Glossary

Common Terms
Used in Drug Access Navigation

Appeal

A submission made to the drug plan or plan sponsor upon receipt of a denied claim, based on the patient not meeting a drug's criteria or clinical guidelines. Appeals can be done in writing or by phone by the prescribing physician. Appeals should first be submitted to the patient's drug plan unless otherwise directed. Appeals should not be attempted in cases where a drug is simply not included on the person's plan (i.e. it is in the process of being reviewed for listing, or it is a non-benefit).

Assignment of Benefits

An agreement between the insurance company, the patient and the patient's pharmacy to assign reimbursement on a claim to the pharmacy instead of the patient. The pharmacy must be willing to participate and wait on payment. Typically, the receipt is submitted to the insurer directly from the pharmacy. This is an option only applies to drug plans that are a reimbursement plan and who allow for the assignment of benefit option to be requested. Used in cases of high cost that are unmanageable by the patient.

Benefits

The items on a person's plan that are eligible for payment. Some benefits on conditional on a patient meeting certain clinical criteria or other requirements.

Benefit Year

A period of 12 months in which a drug plan is active. It may be set by calendar year or by a particular start date. The dates used vary by plan. Annual premiums, deductibles, and maximums are applied to this time frame.

Brand

The version of a drug product that is licensed and patented by a pharmaceutical company. Typically, the brand product is the original formulation of the drug.

Bridging Supply

A term used to describe an allotment of drug provided at no charge to eligible patients for a specific and pre-determined period of time. The supply is usually approved and coordinated through a patient support program and provided by the pharmaceutical manufacturer of the drug. A bridging supply is often used for newly approved drugs (i.e. while waiting on plan/hospital listing approvals) or in cases where a patient is waiting for Special Authorization approval on their plan.

Claim

A formal request to a drug plan for payment of a benefit. On reimbursement plans this is done with a receipt and claim form, on direct pay plans it is completed automatically on-line by the pharmacy.

Co-insurance

A set arrangement on a drug plan where the patient shares the cost of the drug, usually by paying a portion of the cost (e.g. 20%). A co-insurance may be the same on all drugs, or may fluctuate based on the type of drug ("tiered" plan) or extent of plan use ("sliding").

Compassionate Supply

A one-time, exceptional provision of a drug at no charge on the basis of compassionate grounds. The decision to provide compassionate supply rests with the manufacturer, and is often granted for unusual circumstances (e.g. patient moved from out of province and is waiting on health card, or patient denied coverage of drug on plan and has no other means of payment). Compassionate supply requests are made for on-label use requests only.

Coordination of Benefits

The order in which two or more drug plans for the same person/family are billed. The general guidelines used for billing are applied based on who the patient is on the plan:
Primary on both plans – plan held longest is billed first
Primary/dependent – primary plan is billed first
Children – Parental birthday/custody
Student – student plan billed first

Co-payment

A set arrangement on a drug plan where the patient pays a set amount of money on each prescription (e.g. $5).

Coverage

In drug access navigation, "coverage" is a term used to describe approval and payment of a benefit on a person's plan (i.e. the person was "covered" for the drug on their plan)

Deductible

The amount a plan member is required to pay before the insurer will provide payment on benefits. Deductibles may be annual, quarterly, or monthly. Deductibles may be a set amount (insurance plans) or a sliding amount based on income (provincial public plans).

Deferred Payment

A method used by some insurers in Québec on reimbursement plans. The patient is required to pay the full cost of the drug up front but does not have to send in a claim form and receipt to the insurer for reimbursement. The pharmacist is able to send the claim directly to the insurer and can sometime confirm with the patient at that point if the claim will be approved. When approved, the reimbursement is sent directly to the patient.

DIN

Drug Identification Number. A unique identifying number assigned by Health Canada to each drug (by form and dosage) upon approval for market in Canada. A DIN can be located on-line through Health Canada's Drug Product Database. The DIN is essential to have when inquiring about coverage of a drug on a plan.

EAP

Exceptional Access Program. A term unique to the Ontario Drug Benefit (ODB) program. This process allows for prescribing doctors to apply for drugs not listed for coverage under the Ontario Drug Benefits or Trillium programs. Drugs are listed under EAP when they have specific clinical criteria that need to be met for approval of coverage. Similar to Special Authorization processes. As of July 2018, prescribing physicians will be able to apply on-line.

Exception

A request made to a drug plan, in writing, to consider coverage of a drug for a patient due to unique circumstances. Usually, this is done for drugs that have "Special Authorization" requirements where the patient narrowly falls outside the criteria for approval. This can also be done in cases where the patient has a contraindication to the traditionally prescribed therapy. The request is made in writing to the plan.

Exception Status

A term used on some provincial drug plans instead of "Special Authorization".

Exclusions

Items or amounts not covered by a plan . Excluded items can include vitamins, smoking cessation products, etc. Excluded amounts can be dispensing fees, pharmacist counseling fees, etc.

