

Background

The *Veterinary Professionals Act, 2024*, (VPA) will replace the *Veterinarians Act, 1990* and its associated *Regulation 1093*. The VPA was first open to comments in 2017/2018. The OCP put out a consultation in October, 2018, and received significant comments from both practising pharmacy registrants and associations, including the Association of Compounding Pharmacists of Canada (ACPC). Significant concerns were voiced at that time, and those comments should be reviewed along with those received at this time.

At the June 15, 2026 OCP Board meeting, Agenda Item 9 spoke to this matter and forms one of the reference documents on the consultation page. A specific positive inclusion was **“that pharmacy professionals are not required to provide services to animals but may do so only if they have the knowledge, skills and judgment to do so safely...Based on the risk assessment, it was determined that continuing with the current scope of selling, dispensing and compounding for animals is appropriate without additional training requirements.”** Some comments about that Agenda item are necessary to reflect what should have been discussed since that time period, before this consultation arose, and now forms an essential part of the context of that consultation. One concern is the number of times that upon contacting the OCP for clarification, “use your judgement” is the answer provided. That judgement cannot be questioned when employed by a pharmacist deciding if they have the requisite knowledge, training and skill to participate in dispensing veterinary prescriptions.

The OCP has been silent on veterinary practice within our profession for decades, until more recently when approached by the CVO (now CVPO) about the VPA. However, as a college, it has recognized the legality of “legal prescriptions by a practitioner” and that has included both human and veterinary prescriptions.

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“Recognizes the (VPA) as the Act authorizing pharmacy professionals to sell, dispense and compound for animals.” – The VPA has no business impacting upon what pharmacists are licensed and trained to do (dispense legal prescriptions). That is permitted by the scope of practice for pharmacists, as well as federally under the Food & Drug Regulations. The DPRA definition of “drug” makes it clear that the DPRA includes humans, animals, and fowl. Thus, “prescription” also must cover practitioner orders for those species.

Situations will arise in practice (such as complicated oncology prescriptions) where the pharmacist does not feel comfortable dispensing the drug due to lack of extensive training in that field of practice. No pharmacist can be competent in all areas of practice that may arise in this current day and age, given the number of inter-professional prescribing privileges being put into legislation by various regulatory bodies.

Furthermore, the history with the OCP regarding veterinary prescriptions and regulatory “confusion” has extended back to pre-2008 when section 158 of the DPRA was finally amended to its present iteration, largely through the efforts of pharmacies, OPA, and ACPC engaging with the Ontario Ministry of Health. Given the professional scope of practice of pharmacists and technicians, as well as recent decisions issued by the federal Competition Bureau, and the defined controlled acts that apply to pharmacy (RHPA), there are serious concerns with some areas within the proposed Policy and its Supplemental Guidance (SG) document.

Comments re the Proposed Policy

As submitted in 2018, there should not be re-defining of terms that already exist in federal and provincial statutes, for fear that variation could occur and a “which definition applies” debate arises. An example is including “drug,” “prescription,” and “ELDU” definitions. ELDU is accepted practice within both human and animal practice, and any risks are accepted by the practitioner utilizing ELDU to treat their patient(s). Compounding has consistently been seen as yet another form of ELDU, but given that by their nature, compounds are not “labelled” in the traditional, DIN sense, there is no Health Canada (HC) approved labelling to mimic DIN labelling requirements. The “prescription” definition is actually footnoted to the DPRA – which is NOT ACCURATELY QUOTED. Thus, we have two “prescription” definitions to contend with, when it is not needed as it appears already in federal and provincial statutes. Pharmacists should not have to wonder if there are other definitions that exist for any term they memorized by rote in undergraduate jurisprudence; there is no room for confusion in pharmacy practice, and multiple definitions of one term create confusion; confusion can cause errors.

What is not in question, is that compounding has been present as a fundamental practice within pharmacy practice since before “big pharma” came about with its marketed products. It is an art that will naturally result in differences from one pharmacy to another; but the USP created chapters to ensure consistency and reasonable safety of patients when followed. The current NAPRA compounding standards actually reference much of their content to the USP (the term “USP” appears 39 times in the non-sterile compounding document, and 276 times in the sterile compounding document of NAPRA).

Policy

Lines 38-41: *“Pharmacy professionals have an exemption under this Act to perform the authorized activities of compounding, dispensing and selling drugs pursuant to a veterinary prescription.”*

In fact, pharmacists already have this authority. Plus, there are drugs for veterinary use that do not require a prescription, which pharmacists are entitled to sell (recently recognized by the Competition Bureau). Would veterinarians be required to be exempted by the OCP in order to compound or dispense? Would they be equally qualified, since the NAPRA standards are not being applied outside of pharmacy practice?

