PHARMACISTS' EXPERIENCE WITH THE EXCEPTION DRUG STATUS (EDS) PROGRAM IN SASKATCHEWAN

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By

Jason Paul Perepelkin

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ABSTRACT

In 1999, Saskatchewan Health sanctioned licensed pharmacists in the province to initiate Exception Drug Status (EDS), also referred to as prior approval, requests on behalf of their patients. The objectives of this study were to obtain pharmacists' opinions about the benefits of the EDS program to stakeholders, and to identify factors associated with pharmacists initiating a request.

In the fall of 2004, a census of community-pharmacy managers in Saskatchewan was conducted using a postal questionnaire, consisting of an introductory letter, two survey mailings and one reminder card. The questionnaire consisted primarily of seven-point Likert scale questions, and was analyzed using descriptive statistics and frequencies, followed by non-parametric analysis using Mann-Whitney U and Kruskal-Wallis tests; post-hoc analysis was carried out using the Bonferroni test.

A response rate of 82.6% was achieved. Those living in Saskatoon or Regina made up 39% of respondents, with another 39% located in centres of less than 5,000 people.

A majority of respondents (63%) agreed or strongly agreed the EDS program benefited patients and the Drug Plan (64%). Only 15%, 37% and 39% of

respondents agreed or strongly agreed EDS benefits pharmacists, physicians and the health care system respectively.

Factors that were important or very important to pharmacists in deciding whether they would initiate an EDS request on behalf of their patient were: the ability of the pharmacist to obtain the required information to initiate the EDS request (77%); their ability to contact the prescribing physician (70%); and patient centred concerns such as the ability to pay (74%) or the patient had exceeded their deductible (66%). However, time (39%) was not as important relative to other factors in whether the pharmacist would apply for EDS on behalf of their patient.

The majority of respondents agreed or strongly agreed that changing the policy in 1999 was beneficial to patient care (71%), while it also contributed substantially to their administrative workload (87%).

The results of this study indicate community pharmacy managers in Saskatchewan acknowledge that the Exception Drug Status process is beneficial for their patients. While pharmacists were supportive of the benefits of an EDS program, their apprehensions towards the program lie in the administrative processes, particularly in obtaining the required information, from physicians, to submit a claim. There is also concern with

the methods pharmacists must use to apply for EDS, which can be burdensome and prolong the administrative process.

To enhance pharmacists' support for the program it may be necessary to develop strategies designed to reduce the administrative workload associated with the program, and to streamline the efficient communication of required information between the prescriber and pharmacist. Alternatively, financial compensation to pharmacists for their expertise and efforts might be considered; although this would not address the workload and communication concerns of pharmacists, it does provide recognition for their professional role in securing appropriate drug therapy for their patients.

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TABLE OF CONTENTS

PERMISSION TO USE i

ABSTRACT ii

ACKNOWLEDGEMENTS v

TABLE OF CONTENTS vi

LIST OF TABLES x

LIST OF FIGURES xi

1. INTRODUCTION 1

1.1 General Background 1

1.2 Statement of Problem 2

1.3 Purpose of Study 3

1.4 Research Questions 4

1.5 Significance of Study 4

1.6 Relevant Terms and Definitions 5

2. LITERATURE REVIEW 7

2.1 The Dynamic Nature of Health Care 7

2.2 The Formulary System 10

2.3 Objectives of a Formulary System 12

2.4 Formulary Types 14

2.4.1 Open Formularies 14

2.4.1.1 Tiered Lists 16

2.4.2 Closed Formularies 16

2.4.2.1 Prior Authorization 17

2.4.2.2 Reference-based Pricing 20

2.5 Drug Review Processes 22

2.5.1 Saskatchewan Formulary Review Process 22

2.5.2 The Common Drug Review 24
2.6 Resistance to the Formulary Concept 24
2.7 Alternatives and Complements to Formularies 29
2.8 Administrative Workload 32
2.9 Remuneration 35
2.10 Automated Adjudication 37
2.11 Summary 38
3. METHODOLOGY 40
3.1 Study Design 40
3.2 Study Population 42
3.3 Measures 42
3.4 Data Analysis 49
3.4.1 Qualitative Analysis and Themes 50
3.5 Questionnaire Distribution and Data Collection 51
3.5.1 Non-responder Questionnaire 52
3.6 Data Entry 53
3.6.1 Recoding 53
3.7 Ethical Considerations 54
4. RESULTS 55
4.1 Response Rate 55
4.1.1 Non-responder Response Rate 56
4.2 Demographic Characteristics 56
4.2.1 Non-responder Demographics 59
4.3 Responder/Non-responder Comparison 60
4.4 Stakeholders and the EDS Program 61
4.4.1 Factor Analysis - Stakeholders and the EDS Program Constructs 68
4.5 Participation in the EDS Program 69
4.6 Factors Associated with an EDS Request 72

4.6.1 Factor Analysis – Factors Associated EDS Requests Constructs 76
4.7 EDS Procedures 77
4.8 Pharmacy Dynamics 80
4.9 Maximum Allowable Cost 86
4.10 Qualitative Themes 88
5. DISCUSSION 90
5.1 Research Question 1 90
5.2 Research Question 2 92
5.3 Research Question 3 95
5.3.1 Research Question 3a 97
5.3.2 Research Question 3b 98
5.3.3 Research Question 3c 99
5.4 Research Question 4 100
5.4.1 Research Question 4a 101
5.4.2 Research Question 4b 102
5.4.3 Research Question 4c 103
5.5 Study Limitations 103
5.6 Conclusion 105
5.7 Recommendations 106
REFERENCES 110
APPENDICIES 116
A. Original Questionnaire 116
B. Pre-notice Letter 123
C. Initial Mailing Cover Letter 125
D. Reminder Letter 127
E. Second Mailing Cover Letter 129
F. Non-responder Questionnaire 131
G. Non-responder Cover Letter 133
H. Main Survey Ethics Approval 135

I. Non-responder Ethics Approval 137
J. Qualitative EDS Responses 139
K. Qualitative MAC Responses 166
L. Provincial and Territorial Drug Plan Websites 172

LIST OF TABLES

4.1 Demographic Summary	57
4.2 Non-responder and Responder Demographic Summary	60
4.3 Responder/Non-responder Comparison	61
4.4 Saskatchewan Health's EDS Program	61
4.5 Human Stakeholder Construct	69
4.6 Participation in Saskatchewan Health's EDS Program	70
4.7 Factors Associated with the Initiation of an EDS Request	72
4.8 Pharmacist Centred Issues Construct	76
4.9 Patient Centred Issues Construct	77
4.10 Appropriateness of Procedures used in Obtaining EDS	78
4.11 Pharmacy Dynamics	81
4.12 Maximum Allowable Cost	86

LIST OF FIGURES

2.1 Automated Adjudication Process 38
4.1 Benefits Patients Increased Number of Drugs by Hours Open 63
4.2 Benefits Patients More Affordable Drugs by Community Size 63
4.3 Benefits Patients More Affordable Drugs by Hours Open 64
4.4 Benefits Physician More Drugs Choices by Hours Open 65
4.5 Benefits Drug Plan More Control by Percent Pharmacy Submitted 66
4.6 Benefits Health Care System by Community Size 67
4.7 Benefits Pharmacist by Percent Submitted at Request of Physician 68
4.8 Factor Time by Percent Submitted at Request of Physician 73
4.9 Factor Contact Physician by Proximity of Prescribing Physician 75
4.10 Access to Information by Hours Open 79
4.11 Notification of Status by Community Size 80
4.12 Adequate Information by Prescription Volume 82
4.13 Important Service for Patients by Percent Pharmacy Submitted 83
4.14 Policy Change Benefits Patients by Percent Pharmacy Submitted 84
4.15 Increased Workload by Prescription Volume 85
4.16 Increased Workload by Percent Pharmacy Submitted 85
4.17 Change in EDS Requests by Prescription Volume 88

1. INTRODUCTION

1.1 General Background

Health care operates in an ever changing environment. Within this environment is the profession of pharmacy and the interconnected factors that aid, hinder and shape pharmaceutical care. As health care delivery evolves, so too does pharmacy practice. Pharmacy has advanced from a time when apothecaries ground and created in-exact compounds to the current state where pharmacists are integral to the delivery of sophisticated drug products and services. Within this dynamic environment are many obstacles including the challenges of appropriate drug utilization, cost control, affordability, and access to effective pharmaceutical agents.

To address these issues, public and private drug plans have developed various management strategies. However, some of these strategies become sources of contention between payers, patients and health care providers; particularly those policies that restrict what may be prescribed or dispensed. While these strategies may limit access to required drugs, patients may also find it more difficult to qualify for financial assistance. Pharmacists are increasingly required to perform additional administrative tasks before they can dispense the medication to the patient [1]. As well,

pharmacists often find themselves in the difficult position of mediating between the physician, patient, drug plan, and conflicting expectations.

Escalating growth in drug utilization and costs has also "escalated demand for pharmacists that has outpaced supply" [2]. As a result, the average community pharmacy in Canada filled over 43,000 prescriptions in 2002, compared to just under 36,000 in 1995 [3]; a growth of 20.8 percent. At the same time the number of community pharmacies also grew, up from 6,527 in 1995 to 7,296 in 2002 [3]; a growth of 11.8 percent.

1.2 Statement of Problem

As drug utilization rates continue to grow, so too do the costs of providing prescription drug coverage for both public and private insurers. As well, "irrational use of cost-effective medicines reduces their effectiveness and their cost-effectiveness [4]." Over time this has led to the use of various managerial methods, such as restrictive formularies, to control the utilization of prescription medicines while maintaining access to effective therapy through the use of policies such as Saskatchewan Health's Exception Drug Status (EDS) program.

In Saskatchewan, the EDS program has been an area of concern due to the potential for reduced access that might occur as the result of administrative delays in completing the necessary paperwork. To improve access, beginning in 1999, Saskatchewan Health sanctioned licensed pharmacists in the province to apply for EDS (also referred to as prior/special

authorization) on behalf of their patients. Prior to 1999, only those practitioners licensed to prescribe in the province were able to initiate such requests.

While allowing pharmacists to initiate the EDS request appears to be a logical step toward improved access to appropriate drug therapy for patients, it raises the concern that this policy change might be overburdening pharmacists, with a shifting of administrative duties and workload from physicians to pharmacists.

> Recently [1997], restrictive formularies, special authorizations and increased cost-sharing have been introduced to curb escalating expenditures. While some costs have been reduced through the development of these plans, the administrative costs of implementing these changes and explaining them to patients has shifted to the pharmacists [5].

Finally, in July 2004, Saskatchewan Health began implementation of a Maximum Allowable Cost (MAC) policy, also referred to as reference-based pricing, beginning with Proton Pump Inhibitors (PPIs). With this change in policy, the pharmacists' role in the administration of the Drug Plan further increased.

1.3 Purpose of Study

Since the sanctioning of licensed pharmacists to initiate EDS requests in 1999, research has not been conducted within the province pertaining to how the policy has affected community pharmacy practice. This study sought to obtain the opinions of community-pharmacy managers with regard to Saskatchewan Health's EDS program, and the affect the policy has on

community pharmacy. A secondary rationale for the study was to gain baseline knowledge from community-pharmacy managers towards Saskatchewan Health's Maximum Allowable Cost (MAC) policy, and the effect of the policy on community pharmacy.

1.4 Research Questions

To address these issues, the following research questions were posed:

1. In the opinion of community-pharmacists, which stakeholders benefit from Saskatchewan Health's Exception Drug Status (EDS) program?

2. To what extent do pharmacies in Saskatchewan participate in the EDS program?

3. Under what circumstances will a pharmacist initiate an EDS request?

    a. Is the initiation of an EDS request part of the continuum of care pharmacists provide to their patients?
    b. Do pharmacists have access to all the information necessary to initiate an EDS request?
    c. Is additional administrative workload a factor when initiating an EDS request?

4. How is the new Maximum Allowable Cost (MAC) policy affecting the administrative workload of pharmacists?

    a. Has the number of EDS requests initiated by pharmacies changed since the implementation of MAC?
    b. Do pharmacists have sufficient information on MAC to allow them to adequately explain the policy to patients?
    c. Since the implementation of MAC, have pharmacists been spending more time with patients explaining the Drug Plan?

1.5 Significance of Study

The significance of this study lies in gaining baseline knowledge from community-pharmacy managers with regard to Saskatchewan Health's EDS

and MAC policies. This knowledge may be used to help inform those who implement such policies, primarily government sponsored drug plans, by relaying the opinions of those who carry out this administrative duty.

1.6 Relevant Terms and Definitions

FORMULARY: a catalog of therapeutically effective drugs of demonstrated quality that have been approved for coverage/reimbursement under a given drug plan [6].

OPEN FORMULARY: a listing of pharmaceutical preparations available to be prescribed in a given setting.

CLOSED FORMULARY: a listing composed of pharmaceuticals that have been approved for reimbursement at a preconceived level. May also be referred to as a *Restricted Formulary, Limited Use List,* or *Preferred Medicines List.*

PRIOR AUTHORIZATION: “a cost-control policy that restricts the use of services by requiring pharmacies to obtain advance approval before dispensing certain drugs, usually effective drugs for which there are less costly therapeutic alternatives” [7]. May also be referred to as *Special Authorization/Approval, Prior Approval* or *Exception(al) Drug Status.*

REFERENCE-BASED PRICING: a base price is established for each therapeutic class through an evaluation process and if the patient wishes to acquire a pharmaceutical other than the base, the patient is required to pay the difference unless the physician or pharmacist has obtained prior

authorization for the more expensive medication. May also be referred to a *Maximum Allowable Cost*.

2. LITERATURE REVIEW

In reviewing Saskatchewan Health's Exception Drug Status (EDS) program and the role of community pharmacists, the relevant literature is presented in the following manner. First, an overview of the changing nature of health care in Canada. This is followed by a review of the formulary system, along with a summary of the objectives of a formulary system.

The fourth section reviews the characteristics of the main types of formularies (open and closed), as well as their underlying mechanisms. This is followed by a synopsis of the drug review process in Canada and Saskatchewan. Alternatives and complements to formularies are covered, followed by resistance to the formulary concept.

Once matters pertaining directly to the formulary system have been addressed, other related issues will be explored, such as administrative workload. Next, the issue of remuneration is focused on, followed by automated adjudication. The literature review concludes with a summary of the issues presented.

2.1 The Dynamic Nature of Health Care

Medicare, or the publicly funded part of the Canadian health care system, as defined by the Canada Health Act (CHA), is based on five

principles: public administration, comprehensiveness, universality, portability, and accessibility [8]. Although the CHA is a federally funded program, each province administers the services that are part of the Act through transfer payments. Medicare and the CHA are meant to ensure all Canadians receive first dollar care for all necessary physician and hospital services.

Notable by their absence, most prescription drugs are not covered under Medicare. Individual provinces exercise full discretion over any publicly funded program that might be made available; the result is a patchwork of coverage, with most prescriptions not publicly funded. Thus, despite the objective for a publicly funded health care system, deficiencies in the CHA allow private enterprises to offer pharmaceutical insurance [9].

When Medicare was implemented in 1948 in Saskatchewan, and nationwide in 1964, pharmaceutical care and drug therapy played a minor role in health care [10]. The prevailing strategy was towards treating diseases once onset had occurred, instead of prevention, and may have led to a failure to appreciate the important role pharmaceutical preparations would play in future health care.

Health care in Canada has evolved to its current state through various transformations. This evolution began with two open-ended, cost-sharing programs where funds were transferred to the provinces from the federal government: the Hospital Insurance and Diagnostic Services Act of 1958 that insured in-hospital care, and in 1968 with the Medical Care Act which insured all physician services [11]. In 1977, there was an adjustment in the transfer

payment mechanism to block funding, which linked a formula that took into account various measures, such as increases in population and gross domestic product [11].

The final change came in 1984 with the adoption of the CHA which prohibited any direct charges or deductibles for services insured under the CHA [8, 11-14]. This allowed the federal government to withhold transfer payments to the provinces if the province violated the regulations of the CHA. However, a recent Supreme Court ruling has determined that it is unconstitutional for provinces to restrict access to medically necessary procedures [15, 16]. Therefore, if the ruling stands, private insurers may enter the system to cover medically necessary procedures, such as hip replacement surgery. Only time will tell if this ruling is challenged and/or overturned and whether there will be changes to the interpretation of the CHA by the provinces as a result.

Throughout the 1990s, the federal government cut transfer payments to the provinces in order to balance federal budgets. As a result, provincial governments reduced spending on health care, most notably to hospitals, and began to consolidate hospitals under regional authorities [13, 14]. This shift in funding resulted in procedures being pushed out of the hospital to be performed in out-patient settings and/or using other technologies, such as prescription medications, to reduce the time and money spent in hospitals.

> As health care becomes less focused on hospital and physician care … and more on community care and drugs …, less and less services fall under the rules of Medicare [14].

Not surprisingly, with changes in how health care was provided, utilization rates and expenditures for prescription drugs began to increase [2, 3, 17]. To control this growing area of health care expenditure, at least in terms of its effect on public expenditures, provincial governments began to look for ways to reduce prescription drug coverage for some or all of their beneficiaries; for example, by providing coverage only to seniors and children in poor families, or increasing co-payments and deductibles.

In Saskatchewan, where the government implemented the provincial drug plan in the mid-1970s, all costs were covered publicly, with the exception of a dispensing fee [14, 18]. Today, while residents are still "covered" by the provincial drug plan, most beneficiaries must meet an annual, income-based deductible (3.4% of household income [6]) before receiving any financial support from the government; approximately one-quarter of beneficiaries receiving a prescription in a given year will receive a financial benefit through the provincial drug plan [6]. Ironically, the very policies that restrict the coverage of prescription medications can also contribute to reduced patient adherence and in the long run increase costs to the health care system [19] and other sectors of society.

2.2 The Formulary System

Regardless of the nature of the funding mechanism in a health care system, whether public or private, a common characteristic is the use of formularies. Formularies are found in both ambulatory and hospitals settings.

The basic premise of a formulary is to provide a listing of pharmaceutical agents that are available in a given health care setting/region [20].

Formularies are thought to be an effective way to improve the efficacy and efficiency in the health care environment, without sacrificing the health and welfare of patients [21]. Recently, formularies have started to serve a more 'administrative' purpose for clinical reasons, such as reducing adverse drug events [22]. Formularies have also evolved from merely listing available agents, to providing a method for containing and monitoring costs and expenditures [7].

While there is some debate as to the primary purpose of a formulary, they are an important factor in decisions affecting the therapeutic treatment of patients. There are seemingly too many pharmaceuticals on the market, with some being inferior to others, and others having a higher initial drug cost and/or replicating the therapeutic worth of an existing and proven agent. Thus, invariably, some agents will be excluded from the formulary.

Economic considerations also limit the number of agents as the initial cost of some agents are seen as too large to a health care system and/or drug plan to cover all pharmaceuticals available. With the costs of medications rising rapidly, due in part to new, more efficacious agents, it is increasingly important to ensure that drugs be prescribed as rationally as possible; yet physicians' choices of drugs frequently fall short of the ideal circumstance of precise and cost-effective assessment [23].

2.3 Objectives of a Formulary System

> Formularies have been developed in response to specific forces which have affected pharmaceutical utilization and costs. Specifically, this is in response to an increase in the aging population requiring more drugs, inflation in the acquisition cost of drugs, increasing utilization, and the introduction of new technology [24].

If carefully designed, a formulary can assist prescribers in choosing the safest, most effective pharmaceutical agent [25]. However, formularies are continuously being challenged as to their benefit and detriment in the health care arena. The intent of formularies is to identify pharmaceuticals that are the most therapeutically suitable and cost-effective in order to provide for the health interests of a particular patient population [26]. Naturally, this is an inherently difficult task [20].

It must be recognized that medications and their applications are often complex, especially when considering the fact that an agent may have therapeutic worth outside its labeled indications. Formulary systems seek to establish a standard of care in pharmaceutical therapy, as opposed to a mere compilation of pharmaceuticals [27]. However, groups assigned to develop and maintain formularies, such as pharmacy and therapeutic committees, may disagree as to the worth of a pharmaceutical; whether considering efficiency, effectiveness, initial and future costs, or any topic brought about in deliberations.

Drug formularies, when implemented and administered correctly, can be crucial methods for delineating and directing prescribing to the most appropriate drugs; however, complete recognition of their potential has been

burdened by insufficient comparative data on drug efficacy/safety and limited resources for formulary development. Use of a carefully planned formulary theoretically provides the foundation for guiding prescribers in choosing the safest and most effective agents for treating particular medical conditions [25].

In an ideal situation, an effective formulary would include the following components:

Basic Objectives

1. Specify drugs of choice as determined by relative safety and efficacy.
2. Include second-line alternatives in categories where needed.
3. Minimize therapeutic redundancy by excluding superfluous/inferior preparations.
4. Maximize cost effectiveness and benefits by excluding more expensive agents when possible without compromising patient care.

Operational Requirements

1. Content and procedures determined by representative group of knowledgeable health care professionals.
2. Deletion/addition decisions based on criteria consistent with scientific information that supports basic objectives.
3. Newly marketed products added when evidence of unique therapeutic contribution is accumulated.
4. Nonformulary orders permitted only under well-controlled protocol.
5. Communication methods support user productivity and understanding.
6. Adequate administrative support [25].

2.4 Formulary Types

Individually, formularies and formulary systems are as varied as the institutions that establish them. However, most ascribe to a number of common characteristics. Below are the two principle formats (open and closed) to which most formulary systems generally conform.

Of note, regardless of the type of formulary, there is often some form of a co-payment or deductible that must be paid up front by the patient. A co-payment may come as a set fee per prescription, such as $3.00, or a set percentage of the prescription cost, such as 35%. A deductible will be in the form of the patient paying up to a set amount annually or semi-annually, such as $400 per year, or a percentage of their income, such as 3.4% in Saskatchewan. After this limit has been reached, the patients' benefits will start to take effect, or the drug plan will pay all, or a greater portion of prescription costs.

2.4.1 Open Formularies

An open formulary fundamentally serves the purpose of allowing the prescriber to know what is available for pharmaceutical therapy; the prescriber is encouraged to use the formulary to prescribe from, but in most instances the drug plan will reimburse the patient for non-formulary medications [28]. In some settings, if the prescriber chooses to prescribe a drug that is not on the formulary, the patient will incur the total cost of the

prescription. There is no prior authorization mechanism in place with an open formulary.

None of the public drug plans in Canada operate as open formularies [29]. Open formularies are in place where competition for beneficiaries exists, such as in the United States, but may also be present within Canada through private drug plans.

One study that looked at open formularies found that moving from a restricted/closed formulary, to an open formulary resulted in 720 entities being prescribed following relaxation in restrictions, as opposed to 397 entities under a restricted formulary [30]. Despite almost doubling the number of different pharmaceuticals prescribed, the entities prescribed once restrictions were relaxed only accounted for 8% of total drug claims.

In another study, the relaxing of formulary restrictions resulted in a 45.1% increase in the number of different pharmaceutical products prescribed, but again just an 8% increase in terms of total claims [28]. There was also an increase in the utilization of prescription, physician and outpatient services, while at the same time a decrease in utilization of inpatient services [28].

One needs to be cautious when examining the effects of formulary systems, as changes in coverage of pharmaceuticals may have a direct impact on the utilization of other health services. However, in a system as complex as health services, where numerous variables factor into patient

outcomes, it may be difficult to attribute cause and effect to one treatment mode or policy.

2.4.1.1 Tiered Lists

A tiered prescription list is a type of formulary that is based on the open formulary model. This system works by having tiers of drugs that are reimbursed at differing levels. As each tier of drugs becomes less desirable to insure by the drug plan, the co-payment increases for the patient. The reasons for placing a drug in one tier over another will hinge on factors such as whether the manufacturer provides rebates for their drugs, or one drug is therapeutically similar and financially less costly than another [31].

2.4.2 Closed Formularies

A closed formulary is a list of pharmaceutical agents that have been approved for reimbursement at a predetermined level. This register allows patients to obtain the pharmaceutical after receiving a prescription from a physician for those agents included in the formulary. However, this type of formulary, by design, eliminates or reduces financial reimbursement for many drugs currently available for use in Canada.

Prescription medications that would be of use for some indications may be eliminated due to the potential for inappropriate use in other indications or the cost to the payer is seen as too large. As a way to address this problem, prior authorization is an essential feature of many closed formularies.

Occasionally, there are patients who do not respond in a positive manner to the listed formulary drugs; in order to account for these cases, methods of authorization for use of non-formulary drugs should be developed [24].

2.4.2.1 Prior Authorization

Prior authorization is a cost-control policy that restricts the use of services by requiring pharmacies to obtain advance approval before dispensing certain drugs, usually effective drugs for which there are less costly therapeutic alternatives [7].

In Saskatchewan, the prior authorization program is for pharmaceuticals labeled Exception Drug Status (EDS) by the Saskatchewan Formulary Committee. EDS drugs are subject to the same co-payment/deductible structure as regular formulary preparations, with the exception of high cost drugs where the drug plan covers the cost for the patient when they cannot afford the cost; this is usually for chronic medication use for disease states such as Alzheimer's and Multiple Sclerosis. For example, two drugs to treat Multiple Sclerosis, Betaseron ® and Copaxone ®, were not originally covered in Saskatchewan due to their high cost, but were eventually insured [32].

There are typically seven reasons that EDS is placed on a pharmaceutical:

1. The drug is ordinarily administered only to hospital in-patients, but is being administered in the ambulatory setting due to unusual circumstances.

2. The drug is not ordinarily prescribed or administered in the province, but is being prescribed because it is required in the diagnosis or treatment of an illness, disability, or condition rarely found in the province.

3. The drug is infrequently used because formulary products are usually effective, but are contraindicated or found to be ineffective due to the clinical conditions of the patient.

4. The drug has been deleted from the formulary, but is required by patients previously stabilized on the drug.

5. The drug has potential for use outside its labeled indication.

6. The drug has the potential for the development of widespread inappropriate use.

7. The drug is more expensive than those already listed on the formulary and only offers an advantage in a limited number of indications [6].

Formularies and prior approval programs also look to influence prescribing decisions, and many times are used interchangeably and/or complimentary to one another [26]. Information commonly requested when submitting a claim for prior authorization includes the diagnosis for the patient requiring the medication, prior drug therapies initiated for the particular condition, and the response to previous therapies.

As an administrative tool, prior approval programs require the prescriber, or pharmacists in Saskatchewan beginning in 1999, to obtain prior consent in order for their patient to be reimbursed for the prescription in question [21]. Via an Internet search of provincial and territorial government websites (Appendix L), Newfoundland and Labrador is the only other province that has granted authority to pharmacists to initiate prior authorization requests.

With prior authorization requests in Canada, there is no emergency supply of the drug in question before approval is obtained; however,

programs do reimburse the patient if the request is approved by backdating the approval to the date when the request was made. There are programs elsewhere, such as the Iowa Medicaid program, which allow up to a 72 hour emergency supply of the medication [33].

Prior authorization often creates increased administrative workload for those involved in obtaining the drug approved for the patient. A Canadian survey of community pharmacists found that prior authorization programs were the third most significant issue in terms of administrative services; the most significant was having to explain drug plans to patients, followed by the insurer not reimbursing a full professional fee [5].

Bacovsky and Virani reported that physicians in some provinces, including Saskatchewan, are able to charge the patient a fee for filling out prior authorization requests, as completing these forms is not considered to be part of what is reimbursed for a consultation [34].

In Saskatchewan, physicians are remunerated for EDS submissions for Alzheimer and Multiple Sclerosis medications. However, these drugs require the physician to perform tests before applying for EDS status, and may also include on-going monitoring of the patient. As well, through the Medical Services Division of Saskatchewan Health, physicians are compensated ($4) for information requests made by pharmacists [35]. Therefore, compensation by Saskatchewan Health is only provided to physicians if information is requested by the pharmacist, or the indication for the EDS drug is restricted and only physicians may apply for EDS.

2.4.2.2 Reference-based Pricing

Reference-based pricing is a policy that borrows components of open and closed formularies. However, reference-based pricing has come about in systems where a closed formulary has been in place; they can also co-exist within a drug plan.

There are some drug plans, such as British Columbia's PharmaCare [10], that employ a reference-based pricing and low-cost acquisition program. Beginning July 1, 2004, the Government of Saskatchewan started to gradually introduce this mechanism, one therapeutic class at a time beginning with Proton Pump Inhibitors (PPIs). Under this system, a base price is established for a therapeutic drug class through an evaluation process, usually some form of drug quality assessment. If the patient wishes to acquire a pharmaceutical other than the base, the patient is required to pay the difference unless the physician or pharmacist has obtained prior approval for the more expensive medication. Although a restricted formulary is not technically in place, this system encourages the selection of less expensive, equally effective agents. In effect, the policy is structured to work like a closed formulary.

Although there is a sense of involvement by the patient in choosing their pharmaceutical therapy, this type of program may increase the administrative burden on the health care system. Patients are given the choice of having complete coverage for the reference-based drug, or paying

the difference to obtain a more expensive one. However, the vast majority of patients do not have the information or training to make a clinically informed decision.

Even though patients can access information to gain insight as to what is available through various mediums such as the Internet, it is often necessary to discuss available options with their health care professional. As a result, physicians and pharmacists will continue to play an important, expert role in final product selection. As well, the pharmacist or physician may be required to submit a prior authorization request on behalf of their patient to have a drug that is more costly, in terms of the drug itself, than the reference-based drug. This inevitably increases the administrative workload of the pharmacist and/or physician submitting the request.

Within closed formularies, a form of reference-based pricing exists within most drug plans in Canada [36]. This is because these plans implement therapeutic substitution. Therapeutic substitution allows pharmacists and physicians to switch from the prescribed medication, to one that is either bio-equivalent or therapeutic equivalent: bio-equivalent is switching between products that have the same ingredient drug and have the same bioavailability as the prescribed drug, where as therapeutic equivalent is switching the prescribed drug with a drug listed in the same therapeutic category [37].

2.5 Drug Review Processes

2.5.1 Saskatchewan Formulary Review Process

A formulary is a catalog of therapeutically effective drugs of demonstrated quality that have been approved for coverage under a given drug plan [6]. There are presently 19 different public formularies that exist in the country under the direction of federal, provincial or territorial governments. Altogether the public plans account for roughly 34% of prescription drug spending in Canada [17]. In addition, there are numerous private insurance plans. However, these private plans tend to lend their composition to decisions made by the formulary committee, or a similar body, of the province or territory the patient resides in.

The goal of a formulary is to provide health care providers and patients with a listing of prescription medications that will be reimbursed at a prearranged level. To establish this process, drug plans form groups of health care experts, including physicians, pharmacists, economists, and may incorporate other stakeholders such as nurses, to objectively analyze the clinical and economic implications of each submission. The factions brought together to ultimately compile the drug formulary is commonly referred to as the formulary committee, or pharmacy and therapeutics committee.

In Saskatchewan, there are two committees that work together and make recommendations to the Minister of Health on what should and should not be included in the formulary; these groups are the Drug Quality

Assessment Committee (DQAC), and the Saskatchewan Formulary Committee (SFC).

