



**Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive**

**National Shared Services
Primary Care Reimbursement Service**

**Information and Administrative
Arrangements
For Pharmacists**

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1.0 HSE - National Shared Services - Primary Care Reimbursement Service

HSE - National Shared Services - Primary Care Reimbursement Service carries out the following functions on behalf of the Health Service Executives in relation to the provision of services by General Practitioners, Pharmacists, Dentists and Optometrists / Ophthalmologists:

- Calculation of payments
- Making of such payments
- Verification of accuracy and reasonableness of claims
- Compilation of statistics

In respect of the following schemes:

- General Medical Services Scheme (GMS)
- Drugs Payment Scheme (DPS)
- Long Term Illness Scheme (LTI)
- Health (Amendment) Act, 1996 (HAA)
- High Tech Drugs (HTD)
- Methadone Treatment Scheme
- Dental Treatment Services Scheme (DTSS)
- Community Ophthalmic Services Scheme (HBCOSS)
- Primary Childhood Immunisation SchemeEuropean Economic Area (EEA)

The PCRS currently deals with claims in respect of some 40.2 million prescription items per annum (2002 figures, increasing by approx. 4.2 million per annum) plus payments to Doctors, Pharmacists, Dentists, Optometrists/Ophthalmologists and Wholesalers.

2.0 Schemes Overview

2.1 General Medical Services Scheme (GMS Scheme)

Eligibility

Persons who are unable, without undue hardship, to arrange General Practitioner medical and surgical services for themselves and their dependants. Since the 1st July 2001, all persons aged 70 years and over are eligible for GMS services.

The person registers with the Doctor of his/her choice and is entitled to receive free Doctor, Dentist and Optometrist/Ophthalmologist treatment and prescribed medicines and appliances from the list approved by the Minister for Health and Children.

Each GMS eligible person is issued with a laminated plastic medical card by the HSE, which contains the person's name, medical card number and other information embossed thereon. All cards are valid for a particular period of time and contain a 'Valid To' date.

Medical Card trail

- GMS person issued with GMS prescription form by Doctor where medically indicated
- Patient goes to Pharmacist to have prescription dispensed
- Pharmacist submits prescription to the Primary Care Reimbursement Service for payment
- Prescription logged and processed in the Primary Care Reimbursement Service
- Payments calculated
- Pharmacist receives payment from the Primary Care Reimbursement Service according to agreed schedule

Drugs and Medicines reimbursable under the GMS Scheme

- Products must belong to a category eligible for reimbursement under the GMS Scheme, pursuant to EU Council Directive 89/105 EC
- Medicinal Products are approved by the GMS Division of the Department of Health and Children on a monthly basis
- Manufacturer/ Agent submits application to the Department of Health and Children
- Product must have a current EU Commission Marketing Authorisation (MA) or a Product Authorisation (PA) issued by the Irish Medicines Board (IMB)
- Products must comply with the Pricing Structure of the IPHA Agreement (Agreement between the Department of Health and Children and the Irish Pharmaceutical Healthcare Association)
- Product, if approved, is notified by Department of Health and Children to the Primary Care Reimbursement Service
- Monthly Updates are prepared by the Primary Care Reimbursement Service and sent out to all relevant Contractors – Doctors and Pharmacists
- Product is then reimbursable from 1st day of following month
- Manufacturers must also notify the Department of Health and Children and the Primary Care Reimbursement Service of any changes to the list of approved products e.g. change of pack size, discontinuation of pack size and these changes are also approved by the Department of Health and Children. The approved trade price is the basis of calculation of payment in all cases.

Drugs and Medicines are listed as part of the Product File on the Primary Care Reimbursement Service's website with prices stated.

Non Drug Items Reimbursable under the GMS Scheme

- Drug Review Group of the Primary Care Reimbursement Service and approved by the Minister for Health and Children
- Decisions are made once a year at the Autumn Review
- Manufacturer / Agent submits application each autumn to the Primary Care Reimbursement Service
- Products must comply with the criteria published by the Primary Care Reimbursement Service
- Products must be CE Marked and/or comply with EU Legislation
- Manufacturer/Agent must submit satisfactory results of relevant trials i.e. user/clinical trials
- Manufacturer/Agent must submit final sample of product
- Products must comply with agreed pricing structure Draft Update of Proposals sent to Manufacturers – 2-week period for representation allowed
- Representations received and final decisions made by the Non Drug Review Group
- Update prepared and sent out to all relevant Contractors and Healthcare Personnel
- Update effective from 1st January each year.

Non Drug Items are listed as part of the Product File under their various categories on the Primary Care Reimbursement Service's website with prices stated.

Instructions For Use of Codes

This set of instructions is written primarily for Pharmacists who submit their claims for manual processing.

Note for Pharmacies Claiming Electronically: These instructions should be followed in general subject to any variation in the Help Text provided by the Primary Care Reimbursement Service and available through your service provider.

The principles of the code are:

A code number of five figures is assigned to a specific pack of each product or standard preparation. When this number is entered on the prescription form it will identify the product or preparation dispensed and the pack from which it was dispensed. Code numbers are special unique computer numbers, which if used incorrectly, cannot be processed by the Primary Care Reimbursement Service's computer system.

Quantities of less than 10,000 computer units dispensed on a prescription form, claim form or stock order form **MUST** be indicated by the use of four digits. Where the quantity supplied is less than 1000, leading zeros **MUST** be used, e.g. 0001; 0005; 0050; 0100; 0900.

Special Mark for Uncoded Items – ⊗

Quantities in excess of 9,999 computer units dispensed on a prescription form, claim form or stock order form must be left uncoded, supply indicated by the official uncoded sign ⊗.

When coding a prescription form, each dispensed prescription item must be coded separately and clearly with a ball point pen or similar pen, or be printed directly onto the form.

If a prescription form contains some prescription items that can be coded and some that cannot be coded, as many prescription items as possible should be coded.

Where a reimbursable item cannot be coded, the uncoded sign ⊗ **MUST** be used to indicate that the item has been dispensed.

On a standard prescription form or claim form with more than eight codable items, it is no longer necessary to restrict coding to a maximum of eight items provided that sufficient space exists on the form to code clearly the ninth or subsequent item(s). However where space is insufficient for clear coding **EACH** of the remaining items should be marked with the official uncoded sign □, stating strength, brand and pack size used. Illegible items should be clarified so as to indicate to the Primary Care Reimbursement Service the exact items supplied.

Each line of a stock order form should be coded where possible and only one item **MUST** be entered on each stock order line.

The Quantity Codes (A and B)

Quantity Code A for preparations dispensed by number.

Quantity Code B for preparations dispensed by weight or volume.

Quantity Code A – For Tablets, Capsules, Pessaries, Suppositories, Aerosols Ampoules, Vials and other preparations dispensed by number, including all appliances and dressings.

Quantity Dispensed	1	30	60	And any quantity up to a maximum of	9999
Code	0001	0030	0060		9999

N.B. – Appliances and Dressings are coded according to the number of individual items supplied, e.g.

Stock Order (Pink)

	Drug Code	Quantity Supplied
Cotton Wool Hospital 250 G. Pack	80926	0001
Crêpe Type Bandage 8 cm. x 5 m. 6 Bandages	80055	0006
Non-Allergic Tape Silk 2.5cm x 9 m. 2 Rolls	85596	0002
Non Woven/Filmed Swabs (Not Sterilised)	86177	0001
10 cm. x 10 cm. 100 swabs/pack 1 Pack	86231	0010
Paraffin Gauze Dressing 10 cm. x 10 cm. Individual 10 Dressings	80128	0004
Plaster Zinc Oxide 2.5 cm. x 5m. 4 rolls		

Quantity Code B – Metric Code. To be used for all liquid and solid preparations, dispensed by weight or volume, including ALL ointments, creams, pastes, etc.

Quantity Dispensed	1 G. or ml.	2 G. or ml.	→	15 G. or ml.	→	100 G. or ml.	and by grammes or milliliters up to	999 G. or ml.	then	1 Kg. or 1 Litre	10 Kg. Or 10 Litres
Code	000 1	000 2		001 5		010 0		099 9		100 0	9999

Conversion Table

N.B. – Preparations dispensed by weight or volume should be coded in the metric code, using the following conversion table, which is based on 1 oz. = 28.4 G./ml., calculated to the nearest G./ml. up or down, e.g. 1.4 as 1; and 1.5 as 2.

Weight or Volume	1 drm.	2 drm.	3 drm.	4 drm.	5 drm.	6 drm.	7 drm.
Equivalent Metric Code	0004	0007	0011	0014	0018	0021	0025

Weight or Volume	1 oz.	1.5 oz.	2 oz.	3 oz.	4 oz.	5 oz.	6 oz.	7 oz.	8 oz.
Equivalent Metric Code	0028	0043	0057	0085	0114	0142	0170	0199	0227

Weight or Volume	9 oz.	10 oz.	12 oz.	14 oz.	16 oz.	20oz.	24 oz.	28 oz.	32 oz.
Equivalent Metric Code	0256	0284	0341	0398	0454	0568	0682	0795	0909

Examples of Operating the Code

To operate the code, obtain the code number assigned to the product ordered and dispensed, enter the relevant pack size code number on the prescription form in the column headed "DRUG CODE", and then code the quantity supplied.

	Drug Code	Quantity Supplied
R _x Adcortyl Inj. 10 mg./ml. 1ml. – Mitte 5	60054	0005
R _x Betnovate Cream – Mitte one tube	14893	0030
R _x Difene Inj. 75 mg.3 ml. – Mitte 5	19690	0005
R _x Flixotide 250 Inhaler 60 Dose Aerosol	24933	0001
R _x Scheriproct Suppos. – Mitte 12	45217	0012
R _x Stafoxil Caps. - 250 mg.20 (ex. 500 pack size)	45357	0020
R _x Eumovate Oint. 30 G. Emulsifying Oint. B.P. ad 150 G.	⊗	0150

Note: *It is important that Pharmacists should, when coding, make figures that can be read at a glance, and avoid joining figures together*
Roman numerals should never be used

Clear, legible figures are essential for fast, efficient and accurate data entry

Extemporaneous Preparations

Generally, extemporaneously prepared formulations that are identical with or similar to excluded medicinal products will not be considered for payment on the GMS Scheme.

Mixtures

All cough mixtures are non-reimbursable, including those that have a reimbursable item in the formulation.

Expectorant mixtures are non-reimbursable, including those that have a reimbursable item in the formulation. Exceptions are laxative mixtures of reimbursable items or their dilutions with an inert substance, e.g. water, syrup.

Gargles and Mouthwashes

All gargles and mouthwashes are non-reimbursable.

Liniments, Paints and Inhalations

All liniments, paints and inhalations are non-reimbursable.

Lotions

Calamine, Formaldehyde, Potassium Permanganate, Sodium Bicarbonate, Sodium Chloride and Eye Lotions are non-reimbursable.

Ointments, Creams and Pastes

Calamine, Boric, Sulphur, Zinc – ointments, creams and pastes – or mixtures of these, are non-reimbursable.

Preparations for corn and wart treatments are non-reimbursable.

Ear Drops and Nasal Drops

Ear drops and nasal drops are non-reimbursable.

Dilutions of reimbursable items with inert diluents such as water, syrup or sucrose are reimbursable

Coding of Extemporaneous Prescriptions

Extemporaneous prescriptions that are reimbursable are classified as follows for the purpose of coding:

- A. Liquid preparations for internal use.
- B. Ointments, creams, pastes.

Type	Ingredient Cost	Per	Drug Code
A	72c	100 ml.	92494
B	109c	100 G.	92495
		Drug Code	Quantity Supplied
R _x	Potassium Citrate 6 G. Citric Acid 1 G. Syrup 5 ml. Chloroform Water to 20 ml. Mitte 300 ml.	92494	0300
R _x	Coal Tar Solution 12 ml. Sulphur pptt 4 G. Salicylic Acid 2 G. Coconut Oil 60 G. Emulsifying Base to 100 G.	92495	0100

Where a Pharmacist submits uncoded a claim in respect of the ingredient cost of any prescribed item, with quantity up to 1,000 Computer Units, the actual ingredient cost will be recouped, even if it is less than the standard recoupment rate.

