Prescriptive Authority for Pharmacists
Information for Physicians and Other Prescribers

Answers to common questions:

1) Who is this information intended for?
Besides physicians, it has been prepared for dentists, nurse practitioners, optometrists and midwives (practitioners).

2) What does prescriptive authority for pharmacists mean?
It means changes to provincial regulations and the bylaws of the Saskatchewan College of Pharmacists (SCP) to expand the drugs that the pharmacist may prescribe beyond emergency contraception.

The legislation authorizes Level I (basic) and Level II (advanced) prescribing within collaborative practice environments. Level I activities are within the competency of all pharmacists licensed in the province of Saskatchewan.

Collaborative practice environment means that collaboration in the relationship between the pharmacist and practitioner involved in the care of the patient must be sufficient so that the practitioner can rely upon the basic skills of the pharmacist to prescribe in the best interests of the patient, communicate those decisions back to the practitioner, and refer the patient to them or other health care providers as appropriate. Ongoing communication between the pharmacist and the practitioner is expected.

3) What is Level II authority?
The legislation also authorizes Level II authority where the pharmacist possesses advanced skills and/or where there are more sophisticated or advanced relationships between pharmacists and practitioners. It is permitted within formal, written agreements between pharmacists and practitioners. Generally, such agreements stipulate the conditions, limitations or qualifications to the authority of a pharmacist to prescribe. Both parties formally agree that the pharmacist prescribe within the parameters of the agreement. This includes:
- initiation of therapy, for example, upon receipt of your diagnosis and/or therapeutic goal;
- therapeutic substitution of one molecule for another within the same therapeutic class; and,
- dosage or therapeutic regime adjustments, for example community warfarin dosage adjustment protocols.

For example, they could authorize pharmacists with more advanced training in the treatment of certain disease states to initiate pharmacotherapy for the patient upon receipt of the diagnosis of that disease state from the physician.

SCP has prepared a framework and template to guide the development of these agreements.

4) Are there any limits on pharmacist prescribing?
Yes. Pharmacists cannot prescribe drugs beyond their competency to do so, and only in the following defined circumstances, with quantity limits:
Pharmacists will have the authority to prescribe drugs in the following situations:
1. Continuing Therapy – interim supplies and maintenance therapy (the lesser of the amount of the last fill, or 100 days supply);
2. Drugs in emergency circumstances (previously prescribed or dispensed medication within the last 6 months – sufficient quantity to meet the emergency needs of the patient up to 100 days supply);
3. Incomplete or inaccurate prescription (the lesser of the amount of the last fill, or 100 days supply);
4. Refills of medications during practitioner absence (as specified by the practitioner up to 100 days supply);
5. Non-prescription drugs (to obtain third party coverage) up to 100 days supply;
6. Seamless care (up to 100 days supply); and,
7. For the self care treatment by the patient of minor and/or self-limiting ailments, prescription drugs in accordance with the protocols approved by the SCP Council. Amongst other things these protocols will assist the pharmacist in assessing the accuracy of the patient’s self-diagnosis and recommend drugs of choice. Implementation is delayed until pharmacists are trained on using the protocols and will be phased in as conditions for treatment are approved.

5) How will we know when a pharmacist prescribes?
Pharmacists are expected to consult your patient’s medication history and record their prescribing decision in the PIP system. They are also expected to complete a Pharmacist Assessment Record and provide it to you to directly notify you when you are the patient’s primary practitioner. The PAR represents the pharmacist’s prescription, but also contains the pharmacist’s rationale for the prescription. The pharmacist will most likely fax it to you.

You can also view the pharmacist’s prescription and rationale in the patient’s profile in the PIP medication viewer.

6) What about Controlled Substances?
Pharmacists cannot prescribe Controlled Substances (i.e. Narcotics, Controlled Drugs, Benzodiazepines and Other Targeted Substances) until they are recognized as practitioners under the federal Controlled Drugs and Substances Act.

7) Does this mean that patients no longer need to see their physician or other practitioner for their medications?
Certainly not.

