Pharmacare Programs

Pharmacists' Guide

This guide provides information on the Nova Scotia Pharmacare Programs, but it does not replace either the Health Services and Insurance Act or the Nova Scotia Seniors' Pharmacare Program Regulations.

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It's easy to CONTACT US when you have a question.

Our representatives are available Monday to Friday, 8:00 a.m. to 5:00 p.m.

Pharmacy Claims

Local Calls: 496-7001
Toll Free: 1-800-305-5026
Fax: 468-9402

Mailing: Nova Scotia Pharmacare Programs
P.O. Box 500
Halifax, NS B3J 2S1

Seniors' Pharmacare Program

Local Calls: 429-6565
Toll Free: 1-800-544-6191
Fax: 468-9402

Mailing: Nova Scotia Seniors' Pharmacare Program
P.O. Box 9322
Halifax, NS B3K 6A1

MSI Registration (Health Cards, new residents)
P.O. Box 500, Halifax NS B3J 2S1
Local Calls: 496-7008
Toll Free: 1-800-563-8880

Pharmacare Audit
P.O. Box 500, Halifax NS B3J 2S1
Local Calls: 496-7030 or 496-7511
Toll Free: 1-800-563-8880

Nova Scotia College of Pharmacists
P.O. Box 3363(S), Halifax NS B3J 3J1
Phone: 422-8528

Pharmacy Association of Nova Scotia
1470 Dresden Row, Halifax, NS B3J 3T5
Phone: 422-9583

Nova Scotia Prescription Monitoring Program
P.O. Box 2200, Halifax NS B3J 3C6
Local Cals: 496-7123
Toll Free: 1-800-667-4511

Drug Dependency Services
P.O. Box 896, Dartmouth NS B2Y 3Z6
Phone: 424-5623

Public Health
Nova Scotia Department of Health
P.O. Box 488, Halifax NS B3J 2R8
Phone: 424-8100

Drug Assistance for Cancer Patients
Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax NS B3J 2S1
Local Calls: 429-6565
Toll Free: 1-800-544-6191

Dalhousie MS Research Unit
5790 University Ave, Halifax NS B3H 1B7
Phone: 422-7817

Diabetes Assistance Program
Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax NS B3J 2S1
Local Calls: 429-6565
Toll Free: 1-800-544-6191

Under 65 - LTC Pharmacare Plan
Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax NS B3J 2S1
Local Calls: 429-6565
Toll Free: 1-800-544-6191

ADMINISTRATION

Pharmacy Registration

Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1

Local calls: 496-7001
Toll free: 1-800-305-5026
Fax: 468-9402

A participating pharmacy is a pharmacy that dispenses prescriptions to eligible beneficiaries and submits claims to the Pharmacare Programs according to the rules and regulations of the Programs.

Participating pharmacies must be licensed with the Nova Scotia College of Pharmacists.

New pharmacies and pharmacies that have changed ownership are required to complete the following forms provided by the Pharmacare office :

- Registration of Pharmacy form, providing information to establish the pharmacy as an authorized provider of pharmaceutical services under the Pharmacare Programs.
- Confirmation of Agreement form, as acceptance of the tariff agreement.
- MSI Provider Business Arrangement form, authorizing direct payment to the pharmacy's account.
- Provider Accreditation Application form, to request accreditation of the pharmacy's software package and to accept the Terms and Conditions of MSI Provider Accreditation.
- Certification of Responsibility for Electronic Claims Submission.

> *The Pharmacare office should be notified immediately regarding any changes affecting the information provided on the above forms.*

Upon registration, a new pharmacy is provided with some key information, including:

- Assigned pharmacy provider number
- Assigned business arrangement number
- Nova Scotia Formulary
- Tariff Agreement
- Maximum Allowable Cost List
- List of College of Physicians and Surgeons of Nova Scotia (CPSNS) Numbers for physicians in Nova Scotia and lists of other authorized prescribers
- Recent Pharmacists' Bulletins
- Request for Adjustment forms
- Nova Scotia Pharmacare Programs Pharmacists' Guide
- Nova Scotia Seniors' Pharmacare Program Information Booklet

Conditions of Participation

A participating pharmacy shall:

- determine that the prescription is for the use of the eligible beneficiary,
- determine to the best of their knowledge that the beneficiary is not entitled to drug benefits from the Workers' Compensation Board (WCB), Veterans Affairs Canada (VAC), First Nations and Inuit Health Services, or a private benefit plan,
- dispense all prescriptions in accordance with the directions of the prescriber, Pharmacare rules and regulations, and all applicable Pharmacy legislation,
- submit claims to the Pharmacare Programs in an approved manner (CPhA Pharmacy Claims Standard),
- bill the Pharmacare Programs according to the current tariff agreement,
- collect all applicable co-payments,
- be subject to audit, ensuring the Pharmacare Programs are being billed correctly and benefits are provided according to the rules and regulations of the Programs.

Nova Scotia Seniors' Pharmacare Program

The Nova Scotia Seniors' Pharmacare Program is a provincial drug insurance plan that helps seniors with the cost of their prescription drugs. Seniors are not obligated to join the Pharmacare Program, and not every senior is eligible to join.

The following general information applies to the Seniors' Pharmacare Program. This information is subject to change at any time. Pharmacists' Bulletins are sent when changes occur.

Benefits

The benefits for the Seniors' Pharmacare Program are indicated in the Nova Scotia Formulary with a "S" in the benefit status column.

Eligibility

The Nova Scotia Seniors' Pharmacare Program is offered to Nova Scotia residents who;

- are registered under the Medical Services Insurance (MSI) program,
- are 65 years of age or older and
- do not already have prescription drug coverage through a private benefit plan, Veterans Affairs Canada or First Nations and Inuit Health Services.

Enrollment

Pharmacare sends an information package and form approximately three months prior to the 65th birthday of an eligible resident of Nova Scotia. Seniors become eligible for Pharmacare on the first day of the month of their sixty-fifth birthday, only if Pharmacare has received the proper registration form and any required payment prior to this date.

Premium for Seniors Who Apply Late

If a senior does not apply for Pharmacare coverage within three months of the date on which they are eligible, or decides to leave Pharmacare, but then wants to join later; they will

- have to wait 90 days for coverage to begin once accepted into Pharmacare and
- have to pay one and a half times the premium for five years.

Seniors Whose Private Drug Coverage Ceases

Any senior providing proof of continuous private prescription drug coverage since becoming 65 years of age is exempt from late entry requirements.

Identification Card

All individuals registered for MSI have a personalized plastic health card. This card is also used for the Seniors' Pharmacare Program. The card can only be used by the person whose name appears on the card.

Public Service Health Care Plan (PSHCP) Members

The Public Service Health Care Plan provides primary drug coverage to their members who do not receive the Guaranteed Income Supplement (GIS). The Seniors' Pharmacare Program provides coverage to PSHCP members who receive the GIS.

Reimbursement of Co-Payments for Seniors with Private Drug Coverage (including PSHCP)

Seniors who are not eligible to join Pharmacare because they have drug coverage through a private benefit plan may be eligible to have their drug co-payments reimbursed. They can make a request for reimbursement if the amount they paid in co-payments under their private plan exceeds the amount of premium plus co-pay they would have paid if a member of Pharmacare. At the time of printing, this amount is $760 ($400 for premium plus a maximum of $360 for co-payment), but it may be less if the senior has a low income and would have qualified for a reduced premium.

Only drugs eligible under the Seniors' Pharmacare Program are included in the co-payment calculation.

Seniors who meet this requirement should contact the Pharmacare office. Their receipts, detailing co-payment amounts, must be submitted to Pharmacare. The private benefit plan continues to be the primary insurer.

Premiums

At time of printing, the premium to join the Seniors' Pharmacare Program is $400 per year. Seniors receiving the Guaranteed Income Supplement (GIS) from the federal government do not have to pay a premium for coverage.

Seniors not receiving the GIS must pay a premium for Pharmacare coverage. Some low-income seniors who do not receive the GIS may qualify for reduced premiums. Applications for premium reductions are sent to all new seniors and to those who have qualified for reduced premiums the previous year. The application forms can be obtained by calling the Pharmacare office.

Co-payment (Co-pay)

At the time of printing, seniors are responsible to pay 33% of the total cost of each prescription to a maximum of $30 per prescription. The minimum co-pay amount per prescription is $3.00, even if this is greater than 33% of the total cost of the prescription. The Pharmacare on-line adjudication system calculates the amount of co-pay to be billed for each prescription and automatically stops co-pay requirements when the senior has reached their annual co-pay maximum of $360. The regular procedure for MACs and special MACs is not affected by the co-pay cap. The difference in cost over and above the MAC value is the individual's responsibility and is not included in the $360 yearly maximum.

Pharmacies participating in the Pharmacare Programs are responsible for collecting the co-pay amount. Failure to do so will result in the suspension of the pharmacy's Pharmacare billing privileges and provider status.

The co-pay year begins April 1st and ends March 31st. Therefore, on April 1st of each year, all seniors start paying co-pay again.

Department of Community Services Pharmacare Programs

The Department of Community services provides a Pharmacare Program that is available to clients who qualify under the Income Assistance Program and the Community Supports for Adults Program. The mandate of the Community Services Pharmacare Program is to provide prescription drug coverage to eligible clients.

Benefits

The Community Services drug plan follows the Nova Scotia Formulary. Specific benefits are indicated with a "F" in the benefit status column of the Formulary.

Programs include:

Community Services Pharmacare Programs

The Department of Community Services provides drug coverage to Income Assistance clients, Community Supports for Adults clients, Extended Pharmacare clients, Transitional Pharmacare clients and children in the care of child welfare through either a District Office of the Department of Community Services or a Children's Aid Society/Family and Children's Services Agency. Eligibility is determined by the Department of Community Services.