Where the quantity of an extemporaneous preparation is greater than 1,000 Computer Units, the claim should be submitted uncoded to the Primary Care Reimbursement Service. The actual ingredient cost will be reimbursed.

Payment for Purified Water or Water for Injections as an ingredient will only be made where the use of either is prescribed or necessarily implied.

Where alcohol is prescribed as an ingredient, the Pharmacist should indicate clearly on the prescription the type of alcohol incorporated in the formulation.

Extemporaneous Codes

Extemporaneous codes must *not* be used for preparations that are coded and listed in the Code Book, even though at times they may have to be prepared extemporaneously, e.g. reconstitution of an antibiotic medicinal product from dry powder to form an oral suspension.

GP (General Practitioner) Visit Card

Holders of GP Visit Cards are not entitled to Dentist or Optometrist treatment or prescribed medicines and appliances.

Eligibility

Persons whose income limit is less than the income guideline that applies to their circumstances are eligible for a GP Visit Card. If it is decided by the Health Service Executive that financial hardship would arise because of medical costs or other exceptional circumstances even when the income limit is greater than the guideline that applies to that person they will be issued with a discretionary GP Visit Card.

A card may be granted for the whole family or for an individual member of the family on the grounds of financial hardship

The person registers with the doctor of their choice and is entitled to receive free Doctor treatment. **They are not entitled to Dentist or Optometrist treatment or prescribed medicines and appliances.**

Each GP Visit eligible person is issued with a laminated plastic GP Visit card by their Local HSE Office, which contains the person's name, GP Visit card number and other information. All cards are valid for a particular period of time and contain a 'Valid To' date.

2.2 Drugs Payment Scheme (DPS)

On the 1st July 1999 the Drugs Payment Scheme was launched. No individual or family now has to pay no more than €85 in a calendar month for approved medicines and appliances. Persons wishing to avail of their entitlement **must** register with their local HSE Office and will receive a DPS Card which bears a family identification number, eligible persons name, Personal Public Service Number (PPSN) and a 'valid to' date

DPS Card Trail

- DPS patient receives prescription from Doctor (Liable for consultation fee)
- Patient goes to Pharmacist to have prescription dispensed
- Does not pay over €85 per month in respect of approved medicines or appliances
- Pharmacist submits DPS Claim to the Primary Care Reimbursement Service for payment
- DPS Claim logged and processed in DPS Unit of the Primary Care Reimbursement Service
- Payments calculated for Claim
- Pharmacist receives payment from the Primary Care Reimbursement Service for balance over €85 per month in respect of each family unit

The DPS applies to persons who are ordinarily resident in Ireland and who do not have a current medical card.

Under the DPS no individual or family will ordinarily have to pay more than €85 in any calendar month for approved prescribed drugs, medicines and appliances for use by that person or his/her family in that month, provided such individuals have all of their prescribed medication dispensed in the same Pharmacy in that month. Where the cost of the medication is less than €85 only the actual cost of the medication will be paid by the eligible person.

Eligible persons who have been registered by their Local HSE Office will be issued with a Drugs Payment Scheme card that must be presented in order to benefit under the scheme when having prescriptions dispensed at a Community Pharmacy.

The card shows a family identification number (i.e. head of household's PPSN number). A position in family code is also displayed. The eligible person's name and PPSN number are displayed on the card. The DPS card is not an identification card for any other purpose.

When members of the same family have all of their prescriptions dispensed in the same pharmacy, the maximum liability will be €85 in a calendar month. If a second pharmacy is used there will be a liability for a further charge of up to €85. Receipts for amounts paid must be issued in all cases so that when the limit of €85 is exceeded excess amounts may be reclaimed at month end from the relevant HSE Office.

Drugs Payment Scheme Guidelines

The Drugs Payment Scheme (DPS) is a Community Drugs Scheme under which registered individuals or families do not have to pay more than the relevant monthly threshold in a calendar month for approved medicines and appliances for use in that month. Persons wishing to avail of their entitlement must register with their local HSE Office and will receive a DPS card, which bears a family identification number, eligible persons name, Personal Public Service Number (PPSN) and a 'valid to' date. At the time of registration, the family must nominate an adult member of the family unit as the 'Head of Household' for the purposes of the Scheme.

Definition of 'Family' for the Purpose of the Scheme

Family expenditure covers the nominated adult, his/her spouse (including a person with whom s/he is living as husband or wife) and children under 18 years of age.

Dependants over 18 years and under 23 years of age who are in full time education may also be included. A dependant with a physical disability or a mental handicap or illness who cannot maintain himself/herself fully, who is ordinarily resident in the family home, may be included in the family expenditure under this Scheme regardless of age.

Eligibility

All those who are ordinarily resident in Ireland are eligible to apply for the DPS, providing they do not hold a current medical card.

The Drug Payment Scheme can be used with a Long Term Illness Book.

If a client moves to a new HSE area they should re-register with their new Local HSE Office for review and administrative purposes. Pharmacists will continue to be paid under the old card while the registration is being processed.

Registration Process

It is important that all current members of a family unit are registered at the same time. When additional children are born, or additional family members are added through a change of family circumstances, these additions should be notified to the HSE using the normal DPS application form.

1. The names, dates of birth, gender, and Personal Public Service Numbers of all members of the Family Unit must be listed on the DPS application form, which should also designate an adult member as Head of Household for the purposes of the Scheme.
2. The Address and telephone number of the Client / Family should be provided.

3. When registering children, the Child's PPS Number is required. Where children's PPS numbers are not readily available, the Registration Section of the Department of Social and Family Affairs will assist.
4. Dependants over 18 years and under 23 years of age who are in full time education may be included by ticking the appropriate box. Additional verification will be required, either through a college stamp or letter.
5. Any Change in circumstances e.g. birth, death, medical card registration, dependant(s) leaving full time education should be notified to the relevant HSE Office.
6. The application form must be forwarded to the relevant local HSE office / regional DPS office (See Appendix 1)

Emergency Registration under the Drugs Payment Scheme

The HSE will make emergency registration forms available (see Appendix 2), in duplicate format, to Pharmacists in their region. The top copy will be sent to the Local HSE Office as the registration form for the family, and the bottom copy will be attached to the unified claim form when making a claim for payment to the Primary Care Reimbursement Service.

A pad of DPS Emergency registration forms is attached.

Labels displaying the address of Drugs Payment Scheme registration offices will also be made available to Pharmacists.

Procedures for emergency registrations:

1. The Patient must complete the DPS Emergency Registration form for the family in the Pharmacy specifying the Nominated Head of Household (who must be an adult) including the Head of Household's PPS Number. All other family members in the household must be listed on the registration form with their dates of birth.

2. The Pharmacist must complete the Pharmacy section on the form, which requests the reason for which the emergency registration process has been invoked, the GMS number of the pharmacy and space for the pharmacy stamp.
3. The DPS Emergency Registration form must be faxed by the Pharmacist to the appropriate local DPS HSE office where the patient lives.
4. When the pharmacist is making a claim for payment for the prescription, the bottom copy of the DPS emergency registration form must be sent to the Primary Care Reimbursement Service attached to the unified claim form to show that the prescription was dispensed in the emergency situation.
5. The top copy of the DPS emergency registration form must be posted to the appropriate local HSE, DPS Office, where the patient lives.

Each Health area will collate the information received on claims in relation to emergency registrations in their individual area to facilitate review exercises.

Retrospective Eligibility

All clients who do not hold a medical card are eligible for the Drugs Payment Scheme. Therefore claims will be honoured by the Primary Care Reimbursement Service where a client's DPS application is being processed.

Transfer from DPS to Medical Card

Where circumstances change, the client's / family's DPS entitlement is deactivated.

Where only the Head of Household changes from DPS to Medical card, then a new Head of Household is generated and new cards issued for the rest of the family.

All relevant communication from the HSE now informs the patient to destroy their old cards and produce their new valid cards to their pharmacy at each visit.

Death of Head of Household

The Local Health Office should be informed when the Head of Household dies in order that a new Head of Household is generated for the purposes of the scheme and new cards issued for the family.

Arrangements for Separated Families under the DPS Scheme

It is accepted that family units might change. Where the Head of Household changes procedures are in place as set out in the two standard letters agreed for use across Health Areas (See Appendix 3 and 4).

Significant Milestones

At Age 18: Confirmation that the client is still in full time education will be required to remain on the family card. (See Appendix 5 for agreed communication)

At Age 23: Eligibility to remain on the original family card by virtue of full time education will be removed. (See Appendix 6 for agreed communication)

Eligibility for those in Continuing Education between 18 and 23 years of age

There are arrangements in place at each Health Area to contact persons who will reach 18 years of age requesting that they clarify if they are eligible to continue as a dependant on the family card.

Expiry Dates

All DPS cards display a 'valid to' date.

High Tech Scheme

Where the patient is obtaining their High Tech Medication under their DPS eligibility, it is essential to be registered in the Health Area in which the patient resides.

Drugs Medicines and Appliances reimbursable under the Drugs Payment Scheme

General

The list of drugs, medicines, appliances and other non drug items specified in the GMS Code Book (including all updates) form the common list of items for both the GMS Scheme and the Drugs Payment Scheme, with the exception of Nicotine Replacement Therapy, which is confined to the GMS Scheme.

Extemporaneous Preparations

Only extemporaneous preparations currently reimbursable under the GMS Scheme are covered under the DPS.

Ostomy and Urinary Products.

Ostomy and Urinary Products previously being claimed for under the two previous schemes, which are not reimbursable under the GMS Scheme, will continue to be reimbursed until further notice. Claims for such non GMS listed products should be submitted as exceptions with a copy of the relevant invoices attached.

The following categories of products will not form part of the Common List. Medical Cardholders will continue to have their requirements for these products met by their Local Health Area.

Dressings

Dressings reimbursable under the DPS will be those listed under the dressings section of the list of flat rated non drug items currently reimbursable on Stock Order forms under the GMS Scheme, effective 1 January each year. However as an exceptional transitional measure non-GMS dressings (except those advertised to the public) which were reimbursed under the previous schemes, will continue to be reimbursable under the DPS. A review will take place and a final supplementary list of dressings will be drawn up. Claims for such non GMS dressings must be submitted as exceptions and supported by copy invoices.

Incontinence Products

Incontinence products previously claimed for under the previous schemes will be reimbursed under the DPS. Only genuine incontinence products not advertised to the public will be reimbursable. Claims for such products must be submitted (by manual claimants) as exceptions and supported by copy invoices.

During the interim period a review will take place and a supplementary list of incontinence products will be drawn up.

Infertility Drugs

Infertility drugs previously claimed for under the DCS and Refund of Drugs Schemes will be reimbursed under the DPS as a transitional measure. Any medicinal product for female infertility newly available since July 1999 may only be reimbursed with the approval of the Department of Health and Children. This does not refer to drugs intended for use or administration in hospitals. Claims should be submitted as exceptions with copy invoices attached.

Unauthorised Medicines

In certain exceptional circumstances unauthorised medicinal products will be allowed on the DPS provided that they are prescribed and dispensed in accordance with an agreed Protocol (See 'Supply of Unauthorised Medicinal Products'). Claims should be submitted as exceptions with copy invoices attached. These claims must be endorsed by the Pharmacist, confirming that the circumstances specified in paragraphs (a) to (i) have been adhered to as outlined in the Protocol.

Hand Priced Items Reimbursable under the Common List

Exception type claims.

Hand Price to pay 1 fee VAT Code 1 (0%) 44444 (electronic claiming code)

Hand Price to pay 1 fee VAT Code 3 (21%) 55555 (electronic claiming code)

Where a Pharmacist wishes to claim in respect of one of these circumstances he/she will use the appropriate code and insert the price in the quantity field. e.g. code 44444 and qty 0760 will pay €7.60 plus 1 fee and no VAT. Claims coded as such should continue to be submitted as exceptions with copy invoices attached. This arrangement applies to the following:

Dexedrine (Dexamphetamine) Tabs. 5mg. 28

Hydromorphone Hyd. (Martindale) Inj. 20mg./ml. 1ml. 10

Hyoscine Hydrobromide (Martindale) Inj. 400mcg./ml. 1ml. 10

Hyoscine Hydrobromide (Martindale) Inj. 600mcg./ml. 1ml. 10

And the following barbiturate medicinal products for supply on a compassionate use basis: Seconal Sodium Capsules 50 mg. and 100 mg., Sodium Amytal Pulvules 60 mg., Tuinal Capsules 100 mg.

