General Provisions for Prescribing Authority

When to Dispense and When to Prescribe

The SCPP Regulatory Bylaws allow pharmacists to prescribe drugs under certain circumstances, where they are competent to do so, while working in collaboration with other members of the health care system.

The intent of the expanded activities under Pharmacist Prescribing Authority is to address gaps in health services by providing patients with continuous access to safe and appropriate drug therapy management when needed in everyday situations, emergencies, or extraordinary circumstances.

These expanded prescribing activities are not intended to replace pharmacists dispensing scope of practice. (See Dispensing Standards in SCPP Reference Manual.) Nor are they intended to replace family physicians and other health professionals or override their clinical decisions.

This means that pharmacists must be mindful of which scope of practice is to be used in the circumstances presented by the patient to ensure that they are prescribing responsibly and in accordance with the standards of practice and Code of Ethics. For example, see:

- section 2 on Professional Accountability; and
- section 13 for Conflict of Interest.

All pharmacist prescribing must meet the practice requirements specified in Council policy, as per subsection 4(7) for Level I and subsection 12(5)(b) for Level II prescribing authority. All SCPP bylaws, policies, guidance and standards pertaining to prescribing authority must be taken together as whole.

DEFINITIONS

For the purposes of this Policy, the following phrases have the meaning ascribed to them in the SCPP Regulatory Bylaws Part K section 1:

"**Collaborative Practice Agreement"** (Public Health Care Institution) means a written bylaw, policy, clinical standard of a Public Health Care Institution, or agreement between one or more licensed pharmacists and a Public Health care Institution, that outlines patient care and drug therapy management functions performed by licensed pharmacists and other health care providers employed by, or practising in the Public Health Care Institution, which includes the conditions or limitations authorized by the Public Health Care Institution and by Council;

"**Collaborative Practice Environment"** means a deliberate and committed professional approach to communication, decision-making, and shared knowledge and skills that health care providers can reasonably rely upon to provide safe patient care, including the referral to practitioner(s) or other health care provider as appropriate;

"Dosage amount" or "Dose" means a specific amount or strength of drug prescribed or directed to be taken;

"Dosage form" means the physical formulation, including release profile, in which the drug is manufactured and made available for use;

"Dosage regimen" means the frequency in which a dose of drug should be ingested for a specified duration;

"Level I Prescribing Authority" means the ability of a licensed pharmacist to prescribe drugs in the circumstances enumerated in sections 4, 5, 6, 7, 8, 9, 10 or 11 of Part K;

"Level II Prescribing Authority" means the ability of a licensed pharmacist to prescribe drugs in the circumstances enumerated in sections 12, 13, 14, 15, 16, 17 or 19 of this Part K;

"Practitioner" for the purposes of Part K, means a practitioner as defined in clause 2(i) of Part A of these bylaws, excluding a licensed pharmacist;

Defining "Practitioner" for the Purposes of Part K

Unlike the definition of "practitioner" for all other parts of the *SCPP Regulatory Bylaws*, in Part K, the definition of "practitioner" does not include pharmacists. *Source: The SCPP Regulatory Bylaws Part A, clause 2(i).*

"Professional relationship" means a relationship between a patient and a licensed pharmacist or practitioner in which a professional service is provided for the purpose of optimizing the patient's health or drug therapy;

"Therapeutic substitution" means substituting a prescribed drug for a drug that is within the same pharmacologic class and limited to the scientific properties defined in clause 1(k) of this Part K;

GLOSSARY OF ACRONYMS

CPA – Collaborative Practice (Prescribing) Agreement
CPE – Collaborative Practice Environment
NAPRA – National Association of Pharmacy Regulatory Authorities
PAR – Pharmacist Assessment Record
PIP – Pharmaceutical Information Program
PPDA – *The Pharmacy and Pharmacy Disciplines Act*
SCPP – Saskatchewan College of Pharmacy Professionals
SCPP Bylaws – SCPP Regulatory Bylaws

1. PURPOSE

The laws in Saskatchewan allow pharmacists to prescribe drugs under certain circumstances, where they are trained to do so. These circumstances and the associated restrictions and conditions are outlined in the SCPP Bylaws (Part K – Prescribing of Drugs).

Prescribing authority allows pharmacists to optimize the use of their current competencies as medication experts in a collaborative environment where the practitioner provides the medical diagnosis, treatment decisions and therapeutic goals for the patient (Level I). It also allows some pharmacists with advanced skills and advanced partnerships to make treatment decisions and develop therapeutic goals for the patient once the practitioner provides the medical diagnosis (Level II). In all situations the collaborative environment with other practitioners is the foundation to safe and effective prescribing decisions.

See Appendix A for an overview of the prescribing authority framework in Saskatchewan, which summarizes pharmacist prescribing authority under normal and extraordinary circumstances.

The following is intended to provide guidance in the interpretation of the SCPP Bylaws and application of Council policy and expectations in addition to the requirements specified in the bylaws. The bylaws should be consulted for full details and requirements.

GENERAL REQUIREMENTS (APPLIES TO ALL PHARMACIST PRESCRIBING)

2. PROFESSIONAL ACCOUNTABILITY (LEVEL I AND II)

SCPP Bylaws: Professional Accountability

Part K clause 2(1)(e): *The pharmacist must have reasonably satisfied themselves that the prescribing decision is appropriate in the circumstances based on their assessment of the patient and that the prescribing decision is proper in the judgment of the pharmacist.*

2.1. Professional accountability as per clause 2(1)(e), means that pharmacists must:

2.1.1. respect scope, role, expertise and diverse experiences of the patient's other practitioners; and

2.1.2. preserve the patient and practitioner's relationship and treatment plan while delivering pharmaceutical care. This includes, where applicable:

2.1.2.1. performing all steps in the dispensing process (see Dispensing Standards) before the pharmacist alters or continues the existing prescriptions issued by a practitioner, including communication with the practitioner who initiated the prescription (e.g. interim supply, antibiotic or opioid stewardship); and

2.1.3. assess patient access to care versus patient convenience when deciding whether it is reasonable to exercise prescribing authority;

When a Pharmacist is Permitted to Prescribe but Decides Not To

As with other health professionals, pharmacists will use their professional judgement to determine if they have the competency and confidence to prescribe in the best interest of the patient. As per the NAPRA/SCPP Model Standards of Practice, pharmacists must refer patients to appropriate members of the health care team for any medication therapy problems beyond their individual competence or for any health care issues requiring medical, dental or optometric care.

Pharmacists who refuse to provide services for moral or religious reasons must refer the patient to a health care practitioner who can provide the service to ensure safe patient care. See also Conscientious Objection and Pharmacy Services.

2.2. Further, pharmacists must comply with the Code of Ethics and the SCPP/NAPRA Standards of Practice. As such, a pharmacist prescribing a drug must also:

2.2.1. follow the same standard as other prescribers by taking responsibility for their decisions, monitoring the patient's response and following up as needed to ensure continuity of care;

2.2.2. understand the decision making and prescribing processes as outlined in the Prescribing Authority Decision-Making Framework, as well as the requirements, circumstances or areas within which they may prescribe;

2.2.3. apply their professional judgement by incorporating evidence-informed practice in all aspects of professional care including the use of current, peer-reviewed evidence-based resources or clinical practice guidelines;

2.2.4. maintain the skills, knowledge and abilities needed when prescribing;

2.2.5. ensure that they are competent and confident in their skills;

2.2.6. recognize and practice within the limits of their competence;

2.2.7. identify when their competency is insufficient to meet the needs of the patient and refer patients to appropriate members of the health care team; and

2.2.8. maintain competency through continuing education and professional development;

Training and Competency Requirements

The training and competency required may vary with each authorized prescribing practice under Level I and II Prescribing Authority. See SCPP's Training and Development webpage for current training and competency requirements as per Part K clause 2(1)(a).

