Part K Prescribing Drugs (Level I) - Frequently Asked Questions

Disclaimer: The SCPP responses below have been provided in response to the situation described by the member and may not be relevant in all circumstances. It is intended for use to support your professional judgment in decision making.

The SCPP response is not to be construed as legal advice. Should you require legal advice, we would encourage you to seek independent legal counsel.

Notes:

- The SCPP cannot tell a member what course of action to take or make any decisions on their behalf; and
- obtaining SCPP advice on professional issues does not absolve you from personal accountability for your actions as a licensed pharmacist.

Note: Questions with an * were submitted at the February 13, 2024 Live Q-and-A session

1) BILLING

	Submitted Questions – Interim supply billing	SCPP Response
1.1	If I provide more than 1 month of an interim supply do I enter it as refills? (See #4) And can I then bill a fee every fill?	Prescribing 1 month with 2 refills is permitted (see #4) and does not constitute BTB prescribing (see #5). SCPP has been advised by the DPEBB that all policies and billing processes for currently available prescribing authority services remain status quo at this time. The DPEBB will communicate directly with pharmacies should there be any updates to the policies and processes in the future.
1.2	Is the College now expecting us to do multiple months for one dispensing fee? As back to back prescribing not allowed	See 1.1 for questions on fees and billing.
1.3	When you say x 3 months interim and not back to back pharmacist can it be under our contract 1 month at a time? Need clarification.	

1.4	How can we interim 3x34 days when we cannot do BTB prescribing - expect refills? (See #4) Cannot bill fee?	
1.5	For interim supply of pharmacist prescribed for 34 days and billed interim fee. Can another pharmacist give 2nd interim (No, see #5) & bill?	
1.6	Interim Supply - -I know we can do a 34 day supply up to three times, but the "back to back" restriction has me slightly confused. (See #5) We can still bill for the service fee for interim supply with each of those three fills, yes?	
1.7	Interim supplies – I understand that 3 months total is allowed but we cannot have back-to-back pharmacist prescribers. Does this mean I could provide an interim supply for 1 month with 2 refills (for a monthly drug)? (Yes, see #4) Can we only bill one fee for a 3 month supply?	
1.8	Is compensation for interim supplies going to change now that we are doing 3 months at a time? (Interim supply prescription of 1 month with 2 refills is one prescribing event. See 1.1 above)	
1.9	For Unable to access medications - Can we only Rx until they can access? IE their pharmacy is closed. (See Part K Bylaws s.5(4) and 5(5)(a) must limit the quantity to the amount necessary to meet reasonable needs of patient) Full fee for 2 days?	
1.10	Interim supply: For pharmacists prescribing 3 months interim supply does it have to be 3 months all at once for one dispensing fee or are pharmacists able to prescribe 3 consecutive months ie) 34 days supply 3 months in a row or 1 month with 2 refills? (See #3, #4 and #5) Does a pharmacist get paid an interim supply fee for each month prescribed or 1 fee for 3 months?	Dispensing fee billing ≠ Prescriptive Authority Fee (PAF) Also, the billing does not determine the scope of practice used. See 1.1.
1.11	Can you please clarify the up to 3 months interim supply but can't be back to back pharmacist prescribing unless it is an emergency supply following interim supply. Does this mean that I can prescribe an interim supply of 1 month with 2 refills for a total of 3 months (Yes, see #4) and dispense one at a time with a dispensing fee each time (but can only bill the interim supply fee to SPDP once) or does it mean that I have to prescribe and fill 3 months at once for one dispensing fee and one interim supply fee?	See 1.1. Notes: Dispensing fee billing ≠ PAF Dispensing scope of practice ≠ Prescribing scope of practice

	Submitted Questions – Administrative prescribing billing	SCPP Response
1.12	Under admin prescribing can pharmacist prescribe schedule 2 and 3 and unscheduled to plan 2 and plan 3 SPDP coverages?	Drug coverage benefits will be subject to a patient's private or public coverage program. Pharmacists should work with patients to confirm their individual eligibility for coverage. (See Policy 2.3 Level I – Pharmacist-initiated Public and private drug coverage benefits are not determined by changes to scope of practice.
1.13	A patient who is covered by SPDP for vitamins or other OTC products can now be billed through as administrative prescribing?	See 1.12
1.14	Admin Prescribing - We have always been able to prescribe OTCs and schedule II medications for NIHB patients for coverage purposes, but were limited to diabetic supplies for SPDP patients (see attached SCOPE from Dec/21) and nothing for private insurance. (See also #34.1.) Does this update mean we can prescribe all OTCs and schedule IIs (when appropriate) and bill to any insurance (private or government) without clawback? Whether or not they will cover it is individual, but if they do (based on DIN, personal coverage [SAIL, Palliative, Plan1/2 etc.], private insurance formulary etc.) there is no chance for claw back with a pharmacist being the prescriber?	
1.15	Level 1 admin prescribing for Schedule 2 and 3 products only specifies for 3rd party coverage. Does this apply for SPDP coverage (ex. Plan 1)? For example, patient with plan 1 coverage requires lice product-are we able to prescribe and bill to SPDP?	
1.16	I would like further clarification about administrative prescribing of Schedule II, III and Unscheduled medications. The bylaws appendix examples state that pharmacists can prescribe in cases where patients cannot afford lice treatment but would be covered by their plan. Does this apply to patients under Social Services (Plan 1, 2, or 3)? In previous years, it was stated that if a medication can be purchased without a prescription, then a pharmacist cannot prescribe for	

	the sole purpose of getting covered through SPDP. Please confirm what the regulations are.	
1.17	Can we do administrative prescribing also for coverage through SPDP? In the SCOPE Dec.2021 it says we can prescribe certain medical supplies and bill to SPDP. Does the new administrative prescribing allow us to prescribe a) other medical supplies like ostomy supplies to bill to SPDP, or b) OTCs for Plan 3 patients to bill to SPDP	
1.18	Administrative Prescribing – Does this apply to initiating a prescription for OTC meds for patients with SK health coverage, NIHB coverage, and/or private insurance?	
1.19	Could the DPEBB be more forth coming about what can be billed in regards to the prescribing authority of pharmacist. Under 11 (1) (b), " to support drug formulary management initiatives of the Ministry of Health" doesn't say much of anything. (This prescribing activity is enacted by the Registrar and Ministry of Health when needed. Billing would be determined when the formulary management initiative is enacted. See section 3 of Level I Prescribing Authority (Structured).) I appreciate the example of prescribing for lice treatment. I assume that means I can bill through to plan C then? What about epi-pens or nitro sprays. I know some pharmacist who put their names on incontinence supplies for SAIL, is that okay? (see 1.12 above)	
1.20	Admin prescribing - initiating a prescription for non-Rx meds to get insurance coverage: Many insurance companies do not recognize pharmacists as prescribers and will claw back any money paid on such prescriptions. How are we supposed to know how and when we can do this to obtain 3rd party coverage without contacting each individual insurer?	The SCPP does not provide advice on operational processes in the pharmacy. See Policy 2.3 Level I – Pharmacist-initiated. PAS members may have access to tools which may assist with this question.
1.21*	Please verify if Schedule II & III prescribing is only for Third Party coverage (Private Coverage), not SPDP.	See #18.9 below

	Submitted Questions – Emergency supply billing	**SCPP Response**
1.22	There was an example where a 1 month interim supply was provided followed by a 5 month emergency supply. In this situation, do you bill 1 fee for your 5 month emergency supply and fill each month as required (ie. you can't dispense 5 months in one fill)? (Yes, bill once if the prescription is for a 5-month supply.)	SCPP has been advised by the DPEBB that all policies and billing processes for currently available prescribing authority services remain status quo at this time. The DPEBB will communicate directly with

		pharmacies should there be any updates to the policies and processes in the future. Dispensing question - see #3
1.23	Please explain the 6 month max when a drug was dispensed for 1 month under interim supply, 5 months/1 emergency fee?	See 1.22
1.24*	so it appears emergency supplies have been changed...used to be this could only be done under exceptional circumstances, such as venturing for a wheezing patient. now we are allowed to bill maintenance drugs as emergency supplies due to physician shortages?	See 1.22 and #8 (Emergency supply) below Emergency supplies addresses many patient situations (e.g. see Prescribing Authority Tools for Patient Situations and Bylaw Examples).
1.25*	Are we still able to receive only a single $10 emergency supply fee every 28 days, no matter how many drugs we need to write/dispense as an 'emergency prescribe'	See 1.22
1.26*	The question about only ONE emergency fee per month was not actually answered...what if the patient requires a few different meds? Will this change?	See 1.22 The SCPP has no authority to answer billing questions.

	Submitted Questions – other billing*	**SCPP Response**
1.27*	I have one question about billing (Sorry) - for "Altering for efficacy" is there a billable fee? If so which fee should we be using??	Altering for efficacy is a new professional service. Contact Pharmacy Association of Saskatchewan regarding compensation for new pharmacy professional services related to expanded scope of practice. Also see #1.22 above
1.28*	So to clarify…we only get paid a prescribing fee for EACH PRESCRIBING EVENT…regardless of the duration of prescription authorized.	This is status quo. SCPP has been advised by the DPEBB that all policies and billing processes for currently available prescribing authority services remain status quo at this time.
1.29*	Why would we prescribe for more than one month and get paid only one interim fee? Isn't the point to be a bridge for the patient to make an appointment with	See Part K Bylaws section 5 for the purpose. Also see

	their Dr? If the Dr wanted more than whatever they prescribed… why wouldn't they write for more?	#10 below – Professional Judgement
1.30*	Consider the following and what you can do: -You prescribe 1 month for a pt, as they are expected to go in to see their doctor. -The month passes and for whatever reason they are unable to see their doctor now for another month -Pharmacist has only prescribed 1 month, and now they cant do another month interim. Or can they dispense and prescribe another month - but just NOT bill the interim fee? No. You are not authorized to dispense unless there is a valid Rx. Also consider whether it meets the criteria of Emergency Prescribing.	Also see #5.2 and #7 below.
1.31*	I may have missed it, but could you explain the difference between the Emergency Supply fee and the Unable to Access fee and when we should use each of these? (separate from interim supply fees)	The SCPP has no authority to answer billing questions. See #1.22 above. See Prescribing Authority – General Provisions text box on Distinguishing Prescribing Authority from Compensation
1.32*	When we check discharge prescriptions and found out one of the chronic medications has been missing during the hospital stay (due to entering omission) and a community pharmacist has been contacting a hospital pharmacist and physician and ended up restarting the chronic medication- the proper billing is Seamless Care fee (1.5 times of dispensing fee?) ? Not Drug Reconciliation because the physician is prescribing again?	See #1.22 above
1.33*	It seems this is just about Drug plan saving money , us being able to do more or same amount of work, yet can only bill for less?	Compensation for prescribing authority is negotiated by the Pharmacy Association of Saskatchewan (PAS). Questions regarding funding of new pharmacy professional services related to the expanded scope of practice for Saskatchewan pharmacists should be directed to PAS. See also #18.9 below.

