

# SCRIPT STANDARD

## ***IMPLEMENTATION GUIDE*** **VERSION 2017071**

*This is the NCPDP SCRIPT Implementation Guide, which provides guidelines for consistent implementation of the SCRIPT Standard for the purpose of transmitting electronic prescription transactions.*



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# **SCRIPT Standard Implementation Guide**

Version 2017071

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## 1. INTRODUCTION

SCRIPT is a standard created to facilitate the transfer of prescription data between pharmacies, prescribers, and payers. The current standard supports transactions regarding new prescriptions, prescription changes, renewal requests, prescription fill status notification, and prescription cancellation. Enhancements have been added for drug utilization review/use (DUR/DUE) alerts and formulary information as well as transactions to relay medication history and for a facility to notify a pharmacy of resident information. Enhancements have been added to support electronic prior authorization functions as well as electronic transfer of prescriptions between pharmacies.

If you have any questions regarding the availability or content of the NCPDP **SCRIPT Standard Implementation Guide**, see [www.ncpdp.org](http://www.ncpdp.org), or contact the Council office at (480) 477-1000 or via e-mail at ncpdp@ncpdp.org.

### 1.1 DOCUMENT SCOPE

This document contains the implementation guide. Users of this document should consult the NCPDP documents listed below for further information and clarification.

#### **NCPDP XML STANDARD**

---

This document contains the general information needed for implementing NCPDP XML transactions.

#### **SCHEMAS USED**

---

This package of information contains the actual XML schema used in implementing NCPDP XML transactions. Schemas include

transport.xsd	The NCPDP transport.xsd defines the envelope structures for the transactions and highest level elements for each transaction.
structures.xsd	The NCPDP structures.xsd defines common and reusable domain structures typically composed of datatypes and potentially other structures.
ecl.xsd	Vocabulary constraints for a business transaction.
datatypes.xsd	The NCPDP datatypes.xsd defines small, static, reusable structures (structural components) whose usage and validation is not typically impacted by the context of its use.  For instance, PostalCode structure and validation is not impacted if it is used as part of a pharmacy address or a patient's address.
Transaction schemas	(examples but not limited to)
script.xsd	The NCPDP script.xsd defines SCRIPT domain transactions
specialized.xsd	The NCPDP specialized.xsd defines Business Domain Transactions.

#### **DATA DICTIONARY**

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Full reference to all fields and values (contained within or reference to the *External Code List*) used in the NCPDP standard with examples.

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**EXTERNAL CODE LIST**

---

Full reference to values used in the NCPDP standard.

**STANDARDS MATRIX**

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This document contains a high-level overview of the latest version/release and/or the most commonly used of those standards and implementation guides, as well as NCPDP's Data Dictionary and External Code List. Additionally, this document provides version/release/publication reference charts for approved and draft NCPDP standards/implementation guides.

**SCRIPT STANDARD EXAMPLES GUIDE**

---

This document provides examples for the SCRIPT Standard xml messages.

**SCRIPT IMPLEMENTATION RECOMMENDATIONS**

---

This document provides implementation requirements for complying with the Prescription Model Act requirements when transmitting NCPDP SCRIPT transactions. This document also contains editorial corrections and clarifications to the NCPDP SCRIPT Implementation Guide documents.

**RISK EVALUATION & MITIGATION STRATEGIES (REMS) REFERENCE GUIDE FOR TELECOMMUNICATION STANDARD**

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While this document was created as a reference for claim billing processes, it provides background information on REMS that may be of interest.

**PRODUCT IDENTIFIERS STANDARD IMPLEMENTATION GUIDE**

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The NCPDP Product Identifier Standard Implementation Guide provides education and general guidance for consistent formatting and utilization of product identifiers in healthcare. Additionally, it provides rules to avoid changes to identifiers that would disrupt the provision of healthcare and have negative effects on patient care.

Other documents referenced in this guide:

**HL7 INTERNATIONAL CLINICAL DOCUMENT ARCHITECTURE (CDA)**

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Provides standards for the exchange, management and integration of data that support clinical patient care and the management, delivery and evaluation of healthcare services.

The Consolidated CDA implementation guide (CCDA) contains a library of CDA templates. The document level templates define the type of CDA document.

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<http://www.hl7.org/implement/standards/cda.cfm>

CDAs can use an XSL stylesheet to convert it to HTML for display.

These documents are available with NCPDP membership; contact the NCPDP office at 480-477-1000, or via e-mail at [ncpdp@ncpdp.org](mailto:ncpdp@ncpdp.org). The documents are available in the “Members” section of the website at [www.ncpdp.org](http://www.ncpdp.org).

## **2. BACKGROUND**

This document provides general guidelines for developers of pharmacy or physician management or payer or other entity systems who wish to provide prescription transmission functionality to their clients. The guide will describe the SCRIPT specification, provide a set of transactions, and address various issues related to implementation of SCRIPT.

### **2.1 NCPDP AND USE OF SCRIPT STANDARD**

SCRIPT is a data transmission intended to facilitate the communication of prescription information between prescribers, pharmacies, facilities, intermediaries, and payers.

#### **2.1.1 REMS**

Functionality for a Risk Evaluation and Mitigation Strategy (REMS) Administrator has been added. The Food and Drug Administration Amendments Act (FDAAA) of 2007 (Public Law 110-85) enables the Food and Drug Administration (FDA) to require a REMS from a pharmaceutical manufacturer if the FDA determines that a REMS is necessary to ensure the benefits of a drug outweigh the risks associated with the drug. Drugs currently approved by the FDA, including those with existing RiskMap programs, are also subject to a retrospective FDA review to determine if REMS is necessary. This authority extends to any manufacturer submitting a new drug application (NDA), abbreviated new drug application (ANDA), and biologics license application (BLA).

A REMS includes a timetable for the submission of assessments of the REMS. A REMS may also include any of the following:

- A Medication Guide (MedGuide) and a
- Patient Package Insert (PPI)
- A Communication Plan
- Certain “Elements to Assure Safe Use” (ETASU)
- Implementation System

The ETASU may include any combination of the following requirements:

- Healthcare providers who prescribe the drug have particular training or experience, or are specially certified.
- Pharmacies, practitioners, or healthcare settings that dispense/or administer the drug are specially certified.
- The drug is dispensed to patients only in certain healthcare settings.
- The drug is dispensed to patients with evidence of safe use conditions, such as laboratory test results.
- Each patient using the drug is subject to certain monitoring.
- Each patient using the drug is enrolled in a registry.

During the drug approval process, the FDA will determine whether a REMS will be required. If the FDA finds that a REMS is necessary to ensure the benefits of the drug or biological product

outweigh the risks of the product, and FDA notifies the sponsor of the application to submit a proposed REMS, the REMS will be approved as part of the drug/biological approval process.

FDAAA also permits the FDA to require REMS for drug and biological products that have already been approved. This allows for new REMS requirements for drugs/biologicals that have been on the market for some time.

The FDA created guidance for the first “Class REMS” for opioids in 2012 ER and Long-Acting Opioid Analgesics. This opioid Class REMS is applied to all current and proposed extended-release opioids and methadone, which are dispensed via retail pharmacies. It is assumed a “Class REMS” will have the same features as cases when both innovator and generic forms of the same drug exist.

The currently approved REMS programs vary in levels of complexity. Most require only a Med Guide and Communication Plan, but some require ETASU. The large majority of existing REMS programs are for drugs dispensed through specialty pharmacy, clinics, and hospitals but as REMS become more common they will ultimately have a greater impact on retail-based products.

Ensuring REMS compliance for products commonly found in a retail or community pharmacy setting presents pharmacies and manufacturers with several logistic challenges. This guide directly addresses these types of REMS and challenges with the goal of integrating these processes into the retail/community pharmacist’s workflow and minimizing burden as much as possible.

The primary implication of REMS for the industry is twofold. First, REMS with ETASU may require the pharmacist to verify prescriber, patient, and/or pharmacy enrollment in a registry and, in some cases, verify or check certain information, such as lab results. Second, all REMS, including those without ETASU, must fulfill FDA-approved reporting requirements. All REMS are subject to FDA audits which are based on detailed data capture and reporting elements. Each REMS program must also include a program assessment schedule that examines the program’s effectiveness on intervals approved by the FDA as part of the overall REMS program. The results of these assessments are submitted to the FDA as part of the ongoing evaluation of REMS program effectiveness. Failure to comply with REMS requirements can result in fines and potentially lead to removal of a drug from the market.

### **3. BUSINESS ENVIRONMENT**

#### **3.1 OBJECTIVES**

The transactions moved between business partners will vary according to the business needs and State and Federal laws. Described below in the business models are the Communication Modes and Business Operations. These are not exhaustive nor restrictive except where noted within the "Business Functions" and "Compliance" sections.

##### **3.1.1 BUSINESS OPERATIONS**

Basic business operation is the communication of prescription information between prescriber and pharmacy and medication history information between entities, prior authorization exchanges between prescribers and entities, and transfer exchanges between pharmacies. This includes new prescription and renewal prescription transactions, as well as auxiliary transactions. The "Transactions" section provides more detail of the transactions that are included in the SCRIPT format. The data included in the elements within the transactions is subject to agreements between business partners as well as State and Federal laws.

Participating entities must ensure that appropriate security measures are in place to protect patient confidentiality and against fraud and abuse. Also see "Compliance" section.

For the purposes of this implementation guide,

#### **PHARMACY**

The pharmacy typically will:

- initiate a request for a renewal
- initiate a request for a change to a new prescription
- initiate a request for a password change
- initiate a notification of a dispensed, not dispensed, partially dispensed prescription, or transferred
- initiate a response to a cancel prescription request
- initiate a request for a medication history to a prescriber
- initiate a request for a medication history to a payer
- initiate a request for a new prescription
- initiate a request to transfer of one or more prescriptions for a patient
- initiate a response to a prescription transfer request
- confirm a prescription transfer

#### **PREScriBER**

The prescriber typically will:

- initiate a request for a new prescription
- initiate a response to a renewal request from a pharmacy
- initiate a response to a prescription change request
- initiate a request for a password change
- initiate a request to cancel a prescription that has already been transmitted

- initiate a request for a medication history to a pharmacy
- initiate a request for a medication history to a payer
- modify the prescription order and notify the pharmacy (in long term care environments)
- notify a pharmacy or other entity of drug administration events such as suspending administration
- initiate a response to a new prescription request
- initiate a request for information required to submit a prior authorization request
- initiate a request for a prior authorization
- initiate a request for an appeal of a prior authorization response
- initiate a request to cancel a prior authorization request
- initiate a request to modify or cancel a previously submitted fill status notification request
- initiate a request for information required to submit a REMS request to a REMS Administrator
- initiate a request for REMS verification to a REMS Administrator

**Long Term or Post-Acute Care (LTPAC) Organization**

The LTPAC organization typically will:

- initiate a request for a resupply of a medication
- initiate a recertification for a medication order

**Entities (pharmacy, prescriber, intermediary, payer/health plan) typically will:**

- request medication history request from another entity
- provide medication history

**Entities (intermediary, payer/processor/health plan) typically will:**

- respond to an initiation request with information required to submit a prior authorization request
- respond to a prior authorization request
- respond to a prior authorization appeal request with information required to submit a prior authorization appeal
- respond to a prior authorization appeal request
- respond to a prior authorization cancellation request

**A REMS Administrator typically will:**

- respond to an initiation request with information required to submit a REMS request
- respond to a REMS request

Note that for the purposes of this guide, the terms “health plan” “payer” “processor” “pharmacy benefit manager” are all cited as “payer”. One of these entities may contract with a third party to perform prior authorization functions; the term should be treated the same for these purposes.

The specific use of transactions within the Business Operations and Communication Modes are illustrated in sample information exchanges within the “Transactions” and “Transmission Examples” sections.

## **3.2 COMPLIANCE**

Electronic prescribing is legal in all states, however, many states have legal requirements that application vendors and/or end users must adhere to in order to engage in e-prescribing communications. Examples of such legal obligations include requirements that: (1) vendors apply for approval of their applications prior to doing business in a state, (2) specific data elements be included in e-prescribing transactions, (3) protect transaction security and patient confidentiality, (4) address prescriber choice of medication and patient choice of pharmacy. Accordingly, all industry stakeholders are strongly encouraged to perform legal due diligence with respect to state and local laws prior to engaging in e-prescribing communications in a locale.

### **3.2.1 REVERSALS**

This implementation of SCRIPT does not support a reversal type of transaction. If a transaction is transmitted in error, the sender should communicate through traditional channels to alert the receiver. At some future point if the industry requires an electronic method, NCPDP may undertake design of reversal transactions.

## 4. BUSINESS FUNCTIONS

### 4.1 INTRODUCTION

This implementation guide supports these business functions.

- New Prescription Functions
- Renewal Prescription Functions
- Resupply Functions
- Recertification Functions
- Medication History Functions
- Drug Administration Functions
- Query Functions
- Prior Authorization Functions
- Prescription Transfer Functions
- REMS Functions

The functions described above may be supported by using the following basic transactions (found in the NCPDP **XML Standard**).

- GetMessage Transaction - Requests from a Mailbox, a renewal prescription request, prescription change request, new prescription request, prescription fill status notification, verification, transfer request, transfer response, transfer confirmation or an error or other transactions that have been sent by a pharmacy or prescriber system.
- PasswordChange Transaction - Requests Mailbox to change the password.
- Verify Transaction - Response to a pharmacy or prescriber indicating that a transaction requesting a return receipt has been received.
- Status - Is used to relay acceptance of a transaction back to the sender.
  - A Status in response to transactions indicates acceptance and responsibility for a request (see list in the NCPDP **XML Standard**).
  - A Status in response to GetMessage indicates that no mail is waiting for pickup. A Status cannot be mailboxled and may not contain an error.
- Error - This transaction indicates an error has occurred indicating the request was terminated. (An Error can be generated when there is a communication problem or when the transaction actually had an error.)

### 4.2 TRANSACTION TYPES

The functions of this implementation guide include:

NewRx	New Prescription Transaction - This transaction is a new prescription from the prescriber to the pharmacy electronically so that it can be dispensed to a patient.
RxRenewalRequest	This transaction is from the pharmacy to the prescriber requesting additional refills.
RxRenewalResponse	This transaction is the response to a request for additional refills (RxRenewalRequest). The response may be a new prescription (replace).
RxFill	This transaction is sent to the prescriber or long term or post-acute care (LTPAC) organization from the pharmacy and indicates the status of the prescriptions dispensing (dispensed, partially dispensed, not dispensed, transferred). It is the notification from a pharmacy to a prescriber when the prescription has been dispensed (medication picked up by patient), partially dispensed (partial amount of medication picked up by the patient), not dispensed (medication not picked up by patient) and medication returned to stock, or transferred to another pharmacy. For

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	long term or post-acute (LTPAC), It is the notification from a pharmacy to a LTPAC organization when the prescription has been dispensed (medication to be delivered to the specified facility or medication has been added to profile for administration to the patient), partially dispensed (partial amount of medication to be delivered to the specified facility), not dispensed (medication will not be delivered to the specified facility) or transferred to another pharmacy.
<b>RxFillIndicatorChange</b>	This transaction is sent by the prescriber to the pharmacy to indicate that the prescriber is changing the types of RxFill transactions that were previously requested. The prescriber may modify the fill status of transactions previously selected or cancel future RxFill transactions.
<b>CancelRx</b>	This transaction is a request from the prescriber to the pharmacy to not fill a previously sent prescription.
<b>CancelRxResponse</b>	This transaction is a response from the pharmacy to the prescriber to acknowledge a cancel request. A CancelRxResponse is the response to a cancel request (CancelRx).
<b>GetMessage</b>	This transaction is used by the prescriber or pharmacy asking the mailbox if there are any transactions.
<b>RxChangeRequest</b>	Prescription Change Request Transaction - This is used when the pharmacy is asking for a change in the original prescription or validation of prescriber credentials. It is a request from a pharmacy to a prescriber asking for a change in a new prescription or a "fillable" prescription. It may also be utilized to request a prescriber to review the drug requested, and obtain a prior authorization from the payer for the prescription. An example may be to allow for generic substitution.
<b>RxChangeResponse</b>	This is the response from the RxChangeRequest. It is a response from a prescriber to a pharmacy for a prescription change. It may also be used to send a response to a request for a prior authorization back to the pharmacy or prescriber credential validation.
<b>RxHistoryRequest</b>	This transaction is from an entity requesting medication history from an entity. It is a request from an entity to an entity requesting a list of medications that have been prescribed, dispensed, claimed or indicated (OTCs) by patient.
<b>RxHistoryResponse</b>	This transaction is a response from an entity to an entity to describe the patient's medication history. The medication history result includes the medications that were dispensed or obtained within a certain timeframe, optionally including the prescriber that prescribed it. An RxHistoryResponse is the response to a request for medication history (RxHistoryRequest).
<b>CancelRx and NewRx</b>	Long Term Care (LTC) Medication Change - A prescriber has the need to modify the order and notify the pharmacy. The prescriber system will always send a CancelRx and a NewRx, regardless of the type of change.
<b>Resupply</b>	This transaction is a request from a Long Term or Post-Acute Care (LTPAC) organization to a pharmacy to send a an additional supply of medication for an existing order. An example use case is when a medication supply for a resident is running low (2-3 doses) and a new supply is needed from the pharmacy, the LTPAC organization need a way to notify the pharmacy that an additional supply for the medication is needed.
<b>Recertification</b>	This transaction is a notification from a facility, on behalf of a prescriber, to a pharmacy recertifying the continued administration of a medication order. An example use is when an existing medication order has been recertified by the prescriber for continued use. Long term or post-acute care use only.
<b>DrugAdministration</b>	This transaction communicates drug administration events from a prescriber/care facility to the pharmacy or other entity. It is a notification from a prescriber/care facility to a pharmacy or other entity that a drug administration event has occurred - for example, a medication was suspended or administration was resumed.
<b>NewRxRequest</b>	This transaction is a request from a pharmacy to a prescriber for a new prescription for a patient.
<b>NewRxResponseDenied</b>	This transaction is a denied response to a previously sent NewRxRequest. (If approved, a NewRx would be sent.)
<b>PAInitiation Request</b>	This transaction is a request from the prescriber to the payer for the information required to submit a PARequest. It is a request from a prescriber to a payer for the

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	information required to submit a prior authorization request for a specified patient and drug.
<b>PAInitiation Response</b>	This transaction is a response from the payer to the prescriber with the information required to submit a PARRequest. It is a response from a payer to a prescriber with the information required to submit a prior authorization request for a specified patient and drug.
<b>PAResponse</b>	This transaction is a request from the prescriber to the payer with information (answers to question set; clinical documents) for the payer to make a PA determination (approved, denied, pended, etc.).
<b>PAAppealRequest</b>	This transaction is a response from the payer to the prescriber with the status of a PAAppealRequest.
<b>PAAppealResponse</b>	This transaction is a request from the prescriber to the payer to appeal a PA determination.
<b>PACancelRequest</b>	This transaction is a response from the payer to the prescriber with the status of a PACancelRequest.
<b>PACancelResponse</b>	This transaction is a request from the prescriber to the payer to cancel a PARRequest.
<b>RxTransferRequest</b>	This transaction is used when the pharmacy is asking for a transfer of one or more prescriptions for a specific patient to the requesting pharmacy.
<b>RxTransferResponse</b>	This transaction is the response to the RxTransferRequest which includes the prescription(s) being transferred or a rejection of the transfer request. It is sent from the transferring pharmacy to the requesting pharmacy.
<b>RxTransferConfirm</b>	This transaction is used by the pharmacy receiving (originally requesting) the transfer to confirm that the transfer prescription has been received and the transfer is complete.
<b>REMSInitiation Request</b>	This transaction is a request to the REMS Administrator for the information required to submit a REMSRequest. It is a request for the information required to submit a REMS request for a specified patient and drug.
<b>REMSInitiationResponse</b>	This transaction is a response from the REMS Administrator with the information required to submit a REMSRequest. It is a response with the information required to submit a REMS request for a specified patient and drug.
<b>REMSRequest</b>	This transaction is a request to the REMS Administrator with information (answers to question set; clinical documents) to make a REMS determination (approved, denied, pended, etc.).
<b>REMSResponse</b>	This transaction is a response from the REMS Administrator to a REMSRequest.

## 5. TRANSACTIONS

The following functions are described in further detail in the NCPDP **XML Standard** and apply to any transaction exchange that supports this functionality.

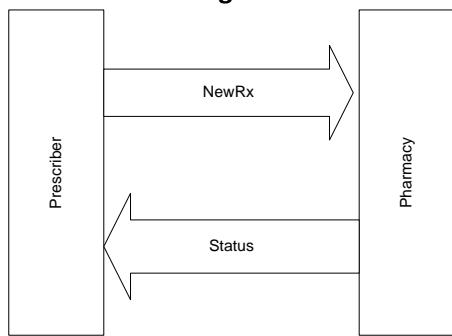
- GetMessage Transaction
- PasswordChange Transaction
- Verify Transaction
- Status Transaction
- Error Transaction

### 5.1 NEW PRESCRIPTION TRANSACTION

The new prescription transaction is used to send a new prescription from a prescriber to a pharmacy for a patient. It can also be used to designate a free/discounted “sample” transaction by including the sample coupon number. The new prescription transaction is originated by the prescriber's system as a NewRx.

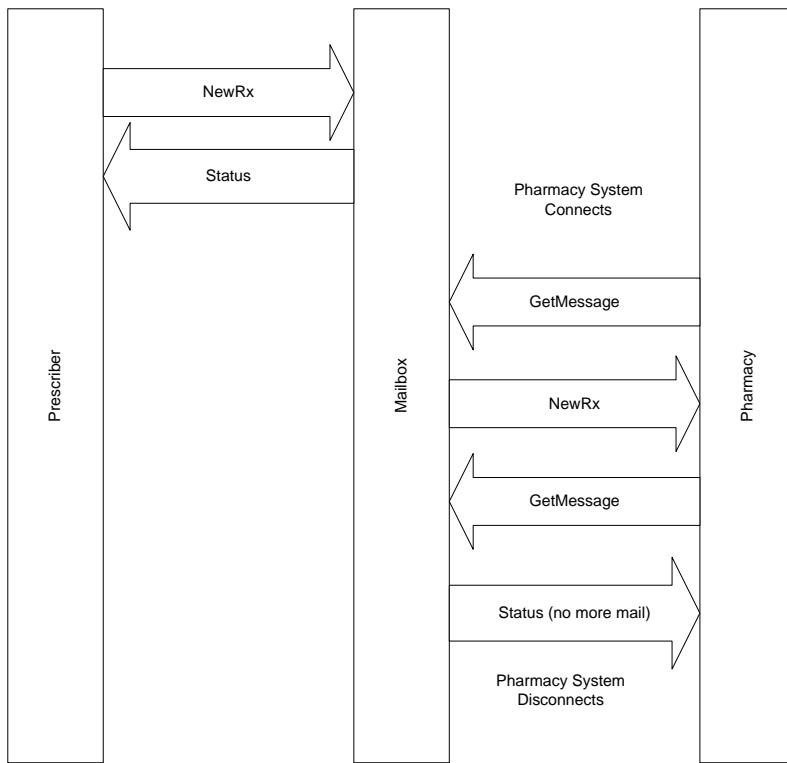
<RxFillIndicator> informs the pharmacy of the prescriber's intent for fill status notifications for a specific patient/medication.

In the direct connect configuration, the prescriber's system sends the NewRx directly to the pharmacy's system. The pharmacy system responds with a Status upon successful acceptance of the NewRx. See **Figure 1**.



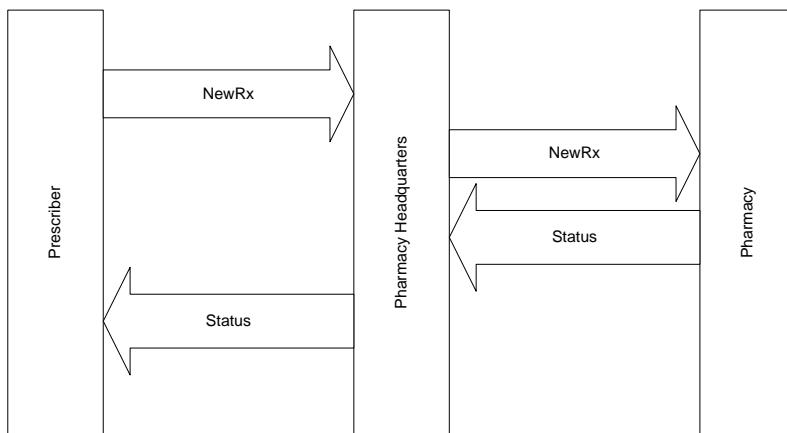
**Figure 1 Flow for a successful NewRx Transaction on a direct connection between prescriber and pharmacy.**

In one type of Mailbox configuration, the prescriber sends the NewRx to the Mailbox. The Mailbox responds with a Status response. The pharmacy system dials in and asks for transactions (GetMessage). The Mailbox responds with the NewRx. The pharmacy asks for another transaction (GetMessage) and the Mailbox responds with a Status (no more mail). See **Figure 2**. More mailbox functionality is described in further detail in the NCPDP **XML Standard**.



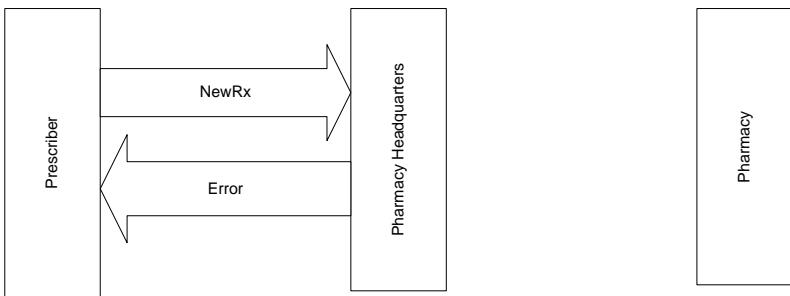
**Figure 2 Flow for a successful NewRx Transaction in a Mailbox configuration. Prescriber system is directly connected to Mailbox; Pharmacy system is a dial connection to Mailbox.**

**Figure 3** indicates the flows for such a transaction where the <ReturnReceipt> field is not set and the pharmacy management system has received the transaction on a direct connect.

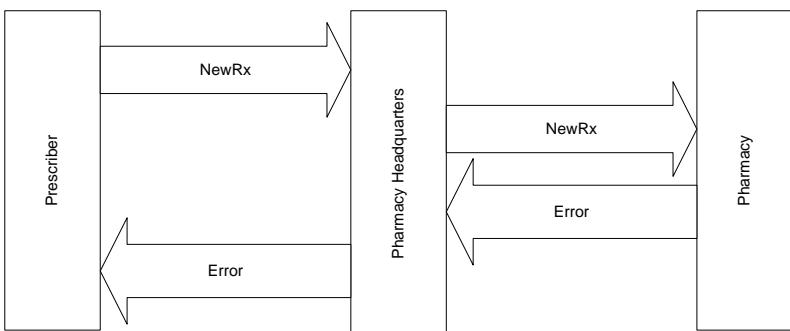


**Figure 3 Flow for a successful NewRx Transaction on a direct connect.**

Below, **Figure 4** illustrates the flow for a NewRx that is found to contain an error by the pharmacy headquarters system. **Figure 5** illustrates the flow for a NewRx that is found to contain an error by the pharmacy management system.



**Figure 4 Flow for a NewRx Transaction where an error is detected by the Pharmacy Headquarters System.**



**Figure 5 Flow for a NewRx Transaction where an error is detected by the Pharmacy Management System.**

See section "[RxFillIndicator Usage](#)".

For information on <ReturnReceipt> functionality, see section "*Verify Transaction*" in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

### **5.1.1 ORDERCAPTUREMETHOD – USAGE**

The <OrderCaptureMethod> is used in long term care, post-acute, and other settings where prescribers commonly communicate medication orders to nursing staff in verbal or written form, often from outside of the care facility. For example, the prescriber may give a medication order to a nurse during a telephone call regarding a patient's status.

These medication orders may be entered into the facility's electronic medical record or prescribing system and transmitted electronically to the pharmacy.

Depending on the location of the pharmacy and the nature of its relationship with the care facility, dispensing rules may require that the pharmacist obtain additional documentation from the facility when receiving an electronic order that was not entered directly by the prescriber into the electronic prescribing system. Typically, different rules apply for orders received verbally versus those transcribed from a written form.

For example, state regulations commonly treat orders given verbally (by telephone or in person) and entered by the person receiving them as electronic orders that do not require further documentation. *Note, however, that pharmacists and other clinicians must follow the rules that apply in their particular state.*

The <OrderCaptureMethod> informs the pharmacist of the means by which each medication order was captured into the electronic prescribing system. Based on that information, the pharmacist can determine whether their particular circumstances require additional documentation to be obtained from the ordering facility.

The <OrderCaptureMethod> value "VI" (Verbal In-Person) may be used to convey orders received by telephone in addition to in-person verbal orders, if the prescribing system does not have the ability to capture telephone orders separately. It is recommended that the dedicated value "VT" (Verbal Telephone) be used if possible.

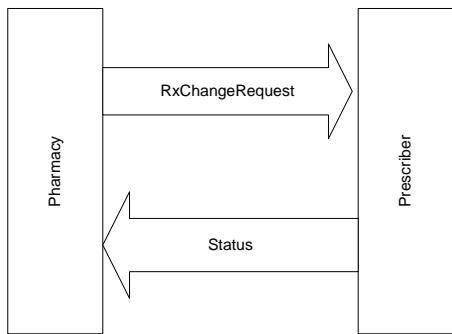
The <OrderCaptureMethod> element is situational. If it is supported by the prescribing system, it should always be populated in orders transmitted from a long term or post-acute care setting.

## **5.2 PRESCRIPTION CHANGE REQUEST TRANSACTION**

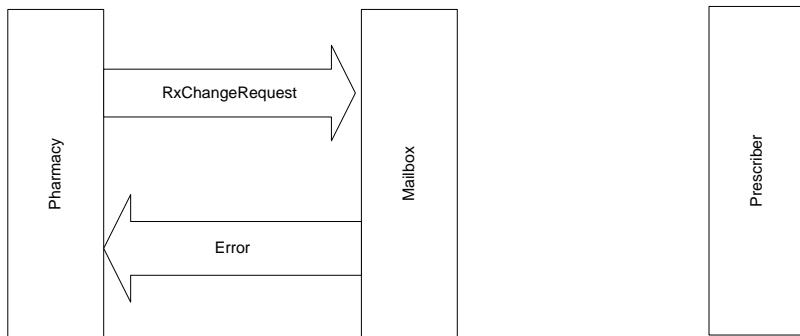
The RxChangeRequest Transaction is originated by the pharmacy. This transaction is used to request a change of a new prescription or a "fillable" prescription or for validation of prescriber credentials. This request may be used when the pharmacy needs a change to the prescription. This change might be requesting a switch from brand to generic, based on the pharmacy's participation in formulary programs, or due to a therapeutic intervention. It may also be utilized to request a prescriber to review the drug requested, and obtain a prior authorization from the payer for the prescription. It may be used to request drug use evaluation information, to clarify a prescription or request prescriber credential validation. <MessageRequestCode> is used to differentiate between the types of change. **The <ChangeReasonText> field is only allowed to be used for global messages. For drug specific messages, the <Note> field is to be used.**

The multiple medication elements may be sent, with specific rules, designating the element is describing a <MedicationPrescribed> or <MedicationRequested>.

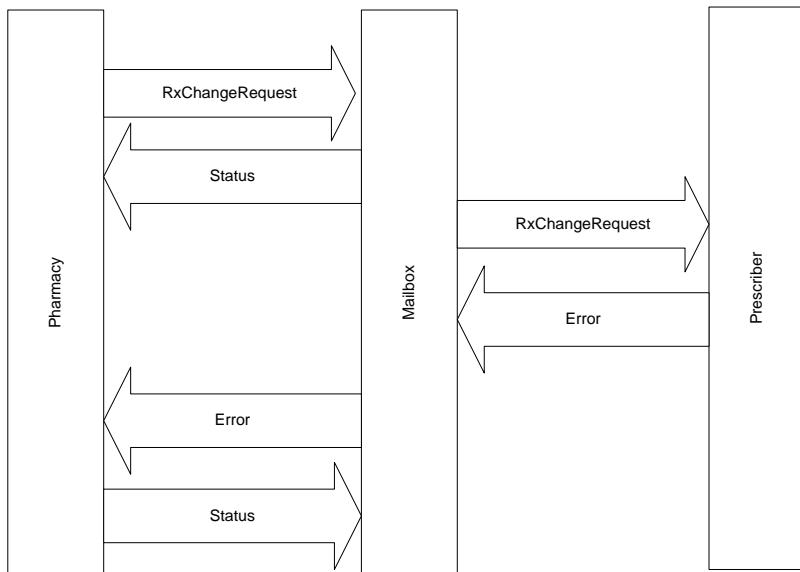
In an RxChangeRequest scenario, the pharmacy may offer a choice of drugs as alternatives for the originally prescribed drug. The <MedicationRequested> would be used in this case, to denote a loop for each alternative. The first alternative listed should be the preferred drug.



**Figure 6 Flow for a successful RxChangeRequest Transaction between a pharmacy and prescriber system on a direct connect.**



**Figure 7 Flow for an RxChangeRequest Transaction where an error is detected by the Mailbox.**



**Figure 8 Flow for an RxChangeRequest Transaction when an error is detected by the Prescriber Management System. The pharmacy and prescriber system is connected via dedicated line to Mailbox.**

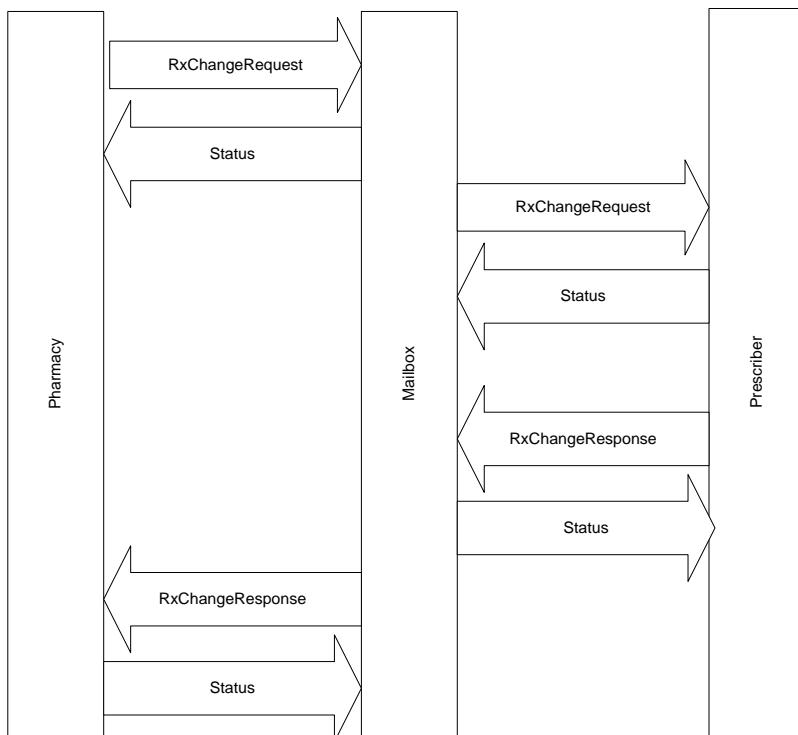
Like other transactions described previously, the RxChangeRequest may be responded to with Status, Error or Verify transaction. The RxChangeRequest can be mailboxd. For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

### **5.3 PRESCRIPTION CHANGE RESPONSE TRANSACTION**

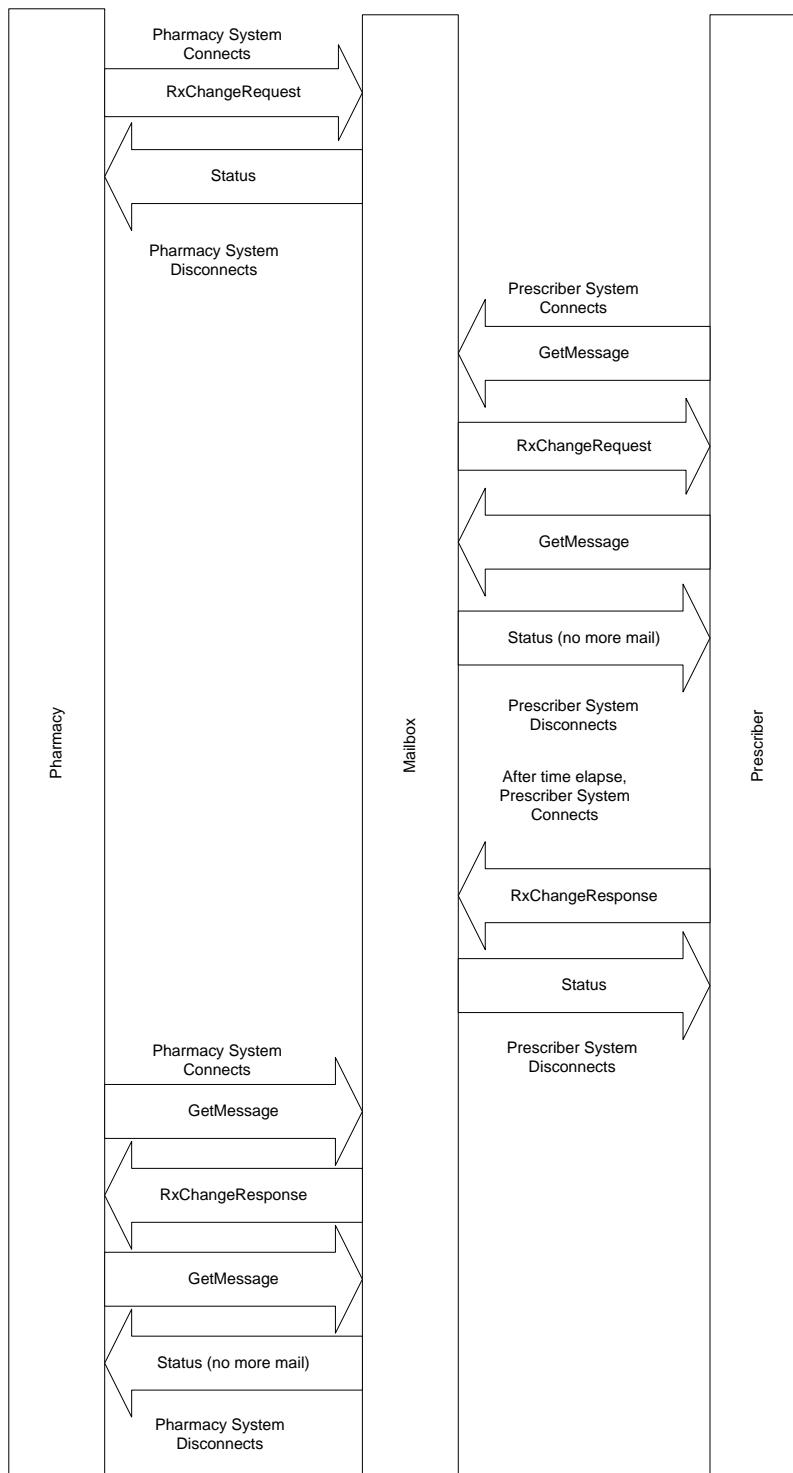
The RxChangeResponse transaction is originated by the prescriber. It is in response to the pharmacy requesting changes to a prescription or validation of prescriber credentials, via the RxChangeRequest transaction. The prescription change response transaction is used to either approve, approve with change or to decline the requested change in the RxChangeRequest or prior authorization request. In addition, the prescription change response may be used to respond to a prescriber credential validation request. The response may or may not be sent with additional comments in the <Note> field. <MessageRequestCode> must contain what was sent in the RxChangeRequest transaction.

<RxFillIndicator> informs the pharmacy of the prescriber’s current intent for fill status notifications for a specific patient/medication. This may be a change to the current fill status or a cancellation of further RxFill notifications.

If the REMS Administrator has provided authorization to the prescriber-submitted REMSRequest with an authorization, this can be placed in the <REMSAuthorizationNumber> on the RxChangeResponse. <PrescriberCheckedREMS> identifies if the prescribing system has performed an inquiry to the REMS Administrator in order to verify the REMS component of the prescription.



**Figure 9 Flow for a successful RxChangeRequest and Response. Pharmacy and prescriber system might both be dedicated.**



**Figure 10 Flow for a successful RxChangeRequest and Response without a <ReturnReceipt> requested. Pharmacy and prescriber system might both be dial scenarios.**

### 5.3.1 DISCUSSION OF PRIOR AUTHORIZATION

The following assumptions are made:

1. The prescriber may obtain a prior authorization and may or may not send back the actual <PriorAuthorizationID> to the pharmacy on the RxChangeResponse so the <PriorAuthorizationID> is not required on an RxChangeResponse.
2. A <PriorAuthorizationID> may or may not be required. It just may need to be indicated by the patient's payer on the patient's record once the prescriber has secured one.
3. The prescriber may not respond at all even though the prior authorization was obtained.
4. The prescriber may deny or refuse the RxChangeRequest for a prior authorization and send a new prescription to replace the previously ordered prescription.
5. The pharmacy should be able to utilize the <Note> field to add a note, and/or send <BenefitsCoordination><CommunicationNumbers> (the phone number) of the payer the prescriber needs to call to obtain the prior authorization. Any additional information provided by the payer during the claim processing or known by the pharmacy that would assist the prescriber in obtaining the prior authorization could be sent in the <Note> field. Again, this is not a required field.

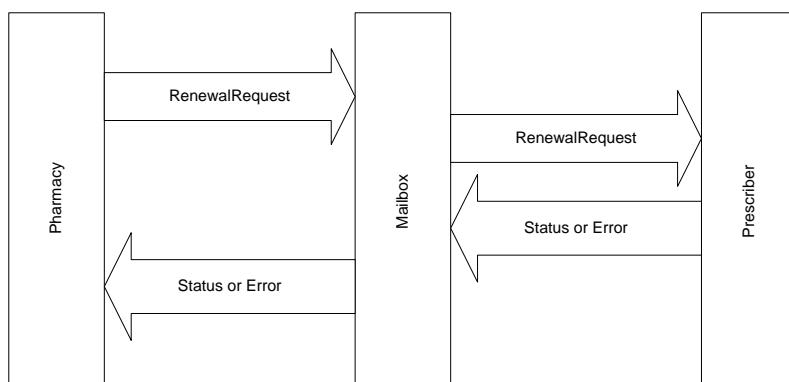
See section "Prior Authorization Introduction" for more information on the transactions used in prior authorization functions.

### **5.3.2 DISCUSSION OF WRITTENDATE**

When the prescriber responds <Approved> or <ApprovedWithChanges> to an RxChangeRequest for Therapeutic Interchange or Generic Substitution, the approval is considered authorization for a new prescription. Therefore the approval date is effectively the <WrittenDate> and the prescriber MUST set the <MedicationPrescribed> <WrittenDate> to the date the request is approved. It is incorrect to echo the <MedicationPrescribed> <WrittenDate> from the original request or send the start date of therapy in the <MedicationPrescribed> <WrittenDate> field.

## **5.4 RENEWAL PRESCRIPTION REQUEST TRANSACTION**

The RxRenewalRequest transaction is originated by the pharmacy. This transaction is for the purpose of requesting approval for additional refills of a prescription beyond those originally prescribed.



**Figure 11 Flow for an RxRenewalRequest and Response. Simplified scenario.**

Notice in **Figure 11**, that either a Status or an Error may be returned in response to an RxRenewalRequest by the Mailbox. The Status indicates the transaction was accepted by the Mailbox for delivery to the prescriber, while the Error indicates the Mailbox has not accepted the transaction and it will not be forwarded.

In the case of a direct connection between the pharmacy and prescriber, it is possible that the RxRenewalRequest could be answered with an RxRenewalResponse, if the prescriber system is able to review the request and respond immediately. In most situations, this may not be the case. **An RxRenewalRequest should never be responded to with a NewRx. If there are any changes beyond what is outlined in section “Response Element”, the <Replace> response should be used.**

#### **5.4.1 <DENIEDNEWPRESCRIPTIONTOFOLLOW> USE AND SUNSET**

Note the <DeniedNewPrescriptionToFollow> response will be sunsetted in a future version.

<DeniedNewPrescriptionToFollow> response is *not to be sent* in an RxRenewalResponse for this version of SCRIPT. However, <DeniedNewPrescriptionToFollow> response *could be received* in an RxRenewalResponse from a previous version of SCRIPT and is included for backwards compatibility. <DeniedNewPrescriptionToFollow> response only exists for entities that need to map this version to a previous version of SCRIPT that does not support a <Replace>.

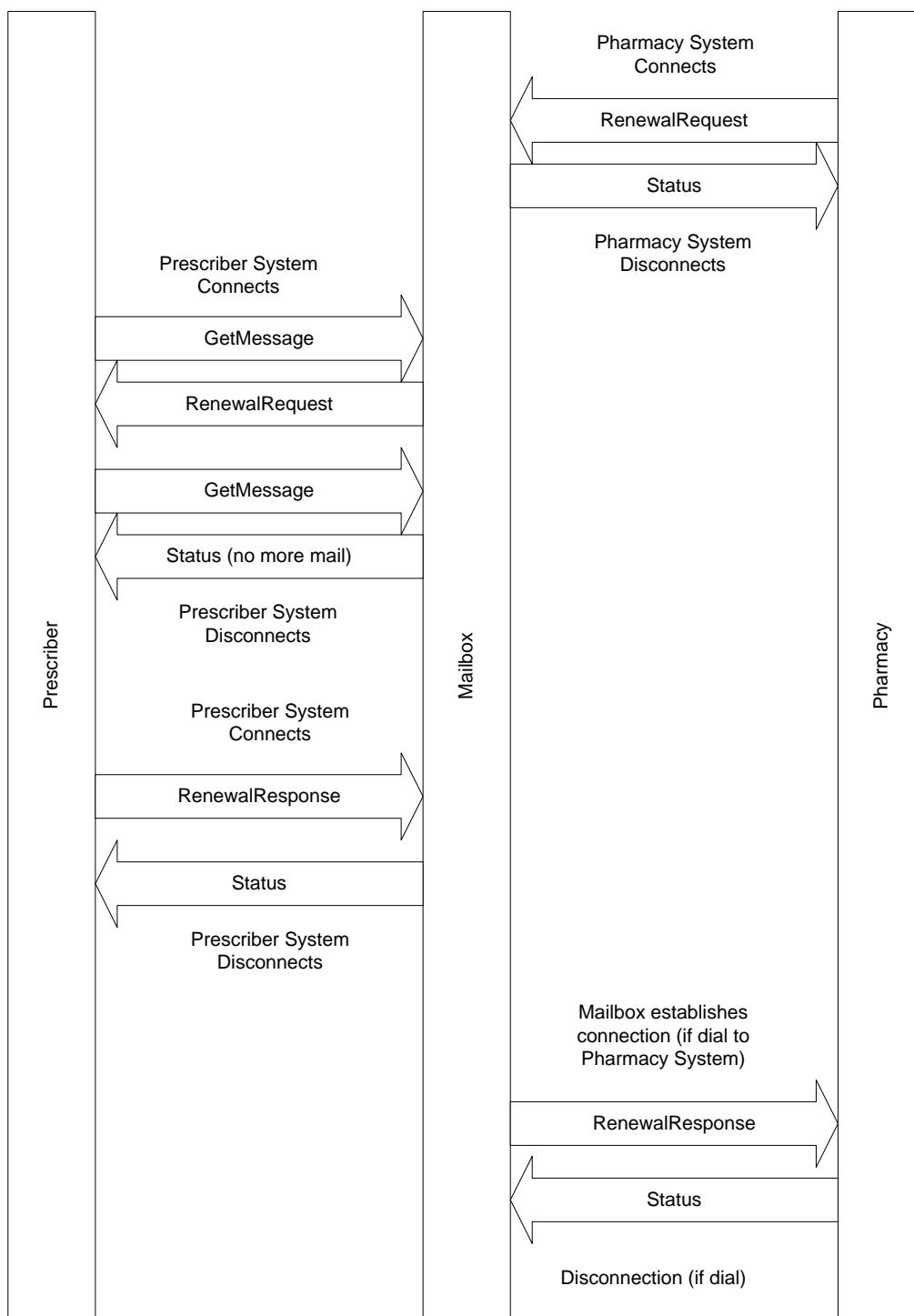
### **5.5 RENEWAL PRESCRIPTION RESPONSE TRANSACTION**

The RxRenewalResponse transaction is used to respond to an RxRenewalRequest. The RxRenewalRequest is received by the prescriber system, which may use the GetMessage described above. The purpose of the RxRenewalResponse is for the prescriber to allow the pharmacist to provide a patient with additional refills, a replacement prescription, or to decline to do so. Discussion of the RxRenewalResponses is found in section “Response Element”.

<RxFillIndicator> informs the pharmacy of the prescriber’s current intent for fill status notifications for a specific patient/medication. This may be a change to the current fill status or a cancellation of further RxFill notifications.

If the REMS Administrator has provided authorization to the prescriber-submitted REMSRequest with an authorization, this can be placed in the <REMSAuthorizationNumber> on the RxRenewalResponse. <PrescriberCheckedREMS> identifies if the prescribing system has performed an inquiry to the REMS Administrator in order to verify the REMS component of the prescription.

Having received the RxRenewalRequest from Mailbox, the prescriber system must provide a mechanism to obtain the approval or denial of the prescriber for the requested change. This mechanism is up to the prescriber system designer. However, it may involve the facility to print out a paper version of the change for the prescriber to examine and take action on. In any case, at some point the information will need to be entered into the prescriber system. At that or a later time the RxRenewalResponse will be created and the Mailbox may be called to deliver the transaction. **Figure 12** illustrates the flow for this transaction.



**Figure 12 Flow for an RxRenewalResponse. The prescriber system is dial to the Mailbox. The pharmacy is direct or able to receive dial from Mailbox.**

Notice in **Figure 12**, that either a Status or an Error may be returned by the Mailbox in response to an RxRenewalRequest. The Status indicates the transaction was accepted by Mailbox for delivery to the pharmacy, while the Error indicates that the Mailbox has not accepted the

transaction and it will not be forwarded. Also, notice that **Figure 13** indicates this transaction involves the prescriber system calling and connecting to Mailbox and then disconnecting without any other transactions occurring. While this can certainly happen, the connection to Mailbox, once established, can be used to perform as many transactions as the prescriber system has to perform.

As discussed above, the Mailbox will deliver a response by the prescriber to an RxRenewalRequest as quickly as is practical on receipt of that transaction from the prescriber. As with the NewRx, it is the responsibility of the pharmacy headquarters system (in dedicated line situations) to direct the transaction to the appropriate destination based on the NCPDP Provider ID Number. Also, the RxRenewalResponse can include a <ReturnReceipt> field. This field should be responded to by the pharmacy system or the pharmacy headquarters system, preferably the former, in the form of a Verify transaction.

For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

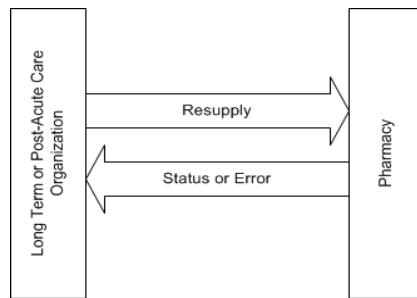
#### **5.5.1 DISCUSSION OF WRITTENDATE**

When the prescriber responds <Approved> or <ApprovedWithChanges> to an RxRenewalRequest, the RxRenewalResponse approval is considered authorization for a new prescription. Therefore the approval date is effectively the <WrittenDate> and the prescriber MUST set the <MedicationResponse> to the date the request is approved. When the prescriber responds <Replace>, the <WrittenDate> indicates the date of the replacement prescription. It is incorrect to echo the <MedicationPrescribed> or <MedicationDispensed> <WrittenDate> from the original request or send the start date of therapy in the <MedicationResponse> <WrittenDate> field.

### **5.6 RESUPPLY TRANSACTION**

In the long term care environment there is a need for a Long Term or Post-Acute Care (LTPAC) organization to send a resupply request from a facility for an additional supply of a medication from an existing authorized order to a pharmacy. An example use case is when a medication supply for a resident is running low (2-3 doses) and a new supply is needed from the pharmacy, the LTPAC organization needs a way to notify the pharmacy that an additional supply for the medication is needed. The Resupply transaction meets this need by providing the capability to request an additional supply of the medication from the pharmacy.

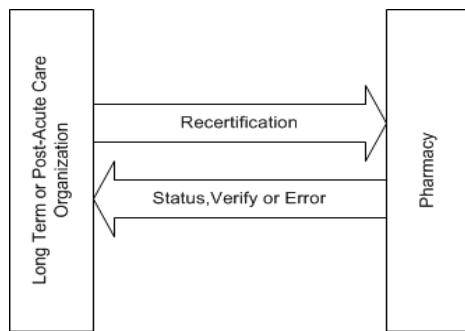
<RxFillIndicator> informs the pharmacy of the prescriber's current intent for fill status notifications for a specific patient/medication. This may be a change to the current fill status or a cancellation of further RxFill notifications.



**Figure 13 Flow for a Resupply with response. Simplified scenario.**

## **5.7 RECERTIFICATION TRANSACTION**

In the long term or post-acute care environment there is a need to communicate from the long term or post acute care organization the recertification of an existing medication order for continued patient administration. An example use case is a prescriber must review and recertify a patient's medication orders on a periodic basis especially for those medication orders without a predetermined administration end date. This recertification period (typically every 30 or 60 days) varies by state regulations and facility practice, but must be documented by the facility and if requested made available to the pharmacy. The recertification transaction meets this need by providing the capability to communicate the authorization for continued administration of the medication order. A recertification message informational only and is not intended to have prescriptive authority (i.e. does not request additional medications to be dispensed).



**Figure 14 Flow for a Recertification with response.**

## **5.8 PRESCRIPTION FILL STATUS NOTIFICATION TRANSACTION INTRODUCTION**

The RxFill transaction is originated by the pharmacy. The transaction notifies the prescriber or long term or post-acute care (LTPAC) organization about the status of a prescription - either new, refill or resupply. The transaction can be used in cases when

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1. Initially requested - to notify of a dispensed prescription (the patient picked up the medication) or (the medication will be delivered to the specified LTPAC organization),
2. To notify of a partially dispensed prescription (patient picked up part of the medication) or (the medication will be delivered to the specified LTPAC organization),
3. To notify of a prescription never dispensed (patient did not pick up the medication) or (the medication will not be delivered to the specified LTPAC organization), and/or
4. To notify a prescriber that the prescription has been transferred to another pharmacy.

The differentiation of the cases is with the use of <FillStatus>.

The response to an RxFill may be a Verify if <ReturnReceipt> is requested, a Status, or an Error.

For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

#### **5.8.1 OPT-IN FOR THE PRESCRIBER**

Adoption of RxFill may be improved by the additional functionality allowing prescribers to specify which prescriptions are to receive RxFill transactions and which RxFill message types to receive. Pharmacies that support RxFill status messages and the message level support (e.g. support all message types but transferred) will be a part of the pharmacy directory. An electronic health/medical record (EMR) will enable RxFill as part of the prescription writing process if the selected pharmacy supports RxFill Status. Prescribers have the following options when they request RxFill status messages in SCRIPT

Description	Dispensed	Partially Dispensed	Not Dispensed	Transferred
All RxFill status messages	X	X	X	X
All RxFill status messages but Transferred	X	X	X	
Dispensed and Partially Dispensed	X	X		
Partially Dispensed and Not Dispensed		X	X	
Not Dispensed or Transferred			X	X
Partially Dispensed Only		X		
Not Dispensed Only			X	
Cancel all RxFill Statuses				

Prescribers may choose to receive RxFill transactions for patients receiving certain medications. An example might be the prescriber requests all RxFill transactions for prescriptions for diabetes and heart conditions, but not for prescriptions for seasonal allergies and common antibiotics. EMRs may also provide additional capabilities to support RxFill message handling and prescriber notification (e.g. only provide alerts for ‘Not Dispensed’). This prescriber-chosen criterion may provide process improvements such as limiting the number of transactions received, the cost of transactions, privacy concerns and information overload.

#### **5.8.2 CANCEL/MODIFY RXFILL BY THE PRESCRIBER**

Prescribers may decide to modify or cancel all further RxFill status transactions. RxFill supports an independent transaction <RxFillIndicatorChange> (versus as part of a new prescription, renewal request, or change request) where the prescriber informs the pharmacy of the cancellation or modification to a previously sent <RxFillIndicator> value for a specific

patient/medication combination.

### **5.8.3 AUTOMATED TRIGGERING OF RXFILL TRANSACTION WITHIN PHARMACY TO INDICATE A FILL**

RxFill transactions are intended to be sent by the pharmacy as requested by the prescriber to indicate the prescription has “left the pharmacy” and not just that the prescription has been filled. The timing of the RxFill transaction must therefore be tied to the dispensing action and confirmation of the actual date the prescription was picked up or shipped.

### **5.8.4 TRIGGERING OF RXFILL TRANSACTION WHEN AN ITEM HAS BEEN RETURNED TO STOCK**

A pharmacy system should not send an RxFill transaction when the prescription is filled but has not been dispensed. It should send the “Not Dispensed” indicator only after the medication has been returned to stock. Many pharmacies use “Return to Stock” as an indication the prescription has not been dispensed. During Return to Stock processing, the pharmacy system updates the prescription’s status while performing any necessary billing reversals. For many systems, this is the first active indication of the patient’s inaction, and can be used to trigger an appropriate RxFill transaction, i.e., “not dispensed”. The timing of the RxFill transaction will vary based on the pharmacy’s Return to Stock process.

### **5.8.5 PRESCRIBER SYSTEM MATCHING**

The prescriber must electronically send the prescription via the NCPDP SCRIPT Standard in order for the prescriber’s system to receive RxFill transactions. The prescription is not considered electronic if sent via paper, phone e-fax or fax. Sending the prescription electronically ensures the correct matching between the original prescription and the subsequent RxFill transactions.

### **5.8.6 CHANGES IN PRESCRIBER WORKFLOW FROM RXFILL**

RxFill transactions are intended to inform the prescriber. Adherence monitoring processes within an EMR system should be designed to fit the prescriber/office workflow and notify the prescriber via judicious use of safety alerts without causing alert fatigue.

### **5.8.7 VOLUME OF RXFILL TRANSACTIONS**

The volume of RxFill transactions will typically be higher than most other electronic prescribing transaction types. For example, when a prescriber sends a NewRx transaction to the pharmacy, it will often include a number of refills for the prescription. No additional electronic prescribing transactions are sent between prescriber and pharmacy for normal refills. RxFill transactions are different in that they are sent for each dispensing related event:

- Dispensed prescription: An RxFill transaction is sent each time a prescription is dispensed. A prescription with two refills would result in a total of three RxFill transactions – the original, or new prescription plus two subsequent refills.
- Partially Dispensed – Occasionally, a pharmacy is not able to dispense the full prescription as ordered. In this scenario, a pharmacy system would send the prescriber a minimum of two RxFill transactions. A partially dispensed message could be sent multiple times, until the entire prescription quantity, as originally ordered, has been dispensed. The first RxFill transaction would indicate what was dispensed initially and

subsequent transactions would be sent until the remainder was dispensed. Each transaction back to the prescriber should indicate the quantity dispensed.

- Not Dispensed – There are scenarios where a prescription is received by a pharmacy, but it is not dispensed. In these cases, the pharmacy is expected to send a “Not Dispensed” transaction to the prescriber based on the pharmacy system rules for placing a prescription on hold or when a medication is returned to stock. Prescriptions may be placed on hold pending additional information, resolving a conflict with other medications, or for future filling. It is recommended that the “Not Dispensed” response include additional information as to why a prescription was not dispensed, if known. Free text such as “Patient did not pick up the prescription”, “Patient unable to pay for prescription”, “Potential interaction with other medication” or “Prescription transferred” should be added to <FillStatus><NotDispensed><Note>. Due to variations in business practices, trading partner agreements will determine the timing of not dispensed RxFill transactions.
- Transferred – The prescription was transferred to another pharmacy. This response should also include the destination pharmacy so the prescriber or practice can perform any additional follow-ups on that prescription with the new pharmacy instead of the original pharmacy. The ***Pharmacy to Pharmacy Prescription Transfer Standard*** supports communication addressing whether the receiving pharmacy supports RxFill.

### **5.8.8 RXFILL AND TRANSFERS**

A prescriber who requested an RxFill transaction that includes the ‘transferred’ type will receive a “Transferred” transaction when a prescription is transferred. This RxFill transaction will be sent by the original pharmacy to notify the prescriber of the dispensing pharmacy change and who the pharmacy is. The RxFill ‘Transferred’ message will provide all of the information except if the receiving pharmacy supports RxFill. RxFill support notification will be provided as part of the prescription transfer process.

When transferring a prescription, the <RxFillRequestIndicator> should be passed to the new pharmacy as part of the prescription information. If it supports the RxFill transaction, the pharmacy to which the prescription was transferred is responsible to send the appropriate Physician RxFill Request Flag with each subsequent dispensing event. Once the prescription is transferred, the originating pharmacy has no further responsibility for sending RxFill transactions. Reference fields will need to be passed to the new pharmacy to help tie the RxFill transactions with the original prescription.

### **5.8.9 ASSOCIATING A NEWRX WITH AN RXFILL TRANSACTION**

The RxFill transaction is designed to be associated with an electronic prescription. The chart below describes how the matching schema is structured. There are examples in the NCPDP ***XML Standard Version 2013041*** (and above) that show the re-association using the trace numbers. Specific examples may be found in section “Trace Number Usage” (Example 2) and (Example 5). Below is an excerpt of Example 2.

Prescriber sends a new prescription. Pharmacy reports two RxFill transactions.

	NewRx from Prescriber	RxFill (partial fill) from Pharmacy	RxFill (partial fill) from Pharmacy
Field Name	Value		
<MessageID>	1234567	3311	3433
<RelatesToMessageID>		1234567	1234567
<RxReferenceNumber>		PH456	PH456
<PrescriberOrderNumber>	110088	110088	110088
	Status from Pharmacy	Status from Prescriber	Status from Prescriber
<MessageID>	ABC11	8899	9988
<RelatesToMessageID>	1234567	3311	3433
<RxReferenceNumber>			
<PrescriberOrderNumber>			

### **5.8.10 USAGE WITH THE MEDICATION HISTORY TRANSACTION**

Medication History information may include adjudicated claims and/or pharmacy dispensed/point of sale prescription information. Medication History transactions may be exchanged among pharmacies, payers, and prescribers. RxFill Status transactions are exchanged between pharmacies and providers. Information supplied in the RxFill transaction may be duplicative of information provided in the Medication History transaction because more than one source may send information about a specific prescription (e.g. the pharmacy sends an RxFill status and prescription history and the payer sends claim history).

The RxFill value lies in its usage: it is intended to be requested by a prescriber for a specific reason(s). The most likely use is for adherence monitoring where the prescriber prefers active messaging on a patient's specific compliance as opposed to background medication checks that may overwhelm him/her with extraneous information. RxFill can be a valuable tool to actively monitor adherence on conditions that may require closer attention.

The Medication History transaction is most often sent by the data source to the requesting entity based on information the data source receives and consolidates from pharmacies and payers. The data source can consolidate and send Medication History on all prescriptions, even if the originating pharmacy does not support electronic prescribing or RxFill transactions. Medication history may differ based on the source:

- Processor/Payer: Medication history from these sources is based on adjudicated claims.
  - Advantages:
    - Includes all adjudicated prescriptions.
    - May contain prescriptions that were dispensed at pharmacies that are not supporting the ability to send prescription dispensing history.
  - Limitations:
    - Not all Processors/Payers may participate.

- Does not contain prescriptions that were paid with cash or includes only items eligible under the patient's benefit.
- May include data from claims that were subsequently reversed (i.e., returned to stock). This happens in the short time window where a prescription is dispensed; waiting for patient to pick-up and the patient decides not to pick it up so it is returned to stock.
- Claims-based so Sig information is not available.
- If beneficiaries change Processors/Payers, Medication History from the previous payer may not be available.
- Pharmacy: Many pharmacies make their dispensed prescription histories available to support patient care.
  - Advantages:
    - Includes all medications dispensed by pharmacy, regardless of payment sources (plan or patient).
    - Includes information not needed for claims adjudication, such as Sig.
  - Limitations:
    - Includes only medications dispensed by participating pharmacies.

It is recommended that prescribers request Medication History from all applicable sources, whenever appropriate, to ensure the most complete view of a patient's medication history. The Medication History may be reconciled with the prescriber's patient record for improved medication management. This is especially useful if the prescriber does not have the ability to receive RxFill transactions and is monitoring certain medical conditions.

The major differences between the RxFill and the Medication History transactions are timing, accuracy, and the automation of their processes. Medication History transactions are generally requested by the prescriber prior to a patient visit to facilitate complete and accurate records for that encounter and to assist in clinical decision support. Updates to the patient's medication history might not be made until their next appointment. RxFill transactions could be received automatically by the prescriber, therefore keeping an accurate picture of patient medication compliance at all times, not just prior to a patient visit. RxFill transactions (of 'Dispensed' or 'Partially Dispensed type) are to be sent specifically at time of dispensing, so the accuracy of the information and timing surpasses the Medication History transaction.

If the prescriber intends to perform proactive medication compliance management with patients independent of an office visit, the difference in timing of the two transactions is important. If the prescriber does not use RxFill in a proactive way between patient visits, the value of RxFill is diminished and its overlap with the Medication History transaction increases.

### **5.8.11 CHANGING PHYSICIANS**

When a patient changes physicians, the RxFill transactions for his/her prescriptions will continue to be sent to the prescriber who originally prescribed each prescription as long as the patient continues to refill those prescriptions. The pharmacy cannot change the prescriber of record for an existing prescription so the RxFill transactions cannot be redirected to a new prescriber. To have RxFill transactions sent to a new physician, the new prescriber must provide a new prescription to the pharmacy.

### **5.8.12 DEFINITIONS**

*Dispensed* - in the context of the RxFill transaction, a medication that has been handed, shipped, or delivered to the patient (or the patient's caregiver/representative) and the pharmacy no longer has possession of it. If the medication is still located in the pharmacy, it has not yet been 'dispensed'.

*Medication History* – transactions used to provide details of medications previously provided to a patient. The medication history result includes medications that were dispensed or obtained by a patient within a timeframe. Medication history can include adjudicated and/or cash and carry, prescribed, administered and/or sample medications.

*On Hold* – a status denoting an interruption occurring in the pharmacy dispensing procedure prior to dispensing for various reasons that include but are not limited to:

- prescriptions pending additional information
- resolving a conflict with other medications
- future filling

*Partially Dispensed* – reported when a pharmacy is not able to dispense the full prescription as ordered. A partially dispensed transaction could be sent multiple times, until the entire prescription quantity, as originally ordered, has been dispensed, the prescription expires or the medication is no longer being taken. The first RxFill transaction would indicate what was dispensed initially and subsequent transactions would be sent until the remainder was dispensed. Each transaction back to the prescriber should indicate the quantity dispensed.

*Not Dispensed* – reported when a pharmacy does not dispense the prescription as ordered. This could occur when in conjunction with a return to stock, manufacturer backorder, pharmacy out of stock and not able to get in a timely manner or has no intention to stock, drug recalled, and conscientious objection.

*Return/Returned to Stock* – a pharmacy procedure that occurs after a prescription has been processed (filled and billed to the appropriate third party, if applicable) and the patient (or the patient's caregiver/representative) does not pick up the prescription after a designated period of time, resulting in the medication either being placed back into inventory or destroyed. Note: each pharmacy makes its own determination of how much time should elapse before a prescription is "Returned to Stock".

*Transferred* – a pharmacy procedure that occurs when a patient requests a prescription be dispensed from a pharmacy other than the one that originally received the prescription. The pharmacy requesting the transfer of a prescription may or may not be within the same organization.

While this may be perceived as noise to prescribers, the RxFill messages inform the prescriber of the prescription status and potentially indicate prescription shopping by the patient.

### **5.8.13 ASSUMPTIONS**

- The implementation of RxFill will be a transition over a significant period of time due to the requirements for coding and rollout of pharmacy and prescriber systems to utilize RxFill.
- Since RxFill is not a mandatory transaction, utilization will likely not achieve 100% participation.
- Since all pharmacies and prescriber practices may not have all the technology required to send all types of RxFill, some percentage of providers will not participate in RxFill.
- Because of the variation in participation, capability, and timing by pharmacies in the utilization of RxFill, the prescriber should be careful in the analysis and assumptions based on their usage.
- RxFill should be viewed by the prescriber as individual snapshots in time regarding a prescription, not a final or complete status.

#### **5.8.13.1 Assumption for Long Term or Post-Acute Care (LTPAC) Organization Receipt of RxFill Transactions**

- Implementation of RxFill is standard in LTPAC pharmacy/organization communication and is used to inform the LTPAC organization of medication review and pharmacy approval for dispensing/administration. In addition, this message indicates that a medication order has/not been dispensed by the pharmacy.
- Where RxFill is not a mandatory transaction, utilization in LTPAC is likely to still be 100% participation as most trading partner agreements consider this transaction mandatory.
- Because of the variation in the use cases of RxFill in LTPAC, careful consideration should be taken to consume the information provided as sent by the pharmacy.
- RxFill should be viewed by the LTPAC organization as individual snapshots in time regarding a prescription, not a final or complete status.

### **5.8.14 GENERAL REQUIREMENTS**

- Participation in RxFill usage is voluntary for both pharmacies and prescriber systems.
- RxFill may be sent for prescriptions received by the pharmacy when requested by the prescriber.
- Prescriber software systems must anticipate and successfully process RxFill where the status (dispensed, partially dispensed, not dispensed, transferred) changes over time. For example, the physician may receive an RxFill (not dispensed) for a specific prescription because it was returned to stock. Subsequently the patient may request and receive the prescription causing the RxFill (dispensed) transaction to be sent. The RxFill should be viewed as a snapshot in time, not a permanent status indicator.
- Prescriber software systems should anticipate receiving a fill status notification only for prescriptions from pharmacies that support the RxFill transaction.
- Prescriber systems must anticipate there may be significant time delays between writing the prescription and the receipt of an RxFill indicating the current status. Some pharmacies may conduct return to stock processing after as much as 14 days; so any RxFill (not dispensed) for affected prescriptions would only be sent after that period. The prescriber system should be careful in making assumptions based on the timing of receiving (or not receiving) RxFill. For acute medications, the RxFill may not provide

timely enough information for proper patient management and follow up.

#### **5.8.14.1 General Requirements for Long Term or Post-Acute Care (LTPAC)**

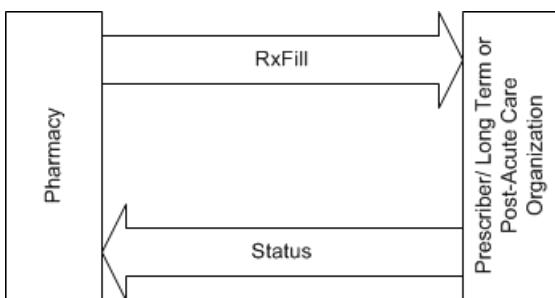
- Participation in RxFill usage is voluntary for both pharmacies and LTPAC organization systems.
- RxFill may be sent for prescriptions received by the pharmacy when requested by the LTPAC organization.
- LTPAC organizations software systems must anticipate and successfully process RxFill where the status (dispensed, partially dispensed, not dispensed, transferred) changes over time. The RxFill information should be viewed as a snapshot in time, not a permanent status indicator.
- LTPAC organizations software systems should anticipate receiving a fill status notification only for prescriptions from pharmacies that support the RxFill transaction.
- LTPAC organizations systems must anticipate there may be significant time delays between writing the prescription and the receipt of an RxFill indicating the current status.

#### **5.8.15 PRESCRIPTION FILL STATUS NOTIFICATION TRANSACTION – DISPENSED**

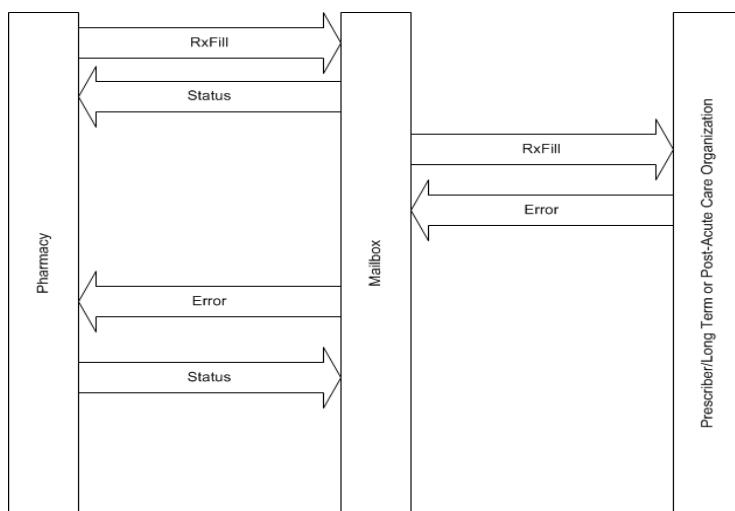
The RxFill Transaction <FillStatus><Dispensed> is originated by the pharmacy. This transaction is used to notify the prescriber or long term or post-acute care (LTPAC) organization when a prescription has been **dispensed**. RxFill can be used to notify dispensing status of new prescriptions, refills or resupply requests. For RxFill <FillStatus><Dispensed><ReasonCode> value “DH” (Profile Medication) requires, at a minimum, the <MedicationDispensed> element with the quantity dispensed to be “0”.