Also complicating this will be cross-jurisdictional situations when this policy is Ontario-centric, and could conflict with another jurisdiction where any legal prescription is presented and allowed to be filled. Historically, when OCP staff have been questioned about the DPRA visavis veterinary orders, they have actually stated “the DPRA doesn’t apply to animals.” But it does, as it contains them within the definition of a drug, and the DPRA regulates the dispensing and control of drugs in Ontario (including illegal sale by non-pharmacy entities).

Lines 51-54: *(MUST sell or dispense exactly as prescribed; any modification of a component of a prescription must be approved by the veterinarian...including the drug, brand of drug, dose, dosage form, strength, or directions for use).*

Problems here. Generic substitution is mandated in Ontario via DIDFA, which does not distinguish between species of patient. To not permit “brand” substitution conflicts with the established law. Price controls prevent pharmacists from dispensing the name brand, but only being able to charge the generic price. The pharmacy would not survive. Strength can also become a problem, if for example, a 60mg dose is not available, but 30mg doses are and would be permitted in the usual course of practice to be substituted accordingly. This applies for controlled substances based on the HC/OCS examples of “not exceeding the total mg prescribed originally” but permitting substitution of the same drug with another strength, if needed.

Lines 57-64: *(MUST only dispense or sell a drug for ELDU pursuant to a prescription following the same decision-making **cascade** as veterinarians)*

This topic has existed for decades now, driven by CAHI and its member companies trying to force sale of their products, or if not available, next requiring use of HUMAN products before considering use of compounding. That must not be tolerated by this college. “Cascade” is the actual term used in the CAHI/CVMA documents, and disregards the “good compounding practices” established around the world for pharmacy practices.

On the one hand, regulatory bodies expect you to be able to ensure that compounds are consistent from script to script. Yet, on the other hand, they would have you use commercial products with all the various excipients in them (all of which can affect stability, integrity, etc.) where a compounder cannot identify every one of those ingredients as opposed to using a FDA-approved API as starting material, eliminating any variability caused not only by excipients, but through HC-permitted variability between individual dosage units in a stock bottle (usually +/- 10%).

The cascade, from a professional compounding aspect, should be INVERTED with the filling of an unavailable commercial drug through compounding FIRST, before using a drug (human DIN product) not approved for that species (off-label). It was not tested or approved for use in that species. There is no less “risk” for that type of use, than exists for a professionally-compounded preparation.

https://compoundingtoday.com/Newsletter/Doc/Science_and_Tech_1205.cfm

The above is from an international compounding expert, Dr. Loyd V. Allen Jr. An example relevant to veterinary practice is included in the newsletter, but most relevant is his closing statement, which most experienced compounding pharmacists realize:

*“Bottom line, bulk substances are the only rational source of drugs for **ALL** compounding activities, unless they are not available. Excipients in commercial dosage forms can also contribute to compatibility and stability problems as well as elegance and compliance considerations.”*

As such, lines 57-64 should be completely amended in the proposed Policy, and not perpetuate the “cascade decision” tree put forward by companies with commercial interests ahead of patient safety. These are not based in science. Before dispensing a compounded preparation, pharmacists will have interacted with the prescriber, who ultimately then decides on what s/he needs for her/his patient, when electing to use a compounded preparation.

Lines 65 to 70: (sale to veterinarians)

This is already covered under existing federal regulations (C.01.043, as footnoted). As well, it actually would conflict with line 32. The problem as worded also involves the OCP thinking a pharmacist would be aware of what is “reasonable” when it is not defined, nor are they part of the practice environment of the veterinary office. Nor do they know, with certainty, that there is a VCPR at the practice end; that is a relationship between the veterinarian, client, and patient and is regulated by their provincial licensing body. If a veterinarian requires a drug for the practice, they know how much they need. It is not wise to use the vague “at a frequency and reasonable for the VCPR” phrase, when those terms are not defined and will vary with the individual veterinary practice. Even POL-0051 does not define a “period” for “based on a history of prescriptions received.” That history is adequate to determine as “reasonable” without another interpretation that would be applied subjectively by inspectors, rather than per a legal definition – which would also vary with the practice environment.

Line 68 states “for **the** (VCPR)...” not “**a** VCPR” when an office-use order would be for multiple end-users, each requiring a VCPR. But the VCPR is not relevant at the time of dispensing office-use prescriptions.

Lines 76-78: This has already been discussed in the Dr. Allen reference material. It is the reverse of what should be in place, determined by the veterinarian when they choose a treatment. Small patients, exotic animals, etc. may not have commercial products available for use, and a compounded format is necessary in order to alleviate suffering and treat the patients compassionately. But the preparation must be made with due respect to ALL ingredients, which one cannot know using a commercial product as starting material. Lines 79-81 show the dilemma: “Ensure the formulation and dosage form is safe and appropriate...ensure all ingredients are safe for subsequent human consumption.” This consultation is supposed to be about veterinary matters.