The mandate of the DQAC is to:

- Evaluate manufacturer submissions for consideration for coverage of new drugs and report its findings to the Saskatchewan Formulary Committee;
- Review available manufacturing documentation including clinical documents, scientific studies reports and published literature; and
- Evaluate comparative bioavailability studies and/or comparative clinical studies to determine compliance with accepted standards for interchangeability [6].

The mandate of the SFC is to:

- Recommend to the Minister of Health additions and deletions to the Saskatchewan Formulary;
- Consider economic information including utilization patterns, as well as clinical assessment by the DQAC assessment;
- Provide advice in compiling and maintaining the Saskatchewan Formulary;
- Identify those products that are interchangeable (different brands of the same drug that are equivalent in therapeutic effectiveness and quality); and
- Conduct reviews of new drug products and re-evaluation of listed products based on new information about use, efficacy and cost [6].

After the DQAC and the SFC have reviewed the submissions, recommendations are made to the Minister of Health who ultimately decides if the pharmaceutical will be placed on the Saskatchewan Formulary and the stipulations to its use if need be.

2.5.2 The Common Drug Review

Beginning in September 2003, the Common Drug Review (CDR), which operates as a branch of the Canadian Coordinating Office for Health Technology Assessment (CCOHTA), began operations.

> The CDR is a single process for reviewing new drugs and providing formulary listing recommendations to participating publicly-funded federal, provincial and territorial (F/P/T) drug benefit plans in Canada. All jurisdictions are participating except Quebec [38].

A review is completed on all available clinical evidence, as well as a pharmacoeconomic evaluation.

Being a relatively new venture, the impact of the CDR has yet to be evaluated. Saskatchewan Health has begun to adapt to the changes present since the implementation of the CDR, in order to reduce overlap in evaluation procedures.

2.6 Resistance to the Formulary Concept

As with any policy that restricts the clinical freedom of health care professionals, the formulary concept has its critics. Comments commonly expressed towards formularies are:

- they interfere with the clinical freedom a physician possesses;
- they sacrifice patient care to cost control by limiting the preparations available for which the patient is insured;
- widespread use equals drug of choice if the agent is used in other regions and/or countries;

- that a specialist knows best what to prescribe their patient, not a diverse committee of health care professionals; and
- education requires experience with a multitude of drugs in order to learn when to prescribe appropriately [25].

Objective data on clinical trials is often not available, especially within the first two years a pharmaceutical is on the market. Therefore, formularies can be put in place, or are in place, to restrict the use of preparations with insufficient clinical results, those which provide little or no therapeutic benefit over other agents, and/or proven preparations already on the formulary [32]. Formularies may limit the clinical freedom of a physician, but this freedom should be balanced with the clinical and costing evidence used to compile formularies.

"It is a common misconception that drugs are placed on a formulary on the basis of cost alone" [24]. The idea of sacrificing patient care to cost control is a narrow focus on a much larger issue. Some may argue that this is due to increased drug utilization in patient treatment; however, what must not be lost is that newer, patented medicines are expensive and continue to flood the market, with many being of questionable therapeutic worth compared to older, established drugs [39]. Between 1990 and 2001, prescription drug spending in Canada rose by an average of 9% per year, with 12% of expenditures in health care occurring from the provision of pharmaceuticals [17]. Therefore, if formularies were simply in place to contain costs, one

would be safe to assume that this trend of rising drug expenditures would not be so.

In presenting the idea that widespread use equals drug of choice, one needs to consider the economic implications of attempting to cover and stock every available pharmaceutical preparation on the market. It just is not sensible, especially economically, to cover every available preparation for a given disease, when the majority will have little to no therapeutic advantage over others. A decision needs to be made via a pharmacy and therapeutics committee on what best meets the needs of all involved; patient, physician, and insurer.

Looking at the idea that a specialist knows best what to prescribe to her/his patient may be true, but with the diverse nature of patients seen, the specialist would have to be present in many cases to make the proper diagnoses. However, this is not feasible since patients require a primary care physician to refer him/her to a specialist and many times the waiting list to see a specialist is numerous months. What is good for one patient, or even the majority, is not the case in all encounters. An informed decision needs to be made in pharmaceutical therapy; simply relying on the adage that the specialist knows best is an ill-advised approach to take in patient care within the current health care model [40]. Also, a diverse committee of health care practitioners are able to make an informed judgement on what to include in the formulary via reviewing all available information on the drug in question.

When looking at the idea that in order to become educated on various pharmaceutical preparations, the pharmacy and therapeutics committee has done much of the work for physicians by obtaining the most accurate, up-to-date information available. Many times the information available to a pharmacy and therapeutics committee is more diverse and complete than the information available to physicians. Also, there is nothing holding back the physician from prescribing a drug, so long as it has been approved for sale in Canada by Health Canada. But, the onus of payment will then fall solely on the shoulders of the patient in allowing physicians to educate themselves in varying pharmaceutical therapies. This is unless the physician applies for prior authorization and has tried other preparations that were ineffective or of sub-optimal effect for the patient, and the application is accepted.

As a result of the continuing resistance to the formulary concept, there has been movement to make the decisions affecting formularies more transparent [41]; improving the chance to submit input from interested stakeholders, as well as allowing individuals the opportunity to witness the selection process. The latter idea faces some scepticism because what is discussed within a formulary committee meeting is not ‘common knowledge’ to the public and many wish to keep it this way to maintain privacy of the manufacturer who has a decision before the committee.

Within committee meetings, such as the DQAC and SFC, discussing recommendations for inclusion into a formulary are sensitive and highly confidential. In reality, if a preparation is not approved for coverage within a

drug plan, the result may not only be a detriment to the pharmaceutical manufacturer in lost revenues, but also the representative that may lose their job due to little or no need to promote the drug in the region. One must also consider the possible effects on patient care and future health care costs.

Formularies also exist to ideally improve prescribing decisions towards reducing the number of adverse drug reactions and/or hospitalizations due to drug interactions or inappropriate use. If accurately developed, implemented and utilized, the formulary can be a risk-limiting factor [27]. What must not be lost in the shuffle is that formularies also look to increase the cost-effectiveness not only of pharmaceuticals, but also in the entire therapeutic treatment of patients.

The most expensive drug is not always the most effective clinically and vice versa. Transparency and disseminating of decisions made by formulary committees should be available to educate and gain acceptance to the formularies merit for all stakeholders, but most importantly by the prescriber [40]. This can be done with final decisions and the reasoning behind the recommendation, but will in all likelihood not include specifics discussed within committee meetings.

Some have argued that restrictions and regulations, as opposed to other methods such as education, are simpler and more effective strategies for improving prescribing practice. While formularies have been found to be a valuable means of reducing inappropriate use of some medications, for many medications the problem is misuse of an otherwise effective agent [23]. In

2001, Saskatchewan listed almost 3,000 pharmaceuticals on the formulary, on top of over 500 Exception Drug Status preparations [18]. A formulary therefore lists what is 'covered' under a drug plan, but does not provide in-depth information to the prescriber on the indications of the pharmaceuticals listed.

2.7 Alternatives and Complements to Formularies

In the past, formularies were primarily found in the hospital and in-patient setting. More recently, they are commonly found in the out-patient setting. To help ensure quality pharmaceutical care, as well as fiscal responsibility, formularies and other administrative measures to change ways in which pharmaceuticals are prescribed have emerged.

The changing nature of health care technology impacts the quality of care patients receive [23]. Various approaches are used to increase the efficiency and effectiveness of these new technologies, as well as to communicate the risk and benefits. The methods used include academic detailing, prescribing guidelines and audit-and-feedback.

Changes in the methods currently in place to communicate risks of pharmaceuticals need to be addressed [42]. Currently labelling of drugs by pharmaceutical firms, as required through Health Canada, aim to disseminate risks associated with use of the drug, as well as serving to fulfill a legal requirement. Many times the contraindications and warnings may be lost in the plethora of information contained in the product specifications. An

improvement in the partnership between pharmacists and prescribers, together with respect for the knowledge and strengths each has, increases the chance of optimal drug therapy [43] that ultimately benefits everyone, from those who fund health care, to the most important player, the patient.

There is a changing role of the formulary system towards a method of drug-use controls, whether in terms of costs or therapeutic merit, coupled with an increasing role of educating prescribers in the goal of optimal drug therapy [44]. Transition continues from a listing of what is available and recommended for use, to a means in helping to ideally promote appropriate and cost-effective use of pharmaceuticals. There has also been an expanding role within the health care segment towards increasing education in the direction of prescribers and other stakeholders, many times by pharmacists, about pharmaceuticals via what is commonly referred to as academic detailing [23, 45-48].

Academic detailing was first developed and reported on in 1983 by Avorn and Soumerai [45], and is described as a program of one-on-one interactive educational outreach provided by an individual who has been trained to discuss prescribing decisions with physicians in a manner likely to induce evidence-based practice change [47]. Evidence has shown a positive correlation between educational programs, such as academic detailing, towards general practitioners with improvement in attitudes, prescribing habits and costs [48].

Similar to academic detailing, practice and/or prescribing guidelines are in place to help inform, while at the same time educate, prescribers in decisions leading to pharmaceutical therapy. However, much like formularies, guidelines are in place and the prescriber is the one who ultimately decides whether to consult/use them or not. Many guidelines are not written to the audience of the practicing physician, but instead are focused on scientific knowledge that may be hard to transfer into the practice setting [46]. The prescriber is the defining indicator as to the impact, positive or negative, that guidelines, formularies and such will have on the health care system [49].

Access to timely information by primary health care providers needs to be coupled with practice guidelines, academic detailing and such if there is going to be significant change in the prescribers' behaviour and practice [50]. If needed information is not available within 30 seconds then guidelines are ineffective in the clinical situation; the probability that prescribers will adapt their prescribing decisions increases as guidelines enhance their credibility and simplicity of use [51].

Another strategy designed to increase appropriate prescribing is audit-and-feedback. This intervention looks at the drug therapy given to a patient, or numerous patients, and the results are discussed between the prescriber and another health care professional and compared against predefined criteria [46]. This intervention, much like academic detailing, relies on the physicians' willingness to participate.

2.8 Administrative Workload

Physicians are vital to the development, implementation and utilization of the formulary. The importance of physicians' in formulary development is tacitly acknowledged by the fact that physicians are well represented on the advisory committees in all Canadian provinces [52]. The only other groups with substantial representation on formulary development committees are pharmacists, as would be expected, and government officials due to the nature of formulary systems in Canada.

In essence, physicians and their representative bodies exert significant control over the selection of pharmaceutical therapies that will be accessible to patients. In order to assist and maintain the quality of care patients receive in a system where a formulary exists, it is vital that the involvement and support include the prescriber [53]. "Ultimately, the individual prescriber retains control over his or her prescribing decisions" [27].

The administration and managerial demand not only of clerical and administrative staff, but also of physicians, pharmacists, nurses and others in the day-to-day operations of health care, detract from time, and one would assume care that is available to the patient. Sixty percent of family physicians reported spending 10% - 25% of their time billing and conducting paperwork and another 21% said more then one-quarter of their time is exhausted on such duties [54]. This percentage will only increase as more responsibilities are expected of physicians, not to mention other primary care providers, through formulary systems and other mechanisms such as prior

authorization. The escalating pressures family physicians are facing in Canada are predicted to increase as the profession ages, coupled with more than four million Canadians already without a family physician [54].

Collier questioned how many patients knew where physicians received their training, as well how long it has been since the physician received their formal training in medical school [55]. Due to the increasing workload physicians are faced with in times of contraction in health care budgets, it is the pharmaceutical industry that many times disseminates information on preparations. This may in turn lead to implications to the health care provided to patients because the benefits are the focus of the industry, with risks being minimized or not discussed at all.

As the rate of drug utilization continues to climb, so do the pressures on pharmacists for their time. Throughout Canada there is a shortage of pharmacists leading to greater demands on those already practicing [5]. Pharmacy technicians play an important role in relieving some of the time pressures, but the scope of his/her duties are limited, with a pharmacist still required to review most of the work completed by a pharmacy technician. Some pharmacies are beginning to use a tech-check-tech system where pharmacy technicians check each others work, instead of requiring the pharmacists to check a pharmacy technician's work. However, there remains a limit to what a pharmacy technician can perform without the participation of a pharmacist.

With pharmacists being the most accessible health care practitioner available to patients, many times cognitive services are sought out. Coupled with this demand are administrative duties such as therapeutic substitution and prior authorization programs. As well, prior authorization programs are time-consuming and expensive [37], and carry an administrative burden [21].

Since 1999, pharmacists in Saskatchewan have been authorized to initiate a prior authorization request on behalf of a patient. One would assume that this relieves some administrative duties from physicians, and places the responsibility on pharmacists. As well, pharmacists across Canada have "complained about their increasing workloads due to prior approval processes. Valuable time is required to explain the policies, facilitate obtaining prior approval and providing interim supplies" [34].

As of 2001, approximately 60% of EDS requests in Saskatchewan were initiated by pharmacists [56]. In fact, in cases of special claims (prior authorization), "it would appear that physicians are off-loading workload onto pharmacists. The pharmacists in turn *must* provide this administrative service without the reassurance that the claim will be accepted" [5].

In Saskatchewan, if the EDS claim is not approved for coverage by Saskatchewan Health and the patient is not prescribed a formulary drug, where a dispensing fee could be collected, then the pharmacist is not provided a fee for their service [57]. Pharmacies do not receive any fees for initiating an EDS request on behalf of their patient; therefore, the only

remuneration a pharmacy will receive is the dispensing fee if a prescription is dispensed.

In a review of conclusions constructed during an optimal drug therapy symposium, management techniques, which rely on regulatory means, were reported to be generally ineffective [50]. These regulatory means, such as formularies and prior authorization, have been in response to pharmaceuticals that are many times overprescribed and/or have the tendency to be abused [58].

2.9 Remuneration

In Canada the vast majority of physicians are paid on a fee-for-service basis. Therefore, in order to obtain a desirable salary, physicians are by default encouraged to see as many patients as possible in the shortest time frame. "Because Canada's fee-for-service system provides financial incentives to see as many patients as possible, prescribing drugs may be used as a strategy to end patient visits" [59]. Consequently when administrative duties are presented that require time away from patient consultations, the primary source of a physicians' remuneration, resistance is present.

> Regulations imposed by governments, provincial licensing bodies and relevant professional associations, corporate practices, and inertia in fee systems are serious barriers to the kind of change needed to both relieve the current excess demand for pharmacists and to provide health care services at reduced costs for all Canadian consumers [60].

Community pharmacists in Canada are commonly paid on an hourly basis. In order for a pharmacy to receive payment for pharmacists' services, dispensing fees are the major, and many times the only source of revenue aside from sales of store front items such as over-the-counter products. This is unless the pharmacy is to charge the patients directly for pharmaceutical services provided that lie outside of the current fee structure provided by Saskatchewan Health. Therefore, when administrative duties are required, such as initiating prior authorization requests and contacting physicians for clarification on a prescribing decision, revenue is in essence being lost; this is exacerbated by the absence of remuneration for performing such duties.

The payment structure for community pharmacists does not encourage the cognitive services that pharmacists are trained and able to do, which benefit the patient and the health care system as a whole [61]. The British National Health Service has proposed "a change in the remuneration system that rewards services provided and not just the volume of prescriptions dispensed" [62]. To date in Saskatchewan, no such plans are said to be under consideration.

A move towards pharmaceutical care, such as providing cognitive services, has been growing in popularity since the late 1980s and has transformed pharmacists' job requirements away from one that was primarily based on dispensing duties [63]. As well, approximately 31% of all prescriptions and 72% of new prescriptions require administrative services; with a mean of 174 prescriptions requiring such services a week per

pharmacy, this translates into an average cost of over $28,000 each year per pharmacy [5].

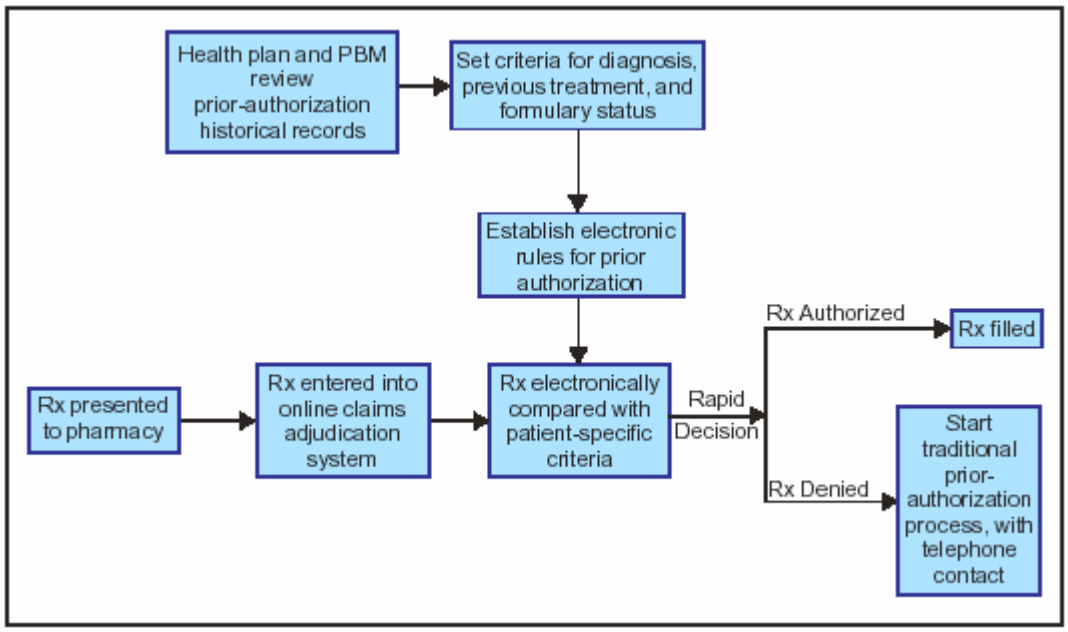
2.10 Automated Adjudication

Currently in Canada, automated adjudication of prior authorization requests in public drugs plans is non-existent. However, most provincial drug plans anticipate developing and implementing an automated system [64]. More specifically, the Quebec Department of Health and Social Services highlighted the need to reduce the administrative bureaucracy involved in prior authorization requests through such measures as submitting requests via the Internet [65]. Many managed care organizations in the United States have implemented online adjudication as part of their prior authorization programs [1]. Evaluation of such systems is not available, and the sparse literature on automated adjudication is descriptive in nature.

The automated, online adjudication process is in place to streamline requests for prior authorization and encourages use of the most cost effective prescription medication [66]. In this system, various forms and/or prompts are in place for a restricted medication, and are linked directly with the point-of-sale system within the pharmacy. The health care professional applying for prior authorization must fill in the required fields to have the claim processed automatically. If the system deems the information to warrant approval, then the request is approved without any interjection from the drug plan. However,

if the claim does not meet the online system requirements, it is not approved and a drug plan representative then evaluates the claim.

The automated adjudication system seeks to standardize and streamline the prior approval process. Human contact from the drug plan is reduced to only the claims that are unique. As well, the claimant is notified automatically as to whether the medication is going to be reimbursed, with the exception of requests requiring drug plan analysis.



Source: [1]

Figure 2.1 Automated Adjudication Process

2.11 Summary

As a whole, health care is a continuously evolving entity. When addressing issues related to pharmaceutical therapy, one needs to recognize the interconnected factors that impact and are impacted by policies governing

coverage of prescription drugs. The effects of pharmaceutical policy are far reaching and influence how and what therapies a patient will receive while using the health care system.

No matter how one approaches the health care spectrum, physicians are the dominant profession. However, physicians must work in unison with other health care professionals, such as pharmacists and nurses, and practice within environments shaped by other stakeholders, most notably the financiers of health care who form and implement the policies that dictate how health care is delivered.

One policy that influences the way in which a physician practices his or her profession is the formulary system. Formularies are a management technique used to influence prescribing, from an economic and clinical perspective, and the choice of what pharmaceutical to prescribe, if prescribing is warranted, is impacted by this policy.

As drug experts, pharmacists play a key role in the drug therapy of patients. By authorizing pharmacists to apply for EDS on behalf of his or her patient, Saskatchewan Health acknowledged this expertise to a greater extent. However, this acknowledgment may come as more of a burden than a benefit to the profession of pharmacy due to the administrative requirements encompassed within the policy.

3. METHODOLOGY

3.1 Study Design

The study design was a mail questionnaire. A modified Tailored Design Method [67] was utilized to ensure the writing of questions, construction of the questionnaire and survey implementation were carried out in a manner to maximize response rate.

For simplicity of response by community-pharmacy managers, the instrument was designed primarily using a seven-point Likert scale, consisting of 5 pages of questions, with an average of 8 questions on each page. The elements not consisting of seven-point Likert scale questions were comprised of open-ended questions focussing on the operations of the pharmacy, such as the number of prescriptions filled per week, the dynamics of the pharmacy in which the respondent operated, and the respondent himself/herself.

"Surveys of patients and health professionals may be perceived by the target respondents as having relatively high saliency, … a relatively long questionnaire on a health-related topic may therefore be acceptable" [68]. Although the questionnaire was not lengthy, it could not be classified as short either, with time to complete the survey being under fifteen minutes. The objective was to balance length with the need to cover the subject in a comprehensive manner.

The questionnaire was designed to obtain a subjective understanding of community-pharmacy managers' perceptions of the EDS program.

> Dispensing has a number of interrelated components that to varying degrees take up a pharmacist's time. In effect, pharmacists have diverse "workloads" and attempts to control just one aspect may overlook something that is potentially important [69].

Although some may question using subjective measures to study pharmacists' workload, studies have shown that this form of data collection (mail survey) can be accurate [5, 70], is less intrusive than direct observation or work sampling, and allows research to be conducted on a larger sample [70, 71]. This research project was designed to obtain data on the behavioural nature of pharmacy practice.

When dealing with prescription volume, community pharmacists were able to recall and report numbers that were found to be within ten percent of actual, objective numbers [5]. Therefore, questions pertaining to recall of prescription volume and/or workload that were part of this research project, although subjective, are felt to have relative accuracy.

With modest literature on the subject matter of the questionnaire, the questionnaire looked to gain an overview of perceptions from community-pharmacy managers to help formulate areas of saliency that would potentially deserve further investigation; therefore, subjective research was warranted [72]. As well, the focus of the research was on community-pharmacy managers' perceptions, and not necessarily objective data one would

achieve, for example, by analyzing drug claims data captured at the point-of-service terminals in pharmacies.

3.2 Study Population

There are approximately 1,200 pharmacists in the province of Saskatchewan, and approximately 346 community-based pharmacies [73]. In September 2004, a list was received from the Saskatchewan College of Pharmacists consisting of all 346 community pharmacies in the province. This list was arranged to identify the pharmacy and its manager, as well as the mailing address. A census was carried out of the 346 community-pharmacy managers. A census of community-pharmacy managers was used to reflect the dynamics present in each store, and therefore was skewed towards older, more established professionals who were in the position of management and/or owner.

3.3 Measures

The measures used in this study were selected for the purpose of understanding the environment of various community pharmacies and their day-to-day operations, as well as gaining an initial perspective on the new Maximum Allowable Cost policy that began July 1, 2004. Described below are the measures that encompassed each section of the questionnaire, separated by sections.

Part A –Saskatchewan Health's EDS Program: Items in this section focused on EDS stakeholders and the benefits each might obtain from the

EDS program. Those groups identified as having a vested interest in the prior authorization process are: patients, pharmacists, physicians, drug plans, and the health care system as a whole [21, 22, 25, 39, 74].

Health care centres on the patient. In regard to prior authorization policies, patients have a stake in the medications that are included as part of the policy, as opposed to not being included in a closed formulary, as well as the costs of the drugs to the patient.

Another important stakeholder in any prior authorization program is the physician. In most jurisdictions, physicians are the principle health care profession that is responsible for initiating prior authorization requests on their patients' behalf. As health care systems evolve, so do the methods of administering and managing the delivery of health care. As a result, pharmacists are an increasingly integral part of prior authorization programs. In Saskatchewan, this is most evident with the sanctioning of pharmacists to initiate EDS requests.

Within the mix of stakeholders lies the drug plans that develop and administer prior authorization programs, from a policy and implementation perspective, with the aid of other stakeholders. The drug plan is looking to manage the costs associated with prescription medications, but is also seeking to improve the chances of delivering optimal drug therapy to patients through the management technique of prior authorization.

The final stakeholder is the health care system as a whole. The health care system's consideration in prior authorization is in how the system is

affected by the decisions made with regard to policy; this would be in terms of health outcomes, and the resources that are saved and/or used in other sectors of the health care system as a result of policy decisions.

Part B – Participation in Saskatchewan Drug Plan's EDS Program: Items in this section addressed the circumstances surrounding an EDS request and the volume of requests received by the pharmacy [5, 75]. In essence, questions in this section were included to act as independent comparative factors to be used in the analysis of responses to measures in other sections of the questionnaire. Items in this section included the volume of restricted and non-formulary prescriptions per week, the percentage of these prescriptions received that are submitted for prior authorization coverage, the percent submitted by the pharmacy as opposed to the prescribing physician, and the percent submitted by the pharmacy resulting from a request by the prescribing physician.

Part C – Factors Surrounding the Initiation of an EDS Request: This section was devoted to understanding the circumstances under which a community pharmacist initiates an EDS request. Specifically: time, patient ability to pay, the initiators familiarity with the policy, and the ability to obtain the required information [50, 58, 69, 76].

Time is a finite resource. Pharmacists are limited in the amount of services they are able to provide in a given day by the pressures of time. Therefore, with the shortage of pharmacists in Canada comes the increased

need for efficiency with what is and can be provided. Administrative duties, in particular, often reduce the time available for clinical activities.

Patients are the focal point in providing health care services. Despite the concept of universal health care in Canada, there are areas where patients' are required to pay out-of-pocket expenses for certain services and/or technologies; in the community setting, prescription drugs are one such area. The shift to reducing or all together eliminating the need for in-patient services has resulted in patients paying for prescription drugs when they used to be covered via the Canada Health Act in the in-patient setting [13]. Therefore, the ability of the patient to pay for their prescription factors into whether or not a pharmacists' energy should be put into applying for prior authorization.

Whether a pharmacist will apply for prior authorization may centre on his or her knowledge of the policy itself. If the pharmacist is unfamiliar with the policy, one of two possible scenarios may play out: first, the pharmacist applies for prior authorization, not knowing what is required and/or if the medication will be covered, resulting in uncertainty; second, the pharmacist is familiar with the program and will only apply if there is the likelihood of success as not all applications are approved (the medication will be covered by the drug plan).

With many prior authorization programs, the prescriber is the sole health care professional that applies for coverage [37]; therefore, they have access to the information required by the drug plan to assess the application.

In Saskatchewan pharmacist are authorized to apply for EDS on behalf of patients, yet they do not always have the necessary information required by the drug plan. Therefore, the submission hinges on the pharmacists ability to obtain the required information from the prescriber, which is not always provided.

Part D – Appropriateness of Procedures used for Obtaining EDS: Items in this section sought to understand community-pharmacy managers' opinions on the procedures used to submit an EDS request. In particular, questions addressed whether: the respondent finds it difficult to apply for EDS, they have access to the required information, and they receive notification of the submission being accepted or rejected [7, 39, 74, 77].

The difficulty in applying for EDS and if the pharmacist has the required information to submit the claim relate to factors that influence whether a pharmacist will submit the claim, which were alluded to in Part C. However, Part C looked at influencing factors on whether or not the pharmacist will apply for EDS, while this section concentrated on the appropriateness of the procedures in place. In looking at whether notification of acceptance or rejection is received, interest focused on the communication between the Drug Plan and the pharmacist. Currently, the policy does not stipulate that the pharmacist will be notified, even when the pharmacist submits the claim.

Part E – About the EDS Program: This section addressed the circumstances surrounding an EDS request in the community-pharmacy.

Focus centred on: whether staff pharmacists had adequate information on the EDS program, the importance of pharmacist initiated EDS, the benefits of the policy change to patient health care, and the administrative workload as a result of EDS [2, 62].

The first question looked at whether all pharmacists within the respondents store had the appropriate information on administering the EDS program. The second question addressed if pharmacists feel that initiating an EDS request is an important service they now provide to patients.

With part of the reasoning behind administrative measures such as prior authorization to improve patient outcomes, the third question was addressing whether the respondent felt the change in policy benefits patient health care. The last question in the section was direct in addressing if the policy change had significantly increased the administrative workload of pharmacists.

Part F – Maximum Allowable Cost: This section looked to appreciate the experiences of community-pharmacy managers' and their staff since the MAC policy began to be phased in July 1, 2004. Emphasis was on: the information provided to pharmacies, the preparedness in addressing questions on MAC, time spent explaining the Drug Plan to patients, the change in EDS requests since the implementation of the policy, and the effects of the policy on patients access to the appropriate drug therapy [39, 78, 79].

The first item addressed whether Saskatchewan Health provided adequate information to pharmacies on the MAC policy. The second question, which progressed logically from the first, was measuring whether pharmacists were prepared to answer questions on the policy. And the third question addressed whether the time spent explaining the Drug Plan in general had changed since the implementation of the MAC policy.

With the MAC policy decreasing the number of prescription drugs covered by the Drug Plan, changes might be seen in the number EDS requests; therefore, a question addressing this issue was included. There is also the chance that restrictive policies such as MAC impair the ability of a patient to receive the appropriate drug therapy, and the final question sought to gain insight into this issue.

Part G – The Pharmacy: Items in this section were in place to value the dynamics behind the pharmacy setting in which the respondent operates. Information was gathered with regard to: the area, location and type of pharmacy, the number of pharmacists and pharmacy technicians in the respondents store, the proximity of the prescribing physician, prescription volume, and the hours the dispensary was open.

Part H – The Pharmacist Completing the Questionnaire: Items in this section were to capture the demographics of the respondent. In particular, information sought was the gender, age, position and years in current position of the respondent.

Part I – Additional Comments: This section was an open-ended question where the respondent was free to add any additional comments that he/she felt were relevant to the subject matter of the questionnaire. The responses in this section were not a part of the data analysis, but were in place to add to the discussion on the findings of the survey.

3.4 Data Analysis

Content validity was strengthened through pre-testing with five community-pharmacy managers. The validity of the questionnaire was further enhanced through review by the Acting Director of Pharmaceutical Services and Acting Executive Director of Saskatchewan Health's Drug Plan and Extended Benefits Branch, and the Executive Director and Board Members of the Representative Board of Saskatchewan Pharmacists. As well, an expert in Market Research and Questionnaire Design reviewed and provided feedback on the structure of the questionnaire.

Due to the fact that this was a descriptive study, the statistical analysis was relatively straight forward. Therefore, analysis using descriptive statistics was conducted to explore means, medians, modes, standard deviation, ranges, etc. Results are displayed below according to the sections of the questionnaire.