##### **5.8.15.1 General Requirements**

- RxFill <FillStatus><Dispensed> would be sent for all **dispensed** prescriptions including each refill/resupply, but, excluding partial fills, which are represented by a separate RxFill.
- RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and not simply filled and waiting. Therefore, the RxFill <FillStatus><Dispensed> should not be triggered simply by label printing or adjudication in the pharmacy, but, through an action such as a point of sale transaction, electronic signature capture at pickup, a will call bin management action, or similar positive indication of actual dispensing. For long term or post-acute care RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and/or approved for administration to the patient by the LTPAC organization.



**Figure 15 Flow for a successful RxFill Transaction (<FillStatus><Dispensed>) between a pharmacy and prescriber system on a direct connect.**



**Figure 16 Flow for a RxFill Transaction (<FillStatus><Dispensed>) when the Prescriber Management System detects an error. The pharmacy and prescriber system are connected via direct connect to Mailbox.**

Like other transactions described previously, the RxFill may be responded to with Status, Error or Verify transaction.

For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

### 5.8.16 PRESCRIPTION FILL STATUS NOTIFICATION TRANSACTION - NOT DISPENSED

The RxFill Transaction <FillStatus><NotDispensed> is originated by the pharmacy. This transaction is used when the pharmacy has not **dispensed** either a new prescription or a previously filled prescription. This transaction is used to notify the prescriber or long term post-acute care organization the status and reason the prescription will not be dispensed. RxFill can be used to notify dispensing status of new prescriptions, refills or resupply requests.

#### 5.8.16.1 General Requirements

- RxFill <FillStatus><NotDispensed> would be sent when a pharmacy does not successfully

- dispense** or does not intend to dispense a prescription that has been received and processed by the pharmacy, and, has been waiting for patient pickup.
- RxFill <FillStatus><NotDispensed> should be triggered by the return to stock process of the pharmacy, which indicates the patient has not picked up the prescription within the time period set by the pharmacy for their return to stock procedures.
  - RxFill <FillStatus><NotDispensed> should be sent for any prescription (first fill, refill, partial fill, etc.) that is processed by the pharmacy during return to stock procedures.
  - RxFill <FillStatus><NotDispensed> should not be sent by the pharmacy system in the case where a prescription is being reversed but with the intent of subsequent reprocessing and dispensing. An example would be a change in payment coverage requested by the patient at the time of pickup.
  - RxFill <FillStatus><NotDispensed> should not be sent by the pharmacy system to indicate that the patient has not requested his/her next refill based on elapsed time since the patient's previous refill. For example, if the pharmacy dispensed a 30 day supply to the patient but more than 30 days have elapsed and the patient has not requested another refill, the pharmacy system should not automatically generate an RxFill <NotDispensed>. The pharmacy system should use the specific actions of the patient when sending RxFill, and, not inferences in every case possible.
  - RxFill <FillStatus><NotDispensed> in LTPAC should be triggered by events as determined by the pharmacy at the time of processing. Examples include Drug Use Evaluation conflicts that could not be resolved, the medication order has expired, the pharmacy has no intent to stock the prescribed medication or a prior authorization was required for the prescribed medication and the payer has denied.
  - Since return to stock procedures and timing differ between pharmacies, the timing of the RxFill <FillStatus><NotDispensed> will also vary.

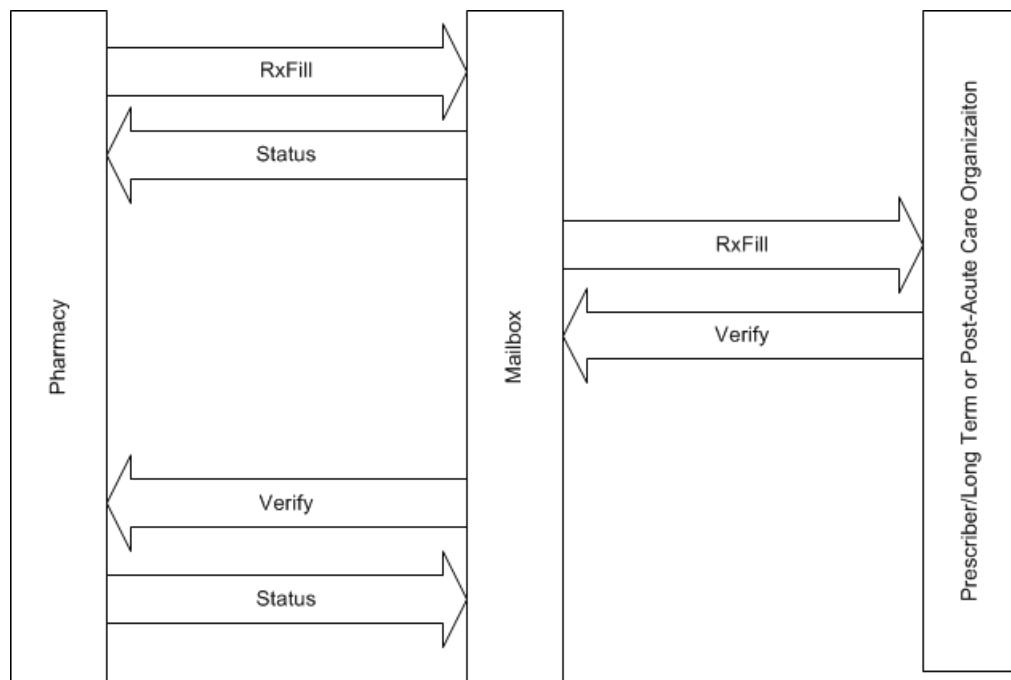
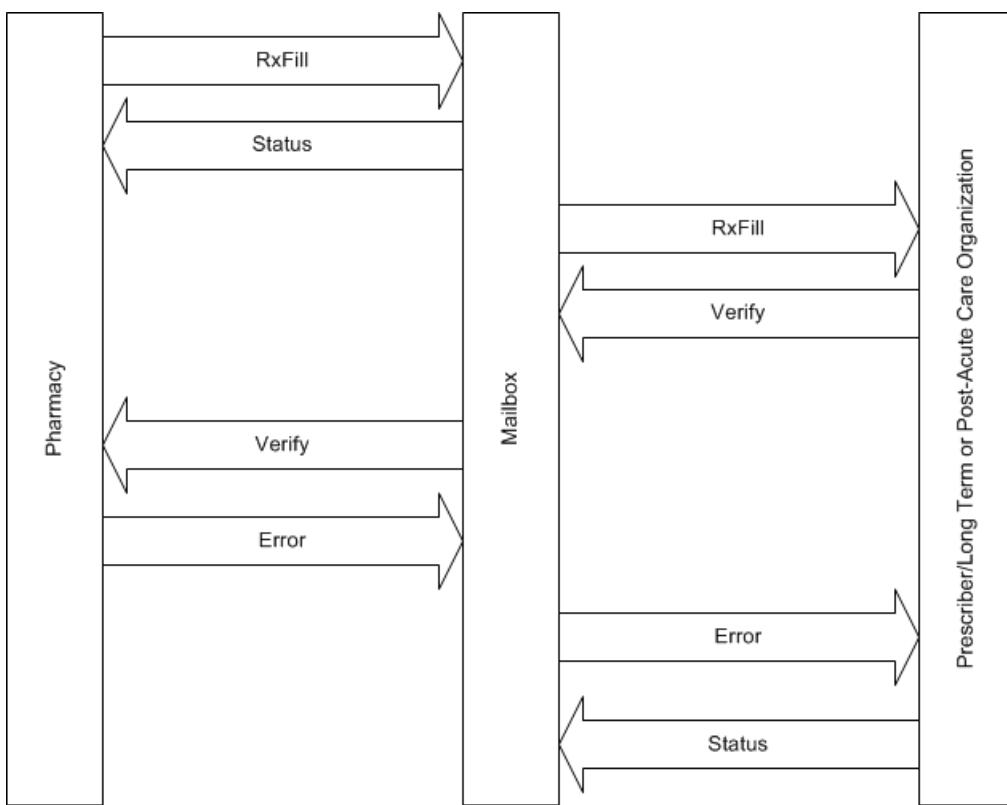


Figure 17 Flow for an RxFill Transaction (<FillStatus><NotDispensed>) with a <ReturnReceipt>

requested. Pharmacy and prescriber system are directly connected to the mailbox.



**Figure 18 Flow for an RxFill Transaction (<FillStatus><NotDispensed>) with a <ReturnReceipt> requested which fails on the return verification. Pharmacy and prescriber system are directly connected to the mailbox.**

For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

### 5.8.17 PRESCRIPTION FILL STATUS NOTIFICATION TRANSACTION – PARTIALLY DISPENSED

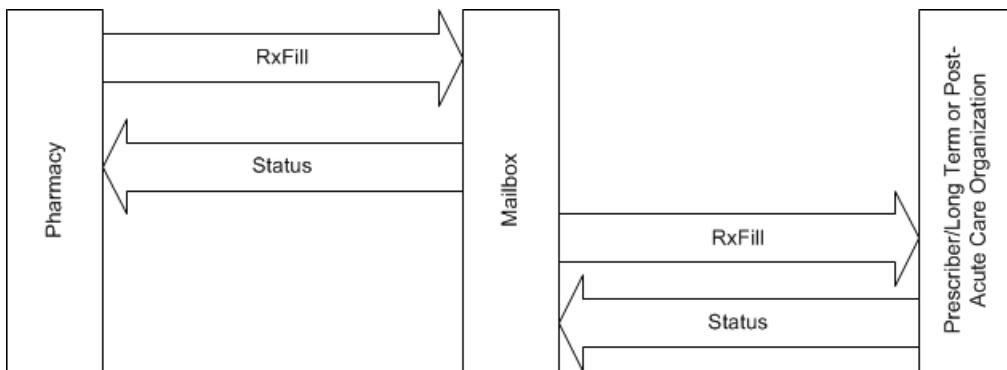
The RxFill Transaction <FillStatus><PartiallyDispensed> is originated by the pharmacy. This transaction is used to notify the prescriber or long term or post-acute care organization (LTPAC) when a prescription has been **partially dispensed**. RxFill can be used to notify dispensing status of new prescriptions, refills or resupply requests. An RxFill <FillStatus><PartiallyDispensed> should be repeated until the prescribed quantity of each fill has been completely returned to stock. RxFill <FillStatus><PartiallyDispensed> requires, at a minimum, the <MedicationDispensed> element with the quantity dispensed be included and it is suggested that the <MedicationPrescribed> element be included for clarification.

#### 5.8.17.1 General Requirements

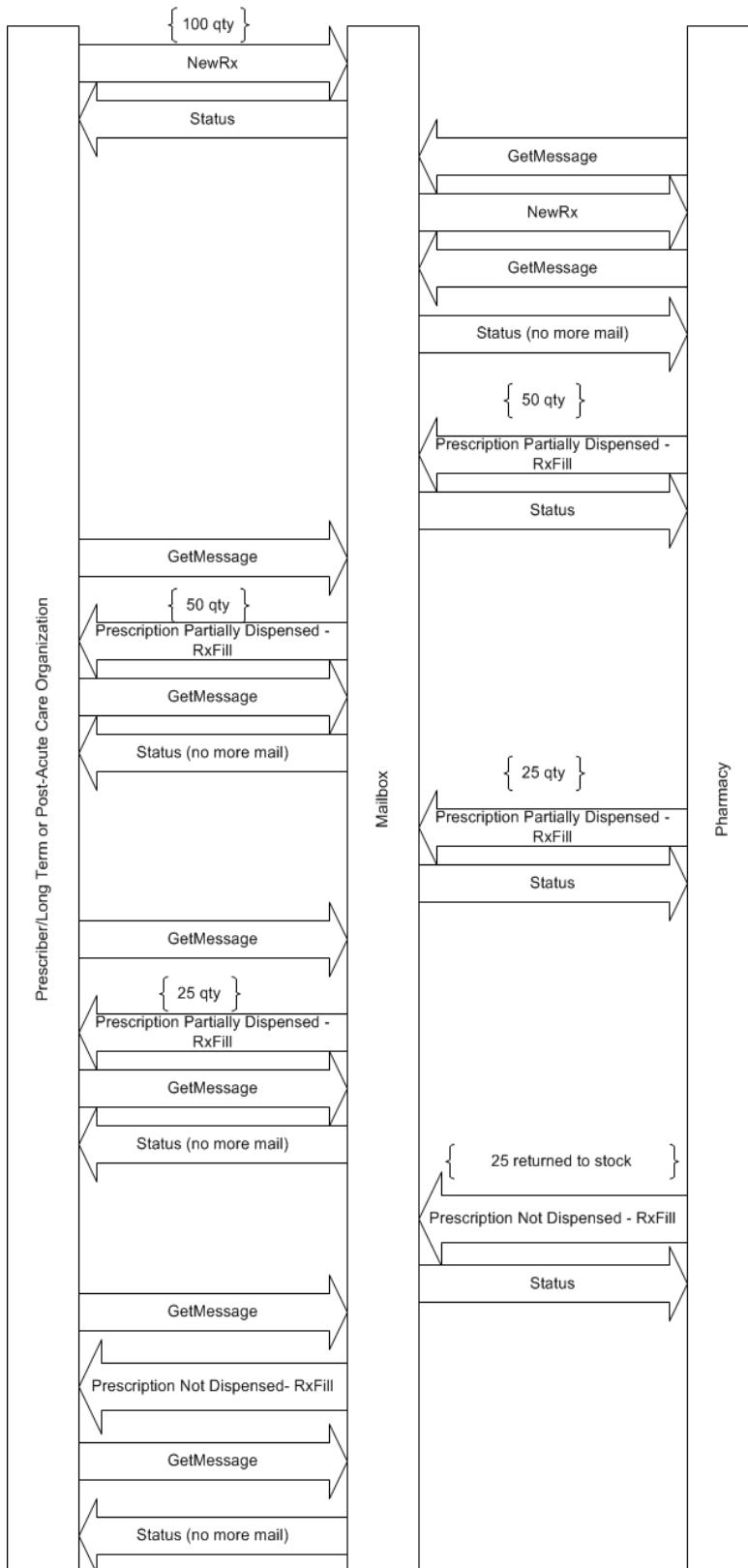
- RxFill <FillStatus><PartiallyDispensed> would be sent for all **dispensed** prescriptions where only a portion of the specified quantity is provided. Subsequent dispensing of

the remainder of the partial fill, or additional partial fills, would also require an appropriate RxFill <PartiallyDispensed> to be sent.

- RxFill <FillStatus><PartiallyDispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and not simply filled and waiting. Therefore, the RxFill <FillStatus><PartiallyDispensed> should not be triggered simply by label printing or adjudication in the pharmacy, but, through an action such as a point of sale transaction, electronic signature capture at pickup, a will call bin management action, or similar positive indication of actual dispensing.



**Figure 19 Flow for an RxFill Transaction (<FillStatus><PartiallyDispensed>). Simplified scenario.**



**Figure 20 Flow for a NewRx and RxFill Transaction (<FillStatus><PartiallyDispensed>). Both Prescriber and Pharmacy are direct connect to the Mailbox.**

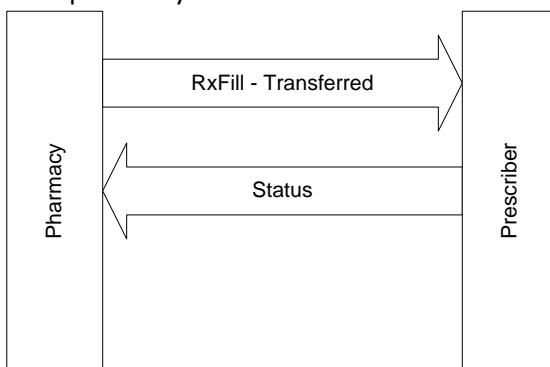
For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

### **5.8.18 PRESCRIPTION FILL STATUS NOTIFICATION TRANSACTION – TRANSFERRED**

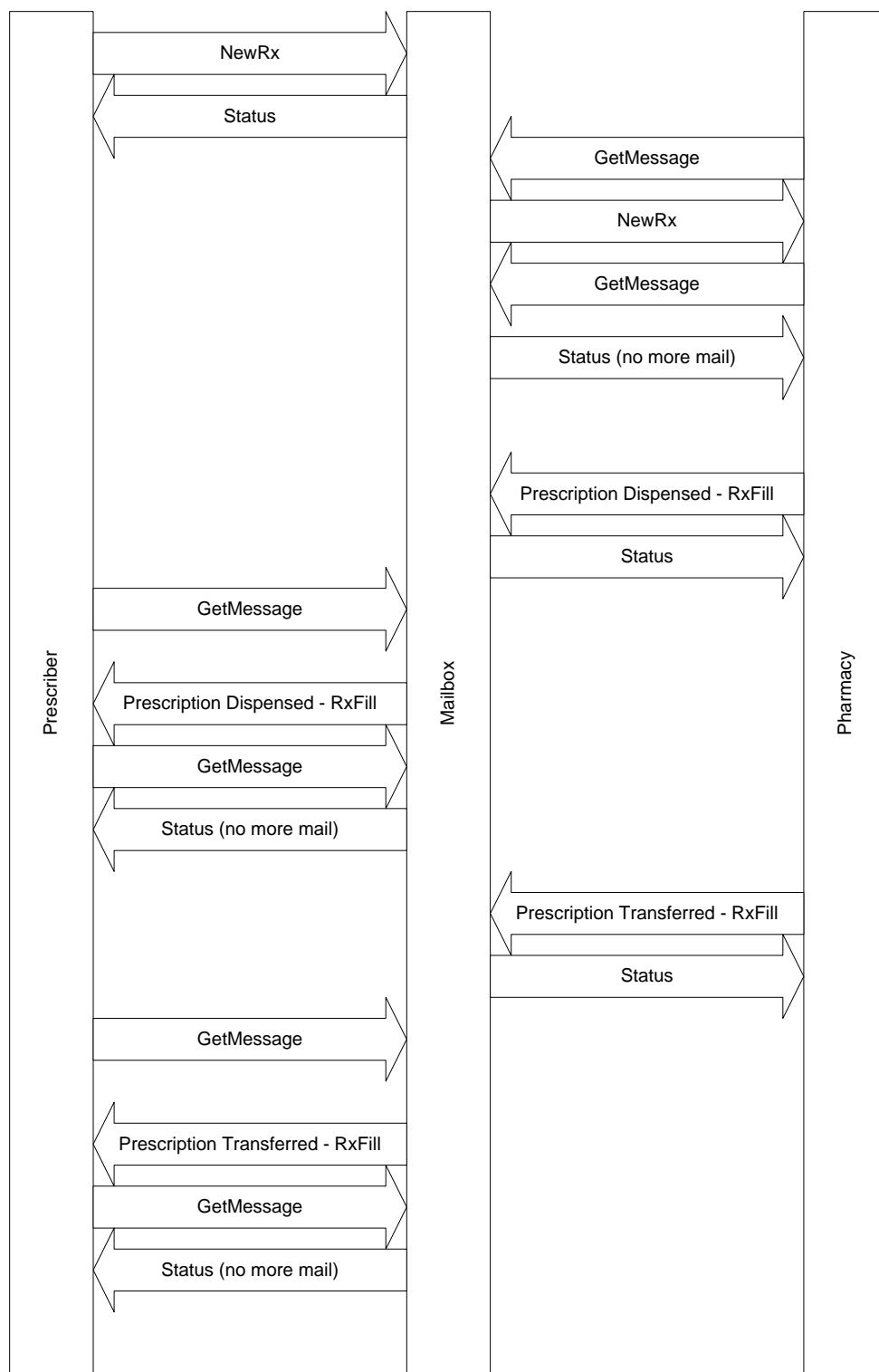
The RxFill Transaction <FillStatus><Transferred> is originated by the *transferring pharmacy* once the <RxTransferConfirm> is received from the *transfer to* pharmacy. This transaction is used to notify the prescriber when a prescription has been transferred to another pharmacy and can no longer be filled at the original pharmacy. The RxTransfer transaction will identify if the receiving pharmacy supports RxFill.

#### **5.8.18.1 General Requirements**

- RxFill <FillStatus><Transferred> would be sent for all **transferred** prescriptions.
- RxFill <FillStatus><Transferred> should be triggered by a specific action in the pharmacy that indicates that the prescription was transferred to another pharmacy and can no longer be filled at this pharmacy.



**Figure 21 Flow for an RxFill Transaction (<FillStatus><Transferred>). Simplified scenario.**

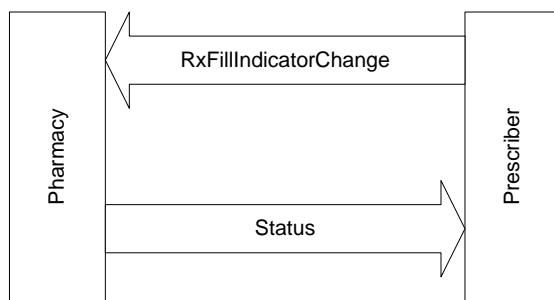


**Figure 22 Flow for a NewRx with one refill and RxFill Transaction (<FillStatus><Dispensed>) followed by an RxFill Transaction (<FillStatus><Transferred>). Both Prescriber and Pharmacy are direct connect to the Mailbox.**

For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

## **5.9 CHANGE IN PRESCRIPTION FILL STATUS NOTIFICATION TRANSACTION**

The RxFillIndicatorChange transaction is used to notify the pharmacy of a modification to the <RxFillIndicator> which was previously sent on a prescription. The transaction is originated by the prescriber system as an RxFillIndicatorChange. The <RxFillIndicator> is used to inform the pharmacy of the prescriber’s current intent for fill status notifications for a specific patient/medication. This may be a change to the current fill status or a cancellation of further RxFill notifications.



**Figure 23 Flow for an RxFillIndicatorChange Transaction. Simplified scenario.**

For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

### **5.9.1 LINKAGE TO THE ORIGINAL PRESCRIPTION**

The <RelatesToMessageID> on the RxFillIndicatorChange should be populated with the contents of the <MessageID> from the electronic prescription to provide linkage. If the original electronic prescription contained a <PrescriberOrderNumber>, the RxFillIndicatorChange transaction should include this element to provide linkage.

If the pharmacy has exchanged an <RxReferenceNumber> with the prescriber on other transactions (e.g. RxChange, RxRenewalRequest, etc.) it is recommended that the prescribing system include the <RxReferenceNumber> in the RxFillIndicatorChange transaction to assist the pharmacy in matching to the prescription.

## **5.10 CANCEL PRESCRIPTION REQUEST TRANSACTION**

The CancelRx transaction is used to notify the pharmacy that a previously sent prescription should be canceled and not filled. The transaction is originated by the prescriber system as a CancelRx. The <ChangeOfPrescriptionStatusFlag> is used when the prescriber wishes to notify the pharmacy to no longer continue dispensing any open refills on an active prescription or to cancel a prescription that has not yet been dispensed.

A prescriber who did not write the original prescription but has assumed responsibility for the patient's care may potentially cancel any prescription. It remains up to the pharmacy to determine if the CancelRx from the prescriber is appropriate.

The CancelRx must contain pertinent information for the pharmacy to be able to find the prescription in their system.

If the original prescription was electronic, the CancelRx must contain the RelatesToMessageID if available. The CancelRx should contain the RxNorm in the <DrugCoded>. If the prescription number is available, it should be sent.

If the original prescription was not electronic, the CancelRx must contain pertinent information for the pharmacy to be able to find the prescription in their system (patient, medication (name, strength, dosage form), prescriber). If the pharmacy cannot definitively determine the prescription to be canceled, manual processes will occur to verify the cancellation. If the prescription number is available, it should be sent.

Prescribers should not send a CancelRequest for a prescription that is expired based on federal or state regulations.

- There should be programmatic checks in place to allow a CancelRequest up to the expiration date of the prescription based off of the written date of the prescription.
  - For example, the DEA requires Controlled Substance Rx to be filled within 6 months from the date written, and most states limit the filling of non-controlled Rx's to 1 year from the date written.

The prescriber should notify the patient or caregiver to inform them of the cancellation of a prescription.

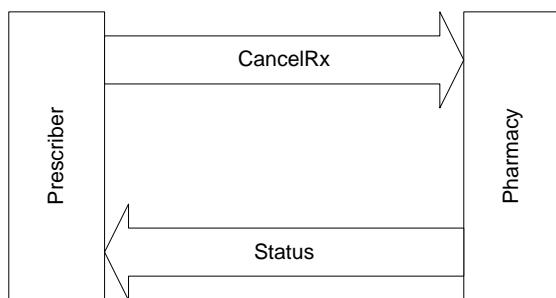
- The Cancel Request was not intended to relieve the prescriber of the responsibility of notifying the patient or caregiver to advise of the drug therapy change – it is only intended as a backup to prevent inadvertent drug therapy continuation or resumption at a later date.

If the prescriber received a denial code indicating the prescription was referred to a different pharmacy, the prescriber could be given the option to route the Cancel Request message to the new pharmacy.

Prescribers should include the most recent “relates to message ID” and most recent prescriber order number (where possible) on Cancel Requests where the original NewRx was electronic, so the pharmacy is able to more easily identify the original NewRx being cancelled.

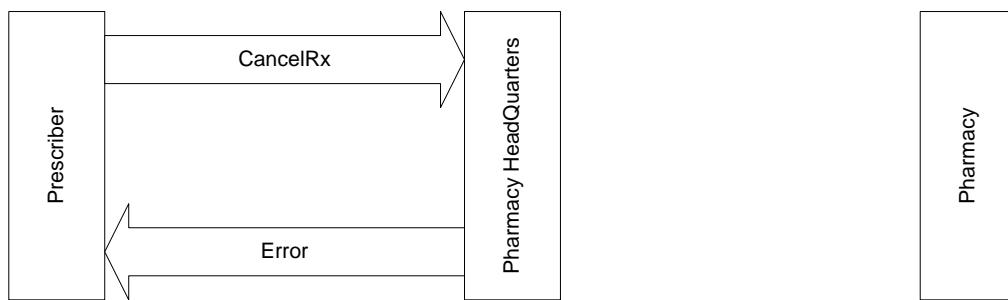
- See the NCPDP XML Standard for guidance on using the <RelatesToMessageID>.

In the direct connect configuration, the prescriber system sends the CancelRx directly to the pharmacy system. The pharmacy system responds with a Status upon successful acceptance of the CancelRx. See **Figure 24**.

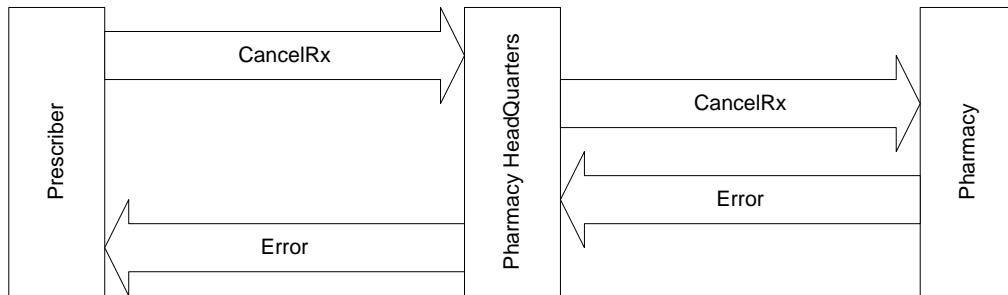


**Figure 24 Flow for a successful CancelRx Transaction on a direct connection between prescriber and pharmacy system.**

Below, **Figure 25** illustrates the flow for a CancelRx that is found to contain an error by the pharmacy headquarters system.



**Figure 25 Flow for a CancelRx where an error is detected by the Pharmacy Headquarters System.**



**Figure 26 Flow for a CancelRx Transaction where an error is detected by the Pharmacy Management System.**

See FAQ section "[How to Link the CancelRx to the NewRx](#)".

For information on <ReturnReceipt> functionality, see section "*Verify Transaction*" in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

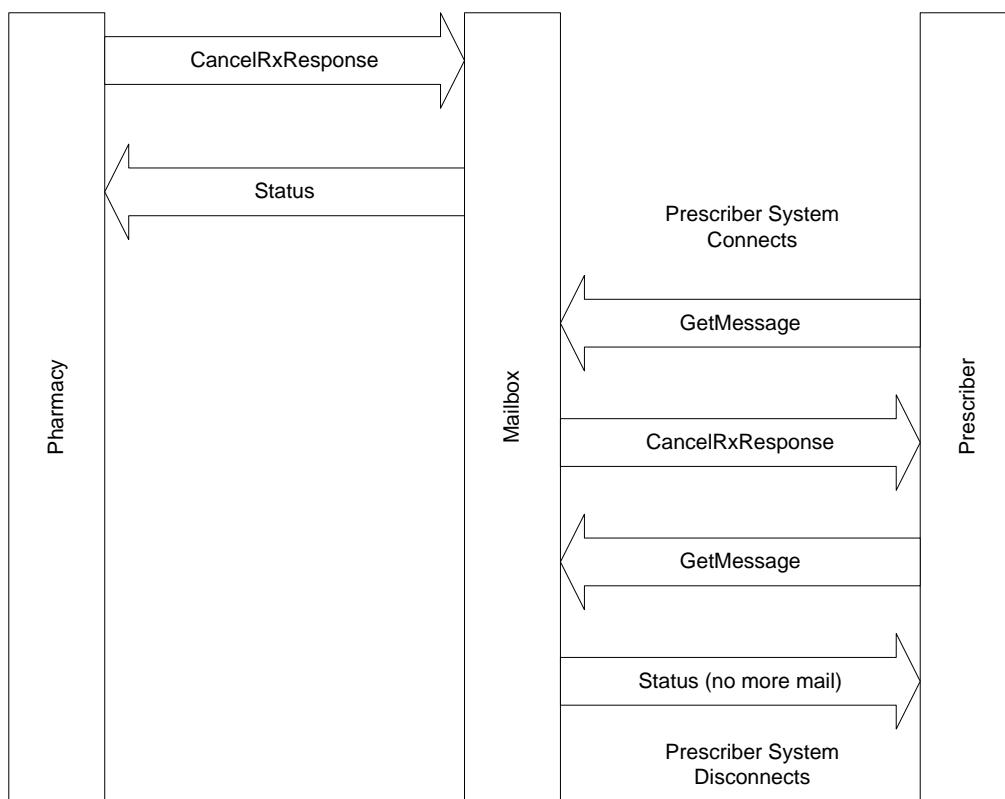
## **5.11 CANCEL PRESCRIPTION RESPONSE TRANSACTION**

The CancelRxResponse transaction sends to the prescriber system the results of a prescription cancellation request. The transaction is originated by the pharmacy system as a CancelRxResponse.

Response is used to denote <Approved> or <Denied> of the cancellation.

- Pharmacy should provide clear denial reasons on CancelRxResponse denial responses.
- Pharmacy should respond to all Cancel Requests within 48 hours. Pharmacies should not delete a Cancel Request message from a processing queue without a response being generated to the requestor.
  - Pharmacy edits should be put in place to not allow a medication to be provided to the patient if a Cancel Response has not been sent.
- As with all appropriate messages, the pharmacy should respond with a Status or Verify message containing code 010 as soon as they receive a Cancel Request.
- The pharmacy should always include a <Note> in an “A” (Approval) Cancel Response message when responding to a Cancel Request message if the patient has ever received a fill of the medication and the pharmacy is cancelling the remaining refills on the prescription.

In a Mailbox configuration, the pharmacy system sends the CancelRxResponse to the Mailbox. The Mailbox responds with a Status. The prescriber system dials in and asks for transactions (GetMessage). The Mailbox responds with the CancelRxResponse. The prescriber system asks for another transaction (GetMessage) and the Mailbox responds with a Status (no more mail). See **Figure 27**.



**Figure 27 Flow for a success CancelRxResponse Transaction in a Mailbox configuration. Pharmacy system is directly connected to Mailbox, Prescriber system is a dial connection to Mailbox.**

For information on <ReturnReceipt> functionality, see section “Verify Transaction” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

### 5.11.1 CANCELLATION RECEIVED BUT PRESCRIPTION HAS BEEN TRANSFERRED

This situation is not for intra-organization transfer situations.

When the pharmacy receives a CancelRx but the prescription has been transferred to another organization’s pharmacy, the pharmacy is to signify in the CancelRxResponse that the cancellation has been <Denied> from the receiving pharmacy because the prescription has been transferred to another organization’s pharmacy. The CancelRxResponse contains as much information about the transferred to pharmacy as is known. The prescribing system can then cancel the prescription at the transferred to pharmacy.

Note the Description of <DenialReasonCode> is the description of the value defined in the NCPDP External Code List. If the <DenialReasonCode> is sent, the <DenialReason> should not contain the echoing of this description as it adds no information.

Scenario	Scenario Description	<DenialReasonCode> Value	External Code List Value Description	<DenialReason> textual intent recommendation for display to prescriber user
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Scenario	Scenario Description	<DenialReasonCode> Value	External Code List Value Description	<DenialReason> textual intent recommendation for display to prescriber user
Denied	Patient is unknown or cannot be determined by the pharmacy.	AA	Patient unknown to the provider	Patient is unknown to the pharmacy.
Denied	Patient is found, but no prescription is found that matches the drug on the cancel request.	AE	Medication never prescribed for the patient	Unable to Cancel Rx. Prescription not found at pharmacy.
Denied	Prescription was transferred to another pharmacy.	AC	Patient no longer under provider care.	Unable to Cancel Rx. Rx transferred. Include available pharmacy contact information.
Denied	Prescription was already responded to by a non-electronic workflow.	AP	Request already responded to by other means (e.g. Phone or Fax)	N/A – <DenialReasonCode> Description provides enough clarity.
Denied	All other denials	N/A (Send free text reasoning)	N/A	Unable to Cancel Rx. Please contact Pharmacy.

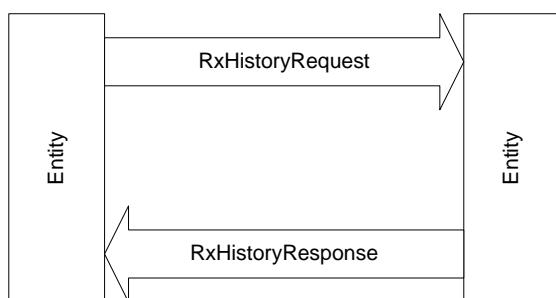
## 5.12 MEDICATION HISTORY REQUEST TRANSACTION

The RxHistoryRequest is a request transaction with a reply transaction. The requesting entity generates a patient specific RxHistoryRequest transaction. An entity sends a RxHistoryRequest for a patient, supplying enough information to uniquely identify the patient.

The request is routed to the appropriate entity for processing. The entity must return the prescriptions that fill the request criteria in the order of the most recent date filled first. The entity must evaluate the <Consent> for accurate reporting.

### Direct Connection

For a direct connection between the requester of the history and the supplier of the history, the response is returned as soon as the responder can process the request. See **Figure 28**.



**Figure 28 Flow for a successful RxHistoryRequest and Response. Simplified version.**

Another use case for RxHistoryRequest: The pharmacy system has the need to request an RxHistoryRequest from a prescriber system to obtain information about medication that was dispensed and/or administered while at the prescriber's office. This information could include but is not limited to samples that were given to the patient during their visit. See response below.

For information on Status, Error and GetMessage transactions, see the NCPDP **XML Standard**.

## **5.13 MEDICATION HISTORY RESPONSE TRANSACTION**

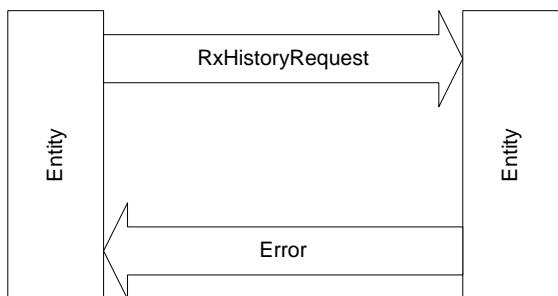
A RxHistoryRequest can be responded to with a RxHistoryResponse, a Status, or an Error.

RxHistoryResponse includes <HistorySource> and <FillNumber> information when appropriate to send, so receivers will be able to de-duplicate records from multiple sources that reflect the same medication dispensing, and better determine patient compliance for the medication. The information also assists the receiver if follow-up contact is required regarding the medication records.

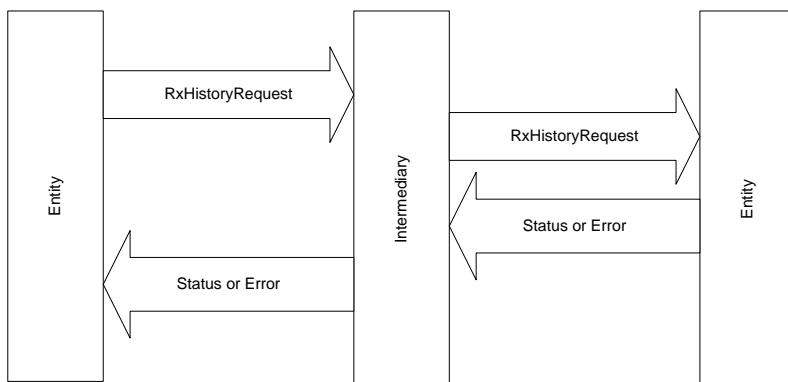
If more medication history information is available within the date range provided, or if no date range was provided and more medication history information is available, a <ReasonCode> value “AQ” (More Medication History Available) is returned.

Another use case for RxHistoryResponse: The prescriber system would respond sending medications that were given under his/her direction. Medications that were prescribed, either electronically or on paper, would not be reported. The pharmacy system could use the information returned for clinical screenings or other functions.

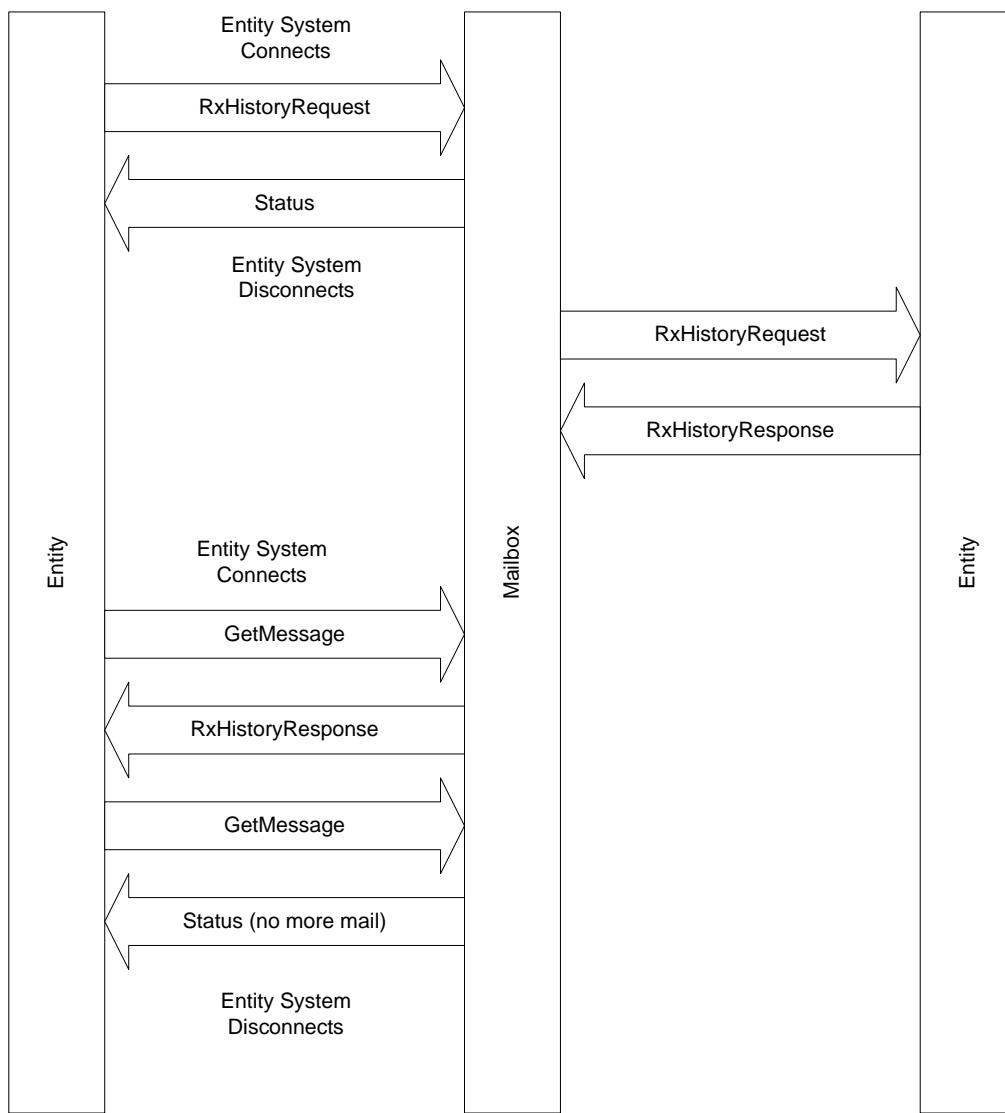
If the RxHistoryRequest fails, an Error is returned. See **Figure 29**.



**Figure 29 Flow for an RxHistoryRequest with an Error response. Simplified version.**



**Figure 30 Flow for an RxHistoryRequest with a Status or Error response through an intermediary. Simplified version.**



**Figure 31 Flow for an RxHistoryRequest with RxHistoryResponse through a Mailbox.**

For information on Status, Error and GetMessage transactions, see the NCPDP **XML Standard**.

## 5.14 LONG TERM CARE (LTC) MEDICATION CHANGE PROCESS

In Long Term Care (LTC) there is a need for the physician to make changes to active orders. These changes need to be transmitted to the pharmacy for processing. The changes would include the significant change of dose, form, strength, or route, or the modifications of frequency, or minor change related to the order. The prescriber system will always send a CancelRx and a NewRx, regardless of the type of change. The pharmacy, upon reviewing these changes, would determine if the original order needs to be canceled or if it can be modified.

In Long Term Care, prescription orders are typically open orders with no end date or a date far in the future. At times, a prescriber has the need to modify this order and notify the pharmacy.

This process is accomplished through the CancelRx and the NewRx with some additional data requirements. This process differs from the RxChangeRequest because it is initiated from the prescriber not the pharmacy. With the request coming from the prescriber, there is no need for a response approving the request.

For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

#### **5.14.1 PRESCRIBER-SYSTEM TRIGGERED CHANGE FLOW**

The following steps depict the transaction flow:

1. Prescriber system transmits a NewRx for the desired medication.
2. The Pharmacy System responds with a Verify, Error, or Status.
3. The Pharmacy System processes the order.

#### **5.14.2 AT A LATER DATE, WHILE THE ORDER IS STILL ACTIVE, THE PRESCRIBER MODIFIES THE ORDER**

4. The Prescriber System cancels the original order (CancelRx).
5. The Pharmacy System responds with a Verify, Error, or Status.
6. The Prescriber System transmits a new order (NewRx).
7. The Pharmacy System responds with a Verify, Error, or Status.
8. The Pharmacy System processes the CancelRx and the NewRx in the appropriate manner.

#### **5.14.3 SIGNIFICANT CHANGES**

Significant changes are defined as changes that result in a different drug or form of drug. The change is considered significant if the prescriber changes the:

- Medication
- Drug Strength
- Drug Form
- Drug Route
- Dosage

The sending prescriber system will indicate this by sending a “C1” (Significant change (Any changes to the Drug, form, strength, or route)) in <MessageRequestCode> on the CancelRx for the original script and a “C1” in <MessageRequestCode> on the NewRx for the new order.

Upon receipt, the pharmacy system can determine what process they need to follow. Typically this would be to process the CancelRx on the original script and process the NewRx as a new order.

#### **5.14.4 FREQUENCY CHANGES**

A physician may decide to change only the frequency or hours of administration for a prescription. They may decide to increase or decrease when the patient receives the

medication. The pharmacy needs to be aware of this change because it may affect the overall quantity to dispense. The sending physician system will indicate this by sending a “C2” (Frequency Change (Any change to the frequency or hours of administration for the drug)) in <MessageRequestCode> on the CancelRx for the original script and a “C2” in <MessageRequestCode> on the NewRx for the new order.

Upon receipt, the pharmacy system can determine what process they need to follow. Typically this would be to process the CancelRx on the original script and process the NewRx as a new order.

#### **5.14.5 INSIGNIFICANT CHANGES**

All other changes made to the order are considered insignificant. The sending physician system will indicate this by sending a “C3” (Insignificant Change (All other changes)) in <MessageRequestCode> on the CancelRx for the original script and a C3 in <MessageRequestCode> on the NewRx for the new order. This may result in the pharmacy system simply updating the order with the changes. By sending the CancelRx, the pharmacy system could still determine they need to cancel the original script and create a new script with the changes off of the NewRx.

Note: When determining change significance, the highest level of significance takes precedence. For instance, if frequency and drug changes, the change level is significant (C1).

#### **5.14.6 GENERAL INFORMATION**

The differentiation of the three use cases is with the use of <MessageRequestCode>. If a NewRx or CancelRx does not have a C1, C2, or C3 indicator, it is treated as a normal CancelRx and/or NewRx, regardless if it has a reference to an original order in the <RelatesToMessageID>.

### **5.15 RESUPPLY TRANSACTION**

In the long term care environment there is a need for a long term or post-acute care (LTPAC) organization to send a request for an additional supply of medication from an existing authorized order to a pharmacy. An example use case is when a medication supply for a resident is running low (2-3 doses) and a new supply is needed from the pharmacy, the LTPAC organization needs a way to notify the pharmacy that an additional supply for the medication is needed from the pharmacy.

For the Resupply transaction, the valid response transactions are Status, Error, and Verify. For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

There is a need to maintain three separate identifiers for the Resupply transaction. These are accomplished by using the following fields.

- <RxReferenceNumber> - this field is the prescription number assigned by the pharmacy.
- <PrescriberOrderNumber> - This field assigned by the prescriber system.
- <Mailbox><AcknowledgementID> – For Resupply – In the LTC environment this is the prescription number assigned by the facility.

## **5.16 RECERTIFICATION TRANSACTION**

In the long term or post-acute care environment there is a need to communicate from a long term or post acute care organization the recertification notification from a long term or post-acute care organization for a recertification of an existing medication order for continued patient's administration. An example use case is a prescriber must review and recertify a patient's medication orders on a periodic basis especially for those medication orders without a predetermined administration end date. This recertification period (typically every 30 or 60 days) varies by state regulations and facility practice, but must be documented by the facility and if requested made available to the pharmacy. The recertification transaction meets this need by providing the capability to communicate the authorization for continued administration of the medication order. A recertification message informational only and is not intended to have prescriptive authority (i.e. does not request additional medications to be dispensed).

For the Recertification transaction the date the prescriber reviewed the chart and determined recertification is appropriate is contained in <MedicationPrescribed><DateRecertified>.

For the Recertification transaction, the valid response transactions are Status, Error, and Verify. For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

There is a need to maintain two separate identifiers for the Recertification transaction. These are accomplished by using the following fields.

- <RxReferenceNumber> - This field is the prescription number assigned by the pharmacy.
- <PrescriberOrderNumber> - This field assigned by the prescriber system.

## **5.17 DRUG ADMINISTRATION NOTIFICATION TRANSACTION**

In environments where the pharmacy operates under protocol to maintain a supply of prescribed medications at the point of care (e.g., a skilled nursing facility), the pharmacy may wish to be notified of events related to administration of a medication to the patient. In particular, it is valuable for the pharmacy to know when a medication is being suspended (not administered to the patient) due to clinical or other reasons. Once administration of the drug is resumed, the pharmacy is also notified. In these settings, information about medication administration suspension can be used by the pharmacy to adjust dispensing timing and/or amount—to match the inventory needs of the facility.

The DrugAdministration is used by prescribers/care facilities to communicate drug

administration events to the patient's pharmacy or other entity. In particular, it may be used to alert the recipient when a medication is suspended and when administration is resumed, enabling supplies to be managed appropriately.

<RxFillIndicator> informs the pharmacy of the prescriber's current intent for fill status notifications for a specific patient/medication. This may be a change to the current fill status or a cancellation of further RxFill notifications.

For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

### 5.17.1 DEFINITIONS

**Fixed length suspension.** A suspension period of known duration that is specified by both a “suspend date” and a “resume date”.

**Indefinite suspension.** A suspension period of unknown duration that is specified by only a suspend date. An indefinite suspension is typically followed by a DrugAdministration containing the resume date once the resumption date/time is known.

**Active suspension.** A previously communicated administration suspension with a resume date equal to or greater than the current date or with an unspecified resume date.

**Active medication order.** A previously communicated medication order that is either open-ended or for which the administration end date has not been reached.

### 5.17.2 USAGE RULES

**Transaction actions.** The transaction is originated by the prescriber system as a DrugAdministration and sent to the recipient's system to specify the particular event being communicated <FixedLengthSuspension>, <IndefiniteSuspension>, or <ResumeAdministration> or to indicate that a previously-communicated event has been canceled <CancelSuspension>.

**Transactions are drug-specific.** The DrugAdministration is drug-specific; if multiple medications are being suspended at the same time, a DrugAdministration must be sent for each. The DrugAdministration is meant to communicate drug-specific administration events caused by clinical factors or other reasons. The DrugAdministration is not intended to be used to communicate leaves of absence or other events that have the effect of stopping administration of many or all of the patient's medications (due to the resident leaving the facility, for example).

**Drug order identification.** The DrugAdministration relates to a particular medication identified in the transaction using the prescription ID assigned by the prescribing system. The following element references the prescription number assigned by the prescriber system.

- <PrescriberOrderNumber>

**Suspend dates/times.** An administration event (suspension, resumption) is communicated with the date and time of the event. Note that a practitioner may at times order a certain number of doses of a medication to be suspended. In this scenario, it is up to the prescriber's/facility's

software to convert these events into the correct dates and times for transmission using the DrugAdministration.

**One active suspension at a time.** Only one administration suspension can be active for any given order. It is not appropriate, for example, for the prescriber's system to communicate multiple suspensions to occur in the future. Accordingly, when the <ResumeAdministration> or <CancelSuspension> are used, the transaction relates to the single, active (current or future) suspension for the specified drug.

The prescriber's system must not send notification of a new suspension <IndefiniteSuspension> or <FixedLengthSuspension> for a given order if there is already an active suspension in effect.

**Changing the start of a suspension period.** A change to the start date/time of an active suspension (a previously-communicated suspension period that is currently in effect or will be in effect in the future) must be accomplished in two steps:

1. Send a DrugAdministration for <CancelSuspension>
2. Send a DrugAdministration for either <FixedLengthSuspension> with <SuspendDateTime> and <ResumeDateTime>  
*OR*  
Send a DrugAdministration for <IndefiniteSuspension> with <ResumeDateTime>.

**Changing the resume date/time.** The resume date/time for an active suspension may be adjusted using a single DrugAdministration containing the <ResumeAdministration>.

Note: This only is applicable if the original resume date/time is in the future. If the resume date/time has already passed, the suspension is not active and therefore cannot be changed. A new suspension would be needed.

**Cancelling an active suspension.** To cancel an active suspension (one that is currently in effect or is dated to go into effect the future), the prescriber's system sends a DrugAdministration containing <CancelSuspension>.

The prescriber's system must not send a cancellation for a suspension that isn't active or an error will occur.

**Reason code and text.** The sender may optionally provide a reason for the administration event, using the <DrugAdminReasonCode> and <DrugAdminReasonText>.

Below is a summary of the <MessageRequestCode> and associated usage rules

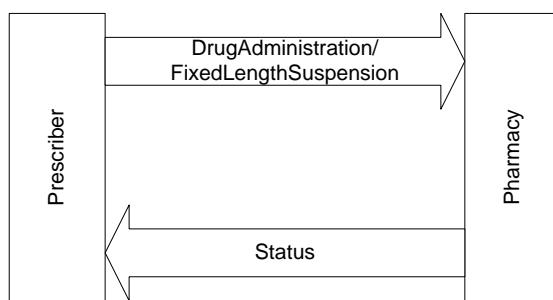
Event/Action	SuspendDateTme	ResumeDateTme	Validity Requirements	Description
--------------	----------------	---------------	-----------------------	-------------

Event/Action	SuspendDateT ime	ResumeDateT ime	Validity Requirements	Description
<FixedLengthSuspension>	Required	Required	<SuspendDateTime> must be prior to <ResumeDateTime>  Must refer to an active medication order (prescribing system's order ID)  Only one suspension may be active at a time (currently in effect or set for a future date).	Administration of the specified medication has been temporarily suspended, for a pre-determined period of time.  Only one suspension may be active at a time (currently in effect or set for a future date).  Two dates are required.
<IndefiniteSuspension>	Required	Not used	Must refer to an active medication order  Only one suspension may be active at a time (currently in effect or set for a future date).	Administration of the specified medication has been suspended for an undetermined time period.  Only one date is allowed.
<ResumeAdministration>	Not used	Required	Must refer to an active medication order  Must be preceded by an <IndefiniteSuspension> that is currently in effect or will be in effect in the future  <ResumeDateTime> must be later than the <SuspendDateTime> of the active suspension	Administration of the specified medication has been resumed or the resume date/time resumption has been set or changed.  Only date is allowed.
<CancelSuspension>	Not used	Not used	Must refer to an active medication order  Must be preceded by an active suspension	Cancels the previously-communicated administration suspension—indicating that the suspend event did not actually occur as communicated.  No dates are allowed.

### 5.17.3 TRANSACTION FLOWS

In the direct connect configuration, the prescriber system sends the DrugAdministration directly to the pharmacy system. The pharmacy system responds with a Status upon successful acceptance. The figures below illustrate flows associated with the transactions.

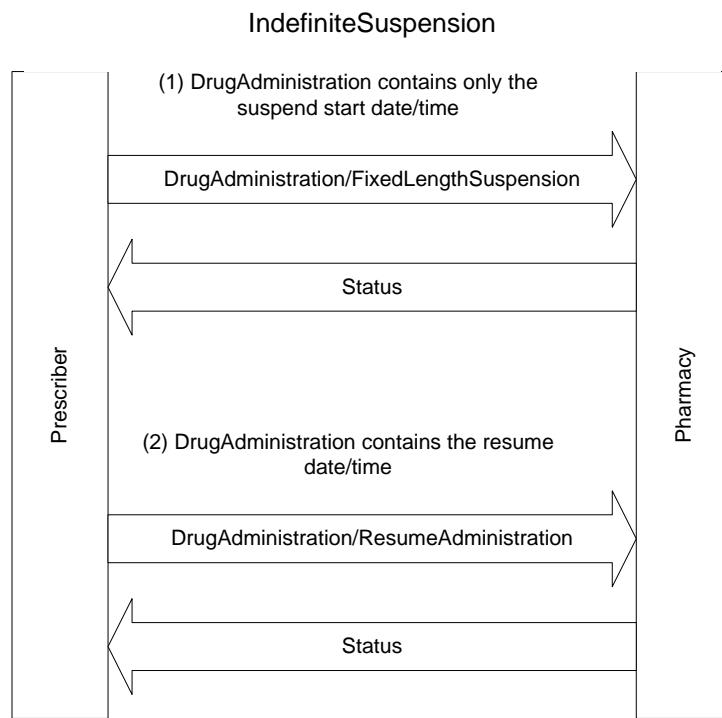
**FixedLengthSuspension**  
DrugAdministration contains (a) suspend date/time and (b) resume date/time



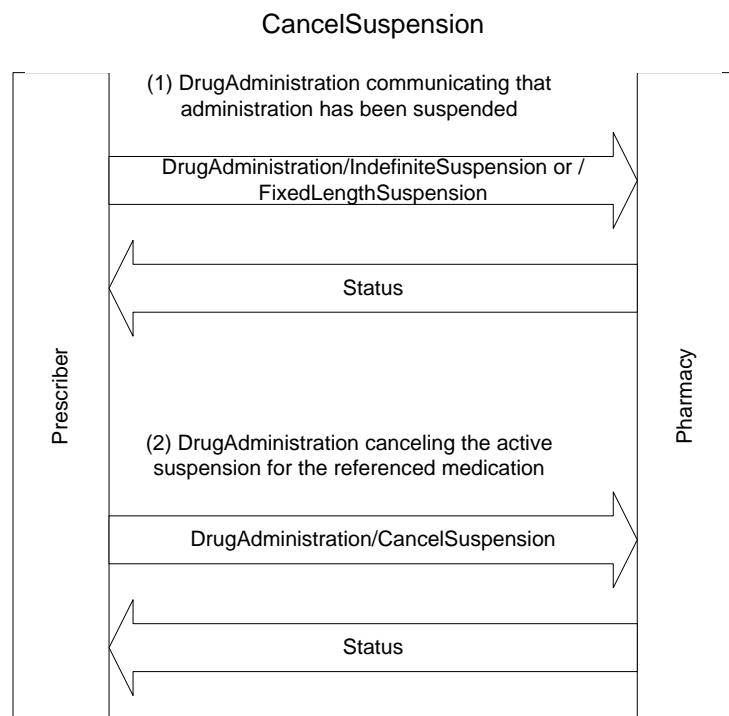
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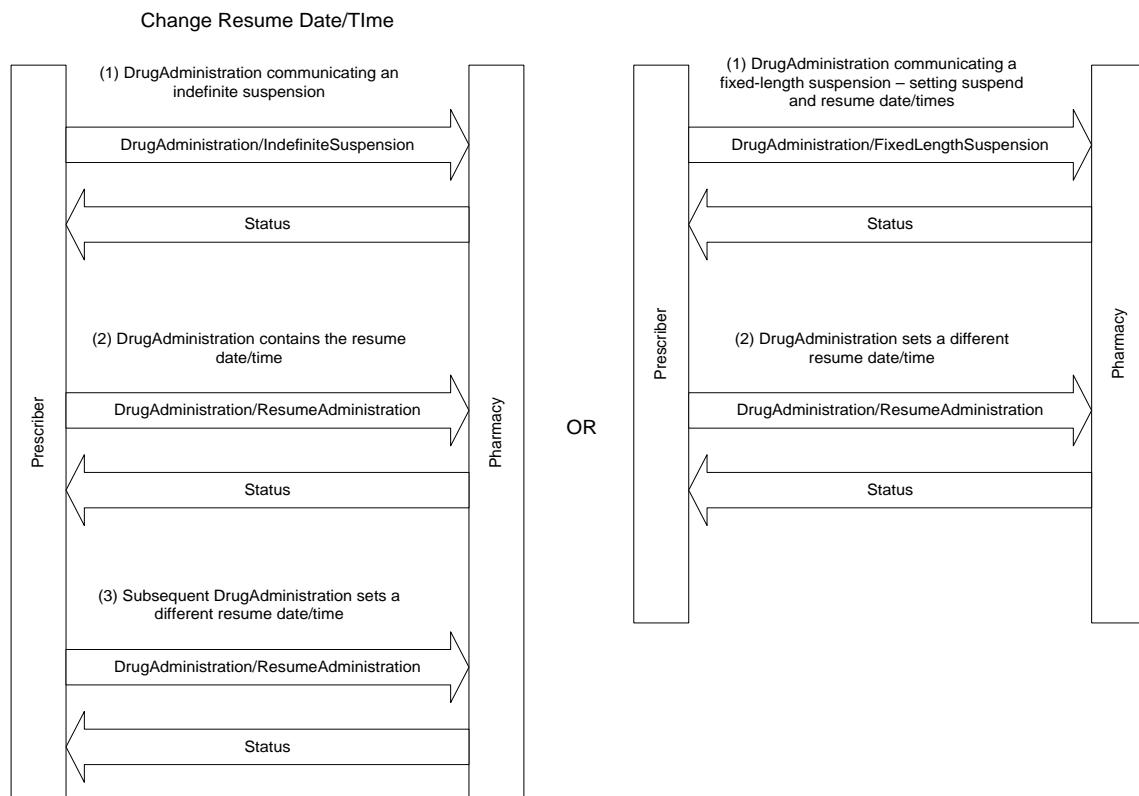
**Figure 32 Flow for a <FixedLengthSuspension>**



**Figure 33 Flow for an <IndefiniteSuspension>, followed by a <ResumeAdministration> in a separate transaction.**



**Figure 34 Flow for canceling an active suspension.**



**Figure 35 Flow for changing the <ResumeDateTime> for an active suspension.**

#### **5.17.4 ERROR SCENARIOS**

**DrugAdministration refers to non-existent drug order.** As noted above, each DrugAdministration must refer to a previously-communicated prescription <PrescriberOrderNumber>. If the pharmacy or other entity receives a DrugAdministration containing no prescription number or an unrecognized prescription number, it should respond with an Error.

**Multiple suspensions.** As discussed above, only one medication suspension can be active for a given order. If the pharmacy or other entity receives a DrugAdministration containing a <FixedLengthSuspension> or <IndefiniteSuspension> referencing a prescription for which an active suspension exists, it should disregard the transaction and respond with an Error transaction.

**“Resume” function with no active suspension.** If the pharmacy or other entity receives a DrugAdministration containing the <ResumeAdministration>, but determines that the referenced prescription does not have an active suspension, it should disregard the transaction and respond with an Error transaction.

### **5.18 QUERY INTRODUCTION**

Query transactions are used by a pharmacy to request a NewRx prescription from a prescriber. Query transactions are also used for the exchange of patient-centric clinical health information, such as allergies, conditions and medical histories between electronically enabled healthcare providers (see the NCPDP **Specialized Standard Implementation Guide**). It is recommended that all functions of the query be supported. This implementation guide supports

- NewRxRequest
- NewRxResponseDenied

#### **5.18.1 NEWRXREQUEST TRANSACTION**

The NewRxRequest provides the mechanism for a pharmacy to request a new prescription. The NewRxResponseDenied provides a mechanism for the prescriber to deny the new prescription request. If the new prescription request is approved, the NCPDP NewRx transaction will be sent as a follow-up transaction. The NewRx must not be contained in the NewRxResponseDenied.

<Note> at the highest query level is optional, but the sender can use it to provide extra information about the request as desired. <Note> could be used for further reason for the request. <Note> should never be used as a simple email communication between parties. It must be relevant to the purpose of the initial request.

The <NewRxMedicationRequested> is composed of the following specific sub elements to provide information to the prescriber of what the pharmacy is requesting.

- <DrugDescription> - (required)

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- <DrugCoded> (optional)
- <Diagnosis> (optional)
- <Quantity> (optional)
- <Days Supply> (optional)
- <OtherMedicationDateQualifier> value of <Last Fill Date> (optional)
- <Substitutions> (optional)
- <Sig> (optional)

If the pharmacy knows the specific drug that is being requested on behalf of the patient it can be specified as follows:

- <DrugDescription> contains the Name, Strength, Form of the drug being requested
- <DrugCoded> sub-elements to correspond if known and appropriate
  - <ProductCode>, <Strength>, <DrugDBCode> specifics

If the pharmacy does not know the specific drug being requested on behalf of the patient but knows the specific class or category of drug (e.g. a statin, an ACE inhibitor), it can be specified as follows:

- <DrugDescription> contains a description of the class/category of drug being requested
- <DrugDBCode><Qualifier> value "AF" to indicate an American Hospital Formulary Service (AHFS) code to indicate the class of drug being requested
- <DrugDBCode><Code> ID contains the AHFS code of the class of drug being requested

If the pharmacy does not know the specific drug being requested or the specific class or category of drug on behalf of the patient, but knows what the drug is being used to treat (e.g. hypertension, asthma medicine), it can be specified as follows:

- <DrugDescription> contains a description of the type of drug being requested
- <Diagnosis><Primary><Value> contains the ICD9 or ICD10 code associated with the condition

If the pharmacy has a prescription on file for a patient that has never been filled and is now expired it can be specified as follows:

- <DrugDescription> contains the Name, Strength, Form of the drug being requested
- <DrugCoded> sub-elements to correspond if known and appropriate
  - <ProductCode>, <Strength>, <DrugDBCode> specifics including <Quantity> and <Days Supply>
- <Sig>if known
- <Substitutions> if known and appropriate
- <Last Fill Date> is not sent (unknown)

If the pharmacy has a prescription for a patient that has never been filled and it is now expired and the prescriber has changed it can be specified as follows:

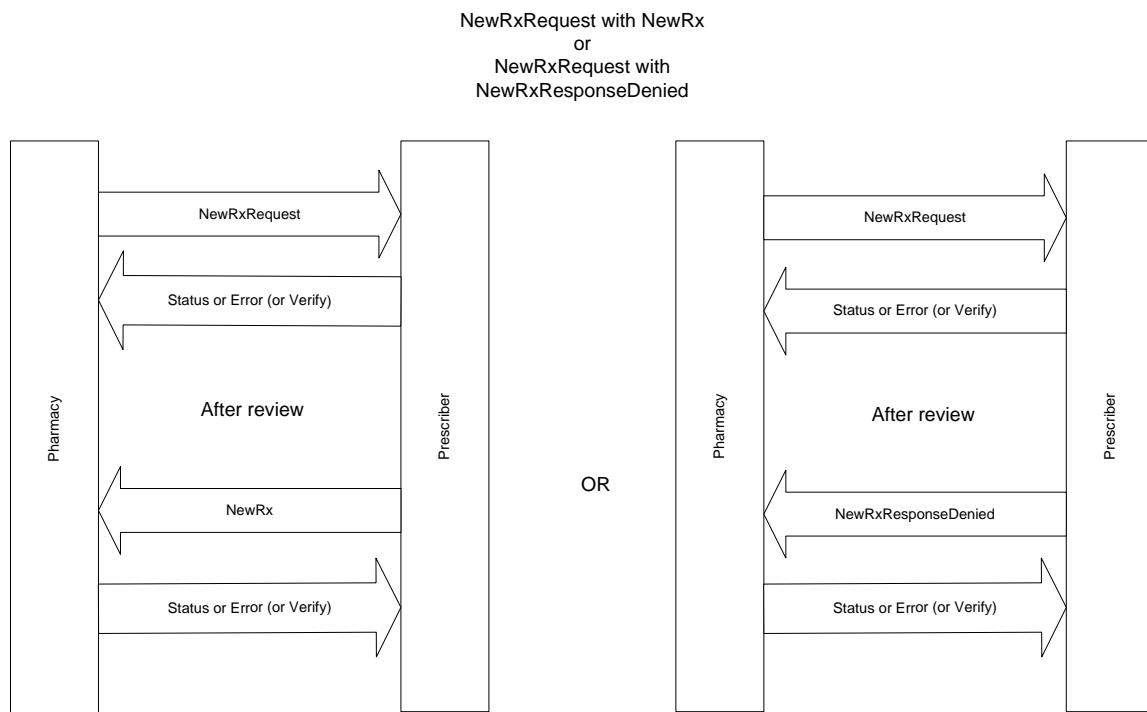
- <DrugDescription> contains the Name, Strength, Form of the drug being requested
- <DrugCoded> sub-elements to correspond if known and appropriate
  - <ProductCode>, <Strength>, <DrugDBCode> specifics including <Quantity> and <Days Supply>
- <Sig>if known

- <Substitutions> if known and appropriate
- The Prescriber element contains the name and identification of the prescriber to whom the new prescription request is directed
- <OtherMedicationDateQualifier> value of <Last Fill Date> is not sent (unknown)

If the pharmacy has a prescription for a patient that has been filled at another pharmacy (patient brings in bottle) but prescription is expired it can be specified as follows:

- <DrugDescription> contains the Name, Strength, Form of the drug being requested
- <DrugCoded> sub-elements to correspond if known and appropriate
  - <ProductCode>, <Strength>, <DrugDBCode> specifics including <Quantity> and <Days Supply>
- <Sig>if known
- <Substitutions> if known and appropriate
- The Prescriber element contains the name and identification of the prescriber to whom the new prescription request is directed
- <Last Fill Date> is sent if it is known

If the patient is requesting more than one prescription, a separate NewRxRequest must be sent for each medication.



**Figure 36 NewRxRequest and Response Flow**

### 5.18.2 NEWRXRESPONSEDENIED TRANSACTION

The NewRxResponseDenied provides a mechanism for the prescriber to deny the new prescription request. If the request is approved, the NCPDP NewRx transaction will be sent as a follow-up transaction. The NewRx must not be contained in the NewRxResponseDenied.

### **5.18.3 Flows**

1. Scenario 1: Pharmacy requests a new prescription.
  - 1.1. Pharmacy sends a NewRxRequest for a new prescription to a Prescriber.
  - 1.2. Prescriber acknowledges the NewRxRequest with a response of:
    - Status with <Code> 010 – transaction delivered/received
    - Status with <Code> 000 - delivery not complete but pending – Verify or Error to follow.
    - Status or Verify with <Code> 010 - transaction delivered/received.
    - Error with appropriate <Code> - transaction not delivered and indicating the problem(s) with the transaction.
  - 1.3. Prescriber reviews the NewRxRequest and determines whether to approve or deny the request.
  - 1.4. If approved, the Prescriber sends a NewRx for the prescription.
    - 1.4.1. The Prescriber must set the NewRx's <RelatesToMessageID> to the value of the <MessageID> of the NewRxRequest transaction. This provides traceability for the recipient to know that the NewRx is the response to a request and not simply any other NewRx.
    - 1.4.2. Pharmacy acknowledges the NewRx indicating:
      - Status with <Code> 000 - delivery not complete but pending – Verify or Error to follow.
      - Status or Verify with <Code> 010 - transaction delivered/received.
      - Error with appropriate <Code> - transaction not delivered and indicating the problem(s) with the transaction.
  - 1.5. Or if denied, the Prescriber sends a NewRxResponseDenied.
    - <Denied>. The request cannot be processed or information is unavailable. This response completes the transaction. No additional information will follow.

- 1.5.1. Pharmacy acknowledges the NewRxResponseDenied indicating:
  - Status with <Code> 000 - delivery not complete but pending – Verify or Error to follow.
  - Status or Verify with <Code> 010 - transaction delivered/received.
  - Error with appropriate <Code> - transaction not delivered and indicating the problem(s) with the transaction.

For information on <ReturnReceipt> functionality, see section “Verify Transaction” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

### **5.19 PRIOR AUTHORIZATION INTRODUCTION**

The NCPDP prior authorization transactions are intended to be used for products covered by a patient’s pharmacy benefit (e.g. medications and supplies). These transactions are not intended

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to be used to obtain authorization for other medical services. The prior authorization transactions are exchanged as other SCRIPT Standard transactions, in a real-time request and response mode. (Mailboxing may be used.)

While the NCPDP prior authorization transactions enable a standard *means for communicating* each payer's set of PA questions, it does not *standardize the questions* themselves nor does it specify *how* the questions are presented to the prescriber.

The prior authorization transactions:

- Provide a fully electronic means for determining whether prior authorization is required for a particular medication and particular patient.
- Present prior authorization information needs to the prescriber in a consistent format while enabling each payer to request the particular information it requires.

Note: for the purposes of the prior authorization discussion, the term "payer" may be seen as the plan, the processor, the Pharmacy Benefit Manager, etc. – the entity (or contracted entity) to perform the functions of eligibility, benefit, prior authorization functions. This may be one or more entities. The phrase "prescriber system" refers to the system used by the prescriber or by a representative of the prescriber - which might be an electronic prescribing system, a provider portal, an affiliated provider's facility or pharmacy system, etc.

**Note:** the PA transactions should not be confused with a NewRx transaction. The PA transactions are between the prescriber system and the payer system for PA determination. A NewRx transaction is between the prescriber system and the pharmacy system for exchanging an electronic prescription.

Note that attachments should only be sent when needed to fulfill prior authorization requirements. Sending attachments when not necessary may result in an interruption of the electronic process (e.g. manual review) by the payer which may cause a possible delay in the prior authorization determination. In addition, payers should only require Attachments in electronic Prior Authorization when the required information cannot be sent in a discrete field within the SCRIPT Prior Authorization Transactions. Payers that are considering requiring Attachments for Prior Authorization should first closely review the SCRIPT Prior Authorization question set capabilities to ensure the necessary data cannot be captured within the transaction. Minimization of Attachment use in electronic Prior Authorization transactions will maximize automation and reduce administrative burdens for both prescribers and payers. It is recommended that both PBMs and vendor systems support at least the "PDF" attachment type.

When the PAInitiationResponse or PAResponse reason status is "Closed" and the <ReasonCode> is Other (BY), the payer should populate the <PANote> with the reason why the request was closed.

