PHARMACY GUILD OF NEW ZEALAND

25 July 2025

PHARMAC
PO Box 10254
The Terrace
Wellington 6143

Sent via email to: *consult@pharmac.govt.nz*

Dear Sir/Madam,

Re: Consultation on changes to support increased prescription lengths

The Pharmacy Guild of New Zealand (Inc.) (the Guild) is a national membership organisation and the largest representative of community pharmacy owners in New Zealand. We provide leadership on all issues affecting the sector and advocate for the business and professional interests of community pharmacy.

This submission focuses on Guild members' concerns around general economic, funding, access and supply issues. Guild submissions should not be taken as any endorsement of, or any attempt to comment on, medicine safety, efficacy, or appropriateness for individual patients.

We acknowledge and commend Pharmac's proactive approach to implement changes to the Pharmaceutical Schedule from 1 February 2026 to support the government's decision to increase the length of a prescription for any period up to 12 months, where deemed clinically appropriate by the prescriber. However, at this stage, our submission raises more questions than makes comments, largely due to the ongoing development of new regulations by the Ministry of Health, limited engagement with community pharmacy sector organisations, and a lack of clarity around how Health New Zealand (HNZ) intends to operationalise and implement this Ministerial directive. These uncertainties make it challenging to fully evaluate the potential downstream implications for:

- Community pharmacy operations, workloads and staffing capacity
- Funding mechanisms and associated administrative burdens
- Clinical safety, quality assurance, and medicine adherence
- Existing and future digital infrastructure requirements, including updates to prescriber patient management systems (PMS) and community pharmacy patient management systems (PhMS).

The proposed funding changes from this consultation are being introduced ahead of clearly defined operational expectations and system readiness, which poses risks to the safe and consistent implementation of these changes. Without greater clarity and timely sector engagement, this approach risks undermining the consistent implementation of this transition and could limit the community pharmacy sector's ability to prepare effectively and continue to deliver high-quality, safe, consistent, and efficient care to patients.

Your community pharmacist:
the health professional you see most often.

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Key areas for consideration

Community pharmacy operations and funding considerations

The information provided to date by the Ministry of Health and HNZ highlights several regulatory, practical dispensing, and funding considerations that should be carefully evaluated as part of this consultation:

- **Maximum supply period:** The maximum period of supply that can be dispensed at any one time remains limited to three months, except for oral contraceptives, which may be dispensed for up to six months at a time. While this approach retains the current dispensing process and maintains current cash flow and stockholding patterns for community pharmacies, several important implementation issues remain unresolved. It is currently unclear how compliance with the three-month dispensing rule will be monitored or enforced within the extended 12-month prescription framework and raises important operational and regulatory questions, including:
    - Will there be a new or adapted audit framework to verify compliance with dispensing limits, and which agency will be responsible for oversight – Medsafe, HNZ, or another regulatory body?
    - How will discrepancies be identified and addressed when inappropriate quantities are dispensed or when multiple pharmacies are involved in fulfilling prescriptions of longer duration for a single patient?
    - Will community pharmacy and prescriber patient management systems be required to include automatic alerts or lockouts to prevent over-dispensing, particularly for higher-risk medicines?

- **Longer prescription lifecycle:** Extending prescriptions for a period of a maximum of 1 2 months will mean repeat dispensing of a medicine will occur under a significantly longer lifecycle, which introduces several risks:
    - Increasing exposure to inappropriate medicine use if a patient's health circumstances change during the 12-month period, such as new diagnoses, contraindications, or interactions with newly prescribed medicines. This is particularly concerning when patients see multiple prescribers, e.g. GPs and specialists, and changes are not communicated to the patient's regular pharmacy, where the dispensary staff may unknowingly continue to dispense medicines that are no longer clinically appropriate, especially in the absence of a nationally shared medicines record.
    - Increase in medicine wastage if patients continue collecting repeats for medicines they no longer require, particularly for long-term therapies. This is compounded by the fact that community pharmacies do not currently have funded access to real-time, nationally consistent patient medicines records or clinical notes, limiting their ability to verifying ongoing medicine appropriateness at the time of dispensing.
    - Increased risk of misalignment between repeat dispensing and the validity of special authority approvals expiring or changing during the 12-month period, which may lead to prescriptions being dispensed without appropriate authority or funding, potentially requiring retrospective cost recovery, and placing administration burden on community pharmacies.

