BC PharmaCare Newsletter

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March 1, 2022

The PharmaCare Newsletter team works from the territory of the Lekwungen peoples, including the Songhees and Esquimalt Nations. Our gratitude extends to them, and all the Indigenous peoples on whose territories and lands we build relationships.

The PharmaCare Newsletter is published by the Pharmaceutical, Laboratory & Blood Services Division to provide information to British Columbia's health care providers.

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.

www.gov.bc.ca/pharmacarepharmacists
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www.gov.bc.ca/pharmacaredeviceproviders

BRITISH COLUMBIA

In this edition

COVID-19 Vaccinations: Single entry; Fee Changes (Published Mar 29)

Recording requirements and administration fees are changing for COVID-19 vaccinations. As of April 1, 2022, pharmacies will record COVID-19 vaccination information once only ("single-entry"), in the ImmsBC application, instead of in both PharmaNet and ImmsBC. As a result, the "dual-entry" fee of $1 will end on April 1, 2022.

Also, as indicated when it was launched, the $4 weekend premium ended on Sunday, March 27, 2022.

The information entered in ImmsBC will result in the automatic entry of the vaccination information in PharmaNet. However, this automatic process will be different from what pharmacists are familiar with, and the information will not be visible or present in the patient's PharmaNet dispense history. The information in PharmaNet will be used to pay pharmacies the vaccination administration fee, but will not be accessible for clinical purposes. Pharmacists, physicians, and other health care professionals can view the patient's full clinical record of COVID-19 vaccinations in ImmsBC or CareConnect.

As information entered in ImmsBC for COVID-19 vaccinations is then entered in PharmaNet, the Ministry expects that pharmacy entry of information in ImmsBC will comply with the same standards as any other entry in PharmaNet.

When a vaccination is entered in ImmsBC, a drug use evaluation (DUE) will not automatically occur. While the risk of adverse side effects is low, pharmacists are reminded to check a patient's allergies and drug history before administering the vaccine, and to record any reaction in ImmsBC.

Pharmacies should not submit COVID-19 vaccination claims in PharmaNet for service dates on or after April 1, 2022, neither under the PIN nor the DIN. PharmaNet will be actively monitored for any such claims, and in addition to such claims being subject to recovery, pharmacies may be contacted directly to reverse the claims. In extenuating circumstances, vaccinations administered before April 1 can be entered or corrected on or after April 1 using the PINs.

Payment Change

The COVID-19 vaccine administration fee for community pharmacies will be $18 per administration as of April 1, 2022.

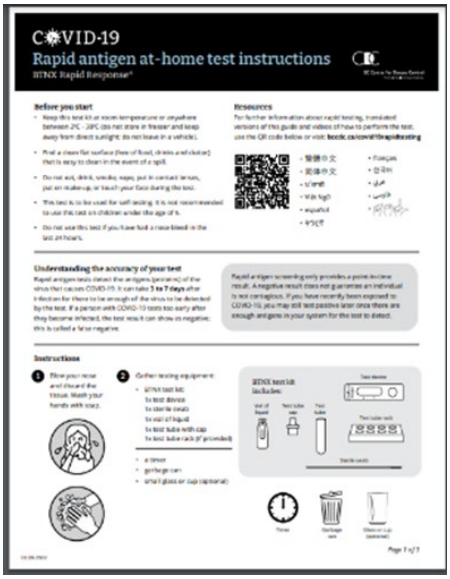
The $1 "dual entry" fee announced on February 14, 2022, will be rescinded on April 1, 2022, and the $4 weekend premium announced on December 8, 2021, ended March 27, 2022. The $4 weekend premium will be paid in a lump sum with payment details provided in a future newsletter.

Pharmacies can continue to have other qualified health care professionals such as nurses and pharmacy technicians administer COVID-19 vaccinations. Vaccinations performed by these other professionals will continue to be eligible for the $18 COVID-19 vaccine administration fee until the end of B.C.'s COVID-19 public health emergency.

As COVID-19 vaccination claims will no longer be entered in PharmaNet through the usual local pharmacy system, pharmacies will not be able to reconcile monthly vaccine payments using their local system; they will need to use the report available in ImmsBC. The Pharmacy Remittance Advice Form will continue to be available on request from Health Insurance BC and will include vaccination administration fees paid based on vaccinations entered in ImmsBC.