(Also see section 13 for Conflict of Interest that applies to all prescribing, section 16 for additional Professional Accountability requirements specific to Level II prescribing, in addition to those found in reference documents for each specialty area of prescribing.)

Malpractice Insurance for Level I and II Prescribing Authority

SCPP encourages members to consult with their insurance provider to determine if supplemental coverage beyond the minimum is required for their prescribing practices, and to confirm what is covered by their policy (e.g. would prescribing practices that do not align with the terms and conditions established by SCPP be a covered activity).

Pharmacists prescribing Level II authorized practices under a CPA (excluding Public Health Care Institutions) see Framework for Developing a Safe and Functional Collaborative Practice Agreement.

3. COLLABORATIVE PRACTICE ENVIRONMENT (LEVEL I AND II)

Collaborative practice environments are foundational to all pharmacist prescribing and the requirements have been built into the bylaws. Key principles supporting this environment are transparency, accountability and thorough communication to ensure that the best interest of the patient is addressed.

SCPP Bylaws – Collaborative Practice Environment

Part K subsection 1(b): *"Collaborative practice environment" means a deliberate and committed professional approach to communication, decision-making, and shared knowledge and skills that health care providers can reasonably rely upon to provide safe patient care, including the referral to practitioners(s) or other health care providers as appropriate*.

Part K subsection 4*(4) A licensed pharmacist may only exercise Level I Prescribing Authority with respect to an individual patient if a Collaborative Practice Environment exists between the licensed pharmacist and a practitioner who is responsible for the care of the individual patient.*

Part K clause 12(6)(a) *A licensed pharmacist who exercises Level II Prescribing Authority for one or more of the specialty areas listed in clause 12(1)(b) shall ensure collaboration with the health care system as required by Council.*

3.1. The SCPP position is that the pharmacist is fulfilling their requirements of a CPE when they prescribe according to the requirements of the bylaws;

3.2. In fulfillment of the practice requirements established in subsection 4(7) of Part K when exercising Level I prescribing authority and clauses 12(6)(a) and (b) when exercising Level II prescribing authority, pharmacists must adhere to the collaboration requirements as documented in the SCPP/NAPRA Standards of Practice (e.g.

Standard 3.3). Additional examples of pharmacist behaviours that emulate these standards of practice include:

3.2.1. sharing their unique knowledge and skills with other health care providers to meet the patient's drug related needs and to achieve positive outcomes by maintaining or improving the patient's quality of life;

3.2.2. maintaining appropriate and constructive inter-professional relationships required to provide quality pharmacy care to individual patients;

3.2.3. providing patients with accurate information about the role of other health providers;

3.2.4. partnering with other health professions to facilitate effective transitions of care as patients move between healthcare settings and health professionals; and

3.2.5. referring patients to other health providers, when required.

(See section 15 for CPE requirements in Level I and section 17 in Level II).

4. PROFESSIONAL RELATIONSHIP (LEVEL I AND II)

Patient-Pharmacist Relationships

The SCPP Bylaws have built in flexibility so that pharmacists have additional tools to respond to patients' health needs in various circumstances. However, regardless of the patient circumstance and the model of delivering care, the standards of practice expected of the pharmacist remain the same.

The SCPP Bylaws require that*:*

> *prescribing shall only be done for patients with whom the pharmacist has developed a professional relationship (*Part K clause 2(1)(b));

The Standards (Standard 3.2.1.) require:

> *Pharmacy professionals are required to develop and maintain an effective professional relationship with each patient, regardless of the model used to deliver care.*

When the pharmacy service is provided in accordance with the bylaws, standards of practice and Council policies, it is considered that the pharmacist is fulfilling the requirements of clause 2(1)(b) regarding the professional relationship with the patient.

4.1. In addition to the SCPP/NAPRA Standards of Practice, to satisfy the SCPP expectations in clause 2(1)(b) for **all prescribing**, the pharmacist must:

4.1.1. Provide the same level of service for patients who may not regularly attend their practice site;

4.1.2. Remain responsible for any patient outcomes related to the service provided until care has been transferred to another authorized provider;

4.1.3. Clearly establish and communicate the normally accepted roles and responsibilities of themselves, the patient and their primary practitioner where applicable, including:

4.1.3.1. explaining their common goal of ensuring that the patient appropriately takes the right drug in the correct dose and dosage form, on the best schedule, for the appropriate duration of therapy;

4.1.3.2. how side effects or lack of efficacy are identified and managed appropriately; and

4.1.3.3. when patients should follow up with the pharmacist and when they should follow up with the primary practitioner or other practitioners, in fulfillment of the collaboration requirements specific to the prescribing authority being exercised;

4.1.4. Confirm that the patient understands their health condition, care plan, therapy, and required monitoring and provide additional information or referrals when required.

(See section 9 for additional expectations when the patient-pharmacist relationship involves self, family members or close personal relationships).

(See section 18 for additional expectations for patient-pharmacist relationship for Level II prescribing).

Patient – Practitioner Relationship and Exceptions

One of the longstanding foundational principles for pharmacist prescribing is that of pharmacist and practitioner working closely together for the benefit of the patient. This is reinforced in the SCPP Bylaws, Part K clause 2(1)(c):

> *The pharmacist reasonably believes, after making inquiries that are reasonable in the circumstances, that there exists an active professional relationship between the practitioner and the patient;*

However, there are some situations where the pharmacist may provide the patient with access to appropriate medication regardless of the patient's relationship status with a practitioner, including:

<u>Level I Prescribing Authority:</u>

- 5(8) emergency situations
- 10(1) minor ailments
- 11(1) administrative prescribing

<u>Level II Prescribing Authority:</u>

- 13(1) vaccine preventable diseases in Canada
- 14(1) and 15(1) travel health A and B
- 19(1) other diseases identified by the Minister of Health

Also see:

- Applicable sections and reference documents specific to each authorized prescribing practice in SCPP Reference Manual for additional terms and conditions; and
- Level I Prescribing Authority (Dec 2023 webinar), the Level I Prescribing Authority Q&A (Feb 2024 webinar) and Level I FAQs.

