

Repeat Dispensing in Australia

The patient hands their repeat prescription to the pharmacist who passes it under the barcode reader. Without further input the pharmacy computer prints all the labels, produces the next Repeat Authorisation, prepares an order to replace the stock, and produces an electronic invoice against which the NHS will make payment. The assembled products are passed under the barcode reader by the pharmacist and the pharmacy computer confirms that they are the correct products for the prescription. The labels are then applied by hand.

This is the reality of Australian pharmacy today.

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Repeat Dispensing in Australia

A report by R Gartside, FRPharmS.

A). Executive Summary

The Health Service system of repeat dispensing in Australia makes use of pharmacy computers to provide a first class, secure, service which makes minimal demands on prescribers, patients, pharmacists, pharmacies, and the payment authority while ensuring patient convenience and free choice of pharmacy.

The basis is that the patient holds a document which is an authority for pharmacists to dispense their medication on a fixed number of occasions and also a document which acts as a pharmacy payment instrument when a supply is made. A new payment instrument is produced by the pharmacy dispensing an instalment of the supply, given to the patient, and this is then used by the next pharmacy to claim payment for the next supply.

The system is described in detail; it is recommended that it be further investigated both as an insurance policy in case the proposed British system encounters unexpected problems during roll-out and also because the Australian system preserves patient choice of pharmacy on each and every occasion of dispensing and this may become important at a later date to ensure optimum take-up of repeat dispensing.

B). Notes.

1).The Pharmacy Benefits Scheme (PBS) in Australia is viewed as providing subsidies for the purchase of medicines. Not all medicines are included in the scheme, and disadvantaged patients still have to pay a small amount towards the cost of their medicines (unless they need very large numbers of prescriptions). There are also restrictions on products, disease indications, quantities prescribed and numbers of repeat prescriptions. These are discussed in Appendix 5. since they do not affect the principle of the repeat prescription scheme.

2). Prescriptions which do not comply with PBS can be dispensed as private prescriptions if the patient so desires, even if written on NHS paper. However, it is not possible to have both private and NHS items on the one prescription form – if the private dispensing option is exercised then it covers all products on the form.

3). It is hoped that HealthConnect, the new Australian scheme to provide secure access to medical and pharmaceutical records across the health system will begin to roll out in Tasmania and South Australia on July 1st. 2004. It has not proven possible to ascertain how the computer systems described here will interface with HealthConnect since it will not be rolled out in Western Australia for some time.

C). Method.

Visits were made six pharmacies in Perth, Western Australia during February and March 2004. Discussions were held with the Health Department of Western Australia, the Pharmacy Council of Western Australia, the Health Insurance Commission Western Australia, and the Pharmacy Guild of Western Australia.

Mr. Mark Wilson, of the Medical Centre Chemist, Sir Charles Gairdner Hospital (a private pharmacy situated inside this teaching hospital), Mr. David Haig of the Western Australia DoH, Mr. Bob Brennan of the Pharmacy Council of Western Australia and Mr. John Jack, retired pharmacist of Chidlow, WA, were particularly helpful but thanks are due to all the persons interviewed.

D). Basic Principles of the Repeat Dispensing Scheme.

1).The prescription is written by the physician as an 'Original' (O) and a 'Pharmacy/Patient Copy' (PPC); they may be hand-written using NCR paper or they may be computer printed, both copies are signed by the physician.

2).The patient takes both (O+PPC)to the pharmacy of their choice, where the first dispensing is made and the patient signs a detachable strip at the bottom of the Pharmacy/Patient Copy and this is then stapled to the Original (O) as a receipt.

3).The Original (O) is retained by the pharmacy and later submitted to the Health Insurance Commission (HIC) for payment; this alerts HIC that there is a new repeat prescription for this patient.

4).The pharmacy prints 'Repeat Authorisation One' (RA1) of the prescription, sample as Appendix 1, (with the repeat number less one dispensing) which is given to the patient together with the Pharmacy/Patient Copy (PPC), and the medication.

5).The patient takes the Repeat Authorisation One (RA1) and the Pharmacy/Patient Copy PPC) to a pharmacy of their choice when the second dispensing is needed and the patient signs the bottom of the Repeat Authorisation One (RA1) as a receipt.

6).Repeat Authorisation One (RA1) is retained by the pharmacy and later submitted to HIC for payment.

7).The pharmacy prints Repeat Authorisation Two (RA2) which is given to the patient together with the Pharmacy/Patient Copy (PPC) and the medication.

