National Prescription Drug Utilization Information System

Plan Information: Summary of Changes

March 2023

Canadian Institute for Health Information
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Introduction

This document summarizes changes to plan information, from June 2005 to December 2022, for federal, provincial and territorial public drug benefit plans and programs that provide data to the National Prescription Drug Utilization Information System (NPDUIS) at the Canadian Institute for Health Information (CIHI).

The version of the NPDUIS plan information document in which the change was documented is included as the "report version."

The current plan information document is the March 2023 version available at www.cihi.ca/drugs or from CIHI's eStore.

Summary of changes

British Columbia

Effective February 1, 2001: The Palliative Care Program (Plan P) no longer requires patients to be enrolled in the palliative care portion of home and community care. (Report version: January 2006)

Effective January 1, 2008: PharmaCare no longer reimburses prescription or medical supply costs paid before the date on which a family registers for Fair PharmaCare. These costs will count toward the Fair PharmaCare deductible and annual family maximum; however, costs above the deductible will not be reimbursed. (Report version: January 2008)

Effective May 1, 2008: PharmaCare provides coverage for out-of-province travel supplies of medication up to the usual PharmaCare maximum days' supply for the drug. (Report version: July 2008)

Effective January 1, 2009: The Interim Policy — Pricing for New Multi-Source Generic Drugs states that where there is more than one source for a new generic drug, the ingredient cost paid by PharmaCare will be adjusted by a cost-reduction factor. The cost-reduction factor is specific to each generic drug and is equal to the difference between

- The new generic drug manufacturer's list price for the new generic drug; and
- 50% of the brand-name manufacturer's list price for the equivalent brand-name drug, based on the average price for the last 12 months.

The Interim Policy — Pharmacist Clinical Services Associated with Prescription Adaptation states that pharmacists will be reimbursed for prescription adaptation services, which are defined as

- Renewing a prescription;
- Changing the dose, formulation, or regimen of a prescription to enhance patient outcomes; and
- 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 up to the maximum $8.60 PharmaCare dispensing fee. For making a therapeutic drug substitution, pharmacists will be paid up to twice the maximum $8.60 PharmaCare dispensing fee (i.e., $17.20).

These interim policies are part of an interim agreement between the Province of British Columbia and the BC Pharmacy Association, which expires on December 31, 2009. However, the parties have agreed to seek a longer-term agreement under which these, or similar, policies may continue. (Report version: July 2009)

Effective February 1, 2009: The Frequency of Dispensing Policy limits the number of dispensing fees that PharmaCare pays for drugs dispensed in less than a 28-day supply:

- PharmaCare pays a maximum of 3 dispensing fees for drugs dispensed daily.
- PharmaCare pays a maximum of 5 dispensing fees for drugs dispensed in a 2- to 27-day supply.

(Report version: July 2009)

Effective October 15, 2009: Regulatory changes expand B.C. pharmacists' scope of practice to include the administration of vaccinations. Authorized pharmacists are paid $10 for each publicly funded vaccination provided. (Report version: July 2010)

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

Effective January 1, 2010: PharmaCare pays all participating pharmacies a set amount for providing clinical services associated with prescription adaptation by a pharmacist for patients who are residents of British Columbia. Clinical services fees are paid whether or not the drug or the patient is covered by PharmaCare.

Fees are paid only for prescription adaptation as defined by the College of Pharmacists of British Columbia Professional Practice Policy 58 (PPP-58); that is, for

- Renewing a prescription;
- Changing the dose, formulation or regimen of a prescription; and/or
- Making a therapeutic drug substitution within the same therapeutic class.

Effective July 28, 2010: On July 7, 2010, a new agreement was signed between B.C.'s Ministry of Health, the BC Pharmacy Association and the Canadian Association of Chain Drugstores.

- The maximum reimbursable fee increases from $8.60 to $9.10.
- From July 28 to October 14, 2010, the cost-reduction factor for new multiple-source generic drugs is the difference between:
  - The manufacturer's list price for the drug; and
  - 42% of the manufacturer's list price for the equivalent brand-name drug.

Effective October 15, 2010:

- PharmaCare reimburses up to $9.60 for dispensing fees.
- Capitation fees increase to $43.75 for pharmacy services to residential care facilities.
- The maximum that PharmaCare reimburses for brand-name and generic drugs eligible for PharmaCare coverage is the manufacturer's list price plus 8%.
- The Full Payment (no copayment) Policy is introduced. If a patient is receiving full PharmaCare coverage, a pharmacy is not permitted to collect directly from that patient any amount above the maximum drug price and maximum dispensing fee set by PharmaCare. This applies to patients covered under plans B, C, D, F, G and P, and to those who have reached the Fair PharmaCare family maximum. (Report version: January 2011)
- From October 15, 2010, to July 3, 2011, the Maximum Accepted List Price (MALP) for existing generics that are subject to the Low-Cost Alternative (LCA) policy is 50% of the brand-name list price as of January 1, 2010; the MALP for new generics that are subject to the LCA policy is 42% of the brand-name list price as of January 1, 2010.

(Report version: July 2011)

Effective November 1, 2010: The Rural Incentive Program is enhanced to support community-based pharmacies more fully in rural B.C. The qualifying claim volume increases from 750 to 1,700, and the subsidy to rural pharmacies increases as well. (Report version: July 2011)

Effective April 1, 2011: The B.C. Medication Review Services Program is introduced with 3 types of review:

1. Medication Review — Standard (MR-S)
2. Medication Review — Pharmacist Consultation (MR-PC)
3. Medication Review — Follow-Up (MR-F)

PharmaCare reimburses certain eligible high-cost drugs to a maximum price based on the manufacturer's list price plus a 5% markup.

The maximum amount that PharmaCare reimburses for prescription renewals and changes increases from $8.60 to $10. The fee for therapeutic substitution remains the same, at $17.20. (Report version: July 2011)

Effective July 4, 2011:

- Dispensing fees that are covered by PharmaCare increase from $9.60 to $10.
- From July 4, 2011, to April 2012, the MALP for every generic drug that is subject to the LCA policy is 40% of the brand-name list price as of January 1, 2010.

(Report version: July 2011)

Effective September 30, 2011: The B.C. Smoking Cessation Program offers British Columbians Nicotine Replacement Therapy (NRT) products (nicotine gum and patches) at no cost and smoking cessation prescription drugs as benefits under PharmaCare. The program covers 2 types of smoking cessation aids:

1. The 2 prescription smoking cessation drugs bupropion (brand name Zyban®) and varenicline (brand name Champix®); and
2. Eligible non-prescription (over-the-counter) NRT chewing gum or patches.
    - B.C. residents can get up to 12 continuous weeks (84 continuous days) of coverage for either 1 NRT product or 1 prescription drug, once every calendar year (January 1 through December 31).

(Report version: July 2012)

Effective April 1, 2012: The Pharmacy Services Agreement (PSA) terminates. Current PharmaCare policies will **not** change as a result of the PSA termination until further notice. (Report version: July 2012)

Effective April 2, 2012: The MALP that manufacturers can charge for generic LCA products is reduced to 35% of the equivalent brand-name product's list price. (Report version: July 2012)

Effective May 31, 2012: Royal assent is received for the Pharmaceutical Services Act. (Report version: July 2012)

Effective April 1, 2013: Drug price regulation comes into force, reducing the list price of generic drugs to 25% of the brand-name price. (Report version: July 2013)

Effective October 1, 2013: Health Canada transfers its role in the design, management and delivery of First Nations health programming in British Columbia to the new First Nations Health Authority (FNHA). (Report version: July 2014)

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

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

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

Effective January 1, 2015: Annual quantity limits for blood glucose test strips will depend on the beneficiary's diabetes treatment category. (Report version: July 2015)

Effective January 1, 2016: The B.C. Smoking Cessation Program's selection of eligible non-prescription NRT products expands to include specific lozenges and inhalers. (Report version: July 2016)

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

Effective March 1, 2017: The maximum markup on certain high-cost hepatitis C drugs covered by PharmaCare is reduced from 5% to 2%. (Report version: July 2017)

Effective April 1, 2017: B.C. no longer has annual confirmation of generic drug pricing. The previous annual pricing period (April 1 to March 31) is replaced with an indefinite pricing period, except for competitive MALP generic drug listings. New generic drug listings and price decreases are processed throughout the year, while price increases are accepted once a year, announced on March 1, to be effective April 1. (Report version: July 2017)

Effective October 1, 2017: FNHA clients who were previously covered by Health Canada's Non-Insured Health Benefits (NIHB) Program are eligible for PharmaCare Plan W, which offers 100% coverage of eligible benefits. (Report version: July 2018)

Effective January 15, 2018: PharmaCare provides 100% coverage of the medical abortion drugs mifepristone and misoprostol (Mifegymiso) for all B.C. residents. (Report version: July 2018)

Effective July 3, 2018: The coverage of insulin pumps — previously with an age restriction of age 25 and younger — is expanded to include all individuals living with diabetes, regardless of age. (Report version: July 2019)

Effective January 1, 2019: Families with net annual incomes between $15,000 and $30,000 are no longer required to pay a deductible; therefore, families with net annual incomes up to $30,000 are not required to pay a deductible. Copayments are eliminated for families with a net income up to $13,750. The maximum copayment contribution is lowered for regular assistance families with net incomes up to $45,000. (Report version: July 2018)

Effective April 1, 2019: The Maximum Accepted List Price (MALP) of the brand-name drug price for oral solids increases from 20% to 25%. (Report version: July 2019)

Effective May 27, 2019: The Biosimilar Initiative, which focuses on the expansion of the use of biosimilar drugs, is implemented. The goal of this initiative is to switch patients who use the affected biologic drugs to biosimilar versions by November 25, 2019. (Report version: July 2020)

Effective August 27, 2019: Assurance Plan (Plan Z) is introduced to provide 100% coverage of the medical abortion drug (Mifegymiso) to all residents with active Medical Services Plan (MSP) coverage. (Report version: July 2020)

Effective September 5, 2019: Phase 2 of the Biosimilar Initiative is implemented. (Report version: July 2020)

Effective January 1, 2020: Financial eligibility for PharmaCare Plan G (Psychiatric Medications) is based on eligibility for Medical Services Plan (MSP) supplemental benefits, rather than on eligibility for MSP Premium Assistance. This is a change to a regulatory reference, with no actual change to patient eligibility criteria. (Report version: July 2021)

Effective March 5, 2020: Phase 2 of the Biosimilars Initiative ended. (Report version: July 2021)

Effective September 1, 2020: Administration for publicly funded vaccines increased from $10 to $12.10. (Report version: July 2021)

Effective March 31, 2021: $18.00 is paid for each COVID-19 vaccine administered in pharmacies. (Report version: March 2023)

Effective July 6, 2021: Dexcom G6 CGM system is covered with criteria for individuals living with diabetes who are 2 years of age and older. (Report version: March 2023)

Effective January 19, 2022: Nirmatrelvir/ritonavir (Paxlovid™) is covered under Plan Z as a regular benefit. (Report version: March 2023)

Effective March 1, 2022: Community pharmacies are able to fill prescriptions for Paxlovid. (Report version: March 2023)

Effective June 13, 2022: Pharmacists can claim a $30 fee for assessments related to a prescription for Paxlovid, and the Paxlovid follow-up fee was increased from $15 to $25. (Report version: March 2023)

Alberta

(Effective date unknown): The income ranges for Non-Group coverage subsidized premiums change to the following:

- Singles: less than $17,450
- Families with no children: less than $26,200
- Families with children: less than $32,210

(Report version: July 2008)

Effective April 1, 2009: The Rare Diseases Drug Program is introduced to cover catastrophic drug costs for Albertans with extremely rare diseases resulting from genetic disorders. (Report version: July 2009)

Effective July 1, 2009: The premiums and income ranges for subsidized premiums for Non-Group coverage change to the following:

- Singles: The monthly premium is $41, subsidized to $28.70 for those with incomes less than $20,970.
- Families with no children: The monthly family premium is $82, subsidized to $57.40 for those with an income less than $33,240.
- Families with children: The monthly family premium is $82, subsidized to $57.40 for those with an income less than $39,250.

