10. PROGRAM CLAIMING POLICIES (Updated June 2020)

10.1 Overview

Providers and staff are expected to follow all applicable federal and provincial legislation, Program polices, 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 expected 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 (please see Section 12 for further information).

It is also important to note that:

- All required documentation relating to claims submitted to the Program must be completed before being submitted.

- All claims submitted must be verifiable from the Original Prescription (i.e. the prescription as written by 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

    - Upon request of an Auditor, provide copies of requested Original Prescription and all applicable documentation as may be required.

When claims are identified that are not billed in accordance with Program requirements / policies, payment recoveries will occur.

10.2 Benefit Limitations

There are a number of medication benefits covered under the Program for which limitations on their coverage apply.

NOTE: Over-the-Counter (OTC) Medications are limited to Children in Care of the Regional Health Authorities or the Department of Children, Seniors and Social Development unless a special approval is in place on the beneficiary file.

Please note that 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 once in a 365 day period (starting the date of the first claim for an areochamber).

The Intervention Code MR (Appendix E) may 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. If documentation cannot be produced during audit activity the claim will be considered not validated and will be recovered.

Pharmacists are able to fill claims for aerochambers and spacers without a prescription from a physician. These claims may be submitted as normal claims to the NLPDP, with the pharmacist providing the product to the client listed as the prescriber on the claim, 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 are Anti-emetics covered by the Program only for chemo 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 chemo anti-emetic drugs. A Special Authorization is required for a higher quantity dispensed than noted above for a first fill or for any subsequent fills of any chemo anti-emetic drug.

10.2.3. Cephalexin Suspension

The following DINs will have an **age limitation, beneficiary must be less than 13 years old:**

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

10.2.4. Diabetic Test Strips
Coverage of glucose test strips is restricted to:

- An annual maximum of 700 test strips for Beneficiaries receiving long acting insulin (with or without non-insulin diabetes medications but **not** using short acting insulin).

- An annual maximum of 100 test strips for Beneficiaries receiving **only** non-insulin diabetes medications.

- An annual maximum of 50 test strips for Beneficiaries receiving **no** insulin or non-insulin diabetes medications.

- An annual maximum of 2500 test strips for Beneficiaries receiving short acting insulin (with or without other insulin or non-insulin diabetes medications).

No prior approval will be needed to access the test strips amounts listed above.

The following Patient Categories will require prior approval:

- An additional 50 test strips may be considered annually under exceptional circumstances for Beneficiaries receiving **no** diabetes medications requiring in excess of the 50 test strips maximum. Fill dates must be 6 months apart.

- An additional 100 test strips may be considered annually under exceptional circumstances for Beneficiaries receiving insulin and other non-insulin diabetes medications requiring in excess of the 700 test strips maximum.

- An additional 50 test strips may be considered annually under exceptional circumstances for Beneficiaries receiving non-insulin diabetes medications requiring in excess of the 100 test strips maximum.

- Beneficiaries with Type I or Type II Diabetes being treated with insulin and/or non-insulin diabetes medications not funded through NLPDP in order to access the annual maximum for that individual.

- For Beneficiaries with gestational diabetes or pregnant with Type II Diabetes, the number of test strips will be determined by the requesting healthcare professional.

Claims for glucose test strips will only be paid if the Beneficiary has had a paid claim for insulin and/or non-insulin diabetic medication within the past year or has a Special Authorization in place.

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 children under the age of 12 years

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. The only exceptions are beneficiaries whose Pediatric Endocrinologists have demonstrated the need to continue on a low dose of Growth Hormone into adult years and for individuals diagnosed with Turner's Syndrome for which special authorization approvals have been set up.

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 for the past year, unless a Special Authorization is in place.

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

10.2.11. Wellbutrin
Coverage is provided if the Beneficiary has a paid claim for an anti-depressant in their history within the past 365 days, otherwise a Special Authorization is required.

10.2.12. Dostinex (and its generics) and Norprolac
Coverage for Dostinex (and its generics) or Norprolac is provided if the Beneficiary has a paid claim for Dostinex (and its generics), Norprolac or Bromocriptine within the past year, otherwise a Special Authorization is required.

10.2.13. Asmanex Twisthaler

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

10.3 Compounded Preparations

Compounds (Extemporaneous Preparations as referred in PANL Contract) are defined as mixtures of **three or more** ingredients where the mixture is prepared by a Provider according to the order of a Prescriber.

NLPDP will reimburse 1.5 X Base fee ($11.96- $12.00) for compounds containing three or more ingredients.

Compounds containing two ingredients will be reimbursed the base fee only.

NLPDP reserves the right to require submission of the details of the Compound prior to or after payment of the claim to verify the defined cost.

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 alter in 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,
- **Special Authorization** Approval is required for compounds that contain one or more Special Authorization drugs and/or where the route of administration is changed.

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 Contract, (Appendix I) or in the event no agreement exists a fee as set by the Minister, and 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.

   Examples: 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.

   Examples: Diclofenac topical is a non-benefit compound as only the oral formulations of diclofenac are benefits of the Program. Topical diclofenac (Pennsaid) was reviewed through the Atlantic Common Drug Review and coverage was not recommended and is not considered a benefit of the NLPDP.

Special Authorization Compound:

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

   Example: Carvedilol compounded in a liquid formulation requires Special Authorization; carvedilol is a special authorization drug under the Program.

   Example: Differin 0.1% gel/Benzagel 5%(Benzagel is only covered for Children-in-Care) 1:1 requires Special Authorization prior to dispensing even though Benzagel is an open benefit because Differin gel requires special authorization.