At the time of printing, all income assistance clients and dependents are required to pay a flat fee of $5.00 per prescription unless the client or dependent is eligible for co-pay exemption.

All clients and their dependents requiring Pharmacare coverage must provide their Health Card Number (HCN).

Drug Assistance for Cancer Patients

Assistance is available through Drug Assistance for Cancer Patients to help defray the cost of approved cancer-related benefits. To be eligible the person must be a resident of Nova Scotia, have a gross family income of $15,720 or less, and not be eligible for coverage under other drug programs. Clients wishing to apply for coverage should contact Drug Assistance for Cancer Patients at the contact numbers provided at the beginning of this document. Additional information and application form can be found on the Nova Scotia Pharmacare Programs website at *www.gov.ns.ca/health/pharmacare* .

Benefits

A “C” in the benefit status column of the Nova Scotia Formulary indicates benefits available for clients on Drug Assistance for Cancer Patients. Standard benefits include chemotherapeutic agents, pain medications, antiemetic agents, and laxatives for use with chronic opioid therapy. Other agents that are directly related to a patient's cancer therapy can be considered by the Pharmacare Office upon receipt of a written request from the patient's doctor.

Restrictions

The same guidelines and restrictions of the Pharmacare Programs also apply to Drug Assistance for Cancer Patients including the maximum allowable cost (MAC) and Special MAC categories. Exception Status Drugs in the Pharmacare Programs are also restricted for cancer patients (e.g., ondansetron, benzydamine oral rinse) and require a letter from the physician for consideration. A notable exception is laxatives for use with chronic opioid therapy which are fully insured. Exception status drugs which can be considered for coverage are indicated by an asterisk (*) in Appendix III of the Nova Scotia Formulary.

Billing/Co-pay

Claims are submitted on-line using the Nova Scotia Health Card as the client's identification number. Professional fees and markups are paid according to the Pharmacare Tariff Agreement. Clients do not pay a co-pay.

Multiple Sclerosis Funding Assistance

Multiple sclerosis funding assistance is provided by the province of Nova Scotia through the Dalhousie MS Research Unit. This funding provides coverage of select high cost medications for multiple sclerosis to Nova Scotia residents who meet established disease state criteria and who do not have other drug coverage.

Private insurance co-pay coverage is available for clients who meet the disease state criteria and have been enrolled in the Dalhousie MS Research Unit program.

Diabetes Assistance Program

The Diabetes Assistance Program (NSDAP) provides funding for diabetic medications and supplies for residents who meet specific eligibility requirements. The aim of this program is to assist Nova Scotians who are not currently insured for medications and supplies used in the management of diabetes.

To be eligible the individual must be a resident of Nova Scotia who is registered under the Medical Services Insurance (MSI) program, have a medical diagnosis of diabetes, agree to family size information and an annual family income verification through Canada Revenue Agency (CRA), and not be eligible for coverage under other drug programs.

If the individual meets this criteria, they may enroll in the NSDAP by completing a registration form and forwarding it to NSDAP, Nova Scotia Pharmacare Programs. Forms can be found in the doctor's office, community pharmacies, Diabetes Centers, Nova Scotia Pharmacare Programs office, the Canadian Diabetes Association and online at our website: *www.gov.ns.ca/health/pharmacare*

Benefits

A "D" in the benefit status column of the Nova Scotia Formulary indicates benefits available for clients on the Diabetes Assistance Program.

Standard benefits include:

- insulin and analogues
- oral blood glucose lowering drugs
- blood glucose test strips, needles, syringes and lancets

Restrictions

The same guidelines and restrictions of the Pharmacare Programs also apply to Diabetes Assistance Program including the maximum allowable cost (MAC) and Special MAC categories. Exception Status Drugs in the Pharmacare Programs are also restricted for diabetes patients (e.g., insulin aspart, insulin lispro, thiazolidinediones) and require a letter from the physician for consideration.

The NSDAP does not cover blood glucose monitors, insulin pumps or pump supplies.

Billing/Co-pay

Beneficiaries will be provided a letter with a detachable card containing their enrolment details, which they will present at the pharmacy when they have prescriptions for NSDAP benefits filled. All patients who are enrolled in the program will be required to pay a part of the cost of prescriptions for medications or supplies that are covered under the program. There is an annual family deductible which begins on January 1st of each year. The deductible is calculated on the number of people in the family and the total annual family income.

Eligible prescription claims for the NSDAP clients are submitted electronically to the Pharmacare Programs through the POSv (Point of Sale-version) system of Medavie Blue Cross. As with all Pharmacare Programs, the NSDAP is subject to the Pharmacare Tariff Agreement

Each electronic claim for the NSDAP will be submitted by the pharmacy to Medavie Blue Cross and the claim will be adjudicated according to the patient's deductible and co-pay agreement. An electronic response is returned to the pharmacy. The resident pays the co-pay and deductible component to the pharmacy and Medavie Blue Cross will reimburse the pharmacy for the portion covered by the NSDAP according to the payment rules as per the Nova Scotia Pharmacare Tariff Agreement.

Under 65 - LTC Pharmacare Plan Program

The Under 65 - LTC Pharmacare Plan provides for long-term care (LTC) residents under age 65 who have no drug insurance.

To be eligible the individual must be a resident of Nova Scotia who is registered under the Medical Services Insurance (MSI) program, under age 65, a regular bed resident of a long-term care facility, and does not have access to, or coverage under, another public or private drug plan.

Benefits

Benefits for the Under 65 - LTC Pharmacare Plan follows the same benefits as the Community Services Pharmacare Program. Specific benefits are indicated with a "F" in the benefit status column of the Nova Scotia Formulary.

Restrictions

Drugs not listed as benefits in the Nova Scotia Formulary or drugs not approved for exception status coverage will not be covered. All guidelines and restrictions that apply to the Pharmacare Programs apply to the Under 65 - LTC Pharmacare Plan; for instance, maximum allowable cost (MAC), Special MAC and days supply.

Billing/Co-Pay

Prescriptions for these clients are submitted on-line to Pharmacare. The long term care facilities will notify their respective pharmacy providers when eligible individuals have been enrolled as beneficiaries in the Under 65 - LTC Pharmacare Plan. The resident identification number for the plan will be the resident's Nova Scotia Health Card Number. Beneficiaries of the Under 65 - LTC Pharmacare Plan will not be charged a premium, deductible or co-pay.

Nova Scotia Seniors' Pharmacare & Community Services Pharmacare Only

Benefits

Benefits generally include:

- Drugs requiring a prescription by law under Schedule F of the Food and Drugs Act, the Controlled Drug Substances Act or Schedule A of the Regulations to the Nova Scotia Pharmacy Act and that have been specifically included as a benefit for recipients of these Pharmacare Programs.
- Over-the-counter products that have been specifically included on the benefit list (e.g. enteric coated ASA)
- Selected diabetic supplies including insulin, needles, lancets and testing strips but not including glucose testing meters, lancet devices or alcohol swabs, insulin pump or pump supplies.
- Selected ostomy products for use by clients with ileostomy, colostomy or urostomy.
- Selected products to heal skin ulcers.

> *A complete list of benefits is available in the Nova Scotia Formulary which details the benefit status of each medication that has been reviewed.*

Pharmacists' Bulletins are also an important source of information as they provide timely information on recent changes to the benefit list. A tab page for bulletins is included in the Nova Scotia Formulary where they may be placed for easy reference.

Please note that it usually takes several months for a new drug to be reviewed by the Atlantic Expert Advisory Committee.

> *ALL benefits require a prescription and must be dispensed as a prescription by a pharmacy. The Nova Scotia Formulary provides "Prescriber Codes" which indicate the health care provider (physicians, prescribing optometrists, nurse practitioners and pharmacists) who are authorized to prescribe a specific drug product for payment under the Nova Scotia Pharmacare Programs.*

Benefit Exclusions

Exclusions include but are not limited to:

- proprietary medicines and household remedies;
- nonprescription analgesics, vitamins, mouth preparations, throat preparations, nasal preparations, laxatives, antacids and cough and cold preparations;
- artificial sweetening agents;
- dietary supplements and food products;
- soaps, cleaners and shampoos, medicated or otherwise;
- supportive or physical aids/devices, mechanical or otherwise;
- prescription accessories, convalescent aids or other non-drug items of a similar nature;
- cosmetic, health and beauty aids;
- blood derivatives (Immune Serum Globulin for prophylaxis against infectious hepatitis or measles for treatment of immune deficiency disease is available from Public Health);
- vaccines and sera (most are available from Public Health);
- smoking cessation therapies;
- anti-obesity therapies;
- erectile dysfunction therapies;
- infertility therapies;

- antihistamines;
- therapies for environmental illness; and
- drug products identified by trade names deemed to be inappropriate, confusing and/or misleading.

Prescriptions filled outside Nova Scotia

Please note that prescriptions filled by pharmacies not licensed with the Nova Scotia College of Pharmacists are not covered by the Pharmacare Programs. Clients traveling out of province are advised to take adequate supplies of medications with them and to have adequate travel insurance.

Exception Status Drugs

Certain drugs are only eligible for coverage under the Pharmacare Programs when an individual meets criteria developed by the Formulary Management Committee. A list of these drugs is included in the Formulary as Appendix III, "Criteria for Coverage of Exception Status Drugs" and are indicated by “E” in the benefit status column of the ATC Classification Sections of the Formulary. A copy of the standard request form, as well as a special form for proton pump inhibitors, B12 and cholinesterase inhibitors, are also included in the Formulary.

Requests for Coverage

To request coverage, the physician should mail or fax a completed Standard Request Form or letter to the Pharmacare office. Physicians may also contact the Pharmacare office and speak directly to a pharmacist consultant to request coverage. The physician must provide the following information as part of the request:

- client identification,
- diagnosis,
- drug requested,
- criteria met, and
- other pertinent information.