2) COMPENSATION

	Submitted Questions	SCPP Response
2.1	When can we expect reimbursement for prescribing activities/authorities that do not yet have it in place?	Compensation for prescribing authority is negotiated by the Pharmacy Association of Saskatchewan (PAS). Questions regarding funding of new pharmacy professional services related to the expanded scope of practice for Saskatchewan pharmacists should be directed to PAS.
2.2	Why is there a limit on being able to provide int.supply and chg a fee i should be compensated for my work i am responsible for.	
2.3	I'm concerned about the lack of remuneration for many of the new prescribing abilities that pharmacists now have. It appears that in order to give more than one interim, we are expected to put refills on such interim and only get one fee. It also appears that there is no remuneration for administrative prescribing for insurance purposes or for antimicrobial stewardship, despite the time and effort that these services will require. I have brought these issues to PAS, but I also feel that SCPP should be aware.	
2.4	Is there going to be a summary of the compensation model/safety features for the extra workload being put on pharmacists with the new prescribing authority? I'm sure other pharmacists have expressed this concern. We are already at maximum workload with all compensation being paid to companies/business owners. Pharmacists are being expected to add these duties into the workflow with no extra compensation but certainly extra liability and increased risk of errors due to lack of time and staff. I appreciate our profession advancing and am encouraged by it but, the way it is being implemented is potentially dangerous to patients. Whether it's admitted or not, **big companies have quotas set for these extra services.** The current model is very susceptible to having pharmacists being pressured to provide services they are not comfortable with and/or don't have time to do safely. I would suggest a pause on this initiative until we can negotiate individual pharmacist compensation (as the liability falls on the individual pharmacist) and mandatory appointment based format. To be frank pharmacists are burnt out and many are considering leaving the profession.	Contact PAS for more information on compensation models for pharmacists and pharmacies. Also see 2.1 to 2.3 above. Proprietors have responsibility to support safe patient care under *The Pharmacy and Pharmacy Disciplines Act* (e.g. see "Proprietor Responsibility to Support Patient-Centred Care" text box in General Provisions for Prescribing Authority. The SCPP is also working to address inappropriate business influence over pharmacy practice as part of its Strategic Plan (e.g. conflict of interest policies).
2.5 *	When can we expect new billing codes for these new authorities?	See SCPP response for #2.1.

2.6	Regarding a pharmacist in a CPA with physicians, is there currently a standard for billing procedures set by the SCPP or are financial responsibilities at the liberty of the physician, pharmacist, and patient within the CPA? Do Pharmacists have the potential to bill for Pharmacist assessment fees with every new Prescription or change in current Therapy?	No. The SCPP does not set standards for billing procedures or financial responsibilities of physicians, pharmacists, and patients for prescribing, including that which occurs within CPA between physicians and pharmacists. CPAs are an agreement between health professionals to deliver professional services. Framework for Developing a Safe and Functional Collaborative Practice Agreement includes some guidance that may help you develop a compensation plan. The SCPP is not aware of any ongoing "public funding" for these models of service delivery. However, the Pharmacy Association of Saskatchewan may have information on such initiatives.

3) DISPENSING

	Submitted Questions	SCPP Response
3.1	When prescribing interim supplies, can we prescribe 3 months, but dispense 1 month at a time (prescribe 90, dispense 30/month)?	Prescribing ≠ Dispensing It is the *Prescribing pharmacist* who determines the quantity on the prescription based on their clinical assessment of the patient and the conditions and limitations outlined in Part K of the Bylaws. Whereas, it is the *dispensing pharmacist* who will determine

		how that quantity on the Rx is to dispensed to the patient. See #25 below for Impacts of DPEBB policies that impact prescribing.
3.2	Is it acceptable to prescribe a 3 month to interim supply but dispense this monthly?	See answer to 3.1
3.3	Can we prescribe for 3 months and dispense monthly? i.e. 1 month with 2 refills? (see #4)	
3.4	For interim supplies does the entire 3 month supply need to be dispensed at once or can we prescribe a 34 days with refills? (see #4)	
3.5	For blister pack patients, Can we do an interim supply of 3 months but fill it in three 28 day intervals?	
3.6	With 3 months interim/ 3months emergency limit, must we dispense all 3 months at once, or can we issue 1 month with 2 refills? (see #4)	
3.7	Clarification on BTB for interim (see #5) re: allowed 3 months but multiple dispenses? Or 3 months at once?	
3.8	For interim of 3 months - do we dispense 1 month and provide 2 refills?	
3.9	If a three month interim supply is provided for 3 months, is that dispensed as the full three months or as 1 fill and 2 refills?	
3.10	Can you provide three one month interim supplies in a row (no, see #5) or do you have prescribe 3 months in one fill even for antidepressants	
3.11	Can interim and emergency supplies be dispensed in parts (like part fills with a total quantity) because of quantity limits?	
3.12	Interim Supply (see #4) – if prescribing for 3 months, can these be filled as one month with 2 refills?	
3.13	Interim and Emergency Supply Interplay – scenario #2. If an interim supply is only prescribed for 1 month, after the 1 month a pharmacist can prescribe in an emergency situation. To reach the six month maximum, the pharmacist could prescribe for 5 months. (Yes, interim and emergency correctly understood.) Would the expectation that this be dispensed all at once, or provide 1 month supply with 4 refills?	
3.14	Where does changing from Pantoprazole sodium to magnesium fall if the prescriber inadvertently writes the wrong one?	**Dispensing scope** of practice. These 2 products are not interchangeable. SK standard is to *communicate with prescriber when required to verify the Rx*

		for accuracy and clarify any uncertainties in the Rx. (See Standards of Practice for Saskatchewan Pharmacists) Also, consistent with the Drug Plan's Maximum Allowable Cost (MAC) Policy, changing from pantoprazole sodium to pantointernprazole magnesium needs a prescription from the prescriber. Will constitute Advanced Prescribing A- Therapeutic Substitution (when enacted).
3.15*	When doctors continue to write prescriptions for the wrong Ozempic pen strength or incorrect pantoprazole salt (magnesium or sodium) - if the pharmacist corrects this, is it a case of increasing suitability?	No. See #3.14 for incorrect Pantoprazole. Wrong pen strength – use dispensing function to determine the appropriate Ozempic pen to be dispensed. See Standards of Practice for Saskatchewan Pharmacists.
3.16*	Where does filling additional liquid antibiotic for a child to finish a course fall for example 1 bottle should have been enough but parents request more due to waste	Dispensing scope of practice provides options to deal with this scenario, so that the patient receives the entire course of treatment. Use professional judgment to determine the proper quantity.
3.17*	If a kid barfs/spills their abx can we replace as emergency supply?	No. See #3.16
3.18	One of the questions in the Q&A someone asked how to handle the situation when an antibiotic suspension was spilled and how to replace it for the patient to finish treatment-wouldn't that be unable to access prescribing?	No. See #3.16

4) INTERIM SUPPLY - QUANTITY LIMITS

	Submitted Questions	SCPP Response
4.1	I have a feeling you're going to get this a lot! For an interim supply, can you prescribe 1 months with 2 refills? Thank-you!	Yes. Wording in the Policy has been revised for clarity: *For the purposes of subsection 5(2) and 5(5)(a), the total duration of pharmacist prescribing is limited to three months, such as:* • *a 34-day supply, with two refills;* • *a 3-month supply, with zero refills.* See Policy 2.3. Level I Prescribing Authority Practitioner-initiated
4.2	In order to avoid back to back pharmacist prescribing but still provide 3 months can we do 1 month with 2 refills?	See answer #4.1 and #5 Interim supply (Back-to-back)
4.3	Interim supplies-can we interim-refill a 34 day drug with 2 refills to obtain the 3 month maximum?	
4.4	Interim supply for up to 3 months on 1 month medications (ex ramipril). Are we to put 1 month x 2 rpts under our name?	
4.5	3 month interim supply clarification	
4.6	interim supply clarification - can be extended up to 3 months - so can do 34 day supply 3 times? No	
4.7	Interim supply x 3 months. Is this to be done monthly up to 3 times, or refills are added on the initial Rx?	
4.8	I was looking for some clarification on providing an interim supply for patients. A limit up to 3 months may be provided for the patient (3 x 34 days, 3 months as a single fill or 100 days), as per the document Level 1 Prescribing (Practitioner- Initiated), but back to back (BTB) pharmacist prescribing is not permitted. Is a prescription for 3 months (3 x 34) supposed to be written for a 34 day supply with 2 repeats? So there would be multiple dispenses by a pharmacist but there would only have been one pharmacist prescription?	
4.9	We are allowed 3 months as an interim? Does that mean 1 month and 2 refills or does it have to be a 90 day supply as 1 fill?	
4.10	When prescribing an interim supply, once we completed assessment, may we prescribe 1 month with	

	2 refills (i.e. part filling after assessment), or will this be deemed 3 separate prescribing events and therefore inappropriate? If OK, does the same apply to emergency prescribing for maintenance therapy?	
4.11	Just inquiring about the specifics surrounding the changes in the prescribing opportunities for "3 month supply" for a 34 day supply medication. Are we able to do an "interim" supply on 3 separate occasions or do we have to decide at initiation of the interim if you are going to give 3 months (ie 1 fill with 2 refills).	
4.12	Can a pharmacist (same pharmacist or Different) offer an interim supply, if a month's interim supply was given initially? up to the total of 3 months i.e 3 times? No I have heard some pharmacists interpreting this as ONE INTERIM SUPPLY (for 1 month) X2 REPEATS !!!!!! Yes	
4.13	For the new limits - a pharmacist can issue a script for 3 months. Does it have to be 3/12 altogether, or could it be 1/12 with 2 refills for non 100 day drugs? To my mind, it is more likely that the patient will return to the practitioner if we only authorize 1/12 without refills, and have the option to renew the prescription another time if there is some sort of delay. Key to communicate to the patient that this is an interim measure.	Also see section 2.4, Level I Prescribing Authority (Practitioner-Initiated)

5) INTERIM SUPPLY - BACK-TO-BACK (BTB)

	Submitted Questions	SCPP Response
5.1	For Interim supply of 3 months, Can we provide 1 month with 2 refills? (Yes, may prescribe 1 month with 2 refills) Does this consider BTB prescribing.? (No)	Prescribing 1 month with 2 refills does not constitute BTB prescribing.
5.2	Interim supply of 1 mon, then 1 mon, then 1 more mon (total 3 month) allowed? No By same pharmacist? No By different pharmacists? No	BTB interim supplies is not permitted.
5.3	What are the implications for interim supplies with one month dispensing, can we do back to back in this case up to 3 months? No	See 5.2. and #3 Dispensing
5.4	Please clarify “back to back” pharmacist prescribing as it relates to our ability to provide interim supplies for up to 3 months	See 5.1 and 5.2
5.5	Please clarify no BTB interim supplies (3mths?)	
5.6	Can pharmacists prescribe an interim supply 1 month at a time, back to back up to 3 months or has to be 3 months all at once?	
5.7	Interims and back to back prescribing?	
5.8	Please clarify - B2B pharmacist interim supplies are no longer allowed?	