Extemporaneous Items Reimbursable under the Common List

Extemporaneous Preparations VAT Code 1 (0 %) 99988 (electronic claiming code)
Extemporaneous Preparations VAT Code 3 (21%) 99989 (electronic claiming code)

Where a Pharmacist wishes to claim in respect of one of these circumstances s/he will use the appropriate code and insert the price in the quantity field in units of one cent (0001). Claims coded as such should continue to be submitted as exceptions with clarification of the formula used and quantities supplied.

Non GMS listed Ostomy and Urinary Products, Incontinence Products, Infertility Drugs and Unlicensed Medicines should be submitted as exceptions with copy invoice attached and coded as follows:

Ostomy/Urinary: to pay 1 fee VAT Code 1 (0%) 77770

to pay 1 fee VAT Code 3 (21%) 77771

Dressings: to pay 1 fee VAT Code 3 (21%) 77720

Incontinence Products: to pay 1 fee VAT Code 1 (0%) 77730

to pay 1 fee VAT Code 2 (13%) 77731

to pay 1 fee VAT Code 3 (21%) 77732

Infertility Drugs: to pay 1 fee VAT Code 1 (0%) 77740

to pay 1 fee VAT Code 3 (21%) 77741

Unlicensed Medicines: to pay 1 fee VAT Code 1 (0%) 77750

to pay 1 fee VAT Code 3 (21%) 77751

Where a Pharmacist wishes to claim in respect of one of these circumstances s/he will use the appropriate code and insert the price in the quantity field in units of one cent (0001).

N.B. In addition the exact quantity of each item supplied must be specified in writing for clarification in the Drug Name and Strength panel.

When claims under this Scheme are being submitted for processing the following guidelines should be adhered to, to facilitate high speed processing.

- DPS bundles should be submitted by manual claimants with LTI and EEA claims to the usual address - Primary Care Reimbursement Service, PO Box 2923, Exit 5, M50, North Road, Finglas Dublin 11.
- It is important that each claim category is separately tagged.

Remuneration and Payment Schedule

Pharmacists whose claims are received by the Primary Care Reimbursement Service on or before the 6th of a month will be paid by the 5th of the following month.

Supply of Unauthorised Medicinal Products under the Drugs Payments Scheme

It is recognised that in certain exceptional circumstances the supply of unauthorised medicinal products will be necessary under the Scheme. The circumstances in which payment for such medicinal products will be made are as follows:

(a) The medicinal product concerned should be an 'allopathic' medicinal product which has been industrially produced and which is appropriate for use in the Community

(b) The medicinal product concerned should be such that no authorised medicinal product of essential similarity is available for prescription and supply under the Community Drug Scheme concerned

(c) The prescription concerned should be written or initiated by a medical consultant who is aware of the unauthorised status of the medicinal product concerned and who has informed the patient of the situation

(d) The dispensing Pharmacist has also informed the patient of the unauthorised status of the medicinal product prescribed and that its quality, safety and efficacy has not been established in this country

(e) The medicinal product concerned is not being advertised or promoted in the State either as such or in any trade catalogue or price list in circulation in the State

(f) The application made for reimbursement is accompanied by a copy of the invoice in relating to the supply of the medicinal product to the Pharmacist concerned and, if necessary, is supported by an explanation of the special circumstances which required the supply of the unauthorised medicinal product

(g) The medicinal product concerned has been written on a prescription form as the only item on the form

(h) The cost of the medicinal product concerned should be reasonable in the context of medicinal products ordinarily supplied and used in the Community and be of a category which, if it were authorised, would be eligible for reimbursement in the Community Drug Scheme concerned

(i) The original prescription or a copy thereof, together with appropriate records of supply, is retained in the pharmacy and kept available for inspection as required.

Packaging of Drugs

The packaging of some drugs and medicines in '28 days' packs appears to be causing difficulties for some Pharmacists when dispensing under the Drugs Payment Scheme. It is a condition of the scheme that no individual or family grouping will pay more than €85 in a calendar month (i.e. €85 x 12 in a full year). The payment of a second €85 (in the same pharmacy) should only arise when a person is intentionally getting the next month's supply on the grounds that he/she will be away the following

month or for other such reason. To ensure that an individual or family makes no more than 12 payments in a year it is suggested that, where appropriate, once in a 12-month period or periodically throughout the year more than a 28-day supply is given. The packaging will influence how this can be achieved.

2.3 Long Term Illness Scheme (LTI Scheme)

On approval by the Local HSE Office, persons who suffer from one or more of a schedule of illnesses are entitled to obtain, without charge, irrespective of income, necessary drugs/medicines and/or appliances under the LTI Scheme. LTI cardholders are only approved for drugs relating to their Long Term Illness. The Primary Care Reimbursement Service makes payments on behalf of the Local HSE Offices for LTI claims submitted by pharmacies. The LTI Card holder must pay for the Doctor's services

LTI Card Trail

- LTI card holder receives prescription from Doctor (Liable for consultation fee)
- Patient goes to Pharmacist to get prescription dispensed
- Patient does not pay for approved medicines or appliances but should pay for medical requirements not directly related to the scheduled illness
- Pharmacist submits LTI Claim to Primary Care Reimbursement Service for payment
- LTI Claim logged and processed in LTI Unit of Primary Care Reimbursement Service
- Payments calculated
- Pharmacist receives payment from the PCRS for the LTI claim

There are 15 specified LTI Conditions:

- Mental Handicap
- Hydrocephalus
- Cerebral Palsy
- Muscular Dystrophy
- Haemophilia
- Diabetes Mellitus
- Diabetes Insipidus
- Epilepsy
- Multiple Sclerosis
- Parkinsonism
- Cystic Fibrosis
- Phenylketonuria
- Acute Leukaemia
- Mental Illness (Under 16 years of age)
- Spina Bifida.

Drugs, Medicines and Non Drug Items reimbursable under the LTI Scheme are intended for the treatment of the primary condition and are approved by the Local Health Office in which the eligible person resides.

Diabetes Mellitus

The Department of Health and Children circulated to Health Areas (in 2000) the decision by the Minister “to include medicines for the treatment of hypertension and hypercholesterolaemia in diabetic patients under the Long Term Illness Scheme” (Illness Code F in the Long Term Illness Scheme – both insulin dependent and non-insulin dependent).

The effect of this decision is that patients with diabetes mellitus who develop hypertension and/or hypercholesterolaemia as a result of their condition are entitled to be prescribed GMS reimbursable medication under the following drug categories as per the WHO Anatomical Therapeutic Chemical (ATC) 2nd level classification [the 1st level being ‘C’ (Cardiovascular System)].

Treatment of Hypertension

- Antihypertensives (C02)
- Diuretics (C03)
- Beta Blocking Agents (C07)
- Calcium Channel Blockers (C08)
- Agents acting on the Renin-Angiotensin system (C09)

Treatment of Hypercholesterolaemia

- Serum Lipid reducing agents (C10)

The Primary Care Reimbursement Service wishes to assist you in arriving at the current position for approved medicinal products in the six ATC 2nd level categories enumerated above. In the Primary Care Reimbursement Service’s view, it is preferable to present the approved categories in this way compared with a printed document, which may diminish in value to you in a relatively short period due to routine changes in the List of GMS Reimbursable Items.

If you wish to learn more about the ATC System, you may visit the WHO Collaborating Centre for Drug Statistics Methodology Website, www.whocc.no/atcddd/.

2.4 Health (Amendment) Act, 1996 (HAA)

The Government has provided in the above Act, for the making available without charge of certain health services to certain persons who have contracted Hepatitis C directly or indirectly from the use of Human Immunoglobulin-Anti-D or the receipt within the State of another blood product or blood transfusion. GP services, Pharmaceutical services, Dental services and Optometric/Ophthalmic services provided under the Act are paid for by the Primary Care Reimbursement Service.

Eligible persons will receive a Health (Amendment) Act, 1996 Services Card from their Local HSE Office. This card is personal to the holder and is valid indefinitely. It should be presented when the eligible person wishes to avail of services under the Act.

Persons eligible under the Act are entitled to receive drugs, medicines and medical and surgical appliances, which are prescribed by a medical practitioner free of charge. Arrangements similar to those in place under the Drugs Payment Scheme (DPS) will apply in relation to this service but without the need for the person to pay a contribution towards the cost of medication and appliances supplied and without the requirement for the person concerned to have their prescriptions dispensed from the same pharmacy in respect of the same month.

On dispensing of a prescription to a person eligible for services under this Act, the Pharmacist must complete a 'unified claim form' (in the format of claims for this scheme), which should also be signed by the authorised person and forwarded to the Primary Care Reimbursement Service. Claims should be tagged and submitted to the Primary Care Reimbursement Service with DPS Claims to be received not later than the 6th of the month following the month of dispensing.

In the case of high-tech medicines prescribed for persons with eligibility under the Health (Amendment) Act, 1996, the usual arrangements in relation to the supply of high-tech medicines will apply.

2.5 High Tech Drugs Scheme (HTD Scheme)

Commenced in November 1996, the HTD Scheme provides for the supply and dispensing of high-tech medicines through Community Pharmacies. The medicines are purchased by the Local Health Office and supplied through Community Pharmacies for which pharmacies are paid a patient care fee by the Primary Care Reimbursement Service each month.

Examples of high-tech drugs are: anti-rejection drugs for transplant patients, chemotherapy and growth hormones.

Drugs reimbursable under the High Tech Drugs Scheme

- All Drugs reimbursable under the HTD Scheme are approved by the Department of Health and Children in a similar manner to those on the GMS Scheme
- In addition, consultation takes place with the Pharmaceutical Contractors Committee, the Irish Pharmaceutical Healthcare Association and the Pharmaceutical Distributors Federation.
- Approvals are notified by the Department of Health and Children to the Primary Care Reimbursement Service.
- Periodic updates, prepared by Primary Care Reimbursement Service, are sent to all relevant Contractors and the HSE.
- Update is effective from 1st day of the stated month.

These arrangements are designed to provide a quality Community based service to patients by ensuring the active involvement of Community Pharmacists in the dispensing of High Tech medicines that were previously supplied in the main through Hospitals or Local Health Offices.

For the purpose of ensuring smooth operation of this Scheme each Local Health Office has designated a person known as the High Tech Liaison Officer – the Liaison Officer will be responsible for co-ordinating the Scheme.

A patient who, on discharge from hospital, is prescribed one or more High Tech item(s) from the list will be asked to nominate a Community Pharmacy where s/he

proposes to obtain the prescribed High Tech Medication. All information relevant to the patient and the items prescribed will be recorded within the hospital on the form provided for the purpose – the said form will be faxed by the hospital to the relevant Liaison Officer. The Liaison Officer will advise the nominated Community Pharmacist of authorisation to supply the High Tech drugs. If a Patient presents unexpectedly to a Pharmacist with a Prescription Form for any of the agreed High Tech medicines the Patient should be facilitated and the Pharmacist should contact the appropriate Liaison Officer. The Liaison Officer should also be contacted in relation to viable stock surplus to requirements.

A Pharmacist will obtain High Tech items from his pharmaceutical wholesaler using the usual ordering facility and quoting the appropriate drug code(s). Items should be dispensed in original packs when possible.

A Pharmacist should transcribe the details of High Tech items dispensed onto a **High Tech Prescription Claim Form (i.e. a 'unified claim form' in the HTD Scheme mode)**. Where items have been dispensed the Pharmacist should, in addition to the required patient details, record the Name, Strength, Drug Code and Quantity of each item dispensed. The Patient or his/her representative will sign a declaration of receipt of such items. A Patient Care Fee is payable in respect of each patient registered with a Pharmacist for whom a claim is submitted.

Because of the need for ongoing monitoring by Community Pharmacists of a patients overall drug therapy, it is accepted that situations will arise where a Pharmacist may claim a patient care fee even though no High Tech items have been dispensed in a particular month. Such situations would include, for example, drug regimes/pack sizes that require less than monthly dispensing or intermittent admission of patients to hospital. However, in these circumstances, payment will only be made where –

- The claim date is between the Commencement Date and estimated Completion Date of Therapy as notified by the Local Health Office
- A brief explanation is given on the form of the reason why no High Tech Drug has been dispensed.