Coverage for non-benefit drugs may also be considered for coverage in exceptional circumstances following a written request from the attending physician.

Every effort is made to process requests within 7 days. Requests of a more urgent nature are done more quickly. Requests that do not meet defined criteria but warrant further review may take longer.

Notification

Clients are notified by a letter if the request is approved. Clients may bring this letter to the pharmacy to verify that coverage has been approved or the pharmacist may simply bill the claim on-line for immediate response. The physician is notified if coverage is authorized, if the request is refused because the criteria for coverage is not met, or if more information is required.

Billing

Once authorization is approved, the claim for the exception status drug is billed on-line to the Pharmacare Programs. Usual co-pay rules apply. If the client has received the drug while awaiting authorization and the request is eventually approved, the client can seek reimbursement if the receipt is forwarded to the Pharmacare Office within 3 months of the dispense date. Likewise, coverage may also be backdated to a maximum of three months to allow the pharmacy to bill any waiting claims on-line or to reimburse the client.

Use of Criteria Codes

Selected exception status drugs can be billed on-line without prior approval if criteria codes are provided during the billing process. Those exception status drugs that have been assigned criteria codes are noted in the "Criteria for Coverage of Exception Status Drugs" (Appendix III) of the Nova Scotia Formulary.

Criteria Codes Provided by Authorized Prescribers

For most of the drugs that can be billed using criteria codes, the criteria codes must be supplied directly by an authorized prescriber. By supplying a code, the prescriber is verifying that he/she is prescribing the drug for an indication approved under the Pharmacare Programs. The prescriber may provide diagnostic information on the prescription (instead of the actual code) but it must clearly indicate to the pharmacist which code should be used.

Please note: Nurse practitioners have authority to supply criteria codes for selected drugs/criteria. Please refer to the "Criteria for Coverage of Exception Status Drugs" (Appendix III) of the Nova Scotia Formulary for further information.

Any situation that falls outside the criteria identified by the codes, requires preapproval and the procedure mentioned previously under “Requests for Coverage” must be followed.

Rules for Using Codes Supplied by Authorized Prescribers

- Criteria codes or diagnostic information can only be provided by the prescriber (not the patient or the pharmacist). This information can be provided by an authorized prescriber in writing on the prescription or verbally to the pharmacist.
- If criteria code information is provided verbally to the pharmacist, the documentation on the prescription must include:
  - criteria code
  - name of doctor contacted
  - pharmacist initials (e.g., "verified code 01 with Dr. Smith/PhC initials")

  Codes added to a prescription with no notation are not acceptable and monies will be recovered upon audit.
- When a criteria code is part of a verbally received prescription, the criteria code must be documented on the hard copy.
- If diagnostic information is provided, it must be specific enough that the code is clearly identified (e.g., "patient had stroke on ASA" for ticlopidine therapy)
- If the therapy is long term (bupropion, ticlopidine) and the code has been supplied correctly on the original prescription but not on subsequent prescriptions, please reference the original prescription number on subsequent prescriptions. The original code must be easily located upon audit. Alternatively, the original prescription indicating the code can be faxed to the Pharmacare Office and permanent coverage will be set up in our system (no further codes will be necessary).

If appropriate information is not evident upon audit, monies will be recovered.

Prescriptions for Drugs Where Criteria Codes or Diagnostic Information is not Provided

If the prescriber has not provided a code or diagnostic information on the prescription, the drug is not considered a benefit and will not be paid. The pharmacist may, of course, choose to contact the prescriber regarding a code or exception status form on behalf of the client, or request payment and refer the client back to the prescriber.

Drugs where the Pharmacist May Select the Criteria Code

In selected cases, the pharmacist may provide the criteria code to permit on-line billing. By doing so, the pharmacist is verifying that the drug is being prescribed for an indication under the Pharmacare Programs.

Pharmacists may select an appropriate criteria code in the following cases only:

- proton pump inhibitor and/or clarithromycin when they are used in the standard triple therapy regimens for the eradication of H. pylori.

  These prescriptions should be apparent to the pharmacist. These codes are for prescriptions that are clearly for H. pylori eradication (e.g., PPI + clarithromycin + amoxicillin or metronidazole)
- ophthalmic fluoroquinolones (e.g., Ciloxan®, Ocuflox® ophthalmic drops) prescribed by an ophthalmologist
- spacer devices (Aerochamber®)

These prescriptions are audited to determine that the appropriate criteria were met.

Billing

To allow payment when using a criteria code, two codes are required:

1. the code 'ED' must be entered in the Intervention Code field and
2. the specific criteria code (01, 02, etc.) is entered in the Special Authorization Code field.

Please continue to refer to Pharmacists' Bulletins for updated information regarding the use of criteria codes.

Coverage of Pharmacist-Prescribed Benefits

Effective immediately, pharmacists licensed with the Nova Scotia College of Pharmacists may prescribe and submit claims to any of the Nova Scotia Pharmacare Programs for eligible benefits in the following ATC categories in the Nova Scotia Formulary:

- R07AX01 Miscellaneous Respiratory Products (AeroChambers®)
- V04CA02 Glucose (Diabetes Supplies listed in the Miscellaneous Section)
- V07AS01 Stomi Equipment (Ostomy Supplies listed in the Miscellaneous Section)

To be eligible for reimbursement:

- The pharmacist must document a prescription for each supply, specifying the number of refills. The prescription must comply with all applicable legislation.
- The pharmacist must sign the prescription as the prescriber, thereby assuming full responsibility for the prescription.
- Once a product is established for a patient, the pharmacist must prescribe a minimum of 30 days supply.
- Prescriptions must be retained by the pharmacy in compliance with all applicable legislation and must be available for Pharmacare audit. (Refer to the Audit Section for the prescription audit procedures that apply.)

Claims Submission

Prescriptions for pharmacist-prescribed supplies are to be billed to the Pharmacare Programs for real-time, electronic adjudication as follows:

- Claims must have the pharmacist prescribing number in the Prescriber field. Until individual prescribing numbers are assigned, all pharmacists will use the interim pharmacist prescriber number, **9000**. (Refer to the Billing the Pharmacare Programs Secition.)
- Claims must be submitted in accordance with the terms and conditions of the Nova Scotia Pharmacare Tariff Agreement. Reimbursement will be in accordance with the payment rules of this Agreement.

Coverage of Continued Care Prescriptions

In a May 1, 2006 Professional Memorandum, the Nova Scotia College of Pharmacists provided details of the "Continued Care Prescriptions Agreement" between the Nova Scotia College of Pharmacists and the College of Physicians and Surgeons of Nova Scotia. The agreement authorizes pharmacists to extend existing prescriptions as continued care prescriptions (CCPs) provided certain conditions are met.

Pharmacists may submit claims for CCPs to the Nova Scotia Pharmacare Programs for reimbursement provided:

- The medication being continued is **not** a benzodiazepine or a drug monitored by the Nova Scotia Prescription Monitoring Program.
- The CCP is for an eligible benefit under the applicable Pharmacare Program.
- The pharmacist prescribing the CCP is licensed with the Nova Scotia College of Pharmacists.
- The physician who prescribed the original prescription being extended is licensed with the College of Physicians and Surgeons of Nova Scotia.
- The patient has an immediate need for a prescription extension and the patient's physician is unavailable to provide refill authorization.
- The pharmacist is reasonably satisfied that the physician, if available, would provide the authorization.
- The medication to be continued is for a chronic or long-term condition.
- The patient has established a stable history with the medication (no recent changes to dosages or drug therapy).
- The prescription is being extended in the same pharmacy where it originated and the patient is under the current care of that pharmacy.
- The prescription has not previously been extended though a CCP.
- The amount of the medication provided does not exceed the previous amount prescribed or one month (30 days), whichever is lesser.
- The CCP is documented in a manner that complies with all applicable legislation. It is assigned its own prescription number and the prescription number of the prescription being extended must be noted on the CCP.
- The pharmacist signs the CCP as the prescriber, thereby assuming full responsibility for the CCP.
- CCPs are retained by the pharmacy in compliance with all applicable legislation and are available for Pharmacare audit. (Refer to the Audit Section for the prescription audit procedures that apply.)

As with any other prescription, the CCP should be documented on the patient's medication profile. The primary care physician or physician providing overall care to the patient, if different from the prescribing physician, should be notified of the CCP as soon as reasonably possible.

Claims Submission

CCPs are to be billed to the Pharmacare Programs for real-time, electronic adjudication as follows:

- Claims must include the prescription number assigned to the CCP.
- Claims must have an "N' in the New/Refill code field and an "EA" (pharmacist authorized off-hours claim) in the Intervention/Exception Code field. (Refer to the Billing the Pharmacare Programs Secition.)
- Claims must have the pharmacist prescribing number in the Prescriber field. Until individual prescribing numbers are assigned, all pharmacists will use the interim pharmacist prescriber number, **9000**. (Refer to the Billing the Pharmacare Programs Secition.)
- Claims must be submitted in accordance with the terms and conditions of the Nova Scotia Pharmacare Tariff Agreement. Reimbursement will be in accordance with the payment rules of this Agreement.

The Nova Scotia Formulary

The Nova Scotia Formulary details which drugs are benefits under the Nova Scotia Seniors' Pharmacare Program, Community Services Pharmacare Programs, and Drug Assistance for Cancer Patients. Each pharmacy is issued a copy of the Formulary. The Formulary may also be accessed through the Nova Scotia Pharmacare Programs website *www.gov.ns.ca/health/pharmacare*.

Drugs which have been deemed non-benefits are also listed in the Formulary to indicate the entire range of agents available in a therapeutic class. The benefit column is blank for these agents.

Drugs are listed according to the Anatomical Therapeutic Chemical (ATC) Classification System.

