

5 Reimbursement and Pricing Policies

5.13	Compounded Prescriptions	4
	Compound Benefits	4
	<i>Compounds eligible for coverage</i>	4
	<i>List of eligible compounds</i>	5
	Ineligible Compounds	7
	Discontinued Products	7
	Manufacturer Shortages	7
	Special Authority for Non-Benefit Compounds	7
	Maximum Allowable Fees	8
	<i>Relationship of Compounding Fees to Dispensing Fees</i>	9
	Ingredient Costs	9
	Equipment and Supply Costs	9
	Product Identification Numbers (PINs)	9
	Contracted Compounding Services	10
	Record Keeping Requirements	10
	Procedural requirements for pharmacists	10
	<i>Submitting a claim for a compound on PharmaNet</i>	10
	<i>Submitting a Special Authority Request for a compound</i>	12
	<i>Submitting same-day/same-PHN compound prescriptions</i>	13
5.14	Insulin	14
5.15	Needles and Syringes	15
	<i>Needles and Syringes for Insulin Therapy</i>	15
	<i>Needles and Syringes for Non-Insulin Therapy</i>	15
5.16	Blood Glucose Test Strips.....	16
	Patient Eligibility	16
	Plan Eligibility	16
	Reimbursement.....	16
	Certificates of Training.....	17
	Provisional Coverage.....	17

	Quantity Limits.....	17
	<i>Exceptions to the Annual Quantity Limit for BGTS.....</i>	<i>18</i>
	Procedures for Pharmacists.....	18
	<i>Determining if a Patient has a Confirmation (“Certificate”) of Training.....</i>	<i>18</i>
	<i>Submitting claims</i>	<i>19</i>
5.17	Insulin Pumps.....	20
	Patient and Plan Eligibility.....	20
	Coverage	20
	Coverage Requirements.....	21
	Patients with Existing Insulin Pumps not Covered by PharmaCare	21
	Reimbursement.....	22
	Insulin Pump Repairs and Replacement	22
	Lost or Stolen Insulin Pumps.....	22
	Insulin Pump Vendors	22
5.18	Insulin Pump Supplies	24
	Patient and Plan Eligibility.....	24
	Supplies covered by PharmaCare	24
	Purchasing and Reimbursement.....	24
5.19	Reimbursement for Non-Returnable High-cost Injectable Drugs.....	26
	Funding and Payments.....	26
	Drugs Eligible for Reimbursement	26
	Reimbursement Policy and Conditions.....	26
	Procedures for Pharmacists	27
	<i>Claiming reimbursement for an eligible high-cost injectable drug</i>	<i>27</i>
5.20	Smoking Cessation Program Policy	28
	General Policies.....	28
	<i>Smoking Cessation Products Covered</i>	<i>28</i>
	<i>Duration and Frequency of Coverage</i>	<i>28</i>
	<i>Supplemental Coverage or Changes in Coverage</i>	<i>29</i>
	<i>Claims for Plan B Patients.....</i>	<i>29</i>
	<i>B.C. Residents Covered by Federal Drug Plans.....</i>	<i>29</i>
	<i>Medication Review Eligibility.....</i>	<i>30</i>
	<i>Partial Fills Due to Product Shortages.....</i>	<i>30</i>

Nicotine Replacement Therapies	30
<i>Eligibility</i>	30
<i>Products Covered</i>	30
<i>Access to Nicotine Replacement Therapies</i>	30
<i>Maximum Days' Supply Per Fill and Dispensing Interval</i>	31
<i>Changing Nicotine Replacement Therapy Products During a Course of Treatment</i>	32
<i>Dispensing Fees</i>	32
<i>Clinical Services Fees</i>	32
<i>Special Services Fees</i>	32
<i>Application of the Full Payment Policy</i>	32
<i>GST Reimbursement for Nicotine Replacement Therapies [revised Nov 13, 2013]</i>	32
<i>Returns or Exchanges of Nicotine Replacement Therapies</i>	33
Smoking Cessation Drugs	33
<i>Eligibility</i>	33
<i>Products covered</i>	33
<i>Coverage</i>	33
<i>Maximum Days' Supply Per Fill and Dispensing Interval</i>	34
<i>Dispensing Fees</i>	34
<i>Clinical Services Fees</i>	34
<i>Special Services Fees</i>	34
<i>Application of the Full Payment Policy</i>	34
Procedures for Pharmacists	34
<i>Submitting Claims for Nicotine Replacement Therapies</i>	34
<i>Submitting Claims for Prescription Smoking Cessation Drugs</i>	35
<i>Submitting Claims for Patients with Federal Drug Plan Coverage</i>	36
5.21 Ostomy Supplies	37
5.22 Prosthetics and Orthotics	38
5.23 Pricing Exceptions Where Multiple Dosage Forms or Strengths Are Available	39

5.13 *Compounded Prescriptions*

[Policy revision effective—December 10, 2012]

General Policy Description

PharmaCare recognizes compounded prescriptions as rational combinations of active ingredients requiring professional judgment and technical skill in their preparation.

PharmaCare reimburses pharmacies for specific compounds and for compounding costs, up to certain limits.

Policy Details

Compound Benefits

Compounds eligible for coverage

- The compounds on the list of eligible compounds below are PharmaCare benefits when:
 - no suitable alternative is available commercially (e.g., different brand, different drug, etc.), and
 - the specific eligibility criteria for the ingredient (as noted below) are met, and
 - the pharmacy has a current medical practitioner’s prescription for the compound on file, and
 - the compound is produced by trained staff with appropriate expertise using appropriate and cost-effective ingredients and procedures.
- PharmaCare covers other types of compounds (i.e., those not on the list of eligible compounds) only if Special Authority approval is granted before the compound is dispensed.
- **Important:** Unsure if PharmaCare will cover a specific compound? Please contact the PharmaNet Help Desk for clarification **before** submitting the claim on PharmaNet.
- For full information on eligible compounds, see the following sections:

[List of eligible compounds](#)

[Dermatological compounds—Eligible active ingredients & criteria for coverage](#)

[Dermatological compounds—Eligible non-medicated bases](#)

List of eligible compounds

ELIGIBLE COMPOUND	CRITERIA FOR COVERAGE
Oral Solutions	N/A
Oral Suspensions	<p>Oral suspensions are a benefit only:</p> <ul style="list-style-type: none"> • for a paediatric or adult patient who cannot swallow tablets/capsules due to age or disability (includes J/G tube patients); OR • for paediatric patients only, when the prescribed dosage is not available commercially or cannot be achieved safely by modifying a commercial product; AND • when a specific compound benefit PIN has been assigned by PharmaCare for the active ingredient or particular combination of active ingredients. Refer to the List of PINs for Compounds. <p>The active ingredient(s) must be a PharmaCare benefit in another oral form or the patient must have a current Special Authority in place for the active ingredient(s). Pharmacists must document, on the original prescription, the reason the patient requires a suspension.</p>
Dermatological Compounds	<p>GENERAL CRITERIA—Dermatological compounds are a benefit when all of the following conditions are met:</p> <ul style="list-style-type: none"> • the active ingredients are prescribed by a medical practitioner • the active ingredients are on the list of eligible active ingredients, below • any specific coverage criteria for each active ingredient is met • the active ingredients are compounded into an eligible medicated base—or eligible non-medicated base, listed below • a specific compound benefit PIN has been assigned by PharmaCare for the active ingredient or particular combination of active ingredients. Refer to the List of PINs for Compounds. • Important: Transdermal compounds are not a benefit.
Topical antifungals	<ul style="list-style-type: none"> • Topical antifungal compounds are a benefit only if the patient has a current Special Authority for the specific active ingredient.
Retinoic acid	<ul style="list-style-type: none"> • Retinoic acid compounds are a benefit only if the patient has a current Special Authority for the specific active ingredient.
Preservative-Free Sterile Eye Drops	<p>Preservative-free sterile eye drops are a benefit when:</p> <ul style="list-style-type: none"> • prescribed by an ophthalmologist due to a patient allergy to preservatives in commercially available prescription eye drops; and • a specific compound benefit PIN has been assigned by PharmaCare for the active ingredient or particular combination of active ingredients. Refer to the List of PINs for Compounds. <p>The prescriber must verify on the original prescription that there has been a significant allergic reaction and identify the ingredient suspected of triggering the reaction.</p>
Plan P Injectable Analgesics—CADD Pumps	<p>The required repackaging of a prescribed injectable benefit opioid analgesic into a continuous ambulatory delivery device (CADD) pump is a compound benefit when the patient is registered under the PharmaCare Palliative Care Drug Plan (Plan P).</p>
Plan P Intrathecal Analgesics	<p>Intrathecal benefit analgesic compounds are a benefit for patients registered under the PharmaCare Palliative Care Drug Plan (Plan P).</p>