4.2. When exercising prescribing authority that does not require an active patient-practitioner relationship, pharmacists are expected to use their professional judgement, as noted in the SCPP/NAPRA Standards of Practice (Standard 1.2), where all pharmacy professionals are expected to work "*In collaboration with the patient and their circle of care, pharmacy professionals use their professional judgment to make evidence-informed decisions that are based on the patient's unique needs, goals, and preferences.*"

5. APPROPRIATE INFORMATION (ASSESSMENT OF THE PATIENT AND MEDICATION HISTORY IN PIP) (LEVEL I AND II)

SCPP Bylaws

Part K clause 2(1)(d): *the pharmacist must have the appropriate information to inform the prescribing decision;*

Part K clause 2(1)(e): *the licensed pharmacist must have reasonably satisfied themself that the prescribing decision is appropriate in the circumstances based on their assessment of the patient and that the prescribing decision is proper in the judgment of the licensed pharmacist;*

Part K clause 2(1)(f) *a pharmacist must have reviewed the patient's medication history in the Pharmaceutical Information Program prior to prescribing a drug;*

5.1. For the purposes of clause 2(1)(d), appropriate information means the following information in relation to a patient:

5.1.1. Symptoms or signs to be treated and/or the patients' self-diagnosis;

5.1.2. History of the current condition, including treatment and drug therapy outcomes;

5.1.3. Drug and demographic information outlined in Patient Assessment and Documentation Recommendations (e.g. allergies, current and past drugs, height, weight, social history); and

5.1.4. Medical information including:

5.1.4.1. relevant medical history;

5.1.4.2. active health problems;

5.1.4.3. pregnancy or lactation status, if applicable;

5.1.4.4. relevant family history;

5.1.4.5. the practitioner's diagnosis or therapeutic indication;

5.1.4.6. relevant laboratory or point-of-care test results; and

5.1.4.7. organ function that may affect therapy;

Gathering Relevant Information (PIP, eHR Viewer and Local Pharmacy Profile)

Much of the relevant health information needed to inform the pharmacist's assessment of the appropriateness of care is available through provincial resources/databases such as the Pharmaceutical Information Program (PIP), the electronic Health Record Viewer (eHR Viewer) and the local pharmacy profile. (See Accessing PIP and eHR Viewer reference document).

5.2. For the purposes of Part K clause 2(1)(e), the pharmacist is expected to follow the steps outlined in the Prescribing Authority Decision-Making Framework, where they determine the best treatment plan in the best interest of the patient using current, peer-reviewed evidence-based resources or clinical practice guidelines;

5.3. For the purposes of Part K clause 2(1)(f), a pharmacist prescribing a drug for an out-of-province resident must make reasonable attempts to obtain their medication history from other sources such as the patient and other pharmacies.

6. MONITORING AND FOLLOW-UP (LEVEL I AND II)

SCPP Bylaws

Part K clause 2(1)(g): *The pharmacist must have a system in place to ensure patients receive appropriate follow-up care;*

Part K clause 2(1)(h): *The pharmacist shall take appropriate follow-up action if the therapeutic results are outside of the expected, normal or reference range, which may include one or more of, but is not limited to:*

(i) discussing the results with the patient or other members of the patient's health care team;

(ii) developing and implementing a plan for ongoing monitoring or management;

(iii) revising drug therapy, if authorized pursuant to Part K of these bylaws; or

(iv) recommending changes to drug therapy by another member of the patient's health care team;

For the purposes of clauses 2(1)(g) and (h) of Part K, all monitoring and follow up must meet the SCPP/NAPRA Standards of Practice. This means that:

6.1. All pharmacists prescribing a drug must develop, implement and fulfill plans to monitor the patient's progress towards desired therapeutic outcomes and ensure continuity of care, including:

6.1.1. routinely and accurately identify the degree of monitoring required by a patient according to the health risks posed by the patient's medication, drug related problem or disease;

6.2. Routinely, effectively and in consideration of 6.1., a pharmacist must appropriately educate patients on:

6.2.1. what the patient should do to monitor their therapeutic response or development of side effects;

6.2.2. actions the patient should take if the intended therapeutic response is not obtained or side effects develop;

6.2.3. when appropriate, the actions the pharmacist will undertake to monitor the patient's progress;

6.3. A pharmacist must ensure the patient has received all relevant information with respect to follow-up plans including:

6.3.1. monitoring parameters determined by the pharmacist that support a patient's ongoing medication therapy; and

6.3.2. a clear description of what follow up will be provided by the pharmacist and when the patient should see another practitioner;

6.4. If the monitoring involves laboratory testing, then the pharmacist must adhere to the requirements outlined in Laboratory Tests and Medical Devices – Accessing, Ordering, Performing, Using, or Interpreting;

6.5. A pharmacist must communicate with patients care providers as necessary regarding the results of patient monitoring.

(See also, communicating with practitioners section 3 CPE and section 11 Documentation).

7. INFORMED CONSENT (LEVEL I AND II)

SCPP Bylaws

Part K clause 2(1)(i): *the licensed pharmacist must only prescribe a drug if the licensed pharmacist reasonably believes that the prescription decision of the licensed pharmacist has been consented to by the patient, in accordance with the following:*

(i) in the context of services provided within a Public Health Care Institution, the licensed pharmacist reasonably believes that the prescription decision of the licensed pharmacist has been consented to in accordance with the bylaws or policies of the Public Health Care Institution regarding consent; or

(ii) in the context of a practice outside of a Public Health Care Institution, the licensed pharmacist reasonably believes, after the making of inquiries that are reasonable in the circumstances, that the prescription decision of the licensed pharmacist has been consented to:

(A) by the patient, if the licensed pharmacist has a reasonable basis to believe that the person has the capacity to make an informed health care decision;

(B) by a person appointed as the patient's personal guardian or the patient's co-decision maker pursuant to The Adult Guardianship and Co-decision-making Act;

(C) by the patient's parent or legal guardian, if the licensed pharmacist has a reasonable basis to believe that the person does not have the capacity to make an informed health care decision by reason of the patient's infancy; or

(D) by the patient's spouse, if the patient does not have the capacity to make an informed health care decision and no person has been appointed as the patient's co-decision maker or personal guardian;

7.1. Patients have the right to be informed about the benefits and risks of any treatment or health service offered to them and to make a voluntary decision about whether to undergo the treatment or health service;

7.2. Patient consent must be informed, specific and given voluntarily. In addition to the requirements in clause 2(1)(i) of Part K, the process for informed consent may include, as applicable:

7.2.1. a description of the drug including benefits, side effects and life-threatening risks;

7.2.2. alternative therapies, if clinically appropriate, including benefits and risks;

7.2.3. the consequences of not receiving the drug;

7.2.4. confirmation that the information provided is understood; and

7.2.5. the opportunity for questions and answers;

7.3. The consent must be documented by the pharmacist:

7.3.1. the note should be specific enough to clearly reflect that the conversation took place to obtain the patient's consent;

7.3.2. a signature on a consent form is not a substitute for having a conversation with a patient to ensure that the patient has the information and facts needed to make an informed decision; and

7.3.3. a check box on a Pharmacist Assessment Record is not a substitute for having a conversation with a patient to ensure that patient has the information and facts needed to make an informed decision;

8. AUTHORIZED DRUGS (LEVEL I AND II)

8.1. A pharmacist must only prescribe a drug if the intended use is:

8.1.1. an indication approved by Health Canada and as per the product monograph;

8.1.2. considered a best practice in current peer-reviewed evidence-based resources or clinical practice guidelines; or

8.1.3. part of an approved research protocol, where applicable.

8.2. When prescribing "off-label", a very cautious assessment is required by the pharmacist, along with patient consent and thorough documentation including:

8.2.1. obtaining a detailed history to determine if the patient has a condition that would place them at increased risk of potential side-effects from the off-label use;

8.2.2. a discussion that the drug being considered is not approved for the patient's particular condition or is being used in a manner that differs from the original authorization by Health Canada;

8.2.3. broadening the extent of the consent discussion as it pertains to potential risks not typically disclosed; and

8.2.4. explaining and documenting the rationale for using an off-label drug, including reference to clinical resources.

