

5 Reimbursement and Pricing Policies

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5.6 Maximum Pricing Policy

[Policy effective date – October 15, 2010][Policy revised April 1, 2013]

[June 1, 2015: Updated to reflect Provider Regulation terminology and requirements]

General Policy Description

PharmaCare sets a maximum price it will reimburse for drugs under the [Drug Price Regulation](#). This maximum price is applied during PharmaNet claims adjudication. The maximum pricing policy also applies to some non-drug products.

Policy Details

- PharmaCare reimburses drugs and some non-drug products eligible for PharmaCare coverage up to a maximum price based on:
 - the sum of the manufacturer list price and 8% of that price for most drugs;
 - the sum of the manufacturer list price and 5% for drugs subject to the [High-Cost Drugs Policy](#).
- The level of PharmaCare reimbursement may be further limited when the product is subject to the [Reference Drug Program \(RDP\)](#), the [Low Cost Alternative Program](#), a price established in an agreement entered into under the *Pharmaceutical Services Act*, or another PharmaCare pricing program or policy.
- PharmaCare reimburses the lesser of the costs adjudicated under all pricing programs and policies applicable to a particular product.

Procedures

- When entering a claim in PharmaNet, ensure that the unit of measure used for the dispensed quantity matches that used in PharmaNet. PharmaNet divides the product cost by the dispensed quantity and compares the result to the PharmaCare pricing rules for the product. Using the correct unit of measure ensures accurate adjudication of claims in PharmaNet.
- Refer to the [PharmaCare Formulary Search](#) and the [Correct Quantities](#) list to determine the unit of measure used for a product's PharmaCare pricing.

Tools & Resources

- For information on current PharmaCare reimbursement of specific products, use the online [PharmaCare Formulary Search](#).

5.7 Actual Acquisition Cost Policy

[Policy revisions effective date October 15, 2010]

General Policy Description

For certain products, PharmaCare covers only the pharmacy's actual cost of procuring the product.

Policy Details

- For products subject to the Actual Acquisition Cost (AAC) policy, PharmaCare reimbursement will not exceed the provider's AAC for the product up to a maximum price based on the manufacturer list price plus a 7% mark-up.
- The product cost submitted in PharmaNet is to be reduced by any volume rebates or free goods received. Actual freight costs can be included in the AAC.
- A discount paid or credited by a supplier for prompt payment of invoices is not included in the calculation of AAC. (The PharmaCare-recognized discount is usually no more than two per cent.)
- When submitting claims, the Drug Cost field should contain only the AAC. Charges in excess of the AAC must be entered in the Drug Upcharge field so they do not adjudicate to PharmaCare.
- PharmaCare will recover overpayments made as a result of claims submitted above the AAC.
- Product costs submitted in excess of a PharmaCare maximum price will be adjudicated based on the applicable maximum price and any other applicable PharmaCare pricing policies.
- Products subject to this policy include:
 - Blood Glucose Test Strips—reimbursed at AAC up to the PharmaCare maximum price for the product plus a dispensing fee (up to the PharmaCare maximum dispensing fee).
 - Cystic Fibrosis vitamin and nutritional supplements—reimbursed at AAC up to the PharmaCare maximum price for the product plus a dispensing fee (up to the PharmaCare maximum dispensing fee).

Procedures

Entering claims under the AAC Policy

- Enter the AAC of the product in the PharmaNet **Drug Cost** field.
- Enter any product cost in excess of the AAC in the **Drug Upcharge** field not the Drug Cost field.
- When entering a claim in PharmaNet, ensure that the unit of measure used for the dispensed quantity matches that used in PharmaNet. PharmaNet divides the cost by the dispensed quantity and compares the result to the PharmaCare pricing rules for the product. Using the correct unit of measure ensures accurate adjudication of claims in PharmaNet.

>> Refer to the PharmaCare Formulary Search and the Correct Quantities list to determine the unit of measure used for a product's PharmaCare pricing.

