National Prescription Drug Utilization Information System Database

Plan Information Document

July 1, 2010

Canadian Institute for Health Information
Institut canadien d'information sur la santé

Who We Are

Established in 1994, CIHI is an independent, not-for-profit corporation that provides essential information on Canada's health system and the health of Canadians. Funded by federal, provincial and territorial governments, we are guided by a Board of Directors made up of health leaders across the country.

Our Vision

To help improve Canada's health system and the well-being of Canadians by being a leading source of unbiased, credible and comparable information that will enable health leaders to make better-informed decisions.

Introduction

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

Summary of Major Changes

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Plan/Program Information by Category and by Jurisdiction:

- Eligibility

British Columbia	Alberta	Saskatchewan
Manitoba	Ontario	New Brunswick
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The Yukon	First Nations and Inuit Health Branch	

- Cost-Sharing Mechanism

British Columbia	Alberta	Saskatchewan
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- Policy-Related Information

British Columbia	Alberta	Saskatchewan
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Glossary of Terms

Summary of Major Changes

British Columbia

Effective January 1, 2010: A transition agreement came into effect to bridge the period required to develop a long-term agreement to ensure the continuation of benefits specified in the interim policy.

Alberta

Effective July 1, 2010: Monthly Non-Group Coverage premiums were increased to make premiums comparable to those of employer and private plans: singles—$63.50; family—$118.00.

New Brunswick

Effective March 31, 2010: The H1N1 program ended and dispensing the provincial pandemic supply of oseltamivir (Tamiflu), under the Provincial Antiviral Stockpile guidelines, stopped.

Nova Scotia

Effective April 1, 2010: Seniors Pharmacare will cover up to 100 test strips per fiscal year for patients with diabetes not using insulin. Coverage for patients with type 1 and type 2 diabetes using insulin remains unaffected.

Eligibility (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario)

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
Plan/ Program	• **Fair PharmaCare**—All B.C. residents with active BC Medical Services Plan coverage • **Plan B**—Permanent residents of licensed residential care facilities • **Plan C**—Recipients of British Columbia Income Assistance Benefits • **Plan D**—Cystic fibrosis • **Plan F**—Children in the At-Home Program • **Plan G**—No-Charge Psychiatric Medication Plan • **Plan P**—Palliative care	• **Seniors** • **Widows** • **Palliative** • **Non-Group** • **Rare Diseases Drug Program**	• **Universal Program**	• **FS03**—Employment and Income Assistance Program • **NH02**—Personal Care Home/ Nursing Homes • **PA04**—Palliative Care Drug Access Program • **PC01**—Pharmacare	• **ODB**—Ontario Drug Benefit Program • **Trillium Drug Program** • **Special Drugs Program** • **New Drug Funding Program for Cancer Care**
Beneficiary Group	• Residents of British Columbia for at least three months	• **Seniors** Alberta residents age 65 or older and eligible dependants • **Widows** Alberta residents age 55 to 64 who qualify for Alberta Widows Pension and eligible dependants • **Palliative** Palliative residents treated at home • **Non-Group** Alberta residents younger than age 65 and eligible dependants • **Rare Diseases Drug Program** Albertans with rare diseases who have government-sponsored	• Families/individuals applying for and approved for the drug plan's Special Support Program (income tested) • Supplementary Health Program – People nominated for coverage by Saskatchewan Social Services • Guaranteed Income Supplement (GIS) recipients – Government of Canada program for low-income seniors • Saskatchewan Income Plan recipients – Provincial program to provide a monthly supplement to low-income seniors • Seniors Drug Plan (income tested) – Seniors age 65 or older who have applied and qualified based on income • Families/individuals approved for Family Health Benefits (eligibility is established by Saskatchewan Social Services, based on the number of children in the family and	• **FS03** Individual Manitobans who are receiving drug benefits pursuant to the Employment and Income Assistance Program • **NH02** Manitoba residents of personal care homes • **PA04** Residents who are terminally ill and wish to remain at home • **PC01** All provincial residents who are eligible for benefits under *The Prescription Drugs Cost Assistance Act*	• **Ontario Drug Benefit (ODB) Program** Drug benefits for Ontarians age 65 or older, residents of long-term care homes and homes for special care, recipients of professional home services and social assistance, and recipients of the Trillium Drug Program • **Trillium Drug Program** Drug benefits for Ontario residents who have high drug costs in relation to their household income; any Ontario resident who does not qualify under any of the other plans can apply for the Trillium Drug Program

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
		drug coverage and whose physician has applied for coverage will be considered; an individual or family must reside in Alberta for five years to be eligible for the program; the residency requirement will be waived for individuals moving to Alberta from another province in Canada if they were covered by that province's program for these drugs	the family's annual income) • Saskatchewan Aids to Independent Living (SAIL) beneficiaries (paraplegics, cystic fibrosis and chronic renal disease) • Persons approved for the drug plan's palliative care coverage (residents who are in the late stages of a terminal illness) • Government wards • Inmates of provincial correctional institutions • Families' granted emergency assistance (residents who require immediate treatment with covered prescription drugs and are unable to cover their share of the cost; this is a one-time benefit and individuals are encouraged to apply for income-tested coverage for future assistance) • Workers' Health Benefits Program (Note: As of March 19, 2008, the Saskatchewan Workers' Health Benefits Program was discontinued. Working adults without children who are currently enrolled and receiving benefits will maintain coverage until June 2010, if they continue to meet the original criteria.) – Single: income less than $21,000; married or common law: income less than $26,000 – In addition applicant must be > A Saskatchewan resident with a valid Saskatchewan health card; > Single or a couple, without dependent children; > Younger than age 65; and > Employed or self-employed and not be	Persons who meet the following qualifications are designated as eligible individuals 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; and • 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. Not eligible are citizens whose health services are covered under First Nations and Inuit Health, Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers' Compensation, federal penitentiaries or private drug benefit plans as per sections 2(2) (a) and (b) in *The Prescription Drugs Cost Assistance Act*.	• Special Drugs Program Drug benefits for Ontarians with a valid health card for certain expensive outpatient drugs used to treat specific diseases or conditions • New Drug Funding Program for Cancer Care Drug benefits for newer, intravenous drugs, typically administered in hospitals and cancer care facilities; the ministry provides about 75% of the overall funding for intravenous cancer drugs in Ontario and hospitals fund the remaining 25% through their operating budgets

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
			> Receiving benefits under a private or employer-sponsored health plan or the federal government's Non-Insured Health Benefits program; and > Not be attending a post-secondary education institution on a full-time basis (university or technical school). • Children's Insulin Pump Program – Applicants must be age 17 or younger. – Applicants must have type 1 diabetes and require a pump to adequately stabilize blood sugar levels. • Children's Drug Program – Children age 14 or younger • Not eligible: Citizens whose health services are covered under First Nations and Inuit Health, Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers' Compensation or federal penitentiaries are not eligible for drug plan benefits under Saskatchewan Health. • Note: Residents may qualify and be covered under more than one program at the same time. The better benefit applies at the time a prescription is filled.		
Income Range	• Plan C B.C. residents receiving medical benefits and income assistance through the Ministry of Housing and Social Development • Plan G Low-income residents; an application for psychiatric medication coverage to a mental health service centre is required for approval		• Seniors Program Individual annual net income must be below the limit for the federal age credit.	N/A	N/A

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
Age Range	• **Fair PharmaCare** Fair PharmaCare (Regular Assistance) – Residents born in 1940 or later Fair PharmaCare (Enhanced Assistance) – Residents born in 1939 or earlier • **Plan F** Younger than age 18	• **Seniors** Alberta residents age 65 or older, or their spouse/ partner, or their eligible dependent(s) • **Widows** 55 to 64 • **Non-Group** Younger than 65	• **Children's Drug Program** Children age 14 or younger • **Seniors Program** 65 or older	N/A	N/A
Disease Specific	• Individuals with cystic fibrosis (plan D) • Severely handicapped children—At-Home Program (plan F) • Clients of mental health service centres (plan G) (meeting clinical and income criteria)	Alberta Health and Wellness provides additional coverage for prescription drugs: • **Specialized High-Cost Drugs** provides funding to Alberta Health Services for high-cost drugs: immunosuppressants for prevention of solid organ and bone marrow transplant rejection; HIV drugs; Pulmozyme (for cystic fibrosis); human growth hormone (for pediatric growth hormone deficiency and chronic renal failure); Flolan, Tracleer, Revatio and Remodulin (for primary pulmonary hypertension); Visudyne (for classic form of wet age-related macular degeneration); bone marrow transplant adjunctive agents (Neupogen); and Copaxone, Avonex, Rebif	N/A	N/A	**Special Drugs Program** covers specific drugs for • Cystic fibrosis and thalassemia; • HIV; • Erythropoietin (EPO) for end-stage renal disease; • Cyclosporine for solid organ or bone marrow transplant; • Human growth hormone for children with growth failure; • Clozapine for treatment of schizophrenia; and • Alglucerase for people with Gaucher's Disease.