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

Reimbursement for Compounds requires the Provider to calculate the total product cost for the preparation. The claim will be submitted with the PIN '00999997' and the calculated cost of the compound provided in the Drug Cost/Ingredient Cost field of the claim.

A compound charge (up to 50% of the paid base professional fee) may 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, a fee as set by the Minister. If the compound charge is claimed in the compound fee field, a valid Compound Code must be submitted on the claim.

Compound Codes

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 information must be documented on the Original Prescription or attached to the prescription hardcopy at time of dispensing:

- General identification of Compound

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

- Identification of each ingredient used by name (the Program notes that the ingredient may have different DINs/PINs depending on the third party provider billed).

- Specific quantity used of each ingredient for the amount of Compound dispensed.

- Package size* used in the Compound when there is more than one size available. **Example:** 15g, 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 noted on the prescription, computer generated hard copy of the prescription and/or handwritten 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 as indicated at the time of dispensing will result in a recovery during audit activity.

Reimbursement shall 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 Table 1, 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.

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

Providers are not required to submit special claims or comments with their compound claims to have them adjudicated in real-time.

The following table lists the Product Identification Number (PIN) and unit price 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 one of the clinical pharmacists at (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	903842	1.0000

Anthralin Powder (All Brands)	903057	4.3292
Betamethasone Valerate Powder	99099946	1.7800
Camphor Crystals (All Brands)	968885	0.0109
Clindamycin Phosphate Powder	99099969	3.2260
Cold Cream (All Brands)	903372	0.0434
Crude Coal Tar (All Brands)	900974	0.3906
Diltiazem HCI USP	903210	3.1600
Distilled Water (All Brands)	977772	0.0005
Disulfiram Powder	999087	0.5750
Eucerin Cream (All Brands)	903193	0.0621
Eucerin/Glycerin/Water	903019	0.0160
Fluoxetine HCI Powder	99099971	12.6666
Friar's Balsam (All Brands)	509051	0.1489
Gelatin Capsules	903745	0.0340
Glaxal Base/Dermabase	902977	0.0402
Glycerin (All Brands)	179132	0.0307
Guaifenesin USP	99099953	0.0510
Hydrocortisone Powder (All Brands)	990821	3.7324
Hydroxyurea Powder	99099970	2.5600
Ihles Paste (All Brands)	903116	0.0201
Isopropyl Alcohol 70% (All Brands)	977153	0.0098
Lactose Monohydrate NF	903603	0.0165

Lanolin (All Brands)	1923129	0.0333
Lassar's Paste (All Brands)	900982	0.0537
LCD (All Brands)	999972	0.0516
Mechlorethamine hydrochloride powder	99099952	36.3600
Menthol Crystals (All Brands)	969931	0.1736
Methoxsalen Powder	903588	70.8000
Methycellulose Suspension	967297	0.0470
Methylphenidate Powder	99099960	13.5700
Mineral Oil (All Brands)	481386	0.0117
Nifedipine USP Powder	99099967	10.4000
Nitrofurantoin USP Powder	903649	7.2000
Omeprazole USP Powder	99099968	3.5640
Ora Sweet	903547	0.0600
Ora Sweet SF	903548	0.0600
Ora Plus	99099959	0.0320
Petrolatum Ointment (All Brands including Vaseline)	999005	0.0093
Phenazopyridine HCl USP - per gram	903560	1.0800
Phenol Crystals (All Brands)	969990	0.3472
Potassium Iodide USP	99099958	0.1300
Potassium Permanganate Crystals (All Brands)	987735	0.0635
Propylene Glycol	99099947	0.0228
Pyrilamine Maleate USP	99099957	0.8070
Salicylic Acid Powder (All Brands)	999036	0.0636

Simple Syrup (All Brands)	988006	0.0169
Sodium Bicarbonate 8.4%	261998	0.3878
Sorbitol 70% solution USP 3000ml pack size	99099955	0.0115
Sulfamethoxazole EP - per gram	99099961	0.5600
Sulphur Powder (All Brands)	969923	0.0488
Tar Distillate (All Brands)	579963	0.2875
Theophylline USP Anhydrous	99099954	0.3200
Thioridazine Capsules	903700	0.6778
Trimethoprim USP Micronized – per gram	99099962	1.5200

10.4 Confirmations

At times, 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.

NOTE: Depending on the information provided by the Beneficiary and/or the Prescriber, the Program may contact the Provider for further information to consider.

10.5 Discrepancy between Pharmacy Records and Claim

In the event that a discrepancy is identified between the records of the Provider and claims information, payment recoveries may occur.

10.6 Documentation Requirements

In order for a prescription to be considered valid, a minimum of the following items must be detailed on the prescription:

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 who received the verbal order and reduced the prescription to writing.

Verbal prescriptions may be documented either in:

- handwriting, and/or

- by the Pharmacy Management System's Hardcopy, provided that all required information is noted. 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.

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 transferring the prescription,
- Date of the last refill,
- Date of the Original Prescription, and
- Name/initials of the pharmacist who received the transferred order and reduced the prescription to writing.

Verbally Transferred Prescriptions may be documented either in:

- handwriting and/or

- by the Pharmacy Management System's Hardcopy, provided that all required information is noted. 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 note all the required fields.

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.

In cases where a prescriber practitioner writes “all regular meds” or “diabetes supplies”, the Program will allow the hard copy of the prescription to be used to provide the details as long as the patient has a documented history of the medication.

NOTE: Identified cases where a Verbal Prescription, Transferred Prescription, or prescription written by a prescribing practitioner does not note the required information, recoveries will occur.

10.7 Expiry of a Prescription

Prescriptions are valid for only one year from the date that it was originally written or ordered by a Prescriber, except in cases authorized by Medication Management.

