................................................................................. 8

Plan/program information by jurisdiction and category .............................................................. 10
British Columbia .................................................................................................................. 10
    Eligibility ........................................................................................................................ 10
    Cost-sharing mechanism ............................................................................................... 12
    Policy information ........................................................................................................ 13
Alberta......................................................................................................................................... 18
    Eligibility ........................................................................................................................ 18
    Cost-sharing mechanism ............................................................................................... 20
    Policy information ........................................................................................................ 20
Saskatchewan................................................................................................................................ 25
    Eligibility ........................................................................................................................ 25
    Cost-sharing mechanism ............................................................................................... 27
    Policy information ........................................................................................................ 28
Manitoba ....................................................................................................................................... 32
    Eligibility ........................................................................................................................ 32
    Cost-sharing mechanism ............................................................................................... 33
    Policy information ........................................................................................................ 34
Ontario ......................................................................................................................................... 36
    Eligibility ........................................................................................................................ 36
    Cost-sharing mechanism ............................................................................................... 37
    Policy information ........................................................................................................ 38
Introduction

This document provides contextual information regarding public federal/provincial/territorial drug benefit plans/programs across Canada.

Summary of major changes (January 2015 to December 2016)

Pan-Canadian Generic Price Initiative

Effective April 1, 2015: The prices of the following generic medications are limited to 18% of the equivalent brand-name price:

- Clopidogrel: used to inhibit the formation of blood clots and to prevent myocardial infarction
- Gabapentin: used to treat epilepsy
- Metformin: used to treat type 2 diabetes
- Olanzapine: used to treat psychotic conditions

Effective April 1, 2016: The prices of the following generic medications are limited to 18% of the equivalent brand-name price:

- Donepezil: used to treat dementia in Alzheimer’s patients
- Ezetimibe: used to lower cholesterol
- Quetiapine: used to treat psychotic conditions, including schizophrenia and bipolar disorder
- Zopiclone: used to treat insomnia

British Columbia

Effective January 1, 2015: Annual quantity limits for blood glucose test strips will depend on the beneficiary’s diabetes treatment category.

Effective January 1, 2016: The B.C. Smoking Cessation Program’s selection of eligible non-prescription nicotine replacement therapy (NRT) products expands to include specific lozenges and inhalers.

Effective December 1, 2016: The Reference Drug Program expands to include 3 new categories: angiotensin receptor blockers (ARBs), proton pump inhibitors (PPIs) and statins.
Alberta

**Effective April 1, 2016:** The allowable upcharge for purchased compound prescriptions increases from 6% to 6.5% (to a maximum of $100).

Saskatchewan

**Effective July 1, 2015:** The individual income threshold that determines eligibility for the Seniors’ Drug Plan changes from the federal age credit to the provincial age credit. To be eligible, a senior’s individual net income (line 236 of the 2013 income tax form) must be $65,515 or less.

**Effective September 1, 2015:** The maximum dispensing fee increases from $11.25 to $11.40.

**Effective September 1, 2015:** The CeRx (Pan-Canadian Electronic Drug Messaging) integration supplement will continue until August 31, 2016, at $0.10 per prescription successfully transmitted to and accepted by the Pharmaceutical Information Program (PIP) using the CeRx messaging standard. The previous fee of $0.20 per prescription is reduced to $0.10, and the remaining $0.10 is permanently reallocated to the dispensing fee.

**Effective September 1, 2015:** The list of eligible clients under the Medication Assessment and Compliance Packaging Program expands to include clients who require medication management and are living in an approved Community Living Services Delivery (CLSD) group home or living in a CLSD-approved private service home. Referral to the program for these clients must be made by a pharmacist. The home care and mental health criteria and referral process remain the same.

**Effective September 1, 2015:** Compliance Packaging Services through the Saskatchewan Medication Assessment Program (SMAP) expand to include clients living in a CLSD-approved group home, a CLSD-approved private service home or a licensed personal care home with 11 beds or less. All other criteria for the SMAP annual medication assessment and follow-up patient assessments remain the same.

**Effective October 15, 2015:** The approved quantities for blood glucose test strips change. For eligible Saskatchewan Health beneficiaries, this may affect how the test strips are covered or how much the beneficiary will pay, according to the deductible and/or copayment. The new approved quantities for test strips are aligned with Canadian Diabetes Association (CDA) guidelines.
Effective October 19, 2015: The Drug Plan and Extended Benefits Branch (DPEBB) will pay an influenza immunization fee of $13 to pharmacies, commencing on the official start date of the Saskatchewan Ministry of Health’s annual Seasonal Influenza Program, when the publicly funded influenza vaccine is administered under Influenza Immunization Program criteria.

Manitoba

Effective April 1, 2015: The deductible rate increases from between 2.91% and 6.60% for 2014–2015 to between 2.97% and 6.73% for 2015–2016.

Effective April 1, 2016: The deductible rate increases from between 2.97% and 6.73% for 2015–2016 to between 3.01% and 6.81% for 2016–2017.

Ontario

Effective October 1, 2015: All dispensing fees for claims for residents of long-term care homes, which ranged from $8.83 to $13.25, are reduced by $1.26 and now range from $7.57 to $11.99.

Effective October 1, 2015: The markup for all Ontario Drug Benefit (ODB) claims for high-cost drugs (total drug cost equal to or greater than $1,000) is reduced from 8% to 6%. For claims where the total drug cost is less than $1,000, pharmacies will continue to receive an 8% markup on the drug benefit price of the product dispensed.

Effective October 1, 2015: Pharmacies will be entitled to receive a maximum of 5 dispensing fees per 365-day period, beginning with the first dispensing transaction for an identified chronic-use medication on or after the changes come into effect. Pharmacists are encouraged to provide recipients with a 100-day supply of most chronic-use medications.

Effective October 1, 2015: Changes are made to maximize the utilization of lower-cost generics through changes to the current “no substitution” provisions. Patients are now required to try 2 or more generics (and therefore experience 2 documented adverse reactions to the 2 formulations) prior to having a brand-name product paid for by the public plan.

New Brunswick

Effective April 1, 2015: 2 new premiums and maximum copayments are implemented under the New Brunswick Drug Plan.
Nova Scotia

**Effective April 1, 2015:** Dispensing fees increase from $11.50 to $11.65 for ostomy supplies, from $17.25 to $17.47 for compounded extemporaneous products (excluding methadone and injectables) and from $11.50 to $11.65 for all other prescriptions (including methadone).

**Effective April 1, 2015:** The Insulin Pump Program expands to help cover the cost of both insulin pumps and pump supplies for patients with type 1 diabetes who are age 25 and younger (previous age restriction was age 18 and younger).

**Effective April 1, 2016:** New income-based premium reductions and exemptions are introduced for the Seniors’ Pharmacare Program.

**Effective April 1, 2016:** Dispensing fees increase from $11.65 to $11.75 for ostomy supplies, from $17.47 to $17.62 for compounded extemporaneous products (excluding methadone and injectables) and from $11.65 to $11.75 for all other prescriptions (including methadone).

Prince Edward Island

**Effective April 2, 2015:** The maximum reimbursable professional fee is up to $12.36 and the extemporaneous fee is $18.54. The private nursing home capitation fee is $76.52.

**Effective October 1, 2015:** The Generic Drug Program is introduced to limit out-of-pocket costs for generic prescription drugs to a maximum of $19.95.

Newfoundland and Labrador

**Effective April 1, 2015:** The professional fees for the Foundation Plan, Access Plan and Assurance Plan change to
- $11.96 for drug costs between $0 and $49.99
- $23.93 for drug costs between $50 and $249.99
- $50 for drug costs $250+

The professional fees for the 65Plus Plan change to
- $12 for drug costs between $0 and $249.99
- $40 for drug costs $250+

These fees will remain in effect until March 31, 2016.
Cognitive services

- Refusal to fill: Pharmacies may bill up to the maximum dispensing fee, which is up to double the base dispensing fee of $11.96.

- Medication management: Pharmacies may bill up to the maximum dispensing fee of $11.96 (the base dispensing fee).

- Medication review: The new agreement allows for payment for medication review as a cognitive service. Pharmacies may bill $52.50 for beneficiaries older than age 65 who have chronic illnesses and who are taking 3 or more medications, as well as for beneficiaries of any age who have diabetes who are taking oral hypoglycemics and/or insulin, up to 72 times per year per pharmacy.
Plan/program information by jurisdiction and category

British Columbia

Eligibility

Plans/programs

- Fair PharmaCare (Plan I)
- Residential Care (Plan B)
- Income Assistance (Plan C)
- Cystic Fibrosis (Plan D)
- Children in the At Home Program (Plan F)
- Psychiatric Medications (Plan G)
- Medication Management (Plan M)
- Palliative Care (Plan P)
- HIV/AIDS (Plan X)
- Smoking Cessation Program (Plan S)

General beneficiary information

For any plan, beneficiaries must be residents of British Columbia. For plans D, F, G, P, S and I, beneficiaries must have Medical Services Plan (MSP) coverage.

Fair PharmaCare: Regular assistance: residents born in 1940 or later; enhanced assistance: residents born in 1939 or earlier

Residential Care: Permanent resident of a licensed residential care facility

Income Assistance: Recipients of B.C. income assistance and medical benefits

Cystic Fibrosis: Individuals with cystic fibrosis who are registered with a provincial cystic fibrosis clinic

Children in the At Home Program: Non-institutionalized severely handicapped children, age 18 and younger, receiving full benefits or medical benefits through the At Home program of the Ministry of Children and Family Development
Psychiatric Medications: Individuals who have demonstrated clinical and financial need

Medication Management: Individuals who require eligible medication management services (e.g., clinical services, medication review services, 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

HIV/AIDS: HIV-positive individuals enrolled in the British Columbia Centre for Excellence in HIV/AIDS

Smoking Cessation Program: Prescription smoking cessation drugs: individuals who are registered in Fair PharmaCare, Plan B, Plan C or Plan G. NRTs are available to all smokers (and users of other tobacco products) who are B.C. residents with active MSP coverage. NRTs can be provided with neither a prescription nor PharmaCare registration. Both the patient and pharmacist must sign a declaration form.

Other eligibility criteria

Fair PharmaCare: An individual must have effective British Columbia MSP coverage, have a social insurance number (SIN) and have filed an income tax return for the relevant taxation year. Coverage is based on income. Families with lower net incomes receive more coverage than families with higher net incomes.

Residential Care: Recipients must be permanent residents of a licensed residential care facility who are enrolled and who receive coverage through the care facility.

Income Assistance: Recipients must be registered in the MSP and be receiving medical benefits and income or disability assistance through the Ministry of Social Development and Social Innovation.

Children in the At Home Program: Recipients must be age 18 or younger, residents 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.