With the vast majority of the data being ordinal in nature, comparative statistical analysis was carried out using non-parametric tests. In particular, the Mann-Whitney U Test and Kruskal-Wallis One-Way Analysis of Variance

were used rather than the parametric methods, respectively, of an Independent t-Test and Analysis of Variance (ANOVA). The Mann-Whitney U Test and Independent t-Test are used to compare the mean value of two groups; where as the Kruskal-Wallis and ANOVA tests are used to test the mean value of more than two groups.

As a method for post-hoc analysis of more than two groups of non-parametric data, the Bonferroni test was used, as opposed to the Scheffe method which is used when analyzing post-hoc parametric data. The Bonferroni test was used to identify statistically significant differences ($p < 0.05$) between respondents when comparing factors.

Exploratory factor analysis was used to identify relationships between variables and consider the possibility of multi-item constructs. Factor analysis identifies questions with similar or related responses, creating a single scale from multiple measures that allows further analysis of a single, more complex scale. Comparative analysis was carried out on those constructs that were identified and demonstrated content validity and inter-item reliability (Cronbach's alpha < 0.700). Subsequent multi-item constructs were analyzed using comparative parametric tests (Independent t-test and one-way ANOVA).

3.4.1 Qualitative Analysis and Themes

Sections I and J of the questionnaire asked respondents open-ended questions to allow an opportunity to provide opinions and/or suggestions

regarding the EDS and MAC policies. Due to the fact that these two questions were asked to gain general knowledge, and were not seeking answers to specific questions, their analysis was quite limited [80, 81]. The analysis was restricted to developing common themes that were present when compiling responses.

3.5 Questionnaire Distribution and Data Collection

One week prior to the questionnaire being sent out, an overview of the research and the reasons for the survey were sent to the sample (Appendix B). This gave the subject an idea of the reasoning behind the research being conducted, why they were selected for the research project, the importance of a high response, and methods of dissemination on the research findings.

The first wave of questionnaires (Appendix A) were mailed out one week after mailing the overview letter. The questionnaire was sent along with a cover letter (Appendix C) and a pre-stamped return envelope. Two weeks after the first wave of the survey had been sent out a reminder postcard (Appendix D) was mailed to those that had not responded.

With the EDS program being a part of the daily routine of community pharmacists, it was anticipated that the response would be above 40% (> 140 respondents). “Surveys on health-related topics typically achieve better response rates than those on more general issues” [68].

Surveys completed by pharmacists that involve recall similar to this survey have achieved response rates between 30% [82] to 52.4% [5, 83]. In

particular, the response rate of pharmacists in Saskatchewan for research conducted by Loh and colleagues was 61.2% [5]. However, to achieve a response rate above 40% a second wave was planned for and mailed out two weeks after the reminder postcard and included a cover letter (Appendix E) and pre-stamped return envelope. Four weeks after the second wave of the survey was sent out, data collection concluded. Each questionnaire was coded for administrative purposes.

The timeline for conducting the research was:

October 18th, 2004:	Overview of research mailed out
October 25th, 2004:	First wave of survey mailed out
November 8th, 2004:	Reminder postcard mailed out
November 22nd, 2004:	Second wave of survey mailed out
December 20th, 2004:	Data collection concluded

3.5.1 Non-responder Questionnaire

Despite the high response to the questionnaire, a non-responder survey was implemented, although not a part of the original research protocol, to investigate whether there were differences between responders and non-responders. A total of 50 non-responder questionnaires were mailed out on March 7th, 2005. The mailing included a one-page questionnaire (Appendix F), a cover letter (Appendix G), and a pre-stamped return envelope. This was a one-time mailing, with no follow-up. Data collection concluded April 15th, 2005.

3.6 Data Entry

The analytical plan commenced once the data from all respondents had been compiled into a database using the Statistical Package for Social Sciences (SPSS© 13.0 for Windows). The variables were labelled and coded in a logical pattern beginning with the first question on the questionnaire.

3.6.1 Recoding

Once all the data was entered into SPSS, it was recoded for analysis purposes. Collapsing and recoding of data was done to allow for an easier interpretation of the displayed results by those viewing the research. All recoding was done before the analysis for this study.

Where sections had seven-point Likert scale questions, these response categories were collapsed to create a five-point Likert scale. The responses categories of Strongly Agree and Agree were collapsed into one category, as well as Disagree and Strongly Disagree being condensed into one category. The response categories of Very Important and Important were collapsed into one category, as well as Unimportant and Very Unimportant being condensed into one category. And the response categories of Greatly Increased and Increased were collapsed into one category, as well as Greatly Decreased and Decreased.

Interval and ratio data in Section B, G and H of the questionnaire were recoded into ordinal scales to allow analysis between independent and dependent variables throughout the questionnaire.

3.7 Ethical Considerations

Due to the nature of the research requiring input from community-pharmacy managers, ethics approval was required. Therefore, an application was submitted to the University of Saskatchewan Behavioural Research Ethics Board in July, 2004. Approval was granted (BEH 04-175) on August 27th, 2004 (Appendix H).

An ethics application for a non-responder survey was submitted to the University of Saskatchewan Behavioural Research Ethics Board in December 2004. Approval for the non-responder portion of the research was obtained on January 6th, 2005 (Appendix I).

4. RESULTS

This section begins with an overview of the response rate and demographic characteristics of respondents. This is followed by analysis of the four research questions and sub-questions that are addressed in the six sections of the questionnaire.

4.1 Response Rate

From the original mailing list of 351 community-pharmacy managers and owners provided by the Saskatchewan College of Pharmacists, 5 were excluded due to duplication of contacts; therefore, the first mailing consisted of 346 questionnaires. After the initial mailing and reminder card, 219 questionnaires were returned, for a response rate of 63.3% (219/346).

At this time it became apparent that some of the questionnaires mailed out could not be completed due to: pharmacy closure (1), pharmacy located on a First Nations reserve which dealt solely with Non-Insured Health Benefits patients (1), and satellite pharmacies that did not dispense medications (11). Therefore, the list of 346 was further reduced for a final study population of 333.

Four weeks after the second mailing, data collection closed with another 60 questionnaires being received for a second round response rate of 52.6% (60/114). After data collection concluded, 4 additional

questionnaires were received, but were not included in the analysis. Of the 279 eligible questionnaires received, 275 were completed for a final response rate of 82.6% (275/333).

4.1.1 Non-responder Response Rate

Of the 50 non-responder questionnaires mailed out, 15 were returned (30%). All returned questionnaires were completed fully, with the exception of 3 questionnaires where the responders choose not to enter his or her age.

4.2 Demographic Characteristics

Demographic characteristics were collected and are displayed in Table 4.1. Each characteristic is displayed according to the percentage and number of respondents in each category.

Of the 275 respondents, 100 were female and 173 were male; 2 respondents did not state *gender*. In terms of *community size*, 105 respondents resided in Saskatoon/Regina (53 females; 52 males), 61 respondents resided in locations with a community size between 150,000 and 5,000 inhabitants (21 females; 40 males), and 107 respondents resided in centres of less than 5,000 residents (26 females; 81 males).

There were 109 respondents that reported their *age*, with a mean of 44 years, a range of 24 – 76 years, and a median 43 years (data not displayed). A total of 207 respondents answered the question on the *length of time in their current position,* which had a mean of twelve years, with 87.4% of respondents indicating owner or pharmacy manager as their *position*.

Table 4.1 Demographic Summary

Variable	Total Responses N (%)
Gender	
Female	100 (36.4)
Male	173 (63.1)
Total	273 (99.3)
Position*	
Owner	100 (36.4)
Pharmacy Manager	135 (49.1)
Pharmacist	30 (10.9)
Other	4 (1.5)
Total	269 (97.9)
Area	
Commercial	110 (40.0)
Residential	70 (25.5)
Mixed	95 (34.5)
Total	275 (100)
Location**	
Stand Alone Building	141 (51.3)
Strip Mall	43 (15.6)
Enclosed Mall	36 (13.1)
Medical Building/Complex	48 (17.5)
Other	7 (2.5)
Total	275 (100.0)
Type^	
Independent	115 (41.8)
Banner	38 (13.9)
Chain	23 (8.4)
Franchise	31 (11.2)
Grocery Store	44 (16.1)
Department Store	11 (4.1)
Mass Merchandiser	7 (2.5)
Other	4 (1.4)
Total	273 (99.3)
Proximity to Prescriber^^	
Same Location	58 (21.2)
Next Door	24 (8.9)
Close By	72 (26.3)
Somewhat Removed	109 (39.6)
Distant	8 (2.9)
Total	271 (98.6)
Community Size	
Saskatoon or Regina	107 (38.9)
5,000 – 150,000 People	61 (22.2)
< 5,000 People	107 (38.9)
Total	275 (100.0)

* Collapsed *Pharmacist* and *Other* into one category (*Other*) for analysis

** Collapsed *Strip Mall* and *Enclosed Mall* into one category (*Mall*), as well as *Medical Building/Complex* and *Other* into one category (*Other*) for analysis

^ Collapsed *Department Store*, *Mass Merchandiser* and *Other* into one category (*Other*) for analysis

^^ Collapsed *Same Location* and *Next Door* into one category (*Same Location*), as well as *Somewhat Removed* and *Distant* into one category (*Removed*) for analysis

On average, responding pharmacies employed 2.8 *pharmacists per store*, or 2.4 *full-time equivalents per store*. A total of 70.4% of responding pharmacies employed 3 or fewer pharmacists, with 79.8% of responding pharmacies employing 3 or fewer full-time equivalent pharmacists (data not displayed).

On average, pharmacies employed 1.4 *pharmacy technicians per store*, or 1.0 *full-time equivalent per store*. A total of 88.9% of responding pharmacies employed 3 or fewer pharmacy technicians, with 94.8% of responding pharmacies employing 3 or fewer full-time equivalent pharmacy technicians (data not displayed).

Of the respondents, 266 (96.7%) reported the *number of hours their dispensary was open per week*. A total of 41 (15.4%) were open 40 hours or less per week, 59 (22.2%) were open 40.5 – 50 hours per week, 54 (20.3%) were open 50.5 – 60 hours per week, 58 (21.8%) were open 60.5 – 80 hours per week, and 54 (20.3%) were more than 80 hours per week. There were 36.4% of responding pharmacies open up to 50 hours per week, with 22.9% open over 80 hours per week. In total, the average responding pharmacy was open 62 hours per week (data not displayed).

A total of 264 (96.0%) respondents reported the *number of prescriptions their pharmacy fills per week*: 35 (13.3%) filled 250 or fewer prescriptions per week, 71 (26.9%) filled 251 – 500 prescriptions per week, 56 (21.2%) filled 501 – 750 prescriptions per week, 47 (17.8%) filled 751 –

1000 prescriptions per week, and 55 (20.8%) filled more than 1000 prescriptions per week. As a whole, the average responding pharmacy filled 738 prescriptions per week (data not displayed).

4.2.1 Non-responder Demographics

All 15 respondents reported their *gender*: 3 were female and 12 were male (Table 4.2). In terms of *community size*, there were 6 respondents that resided in Saskatoon/Regina (1 female; 5 males), 3 respondents residing in locations where the community size was between 150,000 and 5,000 inhabitants (1 female; 2 males), and 6 respondents residing in centres of less than 5,000 residents (1 female; 5 males).

There were 12 respondents that reported their *age*, with a mean of 45 years, a range of 32 – 63 years, and a median of 44 years (data not displayed). All 15 respondents reported their *current position*, with 5 listing Owner, 9 responding Pharmacy Manager, and one Pharmacist.

In statistically analyzing responders and non-responders, the p-value was set at $p < 0.05$. As displayed in Table 4.2, there were no statistically significant differences between responders and non-responders. Despite no statistically significant differences, the results are to be approached with caution as the high response rate on the original questionnaire limited the possible number of responses to the non-responder questionnaire. Therefore, responses by one respondent to the non-responder questionnaire

may have a greater impact than would be the case if the number of responses were larger.

Table 4.2 Non-responder and Responder Demographic Summary

Variable	Total Non-responder Responses N (%)	Total Responder Responses N (%)	p Value
Gender			
Female	3 (20.0)	100 (36.4)	0.271
Male	12 (80.0)	173 (63.1)	
Total	15 (100.0)	273 (99.3)	
Position*			
Owner	5 (33.3)	100 (36.4)	0.847
Pharmacy Manager	9 (60.0)	135 (49.1)	
Pharmacist	1 (6.7)	30 (10.9)	
Other	0 (0.0)	4 (1.5)	
Total	15 (100.0)	269 (97.9)	
Proximity to Prescriber^			
Same Location	2 (13.3)	58 (21.2)	0.479
Next Door	0 (0.0)	24 (8.9)	
Close By	6 (40.0)	72 (26.3)	
Somewhat Removed	5 (33.3)	109 (39.6)	
Distant	0 (0.0)	8 (2.9)	
Total	13 (86.7)	271 (98.6)	
Community Size			
Saskatoon or Regina	6 (40.0)	107 (38.9)	0.981
5,000 – 150,000 People	3 (20.0)	61 (22.2)	
< 5,000 People	6 (40.0)	107 (38.9)	
Total	15 (100.0)	275 (100.0)	

* Collapsed *Pharmacist* and *Other* into one category (*Other*) for analysis
^ Collapsed *Same Location* and *Next Door* into one category (*Same Location*), as well as *Somewhat Removed* and *Distant* into one category (*Removed*) for analysis

4.3 Responder/Non-responder Comparison

Table 4.2 displays demographic comparisons between responders and non-responders. Table 4.3 displays the remaining six questions that were the same between the responder and non-responder questionnaires. Statistical significance was set at $p < 0.05$. As displayed, there is no statistically significant difference between responders and non-responders.

Table 4.3 Responder/Non-responder Comparison

	Number Of Restricted & Non-Formulary Drugs Per Week	Percent Of Restricted & Non-Formulary Submitted For Coverage	Percent Of Submitted Initiated By Pharmacy Vs. Prescribing MD	Percent Submitted At Request Of MD	Average Number Of Prescriptions Per Week	Hours Pharmacy Open Per Week
Z	-1.772	-.254	-.016	-.842	-1.161	-.465
p - Value	.076	.799	.987	.400	.246	.642

4.4 Stakeholders and the EDS Program

Table 4.4 Saskatchewan Health's EDS Program

Question	Strongly Agree/Agree N (%)	Somewhat Agree N (%)	Neutral N (%)	Somewhat Disagree N (%)	Strongly Disagree/ Disagree N (%)	Total Responses N (%)
1. The EDS program benefits patients by expanding the number of prescription drugs covered by the provincial Drug Plan.	173 (62.9)	67 (24.4)	8 (2.9)	11 (4.0)	15 (5.5)	274 (99.6)
2. The EDS program benefits patients by making their prescription drug more affordable.	132 (48.0)	87 (31.6)	12 (4.4)	19 (6.9)	24 (8.7)	274 (99.6)
3. The EDS program benefits physicians by providing them more drug therapy choices for their patients.	101 (36.7)	80 (29.1)	22 (8.0)	30 (10.9)	40 (14.5)	273 (99.3)
4. The EDS program benefits the Drug Plan by allowing potentially costly drug therapies to be available in a more controlled fashion.	176 (64.0)	51 (18.5)	19 (6.9)	12 (4.4)	16 (5.8)	274 (99.6)
5. The EDS program benefits the health care system by promoting more appropriate utilization of drugs.	106 (38.5)	84 (30.5)	19 (6.9)	34 (12.4)	31 (11.3)	274 (99.6)
6. The EDS program benefits pharmacists by providing them with an opportunity to be more actively involved in securing the most appropriate drug therapy for their patients.	41 (14.9)	51 (18.5)	36 (13.1)	46 (16.7)	100 (36.4)	274 (99.6)

Section A of the questionnaire referred to the five stakeholders identified as being involved in the EDS program: patients, the Drug Plan, the

health care system, physicians, and pharmacists. Respondents were asked to what extent they agreed or disagreed with each statement. Frequency distributions were carried out for each of the six questions within this section and are displayed in Table 4.4. For post-hoc analysis, statistical significance was set at $p < 0.05$.

When asked whether *the EDS program benefits patients by expanding the number of prescription drugs covered by the provincial Drug Plan*, 62.9% of respondents Agreed or Strongly Agreed with the statement. Bonferroni analysis revealed a statistically significant difference in terms of hours the responding pharmacy was open. Pharmacies open more than 80 hours per week (44.4%) were less likely to agree with the statement compared to pharmacies open up to 60 hours per week (70.8%) ($\chi^2 = 17.094$; $p < 0.002$) (Figure 4.1).

Slightly less than half of respondents (48.0%) Agreed or Strongly Agreed that *the EDS program benefits patients by making their prescription drug more affordable*. Bonferroni analysis exposed statistically significant differences in responses based on community size, number of prescriptions filled per week, hours respondents' pharmacy was open per week, and the number of restricted and non-formulary prescriptions submitted for coverage.

Respondents in Saskatoon/Regina (40.6%) were less likely to agree with the statement than those in a community size of less than 5,000 people (59.8%) ($\chi^2 = 10.509$; $p < 0.005$) (Figure 4.2).

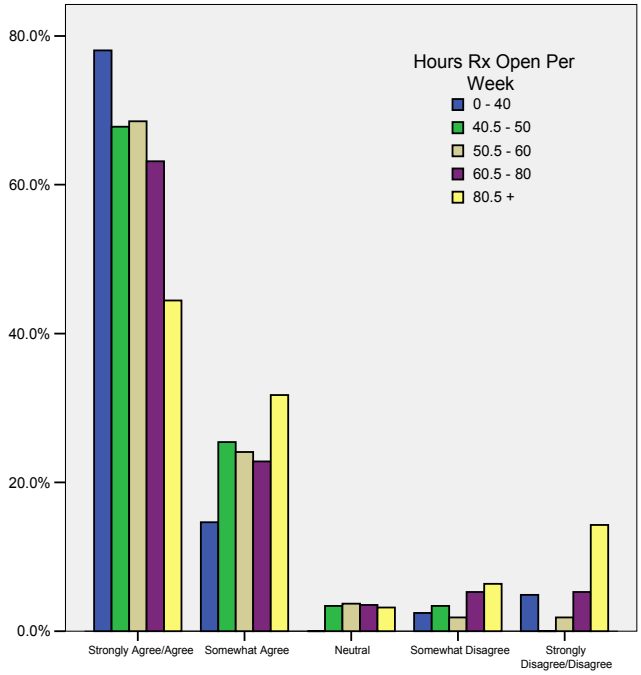


Figure 4.1 Benefits Patients Increased Number of Drugs by Hours Open

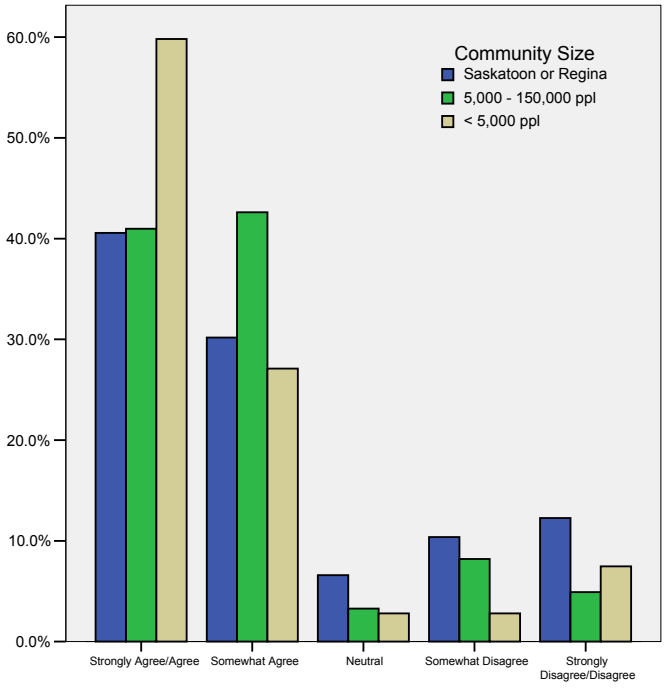


Figure 4.2 Benefits Patients More Affordable Drugs by Community Size

Pharmacies filling 501-750 prescriptions per week (60.7%) were more likely to agree with the statement than those filling more than 1000 prescriptions per week (38.2%) (χ^2 = 10.250; p < 0.036). Pharmacies open more than 80 hours per week (27.0%) were less likely to agree with the statement than those open 40.5-60 hours per week (59.3%) (χ^2 = 20.865; p = 0.00) (Figure 4.3).

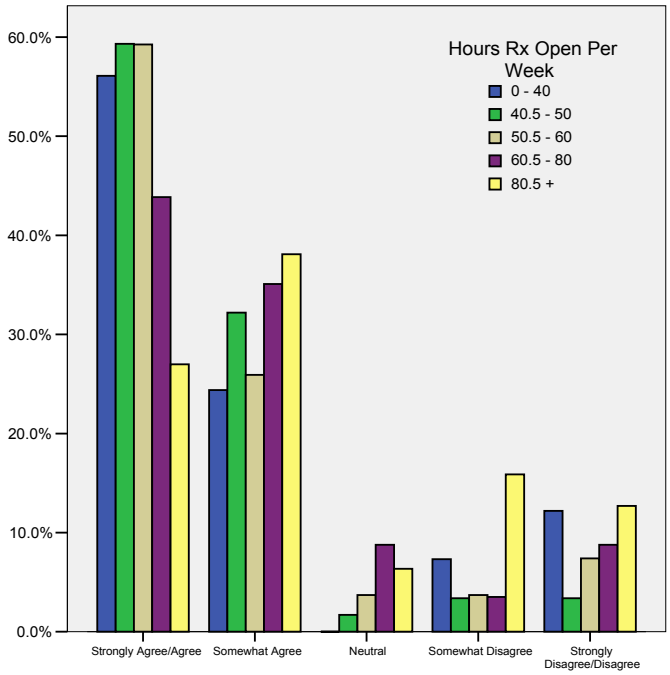


Figure 4.3 Benefits Patients More Affordable Drugs by Hours Open

Pharmacies that submitted between 26-50% of restricted and non-formulary prescriptions (35.7%) were less likely to agree with the statement than those submitting 86-100% (61.6%) (χ^2 = 11.009; p < 0.026).

Participants were next asked whether *the EDS program benefits physicians by providing them more drug therapy choices for their patients;* 36.7% of respondents Agreed or Strongly Agreed with this statement. Bonferroni analysis revealed a statistically significant difference with the number of hours the respondents' pharmacy was open per week. Pharmacies open 50.5-60 hours per week (55.6%) were more likely to agree with the statement than those open more than 80 hours per week (25.8%) (χ^2 = 11.556; p < 0.021) (Figure 4.4).

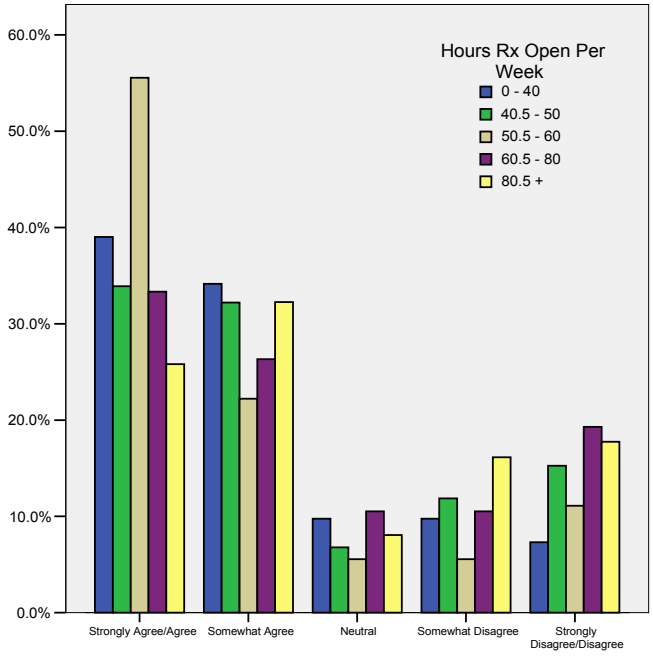


Figure 4.4 Benefits Physician More Drugs Choices by Hours Open

A total of 64% of respondents Agreed or Strongly Agreed that *the EDS program benefits the Drug Plan by allowing potentially costly drug therapies to be available in a more controlled fashion*. Bonferroni analysis revealed a

statistically significant difference between pharmacies in terms of the percentage of EDS requests that were submitted by the pharmacy versus the prescribing physician. Pharmacies where 0-50% of EDS requests (43.8%) were submitted by the pharmacy versus the prescribing physician were less likely to agree with the statement than those where 51-80% were (66.7%) (χ^2 = 10.892; p < 0.028) (Figure 4.5).

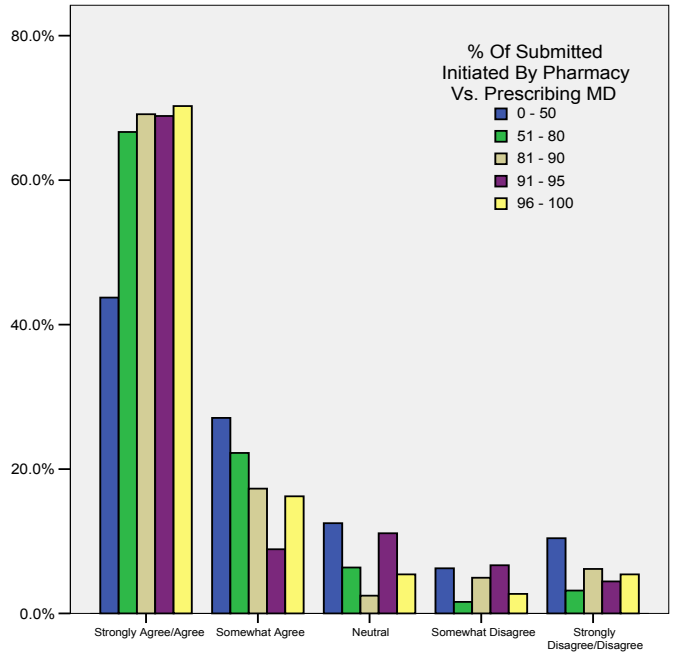


Figure 4.5 Benefits Drug Plan More Control by Percent Pharmacy Submitted

There were 38.5% of respondents who Agreed or Strongly Agreed that *the EDS program benefits the health care system by promoting more appropriate utilization of drugs*. Bonferroni analysis revealed a statistically significant difference between pharmacies in terms of community size. Pharmacies situated in a region where the community size was less than

5,000 people (46.7%) were more likely to agree with the statement than those with 5,000-150,000 people (26.2%) ($\chi^2 = 7.055$; $p < 0.029$) (Figure 4.6).

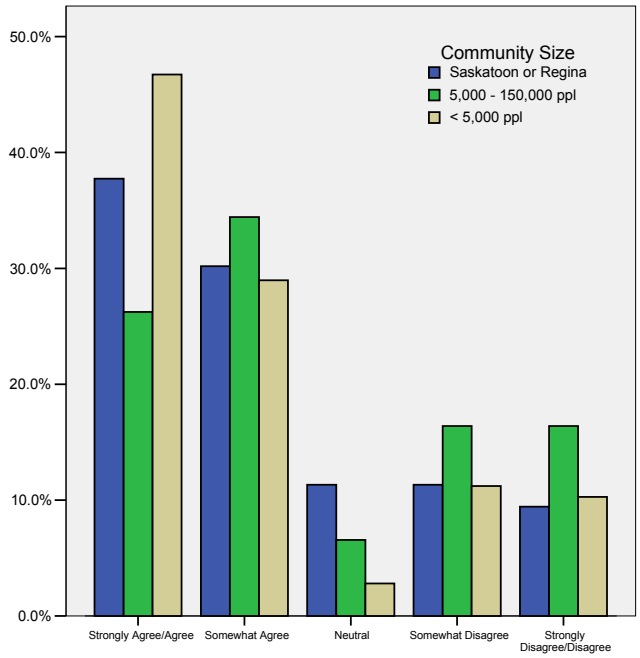


Figure 4.6 Benefits Health Care System by Community Size

Only 14.9% of respondents Agreed or Strongly Agreed that *the EDS program benefits pharmacists by providing them with an opportunity to be more actively involved in securing the most appropriate drug therapy for their patients,* while 36.4% of respondents Disagreed or Strongly Disagreed. Bonferroni analysis exposed a statistically significant difference between pharmacies with regard to the percentage of requests submitted at the request of the prescribing physician. Pharmacies where 26-40% of EDS requests (27.7%) were submitted at the request of the prescribing physician

were more likely to agree with the statement than those where 0-10% (12.8%) and 61-100% were (10.0%) ($\chi^2 = 11.422$; $p < 0.022$) (Figure 4.7).

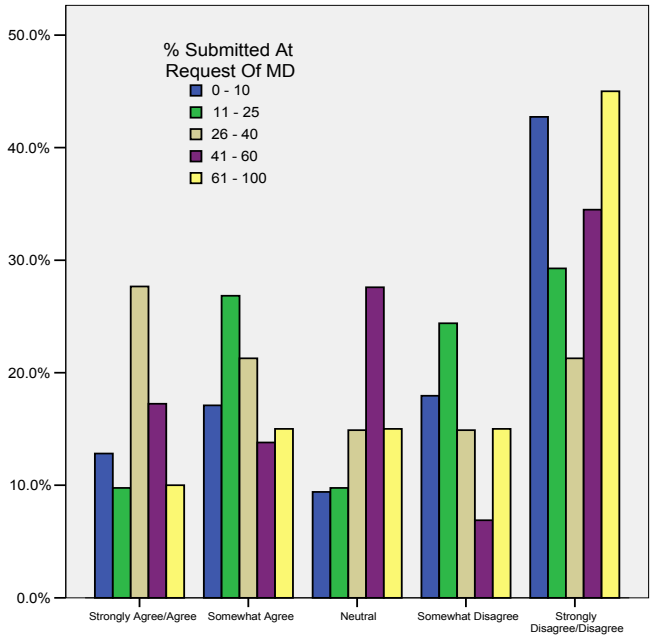


Figure 4.7 Benefits Pharmacist by Percent Submitted at Request of Physician

4.4.1 Factor Analysis - Stakeholders and the EDS Program Constructs

Section A exposed one construct. Reliability statistics for Cronbach's Alpha based on standardized items was 0.805. The construct is based on the four questions of the questionnaire that dealt with the three identified human stakeholders of the EDS program: patients, pharmacists and physicians. In particular, patients were identified as stakeholders due to the number of prescription drugs covered and costs associated with the EDS program. While physicians were included as stakeholders as the EDS program theoretically provides them with more drug therapy choices, and pharmacists

were stakeholders by becoming more actively involved in securing appropriate drug therapy for patients. See Table 4.5.

Analysis using one-way ANOVA resulted in one factor having a statistically significant difference of $p < 0.05$. There was a significant difference between pharmacies in terms of the type of pharmacy between independent and grocery stores ($p < 0.036$).