Dermatological compounds—Eligible active ingredients & criteria for coverage

ELIGIBLE ACTIVE INGREDIENT	COVERAGE CRITERIA
Anthralin	<ul style="list-style-type: none"> For psoriasis, eczema, and other severe dermatological conditions
Camphor	<ul style="list-style-type: none"> Only when in combination with at least one prescription, benefit ingredient
Clindamycin in Duonalc™	<ul style="list-style-type: none"> Only clindamycin in Duonalc™ is a benefit; clindamycin in Reversa™ or any other over-the-counter medicated base is not a benefit.
Coal Tar	<ul style="list-style-type: none"> None
Corticosteroids	<ul style="list-style-type: none"> Only when used as additives or as a medicated benefit base (e.g., hydrocortisone, betamethasone, clobetasol) Preparations containing a corticosteroid compounded with a non-benefit or over-the-counter medicated product are not benefits.
Erythromycin	<ul style="list-style-type: none"> None
Liquor Carbonis Detergens (LCD)	<ul style="list-style-type: none"> None
Menthol	<ul style="list-style-type: none"> Only in combination with at least one prescription, benefit ingredient
Metronidazole	<ul style="list-style-type: none"> None
Salicylic Acid	<ul style="list-style-type: none"> For psoriasis, eczema, and other severe dermatological conditions
Sulfur, Sulfacetamide	<ul style="list-style-type: none"> When added to, or combined with, a medicated benefit base

Dermatological compounds—Eligible non-medicated bases

- Compounds for dermatological conditions that contain non-medicated bases are eligible for coverage only when they:
 - are prescribed by a medical practitioner, and
 - include one or more of the active ingredients eligible for dermatological compound benefit status (including meeting any eligibility criteria for the active ingredient).
- Eligible non-medicated bases include—but are not limited to—the following:

Aquaphor™	Dormer™	Medi-Derm™
Aquatain™	Duonalc™	Moisturel™
Cetaphil®	Emollient cream	Neutrogena®
Cliniderm™	Eucerin™	Nutraderm™
Cold cream	Glaxal™	Spectro Gel™
Complex 15™	Hydrophilic petrolatum +/- 25% water	Unibase®
Dermabase™	Lanolin	Vanishing cream
Dilusol™	Lubriderm®	Vaseline™

Important: If a non-medicated base is not listed above, please contact the PharmaNet Help Desk to determine whether the base is eligible for coverage before submitting a claim.

Ineligible Compounds

- PharmaCare does not cover compounds containing non-benefit ingredients.
- If a compound is not eligible for PharmaCare coverage but is claimed using a Product Identification Number (PIN) for a benefit compound, the claim is subject to recovery upon audit.
- **Important:** Unsure if PharmaCare will cover a specific compound? Please contact the PharmaNet Help Desk for clarification **before** submitting the claim on PharmaNet.

Discontinued Products

- PharmaCare does not cover compounds intended to replace commercially available products that have been discontinued by the manufacturer even if the commercial product was a benefit.
- Special Authority coverage for compounds to replace discontinued products may be requested only after the patient's medical practitioner has:
 - reassessed the patient's need for that specific drug and dosage form, and
 - has contacted Health Canada's Special Access Programme to see if the product is available through that route.

Manufacturer Shortages

- PharmaCare does not automatically cover compounds intended to replace products unavailable due to a manufacturer shortage. When notified of a shortage, PharmaCare will first verify the shortage and expected duration of the shortage with the manufacturer.
- If a shortage is expected to last for an extended period of time, PharmaCare normally establishes a specific PIN and maximum price in PharmaNet for replacement compounds. Replacement compounds can then be claimed using these PINs for the duration of the shortage. The submission of Special Authority requests is not required if a specific PIN has been assigned.
- **IMPORTANT:** The PIN assigned must be in place *before* a claim is submitted.
- If PharmaCare has not assigned a specific PIN for a replacement compound, prior Special Authority approval is required.
- Information about current manufacturer drug shortages and the replacement products PharmaCare is covering (including compounds) is available by calling the PharmaNet Help Desk.

Special Authority for Non-Benefit Compounds

- PharmaCare recognizes that there may be exceptional, "last resort" circumstances in which coverage of non-benefit compounds is justified.
- Special Authority approval is required for PharmaCare coverage of non-benefit compound prescriptions.

>> See [Submitting a Special Authority Request for a compound](#) at the end of this section.

- Such requests are reviewed on a case-by-case basis.
- PharmaCare may approve full, partial or no coverage for a Special Authority request.

- If Special Authority coverage for a compound is approved, PharmaCare provides the pharmacy with a specific PIN that must be used when submitting the claim.
- Pharmacies are required to submit a [Compound Costing Worksheet \(HLTH 5425\)](#) for compounds that require Special Authority approval.
- A copy of the approved Compound Costing Worksheet must be retained on file with the original prescription.

Maximum Allowable Fees

- The maximum allowable compounding fees that PharmaCare will reimburse are specified below. If a compound does not appear on the schedule of maximum allowable compounding fees below, PharmaCare Special Authority will review compounding costs on a case-by-case basis and determine an appropriate compounding fee.
- Compounding fees must be added to the ingredient costs, and the combined amount entered in the Drug Cost field of PharmaNet. Do not include the compounding fee in the Dispensing Fee field.
- Compounding fees in excess of PharmaCare maximums—or the amount approved by Special Authority—must not be claimed in the Drug Cost field. Upcharges on compounding fees must be entered in the Cost Upcharge field so that the amount becomes payable by the patient or their alternate insurer.
- **Important:** The table below establishes maximum fees for both benefit compounds and for compounds approved via the Special Authority process that would otherwise be a non-benefit. **The inclusion of a fee for a particular type of compound in the schedule below, therefore, does not necessarily confer benefit status.**

COMPOUNDING FEE SCHEDULE

Compound	Maximum Allowable Compound Fee
• Oral Solutions	• \$20.00
• Oral suspensions	• \$20.00
• Capsules	• \$0.30 per capsule
• Suppositories	• \$40.00 *
• Oral Lozenges	• \$40.00 *
• CADD injections	• \$20.00
• Sterile IV, IM, SC Injections	• \$20.00
• Intrathecal injections	• \$40.00
• Creams/ointments/lotions: < or = 250gm/mL	• \$15.00
• Creams/ointments/lotions: > or = 251gm/mL	• \$20.00
• Sterile Eye Drops, preservative-free	• \$30.00

* Where appropriate (e.g., when the prescription will be dispensed on a frequent, short days' supply basis), the compounding fee for suppositories and oral lozenges will be pro-rated during Special Authority adjudication.

Relationship of Compounding Fees to Dispensing Fees

- Pharmacies can claim both their usual dispensing fee and a compounding fee.

Ingredient Costs

- Ingredient costs for compounds are subject to all PharmaCare [Pricing Policies](#).
- Ingredient costs for commercial products must be claimed at the lowest of any pricing policy applicable to the product (e.g., the Maximum Pricing Policy, Low Cost Alternative Program, Reference Drug Program).

>> *For more information on pricing policies, see Section 5 of [this manual](#).*

- Raw ingredients are subject to the [Actual Acquisition Cost Policy](#).
- PharmaCare expects pharmacies to use the most reasonably priced ingredients when compounding PharmaCare benefits. For example:
 - Omeprazole—use powder versus capsules
 - Sodium bicarbonate—use powder and water vs. sodium bicarbonate injectable for oral/topical products that do not require sterility.

Equipment and Supply Costs

[Policy clarification – May 15, 2014]

- PharmaCare covers the cost of the following supplies and equipment when used in the preparation of a compound:
 - required supplies and special packaging such as gelatin capsules, cassettes/bags/syringes for administration devices, IV bags, adapta-caps, EMP jars.
 - disposable, required supplies and equipment applicable to a particular compound claim, such as weighing boats, syringes, filters, needles for compounding/measuring.
- Reimbursement for eligible supplies and equipment is subject to the Actual Acquisition Cost Policy.

>> *For more information on the Actual Acquisition Cost Policy, see [Section 5.7 of this manual](#).*

- The following costs are **not** covered: Charges for equipment use, lab fees, pH metre fees, etc., as well as the cost of gowns, booties, and similar items.

Product Identification Numbers (PINs)

- Enter claims for prescription compounds using the applicable benefit or non-benefit compound PIN.
- Claims for non-benefit compounds that are submitted using a PIN for a benefit compound are subject to recovery upon audit.
- For current PINs, refer to the [List of PINs for Compounds](#).
- **Important:** When Special Authority coverage for a compound is approved, PharmaCare will provide the pharmacy with a specific PIN for use when submitting the claim. Pharmacists must use that specific PIN when submitting the claim to PharmaNet.