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 even if it is not listed on the Newfoundland and Labrador Interchangeable 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 patient adherence to the medication regimen (e.g. the patient 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 being substituted is equal to or less than the cost of the medication prescribed.

10.9 Methadone for Addictions

There are two medications reimbursed for Methadone to treat addictions:

1. Methadose – DIN 02394618

2. Metadol-D – DIN 02244290

Methadose 10mg/ml Oral Concentrate – Dye Free, Sugar Free, Unflavored / Metadol-D 10mg/ml

The Program provides coverage for the preparation of Methadose / Metadol-D for the purpose of treating opiate addiction. For the duration of the COVID-19 Pandemic, Methadose / Metadol-D will not require a special authorization under the Program.

Pricing

As per the current agreement with PANL, the maximum paid drug cost for Methadose / Metadol-D will be $1.50 per day. The paid drug cost will be calculated as follows:

Paid Drug Cost = Paid Days Supply X $1.50

Claiming for Methadose / Metadol-D

The claiming process will be as follows:

Methadone Maintenance (Daily Witnessed Doses)

- DIN = 02394618 / 02244290
- Days Supply = 1
- Quantity = the actual amount of Methadose dispensed (ml)

Methadone Carries

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

The following guidelines must be followed when submitting claims for Methadose / Metadol-D:

- DIN = 02394618 / 02244290
- All claims must have a Days Supply of 1 submitted. If the claim is submitted with any other value then the claim will reject with message DM (Day's Supply Error);
- For the duration of the COVID-19 Pandemic, the NLPDP will reimburse a $3.00 Dispense Fee for each methadone carry. The initial Dispense Fee will remain at $1.50. The second and remaining dispenses for carries will automatically apply the $3.00 Dispense Fee, $3.00 does not need to be keyed. This carry fee will apply to patients picking up any number of carries including the initial dose from 1 to 14. The quantity submitted with the claim should

be the actual quantity of Methadose / Metadol-D dispensed and as reflected on the printed label for the carry;

- If a claim is after the Beneficiary has reached their maximum allowed Methadose / Metadol-D claims for the day (maintenance and carry claims), the claim will reject with message CN (Patient Has Exceeded Quantity Limit).

The **CN Response Code CANNOT be overridden.**

10.10 Multiple Billings

Cases identified 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

Any claim identified where a medication not listed as a Benefit is claimed under a DIN listed as a Benefit will be recovered.

10.12 Intervention Codes

The Program system may return Drug Utilization Review (DUR) messages as part of the claims adjudication process (for further information, please see Section 9.4.1). As appropriate, Providers may use allowable CPhA Exception/Intervention Codes to over-ride the DUR messages. Please ensure you have adequate documentation on the beneficiary file to support 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) to NLPDP 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, who is registered with the NLPB as having authorization to prescribe and has documented his/her action in accordance with the Prescribing by Pharmacists standards of the NLPB. 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 handwriting and/or by 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, that is 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 Newfoundland and Labrador Pharmacy Board, Standard of Pharmacy Practice Guidelines. Each of which shall be dispensed in quantities of 28 to 35 day supply (depending on manufacturing 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 NLPDP's Days Supply Policy was intended to limit benzodiazepines and antidepressants to a 30 day supply only to deter abuse/misuse of these medications. Beneficiaries taking these medications long term with no history of abuse/misuse should receive a 90 day supply if prescribed by their physician.

The NLPDP has established Intervention Codes within the Adjudication System to allow a pharmacist to override a claim so that a beneficiary can obtain a 90 day supply of benzodiazepines and antidepressants in instances where the prescriber has ordered a 90 day supply and the dispensing pharmacist has no concerns of abuse/misuse.

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

NLPDP requests that the dispensing pharmacist document on the prescription or hardcopy the reason for the use of the Intervention Code.

10.15 Vacation Supply – Medications

Effective January 12, 2017, the NLPDP implemented a Vacation Supply Policy of Medications to allow beneficiaries an adequate supply of medications while on vacation.

Policy

Beneficiaries travelling outside the province for **vacation only** for more than 100 days will be allowed to obtain up to two prescriptions (maximum of 180 day supply) for the same medication before leaving Newfoundland and Labrador as approved by the Prescriber.

NLPDP will allow pharmacies to dispense up to two 90 day fills for each medication (including benzodiazepines and anti-depressants). The usual dispense fee is to be applied to each 90 day prescription as per the PANL Contract. This will allow a 180 day maximum supply of medication for beneficiaries to take with them. **Prescriptions for narcotics can only be dispensed in 30 day supplies.**

Beneficiaries will be responsible for applicable copayments for each 90 day supply of the prescriptions.

NLPDP **will not** be 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** should request his/her vacation supply from the pharmacy at least 4 days before leaving the province to ensure the pharmacy has enough stock on hand and provide the pharmacist with the following information;

- Dates of departure and return
- Destination

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

Process for Claiming

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

Day 1

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

Day 2

a. Drug cost and dispense fee submitted;
b. The Prescriber;
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

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

Amount dispensed/billed should be equal to the closest package size. In cases where the nearest package size to quantity prescribed is greater /less than 10, the Program will reimburse for the larger package size. Examples:

- A cream comes in 40 and 60 gm sizes and the physician writes an Rx for 50 gm, the program will reimburse for the 60 gm package size.
- A prescription is written 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 Prescribing by Pharmacists standards of the NLPB to extend a prescription past the normal limits when:

- There is notice from the Newfoundland and Labrador Pharmacy Board (NLPB) and the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) in consultation with the Department of Health and Community Services that a physician is no longer in practice as he/she is:
    - deceased;
    - retired;
    - relocated;
    - suspended from medical practice; or
    - absent due to illness or other reason; and

- The claims adhere to the principles of the Prescribing by Pharmacists Standards (outlined in Section 10.24 of this Guide) 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 the NLPB Standards of Practice. Please refer to Sections C.01.041 – C.01.049 of the *Food and Drugs Regulations* under the *Food and Drugs Act* (Canada) and Regulation 13(12) of the *Pharmacy Regulations* under the *Pharmacy Act* (Newfoundland and Labrador) or in the case of records associated with exercising Prescribing by Pharmacists in accordance with the manner and time period specified by NLPB.