Psychiatric Medications: Patients must be prescribed a psychiatric drug that is a benefit under the plan, must qualify for premium assistance under the MSP and must declare that they lack other insurance and that cost is a barrier to obtaining the drug. Prescribers must certify that without the drug, patients will be hospitalized or suffer serious harm.

Palliative Care: Recipients must be diagnosed as having an illness or condition that will likely result in death within 6 months. Recipients wish to receive palliative care at home and consent to the focus of care being palliative rather than treatment aimed at a cure. The medical or nurse practitioner submits an application, certifying that the individual meets the above criteria. Persons enrolled in the Residential Care plan are not eligible for the Palliative Care plan.
Cost-sharing mechanism

Premium

None

Copayment/co-insurance

Fair PharmaCare: After annual deductible has been met, 30% of the eligible prescription drug costs up to the annual maximum

Fair PharmaCare enhanced assistance: After annual deductible has been met, 25% of the eligible prescription drug costs up to the annual maximum

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.

Deductible

Fair PharmaCare

<table>
<thead>
<tr>
<th>Net family income</th>
<th>Approximate deductible (as a percentage of net income)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$15,000</td>
<td>0%</td>
</tr>
<tr>
<td>$15,000–$30,000</td>
<td>2%</td>
</tr>
<tr>
<td>&gt;$30,000</td>
<td>3%</td>
</tr>
</tbody>
</table>

Fair PharmaCare enhanced assistance

<table>
<thead>
<tr>
<th>Net family income</th>
<th>Approximate deductible (as a percentage of net income)</th>
</tr>
</thead>
<tbody>
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<tr>
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<td>1%</td>
</tr>
<tr>
<td>&gt;$50,000</td>
<td>2%</td>
</tr>
</tbody>
</table>
For a family registered for Fair PharmaCare whose income cannot be verified or for a person actively enrolled in the MSP but not registered for Fair PharmaCare, the deductible is $10,000.

No deductible is applied to the remaining plans/programs.

**Maximum beneficiary contribution**

**Fair PharmaCare**

<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>
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<tr>
<td>$15,000–$30,000</td>
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</tr>
<tr>
<td>&gt;$30,000</td>
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</table>

**Fair PharmaCare enhanced assistance**

<table>
<thead>
<tr>
<th>Net family income</th>
<th>Approximate maximum (as a percentage of net income)</th>
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<tr>
<td>&gt;$50,000</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Policy information**

**Ingredient price**

**Maximum pricing:** Drugs are reimbursed to a maximum price based on the manufacturer’s list price, plus 8% (5% for high-cost drugs).

**Low-Cost Alternative (LCA) 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). When the same drug is made and sold by 2 or more manufacturers, PharmaCare covers the less-expensive version — the low-cost alternative.
Reference Drug Program (RDP): Reimbursement for certain drugs in designated therapeutic categories is limited to a maximum daily amount payable. The reference drug is fully covered. Other drugs within the category are only partially covered, up to a maximum daily cost based on the cost of the reference drug. The RDP applies to the following classes of drugs: H2 blockers, nitrates, ACE (angiotensin converting enzyme) inhibitors, dihydropyridine calcium channel blockers, nonsteroidal anti-inflammatory drugs (NSAIDs), angiotensin receptor blockers (ARBs), proton pump inhibitors (PPIs) and statins.

Retail price: Certain products (such as insulin, insulin needles and syringes, insulin pump supplies and ostomy supplies) are reimbursed at the regular retail price.

Actual acquisition cost (AAC): 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.

Generic pricing policy (percentage of brand-name drug)

Effective April 1, 2014, generic drugs are priced as follows:
- Oral solid products: 20% of the equivalent brand-name product’s list price
- All other forms: 35% of the equivalent brand-name product’s list price

Effective April 1, 2015, generic drugs are priced as follows:
- Drugs subject to the Pan-Canadian Generic Value Price Initiative’s 18% category: 18% of brand-name drug’s list price

Professional fees: Product-related fees/services

Dispensing fee: $10 maximum

Trial Prescription Program: The pharmacy can claim a second dispensing fee for filling the balance of the prescription, once it has been established that the patient can tolerate the medication (following a 14-day trial period).

Methadone Maintenance Program: Effective February 1, 2014, pharmacists are reimbursed for methadone for maintenance at a maximum of $0.162/mL, plus the usual dispensing fee, plus an interaction fee of $7.70 for each dispensation involving direct interaction with the patient.

Frequency of Dispensing Policy: Methadone dispensed under the Methadone Maintenance Payment Program is subject to a maximum of 1 dispensing fee and 1 interaction fee per patient per day (in cases where the interaction fee is applicable), regardless of physician administration instructions on the prescription.
For drugs that are dispensed daily, PharmaCare covers 1 dispensing fee per drug per day, up to a maximum of 3 dispensing fees. For 2- to 27-day supplies, PharmaCare covers 1 dispensing fee per drug per day, up to a maximum of 5 dispensing fees.

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

**Rural Incentive Program:** A per-claim subsidy (from $3 to $10.50) is provided to rural pharmacies with monthly claims volumes of less than 1,700.

**Vaccination administration:** $10 is paid 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 (continuous ambulatory delivery device) injections: $20
- Sterile intravenous (IV), intramuscular (IM) and subcutaneous (SC) injections: $20
- Intrathecal injections: $40
- Creams/ointments/lotions less than or equal to 250 g/mL: $15
- Creams/ointments/lotions greater than or equal to 251 g/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 2 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

The maximum reimbursement for a combination of medication review services, clinical services or administration of vaccines for the same patient, on the same day, from the same pharmacy is $70.

Pharmacy markup

- Most drugs maximum: 8%
- High-cost drugs\(^i\) maximum: 5%
- Products subject to AAC pricing maximum: 7%

Coordination of benefits (public/private)

PharmaCare does not provide coverage for B.C. residents who are covered under other acts or programs as listed in Part 2, Section 6 of the Drug Plans Regulation 73/2015. These include Veterans Affairs Canada, Canadian Forces, Workers' Compensation and the Federal Non-Insured Health Benefits Program.

PharmaCare is considered the first payer and private insurance is the second payer.

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.

Reimbursement policy

The province does not reimburse for most out-of-province claims.

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\(^i\) 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).
Miscellaneous

**Prescription quantities:** 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).

**Quantity limits for blood glucose test strips:** Effective January 1, 2015, annual limits will depend on the beneficiary’s diabetes treatment category:

- Insulin dependent: 3,000 strips per year
- Managed with medications that have a high risk of causing hypoglycemia: 400 strips per year
- Managed with medications that have a low risk of causing hypoglycemia: 200 strips per year
- Managed through diet/lifestyle: 200 strips per year

**Travel supply:** PharmaCare covers out-of-province travel supplies of medication up to the PharmaCare maximum allowable days’ 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 pharmacy is required to retain this form on file for the normal record retention periods specified by the College of Pharmacists of British Columbia.

**Smoking cessation:** Each calendar year, eligible B.C residents will be able to get up to 12 continuous weeks of coverage for either 1 prescription smoking cessation drug or 1 NRT product (gum, patch, lozenge or inhaler).

**Source:** For more information, see [British Columbia PharmaCare](https://www.pharmacare.gov.bc.ca/).
Alberta

Eligibility

Plans/programs

- Seniors
- Widows
- Palliative
- Non-Group
- Rare Diseases Drug Program
- Outpatient Cancer Drug Benefit Program
- Specialized High Cost Drug Program
- Disease Control and Prevention
- Diabetic Supply Coverage
- Insulin Pump Therapy Program
- Low-income health benefits programs

General beneficiary information

Seniors: Residents age 65 and 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 65 and eligible dependents

Rare Diseases Drug Program: Residents who meet the clinical criteria for a rare disease drug product published on the list and who must not have an additional significant illness (i.e., not including the rare disease) likely to affect life expectancy

Outpatient Cancer Drug Benefit Program: Residents who require selected medications used in the direct treatment of cancer

Specialized High Cost Drug Program: Residents who require drugs used in highly specialized procedures and treatments, such as transplant, HIV, cystic fibrosis, human growth hormone, primary pulmonary hypertension and macular degeneration
Disease Control and Prevention: Residents who require prescription drugs for the treatment of tuberculosis and sexually transmitted diseases

Diabetic Supply Coverage: Residents who require insulin to treat diabetes

Insulin Pump Therapy Program: Residents who are diagnosed with type 1 diabetes and under the care of a physician or nurse practitioner for the condition

Low-income health benefits programs:

- **Income Support**: Residents who do not have the resources to meet their basic needs
- **Alberta Adult Health Benefit**: Residents with low income
- **Assured Income for the Severely Handicapped (AISH)**: Residents age 18 to 64 who have a permanent disability that severely affects their ability to earn a livelihood
- **Alberta Child Health Benefit**: Children of low-income families

Other eligibility criteria

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 be eligible to receive the Alberta Widows Pension or be in premium arrears for the plan.

Rare Diseases Drug Program: Residents must have government-sponsored drug coverage and

- Have been continuously registered in the AHCIP for at least 5 continuous years; or
- If younger than age 5, parents/guardians have been registered in the AHCIP for at least 5 continuous years; or
- Have moved from another province in Canada where they were covered by that province’s program for these drugs.

Outpatient Cancer Drug Benefit Program: A person must be a resident of Alberta, registered with AHCIP, registered in the Cancer Registry and require drugs to treat cancer.

Specialized High Cost Drug Program: A person must be a resident of Alberta, registered with AHCIP and require a high-cost drug to treat an eligible medical condition specified in the program.
**Diabetic Supply Coverage:** A person must be treated with insulin for diabetes and be registered with one of Alberta’s supplementary health benefit plans.

**Cost-sharing mechanism**

**Premium**

**Non-Group**
- Single: $63.50/month
- Family: $118/month

Subsidized rates are available, based on information reported on the prior year’s income tax return:
- Single: $44.45/month
- Family: $82.60/month

**Copayment/co-insurance**

**Seniors, Widows, Palliative and Non-Group drug plans:** 30% copayment per prescription, to a maximum $25

**Deductible**

None

**Maximum beneficiary contribution**

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

**Policy information**

**Ingredient price**

**Least-cost alternative (LCA) price:** The lowest unit cost established for a drug product within a set of interchangeable drug products

**Maximum allowable cost (MAC) price:** The maximum unit cost established for a specific drug product or group of drug products

**Manufacturer’s list price (MLP):** 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.
**Base price:** The price per unit of a drug product that is published in the Alberta Blue Cross Drug Price List. The base price applies to drug products not listed on the ADBL.

**Fixed pricing rules:** A tiered pricing system for entry interchangeable drugs is based on the number of products in the drug’s new interchangeable grouping. For an interchangeable drug listed or under consideration for listing in an established interchangeable grouping, the fixed price must be the lowest of the following:

- The lowest published price in Canada;
- The LCA (where the LCA price policy applies) or the submitted price (where the LCA price policy does not apply); or
- The most recent ADBL list price.