5.9	An interim supply is for a max of 3 months but we can only do this once? Can't extend for 1 month x 3 if they can't get an rx?	
5.10	I have a question regarding interim supply prescribing and back-to-back pharmacist prescribing. I am aware that we can provide up to 3 months of an interim supply using clinical discretion, however the no back-to-back prescribing is slightly confusing. For example, if I supply a one month interim for a patient I deem appropriate due to chronic medication, good adherence, no recent changes in dose and any relevant lab work is (WNL), am I not able to provide a second interim? The interim supply could Would best practice in this sort of situation (should it be deemed appropriate by myself), to provide 1 month of an interim and one refill, or up to a maximum of 2 refills?	
5.11	For interim supplies: since you're allowed to do 3 months are you allowed to give for example 1 month supply of ramipril then if the dr doesn't respond to our fax give another 1 month interim supply? As it says no BTB but it also says you can extend up to 3 months so I'm confused.	See 5.1 and 5.2 You are permitted to prescribe to give pt time to have their next doctors appoint. Use your professional judgement to determine this. You are not permitted to prescribe an interim supply BTB. If later, pt situation meets Emergency Supply criteria then use professional judgement to determine quantity of drug sufficient to meet the reasonable needs of the patient (see s. 5(8) of Part K Bylaws.
5.12	Why are we not able to prescribe back to back (ie interim supply) with the update when we could before?	Back-to-back (BTB) pharmacists prescribing has not been permitted since prescribing authority was introduced in 2011. However, in August 2019, the bylaws were amended to permit BTB under emergency exemptions when enacted by the registrar in extraordinary circumstances. (See Emergency Exemptions for Prescribing Authority.) In October 2022 the Registrar enacted an emergency exemption which allowed a pharmacist to prescribe BTB for a maximum duration of 3 months.

		This exemption is no longer needed with the bylaw amendments to Part K, where BTB pharmacist prescribing is permitted in select situations (see ss. 5(6) insufficient information + interim supply (a), dosage form + interim supply (b), administrative prescribing + interim supply (c) and 5(8) interim supply + emergency Rx). Also see 5(9)(d)) BTB emergency prescribing is not permitted).
5.13*	May I prescribe 1 month at a time until the max. limit is reached, or should I do all 3-6 months at once but dispensed monthly?	No. See #5.2 and #3 Dispensing and #7 Interim and Emergency Interplay

6) INTERIM SUPPLY – ACTIVE PATIENT-PRACTITIONER RELATIONSHIP

	Submitted Questions	SCPP Response
6.1	**Patient-prescriber relationship**: It says for interim supplies, a patient-prescriber relationship must exist. But what about in situations where the prescriber has left their practice and the patient no longer has a primary prescriber or the clinic has one coming but isn't there yet? See Prescription Validity - When Prescriber No Longer Practising, for options available under dispensing scope of practice. This is a situation where interim supplies are the most necessary, especially with the current doctor shortage. We currently give interim supplies in these cases so wouldn't that still be permitted? (yes) Or is this a situation where it is classified as an emergency supply? (Emergency prescription is permitted only if an additional extension is required after an interim supply was prescribed, s. 5(8) of Part K) And either way, this would be a situation where we would possibly need to do "back-to-back prescribing", depending on what that means. (The authorization for BTB prescribing is specific to certain Level 1 prescribing activities. See #5.12 above and #7 below. Also refer to bylaws and reference manual documents for more information.)	This is a dispensing question first. A "prescription" is an authorization given by a practitioner directing that a stated amount of any drug or mixture of drugs specified in it be dispensed for the person named in the authorization (*The Pharmacy and Pharmacy Disciplines Act (PPDA),* s. 2(u)). The prescription is therefore the result of an active "patient-practitioner relationship." See Prescription Validity - When Prescriber No Longer Practising, for options available under dispensing scope of practice. Also note that an active patient-practitioner relationship does not require the patient to have a family physician/ primary care practitioner. The prescription could be from a nurse practitioner, an emergency room physician, a specialist, or practitioner from other practice settings.

6.2	Am I understanding correctly that if a patient does not have a family dr or Dr has left the practice, we are NOT allowed to do an interm supply, only an emergency one? So in our community we would have to send them to the hospital outpatients to get a prescription from a physician, even though no doctors in our community are taking new patients?	Pharmacists are not trained to be the most responsible health care provider (MRP) nor do they have access to health system privileges required to be the MRP. Also see #5.12 above, #7 below, as well as SCPP Bylaws and reference manual documents for more information (including section 11.10 in General Provisions for notification when patient does not have a primary care practitioner).
6.3	Interim Supply: patient-practitioner relationship must exist. What if the patient doesn't have a family physician but on a hospital discharge prescription, the doctor prescribed 4 months of a new med and the patient consistently filled it monthly for 4 months, can an interim be done or only an emergency supply? Same question if a patient receives a 4 month prescription from a walk-in doctor and doesn't have a family physician?	
6.4	Scenario: A medication is started in the hospital, lets say it's a prescription for 3 months at hospital discharge. At 3 months the patient is stable on it, then needs an interim supply. But there isn't a patient-hospital practitioner relationship existent. What are my options?	
6.5	Emergency Supply: patient-practitioner relationship does not exist – is this if a physician retires and the patient hasn't found a new family physician, we do an emergency supply only without an interim supply first?	
6.6	Please clarify, no interims if they have no primary practitioner?	
6.7	Is no GP/looking for GP reason for emergency supply?	
6.8*	We have had several physicians retire or leave the province recently with no other physicians accepting new patients (this is rural area). So if a patient who has cardiac issues and needs continued prescription, we can provide up to 6 months of medication (via interim and/or emergency supply) even though they do not have a current physician/patient relationship.	See #6.1 and #7 below

7) INTERIM AND EMERGENCY INTERPLAY

	Submitted Questions	SCPP Response
7.1	Requiring clarification on BTB for interim and emergency prescribing.	See #5.11 and 5.12 above
7.2	Is only 1 interim supply allowed (of any length) before having to move to emergency supply? Yes (ex. If a 2 month interim supply is provided by a pharmacist, can a 1 month interim supply be provided before having to turn to an emergency supply?) No	BTB Pharmacist Prescribing is allowed if it is an Interim Supply + Emergency. But combined must not exceed 6 months supply of drug. (Interim = max of 3 months, and total must not exceed 6 months combined).
7.3	How does a five month emergency supply protect patients more than a three month interim supply?	See #7.1 and 7.2. Each Level 1 prescribing activity is intended to address a specific patient situation while managing the risk to patients. No one type of prescribing activity is intended to protect patients "more" than another. Pharmacists must use their professional judgment to determine that which meets the patient's needs in the given situation.
7.4	Another Level 1 prescribing thought: If we write a three month interim and a three month emergency and the patient presents to the pharmacy STILL with no rx, what do we do?	Pharmacists are expected to use their professional judgement to determine where they can refer patients within their communities. Pharmacists are not trained as physicians or nurse practitioners, or others listed in *The Drug Schedule Regulations.* Nor do pharmacist have access to health system privileges required to be the Most Responsible Provider.
7.5*	What if you have a physician leave in June and a new physician does not arrive until the fall and then they only take half of the other physicians patients. How do we help these patients if they only were given 6 months and will run out but do not yet have a new physician?	See #7.4
7.6*	for following interim with an emergency supply - would this apply to all medications even ones such as a statin	See Part K Bylaws section #5 and #10 below (Professional Judgement).

8) EMERGENCY SUPPLY (PART K s.5(8))

	Submitted Questions	SCPP Response
8.1	The term "emergency situation" should be subject to the pharmacist assessment of the situation and should not necessarily be a life or life threatening situation. My point is perception and assessment of the situation by the pharmacist and patients can be subjective. A pharmacist should be able to assess and document his/her rationale for making clinical decisions that would benefit patient outcomes and project the profession in a manner that puts the patient care first; without a cloud over his/her head- is this interim or emergency situation? Agreed we might have some colleagues making decisions with "financial biases "..	Historically there was misuse of this activity where pharmacists were improperly categorizing prescribing authority claims as emergency supply instead of interim supply in favour of a higher fee. This led to emergency supplies being limited to life threatening only. The changes aim to increase use of this prescribing activity the way it was intended. Emergency situations are now defined as life threatening **or** situations where an interrupt in therapy would result in imminent harm (e.g. an interim supply has already been exhausted).
8.2	If we are unable to BTB on pharmacist how are we able to go 5 months emergency? Are we giving refills for this duration?	Prescribing ≠ Dispensing It is the *Prescribing pharmacist* who determines the quantity on the prescription based on their clinical assessment of the patient and the conditions and limitations outlined in Part K of the Bylaws. Whereas, it is the *dispensing pharmacist* who will determine how that quantity on the Rx is to dispensed to the patient. Also see #5.12
8.3*	Can we prescribe an emergency supply if the pt has a relationship with a practitioner? The previous webinar had stated this prescribing activity was allowed when there is no active relationship with a practitioner.	Yes. See section 4 "Professional Relationship" in General Provisions. Also see Part K Bylaws clause 5(10)(c) - *emergency prescribing is not limited by the patient no longer having an active professional relationship with a practitioner.*
8.4*	What happens when we do a 1 month interim supply and the patient doesn't make their scheduled appointment? Next step, an emergency supply is done for another month?	No. BTB emergency supply is not permitted. See also #7 and #8.2.

	Patient still hasn't seen their prescriber as promised. Are we able to do an emergency supply again for another month? Can we continue this for up to 6 total months?	