Table 4.5 Human Stakeholder Construct

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Benefits Patients By # Of Drugs Available	10.68	14.761	.680	.520	.719
Benefits Patients By Making Drugs More Affordable	10.32	14.321	.612	.476	.742
Benefits MD By More Drug Therapy Choices	9.82	13.023	.659	.435	.717
Benefits Pharmacists By Being Actively Involved In Drug Therapy	8.62	13.708	.511	.290	.801

4.5 Participation in the EDS Program

Section B of the questionnaire focused on how often the responding pharmacy dealt with prescriptions for EDS drugs. A summary of responses are displayed in Table 4.6.

The first item asked *on average, how many new prescriptions for restricted or non-formulary medications does your pharmacy receive per week*? Just over half (54.1%) of pharmacies reported between 0 and 20 restricted or non-formulary prescriptions per week. Each pharmacy received,

on average, 36 restricted or non-formulary prescriptions per week, accounting for 4.88% of all prescriptions. Pharmacies reported receiving anywhere from a minimum of one request per week, to a maximum of 400 requests per week.

Table 4.6 Participation in Saskatchewan Health's EDS Program

Question	0 - 10 N (%)	11 - 20 N (%)	21 - 40 N (%)	41 - 75 N (%)	76 + N (%)	**Total Responses** N (%)
1. On average, how many new prescriptions for restricted or non-formulary medications does your pharmacy receive per week?	87 (31.6)	62 (22.5)	56 (20.4)	31 (11.3)	39 (14.2)	275 (100.0)
Question	0 – 25% N (%)	26 – 50% N (%)	51 – 75% N (%)	76 – 85% N (%)	86 – 100% N (%)	**Total Responses** N (%)
2. On average, what percent of these restricted or non-formulary medications are submitted for coverage under the EDS program?	58 (21.1)	56 (20.4)	50 (18.2)	37 (13.5)	74 (26.9)	275 (100.0)
Question	0 – 50% N (%)	51 – 80% N (%)	81 – 90% N (%)	91 – 95% N (%)	96 – 100% N (%)	**Total Responses** N (%)
3. On average, what percent of the EDS submissions are initiated by your pharmacy rather than by the prescribing physician?	48 (17.5)	63 (22.9)	82 (29.8)	45 (16.4)	37 (13.5)	275 (100.0)
Question	0 – 10% N (%)	11 – 25% N (%)	26 – 40% N (%)	41 – 60% N (%)	61 – 100% N (%)	**Total Responses** N (%)
4. On average, what percent of EDS submissions initiated by your pharmacy are the result of a request by the prescribing physician?	117 (42.5)	41 (14.9)	47 (17.1)	30 (10.9)	40 (14.5)	275 (100.0)

In relation to the previous response, respondents were asked *on average, what percent of these restricted or non-formulary medications are*

submitted for coverage under the EDS program? An average of 59% were submitted for coverage. This translated into 21.2 prescriptions per week submitted for coverage, with pharmacies submitting between 2% and 100% of restricted and non-formulary prescriptions for coverage.

Continuing with the progression of questions, respondents were asked, *on average, what percent of the EDS submissions are initiated by your pharmacy rather than by the prescribing physician*? An average of 79% of EDS requests submitted were initiated by the pharmacy as opposed to the prescribing physician. This translated into approximately 16.65 prescriptions per week submitted for EDS coverage by the pharmacy instead of the prescribing physician, with pharmacies reporting between 5% and 100% of EDS request being initiated by the pharmacy.

The final area of interest asked, *on average, what percent of EDS submissions initiated by your pharmacy are the result of a request by the prescribing physician*? An average of 29.1% of EDS claims submitted by pharmacies were at the request of the prescribing physician. Therefore, each responding store submitted 4.85 EDS submissions per week at the request of the prescribing physician, where responding pharmacies reported submitting between 0% and 100% of EDS submissions at the request of the prescribing physician.

4.6 Factors Associated with an EDS Request

Section C of the questionnaire consisted of items used to identify factors that might influence whether a pharmacy initiated an EDS request on behalf of the patient. Respondents were asked to rate the importance of each factor on whether to initiate an EDS request. Results of analysis using frequency distributions are displayed in Table 4.7. For post-hoc analysis, statistical significance was set at $p < 0.05$.

Table 4.7 Factors Associated with the Initiation of an EDS Request

Question	Very Important/ Important N (%)	Somewhat Important N (%)	Neutral N (%)	Somewhat Unimportant N (%)	Very Unimportant/ Unimportant N (%)	Total Responses N (%)
1. The time needed to submit an EDS request.	107 (38.9)	43 (15.6)	25 (9.1)	21 (7.6)	79 (28.7)	275 (100.0)
2. The ability of the patient to pay for the prescription.	202 (73.5)	32 (11.6)	11 (4.0)	12 (4.4)	18 (6.5)	275 (100.0)
3. The patient has exceeded the Drug Plan deductible.	181 (65.8)	49 (17.8)	17 (6.2)	9 (3.3)	19 (6.9)	275 (100.0)
4. The likelihood that the patient will eventually exceed the Drug Plan deductible.	163 (59.3)	60 (21.8)	21 (7.6)	12 (4.4)	19 (6.9)	275 (100.0)
5. Your familiarity with the administrative processes of the EDS program.	123 (44.7)	37 (13.5)	54 (19.6)	10 (3.6)	50 (18.2)	274 (99.6)
6. Ability to obtain all the information needed to make an EDS request.	211 (76.7)	30 (10.9)	10 (3.6)	6 (2.2)	18 (6.5)	275 (100.0)
7. Ability to track the status of your EDS request once it has been submitted.	141 (51.3)	54 (19.6)	38 (13.8)	2 (2.2)	36 (13.1)	275 (100.0)
8. Your ability to contact the prescribing physician.	193 (70.2)	47 (17.1)	14 (5.1)	2 (0.7)	19 (6.9)	275 (100.0)

Only 38.9% of respondents reported that *the time needed to submit an EDS request* was an Important or Very Important factor in applying for EDS. Bonferroni analysis revealed a statistically significant difference between responding pharmacies with regard to the number of EDS submissions resulting from a request by the prescribing physician. Respondents' whose pharmacy submitted 11-25% of EDS submissions (19.5%) at the request of the prescribing physician were less likely to find the statement important than those where 26-60% were (49.4%) (χ^2 = 15.685; p < 0.003) (Figure 4.8).

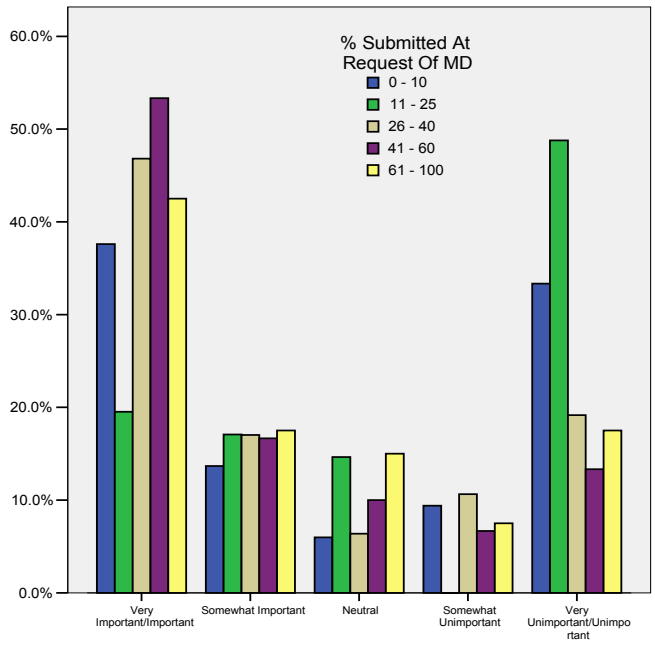


Figure 4.8 Factor Time by Percent Submitted at Request of Physician

Almost three-quarters of respondents (73.5%) reported that *the ability of the patient to pay for the prescription* was an Important or Very Important

factor in whether they will submit an EDS request. There was no statistically significant difference between groups.

Two-thirds of respondents (65.8%) indicated *whether the patient has exceeded the Drug Plan deductible* to be an Important or Very Important factor. There was no statistically significant difference between groups.

In terms of *the likelihood that the patient will eventually exceed the Drug Plan deductible*, 59.3% of respondents reported this to be an Important or Very Important factor. There was no statistically significant difference between groups.

Less than half of respondents (44.7%) revealed that his or her *familiarity with the administrative processes of the EDS program* was an Important or Very Important factor. There was no statistically significant difference between groups.

Over three-quarters of respondents (76.7%) indicated his or her *ability to obtain all the information needed to make an EDS request* was an Important or Very Important factor. There was no statistically significant difference between respondents.

Slightly more than half of respondents (51.3%) reported that his or her *ability to track the status of your EDS request once it has been submitted* to be an Important or Very Important factor. There was no statistically significant difference between respondents.

Almost three-quarters of respondents (70.2%) found his or her *ability to contact the prescribing physician* to be an Important or Very Important factor. Bonferroni analysis revealed a statistically significant difference between respondents' in terms of proximity to the prescribing physician. Responding pharmacies where the prescribing physician was in the Same Location (54.9%) as the pharmacy were less likely rate the factor as important than those that were Removed (82.1%) (χ^2 = 18.408; p = 0.000) (Figure 4.9).

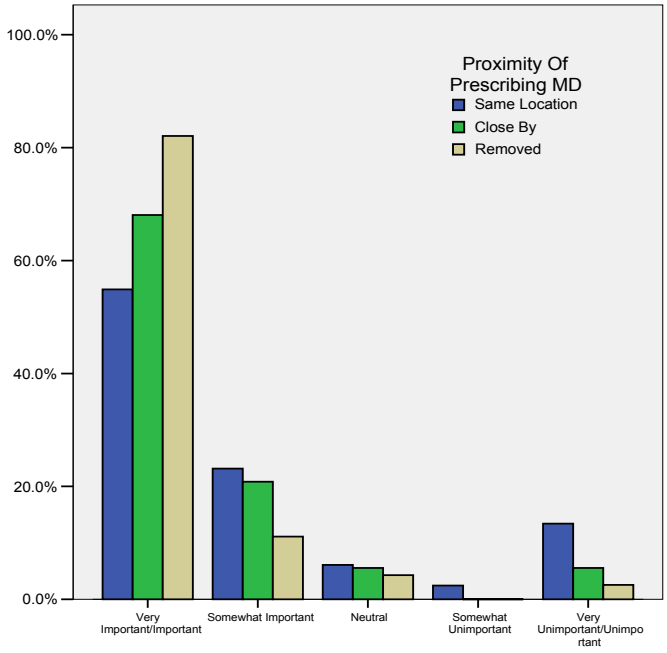


Figure 4.9 Factor Contact Physician by Proximity of Prescribing Physician

There were eight separate questions on factors affecting whether a pharmacy will apply for EDS or not, yet only two factors, time and ability to contact the prescribing physician, displayed statistically significant differences between respondents. This highlights the uniform nature of responses when

pharmacies consider whether to apply for EDS despite the diverse nature of community-pharmacy practice.

4.6.1 Factor Analysis – Factors Associated EDS Requests Constructs

Reliability statistics for Cronbach's Alpha based on standardized items was 0.831. The construct is based on the five questions of the questionnaire that dealt with issues pertaining directly to the pharmacist. In particular, the factors included the: time needed to submit an EDS, pharmacists' familiarity with the administrative processes, ability to obtain the required information, ability to track the status of the EDS request, and ability to contact the prescribing physician. See Table 4.8.

Table 4.8 Pharmacist Centred Issues Construct

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Time Needed To Submit EDS	10.58	25.425	.572	.347	.804
Pharmacist Familiarity With Administrative Processes	10.96	28.021	.543	.301	.805
Ability To Obtain Information Required	12.13	28.976	.674	.544	.771
Ability To Track The Status Of EDS Request	11.38	26.536	.689	.479	.760
Ability To Contact The Prescribing MD	11.98	29.604	.641	.505	.780

Analysis using one-way ANOVA resulted in one factor having a statistically significant difference of $p < 0.05$. There was a significant

difference between pharmacies with regard to the area of pharmacy between mixed and those situated in residential and commercial areas ($p < 0.002$).

Reliability statistics for Cronbach's Alpha based on standardized items was 0.756. The construct is based on the three questions of the questionnaire that were patient centred concerns. In particular, the factors included the: ability of the patient to pay for the prescription, patient had exceeded the deductible, and patient will eventually exceed the deductible. See Table 4.9. Analysis using one-way ANOVA resulted in no statistically significant difference between respondents; $p < 0.05$.

Table 4.9 Patient Centred Issues Construct

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Ability Of Patient To Pay For Rx	4.99	7.536	.397	.158	.873
Patient Has Exceeded Deductible	4.81	5.882	.692	.609	.541
Patient Will Eventually Exceed Deductible	4.58	6.040	.688	.606	.548

4.7 EDS Procedures

Section D of the questionnaire was seeking to understand the experiences in pharmacies since the EDS program came into effect. Responses are displayed in Table 4.10 as analyzed using frequency distributions. For post-hoc analysis, statistical significance was set at $p < 0.05$.

Table 4.10 Appropriateness of Procedures used in Obtaining EDS

Question	Always N (%)	Usually N (%)	Sometimes N (%)	Rarely N (%)	Never N (%)	Total Responses N (%)
1. Do you find it difficult to apply for EDS?	14 (5.1)	47 (17.1)	137 (49.8)	66 (24.0)	11 (4.0)	275 (100.0)
2. Do you have access to all the information required by the Drug Plan (e.g. diagnosis relevant to use of drug)?	15 (5.5)	70 (25.5)	78 (28.4)	99 (36.0)	13 (4.7)	275 (100.0)
3. When you submit an EDS request, do you receive notification from the Drug Plan as to whether the request is accepted or rejected?	3 (1.1)	17 (6.2)	21 (7.6)	77 (28.0)	157 (57.1)	275 (100.0)
Question	Always N (%)	Usually N (%)	Sometimes N (%)	Rarely N (%)	Do Not Receive N (%)	Total Responses N (%)
4. If you receive notification from the Drug Plan as to whether the EDS request is accepted or rejected, is that notification provided in a timely manner (within two days of submission)?	2 (0.7)	28 (10.2)	34 (12.4)	66 (24.0)	137 (49.8)	267 (97.1)

A total of 22.2% of respondents Usually or Always reported it to be *difficult to apply for EDS*. There was no statistically significant difference between respondents.

Only 31.0% of respondents Usually or Always *have access to all the information required by the Drug Plan*. Bonferroni analysis exposed a statistically significant difference between respondents in terms of hours the pharmacy was open. Pharmacies open 50.5 – 60 hours per week (42.6%) were more likely to have access to the information required than those open more than 60 hours per week (21.5%) ($\chi^2 = 13.956$; $p < 0.007$) (Figure 4.10).

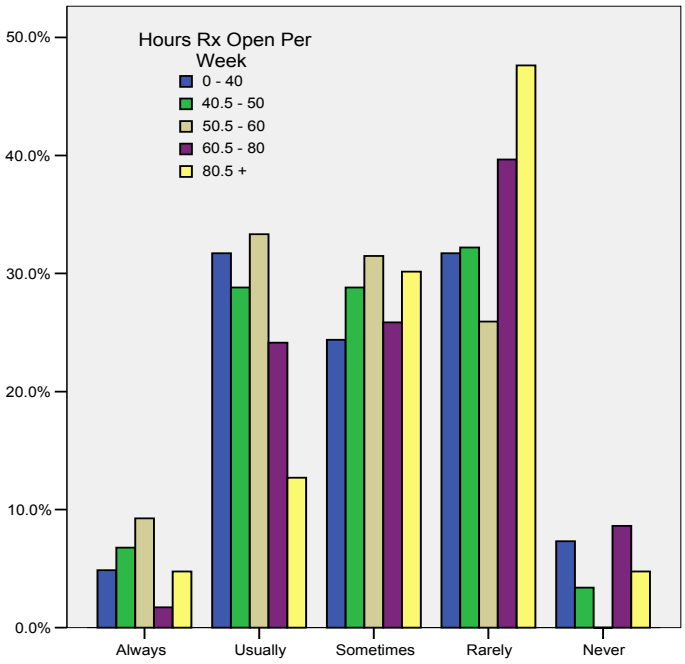


Figure 4.10 Access to Information by Hours Open

Respondents were asked *when you submit an EDS request, do you receive notification from the Drug Plan as to whether the request is accepted or rejected*, 7.3% of respondents Usually or Always receive notification; while 85.1% of respondents Rarely or Never receive notification. Bonferroni analysis revealed a statistically significant difference in terms of the community size the pharmacy was situated in. Pharmacies located in Saskatoon/Regina (4.7%) were less likely to receive notification than those in regions where the community size was less than 5,000 people (9.4%) ($\chi^2 = 10.169$; $p < 0.006$) (Figure 4.11).

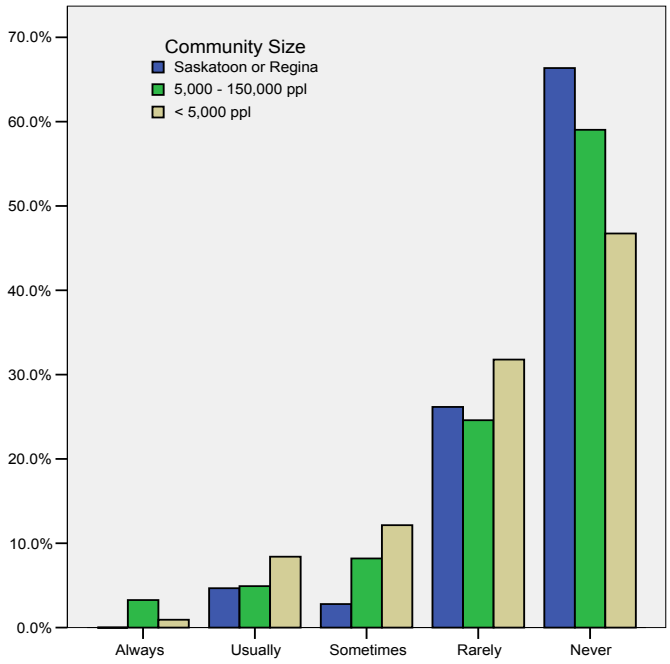


Figure 4.11 Notification of Status by Community Size

Respondents were questioned on *if they receive notification from the Drug Plan as to whether the EDS request is accepted or rejected, is that notification provided in a timely manner*? A total of 10.9% reported Usually or Always receiving notification in a timely manner, while 49.8% Do Not Receive notification. There was no statistically significant difference between respondents.

4.8 Pharmacy Dynamics

Section E of the questionnaire was formed to gain an appreciation for the dynamics that existed in the responding pharmacy and the circumstances surrounding an EDS request. Respondents were asked to what extent they agreed or disagreed with each statement. Frequency distributions were

carried out for each of the four questions within this section and are displayed in Table 4.11. For post-hoc analysis, statistical significance was set at $p < 0.05$.

Table 4.11 Pharmacy Dynamics

Question	Strongly Agree/ Agree N (%)	Somewhat Agree N (%)	Neutral N (%)	Somewhat Disagree N (%)	Strongly Disagree/ Disagree N (%)	Total Responses N (%)
1. Pharmacists in your store have adequate information on the administrative nature of the EDS program.	207 (75.3)	44 (16.0)	13 (4.7)	7 (2.5)	3 (1.1)	274 (99.6)
2. Pharmacists in your store feel that initiating an EDS request is an important service for their patients.	218 (79.3)	35 (12.7)	12 (4.4)	4 (1.5)	6 (2.2)	275 (100.0)
3. Changing the policy in 1999 to allow pharmacists to initiate an EDS request on behalf of patients has been beneficial to patient health care.	195 (70.9)	43 (15.6)	19 (6.9)	6 (2.2)	12 (4.4)	275 (100.0)
4. The EDS program contributes significantly to the administrative workload of pharmacists.	238 (86.5)	25 (9.1)	7 (2.5)	2 (0.7)	3 (1.1)	275 (100.0)

Just over three-quarters of respondents (75.3%) Agreed or Strongly Agreed that *pharmacists in your store have adequate information on the administrative nature of the EDS program*. Bonferroni analysis revealed a statistically significant difference in terms of the number of prescriptions filled. Pharmacies that filled 0 – 500 prescriptions per week (63.2%) were less likely to agree with the statement than those that filled 501-750 (92.9%) and more

than 1000 prescriptions per week (76.6%) (χ^2 = 20.475; p = 0.000) (Figure 4.12).

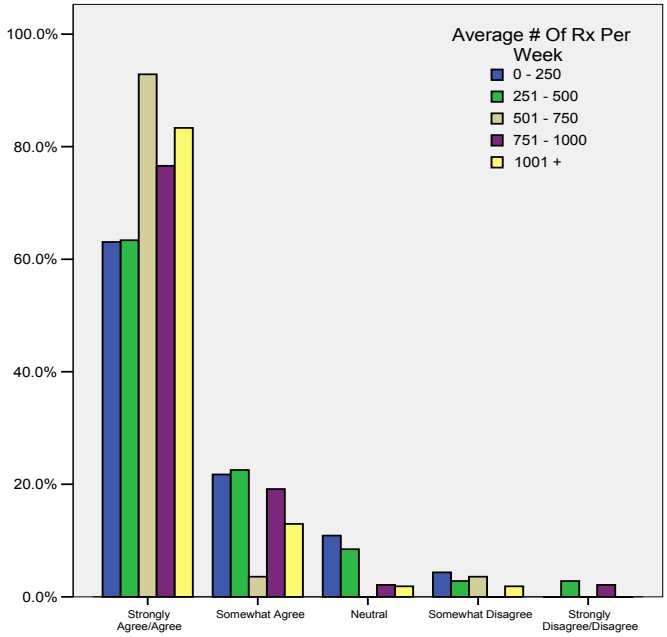


Figure 4.12 Adequate Information by Prescription Volume

A total of 79.3% of respondents Agreed or Strongly Agreed that *pharmacists in your store feel that initiating an EDS request is an important service for their patients*. A statistically significant difference was revealed via Bonferroni analysis with regard to the percentage of EDS requests submitted by the pharmacy instead of the prescribing physician. Pharmacies where 0-50% of EDS requests (60.4%) were submitted by the pharmacy as opposed to the prescribing physician were less likely to agree with the statement than those where 81-90% (79.3%) and 96-100% were (97.3%) (χ^2 = 20.320; p = 0.000) (Figure 4.13).

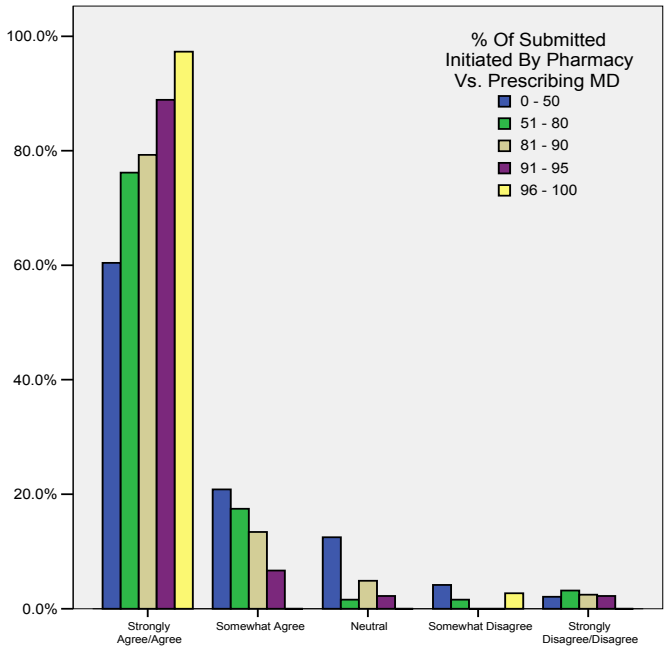


Figure 4.13 Important Service for Patients by Percent Pharmacy Submitted

There were 70.9% of respondents who Agreed or Strongly Agreed that *changing the policy in 1999 to allow pharmacists to initiate an EDS request on behalf of patients has been beneficial to patient health care*. Bonferroni analysis revealed a statistically significant difference between the percentage of EDS requests submitted by the pharmacy instead of the prescribing physician. Pharmacies where 0-50% of EDS requests (50.0%) were submitted by the pharmacy as opposed to the prescribing physician were less likely to agree with the statement than those where 96-100% were (78.4%) ($\chi^2 = 12.476$; $p < 0.014$) (Figure 4.14).

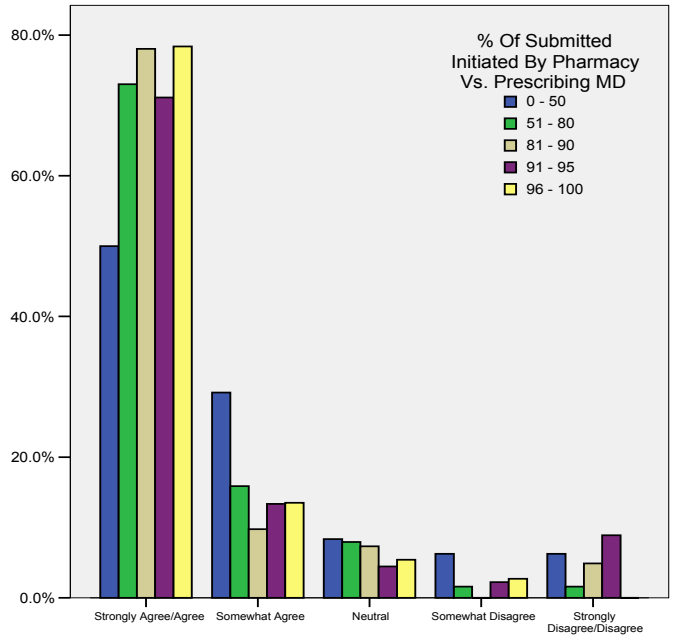


Figure 4.14 Policy Change Benefits Patients by Percent Pharmacy Submitted

A large majority of respondents (86.5%) Agreed or Strongly Agreed that *the EDS program contributes significantly to the administrative workload of pharmacists.* Only 1.8% of respondents Somewhat Disagreed or Disagreed with the statement, and no respondents Strongly Disagreed. Bonferroni analysis revealed statistically significant differences in terms of the volume of prescriptions filled per week and the number of EDS requests submitted by the pharmacy instead of the prescribing physician.

Pharmacies that filled 0-250 prescriptions per week (73.9%) were less likely to agree with the statement than those that filled more than 500 prescriptions per week (91.8%) ($\chi^2 = 12.873$; $p < 0.012$) (Figure 4.15).

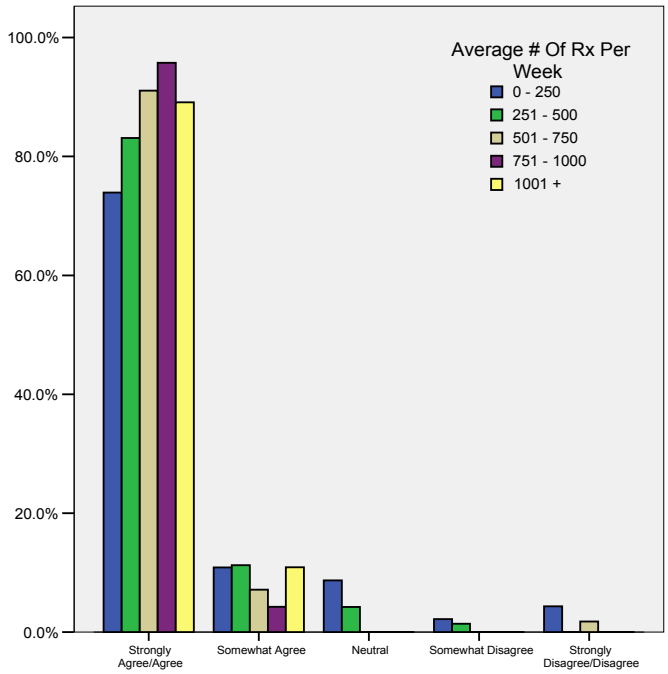


Figure 4.15 Increased Workload by Prescription Volume

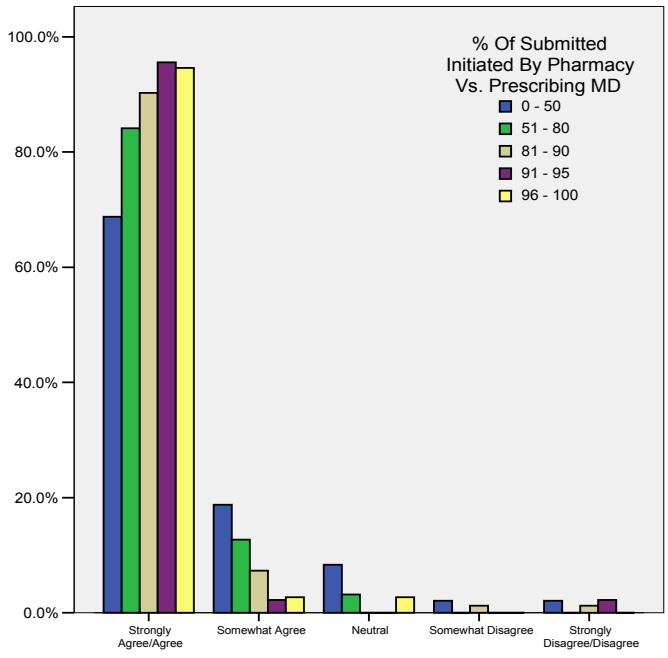


Figure 4.16 Increased Workload by Percent Pharmacy Submitted

Pharmacies submitting 0-50% of EDS request (68.8%) versus the prescribing physician were less likely to agree with the statement compared to those where more than 50% were (90.3%) ($\chi^2 = 19.536$; $p < 0.001$) (Figure 4.16).

4.9 Maximum Allowable Cost

Table 4.12 Maximum Allowable Cost

Question	Strongly Agree/ Agree N (%)	Somewhat Agree N (%)	Too Early To Say N (%)	Somewhat Disagree N (%)	Strongly Disagree/ Disagree N (%)	Total Responses N (%)
1. Saskatchewan Health has provided adequate information to pharmacists in your store on the administrative nature of the MAC policy.	139 (50.5)	71 (25.8)	25 (9.1)	11 (4.0)	29 (10.5)	275 (100.0)
2. The staff in your pharmacy are sufficiently prepared to deal with questions on MAC.	168 (61.1)	63 (22.9)	21 (7.6)	15 (5.5)	8 (2.9)	275 (100.0)
5. The MAC policy is impairing the ability of my patients to receive appropriate drug therapy.	37 (13.5)	75 (27.3)	111 (40.4)	21 (7.6)	30 (10.9)	274 (99.6)
Question	Greatly Increased/ Increased N (%)	Somewhat Increased N (%)	Not Changed N (%)	Somewhat Decreased N (%)	Greatly Decreased/ Decreased N (%)	Total Responses N (%)
3. Since the MAC policy came into effect, the amount of time your staff spends explaining the Drug Plan to patients has:	182 (66.2)	64 (23.3)	25 (9.1)	1 (0.4)	2 (0.7)	274 (99.6)
4. Since the MAC policy came into effect, the number of EDS requests initiated by your pharmacy has:	83 (30.2)	69 (25.1)	122 (44.4)	0 (0.0)	1 (0.4)	275 (100.0)

Section F of the questionnaire was formed to obtain initial perceptions of the MAC policy. Results of frequency distribution analysis are displayed in Table 4.12. For post-hoc analysis, statistical significance was set at $p < 0.05$.