(Adapted from: CMPA – Medication Safety - Good Practice Guidance for Off-label Medications and Devices.)

Off-Label Medications and Devices

Off-label refers to using a prescription pharmaceutical or device approved for sale by Health Canada beyond the criteria set out in the product's approval. While this may usually mean using a drug or device for an illness or disease not listed in the original authorization, it can also include prescribing different dosages or frequencies, lengthening or shortening the duration of treatments, prescribing to different patient populations (e.g. children) or using different routes of administration than indicated on the drug label.

Source: CMPA – Medication Safety - Good Practice Guidance for Off-label Medications and Devices.

8.3. Prescribing for a drug that is monitored by the PRP must follow the requirements of the PRP. (See SCPP's Prescription Review Program for applicable policies and procedures for prescribing and dispensing).

Drugs Monitored by the Prescription Review Program (CDSA and non-CDSA drugs)

CDSA Drugs (i.e. narcotics, controlled drugs, benzodiazepines and other targeted)

- A pharmacist is **not** authorized to **initiate** a controlled substance[1] under the *Controlled Drugs and Substances Act* (CDSA) and its *Regulations*. This includes prescribing within a Collaborative Practice Agreement. Source: Health Canada FAQs.
- Note: a CDSA drug may be eligible for certain Part K authorized prescribing practices depending on the authorized practice and/or any Health Canada exemptions in place. See Appendix A for how this applies.

Non-CDSA Drugs (PDL drugs such as gabapentin, oxybutynin)

- The addition of drugs to the PRP does **not** change the schedule of the drug. As such, drugs listed in the Prescription Drug List (PDL) are eligible for all authorized prescribing practices described in Part K. Source: *Food and Drug Regulations* Part C.

The SCPP Bylaws require a pharmacist who is prescribing a drug monitored by the PRP to do so in accordance with policies and procedures of the PRP [Part K, clause 2(1)(j)].

Also see SCPP's Drug Distribution by Prescription for a synopsis of federal and provincial prescription requirements.

Caution: There are unique risks and challenges associated with prescribing PRP-monitored drugs that warrants special consideration. Given the ongoing opioid crisis and deaths related to opioids and benzodiazepines, diligence is warranted when deciding to exercise prescribing authority under Part K.

[1] Controlled substance: A substance listed in Schedules I – V to the *Controlled Drugs and Substances Act* (CDSA). Includes narcotics (defined in NCR), controlled drugs (defined in FDR), and targeted substances (defined in BOTSR).

9. PRESCRIBING RESTRICTIONS (LEVEL I AND II)

Prohibition for Self, Family Members and Close Personal Relationships

SCPP Bylaws

Part K clause 2(1)(k): *A pharmacist must not prescribe for themselves, family members or for any person with whom they have a close personal relationship except in emergency circumstances or when another appropriate health care professional is not readily available.*

9.1. Similar to codes of conduct in place for other health professionals who have the authority to prescribe, pharmacists shall limit treatment of themselves, their immediate family, or anyone with whom they have a similarly close relationship to minor or emergency interventions **and** only when another appropriate health care professional is not readily available. As such, for the purposes of Part K clause 2(1)(k):

9.1.1. there should be no prescriptive authority fee for such treatment;

9.1.2. pharmacists should **not** prescribe for themselves or family members for controlled substances or any drugs that are addicting or habituating, even when another practitioner is in charge of managing the medication;

9.1.3. the decision of whether to provide treatment or not must be assessed based on the individual's clinical presentation and their ability to access care, rather than solely convenience for the individual;

9.1.4. pharmacists must **not** provide recurring episodic treatment for the same disease or condition, or provide ongoing management of a disease or condition; even where the disease or condition is minor;

9.1.5. care must be transferred to another pharmacist or practitioner as soon as it is practical or possible; and

9.1.6. all prescribing details, including the rationale and referral details as required by SCPP Bylaws subsection 5(11), must be documented as is required for all prescribing;

(See also section 11 Documentation and SCPP Bylaws emergency situations Part K subsections 5(8) to 5(11)).

Treating Family and Friends (Risks of Personal Relationships)

The SCPP recognizes that pharmacists often have personal relationships with many or all of the individuals seeking treatment (e.g. in rural or isolated communities). However, when emotionally involved, there is a chance that professional judgement may be compromised.

Sometimes it can be difficult for a pharmacist to evaluate whether there is a personal relationship with an individual or whether it will impact the quality of the care provided. Here are a few questions that may help pharmacists determine the nature of their relationship with individuals:

- Could the relationship impact acting in this individual's best interests?
- Could treating this person be difficult because it would be too uncomfortable to ask the questions or perform the assessments required to determine the proper treatment?
- Could this person feel uncomfortable providing truthful answers or undergoing the assessments that are necessary for the treatment decision?
- Would the pharmacist make assumptions based on their personal knowledge of the patient that could affect treatment?
- Would the relationship with this person make it difficult to maintain patient confidentiality or make a mandatory report?
- Would it be difficult to allow this person to make a personal healthcare decision that does not adhere to the professional advice given?

If the personal relationship between the pharmacist and the individual will not impact the quality of care provided, the pharmacist will be able to act as that individual's pharmacist.

Sources: Adapted from the Canadian Medical Protective Association, Know the rules, avoid the risks: Treating family and friends, February 2022 and the College of Physicians and Surgeons of Ontario, Physician Treatment of Self, Family Members or Others Close to Them, May 2018.

Prohibition for Animals

9.2. Pharmacists are not authorized to prescribe a drug for an animal, as per subsection 9.1(1) of *The Drug Schedules Regulations*.

Dispensing for Animals

Pharmacists are authorized to dispense a drug for an animal, as per subsection 2(u) of *The Pharmacy and Pharmacy Disciplines Act*)

10. EXEMPTIONS IN EXTRAORDINARY CIRCUMSTANCES

SCPP Bylaws

Part K Subsections

2(*3) If, in the opinion of the Registrar, extraordinary circumstances exist which demonstrate that it is in the public interest to do so, the Registrar may, according to the terms and conditions prescribed by Council, authorize licensed pharmacists to:*

(a) prescribe a supply of a drug which exceeds the amount in subsection 5(2) or subsection 5(5) without the express authority of a practitioner;

(b) prescribe a drug without complying with subsections 5(1), 5(4) or clause 5(9)(d);

(c) prescribe a drug without complying with clause 2(1)(c);

(d) prescribe a drug without complying with subsection 3(3); or

(e) make a therapeutic substitution for a drug without complying with the practice, training, and competency requirements for Level II Prescribing Authority.

***2**(4) The Registrar shall specify the limitations or restrictions on such authorization conferred pursuant to subsection 2(3).*

10.1. In extraordinary circumstances, the Registrar may waive or temporarily suspend specific requirements of prescribing authority. In these situations, the Registrar will notify pharmacists when these exemptions are in effect, and the conditions and limitations in place.

(See Emergency Exemptions for Prescribing Authority Policy).

11. DOCUMENTATION AND NOTIFICATION (LEVEL I AND II)

Information flow is critical to quality patient care. It ensures that healthcare decisions are based on the most accurate and up-to-date information, and maintains the CPE. Proper documentation ensures the information is available, and may move between the pharmacist and the patient, primary care provider, pharmacy team and other health providers as needed.