8).This process is repeated until the final dispensing, when all repeats are exhausted, and at this stage the final pharmacy retains the Pharmacy/Patient Copy (PPC) and keeps it for twelve months in case an audit is required. The final Repeat Authorisation (RAn) is signed by the patient as a receipt and is submitted by the pharmacy to HIC for payment.

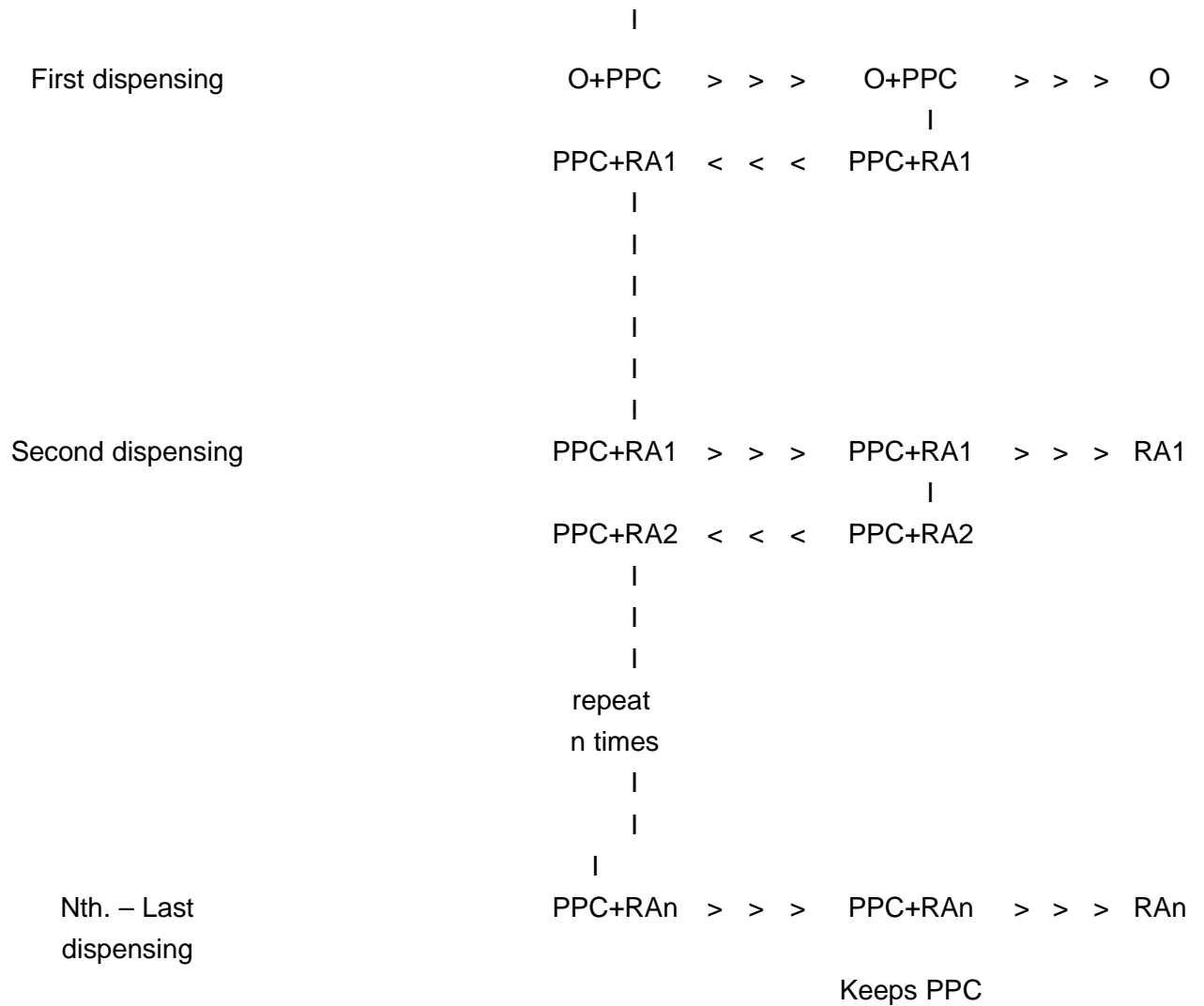
9). In practice, good pharmacy computer systems make the process simple and rapid. For example, some software prints a barcode on the Repeat Authorisation and if the patient returns to the same pharmacy the whole process can be done automatically by using a bar code reader.

10). Prescription payments are actually made against floppy discs, which are accompanied by the paper Pharmacy Copies for random audit.

11). A flowchart outlining the flow of documents follows as page 4.