Contracted Compounding Services

- When a pharmacy contracts another pharmacy to provide a compound for individual prescriptions, the dispensing pharmacy may not claim more than is permitted under the PharmaCare Compounded Prescriptions policy.
- When determining if contracting this service is appropriate, the dispensing pharmacy should ensure the contracted pharmacy will provide the compound at a cost within PharmaCare policy limits.
- *[Clarification as of February 28, 2013]* If a pharmacy contracts another pharmacy to provide a compound, the pharmacy must ask the compounding pharmacy for a cost breakdown and must retain that cost breakdown on file in keeping with the record keeping requirements below.

Record Keeping Requirements

- **For benefit compounds:** Pharmacies must document the following information and retain it on file with the original prescription:
 - the compound ingredients and their concentration, dosage form and quantity
 - the itemized cost of each ingredient and total ingredient costs
 - the itemized supply and equipment costs and total costs
 - the compounding fee
- This information may be recorded on the prescription or on a separate document attached to the prescription. The [Compound Costing Worksheet \(HLTH 5425\)](#) may be used for this purpose.
- *[Clarification as of February 28, 2013]* If a change in costs occurs for a refill of a compound, pharmacies must complete and retain a new compound costing document, including all the information above.
- **For compounds requiring Special Authority:** Pharmacies must retain on file with the original prescription a copy of the [Compound Costing Worksheet \(HLTH 5425\)](#) approved during Special Authority adjudication.

Procedures

Procedural requirements for pharmacists

>> [Submitting a claim for a compound](#)

>> [Submitting a Special Authority Request for a compound](#)

>> [Submitting same-day/same-PHN compound prescriptions](#)

Submitting a claim for a compound on PharmaNet

- When submitting a claim for a compound:
 - In the **Drug Cost** field, enter the combined amount for:
 - eligible ingredient costs, plus
 - eligible compounding fee, plus
 - eligible equipment and supply costs.

Do not add the compounding fee to the Dispensing Fee field.

- In the **Dispensing Fee** field, enter your usual dispensing fee.
- In the **Upcharge** field, enter any portion of the compounding fee, ingredient costs, or supply/equipment costs that exceeds PharmaCare reimbursement maximums or the amounts approved by Special Authority.

These amounts will then be payable by the patient or their alternate insurer.

- Enter the appropriate benefit PIN from the [List of PINs for Compounds](#) or the specific PIN provided for a Special Authority compound.
- To ensure complete information regarding a compounded prescription is visible to other healthcare providers using PharmaNet for patient care purposes, the following information must be entered at the beginning of the Directions for Use (SIG) field:
 - If the PIN description identifies the active ingredient(s): Enter the dose and/or concentration along with the directions for use.
 - If the PIN description does **not** adequately identify the active ingredient: Enter the active ingredient(s), the dose and/or concentration, along with the directions for use.

Please see examples for specific compound types below.

BENEFIT COMPOUND SUSPENSIONS	
<i>Benefit compound PINs are drug/dosage form specific. To ensure the dose and concentration is visible to other PharmaNet users, enter it exactly as indicated in the example below:</i>	
<i>Prescription</i>	<i>Felodipine 10mg (in suspension) once daily.</i>
<i>PIN</i>	<i>22123241</i>
<i>Description on PharmaNet</i>	<i>felodipine compounded suspension</i>
<i>Directions to be entered in SIG field</i>	<i>Take 5mL (10mg) once daily</i>
PALLIATIVE BENEFIT CADD PUMP COMPOUNDS	
<i>CADD pumps PINs specify whether or not the ingredient is narcotic. The dose is usually included in the directions of the prescription. To identify the specific drug being used, it must be entered as indicated in the example below.</i>	
<i>Prescription</i>	<i>Hydromorphone 20mg/mL for CADD. 3.5mg/hr and 7mg BTP q20min.</i>
<i>PIN</i>	<i>22123288</i>
<i>Description on PharmaNet</i>	<i>Narcotic CADD pump compound: Palliative</i>
<i>Directions to be entered in SIG field</i>	<i>Run 3.5mg/hr (hydromorphone) and 7mg for BTP every 20min</i>
BENEFIT DERMATOLOGICAL COMPOUNDS	
<i>PINs for these medications identify the ingredient or class of ingredients. It is not mandatory that a pharmacist enter the specific corticosteroid or concentration of ingredients. See example below.</i>	
<i>Prescription</i>	<i>HC 1% + menthol 0.25% cream. BID.</i>
<i>PIN</i>	<i>22123278</i>
<i>Description on PharmaNet</i>	<i>corticosteroid + menthol +/- or camphor</i>
<i>Directions to be entered in SIG field</i>	<i>No change in entry required. Enter usual directions for use.</i>

BENEFIT COMPOUNDED PRESERVATIVE-FREE EYEDROPS	
<i>PINS for eyedrops identify the active ingredient and that the eyedrops are preservative-free. Add the concentration of the eyedrops to the directions as indicated in the example below.</i>	
<i>Prescription</i>	<i>Timolol 0.25% preservative-free eyedrops. 1 gtt BID.</i>
<i>PIN</i>	<i>22123295</i>
<i>Description on PharmaNet</i>	<i>timolol PF cpd eyedrop</i>
<i>Directions to be entered in SIG field</i>	<i>Instil 1 drop (0.25%) in left eye twice daily.</i>
PALLIATIVE BENEFIT COMPOUNDED INTRATHECAL INJECTIONS	
<i>Due to wide variation in ingredients and in concentration of ingredients, the PINs give only a general description. It is not necessary to add information to the usual instructions for use. See example below.</i>	
<i>Prescription</i>	<i>Intrathecal fentanyl 1000mcg+bupivacaine 40mcg + clonidine 100 mcg/mL</i>
<i>PIN</i>	<i>22123301 [Corrected July 22, 2014]</i>
<i>Description on PharmaNet</i>	<i>narcotic + non-narcotic intrathecal cpd: palliative</i>
<i>Directions to be entered in SIG field</i>	<i>No change in entry required. Enter usual directions for use.</i>

Important: Ensure you retain on file with the original prescription the information required in support of compound claims (see Record Keeping Requirements).

Submitting a Special Authority Request for a compound

- To obtain Special Authority approval for extraordinary coverage, the following documentation is needed:

From a medical practitioner

- A completed [General Special Authority Request](#) indicating:
 - the compound prescribed
 - why the compound is required for the particular patient
 - the name of the compounding pharmacy (so that PharmaCare can contact the pharmacy)

Palliative care compounds: *A copy of the prescription may suffice as supporting documentation for Special Authority requests for certain palliative care compounds. Contact the [PharmaNet HelpDesk](#) to determine the documents required for particular palliative care compounds.*

- For assistance in completing the request form, consult the [Special Authority Requests Prescriber Checklist](#).

From a pharmacy

- A [Compound Costing Worksheet \(HLTH 5425\)](#) including:
 - drug, concentration, dosage form, and quantity
 - itemized cost of each ingredient
 - itemized supply and equipment costs
 - days' supply

- the time required to compound (actual, active compounding time only. Do not include set-up, cleaning, or administrative time.)

Important: Retain a copy of the *Compound Costing Worksheet* on file with the prescription.

- Wait for PharmaCare Special Authority approval before dispensing the compound.
- When PharmaCare receives the Special Authority Request and cost breakdown, it will decide the amount, if any, that is eligible for PharmaCare coverage.
- PharmaCare will advise the:
 - prescriber of Special Authority approval or denial.
 - pharmacy of the amount eligible for PharmaCare coverage and the specific PIN to be used when submitting the claim.

Submitting same-day/same-PHN compound prescriptions

- If a pharmacy submits multiple claims for compounded prescriptions on the same day using the same PIN for different preparations for the same PHN, PharmaNet cannot determine that they are separate prescriptions and will reject them (PharmaNet will interpret them as an error).
- To prevent rejection of multiple legitimate same-day/same PHN claims for compounds, submit the claim with the Intervention Code UF (“Patient Gave Adequate Explanation. Rx filled as written”).

Tools & Resources

- [List of PINs for Compounds](#)
- [Compound Costing Worksheet \(HLTH 5425\)](#)
- [General Special Authority Request Form](#)
- [Special Authority Requests Prescriber Checklist](#)

5.14 Insulin

General Policy Description

PharmaCare covers insulin for patients with insulin-dependent diabetes.

Policy Details

- Insulin claims are reimbursed in the following manners:
 - **Regular insulin** is reimbursed at the regular retail price with no dispensing fee.
 - **Short acting insulin analogues** such as insulin aspart (Novorapid®), insulin lispro (Humalog®), and insulin glulisine (Apidra®) are reimbursed up to the applicable PharmaCare maximum allowable cost for the product with no dispensing fee. Patients are required to pay any cost in excess of the PharmaCare maximum allowable cost.
 - **Long acting insulin analogues** such as insulin glargine (Lantus®) and insulin detemir are reimbursed at the regular retail price with no dispensing fee. These insulins are Limited Coverage products and therefore require prior Special Authority approval for coverage.