9) EXEMPTIONS FOR EXTRAORDINARY CIRCUMSTANCES

	Submitted Question	SCPP Response
9.1	Pharmacist back to back prescribing not allowed in the new framework (BTB prescribing is allowed in select Level 1 prescribing activities, see 5.11 and 8.1 above) - BUT THE REGISTRARS SUBSECION 56 ENACTMENT is still in effect and this IS allowed? (There are 2 different exemptions in place, one by the SCPP Registrar and one by Health Canada.) Therefore, pharmacist may prescribe back-to-back. (BTB prescribing is allowed in select Level 1 prescribing activities, see 5.11 and 8.1 above)	See 5.12 above for Exemption enacted by SCPP registrar which is no longer needed due to bylaw amendments. See Community Pharmacy Practice Enactments for section 56 exemption to the *Controlled Drugs and Substances Act* issued by Health Canada for dispensing and prescribing controlled substances

10) PROFESSIONAL JUDGMENT

	Submitted Question	SCPP Response
10.1	How long does a patient have to be on a medication for it to be considered a chronic med?	Rather than using an arbitrary timeframe to determine whether there is chronic and stabilized use of a relevant drug, the pharmacist must use their professional judgment. As noted in S. 2.2 of Level I Prescribing Authority (Practitioner-Initiated) the pharmacist must judge each request on an individual basis and only after considering the patient's medical history and medication profile; whether the drug is still be safe, effective and indicated; and whether the treatment with the medication has remained relative stable (i.e. no significant changes to dosages or drug therapy.

10.2	When doing interims, is it acceptable to do one fill with 2 refills to give the patient the maximum amount of time?	See #10.1. As noted in s. 2.4 of Level I Prescribing Authority (Practitioner-Initiated) when providing an interim supply, the pharmacist must ensure that the patient understands that they will need to follow up with their practitioner before the interim supply has run out, as a pharmacist will not be permitted to extend it again unless it is under emergency situations s. 5(8) of Part K.
10.3	For interim supplies, it is mentioned that PAR to primary practitioner is not require. So, we do not need to notify them?	As noted in s. 5(7) of Part K, a licensed pharmacist who prescribes an interim supply is not required to provide the PAR to the patient's primary practitioner, unless it is requested by a practitioner. Aso see s. 11 of General Provisions for additional considerations.
10.4	what is the definition of a "reasonable attempt to contact the prescriber"? If I know I can't get a reply from the physician within the same day sufficient to meet this requirement even though I know the doc would be available in a couple of days?	As per s. 2.1 of General Provisions, where applicable, pharmacists must perform all steps in the dispensing process before altering or continuing the existing prescriptions issued by a practitioner. Have all forms of contact (e.g. fax and phone) with the practitioner been tried? (s 2.1.2.1) Also, 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. Pharmacists must use their professional judgement to determine what is "reasonable" in the situation. Consideration may be given to such things as: • Does the practitioner have time to respond (e.g. patient does not require the prescription for 1 week); and

		• the urgency of the situation (e.g. practitioner cannot be reached, but the patient requires the prescription now).
10.5*	What does " a reasonable attempt to contact the physician" mean? If we call and they do not answer is that a reasonable attempt to contact if we need to reduce an antibiotic dose based on CrCl?	See #10.4
10.6*	Why is pharmacist judgement to not considered if we need to prescribe more than 1 month? the 1 month goes by and now we cannot do it again. There is no way to be certain when the next doctor prescription will come. Do you suggest automatically adding 2 refills to a 1 month interim to avoid this problem?	Pharmacist professional judgement is always needed to weigh the specifics of the situation. See #10.1 and #10.2

11) CREATING THE PRESCRIPTION IN PIP GRAPHICAL USER INTERFACE (GUI)

	Submitted Questions	SCPP Response
11.1	Is it a requirement that pharmacist prescribing be completed directly through PIP to generate the prescription?	Most pharmacists will generate the prescription using the pharmacy or public institution's vendor software. However, when using the PIP GUI to create a Rx, Standards Entries have been created for to be entered into the SIG field. (See Appendix B in General Provisions revised for clarity.) *SIG instructions* when prescribing in the PIP GUI ≠ directions to the patient on the dispensed label.
11.2	You are always saying "when you create the rx in pip..." are you meaning we should be going on the PIP website to do this?	
11.3	Please clarify reference to an Rx being created in PIP. This should not be needed since CeRx PIP integration.	
11.4	Does this process, using pharmacy software, still meet SCPP's requirements to submit their rational to PIP? Are pharmacists allowed to continue using the existing process while SCPP works with e-health / PMS providers to update their systems to reflect the changes in the bylaws?	
11.5	Rationale in sig – may cause confusion for patients. Can this be addressed?	
11.6	The changes to the sig field- are the comments suppose to appear on the mediation itself Ex. Ramipril - the sig would have to say . "Take 1 capsule daily . Continuing therapy- interim supply " This may be confusing for the patients to change their sig fields.	
11.7	Minor Ailments sig for PIP: If we are prescribing for a minor ailment is it sufficient to put "Minor ailment- cold sore " in the Sig of the prescription or are we required to put more information about why we prescribed? (There is not much room in the Sig field of our software).	

11.8	When pharmacist prescribes and enters Rx in PIP, it says to enter their rationale “in the SIG Instructions field”. Is the pharmacy to also include this ON THE PATIENT’S PRESCRIPTION LABEL???	
11.9	PIP entry requirements – Does this mean that all pharmacist-initiated prescriptions must include the reason for prescribing in the SIG? Was this always a requirement? Should we be concerned about confusing patients if they see this information on the vial??	
11.10	The sig is printed on the prescription. If we are putting all this stuff in there, do we not put the actual instructions in there? Is this the right place for this information if the patient is going to see it? Seems super unprofessional to write “mother asked for liquid” where it should say take one tsp…. Thoughts?	
11.11	Please give more examples of what "providing rationale in the Sig code" means	
11.12	how we will be able to fit rationale for prescribing in the SIG	
11.13	What is an example of a rationale that would be appropriate to put in the SIG and meet requirements without being too long?	
11.14	Sig will be too long and confusing to patients if need to add the reason. Is there a way around this?	
11.15	SIGs: For our Rxs, are the basic SIGs (e.g. "continuing therapy - emergency drug", "admin prescribing", etc.) enough or are we supposed to add more information? It says we need to put our rationale which to me means those basic SIGs, but then other places it makes it seem like we need to add more detailed info such as length of time to patient's next doc appt. If we do need to add more detailed information, my concern is that SIGs will get so lengthy that they will confuse the patient, make them difficult to read for those who struggle to read small print, make them difficult to read for those whose first language is not English, etc.	
11.16	Is there not an easier way on PIP to make aware that an rx was filled by a pharmacist previously? Rather than having to change the SIG every single time? And then if the secondary pharmacist has further questions, they can contact the primary pharmacist directly? This is VERY cumbersome and almost entirely defeats the purpose of the "copy to new rx and make unfilled" function on kroll.	
11.17*	It might have been asked because i missed the first 5 mins - how much detail are we putting into the sig if we are extending a prescription.	See 11.1 above.
11.18*	So where do you want us to put our rationale for prescribing when we do the interim or emergency supply for a pt on our Kroll system (if not in the sig)? If we just put on hardcopy, no one can see it on PIP?	See 11.1 above. Documenting rationale - see Part K Bylaws s. 3 Pharmacist

		Assessment Record and Prescribing Authority – General Provisions section 11 Documentation and Notification.
11.19*	Same question. Even when inputted through PIP GUI in the Instructions to Pharmacist Section, I thought that did not show up for other prescribers to see unless they have the hard copy. We've tried this and the instructions to pharmacist section on the PiP GUI was overwritten by what the dispensing pharmacist put in the SIG on dispensing software. Future prescribers only could see the most recent SIG	The functionality of PIP GUI is different when prescribing vs. dispensing. See APPENDIX B – Creating Prescriptions in PIP - Graphical User Interface (GUI), General Provisions. Also explore vendor software training for how to prescribe through pharmacy software. eHealth is working with vendors to reflect new bylaws.
11.20*	To be clear - prescriptive authority action does not need to be on the label -- wait for our vendor to include as a function to send	See 11.1 and 11.19.
11.21*	Until software accommodates a place to enter a reason for prescribing do we add a note to the sig code of our software program?	See 11.1 and 11.19.

12) MINOR AILMENTS (PART K s. 10)

	Submitted Questions	SCPP Response
12.1	Clarification of the changes to minor ailments and modifying prescriptions would be appreciated	Minor Ailments – status quo plus two new conditions added (recurrent genital herpes, nausea and vomiting of pregnancy). See Level I Prescribing Authority (Structured) Modifying Prescriptions – see Level I Prescribing Authority (Practitioner-initiated) and questions below - #13 Missing Info, #14 adjusting dosage form, #15 enhancing safety and effectiveness

12.2	If a pharmacist has prescribed a year of birth control for a patient through minor ailment prescribing-once a year is up can a pharmacist provide an interim supply or would this be an emergency supply? (Ex. Patient doesn't have time to go through paperwork to do another minor ailment prescribing and wants something in the meantime before we prescribe again).	Note: if pharmacist is working off a Rx initiated a practitioner other options may be available. (See Level I Prescribing Authority (Practitioner-Initiated). In this question the pharmacist prescribed birth control as part of Minor Ailment Prescribing, which remains status quo. Part K of the Bylaws (s.10) requires that all minor ailment prescribing must be done according to the medSask guidelines. Therefore, if pharmacist unable to perform the assessments and documentation as required in the medSask guidelines, then they are not authorized to prescribe for this patient in this situation. Also see General Provisions for Prescribing Authority that apply to all pharmacist prescribing, and Level I Prescribing Authority (Structured) which details specifics for minor ailment prescribing.

13) MISSING INFORMATION (PART K s.6)

	Submitted Questions	SCPP Response
13.1	**Missing information**: It is stated what constitutes missing info for when we would put our names in the prescriber field. However, it is not clear if in the situations where the missing information is not when we would put our name on it (e.g. prescriber signature, date), we can still dispense it. Confirmed, a Rx without a prescriber signature or date are not legal prescriptions and must not be dispensed. I assume not since these are then technically not legal prescriptions but so are the ones that we can alter and put our name on. Part K s. 6, authorizes pharmacists to add medically necessary information only to the prescription.	This is a dispensing question.