Australian Repeat Dispensing Flow Chart

Activity	Physician		Patient		Pharmacy	HIC
Write prescription	O+PPC	>	>	O+PPC		



Original prescription O
 Pharmacy/Patient PPC
 Copy
 Repeat Authorisation RA1
 1

E). Numbering

- 1). Much use is made of identification numbers, which enable complete computer control and audit of the whole process.
- 2). No prescription is valid unless it carries the patient's NHS number and the prescriber's NHS number, and it will not be priced if it does not carry the pharmacy dispensing number.
- 3). All patients were issued some years ago with a card carrying their NHS number, pharmacies are allowed to keep this number on machine file and add it to the prescription with their endorsements. GPs apparently initially resisted putting patient numbers on prescriptions but now are beginning to appreciate the wider value of patient NHS numbers.
- 4). All GPs and all pharmacies have a unique identifying NHS number and these must also appear on all prescriptions submitted for pricing. It seems that these, and all other numbers, are structured to both provide extra information (addresses or localities or categories) and to enable computer authentication checks. Of course computers make all the numbering easy.
- 5). It occasionally happens that the patient NHS number does not co-incide with the name and/or address on the prescription, for example if the patient has married. In such cases the labels for the medicine will carry the name and address written on the prescription, but the data submitted to HIC will carry the name and address from the patient's NHS card. Obviously checks will be carried out before the prescription is dispensed and normally the reasons will be marriage or change of co-habitation but there must remain a lingering doubt, as in UK, as to the possible extent of patient deception; modern medicines are high value items.
- 6). A minor convenience is that the same telephone (132 290) and PO Box numbers (GPO Box 9826) are used for HIC throughout Australia.

F). Pharmacy Computer Systems.

1). Examples of two common pharmacy computer systems have been examined and operation of them observed. Examples of other systems could not be easily found in Perth, Western Australia.

2). Both systems produced Patient Medication Records, labels and orders and both could be seamlessly linked to Epos (Electronic Point of Sale) systems. Both could also seamlessly cope with the private prescription option.

3). Both systems produced pricing reports on floppy disc for HIC. As previously stated these could be submitted, together with supporting prescriptions, weekly, fortnightly, or monthly depending on the particular pharmacy's volume and the choice of the pharmacy.

4). With either system (FRED, with WINIFRED as the windows based system, or L.O.T.S.) entry of a repeat prescription previously dispensed by the pharmacy is by entering either complete patent details, the patient number or the pharmacy prescription serial number from the pharmacy produced copy prescription. The entry by barcode reader from the Repeat Authorisation was a particularly quick and accurate operation.

5). Both systems had the capability to confirm by bar code reading that the correct product(s) had been selected for dispensing. This is a legal requirement for pharmacy computer systems in the state of Victoria and is increasingly used elsewhere on a voluntary basis. It is beginning to become a Professional Liability Insurance requirement.

6). Both systems produced several labels at the same printing. Examples are attached as Appendix 2. The small labels are for attaching to the prescription as endorsements, there are also a bag label and various others used for stock control purposes. Notable is the facility to produce narrow product labels for eye drops and inhaler cans.

7). Both systems could cope with Monitored Dosage Systems (MDS) and with homes and both could also cope through other modules with narcotics maintenance programs, although demonstrations of these two capabilities were not seen.

8). Future developments include an automatic patient recall system which will remind patients that they have not picked up a repeat when it is due. This is a pharmaceutical industry initiative and pilots currently in progress are being industry funded, it being expected that industry funding will be forthcoming if the pilots are successful and the system widely adopted. The hope is, of course, that increased patient compliance and concordance will lead to better disease control and fewer episodes of hospitalisation.

It is also hoped that Just In Time ordering systems can be developed so that patients taking rare or expensive medication can nevertheless expect their medication to be waiting for them when they call in to the pharmacy for a repeat.

G). Submission of prescriptions for pricing.

1). Submission of prescriptions for pricing is by floppy disc, accompanied by the paper prescriptions (originals and repeats) for audit purposes. All of the pharmacy computer systems have the ability to produce floppy discs for pricing in an agreed format.

2).Prescriptions must be sorted into numerical order based on the pharmacy's own computer generated numbers. These numbers are structured so as to identify the dispensing pharmacy and it is possible that the number also provides information on the prescriber and, perhaps, the patient. Certainly there is a belief by some pharmacists that this may be the case.

3).Pharmacies are required to submit prescriptions monthly. Busy pharmacies may submit fortnightly or weekly since this helps both them and the pricing office and can improve their cashflow.

