10. PROGRAM CLAIMING POLICIES (Updated January 18, 2024)

The term 'Provider' in the Newfoundland and Labrador Prescription Drug Program Provider Guide, including this section, refers to a community-based retail pharmacy or dispensing physician that provides professional services, covered products, and has been assigned a Provider Number by the Program. No Professional Fees are paid directly to a pharmacist.

10.1 Overview

Providers and staff are to follow all applicable federal/provincial legislation, Program policies, as well as the by-laws and Standards of Practice set by their relevant governing bodies. This section details specific Program claiming policies that Providers are to adhere to when submitting claims to the Program.

Adherence to these policies, as well as all applicable legislation, by-laws, and Standards of Practice, are checked as part of Program Audit Activity (see Section 12 for further information).

Additionally:

- All required documentation relating to claims submitted to the Program must be completed prior to submission.

- All claims submitted must be verifiable from the Original Prescription (i.e., the prescription as written by a Prescriber, the verbal prescription, or the transferred prescription).

- To clarify or verify services for which claims have been paid, a Provider must, upon request of an Auditor:

    - During an on-site audit, make available the Original Prescription for the purposes of examination and/or copying/scanning; and
    - Provide copies of Original Prescription and all applicable documentation, as requested.

Payment recoveries will occur for claims determined to not have been billed in accordance with Program requirements/policies.

10.2 Benefit Limitations

There are a number of benefits under the Program which have coverage limitations.

NOTE: Over-the-Counter (OTC) medications are limited to children in care of Newfoundland and Labrador Health Services or the Department of Children, Seniors and Social Development, unless a special approval is in place on the Beneficiary file.

The following limitations apply to all benefit brands in the drug category specified. For beneficiaries who require product(s) in any of the listed categories but do not meet the specified limitations, prior approval is required under the Special Authorization process.

> **Example**: Cephalexin suspension prescribed for an adult will require prior approval under the Special Authorization process.

10.2.1. Aerochambers / Optichambers

Coverage is limited to 1 aerochamber per Beneficiary in a 365-day period (starting the date of the first claim for an aerochamber).

The Intervention Code MR (Appendix E) is to be used to replace an aerochamber that is lost, broken, or stolen. Documentation for use of this code must be noted on the replacement prescription or Original Prescription if refills were authorized. Where documentation cannot be produced during audit activity, the claim will be considered not validated and will be recovered.

Pharmacists are able to submit claims for aerochambers and spacers. These claims may be submitted as standard claims to the Program as follows:

- PIN/DIN: The PIN/DIN for the aerochamber claimed.
- Prescriber Reference ID: 16
- Prescriber: Use the NLPDP Billing Number of the Pharmacist
- Day Supply: 1
- Qty: 1

10.2.2. Anti-emetics

The following anti-emetics are covered by the Program only for chemotherapy-induced nausea:

- Ondansetron 4mg and 8mg tab: up to 3 tablets for one 24-hour period
- Granisetron 1mg tab: up to 2 tablets for one 24-hour period

The quantity limits above may only be filled as an Open Benefit for the first fill of any of the above chemotherapy anti-emetic drugs. A Special Authorization is required for a higher quantity dispensed than identified above for a first fill or for any subsequent fills of any chemotherapy anti-emetic drug.

10.2.3 Cephalexin Suspension

The following DINs have an age limitation; Beneficiary must be less than 13 years old:

- TEVA-Cephalexin Susp 250mg/5ml – DIN 00342092
- TEVA-Cephalexin Susp 125 mg/5ml – DIN 00342106
- TEVA-Trimel Oral Susp 200-40mg/5ml – DIN 00726540

10.2.4. Diabetic Test Strips

Coverage of blood glucose test strips:

	# of Test Strips Covered Annually	
	Open Benefit (no Special Authorization required)	**Additional Annual Quantity Available under Special Authorization**
NLPDP Beneficiaries receiving long-acting insulin (with or without non-insulin diabetes medications but **not** using short acting insulin)	700	100
NLPDP Beneficiaries receiving **only** non-insulin diabetes medications	100	50
NLPDP Beneficiaries receiving **no** insulin or non-insulin diabetes medications (i.e., not receiving any diabetes treatment(s)	50	50 (Fill dates must be 6 months apart.)
NLPDP Beneficiaries receiving short-acting insulin (with or without other insulin or non-insulin diabetes medications)	2,500	
NLPDP beneficiaries with gestational diabetes or pregnant with Type II Diabetes		Quantity as indicated by requesting health professional.
NLPDP beneficiaries with Type I or Type II Diabetes being treated with non-benefit insulin and/or non-insulin diabetes medications		Will be approved for the appropriate quantity of strips that corresponds to the Beneficiary's diabetes treatment(s), consistent with the eligible Open Benefit quantity.

Claims for glucose test strips will only be paid if the Beneficiary has:

- A paid claim for insulin and/or non-insulin diabetic medication within the past year; or
- A Special Authorization in place.

Requests for glucose test strips beyond the amounts identified above may be considered for exceptional circumstances. Written requests may be submitted by a health professional identifying the specific medical need and the number of test strips required. The purpose of additional testing must be clearly demonstrated, and relevant supporting information provided, including:

- Number of times per day the Beneficiary is required to test.
- How long increased testing will be required (e.g., two weeks, one month, three months, etc.).
- How often the results will be reviewed by a health professional.
- Specific actions that will be taken based on the results (e.g., change therapy, change medication dose, etc.).
- Any other relevant information to support additional testing.

10.2.5. Prenatal Vitamins

These products are limited to women under the age of 53.

10.2.6. Contraceptive Medications and Devices

These products are limited to women under the age of 53. Exception is Mirena which is an Open Benefit with no limitations but is not used for contraception in those above 53.

10.2.7. Pediapred

Limited to beneficiaries less than 13 years old.

10.2.8. Growth Hormones

Coverage under the Growth Hormone component of the Select Needs Plan is limited to beneficiaries 18 years of age or younger. Exceptions, through Special Authorization, can be made for beneficiaries whose Pediatric Endocrinologists have demonstrated the need to continue a low dose of Growth Hormone into adult years; and for individuals diagnosed with Turner's Syndrome.

10.2.9. Inhalers (Non-Salbutamol)

Coverage for Open Benefit inhalers (non-salbutamol) will be limited if the Beneficiary has a paid claim for a wet nebulizer in their history in the past year unless a Special Authorization is in place.

10.2.10. Cystic Fibrosis (CF)

Coverage under the CF component of the Select Needs Plan is limited to claims for CF specific medications.

10.2.11. Asmanex Twisthaler 100 mcg

Coverage for Asmanex Twisthaler 100 mcg is limited to children aged 4-11 years, otherwise a Special Authorization is required.

10.3. Compounded Preparations

Compounds,extemporaneous preparations, are defined as mixtures of **three or more** ingredients where the mixture is prepared by a Provider according to the order of a Prescriber.

The Program will reimburse:

- Base fee ($11.96 or $12.00) for Compounds containing two ingredients.
- 1.5 X Base fee ($11.96 or $12.00) for Compounds containing three or more ingredients.

The Program reserves the right to request the details of the Compound prior to, or after payment of the claim, to verify the fee claimed.

To be eligible as a benefit, Compounds:

- must be specifically tailored to a Prescriber's prescription,
- must contain one or more drugs presently considered as an Open Benefit under the Program for which the person is eligible, and must not be diluted or altered n its formulation or alter the drug's route of administration, as to result in a product which offers no clear therapeutic advantage relative to a listed Open Benefit; or
- containing one or more Special Authorization drugs and/or where the route of administration is changed, must have Special Authorization Approval.

Duplicate formulations of benefit manufactured drug products will be reimbursed to a maximum of the cost of the individual ingredients and applicable maximum professional fees as per Section 5.1 of the **PANL Agreement**, (appendix I). In the event no agreement exists, a fee as set by the Minister, shall not exceed the reimbursable amount (ingredient cost and associated dispense fee) cost for the commercially manufactured product.

Examples of Program Open Benefit/Non-benefit/Special Authorization compounded preparations:

Open Benefit Compound:

Compounded in a therapeutic concentration AND where at least one ingredient in a specified formulation is an Open Benefit of the Program.

> **Example:** Spironolactone, in a therapeutic dose, compounded in a liquid formulation will be reimbursed; spironolactone is an Open Benefit of the Program.

Non-Benefit Compound:

1. A Compounded Product that does not include a benefit ingredient.

   Example: Esomeprazole suspension will NOT be reimbursed; esomeprazole is not a benefit of the Program.