The Formulary provides the following information for each drug:

- name of each product manufactured (including dosage form and/or route and strength)
- authorized prescribers for each benefit
- whether a Maximum Allowable Cost applies
- benefit status (programs for which the product is a benefit)
- drug identification number (DIN)
- manufacturer
- interchangeability information (products grouped within a box are interchangeable with a brand name product)

Please refer to the Formulary for more information.

Benefit Review Process

All drugs considered for benefit status in Nova Scotia are subject to a standard review process and are reviewed by one of three committees, the Canadian Expert Drug Advisory Committee (CEDAC), the Atlantic Expert Advisory Committee (AEAC) or the Nova Scotia Formulary Management Committee (FMC), who make listing recommendations to the Nova Scotia Minister of Health.

All three committees are expert advisory committees composed of medical specialists, family practitioners and pharmacists who make recommendations to the Department of Health regarding the management of the Pharmacare benefit lists. Pharmacare Program administrators and individuals with expertise in drug evaluation and policy analysis act as resources to the Committee. As required, experts in specialty areas are consulted.

The benefit evaluation process typically begins when a manufacturer requests to have a product evaluated for benefits status. Guidelines for drug submissions are available to manufacturers, and can be found on the Nova Scotia Pharmacare Programs website at *www.gov.ns.ca/health/pharmacare*. Clinical studies are reviewed extensively. Coverage for new products is not available until this process is completed and the drug has been added to the benefit list.

A drug may be added as a full benefit, denied any benefit status, or added as a benefit with criteria (exception status).

The management of the Formulary is a dynamic process and as such, categories of drugs may be reviewed periodically and the benefit status of agents in a category may change.

PRICING PROCEDURES

Tariff Agreement

The Nova Scotia Department of Health negotiates with the Pharmacy Association of Nova Scotia to determine maximum professional fees, allowable mark-ups, definitions of actual acquisition cost (AAC), etc. for pharmacies participating in the Pharmacare Programs. A copy of the current tariff agreement is provided in Appendix I of this guide.

Confirmation of Agreement

The Confirmation of Agreement form must be completed when a pharmacy opens or changes ownership, as well as when the usual and customary charge to cash customers changes.

Actual Acquisition Costs (AAC)

The tariff agreement provides a definition of AAC. Please refer to Appendix I.

For drugs that are not assigned a Maximum Allowable Cost (MAC), the drug cost billed to the Pharmacare Programs shall be AAC, with no mark-up, plus the applicable professional fee. In the case of injectable products and ostomy supplies, a markup is allowed in addition to the AAC and professional fee.

Maximum Allowable Cost (MAC)

A Maximum Allowable Cost (MAC) is applied to those drugs which are benefits, have multiple suppliers and have been deemed interchangeable (e.g. brand name drugs and their generic equivalents).

For each interchangeable category, a maximum allowable cost per unit (e.g. tablet, capsule, milliliter, etc.) is determined by examining costs available from each manufacturer. The MAC is based on the lowest price available to the pharmacy, including prices available from direct ordering if the manufacturer is a direct order company.

The pharmacy may bill the Pharmacare Programs the actual acquisition cost (AAC) or MAC price for these products. In either case, the MAC price will be paid.

Pharmacists can bill the patient extra costs above the MAC price, if the patient requests a particular brand and is willing to pay the difference. This extra cost is not counted towards the senior's maximum annual co-pay.

In January and July, all MAC prices are reviewed and a new list is published. Updates may also be provided in the interim. A tab page is included in the Nova Scotia Formulary where the MAC list may be placed for easy reference.

Exemptions to a MAC are available for clients who have experienced side effects with lower cost alternatives. A request must be received from the physician detailing the reaction. Exemptions will not be considered when there is an 'ultra generic' alternative available (i.e. where the brand name company manufacturers their own identical generic).

Special MAC Categories

For certain categories of drugs, a special MAC has been assigned to drugs within that therapeutic category. Products subject to a special MAC are designated by an asterisk beside the MAC designation (MAC*) in the Nova Scotia Formulary. The special MAC products are listed in the body of the MAC List, as well as on the final pages of the list. For products that have been assigned a special MAC, pharmacies can bill the patient the portion of their acquisition cost that exceeds the special MAC price. This portion of the patient's cost is not counted towards the senior's maximum annual co-pay. The following categories have been assigned special MACs:

- **Unit-dose dosage forms** (e.g. aerosol solutions packaged as nebules)
  The special MAC is based on an equal dose of the bulk form.

- **Modified dosage forms** (e.g. orally dissolved tablets, sustained release oral dosage formulations)
  The special MAC is based on an equal dose of the regular release dosage form.

- **Categories of drugs considered similar in therapeutic effect:**
  - Nonsteroidal anti-inflammatory drugs (NSAIDs) – The special MAC is based on the maximum daily amount that Pharmacare will reimburse for any drug in that category. For example, at the time of printing, the special MAC for NSAIDs is $0.6648/day. For each NSAID, the manufacturer's maximum recommended daily dose is identified. The maximum daily amount is then divided by the number of tablets or capsules required to achieve this dose. A special MAC is assigned such that Pharmacare reimburses no more than $0.6648/day when the maximum recommended daily dose of a NSAID is dispensed. NSAIDs whose maximum daily dose costs less than $0.6648/day are assigned a regular MAC price based on interchangeable generic products. Naproxen sodium is assigned a special MAC based on naproxen.
  - Histamine-2 Receptor Antagonists (H2RAs) –The special MAC is based on a comparable dosage of ranitidine.
  - Certain benzodiazepines used as hypnotics and sedatives – At the time of printing, the special MAC for the short-acting benzodiazepines (e.g. zopiclone) is $0.0700/day. The special MAC for the intermediate-acting benzodiazepines (e.g. temazepam) is $0.0699/day. The MAC for other benzodiazepines are calculated as described for NSAIDs.

- **Group of devices indicated for the same function** (e.g. lancets, blood glucose testing strips)
  The special MAC is based on the amount that Pharmacare will reimburse for each unit of the device. A special MAC is assigned for each brand of the product and package size.

Quantitative Limits

Pharmacies shall fill claims up to 100 days supply if prescribed.

The Tariff Agreement states: "The Plan will not pay multiple fees where the pharmacist dispenses a quantity less than the quantity prescribed." Therefore, more than one professional fee cannot be charged on a prescription when the original quantity is reduced and refills are generated, (even at the patient's request) unless the prescriber is contacted and the reduced quantity plus refills are authorized. This must be clearly documented on the prescription.

However, Seniors' Pharmacare Program beneficiaries traveling outside the province for more than 100 days will be allowed to obtain two prescriptions for the same medication before leaving Nova Scotia. Neither prescription shall exceed a 90 days' supply (maximum 180 days' supply for the two prescriptions). The usual co-payment and professional fee will apply to each of the prescriptions. The Department of Community Services Pharmacare Programs are limited to a 100 days' supply.

Claims for supplies exceeding 100 days for the Seniors' Pharmacare Program and Community Services Programs will be reduced to the cost associated with the maximum days supply.

Standardization of Package Sizes

Please use the following guidelines when calculating quantities for each claim and ensure your cost per unit is correct in your system.

Form	Quantity
Aerosols	per dose
Capsules	per capsule
Creams	per gram
Enemas	per mL
Gels	per gram
Inhalers	per dose
Insulin (vials, penfills, cartridges)	per mL
Kit	per kit
Liquid injectables	per mL
Liquids	per mL

Form	Quantity
Nasal Sprays	per dose
Nebules	per mL
Ointment	per gram
Oral contraceptives	as 21 or 28
Ostomy supplies	per item (e.g. 20 pouches)
Patches	per patch
Powders	per gram
Powder injectables	per vial
Suppositories	per suppository
Tablets	per tablet

Other:

Form	Quantity
Packages of more than one Drug	per pkg (e.g. HP-Pac, Monistat 3 Dual-Pak, Didrocal)

If a product is packaged in amounts not equivalent to a whole number (e.g. 2.5mL), ***round the decimal to the next whole number and multiply by the number of units dispensed.*** *For example, Ventolin Nebules (2.5mL per nebules) should be rounded to 3mL and then multiplied by the number of nebules dispensed.*

Claim Information for On-line Adjudication

Claims to the Pharmacare Programs are transmitted in accordance with the Canadian Pharmacists Association Pharmacy Claim Standard, Version 03. Copies of the Standard can be obtained from:

The Canadian Pharmacists Association
1785 Alta Vista Drive
Ottawa, ON K1G 3Y6
Phone: (613) 523-7877
Fax: (613) 523-0445

The following are some important fields that are transmitted and adjudicated with each claim.

- Pharmacy ID: number assigned by Pharmacare,
- Client ID,
- Client Date of Birth,
- Patient first and last name,
- Gender,
- Prescription Number,
- Transaction Date,
- DIN or assigned PIN,
- Quantity,
- Days supply,
- New or Repeat Code,
- Number of refills,
- Prescriber ID,
- Drug Cost,
- Mark-up,
- Professional fee, and
- Intervention and Exception Codes, if applicable (e.g. for on-line authorization of selected agents).

Prescriber Numbers

- A physician's assigned College of Physicians and Surgeons of Nova Scotia (CPSNS) number must be used when billing the Pharmacare Program.

- Updated lists of physicians and their CPSNS numbers, as well as the billing numbers for optometrists and nurse practitioners who are authorized to prescribe, are provided to pharmacies by the Pharmacare office.

- The "dummy" physician number of 9999 is only to be used when the prescriber is a medical resident without a CPSNS number or when a temporary prescriber number has not been assigned.

- Out of province physicians should be indicated by the number 3333.

- The prescriber number 8888 is used for all dentists.

- The prescriber number 9000 is used for all pharmacists until individual prescribing numbers are assigned.

Response Codes

The following response codes below are commonly utilized by the Pharmacare Programs as per the Pharmacy Claims Standard. Please refer to Claims Standard for a listing of all CPhA response codes.