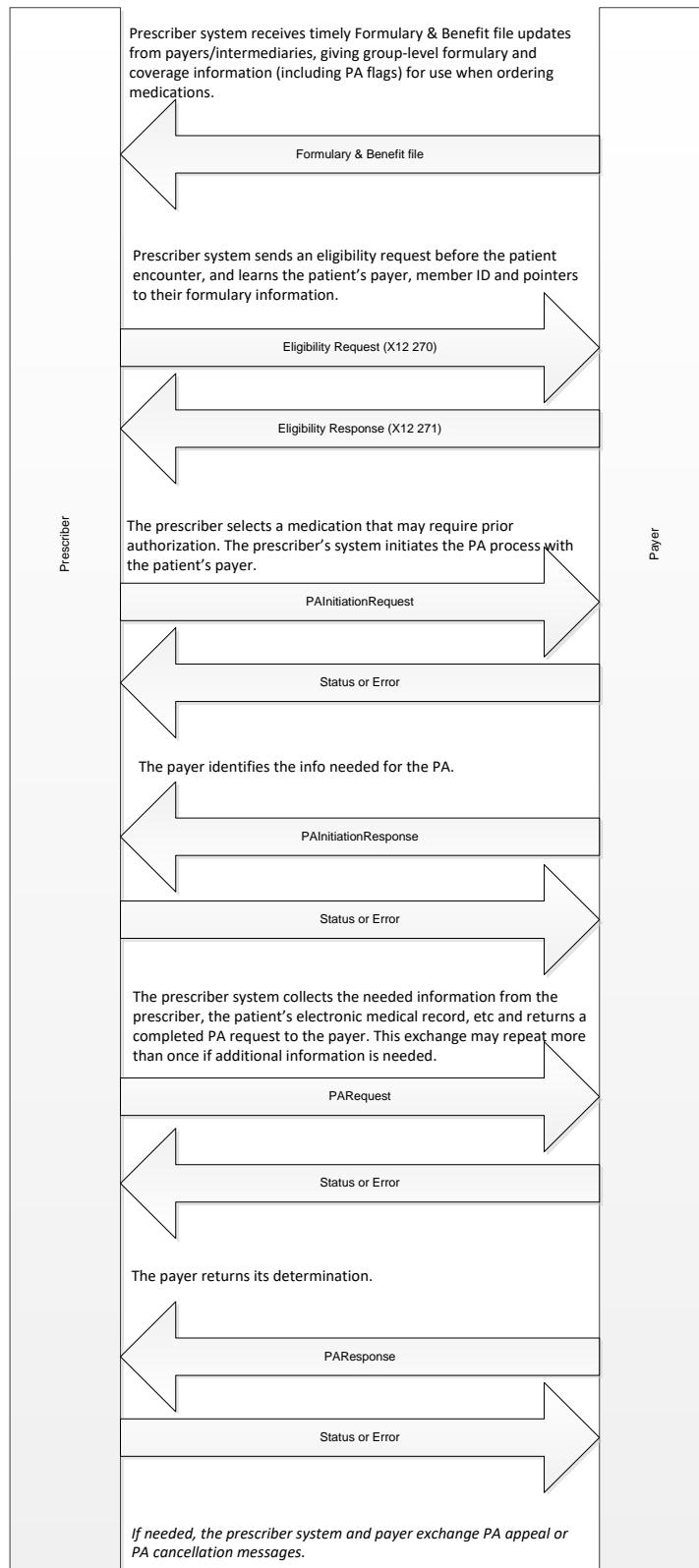
### **5.19.1 PRIOR AUTHORIZATION WITHIN THE ELECTRONIC PRESCRIBING WORKFLOW**

The NCPDP prior authorization transactions support the electronic prescribing workflow by leveraging information through other electronic exchanges including the ASC X12 eligibility transaction and the NCPDP Formulary & Benefit Standard.

In addition, the prior authorizations transactions are designed to support the exchange of information obtained from the electronic health record system. The transactions allow for the use of coded references, increasing the opportunity for interoperability.

The prior authorization transactions are not dependent on a particular workflow. There are two possible prior authorization transaction flows: solicited and unsolicited. In the solicited model, the prescriber will notify the payer that they wish to start the prior authorization process to determine if an authorization is needed for their patient and desired medication. In the unsolicited model, the prescriber presumes that an authorization is needed and they will submit the information they anticipate the payer needs.

While the prior authorization transactions are designed to be used during the electronic prescribing workflow when possible, they can also be used later – when a prescriber is informed a prescription sent to a pharmacy was determined to require prior authorization during claims processing. When integrated into the electronic prescribing process, the use of the prior authorization transactions is said to be “prospective,” whereas use after a claim rejection is referred to as “retrospective.”



**Figure 37 Prior Authorization Transactions Flow General**

### **5.19.2 USE OF THE ELIGIBILITY TRANSACTION**

The NCPDP prior authorization transactions are enhanced by another transaction that is supported in electronic prescribing: patient eligibility using the ASC X12 Standards for Electronic Data Interchange Technical Report 3 - Health Care Eligibility Benefit Inquiry and Response - 270/271. The eligibility transaction is typically exchanged prior to the patient encounter and can supply the prescriber system with information about the patient's pharmacy benefit, including the payer, member ID, formulary and coverage pointers, and other details.

The eligibility transaction identifies the patient's pharmacy benefit identifiers (IIN Number, Processor Control Number, Group), and the unique identifier the payer uses for the patient. Submitting this patient identifier in the PBMMemberID element of the transaction sent to initiate the prior authorization process (PAInitiationRequest in the solicited model; PAResponse in the unsolicited model) helps the payer retrieve the patient's records and respond appropriately to the request.

When the prior authorization transactions are used retrospectively, it is still beneficial to request eligibility information using the eligibility transaction before initiating the prior authorization process, in order to confirm the patient's coverage and payer information and to retrieve the unique identifier the payer uses for the patient.

### **5.19.3 USE OF THE FORMULARY AND BENEFIT STANDARD**

The NCPDP **Formulary and Benefit Standard** (F&B Standard) provides a standard means for pharmacy benefit payers (including health plans and pharmacy benefit managers) to communicate formulary and benefit information to prescribers via technology vendor systems.

The F&B Standard includes a prior authorization list that may be used to indicate medication that may require prior authorization. However, the information provided is not patient-specific. It is meant to serve as a trigger for the prescriber that prior authorization may be needed for the particular patient and medication.

If, during the ordering process, the prescriber selects a medication flagged in the formulary as potentially requiring prior authorization, they can use the prior authorization transactions to determine whether prior authorization will be required for this prescription for this patient.

### **5.19.4 PRIOR AUTHORIZATION TRANSACTIONS**

The prior authorization transactions include:

1. PAInitiationRequest and PAInitiationResponse
2. PAResponse and PARequest
3. PAAppealRequest and PAAppealResponse
4. PACancelRequest and PACancelResponse

Each transaction supports a particular step in the prior authorization process:

- The PAInitiationRequest transaction is used by the prescriber, in the solicited model, to initiate the prior authorization process, by notifying the payer of the patient and the medication for which prior authorization is being requested, along with the prescriber's

- information and other related details.
- In the PAInitiationResponse transaction:
    - In the first use case, the payer indicates the information needed from the prescriber to determine approval or denial of the authorization. In some cases, the payer indicates to the prescriber that prior authorization is not required for the requested medication and patient. The PAInitiationResponse is for the medication (name, strength, dosage form) indicated in the PAInitiationRequest. The payer should not respond for an equivalent to the medication (e.g., generic product equivalent to brand product) indicated in the PAInitiationRequest.
    - In the second use case, the payer may send PAInitiationResponse transaction without receiving PAInitiationRequest from the prescriber to renew an existing PA that will be expiring soon. The prescriber system gathers the requested information by presenting questions for the prescriber to answer and/or by extracting information from the patient's electronic medical record using the coded references associated to the question. The information is sent to the payer in the PAResponse transaction. This occurs in both the solicited and unsolicited models.
    - The payer uses the PAResponse transaction to notify the prescriber of:
      - A determination on the PAResponse.
      - A notification the request is in process, including the expected resolution date if known.
      - A request for additional information in order to make a determination.
  - The PAAppealRequest and Response transactions support two functions:
    - The PAAppealRequest transaction enables the prescriber to obtain the information required to submit an appeal.
      - The PAAppealResponse transaction provides information from the payer to the prescriber on what is needed for an appeal.
    - The PAAppealRequest transaction also enables the prescriber to submit the appeal information for a prior authorization determination.
      - The PAAppealResponse transaction is used by the payer to indicate the outcome of an appeal.
  - The PACancelRequest transaction is used by the prescriber to notify the payer that the prior authorization request is no longer needed.
    - The PACancelResponse transaction is used by the payer to acknowledge the prior authorization request was canceled or to indicate the prior authorization request wasn't canceled.

Electronic prior authorization transactions are not intended to be used by a payer to inform the prescriber of alternatives to the medication for which authorization is being requested. Generally, information regarding medication alternatives is obtained by reviewing benefits and formulary information.

#### **5.19.4.1 Renewal of an Existing Prior Authorization**

Payers/PBMs should make the following checks before initiating a request for a PA renewal:

1. Member is currently eligible by running eligibility check
2. Member is currently on drug/therapy by running a check against the claims

Payers/PBMs should send a message with the PA Renewal in the <PANote> element informing the doctor “the current PA approved on <> will expire on <> and requires a PA renewal for uninterrupted drug therapy”.

### 5.19.4.2 *Solicited and Unsolicited Model*

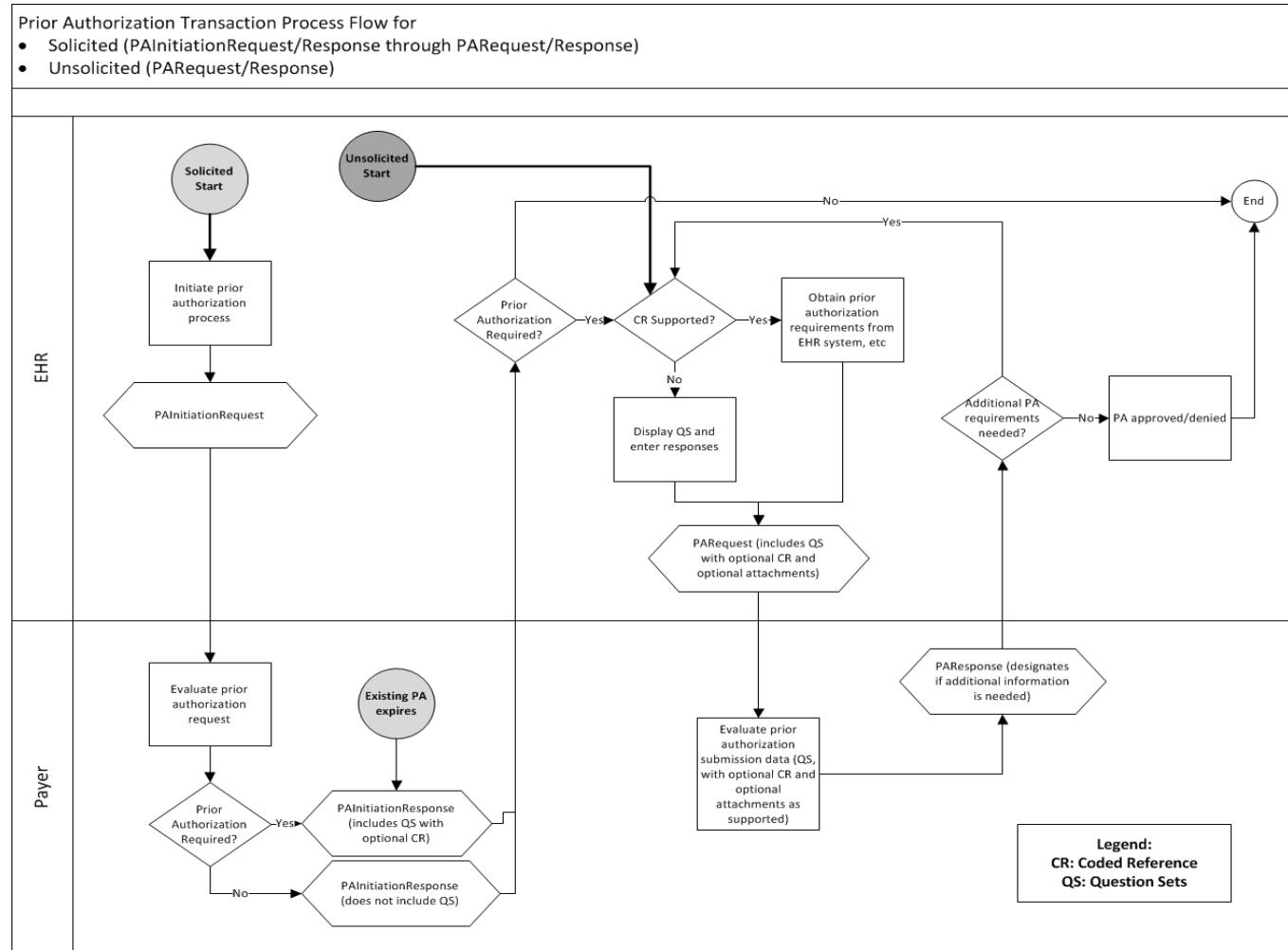


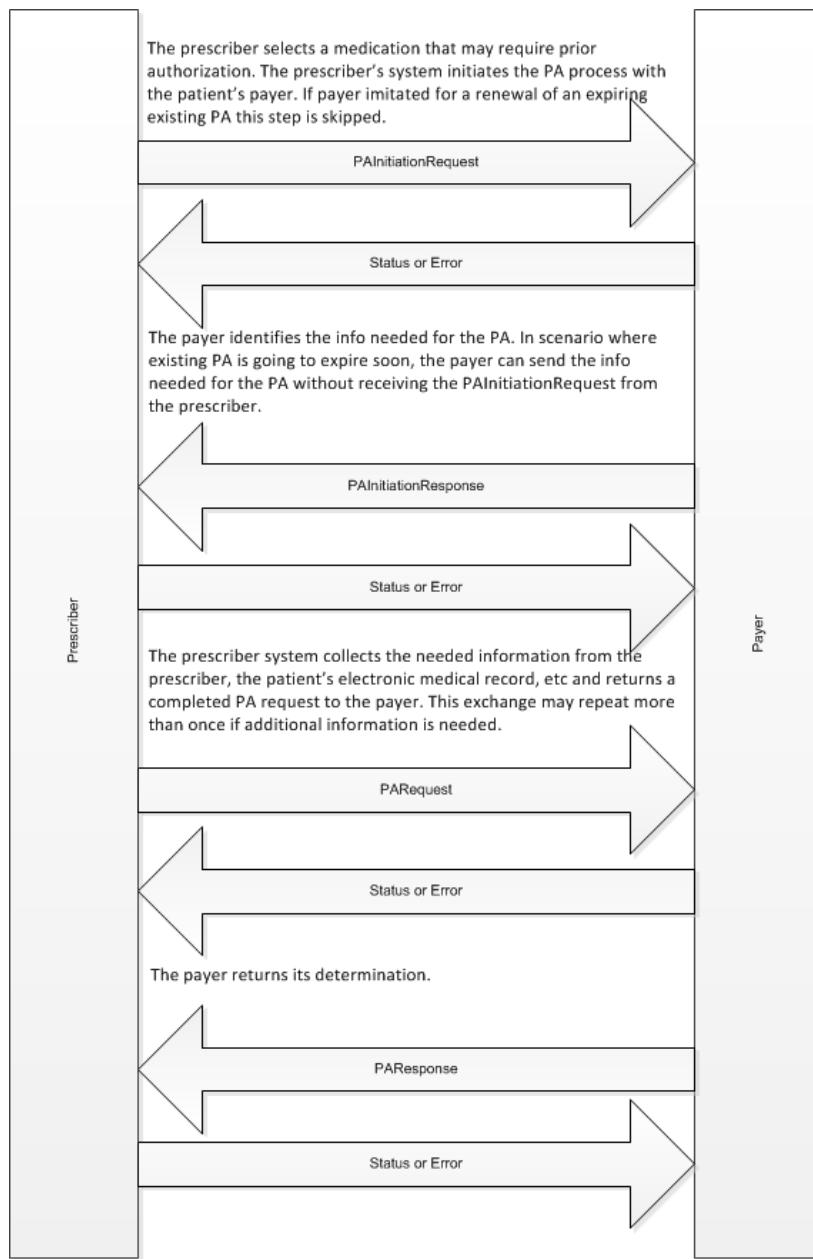
Figure 38 *Solicited and Unsolicited Transaction Flow*

**5.19.4.2.1 Solicited Model**

In the solicited model, the prescriber initiates the request for prior authorization by providing information about the patient and the medication requested. In response, the payer sends a list of required information the prescriber must supply to support the decision process. The payer may send a list of required information without receiving a request from the prescriber for renewal of an existing expiring PA. The prescriber system gathers the needed information from the prescriber and/or the patient's electronic medical record using coded references and returns it to the payer. The payer then notifies the prescriber of the determination.

The transactions involved include:

- PAInitiationRequest and PAInitiationResponse, where the prescriber system initiates the authorization process and the payer identifies the information required of the prescriber.
- PARequest and PAResponse, which convey the collected information to the payer, and the payer's determination to the prescriber.



**Figure 39 Solicited Transaction Flow**

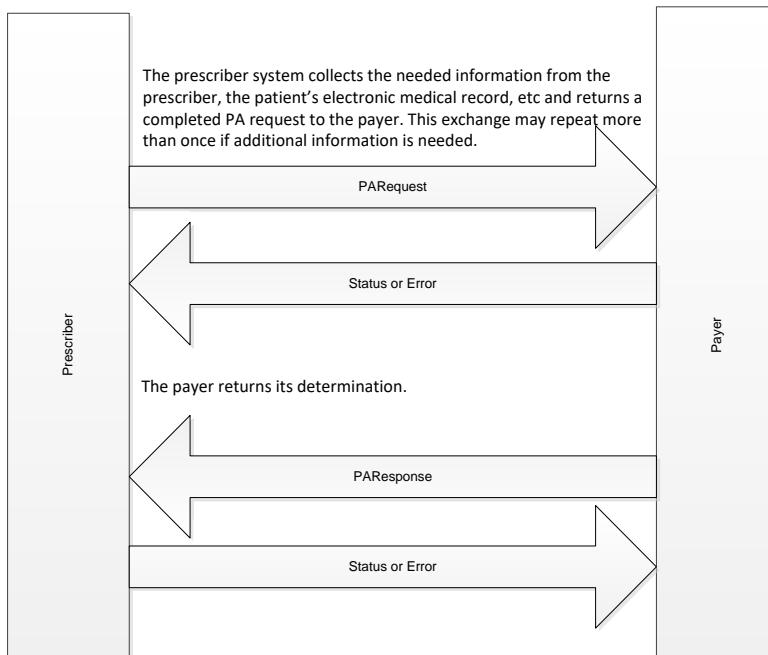
#### 5.19.4.2.2 Unsolicited Model

In the unsolicited model, the prescriber's system maintains the information certain payers require for processing of prior authorization requests, so the needed information can be included with the first prior authorization transaction sent to the payer.

In this model, the prior authorization process starts with the prescriber sending a 'PARequest' transaction to the payer, including the set of information they understand to be needed in processing the request. The 'PAInitiationRequest' and 'PAInitiationResponse' transactions are not exchanged; instead the exchange begins with the 'PARequest' transaction.

The transactions involved include:

- PARequest and PAResponse, which convey the collected information to the payer, and the payer's determination to the prescriber.



**Figure 40 Unsolicited Transaction Flow**

#### **5.19.4.3 Mirror Data from Transaction**

All elements in the body of the transaction sent to initiate the prior authorization process except those noted below are echoed in all subsequent prior authorization transactions in the prior authorization process.

Exceptions:

- <RequestReferenceNumber> is populated when a mailbox is part of the communication process and its value is set according to mailbox processing rules (see the NCPDP XML Standard Implementation Guide).
- When the PAInitiationResponse or PAResponse indicates the receiver is not the prior authorization processor for the patient or medication, the <BenefitsCoordination> may be sent with information about the party that does process prior authorization for the requested patient/medication combination, if known.
- The <ATTACHMENT> element should not be mirrored if submitted in the PAREQUEST or PAAPPEALREQUEST. This allows trading partners to submit relevant supporting documentation only when necessary. If an Attachment is returned this allows the payer to return a different Attachment than the one submitted by the prescriber system.

#### **5.19.5 PA INITIATION REQUEST AND RESPONSE**

The PAInitiationRequest transaction enables the prescriber system to initiate the prior

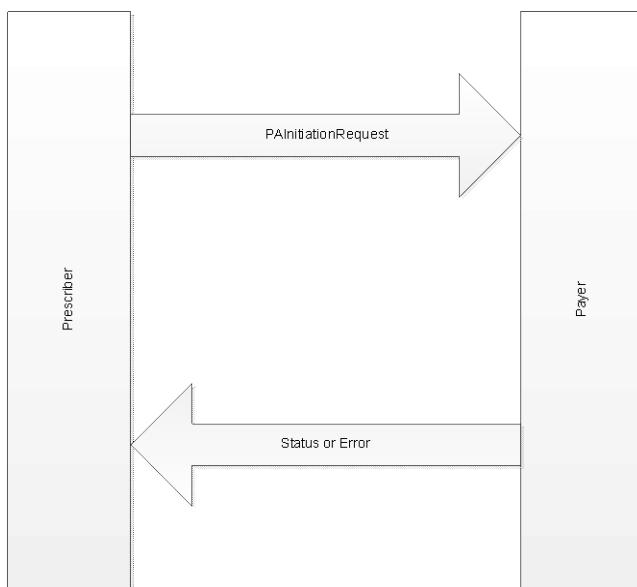
authorization process by notifying the payer of the patient and the medication for which prior authorization is being requested by providing basic request information. This PAInitiationRequest enables the payer to indicate the information needed from the prescriber to support authorization.

The payer may send a PAInitiationResponse transaction without receiving a PAInitiationRequest from the prescriber for renewal of an existing expiring PA. The payer may use this transaction to indicate that prior authorization is not required for the requested medication and patient.

#### **5.19.5.1 *PAInitiationRequest Transaction***

A prescriber system sends the PAInitiationRequest to a payer to request the information required to accompany a PARequest for a particular patient and medication.

The PAInitiationRequest includes the information to identify the patient, prescriber, medication and may also include the patient plan identifiers and the desired dispensing pharmacy.



**Figure 41 PAInitiationRequest Flow**

#### **5.19.5.2 *PAInitiationResponse Transaction***

Either, after receiving the PAInitiationRequest or for existing expiring PA, the payer returns a PAInitiationResponse. As this transaction contains the set of questions which have already been established by the payer for the prior authorization, the PAInitiationResponse should be sent from the payer to the prescriber timely. This will typically contain a set of questions to be completed by the prescriber, or, information that could be obtained from the patient's electronic medical record using coded references and sent in lieu of the prescriber answering one or more questions.

This transaction may indicate that prior authorization is not needed for the patient and medication identified in the initiation request.

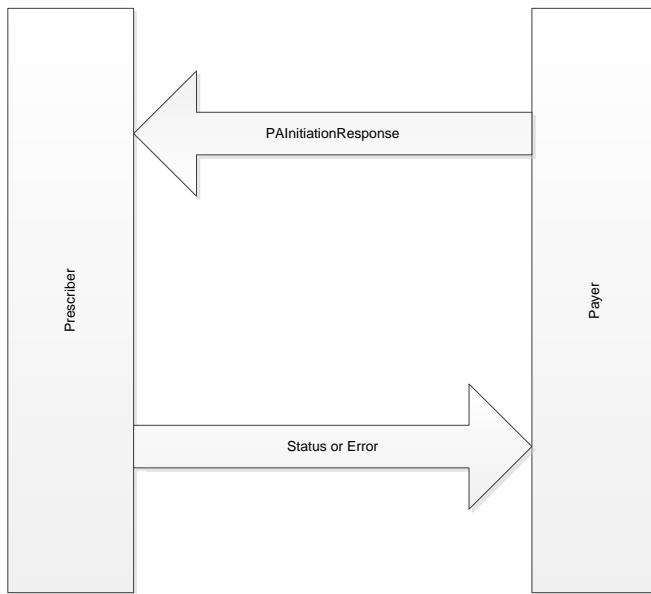


Figure 42 PAInitiationResponse Flow

## Recommendations:

1. It is recommended that the payer communicate the "time to process" a PARequest. This information may be communicated in either:
  - a. The <QuestionSetDescription> element in the PAInitiationResponse transaction. This element is intended to include the information commonly found on prior authorization forms today. This may include the amount of time in which the payer will respond once the prescriber submits the information needed by the prior authorization request.
  - b. The <PANote> field in the PAResponse transaction. If the payer responds with a status of <Open>, the <PANote> field can be used to provide further information regarding the status including time to process the PARequest.
2. It is recommended that the payer use the <AuthorizationNumber>, <AuthorizationDetails>, and <AuthorizationPeriod> fields only in scenarios where the payer is indicating the requested PA has already been adjudicated. For example, if the payer has already approved the PA, in the PAInitiationResponse they would send back a <Closed> response with a <ReasonCode> of "CF" (Prior Authorization duplicate/approved). The payer could then include (optionally) the authorization details for that approved PA.

When providing the question set to the prescriber, the payer must return a <PACaseID> containing a unique identification for the prior authorization case opened based on the PAInitiationRequest. This tracking identifier will be used on other transactions as a unique reference to this prior authorization case. If payer is providing the question set for renewal of an existing expiring PA, the payer shall also return <ExpirngPACaseID> which is the original <PACaseID> and the expiration date of the PA in <ExpirationDate>.

A payer should **not** provide a set of questions to the prescriber for reasons such as:

1. a prior authorization is not required for the particular patient and/or medication, or

2. a current prior authorization for this patient and medication is already on file, or
3. the payer is unable to locate the patient among its members, or
4. the prescriber is not allowed to submit a prior authorization, or
5. the payer is not the PA processor for this member or this combination of member and medication.

When a payer does not return a question set, they indicate the reason for not doing so.

#### **5.19.5.3 Question Set and Coded Reference Support**

The Prior Authorization transactions enable payers to request information in a way that a prescriber system can recognize programmatically - so the prescriber's system can retrieve the requested information from the patient's electronic medical record, rather than making the prescriber enter it manually. The payer makes this request by associating a "coded reference" to a question in the PAInitiationResponse.

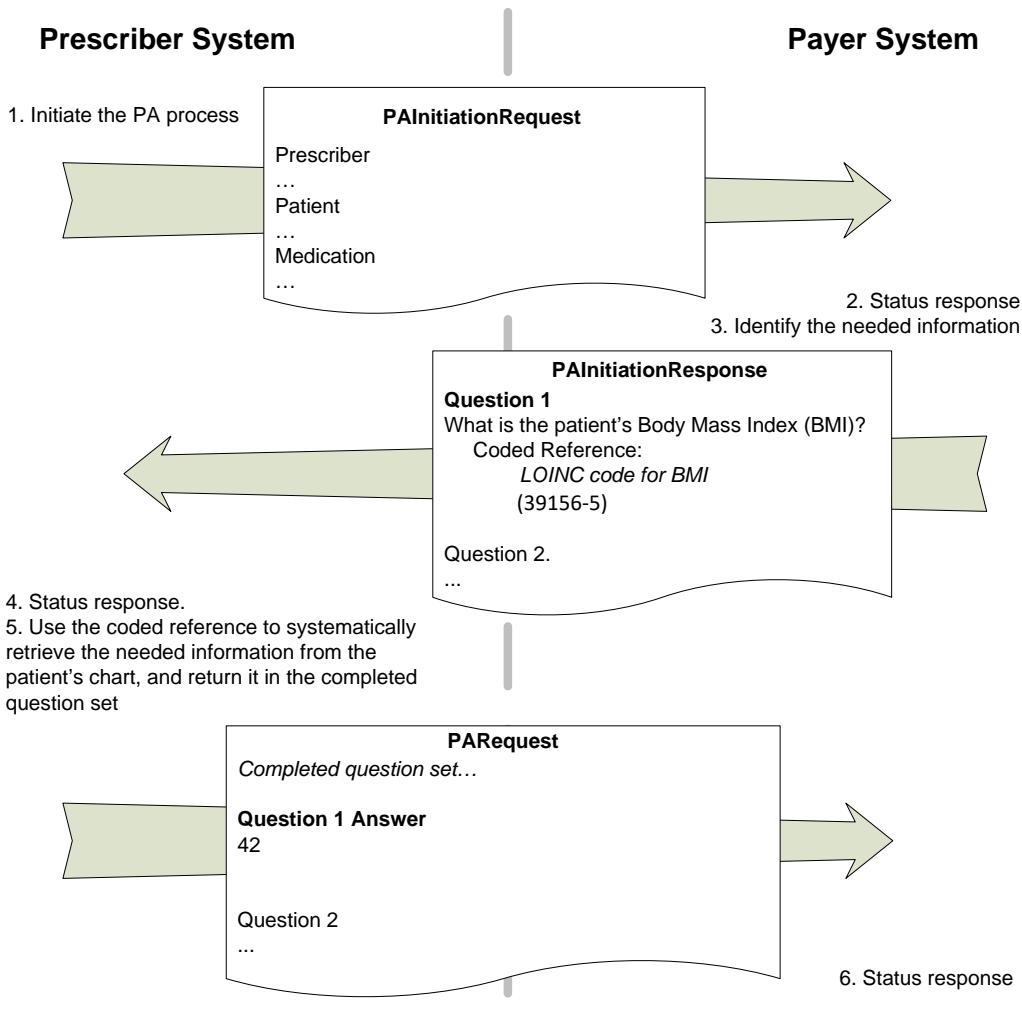
"Coded reference" is a general term representing the use of an industry standard code system, terminology or other standard to describe clinical concepts or other patient information. The prior authorization transactions currently support use of several vocabularies or standards including SNOMED, LOINC, and Clinical Document Architecture (CDA) templates.

In practice, the prior authorization transactions enable multiple coded references to be used to further specify needed information. An example is the combination of a CDA template representing a laboratory result and a LOINC code indicating a particular laboratory test for which the information is desired.

When a payer sends a coded reference for a question, they include it in addition to the question/answer details used if necessary to display question/answers to the prescriber system to answer.

In turn, when the prescriber system receives a question containing a coded reference, it may retrieve the requested information, present it to the prescriber for their review or modification, and place it in the completed question set that it returns in the PARequest transaction.

**Example question/answer workflow using coded references:**



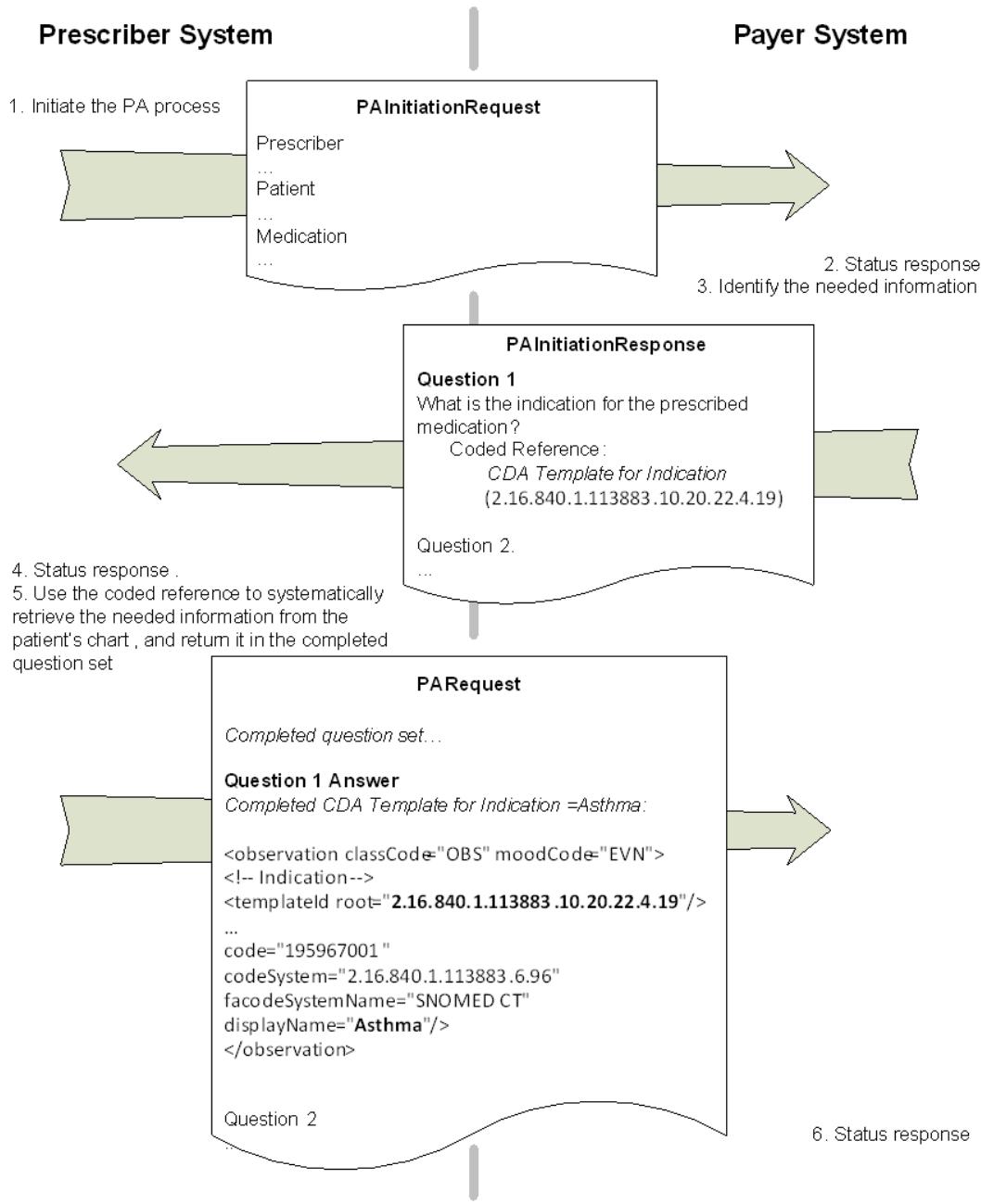
**Figure 43 Example question/answer workflow using coded references**

**Using CDA Templates as coded references**

Using Clinical Document Architecture (CDA) templates as coded references enables the answer and the question to be conveyed in a system-recognizable format. CDA templates identify a wide range of clinical concepts from particular observations to sets of information such as a patient's medication profile or their entire clinical summary. In addition to identifying the needed information, CDA templates also define the system-readable format in which the information is to be exchanged.

The Consolidated CDA implementation guide (CCDA) contains a library of CDA templates. The document level templates define the type of CDA document. CDAs can use an XSL stylesheet to convert it to HTML for display. See HL7 reference in section "[Document Scope](#)".

The example below illustrates a request for patient clinical information using a CDA template:



**Figure 44 Request for patient clinical information using a CDA template**

#### Using multiple terms in a coded reference to refine the request

The PA transactions enable multiple coded references to be used to further specify needed information. An example is the combination of a CDA template representing a laboratory result (2.16.840.1.113883.10.20.24.3.40) and a LOINC indicating a particular laboratory test for which the information is desired (e.g., 57021-8 blood panel).

When multiple terms are included in a coded reference, each additional term further qualifies the concept defined by the earlier term(s). For instance, in the example above, the CDA template identifying a laboratory result is further qualified by the LOINC code indicating the specific test results desired.

#### **Supplying coded references for answers to multiple-choice questions**

The prior authorization transactions enable payers to provide coded references at the choice-level within a multiple-choice question, as well as at the overall question-level.

The example below illustrates a use of this feature.

Question type: Select

Question text: "Select the patient's diagnosis from the options below"

Choice options:

- Asthma (with matching *ICD-10 code*)
- Diabetes (with matching *ICD-10 code*)
- ... other choices

When replying, the prescribing system uses one of the provided ICD-10 codes as its answer in the completed question set.

#### **Attachments**

Attachments are supported both to answer or clarify a specific question, or more than one question. If an attachment is sent to address a specific question, then the <CodedReferenceAnswer><Attachment> element is used. If an attachment will address multiple questions, then <SeeTransactionLevelAttachmentControlNumber> indicates an attachment at the transaction level should be viewed. For example, if one clinical document can be used to answer multiple questions, the document can be sent once and referred to for the multiple answers. It is recommended that both PBMs and vendor systems support at least "PDF" attachment type.

As example, there may be situations where sending one clinical document attachment will answer multiple questions. Instead of sending multiple clinical documents or duplicate sections of a clinical document to answer multiple questions, one clinical document at the transaction level provides efficiencies.

#### **Pilot use**

Use of coded references by pilots/early adopters will identify practical usage conventions and possible refinements to the use of coded references in prior authorization transactions. The transactions are designed to be flexible to enable different approaches to be tested by early adopters, with the expectation that learnings will be introduced into the transactions in the form of additional guidance and, potentially, adjustments to the transactions.

### **5.19.6 PA REQUEST AND RESPONSE TRANSACTIONS**

These transactions enable the prescriber to transmit the requested information to the payer, and the payer to communicate to the prescriber the PA determination. In the solicited model, these are the third and fourth transactions to occur. In the unsolicited model, these are the first and second transactions.

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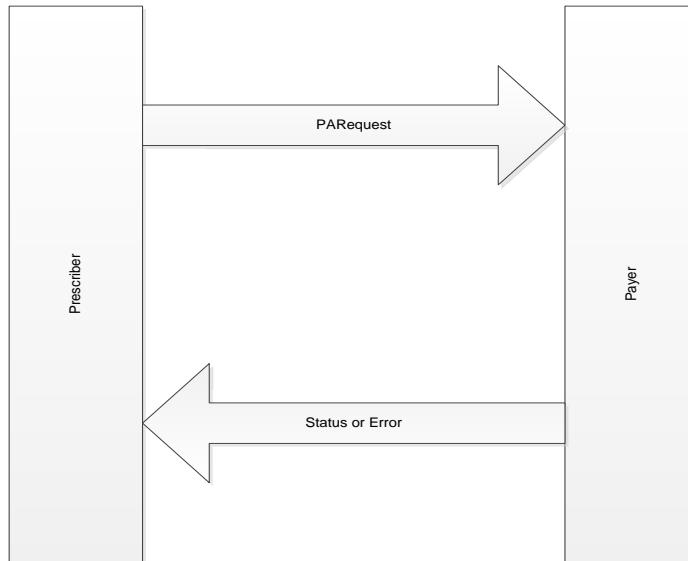
It is anticipated that the PAInitiationResponse from the payer will identify all the information needed from the prescriber system to complete the PA determination, so the determination can be made based on information contained in one exchange of the PA request and response transactions.

However, the PAResponse and Response transactions are built to support multiple exchanges, if additional information is necessary. In response to the initial PAResponse transaction, the payer may request additional information by including a question set in its PAResponse. In turn, the prescriber system will submit another PAResponse containing the additional information, and the payer will respond with a second PAResponse. Further additional sets of PAResponse and Response transactions may be exchanged between the prescriber and payer as needed to gather sufficient information to support the decision process.

The PAResponse transaction may be used to notify the prescriber the request is in process, including either the expected resolution date or a PANote, and they will receive an additional PAResponse with either the final determination or request for additional information in order to make a determination.

#### **5.19.6.1 *PAResponse Transaction***

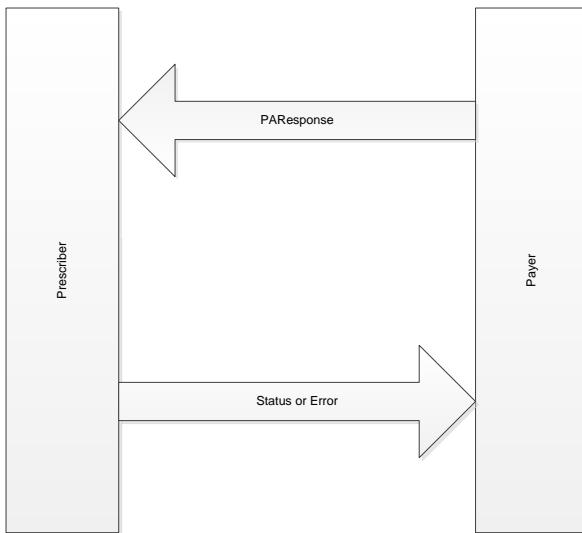
The prescriber sends the PAResponse to a payer with information (answers to question set; responses to coded references, other attached clinical documents) for the payer to make a prior authorization determination (approved, denied, more information required, etc.).



**Figure 45 PAResponse Flow**

#### **5.19.6.2 *PAResponse Transaction***

The payer returns the PAResponse to a prescriber with the status of a PAResponse. The payer may indicate whether the authorization can be granted or not or if more information is required in order to make a determination.



**Figure 46 PAResponse Flow**

#### **5.19.7 PA APPEAL REQUEST AND RESPONSE TRANSACTIONS**

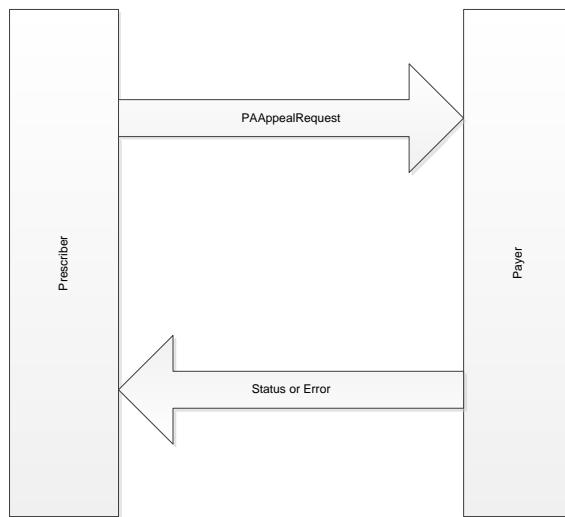
These transactions enable the prescriber to initiate an appeal request for the prior authorization when a payer supports electronic PA appeals. These transactions are used if, based on the information received in the PAResponse, there is an appealable action. The prescriber sends a request to appeal the prior authorization determination. This request may include information to support the appeal. The payer responds either with the information needed for the prior authorization appeal or with the outcome of the appeal.

These transactions are used to exchange prior authorization appeal information. The PAAppealRequest and Response transactions are modeled on the same question set and coded reference foundation as the other prior authorization transactions.

Like the PARequest and Response transactions, additional sets of PAAppealRequest and Response transactions may be exchanged between the prescriber and payer as needed to gather sufficient information to support the decision process.

#### **5.19.7.1 PAAppealRequest Transaction**

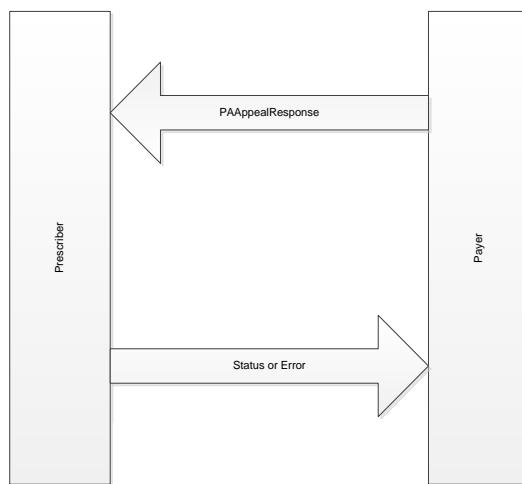
The prescriber sends the PAAppealRequest to a payer to appeal a prior authorization determination.



**Figure 47 PAAppealRequest Flow**

#### **5.19.7.2 PAAppealResponse Transaction**

The payer returns the PAAppealResponse determination to a prescriber based on a PAAppealRequest.



**Figure 48 PAAppealResponse Flow**

### **5.19.8 PA CANCEL REQUEST AND RESPONSE TRANSACTIONS**

These transactions enable the prescriber to cancel a PA notifying the payer that prior authorization is no longer needed. This can be used in cases such as when the prescriber prescribes an alternative or makes a change such as quantity to the initially requested medication.

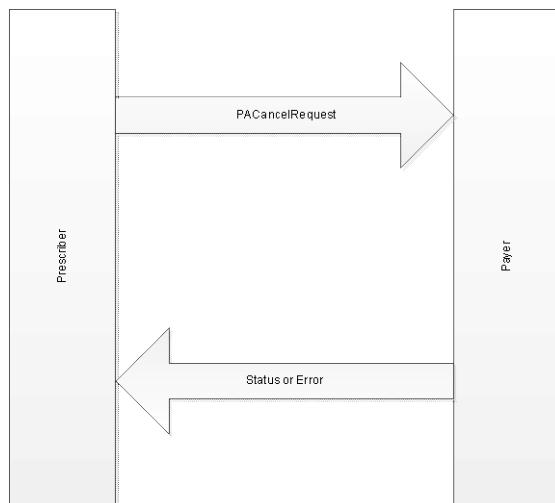
Note the prior authorization cancel transactions require the use of the <PACaseID> to identify the prior authorization to be cancelled when the <PACaseID> has been assigned by the payer. The intent of the transactions to cancel a request for which the payer has already assigned a <PACaseID> (in a PAInitiationResponse or PAREsponse transaction), and is awaiting the prescriber's reply.

If the prescriber wants to modify details such as quantity or days supply for which a PAInitiationResponse or PAREsponse has been received, a PACancelRequest should be sent to cancel the initial <PACaseID> prior to sending a new PAInitiationRequest. Logic to detect duplicates differ from payer to payer (or from line of business). If the initial <PACaseID> is not cancelled, the new PAInitiationRequest may be identified as a duplicate.

**The prior authorization cancel transactions are not used to cancel a new prescription sent to a pharmacy. The CancelRx transaction is used by the prescriber to notify the pharmacy to cancel the new prescription if appropriate.**

#### **5.19.8.1 *PACancelRequest Transaction***

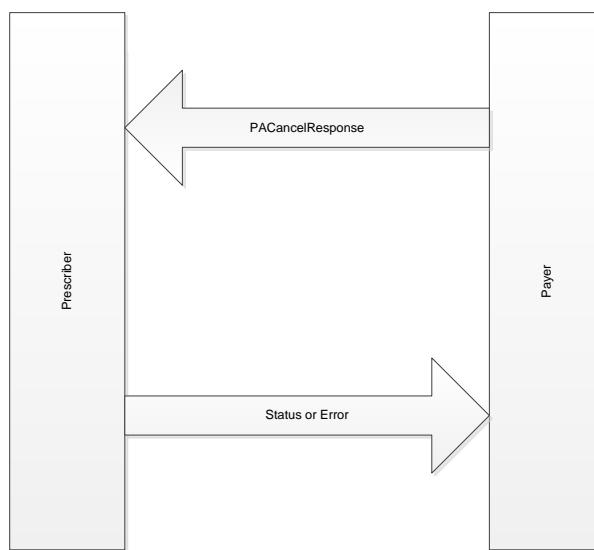
The prescriber sends the PACancelRequest to a payer to cancel a PAInitiationRequest (that has been assigned a <PACaseID>), PAREquest or PAAppealRequest. The prescriber may include a <CancelReasonCode> and indicate the patient has been notified in <IsPatientNotified>.



**Figure 49 PACancelRequest Flow**

### 5.19.8.2 **PACancelResponse Transaction**

The payer sends the PACancelResponse to a prescriber to indicate whether the PAInitiationRequest, PARequest or PAAppealRequest was canceled.



**Figure 50 PACancelResponse Flow**

## 5.20 PRESCRIPTION TRANSFER TRANSACTIONS INTRODUCTION

RxTransferRequest is used when the pharmacy is asking for a transfer of one or more prescriptions for a specific patient. The patient may request the transfer in a variety of ways (in person, online, telephone, etc.) How the patient requests the transfer does not impact the use of the prescription transfer transactions. RxTransferResponse is the response from the RxTransferRequest to complete the transfer. RxTransferConfirm is used by the pharmacy receiving (originally requesting) the transfer to confirm the transfer prescription has been received and the transfer is complete.

### 5.20.1 IN SCOPE

1. Each prescription will be filled when the patient requests. There is no assumption the prescription is to be filled when it is transferred. The patient may choose different dispensing timeframes.
2. The transfer is for a fillable prescription which may be:
  - Yet to be filled
  - On hold
  - Open (active) fills
  - “Current therapy”
    - Current therapy is defined as drug therapy that, based upon the most recent fill date, quantity and instructions, should still be active. For system purposes, the days’ supply is an adequate surrogate for instructions.
3. Only prescriptions that are allowed to be transferred by law/regulation. Such as
  - Single prescription transfer restriction according to law/regulation

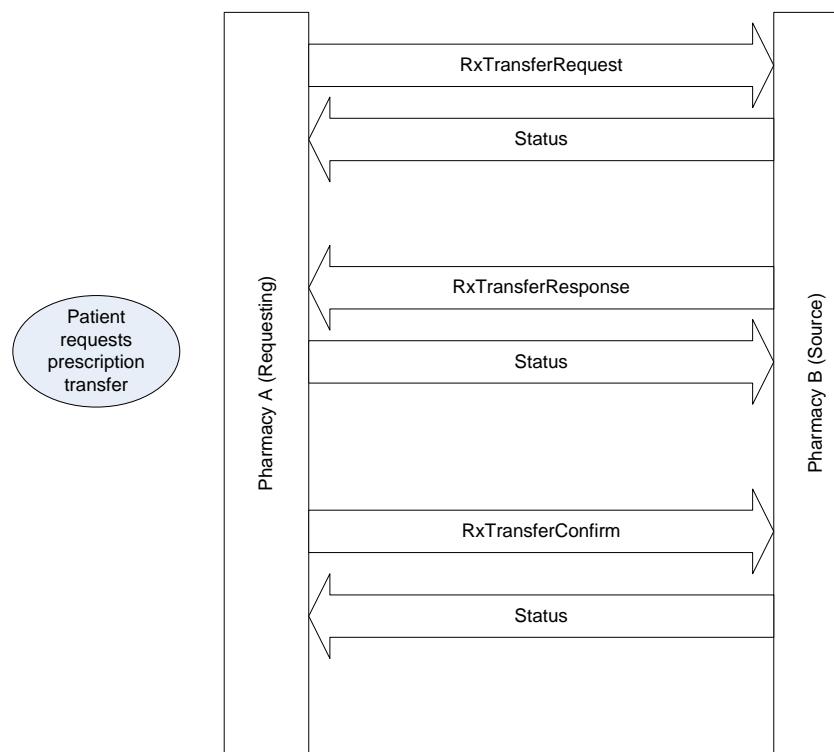
- Only transfer the prescription in full once (e.g. controlled substance)
  - One refill at a time
4. It is assumed that Pharmacy A (requesting pharmacy) needs directory information to obtain identifiers, routing information, etc. for Pharmacy B (source).
  5. Inter-organization or intra-organization transfers are in scope, depending on business need. The transactions can be used for intra-organization, but are not required.

### **5.20.2 OUT OF SCOPE**

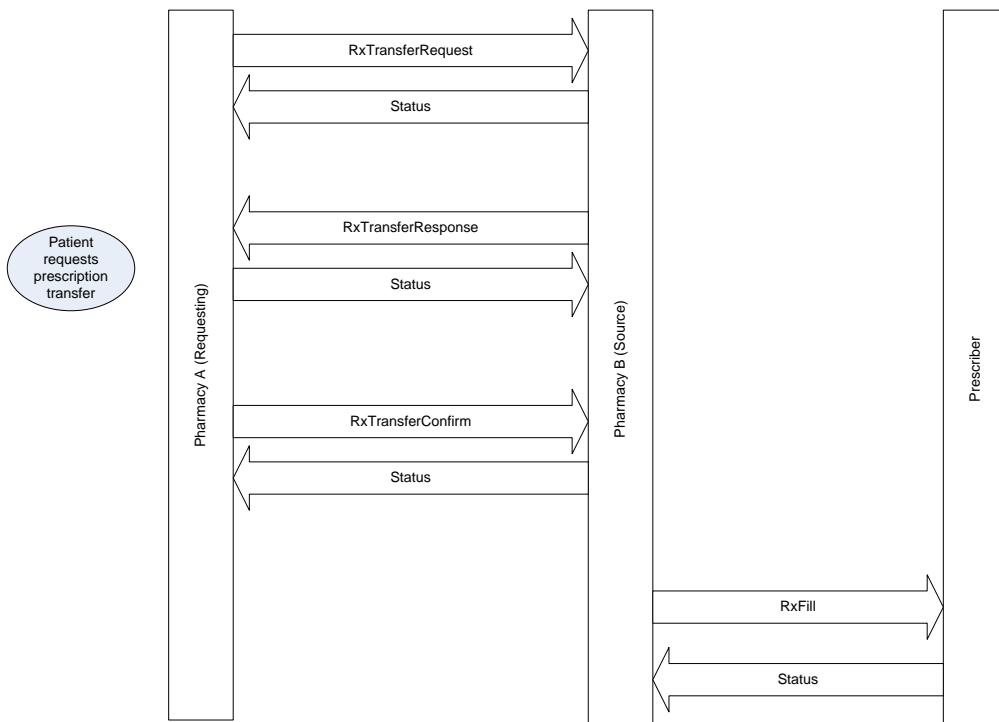
The following are considered out of scope:

1. A transfer will not take place for a prescription with no refills left, except for current therapy. Because there are no refills left, the information exchanged is only informational.
2. Expired prescriptions or those that have exceeded the stop date, except for current therapy. Because the prescription is expired or exceeded the stop date, the information exchanged is only informational.
3. Compounds.
4. Bulk transfers/transferring liability/etc. (See NCPDP **Prescription Transfer Standard Implementation Guide**.)
5. Medication history is a different transaction for a different business purpose (note Medication History can be sent from pharmacy to pharmacy.) See sections in this guide.
6. How the “transfer to pharmacy” processes the prescription(s) transferred.
7. How the patient initiates the request for transfer.
  - Patient contacts the pharmacy via
    - Phone
    - Website
    - Sends bar code(s) to pharmacy
    - Etc.
8. Connectivity and security between pharmacies (transport).
9. From discussions, long term care transfers from facility to facility were deemed out of scope. When a patient moves from one facility to another the original facility discontinues the orders and the new facility is required to obtain a new order from the prescriber. A long term care transfer from a retail pharmacy is not considered a transfer as the prescriber generates a new prescription.

### **5.20.3 TRANSACTION FLOW**



**Figure 51 Flow for a successful RxTransferRequest and Response, with RxTransferConfirm.**



**Figure 52 Flow for a successful RxTransferRequest and Response, with RxTransferConfirm. Followed with RxFill.**

If the transfer cannot be completed electronically, a manual process should be used (whatever is currently in place today at the pharmacy).

If there is a need to send patient general information (allergies, conditions) that are not related to a prescription, the ClinicalInformation transactions should be used. See the NCPDP **Specialized Implementation Guide**.

Sharing of notes – notes based on the prescription can be shared between pharmacies if they are part of healthcare treatment, payment or healthcare operations. Notes can be shared if they are part of patient therapy. Professional judgment should be used on what needs to be shared about the patient and/or prescription.

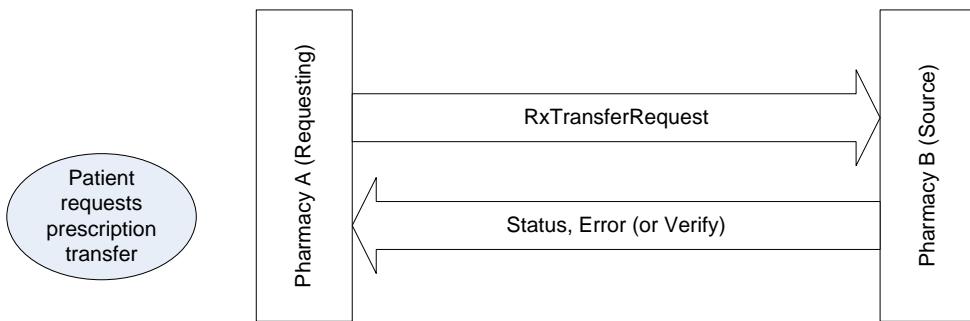
Attachments are supported in prescription transfers. The sender sends the type of attachment they have and the receiver upon interrogation of the transaction will determine if they support the attachment sent. If not, the attachment should be noted to the user that information could not be displayed/rendered. The attachment would be ignored however it is not recommended.

See sections "[Prescription Transfer Medication Elements and Refill Elements](#)" and "[Specific RxTransfer Element Discussion](#)".

For information on Status, Error and GetMessage transactions, see the NCPDP **XML Standard**.

#### **5.20.4 PRESCRIPTION TRANSFER REQUEST TRANSACTION**

The prescription transfer request transaction is used when one pharmacy is asking another pharmacy for a transfer of one or more prescriptions for a specific patient. The element <TransferRequest> is used to specify "ALL" (all prescriptions) or "SPECIFIC" (specific prescriptions). If multiple "SPECIFIC" prescriptions are to be transferred, but not "ALL" prescriptions, a separate RxTransferRequest must be sent for each specific prescription.



**Figure 53 Prescription Transfer Request Flow**

##### **5.20.4.1 Which Prescription(s) to Transfer?**

###### **5.20.4.1.1 Individual Prescription**

Key to the transfer is the prescription number for the transfer. The prescription number and pertinent information may be obtained via:

- Conversation with the patient

- The patient's profile
  - A Medication History transaction may be used to retrieve a current medication list
  - Conversation with the transferring pharmacy (source pharmacy/Pharmacy B)
  - Conversation with the prescriber
1. Patient has the prescription container/label
    - a. The pertinent information is available, including the prescription number.
  2. The patient doesn't have the container/label but knows the drug name and wishes to transfer to a pharmacy within a chain/organization
    - a. Pharmacist has conversation with patient and is able to retrieve prescription from the chain/organization profile.
    - b. The prescription number is then known.
  3. The patient doesn't have the container/label but knows the drug name and wishes to transfer to a pharmacy **not within** same chain/organization
    - a. A Medication History transaction may be used to retrieve a current medication list.
    - b. Pharmacist has conversation with patient and is able to ascertain prescription.
    - c. The prescription number is then known.
  4. The patient doesn't have the container/label and does not know the drug name
    - a. A Medication History transaction may be used to retrieve a current medication list.
    - b. Pharmacist has conversation with patient and is able to ascertain prescription.
    - c. The prescription number is then known.

If the prescription number is not available,

If the pharmacy knows the specific drug that is being requested on behalf of the patient it can be specified as follows:

- <DrugDescription> contains the Name, Strength, Form of the drug being requested
- <DrugCoded> sub-elements to correspond if known
  - <ProductCode>, <Strength>, <DrugDBCode> specifics

If the pharmacy does not know the specific drug being requested on behalf of the patient but knows the specific class or category of drug (e.g. a statin, an ACE inhibitor), it can be specified as follows:

- <DrugDescription> contains a description of the class/category of drug being requested
- <DrugDBCode><Qualifier> value "AF" to indicate an American Hospital Formulary Service (AHFS) code to indicate the class of drug being requested
- <DrugDBCode><Code> ID contains the AHFS code of the class of drug being requested

If the pharmacy does not know the specific drug being requested or the specific class or category of drug on behalf of the patient, but knows what the drug is being used to treat (e.g. hypertension, asthma medicine), it can be specified as follows:

- <DrugDescription> contains a description of the type of drug being requested
- <Diagnosis><Primary><Value> contains the ICD code value associated with the condition

#### **5.20.4.1.2 All Prescriptions**

Interrogation of the specific medication is necessary. See section "*In Scope*" for which prescriptions would be provided.

### **5.20.5 PRESCRIPTION TRANSFER RESPONSE TRANSACTION**

The prescription transfer response is the response from the prescription transfer request to complete the transfer.

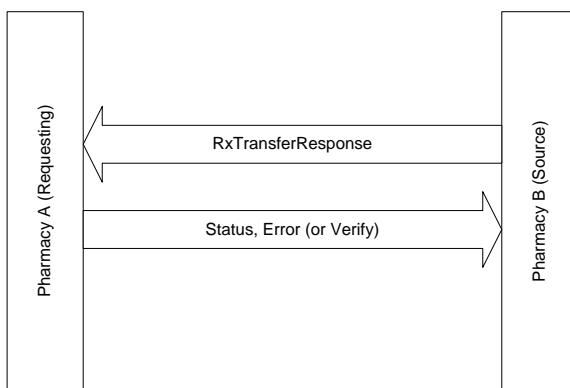
The prescription transfer confirm transaction is used by the pharmacy receiving (originally requesting) the transfer to confirm that the transferred prescription has been received and the transfer is complete.

Pharmacy A sends Pharmacy B the <RxReferenceNumber> that Pharmacy A has now assigned to the transferred prescriptions.

This transaction also relays if the pharmacist that originally requested the transfer and the pharmacist that actually sent the transfer transaction are different. There may be a time lapse of hours or days between the request and response. There is a need to insure that the pharmacist handling the response (i.e. completing the transfer) is provided to transferring pharmacy.

When transferring multiple prescriptions at one time, there is one pharmacist for the entire transfer (for example if 8 prescriptions were transferred, just one <Pharmacist> is sent.)

If the REMS Administrator has provided authorization to the prescriber-submitted REMSRequest with an authorization, this can be placed in the <REMSAuthorizationNumber> on the RxTransferResponse. <PrescriberCheckedREMS> identifies if the prescribing system has performed an inquiry to the REMS Administrator in order to verify the REMS component of the prescription.



**Figure 54 Prescription Transfer Response Flow**

For information on Status, Error and GetMessage transactions, see the NCPDP **XML Standard**.

#### **5.20.5.1 Prescription Transfer and Fill Status Notification**

See section "[Prescription Fill Status Notification Transaction](#)" for background information.

When the RxTransfer transactions were being developed, there were gaps identified in the

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different support of the RxFill transactions by the electronic prescribing stakeholders. After much evaluation, it was decided that the *transferring pharmacy* has the initial relationship with the prescriber system for a given prescription. The *transferring pharmacy* can therefore relay information to the prescriber system concerning any further RxFill exchanges. If the *transfer to* pharmacy does not support the RxFill transaction, the prescriber system may never know why RxFill transactions are not being received for this prescription. Directory services were recommended to fill in gaps. However it was felt that the *transferring pharmacy* could inform the prescriber system of the *transfer to* pharmacy's inability to support RxFill transactions based upon information provided in the RxTransferConfirm transaction using the value in the <RxFillConfirmIndicator>. The prescriber system is made aware that no (or no more) RxFill transactions will be received on this prescription from the *transfer to* pharmacy.

Scenario: Prescriber sends an electronic prescription (NewRx) with <RxFillIndicator> value of "ALL FILL STATUSES" or "NOT DISPENSED AND TRANSFERRED". The prescription is then electronically transferred and the <RxFillIndicator> is included on the RxTransferResponse for the *transfer to* pharmacy's benefit. However, in this scenario, the *transfer to* pharmacy (Pharmacy A in above figures) does not support RxFill transaction functionality.

The RxFill transaction will be sent by Pharmacy B to notify the prescriber that the dispensing pharmacy has changed, who the new dispensing pharmacy is, and the fill status. The RxFill 'Transferred' transaction will provide all of the information except if the receiving pharmacy supports RxFill. (A directory would need to provide this information.) RxFill support notification will be provided as part of the prescription transfer process.

Pharmacy B informs the prescriber system of Pharmacy A's inability to support RxFill transactions based upon information provided in the RxTransferConfirm transaction, specifically the value in the <RxFillConfirmIndicator>. The prescriber/vendor is aware that no (or no more) RxFill transactions will be received on this prescription from the *transfer to* Pharmacy A.

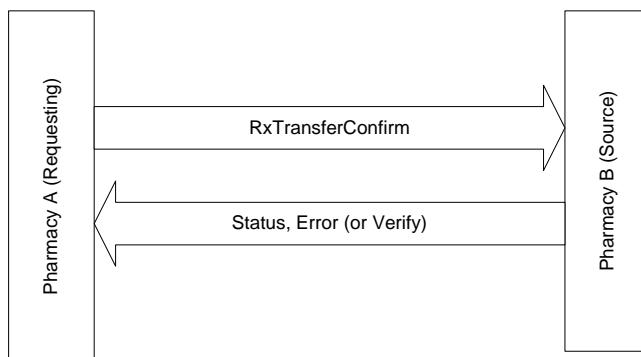
#### **5.20.6 PRESCRIPTION TRANSFER CONFIRM TRANSACTION**

The prescription transfer confirm transaction is used by the pharmacy receiving (originally requesting) the transfer to confirm that the transferred prescription has been received and the transfer is complete.

Pharmacy A sends Pharmacy B the <RxReferenceNumber> that Pharmacy A has now assigned to the transferred prescriptions.

This transaction also relays if the pharmacist that originally requested the transfer and the pharmacist that actually sent the transfer transaction are different. There may be a time lapse of hours or days between the request and response. There is a need to insure that the pharmacist handling the response (i.e. completing the transfer) is provided to transferring pharmacy.

When transferring multiple prescriptions at one time, there is one pharmacist for the entire transfer (for example if 8 prescriptions were transferred, just one <Pharmacist> is sent.)

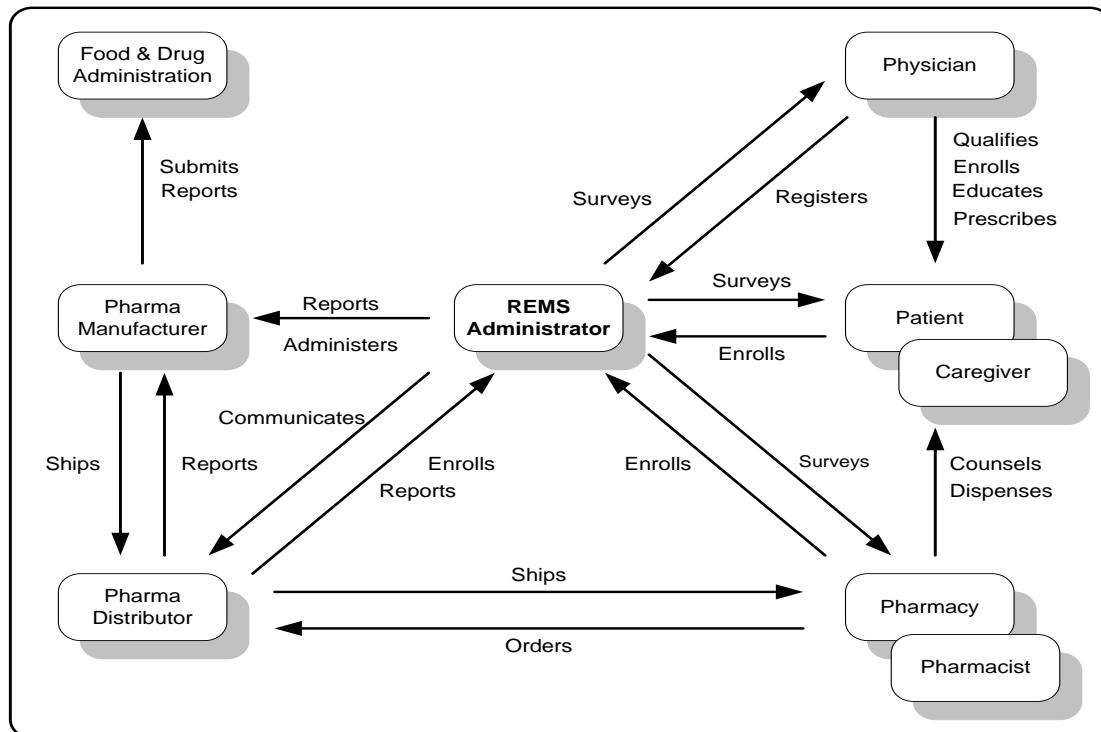


**Figure 55 Prescription Transfer Confirmation Flow**

For information on Status, Error and GetMessage transactions, see the NCPDP **XML Standard**.

## 5.21 REMS INTRODUCTION

REMS transactions are used for REMS validation. The transactions are built to be used by the prescribing system but further discussion will refer to the prescribing system. Future enhancements to this standard may include the exchange of information regarding voided prescriptions by the prescriber and pharmacy confirmation or voiding of a dispensing. Refer to the NCPDP **Telecommunication Standard vE.3** for the claims adjudication process which incorporates the REMS validation used in the dispensing processes.



**Figure 56 Sample REMS Model for Medications Dispensed by Pharmacies**

The NCPDP REMS transactions are exchanged as other SCRIPT Standard transactions, in a real-time request and response mode. (Mailboxing may be used.)

While the NCPDP REMS transactions enable a standard *means for communicating* each REMS Administrator's set of questions, it does not *standardize the questions* themselves nor does it specify *how* the questions are presented to the prescriber.

The REMS transactions:

- Provide a fully electronic means for determining whether REMS is required for a particular medication and particular patient.
- Present REMS information to the prescriber in a consistent format while enabling each REMS Administrator to request the particular information it requires.

Note: for the purposes of the REMS discussion, the term "prescriber system" refers to the system used by the prescriber or by a representative of the prescriber - which might be an electronic prescribing system, a provider portal or an affiliated provider's facility, etc.

It is recognized that the prescriber system may send the REMS verification directly to a REMS Administrator. However based on current exchanges the prescriber system would more likely use an intermediary rather than maintaining individual connections with each REMS Administrator.

A less optimal, but possible flow is where the prescriber does not obtain REMS approval and the NewRx transaction is sent to the pharmacy without any REMS identification of approval. The pharmacy (or the intermediary on behalf of the pharmacy) must then perform the REMS verification before billing the new prescription via the NCPDP **Telecommunication Standard**.

A derivation of this less optimal flow is where a paper or fax prescription is presented at the pharmacy without any REMS identification of approval. The pharmacy must then perform the REMS verification before processing the new prescription.

Note that attachments should only be sent when needed to fulfill REMS requirements. Sending attachments when not necessary may result in an interruption of the electronic process (e.g. manual review) by the REMS Administrator which may cause a possible delay in the REMS determination.

When the REMSInitiationResponse or REMSResponse reason status is "Closed" and the <ReasonCode> is Other (BY), the REMS Administrator should populate the <REMSNote> with the reason why the request was closed.

### **5.21.1 REMS WITHIN THE ELECTRONIC PRESCRIBING WORKFLOW**

The REMS transactions are designed to support the exchange of information obtained from the electronic health record system. The transactions allow for the use of coded references, increasing the opportunity for interoperability.

The REMS transactions are not dependent on a particular workflow. There are two possible REMS transaction flows: solicited and unsolicited. In the solicited model, the prescriber will notify the REMS Administrator to initiate the REMS process to determine if an authorization is needed for their patient and desired medication. In the unsolicited model, the prescriber presumes that an authorization is needed and they will submit the information they anticipate the REMS Administrator needs.

### **5.21.2 REMS TRANSACTIONS**

This implementation guide supports

- REMSInitiationRequest and REMSInitiationResponse
- REMSRequest and REMSResponse

Each transaction supports a particular step in the REMS process:

- The REMSInitiationRequest transaction is used by the prescriber to initiate the REMS process, by notifying the REMS Administrator of the patient and the medication for which REMS authorization is being requested, along with the prescriber's information and other related details.
  - In the REMSInitiationResponse transaction, the REMS Administrator indicates the information needed from the prescriber to determine approval or denial of the authorization. In some cases, the REMS Administrator indicates to the prescriber that REMS authorization is not required for the requested medication and patient. The REMSInitiationResponse is for the medication (name, strength, dosage form) indicated in the REMSInitiationRequest. The REMS Administrator should not respond for an equivalent to the medication (e.g., generic product equivalent to brand product) indicated in the REMSInitiationRequest.
- The prescriber system gathers the requested information by presenting questions for the prescriber to answer and/or by extracting information from the patient's electronic medical record using the coded references associated to the question. The information is sent to the REMS Administrator in the REMSRequest transaction. This occurs in both the solicited and unsolicited models.
  - The REMS Administrator determines whether authorization can be granted and provides the determination to the prescriber in the REMSResponse transaction. In some cases the REMSResponse transaction may indicate the REMS Administrator needs additional information in order to make a determination.

#### **5.21.2.1 Mirror Data from Request**

All elements in the body of the transaction sent to initiate the REMS process (REMSInitiationRequest; REMSRequest) except those noted below are echoed in the response transaction (REMSInitiationResponse ; REMSResponse) and all subsequent REMS transactions in the REMS process.

Exceptions:

- <RequestReferenceNumber> is populated when a mailbox is part of the communication process and its value is set according to mailbox processing rules (see the NCPDP **XML Standard Implementation Guide**).

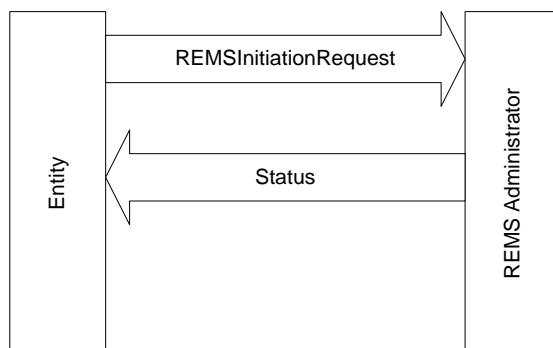
### **5.21.3 REMS INITIATION REQUEST AND RESPONSE TRANSACTIONS**

These transactions enable the prescriber system to initiate the REMS process by notifying the REMS Administrator of the patient and the medication for which REMS is being requested and providing basic request information. This initial request enables the REMS Administrator to indicate the information needed from the prescriber to support authorization. The REMS Administrator may use the response to indicate REMS authorization is not required for the requested medication and patient.