These changes are retroactive to 2006. (Report version: July 2009)

Effective July 1, 2010: Non-Group coverage premiums increase to make them comparable to those of employer and private plans.

- Singles: The monthly premium is $63.50, subsidized to $44.45 for those with incomes less than $20,970.
- Families with no children: The monthly family premium is $118, subsidized to $82.60 for those with an income less than $33,240.
- Families with children: The monthly family premium is $118, subsidized to $82.60 for those with an income less than $39,250.

(Report version: July 2010)

The price for **existing** generic drugs is reduced to 56% of the brand-name price from April 2010. The price for **new** generic drugs is reduced to 45% of the brand-name price from April 2010. (Report version: July 2011)

Effective July 1, 2012: The fixed price is further reduced to 35% of the brand-name price for both existing and new generic drugs. (Report version: July 2012)

Effective July 1, 2012: Alberta Health covers pharmaceutical services under 2 care plans: the Comprehensive Annual Care Plan and Standard Medication Management Assessment. (Report version: July 2013)

Effective April 15, 2013: The transition fee of $1 is reintroduced. (Report version: July 2013)

Effective May 1, 2013: 2 new services — trial prescription and refusal to fill — are added to the clinical pharmacy services. (Report version: July 2013)

Effective May 1, 2013: All generic drug prices are reduced to 18% of the brand-name price. (Report version: July 2013)

Effective June 1, 2013: The Insulin Pump Therapy Program launches. The program provides funding for the cost of insulin pumps and basic insulin pump therapy supplies for Alberta residents with type 1 diabetes mellitus who meet eligibility criteria. (Report version: July 2014)

Effective April 1, 2014: A 3-tiered professional fee is replaced by a new dispensing fee of $12.30 for all products except compounds and diabetic supplies. The Actual Acquisition Cost (AAC) is replaced with the Manufacturer’s List Price (MLP) or base price, and the exceptions for injectables, oral contraceptives and insulin products are removed. 2 new allowable upcharges, referred to as Allowable Upcharge #1 and Allowable Upcharge #2, are added:

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

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

Alberta Health expands pharmaceutical services covered by the Compensation Plan for Pharmacy Services (please refer to Ministerial Order #23/2014 — Pharmacy Compensation for details). (Report version: July 2014)

Effective October 1, 2015: The Retina Anti-Vascular Endothelial Growth Factor Program for Intraocular Disease (RAPID) is established. This is a 3-year pilot program in partnership with the Retinal Society of Alberta. (Report version: July 2018)

Effective April 1, 2016: The allowable upcharge for all drug products, including purchased compound prescriptions, increases from 6% to 6.5% (to a maximum of $100). (Report version: July 2016)

Effective April 1, 2017: The allowable upcharge for all drug products, including purchased compound prescriptions, increases from 6.5% to 7% (to a maximum of $100). (Report version: July 2017)

Effective July 24, 2017: Alberta Health introduces the Women's Choice Program, which provides coverage for Mifegymiso at no cost through licensed pharmacies in Alberta to allow women to exercise their choice in sexual health. Alberta is the second province to provide this coverage. (Report version: July 2018)

Effective August 1, 2017: Eylea is added to the available drugs covered by RAPID. (Report version: July 2018)

Effective May 17, 2018: A new pharmacy funding framework comes into effect. Changes include a lowered dispensing fee, limitations on reimbursement for daily and frequent dispensing, the elimination of tiered fees for Comprehensive Annual Care Plans and Standard Medication Management Assessments and a cap on the number of follow-up assessments, the introduction of a new assessment to provide continuity of care in the event of an emergency and the reduction of the fee for administering a publicly funded vaccine. (Report version: July 2018)

Effective October 1, 2018: Alberta launches the Alberta HIV PrEP Program, which provides the generic versions of tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) for HIV Pre-Exposure Prophylaxis (PrEP) medication for all eligible Albertans at high and ongoing risk of HIV infection. Medications are covered at no cost, for a maximum 100-day supply, when prescribed by a designated prescriber. (Report version: July 2019)

Effective January 15, 2019: Eligibility for the Insulin Pump Therapy Program expands to include individuals with Type 3c diabetes, enrolment for “insulin pump supplies only” is cancelled, and program clinical and eligibility criteria are updated to standardize the process of assessing program participants. (Report version: July 2020)

Effective April 1, 2019: The Holdback Policy is implemented. This is a new concept to share the risk associated with ensuring that Alberta Health meets its projected budget for Pharmacy Compensation Expenditures related to the payment of dispensing fees, upcharges and pharmacy services/public health in 2019–2020. (Report version: July 2019)

Effective November 12, 2019: Maximum Allowable Cost (MAC) pricing is expanded to include 3 additional drug categories (angiotensin-converting enzyme inhibitors, calcium channel blockers and statins). Patients currently using a product in a MAC grouping that is priced higher than the applicable MAC price are granted a transition period until December 11, 2019, to have their prescription changed to another product within the MAC grouping that is at or below the MAC price, where applicable. (Report version: July 2020)

Effective December 12, 2019: The Alberta Biosimilar Initiative, which aims to expand the use of biosimilar drugs, is implemented. As part of the initiative, adult patients who use the affected originator biologic drugs must switch to its biosimilar versions for the approved indications by July 1, 2020. Due to the COVID-19 (coronavirus) pandemic, this has been extended to January 15, 2021, to maintain coverage of the molecule under patients’ government-sponsored drug plan. (Report version: July 2020)

Effective March 1, 2020: Family members younger than age 65, including spouses and dependents, are no longer eligible for the Coverage for Seniors program. Albertans age 65 and older continue to be covered by the program. (Report version: July 2020)

Effective March 1, 2020: Copayments for eligible prescriptions under the Palliative Coverage Program are no longer required. (Report version: July 2020)

Effective March 20, 2020: A temporary 30-day supply limit on prescriptions is in place in an effort to reduce supply chain demand and prevent stockpiling. Furthermore, the copay structure for Coverage for Seniors and Non-Group Coverage programs is temporarily adjusted to a copay of 30%, to a maximum of $8 per prescription. Originally, these plans had a copay of 30%, to a maximum of $25 per prescription for up to a 100-day supply. This guidance was lifted on June 15, 2020. (Report version: July 2020)

Effective April 1, 2020: The Holdback Policy is eliminated and replaced with the Authorized Adjustment Policy. (Report version: July 2020)

Effective April 1, 2020: The Opioid Agonist Therapy (OAT) Gap Coverage Program is introduced to enhance access to opioid agonist therapy. The program provides Albertans who currently do not have supplementary health benefits coverage with no-cost coverage for 120 days of buprenorphine/naloxone or methadone. (Report version: July 2020)

Effective October 1, 2020: The fee for the Assessment for the Administration of a Publicly Funded Vaccine temporarily increased from $13 to $15. This increase will remain in place until March 31, 2022. (Report version: July 2021)

Effective August 1, 2021: Coverage for diabetes supplies — including blood glucose test strips, needles, syringes and lancets — increased for Albertans living with diabetes who are enrolled in government-sponsored health benefit plans. Albertans with Non-Group Coverage, Seniors Coverage or Palliative Coverage health benefit plans currently have up to $2,400 annual coverage for eligible diabetes supplies, depending on their method of diabetes management. Albertans with government-sponsored, low-income health benefit plans currently have coverage for up to 3,000 blood glucose test strips depending on their method of diabetes management. (Report version: March 2023)

Effective November 15, 2021: Sublocade (buprenorphine extended release) was included as an eligible benefit under the Opioid Agonist Therapy (OAT) Gap Coverage Program, in addition to methadone and buprenorphine/naloxone. (Report version: March 2023)

Effective February 2, 2022: The Government of Alberta introduced restricted benefit coverage for continuous glucose monitors (CGMs) for eligible Albertans younger than age 18 who are enrolled under government-sponsored supplementary health benefit plans. (Report version: March 2023)

Saskatchewan

Effective December 1, 2005: The maximum dispensing fee increases from $7.97 to $8.21. (Report version: September 2006)

Effective October 1, 2006: The maximum dispensing fee increases from $8.21 to $8.46.

Effective July 1, 2007:

- The new Seniors' Drug Plan for residents age 65 and older is introduced. Seniors pay no more than $15 per prescription for drugs listed under the Saskatchewan formulary. (Report version: July 2007)
- The Workers' Health Benefits Program designed to help lower-income workers access health services is implemented. (Report version: January 2008)
- The Saskatchewan Children's Insulin Pump Program is implemented. (Report version: January 2008)

Effective October 1, 2007: The maximum dispensing fee increases from $8.46 to $8.63. (Report version: July 2008)

Effective March 19, 2008: The Saskatchewan Workers' Health Benefits Program is 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. (Report version: July 2008)

Effective July 1, 2008:

- An income test component is introduced to the Seniors' Drug Plan. Saskatchewan residents who are age 65 and older with a reported income (line 236) that is less than the limit for the federal age credit ($64,044 for 2006 or $65,450 for 2007) will be eligible. Eligible seniors pay no more than $15 per prescription for drugs listed in the Saskatchewan formulary and for those approved under Exception Drug Status (Maximum Allowable Cost [MAC] and LCA policies apply).
- The Children's Drug Plan is available to all Saskatchewan children age 14 and younger. The Children's Drug Plan will ensure that families pay a maximum of $15 for drugs listed on the Saskatchewan formulary and for those approved under Exception Drug Status (MAC and LCA policies apply).

(Report version: July 2008)

Effective August 1, 2009: The maximum dispensing fee increases from $8.63 to $9.15. (Report version: July 2010)

Effective January 15, 2010: The Drug Plan and Extended Benefits Branch (DPEBB) will pay pharmacies 1 medication assessment fee to a maximum of $60 per year per person and 1 compliance packaging fee to a maximum of $6.25 for a 7-day supply of medication(s) dispensed in compliance packaging under the Medication Assessment and Compliance Packaging Program. Both fees will be paid for services provided to eligible community-based clients who require medication management as assessed by home care services. (Report version: July 2016)

Effective August 1, 2010: The maximum dispensing fee increases from $9.15 to $9.43. (Report version: January 2011)

Effective October 1, 2010: The list of eligible clients under the Medication Assessment and Compliance Packaging Program expands to include eligible community-based clients who require medication management as assessed by health region outpatient mental health programs. (Report version: July 2016)

Effective March 4, 2011:

The DPEBB will pay the following amounts in Patient Assessment Fees (PAFs) to community pharmacies:

- $6 for continuing existing prescriptions
  - When the patient requires interim supplies because the remaining supplies will not be sufficient until the date of their next appointment with a practitioner
  - Maximum of 4 claims in a 28-day period per patient

OR

- $6 for continuing existing prescriptions
  - When the patient is unable to access their supplies due to distance or other reasons
  - Maximum of 4 claims in a 28-day period per patient

OR

- $6 for increasing the suitability of a drug
  - Where the pharmacist may alter the dosage form if it will be more beneficial for the patient
  - Maximum of 4 claims in a 28-day period per patient
- $6 for altering insufficient information
  - Where the pharmacist may alter missing information in order to dispense the drug
  - Maximum of 1 claim in a 28-day period per patient
- $10 for continuing existing prescriptions
  - When the patient is in an emergency situation and requires supplies until they can consult a practitioner
  - Maximum of 1 claim in a 28-day period per patient
- $25 for performing drug reconciliation
  - Where the pharmacist may prescribe a drug to a patient who was recently discharged if the patient has not obtained a continuing prescription while in a hospital, licensed special care home or personal care home. The pharmacist may prescribe a drug if the patient has been admitted to a hospital, licensed special care home or personal care home and the pharmacist determines that the patient should receive the drug.
  - Maximum of 1 claim in a 28-day period per patient

(Report version: July 2011)

Effective April 1, 2011:

Changes to generic drug pricing and pharmacy reimbursement are as follows:

Phase 1: Effective April 1, 2011

- The first group of Standing Offer Contract (SOC) products expires.
- Products in these former SOC categories will transition to 35% of the brand-name price.
- The price requirement for first-entry generic drug submissions received after April 1, 2011, will be 40% of the brand-name price.