5.8 High-Cost Drugs Policy

[Policy effective date – April 1, 2011][Policy revised April 1, 2013]

General Policy Description

Certain high-cost drugs are subject to a specific reimbursement limits under the [Drug Price Regulation](#).

Policy Details

- PharmaCare reimburses drugs designated as high-cost drugs under the Drug Price Regulation up to a maximum price based on the sum of the manufacturer list price for the drug and specific percentage of that price (usually 5% or less).
- Whether a medication is for short term, PRN, and/or acute treatment may be taken into consideration when determining if a drug should be designated as a high-cost drug.
- Drugs designated as high-cost drugs are published on the [List of Designated High-Cost Drugs](#).

Procedures

- When entering a claim in PharmaNet, ensure that the unit of measure used for the dispensed quantity matches that used in PharmaNet. PharmaNet divides the drug cost by the dispensed quantity and compares the result to the PharmaCare pricing rules for the product. Using the correct unit of measure will ensure accurate adjudication of claims in PharmaNet.
- Refer to the [PharmaCare Formulary Search](#) and the [Correct Quantities](#) list to determine the unit of measure used for a product's PharmaCare pricing.

Tools & Resources

- [List of Designated High-Cost Drugs](#)

5.9 Retail Pricing Policy

General Policy Description

For certain products, PharmaCare covers the retail price of the product.

Policy Details

- For products subject to the Retail Pricing Policy, PharmaCare reimburses the retail price of the product with no dispensing fee.
- Products subject to this policy include the following:
 - Insulin Pump Cartridges/Reservoirs—reimbursed up to a maximum of the manufacturer's suggested retail price for the product with no dispensing fee.
 - Insulin Pump Infusion Sets—reimbursed up to a maximum of the manufacturer's suggested retail price for the product with no dispensing fee.
 - Regular Insulin—reimbursed at the regular retail price with no dispensing fee.
 - Long Acting Insulin Analogues—reimbursed at the regular retail price with no dispensing fee.

Note: Short Acting Insulin Analogues are reimbursed up to a maximum price not at the retail price.

- Needles/Syringes for Insulin Therapy—reimbursed at the regular retail price with no dispensing fee.
- Ostomy Supplies—reimbursed at the regular retail price with no dispensing fee.

5.10 Full Payment Policy

[Policy effective date – October 15, 2010]

[June 1, 2015: Updated to reflect Provider Regulation terminology]

General Policy Description

Under the Full Payment Policy, pharmacies are not permitted to charge any amount directly to patients who are receiving full PharmaCare coverage for a claim.

Policy Details

When does the Full Payment Policy Apply?

- The Full Payment Policy applies to all pharmacy providers that submit claims to PharmaCare.
- Pharmacies must not charge any amount directly to an individual receiving full PharmaCare coverage for a full benefit drug.
- Individuals receiving full PharmaCare coverage are those covered under PharmaCare plans B, C, D, F, G, P, and those that have reached their Fair PharmaCare (Plan I) family maximum.
- A product is a full benefit when it is:
 - a regular PharmaCare benefit (that is, no Special Authority required), or
 - a Limited Coverage drug for which Special Authority approval has been granted, and
 - not subject to any reimbursement limit on adjudication under the Low Cost Alternative Program or Reference Drug Program.

When does the Full Payment Policy Not Apply?

- The Full Payment Policy does not apply when the drug/product:
 - is not a PharmaCare benefit
 - adjudicates as a partial PharmaCare benefit under the Low Cost Alternative Program or Reference Drug Program
 - is exempt from the Full Payment Policy
- The following products are exempted from the Full Payment Policy:
 - Insulin
 - Medical supplies and devices including:
 1. prosthetics
 2. orthotics
 3. ostomy supplies
 4. cystic fibrosis nutritional supplements/vitamins
 5. diabetes supplies (insulin pumps and supplies, needles and syringes, blood glucose test strips).