13.2	Adding refills to Rx if it is obvious that the refills were omitted (all others have refills): Can we just add the refills without changing the prescriber or do we have to put our name on this as well since we are altering the Rx?	First step is to use your dispensing scope of practice by calling the practitioner to verify the missing info, s. 5(5) of the Level 1 Practitioner document . If reasonable attempts have been made with no success, adding refills is authorized under s. 6 of Part K. Any activity that is authorized under Part K, means that you have used your prescribing authority, and are the prescriber. Also see Level I Prescribing Authority (Practitioner-Initiated).
13.3*	have physicians that routinely forget to refill routine chronic medications when sending in refills ...faxing sometimes gets no answer. can we prescribe to maintain patient	See #13.2

14) ADJUSTING DOSAGE FORM (PART K s.7)

	Submitted Question	SCPP Response
14.1	Altering dosage forms: Is it considered altering a dosage form if a prescriber writes for tabs instead of caps or vice versa? No. Again, we are supposed to put our names on these Rxs if we alter them and it seems unnecessary and more confusing to do that when just switching the dosage form, especially in this instance.	This is dispensing scope of practice where the pharmacist determines the product to be dispensed. See Standards of Practice for Saskatchewan Pharmacists. Tablets to capsules and vice versa (with no change in release profile) are not considered a change in dosage form as per Part K s.7
14.2	Dosage form change: If a doctor prescribes ramipril tablets but ramipril only comes in capsules do we change the dosage form under a dispensing function (there are no commercially tablets) Yes or would that fall under a billable dosage form change? No	
14.3	A prescription is written for Ondansetron oral tablets. The oral tablets aren't covered by the patient's insurance but the ODT are covered. We cannot prescribe for ODT formulation because it is a different route (same route. Source: USP Ch. 1151 Pharmaceutical Dosage Forms) and the one the doctor prescribed is commercially available - correct?	This is dispensing scope of practice where the pharmacist determines the product to be dispensed. See Standards of Practice for Saskatchewan Pharmacists. Oral tablets to ODT formulation and vice versa (with no change in

		release profile) are not considered a change in dosage form as per Part K s.7
14.4	A patient receives a prescription for carbamazepine 200 mg immediate release tablets twice a day from a walk-in clinic. The patient has been stabilized on carbamazepine 200 mg CR tablets twice a day and states there wasn't supposed to be any changes. Their primary practitioner is away and we cannot contact the physician at the walk-in clinic. A pharmacist can prescribe the CR tablets according to Practitioner Initiated Prescribing-Adjusting Dosage Form – correct?	Several options are available. Professional judgement is required. The pharmacist could use their dispensing scope of practice where the pharmacist communicates with the prescriber to verify the prescription for accuracy and clarify any uncertainties in the prescription. See Standards of Practice for Saskatchewan Pharmacists. Another tool available is Part K Bylaws section 7 (adjusting dosage form). See also Level I Prescribing Authority (Practitioner-initiated), in particular 6.2.2.
14.5	Adjusting Dosage Form -so this will help with the drug shortage of Verapamil SR (will allow me to sub with the IR tablets at increased frequency) from what I understand, Yes, see Level I (Practitioner-initiated) 6.2.2 but will it allow me to sub Rybelsus for Ozempic? Yes, see Level I (Practitioner-initiated) 6.2.3 There was info about having to be approved by Health Canada for the same indication, so I'm not clear on whether we are allowed to make that switch (especially when a patient is already taking ozempic for an off-label indication that the rybelsus is actually indicated to treat) Re: off-label – see #23.1 below	See Part K Bylaws section 7, Level I Prescribing Authority (Practitioner-initiated) section 6
14.6	Does altering the dosage form apply to situations such as changing from Canadian to American Depo-Provera?	No, changing from Canadian brand to American brand Depo-Provera is not a change in dosage form. Note: answer updated based on feedback in #14.7.
14.7	I think question 14.6 is referring to the case when there was a shortage of Depo Provera in Canada and the american version was imported, but it's not technically interchangeable, so we had to	Interchangeable pharmaceutical products are identified in the Saskatchewan formulary as being interchangeable with another

	contact prescribers to change prescriptions to the American Depo-Provera (or only write Medroxyprogesterone Acetate 150mg/ml). This also happened with Timolol eye drops at some point. This is just to clarify the question. Does the new Prescribing Authority let us make the switch and prescribe?	product. (See *The Pharmacy and Pharmacy Disciplines Act, s. 2(l)).* Drug shortages that impact the formulary, may be one situation in which the Ministry of Health and SCPP may decide to enact Level II prescribing under "Other Diseases Identified by the Minister of Health or Designate."
14.8*	Is it correct that the physician has to be contacted ("a reasonable effort to contact") for all prescriptive authority events? example: dosage form change. This seems to be counter productive	No. Each prescribing activity has specific requirements based on the risks to the patient. See policy documents for complete details on each prescribing activity. Example for dosage form: first see Prescribing Authority – General Provisions, then look to Level I Prescribing Authority (Practitioner-initiated)).

15) ENHANCING SAFETY & DRUG EFFECTIVENESS (PART K s.8)

	Submitted Question	SCPP Response
15.1	On the handout 'Prescribing Authority Tools for Patient Situations', under the patient situation 'Wrong dose that is harmful to patient or not effective" it states that after dispensing tools are exhausted to use level 1 prescriptive authority to adjust the dose amount or regimen. Will this be limited to certain drugs/conditions or does this apply to any prescription?	See Part K Bylaws section 8 and Level I Prescribing Authority (Practitioner-initiated) section 7, in particular 7.1.
15.2	Safety and effectiveness: In order for us to alter Rxs for this reason, we must know the diagnosis, yet it is still not mandatory for a prescriber to include the diagnosis on the Rx. Since this is not the case, we would likely have to contact the prescriber to get the diagnosis so in the end we would just obtain an Rx with the necessary changes at that point (unless the prescriber does not agree). Regardless of this prescribing authority, mandatory inclusion of diagnoses on Rxs would improve patient care and streamline the dispensing process. (I realize this is not your area but I thought it is worth mentioning since it does pertain to this authority.)	• General Provisions – text box, p. 9 SCPP recommends that pharmacist review eHR Viewer. • The SCPP also recognizes that indications on prescriptions is one strategy to reduce harm and prevent medication errors, and has raised it with other stakeholders. • As per ISMP, SCPP is encouraging pharmacists to include the indication on the Rx when known.

	Also, what happens if prescribers do not agree with our decision to alter for safety and effectiveness? Does this not put us at risk for complaints, reduced prescribing authority with that practitioner, and poor relationships with practitioners? I agree that this authority needs to be allowed because there are situations where the Rx is just not appropriate and patient care comes first, but I'm wondering what SCPP's thoughts are on this.	The SCPP recognizes the sensitive nature of this prescribing situation. To assist pharmacist the steps for navigating this situation have been clearly laid out in section 7 of Level I Prescribing Authority (Practitioner-Initiated). Patient's right to make an informed decision is central, however, ensuring that it based on current evidence based clinical practice guidelines and resources is a professional accountability measure. See also #22.1 and #27.1 below.
15.3	A prescription is written for Tamiflu 75 mg tablet twice a day for 10 days. The patient says they have influenza. The physician has left and cannot be reached until the next day. The pharmacist can prescribe Tamiflu 75 mg twice a day for 5 days according to Practitioner Initiated Prescribing-Alter Dose/Regimen - correct?	Several options are available. Professional judgment is required, see clause 2(1)(e) of Part K 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. Also see General Provisions for additional guidance. Following the principle of exhausting all dispensing options is the first course of action where applicable, s. 2.1 General Provisions, the pharmacist could dispense 5 days and confirm treatment duration with the prescriber when they are available the next day. Also note that seasonal influenza is one of the Other Diseases identified by the Minister, which may be applicable to the patient's condition. The pharmacist may verify whether this option is available to the patient (see Part K s. 19 Other Diseases, Community Pharmacy Practice Enactments and #30 below) and inform the patient of their options using the steps outlined in S. 7 – informed

		consent, General Provisions, and in section 7 of Level I Prescribing Authority (Practitioner-Initiated), enhancing safety and efficacy. Document as required (see Section 11, General Provisions) Community Pharmacy Practice Enactments

16) DRUG RECONCILIATION (PART K s.9)

	Submitted Question	SCPP Response
16.1	Why is drug reconciliation not allowed for correctional facilities? Can you perform any prescribing authority upon discharge?	The addition of correctional facilities was not suggested during the extensive stakeholder consultations in December 2022. The consultation process sought input from all pharmacy professionals, other health professionals, and other stakeholders in Saskatchewan to ensure that the bylaws supported practice in community and hospital pharmacies.
16.2	Can you review drug reconciliation and seamless care	See Part K Bylaws section 9 and section 4, Level I Prescribing Authority (Practitioner-initiated). Pharmacists who work in a public institution – see #17 below.
16.3	Further detail of when to use drug reconciliation?	
16.4	As a **hospital BSP**-what is my role in prescribing for "Drug Reconciliation"? Does it help for new admissions? or only discharges?	
16.5	Drug Reconciliation – If admitted to hospital and a regular medication is not ordered. Does this mean **the hospital pharmacist** could write an order for the missed medication without a physician signing off on the order? Has this always been allowed but just not commonly done since physicians are often available to sign off on orders?	

17) PHARMACISTS WHO WORK IN A PUBLIC INSTITUTION

	Submitted Questions	SCPP Response
17.1	How does Level 1 apply to hospital pharmacists?	Status Quo for pharmacists working in public institutions (i.e. Saskatchewan Health Authority (SHA) and Cancer Agency). See Prescriptive Authority for Pharmacists – Hospital Pharmacy) However more information forthcoming with the roll out of Level 1 Prescribing Authority for pharmacists working in public). All pharmacist prescribing within the hospitals or SHA ambulatory settings, must be done in accordance with the written bylaws, policies, clinical standards or other agreements as outlined by the Public Health Care Institution. This includes the conditions or limitations authorized by the Public Health Care Institution and by Council. (see ss. 1(a)(ii), 4(6), and 12(5) of Part K). Also see #16.4 and 16.5 above.
17.2	How to apply prescribing authority to clinical pharmacists working in an ambulatory setting.	
17.3*	Could a pharmacist who works in primary health care (ie. a primary care clinic, not a dispensing pharmacy) provide an interim supply Rx that the patient brings to the pharmacy if the prescriber is not in the clinic when the primary care pharmacist is seeing that patient?	Question is unclear. See 17.1 if this pharmacist is working within or through a publicly-funded clinic (i.e. Saskatchewan Health Authority or Saskatchewan Cancer Agency).

18) MULTIPLE QUESTIONS

	Submitted Question	SCPP Response
18.1	Which prescribing category do OTCs - for example vitamin D, iron and ASA 81mg - fall under when they are included in blisterpacks? Dispensing question – No Rx is needed to put Schedule II, III or unscheduled drugs, in a blister pack. No Rx is needed to put Natural Health Products (NHPs) such as vitamins or minerals in a blister pack. Is this Level I Prescribing Authority (Pharmacist-Initiated) "administrative prescribing solely for patient to access coverage for Schedule II, III or unscheduled drugs"? (Yes) If yes, does this category also include OTC products that are not covered but filled as prescriptions to have them show up on the patient's med record? (Ss. 11(1) to 11(3) of Part K do not apply to NHPs, however the NAPRA/SCPP Supplemental Standards of Practice for Schedule II and II Drugs may be of assistance. Some patients have prescriptions written once by their doctor for an OTC and then it is assumed that they are to continue it (example: calcium) and other patients start getting their meds blisterpacked and want supplements that they started taking on their own included in the packs.	Dispensing question. The container that the pill is in (e.g. blister pack), has no impact on prescribing authority. Also see: • Compliance Packaging for requirements on customizing patient medication packaging; and • SCPP Long-Term Care Standards, for different rules which may apply to public or private group home settings. Creating a label for compliance pack of non-Rx drugs or NHPs does not require administrative prescribing. Explore vendor software training for how to enter a non-Rx drug or NHP on a compliance pack label. The pharmacist is reminded to verify coverage for schedule II, III or unscheduled drugs, as per s. 2.3 of Level I Prescribing Authority (Pharmacist-Initiated). If the Rx is covered by the public or private coverage program, then the pharmacist would enter their name in the prescriber field accordingly. **Note:** All NHPs are regulated under a separate and distinct regulatory framework from prescription drugs, which are regulated in a manner appropriate for the lower-risk nature of these products. See Health Canada website for more information.