Key information used by members of the pharmacy team and other health providers, is documented in the pharmacist assessment records (PARs) as required in section 3 of Part K and the pharmacy's patient profile, as required in subsection 11(6) of Part J of the SCPP Bylaws for community pharmacies or as per the documentation, record keeping and notification requirements in public health care institutions, where applicable.

11.1. Regardless of the scope of practice being exercised, the SCPP/NAPRA Standards of Practice require all pharmacists to:

11.1.1. document in a timely and effective fashion, using recognized formats that are easily understood by pharmacy professionals and other health professionals, including:

11.1.1.1. decisions or recommendations and rationale;

11.1.1.2. interactions with, and care provided to patients;

11.1.1.3. interactions with other health professionals;

11.1.2. ensure that records are clear, accurate and legible;

11.1.3. ensure that records of care, actions, and decisions are documented in the patient record and indicate:

11.1.3.1. the pharmacy professionals involved;

11.1.3.2. the nature of the care, action or decision;

11.1.3.3. the evidence-informed rationale;

11.1.3.4. the time and date; and

11.1.3.5. the location, where appropriate.

11.1.4. ensure that all documentation is kept in a retrievable format and retained as outlined in Record Retention.

(See section 12 Other Documentation of this policy for more information on documentation in fulfillment of obligations under section 3.3 of *The Prescription Drugs Act*, which require all drugs prescribed or dispensed in Saskatchewan to be recorded in the Pharmaceutical Information Program (PIP).)

Pharmacist Assessment Record

SCPP Bylaws

"Pharmacist Assessment Record" means the **clinical record** completed, or caused to be completed, by one or more licensed pharmacists for the purpose of documenting the information described in subsection 3(2) of this Part K;

> Part K subsection 3(1): *A licensed pharmacist who prescribes a drug pursuant to the authority of these bylaws must record, or cause to be recorded, a record of such prescription in a Pharmacist Assessment Record and may request a licensed pharmacy technician to assist in recording only the drug distribution information required by subsection 3(2).*
>
> Part K subsection 3(2): *The Pharmacist Assessment Record for each drug prescribed under the authority of these bylaws must include:*
>
> *(a) the date of the prescription;*
>
> *(b) the name, address, birthdate, and provincial Health Services Number of the person for whose benefit the drug is given;*
>
> *(c) the proper name, common name or brand name of the prescribed drug, and the quantity thereof;*
>
> *(d) the drug's strength, where appropriate;*
>
> *(e) the dosage regimen;*
>
> *(f) the amount prescribed;*
>
> *(g) the assessment of the licensed pharmacist, including relevant patient information, any drug-related problems, action plans, and explicit instructions for patient usage of the drug;*
>
> *(h) the name of the prescribing licensed pharmacist; and*
>
> *(i) the rationale of the prescribing licensed pharmacist for the prescription, including reference to the current peer-reviewed evidence-based resources or clinical practice guidelines used, when required by this Part K.*

The PAR serves multiple functions. It is a clinical record. It is a clinical assessment tool to support the pharmacist's consultation with the patient. It is also a communication tool that allows other health professionals to understand the pharmacist's assessment, the evidence that informed it, the actions taken and the reasoning behind those actions.

11.2. The PAR should not simply duplicate information that is readily available in PIP;

11.3. **All prescribing** requires a PAR as per subsection 3(1) of Part K, which includes the pharmacist's assessment for the initial prescribing decision and the pharmacist's monitoring, follow-up and action plan thereafter;

(Note: See practice resource PAR – General for a sample template that may be used).

11.4. For the purposes of subsection 3(2) of Part K, pharmacist documentation in the PAR must also adhere to the following standards of practice:

11.4.1. The pharmacist must document the date, year, edition or version of the peer-reviewed evidence-based resource or clinical practice guideline used, when required by Part K to verify that it is current;

11.5. Some prescribing requires a specific PAR to be used.

11.5.1. Under Level I prescribing authority this includes:

11.5.1.1. minor ailments (subsection 10(1));

11.5.2. Under Level II prescribing authority (clause 12(6)(b)) this includes:

11.5.2.1. vaccine preventable diseases in Canada;

11.5.2.2. travel health A and B; and

11.5.2.3. other diseases identified by the Minister of Health (see Community Pharmacy Practice Enactments);

11.5.3. Under federal exemptions this includes:

11.5.3.1. methadone maintenance treatment extension PAR;

11.5.3.2. suboxone maintenance treatment extension PAR;

11.5.3.3. CDSA drugs maintenance treatment extension PAR; and

11.5.4. Under SCPP exemptions, as per subsection 2(4) of Part K, this includes:

11.5.4.1. therapeutic substitution in extraordinary circumstances PAR when enacted;

(Note: See Community Pharmacy Practice Enactments)

11.6. The PAR used when a pharmacist is prescribing under a collaborative practice agreement, as authorized under subclauses 12(7)(a)(i) or 12(7)(a)(ii) in a Public Health Care Institution, must not interfere with the pharmacist's ability to fulfill the requirements under section 3 of Part K (as per clause 12(7)(d) of Part K); and

11.7. Advanced prescribing B (chronic and other diseases approved by Council) requires medical record keeping in addition to the PAR as per section 18 of Part K. (Also see Record Retention for additional requirements).

Scope of Practice/Roles - Documenting in the PAR:

Neither **pharmacist interns (students/extended)** nor **pharmacy technician interns (students/extended)** are permitted, under s. 23 of *The Pharmacy and Pharmacy Disciplines Act*, to assist with filling in the PAR under the supervision of a pharmacist, regardless of whether it is drug distribution information or clinical information.

Notifying Prescribing Practitioners and Primary Practitioners

SCPP Bylaws

Part K subsection 3(3): *a licensed pharmacist who prescribes a drug under the authority of these bylaws, must provide, or cause to be provided, the Pharmacist Assessment Record associated with that prescription to the patient's* ***primary practitioner*** *and, where appropriate, other practitioners involved in the patient's care:*

(a) immediately, if in the judgment of the licensed pharmacist, the practitioner immediately requires the record to provide safe care to the patient; or

(b) as soon as reasonably possible, in all other cases.

See Level I Prescribing Authority documents in SCPP Reference Manual for exceptions to this rule.

11.8. The SCPP recognizes that the notification may not be the first contact with the patient's practitioner as some of the concerns will be communicated while the pharmacist is exercising their dispensing scope of practice upon receipt of a prescription (see Dispensing Standards);

11.9. Sending a PAR may satisfy the notification requirements in s. 3(3) of Part K, however, it may not satisfy the CPE requirements as per SCPP Bylaws and policies for Level I and II prescribing; (See section 3 of this policy for guidance on the appropriate level of communication to maintain a CPE.)

11.10. For the purposes of subsection 3(3) of Part K, if the patient does not have a primary care practitioner, the SCPP recommends that the pharmacist notify any practitioner whose care of the patient may be affected by their prescribing decision;

11.11. Depending on the clinical situation, the pharmacist may decide to communicate with more than one practitioner involved in the patient's care (e.g. when the **prescribing practitioner** is not the patient's **primary practitioner)**.

(Also see the additional notification requirements specific to each authorized prescribing practice (Level I and II).)