**Non-fixed pricing rules:** The confirmed price for a brand-name drug or other drug must be the lowest of

- 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);
- The submitted price where that drug product was not previously listed on the ADBL; or
- The previous price of the drug product listed on the ADBL, plus an increase that is less than or equal to the current Patented Medicine Prices Review Board (PMPRB) Guidelines, which will be used to determine acceptable price increases, up to a maximum of 5%.

**Non-oral solid dosage form drug pricing rules:** The confirmed price for a brand-name, interchangeable or other drug must be the lowest of the following:

- The lowest published price in Canada;
- The submitted price;
- The LCA price (if applicable); or
- The most recent ADBL list price.

**Transitional Period Price Policy:** 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.

**Generic pricing policy (percentage of brand-name drug)**

Effective May 1, 2013, all generic drugs are priced at 18% of the brand-name price. The price policy applies to both public and private plans.
**Professional fees: Product-related fees/services**

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

**Compounding fee:** For compound prescriptions prepared in a pharmacy, the cost of the prescription is the aggregate cost of all the ingredients plus an upcharge of 7.5%, plus a dispensing fee of $18.75. For purchased compound prescriptions, the cost is the purchased compound price, plus an allowable upcharge (6.5% to a maximum of $100 as of April 1, 2016), plus a dispensing fee of $12.30.

**Medication assessment fees**
- Trial prescription: $20
- Refusal to fill: $20
- Administration of injected medication: $20
- Prescription adaptation: $20
- Prescription renewal: $20
- Medication-related emergency: $20
- Initiation of medication therapy: $25

**Professional fees: Clinical services**

**Comprehensive Annual Care Plans (CACPs)**
- 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 the 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, chronic obstructive pulmonary disease (COPD), asthma, heart failure, ischemic heart disease and chronic renal failure

Group B (risk factors): mental health disorders, tobacco, obesity and addictions

**CACP fees**
- $100/medication review and $20/follow-up
- $125/medication review and $25/follow-up, if pharmacist has prescribing authority
Standard Medication Management Assessment (SMMA): Patients who do not meet the CACP criteria. Patients must have 1 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. 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.

SMMA fees
- $60/medication review and $20/follow-up
- $75/medication review and $25/follow-up, if pharmacist has prescribing authority

Pharmacy markup

Effective April 1, 2014

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowable Upcharge #1</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Allowable Upcharge #2*</td>
<td>5.5%</td>
<td>6%</td>
<td>6%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Note
Upcharge #2 to a maximum of $100

Coordination of benefits (public/private)

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.

Restricted/exception drug coverage process

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’s criteria (the approval period). If continued treatment is necessary beyond the approval period, it is the responsibility of the patient and physician to reapply for coverage prior to the expiration date of the approval period, unless the Auto-Renewal Process or Step Therapy Approval Process applies.
Reimbursement policy

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 ADBL at the time of service. Claims must be received within 12 months of the service date.

Miscellaneous

**Prescription quantities:** Seniors, Widows, Non-Group and Palliative programs: There is 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. 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

**Diabetic supply coverage:** Up to $600 worth of supplies

**Source:** For more information, visit [Alberta Health](https://www.albertahealth.ca).
Saskatchewan

Eligibility

Plans/programs

- Family Health Benefits
- Income Supplements
- Seniors’ Drug Plan
- Special Support Program
- Palliative Care Program
- Emergency Assistance for Prescription Drugs
- Saskatchewan Aids to Independent Living (SAIL)
- Supplementary Health Benefits
- Children’s Drug Program
- Saskatchewan Insulin Pump Program

General beneficiary information

Family Health Benefits: Low-income families with at least 1 child younger than 18. Eligible families must meet the standards of an income test administered by the Canada Revenue Agency, or they must receive benefits from the Ministry of Social Services’ Saskatchewan Employment Supplement (SES) or the Saskatchewan Rental Housing Supplement (SRHS).

<table>
<thead>
<tr>
<th>Number of children younger than 18</th>
<th>Previous year’s net annual family income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–3</td>
<td>&lt;$29,291</td>
</tr>
<tr>
<td>4–10</td>
<td>Add $1,392 per additional child</td>
</tr>
<tr>
<td>11–15</td>
<td>Up to $51,313</td>
</tr>
</tbody>
</table>

Income Supplements: Residents qualifying for the federal Guaranteed Income Supplement (GIS) and the Saskatchewan Seniors Income Plan (SIP)

Seniors’ Drug Plan: Residents age 65 and older who have applied and qualified based on income

Special Support Program: Residents who have high drug costs in relation to their income and who have qualified based on income
**Palliative Care Program:** Residents who are in the late stages of a terminal illness with a life expectancy measured in months, who have no appropriate treatment options to cure the illness or prolong life and who require care to maintain quality of life.

**Emergency Assistance for Prescription Drugs:** Residents who require immediate treatment with covered prescription drugs and are unable to cover their share of the cost may access a 1-time Emergency Assistance plan. 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):** Residents with specific disabling conditions, physical disabilities and chronic health conditions may be eligible for benefits under the various universal and special benefit programs (e.g., Paraplegia Program, Cystic Fibrosis Program, End Stage Renal Disease Program, Ostomy Program, Aids to the Blind Program). A resident must be referred for the service by an authorized health care professional. Unless preauthorized by Saskatchewan Health, the service must be obtained in Saskatchewan and the person must not be eligible to receive the service from any other government agency.

**Supplementary Health Benefits:** Government wards, inmates in correctional institutions, residents in care facilities and persons enrolled in certain income-support programs. There are 3 supplementary drug coverage programs:

- All plans: Individuals younger than 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 who need several different drugs on a long-term basis may be eligible for prescriptions at no charge. The physician or pharmacist may request coverage.
- Plan Three: Benefit prescriptions are received at no charge. The plan is designed for people receiving the SIP and residing in special care homes. Individuals living in approved homes and group homes may also be eligible.

**Children’s Drug Program:** Residents age 14 and younger

**Saskatchewan Insulin Pump Program:** Residents who are age 25 and younger, and who have type 1 diabetes and require a pump to adequately stabilize blood sugar levels

**Other eligibility criteria**

Residents 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 for and be covered under more than 1 program at the same time. The better benefit applies at the time a prescription is filled.

**Cost-sharing mechanism**

**Premium**
None

**Copayment/co-insurance**

**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.

**Seniors’ Drug Plan:** Up to $20 per benefit prescription; no charge for seniors who have SAIL or Palliative Care coverage

**SIP supplement or GIS recipients:** After deductible is met, 35% copayment; may apply for income-tested coverage

**Family Health Benefits:** After deductible is met, 35% copayment; however, no copayment on benefits for children younger than age 18

**Supplementary Health Benefits:**

- Younger than 18: None
- Plan One: Maximum $2 per benefit prescription
- Plan Two: May be eligible for prescriptions at no charge
- Plan Three: None

**Children’s Drug Plan:** Up to $20 per benefit prescription

**Deductible**

**GIS recipients**

- If living in the community: $200 semi-annual deductible
- If living in a special care home: $100 semi-annual deductible

**SIP recipients**

- $100 semi-annual deductible
Family Health Benefits

- $100 semi-annual family deductible

Deductibles may be reduced if recipients are eligible for additional drug coverage through the Special Support Program.

Policy information

Ingredient price

Low-cost alternative (LCA): Benefits are based on the lowest-priced interchangeable brand-name drug, as listed in the formulary.

Maximum allowable cost (MAC): This is the maximum price that the drug plan will cover for similar drugs used to treat the same condition.

Actual acquisition cost (AAC): 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.

Saskatchewan Insulin Pump Program: The program will pay the AAC up to the maximum formulary list price for insulin pump supplies.

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).

Generic pricing policy (percentage of brand-name drug)

Effective April 1, 2015, generic drugs (with certain exceptions, including pan-Canadian molecules at 18%) are priced as follows:

- Oral solid products: 25% of the brand-name price
- Other forms: 35% of the brand-name price

The price policy applies to both public and private sectors.

Professional fees: Product-related fees/services

Dispensing fee: Effective September 1, 2015, the maximum dispensing fee is $11.40.
**Trial prescriptions:** A specific list of drugs is eligible for a 7- or 10-day trial. Follow-up by a pharmacist is required. The usual and customary professional fee (to a maximum of $11.40) is paid for the trial quantity; if the medication is continued, no fee may be claimed on the remainder of the 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:** The methadone fee is $3.50 per day ($24.50 per week) and is paid only for face-to-face interactions with the pharmacist.

**Direct observed therapy (DOT) for Sovaldi and Harvoni:** Effective April 1, 2015, the DOT fee is $3.50 per day ($24.50 per week) and is paid when pharmacists observe the patient ingest these drugs.

**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

The current CeRx integration supplement of $0.20 per prescription for integrated pharmacies will remain in effect for 2015–2016.

**Professional fees: Clinical services**

**Emergency contraception prescribing:** Prescribing fee equal to 2 times the usual dispensing fee above and beyond the cost of the 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: 1 annual medication assessment fee to a maximum of $60 per year per person
- Up to 2 follow-up patient assessment fees at a rate of $20 each, to a maximum of $40 per person per year
Patient assessments (maximum amount per 28 days per patient)
- Continuing existing prescription (interim supply and unable to access): $6 (maximum 4)
- Insufficient information: $6 (maximum 1)
- Continuing existing prescription (emergency situation): $10 (maximum 1)
- Drug reconciliation: $25 (maximum 1)
- Increasing suitability of a drug: $6 (maximum 4)
- Minor ailments: A patient assessment fee of $18 will be paid where an assessment results in a pharmacist prescribing an eligible prescription medication. Maximums vary depending on the minor ailment condition.

Smoking cessation
- Bronze level (identification of tobacco users in practice site and assessing stage of change): maximum $5 per person per year
- Bronze Plus level (identification of tobacco users in practice site, assessing stage of change and level of conviction and confidence): maximum $10 per person per year
- Silver/Gold level (tobacco user previously indicates quitting tobacco within 6 months or ready to quit): maximum $180 per person per year
- Follow-up: $10 per follow-up (maximum $100 per person per year)
- Group sessions: maximum $150 per person per year

Pharmacy markup

Maximum markup allowance calculated on the prescription drug cost:

<table>
<thead>
<tr>
<th>Drug cost</th>
<th>Markup</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.01–$6.30</td>
<td>30%</td>
</tr>
<tr>
<td>$6.31–$15.80</td>
<td>15%</td>
</tr>
<tr>
<td>$15.81–$200.00</td>
<td>10%</td>
</tr>
<tr>
<td>&gt;$200.01</td>
<td>$20 maximum</td>
</tr>
</tbody>
</table>

Urine testing agents: Markup as above, plus 50%

Insulin: Acquisition cost plus a negotiated markup

Saskatchewan Insulin Pump Program: No markup allowed
Coordination of benefits (public/private)

The drug plan is the first payer on eligible claims for eligible beneficiaries.