$5 service fee for rapid antigen tests

Effective March 21, 2022, community pharmacies can claim $5 for providing the publicly funded Rapid Response® COVID-19 Antigen Test kit ("RAT kit") along with an instruction sheet to B.C. **residents aged 18 years and over**. The RAT kit fee was launched on February 23 for B.C. residents, originally to those over 70. The age limit was lowered to 60 on March 7; to 50 on March 11; to 40 on March 15; and to 30 on March 21; and 18 on March 23.


COVID-19
Rapid antigen at-home test instructions

More than 865,000 kits were originally pre-positioned with distributors. Order your kits through your distributor if you've not already done so.

The instruction sheet (PDF) can be printed from the BC Centre for Disease Control (BCCDC) website in different languages*. Pharmacies should include a sheet with every kit, or share the QR code with patients who want to read the instructions online.

Patients must present their BC Services Card (or CareCard) to receive a kit. People can also pick up kits for family members or another person; they must provide the person's name, date of birth, and PHN (they do not need to show their BC Services Card).

Pharmacists are to check patient ID for age. The age limit will be lowered as more kits become available; watch the PharmaCare Newsletter for updates.

The tests are available for asymptomatic patients and are to be used if they become symptomatic. They should not be used for other purposes. People with symptoms of COVID-19 should be encouraged stay home and follow BCCDC health guidance.

The 5-test kits are being distributed to community pharmacies through the regular pharmacy distribution channels.

A RAT Kit Fee PIN has been created under PharmaCare Plan Z (Assurance Plan). See PharmaNet Instructions below.

*Arabic | Chinese (Simplified) | Chinese (Traditional) | Farsi | French | Korean | Punjabi | Spanish | Vietnamese | Tigrinra

28-day claim limit

Pharmacists may claim the fee only once per patient every 28 days. If a patient exceeds the quantity limit (one kit per 28 days), PharmaNet will return the response code "LO," meaning "benefit maximum exceeded." Pharmacies **must not** provide another kit if the patient has received one at any pharmacy within the 28-day window. Note: Patients cannot pay for a publicly funded kit.

Plan Z

The RAT Kit Fee is a related service under Plan Z. Plan Z products and services are fully covered for any resident of B.C. with active MSP coverage.

Products and services covered under Plan Z are subject to the Full Payment Policy. Providers may not charge patients any costs for a drug, substance, or related service that is a full benefit under Plan Z.

Non-B.C. residents

Do not provide RAT kits to non-B.C. residents. Instead, direct them to the nearest B.C. COVID-19 collection centre to be assessed and tested. See the map of B.C. collection centres.

PharmaNet instructions

1. Enter $0.01 in the Drug Cost field.
2. Enter PIN for 5-test kit: **66128312**.
3. Enter Quantity as "1".
4. Enter $5.00 in the Dispensing Fee field.
5. If response code is “LO,” patient has exceeded the quantity limit (one kit per 28 days). Do not provide a kit and do not claim the service fee.

Changes to enoxaparin coverage and modifying criteria for cancer-associated thrombosis (CAT) (published Mar 23)

Effective March 22, 2022, enoxaparin biosimilars are added for PharmaCare coverage and limited coverage criteria is being modified for CAT. There is no switch period involved, and therefore no support fees.

enoxaparin biosimilar listings

Drug name	PharmaCare-covered biosimilars	Condition(s)
enoxaparin (Lovenox®; Lovenox® HP)	Inclunox®; Inclunox® HP; Noromby®; Noromby® HP; Redesca®; Redesca® HP	prophylaxis and treatment of venous thromboembolism (VTE)

As of March 22, PharmaCare is de-listing enoxaparin originator (Lovenox) and listing biosimilar versions Inclunox, Noromby, and Redesca as limited coverage benefits for the same conditions.

Existing PharmaCare patients taking Lovenox for prophylaxis and treatment of venous thromboembolism (VTE) will keep their currently approved coverage until it ends. Treatment is usually expected to be short term, but if a renewal of coverage is needed, patients must switch to a biosimilar for continued coverage. As of March 22, only enoxaparin biosimilars will be covered for new starts or renewals of prior coverage.

For orthopedic surgeons who have signed a collaborative prescribing agreement (CPA) for Lovenox, no action is required. The CPA will automatically be adjusted to replace Lovenox with the approved biosimilars. Orthopedic surgeons with CPAs will be exempt from submitting Special Authority requests for the biosimilars, if their patient meets criteria. See our quick reference sheet for prescribers.