Pharmacists as prescribers of drugs are NOT intended to replace any practitioner. The intent is quite the opposite. The new laws depend upon a close working relationship between the patient, practitioner and pharmacist. They give the pharmacist added tools to help practitioners manage their patients’ drug therapy, and to help patients maximize the benefits of drug therapy.

8) What are these added tools?
The new laws provide the pharmacist with added flexibility to respond to a variety of situations without having to consult with the practitioner first

However, pharmacists are not trained to diagnose diseases and medical conditions. They are trained to recognize what might be the best medication for the diagnosis. That is why the new authority is based upon collaboration.

Examples:
Prescribing by pharmacists will be allowed in various circumstances – continuing maintenance therapy, emergencies, incomplete prescriptions, practitioner’s absence, patient self care for minor
and/or self-limiting ailments and seamless care, and when pharmacists have advanced skills or are involved in more sophisticated or developed teams. Instead of having to contact you first, pharmacists can make these prescribing decisions will then advise you accordingly when you are the patient’s primary practitioner. An example or two of each:

Continuing maintenance therapy – Your patient is stabilized on chronic therapy, their prescription has run out and they cannot see you for several days. The pharmacist can provide the supply needed until your patient’s visit.

Emergencies – Your patient takes a medication when needed or regularly. Your patient is on a trip, has left their medication at home and needs it. The pharmacist can provide a supply to meet your patient’s needs until they can access their medication.

Incomplete prescriptions - Sometimes practitioners will inadvertently omit legally required information on prescriptions, but the pharmacist can reasonably deduce the intent. Under those circumstances, the pharmacist may complete the prescription without checking with you first.

Practitioner’s absence – When you temporally leave practice, such as for vacation or education, you can leave instructions with local pharmacist(s) to continue the medications for your patients if their prescriptions run out while you are away.

Minor and/or Self-Limiting Ailments – Your patient may either be self-medicating or otherwise treating a minor, self-limiting ailment (e.g. cold sores, severe insect bites, athlete’s foot). Over-the-counter remedies are either inappropriate or do not help. Depending upon the ailment and assessment of the patient’s self-diagnosis, needs and experience, the pharmacist may prescribe a prescription drug that is a better option for your patient.

This will only be permitted under evidence based guidelines or protocols approved by the SCP Council. They are intended to identify the drug and indications, prescribing limits and when to refer the patient to a practitioner. The guidelines will be selected based upon certain criteria, including:
- the condition can be reliably diagnosed by the patient;
- the ailment is minor and/or self-limiting;
- medical or laboratory diagnostic tests are not needed;
- no significant potential exists to mask more serious underlying conditions;
- the drug has a wide safety margin; and,
- the drug has good evidence of efficacy.

Seamless care - When patients are transferred from one health care setting to another, the pharmacist can prescribe to correct discrepancies that may occur according to established drug reconciliation practices and without consulting with you first.

9) When will this happen?
It will begin March 4, 2011.

10) Can the pharmacist prescribe for out-of-province patients?
Yes, and they are expected to meet the same standard of care as with Saskatchewan residents.

11) Are there times when the pharmacist is able to prescribe, but decides not to?
Yes, under two main circumstances and with some limits. Firstly, the bylaws prohibit the pharmacist from prescribing when the collaborative practice environment does not exist. This occurs when practitioners notify, either verbally or in writing, the pharmacist that you do not want the pharmacist to prescribe to your patient or a class of patients. Pharmacists expect that this will occur for patient related reasons. That will mean that the pharmacist will consult with you first before dispensing the medication.
The second is when, in the judgement of the pharmacist, prescribing a drug is not appropriate. Pharmacists are trained to recognize when it is appropriate to refer the patient to you.

12) **Does the change in law apply to all pharmacists?**
Yes it does with some exceptions.

For Level I prescribing, licensed pharmacists must take orientation training on the process and standards they are expected to follow. For a variety of reasons, some may decide to not take this training, and are not allowed to prescribe. In the future however, SCP will make this training a requirement for licensure.

13) **Where can I find more information?**
At the SCP web site:
http://napra.ca/pages/skprescriptiveauthority/default.aspx

At the SCP public education web site:
www.mypharmacistknows.com

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