The requirement to keep the Original Prescription on file for two years after the date of the last time it was refilled would mean that the original of such a prescription must be kept on file for almost 3 years.

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 result in recovery.

10.20 Payor of Last Resort

The *Pharmaceutical Services Act* states the Program is Payor of Last Resort which means if a Beneficiary has private insurance coverage then the claims must be submitted to the private insurance first with the remaining unpaid balance

being submitted to the Program (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 that Provider shall first bill the alternate insurer, and shall not bill to the NLPDP any amount of a covered product paid for or eligible for payment under, the alternate insurer.

10.21 Tamper Resistant Prescription Drug Pad Program

For medications listed in Schedule 1, a Provider shall not dispense and bill the Program for the medication unless the supporting prescription is written or typed on a tamper resistant prescription drug pad.

The complete schedule is found at http://www.health.gov.nl.ca/health/prescription/schedule_of_drugs_tamper_resistent.pdf

If the patient's address and/or MCP number is missing from the prescription, the missing information must appear on the attached hard copy (for audit purposes).

10.22 Verbal Prescription – Narcotic

Verbal prescriptions are not valid for a narcotic. Only prescriptions written and signed by a licensed physician are valid.

10.23 Refusal to Fill

A Provider may bill the Program 2x the Base Professional Fee as stated in Section 5.2 of the PANL Contract (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 pharmacist refuses to fill a claim to the Program (s)he must:

- bill using the PIN 00999890:
- enter his/her NLPB License Number (e.g., 12345 – minus 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 (found in Appendix K) both of which must be retained for two years for audit purposes.

NOTE: This Intervention Form is to be completed at the time of billing. If this completed Intervention Form cannot be produced during the on-site audit, the claim will be considered not validated and will result in a recovery.

10.24 Prescribing by Pharmacists

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

The Program will reimburse the drug cost and professional fee determined as per the current NLPDP rules only for claims where a Pharmacist prescribes for:

1. A Schedule I, II, III or Unscheduled Drug for a minor ailment to treat a condition listed in the Newfoundland and Labrador Pharmacy Board Standards of Practice – Prescribing by Pharmacists January 2020 at https://nlpb.ca/media/SOPP-Prescribing-by-Pharmacists-Jan2020.pdf
2. A Schedule I, II, III or Unscheduled Drug for a Preventable Disease listed in the Newfoundland and Labrador Pharmacy Board Standards of Practice – Prescribing by Pharmacists January 2020;
3. A Schedule I, II, III or Unscheduled Drug for Other Purposes, except Exempted Codeine Products; or
4. Making a Therapeutic Substitution.

10.24.1 Requirements

The Pharmacist must follow the Overall and Individual Requirements specified in the Newfoundland and Labrador Pharmacy Board Standards of Pharmacy Practice – Prescribing by Pharmacists January 2020 in order to be reimbursed by the Program. **This includes documenting all instances of prescribing as set by the NL Pharmacy Board. Failure to present documentation of prescribing activities, pharmacist's rationale, and related follow-up plan during NLPDP audit activity will result in recovery.**

If a pharmacist is prescribing an interim supply or for a minor ailment in a claim to the Program (s)he must:

- enter his/her NLPB License Number (e.g., 12345 – minus the dash between the second and third digits) in the Prescriber field; and
- enter a value of 16 in the Prescriber Reference ID Field.

10.24.2 Limitations under the Program

1. 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 medication **AND**
   - 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 from the department, clear, concise documentation supporting a reasonable rationale for non-adherence.

   Example: A client who normally received a 90 day supply of Lorazepam who now has coverage under the Program can only receive an interim supply or extension of up to 30 days as the Program will not allow more than a 30 day supply of a Controlled Substance unless the Pharmacist overrides the claim using one of the allowed Intervention Codes (CS, NF, UA, or UE) **and** documents on the prescription or hardcopy the reason for use of the override code.

3. If it is necessary to extend a prescription that has already been extended the claim must be submitted with **both** the NL (Renewal of Prescription) **AND** NN (Emergency Supply of Medication) Codes. If the NN code is not submitted the claim will reject with message KO (Good Faith Code Previously Used).

10.24.3 Prescribing for an Interim Supply

The Program will provide coverage for an interim supply as long as it is 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. Therefore, the Program will provide coverage for an interim supply as long as it is less than or equal to the quantity on the original prescription up to a quantity of 90 days and in accordance with the Program's Days Supply Policy. These claims must be submitted with the CPhA Intervention Code MK (Good Faith Emergency Coverage Established).

The process for submitting a claim for an Interim Supply 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,

If the claim does not adjudicate correctly, then use the following process:

1. Submit the original claim using the CPhA Intervention Code MK and omit the submission of the Medication Management Fee in the Special Services Fee field.