Phase 2: Effective May 1, 2011

- A select group (priority listing) of existing generic drugs will be listed at 45% of the brand-name price.
- The maximum dispensing fee will increase to $9.85.

Phase 3: Effective June 1, 2011

- The price requirement for the remainder of existing generic drugs will be 45% of the brand-name price.
- Changes to the wholesale markup and cap will be implemented.

Phase 4: Effective October 1, 2011

- Products in the second group of SOCs will expire.
- As SOC inventory is depleted in these categories, the price requirement will immediately transition to 35% of the brand-name price.

Phase 5: Effective April 1, 2012

- The price requirement for all existing generic drugs will be 35% of the brand-name price.
- The price requirement for first-entry generic submissions received after April 1, 2012, will be 35% of the brand-name price.
- The maximum dispensing fee will increase to $10.25.

(Report version: July 2011)

Effective May 1, 2011: The maximum dispensing fee increases from $9.43 to $9.85.
(Report version: July 2011)

Effective June 1, 2011:

The following wholesale markups are in effect:

- Insulins: 5%
- SOC products: 6%
- Generic drugs: 6%
- Most other drugs: 8.5%

(Report version: July 2012)

Effective February 1, 2012: The DPEBB will pay community pharmacies up to $18 for a PAF where an assessment results in a pharmacist prescribing an eligible prescription medication according to the medSask guidelines for an approved minor ailment condition. The approved minor ailment conditions are cold sores, minor acne and insect bites. (Report version: July 2016)

Effective March 21, 2012: The maximum copay for the Seniors' Drug Plan and the Children's Drug Plan increases from $15 to $20. (Report version: July 2012)

Effective April 1, 2012: The maximum dispensing fee increases from $9.85 to $10.25. (Report version: July 2012)

Effective May 23, 2012: The approved minor ailment conditions expand to include allergic rhinitis, diaper dermatitis, oral aphthous ulcer and oral thrush. (Report version: July 2016)

Effective May 1, 2013: The maximum dispensing fee increases from $10.25 to $10.75. (Report version: July 2013)

Effective July 8, 2013: The DPEBB will pay pharmacies 1 annual medication assessment fee of $60 per year per person and up to 2 follow-up PAFs of $20 per year per person (maximum $40 per year) under the Saskatchewan Medication Assessment Program (SMAP) for eligible seniors (age 65 and older) who are community-based, are living in their own residence and meet other program criteria. The DPEBB will pay pharmacies 1 compliance packaging fee to a maximum of $6.25 for a 7-day supply of medication(s) dispensed in compliance packaging for an eligible senior if, in the course of conducting the annual medication assessment or a follow-up patient assessment, it is determined that the individual may benefit from receiving assistance with medications by use of an adherence aid. (Report version: July 2016)

Effective October 1, 2013: The DPEBB will remunerate pharmacists to provide tobacco cessation support and services, as well as follow-up sessions, under the Partnership to Assist With Cessation of Tobacco (PACT) program. The plan will pay pharmacies $2 per minute to a maximum of $300 per patient per year (365 days) (or $1 per minute for silver-/gold-level group sessions to a maximum of $150 per patient per year). The number of claim submissions and the total amount reimbursed for each level of service under PACT remains unchanged. (Report version: July 2016)

Effective April 1, 2014: The maximum dispensing fee increases from $10.75 to $11.25. (Report version: July 2014)

Effective April 1, 2014: The CeRx (Pan-Canadian Electronic Drug Messaging) integration supplement fee increases to $0.20 for integrated pharmacies until March 31, 2015. (Report version: July 2014)

Effective April 1, 2014: The list of seniors eligible for an annual medication assessment and follow-up patient assessments under the SMAP expands to include eligible individuals living in personal care homes, approved private service homes and group homes. Compliance packaging for this group of patients is not part of this expansion. (Report version: July 2016)

Effective May 1, 2014: The approved minor ailment conditions expand to include atopic dermatitis, dysmenorrhea, Gastroesophageal Reflux Disease (GERD), headache, hemorrhoids, musculoskeletal strains and sprains, superficial bacterial skin infections and tinea skin infections (tinea corporis, tinea cruris, tinea pedis). (Report version: July 2016)

Effective August 1, 2014: The wholesale markup allowed on generic drugs increases from 6% to 6.5%. (Report version: July 2015)

Effective July 1, 2015: The individual income threshold that determines eligibility for the Seniors' Drug Plan changes from the federal age credit to the provincial age credit. To be eligible, a senior's individual net income (line 236 of the 2013 income tax form) must be $65,515 or less. (Report version: July 2016)

Effective September 1, 2015: The maximum dispensing fee increases from $11.25 to $11.40. (Report version: July 2016)

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

Effective September 1, 2015: The list of eligible clients under the Medication Assessment and Compliance Packaging Program expands to include clients who require medication management and are living in an approved Community Living Services Delivery (CLSD) group home or living in a CLSD-approved private service home. Referral to the program for these clients must be made by a pharmacist. The home care and mental health criteria and referral process remain the same. (Report version: July 2016)

Effective September 1, 2015: Compliance Packaging Services through the SMAP expand to include clients living in a CLSD-approved group home, a CLSD-approved private service home or a licensed personal care home with 11 beds or less. All other criteria for the SMAP annual medication assessment and follow-up patient assessments remain the same. (Report version: July 2016)

Effective October 15, 2015: The approved quantities for blood glucose test strips change. For eligible Saskatchewan Health beneficiaries, this may affect how the test strips are covered or how much the beneficiary will pay, according to the deductible and/or copayment. The new approved quantities for test strips are aligned with Canadian Diabetes Association guidelines. (Report version: July 2016)

Effective October 19, 2015: The DPEBB will pay an influenza immunization fee of $13 to pharmacies, commencing on the official start date of the Saskatchewan Ministry of Health's annual Seasonal Influenza Program, when the publicly funded influenza vaccine is administered under Influenza Immunization Program criteria. (Report version: July 2016)

Effective January 1, 2016: A net income of $66,100 or less in 2014 is required for eligibility under the Seniors' Drug Plan for the 2016 calendar year. (Report version: July 2017)

Effective June 1, 2016: The copayment per prescription for the Seniors' Drug Plan and the Children's Drug Plan increased from $20 to $25. (Report version: July 2017)

Effective January 1, 2017: The CeRx integration supplement of $0.10 per prescription for integrated pharmacies is eliminated. (Report version: July 2017)

Effective September 1, 2017: The Direct Observed Therapy Program policy is updated to include additional drugs listed on the Saskatchewan formulary for hepatitis C treatment. (Report version: July 2018)

Effective September 5, 2017: Mifepristone/misoprostol (Mifegymiso) is added to the Saskatchewan formulary. The cost of a prescription is subject to an individual's usual deductible and/or copayment. (Report version: July 2018)

Effective July 1, 2018: The Saskatchewan Rental Housing Supplement (SRHS) — previously 1 of 3 methods used to determine eligibility for the Family Health Benefits drug plan — suspends intake of new applications. Current SRHS clients will continue to receive benefits as long as they remain eligible, but applications received on or after July 1, 2018, are not accepted. (Report version: July 2018)

Effective November 1, 2018: Prescription dispensing fees increase from $11.40 to $11.60. (Report version: July 2019)

Effective March 18, 2020: A temporary restriction on the number and quantity of prescription drug dispenses is in place in an effort to prevent stockpiling. The restriction includes, but is not limited to, a 1-month supply (to a maximum of a 35-day supply) in a 28-day period for all drugs not on the Maintenance Drug Schedule. This restriction was lifted on May 20, 2020. (Report version: July 2020)

Effective March 1, 2021: The maximum dispensing fee increased from $11.60 to $11.85. (Report version: July 2021)

Effective March 1, 2021: The maximum charge for refusal to dispense and seamless care increased from $17.40 to $17.78. This will be effective until February 28, 2022. (Report version: July 2021)

Effective June 1, 2021: The Insulin Pump Program was expanded to include type 1 diabetes patients of all ages (previously included only those age 25 and younger) who meet the associated medical criteria. (Report version: March 2023)

Manitoba

Effective April 1, 2006: Pharmacare deductible rates increase, from between 2.44% and 5.25%, to between 2.56% and 5.51%. (Report version: September 2006)

Effective February 2, 2007: The Deductible Instalment Payment Program for Pharmacare is a financing program that provides eligible Pharmacare beneficiaries with high monthly prescription drug costs (relative to their average monthly income) the opportunity to pay the annual deductible in monthly instalments. (Report version: July 2008)

Effective April 1, 2008: Pharmacare deductible rates increase, from between 2.56% and 5.51%, to between 2.69% and 5.79%. (Report version: July 2008)

Effective April 1, 2009: Manitoba's Pharmacare deductible rate structure changes to include more income brackets, allowing for a more gradual increase in deductibles. (Report version: July 2009)

Effective January 1, 2011: The deductible rate increases from between 2.71% and 6.12% for 2010–2011 to between 2.73% and 6.17% for 2011–2012. (Report version: July 2011)

Effective April 12, 2012: The deductible rate increases from between 2.73% and 6.17% for 2011–2012 to between 2.81% and 6.36% for 2012–2013. (Report version: July 2012)

Effective April 12, 2012: The Pediatric Insulin Pump Program launches. (Report version: July 2014)

Effective April 19, 2012: Manitoba Health announces the Home Cancer Drug Program for Manitobans who are diagnosed with cancer. The program allows these patients to access eligible outpatient oral cancer and specific supportive drugs at no cost. (Report version: July 2013)

Effective April 1, 2013: The deductible rate increases from between 2.81% and 6.36% for 2012–2013 to between 2.85% and 6.46% for 2013–2014. (Report version: July 2013)

Effective April 1, 2014: The deductible rate increases from between 2.85% and 6.46% for 2013–2014 to between 2.91% and 6.60% for 2014–2015. (Report version: July 2014)

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

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

Effective April 1, 2017: The deductible rate increases from between 3.01% and 6.81% for 2016–2017 to between 3.05% and 6.90% for 2017–2018. (Report version: July 2017)

Effective June 15, 2017: Changes are made to Pharmacare and Employment and Income Assistance coverage for blood glucose test strips to more closely align with testing frequency guidelines endorsed by Diabetes Canada. (Report version: July 2018)

Effective August 18, 2017: Manitoba introduces a cap on dispensing fees. Pharmacies are able to charge provincial drug programs a professional fee of no more than $30 per prescription, or up to $60 if the specified drug is a sterile compound, regardless of the base cost of a drug or how a drug is packaged. (Report version: July 2018)

Effective October 1, 2017: Many Part 3 drugs no longer require Exception Drug Status renewal for coverage under Manitoba’s provincial drug programs and the Employment and Income Assistance Drug Program. (Report version: July 2018)

Effective April 1, 2018: The deductible rate increases from between 3.05% and 6.90% for 2017–2018 to between 3.09% and 6.98% for 2018–2019. (Report version: July 2018)

Effective April 1, 2019: The deductible rate increases from between 3.09% and 6.98% for 2018–2019 to between 3.17% and 7.15% for 2019–2020. (Report version: July 2019)

Effective May 31, 2019: The Pharmaceutical Distribution Rate (the supplemental cost added by wholesale distributors to the published list price) increases for all generic products from 0% to 5%. (Report version: July 2020)

Effective March 19, 2020: A temporary 1-month supply limit on prescription drugs is in place in an effort to prevent stockpiling. This restriction was lifted on May 11, 2020. (Report version: July 2020)

Effective September 14, 2021: Insulin pump coverage was expanded to include type 1 diabetes patients up to age 26 who meet the associated medical criteria. (Report version: March 2023)

Effective December 1, 2021: Pharmacists who have completed an approved training program may prescribe a drug for use in the treatment of uncomplicated cystitis. Pharmacists can claim a $20 professional fee for this prescribing service. (Report version: March 2023)

Ontario

Effective September 27, 2005: Limited-use prescription forms are no longer required from the physician. (Report version: July 2009)

Effective October 1, 2006: The maximum dispensing fee increases from $6.54 to $7. (Report version: July 2007)

Effective October 23, 2006:

- The Ontario Public Drug Programs may enter into listing agreements with manufacturers.
- The price of a generic product must be no more than 50% of the price of the corresponding brand-name product.