12. OTHER DOCUMENTATION (LEVEL I AND II)

Documentation in PIP as Required in *The Prescriptions Drugs Act*

Under section 3.3. of *The Prescription Drugs Act*, all drugs dispensed or prescribed in Saskatchewan must be recorded in a provincial database. In Saskatchewan the provincial database is called PIP.

When entering data into PIP, the name entered in the "prescriber field" will depend on what authorized scope of practice the pharmacist is using. For example:

- The practitioner's name is entered when the pharmacist is using their dispensing scope of practice.
- The pharmacist's name is entered when the pharmacist is exercising prescribing authority under Part K of the SCPP Bylaws.

See Level I Prescribing Authority documents and Dispensing Standards in the SCPP Reference Manual for clarity on what activities are dispensing versus prescribing and what additional information may need to be entered into PIP when adapting a practitioner's prescription.

See also, Appendix B – Creating Prescriptions in PIP Graphical User Interface (GUI)

12.1. The Drug Plan and Extended Benefits Branch (DPEPB) should be contacted for information regarding documentation for billing details.

Distinguishing Prescribing Authority from Compensation

Part K of the SCPP Bylaws specify the conditions, limitations, and restrictions for pharmacists' prescribing authority. However, it must be noted that this is different from the compensation they receive from the DPEBB for the Prescriptive Authority Fees negotiated by the Pharmacy Association of Saskatchewan. Pharmacists must ensure that they are following the prescribing requirements of the SCPP at all times.

For example, pharmacists may prescribe for Schedule 2, 3 or Unscheduled drugs meeting the same standards as for Schedule 1 drugs. However, the DPEBB will only provide the Prescriptive Authority Fee for prescribing activities as per relevant DPEBB policy.

13. CONFLICT OF INTEREST (LEVEL I AND II)

13.1. As per the Code of Ethics in Part H subsections 1(1) and 1(4) of the SCPP Bylaws, pharmacists and proprietors shall hold the health and safety of the public to be of first consideration and shall not engage in any practice which may compromise acceptable standards of the profession. Therefore:

13.1.1. when presented with a new prescription or refill request, a pharmacist must:

13.1.1.1. use their dispensing scope of practice first; and

13.1.1.2. follow through with their dispensing scope of practice until all the dispensing options have been reasonably exhausted; and

13.1.1.3. only exercise their prescribing authority after the dispensing options have been reasonably exhausted;

(See Dispensing Standards in SCPP Reference Manual).

13.1.2. decisions to prescribe shall be based on clinical suitability, cost effectiveness and the patient's best interest;

13.1.3. decisions to prescribe shall **not** be based on managing drug inventory in the pharmacy; and

13.1.4. prescribing decisions that provide financial advantage to the pharmacist and/or pharmacy, that do not provide clinical benefit to the patient, may be regarded as professional or proprietary misconduct, as per sections 25 and 26 of the PPDA. For example:

13.1.4.1. prescribing before exhausting all reasonable dispensing options to claim a prescriptive authority fee;

13.1.4.2. improperly categorizing prescribing authority claims as emergency supplies in favour of a higher fee (see SCOPe November 2011);

13.1.4.3. unwilling to prescribe refills on Minor Ailments (e.g. cold sores) so they can bill another prescriptive authority fee;

Proprietor Responsibility to Support Patient-Centred Care

As per section 65 of PPDA every proprietor shall comply with the Act and bylaws. Further, it is considered proprietary misconduct if a proprietor's conduct is:

- harmful to the best interests of the public or the members (subsection 26(a)),
- harms the standing of the profession (subsection 26(b)), or
- encourages a member to breach the PPDA, the regulations or the bylaws ((subsection 26(e)).

It is the expectation of the SCPP that all licenced members, pharmacies, and proprietors collaborate in the best interest of the patient and that proprietors will support members to fulfill the requirements of the bylaws, the standards of practice, and this policy.

Pharmacists must maintain professional autonomy in their decision-making regarding all prescribing decisions. Any business-related influence over decision-making regarding prescribing authority (e.g. corporate directives, prescribing quotas) may be proprietary misconduct.

See SCPP Reference Manual for additional clarity on conflict of interest situations in prescribing (e.g. extending prescriptions under Level I prescribing authority or prescribing therapeutic substitutions under Level II prescribing authority).

14. SPECIAL CONSIDERATIONS (LEVEL I AND II)

Out-of-Province Residents (Present in Saskatchewan)

14.1. Pharmacists may prescribe for out-of-province residents as the CPE is deemed to exist.

14.2. Pharmacists must prescribe following the same standards required for Saskatchewan residents, as outlined in SCPP policies for prescribing, including:

14.2.1. prescribe in the best interest of the patient,

14.2.2. communicate decisions with the practitioner, and

14.2.3. refer the patient when appropriate.

14.3. As the resident's information will not be in PIP, the pharmacist must perform a reasonable inquiry into the patient's medication history before prescribing. This could include interviewing the patient or obtaining their history from their usual pharmacy;

14.4. The pharmacist must still complete a PAR and provide it to the patient's primary practitioner.

Out-of-Country Residents (Present in Saskatchewan)

14.5. Pharmacists may prescribe for minor ailments as there is an exemption in the bylaws that a relationship between the patient and a practitioner does not need to exist before the pharmacist is authorized to prescribe. Minor ailments prescribing is an independent assessment by the pharmacist which must be done in accordance with Council-approved medSask guidelines. For these reasons, the existence of a CPE is not as stringent.

14.6. Pharmacists may not prescribe for other Level I authorized practices (e.g. interim supply, emergency supply, unable to access medications) as there is no existence of a CPE as prescribers from other countries are not recognized by *The Drug Schedules Regulations*. Pharmacists should refer the patient when appropriate.

Using Professional Judgement in an Emergency Situation

In an emergency situation (e.g. someone is having an obvious asthma attack or a diabetic emergency) and another health professional is not readily available, the SCPP recognizes the pharmacist will use their professional judgement to address the situation in the best interest of the individual. In emergency situations, all details, including the pharmacist's decision and rationale must be documented.

REQUIREMENTS SPECIFIC TO LEVEL I PRESCRIBING

15. COLLABORATIVE PRACTICE ENVIRONMENT (LEVEL I ONLY)

15.1. Subsections 4(4) and 4(5) of Part K do not apply when the pharmacist is prescribing pursuant to subsection 5(8) emergency situations, 10(1) minor ailments, 11(1) administrative prescribing, as these do not require an active professional relationship between the patient and the practitioner. (See text box Patient-Practitioner Relationship and Exceptions.)

SCPP Bylaws – Collaborative Practice Environment (Level I Only)

Part K section **4**:

(4) A licensed pharmacist may only exercise Level I Prescribing Authority with respect to an individual patient if a Collaborative Practice Environment exists between the licensed pharmacist and a practitioner who is responsible for the care of the individual patient.

(5) For the purposes of subsection 4(4), a Collaborative Practice Environment does not exist between a licensed pharmacist and a practitioner when:

(a) the practitioner has communicated to the licensed pharmacist in writing that no Collaborative Practice Environment exists, the nature of the concerns, and the individual patient or class of patients impacted; and

(b) the practitioner confirms that the patient or class of patients have been informed of the concerns with the pharmacist's prescribing and the potential impact on patient care.

(6) A Collaborative Practice Environment is presumed to exist with a Public Health Care Institution, in any circumstance where the patient care functions or drug therapy management services performed in, or through a Public Health Care Institution, are in accordance with the Collaborative Practice Agreement.