2. After the original claim is processed, submit a separate claim for the Medication Management Fee using PIN 00999882:
    a. The client ID and Service Date MUST match the values on the original claim;
    b. The claim MUST be submitted with the Prescriber Reference ID = 16 and the pharmacists NLPDP provider number in the Prescriber field (as with the original claim);
    c. The Intervention Code MUST match the code submitted on the original claim;
    d. The Medication Management Fee MUST be submitted in the Special Services field, and all other cost fields left blank or set to 0;
    e. If the client has other coverage, submit Intervention Code DB to allow the claim to be submitted directly to NLPDP without having to undergo Coordination of Benefits.

If the submitted claim for the Medication Management Fee does not contain MK (Good Faith Emergency Coverage Established) it will reject with message D3 (Prescriber Not Authorized).

10.24.4 Extending a Prescription (Continuation of Care)

A Pharmacist may extend a patient's existing prescription by providing an additional refill. The amount of medication provided should be determined by the Pharmacist based on the circumstances of the particular patient but should not exceed the amount previously filled or 90 days whichever is less and be dispensed in accordance with the Program's Days Supply Policy.

The previous prescription for the medication must have been filled at the pharmacy where the Pharmacist is providing the extended prescription.

These claims must be submitted with the CPhA Intervention Code NL (Renewal of Prescription).

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

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

If the claim does not adjudicate correctly, then use the following process:

1. Submit the original claim using the CPhA Intervention Code NL and omit the submission of the Medication Management Fee in the Special Services Fee field.

2. After the original claim is processed, submit a separate claim for the Medication Management Fee using PIN 00999882:
    a. The client ID and Service Date MUST match the values on the original claim;
    b. The claim MUST be submitted with the Prescriber Reference ID = 16 and the pharmacists NLPDP provider number in the Prescriber field (as with the original claim);
    c. The Intervention Code MUST match the code submitted on the original claim;
    d. The Medication Management Fee MUST be submitted in the Special Services field, and all other cost fields left blank or set to 0;
    e. If the client has other coverage, submit Intervention Code DB to allow the claim to be submitted directly to NLPDP without having to undergo Coordination of Benefits.

If the submitted claim for the Medication Management Fee does not contain NL (Renewal of Prescription) it will reject with message D3 (Prescriber Not Authorized).

The Program will require a copy of the previous prescription attached to the documentation completed for extending the prescription. If the previous prescription cannot be produced during audit activity both the claims of the previous prescription and the extended claim will be considered not validated and will result in a recovery.

10.24.5 Adapting a Prescription

The Program will provide coverage for claims adapting the prescription only when the change is for a product in the Program's Benefit list. Please refer to the Coverage Status Table online at: http://www.health.gov.nl.ca/health/prescription/coverage_status_table.pdf 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,

If the claim does not adjudicate correctly, then use the following process:

1. The first claim will be for the adapted drug product itself, with the following:
    a. Drug cost and dispense fee submitted;
    b. The physician who wrote the prescription as the prescriber;
    c. Intervention Code NJ;
    d. No Special Services Fee submitted.
2. The second claim would be for the Medication Management fee only, using the Medication Management Fee Only PIN (00999882), as follows:
    a. DIN/PIN: 00999882;
    b. $0 drug cost and dispense fee submitted;
    c. Intervention Code NJ;
    d. Prescriber Reference ID = 16 and the pharmacist making the adaptation submitted as the prescriber;
    e. The Medication Management Fee submitted as a Special Services Fee;
    f. The Service Date must match the Service Date of the first claim.

Failure to put the NJ Intervention Code on the first claim (indicating that it was adapted) or to submit the claim for Medication Management Fee Only without the same service date will result in the claim for the fee rejecting.

The Program will not provide coverage for a claim where the adaptation results in increased costs to the Program unless a Special Authorization is in place. Adaptations of this nature will be recovered during audit activity.

Please refer to the Newfoundland and Labrador Pharmacy Board Standards of Practice – Prescribing by Pharmacists January 2020 for the types of adaptations a Pharmacist is authorized to make.

10.24.6 Prescribing for a Minor Ailment

The Program will provide coverage for claims where the Pharmacist has prescribed for a minor ailment only for a product in the Program's Benefit list. Please refer to the Coverage Status Table online at: http://www.health.gov.nl.ca/health/prescription/coverage_status_table.pdf These claims must be submitted with the CPhA Intervention Code MH (Prescribing for Minor Ailment).

If the claim is not submitted with the Intervention Code MH then the claim will reject with the CPhA message D3 – Prescriber Not Authorized.

Payments for claims submitted with Intervention Code MH will be paid as normal NLPDP claims, with the drug cost and professional fee determined as per the current NLPDP rules. A Special Services Fee WILL NOT be paid for claims submitted with Intervention Code MH – if a Special Services Fee is submitted it will be cut back to $0.00.

Please refer to the Newfoundland and Labrador Pharmacy Board Standards of Practice – Prescribing by Pharmacists January 2020 for the list of conditions for which a Pharmacist may prescribe.

10.24.7 Documentation Requirements

The Program will provide coverage for claims where documentation required by NLPB has been completed. Please refer to the Newfoundland and Labrador Pharmacy Board Standards of Practice – Prescribing by Pharmacists January 2020 at https://nlpb.ca/media/SOPP-Prescribing-by-Pharmacists-Jan2020.pdf

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 result in a recovery.

10.24.8 Requesting Special Authorization as a Prescriber

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

If a pharmacist is prescribing and requesting a special authorization medication be assessed for coverage and would like to receive notification of the assessment outcome, the pharmacist is encouraged to:

- Indicate at the top of the SA Request Form if (s)he would like to receive a response letter notifying whether or not the request has been approved or if additional information is required to make an assessment; and
- Fill out the address section of the SA Request Form.

10.25 Medication Review

The following section provides information on Medication Review as it relates to claims billed to the Program.