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
		and Betaseron for pediatric multiple sclerosis. • The Alberta Cancer Board may provide medically required cancer drugs.			
Other Eligibility Criteria	• Fair PharmaCare: An individual must – Have effective British Columbia Medical Services Plan (MSP) coverage; and – Have filed an income tax return for the relevant taxation year. • Criteria for Fair PharmaCare Enhanced Assistance: An individual must – Have been born in 1939 or earlier; – Have effective British Columbia Medical Services Plan (MSP) coverage; and – Have filed an income tax return for the relevant taxation year. • Plan B recipients are enrolled and receive coverage through the care facility. • Plan C recipients must be registered in MSP and receiving medical benefits and income assistance through the Ministry of Housing and Social Development. • Plan D individuals with cystic fibrosis are registered with a provincial cystic fibrosis clinic.	• Seniors In order to be registered, seniors must complete a proof-of-age declaration, which Alberta Health and Wellness mails to them; registration with the Alberta Health Care Insurance Plan (AHCIP) is required • Widows Recipients of the Alberta Widows Pension • Palliative Be registered with the AHCIP; diagnosed by a physician as being palliative and receiving treatments at home • Non-Group Be registered with AHCIP and not eligible to receive the Alberta Widows Pension or be in premium arrears for the plan	N/A	N/A	N/A

Eligibility	B.C.	Alta.	Sask.	Man.	Ont.
	• Plan F recipients must be – Age 17 or younger; – A resident of B.C.; – Living at home with a parent or guardian; and – Assessed as dependent in at least three of four areas of daily living. • Plan G – The patient's physician or psychiatrist must submit an application for psychiatric medication coverage to a mental health service centre for approval. – Patient must qualify for premium assistance under the Medical Services Plan. • Plan P recipients must be – Enrolled in MSP, living at home; – Diagnosed as being in the terminal stage of a life-threatening illness; and – Have a life expectancy of up to six months. The physician submits an application, certifying the individual meets the criteria.				
Sources	For more information: British Columbia PharmaCare	For more information: Alberta Health and Wellness	For more information: Saskatchewan Health Drug and Extended Benefits Branch	For more information: Manitoba Health	For more information: Ontario Drug Benefit Program

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Eligibility (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, the Yukon, First Nations and Inuit Health Branch)

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Plan/Program	• A—Seniors Program • B—Cystic Fibrosis • E—Adults in Licensed Residential Facilities • F—Department of Social Development • G—Children in the Care of the Minister of Social Development • H—Multiple Sclerosis • R—Organ Transplant • T—Human Growth Hormone Deficiency • U—HIV/AIDS • V—Nursing Home	• A—Family Pharmacare Program • C—Drug Assistance for Cancer Patients • D—Nova Scotia Diabetes Assistance Program • F—Department of Community Services Programs • S—Seniors Pharmacare Program	• A—AIDS/HIV Program • B—Community Mental Health Program • C—Cystic Fibrosis Program • D—Diabetes Control Program • E—Erythropoietin Program • F—Family Health Benefit Program • G—Growth Hormone • H—Hepatitis Program • I—Immunization Program • J—Intron A (Interferon alfa-2b) Program • K—Meningitis Program • M—High-Cost Drug Program • N—Institutional Pharmacy/Nursing Home Program • O—Nutrition Services Program • P—Phenylketonuria (PKU) Program • R—Rabies Program • S—Seniors Drug Cost Assistance Plan • T—Transplant Program • U—Rheumatic Fever Program • V—Sexually Transmitted Diseases (STD) Program	• **The Foundation Plan** (Previously Income Support Drug Program or plan E) • **The Access Plan** (Previously Low Income Drug Program or plan L) • **The 65Plus Plan** (Previously Senior Citizen's Drug Subsidy Plan or plan N) • **The Assurance Plan** (plan H) • **The Select Needs Plan**	• Children's Drug and Optical Program • Chronic Disease Program • Pharmacare	• **NIHB**—Non-Insured Health Benefits

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
			• W—Children-In-Care/ Financial Assistance Program • X—Tuberculosis (TB) Drug Program • Z—Quit Smoking Program			
Beneficiary Group	• A—Seniors who receive the Guaranteed Income Supplement (GIS) or who qualify for benefits based on an annual income as follows: – A single senior with an annual income of $17,198 or less; – A senior couple (both age 65 or older) with a combined annual income of $26,955 or less; or – A senior couple with one spouse younger than 65 with a combined annual income of $32,390 or less. • B—Cystic fibrosis patients or patients with juvenile or infant sclerosis of the pancreas • E—Individuals residing in a licensed adult residential facility who hold a valid health card for prescription drugs issued by the Department of Social Development • F—Individuals holding a valid health card for prescription drugs issued	• A—Families, including families of one, who apply for the program; any permanent Nova Scotia resident with a valid Nova Scotia health card number is eligible to enrol; must not have coverage through Department of Community Services Programs, Seniors Pharmacare, Diabetes Assistance Program or 65 Long-Term Care Pharmacare Plan • C—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 • D—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	• A—Persons diagnosed as HIV positive, diagnosed with AIDS or with a needle-stick injury and registered with the program through the chief health officer • B—Approved long-term psychiatric patients living in the community • C—Persons eligible for P.E.I. Medicare, diagnosed with cystic fibrosis and who are registered with the program • D—Persons eligible for P.E.I. Medicare, diagnosed with diabetes and registered with the program • E—Persons eligible for P.E.I. Medicare, diagnosed with chronic renal failure or receiving kidney dialysis and registered with the program • F—Families (parents, guardians and children younger than 18 or younger than 25 and in full-time attendance at a post-secondary educational institution), eligible for P.E.I. Medicare with a total net family income less than the threshold (see Income	• **The Foundation Plan** provides 100% coverage of eligible prescription drugs for those who need the greatest support. This includes persons and families in receipt of income support benefits through the Department of Human Resources, Labour and Employment, and certain individuals receiving services through the regional health authorities, including children in the care of Child, Youth and Family Services and individuals in supervised care. • **The Access Plan** offers individuals and families with low incomes access to eligible prescription medications. The amount of coverage is determined by net income level and family status (see Income Range section). • **The 65Plus Plan** provides coverage for eligible prescription drugs to residents age 65 or older who receive Old Age Security benefits and the	• **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* and not having coverage through First Nations and Inuit Health; program may also include clients receiving palliative care • **Pharmacare** Seniors age 65 or older (and seniors spouses age 60 or older) registered with Yukon Health Care Insurance Plan (YHCIP) and not having coverage through First Nations and Inuit Health; program may also include clients receiving palliative care **For all programs:** • Benefits are not covered if they are already available through a federal or territorial drug program,	• Registered Indian according to the *Indian Act*; or • Inuk recognized by one of the Inuit Land Claim organizations; or • An infant younger than one year of age 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.

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
	by the Department of Social Development • G—Special needs children and children under the care of the Minister of Social Development • H—Residents in possession of a prescription written by a neurologist for the medications Avonex, Rebif, Betaseron or Copaxone are eligible to apply for assistance • R—Recipients of an organ or bone marrow transplant who are registered with and qualify for the NBPDP • T—Individuals with growth hormone deficiency or hypopituitarism who are registered with and qualify for the NBPDP • U—Individuals diagnosed with HIV/AIDS and who are registered with the NBPDP through a provincial infectious disease specialist • V—Individuals who reside in a registered nursing home	drug insurance plan for medications and supplies for diabetes • F—Eligible clients 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 • S—Permanent Nova Scotia residents who are age 65 or older with a valid Nova Scotia health card number 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	Range section below); families must apply for coverage on an annual basis and provide income information to the program • G—Children eligible for P.E.I. Medicare with a proven growth hormone deficiency or Turner Syndrome and who are registered with the program • H—Persons diagnosed with hepatitis; persons who have been in close contact with a person diagnosed with hepatitis or are at risk of infection; persons with an occupational risk of infection • I—Children and persons at risk for exposure to various communicable diseases • J—For the treatment of patients diagnosed with hairy cell leukemia, AIDS-related Kaposi's sarcoma and basal cell carcinoma; the person's physician must request coverage from the chief health officer of the Department of Health and Social Services • K—Persons who have been in close contact with a person diagnosed with meningitis or are at risk of infection	Guaranteed Income Supplement (GIS). • The Assurance Plan offers protection for individuals and families against the financial burden of eligible high drug costs, whether it be from the cost of one extremely high-cost drug or the combined cost of different drugs. • The Select Needs Plan provides 100% coverage for disease-specific medications and supplies for residents with cystic fibrosis and growth hormone deficiency.	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.	

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
			• M—Persons eligible for P.E.I. Medicare and approved for coverage of one or more of the medications included in the program; patients must apply for coverage on an annual basis and provide income information to the program • N—Residents in government manors or private nursing homes eligible for coverage under the *Long-Term Care Subsidization Act* • O—High-risk pregnant women diagnosed with a nutritional deficiency • P—Persons eligible for P.E.I. Medicare, diagnosed with phenylketonuria and registered with the program • R—Persons with exposure to or at risk for exposure to rabies through an animal bite • S—Persons eligible for P.E.I. Medicare and age 65 or older • T—Persons eligible for P.E.I. Medicare, who have had an organ or bone marrow transplant and are registered with the program • U—Persons eligible for P.E.I. Medicare and who have a well-documented history of rheumatic fever or rheumatic heart disease and are registered with the program			

<table>
<tr><th>Eligibility</th><th>N.B.</th><th>N.S.</th><th>P.E.I.</th><th>N.L.</th><th>Y.T.</th><th>FNIHB</th></tr>
<tr><td></td><td></td><td></td><td>• V—Persons diagnosed with a sexually transmitted disease or identified contacts of a person diagnosed with a sexually transmitted disease
• W—Persons eligible under the Social Assistance Act and persons in the temporary or permanent care of the director of child welfare
• X—Patients must have a diagnosis of tuberculosis confirmed by the chief health officer of the Department of Health and Social Services
• Z—Persons eligible for P.E.I. Medicare and who have registered with the program</td><td></td><td></td><td></td></tr>
<tr><td>Income Range</td><td>• A—For seniors without the Guaranteed Income Supplement (GIS): single senior with an annual income of $17,198 or less; senior couple (both age 65 or older) with a combined annual income of $26,955 or less; or senior couple with one spouse younger than 65 with a combined annual income of $32,390 or less</td><td>• A—No income-based criteria for eligibility; however, family deductible is based on income; see section on deductible
• C—Gross family income no greater than $15,720
• D—No income-based criteria for eligibility; however, deductible is based on income; see section on deductible
• F—As determined by Department of Community Services
• S—No income-based criteria for eligibility, however, premium is based on income; see section on premium</td><td>• F—Family Health Benefit Program:<table><tr><th>Number of Children</th><th>Net Annual Family Income</th></tr><tr><td>1</td><td><$24,800</td></tr><tr><td>2</td><td><$27,800</td></tr><tr><td>3</td><td><$30,800</td></tr><tr><td>4</td><td><$33,800</td></tr><tr><td>More Than 4</td><td>Add $3,000 per Additional Child</td></tr></table>• M—Prescription copay is based upon total net family income.</td><td>• The Access Plan:
– Families with children, including single parents: net annual incomes of $30,000 or less
– Couples without children with net annual incomes of $21,000 or less
– Single individuals with net annual incomes of $19,000 or less
• The Assurance Plan maximum out of pocket is based on the following net income ranges:
– Up to $39,999
– $40,000 to $74,999
– $75,000 to $149,999</td><td>• Tables with family income and family size are used to determine deductibles for Chronic Disease and Children’s Drug and Optical programs; the table for Children’s Drug and Optical indicates income ranges that would not be eligible for the program</td><td>N/A</td></tr>
</table>