Line 78 makes reference to the CAHI “decision cascade,” which conflicts with established good compounding practice.

Withdrawal times are the jurisdiction and responsibility of the prescriber. Period. Pharmacists can advise a misinformed prescriber that the substance desired is not to be used in food animals (per F&D Regs, which define a limited number of drugs); but beyond that, to comply with this requirement, you would want to start with a single API, rather than the multitude of unknowns in commercial tablets, etc. and the fact that you get variance between each tablet’s potency, but are assuming the full labelled quantity is in the dosage unit – bad pharmacy practice. A Certificate of Analysis for an API gives a pharmacist far more information, than using a commercial product where the manufacturer doesn’t give all those details due to “trade secret” protectionism.

Lines 83-92: This section needs attention as it does not consider “office-use” prescription orders. In those cases, the patient and prescriber are one and the same; the prescriber then records the use of those drugs in his practice, subject to review by their regulatory body and federal authorities. A pharmacist cannot know in advance who the drugs will be issued to at the veterinarian’s end; and in fact, if pressed to get names at a later date, a violation of confidentiality arises. More simply: how do you “backdate” an already-dispensed drug, to change the name of the patient (being one patient at the time, the prescriber) to multiple patients? In effect, the OCP is endorsing fraudulent recording of data, setting a dangerous precedent for other prescriptions.

At the time an office-use order is filled, the pharmacist and the veterinarian will not know how many animals will receive the drug, until it is needed by the veterinarian for a herd, a single, or multiple patients, in the practice.

Lines 94-95: This is going to conflict with line 50. Pricing is DIDFA-regulated. That includes maximum fees and cost based on the cheapest drug in inventory (even if the name brand interchangeable is dispensed). But if you say sale must be “exactly as prescribed” then the only way DIDFA justifies charging for a higher drug brand dispensed, is to have the prescriber notate “NO SUBSTITUTION” on every order. I have yet to see the CVPO mention this to its members in formulating this legislation.

Supplemental Guidance Document

Lines 69-71: The wording suggests that only drugs “approved for use in Canada” may be used to fill prescriptions. However, I have interacted regularly with the former manager of the HC-GMP Inspection Unit for Ontario Region, and **have received in writing** that if a drug has not been banned due to being declared dangerous, but is available outside Canada and is needed for modification prior to dispensing, it is permissible to obtain that drug. The caveat, of course, is that you should try to get a Certificate of Analysis for the drug, and perform reasonable due diligence in obtaining the source ingredient. But a DEL is not required, as it is needed for a prescription and will be compounded/modified prior to dispensing (see next paragraph).

Lines 102-103: This statement is not accurate. A DEL is not required for importation of APIs for veterinary (or human) use, unless they are List A antimicrobial drugs. [Ref: C.01A.002(1)(b) and C.01A.002(3)] No such inference should be made (or possibly interpreted to be the case) for non-List A drugs, as they are exempted by the regulations cited previously. This wording suggests differently.

Lines 129-144: There are serious issues with this section’s veracity.

At lines 131-133, reference is made to “emergency purposes” allowing sale of a narcotic or controlled drug to a veterinarian upon receipt of a WRITTEN ORDER specifying as such. There is NO reference in statute to veterinarians and “emergency use” as pre-conditions. Rather, “emergency use” is covered for the sale by a pharmacist TO a pharmacist for emergency purposes. Food & Drug Regulation G.03.003, and NCR 31.(2)(b), and (3), are the relevant sections, and either a written or verbal order will authorize sale to a practitioner (which includes a veterinarian).

That also applies to the benzo reference, which is covered by those regulations (ss. 51.(1) & (3); and 55.(1) which permits a verbal or written order for sale to a practitioner).

“Emergency supply” is not the precondition required for sale to a practitioner.

Lines 166-172: The reference to “dispensing volume” must be removed, as there is no definition that can be reasonable; it’s based on the practice requirements. “Volume” has never been a condition for determining “office-use” dispensation, nor has it been defined. The only benchmark has been per POL-0051 which says that there should be a history of prescriptions that justifies the preparation of drugs in anticipation of a prescription.

The suggestion about trying to have a prescriber switch an office-use order to a patient-specific prescription also has no place in this document. Office-use is a historic privilege permitted for practitioners to use within their practices. The OCP should not be trying, directly or indirectly, to eliminate this privilege, as if that was to become evident to practitioners I am certain there would be huge outcry. And again, consider that this is but an Ontario policy, not national; the office-use privilege is national in scope.

Thank you for the opportunity to comment on this crucial consultation.