(Report version: July 2009)

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. (Report version: July 2009)

Effective April 1, 2007: The markup paid on eligible Ontario Drug Benefit (ODB) claims is reduced from 10% to 8%. (Report version: July 2007)

Effective April 2007: A professional allowance is introduced for MedsCheck, a medication review program. Residents of Ontario with 3 or more chronic conditions are eligible to receive annual MedsCheck reviews. Follow-up MedsCheck reviews are introduced in November 2007. (Report version: July 2009)

Effective May 16, 2008: For limited-use prescriptions, reason for use codes can be handwritten on the prescription or provided electronically or verbally by the physician. (Report version: July 2009)

Effective August 1, 2008: Changes are made to the conditions for payment of the professional/dispensing fee. The dispensing fee shall be set at a maximum of 2 fees per medication per patient per month; there are exceptions for patients in long-term care homes and/or drugs on the exemption medication list. (Report version: July 2009)

Effective November 27, 2008: The Exceptional Access Program introduces a telephone request service for selected drugs. (Report version: July 2009)

Effective July 1, 2010:

- The price of multiple-source drugs must be no more than 25% of the price of the original brand-name product. This percentage has decreased from 50%.
- Higher dispensing fees for pharmacies and tiered dispensing fees for rural pharmacies are introduced.

(Report version: July 2011)

Effective September 2010: The MedsCheck program expands to incorporate residents of licensed long-term care homes, all people in Ontario who are living with diabetes, and those who are homebound and not able to attend their community pharmacy for the service. (Report version: July 2011)

Effective April 1, 2011: Dispensing fees for non-rural pharmacies increase from $7 to $8.20; fees for rural pharmacies now range from $9.20 to $12.30. (Report version: July 2011)

Effective April 1, 2011: The Pharmaceutical Opinion Program is introduced with a fee for pharmacists of $15 per clinical intervention done in collaboration with a prescriber to identify a potential drug-related problem at the time of dispensing a new/repeat prescription or when conducting a MedsCheck. (Report version: July 2016)

Effective September 1, 2011: A pharmacy smoking cessation program is implemented for eligible program recipients who want to quit smoking. (Report version: July 2012)

Effective April 1, 2012: Dispensing fees for non-rural pharmacies increase from $8.20 to $8.40; fees for rural pharmacies now range from $9.45 to $12.61. (Report version: July 2012)

Effective April 1, 2012: Interchangeable products that are supplied in the private market and designated as listed drug products under the *Ontario Drug Benefit Act* (ODBA) will be required to be priced at the same drug benefit price as set out under the ODBA (i.e., priced at a maximum of 25% of the original product price). (Report version: July 2012)

Effective April 1, 2013:

- Dispensing fees for non-rural pharmacies increase from $8.40 to $8.62; fees for rural pharmacies now range from $9.69 to $12.92. (Report version: July 2013)
- The transition fee payment of $0.15 per eligible ODB claim ended March 31, 2013, as scheduled. (Report version: July 2013)

Effective April 1, 2014: Dispensing fees for non-rural pharmacies increase from $8.62 to $8.83; fees for rural pharmacies now range from $9.93 to $13.25. (Report version: July 2014)

Effective October 1, 2015: All dispensing fees for claims for residents of long-term care homes are reduced by $1.26 and now range from $7.57 to $11.99. (Report version: July 2016)

Effective October 1, 2015: The markup for all ODB claims for high-cost drugs (total drug cost equal to or greater than $1,000) is reduced from 8% to 6%. For claims where the total drug cost is less than $1,000, pharmacies will continue to receive an 8% markup on the drug benefit price of the product dispensed. (Report version: July 2016)

Effective October 1, 2015: Pharmacies will be entitled to receive a maximum of 5 dispensing fees per 365-day period, beginning with the first dispensing transaction for an identified chronic-use medication on or after the changes come into effect. Pharmacists are encouraged to provide recipients with a 100-day supply of most chronic-use medications. (Report version: July 2016)

Effective October 1, 2015: Changes are made to maximize the utilization of lower-cost generics through changes to the current “no substitution” provisions. Patients are now required to try 2 or more generics (and therefore experience 2 documented adverse reactions to the 2 formulations) prior to having a brand-name product paid for by the public plan. (Report version: July 2016)

Effective August 1, 2016: There are new income eligibility requirements for the ODB Low-Income Seniors Co-Payment Program. Single seniors with an annual net income of $19,300 or less, and senior couples with a combined annual net income of $32,300 or less, pay no annual deductible and a copayment of up to $2 per prescription. (Report version: July 2017)

Effective November 1, 2016: Pharmacists must now dispense an off-formulary interchangeable generic product in the pharmacy’s inventory to ODB recipients with an Exceptional Access Program (EAP) approval from the ministry. Pharmacists will be reimbursed the cost of the generic product that is dispensed. (Report version: July 2017)

Effective July 1, 2017: Nurse practitioners may prescribe therapeutic products listed on the formulary such as diabetes testing strips and nutritional products to be reimbursed under the ODB Program. Nurse practitioners may also submit a funding application to the Ministry of Health and Long-Term Care for drug products under the EAP. (Report version: July 2018)

Effective January 1, 2018: Ontario implements a new eligibility stream (OHIP+) extending the ODB Program to cover OHIP-insured children and youth age 24 and younger. (Report version: July 2018)

Effective February 9, 2018: The Palliative Care Facilitated Access Drug Products mechanism is expanded to include certain nurse practitioners who are authorized to prescribe controlled drugs and substances. (Report version: July 2018)

Effective August 1, 2018: The 35-day supply limit for Ontario Works recipients eligible for ODB Program benefits is removed. In most cases, persons who are eligible for the ODB Program could receive up to a 100-day supply of medication, regardless of eligibility stream. (Report version: July 2018)

Effective April 1, 2019: OHIP+ coverage for individuals age 24 and younger has changed to cover only those who do not have a private plan. (Report version: July 2019)

Effective January 1, 2020: A Long-Term Care (LTC) capitation funding model is implemented for which no copayments may be charged to a resident of an LTC home for dispensing an eligible ODB drug product or listed substance. Furthermore, the payment model for professional pharmacy services (dispensing fee and professional pharmacy services) for LTC homes changed from an existing fee-for-service model to a fee-per-bed capitation model. ODB-eligible prescription claims submitted for residents of LTC homes reflect a zero-dollar dispensing fee. (Report version: July 2020)

Effective January 1, 2020: A time-limited reconciliation adjustment is made to the amount the ministry pays to pharmacies, as follows: the ministry deducts a percentage from the sum of the dispensing fee and markup for all drug claims submitted to the ODB program between January 1, 2020, and March 31, 2023, for ODB-eligible persons, except LTC home residents. (Report version: July 2020)

Effective January 1, 2020: The value of the generic drug, as set out in the Ontario Drug Benefit Formulary, sees the removal of the 10% limit due to the changes made to Ordinary Commercial Terms. (Report version: July 2020)

Effective March 20, 2020: A temporary 30-day supply limit on prescriptions is recommended in an effort to prevent stockpiling. This was lifted on June 15, 2020. (Report version: July 2020)

Effective April 1, 2020: Regulatory amendments allow Private Label Products (PLPs) to be designated as listed drug products under the Ontario Drug Benefit Act (ODBA) and as interchangeable products under the Drug Interchangeability and Dispensing Fee Act (DIDFA). (Report version: July 2020)

Effective August 1, 2021: New income eligibility requirements for the ODB Seniors Co-Payment Program are implemented. Single seniors with an annual income of $22,200 (increased from $19,300) or less and senior couples with a combined annual income of $37,100 (increased from $32,300) or less pay no annual deductible and a copayment of up to $2 per prescription. (Report version: July 2021)

Quebec

Effective September 15, 2017: Pharmacists are required to provide patients paying for pharmaceutical services, supplies or drugs covered by the Quebec basic prescription drug insurance plan a more detailed invoice that clearly shows

- The pharmacist's professional fee;
- The amount covered by the basic prescription drug insurance plan; and
- The wholesaler's profit margin, if applicable.

Depending on the client's coverage (public plan, group insurance plan or employee benefit plan), the invoice may contain additional information. (Report version: July 2019)

Effective November 10, 2017: Free access in pharmacies to naloxone and related supplies is introduced as an antidote to opioid overdose. No prescription is needed. The pharmacist must provide instructions for the adequate and safe use of the product. (Report version: July 2019)

Effective December 15, 2017: Free access in pharmacies to abortion pills to end a pregnancy of 9 weeks or less is introduced. To obtain an abortion pill kit, a prescription is needed and must be presented to a pharmacist. (Report version: July 2019)

Effective July 1, 2019: The net family income–based premium range increases from $0–$616 to $0–$636 per person for 2019–2020. (Report version: July 2020)

Effective July 1, 2019: The monthly deductible rate increases from $19.90 to $21.75 for 2019–2020. (Report version: July 2020)

Effective July 1, 2019: Coinsurance increases from 34.9% to 37% of the prescription cost minus the deductible (where applicable) for 2019–2020. (Report version: July 2020)

Effective July 1, 2019: The maximum contribution increases from $90.58 to $93.08 per month, or from $1,087 to $1,117 per year for 2019–2020. For persons age 65 and older who receive 1% to 93% of the Guaranteed Income Supplement, the maximum contribution increases from $53.16 to $54.08 per month or from $638 to $649 per year for 2019–2020. (Report version: July 2020)

Effective July 1, 2020: The net family income–based premium range increases from $0–$636 to $0–$648 per person. (Report version: July 2020)

Effective July 1, 2020: The maximum contribution increases from $93.08 to $95.31 per month, or from $1,117 to $1,144 per year for 2019–2020. For persons age 65 and older who receive 1% to 93% of the Guaranteed Income Supplement, the maximum contribution increases from $54.08 to $54.83 per month or from $649 to $658 per year. (Report version: July 2020)

Effective January 1, 2021: The net family income–based premium range increases from $0–$648 to $0–$662 per person per year. (Report version: July 2021)

Effective January 1, 2021: The monthly deductible increases from $21.75 to $22.25 until June 30, 2021. (Report version: July 2021)

Effective January 1, 2021: Coinsurance decreases from 37% to 35% of the prescription cost minus the deductible (where applicable) in 2020–2021. (Report version: July 2021)

Effective May 27, 2021: The limited maximum for an accredited wholesaler's markup increases from $39 to $49. (Report version: July 2021)

Effective July 1, 2021: The net family income–based premium range increases from $0–$662 to $0–$710 per person per year. (Report version: March 2023)

Effective July 1, 2021: The maximum contribution increases from $95.31 to $96.74 per month, or from $1,144 to $1,161 per year. For persons age 65 and older who receive less than 94% of the Guaranteed Income Supplement, the maximum contribution increases from $54.83 to $55.08 per month or from $662 to $710 per year. (Report version: March 2023)

New Brunswick

Effective January 1, 2009: The dispensing fees increase. (Report version: July 2009)

Effective September 1, 2009: The professional fees increase. (Report version: January 2010)

Effective October 21, 2009: A new plan, Plan C (Influenza), comes into effect. (Report version: January 2010)

Effective March 31, 2010: The H1N1 program (Plan C) ends and dispensing of the provincial pandemic supply of oseltamivir (Tamiflu), under the Provincial Antiviral Stockpile guidelines, stops. (Report version: July 2010)

Effective August 24, 2010: Plan I has been added for the seasonal influenza vaccine. The New Brunswick Prescription Drug Program (NBPDP) adjudicates these claims for Public Health.