Please note that the same DIN cannot be billed for a client twice on the same day. Payment will not be provided for the second prescription, generating a reject code of A3, "Identical claim has been processed".

30 - Carrier ID error
31 - Group number error
32 - Client ID error
34 - Patient DOB error
35 - Cardholder identity error
36 - Relationship error
37 - Patient first name error
38 - Patient last name error
40 - Patient gender error
56 - DIN error
58 - Quantity error
59 - Days supply error
61 - Prescriber ID error
62 - Product selection code error
A1 - Claim too old
A3 - Identical claim has been processed
A6 - Submit manual claim
A7 - Submit manual reversal
A8 - No reversal made - original claim missing
C2 - Services provided before effective date
C4 - Coverage terminated before service
D1 - DIN not a benefit
MT - Drug/gender conflict indicated

Manual Claims

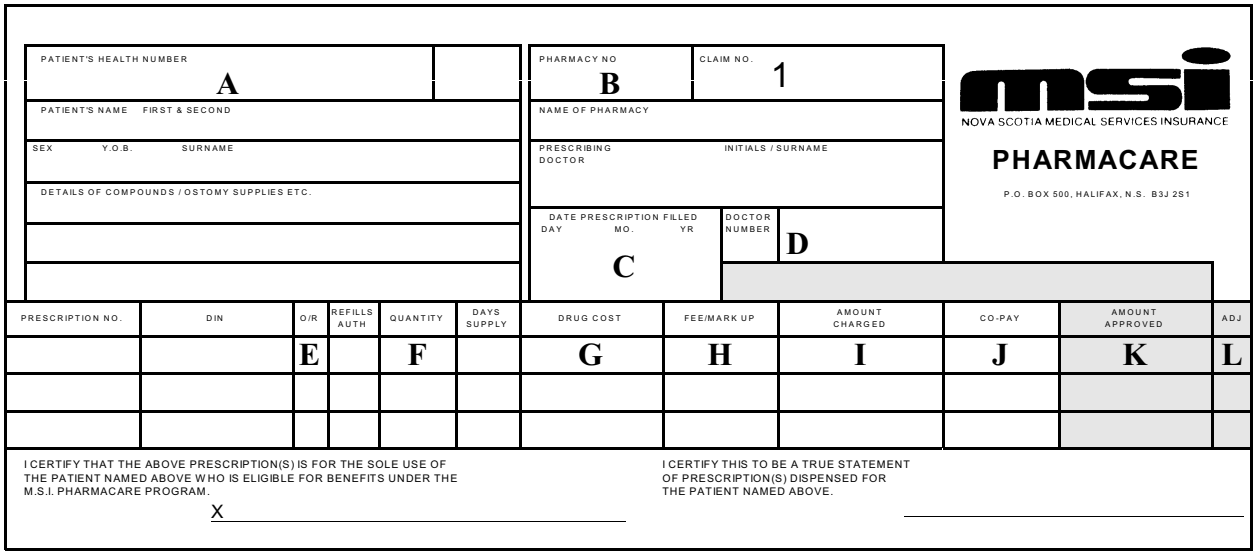
In very exceptional circumstances, or for providers who are not on-line, it may be necessary to bill the Pharmacare Programs utilizing a manual claim. Claims must be submitted within three months of the date of service.

Please note that if there is a mark-up associated with the claim, e.g. for injectable products, the total of the drug cost and the mark-up should be entered in the drug cost field.

A charge of $0.25 per claim is deducted for each manual claim. This appears as a bottom line deduction on the payment statement.

Manual Claim Form Sample

The claim form consists of two parts, the Pharmacist Copy and M.S.I. Copy. Below is the claim form with an explanation of the various fields.



PATIENT'S HEALTH NUMBER **A**

PHARMACY NO **B** CLAIM NO. 1

PATIENT'S NAME FIRST & SECOND

NAME OF PHARMACY

SEX Y.O.B. SURNAME

PRESCRIBING DOCTOR INITIALS / SURNAME

DETAILS OF COMPOUNDS / OSTOMY SUPPLIES ETC.

DATE PRESCRIPTION FILLED DAY MO. YR **C**

DOCTOR NUMBER **D**

msi NOVA SCOTIA MEDICAL SERVICES INSURANCE

PHARMACARE

P.O. BOX 500, HALIFAX, N.S. B3J 2S1

PRESCRIPTION NO.	DIN	O/R	REFILLS AUTH	QUANTITY	DAYS SUPPLY	DRUG COST	FEE/MARK UP	AMOUNT CHARGED	CO-PAY	AMOUNT APPROVED	ADJ
		E		**F**		**G**	**H**	**I**	**J**	**K**	**L**

I CERTIFY THAT THE ABOVE PRESCRIPTION(S) IS FOR THE SOLE USE OF THE PATIENT NAMED ABOVE WHO IS ELIGIBLE FOR BENEFITS UNDER THE M.S.I. PHARMACARE PROGRAM.

X _____

I CERTIFY THIS TO BE A TRUE STATEMENT OF PRESCRIPTION(S) DISPENSED FOR THE PATIENT NAMED ABOVE.

_____

- **A** - Nova Scotia Health Card Number entered as follows 5555-555-555.
- **B** - Pharmacy Number as assigned by Pharmacare Program.
- **C** - Date entered numerically e.g. 15.02.00 (15th of February 2000).
- **D** - College of Physician and Surgeons (CPSNS) number, 9999 for medical resident, 8888 for dentist.
- **E** - "O" for original prescription, "R" for refill.
- **F** - Refer to "Standardization of Package Sizes" in guide.
- **G** - Drug cost (AAC or MAC) plus any mark-ups.
- **H** - Professional fee. Do not put any mark-up in this field.
- **I** - Total cost of prescription.
- **J** - Amount of co-pay charged to client, if applicable.
- **KL** - For Pharmacare use only.

Adjustments

If a claim has been billed incorrectly on-line, the pharmacist may, within 14 days of the original claim, reverse and resubmit the claim with the correct information.

It is expected that pharmacists will check the response screen when claims are submitted to determine if the appropriate amount has been paid, instead of waiting to identify problems when the payment statement arrives.

After 14 days, reversals and adjustments must be submitted on a Request for Adjustments form (reference sample below). This form is also used for adjustments to manual claims. Adjustments to previously paid claims can be submitted up to a maximum of six months from the date of service.

Pharmacare staff will make the necessary adjustments and these will appear on the next pharmacy statement. Should there be a problem, the request for adjustment will be returned to the pharmacy with an explanation.

NS PHARMACARE PROGRAMS - REQUEST FOR ADJUSTMENTS DATE: ______________________

PHARMACY NAME: ____ NUMBER: _____________

PAYMENT STATE. DATE - ____________	REASON FOR ADJUSTMENT	PHARMACARE REPLY
CLAIM NO. - ____________	____________	____________
REFERENCE NO. - ____________	____________	____________
HEALTH CARD NO. - ____________	____________	____________
PRESCRIPTION NO. - ____________	____________	____________
DATE RX DISPENSED - ____________	____________	____________
CO-PAY CHARGED - ____________	____________	____________

PAYMENT STATE. DATE - ____________	REASON FOR ADJUSTMENT	PHARMACARE REPLY
CLAIM NO. - ____________	____________	____________
REFERENCE NO. - ____________	____________	____________
HEALTH CARD NO. - ____________	____________	____________
PRESCRIPTION NO. - ____________	____________	____________
DATE RX DISPENSED - ____________	____________	____________
CO-PAY CHARGED - ____________	____________	____________

PAYMENT STATE. DATE - ____________	REASON FOR ADJUSTMENT	PHARMACARE REPLY
CLAIM NO. - ____________	____________	____________
REFERENCE NO. - ____________	____________	____________
HEALTH CARD NO. - ____________	____________	____________
PRESCRIPTION NO. - ____________	____________	____________
DATE RX DISPENSED - ____________	____________	____________
CO-PAY CHARGED - ____________	____________	____________

PAYMENT STATE. DATE - ____________	REASON FOR ADJUSTMENT	PHARMACARE REPLY
CLAIM NO. - ____________	____________	____________
REFERENCE NO. - ____________	____________	____________
HEALTH CARD NO. - ____________	____________	____________
PRESCRIPTION NO. - ____________	____________	____________
DATE RX DISPENSED - ____________	____________	____________
CO-PAY CHARGED - ____________	____________	____________

Medications Returned to Stock

Prescriptions that were billed to the Pharmacare Programs but never provided to the client must be credited to the Pharmacare Programs. This can be done on-line or by using the Request for Adjustments form.

Unit dose medications that have been returned to the pharmacy (e.g. from nursing homes or other institutions) and can be reissued should be credited to the Pharmacare Programs by using the "Statement of Returned Medications" form (reference sample below). The quantity, description and total drug cost associated with each item must be provided. A restocking fee of 10% of the value of medications returned for reuse is allowed. A cheque for the net amount can be submitted with the form or the net amount will be deducted from a future payment statement.

msi

NOVA SCOTIA MEDICAL SERVICES INSURANCE
P.O. BOX 500, HALIFAX, N.S. B3J 2S1

STATEMENT OF RETURNED MEDICATION

PHARMACY NUMBER	DATE

PHARMACY NAME	INSTITUTION NAME
ADDRESS	ADDRESS

QUANTITY	DESCRIPTION	AMOUNT

CHECK √ ONE

☐ PAYMENT ENCLOSED FOR THE NET AMOUNT
☐ DEDUCT THE NET AMOUNT FROM PAYMENT STATEMENT

TOTAL
LESS RESTOCKING FEE
NET AMOUNT ➧

I CERTIFY THIS TO BE AN ACCURATE STATEMENT OF THE MEDICATIONS DESTROYED AND OF THE AMOUNT DUE MSI FOR RETURNED MEDICATIONS RESTOCKED TO INVENTORY	I CERTIFY THIS TO BE AN ACCURATE STATEMENT OF MEDICATIONS EITHER RETURNED TO THE PHARMACY OR DESTROYED IN MY PRESENCE
SIGNATURE OF PHARMACIST	SIGNATURE OF ADMINISTRATOR OR DESIGNEE

Payments and Statements

Payments to pharmacies are made every two weeks on a predetermined schedule and are deposited electronically into the appropriate account. The cutoff date, for claims to be included in the payment, is three days prior to payment date.