- **Changes to brand and use of unapproved medicines within the life of a prescription:** Over the course of a 12-month prescription, changes may occur under Pharmac's Sole Supply and Principal Supply arrangements, such as brand changes driven by tender outcomes or supply disruptions. We seek confirmation that existing mechanisms outlined in the Pharmaceutical

Schedule for managing such brand changes will continue to apply under the new prescribing model. Additionally, if a prescriber has endorsed a prescription with "no substitution allowed," it remains unclear how brand changes partway through the life of a prescription will be handled, and we request clarification on what safeguards will be in place to ensure patients are not required to return to their prescriber for a new prescription solely due to a system-driven brand change.

We also seek clarification on how the use of unapproved medicines, particularly during stock shortages, will be managed within the life of an extended prescription. While we acknowledge that Pharmac's use of unapproved medicines under section 29 of the Medicines Act 1981 is sometimes necessary to maintain continuity of care, this pathway was originally intended for exceptional circumstances where no approved alternative was available, and its increasing use to manage temporary shortages of approved, funded medicines deviates from the legislation's original intent. This raises concerns around legal and professional risk, where both authorised prescribers and pharmacists may be exposed to liability or disciplinary action, particularly if patients are not fully informed that they are receiving an unapproved medicine, if the prescriber has not had a discussion with the patient on the use of an unapproved medicine and obtained the patient's consent, or if proper documentation is lacking.

- **Dispensing timeframe rules:** There appears to be some ambiguity in the consultation regarding the proposed updates to the dispensing timeframe rules. The proposed changes to Section 1.2. 'Community Pharmaceuticals period of supply for Subsidy' of the Pharmaceutical Schedule states that:

  "*Pharmaceuticals will be Subsidised only if the prescription under which the Community Pharmaceutical has been first been dispensed by the Contractor within 3 Months of the date on which the Prescription was written; and*
  1.2.1 Only a quantity sufficient to provide treatment up to the legal period of supply limit will be Subsidised as specified in the Medicines Act 1981 and Medicines Regulations 1984 and the Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977.
  1.2.2 Where there is no legal period of supply limit, only a quantity sufficient to provide treatment for a period up to 12 months will be Subsidised, subject to the dispensing requirements in 3.2 below.

  However, the proposed wording in Section 3.2.1 of the 'Dispensing' rules introduces potential confusion:

  "3.2.1 A Prescription, or part thereof, will be eligible for Subsidy if it is fulfilled within the maximum period specified in Medicines Act 1981 and Medicines Regulations 1984 and the Misuse of Drugs Act 1975 and Misuse of Drugs Regulations 1977."

  The wording in Section 3.2.1 could be interpreted to mean that a prescription may still be subsidised even if first dispensed more than three months after it was written, which contradicts the intention of Section 1.2. We seek clarification to ensure consistent interpretation and application of these rules and to prevent confusion when the new rules are implemented.

  The regulations underpinning this government-led change are still being drafted. A meeting involving the Ministry of Health, Medsafe and community pharmacy sector representatives was held to explore the legal implications, including the legal life of a prescription. Currently, prescriptions are legally valid for six months, with funding limited to three months. Discussions explored the possibility of extending the legal validity of a prescription beyond 12

months, e.g. up to 15 months, to allow continued dispensing of a medicine beyond the funded period and to support patients in accessing their prescribed medicines while arranging their next prescription. These discussions remain ongoing, and no final decision on the legal life of a prescription has been made. Consequently, the proposed wording in Section 3.2.2 and other proposed changes to the Schedule rules could allow for funded supply of a medicine beyond 12 months if the legal validity of prescriptions is formally extended.