Formulary

A list of drugs approved as benefits on a plan. The drugs may or may not require pre-approval according to specific criteria. Most public drug plan formularies can be located online on the plan's website. Insurer formularies are usually not published although some plans allow plans to look up information using their plan policy numbers.

Generic

The version of a drug that is produced once a brand drug's patent has expired. Multiple companies adopt the "recipe" and technology used in making the drug but may (or may not) change certain components (e.g. fillers, packaging, etc). Generic drugs are usually considered more cost-effective.

Government Plan Integration

A stipulation for a drug on a drug plan that requires a patient to inquire if they are eligible for a relevant government program first. Occurs in cases where a province has a specific plan for a certain class of drugs or group of patients (e.g. post-transplant). If patient is not eligible the prescribing doctor must confirm this with the plan by phone or in writing.

Health Benefits Case Manager

A person assigned to a patient's file for the purpose of reviewing the person's drug need or support that person in various aspects of chronic care. The person may be an employee of the insurer or contracted from an external provider. The goal is to ensure the drug or therapy prescribed is reasonable and cost-effective. Often the case manager receives a file upon submission of a Special Authorization and may contact the prescriber with questions, or may recommend another therapy as per clinical guidelines. The case manager may also contact the patient regularly to track compliance and recommend coverage cease if drug not taken properly.

Health Spending Account (HSA)

An arrangement in a group plan where the plan member gets a number of credits in an account. The member can use the credits to pay for health and dental expenses not covered elsewhere in their plan.

Limited Use

A restriction put on a drug by a plan that limits its use to only certain populations, certain amounts, or under certain conditions. On some plans, limited use "codes" are allowed to be applied on prescriptions for frequently prescribed drugs. Pharmacists are usually aware of these codes but they can also be found for public drug plans on-line.

Mandatory Substitution

A requirement by a plan to defer coverage to a more cost-effective drug product considered of equal clinical value. The plan will only pay up to the cost of the more cost-effective equivalent, the patient is required to pay the difference.

Maximum

A pre-determined limit to plan use. Usually applies only to insurance plans. A maximum may be applied to the amount the patient or plan member has to pay (e.g. "you are responsible for drug copayments up to $500 then coverage will change to 100%) or the amount a plan is willing to pay (e.g. the plan member has up to $5,000 worth of coverage per year, or $100,000 per lifetime). A maximum may be applied to a specific benefit (e.g. drugs) or the entire range of plan benefits. Not all plans have maximums, and maximums can vary widely. They are usually based on the size of a plan or type of plan the person has chosen.

Notice of Compliance (NOC)

A document issued by Health Canada once a drug is approved for sale in Canada and has a DIN assigned. The document outlines the clinical characteristics, dosages, contraindications and prescribing considerations of the drug.

Notice of Compliance with Conditions (NOC/c)

Like the NOC, but issued under conditions for use and the requirement that the manufacturer understand additional studies to verify the clinical benefits of the drug.

Patient Assistance

A term used to refer to the reimbursement and financial services for a drug product provided by a pharmaceutical company through a program, card, or other arrangement. Patient assistance is a method used to help with leftover costs to patients after plan billing, cost-share, or mandatory generic billing in cases where patient is purchasing brand drug.

Patient Support Program (PSP)

A term used to refer to a spectrum of services provided by a pharmaceutical company through a program. Services may include reimbursement and financial assistance, nursing support, pharmacy services, etc.

Pay-direct Plan

A type of drug plan where a patient is given a card or number to allow a pharmacy to bill the prescribed drug on-line. Usually, the pharmacy is informed in real-time if the drug is an approved benefit and any costs to the patient. Also, the pharmacist is restricted to billing the plan for the costs specified by the plan. The pharmacist may or may not charge additional $ to the patient. This depends on the pharmacy, the plan, and the province.

Premium

The fee paid to a plan to initiate and maintain enrollment in the plan. A premium is usually required by insurance plans but may be cost-shared with an employer as part of a group plan. Some, not all, public plans require premiums. Premiums are usually paid to the plan at the start of the benefit year but may also be paid in installments.

Prior Authorization

See “Special Authorization”

Reimbursement Plan

A type of drug plan where a patient has to pay the full cost of the drug up front at the pharmacy, and submit the claim and receipt to the insurer. The patient is responsible for any price difference in what the pharmacy charges and the insurer pays.

Special Authorization

A mechanism for pre-screening drug benefit claims. To have the drug approved for coverage, a patient must meet certain clinical requirements. These requirements may include: prior treatment with another more cost-effective drug, the presence of a specific disease/illness, specific test results (e.g. genetic markers, lung function, etc), symptom progression, or confirmation that the drug is being used for a certain procedure. Usually, clinical criteria follow CADTH/pCODR/INESSS recommendations or the product monograph, but may be altered by the plan. A Special Authorization request must be approved before coverage is granted.