A payment statement is generated on the predetermined date and itemizes each claim paid.

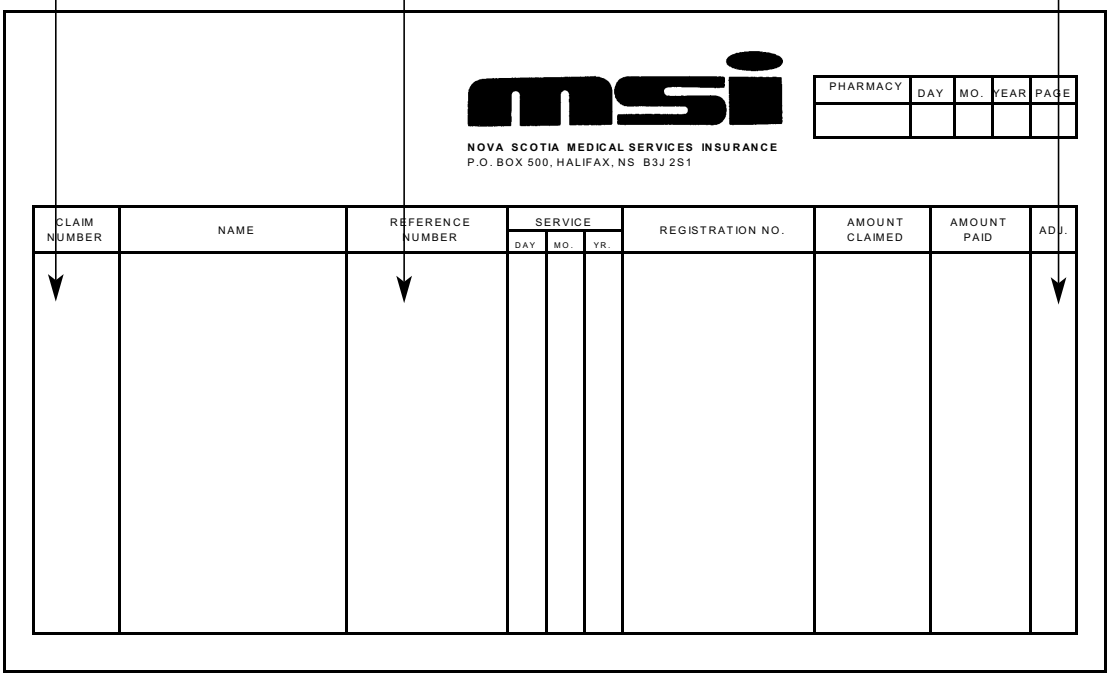
- A double asterisk beside a claim indicates that the amount paid is different than the amount claimed.
- Rejected claims are not included on the payment statement.
- Reversed claims are indicated by a zero amount claimed and a negative amount paid.
- Bottom line adjustments appear on the last page of the statement and are deducted from the total amount owed to the pharmacy. These adjustments include a $0.03 per claim deduction which is forwarded to the Pharmacy Association of Nova Scotia, and may also include any charges recovered due to an audit, medications returned to stock, and deductions of $0.25 for each manual claim submitted.

Below is a sample of the Payment Statement form:

Claim Number
Numbers are in sequence.

Reference Number
This number should be quoted when you are corresponding with MSI — the number uniquely identifies each claim.

Adjustment Codes
If the amount paid is less than the amount claimed an adjustment code will be entered. — below is a list of the codes.



ADJUSTMENT CODES

22 - Provider transaction data error
32 - Patient Identification Information error
52 - New/refill code error
56 - DIN error
58 - Quantity error
59 - Days supply error
61 - Prescriber ID error
66 - Drug cost error

A2 - Claim is post dated
A3 - Identical claim has been processed
C2 - Service provided before effective date
C4 - Coverage terminated before service
D1 - DIN not a benefit
TR - Trial Prescription error
** - Payment reduced to comply with Tariff Agreement

Pharmacare Audit

Pharmacare Audit
P.O. Box 500, Halifax, NS B3J 2S1

Local calls: 496-7030 or 496-7511
Toll free: 1-800-563-8880

The Monitoring and Statistics department performs the following types of Pharmacare audits:

- **Actual Acquisition Cost Audit**

  An actual acquisition cost audit consists of a review of a provider's suppliers' invoices to determine if the Pharmacare Programs was billed the actual cost paid by the pharmacy as per the Tariff Agreement terms.

- **Prescription Audit**

  A prescription audit is conducted to determine if the provider has on file valid prescriptions to support claims paid. Detailed information associated with the prescription audit process can be found in the "Pharmacare Prescription Audit Recovery Procedures" contained in Appendix II of this guide. The specified guidelines are applicable to all providers billing the Pharmacare Programs, including Home Health Care Suppliers, Hospitals, Long Term Care Facilities, and Dispensing Physicians.

- **Prescription Verification**

  A percentage of prescriptions audited may be verified with the prescriber(s) to ensure that the prescriptions were prescribed as claimed. For example, a diagnosis of Community Acquired Pneumonia (CAP) documented on the prescription by the pharmacist may be verified with the prescriber.

AGREEMENT

BETWEEN:

THE NOVA SCOTIA DEPARTMENT OF HEALTH
(hereinafter referred to as "Department")

- and -

THE PHARMACY ASSOCIATION OF NOVA SCOTIA
(hereinafter referred to as "PANS")

EFFECTIVE APRIL 1, 2004 to MARCH 31, 2007

1.0 Definitions

In this agreement,

(a) "Agreement" means this agreement

(b) "Actual Acquisition Cost" means the net cost to the provider after deducting all rebates, allowances, free products, etc. No mark-up or buying profit is to be included in the calculation of AAC. The net cost to the provider is defined as the drug ingredient (or supply) costs based on date of purchase and inventory flow, even though the current prices available may be lower or higher when the product is dispensed. Incentives for prompt payment (payment within 15 days up to a maximum of 2%) will not be included in the calculation of AAC.

(c) "Department" means The Nova Scotia Department of Health

(d) "PANS" means The Pharmacy Association of Nova Scotia

(e) "Pharmacist" means a person licensed to practice pharmacy pursuant to the Pharmacy Act of Nova Scotia

(f) "Pharmacy" means a pharmacy as defined in the Pharmacy Act of Nova Scotia and licensed with the Nova Scotia College of Pharmacists

(g) "Plan" means the insured prescription drug plan

(h) "Professional Services" means those services provided by a pharmacist resulting in the supplying and dispensing of a drug as prescribed in the Pharmacy Act of Nova Scotia and Regulations in effect on April 1, 2004

(i) "**Provider**" means a:

a) pharmacy that provides professional services, drugs and supplies has entered into this agreement and has been assigned a Pharmacare provider number; or
b) non-pharmacy provider of supplies that has entered into this agreement and has been assigned a Pharmacare provider number.

2.0 Tariff Levels

The Pharmacare Tariff for prescriptions is the LESSER of the usual and customary charges to cash customers of the provider

OR

(a) With respect to insured compounds, the Actual Acquisition Cost (AAC), plus a maximum professional fee of 1.5 times the fee in Section 2(f);

(b) Insulin - AAC plus the professional fee in Section 2(f);

(c) Diabetic supplies - AAC plus the professional fee in Section 2(f);

(d) Ostomy supplies - AAC plus a maximum mark up of 10% plus the professional fee in Section 2(f)(i);

(e) Injectables (exclusive of immunization programs) - AAC plus a maximum mark up of 10% plus the professional fee in Section 2(f)(i) [Effective March 31, 2007, injectables with an AAC of greater than $2,500 will be paid at AAC plus a maximum mark up of 10% to a maximum of $250 plus the professional fee in 2(f)(i)];

(f) In all other cases, the tariff will be AAC or, where applicable, the Maximum Allowable Cost (MAC), plus a maximum professional fee of:

Effective April 1, 2004 - March 31, 2005

(i) for prescriptions with a drug ingredient cost of up to $135.00, the maximum fee is $9.83;

(ii) for prescriptions with a drug ingredient cost of more than $135.00, the maximum fee is $14.74.

Effective April 1, 2005- March 31, 2006

(i) for prescriptions with a drug ingredient cost of up to $140.00, the maximum fee is $10.12;

(ii) for prescriptions with a drug ingredient cost of more than $140.00, the maximum fee is $15.18.

Effective April 1, 2006 - March 31, 2007

(i) for prescriptions with a drug ingredient cost of up to $145.00, the maximum fee is $10.42;

(ii) for prescriptions with a drug ingredient cost of more than $145.00, the maximum fee is $15.64.

The Plan will not pay a provider more than its usual and customary charges to cash customers. All providers shall file a signed Confirmation of Agreement form (Appendix A).

3.0 Actual Acquisition Cost

Actual acquisition cost of a drug product is subject to the following conditions:

- The provider shall make every effort to purchase each drug product from the supplier providing the lowest actual acquisition cost; and
- The provider shall make every effort to purchase the drug product in the size most reasonably purchased to obtain the lowest actual acquisition cost.

The Department reserves the right to reduce the ingredient cost of claims if the average cost for any drug exceeds provincial weighted average cost.