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Age Range	• A—65 or older	• A—No age range criteria for eligibility; all adults (age 18 or older) must register as their own family • C—Younger than 65 • D—Younger than 65 • F—Younger than 65 • S—65 or older	• G—Younger than 18 • S—65 or older	• The 65Plus Plan for those age 65 or older • The Select Needs Plan for beneficiaries with growth hormone deficiency age 18 or younger	• Children's Drug and Optical Program Children age 0 to 18 years • Pharmacare Seniors age 65 or older (and seniors spouses age 60 or older)	N/A
Disease Specific	• B—Cystic fibrosis or juvenile or infant sclerosis of the pancreas • C—H1N1 influenza • H—Multiple sclerosis • R—Organ transplant • T—Human growth hormone • U—HIV/AIDS	• C—Cancer • D—Diabetes	• A—AIDS/HIV • B—Mental health • C—Cystic fibrosis • D—Diabetes • G—Growth hormone • H—Hepatitis • I—Immunization • J—Intron A (Interferon alfa-2b) • K—Meningitis • M—High-cost drugs • P—Phenylketonuria (PKU) • R—Rabies • T—Transplant • U—Rheumatic • V—Sexually transmitted diseases (STDs) • X—Tuberculosis (TB)	• The Select Needs Plan—Cystic fibrosis and growth hormone deficiency	• Chronic Disease Program—Residents who have a chronic disease or a serious functional disability as provided under the *Chronic Disease and Disability Benefits Regulations* (residents must use private insurance plans first)	• Special formularies for chronic renal failure patients and palliative care
Other Eligibility Criteria	N/A	• A—Family members must agree to provide family size information and annual family income verification through Canada Revenue Agency (CRA) • D—Residents must agree to provide family size information and to allow family income verification through Canada Revenue Agency (CRA)	N/A		• Absence from the territory for more than 183 consecutive days (six months) will result in suspension of drug and benefit cost reimbursement starting the date of departure. A one-month extension will be considered on application to the director of health care insurance where the Yukon is the location of the applicant's only principal residence.	• NIHB program is the payer of last resort; that is, resident must use private, provincial or territorial health plan first if eligible for any of those.

Eligibility	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
					On return to the territory, the resident may re-apply for coverage under the respective program.	
Sources	For more information: New Brunswick Prescription Drug Program	For more information: Nova Scotia Pharmacare Drug Programs and Funding	For more information: Prince Edward Island Drug Programs	For more information: Newfoundland and Labrador Prescription Drug Program	For more information: Yukon Health and Social Services	For more information: Non-Insured Health Benefits

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Cost-Sharing Mechanism (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario)

Cost-Sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
Premium	None	Non-Group, July 2010 Single: $63.50/month Family: $118.00/month Subsidized rates are available to those who qualify, based on information reported on their prior year's income tax returns. Subsidized rates are: Single: $44.45/month Family: $82.60/month	None	None	None
Copayment/ Co-Insurance	• Fair PharmaCare – After meeting their annual deductible, families pay 30% of the eligible prescription drug costs for the remainder of the calendar year (or until reaching their annual maximum, whichever comes first). • Fair PharmaCare Enhanced Assistance – After meeting their annual deductible, families pay 25% of the eligible prescription drug costs for the remainder of the calendar year (or until reaching their annual maximum, whichever comes first).	• Seniors 30% per prescription up to a maximum of $25 • Widows 30% per prescription up to a maximum of $25 • Palliative 30% per prescription up to a maximum of $25; the lifetime maximum amount the patient pays out of pocket is $1,000 • Non-Group 30% per prescription up to a maximum of $25	• Special Support Program— Income tested (based on benefit drug costs, to help spread cost out evenly over the year) • Up to $15 per prescription for the Seniors Drug Plan for drugs listed on the Saskatchewan formulary and those approved under exception drug status; no charge for seniors who have SAIL or Palliative Care coverage • 35% for seniors receiving the Saskatchewan Income Plan supplement or receiving the federal Guaranteed Income Supplement (automatically receive this copayment once the deductible has been met but may also apply for income-tested coverage); 35% for Family Health Benefits once the deductible has been met; no charge for benefit prescriptions for FHB children younger than 18	None	• ODB recipients pay up to $2 per prescription (copayment) if they are – A senior single person with an annual net income of *less than* $16,018; – A senior couple with a combined annual net income of *less than* $24,175; – Receiving benefits under the *Ontario Works Act* or the *Ontario Disability Support Program Act*; – Receiving professional services under the Home Care Program; – Residents of long-term care facilities and homes for special care; or – Eligible under the Trillium Drug Program.

Cost-Sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
			• 35% for Workers' Health Benefits • Up to $2 per prescription for Supplementary Health (persons nominated by Saskatchewan Social Services for special coverage, including persons on social assistance, wards, inmates, etc.); some drugs covered at no charge; individuals younger than 18 and certain other categories receive benefit prescriptions at no charge • For the Emergency Assistance Program, the level of assistance provided is in accordance with the consumer's ability to pay • Up to $15 per prescription for the Children's Drug Plan for drugs listed on the Saskatchewan formulary and those approved under exception drug status		• ODB recipients each pay their first annual $100 (that is, prorated deductible based on number of months) in prescription costs each year. After that, they pay up to $6.11 (copayment) toward the ODB dispensing fee on each prescription if they are – A senior single person with an annual net income *equal to or greater than* $16,018; or – A senior couple with a combined annual net income *equal to or greater than* $24,175. The Ontario Drug Benefit (ODB) Program benefit year runs from August 1 to July 31 of the following year. • Copayment of $2.83 for prescriptions dispensed in outpatient hospital pharmacies

<table>
<tr><th>Cost-Sharing Mechanism</th><th>B.C.</th><th>Alta.</th><th>Sask.</th><th>Man.</th><th>Ont.</th></tr>
<tr>
<td>Deductible</td>
<td>
• Fair PharmaCare

Net family income
<$15,000
Deductible = $0

Net family income
$15,000 to $30,000
Deductible = 2% of net income

Net family income
>$30,000
Deductible = 3% of net income

• Fair PharmaCare Enhanced Assistance

Net family income
<$33,000
Deductible = $0

Net family income
$33,000 to $50,000
Deductible = 1% of net income

Net family income
>$50,000
Deductible = 2% of net income

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

Note: The deductible is based on income bands so the percentages provided are approximate.

No deductible is applied to the remaining plans/programs.
</td>
<td>None</td>
<td>
• Special Support Program— Income tested (annual threshold based on 3.4% of adjusted family income)
• $100 semi-annual family deductible for seniors receiving the Saskatchewan Income Plan supplement or receiving the federal Guaranteed Income Supplement and residing in a special care home (automatically receive this deductible but may also apply for income-tested coverage)
• $200 semi-annual family deductible for seniors receiving the Guaranteed Income Supplement and living in the community (automatically receive this deductible but may also apply for income-tested coverage)
• $100 semi-annual family deductible for Family Health Benefits
• $100 semi-annual deductible for Workers' Health Benefits
• No deductible for people covered under the Palliative Care Drug Program
</td>
<td>
• Income based—Annual threshold based on total adjusted family income (total adjusted family income is total annual income on line 150 of the Notice of Assessment, less $3,000 for a spouse and each eligible dependent, if applicable)

Deductible rates for adjusted family incomes for 2010–2011:
<table>
<tr><th>Lower Limit</th><th>Upper Limit</th><th>Deductible</th></tr>
<tr><td></td><td>≤$15,000</td><td>2.69%</td></tr>
<tr><td>>$15,000</td><td>≤$21,000</td><td>3.82%</td></tr>
<tr><td>>$21,000</td><td>≤$22,000</td><td>3.86%</td></tr>
<tr><td>>$22,000</td><td>≤$23,000</td><td>3.92%</td></tr>
<tr><td>>$23,000</td><td>≤$24,000</td><td>3.98%</td></tr>
<tr><td>>$24,000</td><td>≤$25,000</td><td>4.02%</td></tr>
<tr><td>>$25,000</td><td>≤$26,000</td><td>4.07%</td></tr>
<tr><td>>$26,000</td><td>≤$27,000</td><td>4.11%</td></tr>
<tr><td>>$27,000</td><td>≤$28,000</td><td>4.15%</td></tr>
<tr><td>>$28,000</td><td>≤$29,000</td><td>4.19%</td></tr>
<tr><td>>$29,000</td><td>≤$40,000</td><td>4.22%</td></tr>
<tr><td>>$40,000</td><td>≤$42,500</td><td>4.59%</td></tr>
<tr><td>>$42,500</td><td>≤$45,000</td><td>4.70%</td></tr>
<tr><td>>$45,000</td><td>≤$47,500</td><td>4.79%</td></tr>
<tr><td>>$47,500</td><td>≤$75,000</td><td>4.86%</td></tr>
<tr><td>>$75,000</td><td>—</td><td>6.08%</td></tr>
</table>
No deductible for people covered under the Palliative Care Drug Access Program
</td>
<td>
• $100 deductible for
– Single seniors (65 or older) with annual income of $16,018 or more
– Senior couples with a combined annual income of $24,175 or more
• Trillium Drug Program applicants must pay a quarterly or prorated deductible that is based on income
• No deductible for other ODB-eligible people
</td>
</tr>
</table>