>> See the [list of Limited Coverage Drugs on the Special Authority page](#) for more information.

- Insulin can be dispensed and the claim entered on PharmaNet without a prescription.
- When submitting a claim for non-prescription insulin, pharmacists should enter their Pharmacist ID in place of the Practitioner ID. Before using a Practitioner's ID for a claim, the pharmacist must obtain authorization from the practitioner for the insulin to be dispensed.

5.15 Needles and Syringes

General Policy Description

PharmaCare covers needles and syringes for patients with insulin-dependent diabetes.

PharmaCare does not cover needles and syringes for non-insulin therapy, alcohol swabs, BG glide syringes or safety needles.

Policy Details

Needles and Syringes for Insulin Therapy

- PharmaCare covers needles and syringes for insulin therapy for patients with insulin-dependent diabetes only.
- Claims **must** be submitted using the PIN 999725 (Needles/Syringes–Insulin Use Only).
- Needles and syringes for insulin therapy are reimbursed at the regular retail price with no dispensing fee.

Needles and Syringes for Non-Insulin Therapy

- PharmaCare does **not** cover needles and syringes for non-insulin therapy (e.g., injectable heparin or dimenhydrinate).
- Such claims **must** be entered using the PIN 66123227 (Non-Drug Medical Supplies–Non-Benefit).
- Claims for needles and syringes for non-insulin use made using the benefit PIN 999725 (Needles/Syringes–Insulin Use Only) are subject to recovery by PharmaCare.

5.16 Blood Glucose Test Strips

[Revised December 8, 2014—Changes to the eligibility procedures for coverage of Blood Glucose Test Strips and increased in provisional coverage][Revised January 1, 2015—Introduction of Quantity Limits for Blood Glucose Test Strips] [October 1, 2017: Updated to reflect the addition of Plan W]

General Policy Description

PharmaCare covers blood glucose test strips (BGTS) for eligible patients who have completed blood glucose monitoring training at an accredited Diabetes Education Centre, subject to specific annual quantity limits.

PharmaCare does **not** cover alcohol swabs, lancets, blood glucose monitoring devices/metres/sensors, or urine test strips.

Policy Details

Patient Eligibility

- PharmaCare covers BGTS for patients who meet both of the following conditions:
 - blood glucose testing is deemed medically necessary for the patient; and
 - a Diabetes Education Centre operated by a Regional Health Authority or accredited by the Ministry of Health has faxed Confirmation of Training in Blood Glucose Monitoring for the patient to Health Insurance BC.

Plan Eligibility

- BGTS are a benefit under Fair PharmaCare, Plan C (Income Assistance), Plan F (At Home Program) and Plan W (First Nations Health Benefits).
- BGTS are not covered under Plan B since routine medical supplies are to be provided to patients at no cost by the residential care facility. Refer to the [Home and Community Care Manual, Section 6](#), for details.
- Using another PharmaCare plan to submit PharmaCare claims for BGTS for individuals covered under Plan B is inappropriate. Such claims are subject to recovery.

Reimbursement

- BGTS are reimbursed at their actual acquisition cost up to the PharmaCare maximum price for the product plus a dispensing fee (up to the PharmaCare maximum allowable fee).
- Consult the [list of BGTS](#) to determine the eligibility of particular strips for PharmaCare coverage and the PIN to be used to enter claims in PharmaNet.
- Pharmacists must use the specific PIN assigned to each strip when submitting a claim.

Certificates of Training

- Diabetes Education Centres need submit only an initial Confirmation of Training in Blood Glucose Monitoring to Health Insurance BC for their patients. Once the patient's eligibility has been entered on PharmaNet, the patient receives ongoing coverage of BGTS. Re-certification is not required for PharmaCare purposes.
- If a patient's Confirmation of Training in Blood Glucose Monitoring has not yet been entered on PharmaNet, the patient can present a Blood Glucose Test Strip Coverage Voucher at the pharmacy for one-time provisional coverage of BGTS (see Provisional Coverage, below).
- When a patient's eligibility for BGTS is not yet in PharmaNet and the patient presents a Coverage Voucher, the pharmacy must FAX a copy of **both sides** of the Coverage Voucher to Health Insurance BC at (250) 405-3587.
- Note that NIHB will cover the first fill of BGTS for newly-diagnosed individuals covered under the First Nations Health Benefits (Plan W), providing the BGTS is a PharmaCare benefit. Submit these claims to NIHB using the NIHB PIN **09991549**. For issues concerning coverage of blood glucose test strips for Plan W clients, contact the PharmaNet HelpDesk.
- Patients can contact their physician or local Diabetes Education Centre for information on obtaining training and certification.

>> See the procedure below for *Determining if a Patient has a Valid Certificate of Training entered on PharmaNet below.*

Provisional Coverage

- PharmaNet Help Desk representatives may enter provisional (1 day) coverage on PharmaNet if the pharmacy faxes a copy of both sides of the Coverage Voucher to Health Insurance BC.
- A provisional certificate is subject to a \$100.00 maximum.
- Provisional coverage is provided only once for an individual.
- Provisional coverage is limited to one fill.

Quantity Limits

- PharmaCare applies an **annual quantity limit** of BGTS that will be reimbursed **per patient per calendar year** based on four categories of patients.
- The categories are determined by the type of diabetes-related medications a patient is taking, if any.
- When a claim is submitted for BGTS, PharmaNet reviews all claims submitted in the **previous 180 days** for anti-diabetes medications, whether or not the medications are covered by PharmaCare, and assigns the patient to one of four categories.
- The four patient BGTS categories and the associated annual quantity limits for BGTS are as follows:

Patient BGTS Category	Annual Quantity Limit
-----------------------	-----------------------

Managing diabetes with insulin	3,000
Managing diabetes with anti-diabetes medications with a higher risk of causing hypoglycemia†	400
Managing diabetes with anti-diabetes medications with a lower risk of causing hypoglycemia‡	200
Managing diabetes through diet/lifestyle	200

†Including but not limited to insulin secretagogues (e.g., sulfonylureas, meglitinides).

‡Including but not limited to: alpha-glucosidase inhibitors (e.g., acarbose), biguanides (e.g., metformin), dipeptidyl peptidase-4 inhibitors (DPP4i), incretin mimetics/glucagon-like peptide (GLP-1) agonists, sodium-glucose cotransporter 2 (SGLT2) inhibitors (e.g., canagliflozin), thiazolidinediones (TZDs).

- If a patient is determined to belong to more than one patient category, the patient is deemed to belong to the category with the highest annual quantity limit.
- Depending on a patient’s medication history at the time a BGTS claim is submitted, a patient may belong to different BGTS categories within a calendar year. If a change in a patient’s BGTS category occurs within the same calendar year, previous claims made during the year will be applied to their updated annual quantity limit.
- All BGTS purchased, regardless of coverage, count toward a patient’s annual limit.

Exceptions to the Annual Quantity Limit for BGTS

- There may be exceptional clinical circumstances in which patients need additional test strips above their annual quantity limit.
- Requests for coverage of additional strips, up to the maximums indicated below, can be made through the PharmaCare Special Authority process.

Patient BGTS Category	Annual Quantity Limit	Annual Exception Limit
Managing diabetes with insulin	3,000	No additional allowance
Managing diabetes with anti-diabetes medications with a high risk of causing hypoglycemia†	400	100
Managing diabetes with anti-diabetes medications with a low risk of causing hypoglycemia‡	200	100
Managing diabetes through diet/lifestyle	200	100

- The [Blood Glucose Test Strip Special Authority web page](#) provides the clinical criteria for coverage of additional strips, the Special Authority request form, information on the health care practitioners who can request coverage, and instructions.

Procedures

Procedures for Pharmacists

Determining if a Patient has a Confirmation (“Certificate”) of Training

1. Call the PharmaNet Help Desk.

2. After selecting the **PharmaCare Information Line** option, select the **Blood Glucose Certificate option**.
3. Enter the patient's **10-digit PHN**, and **press #**.

If a valid Confirmation of Training is on record, the recording will confirm this.

- As an alternative to the procedure above, the pharmacist can send the transaction through on PharmaNet, and then reverse it if adjudication indicates there is no valid certificate.

Submitting claims

Submitting claims for strips within the patient's annual limit or for which the patient or a third-party insurer will pay

- Use the PIN indicated on the list as the "Regular (Within Annual Limit/Patient Pay)" PIN.