It has been agreed that, in the interests of public accountability, the maximum number of consecutive months for which a Pharmacist may claim a patient care fee in respect of a particular patient, where there has been no dispensing of High Tech medicines for that patient shall be three months. Such a fee may not be claimed in respect of a deceased person. Where a Pharmacist becomes aware that a patient no longer required High Tech medication they should inform the Local Health Office Liaison Officer.

Pharmacy claims together with the appropriate suppliers delivery docket (or reference to same where it has been submitted previously) should be submitted to the Primary Care Reimbursement Service under separate cover in an envelope marked **HIGH TECH SCHEME** not later than 10th of each month.

The patient or a representative must sign all claims for items dispensed.

Patient Entitlement Categories

Patients entitled to services under the High Tech Scheme will be categorised under one of the following categories

- Medical card holders are entitled to all High Tech items from the agreed list free of charge
- Persons covered under the Health (Amendment) Act, 1996 are entitled to all items from the agreed list free of charge
- LTI persons are entitled to an item(s) from the agreed High Tech list free of charge only if the item has been authorised for their particular Long Term Condition
- DPS card holders will continue to pay €85 towards the total cost of all their medication (High Tech and regular medicines).

A patient with entitlement under any other Scheme will retain his/her existing authorisation number, e.g. Medical Card Number/DPS Card Number; the relevant Patient Number must be quoted on Pharmacy claim forms. The Local Health Office will issue the patient with a letter of authorisation that will serve the purpose of identifying the patient to the pharmacy when High Tech drugs are dispensed.

When a Pharmacist collects €85 from a DPS person under the DPS Scheme and where High Tech medicines are dispensed to such person in the same calendar month such Pharmacists would be due the full amount of the Patient care fee, for example:

- A person receives items under the DPS Scheme in a calendar month, pays €85 to the Pharmacist under that scheme. If High Tech items are also dispensed in the same calendar month to the same patient in the same

Pharmacy the Primary Care Reimbursement Service will credit the Pharmacy with the patient care fee.

Where a Pharmacist dispenses High Tech medicines only to a DPS person such person will pay €85 to the Pharmacist and therefore the Pharmacist will owe to the Primary Care Reimbursement Service the difference between the amount collected (€85) and the amount of the patient care fee, for example:

- A person with DPS entitlement who has items dispensed under the High Tech Scheme only will pay €85 to the Pharmacy. The pharmacy account with the Primary Care Reimbursement Service will be credited with the patient care fee amount, which will result in a balance due to the Primary Care Reimbursement Service of the difference between the patient care fee and €85 in respect of such transaction.

The remittance advice to the Pharmacist will contain a reconciliation of amount paid to the Pharmacy by eligible persons and the total of Patient care fees paid by the Primary Care Reimbursement Service.

Where there is a net balance due by the pharmacy such balance will be recouped from other payments that may be due under this scheme or from any other payment due to the contractor.

Any professional queries that a Pharmacist has relating to the prescription should be directed to the Doctor.

Annual Stock Balance

Under the arrangements in place for the supply of High Tech Medicines by Community Pharmacies, Pharmacists can call supplies of drugs forward from Wholesalers for dispensing to approved persons. Pharmacists are expected to anticipate the requirements of their patients and have available the necessary drugs for dispensing to their High Tech Clients. This of necessity requires Pharmacists to carry stock ready for dispensing. Patients should be encouraged to give adequate notice to the Pharmacist when their drug is required.

For the purpose of accounting it is necessary to establish the value of stock held by each Pharmacy at year-end. It will not be necessary for Pharmacists to value their High Tech stock. The Primary Care Reimbursement Service will send out a list (stock form) containing the named drugs for High Tech clients to each pharmacy towards the end of each year. Pharmacists should confirm the quantity of each drug on the list held at 31st December. The stock form should be returned to the Primary Care Reimbursement Service before the 31st January each year in the pre-paid envelope provided.

2.6 Methadone Treatment Scheme

The Methadone Treatment Scheme commenced in October 1998. Under the Scheme Methadone is prescribed and dispensed by Doctors and Pharmacists for approved clients. Patient Care fees under this Scheme are paid to participating Doctors and Pharmacists. Claims by Pharmacists for the ingredient cost of the Methadone dispensed and the associated dispensing fees are processed and paid by the Primary Care Reimbursement Service.

Central Treatment List

The Central Treatment List contains information on all persons for whom methadone treatment has been prescribed. The information contained in this list is based on information that must be supplied by Doctors under Regulation 3 of the 1998 Regulations.

Information contained in the Central Treatment List is confidential.

Drug Treatment Card

A drug treatment Card is issued in respect of all patients notified to the Central Treatment List. The card contains the name and photograph of the relevant patient and the name of the patient's Doctor and pharmacy. The card is sent directly to the patient's pharmacy where it is held on behalf of the patient.

Prescriptions for the treatment of opiate dependent patients may only be dispensed for patients for whom a drug treatment card has been issued and remains valid.

Methadone Prescriptions Writing Requirements

All prescriptions for methadone must be written on a Methadone Prescription form.

It is unlawful for a practitioner to issue, or a Pharmacist to dispense, a prescription for a Schedule 2 or 3 controlled drug unless it complies with the following requirements:

The prescription must:

- Be in ink or otherwise indelible and be signed by the practitioner with his/her usual signature and dated by him/her
- Clearly indicate the name of the practitioner issuing it and, except in the case of a health prescription (GMS), specify his/her name and address
- Specify (in the Prescriber's handwriting) the name including the given name, and address of the person for whose treatment it is issued
- State that the person issuing it, is a registered medical practitioner, and the telephone number at which the practitioner may be contacted
- Specify (in the Prescriber's handwriting) (i) the dose to be taken, (ii) the form in the case of preparations, (iii) the strength (where appropriate) and (iv) in both words and figures, either the total quantity of the drug or preparation or the number of dosage units to be supplied
- In the case of a prescription for a total quantity intended for dispensing by instalments, specify the amount of the instalment and the intervals at which the instalments may be dispensed.

In the case of a prescription for methadone, which is being issued for or in connection with the treatment of opiate dependence, the prescription shall not be issued unless:

- The person for whom it is issued is the holder of a valid drug treatment card, and
- The prescription is written on a form supplied by or on behalf of the Minister for Health and Children.

In the case of a prescription for methadone, which is being issued for the treatment of a person for the purposes other than for or in connection with opiate dependence, the prescription shall not be issued unless:

- The prescription has been issued by a medical consultant (in hospital practice) or has been initiated by such consultant, whose name and address must be included on the prescription, and

- The prescription is written on a form supplied by or on behalf of the Minister for Health and Children

In all cases the practitioner must be satisfied as to the identity of the person for whose treatment the prescription is being issued.

Pharmacists are equally obliged not to supply methadone to any person unless the procedures and requirements outlined above are fully complied with and that they too are satisfied as to the identity of the person for whose treatment the prescription has been issued and that the person is the holder of a valid drug treatment card.

The information on the prescription forms must be clearly stated. Information that is incomplete, illegible or misleading will present difficulties to the Pharmacist in attempting to dispense it to the patient, who may urgently require the medication, and to the prescribing Doctor to whom the patient may be required to return to have the prescription appropriately completed.

Submission of Claims

Under the Misuse of Drugs (Supervision of Prescription and Control of Supply) Regulations, 1998, a Pharmacist is required to notify the Minister for Health and Children, on a monthly basis, of each Methadone prescription dispensed (whether or not issued in connection with opiate addiction). The bundle of Methadone claims for submission each month should be posted so as to reach the Minister for Health and Children, P.O. Box 6422, Exit 5 M50, North Road, Finglas, Dublin 11, not later than 10th of the following month.

Please ensure that the Summary of Claims form contains your GMS Pharmacy Number (where applicable) and Name and Address. Further supplies are available on request from Registry Unit, Primary Care Reimbursement Service, Exit 5 M50, North Road, Finglas, Dublin 11.

2.7 Dental Treatment Services Scheme (DTSS)

Under the Dental Treatment Services Scheme GMS eligible adults have access to a range of dental treatments and clinical procedures. Dentists may prescribe a range of medicines to eligible persons and the cardholder receives the drugs free of charge e.g. antibiotics for an abscess. The medicines are listed in the Dental Practitioners List of Prescribable Medicinal Products, which is updated periodically with approvals from the Department of Health and Children. Claims by Dentists are processed and paid by the Primary Care Reimbursement Service.

Dentists will prescribe for GMS persons on specially designed prescription forms. The Dental Treatment Services Scheme prescription form is a two-part set. The top copy is the original prescription form and the duplicate is the pharmacy copy.

The Pharmaceutical Code Book is used for the relevant code numbers.

The Dentist will have completed the white panel on the DTSS prescription form and the Pharmacist must complete the blue panels as follows:-

- Drug Code
- Quantity
- Dispensing Pharmacist's Name and Address
- Pharmacy Number
- Pharmacy Sequence Number

Incorrect or incomplete prescription forms may be rejected for payment.

The reimbursement of DTSS claims is based on the Trade Price and the rate of remuneration is the GMS professional fee.

Claims in respect of the Dental Treatment Services Scheme should be included with *GMS claims*.

Payment of these prescriptions is included with your GMS payment each month and reported on the GMS itemised listings.

Claims should be tagged as a separate bundle using the appropriate summary form.

Queries relating to this Scheme should be directed to Pharmacy Claims Unit.

2.8 Health Board Community Ophthalmic Services Scheme (HBCOSS)

Under this scheme adult medical card holders and their dependants are entitled, free of charge, to eye examinations and necessary spectacles/appliances. Claims made under this scheme are processed and paid by the Primary Care Reimbursement Service.

2.9 Primary Childhood Immunisation Scheme

A national scheme providing immunisation of the total child population with the aim of eliminating, as far as possible, infectious diseases such as Polio, Measles, Mumps, Rubella etc. The appropriate Local HSE Office generally makes payments to Doctors under this scheme, however the Primary Care Reimbursement Service makes such payments on behalf of some Local HSE Offices.

2.10 Mother and Child Scheme

Prescriptions under the Mother and Child Scheme should be forwarded to the Primary Care Reimbursement Service offices for pricing only. Such prescriptions should be sent in a separate bundle and according to the same timetable (i.e. to reach the Primary Care Reimbursement Service by the 7th day of the month following that in which the forms are dispensed). Payment is calculated on the basis of ingredient cost, 25% on cost allowance and container allowance.

When the prescriptions have been priced they will be sent to the appropriate HSE Office for payment. The Pharmacist will be informed at the same time and will be given a listing showing the total payment due for each month's prescriptions together with a breakdown of the VAT as calculated.

2.11 European Economic Area (EEA) Entitlements – Visitors and Workers

This section clarifies the circumstances in which a person from one of the other EEA countries is entitled to free emergency general practitioner services, including the issue, where necessary, of a prescription. A common misunderstanding is the assumption that possession of UK documentation by an Irish National entitles the holder to full medical care over a prolonged period.

A resident of one of the other European Community countries, with established eligibility, who needs **emergency** general practitioner services while on a **temporary visit** to the State, is entitled to receive, without charge, such services and such medication as the Doctor may prescribe. It was pointed out at the commencement of the arrangements in 1973 that the visitors are entitled only to medical treatment for sickness or accidents which need urgent attention and this position still obtains. Continuous treatment, including repeat prescriptions, should not ordinarily be involved.

It is stressed that the arrangements do not cover persons who come to the country specifically for the purpose of obtaining medical treatment, or for continuous residence, or for retirement, or are returning emigrants not in one of the three categories listed in this paragraph.

Form E111

A resident of any of the other EEA countries, except the UK (with which the State has a reciprocal agreement covering emergency treatment of visitors), must establish eligibility for free services by producing the Form E111. It should be noted that the Form E111 is valid only for the period specified on it.