Half of respondents (50.5%) Agreed or Strongly Agreed that *Saskatchewan Health has provided adequate information to pharmacists in your store on the administrative nature of the MAC policy*. There was no statistically significant difference between groups.

A total of 61.1% of respondents Agreed or Strongly Agreed that *the staff in your pharmacy are sufficiently prepared to deal with questions on MAC*. There was no statistically significant difference between groups.

When asking respondents *since the MAC policy came into effect, the amount of time your staff spends explaining the Drug Plan to patients has*, 66.2% of respondents reported that the time their staff spent explaining the Drug Plan to patients had Increased or Greatly Increased since the Policy came into effect. There was no statistically significant difference between groups.

When addressing the issue of *since the MAC policy came into effect, the number of EDS requests initiated by your pharmacy has*, 30.2% of respondents indicated that the number of EDS requests has Increased or Greatly Increased since the Policy came into effect. Bonferroni analysis revealed a statistically significant difference in terms of prescription volume. Pharmacies that filled 251-500 prescriptions per week (19.7%) were less

likely to report an increase in EDS requests than those that filled 751-1000 per week (46.8%) ($\chi^2 = 9.693$; $p < 0.046$) (Figure 4.17).

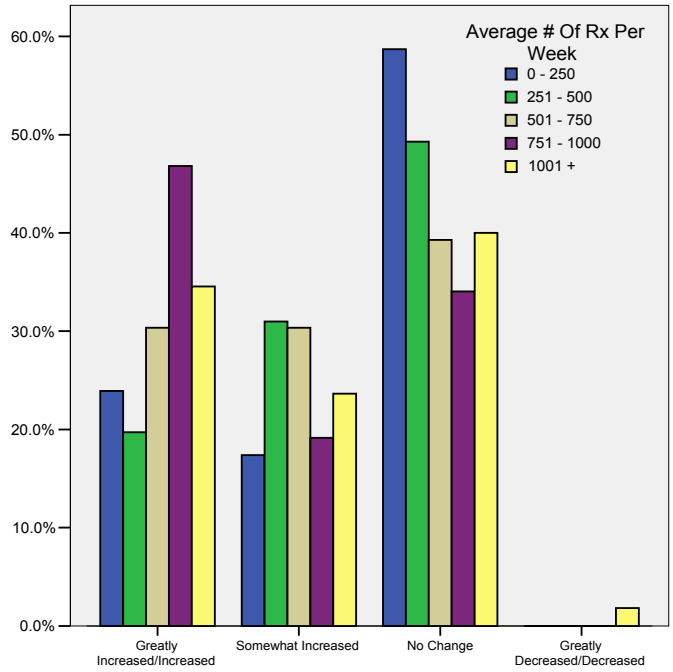


Figure 4.17 Change in EDS Requests by Prescription Volume

Only 13.5% of respondents Agreed or Strongly Agreed that *the MAC policy is impairing the ability of my patients to receive appropriate drug therapy*; while 40.4% of respondents felt it was too early to assess whether this was true. There was no statistically significant difference between groups.

4.10 Qualitative Themes

As indicated in Section 3.4.1, the qualitative themes of the study and responses are displayed in Appendices J and K.

Eight general themes were developed for the EDS responses (Appendix J), with one theme changing for responses pertaining to MAC (Appendix K); these themes are displayed with an explanation, along with all responses.

The themes were not mutually exclusive, as some responses were coded into more than one category, and are therefore displayed in Appendices J and K in no particular order or theme. Responses from the open-ended questions were used to add to the discussion that is to follow, and will not be alluded to in the results section.

5. DISCUSSION

Results of this study are revealing, but as with survey-based research should be approached with some caution. The intention of this study was not to gain hard, objective results one might gain through other methods, such as exploring administrative databases. Instead, the results can be used to build upon in future research pertaining to pharmacy practice.

This study is based on four research questions, which were formed to gain a greater appreciation of pharmacy practice with regard to the EDS and MAC policies, as well as to potentially generate hypotheses for future research. Therefore, there are no hypotheses to accept or reject. This section begins with a discussion on the four research questions and sub-questions. This is followed by the conclusion and recommendations.

5.1 Research Question 1

> *In the opinion of community-pharmacists, which stakeholders benefit from Saskatchewan Health's Exception Drug Status (EDS) program?*

As identified through the literature, the principal stakeholders in prior authorization programs are: patients, pharmacists, physicians, drug plans, and the health care system as a whole [21, 22, 25, 39, 74]. And while all these stakeholders differ as to their interest in the program, the respondents

(pharmacists) indicated the Drug Plan and patients benefited more from the program than pharmacists, physicians, or the health care system as a whole. Specifically, patients were seen to benefit from having more prescription drugs covered by the Drug Plan than would be the case if EDS were not in place.

While one may view the inclusion of some prescription drugs on the formulary via the EDS program as beneficial, in reality many patients would not receive any benefit from this inclusion unless they met the 3.4% of adjusted income deductible. Even though there are varying levels of coverage under the Drug Plan, depending on the beneficiary, the majority fall within this structure [6]. This may have been the perspective in the minds of respondents who did not agree, relatively, that the EDS program was beneficial for patients in terms of making the drug more affordable, compared to the benefit of including more drugs on the formulary.

Respondents were less likely to agree, relative to other stakeholders, that the EDS program was beneficial to the health care system by promoting more appropriate utilization of drugs, physicians by providing them with more drug therapy choices, or pharmacists by providing them the opportunity to be more actively involved in securing drug therapy for patients. These findings are interesting as it suggests that some pharmacists may have an appreciation and orientation to other stakeholders within the health care system, and not just to their own profession. One would expect pharmacists

to find administrative programs, such as EDS, unbeneficial to their own profession.

There was a difference in terms of the hours a pharmacy was open per week. The differences in opinion by respondents' in pharmacies open more than 80 hours a week may reflect the dissatisfaction with the EDS program. This dissatisfaction may arise as the result of the reduced access to information that is inherent in the current EDS program. The restricted hours Drug Plan representatives are available, compared to pharmacies open more than 80 hours per week, and the hours physician offices are open, both limit a pharmacies access to the required information.

5.2 Research Question 2

To what extent do pharmacies in Saskatchewan participate in the EDS program?

Section B of the questionnaire was used to address the above research question. Results are displayed in Table 4.6. Each of the four questions in this section were used as independent factors for analysis purposes. Therefore, these factors are also alluded to in the other three research questions, as comparators if there was a statistically significant difference between respondents based on the questions in Section B.

While the average number of restricted and non-formulary prescriptions received per pharmacy was 36, the range highlights the diverse nature of community pharmacies in Saskatchewan. Pharmacies reported

receiving between one and 400 restricted and non-formulary prescriptions per week, with a mode of 10 and a median of 20.

These numbers reveal that even though on average community pharmacies receive 36 non-formulary and restricted prescriptions per week, half of all pharmacies receive fewer than 20 such requests per week. Therefore, pharmacies that handle a greater volume of requests bring up the average for all. Because data was not captured with regard to the type of patients' community pharmacies primarily serve, such as seniors who tend to obtain a disproportionate amount of prescriptions in comparison to other demographics, it is not feasible to assume that pharmacies in one demographic area contributed to the higher volume of restricted and non-formulary prescriptions.

In terms of the percentage of restricted and non-formulary prescriptions submitted for EDS coverage, an average of 59% were submitted. There was a range of responses with some pharmacies submitting 2% of restricted and non-formulary requests, and others that submitted 100%. The mode was 40%, with a median of 60%.

Due to the methods used to capture data for this study being almost exclusively quantitative, one is not able to make assertions on why only 59% of restricted and non-formulary prescriptions were submitted for coverage. However, assumptions can be derived on why the remaining 41% of such prescriptions were not submitted for coverage.

As reported in the results section, communication between the prescriber and pharmacist are important in whether a pharmacy will apply for EDS. Therefore, one might assume that part of the reason why not all restricted and non-formulary prescriptions are submitted for coverage is the lack of communication and in turn information available to the pharmacy. Other reasons may centre on the patient not receiving coverage even if the request was approved, due to not reaching the deductible, or the fact that the prescription is not covered under the formulary or through EDS.

Since the policy change in 1999, pharmacists, by default, have taken some of the administrative burden of the EDS program from physicians. Pharmacies reported submitting an average of 79% of all EDS requests. The range of responses went from a low of 5%, to a high of 100%. While the mode and median were identical at 90%. Therefore, pharmacies submitting a small percentage of EDS requests tended to bring down the average overall, since over half of all respondents reported submitting 90% of EDS requests.

The reported numbers are not objective due to the way in which data was collected, but perceptions are that over three-quarters of all EDS requests are submitted by the pharmacy. This is a significant shift in administrative burden from physicians to pharmacists in just over 5 years from the time the policy changed to the time of the study.

A direct sign of physicians offloading the administrative workload associated with the EDS program is requesting that the pharmacy initiate the request. Pharmacies reported that an average of 29% of EDS requests

submitted by their pharmacy were at the request of the prescribing physician. There was the maximum range of responses from 0% to 100% of EDS submissions by the pharmacy coming at the request of the prescribing physician. The mode was 10%, while the median was 20%.

Again, due to the nature of the study being survey-based, these numbers do not communicate the entire story. One might be interested to explore the communication processes that occur between the physician and pharmacist when the physician has asked the pharmacist to initiate the request. It is just speculation, but one would assume that the sharing of information would be more forthright from the physician if he or she was asking the pharmacist to apply for EDS, versus the physician who did not. In essence, the physician is asking for a favour from the pharmacists, and in turn may be more likely to provide the required information.

5.3 Research Question 3

Under what circumstances will a pharmacist initiate an EDS request?

The above research question was addressed in Section C of the questionnaire. Table 4.7 displays the respondents' responses.

The most surprising and interesting finding with regard to this research question revolve around the issue of time. Out of the eight questions in this section, time was the least important, relatively speaking, with only 38.9% of respondents reporting it to be an Important or Very Important factor. In relation to the other factors that impact whether a pharmacist will submit an

EDS request, time is secondary. Therefore, one would assume that pharmacists are willing to take the time needed to apply for EDS, but other factors will affect time as well, such as the ability to obtain the required information and contacting the prescribing physician.

In relation to the strongest factors when determining if a pharmacists will initiate an EDS request, more than 70% of respondents indicated three factors to be Important or Very Important: the ability of the patient to pay for the prescription (73.5%), ability to obtain all the information needed to make the request (76.7%), and the ability to contact the prescribing physician (70.2%).

The ability of the patient to pay for the prescription is key in deciding whether to apply for EDS coverage. If the patient is unable to afford the medication, even if EDS is approved, it is a misuse of resources to apply for EDS coverage with regard to the pharmacist, physician, and Drug Plan. Of course, this does not take into consideration the direct and indirect effects of the patient not receiving pharmaceutical therapy, such as the possible need to treat the patient in an in-patient setting, resulting in a greater cost to the system, or the patients' condition deteriorating resulting in a lower quality-of-life.

The other two areas that emerged as Important or Very Important are interconnected: the ability to obtain information and the ability to contact the prescribing physician. Pharmacists are faced with having the authority to apply for EDS on behalf of patients, yet are restricted in the access to

relevant and vital information. The introduction of the Pharmacy Information Project (PIP), which is being developed as "a solution to link community physicians, pharmacies and hospitals, giving confidential shared access to patient medication histories [84]" may help alleviate some of the restrictions currently in place. However, this project may bring with it another set of concerns, such as an unwillingness to input patient information into the system.

With regard to ability to contact the prescribing physician, respondents' whose pharmacies were in the same location as the prescribing physician were less likely to find their ability to contact the physician a factor than those who were removed. This may be the result of having easier accessibility to the prescribing physicians where the dispensary is in the same location resulting in a more personal relationship than would be possible with more removed geographic locations.

5.3.1 Research Question 3a

Is the initiation of an EDS request part of the continuum of care pharmacists provide to their patients?

This research question was looked at in questions 2 and 3 in Section E of the questionnaire.

With almost all respondents agreeing (92.0%) that initiating a request is an important service to their patients, one is reminded that pharmacists believe the EDS program is beneficial to patients. As well, a large majority of respondents agreed (86.5%) that patient health care has benefited by

authorizing pharmacists to initiate EDS requests. These viewpoints would be expected to be strengthened if and when the underlying issues of communication and workload were addressed.

Respondents in pharmacies that submitted fewer than 50% of EDS requests were less likely to agree with the statements than those who submitted close to 100%. This is not surprising as one who submits a greater percentage of requests would naturally be more likely to agree that the service is important to patients and the patients' health care because of his or her professional experience with patients who use the program. Therefore, pharmacies that submit a higher percentage of requests may do so because they see the EDS program as beneficial to patient health care and as a result are providing an important service that was not part of pharmacy practice until 1999.

5.3.2 Research Question 3b

Do pharmacists have access to all the information necessary to initiate an EDS request?

Section D of the questionnaire was used to address the above research question, with question 2 asking the question specifically.

Only 31% of respondents Always or Usually have access to all the information required. The fact that pharmacists are more likely not to have the information required rather than have the information is troubling. The idea behind authorizing pharmacists to apply for EDS on behalf of patients was to increase access to drugs for patients. However, if the pharmacist

does not have the necessary information to make that request, the authorization may in fact lengthen the process. In light of this, the introduction of the PIP system by Saskatchewan Health may resolve some of the issues around access to patient information. However, it is only speculation to assume that this system would increase access to information without causing unanticipated problems.

A statistically significant difference was revealed between respondents' whose pharmacy was open 50.5-60 hours per week being more likely to have access to the information required than pharmacies open more than 60 hours per week. This difference may be attributable to pharmacies open longer hours filling prescriptions after physicians' offices have closed, making it more difficult to obtain the information required if it was not provided. As well, Drug Plan representatives that handle EDS requests are not available to provide needed information or authorize requests at all times.

5.3.3 Research Question 3c

Is additional administrative workload a factor when initiating an EDS request?

The above research question was asked in a blunt manner in question 4 of Section E of the questionnaire. However, questions 1 and 5 – 8 of Section C addressed the question indirectly.

The response to question 4 in Section E was strong, with 95.6% of respondents agreeing that the EDS program contributes significantly to their workload. Statistically significant differences were reported as responding

pharmacies that filled 0-250 prescriptions per week were less likely to agree with the statement that those that filled more than 500 prescriptions per week. Also, pharmacies that submitted 0-50% of EDS requests as opposed to the prescribing physician were less likely to agree with the statement than those who submit more than 50% of EDS requests.

Not surprisingly, these two differences between pharmacies reveal that the lower the prescription volume and number of EDS requests, the less pharmacists see the EDS program as contributing to their administrative workload.

While the time required when submitting an EDS request was less important than other factors in determining whether a pharmacy would initiate a request, the ability to obtain the information required and contacting the prescribing physician were important. Again, it appears that respondents do not necessarily mind the time required submitting an EDS request, yet they do find their ability to obtain the information from the physician important. Therefore, the ability to communicate with the prescribing physician appears to be a deciding factor on whether the pharmacist will initiate a request.

5.4 Research Question 4

> *How is the new Maximum Allowable Cost (MAC) policy affecting the administrative workload of pharmacists?*

The above question is a combination of questions 3 and 4 in Section F of the questionnaire, which are addressed in research questions 4a and 4c.

5.4.1 Research Question 4a

Has the number of EDS requests initiated by pharmacies changed since the implementation of MAC?

Research Question 4a is addressed via question 4 in Section F. A total of 55.3% of respondents saw an increase in the number of EDS requests since the MAC policy came into effect. Pharmacies that filled 251-500 prescriptions per week were less likely to report an increase in comparison to pharmacies that filled 751-1000 prescriptions per week.

The idea behind an increase in EDS requests following the implementation of the MAC policy may result from increasing the restrictions on pharmaceutical therapy. And while over half of the responding pharmacies reported an increase, this increase may fade as pharmacists, physicians and patients become familiar with the policy and begin to work within the parameters of MAC. However, in the future this will depend on the number of new beneficiaries that are prescribed a MAC drug who may not be familiar with the policy.

EDS requests may have increased, yet in order for the patient to receive EDS coverage, they would have had to meet the regular criteria for obtaining EDS coverage. Therefore, unless the patient had tried other drugs that fall within the MAC ceiling for coverage, they would either have to try the agents for which there is coverage, or pay the difference between what has been prescribed, and the MAC insured portion ($1.51 per tablet or capsule). As well, formulary restrictions, such as MAC, can result in both intended and

unintended therapeutic substitutions [7]. Further analyses of patient outcomes on the trends since the implementation are required to attempt to fully understand the impact, positive and negative, of the policy.

5.4.2 Research Question 4b

Do pharmacists have sufficient information on MAC to allow them to adequately explain the policy to patients?

This question was addressed in questions 1 and 2 of Section F. While over three-quarters (76.3%) of respondents were provided with adequate information on the MAC policy, there were additional comments which added to the interpretation through the open-ended opportunity to respond. Some respondents reported receiving information on the Policy after patients; catching many off guard and exhibiting inefficient communication by the Drug Plan (see Appendix K).

The Government of Saskatchewan presented the 2004-2005 provincial budget on March 31st, 2004. Within this budget was the announcement of the MAC policy being implemented on July 1st, 2004. In order for policies to be properly implemented, it is essential to communicate vital information to those charged with administering the policies. However, the Government knew it would be implementing this policy, yet it appears that the Government did not prepare some pharmacists well enough in advance on the administration of the program.

A large majority (84.0%) of respondents reported that pharmacists in their pharmacies were prepared for questions on MAC. It is unclear as to

whether pharmacists were prepared for questions when the Policy was implemented, or whether this happened sometime after implementation. MAC is not a novel idea, and may have been a policy that pharmacists were aware of before implementation.

5.4.3 Research Question 4c

> *Since the implementation of MAC, have pharmacists been spending more time with patients explaining the Drug Plan?*

Question 3 in Section F of the questionnaire addressed the above question. A total of 89.5% of responding pharmacies reported an increase in the time spent explaining the Drug Plan since the implementation of MAC. The Drug Plan may not have provided patients with the appropriate information and/or did not communicate it in a manner that facilitated the appropriate understanding, leaving pharmacists to explain the Policy to patients. Once patients' understanding of the Policy was established, one would assume that the time spent explaining the Drug Plan would decrease. However, a policy is often important to a patient only when it applies to them so there will be a continuing need to explain the policy to new patients when it applies to them.

5.5 Study Limitations

First, the nature of the study relies on pharmacist recall. Therefore, the results must be interpreted as such, as no comparative analysis between responses in this study with other objective measures was conducted.

Previous research has shown that community pharmacists are accurate when asked to recall workload within ten percent in comparison to objective numbers [5]. As well, trying to control for certain factors, such as prescription volume or hours worked, can cause researchers to miss aspects that contribute to pharmacist workload [69].

The study took place in the province of Saskatchewan and may not be applicable to other jurisdictions. Saskatchewan is unique in that pharmacists are authorized to initiate EDS requests, and therefore may further limit the transferability of the results; with the possible exception of Newfoundland and Labrador who also grant authority to pharmacists when applying for prior authorization. However, the research does add to the available literature by allowing those interested an account of community-pharmacy managers' perceptions towards restrictive policies like EDS and MAC. Not only will this aid policy makers in the province, but it may serve as an information piece in other jurisdictions contemplating implementation of pharmacist initiated prior authorization and/or a reference-based pricing strategy.

There has not been any research on the subject matter of this study done in the province of Saskatchewan. Therefore, there is no baseline data to compare the results to. However, this research was carried out, in part, to gain baseline knowledge and can be used as a basis for future comparisons. This is especially apparent with regard to the MAC policy that was in place for between three-and-a-half and five-and-a-half months at the time of data

collection. Therefore, future opinion seeking research can be compared against the baseline knowledge gained via this research.

5.6 Conclusion

Pharmacists appear to have an appreciation of the health care system that extends beyond their own profession, and understand the way policies such as EDS affect other stakeholders. However, the findings highlight the need to improve aspects of the Program to increase its efficiency and effectiveness.

On the whole, pharmacists appear to find the EDS program beneficial to patients. Pharmacists seem to be putting aside their own dissatisfaction with the Program so that patients can benefit. And while this reinforces the professionalism of pharmacists, one can only sustain the displeasure and lack of cooperation for so long. There may come a time when the profession of pharmacy in Saskatchewan agrees collectively to reduce or abolish providing administrative duties, such as EDS, unless their concerns are addressed. Individual pharmacies are restricted in voicing their concerns, through such means as not initiating EDS requests, due to the prospect of having their license revoked, but this may change if the profession acts as a whole.

Where contention towards the Program emerges is with the inefficient manner in which pharmacists are required to apply for EDS, and the inaccessibility to required patient information, which can be burdensome and

prolong the administrative process. Like many issues in health care and other social programs, money is many times thrown into a system to theoretically help solve the problem. Although money is required to institute measures that expedite and streamline the manner in which pharmacists apply for EDS, while enhancing the communication of pertinent information, paying pharmacists an administrative fee is not likely to improve the processes without addressing the underlying sources of discontent.

With regard to the MAC program, pharmacists appear to recognize the need and benefits of such a policy. However, there should be clearer communication between the Drug Plan and pharmacists when future changes take place so that pharmacists can prepare for the change, to the benefit of all stakeholders. Pharmacists continue to be the most accessible health care professional, and it is in the best interest of the Drug Plan to ensure that pharmacists are sufficiently consulted and informed on the policies that directly concern their profession.

5.7 Recommendations

Results of this study show dissatisfaction by community pharmacists with certain aspects of the EDS program and the new MAC policy. The following are suggestions based on the literature review and results of the study to possibly help improve the acceptance by community pharmacists for these policies. As well, suggestions from the open-ended responses

(Appendices J and K) made a substantial contribution to the recommendations that follow.

- Implementation of an online, automated adjudication system for EDS claims that is accessible by all health professionals who are authorized to submit claims [1, 66]; failing that an increase the amount of staff at the Drug Plan who handle EDS requests and/or longer working hours to decrease the turn around time.
- Prescription pads specifically made for EDS drugs which have space, either on the front or the back, to place the diagnosis on, as well as previous therapies tried [Appendix J].
- Remuneration for the time it takes pharmacists and physicians to submit an EDS request, regardless of whether the request is accepted or rejected [Appendix J].
- Access for pharmacists to patient records in order to find out what the diagnosis is, and what prior therapy has been tried. This would reduce the time spent trying to obtain this information. The PIP program may address this issue [84].
- Some form of notification, preferably online or at the point-of-service terminal, as to whether the EDS submission was accepted or rejected; especially if it is the pharmacist initiating the request [Appendix J]. Currently only the patient and physician are receiving notification.
- More authority for pharmacists to make a professional judgment on patient diagnosis and past therapies tried [Appendix J]. This especially

holds true when the patient solely uses the pharmacy in question, and when the patient is on a chronic medication and the EDS claim is to renew coverage.

- Educate physicians on what information pharmacists require from them to initiate an EDS request, as well as on Drug Plan coverage and when the patient begins to receive benefits (once the 3.4% threshold is reached) [Appendix J]. This may reduce the incidents when a patient is under the impression that they will have the EDS drug paid for if the request is approved due to unintentionally misguided information from the physician.
- Have an emergency supply of medications when EDS is being applied for to cover 48 or 72 hours of the drug to tie the patient over while the request is being processed [33]. This supply may need to be restricted for certain medications, like antibiotics, for obvious clinical reasons
- Before implementing other changes to the Drug Plan, such as MAC, inform the pharmacist well before the patient [Appendix K].
- Reinforce to pharmacists and physicians that the EDS policy is not just to save money, but is also linked to clinical guidelines to reduce the likelihood of inappropriate prescribing. There may also be a benefit to educate on the reasoning behind formularies in general, as most appear to simply see management techniques like formularies as cost control strategies, and nothing more [22, 24, 27]. Although the RxFiles is an ‘arms length’ program of the Drug Plan, this group may be in the

best position to educate health professionals on formularies and the underlying policies.

- Implement some form of educational campaign targeted to users of the Drug Plan on how the Plan works, such as when they will receive benefits, why a formulary is in place, etc. [Appendix J and K].

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APPENDIX A

Original Questionnaire

Pharmacists' Experience with the Exception Drug Status (EDS) Program in Saskatchewan

College of Pharmacy and Nutrition
University of Saskatchewan
Saskatoon, SK

A – Saskatchewan Health's Exception Drug Status (EDS) Program
Various stakeholders, from patients, pharmacists and physicians, to those who develop the Drug Plan are cited to have an interest in the EDS Program. To what extent do you agree or disagree with the following statements?

1. The EDS program benefits **patients** by expanding the number of prescription drugs covered by the provincial Drug Plan.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

2. The EDS program benefits **patients** by making their prescription drug more affordable.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

3. The EDS program benefits **physicians** by providing them more drug therapy choices for their patients.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

4. The EDS program benefits the **Drug Plan** by allowing potentially costly drug therapies to be available in a more controlled fashion.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

5. The EDS program benefits the **health care system** by promoting more appropriate utilization of drugs.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

6. The EDS program benefits **pharmacists** by providing them with an opportunity to be more actively involved in securing the most appropriate drug therapy for their patients.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

B – Participation in Saskatchewan Health's EDS Program
Questions in this section relate to how often your pharmacy deals directly with the EDS program.

1. On average, how many new prescriptions for restricted or non-formulary medications does your pharmacy receive per week?

_____ Per Week

2. On average, what percent of these restricted or non-formulary medications are submitted for coverage under the EDS program? (Please circle appropriate percentage)

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 10 20 30 40 50 60 70 80 90 100

3. On average, what percent of the EDS submissions are initiated by your pharmacy rather than by the prescribing physician? (Please circle appropriate percentage)

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 10 20 30 40 50 60 70 80 90 100

4. On average, what percent of EDS submissions initiated by your pharmacy are the result of a request by the prescribing physician? (Please circle appropriate percentage)

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 10 20 30 40 50 60 70 80 90 100

C – Factors Surrounding the Initiation of an EDS Request
Rate the importance of the following factors in determining whether your pharmacy will initiate an EDS request for a new prescription for a restricted or non-formulary medication for which **the physician has not initiated an EDS request.**

1. The **time** needed to submit an EDS request.

Very Important	Important	Somewhat Important	Neutral	Somewhat Unimportant	Unimportant	Very Unimportant
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

2. The ability of the patient to **pay for the prescription.**

Very Important	Important	Somewhat Important	Neutral	Somewhat Unimportant	Unimportant	Very Unimportant
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

3. The patient has **exceeded** the Drug Plan deductible.

Very Important	Important	Somewhat Important	Neutral	Somewhat Unimportant	Unimportant	Very Unimportant
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

4. The likelihood that the patient **will eventually exceed** the Drug Plan deductible.

Very Important	Important	Somewhat Important	Neutral	Somewhat Unimportant	Unimportant	Very Unimportant
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

5. Your **familiarity** with the administrative processes of the EDS program.

Very Important	Important	Somewhat Important	Neutral	Somewhat Unimportant	Unimportant	Very Unimportant
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

6. Ability to obtain all the **information** needed to make an EDS request.

Very Important	Important	Somewhat Important	Neutral	Somewhat Unimportant	Unimportant	Very Unimportant
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

7. Ability to **track the status** of your EDS request once it has been submitted.

Very Important	Important	Somewhat Important	Neutral	Somewhat Unimportant	Unimportant	Very Unimportant
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

8. Your ability **to contact** the prescribing physician.

Very Important	Important	Somewhat Important	Neutral	Somewhat Unimportant	Unimportant	Very Unimportant
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

D - Appropriateness of Procedures used for Obtaining EDS

Since 1999, pharmacists have been authorized to submit an EDS request. We are interested in gaining an understanding of your experiences since pharmacists were granted this authority.

1. Do you find it difficult to apply for EDS?

Always	Usually	Sometimes	Rarely	Never
[ ]	[ ]	[ ]	[ ]	[ ]

2. Do you have access to all the information required by the Drug Plan (e.g. diagnosis relevant to use of drug)?

Always	Usually	Sometimes	Rarely	Never
[ ]	[ ]	[ ]	[ ]	[ ]

3. When you submit an EDS request, do you receive notification from the Drug Plan as to whether the request is accepted or rejected?

Always	Usually	Sometimes	Rarely	Never
[ ]	[ ]	[ ]	[ ]	[ ]

4. If you receive notification from the Drug Plan as to whether the EDS request is accepted or rejected, is that notification provided in a timely manner (within two days of submission)?

Always	Usually	Sometimes	Rarely	Do Not Receive
[ ]	[ ]	[ ]	[ ]	[ ]

E- About the EDS Program

We are looking to gain an appreciation for the dynamics that exist in your pharmacy. The following questions deal with the circumstances surrounding an EDS request.

1. Pharmacists in your store have adequate information on the administrative nature of the EDS program.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

2. Pharmacists in your store feel that initiating an EDS request is an important service for their patients.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

3. Changing the policy in 1999 to allow pharmacists to initiate an EDS request on behalf of patients has been beneficial to patient health care.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

4. The EDS program contributes significantly to the administrative workload of pharmacists.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

F – Maximum Allowable Cost

Starting July 1, 2004, Saskatchewan Health began to phase in a Maximum Allowable Cost (MAC) policy into the Drug Plan, beginning with Proton Pump Inhibitors (PPIs). We are interested in gaining an understanding of the experiences in your pharmacy to date with this new policy.

1. Saskatchewan Health has provided adequate information to pharmacists in your store on the administrative nature of the MAC policy.

Strongly Agree	Agree	Somewhat Agree	Too Early To Say	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

2. The staff in your pharmacy are sufficiently prepared to deal with questions on MAC.

Strongly Agree	Agree	Somewhat Agree	Too Early To Say	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

3. Since the MAC policy came into effect, the amount of time your staff spends explaining the Drug Plan to patients has:

Greatly Increased	Increased	Somewhat Increased	Not Changed	Somewhat Decreased	Decreased	Greatly Decreased
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

4. Since the MAC policy came into effect, the number of EDS requests initiated by your pharmacy has:

Greatly Increased	Increased	Somewhat Increased	Not Changed	Somewhat Decreased	Decreased	Greatly Decreased
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

5. The MAC policy is impairing the ability of my patients to receive appropriate drug therapy.

Strongly Agree	Agree	Somewhat Agree	Too Early To Say	Somewhat Disagree	Disagree	Strongly Disagree
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

G – The Pharmacy

Location and Type of Pharmacy (Check all that apply)

Area:
[ ] Commercial [ ] Residential [ ] Mixed

Location:
[ ] Stand Alone Building [ ] Strip Mall [ ] Enclosed Mall
[ ] Medical Building/Complex [ ] Other: _____

Type of Pharmacy:
[ ] Independent [ ] Banner [ ] Chain
[ ] Franchise [ ] Grocery Store [ ] Department Store
[ ] Mass Merchandiser [ ] Other: _____

Pharmacists employed at your location
Total Number (Full and Part-time): _____ Full Time Equivalents: _____

Pharmacy technicians employed at your location
Total Number (Full and Part-time): _____ Full Time Equivalents: _____

Proximity of the majority of physicians prescribing to your patients (**indicate one that best applies**)

[ ] Same Location (same building or mall)
[ ] Next Door (on the same block or just across the street)
[ ] Close By (within easy walking distance)
[ ] Somewhat Removed (short driving distance in same town)
[ ] Distant (one hour or less drive to different town or city)
[ ] Remote (one than one hour drive to another town or city)

Average number of prescriptions filled per week. (Can be a single number or a range, e.g. 250 – 300) _____ Per Week

Hours the dispensary is open: _____ Per Week

H – The Pharmacist Completing the Questionnaire

Gender: Female ( ) Male ( ) Age (years): _____

Current position (Job Title): _____

How many years in your current position? _____

I – Do you have suggestions or comments on how the EDS program and/or MAC policy could be improved? (Please feel free to attach additional pages):

J – Additional Comments (Please feel free to attach additional pages):

Thank you for participating in this study.