Restricted/exception drug coverage process

Eligible prescribers, authorized office staff or pharmacists may apply for Exception Drug Status (EDS) on behalf of a patient.

Patients are notified of approvals; 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.

Reimbursement policy

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.

Miscellaneous

Prescription quantities: 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 a time.

A pharmacist may charge 1 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 that 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 100-day-supply drugs. 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 products: 6%
- Generic drugs: 6.5%
- Most other drugs: 8.5%

Wholesale markup is capped at $50 per package size.

Source: For more information, visit Saskatchewan Health Drug Plan and Extended Benefits Branch.

Manitoba

Eligibility

Plans/programs

- Pharmacare
- Employment and Income Assistance Program
- Personal Care Home/Nursing Homes
- Palliative Care Drug Access Program
- Home Cancer Drug Program
- Pediatric Insulin Pump Program

General beneficiary information

Pharmacare: All residents who are eligible for benefits under The Prescription Drugs Cost Assistance Act

Employment and Income Assistance Program: Residents who demonstrate financial need

Personal Care Home/Nursing Homes: Residents of personal care homes

Palliative Care Drug Access Program: Residents who are terminally ill and wish to remain 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 and whose prescriptions for eligible outpatient oral cancer and specific supportive drugs are not being covered by other provincial or federal programs
Pediatric Insulin Pump Program: Residents younger than age 18 diagnosed with type 1 diabetes and for whom a pediatric insulin pump is medically appropriate, as determined by Diabetes Education Resource for Children and Adolescents (DER-CA) physicians and who agree to be regularly monitored by DER-CA

Other eligibility criteria

Persons who meet the following qualifications are designated as individuals eligible to receive benefits under the act:

- A person must be a resident as defined in *The Health Services Insurance Act* and be registered and eligible for benefits under that act.
- 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.

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

None

Deductible

Pharmacare

- Annual threshold based on total adjusted family income
- Minimum deductible is $100
## Deductible rates for adjusted family incomes, 2016–2017

<table>
<thead>
<tr>
<th>Lower limit</th>
<th>Upper limit</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤$15,000</td>
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<td>3.01%</td>
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<tr>
<td>&gt;$15,000</td>
<td>≤$21,000</td>
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<td>&gt;$42,500</td>
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<td>5.26%</td>
</tr>
<tr>
<td>&gt;$45,000</td>
<td>≤$47,500</td>
<td>5.36%</td>
</tr>
<tr>
<td>&gt;$47,500</td>
<td>≤$75,000</td>
<td>5.43%</td>
</tr>
<tr>
<td>&gt;$75,000</td>
<td>—</td>
<td>6.81%</td>
</tr>
</tbody>
</table>

**Pediatric Insulin Pump Program:** While the insulin pump is fully funded, supplies designated as benefits may be eligible for coverage under provincial drug programs, including the Manitoba Pharmacare Program. To have the cost of eligible insulin pump supplies covered by Manitoba Health, the patient and family must be enrolled in a provincial drug program.

### Maximum beneficiary contribution

The maximum beneficiary contribution is the calculated deductible.

### Policy information

#### Ingredient price

**Lowest-cost pricing:** Benefits are based on the lowest-priced interchangeable brand-name drug as listed in the formulary, whether or not the specified drug is prescribed with a “no sub” or “no substitution” instruction.
Generic pricing policy (percentage of brand-name drug)

Manitoba has established a policy/contractual approach for multisource generic pharmaceutical products. The policy/contractual framework for multisource generic pharmaceutical products includes submission criteria requiring pricing equal to that of other jurisdictions, a price guarantee for a minimum of 365 days and supply commitments by the manufacturer.

Professional fees: Product-related fees/services

The professional fee for Pharmacare is equal to the amount regularly charged by a pharmacist to persons who are responsible for paying the fee without reimbursement.

The Employment and Income Assistance Program has a maximum professional fee of $6.95.

Monthly capitation fee for personal care homes: $37.50 per bed per month for Winnipeg; $38.20 per bed per month for rural areas

Restricted/exception drug coverage process

The prescriber must contact the Exception Drug Status (EDS) office of Provincial Drug Programs to request eligibility for a prescription; eligibility is from the date of approval.

Reimbursement policy

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.

Miscellaneous

Prescription quantities: 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 days
- Up to an additional 100 days, if the prior approval of the minister has been obtained and the person will be outside of Canada for more than 90 consecutive days

Source: For more information, visit [Manitoba Health, Seniors and Active Living](https://www.gov.mb.ca/health/services/pharmacare/).
Ontario

Eligibility

Plans/programs

- Ontario Drug Benefit Program (ODB)
- Trillium Drug Program (TDP)
- Special Drugs Program (SDP)
- Inherited Metabolic Diseases Program (IMD)
- Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program (RSV)
- Pharmacy Smoking Cessation Program
- Visudyne Program

General beneficiary information

Ontario Drug Benefit Program: Residents age 65 and 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 residents who do not qualify under any of the other public drug plans or whose private insurance does not cover 100% of the prescription drug costs and who 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 deficiency, schizophrenia, Gaucher’s disease and thalassemia. Patients must be under the care of an Ontario doctor at a designated treatment centre for the disease or condition.

Inherited Metabolic Diseases Program: Residents with a valid health card for certain outpatient drugs, supplements and specialty foods used in the treatment of specific inherited metabolic disorders

Respiratory Syncytial Virus Prophylaxis for High-Risk Infants Program: Residents who are younger than age 2 at the start of the RSV season and who are at high risk for hospitalization and complications from RSV infection
**Pharmacy Smoking Cessation Program:** 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.

**Visudyne Program:** Residents who require treatment for age-related macular degeneration. This program funds the full cost of the drug verteporfin under specific circumstances.

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

**Other eligibility criteria**

**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 to 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 to 35 completed weeks gestation and those younger than 6 months at the start of or during the local RSV season and who live in isolated communities where pediatric hospital care is not readily accessible and ambulance transportation for hospital admission is required; or
- Infants younger than age 24 months with Down syndrome/trisomy 21 syndrome; or
- Infants younger than age 24 months 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 age 24 months with hemodynamically significant cyanotic or acyanotic congenital heart disease who require corrective surgery or are on cardiac medication for hemodynamically significant disease; or
- Infants with other specific medical illnesses that place them at high risk of hospitalization and complications from an RSV infection, if they meet necessary requirements

**Cost-sharing mechanism**

**Premium**

None
Copayment/co-insurance

**ODB:** A recipient pays up to $2 per prescription if he or she is
- A senior single person with an annual net income of less than $16,018;
- Part of a senior couple with a combined annual net income of less than $24,175;
- A recipient of benefits under the *Ontario Works Act* or the *Ontario Disability Support Program Act*;
- A recipient of professional services under the Home Care Program; or
- A resident of a long-term care facility or home for special care.

**ODB:** A recipient pays up to $6.11 toward the ODB dispensing fee per prescription if he or she is
- A senior single person with an annual net income equal to or greater than $16,018; or
- Part of a senior couple with a combined annual net income equal to or greater than $24,175.

$2.83 for each prescription dispensed from an outpatient hospital pharmacy

**Trillium Drug Program:** Recipients pay up to $2 for each prescription.

Deductible

**ODB:** $100 deductible for
- Single seniors with annual income equal to or greater than $16,018; and
- Senior couples with a combined annual income equal to or greater than $24,175.

**Trillium Drug Program:** Applicants must pay a quarterly or prorated deductible that is based on income.

Policy information

Ingredient price

**Drug benefit price (DBP):** 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.

Drug products are reimbursed at the listed DBP (or lowest DBP for an interchangeable category) plus a markup, plus the lesser of a pharmacy’s posted usual and customary fee or the ODB dispensing fee, minus the applicable copayment amount.
Generic pricing policy (percentage of brand-name drug)

All generics as of April 1, 2012: 25%

The price policy applies to both public and private sectors.

Professional fees: Product-related fees/services

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

Effective October 1, 2015, the dispensing fee for claims for long-term care home residents is between $7.57 and $11.99.

Effective October 1, 2015, the number of dispensing fees paid to pharmacies for 15 categories of chronic-use medications is limited to a maximum of 5 dispensing fees per recipient, per drug (by interchangeable category), per 365-day period. Exceptions exist for patients in long-term care homes, Ontario Works recipients and/or all extemporaneous preparations of chronic-use medications.

Professional fees: Clinical services

MedsCheck (MC) Program: Residents are eligible to receive an annual review and follow-up reviews if they are

- 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 homebound 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 Long-Term Care and $50/quarterly review

Pharmaceutical Opinion Program fee (ODB recipients only)

Pharmacist clinical intervention (identification of a potential drug-related problem) at the time of dispensing a new/repeat prescription or when conducting a MedsCheck

- $15 per intervention in collaboration with prescriber
**Pharmacy Smoking Cessation Program fee** (ODB recipients only)

- $40 for first consultation (once per year)
- $15 for primary follow-up counselling sessions (3 times per year = $45 total)
- $10 for secondary follow-up counselling sessions (4 times per year = $40 total)

**Pharmacy markup**

Claims for prescriptions with total drug costs less than $1,000 are reimbursed with an 8% markup.

Effective October 1, 2015, the markup for all claims for high-cost drugs (total drug cost equal to or greater than $1,000) will be 6%.

**Coordination of benefits (public/private)**

ODB is considered the first payer and private insurance is the second payer.

**Restricted/exception drug coverage process**

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 certain drugs and assessed in real time.

**Reimbursement policy**

Claims can be reimbursed for eligible drugs only, when the prescription is written by a physician licensed in Ontario and the drug is dispensed in Ontario.

**Miscellaneous**

**Prescription quantities**

- 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 the 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.

**Source:** For more information, visit [Ontario Public Drug Programs](#).

**New Brunswick**

**Eligibility**

**Plans/programs**

- Seniors (A)
- Cystic Fibrosis (B)
- Adults in Licensed Residential Facilities (E)
- Social Development Clients (F)
- Special Needs Children and Children in the Care of the Minister of Social Development (G)
- Multiple Sclerosis (H)
- Influenza (I)
- Tuberculosis (TB) Drug Program (P)
- Organ Transplant (R)
- Growth Hormone Deficiency (T)
- HIV/AIDS (U)
- Nursing Home (V)
- Extra-Mural Program (W)
- New Brunswick Drug Plan (D)
- New Brunswick Drugs for Rare Diseases Plan

**General beneficiary information**

**Seniors:** Residents age 65 and older who receive the GIS or who qualify for benefits based on an annual income. Residents age 65 and older who are not eligible for the Seniors Plan under the New Brunswick Prescription Drug Program (NBPDP) because they do not meet the income requirements may enrol in the Medavie Blue Cross Seniors’ Prescription Program.