#### **5.21.3.1 REMSInitiationRequest Transaction**

A prescriber system sends the REMSInitiationRequest to a REMS Administrator to request the information required to accompany a REMSRequest for a particular patient and medication.

The REMSInitiationRequest includes the information to identify the patient, prescriber, medication and may also include the desired dispensing pharmacy.

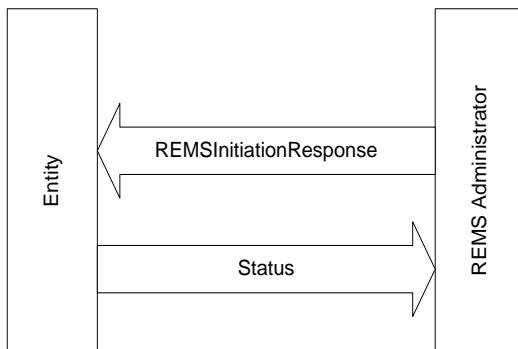


**Figure 57 REMSInitiationRequest Flow**

#### **5.21.3.2 REMSInitiationResponse Transaction**

After receiving the REMSInitiationRequest, the REMS Administrator returns a REMSInitiationResponse. As this transaction contains the set of questions which have already been established by the REMS Administrator for the REMS, the REMSInitiationResponse should be sent from the REMS Administrator to the prescriber timely. This will typically contain a set of questions to be completed by the prescriber, or, information that could be obtained from the patient's electronic medical record using coded references and sent in lieu of the prescriber answering one or more questions.

This transaction may indicate that REMS is not needed for the patient and medication identified in the initiation request.



**Figure 58 REMSInitiationResponse Flow**

Recommendations:

1. The REMS Administrator should communicate the "time to process" a REMSRequest. This information may be communicated in either:
  - a. The <QuestionSetDescription> element in the REMSInitiationResponse transaction. This element is intended to include the information commonly found on REMS forms today. This may include the amount of time in which the REMS Administrator will respond once the prescriber submits the information needed by the REMS request.
  - b. The <REMSNote> field in the REMSResponse transaction. If the REMS Administrator responds with a status of <Open>, the <REMSNote> field can be used to provide further information regarding the status including time to process the REMSRequest.

When providing the question set to the prescriber, the REMS Administrator must return a <REMSCaseID> containing a unique identification for the REMS case opened based on the REMSInitiationRequest. This tracking identifier will be used on other transactions as a unique reference to this REMS case.

A REMS Administrator should **not** provide a set of questions to the prescriber for reasons such as:

- a REMS is not required for the particular patient and/or medication, or
- a current REMS for this patient and medication is already on file, or
- the REMS Administrator is unable to locate the patient among its members, or
- the prescriber is not allowed to submit a REMS, or
- the REMS Administrator is not the REMS Administrator for this member or this combination of member and medication.

When a REMS Administrator does not return a question set, they indicate the reason for not doing so.

#### **5.21.3.3 Question Set and Coded Reference Support**

The REMS transactions enable prescribers to request information in a way that a prescriber system can recognize programmatically - so the prescriber's system can retrieve the requested information from the patient's electronic medical record, rather than making the prescriber enter it manually. The REMS Administrator makes this request by associating a "coded

reference” to a question in the REMSInitiationResponse.

“Coded reference” is a general term representing the use of an industry standard code system, terminology or other standard to describe clinical concepts or other patient information. The prior authorization transactions currently support use of several vocabularies or standards including SNOMED, LOINC, and Clinical Document Architecture (CDA) templates.

In practice, the REMS transactions enable multiple coded references to be used to further specify needed information. An example is the combination of a CDA template representing a laboratory result and a LOINC code indicating a particular laboratory test for which the information is desired.

When a REMS Administrator sends a coded reference for a question, they include it in addition to the question/answer details used if necessary to display question/answers to the prescriber system to answer.

In turn, when the prescriber system receives a question containing a coded reference, it may retrieve the requested information, present it to the prescriber for their review or modification, and place it in the completed question set that it returns in the REMSRequest transaction.

#### **Using CDA Templates as coded references**

Using Clinical Document Architecture (CDA) templates as coded references enables the answer and the question to be conveyed in a system-recognizable format. CDA templates identify a wide range of clinical concepts from particular observations to sets of information such as a patient’s medication profile or their entire clinical summary. In addition to identifying the needed information, CDA templates also define the system-readable format in which the information is to be exchanged.

The Consolidated CDA implementation guide (CCDA) contains a library of CDA templates. The document level templates define the type of CDA document. CDAs can use an XSL stylesheet to convert it to HTML for display. See HL7 reference in section “Document Scope”.

#### **Using multiple terms in a coded reference to refine the request**

The REMS transactions enable multiple coded references to be used to further specify needed information. An example is the combination of a CDA template representing a laboratory result (2.16.840.1.113883.10.20.24.3.40) and a LOINC code indicating a particular laboratory test for which the information is desired (e.g., 57021-8 blood panel).

When multiple terms are included in a coded reference, each additional term further qualifies the concept defined by the earlier term(s). For instance, in the example above, the CDA template identifying a laboratory result is further qualified by the LOINC code indicating the specific test results desired.

#### **Supplying coded references for answers to multiple-choice questions**

The REMS transactions enable the REMS Administrator to provide coded references at the choice-level within a multiple-choice question, as well as at the overall question-level.

The example below illustrates a use of this feature.

Question type: Select

Question text: "Select the patient's diagnosis from the options below"

Choice options:

- Asthma (with matching *ICD-10 code*)
- Diabetes (with matching *ICD-10 code*)
- ... other choices

When replying, the prescribing system uses one of the provided ICD-10 codes as its answer in the completed question set.

### **Attachments**

Attachments are supported both to answer or clarify a specific question, or more than one question. If an attachment is sent to address a specific question, then the <CodedReferenceAnswer><Attachment> element is used. If an attachment will address multiple questions, then <SeeTransactionLevelAttachmentControlNumber> indicates an attachment at the transaction level should be viewed. For example, if one clinical document can be used to answer multiple questions, the document can be sent once and referred to for the multiple answers.

As example, there may be situations where sending one clinical document attachment will answer multiple questions. Instead of sending multiple clinical documents or duplicate sections of a clinical document to answer multiple questions, one clinical document at the transaction level provides efficiencies.

### **Pilot use**

Use of coded references by pilots/early adopters will identify practical usage conventions and possible refinements to the use of coded references in REMS transactions. The transactions are designed to be flexible to enable different approaches to be tested by early adopters, with the expectation that learnings will be introduced into the transactions in the form of additional guidance and, potentially, adjustments to the transactions.

#### **5.21.4 REMS REQUEST AND RESPONSE TRANSACTIONS**

These transactions enable the prescriber to transmit the requested information to the REMS Administrator, and the REMS Administrator to communicate to the prescriber the REMS determination.

It is anticipated the REMSInitiationResponse from the REMS Administrator will identify all the information needed from the prescriber system to complete the REMS determination, so the determination can be made based on information contained in one exchange of the REMS request and response transactions.

However, the REMSRequest and Response transactions are built to support multiple exchanges, if additional information is necessary. In response to the initial REMSRequest transaction, the REMS Administrator may request additional information by including a question set in its REMSResponse. In turn, the prescriber system will submit another REMSRequest containing the

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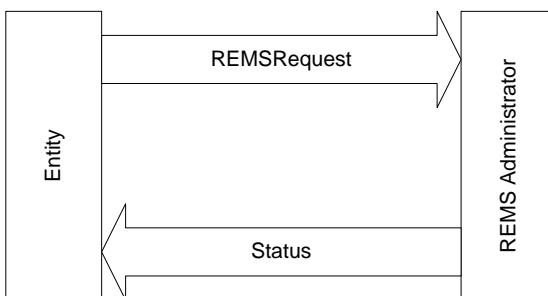
additional information, and the REMS Administrator will respond with a second REMSResponse. Further additional sets of REMSRequest and Response transactions may be exchanged between the prescriber and REMS Administrator as needed to gather sufficient information to support the decision process.

#### **5.21.4.1 REMSRequest Transaction**

The prescriber sends the REMSRequest to a REMS Administrator with information (answers to question set; responses to coded references, other attached clinical documents) for the REMS Administrator to make a determination (approved, denied, more information required, etc.).

Assumptions:

1. For the processes to work effectively, the REMS Administrator must be able to respond that for a given program safe use conditions are in place in one real-time transaction response.
2. Efficient workflow requires the pharmacy, the prescriber, and the intermediary to recognize medications requiring REMS verification. It is hoped that manufacturers and/or the Food and Drug Administration (FDA) will provide this information via the Structured Product Label (SPL). The SPL can then either be incorporated in a drug knowledge base or a separate file that will provide a trigger to the system.
3. It is anticipated the REMSInitiationResponse from the REMS Administrator will identify all the information needed from the prescriber system to complete the REMS determination, so the determination can be made based on information contained in one exchange of the REMS request and response transactions.
4. The NewRx would not be transmitted to the pharmacy if a denial is received.



**Figure 59 REMSRequest Flow**

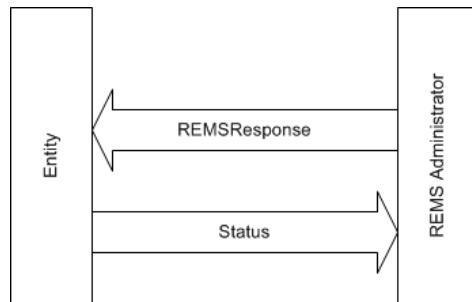
For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.

#### **5.21.4.2 REMSResponse Transaction**

The REMSResponse provides the mechanism for the REMS Administrator to relay approval or denial of the medication, patient, prescriber, and/or pharmacy for the designated REMS program, or if more information is needed.

Response is used to denote <Approved> or <Denied> by the REMS Administrator.

For information on <ReturnReceipt> functionality, see section “*Verify Transaction*” in the NCPDP **XML Standard**. For information on Status, Error and GetMessage transactions, see this same document.



**Figure 60 REMSRequest Flow**

## **6. GENERAL STRUCTURAL OVERVIEW**

For the purpose of this implementation guide, only one Transaction per Transmission is suggested.

See NCPDP **XML Standard** section “*Standard Conventions*”.

## 7. STRUCTURE QUICK REFERENCE

See NCPDP **XML Standard** for more information on the Status, Error, and Verify transactions. See this document for information on the Message, Header, and Body that encompass transactions.

### 7.1 ELEMENT USAGE IN EACH TRANSACTION

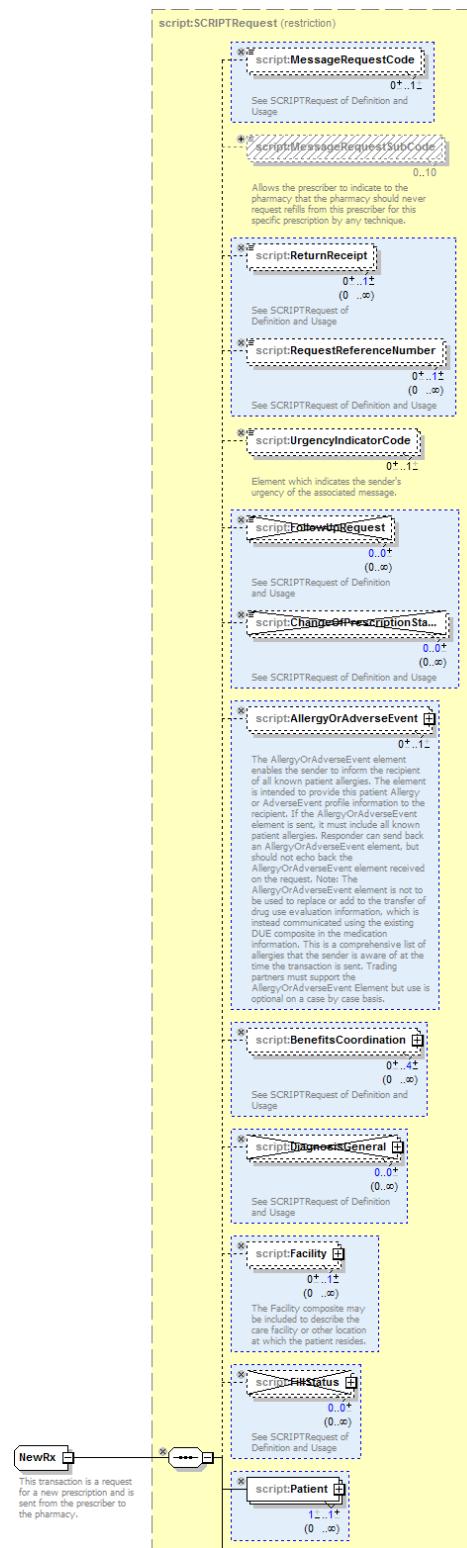
#### Legend

	Mandatory
	Situational
	Not used

Note: Annotations in element diagrams provide instructional usage. Where a value may be cited (for example in element <Pharmacy>, the annotation may read “Value P2. When the recipient is a pharmacy, one loop is required for the pharmacy” – the value P2 refers to a value in the NCPDP External Code List. While explicit tags do not need values, the annotation was included to provide guidance to lists in the NCPDP External Code List.

The model-driven environment supports the reuse of elements where possible. The transactions supported by this document provide the implementer with the ability to create a superset transaction of all applicable elements, reuse the superset, and only use the elements supported in the transaction subset. Elements in the superset that are not supported in the transaction subset are marked with the “X” Not used. Not used elements are not allowed to be sent.

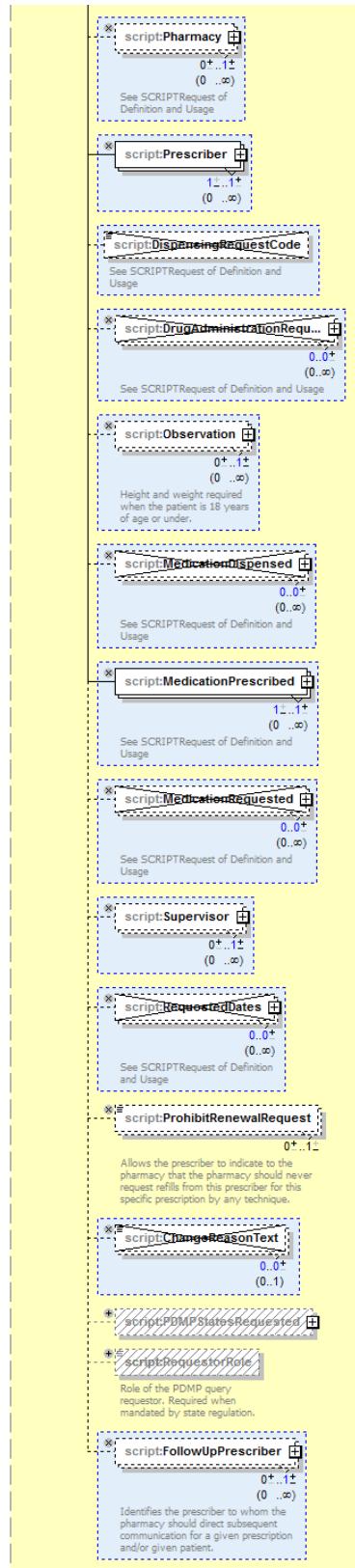
### 7.1.1 NEWRx TRANSACTION



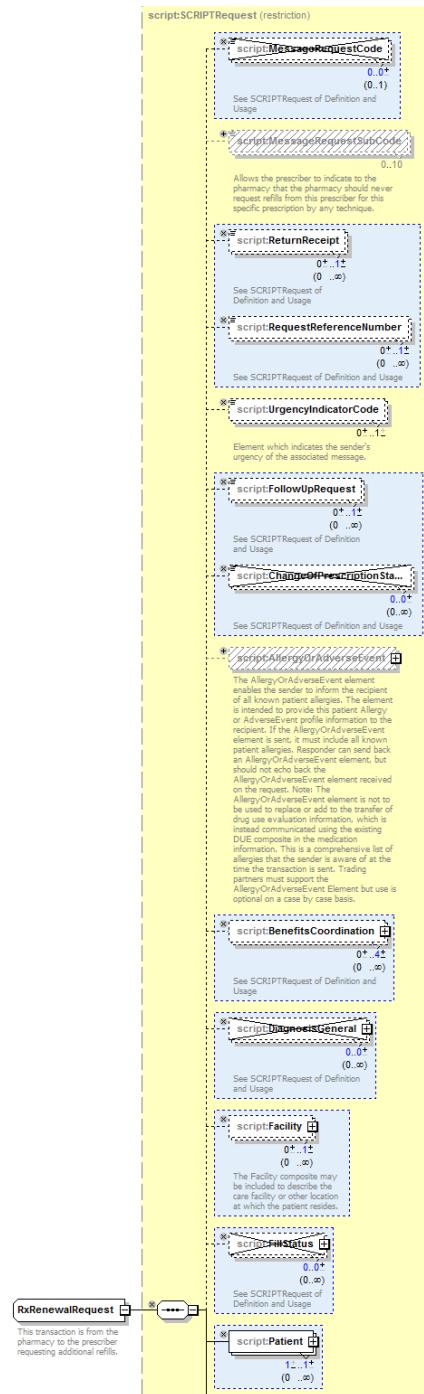
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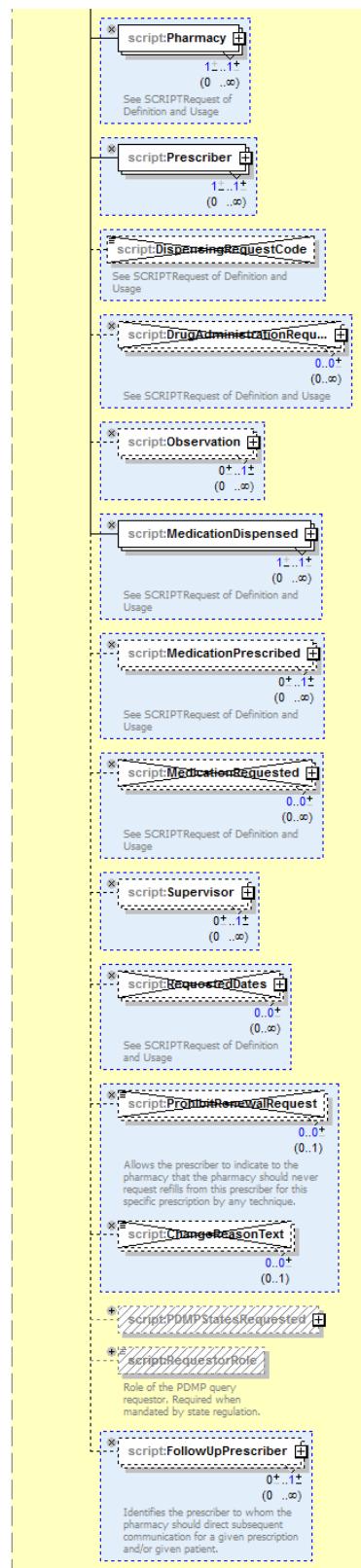
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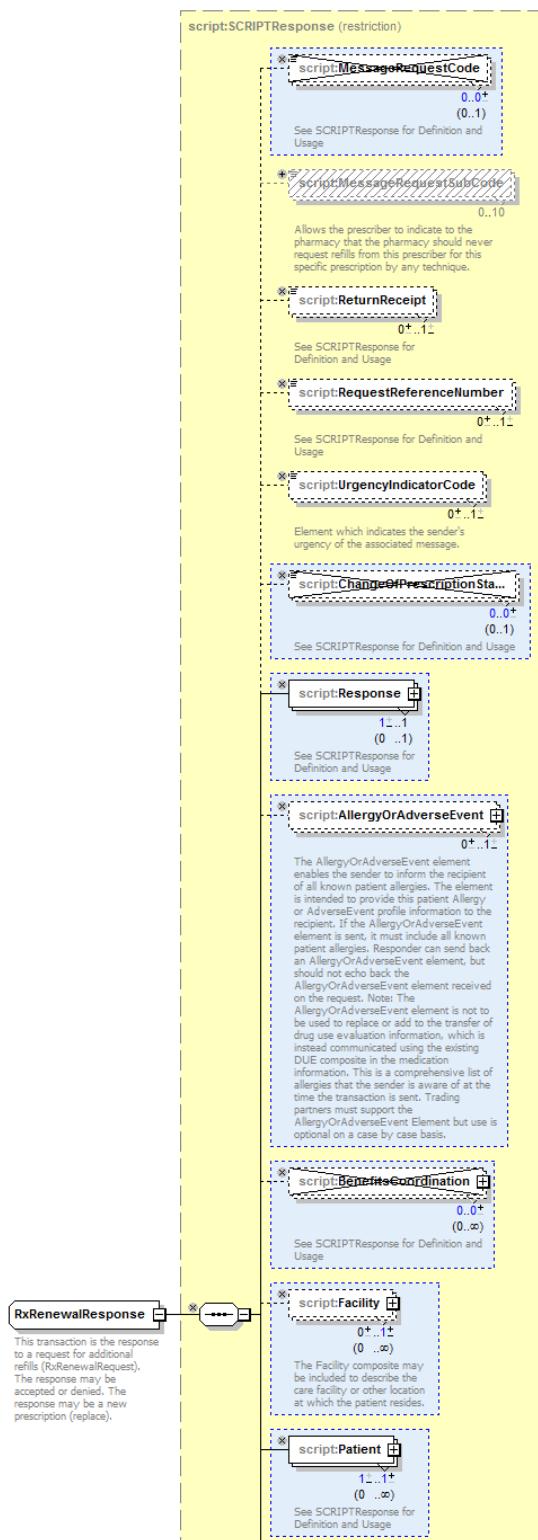


### 7.1.2 RxRENEWALREQUEST TRANSACTION





### 7.1.3 RxRENEWALRESPONSE TRANSACTION

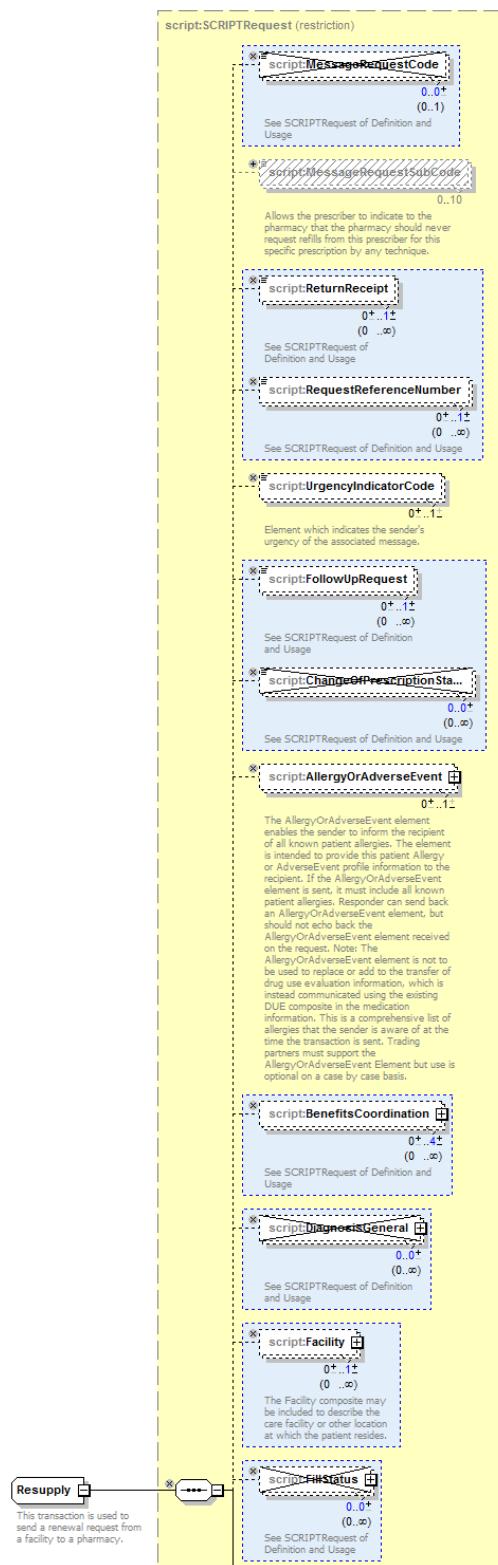


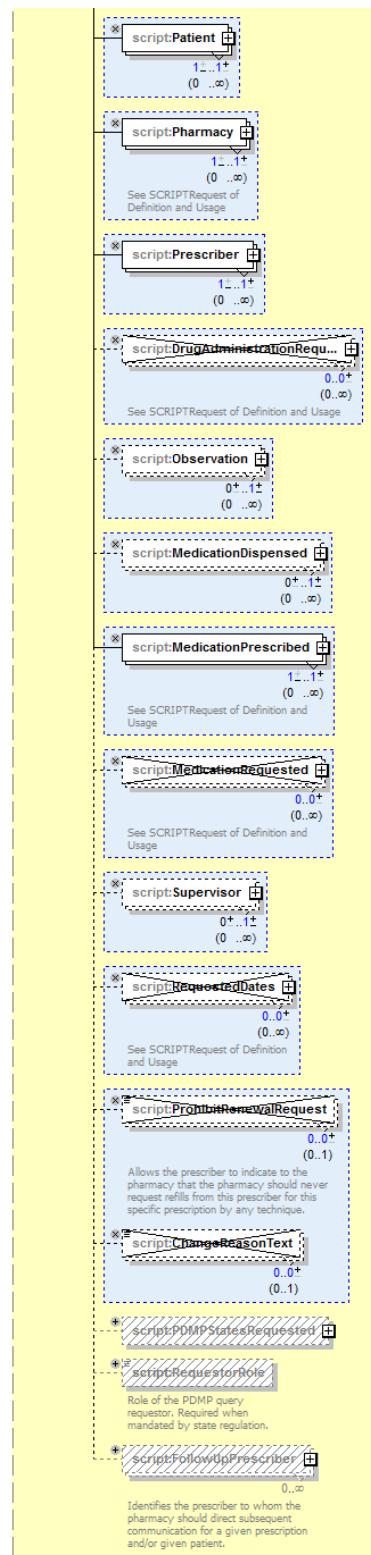


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### 7.1.4 RESUPPLY TRANSACTION



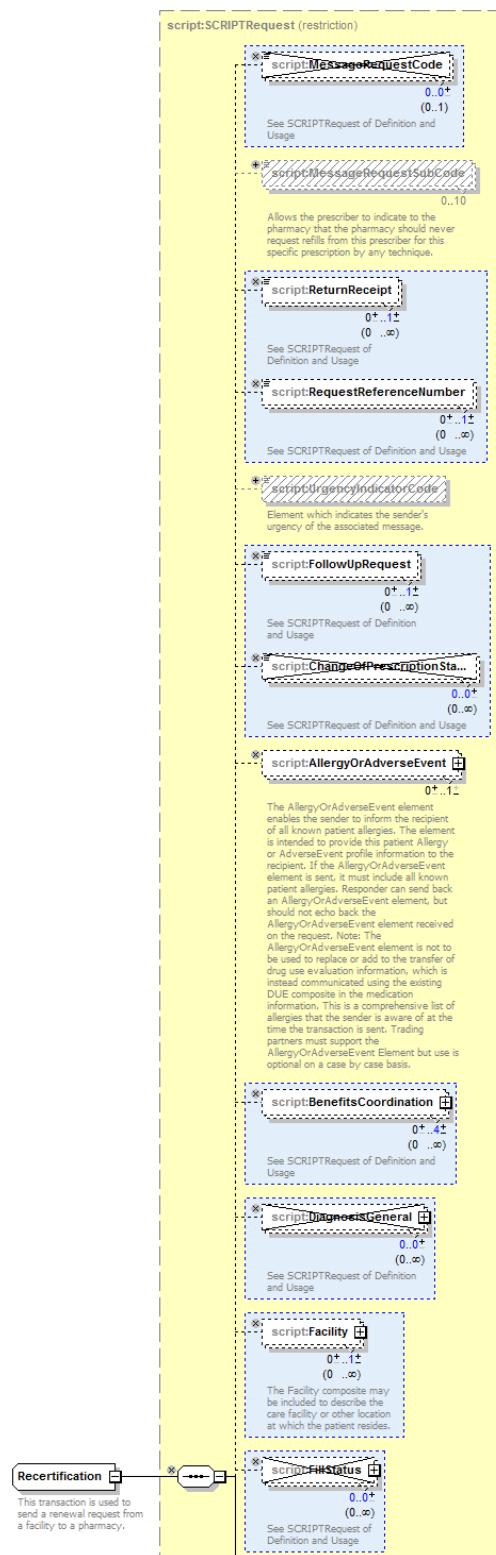


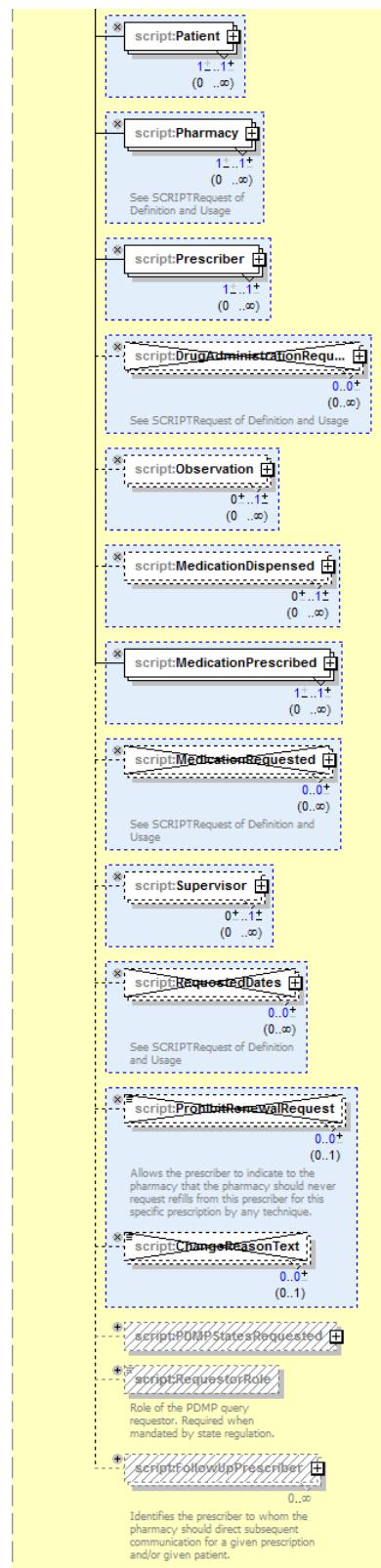
### 7.1.5 RECERTIFICATION TRANSACTION

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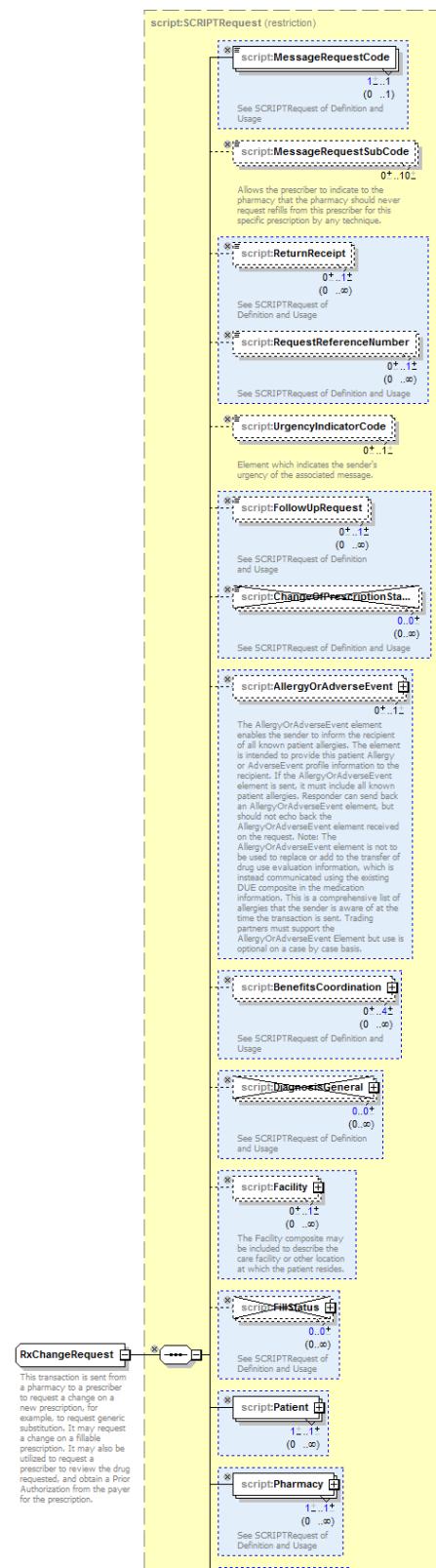
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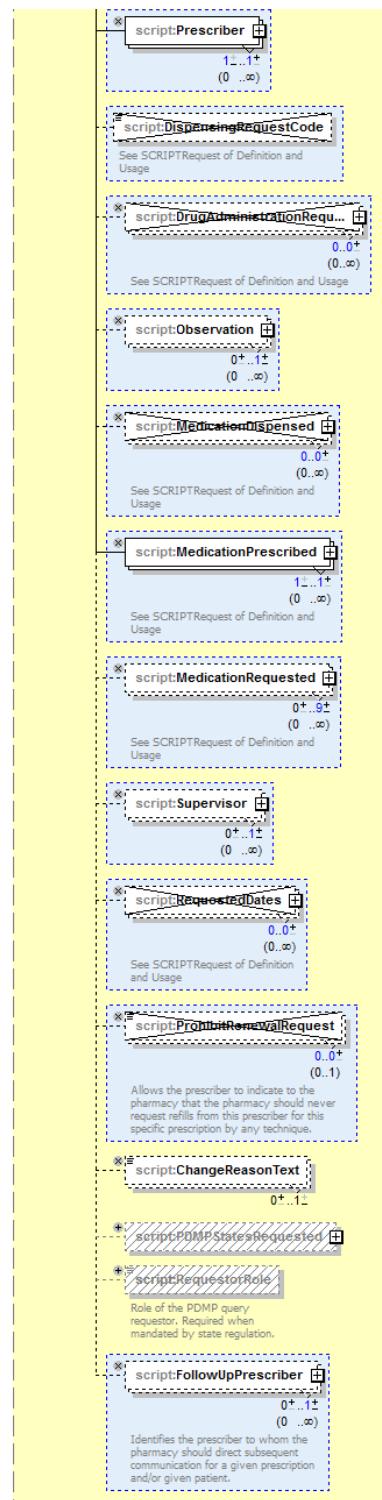
### 7.1.6 RxCHANGEREQUEST TRANSACTION



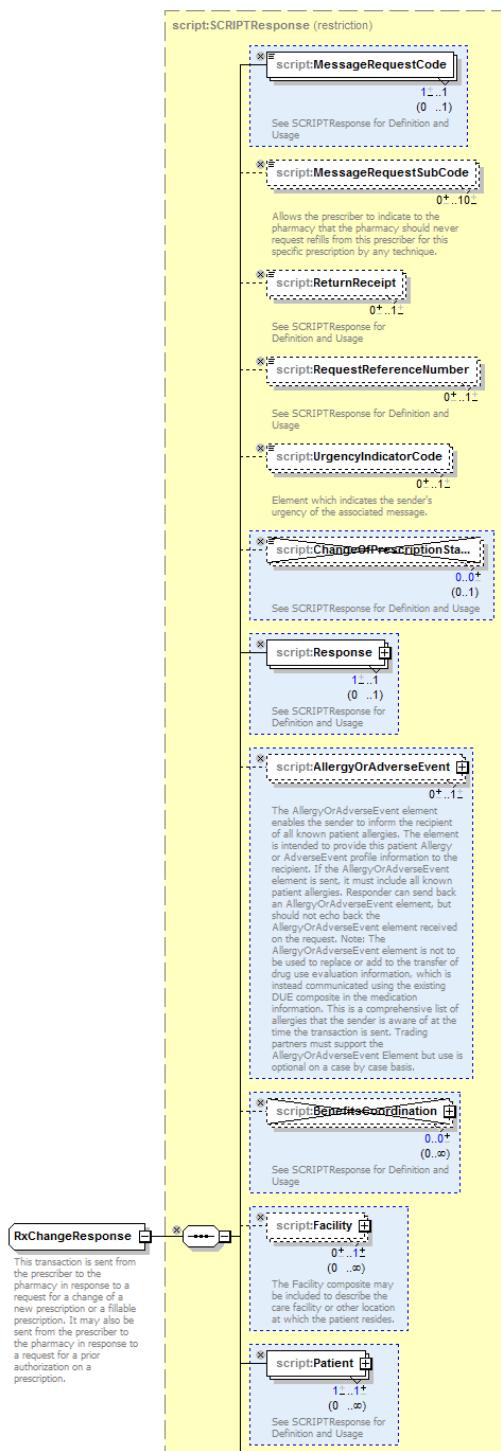
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### 7.1.7 RxCHANGERESPONSE TRANSACTION

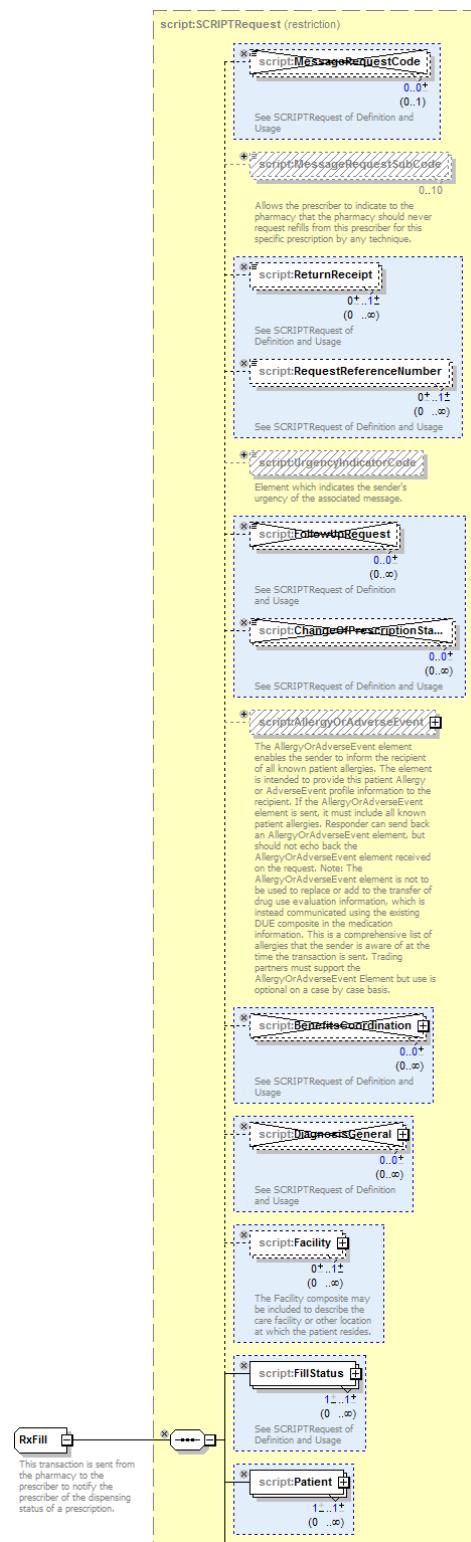


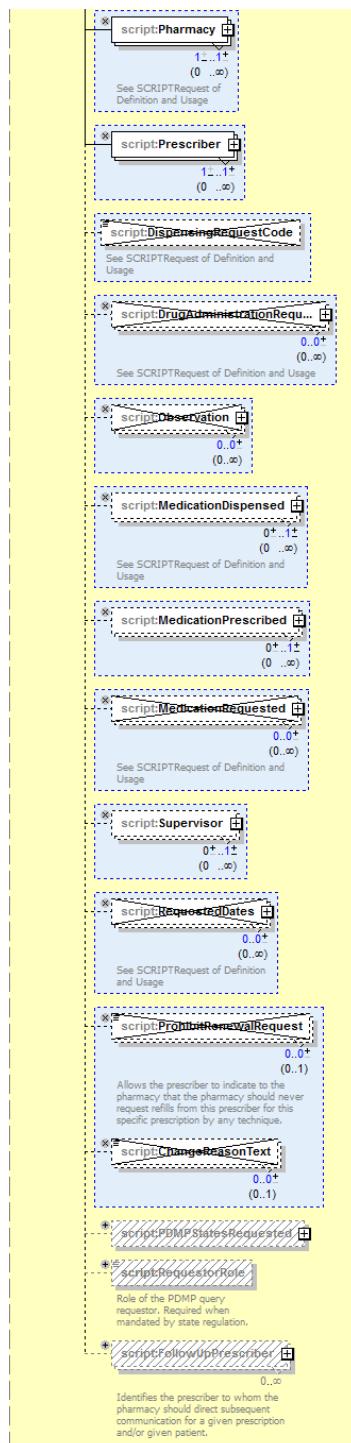


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### 7.1.8 RxFill TRANSACTION

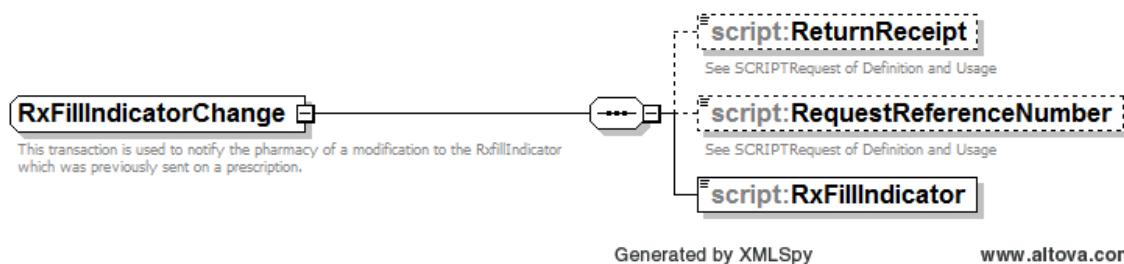




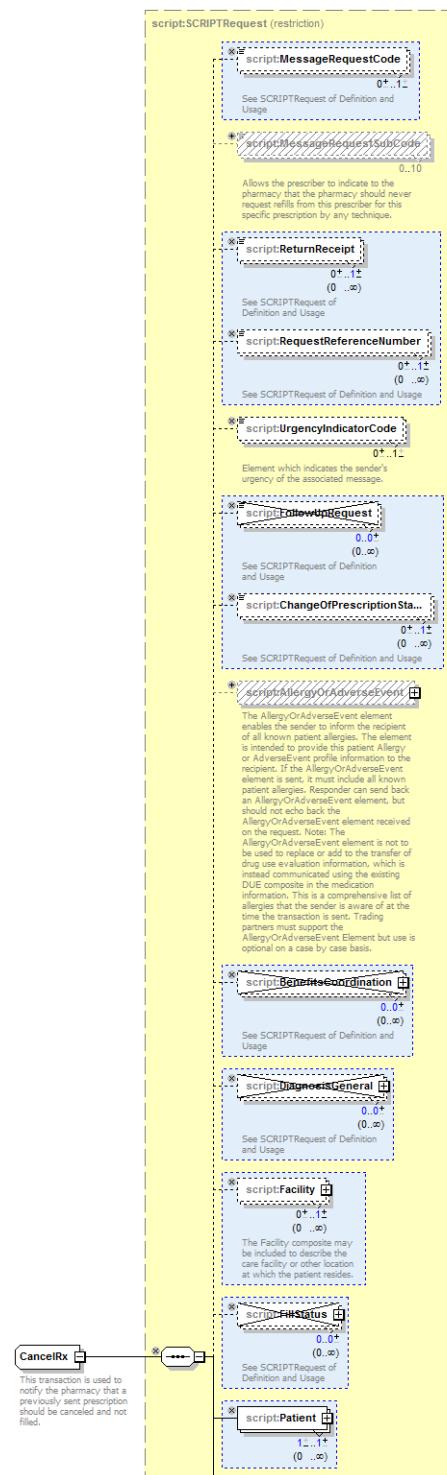
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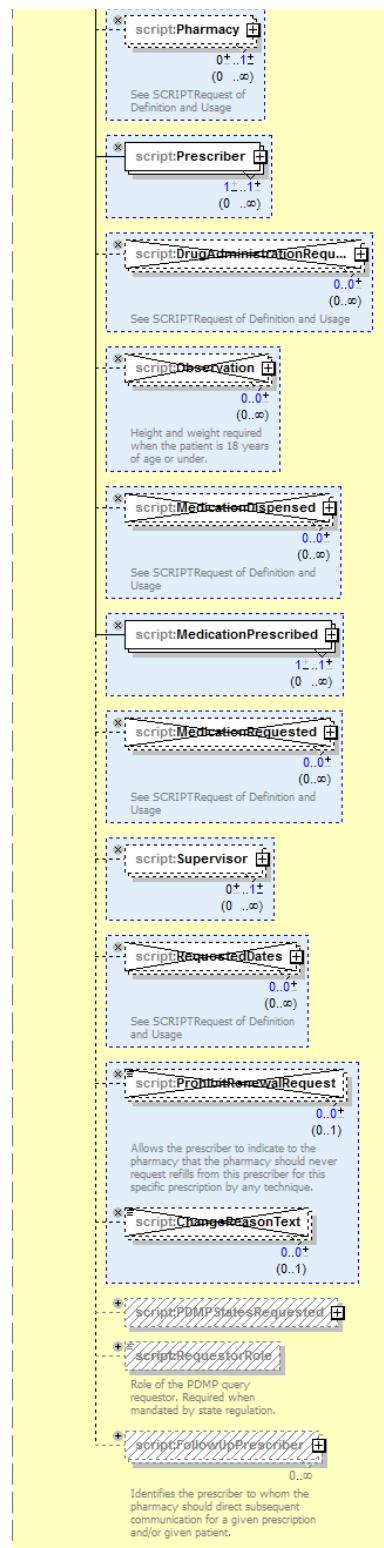
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### 7.1.9 RxFillIndicatorChange TRANSACTION

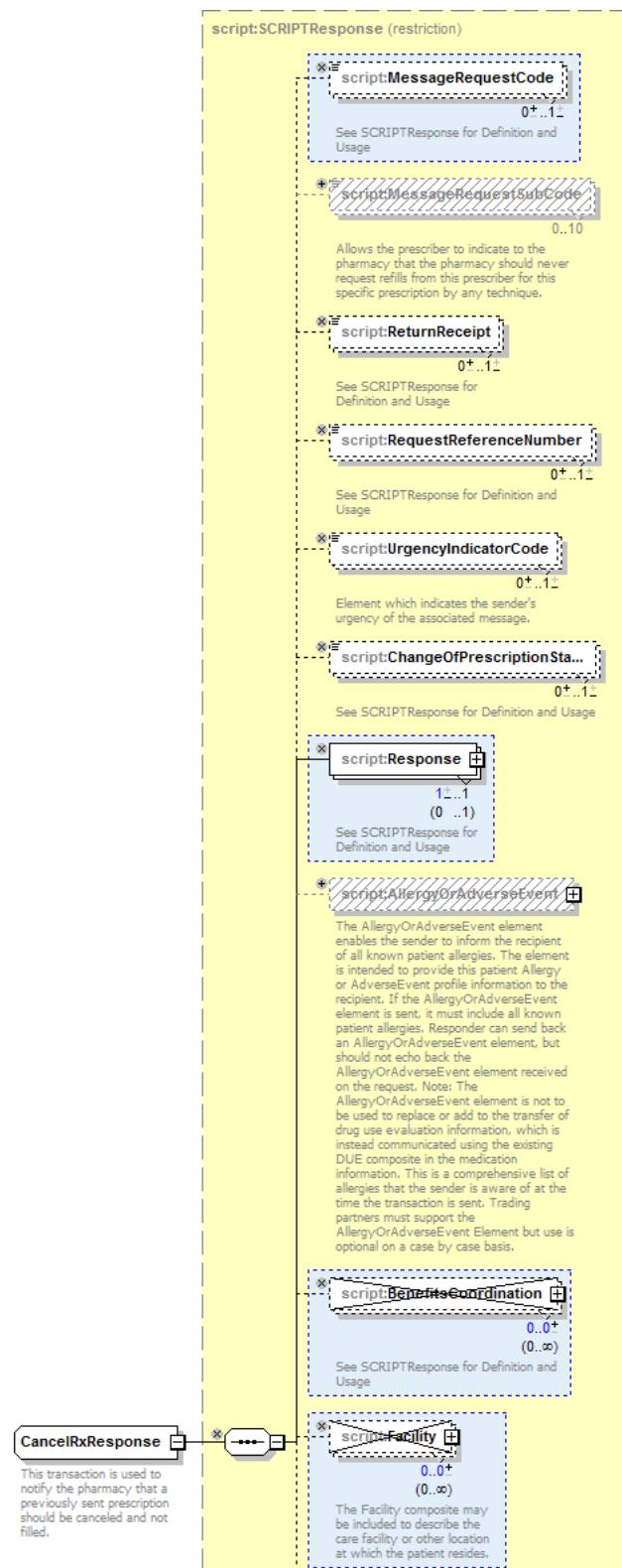


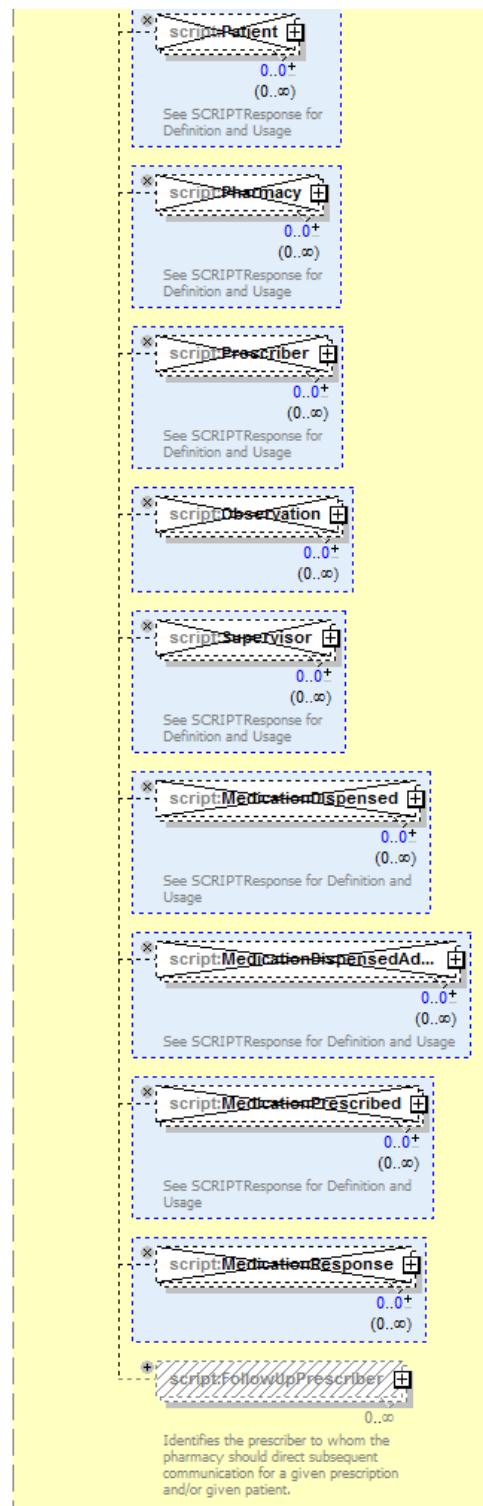
### 7.1.10 CANCELRX TRANSACTION



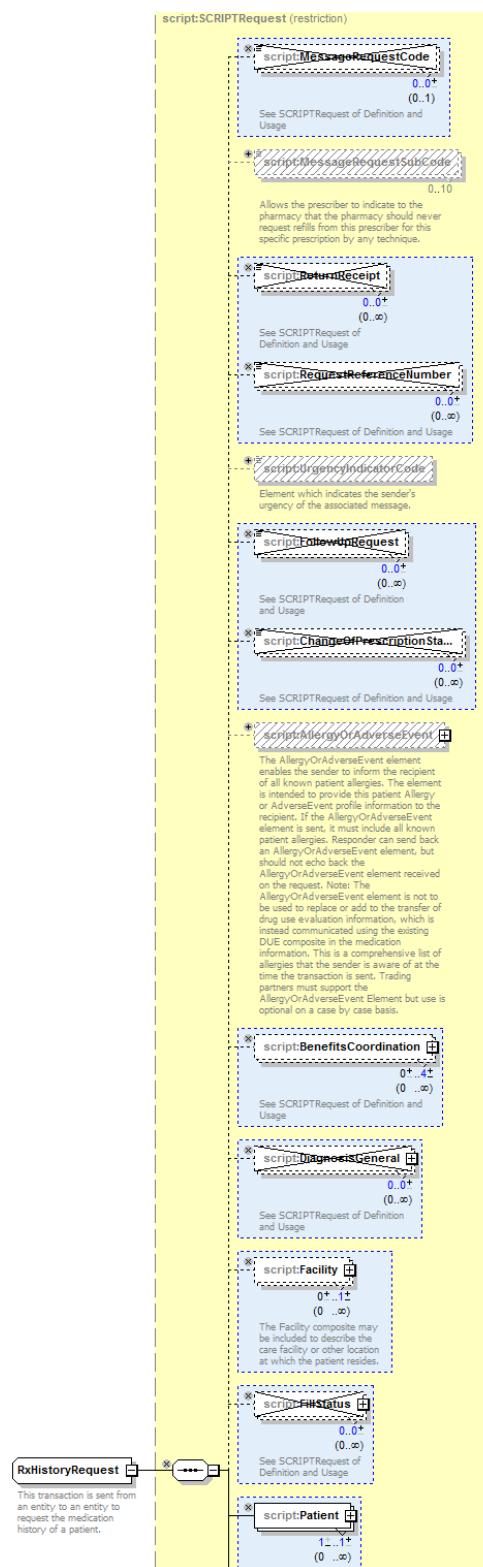


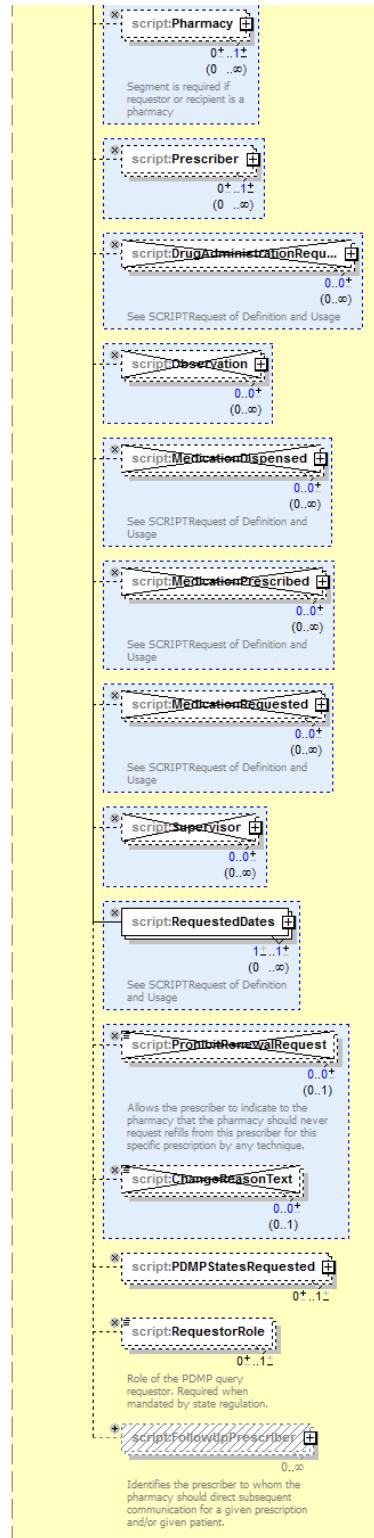
### 7.1.11 CANCELRXRESPONSE TRANSACTION



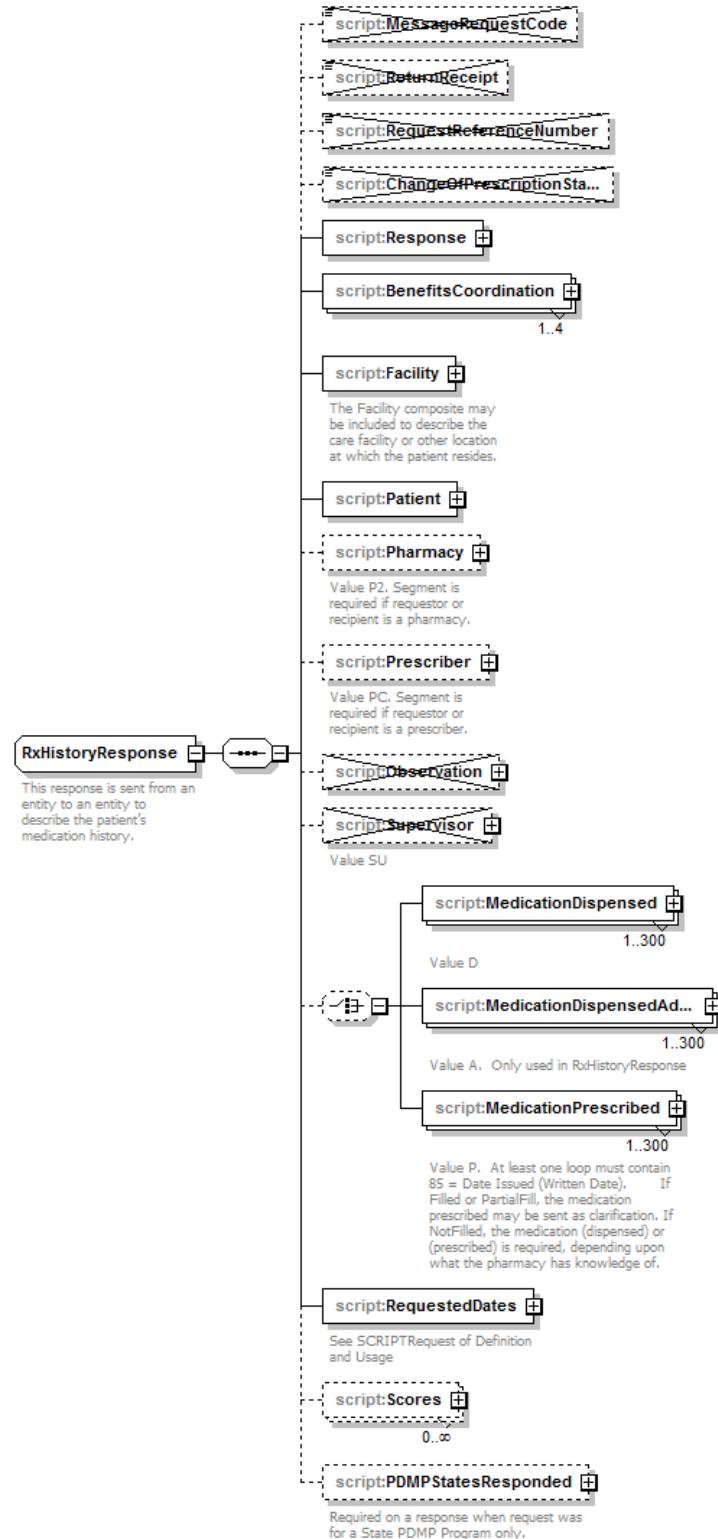


### 7.1.12 RxHISTORYREQUEST TRANSACTION

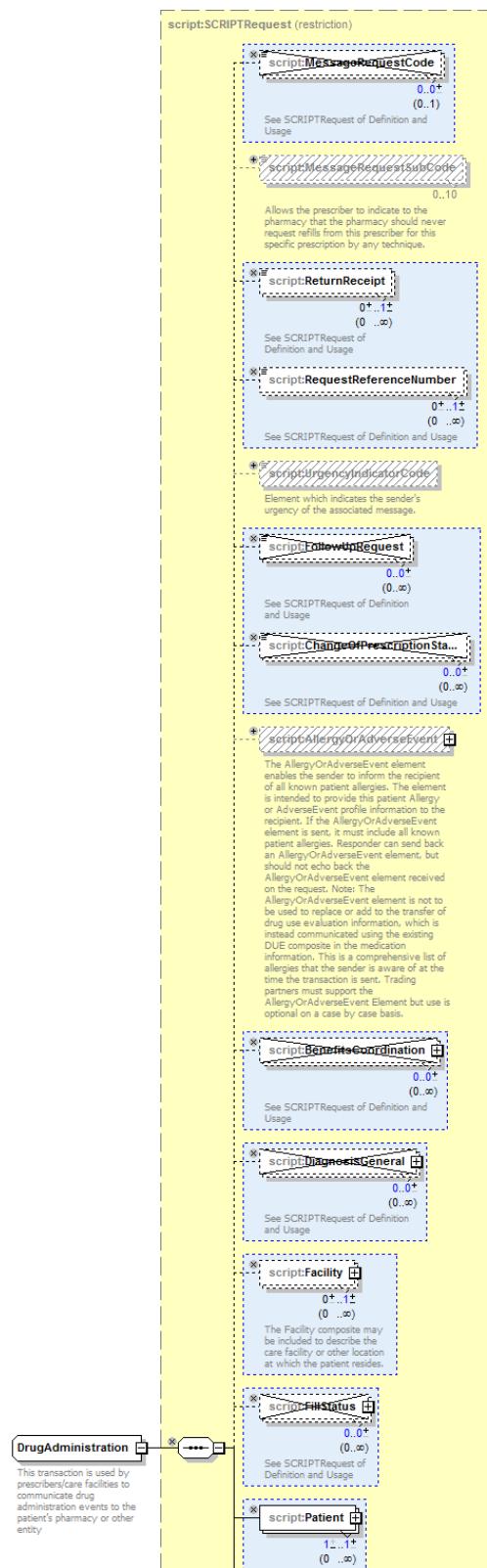




### 7.1.13 RxHISTORYRESPONSE TRANSACTION



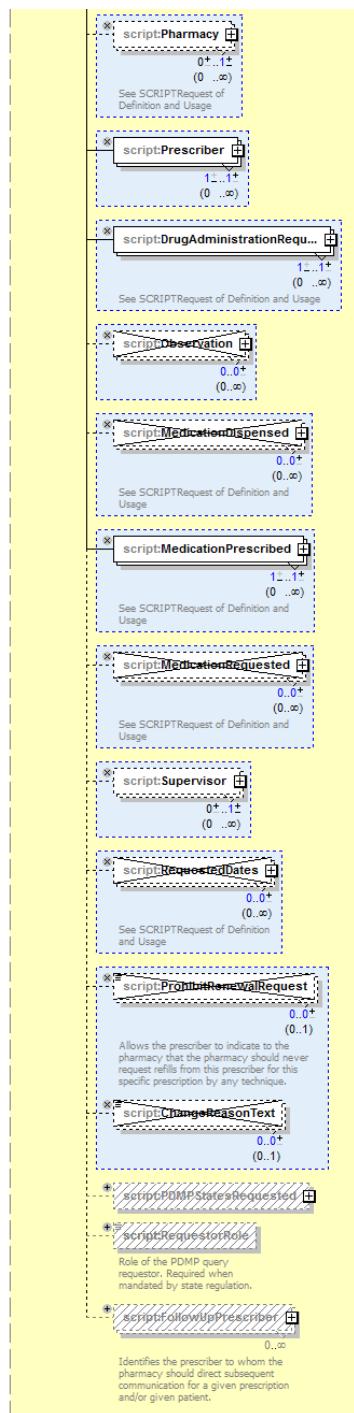
### 7.1.14 DRUG ADMINISTRATION TRANSACTION



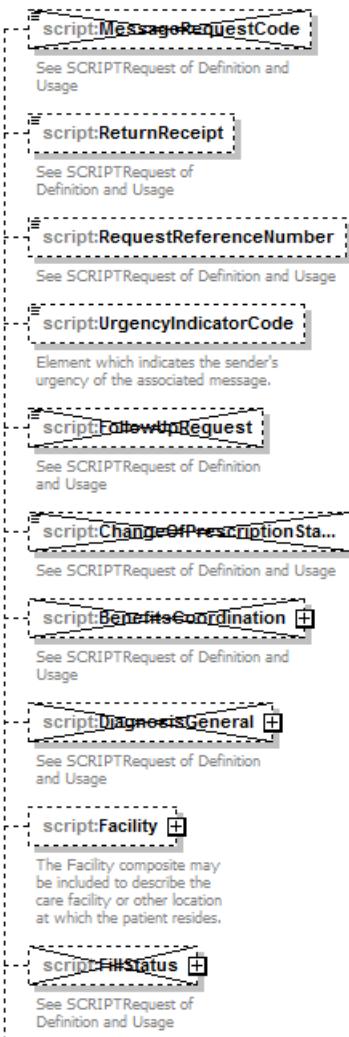
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### 7.1.15 NEWRxREQUEST TRANSACTION

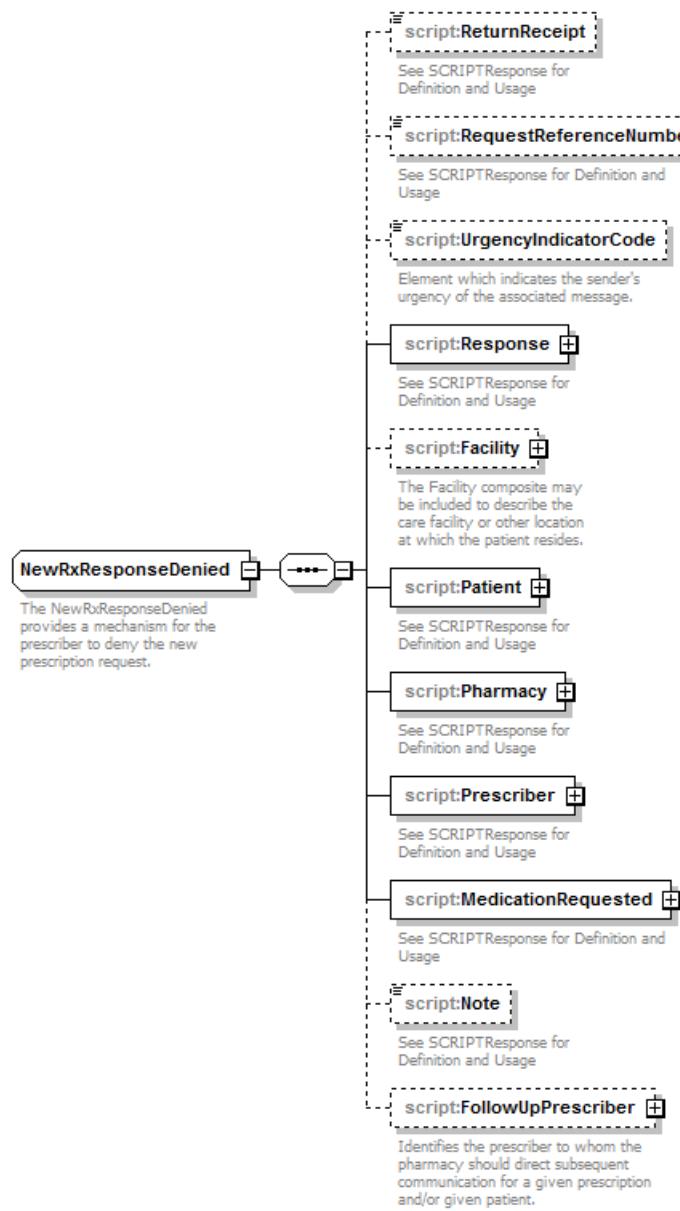




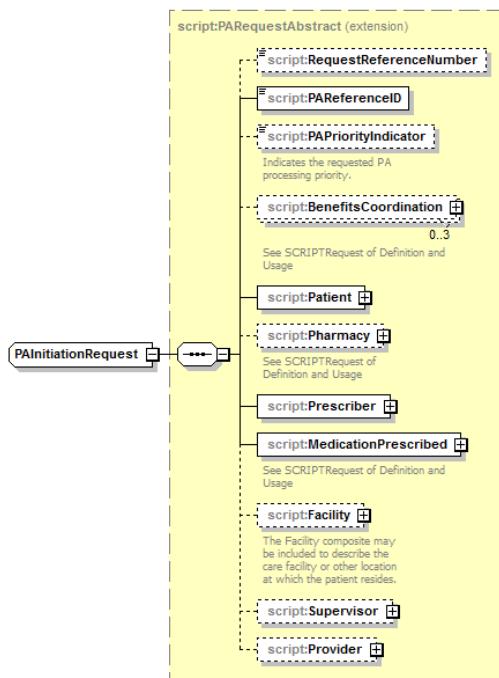
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### 7.1.16 NEWRXRESPONSEDENIED TRANSACTION



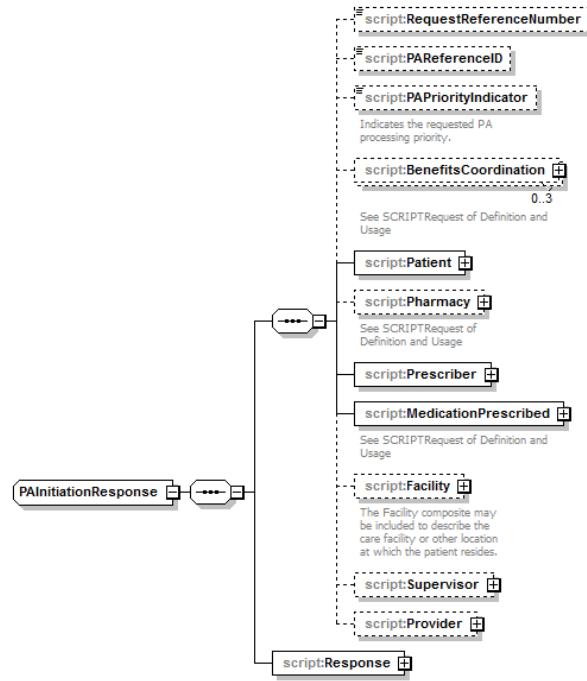
### 7.1.17 PA INITIATION REQUEST TRANSACTION



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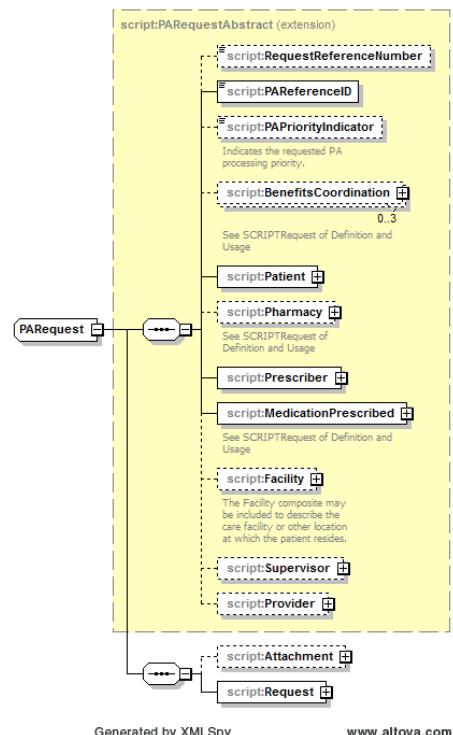
### 7.1.18 PA INITIATION RESPONSE TRANSACTION



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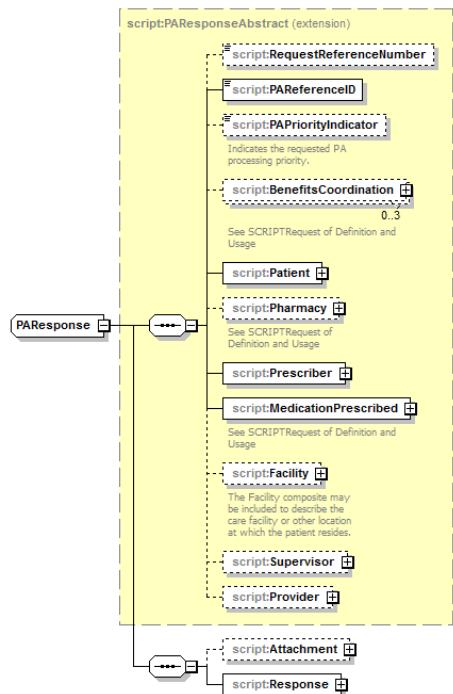
### 7.1.19 PARREQUEST TRANSACTION



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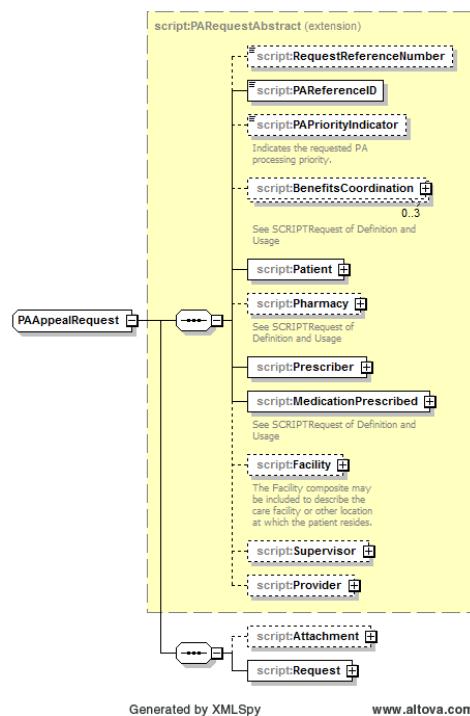
### 7.1.20 PARRESPONSE TRANSACTION