APPENDIX B

Pre-notice Letter

October 18th, 2004

«Title» «UsualName» «Pharmacy_Manager_Last_Name»
«Pharmacy_Name»
«Street»
«City», «Province» «PostalCode»

Dear «Title» «Pharmacy_Manager_Last_Name»:

Within the next week you will receive in the mail a request to complete a brief questionnaire for an important research project being conducted at the College of Pharmacy & Nutrition at the University of Saskatchewan.

The questionnaire we are asking you to complete concerns your experiences with the Exception Drug Status (EDS) program and how it has affected your workload. There will also be a brief section on your experiences to date with the Maximum Allowable Cost (MAC) policy recently implemented by Saskatchewan Health.

Should you have any concerns about this research do not hesitate to contact the principal investigator (Roy Dobson) by e-mail (roy.dobson@usask.ca), facsimile (306-966-6377) or phone (306-966-6363).

Thank you for your time and consideration. It's only through people like you who are willing to help in our research that we are able to gain a greater appreciation for how these programs are perceived by pharmacists, as well as how they affect the workload of your pharmacy.

Sincerely,

Jason Perepelkin, BA, BComm
Graduate Student
College of Pharmacy & Nutrition

Roy Dobson, BScPharm, MBA, PhD
Assistant Professor of Pharmacy
College of Pharmacy & Nutrition

APPENDIX C

Initial Mailing Cover Letter

October 25th, 2004

«Title» «UsualName» «Pharmacy_Manager_Last_Name»
«Pharmacy_Name»
«Street»
«City», «Province» «PostalCode»

Re: Pharmacists and the Exception Drug Status Program

Dear «Title» «Pharmacy_Manager_Last_Name»:

The purpose of this study is to gain pharmacists perceptions on Saskatchewan Health's Exception Drug Status (EDS) program and the new Maximum Allowable Cost (MAC) policy. The questionnaire includes questions on: who benefits from the EDS program; factors surrounding an EDS request; the appropriateness of the procedures in place to initiate an EDS request; the dynamics of your pharmacy; as well as initial thoughts about the MAC policy. The questionnaire should take less than 15 minutes to complete.

Your participation is important. However, it is completely voluntary and you do not have to complete the questionnaire if you do not wish to; you may also refuse to answer individual questions. You may withdraw from the study at any time. The code number on the questionnaire is designed to give the investigators the ability to track questionnaires while keeping your identity strictly confidential. Once the data collection is complete, the list that links code numbers to names will be destroyed. Only the principal investigator (Roy Dobson) and co-investigator (Jason Perepelkin) will have access to the data arising from this study. All information will be stored in secure facilities at the University of Saskatchewan. Results will be aggregated to ensure that the identities of individual respondents are safeguarded. Results will be reported in the student-researcher's Thesis, refereed periodicals and at conferences and meetings associated with pharmacists and health care organization.

Should you have any concerns about this research do not hesitate to contact the principal investigator (Roy Dobson) by e-mail (roy.dobson@usask.ca), facsimile (306-966-6377) or phone (306-966-6363). You completing and returning this questionnaire constitutes consent for the researchers to use the data for the purposes of conducting the study as approved by the University of Saskatchewan Behavioural Research Ethics Board on August 27th, 2004. Should you have any questions regarding your rights as a participant in this study you may call the Office of Research Services at the University of Saskatchewan (306-966-2084). Out of town participants may call collect.

If you feel that another pharmacist in your practice would be more knowledgeable about the subject matter of this questionnaire, please feel free to have that person complete it.

Sincerely,

Jason Perepelkin, BA, BComm
Graduate Student
College of Pharmacy & Nutrition

Roy Dobson, BScPharm, MBA, PhD
Assistant Professor of Pharmacy
College of Pharmacy & Nutrition

APPENDIX D

Reminder Letter

November 8th, 2004

«Title» «UsualName» «Pharmacy_Manager_Last_Name»
«Pharmacy_Name»
«Street»
«City», «Province» «PostalCode»

Re: Pharmacists and the Exception Drug Status Program

Dear «Title» «Pharmacy_Manager_Last_Name»:

You recently received a request to complete a questionnaire on Saskatchewan Health's Exception Drug Status (EDS) program and Maximum Allowable Cost (MAC) policy. If you have already completed and returned the questionnaire, thank you. If you have not yet completed the questionnaire, we would ask that you complete it as soon as possible and to return it in the pre-stamped envelope provided. Your participation is important and we look forward to receiving a completed questionnaire from you.

As you know, the purpose of this study is to gain pharmacists perceptions on the EDS program, as well as the MAC policy. In addition to informing members of the pharmacy profession about pharmacists' perception on these programs, the information obtained from you and other participants in the study will help to better inform those charged with planning and implementing changes in the delivery of the programs.

Should you have any concerns about this research do not hesitate to contact the principal investigator (Roy Dobson) by e-mail (roy.dobson@usask.ca), facsimile (306-966-6377) or phone (306-966-6363).

Sincerely,

Roy Dobson, BScPharm, MBA, PhD
Assistant Professor of Pharmacy
College of Pharmacy and Nutrition

APPENDIX E

Second Mailing Cover Letter

November 22nd, 2004

«Title» «UsualName» «Pharmacy_Manager_Last_Name»
«Pharmacy_Name»
«Street»
«City», «Province» «PostalCode»

Re: Pharmacists and the Exception Drug Status Program

Dear «Title» «Pharmacy_Manager_Last_Name»:

You recently received a request to complete a questionnaire on Saskatchewan Health's Exception Drug Status (EDS) program and Maximum Allowable Cost (MAC) policy. If you have already completed and returned the questionnaire, thank you. If you have not yet completed the questionnaire, we would ask that you complete it as soon as possible. We have included an additional questionnaire and pre-stamped envelope in case you misplaced the original. Your participation is important and we look forward to receiving a completed questionnaire from you.

As you know, the purpose of this study is to gain pharmacists perceptions on the EDS program, as well as the MAC policy. In addition to informing members of the pharmacy profession about pharmacists' perception on these programs, the information obtained from you and other participants in the study will help to better inform those charged with planning and implementing changes in the delivery of the programs.

Should you have any concerns about this research do not hesitate to contact the principal investigator (Roy Dobson) by e-mail (roy.dobson@usask.ca), facsimile (306-966-6377) or phone (306-966-6363). You completing and returning this questionnaire constitutes consent for the researchers to use the data for the purposes of conducting the study as approved by the University of Saskatchewan Behavioural Research Ethics Board on August 27th, 2004. Should you have any questions regarding your rights as a participant in this study you may call the Office of Research Services at the University of Saskatchewan (306-966-2084). Out of town participants may call collect.

If you feel that another pharmacist in your practice would be more knowledgeable about the subject matter of this questionnaire, please feel free to have that person complete it.

Sincerely,

Jason Perepelkin, BA, BComm
Graduate Student
College of Pharmacy & Nutrition

Roy Dobson, BScPharm, MBA, PhD
Assistant Professor of Pharmacy
College of Pharmacy & Nutrition

APPENDIX F

Non-responder Questionnaire

A – Participation in Saskatchewan Health's EDS Program
Questions in this section relate to how often your pharmacy deals directly with the EDS program.

1. On average, how many new prescriptions for restricted or non-formulary medications does your pharmacy receive per week?

_____ Per Week

2. On average, what percent of these restricted or non-formulary medications are submitted for coverage under the EDS program? (Please circle appropriate percentage)

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 10 20 30 40 50 60 70 80 90 100

3. On average, what percent of the EDS submissions are initiated by your pharmacy rather than by the prescribing physician? (Please circle appropriate percentage)

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 10 20 30 40 50 60 70 80 90 100

4. On average, what percent of EDS submissions initiated by your pharmacy are the result of a request by the prescribing physician? (Please circle appropriate percentage)

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 10 20 30 40 50 60 70 80 90 100

B – The Pharmacy

Proximity of the majority of physicians prescribing to your patients (**indicate one that best applies**)

[ ] Same Location (same building or mall)
[ ] Next Door (on the same block or just across the street)
[ ] Close By (within easy walking distance)
[ ] Somewhat Removed (short driving distance in same town)
[ ] Distant (one hour or less drive to different town or city)
[ ] Remote (one than one hour drive to another town or city)

Average number of prescriptions filled per week. (Can be a single number or a range, e.g. 250 – 300) _____ Per Week

Hours the dispensary is open: _____ Per Week

C – The Pharmacist Completing the Questionnaire

Gender: Female ( ) Male ( ) Age (years): _____

Current position (Job Title): _____

Thank you for participating in this study.

APPENDIX G

Non-responder Cover Letter

March 7th, 2005

«Title» «UsualName» «Pharmacy_Manager_Last_Name»
«Pharmacy_Name»
«Street»
«City», «Province» «PostalCode»

Re: Pharmacists and the Exception Drug Status Program

Dear «Title» «Pharmacy_Manager_Last_Name»:

We respect your decision not to complete the questionnaire, "Pharmacists Experience with the Exception Drug Status (EDS) Program in Saskatchewan." However, we would ask you to take a couple of minutes and complete the enclosed non-responder questionnaire and return it in the pre-stamped envelope provided? The data you provide will only be used to evaluate the validity of the questionnaires completed by your colleagues. This is our last request of you.

Your participation is important. However, it is completely voluntary. The code number on the questionnaire is designed to give the investigators the ability to track questionnaires while keeping your identity strictly confidential. Results will be aggregated to ensure that the identities of individual respondents are safeguarded. Only the principal investigator (Roy Dobson) and co-investigator (Jason Perepelkin) will have access to the data arising from this study. All information will be stored in secure facilities at the University of Saskatchewan.

You completing and returning this questionnaire constitutes consent for the researchers to use the data for the purposes of conducting the study as approved by the University of Saskatchewan Behavioural Research Ethics Board on January 6th, 2005. Should you have any questions regarding your rights as a participant in this study you may call the Office of Research Services at the University of Saskatchewan (306-966-2084). Out of town participants may call collect.

Should you have any concerns about this research do not hesitate to contact the principal investigator (Roy Dobson) by e-mail (roy.dobson@usask.ca), facsimile (306-966-6377) or phone (306-966-6363).

If you feel that another pharmacist in your practice would be more knowledgeable about the subject matter of this questionnaire, please feel free to have that person complete it.

Sincerely,

Jason Perepelkin, BA, BComm
Graduate Student
College of Pharmacy & Nutrition

Roy Dobson, BScPharm, MBA, PhD
Assistant Professor of Pharmacy
College of Pharmacy & Nutrition

APPENDIX H

Main Survey Ethics Approval

UNIVERSITY OF SASKATCHEWAN
BEHAVIOURAL RESEARCH ETHICS BOARD

http://www.usask.ca/research/ethics.shtml

NAME: Roy Dobson — Beh 04-175
Pharmacy & Nutrition

DATE: August 27, 2004

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the Application for Ethics Approval for your study Pharmacists Experience with the Exception Drug Status (EDS) Program in Saskatchewan" (Beh 04-175).

1. Your study has been APPROVED.

2. Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Committee consideration in advance of its implementation.

3. The term of this approval is for 5 years.

4. This approval is valid for one year. A status report form must be submitted annually to the Chair of the Committee in order to extend approval. This certificate will automatically be invalidated if a status report form is not received within one month of the anniversary date. Please refer to the website for further instructions http://www.usask.ca/research/behavrsc.shtml

I wish you a successful and informative study.

Dr. Scott Bell, Acting Chair
University of Saskatchewan
Behavioural Research Ethics Board

VT/ek

Office of Research Services, University of Saskatchewan
Room 1607, 110 Gymnasium Place, Box 5000 RPO University, Saskatoon SK S7N 4J8 CANADA
Telephone: (306) 966-8576 Facsimile: (306) 966-8597
http://www.usask.ca/research

APPENDIX I

Non-responder Ethics Approval

UNIVERSITY OF SASKATCHEWAN
BEHAVIOURAL RESEARCH ETHICS BOARD

NAME: Roy Dobson
Pharmacy and Nutrition

Beh #04-175

DATE: January 6, 2005

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the modifications to the Application for Ethics Approval for your study "Pharmacists Experience with the Exception Drug Status (EDS) Program in Saskatchewan" (Beh #04-175).

1. The modification(s) to your study, received December 17, 2004, has been APPROVED.

2. Any significant changes to your study should be reported to the Chair for Committee consideration in advance of its implementation.

3. The term of this approval remains five years from the original approval date.

4. In order to maintain ethics approval, a status report must be submitted to the Chair for Committee consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.usask.ca/research/ethics.shtml.

I wish you a successful and informative study.

Dr. Valerie Thompson, Chair
University of Saskatchewan
Behavioural Research Ethics Board

VT/es

Office of Research Services, University of Saskatchewan
Room 1607, 110 Gymnasium Place, Box 5000 RPO University, Saskatoon SK S7N 4J8 CANADA
Telephone: (306) 966-8576 Facsimile: (306) 966-8597
http://www.usask.ca/research

APPENDIX J

Qualitative EDS Responses

EDS Themes

- Process [PRO] – issues pertaining to system being too slow, not receiving notification of acceptance or rejection, etc.
- Automation [AUTO] – responses centred on an online and/or automated adjudication system to handle requests.
- Administrative [ADMIN] – the subject of administrative burden, having to balance regular duties with EDS, etc.
- Remuneration [REMUN] – focus on being compensated for initiating EDS requests
- Education [ED] – concern with the lack of understanding regarding the EDS process by physicians and patients, as well as suggestions to educate the two
- Cooperation [COOP] – distress over the lack of cooperation seen from physicians and the Drug Plan on matters relating to EDS
- Communication [COMM] – centring on lack of, or insufficient communication between Drug Plan and pharmacists, Drug Plan and physicians, Drug Plan and patients, physicians and patients, and/or physicians and pharmacists
- Coverage [COV] – anxiety over the issue of what is and isn't covered, when patients benefits start to take effect, why a drug is labelled EDS, third-party plans, etc.

Responses

- EDS is too slow – they are often 3 – 5 days behind. [PRO]
- Pharmacists seem to accept more & more administrative work to administer government plans, as well as private for free. Doctors get paid for every fax we send, but we get paid $0. We chase for EDS information from doctors, spend countless hours explaining MAC & EDS for no pay and yet we continue to have to fit it into an already busy work day. Countless audits & requests by NIHB require valuable time best spent elsewhere. [ADMIN] [REMUN] [PRO]
- Provide physicians more information about what Exception Drug Status means in regards to drug costs, etc. Many doctors assume that by applying for EDS means the patients' drug cost for the medication is $0. [ED]
- If EDS criteria is met for one drug in a class (i.e. PPIs, Cox-2) it should be extended to all drugs in that class and not require renewing. [PRO] [COV]
- The EDS program is quite workable; however, more doctor involvement would make it more efficient. [COOP] [COMM]
- Get SHIN running province wide – allow SPDP to access patient diagnosis, etc. [PRO]
- Use funds collected for previously failed 'trial prescription program' to reimburse pharmacists for time spent on EDS requests. [REMUN]
- We [should] get paid a fee for every EDS request made on our patients' behalf. [REMUN]
- Implement a fee for this service. [REMUN]

- If SHIN were available, it would possibly save time in determining EDS criteria. [PRO]
- I feel the turn around time is sometimes lacking, which then creates us another job as to checking whether or not coverage is granted. [PRO] [COMM]
- I understand physicians are being paid for fax requests & as well being paid or lobbying to be paid for EDS – why are pharmacists doing the work requesting, checking, obtaining diagnosis from physicians & for patients & we are not paid or being considered for payment for services? In fact, a pharmacy some years ago was disciplined for charging the patient for this service – I am tired of being expected to educate the public & check on physicians (which provide positive outcomes) for NO PAYMENT. [PRO] [ADMIN] [REMUN] [COMM]
- Provide information sessions to all physicians. I don't think they understand it all & are misleading the patients & then it is up to us, pharmacists, to try and sort out the situation & this takes more time for us than if the doctor had not told the patient anything or better yet had given them the right information! [ED] [COMM]
- I cannot let this pass without a comment(s). We spend an inordinate amount of time on EDS. The doctor & patient EXPECT us to do it. The most offensive and abused plan is that with SAHO. If ANY of our SAHO patients get a rejection slip, they immediately turn heaven & earth upside down to get coverage. EVERY trick in the book is evident – and many times the truth is stretched! The rejection slip from SAHO blatantly states – take this to your pharmacists to get EDS – then re-submit. No where does it say you must meet certain criteria – to this end I have made countless phone calls – to no AVAIL. One case: we got coverage (or someone did) for Duragesic; it expired (turns out only for 50 UG); re-applied and had to phone twice, advised to give it to her; 3rd phone call – in system – give it to her; 4th phone call – wrong strength; 4 faxes; 3 hours time; got the stuff – not paid for and we have to keep track of this?; and backdated, and it's a triple Rx – and ??? one patient only! This is the tip of the iceberg! [PRO] [ADMIN] [COMM]
- More drugs that are automatically approved due to the age or medical condition, i.e. Cox-2 > 65, palliative care. [COV]
- Perhaps when SHIN comes into effect process can be streamlined. [PRO]
- Patients need to jump through hoops – decrease if possible, i.e. bi-polar patient must try Risperdal or Seroquel before Zyprexa. [PRO]
- The drug company had heavily sampled Symbicort when it came out so patients with COPD often went straight to this medication without trying a long acting beta-agonist alone. In order to qualify had to switch back or use 2 separate products. [PRO]
- EDS criteria don't always keep up with current medical uses – some lag time. [COV] [COMM]

- Some of the more expensive antibiotics want direct proof of infection, i.e. "known to be resistant" determined via C&S – sometimes difficult to obtain good sample in pneumonia & would result in extra delay. [PRO] [ADMIN]
- [The] drug plan could fax us when an EDS drug is either approved or not approved and the reason why; saves us calling about why a claim is not going through. [PRO] [ADMIN] [COMM]
- Do something similar to Ontario – have a separate Rx pad for doctors with a reference number that can be entered; this online number automatically adjudicates the EDS claim instead of phoning in a diagnosis. [PRO] [AUTO]
- EDS, 1st time for patient, should be applied for and approved by pharmacist and then verified by the Drug Plan. We often have to renew EDS for drugs the patient has already had EDS for. Quite often the Drug Plan will ask what the diagnosis is even though it is the same diagnosis and drug as [the] last time (waste of time!!!). EDS should possibly be eliminated all together. With the new Adapt program, if a patient decides to fill a Rx that requires EDS we should be able to check off the criteria that applies to this particular drug and patient if it fits criteria, it is covered automatically. Physicians can be asked to include that diagnosis on those Rx's so that can also be checked off right away. A separate box with yes or no answers to determine eligibility instantly would save a lot of time and paper. [PRO] [ADMIN] [COMM]
- Pharmacists need to be paid for initiating EDS requests, i.e. at least $5 per request. [REMUN]
- I think the formulary should be the formulary and remove all exceptions. To me this would provide a better idea of costs and make the people decide about affordability. I liken this to wants and needs. Same with MAC; e.g. now we are having physicians requesting EDS for Nexium because Pariet did not work; I question the validity of the request. [PRO] [ADMIN]
- Has to be improved to reduce the workload for pharmacists who wish to provide a superior service for customers. [ADMIN]
- Make doctors more responsible for applying for EDS or make the process simpler for pharmacists. We try to provide a superior service at our store to make medications more affordable for all our customer, welfare and low-income earners, as well as patients with Drug Plans that require the medications be on the Drug Plan. Have more people on the Drug Plan working Monday and Tuesday to clear back logs. Have Drug Plan people follow-up with doctors to clarify diagnosis, etc. NOT pharmacists – it is adding an extra step to the process that is not necessary. One call from the Drug Plan to the doctors' office should clear up the query. [PRO] [ADMIN] [ED] [COOP] [COMM]
- The worst part of applying for EDS is getting the diagnosis from the physicians. Perhaps they could be encouraged to write it on the Rx more often. The second worst part is explaining to patients why they don't qualify – e.g. they can't get Fosamax until they try Diflucan, or they can't get Advair until they try Flovent. The Drug Plan should notify patients, in writing, with an explanation of the rejection. They could then take that letter to their

physician and attempt to meet the criteria. Lastly, the new requirement for C & S testing for antibiotics is unreasonable. The reality is that while these drugs are frequently prescribed, often as the first choice antibiotic for a particular infection, C & S testing is rarely performed. The Drug Plan should tell doctors that they must do C & S if they want to prescribe these antibiotics. I've been yelled at on several occasions when I asked a doctor if they had done C & S – they see it as a waste of time and money, and they're probably right. It seems to me that the Drug Plan is simply using a lack of C & S as an excuse to avoid paying for an expensive antibiotic. In the big picture, C & S testing costs far more than paying for a second line antibiotic. The Drug Plan is attempting to off-load costs onto the labs, and onto patients, who have no control over what their doctor prescribes. [PRO] [ADMIN] [ED] [COV] [COMM]

- Tedious and time consuming to get diagnosis/criteria met from the doctors. Frustrating as we do not get any additional benefit for this work. [PRO] [COMM]
- Prometrium should be automatically covered (not equivalent to Provera). [COV]
- I feel strongly that if the doctor feels the patient requires the medication, some obscure person CANNOT over-ride this. Also, often the EDS is for an antibiotic which they need now, not in 7 days!!! [PRO]
- Reimburse pharmacists for time spent on administering the program. Some pharmacies are charging patients a fee to provide this service. [REMUN]
- Pharmacists [should] get compensated for filling out and explaining EDS to patients. [REMUN]
- [Should] notify pharmacists when there is a problem with an EDS they have applied for. [PRO] [COMM]
- EDS for long-term drugs (e.g. Plavix) should not have to be renewed as this can be very time consuming – which doctor wrote the original, when, what was the diagnosis back then, etc. [PRO] [COV]
- The approval has to be made within minutes, not days; the patient requires the medication then. The process is totally useless for antibiotics unless you count (which you have to) on the pharmacist to ensure [the] patient is looked after. Pharmacists spend way too much time describing the Drug Plan and explaining it to patients; we do not work for the Drug Plan. No reimbursement for this. [PRO] [COV] [REMUN]
- Communication is a one-way street with the Drug Plan. We have our number if there is a problem with an EDS application but never hear from them if there is. The letter is sent only to the patient and often the patient interprets it to mean that they don't have to pay for it. For the majority of patients EDS is useless. Once it is in place they then have to apply for additional support which again takes weeks to hear about. The letters sent to patients, most have a difficult time understanding. [COMM] [PRO] [ED]
- The EDS program places the pharmacist between a rock and a hard place. Doctors do not share information, Drug Plan treats us with indifference and patients get angry. [COMM] [PRO]

- Some reimbursement for our time would be nice. [REMUN]
- It is often difficult to obtain information from medical records departments in hospitals. They usually refuse to release information to me, which can sometimes leave patients without EDS coverage. [COMM] [PRO]
- Stream-line all manual portions [of EDS application] as much as possible. [AUTO]
- Education to physicians [on EDS] to ensure they supply sufficient information to patients and pharmacists. [ED]
- Extend inquiring capability [of pharmacists] to get specifics. [PRO]
- Better education of physicians regarding writing diagnosis on prescription. [ED]
- All the work in applying for EDS [is] done by pharmacists. Physicians rarely do EDS prior to patient coming into the pharmacy. Physicians should be required to automatically apply for EDS everytime they write a prescription for an EDS drug. Physicians should be better informed on purpose of EDS program and how it benefits the patients regarding their drug costs. [PRO] [COMM] [ED]
- It would be nice if the pharmacy could be faxed when EDS goes through (similar to NIHB requests for prior approval). This would speed up filling these prescriptions and prevent multiple tries/phone calls to SK Health which is very time consuming. [COMM] [PRO]
- I think doctors need to be more aware of what drugs require EDS. Some seem almost surprised when we call for information. Also, if doctors could be told to always include information like diagnosis, previous treatment failures, etc. it would make it easier for pharmacists to apply for EDS and reduce the number of phone calls and faxes to doctors requesting this information. Plus then the doctors wouldn't have to do the applying. [ED] [PRO] [COMM]
- Doctors should provide [the] diagnosis without being asked AND give alternative drugs tried, etc. so we are NOT searching for this information. [PRO] [ADMIN]
- Have software to do it online; no paperwork! [AUTO]
- The EDS program needs to be revamped as it is to time consuming. A pharmacist should be able to determine if therapy is appropriate by talking to patient only. Contacting the physician is to time consuming for both health professionals. Simple questions can determine if therapy is appropriate. [ADMIN] [PRO]
- Educate physicians on the program and it's requirements (our physicians do not do anything with this – their receptionist calls in requests and tries to find the diagnosis in the chart so often EDS is denied because not enough information is given). [ED] [PRO]
- Educate the public or pay pharmacists for the time taken to explain the program. [ED] [REMUN]
- Send the pharmacy a copy of the approval or rejection so that I can follow up with the doctor if the request is denied (as EDS requests that are denied are never looked at by our local physicians). [COMM] [PRO] [ADMIN]

- Improve how quickly requests are processed. Often in our town patients' are not able to afford full price and to submit receipts for reimbursement, so I am in the difficult position of billing for products after the EDS is approved or to with-hold the drug. [ADMIN] [PRO]
- Follow up with physicians when prescribing is not appropriate. [COMM]
- Thanks for doing this study – I think that many improvements need to be made to this program!
- Pharmacists should be notified when a EDS request is approved or declined just as doctors are. Sometimes the Drug Plan needs more information to complete the request approval but don't ask us for it. We have to call them to see why a request hasn't been approved. Extra work for us and delays for patients. How about being able to make requests online and then notifying us online when requests are approved? [PRO] [COMM] [ADMIN] [AUTO]
- I feel that many of the meds that are available for EDS would not be prescribed if the doctor did not feel that they would be beneficial to the patient. I know of more then one instance where a patient was denied EDS but had extraordinary circumstances that that patient should be on the drug but did not "meet criteria" and therefore [was] denied assistance from the Drug Plan. There are also people who demand EDS be gotten for them and somehow they always get it. [ADMIN] [COV]
- Pharmacists could have the authority to switch patients to lower costs meds – like interchangeable or no substitution situations. [PRO]
- Pharmacists should get a fee for EDS & MAC administration. [REMUN]
- The lack of physician understanding of the EDS and MAC policies [is a barrier to proper administration]. Most do not provide a diagnosis on the prescription when they write for an EDS medication. A pharmacist administrates an EDS submission and is required to make a fax or phone call to the physician to attain this information. Thus, the pharmacists and physician have duplicated the administration time on the prescription. [ED] [COMM] [ADMIN] [PRO]
- The cost of administration of these programs (EDS & MAC) to the pharmacy is huge. The time consumption of the pharmacist to administer these programs has grown tremendously especially since 1999 without monetary compensation from the SPDP. The reasons for this growth are prescribing trends and the majority of new therapies are only considered EDS benefits. The EDS program as administered by the Drug Plan believes that potential costly drug therapies will be available in a more controlled fashion therefore benefiting the health of the public. It is my belief that these are money saving controls, not health wellness controls. I have personally brought forward clients which required the EDS medication but did not specially meet any of the criteria exactly as wanted by the SPDP. I would have to call Gail Bradley personally on behalf of the resident to explain why this client should be covered by the Plan. There is a bias formed when it comes to the cost of medication and how much the literature would be used or not used to save the money. One great example would be the bisphosphates.