- **Changes to dispensing frequency within the life of a prescription**: The dispensing frequency of a medicine may change during the lifespan of a 12-month prescription due to factors such as brand changes, supply constraints, or other Pharmac decisions. We seek clarification on how such mid-cycle changes will be managed for 12-month prescriptions, particularly in scenarios where a medicine is originally listed for 'Stat' dispensing (three months' supply at once) and then changed to monthly dispensing partway through the life of a 12-month period, with key questions including:
  - Will the original prescription and remaining repeats remain valid under the updated dispensing frequency, or will a new prescription need to be obtained from the prescriber?
  - How will community pharmacies be notified of changes that impact dispensing frequency, and what lead times will be provided to implement such changes safely?

  This current lack of clarity has the potential to disrupt the continuity of care for patients and impose unnecessary administrative burden on prescribers and community pharmacy staff if reissuing prescriptions is required. Additionally, practical implementation considerations must be addressed, particularly how dispensing intervals and remaining repeats will be recalculated and managed within PhMS, so that community pharmacies are assured that any system-driven changes in dispensing frequency will still allow for accurate and timely reimbursement and prevent claim rejections.

Financial and sustainability considerations

To date, there has been no indication from HNZ or within this consultation regarding how key financial implications for community pharmacy will be addressed under the proposed 12-month prescription changes. These include:

- **Dispensing fee structures:** It remains unclear whether the current dispensing fee model will be retained or revised in response to the shift toward longer prescription durations. We are actively discussing this issue with HNZ and government officials. While dispensing will still occur at three-monthly intervals (except for oral contraceptives), the administrative and clinical workload for a 12-month prescription is significantly front-loaded, requiring early investment in patient data entry, prescription validation, special authority checks, clinical appropriateness assessment, and medicines reconciliation and synchronisation, all of which are resource-intensive and incur immediate costs.

  Under the current ICPSA, the dispensing fee for subsequent repeats is lower than for the initial dispensing, on the assumption that repeat supplies require less effort, however, this does not reflect the actual work and accuracy required to safely and effectively dispense each repeat, which still involves patient counselling, safety checks, stock preparation, and claim submission. If this current funding structure is applied to 12-month prescriptions without adjustment, the cumulative impact of reduced remuneration per repeat could significantly erode the financial viability of community pharmacy services, particularly for high-volume dispensing or in pharmacies serving vulnerable or complex patient populations. Furthermore, a longer prescription cycle increases the risk of patient condition changes, non-adherence,

medicine changes, and expired special authority approvals, requiring pharmacists to intervene more frequently throughout the life of the prescription.

- **Stockholding and wastage reimbursement:** Community pharmacies will need to maintain adequate stock levels to support upcoming repeat dispensing from 12-month prescriptions, particularly for high-cost, low-turnover, cold-chain, or short shelf-life medicines, which could significantly tie up working capital, increase inventory management complexity, and expose community pharmacies to greater financial risk. If a patient's therapy is altered, paused, or discontinued partway through the prescription cycle, due to clinical reasons, hospitalisation, prescriber intervention, or non-adherence, community pharmacies may be left with unused stock for which reimbursement is not possible, and this is particularly problematic for expensive or infrequently used items, where one or two unused packs could represent a substantial loss.

  Currently, there is no mechanism proposed within this consultation to address or compensate for the increased risk of medicine wastage resulting from longer prescription cycles. In addition to the financial burden, there are implications for medicine storage space, cold-chain logistics, and expiry management, all of which must be accounted for in operational planning. We seek clarity on how community pharmacies will be protected from the financial consequences of stockholding losses, and whether any reimbursement pathway, return mechanism, or risk-sharing arrangement will be introduced to mitigate the impact of unused or expired medicines.

- **Clawbacks and administrative risk:** The introduction of 12-month prescriptions significantly increases the potential for clawbacks, rejected claims, and administrative burden due to changes in patient eligibility or clinical status over an extended period. For example, if a prescriber initiates a 12-month prescription for a medicine requiring a special authority and the approval expires partway through the dispensing cycle, community pharmacies may unintentionally dispense a non-funded item, leading to unrecoverable losses, claim rejections, or audit concerns. Similarly, if a patient's condition changes, a medicine is no longer clinically appropriate, or the patient becomes ineligible due to a change in funding criteria or diagnosis, the lack of visibility across systems may leave community pharmacies at risk of non-compliance despite acting in good faith.