*If the claim adjudication response is **LO – Benefit maximum exceeded**, the patient has exceeded their annual limit.*

*Submitting claims for strips **above** the patient's annual limit:*

- **A Special Authority may be in place in some cases.** If the patient indicates they requested additional strips through their doctor or a Diabetes Education Centre, please phone the PharmaCare Information Line or contact the PharmaNet HelpDesk to ask if Special Authority coverage is in place for additional strips.

⇒ **If Special Authority is in place:**

- Create a new claim with a new prescription number and use the PIN indicated on the list as the "Special Authority" PIN.

IMPORTANT: If Special Authority is in place, but you process the claim with the Regular PIN instead of the Special Authority PIN, the cost of the claim will not count toward the patient's Fair PharmaCare deductible.

⇒ **If Special Authority is NOT in place:**

- Advise the patient that they can see their doctor or visit a Diabetes Education Centre if they believe they may be eligible for approval of additional strips, **OR**
- Submit the claim using the "Regular (Within Annual Limit/Patient Pay)" PIN.

Submitting claims at the start of each calendar year:

- On January 1 of each following year, for all patients, be sure to revert to using the "Regular" PINs for all patients.

Tools & Resources

- [List of eligible blood glucose test strips](#)
- [Special Authority criteria page for Exceptions to the Annual Limit of BGTS](#)
- [Information page for medical practitioners](#)
- [Information page for patients](#)

5.17 Insulin Pumps

[Policy effective: November 17, 2008][Policy revised February 5, 2013][April 1, 2014][October 1, 2017: addition of Plan W] [July 3, 2018: Removal of age restriction for insulin pump coverage]

General Policy Description

PharmaCare covers insulin pumps to ensure that cost is not a barrier to the use of an insulin pump for patients with diabetes requiring the use of regular or rapid acting insulin.

Policy Details

Patient and Plan Eligibility

- Insulin pump coverage is available to patients who:
 - have Type 1 diabetes or another form of diabetes requiring the use of regular or rapid acting insulin, and
 - are covered under Fair PharmaCare, Plan C (Income Assistance), Plan F (Children in the At Home Program), or Plan W (First Nations Health Benefits), and
 - have been confirmed as meeting the [medical criteria for coverage](#) by their diabetes physician, and
 - have received Special Authority approval for coverage.
- Patients are encouraged to register for Fair PharmaCare before applying for insulin pump coverage. This ensures the patient knows what their Fair PharmaCare deductible is in advance and that all eligible prescription and medical device/supply costs already incurred during the year have been counted towards their deductible before their insulin pump purchase.

Coverage

- PharmaCare coverage is limited to one insulin pump every five years.
- PharmaCare covers insulin pumps in a tiered approach:
 - All approved patients will receive coverage for the first tier product, regardless of whether it is an initial or replacement pump, unless there is a significant clinical requirement preventing the patient from using the first tier product.
 - Exceptional coverage of the second tier product will be provided if the patient's clinical requirement, as detailed by the patient's endocrinologist, is assessed and approved by the Special Authority department.
- Only the makes and models of insulin pumps approved by PharmaCare are eligible for PharmaCare coverage, and only when the insulin pump is purchased from an [approved vendor](#), as identified for the patient and their endocrinologist in their Special Authority approval confirmation letter.
- Coverage will not exceed the PharmaCare maximum price for a particular insulin pump make and model, with no dispensing fee.

- Coverage is subject to the rules of the patient's PharmaCare plan. For example:
 - if a patient is on Plan C (Income Assistance), PharmaCare covers 100%.
 - if a patient is on Plan F (Children in the At Home Program), PharmaCare covers 100%.
 - if a patient is covered under Plan W (First Nations Health Benefits), PharmaCare covers 100%.
 - if a patient is covered under the Fair PharmaCare plan, PharmaCare covers 70% of costs above the patient's deductible and 100% of costs above their family maximum.

Important: Patients should register for Fair PharmaCare before purchasing an insulin pump.

Coverage Requirements

- PharmaCare coverage of insulin pumps requires prior Special Authority approval by PharmaCare. Approval is provided on a case-by-case basis.
- Special Authority approval for insulin pump coverage cannot be provided retroactively.
- Special Authority approval for the purchase of an insulin pump may be requested once every five years on behalf of an eligible patient. Special Authority requests must be submitted by the referring specialist physician or endocrinologist.
- The [Insulin Pump Special Authority web page](#) provides the medical criteria for coverage, the Special Authority request form, and instructions about how to secure coverage.
- PharmaCare sends a letter confirming or denying coverage to the referring specialist physician or endocrinologist. The physician must provide a copy of the approval letter to the patient for use in purchasing the approved insulin pump.
- The patient must provide a copy of the Special Authority approval letter to the insulin pump vendor prior to or at the time of purchase.
- Insulin pump claims for patients who do not have PharmaCare Special Authority approval will not be paid by PharmaCare.

Patients with Existing Insulin Pumps Not Covered by PharmaCare

- Patients with an existing insulin pump that was not covered by PharmaCare may be eligible for PharmaCare coverage if:
 - they meet the patient and plan eligibility criteria,
 - they meet the medical criteria for a subsequent insulin pump, and
 - their current pump is four or more years old, and
 - the manufacturer's warranty for their current pump has expired.
- The patient's specialist physician or endocrinologist must submit a [Special Authority](#) request to PharmaCare requesting coverage.
- The patient must contact their insulin pump manufacturer for a letter confirming the warranty expiry date. The physician must include this proof of warranty expiry with the Special Authority request.

Reimbursement

- Insulin pumps are reimbursed at the retail price up to the PharmaCare maximum allowable cost for the pump with no dispensing fee.

Insulin Pump Repairs and Replacement

- PharmaCare does not cover insulin pump repairs.
- PharmaCare does not cover insulin pump replacement prior to the end of the five year period since coverage for their last pump was issued.
- Insulin pump repairs and/or replacement of broken pumps are subject to the terms of the manufacturer's warranty during the warranty period. The patient should refer all enquiries about pump repair and replacement to the vendor from which the pump was purchased.

Lost or Stolen Insulin Pumps

- Replacement costs for stolen or lost insulin pumps are not covered by PharmaCare.

Information for Insulin Pump Vendors

- A copy of the PharmaCare letter confirming Special Authority approval for insulin pump coverage must be obtained from the purchaser and maintained on file. This letter will identify the model of pump that the patient has coverage for.
- Insulin pump claims for patients who do not have PharmaCare Special Authority approval for insulin pump coverage will not be paid by PharmaCare.
- Insulin pump vendors must use the correct Product Identification Number (PIN) for the insulin pump that the patient has been approved for, as identified in the Special Authority confirmation letter.
- Information on connection to PharmaNet and online claims payment processes, as well as the processing of manual, paper-based PharmaCare claims, is contained in the *PharmaCare Claims for Insulin Pump Vendors Quick Guide*.

Questions & Answers

What if I encounter problems using a pump instead of regular injections?

- Speak to your endocrinologist or diabetes specialist. If, in consultation with your specialist, it is determined that you cannot continue using a pump, you may be able to return it. Vendors may allow you to return the pump for a refund within 90 days of purchase. In this case, the vendor will reverse the PharmaCare claim and refund any portion of the cost you paid.

What if my pump stops working after the five year period is up?

- If your pump is beyond economical repair, contact the vendor of your pump and ask for a letter confirming your warranty expiry date. Take the letter to your endocrinologist or specialist physician, who will include the letter with a new Special Authority request to PharmaCare.

Tools & Resources

- [List of eligible insulin pumps and their PINs](#)
- [List of eligible insulin pump supplies and their PINs](#)
- [Insulin Pump Special Authority criteria](#)

5.18 Insulin Pump Supplies

[Policy effective: November 17, 2008] [October 1, 2017: addition of Plan W]

General Policy Description

PharmaCare covers insulin pump infusion sets/kits and reservoirs/cartridges. PharmaCare does not cover other insulin pump supplies such as batteries, battery caps, adhesive pads, and pump covers.

Policy Details

Patient and Plan Eligibility

- PharmaCare covers insulin pump infusion sets/kits and reservoirs/cartridges for patients if they are covered under:
 - Fair PharmaCare
 - Plan C (Income Assistance)
 - Plan F (Children in the At Home Program)
 - Plan W (First Nations Health Benefits)
- This coverage is available whether or not the cost of the insulin pump was covered by PharmaCare.
- PharmaCare Special Authority pre-approval is not required for insulin pump supplies.

Supplies covered by PharmaCare

- PharmaCare covers only the pods, infusion sets/kits and insulin pump reservoirs/cartridges listed on the [Insulin Pump Supplies](#) page.
- PharmaCare does not cover other insulin pump supplies, such as batteries, battery caps, adhesive pads, pump covers, etc.

