Frequent Dispensing – Frequently Asked Questions

What is the Frequent Dispensing Policy?

The frequent dispensing policy covers a maximum number of dispensing fees for prescriptions filled daily or in 2 to 27 day supplies. The current policies regulating the dispensation of medications with a day supply for 28 or greater remains the same.

How does the Frequent Dispensing Policy differ from standard dispensing?

For most patients, the standard for dispensing long term or chronic medications is to dispense for a 100 days supply. The frequent dispensing policy will only apply for claims dispensed on a frequent basis for less than 28 days.

How many dispensing fees will be paid?

For daily dispensing – the maximum number of dispensing fees per patient that are eligible is three.

For 2 to 27 day supply – the maximum number of dispensing fees per patient that are eligible is two per drug grouping in a 27 day period.

How is a "drug grouping" defined?

A drug grouping is based on the Drug Product Database (DPD) **Active Ingredient Group (AIG)**. An AIG is a product that has the same active ingredient(s) and ingredient strength(s). 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.

What will happen if I enter a dispensing fee once the limit is reached?

The claims will be rejected. A $0.00 dispensing fee must be submitted for the claim to be accepted.

Will drug cost, upcharge #1 and upcharge #2 be covered for claims that exceed the limits?

Yes, the drug cost and the upcharges will adjudicate in the usual manner. Pharmacies will be reimbursed to the eligible drug cost.

Can I charge the dispensing fees that are not paid to the patient?

Pharmacies will NOT be permitted to pass on the costs or additional dispensing fees to beneficiaries/Albertans.

Can I waive the copay amount?

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.*

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Can I charge the dispensing fees that are not paid to another insurer?

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

Is there any eligibility criteria required for frequently dispensed claims?

Yes, the following criteria apply to frequently dispensed claims and the following special services codes must be entered on the claims:

For daily claims use special service code **8** – claiming multiple dispensing fees
For 2 – 27 day claims use special service code of letter **O**

Eligibility Criteria:

1. Physical or Sensory Impairment: a medical condition that limits a person's physical or sensory function to an extent where the patient requires frequent dispensing of medications;
2. Mental or Cognitive Impairment: a medical condition that may impair the mental or cognitive functioning of a patient, necessitating more frequent dispensing of medications;
3. Medication Safety: a broad category that includes complex medication regimens that require more frequent dispensing but also includes safety issues such as a patient history or risk of abuse, poor compliance, dependence, misuse or loss of belongings;
4. Facility Living: patients who reside in a continuing care facility where medications are dispensed by or with the assistance of staff at the facility.

Eligibility	**Special Service Code**
Physical Impairment/Sensory Impairment	**W** – EC consultation level 1
Mental/Cognitive Impairment	**X** – EC consultation level 2
Medication Safety	**Y** – EC consultation level 3
Facility Living	**5** – Approved for home care service*

The pharmacist is required to enter two special services codes, one to discern between daily and 2-27 patients (8 or O) and one to outline the rationale for the patient being a daily or 2-27 patient (W, X, Y or 5). Alberta Blue Cross will rely on the discretion of pharmacists to choose the appropriate codes.

*SSC 5 encompasses all frequent dispensing activities delivered in the patients residence under the care of a third party in a designated facility.

How will the Alberta Blue Cross PrideRT system determine if the claim is for a frequently dispensed drug?

The pharmacy must include the special services codes 8 for daily dispensing and O for dispensing a 2-27 days supply. In addition, at time of adjudication, a 28-day historical review of claims for that patient is completed to determine if the drug is a frequently dispensed drug.

Frequent Dispensing – Frequently Asked Questions

Will a dispensing fee be paid if the patient requires short-term acute dispensing?

Yes. If the claim rejects because the limits have been reached for that period you may enter the intervention code **UT – treatment of acute condition.** Enter this code only if the claim rejects. This code may only be used four times per drug grouping per person per floating year, and all other claims submitted with this code thereafter will be rejected. Short-term acute dispensing is not based on the type of drug, but rather the need for dispensing a drug or drug product within a 28 day period that would not be considered chronic or long-term therapy. It is up to the professional judgment of the pharmacist to determine when to utilize this intervention for a patient whether they receive frequent dispensing regularly or not.

How will claims be paid if a patient that normally has daily dispensed drugs receives carries on a weekend?

In these instances, the drugs will be dispensed with a two to three days supply and will be subject to the 2 – 27 day frequent dispensing policy. For example, a drug dispensed daily with a one day supply will be adjudicated according to the daily dispensing policy, which means that if that drug is within the three claims per day the dispensing fee will pay up to $12.15. If it is above the three claims per day limits the dispensing fee will reject unless it is submitted as $0.00. When that drug is dispensed for more than one day (two to three days) it will be subject to the 2 to 27 day policy, which means that the dispensing fee for two claims for that drug will be paid every 28 days.

The policies for daily dispensing and 2 – 27 day dispensing are mutually exclusive.