2. A Compounded Product where there is a change in the drug's route of administration.

   Example: Diclofenac topical is a non-benefit compound as only the oral formulations of diclofenac are benefits of the Program.

Special Authorization Compound:

1. A Compounded Product that includes a Special Authorization drug.

2. A Compounded Product that includes an Open Benefit drug where the route of administration is changed and there is evidence to support therapeutic benefit.

   Example: Diltiazem 2% topical ointment requires Special Authorization. Oral diltiazem is an Open Benefit drug, but the route of administration is changed to a topical preparation.

10.3.1 Reimbursement and Documentation Requirements for Compound Claims

The Provider is to calculate the total product cost for the compounded preparation. The claim is to be submitted with the PIN '00999997' and the calculated cost of the compound entered in the Drug Cost/Ingredient Cost field.

A compound charge (up to 50% of the paid base professional fee) can be claimed if the preparation has 3 or more ingredients. The Professional Fee is set out in the PANL Agreement, or in the event that no agreement exists, the fee is set by the Minister. If a compound charge is claimed in the compound fee field, a valid Compound Code must be submitted on the claim.

<u>Compound Codes</u>

The claim must provide a valid compounding code (otherwise, the claim will be rejected). The current code values are:

- 0 = compounded topical cream
- 1 = compounded topical ointment
- 2 = compounded external lotion
- 3 = compounded internal use liquid
- 4 = compounded external powder

- 5 = compounded internal powder
- 6 = compounded injection or infusion
- 7 = compounded ear/eye drop
- 8 = compounded suppository
- 9 = compounded other

The following must be documented on the Original Prescription or attached to the prescription Hardcopy at the time of dispensing:

- General identification of Compound

  Example: Menthol 0.25% Camphor 0.25% in Hyderm 1% cream

- Identification of each ingredient by name (the ingredient may have different DINs/PINs depending on the third-party Provider billed).
- Specific quantity of each ingredient for amount of Compound dispensed.
- Package size* used in the Compound when there is more than one size available.

  Example: 15 g, 30g, 45g.

  *If package size is not noted, the Program will reimburse based on largest package size available.

  Example: Menthol 0.25% Camphor 0.25% in Hyderm 1% cream – Mitte: 100g

The information below must be on the prescription, computer generated Hardcopy of the prescription, and/or written on the back of the Original Prescription:

Menthol 0.25% Camphor 0.25 % in Hyderm 1% cream

Menthol – 0.25 gram

Camphor – 0.25 gram

Hyderm 1% cream – 99.5 gram using 15-gram package size.

Failure to document this information at the time of dispensing will result in a recovery during audit activity.
Reimbursement will be provided for approved Compound ingredients that are listed in the table below.

In order to provide some flexibility in compounding and allow for the use of ingredients similar to those listed in the table, any non-approved ingredient shall be reimbursed up to a maximum allowable limit of $0.03 per unit (milliliter or gram).

> **Example**: Calamine Lotion is not a benefit or an approved compound ingredient. If Calamine Lotion is used in a Benefit Compound, it will be reimbursed at no more than $0.03 per ml of Calamine used.

Flavoring/sweetening agents – maximum allowable reimbursement per claim is $0.25.

Providers are not required to submit special claims or comments with their compound claims for the claim to be adjudicated in real-time.

The following table lists the PIN and unit prices that will be reimbursed when submitting compound claims to the Program. It should be noted that this list is not all-inclusive.

If you are unsure of the benefit status of a compound, please call (709) 729-6507 or 1-888-222-0533 and select Option 2.

Table: Approved Compound Ingredients

PRODUCT	PIN/DIN	UNIT PRICE per ML or GM (Includes 8.5%)
Acyclovir Powder	00903842	1.0000
Anthralin Powder (All Brands)	00903057	4.3292
Betamethasone Valerate Powder	99099946	1.7800
Camphor Crystals (All Brands)	00968885	0.0109
Clindamycin Phosphate Powder	99099970	2.56
Cold Cream (All Brands)	00903372	0.0434
Crude Coal Tar (All Brands)	00900974	0.3906
Diazepam USP Powder	99099963	1.476
Diltiazem HCI USP	00903210	3.1600
Distilled Water (All Brands)	00977772	0.0005
Disulfiram Powder	00999087	0.5750
Eucerin Cream (All Brands)	00903193	0.0621
Eucerin/Glycerin/Water	00903019	0.0160
Fluoxetine HCL Powder	99099971	12.6666
Friar's Balsam (All Bands)	00509051	0.1489
Gelatin Capsules	00903745	0.0340
Glaxal Base/Dermabase	00902977	0.0402

Glycerin (All Brands)	00179132	0.0307
Guaifenesin USP	99099953	0.0510
Huile Minerale	00481386	0.0117
Hydrocortisone Powder (All Brands)	00990821	3.7324
Ihles Paste (All Brands)	00903116	0.0201
Lactose Monohydrate NF	00903603	0.0165
Lanoline Hydratee	01923129	0.0333
Lassar's Paste (All Brands)	00900982	0.0537
LCD (All Brands)	00999972	0.0516
Lidocaine USP	99099951	0.168
Mechlorethamine hydrochloride powder	99099952	36.3600
Menthol Crystals (All Brands)	00969931	0.1736
Methoxsalen Powder	00903588	70.8000
Methycellulose Suspension	00967297	0.0470
Methylphenidate Powder	99099960	13.5700
Nifedipine USP Powder	99099967	10.4000
Nitrofurantoin USP Powder	00903649	7.2000
Omeprazole USP Powder	99099968	3.5640
Ora Sweet	00903547	0.0600
Ora Sweet SF	00903548	0.0600
Ora Plus	99099959	0.0320
Ora Blend Sugar Free	99099924	0.0711
Ora Blend	99099925	0.0711
Petrolatum Ointment (All Brands including Vaseline)	00999005	0.0093
Phenazopyridine HCI USP-per gram	00903560	1.0800
Phenol Crystals (All Brands)	00969990	0.3472
Potassium Iodide USP	99099958	0.1300
Potassium Permanganate Crystals (All Brands)	00987735	0.0635
Pyrilamine Maleate USP	99099957	0.8070
Salicylic Acid Powder (All Brands)	00999036	0.0636
Simple Syrup (All Brands)	00988006	0.0169
Sodium Bicarbonate 8.4%	00261998	0.3878
Sorbitol 70% solution USP 3000 ml pack size	99099955	0.0115
Sulfamethoxazole EP – per gram	99099961	0.5600
Sulphur Powder (All Brands)	00969923	0.0488
Tar Distillate (All Brands)	00579963	0.2875
Theophylline USP Anhydrous	99099954	0.3200
Thioridazine Capsules	00903700	0.6778
Trimethoprim USP Micronized – per gram	99099962	1.5200

10.4. Confirmations

The Program may request confirmation of billing details from a Beneficiary or a Prescriber.

Beneficiary

In cases where a Beneficiary provides information which differs from that submitted by a Provider in a claim, payment recoveries may occur.

Prescriber

In cases where a Prescriber provides information which differs from that submitted by a Provider in a claim, payment recoveries may occur.

The Program may contact the Provider for additional information upon review of the submitted documentation.

10.5 Discrepancy between Provider Records and Claim

Should a discrepancy be identified between the records of the Provider and claims information, payment recoveries will occur.

10.6 Documentation Requirements

For a prescription to be considered valid, the following items, at a minimum, must be detailed on the prescription:

10.6.1 Verbal Prescription

Minimum documentation requirements as per Section C.01.041 of the *Food and Drugs Regulations* under the Food and Drugs Act (Canada):

- Date the verbal order was received,
- Original Prescription number,
- Beneficiary name,
- Drug name (proper name, common name or brand name),
- Quantity,
- Strength (where more than one exists),
- Directions for use (exceptions may apply where directions for use are outlined within manufacturer packaging requiring pharmacist consult. E.g., HP pack),
- Number of refills (if any),
- Prescribing practitioner name, and
- Name/initials of the pharmacist or registered pharmacy technician who received the verbal order and reduced the prescription to writing.

Verbal Prescriptions may be documented either in:

- Writing, and/or
- By the Pharmacy Management System's Hardcopy, provided that all required information is included. This Hardcopy is to be produced either

upon the first fill or upon the prescription being logged (i.e., entered into the system but not filled), whichever is first.

Verbal Prescriptions are to be documented when received from the Prescriber.