4).Information on the audit process is, naturally, retained within HIC as confidential. It is believed by pharmacists that 10% of all scripts are randomly audited but confirmation of this did not prove possible.

5). Electronic submission for pricing is under consideration but has no high priority because the floppy discs work so well and submission of the paper copies for audit is in any event going to remain essential, so there is little gain from e-submissions.

H). Payments for prescriptions.

1). Patients make a co-payment for their prescriptions up to a maximum cost of A\$23.70 (c.£10.00) for general patients or A\$3.80 (c.£1.70) for concessional patients holding one of several kinds of concessional card. There are minor differences between States as to the concessions allowed. There is a Safety Net Scheme for patients needing large numbers of prescriptions; this becomes operative once a patient has exceeded a payment threshold for the year.

2). Pharmacies are paid the basic cost of the prescription medicine plus 10% (5% for very expensive items) plus a dispensing fee of A\$4.66 (c £2.00) with additional fees for narcotics and extemporaneously dispensed items. A general impression was formed that there may be an additional element of profit through prudent purchasing but confirmation of this could not be obtained.

I). Problem solving.

1). The responsibility for problem solving lies squarely with the physicians and pharmacists concerned who are expected to use their professional knowledge and expertise to handle problem situations; there are thus few, if any, formal guidelines.

2). Examples of various problems were put to a number of pharmacists and the following summarises their responses:-

a). The two copy prescriptions presented by the patient do not agree.

If the problem is simple, i.e. differences in dosage, the pharmacist would question the patient and amend the next copy prescription. More complex problems, i.e. changes in strength of product, or different product, would be for the pharmacist and physician jointly to solve.

b). Patient who has already presented repeat prescription now presents an extra 'normal' prescription for the same product.

This is a matter for liaison between pharmacist and physician.

c). Patient is suddenly called away and needs several months supply of medication.

This is at the pharmacist's discretion under 'Section 24' for most products. For products on which there are special restrictions, Authorisation can be obtained by phoning the Department of Health where there is always a pharmacist on duty to issue Authorisation Numbers. The DoH employs community pharmacists on a one day a week secondment basis to undertake this rôle.

d). Patient has lost or spoilt their supply of medication and requires the next supply before the due date.

By custom and practice this is at the pharmacist's discretion for a few days, otherwise a matter for the pharmacist and physician.

e). Physician wishes to cancel prescription 'mid-life'.

The physician would be expected to contact the pharmacies direct, this may not be too difficult since most patients use the same pharmacy on a regular basis.

f). Patient insists that the original prescription is 'wrong'.

This is a matter for liaison between pharmacist and physician.

g). Patient (or physician) wishes to change product, strength, dosage or quantity.

Must be referred to physician who will produce new prescription.

h). 'Hospital' have allegedly told patient to alter dosage strength or frequency, or both.

A new prescription will be necessary.

J). Discussion.

1). The system as here described has evolved over a considerable period of time from a system for private prescriptions which owed much to the British model. One notable characteristic of all the people interviewed was a pronounced pragmatic willingness to consider changes to the system in response to events or in response to changed circumstances. It seems that change in the system is relatively easy to agree and produce. Perhaps as a result, there was a strong feeling of ownership of the system which all concerned strongly believed to be the best in the World -- "because the actual working pharmacists designed it and are responsible for its maintenance"

2). The system is undoubtedly highly popular with patients, physicians, and pharmacists; it is noteworthy that no serious adverse comments were encountered from any quarter.

3). Careful consideration of the system shows that it contains a number of checks and balances which make for accuracy and that it also produces a robust audit trail. The Pharmacist/Patient Copy prescription is largely responsible for this since it acts as a continuous record of the physician's original prescription against which the copies can be checked. The extensive use of numbers is also an important safeguard which is easy to operate because of the sensible use made of computers in the whole process.

4). The necessary pharmacy software is well proven and in discussion with the manufacturer's representatives they felt that there would be little difficulty in providing software which would operate only the repeat function without the other functions necessary under the Pharmacy Benefits Scheme. It should be noted, however, that these discussions were with sales staff and not with programming staff. There appeared to be good interest in servicing the British market, whose size had not previously been realised.

5). In an Option Appraisal report to the Scottish Executive, RPSGB, Alison Strath in June 2001 came to the conclusion that a 'master/slave' model with one pharmacy dispensing all repeats should be implemented for UK because it made minimal demands for new computer programs and because it was felt that having all of a patient's prescription dispensed at one pharmacy would facilitate record keeping and medicines management. It was also argued that the imminent roll-out of electronic transfer of prescriptions would render any paper based system quickly redundant.