Reciprocal Arrangements with the UK

A resident of the UK must produce documentary evidence of such residence. Patients claiming UK residency can establish eligibility for free Doctor services under

the GMS Scheme by producing documentary evidence of their entitlement to services in the UK in the form of a DHSS card or Medical Card. Should a DHSS card/Medical Card not be readily available and where a Doctor has sight of a DHSS exemption notice or current passport or similar documents, which would establish bona fide residence in the UK, such document may be accepted as evidence of eligibility. If the Doctor has reason to believe that the person, while in possession of such documentation is, in fact, ordinarily resident in the State, the person should be asked to have his/her eligibility confirmed by the local HSE Office. If the HSE considers that the person is ordinarily resident here, he or she will be assessed for a medical card in the normal manner and the EEA arrangements will not apply. Presentation of UK documentation does not entitle the holder to free services outside the terms stated.

Details of the person's Form E111 or of the UK documentation produced should be recorded by the Doctor on all STC claim forms and on **all prescription forms**

Form E128

EU Administrative Commission Decision No. 165 of 30th June 1997 provides for the introduction of full health cover in EEA member states for certain workers and their dependants who accompany them abroad, and also for students and their dependants who accompany them abroad for the duration of a course of studies. A Form E128 has been introduced to certify the entitlement to the full range of health care in the country into which a migrant has come for persons in the categories mentioned above - this form must be presented when treatment is required.

In this country the effect of this decision is that persons from other EEA countries who present with a form E128 are entitled to free Doctor services, including prescriptions where necessary, and free public hospital treatment for any condition whether or not it is of an emergency nature.

As the range of services which may be provided are those which are currently available to Medical Card holders persons seeking treatment must present to Doctors / Pharmacists who are participating in the General Medical Services Scheme. Where

it is necessary to prescribe drugs / medicines / appliances the patient must be issued with a GMS prescription form. Items currently reimbursable under the General Medical Services Scheme will be supplied under this arrangement free of charge. The name, address and country of origin of the person to whom services are provided must be clearly stated on all prescription forms. 'E128' must also be clearly written in the space provided for Medical Card number.

Prescriptions in respect of qualifying persons will be processed and paid in the same manner as those for EEA visitors and should be submitted together with your bundle of LTI/EEA claims each month.

European Health Insurance Card (EHIC)

The European Health Insurance Card was introduced in Ireland and in many other EU / EEA member states from **1 June 2004**. It replaced all the paper forms needed to access necessary healthcare under EU regulations within the public system when on a **temporary stay** in another EU / EEA member state or Switzerland.

Of these forms, the E111 is the most widely used, but the Card also replaced some other forms including the E128 (used by posted workers and students), the E110 (used by international transport workers) and the health aspect of the E119 (used by jobseekers). In order to facilitate the replacement of all these forms by a single Card, an amendment to the relevant EU Regulation has been agreed, which ensures that all those on temporary stays in another member state now receive care that *becomes necessary, taking into account the nature of the care and the expected length of stay*.

Those persons presenting for treatment with Form EHI Card should in the first instance be referred to a Health Service Executive clinic for Dental Treatment in the same way as E111and/or E128 holders.

The Health Service Executive may in certain circumstances make special arrangements for private practitioners to provide treatment to such persons but the resulting claim must be made directly to the Health Service Executive concerned.

You may wish to note that there is no change to the existing arrangements between Ireland and the UK, and residents of either country travelling to the other on a temporary stay are not required to present a European Health Insurance Card or an equivalent paper form. Proof of residency is sufficient.

Queries in relation to the European Health Insurance Card procedure or guidelines should be directed to your Health Service Executive, or visit the new website set up for this at www.ehic.ie.

3.0 Administrative Arrangements

3.1 General

Each eligible person under any of the above schemes is provided, by his or her Local HSE Office, with an identifier, with the exception of the Primary Childhood Immunisation Scheme:

- General Medical Services Scheme (GMS) – GMS Card; A laminated plastic card containing information on the card relating to the individual and a 'valid to' date.
- Drugs Payment Scheme (DPS) – DPS Card; A laminated plastic card containing information printed on the card relating to the individual and a 'valid to' date.
- Long Term Illness Scheme (LTI) – LTI Book
- Health (Amendment) Act, 1996 – Health Amendment Act Entitlement Card
- Dental Treatment Scheme (DTSS) – GMS Card
- High Tech Drugs (HTD) – Pharmacy designated by patient – present whichever card is appropriate (e.g. GMS card)
- Methadone Treatment Scheme – Drug Treatment Centre issue a card number, card is given to designated Pharmacy - Drug Treatment Card
- Health Board Community Ophthalmic Services Scheme (HBCOSS) – GMS Card

It is important that the person's identification number (e.g. DPS Card Number and Patient Code Letter) is presented on every claim submitted to the Primary Care Reimbursement Service for payment.

3.2 Claim Processing and Payment

Claims should be submitted on a monthly basis.

Electronic Claims – GMS and DPS

- The majority of Pharmacists submit their claims for payment in respect of the GMS and DPS claims electronically. Where these electronic files are received by the third working day of the month the Pharmacist qualifies for payment within 14 working days of the beginning of the month. Almost all electronic pharmacy claims qualify for this 'early pay' facility.
- To qualify for early payment of your GMS and DPS claims you are required to:
- Transmit both GMS and DPS claims electronically to the Primary Care Reimbursement Service within 3 working days of the end of a claim month using the Primary Care Reimbursement Service's contracted data carriers
- Send in all claim forms to be received by the Primary Care Reimbursement Service not later than the 5th of the month following the month of dispensing;
 - The distinctive packaging (bag) supplied to all electronic claimants must be used when submitting all paper records (including claim bundles for Schemes not currently processed through electronic media). Bags are provided to those transmitting GMS and DPS claims electronically. Requests for supplies of these distinctive bags should be made to **Electronic Claims Unit**. One bag per claimant per month should suffice.
 - All GMS and DPS and other claim forms should be tagged in separate bundles.

Manual Claims

- Fully completed claim forms should be submitted so as to reach the Primary Care Reimbursement Service not later than a specified date in the month following the month in which the service or services were supplied.
- The number of claim forms being submitted in each category of claim to the Primary Care Reimbursement Service each month should be recorded on a 'Summary of Claims' Form – this is a multi part form – the top copies should be sent to the Primary Care Reimbursement Service with your claims – the last carbon copy should be retained for your records.

3.3 Payments

- Payments for valid claims are made on a specified date in the month following the submission of the claims to the Primary Care Reimbursement Service.
- Payment is made by Credit Transfer to the Bank Account most recently identified on the Pay Mandate form received by the Primary Care Reimbursement Service. It is your responsibility to keep the Primary Care Reimbursement Service advised of your correct bank account details.
- Details of claims paid are reported on a 'Detailed Payment Listing', which is issued within a week of payment to each Pharmacist paid in that month
- A Form F45-1 is also issued, under separate cover, in respect of each Pharmacist paid in a particular month.

Errors encountered in the processing of data entered on a form will result in the non-payment of such claims. These will be reported on a Reject/Reclaim Listing, which form part of the monthly detailed payment listing issued by the Primary Care Reimbursement Service. The reason for the rejection will be given and where applicable the claimant will be asked to insert additional/corrected information on the listing and return same to the Primary Care Reimbursement Service for processing.

Queries in respect of electronic claims should be address to the Unit Head, Electronic Claims Unit. Queries in respect of manually submitted claims should be addressed to the Unit Head, Pharmacy Claims Unit.

3.4 Withholding Tax from Payments for Professional Services

Under the terms of the Finance Act, the Primary Care Reimbursement Service is obliged to deduct Withholding Tax, (currently 20%) from all payments for professional services by Pharmacists under all Schemes administered by the Primary Care Reimbursement Service.

Each Pharmacist is required under the relevant legislation to furnish the Primary Care Reimbursement Service with his/her income tax reference number on a form provided. The Primary Care Reimbursement Service will issue a completed Form F45-1 showing details of the payment and tax deducted to each Pharmacist who has submitted a Tax Reference Number – such information is also shown on monthly Summary Listings.

Where a Pharmacist fails to furnish a tax reference number the Primary Care Reimbursement Service will be obliged to deduct the tax but will not be authorised to issue form F45-1. It appears that in such circumstances a Pharmacist would be unable to make a claim to the Inspector of Taxes in respect of Withholding Tax paid.

Any queries a Pharmacist may have in relation to Withholding Tax should be directed to the Inspector of Taxes for the Pharmacist's own region.

3.5 Christmas/New Year Arrangements:

Because of Christmas/New Year leave arrangements, public holidays, postal services etc. almost two full processing weeks are lost during this period. To facilitate timely processing we may ask Pharmacists to submit their November claims earlier in December.

A specific letter of request may be made towards year end detailing the appropriate arrangements.

4.0 General Information

4.1 Prescription Forms and Dispensing Requirements

General

GMS prescription forms may only be used to prescribe Drugs, Medicines and Appliances reimbursable under the GMS Scheme.

Prescription forms must be completed in ink or be otherwise indelible. Each Form must be dated and bear the name, address and medical card number of the patient. Name, strength, quantity and dosage of the preparation to be supplied must be clearly shown. Each form must bear the name, address and full signature of the prescribing Doctor. Doctors should use their own personalised GMS prescription forms when prescribing for eligible patients of their partners or colleagues. The computer number of the Doctor shown in the space at the top right-hand corner of the prescription form must not be obscured or obliterated. Incomplete or incorrect prescription forms may be rejected for payment to the Pharmacist.

Prescriptions, whether for controlled preparations or otherwise, must conform to all legal requirements. Where any drug or preparation, the use of which is controlled by the Misuse of Drugs Regulations 1988 and 1993, is prescribed, the Prescriber must comply with the requirements of Article 13 of the 1988 Regulations on the issuing of prescriptions for such drug or preparation. A prescription for items subject to the Medical Preparations (Prescription and Control of Supply) Regulations, 2003 (S.I. No. 540 of 2003) is required to “be in ink and be signed by the person issuing it with his usual signature and be dated by him.”

The Prescriber must sign alterations and additions.

Unused parts of a prescription form should be cancelled, e.g. by a series of vertical lines or a large “Z”, to prevent unauthorized additions.

Where a Special Type Consultation requires the writing of a prescription and there is no patient number available the words “Special Type Consultation” or “S.T.C.” should

be written in the patient number area. Prescription forms issued to visitors from other European Economic Area Countries should have "E.E.A." written in the patient number area. E.E.A. visitors are entitled to emergency treatment only; they are required to bring with them sufficient supplies of their routine medicinal requirements. Continuation therapy, including the issue of GMS repeat prescription forms, should not be involved.

Where a prescription form is issued outside pharmacy opening hours, or very close to their commencement or cessation, and the Prescriber considers that because of the medically urgent condition of the patient the form should be dispensed without delay, the words "Medically Urgent", endorsed with his/her signature, may be written by the Prescriber on the prescription form at the time of its issue.

Prescribing and Dispensing Requirements

With regard to these prescriptions, the Misuse of Drugs Regulations, 1988 and 1993 and the Medicinal Products (Prescription and Control of Supply) Regulations, 2003 apply in full.

1. Medicinal preparations containing a drug the subject of an entry in Schedule 1A of the Medicinal Products (Prescription and Control of Supply) Regulations, 2003 are not repeatable unless the Doctor explicitly specifies in writing, "Repeat (once or twice)".

Prescriptions for Schedule 1A (S1A) Drugs which are not specifically so indicated cannot be repeated. Preparations containing or consisting of the following are among those covered by Schedule 1A: antibiotics, antidepressants and hypnotic drugs.

2. Controlled drugs in Schedules 2 and 3 of the Misuse of Drugs Regulations, 1988 should not be written on, or dispensed on foot of, a repeat prescription under any circumstances.

Authentication of prescriptions

There have been several instances when medicines were supplied in good faith on foot of GMS prescription forms where such forms were either, duly issued by a Doctor and altered with intent to deceive, or, stolen from a Doctor and issued with fraudulent intent by a person without authority to prescribe.

If any irregularity is suspected, Pharmacists have the obligation and the entitlement to make enquiry of the person presenting the prescription. Pharmacist should satisfy themselves regarding the bona fides of persons presenting prescriptions (including GMS and other prescription forms) which have been issued, or purport to have been issued, by Doctors in areas far removed from the Pharmacists' own locality.