**Cystic Fibrosis:** Cystic fibrosis patients or patients with juvenile or infant sclerosis of the pancreas who have a valid health card and who do not have coverage for any portion of the cost of cystic fibrosis drugs from any other drug plan
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

Social Development Clients: Individuals holding a valid health card for prescription drugs issued by the Department of Social Development

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

Multiple Sclerosis: Residents diagnosed with MS who are in possession of a prescription written by a neurologist for eligible medications

Influenza: Residents and children with selected chronic health conditions significant enough to require regular medical follow-up or hospital care; or residents of nursing homes and other chronic-care facilities; or residents older than age 65; or pregnant women; or healthy children age 6 months to 18 years; or Aboriginal people; or residents capable of transmitting influenza to those at high risk

Tuberculosis (TB) Drug Program: Any patient (regardless of permanent residence) who presents a prescription on which “TB Plan” is written by the prescriber

Organ Transplant: New Brunswick residents who have received (or are on the active waiting list to receive) a solid organ or bone marrow transplant, who are registered with New Brunswick Medicare and who are not entitled to receive similar benefits from any other source

Growth Hormone Deficiency: Residents younger than age 18 with growth hormone deficiency or hypopituitarism who are registered on the plan by an endocrinologist and who are not entitled to receive similar benefits from any other source

HIV/AIDS: Individuals diagnosed with HIV/AIDS who are registered with the NBPDP through a provincial infectious disease specialist and who are not entitled to receive similar benefits from any other source

Nursing Home: Individuals who reside in a registered nursing home

Extra-Mural Program: Residents with a valid Medicare card (or who are in the process of receiving one) are eligible to receive extra-mural services, as long as their health care needs can be met safely in the home. Patients must be in possession of a Prescription Drug Authorization Form.

New Brunswick Drug Plan: Residents with an active Medicare card 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 early or lifetime maximum for drug coverage
New Brunswick Drugs for Rare Diseases Plan: Individual must have one of a specific list of rare diseases and must be a permanent resident of New Brunswick and have a valid Medicare card. A request form for a listed drug must be completed by the physician and the individual must meet the clinical criteria for the drug requested.

Other eligibility criteria

Seniors

For those not receiving the GIS:

- Single: annual income of $17,198 or less
- Senior couple, both age 65 and older: combined annual income of $26,955 or less
- Senior couple with 1 spouse younger than 65: combined annual income of $32,390 or less

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.

Cost-sharing mechanism

Premium

Medavie Blue Cross Seniors’ Prescription program: Effective July 1, 2015: $115 per month

Cystic Fibrosis, Multiple Sclerosis, Organ Transplant, Growth Hormone Deficiency, HIV/AIDS: $50 per year for each plan

New Brunswick Drug Plan: Income-based premiums

Effective April 1, 2015

<table>
<thead>
<tr>
<th>Gross income (individual)</th>
<th>Annual premium</th>
<th>Monthly premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$17,884</td>
<td>$200</td>
<td>$16.67</td>
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<tr>
<td>$17,885–$22,346</td>
<td>$400</td>
<td>$33.33</td>
</tr>
<tr>
<td>$22,347–$26,360</td>
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<tr>
<td>$26,361–$50,000</td>
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</tr>
<tr>
<td>&gt;$75,000</td>
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</tbody>
</table>
### Gross Income (single with children/couple without children)

<table>
<thead>
<tr>
<th>Gross Income Range</th>
<th>Annual Premium</th>
<th>Monthly Premium</th>
</tr>
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<tbody>
<tr>
<td>&lt;$26,826</td>
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<tr>
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</tr>
<tr>
<td>&gt;$100,000</td>
<td>$2,000</td>
<td>$166.67</td>
</tr>
</tbody>
</table>

### Copayment/co-insurance

#### Seniors
- GIS: $9.05 per prescription
- Non-GIS: $15 per prescription
- Medavie Blue Cross Seniors’ Prescription Drug Program: $15 per prescription

#### Adults in Licensed Residential Facilities
- $4 per prescription

#### Social Development Clients
- $4 per prescription for adults 18 and older
- $2 per prescription for children younger than 18

#### Multiple Sclerosis
- Income-tested annually

#### Cystic Fibrosis, Organ Transplant, Growth Hormone Deficiency and HIV/AIDS
- 20% per prescription to a maximum of $20

#### Extra-Mural Program
- $9.05 per prescription

#### New Brunswick Drug Plan
- 30% per prescription to a maximum amount as outlined below
Effective April 1, 2015

<table>
<thead>
<tr>
<th>Gross income (individual)</th>
<th>Maximum copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$17,884</td>
<td>$5</td>
</tr>
<tr>
<td>$17,885–$22,346</td>
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<tr>
<td>$22,347–$26,360</td>
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<td>$25</td>
</tr>
<tr>
<td>&gt;$75,000</td>
<td>$30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gross income (single with children/couple without children)</th>
<th>Maximum copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$26,826</td>
<td>$5</td>
</tr>
<tr>
<td>$26,827–$33,519</td>
<td>$10</td>
</tr>
<tr>
<td>$33,520–$49,389</td>
<td>$15</td>
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<tr>
<td>$49,390–$75,000</td>
<td>$20</td>
</tr>
<tr>
<td>$75,001–$100,000</td>
<td>$25</td>
</tr>
<tr>
<td>&gt;$100,000</td>
<td>$30</td>
</tr>
</tbody>
</table>

**Deductible**

None

**Maximum beneficiary contribution**

- **Seniors Receiving GIS**: $500 per calendar year
- **Cystic Fibrosis, Organ Transplant, Growth Hormone Deficiency and HIV/AIDS**: $500 maximum copayment plus a premium per family unit per fiscal year
- **Adults in Licensed Residential Facilities**: $250 per person in a fiscal year
- **Social Development Clients**: $250 per family unit in a fiscal year
Policy information

Ingredient price

Effective June 1, 2013, the drug cost for each eligible prescription is as below:

<table>
<thead>
<tr>
<th>Drug category</th>
<th>Ingredient cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interchangeable</td>
<td>Up to MAP</td>
</tr>
<tr>
<td>Non-interchangeable</td>
<td>Up to MLP + up to 8%</td>
</tr>
<tr>
<td>Extemporaneous preparations (compounds)</td>
<td>AAC</td>
</tr>
<tr>
<td>Methadone oral solution</td>
<td>Up to MAP</td>
</tr>
</tbody>
</table>

Notes
MAP: Maximum allowable price.
MLP: Manufacturer’s list price.
AAC: Actual acquisition cost.

Generic pricing policy (percentage of brand-name drug)

Effective June 1, 2013

- 25% for solid oral dosage forms
- 35% for non-solid oral dosage forms

Professional fees: Product-related fees/services

Effective June 1, 2014

- Pharmaceutical equivalent (interchangeable): up to $11
- Non-pharmaceutical equivalent (non-interchangeable): up to $11
- Extemporaneous preparations (compounds): up to $16.50
- Methadone for chronic pain: up to $11
- Drugs for opioid dependence (e.g., methadone, buprenorphine/naloxone): up to $9.50

Effective July 2, 2013, the NBPDP will pay for 1 dispensing fee every 28 days or more for drugs in solid oral dosage form taken on a continuous basis.

The NBPDP rural pharmacy incentive pays an additional $2 dispensing fee for each of the first 10,000 NBPDP prescriptions filled per fiscal year to the pharmacies in a community that are 25 kilometres or more apart from each other.
Professional fees: Clinical services

New Brunswick PharmaCheck Program: $52.50

Limit of 1 medication checkup review per NBPDP (Plan A, Plan E and Plan F) beneficiary who is taking 3 or more chronic prescription medications per year

Pharmacy markup

Effective June 1, 2013: Up to 8% markup on interchangeable drugs

Coordination of benefits (public/private)

N/A

Coordination of benefits (intrajurisdictional)

N/A

Restricted/exception drug coverage process

Drugs not listed as regular benefits may be eligible for reimbursement under the NBPDP 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 on a case-by-case basis 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)
- Products specifically excluded as benefits as identified on the exclusion list (NBPDP formulary)

Special authorization requests must be submitted in writing by a prescriber to the NBPDP Special Authorization Unit.
Reimbursement policy

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.

Miscellaneous

Prescription quantities

- 100-day supply
- 35-day supply for narcotics, controlled drugs and benzodiazepine

Quantitative limits have been established for a number of products listed as benefits of the NBPDP.

Travel supply: 1 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.

Source: For more information, visit New Brunswick Prescription Drug Program and New Brunswick Drug Plan.

Nova Scotia

Eligibility

Plans/programs

- Family Pharmacare Program (F)
- Department of Community Services Pharmacare Benefits (F)
- Seniors’ Pharmacare Program (S)
- Drug Assistance for Cancer Patients (C)
- Diabetes Assistance Program (D)
- Palliative Home Care Drug Coverage (PHCDC) Program
- Insulin Pump Program
- Under 65 — Long-Term Care (LTC) Pharmacare Plan (F)
- Low Income Pharmacare for Children
General beneficiary information

**Family Pharmacare Program:** Families, including families of 1, who apply for the program; any permanent Nova Scotia resident (age 18 and older) with a valid Nova Scotia health card number is eligible to enrol; must not have coverage through Department of Community Services Programs, Seniors’ Pharmacare Program, Diabetes Assistance Program or Under 65 — Long-Term Care Pharmacare Plan

**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

**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 Veterans Affairs Canada, First Nations and Inuit Health, Nova Scotia Family Pharmacare or any other drug insurance plan for diabetes medications and supplies (this program closed to new enrolments as of April 1, 2010)

**Department of Community Services Pharmacare Benefits:** Residents younger than age 65 and their dependents in receipt of income assistance who do not have access to another drug plan, be it from a public or private entity

**Seniors’ Pharmacare Program:** Residents age 65 and older and who do not have drug coverage through Veterans Affairs Canada, Non-Insured Health Benefits, Nova Scotia Family Pharmacare or any other public or private plan that covers most medications and supplies after age 65

**Palliative Home Care Drug Coverage (PHCDC) Program:** Residents diagnosed as palliative and receiving treatments at home

**Insulin Pump Program:** Residents younger than age 25 who have type 1 diabetes

**Under 65 — Long-Term Care (LTC) Pharmacare Plan:** Regular bed residents of a long-term care facility who are younger than 65, have a valid Nova Scotia health card and do not have access to, or coverage under, another public or private drug plan

**Low Income Pharmacare for Children:** Children of low-income families who receive the Nova Scotia Child Benefit

**Other eligibility criteria**

**Drug Assistance for Cancer Patients:** Gross family income no greater than $15,720
Family Pharmacare Program, Drug Assistance for Cancer Patients and Diabetes Assistance Program: Residents must agree to provide family size information and annual family income verification through Canada Revenue Agency.