18.2	If a pharmacist decides to give a 1 month interim supply, and next month the patient needs another interim supply, Can we add 2 refills at that point? Or would that be considered BTB? (This would be BTB interim supply which is not permitted.) Does that mean the first time an interim supply is issued, we should already be prescribing 1 month and 2 refills? (This is an option.) With 1 prescribing fee, or total 3, when filling the other refills? (Billing question) Or do we have to dispense all 3 months at once (3x34, 3 months, or 100 days)? (Dispensing question)	
18.3	Is all Level I Practitioner-initiated Prescribing only possible after reasonably exhausting dispensing options (Rx transfers, authorization from practitioner)? (There are 9 different prescribing activities authorized under Level 1, each with its own rules. For more clarity on dispensing vs. prescribing, see General Provisions (including s. 2 – professional accountability and 13 - conflict of interest) and the bylaws/reference documents specific to each prescribing activity.) It is very specifically mentioned with the new "Altering dose or regimen" prescribing, and I think interim supply and emergency situations. (This is correct. A risk-based analysis was taken with each prescribing activity. When altering a dose or regimen the pharmacist interjects their clinical decision with that of the prescriber.) But what about the scenario (that happens very often): RX for a teenager/older child for tablets, and once they get to the pharmacy, they decide they would rather have a liquid. Do I have to contact the prescriber (wastes everyones time), or can I just adjust the dosage form? (This is adjusting Dosage Form under Level 1 Prescribing Authority. See s. 6 of Level I Prescribing Authority (Practitioner-Initiated), for requirements specific to this prescribing activity).	As per s. 2.1 of General Provisions, where applicable, pharmacists must perform all steps in the dispensing process before altering or continuing the existing prescriptions issued by a practitioner. see General Provisions (including s. 2 – professional accountability and 13 - conflict of interest) and the bylaws/reference documents specific to each prescribing activity.
18.4	Lots of our patients in the community with compliance packs want their vitamins and minerals etc packed too (not covered by SPDP or 3rd party coverage). Vitamins/minerals can placed in a blister pack regardless of whether there is public/private coverage) Administrative prescribing is only to obtain 3rd party coverage, which doesn't apply here, and would vitamins be considered use for a self-limiting condition? (Ss. 11(1) to 11(3) of	See #18.1 above. Ss. 11(1) to 11(3) of Part K do not apply to NHPs, however the NAPRA/SCPP Supplemental Standards of Practice for Schedule II and II Drugs may be of assistance.

	Part K only apply to Schedule II, II or unscheduled drugs. They do not apply to NHPs.) Do we have to get the practitioner to prescribe these vitamins etc, or can we do it (after checking for appropriateness or no harm etc which we do in med reviews anyways)? (An Rx is not required to put a NHP in a compliance pack.)	
18.5	Can you talk more about the scenario in the document "Level I Prescribing Authority (Practitioner-initiated)" 7.4.: "If the safety or drug efficacy concerns are not resolved after communicating with the practitioner": Can we alter the prescription, with the patient's consent, against the intention of the prescriber, when there are safety or drug efficacy concerns? (See Bylaw Example Sheet – February 2024. Also see section 7, Level I Prescribing Authority (Practitioner-Initiated) for in depth information about the steps that must be considered by the pharmacist, also see Professional Accountability and other standards of practice outlined in General Provisions . Or better refuse to fill? (Dispensing) What if the patient doesn't consent and wants the RX filled as written by the prescriber? (Dispensing scope of practice. Use professional judgement to determine whether the fill the prescription (e.g. risk vs benefit of dispensing vs withholding.)	See Bylaw Example Sheet – February 2024. Also see section 7, Level I Prescribing Authority (Practitioner-Initiated) for in depth information about the steps that must be considered by the pharmacist when considering this prescribing activity. Also see General Provisions for professional accountability and other standards of practice when determining the correct course of action.
18.6	**Interim vs emergency supplies and back-to-back prescribing**: To me, an interim supply is provided so as to not interrupt a patient's drug therapy because doing so would be harmful. Otherwise, why would we provide interim supplies at all? Yet the definition for an emergency supply is that the situation is life-threatening or interrupting therapy would cause harm to the patient. It is not clear to me when you would choose one over the other. It does state that an emergency supply cannot be given if an interim supply has not yet been given (i.e. last Rx was by prescriber (This is unclear)), yet it is not clear when you would choose an interim vs emergency supply after an interim has been given. (If the interim supply has been prescribed by a pharmacist, the only other option to further extend a Rx through emergency prescribing, see SCPP Regulatory Bylaw Part K section 5(6). This leads to the confusion over back-to-back prescribing. It says we can give 3 months of interims (which would be 3 x 1 month supplies for non-100 day maintenance drugs or	*See #5.12 and #7 above.*

	100 days of said drugs) but then says we cannot prescribe if the last Rx was prescribed by a pharmacist. (See revised wording of s. 2.3.1 of the Level I Prescribing Authority (Practitioner-Initiated) , e.g. prescribe 1 month with 2 refills). Then it says that the maximum months' supply that can be given to a patient by a pharmacist is 6 months between interims and emergencies. So how does that work if we cannot "back-to back prescribe"? (See sections 2 and 3 in the Level I Prescribing Authority(Practitioner-Initiated) + appendix)	
18.7	**PARs vs notifications**: When it says we don't need to send the PAR to the prescriber(s), do we still need to send a notification that a prescription was issued (e.g. interim, unable to access supplies)? (see SCPP Regulatory bylaws Part K 3(3), also see section 11 Documentation and Notification in General Provisions Do we need to send a PAR for emergency supplies?)? (see Part K 3(3) and 5(11) for additional notification requirements). In cases where we do need to send the PAR, what if the patient does not have a primary prescriber? (Status quo, see 11.10 in See General Provisions)., Are we not allowed to initiate these prescriptions in those cases? (see above) My understanding was that this new/modified prescribing authority was (somewhat) developed to help ensure patient care through doctor shortages. If the case is that we cannot do this in those situations, it kind of defeats the purpose. So that is why this is very unclear to me. (See #5.11, #5.12 and #6 above.)	See SCPP Regulatory bylaws Part K 3(3), also see section 11 Documentation and Notification in General Provisions.
18.8	**Putting the pharmacists' names on prescriptions**: My concern with this is that when anyone looks at PIP, they cannot see who the original prescribing doctor was. I feel this is important information for PIP users to be able to see and it does not make sense that in order to obtain that information, someone would have to call the pharmacy at which the medication was dispensed. This is especially true for the Rxs that have refills and our name is on the Rx for the duration of those refills. As far as I know, there is no way to add a note into PIP to provide this information for all to see (which is why we have to include rationales in SIGs and not in a notes section). I feel that putting our names as the prescribers in all these situations will cause more confusion than if we kept the original prescriber in	When a pharmacist is prescribing as authorized under Part K of the bylaws, legally they are the prescriber and are professionally accountable for their decisions.

	that field and then added to the SIG the rationale. Everyone can see on PIP in the SIG that the Rx was modified, altered, etc. by a pharmacist if those rationales are in there, but they can't see the original prescriber when we put our name on it.	
18.9	Question: Is Level 1 pharmacist initiated prescribing ONLY for THIRD PARTY coverage, not patients with PROVINCIAL coverage? (Language has been updated for further clarity, to include private and public coverage, as permitted by the payor. See sec. 2 of the Level I Prescribing Authority (Pharmacist-Initiated).) Level 1 pharmacist initiated prescribing is prescribing of non-prescription drugs for 3rd party coverage. Third parties RARELY cover non-prescription products except for insulin and diabetic supplies. Is that all this in intended for? Does it apply to patients with provincial coverage? Many patients with provincial coverage are eligible for coverage of Tylenol, Advil, multivitamins, lice treatments etc. Can we prescribe these products for provincial coverage? If feel like that is where this prescribing would be most beneficial to patients and reduce burden to prescribers. Patients with private insurance can often afford to purchase non-prescription products but patients on provincial programs would benefit from us being able to prescribe non-prescription products to be covered for them. (SCPP does not determine the coverage provided by public or private payors. The pharmacist must verify coverage as per s. 2 of Level I Prescribing Authority (Pharmacist-Initiated).) Comment: • Many of the other changes to regulations seem to be mostly targeted at reducing the amount that pharmacists can bill for prescribing. Removing back to back prescribing but allowing a 6 month emergency supply is absolutely ridiculous. Pharmacists should be paid for assessing that patient monthly to determine if they are still in an emergency situation and prescribing as needed. How are we to assume how long an emergency situation will last for? And if we under-assume then that patient may be stuck with no medication unless we prescribe outside of the guidelines and risk our license	Ss. 11(1) to 11(3) of Part K only apply to schedule II, II and unscheduled drugs. They do not apply to NHPs (see #18.1 and #18.4 above) or other supplies. The SCPP does not determine drug coverage and other benefits for private or public coverage programs. This is determined by the program provider. The SCPP does not determine compensation matters for billing. This is the purview of the Saskatchewan Drug Plan and Pharmacy Association of Saskatchewan. To ensure that the bylaws supported practice in community and hospital pharmacies, they were developed in consultation with all pharmacy professionals in Saskatchewan, regulatory bodies and associations for other health professionals, training institutions, as well as the Saskatchewan Health Authority, the Saskatchewan Cancer Agency and the Ministry of Health. All policy documents are based on the national standards of practice for all pharmacy professionals in Canada.

	for the safety of the patient due to unrealistic guidelines. If we over-assume then the patient will delay dealing with the emergency since we have given them a 6 month grace period with no requirement for follow up or assessment. These guidelines were clearly not created with real world retail pharmacy practice in mind and they are making it harder for us to effectively help patients.	
18.10*	This is quite a specific scenario question. If a pharmacist adapts/modifies an Rx using their professional judgement, can another pharmacist modify/adapt after that? (i.e. pharmacist modifies an Rx, that Rx is transferred to another pharmacy, a pharmacist at the receiving pharmacy does not agree with the modification/adaptation and wants to change it back to the original Rx from the original prescriber).	Level 1 prescribing authority contains 9 discrete activities, each with its own rules. More details are required about this specific scenario to answer the question. Note: there may be situations where the dispensing pharmacist assesses the appropriateness of a Rx issued by a prescribing pharmacist under certain Level II prescribing authority (i.e. Collaborative Practice Agreements or Advanced Prescribing B.)