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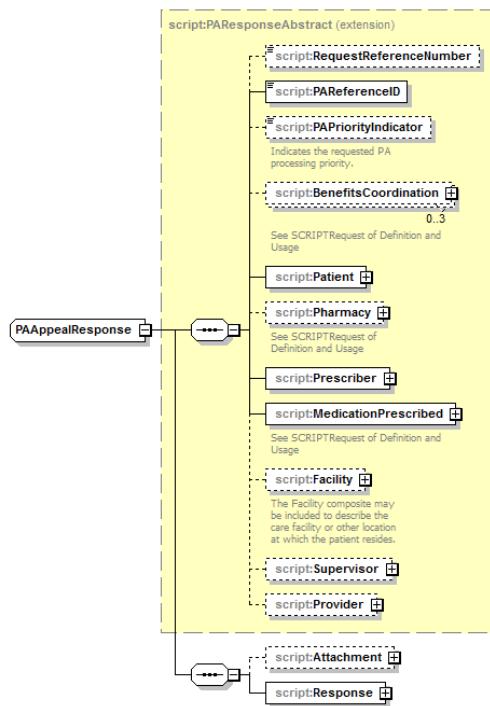
### 7.1.21 PAAPPEALREQUEST TRANSACTION



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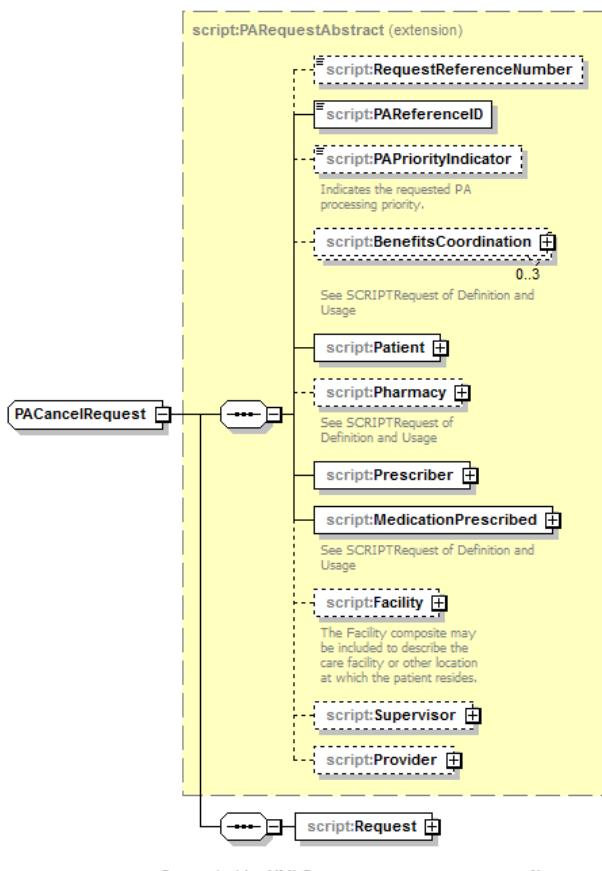
### 7.1.22 PAAPPEALRESPONSE TRANSACTION



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[www.altova.com](http://www.altova.com)

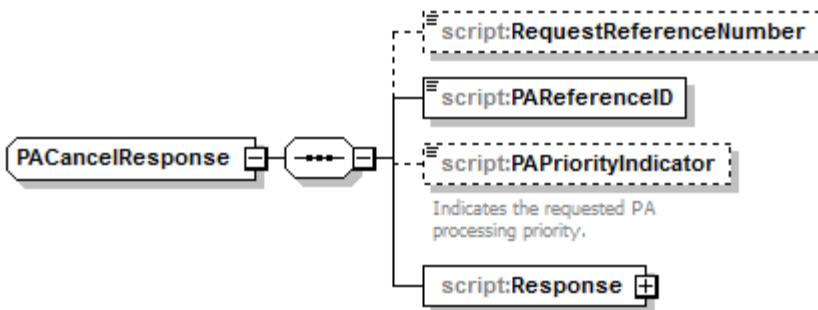
### 7.1.23 PACANCELREQUEST TRANSACTION



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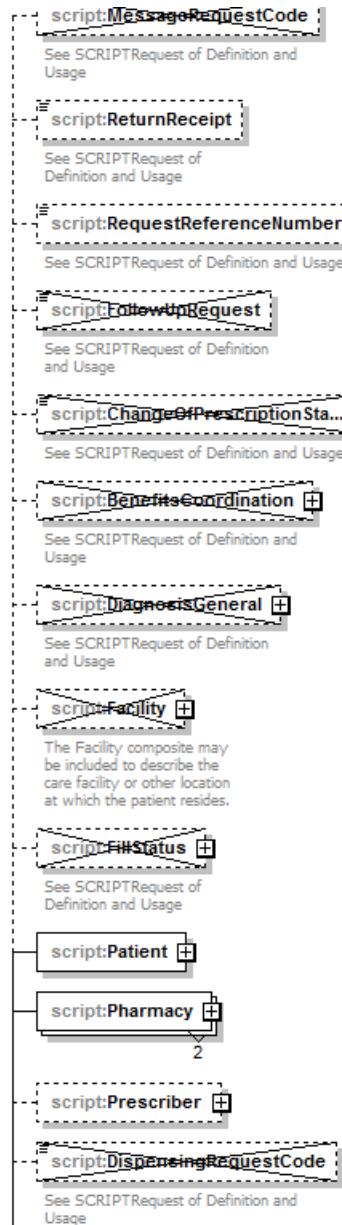
### 7.1.24 PACANCELRESPONSE TRANSACTION



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### 7.1.25 RxTRANSFERREQUEST TRANSACTION

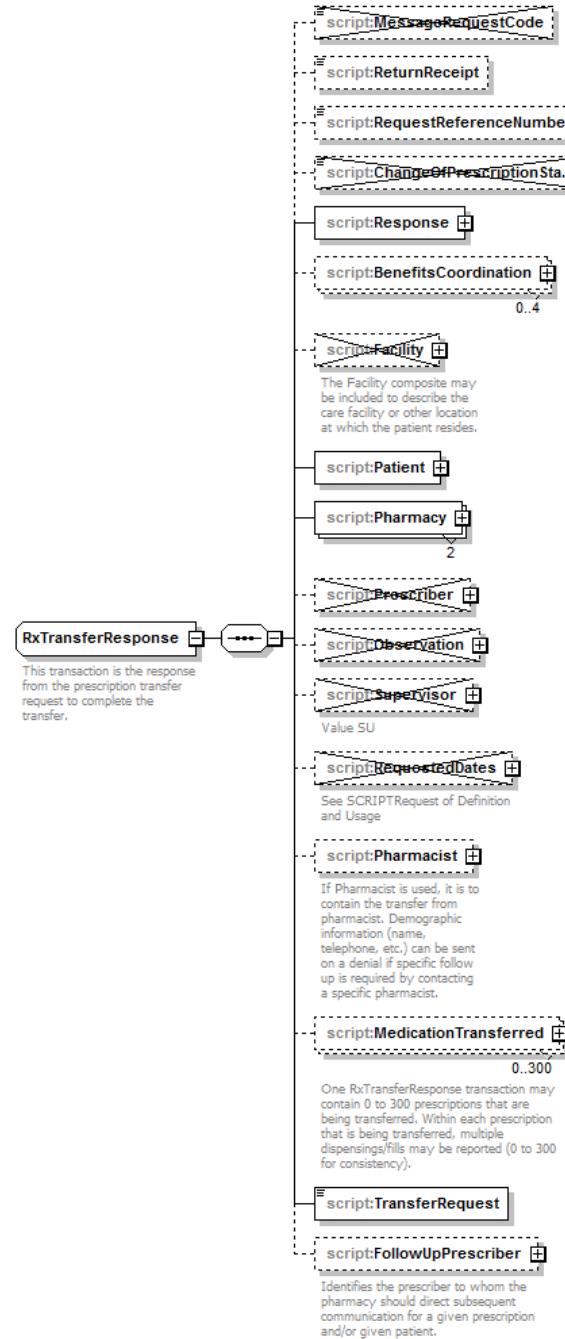




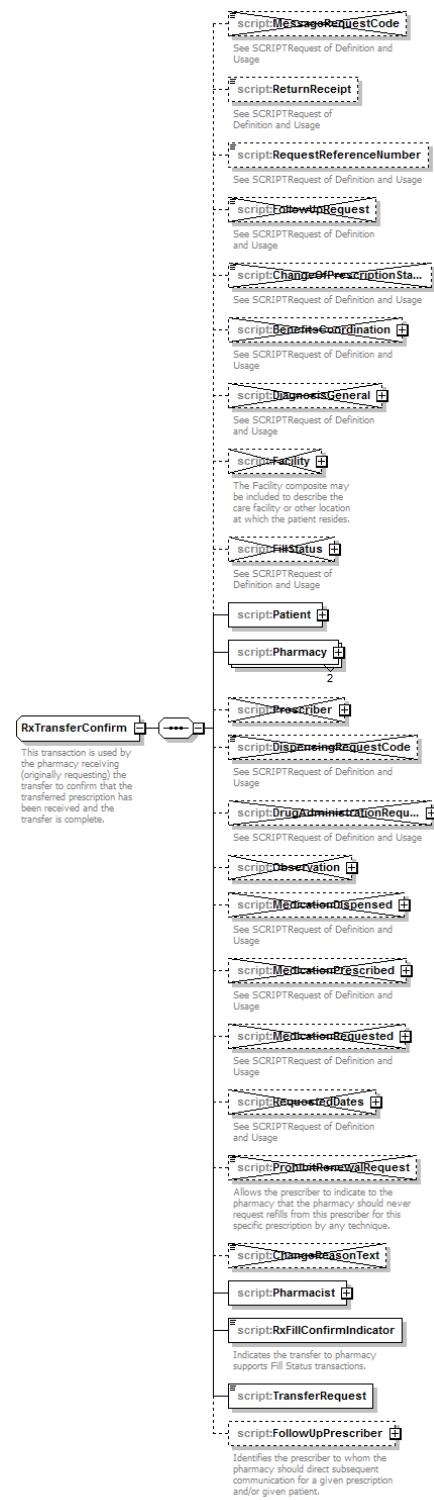
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### 7.1.26 RxTRANSFERRESPONSE TRANSACTION

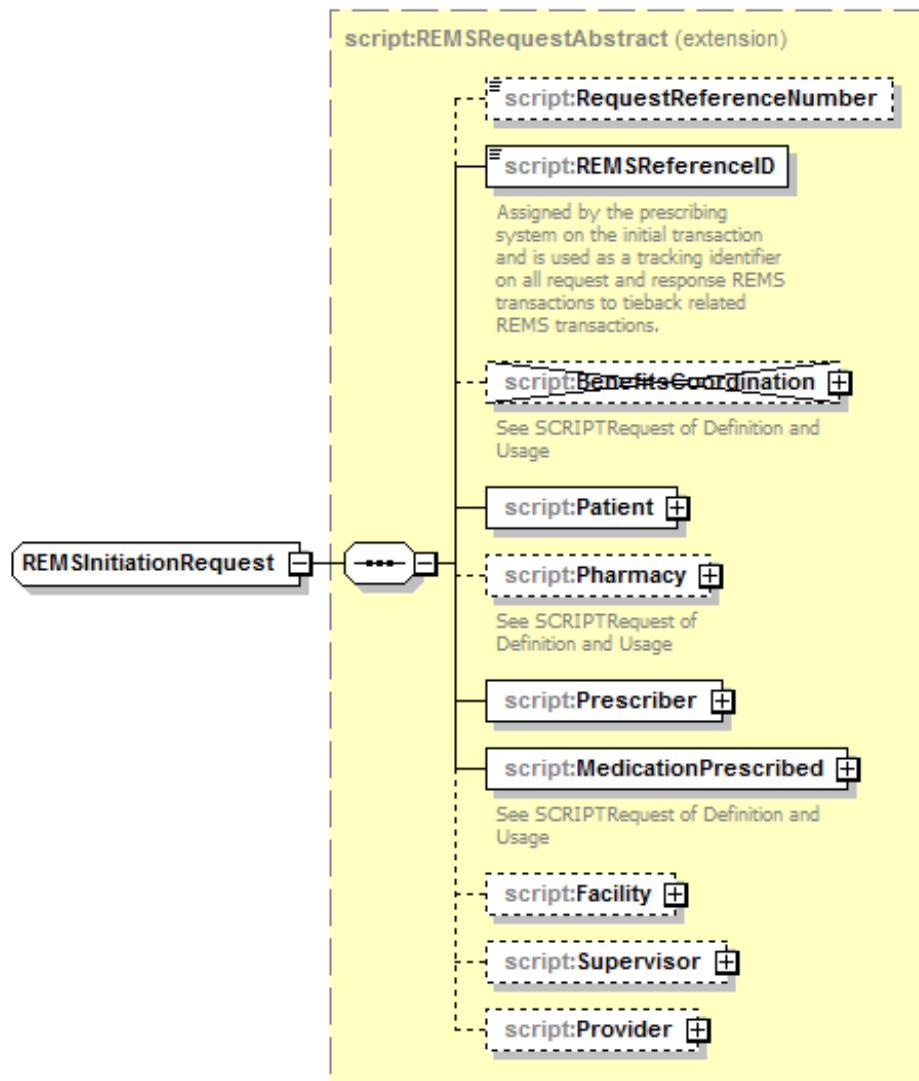


### 7.1.27 RxTRANSFERCONFIRM TRANSACTION



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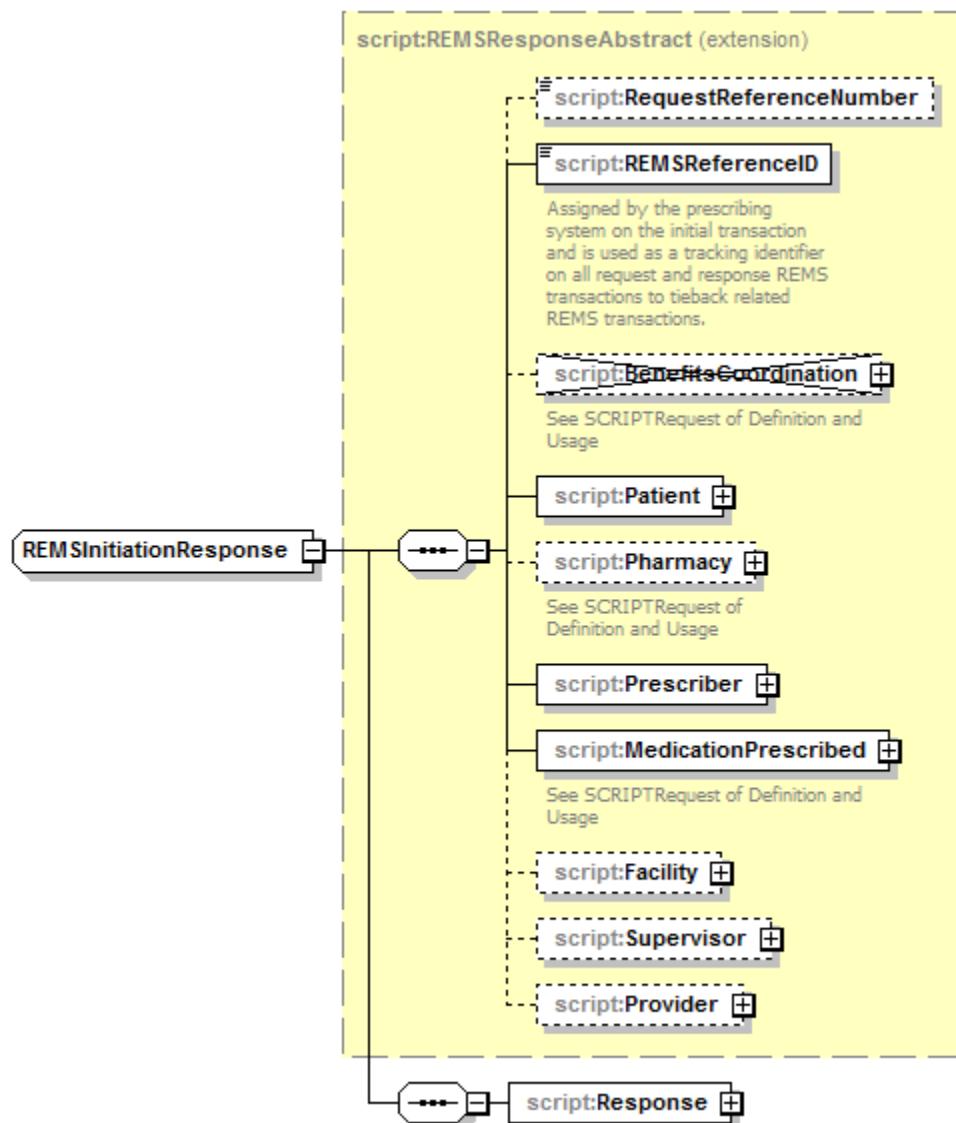
### 7.1.28 REMSINITIATIONREQUEST TRANSACTION



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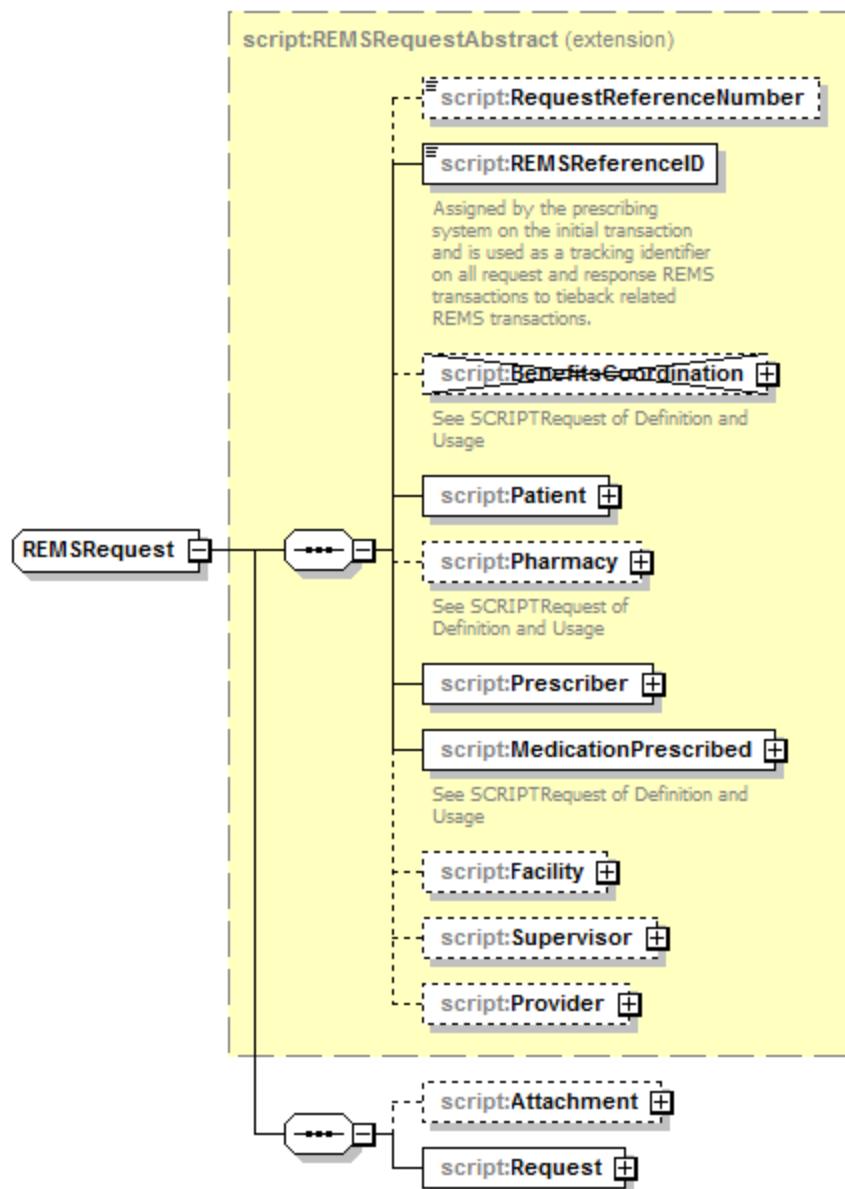
### 7.1.29 REMSINITIATIONRESPONSE TRANSACTION



Generated by XMLSpy

[www.altova.com](http://www.altova.com)

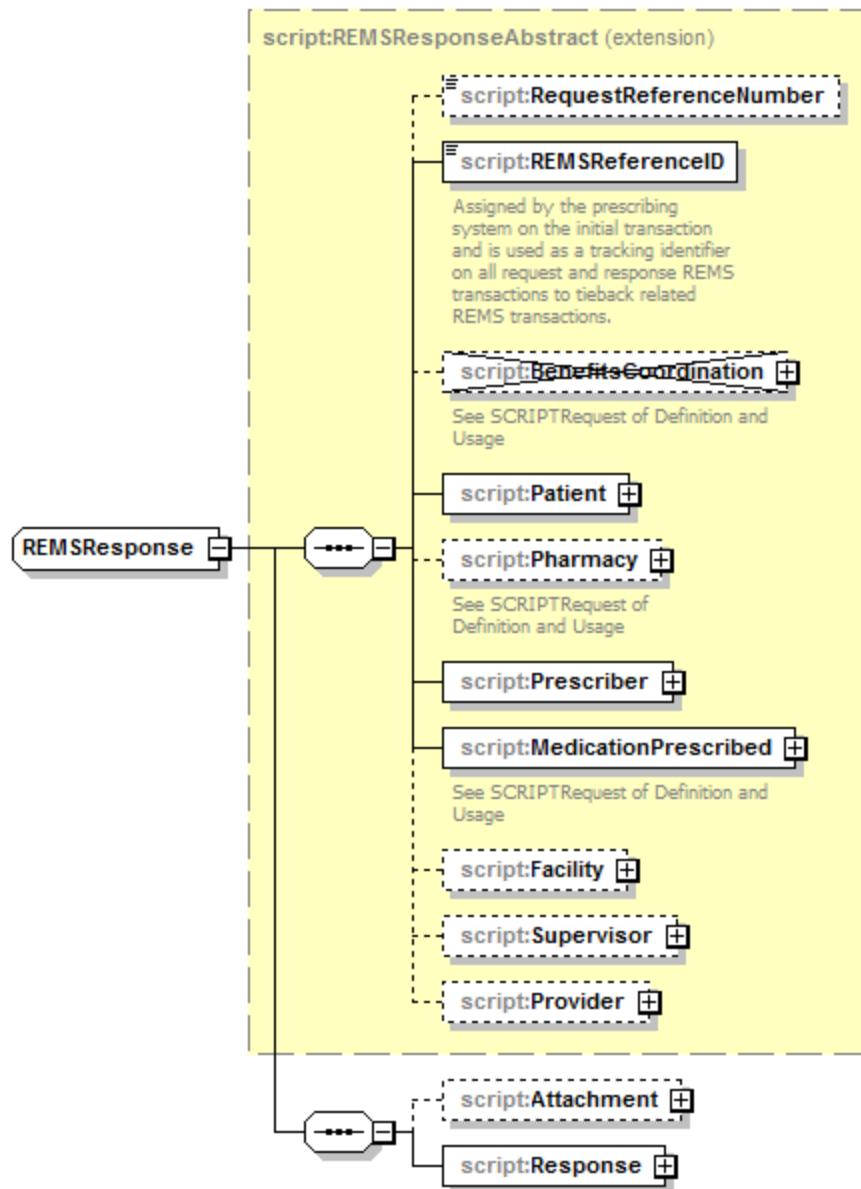
### 7.1.30 REMSREQUEST TRANSACTION



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### 7.1.31 REMSRESPONSE TRANSACTION



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## **8. SPECIFIC ELEMENT DISCUSSION**

### **8.1 SPECIFIC FIELD DISCUSSION**

This section discusses specific elements used within the SCRIPT format and the usage intended for this implementation. The schemas contain annotations to help the implementer with rules of usage.

See section "Veterinarian Prescriptions" for specific element usage.

#### **8.1.1 GENERAL ELEMENT**

##### **8.1.1.1 Address**

If <AddressLine2> is mandatory, it must contain a second address line and <AddressLine1> must be populated with a first address line. If <AddressLine2> is optional, use only when a second address line is needed and <AddressLine1> has been used.

<State> must be mailable in the country (e.g. when exchanging US States, the two digit alpha code is to be used, in Canada the “two space two” Province code is to be used). (ISO-3166-2 link from [http://www.iso.org/iso/country\\_codes](http://www.iso.org/iso/country_codes) or [http://en.wikipedia.org/wiki/ISO\\_3166-2](http://en.wikipedia.org/wiki/ISO_3166-2))

<PostalCode> must be mailable in the country (e.g. for US, the PostalCode length is 5 or 9, when used for Canadian Postal Code – This left justified field contains the three-digit forward sortation area (FSA) followed by a space, then followed by a Local Delivery Unit. (Format A0A 0A0, where A is a letter and 0 is a digit, with a space separating the third and fourth characters.))

Note: The <PostalCode> does not have a pattern. While the schema can actually support some patterns and value lists, it actually can get in the way of the validations. The receiver application must verify what is received, but gives the flexibility of how much validation it wishes to do. It takes some limited validation out of the schema, but allows the flexibility of sending international variations.

<CountryCode> - The situation “Required if country is not “US” is placed on CountryCode when it is in an optional address type. ISO-3166-1 [http://www.iso.org/iso/country\\_codes](http://www.iso.org/iso/country_codes).

##### **8.1.1.2 FormerName**

A FormerName complex type was added at the same level as Name for human. It was added for prescriber, supervisor/supervising prescriber and patient. It has the same cardinality as the Name in that transaction. For clarity, FormerName was not added to CardholderName in

BenefitsCoordination or ResponsibleParty in BenefitsCoordination. FormerName is used to provide additional matching criteria when the current Name does not match.

#### 8.1.1.3 *AlternateContact*

An AlternateContact complex type was added at the same level as Name for both human and non-human patients. The AlternateContact elements will be used to indicate a patient's alternate contact, such as spouse, caregiver, guardian. Usage of the AlternateContact composite does not mean the person named has any financial responsibility for the patient's treatment.

#### 8.1.1.4 *SubstanceUse*

These fields are used to allow the prescriber to indicate to the pharmacy information they may have regarding a patient's substance use. A substance could be tobacco, alcohol, cannabis or other products as reported by the patient. Prescribers can also indicate the route of administration and the level of use. The segment repeats to allow for reporting of multiple substances, i.e. tobacco and alcohol. This information could be of clinical relevance to the pharmacist when dispensing medication and counseling the patient and the use of the prescribed medication. SNOMED codes are used for each element. These elements replace "Smoking Status" in previous versions of SCRIPT.

##### Example for Tobacco Smoker

```
<structures:SubstanceUse>
    <structures:Substance>
        <structures:Type>
            <datatypes:Text>TOBACCO</datatypes:Text>
            <datatypes:Qualifier>SNOMED</datatypes:Qualifier>
            <datatypes:Code>39953003</datatypes:Code>
        </structures:Type>
        <structures:Level>
            <datatypes:Text>LIGHT CIGARETTE SMOKER</datatypes:Text>
            <datatypes:Qualifier>SNOMED</datatypes:Qualifier>
            <datatypes:Code>230060001</datatypes:Code>
        </structures:Level>
        <structures:RouteOfAdministration>
            <datatypes:Text>INHALE</datatypes:Text>
            <datatypes:Qualifier>SNOMED</datatypes:Qualifier>
            <datatypes:Code>421134003</datatypes:Code>
        </structures:RouteOfAdministration>
    </structures:Substance>
</structures:SubstanceUse>
```

The example above is for a smoker.

Notes:

Element	Value	Note
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Element	Value	Note
SubstanceTypeText	TOBACCO	Textual representation of the SubstanceTypeCode.
SubstanceTypeQualifier	SNOMED	SNOMED is the code set used for SubstanceTypeCode
SubstanceTypeCode	39953003	39953003 is the SNOMED Code for Tobacco.
SubstanceLevelText	LIGHT CIGARETTE	Textual representation of the SubstanceLevelCode.
	SMOKER	
SubstanceLevelQualifier	SNOMED	SNOMED is the code set used for SusbtanceLevelQualifier
SubstanceLevelCode	230060001	230060001 is the SNOMED Code for Light Cigarette Smoker
RouteOfAdministrationText	INHALE	Textual representation of the RouteOfAdministrationCode.
RouteOfAdminidtrationQualifier	SNOMED	SNOMED is the code set used for RouteOfAdministrationCode.
RouteOfAdministrationCode	421134003	421134003 is the SNOMED Code for Inhale.

Other examples of substance type might include:

Text	SNOMED Code
Alcohol	53527002
Cannabis	398705004

## 8.1.2 REQUEST ELEMENT

### 8.1.2.1 *FollowUpRequest Use*

<FollowUpRequest> is used in RxRenewalRequest or RxChangeRequest transactions. It's use is to allow pharmacies to tell prescribers this is a follow-up RxRenewalRequest or RxChangeRequest transaction (when the prescriber has not responded to the first RxRenewalRequest or first RxChangeRequest transaction in a reasonable amount of time). The field is not sent on the original request of the RxRenewalRequest or RxChangeRequest transaction.

The values correspond with the follow up (e.g. 1 = First Follow Up to the Original Request, 2 = Second Follow Up to the Original Request, etc.). The trace numbers (<MessageID>, <RelatesToMessageID>) are used to tie transactions (see section “*Trace Number Usage*” in the NCPDP **XML Standard**.)

## 8.1.3 RESPONSE ELEMENT

### 8.1.3.1 Clarification Of ResponseType

The specification allows a prescriber four (4) options (note that there are five, but <DeniedNewPrescriptionToFollow> will be sunsetted in a future version) when generating an RxRenewalResponse in response to an RxRenewalRequest from a pharmacy:

Option	Prescriber's Intent See section " <i>Medication Elements and Refill Elements</i> ".
<Approved>	<p>Grant the RxRenewalRequest as requested by the pharmacy, or, when the pharmacy does not request a specific number of fills (&lt;PharmacyRequestedRefills&gt; is not present) and the prescriber approves any number of fills.</p> <p>The only conditions where an &lt;Approved&gt; response should be sent by the prescriber system in a RxRenewalResponse –</p> <ul style="list-style-type: none"> <li>(1) When (&lt;PharmacyRequestedRefills&gt; is greater than 0 and the prescriber concurs with the request by the pharmacy. The prescriber must submit an RxRenewalResponse that includes a &lt;NumberOfRefills&gt; equal to what the pharmacy requested. &lt;WrittenDate&gt; must be updated when the current date differs from the one on the RxRenewalRequest.</li> <li>(2) When &lt;PharmacyRequestedRefills&gt; is not present in RxRenewalRequest, the prescriber must submit an RxRenewalResponse that includes a &lt;NumberOfRefills&gt; greater than zero. &lt;WrittenDate&gt; must be updated when the current date differs from the one on the RxRenewalRequest.</li> </ul> <p>See the &lt;Replace&gt; response for any changes in an RxRenewalResponse beyond what is stated here.</p>
<ApprovedWithChanges>	<p>Grant the RxRenewalRequest, approving a &lt;NumberOfRefills&gt; different than the &lt;PharmacyRequestedRefills&gt; requested by the pharmacy. This response type will flag the pharmacy system that the &lt;NumberOfRefills&gt; differs from what was sent in the RxRenewalRequest.</p> <p>If the pharmacy did not request a specific number of refills (&lt;PharmacyRequestedRefills&gt; is not present on the RxRenewalRequest), &lt;ApprovedWithChanges&gt; is an inappropriate response.</p> <p>The only condition where an &lt;ApprovedWithChanges&gt; response should be sent by the prescriber system in a RxRenewalResponse –</p> <ul style="list-style-type: none"> <li>(1) When the number of &lt;PharmacyRequestedRefills&gt; requested by the pharmacy system (greater than zero) is a different number than the response &lt;NumberOfRefills&gt;. The prescriber must submit an RxRenewalResponse that includes a &lt;NumberOfRefills&gt; (greater than zero and that differs from what the pharmacy requested). &lt;WrittenDate&gt; must be updated when the current date differs from the one on the RxRenewalRequest.</li> </ul> <p>See the &lt;Replace&gt; response for any changes in an RxRenewalResponse beyond what is stated here.</p>
<Denied>	<p>Deny the RxRenewalRequest as requested by the pharmacy.</p> <p>In a &lt;Denied&gt; response, the only new meaning that should be conveyed to the pharmacy is information that explains the denial. It is recommended that the prescribing software update the &lt;NumberOfRefills&gt; to zero and leave all other data as is in the</p>

<b>Option</b>	<b>Prescriber's Intent</b> See section " <i>Medication Elements and Refill Elements</i> ".
	RxRenewalResponse.
<DeniedNewPrescriptionToFollow>  This will be sunsetted in a future version.	Deny the RxRenewalRequest as requested by the pharmacy. The meaning or intent of significant fields will not be changed in the RxRenewalResponse. A new prescription with <b>substantive differences</b> from the originally requested prescription will be sent.  See section " <u>&lt;DeniedNewPrescriptionToFollow&gt; Use and Sunset</u> ".
<Replace>	<p>Data is allowed to be changed except the patient &lt;DateOfBirth&gt;. If patient &lt;DateOfBirth&gt; changes, a &lt;Denied&gt; would be sent. A NewRx would then be sent.</p> <p>The &lt;Replace&gt; response is to be used when changes outside of what is listed under &lt;Approved&gt; and &lt;ApprovedWithChanges&gt; must be made in the RxRenewalResponse. Edits to the pharmacy are not permitted. Minor corrections to the patient (except DateOfBirth) are allowed as long as it refers to the same patient. On a &lt;Replace&gt; response the data content for the patient information does not have to match exactly as long as it is referring to the same patient, for example if the patient &lt;FirstName&gt; in the RxRenewalRequest is Bob and the patient &lt;FirstName&gt; in the RxRenewalResponse is Robert, there is no difference <i>unless the prescriber believes he is referencing a different patient than the pharmacy</i> or vice versa. &lt;WrittenDate&gt; must be updated when the current date differs from the one on the RxRenewalRequest.</p> <p>If the prescriber wishes to send a new prescription to a different pharmacy (other than the one who made the RxRenewalRequest) the &lt;Replace&gt; is an inappropriate response. A &lt;Denied&gt; should be sent to the pharmacy that made the RxRenewalRequest and a new prescription should be sent to the new pharmacy.</p>

The receiving pharmacy might handle each of these responses differently. <Approved>, <ApprovedWithChanges>, and <Replace> responses might be directed to a fulfillment queue, where a <Denied> response might be directed to a review queue. Therefore, it is important that both prescriber and pharmacy share a common understanding of the significance of each response option.

If mapping from previous versions of SCRIPT to this version of SCRIPT for RxRenewalResponse, <MedicationPrescribed> and <MedicationDispensed> will have to be filled in with elements from <MedicationResponse> as appropriate.

#### **<WrittenDate> usage:**

When the prescriber responds <Approved> or <ApprovedWithChanges> the prescriber MUST set the <MedicationResponse> <WrittenDate> to the date of the approval. When the prescriber responds <Replace>, the <WrittenDate> indicates the date of the replacement prescription. It is incorrect to echo the <MedicationResponse> <WrittenDate> from the original request or send the start date of therapy in the <MedicationResponse> <WrittenDate> element.

#### **Examples:**

**Example 1:**

Physician wishes to deny the request because the patient must be re-examined.

Response: <Denied>

**Example 2:**

Pharmacy has not requested a specific number of refills (<PharmacyRequestedRefills> not sent); Prescriber wishes to approve the request, specifying 3 additional dispensings.

Since the pharmacy did not request a specific number of refills <PharmacyRequestedRefills>, and the <NumberOfRefills> contains a value greater than zero, the Response: <Approved>

**Example 3:**

Pharmacy requests 5 refills <PharmacyRequestedRefills>; Prescriber approves 3 refills <NumberOfRefills>. Since this is a change in <NumberOfRefills> versus <PharmacyRequestedRefills>, the Response: <ApprovedWithChanges>

**Example 4:**

Prescriber changes <Sig> from “Take one tablet daily” to “Take one tablet morning and evening.” (<Quantity> and other fields may change as well.)

Response: <Replace>

**Example 5:**

Pharmacy has not requested a specific number of refills (<PharmacyRequestedRefills> not sent); Prescriber wishes to approve the request, specifying 3 additional dispensings. In addition, the prescriber changes <Sig> from “Take one tablet daily” to “Take one tablet morning and evening.” (<Quantity> and other fields may change as well.)

Response: <Replace>

#### **8.1.3.2 Clarification of RxChangeResponseType**

The specification allows a prescriber four (4) options (note that there are five, but <DeniedNewPrescriptionToFollow> will be sunsetted in a future version) when generating an RxChangeResponse in response to an RxChangeRequest from a pharmacy:

<b>Option</b>	<b>Prescriber's Intent</b> See section " <i>Medication Elements and Refill Elements</i> ".
<Approved>	Grant the RxChangeRequest <b>as requested</b> by the pharmacy The only conditions where an <Approved> response should be sent by the prescriber system in a RxChangeResponse –

Option	Prescriber's Intent See section " <i>Medication Elements and Refill Elements</i> ".
	(3) When the prescriber concurs with the request by the pharmacy. The prescriber must submit an RxChangeResponse equal to what the pharmacy requested. <WrittenDate> must be updated when the current date differs from the one on the RxchangeRequest. The <WrittenDate> on the RxChangeResponse is the date of the approval.
<ApprovedWithChanges>	The only condition where an <ApprovedWithChanges> response should be sent by the prescriber system in a RxChangeResponse – (4) When the information submitted in the RxChangeRequest does not include all elements constituting a fillable prescription. In this case the prescriber should include all information when sending a RxChangeResponse of <ApprovedWithChanges>. <WrittenDate> must be updated when the current date differs from the one on the RxchangeRequest. The <WrittenDate> on the RxChangeResponse is the date of the approval.
<Denied>	Deny the RxChangeRequest as requested by the pharmacy.  In a <Denied> response, the only new meaning that should be conveyed to the pharmacy is information that explains the denial.
<DeniedNewPrescriptionToFollow>  This will be sunsetted in a future version.	See section " <i>&lt;DeniedNewPrescriptionToFollow&gt; Use and Sunset</i> ".
<Validated>	The only condition where a <Validated> response should be sent by the prescriber system in a RxChangeResponse – (1) When the RxChangeRequest <MessageRequestCode> category is 'Prescriber Authorization' See section " <i>&lt;Validate&gt; Reason Code use with Message Request Code Sub-categories</i> "

The receiving pharmacy should handle <Approved>, <ApprovedWithChanges>, and <Validated> responses as a NewRx where the original linked prescription/order is discontinued and the <Approved>, <ApprovedWithChanges>, and <Validated> RxChangeResponse message is now the fillable NewRx. A <Denied> response should be directed to a review queue where the Denial reason code is displayed. Therefore, it is important that both prescriber and pharmacy share a common understanding of the significance of each response option.

#### 8.1.4 PATIENT ELEMENT(s)

All elements describes the patient.

#### **8.1.4.1 *Patient Contact Information***

The patient last name and first name must always be sent. The street address of the patient is also required to be sent on a NewRx. It is recommended to include the patient's communication information (preferably cellular or home telephone number and/or email). These data elements are supported within the Patient Segment. When a Communication Number is sent, at least one occurrence must be for TE (telephone) which should be the patient's primary contact number. If the patient only has a cellular phone, then the cellular phone number may be sent twice – once as TE (telephone) and once as CP (cellular phone).

#### **8.1.4.2 *Inclusion of Patient Insurance Information***

SCRIPT has an optional COO Segment (Coordination of Benefits), which supports up to 3 loops (primary, secondary, tertiary) that is used to forward the patient's insurance information. EHR/electronic prescribing vendors are encouraged to include pharmacy and medical insurance information, preferably obtained from the ASC X12 270/271 Eligibility Request and Response, in the COO Segment when transmitting all prescriptions to the pharmacy. If more than one ASC X12 271 Response is received (i.e. one for medical benefits and one for pharmacy benefits) that information can be sent. Providing as much available insurance information as possible on the prescription may reduce call backs to prescribers to obtain this information, expediting the access to the medications for chronic and life threatening conditions.

If available, the patient relationship to the cardholder should be sent. This data element is in the Patient Segment.

#### **8.1.5 PROVIDER ELEMENT(S)**

An element describes the prescriber and the pharmacy. An element may describe the pharmacist and the supervisor. Supervisor information may be needed based upon state law. A supervisor is the supervising physician under whose authority the prescription is being prescribed by the prescriber. An element may describe the facility. Elements may describe the designated provider (primary care provider, medical home provider, facility's provider, or other primary provider.)

#### **8.1.6 MEDICATION ELEMENT(S)**

##### **8.1.6.1 *Recommendations for Consistent Use of the Drug Identification Fields***

To increase efficiencies and reduce potential errors associated with electronic prescribing related to inconsistent use of the NCPDP SCRIPT Drug Identification fields, the following recommendations are made.

###### **8.1.6.1.1 *Defining the Problem***

The NCPDP membership has raised a concern regarding inconsistencies in the use of drug identification fields in the NCPDP SCRIPT message

format used to create electronic prescription messages. These messages include new prescriptions, refill/renewals, fill status notifications, medication history, etc. Drug identification inconsistencies have a potential to cause confusion at the pharmacy for drugs that are electronically prescribed. These inconsistencies in the use of the drug description fields can lead to potential patient safety issues and inefficiencies for the pharmacy and prescriber.

Problems identified:

1. Lack of standardization –
  - a. An electronic prescribing system that is not using a drug knowledgebase compendium and not exchanging industry recommended drug description data and lack of standardization on drug description names among drug knowledgebase compendium.
  - b. An electronic prescribing system that is using a drug knowledgebase compendium but allows the prescriber to manually change the drug description.
  - c. Healthcare systems and technology vendors implementing their own editorial policies to create drug description strings. In most instances, these organizations do use a standard drug knowledgebase compendium.
  - d. When a product does not have an identifier.
2. Guidance available is limited - from drug knowledgebase compendia to their customers for providing appropriate source data element guidance for the drug description.
3. Lack of awareness - electronic prescribing system that is using a drug knowledgebase compendium but not sending the compendium's recommended appropriate source data element for the drug description.
4. Lack of timely updates - to drug files, at the vendor and at the end user system.

#### **8.1.6.1.1.1 Example of Problem**

The extended release dose form of glipizide has been transmitted in prescriptions as:

GlipiZIDE 5 MG Tablet Extended Release 24 Hour  
GLIPIZIDE 5 MG TB24  
GLIPIZIDE 5MG TAB OSM 24  
GlipiZIDE Extended Release 5 mg tablet, extended release  
GLIPIZIDE ORAL TABLET 24 HR 5 MG  
GlipiZIDE XL 5 MG Oral Tablet Extended Release 24 Hour  
Glipizide Tab,Sust Rel Osmotic Push 24hr 5 mg

In the above examples, abbreviations such as "TB24" "OSM 24" should not be used. The appropriate description should be used.

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#### **8.1.6.1.2 Recommendation Summary'**

1. Information transmitted must be clear and not cause confusion in patient safety.
2. The end result is the prescriber and the pharmacist have the final review of the medication to be prescribed or dispensed.
3. EHR, electronic prescribing, and pharmacy systems are strongly encouraged to use a commercial compendia source for ePrescribing Drug Names.
4. EHR, electronic prescribing, and pharmacy systems are strongly encouraged to support timely and accurate updates for drug files from a recognized authoritative source.

The drug compendia use industry recognized best vocabulary, practices of vocabulary and publication. These same practices should be followed by electronic prescribing and pharmacy vendors who do not choose to use a drug compendium.

#### **8.1.6.1.3 Recommendations to Drug Compendia**

The following are recommendations to drug compendia for best practices so information used by electronic prescribing systems on prescriptions will minimize potential patient harm and operational inefficiencies.

1. All commercial compendia should adhere to certain guidelines when creating their ePrescribing Drug Name. At a minimum, the compendia guidelines should include:
  - a. A proper ePrescribing Drug Name
    - i. Needs to contain the appropriate elements to enable the accurate filling of the prescription. It should minimize prescriber and pharmacist confusion. It should not compromise patient safety.
    - ii. The appropriate source data element should contain the description from the commercially available product name (or the name that appeared when it was commercially available). It may generally contain the drug name, strength unit, and form, as appropriate.
    - iii. Generic drug descriptions are permissible. If used, they should follow the same protocol as brand names. However if potential confusion exists between similar generic descriptions, brand names should be considered. Note, the SCRIPT field Item Number (<ProductCode>) provides specificity.
    - iv. Care should be taken to minimize the use of clinically accepted and significant abbreviations (e.g. Hydrochloride is clinically abbreviated as HCl and considered clinically accurate and accepted. Hydrochlorothiazide is clinically abbreviated as HCTZ, but is not ISMP compliant and should not be abbreviated unless part of the brand name).
    - v. Abbreviations (e.g. HBr, NaCl, HFA) and suffixes (e.g. XL, SR) are acceptable to use. (ISMP recommendations should be used.)

The following table summarizes and illustrates good and bad methods of representing the various elements of a drug

description:

Element	Good examples	Bad examples
Product Name(s)	<ul style="list-style-type: none"> <li>• Lipitor</li> <li>• Diltiazem HCl</li> </ul>	<ul style="list-style-type: none"> <li>• HCTZ</li> <li>• APAP</li> <li>• AZT</li> </ul>
Strength and Strength Form (when necessary)	<ul style="list-style-type: none"> <li>• 180 MG</li> <li>• 200MG/5ML or 200 mg/5 mL</li> <li>• Adderall (note: mixed salts of a single-entity/amphetamine product can be listed per label expression instead of the list of individual ingredients)</li> <li>• Arthrotec 50 Delayed-Release Tablet (note: product contains two active ingredients but name reflect only one with no mg designation.)</li> </ul>	<ul style="list-style-type: none"> <li>• 180</li> <li>• 200-5</li> <li>• 40/ML</li> </ul>
Dosage Form	<ul style="list-style-type: none"> <li>• Tablets</li> <li>• Capsules</li> <li>• Kits (note: when more than one dosage form)</li> <li>• 12 HR Delayed Release Tablets</li> <li>• 24 HR Extended Release Capsules</li> <li>• Each (Prevac is provided as 14 cards of 8 tablets and capsules for a total quantity of 112 Each per NCPDP recommendations)</li> </ul>	<ul style="list-style-type: none"> <li>• TB</li> <li>• CP</li> <li>• KT</li> <li>• 12h</li> <li>• TB24</li> <li>• EA</li> </ul>
Route of Administration (when necessary)	<ul style="list-style-type: none"> <li>• Oral</li> <li>• Topical</li> <li>• External</li> </ul>	<ul style="list-style-type: none"> <li>• PO</li> <li>• OR</li> <li>• Do not abbreviate oral as OR</li> </ul>

The registered trademarks are not represented on the chart.

b. A proper ePrescribing Drug Identifier

- i. If an RxNorm concept exists, present the link to the RxCUI that relates to the compendia recommended ePrescribing Name.
- ii. If an RxNorm concept does not exist, present the link to the NDC that relates to the compendia recommended ePrescribing Name.
- iii. In certain cases (e.g. insulin syringe), no RxCUI or NDC may be available. In these cases, the compendia are encouraged to present a link to the identifier (UPC, HRI, etc.) that relates to the compendia recommended ePrescribing Name.

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2. All commercial compendia should publish guidelines to their customers indicating which data elements within their proprietary database systems should be used to construct an appropriate ePrescribing Drug Name. In the instructional information provided by the compendia to its customers, it should be clear which appropriate source data elements should be used to populate the SCRIPT field Item Description (DRU 010-I013-02-7008) or (<DrugDescription> in <Medication>) in electronic prescribing exchanges.

#### **8.1.6.1.4 Recommendations to EHR and Electronic Prescribing Vendors**

The following are recommendations to EHR and electronic prescribing vendors for best practices and standardized field usage, so that information sent to the pharmacy on prescriptions will minimize confusion and possible patient harm.

1. EHR and electronic prescribing systems are strongly encouraged to use a commercial compendia source, and to use the compendia's recommended ePrescribing Drug Name.
  - a. The recommended ePrescribing Drug Name is not to be modified.
2. If an EHR and electronic prescribing system does not use a commercial compendia source, at a minimum, it should use RxNorm for ePrescribing Drug Name.
3. EHR and electronic prescribing systems should transmit drug identification fields as follows:
  - a. If an EHR and electronic prescribing system utilizes a compendia,
    - i. If an RxNorm concept exists, send the RxCUI and the compendia recommended ePrescribing Name.
    - ii. If an RxNorm concept does not exist, send a Representative NDC and the compendia recommended ePrescribing Name.
    - iii. In certain cases (e.g. insulin syringe), no NDC (therefore no Representative NDC) may be available. The identifier (UPC, HRI, etc.) from the compendia should be sent with the compendia recommended ePrescribing Name.
  - b. If an EHR and electronic prescribing system doesn't utilize a commercial compendia it should use RxNorm
    - i. If an RxNorm concept exists, send the RxCUI and RxNorm Name that most closely mirrors the label name.
      1. The RxNorm Name is not to be modified.
    - ii. If an RxNorm concept doesn't exist, do not send it electronically.
  - c. For compound drugs
    - i. Because no NDC or RxCUI is available for the entire formulation the Item Number (or <ProductCode>) must not be populated.
    - ii. If the complete description of the components of the compound cannot be provided in the Item Description (or <Drug Description>), the prescription should be sent in an alternative method (written/phone/etc.).
    - iii. See Specific Guidance for Compound section for additional information.
4. EHR and electronic prescribing systems should support timely and accurate updates for drug files from a recognized authoritative drug information source.

- a. Updates should be added timely via the maintenance process established by the vendor/system. The industry recommends updates are made within a clinically-appropriate timeframe (online real-time, daily, weekly, no less than monthly), to reduce the need for manual drug description entry and use of inappropriate, inaccurate, inconsistent drug descriptions instead of using industry recommendations.
  - b. Consideration should be made for manual updates for timely use. Manual updates for items not listed but prescribed should follow the same guidelines as in section "*Recommendations to Drug Compendia*".
  - c. In the rare cases when a drug description was manually added (e.g. new drug added to market), it should be modified and/or deleted as soon as a compendia- or RxNorm-based record is electronically loaded.
5. For electronic prescribing using the NCPDP SCRIPT Standard, the following recommendations support best practices:
    - a. A controlled substance electronic prescription must contain an industry-established identifier.
    - b. When item dosage form and item strength fields are properly included in the drug description, they should not be sent as individual fields.

EHR and electronic prescribing systems may choose to support local drug names on “favorite’s or quick pick lists”, but the final review and the transmission of the ePrescribing drug name should follow these recommendations.

#### **8.1.6.1.5 Recommendations for Pharmacy System Vendors**

The following are recommendations to pharmacy system vendors supporting electronic prescribing.

1. The pharmacist should be shown the actual drug description transmitted as well as the drug description obtained by the dispensing system.
2. For best practices, it is recommended when the Pharmacy System receives a transaction containing medication information, if an RxCUI is sent, the pharmacist should be shown the actual drug description transmitted as well as the drug description obtained by the search of the RxCUI; the drug name sent as well as the drug name looked up.
3. Pharmacy Systems are strongly encouraged to use a commercial compendia source for ePrescribing Drug Names.
4. If a Pharmacy System does not use a commercial compendia source, at a minimum, it should use RxNorm for ePrescribing Drug Names.
5. When transmitting the drug, the drug identification fields should be used as follows:
  - a. If a Pharmacy System utilizes a compendia,
    - i. If an RxNorm concept exists, send the appropriate RxCUI and the compendia recommended ePrescribing Name.
    - ii. If an RxNorm concept does not exist, send a Representative NDC for the prescribed or requested drug, and the compendia recommended ePrescribing Name.
    - iii. For the dispensed drug, send the appropriate product identifier (e.g. NDC) and the associated drug name.

- iv. In certain cases (e.g. insulin syringe), no NDC (therefore no Representative NDC) may be available. The identifier (UDI-DI, UPC, HRI, etc.) from the compendia should be sent with the compendia recommended ePrescribing Name.
- b. If a Pharmacy System doesn't utilize commercial compendia it should use RxNorm.
  - i. If an RxNorm concept exists, send the appropriate RxCUI and RxNorm Name that most closely mirrors the label name for the prescribed or requested drug.
    - a. The RxNorm Name is not to be modified.
  - ii. For the dispensed drug, send the appropriate product identifier (e.g. NDC) and the associated drug name.
  - iii. If an RxNorm concept doesn't exist, do not send it electronically.

#### **8.1.6.2 Diagnosis Element**

To document and communicate the reason for the prescription, NCPDP strongly recommends that diagnosis and indication be included in all prescriptions. Communicating this information will improve patient safety, enhance efficiency and expedite prior authorization. Inclusion of this information will reduce the need for the pharmacist to contact the prescriber for missing information such as that needed for prior authorization or claim processing.

Including the indication/diagnosis can also support providing patient friendly language for the medication label and patient information leaflet.

If a SNOMED CT® code is sent in the <Diagnosis><Primary> or <Secondary>, the corresponding ICD code for each SNOMED CT® code must also be sent. If no diagnosis is sent and the Structured and Codified Sig is not sent, the indication would be sent in the free text field.

When the ICD code is sent, it should be the diagnosis code pertaining specifically to the medication being prescribed. The medication level diagnosis code may be needed by the patient's prescription benefit plan to determine coverage. Note: ICD-10 codes do have a decimal; however, for transaction/submission of the codes, the decimal is not included in the code. The reporting of the decimal between the third and fourth characters is unnecessary because it is implied.

When the SNOMED CT® code is sent, it must correspond to the problem or indication for which the medication is being prescribed. If the Structured and Codified Sig Format is being used (see NCPDP **Structured and Codified Sig Format Implementation Guide** <IndicationForUse>), the SNOMED CT® code corresponding to the patient's problem or indication for the prescribed medication is transmitted in <IndicationForUse> and be consistent with the ICD codes sent in the diagnosis element(s).

### 8.1.6.3 DrugUseEvaluation Element

The elements <ServiceReasonCode>, <ProfessionalServiceCode>, and <ServiceresultCode> reference data elements from the NCPDP **Data Dictionary**. For example, <ServiceReasonCode> uses the possible values from the NCPDP **Data Dictionary** element Reason For Service Code. Not all values listed in the fields in the NCPDP **Data Dictionary** may be appropriate for all business case scenarios. Consult trading partners for more information on the appropriate values supported.

#### 8.1.6.3.1 Drug-to-Allergy Interaction Example

In this example, a potential drug-to-allergy conflict is identified during the prescribing process, based on the patient's screened allergy codes. The prescriber's system deems the severity of the conflict to be major.

Because the patient has tolerated the medication in the past, the prescriber is proceeding with the prescription, and has provided a coded acknowledgment reason in the <ProfessionalServiceCode> as well as further textual information in the <AcknowledgmentReason>.

Element	Value	Note
<ServiceReasonCode>	DA	Type of conflict identified: Drug-to-Allergy
<ProfessionalServiceCode>	PA	Previous patient tolerance - Patient has taken medication previously without issue
<ServiceresultCode>	4A	Prescribed with Acknowledgements
<CoAgentID>	[NDC11] Or [RxNorm Code]	Representative NDC or RxNorm Code for related drug
<CoAgentIDQualifier>	03 or 38, 39, 40, or 41	NDC qualifier or appropriate RxNorm Code qualifier
<CoAgentCodeDescription>	xxxxxx	Textual representation of the CoAgent ID
<ClinicalSignificanceCode>	1	Major
<AcknowledgementReason>	"Tolerated course of medication in October 2007"	Prescriber's additional free text explanation.

#### 8.1.6.3.2 Drug-to-Condition Interaction Example

In this example, a potential drug-to-condition conflict is identified during the prescribing process, based on the patient's current diagnoses. The prescriber's system deems the severity of the conflict to be minor.

The prescriber is proceeding with the prescription, and has provided an appropriate value in the DUE <AcknowledgmentReason> element.

Element	Value	Note
<ServiceReasonCode>	MC	Type of conflict identified: Drug-Disease (Reported)
<ProfessionalServiceCode>	MP	Prescriber is aware of the risk and will be monitoring the patient
<ServiceresultCode>	4A	Prescribed with Acknowledgements

Element	Value	Note
<CoAgentID>	[ICD9 code] Or [ICD10 code]	ICD9 or ICD10 code representing the conflicting diagnosis
<CoAgentIDQualifier>	20 or 21	ICD9 qualifier or appropriate ICD10 qualifier
<CoAgentCodeDescription>	xxxxx	Textual representation of the CoAgent ID
<ClinicalSignificanceCode>	3	Minor
<AcknowledgementReason>		Blank. Element is not required unless the value in the <ProfessionalServiceCode> is ZZ – Other Acknowledgment

#### 8.1.6.3.3 Drug-to-Drug Interaction Example

In this example, a potential drug-to-drug conflict is identified during the prescribing process, based on the patient's current medication profile. The prescriber's system deems the severity of the conflict to be moderate.

The prescriber is proceeding with the prescription, and has provided an appropriate value in the DUE <AcknowledgmentReason> element.

Element	Value	Note
<ServiceReasonCode>	DD	Type of conflict identified: Drug-Drug Interaction
<ProfessionalServiceCode>	MP	Prescriber is aware of the risk and will be monitoring the patient.
<ServiceResultCode>	4A	Prescribed with Acknowledgements
<CoAgentID>	[NDC11] Or [RxNorm Code]	Representative NDC or RxNorm Code for related drug
<CoAgentIDQualifier>	03 or 38, 39, 40, or 41	NDC qualifier or appropriate RxNorm Code qualifier
<CoAgentCodeDescription>	xxxxx	Textual representation of the CoAgent ID
<ClinicalSignificanceCode>	2	Moderate
<AcknowledgementReason>		Blank. Element is not required unless the value in the <ProfessionalServiceCode> is ZZ – Other Acknowledgment

#### 8.1.6.3.4 Duplicate Drugs Example

In this example, a drug duplication is identified during the prescribing process, reflecting that multiple prescriptions of the same drug formulation are present in the patient's current medication profile. The prescriber's system deems the severity of the conflict to be major.

The prescriber is proceeding with the prescription, and has provided a textual acknowledgment reason in the <AcknowledgmentReason> element, using the ZZ – Other Acknowledgment value in the <ProfessionalServiceCode>

Element	Value	Note
<ServiceReasonCode>	UD	Duplicate Drug
<ProfessionalServiceCode>	ZZ	Other Acknowledgment

Element	Value	Note
<ServiceResultCode>	4A	Prescribed with Acknowledgements
<CoAgentID>	[NDC11] Or [RxNorm Code]	Representative NDC or RxNorm Code for related drug
<CoAgentIDQualifier>	03 or 38, 39, 40, or 41	NDC qualifier or appropriate RxNorm Code qualifier
<CoAgentCodeDescription>	xxxxxx	Textual representation of the CoAgent ID
<ClinicalSignificanceCode>	4	Major
<AcknowledgementReason>	"This medication..."	Prescriber's free text. Element is required when the value in the <ProfessionalServiceCode> is ZZ – Other Acknowledgment

#### 8.1.6.3.5 Duplicate Ingredients Example

In this example, a duplicate ingredient conflict is identified during the prescribing process, reflecting multiple prescriptions with the same active ingredient are present in the patient's current medication profile.

Element	Value	Note
<ServiceReasonCode>	ID	Ingredient Duplication
<ProfessionalServiceCode>	ZZ	Other Acknowledgment
<ServiceResultCode>	4A	Prescribed with Acknowledgements
<CoAgentID>	[NDC11] Or [RxNorm Code]	Representative NDC or RxNorm Code for related drug
<CoAgentIDQualifier>	03 or 38, 39, 40, or 41	NDC qualifier or appropriate RxNorm Code qualifier
<CoAgentCodeDescription>	xxxxxx	Textual representation of the CoAgent ID
<ClinicalSignificanceCode>	4	Major
<AcknowledgementReason>	"This medication..."	Prescriber's free text. Element is required when the value in the <ProfessionalServiceCode> is ZZ – Other Acknowledgment

#### 8.1.6.3.6 Duplicate Therapy Example

In this example, a duplicate therapy conflict is identified during the prescribing process, reflecting that multiple prescriptions of the same therapeutic class are present in the patient's current medication profile.

Element	Value	Note
<ServiceReasonCode>	TD	Duplicate Therapy
<ProfessionalServiceCode>	ZZ	Other Acknowledgment
<ServiceResultCode>	4A	Prescribed with Acknowledgements
<CoAgentID>	[NDC11] Or [RxNorm Code]	Representative NDC or RxNorm Code for related drug
<CoAgentIDQualifier>	03 or 38, 39, 40, or 41	NDC qualifier or appropriate RxNorm Code qualifier
<CoAgentCodeDescription>	xxxxxx	Textual representation of the CoAgent ID

Element	Value	Note
<ClinicalSignificanceCode>	4	Major
<AcknowledgementReason>	"This medication..."	Prescriber's free text. Element is required when the value in the <ProfessionalServiceCode> is ZZ – Other Acknowledgment

#### 8.1.6.3.7 Geriatric Precaution Example

In this example, a geriatric precaution is noted during the prescribing process, indicating that the prescribed medication should be used with caution for a geriatric patient. The associated <ServiceReasonCode> value is "PA, Drug–Age."

Element	Value	Note
<ServiceReasonCode>	PA	Drug - Age
<ProfessionalServiceCode>	MP	Prescriber is aware of the risk and will be monitoring the patient.
<ServiceResultCode>	4A	Prescribed with Acknowledgements
<CoAgentID>		(not sent)
<CoAgentIDQualifier>		(not sent)
<CoAgentCodeDescription>	xxxxxx	Textual representation of the CoAgent ID
<ClinicalSignificanceCode>	3	Moderate
<AcknowledgementReason>		Not sent. Element is not required unless the value in the <ProfessionalServiceCode> is ZZ – Other Acknowledgment

#### 8.1.6.4 DrugCoverageStatusCode Discussion

<DrugCoverageStatusCode> may be relayed from a prescriber to a pharmacist when the prescriber is aware of a formulary status for the drug and chooses the selected drug after this consideration. The prescriber may be aware a prior authorization is required or there may be a differential (potentially higher) copay.

When <DrugCoverageStatusCode> is relayed from a pharmacist to a prescriber, the pharmacist could give the reason for wanting to change to a different drug (i.e., the drug selected by the prescriber is "not reimbursed").

#### 8.1.6.5 Quantity and Quantity Unit Of Measure

It is important that pharmacies receive the prescription Quantity and Quantity Unit Of Measure in a format that specifies a discrete, measurable quantity for the following reasons.

- Patient Safety - In order for the patient to receive the quantity that is intended for therapy by the prescriber. Since clinical edits are based on the metric system, ambiguity could lead to patient harm.
  - There have been deaths associated with the excess application of creams and ointments.
  - Insufficient quantities may result in poor outcomes.

- Patient Expense - It might also lead to additional and/or unnecessary patient expense if the correct quantity intended is left to the pharmacist's discretion.
- To reduce the call backs from the pharmacy to the prescriber office to clarify the quantity appropriate for the patient.

In addition,

- Pharmacies must comply with state and federal regulations that require that the exact, prescribed quantity be on the prescription.
- Pharmacies must successfully comply with third party requirements. Audits that determine the quantity dispensed was not adequately supported by the quantity prescribed result in recoupment for the entire prescription as well as any refills of that prescription.
  - Dispensing 30 GM of fluocinolone 0.025% ointment for a prescription written for "1 Tube" is an example since it is also available in a 15 GM Tube.

Below is a list of recommendations that Drug Compendia, EHR, Electronic Prescribing System Vendors and Prescribers are highly urged to follow.

#### **Drug Compendia**

The drug compendia should ensure each drug/item description is mapped to a valid and appropriate National Cancer Institute (NCI) NCPDP Terminology Quantity Unit of Measure Code (<http://www.cancer.gov/cancertopics/cancerlibrary/terminologyresources/ncpdp>). In the NCPDP Terminology tables this is the NCPDP QuantityUnitOfMeasure Terminology concepts. This guidance does not affect other concepts in these tables such as NCPDP DEASchedule Terminology, NCPDP MeasurementUnitCode Terminology, NCPDP StrengthForm Terminology, or NCPDP StrengthUnitOfMeasure Terminology.

- The drug compendia should provide guidance, based upon their data set, for displaying unit-of-use packaging to vendors of electronic prescribing systems so both the metric-decimal Quantity and the Quantity Unit of Measure description should be displayed to the prescriber when creating a prescription.
- For drugs/items that are measured in volume (ML) or weight/mass (GM) and that are dispensed in unit of use packaging, the prescription metric decimal quantity options displayed to the prescriber should represent what is commercially available from the pharmaceutical company for the drug/item prescribed (e.g. eye drops – 5 ML, 10 ML or 15 ML).
- The Quantity and Quantity Unit of Measure description along with the package information should be displayed to the prescriber. Only the Quantity and Quantity Unit of Measure code information is transmitted in the prescription from the prescriber to the pharmacy.
- The drug compendia should create such specific guidance as described in the above bullets for vendors of electronic prescribing systems to facilitate the integration of their products in electronic prescription messaging.

#### **EHR and Prescribing System Vendors**

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- Use a commercial compendium as a source for drug information.
  - If a commercial compendium is not used, the Structured Product Label (SPL) provides a dose form qualifier (see [DailyMed](#)) which should be mapped to the NCI list of available codes.
- Regularly scheduled updates from the compendia are processed and loaded in the prescribers' system.
- The Quantity Unit of Measure code value C38046 (Unspecified) is only to be used for translation purposes when a Quantity Unit Of Measure value is not available for use in the version of the NCI Codes.
- For drugs/items that are measured in volume (ML) or weight/mass (GM), the prescription metric decimal quantity options displayed to the prescriber represent what is commercially available from the pharmaceutical company for the drug/item prescribed.
- The Quantity and Quantity Unit of Measure description along with the package information should be displayed to the prescriber. Only the Quantity and Quantity Unit of Measure code information is transmitted in the prescription from the prescriber to the pharmacy.
  - Examples
    - Oral and Topical Liquids: 60 ML Bottle, 100 ML Bottle, etc.
    - Ophthalmic, Otic or Oral Drops: 5 ML Bottle, 7.5 ML Bottle, 30 ML Bottle, etc.
    - Creams, Gels and Ointments: 30 GM Tube, 42.5 GM Tube, 454 GM Jar, etc.
    - Inhalers: 8 GM Canister, 15 GM Bottle, etc.
    - Cans: 240 GM Can or 240 ML Can, etc.
    - Blood Glucose Test Strips: 100 EA Box, etc.
    - Lancets: 100 EA Box, etc.
- Package descriptions alone are strongly discouraged from being available to select as a Quantity Unit of Measure description.
  - Not Recommended Examples
    - Cans
    - Bottle
    - Box
    - Tube

The table below provides examples of how to implement these recommendations. In the column “Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription”, the description is shown for readability. In the actual transmission, the code would be sent (e.g. ML code is C28254; GM code is C48155; EA is C64933, etc.)

Examples of Drugs/Items	Example of Incorrect Quantity to Display and Transmit	Example of Correct Quantity to Display to the Prescriber	Example of Correct Quantity and Quantity Unit of Measure to

			<b>Transmit with the Prescription</b>
Amoxicillin 250 mg/5 ML for Oral Suspension	1 Bottle	100 ML Bottle	100 ML
Hydroxyzine Hydrochloride 10 mg/5 ML Syrup	4 oz	120 ML Bottle	120 ML
Albuterol Sulfate HFA 108 mcg/act Inhalation Aerosol	1 canister	18 GM Canister	18 GM
Lindane 1% Shampoo	1 Bottle	60 ML Bottle	60 ML
Timolol Maleate 0.5% Ophthalmic Solution	1 Bottle	10 ML Bottle	10 ML
Ear Wax Drops	1 Bottle	15 ML Bottle	15 ML
Fluocinonide 0.05% Cream	1 Tube	30 GM Tube	30 GM
Triamcinolone Acetonide 0.025% Cream	1 Jar	454 GM Jar	454 GM
Flunisolide 0.025% Nasal Spray	1 Bottle	25 ML Bottle	25 ML
Cholestyramine 4 gm Powder	1 Can	378 GM Can	378 GM
Cholestyramine 4 gm Powder Packet	1 Box	120 Packet Box	120 Packet
Blood Glucose Test Strips	1 Box	50 Strip Box	50 Strip
Promethazine 25 mg Suppository	1 Box	12 Suppository Box	12 Suppository
Incontinence Brief / Large	1 Package	25 EA Package	25 EA
TED Hose (2 stockings)	1 Box	2 EA Box	2 EA

- An example is when 2 tubes of a 15 GM cream are prescribed; one tube may be for use at home and the other for use at school. The prescription quantity to transmit to the pharmacy is the total quantity that represents the number of units to dispense times the metric-decimal quantity of each unit dispensed along with the appropriate Quantity Unit of Measure code. In addition, the prescriber needs to include a note in the Notes field instructing the pharmacist how to fulfill the prescription quantity.

The table below provides guidance on how this scenario is to be handled. In the column “Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription”, the description is shown for readability. In the actual transmission, the code would be sent (e.g. GM code is C48155.)

<b>Example of Drug/Item</b>	<b>Example of Correct Quantity to Display to the Prescriber</b>	<b>Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription</b>	<b>Note that Prescriber Includes in the Notes Field</b>
Triamcinolone Acetonide 0.025% Cream	2 x 15 GM Tube	30 GM	Dispense 2 Tubes, one for home use and one for school use.

- A second example is when multiple prefilled syringes that contain liquid for injection are prescribed. According to the NCPDP **Billing Unit Standard**, the quantity for a liquid filled syringe is represented by the metric decimal volume of liquid that the syringe contains along with the Quantity Unit of Measure code for ML.

The table below provides guidance on how this scenario is to be handled. In the column “Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription”, the description is shown for readability. In the actual transmission, the code would be sent (e.g. ML code is C28254.)

Example of Drug/Item	Example of Correct Quantity to Display to the Prescriber	Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription	Pharmacy Calculation to Determine the Quantity to Dispense
Enoxaparin 40 MG/0.4 ML Solution for Injection	10 x 0.4 ML Syringes	4 ML	$4 \text{ ML} \div 0.4 \text{ ML/syringe} = 10 \text{ syringes}$

- A third example is when multiple vials that contain a dosage form that has to be reconstituted for injection are prescribed. According to the NCPDP **Billing Unit Standard**, the Quantity for a drug that is in a dosage form that is marketed in a vial, etc., that has to be reconstituted prior to injection has the metric decimal Quantity of 1, and the Quantity Unit of Measure is the code for “Each”.
  - For the example below, vial can be directly mapped to the **Billing Unit Standard** “EA”. The metric decimal Quantity is 2. The Quantity Unit of Measure is the code for “EA”.

The table below provides guidance on how this scenario is to be handled. In the column “Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription”, the description is shown for readability. In the actual transmission, the code would be sent (e.g. EA is C64933.)

Example of Drug/Item	Example of Correct Quantity to Display to the Prescriber	Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription	Quantity to Dispense
Risperdal Consta 37.5 MG Reconstituted Suspension for Injection	2 x 1 EA	2 EA	2 Vial of powder

- A fourth example is when single or multiple vials contain a liquid dosage form. According to the NCPDP **Billing Unit Standard**, liquids are measured in ML. The Quantity Unit of Measure is the code for “ML”.

The table below provides guidance on how this scenario is to be handled. In the column “Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription”, the description is shown for readability. In the actual transmission, the code would be sent (e.g. ML code is C28254.)

Example of Drug/Item	Example of Correct Quantity to Display to the Prescriber	Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription	Quantity to Dispense
Cyanocobalamin 1000 mcg/ML injectable solution	2 x 1 ML	2 ML	2 Vial of 1 ML

- Drugs/Items that can be uniquely identified with discrete, measurable quantities should be sent with the most descriptive unit of measure.
  - Recommended Examples
    - Capsule
    - Tablet
    - Strip
    - Patch
    - Kit

Examples are provided in the table below. The description is shown for readability. In the actual transmission, the code would be sent (e.g. EA is C64933.)

Examples of Drugs/Items	Examples of Correct Quantity and Quantity Unit of Measure Alternatives to Display to the Prescriber. Either may be transmitted with the prescription, but the more descriptive is the preferred (e.g. Capsules, Tablets, Patches).	
Amoxicillin 500 mg Capsule	30 Capsule	30 EA
Enalapril 10 mg Tablet	90 Tablet	90 EA
Lidocaine 5% Patch	30 Patch	30 EA

- For instances where the same drug and strength are available in different dosage forms, it is recommended that the dosage form code rather than the code for EA be transmitted as the Quantity Unit of Measure.