10.6.2 Transferred Prescription

Minimum documentation requirements as per Section C.01.041.2 of the *Food and Drugs Regulations under the Food and Drugs Act* (Canada):

- Date of the transferred order,
- Original Prescription number,
- Beneficiary name,
- Drug name (proper name, common name or brand name),
- Strength (where more than one exists),
- Quantity,
- Directions for use (exceptions may apply where directions for use are outlined within manufacturer packaging requiring pharmacist consult, e.g., HP Pack),
- Number of refills remaining (if any),
- Prescribing practitioner name,
- Name and Provider address of the pharmacist or registered pharmacy technician transferring the prescription,
- Date of the last refill,
- Date of the Original Prescription, and
- Name/initials of the pharmacist or registered pharmacy technician who received the transferred order and reduced the prescription to writing.

Verbally Transferred Prescriptions may be documented either in:

- Writing, and/or
- By the Pharmacy Management System's Hardcopy, provided that all required information is included. This Hardcopy is to be produced either upon the first fill or upon the prescription being logged (i.e., entered into the System but not filled), whichever is first.

Prescriptions transferred verbally are to be documented when received from the transferring pharmacy.

In the event that a prescription is transferred by fax, documentation must include all the required fields.

10.6.3 Prescription Written by a Prescribing Practitioner

Minimum documentation requirements:

- Date,

- Beneficiary name,
- Drug name (proper name, common name or brand name),
- Strength (where more than one exists),
- Quantity,
- Directions for use (exceptions may apply where directions for use are outlined within manufacturer packaging requiring pharmacist consult, e.g., HP Pack),
- Number of refills (if any),
- Prescribing practitioner name, and
- Prescribing practitioner signature.

Where the Prescriber writes “all regular meds” or “diabetes supplies”, the Program will allow the Hardcopy of the prescription to be used to provide the details when the Beneficiary has a documented history of the medication.

Identified cases where a verbal prescription, transferred prescription, or prescription written by a prescribing practitioner does not contain the required information, recoveries will occur.

10.7 Expiry of a Prescription

Prescriptions are only valid for one year from the date originally written or ordered by a Prescriber.

10.8 Interchangeability of Medications

10.8.1 Non-Formulary Generic Substitution

A pharmacist may substitute a prescribed brand name product with an equivalent commercially available generic product that is not listed on the Newfoundland and Labrador Drug Product Formulary (NIDPF), as long as there is not another equivalent generic product listed on the NIDPF that is currently available. Appropriate situations include:

- Where the brand name product is not currently available (e.g., discontinued, back ordered, etc.); or
- To facilitate Beneficiary adherence to the medication regimen (e.g., the Beneficiary requests a less expensive alternative).

For claims billed to the Program, reimbursement will occur when:

- The medication billed is an eligible benefit of the Program; or
- The Beneficiary has a Special Authorization in place for the claimed DIN; **AND**
- The medication substituted is equal to or less than the cost of the medication prescribed.

10.9 Methadone for Addictions

There are four Methadone brands reimbursed under the Program to treat opiate addiction:

1. Methadose 10 mg/mL oral concentrate, dye free, sugar free – DIN 02394618
2. Metadol-D 10 mg/mL oral concentrate – DIN 02244290
3. Odan-Methadone 10 mg/mL oral concentrate, dye-free, sugar free – DIN 02495880
4. Jamp Methadone 10 mg/mL oral concentrate – DIN 02495783

The Program provides coverage for the above preparations of Methadone for the purpose of treating opiate addiction. The benefit Methadone brands above will not require a Special Authorization under the Program.

10.9.1 Pricing

The maximum paid drug cost for benefit Methadone DINs is $1.50 per day. The paid drug cost is calculated as follows:

Paid Drug Cost = Paid Days' Supply x $1.50

10.9.2 Claiming for Methadone

The claiming process is as follows:

Methadone Maintenance (Daily Witnessed Doses)

- DIN = 02394618 / 02244290 / 02495880 / 02495783
- Days' Supply = 1
- Quantity = the actual amount of Methadone dispensed (ml)

Methadone Carries

Each carry dose will be submitted and adjudicated as a separate claim, with the Day's Supply and Dispensed Quantity values conforming to the actual amount in the carry dose of Methadone in milliliters and corresponding to the values on the printed label.

When claiming for Methadone:

- DIN = 02394618 / 02244290 / 02495880 / 02495783
- All claims must have a Day's Supply of 1 submitted. If the claim is submitted with a value other than 1, the claim will reject with message DM (Day's Supply Error).
- The Program will reimburse a $3.00 dispense fee for each methadone carry. The initial dispense fee will remain at $1.50. The $3.00 dispense fee will be automatically applied to second and remaining dispenses for carries. The carry fee will apply to

beneficiaries picking up 1 to 14 carries, including the initial dose. The quantity submitted with the claim should be the actual quantity of Methadone dispensed in milliliters and as reflected on the printed label.

- Claims after the Beneficiary has reached their maximum allowed Methadone claims for the day (maintenance and carry claims), will claim reject with the message CN (Client Has Exceeded Quantity Limit). **The CN Response Code cannot be overridden**.

10.10 Multiple Billings

In instances where a Provider has multiple billings for a medication of the same strength on same day dispensed to a Beneficiary, the excess multiple billings will be recovered.

10.11 Non-benefit Item Prescribed but Benefit Item Claimed

Claims where a medication not listed as a Benefit is claimed under a DIN listed as a Benefit will be recovered.

10.12 Intervention Codes

As part of the claim adjudication process, the system may return Drug Utilization Review (DUR) messages (see Section 9.4.1). Providers may use appropriate CPhA Exception/Intervention Codes to override the DUR messages. Appropriate documentation must be on the Beneficiary file and/or Original Prescription to support the use of the Response/Intervention Code.

10.13 Prescription Requirement

A Provider shall only submit a claim for medications (including eligible over-the-counter items) for the provision of Pharmaceutical Services upon:

a) The written or verbal order of a Prescriber, entitled to prescribe the specified covered product. When the prescription is verbal, the prescription shall be reduced to writing in the manner specified in Section C.01.041 of the *Food and Drugs Regulations* under the *Food and Drugs Act* (Canada); or

b) The order of a pharmacist, registered with the Newfoundland and Labrador Pharmacy Board (NLPB) as having authorization to prescribe, and has documented the action in accordance with the **NLPB Prescribing by Pharmacists Standards of Practice**. The early dispensing of a medication will be acceptable by the Program **only** in cases where the early dispense was authorized by the Prescriber in writing or by verbal order and documented on the Original Prescription or in the Pharmacy Management System at time of dispense.

10.14 Program's Days' Supply Policy

Quantities of covered products dispensed should be in accordance with the Prescriber's prescription, to a maximum of 90-day supply, with the exception of the following:

- The first fill of a medication (i.e., a medication, or dosage of a medication, new to the Beneficiary) shall be dispensed as written to a maximum of 30-day supply.

- Controlled substances (drugs that fall under the *Controlled Drugs and Substances Act*, including benzodiazepines), each of which shall be dispensed as written, to a maximum of 30-day supply.

- Antidepressant, antipsychotic and injectable agents (excluding long-acting formulations), each of which shall be dispensed as written, to a maximum of 30-day supply.

- Pharmacy manufactured Customized Patient Drug Packaging, in accordance with the **NLPB Standard of Pharmacy Practice Guidelines**. Each of which shall be dispensed in quantities of 28 to 35-day supply (depending on packaging process used by the pharmacy).

- Where a Special Authorization approval limits the amount of medication to be dispensed at one time.

Non-adherence to the above is acceptable only under circumstances where the dispensing pharmacist makes available, on request from the Department, clear, concise documentation supporting a reasonable rationale for non-adherence.

The Program's Days' Supply Policy is intended to limit benzodiazepines and antidepressants to a 30-day supply to deter abuse/misuse of these medications. Beneficiaries taking these medications long-term with no history of abuse/misuse and no medication safety concerns are to receive a 90-day supply if prescribed by their physician and the dispensing pharmacist has no concerns of abuse/misuse.

Intervention Codes are within the Adjudication System to allow a pharmacist to override a claim to allow these beneficiaries to obtain a 90-day supply of benzodiazepines and antidepressants where the Prescriber has ordered a 90-day supply.

Intervention Codes allowed are:

CS = was preauthorized by telephone.

NF = override quantity appropriate.

UA = Consulted Prescriber and filled as written.

UE = Consulted Prescriber and changed quantity

The dispensing pharmacist is to document the reason for the use of the Intervention Code on the prescription or Hardcopy.

10.15 Vacation Supply - Medications

The Vacation Supply Policy for medications allows Providers to dispense an adequate supply of medications for beneficiaries going on vacation.

Policy

Beneficiaries travelling outside the province for **vacation only** for more than 100 days are allowed to obtain up to two prescriptions (a maximum of 180-day supply) for the same medication before leaving the province, as approved by the Prescriber.