Will a dispensing fee be paid if I substitute with an interchangeable drug?

The system is built to identify drugs within a drug grouping and will not pay if the substitute drug is within the same drug grouping. If the substitute drug is from a different drug grouping, then a dispensing fee will be paid.

How will this policy affect coordination of benefits with other third party payers?

This policy does not affect coordination of benefits. For claims over the set limits, coordination of benefits will be based upon drug cost and upcharges. As the dispensing fee must be $0.00 for the claim to be accepted the coordination of benefits will apply to the $0.00 dispensing fee.

What will happen if the patient is going to more than one pharmacy?

The limits are set at a per patient level. Once the patient has reached their dispensing fee limits, no additional dispensing fees will be paid even if submitted from another pharmacy. See examples on page 5.

Do drugs for opioid dependency treatment count towards the dispensing fee limits?

Claims for methadone and suboxone will not count toward the dispensing fee limits for daily or 2 – 27 day dispensing.

Will drugs such as naloxone and Mifegymiso count towards the dispensing fee limits?

Claims for drugs which fall under the Alberta Public Health Activities programs for all Albertans do not count towards the frequent dispensing policy.

Will nutritional products or diabetic supplies count towards the dispensing fee limits?

Claims for nutritional products and diabetic supplies will not count towards the dispensing fee limits for daily or 2 to 27 day dispensing as they are already submitted with a $0.00 dispensing fee.

Frequent Dispensing – Frequently Asked Questions

What type of documentation will be required for frequently dispensed claims?

The documentation must include

- the patient identification information,
- who initiated the request for frequent dispensing,
- the names of the drugs being frequently dispensed, and
- the timeframe for frequent dispensing.

The documentation must also outline both of the following:

1. The rationale of frequent dispensing (physical or sensory impairment, mental or cognitive impairment, medication safety or facility living)
    a. Physical or sensory impairment may include a medical condition that limits a person's physical or sensory function to an extent where the patient requires frequent dispensing of medications.
    b. Mental or cognitive impairment may include a medical condition that may impair the mental or cognitive functioning of a patient, necessitating more frequent dispensing of medications.
    c. Medication safety is a broad category that includes complex medication regimens that require more frequent dispensing but also includes safety issues such as a patient history or risk of abuse, poor compliance, dependence, misuse or loss of belongings.
    d. Facility living refers to patients who reside in a continuing care facility where medications are dispensed by or with the assistance of staff at the facility.
2. The rationale for why less frequent dispensing is not appropriate. For example, for daily dispensing rationale must indicate why weekly dispensing is not appropriate.

This documentation must be kept for compliance verification purposes. This documentation must be completed prior to the initiation of frequent dispensing and is valid for 1 year. In cases where the requirement for frequent dispensing extends beyond one year, documentation must be completed each year.

Who may initiate the request for frequent dispensing?

Any healthcare practitioner who is actively involved in the patients care may initiate the request.

Will there be a transition period to allow pharmacies to meet the documentation requirements?

No, there will not be a transition period as the documentation requirements have not changed from those listed in the Pharmacy Reference Guide for Alberta Pharmacies, under Quantitative Limits located on the Alberta Blue Cross website at https://www.ab.bluecross.ca/pdfs/82477-ab-pharmacy-reference-guide.pdf

Will there be additional forms that need to be filled out for documentation?

No, there are no additional forms for documentation. Documentation may be paper based or in an electronic format that can be provided to Alberta Blue Cross on request.

Frequent Dispensing – Frequently Asked Questions

Is the Frequent Dispensing Policy applied to all Alberta Blue Cross members?

Yes, all Alberta Government sponsored drug plans, Alberta Blue Cross employer and individual product plans will be subject to this policy.

How are the dispensing fees calculated?

For Daily Dispensing

Daily dispensing fee is triggered by days' supply = 1

- One dispensing fee per person / per drug per day. A maximum of **three** dispensing fees allowed per person per day, **the fourth** dispensing fee and after will be rejected if not submitted at $0.00.

