



# BC PharmaCare Newsletter

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## UPDATE FOR NON-PHARMACEUTICAL SUPPLIERS

### Ensure your patients get the coverage they need



Did you know that any item that is a PharmaCare benefit counts towards a patient's Fair PharmaCare annual deductible and family maximum *whether or not PharmaCare contributes to the cost?*

Be sure to enter all claims for PharmaCare benefits on PharmaNet (or remind your patient to submit a claim to PharmaCare). The portion eligible for PharmaCare coverage will be applied towards the patient's deductible, ensuring they get the appropriate coverage for PharmaCare benefits they purchase later in the year.

The use of PharmaNet is not intended as a substitute for professional judgment.  
Information on PharmaNet is not exhaustive and cannot be relied upon as complete.

The absence of a warning about a drug or drug combination is not an indication that the drug or drug combination is safe, appropriate or effective in any given patient. Health care professionals should confirm information obtained from PharmaNet, and ensure no additional relevant information exists, before making patient care decisions.

## CHANGES TO PHARMACARE COVERAGE OF MULTIPLE SCLEROSIS (MS) DRUGS

PharmaCare is changing its coverage of drugs used to treat Multiple Sclerosis (MS).

### A. NEW PHARMACARE COVERAGE FOR NATALIZUMAB (TYSABRI®)

Effective **October 26, 2010**, natalizumab (Tysabri®) became available for PharmaCare coverage as a Limited Coverage benefit when prescribed by a neurologist according to the following criteria:

**Initial Coverage (One Year):** As third-line monotherapy for the treatment of relapsing-remitting multiple sclerosis (MS), diagnosed according to the current clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist from a designated MS clinic, for patients who meet ALL of the following criteria:

1. Patient has failed to respond to full and adequate courses of treatment with at least two (2) other disease modifying therapies, OR has contraindications or intolerance to these therapies, AND
2. Patient has had a significant increase in T2 lesion load compared to a previous MRI scan OR at least one gadolinium-enhancing lesion, AND
3. Patient has had at least two (2) disabling attacks of MS in the previous one (1) year.

**Renewal Coverage (Annual):** When prescribed by a neurologist from a designated MS clinic, for the treatment of patients with relapsing-remitting multiple sclerosis, a lack of neutralizing antibodies, AND who have demonstrated continued therapeutic benefit outweighing any potential risks, as shown by relapse rate, EDSS, MRI scan, or overall clinical impression.

### B. NEW PHARMACARE COVERAGE FOR INTERFERON BETA-1B (EXTAVIA®)

PharmaCare began covering interferon beta-1b (Extavia®) effective **October 26, 2010**, as a Limited Coverage drug. The coverage criteria for interferon beta-1b are the same as for the other interferons:

**Initial Coverage (One Year):** As first- or second-line monotherapy for the treatment of relapsing-remitting multiple sclerosis OR secondary progressive MS, diagnosed according to the current clinical criteria and magnetic resonance imaging (MRI) evidence, when prescribed by a neurologist from a designated MS clinic, for patients who meet ALL of the following criteria:

1. Patient has had at least two (2) disabling attacks of multiple sclerosis in the previous two (2) years, AND
2. Patient is ambulatory with or without aid (EDSS of 6.5 or less), AND
3. Patient is 18 years of age or older.

**Renewal Coverage (Annual):** When prescribed by a neurologist from a designated MS clinic for the treatment of patients who have relapsing-remitting multiple sclerosis OR secondary progressive MS, AND who have demonstrated continued therapeutic benefit outweighing any potential risks, as shown by relapse rate, EDSS, MRI scan, or overall clinical impression.

**Change of Therapy Coverage:** When prescribed by a neurologist from a designated MS clinic for the treatment of patients who have relapsing-remitting multiple sclerosis OR secondary progressive MS, AND who have experienced failure or intolerance to a previous disease-modifying therapy.