Didrocal does not have the indication for the treatment of male osteoporosis and will not get that indication. But the SPDP will not allow all males to have EDS on Actonel or Fosamax based on being male alone when these 2 medications have the indication for male osteoporosis but are more expensive then Didrocal. Is this more controlled fashion really benefiting the health of the patient or benefiting the SPDP pocketbook because Didrocal is less money? Another example would be the use of respiratory fluoroquinolones. They are only to be used in documented pneumonias. The Drug Plan is trying to get physicians to use the combo 2nd generation cephlasporins with a macrolide to help decrease over usage and resistance. Great we now have 2 EDS submissions to apply for the 2nd generation cephlasporins and the macrolide because erythromycin is not favoured over clarithromycin or azithromycin. In the nursing home residents getting a chest x-ray is extremely difficult and expensive when they have to use an ambulance. Yet there are some of these residents who should be on the respiratory fluoroquinolones but following criteria made by SPDP there are not exceptions until they get hospitalized. [ADMIN] [PRO] [REMUN] [COV] [COMM]

- In the end pharmacists are great contributors to health outcomes. We assist in the administration of the programs, help patients decrease medication costs, are educators of both the public and healthcare professionals on programs like EDS and MAC however we are not reimbursed by any 3rd party payer for these services. In my opinion this needs to change. The push for increased pharmacist involvement in patient care has grown and will continue to grow until we don't have the resources available to pay for these extra administrative costs. The pharmacies will not be able to afford these free services much longer, a dispensing fee only covers so much!!! [ADMIN] [PRO] [REMUN]
- I think there should be some kind of compensation for EDS requests. EDS requests can require significant time; requires professional judgement and knowledge (cannot be done by a technician). [REMUN] [PRO]
- I fail to understand the rationale for requiring the pharmacist to confirm the diagnosis with a physician for every EDS request. Should I not be able to know that my client has asthma if I have been dispensing asthma medication monthly [to the client] for 5 years? [PRO] [ADMIN]
- EDS should be reserved for the exception, not the norm. A MAC drug like Pariet should be on the Plan. EDS for others (PPIs) with Pariet MAC pricing. Same for Celebrex. Also, a much shorter list of EDS drugs should be developed. Either a shorter list or no list at all. The Drug Plan takes as many as 7 days to authorize drugs. They are severely understaffed and don't work on weekends of evening when they might actually help patient care. I just finished waiting 2 weeks for palliative care for a patient as well and the doctor phoned in 3 times and I phoned/faxed 3 times. I am exceptionally disappointed with their service. The Drug Plan is the weakest link in providing seamless care. Limit EDS drugs, put more EDS drugs on the Plan, or drop the program. The Drug Plan can't do the job so please do

not hire more people (this is not cost saving to health care). It is just robbing Peter to pay Paul. Finally, if the pharmacist is doing all the information gathering, and patient counselling, doctor follow up, there should be a fee for our service. You could easily replace the whole EDS wing of the Drug Plan if we could bill on the web with certain indications checked off and not require patients to be without medications or wait to be reimbursed via the Drug Plan. You could spend money on one auditor to replace the EDS staff and have the pharmacy finish the job you already partially handed over. [COV] [PRO] [COMM] [ADMIN] [AUTO]

- EDS should only be initiated by hospital pharmacists as they commonly have access to appropriate information. Approximately 80% of EDS requests should be initiated by the physician, knowing they have all the appropriate information to make the request. Unfortunately physicians are not only dumping the job on retail pharmacists, but they rarely provide the information necessary to make the request possible. Many patients are being given improper information about EDS and how it works, by the physicians. Unfortunately the patients are commonly the victims of this process. Overall, I have yet to see the government properly educate the public on the ins and outs of Drug Plan policy. The pharmacist seems to be the only accessible person the public has for their inquiries. Unfortunately we DON'T HAVE TIME FOR THIS! Things must change and SOON! [ED] [PRO] [COMM] [ADMIN] [COOP]
- Doctor suggests pharmacist get EDS when patient is not qualified for SPDP help. Doctors need to understand the reason for EDS. [ED] [COV]
- Physicians and patients need to understand that coverage under EDS does not mean the drug is free. This is a common misconception. [ED] [COMM]
- Pharmacists need easier access to diagnosis and lab values to ensure EDS eligibility. [COMM] [COOP]
- Prescriptions should have [an] area for physicians to write diagnosis. [PRO]
- Physician samples cause most [of the] problems when continuation of therapy is required. It discourages the proper sequence in order to get EDS coverage. For example, samples of Symbicort – Symbicort will not be covered unless other products are used first. The list goes on – Spiriva, Pariet, etc. Often the prescriber will give the product (samples) he [/she] has rather than what the patient should be started on. This is where a great deal of pharmacists' time is spent – explaining [to patients] the physician samples and why coverage cannot be given or applied for. [PRO] [COV] [ADMIN]
- The EDS that we apply for should at least be responded to as (1) problems with the application – physician, and/or (2) approved or not approved within 2 days. The same applies for MAC – we are constantly having to phone or try to adjudicate the claim for the patient – not having any idea if it has been accepted or not. Please get someone on a fax machine to let us know! [COMM] [PRO] [ADMIN]
- Feedback from Drug Plan to pharmacists as well as patients – i.e. fax back approval – could speed up the process. [COMM] [PRO]

- Phoned in EDS – respond too – rather than faxing. [COMM]
- EDS program must be more transparent. We were told to fax requests. This has NOT resulted in any improvement in speeding up approvals. We never receive information regarding our requests. [PRO] [COMM]
- I think preparations such as Duragesic should NOT require EDS approval. Patients in nursing homes or on palliative care need these pain relievers and it takes considerable time to obtain approval. [COV] [PRO]
- Would be nice to be contacted once EDS has been accepted/denied; many times our customers bring in their letters once the accepted date has past – antibiotics especially. [COMM] [PRO]
- Just eliminate the EDS portion [of the Drug Plan], and cover the 2 drugs they will pay for [in a category] and that's it. [COV] [ADMIN]
- I hate the EDS program; it makes so much extra work for us [pharmacists]. The doctors have no idea most of the time of the process of stuff and write whatever. Even if they know its EDS they get us to do the paperwork – a simple phone call for them and at least 2 faxes for us just for the information to fill it out. Eliminate this program. When we get it in place we have to refund the patient back and date the prescription – the paperwork is huge. It really annoys me that the Drug Plan just off-loaded this from physicians [onto pharmacists]. Sometimes we have to get EDS for a person because their third-party won't pay for it unless it goes thru SPDP. Paperwork for nothing. I'd like to bill them but it'd just be more paperwork! [ADMIN] [PRO] [ED] [COMM] [COV] [REMUN]
- The waste is in the bureaucracy. Pharmacists should be the gate keepers for drug therapy. An override code costing nothing would save thousands of dollars per year. [PRO] [ADMIN] [AUTO]
- Currently, we apply for EDS without complaint. The Saskatchewan Drug Plan EDS application is far better than NIHB or third-party plans. My main complaint is that less than 0.1% of requests for EDS are turned down. They only ones that are troublesome are the Alzheimer drugs where the Drug Plan is possibly depriving a patient of his/her last grasp at reality before he/she dies. I think this is cruel and cold. [PRO] [COV] [ADMIN]
- Improve wait time – 2 to 4 days is unacceptable. [COMM] [PRO]
- Allow pharmacist to get diagnosis information from the patient. [PRO] [COMM]
- Allow submissions electronically during claim adjudication. [AUTO] [PRO]
- Please explain both policies (EDS & MAC) more clearly to physicians and patients. Countless time I've been yelled at because a doctor will tell the patient the drug is paid for when EDS is approved, but they have no coverage. The letter the patient gets us very unclear for EDS. Remove some items from EDS that are extremely necessary or are not used for other purposes. [ED] [PRO] [COV] [ADMIN]
- Take the EDS drugs off EDS and make them "open formulary." [COV]
- We waste a lot of time calling/faxing doctors and waiting for diagnosis. I'm not sure how to improve that but it is something that needs to be looked at. [PRO] [COMM]

- EDS program needs a more efficient manner of notification of either rejection of approval – i.e. notification should be more readily forthcoming to the pharmacist. "On-line" applications for dispensaries – i.e. at the time of dispensing – more efficient time-wise, etc. [COMM] [PRO] [AUTO]
- [Drug Plan] must recognize the time it takes and pay us a fee for doing it. Government needs to understand that most EDS are because of other drug plans and they are doing the work. Very few are turned down so there is really no purpose in the program. The program is also not universal – if no one applies that person is not treated the same. I think that in most cases [when] EDS is done no one benefits. Most people do not get help from government. I feel that this should be assessed before an EDS application is made. If government wants us to administer their programs we need to be paid for it. [REMUN] [PRO] [COV] [ADMIN]
- Pharmacist [should] get paid for service. Government should look at how increasing drug coverage could save money on hospital stays. Person could be treated at home. [REMUN]
- Patients who already have EDS for Losec, Pantoloc, Prevacid, etc. should automatically be granted EDS for the alternative i.e. Omeprazole, Pariet – pharmacists or physicians should not have to reapply. [COV] [PRO]
- Decrease the number of drugs available on EDS (the balance fully covered). [COV]
- If a drug has 8 or more indications for EDS coverage perhaps it should be put on the drug plan. [COV]
- Educate doctors on which medications are on the EDS program, the criteria for them, and [to] write [the] diagnosis and relevant information on the prescription. This will speed up [the] process of EDS application, [make it] easier on the pharmacist, and more beneficial for [the] patient. Or tell doctors to phone for EDS him/herself and write on the prescription that EDS has been applied [for]. This will reassure [the] patient knowing that coverage [may be] coming. [ED] [COMM] [PRO]
- Compensate the pharmacy for applying [for] EDS on behalf of the patient where the doctor did not do anything. They are compensated, but we do all the frustrating work, e.g. calling doctors (who are seldom available) for diagnosis, allergies or intolerances. We have to do all the work, fill out [the] form and then follow-up whether it was successful or not, then call the patient, either because there is a refund, or more so, try to explain to [the] patient why it is not covered. They take it out on us, not the doctor. [REMUN] [COMM] [ADMIN]
- We should be able to use our professional judgement as to the diagnosis after looking at the profile. [PRO]
- Less restrictions on guidelines in formulary and more input allowed from pharmacists who are more aware of situation than anyone – i.e. antibiotic acceptance from pharmacists' recommendation. We know best what medications patients can and cannot use. [COV] [PRO] [ADMIN]
- It's good that pharmacists can apply for EDS but we still don't have the impact that physicians have in getting approval – particularly antibiotics.

- Pharmacists should be paid for every fax [when] applying for EDS. [COV] [PRO]
- Online EDS with immediate approval for situations when the criteria are met. [AUTO [PRO]
- Physicians [should be] indicating diagnosis on EDS prescriptions. [COMM]
- The time lag for EDS for antibiotics is too long. Some people will not take the prescription if it is not covered and a few days is too long to wait for an antibiotic. [COV] [COMM] [PRO]
- Find it interesting how physicians constantly fight to be paid for any additional work they perform for their patients, where we as pharmacists are constantly increasing our workload thru pill packs, EDS submissions, increasing pharmaceutical care, aiding patients in applying for drug coverage with Saskatchewan Health, insurance claims, faxing for refills, phoning doctors and are reimbursed NOTHING! We as an association need a backbone! [REMUN] [PRO]
- At this location we find the EDS/MAC programs very time consuming. Some physicians are helpful by writing the diagnosis on the prescription but many do not so tracking down a diagnosis is very time consuming. We are located in a low-income neighbourhood and the time it takes to get approval after the request is made is also time consuming because we are continually trying to re-bill prescriptions to see if coverage has gone thru. Most of out customers cannot afford to pay full price and then get reimbursed so we try to "loan" the a few pills and if the EDS is not accepted it is difficult for out customers to pay for what they have already taken. We have a big issue with the "unpublished" EDS list. We have no idea how to handle drugs that might be covered by EDS but we have no way of knowing one way or another. We definitely feel we should be compensated for the time it takes to administer this program. Physicians are now compensated for Alzheimer medication EDS applications. I would argue that many times we spend just as much time making the call to the doctor for diagnosis, phoning in the request, trying to re-bill, phoning to see why it's not going thru, and phoning the doctor for more information or a change in medication. The time it takes to administer this program is definitely adding to the stress of a busy workplace and taking away from the time we could be spending counselling patients on their medications. [ADMIN] [COMM] [PRO] [COV] [REMUN]
- Have online approval immediately (see Manitoba's plan) with reason codes online with documentation for audit purposes kept at the pharmacy regarding diagnosis, etc. [AUTO [PRO]
- Get many of the antibiotics off EDS. This is a waste of precious time. Reserve it for truly costly drugs, not as a deterrent to prescribing habits. [COV] [PRO]
- Moved here from Alberta → comparison? → EDS is a nightmare to administer. Make more efficient or pay us for it (our time)! [ADMIN] [REMUN] [PRO]

- Renew EDS for longer periods of time or completely disregard [the] need for renewal to decrease time spent. [COV] [ADMIN] [PRO]
- Make it (EDS) part of computer software so [requests] could be done online somehow rather than paper. [AUTO] [PRO]
- I'm not sure it (EDS) changes prescribing or not – often see doctor indicating whatever diagnosis to get EDS for their patient. Those who can afford still pay –those who can't, don't. [PRO] [COV]
- We get a lot of angry customers whose third-party plans won't cover EDS medications without a form and so they expect us to apply 3 months later when they've gotten around to submitting receipts. We have no way of knowing who might benefit or be eligible at the time. [COV] [PRO] [ADMIN]
- Time consuming, especially when [the] pharmacist initiates the EDS because the form has to be faxed to the doctor, [and] then send it to SPDP. If there are problems with it SPDP faxes us with questions, which we don't know then it's faxed back to the doctor. Better if the Drug Plan faxed the physician with their questions than us. [ADMIN] [COMM] [PRO]
- Majority of the onus for EDS is on the pharmacist as the physician will not do it if he/she does not get paid. Financial reimbursement is required for pharmacists to continue this process. Very time consuming, i.e. paper work, faxing, phoning doctors for diagnosis, forwarding medication until EDS comes through, etc. [PRO] [COMM] [ADMIN]
- The EDS program is taking up too much of our time to get diagnosis and other information, etc. [PRO] [COMM]
- Increase the hours someone is at the EDS office. EDS office staff should contact us if there is a problem → we only find out if we call them. If a pharmacy is calling, we should get a fax back when coverage is initiated. Patients call us repeatedly to put through [a] prescription to check coverage → real time waster. [ADMIN] [COMM] [PRO]
- The whole EDS program is not saving money – at least 95% of my applications are approved. The system puts extra workload on pharmacists and/or doctors, plus there must be extra staff at the Drug Plan so saving could be used as staff costs. Patients must take other medications (i.e. Ranitidine, etc.) before getting a PPI. Therefore the patient is inconvenienced and pre-requisite drugs are wasted because they did not work. "EDS" system is a "make work project" – a complete waste of time. [ADMIN] [COV] [PRO]
- Have the doctor fill in diagnosis on all prescriptions requiring EDS at the time of writing the prescription and all other pertinent information. Have people at the Drug Plan who can believe a pharmacists word as equal to a physicians word regarding previous treatments i.e. not have to relay all requests for more information back to the doctor when you as a pharmacists know the answer. [COMM] [PRO] [ADMIN]
- Go online – be able to click on appropriate requirements and audit a percentage of requests instead of 100% of all requests handled by each pharmacist, doctor and corresponding worker at the Drug Plan. [AUTO] [PRO] [ADMIN]

- If this program saves the Drug Plan money, a percentage of that money should be paid back to the person doing the EDS submission. Third-party payers who use the same EDS requirements for their formularies should also be required to pay a percentage back to the person doing the EDS submission. [REMUN] [COV]
- Coverage should be by drug classes – not individual drugs i.e. all PPIs or all quinolones, etc. for the Saskatchewan Drug Plan and other third-party payers using [the] same EDS requirement. [COV] [PRO]
- The single most frustrating part for me is that I cannot phone for EDS if I don't know the diagnosis or what has been tried before. [COMM] [PRO]
- EDS should not be required for palliative care patients. [COV]
- Would be good to be informed on the acceptance of EDS for your patients. [COMM]
- Allow a code to be transmitted online so that EDS dollar amount can be calculated at time of initial prescription pick up e.g. Code 1 – meets criteria for SPDP EDS – then when we process [the] prescription the correct dollar amount will be calculated. Information documented on hard copy prescription subject to audit. [AUTO] [PRO] [COMM]
- Expand criteria for certain antibiotics e.g. a patient with a past history of ineffectiveness of 2 other antibiotics for Sinusitis but not C&S done – has had success with Ceftin but EDS was refused – why does Saskatchewan Health have to pay for a C&S test when we know Ceftin works? [COV] [PRO] [ADMIN]
- The administrative issues facing pharmacy have increased dramatically over the past 10 years; mostly to the benefit of third-party payers and government. Pharmacy staff spend an inordinate amount of time explaining insurance programs to their patients without any financial recognition; this is unacceptable. [ADMIN] [PRO] [REMUN]
- Reviewing the EDS criteria on a regular basis and making them reality based e.g. a C&S on a pneumonia patient is rarely done because they are often contaminated during the collection process. [COMM] [PRO] [ADMIN]
- Most of our EDS requests are required in order to have the prescription covered by the patients' private insurance (must be on the SPDP formulary to be a benefit for their plan) therefore more responsibility should be on the insurance company and the patient (i.e. insurance company should supply forms to their patients to [be] filled out and sent in on their own → when approved let us know! [COV] [COMM] [ADMIN]
- Getting prescriptions paid for often seems to take more time and effort than giving patients "pharmaceutical care." [PRO] [COV]
- It seems only a few physicians are aware that pharmacists can apply for EDS – why not get the word out so that they would get in the habit of writing [the] diagnosis on [the] prescription? We often fax them for a diagnosis. It takes a lot of time to explain the procedure to the patient, then fax, etc. Doctors get reimbursed for faxes all the time. Paying pharmacists for this time is critical to making this whole procedure happen. I work in a slower pharmacy and I enjoy giving this service but if I were busier there in now

way I would make all the EDS requests happen unless I have some funding to staff this. [ED] [COMM] [REMUN] [PRO] [ADMIN]

- The amount of time spent [on EDS] is ridiculous - #1 explain to [the] patient, #2 try to get [the] diagnosis, and #3 [the] wait time is too long. Doctors need to be educated about EDS, [on] both requirements and criteria. They seem to have no regard for their patient at all. Or pharmacists should be able to have instant coverage if criteria are met. [PRO] [COMM] [ADMIN] [ED]
- We should be paid for EDS submissions. [REMUN]
- Physicians need to be educated very well about MAC, EDS, and Drug Plans. [ED]
- The letter sent out to patients has to be reworded → in this province they only get to the word "covered" and then they come [in] for their refund. [ED] [COMM]
- My biggest beef is with the special support program – doesn't seem to cover those who should be covered. [COV]
- If we could have a reply from [the] Drug Plan within one or two days, whether approved or denied, would be very helpful. [COMM]
- [Make it] mandatory [for] physicians [to] put down diagnosis. [COMM]
- It would be beneficial if the Drug Plan could fax a confirmation or denial of EDS claims; would save us and them many phone calls. [COMM] [PRO]
- Recently had a case where the patient ended up back in the hospital while waiting for Avelox to be approved or denied. Applied for EDS October 14th (now October 26th); I have no idea what the Drug Plan has decided (i.e. will approve, not approve). [COMM] [PRO]
- Please inform pharmacists if request is: (1) yes, (2) no, or (3) pending – within 24 hours! Should be paid $5 per request [whether] approved or not approved. [COMM] [REMUN]
- Please, please, please fax us a confirmation or rejection within 24 hours (Indian Affairs can). Also, the Drug Plan should be chasing down the diagnosis by fax as is done by Indian Affairs! [COMM] [PRO] [ADMIN]
- EDS – for example – if a patient has been on Metformin and Avandia is added, why couldn't the Drug Plan check the profile, see that Metformin has been inadequate and grant EDS without a request? Similarly, Ranitidine and PPIs. [PRO]
- Drug Plan indicated <u>rejection</u> of an EDS application if not done verbally. They never acknowledge acceptance – whether verbal or written request is made. [COMM] [PRO]
- Drug Plan should pay pharmacists for applying for EDS. [REMUN]
- I have a client whose mother lives in the country (rural location) and neither her doctor of her pharmacist will request EDS or special coverage. Actually I have applied for EDS for her on several occasions. This pharmacist is not doing their job. [COMM] [COV] [ADMIN]
- When an EDS request is made the pharmacy should be contacted within 3 days if it is rejected. <u>ALL</u> EDS eligible drugs should be listed in the formulary i.e. acetaminophen suppositories, etc. and automatic EDS for palliative care patients and other groups. [COMM] [COV] [PRO]

- Give pharmacists authority to approve EDS online in real time. Pay us for our time! [AUTO] [COV] [PRO] [REMUN]
- I feel that it is unfair that when doctors make EDS request that they are paid for it – yet we are not. We have to spend time contacting the doctor for [the] diagnosis and then phoning it in and we are not compensated. [REMUN] [ADMIN] [COMM] [PRO]
- Pay pharmacists to administer these programs at $2 per minute therefore $5 per claim. [REMUN]
- It is difficult to be responsible for applying for EDS when we don't have all the information. It seems we are secretaries for the Drug Plan which eats up our time. [COMM] [ADMIN] [PRO]
- The Drug Plan has too many items that they don't cover. If they would become a real drug plan, there would be a lot less EDS requests. It appears to me that any drug that is expensive or good they don't cover i.e. Clavulin, Ceftin, etc. [COV] [PRO]
- My concern is the time spent gathering information, checking deductibles, filling out the form, reviewing criteria, discussing with patient, reimbursing patient if necessary, making notes on patient files and on hardcopy so we can remember what stage we are at with each request and not being paid to perform this time consuming task; something is wrong with this scenario. I believe doctors receive something for their time but [it] must not be enough as most download to us the job of making the applications. [PRO] [ADMIN] [COMM] [REMUN]
- Faster approval. [PRO]
- Saskatchewan Health needs to do a better job of explaining these policies and take the onus off of the pharmacists to explain. There are still numerous people that are not aware that the $850, every 6 months, family deductible is gone. [ED] [COMM]
- EDS requests are regularly lost at the Drug Plan. Also if a request is deemed to not have adequate information, no one informs you of that. And as of October 26th, they were two weeks behind [in] processing some requests (Aricept). [PRO] [COMM]
- I simply fax [the] doctor and tell him/her to apply to [the] Drug Plan for EDS when it would benefit the patient. Therefore, the doctor collects the $4 for my fax…but then has to do the work. If they don't pay me then I rarely do everything. I used too but too much work for nothing. [REMUN] [PRO] [ADMIN]
- Software program to facilitate requests by software vendors and SPDP. Emergency trial program. [AUTO] [COV]
- Physicians are paid for administrative work; why are pharmacists not paid? Veteran Affairs pays for this type of service – very much appreciated. [REMUN] [ADMIN]
- Physicians should be more aware of the programs and provide appropriate information on the written prescription to reduce the time wasted calling them back for information. [ED] [COMM] [PRO] [ADMIN]

- The pharmacy should receive a fax as soon as the EDS has been approved. [COMM]
- [The Drug Plan] should be more up-to-date in their criteria i.e. Zyprexa is on the hospital formulary but not the community formulary. Also with Fosamax and Didrocal. All [the Drug Plan] cares about is their own budget and not the whole picture. [COV] [COMM] [PRO]
- About the EDS [program], physicians should indicate the diagnosis and other relevant information on the prescription; that way the pharmacist does not have to phone the doctor. Also, it would beneficial to the patient if the EDS application was processed faster by the Drug Plan (i.e. within the same day). [COMM] [PRO]
- Pharmacists should be paid for this service as it is a means for SPDP to save or cut costs. Politicians talk about the "value" of pharmacists but no one mentions reimbursement for a valued service. Electronic integration with SPDP should be considered – i.e. submission should be done via internet instead of fax alone. [REMUN] [AUTO] [PRO] [ADMIN]
- Scrap it totally – allow physicians to prescribe – have guts and stop listing everything but have the best on the formulary or the first based on evidence-based medicine. [COV] [PRO] [ADMIN]
- 2 year old refused coverage (Plan 2) for Prevacid after hospital discharge re: esophagitis, severe from acid reflux (docs thought patient has asthma). Money saved on puffers could have been used to cover the Prevacid completely but no provision made for children or any exceptions or unusual circumstances. [COV] [PRO] [COMM]
- Physicians should not tell patient that EDS coverage means that prescriptions are free. Also, have more staffing arranged for Thursday and Friday for EDS coverage, e.g. if an antibiotic is prescribed, the patient usually has to wait for 5 days. Have EDS approved in a more timely manner. Also, physicians are not aware of the MAC policy. Also if the physician wants pharmacists to apply for EDS, please indicate all the appropriate information on the prescription. So we don't have to keep phoning the doctor. [ED] [COMM] [PRO] [ADMIN]
- Need Drug Plan feedback; never know status of EDS. [COMM]
- Doctors do not understand EDS. They think it means patients will get medication for free. I spend much time with irate customers who think the drug should be cheaper because the doctor said so. MUST EDUCATE PHYSICIANS! Doctors think a drug should be covered simply because they want to use it. They do not understand nor care about approved indications. [ED] [COMM] [COV]
- Must simplify process. The burden on the pharmacy for EDS is often overwhelming. Very few physicians in this area do it themselves, they rely on the pharmacy to do it for them. Physicians now get paid for faxed refills, and quite frankly, pharmacists should get some sort of payment for the administrative burden of doing an EDS. This is one more service which our profession is doing for nothing, and out time could be better spent elsewhere. The patients put significant pressure on the pharmacists to get

EDS, and if they do not qualify for it because the doctor has not used the drug for an approved indication, the patient is upset and it is too late to change the drug, because it takes one to two weeks to get a response from the Drug Plan, even if you fax. By this time, the patient is taking the drug, hoping they will get a refund if EDS is approved. [PRO] [REMUN] [ADMIN] [COMM]

- I had called in an "emergency" EDS request for a cancer patient who needed Duragesic patches. This patient was on palliative care. They Drug Plan said they were back logged and it would take several days. This was NOT acceptable with the patient's circumstances and pain levels. I understand having to wait for other circumstances, such as a PPI drug, but this was a situation that required immediate attention and did not receive it. There is no such thing as "emergency" EDS requests. [PRO] [COMM] [COV]
- Doctors prescribe what they want. If a patient presents with "gerd" they seldom start with an H2RA, they jump straight to PPIs. Very seldom do they prescribe Amoxicillin for a simple sinus infection, they go straight to Biaxin or Zithromax. Physicians in this area want the Drug Plan to cover drugs because they have decided it is the best one and they want it. They get annoyed if we ask if they've tried something else on the Drug Plan first, or tell them the condition is not an approved one. [COV] [COMM] [PRO]
- Longer or indefinite EDS coverage for certain maintenance drugs. [COV]
- Notify the applying agency (pharmacy) if there is a problem with the application instead of simply doing nothing. [COMM]
- Apply a lot more common sense and treat each application on its individual merits rather than the strict "cookie cutter" approach used now. i.e. work in the best interests of the patient rather than SPDP. [PRO] [COV]
- When a diagnosis is obvious (e.g. Actos or Avandia for a diabetic or H. P. Pac for H. Pylori) why do we need to contact the doctor for a diagnosis (make-work project?) as per the Drug Plan rules? [PRO] [ADMIN] [COMM]
- Whether approved or rejected – the faxed EDS form should always be returned to the pharmacy which sent in the form in a reasonable time frame. [PRO] [COMM]
- Many EDS application are for medications which patients receive who have other insurance benefits. If they get the EDS approved then the other insurance program cuts in for payment. [COV] [PRO] [ADMIN]
- Explain to patients that EDS does not equal 100% "free" medicine. Only 100% coverage under their plan. Some patients think if the Drug Plan covers something, it means that the cost is covered by government. [ED] [COMM]
- Can EDS be extended to cover "classes" of drugs? For Example, a patient is put on Fosamax, and receives EDS. However, experiences side effects and switches to Actonel. Have to apply for EDS again. Also, some third-party plans that cover only formulary medications assume EDS is automatically granted whenever it is applied for. For example, patient gets a prescription for Zithromax (first prescription). Sends receipt to work

insurance, and receives letter telling them they require EDS to receive money back. Most letters are written as if EDS will be automatically granted whether the patient has actually met conditions of EDS or not (in this case, didn't try other antibiotic first). It is then up to the pharmacist to explain why the patient shouldn't expect any money back, making us look bad and not their plan. [COV] [COMM] [PRO] [ADMIN]

- We should be reimbursed for our time and effort and expertise. We are saving the SPDP and third-party insurance money – they need us in the link – we should be reimbursed. [REMUN] [PRO]
- Put all EDS drugs on Plan and encourage doctors to use discretion in prescribing them. It is impossible (nearly) to get a diagnosis in a timely fashion – very annoying! [COV] [PRO] [COMM]
- Increase turn around time for EDS requests. Too long of a wait. [PRO]
- Better communication when more information is needed or requests are denied. We currently get NOTHING from the Drug Plan to say when requests are approved/denied. We can wait days to try and process and EDS claim only to find out, by phoning, that there was a problem. Perhaps they could institute a priority policy to get acute care medications approved in a more timely fashion (i.e. same day!!). [COMM] [COV] [PRO] [ADMIN]
- I think doctors need to be better informed on both EDS and MAC. The number of patients who have been told their medication will be "fully covered" once they get EDS is astonishing and we spend a lot of time explaining the process to very upset patients. All the pharmacists here feel that if the onus to apply for EDS is put on us (which it is) the doctors should be required to provide us with the information needed in a timely matter. Often we spend weeks trying to get the information because the doctor can't be bothered to get back to us. [ED] [COMM] [PRO] [ADMIN]
- EDS program is prone to abuse. Many are the times when a physician will request EDS simply to have his/her choice covered. [PRO] [COV]
- Seems to be too much work that should be done by the doctor not the pharmacists as they have the needed information not us. Being done mainly for low income people or people with third-party plans as a requirement that their third-party plan pays for the drug. Lots of times we don't even bother to apply as patients' deductible is $99,000 and their third-party plan pays for it even if not a SPDP benefit. Give it back to the doctors! [ADMIN] [PRO] [COMM]
- Most people believe they don't have to pay for it if on EDS. [COMM] [ED]
- Too much work to credit return prescription and re-bill and give patient refund when it is backdated. [PRO] [ADMIN]
- If program is to continue [the] public must be better educated as trying to explain it to them is a major waste of time and aggravation. [ED] [COMM]
- Make the doctors do it again. They are much more apt to write expensive drugs now that the pharmacist has to do everything. If they had to do it, they would give cheaper drugs. The doctors also don't understand how the special support program or EDS works – a lot of them actually think the drug is either free or very cheap if they request EDS. [ED] [PRO] [ADMIN] [COV]

- Doctors need to look at the EDS criteria before they prescribe to ensure patients will be eligible. It is not good enough to scribble on a prescription "apply for EDS" if the patient isn't going to meet the proper criteria. Doctors need to be educated that even though a patient may receive EDS on a particular drug, it does not mean it will automatically be cheaper for them. Doctors need to understand that this is only true if a patient actually has coverage from the Drug Plan – most do not! [COMM] [PRO] [ED] [COV]
- Educate doctors to put necessary information for criteria on EDS on prescription. [ED] [COMM]
- Once someone is approved for EDS for a drug that is treating a non-curable condition, e.g. osteoporosis, COPD, reflux with erosive esophgitis, etc. there should not be a time line on EDS coverage. It is frustrating having to re-apply for the same drug for the same person and condition ever 1, 2, or 3 years when their condition is non-curable and the will require treatment indefinitely. [PRO] [COMM] [ADMIN] [COV]
- Patient in a correctional facility should be exempt because they are unable to receive drugs that are not covered (they do not have the ability to pay) and therefore cannot receive a drug if they do not meet the criteria but would still benefit. [COV] [PRO]
- Anytime doctors write for an EDS drug, they should give a diagnosis or any criteria needed to phone a EDS request in. If they won't phone the EDS in then they should supply us with the information we need. As the pharmacist, you feel an obligation to help your patient save money. They (patients) have no idea how EDS works. [COMM] [ED] [PRO] [ADMIN]
- The EDS request takes the pharmacist a lot of time. You have to be like a private detective and track down the doctor to get all of your information to make the request. This takes time and money to do. Money being spent on wages and phone calls. Time you don't have. A lot of time these requests just pile up by the phone in hope that the doctor would call a prescription in. When he/she calls a prescription in you hope you can get all the information you need from him/her to finish your EDS request. [PRO] [COMM] [ADMIN]
- The problem we have is we have a SAHO insurance company that needs EDS to settle in order for them to pay the patient. These people are no where near their deductible but we have to bother the doctor for the information needed to make the request, bother the pharmacist to make the request, bother the Drug Plan to process the request, just so the SAHO insurance company can process a insurance claim. No other insurance company requires this but a health organization insurance company. This puts more strain on an already overworked system. The only way the insurance company got the SAHO insurance is the government moved the company to Saskatchewan from down east and gave them the business. [COV] [ADMIN]
- It is one thing for the Drug Plan to allow us to apply for EDS (and not compensate us for doing their (?whose?) job), it is a whole other thing when we are asked to track down a diagnosis, to track down applicable patient information to meet EDS criteria and then to continually try to submit the

same claim to see if it has been accepted. If not accepted, eventually we must call the Drug Plan to find out why it was rejected and explain this to the patient. If claim is accepted we still have a paper trail to fix, in resending the original claim and refunding part to the client, changing our end-of-day reports and payer totals → or the alternative, explaining to the patient how to get reimbursed from Saskatchewan Health… This is the time consuming part. [ADMIN] [PRO] [REMUN]