19) TRAINING

	Submitted Question	SCPP Response
19.1	What are the required courses?	For Level I, see SCPP Training Table
19.2	Level II: If we have training to prescribe under some Level II authorities but not others, are we still able to prescribe under those authorities? Or do we need to do the training to prescribe under all Level II authorities? Basically, is it all-or-nothing or can we have partial training?	Level 2 – there are 7 discrete types of prescribing activities authorized under Level 2 PA. Although there may be some overlap, each has its own training, competency, and practice requirements as outlined in Part K of the bylaws. These are under development. Monitor SCPP communications and website for more information as it becomes available (e.g. Scope of Practice Updates page and the Training and Development table.)

20) BUSINESS INFLUENCE

	Submitted Question	SCPP Response
20.1	Our computer software is set up to automatically send a Pharmacist Renewal Request for an interim supply when the patient uses their digital account to order a medication that is out of refills (instead of automatically faxing the doctor). Please confirm that a conversation with the patient should be part of the process in deciding if the pharmacist will issue a 1, 2 or 3 month interim supply.	As required in s 2.1 of General Provisions before prescribing, all pharmacists must performing all steps in the dispensing process before altering or continuing an existing prescription issued by a practitioner (s 2.1.2 of General Provisions). This means contacting the practitioner for refills **before** prescribing an interim supply, regardless of how the patient makes the request (e.g. in-person, over the phone, or automated computer software). Automation does not permit a pharmacist to practice contrary to the SCPP Bylaws, policies and standards. The pharmacist must have a conversation with the patient before any prescribing activity (see sections 5, 6 and 7 of General Provisions as well as section 2.2 in Level I Prescribing Authority (Practitioner-Initiated.

21) PATIENT-PHARMACIST RELATIONSHIP

	Submitted Question	SCPP Response
21.1	Patient-pharmacist relationships – The documents state that "prescribing shall only be done for patients with whom the pharmacist has developed a professional relationship". I understand there is some flexibility to this definition but how does this apply for floater pharmacist or casual pharmacists? Who is responsible for follow-up if they will not be available? Does this mean they should not be prescribing?	As noted in s. 1(m) of Part K, "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. This definition provides flexibility for "floater" or "casual" pharmacists to exercise their prescribing authority. However, like all other pharmacists they must adhere to the standards of practice.

		See expectations outlined in General Provisions, including monitoring/follow up (s. 6) and professional relationships (s. 4). For example, as per s. 4.12, the pharmacist who prescribes remains responsible for any patient outcomes related to the service provided until care has been transferred to another authorized provider.

22) DOCUMENTATION

	Submitted Question	SCPP Response
22.1	**Referencing clinical tools**: It says that when prescribing, we must reference clinical resources, tools, etc. and include the name, date, year, edition/version, etc. in our documentation. Is this only for advanced prescribing that is still to come? Either way, I understand the thought behind this but it is not feasible to require pharmacists, who are already short on time to fill their regular dispensing and clinical roles, to document such detailed information such as this. Can we not even just state the resource used if we must include this information? It makes sense that when we initiate prescriptions, we need to document in a similar way to other prescribers. However, other prescribers are not required to include this level of detail in their documentation.	The standard of practice identified in s. 11.4.1 of General Provisions, applies to both Level I and II prescribing (i.e. document the date, year, edition or version of the peer-reviewed evidence-based resource or clinical practice guideline used to verify that it is current). This ensures that the clinical resources used are current. Documentation fulfills one of the foundational principles established by the interdisciplinary committee when pharmacist prescribing authority was introduced in 2011. It ensures professional responsibility, accountability, and transparency of prescribing decisions, as well as information flow between the pharmacist and the primary care provider, pharmacy team and other health providers as needed. See sections 11 and 12 in General Provisions document.

23) AUTHORIZED DRUGS

	Submitted Question	SCPP Response
23.1	Authorized drugs – In 'General Provisions for Prescribing Authority' section 8.1.1 states that pharmacist can only prescribe a drug for a Health Canada approved indication but section 8.2 is about off-label prescribing. Does this mean pharmacists can prescribe for off-label use, as long as appropriate rationale is documented	Yes, pharmacists are permitted to prescribe off-label, however, the prescribing must be according to current, evidence-based clinical practice guidelines or resources. See section 8 of General Provisions, for additional steps that must be taken when prescribing off-label (e.g. documenting rationale, informed consent).

24) AUTHORIZED TO PRESCRIBE BUT DECIDE NOT TO

	Submitted Question	SCPP Response
24.1	Is being eligible to prescribe mandatory for licensure? I work in an environment where I have not participated in "pharmacist initiated" prescribing in 7 years. Extending prescriptions sure. But prescribing is not something that I do. It's not something I am interested in. I am more than happy to explain to my patients that I don't prescribe for minor ailments and I'm also more than happy to direct them to someone that is willing.	Level 1 Prescribing Authority is based on entry-to-practice competencies and therefore permitted for all licensed pharmacists. However, pharmacists are not required to prescribe as part of their license. See General Provisions section 2 textbox "*When a Pharmacist is Permitted to Prescribe but Decides Not To"* for other expectations (e.g. referring to other health professional who can provide the service).

25) IMPACTS OF FORMULARY ON PRESCRIBING

	Submitted Question	SCPP Response
25.1	Interim supplies and Sask Formulary Two Month Drug List - do we prescribe an interim of only 2 months and then do a 4 month emergency supply if necessary or do we prescribe 3 months as an interim and fill 2 months initially and have 1 month remaining as a part fill if the patient needs it?	Saskatchewan Health has appended a list of drugs to its contract with all Saskatchewan pharmacies (i.e.100-day list and 2 month list in the Maintenance Drug Schedule) in which it expects the prescribing and dispensing to be in these quantities once the medical therapy of a patient is in the maintenance stage, unless there

		are unusual circumstances that require these quantities not be dispensed. Professional judgement is required to follow SCPP requirements (e.g. must not exceed SCPP prescribing limits), while also being mindful of the terms of the contract with the MOH. Also see section 11 of General Provisions for guidance on documenting rationale for the prescribing decision.

26) COSMETIC TREATMENTS

	Submitted Question	SCPP Response
26.1	Will Level 1 Prescribing Authority include cosmetic treatments---ie/ botox prescribing & injecting	Pharmacists are not authorized to prescribe (Part K) or administer drugs by injection (Part L) for cosmetic purposes. (Also see Administration of Drugs by Injection and Other Routes FAQs)

27) OTHER PRACTITIONERS

	Submitted Question	SCPP Response
27.1	How will SCPP be addressing the inevitable backlash from prescribers?	Backlash is expected to be reduced by pharmacists fulfilling their dispensing scope of practice first, when presented with a prescription issued by a practitioner. Also see #22.1 above, the December 2023 webinar, and Section 2- General Provisions for additional professional accountability measures for pharmacist prescribing.
27.2	Are these changes being conveyed to the SMA?	Yes. SMA has been consulted on the bylaws. Concerns expressed have been built into the bylaws and policies where it makes sense to do so.

28) LEVEL II – VACCINE PREVENTABLE DISEASES IN CANADA (PART K s.13)

	Submitted Question	SCPP Response
28.1	I would like clarification on Level 2 prescribing for VPD. ie) will anyone be able to prescribe for vaccines like Shingix?	Prescribing for Vaccine Preventable Diseases in Canada (VPD) is a Level II Prescribing Authority. (see Part K, ss. 12 & 13 of SCPP Bylaws). Level II Prescribing – VPD, Travel Health A and B are being rebranded to provide clarity and support members with education in order to encourage more members to feel comfortable and competent to provide the service. Stay tuned for updates to SCPP documents, website and updates to CPDPP's training and education. As per SCPP Scopes of Practice Update webpage, pharmacists' scope of practice is status quo until Council-approved policies, competencies, and training are established and have been officially communicated to members. There are no immediate changes as a result of the bylaws. Pharmacists are allowed to prescribe for the VPD listed in s. 13 of Part K in the Bylaws, so long as they have met the status quo training and practice requirements which may be found in the following: • SCPP Training & Development webpage; • Disease Prevention and Travel Health Services Policy and Framework for Saskatchewan Pharmacists; • Travel Health Services and Vaccine-Preventable Diseases FAQs Shingles, hepatitis and pneumococcal disease are included in s. 13 of Part K. RSV is not included in the list of diseases in s. 13 of Part K. See #30 below Other Diseases Identified by the Minister of Health.
28.2	I would like clarification on Vaccine Preventable Ds in Canada - How is it possible for LVL 1 prescribers to do.	
28.3	Please provide clarity on training required for prescribing VPD in Canada	
28.4	Can you clarify rules around prescribing for Prevnar 20 and Shingrix.	
28.5	Can pharmacists prescribe vaccines (eg, Shingles, Hepatities, RSV, ect) for patients who are NOT travelling?	

28.6*	What exact training is required to prescribe vaccine as I am a little bit confused about this piece. Just CPDPP training or?	See #28.1 above for training information. If prescribing a vaccine with a travel indication, see #29.1 below.
28.7	Per the **Disease Prevention and Travel Health Services Policy and Framework** document in the reference manual on the SCPP website updated April 2021, I am under the impression that we are able to prescribe select vaccines for prevention of diseases such as shingles, hepatitis A and B, etc, without having ISTM certification as long as we are competent in the prescribing in those specific circumstances. With the new prescribing framework coming I am unable to find any info in the documents as to if this is changing or has changed. I see **Vaccine Preventable Diseases** and **Travel health A and B** are under Level 2 prescriptive authority which has not launched yet. As it stands now, is the previous list of diseases that can be prescribed for still applicable? I have patients who will be travelling in the coming months and inquiring about hepatitis A and B vaccination and I would like to know if I have the ability to provide those or if they need to try and get in to the local clinic. Any clarification would be appreciated.	See #28.1 above and #29.1 below

29) LEVEL II – TRAVEL HEALTH A (PART K s.14)

	Submitted Question	SCPP Response
29.1	With weak supporting evidence and low efficacy, can pharmacists prescribe dukoral for traveller's diarrhea?	See SCPP Training Table and continue to monitor SCPP communications for further updates or visit Scope of Practice Updates webpage (as per #28 above for information the roll out of bylaw amendments for Level II prescribing authority Travel Health A).
29.2	Can all pharmacists prescribe antibiotics for travellor's diarrhea or do you require additional ISTM training.	
29.3	Please explain what training is optional and mandatory training needed for travel vaccination and high/low risk etc	

29.4	Level II - Travel Health A: It mentions that pharmacists can only prescribe under this authority if they have Advanced Methods, have completed the training provided by the U of S, and if additional training has been done. Originally, the first two conditions were the only ones that had to be met. So for those of us who have had this training and were already prescribing under this authority, do we need to now complete extra training or am I misunderstanding this?	See s. 14 of Part K of SCPP Bylaws for the diseases included in this category and additional information on what may be prescribed (e.g. antibiotics). As per s. 12(5) of Part K, community pharmacists must use current peer-reviewed evidence-based resources or clinical practice guidelines pertaining to the condition being treated to determine appropriate drug choice. This includes the use of Dukoral for traveller's diarrhea.