Injection devices for enoxaparin biosimilars may look like the ones for Lovenox, but may feel or be slightly different (e.g., more pressure needed). Practitioners should read the manufacturer's instructions and be familiar with the various devices in order to counsel patients.

Note: Special Authority requests for Lovenox coverage will only be considered on an exceptional, case-by-case basis.

>> See the criteria page for biosimilar enoxaparin
>> See the drug decision summary for enoxaparin

Modified criteria for cancer-associated thrombosis (CAT)

Effective March 22, 2022, coverage criteria changes for cancer-associated thrombosis (CAT).

Dalteparin and tinzaparin will both change to first-line treatment (from second-line), removing the requirement for patients to try warfarin first.

Enoxaparin biosimilars will also be added as covered first-line treatment options for CAT, without the need to try warfarin first.

The biosimilar listings result in costs-savings for the province, which offset the costs of modifying treatment options for CAT.

>> See the modified criteria for dalteparin
>> See the modified criteria for tinzaparin
>> See the drug decision summary for CAT

For any questions, please contact Biosimilars.Initiative@gov.bc.ca

Limited coverage criteria

Effective March 22, 2022, the following enoxaparin biosimilar products will be listed as limited coverage benefits:

<table>
<tr><td>Drug name</td><td colspan="3">enoxaparin (Inclunox®; Inclunox® HP)</td></tr>
<tr><td>Date effective</td><td colspan="3">March 22, 2022</td></tr>
<tr><td>Indication</td><td colspan="3">prophylaxis and treatment of venous thromboembolism (VTE)</td></tr>
<tr><td rowspan="8">DINs</td><td>02507501</td><td rowspan="8">Strength and form</td><td>30mg/0.3mL pre-filled syringe (PFS)</td></tr>
<tr><td>02507528</td><td>40mg/0.4mL PFS</td></tr>
<tr><td>02507536</td><td>60mg/0.6mL PFS</td></tr>
<tr><td>02507544</td><td>80mg/0.8mL PFS</td></tr>
<tr><td>02507552</td><td>100mg/mL PFS</td></tr>
<tr><td>02507560</td><td>120mg/0.8mL PFS</td></tr>
<tr><td>02507579</td><td>150mg/mL PFS</td></tr>
<tr><td>Covered under Plans</td><td colspan="3">Fair PharmaCare, B, C, F, P, W</td></tr>
</table>

Drug name	enoxaparin (Noromby®; Noromby® HP)		
Date effective	March 22, 2022		
Indication	prophylaxis and treatment of venous thromboembolism (VTE)		
DINs	02506440	**Strength and form**	20 mg/0.2 mL pre-filled syringe (PFS)
	02506459		30 mg/0.3 mL PFS
	02506467		40 mg/0.4 mL PFS
	02506475		60 mg/0.6 mL PFS
	02506483		80 mg/0.8 mL PFS
	02506491		100 mg/mL PFS
	02506505		120 mg/0.8 mL PFS
	02506513		150 mg/mL PFS
Covered under Plans	Fair PharmaCare, B, C, F, P, W		

Drug name	enoxaparin (Redesca®; Redesca® HP)		
Date effective	March 22, 2022		
Indication	prophylaxis and treatment of venous thromboembolism (VTE)		
DINs	02509075	**Strength and form**	30 mg/0.3 mL pre-filled syringe (PFS)
	02509083		40 mg/0.4 mL PFS
	02509091		60 mg/0.6 mL PFS
	02509105		80 mg/0.8 mL PFS
	02509113		100 mg/mL PFS
	02509121		300 mg/3 mL vial
	02509148		120 mg/0.8 mL PFS
	02509156		150 mg/mL PFS
Covered under Plans	Fair PharmaCare, B, C, F, P, W		

Non-benefits

As of March 22, 2022, the following products will no longer be covered by PharmaCare except for existing patients, until their coverage ends:

Drug name	enoxaparin (Lovenox®; Lovenox® HP)		
Date effective	March 22, 2022		
Indication	prophylaxis and treatment of venous thromboembolism (VTE)		
DINs	02012472	**Strength and form**	30 mg/0.3mL pre-filled syringes (PFS)
	02236883		40 mg/0.4 mL PFS
	02378426		60 mg/0.6 mL PFS
	02378434		80 mg/0.8 mL PFS
	02378442		100 mg/mL PFS
	02236564		300 mg/3 mL vial
	02242692		120 mg/0.8 mL PFS
	02378469		150 mg/mL PFS