A Medication Review is a patient-care service in which a pharmacist meets one-on-one with a Newfoundland and Labrador Prescription Drug Program (NLPDP) Beneficiary or the Beneficiary's caregiver to review his/her medication regime. The NLPDP will pay as per Section 5.2 (Enhanced Pharmacy Services) of the PANL Contract.

Policy

A Medication Review can be completed for any Beneficiary diagnosed with a chronic illness 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 human 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. A chronic disease includes, but is not limited to:

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

Purpose

The purpose of a Medication Review is to:

- Improve the beneficiary's knowledge of and compliance with his/her medications.
- Minimize side effects with a view to improve overall safety and health outcomes.

- Solve drug related problems where possible and within a pharmacist's scope, prevent emergency room visits and hospitalizations.
- Reduce wastage of medication.
- Instruct beneficiary on the use and disposal of medications and/or supplies.
- Discuss the impact of lifestyle changes on health.
- Recognize the role of the pharmacist in providing additional cognitive services to NLPDP beneficiaries.

Procedure

The Pharmacist completing the Medication Review will:

- Articulate to the beneficiary the purpose of the medication review and that there will be no out of pocket cost for him/her.
- Remind the beneficiary to bring his/her medication containers (even those obtained from other pharmacies) and over-the counter drugs, vitamins, and herbal remedies to his/her medication review appointment.
- Meet with the beneficiary for an in-person consultation for a minimum of 20-30 minutes. During the COVID-19 Pandemic, the NLPDP will temporarily lift the in-person consultation requirement for Medication Reviews. Reviews may be conducted virtually 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 auditing purposes. **As of June 1, 2020, Medication Reviews can be conducted via telephone consult during the COVID-19 Pandemic.**
- Conduct an assessment of all available prescription or non-prescription medications with a view to identifying drug related problems and resolving problems where possible and within a pharmacist's scope or, if applicable, making recommendations to the prescribing physician. A template for a Medication Review Form is attached in Appendix J. The intention of this form is that, once completed, it can be easily faxed to the prescribing physician for notification purposes and then filed as part of the pharmacy records. Pharmacies may develop their own Medication Review Form if desired (with the company header, for example) as long as a standard format is used and ALL of the information on the template is on the modified form.
- Provide the beneficiary with a comprehensive list summary including recommendations as a result of the review.
- Forward a copy of the beneficiary's Medication Review Form to his/her family physician if applicable.
- Retain Medication Review Forms **AND** mail or fax confirmation along with hardcopy of claim billed to the NLPDP on behalf of the beneficiary for 2 years for audit purposes.

NLPDP Requirements

The NLPDP will require the following information on Medication Review Forms to be kept on file for two years for audit purposes:

- Beneficiary information as noted on NLPDP drug card (first/last name, MCP number, date of birth, and gender);
- Beneficiary consent with signature;
- Date Medication Review was conducted;
- Beneficiary diagnosis (Blood test results are not mandatory fields);
- Provider name, address, and provider number (as assigned by the NLPDP for billing purposes);
- Name and signature of Pharmacist performing the medication review;
- Additional Counseling Provided;
- Complete medication list for Beneficiary's reference post review;
- Pharmacist Assessment, recommendations, and comments;
- Proof of mail or fax confirmation kept on file with Medication Review Form for 2 years for audit purposes. For proof of mail: Before mailing, stamp/sign the original with the date mailed. Mail the original and retain a photocopy for your records.

Claims Submission Information

The NLPDP will allow payment of up to 72 claims per Provider for Medication Review in a given year (a year is defined as April 1 – March 31).

Claims for Medication Review 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 for Medication Review 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).

Consistent with claims for other services (e.g. Medication Management), claims for Medication Review must be submitted with the following Prescriber information:

- Prescriber Reference ID=16
- Prescriber= the pharmacist's NLPB License Number (e.g., 12345 – minus the dash between the second and third digits)

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

If a pharmacy has already had 72 paid (non-reversed) claims for Medication Review in a year any subsequent claims will be rejected with message 72 (Special Services Fee Error).

10.26 SaferMedsNL

SaferMedsNL is a de-prescribing initiative to decrease the use of potentially inappropriate medications and improve the quality of life of Newfoundlanders and Labradorians. SaferMedsNL launched on January 28, 2019 and will run for 3 years with a focus on three classes of drugs:

1. Proton Pump Inhibitors (Year 1), continued in Year 2
2. Sedative Hypnotics (Year 2)
3. Opioids (Year 3)

Proton Pump Inhibitors (PPIs) Policy:

- Includes all residents of NL who are receiving long term prescriptions (greater than 12 weeks) for PPIs (Dexilant, Losec, Pariet, Nexium, Pantoloc, Prevacid, Tecta and their generic equivalents);
- Residents of Long Term Care and Personal Care Homes are included in the program;
- Government will reimburse pharmacies for an initial and follow-up deprescribing consultation. Claims can be billed online through the Newfoundland and Labrador Prescription Drug Program (NLPDP) Adjudication System;
- A deprescribing consultation is NOT considered a medication review and cannot be billed as one. However, a deprescribing consultation may be performed at the same time as a medication review, in which case, a pharmacy can bill for both services. Please note: Audits will be conducted on medication reviews performed on the same day as a deprescribe consultation for the same patient.

Sedative Policy:

- Includes all residents of NL 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);
- Residents of Long Term Care and Personal Care Homes are included in the program;
- Government will reimburse pharmacies for an initial and follow-up deprescribing consultation. Claims can be billed online through the Newfoundland and Labrador Prescription Drug Program (NLPDP) Adjudication System;
- A deprescribing consultation is NOT considered a medication review and cannot be billed as one. However, a deprescribing consultation may be

performed at the same time as a medication review, in which case, a pharmacy can bill for both services. Please note: Audits will be conducted on medication reviews performed on the same day as a deprescribe consultation for the same patient.