The table below provides an example. In the column “Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription”, the description is shown for readability. In the actual transmission, the code would be sent (e.g. Capsule is C48480, etc.)

Examples of Drugs/Items	Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription
Doxycycline Hyclate 100Mg Capsule	30 Capsule
Doxycycline Hyclate 100Mg Tablet	30 EA

#### EHR, Prescribing System Vendors and Prescribers

The above recommendations are strongly encouraged to be applied when a prescriber creates a prescription via free text. The examples in the tables above should be used as guidance.

##### 8.1.6.6 *Quantity Sufficient*

In care settings where there are established dispensing protocols between the prescriber and the pharmacy/pharmacist, dispensed quantities for certain medication orders are appropriately determined by the pharmacy—based on the prescriber’s dosing directions as well as other factors. For example, in the Long Term Care setting, medication orders are typically open-ended. A medication is delivered to the resident’s facility on a scheduled basis until the pharmacy is notified that the order has been discontinued by the prescriber. The delivery schedule is determined by each pharmacy based on a variety of factors—with deliveries occurring every 7 days, every 14 days, monthly, etc. Accordingly, the quantity to be dispensed for a given delivery must be determined by the pharmacy to match their particular delivery schedule.

For use on the NewRx transaction only, <Quantity><CodeListQualifier> value of “QS” is limited to settings where dispensing protocols are in force between the physician and pharmacy/pharmacist, where such use is in accordance with federal and state regulations. Example settings include long term care, home healthcare, and outpatient clinics.

When the <Quantity><CodeListQualifier> value of “QS” is used, QuantityUnitOfMeasureCode must equal “C38046”. <Quantity><Value> must equal “0”.

“QS” is not used in the <MedicationPrescribed> element for retail pharmacy NewRx transactions. If a NewRx transaction is received by a retail pharmacy with the QS qualifier for a quantity of 0, then an Error response transaction must be returned. The Error transaction will contain a <Code> = “900” (Transaction Rejected). In addition, the <DescriptionCode> should indicate the rejection; for example, a reject code value of

“134” to indicate “Sending a Quantity Sufficient with Quantity of 0 is invalid for this pharmacy.” See **Compound - Quantity for the correct use of Quantity Sufficient value in compounds.**

#### **8.1.6.7 Days Supply**

1. Length of therapy and Days Supply are not synonyms; they are not the same concept or used the same.
2. Length of therapy is a defined period of time during which the patient will be using this drug regimen. The Directions or the appropriate fields within Structured Sig are to be used to provide more information when necessary to indicate the length of therapy.
  - a. Examples of length of therapy:
    - i. 1 tablet daily **for 7 days until gone**
    - ii. 2 drops in each eye 2 times a day **for 5 days** (a 5 mL container with these instructions would have a Days Supply of 25; based on 20 drops per mL)
3. Since Days Supply is an optional field, if not aware of how many doses are in the container, do not transmit a Days Supply. The value 0 should not be sent. Days Supply may be sent for specialty prescriptions (e.g. titration range) or may be used for drug utilization review.
4. For maintenance medications - Length of therapy is typically not sent unless it is for a clinically necessary specification.
5. Days Supply is the estimated number of days the prescription will last excluding refills, based upon the prescribed quantity and directions. It is the prescribed quantity divided by the daily doses. While this is typically system calculated, the prescriber retains responsibility for the value. **If a number is entered into this field and it conflicts with the quantity and calculated metric dose per day, a RxChange message or a call back from the pharmacy should be expected.**
  - a. Examples:
    - i. 10 mg tablet, Quantity = 30, take one tablet per day, Refills = 5. Days Supply = 30
    - ii. 1 tablet every week, quantity = 4, Refills = 5. Days Supply = 28
    - iii. 1-2 tablets every 4-6 hours as needed for pain. Quantity = 36, Refills = 0. Days Supply = 3
    - iv. 5 mLs twice daily, Quantity = 100 mLs, Refills = 0, Days Supply = 10
    - v. Metered dose inhaler – 1-2 puffs every 6 hours as needed. Quantity = 6.7 grams (200 puffs in container). Refills = 0. Days Supply = 25
  1. Note: If not aware of how many doses are in the container, do not transmit a Days Supply.
- b. Incorrect use of Days Supply:
  - i. 10 mg tablet, Quantity = 30, take one tablet per day, Refills = 5. Days Supply = 180 (should be 30)

- ii. 5 mLs twice daily, Quantity = 100 mLs, Refills = 0, Days Supply = 30 (should be 10)
6. For ambiguous dose forms (e.g. creams, ointments, gels, drops), it is recommended that Days Supply should not be sent, unless the dose form has a specific measurable unit dosage (e.g. pump, gel packs).
7. The Free Text(<Notes>) field can be used for further clarification if the instructions cannot be clearly designated in the Directions or appropriate fields in the Structured Sig, but should not cause confusion in explanation with the discrete medication fields.

#### 8.1.6.8 Medication Elements and Refill Elements

The following chart parallels section "Element Usage in Each Transaction" to clarify the use of the Medication and Compound elements. **Note** <MedicationTransferRequested> is not used in any transaction discussed in this section. See specific section below for RxTransfer Transactions.

Note, Resupply and DrugAdministration do not use Refill elements, but their use of the Medication element is shown for clarity:

Medication and Compound element	Resupply	DrugAdministration
<MedicationPrescribed>	M	M
<MedicationDispensed>	C	N
<MedicationRequested>	N	N
<MedicationDispensedAdministered>	N	N
<MedicationResponse>	N	N
<MedicationTransferRequested>	N	N

Use of Refill element (Only one value is allowed per) for Medication and Compound elements.

<b>&lt;MedicationPrescribed&gt; for medication and compound elements</b>	NewRx	RxRenewalRequest	RxRenewalResponse	RxFill	RxChangeRequest	RxChangeResponse	CancelRx	RxHistoryResponse	Comment See guidance in section " <a href="#">Structure Quick Reference</a> ".
<b>Medication and Compound element</b>	<b>M</b>	<b>C</b>	<b>N</b>	<b>C</b>	<b>M</b>	<b>C</b>	<b>M</b>	<b>C</b>	Prescribed medication perspective.
<NumberOfRefills>	<b>M</b>	<b>M</b>	<b>N</b>	<b>M</b>	<b>M</b>	<b>M</b>	<b>M</b>	<b>M</b>	If sending <MedicationPrescribed>, <NumberOfRefills> must be sent, even if zero.
<PharmacyRequestedRefills>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	
<RefillsRemaining>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	
<b>&lt;MedicationDispensed&gt; for medication and compound elements</b>	NewRx	RxRenewalRequest	RxRenewalResponse	RxFill	RxChangeRequest	RxChangeResponse	CancelRx	RxHistoryResponse	Comment See guidance in section " <a href="#">Structure Quick Reference</a> ".
<b>Medication and Compound element</b>	<b>N</b>	<b>M</b>	<b>N</b>	<b>C</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>C</b>	Pharmacy dispensed perspective.
<NumberOfRefills>	<b>N</b>	<b>N</b>	<b>N</b>	<b>M</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	
<PharmacyRequestedRefills>	<b>N</b>	<b>C</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	RxRenewalRequest may include pharmacy requesting more refills.
<RefillsRemaining>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>N</b>	<b>C</b>	Only allowed on RxHistoryResponse.

<MedicationDispensedAdministered> for medication and compound elements	NewRx	RxRenewalRequest	RxRenewalResponse	RxFill	RxChangeRequest	RxChangeResponse	CancelRx	RxHistoryResponse	Comment See guidance in section " <a href="#">Structure Quick Reference</a> ".
<b>Medication and Compound element</b>	N	N	N	N	N	N	N	C	What the entity dispensed and administered. Not applicable to dispensed or administered on RxFill as transaction originates from the pharmacy.
<NumberOfRefills>	N	N	N	N	N	N	N	N	
<PharmacyRequestedRefills>	N	N	N	N	N	N	N	N	
<RefillsRemaining>	N	N	N	N	N	N	N	C	Only allowed on RxHistoryResponse.
<MedicationRequested> for medication and compound elements	NewRx	RxRenewalRequest	RxRenewalResponse	RxFill	RxChangeRequest	RxChangeResponse	CancelRx	RxHistoryResponse	Comment See guidance in section " <a href="#">Structure Quick Reference</a> ".
<b>Medication and Compound element</b>	N	N	N	N	C	N	N	N	Pharmacy requesting alternative medication(s) perspective.
<NumberOfRefills>	N	N	N	N	C	N	N	N	
<PharmacyRequestedRefills>	N	N	N	N	N	N	N	N	
<RefillsRemaining>	N	N	N	N	N	N	N	N	

<MedicationResponse> for medication and compound elements	NewRx	RxRenewalRequest	RxRenewalResponse	RxFill	RxChangeRequest	RxChangeResponse	CancelRx	RxHistoryResponse	Comment See guidance in section " <a href="#">Structure Quick Reference</a> ".
<b>Medication and Compound element</b>	N	N	M	N	N	N	N	N	See section " <a href="#">Clarification of Response Type</a> ".
<NumberOfRefills>	N	N	M	N	N	N	N	N	RxRenewalResponse includes prescriber's additional refills authorized. If no additional refills authorized, quantity is zero. See Notes below.
<PharmacyRequestedRefills>	N	N	N	N	N	N	N	N	
<RefillsRemaining>	N	N	N	N	N	N	N	N	

**A summarization:**

Medication	Allowed Value
NewRx <MedicationPrescribed>	<NumberOfRefills>
RxRenewalRequest <MedicationPrescribed>	<NumberOfRefills>
RxRenewalRequest <MedicationDispensed>	<PharmacyRequestedRefills>
RxRenewalResponse <MedicationResponse>	<NumberOfRefills>
RxFill <MedicationPrescribed>	<NumberOfRefills>
RxFill <MedicationDispensed>	<NumberOfRefills>
RxChange <MedicationPrescribed>	<NumberOfRefills>
RxChange <MedicationRequested>	<NumberOfRefills>
RxChangeResponse <MedicationPrescribed>	<NumberOfRefills>
CancelRx <MedicationPrescribed>	<NumberOfRefills>
RxHistoryResponse <MedicationPrescribed>	<NumberOfRefills>
RxHistoryResponse <MedicationDispensed>	<RefillsRemaining>
RxHistoryResponse <MedicationDispensedAdministered>	<RefillsRemaining>

**Notes:**

<NumberOfRefills> is an Original Dispensing in addition to the <Quantity>.

- <NumberOfRefills> is used in <MedicationPrescribed> of noted transactions above to denote the prescriber's instruction, or

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- In <MedicationRequested> of RxChangeRequest transaction to denote the requested change in number of refills in the new prescription, or
- In <MedicationDispensed> of RxFill transaction to denote the number of refills of the prescription, or
- In <MedicationResponse><Replace>, <Approved>, or <ApprovedWithChanges> of RxRenewalResponse transaction to denote the prescriber's instruction. See rules in section "Clarification of ResponseType".

See Note 2.

- Example <MedicationPrescribed>: In a NewRx - If <NumberOfRefills> = 3, the prescriber is authorizing **four** dispensings on the prescription (original <Quantity> plus 3 refills).
- Example <MedicationPrescribed>: In other transactions noted above - If <NumberOfRefills> = 3, this is the number of refills of the prescription.
- Example <MedicationDispensed>: If RxFill <NumberOfRefills> = 4, this is the number of refills of the prescription.
- Example <MedicationRequested>: In RxChangeRequest <NumberOfRefills> = 3, this is the number of refills being requested by the pharmacy to change the new prescription.
- Example: If an RxRenewalResponse <NumberOfRefills> = 3, the prescriber is authorizing three dispensings.

#### **<PharmacyRequestedRefills>**

- A pharmacy may submit a RxRenewalRequest with <MedicationDispensed> without requesting a particular number of refills (<PharmacyRequestedRefills> not sent). If a pharmacy wishes to request a specific number of refills, it should submit <PharmacyRequestedRefills> - the desired number of refills. If the pharmacy wishes to request additional refills without specifying how many, <PharmacyRequestedRefills> must not be sent. **If <PharmacyRequestedRefills> is used, the number of refills requested must not be zero.**

**<RefillsRemaining>** is used to relay a value of refills remaining as part of the information that comes on a medication history record.

- <RefillsRemaining> is used in <MedicationDispensed> or <MedicationDispensedAdministered> of the RxHistoryResponse transaction.
- Example: If <RefillsRemaining> = 5, **five** refills remain on the prescription.

**Note 2:** A Pharmacy receiving an RxRenewalResponse may implement the dispensings authorized pursuant to the RxRenewalResponse in accordance with applicable laws and regulations, and its own practices. Thus, if an RxRenewalResponse authorizes four dispensings, the pharmacy may:

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- Generate a new prescription with an original dispensing and three refills
- Add four refills to an existing prescription

<LastFillDate> - If the prescription was filed but never filled, a Last Fill Date is not available and the transaction should not be sent.

<MedicationPrescribed> - SCRIPT transactions sent from the pharmacy to the prescriber **should not** contain the literal prescribed medication information that was provided by the prescriber on a NewRx but instead should include the pharmacist's interpretation of the medication ordered by the prescriber. For example,

Prescriber drug name: simvastatin (aka Zocor) 20 mg tablet oral

Pharmacy drug name: simvastatin 20mg tablet

In this case, the Renewal Response should be approved as the **medication intent is the same** in this example. This guide indicates this difference in drug name is a difference in form, not meaning. The system should leverage the RxNorm code in the transaction and not key on a textual field. It is noted that established code sets may support synonym descriptions. The Prescriber Order Number is used to tie back.

#### 8.1.6.9 Prescription Transfer Medication Elements and Refill Elements

##### RxTransferRequest:

<MedicationTransferRequested> for medication elements – note compounds are not supported in transfer transactions	RxTransferRequest	Comment See guidance in section " <a href="#">Structure Quick Reference</a> ".  Only sent if <TransferType> = "SPECIFIC".
<b>Medication element</b>	<b>M</b>	Derived medication perspective.
<NumberOfRefills>	N	
<AdditionalRefillsAuthorized>	N	
<PharmacyRequestedRefills>	N	
<RefillsRemaining>	N	
<QuantityTransferred>	N	

**RxTransferResponse:**

<b>&lt;MedicationPrescribed&gt; for medication elements – note compounds are not supported in transfer transactions</b>	<b>RxTransferResponse</b>	<b>Comment</b> See guidance in section " <a href="#">Structure Quick Reference</a> ".
<b>Medication element</b>	<b>M</b>	Prescribed medication perspective with overall prescription information.
<NumberOfRefills>	<b>M</b>	<MedicationPrescribed><NumberOfRefills> must be sent, even if zero.
<AdditionalRefillsAuthorized>	<b>N</b>	
<PharmacyRequestedRefills>	<b>N</b>	
<RefillsRemaining>	<b>M</b>	At the prescription level, not the fill level.
<QuantityTransferred>	<b>M</b>	At the prescription level, not the fill level.
<b>&lt;MedicationDispensed&gt; for medication elements – note compounds are not supported in transfer transactions</b>	<b>RxTransferResponse</b>	<b>Comment</b> See guidance in section " <a href="#">Structure Quick Reference</a> ".
<b>Medication element</b>	<b>M</b>	Pharmacy dispensed perspective.
<NumberOfRefills>	<b>N</b>	See <MedicationPrescribed> above.
<AdditionalRefillsAuthorized>	<b>N</b>	
<PharmacyRequestedRefills>	<b>N</b>	
<RefillsRemaining>	<b>N</b>	See <MedicationPrescribed> above.
<QuantityTransferred>	<b>N</b>	See <MedicationPrescribed> above.

**A summarization:**

Medication	Allowed Value
RxTransferResponse <MedicationPrescribed>	<NumberOfRefills>
RxTransferResponse <MedicationPrescribed>	<RefillsRemaining>
RxTransferResponse <MedicationPrescribed>	<QuantityTransferred>

**Note 1:**

<NumberOfRefills> is an Original Dispensing in addition to the <Quantity>.

- <NumberOfRefills> is used in <MedicationPrescribed> of noted transactions above to denote the prescriber's instruction.
- Example <MedicationPrescribed>: In a RxTransferResponse - If <NumberOfRefills> = 3, the prescriber is authorizing four dispensings on the prescription (original <Quantity> plus 3 refills).

<RefillsRemaining> is used to relay a value of refills remaining.

- <RefillsRemaining> is used in <MedicationPrescribed> of the RxTransferResponse transaction.
- Example: If <RefillsRemaining> = 5, five refills remain on the prescription.

**Note 2:** A Pharmacy receiving an RxTransferResponse may implement the dispensings authorized pursuant to the transfer in accordance with applicable laws and regulations, and its own practices. Thus, if an RxTransferResponse authorizes four dispensings, the pharmacy may:

- Generate a new prescription with an original dispensing and three refills
- Add four refills to an existing prescription

<QuantityTransferred> – The amount to be transferred. This may/not contain a whole number. See the scenarios in section "[Prescription Transfer Elements](#)".

Note: Total Quantity Prescribed = Original Prescribed Quantity + (Number of Refills \* Original Prescribed Quantity)

#### 8.1.6.10 **WrittenDate**

On a NewRx the <WrittenDate> indicates the date the prescriber created this prescription being transmitted.

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It is recommended that transmission of the NewRx should be within 72 hours of the <WrittenDate>, with exceptions for state/federal regulations timeframe requirements. <WrittenDate> must precede or be equal to the transmission date. For future dating, see <OtherMedicationDateQualifier> value of <EffectiveDate>.

<OtherMedicationDateQualifier> value of <EffectiveDate>: The date or date/time after which this prescription being transmitted can be dispensed (i.e. do not fill before date) as authorized by the prescriber.

For receipt of prescriptions with transmission of the NewRx greater than 72 hours of the <WrittenDate>, the RxChange transaction can be used for clarification with the prescriber.

**EXCEPTION:** Electronic prescriptions for patients receiving Long Term Care Pharmacy Services are exempt from the <OtherMedicationDateQualifier> value of <EffectiveDate> usage stated above. LTPAC pharmacies may dispense prior to the <OtherMedicationDateQualifier> value of <EffectiveDate> to ensure availability for medication administrations.

On an RxRenewalResponse or RxChangeResponse <Approved> or <ApprovedWithChanges>, the <WrittenDate> must indicate the date of approval. On an RxRenewalResponse <Replace>, <WrittenDate> must indicate the date of the replacement prescription. It must not indicate the <WrittenDate> of the original prescription indicated in the request.

#### **8.1.6.11 *Brand Medically Necessary for Medicaid Prescriptions***

If <Substitutions> = 1, <ReasonForSubstitutionCodeUsed> must contain "BRAND MEDICALLY NECESSARY" (for all Medicaid programs).

Regardless of a prior authorization or lack thereof, any electronic prescription requires 3 elements to be eligible for Medicaid reimbursement per CMS:

1. A Prescription Origin Code (419-DJ) on the claim indicating the electronic origin (the pharmacy is responsible to add the correct value to the claim and transmit the claim).
2. A Dispense As Written (408-D8) code of "1" (must appear on the prescription that meets the prescriber's requirement, be "honored" by pharmacy, and be transmitted on the claim).
3. The actual text (without quotes) "Brand Medically Necessary" in the prescription provided directly by the prescriber or prescriber office that displays/prints on the prescription image/hard copy.
  - a. Per CMS, the specific text is to be sent; it is not to be abbreviated or truncated.

- b. Per CMS, the above requirement would NOT be satisfied by printing the hard copy, calling the prescriber and documenting on that hard copy “Brand Medically Necessary” even if the prescriber him/herself told the pharmacist in person. It MUST come from the prescriber hand/system.
- c. The prescriber hand/system will add this text “Brand Medically Necessary” in the NCPDP SCRIPT ReasonForSubstitutionCodeUsed element to the pharmacy.

With these elements present, the prescriber is fully liable for the use of the brand and the pharmacy will have no liability, per CMS.

#### **8.1.6.12 *DoNotFill***

When using this field on the <NewRx>, it is important for the prescriber to populate the medication prescribed with the same exact intent as indicated on the phone. The <DateWritten> must reflect the date that the oral prescription was issued.

Value “E” (A cover prescription for a previously called in emergency oral prescription– do not fill) is **only generated on a <NewRx>**. Value “E” indicates to the pharmacy that they should not fill this prescription. This is a cover prescription for a previously called in emergency oral prescription as necessary for controlled substances.

An Example of an Emergency Oral Manual Process for Controlled Substances:

A prescriber calls in an emergency oral prescription for a controlled substance. The pharmacy commits the prescription to writing and fills the oral prescription. The pharmacy tracks that this was an emergency oral controlled substance prescription and waits for the follow up cover prescription on paper.

The prescriber fills out a paper prescription and mails it to the pharmacy. When the pharmacy receives the paper prescription, they do not fill the paper prescription but rather staples the paper to the written prescription and files the information.

If no paper prescription is received by the pharmacy timely, the pharmacy calls the prescriber.

Use of <DoNotFill> value “E”:

With electronic prescribing, the prescriber can send an electronic prescription to “cover” for the oral prescription.

It is important that the pharmacy not fill the electronic prescription when it is received. Instead the pharmacy should link it to the original oral emergency prescription and not fill it – just like the manual process.

### 8.1.6.13 *OfficeOfPharmacyAffairsID*

<OfficeOfPharmacyAffairsID> is a medication-by-medication indication and therefore included in the Medication as appropriate.

Example: An entity could be eligible for a tuberculosis grant and this is their only 340B eligibility. The prescriber writes a prescription for a tuberculosis medication and a blood pressure medication for the same patient on the same day in the same visit. The tuberculosis medication prescription is sent with the <OfficeOfPharmacyAffairsID>; the blood pressure medication prescription is not sent with an <OfficeOfPharmacyAffairsID>.

Example: A community health center could have multiple grants and multiple IDs each of which could appear on the prescription. If the community health center is eligible as a "comprehensive health center" and has a family planning grant both the Comprehensive Health Center ID and the Family Planning ID could appear on a prescription for prenatal vitamins, but not on a blood pressure medication prescription.

<OfficeOfPharmacyAffairsID> indicator is sent by the prescribing system when the appropriate value can be determined. The pharmacy would know if the prescription is eligible under the contract (therefore the ID) they receive. The <OfficeOfPharmacyAffairsID> occurs up to 10 times. Occurrence values must not repeat. There is no intelligence in what order the IDs are sent. Eligibility for the Section 340B drug does not require that the pharmacy fill the prescription with Section 340B drug.

### 8.1.6.14 *RxFillIndicator Usage*

The element <RxFillIndicator> is used on the NewRx to indicate what type of fill status notifications are desired by the prescribing system.

It is used on all other applicable transactions to change the fill status notification. The field is **not sent** on the other applicable transactions if there is no change to the fill status notification. If the field is **not sent** on the applicable transactions it means there is no change to the value previously requested for this patient and medication combination.

Example of NewRx from prescriber requesting a fill status notification only when the medication has been dispensed or partially dispensed.

Element	Value	Note
To	7701630:P	NCPDP Provider ID Number of pharmacy; P means it is a pharmacy. This is the destination.
From	77777777:C	This is the Clinic ID of the sender; C means it is a Clinic.
MessageID	1234567	Clinic system trace number for the transmission. Echoed back in the response transaction in RelatesToMessageID.

Element	Value	Note
<b>RelatesToMessageID</b>		<b>Not sent. Not applicable.</b>
NewRx	NewRx	The transaction type: New Prescription.
<b>PrescriberOrderNumber</b>	<b>110088</b>	<b>This is the reference number assigned by the prescribing system.</b>
<b>RxReferenceNumber</b>		<b>Not sent. Not applicable.</b>
<i>MedicationPrescribed</i>		
DrugDescription	CALAN SR 240MG	Drug prescribed is Calan Sr 240mg.
Strength,	240	240 is the strength.
StrengthForm	C42998	The Source for NCPDP Drug Dosage Form Terminology- C42998 is the code for "Tablet dosing form". So this means the prescription is for 240mg tablets.
StrengthUnitOfMeasure	C28253	The Source for NCPDP Drug StrengthUnitOfMeasure Terminology. C28253 is the code for "Milligram".
RxFillIndicator	DISPENSED AND PARTIALLY DISPENSED	Only send fill status .notification when the medication has been dispensed or partially dispensed.

The pharmacy then requests a change in the medication asking for permission to substitute a generic equivalent.

Element	Value	Note
To	77777777:C	This is the Clinic ID of the receiver; C means it is a Clinic.
From	7701630:P	NCPDP Provider ID Number of pharmacy; P means it is a pharmacy. This is the sender. It must be the pharmacy ID.
<b>MessageID</b>	<b>A55</b>	<b>Pharmacy system trace number for the transmission. Echoed back in the response transaction in RelatesToMessageID.</b>
<b>RelatesToMessageID</b>	<b>1234567</b>	<b>Prescriber trace number is used to link the original transaction (NewRx) (MessageID) to this subsequent transaction.</b>
RxChange	RxChange	The transaction: RxChange.
<b>PrescriberOrderNumber</b>	<b>110088</b>	<b>This is the reference number assigned by the prescribing system.</b>
<b>RxReferenceNumber</b>	<b>PH888</b>	<b>This is the prescription number assigned by the pharmacy system.</b>
MessageRequestCode	G	Generic substitution is being requested.
Note	SUBSTITUTE GENERIC?	Pharmacy is asking to substitute generic for PCE.

Response Option1: The prescriber responds to the request for substitution with no change to the previous requested fill status notification value. Therefore <RxFillIndicator> is not sent.

See detail above.

Element	Value	Note
To	7701630:P	NCPDP Provider ID Number of pharmacy; P means it is a pharmacy. This is the receiver. It must be the pharmacy ID.

Element	Value	Note
From	77777777:C	This is the Clinic ID of the sender; C means it is a Clinic.
MessageID	2291	<b>Prescriber system trace number for the transmission. Echoed back in the response transaction in RelatesToMessageID.</b>
RelatesToMessageID	A55	Pharmacy trace number is used to link the original transaction (RxChangeRequest) (MessageID) to this subsequent transaction.
PrescriberOrderNumber	110088	This is the reference number assigned by the prescribing system.
RxReferenceNumber	PH888	This is the prescription number assigned by the pharmacy system.
RxChangeResponse	RxChangeResponse	The transaction: Prescription Change Response.
Approved	Approved	The request for substitution was approved by the prescriber.

Response Option 2: The prescriber responds to the request for substitution but decided he wants a fill status notification for dispensed, partially dispensed, not dispensed and transferred.

Element	Value	Note
To	7701630:P	NCPDP Provider ID Number of pharmacy; P means it is a pharmacy. This is the receiver. It must be the pharmacy ID.
From	77777777:C	This is the Clinic ID of the sender; C means it is a Clinic.
MessageID	2291	<b>Prescriber system trace number for the transmission. Echoed back in the response transaction in RelatesToMessageID.</b>
RelatesToMessageID	A55	Pharmacy trace number is used to link the original transaction (RxChangeRequest) (MessageID) to this subsequent transaction.
PrescriberOrderNumber	110088	This is the reference number assigned by the prescribing system.
RxReferenceNumber	PH888	This is the prescription number assigned by the pharmacy system.
RxChangeResponse	RxChangeResponse	The transaction: Prescription Change Response.
Approved	Approved	The request for substitution was approved by the prescriber.
<i>MedicationPrescribed</i>		
DrugDescription	CALAN SR 240MG	Drug prescribed is Calan Sr 240mg.
Strength,	240	240 is the strength.
StrengthForm	C42998	The Source for NCPDP Drug Dosage Form Terminology- C42998 is the code for "Tablet dosing form". So this means the prescription is for 240mg tablets.
StrengthUnitOfMeasure	C28253	The Source for NCPDP Drug StrengthUnitOfMeasure Terminology. C28253 is the code for "Milligram".
RxFillIndicator	ALL FILL STATUSES	Only send fill status .notifications when the medication has been dispensed, partially dispensed, not dispensed or transferred.

#### **8.1.6.15 *DeliveryRequest and DeliveryLocation Usage***

These elements are used on the NewRx to indicate whether the patient requests delivery of prescription and if so, which location. These elements are sent if the prescriber and the patient have discussed to relay to the pharmacy. Delivery and shipment may have the same meaning. It is acknowledged that the pharmacy will need to consider workflow and data integrity when receiving this information.

If a patient desires delivery, <DeliveryLocation> designates the location for the delivery. The pharmacy may have to work with the patient before the delivery is made or the pharmacy would use their protocols, etc., if not an established relationship.

If <DeliveryLocation> = “HOME” the information specified in the <PatientAddress> is to be used.

If <DeliveryLocation> = “FACILITY” the information specified in the <FacilityAddress> is to be used. Facility may be, but is not limited to, a hospital, hospice, care facility, etc. The Patient <FacilityUnit>, <Room> and <Bed> may also be designated as applicable.

If <DeliveryLocation> = “CONTACT PATIENT FOR DELIVERY” the contact information for the patient must be sent in the Patient Segment.

If <Delivery Location> = “AGENCY OF SERVICE” the information specified in the <AgencyOfServiceAddress> is to be used.

If <DeliveryLocation> = “PROVIDER” the information specified in the <ProviderAddress> is to be used.

#### **8.1.6.16 *Use of Number of Packages Element***

##### **<NumberOfPackagesToBeDispensed>**

This optional element is designed to alert the pharmacy of the need to divide the prescription quantity into the requested number of packages for administrative purposes and does NOT always require an increase in the dispensed quantity. If it is not sent the <NumberofPackagesToBeDispensed> is implied to be 1, otherwise send desired number. Situations for which this field could be used include provisions for childcare, school or other caregiver locations where the product packaging allows the product to be divided into multiple labeled packages.

##### **<NumberOfPackagesDispensed>**

This element is optional. If it is not sent it is implied it is 1, otherwise send actual number that was dispensed.

See the following examples. What is displayed to the prescriber is out of scope for what is transmitted but is shown here for context.

Examples of Drugs/Items	Quantity	Intended Number of Packages to be Dispensed (to Transmit on the Prescription)	Dispensed Examples	Outcome
Amoxicillin 250 mg/5 ML for Oral Suspension	150 ML	2	2 Bottles 75 mL each*	
Hydroxyzine Hydrochloride 10 mg/5 ML Syrup	240 ML	2	2 Bottles 120 mL each*	
Bactroban Cream 2%	30 GM C	2	2 Tubes, 15 GM each	
Adderall 10 mg Tablet	60 Tablets	2	2 Vials, 30 Tablets each	
Timolol Maleate 0.5% Ophthalmic Solution	10 mL	2	2 Bottles, 5 mL each or 2 vials, one with 15 tablets, one with 45 tablets.	

<Notes> should be used by the prescriber, if needed, to further explain the request for multiple packages.

**Quantity Sufficient is limited to settings where dispensing protocols are in force between the physician and pharmacy/pharmacist, where such use is in accordance with federal and state regulations.** Example settings include long term care, home healthcare, and outpatient clinics.

Examples of Drugs/Items	Example of Correct Quantity to Display to the Prescriber (this is not transmitted)	Number of Packages to be Dispensed to Transmit on the Prescription	Example of Correct TOTAL Quantity and Quantity CodeListQualifier to Transmit on the Prescription
Hydroxyzine Hydrochloride 10 mg/5 ML Syrup	120 ML Bottle	2	0 ML when Quantity><CodeListQualifier> value of "QS" is used

#### 8.1.6.17 Use of Manufacturer Name and LotNumber

To assist pharmacies in complying with regulations that require reporting to prescribers when a biosimilar biologic product is dispensed, Manufacturer Name and Lot Number are being added to the Medication Dispensed Segment. These fields are optional and can be populated when a biosimilar biologic is dispensed and the pharmacy is required to report that information to the prescriber. This can be done via either (or both) RxFill or MedicationHistoryResponse. It will be up to the pharmacy to determine which transaction(s) will be used. EMR systems will need to consider how to handle situations where the data may be received in both transactions as well as how the information will be accessed by the end user.

#### 8.1.6.18 MedicationNote

In order to minimize confusion and possible harm to the patient, the <Note> should never conflict with other information in the transaction.

1. <Note> should be presented to the prescriber and used for ***supplemental information*** to the pharmacist regarding the patient, ***not additional instructions*** (sig).
  - a. Examples of proper use of <Note> are
    1. The pharmacist to relay to the patient that lab tests are needed.
    2. The pharmacist to relay to the patient that a follow-up appointment is needed.
    3. The patient's flavoring choice
    4. Multiple packaging (e.g. split up the quantity into one for school/one for home, etc.).
    5. Reminder to suspend use of contraindicated medication until other drug therapy complete.
2. If information related to the sig does not fit, <Note> should not be used. An alternate method of sending the prescription should be used.
  - a. Example: If the additional instructions (sig) are longer than can be transmitted (e.g. complicated sliding scale).
3. The prescriber should have the final review all of the prescription information to be transmitted.
4. Information transmitted must be clear and not cause confusion in patient safety. For example:
  - a. The drug or the strength must not be changed in the <Note> as this textual information then conflicts with the discrete drug elements in the transaction.
  - b. <Substitution> contains value 0 but <Note> contains Brand Medically Necessary (or vice versa).
5. If a transaction supports the needed functionality, but the entity has not yet implemented the transaction, the <Note> field should not be used for this gap. Manual current processes should be used.

Transaction and Field Usage Recommendations:

1. If there is a change in therapy, the RxChange transaction is to be used.
2. A cancellation of the prescription must not be given in the <Note>. The CancelRx transaction is to be used.
3. The Drug Use Evaluation (DUE) information can be exchanged for drug/drug, drug/allergy, conflicts, etc. The DUE information is available for exchange in many of the eprescribing transactions.
4. Order on hold – the field Do Not Fill should be used for this purpose. (NCPDP ***External Code List*** has added values).
5. For intended prescriptions in a specific order (e.g. tapered doses) – the field <OtherMedicationDateQualifier> value of <EffectiveDate> should be used. The structured Sig should be used for tapered doses.
6. Needed No Later Than field is available for the facility to relay to the long term care pharmacy the timeframe when the medication is needed for delivery.
7. The use of the AllergyOrAdverseEvent elements should be used for the exchanges of allergies or adverse events.

If a consist use of <Note> is found that could be incorporated into the standard in discrete data fields, it is recommended to submit these

requests to NCPDP via a Data Element Request Form (DERF) at <http://www.ncpdp.org/standards-development-process.aspx>

#### 8.1.6.19 REMS

If the REMS Administrator supports issuing an authorization number to the prescriber-submitted REMSRequest, the <REMSAuthorizationNumber> is used to relay this information on the appropriate transactions for this medication.

While the pharmacy may perform REMS checking as part of the dispensing process, the use of the <PrescriberCheckedREMS> on the appropriate transactions provides information from the prescriber to the pharmacy that can be incorporated into operational processes, if desired.

<REMSPatientRiskCategory> (provided on the Structured Product Label (SPL) information) is used in programs where the prescriber is required by the REMS to provide this information to the pharmacy on the appropriate transactions. This field can be incorporated into operational processes, if desired. For example, a prescription for an Adult Male would not have to go through the same automated business rules as one for a Female of Child-Bearing Age, where a negative pregnancy test might be a prerequisite for dispensing the medication.

#### 8.1.6.20 Use of WoundLocation, WoundWidth and WoundLength

<WoundLength>, <WoundWidth> and <WoundDepth> are to be expressed in centimeters. The use of decimals is allowed in these fields.

Example: Patient has a wound on their upper right arm that is 2.75 cm long and 0.02 cm wide.

ElementName	Value
WoundLocationText	UPPER ARM STRUCTURE
WoundLocationCode	24028007
WoundLateralityText	RIGHT
WoundLateralityCode	24028007
WoundLength	2.75
WoundWidth	0.02

#### 8.1.6.21 Use of FlavoringRequested

The <FlavoringRequested> element is only to be included when the prescriber has had a conversation with the patient and/or their caregiver, and is recommending flavoring be added to the product being prescribed.

<FlavoringRequested> is optional and the only acceptable value is “Y”.

For Refill Request and Change messages, the pharmacy should echo back what the prescriber sent in the NewRx.

#### **8.1.6.22 *Use of UrgencyIndicator***

The UrgencyIndicatorCode element must only be sent when the sender deems the request to be of an urgent nature for which a delay of therapy could result in a potential adverse health outcome.

#### **8.1.6.23 *Use of PatientCodifiedNotes***

The <PatientCodifiedNote> provides information to the dispensing pharmacy which clarifies/justifies the product selection, dispensing, or instructs the dispensing pharmacy to take specific action per request of the provider. It codifies items commonly found in <Note> and is specific to the patient and the medication/product being prescribed.

##### **LTPAC Facility Product Administration:**

Product administration in a LTPAC facility is managed by facility nurses where patient specific product administration related information is documented. This information is communicated to the dispensing pharmacy to clarify/justify product selection. If additional context or detail is needed outside of the available code values or the applicable code value is not available then the <Note> field shall be utilized.

##### **Ambulatory Care Setting Considerations:**

There are common notes which are communicated to dispensing ambulatory pharmacies by the provider and ancillary staff. This information is communicated to the dispensing ambulatory pharmacy to clarify product prescribing, providing additional information, or other types of common instructions.

This element is to be used to communicate patient specific product administration information when not entered in the prescribed directions. For example the element would be sent when there is a patient specific clinical condition, i.e. swallowing difficulty where product are being crushed, which would preclude dispensing products which should not be crushed.

##### **Documentation for Compounds**

Based on section 503A of the a Food and Drug Administration Modernization Act in 1997 and amended by the Drug Quality and Security Act in 2013, prescribers and pharmacies have prescription documentation requirements when compounding a product that is commercially available in the marketplace. The product must not be on the “do not compound list” which can be found on the FDA website. This documentation must

show the significant differences requiring this product to be compounded. Examples include, but are not limited to:

- Patient allergic to an inactive ingredient in the commercially available medication/product such as “red dye”
- Patient requires a liquid version and the commercially available product only comes in solid dose form
- Patient needs a higher/lower dose (within current guidelines) not commercially available

#### **8.1.6.24 Use of <PrescriberExplicitAuthorizationToAdminister>**

<PrescriberExplicitAuthorizationToAdminister> is used when the prescriber is giving a pharmacist explicit permissive authority to administer a medication, device or vaccine as required by statute or regulation.

### **8.1.7 SIG ELEMENT**

#### **8.1.7.1 Use of the Sig Element**

This element is used to support electronic prescribing for the consistent expression of the directions for use to a patient for the corresponding prescription. It is to be used to relay information between the prescriber and the pharmacist. It is **not** patient instructions.

SigText contains either completely free text with no corresponding structured content OR is a generated structured Sig that contains all the elements semantically captured by and corresponding to the codified elements and clarifying free text fields. If the composites contain codified information, the codes and their textual translations must semantically match with the string in the SigText. For example, if the codes 419652001 and 26643006 are sent in the codified Sig composites, then the string in the SigText should contain the word “Take” that semantically matches with the first code, and the words “oral route” (or established synonyms such as “by mouth” or “orally”) that semantically matches with the second code.

The Sig supports a text element and a structure. If a structured Sig is supported, the text and the structure are populated. If a structured Sig cannot be generated, then the text is populated with free text and structure is not populated.

Refer to the NCPDP **Structured and Codified Sig Format Implementation Guide (Version 2.1 or greater)** for more information. The NCPDP **Structured and Codified Sig Format Implementation Guide** is syntax free and shows elements via tables. This structured Sig implementation is XML specific with grammar applied. There are differences between the Sig general implementation guide and this specific implementation in XML such as elements that are shown in the table but are not necessary in the XML schema because the schema imposes structural rules.

### High Level Chart of Sig

ELEMENT NAME	ELEMENT DEFINITION	MANDATORY/CONDITIONAL	REMARKS
<SigText>	SigText contains either completely free text with no corresponding structured content OR is a generated structured Sig that contains all the elements semantically captured by and corresponding to the codified elements and clarifying free text fields.	M	<p>Required.</p> <p>If you cannot fully represent the content of the prescriber's intended directions in the structured sig only populate the free text. If the composites contain codified information, the codes and their textual representation must semantically match with the string in the SigText.</p>
If the structured Sig is supported, the following are supported:			
<CodeSystem>	Identifies which code system and version are used.	C	Required if structured Sig is sent.
<Instruction>	Instruction is the focal point of the structured Sig. An Instruction is defined as Dose Administration with one-to-many associated Timing and/or Durations.	C	Required if structured Sig is sent.
<MultipleInstructionModifier>	Used to express when there is more than one Sig as to whether all the Sigs must apply (AND) or if any of the Sigs can apply (OR) or if the Sigs are sequential (THEN), in the sequence defined by Sig Sequence Position Number.	C	Required if more than one set of <Instruction>. 0 to 49 occurrences.
<Instruction>	Instruction is the focal point of the structured Sig. An Instruction is defined as Dose Administration with one-to-many associated Timing and/or Durations. This <Instruction> will be present when multiple instructions are needed for the Sig (ranges, maximums, limits, etc.).	C	Required when additional instructions are supplied when <MultipleInstructionModifier> is used.
<IndicationForUse>	Defines the indication for use of the medication as meant to be conveyed to the patient.	C	Required when prescriber specifies. 0 to 50 occurrences.

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ELEMENT NAME		ELEMENT DEFINITION		MANDATORY/CO NDITIONAL	REMARKS
<MaximumDoseRestriction>	The dose restriction element of the Sig which defines a maximum or dose limit, as specified by the prescriber.	C		Required when prescriber specifies.  0 to 50 occurrences.	
<ClarifyingFreeText>	Used to add clarity for the entire structured Sig for elements that cannot be codified within the specific sections.	C		Required when prescriber specifies.  Example: Do not lie down after taking.	

The most recent version of the Code System is recommended to be used; if not, trading partner agreement is required as to which version is used.

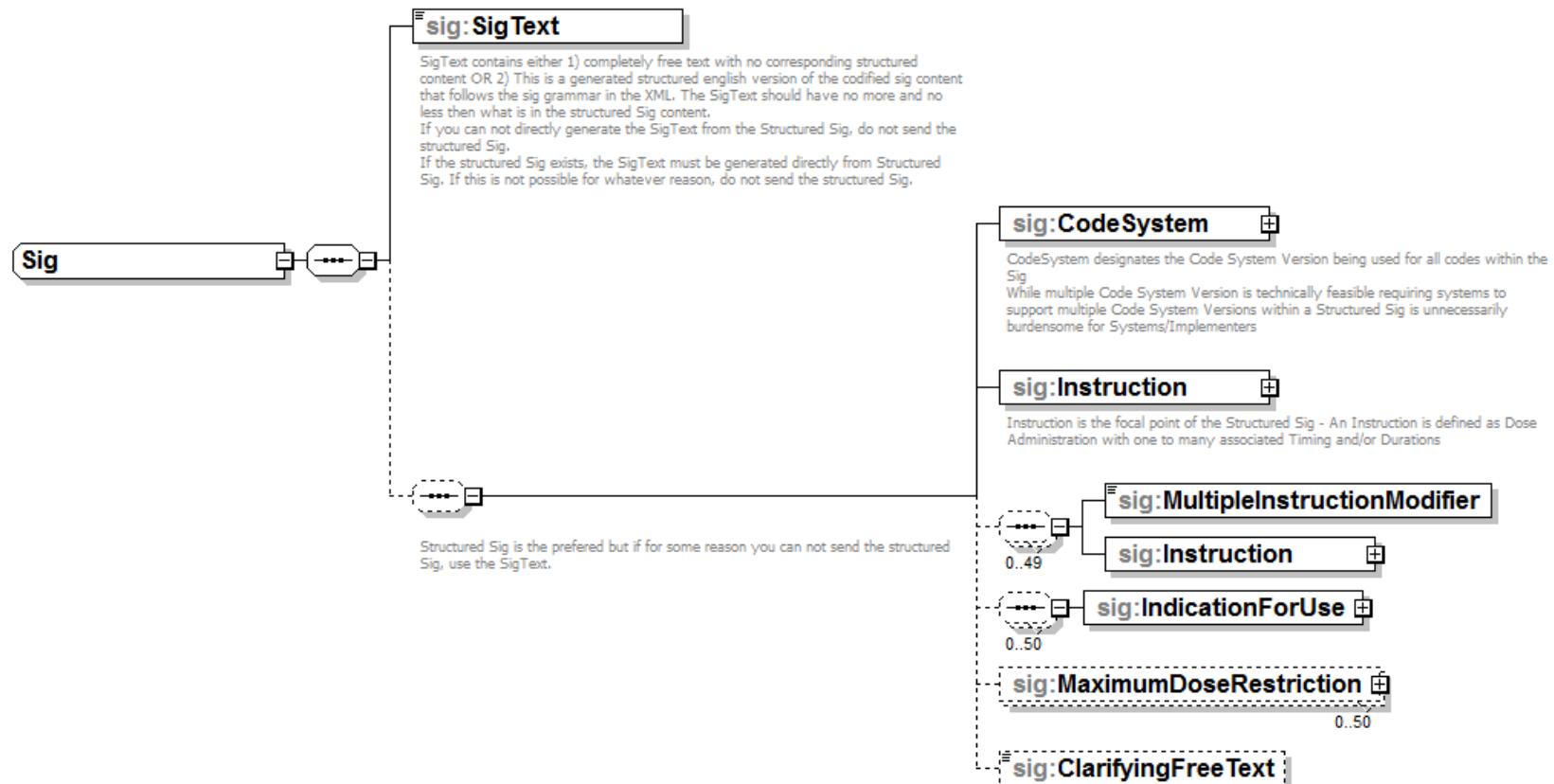
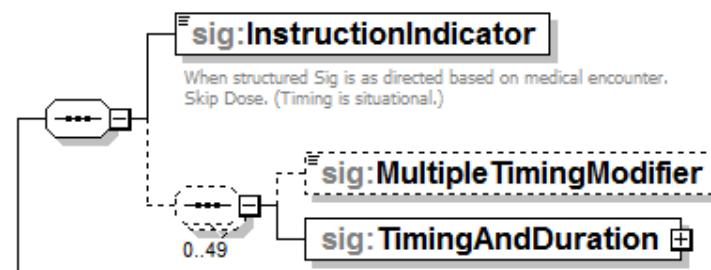


Figure 61 High Level Sig Schema

### Overview of <Instruction> for Use as Directed based on Medical Encounter

ELEMENT NAME	ELEMENT DEFINITION	MANDATORY/C OPTIONAL	REMARKS	
<InstructionIndicator>	Indicates the action to be taken on the Instruction fields.	C	Required if MEDICALENCOUNTER (when structured Sig is as directed based on medical encounter.)	
<TimingAndDuration>	This element is used to provide instruction about the timing of the Sig — when/how often/at what rate/for how long — the medication is to be taken.		C	<p>Required when prescriber specifies.</p> <p>Required when additional timing/duration are supplied when &lt;MultipleTimingModifier&gt; is used.</p> <p>0 to 49 occurrences.</p> <p>Specific time fields must be consistent with ISO format.</p>
<MultipleTimingModifier>	Used to express when there is more than one as to whether the times are all required to be used (AND) or if any of the times can be used (OR).		C	<p>Required when there is more than one timing/duration specified.</p> <p>0 to 49 occurrences.</p>

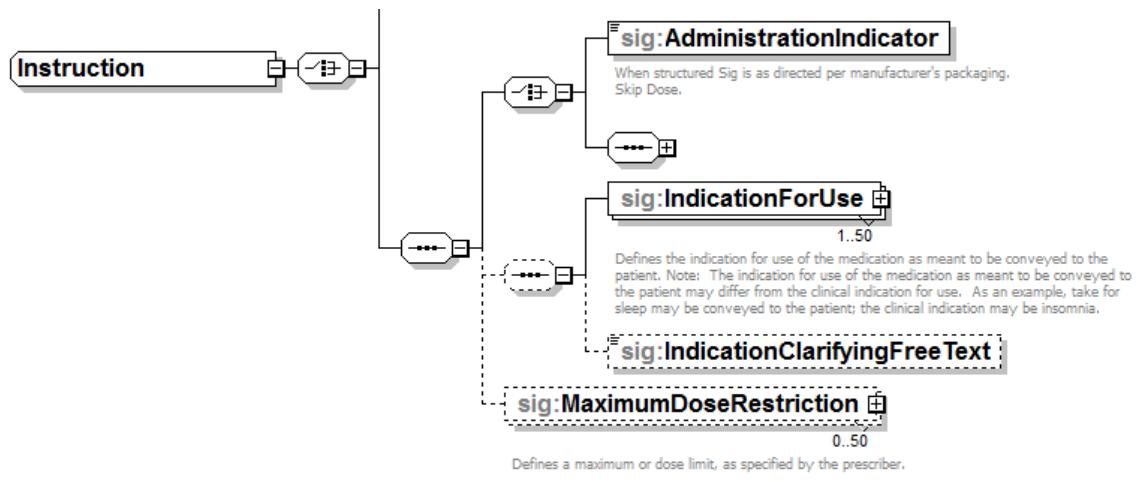


**Figure 62** Sig Schema for Use as Directed based on Medical Encounter

**Or**

**Overview of <Instruction> for Use as Directed based on Manufacturer's Instructions**

ELEMENT NAME	ELEMENT DEFINITION	MANDATORY/C ONDITIONAL	REMARKS
<AdministrationIndicator>	Indicates the action to be taken on the Administration fields.	C	Required if MANUFACTURERSINSTRUCTIONS (when structured Sig is as directed based on manufacturer's instructions). Skip Dose.
<IndicationForUse>	Defines the indication for use of the medication as meant to be conveyed to the patient. Note: The indication for use of the medication as meant to be conveyed to the patient may differ from the clinical indication for use. As an example, take for sleep may be conveyed to the patient; the clinical indication may be insomnia.	C	Required when prescriber specifies.  1 to 50 occurrences.
<MaximumDoseRestriction>	The dose restriction element of the Sig which defines a maximum or dose limit, as specified by the prescriber.	C	Required when prescriber specifies.  0 to 50 occurrences.



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**Figure 63** Sig Schema for Directed based on Manufacturer's Instructions**Or****Overview of <Instruction> for structured Sig**

<DoseAdministration>	Defines a fixed dose or can repeat to define a variable dose, dose range, or dose options.	M	Required.
<DoseDelivery>	This is the method in which the dose is delivered (describes how the dose is administered/consumed).	M	Required.  Examples: take, apply, swish, swallow, inject, insert, chew, use, give, sprinkle, mix, dissolve.
The Dose can define a fixed dose or can repeat to define a variable dose, dose range, or dose options.			
<Dosage>	The expression of the dose.	C	Required when dose is expressed as a quantity.

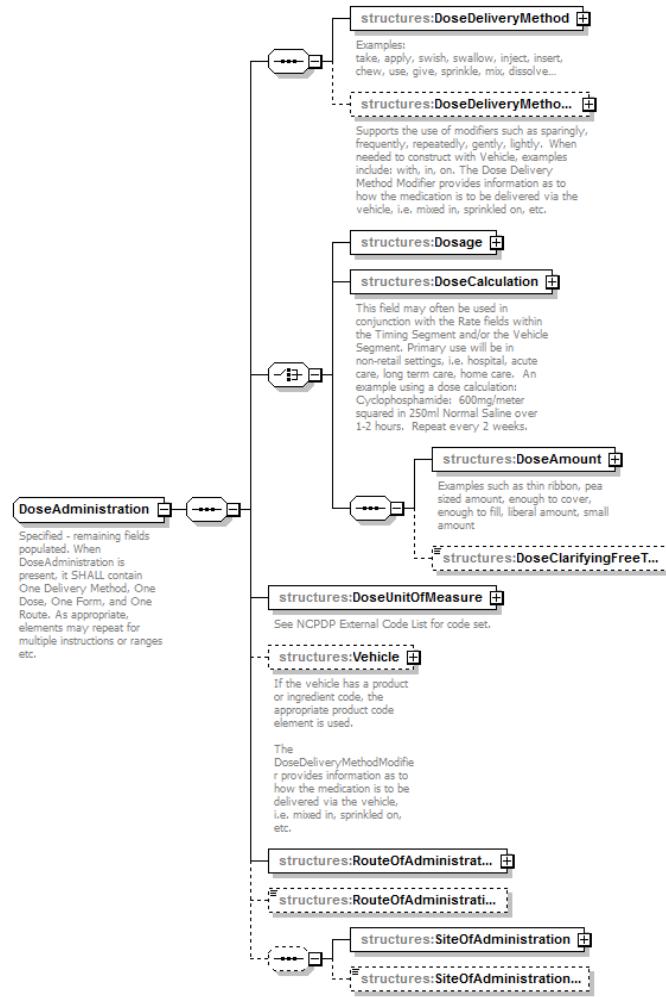
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			<DoseRangeModifier> is not dependent on another field such as a body metric but it may be related to indication (as needed for pain).
<DoseCalculation>	Used to calculate a dose where a body metric such as metric weight or surface area is used to calculate a dose for a patient.	C	Required when dose is to be calculated.  Primary use will be in non-retail settings, i.e. hospital, acute care, long term care, home care.  May often be used in conjunction with the Rate within <TimingAndDuration> and/or the Vehicle.  Examples: milligram per kilogram milligram per meter squared
<DoseAmount>	Used when dose amount cannot be expressed as a unit of measure.	C	Required when dose cannot be expressed as a unit of measure.  Examples: “thin ribbon”, “pea sized amount”, “enough to cover”, “enough to fill”, “liberal amount”, “small amount”.
<DoseUnitOfMeasure>	Used to define the dose unit of measure.	M	Required.
<Vehicle>	Defines a vehicle specified for the delivery of the product. Only those vehicles without a product (i.e. NDC) or ingredient (UNII) code should be included here.	C	Required when prescriber specifies.
<RouteOfAdministration>	Defines the route of administration.	M	Required.
<SiteOfAdministration>	Defines the site of administration.	C	Required when prescriber specifies.
<TimingAndDuration>	Used to provide instruction about the	C	Required when prescriber specifies.

		timing of the Sig - when/how often/at what rate/for how long - the medication is to be taken.		0 to 50 occurrences.  Specific time fields must be consistent with ISO format.
	<AdministrationTiming>	Defines a specific administration day, date time, or event.	C	Examples: Breakfast, lunch, dinner, sleep, appointment, procedure, surgery, exercise, sex, school, travel, cycle (HRT, PMS, etc.), completion of other medication regimen. Empty stomach. May also relay a time element, such as 30 minutes.
	<Frequency>	Defines a frequency of administration. Frequency is events per unit of time.	C	Examples: Twice daily, 4 times a day.
	<Interval>	Defines an interval of administration. Interval is the time between events.	C	Examples: 4 to 6 hours, Every 2 hours.
	<RateOfAdministration>	The amount of time for a {single} dose to be administered.	C	Examples: Seconds, minutes, hours, days. May be used in conjunction with <DoseCalculation>.
	<Duration>	Defines the duration of use/therapy.	C	Required when prescriber specifies.
	<DurationTrigger>	The event that indicates the completion of the duration of use or reason to stop.	C	Examples: Until gone. Until symptoms relieved. Unless symptoms worsen. Until return from trip. Unless new symptoms appear. If lightheaded. If side effects appear.
	<Stop>	The event that indicates the completion of the duration of use or reason to stop.	C	Used to express a hard stop, such as the last Sig sequence in a tapering dose, where the last sequence is 'then D/C' or where the therapy/drug is

				used to treat a condition and that treatment is for a fixed duration with a hard stop, such as antibiotic treatment, or if the stop is related to a change in the patient's condition (i.e. new or worsening symptoms), etc.
<IndicationForUse>	Defines the indication for use of the medication as meant to be conveyed to the patient.	C	Required when prescriber specifies.  1 to 50 occurrences.	
<MaximumDoseRestriction>	The dose restriction of the Sig which defines a maximum or dose limit.	C	Required when prescriber specifies.  0 to 50 occurrences.	



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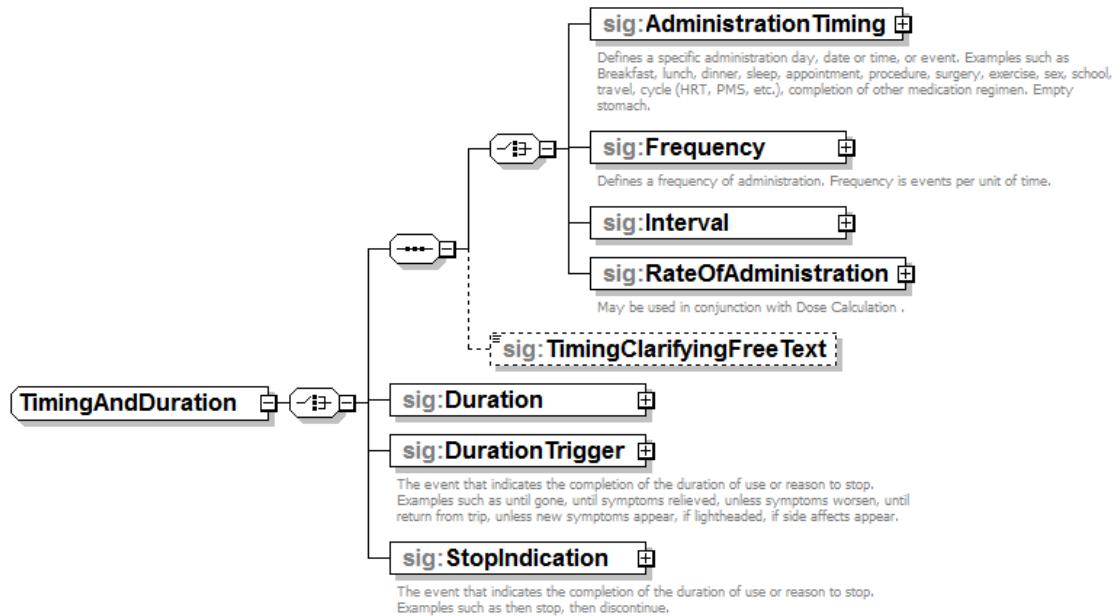
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**Figure 64** Sig Schema for structured Sig – DoseAdministration

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**Figure 65** Sig Schema for structured Sig – TimingAndDuration

#### 8.1.7.2 <Sig> Discussion

<Instruction> is the focal point of the Structured Sig - An Instruction is defined as Dose Administration with one-to-many associated Timing and/or Durations.

If a structured Sig cannot be generated, then the complete free text instructions are to be conveyed in the <SigText> field. When only the <SigText> is populated; no other Sig elements are populated. The rest of this section is skipped.

While the structured Sig appears complicated, experience has shown that many Sigs are “simple” and will utilize only certain elements in the structured Sig. Other elements will be ignored as they are used for more complex Sigs.

Refer to the NCPDP **Structured and Codified Sig Format Implementation Guide version 2.0** and above for more information.

See section "[Transmission Examples](#)" for charts of the Sig used in examples.

#### 8.1.7.3 **Sig Grammar Tool**

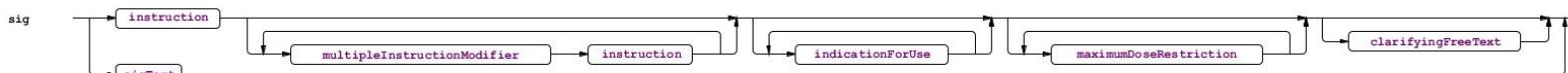
NCPDP designed a grammar tool to clarify what and how to support and implement structured Sig to "lower the bar" for providers and developers implementing this complex but critical information exchange. The intent of the tool is to improve validation, xsd implementation and ultimately implementation of codified Sigs. The Sig grammar defines the "preferred" way to write a Sig but is not intended to identify all ways a Sig could be written. The Sig grammar will not "flag" a nonsensical Sig, but it will flag any Sig that is not grammatically valid.

The focal point of the Sig is the Instruction. From the figures below, a structured Sig contains one-to-many instruction using the MultipleInstructionModifier. An instruction may contain an indicationForUse, MaximumDoseRestriction, and clarifyingFreeText. (See figures below.)

The focal structure of the instruction is the DoseAdministration structure and TimingAndDuration. The MultipleTimingModifier assists when there are multiple TimingAndDuration.

The DoseAdministration may contain Dosage or DoseCalculation or DoseAmount. The DoseAdministration contains a DoseUnitOfMeasure, may contain a vehicle, contains a RouteOfAdministration, and may contain clarifying text. The figures below were created using

- Extended Backus–Naur Form
  - notations used for expressing grammars
  - [http://en.wikipedia.org/wiki/Extended\\_Backus%20Naur\\_Form](http://en.wikipedia.org/wiki/Extended_Backus%20Naur_Form)
- ANTLR
  - ANOther Tool for Language Recognition, Open Source tool supporting Grammar Development
  - <http://www.antlr.org/>



**Figure 66** Sig Grammar Diagram

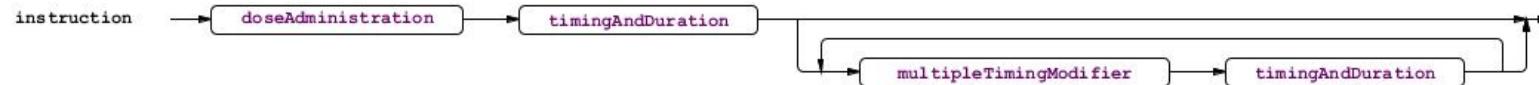


Figure 67 Sig Instruction Grammar Diagram

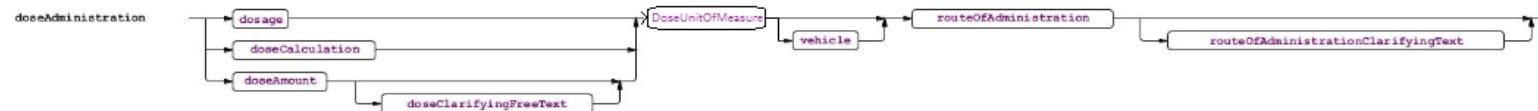


Figure 68 Sig Dose Administration Grammar Diagram

A reference implementation using XSLT is also available in the download for **SCRIPT**. The XSLT can be used to transform structured Sig xml files into SigText. The XSLT supports the Sig Grammar which is strongly recommended to be followed. The XSLT also supplies limited punctuation.

#### 8.1.7.4 <SigText> Rules

The Sig is either:

Generated from structured Sig.

The <SigText> is used and is a textual representation of structured and codified Sig values and clarifying free text fields and will be grammatically correct and pharmacist/patient friendly. It is a conversion to human-readable descriptions of each value, i.e. "take" instead of a value "xxxx", or "capsule" instead of "yyyy", allowing the sender and receiver the ability to confirm that their selected values represent their intentions. **The generated <SigText> should conform to the Sig grammar recommendations by NCPDP for consistency (See Section: [Sig Grammar Tool](#) for additional information)**. The generation may include clarifying free text fields. The <SigText> and the structured Sig are sent.

Pure free text.

If a structured Sig cannot be generated, then the complete free text instructions are to be conveyed in the <SigText> field. When the <SigText> is purely free text; no other Sig elements are populated.

Note: The <SigText> will contain what is *signed* as part of controlled substance procedures.

Note: If the Sig is:

- Generated from pure free text and is over 1000 bytes, or
- Generated from the structured Sig and is over 1000 bytes or
- Signed as part of controlled substance procedures and is over 1000 bytes

**8.1.7.5 *In the above cases, the prescription should be transmitted by a method other than electronic. Use of <InstructionIndicator> and <AdministrationIndicator>***

Good clinical practice dictates that Dose be specified. There are examples where the manufacturer's packaging contains the pertinent information for the patient (e.g. Medrol Dosepak™) or a personalized schedule is provided to the patient by their provider (e.g. Coumadin™, insulin).

The element <InstructionIndicator> directs the structured Sig for medical encounter. The medical encounter instructions are used when the prescriber provides instructional information for the medication for the patient due to the complexity. While the structured Sig supports these lengthier or complex medical encounter instructions, the industry requested the ability to be able to designate the information was given without specifying all the components in the structured Sig.

The element <AdministrationIndicator> directs the structured Sig for manufacturer's packaging. This is used when the prescriber expects the instructions on the package provide the necessary information for the medication use by the patient. While the structured Sig supports these more lengthy or complex manufacturer's instructions, the industry requested the ability to be able to designate the information was given without specifying all the components in the structured Sig.

SCRIPT (previous) schema contained <DoseCompositeIndicator>. This element has been sunsetted as the schema can control the population of the structured Sig. Value 1 (Specified - remaining fields populated) is not supported in the new indicators as the construct of the schema supports the population of the structured Sig. Value 4 (Unspecified - see free text) is not specified in the new indicators as the absence of the structured Sig elements denotes the lack of structure sent.

### **8.1.7.6 Use of CodeSystem**

#### **8.1.7.6.1 SNOMED and FMT Versions**

When the structured Sig is sent, the <CodeSystem> is mandatory. There may be structured Sigs sent which based on their elements do not use SNOMED or FMT Term from NCI for dose unit of measure. However, the recommendation is that both <SNOMEDVersion> and <FMTVersion> are mandatory elements. Each system that supports structured Sig will need to support the SNOMED and FMT Term from NCI for dose unit of measure for some Sigs they will send or receive. Therefore, the system should have the ability to populate a default version they support. Version may also mean release/release date.

#### **8.1.7.6.2 Specific Code Not Available and the Use of Clarifying Free Text elements**

Clarifying free text elements allow for greater specificity and to support situations that may not be codifiable. Clarifying free text fields when used must only contain information related the directions for use for the patient. In cases where a specific code is not available, and the information cannot be conveyed using an alternative code (i.e. where half-day equals 12 hours) the following **must** be used:

**For SNOMED:**

- the code is **10003008**,
- the code text is “Unspecified”,
- and the clarifying free text must be used.

(Specifically, in SNOMED, there is a general qualifier value **10003008 – Non-specific (qualifier value)** with a synonym of “Unspecified”.)

**For FMT Term from NCI for <DoseUnitOfMeasureQualifier>:**

- the code is **C38046**,
- the text is “Unspecified”,
- and the clarifying free text must be used.

(Specifically, in FMT Term from NCI for <DoseUnitOfMeasureQualifier>, there is a general qualifier value **C38046** with an NCPDP Preferred Term of “Unspecified”.)

The examples below only illustrate use of SNOMED codes, but the same rules apply when FMT Term from NCI for <DoseUnitOfMeasureQualifier> is used for <DoseUnitOfMeasure>, <MaximumDoseRestrictionForm> or any other element designated to use FMT Term for dose unit of measure.

**8.1.7.6.3 Example 1: Further clarification is needed to the Code and specified in Clarifying Text**

Correct Use:

<RouteOfAdministrationText>:	By mouth
<RouteOfAdministrationQualifier>:	SNOMED
<RouteOfAdministrationCode>:	2162363018
<RouteOfAdministrationClarifyingFreeText>:	Remain upright

**8.1.7.6.4 Example 2: Further clarification is needed to the Code and specified in Clarifying Text**

Correct Use:

<RouteOfAdministrationText>:	apply
<RouteOfAdministrationQualifier>:	SNOMED
<RouteOfAdministrationCode>:	417924000
<SiteOfAdministrationText>:	Left upper arm
<SiteOfAdministrationQualifier>:	SNOMED
<SiteOfAdministrationCode>:	507687013
<RouteOfAdministrationClarifyingFreeText>:	Remove old patch before applying new patch

**8.1.7.6.5 Example 3: no code exists so Clarifying Text needs to be used**

Correct Use:

<TimePeriodBasisText>:	Unspecified
<TimePeriodBasisQualifier>:	SNOMED
<TimePeriodBasisCode>:	10003008
<TimingClarifyingFreeText>:	Drink with orange juice

Incorrect Use:

<TimePeriodBasisText>:	Drink with orange juice
<TimePeriodBasisQualifier>:	SNOMED
<TimePeriodBasisCode>:	(none)
<TimingClarifyingFreeText>:	(none)

This is incorrect because the Code of 10003008 and the Code Text of "Unspecified" must be present.

Incorrect Use:

<TimePeriodBasisText>:	Drink with orange juice
<TimePeriodBasisQualifier>:	SNOMED
<TimePeriodBasisCode>:	10003008
<TimingClarifyingFreeText>:	(none)

This is incorrect because the Time Period Basis Code Text for Time Period Basis Code 10003008 must be “Unspecified”.

Incorrect Use:

<TimePeriodBasisText>:	(none)
<TimePeriodBasisQualifier>:	SNOMED
<TimePeriodBasisCode>:	(none)
<TimingClarifyingFreeText>:	Drink with orange juice

This is incorrect because the Time Period Basis Code of 10003008 and the Time Period Basis Text of “Unspecified” must be present.

#### **8.1.7.6.6 Example 4: no code exists**

This example is trying to convey “take for 3 days upon returning home from travel”.

Correct Use:

<DurationNumericValue>:	3
<DurationText>:	day
<DurationQualifier>:	SNOMED
<DurationTextCode>:	258703001
<DurationTriggerText>:	travel
<DurationQualifier>:	SNOMED
<DurationTriggerTextCode>:	420008001
<DurationClarifyingFreeText>:	upon returning home

#### **8.1.7.7 Sig Exchange Guidelines in different versions of SCRIPT**

This section explains the expected processing/requirements for the exchange of the Sig, specifically the implications of the <SigText> when supporting this and subsequent versions of **SCRIPT** with previous versions of **SCRIPT** that supported the structured Sig.

#### **8.1.7.7.1 <SigText> Content**

This provides the implementer with rules about supporting an environment with multiple versions of **SCRIPT** that support the structured Sig. The following scenarios describe exchanges in a (previous) **SCRIPT** and a (current) **SCRIPT** environment. For clarity,

**SCRIPT** (previous) is **SCRIPT Version 10.6** through **SCRIPT 2012** versions that support the original structured Sig.

**SCRIPT** (current) is **SCRIPT** published in 2013 and above that supports the enhanced structured Sig.

The following producers have been identified:

1. **SCRIPT** (previous) Sig Producer
2. **SCRIPT** (current) Sig Producer cannot populate structured Sig
3. **SCRIPT** (current) Sig Producer can populate structured Sig

These producers have the following characteristics:

1. **SCRIPT** (previous) Sig Producer:
  - a. No changes to current Sig exchange guidelines.
2. **SCRIPT** (current) Sig Producer cannot populate structured Sig:
  - a. The <SigText> will be populated with a textual representation of the Sig. It is expected to follow the Sig Grammar structure if possible.
3. **SCRIPT** (current) Sig Producer can populate structured Sig:
  - a. The <SigText> is populated with a generated textual representation of the structured Sig. The <SigText> content will conform to the Sig Grammar.

### Sig Exchange Matrix

	SCRIPT (previous) Sig Text Only Consumer	SCRIPT (previous) structured Sig Consumer	SCRIPT (current) Sig Text Only Consumer	SCRIPT (current) structured Sig Consumer
SCRIPT (previous) Sig Text Only Producer	Sig Text Exchange	Sig Text Exchange	Sig Text Exchange	Sig Text Exchange
SCRIPT (previous) structured Sig Producer	Sig Text Exchange	Structured Sig Exchange	Sig Text Exchange	Sig Text Exchange (See 2)
SCRIPT (current) Sig Text Only Producer	Sig Text Exchange (See 1)	Sig Text Exchange (See 1)	Sig Text Exchange	Sig Text Exchange
SCRIPT (current) structured Sig Producer	Sig Text Exchange (See 1)	Sig Text Exchange (See 3)	Sig Text Exchange	Structured Sig Exchange

1. **SCRIPT** (previous) size restrictions apply to the exchange of <SigText> when a **SCRIPT** (current) to **SCRIPT** (previous) transformation.
2. Currently there are no plans for NCPDP to create a tool to support a seamless transformation from **SCRIPT** (previous) structured Sig and **SCRIPT** (current) structured Sig. If there was development of additional rules/mapping on a **SCRIPT** (previous) structured Sig there might be a limited automated transformation from a **SCRIPT** (previous) structured Sig to a **SCRIPT** (current) structured Sig. The recommendation is to send the <SigText> that follows Sig Grammar rules.
3. Currently there are no plans for NCPDP to create a tool to support a seamless transformation from **SCRIPT** (current) **structured Sig** to **SCRIPT** (previous) **structured Sig**. If there was development of additional rules/mapping on a **SCRIPT** (current) structured Sig to less constraints on the **SCRIPT** (previous) structured Sig, a limited automated transformation might occur. However, **SCRIPT** (current) structured Sig may contain elements, values, constraints that are not available in **SCRIPT** (previous) structured Sig.

## 8.1.8 HISTORYSOURCE ELEMENT

### 8.1.8.1 Use of the HistorySource Element

#### 8.1.8.1.1 Pharmacy Requests

##### 8.1.8.1.1.1 Example 1 Pharmacy Requests Medication History of Another Pharmacy

RxHistoryResponse is returned with Medication element, HistorySource element (pharmacy), Prescriber element, no Pharmacy element  
No Pharmacy element allowed. HistorySource element is used to describe the receiver (pharmacy).

Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	N	N/A
<HistorySourceID>	Identification for the history source.	N	N/A
<SourceReference>	Prescription number associated to medication history record.	Y	From pharmacy system
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From pharmacy system
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

This allows support of de-duping medication history information, but does not relay what is viewed to be competitive information between pharmacies; following the rule already established for the Pharmacy noted in section “Structure Quick Reference”, “Element Usage in Each Transaction”, “Medication History Response Transaction”.

#### 8.1.8.1.1.2 Example 2 Pharmacy Requests Medication History of Prescriber

RxHistoryResponse is returned with Medication element, HistorySource element (prescriber), Prescriber element, no Pharmacy element  
No Pharmacy element allowed. HistorySource element is used to describe the receiver (prescriber).

Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PC (Prescriber)
<SourceDescription>	Name of medication history source.	Y	Prescriber name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, StateLicenseNumber

Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceReference>	Prescription number associated to medication history record.	N	N/A
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	N	N/A
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.1.3 Example 3 Pharmacy Requests Medication History of “payer”

(There is no value defined for payer in “To” element, but value “ZZZ” might be used; it is requested that if a business need is required, a value be brought forward for “Payer”)

RxHistoryResponse is returned with Medication element, HistorySource element (payer), Prescriber element, no Pharmacy element  
No Pharmacy element allowed. HistorySource element is used to describe the receiver (payer).

Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PY (Payer)
<SourceDescription>	Name of medication history source.	Y	Payer name
<HistorySourceID>	Identification for the history source.	Y	For example IIN Number, PayerID
<SourceReference>	Prescription number associated to medication history record.	Y	Prescription Number from payer system from claims processing.
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	Fill Number from payer system from claims processing.

<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A
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#### 8.1.8.1.1.4 Example 4 Pharmacy Requests Medication History of ZZZ (an aggregator)

RxHistoryResponse is returned with Medication element, HistorySource element (pharmacy, prescriber, payer), Prescriber element, no Pharmacy element

No Pharmacy element allowed. The aggregator is the source, but the ultimate source is the entities from which the aggregators obtain the data. Some of the loops could come back from the source of prescriber(s), some from payers, some from pharmacies.

The aggregator will return the loops, with the HistorySource containing, according to the rules for the <SourceDescription>.

If aggregator returns loop for Payer as ultimate source:

Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PY (Payer)
<SourceDescription>	Name of medication history source.	Y	Payer name
<HistorySourceID>	Identification for the history source.	Y	For example IIN, Number PayerID
<SourceReference>	Prescription number associated to medication history record.	Y	Prescription Number from payer system from claims processing.
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	Fill Number from payer system from claims processing.
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

If aggregator returns loop for Pharmacy as ultimate source:

Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	N	N/A
<HistorySourceID>	Identification for the history source.	N	N/A
<SourceReference>	Prescription number associated to medication history record.	Y	From pharmacy system
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From pharmacy system
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

This allows support of de-duping medication history information, but does not relay what is viewed to be competitive information between pharmacies; following the rule already established for the Pharmacy element noted in section “Structure Quick Reference”, “Element Usage in Each Transaction”, “RxHistory Response Transaction”.

If aggregator returns loop for Prescriber as ultimate source:

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PC (Prescriber)
<SourceDescription>	Name of medication history source.	Y	Prescriber name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, StateLicenseNumber
<SourceReference>	Prescription number associated to medication history record.	N	N/A
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	N	N/A

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.1.5 Example 5 Pharmacy Provides Prescription Transfer(s) to Another Pharmacy

The RxTransferResponse contains the Medication element, HistorySource element (pharmacy), Prescriber element.

HistorySource element is used to designate each fill of the prescription.

In this example the transferring pharmacy (Pharmacy 2) performed each of the fills. If there were two fills, the HistorySource occurs per loop of Medication, so in this example, for each <MedicationDispensed> there would be a <HistorySource>.

Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	N	N/A
<HistorySourceID>	Identification for the history source.	Y	Pharmacy 2 identification
<SourceReference>	Prescription number.	Y	From Pharmacy 2 system
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From Pharmacy 2 system
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.1.6 Example 6 Pharmacy Provides Prescription Transfer(s) to Other Pharmacies

The RxTransferResponse contains the Medication element, HistorySource element (pharmacy), Prescriber element.

HistorySource element is used to designate each fill of the prescription. In this example the transferring pharmacy performed one of the fills and

transferred a fill to two different pharmacies. See #6 in section “*RxTransferResponse*” subsection “*Example Scenarios*”.

This is the HistorySource information for the fill that was filled by Pharmacy 2.

Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	N	N/A
<HistorySourceID>	Identification for the history source.	Y	Pharmacy 2 Identification
<SourceReference>	Prescription number.	Y	From Pharmacy 2 system
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From Pharmacy 2 system

This is the HistorySource information for the fill that was transferred to Pharmacy X.

Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	N	N/A
<HistorySourceID>	Identification for the history source.	Y	Pharmacy X Identification
<SourceReference>	Prescription number.	Y	From Pharmacy X system (sent if known by Pharmacy 2)
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From Pharmacy 2 system for the fill that was transferred to Pharmacy X.
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

This is the HistorySource information for the fill that was transferred to Pharmacy Z.

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Element	Remarks	ELEMENT ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	N	N/A
<HistorySourceID>	Identification for the history source.	Y	Pharmacy Z Identification
<SourceReference>	Prescription number.	Y	From Pharmacy Z system (sent if known by Pharmacy 2)
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From Pharmacy 2 system for the fill that was transferred to Pharmacy Z.
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.2 Prescriber Requests

##### 8.1.8.1.2.1 Example 1 Prescriber Requests Medication History of Another Prescriber

RxHistoryResponse is returned with Medication element, HistorySource element (prescriber), Prescriber element, Pharmacy element (if known) HistorySource element is used to describe the receiver (prescriber).

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PC (Prescriber)
<SourceDescription>	Name of medication history source.	Y	Prescriber name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, StateLicenseNumber
<SourceReference>	Prescription number associated to medication history record.	N	N/A
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	N	N/A

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.2.2 Example 2 Prescriber Requests Medication History of Pharmacy

RxHistoryResponse is returned with Medication element, HistorySource element (pharmacy), Prescriber element, Pharmacy element HistorySource element is used to describe the receiver (pharmacy).

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	Y	Pharmacy name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, NCPDPID
<SourceReference>	Prescription number associated to medication history record.	Y	From pharmacy system
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From pharmacy system
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.2.3 Example 3 Prescriber Requests Medication History of a “payer”

(There is no value defined for payer in “To” element, but value “ZZZ” might be used; it is requested that if a business need is required, a value be brought forward for “Payer”)

RxHistoryResponse is returned with Medication element, HistorySource element (payer), Prescriber element, Pharmacy element HistorySource element is used to describe the receiver (payer).

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PY (Payer)
<SourceDescription>	Name of medication history source.	Y	Payer name
<HistorySourceID>	Identification for the history source.	Y	For example IIN Number, PayerID
<SourceReference>	Prescription number associated to medication history record.	Y	Prescription Number from payer system from claims processing.
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	Fill Number from payer system from claims processing.
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.2.4 Example 4 Prescriber Requests Medication History of ZZZ (an aggregator)

RxHistoryResponse is returned with loops of Medication element, HistorySource element (pharmacy, prescriber, payer), Prescriber element, Pharmacy element

The aggregator is the source, but the ultimate source is the entities from which the aggregators obtain the data. Some of the loops could come back from the source of prescriber(s), some from payers, some from pharmacies.

The aggregator will return the loops, with the HistorySource containing, according to the rules for the <SourceDescription>.

If aggregator returns loop for Payer as ultimate source:

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PY (Payer)
<SourceDescription>	Name of medication history source.	Y	Payer name
<HistorySourceID>	Identification for the history source.	Y	For example IIN Number, PayerID
<SourceReference>	Prescription number associated to medication history record.	Y	Prescription Number from payer system from claims processing.

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	Fill Number from payer system from claims processing.
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

**If aggregator returns loop for Pharmacy as ultimate source:**

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	Y	Pharmacy name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, NCPDPID
<SourceReference>	Prescription number associated to medication history record.	Y	From pharmacy system
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From pharmacy system
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

**If aggregator returns loop for Prescriber as ultimate source:**

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PC (Prescriber)
<SourceDescription>	Name of medication history source.	Y	Prescriber name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, StateLicenseNumber
<SourceReference>	Prescription number associated to medication history record.	N	N/A
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	N	N/A
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.3 Other Entity Requests (for example ZZZ aggregator)

##### 8.1.8.1.3.1 Example 1 ZZZ (the aggregator) Requests Medication History of Pharmacy

RxHistoryResponse is returned with Medication element, HistorySource element (pharmacy), Prescriber element, Pharmacy element HistorySource element is used to describe the receiver (pharmacy).

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	Y	Pharmacy name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, NCPDPID
<SourceReference>	Prescription number associated to medication history record.	Y	From pharmacy system
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From pharmacy system

##### 8.1.8.1.3.2 Example 2 ZZZ (the aggregator) Requests Medication History of Prescriber

RxHistoryResponse is returned with Medication element, HistorySource element (prescriber), Prescriber element, Pharmacy element HistorySource element is used to describe the receiver (prescriber).

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PC (Prescriber)
<SourceDescription>	Name of medication history source.	Y	Prescriber name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, StateLicenseNumber
<SourceReference>	Prescription number associated to medication history record.	N	N/A
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	N	N/A
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.3.3 Example 3 ZZZ (the aggregator) Requests Medication History of Another ZZZ (aggregator)

RxHistoryResponse is returned with loops of Medication element, HistorySource element (pharmacy, prescriber, payer), Prescriber element, Pharmacy element

The aggregator is the source, but the ultimate source is the entities from which the aggregators obtain the data. Some of the loops could come back from the source of prescriber(s), some from payers, some from pharmacies.

The aggregator will return the loops, with the HistorySource containing, according to the rules for the <SourceDescription>.

If aggregator returns loop for Payer as ultimate source:

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PY (Payer)
<SourceDescription>	Name of medication history source.	Y	Payer name
<HistorySourceID>	Identification for the history source.	Y	For example IIN Number, PayerID

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceReference>	Prescription number associated to medication history record.	Y	Prescription Number from payer system from claims processing.
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	Fill Number from payer system from claims processing.
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

**If aggregator returns loop for Pharmacy as ultimate source:**

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	Y	Pharmacy name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, NCPDPID
<SourceReference>	Prescription number associated to medication history record.	Y	From pharmacy system
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From pharmacy system
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

**If aggregator returns loop for Prescriber as ultimate source:**

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	PC (Prescriber)
<SourceDescription>	Name of medication history source.	Y	Prescriber name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, StateLicenseNumber
<SourceReference>	Prescription number associated to medication history record.	N	N/A
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	N	N/A
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	N	N/A

#### 8.1.8.1.4 Prescriber or Pharmacy request Medication History from a State Prescription Drug Monitoring Program (PDMP)

RxHistoryResponse is returned with loops of Medication element, HistorySource element (pharmacy), Prescriber element, Pharmacy element, Patient element.

The State Prescription Drug Monitoring System (PDMP) is the source, but the ultimate source is the entity from which the PDMP obtain the data, which is the pharmacy.

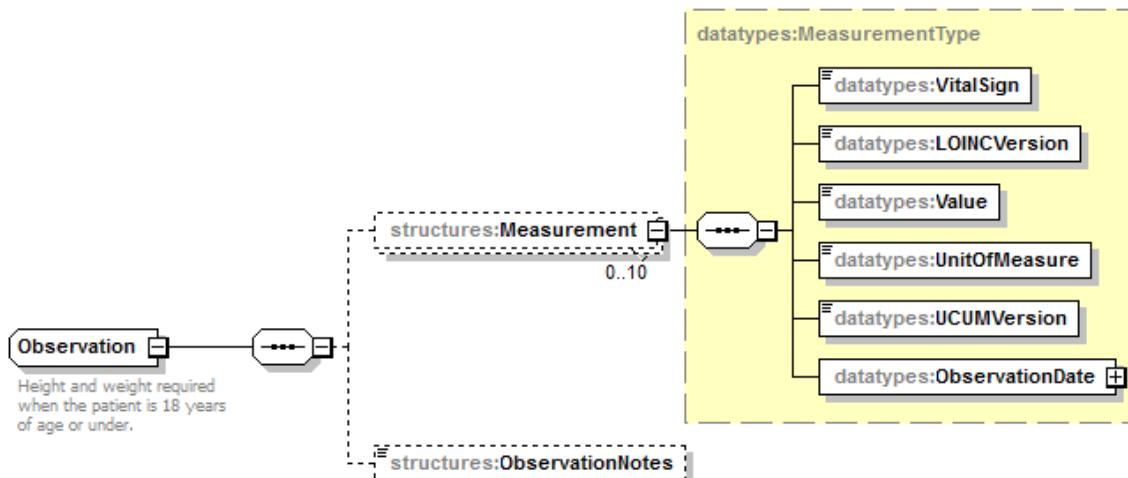
#### PDMP returns loop for Pharmacy as ultimate source:

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<SourceQualifier>	Qualifies the SourceDescription.	Y	P2 (Pharmacy)
<SourceDescription>	Name of medication history source.	Y	Pharmacy name
<HistorySourceID>	Identification for the history source.	Y	For example NPI, NCPDPID
<SourceReference>	Prescription number associated to medication history record.	Y	From pharmacy system

Element	Remarks	FIELD ALLOWED	VALUE IN THIS SCENARIO
<FillNumber>	Defines the dispensing episode as an initial fill or an authorized refill.	Y	From pharmacy system
<PaymentType>	Defines the type of payment received for the prescription fill as recorded by a State Prescription Drug Monitoring Program (PDMP). Used only when response is from a State PDMP.	Y	Value as reported by pharmacy system to the PDMP.

### 8.1.9 OBSERVATION ELEMENT

The following example shows how to use the <Observation> element for patient weight, height, and blood pressure. The repeating group <VitalSign> through <ObservationDate> may repeat. <ObservationNotes> does not repeat.



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Figure 69 Observation Segment

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Observation Element	Remarks	Example 1 Height	Example 2 Weight	Example 3 Blood Pressure- Systolic	Example 4 Blood Pressure - Diastolic
	May repeat: <VitalSign>	Use LOINC Code Qualifies the Measurement value.	8302-2	8336-0	8480-6
	<LOINCVersion>	2.42	2.42	2.42	2.42
	<Measurement Value>	Actual value of clinical information.	60	145	120
	<UnitOfMeasure>	Use UCUM	[in_i]	[lb_av]	mm[Hg]
	<UCUMVersion>		1.8.2	1.8.2	1.8.2
	<ObservationDate>	Date or DateTime	2013-04-02	2013-04-02	2013-04-02
<ObservationNotes>					

See the NCPDP **External Code List** for information on obtaining the LOINC Codes and UCUM. UCUM supports components which can be assembled to create standardized concepts for frequently used prescribing expressions such as mg/ml. While components can be assembled many ways, standardized prescribing expressions are to be used. Creating non-standardized expressions can lead to misinterpretation, errors, and follow up calls to clarify.

#### 8.1.9.1 Patient Height and Weight

Currently, **SCRIPT** does not require patient height and/or weight be sent for patients over the age of 18. The transmission of this additional patient information is supported in the Observation Segment. This information is especially important for infused, injected, oncology, and pediatric medications. To enhance patient safety, accurate dosing, and potentially assist with clinical management programs:

- For pediatric patients (18 years and younger), it is required. The most recent patient height and patient weight is included on all new and renewal prescriptions sent from the prescriber to the pharmacy.
- For patients over the age of 18, it is recommended the most recent height and weight be included on all new and renewal prescriptions sent from the prescriber to the pharmacy.

The date associated with the measures must also be sent. If the height and/or weight have changed and the prescriber is sending an approved renewal response, the response should be coded as "Approved with Changes".

#### 8.1.10 ATTACHMENT

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The <AttachmentWithControlNumber> structure contains an optional control number, the source of the information, a definition of the content of the attachment, and the actual attachment.

The <AttachmentControlNumber> is an optional reference number assigned by the prescribing system.

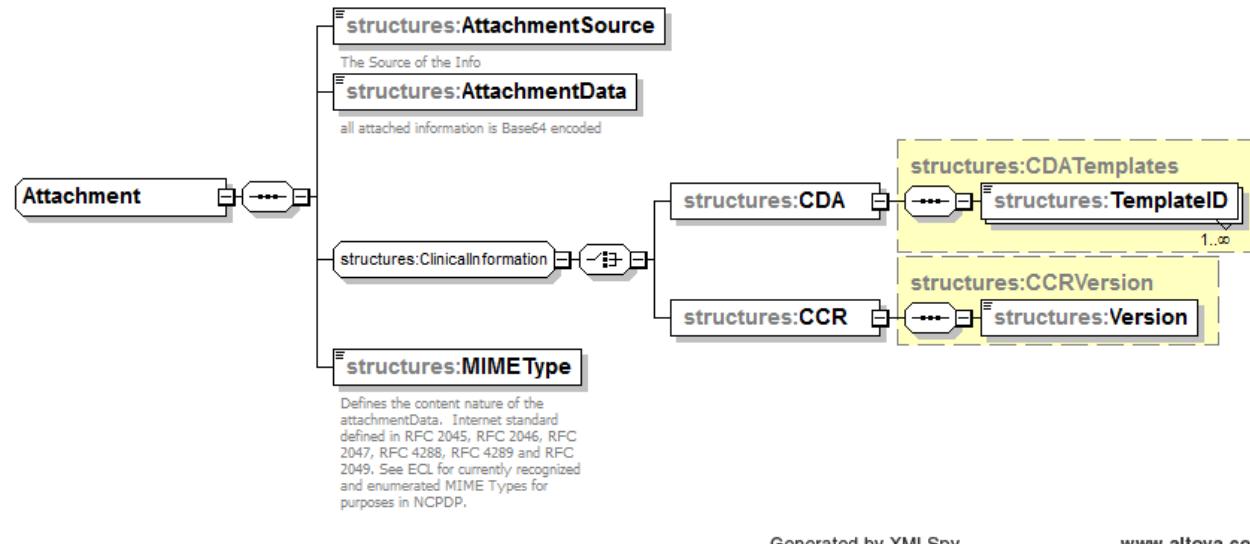
The <AttachmentSource> contains free text for the prescribing system to indicate where the information has originated. Any free text can be specified in this element at this time.

- Some examples could include
  - “XXX” (product name of PHR) if the information was obtained from a personal health record repository or
  - “Prescriber’s EMR” if it was constructed from electronic medical records.

The <AttachmentData> is transmitted as Base64encoded, which is used for storing complex data in XML. Information on Base64encoding and decoding can be found on the Internet.

Multipurpose Internet Mail Extensions (MIME) is an Internet standard used to describe content type in general. The <MIMEType> defines the content nature of the <AttachmentData>. It is an Internet standard defined in RFC 2045, RFC 2046, RFC 2047, RFC 4288, RFC 4289 and RFC 2049. See the NCPDP External Code List for values supported. (Note: PDF, jpeg, and other unstructured documents can be exchanged using the <MIMEType> and <AttachmentData> elements. The CDA also supports an unstructured document. See the implementation guidance created by Healthcare Information Technology Standards Panel entitled “Unstructured Document Component” known as “HITSP C62” which can be found at <http://www.hitsp.org/> under the complete library, under Components.)

References to MIME and Base64encoding/decoding may be found on [www.wikipedia.org](http://www.wikipedia.org).



Generated by XMLSpy

[www.altova.com](http://www.altova.com)**Figure 70** Attachment

### 8.1.11 ALLERGY OR ADVERSE EVENT ELEMENT

The AllergyOrAdverseEvent element enables the sender to inform the recipient of all known patient allergies and/or adverse reactions. The element is intended to provide this patient's allergy and/or adverse reactions profile information to the recipient. If a patient's allergies and/or adverse events (or lack thereof) are known, it is strongly recommended to send the AllergyOrAdverseEvent element. If the AllergyOrAdverseEvent element is sent, it must include all known patient allergies and/or adverse reactions, or it must designate <NoKnownAllergies> = "Y".

**Note:** The AllergyOrAdverseEvent element is not to be used to replace or add to the transfer of drug use evaluation information, which is instead communicated using the existing drug use evaluation information within the medication information to indicate an awareness of a potential DUR issue with the Product Written. This AllergyOrAdverseEvent element is a comprehensive list of all allergies and/or adverse events that the sender is aware of at the time the transaction is sent.

Trading partners must support the AllergyOrAdverseEvent element but use is optional on a case by case (transaction by transaction) basis.

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<DrugProductCoded> is mandatory and is expressed by sending a code and qualifier where an item is codified with the code's description as mandatory text, or mandatory text only when the item is not codified/codifiable.

<AdverseEvent>, <ReactionCoded>, <SeverityCoded> are expressed by sending a SNOMED code with the code's description as mandatory text, or mandatory text only when the item is not codified/codifiable. See the NCPDP **External Code List** for linkage to the SNOMED code list.

Of note, due to differing perspectives when exchanging:

- In NewRx, RenewalResponse, ChangeRequest, ChangeResponse transactions:
  - <SourceOfInformation>, <DrugProductCoded> and <AdverseEvent> - mandatory.
- In Census and Resupply (see Specialized Implementation Guide for Census):
  - <DrugProductCoded> – mandatory.
  - <AdverseEvent> – optional.
  - <SourceOfInformation> – optional.

#### **8.1.12 AGENCY OF SERVICE AND TYPE OF SERVICE ELEMENTS**

A prescriber may specify an agency(s), service(s) or no information. The prescriber may send desired agencies to use but it is at the pharmacy's discretion to choose the agency based on their business relationships and information available about the patient (i.e. benefits, preferred providers, etc.).

There may be a relationship between <AgencyOfService> and <TypeOfService>. Examples include the following:

- Agency and service type(s)
- Agency and no service type
- Many agencies and many services types with no association.
- Service type(s) and no agency

If <AgencyOfService> is used it must contain either <Address> or <CommunicationNumbers>.

Examples of items included in the <ServiceType> composite include:

- Nurse to visit patient for administration of medication
- Administration training needed

### **8.1.13 COUPONS AND DISCOUNT PROGRAMS**

The discrete fields in the Benefits Coordination element must be used when sending Coupon/Discount information. These fields are the IIN Number, PCN, Group ID, and Cardholder ID. The <PayerType> OF “M” (Coupon) OR “L” (Discount) must be sent when sending coupon or discount information. This information must not be sent in the medication notes field.

### **8.1.14 REQUESTORROLE**

<RequestorRole> is primarily used when required by State Prescription Drug Monitoring Programs (PDMP) to identify the role of the requestor of the medication history.

## **8.2 VETERINARIAN PRESCRIPTIONS**

The following are used for consistency in non-human prescriptions. Follow the requirements for human prescriptions for use of other elements in this standard implementation guide.

To identify the patient in non-human prescriptions

- Patient FirstName is to contain the first name of animal (e.g. Fido, Fluffy) or the species name if no name has been given (e.g. Horse, Fish).
- Patient LastName is to contain the last name of owner.
- Gender – specified if known, or value for “Unspecified” if unknown.
- DateOfBirth – is mandatory; if not known, send the best estimated valid date.
- Species – is mandatory. <Text> must derive from the <Code>.

To identify the owner, use ResponsibleParty in BenefitsCoordination. For veterinarian prescriptions, it is recommended that the owner’s name should be displayed near the patient’s name.

For prescriber identification:

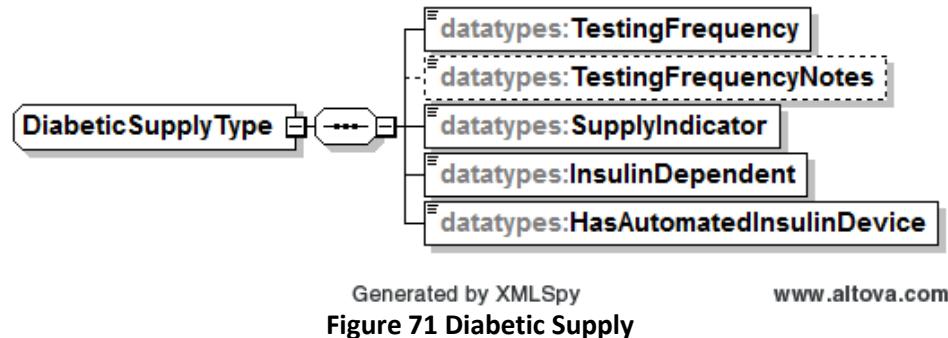
- State License is mandatory.
- DEANumber is sent when applicable.
- Specialty is mandatory. The valid values below are to be populated by the eprescribing software.
  - Veterinarian: 174M00000X

- Medical Research Veterinarian: 174MM1900X

### **8.3 ITEMS FOR DIABETES MANAGEMENT**

When ordering the items used in the management of Diabetes, a separate electronic prescription (NewRx) is required for each item. The prescription for the medication and the prescription(s) for the item(s) do not need to be tied together electronically although they may be with the use of the tie back fields if desired. The EHR and pharmacy systems will tie them together via the patient records.

Items used in the management of Diabetes, but not directly related to the treat the condition require the <DiabeticSupply> be submitted. <DiabeticSupply> includes elements which could be required for the pharmacy during the dispensing process.



The sig is required for both the medication and for the item(s) used in the management of the condition. It is expected that the sig for the medication and the sig for the item(s) will differ. When sig is sent in text only, the route of administration is strongly recommended. When structured Sig is sent, the route of administration is required. When sig is sent in text only, the frequency is strongly recommended. When structured Sig is sent, frequency is strongly recommended. When the structured Sig is used the <TestingFrequency> must match to the structured Sig <FrequencyNumericValue>.

When ordering items such as test strips or lancets, the <Quantity> must reflect the package quantity of the item (i.e. 100 instead of 1 box).

<TestingFrequencyNotes> if used, should contain additional information that is **not duplicative** to the discrete elements in the transaction including, but not limited to, the medication elements or the sig elements.

## **8.4 IV ADMINISTRATION AND TITRATION ELEMENTS USAGE**

### **8.4.1 IV ADMINISTRATION**

The IV Administration elements are used when additional information is need to support the administration of the IV. Items include:

<IVAccessTypeDescription> would be used to indicates the type of IV access to be used for medication administration, i.e. central, midline, peripheral.

<NumberOfLumens> would be used to indicates the number of lumens in the IV access line that will be used for administering the medication. <DiluentAmount> Composite –would be used to Indicates the amount of diluent to be used for administration. For example, the diluent order may be for 1L normal saline, but the amount used when administering the medication is 10 mL. A separate prescription order must be sent for the dispensing of the actual Diluent.

<SpecificAdministrationGauge> would be sent to indicates the size of the needle being used for medication administration, i.e. 14, 18, 20. The location of the IV access point would be included in the <Site> element of the structured and codified Sig.

IVAccessDeviceTypeDescription> would be sent to indicate the specific device used for central IV access, if applicable i.e. implanted port, PICC line, tunneled line, non-tunneled line.

<IVAccessCatheterTipTypeDescription> would be sent to indicate the specific structure of the catheter tip for the specific device used for central or midline IV access., if applicable i.e. valved, non-valved.

<IVInfusionTypeDescription> would be sent to indicate the intended type of IV infusion i.e. continuous, intermittent, TOTAL parenteral nutrition (TPN), PARTIAL parenteral nutrition (PPN), maintenance.

<SpecificAdministrationGauge> would be sent to indicate the size of the needle or catheter being used for medication administration, i.e. 14, 18, 20.

<SpecificAdministrationBrand> would be send to indicate the Brand of the PICC line used for central IV access.

<SpecificAdministrationLength> would be sent to indicate the length of the PICC line used for central IV access.

Exchange of clinical/protocol data:

The Clinical Information exchange can be sent at the time the prescription is sent and can include information such as: past medical history, including other related drug therapies attempted, diagnoses/problem lists, lab and drug level results, additional disease/condition information,

flushing protocol parameters, guidelines for dosing parameters or drug level ranges. Information is exchanged via attachments.

If discrete clinical data is to be exchanged, the **SCRIPT Standard** supports elements such as: primary and secondary medication related diagnoses <Diagnosis>. A diagnosis, such as diabetes, may be important for the pharmacy to know what diluent to mix medication in if not specified. The **SCRIPT Standards** support patient allergies <Allergy>. The **SCRIPT Standards** also supports measurement information via <Observation>.

#### **8.4.2 TITRATION**

<PharmacyToTitrateDose> would be sent if the pharmacy/pharmacist dose is to calculate the medication dose based data from the message or pharmacy/facility protocol agreement.

The use of <TitrationDose> will be for non-retail settings only. For example: LTC, hospital, acute care, home care or specialty.

### **8.5 EXCHANGE OF CLINICAL INFORMATION**

The pharmacy can send a ClinicalInformationRequest, which the prescriber can then send a ClinicalInformationResponse. The ClinicalInformation exchange can be sent at the time the prescription is sent and can include information such as: past medical history, including other related drug therapies attempted, current medication regimens, diagnoses/problem lists, lab and imaging results, additional disease/condition information. Information is exchanged via attachments. See the NCPDP **Specialized Implementation Guide** for additional information on the ClinicalInformationRequest and ClinicalInformationResponse.

If discrete clinical data is to be exchanged, the **SCRIPT Standard** supports elements such as: primary and secondary diagnoses <Diagnosis>. A diagnosis, such as diabetes, may be important for the pharmacy to know when providing diluents. The **SCRIPT Standards** also supports measurement information via <Observation>.

### **8.6 SPECIFIC LONG TERM CARE ELEMENT DISCUSSION**

#### **8.6.1 DEMOGRAPHIC AND CONTACT INFORMATION FOR PHARMACY, FACILITY, PRESCRIBER AND SUPERVISOR**

The following tables provide the usage for all demographic and contact information fields in all applicable transactions. In addition it is recommended:

- The <Facility> should be sent for a resident of a facility except in the case of acknowledgement messages such as Verify.
- The <PrescriberAgent> should be sent to capture the person entering the information if different than prescriber in <Prescriber>.

- The <Supervisor> should be sent for all extenders (non-physician prescribers), as required.

Legend:

Code	Definition
C	Conditional – specific conditions appear at end of table
F	Follow <b>SCRIPT Standard Implementation Guide Version 10.6</b> for specific requirements
M	Mandatory
N	Not Used
O	Optional
R	Required for LTPAC

Field	Pharmacy	Facility	Prescriber	Supervisor
<StoreName>	M	N	N	N
<ClinicName>	N	N	C	O
<FacilityName>	N	R	N	N
<Specialty>	N	N	O	O
<LastName>	N	N	M	M
<FirstName>	N	N	R	R
<MiddleName>	N	N	C	C
<Suffix>	N	N	O	O
<Prefix>	N	N	O	O
<AddressLine1>	F	F	F	F
<AddressLine2>	O	O	O	O
<City>	F	F	F	F
<State >	F	F	F	F
<ZipCode>	F	F	F	F
<CommunicationNumber> value Beeper	O	O	O	O
<CommunicationNumber> value Cellular	O	O	O	O
<CommunicationNumber> value eMail	C	C	C	C
<CommunicationNumber> value Fax	O	O	R	O
<CommunicationNumber> value Home	O	O	O	O
<CommunicationNumber> value Night	O	O	O	O
<CommunicationNumber> value Telephone	M	M	M	M
<CommunicationNumber> value Work	O	O	O	O
<PrescriberAgent>< Last Name>	N	N	C	N
<PrescriberAgent><First Name>	N	N	C	N

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Field	Pharmacy	Facility	Prescriber	Supervisor
<PrescriberAgent><MiddleName>	N	N	O	N
<PrescriberAgent><Suffix>	N	N	O	N
<PrescriberAgent><Prefix>	N	N	O	N

Conditional Usage:

- <MiddleName> should be sent if known for the prescriber or supervisor.
- Email address should be sent when available. The email address is to be used only for non-patient specific content.
- <ClinicName> should be sent if known.
- <Prescriber><Agent> <LastName> and <Prescriber><Agent><FirstName> should be sent to record the person entering the order.

### 8.6.2 PRESCRIBER, PHARMACY AND FACILITY IDENTIFIERS

The following identifiers are recommended for use in <Prescriber><Identification>:

- <NPI> is required (Type 1 Individual NPI).
- <DEANumber> is required if the prescriber has a DEA Number and the medication being prescribed is a controlled substance.
- <StateLicenseNumber> is recommended as an additional identifier for informational purposes.

The following identifiers are recommended for use in <Pharmacy><Identification>:

- <NCPDPID> is required.
- <NPI> is required.

The following identifiers are recommended for use in <Facility><Identification>:

- <NPI> is required if the facility has obtained an NPI.
- <MutuallyDefined> is required if there is a need to differentiate between facility locations that share the same NPI.

### 8.6.3 PATIENT DEMOGRAPHICS AND IDENTIFICATION

The following table provides the usage for all demographic and contact information fields for patients.

Legend:

Code	Definition
------	------------

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<b>Code</b>	<b>Definition</b>
C	Conditional – specific conditions appear at end of table
F	Follow <b>SCRIPT Standard Implementation Guide Version 10.6</b> for specific requirements
M	Mandatory
N	Not Used
O	Optional
R	Required for LTPAC

<b>Field</b>	<b>Patient</b>
<PatientRelationship>	O
<Identification>	R
<LastName>	M
<FirstName>	M
<MiddleName>	O
<Suffix>	O
<Prefix>	O
<Gender>	M
<DateOfBirth>	R
<AddressLine1>	O
<AddressLine2>	O
<City>	O
<State>	O
<ZipCode>	O
<CommunicationNumber> value Beeper	O
<CommunicationNumber> value Cellular	O
<CommunicationNumber> value eMail	O
<CommunicationNumber> value Fax	O
<CommunicationNumber> value Home	O
<CommunicationNumber> value Telephone	M
<CommunicationNumber> value Work	O
<FacilityUnit>	C
<Bed>	C
<Room>	C

Conditional Usage:

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- <Bed> is required for Census messages except discharge if more than one bed is assigned to a room. It is also recommended to be sent on a discharge if known.
- <FacilityUnit> is required for Census messages except discharge. It is also recommended to be sent on discharge if known.
- <Room> is required for Census messages except discharge. It is recommended to be sent on discharge if known.

**Patient Identification:**

The <Patient><Identifiers> element supports up to two occurrences. The following identifiers provide the usage in <Patient><Identification>:

- A unique patient identifier (<PatientAccountNumber> or <MedicalRecordIdentificationNumberEHR>) is required to be provided by the facility and stored by the pharmacy to use as a unique identifier for communications related to the patient.
- <SocialSecurity> is required to be exchanged to assist in eligibility checks and billing of claims. If the Social Security Number is not known or not allowed for use by law, then <MedicareNumber> should be used.

#### **8.6.4 FACILITY SPECIFIC HOURS OF ADMINISTRATION**

Facility Specific Information Related to the Product:

There is a need for the facility to be able to send additional information to the pharmacy on an electronic prescription related to the medication being prescribed. This information may include but not limited to:

- Facility specific hours of administration
- Day of the week a product will be started
- Facility specific days of administration
- Patient preferences/needs related to administration for a given product
- Patient specific product related instructions as adjunct to prescribed directions
- Date of the month the product is to be administered.

The addition of this facility specific information cannot lead to a delay in transmitting the electronic prescription to the pharmacy. This clarifying information is not part of the legal prescription order, and should not delay transmission. It is recommended that facility EHR vendor systems access ‘standardized HOA time’ tables and/or other unique patient attributes to automatically include the applicable element when the product prescription order is signed and sent to the pharmacy.

Facility specific hours or administration and days of administration are used to designate the time of day and/or days of the week when not specified in the Sig by the prescriber. The <FacilitySpecificHoursOfAdministrationTiming> element may repeat.

<HoursOfAdministrationValue> is used to report the specific time the product is to be administered in military time. For example, if a once daily medication is always scheduled to be administered by the nursing staff at 5:00 p.m. each day the value would be “17:00”.

<HoursOfAdministrationText> is used to report the textual representation of the associated SNOMED code in <HoursOfAdministrationTextCode>.

<HoursOfAdministrationTextQualifier> is always “SNOMED”.

<HoursOfAdministrationTextCode> is the associated SNOMED code value.

Days of administration would be reported using:

- <HoursOfAdministrationText>
- <HoursOfAdministrationTextQualifier>
- <HoursOfAdministrationTextCode>

## **8.7 SPECIFIC GUIDANCE FOR COMPOUNDS**

It is not always practical/necessary to send inactive ingredients since not all prescribers know all inactive bases and wetting/mixing agents available. The examples given were commercially available medications that were compounded. To accommodate the use of bulk powders when compounding, a total quantity for the prescription should list each ingredient as its percent of the total quantity in grams. Representing each ingredient as the percent of the total quantity allows the compounding pharmacist to select the best formulation (i.e. using the recommended inactive base or wetting/mixing agents best suited to the active ingredients prescribed) for the compounded product.

For example instead of

Non-preferred	Preferred
Nifedipine Powder 0.12 gm Aquaphor 58.88 gm Propylene Glycol 1 ml Sig: Apply to the affected area twice a day.	Nifedipine 0.2% ointment Qty 60gm Sig: Apply to the affected area twice a day
Diclofenac 7.2 gm Ibuprofen 7.2 gm Pentoxifylline 7.2 gm Cream base 218.4 gm	Diclofenac 3% Ibuprofen 3% Pentoxifylline 3% Dosage form: Cream

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Sig: Apply 1 gram bid.	Qty 240gm Sig: Apply 1 gram bid.
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The <CompoundIngredient> element may repeat up to 25 times.

The <MedicationPrescribed><DrugDescription> should contain the prescriber's preferred name.

## **8.8 GROUPING OF PRESCRIPTION ORDERS**

The use of the <PrescriberOrderGroup> and <RxReferenceOrderGroup> elements in the <Header> allows the prescriber to link multiple prescriptions and inform the pharmacy the reason for the grouping. Current uses for the grouping include notifying the pharmacy of:

- Grouped prescriptions where one denotes a trial fill quantity prescription and another denotes a maintenance quantity prescription.
- Prescriptions grouped where one is for the IV product and the other is for the IV flushing supplies associated with IV Admin
- Multiple prescriptions for multiple products for the same patient prescribed at same time
- Multiple prescriptions for products only available for dispensing in an unbreakable package where multiple administration locations are needed. One prescription denotes quantity needed for each administration location and another prescription denotes a maintenance quantity.
- Multiple prescriptions to request a loading dose quantity prescription and a maintenance quantity prescription.
- Multiple prescriptions for multiple strengths of the same product for the same patient prescribed together for administration of a dose that is not currently commercially available.

In addition, the grouping elements could also be used to link a MTM service request to a NewRx.

The <PrescriberOrderGroup> and <RxReferenceOrderGroup> composites are optional, but all elements within are mandatory.

<OrderGroupNumber> is a unique ID assigned on a NewRx or on an RxChange linking multiple product orders together.

<ItemCountInOrderGroup> indicates the specific item counter in order group i.e. "1"," 2","3" of the "1 of 3", "2 of 3" and "3 of 3".

<TotalCountForOrderGroup> indicates the total number of items within the group i.e. the "3" of "1 of 3", "2 of 3" and "3 of 3".

<OrderGroupReason> indicates the reason why the product orders are being grouped.

\*Best practices would be to send initial quantity order (i.e. Trial Fill, Loading Quantity etc.) before the maintenance quantity order and the IV product orders before supply or service orders.

Where applicable, the prescriber must use the <DoNotFill> flag value of "H" to indicate the pharmacy is not to fill the second or subsequent grouped NewRx prescription(s) until requested by the patient. In addition, the <OtherMedicationDateQualifier> value of <EffectiveDate> could be used to indicate to the pharmacy the date the order is to be filled if different from the other prescriptions in the group.

The following examples show how the <OrderGroupReason> and <DoNotFill> flag would appear in each of the linked orders:

Order 1 of 2	Order 2 of 2	Order 2 of 2 Do Not Fill Flag
*NewRx	Additional Service (i.e. MTM)	
*Trial Fill	Maintenance Quantity	H
IV Product	IV Administration Supplies	
*Loading Quantity	Maintenance Quantity	H
*Multiple Admin Locations Unbreakable Packs	Maintenance Quantity	H
Multiple Drugs Prescribed at Same Time	Multiple Drugs Prescribed at Same Time	
Other	Other	

NewRx Transactions examples:

**Example 1:** Trial Fill Requested for a non-controlled substance with a 10 tablet trial fill (NewRx 1) followed by a 30 tablet refill quantity with nine refills (NewRx 2):

NewRx 1:	NewRx 2:
<pre>&lt;PrescriberOrderGroup&gt;     &lt;OrderGroupNumber&gt;1234&lt;/OrderGroupNumber&gt;     &lt;ItemCountInOrderGroup&gt;1&lt;/PositionInOrderGroup&gt;     &lt;TotalCountForOrderGroup&gt;2&lt;/TotalCountForOrderGroup&gt;     &lt;OrderGroupReason&gt;TF&lt;/OrderGroupReason&gt; &lt;/PrescriberOrderGroup&gt; ...</pre>	<pre>&lt;PrescriberOrderGroup&gt;     &lt;OrderGroupNumber&gt;1234&lt;/OrderGroupNumber&gt;     &lt;ItemCountInOrderGroup&gt;2&lt;/PositionInOrderGroup&gt;     &lt;TotalCountForOrderGroup&gt;2&lt;/TotalCountForOrderGroup&gt;     &lt;OrderGroupReason&gt;MQ&lt;/OrderGroupReason&gt; &lt;/PrescriberOrderGroup&gt; ...</pre>

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<pre> &lt;MedicationPrescribed&gt;   ...   &lt;Quantity&gt;     &lt;Value&gt;10&lt;/Value&gt;     &lt;CodeListQualifier&gt;38&lt;/CodeListQualifier&gt;     &lt;UnitSourceCode&gt;AC&lt;/UnitSourceCode&gt;     &lt;PotencyUnitCode&gt;C48542&lt;/PotencyUnitCode&gt;   &lt;/Quantity&gt;   ...   &lt;Refills&gt;     &lt;Qualifier&gt;R&lt;/Qualifier&gt;     &lt;Value&gt;0&lt;/Value&gt;   &lt;/Refills&gt;   ... &lt;/MedicationPrescribed&gt;</pre>	<pre> &lt;MedicationPrescribed&gt;   ...   &lt;Quantity&gt;     &lt;Value&gt;30&lt;/Value&gt;     &lt;CodeListQualifier&gt;38&lt;/CodeListQualifier&gt;     &lt;UnitSourceCode&gt;AC&lt;/UnitSourceCode&gt;     &lt;PotencyUnitCode&gt;C48542&lt;/PotencyUnitCode&gt;   &lt;/Quantity&gt;   &lt;OtherMedicationDateQualifier&gt;   &lt;EffectiveDate&gt;20161015&lt;/EffectiveDate&gt;   ...   &lt;Refills&gt;     &lt;Qualifier&gt;R&lt;/Qualifier&gt;     &lt;Value&gt;8&lt;/Value&gt;   &lt;/Refills&gt;   ...   &lt;DoNotFill&gt;H&lt;/DoNotFill&gt;   ... &lt;/MedicationPrescribed&gt;</pre>
--	--

In NewRx 2 the use of the <OtherMedicationDateQualifier> value of <EffectiveDate> to indicate the pharmacy is not to fill the order before October 15, 2016.

**Example 2:** Multiple Dosing Locations – Increased quantity of two 17 gram inhalers requested one for home and one for school (NewRx 1) and one 17 gram inhaler requested as the maintenance quantity (NewRx2).

Message 1:	Message 2:
<pre> &lt;PrescriberOrderGroup&gt;   &lt;OrderGroupNumber&gt;4321&lt;/OrderGroupNumber&gt;   &lt;ItemCountInOrderGroup&gt;1&lt;/PositionInOrderGroup&gt;   &lt;TotalCountForOrderGroup&gt;2&lt;/TotalCountForOrderGroup&gt;   &lt;OrderGroupReason&gt;MA&lt;/OrderGroupReason&gt; &lt;/PrescriberOrderGroup&gt; ... &lt;MedicationPrescribed&gt;   ...   &lt;Quantity&gt;</pre>	<pre> &lt;PrescriberOrderGroup&gt;   &lt;OrderGroupNumber&gt;4321&lt;/OrderGroupNumber&gt;   &lt;ItemCountInOrderGroup&gt;2&lt;/PositionInOrderGroup&gt;   &lt;TotalCountForOrderGroup&gt;2&lt;/TotalCountForOrderGroup&gt;   &lt;OrderGroupReason&gt;MQ&lt;/OrderGroupReason&gt; &lt;/PrescriberOrderGroup&gt; ... &lt;MedicationPrescribed&gt;   ...   &lt;Quantity&gt;     &lt;Value&gt;17&lt;/Value&gt;</pre>

```

<Value>34</Value>
<CodeListQualifier>38</CodeListQualifier>
<UnitSourceCode>AC</UnitSourceCode>
<PotencyUnitCode>C48155</PotencyUnitCode>
</Quantity>
<NumberOfPackagesToBeDispensed>2</NumberOfPackagesToBeDispensed>

...
<Refills>
    <Qualifier>R</Qualifier>
    <Value>0</Value>
</Refills>
...
</MedicationPrescribed>
```

```

<CodeListQualifier>38</CodeListQualifier>
<UnitSourceCode>AC</UnitSourceCode>
<PotencyUnitCode>C48155</PotencyUnitCode>
</Quantity>
<Refills>
    <Qualifier>R</Qualifier>
    <Value>6</Value>
</Refills>
...
<DoNotFill>H</DoNotFill>
...
</MedicationPrescribed>
```

In NewRx1 the use of the <NumberOfPackagesToBeDispensed> of "2" indicates the pharmacy (or pharmacy system) two packages (in this case two inhalers) need to be labeled.

In NewRx 2 the use of the <DoNotFill> flag of "H" indicates the pharmacy is not to fill the order until requested by the patient.

## 8.9 PRESCRIBER AUTHORIZATION STATUS RESPONSE REASON CODES

The following table describes the <ResponseReasonCode> to be associated with each of the <MessageRequestSubCode> and the fields to be populated on the response:

MessageRequestCode Sub-Category	ResponseReasonCode	Applicable ResponseReasonCode Description	Additional Fields to be populated
Prescriber must confirm their State license status	GM	Active Registration Status	Identification
	GN	In-Active License with prescriptive authority based on state/federal regulations	
Prescriber must confirm their DEA license status in prescribing state	GM	Active Registration Status	Identification
Prescriber must confirm their DEA registration by DEA class	GM	Active Registration Status	Identification
Prescriber must confirm their State Controlled	GM	Active Registration Status	Identification

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Substance Registration license status			
Prescriber must confirm their registration by State Controlled Substance Registration class	GP	Active with Prescriptive Authority – prescribed product class	Identification
Prescriber must confirm their Certificate to Prescribe Number status	GM	Active Registration Status	Identification
Prescriber must confirm their NADEAN license status	GS	Registered	Effective Date
Prescriber must obtain/validate Type1 NPI	GM	Active Registration Status	Identification
Prescriber must enroll/re-enroll with prescription benefit plan	GT	Enrolled/Re-Enrolled	Effective Date
Prescriber must confirm prescriptive authority criteria for prescribed medication is met	GQ	Active with Prescriptive Authority – Prescriber Type	Specialty
Prescriber must enroll/re-enroll in REMS	GT	Enrolled/Re-Enrolled	Effective Date
Prescriber must confirm their assignment as patients' lock-in prescriber	GU	Assigned	Effective Date
Prescriber must obtain/validate their supervising prescriber	GR	Active with Prescriptive Authority – Supervising Prescriber Type	Supervisor

Note: Prescriptive authority criteria – acting in the usual course of his/her professional scope of practice.

## **8.10 SPECIFIC GUIDANCE ON USE OF FOLLOWUPPRESCRIBER**

In order to communicate to the pharmacy filling the prescription(s)/order(s) that continuation of care should be directed to the patients' follow-up prescriber, the originating prescriber or prescriber providing the episodic care should:

- confirm with the patient their follow-up prescriber's information
- obtain patient approval for the dispensing pharmacy to transmit follow-up communication to the designated follow-up prescriber
- populate the <FollowUpPrescriber> element with as much information as known
- set the <ProhibitRenewalRequest> flag to 'Y'

## **9. SPECIFIC PRIOR AUTHORIZATION ELEMENT DISCUSSION**

### **9.1 GENERAL RECOMMENDATIONS**

In the display of questions and answers to the end user it is recommended that if an end user wishes to change an answer, the software should run through the questions again before the transaction is submitted as the answer to the question or the sequence of the questions may change.

Note that for the purposes of this guide, the terms “health plan” “payer” “processor” “pharmacy benefit manager” are all cited as “payer”. One of these entities may contract with a third party to perform prior authorization functions; the term should be treated the same for these purposes.

Use of other conditional elements may depend on a participant’s choice to make use of an enhanced prior authorization feature such as coded references in question sets. In such cases, participants are expected to be able to accept transactions containing all elements in the standard, even if they do not yet use them in internal processing. For example, a prescriber system may not have the capability to systematically retrieve answers using coded references supplied in a question set, but it must at least be able to accept a transaction containing those references.

The payer should provide pertinent information on items in the <QuestionSetDescription> or <PANotes> for effective communication such as

- prior authorization processing timeframes or parameters
- preamble information that is included in forms today
- agreement parameters with prescribers

Because priorities and urgent processing requirements vary widely between different health plans, government programs, etc., the electronic prior authorization transactions do not include a dedicated, pre-defined urgency element. If there is a need for a payer to support a regulatory requirement to exchange the designation of a priority of a prior authorization, a question is to be used in the question set to relay this information to the end user.

One PAInitiationResponse (solicited) or one PAResponse (unsolicited) should support the questions of a payer. It has been noted that there may be payers that may support multiple prior authorization forms for the same prior authorization questions or may support questions across multiple forms. As the prior authorization transactions support the ability to exchange many questions, one transaction is sufficient for these exchanges. If there is a business case to support questions across forms, multiple transactions are to be exchanged.

#### **9.1.1 QUESTION RECOMMENDATIONS**

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When transforming questions from the paper forms to the electronic prior authorization transactions, changes to the questions may be required for standardization of answers or efficiencies in processing.

#### **9.1.1.1 *Example 1: Compound Questions***

Compound questions must be separated into individual questions.

On the prior authorization paper form:

1. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration)? If yes, provide registration number.

Yes

No

This is an example of a compound question as it requires two answers.

In the electronic prior authorization transaction:

When transformed into the electronic PA questions, this question must be sent as two questions. The next question indicator would point to the second question if the first question is answered “yes”.

1. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration)?

Yes

No

2. Provide SAMHSA (Substance Abuse and Mental Health Services Administration) registration number.

#### **9.1.1.2 *Example 2: Data Available in the PA Transactions***

When data is provided in the PAInitiationRequest (e.g., patient’s date of birth, gender, etc.), efficiencies for the payer and provider may be realized by the payer using the data in other segments of the prior authorization transaction and not asking for this data in the Question Set.

On the prior authorization paper form:

What is the patient’s age?

What is the patient’s gender?

In the electronic prior authorization transaction:

These questions do not need to be asked in the Question Set because the data is provided in the PAInitiationRequest in the <Patient> element.

## 9.2 IDENTIFICATION ELEMENTS

The overarching trace numbers (<MessageID>, <RelatesToMessageID>) are used to tie transactions (see section “Trace Number Usage” in the NCPDP **XML Standard**.) Specifically for PA transactions, the following information is provided.

### 9.2.1 <PAREFERENCEID>

This element is mandatory in all prior authorization transactions except PAInitiationResponse. The <PAREferenceID> is assigned by the prescribing system on the initial transaction and is used as a tracking identifier on all prior authorization request and response transactions to tieback related prior authorization transactions. It is the identifier established by the prescribing system sending a PAInitiationRequest in the solicited model or PARequest in the unsolicited model to initiate the process to request prior authorization. The identifier must be echoed in any subsequent prior authorization transactions related to that request for prior authorization (including prior authorization appeal and cancel transactions). The identifier must be unique per prescribing system. If the <PaReferenceID> is not present on the PAInitiationResponse, it is because the payer is renewing an expiring PA.

### 9.2.2 <PACASEID>

This tracking identifier will be used on appropriate PA transactions as a unique reference to this prior authorization case. The <PACaseID> can also be used by the end user to identify the prior authorization case if they need to contact the payer regarding the case. The <PACaseID> should be displayed to the end user.

Model	Transaction	<PACaseID> Comments
Solicited	PAInitiationRequest	Not used
	PAInitiationResponse	Payer must return a unique identification for this prior authorization case when a prior authorization is needed. If the payer determines a prior authorization isn't needed, it is optional for the payer to return a unique identification for this prior authorization case.
	PARequest	Prescriber system must send the value from the PAInitiationResponse.
	PAResponse	Payer must return the value from the PARequest (which was originally obtained from the PAInitiationResponse).
Unsolicited	PARequest	Not used on initial PARequest.

Model	Transaction	<PACaseID> Comments
		Prescriber system must send the value from the PAResponse if sending a subsequent PARequest when PAResponse indicated more information is required from the prescriber.
	PAResponse	Payer must return a unique identification for this prior authorization case, except when the payer determines a prior authorization isn't needed. If the PAResponse indicates a prior authorization isn't needed, it is optional for the payer to return a unique identification for this prior authorization case.
Solicited and Unsolicited	PACancelRequest	Prescribing system must send.
	PACancelResponse	Payer system must echo back what was sent on PACancelRequest.
	PAAppealRequest	Prescribing system must send.
	PAAppealResponse	Payer system must echo back what was sent on PAAppealRequest.

### 9.2.3 <APPEALCASEID>

The payer may choose to assign a <AppealCaseID> to use for tracking **within** the <PACaseID>. If a <AppealCaseID> is assigned, it is to be exchanged on all subsequent appeal transactions.

### 9.2.4 <EXPIRINGPACASEID>

The payer shall return <ExpiringPACaseID> when the payer is sending PAInitiationResponse to renew an existing expiring PA. It is recommended the vendor application display both the <ExpirationDate> and the <ExpiringPACaseID> to the prescriber.

## 9.3 PROVIDER ELEMENTS

The prior authorization transactions enable all parties related to the request to be defined:

- The Prescriber composite in the prior authorization transactions describes the prescriber of the medication for which authorization is being requested. An element may describe the supervisor of the prescribing clinician. (Supervisor information may be needed based

upon state law. A supervisor is the supervising physician under whose authority the prescription is being prescribed by the prescriber.) (Prescribing Agent information may be supplied when applicable.)

- The Pharmacy composite is used to describe a pharmacy that is related to the request, including elements describing the pharmacist.
- The Facility composite may be included to describe the care facility or other location at which the patient resides.
- A Provider composite may be included to identify and provide contact information for a person initiating the prior authorization, if that person is not the prescriber. When included in the PAInitiationRequest, it is intended that the person identified in the Provider composite is the appropriate contact if telephone or other communication is required.

### **9.3.1 ADDITIONAL CONTACT**

The prior authorization transactions support contact information for effective follow up. Depending on the workflow and staff roles at the prescriber's practice or the patient's care setting, the prescribing clinician may not be the contact person for questions or other correspondence related to a prior authorization request. For example, office staff or others working under protocol with the prescriber may serve as the prior authorization submitter and contact person. The prior authorization transactions support this need by including a <Provider> composite that can be used to convey contact person information in addition to details for the prescribing clinician.

The presence of a <Provider> composite in prior authorization transactions identifies to the receiving payer that the party identified in that composite is the appropriate contact for questions or other communication related to the request. The <PrescriberAgent> is not used in this situation as they are identified in the prescribing functions, and may be a different role in the prior authorization functions.

## **9.4 MEDICATION ELEMENTS**

**Excluding the support of mandatory elements, if the medication-related data is contained within the <MedicationPrescribed>, it does not need to be asked for in the questions.**

### **Guidance for some of the elements**

- <DaysSupply> when used implies the daily dose. (Note the <Sig> is to be used for length of therapy and directions for use.)
- Prescription-related dates are not supported for prior authorization functions.
- <PriorAuthorization> is not used for PA transactions. This is used in e-prescribing exchanges, not in prior authorization exchanges.
- <PriorAuthorizationStatus> is not used for PA transactions. It is used in the NewRx and other transactions to show the status between the prescriber and the pharmacy.
- Compounds – prior authorization for compounds is supported.

In order for the PA processor to more effectively/efficiently determine if a PA request will be needed, either days supply or doses per day must be included on the PAInitiationRequest (or PAResponse). Including this information may negate the need for a PA question set to be completed.

## **9.5 PAPRIORITYINDICATOR USAGE**

The <PAPriorityIndicator> value of “X” (Urgent/Expedited Priority) should be sent when the drug/biologic will prevent serious deterioration in the member’s health or could jeopardize the member’s ability to regain maximum function. The value of “S” (Standard Priority) should be the default if the tag is sent in the transaction.

## **9.6 QUESTION SET USAGE**

The prior authorization transactions use question sets to convey:

- the information needed by the payer to support the authorization or appeal process. The information needed may be contained in the following transactions:
  - PAInitiationResponse
  - PAResponse
  - PAAppealResponse and
- the prescribing system’s completed information back to the payer. The completed information is contained in the following transactions:
  - PAResponse
  - PAAppealRequest

A question set contains a header section with information about the set of questions as a whole (including a question set identifier and title), and a body containing one to many questions, each of which may optionally contain coded references (i.e. LOINC codes, CDA templates, etc.) to identify information that can be extracted from the patient’s electronic medical record. The type of answer expected for each question is noted by the payer, which may be select, date, numeric or free text. Each question indicates the next question to ask (either a question level default or based on the answer selected/provided) to provide the rule set for the vendor and the end user to know what questions are expected and the associated order.

For consistency of prior authorization exchanges, the question set information from the request is mirrored in the response. The response contains the mirror back of all questions regardless if answered by end user. Questions answered include the <Answer> element.

If the payer does not obtain all the needed information for prior authorization determination, the PAResponse and PAAppealResponse contain <Open><MoreInformationRequired> elements that will include a question set for more information.

### 9.6.1 KEY QUESTION SET ELEMENTS

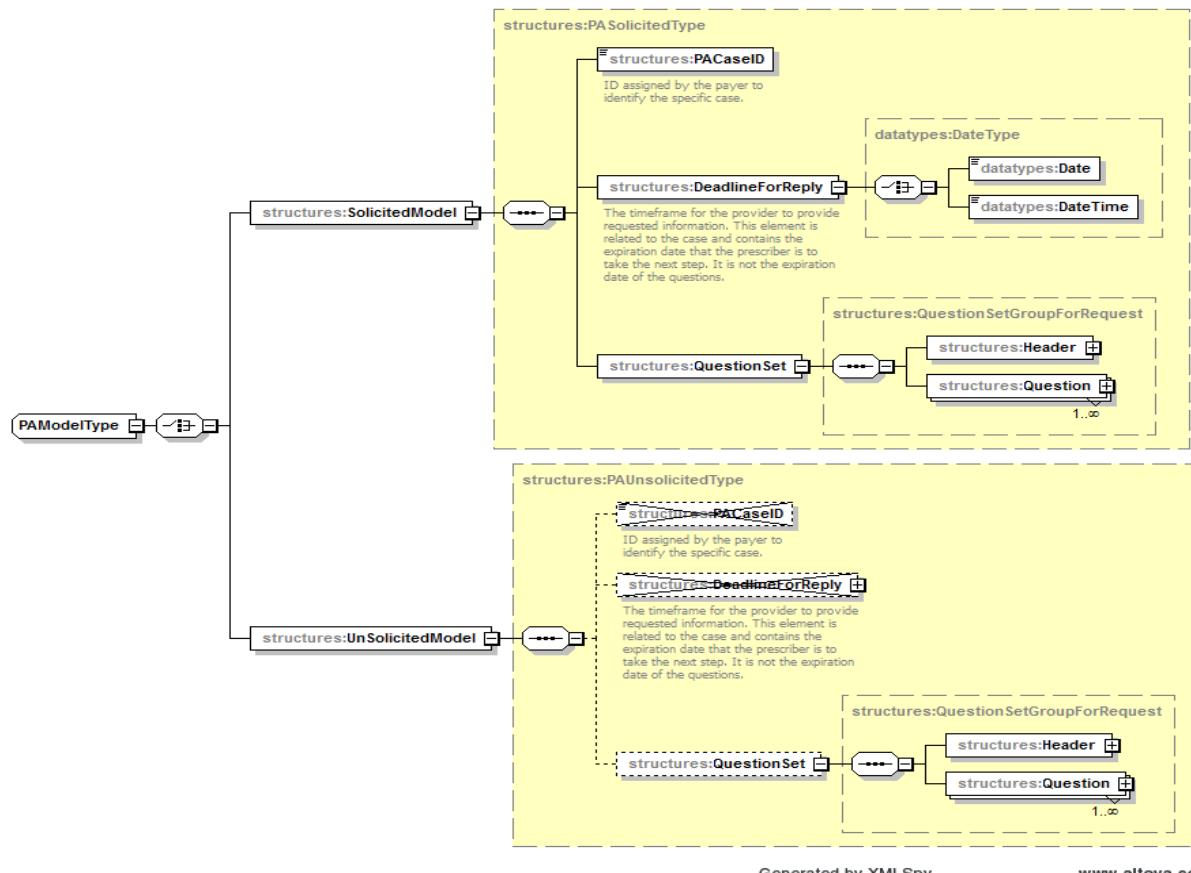


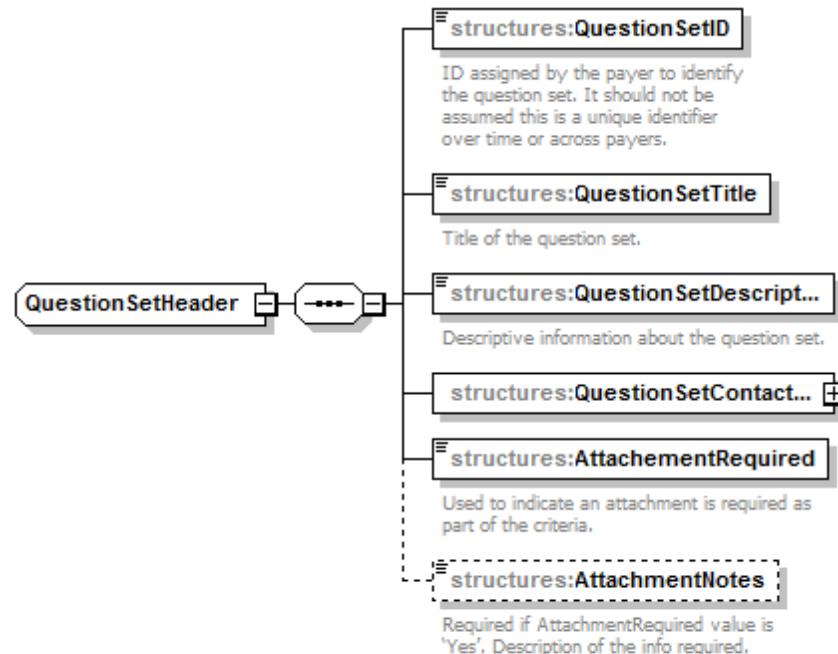
Figure 72 QuestionSet Solicited/Unsolicited and DeadlineForReply

**<DeadlineForReply>** If the prescribing system hasn't completed the question set and submitted the PARequest by this date, to continue with the prior authorization process a new PAInitiationRequest must be sent to receive the most current question set. This is used in the solicited model, and is not used in the unsolicited model. This element is outside the <QuestionSet> because it is related to the case and contains the deadline

for the prescriber to reply with a completed question set.

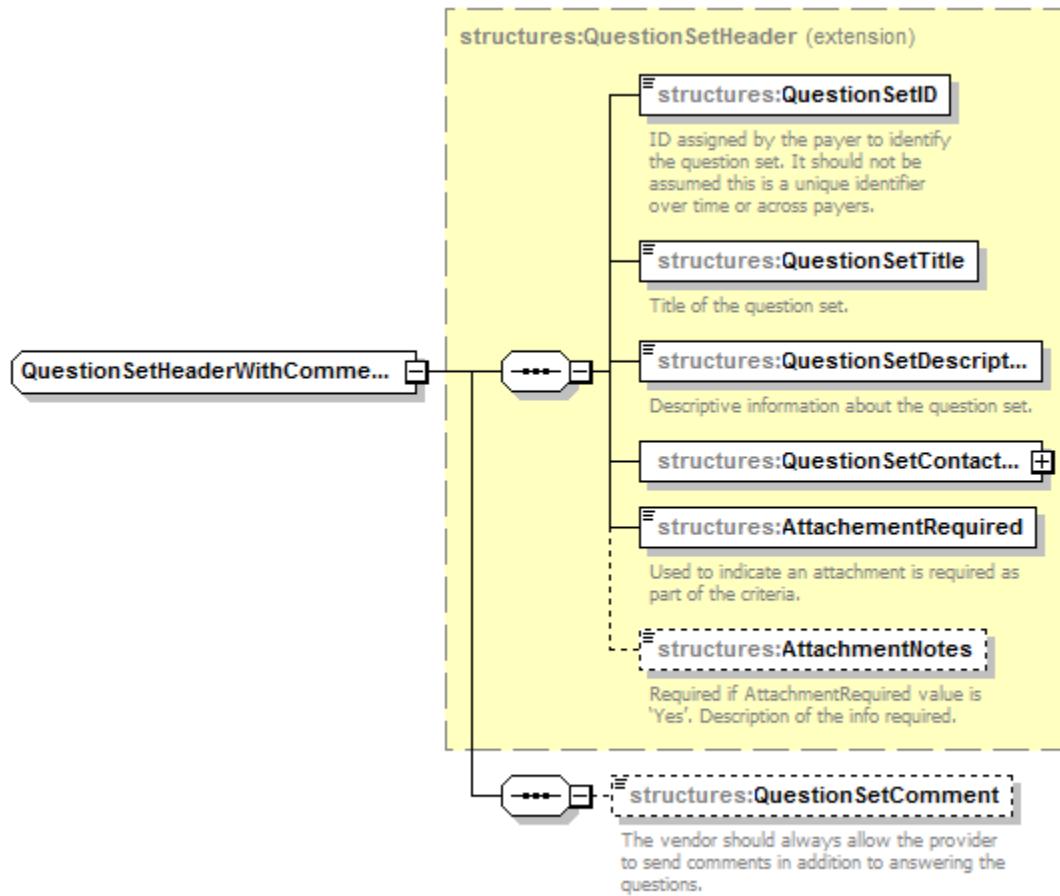
<AttachmentRequired> is used to indicate an attachment is required as part of the criteria to the prescribing system.

<AttachmentNotes> should be used to provide a summary of all clinical information required on an attachment as part of the criteria.



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Figure 73 QuestionSetHeader without or with comment

**<QuestionSetID>** is an identifier assigned by the payer to the question set. The payer may define this identifier as is appropriate to its business, and may choose to embed logic in the identifier, such as a version name or number or other characteristics for use in internal management. This

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identifier is assigned by the payer, and it should not be assumed this is a unique identifier over time or across payers. This is intended to support the systematic exchange process and should not be displayed to the end user, as it provides no value.

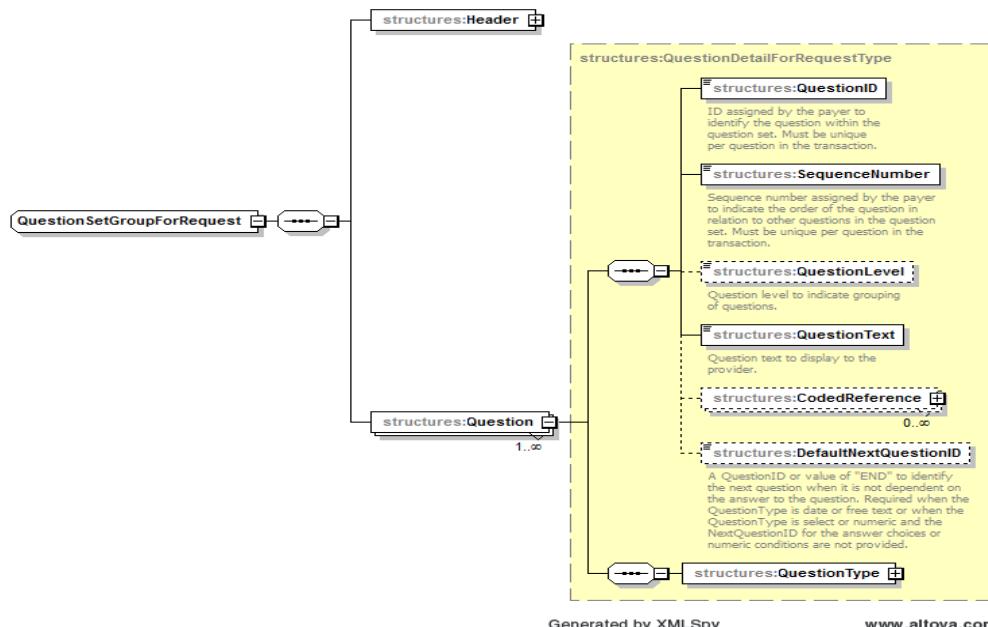
**<QuestionSetTitle>** The content of this element is determined by each payer and is to be displayed to the end user. It is useful to include information that describes the question set to the end user, such as:

- Payer/plan name
- Drug and/or drug class.

**<QuestionSetDescription>** This is to be displayed to the end user as it provides more detailed useful information about the question set. (This may include information that is included in the preamble of the form today.)

**<QuestionSetContactCommunicationNumber>** The communication number the end user can use to contact the payer regarding the prior authorization case. This information should be available to the end user for use in any manual communication throughout the life of this prior authorization.

**<QuestionSetComment>** The QuestionSetHeader is used with or without comment. The <QuestionSetComment> element is available for the prescribing system answering the question set. The vendor should always allow the provider to send comments in addition to answering the questions. The <QuestionSetComment> element is not used in payer's responses.

**Figure 74 QuestionSetDetail**

**<QuestionID>** This is a pointer to a particular question within a question set that is intended to be used by the sending and receiving systems; it is not intended to be displayed to the end user. As such, the **<QuestionID>** is not guaranteed to be sequential or to have any relation to the proper ordering of questions. **<QuestionID>** is unique per question in the transaction.

**<SequenceNumber>** The sequence number indicates the order of the question in relation to other questions in the question set. The sequence number does not imply or take into account the conditional logic to determine the next question based on the answer provided. For example, the question with the SequenceNumber “3” may be conditional and in some cases will not be presented to the end user. In this case, the **<SequenceNumber>** of questions presented to the end user may be: 1, 2, 4, etc. The **<SequenceNumber>** is also used to indicate the first question that should be presented to the end user. **<SequenceNumber>** is unique per question in the transaction.

**<QuestionLevel>** The <QuestionLevel> is an optional element to indicate grouping and dependency relationships among questions. The format is n.n.n...n where n >= 1 that can include as many levels as required. The <QuestionLevel> does not imply or take into account the conditional logic to determine the next question based on the answer provided.

The following example shows possible values for this element:

**1** Previously tried and failed for treatment of this diagnosis: \_\_\_\_\_

**1.1** Start Date: \_\_\_\_\_

**1.2** End Date: \_\_\_\_\_

**2** Previously tried and failed for treatment of this diagnosis: \_\_\_\_\_

**2.1** Start Date: \_\_\_\_\_

**2.2** End Date: \_\_\_\_\_

**3** Is the patient currently treated with the requested medication: (Y/N?)

**3.1** If Yes, Start Date: \_\_\_\_\_

Groupings can be used to display related questions at once. In the above example:

- Questions 1, 1.1 and 1.2 are the same group.
- Questions 2, 2.1 and 2.2 are the same group.
- Questions 3 and 3.1 are the same group.

Dependency relationships can be used to establish dependencies between parent and child questions. In the above example:

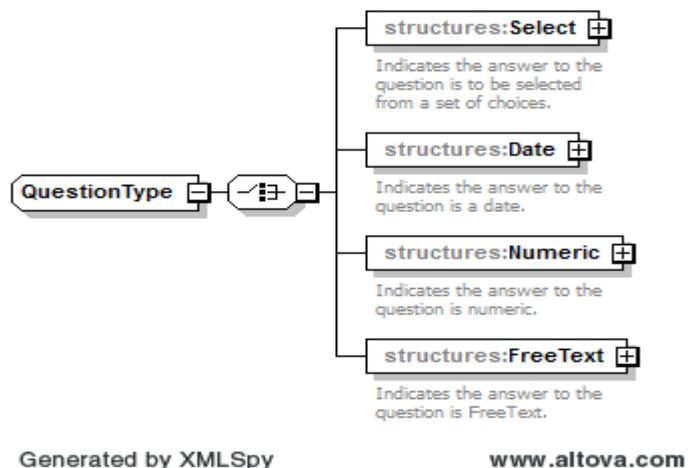
- Questions 1.1 and 1.2 depend on question 1.
- Questions 2.1 and 2.2 depend on question 2.
- Question 3.1 depends on question 3.

**<QuestionText>** This is the question text to be displayed to the end user. **Important:** Questions that require more than one response (for example: "answer yes/no and provide a reason") must be sent as separate questions. Compound questions must be separated into individual questions.