Charges in Error

- When a pharmacy provider mistakenly charges product or dispensing fee costs directly to an individual for a claim to which the Full Payment policy applies, the pharmacy provider must refund those charges to the individual.

Procedures

- When submitting claims to which the Full Payment Policy applies, do not charge patients for any amount in excess of that accepted for reimbursement by PharmaCare.

Questions & Answers

What if a patient has drugs covered under multiple plans?

- When multiple plans are involved, a patient may have claims that are subject to the Full Payment Policy and others that are not.
- Example: Robert arrives with two prescriptions. One is for a psychiatric medication covered under Plan G. The other is for ointment covered under Fair PharmaCare. The claim for the psychiatric medication will be subject to the Full Payment Policy. Robert has met his Fair PharmaCare deductible but has not yet reached his Family Maximum, so the claim for the ointment will not be subject to the Full Payment Policy.

What if the patient is fully covered by PharmaCare but also has private coverage?

- If a pharmacy provider is able to determine *at the time medication is dispensed* that the patient's private insurer will cover any costs in excess of the amount PharmaCare covers, they can charge the private insurer.
- A pharmacy provider cannot charge a patient on the understanding that a private insurer may pay all or some of the cost at a later date. The determination of coverage by the private insurer must be made at the time the product is dispensed.

Tools & Resources

- [PharmaCare Formulary Search](#)

5.11 Low Cost Alternative Program

[Policy revisions effective date October 15, 2010][Policy revisions effective April 1, 2013]

General Policy Description

The Low Cost Alternative (LCA) Program established under the Drug Price Regulation is intended to ensure the best value is obtained for expenditures on multi-source drugs. The program works by limiting PharmaCare reimbursements for drugs subject to an LCA price.

Drugs included in the LCA Program may also be subject to the Reference Drug Program (RDP). Unlike the LCA Program, the RDP applies to drugs with different active ingredients that are in the same therapeutic category and are used to treat the same conditions.

Policy Details

General Low Cost Alternative Program Policies

- The LCA Program uses LCA categories consisting of drugs that have the same active ingredient or combination of active ingredients, and the same strength.
- Generic drugs included in an LCA category have one of two benefit statuses: full benefit or non-benefit.
- Pharmacy claims for a full benefit generic product are reimbursed up to the lesser of any applicable Reference Drug Program price or the PharmaCare maximum price for the product.
- Non-benefit products are not reimbursed. PharmaCare does not cover generic drugs subject to the LCA Program as partial benefits.
- Brand drugs included in an LCA category remain eligible for reimbursement as partial benefits unless they have a list price that is equal to or less than the applicable maximum accepted list price for the category, in which case they are eligible for reimbursement as full benefits. Reimbursement for partial benefit brand drugs is limited to the LCA price for the category.
- LCA prices are set at the sum of the maximum accepted list price for generic drugs in an LCA category plus 8% for most drugs. For drugs subject to the [High-Cost Drugs Policy](#), LCA prices are set at the sum of the maximum accepted list price for generics drugs in an LCA category plus 5%.
>> Refer to the [Maximum Accepted List Prices](#) section below.
- For information regarding the drugs subject to the LCA Program (LCA categories, prices, benefit status, etc.) refer to the [Low Cost Alternative \(LCA\) and Reference Drug Program \(RDP\) Data Files](#).
- Pharmacists may also call the [PharmaNet HelpDesk](#) for information on drugs subject to the LCA Program.

Maximum Accepted List Prices

- For each Low Cost Alternative (LCA) Program category, PharmaCare determines a maximum accepted list price (MALP) for generic drugs within the category.

LCA Categories established on or after April 1, 2013

LCA Comparators

- For LCA categories established on or after April 1, 2013, an LCA comparator is designated and used to determine the maximum accepted list price (MALP) for generic drugs in each LCA category.
- The designated LCA drug comparator is the:
 - brand drug in the LCA category when there is a single brand drug in the category;
 - most cost-effective brand drug in the LCA category when there is more than one brand drug in the category;
 - LCA drug comparator of another LCA category consisting of drugs with the same active ingredient or combination of active ingredients but a different strength, when there is no brand drug in a category.