Cost-Sharing Mechanism	B.C.	Alta.	Sask.	Man.	Ont.
Maximum Beneficiary Contribution	• Fair PharmaCare Net family income <$15,000 Maximum = 2% of net income Net family income $15,000 to $30,000 Maximum = 3% of net income Net family income >$30,000 Maximum = 4% of net income • Fair PharmaCare Enhanced Assistance Net family income <$33,000 Maximum = 1.25% of net income Net family income $33,000 to $50,000 Maximum = 2% of net income Net family income >$50,000 Maximum = 3% of net income Note: The maximum is based on income bands so the percentages provided are approximate. No maximum beneficiary contribution is applied to the remaining plans/programs.	• Palliative: $1,000	• Eligible seniors pay no more than $15 per prescription for drugs listed under the Saskatchewan formulary and those approved under exception drug status (MAC and LCA policies apply). • Children up to age 14 will pay no more than $15 per prescription for drugs listed under the Saskatchewan formulary and those approved under exception drug status (MAC and LCA policies apply).	The maximum beneficiary contribution is based on the beneficiary deductible. Once a family's deductible has been met, all eligible drug costs are reimbursed.	N/A
Sources	For more information: British Columbia PharmaCare	For more information: Alberta Health and Wellness	For more information: Saskatchewan Health Drug and Extended Benefits Branch	For more information: Manitoba Health	For more information: Ontario Drug Benefit Program

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Cost-Sharing Mechanism (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, the Yukon, First Nations and Inuit Health Branch)

<table>
<tr><th>Cost-Sharing Mechanism</th><th>N.B.</th><th>N.S.</th><th>P.E.I.</th><th>N.L.</th><th>Y.T.</th><th>FNIHB</th></tr>
<tr><td>Premium</td><td>• B—$50 yearly registration fee
• H—$50 yearly registration fee
• R—$50 yearly registration fee
• T—$50 yearly registration fee
• U—$50 yearly registration fee</td><td>• A—No premium
• C—No premium
• D—No premium
• F—No premium
• S—No premium for people who receive the GIS; for those who do not receive the GIS, they must pay a premium of up to $424 a year; some low-income seniors who do not get the GIS may qualify for reduced premiums</td><td>None</td><td>None</td><td>None</td><td>None</td></tr>
<tr><td>Copayment/ Co-insurance</td><td>• A—Seniors with GIS: $9.05 for each prescription, up to a maximum of $250 in one calendar year; seniors without GIS: $15 per prescription
• B—20% of the costs for each prescription up to a maximum of $20
• E—$4 for each prescription
• F—$4 for each prescription for adults (18 or older) and $2 for children (younger than 18)
• H—Ranges from zero to 100% of the prescription cost, depending on discretionary income; the copay is determined annually during the</td><td>• A—20% copayment with annual copayment maximum; annual family copayment maximum based on adjusted family income
• C—No copayment
• D—20% of the total prescription cost
• F—$5 per prescription unless the client or dependent is eligible for copayment exemption
• S—30% of the total prescription cost (minimum of $3 per prescription); maximum annual copayment of $382</td><td>• D—Insulin:
– $10 per 10 mL vial of insulin or box of 1.5 mL insulin cartridges
– $20 per box of 3 mL insulin cartridges
– 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
• High-cost diabetes medications: An income-based portion of the medication plus the professional fee for</td><td>• The 65Plus Plan—Markup and professional fee
• The Access Plan—Copayments are based on income as follows:
Families (With Children)
<table><tr><th>Income</th><th>Copay</th></tr><tr><td><$21,000</td><td>20.0%</td></tr><tr><td>$22,000</td><td>25.6%</td></tr><tr><td>$23,000</td><td>31.1%</td></tr><tr><td>$24,000</td><td>36.7%</td></tr><tr><td>$25,000</td><td>42.2%</td></tr><tr><td>$26,000</td><td>47.8%</td></tr><tr><td>$27,000</td><td>53.3%</td></tr><tr><td>$28,000</td><td>58.9%</td></tr><tr><td>$29,000</td><td>64.4%</td></tr><tr><td>$30,000</td><td>70.0%</td></tr></table></td><td>None</td><td>None</td></tr>
</table>

Cost-Sharing Mechanism	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
	re-qualification period • R—20% of the costs for each prescription up to a maximum of $20 • T—20% of the costs for each prescription up to a maximum of $20 • U—20% of the costs for each prescription up to a maximum of $20		each high-cost medication obtained • F—The pharmacy professional fee per prescription • M—Income-based portion of the drug plus the pharmacy professional fee for each prescription • S—First $11 of the medication cost plus the pharmacy professional fee for each prescription; reducing to $8.25 as of September 1, 2010 • Z—Patients are responsible for all medication costs approved, except for the first $75, which will be paid by the program	Couples (With No Children) Income / Copay <$15,000 / 20.0% $16,000 / 28.3% $17,000 / 36.7% $18,000 / 45.0% $19,000 / 53.3% $20,000 / 61.7% $21,000 / 70.0% Single Individuals Income / Copay <$13,000 / 20.0% $14,000 / 28.3% $15,000 / 36.7% $16,000 / 45.0% $17,000 / 53.3% $18,000 / 61.7% $19,000 / 70.0% • The Assurance Plan—Beneficiaries can have a copayment between 0% and 99%		

Cost-Sharing Mechanism	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Deductible	None	• A—Annual family deductible is a sliding scale percentage based on adjusted family income • C—No deductible • D—Annual deductible is a sliding scale percentage based on adjusted family income • F—No deductible • S—No deductible	None	None	• Children's Drug and Optical Program—Maximum $250 per child and $500 per family; deductible may be waived or reduced depending on income • Chronic Disease Program—Maximum $250 per individual and $500 per family, waived for palliative care recipients; deductible may be waived or reduced depending on income	None
Maximum Beneficiary Contribution	• A—Seniors with the Guaranteed Income Supplement (GIS): $250 in one calendar year • B—$500 per family unit in one fiscal year + premium (see above) • E—$250 per person in a fiscal year • F—$250 per family unit in a fiscal year • R—$500 per family unit in a fiscal year + premium (see above) • T—$500 per family unit in one fiscal year + premium (see above) • U—$500 per family unit in one fiscal year + premium (see above)	• A—Annual family copayment plus annual family deductible • S—Annual maximum copayment of $382 + premium (see above)	N/A	• The Assurance Plan maximums are based on net income as follows: Net Income / Max Up to $39,999 / 5.0% $40,000 to $74,999 / 7.5% $75,000 to $149,999 / 10.0%	N/A	N/A
Sources	For more information: New Brunswick Prescription Drug Program	For more information: Nova Scotia Pharmacare Drug Programs and Funding	For more information: Prince Edward Island Drug Programs	For more information: Newfoundland and Labrador Prescription Drug Program	For more information: Yukon Health and Social Services	For more information: Non-Insured Health Benefits

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Policy-Related Information (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario)

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Prescription Cost Components	PharmaCare will pay the pharmacy's actual acquisition cost (AAC), including freight costs, up to a maximum of 7% above the manufacturer's list price for wholesale drugs, plus the professional/dispensing fee. PharmaCare coverage is subject to • Low-Cost Alternative Policy: If several drugs contain identical active ingredients, PharmaCare sets a maximum low-cost alternative (LCA) price that it will pay for any of the drugs in that group. The LCA price is set at the lowest average cost claimed by B.C. pharmacies for the drugs in the group. Drugs in the group within one percent of that LCA price are fully covered. • Reference Drug Program: If there is more than one drug in a therapeutic class, PharmaCare provides full coverage of only those drugs considered to be the most medically effective and the most cost effective in that category—the reference drug. Five classes of drugs are included in the Reference Drug Program:	Actual acquisition cost + professional fees + inventory allowance There are three drug price policies: least-cost alternative (LCA), maximum allowable cost (MAC) and actual acquisition cost (AAC). The LCA price is the lowest unit cost established for a drug product within a set of interchangeable drug products. Alberta's supplemental health plans will only pay for the lowest-priced drug product where interchangeable (generic) products can be used to fill a prescription. Beneficiaries who choose higher-cost alternatives are responsible for paying the difference. The MAC price is the maximum unit cost established for a specific drug product or a group of drug products. A small number of products are subject to MAC pricing. Pursuant to the pharmacy agreement, pharmacists are expected to charge the AAC of a drug product. For interchangeable drug products, pharmacists can only charge the AAC to a maximum of the lowest LCA or MAC price.	Low-Cost Alternative Benefits are based on the lowest-priced interchangeable brand as listed in the formulary. Maximum Allowable Cost Classes of drugs are reviewed by the province's expert drug review committees to determine which products are equally safe, beneficial and cost effective. The price of the most cost-effective drugs are used as a guide to set the maximum price that the drug plan will cover for other similar drugs used to treat the same condition. Prescription Cost The prescription cost is calculated by adding the actual acquisition cost of the drug material (which can include an allowable wholesale markup), the pharmacy markup (up to a maximum) and dispensing fee (up to a maximum). Extemporaneous preparations add a compounding fee of $0.75/minute to a maximum of 60 minutes; a maximum of 20 minutes applies for most methadone compounds.	Prescription Cost The prescription cost is equal to the cost of the specified drug (the price of the specified drug to the pharmacist or holder of the pharmacy license) and a professional fee (the professional fee is equal to the amount regularly charged by a pharmacist to persons who are responsible for paying the fee without reimbursement). Lowest Cost Pricing Benefits are based on the lowest-priced interchangeable brand as listed in the formulary whether or not the specified drug is prescribed with a "no sub" or "no substitution" instruction.	Drug benefit price (DBP) + markup + professional fee Effective March 2007: Cost-to-operator claims are restricted to cases where a pharmacy is unable to acquire an interchangeable generic product and must dispense the original product or an interchangeable generic product with a higher drug benefit price.