Effective November 2, 2010: Plan P has been added for Tuberculosis (TB) drugs approved by Public Health for treatment of active TB. NBPDP adjudicates these claims for Public Health.

Effective April 1, 2011:

The dispensing fee for each eligible methadone claim is as follows:

- $11.75: Effective April 1, 2011
- $10.60: Effective June 1, 2011
- $9.40: Effective September 1, 2011

(Report version: July 2011)

Effective January 1, 2012: The maximum annual copay contribution for seniors receiving the Guaranteed Income Supplement (GIS) increases from $250 to $500. (Report version: July 2012)

Effective June 1, 2012: The dispensing fee for each prescription of an interchangeable drug is $10.40. A pharmacy markup of 4% of the drug cost, to a maximum of $50, will also be paid.

The dispensing fee increases for non-interchangeable drugs (including compounded methadone oral solution and Metadol™ oral solution) and extemporaneous preparations. No markup on the drug cost will be paid to pharmacies.

The NBPDP rural pharmacy incentive will pay an additional $2 dispensing fee for each of the first 10,000 NBPDP prescriptions filled per fiscal year to qualifying pharmacies. (Report version: July 2012)

Effective June 1, 2012: All generic drug prices have been reduced to 40% of the brand-name price. (Report version: July 2012)

Effective December 1, 2012: All generic drug prices have been further reduced to 35% of the brand-name price. (Report version: July 2012)

Effective June 1, 2013:

- The dispensing fee for each prescription of an interchangeable drug, non-interchangeable drug and methadone for chronic pain is $10.50; the fee for methadone for opioid dependence is $9.50; and the fee for extemporaneous preparations (compounds) is $15.75.
- For interchangeable drugs, a markup of up to 8% of the maximum allowable price will be paid.

(Report version: July 2013)

Effective June 1, 2013: All interchangeable generic drug prices are reduced to 25% of the brand-name drug prices for solid oral dosage forms and to 35% of the brand-name drug prices for non-solid oral dosage forms. (Report version: July 2013)

Effective July 2, 2013: NBPDP will pay for 1 dispensing fee every 28 days or more for drugs in solid oral dosage form taken on a continuous basis. (Report version: July 2014)

Effective September 1, 2013: NBPDP will pay for 1 transition fee, included in the dispensing fee, for each eligible claim.

The transition fee for each eligible claim will be as follows:

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

The transition fee will not apply to drugs used for the treatment of opioid dependence, to NB PharmaCheck, to the Extra-Mural Program (Plan W), to the influenza vaccine (Plan I) and to tuberculosis drugs (Plan P). (Report version: July 2014)

Effective May 1, 2014: The New Brunswick provincial government introduces the New Brunswick Drug Plan. (Report version: July 2014)

Effective June 1, 2014:

The dispensing fees for eligible claims are as follows:

- Pharmaceutical equivalent (interchangeable): up to $11
- Non-pharmaceutical equivalent (non-interchangeable): up to $11
- Extemporaneous preparations (compounds): up to $16.50
- Methadone for chronic pain: up to $11 (no change)
- Drugs for opioid dependence (e.g., methadone, buprenorphine/naloxone): up to $9.50

Effective July 28, 2014: The New Brunswick Drugs for Rare Diseases Plan is established to provide assistance to those with certain rare diseases who face high drug costs. New Brunswick has partnered with Ontario to deliver the plan using Ontario's Drug for Rare Diseases Framework. The plan considers coverage of the following drugs:

- Aldurazyme: Used to treat Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPSI)
- Elaprase: Used to treat Hunter syndrome
- Ilaris: Used to treat cryopyrin-associated periodic syndrome (CAPS)
- Myozyme: Used to treat infantile/early and adult/late onset Pompe disease
- Zavesca: Used to treat Niemann-Pick Type C (NPC)

(Report version: July 2015)

Effective April 1, 2015: 2 new premiums and maximum copayments are implemented under the New Brunswick Drug Plan. (Report version: July 2015)

Effective July 1, 2015: The Medavie Blue Cross Seniors' Prescription Program monthly premium increased from $105 to $115 per month. (Report version: July 2015)

Effective July 7, 2017: The Medical Abortion Program is introduced to provide universal coverage for the cost of drug products used for medical abortions. (Report version: July 2018)

Effective August 1, 2019: Monthly premiums for the Medavie Blue Cross Seniors' Prescription Drug Program increased from $115 to $125. (Report version: July 2020)

Effective March 16, 2020: The New Brunswick College of Pharmacists directed community pharmacies to limit prescription quantities to a 30-day supply in an effort to prevent stockpiling. This directive was lifted on April 23, 2020. (Report version: July 2020)

Effective March 20, 2020: The New Brunswick Drug Plan charges a copayment to members only for their initial 30-day prescription fill or refill. This coverage remained in effect until June 23, 2020. (Report version: July 2020)

Effective January 1, 2021: The monthly premium for the Medavie Blue Cross Seniors' Prescription Drug Program increased from $125 to $135. (Report version: July 2021)

Effective April 21, 2021: The Biosimilars Initiative, which focuses on the expansion of the use of biosimilar drugs, was implemented. (Report version: March 2023)

Effective October 1, 2021: The maximum professional fee for prescription renewals and for assessment and prescribing for uncomplicated urinary tract infection (UTI) is $20. (Report version: March 2023)

Effective January 1, 2022: The monthly premium for the Medavie Blue Cross Seniors' Prescription Drug Program increased from $135 to $140. (Report version: March 2023)

Effective June 6, 2022: The maximum professional fee for assessment and prescribing for contraception management and assessment and prescribing for shingles (herpes zoster) by pharmacists is $20. (Report version: March 2023)

Effective October 1, 2022: The Correctional Services Program was introduced to provide drug coverage for eligible individuals in provincial correctional facilities. (Report version: March 2023)

Effective November 1, 2022: The premium and maximum copayment amounts under the New Brunswick Drug Plan were revised. (Report version: March 2023)

Nova Scotia

(Effective date unknown): A 10% markup is implemented on injectable products and ostomy supplies. (Report version: January 2006)

Effective April 1, 2004: The annual premium increases from $360 to $390 for the Seniors' Pharmacare Program for people who do not receive the GIS. The late-entry premium penalty for seniors who do not join the program when they become eligible is reduced to 5 years. The penalty was previously for as long as they were in the program. (Report version: January 2006)

Effective January 1, 2006: The Nova Scotia Diabetes Assistance Program (Plan D) is introduced. (Report version: January 2006)

Effective April 1, 2006: The premium for the Seniors' Pharmacare Program increases for people who do not receive the GIS to $400 a year. The annual maximum copayment increases to $360 (was $350). (Report version: September 2006)

Effective April 1, 2006, to March 31, 2007: The professional fee and the ingredient cost for these fees increase for all programs. For prescriptions with an ingredient cost of up to $145 (was $140), the maximum fee is $10.42 (was $10.12). For prescriptions with a drug ingredient cost of more than $145 (was $140), the maximum fee is $15.64 (was $15.18). (Report version: September 2006)

Effective April 1, 2007: The annual premium increases from $400 to $424. The annual maximum copayment increases from $360 to $382. (Report version: January 2008)

Effective August 15, 2007:

- Drug costs for prescriptions will be eligible for a 0.5% markup.
- Professional fees for compounded prescriptions (except methadone) are $15.63.

(Report version: January 2008)

Effective March 1, 2008: The Nova Scotia Family Pharmacare drug plan is introduced to help Nova Scotians with the cost of prescription drugs. The program offers protection against drug costs for families who have no drug coverage or if the cost of prescription drugs becomes a financial burden to them. The program is available to all Nova Scotians with a valid health card; there is no premium or fee to join the program. The annual out-of-pocket cost is capped at a percentage of family income. (Report version: January 2008)

Effective April 1, 2008:

- The $30 per prescription copayment maximum is eliminated under the Seniors' Pharmacare Program.
- The eligible pharmacy markup increases from 0.5% to 1%.

(Report version: July 2008)

Effective April 1, 2009:

- The eligible pharmacy markup increases from 1% to 2%. (Report version: July 2008)
- The copayment for the Seniors' Pharmacare Program (Plan S) decreases from 33% to 30%. (Report version: July 2009)

Effective April 1, 2010: Enrolment under the Diabetes Assistance Program ceases. New patients can choose to register in the Family Pharmacare Program.

Effective July 1, 2011: A cap is set on the price of generic drugs, including both generic drugs currently covered by Pharmacare and new ones, at a percentage of the equivalent brand-name drug's price.