Diabetes Assistance Program: Enrolment for this program ceased March 31, 2010. New patients can choose to register in the Family Pharmacare Program.

Cost-sharing mechanism

Premium

Seniors’ Pharmacare Program: Married and joint income between $21,000 and $28,000

Effective April 1, 2016

<table>
<thead>
<tr>
<th>Gross income (individuals)</th>
<th>Annual premium</th>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>$22,986–$35,000</td>
<td>&lt;$424</td>
</tr>
<tr>
<td>≥$35,000</td>
<td>$424</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gross income (couples)</th>
<th>Annual premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$26,817</td>
<td>$0</td>
</tr>
<tr>
<td>$26,817–$40,000</td>
<td>&lt;$424 each</td>
</tr>
<tr>
<td>≥$40,000</td>
<td>$424 each</td>
</tr>
</tbody>
</table>

Copayment/co-insurance

Family Pharmacare Program: 20% copayment per prescription, to an annual maximum based on a sliding scale (percentage of adjusted family income)

Diabetes Assistance Program: 20% per prescription

Department of Community Services Pharmacare Benefits: $5 per prescription unless eligible for copayment exemption

Seniors’ Pharmacare Program: 30% per prescription with an annual maximum

Insulin Pump Program: Calculated based on family income and dependents

Low Income Pharmacare for Children: Families pay $5 per prescription
Deductible

Family Pharmacare Program: Sliding scale percentage based on adjusted family income

Diabetes Assistance Program: Percentage based on adjusted family income and size

Maximum beneficiary contribution

Family Pharmacare Program: Annual family copayment plus deductible based on family income and size

Seniors’ Pharmacare Program: Annual maximum copayment of $382 plus a premium

Policy information

Ingredient price

Manufacturer’s list price (MLP): The published price at which a drug or device is sold to a provider or wholesaler and does not include any markup for distribution

Maximum reimbursable price (MRP): The maximum cost established by the Pharmacare Program at which a benefit is reimbursed to a provider or beneficiary for a category of interchangeable products

Pharmacare reimbursement price (PRP): A special maximum amount the program reimburses providers for 1 unit of a drug, supply or service as assigned by the minister to each of the following:

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

Actual acquisition cost (AAC): The net cost to the provider after deducting all rebates, allowances, free products, etc.

Net cost is the drug ingredient (or supply) costs based on date of purchase. Incentives for prompt payment are not included in the calculation.

Generic pricing policy (percentage of brand-name drug)

Effective November 12, 2014

- 25%: solid oral form, multisource generics
- 35%: non-solid oral dosage forms
**Professional fees: Product-related fees/services**

**April 1, 2016, to March 31, 2017**

- Ostomy supplies: $11.75
- Compounded extemporaneous products (except methadone and injectables): $17.62

All other prescriptions for drugs or supplies, including methadone: $11.75

**Professional fees: Clinical services**

The Pharmacare Program reimburses special services fees to the following maximums:

- **Advanced medication review (AMR):** $150
  - Only beneficiaries of the Seniors' Pharmacare Program are eligible.
  - Limit of 1 AMR per benefit year

- **Basic medication review (BMR):** $52.50
  - Beneficiaries of any Nova Scotia Pharmacare Program except the Under 65 — LTC program are eligible.
  - Limit of 1 BMR per benefit year

- **Prescription adaptation:** $14

- **Therapeutic substitution:** $26.25

**Pharmacy markup**

**Effective October 1, 2014**

- Ostomy supplies: AAC plus 10.0% (maximum $50)
- Compounded extemporaneous products (except methadone and injectables): AAC plus 2.0% (maximum $50)
- Methadone: MRP or PRP plus 8%

All other prescriptions

- MLP plus 10.5% (if the ingredient cost is $3,000 or less); or
- MLP plus 8% (if the ingredient cost is greater than $3,000); or
- MRP or PRP plus 8%
Coordination of benefits (public/private)

**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.

**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.

Restricted/exception drug coverage process

Exception Status Drugs are those that are eligible for coverage under the Pharmacare Program only when an individual meets criteria developed by the Atlantic or Canadian Expert Advisory Committee.

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 pharmacy 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 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 Pharmacare. 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.

Reimbursement policy

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.
**Miscellaneous**

**Prescription quantities:** 100-day supply maximum, if prescribed

A maximum of 1 dispensing fee per 28 days for maintenance medication

**Travel supply:** Seniors’ Pharmacare Program beneficiaries travelling outside the province for more than 100 days will be allowed to obtain 2 prescriptions for the same medication before leaving Nova Scotia. Neither prescription can exceed a 90-day supply (maximum 180-day supply for 2 prescriptions). The usual professional fee and copayment are applied to each of the prescriptions.

**Source:** For more information, visit [Nova Scotia Pharmacare Drug Programs](#).

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**Prince Edward Island**

**Eligibility**

**Plans/programs**

- AIDS/HIV Program (A)
- Community Mental Health Program (B)
- Cystic Fibrosis Program (C)
- Diabetes Drug Program (D)
- Erythropoietin Program (E)
- Family Health Benefit Drug Program (F)
- Generic Drug Program (G)
- Hepatitis Program (H)
- Immunization Program (I)
- Meningitis Program (K)
- Opioid Replacement Therapy Program (L)
- High Cost Drug Program (M)
- Institutional Pharmacy Program (N)
- Nursing Home Drug Program (N)
- Nutrition Services Program (O)
- Phenylketonuria (PKU) Program (P)
- Catastrophic Drug Program (Q)
- Rabies Program (R)
• Seniors Drug Cost Assistance Program (S)
• Transplant Anti-rejection Drug Program (T)
• Rheumatic Fever Program (U)
• Sexually Transmitted Diseases (STD) Program (V)
• Children in Care Program (W)
• Financial Assistance Program (W)
• Tuberculosis (TB) Drug Program (X)
• Growth Hormone Drug Program (Y)
• Quit Smoking Program (Z)
• Home Oxygen Program
• Insulin Pump Program

**General beneficiary information**

**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 non–work related needle stick injury and do not have private insurance

**Community Mental Health Program:** Approved long-term psychiatric patients living in the community

**Cystic Fibrosis Program:** Persons diagnosed with cystic fibrosis

**Diabetes Drug Program:** Persons diagnosed with diabetes and registered with the provincial Diabetes Drug Program

**Erythropoietin Program:** Persons diagnosed with chronic renal failure or receiving kidney dialysis

**Family Health Benefit Drug Program:** Families (parents, guardians and children younger than 18 or younger than 25 and in full-time attendance at a post-secondary educational institution while supporting at least 1 child), with a total net family income less than the threshold (see Other eligibility criteria below); coverage must be applied for on an annual basis.

**Generic Drug Program:** Persons younger than age 65 who do not have private drug insurance

**Hepatitis Program:** Persons diagnosed with hepatitis, persons who have been in close contact with a person diagnosed with hepatitis or persons with an occupational risk of infection

**Immunization Program:** Children (younger than age 18) at risk for exposure to various communicable diseases
Meningitis Program: Persons diagnosed with meningitis or persons who have been in close contact with a person diagnosed with meningitis and are at risk of infection

Opioid Replacement Therapy Program: Persons assessed by a clinical team and determined to require treatment for an opioid dependency who are registered in a program of opioid addiction therapy

High Cost Drug Program: Persons approved for coverage of 1 or more of the medications for ankylosing spondylitis, cancer, Crohn's disease, multiple sclerosis, pulmonary hypertension, plaque psoriasis, psoriatic arthritis, rheumatoid arthritis and wet age-related macular degeneration included in the program; coverage must be applied for annually and is based on household income

Institutional Pharmacy Program: Residents in government long-term care nursing homes or manors

Nursing Home Drug Program: Permanent residents in private nursing homes who qualify for financial assistance through the Social Assistance Program

Nutrition Services Program: High-risk pregnant women diagnosed with a nutritional deficiency who are receiving service from a community nutritionist or low-income pregnant women who are receiving financial assistance or determined to be in need of financial assistance by a community nutritionist

Phenylketonuria (PKU) Program: Persons diagnosed with phenylketonuria

Catastrophic Drug Program: Permanent residents of P.E.I. with a valid PEI Health card and with the financial burden of eligible high prescription drug costs

Rabies Program: Persons exposed to or at increased risk of exposure to rabies through an animal bite

Seniors Drug Cost Assistance Program: Persons age 65 and older

Transplant Anti-rejection Drug Program: Persons who have had a solid organ or bone marrow transplant

Rheumatic Fever Program: Persons who have a well-documented history of rheumatic fever or rheumatic heart disease

Sexually Transmitted Diseases (STD) Program: Persons diagnosed with a sexually transmitted disease or identified contacts of a person diagnosed with a sexually transmitted disease
**Children in Care Program:** Persons in the temporary or permanent custody of the director of child protection; persons eligible for financial assistance under the *Social Assistance Act* and its regulations

**Tuberculosis (TB) Drug Program:** Persons diagnosed with tuberculosis or who have been in close contact with a person diagnosed with tuberculosis (confirmed by the chief health officer of the Department of Health and Social Services)

**Growth Hormone Drug Program:** Children (younger than age 18) with a proven growth hormone deficiency or Turner syndrome

**Quit Smoking Drug Program:** Persons participating in the smoking cessation program through Addiction Services

**Home Oxygen Program:** Persons prescribed oxygen by a specialist and who have been diagnosed with chronic obstructive pulmonary disease (COPD)

**Insulin Pump Program:** Children and youth younger than age 19 with type 1 diabetes who have been referred to the provincial Diabetes Program

**Other eligibility criteria**

**Family Health Benefit Drug Program**

<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</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0–$20,000</td>
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<tr>
<td>&gt;$20,000–$50,000</td>
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<tr>
<td>&gt;$50,000–$100,000</td>
<td>8%</td>
</tr>
<tr>
<td>&gt;$100,000</td>
<td>12%</td>
</tr>
</tbody>
</table>

**Insulin Pump Program**

<table>
<thead>
<tr>
<th>Yearly household income</th>
<th>Percentage of eligible coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0–$20,000</td>
<td>90%</td>
</tr>
<tr>
<td>&gt;$20,000–$50,000</td>
<td>80%</td>
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<tr>
<td>&gt;$50,000–$100,000</td>
<td>70%</td>
</tr>
<tr>
<td>&gt;$100,000</td>
<td>60%</td>
</tr>
</tbody>
</table>

**Cost-sharing mechanism**

**Premium**
None

**Copayment/co-insurance**

**Diabetes**
- Insulin: $10/10 mL vial or $20/5 × 3 mL cartridges of insulin
- Blood glucose test strips: $11 per prescription to a maximum of 100 strips every 30 days
- Oral medications and urine testing materials: $11 per prescription

**Family Health Benefit Drug Program**: Professional fee for each prescription

**High Cost Drug Program**: Income-based portion of the drug plus the professional fee for each prescription
Seniors Drug Cost Assistance Plan: First $8.25 of the medication cost plus $7.69 of the professional fee for each prescription

Quit Smoking Program: Patients are responsible for all medication costs approved, except for the first $75 per year, which will be paid by the program.