Paxlovid™ updates: Follow-up by pharmacists and changes to eligibility criteria (published Mar 23)

Since March 1, 2022, nirmatrelvir/ritonavir (Paxlovid™) has been available through community pharmacies. Given their close relationship with patients, community pharmacists are well-positioned to provide follow-up and monitor patients for potential adverse drug events (ADEs). Follow-up should be conducted with the patient or caregiver 6 to 10 days after dispensing Paxlovid.

To date:

- Pharmacists have followed up on approximately 45% of eligible Paxlovid dispenses
- Of those follow-ups:
    - over 100 ADEs have been identified
    - 92% of patients completed all 5 days of therapy

A small number of claims contained errors in the SIG code used to document follow-up. The most common omission is a **missing *'Stopped Early/ Reason'* code** (i.e., NA – Not stopped early - Adverse Effects).

Example: 888-348-9284_5_ADE1MP should be 888-348-9284_5_**NA**_ADE1MP indicating the patient did not stop early but did experience ADEs.

Information about Paxlovid dispensing, follow-up and other procedures are updated weekly, as needed, at Dispensing Paxlovid and Monitoring Adverse Drug Events: A Guide for B.C. Community Pharmacists.

Changes to eligibility criteria

Effective March 23, 2022, the eligibility criteria for Paxlovid is changing and is available on the BCCDC website. An updated prescription form is also available.

Paxlovid information sessions

Over 750 health professionals have attended Paxlovid information sessions hosted by the Ministry of Health since February 22, 2022. If you were not able to attend, or would like to review any part of the session, recordings are available. Your group may also book a private live session, which allows for Q&A with a pharmacist.

Two options for the live session:

1. For **Paxlovid evidence, dosing and drug interaction education session** with a Provincial Academic Detailing (PAD) pharmacist (30-60 mins), please email PAD@gov.bc.ca.
2. For **Paxlovid dispensing, counselling and follow-up procedures** with a Ministry of Health pharmacist (15-30 mins), please email PCI@gov.bc.ca.

Please include the following information in your request:

- 2 or 3 preferred dates and times
- Approximate number of attendees (max. is 99, small groups preferred)
- Name of your business/group and type of practice setting
- Email and phone number of contact person

New electronic recordkeeping policy

PharmaCare has created a new policy that allows community pharmacies enrolled as PharmaCare providers to keep electronic records.

The new policy outlined in Section 10.1 of the PharmaCare Policy Manual applies to prescriptions, faxes, forms, invoices, and other paper documents. It addresses such things as storage, record preservation, and access. As of today, documents can be saved in electronic format, as long as your software meets the requirements of the policy and the technical requirements of the Ministry of Health's supporting conformance standards.

The new policy lays out guidelines for paperless recordkeeping that meets PharmaCare's requirements. These guidelines largely pertain to maintaining the integrity of physical records, and are aligned with the requirements from the College of Pharmacists, with additional elements to meet the needs of the PharmaCare program and financial recordkeeping. The policy also covers a host of situations, such as pharmacy transfers, closures, etc.

The policy does not apply to prescriptions for drugs in the controlled prescription program and part-fill accountability logs associated with opioid agonist treatment (OAT) prescriptions; in those cases, original hardcopy records must be retained regardless of whether they have also been stored electronically.

Please note that the pharmacy point-of-service (POS) system needs to be able to meet the relevant conformance standards to satisfy the new electronic recordkeeping requirements. Talk to your IT staff or software vendor to see if your system is up to date. You will need to keep hardcopy (i.e., paper) records until your system can meet the standards.

Transmetatarsal prostheses provided by orthotists now covered

Effective March 1, 2022, PharmaCare covers pre-approved transmetatarsal (TM) prostheses manufactured by orthotists. Previously, PharmaCare only covered partial-foot prostheses manufactured by certified prosthetists. The coverage change will improve patient access to treatment and choice of providers.

The partial foot prosthesis must be ankle height and must be for a TM amputation.

Sections 5.2.9 and 6.1 of the Prosthetic & Orthotic Policy Manual, and relevant forms have been updated to reflect this change.