4.0 Quantitative Limits

Providers shall fill claims up to a maximum 100 days' supply, if prescribed. The Plan will not pay multiple fees where the pharmacist dispenses a quantity less than the quantity prescribed.

However, Nova Scotia Seniors' Pharmacare Program beneficiaries travelling outside the province for more than 100 days will be allowed to obtain two prescriptions for the same medication before leaving Nova Scotia. Neither prescription shall exceed a 90 days' supply (maximum 180 days' supply for the two prescriptions). The usual co-payment and professional fee will apply to each of the prescriptions. The Department of Community Services Pharmacare Programs are limited to a 100 days' supply.

5.0 Uninsured Services

Any services provided in addition to professional services as defined in Section 1(h) of this agreement are not insured under this agreement. Notwithstanding the foregoing, there may be specially authorized fees for special preparations or services as approved from time to time by the Department.

6.0 Submission of Claims

A claim submitted to the Plan for payment of insured drugs and supplies shall be honoured by the Department, only if it is received by the Plan within three months of the date upon which the drugs and supplies were supplied.

7.0 Billings to Beneficiaries

Providers shall collect all authorized co-payments. Providers shall not collect any additional amount for professional services as defined in Section 1(h) of this agreement.

8.0 Audit

Providers agree to permit the Department or its authorized agents access to company records deemed necessary by the Department to verify pricing and billings under this agreement.

9.0 Appeals

The parties agree that any reference by a provider pursuant to Section 8 of Appendix B respecting a determination made by MSI as a result of an MSI investigation shall be resolved using the agreed upon procedures detailed in Appendix B.

10.0 Term

10.1 This agreement may be terminated by either party sending a written notice of termination by registered mail addressed to the other party at that party's last known mailing address, in which case the agreement will expire on the 90th day following the date of mailing.

10.2 In the event that:

(a) the provider has its license or certificate of accreditation revoked or suspended, in which case the agreement will immediately terminate without notice.

(b) there is a change in provider ownership, the provider will notify the Department 30 days in advance of the transfer and the agreement will automatically terminate on the date of transfer of ownership. (The Department will retain this information in confidence.)

(c) the provider is found to contravene or default on the obligations under this agreement, the agreement will be immediately terminated by the Department by providing written notice.

Upon termination, the rights of the provider hereunder automatically cease and terminate. The Department agrees to pay the provider all claims then properly due and owing provided pursuant to this agreement, provided that such claims are submitted within 90 days of the date of the termination. Notwithstanding the termination of this agreement, the Department may continue to exercise its audit rights pursuant to Section 8 of this agreement.

11.0 Other

The Department agrees to deduct $0.03 per prescription from all claims and remit the amount to the PANS not less frequently than monthly.

The Department agrees to increase the per prescription rebate to PANS at a level not to exceed $0.10 per prescription, if requested in writing by PANS.

12.0 Amendment

This agreement cannot be opened and/or altered without the written consent of both parties.

This agreement is subject to ratification by the Department and approval by Governor-in-Council.

_____ _____

Witness

Jim Millar, Executive Director
Mental Health, Physician
and Pharmaceutical Services
Department of Health

_____

Date

Accepted on behalf of The Pharmacy Association of Nova Scotia subject to ratification by the Association's Executive.

_____ _____

Witness

Susan MacDonnell, Chair
Pharmacy Association of Nova Scotia
Government Relations

_____

Date

NOVA SCOTIA MEDICAL SERVICES INSURANCE
NOVA SCOTIA DEPT. OF COMMUNITY SERVICES

PHARMACARE

CONFIRMATION OF AGREEMENT

Name of Provider _____ Provider No. _____

Address _____

_____

Effective Date _____

This is to certify that the above provider accepts the terms and conditions of the tariff agreement for the Nova Scotia Pharmacare Programs, notwithstanding the provider's "Usual and Customary" charge level. This provider confirms that all claims will be submitted on the basis of drug cost of either the actual acquisition cost or at the Maximum Allowable Cost of the drug as specified for products listed on the M.A.C. list. I agree not to charge the Nova Scotia Pharmacare Programs more than the usual and customary charge to cash customers.

My usual and customer charges to cash customers are:

Regular Rx	Up to $135	_____
	Over $135	_____
Over The Counter Products		_____
Oral Contraceptives		_____
Insulin		_____
Injectable Dosage Forms		_____
Compounded Prescriptions		_____
Ostomy Supplies		_____
Diabetic Supplies		_____

I certify that the foregoing represents an accurate statement of the Usual and Customary fee formula in effect for the above provider. I understand that Usual and Customary charges mean charges made to customers who pay cash. I agree to permit an examination by the Nova Scotia Department of Health or its designated agent of those provider records deemed necessary by the Department of Health to verify the accuracy of this declaration.

Signed this _____ day of _____ 20 _____

_____ _____
Authorized Signature Title

Appeals Process

Definitions

Act: means the *Health Services and Insurance Act*, R.S.N.S. 1989, c. 197, as amended

DOH: means the Department of Health

Associate Deputy Minister: means the Associate Deputy Minister of the Department of Health

Insured Services: means insured professional services, and drugs, biologicals and related preparations and appliances insured under the Insured Prescription Drug Plan

MSI: means any person, persons, or agency to whom or to which the Minister has delegated authority to administer the MSI Plans or the Insured Prescription Drug Plan

Panel: means the Health Services Hearing Panel as set out in this Appendix

Provider: means a provider of insured professional services pursuant to the *Health Services and Insurance Act*, and includes a pharmacy operating within the Insured Prescription Drug Plan

Provider's Manual: means any billing instructions made available to providers by MSI in the Pharmacists' Guide and Pharmacists' Bulletins

Regulations: means the *Insured Prescription Drug Plan Regulations* made under Section 17 of the *Health Services and Insurance Act*, R.S.N.S. 1989, c. 197, as amended

Investigation

1. Providers shall maintain appropriate patient records or prescription records for all claims for insured services, as required by the Act, Regulations and Provider's Manual.

2. Every provider who makes a claim for insured services must provide to MSI upon MSI's request the particulars of the claim and documentation to support the claim as required by the Act, Regulations and Provider's Manual.

3. MSI may assess and investigate claims for insured services, and MSI shall determine the amounts payable for such claims in accordance with the Act, Regulations and Provider's Manual.

4. Where MSI has grounds to believe that:

   i) All or part of the insured services were not billed according to the billing instructions made available to providers by MSI; or
   ii) All or part of the insured services are not verifiable from the associated patient records or prescription records; or
   iii) An appropriate patient record or prescription record has not been made and maintained for the insured services; or
   iv) The nature of the services is misrepresented; or
   v) All or part of the insured services were not in fact rendered; or
   vi) All or part of such services were not medically necessary; or
   vii) MSI has paid a claim or claims for a service or services which are not insured services.

Appeals Process

MSI may do one or more of the following:

a) Refuse or reduce payment of a claim or claims for injured services, or an account.
b) Order the provider to reimburse to MSI any overpayment made to the provider.
c) Recover any overpayment by MSI to the provider by deducting the amount of the overpayment from any other amounts payable by MSI to the provider.
d) Commence and maintain civil proceeding in the Supreme Court of Nova Scotia, for recovery of any overpayment made to a provider, as a debt owing to MSI.
e) Enter into an agreement with the provider in settlement of the matter upon any terms as may be agreed to.
f) Order the suspension, modification, restriction or termination of the provider's billing privileges under the MSI Plan.
g) Order that the provider pay a penalty in an amount not to exceed fifty thousand dollars.

Appeals Procedure

5. The pool referred to in section 6 shall be established and composed of:
- six (6) providers appointed by the Minister or his delegate. For such appointments, the Minister or his delegate shall consult with, and shall seek nominations from the Pharmacy Association of Nova Scotia, but the Minister shall not be obliged to make appointments from such nominations.
- four (4) lay people appointed by the Minister or his delegate.

6. a) Upon receipt of a reference from a provider, the Panel known as the Health Services Hearing Panel shall be established and composed of:
- three (3) providers chosen by the Minister or his delegate from the pool of six (6) providers appointed in section 5
- two (2) lay members chosen by the Associate Deputy Minister or his delegate from the pool of four (4) lay people appointed in section 5.

b) From hearing to hearing, the Minister shall normally rotate his choice of Panel members from among the pool, but the Minister shall not be required to do so.

c) No member of the Pharmacy Review Committee may be a member of the Panel. No person shall be selected as a member of the Panel who has taken part in the investigation of what may become the subject matter of a hearing before the Panel.

d) One (1) member of the Panel shall be designated as Panel Chairperson and another member shall be designated as Vice-Chairperson.

e) The functions of the Panel are to hear references made by providers pursuant to this Appeals Process and to perform any other duties that may be necessary or incidental to any such references.

f) The Panel is empowered to render its own decision on any matter referred to it and may:
i) confirm, vary or rescind any action taken by MSI under section 4; and
ii) recommend that MSI take any action under section 4.

g) In rendering a decision, the Panel shall have no power or jurisdiction to amend, vary, change or add to the Provider's Manual or the Tariff Agreement. Any decision of the Panel shall be in accordance with the Act, Regulations, Provider's Manual, and the Tariff Agreement.

7. When MSI has completed its investigation and has made a determination pursuant to section 4, a provider may refer the determination to the Panel in accordance with the procedures set out in this provision.

Appeals Process

8. A provider may refer an investigation determination to the Panel using the form attached as Form A. This form sets out fully and concisely the particulars of the reference relied upon by the provider. Notice of the reference shall be served to the Associate Deputy Minister, of the DOH, within thirty (30) days of the date that the provider received the investigative findings.

9. The Associate Deputy Minister shall forward any notice of reference to the Minister.

10. A reference to the Panel shall not operate as a stay of any action taken or order made by MSI under the Act or Regulations, but if the provider is successful on the reference to the Panel, MSI will reimburse the provider monies deemed to have been inappropriately recovered plus interest at a rate equal to the Bank of Canada prime rate. The total amount to be reimbursed including interest, shall be determined by the Panel at its discretion.