Purchasing and Reimbursement

- PharmaCare reimburses claims for eligible insulin pump supplies purchased from pharmacies and approved insulin pump vendors who submit medical supply claims on PharmaNet. PharmaCare does not accept paper/manual claims for insulin pump supplies.
 - Exceptions may apply for patients living in border communities who are served by an out-of-province pharmacy that participates in PharmaCare.
- Insulin pump supplies are reimbursed at the retail price up to the PharmaCare maximum allowable cost for the product with no dispensing fee.
- Pharmacies and insulin pump supply vendors must use the correct Product Identification Number and unit of measure for the dispensed quantity when entering claims in PharmaNet.

>> For correct quantity information and insulin pump supply PINs, see [Insulin Pump Supplies](#).

Tools & Resources

- [List of eligible insulin pump supplies and their PINs](#)
- [Correct dispensed quantity information](#)

5.19 Reimbursement for Non-Returnable High-cost Injectable Drugs

[Policy effective date – April 1, 2011]

General Policy Description

PharmaCare will allocate an annual pool of funds to provide reimbursement for the adjudicated PharmaCare-paid ingredient cost for an eligible high-cost injectable drug that was ordered for a specific patient but, due to circumstances outside the control of the pharmacy, was not received by the patient.

Reimbursement is subject to the eligibility of a drug as determined by PharmaCare, the availability of funds, and the specific conditions defined below under “Reimbursement Policy and Conditions”.

Policy Details

Funding and Payments

- Funds allocated for reimbursement each fiscal year will equal 0.25% of total PharmaCare expenditures in the preceding fiscal year for the list of drugs to which this program applies.
- If the total cost of reimbursements under this program exceeds the funds available for a particular quarter, reimbursements will be pro-rated based on the proportion of total claimed reimbursements that an individual claim represents.
- Funds are allocated evenly across quarters (that is, 25% of the total funds per quarter). Any available funds that are not distributed in a given quarter are carried forward to the following quarter. Any funds not distributed at the end of the fiscal year will be retained by the Province.

Drugs Eligible for Reimbursement

- The drugs eligible for reimbursement under this policy are listed on the [Reimbursement for Non-returnable High-cost Injectable Drugs – Eligible Products List](#).

Reimbursement Policy and Conditions

- A pharmacy may submit a claim for compensation for a reversed claim for an eligible high-cost injectable drug if all the following conditions are met:
 1. The original claim was submitted to PharmaCare and the PharmaCare-paid ingredient cost amount was greater than \$0.00.
 2. The drug was ordered to fill a prescription for a specific patient. After the pharmacy ordered the drug, the patient’s treatment was terminated or suspended or the patient was otherwise unable to take delivery of the drug.
 3. The pharmacy had no opportunity to dispense the drug to another patient or return the drug for refund.
 4. The pharmacy has not submitted a previous claim for compensation of a reversed eligible high-cost injectable drug claim for the same patient within the same fiscal year (April 1 – March 31).

5. Product loss due to theft, fraud, handling error, equipment or power failure, Act of God or other cause not specifically mentioned above is not eligible for reimbursement under this policy.
6. The pharmacy must submit a claim for reimbursement by reversing the claim on PharmaNet within 30 days of the patient's service date for the original claim and use the intervention code specifically assigned for this program.

No retroactive payments can be made for omission of the intervention code or for reversals submitted more than 30 days after the date of the original claim.

- Reimbursements will be paid by a financial adjustment to the pharmacy's payment following the end of the quarter in which the claim is reversed.

Procedures

Procedures for Pharmacists

Claiming reimbursement for an eligible high-cost injectable drug

1. Reverse the original claim using the intervention code **NR – Non-returnable Drug Reimbursement**.

Note that when you submit a reversal with the NR code, PharmaNet appears to process the reversal as a regular reversal—there will be no indication of compensation. This is because NR–Non-returnable Drug Reimbursement reversals are held and processed in a batch once every quarter. Since no financial transaction takes place at the time of submission, no payment message is returned.

Tools & Resources

- [Reimbursement for Non-returnable High-cost Injectable Drugs – Eligible Products List](#)

5.20 Smoking Cessation Program Policy

[Policy Effective Date – September 30, 2011][January 1, 2016: Policy update][October 1, 2017: Updated to reflect the addition of Plan W][September 27, 2018: Removed Champix® as a full benefit]

General Policy Description

The Smoking Cessation Program covers smoking cessation products for eligible B.C. residents of any age who wish to stop smoking or using other tobacco products.

Individuals are covered for eligible prescription smoking cessation drugs under the rules of their primary PharmaCare plan (including any deductible or family maximum).

Eligible nicotine replacement therapy products are provided at no cost to all eligible individuals regardless of the rules of their primary PharmaCare plan.

Policy Details

General Policies

Smoking Cessation Products Covered

- The Smoking Cessation Program covers two types of smoking cessation products:
 - Prescription smoking cessation drugs. Bupropion (brand name Zyban®) and Varenicline (generic brands), and
 - Specific non-prescription nicotine replacement therapy (NRT) products.

Please see the specific NRTs covered in Products Covered.

Duration and Frequency of Coverage

- Coverage is limited to a single continuous course of treatment lasting up to 12 weeks (84 days) of one eligible smoking cessation product (i.e., one course of a nicotine replacement therapy, or bupropion, or varenicline) each calendar year.
- The 12 weeks (84 days) of coverage begins on the day of the first fill of the smoking cessation product.
- All eligible fills of the product must be dispensed within 84 days of the first fill.
- The Smoking Cessation Program coverage year runs from January 1 through December 31. Unused coverage from one calendar year cannot be carried over into the next calendar year.
- Starting January 1 of every year:
 - a new coverage year begins and each patient's existing previous coverage is cancelled, even if the patient is only part way through the 12-week course of treatment; and
 - coverage is reset to 84 consecutive days (12 weeks) for the new year.
- Patients who have not received all their eligible product fills for a course of treatment by December 31 may continue their treatment into the next year by accessing their new 84 days of coverage for the next year.

- PharmaCare recognizes that the pack size of a particular product may result in minor overruns in treatment duration (e.g., six days over the course of treatment for blister-packed products in a 30-day supply pack size), and these small overruns are deemed acceptable.

Supplemental Coverage or Changes in Coverage

- Individuals who want to supplement the coverage available through the Smoking Cessation Program are expected to cover the costs themselves or through their extended health plans.
- Under exceptional and compelling circumstances, PharmaCare may permit a change in the currently covered course of treatment (e.g., a change from a nicotine replacement therapy to one of the prescription smoking cessation drugs or vice versa).
- To request a change in the currently covered course of treatment, the prescribing physician must submit a [General Special Authority Request form](#) requesting exceptional case-by-case consideration.
- The request must include:
 - the patient's diagnosis
 - the current smoking cessation therapy
 - benefits that would accrue from changing the current course of treatment
 - reasons for the change
 - length of treatment needed
 - name and dosage of the alternate product, if applicable.
- Special Authority approval is not provided retroactively.

Claims for Plan B Patients

- Plan B patients are eligible for a prescription smoking cessation drug or nicotine replacement therapy (NRT).
- Since PharmaCare pays a monthly capitation fee to contracted pharmacies in addition to eligible drug costs for Plan B patients, no dispensing fees can be claimed for prescription smoking cessation drugs or non-prescription NRTs dispensed to Plan B patients.
- Claims for bupropion (Zyban®) and varenicline **generics** should be processed in the usual fashion for Plan B patients.
- To ensure NRT claims for Plan B patients adjudicate to Plan S (under which they are a benefit) and not Plan B (under which they are not a benefit), the pharmacy must ensure that the long term care facility code is not entered in NRT claims submitted on PharmaNet.

B.C. Residents Covered by Federal Drug Plans

- As with other prescription medications, PharmaCare is not the first payer for prescription smoking cessation drugs. However, federally insured patients with active Medical Services Plan coverage can choose PharmaCare coverage for NRTs, even if their federal insurer provides coverage. This includes individuals insured under:
 - Veterans Affairs Canada
 - Non-Insured Health Benefits Program
 - RCMP (non-retired members)

- [Interim Federal Health Program](#) (delivered through Immigration, Refugees and Citizenship Canada)

To process a Smoking Cessation Program claim for an individual covered under a federal drug plan, please see [Procedures for Pharmacists](#).

Medication Review Eligibility

- Smoking cessation prescription drugs dispensed under the Smoking Cessation Program count as qualifying medications for purposes of determining a patient's eligibility for medication review services.

>> See the [Section 8.9, Medication Review Services](#) for further information.

Partial Fills Due to Product Shortages

- If a pharmacy cannot provide a patient with the full amount of their prescription smoking cessation drug or nicotine replacement therapy, pharmacists should enter only one claim for the full amount, and ask the patient to return for the balance.
- If a patient does not return to pick up the balance, pharmacists must adjust their claim to reflect the amount actually dispensed and picked up.
- Pharmacies cannot substitute a non-benefit product for those listed as benefits under the Smoking Cessation Program.