Pharmacies are permitted to dispense up to two 90-day fills for each medication (including benzodiazepines and antidepressants). A dispense fee is to be applied to each 90-day prescription as per the PANL Agreement. Prescriptions for narcotics can only be dispensed in 30-day supplies.

Beneficiaries are responsible for applicable co-payments for each 90-day supply of the prescriptions.

The Program is not responsible for the replacement of lost, stolen, or damaged medications (e.g., break in cold chain for medications requiring refrigeration). Replacement of these medications will be at the Beneficiary's expense.

Requirements

The **Beneficiary** is responsible for requesting their vacation supply from the pharmacy, and should do so at least 4 days before departing to ensure the pharmacy has sufficient stock on hand. The Beneficiary is to provide the pharmacist with the following information:

- Dates of departure and return.
- Destination

The **Provider** must document the Beneficiary's vacation details (departure/return dates and destination) on the computer file or prescription Hardcopy.

Providers cannot claim medications for beneficiaries leaving the province for extended periods of time for reasons other than vacation (e.g., work).

Process for Claiming

Providers may submit two claims for each medication required for vacation, billed on two consecutive days as follows:

<u>Day 1</u>

a) Drug cost and dispense fee submitted,

b) The Prescriber; and
c) Intervention Code MV (Vacation Supply).

Day 2

a) Drug cost and dispense fee submitted,
b) The Prescriber; and
c) Intervention Code MV (Vacation Supply).

10.16 Quantities: Pre-packaged drugs

For the following drugs:

- Topical preparations
- Diabetes supplies (e.g., blood glucose test strips alcohol swabs, syringes)
- Ophthalmic/otic preparations
- Injectables
- Inhalers

The amount dispensed/billed should be equal to the closest package size. Where the nearest package size to quantity prescribed is greater/less than 10, the Program will reimburse for the larger package size.

This does not include pre-packaged drugs when used as an ingredient in an Extemporaneous Preparation.

Examples:

- A cream comes in 40 and 60 gm sizes and the prescription is for 50 gm, the Program will reimburse for the 60-gm package size.
- A prescription is for test strips x 100, but the Beneficiary used test strips packaged as 102 strips, the Program will reimburse the 102-package size.

10.17 Expiring Prescriptions for Beneficiaries of a Physician no longer in Practice

The Program will reimburse claims billed where the Pharmacist is exercising their rights as a Prescriber in accordance with the **NLPB Prescribing by Pharmacists Standards of Practice** to extend a prescription when:

- There is notice from the NLPB and /or the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) that a physician is no longer in practice as they are:
    - Deceased,
    - Retired,
    - Relocated,
    - Suspended from medical practice, or
    - Absent due to illness or other reason;

AND

- The claims adhere to the principles of the **NLPB Prescribing by Pharmacists Standards of Practice** including documentation and notification, where applicable, of extended prescriptions that have been dispensed.

10.18 Refills in Excess of that Authorized/Quantity Billed Exceeded That Authorized

The Program does not provide coverage for refills or quantities in excess of that authorized by the Prescriber.

10.19 Retention of Prescription Records

The Original Prescription (whether physically or electronically stored), as well as computer records of filling the prescription (pharmacy billing history), must be retained in the manner and for the time period specified in Federal and Provincial Legislation and NLPB standards. Refer to Sections C.01.041 – C.01.049 of the *Food and Drugs Regulations* under the *Food and Drugs Act* (Canada). In the case of records associated with exercising Prescribing by Pharmacists, records must be kept in accordance with Regulation 13(1) of the *Authorization to Prescribe Regulations* and the manner specified by NLPB via the **NLPB Prescribing by Pharmacists Standards of Practice**.

The requirement to retain the Original Prescription for two years after the date of the last refill means the original may be retained for up to 3 years, depending on the date of the last refill.

In cases where a supporting valid prescription cannot be produced during audit activity, all claims associated with that prescription are considered not validated and will be recovered.

10.20 Payor of Last Resort

The *Pharmaceutical Services Act* states the Program is the Payor of Last Resort, meaning where a Beneficiary has private insurance coverage, claims must first be submitted to the private insurance and the remaining unpaid balance submitted to the Program. The only exception to this is Nunatsiavut Government beneficiaries where the federal government is the Payor of Last Resort.

Where a Provider is aware that a Beneficiary has other drug coverage, the Provider will first bill the alternate insurer, and will not bill the Program any amount of a covered product paid for or eligible for payment under the alternate insurer.

10.21 Tamper Resistant Prescription Drug Pad Program (TRPP)

For medications included in the TRPP Schedule of Drugs, a Provider shall not dispense and bill the Program for the medication unless it is in accordance with TRPP legislation (Section 26 of the *Pharmaceutical Services Act*).

More information about the TRPP and the drugs included can be found at Tamper Resistant Prescription Drug Pad Program.

If the Beneficiary's address and/or MCP number is not on the prescription, this information must be included on the attached Hardcopy for audit purposes.

10.22 Refusal to Fill

A Provider may bill the Program 2 x the Base Professional Fee as stated in Section 5.2 of the PANL Agreement (Appendix I), where a Provider's intervention results in Refusal to Fill a prescription for a controlled substance and where that refusal is related to the identification of probable double-doctoring, or suspected abuse/misuse.

If a Provider refuses to fill and submits a claim to the Program, they must:

- bill using PIN 00999890,
- enter their NLPB License Number (e.g., 12345 without the dash between the second and third digits) in the Prescriber Field, and
- enter a value of 16 in the Prescriber Reference ID Field.

Documentation for Refusal to Fill will consist of the Original Prescription, or a copy of the original, plus a completed Intervention Form (Appendix K) both of which must be retained for two years for audit purposes.

The Intervention Form is to be completed at the time of billing. If the Intervention Form cannot be produced during the audit activity, the claim will be considered not validated and will be recovered.

10.23 Prescribing by Pharmacists – Prescription Claims for NLPDP Beneficiaries

Providers claiming drug cost and professional fees must adhere to the requirements of the *Authorization to Prescribe Regulations* under the *Pharmacy Act, 2012* and the **NLPB Prescribing by Pharmacists Standards of Practice** applicable at time-of-service date.

10.23.1 Prescription Claims Prescribed by Pharmacists

The Program will reimburse the drug cost and professional fee determined as per current Program rules for claims where the Provider's Pharmacist prescribes for:

1. A Schedule I, II, III or Unscheduled Drug for Approved Ailments or Conditions listed in the **NLPB Prescribing by Pharmacists Standards of Practice**
2. A Schedule I, II, III or Unscheduled Drug for a Preventable Disease listed in the **NLPB Prescribing by Pharmacists Standards of Practice**
3. A Schedule I, II, III or Unscheduled Drug for COVID-19
4. Hormonal Contraceptives
5. A Schedule I, II, III or Unscheduled Drug for Other Purposes
6. An Interim Supply
7. Extending a Prescription
8. Adapting a Prescription

9. Making a Therapeutic Substitution
10. Post-Exposure Prophylaxis

Requirements

The Pharmacist must follow all requirements specified in the **NLPB Prescribing by Pharmacists Standards of Practice** in order to be reimbursed by the Program. This includes documenting all instances of prescribing, including the patient assessment, prescribing decision and rationale, medication(s) prescribed (if applicable), patient instructions and follow-up required. Failure to document prescribing activities will result in recovery during NLPDP audit activity.

If a pharmacist is prescribing for an instance listed above in a claim to the Program, they must:

- Enter their NLPB License Number (e.g., 12345 without the dash between the second and third digits) in the Prescriber field; and
- Enter a value of 16 in the Prescriber Reference ID Field.

Limitations under the Program

1. For claims billed to the Program, reimbursement will occur when:
   a) The medication is an eligible benefit of the Program, **or**
   b) The Beneficiary has a Special Authorization in place for the medication; **and**
   c) If adapting a prescription or making a therapeutic substitution, the medication being substituted is equal to or less than the cost of the medication prescribed.

2. The Program will not reimburse claims that are not billed in accordance with the Program's Days' Supply Policy. Non-adherence to this policy is acceptable only under circumstances where the dispensing pharmacist makes available, on request, documentation supporting a reasonable rationale for non-adherence.

   Example: A Beneficiary who normally received a 90-day supply of Lorazepam who now has coverage under the Program can continue to receive a 90-day supply. The pharmacist can override the claim using one of the allowed Intervention Codes (CS, NF, UA, or UE) **and** document on the prescription or Hardcopy, the reason for using the override code.