The Primary Care Reimbursement Service can only accept for payment prescriptions that have been signed in full by the Doctor in ink. Forms initialled only, or those on which a facsimile signature appears, or a signature otherwise reproduced, cannot be accepted.

Unsigned GMS Prescription Forms

Details entered on unsigned GMS prescription forms are keyed into the Primary Care Reimbursement Service's computer system, but payment is withheld and the claim is reported on the Reclaim Listing, with the message "**Form not signed by Doctor**".

The procedure for reclaiming payment in respect of items dispensed on unsigned forms is as follows.

- In the case of prescriptions for S1A and S1B medicines, the corresponding pharmacy copy should be signed by the Prescriber and submitted for payment.

- For CD2 and CD3 medicines a standard GMS prescription form, written and signed by the Prescriber in accordance with the requirements of the Misuse of Drugs Regulations, should be marked 'DUPLICATE' and submitted for payment together with the relevant Reclaim Listing. The Pharmacist's Sequence Number of the original form should be shown on the replacement form.

Use of adhesive strips on prescription forms

The Primary Care Reimbursement Service requires that entries of the code number and quantity supplied be made as direct entries on the claim form. Adhesive strips will not be accepted. Pharmacists who submit their claims electronically will, after a satisfactory initial period of dual manual and electronic operation, not be required to enter manually the code number and quantity supplied for each item claimed.

Illegible Patient numbers on GMS prescription forms

Prescription forms that have 'illegible' numbers in the patient number area make identification of such claims in a reject situation almost impossible. The majority of claims containing 'illegible' patient numbers arise on 'Repeat' forms. The incidence of Repeat Prescription Forms with illegible patient numbers could be reduced if Pharmacists, when dispensing Part 1 or 2 of a Repeat Prescription Set, ensured that the carbonised entries in the Patient Number area are legible and that the patient number corresponds with the Patient Number on the original prescription form (Part 3). If necessary the Patient Number could be written on Part 1 or Part 2 by the Pharmacist in a manner that would not obscure details entered by the Doctor.

Carbonised or Copied Prescriptions

Prescriptions that have been carbonised or copied from one GMS prescription form onto another GMS prescription form, apart from possible legal implications, do not meet Primary Care Reimbursement Service requirements and should not be dispensed. Post-dated prescription forms should be dispensed only in accordance with the Doctor's instructions and submitted for payment to the Primary Care Reimbursement Service in the appropriate processing month.

The Primary Care Reimbursement Service may raise particular instances with the health professionals concerned.

Dispensing of Emergency Supplies on a Hospital Prescription Form for a GMS Patient

It is the current practice that persons with established eligibility under the General Medical Services Scheme who are provided with a prescription form on their discharge from a hospital are required to request a general practitioner, participating in the General Medical Services, to transcribe the prescribed items onto a GMS prescription form in order for such items to be dispensed free of charge for that person. It has however been indicated that this arrangement creates difficulties for those discharged from hospital late in the day, on weekends or at other times outside normal surgery hours or who require to have a hospital prescription dispensed urgently.

To address these difficulties Community Pharmacists participating in the GMS Scheme are authorised to dispense up to a maximum of seven days supply, subject to permitted exceptions, of medicines prescribed for persons who have been in-patients of **Acute General Hospitals** or who have attended the **Accident and Emergency Departments of General Hospitals** and when, because of the circumstances of their discharge and/or the urgency of the prescribed medication it is not possible or very convenient for such persons to attend their general practitioners to have the hospital prescription items transcribed to GMS prescription forms. N.B. Out-Patient Department (OPD) prescriptions are not covered by these arrangements.

Items prescribed on a hospital prescription should be specified by their non-proprietary name.

The name of the Prescriber should be stated in block capitals.

Completion of Claim forms by Pharmacists

- A Pharmacist must be satisfied that a named authorised person, is at the time of dispensing, eligible under the GMS Scheme
- A claim form when received by the Primary Care Reimbursement Service must have attached thereto a photocopy of relevant hospital prescription form
- The medical card number of the person prescribed for and the registered number under the GMS of the named person's Doctor must be inserted in the spaces provided on the claim form
- Dispensing of emergency supply shall be on the day of issue of a hospital prescription. In special circumstances an emergency supply may be dispensed on the following day
- GMS reimbursable items only may be claimed for under this arrangement
- Pharmacists will be reimbursed the ingredient cost of quantities dispensed which are appropriate to seven days supply or less, save in exceptional circumstances e.g. inhalers; the standard GMS fee will be paid for each dispensed item. Extemporaneously dispensed items will attract the extemporaneous fee.
- GMS claims for items dispensed in emergency circumstances must be submitted to the Primary Care Reimbursement Service (supported by copies of relevant hospital prescription forms) with GMS claims under the Exception Claims category so as to reach the Primary Care Reimbursement Service not later than the 7th of the month following the month of dispensing. The same claim category (Type 2) is used by manual and electronic claimants

- On the claim form used under this arrangement the Pharmacist's fields must be accurately completed -failure to do so will cause a rejection of the claim for payment *-instructions on the coding of items dispensed against a GMS prescription form apply.*
- The person collecting the dispensed items must sign for receipt of same in the space provided on the claim form. When a person other than the person named on the prescription is collecting drugs/medicines under this arrangement the relationship of such person to the GMS named person should be recorded on the form.
- Claims of this nature will be included with payments for other GMS claims and will be shown on the monthly itemised listings identified by the appropriate Pharmacist sequence number and included under Exception Claims totals on the Summary Listing

Phased Dispensing

The dispensing of a GMS reimbursable item may be phased for one of the reasons specified under the agreement between the Department of Health and Children and the Irish Pharmaceutical Union. Those reasons are set out below in association with the *phased dispensing indicators* to be used by *manual* claimants.

The 5 digit phased dispensing indicator should be:

- 889-- at the request of a patient's physician;
- 888-- due to the inherent nature of a medicinal product i.e. product stability and shelf life;
- 887-- where a patient is commencing new drug therapy with a view to establishing patient tolerance and acceptability before continuing on a full treatment regime

886-- in exceptional circumstances where the patient is incapable of safely and effectively managing the medication regimen

In the interests of clarity and processing efficiency Pharmacists claiming manually are requested to follow the coding instructions below whenever possible but also to be mindful that only one of these methods for claiming phased dispensing fees should be used on any form:-

(i) Code numbers for additional dispensings to appear on lines beneath the regular code numbers (the preferred method), or,

(ii) Where there is insufficient space on a GMS prescription form to follow the coding instruction at (i) above, insert the appropriate phased dispensing code number alongside the quantity drug code number in the space entitled 'Official Use'.

When an item has been dispensed in 2 lots then the last two digits of these special numbers should be '01 " e.g. at the request of a patient's physician an item is dispensed in, say, 3 lots then the appropriate number to use would be 88902. When an item has been dispensed in, say, 13 lots then the last digits should be '12'. Pharmacists should leave the 'Quantity Supplied' column blank where the phased dispensing indicator is used.

Manual Claimants should submit their phased dispensing claims with their GMS Exception Claims (Type 2)

Electronic claimants should select the relevant category, change the Script Type to Phased Script, then select the appropriate phased reason plus the total phased dispensings being claimed, excluding the initial dispensing. Finally enter the quantity to be dispensed on the day.

Electronic claimants should use the GMS Regular Claims (Type 1) for submission of phased dispensing claims.

'Non Dispensing 'Fee Claims

In order to claim in respect of a fee for the exercise of professional judgment resulting in a decision by a Pharmacist not to dispense a reimbursable item on foot of a GMS prescription form, *manual claimants* will enter '79999' in the space reserved for GMS code opposite the prescribed item. Pharmacists are required not to make any entry in the 'Quantity Supplied' column in this instance. A manuscript note on the form indicating the reason for non-dispensing must be provided.

Electronic claimants may, as an alternative, state that reason using a free text facility, if available, when creating the electronic record of the claim

Manual Claimants should submit their non-dispensing claims with their GMS Exception Claims (Type 2)

Electronic claimants should use the GMS Regular Claims (Type 1) for submission of non-dispensing claims

Re-ordering prescription claim forms

The minimum number of prescription claim forms to be supplied is 2,000 and a post-paid re-order card is included with each box of forms. The minimum number of forms has been set for the most part to reduce the risk to Pharmacists' of running out of forms. However Pharmacists are strongly urged to use the re-order card and to give 2 weeks notice of requirements when re-ordering these forms.

Repeat prescriptions – GMS Scheme

Repeat prescription sets are for use by participating Doctors when they intend that a particular item or items be repeated and repeat dispensing is a legally permissible option.

The “Repeat Prescription Set” consists of three “two-part” sets of self-carbonising forms, the top copy of which is the original prescription (White). When a Doctor wishes to have a prescription for a GMS patient repeated once the patient should be issued with Part 2 and Part 3, i.e. two “two-part” sets - the remaining Part 1 should be shredded - if 2 repeats are required the complete set should be issued. It is important that all parts of forms issued are legible.

Each “Repeat Prescription Set” must have the patient’s name, address and current medical card number entered thereon; a form which does not contain the current medical card number of the named patient will be rejected to the Pharmacist for reference to the Doctor. Each original form (White) must be signed by the Doctor.

The Misuse of Drugs Regulations, 1988 and 1993, and the Medicinal Products (Prescription and Control of Supply) Regulations, 2003 apply to GMS repeat prescription forms as they would to GMS standard prescription forms or other prescriptions.

Medical preparations contained in Schedule 1A of the Medicinal Products (Prescription and Control of Supply) Regulations, 2003, are not repeatable unless the Doctor explicitly specifies by writing, “Repeat (once or twice)”. Prescriptions for Schedule 1A drugs which are not specifically so indicated cannot be repeated.

Controlled Drugs in Schedule 2 and 3 of the Misuse of Drugs Regulations 1988 must not be written on a repeat prescription form under any circumstances.

A patient who has been issued with a Repeat Prescription Set is required to present the complete set to a Pharmacist for dispensing.

On first dispensing the forms comprising Part 1 (i.e. the last two forms of the set) Pharmacist’s Claim Form and a Pharmacy Copy should be detached from the set in the dispensing pharmacy where the dispensing Pharmacist will stamp and date the original prescription form with the Pharmacy Name and Address and the date of dispensing in the space provided marked 1st dispensing. The remaining forms should be returned to the patient.

The Pharmacist's Claim Form should be completed with the signature of the dispensing Pharmacist and the code numbers and quantities of item dispensed entered in the appropriate spaces.

On second dispensing the forms comprising Part 2 of the set should be used and the same sequence as for the first dispensing should be followed.

On third and final dispensing the forms comprising Part 3 i.e. the original prescription form and a Pharmacy Copy should be used. The Pharmacist will retain both parts of the set and will stamp and date the original form in the space provided for '3rd dispensing'.

The Pharmacist's Claim Form and the original prescription forms should be submitted for payment to the Primary Care Reimbursement Service by the claiming Pharmacists as Regular or Exception Claims and entered as such on Summary Forms with other GMS claims.

The Pharmacist must always dispense against the original Prescription Form (Part 3). Pharmacists should not accept for dispensing Part 1 and 2 of a Repeat Prescription set without simultaneous presentation of Part 3 by the patient. After each dispensing any unused portion of the repeat prescription set should be returned to the patient.

As each Part of a Repeat Prescription set comes to be dispensed the code numbers and quantities of items supplied must be completed in ink (by manual claimants) on the relevant Part, [Pharmacy Claim Form Part 1 or 2) or Original Prescription Form (Part 3)].

The patient should not receive a repeat supply earlier than the Doctor expressly provides, or, sooner than intervals the Pharmacist may reasonably infer from the quantity and/or dosage stated on the prescription. If an earlier supply is necessary in any other circumstances, the Pharmacist should set out the reasons for the departure from normal procedure.

Repeat prescription forms should be submitted grouped together (i.e. not interspersed with standard GMS prescription forms) and located after the standard forms in the monthly claim bundle(s). Manual claimants will select GMS Regular Claims (Type 1) or GMS Exception Claims (Type 2) depending on whether or not the claims are fully coded. Electronic claimants will use Type 1 exclusively.

Incomplete GMS Prescription/Stock Order Forms

Pharmacists are obliged to supply medicines and appliances on foot of a properly completed prescription or stock order form in accordance with the terms and conditions of the Pharmacist's agreement with the HSE.