Home Oxygen Program: PEI Medicare program pays 50% of the eligible expenses up to $200 per month.

Hepatitis Program: Vaccine may be purchased at cost by persons with an occupational risk of infection.

Insulin Pump Program: The program will calculate out-of-pocket copayment expenses based on family income, private insurance coverage and other considerations.

Generic Drug Program: The beneficiary pays for each prescription out of pocket up to the program maximum cost of $19.95 per prescription.

Deductible

Catastrophic Drug Program

<table>
<thead>
<tr>
<th>Total household income range</th>
<th>Rate</th>
</tr>
</thead>
<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>
</tr>
</tbody>
</table>

Maximum beneficiary contribution

Catastrophic Drug Plan: The maximum beneficiary contribution is the calculated deductible.

Policy information

Ingredient price

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%.

When no MRP exists, the price is 10% of the ingredient cost of all brand-name drugs for which the prescription cost is $2,702 or less and 9.25% of the ingredient cost of all brand-name drugs where the prescription cost is more than $2,702.
Generic pricing policy (percentage of brand-name drug)

December 2013: 25%

The price policy applies to both public and private sectors.

Professional fees: Product-related fees/services

Effective April 1, 2015

- Dispensing fee is the usual and customary charge to a maximum of $12.36.
- Compounding fee is the usual and customary charge times 1.5, to a maximum of $18.54.
- Private nursing home capitation fee is $76.52.
- Compliance packaging is $25 per 28 days.
- Prescription adaptation is 1.2 times current dispensing fee.
- Refusal to fill is 1.2 times current dispensing fee.
- Therapeutic substitution is 1.2 times current dispensing fee.

Professional fees: Clinical services

Medication review service

Medication reviews are for clients who are eligible under 1 of the following programs:

- Seniors Drug Cost Assistance Program
- Financial Assistance Program
- Private Nursing Home Program
- Diabetes Drug Program

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 4 in that 365-day period.

BMR: $52.50; BMRF: $20

DMR: $65; DMRF: $25

Pharmacy markup

N/A
Coordination of benefits (public/private)

Effective July 1, 2014

Public drug programs are the payer of last resort. Any residents using a public drug program who are also members of a private drug insurance program will have their private insurance billed first and Pharmacare second.

Pharmacare clients with private drug insurance will pay the lesser of

- 20% of the Pharmacare copayment as determined by those without private drug insurance; or
- The prescription balance after the insurance payment.

Pharmacare will cover the balance of the eligible prescription cost after the client and insurance payments are applied to the prescription.

Coordination of benefits (intrajurisdictional)

N/A

Restricted/exception drug coverage process

Prescribers may apply for special authorization coverage by mailing or faxing a completed special authorization form. For some drugs, a patient application is required in addition to the special authorization form.

Allow up to 3 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 1 fill of the prescription received during the assessment period after all of the requested information has been received.

Reimbursement policy

If a beneficiary paid cash at the pharmacy, he or she has 6 months to submit receipts for reimbursement.

Miscellaneous

Program maximum allowable days’ supply

Nursing Home Drug Program: 35 days
Institutional Pharmacy Program: 35 days

AIDS/HIV Program: 60 days

Children in Care Program
- 30 days: regular drugs
- 90 days: maintenance drugs
- 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.

Cystic Fibrosis Program: 60 days

Diabetes Drug Program
- 30 days: insulin and test strips
- 90 days: oral medications
- 30 days: drugs requiring special authorization (SA)
- 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.

Family Health Benefit Drug Program
- 30 days: regular drugs
- 90 days: maintenance drugs
- 30 days: drugs requiring SA coverage
- 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 requiring SA coverage
- 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.

Generic Drug Program
- 30 days: drugs requiring SA coverage
- 90 days: all other drugs covered
- 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 Drug 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 requiring SA coverage
- 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.

Quit Smoking Program

- 7 days: over-the-counter drugs
- 14 days: prescription drugs

Transplant Anti-rejection Drug Program: 60 days

Tuberculosis Drug Program: 60 days

Catastrophic Drug Program

- 30 days: regular drugs and SA drugs
- 90 days: maintenance drugs
- 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.

High Cost Drug Program: 30 days, unless otherwise specified in criteria for drug(s)

Insulin Pump Program

- 1 pump every 5 years
- 140 infusion sets per year
- 140 reservoirs per year
- 1 replacement site insert per device per year
• 150 skin adhesive wipes per year
• 200 sterile transparent dressings per year

Source: For more information, visit Prince Edward Island Pharmacare.

Newfoundland and Labrador

Eligibility

Plans/programs

• The Foundation Plan
• The Access Plan
• The 65Plus Plan
• The Assurance Plan
• The Select Needs Plan
• The Ostomy Subsidy Program

General beneficiary information

The Foundation Plan: Persons and families in receipt of income support benefits through the Department of Advanced Education and Skills 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.

The Access Plan: Individuals and families with low income; the amount of coverage is determined by family net income level and family status (see Cost-sharing mechanism below).

The 65Plus Plan: Residents age 65 and older who receive Old Age Security benefits and the GIS

The Assurance Plan: Individuals and families with the financial burden of eligible high drug costs

The Select Needs Plan: Residents who have been diagnosed with cystic fibrosis and residents age 18 and younger with growth hormone deficiency

The Ostomy Subsidy Program: Residents covered under the 65Plus Plan also qualify for reimbursement of up to 75% of the retail cost of benefit ostomy items.
Other eligibility criteria

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

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

The 65Plus Plan: Up to $6 per prescription

The Access Plan

Families (with children)

<table>
<thead>
<tr>
<th>Income</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$30,009</td>
<td>20.0%</td>
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<tr>
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<tr>
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<td>66.6%</td>
</tr>
<tr>
<td>$42,870</td>
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### Couples (with no children)

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</tr>
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<td>$30,009</td>
<td>70.0%</td>
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### Single individuals

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<tr>
<td>$27,000</td>
<td>69.1%</td>
</tr>
<tr>
<td>$27,151</td>
<td>70.0%</td>
</tr>
</tbody>
</table>
The **Assurance Plan**: Qualifying applicants will be responsible for a copayment depending on their income levels and drug costs:

- 5% of net income for those who earn less than $40,000
- 7.5% of net income for those who earn from $40,000 to less than $75,000
- 10% of net income for those who earn from $75,000 to less than $150,000

The **Ostomy Subsidy Program**: The beneficiary is responsible for 25% of the retail cost of benefit ostomy items.

**Deductible**

None

**Maximum beneficiary contribution**

**Assurance Plan**: Based on net income

<table>
<thead>
<tr>
<th>Net income</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to $39,999</td>
<td>5.0%</td>
</tr>
<tr>
<td>$40,000–$74,999</td>
<td>7.5%</td>
</tr>
<tr>
<td>$75,000–$149,999</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

For example, assume a family income of $35,000 and 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) toward the annual drug costs of $6,000. The program will use the following calculation to determine the copayment:

\[
(35,000 \times 5\%) \div 6,000 = 29.17\%
\]

Each time a prescription for an eligible benefit is filled, the family will pay 29.17% of the total cost of the prescription.

**Policy information**

**Ingredient price**

**Defined cost**: The current published manufacturer’s list price, plus 8.5%

**Interchangeable unit price**: The lowest unit price of all drugs within a Newfoundland and Labrador Interchangeable Drug Products Formulary (NIDPF) category
**Innovator price:** The price for a drug established for a single-sourced ingredient as recorded by the pharmaceutical department at the time the drug submission is received, minus 8.5%

**Inventory adjustment fee:** A percentage set by the minister that may be included in the price that may be charged for a drug listed in the formulary

The maximum price listed for a drug shall not exceed 25% of the brand-name price plus the inventory adjustment fee.

**Generic pricing policy (percentage of brand-name drug)**

July 1, 2013: 25%

The price policy applies to both public and private sectors.

**Professional fees: Product-related fees/services**

**Effective April 1, 2015, to March 31, 2016**

The professional fees for the Foundation Plan, Access Plan and Assurance Plan have been increased to

- $11.96 for drug costs between $0 and $49.99
- $23.93 for drug costs between $50 and $249.99
- $50 for drug costs of $250+

The professional fees for the 65Plus Plan have changed to

- $12 for drug costs between $0 and $249.99
- $40 for drug costs of $250+

**Extemporaneous preparations fee:** 1.5 times the base professional fee ($12 for the 65Plus Plan and $11.96 for all other plans) for non-compound products. This applies to compounds that contain 3 or more ingredients. Additionally, $0.10 per powder paper will be paid when compounded by the pharmacist.

**Professional fees: Clinical services**

**Cognitive services**

- Refusal to fill: Pharmacies may bill up to the maximum dispensing fee of double the base dispensing fee of $11.96.
- Medication management: Pharmacies may bill up to the maximum dispensing fee of $11.96 (the base dispensing fee amount).
• Medication review: Pharmacies may bill $52.50 for beneficiaries older than age 65 who have chronic illnesses and who are taking 3 or more medications, as well as for beneficiaries who have diabetes (of any age) who are taking oral hypoglycemics and/or insulin, up to 72 times per year per pharmacy.

**Pharmacy markup**

*No surcharge* can be applied to the prescription cost under any Newfoundland and Labrador Prescription Drug Program (NLPDP) plan (i.e., neither NLPDP nor the client can be billed or charged a surcharge).

**Coordination of benefits (public/private)**

NLPDP is the payer of last resort. Beneficiaries must first access private insurance plans before seeking reimbursement from NLPDP.

**Coordination of benefits (intrajurisdictional)**

Federal public plans are to be used before the provincial drug plans.

**Restricted/exception drug coverage process**

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.

The following are required to process an out-of-province reimbursement request:

• Documentation of referral out of province by a physician of Newfoundland and Labrador, or documentation of hospitalization if not referred out of province;

• The original prescription receipts; and

• The beneficiary’s NLPDP ID number as noted on the drug card.

**Reimbursement policy**

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.
Miscellaneous

Prescription quantities

- 90-day supply
- 30-day supply for narcotics, antidepressants and benzodiazepines
- 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.

Source: For more information, visit Newfoundland and Labrador Prescription Drug Program.

Yukon

Eligibility

Plans/programs

- Pharmacare (PHRM)
- Children’s Drug and Optical Program (CDOP)
- Chronic Disease Program (CHRN)
- Palliative (PALL)

General beneficiary information

Children’s Drug and Optical Program: Children younger than age 19 from low-income families

Chronic Disease Program: Residents who have a chronic disease or a serious functional disability as provided under the Chronic Disease and Disability Benefits Regulations; program may also include clients receiving palliative care.