3. A Provider may bill the Program the Base Professional Fee as stated in Section 5.1 of the PANL Agreement (Appendix I), where a Pharmacist prescribes an interim supply or adapts a prescription for an NLPDP Beneficiary.

10.23.2 Prescribing for an Interim Supply

The Program will provide coverage for an interim supply for the minimum amount of drug required for the Beneficiary to visit the Prescriber, or their usual pharmacy, usually less than one full refill.

The Program recognizes "one full refill" to be the quantity outlined on the previous prescription label, up to a 3-month supply. The Program will provide coverage for an interim supply that is less than or equal to the quantity on the Original Prescription label, up to a quantity of 90 days and be submitted with the CPhA Intervention Code MK (Good Faith Emergency Coverage Established).

The process for submitting an Interim Supply claim is as follows:

- DIN being provided as an interim supply
- CPhA Intervention Code MK
- Fee in the Special Services Fee field
- Prescriber Reference ID=16
- License number of Prescribing Pharmacist in Prescriber Field

10.23.3 Adapting a Prescription

When adapting a prescription, the Program will only provide coverage for the drug cost and professional fee, when the change is for a product on the Program's benefit list, or the Beneficiary has a current Special Authorization for the product. Please refer to the Coverage Status Table at: Coverage Status Table

These claims must be submitted with the CPhA Intervention Code NJ (Formulation Change).

The process for submitting a claim for Adapting a Prescription is as follows:

- DIN being adapted
- CPhA Intervention Code NJ
- Fee in the Special Services Fee field
- Prescriber Reference ID=16
- License number of Prescribing Pharmacist in Prescriber field

The Program will not provide coverage for a claim where the adaptation results in increased costs unless a Special Authorization is in place. Such adaptations will be recovered during audit activity.

Please refer to the **NLPB Prescribing by Pharmacists Standards of Practice** for the types of adaptations a pharmacist is authorized to make.

10.23.4 Prescribing for Select Minor Ailments

The Program will provide coverage for drug cost and applicable dispense fee where the Provider's pharmacist has prescribed a product in the Programs Benefit list for select ailments and conditions. Refer to the Coverage Status Table at: Coverage Status Table

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Payments for claims will be paid as standard Program claims, with drug cost and professional fee determined as per current Program rules.

Refer to the **NLPB Prescribing by Pharmacists Standards of Practice** for the list of approved ailments and conditions for which a pharmacist may prescribe.

Documentation Requirements

The Program will provide coverage for claims where documentation outlined in the **NLPB Prescribing by Pharmacists Standards of Practice** has been completed.

If the documentation, as completed at the time of dispensing, cannot be produced during audit activity, the claim will be considered not validated and will be recovered.

10.24 Requesting Special Authorization as a Prescriber

The NLPDP Adjudication System does not capture individual pharmacist's work addresses.

If a pharmacist submits a request for a Special Authorization medication as a Prescriber and would like to be notified of the assessment outcome, the pharmacist must:

- Indicate at the top of the Special Authorization Request Form that they would like to receive a response letter regarding the outcome of the request; and
- Fill out the address section of the Special Authorization Request Form.

10.25 Medication Review

A Medication Review is a patient-care service in which a Provider's pharmacist meets with an NLPDP Beneficiary, or the Beneficiary's caregiver, to review their medication regime. The Program will pay the Provider a fee, as per Section 5.2 of the PANL Agreement.

10.25.1 Policy

A Medication Review can be completed for any Beneficiary diagnosed with a chronic disease taking 3 or more medications and NOT residing in a Personal Care Home or Long-Term Care Home.

A chronic disease is defined as a health condition or disease that is persistent or otherwise long-lasting in its effects or a disease that comes with time. The term

"chronic" is usually applied when the course of the disease is expected to last more than three months. Chronic diseases include, but are not limited to:

- Asthma
- Diabetes
- Hypertension
- Hyperlipidemia
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Arthritis

10.25.2 Purpose

A Medication Review recognizes the role of the pharmacist in providing additional cognitive services to NLPDP beneficiaries through:

- Improving the Beneficiary's knowledge of and compliance with their medications.
- Minimizing side effects with a view to improve overall safety and health outcomes.
- Solving drug related problems where possible and within a pharmacist's scope, to help prevent emergency room visits and hospitalizations.
- Reducing wastage of medication.
- Instructing Beneficiary on the use and disposal of medications/supplies.
- Discussing the impact of lifestyle changes on health.

10.25.3 Procedure

The Pharmacist completing the Medication Review will:

- Advise the Beneficiary of the purpose of the medication review and that there is no out-of-pocket cost.
- Advise the Beneficiary to bring all medication containers (even if from other pharmacies), over-the-counter drugs, vitamins, and herbal remedies to the medication review appointment.
- Allot a minimum of 20 minutes for in-person, virtual or via telephone consultations. Virtual reviews may be conducted using applications such as FaceTime, Skype, Zoom, etc.. Documentation is to be kept on file noting the date, time, and how the review was conducted for audit purposes.
- Conduct an assessment of all available prescription/non-prescription medications and identify any drug related problems. Problems should be resolved where possible, and within a pharmacist's scope or, if applicable, make recommendations to the prescribing physician. A Medication Review template is in Appendix J. This template, once completed, can be shared with the prescribing physician for notification

and a copy retained as part of the pharmacy records. Pharmacies may develop their own Medication Review Form if desired, providing it contains all of the information on the template.

- Provide the Beneficiary with a comprehensive summary, including recommendations resulting from the review.
- Forward a copy of the Beneficiary's Medication Review Form to the primary care provider, if applicable.

10.25.4 Program Requirements

Medication Review Forms, mail or fax confirmation, and the Hardcopy of the claim is to be kept on file for 2 years for audit purposes. The forms must contain the following information:

- Beneficiary information (first/last name, MCP number, date of birth, and gender);
- Beneficiary consent with signature;
- Date Mediation Review was conducted;
- Beneficiary diagnosis (blood test results are not mandatory fields);
- Provider name, address, and Provider number (as assigned by the Program for billing purposes);
- Name and signature of pharmacist performing the medication review,
- Details of additional counseling, if provided;
- Complete medication list for Beneficiary's reference post review;
- Pharmacist assessment, recommendations, and comments; and
- Proof of mail or fax confirmation. For proof of mail, , stamp/sign the original with the date mailed, and retain a copy for the file.

10.25.5 Claims Submission Information

A maximum of 72 Medication Reviews can be claimed per Provider in a year (a year is defined as April 1 – March 31).

Claims are to be made using the Medication Review PIN – 00999880. The Medication Review Fee is to be submitted using the Special Services Fee field and all other cost fields should remain blank. The maximum amount that may be claimed is $52.50 per claim, claims in excess of that amount will be reduced to $52.50 with message DV (Reduced to Special Services Fee Maximum).

Medication Review claims must be submitted with the following Prescriber information:

- Prescriber reference ID = 16.
- Prescriber = the pharmacist's NLPB License Number (e.g., 12345 without the dash between the second and third digits).

The Medication Review Fee will be fully paid by the Program, with no co-pay to the Beneficiary.

When a Provider has 72 paid (non-reversed) claims for Medication Review in a year, all subsequent claims for the period will be rejected with Message 72 (Special Services Fee error).

10.26 Smoking Cessation

Claims for Smoking Cessation products are to be submitted for claim adjudication and payment through the Program.

10.26.1 Eligible Products

The following drug products may be claimed for reimbursement:

Bupropion:

- Zyban (DIN 02238441)

Varenicline:

- Champix 0.5 mg Tablet (DIN 02291177)
- Champix Starter Pack (DIN 02298309)
- Champix Continuation Pack (DIN 02291185)
- ACT Varenicline 0.5 mg (DIN 02426226)
- ACT Varenicline 1 mg (DIN 02426234)
- Apo-Varenicline Starter Pack (DIN 02435675)
- Apo-Varenicline 1 mg (DIN 02419890)
- Apo-Varenicline 0.5 mg (DIN 02419882)
- Teva-Varenicline Starter Pack (DIN 94799999)

Nicotine Replacement Therapy (NRT):

Nicotine Gum

- Nicorette 2mg gum (DIN 02091933)
- Nicorette 4mg gum (DIN 02091941)

Nicotine Lozenge

- Nicorette Lozenge 2mg (DIN 02247347)
- Nicorette Lozenge 4mg (DIN 02247348)

Nicotine Patch

- Nicoderm 21mg/24hr Patch (DIN 80044515)
- Nicoderm 14mg/24hr Patch (DIN 80044503)
- Nicoderm 7mg/24hr Patch (DIN 80044518)

- Habitrol 21mg/24hr Patch (DIN 01943073)
- Habitrol 14 mg/24hr Patch (DIN 01943065)
- Habitrol 7 mg/24hr Patch (DIN 01943057)

Nicotine Inhaler

- Nicotrol 10mg Inhaler (DIN 02241742)

Nicotine Spray

- Nicorette Quickmist (DIN 80038858) Special Authorization Required

10.26.2 Beneficiary Eligibility

Coverage under the Smoking Cessation Program is available to all beneficiaries 18 years and older under the following NLPDP Drug Plans:

- Access
- 65+
- Foundation

10.26.3 Treatment Period

All eligible beneficiaries may receive one (1) initial treatment cycle (12 weeks) of a covered product without prior authorization, with the exception of Nicorette Quickmist. Nicorette Quickmist requires prior approval through the Special Authorization process using the Standard Special Authorization Form.