Initial De-prescribing Consultation:

- Involves a 5 – 10 minute *in-person* conversation with the patient or patient's caregiver highlighting some of the harmful side effects associated with taking a PPI and asking if he/she would like to further discuss the possibility of stopping the use of the PPI with their physician;
- **During the COVID-19 Pandemic, pharmacists may conduct the initial consultation over the phone or virtually.** An important component of billing the initial consult is providing the patient with the appropriate educational material. Brochures can be provided to the patient using one of the following processes:
    - 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 date it was mailed. Mail the original and retain a photocopy for your records for audit purposes.
- Completion of the Evidence-Based Pharmaceutical Opinion Form located at https://safermedsnl.ca/resources and forwarding to the prescribing physician. **The provided Evidence-Based Pharmaceutical Opinion Form is the only acceptable form;**
- Professional fee of $23.00;
- Can only be completed once per patient per lifetime;
- Only one initial de-prescribing consultation fee per deprescribing drug class regardless of the number of PPIs or Sedative-Hypnotics the patient may be using.

Follow-up De-prescribing Consultation:

- Can be conducted for two reasons:
    - The physician has made a change to the prescription indicating an intent to deprescribe. This can be indicated by faxing back of the Pharmaceutical Opinion form, verbal order or new prescription. In this case the 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 to further discuss the possibility of deprescribing. This type of 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 pharmacy as the initial consultation;
- Professional fee of $10.00;
- Involves an in-person or telephone consultation with the patient or patient's caregiver;
- Can only be completed once per patient per lifetime;
- Only one follow-up de-prescribing consultation fee per deprescribing drug class regardless of the number of PPIs or Sedative-Hypnotics the patient may be using.

As the Deprescribing Initiative is a government-funded program, claims billed for consultations are subject to audit. Public monies paid for claims not billed in compliance with the policies outlined above will be recovered.

CLAIMS SUBMISSION INFORMATION

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 doing 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 client co-payment required for claims for Deprescribing Consultations

There will be no SSC code required

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 must be kept in pharmacy records. In cases where the patient is not a candidate for deprescribing, the form does not need to be faxed to the physician but must be completed and kept on file for audit purposes. If the Form AND email or fax

confirmation, where applicable, cannot be produced during audit activity, the claim will be considered not validated and will result in a recovery.

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

The Pharmacist must document the follow-up by completing the SaferMedsNL Follow-up Form and keeping it on file 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**

10.27 Smoking Cessation

While the Provincial Smoking Cessation Program is not formally part of the Newfoundland and Labrador Prescription Drug Program (NLPDP), claims for the covered Smoking Cessation products may be submitted for claim adjudication and payment through the NLPDP Real-Time Claim Adjudication System.

The following drug products may be submitted for reimbursement under the Smoking Cessation Program.

- Zyban (DIN 02238441)
- Champix Starter Pack (DIN 02298309)
- Champix Continuation Pack (DIN 02291185)
- Nicorette Rx gum 2mg (NPN 02091933)
- Nicorette Rx gum 4mg (NPN 02091941)
- Nicorette Rx Lozenge 2mg (NPN 02247347)
- Nicorette Rx Lozenge 4mg (NPN 02247348)
- Nicoderm Step 1 Rx Patch 21mg (NPN 02093146)
- Nicoderm Step 2 Rx Patch 14mg (NPN 02093138)
- Nicoderm Step 3 RX Patch 7mg (NPN 02093111)
- Nicorette Rx Inhaler 10mg (NPN 02241742)

For a copy of the SCP health care provider or client brochures and promotional poster, please go to www.gov.nl.ca/cssd/files/healthyliving/tobaccocontrol

Beneficiary Eligibility

All beneficiaries aged 18 years of age and older under the following NLPDP Drug Plans will be eligible for coverage under the Smoking Cessation Program:

- Access
- 65+
- Foundation

Treatment Period

- All covered beneficiaries can receive up to 12 **continuous** weeks (84 days) of a prescription drug (Champix® or Zyban®) or a nicotine replacement product (patch, gum, lozenge or inhaler) within a 365 day period.
- Champix and Zyban are to be dispensed once every 28 days for a total of 84 days with a patient copay of $15.00 for the first dispense, and $30.00 for the second and third dispense (total copay of $75.00).
- NRT's are to be dispensed every 14 days for a total of 84 days with a patient copay of $12.50 per dispense (total copay of $75.00).

For the NRT's, the new "RX" product can be dispensed only under the Provincial Smoking Cessation Program. The quantity limits per dispense for NRT's is:

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

Total: 1155 pieces of gum

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

Total: 1056 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

Providers should use the UPC codes below to ensure they order the correct Rx SKU's:

0 62600 96509 7	NICORETTE Ultra Fresh Mint 2mg 105 Rx Gum
0 62600 96507 3	NICORETTE Mini Lozenge Fresh Mint 2mg 88 Rx
0 62600 96506 6	NICORETTE INHALER REFILL 42 Rx
0 62600 96510 3	NICORETTE Ultra Fresh Mint 4mg 105 Rx Gum
0 62600 96508 0	NICORETTE Mini Lozenge Fresh Mint 4mg 88 Rx
0 62600 96211 9	NICODERM Step 1 patches 21mg 7s DISP
0 62600 96212 6	NICODERM Step 2 patches 14mg 7s DISP
0 62600 96213 3	NICODERM Step 3 patches 7mg 7s DISP

Submitting Claims

Claims for products under the Smoking Cessation Program are to be submitted in the same manner as any other claims under the NLPDP, specifically:

- The drug price paid will be paid based on the standard NLPDP pricing, with a 8.5% markup included;
- The dispense fee paid will be paid as per the current agreement with PANL;
- No additional Special Service Fee's will be paid.

a) Zyban

Claims for Zyban must be submitted with a Special Services Code (SSC) to designate if the claim is the initial dispense for the client or one of the two (2) follow-up dispenses.