  We seek further clarity on how these situations will be managed in practice, including:
  - Who will bear the responsibility for funding errors – prescribers, community pharmacies, or the funder?
  - Whether a defined appeal or reimbursement mechanism will be introduced to address clawbacks resulting from system-level issues or communication failure?
  - How will clinical decision-making and patient medicine records be shared or updated across providers to minimise risk and ensure continuity of care?

Technology and data integrity considerations

The shift to allow prescriptions to cover up to a 12-month supply and proposed funding mechanism from this proposal introduces significant new demands on the digital infrastructure that supports prescribing and dispensing. Key areas requiring attention include:

- **Prescriber and community pharmacy patient management systems (PMS and PhMS):** These systems will require significant updates to align with the proposed regulatory and funding changes associated with 12-month prescriptions and must include enhanced

safeguards to ensure patient safety and compliance, such as controls to prevent prescribing or dispensing outside of permitted regulatory timeframes, automated alerts for prescribers and pharmacists when special authority approvals are approaching expiry or have lapsed, functionality to accurately track repeat dispensing activity over an extended 12-month period, and adjustments to claiming and reconciliation processes to align with any revised funding rules. We seek clarification on several critical implementation matters, including:

- Whether PMS and PhMS vendors will be required to implement these system changes, and if so, what standards will apply to ensure consistency and interoperability across platforms?
- Will vendors, providers, and end users be given adequate lead time for the design, implementation, testing, and rollout of these system upgrades, well in advance of the proposed go-live date?
- Who will bear the financial burden of these software modifications? If costs are passed on to community pharmacies or general practices, it may exacerbate existing financial pressures, particularly for smaller providers.

- **Interoperability with the New Zealand ePrescription Service (NZePS):** The NZePS must be fully equipped to support the updated prescribing, dispensing and funding rules associated with 12-month prescriptions and ensure seamless integration with both prescriber and community pharmacy patient management systems, including accurately transmitting prescription duration, repeat frequency, dispensing limits, and funding conditions between systems. Uniform implementation across all vendors is critical, and if some NZePS functionalities are not updated in time, or if implementations vary between PMS and PhMS, there is a heightened risk of clinical and administrative errors, such as inability to identify expired or ineligible special authorities and rejected or incorrect funding claims, placing financial strain on community pharmacies.

  There must also be assurance that the NZePS can support automated flags or alerts when prescriptions with special authorities approach their expiry or when prescribing rules are breached. Without this, community pharmacy teams may unknowingly dispense outside the regulatory parameters, or prescribers may issue prescriptions that are non-compliant with Pharmac's rules.

- **Audit trails and data monitoring:** Extending the duration of prescriptions to 12 months introduces greater complexity in the ability to track medicine use, patient adherence, and community pharmacy activity over an extended period, and robust, transparent audit functionality must be maintained across all prescribing and dispensing systems to support regulatory oversight by Medsafe, HNZ, and other regulatory bodies.

  In addition, enhanced data monitoring capabilities will be required to track whether patients are collecting their repeats as scheduled over the full 12-month cycle and identify delayed or missed pick-ups, which may suggest deteriorating adherence or emerging barriers to access, detect early patterns that indicate medicines misuse, overuse or underuse over time, monitor and report on equity of access across different population groups and regions, and evaluate whether the new prescription model is improving, maintaining, or inadvertently harming medicine access and therapeutic outcomes. This data must also be readily accessible and analysable at both the national and local levels to inform health policy, guide service development, and ensure that community pharmacy services remain responsive and sustainable.