Nicotine Replacement Therapies

Eligibility

- Coverage is available to all smokers (and users of other tobacco products) of any age who are B.C. residents with active Medical Services Plan (MSP) coverage.
- To enroll, both the individual and pharmacist must sign a [BC Smoking Cessation Program Declaration and Notification form \(HLTH 5464\)](#).

Products Covered

- PharmaCare coverage of nicotine replacement therapies is limited to the products in the list of [Eligible Smoking Cessation Products](#).
- Claims for nicotine replacement therapies must be submitted with the applicable NPN.
- **Important:** Please note that only the package sizes specified are eligible for coverage under the program. Claims for package sizes not specified in the list of [Eligible Smoking Cessation Products](#) above are subject to recovery upon audit.

Access to Nicotine Replacement Therapies

- Eligible individuals receive no-cost (100%) coverage of the designated nicotine replacement therapies (NRTs) purchased at a pharmacy in the same manner as prescription drugs.
- Patients do not need a prescription for NRT coverage.
- Both the patient and the pharmacist must sign a [BC Smoking Cessation Program Declaration and Notification form \(HLTH 5464\)](#).

- Claims without a corresponding signed declaration are subject to recovery upon audit.
- Pharmacies must submit a claim on PharmaNet at the time of purchase to access PharmaCare coverage for NRTs for their patients.
- A new claim must be entered in PharmaNet for each NRT fill.
- NRT coverage is not subject to, and does not contribute to, the Fair PharmaCare annual deductible or family maximum.

Maximum Days' Supply Per Fill and Dispensing Interval

Nicotine Patches

- Eligible nicotine patches are to be dispensed in four week (28 day) intervals.
- PharmaCare limits coverage of eligible nicotine patches to a maximum 28-day supply.
- Patients are covered for 4 boxes of patches (total 28 patches) every 28 days.
- Over the total 12-week (84-day) course of treatment, patients are eligible for coverage of up to 84 NRT patches (supplied as 12 boxes with 7 patches in each box). This quantity is based on the maximum dosing specified in the product monograph.

Nicotine Gum

- Over the total course of treatment, patients are eligible for up to 945 pieces of NRT gum (supplied as 9 boxes with 105 pieces in each box). This quantity is based on the maximum dosing specified in the product monograph. On average, most patients need 3 boxes of NRT gum (total 315 pieces) every 28 days.

Nicotine Lozenges

- Over the total 12-week (84-day) course of treatment, patients are eligible for up to 792 pieces of NRT lozenge (supplied as 9 bottles with 88 lozenges in each bottle). This quantity is based on the dosing range specified in the product monograph. On average, most patients need 3 bottles of NRT lozenge (total 264 lozenges) every 28 days.

Nicotine Inhaler

- Eligible nicotine inhaler cartridges are to be dispensed in four week (28 day) intervals.
- PharmaCare limits coverage of eligible nicotine inhaler cartridges to a maximum 28-day supply per dispense.
- Patients are covered for 4 boxes of inhaler cartridges (total 168 inhaler cartridges) every 28 days.
- Over the total 12-week (84-day) course of treatment, patients are eligible for up to 504 nicotine inhaler cartridges (supplied as 12 boxes with 42 inhalers cartridges in each box). This quantity is based on the dosing range specified in the product monograph.

Changing Nicotine Replacement Therapy Products During a Course of Treatment

- During a course of treatment, patients may switch between different types of nicotine replacement therapy—or from one dosage strength to another—only when picking up one of the three fills covered for the course of treatment. Such changes do not require Special Authority approval.
- All Smoking Cessation Program policy limitations with respect to maximum days' supply, dispensing intervals and dispensing fees continue to apply regardless of changes in product or strength.
- Any changes in product or strength that may create a dispensing that is not in compliance with the Smoking Cessation Program policy limitations require prior Special Authority approval.

Dispensing Fees

- Community pharmacies are reimbursed for a dispensing fee up to the PharmaCare maximum for the dispensing of eligible nicotine replacement therapies (NRTs).
- PharmaCare covers the dispensing fee for up to three dispenses per patient per course of treatment with one of the designated NRTs.
- The Frequency of Dispensing policy (see [Section 8.3](#)) applies to NRTs.
- PharmaNet cannot automatically reject NRT-related dispensing fees above the maximum allowable three dispensing fees. PharmaCare requires pharmacies to check a patient's PharmaNet record to ascertain the number of previous NRT fills a patient has had and to ensure no more than three dispensing fees are claimed per patient per course of treatment.

Clinical Services Fees

- Nicotine replacement therapies are not eligible for Clinical Services fees.

Special Services Fees

- Nicotine replacement therapies are not eligible for Special Services fees.

Application of the Full Payment Policy

- The Full Payment Policy (see [Section 5.10](#)) applies to all PharmaCare paid nicotine replacement therapy claims since they are covered 100% in all cases. Therefore, pharmacies may not charge individuals directly for any amount in excess of the PharmaCare paid amount for nicotine replacement therapy claims covered under the Smoking Cessation Program.

GST Reimbursement for Nicotine Replacement Therapies [revised Nov 13, 2013]

- Nicotine replacement therapies (NRTs) and fees to dispense them are subject to 5% GST.
- The GST must not be included as part of the claim for either the NRT product or the dispensing fee.
- The GST must not be collected directly from either the patient or a third-party insurer.
- The provincial government reimburses pharmacies for the GST associated with NRT claims paid under the Smoking Cessation Program. Pharmacies are reimbursed on a quarterly basis.
- Each pharmacy's NRT claims are reviewed and pharmacy payments are adjusted to reimburse 5% for the GST.

Returns or Exchanges of Nicotine Replacement Therapies

- Patients cannot return any unused products for exchange, reimbursement or credit.

Smoking Cessation Drugs

Eligibility

- Coverage is available to all smokers (and users of other tobacco products) of any age who are BC residents and are registered for Fair PharmaCare or Plan B (Permanent Residents of Licensed Residential Care Facilities), Plan C (Recipients of Income Assistance), Plan G (Psychiatric Medications Plan) or Plan W (First Nations Health Benefits).
- Both the patient and the pharmacist must sign a [BC Smoking Cessation Program Declaration and Notification form \(HLTH 5464\)](#).

Products covered

- PharmaCare coverage of prescription smoking cessation drugs is limited to the following products.

DIN	Brand Name	Dosage Form	Strength
2291177	CHAMPIX	TABLET	0.5 MG
2291185	CHAMPIX	TABLET	1 MG
2298309	CHAMPIX Starter Package	TABLET	0.5 MG & 1 MG
2419882	APO-VARENICLINE	TABLET	0.5 MG
2419890	APO-VARENICLINE	TABLET	1 MG
2435675	APO-VARENICLINE	TABLET	0.5 MG & 1 MG
2238441	ZYBAN	TABLET ER	150 MG

- Of the different versions of bupropion, PharmaCare covers only Zyban® for smoking cessation. Wellbutrin®, Wellbutrin XL® and generic bupropion are not covered as smoking cessation drugs.
- To ensure the prescription is for the version of bupropion eligible for Smoking Cessation Program coverage, prescribers are to indicate on the prescription:
 - the brand name Zyban®,
 - the prescription is for “smoking cessation,” and
 - “no substitutions.”
- PharmaCare only fully covers generic versions of varenicline. Brand name varenicline (Champix®) is a partial benefit.

Coverage

- Coverage is subject to the applicable PharmaCare plan rules. Plans B, C, G and W provide 100% coverage. Fair PharmaCare provides partial, full or no coverage depending on whether an individual has met their annual deductible and family maximum.
- Coverage does not require a request for Special Authority; however, Limited Coverage criteria should be used to assess patient eligibility for coverage.

>> See the [Limited Coverage Drug Program Criteria Information for details](#).

- Patients require a prescription to be eligible for coverage.
- Individuals covered by Fair PharmaCare who receive eligible prescription smoking cessation drugs but who do not receive PharmaCare coverage in whole or part because they have not met their Fair PharmaCare deductible, are eligible for certain free nicotine replacement therapies for that same calendar year.
- Individuals covered by Fair PharmaCare who receive PharmaCare coverage in whole or part for an eligible prescription smoking cessation drug are **not** eligible for coverage of nicotine replacement therapies in that same calendar year.

Maximum Days' Supply Per Fill and Dispensing Interval

- Eligible prescription smoking cessation drugs are to be dispensed in four week (28 day) intervals.
- PharmaCare covers a maximum 28-day supply of eligible prescription smoking cessation drugs.