*continued...*

## C. IMPLEMENTATION OF A COLLABORATIVE PRESCRIBING AGREEMENT FOR THE PRESCRIBING OF INTERFERON BETA 1A (AVONEX® AND REBIF®), INTERFERON BETA 1B (BETASERON® AND EXTAVIA®) AND GLATIRAMER (COPAXONE®)

Effective **October 26, 2010**, MS clinic-affiliated neurologists wishing to prescribe interferon beta 1a (Avonex® and Rebif®), interferon beta 1b (Betaseron® and Extavia®) and glatiramer (Copaxone®) will be able to enter into a Collaborative Prescribing Agreement.

**PHARMACISTS PLEASE NOTE:** Under the terms of the Collaborative Prescribing Agreement, physicians will write "Submit as zero cost to PharmaCare" on prescriptions that do not qualify for PharmaCare coverage (i.e., if the patient does not meet the Limited Coverage criteria.) When you receive prescriptions with this note, submit the claim with the Intervention Code **DE—Adjudicate to \$0.00 as requested**. This ensures appropriate PharmaCare coverage and accurate prescribing feedback to physicians.

PharmaCare coverage will be provided for patients with a prescription written by a MS clinic neurologist who has entered into a Collaborative Prescribing Agreement. Please note that Special Authority coverage cannot be provided retroactively and that actual coverage is subject to the patient's PharmaCare plan rules, including any annual deductible requirement.

Due to the individual nature of each Collaborative Prescribing Agreement, the exemption is granted only to the signing neurologist and not to his or her delegates.

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### Looking for the correct quantities to use for claims for the drugs above?

Check our **Correct Quantities** document at [www.health.gov.bc.ca/pharmacare/pdf/CorrectQuant.pdf](http://www.health.gov.bc.ca/pharmacare/pdf/CorrectQuant.pdf).

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## SPECIAL SERVICES FEES

The number of Special Services fees that PharmaCare paid each month over the past year:

Sep 2010 .... 2,211	May 2010....2,097	Jan 2010..... 1,731
Aug 2010.... 2,170	Apr 2010 .....2,108	Dec 2009 .... 3,103
Jul 2010..... 1,999	Mar 2010 ....2,109	Nov 2009.... 2,584
Jun 2010..... 2,233	Feb 2010 .....1,832	Oct 2009..... 2,758

## BENEFITS

### New Benefits

The following new product is now an eligible PharmaCare benefit for Fair PharmaCare and Plans B, C, F, and, if indicated below, Plan G and/or Plan P.

DIN	DRUG NAME	PLAN G	PLAN P
2324997	LUMIGAN® RC (bimatoprost) 0.01% ophthalmic drops	No	No

**BENEFITS, CONTINUED****Changes to Insulin Pump and Insulin Pump Supply Benefits**

Effective immediately, the following **insulin pumps** are eligible for PharmaCare coverage.

PIN	Product Description
45230007	MiniMed® Paradigm® Veo™ MMT554
45230008	MiniMed® Paradigm® Veo™ MMT754

Effective immediately, the following **insulin pump supplies** are eligible for PharmaCare coverage.

PIN	Product Description	Product Examples / Notes
46340022	Medtronic Paradigm Silhouette™ Cannula Only Infusion set MMT 369600 and MMT370600*	Paradigm Silhouette (13mm and 17mm) Cannula only (10 cannulas with no tubing)

\* The Medtronic Paradigm Silhouette Combo Set (10 cannulas, 5 tubing) is no longer available. It is being replaced by the Medtronic Paradigm Silhouette Cannula Only Infusion Set (10 cannulas per box with no tubing) which is to be claimed under the new PIN 46340022. The Medtronic Paradigm Silhouette Infusion Set (10 cannulas, 10 tubing) is still available and will continue to be claimed under PIN 46340015.

The following **insulin pumps** are no longer being manufactured.

PIN	Product Description
45230004	Medtronic Paradigm 522
45230005	Medtronic Paradigm 722