Proposed changes to special authorities

We acknowledge the intent behind the proposed change to special authority funding criteria, namely, that only dispensing of pharmaceuticals (initial and repeats) occurring prior to the special authority expiry date will be eligible for funding, regardless of the prescription's duration. While we understand the rationale to align dispensing with active special authority approvals, this proposed change introduces several significant operational, clinical, and administrative implications:

- **Prescriber education and awareness:** A comprehensive nationally coordinated prescriber education programme will be critical to ensure prescribers are fully informed about the importance of proactively renewing special authorities before they expire, especially in the context of prescriptions written for greater than three months. Without widespread understanding and reliable clinical prompts, there is a significant risk that patients will present to a community pharmacy with a valid prescription but be unable to receive funded access to either the initial or subsequent repeat supplies due to an expired special authority, leading to treatment disruptions, delays in care, patient dissatisfaction, and added complexity for community pharmacy staff who must manage expectations and attempt to contact prescribers to resolve the issue. In high-volume practices or areas of workforce shortage, these delays could compound and further impact access and continuity of care. We seek clarity on the strategy Pharmac intends to implement to ensure prescribers are fully informed of their responsibilities under the 12-month prescription model, particularly regarding special authority expiry rules, to prevent unintended treatment interruptions or funding issues.

- **Increased responsibility for pharmacists:** This proposal places a greater burden on community pharmacists to function as de facto gatekeepers by checking the validity of special authorities at each dispensing event, including the initial supply and every subsequent repeat over the prescription period. This increased responsibility will add to pharmacists' clinical and administrative workload and may introduce inefficiencies into community pharmacy workflows, particularly if pharmacists must regularly contact prescribers to confirm special authority status or request urgent renewals. Given the volume of prescriptions processed daily in busy community pharmacies, even small delays or inconsistencies can compound quickly, leading to service bottlenecks, patient frustration, and elevating the risk of missed doses, especially for time-sensitive or long-term therapies, if delays occur. We urge that these implications for patient safety, equity of access, and service sustainability be carefully considered, and that appropriate system support, funding, and clear protocols are developed to mitigate the impact.

- **Increased general practice consultations and administrative workload:** While 12-month prescriptions aim to streamline care for stable patients on long-term therapies, the requirement for special authorities to remain valid throughout the prescription period may instead lead to more frequent general practice appointments and increased administrative tasks. If a special authority expires mid-cycle in the life of the prescription, patients may need to book a consultation solely to renew it, regardless of whether their condition or treatment remains unchanged, and this introduces additional pressure on general practice capacity and administrative teams, especially in high-demand settings, and risks delaying treatment if appointments are not readily available. The burden of completing renewal paperwork, monitoring expiry dates, and responding to community pharmacy queries about funding eligibility mid-prescription may undermine the very efficiencies that extended prescriptions were intended to achieve, and without system-level solutions, such as automatic reminders and streamlined renewal processes, these unintended consequences could diminish the anticipated benefits for both patients and the wider health system.

- **Audit, compliance, and accountability risks:** The move to 12-month prescriptions introduces new risks related to audit processes, claim rejections, and financial accountability, particularly in scenarios where special authority approvals expire mid-prescription or a patient's eligibility changes. In such cases, community pharmacies may unknowingly dispense non-funded medicines, resulting in clawbacks or unrecoverable financial losses, despite acting in good faith. It remains unclear how HNZ and Pharmac intend to audit dispensing activity under the new rules, and whether repeat supplies made after an expired special authority will be subject to clawback, and how accountability will be allocated between prescribers and community pharmacies. Additionally, greater clarity is needed regarding operational processes, provider responsibilities, and whether appeal or reimbursement mechanisms will be in place to mitigate unintended consequences and a clear strategy is required for how clinical information and special authority status will be shared across providers to reduce compliance risks.

- **Technology and system safeguards:** Robust, coordinated updates to PMS and PhMS will be essential to support the 12-month prescription model and proposed associated funding changes, with systems mandated to include automated alerts for approaching or expired special authorities, safeguards to prevent unfunded repeat dispensing, and the ability to track dispensing activity over an extended cycle. These updates are not optional from a safety and operational perspective, and without these protections, there is a significant risk of funding errors, rejected claims, patient safety concerns, and increased administrative burden on community pharmacy teams. We seek clarification on what national minimum standards will apply to ensure consistency and interoperability, whether adequate lead time and resourcing will be provided for design, testing, and rollout, and details on an education programme to ensure prescribers are fully informed about the importance of proactively renewing special authorities before they expire to reinforce prescriber accountability and reduce reliance on community pharmacy teams to identify and resolve funding gaps. The financial burden of implementing these changes must also be addressed, particularly for smaller providers, through equitable funding support.