<table>
<tr><th>Policy-Related Information</th><th>B.C.</th><th>Alta.</th><th>Sask.</th><th>Man.</th><th>Ont.</th></tr>
<tr><td></td><td>1. Histamine 2 receptor blockers (H2 blockers)
2. Non-steroidal anti-inflammatory drugs (NSAIDS)
3. Nitrates
4. Angiotensin converting enzyme inhibitors (ACE inhibitors)
5. Dihydropyridine calcium channel blockers (dihydropyridine CCBs)</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Professional Fees</td><td>• PharmaCare reimburses up to $8.60 for dispensing fees.
• Effective February 1, 2009, the Frequency of Dispensing Policy limits the number of dispensing fees that PharmaCare will pay for drugs dispensed in less than a 28 days' supply:
– PharmaCare will pay a maximum of three dispensing fees for drugs dispensed daily.
– PharmaCare will pay a maximum of five dispensing fees for drugs dispensed in 2-to-27 days' supplies.
• Plan B dispensing pharmacies are paid a capitation fee (per long-term care bed).
• Methadone (maintenance) interaction fee: $7.70.
• Special services fee—Remuneration to pharmacists if they choose not to fill a prescription based on their</td><td>• Alberta has two types of professional fees: dispensing fees and additional inventory allowance. The additional inventory allowance pricing component was implemented effective July 1, 2000.
• The fees from April 1, 2010, to March 31, 2011, are
<table><tr><th>Acquisition Cost</th><th>Dispensing Fee</th><th>Additional Inventory Allowance</th></tr><tr><td>Up to $74.99</td><td>$10.22</td><td>$3.71*</td></tr><tr><td>$75 to $149.99</td><td>$15.53</td><td>$2.00</td></tr><tr><td>$150 and More</td><td>$20.94</td><td>$5.03</td></tr></table>• For insulin and oral contraceptives, the prescription charge must not exceed the acquisition cost of the drug product times 5/3.
• For injectable drugs other than insulin, the prescription charge must not exceed the acquisition cost of the injectable drugs times 5/3, to a maximum of $100 more than the acquisition cost of the injectable drug.
• For compounded prescriptions that require more than seven minutes for preparation, the additional charge for compounding must not exceed 75 cents per minute for each minute in excess of seven minutes.</td><td>• The maximum dispensing fee is $9.15 (effective August 1, 2009).
• Trial prescriptions—Specific list of drugs; trial for 7 or 10 days; follow-up by pharmacist required; the usual and customary professional fee (to a maximum of $9.15) is paid for the trial quantity; if the medication is continued, no fee may be claimed on the "remainder" prescription, but an alternative reimbursement fee of $7.50 is paid even if the balance of the prescription is not dispensed; subsequent refills are subject to usual reimbursement
• Methadone managed care—Pharmacists supply a daily quantity of methadone; the managed care fee is $3.50 per day ($24.50 per week) and is paid only for face-to-face interactions between the patient and the pharmacist
• Emergency contraception prescribing—Pharmacists who</td><td>• 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.
• Effective April 1, 2008, monthly capitation fee for personal care homes: $36.76 per bed/month for Winnipeg and $37.46 per bed/month for rural areas.</td><td>• The maximum dispensing fee is $7.

Effective August 1, 2008: Dispensing fee shall be set at a maximum of two fees per medication per patient per month; exceptions are for patients in long-term care homes and/or drugs in exemption medication list

Effective April 2007: Introduction of professional allowance for a medication review program, MedsCheck; residents of Ontario with three or more chronic conditions are eligible to receive annual MedsCheck reviews; follow-up MedsCheck reviews were introduced in November 2007</td></tr>
</table>

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	professional opinion (fee of twice the dispensing fee). • Emergency contraceptive honorarium: $15. The following interim policy was negotiated as part of an interim agreement between the Province of British Columbia and the BC Pharmacy Association. The interim agreement expires on December 31, 2009. However, the parties have agreed to seek a longer-term agreement under which this, or a similar, policy may continue. **Interim Policy—Pharmacist Clinical Services Associated With Prescription Adaptation:** Pharmacists will be reimbursed for prescription adaptation services, defined as follows: 1. Renewing a prescription; 2. Changing the dose, formulation or regimen of a prescription to enhance patient outcomes; and 3. Making a therapeutic drug substitution within the same therapeutic class. For renewing and/or changing the dose, formulation or regimen of a prescription, pharmacists will be paid $8.60.	• The transitional allowance applies to prescriptions with an AAC of between $0.00 and $74.99, with the exception of insulin, oral contraceptives, injectables, diabetic supplies, Alberta Public Health Activities Program drugs and Pharmacy Practice Models Initiative drugs. * The additional inventory allowance field was increased to allow for a transitional allowance to be incorporated. The transitional allowance will apply as follows: April 1, 2010, to March 31, 2011: $3.71 April 1, 2011, to March 31, 2012: $2.71 April 1, 2012, to March 31, 2013: $1.71 April 1, 2013, to March 31, 2014: $0.71	have the required training may charge a prescribing fee equal to two times the usual dispensing fee; this is in addition to the usual cost plus fee for 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—For services related to medication reconciliation for clients who are transferred from an institution to a community setting; may charge 1.5 times the pharmacy's usual and customary dispensing fee • Compliance packaging—Effective January 15, 2010; as set out in the Medication Assessment and Compliance Packaging Policy; currently eligible/nominated home care clients: $6.25 for each 7-day supply ($25 for a 28-day supply or $31.25 for a 35-day supply) • Medication assessment—Effective January 15, 2010; as set out in the Medication Assessment and Compliance Packaging Policy; fee—no more than $60, restricted to payment once per calendar year		

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	For making a therapeutic drug substitution, pharmacists will be paid $17.20. Clinical services fees are paid in addition to the usual dispensing fee to which the pharmacy may be entitled. Special services fees are not paid for any prescription for which a clinical service fee is paid. Clinical services fees are paid in the quarter following the one in which the clinical service was provided. The ministry will pay a maximum of two clinical services fees per drug, per person during a six-month period. A transition agreement came into effect January 1, 2010, to bridge the six-month period required to develop a long-term agreement to ensure the continuation of benefits specified in the interim policy. Regulatory changes effective October 21, 2009, expanded B.C. pharmacists' scope of practice to include the administration of vaccinations. Authorized pharmacists are paid $10 for each publicly funded vaccination they provide.				

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Markup	PharmaCare does not cover (pay for) retail markup. Insulins, with the exception of Humalog, and needles and syringes for insulin therapy are reimbursed at the regular retail price, which includes markup. However, no dispensing fee may be charged.	Prices listed in the *Alberta Health and Wellness Drug Benefit List* include a wholesaler markup, but only if the drug manufacturer distributes through a wholesaler. In such cases, it is asked to include a distribution allowance of up to 7.5%. This includes both single-source and interchangeable products.	The maximum pharmacy markup allowance calculated on the prescription drug cost is • 30% for drug costs up to $6.30; • 15% for drug costs between $6.31 and $15.80; • 10% for drug costs of $15.81 to $200; and • Maximum markup of $20 for drug costs higher than $200; For urine-testing agents, the pharmacy receives the acquisition cost along with the markup and a 50% markup in place of the dispensing fee. For insulin, the pharmacy receives the acquisition cost plus a negotiated markup.	N/A	Maximum 8% where permitted
Ingredient Pricing Policy	PharmaCare payment is based on the actual acquisition cost (AAC) up to a maximum price of 7% above the manufacturer's price for wholesale drugs. AAC is adjusted to reflect the true cost to the pharmacy and is net of any cash discounts, volume discounts, rebates or performance allowances. PharmaCare coverage is subject to • Low-Cost Alternative Policy: If several drugs contain identical active ingredients, PharmaCare sets a maximum LCA price that it will pay for any of the drugs in that group. The LCA price is set	All prices printed in the *Alberta Health and Wellness Drug Benefit List* are based on responses to an Alberta price confirmation for the period of time during which the list is in effect.	Manufacturers are required to guarantee the prices of their listed products during the fiscal year (April to March). The prices published in the formulary include the maximum allowable wholesale markup. Pharmacies are required by contract to submit their actual acquisition cost of the drug, which may be less than the published formulary price. Standing Offer Contract (SOC) The drug plan tenders the drugs in certain interchangeable groups to obtain the lowest possible price. An accepted tender, called a SOC, requires the manufacturer to guarantee delivery of the specific drug to pharmacies through	• The specified drug as listed in the *Specified Drug Regulations* is equal to the cost for the lowest-priced interchangeable product prescribed in the formulary • Or in any other case, the lowest usual price of the specified drug as charged from time to time by wholesalers or manufacturers that supply pharmaceuticals to pharmacists or holders of pharmacy licenses	Since October 2006, through implementation of the *Transparent Drug System for Patients Act* (Bill 102), the OPDP may enter into listing agreements with manufacturers. Before a product is approved for listing, the ministry and the manufacturer must agree on its drug benefit price (DBP). The price of multiple-source drugs must be at no more than 50% of the original brand product. Price increases may be considered for drug products

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	at the lowest average cost claimed by B.C. pharmacies for the drugs in the group. Drugs in the group within one percent of that LCA price are fully covered. • Reference Drug Program: If there is more than one drug in a therapeutic class, PharmaCare provides full coverage of only those drugs considered to be the most medically effective and the most cost effective in that category—the reference drug. Five classes of drugs are included in the Reference Drug Program: 1. Histamine 2 receptor blockers (H2 blockers) 2. Non-steroidal anti-inflammatory drugs (NSAIDS) 3. Nitrates 4. Angiotensin converting enzyme inhibitors (ACE inhibitors) 5. Dihydropyridine calcium channel blockers (dihydropyridine CCBs)		approved distributors at the contracted price. In return, the manufacturer's product will be used almost exclusively. Only the accepted tendered drug can be used to fill a prescription in a SOC-interchangeable group.		that have been listed on the formulary as a benefit under the Ontario Drug Benefit (ODB) Program for at least five years and where the manufacturer is able to submit evidence of substantial raw material cost increases during the previous year. When a pharmacy is not able to purchase a formulary-listed drug at a price less than or equal to its OPDB reimbursement amount (that is, the drug benefit price + 8% markup), payment of the acquisition cost to the pharmacy of the least-expensive listed drug product in the pharmacy's inventory may be claimed. This is referred to as a "cost-to-operator" (CTO) claim. CTO claims may be submitted for eligible drug products only.
Coordination of Benefits (Public/Private)	With the exception of B.C. residents covered by Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers' Compensation or the federal Non-Insured	Alberta Health and Wellness 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.	The drug plan is the first payer on eligible claims for eligible beneficiaries. Costs not covered by the drug plan are either sent electronically by the pharmacy or manually by the patient to the	• For each benefit year beginning on or after April 1, the amount of the benefits payable to a family unit is the cost of specified drugs incurred collectively by the	Claims for seniors with both private insurance and public provincial coverage are processed under their provincial plan first.

