Pharmacy Benefact
A BULLETIN FOR PHARMACY SERVICE PROVIDERS FROM ALBERTA BLUE CROSS

Number 740 • May 2018

Alberta Blue Cross Pharmaceutical Services Provider Agreement update # 4

As announced in Pharmacy Benefact 725, February 28, 2018, Alberta Blue Cross will be answering your questions about the changes introduced in the new Alberta Blue Cross Pharmaceutical Services Provider Agreement effective May 17, 2018. This fourth update is intended to provide further clarity on the Frequent Dispensing Policy (FDP). Update #1 addressed the Holdback policy, Update #2 addressed the Compensation Plan for Pharmacy Services, and Update #3 addressed the Frequent Dispensing Policy. These Benefacts can be viewed online at **www.ab.bluecross.ca/pdfs/pharmacy-benefacts/pharmacy-home.php**.

FDP question and answers

What are the exemptions under the FDP?

There are currently **only** three categories of exemptions under the FDP.

1. Opioid Dependence Treatments **(methadone and suboxone)**.
2. Acute / Short Term Dispensing.
3. Drugs covered under the all Albertans programs, including Mifegymiso under the Women's Choice Program, Take-Home-Naloxone Kits under the Naloxone Program and oseltamivir for influenza outbreak prophylaxis under the Alberta Public Health Activities Program.

There are no exemptions for any other groups of patients, drugs or activities. This includes but is not limited to blister or compliance packaging, liquid preparations and physician or other prescriber requests.

For clarity

1. Opioid Dependence Treatments
   - Includes all forms of methadone and suboxone as listed on the *Alberta Drug Benefit List*, **idbl.ab.bluecross.ca/idbl/load.do**.
   - No other opioids or alternate treatments are included under the exemption.
   - Any and all dispensing activities for methadone and suboxone will be reimbursed for dispensing fees, drug costs and upcharges.
   - There are no documentation or eligibility requirements for this exemption for methadone and suboxone.

2. Acute / Short Term Dispensing
   - If a medication is filled for a patient on a continuous basis (for example daily, weekly or biweekly), it is considered **Long Term or Chronic Dispensing**. Short Term or Acute Dispensing would be considered for medications that are filled occasionally or as needed. Examples could include a brief course of antibiotics, certain inhalers filled as needed, creams for intermittent use or initiation of a new therapy during the stabilization period, or replacement of lost or stolen medications.
   - For any drug groupings (same active ingredient and same strength), the first two claims in a 28-day period will be fully covered. For acute or short term dispensing, in order for further dispensing fees for the drug grouping to be paid within a 28-day period, **the use of the override code UT will be required only if the claim is rejected**. No SSCs are required to be entered for an acute or short-term claim to be adjudicated.

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- The UT code may only be used four times per drug grouping, per person, per floating year, regardless of whether the code facilitated the payment or was entered unnecessarily. All other claims submitted with this code thereafter will be rejected with response code of **RN – Exceeds Annual Limit**. The claim will need to be resubmitted with a dispensing fee of $0.
- A patient may have several different acute or short-term drugs with unique drug groupings; each would have four available UT codes to use within a rolling year.
- A drug grouping is a group of products that has the same active ingredients and ingredient strengths. Therefore, two different strengths of the same drug are considered as two separate drug groupings. However, two different brands of the same drug at the same strength are considered the same drug grouping.

3. Alberta Public Health Activities Program
   - Drug benefits covered by the Alberta Public Health Activities Program are not subject to the frequent dispensing policy. For clarity these include only:
     - Mifegymiso,
     - Take-Home Naloxone Kits, and
     - Oseltamivir for prophylaxis in facilities when notified by the Medical Officer of Health of lab-confirmed influenza outbreaks.

When will the system begin counting the 28-day lookback to determine the eligible number of claims submitted under the FDP?

- Effective May 17, 2018 and going forward. Any claims submitted May 16, 2018 or earlier will not be calculated in the 28-day lookback to determine the eligible number of claims.

  For example, for one drug benefit dispensed on a weekly basis:

Date of service	Dispensing fee paid	Drug cost and upcharges paid
May 4, 2018	YES	YES
May 11, 2018	YES	YES
May 18, 2018	YES	YES
May 25, 2018	YES	YES
June 1, 2018	NO	YES
June 8, 2018	NO	YES
June 15, 2018	YES	YES

- Whenever a claim is made for a days' supply between two to 27, the system will begin the 28-day lookback to determine the eligible number of claims under the FDP rules.

  The FDP rules for daily dispensing (three fees per patient per day) and two to 27-day dispensing (two fees per drug per patient per 28 days) are mutually exclusive of each other. A patient who receives some medications on a daily, weekly and monthly basis or longer will have the edits applied for the FDP rules to each drug claim independent of one another.

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For example, for nine drug benefits from nine different drug groupings dispensed on one day to the same patient:

Date of service	Days supply filled	Dispensing fee paid	Drug cost and upcharges paid
May 18, 2018	1	YES	YES
May 18, 2018	1	YES	YES
May 18, 2018	1	YES	YES
May 18, 2018	1	NO	YES
May 18, 2018	7	YES	YES
May 18, 2018	7	YES	YES
May 18, 2018	7	YES	YES
May 18, 2018	30	YES	YES
May 18, 2018	30	YES	YES

When a **two to27-day** claim for a drug benefit is not eligible for payment of a dispensing fee under the FDP, the claim will reject with the response code of **87 – Exceeds max. number of professional fees for this drug** and the claim will need to be resubmitted with a dispensing fee of $0.

When a **DAILY** claim for a drug benefit is not eligible for payment of a dispensing fee under the FDP, the claim will reject with the response code of **RA – Exceeds maximum number of prescriptions per day** and the claim will need to be resubmitted with a dispensing fee of $0.

For dispensing fees that are over the limits established by the FDP, can the pharmacy collect the dispensing fee from the patient or other third party?

As per section 14.2(b)(ii) of the *Alberta Blue Cross Pharmaceutical Services Provider Agreement*, pharmacies will NOT be permitted to pass on the costs or additional dispensing fees to Alberta Blue Cross plan members.

If any portion of the claim is being paid by Alberta Blue Cross, then it must comply with the FDP. Therefore, there will be no dispensing fee to charge to another insurer on those claims not eligible for a dispensing fee.

Can the copay for prescriptions under the FDP be waived?

No, as per the *Alberta Blue Cross Pharmaceutical Services Provider Agreement* signed by each pharmacy, any and all copay amounts are to be treated in the same manner as any other claim.

To be clear, as per section 3.5; *it is the Plan Member's obligation to pay his/her full Co-payment. Accordingly, the Provider will collect from each Plan Member his/her full Co-payment (i.e. no more/no less) on the day that the Pharmaceutical Service is provided or as soon thereafter as is reasonably possible.*

When you have questions:

For assistance with benefit or claim inquiries, please contact an Alberta Blue Cross Pharmacy Services Provider Relations contact centre representative at:

780-498-8370 (Edmonton and area) • **403-294-4041** (Calgary and area) • **1-800-361-9632** (toll free)

FAX 780-498-8406 (Edmonton and area) • **FAX 1-877-305-9911** (toll free)

Alberta Blue Cross offers online access to current Pharmacy Benefacts and supplemental claiming information to assist with the submission of your direct bill drug claims. **Visit ab.bluecross.ca/providers/pharmacy-home.php**

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