MALP calculation

- For each category established on or after April 1, 2013, under Section 4 of the Drug Price Regulation, the MALP is calculated as a percentage of the manufacturer's list price for the LCA comparator for that category.
- For the period April 1, 2013, to March 31, 2014, MALPs for LCA categories established after April 1, 2013, are calculated as follows:
 - 25% of the LCA comparator list price for LCA categories consisting of drugs available as oral solids only;
 - 35% of the LCA comparator list price for any other LCA category.
- Effective April 1, 2014, MALPs for LCA categories established after April 1, 2013, will be calculated as follows:
 - 20% of the LCA comparator list price for LCA categories consisting of drugs available as oral solids only;
 - 35% of the LCA comparator list price for any other LCA category.
- If an LCA category contains no brand drugs, the MALP for that LCA category is calculated as a proportion, by strength, of the MALP for the LCA category to which the designated LCA comparator belongs.

LCA Categories established before April 1, 2013

LCA Comparators

- For LCA categories established before April 1, 2013, a base price has been established in the Schedule to the Drug Price Regulation.

MALP calculation

- The MALP is calculated as a percentage of the base price for each LCA category.

- For the period April 1, 2013, to March 31, 2014, MALPs for LCA categories established before April 1, 2013, are calculated as follows:
 - 25% of the base price for LCA categories consisting of drugs available as oral solids only;
 - 35% of the base price for any other LCA category.
- Effective April 1, 2014, MALPs for LCA categories established before after April 1, 2013, will be calculated as follows:
 - 20% of the LCA comparator list price for LCA categories consisting of drugs available as oral solids only;
 - 35% of the LCA comparator list price for any other LCA category.
- If a drug in an LCA category had, as of July 1, 2010, a lower manufacturer's list price than the calculated MALP for the LCA category to which it belongs, the MALP for that LCA category will be the manufacturer's list price of that drug as of July 1, 2010.

MALP Exceptions

- In exceptional circumstances (e.g., where proper documentation indicates that a manufacturer's cost to produce and distribute a generic product is greater than the MALP), the effective MALP for a category may be increased from that initially calculated.
- PharmaCare will not consider a request for an exception if the drug is being supplied (or if the drug is intended to be supplied) in another jurisdiction in Canada at a list price that is equal to, or lower than, the MALP as initially calculated by PharmaCare, or at a list price higher than the list price submitted in another jurisdiction.
- For any LCA category for which no manufacturer commits to sell a generic drug at or below the calculated MALP, or where PharmaCare has significant concerns with the sufficiency of supply offered by those manufacturers committing to sell at or below the MALP, PharmaCare will review the exception requests and prices submitted by manufacturers for generic drugs in the category. Based on its review, PharmaCare may, at its sole discretion, take whatever action it deems appropriate, which may include, without limitation, one or more of the following:
 - PharmaCare may grant an exception to the MALP requirement to the manufacturer(s) submitting the lowest list price, or a lower list price for any drug in the LCA category. Where necessary to ensure sufficient supply for PharmaCare beneficiaries, PharmaCare may grant exceptions to more than one drug in an LCA category. In such instances, drugs will be considered for coverage in order of submitted list price, with the lowest priced drug receiving first consideration. Such exceptions will be granted on a provisional basis, meaning that the exception may be rescinded at any time and without opportunity for manufacturers to resubmit the product at a lower price until the following April 1.
 - PharmaCare may deem all generic drugs in the LCA category ineligible for PharmaCare coverage;
 - PharmaCare may deem all drugs in the LCA category ineligible for PharmaCare coverage;
 - PharmaCare may undertake a competitive process to ascertain the lowest price at which a manufacturer is prepared to supply the drug in question for PharmaCare beneficiaries.