- I am tired of working for the Saskatchewan Drug Plan gratis (as well as for other payers). I did not go into pharmacy to explain insurance policies and jump through hoop after hoop to try to obtain the best possible health care for my clients. I feel that EDS & MAC are the Drug Plan's way of making coverage so difficult to obtain that people no longer bother with it. What a short sighted vision! [COV] [PRO] [ADMIN]
- I suggest that when an EDS drug is initially filled, that it is processed through the Drug Plan. At this point, the Drug Plan can contact the prescriber for the information they seek. Once they find out the EDS criteria is not met, at that point they can cancel patients EDS and contact both doctor and patient to explain all of this. They will soon find out how time consuming and cumbersome all of this is, and costly to the Drug Plan! [PRO] [ADMIN]
- Need better and more timely response mechanisms in place. [AUTO] [COMM]
- One big problem with EDS occurs with insurance companies who tie their benefits to SPDP. Sometime months after the fact we are requested to apply for EDS so that insurance companies will accept the claim for reimbursement – big hassle for no compensation. [COV] [PRO]
- Fax back to pharmacy when approved (letter) so we can re-bill or send to third-party payers. [COMM]
- Notify doctors to write diagnosis on all prescriptions (esp. EDS medications). [ED]
- If I, a pharmacist, phone in for immediate coverage and choose that particular selection in the phone cue and the patient meets the criteria in the formulary can we get the coverage immediately or within a few minutes, would make adjudication process with third-party payers easier instead of re-billing/refunding. Otherwise we don't have the choice of immediate coverage that isn't immediate. [PRO] [AUTO] [COMM]
- Education of the physicians. Most of them expect you to initiate EDS but they do not include enough information and a lot of time is wasted trying to get this information from them! [ED] [COMM]
- Scrap them! Drug should either be on or off the Drug Plan. No in-between (EDS)! [COV]
- The EDS program could be improved if [the] pharmacist was allowed to assume diagnosis (e.g. if patient is on Metformin, Glyburide, buying test strips, lancets, and says they are diabetic, are we not safe in assuming (or knowing) they have diabetes without phoning the doctor for confirmation when he/she orders Avandia?). The same for asthmatics on Flovent and

Salbutamol with uncontrolled asthma when needing EDS on Advair. [PRO] [COV]

- EDS program is necessary but pharmacists should receive reimbursement for doing it. It is too time consuming for is to spend all this time for free. [REMUN] [ADMIN]
- Physicians need to be educated on how the Drug Plan works (what medications are formulary, what are not, what are EDS and that criteria must be met in order to get EDS, deductibles, special support plan, etc.). Very few physicians have a good grasp of how the Plan works. Many are of the opinion that getting EDS means that the drug is paid for by the Drug Plan. Physician "detailing" done by someone from the Drug Plan or by a pharmacist would be time well spent. [ED] [COMM]
- Patient understanding of EDS is poor. Letters from Saskatchewan Health do not help – patients do not understand why they still have to pay or meet a deductible when they get a letter of approval for EDS which says that the drug is "covered." The letter should be reworded to make it more clearly understood that EDS does not necessarily mean the medication will be paid for. [ED] [COMM]
- Educate the doctors – patients come out of the hospital or clinic with a script for one of the "SOC" PPIs and hardly ever a diagnosis or trial with Pariet or Apo-omeprazole. Likewise with antibiotics – they ask the patient if he/she has a plan but not all plans cover the expensive antibiotics and we end up calling the doctor to change the prescription, or give diagnosis and call the Drug Plan then the patient has to decide whether they want to pay for it and chance not getting reimbursed. We have had people simply shred the prescription at our counter and say to never mind they'll either see another doctor or tough it out or their doctor always is prescribing the "expensive stuff" and they are going to look for another doctor. [ED] [COMM] [PRO]
- I feel that the EDS program is making unreasonable comments when a rejection fax is received. For example, "was a C & S done (for an antibiotic)?" or "was a culture sensitivity done?" – not a usual question when I take up the doctor's time for a diagnosis. [PRO] [COMM]
- Much more work must be performed by the pharmacist when an EDS application has to be done. The pharmacist should receive remuneration from the Drug Plan and/or patient, and the credit for making the application! Let me tell you the doctors' offices are very glad not to have to do these EDS' any longer! [REMUN] [PRO] [ADMIN]
- As a pharmacy we probably do the most applications for EDS' as any pharmacy our size in this province. I'm proud of that, but feel it is such an integral part of the Saskatchewan Drug Plan and health care network, that pharmacists must receive pay for this! Many third-party drug insurance companies demand EDS applications and imply they will be automatically approved – not so! [REMUN] [COV]
- Why do Celebrex and Bextra require EDS when they are the same price as Arthrotec? [COV]

- I believe that since pharmacists now apply for EDS doctors have lost touch with what requires EDS. For me to apply now often requires 2 or 3 phone calls before I can fill out the fax form. [COMM] [ED] [PRO]
- I estimate that 30 – 40% of our EDS requests are for people who the SPDP does not pay any portion of their prescriptions but their private plan requires us to apply for EDS and transmit to SPDP before they will pay. [COV] [ED]
- We could receive an administrative fee to reflect the large amounts of time spent explaining, interpreting, faxing, long distance phone calls, etc. There is no incentive to physicians to do this, although they have information at [their] fingertips. Both the EDS and MAC programs are excessively burdening pharmacists and resulting in less time available for patient care and higher job stress levels. There must be a lot of money saved → some of this should be used to cover out staffing costs. [REMUN] [ADMIN] [COOP] [PRO]
- Cancel EDS. Either drug to be formulary, or not. Ultimately the costs incurred to [the] province is likely higher with EDS considering most patients are put on first line agents with intent of using EDS drug after words. Province ends up paying for both drugs plus administrative cost of Drug Plan employees. [COV] [PRO]
- If the Drug Plan wishes for pharmacies to continue to have to apply for EDS they should pay us. Very time consuming to not only apply for EDS but essentially process the same prescription twice (initially upon patient arrival and then again once prescription approved, or not, for EDS). Time and money – we should be getting paid. [REMUN] [PRO] [ADMIN]
- The EDS program is just another form of two-tier health care. Allowing pharmacists to apply for EDS is just a download of work from doctors to us. We waste a lot of time calling doctors for diagnosis because they don't indicate it on the prescription. Apparently they think that their time is infinitely more important than the pharmacists. We are tired of taking crap from physicians, be it their EDS load, their incorrect dosing and medication errors, or simply their bad/unreadable writing. Maybe they should spend a shift in our shoes. [COV] [ADMIN] [COMM] [COOP] [PRO]
- Problems are the accessibility of doctors – cannot reach right away if at all, no doctor diagnosis on most scripts and doctors do not know the requirements for EDS drugs; therefore educate doctors and make them more accountable. This service must be paid for. A pharmacists time is worth something! [COMM] [COOP] [ED] [REMUN]
- Time is money – we are very conscientious about completing forms at time of patient presenting prescription. Multiple EDS forms when we are busy are extremely time consuming. I must admit feeling exasperated when I have multiple requests hack-to-back for EDS renewals. We often intervene to get medication changed because the patient cannot afford – this results in considerable time and perhaps improvement in patient care (?) but does not result in an EDS application. I would estimate we intervene approximately 10 times per week. [REMUN] [PRO] [ADMIN]

- Sometimes it is difficult to obtain the official diagnosis from the prescriber. I believe as a health care professional we should be able to indicate a diagnosis such as GERD especially if the patient meets all of the criteria and we are sure of what the patient is being treated for. [COMM] [PRO]
- EDS program could be improved by having the Drug Plan send us (mail/email) a list of our claims which have been approved or not approved. [COMM] [PRO]
- Doctors could be more informed about the program and told to write [the] diagnosis on the prescriptions for EDS drugs. [ED] [COMM]
- Less drugs on EDS program – take TOO MUCH time. [COV] [ADMIN]
- Doctors need more education on documenting and EDS requirements. [ED]
- We spend a great deal of time applying for EDS. Many private drug plans now require non-formulary drugs to be placed on the drug plan. It is a length[y] procedure in many instance[s] to obtain [the] diagnosis, [and] past drug therapy if not filled at our pharmacy. It would be of great assistance if the individuals at the SPDP would be able to guide us with past drug therapy as elder[ly] patients often do not know what [they] last received, etc. I also feel that the application for EDS should be able to be billed for pharmacy reimbursement. [COV] [PRO] [ADMIN] [REMUN]
- Better educate the physicians to either submit the EDS request or write the information needed on [the] script so that we may do it at the pharmacy (without having to phone and track it down and waste our time). [ED] [PRO]
- The biggest obstacle is trying to obtain the diagnosis from the doctor when applying for EDS. Often the doctor will write EDS on the prescription but no diagnosis. [COMM] [ADMIN]
- The EDS form takes less than 5 minutes to fill out, but getting a hold of a busy doctor is most time consuming. [COMM]
- Better communication between SPDP and pharmacy. [COMM]
- EDS requests should be handled in a quicker manner and if someone does not meet criteria (or pending) the pharmacy should be contacted with details. [PRO] [COMM]
- EDS approval or rejection INCLUDING dates should be provided to pharmacy. [COMM]
- Drug Plan warning online that EDS is soon to expire. [COV] [COMM]
- Re-evaluate EDS drugs – for example, Imitrex – criteria is migraine, is this necessary? [COV]
- Educate doctors – encourage them to include diagnosis on prescriptions. [ED] [COMM]
- Biggest problem is third-party payers who insist on EDS – always after the fact. [COV]
- Pharmacy [should] be notified if approved – we sometimes know if rejected. [COMM]
- Doctors [do] not always cooperate in completing information required. [COOP] [COMM]

- Each drug requiring EDS should have it's own request form complete with criteria to assist the doctors in knowing what information is required as more are "much too busy" to read the formulary. [PRO] [ADMIN]
- I feel most doctors use the high end drugs because of marketing from the innovative manufacturers rather than from need. It seems they will not apply for EDS because they don't get paid but still won't fill in required information unless we fax and then they get paid for the fax! I wonder what motivates them? [COV] [COMM]
- Physicians should be more aware of criteria for EDS; pharmacists should NOT have to tell physicians what the criteria is. [ED]
- Physicians should be more accessible to pharmacists. If we are expected to apply for EDS we should not have to spend a lot of time begging for diagnoses and criteria which is what we are doing now. [COMM] [COOP]
- Patients should take more responsibility in this matter – after all it's their pocket book and they best know what they can or can not afford. They should be asking their physician to provide the pharmacist with diagnoses, criteria, etc. if they feel a drug us going to be a financial burden for them. [COV] [COMM]
- It's wonderful to have all these benefits to the patient and the government, again being carried on the backs of pharmacists. We are not allowed to change for the service we provide and we are not given any help in this matter either. [REMUN] [ADMIN]
- There's a safety issue involved. In order to apply for EDS we fax a form to the doctor to be filled out by him/her. This must also include a list of criteria because doctors are very busy and they can't look in the formulary themselves. Then begins the wait for a reply. Meanwhile a stack of faxed EDS forms piles up on the dispensary counter along with faxed prescriptions waiting for signatures. Then some of them come back completed incorrectly or incompletely. Search through the pile, find the corresponding one and shred it or refax it. Meanwhile the phones are still ringing and people need questions answered. It makes for unsafe working conditions as far as making a mistake on someone's prescription is concerned. The more we have piled on our plate the less time we have to do what is most important and that is make sure the prescription is filled appropriately and correctly. [PRO] [COMM] [ADMIN]
- Give us [the] ability to get "instant" approval on short-term medications – for example Cipro, eye drops, etc. Our pharmacy usually gives out and "guesses" on EDS approval and charges the patient as such. Some DO NOT give out drug without EDS or make patient pay full cost. [COV] [PRO]
- SPDP EDS is very prompt 48 – 72 hours most times. When the 72 hours window is passed, it is frustrating and usually requires a call. Even though they request our store information, we are not called back if there is a problem or missing information. On a positive note, the EDS staff has been excellent in getting quick approvals if asked when it impacts a emergency assistance or an appeal of special support. Gail Bradley seems to understand community pharmacy well. [COMM] [PRO]

- Physicians should be responsible for applying for the EDS & MAC policy for their patients. Why should pharmacists manage the doctors' prescribing habits? [PRO] [ADMIN]
- A lot of work – poor support from SPDP. Patients and physicians expect pharmacists to do a lot. If a patient is not granted the EDS, pharmacists are the ones to blame! [COOP] [PRO] [COMM]
- Online submission where you only have to click on relevant information. [AUTO] [PRO]
- Coordinate with software vendors to be able to submit online directly from patient profile. All patient information would already be on form from profile, then click areas relevant to that drug and hit send (Then I woke up and realized it was all just a dream!). [AUTO] [PRO]
- A lot of trouble getting Reminyl coverage. [COV]
- EDS program never calls to let us know of acceptance or refusal. Average time for approval 3 – 5 days (more so for Aricept, Reminyl). [COMM] [PRO]
- Notification if EDS is accepted rather than just rejected would be nice if EDS request was initiated by a pharmacy. [COMM] [PRO]
- It is sometimes very difficult and time consuming to obtain diagnosis and alternative agents tried. Too much time is spent on this requirement. [PRO] [ADMIN] [COMM]
- EDS requests take too long to be approved or not. [PRO] [ADMIN]
- Physicians do not understand the SPDP. They assume that if we apply and receive EDS that the prescription is "cheaper" for them. Patients need to have a special support program in place as well. Physicians need to understand the Drug Plan first before the EDS program will make any sense to them. [ED] [COMM]
- There is no universal drug plan in this province. Only those people with disproportionate drug costs to income may receive benefit. [COV]
- Private third-party drug plans from benefit packages at work should not be able to restrict coverage based on the Drug Plans use of EDS to save money. [COV]
- 80% of the time we apply because [the] patient has third-party private coverage and a deductible that will never be met. I don't mind doing this if we were allowed to charge a service fee. However [the] Drug Plan has said they will void our contract if we charge for this service. [COV] [REMUN] [ADMIN]
- Faster turn around time for EDS requests… has been over one week due to backlog and insufficient staff to process requests. Some patients decide to wait for approval rather than pay up front and wait for refund. This is usually not in the patient's best health interest. [PRO] [COV]
- Perhaps an intervention code that would allow a 4 day supply of the EDS drug while the request is being processed would help. Patient could consider their options after 4 days – if refused continue therapy at own expense or see doctor to change prescription (this option however means another physician visit). [COV] [PRO]

- Physicians should cease and desist with telling patients that EDS reduces the cost of their medication! [ED] [COMM]
- It would be extremely helpful if the physicians, [who] would like us to apply for EDS, included on the prescription the diagnosis and criteria. [COMM] [COOP]
- Need to increase public awareness and knowledge regarding EDS program and/or MAC policy. [ED] [COMM]
- Need to increase doctors' awareness and knowledge (patients often receive incorrect information regarding EDS & MAC). [ED]
- It is time consuming. [ADMIN]
- Physicians get paid for faxes and I believe EDS requests while pharmacists don't. [REMUN]
- Less items should be on EDS – rather just part of the formulary. [COV]
- EDS processing times need to be increased; 2 – 3 day waits are unacceptable. Should be in real-time – i.e. same day approval. [PRO]
- Should fax back store or go to fax system for doctors – most of our time is used finding out if EDS has been applied for – if doctor phones it in it could get "bumped" off the system if it is full. [PRO] [COMM] [ADMIN]
- Response to rejected claims because the patient is waiting and we always must indicate second or third calls. [PRO] [COMM]
- Criteria for EDS is not always clearly indicated or followed as written in formulary – very frustrating. [COV] [COMM]
- For some reason doctors EDS requests seem to get preferential treatment (done faster and less problems with not meeting criteria). [COMM] [COV]
- EDS should be integrated into the online adjudication system and should be followed up by the Drug Plan rather than by the discretion of the patient's physician or pharmacist. If they get a prescription for an EDS eligible product, the system should flag it and initiate the EDS process by contacting the physician to confirm the diagnosis, etc. This is the only way this process can satisfy the concept of universality. [AUTO] [PRO] [COMM]
- Many EDS applications are done to satisfy third-party insurers rather than to lower the cost (get some coverage by the SPDP). [COV]
- Pharmacists should be able to give a few days emergency coverage under certain criteria. [COV]
- Antibiotics are difficult to have on restricted coverage because therapy needs to be initiated immediately and the time it can take to contact the prescriber for a diagnosis, call the Drug Plan to apply for coverage and wait until it is accepted can be far too long especially if it is a prescription received on a Friday evening (can sometimes have to wait almost a week before gaining therapy). [COV] [PRO] [ADMIN]
- If someone's request has been rejected please get back to [the] pharmacy as soon as possible. [COMM] [PRO]
- Sometimes the processing time is long → more than one week to get coverage. [PRO]
- Notification to pharmacist of approval/denial of requests initiated by pharmacist. [PRO] [COMM]

APPENDIX K

Qualitative MAC Responses

MAC Themes

- Process [PRO] – issues pertaining to how the program is run
- Administrative [ADMIN] – the subject of administrative burden, having to balance regular duties with MAC, explaining the policy, etc.
- Remuneration [REMUN] – focus on being compensated for initiating administering MAC
- Education [ED] – concern with the lack of understanding regarding the MAC process by physicians and patients, as well as suggestions to educate the two, and how patients received notification of MAC before pharmacists
- Cooperation [COOP] – distress over the lack of cooperation seen from the Drug Plan on matters relating to MAC and its implementation
- Communication [COMM] – centring on lack of, or insufficient communication between Drug Plan and pharmacists
- Coverage [COV] – anxiety over the issue of what is and isn't covered, when patients benefits start to take effect, patients being stabilized on one medication and are forced to try another
- Future Concerns [FUT] – issue of what may happen in the future when MAC is expanded to more complex categories

Responses

- Consult and inform pharmacists of proposed changes. [COMM]
- The MAC policy undermines the format of the formulary and I can see where the drug plan is going with their reasoning (soon other drug categories will be included). In the short time the MAC policy has been in place, we have had at least two (2) cases where relief was not achieved when a lesser priced drug other than Losec was taken. We are a rather small pharmacy outlet, but if our percentage of clients holds true in the industry, many patients will not be receiving adequate care. The MAC policy drugs, if in the formaulary, would not be considered interchangeable, what the drug plan is implying is somewhat similar to administering a 'Valium' in place of an 'Ativan'. [COV]
- Make all MAC choices a tiered process, then if failure allow EDS for 3rd tier choices. [COV]
- Instead of applying for EDS on PPIs, make their coverage automatic, but limited to the price of the MAC like BC. [COV] [PRO]
- MAC policy disadvantages those people who even though they are in the minority, get less benefit or are unable to tolerate the suggested drug covered on the MAC policy. Suggest [the] drug plan move very slowly before adding more drugs. [COV] [FUT]
- MAC program information was mailed to patients before the pharmacists received their information packages, so we had people bringing in letters and phoning us and we had no background or information about the program. I was very, very angry, that if we were to field questions, we had not been notified well in advance of their implementation. Poor, poor

support from [the] Drug Plan, who always makes us deal with the consequences of their decisions. [COMM] [ADMIN]

- When the MAC policy came into place, people's EDS that had expired should have been automatically extended to generics Apo-omeprazole and Pariet without us applying again. Certainly should have not had to include diagnosis again. They should have this information. It was enough that we had to fax everyone's physician to ask if the switch was appropriate for that patient once changed by the physician to less expensive alternatives, the EDS should have been an automatic thing. I feel it was poor planning and a waste of administrative dollars to not help each other out. Think of how it affects us!!! [COV] [PRO] [ADMIN] [COMM]
- Pharmacists have done most of the explaining of the MAC policy, and I am sure physicians have had to explain a lot too. The minimum → the Drug Plan. We are doing the administrative work for them and get nothing. When a drug is approved, such as Ciprofloxacin, and the patient gets a full page of all generic equivalents and strengths, they have 5 – 10 minutes worth of questions. Quit listing all these drugs; minimum amount of information would be appreciated! [COMM] [PRO] [ADMIN] [COV]
- OK, switch the patients, but if they simply cannot take the alternatives, allow the switch back – for example, we have a patient on multiple drugs including Pantoloc. She has a history of allergies plus condition such as an ulcer, depression, seizures and diabetes. The switch to Omeprazole caused severe vomiting which lead to 3 days in hospital (HUGE COST). Change to Pariet – back in hospital (2 days). Coincidence? Maybe, but probably not. NOW WHAT? She is on social assistance and cannot afford Pantoloc! Cripes!!! [COV] [PRO]
- MAC policy seems to be a make work project, job creation for civil servants. [ADMIN]
- Most patients (actually all patients) who come in and have to get switched because of [the] MAC policy do not understand it. They just nod their heads and say "if you say so" or "I guess if it is cheaper." But they all say that Pariet or Omeprazole works just fine (they just don't want to pay the extra to cover the cost). [COV] [COMM] [ED]
- [Should have] provided more information to pharmacists before changes are made, not after. [COMM] [ED]
- The first I heard about the MAC policy was from a patient. I was hurriedly reading the letter they handed me trying to sort out what it was saying while they were asking me questions. My information letter from the Drug Plan came later that day. [COMM] [ED]
- The MAC policy is idiotic. To allow one person to continue to have full coverage for a product and another not based only when the latest EDS has been approved is not fair, nor equitable. [COV]
- The letter sent to patients about MAC needs to be written so patients can understand [it]. [COMM] [ED]
- Making Losec and Apo-omeprazole interchangeable, as AstraZeneca stated they were when they first introduced the tablets, would be great. [COV]

- So far I feel the MAC program is a good decision. [COV]
- MAC policy a bit confusing. I'm still not clear whether people who need Pantoloc, for example, can get full coverage for it if Pariet doesn't work. Pantoloc is considered to be stronger despite what the MAC policy says. [ED] [COMM] [COV]
- Put Pariet and Apo-omeprazole on the plan and have only the more expensive PPIs on EDS. [COV]
- I think that once physicians are in the habit of prescribing low cost PPIs, there will be less work for pharmacists. [PRO] [ADMIN]
- I find that there are many customers going back to the more expensive PPIs because the cheaper one didn't work. This is occurring much more often then I expected. [COV]
- Our local hospital uses the hospital formulary, which includes all PPIs. We need to have some consistency between hospitals and community. I have noticed that Pantoloc is always used in hospital and we must always contact the doctor to explain that the MAC policy doesn't fully cover Pantoloc and therefore more administrative time is needed for the pharmacist to have to explain both to the doctor and the patient to get the new prescription changed and then apply for EDS. [COV] [PRO] [ADMIN]
- 2 days notice is inexcusable for implementing a new policy. At the beginning lots of questions about it. As of now no questions, since summer actually. [COMM] [ED]
- MAC policy is still in it infancy, so the jury is still out. [FUT]
- The MAC policy should not be absolute. Some patients are not receiving optimal therapy because they are being forced to take a drug based on cost, not on the individuals' therapeutic needs. [COV] [PRO]
- Discontinue. [COV]
- All PPIs should be included on [the] regular formulary with MAC applying – would save an awful lot on faxing. [COV] [PRO]
- The MAC program is preventing some patients from getting the medications that really are more effective. They've tried some other medications before, and only a specific one will be effective. [COV] [PRO]
- Too early to determine the impact of MAC. [FUT]
- If MAC is being expanded – please notify pharmacists prior to announcement. [FUT] [COMM]
- Very scared about MAC and the amount of time required for explaining things. [COMM] [ED]
- Pharmacists should be able to do therapeutic interchange by protocol in order to facilitate the MAC program. Both MAC and EDS would work better if pharmacists had the information and could make the application without spending so much time contacting doctors. We need to be able to be paid a reasonable administrative fee for our time to provide this service. [COV] [COMM] [REMUN]
- Do not agree with the MAC policy. I think it will become a problem when they expand to other groups. [COV] [FUT]

- MORE information to the public – most of the early response indicates the secondary or less expensive drug is doing an adequate job. [ED] [COMM] [COV]
- The MAC policy is a good program and a cost saver to the public, however the public needs to be better informed as to how it works. [ED] [COMM]
- Way more notice should have been sent out to pharmacists first – patients were getting their information before pharmacists had a chance to really know the policy of MAC. [ED] [COMM]
- Include RBSP and SMA in early discussions of new MAC policy. [COV] [COMM] [COOP]
- Allow pharmacist the ability to switch to MAC from non-MAC drug with guidelines provided by SMA. [COV] [PRO]
- The MAC information was very poorly sent out. We received it like 3 days before it was to be implemented. [COMM]
- I do not agree that all PPIs are equal in efficacy and side effects and I think that when this policy is expanded to more classes of drugs, our problems will get worse. [COV] [FUT]
- I'm not sure how pharmacists get hooked into this EDS request job but it's another job in addition to explaining MAC to patients and faxing doctors for renewals. We don't get paid for any of this. When most pharmacies are open 8 hours per day and you spend 15 to 20 minutes per person explaining MAC to them, how much time do you have left to fill prescriptions, patient counselling, etc.? With all the information that was sent out to patients about MAC, they still ended up at the pharmacy to get an explanation of how it worked. [PRO] [ADMIN] [REMUN] [ED] [COMM]
- The Drug Plan did a lousy job with the MAC – giving bad information to the patients created a lot of confusion and pharmacists should have had more notice. [ED] [COMM]
- Suggestions of less expensive alternatives have been something we have always done in the past after discussion with patient and if cost is an issue to them of their payer. We then send a faxed recommendation for trial drug to the doctor along with cost comparison. At this point, after patient involvement, it still remains the doctors' choice. I feel this is a much better way as it doesn't question the doctor's authority or "impose" a drug choice on doctor or patient. This method is received more positively than the MAC. [COV] [PRO] [ADMIN] [COOP]
- I would suggest more academic detailing such as RxFiles does (to doctors and pharmacists). Teach more pharmacists about drug categories and assertiveness in involvement in patient therapy. A small compensation to pharmacists as incentive to reduce Saskatchewan Drug Plan costs and document for compensation might prove useful. Currently there is no incentive to get involved in patient care other than personal satisfaction and that only lasts so long in a stretched and overburdened system. Current compensation for pharmacists such as trial drugs. EDS, special support forms, manual claims, etc. are simply not worth the effort monetarily. [ED] [REMUN] [COMM]

- It (MAC) will be much more time consuming when folks' current EDS run out! Then the major explanations will start. I plan to give a brief explanation and refer the patient directly to SPDP. [ED] [COMM] [COV]
- MAC implementation was horrid. Patients received notification before we as pharmacists had any idea. We found out through patients and the newspapers. This really didn't make us feel like spending hours explaining and recommending this incentive to patients! Perhaps this should have been passed by those of us in the front lines first!?! We were extremely disappointed in SPDP over that and are still resentful! [ED] [COMM]
- MAC program seems cost effective but will be very difficult to administrate once more drug categories get included. [COV] [PRO] [ADMIN] [FUT]
- We had already done considerable work with pharmacy initiated PPI substitution so MAC was not a problem for PPI. [PRO]
- MAC is a good program; should be expanded – Cox-2 Inhibitors are an example of over prescribing. [COV]
- We should have more notice when policy changes so we can better educate patients. [COMM] [ED]
- There should be provision for the higher cost medications on the MAC list to be covered under EDS if the lower cost ones don't work as well for the individual patient. [COV] [PRO]
- Information [should be] sent to pharmacies at least 4 weeks prior to changes. Pharmacy input on changes before they occur. [COMM] [COOP]
- Allow EDS for patients in which the lower priced PPIs don't work. [COV] [PRO]
- If adding a new category, inform pharmacists before patients. We are concerned about future categories… that they may be to the detriment of patients. [COMM] [FUT]
- We need more public information to explain to people how the MAC program is in their best interest. [ED] [COMM]
- I'm not sure where the MAC program is going but it creates more workload → can the pharmacist get reimbursed for the time spent on interventions? [FUT] [PRO] [ADMIN]
- We spend too much time explaining government policies. Many people truly find a difference with the different PPIs and shouldn't have to pay extra. [COV] [COMM] [ADMIN]
- MAC policy not explained to patients well and ended up being pharmacists' responsibility to ensure patient understanding. Very frustrating when I have to do the Drug Plan's work and the we (pharmacists) get stone walled and treated as second class during negotiations for new contract and reimbursement opportunities – for example blister packs. [COMM] [ED] [ADMIN]
- I appreciate the theory of MAC pricing – is it possible to combine RxFiles articles with information mail outs by Drug Plan as I find [the] RxFiles to be unbiased and informative? [ED] [COMM]

APPENDIX L

Provincial and Territorial Drug Plan Websites

Provincial	Drug Plan Name	Review Committee	Website
British Columbia (Ministry of Health Services)	PharmaCare	Drug Benefit Committee of PharmaCare	www.healthservices.gov.bc.ca
Alberta (Health & Wellness)	Drug Benefit List	Expert Committee on Drug Evaluation & Therapeutics	www.health.gov.ab.ca
Saskatchewan (Department of Health)	Saskatchewan Drug Formulary	Drug Quality Assessment Committee (DQAC) & Saskatchewan Formulary Committee	www.health.gov.sk.ca
Manitoba (Department of Health)	Manitoba Drug Benefits & Interchangeability Formulary	Manitoba Drug Standards & Therapeutics Committee	www.gov.mb.ca/health/mdbif/index.html
Ontario (Ministry of Health & Long-term Care)	Ontario Drug Benefit Formulary/Comparative Drug Index	Drug Quality & Therapeutics Committee (DQTC)	www.health.gov.on.ca
Quebec (Department of Health & Social Services)	Basic Presecription Drug Insurance Plan - (Régime général d'assurance médicaments, RGAM)	Conseil Consultatif de Pharmacologie	www.msss.gouv.qc.ca
New Brunswick (Health & Wellness)	New Brunswick Prescription Drug Program Formulary	Atlantic Expert Advisory Committee (AEAC)	www.gnb.ca/0051/index-e.asp
Nova Scotia (Health)	Nova Scotia Formulary	Formulary Management Committee	www.gov.ns.ca/health
Prince Edward Island (Department of Health & Social Services)	PEI Drug Cost Assistance Programs Formulary	PEI Pharmacy Advisory Committee	www.gov.pe.ca/hss/index.php3
Newfoundland & Labrador (Department of Health & Community Services)	Newfoundland & Labrador Interchangeable Drug Products Formulary	Expert Advisory Committee	www.gov.nf.ca/health
Territorial	**Drug Plan Name**	**Review Committee**	**Website**
Yukon (Department of Health & Social Services)	Yukon Drug Programs Formulary	SK Drug Quality Assessment Committee & Yukon Formulary Working Group	www.hss.gov.yk.ca
Northwest Territories (Department of Health & Social Services)	NWT PharmaCare Formulary		www.hlthss.gov.nt.ca
Nunavut (Department of Health & Social Services)			www.gov.nu.ca/hsssite/hssmain.shtml