Day	Pharmacy	Drugs	Three Dispensing fees Allowed	Dispensing fee Rejected **Must submit with $0.00 dispensing fee**	Excluded from Policy
1	**A**	• PMS-RISPERIDONE 0.5 MG • TEVA-LORAZEPAM 1 MG • MYLAN-PAROXETINE 20 MG • RATIO-LENOLTEC NO.3 • APO-ZOPICLONE 7.5 MG • **METHADOSE 10MG/ML** • **BUTTER PECAN BOOST**	• PMS-RISPERIDONE 0.5 MG • TEVA-LORAZEPAM 1 MG • MYLAN-PAROXETINE 20 MG	• RATIO-LENOLTEC NO.3 • APO-ZOPICLONE 7.5 MG	• METHADOSE 10MG/ML • BUTTER PECAN BOOST
2	**A**	• MYLAN-PAROXETINE 20 MG • RATIO-LENOLTEC NO.3 • APO-ZOPICLONE 7.5 mg • PMS-RISPERIDONE 0.5 MG • TEVA-LORAZEPAM 1 MG • **METHADOSE 10MG/ML** • **BUTTER PECAN BOOST**	• MYLAN-PAROXETINE 20 MG • RATIO-LENOLTEC NO.3 • APO-ZOPICLONE 7.5 MG	• PMS-RISPERIDONE 0.5 MG • TEVA-LORAZEPAM 1 MG	• METHADOSE 10MG/ML • BUTTER PECAN BOOST
3	**B**	• PMS-RISPERIDONE 0.5 MG • APO-LORAZEPAM 1 MG • **METHADOSE 10MG/ML** • **BUTTER PECAN BOOST**	• PMS-RISPERIDONE 0.5 MG • APO-LORAZEPAM 1 MG		• METHADOSE 10MG/ML • BUTTER PECAN BOOST
	C	• TYLENOL NO. 3 APO-ZOPICLONE 7.5 MG • JAMP-PAROXETINE 20 MG • **ONE TOUCH ULTRA**	• TYLENOL NO. 3	• APO-ZOPICLONE 7.5 MG • JAMP-PAROXETINE 20 MG	• METHADOSE 10MG/ML • BUTTER PECAN BOOST • ONE TOUCH ULTRA TEST

		TEST STRIPS			STRIPS

On day two the order of claims was changed, which changed the drugs which had their dispensing fee paid. The system pays the first three claims of the day.

On day three the pharmacies change and the claims are split. The system pays the first three claims of the day regardless of the pharmacy involved.

On days one to three, the pharmacies are still eligible to receive the dispensing fees for Methadose as it is exempt from this policy. On days 1-3, the Butter Pecan Boost does not contribute to the cap of three dispensing fees per day as the dispensing fee is $0.00. This is also the case for the One Touch Ultra test strips dispensed on day 3.

For 2 – 27 Day Dispensing

'Dispensing every 2-27 days' Dispensing fee – triggered by days' supply submitted between 2 and 27

- A total of **two** dispensing fees allowed per drug grouping (i.e. by full AIG) per person per 28 days floating. Claims that contain a dispensing fee above $0.00, submitted beyond the limit of 2 per 28 days per drug per person, will be rejected
- No limits on the number of drug groupings
- Special service codes should be used to indicate dispensing every 2-27 days and eligibility category.

Week	Pharmacy	Drugs	Two Dispensing fees Allowed Per Grouping	Dispensing fee Rejected **Must submit with $0.00 dispensing fee**	Excluded from Policy
1	**A**	• RAN-METFORMIN 500 MG • JANUVIA 100 MG • APO-ROSUVASTATIN 10MG • RAN-ENALAPRIL 10 MG	• RAN-METFORMIN 500 MG • JANUVIA 100 MG • APO-ROSUVASTATIN 10 MG • RAN-ENALAPRIL 10 MG		
2	**A**	• RAN-METFORMIN 500 MG • JANUVIA 100 MG APO-ROSUVASTATIN 10 MG • RAN-ENALAPRIL 10 MG	• RAN-METFORMIN 500 MG • JANUVIA 100 MG APO-ROSUVASTATIN 10 MG • RAN-ENALAPRIL 10 MG		
3	**B**	• MAR-METFORMIN 500 MG • JANUVIA 100 MG • APO-ROSUVASTATIN 10 MG • RAN-ENALAPRIL 10 MG		• MAR-METFORMIN 500 MG 500 MG • JANUVIA 100 MG 100 MG • APO-ROSUVASTATIN 10 MG • RAN-ENALAPRIL 10 MG	
4	**C**	• MINT-METFORMIN 500 MG • JANUVIA 100 MG • APO-ROSUVASTATIN 20 MG • TEVA-ENALAPRIL 10 MG • PROCTOFOAM-HC • NALOXONE TAKE HOME KIT	• APO-ROSUVASTATIN 20 MG • PROCTOFOAM-HC	• MINT-METFORMIN 500 MG JANUVIA 100 MG • TEVA-ENALAPRIL 10 MG	• NALOXONE TAKE HOME KIT

On week three even though the pharmacy changes the claim rejects as the two dispensing fees have been paid for each drug.

On week four the brand of enalapril changes which doesn't change its eligibility, however the strength of rosuvastatin changes so it is eligible again. The Proctofoam is also eligible as there have not been claims for it recently. The Naloxone take home kit is also eligible for a dispensing fee as it is exempted from the policy.

Yearly Check for acute medications

Yearly Check is triggered by <28 days' supply submitted with an acute intervention code on the claim

- Only count the claims with the assigned acute intervention code.
- Allow up to four acute intervention codes/drug/person/"floating" year.
- Be aware that the first two claims for an acute medication will pay as per the frequent dispensing policy. It is only after these claims have been paid that the intervention code must be used.