15.2. In keeping with the SCPP/NAPRA Standards of Practice, pharmacists are:

15.2.1. encouraged to seek the involvement of the patient, the practitioner and other health professional as appropriate, to address concerns when it would improve the quality and safety of care (Standard 1.2.3); and

15.2.2. expected to demonstrate sensitivity, respect, empathy and inclusion as they work in partnership with patients and other health professionals, in all situations, including those in which the practitioner no longer wishes to work in a CPE with the pharmacist, pharmacy team or pharmacy (Standards 3.2 and 3.3).

(Also see SCPP/NARPA Standards of Practice for Continuous Quality Improvement and Medication Incident Reporting by Pharmacy Professionals).

What to do when Presented with a Prescription Issued by a Practitioner who has Notified the Pharmacist that a CPE Does Not Exist

The SCPP encourages all pharmacists and/or pharmacy managers, to contact the practitioner if they receive a notification under subsection 4(5) of the SCPP bylaws, to discuss the concerns and plans to avoid interruptions to the patient's drug therapy.

When presented with any prescription, the first course of action is to fulfil the regular steps for dispensing. This includes:

1. Accepting the prescription (includes verifying validity);
2. Assessing the appropriateness of the prescription;
3. Collaborating with the practitioner as needed (e.g. verify treatment options or issues with prescription);
4. Preparing the medication;
5. Releasing the medication to patient (includes counselling and informed consent), and
6. Monitoring and follow up, as required

See Dispensing Standards in SCPP Reference Manual.

The pharmacist must only consider using their Level I prescribing authority when the practitioner is not available and the alternatives presented by the practitioner do not provide the patient with reasonable access to needed medications (e.g. 24-hour coverage as per CPSS Standards for Primary Care).

Assessing Whether the CPE Exists

15.3. If all the criteria listed in subsection 4(5) of Part K have not been satisfied, then the pharmacist is not precluded from exercising their Level 1 prescribing authority as permitted within Part K.

15.4. To determine whether the criteria in subsections 4(5) of Part K have been satisfied the pharmacist must consider:

15.4.1. Whether the information is clear and specific enough for the pharmacist to identify the nature of the concerns and the patients being impacted;

15.4.2. Whether the concerns have been communicated by the practitioner to the patient and are consistent with those communicated to the pharmacist; and

15.4.3. Whether the patient has been informed of the impacts on their access to pharmacy services (e.g. no access to their chronic medications when the prescription has run out until they see a practitioner).

15.5. If the pharmacist determines that the criteria have not been met and they proceed to exercise their Level I prescribing authority, the SCPP would not consider the pharmacist to have breached subsection 4(4) of the Part K.

Informing Patient

15.6. In recognition of the patient's right to be informed when a practitioner has indicated their desire to remove a CPE, (regardless of whether it satisfies the criteria), the pharmacist must inform the patient that their practitioner does not support the pharmacist prescribing for the patient.

(Also see section 7 for additional Informed Consent requirements).

Next Steps when Pharmacist Authorized to Prescribe

15.7. Once the patient has been informed of the practitioner's communication, as per 15.6 above, and has consented to the pharmacist prescribing, the pharmacist may prescribe so long as it is done in accordance with the SCPP bylaws and policies as authorized in Part K.

15.8. The pharmacist must document the prescribing decision in the patient's pharmacy profile as per section 11 of this policy, including:

15.8.1. the information used to determine whether the criteria in subsection 4(5) have been met; and

15.8.2. the pharmacist's full rationale for the prescribing decision.

15.9. The pharmacist must notify the patient's practitioner as per section 11 of this policy;

Next Steps when Pharmacist not Authorized to Prescribe

15.10. If the pharmacist is not authorized to exercise their Level I prescribing authority pursuant to subsection 4(5), then the pharmacist must refer the patient to the alternatives presented by the practitioner, or if needed:

15.10.1. alternate appropriate members of the health team as they would for other medication therapy problems;

15.11. The pharmacist must document the decision in the patient's pharmacy profile as per section 11 of this policy, including the rationale for their actions.

(Also see text box "When a Pharmacist is Permitted to Prescribe but Decides Not To" section 2 above.)

REQUIREMENTS SPECIFIC TO LEVEL II PRESCRIBING

Shifting Roles and Responsibilities with Advanced Prescribing (Level II)

Level II prescribing authority is intended for some pharmacists with advanced knowledge **and** practice skills who are able to maintain advanced partnerships with other health professionals, to ensure appropriate and safe patient care.

Advanced Knowledge and Practice Skills

Even though some of the authorized activities under Level II prescribing authority appear similar to activities performed by pharmacists on a daily basis, they are not considered entry-to-practice competencies. Advanced prescribing requires a mind shift from a passive role (e.g. *recommending drugs*), to an active role (e.g. *selecting and initiating drugs*), and in some advanced prescribing a pro-active role (e.g. *developing treatments plans, monitoring and initiating follow up*).

Advanced prescribing comes with elevated responsibility and standards of practice beyond what is required for common roles assumed by pharmacists, as each authorized activity under Level II has nuances and varying degrees of risk. In addition to the requirements in this document, also see the SCPP Bylaws Part K and reference documents including:

- Collaborative Practice Agreements – Framework for Developing Safe and Functional CPA and Template
- Other diseases identified by the Minister of Health – Community Pharmacy Practice Enactments
- Vaccine preventable diseases and travel health – Disease Prevention and Travel Health Services Policy and Framework
- Advanced Prescribing A – Therapeutic Substitutions (TBD)
- Advanced Prescribing B – Initiating Drugs when Practitioner Diagnosis is Provided (TBD)

Advanced Partnerships

Level II prescribing also requires the pharmacist to move from a prescriptive and reactive type of communication (e.g. sending the PAR as required by the bylaws) to the expectation of **proactive** collaboration (e.g. maintaining contacts with physicians and other health system partners to quickly obtain information required; identifying issues in advance and developing a system to address).

16. PROFESSIONAL ACCOUNTABILITY (LEVEL II ONLY)

SCPP Bylaws – Practice Requirements (Level II)

Part K subsection 12(5):

(5) With the exception of licensed pharmacists who are prescribing according to a Collaborative Practice Agreement in a Public Health Care Institution pursuant to clause 12(1)(a), a licensed pharmacist who exercises Level II Prescribing Authority must be competent in and use current peer-reviewed evidence-based resources or clinical practice guidelines pertaining to the condition being treated to determine appropriate drug choice.

16.1. In addition to the requirements in subsection 12(5) of Part K, the SCPP/NAPRA Standards of Practice required in section 2 above, and any additional professional accountability requirements for the specialty area, pharmacists exercising advanced prescribing must:

16.1.1. use current peer-reviewed evidence-based resources or clinical practice guidelines to identify appropriate monitoring and actions to manage drug treatment according to the specific disease state;

16.1.2. accurately and efficiently identify multiple, complex drug related problems based on extensive knowledge and experience;

16.1.3. immediately recognize and confirm drug related problems based on extensive knowledge and experience and is able to explain the therapeutics, pharmacology and pathophysiology underlying the drug related problem; and

16.1.4. immediately know appropriate therapeutic recommendations based on extensive knowledge and experience and is able to explain the therapeutics, pharmacology and pathophysiology underlying the drug related problem to justify the recommendation;

17. COLLABORATIVE PRACTICE ENVIRONMENT (LEVEL II ONLY)

SCPP Bylaws – Collaborative Practice Environment (Level II Only)

Part K subsection 1(b): *"Collaborative practice environment" means a deliberate and committed professional approach to communication, decision-making, and shared knowledge and skills that health care providers can reasonably rely upon to provide safe patient care, including the referral to practitioners(s) or other health care providers as appropriate*.