The cap will be phased in over a 1-year period, as follows:

- July 1, 2011: 45%
- January 1, 2012: 40%
- July 1, 2012: 35%

(Report version: July 2011)

Effective July 1, 2011:

Period	Prescriptions for drugs and supplies	Pharmacare reimbursement
July 1, 2011, to July 31, 2011	Ostomy supplies	AAC or, where applicable, MAC or Special MAC plus 10.0% (to a maximum of $50 per prescription), plus a maximum Pharmacare dispensing fee of $10.73
	Injectables (except insulin)	AAC or, where applicable, MAC or Special MAC plus 10.0% (to a maximum of $50 per prescription), plus a maximum Pharmacare dispensing fee of $10.73
	Compounded extemporaneous products (except methadone and injectables)	AAC plus 2.0% (to a maximum of $50 per prescription), plus a maximum Pharmacare dispensing fee of $16.10
	All other prescriptions for drugs or supplies	AAC or, where applicable, MAC, MAC less the Pharmacare Allowance, or Special MAC, plus 2.0% (to a maximum of $50 per prescription), plus a maximum Pharmacare dispensing fee of $10.73
August 1, 2011, to August 31, 2011	Ostomy supplies	AAC plus 10.0% (to a maximum of $50 per prescription), plus a maximum Pharmacare dispensing fee of $10.73
	Injectables (except insulin)	AAC or, where applicable, Maximum Reimbursable Price (MRP) or Pharmacare Reimbursement Price (PRP), plus 10.0% (to a maximum of $50 per prescription), plus a maximum Pharmacare dispensing fee of $10.73
	Compounded extemporaneous products (except methadone and injectables)	AAC plus 2.0% (to a maximum of $50 per prescription), plus a maximum Pharmacare dispensing fee of $16.10
	All other prescriptions for drugs or supplies	AAC plus 2.0% (to a maximum of $50 per prescription) or MRP or PRP plus 6.0% (to a maximum of $50 per prescription), plus a Pharmacare dispensing fee of $10.73
September 1, 2011, to December 31, 2011	Ostomy supplies	AAC plus 10.0% (to a maximum of $50 per prescription), plus a transition fee of $0.10 and a maximum Pharmacare dispensing fee of $10.73
	Compounded extemporaneous products (except methadone and injectables)	AAC plus 2.0% (to a maximum of $50 per prescription), plus a transition fee of $0.10 and a maximum Pharmacare dispensing fee of $16.10
	All other prescriptions for drugs or supplies	MLP plus 10.5% (to a maximum of $250 per prescription) including methadone, or MRP or PRP plus 6.0% (to a maximum of $250 per prescription), plus a transition fee of $0.10 and a maximum Pharmacare dispensing fee of $10.73

Period	Prescriptions for drugs and supplies	Pharmacare reimbursement
January 1, 2012, to March 31, 2012	Ostomy supplies	AAC plus 10.0% (to a maximum of $50 per prescription), plus a transition fee of $0.25 and a maximum Pharmacare dispensing fee of $10.73
	Compounded extemporaneous products (except methadone and injectables)	AAC plus 2.0% (to a maximum of $50 per prescription), plus a transition fee of $0.25 and a maximum Pharmacare dispensing fee of $16.10
	All other prescriptions for drugs or supplies	MLP plus 10.5% (to a maximum of $250 per prescription) including methadone, or MRP or PRP plus 6.0% (to a maximum of $250 per prescription), plus a transition fee of $0.25 and a maximum Pharmacare dispensing fee of $10.73
April 1, 2012, to March 31, 2013	Ostomy supplies	AAC plus 10.0% (to a maximum of $50 per prescription), plus a transition fee of $0.75 and a maximum Pharmacare dispensing fee of $10.90
	Compounded extemporaneous products (except methadone and injectables)	AAC plus 2.0% (to a maximum of $50 per prescription), plus a transition fee of $0.75 and a maximum Pharmacare dispensing fee of $16.35
	All other prescriptions for drugs or supplies	MLP plus 10.5% (to a maximum of $250 per prescription) including methadone, or MRP or PRP plus 6.0% (to a maximum of $250 per prescription) plus a transition fee of $0.75 and a maximum Pharmacare dispensing fee of $10.90
April 1, 2013, to June 30, 2014	Ostomy supplies	AAC plus 10.0% (to a maximum of $50 per prescription), plus a transition fee of $1.05 and a maximum Pharmacare dispensing fee of $11.05
	Compounded extemporaneous products (except methadone and injectables)	AAC plus 2.0% (to a maximum of $50 per prescription), plus a transition fee of $1.05 and a maximum Pharmacare dispensing fee of $16.58
	All other prescriptions for drugs or supplies	MLP plus 10.5% (to a maximum of $250 per prescription) including methadone, or MRP or PRP plus 6.0% (to a maximum of $250 per prescription), plus a transition fee of $1.05 and a maximum Pharmacare dispensing fee of $11.05

(Report version: July 2012)

Effective September 1, 2011:

The Pharmacare programs have developed 3 new professional services:

- Basic medication review service: $52.50
- Therapeutic substitution: $26.25
- Prescription adaptation: $14

Advanced medication review has a maximum special services fee of $150.
(Report version: July 2012)

Effective February 1, 2012: The province introduces the Palliative Care Drug Program. This program will cover the full cost of drugs intended for use in end-of-life care at home and is intended for situations where additional coverage is required for home-based end-of-life care. (Report version: July 2013)

Effective April 1, 2012: Dispensing fees increase from $16.10 to $16.35 for compounded extemporaneous products (except methadone and injectables) and from $10.73 to $10.90 for other prescriptions for drugs and supplies. (Report version: July 2012)

Effective April 1, 2013: Dispensing fees increase from $16.35 to $16.58 for compounded extemporaneous products (except methadone and injectables) and from $10.90 to $11.05 for other prescription drugs and supplies. (Report version: July 2013)

Effective September 1, 2013: The Insulin Pump Program launches to help with the cost of an insulin pump and pump supplies for children/youth (younger than age 19) with type 1 diabetes. (Report version: July 2017)

Effective April 1, 2015: The dispensing fees increase to $11.65 for ostomy supplies, to $17.47 for compounded extemporaneous products (excluding methadone and injectables) and to $11.65 for all other prescriptions (including methadone). (Report version: July 2015)

Effective April 1, 2015: The Insulin Pump Program expands to help cover the cost of both insulin pumps and pump supplies for patients with type 1 diabetes who are younger than age 25. (Report version: July 2016)

Effective April 1, 2016: New income-based premium reductions and exemptions are introduced for the Seniors' Pharmacare Program. (Report version: July 2016)

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

Effective April 1, 2017: Dispensing fees increase from $11.75 to $11.85 for ostomy supplies, from $17.62 to $17.77 for compounded extemporaneous products (excluding methadone and injectables) and from $11.75 to $11.85 for all other prescriptions (including methadone). (Report version: July 2017)

Effective November 1, 2017: Mifegymiso, the medication used for medical abortion, is made available to Nova Scotia women with a valid health card for free at pharmacies if they do not have coverage through private insurance. (Report version: July 2019)

Effective February 14, 2018: The Take-Home Cancer Drug Fund is launched to help patients who face high costs for take-home cancer drugs. The program is retroactive for patients who took take-home cancer drugs after April 1, 2017. (Report version: July 2018)

Effective April 1, 2018: Dispensing fees increase from $11.85 to $11.95 for ostomy supplies, from $17.77 to $17.92 for compounded extemporaneous products (excluding methadone and injectables) and from $11.85 to $11.95 for all other prescriptions (including methadone). (Report version: July 2018)

Effective April 1, 2019: Dispensing fees increase from $11.95 to $12.10 for ostomy supplies, from $17.92 to $18.15 for compounded extemporaneous products (excluding methadone and injectables) and from $11.95 to $12.10 for all other prescriptions (including methadone). (Report version: July 2019)

Effective January 1, 2020: Pharmacies are reimbursed when a pharmacist assesses and prescribes for Nova Scotia residents for urinary tract infection, contraceptive management and herpes zoster.

Effective March 18, 2020: The Nova Scotia College of Pharmacists (NSCP) directs pharmacies to limit prescription quantities to a 30-day supply, subject to the pharmacist's discretion. The Pharmacare Programs accept 30-day claims when billed without requiring authorization from the prescriber, even if the prescription is written for a supply of more than 30 days. This directive was lifted on May 19, 2020. (Report version: July 2020)

Effective March 19, 2020: Pharmacies are reimbursed for prescription renewals prescribed by pharmacists for Nova Scotia residents.

Effective April 1, 2020: Dispensing fees increase from $18.15 to $18.37 for compounded extemporaneous products (excluding methadone and injectables) and from $12.10 to $12.25 for all other prescriptions (including methadone) and for ostomy supplies. (Report version: July 2020)

Effective April 23, 2020: For the Seniors' and Family Pharmacare programs, the government agrees to cover any additional copayment costs associated with more frequent dispensing due to the 30-day supply prescription limitation. This coverage remained in effect until June 30, 2020. (Report version: July 2020)

Effective April 23, 2020: The Department of Community Services (DCS) Pharmacare Benefits program waives the $5 copay on all prescriptions. The copay was reinstated August 1, 2020. (Report version: July 2020)

Effective April 1, 2021: Administration for publicly funded vaccines increased from $12.40 to $12.55. (Report version: July 2021)

Effective October 18, 2021: Pharmacies are reimbursed for assessment and prescribing for Lyme disease prevention ($20 per assessment). (Report version: March 2023)

Effective December 12, 2021: Pharmacies are reimbursed for anticoagulation management services ($50 per month per patient). (Report version: March 2023)

Effective January 21, 2022: Pharmacies are reimbursed for dispensing of antiviral medication for treatment of COVID-19 (dispensing fee up to maximum and an additional $3.50 per dispense). (Report version: March 2023)

Effective January 23, 2022: The administration fee for publicly funded COVID-19 vaccines temporarily increased from $16 to $18. (Report version: March 2023)

Effective February 4, 2022: The Biosimilar Initiative, which focuses on the expansion of the use of biosimilar drugs, is implemented. (Report version: March 2023)

Effective April 1, 2022: The dispensing fee increased from $18.59 to $18.81 for compounded extemporaneous products (excluding methadone and injectables) and from $12.39 to $12.54 for all other prescriptions (including methadone) and for ostomy supplies. (Report version: March 2023)

Effective April 1, 2022: The administration fee for publicly funded influenza vaccines increased from $12.55 to $12.70. (Report version: March 2023)

Effective May 9, 2022: Pharmacies are reimbursed for assessment and prescribing of medication for treatment of COVID-19 ($20 per assessment). (Report version: March 2023)

Prince Edward Island

(Effective date unknown): 3 new programs are added — the Erythropoietin Program, the High-Cost Drug Program and the Quit Smoking Program. The Multiple Sclerosis Program is incorporated into the High-Cost Drug Program. (Report version: September 2006)

Effective 2005: The age restriction on the Phenylketonuria Program is removed. (Report version: July 2009)

Effective April 1, 2006: The professional fees for the Financial Assistance, Diabetes, Sexually Transmitted Diseases (STD) and Quit Smoking programs increase from $7.25 to $7.50. (Report version: September 2006)

Effective November 1, 2007: The income range to qualify for the Family Health Benefit Drug Program is as follows: for families with 1 child younger than age 18 or younger than age 25 and in full-time attendance at a post-secondary educational institution (such as university or community college), the net annual family income must be less than $24,800, plus $3,000 for each additional child. (Report version: July 2008)

Effective November 1, 2007: The income ranges for the Family Health Benefit Drug Program (Plan F) change. Youth younger than age 25 and in full-time attendance at a post-secondary educational institution (such as university or community college) are also eligible for coverage under Plan F. (Report version: July 2008)

Effective January 1, 2008: Professional fees increase for the Financial Assistance, Diabetes, STD and Quit Smoking programs. (Report version: July 2008)

Effective April 1, 2008: The MAC list is now distributed on a monthly basis, instead of every 6 months. For cases where there is no MAC, the maximum markup portion of the calculation decreases from 13.5% to 13.0%. (Report version: July 2008)

Effective November 14, 2008: Coverage for blood glucose test strips is added to the Diabetes Control Program for people using insulin. The cost is $11 for a maximum of 100 strips every 30 days. (Report version: July 2009)

Effective April 1, 2009:

- The professional fees for the Children in Care, Diabetes (oral medications and test strips only), Financial Assistance, Quit Smoking and STD programs increase from $7.96 to $8.20 for prescription drugs, from $7.73 to $7.96 for non-prescription drugs and from $11.94 to $12.30 for extemporaneous compounds.
- The drug surcharge for the Family Health Benefit, Nursing Home and Seniors' Drug Cost Assistance programs increases to 9.5% of the defined drug cost, to a maximum of $60.
- The high-cost drug surcharge for multiple sclerosis drugs and other high-cost drugs is 7.5% of the defined drug cost, to a maximum of $150.
- The monthly capitation fee for the Nursing Home Program increases from $50.09 to $51.99.