30) LEVEL II – OTHER DISEASES IDENTIFIED BY MINISTER OF HEALTH (PART K s.19)

	Submitted Question	SCPP Response
30.1	Can Level I pharmacist do RSV vaccines.	Other Diseases identified by MOH is a Level II prescribing activity that is permitted of all pharmacists who have successfully completed the practice, training and competency requirements stipulated for each specific disease, including the timeframe for which they are in effect. Note: this category of prescribing is jointly enacted by the SCPP and the MOH, in response to a specific health need (may be short or long term). When prescribing under this category pharmacists must follow the terms and conditions specified. See Community Pharmacy Practice Enactments, for current list of diseases approved under the Other Diseases category, which includes RSV, along with the training/practice requirements specific to each disease and the timeframe they are in force. Also see Paxlovid Prescribing – Frequently Asked Questions for Pharmacists.
30.2	Starting Jan.29th can we not prescribe Paxlovid, RSV vaccines etc anymore because we don't have the Level II prescribing authorization yet?	
30.3	Note: this is a repeat from 14.7 above	Interchangeable pharmaceutical products are identified in the Saskatchewan formulary as being

	…in the case when there was a shortage of Depo Provera in Canada and the american version was imported, but it's not technically interchangeable, so we had to contact prescribers to change prescriptions to the American Depo-Provera (or only write Medroxyprogesterone Acetate 150mg/ml). This also happened with Timolol eye drops at some point. This is just to clarify the question. Does the new Prescribing Authority let us make the switch and prescribe?	interchangeable with another product. (See *The Pharmacy and Pharmacy Disciplines Act, s. 2(l)).* Drug shortages that impact the formulary, may be one situation in which the Ministry of Health and SCPP may decide to enact Level II prescribing under "Other Diseases Identified by the Minister of Health or Designate."

31) LEVEL II – ADVANCED A (PART K s.16)

	Submitted Question	SCPP Response
31.1	Can MedSask be used as resource for Therapeutic Substitution?	See SCPP Training Table and continue to monitor SCPP communications for further updates or visit Scope of Practice Updates webpage Tabled for future.

32) LEVEL II ADVANCED B (PART K s.17)

	Submitted Question	SCPP Response
32.1	Advanced prescribing B – only when a practitioner has provided a diagnosis. What are the requirements of a diagnosis (verbally, written, inferred, etc.)?	See SCPP Training Table and continue to monitor SCPP communications for further updates or visit Scope of Practice Updates webpage Tabled for future.

33) LABORATORY SCOPE OF PRACTICE (PART M)

	Submitted Question	SCPP Response
33.1	Is ordering lab tests only available to pharmacists with level 2 prescribing or will all pharmacists have the ability to do that?	See SCPP Training Table and continue to monitor SCPP communications for further updates or visit Scope of Practice Updates webpage Tabled for future.

34) PRESCRIBING DEVICES (E.G.TEST STRIPS)

	Submitted Question	SCPP Response
34.1	I'm wondering which category the prescribing for devices (like test strips) falls under, as those are not drugs.	Note: further to response given in #1.14 above. Test strips may be sold to the public without a prescription. If a pharmacist prescribes test strips, as authorized in s. 2(e) of Part M of the SCPP Regulatory Bylaws, the benefits provider will determine whether there is coverage when the Rx for test strip is written by a pharmacist. The pharmacist would need to verify coverage with the patients' benefits program (e.g. see SCOPe "Spotlight on Prevention" December 2021 noting that current coverage must always be verified.)

35) PHARMACIST ASSESSMENT RECORD (PAR)

	Submitted Question	SCPP Response
35.1*	It states that the PARs must be filled out by pharmacists and that the techs can help with drug distribution. Are interns allowed to fill out the PARs with supervision?	No. Neither pharmacist interns nor pharmacy technician interns 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. The Pharmacist Assessment Record (PAR) is a clinical record for prescribing drugs.
35.2*	It states that the PAR must be filled out by pharmacists. Can interns aid in this process under supervision of the pharmacist?	
35.3*	It states that PARs have to be used for everything, including admin prescribing for example. In the past for a script for Tylenol for NIHB for example, we would write a script	The NIHB does not require the pharmacist to use their prescribing authority. Instead, you may **recommend** eligible OTC products.

	and then indicate treatment indication on the script. It is my understanding that we now have to do a full PAR? Or can we just include documentation on our script pad (I.e. include follow up date, rationale for prescribing, section documentation, (I.e. all of the sections from the PAR))?	See SCPP/NAPRA Standards of Practice for Schedule II and III Drugs and NIHB program for documentation requirements.

36) ADMINISTRATIVE PRESCRIBING

	Submitted Question – Pharmacist Initiated	SCPP Response
36.1*	Would the use of vitamins or herbal supplements be considered self-limiting conditions and covered under admin prescribing?	No. Part K is prescribing drugs and NHPs are not drugs. See also #18.1 above.
36.2*	For Admin prescribing, one of the summary sheets says “self limiting” conditions. What about vit D/diabetic strips? What quantity can we put for it? Also, does rationale have to be added into the sig for admin prescribing?	• Vitamin D – see #36.1 above • Diabetic strips – see #34 above • SIG – see #11 above
36.3*	Admin prescribing - states that it should be for self limiting conditions. When we prescribe for insulin/diabetic supplies or vitamins for bubble packs - does this fall under admin prescribing? Are we no longer allowed to do that? How does that frame work look?	• Prescribing Drugs (Insulin) – see Level I Prescribing Authority (Pharmacist-initiated) s. 2.7 • Prescribing Diabetic supplies (test strips) – see #34 • Vitamins for bubble packs – see #18.1 above
36.4*	home care patient require anything that goes into a compliance pack must be written by a physician. can we not use and bill admin prescribing for an OTC in that case ?	See SCPP response to #18.1
36.5*	For pharmacists prescribing schedule 2 and 3 medications – can pharmacists renew prescriptions for OTC meds that were initiated by a physician for a patient that has plan 2 or 3 coverage similar to how we can write prescriptions for diabetic supplies only to be billed to SK health? Prior to the change on Jan 29th, refills could only be written by a doctor to comply with the rules and coverage? But diabetic supplies were something different?	Prescribing “schedule II and III medications” - see #1.12 and #18.9 above. Part K Prescribing “diabetic supplies” - see #34 above. Part M

	Submitted Question – Structured	SCPP Response
36.6*	Lantus (new) is prescribed at hospital discharge, please explain the procedure to change to Biosimilar Basaglar if ER doctor not able to be contacted. PAR required?	Administrative prescribing for Ministry initiatives (e.g. Biosimilar Transition Enactment), must be done according to the terms & conditions established for the specific enactment, including PAR & notification requirements. Monitor communications from the SCPP or the Ministry for details when enacted.

37) PHARMACY SOFTWARE – DATA ENTRY

	Submitted Question	SCPP Response
37.1*	Reading through the question sheet, number 18.1 and 18.6. It seems as though SCPP does not adequately understand these questions. In order to place an OTC/NPH product in a compliance package, it must be ENTERED into the system (ie Kroll) as a prescription (whether or not SCPP requires a prescription), filled as a prescription and thus it shows up on PIP (aiding in med rec). I believe the question askers are requesting clarity as to whose name goes in the prescribing field in this case.	The SCPP does not provide advice on data entry into pharmacy software. Check your vendor software training. See #18.1 above.
37.2*	back to the compliance pack otc question.	See #37.1
37.3*	there seems to be alot of confusion among members regarding administrative prescribing. It has been said that it applies only to drugs (i.e have a DIN) and that NHPs are NOT included. But we are also told we can enter these NHPs and non-RX items into pharmacy softward under our name with no issue. So, if I am understanding correctly - We can enter NHPs (Vitamin D, B12, etc) into our software for patients unrestricted, we just cant send it to third parties (drug plan, private insurance, what ever) for COVERAGE as this requires admin prescribing.	See #37.1

38) LEVEL II – COLLABORATIVE PRACTICE AGRREEMENT (CPA)

	Submitted Question	SCPP Response
38.1	Clarification on the regulatory bylaws regarding level II prescribing under a Collaborative Practice Agreement (CPA)	The following SCPP documents will be of assistance: • General Provisions for Prescribing Authority • Framework for Developing a Safe and Functional Collaborative Practice Agreement • COLLABORATIVE PRACTICE (Prescribing) AGREEMENT TEMPLATE Please note that Part K of the SCPP Regulatory Bylaws has just been amended, and the reference manual documents are being updated for this scope of practice. As noted on the SCPP webpage Scope of Practice Updates, there are no immediate changes as a result of the bylaws – everything is status quo until otherwise communicated by the College. Be sure to monitor communications from the SCPP for updates.

39) IMPLEMENTATION TIMELINES

	Submitted Question	SCPP Response
39.1*	So when do these new prescribing authorities become active?	*Level I Prescribing Authority will launch Jan. 29, 2024.* See Memo - Scope of Practice Update - Level I Prescribing Authority Launch, Dec. 8, 2023
39.2*	So to confirm - we CANNOT “Alter RX’s” at this time?? Is that correct?? Keep faxing Dr’s endlessly to try to resolve by “dispensing activities”?	See #39.1
39.3*	And to be clear, none of these changes are yet in effect? I thought these changes were in effect as of Jan.29…	See #39.1

39.4*	There was a slide showing us all that everything is status quo until all policy updates are completed, meaning that none of these new prescribing policies are yet in place. Now you are saying it is active as of Jan.29th. So which is it?	Prescribing: See #39.1 As per communication provided December 21, 2013 webinar: Billing: • SCPP has been advised by the DPEBB that all policies and billing processes for currently available prescribing authority services remain status quo at this time. • The DPEBB will communicate directly with pharmacies should there be any updates to the policies and processes in the future. Compensation: • Compensation for prescribing authority is negotiated by the Pharmacy Association of Saskatchewan (PAS). • Questions regarding funding of new pharmacy professional services related to the expanded scope of practice for Saskatchewan pharmacists should be directed to PAS