However, electronic transfer of prescriptions has now been subsumed into the work on the single patient record and will be some years in the future. It has also to be said that the history of previous large and ambitious government IT initiatives has

not been encouraging – cost over-runs and long delays have been frequent and have even led to the abandonment of programs after much work. Back-up may be prudent.

There is no doubt that repeat dispensing can show great cost savings, of the order of 14%, as well as being convenient and time-saving for patients and NHS staff; it is also possible that more regular medication may lead to lower hospitalisation rates although this question has not been addressed in the studies so far carried out. For all of these reasons, the aim should be the best possible uptake of repeat dispensing and it may be here that the weakness of the master/slave model shows itself because of the need for the patient to always return to one pharmacy. This may not always be convenient and there is always the possibility that the patient and the pharmacy may come to a permanent disagreement. A system which allows the patient free choice of pharmacy on each occasion of dispensing is therefore preferable.

K). Recommendations.

- 1). A more detailed study should be carried out of the Australian system of Repeat Dispensing both because it is not yet certain that the proposed British system will pass unscathed through scale-up trials and because the Australian system offers the important advantage that the patient has a totally free choice of pharmacy on the occasion of each dispensing. It is possible that the need to use a single pharmacy for all supplies will prove a serious obstacle in the way of widest possible take-up of the proposed British system.
- 2). British pharmacy computer system manufacturers should be encouraged to open discussions with their Australian counterparts with a view to mutual co-operation. Although the Australians have much more highly developed repeat dispensing systems, their management information systems and their control of product use is much less sophisticated than is that provided by British systems and upgrades in this area will become necessary as the size of Australian pharmacy companies increases. A trend towards larger pharmacy companies is now well underway, although perhaps twenty to thirty years later than in Britain.
- 3). Immediate consideration should be given to encouraging large pharmacies in Britain to submit prescriptions for pricing and payment more frequently than monthly since this simple move will, at little cost, produce benefits for both the pharmacies and the PPA.
- 4). Progress in Britain towards electronic pricing of prescriptions has been slow; the principle obstacle being believed to be the lack of a uniform drugs code. Pricing by weekly or monthly floppy disc with the paper prescriptions as an audit back-up is shown by the Australian experience to be both practical and economical and it

appears to be compatible with more sophisticated electronic systems. It should be accorded the highest priority, if need be by buying in the Australian system.

5). The Pharmacy Benefits Scheme will not normally pay for more than one month's supply at a time. There is ample evidence to show that such a restriction in Britain would produce substantial cost savings and its introduction simultaneously with a Repeat Dispensing Scheme should be seriously considered since such a Repeat2 Scheme obviates the need for large quantities to be supplied at one time.

6). Consideration should be given to allowing prescriptions written on NHS paper to be, optionally, treated as private prescriptions, with the proviso that all of the items on one form would be treated as private. As well as cheap items, if recommendation 5).were to be adopted this would give patients the opportunity to have large quantities if they were prepared to pay for them.

7). Consideration should be given to allowing patients with generic prescriptions to make an extra payment direct to the pharmacy for the supply of a branded product in lieu of the generic. The Australian experience appears to be that this exerts a powerful downward pressure on manufacturer's prices.

8). The Western Australian practice of having community pharmacists working one day per week on secondment in the Department of Health appears to have considerable benefits to both the Department and to pharmacists in the community and consideration should be given to the introduction of such an arrangement in Britain.

Appendix 1

Pharmacy Repeat Authorisation

PHARMACEUTICAL BENEFITS - PBS/RPBS
REPEAT AUTHORISATION
 VALID ONLY IF THE PATIENT/PHARMACIST
 OR DUPLICATE PRESCRIPTION IS ATTACHED

A 2115069

MARK RELEVANT BOX




Serial No.	G	Prescriber No.	690193	GEN	XX
PATIENT'S MEDICARE NO.	25437754112		30/06/2005	CON	
PATIENT'S NAME & ADDRESS	MR ARTHUR AAA HOSPITAL AVE NEDLANDS WA POST CODE 6009			ENT	
				RPBS	

Authority Number		Entitlement Number	
------------------	--	--------------------	--

ORIGINAL PRESCRIPTION TRANSCRIPTION (Item, Strength, Quantity, Directions and Deferred Supply if applicable)

20 Amoxicillin 500mg Caps (FH)
Take ONE capsule THREE times daily every EIGHT hours
(GENRX AMOXYCILLIN 500MG C) Rpt. 49904
If needed before 21-Feb-2004 consult pharmacist.