11. When the Panel receives a notice of reference, the Chairperson of the Panel shall set a time, date and place for hearing the reference.

12. The reference shall be heard by the Panel within such time as the Panel shall determine is reasonable.

13. If the Panel obtains expert medical opinion with respect to a hearing, it shall make the nature of the opinion known to the parties and the parties may make submissions with respect to the opinion.

14. (1) The Panel shall give the provider thirty (30) days' notice of the date, time and place that the reference will be heard, unless this period of notice is waived by the provider.
(2) All parties shall provide to the Panel and any opposing parties an opportunity to examine, at least seven days prior to a hearing before the Panel,
    (a) any written or documentary evidence that will be produced at the hearing or any report the contents of which will be given in evidence at the hearing, including any recommendation of the Pharmacy Review Committee; and
    (b) in the case of the evidence of an expert, a copy of the expert's written report, or if there is no written report, a written summary of the expert's evidence; and
    (c) in the case of the evidence of a witness, the identity of that witness.
(3) If any of the provisions of subsections 14 (2)(a), (b) or (c) are not complied with, a party may request an adjournment and the Panel may adjourn the hearing, continue without adjournment, or take any other action or make any order as it deems reasonable and necessary.

15. The Panel may conduct a pre-hearing conference with the provider and MSI, if the Panel determines that this will facilitate the hearing.

16. The Panel may, when it thinks just, permit a notice of reference to be amended to correct errors or omissions of a minor nature. The Panel may make orders as it deems necessary to avoid prejudice to any party or parties, which might be caused by such errors, omissions and amendments.

17. If the provider fails to appear at the time and place appointed for the hearing, the Panel may

    a) dismiss the reference;
    b) proceed in the absence of the provider and render such decision and make such order as it considers appropriate; or
    c) make such order as to the reference as it considers appropriate.

18. The Chairperson, or in the absence of the Chairperson, the Vice-Chairperson of the Panel shall preside at every hearing of the Panel.

Appeals Process

19. A hearing before the Panel shall not be open to the public unless the provider requests in writing that it be open to the public. A request by a provider for an open hearing must be received by the Panel at least three (3) days before the hearing commences, and upon receiving such a request, the Panel will decide, in its sole discretion, whether to open the hearing to the public.

20. The Panel may, in its sole discretion, make orders it considers necessary to prevent the public disclosure of matters disclosed at a hearing, including orders prohibiting publication or broadcasting of those matters.

21. Notwithstanding that a hearing has been scheduled before the Panel, all parties to that hearing may agree on terms of a settlement prior to the hearing and the Panel shall dismiss the reference on consent of all parties.

22. At the commencement of the hearing of a Panel, the Chairperson presiding shall satisfy himself or herself that notice of the date, time and place of hearing was provided to the provider in accordance with section 14(1).

23. At the hearing, both the provider and MSI may present any evidence, written and/or oral submissions, and both the provider and MSI may be represented by legal counsel.

24. On a reference, the Panel may consider all of the information which was previously considered by MSI or by the Pharmacy Review Committee, and may consider such additional information, evidence or submissions as are placed before it with respect to the reference.

25. The oral evidence taken before the Panel at a hearing shall be recorded.

26. The Panel may receive and accept evidence and other information at a hearing, whether on oath or by affidavit or otherwise, as the Panel sees fit, whether or not such evidence or information is or would be admissible in a court of law. However, the Panel may not receive or accept as evidence anything that would be inadmissible in a Court of law by reason of any privilege.

27. The Panel may adjourn any hearing from time to time and place to place, if it considers it necessary to do so.

28. No member of the Panel shall communicate outside the hearing, in relation to the subject matter of the hearing, with a party or the party's representative unless the opposing party has been given notice of the subject matter of the communication and an opportunity to be present during the communication.

29. A member of the Panel who ceases to be a member of the Panel after the hearing of a matter has commenced shall be deemed, for the purposes of dealing with the matter, to remain a member of the Panel until the final disposition of the matter.

30. A decision of a majority of the members of the members of the Panel present at a hearing is a decision of the Panel.

31. Only those members of the Panel who were present throughout a hearing shall participate in making the Panel's decision.

32. The Panel shall provide a copy of its written decision to MSI and to the provider. The decision shall be sent to the provider by registered mail, addressed to the last known address of the provider.

33. The decision of the Panel is deemed to have been received by the provider on the fifth day after it was mailed.

Appeals Process

34. a) A decision of the Panel is final and a party to the proceedings before the Panel may appeal to the Supreme Court of Nova Scotia, but only on the ground of an error of law or a failure to follow the requirements of natural justice;
    b) An appeal to the Supreme Court of Nova Scotia shall not operate as a stay of the decision appealed from;
    c) A provider appealing a decision of the Panel to the Supreme Court of Nova Scotia may apply to a Judge of that Court for an order staying the decision of the Panel to the Supreme Court of Nova Scotia may apply to a Judge of that Court for an order staying the decision of the Panel, and the Judge may grant a stay on terms as the Judge deems just.

35. The Panel shall make available to a party to a hearing copies of the transcript of the hearing, on the party's request and at the party's expense.

36. The Panel shall release documents and things put into evidence at a hearing to the person who produced them at the hearing, upon that person's request, and within a reasonable time after the matter has been finally determined.

Appeals Process

FORM A

NOTICE OF REFERENCE BY PROVIDER

TO: Associate Deputy Minister

FROM: _____
(please print full name)

TAKE NOTICE that I am referring the investigative findings of MSI, dated

_____, to the

Health Services & Insurance Panel,

FURTHER TAKE NOTICE that the particulars of the reference are:

My address for service is _____

_____

DATED this _____ day of _____, 20____.

_____
(Signature of Provider)

PHARMACARE PRESCRIPTION AUDIT RECOVERY PROCEDURES

The purpose of the Pharmacare prescription audit is to confirm that the details of a prescription paid under the Pharmacare Programs comply with the corresponding prescription on file in the pharmacy and to support overall effective operations of the Programs. Providers are audited at least once every two years. Specific audits may be conducted as warranted. A sample shall consist of at least 100 prescriptions. The documentation to support the prescription claimed must be available for review during the on-site audit. For the calculation of an audit recovery, information subsequently solicited from or provided by the prescriber will not be used to support the prescription claimed.

AUDIT FINDING	ACTION
1. PATIENT'S NAME	
(i) First initial/first name or surname missing.	Recover professional fee for original and any refills.
(ii) No patient name indicated	Recover total amount paid for original and any refills.
2. DRUG NAME NOT INDICATED	Recover total amount paid for original and any refills.
3. NO DRUG STRENGTH INDICATED WHERE MULTIPLE STRENGTHS EXIST	Recover total amount paid for original and any refills.
4. NO QUANTITY INDICATED FOR DRUG PRESCRIBED	Unless the quantity claimed is the only size manufactured and the package format is such that it cannot be divided, (e.g., inhalers, insulins, ophthalmic/otic products) recover professional fee(s) for original and any refills.
5. SMALLER QUANTITY CLAIMED THAN PRESCRIBED	Unless the quantity claimed is the closest size manufactured to the quantity prescribed (e.g., topical preparations and ophthalmic/otic products), recover excess professional fee(s) for original and any refills.
6. LARGER QUANTITY CLAIMED THAN TOTAL QUANTITY PRESCRIBED	Unless the quantity claimed is the closest size manufactured to the quantity prescribed (e.g., topical preparations and ophthalmic/otic products), recover excess drug cost for original and any refills.
7. AUTHORIZED SIGNATURE OF PRESCRIBER NOT PRESENT ON WRITTEN PRESCRIPTION	Recover professional fee(s) for original and any refills.

AUDIT FINDING	ACTION
8. REFILLS FOR DRUGS PRESCRIBED	
(i) More refills claimed than authorized by prescriber.	Recover total amount paid for excess refills.
(ii) Non-specific refill directions, e.g., "PRN", and "1 Year".	Recover total amount paid for any refills.
9. MISSING PRESCRIPTION(S)	
(i) One or two prescriptions.	Recover the professional fee for original(s) and any refills, if the prescription(s) cannot be located during the on-site audit.
(ii) Three or more prescriptions.	Recover the total amount paid for original(s) and any refills associated with every missing prescription, if the prescriptions cannot be located during the on-site audit.
10. DIFFERENT DRUG CLAIMED THAN PRESCRIBED	Recover total amount paid for original and any refills.
11. PLAN EXCEPTION PRESCRIPTION SUBMITTED WITH CRITERIA CODE	
(i) Criteria code or diagnosis supporting payment not indicated.	Recover total amount paid for original and any refills.
(ii) Criteria code or diagnosis added by pharmacist but no note indicating that the prescriber was contacted for the additional information required.	Recover total amount paid for original and any refills.

OVERALL FINDINGS

Based on the overall audit findings, the audit sample size and audit time period may be increased to further determine the extent of infractions. The sample audit results may be extrapolated over all of the claims paid during the period from which the sample was drawn for the purpose of calculating a recovery.

A percentage of prescriptions audited may be verified with the prescriber(s) to ensure that the prescriptions were prescribed as claimed. For example, a diagnosis of Community Acquired Pneumonia (CAP) documented on the prescription by the pharmacist, may be verified with the prescriber.

The following examples: "Refill Rx #6234567", "*Refill Lanoxin X 6*", all lack some components of a valid prescription, i.e., drug name, strength, quantity or dosage directions. In order to avoid recoveries for invalid prescriptions, any missing or incomplete prescription information is to be verified with the prescriber prior to dispensing. As well, any alteration of the original prescription is to be verified in this manner. These details are to be added to the prescription along with a notation indicating that the prescriber was contacted for the additional information required.