- For Zyban, up to 3 claims (28 days each) will be allowed per 12-week treatment cycle.
- For Varenicline (Champix and generics), a 12-week treatment consists of one Starter Pack and two Continuation Packs (28 days each).
- For NRTs, a 12-week treatment cycle consists of up to 6 claims (14 days each).

An additional treatment cycle (12 weeks) can be requested through the Special Authorization process using the Standard Special Authorization Form.

10.26.4 Combination Therapy

If a Prescriber determines an individual would benefit from a short-acting NRT to address cravings or an individual requires two treatment products, a second product can be requested through the Special Authorization process using the Standard Special Authorization form (see 10.26.6).

10.26.5 Submitting Claims

Claims for drugs under the Smoking Cessation Program are to be submitted in the same manner as standard claims under the Program, specifically:

- The drug price paid will be paid based on the standard Program pricing, with an 8.5% markup (9% markup for generics) included,
- The dispense fee paid will be paid as per the current PANL agreement, and
- No additional Special Service Fees will be paid.

A Beneficiary can receive three (3) dispenses (28-day supply each) of Zyban for first treatment cycle without a Special Authorization.

A Beneficiary can receive one (1) Starter Pack and two (2) Continuation Packs (28-day supply each) of Varenicline (Champix and generics) for first treatment cycle without a Special Authorization.

NRTs – the following quantity limits per dispense will apply for one (1) treatment cycle (12 weeks):

Nicorette Gum
Fill 1 – 315
Fill 2 – 210
Fill 3 – 210
Fill 4 – 210
Fill 5 – 105
Fill 6 – 105

Total: 1,155 pieces of gum

Nicorette Lozenge
Fill 1 – 176
Fill 2 – 176
Fill 3 – 176
Fill 4 – 176
Fill 5 – 176
Fill 6 – 176

Total: 1,056 lozenges

Nicoderm Patch
Fill 1 – 14
Fill 2 – 14
Fill 3 – 14
Fill 4 – 14
Fill 5 – 14
Fill 6 – 14

Total: 84 patches

Nicorette Inhaler

Fill 1 – 168 cartridges (4 inhalers)
Fill 2 – 126 cartridges (3 inhalers)
Fill 3 – 84 cartridges (2 inhalers)
Fill 4 – 84 cartridges (2 inhalers)
Fill 5 – 42 cartridges (1 inhaler)
Fill 6 – 42 cartridges (1 inhaler)

Total: 13 inhalers

Nicorette Quickmist

Nicorette Quickmist (DIN 80038858) will require prior approval via Special Authorization regardless of treatment cycle.

10.26.6 Special Authorization Consideration

The following circumstances are considered under Special Authorization:

1. Higher daily doses of nicotine patch:
   - Beneficiaries who require more than one patch per day based on number of cigarettes smoked.

2. Additional treatment within a year:
   - Beneficiaries who have received 12 weeks of an Open Benefit treatment but require an additional 12 weeks of treatment within a year (365 days).

3. Combination therapy of two smoking cessation products as follows:
   - Bupropion plus NRT (patch or short-acting)
   - Varenicline plus NRT (patch or short-acting)
   - NRT patch plus short-acting NRT
   - Bupropion plus varenicline

4. Combination therapy with Nicorette Quickmist:
   - Quickmist may be considered in combination with varenicline, bupropion or NRT patches for beneficiaries who require additional support to help control cravings AND have not had an adequate response with a reasonable trial of one other short-acting NRT (gum, lozenge, or inhaler).
   - Nicorette Quickmist will be limited to a maximum of 23 devices over a treatment cycle (sufficient quantity to last 12 weeks at recommended doses).

5. Treatment switches due to failure or intolerance:
   - If within the first 2-4 weeks of treatment, a Beneficiary experiences intolerable side effects, a switch will be permitted to a different smoking cessation agent. Details regarding the nature of the intolerance must be included on the Special Authorization form.
   - Beneficiaries who continue to experience withdrawal symptoms despite the use of an optimal dose of a first-line treatment, and who are not currently taking a short-acting NRT, should consider adding a short-acting NRT to help control cravings. If there has been **no** response to the initial agent after 2-4 weeks and the Beneficiary continues to smoke, a switch to a different first-line treatment will be considered.

Special Authorization requests can be submitted using the Standard Special Authorization Form.

10.26.7 Adjudication Codes and Messaging

When a claim for a Smoking Cessation Product is submitted and the Beneficiary has had a paid claim for a different Smoking Cessation Product in the last 365 days, the claim will reject with message CP – (Eligible for Special Authorization) and the message – "Additional Smoking Cessation Therapy available under Special Authorization".

Once the Beneficiary has used their three (3) dispenses for Zyban/Varenicline or six (6) dispenses for a NRT for the treatment cycle, any subsequent claims in that year will reject with message CP (Eligible for Special Authorization) and the message "Additional Smoking Cessation Therapy available under Special Authorization".

Paid claims for Zyban will return the message "X dispenses remaining" indicating how many dispenses the Beneficiary has remaining for the treatment cycle.

Only one Varenicline Starter Pack can be claimed in a treatment cycle. Any subsequent claims for a Starter Pack in the period will reject with message CN (Client Has Attained Quantity Limit) and the message "Starter Pack already dispensed for this cycle".

Each dispense of NRTs must be for 14 days, with a submitted quantityas in 10.26.3. Up to 6 dispenses (84 days) will be allowed in one treatment cycle without prior authorization.

With each paid dispense of NRT, the system will display the message 'X dispenses remaining" where X is the number of dispenses remaining in the treatment cycle.

If a claim for Zyban, Varenicline, or NRT is submitted, and the Beneficiary has had paid claims for the maximum allowed in a year (24 weeks of treatment), the claim will reject with CP (Eligible for Special Authorization) and the message "Additional Smoking Cessation Therapy available under Special Authorization".

If a claim for Quickmist is submitted and the Beneficiary does not have a Special Authorization, the claim will reject with message CP (Eligible for Special Authorization).

If a claim for Zyban, Varenicline, or NRT (excluding Quickmist) is submitted and is for a quantity greater than the allowed quantity limit as in 10.26.3, the claim will reject with 58 (Quantity Error) and message "Quantity should be less than or equal to SC Max Quantity".

If a claim for Zyban, Varenicline or NRT (excluding Quickmist) is submitted and has a days' supply greater than the allowed days' supply, the claim will reject with 59 (Days' Supply Error) and message "Days' Supply Error should be equal to SC Days' Supply Limit".

If a claim is submitted where the quantity is greater than the quantity remaining on the Special Authorization, the claim will reject with CN (Client has Attained Quantity Limit) and Quantity remaining.

10.26.8 Beneficiary Co-Pays

The standard NLPDP Beneficiary co-payments do not apply to the Smoking Cessation Program. The following co-payment will be applied to each Smoking Cessation Program claim:

- Varenicline (Champix and generics) and Zyban are to be dispensed once every 28 days for a total of 84 days (3 dispenses) with a Beneficiary co-pay of $6.00 per dispense (total co-pay of $18.00 per treatment cycle).
- NRTs are to be dispensed every 14 days for a total of 84 days (6 dispenses) with a Beneficiary co-pay of $3.00 per dispense (total co-pay of $18.00 per treatment cycle).

10.26.9 Coordination of Benefits

Coordination of Benefits will not be required for Smoking Cessation Program claims. If required, the intervention code DB may be used to override Coordination of Benefits on a specific claim.

10.27 Universal Coverage of Select Services

For the following select services, the Program provides universal coverage to all Newfoundland and Labrador residents who hold a valid (non-expired) MCP card.

10.27.1 Flu Vaccines

Providers may be able to claim Special Services fee for delivering a flu vaccine. The following are the flu vaccines that may be provided for the 2023-24 flu season.