(Report version: July 2009)

Effective September 1, 2010: The Seniors' Drug Cost Assistance Program copayment decreases from $11 to $8.25. (Report version: January 2011)

Effective July 2012: The price of generic drugs is equal to or lower than 35% of the cost of the brand-name equivalent. (Report version: July 2013)

Effective November 20, 2012: A methadone program is implemented to provide coverage for the cost of Metadol for clients who are registered through the provincial Methadone Maintenance Program. (Report version: July 2013)

Effective April 1, 2013: The maximum dispensing fee increases from $8.20 to $12. The compounding fee increases to a maximum of $18. The private nursing home capitation fee is $73.55. (Report version: July 2013)

Effective April 1, 2013: Medication reviews are reimbursed for clients who are eligible under one of the following programs: Seniors, Social Assistance, Private Nursing Homes and Diabetes. (Report version: July 2013)

Effective October 1, 2013: A Catastrophic Drug Program will be introduced to assist individuals or families with high prescription drug costs relative to their income. (Report version: July 2013)

Effective November 18, 2013: The Methadone Maintenance Program changes its name to the Opioid Replacement Therapy Program. (Report version: July 2018)

Effective December 1, 2013: Professional fees are introduced for the following pharmacy services:

- Compliance packaging: $25 per 28-day period
- Catastrophic drug program application support: $5 per individual per year
- Therapeutic substitution: 1.2 times the dispensing fee
- Refusal to fill: 1.2 times the dispensing fee
- Prescription adaptation: 1.2 times the dispensing fee

Effective December 30, 2013: Generic drug prices are reduced to 25% of the brand-name list price. (Report version: July 2015)

Effective April 1, 2014: The maximum reimbursable professional fee is $12.18, and the extemporaneous fee is $18.27. The private nursing home capitation fee is $75.02. (Report version: July 2014)

Effective July 1, 2014: The Prince Edward Island Insulin Pump Program is introduced to help offset the cost associated with insulin pump therapy for children and youth younger than 19. The program provides up to 90% coverage to assist with the cost of the pump and monthly pump supplies. The level of coverage under the plan depends on factors such as private health care coverage and income. (Report version: July 2015)

Effective July 1, 2014: Prince Edward Island Pharmacare becomes the payer of last resort for public drug programs. Residents using a public drug program who are also members of private insurance programs must bill their private insurance first and Pharmacare second. (Report version: July 2015)

Effective September 22, 2014: The influenza vaccination program is introduced, allowing pharmacists to be reimbursed for vaccines administered to children and high-risk individuals. (Report version: July 2015)

Effective April 1, 2015: The maximum reimbursable professional fee is up to $12.36 and the extemporaneous fee is $18.54. The private nursing home capitation fee is $76.52. (Report version: July 2015)

Effective October 1, 2015: The Generic Drug Program is introduced to limit out-of-pocket costs for generic prescription drugs to a maximum of $19.95. (Report version: July 2016)

Effective April 1, 2017: Suboxone (and listed generics) are added to the Opioid Replacement Therapy Program and made available in an equal manner to methadone for clients registered in this program. (Report version: July 2018)

Effective August 1, 2017: PEI Pharmacare clients enrolled in the Seniors, Diabetes, Generic or Catastrophic Drug programs and travelling outside of the province may be allowed to obtain up to 180 days of their eligible medication prior to leaving the province. (Report version: July 2018)

Effective January 1, 2019: A new Ostomy Supplies Program is introduced to provide financial assistance for those living with a permanent ostomy. Coverage ranges from 60% to 90% of eligible expenses, dependent on income. (Report version: July 2019)

Effective December 2, 2019: The Smoking Cessation Program is revised to allow eligible P.E.I. residents to receive a single continuous course (12 weeks in a row) of treatment — either Nicotine Replacement Therapy (NRT) products or smoking cessation medication. Treatment is limited to once per 12-month period and there is no cost to the client. (Report version: July 2020)

Effective March 2020: A temporary 30-day supply limit on prescriptions is in place in an effort to prevent stockpiling. Pharmacare clients pay one-third of their copay (if the medication was eligible for a 90-day supply) during the days' supply limit. This restriction was lifted on May 22, 2020. (Report version: July 2020)

Effective June 1, 2022: The Diabetes Glucose Sensor Program is introduced to assist eligible P.E.I. residents with the cost of purchasing glucose sensors at local community pharmacies. (Report version: March 2023)

Effective June 1, 2022: The Opioid Replacement Therapy program transitioned to the Substance Use Harm Reduction Program. It allows full coverage of eligible medications for the treatment of alcohol use disorder and opioid use disorder for any P.E.I. resident enrolled in the program. (Report version: March 2023)

Newfoundland and Labrador

Effective January 31, 2007: The Access Plan focuses on providing assistance to low-income individuals and families who need help paying for their prescription medications. The program is available for families with children (age 18 and younger) with annual incomes of $30,000 or less, couples (without children) with annual incomes of $21,000 or less, and single individuals with annual incomes of $19,000 or less. (Report version: July 2007)

Effective July 10, 2007: Changes are made to the prescription cost components, professional and extemporaneous preparations fees and ingredient pricing policy. (Report version: January 2008)

Effective October 31, 2007:

The Assurance Plan provides financial support to residents for eligible high drug costs, based on either 1 drug or the combined cost of many drugs.

Individuals and families will have their annual out-of-pocket drug costs capped per the following table:

Annual net income	Maximum percentage of net income to spend on drug costs
$0–$39,999	5%
$40,000–$74,999	7.5%
$75,000–$149,999	10%

For example, for a family with an income of $35,000 and annual drug costs of $6,000, the maximum contribution per year would be 5% of the family's income, which is $1,750 ($35,000 × 5%). The program will use the following calculation to determine the copayment:

($35,000 × 5%) ÷ $6,000 = 29.17%

Each time a prescription for an eligible benefit is filled, the family will pay 29.17% of the total cost of the prescription. (Report version: January 2008)

Effective January 1, 2008: The professional and extemporaneous preparations fees increase. Changes apply until March 31, 2011. (Report version: July 2008)

Effective August 1, 2010: The income ranges for the Access Plan increase. The Access Plan focuses on providing assistance to low-income individuals and families who need help paying for their prescription medications. The program is available for families with children (age 18 and younger), including single parents, with annual incomes of $42,870 or less; couples (without children) with annual incomes of $30,009 or less; and single individuals with annual incomes of $27,151 or less.

The following table gives examples of who is eligible and the degree of coverage received:

Single individuals			Couples (no children)			Families (with children) (including single parents)		
Income amount	Government pays	Client pays	Income amount	Government pays	Client pays	Income amount	Government pays	Client pays
Equal to or less than $18,577	80.0%	20.0%	**Equal to or less than $21,435**	80.0%	20.0%	**Equal to or less than $30,009**	80.0%	20.0%
$19,000	77.5%	22.5%	**$22,000**	76.7%	23.3%	**$31,000**	76.1%	23.9%
$20,000	71.7%	28.3%	**$23,000**	70.9%	29.1%	**$32,000**	72.3%	27.7%
$21,000	65.9%	34.1%	**$24,000**	65.0%	35.0%	**$33,000**	68.4%	31.6%
$22,000	60.0%	40.0%	**$25,000**	59.2%	40.8%	**$34,000**	64.5%	35.5%
$23,000	54.2%	45.8%	**$26,000**	53.4%	46.6%	**$35,000**	60.6%	39.4%
$24,000	48.4%	51.6%	**$27,000**	47.6%	52.4%	**$36,000**	56.7%	43.3%
$25,000	42.5%	57.5%	**$28,000**	41.7%	58.3%	**$37,000**	52.8%	47.2%
$26,000	36.7%	63.3%	**$29,000**	35.9%	64.1%	**$38,000**	48.9%	51.1%
$27,000	30.9%	69.1%	**$30,000**	30.1%	69.9%	**$39,000**	45.0%	55.0%
$27,151	30.0%	70.0%	**$30,009**	30.0%	70.0%	**$40,000**	41.2%	58.8%
$27,152 and higher	Not qualified	100.0%	**$30,010 and higher**	Not qualified	100.0%	**$41,000**	37.3%	62.7%
						$42,000	33.4%	66.6%
						$42,870	30.0%	70.0%
						$42,871 and higher	Not qualified	100.0%

(Report version: January 2011)

Effective April 1, 2012: The professional fee for the Foundation Plan, Access Plan and Assurance Plan increases from $7.15 to $8.25, retroactive to April 1, 2011.
(Report version: July 2012)

Effective April 16, 2012: The professional fees for the Foundation Plan, Access Plan and Assurance Plan change to

- $10.90 for drug costs between $0 and $49.99
- $21.95 for drug costs between $50 and $249.99
- $49.85 for drug costs of $250+

The professional fees for the 65Plus Plan change to

- $10.90 for drug costs between $0 and $249.99
- $39.59 for drug costs of $250+

These fees will remain in effect until March 31, 2013.

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

Seniors will pay a copayment not to exceed $6 per prescription. Pharmacies with fees of less than $6 can charge seniors the full amount of their fee.

Cognitive services

- Refusal to fill: Pharmacies may bill up to the maximum dispensing fee of up to double the base dispensing fee of $10.90.
- Medication management: Pharmacies may bill up to the maximum dispensing fee of $10.90 (the base dispensing fee).
- Medication review: The new agreement allows for payment for medication review as a cognitive service. Pharmacies may bill $52.50 (48 times per year).

(Report version: July 2012)

Effective April 16, 2012: All generic drug prices are reduced to 45% of the brand-name price. (Report version: July 2012)

Effective October 1, 2012: All generic drug prices are reduced to 40% of the brand-name price. (Report version: July 2012)

Effective April 1, 2013: The drug price for generic drugs is equal to or less than 35% of the brand-name price. (Report version: July 2013)

The professional fees for the Foundation Plan, Access Plan and Assurance Plan change to

- $11.05 for drug costs between $0 and $49.99
- $22.55 for drug costs between $50 and $249.99
- $49.55 for drug costs of $250+

The professional fees for the 65Plus Plan change to

- $11.05 for drug costs between $0 and $249.99
- $39.53 for drug costs of $250+

These fees will remain in effect until March 31, 2014.

No surcharge can be applied to the prescription cost under any NLPDP Plan (i.e., neither the NLPDP nor the client can be billed or charged a surcharge).

Seniors will pay a copayment not to exceed $6 per prescription. Pharmacies with fees of less than $6 can charge seniors the full amount of their fee.

Cognitive services

- Refusal to fill: Pharmacies may bill up to the maximum dispensing fee of up to double the base dispensing fee of $11.05.
- Medication management: Pharmacies may bill up to the maximum dispensing fee of $11.05 (the base dispensing fee).
- Medication review: The new agreement allows for payment for medication review as a cognitive service. Pharmacies may bill $52.50 (48 times per year).

(Report version: July 2013)

Effective July 1, 2013: Generic drug prices are equal to or less than 25% of the brand-name prices. (Report version: July 2014)

Effective April 1, 2014:

The professional fees for the Foundation Plan, Access Plan and Assurance Plan change to

- $11.50 for drug costs between $0 and $49.99
- $23.23 for drug costs between $50 and $249.99
- $49.77 for drug costs $250+

The professional fees for the 65Plus Plan change to

- $11.50 for drug costs between $0 and $249.99
- $39.75 for drug costs $250+

These fees will remain in effect until March 31, 2015.