- Zyban Initial Dispense – Submit with SSC="L" (Initial Assessment of Patient Need)
- Zyban 2nd and 3rd Dispense - Submit with SSC="M" (Follow-Up Assessment of Patient Need)

If a claim is submitted without a valid SSC it will reject with message 57 (SSC Code Error).

If a claim for Zyban is submitted and the beneficiary has had a paid claim for Champix in the last 365 days the claim will reject with message CN (Patient Has

Attained Quantity Limit) and the message “Client has had treatment with Champix in the past year”

Once the beneficiary has used their three (3) dispenses for Zyban for the year, any subsequent claims for Zyban in that year will reject with message CN (Patient Has Attained Quantity Limit) and the message “Client has used all available treatments for the year”

Paid claims for Zyban will return the message “x dispenses remaining” indicating how many dispenses of Zyban the beneficiary has remaining for the year.

b) Champix

Only one Champix Starter Pack can be claimed in a 365 day period. Any subsequent claims for a Starter Pack in the period will reject with message CN (Patient Has Attained Quantity Limit) and the message “Starter Pack already dispensed this year”

If a claim for Champix is submitted and the beneficiary has had a paid claim for Zyban the last 365 days the claim will reject with message CN (Patient Has Attained Quantity Limit) and the message “Client has had treatment with Zyban in the past year”

Once the beneficiary has used their available quantity for the Champix Continuation Pack for the year, any subsequent claims for that year will reject with message CN (Patient Has Attained Quantity Limit) and the message “All continuation packs used for the year”

Paid claims for the Champix Starter Packs will return the message “x continuation packs remaining” indicating how many dispenses of the Champix Continuation Packs the beneficiary has remaining for the year.

Client Co-Pays

As the Smoking Cessation Program is not part of the NLPDP, the normal NLPDP client co-payments WILL NOT APPLY. Instead, a specific co-payment will be applied to each claim as follows (regardless of the specific NLPDP Plan the beneficiary is covered under):

Claim Type	Co-Pay
Zyban – First Dispense	$15.00
Zyban – 2nd and 3rd Dispenses	$30.00
Champix Starter Pack	$15.00
Champix – 2nd and 3rd Dispenses	$30.00
NRT’s	$12.50

Coordination of Benefits

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

10.28 Flu Vaccines

Authorized pharmacies may be able to claim an enhanced pharmacy services fee for delivering an approved flu vaccine from the public vaccine stockpile to NLPDP beneficiaries. The following are the approved flu vaccines that may be provided to NLPDP beneficiaries for 2019-20 flu season.

Flu Vaccine	**DIN**
FluLaval	02420783
Fluzone	02432730 (mdv)
	02420643 (pfs)
Fluad	02362384

The Fluad vaccine product is specifically intended for people who are age 65 years of age and over and cannot be administered to people below the age of 65. Given the significant proportion of the NLPDP beneficiaries who are age 65 and over, a portion of each order from the public vaccine supply supplied to pharmacies will be comprised of Fluad. This product **MUST** be used when providing a vaccination to NLPDP beneficiaries in this age group. Inappropriate use of the flu vaccines could potentially result in shortages later in the flu season.

Supply

Pharmacies will be expected to deliver flu vaccine from the public stockpile **only** to NLPDP beneficiaries. Pharmacies are expected to use private supply for those who are not NLPDP beneficiaries.

Reimbursement

The NLPDP will reimburse a Special Services Fee of $13.00 for each flu vaccine provided to an NLPDP beneficiary. This will be the only fee paid – no drug cost or dispense fee will be paid for flu vaccines provided to NLPDP beneficiaries from the public drug supply.

Pharmacists may only provide the flu vaccine to beneficiaries aged 5 and over, and intranasal vaccines to beneficiaries aged 2 and over. If a claim is submitted outside of these guidelines then the claim will reject with Response Code MU (Age

Precaution Indicated).

Claiming

Claims for the Flu Vaccine Fee must be submitted as follows:

- DIN: As per the public vaccine provided.
- Prescriber Reference ID: 16
- Prescriber: Use the NLPDP Billing number of the pharmacist doing 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

Beneficiary Co-Payments

There will be NO client co-payment required for claims for the provision of flu vaccines to NLPDP beneficiaries. The full value of the fee will be paid by the NLPDP.

Coordination of Benefits

There will be no coordination of benefits for flu vaccine claims. If the claim rejects with Response Code C6 (Patient has other coverage) please resubmit the claim with Intervention Code DB.

10.29 Mifegymiso

Mifegymiso is an alternative to surgically induced abortions and can be used for medical termination of a pregnancy up to nine weeks gestation age.

Mifegymiso must be prescribed by a doctor or nurse practitioner and is available at no cost to individuals with a valid MCP card. Individuals can receive a prescription through their healthcare provider, the regional health authorities, or the Athena Clinic in St. John's. Those with private insurance will use this first, and then the province will cover any remaining cost as last payer.

Mifegymiso can be submitted real time through the Newfoundland and Labrador Prescription Drug Program (NLPDP) adjudication system regardless of eligibility.

Claiming

Claims for Mifegymiso must be submitted as follows:

- 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 # 5	June 23, 2020