Flu Vaccine	DIN
FLULAVEL TETRA	02420783
FLUZONE QUADRIVALENT	02432730 (mdv)
FLUZONE QUADRIVALENT	02420643 (pfs)
FLUZONE HIGH-DOSE QUAD	02500523

The Fluzone High-dose Quad vaccine product is specifically intended for people who are age 65 years of age and over and should not be administered to people below the age of 65.

10.27.1.1 Supply

Pharmacies will obtain flu vaccine from the public stockpile.

10.27.1.2 Reimbursement

The Program will reimburse a Special Services Fee of $13.00 for each flu vaccine provided to eligible individuals. No drug cost or dispense fee will be paid for flu vaccines.

Pharmacists may only provide the flu vaccine via injection to individuals aged 5 and over, and intranasal vaccines to individuals aged 2 and over. A claim submitted outside of these Guidelines will reject with Response Code MU (Age Precaution Indicated).

10.27.1.3 Claiming

When claiming the Flu Vaccine Fee:

- DIN: As per the public vaccine provided.
- Prescriber Reference ID: 16
- Prescriber: Use the NLPDP Billing number of the Pharmacist completing the consultation.
- Day Supply: 1
- Quantity: 1
- Drug Cost: 0.00
- Professional Fee: 0.00

- Compound Fee: 0.00
- Special Services Fee (SSF): 13.00

10.27.1.4 Co-Payments for Flu Vaccines

There will be no patient co-payments collected for the provision of flu vaccines to eligible individuals. The full fee will be paid by the Program.

10.27.1.5 Coordination of Benefits (NLPDP Beneficiaries)

There will be no Coordination of Benefits for flu vaccine claims. If the claim rejects with Response Code C6 (Client has other coverage) resubmit the claim with Intervention Code DB.

10.27.2 COVID-19 Vaccines

Authorized pharmacies may claim an enhanced pharmacy services fee for delivering an approved COVID-19 vaccine from the public vaccine stockpile to eligible individuals.

10.27.2.1 Reimbursement

The Program will reimburse a Special Services Fee of $17.00 for each COVID-19 vaccine provided to an individual. This is the only fee paid, no drug cost or dispense fee will be paid.

10.27.2.2 Claiming

When claiming for COVID-19 Vaccine Fees:

- DIN: As per DINs provided below:

02541858	COMIRNATY OMICRON XBB.1.5 10 MCG/0.3 ML
02541866	COMIRNATY OMICRON XBB.1.5.3 MCG/0.2 ML
02541823	COMIRNATY OMICRON XBB.1.5 30 MCG/0.3 ML
02541270	SPIKEVAX XBB.1.5

- Prescriber Reference ID: 16
- Prescriber: Use the NLPDP Billing number of the pharmacist completing the consultation.
- Day Supply: 1
- Quantity: 1
- Drug Cost: 0.00
- Professional Fee: 0.00
- Compound Fee: 0.00
- Special Services Fee (SSF): 17.00

10.27.2.3 NLPDP Beneficiary Co-Payments

There will be no patient co-payment required for claims for the provision of COVID-19 vaccines.

10.27.2.4 NLPDP Coordination of Benefits

There will be no Coordination of Benefits for COVID-19 vaccine claims. If the claim rejects with Response Code C6 (Patient has other coverage) resubmit the claim with Intervention Code DB.

For additional information regarding the vaccination process, including questions related to ordering, transporting or storage of vaccines, see Vaccine Resources for Health Care Professionals.

10.27.3 SaferMedsNL

SaferMedsNL is a de-prescribing initiative to decrease the use of potentially inappropriate medications and improve the quality of life of individuals Select medications have been targeted for this initiative.

10.27.3.1 Proton Pump Inhibitors (PPIs)

- Target Group: all residents, including those residing in Long Term Care and Personal Care Homes, who are receiving long-term prescriptions (greater than 12 weeks) for PPIs - Dexilant, Losec, Pariet, Nexium, Pantoloc, Prevacid, Tecta and their generic equivalents.
- Providers will be reimbursed for the initial and a follow-up de-prescribing consultation. Claims are to be submitted through the NLPDP Adjudication System.
- A de-prescribing consultation cannot be billed as a medication review. A de-prescribing consultation may be performed at the same time as a medication review and the Provider can bill for both services. Audits will be conducted on mediation reviews performed on the same day as a de-prescribe consultation for a patient.

10.27.3.2 Sedative Policy

- Target Group: all residents, including those residing in Long Term Care and Personal Care Homes, who are receiving long-term sedative prescriptions (greater than 4 weeks) – Alprazolam, Bromazepam, Clorazepate, Clidinium-chlordiazepoxide, Clobazam, Clonazepam, Diazepam, Flurazepam, Lorazepam, Nitrazepam, Oxazepam, Temazepam, Trazodone, Triazolam, Zolpidem, and Zopiclone.
- Providers will be reimbursed for an initial and follow-up deprescribing consultation. Claims are to be submitted through the NLPDP Adjudication System.

- A de-prescribing consultation cannot be billed as a medication review. A de-prescribing consultation may be performed at the same time as a medication review, and the Provider can bill for both services. Audits will be conducted on medication reviews performed on the same day as a de-prescribing consultation for a patient.

10.27.3.3 Initial De-prescribing Consultation

- Involves a 5 to 10 minute in-person or virtual or consultation with the patient or patient's caregiver to highlight the harmful side effects associated with taking a PPI and asking if they would like to discuss stopping the use of the PPI with their physician.
- Educational brochures can be provided to the patient by:
    - Email: A copy of the sent email containing the electronic brochure must be provided for audit purposes.
    - Mail: Prior to mailing, stamp and sign the original, noting the mailing date. Mail the original and retain a copy for audit purposes.
- Completion of the Evidence-Based Pharmaceutical Opinion Form at http://safermedsnl.ca/resources and forwarding to the prescribing physician.
- Professional fee of $23.00,
- Can only be completed once per patient per lifetime, and
- Only one initial de-prescribing consultation fee per de-prescribing drug class regardless of the number of PPIs or Sedative-Hypnotics the patient is using.

10.27.3.4 Follow-up Deprescribing Consultation

- Can be conducted when:
    - The physician has made a change to the prescription indicating an intent to de-prescribe. This can be achieved by faxing the Pharmaceutical Opinion Form, placing a verbal order or issuing a new prescription. This follow-up consultation should focus on providing advice on weaning and side effect management.
    - There has been no response from the physician or change in prescription, but the pharmacist wishes to conduct another conversation with the patient regarding the possibility of de-prescribing. This follow-up must be conducted at least 30 days after the initial consultation.
- Must document the follow-up by completing the SaferMedsNL Follow-up Form in Appendix L.
- Must be completed within 6 months of the initial consultation.

- Must be completed at the same Provider as the initial consultation.
- Professional fee of $10.00.
- Involves an in-person, telephone or virtual consultation with the patient or patient's caregiver.
- Can only be completed once per patient per lifetime.
- Only one follow-up deprescribing consultation fee per de-prescribing drug class regardless of the number of PPIs or Sedative-Hypnotics the patient is using.

10.27.3.5 CLAIMS SUBMISSION INFORMATION

When claiming a Deprescribing Consultation (Initial or Follow-up):

- PIN:
  - Initial – 92099810 (PPI), 92099805 (Sedatives)
  - Follow-up – 92099975 (PPI), 92099804 (Sedatives)
- Prescriber Reference ID: 16
- Prescriber: Use the NLPDP Billing number of the pharmacist completing the consultation.
- Days' Supply: 1
- Quantity: 1
- Special Services Fee (SSF): Claim $23.00 for Initial or $10.00 for Follow-up.

There will be no patient co-payment required for claims for De-prescribing Consultations.

There will be no SSC code required.

Claims billed for consultations are subject to audit. Claims not billed in compliance with the policies outlined above will be recovered.

10.27.3.6 Required Documentation

The pharmacist must document the initial consultation by completing the Evidence-Based Pharmaceutical Opinion Form.

The Evidence-Based Pharmaceutical Opinion Form must be forwarded to the prescribing physician and proof of email or fax confirmation kept in pharmacy records. When the patient is not a candidate for de-prescribing, the form does not need to be sent to the physician but must be completed and retained for audit purposes If the form and email/fax confirmation, where applicable, cannot be produced during audit activity, the claim will be considered not validated and will be recovered.

For proof of mail, before mailing, stamp/sign the original with the date mailed. Mail the original and retain a copy for your records.

The pharmacist must document the follow-up by completing a SaferMedsNL Follow-up Form and retaining it for audit purposes.