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	Health Benefits Program, PharmaCare covers every individual. PharmaCare will consider coverage first and private insurance will consider coverage second.		private insurance carrier (where applicable).	family unit in the benefit year that exceeds the deductible amount determined. A person is not considered to have spent an amount on the cost of a specified drug in the following cases: • The person is entitled to be reimbursed for the cost of the specified drug from a source other than the government to the extent of the reimbursement. • The person is entitled to have the cost of the specified drug paid from a fund or pursuant to a program established under a law enacted by Parliament or a legislature in Canada or elsewhere. Citizens whose health services are covered under First Nations and Inuit Health, Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers' Compensation, federal penitentiaries or private drug benefit plans are not eligible for provincial drug plan benefits as per sections 2(2) (a) and (b) in *The Prescription Drugs Cost Assistance Act*.	Individuals or families can apply to the Trillium Drug Program if private insurance does not cover 100% of their prescription drug costs and if they are not eligible for drug coverage under the ODB program.

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Coordination of Benefits (Intra-Jurisdictional)	For PharmaCare claims, the rules of plan adjudication are as follows, by plan priority. If patients don't meet the criteria of one plan, they will move on to the next until a plan is selected. If one plan only offers partial coverage (for example, based on medication) then patients could have claims and payments for multiple plans. The order of adjudication is as follows: • Plan B • Plan P • Plan D • Plan G • Plan F • Plan C • Fair PharmaCare Enhanced Assistance • Fair PharmaCare	Alberta Health and Wellness does not permit coordination of benefits across its public plans. It is intended that Albertans only be enrolled in one government plan at a time. As such, coordination of benefits is not necessary. Generally, Albertans eligible for coverage under federal plans do not seek coverage under another Alberta government plan.	Citizens whose health services are covered under First Nations and Inuit Health, Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers' Compensation or federal penitentiaries are not eligible for drug plan benefits under Saskatchewan Health.	Citizens whose health services are covered under First Nations and Inuit Health, Health Canada, Veterans Affairs Canada, Royal Canadian Mounted Police, Canadian Forces, Workers' Compensation, federal penitentiaries or private drug benefit plans are not eligible for provincial drug plan benefits as per sections 2(2) (a) and (b) in *The Prescription Drugs Cost Assistance Act.*	A person cannot be on more than one provincial public drug plan at the same time.
Restricted Benefit Process	• Special authority forms are completed by practitioners on behalf of their patients. • These forms can be forwarded to PharmaCare by mail, fax or telephone. • The special authority requests are adjudicated on an individual basis, according to established criteria. • Approved requests are entered into a patient's PharmaNet record. The special authority coverage is then available through any B.C. pharmacy. Special	• Special authorization request forms are completed by providers and reviewed by clinical pharmacists of the program. • Prior approval must be granted to ensure coverage by special authorization. • Special authorization is granted for a maximum of 12 months. If continued treatment is necessary the providers must re-apply for coverage before the expiry date. • A small number of drugs is restricted to specific age groups.	Exception Drug Status Criteria-based coverage for drug products where regular benefit listing may not be appropriate or possible: • Physicians, dentists, duly qualified optometrists (or authorized office staff), nurse practitioners, midwives and pharmacists may apply for Exception Drug Status (EDS). • Requests can be submitted by telephone, mail or fax. • Patients are notified by letter if coverage has been approved and the time period for which coverage has been approved.	A drug or other item not listed in Part 1, or a specified drug listed in Part 2 for use in a different condition, may be considered for eligibility if • It is ordinarily administered only to hospital inpatients and is being administered outside of a hospital; • It is not ordinarily prescribed or administered in Manitoba but is being prescribed because it is required in the treatment of a patient having an illness, disability or condition rarely found in Manitoba; or	Limited-Use Products Effective September 27, 2005, limited-use (LU) prescription forms are no longer required from the physician. LU prescriptions now require a reason-for-use (RFU) code to be handwritten on the prescription or provided electronically or verbally by the physician. The LU prescription is valid for one year from the initial date unless otherwise stated in the LU note.

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
	authorities are valid from the effective date for various periods of time, depending on the medication and use. • Information regarding requests is returned to the practitioner by fax or mail. • If appropriate, expired special authority coverage may be renewed. The requests for renewal should be submitted at least two weeks before the expiry date.		• If a request has been denied, letters are sent to the patient and prescriber notifying them of the reason for the denial. For pharmacist-initiated EDS requests, the diagnosis, which must be obtained from the physician or physician's agent, is to be consistently documented within the pharmacy, whether the documentation is on the original prescription, computer file or EDS fax form.	• Evidence, including therapeutic and economic evidence, provided to the minister in accordance with the criteria established by him or her, supports a specific treatment regimen which includes use of the drug or other item. Process: Exception Drug Status, Part 2—Adjudicated for payment by the DPIN system automatically if the pharmacist or prescriber indicates on the prescription that the patient meets the established Part 2 criteria Part 3—The prescriber must contact Manitoba Health to request eligibility for prescription; eligibility is from date of approval	Exceptional Access (EAP)—To apply for special coverage for drug products not listed on the formulary, the physician must send a written request to the Drug Programs Branch. Ministry staff coordinates the review process, which includes obtaining a recommendation from the Committee to Evaluate Drugs (CED). The CED requires full details of an individual's case in order to make a recommendation. The ministry's decision on individual coverage in a particular patient's case will be communicated via letter 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. Effective November 27, 2008, EAP introduced a Telephone Request Service (TRS) for select drugs. In most cases, the requests will be assessed in real time. Requests for approximately 40 drugs for specific, often urgent, indications will be considered. Requests for drugs/indications not currently considered through TRS should apply via written request.

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
Reimbursement Policy	Every time an enrolled Fair PharmaCare beneficiary purchases medication at a registered B.C. pharmacy, a claim is automatically submitted for coverage. As of January 1, 2008, PharmaCare no longer reimburses prescription or medical supply costs paid before the date a family registers for Fair PharmaCare. Costs continue to count towards the Fair PharmaCare deductible and annual family maximum, but costs above the deductible that occurred before registration are not reimbursed. Special authorities are prioritized by date received and the urgency of the request. On average, most requests are processed within two weeks. To ensure PharmaCare coverage, approval must take place prior to purchasing or dispensing a prescription drug. Retroactive coverage is not provided. The province does not reimburse for most out-of-province claims.	When beneficiaries pay out of pocket, reimbursement claims are permitted. Claims from out of province and out of country are permitted but coverage is restricted to comparable benefits on the *Alberta Health and Wellness Drug Benefit List*. To be eligible for reimbursement, claims must be received by Alberta Blue Cross within 12 months of the service date. The service must have been provided after the effective date of coverage.	An online computer network transmits prescription information from the pharmacy to the central computer where it is checked against stored data to determine whether it can be approved for payment. The prescription claim is adjudicated and cost information is then transmitted back to the pharmacy, detailing the consumer share and drug plan share. 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 are eligible for the same drug benefits out of province as in Saskatchewan, according to Saskatchewan prices and an individual's coverage level. Original receipts for prescriptions purchased in another province or territory can be submitted to the drug plan.	An online computer network transmits prescription information from the pharmacy to the central computer where it is checked against stored data to determine whether the prescription can be approved for payment. The prescription information is then transmitted back to the pharmacy, detailing the customer's cost share and the drug plan cost share. The cost of a specified drug when purchased in a province or territory of Canada other than Manitoba, incurred to a maximum amount that is considered reasonable by the minister. The original receipts for prescriptions purchased in another province or territory can be submitted to the drug plan for reimbursement.	Claims are only reimbursed when dispensed from an Ontario pharmacy, written by a physician licensed in Ontario and the recipient is an eligible Ontario resident. If patients meet all the above criteria and pay cash at the pharmacy, they may submit receipts for reimbursement to the Ontario Drug Program.