Pharmacare: Seniors age 65 and older (and seniors’ spouses age 60 and older) registered with Yukon Health Care Insurance Plan (YHCIP); program may also include clients receiving palliative care.

Palliative Care: For people who are living with or dying from advanced illness (life expectancy measured in months). Palliative care patients access benefits through either Pharmacare or the Chronic Disease Program and must be registered with 1 of these 2 plans in order to be eligible for the palliative care expanded coverage.
**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.

**Other eligibility criteria**

Family income and family size are used to determine deductibles for the Chronic Disease and the Children’s Drug and Optical programs.

Absence from the territory for more than 183 consecutive days (6 months) results in suspension of drug and benefit cost reimbursement, starting with 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.

**Cost-sharing mechanism**

**Premium**

None

**Copayment/co-insurance**

None

**Deductible**

**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.

**Maximum beneficiary contribution**

**Children’s Drug and Optical Program:** $500 per family per year

**Chronic Disease Program:** $500 per family per year
Policy information

Ingredient price

Lowest-cost alternative: Yukon Drug Programs formulary benefits will be based on the lowest-priced interchangeable brand available.

Prices listed in the formulary are based on wholesale prices.

A written exception drug application form is required with medical reason(s) for “no substitution.” If multiple generics are available, a drug history is required. If approved, the respective program will be responsible for the full cost.

Generic pricing policy (percentage of brand-name drug)

N/A

Professional fees: Product-related fees/services

Professional fee: Up to $8.75

Extemporaneous preparations fee: $13.13

Professional fees: Clinical services

N/A

Pharmacy markup

Pharmacies are allowed a 30% markup. In addition, if the actual acquisition cost (AAC) includes a wholesale upcharge, this can be included up to a maximum of 14%.

Coordination of benefits (public/private)

For all Yukon government plans, residents must access private insurance plans first.

Coordination of benefits (intrajurisdictional)

Residents must access all other drug insurance plans first.

Coordination between Yukon government plans: Children who are eligible for the Chronic Disease Program will use that plan before the Children’s Drug and Optical Plan.
Restricted/exception drug coverage 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.

Reimbursement policy

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; these may be backdated.

Claims older than 1 year will not be reimbursed.

Payment will not be made for any drug or supply receipt that is mailed from an address outside of Yukon.

Miscellaneous

Prescription quantities
The respective drug programs will not pay for more than a 3-month supply. There must be an interval of 75 days before a further 3-month supply can be given.

Physicians shall exercise their professional judgment in determining the course and duration of treatment for their patients.

Source: For more information, visit Yukon Health and Social Services.
Health Canada — First Nations and Inuit Health Branch

Eligibility

Plans/programs

- Non-Insured Health Benefits (NIHB)

General beneficiary information

Non-Insured Health Benefits Program

- Registered Indian according to the Indian Act; or
- Inuk recognized by 1 of the Inuit Land Claim organizations; or
- An Innu member of 1 of the 2 Innu communities in Labrador (Davis Inlet and Sheshatshiu); or
- An infant younger than age 1 whose parent is an eligible recipient; and
  - Is currently registered or eligible for registration under a provincial or territorial health insurance plan; and
  - Is not covered under a separate agreement with federal, provincial or territorial governments.

Other eligibility criteria

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.

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.

Cost-sharing mechanism

Premium

None

Copayment/co-insurance

None
Deductible
None

Maximum beneficiary contribution
N/A

Policy information

Ingredient price

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.

Generic pricing policy (percentage of brand-name drug)
N/A

Professional fees: Product-related fees/services

Fees are negotiated between NIHB and pharmacists’ associations and therefore will differ by province/territory.

The methadone dispensing fee will be paid by the dose, using the following formula:
(usual and customary fee × 1.5 ÷ 7 days + $4.60) per dose

A customary dispensing fee for Suboxone or Kadian will be paid once every 7 days. If Suboxone or Kadian is dispensed daily, one-seventh of the dispensing fee will be paid. An additional fee of $4.60 may be paid if the daily ingestion of Suboxone or Kadian is witnessed in the pharmacy.

Professional fees: Clinical services

Refusal to fill fee: Pharmacies may bill up to their usual customary fee.

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.
Pharmacy markup

Markups, if applicable, are negotiated as part of the pharmacy agreements between NIHB and the pharmacists’ associations in the different jurisdictions.

Coordination of benefits (public/private)

When a beneficiary is covered by a private health care plan, claims must be submitted to it first.

Coordination of benefits (intrajurisdictional)

When a beneficiary is covered by another health care plan, claims must be submitted to it first.

Restricted/exception drug coverage process

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.

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.

Reimbursement policy

Submissions for retroactive coverage must be received by First Nations and Inuit Health Branch 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 Services (HICPS) for pharmacy benefits covered by the NIHB Program.
Miscellaneous

**Prescription quantities:** The normal quantity dispensed shall be the entire quantity of the drug prescribed. A maximum 100-day supply should be considered for those circumstances where the patient has been stabilized on a medication and the prescriber feels that further adjustment during the prescribed period is unlikely. The physician may continue to prescribe a smaller quantity with repeats at certain intervals when it is in the patient's best interest.

**Short-Term Dispensing Policy (STD):** For refills for medications requiring dispensing for a shorter time than 28 days due to compliance concerns, the program will reimburse 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);
- Prescriptions for dose changes;
- Prescriptions for injectables and suppositories;
- Refills of methadone; or
- 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 1 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 one-seventh 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 month, the pharmacy will be entitled to 1 full dispensing fee, up to the regional maximum of the program.

**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.

Persons with diabetes not taking diabetic medication will be allowed 200 test strips per 365 days.

**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).
Effective March 16, 2015, clients with a *permanent* medical condition can be approved for 2 years of ostomy supplies instead of 1.

**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 FNHA.

**Source:** For more information, visit [Non-Insured Health Benefits](#).
Appendix 1: Generic pricing policy summary

The following is a summary of the current generic drug pricing policies. Generic prices set by the pan-Canadian Pharmaceutical Alliance may apply over and above the provincial/territorial generic price policies. For implementation or specific drug product information, contact the individual drug program directly.

**British Columbia:**
Covers 20% of the brand-name price of all oral solid generics and 35% of the brand-name price of all other generics. Applies to the public sector effective April 2014.

**Alberta:**
Covers 18% of the brand-name price for all generics. Applies to public and private plans effective May 2013.

**Saskatchewan:**
Covers 25% of the brand-name price of all solid oral generics, and 35% of the brand-name price of all non-solid generics. Applies to public and private sectors effective April 1, 2015.

**Manitoba:**
Manitoba has established a policy/contractual approach for generic/multisource pharmaceutical products. The policy/contractual framework for generic/multisource pharmaceutical products includes submission criteria requiring pricing equal to that of other jurisdictions, a price guarantee for a minimum of 365 days and supply commitments by the manufacturer.

**Ontario:**
Covers 25% of the brand-name price for all generics. Applies to the public sector effective July 2010 and the private sector effective April 2012.

**New Brunswick:**
Covers 25% of the brand-name price of all solid oral interchangeable generics in the public and private sectors, and 35% of the brand-name price of all non-solid interchangeable generics in the public sector only, effective June 2013.
Nova Scotia:
Covers 25% of the brand-name price of all solid oral interchangeable generics and 35% of the brand-name price of all non-solid interchangeable generics effective November 2014.

Prince Edward Island:
Covers 25% of the brand-name price for all generics. Applies to public and private sectors effective December 2013.

Newfoundland and Labrador:
Covers 25% of the brand-name price for all generics. Applies to public and private sectors effective July 2013.

Yukon:
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.
Appendix 2: Pan-Canadian Pharmaceutical Alliance

Provinces and territories have been working together to achieve greater value for both brand-name and generic drugs for publicly funded drug programs. These initiatives, formerly known as the Pan-Canadian Pricing Alliance and the Generic Value Price Initiative, are now referenced collectively as the pan-Canadian Pharmaceutical Alliance (pCPA).

Established in August 2010, the 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.
Appendix 3: Pan-Canadian tiered pricing framework

The Pan-Canadian Generic Value Price Initiative Generic Pricing Framework, ii as outlined below, was implemented effective April 1, 2014.

New generic drugs are priced according to category: iii

**New single source (i.e., only 1 manufacturer of a generic drug):** Priced at 75% of brand-name drug price if product listing agreement (PLA) or pricing agreement for brand-name drug exists in any jurisdiction. Other single source: 85%. Products at this level will be reassessed after 2 years. iv

**2 generics:** 50%

**3 or more generics:** 25% oral solid; v 35% all dosage forms other than oral solids (liquids, patches, injectables, inhalers, etc.)

Progression: As soon as another manufacturer begins selling its version of the drug in any jurisdiction, the price of the drug will drop to the next tier (i.e., 75% to 50% to 25%).

Note: For products that fall into the “new single source” category, 1-year retro-activity exists on this section of the pricing framework. For all categories, the option exists for the province/territory to retain PLA or pricing agreement with the brand-name drug if it provides better value.

**Pan-Canadian 18% group:** 18% oral solid

For more information regarding the status of pan-Canadian Pharmaceutical Alliance negotiations for brand-name drugs, as well as the list of all generic drugs with an established price point of 18% of the equivalent brand-name product, please visit the pan-Canadian Pharmaceutical Alliance website.

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ii. This framework will be reassessed after 3 years.
iii. Price reduction to the next pricing tier is triggered by market entry of additional competitors.
iv. After 2 years, provinces/territories will reassess continued listing of the single-source product against international prices and the number of Notice of Compliance approvals that Health Canada has granted for the drug.
v. Modified release products will be treated the same as regular tablets and capsules.
Appendix 4: 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 document and are not necessarily the sole definitions of these terms.

age group
Age-specific requirements for beneficiaries to be eligible for coverage under a provincial, territorial or federal drug program

beneficiary group
Recipients of benefits under a specified provincial, territorial or federal plan/program

coordination of benefits
Coordination of benefits is a process whereby payments are coordinated through 2 or more drug plans (public/private, intrajurisdictional). 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.

copayment/co-insurance
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.

deductible
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).

disease specific
Disease-specific requirements for beneficiaries to be eligible for coverage under a provincial, territorial or federal drug program

GIS
Federal Guaranteed Income Supplement
income range
Family or individual income-specific requirements for beneficiaries to be eligible for coverage under a specific provincial, territorial or federal drug program

ingredient pricing policy
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

markup
An amount added to the cost price of a drug or ingredient, usually based on a percentage of the cost price

maximum beneficiary contribution
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.

plan/program
A provincial, territorial or federal program that provides coverage for drugs for a set population. Programs have defined rules for eligibility, payment, etc.

premium
The amount a beneficiary is required to pay to enrol in a provincial, territorial or federal drug plan/program

prescription cost components
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.

professional fees
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.

reimbursement policy
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
restricted benefit process

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

sector

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).