ORIGINAL PRESCRIPTION DETAILS		No. OF TIMES ALREADY DISPENSED (INCLUDING ORIGINAL SUPPLY) IF ORIGINAL NOT SUPPLIED INSERT '0'	PRICED ITEMS ONLY
DATE	PBS APPROVAL No.		
16 Feb 2004	50760N		
No.	No. OF REPEATS AUTHORISED		\$
49904	1	1	

NAME AND PBS APPROVAL NUMBER OF PHARMACIST DISPENSING THIS SUPPLY	NAME AND PBS APPROVAL NUMBER OF PHARMACIST ISSUING THIS AUTHORISATION
 6 000000 499044	MEDICAL CENTRE CHEMIST MARK WILSON QEII MEDICAL CENTRE NEDLANDS WA 6009 Phone: 08 9346 3729 49904 50760N 16/02/2004

PRESCRIPTION No. THIS SUPPLY	DATE THIS AUTHORISATION PREPARED
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I certify that I have received the medication and the information relating to any entitlement to free or concessional pharmaceutical benefits is not false or misleading

Patient's or Agent's Receipt **[Redacted]**

Agent's Address **[Redacted]**

Date of Supply **[Redacted]**

The information recorded on this form, including your Medicare number and details advised by Centrelink and by the Commonwealth Department of Veterans' Affairs will be used to assess your entitlement to benefits under the Pharmaceutical Benefits Scheme and to determine payments due to Pharmacists. Your Medicare number is being collected as it is required by law. In addition, with your consent, the Pharmacist or doctor may store your Medicare number for use on future prescriptions. The collection of this information is authorised by the *National Health Act 1953* and is usually disclosed to the Commonwealth Department of Health and Aged Care. If you require additional information please contact your nearest Medicare Office or the Department of Health and Aged Care Web site. Information pamphlets are also available from Medicare Offices and from pharmacies.

4010A(11/00)

Appendix 2

Composite label set.

These label sets are printed in one pass and comprise a choice of label sizes, a bag label, and small labels to be fixed to the prescription as pack and product endorsements.

NB. These are separate labels on one backing paper when printed, but the reproduction process has not shown the slits in the paper.

MEDICAL CENTRE CHEMIST Mark Wilson, B.Pharm., J.P. GEI Medical Centre, Hospital Ave., NEDLANDS, W.A., 6009. Telephone: 9346 3729		 2 100000 189250
MR ARTHUR AAA 16 Feb 04 1889K 50760N \$11.97 49904 1		
20 Amoxicillin 500mg Caps (FH) Take ONE capsule THREE times daily every EIGHT hours until the medicine is finished. MR ARTHUR AAA 16 Feb 2004 49904 1 Rpt to go (GENRX AMOXYCILLIN) Dr W THYER		Mark Wilson 50760N GEI Medical Centre, Hospital Ave., NEDLANDS. Amoxicillin 500mg 20 1889K 49904 \$14.95 1 16/02/04
MEDICAL CENTRE CHEMIST Mark Wilson, B.Pharm., J.P. GEI Medical Centre, Hospital Ave., NEDLANDS, W.A., 6009. Telephone: 9346 3729		Mark Wilson 50760N GEI Medical Centre, Hospital Ave., NEDLANDS. Amoxicillin 500ma 49904 16/02/04 1 D
MR ARTHUR AAA		

Appendix 3

Sample page from the Schedule of Pharmacy Benefits (SPB)

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ANTIINFECTIVES FOR SYSTEMIC USE —cont.