12(6) A licensed pharmacist who exercises Level II Prescribing Authority for one or more of the specialty areas listed in clause 12(1)(b) shall:

(a) ensure collaboration with the health care system as required by Council;

(b) adhere to the policies for Level II Prescribing as approved by Council; and

(c) successfully complete any additional training and meet competency standards as required by Council.

17.1. It is recognized the collaborative practice environments may vary for Level II Prescribing Authority depending on the specialty area. However, the following practices demonstrate advanced collaboration expectations with the health care system established in subsection 12(6):

Proactive Work with Other Health Care Professionals and Community Supports

17.1.1. Maintain professional contacts and relationships with a variety of health care providers and service providers available within the community, including those whose care is impacted by the pharmacist prescribing;

17.1.2. Take reasonable steps to determine which other health professionals the patient is consulting;

17.1.3. Proactively communicate with the patient's other health professionals to share relevant health information and determine mutual goals of therapy that are acceptable to the patient;

17.1.4. Establish the expectations of each regulated health professional when working with a mutual patient. For example:

17.1.4.1. If monitoring with laboratory tests is required, the pharmacist works in partnership with the other health professional to determine who is responsible for ordering laboratory tests. (See Laboratory Tests and Medical Devices – Accessing, Ordering, Performing, Using or Interpreting); and

17.1.5. Communicate to health professionals whose care of the patient may be affected by the prescribing decision;

Facilitate Quality Referrals

17.1.6. Develop and routinely utilize referral systems;

17.1.7. Routinely refer patients to appropriate health organizations and health care professionals within the community, including complementary and alternative health care providers, where applicable; and

17.1.8. Routinely write referral notes for patients to take with them to their health care provider to facilitate quality collaborative care (e.g. see Saskatchewan Quality Consult/Referral Pocket Checklist).

17.2. The pharmacist must follow the collaboration requirements as outlined in the SCPP bylaws and policies specific to the Level II specialty area;

18. PROFESSIONAL RELATIONSHIP (LEVEL II ONLY)

18.1. For the purposes of clause 2(1)(b) of Part K, depending on the prescribing exercised under Level II prescribing authority, a professional relationship means that, where applicable, the pharmacist who provides the service is responsible for:

18.1.1. the patient from the initial point of contact until the medical issue has been resolved, or

18.1.2. the patient has access to a practitioner who is authorized to provide continuing care.

Appendix A – Overview of Saskatchewan Prescribing Authority Framework

Overview – Part K Prescribing Authority

Level I (All Pharmacists)

STRUCTURED (ALGORITHM / PROTCOL):

- Minor Ailment
- Administrative Prescribing of a Schedule II, III or Unscheduled drug (SCPP / MOH directed)

PRACTITIONER-INITIATED:

Continuing Prescriptions[1]

- Interim supply of chronic, stabilized drug (up to 3 months)
- Emergency situations - life threatening or interruption in drug therapy will result in imminent harm (max of 6 months when combined with interim supply)
- Drug reconciliation (admission or discharge from a hospital or other care setting)

Adapting Prescriptions

- Insufficient Information (medically necessary)
- Increasing suitability of drug (adjusting dosage form)[2]

Altering Prescriptions[2]

- Enhancing safety and drug effectiveness to address imminent harm, obvious error, antibiotic & opioid stewardship (altering dose or regimen)

PHARMACIST-INITIATED:

- Administrative Prescribing of a Schedule II, III or Unscheduled drug (initiate Rx for self-limiting conditions to obtain private or public coverage as permitted by the payer)

Level II (Some pharmacists with advanced skills and advanced partnerships)

STRUCTURED (ALGORITHM / PROTOCOL):

- Collaborative Practice Agreements (Public Institutions & Community)
- Other Diseases Identified by Minister of Health or Designate (SCPP / MOH directed e.g. Paxlovid)

PRACTITIONER-INITIATED:

- Advanced Prescribing A (Therapeutic Substitution sharing "mechanism of action" or "chemical structure")

PHARMACIST-INITIATED[3]**:**

- Vaccine Preventable Diseases in Canada
- Travel Health A
- Travel Health B
- Advanced Prescribing B (chronic & other diseases Council-approved)

Exemption(s) for Extraordinary Circumstances (at the call of the Registrar)

- Tailored to address the needs of the specific extraordinary circumstance at the time it is enacted.
- According to the terms and conditions communicated by SCPP.

Notes:

- General requirements apply to all prescribing (Level I and II).
- Collaborative practice environments are foundational to all prescribing, however the requirements may differ between Level I and each Level II specialty (advanced partnerships).
- Use of current peer-reviewed evidence-based resources or clinical practice guidelines is mandatory when required by Part K (i.e. Level I section 8 enhancing safety and drug effectiveness; and all Level II, except for those prescribing under a public institution CPA).

[1] Permitted for controlled substances in accordance with Health Canada's Section 56 exemption and SCPP Communication

[2] Permitted for controlled substances in accordance with Health Canada's Prescription Management

[3] **Not** permitted to **initiate** controlled substances under the *CDSA* and its *Regulations*

APPENDIX B – Creating Prescriptions in PIP - Graphical User Interface (GUI)

PIP data entry allows pharmacists and other health professionals viewing PIP or the eHR Viewer to easily recognize when the original prescription has been issued by the practitioner or the pharmacist.

Most pharmacists will generate the prescription in the pharmacy or public institution's vendor software. However, as per training to use the PIP GUI to create a Rx, the following information should be entered into the *SIG Instructions* free form field (**similar to "instructions to the pharmacist**"). (see here for PIP GUI training)

Notes:

- *SIG Instructions* when prescribing in the PIP GUI ≠ instructions to the patient on the dispensed label**.**
- When creating the prescription in the PIP GUI, the pharmacist's name is automatically generated as the prescriber, as is required when exercising prescribing authority under the SCPP Regulatory Bylaws Part K. Different steps may be required when using vendor software.

Standard Entry*	**Part K Reference**
Interim supply	ss. 5(1) and 5(4)
Emergency situation	subsection 5(8)
Insufficient information	subsection 6(1)
Adjusting dosage form	subsection 7(1)
Minor ailment	subsection 10(1)
Drug reconciliation	subsection 9(1)
Altering for safety/efficacy	subsection 8(1)
Administrative – private or public coverage	subsection 11(1)(a)
Administrative – MOH/SCPP	subsection 11(1)(b)
* The PIP training video recommends a different Standard Entry, however the list included above reflects the current SCPP Regulatory Bylaws.	

Including the Indication on the Prescription

As one strategy to mitigate harm and prevent medication errors, prescribers are encouraged to **include the indication on the prescription**[1]. This may be done by:

- Selecting the indication from the PIP GUI drop-down meu when creating the prescription in the PIP GUI, or
- Using the steps as described in the vendor software training.

[1] Source: ISMP Medication Safety Agenda August 2023.