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
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). Travel Supply As of May 1, 2008, PharmaCare covers out-of-province travel supplies of medication up to the PharmaCare maximum allowable days' supply. Under the new policy, once every six 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 B.C.	Prescription Quantities • No limitation on the quantities of drugs that may be prescribed. • In most cases, Alberta Health and Wellness will not pay benefits for more than a 100-day supply of a drug at one time. • Drugs considered maintenance or long-term therapy in the following therapeutic classes should be dispensed for 100 days: – Anticoagulants – Anticonvulsants – Digitalis and digitalis glycosides – Hypoglycemic agents – Thyroid drugs – Vitamins – Oral contraceptives – Antihypertensive agents – Conjugated estrogens – Anti-arthritics The Seniors and Widows, Non-Group and Palliative programs do not cover prescription costs exceeding $25,000 per beneficiary per year. On an exception basis, this amount can be modified by Alberta Health and Wellness.	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 three-month supply of a drug at one time. A pharmacist may charge one dispensing fee for each prescription for most drugs listed in the formulary. If a prescription is for a duration of one month or more, the pharmacist is entitled to charge a dispensing fee for each 34-day supply; however, the contract the drug plan has with pharmacies does not prohibit the pharmacist from dispensing more than a 34-day supply for one fee. The contract also contains a list of two-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.	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; and • Up to an additional 100, if – The prior approval of the minister has been obtained; and – The person will be outside of Canada for more than 90 consecutive days.	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. • Beginning November 14, 2002, the 30-Day Prescription Program was implemented by ODB. All new prescriptions for ODB recipients are subjected to a 30-day maximum prescription limit if they have not been taken in the preceding 12 months. If the newly prescribed drug helps a patient after the initial 30-day supply and the patient is not having any problems with it, the remainder of the prescription can be dispensed up to the maximum 100-day supply. Some recipients are exempt from this program (that is, travel out of province for extended periods, samples from physician, insulin prescriptions). • For recipients covered under the *Ontario Works*

Policy-Related Information	B.C.	Alta.	Sask.	Man.	Ont.
					Act, the maximum quantity of medication claimed under the ODB program must not exceed that required for a 35-day course of treatment.
Sources	For more information: British Columbia PharmaCare	For more information: Alberta Health and Wellness	For more information: Saskatchewan Health Drug and Extended Benefits Branch	For more information: Manitoba Health	For more information: Ontario Drug Benefit Program

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

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Prescription Cost Components	Actual acquisition cost (AAC) or maximum allowable price (MAP) + dispensing fee	Actual acquisition cost (AAC) or, where applicable, maximum allowable cost (MAC), MAC Less the Pharmacare Allowance, or Special MAC + 2% markup (from April 1, 2009, to March 31, 2010, to a maximum of $50 per prescription) + applicable professional fee (to a maximum of $10.42) In the case of injectable products (except insulin) and ostomy supplies: AAC or, where applicable, MAC or Special MAC + 10% markup (to a maximum of $250 per prescription) + applicable professional fee (to a maximum of $10.42)	Maximum allowable cost (MAC) + professional fee Where no MAC exists the cost is based upon the manufacturer's net catalogue price and professional fee for manufacturers defined as direct. If the manufacturer is not defined as direct, the cost is the manufacturer's net catalogue price plus a markup to a maximum of 13% plus the professional fee.	Total prescription price = (defined cost) + (up to the maximum professional fee) + (up to the maximum surcharge) Defined Cost Products listed in the NIDPF will be the published price. Products specified under reasonable-based pricing will be the lesser of the reasonable-based pricing published price or manufacturer's list price (MLP) plus 8.5%. Extemporaneous preparations will be the MLP plus 8.5% for each covered product used in the extemporaneous preparation. All other cases (except methadone) will be MLP plus 8.5%. Methadone, when used for the purposes of addiction only and billed under the specific PIN 967211, shall have a defined cost set at $1.50 per dose for the	AAC + markup + professional fee	Drug benefit list price + professional fee + markup (if applicable)

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<tr><th>Policy-Related Information</th><th>N.B.</th><th>N.S.</th><th>P.E.I.</th><th>N.L.</th><th>Y.T.</th><th>FNIHB</th></tr>
<tr><td></td><td></td><td></td><td></td><td>duration of the agreement (July 10, 2007, to March 31, 2011).</td><td></td><td></td></tr>
<tr><td>Professional Fees</td><td><table><tr><th>Ingredient Cost/ Prescription</th><th>Dispensing Fee</th><th>Dispensing Fee for Compounds</th></tr><tr><td>$0.00–$99.99</td><td>$9.40</td><td>$14.10</td></tr><tr><td>$100.00–$199.99</td><td>$11.90</td><td>$17.85</td></tr><tr><td>$200.00–$499.99</td><td>$17.00</td><td>$18.00</td></tr><tr><td>$500.00–$999.99</td><td>$22.00</td><td>$22.00</td></tr><tr><td>$1,000.00–$1,999.99</td><td>$62.00</td><td>$62.00</td></tr><tr><td>$2,000.00–$2,999.99</td><td>$82.00</td><td>$82.00</td></tr><tr><td>$3,000.00–$3,999.99</td><td>$102.00</td><td>$102.00</td></tr><tr><td>$4,000.00–$4,999.99</td><td>$122.00</td><td>$122.00</td></tr><tr><td>$5,000.00–$5,999.99</td><td>$142.00</td><td>$142.00</td></tr><tr><td>Greater Than or Equal to $6,000.00</td><td>$162.00</td><td>$162.00</td></tr></table>
Note: Dispensing physicians are reimbursed 80% of the applicable fee listed in the above table.</td><td>For prescriptions the maximum fee is $10.42.</td><td>• The professional fees for the Children in Care, Diabetes (oral medications and test strips only), Financial Assistance, Quit Smoking and STD programs is $8.20 for prescription drugs, $7.96 for non-prescription drugs and $12.30 for extemporaneous compounds.
• The surcharge for the Family Health Benefit, Nursing Home and Seniors programs for medications with defined ingredient cost equal to or greater than $45 is 9.5% to a maximum of $60.
• The high-cost drug surcharge for MS drugs and other high-cost drugs is 7.5% of defined ingredient cost to a maximum of $150.
• The monthly capitation fee for the Nursing Home Program is $51.59.
• There is no maximum fee on all the other programs.</td><td>Professional Fee
$7.15 from January 1, 2008, to March 31, 2011

Extemporaneous Preparations Fee
$10.73 from January 1, 2008, to March 31, 2011
This applies to compounds that contain three or more ingredients. Additionally, 10 cents per powder paper will be paid on compounded prescriptions where the pharmacist compounds powder papers.</td><td>The professional fee maximum is $8.75.</td><td>Pharmacists can charge dispensing fees. They are negotiated between NIHB and pharmacists' associations in a number of provinces/ territories and will differ in each jurisdiction.</td></tr>
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Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Markup	None	10% for injectable products and ostomy supplies and 2% for all other prescriptions	See **Prescription Cost Components** and **Ingredient Pricing Policy**.	**Maximum Surcharge** 10% of the defined cost (chargeable only when the defined cost exceeds $30)	• Pharmacies are allowed a 30% markup. • In addition, if AAC includes a wholesale up charge, this can be included up to a maximum of 14%.	Markups, if applicable, are negotiated as part of the pharmacy agreements between NIHB and the pharmacists' associations in the different jurisdictions. If a markup exists, it will be submitted by the pharmacy in a separate field in the electronic claim document. The markups are not built into the price file.
Ingredient Pricing Policy	The NB Prescription Drug Program MAP list establishes the maximum amount payable to pharmacies for interchangeable and certain single-source drugs.	**Actual acquisition cost** (AAC) means the net cost to the provider after deducting all rebates, allowances, free products, etc. No markup or buying profit is to be included in the calculation of AAC. The net cost to the provider is defined as the drug ingredient (or supply) costs based on date of purchase and inventory flow, even though the current prices available may be lower or higher when the product is dispensed. Incentives for prompt payment (payment within 15 days up to a maximum of 2%) will not be included in the calculation. **MAC** is the maximum allowable cost established by the Pharmacare programs for an interchangeable drug	P.E.I. Drug Programs creates a maximum allowable cost (MAC) list, which is published and distributed to pharmacies on a monthly basis. For products with a MAC, the ingredient cost is based on the manufacturer's net catalogue price of the lowest product within an interchangeable category plus a markup to a maximum of 5%. Where no MAC exists and the manufacturer is defined as being direct, the cost is based upon the manufacturer's net catalogue price. If there is no MAC and the manufacturer is not defined as direct, the cost is based upon the manufacturer's net catalogue price plus a markup to a maximum of 13%.	As of July 10, 2007, there are no longer three definitions for manufacturer up-charge: direct, wholesale and tendered wholesale price. Reimbursement will be as noted under defined cost. Diabetic supplies and insulin will no longer be reimbursed at a 33 1/3% markup. Reimbursement will be as noted under defined cost. Birth control fee will be reimbursed at the maximum professional fee as noted above, instead of the previous $4.10.	Yukon Drug Programs formulary benefits will be based on the lowest-priced interchangeable brand available as negotiated with the Pharmacy Society of Yukon. Prices listed in the formulary are based on McKesson wholesale prices.	NIHB pays the amount identified on the price file that is created and maintained on NIHB's behalf by the claims processor. The principles guiding the price file are the following: • If an item is listed on both a provincial formulary and the NIHB benefits list, NIHB pays the same. • If an item is unique to NIHB, the program will pay according to the price list of a national wholesaler. Exceptions exist in Atlantic Canada and Quebec.