PRIME enrolment for pharmacy technicians

The Ministry of Health is aware of technical and process issues that may prevent PharmaNet provisioning of pharmacy technicians as independent users. If this is the case at your pharmacy, please continue to set up pharmacy technicians as before.

Pharmacy technicians are still required to enrol in PRIME by April 30, 2022, to retain existing access to PharmaNet.

We are working with pharmacy vendors to identify technical options for addressing the issue. Stay tuned for updates.

Reminders

PRIME enrolment for pharmacists and those who support them

As of March 1, 2022, any pharmacist who now uses PharmaNet can enrol in PRIME, and must be enrolled by April 30, 2022, to continue to use PharmaNet. If you have already enrolled in PRIME, you do not need to enrol again. You may be prompted to complete the annual enrolment renewal.

If you use PharmaNet to support a pharmacist (e.g. pharmacy assistant, pharmacy student), you should also enrol in PRIME between March 1 and April 30, 2022. If you are already enrolled in PRIME, you do not need to enrol again. You may be prompted to complete the annual enrolment renewal.

Pharmacy technicians must also enrol in PRIME by April 30, 2022, to retain existing access to PharmaNet.

Other health professionals

If you are another type of health professional using PharmaNet (e.g. nurse practitioner, dentist, physician, etc.), you need to enrol in PRIME during a specific period in 2022 or 2023 to maintain access. Specific information will be coming from your college and the Ministry of Health closer to your enrolment periods. For details, see PRIME Enrolment Dates.

Resources - How to enrol

To learn more about PRIME, see

- PRIME web page (with video enrolment tutorial)
- BC Services Card app

Questions?

Questions about PRIME should be directed to:

- 1-844-397-7463 *or*
- PRIMESupport@gov.bc.ca

PharmaCare 101 Live Q&A

Are you familiar with all that PharmaCare has to offer? Students, healthcare professionals, and prescribers are encouraged to view PharmaCare 101, a series of five short videos.

A follow-up Q & A session with a PharmaCare professional is available by appointment. This is an excellent opportunity to speak directly with a PharmaCare expert.

pad Refills
Your dose of drug information in between details

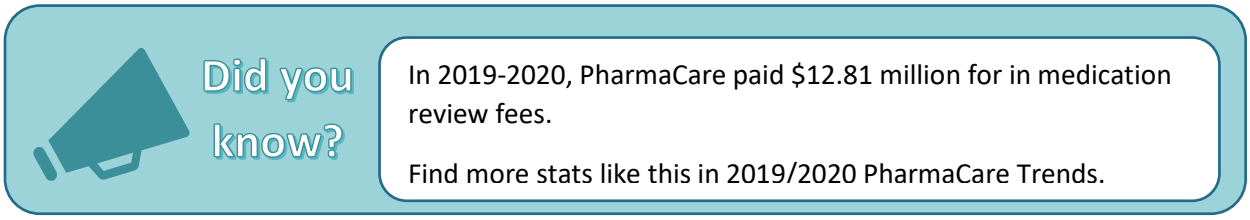
Q: Now that some of the newer type 2 diabetes medications are prioritized in patients with specific comorbidities, what do I need to know about sulfonylurea medications' glucose lowering effect, dose and cost?

HINT: The answer is in the February 2022 edition of PAD Refills. Don't forget to subscribe!

Non-benefits

As of February 18, 2022, PharmaCare has determined the product(s) below will not be covered:

Drug name	canagliflozin-metformin (Invokamet®)
Date effective	February 18, 2022
Indication	type 2 diabetes mellitus (T2DM)
Strength and form	• 50 mg/500 mg oral tablet • 50 mg/850 mg oral tablet • 50 mg/1,000 mg oral tablet • 150 mg/500 mg oral tablet • 150 mg/850 mg oral tablet • 150 mg/1,000 mg oral tablet



Your Voice: Patient input needed for drug decisions

The knowledge and experience of patients, caregivers and patient groups is integral to B.C.'s drug review process.

The Ministry depends on pharmacies and practitioners to help connect patients and their caregivers with opportunities to give input. If you have a patient currently taking one of the drugs under review or who has the condition the new drug treats, please encourage them to visit http://www.gov.bc.ca/BCyourvoice.