Impact on Eligibility for PharmaCare Coverage

- A generic drug that is, or would be, assigned to an LCA category and that has a manufacturer's list price exceeding the applicable maximum accepted list price will not be eligible for PharmaCare coverage except when the drug is:
 - designated as a provisional drug under Section 14 of the Drug Price Regulation;
 - subject to an agreement under Section 20 of the *Pharmaceutical Services Act*.
- A generic drug for which PharmaCare coverage is refused or cancelled due to a manufacturer's list price exceeding the MALP, will not be eligible for PharmaCare coverage until the next April 1, except when the drug is provided temporary coverage under Section 16 of the Drug Price Regulation.
- If a drug's designation as a provisional drug is cancelled, PharmaCare coverage is removed and the drug will not be eligible for PharmaCare coverage again until the next April 1, except when the drug is provided temporary coverage under Section 16 of the Drug Price Regulation or if the drug is subject to an agreement under section 20 of the *Pharmaceutical Services Act*.
- Drugs subject to the LCA Program that have been determined to be ineligible for PharmaCare coverage are published in the "Non-Benefits" worksheet in the [Low Cost Alternative \(LCA\) and Reference Drug Program \(RDP\) Data Files](#).

Pan-Canadian Competitive Value Price Initiative for Generic Drugs

- Under the Pan-Canadian Competitive Value Price Initiative for Generic Drugs, participating provinces and territories, including British Columbia, have agreed to establish a price point for six of the most common generic drugs at 18% of the equivalent brand name drug.
>>> See [more details on this coordinated approach to pharmaceutical management in Canada](#).
- The six generic drugs currently subject to this initiative are:
 - Atorvastatin 10, 20, 40 and 80 mg tablets
 - Ramipril 1.25, 2.5, 5 and 10 mg capsules
 - Venlafaxine 37.5, 75 and 150 mg extended release capsules
 - Amlodipine 2.5, 5 and 10 mg tablets
 - Omeprazole 20 mg delayed/sustained release tablets and capsules
 - Rabeprazole 10 and 20 mg tablets.
- PharmaCare will use the Low Cost Alternative Program to implement pricing under this initiative.
- PharmaCare does not cover a generic product subject to this initiative if its pricing is in excess of that established under the initiative.
- PharmaCare reimbursement reflects pricing under this initiative effective April 1, 2013.
- Products and pricing under this initiative are identified in the [Low Cost Alternative \(LCA\) and Reference Drug Program \(RDP\) Data Files](#).

Low Cost Alternative and Reference Drug Program Data Files

- The PharmaCare website provides regularly updated Low-Cost Alternative (LCA) and Reference Drug Program (RDP) listings in downloadable spreadsheets and related documents.

>> See the *Low Cost Alternative (LCA) and Reference Drug Program (RDP) Data Files*.

- For the LCA Program and RDP, PharmaCare typically provides at least thirty (30) days prior notice of any changes to categories, included products, reimbursement limits and product benefit status via the LCA/RDP Updates Workbook on the website.
- All spreadsheets are in Microsoft Excel format. Users can sort and filter the file contents and import them into Excel or a database.
- LCA and RDP spreadsheets, as well as the LCA/RDP Updates Workbook, are updated monthly and published on the website on the first Thursday of every month.
- On occasion, a change to the LCA or RDP program may come into effect between the regular monthly updates, including but not limited to the:
 - implementation of generic drug pricing adjustments; or
 - expedited implementation of coverage for significant first-entry generic drugs.
- If a change to the LCA or RDP program comes into effect between the regular monthly updates, PharmaCare publishes updated versions of the LCA and RDP spreadsheets and the LCA/RDP Updates Workbook online on the effective date of the PharmaCare reimbursement change.
- Check the website on the first Thursday of the month and then again in the middle of the month to ensure you always have the most recent LCA/RDP information.

Interchangeability

- The PharmaCare Low Cost Alternative and Reference Drug Program spreadsheets should not be considered an endorsement by PharmaCare of the interchangeability of any products identified.
- The College of Pharmacists of B.C. has delegated the responsibility for determining the interchangeability of products to B.C. pharmacists.
- Pharmacists are advised to consult with the prescriber to obtain the appropriate legal authority to dispense an LCA or RDP product.