For more information on the SafermedsNL initiative and to access the fillable Evidence-Based Pharmaceutical Opinion Form, please visit www.SaferMedsNL.ca website and select Health Care Provider Resources under the Resources tab.

10.27.4 Extending a Prescription

Providers will be reimbursed for extending a prescription for eligible individuals. Reimbursement conditions are as follows.

A pharmacy Provider may claim up to 4 prescription extensions per patient, in a 12-month period using any combination for the PINs in the following table:

Number of Prescriptions Renewed	Fee Reimbursed	PIN
2 or less	$10	92099663
3	$15	92099662
4 or more	$20	92099661

10.27.4.1 Requirements

- At least 1 prescription must be dispensed on the date of the claim.
- The Provider is not permitted to charge the patient renewal fee(s) over and above the renewal fee(s) outlined in the table above.
- Pharmacists are encouraged to assess at the time of dispensing whether other prescriptions may require renewal within a reasonable timeframe and also renew those prescriptions. These additional prescriptions can remain on file until dispensing is required.
- The days' supply of the prescription renewal is not less than the usual quantity dispensed for the mediation unless it is unsafe to do so, and the specific circumstances are documented on the patient's file.
- The fee reimbursed is solely for the renewal service. Cost of medication and associated fees such as dispense fee and/or markup are the responsibility of the patient using their usual form of payment (NLPDP drug card, private insurance, cash, etc.).

10.27.4.2 Claiming Procedure

When claiming a prescription extension: DIN: As per the PINs provided above.

- Prescriber Reference ID: 16

- Prescriber: Use the NLPDP Billing Number of the pharmacist prescribing the extensions.
- Days' Supply: 1
- Quantity: 1
- Drug Cost: 0.00
- Professional Fee: 0.00
- Special Services Fee: As per the applicable fee provided above.

10.27.4.3 Required Documentation

Claims will be processed where the documentation requirements outlined by the **NLPB Prescribing by Pharmacists Standards of Practice** have been completed in either electronic or paper-based format, and must include:

- Patient Name, address, and MCP number,
- Reason for assessment (requiring prescription extensions of current medications),
- Name of medication prescribed and rationale, if applicable, and
- Instructions given to patient, including any follow-up required.

If the documentation, as completed at the time of claiming for prescription extensions cannot be produced during audit activity, the claim will be considered not validated and will be recovered.

10.27.5 Select Ailment/Condition Assessments:

Providers will be reimbursed an assessment fee for the ailments and conditions outlined for eligible individuals.

A pharmacy Provider may claim for the assessment and prescribing (if applicable) for:

1. Uncomplicated urinary tract infections (UTIs)
2. Conjunctivitis
3. Herpes Zoster (Shingles)
4. Fungal nail infections
5. Gastroesophageal reflux disease
6. Nicotine dependence
7. Herpes Simplex (cold sores)
8. Fungal skin infections
9. Hemorrhoids

Limitations, fees and claiming PINs are set out in the following table.

Assessment Type	PIN	Total # of Claims /12-month Period	Fee per Claim
Uncomplicated UTI resulting in a prescription	93899857	3	$20
Uncomplicated UTI without prescription	93899852		
Conjunctivitis resulting in a prescription	93899784	2	$20
Conjunctivitis without a prescription	93899785		
Shingles resulting in a prescription	93899858	2	$20
Shingles without a prescription	93899853		
Fungal nail infection resulting in prescription	93899782	3	$20
Fungal nail infection without prescription	93899783		
GERD resulting in prescription	93899779	2	$20
GERD without prescription	93899780		
Nicotine dependence resulting in a prescription	93899989	3	$20
Nicotine dependence without prescription	93899774		
Cold sores resulting in a prescription	93899777	4	$20
Cold sores without prescription	93899787		
Fungal skin infection resulting in prescription	93899809	3	$20
Fungal skin infection without prescription	93899781		
Hemorrhoids resulting in prescription	93899807	3	$20
Hemorrhoids without prescription	93899778		

10.27.5.1 Requirements

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- The Provider is not permitted to charge the patient assessment fee(s) over and above the assessment fee outlined in the table above.
- The fee reimbursed is solely for assessment of the select ailment/condition. Cost of medication and associated fees such as dispense fee and/or mark-up are the responsibility of the patient using their usual form of payment (NLPDP drug card, private insurance, cash, etc.).

- The assessment is not eligible for the purpose of prescription renewal.

10.27.5.2 Claiming Procedure

When claiming for select ailment/condition assessments:

- DIN: As per the PINs identified in 10.27.5.
- Prescriber Reference ID: 16
- Prescriber: Use the NLPDP Billing Number of the pharmacist completing the assessment
- Days' Supply: 1
- Quantity: 1
- Drug Cost: 0.00
- Professional Fee: 0.00
- Special Services Fee: 20.00

10.27.5.3 Required Documentation

Claims will be covered where the documentation requirements outlined by the **NLPB Prescribing by Pharmacists Standards of Practice** have been completed in either electronic or paper-based format and include:

- Patient name, address, and MCP number,
- Reason for assessment (requiring assessment for a select ailment or condition),
- Name of medication prescribed and rationale, if applicable,
- Reason(s)for a decision not to prescribe, if applicable, and
- Instructions given to patient, including any follow-up required.

If the documentation, as completed at the time of claiming for assessments of select ailments/conditions, cannot be produced during audit activity, the claim will be considered not validated and will be recovered.

10.27.6 Hormonal Contraceptive Assessments

Providers will be reimbursed an assessment fee for Hormonal Contraceptives for all eligible individuals. Reimbursement conditions are outlined below.

A pharmacy Provider may claim up to 3 assessments per 12-month period to assess a patient for hormonal contraceptives.

Assessment Type	PIN	Fee
Initial assessment resulting in prescription	93899856	$20
Initial assessment **not** resulting in prescription	93899851	$20
Follow-up assessment resulting in change of prescription	93899855	$20
Follow-up assessment **not** resulting in change of prescription	93899854	$20

Follow-up assessment where hormonal contraceptive is discontinued and/or client is referred	93899776	$20

10.27.6.1 Requirements

- Patient is between the ages of 12 and 53.
- The Provider is not permitted to charge the patient an assessment fee(s) over and above assessment fee(s) outlined in in 10.27.6.
- The assessment is not eligible for purposes of prescription renewal.
- The assessment is not eligible for the purposes of prescribing and/or dispensing emergency contraception.
- It is expected that each dispense of oral contraceptive pills is for a day's supply of 84-90 days and refills are provided for a year unless there are limitations with a third-party insurer, or there are other reasons why it would not be in the patient's best interest to do so. Specific circumstances must be documented in the patient's file.
- The fee reimbursed is solely for assessment of Hormonal Contraceptives. Cost of medication and associated fees such as dispense fee and/or mark-up are the responsibility of the patient using their usual form of payment (NLPDP drug card, private insurance, cash, etc.).

10.27.6.2 Claiming Procedure

When claiming for hormonal contraceptive assessments:

- DIN: As per the PINs provided in 10.27.6.
- Prescriber Reference ID: 16
- Prescriber: Use the NLPDP Billing Number of the pharmacist completing the assessment.
- Days' Supply: 1
- Quantity: 1
- Drug Cost: 0.00
- Professional Fee: 0.00
- Special Services Fee: 20.00

10.27.6.3 Required Documentation

Claims will be covered where the documentation requirements outlined by the **NLPB Prescribing by Pharmacists Standards of Practice** have been completed in either electronic or paper-based format and include:

- Patient name, address, and MCP number,
- Reason for assessment (requiring hormonal contraceptive),
- Name of medication prescribed and rationale, if applicable,

- Reason(s) for a decision not to prescribe, if applicable, and
- Instructions given to patient, including any follow-up required.

If the documentation, as completed at the time of claiming for assessments of hormonal contraceptives cannot be produced during audit activity, the claim will be considered not validated and will be recovered.

10.27.7 Mifegymiso

Mifegymiso is used for medical termination of a pregnancy up to nine weeks' gestation age.

10.27.7.1 Requirements

- Mifegymiso must be prescribed by a doctor or nurse practitioner and is available at no cost to patients.
- Patients can receive a prescription through their primary Health Care Professional, the provincial health authority, or the Athena Clinic.
- Those with private insurance will use this first, and a claim submitted to NLPDP for the balance.

10.27.7.2 Claiming

When claiming for Mifegymiso:

- DIN 02444038
- Quantity: 1
- Days' Supply: 1
- Drug Cost: Manufacturer List Price plus 8.5% - currently $325.50 per dose.
- Professional Fee: based on current tiered structure.

Policy Amendment History	***Effective Date***
Original Policy	November 30, 2011
Revision #6	January 22, 2024