Dispensing Fees

- Except as noted below, PharmaCare covers the dispensing fee for up to three dispenses per patient (not per pharmacy) per course of treatment with an eligible prescription smoking cessation drug.
- When a 14-day starter pack of varenicline (**generics**) is dispensed patients may receive 4 fills of medication (two in the first 28 days, followed by two additional fills of 28 days each) and pharmacies may claim up to a maximum of 4 dispensing fees per patient per course of treatment.
- If specified on the prescription, PharmaCare may cover more frequent dispenses over the course of treatment up to a maximum specified in [Section 8.3](#), Frequency of Dispensing Policy.

Clinical Services Fees

- Prescription smoking cessation drugs are eligible for clinical services fees for dose and regimen changes but not for prescription renewals or therapeutic substitutions.

Special Services Fees

- Prescription smoking cessation drugs are eligible for Special Services Fees.

Application of the Full Payment Policy

- The Full Payment Policy (see [Section 5.10](#)) applies to prescription smoking cessation drug claims in the same manner as any other prescription drug claim.

Procedures for Pharmacists

Submitting Claims for Nicotine Replacement Therapies

1. Confirm in PharmaNet that the patient has received PharmaCare coverage for no more than two previous nicotine replacement therapy (NRT) fills in the current calendar year, with respect to the 84-day course of treatment. If the patient has had three fills in the current calendar year, explain to them that they have used up their coverage for the current year.

Check PharmaNet not your local pharmacy system since a patient may have had NRTs dispensed through a different pharmacy.

2. Ensure that the Declaration and Notification form (HLTH 5464) is fully completed, that is, ensure all required fields are completed and that both you and the patient have signed the form.

A declaration form must be signed for each NRT fill or refill.

3. In separate yearly files, file the declaration form by patient name, then **chronologically**.

Claims without a corresponding signed declaration form or with only one signature are subject to recovery upon audit.

4. Enter the fill as a new prescription (not a refill).
5. Enter the appropriate product NPN.
6. Enter your pharmacist College ID in the **Practitioner ID** field.
7. Enter the number of units dispensed in the **Dispensed Quantity** field (i.e., the number of pieces of gum, lozenges, patches or inhaler cartridges).
8. Enter the drug cost and dispensing fee. Do **not** add GST to either the drug cost or the dispensing fee.

Advising the patient about subsequent fills

- If a patient has refills remaining, remind them to wait at least two weeks before refilling. This ensures their refill is within the limits of the Refilling Prescriptions Too Soon policy.

Submitting Claims for Prescription Smoking Cessation Drugs

1. Confirm that the prescribed drug is eligible for Smoking Cessation Program coverage.
 - Prescriptions for varenicline (Champix® **and generics**) can be written in the usual fashion.
 - Prescriptions for bupropion must specify the Zyban® brand of bupropion and indicate the prescription is for smoking cessation.
2. Review the patient's medication history in PharmaNet to determine if the patient has already received prior PharmaCare coverage for a course of treatment with a smoking cessation product (nicotine replacement therapy, bupropion or varenicline) in the current calendar year or has used up their coverage for a current course of treatment.

Note that you must use PharmaNet rather than your local system as a patient may have had smoking cessation products dispensed by another pharmacy. These fills count towards the total allowable for the patient.

3. If the patient has not had prior coverage or has not used up their current coverage, ensure that the Declaration and Notification form (HLTH 5464) is fully completed, that is, ensure all required fields are completed and that both you and the patient have signed the form.

A declaration form must be signed for each prescription fill or refill.

4. In yearly files, file the declaration form by patient name, then chronologically.
5. Submit the claim.

- If a patient has refills remaining, remind them that, to receive PharmaCare coverage, they cannot refill their prescription until they have a remaining supply of 14 days or less.

Submitting Claims for Patients with Federal Drug Plan Coverage

- Patients with federal drug coverage may request coverage under the Smoking Cessation Program even if they have existing smoking cessation aid coverage under their federal plan.
- Individuals choosing coverage under the Smoking Cessation Program are subject to all policies and procedures of the program.
- Submit the claim as described in the **Claims for Prescription Smoking Cessation Drugs** and **Claims for Nicotine Replacement Therapies** sections above.
- When a patient covered by a federal drug plan requests NRTs or presents a prescription for one of the smoking cessation drugs covered by the program:
 1. Submit the claim to the patient's federal plan first.
 2. If the federal plan indicates it will **not** cover the product for the patient then:
 - Remove the federal coverage in your local system.
 - Call the PharmaNet HelpDesk to have the federal coverage flag removed, so that:
 - the NRT claim can adjudicate as PharmaCare pays 100%, or
 - the prescription smoking cessation drug claim can adjudicate according to the rules of the patient's PharmaCare plan.
 3. If the federal plan claim indicates it **will** cover the product, the patient can choose PharmaCare coverage instead.
 - Ensure the patient understands that, while NRTs will be free of charge, the prescription drugs may not (depending on the rules of the patient's primary PharmaCare plan, including any deductible requirements).
 - For example, patients covered by Fair PharmaCare, due to annual deductibles, receive more coverage under their federal plan for a prescription smoking cessation drug.
 4. If the patient chooses PharmaCare coverage, remove federal coverage as established in Step 2 above.

Tools and Resources

- Visit the appropriate Smoking Cessation Program website for more information:
 - For [pharmacists](#)
 - For [patients](#)
 - For [prescribers](#)

5.21 Ostomy Supplies

General Policy Description

PharmaCare covers certain ostomy supplies for patients who have undergone surgery on the bowel and/or bladder that results in a colostomy, ileostomy or urostomy, requiring the application of an external pouch.

Policy Details

- PharmaCare covers eligible ostomy supplies for patients who have undergone surgery on the bowel and/or bladder that results in a colostomy, ileostomy or urostomy, requiring the application of an external pouch.
- Coverage is subject to the rules of the patient's primary PharmaCare plan, including any annual deductible requirements.
- PharmaCare covers eligible ostomy supplies up to the regular retail price with no dispensing fee.
- Claims must be entered into PharmaNet using the Product Identification Number (PIN) indicated in the list of eligible ostomy supplies.
- Other ostomy supplies, including but not limited to the following, are **not** PharmaCare benefits.
 - Catheters—for any use
 - Ostomy support belts
 - Pouch covers
 - Night drainage bottle covers
 - Stoma hole cutters
 - In-pouch deodorants—such as Banish, M9, Uri-Kleen
 - Cleansers—such as Hollister Restore Wound Cleanser, Uni-Wash, ConvaTec AloeVesta products
 - Room deodorants—such as M9
 - Tapes (other than paper-type)—such as Elastoplast, Dermicel, Waterproof, 3M Blenderm
 - Creams—such as Sween Cream, Chiron Cream, BAZA
 - Lubricants—such as KY Jelly, Hollister Stoma Lubricant
 - Products for management of incontinence—such as catheters, condoms, Attends, drainage containment equipment
 - Hydrocolloid dressings—such as DuoDerm, Restore, Tegaserb
 - Transparent dressings—such as Opsite, Tegaderm
 - Sterile/unsterile gauze
 - Alcohol swabs
 - Products for the management of feeding tubes and draining wounds—such as Hollister Drain Tube Attachment Device, Hollister Drainage Collectors
 - Instruments—such as scissors, dressings sets

5.22 *Prosthetics and Orthotics*

General Policy Description

The Prosthetic and Orthotic Program helps patients to achieve or maintain basic functionality. PharmaCare helps eligible patients pay for the costs of eligible prostheses and orthoses, subject to the rules of their PharmaCare plan, including any annual deductible requirement.

Policy Details

Full details of the Prosthetic and Orthotic Program and associated policies are provided in:

- [General statement of program policy](#)
- [Detailed policy and procedural requirements](#)

5.23 Pricing Exceptions Where Multiple Dosage Forms or Strengths Are Available

[Policy previously included in Section 5.11]

General Policy Description

To ensure the best value is obtained for expenditures on drugs available in multiple dosage forms and/or strengths, PharmaCare may limit reimbursement of a particular dosage form or strength to the cost of a lower cost dosage form and/or strength.

Policy Details

- PharmaCare may limit reimbursement of a particular dosage form or strength to the cost of a lower, or the lowest, priced dosage form and/or strength of a drug.
- For example:
 - If the price of the capsule, sustained release or enteric-coated tablet is significantly higher than the price of the tablet, prices may be based on that of the tablet.
 - If a product strength is priced significantly higher (proportionally) than the price of other strengths, prices may be pro-rated based on that of the lowest cost strength.
 - If the price of the suspension is significantly higher than the price of the solution, prices may be based on that of the solution.
 - For creams and ointments, if the per-unit-price of the tube is significantly higher than the per-unit price of the jar, prices may be based on that of the jar.
- To determine the specific pricing exceptions in force under this policy refer to the [Pricing Exceptions List](#).