Given these concerns, we strongly recommend that this aspect of the consultation be reconsidered. If full reconsideration is not pursued, then robust mitigations and safeguards must be embedded into prescriber education, digital infrastructure, and funding mechanisms prior to implementation, and the system should be designed so that digital tools carry the primary compliance burden, through strong alerts and automation, rather than shifting this responsibility on community pharmacies, who are already working under considerable pressure. We also acknowledge the proposed extension of special authority approval periods for selected medicines (e.g. Venetoclax, Upadacitinib) as a pragmatic interim solution to support continuity of care. While this is a positive step, it does not address the broader inefficiencies of the special authority system, and in the longer term a comprehensive review of these processes may be necessary to streamline long-term prescribing, reduce unnecessary administrative load, and enhance overall system-wide sustainability.

Proposed changes to products with maximum amounts funded on a prescription

We acknowledge the intent behind the proposed changes to products with maximum funded quantities per prescription, however, the implementation of these changes raises several important questions that require further clarification:

- How does Pharmac expect community pharmacies to monitor the quantity of items (e.g., continuous glucose monitors, insulin pump infusion sets, etc.) dispensed to a patient across

multiple pharmacies, when there is currently no funded access to a nationally shared dispensing record or medical record? Without visibility of dispensing activity beyond their own systems, community pharmacies cannot verify whether a patient has exceeded the funded limit elsewhere.
- How will the maximum funded quantities be enforced in practice if a patient chooses to obtain supplies from different pharmacies via multiple prescriptions, e.g. from a prescription written by their GP and a separate prescription written by their specialist? In the absence of an integrated national tracking system, the risk of unintentional over-dispensing or discrepancies increases.
- Has Pharmac factored in the increased need for associated consumables, such as pen needles or insulin syringes, when a patient is started on multiple insulin products? Under the proposed limits, patients may be restricted to 200 devices every three months, which may not reflect actual clinical requirements, especially where therapy intensification has occurred.

Pharmac previously supported the use of the Conporto shared medical record platform to facilitate pharmacist prescribing of Covid-19 antivirals. Conporto enables secure, comprehensive access to key clinical information, such as current medicines, lab results, and other health information, for both enrolled and unenrolled patients, and has the potential to operate nationally if widely adopted by prescribers and community pharmacies. If community pharmacies are now expected to monitor and enforce national dispensing limits, we encourage Pharmac to revisit its earlier endorsement of Conporto and its companion platforms, reScript and reCare. These systems offer integrated prescribing and dispensing functionality, including real-time alerts when a patient's funded supply cap (e.g., for CGMs) is reached, delivering a more efficient, clinically safe, and scalable solution. Additionally, reScript and reCare include features to support the sector through changes linked to extended prescription lengths, such as controls to prevent dispensing outside permitted timeframes, automated alerts for expiring special authorities, and the ability to track repeat dispensing across a 12-month period, which would support compliance, reduce administrative burden, and enhance continuity of care.

With many uncertainties remaining, due to the ongoing development of new regulations by the Ministry of Health and the absence of a formal framework outlining how HNZ will operationalise and implement this Ministerial directive, we strongly recommend a nationally coordinated approach, jointly led by HNZ, Pharmac, PMS/PhMS vendors, and general practice and community pharmacy sector representatives to work collaboratively to address outstanding issues, establish clear implementation timelines, and ensure that the transition to 12-month prescriptions is safe, effective, and well-managed for all stakeholders.

If you have any questions about our feedback, please contact our Senior Advisory Pharmacists, Martin Lowis (martin@pgnz.org.nz, 04 802 8218) or Cathy Martin (cathy@pgnz.org.nz, 04 802 8214).

Yours sincerely,

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