Currently input is needed for the following:

DRUG	cariprazine (Vraylar®)
INDICATION	schizophrenia in adults
INPUT WINDOW	Feb 23 to March 23, 2022

DRUG	ospemifene (Osphena®)
INDICATION	dyspareunia, vaginal dryness
INPUT WINDOW	Feb 23 to March 23, 2022

DRUG	ruxolitinib (Jakavi®)
INDICATION	chronic graft-versus-host disease
INPUT WINDOW	Feb 23 to March 23, 2022

FNHA Partnership series: Coming Together for Wellness

This article is part of a 10-article series by the Ministry of Health and the First Nations Health Authority to increase awareness of First Nations issues and build cultural humility, and as a result, safety in B.C.'s health system. The series began in the PharmaCare Newsletter, edition 21-010.

Article #5: History of Medication Coverage for Indigenous Peoples in B.C.

The 1867 British North America Act (BNA) assigned health services to the provinces, while "Indian Affairs" came under federal jurisdiction. The Indian Act (1876) also identified healthcare for Indigenous people as a federal responsibility. The disconnect in accountability and subsequent cost-shifting between provincial and federal governments has led to significant gaps in health services for Indigenous people in B.C. and Canada.

"Indian hospitals"

In the early 1900s, "Indian hospitals" evolved from federally-funded missionary hospital care in some First Nations communities. Ostensibly to reduce the spread of tuberculosis, the hospitals were "a method of segregation and restriction, and operated in the same way as reserves and residential schools, as a part of the larger colonial system," notes UBC's Indian Residential School History and Dialogue Centre (IRSHDC).

The Canadian Encyclopedia points out that "Indian hospitals did not provide Indigenous medicines, midwives or holistic notions of illness and its treatment. To the contrary, the hospitals were intended to further assimilationist goals and replace traditional healing with biomedicine."

By 1960, the federal government operated 22 hospitals, with 22,000 beds. As the IRSHDC notes, the hospitals were "chronically understaffed, overcrowded, and the staff…were often undertrained and sometimes unlicensed."

Many former patients of the Indian hospitals reported traumatic experiences of experimental treatment, painful and disabling surgeries, physical restraints, and forced sterilization. Joan Morris, who was kept in the Nanaimo Indian Hospital from 1950-1952, notes that those who endured abuse in the hospitals "are now skeptical of the entire health-care system."

In the 1960s, the body that ran the Indian hospitals merged with the federal Medical Services Branch (MSB). In 2000, the MSB was renamed the First Nations and Inuit Health Branch (FNIHB) under Health Canada.

First Nations health benefits

The Non-Insured Health Benefits (NIHB) program under FNIHB administers health benefits, including eligible pharmacy items, for "status Indians" and "registered" Inuit. One jurisdictional dispute led to the legacy of Jordan River Anderson, a child from Norway House Cree Nation in Manitoba, born with multiple disabilities, who died in hospital, because of disputes over who would pay for home-based care. Jordan's Principle makes sure all First Nations children living in Canada can access the products, services and supports they need, when they need them.

In B.C., First Nations leadership decided to take ownership and create a new approach. This led to the creation of the First Nations Health Authority (FNHA) in 2013. The FNHA is the first provincial health authority of its kind in Canada, governed by and responsible to First Nations.[1] The FNHA aims to transform healthcare and health benefits to better meet the unique needs of First Nations in B.C.

The FNHA took responsibility for programs and services formerly delivered by NIHB, and partnered with the BC Ministry of Health to integrate FNHA clients into the provincial drug benefits insurance program and improve ease of access to benefits and services. On October 1, 2017, the delivery of the FNHA's pharmacy benefits transitioned to BC PharmaCare Plan W (for Wellness). Plan W is a unique and integrated provincial drug benefit plan designed to meet the health needs of FNHA clients.

In our next article, we will delve further into the unique characteristics of Plan W.

Suggested reading

- A Guide for Health Professionals Working with Aboriginal Peoples: The Sociocultural Context of Aboriginal Peoples in Canada
- First Nations Health Authority: Governance and Accountability
- This Last Frontier: Isolation and Aboriginal Health

"The experience of receiving discriminatory treatment instills mistrust of health care."

—In Plain Sight Report

[1] The term 'First Nation' came into usage in the 1970s to replace the term "Indian". First Nations are classified according to whether they are registered under the federal Indian Act as Status or non-Status Indians, respectively. First Nations individuals in B.C. registered as Status Indian under the Indian Act are eligible for FNHA Health Benefits.