Code	Name, Restriction, Manner of administration and form	Max. Qty	No. of Rpts	Premium	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Proprietary Name and Manufacturer	
• Imidazole derivatives								
METRONIDAZOLE								
1636D	Tablet 200 mg	21	1	..	6.68	7.61	^a Metrogyl 200	AF
					^b 1.98	8.66	^a Metronide 200	HP
						7.61	^a Flagyl	AV
1626N	Tablet 400 mg	5	2	..	6.57	7.50	Metrogyl 400	AF
1642K	Suppositories 500 mg, 10	‡1	..	..	20.17	21.10	Flagyl	AV
METRONIDAZOLE								
Restricted benefit								
<i>Treatment of anaerobic infections.</i>								
1621H	Tablet 400 mg	21	1	..	9.41	10.34	^a Metrogyl 400	AF
					^b 2.07	11.48	^a Metronide 400	HP
						10.34	^a Flagyl	AV
Restricted benefit								
<i>Prophylaxis in large bowel surgery;</i>								
<i>Treatment, in a hospital, of acute anaerobic sepsis.</i>								
1638F	I.V. infusion 500 mg in 100 mL	5	1	..	*43.11	23.10	BX	
METRONIDAZOLE BENZOATE								
1630T	Oral suspension 320 mg per 5 mL (equivalent to 200 mg metronidazole in 5 mL), 100 mL	‡1	..	..	14.30	15.23	Flagyl S	AV
TINIDAZOLE								
1465D	Tablet 500 mg	4	..	..	7.48	8.41	^a Simplotan	GP
					^b 2.50	9.98	^a Fasigyn	PF
• Nitrofurantoin derivatives								
NITROFURANTOIN								
CAUTION:								
Nitrofurantoin may cause peripheral neuritis and severe pulmonary reactions.								
1692C	Capsule 50 mg	30	1	..	14.56	15.49	Macrochantin	PU
1693D	Capsule 100 mg	30	1	..	13.49	14.42	^a Ralodant	KR
					^b 1.20	14.69	^a Macrochantin	PU
1691B	Paediatric oral suspension 25 mg per 5 mL, 200 mL	‡1	..	..	16.32	17.25	Furadantin	PU
• Other antibacterials								
HEXAMINE HIPPURATE								
3124K	Tablet 1 g	100	5	..	32.41	23.10	Hiprex	MM
SPECTINOMYCIN								
3090P	Injection 2 g with 3.2 mL diluent	1	..	..	22.88	23.10	Trobicin	PH

Appendix 4

Initial page of SPB announcing restricted availability of etanercept

LATE AMENDMENTS — SECTION 2 — NEW ITEMS

Name, Restriction, Manner of Administration and Form	Max. Qty	No. of Rpts	Premium	Dispensed Price for Max. Qty \$	Maximum Recordable Value for Safety Net \$	Proprietary Name and Manufacturer
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Page 180 – after the listing for Cyclosporin, insert the following:

ETANERCEPT

Authority required

Initial treatment by a rheumatologist of adults with severe active rheumatoid arthritis who have a record of rheumatoid factor positive status;

AND

(a) who have signed a patient agreement form indicating that they understand and acknowledge that PBS-subsidised treatment will cease if the predetermined response criteria do not support continuation of PBS-subsidised treatment;

AND

(b) who have failed to achieve an adequate response to methotrexate at a dose of at least 20 mg weekly;

AND

(c) who have failed to achieve an adequate response to methotrexate, in combination with 2 other disease modifying anti-rheumatic drugs (DMARDs), for a minimum of 3 months;

AND

(d) who have subsequently failed to achieve an adequate response following a minimum of 3 months' treatment with:

(i) leflunomide alone; or

(ii) leflunomide in combination with methotrexate; or

(iii) cyclosporin.

If treatment with any of the above-mentioned drugs is contraindicated according to the relevant TGA-approved Product Information, or intolerance of a severity necessitating permanent treatment withdrawal develops during the relevant period of use, the patient is exempted from demonstrating an inadequate response to the above treatment regimens. Details of the contraindication or intolerance, including the degree of toxicity, must be provided at the time of application.

The following criteria must be met in order to demonstrate failure to achieve an adequate response:

an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour or a C-reactive protein (CRP) level greater than 15 mg per L;

AND either

(i) an active joint count of at least 20 active (swollen and tender) joints; or

(ii) at least 4 active joints from the following list:

- elbow, wrist, knee and/or ankle (assessed as swollen and tender); and/or*
- shoulder and/or hip (assessed as pain in passive movement and restriction of passive movement, where pain and limitation of movement are due to active disease and not irreversible damage such as joint destruction or bony overgrowth).*

If the above requirement to demonstrate an elevated ESR or CRP cannot be met, the application must state the reasons why this criterion cannot be satisfied.

The authority application must be in writing and must include sufficient information to determine the patient's eligibility according to the above criteria. The date of joint assessment must be provided.

Where fewer than 3 repeats are requested at the time of the initial authority application, authority approvals for sufficient repeats to complete a maximum of 4 months of treatment may be requested by telephone. Under no circumstances will telephone approvals be granted for initial or continuing authority applications, or for treatment that would otherwise extend the initial treatment period beyond 4 months.

The assessment of the patient's response to the initial course of treatment should be made after at least 12 weeks of treatment so that there is adequate time for a response to be demonstrated. Applications for continuing treatment with etanercept should be made prior to the completion of 16 weeks of treatment to ensure continuity for those patients who meet the criteria.

continued ☞

Appendix 5

Aspects of the Australian Pharmaceutical Benefits Scheme (PBS).