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
		category. A MAC price is applied to those drugs which are Pharmacare benefits, have multiple suppliers and have been deemed interchangeable (for example, brand name drugs and their generic equivalents). For each interchangeable category, a maximum allowable cost per unit (tablet, capsule, millilitre, etc.) is determined by examining costs available from each manufacturer. The MAC is based on the lowest price available to the pharmacy, including prices available from direct ordering if the manufacturer is a direct order company. Exemptions to a MAC are available for beneficiaries who have experienced side effects with lower-cost alternatives. A request must be received from the prescriber detailing the reaction. Exemptions will not be considered when there is an "ultrageneric" alternative available (that is, where the brand name company manufacturers its own identical generic). MAC Less the Pharmacare Allowance is a discount from the MAC of the top 20 (by cost) interchangeable, multi-source, generic categories billed to the				

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
		Pharmacare programs. The product categories to which the Pharmacare Allowance applies are updated twice a year with the Pharmacare Reimbursement List and are based on the utilization over the six months previous to the Reimbursement List calculations. The Pharmacare Allowance pursuant to the Tariff Agreement is 15%, effective August 15, 2007. Special MAC is the special maximum allowable cost assigned to certain groups of drugs that are similar in therapeutic effect; specific services for which coverage is established; certain unit dose and special delivery formats that are also available in less-expensive bulk formats; and certain supplies that are used for the same function.				
Coordination of Benefits (Public/Private)	N/A	A—Program is payer of last resort. Any out-of-pocket costs to client after private plans are used can be applied to Family Pharmacare. S—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	N/A	• The Foundation Plan—Private insurers must be billed first. Government will pay the balance provided it does not exceed the cost government would have paid if there was no private insurance. • The Access Plan—Private insurers must be billed first. Government will pay the balance provided it	For all Yukon government plans, residents must access private insurance plans first.	When beneficiary is covered by a private health care plan, claims must be submitted to it first.

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
		enrolled in Seniors Pharmacare, he or she may request a reimbursement of the difference. See **Eligibility—Beneficiary Group** above for coordination of benefits.		does not exceed the cost government would have paid if there was no private insurance. • **The 65Plus Plan—** Private insurers must be billed first. Government will pay the balance provided it does not exceed the cost government would have paid if there was no private insurance. • **The Assurance Plan—** Private insurers must be billed first. Government will pay a percentage of the balance as defined by the beneficiary's calculated copayment. • **The Select Needs Plan—** Private insurers must be billed first. Government will pay the balance provided it does not exceed the cost government would have paid if there was no private insurance.		

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Coordination of Benefits (Intra-Jurisdictional)	N/A	A—Program is payer of last resort. Any out-of-pocket costs to client after private plans are used can be applied to Family Pharmacare. See Eligibility—Beneficiary Group above for coordination of benefits.	N/A	• The Foundation Plan—Other federal public plans are to be used before this plan. • The 65Plus Plan—Other federal public plans are to be used before this plan. • The Access Plan— Other federal public plans are to be used before this plan. • The Assurance Plan—Other federal public plans are to be used before this plan. • The Select Needs Plan—Other federal public plans are to be used before this plan.	• Residents must access all other drug insurance plans first. • Coordination between Yukon government plans: Children who are eligible for Chronic Disease Program will use that plan before Children's Drug and Optical Plan.	When beneficiary is covered by another public health care plan, claims must be submitted to it first.
Restricted Benefit Process	Drugs not listed as regular benefits may be eligible for reimbursement under New Brunswick Prescription Drug Program (NBPDP) through special authorization. Drugs eligible for consideration through special authorization: • Drugs listed as special authorization benefits have specific criteria for coverage which must be met in order to be approved • Under exceptional circumstances, requests for drugs without specific criteria may be reviewed case-by-case and assessed based on the published medical evidence Drugs not eligible for consideration through special authorization: • New drugs not yet reviewed by the expert advisory committee	Exception Status Drugs are those which are only eligible for coverage under the Pharmacare programs when an individual meets criteria developed by the Atlantic or Canadian Expert Advisory Committees or the Cancer Systemic Therapy Policy Committee (CSTPC). 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	• Prescribers may apply for special authorization coverage by mailing or faxing a completed special authorization form. • Allow two to four weeks for the processing of exceptional drug 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.	A special authorization request form has been prepared at the request of pharmacists and physicians, which may be used to facilitate the approval process. While staff of the division try to accommodate verbal requests where possible, requests are assessed in the order received (fax, mail or verbal) and must be subject to a review of the patient's medication claims summary. The use of the form, while not mandatory, is encouraged to expedite the approval process.	Application process: • Yukon physicians only may apply for exception drug status. • Applications must be submitted in writing. • Criteria for exception drugs—Refer to Exception Drug Status Table Initial 30-Day Approval. • When an exception drug is prescribed the pharmacist may request a 30-day approval. The pharmacist must phone the respective drug program advising that the patient is active; the	There are four types of limited-use benefits: • Limited-use benefits, which do not require prior approval • Limited-use benefits, which 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 which have a quantity and frequency limit

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
	• Drugs excluded as eligible benefits further to the expert advisory committee's review and recommendation • Drugs not licensed or marketed in Canada (for example, 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 NB Prescription Drug Program Special Authorization Unit.	process requests within seven days. A letter notifies clients if the request is approved. 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 the Pharmacare programs. The prescriber may provide diagnostic information on the prescription (instead of the actual code) but it must clearly indicate to the pharmacist which code should be used.	• If the request is approved, patients may be reimbursed for one fill of the prescription received during the assessment period after all of the requested information has been received.		exception drug will be covered for 30 days providing the drug is listed in the formulary. If the drug requires a specialist recommendation according the product's criteria, the 30-day coverage will not be granted unless the specialist information is provided.	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.

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Reimbursement Policy	• If a beneficiary pays out of pocket, he or she may submit the claim for coverage if it is a benefit product and was purchased at a pharmacy within New Brunswick.	• If beneficiary paid cash at the pharmacy he or she has up to six 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.	• If a beneficiary paid cash at the pharmacy he or she has six months to submit receipts for reimbursement.	• The Foundation Plan—Reimbursement can be considered under exceptional circumstances; out-of-province claims are only considered if a patient is referred out of province for medical reasons and approval is obtained prior to leaving the province • The Access Plan—The program only applies to benefits obtained within the province of Newfoundland and Labrador • The 65Plus Plan—For medications purchased in the province only • The Select Needs Plan—The program applies only to benefits obtained through the Health Sciences Centre Pharmacy of the Eastern Regional Health Authority; 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	• When beneficiaries pay out of pocket, receipts may be submitted for reimbursement if eligible under the program. Receipts will be assessed using formulary-listed prices. Exception drugs will require approval and these may be backdated. • Payment will not be made for any drug or supply receipt that is mailed from an address outside of the Yukon.	• Submissions for retroactive coverage must be received by FNIHB on an NIHB Client Reimbursement Request Form within one 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. Effective December 1, 2009, ESI Canada will administer the Health Information and Claims Processing Services (HICPS) for pharmacy benefits covered by the NIHB Program.

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
Miscellaneous	Prescription Quantities • 100 days' supply • 35 days' supply for narcotics, controlled drugs and benzodiazepines or the limit as set for specific medications by the NBPDP Quantitative limits have been established for a number of products listed as benefits of the NBPDP.	Prescription Quantities 100 days' supply maximum, if prescribed Seniors Pharmacare Program beneficiaries travelling outside the province for more than 100 days will be allowed to obtain two prescriptions for the same medication before leaving Nova Scotia. Neither prescription shall exceed a 90 days' supply (maximum 180 days' supply for the two prescriptions). The usual copayment and professional fee will apply to each of the prescriptions. There is a 28-day minimum supply for maintenance medications.	Program Maximum Allowable Days' Supply • Nursing Home Program: 35 days • Institutional Pharmacy Program: 35 days • AIDS/HIV Program: 60 days • Children-In-Care Program: 30 days—regular drugs; 60 days—maintenance drugs Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first two prescriptions or refills. • Cystic Fibrosis Program: 60 days • Diabetes Control Program: 30 days—insulin, 100 blood glucose test strips; 90 days—oral medications and test strips Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first two prescriptions or refills. • Family Health Benefit Program: 30 days—regular drugs; 60 days—maintenance drugs; 30 days—drugs under EDS coverage Note: Prescriptions	Prescription Quantities • 90 days' supply • 30 days' supply for narcotics	Prescription Quantities • The respective drug programs will not pay for more than 100 days' supply. There must be an interval of 75 days before a further 100-day supply can be given. • Physicians shall exercise their professional judgment in determining the course and duration of treatment for their patients.	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. However, effective September 9, 2008, prescriptions for most chronic medications should be refilled no sooner than 28 days. NIHB will reduce the professional fee on most chronic medications that are dispensed less than 28 days apart.

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
			introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first two prescriptions or refills. • Financial Assistance Program: 30 days—regular drugs; 60 days—maintenance drugs; 30 days—drugs under EDS coverage Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a maximum of 30 days for the first two prescriptions or refills. • Growth Hormone Program: 30 days • Hepatitis Program: 30 days • Intron A Program: 30 days • Multiple Sclerosis Drug Program: 30 days • Phenylketonuria Program: 60 days • Rheumatic Fever Program: 60 days • Seniors Drug Cost Assistance Plan: 30 days—regular drugs; 90 days—maintenance drugs; 30 days—drugs under EDS coverage. Note: Prescriptions introducing a medication, strength, dosage or dosage form shall be filled for a			

Policy-Related Information	N.B.	N.S.	P.E.I.	N.L.	Y.T.	FNIHB
			maximum of 30 days for the first two prescriptions or refills. • Transplant Drugs Program: 60 days • Tuberculosis Drug Program: 60 days			
Sources	For more information: New Brunswick Prescription Drug Program	For more information: Nova Scotia Pharmacare Drug Programs and Funding	For more information: Prince Edward Island Drug Programs	For more information: Newfoundland and Labrador Prescription Drug Program	For more information: Yukon Health and Social Services	For more information: Non-Insured Health Benefits

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Glossary of Terms

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

Category	Terminology	Definition
Eligibility	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.
	Disease specific	Disease-specific requirements for beneficiaries to be eligible for coverage under a provincial, territorial or federal drug program.
	Income range	Family or individual income-specific requirements for beneficiaries to be eligible for coverage under a specific provincial, territorial or federal drug program.
	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.
Cost-Sharing Mechanism	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).
	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.
	Premium	The amount a beneficiary is required to pay to enrol in a provincial, territorial or federal drug plan/program.

Category	Terminology	Definition
Policy-Related Information	Coordination of benefits	Coordination of benefits is a process whereby payments are coordinated through two or more drug plans (public/private, intra-jurisdictional). One 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.
	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.
	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.

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