Patient Impact

- If a patient's prescription is for a partial benefit product, the pharmacy is encouraged to make the patient aware that there is a full benefit LCA or RDP product that provides the same or similar therapeutic treatment.
- If the patient chooses the partial benefit product, they will be required to pay any cost in excess of the LCA or RDP price.
- When being dispensed a drug subject to the LCA Program, patients have three choices:
 - obtain a full benefit product which will be fully reimbursed up to the PharmaCare maximum price (or RDP price, where applicable);

- obtain a partial benefit product and pay any portion of the drug cost that exceeds the LCA price (or RDP price, where applicable);

Fair PharmaCare patients should be made aware that only the portion of the drug cost accepted for reimbursement by PharmaCare counts toward their deductible.

- have their physician request a Special Authority for full benefit coverage of a partial benefit product (refer to Special Authorities for Low Cost Alternative Drugs, below), where individual circumstances warrant.

Special Authorities for Low Cost Alternative Drugs

- The Special Authority process is designed to ensure access to drugs based on patient-specific needs.
- If a particular patient has an allergy or intolerance to the non-therapeutic ingredients used in the majority of generic products in a Low Cost Alternative category, a physician may apply to PharmaCare for Special Authority for full benefit coverage of a brand name product in that category.
- Special Authority is not provided on a retroactive basis.
- When a Special Authority is granted, coverage is provided up to the PharmaCare maximum price for the drug, as reflected in the [Maximum Pricing Policy](#).
- A Special Authority does not override plan deductibles or co-payments.

>> See the PharmaCare web page for [Special Authority process and criteria for specific products](#).

Manufacturer Shortages

- Shortages of a particular full benefit product in a Low Cost Alternative (LCA) category may be addressed by stocking a different full benefit product within the same category for the duration of the shortage.
- If a shortage impacts all of the full benefit products within an LCA category, PharmaCare will verify the shortage with the manufacturers and determine the expected duration. When such a shortage may impact the availability of a sufficient supply of full benefit products, PharmaCare will implement measures to ensure supply needs are met. These measures will be communicated to pharmacies and may include:
 - temporary removal of the Special Authority requirement for full coverage of partial benefit product(s) in an LCA category;
 - temporary PharmaCare coverage of a product or products not currently listed for coverage in an LCA category; or
 - other measures to ensure a sufficient supply for PharmaCare beneficiaries.
- Since most shortages are of limited duration, it is recommended that pharmacies confirm the anticipated duration of a shortage before ordering an inventory of a drug provided a temporary change in benefit status. When a shortage is over, PharmaCare will rescind temporary changes in benefit status with minimal notice.
- Pharmacies should contact the PharmaNet Helpdesk to report shortages or enquire about measures being taken to address a shortage.

Tools & Resources

- [Low Cost Alternative/Reference Drug Program Data Files and related information](#)
- [Drug Submission Requirements for Generic Drug Products](#)

5.12 Reference Drug Program (RDP)

[Policy revisions effective April 1, 2013]

[Updated December 1, 2016, to reflect Modernization of the RDP.]

General Policy Description

The PharmaCare Reference Drug Program (RDP) established under the Drug Price Regulation encourages cost-effective, first-line prescribing for common medical conditions by limiting reimbursement for certain drugs in designated therapeutic categories to a maximum daily amount payable.

- Whereas the [Low Cost Alternative Program](#) applies to drugs that have identical active ingredients, the Reference Drug Program applies to drugs that are not identical but are part of the same therapeutic category and are used to treat the same conditions.
- Drugs included in the Reference Drug Program may also be subject to the [Low Cost Alternative Program](#).