- 1). The scheme is regarded as providing a subsidy for the purchase of prescription medicines.
- 2). Only medicines listed in the Schedule of Pharmaceutical Benefits (SPB) will be subsidised, all other medicines must be paid for in full either by way of private prescriptions or by straightforward retail purchase.
- 3). Only the quantities listed against each individual medicine in SPB will be subsidised; larger quantities must be purchased, by private prescription if necessary.
- 4). Only the number of repeats listed against each individual medicine in SPB will be subsidised, greater numbers of repeats will take the prescription out of PBS.
- 5). Any prescription on PBS paper can be treated as a private prescription, but all items on the prescription must be treated privately. Thus if a PBS prescription calls for a medicine not listed in SPB, or for a greater quantity or more repeats of one item than allowed by SPB, all items on the prescription must be treated privately.
- 6). PBS prescriptions are normally dispensed generically but where a patient wishes to have the branded drug they make an extra payment and these payments are listed in the SPB.
- 7). There are different rules in different states as to the frequency or timing of repeats, but there is freedom allowed to the pharmacist under Section 24 to occasionally, in special circumstances, supply all of the repeats at one time – the patient still pays the charge for each repeat, however.
- 8). The maximum co-payment for general patients is A\$ 23.70 (c £10.00) while the maximum charge for concessionary patients is A\$3.80 (c £1.1.70).
- 9). A Safety Net operates for patients who have large numbers of prescriptions. The safety net threshold for general patients is co-payments of A\$726.80 (c £320.00) and for concessionary patients the threshold is A\$197.60 (c £86.00) in any one year; these thresholds are equivalent to 31 and 52 prescriptions respectively. Once the threshold is reached then further prescriptions for concessionary patients are free in that year, while general patients only pay the concessionary rate on further prescriptions in that year. Records of prescriptions are kept on a patient card, there is provision for pharmacists to make a charge of A\$6.87 (c £3.00) for the issuing of the card.

10). Where a prescription calls for a smaller quantity than a standard pack, a 'wastage table' is used to determine how much more than the cost of the ordered quantity must be paid for to ensure that the pharmacy is compensated for the wastage involved. This appears to be easier to administer by computer than the 'broken bulk' arrangements used in Britain, and can be no less fair and economical.

Appendix 6

Useful addresses

Health Department of Western Australia, PO Box 8172, Stirling St., Perth, WA 6000
phone *Ms L. Fry*, (08) 9388 4980

Pharmaceutical Benefits Branch, Health Insurance Commission, Western Australia
11th. Floor, Bankwest Tower, 108, St. George's Terrace, Perth, WA 6000
phone 132 290
www.hic.gov.au

Pharmacy Council of Western Australia
21, Hamilton St., Subiaco, Perth, WA 6008
phone *Mr. Bob Brennan*, 61 8 9388 2886
email pcwa@iinet.au

The Pharmacy Guild of Australia, Western Australian Branch,
1322, Hay St., Perth, WA 6005
phone 08 9324 2355
email guild.wa@guild.org.au

L.O.T.S. computer system, associated with AMFAC.
Pharmasol Pty Ltd., PO Box 2248, Caulfield Junction, VIC3161
Phone (03) 8531 9200
Email lots@pharmasol.com.au www.pharmasol.com.au
WA contact Ms Sandra Cooke, Cosmos Ltd.,
41, Walters Drive, Osborne Park, Perth, WA 6017
phone 61 8 9446 9366
email sandra.cooke@cosmos.com.au

FRED (*for DOS*) and WINIFRED (*for Windows*) computer systems.
Pharmacy Computers Australia Pty. Ltd.,
40, Burwood Road, Hawthorn, VIC 3122
phone (03) 9810 9965 or 1300 73 1888
email info@pharm.com.au
WA contact Nu-Systems Ltd., Unit 12, 502, Balcatta Rd., Perth, WA

Details of more computer suppliers have been promised from Australia.

N.B.

Pharmacy Computers Australia is owned by the Victoria Branch of the Pharmacy Guild of Australia. It was set up in its present form in 1993, having originated in 1983. Programs currently available include:-

Fred – Fast, Reliable, Easy, Dispensing for DOS systems.

Winifred – the Windows version of Fred.

Bill – a billing suite for homes and doctor's accounts with pharmacies.

William – the Windows version of Bill.

Homer – a Home Medication Review program.

Phred – a Private Hospital version of Fred.

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