The Primary Care Reimbursement Service has the obligation in calculating and making payments to verify the accuracy and reasonableness of claims and accordingly has the right to seek clarification or to require that a prescription form or stock order form be returned to the prescribing or Dispensing Doctor for completion and/or clarification as a prerequisite to payment.

Where a prescription presented to a Pharmacist is incomplete, in that the Prescriber has omitted *one* of the following:

- the quantity to be dispensed **or**
- the strength to be supplied where more than one strength is available **or**
- the dosage instructions from the prescription

the Prescriber should be contacted where this is possible and the prescription dispensed as follows: -

Where the Prescriber can be contacted:

The prescription should be dispensed in accordance with the Prescriber's wishes and the missing details inserted by the Prescriber and signed by him/her. Should it not be practicable to have the missing details inserted by the Prescriber, the Pharmacist may with the agreement of the Prescriber: -

- Add the relevant details required.
- Initial and date the endorsement, and
- Indicated that the Prescriber was contacted – P.C. (Prescriber Contacted).

Where the Prescriber cannot be contacted:

If the Pharmacist has sufficient information to make a professional judgement s/he may dispense a sufficient quantity of the preparation for up to seven days treatment depending on the nature of the prescribed item. Where, from experience of the patient's previous requirements the Pharmacist is satisfied that a greater quantity is justified s/he may dispense up to one month's supply. However the smallest pack quantity must be dispensed in the case of combination packs (i.e. packs containing more than one medicinal product) and medicinal products for which pharmaceutical considerations dictate supply in the original unopened container. The Pharmacist should then: -

- Add the relevant details required.
- Initial and date the endorsement, and
- Indicate that the Prescriber could not be contacted – P.N.C. (Prescriber not Contacted).

In the interest of patient care it is recommended that the Pharmacist should subsequently inform the Prescriber of the action he has taken.

Compliance with Statutory Requirements

A Controlled Drug may not be dispensed unless the appropriate statutory requirements are met. The Primary Care Reimbursement Service reserves the right

to bring to the attention of the appropriate authorities serious breaches of statutory requirements that come to its notice.

Pack Sizes

- Where such terms as small, medium or large are used by the Doctor in a prescription to indicate the quantity to be supplied, such prescription should be considered as being incomplete and dealt with as above or alternatively the smallest pack size should be dispensed.
- Where the quantity of a preparation prescribed does not correspond with an original pack size and it is **not feasible** to supply the exact amount prescribed the Pharmacist may, in the exercise of his professional judgement and bearing in mind the nature of the product and his statutory obligations, supply the original pack size nearest to the quantity ordered.

Dressings and Appliances

- Where the size (but not the quantity) of any dressing has been omitted by the Doctor from the order form, the smallest size in the Code Book should be supplied.
- Where the quantity (but not the size) of dressing has been omitted by the Doctor from the order form, a single unit/piece/pack of the specified item should be supplied.
- In certain cases, such as ostomy appliances, units should be supplied unopened as received from the supplier.

4.2 Dispensing Doctors' Stock Order Forms

The Doctors' Agreement stipulates that a Dispensing Doctor shall obtain his/her requirements of GMS reimbursable items from a Contractor Pharmacist whose premises are in the Doctor's normal area of practice. If there are no such premises in that area the Doctor is to obtain his/her requirements from a reasonably convenient Contractor Pharmacist. Only GMS reimbursable items may be obtained on a Dispensing Doctor's Stock Order Form.

A Dispensing Doctor's Stock Order Form consists of an original form and three self-carbonising copies:

- | | | |
|----------|---|--|
| Original | - | the Pharmacist's claim form; |
| Copy 1 | - | for the Pharmacist's records; |
| Copy 2 | - | for the HSE's records; |
| Copy 3 | - | for the Dispensing Doctor's own records. |

A Dispensing Doctor must submit Stock Order Forms to their Local HSE Office for prior approval. All entries in the yellow panels of the original form must be duly completed beforehand. The Dispensing Doctor detaches Copy 3 from each Stock Order Form before forwarding the original with Copies 1 and 2 attached to their Local HSE Office. Stock Order Forms should be submitted to the Local HSE Office usually at monthly intervals. Following approval the Local HSE Office forwards the original and Copy 1 of the Stock Order Form to the Pharmacist nominated by the Dispensing Doctor.

Completion of Stock Order Forms – Yellow Panels

In the appropriate yellow panels, Doctors must (a) enter the name and address of the pharmacy; (b) write or stamp their own name and address on the original copies; (c) write their signature; (d) enter their computer number in the space provided; (e) insert the date on which the Stock Order was issued and (f) clearly indicate in columns 1 and 2 the size, strength and quantity of the item(s) required.

Receipt of Stock Order Items from Pharmacy – Completion of Blue Panel

The Declaration at the foot of each Order Form regarding receipt of stock items should **not** be signed and dated until Doctors have checked the stock received (entered in column 3 – blue panel) against what was ordered (entered in columns 1 and 2 – yellow panel). Any discrepancies, such as items ordered but not supplied or supplied in part only will be identified at that stage. There should also be a check of the expiry dates of drugs received.

To enable Pharmacists to prepare their claims for submission to the Primary Care Reimbursement Service it is required that supplies obtained on Stock Order Forms within any month would be checked and signed for before month end.

Kind and Quantity of Stock Held

In view of the fact that stock is ordered from a local Pharmacist, overstocking should not occur. However the Dispensing Doctor should bring any particular item(s) in stock no longer in demand or excess to requirements to the notice of the Local HSE Office.

Medicines, drugs and appliances should only be supplied to a dispensing Doctor on receipt of a stock order form fully completed by her/him that has received prior approval from the Local HSE Office.

Pharmacists should note that they are responsible for ensuring that the stock items supplies are of the description, specification and quantity as set out in the stock order form and that they are well within expiry date, undamaged and otherwise of a quality and condition suitable for use.

Special Order Forms for Syringes, Needles and Dressings (Pink)

Special Order Forms must have the following entries completed before being given to a Pharmacist. Doctors must: (a) have the name and address of the pharmacy entered in the space provided; (b) write or stamp their own name and address on the original and copy; (c) write their signature; (d) enter their computer number in the

space provided; (e) insert the date on which the special order form is issued and (f) clearly indicate in columns 1 and 2 the size and quantity of the item(s) required.

The Declaration at the foot of each Order Form regarding receipt of stock items should **not** be signed and dated until Doctors have checked the stock received against what was ordered so that any discrepancies, such as items ordered but not supplied or supplied in part only, are identified at that stage.

The Special Order Form should be used by all participating Doctors to obtain supplies of Non-Insulin Disposable Syringes and Needles combined or separate. Dressings for use by Doctors in their surgeries in respect of their GMS patients should be ordered on the Special Order Form from the list of Dressings reimbursable under the Scheme.

4.3 General Information

Parallel imported products

Of the parallel imported products appearing in the Pharmaceutical Code Book, each has a separate GMS Code Number from the originator medicinal product pack. Where a parallel import is dispensed the Pharmacist must ensure that the correct GMS Code Number is entered on the claim form so that the appropriate payment is made.

Request for the production of Invoices

From time to time the Primary Care Reimbursement Service requests Pharmacists to submit relevant invoices to clarify and/or substantiate claims for payment relating to items which do not appear to be completely in order for payment. The Primary Care Reimbursement Service has a statutory duty relating to the reasonableness and accuracy of payments and may withhold payment until it is satisfied that a claim is correct in every respect. Accordingly, Pharmacists should submit invoices without delay, when requested, and facilitate the correct payment of their claims as soon as possible.

Nicotine Replacement Therapy

The Department of Health and Children has approved the reimbursement of Nicotine Replacement Therapy for eligible GMS persons with effect from the 1st April 2001.

The quantity to be prescribed and dispensed on an initial prescription should be limited to a two-week supply, sufficient to evaluate the success of this therapy for individual patients. It should be noted that the products approved in this regard may not be prescribed on GMS Repeat Prescription forms.

Ostomy and Urinary Products

All reimbursable ostomy and urinary products are set out in the relevant sections of the List of Reimbursable Non Drug Items ('White Book') and should be coded and claimed in the normal way.

GMS Scheme: There is one limited exception to the statement in the above paragraph. Persons eligible under the GSM Scheme who immediately prior to 1st September 1994 were being supplied, by a Community Pharmacist or Dispensing Doctor, with any ostomy and/or urinary products that were removed from the List of GSM Reimbursable Items with effect from that date, may continue to receive such items.

Manual claims for GSM delisted products should be submitted in the following way. Such items should be claimed as uncoded items, marked with the uncoded sign ⊗ clarifying the quantity supplied and attaching a copy of the relevant invoice. Copy invoices only should be submitted, as these copies will be retained by the Primary Care Reimbursement Service to facilitate the speedy processing of claims. Claims for uncoded items should be submitted in GSM Exception Claims (Type 2).

Electronic claims for the delisted products should be submitted using the appropriate hand price code and submitted in GSM Regular Claims (Type 1) with a copy of the relevant invoice attached to the claim form.

Seconal Sodium Capsules 50 mg. and 100 mg., Sodium Amytal Pulvules 60 mg., Tuinal Capsules 100 mg.

With effect from 1st February 1998 the above barbiturate medicinal products were deleted from the List of Reimbursable Drugs, Medicines and Appliances in the GSM Scheme. Limited supply of these products in exceptional circumstances may be made via the Professional Services Manager, United Drug Ltd., Dublin. Because of

the nature of the products involved the Department of Health and Children has directed that they continue to be reimbursed for existing patients on a compassionate use basis.

Manual claims for the products should be marked with the uncoded sign ⊗ clarifying the quantity supplied and attaching a copy of the relevant invoice. The prescriptions should be submitted in GMS Exception Claims (Type 2). Electronic claimants should use the Hand Price Code, 44444, for submission in GMS Regular Claims (Type 1).

Oral Dosage forms of Drugs used in the Treatment of Erectile Dysfunction

The Department of Health and Children has approved the admission of certain **oral dosage forms** of drugs used in the treatment of erectile dysfunction to the list of items that are currently reimbursable on the GMS and Community Drug Schemes. To ensure availability for genuine need, but to reduce the possibility of inappropriate usage, the maximum reimbursable level for oral dosage forms of drugs used in the treatment of erectile dysfunction is a total of four per month. This will apply whether or not more than one such oral medicinal product has been prescribed and dispensed for a patient in the same calendar month. The Primary Care Reimbursement Service will not reimburse quantities in excess of this level.

Economic Prescribing and Dispensing in the GMS Scheme

Pharmacists should be mindful of their obligations under Clause 9 of the Community Pharmacy Contractor Agreement to facilitate the prescribing Doctor in establishing the most cost effective treatment for a patient.

Doctors have been asked for their co-operation in securing whatever economies are possible without reducing the effectiveness of the service or affecting the best interests of patients. They have been asked to consider, when prescribing, whether there is an equally effective but less expensive medicinal product available.

Where a Doctor prescribes a medicinal product without specifying a manufacturer's name or brand and the pharmacist receives such prescriptions with reasonable frequency the Pharmacist will be expected to dispense one of the less expensive, if

not the least expensive, of the preparations of the drug properly available to the market. Accordingly, where a medicinal product of higher cost is dispensed the circumstances of his/her doing so may be taken up with the Pharmacist and an appropriate adjustment may be made.

Balance of Stock on Hand

Where, in order to meet the requirements of an expensive prescription, a contractor is obliged to purchase a larger quantity than prescribed and where a portion of that pack remains on hand after an agreed period, the full cost of the balance of the pack will be paid to the contractor and such balance may be taken into stock by a Local HSE Office. To comply with this regulation the cost of the balance of the pack must be in excess of €12.70 and must not have been dispensed within three months prior to the claim being made, unless circumstances warrant otherwise, such as dated products expiring within the time period.

The Pharmacist should produce the pharmacy copy of the relevant prescription, endorsed with the balance of stock on hand and the value of the claim, and the relevant invoice to the Local HSE Office, which will forward the documentation to the Primary Care Reimbursement Service. Eligible claims are met by an adjustment on the Pharmacist's GMS Account.