Cognitive services

- Refusal to fill: Pharmacies may bill up to the maximum dispensing fee of double the base dispensing fee of $11.50.
- Medication management: Pharmacies may bill up to the maximum dispensing fee of $11.50 (the base dispensing fee).
- Medication review: The new agreement allows for payment for medication review as a cognitive service. Pharmacies may bill $52.50 for beneficiaries older than age 65 who have chronic illnesses and who are taking 3 or more medications, as well as for beneficiaries of any age who have diabetes who are taking oral hypoglycemics and/or insulin, up to 72 times per year per pharmacy. (Report version: July 2014)

Effective April 1, 2015:

The professional fees for the Foundation Plan, Access Plan and Assurance Plan change to

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

The professional fees for the 65Plus Plan change to

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

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

Cognitive services

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

(Report version: July 2015)

Effective October 5, 2015: Cognitive service is added. In line with changes in the Pharmacy Act and Regulations, pharmacists will be able to submit claims for drug products under Prescribing for Minor Ailments for NLPDP beneficiaries. No extra fee may be charged to the NLPDP outside of the drug cost and professional fee. (Report version: July 2018)

Effective July 1, 2016: The NLPDP introduced the new Blood Glucose Test Strip Policy. The number of test strips accessible per year without special authorization is limited to a maximum of 2,500 for those receiving short-acting insulin, 700 for those receiving long-acting insulin, 100 for those receiving only non-insulin diabetes medications and 50 for those receiving no insulin or other diabetes medications. (Report version: July 2017)

Effective September 1, 2018: Mifegymiso, the medication used for medical abortion, is made available at no cost to eligible individuals. (Report version: July 2019)

Effective January 28, 2019: SaferMedsNL is initiated and will run for 3 years under the de-prescribing initiative, with a focus on 3 classes of drugs: proton pump inhibitors, sedative hypnotics and opioids. (Report version: July 2019)

Effective March 19, 2020: A temporary 30-day supply limit on prescriptions is in place in an effort to prevent stockpiling, and members are charged a copayment only for their initial 30-day prescription fill or refill. The day-supply restriction was lifted on May 4, 2020. (Report version: July 2020)

Effective January 20, 2022: The fee for administration of COVID-19 vaccines was increased to $17 per service. (Report version: March 2023)

Effective May 16, 2022: Community pharmacists can order and dispense Paxlovid; order and distribute rapid test kits to patients presenting as potential candidates for Paxlovid; and complete the Paxlovid Screening and Prescribing Form to determine the appropriateness of treatment. (Report version: March 2023)

Yukon

(Effective date unknown): The deductible for the Children's Drug and Optical Program and the Chronic Disease Program may be waived or reduced, depending on income. (Report version: January 2006)

Effective January 17, 2011:

- The professional fee is $8.75.
- No surcharges can be applied to the prescription price under any Yukon plan (i.e., neither the government nor the patient can be billed or charged a surcharge).
- Cognitive services are under review.

(Report version: July 2014)

Effective October 31, 2018: Mifegymiso, the medication used for medical abortions, is made available at no cost to eligible individuals. (Report version: July 2019)

Effective May 14, 2020: Temporary changes are introduced that allow pharmacists to use their discretion to extend prescriptions up to 30 days more than once, and that limit their ability to initiate prescriptions. These changes remain in effect until 30 days after Yukon's state of emergency is lifted, or as otherwise directed by the Registrar. (Report version: July 2020)

Effective July 2021: Changes were introduced to the reimbursement structure for prescription and over-the-counter medications. For prescription products, the maximum dispensing fee is increased to $11, and pharmacies are allowed a markup of up to 17.5% calculated on top of the reimbursable drug cost, which is the lowest of either the maximum allowed drug cost or the Actual Acquisition Cost (AAC) as submitted by the pharmacy. For over-the-counter products, the maximum dispensing fee is $7.25, pharmacies are allowed a markup of up to 66% calculated on top of the reimbursable drug cost, which is the lowest of either the maximum allowed drug cost or the AAC as submitted by the pharmacy, and the allowable 14% wholesaler upcharge is removed. (Report version: March 2023)

Indigenous Services Canada

Effective September 9, 2008: There are changes to the NIHB Short-Term Dispensing Policy. Prescriptions for most chronic medications should be refilled no sooner than every 28 days. NIHB will reduce the professional fee on most chronic medications that are dispensed less than 28 days apart. (Report version: July 2010)

Effective July 15, 2012: The NIHB Short-Term Dispensing Policy expands to include anticonvulsants, antidepressants, antipsychotics, benzodiazepines and stimulant medications. When medically necessary, prescriptions can be dispensed daily and/or for periods shorter than 28 days. The NIHB will reduce the professional fee on most chronic medications that are dispensed less than 28 days apart. (Report version: July 2014)

Effective October 1, 2013: Health Canada transfers its role in the design, management and delivery of First Nations health programming in British Columbia to the new FNHA. (Report version: July 2014)

Effective June 1, 2016: The NIHB Program modified compensation for opioid addiction treatment by increasing the methadone reimbursement formula by $0.50. Suboxone and Kadian are no longer subject to the NIHB Short-Term Dispensing Policy. (Report version: July 2017)

Effective June 1, 2016: The Pharmacist Initiated Treatment Policy replaces the Pharmacist Initiated Prescribing Policy. Under this new policy, claims for pharmacist-initiated treatment that do not require prior approval are accepted by the NIHB Program. (Report version: July 2019)

Effective October 1, 2017: First Nations (those who have a status number) who are residents of British Columbia (excluding persons who receive health benefits by way of a First Nations organization pursuant to self-government agreements with Canada) are eligible for FNHA benefit coverage to receive the majority of their pharmacy benefits through B.C.'s PharmaCare Program. NIHB continues to provide claims adjudication and processing services only for a limited number of pharmacy items not available through PharmaCare. (Report version: July 2019)

Effective March 1, 2018: Coverage of unregistered infants is extended up to 18 months of age in order to allow parents time to register their infant children. (Report version: July 2018)

Effective April 9, 2018: A maximum 30-day dispensing policy for stimulants with a dose limit of 100 mg Methylphenidate Equivalents (MEQ) per day, previously 150 mg MEQ per day, is implemented. (Report version: July 2019)

Effective May 14, 2018: The eligible quantity of nicotine patches increases to 252 patches of any listed brand within a 12-month period. (Report version: July 2019)

Effective August 1, 2018: Maximum compensation for the dispensation of methadone for the treatment of opioid use disorder increases from (dispensing fee ÷ 7) plus $5.10 to $5.25. (Report version: July 2019)

Effective October 9, 2018: The quantity limit for lancets is changed to depend on a client's diabetes medications in order to better align reimbursements with those for blood glucose test strips. (Report version: July 2019)

Effective March 20, 2020: NIHB temporarily accepts claims for greater than 30 days for medications that normally fall under NIHB's 30-day dispense policy (i.e., opioids, benzodiazepines, gabapentin, pregabalin, stimulants and nabilone) per the pharmacist's professional judgment. This coverage was lifted on June 1, 2020. (Report version: July 2020)

Effective April 27, 2020: To support unregistered infants in accessing benefits during the COVID-19 pandemic, the NIHB Program provides coverage to an infant under the age of 24 months with an eligible parent. This temporary measure is in effect until further notice. (Report version: July 2020)

Effective July 6, 2020: NIHB accepts a pharmacist's recommendation for coverage of any eligible non-prescription pharmacy benefit. To be eligible for coverage, the item must be listed on the NIHB Drug Benefit List and within the pharmacist's scope of practice to recommend or prescribe. Previously, NIHB had a selected list of non-prescription items that could be recommended by a pharmacist, as outlined in the Non-Prescription Treatment Recommendation Policy. That policy and list are no longer in effect, and are replaced by the updated NIHB Prescriber Policy. (Report version: July 2021)

Effective July 17, 2020: When preparing extemporaneous mixtures for external use, if a generic of an eligible base exists at an equal or lower cost, it may be used in lieu of the listed brand-name bases in the NIHB Drug Benefit List. (Report version: July 2021)

Effective October 19, 2020: The formula to calculate the methadone dispensing fee changed from (dispensing fee ÷ 7) + $5.25 to (dispensing fee ÷ 7) + $5.35. (Report version: July 2021)

Pan-Canadian policies

Get more information regarding the status of pan-Canadian Pharmaceutical Alliance (pCPA) negotiations for brand-name drugs.

Effective April 1, 2013:

Pan-Canadian Generic Price Initiative: All provinces and territories, except Quebec, have set the prices for the following 6 generic drugs at 18% of the equivalent brand-name drug's price:

- Atorvastatin: Used to treat high cholesterol
- Ramipril: Used to treat high blood pressure and other cardiovascular conditions
- Venlafaxine: Used to treat depression and other mental health conditions
- Amlodipine: Used to treat high blood pressure and angina
- Omeprazole: Used to treat a variety of gastrointestinal conditions
- Rabeprazole: Used to treat a variety of gastrointestinal conditions

(Report version: July 2013)

Effective April 1, 2014:

The prices of the 4 generic medications below are being reduced to 18% of the equivalent brand-name drug's price:

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

(Report version: July 2014)

Effective April 1, 2014: The Pan-Canadian Tiered Pricing Framework is implemented for new generic drugs. (Report version: July 2015)

Effective April 1, 2015:

The prices of the following generic medications are being limited to 18% of the equivalent brand-name drug's price:

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

(Report version: July 2015)

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

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

(Report version: July 2016)

Effective April 1, 2017: A 1-year bridging period for the pCPA Generics Initiative will be in effect. Under the bridging arrangement, the price of the following molecules will be further reduced from 18% to 15% of the brand-name reference price:

- Atorvastatin: Used to treat high cholesterol
- Amlodipine: Used to treat high blood pressure and angina
- Simvastatin: Used to treat high cholesterol
- Pantoprazole: Used to treat a variety of gastrointestinal conditions
- Ramipril: Used to treat high blood pressure and other cardiovascular conditions
- Clopidogrel: Used to inhibit the formation of blood clots and to prevent myocardial infarction

(Report version: July 2017)

Effective April 1, 2018: Nearly 70 of the most commonly prescribed drugs in Canada are priced at either 10% or 18% of the equivalent brand-name product:

- **10% oral solid:** Amlodipine, atorvastatin, citalopram, clopidogrel, donepezil, ezetimibe, gabapentin, metformin, olanzapine, olanzapine ODT, omeprazole, pantoprazole, quetiapine, rabeprazole EC, ramipril, ranitidine, rosuvastatin, simvastatin, venlafaxine XR and zopiclone
- **18% oral solid:** Alendronate, almotriptan, amiodarone, anastrozole, atenolol, atomoxetine, azithromycin, bicalutamide, bisoprolol, candesartan, candesartan HCTZ, carvedilol, celecoxib, ciprofloxacin, clonazepam, cyclobenzaprine, domperidone, dutasteride, eletriptan, escitalopram, famciclovir, finasteride, fluoxetine, imatinib, irbesartan, irbesartan HCTZ, lamotrigine, levetiracetam, memantine, minocycline, montelukast, mycophenolate, paroxetine, pramipexole, pravastatin, pregabalin, risedronate, risperidone, sertraline, solifenacin, sumatriptan DF, telmisartan, telmisartan HCTZ, terbinafine, topiramate, valacyclovir, valsartan and valsartan HCTZ

(Report version: July 2018)

Public drug program websites

For current and more detailed information regarding specific federal, provincial or territorial drug programs, please see the following:

British Columbia PharmaCare

Alberta Prescription Drug Program

Saskatchewan Drug Plan

Manitoba Pharmacare Program

Ontario Drug Benefit Program

Quebec Public Prescription Drug Insurance Plan

New Brunswick Prescription Drug Program

Nova Scotia Pharmacare Drug Programs

Prince Edward Island Pharmacare

Newfoundland and Labrador Prescription Drug Program

Yukon Pharmacare

Indigenous Services Canada — Non-Insured Health Benefits

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