Policy Details

General Reference Drug Program Policies

- Effective December 1, 2016, the Reference Drug Program currently applies to eight categories of drugs:
 - angiotensin converting enzyme inhibitors (ACE Inhibitors)
 - angiotensin receptor blockers (ARBs)
 - dihydropyridine calcium channel blockers (CCBs)
 - HMG-CoA Reductase Inhibitors (Statins)
 - histamine₂ receptor blockers (H₂ Blockers)
 - nitrates
 - non-steroidal anti-inflammatory drugs (NSAIDs)
 - proton pump inhibitors (PPIs)
- Designated reference drugs in each category are reimbursed up to the lesser of any applicable Low Cost Alternative Program price and the drug's PharmaCare maximum price as reflected in the [Maximum Pricing Policy](#).
- For each category, one drug is designated as the reference drug comparator and is used to determine the maximum daily amount payable for non-reference drugs in the category.
- The maximum daily amount payable for each category changes in relation to any change in the reference drug comparator itself or to any change in the price of the reference drug comparator, including changes resulting from Low Cost Alternative Program pricing.
- PharmaCare limits reimbursement for non-reference drugs in each category to the applicable maximum daily amount payable.

Low Cost Alternative and Reference Drug Program Data Files

- PharmaCare publishes the following information online in the [Low Cost Alternative \(LCA\) and Reference Drug Program \(RDP\) Data Files](#):
 - reference drugs
 - non-reference drugs
 - maximum daily amounts payable for non-reference drugs
 - reference drug comparators
 - daily therapeutic doses used to determine maximum daily amounts payable.

You can also consult the [list of full and partial RDP benefits](#).

Interchangeability

- The PharmaCare [Low Cost Alternative \(LCA\) and Reference Drug Program \(RDP\) Data Files](#) should not be considered an endorsement by PharmaCare of the interchangeability of any products identified.
- The College of Pharmacists of B.C. has delegated the responsibility for determining the interchangeability of products to B.C. pharmacists.
- Pharmacists are advised to consult with the prescriber to obtain the appropriate legal authority to dispense an LCA or RDP product.

Patient Impact

- If a patient's prescription is for a non-reference drug, the pharmacy is encouraged to make the patient aware of the fully covered reference drug(s) and that the reference drug(s) provide the same or similar therapeutic treatment.
- If the patient chooses the non-reference drug, they will be required to pay any amount in excess of the applicable maximum daily amount payable (and LCA price, where applicable).
- PharmaCare beneficiaries taking a non-reference drug have three options:
 - switch to a reference drug,
 - remain on the non-reference drug and pay any cost in excess of the amount reimbursable under the Reference Drug Program (or Low Cost Alternative Program, where applicable),
Fair PharmaCare patients should be made aware that only the lower amount (i.e., the amount reimbursable under the Reference Drug Program) will accumulate toward the family deductible, even if they choose to pay the price difference for the non-reference drug.
 - have their physician request a Special Authority for full reimbursement of a non-reference drug, when individual circumstances warrant.

Special Authorities for Reference Drug Program Drugs

- The Special Authority process is designed to ensure access to drugs based on patient-specific needs.
- If a patient has a specific medical condition that prevents them from taking the reference drug(s) in an RDP category (e.g., a drug-to-drug interaction, drug intolerance or previous treatment failure),

their physician may submit a Special Authority Request for full benefit coverage of a non-reference drug.

- When a Special Authority is granted, coverage will be provided up to the lesser of:
 - any applicable Low Cost Alternative price for the product, or
 - the claimed drug cost or the maximum allowable price for the drug, as defined by the [Maximum Pricing Policy](#).
- A Special Authority does not override plan deductibles or co-payments.
>> See [Special Authority process and criteria for specific products](#).

Procedures

- Claims for drugs subject to the Reference Drug Program can be claimed in the normal manner. PharmaNet automatically adjudicates the claim under the Reference Drug Program and any other applicable pricing program or policy.

Tools and Resources

- [Low Cost Alternative/Reference Drug Program Data Files and related information](#).
- [Special Authority process and criteria for specific products](#)
- [List of full and partial RDP benefits](#)