General

- The coding of a prescription item identifies the item dispensed and is regarded by the Primary Care Reimbursement Service as a certification by the Pharmacist of the accuracy of the claim.
- To ensure the accuracy of claims, only the Pharmaceutical Code Book issued by the Primary Care Reimbursement Service should be used to obtain the relevant Code Number for Pharmacists submitting claims manually.
- Where the item is uncodable, the official uncoded sign ⊗ must be used by manual claimants to certify its supply. Payments will not be made for items incorrectly marked.

- The Prescriber only must countersign material alterations to a prescription item, otherwise the prescription form will be returned to the Pharmacist. Where a Prescriber approves of a material alteration, the Prescriber must countersign such alteration before the claim is submitted for payment.
- Pharmacists are advised to endorse or clarify prescription and stock order items where necessary, (i.e. in cases of doubt, illegibility, etc.) before submitting claims to the Primary Care Reimbursement Service.

A prescription/stock order form may be queried with the Pharmacist when different handwritings are observed on the prescribing/requisition section, except in those situations described above.

Prescription for Special Type Consultations (STC)

Doctors have been asked to use the GMS standard prescription form when writing prescriptions related to Special Type Consultations and, in circumstances in which GMS patients numbers are not available, e.g. a new GMS eligible person not yet allocated a Medical Card Number to write "Special Type Consultation" ("STC") in the space provided for the number. Properly completed forms presented in this manner will not be rejected by reason only that the patient number is absent.

Prescription forms issued that do not have a patient number and are not clearly shown to relate to Special Type Consultations will be rejected for payment.

Urgent and Late Fee Claims – GMS Scheme

A Pharmacist may claim an urgent fee in respect of a GMS standard prescription form if it was marked urgent by the Doctor at the time of issue provided the prescription was received and dispensed outside contract hours and was endorsed by the Pharmacist with the date and time of dispensing.

The late fee claims refer to prescriptions (other than those specified by the Doctor as being medically urgent), where in exceptional circumstances, it is regarded by the

Pharmacist as being necessary for the patient's requirements that the prescription be dispensed outside normal hours.

As the "late fee" payment will only be payable in circumstances which are clearly exceptional it is expected that claims for such payment will be intermittent and small in number. Pharmacists will be required to keep a record of the circumstances in which the exceptional dispensing was necessary and to provide this information on request.

It should be noted that the date and time of dispensing must be endorsed by the Pharmacist on each form in urgent/late fee claims prior to submission as retrospective claims can not be considered. Forms submitted in these categories without the appropriate endorsement will attract the appropriate basic fee only. The documents reproduced verbatim in Appendices 1 and 2 are those that were issued, or reissued, as the case may be, with Circular PB154 (November 1986). For the majority of Pharmacists, i.e. those who operate the Community Pharmacy Contractor Agreement (the '1996 contract'), there is no exceptional period of up to 30 minutes as described in Paragraphs 2(a) and 3 of Appendix 1.

Appendix 1

Memorandum on Urgent and Late Fees

1. Questions have arisen regarding the definition of urgent and late fees and it was decided by the Pharmaceutical Services Standing Committee to prepare this document for circulation to pharmacists to clarify the position. In order that the position can be fully understood it is necessary first to clarify pharmacists hours.
2. While the hours which a pharmacist “keeps open shop” are primarily his own concern they are the concern of the HSE to the extent that the contract provides that

(a) the hours for which the pharmacy is open to dispense GMS prescriptions are the normal hours the premises are open with the exception of not more than half an hour after opening time and before closing time.^{fn(1)}

(b) any proposed change from the hours in this contract must be notified beforehand to the Local Health Office(s) with whom the pharmacist holds the contract(s).

3. **Normal and contract hours**

For the purpose of this document NORMAL HOURS are those hours during which the shop is open for business. They may vary from place to place because of local custom or they may vary from one season to another. They include the hours when a premise opens on a rota basis. CONTRACT HOURS are normal hours with the exception of not more than half an hour after opening and before closing^{fn(1)}.

^{fn(1)} Under the Community Pharmacy Contractor Agreement (the ‘1996 contract’), there is no exceptional period of up to 30 minutes allowed.

4. **Urgent Fees**

An urgent fee is payable to a pharmacist in respect of a prescription form if it was marked urgent by the prescriber when issued provided the prescription was received and dispensed outside contract hours and was endorsed by the pharmacist with the date and time of dispensing.

5. **Late fees**

These are not part of the contract but were introduced by agreement following the recommendations of the Review Body. There are two essential elements in a valid claim for late fees:

- (a) they are in respect of exceptional circumstances which infers that the incidence of claims should be low.
- (b) they are in the nature of compensation for disturbance, hence the higher fee for a non-resident pharmacist^{fn(2)}. It follows that claims for late fees cannot be made for prescriptions dispensed when the premises are open.

6. Late fees cannot validly be claimed for any period during which the premises are open to the public. This would include periods when a pharmacist remains open late on one or more evenings in the week or provides regular dispensing services to suit surgery hours.
7. Where there is an agreed rota system in operation late fee claims from the pharmacies that are closed will be accepted only in very exceptional circumstances.
8. Claims for urgent and late fees will not generally be accepted in relation to prescriptions received and dispensed more than 24 hours after issue since the fees relate essentially to prescriptions which require to be dispensed before the pharmacy is next open.

^{fn(2)} These two levels of late fee have since been consolidated at the higher (non-residential) rate.

9. The agreement covering the introduction of late fees provides that the level of claims is subject to monitoring and that where there appears to be an excessive level of claims by an individual pharmacist his claims may be investigated, if necessary by a committee similar to that provided for in the contract. The committee would have power to recommend penalties.

SEP 1977

Appendix 2

Payment of Late Fees to Pharmacists in the General Medical Service

1. The late fee provision was introduced in 1976 to deal with a small number of exceptional situations where urgent dispensing was necessary, with serious disturbance to the pharmacist and where the doctor had not marked the prescription as being urgent. It was stressed in the circular issued to pharmacists in February 1976 on the introduction of the scheme that “as the late fee payment will only be payable in circumstances which are clearly exceptional, it is expected that claims for such payment will be intermittent and small in number”. This was repeated in the clarifying memorandum agreed by the then Pharmaceutical Services Committee which was issued in October 1977.

2. Experience of the operation of the system show that late fee claims form a regular part of some pharmacists monthly claims. This is not in accordance with the late fee provision.

3. It is considered that adherence to the spirit of the provision by all pharmacists might be encouraged through clarification of circumstances where a late fee is not payable. The following examples, which are illustrative of the circumstances in which a late fee is not payable, has been drawn up in consultation with the Irish Pharmaceutical Union.
 - (a) in any situation where the pharmacy is open to the public, e.g. where a pharmacy is a late-night opening pharmacy.

 - (b) where a pharmacist provides or offers a regular, routine or established outside contract hours service, whether or not coinciding with evening surgeries of local doctors.

- (c) where there is another pharmacy open within three miles distance at the time of dispensing, which can provide the service.
 - (d) where there is a rota system in operation.
 - (e) where dispensing occurs within 15 minutes of normal business hours.
 - (f) when a claim for a late fee is made for more than one prescription dispensed on the same occasion, whether or not the first prescription has been marked urgent by a doctor, only one additional fee is possible.
 - (g) where there is recurrent presentation of prescriptions for particular medical cards, which show a routine pattern rather than exceptional circumstances.
4. It is only in extremely unusual and documented circumstances that a late fee will be paid in respect of the dispensing of maintenance therapy, or where a significant time has elapsed since the prescription was written or where it is clear that the drugs prescribed could not be medically urgent.

Appendix 3

Letter to Applicant who has previously registered within a Family (Drugs Payment Scheme) Unit

Dear ---,

I confirm receipt of your application to be registered as a family unit under the Drugs Payments Scheme but note that you are already registered as part of a different family unit. The *(Insert relevant Local HSE Office)* has contacted the other adult in the previously registered Drugs Payment Scheme family unit to advise them that their Household registration is being altered.

When you receive your new DPS card, please ensure that you bring it to your pharmacy when next you need medication.

If you have any queries on this matter, please contact this office.

Yours sincerely,

Drugs Payment Scheme Liaison Officer

N.B. Always show your Drugs Payment Scheme card when getting your prescription medicines. This is particularly important when you receive a new card.

Appendix 4

Letter to New Head of Household

Dear-----,

The (*Insert relevant Local HSE Office*) has received an application to register a new family unit under the Drugs Payment Scheme. We note that (*Insert name of individual*) has previously been registered as the Head of Household for your family for the purposes of the Drugs Payment Scheme. New cards, with you as the Head of Household will be produced for you and your family.

If you have any queries on this matter, please contact this office.

Yours sincerely,

Drugs Payment Scheme Liaison Officer

N.B. Always show your Drugs Payment Scheme card when getting your prescription medicines. This is particularly important when you receive a new card.

APPENDIX 5

AGE 18 ELIGIBILITY

At milestone 18:

Re: Drugs Payment Scheme

Head PPSN:

Dear (*Insert Head of Household*),

It is noted that (*Insert Dependent's name*) will shortly reach eighteen years of age and, unless in full time education, will no longer be entitled to be covered under the Drugs Payment Scheme on the family card.

I enclose herewith an application form, which should be completed. If (*Insert Dependent's name*) is in continuing education and under twenty three years of age, this form must be stamped or accompanied by a letter confirming attendance at school / college, and returned to this office if he / she is to continue as a dependent on the family card. If not in full time education, the form should be completed by (*insert dependents name*) so that he / she can be registered independently under this scheme.

If you have any queries on this matter, please contact this office.

Yours sincerely

Drugs Payment Scheme Liaison Officer

N.B. Always show your Drugs Payment Scheme card when getting your prescription medicines in the Pharmacy. This is particularly important when you receive a new card.

Appendix 6

Age 23 Eligibility

Re Drugs Payment Scheme

Date of Birth

Dear (*Name of person who will be 23*),

It is noted that you were in full time education but will shortly reach twenty three years of age. Therefore you will no longer be entitled to be covered as a dependent on the family card under the Drugs Payment Scheme from the end of (*Insert expiry date month end*).

I enclose herewith an application form, which you should complete and return to this office so that you can be registered independently under the Drugs Payment Scheme.

If you have any queries on this matter, please contact this office.

Yours sincerely,

Drugs Payment Scheme Liaison Officer

N.B. Always show your Drugs Payment Scheme card when getting your prescription medicines in the Pharmacy. This is particularly important when you receive a new card.

Appendix 7

Emergency Registration Form

Address of Applicant/Family

Telephone area code [] number []

Do you currently hold a DPS card Yes No

If yes, please state with which HSE Office

Enter existing Card number

(this number is in Bold print on the centre of your DPS Card)

Previous address if changed in last five years

Data Protection Notice

- The General Medical Services (Payments) Primary Care Reimbursement Service, on behalf of the Health Primary Care Reimbursement Service, for Drugs Payment Scheme cards to be issued - it also processes for payment all DPS pharmacy claims. The information on this form will be transmitted to the General Medical Services (Payments) Primary Care Reimbursement Service so that a DPS registration card(s) may be issued to the person(s) named hereon.
- Details of prescription items dispensed to the named person(s) may be notified to the GMS (Payments) Primary Care Reimbursement Service by the dispensing pharmacists to ensure that the said named person(s), individually or as eligible members of a household, pay no more than the parameter amount set by Order of the Minister for Health & Children.

THIS SHOULD BE COMPLETED NOMINATING THE HEAD OF HOUSEHOLD WHO MUST BE AN ADULT

	Surname	First Name	PPS Number A valid number must be entered for each family member										Gen der (M/F)	Date of Birth (DDMMYY)				Dependants in Continuing Education (Y/N)		
Head of Household																				
Spouse/Partner																				
Dependant																				
Dependant																				
Dependant																				
Dependant																				
Dependant																				
Dependant																				
Dependant																				

Signature of Applicant: _____ **Date:** _____

FORWARD COMPLETED APPLICATION TO DRUGS PAYMENTS SECTION, LOCAL HEALTH OFFICES,

For HSE Official Use
Electoral Division

HSE Number

Administrative Area Code

District

Pharmacy Section

High Tech

Medical Card
Withdrawn

Expensive
Medication

Pharmacy Stamp

GMS
No _____