**<CodedReference>** A coded reference to an industry-defined concept is an optional means for a payer to identify needed information, in a way that enables the prescribing system to retrieve the information systematically from the patient's electronic medical record. See section "[Coded Reference Usage](#)" for further usage detail.

**<DefaultNextQuestionID>** Identifies the question the end user should answer next when it is not dependent on the answer to the question. Required when the <QuestionType> is date or free text or when the <QuestionType> is <Select> or <Numeric> and the <NextQuestionID> for the answer choices or numeric conditions are not provided. The value sent is the <QuestionID> of the next question or "END" if there are no more questions that require an answer.

**<QuestionType>** This element indicates the type of the question and defines its characteristics. The information is used by the prescribing system vendor in determining how to present the question to the end user and obtain answers. There are four question types:



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**Figure 75 QuestionType**

Select	This type is used to provide the user with pre-defined answer choices, for multiple choice and true/false questions. Note true/false is a type of multiple choice.
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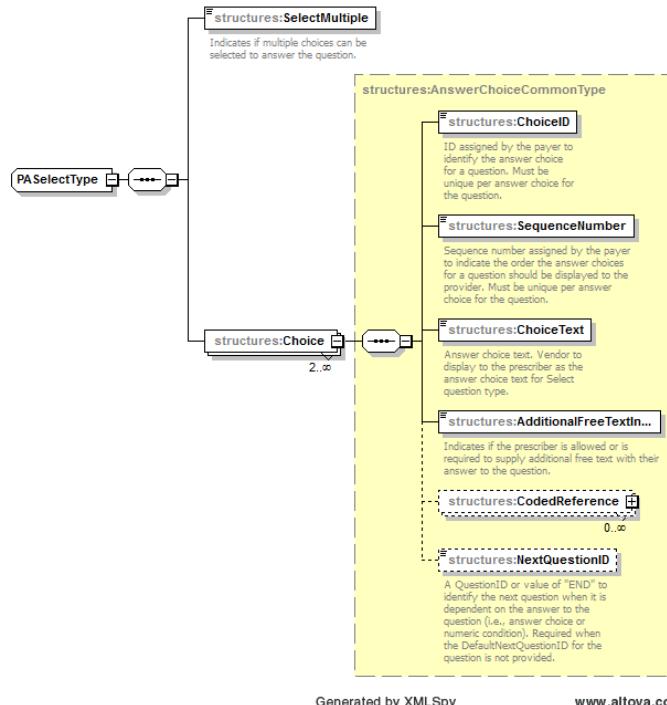
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Date	This type is used to elicit a date or date/time combination from the end user.
Numeric	This question type requests a numeric answer.
FreeText	This is an open-ended question that accepts a free text answer.

The sections below detail each question type.

**<Select>** This question type is used whenever the payer provides the user with pre-defined answer choices. Elements in the composite enable it to support multiple choice, true/false questions with single or multiple selections allowed. Elements in the composite are described below.



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**Figure 76** QuestionType Choice Detail

**<SelectMultiple>** This is a Boolean element that indicates whether the user may select multiple answers to the question (as in a “select all that apply” question), or whether they are limited to a single selection (for example, to reflect a “choose the best answer” question). The value Y (Yes) indicates that multiple selections are allowed, and N (No) indicates that only one selection is allowed.

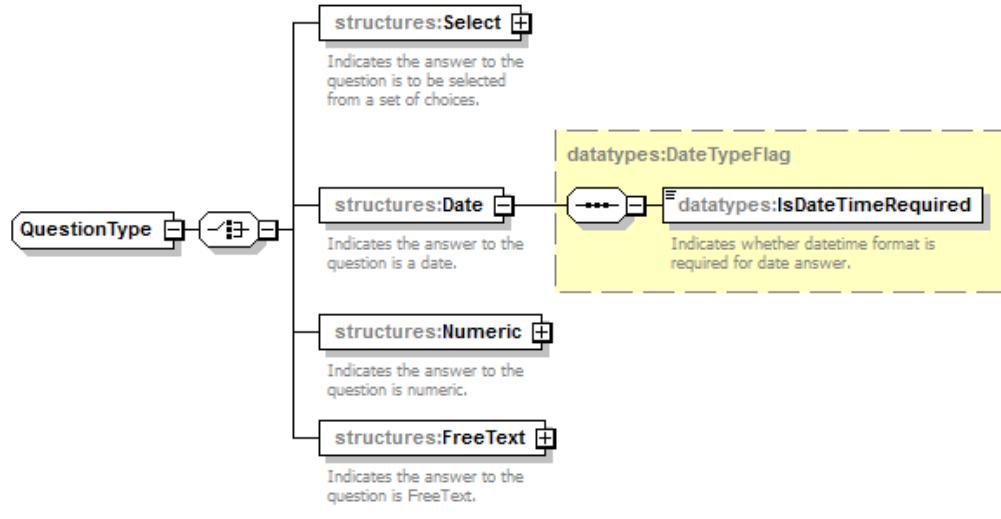
**<Choice>** This sub-composite repeats once for each answer choice provided for the question. Its elements are described below:

- **<ChoiceID>** This is a systemUsable pointer to an answer choice, and is not intended to be displayed to the end user. **<ChoiceID>** is unique per answer choice for the question.

- **<SequenceNumber>** Provides a sequence number to indicate the order answer choices should be displayed to the end user. <SequenceNumber> is unique per answer choice for the question.
- **<ChoiceText>** This field provides the text to be presented to the end user for this choice.
- **<AdditionalFreeTextIndicator>** The Select question type enables the payer to indicate if free text in addition to the answer choice is mandatory, optional or not allowed. For example, the payer may set the <AdditionalFreeTextIndicator> to M (Mandatory) on a choice that has the value “Other-please describe” – requiring the responder to further clarify their choice.
  - There are three values of <AdditionalFreeTextIndicator>:
    - M: Mandatory, the responder is further required to provide clarification
    - O: Optional, where the provider may include additional text but is not required to, and
    - NA: Not used, responder is not able to add any additional text when responding
- **<NextQuestionID>** Identifies the question the end user should answer next if it is dependent on the answer and this answer choice is selected. Required if the <DefaultNextQuestionID> for the question is not provided. The value sent is the <QuestionID> of the next question or “END” if there are no more questions that require an answer.

**<Date>** This type is used to elicit a date or date/time combination from the end user. This question definition consists of a single Boolean element,

**<IsDateTimeRequired>** which indicates whether the responder is expected to respond with a simple date or with a date and time combination. The value Y (True) indicates that the time portion is required, and N (False) indicates that the answer may contain the date (year, month, day).



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[www.altova.com](http://www.altova.com)**Figure 77** QuestionType Date

**<Numeric>** This question type requests a numeric answer. In addition, the `<Numeric>` question type composite contains elements that enable the payer to identify different next questions based on the responder's answer. The structure of the `<Numeric>` question composite is illustrated and described below.

**<IsNumeric>** This element is to be populated with a value of "Y" to indicate the answer to the question is numeric. A value of "N" should not be used. Use other question type if not numeric. This mandatory element is included to ensure the `<Numeric>` element cannot be sent empty.

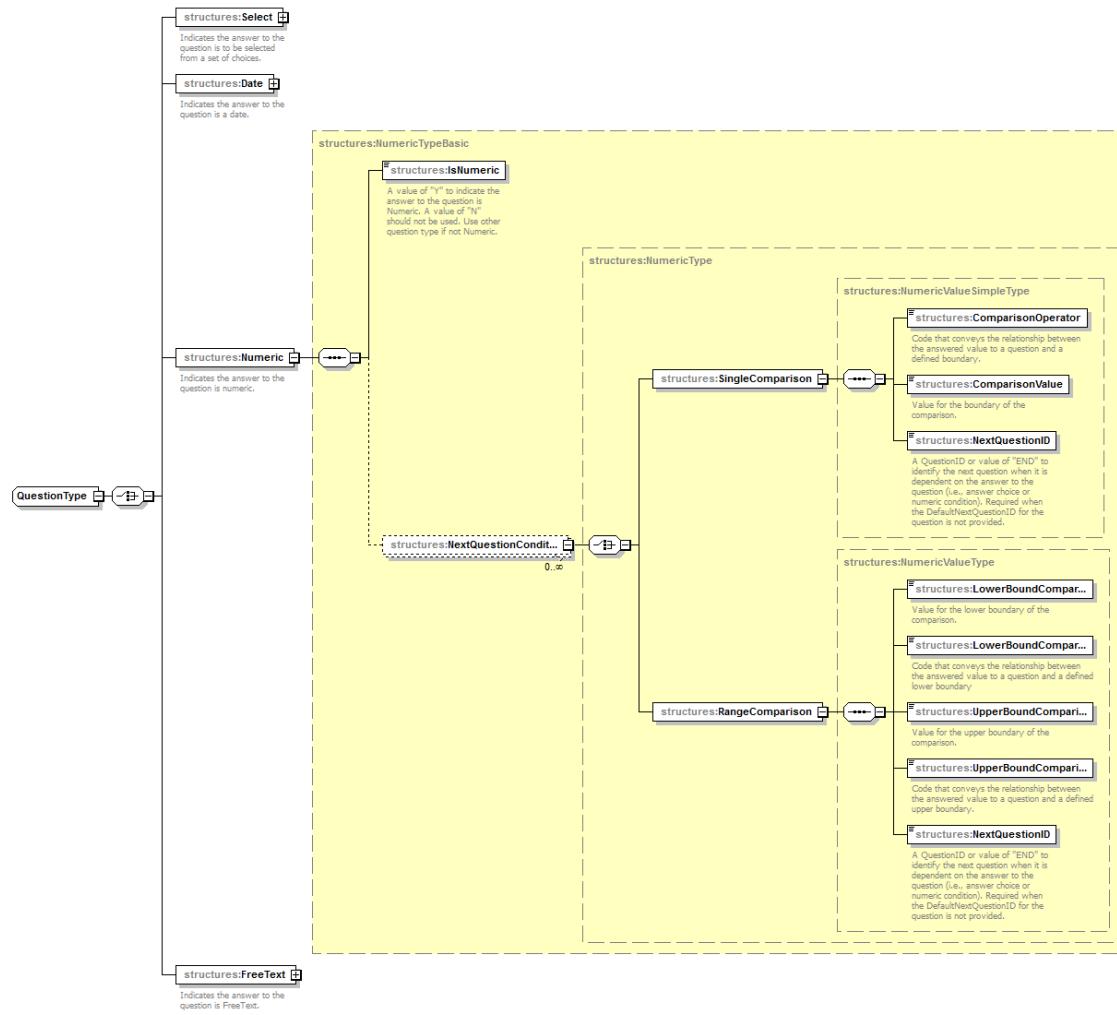


Figure 78 QuestionType Numeric

**<NextQuestionCondition>** This segment contains information that enables the payer to identify the appropriate next questions based on the responder's answer. For example, the question may be defined so that an answer value less than 5 directs the responder to Question #3, whereas an answer of 5 or more is followed by Question #4.

Two different methods for evaluating the responder's answer are provided, each supported by its own subcomposite within <NextQuestionCondition> - <SingleComparison> and <RangeComparison>.

- **<SingleComparison>** This composite enables the responder's answer to be compared to a single value, using a variety of comparison operators.
  - **<ComparisonOperator>** is the comparison to be performed. Supported values are
    - “LT” (less than),
    - “GT” (greater than),
    - “EQ” (equal to),
    - “NE” (not equal to),
    - “LE” (less than or equal to), and
    - “GE” (greater than or equal to).
  - **<ComparisonValue>** indicates the value to which the responder's answer is compared and negative values are allowed.
  - **<NextQuestionID>** Identifies the question the end user should answer next if it is dependent on the answer and it meets this condition. Required if the <DefaultNextQuestionID> for the question is not provided. The value sent is the <QuestionID> of the next question or “END” if there are no more questions that require an answer. For example, given the case below, the appropriate next question is #4:

Respondent's answer is 5.

1st <NextQuestionCondition><SingleComparison> (if answer value is less than 5, the next question is #3)

<ComparisonOperator>	LT (less than)
<ComparisonValue>	5
<NextQuestionID>	3

2nd <NextQuestionCondition><SingleComparison> (if answer value is greater than or equal to 5, the

next question is #4)

<ComparisonOperator>	GE (greater than or equal to)
<ComparisonValue>	5
<NextQuestionID>	4

*Combined: Respondent's answer of 5 is >= 5. Because the 2<sup>nd</sup> condition is met, the next question to present is #4.*

- <RangeComparison> This composite enables the answer to be compared to a value range.
  - <LowerBoundComparisonValue> indicates the range starting value to which the responder's answer is compared and negative values are allowed.
  - <LowerBoundComparisonOperator> gives the comparison to be performed with respect to the range start. Supported values are
    - “LT” (less than),
    - “GT” (greater than),
    - “LE” (less than or equal to), and
    - “GE” (greater than or equal to).
  - <UpperBoundComparisonValue> indicates the range ending value to which the responder's answer is compared and negative values are allowed.
  - <UpperBoundComparisonOperator> gives the comparison to be performed with respect to the range end. Supported values are
    - “LT” (less than),
    - “GT” (greater than),
    - “LE” (less than or equal to), and
    - “GE” (greater than or equal to).
  - <NextQuestionID> Identifies the question the end user should answer next if it is dependent on the answer and it meets this condition. Required if the <DefaultNextQuestionID> for the question is not provided. The value sent is the <QuestionID> of the next question or “END” if there are no more questions that require an answer. For example, given the case below, the appropriate next question is #10:

Respondent's answer is 150.

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1st <NextQuestionCondition><RangeComparison> (if answer value is greater than 120 and less than 160, the next question is #10)

<LowerBoundComparisonOperator>:	GT (greater than)
<LowerBoundComparisonValue>	120
<UpperBoundComparisonOperator>	LT (less than)
<UpperBoundComparisonValue>	160
<NextQuestionID>	10

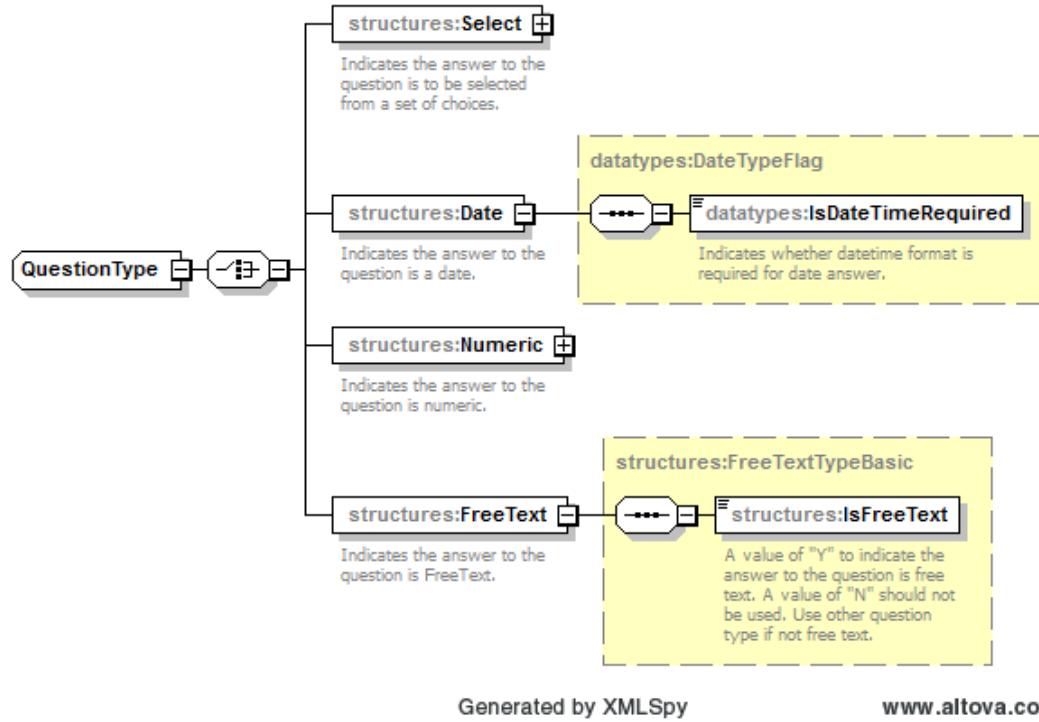
2nd <NextQuestionCondition><RangeComparison> (if answer value is less than or equal to 120 or greater than or equal to 160, the next question is #14)

<LowerBoundComparisonOperator>:	LE (less than or equal to)
<LowerBoundComparisonValue>	120
<UpperBoundComparisonOperator>	GE (greater than or equal to)
<UpperBoundComparisonValue>	160
<NextQuestionID>	14

*Combined: Respondent's answer of 150 is > 120 and < 160. Because the 1st condition is met, the next question to present is #10*

<FreeText> This is an open-ended question that accepts a free text answer.

<IsFreeText> This element is to be populated with a value of “Y” to indicate the answer to the question is free text. A value of “N” should not be used. Use other question type if not free text. This mandatory element is included to ensure the <FreeText> element cannot be sent empty.



**Figure 79** QuestionType FreeText

### 9.6.2 CODED REFERENCE USAGE

**<CodedReference>** - A coded reference to an industry-defined concept is an optional means for a payer to identify needed information, in a way that enables the prescribing system to retrieve the information systematically from the patient's electronic medical record. For example, an industry-defined code for the concept "indication" may be included with a question that asks for the reason a medication has been prescribed.

When a payer sends a coded reference for a question, it includes the coded reference **in addition to** the question/answer details that can be used to display question/answers to the end user to answer. As such, a payer's question set could have:

- No questions with a coded reference
- A mix of questions – some with a coded reference; some without
- All questions with associated coded references.

If the prescribing system has implemented coded reference usage in the PA question set, it can pull information from the patient's electronic medical record and return that data rather than having the end user to answer the question manually. If vendor doesn't support coded reference, they will display the human-readable question for the end user to answer.

Prescribers should have the ability to review, and edit, their answers to all questions prior to submission of the request (PAREquest). This holds true whether the prescriber has manually answered all questions or coded references have been used to populate the answers.

The PA transactions enable multiple coded references to industry concepts to be used together to further specify needed information. An example is the combination of a CDA template representing a laboratory result (2.16.840.1.113883.10.20.24.3.40) and a LOINC indicating a particular laboratory test for which the information is desired (e.g., 57021-8 blood panel).

When coded references are used, the <Qualifier>, <Description>, and <Code> elements are all mandatory:

<Code>	This element conveys a code representing the desired information.
<Qualifier>	This element identifies the code system or vocabulary from which the referenced code is taken. Examples include the LOINC code list and HL7 CCDA Template set.
<CodeSystemVersion>	This element is used to convey the version of the stated code system from which the referenced code is taken.
<Description>	This field must contain source code system's description for the code conveyed in the <Code> element.

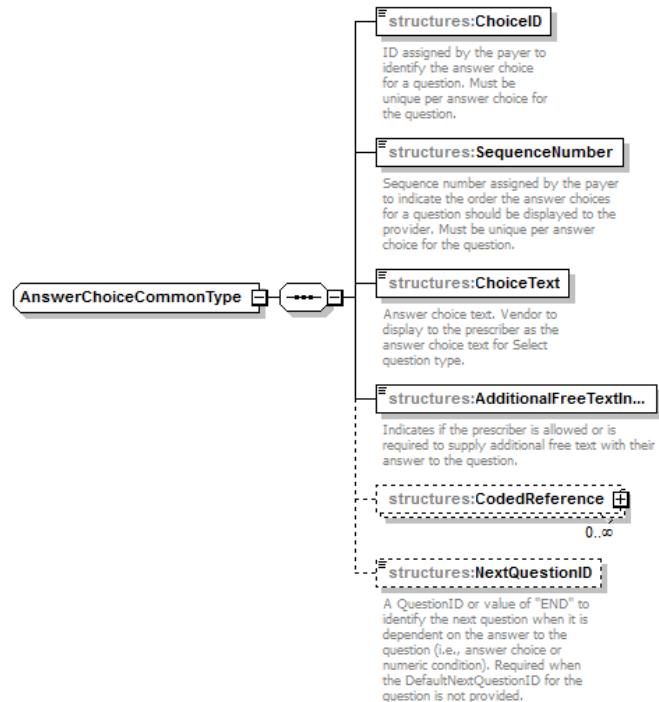
The electronic prior authorization transactions enable payers to provide coded references

- at the **question-level** for all prior authorization question types (numeric, free text, select, date)
- at the choice-level for the select question type (described below)

#### 9.6.2.1 **Coded References Associated with Select Question Choices**

The electronic prior authorization transactions enable payers to provide coded references at the answer **choice-level** for the select question type. This feature enables a payer to construct a question that

- re-states the overall **question** in the form of a coded reference (by including a coded reference that represents “diagnosis”, for example)
- also provides **coded answer choices** to that question (for example representing “asthma”, “diabetes”, etc.).



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**Figure 80** AnswerChoice

When the prescribing system provides its answer to a select question for which coded choices were supplied, it places the selected coded reference in the CodedReferenceAnswer element in the PACompletedAnswerChoice composite. Providing answers to question sets is described further below.

## **9.7 ANSWER USAGE IN COMPLETED QUESTION SET**

For information on supporting the question sets, see section “[Key Question Set Elements](#)”.

<Answer> is sent in the PARequest and PAAppealRequest when responding with a completed Question Set. <Answer> must be sent for any question answered by the prescriber or answered from the patient’s electronic medical record using the coded reference. <Answer> can repeat when there are multiple answers for one question. <Answer> must not be sent for a question not answered.

<Answer> requires either <PrescriberProvidedAnswer> or <CodedReferenceAnswer>. If <CodedReferenceAnswer> is used, the <AnswerValue> uses the qualities (<CodeSystemVersion>, <Qualifier>, <Code>, <Description>) that were defined in the question set. So if the question set supports LOINC, and the prescribing system supports coded reference usage, the <AnswerValue> would be a LOINC code.

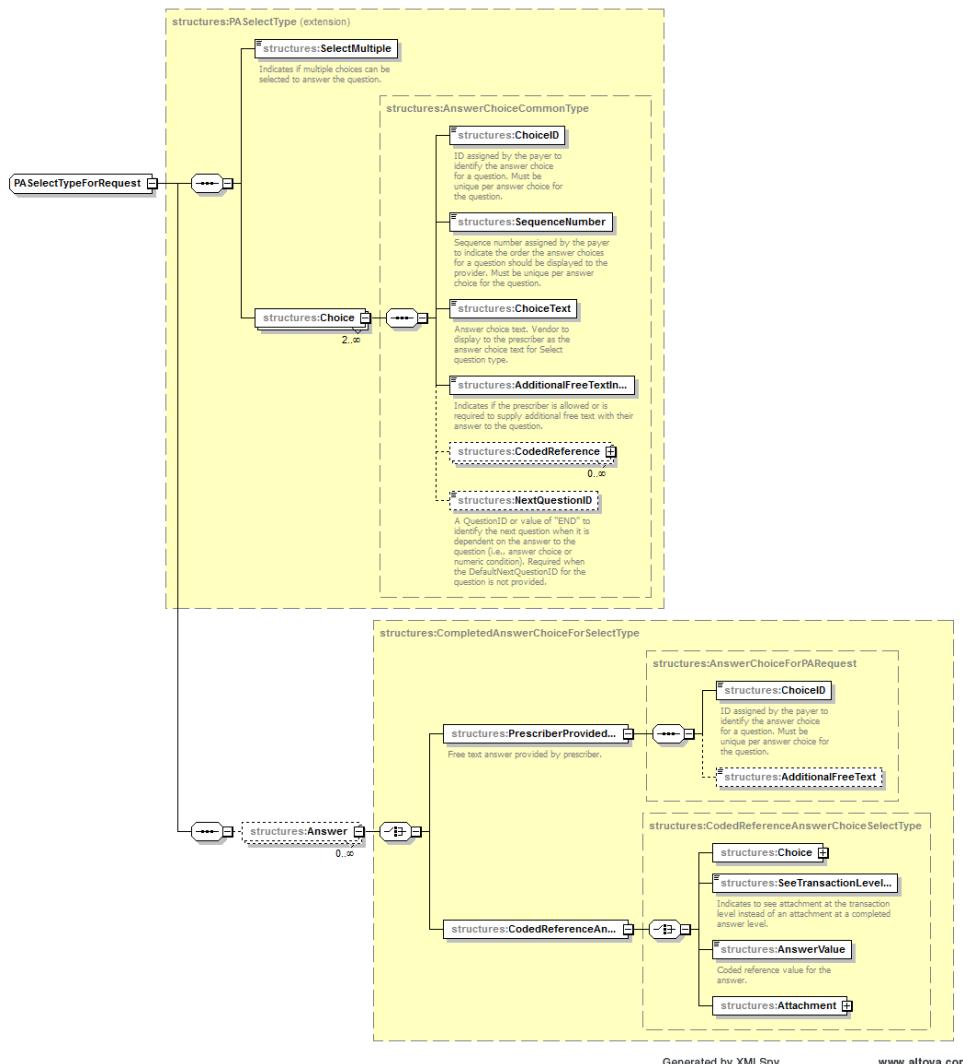
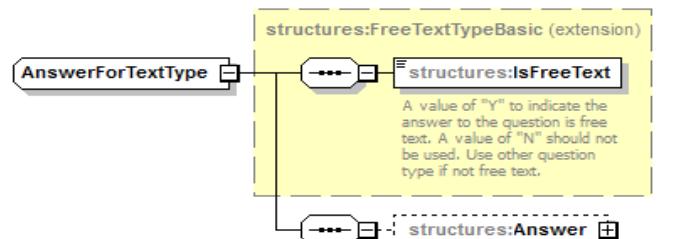


Figure 81 Answer

**<PrescriberProvidedAnswer>** The answer selected/supplied by the provider when the question was presented to them to answer versus a question systemically answered based on a coded reference (see below for CodedReferenceAnswer). The elements included in <PrescriberProvidedAnswer> vary depending on the question type.

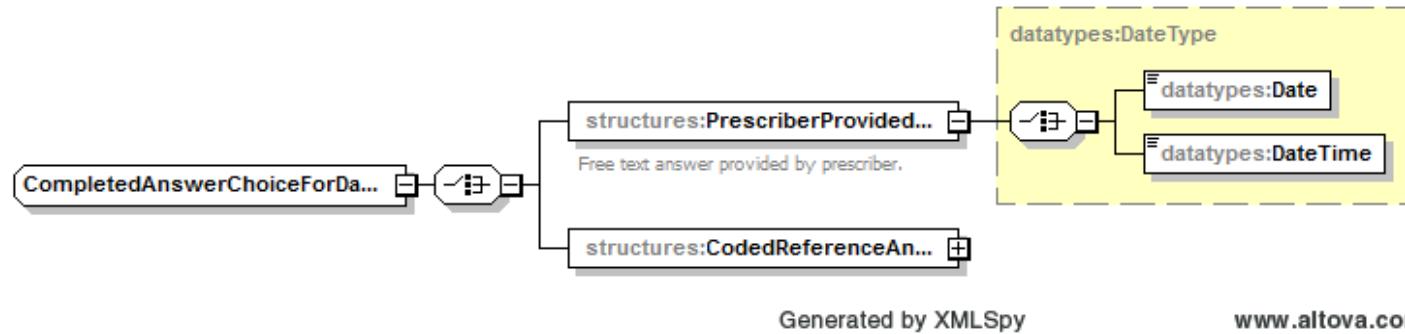
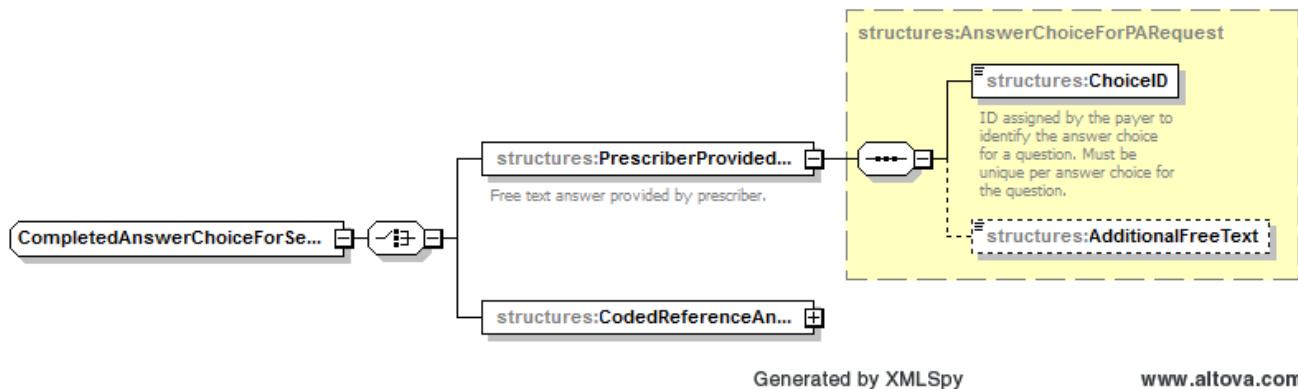
- For the <Numeric> and <FreeText> question types, only the <PrescriberProvidedAnswer> element is included and must be populated with the answer text supplied by the provider.
- For the <Date> question type, the <PrescriberProvidedAnswer> includes subelements <Date> and <DateTime>. The answer supplied by the provider must be sent using the subelements based on the format of the date. The answer must be sent identifying if the answer text is a simple date or a date/time.
- For the **Select** question type, the PrescriberProvidedAnswer includes sub-elements <ChoiceID> and <AdditionalFreeText>.
  - <ChoiceID> The <ChoiceID> of the answer choice selected by the provider.
  - <AdditionalFreeText> The free text supplied by the provider in addition to the answer choice selected. The <AdditionalFreeTextIndicator> in the Question Set indicates if free text in addition to the answer choice is mandatory, optional or not available.



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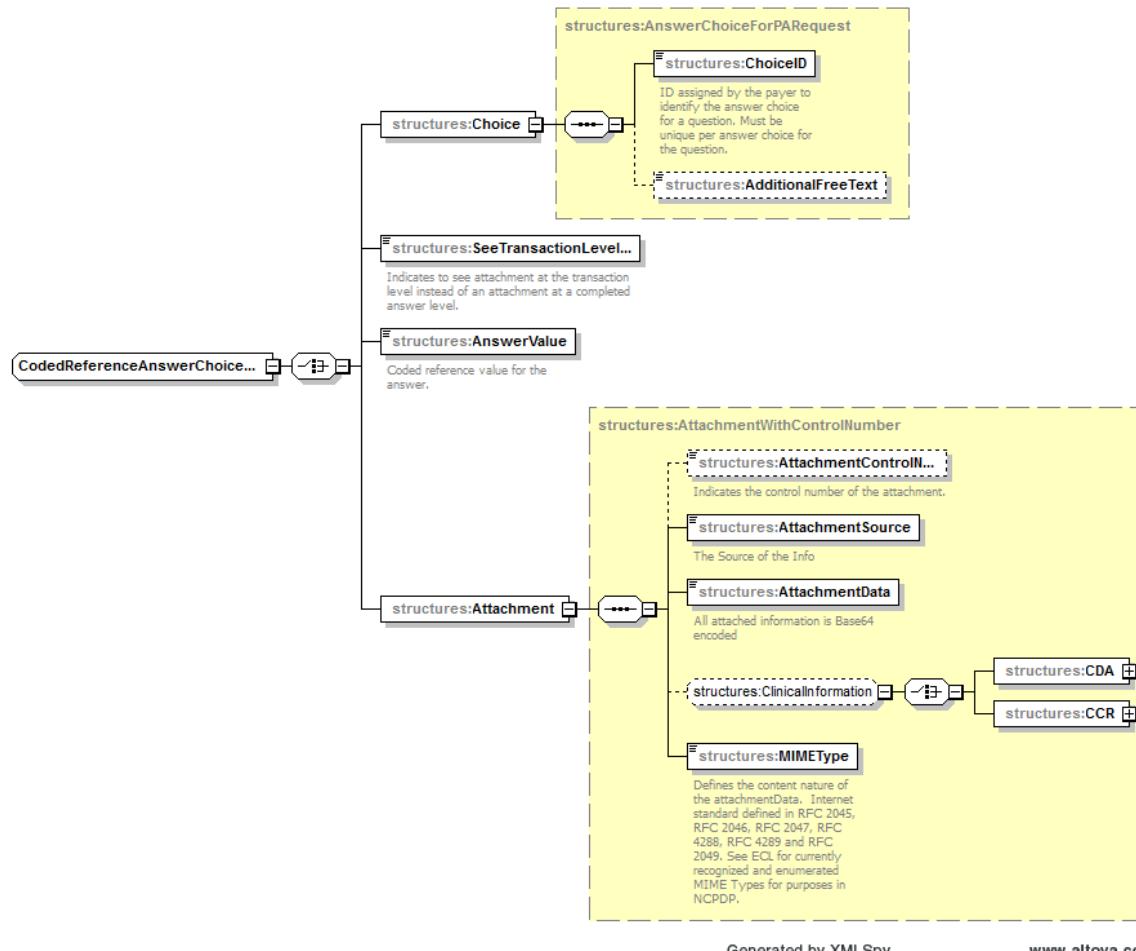
**Figure 82 Answer Free Text**

**Figure 83** Answer Date**Figure 84** PrescriberProvidedAnswer Select

**<CodedReferenceAnswer>** The answer systematically retrieved by the prescribing system from the patient's electronic medical record. CodedReferenceAnswer for all question types include the following three sub-elements.

- **<SeeTransactionLevelAttachmentControlNumber>** The control number of the transaction level attachment that provides the information requested by the coded reference. For example, a CCDA template.

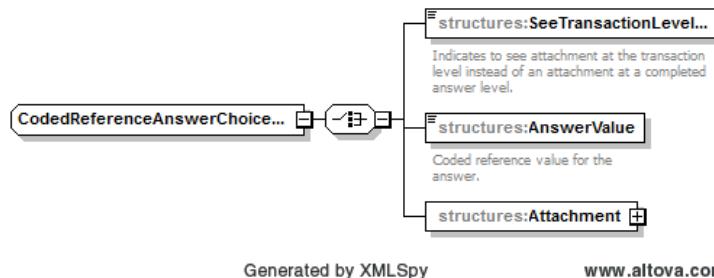
- **<AnswerValue>** The value requested by the coded reference. For example, the patient's weight.
- **<Attachment>** The attachment that provides the information requested by the coded reference. For example, a CCDA template.



**Figure 85 Answer CodedReference Structure**

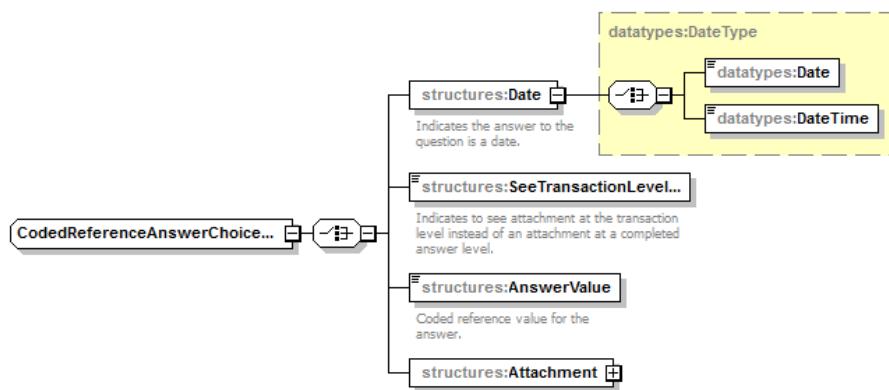
**These additional elements are included depending on the question type.**

- For the <FreeText> question type, there are no additional elements.
- For the <Date> question type, a <Date> element includes sub-elements <Date> and <DateTime>. If a date answer is sent, it must be identified as a simple date or a date/time.
- For the <Numeric> question type, <NumericAnswer> element is to be used when the answer is a numeric value.
- For the <Select> question type, a <Choice> element includes sub-elements <ChoiceID> and <AdditionalFreeText>.
  - <ChoiceID> The <ChoiceID> of the answer choice selected by the provider.
  - <AdditionalFreeText> The free text supplied by the provider in addition to the answer choice selected. The <AdditionalFreeTextIndicator> in the Question Set indicates if free text in addition to the answer choice is mandatory, optional or not available.



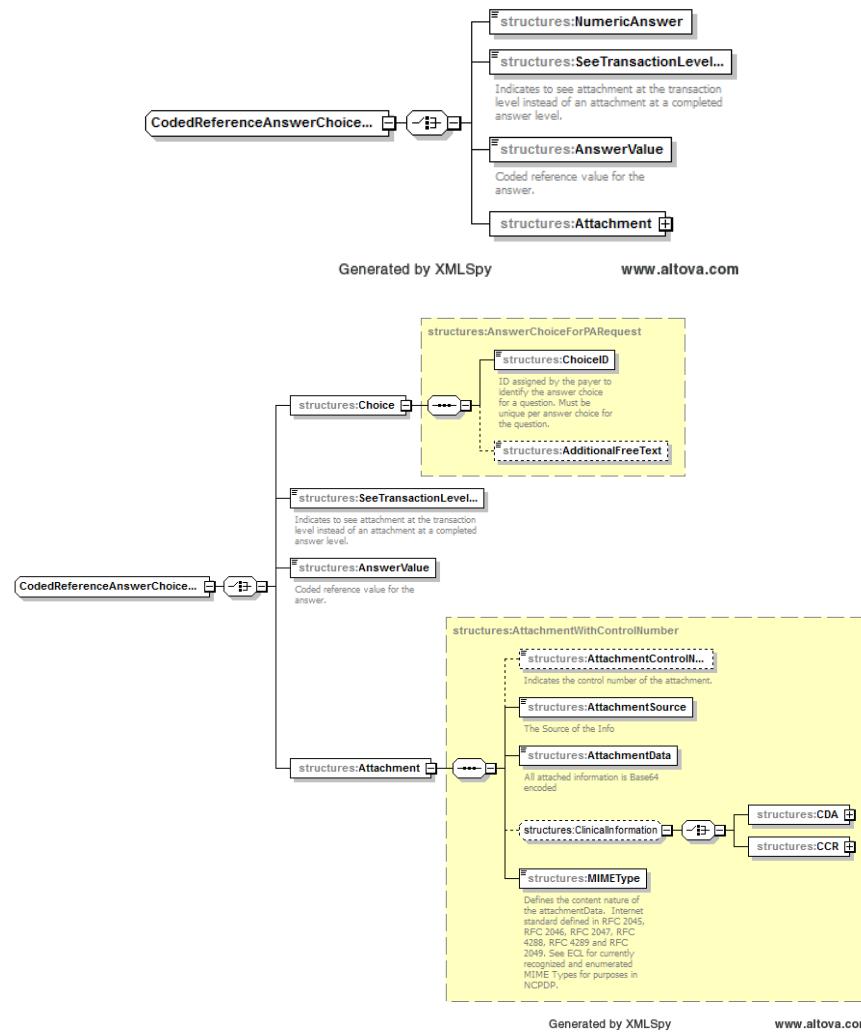
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**Figure 86** Answer CodedReference Structure Additional Elements Depending on Question Type

## **9.8 RECEIVER IS NOT THE PA PROCESSOR**

In some cases, the receiving payer may not be the prior authorization processor for the patient and/or medication identified. For example:

- another entity may process all prior authorizations for a given member, or
- another entity may process prior authorizations for particular medications.

In these instances, the <ReasonCode> must be populated with the values that support the situations.

For example:

- “**CO**” (**The receiver is not the PA processor for this patient**) - This code indicates that the receiver is not the prior authorization processor for any medications for the patient identified in the PARequest.

Or

- “**CP**” (**The receiver is not the PA processor for this patient and medication combination**) - This code indicates that the receiver is not the prior authorization processor for the requested medication, though it does serve as the prior authorization processor for other medications for the identified patient.

If known, the payer should return the <PAProcessor> elements in the response to identify the entity that acts as the prior authorization processor for the requested member and medication:

<PAProcessor> -

- <PAProcessorIdentification> This optional element is the identification number for the prior authorization processor.
- <BusinessName> This mandatory element is the name of the prior authorization processor.
- <Address> This mandatory composite is the address of the prior authorization processor.
- <CommunicationNumbers> This mandatory composite is the prior authorization processor's contact telephone number and optionally the email address or fax.

The PAProcessor element is included in the following message and response statuses:

```
<PAInitiationResponse><ResponseStatus><Closed>
<PAResponse><ResponseStatus><Closed>
<PAResponse><ResponseStatus><Approved>
<PAResponse><ResponseStatus><Denied>
```

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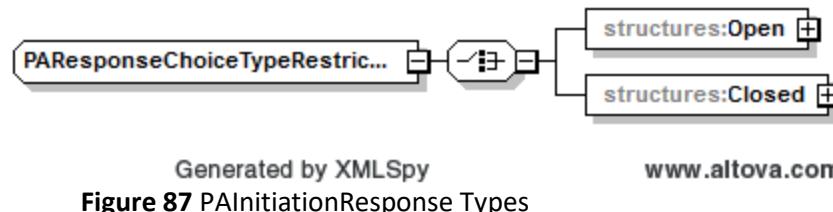
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```
<PAResponse><ResponseStatus><PartiallyDenied>
<PAAppealResponse><ResponseStatus><Closed>
```

## 9.9 PA INITIATION RESPONSE ELEMENTS

<ResponseStatus> in the PAInitiationResponse transaction indicates the state of the initiation request and determines the elements available to be populated in the transaction. Each status is discussed briefly below.



**Figure 87** PAInitiationResponse Types

<**Open**> indicates that the member was identified and the payer is the prior authorization processor for the requested patient and medication. The payer includes a QuestionSet in the PAInitiationResponse when using the **Open** Response Status.

<**Closed**> indicates that the electronic prior authorization process will not continue due to a reason identified by the <**ReasonCode**> contained in the composite.

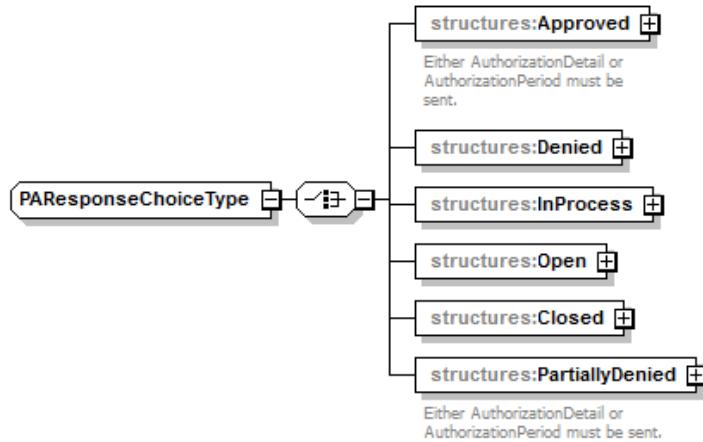
See Section [Receiver Is Not the PA Processor](#) when the receiving payer is not the prior authorization processor for the requested member or medication.

## 9.10 PA RESPONSE ELEMENTS

Contact information may be returned to the end user in the <PAInitiationResponse>. This information should be available to the end user for use in any manual communication throughout the life of this prior authorization. If the <PAInitiationResponse> is not supported (unsolicited), then contact information for manual follow up for the end user may be returned in the < PANote >.

<ResponseStatus> in the PAResponse transaction indicates the state of the prior authorization request and determines the elements available to be populated in the transaction. Each status is discussed briefly below.

Note: Each status composite includes the <PACaseID> element described above.



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**Figure 88** Response Types

**<Approved>** indicates that the prior authorization has been approved by the payer. The elements associated with the approved status are:

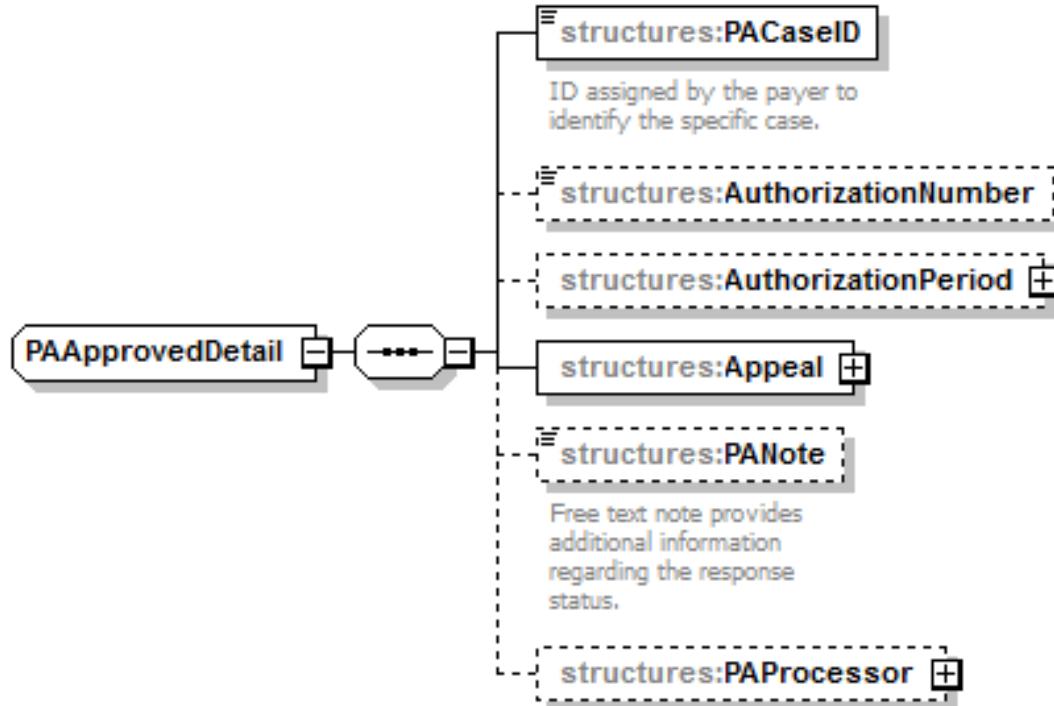
- **<AuthorizationNumber>** - This optional element contains a payer-assigned authorization number.
- **<AuthorizationPeriod>** - This optional composite provides the authorization start and end dates.
- **<Appeal>** - This mandatory composite indicates whether this determination can be further appealed. The **<IsEAppealSupported>** element is mandatory, and the composite also includes an optional **<ExpirationDate>** element indicating the deadline for appealing and a **<PANote>** element for addition information regarding the appeal process.
- **<PANote>** - This optional element is used to provide additional information about the approval.

**<PartiallyDenied>** indicates that the prior authorization has been approved by the payer, but with some limits. These limits may include pharmacy type, quantity, days supply, number of cycles, or refills. The elements associated with the **<PartiallyDenied>** status are:

- **<AuthorizationNumber>** - This optional element contains a payer-assigned authorization number.
- **<AuthorizationDetail>** - This optional composite contains authorization details of the approval granted. Either **<AuthorizationDetail>** or **<AuthorizationPeriod>** must be sent. **<AuthorizationDetail>** may repeat if authorization details are

provided for more than one pharmacy type. All elements in the composite are optional and used if they apply to the case.  
Included elements:

- <PharmacyType> - This element repeats if needed to indicate if only certain pharmacy types are approved to dispense the medication.
- <Quantity> - This indicates the approved quantity of the requested medication.
- <DaysSupply> - This indicates the approved days supply of the requested medication.
- <NumberOfCycles> - This indicates the number of dispensing cycles approved.
- <NumberOfRefills> - This indicates the number of approved refills.
- <PANote> - This element provides additional textual clarifications regarding the authorization details.
- <AuthorizationPeriod> - This optional composite provides the authorization start and end dates. Either <AuthorizationDetail> or <AuthorizationPeriod> must be sent.
- <Appeal> - This mandatory composite indicates whether this determination can be further appealed. The <IsEAppealSupported> element is mandatory, and the composite also includes an optional <ExpirationDate> element indicating the deadline for appealing and a <PANote> element for addition information regarding the appeal process.
- <PANote> - This optional element is used to provide additional information about the approval.



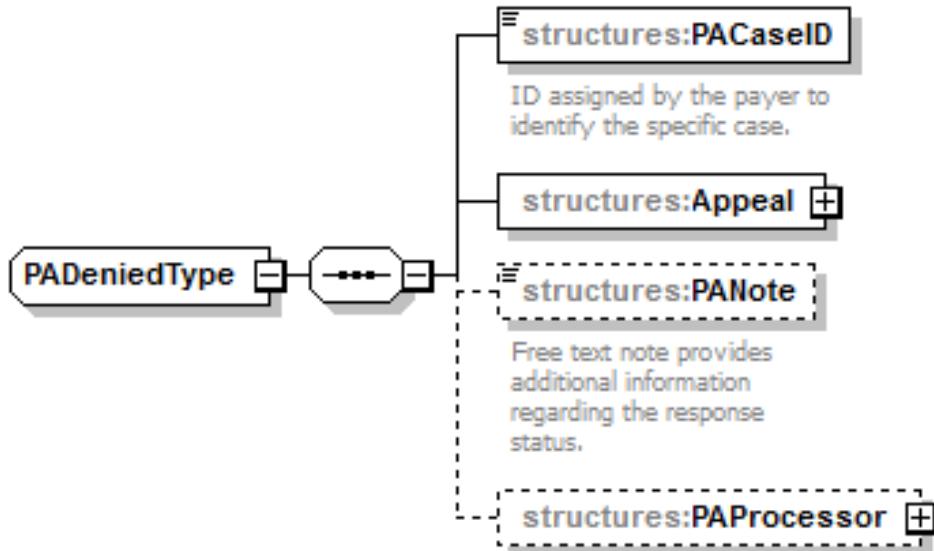
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Figure 89 Approved Response Type

<Denied> indicates that the prior authorization has been denied by the payer. The elements in the <Denied> status are:

- <Appeal> - This mandatory composite indicates whether this determination can be further appealed. The <IsEAppealSupported> element is mandatory, and the composite also includes an optional <ExpirationDate> element indicating the deadline for appealing and a <PANote> element for addition information regarding the appeal process.
- <PANote> - This optional element is used to provide additional information about the denial.

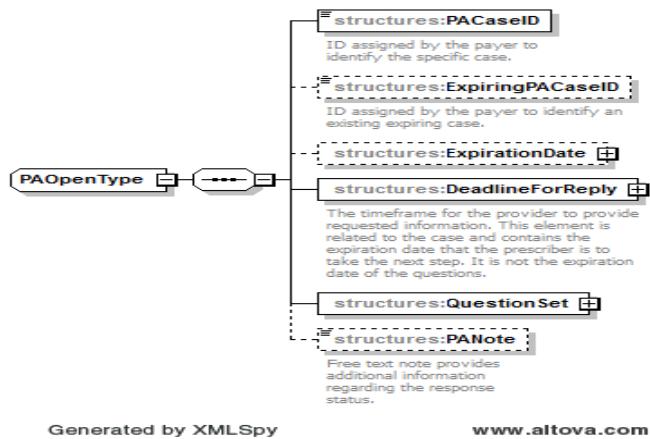


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[www.altova.com](http://www.altova.com)**Figure 90** Denied Response Type

<Open> indicates that the prior authorization is being processed by the payer. The elements in the <Open> status are:

- <**MoreInformationRequired**> - This mandatory composite indicates that the payer needs additional information from the prescriber in order to complete processing of the prior authorization request. The composite provides a <QuestionSet> for completion by the prescriber for additional information. More information may be required when a prior authorization is pended or a Deferred situation occurs.
  - A Deferred situation may occur when regulatory requirements prevent the denying of the prior authorization. An appeal must be filed to either approve this prior authorization or the prescriber would need to prescribe a different medication.
- <**PANote**> - This optional element is used to provide additional information about the <Open> status.

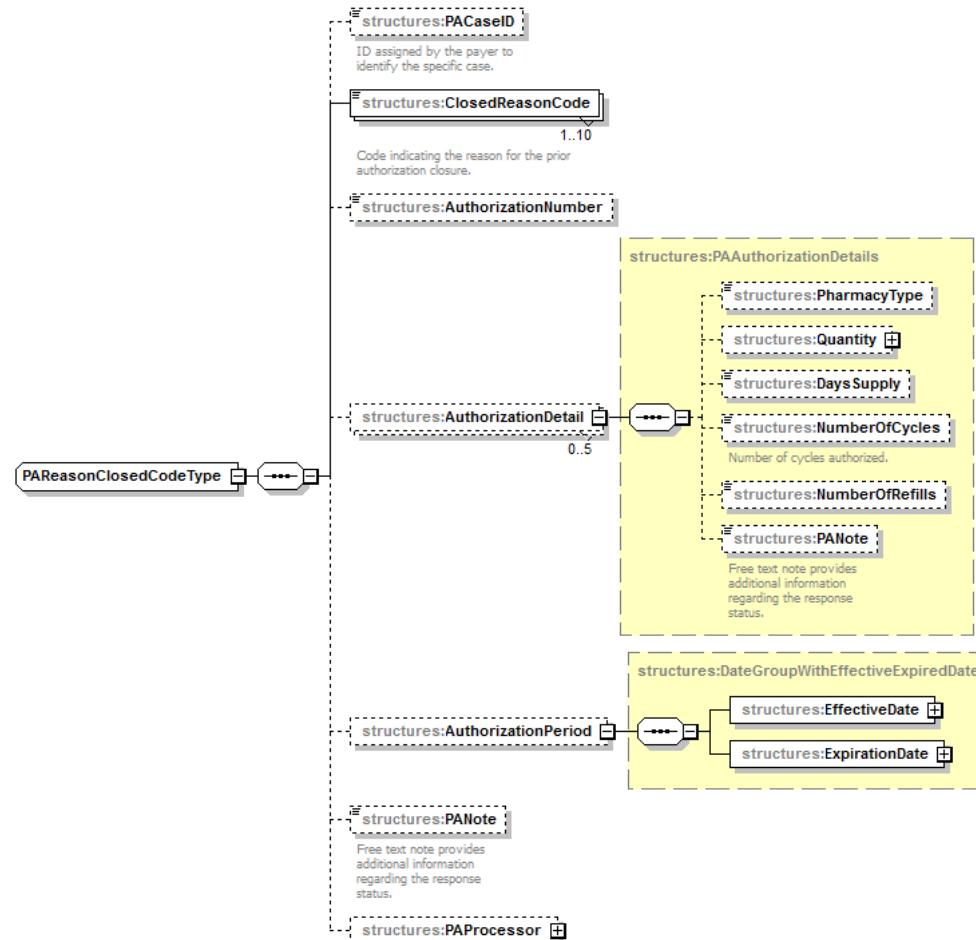
**Figure 91** Open Response Type

<Closed> indicates that the prior authorization request has been closed by the payer. The elements in the <Closed> status are:

- <**ClosedReasonCode**> - This element indicates the closure reason.
- <**AuthorizationNumber**> - This optional element holds a payer-assigned authorization number. This element is only used if there is already a current prior authorization for the patient and medication - the <ClosedReasonCode> is “4” (Prior Authorization duplicate/approved).
- <**AuthorizationDetail**> - This optional composite contains authorization details of the approval granted. Either <AuthorizationDetail> or <AuthorizationPeriod> must be sent. <AuthorizationDetail> may repeat if authorization details are provided for more than one pharmacy type. This element is only used if there already is a current prior authorization for the patient and medication - the <ClosedReasonCode> is “4” (Prior Authorization duplicate/approved). All elements in the composite are optional and used if they apply to the case. Included elements:
  - <**PharmacyType**> - This element repeats if needed to indicate if only certain pharmacy types are approved to dispense the medication.
  - <**Quantity**> - This indicates the approved quantity of the requested medication.
  - <**DaysSupply**> - This indicates the approved days supply of the requested medication.
  - <**NumberOfCycles**> - This indicates the number of dispensing cycles approved.
  - <**NumberOfRefills**> - This indicates the number of approved refills.
  - <**PANote**> - This element provides additional textual clarifications.

- **<AuthorizationPeriod>** - This optional composite provides the authorization start and end dates. Either **<AuthorizationDetail>** or **<AuthorizationPeriod>** must be sent. This element is only used if there is already a current prior authorization for the patient and medication - the **<ClosedReasonCode>** is “4” (Prior Authorization duplicate/approved).
- **<PANote>** - This optional element is used to provide additional information about the closed status.

See Section ***Receiver Is Not the PA Processor*** when the receiving payer is not the prior authorization processor for the requested member or medication.



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Figure 92 Closed Response Type

## 9.11 DUPLICATE PROCESSING

At this time specific duplicate processing has not been incorporated into this guide for prior authorization functions. It was determined that

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industry expertise would bring forward recommendations.

## **9.12 APPEAL TRANSACTION ELEMENTS**

The electronic prior authorization process enables the prescriber to appeal a prior authorization determination using the PAAppealRequest transaction. Both denied and approved PA requests may be appealed, according to requirements by the payer or regulatory body, for example. Prior authorizations might be appealed if the request was denied entirely or if it was approved with limitations that the prescriber wishes to remove.

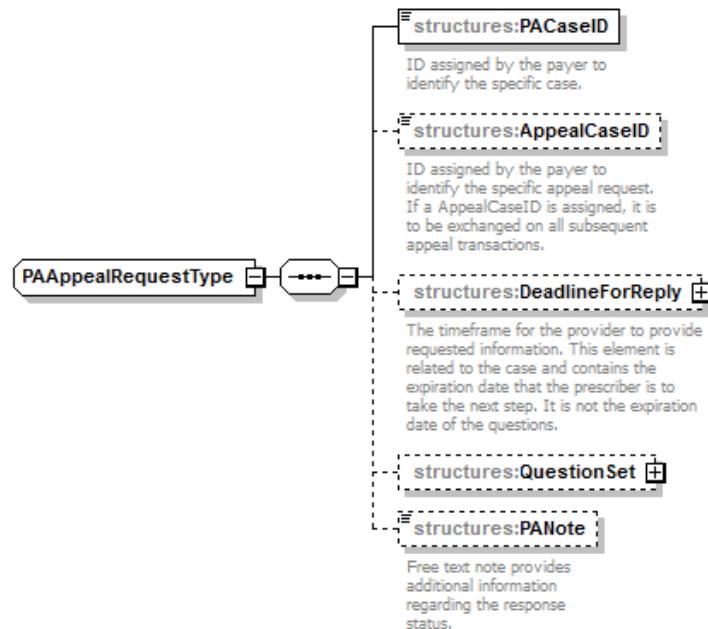
Contact information may be returned to the end user in the <PAInitiationResponse>. This information should be available to the end user for use in any manual communication throughout the life of this prior authorization. If the <PAInitiationResponse> is not supported (unsolicited), then contact information for manual follow up for the end user may be returned in the <PANote>.

### **9.12.1 KEY APPEAL TRANSACTION ELEMENTS**

<PACaseID> is the same PACaseID assigned by the payer when processing the PA request that the prescriber now wishes to appeal.

<AppealCaseID> The AppealCaseID is assigned by the payer and conveyed to the prescriber in the PAAppealResponse transaction. This element is also available in the PAAppealRequest transaction, but is only populated by the prescriber if a PAAppealResponse has previously been received from the payer (for example, if the prescriber is submitting a second PAAppealRequest transaction to answer follow-up questions from the payer).

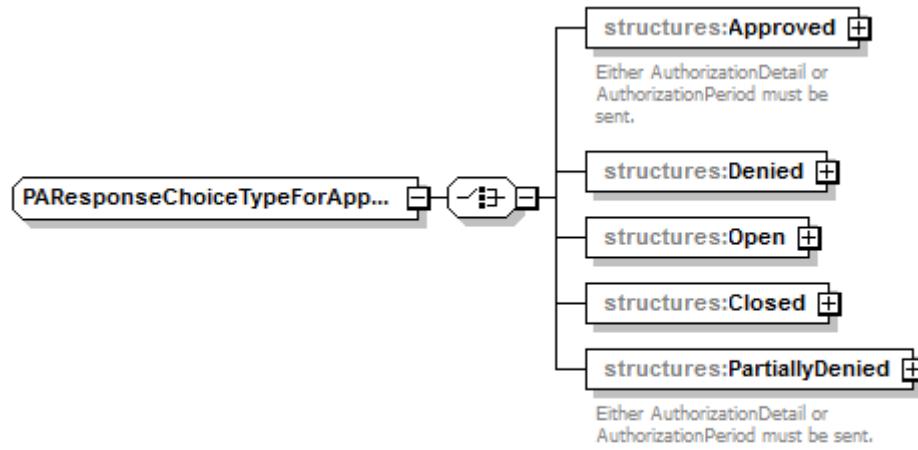
See discussion of <DeadlineForReply> and <QuestionSet> above in section “[Key Question Set Elements](#)”.



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[www.altova.com](http://www.altova.com)**Figure 93** PAAppeal Key Elements

<ResponseStatus> in the PAAppealResponse transaction indicates the state of the appeal request and determines the elements available to be populated in the transaction. Each status is discussed briefly below. Note: Each status composite includes the <PACaseID> and <AppealCaseID> elements described above.



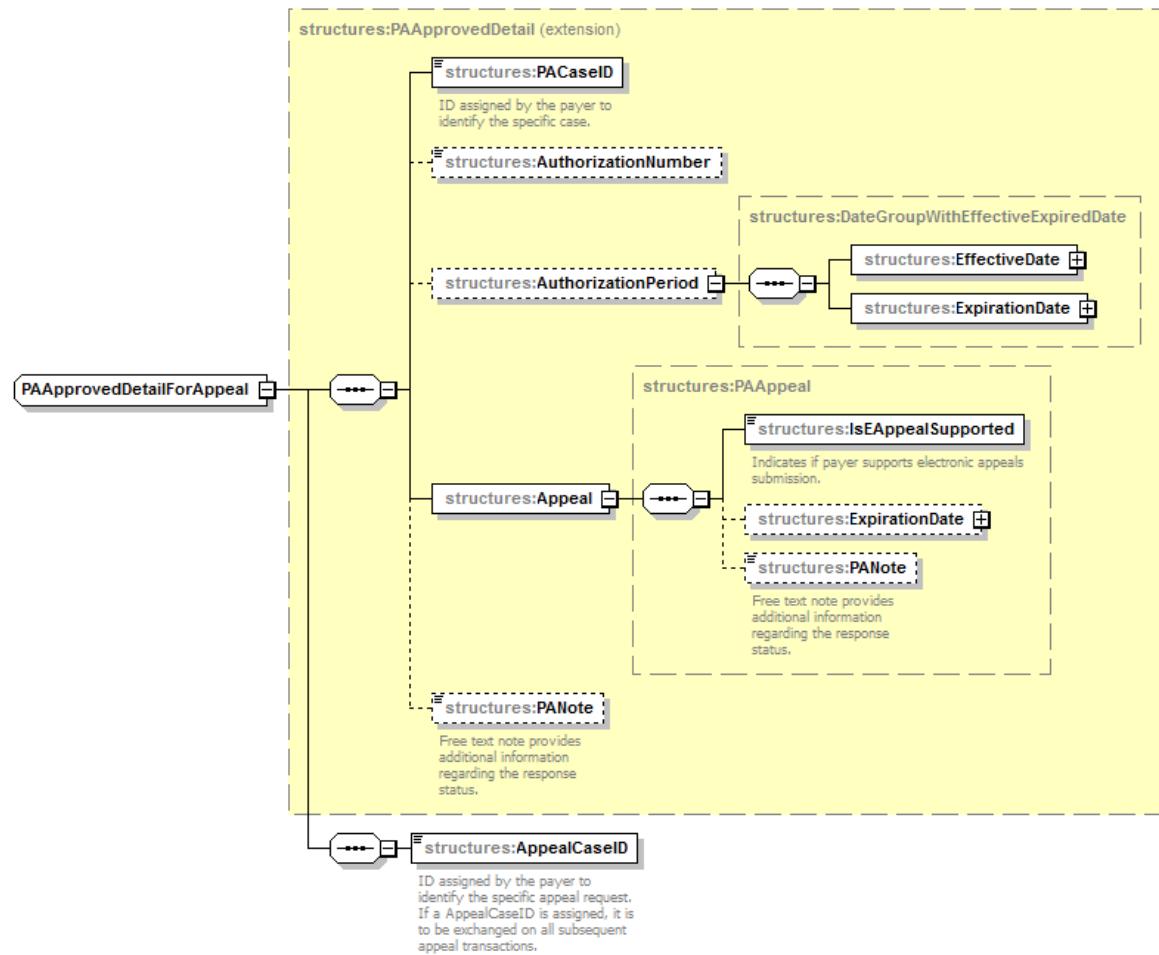
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[www.altova.com](http://www.altova.com)**Figure 94** PAAppeal Response Types

<Approved> indicates that the appeal has been approved by the payer. The elements in the <Approved> status are:

- <AuthorizationNumber> - This optional element holds a payer-assigned authorization number.
- <AuthorizationDetail> - This optional composite contains authorization details of the approval granted. Either <AuthorizationDetail> or <AuthorizationPeriod> must be sent. <AuthorizationDetail> may repeat if authorization details are provided for more than one pharmacy type. All elements in the composite are optional and used if they apply to the case.  
Included elements:
  - <PharmacyType> - This element repeats to indicate if only certain pharmacy types are approved to dispense the medication.
  - <Quantity> - This indicates the approved quantity of the requested medication.
  - <DaysSupply> - This indicates the approved days supply of the requested medication.
  - <NumberOfCycles> - This indicates the number of dispensing cycles approved.
  - <NumberOfRefills> - This indicates the number of approved refills.
  - <PANote> - This element provides additional textual clarifications regarding the authorization details.
- <AuthorizationPeriod> - This optional composite provides the authorization start and end dates. Either <AuthorizationDetail> or <AuthorizationPeriod> must be sent.

- **<Appeal>** - This mandatory composite indicates whether this determination can be further appealed. The **<IsEAppealSupported>** element is mandatory, and the composite also includes an optional **<ExpirationDate>** element indicating the deadline for appealing and a **<PANote>** element for addition information regarding the appeal process.
- **<PANote>** - This optional element is used to provide additional information about the approval.

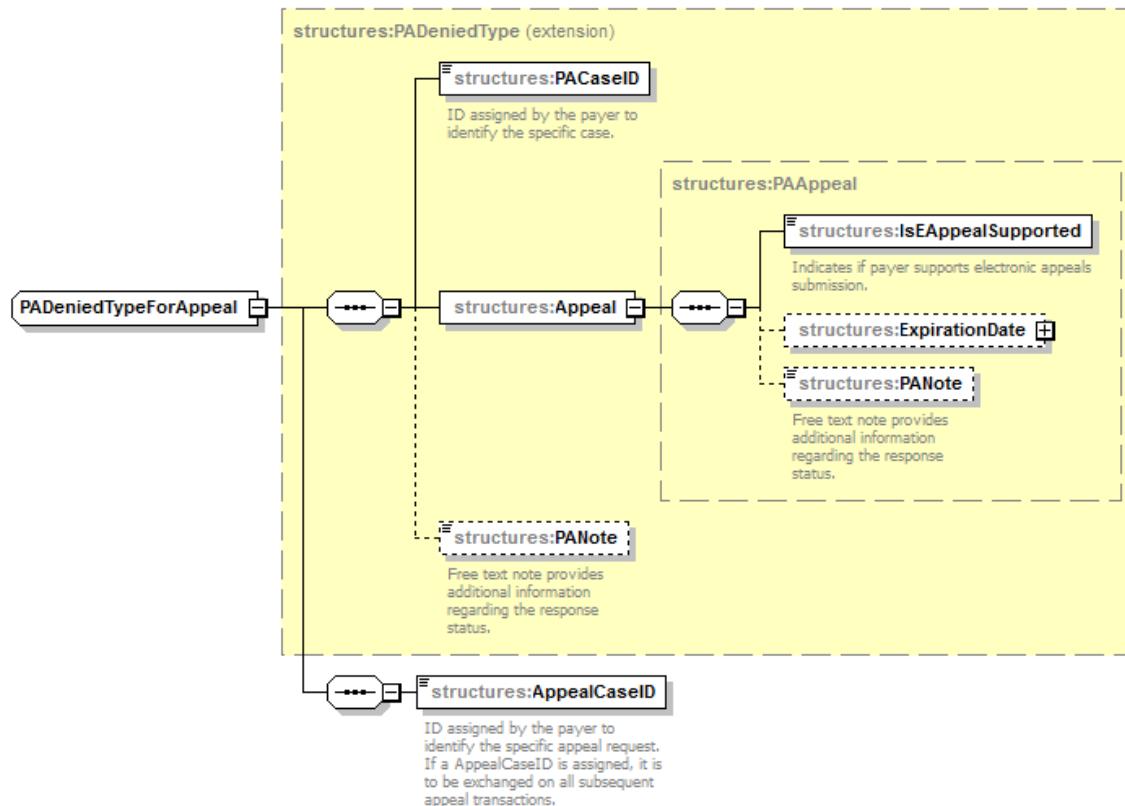


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[www.altova.com](http://www.altova.com)**Figure 95 PAAppeal Approved Response Type**

<Denied> indicates that the appeal has been denied by the payer. The elements in the <Denied> status are:

- **<Appeal>** - This mandatory composite indicates whether this determination can be further appealed. The **<IsEAppealSupported>** element is mandatory, and the composite also includes an optional **<ExpirationDate>** element indicating the deadline for appealing and a **<PANote>** element for addition information regarding the appeal process.
- **<PANote>** - This optional element is used to provide additional information about the denial.

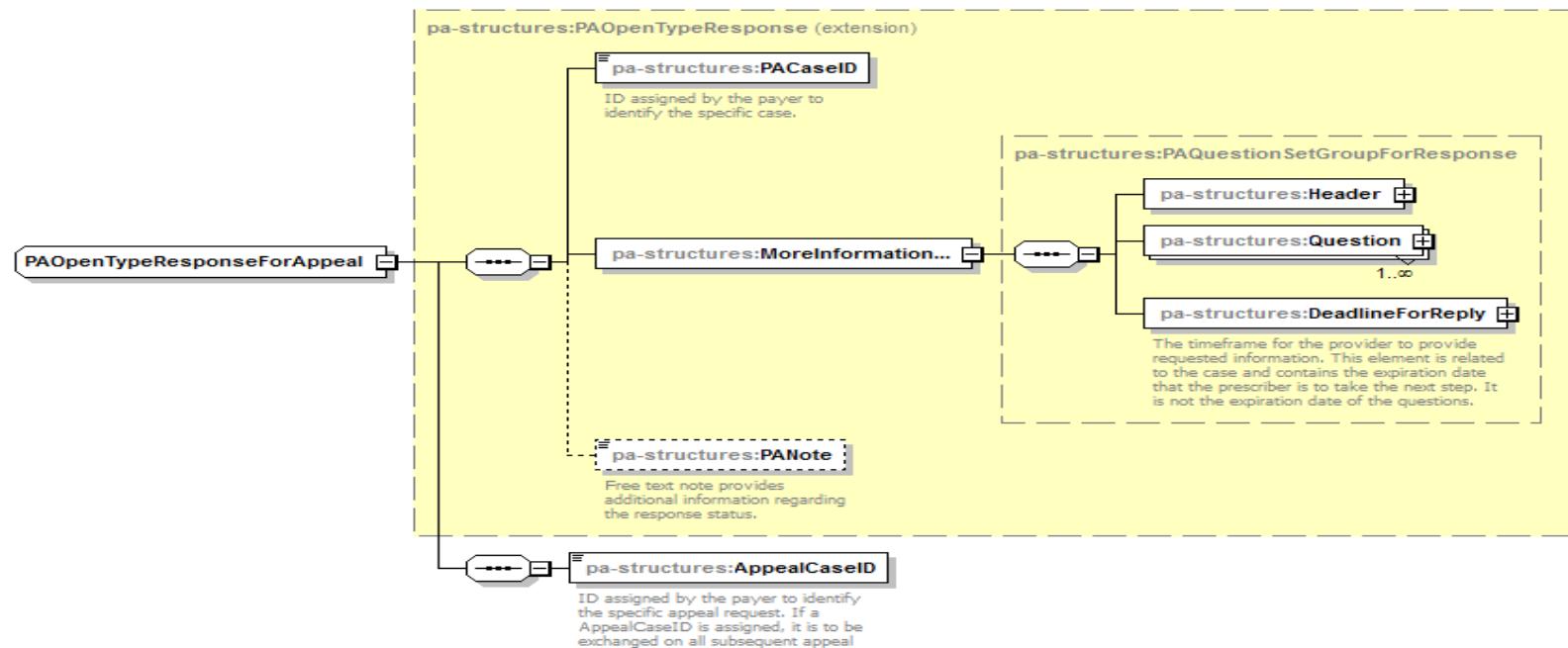


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[www.altova.com](http://www.altova.com)**Figure 96 PAAppeal Denied Response Type**

<Open> indicates that the appeal is being processed by the payer. The elements in the <Open> status are:

- <MoreInformationRequired> - This mandatory composite indicates that the payer needs additional information from the prescriber in order to complete processing of the appeal request. The composite provides a <QuestionSet> for completion by the prescriber for additional information. More information may be required when a prior authorization appeal is pended or a Deferred situation occurs.
- <PANote> - This optional element is used to provide additional information about the <Open> status.



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Figure 97 PAAppeal Open Response Type

<Closed> indicates that the appeal request has been closed by the payer. The elements in the <Closed> status are:

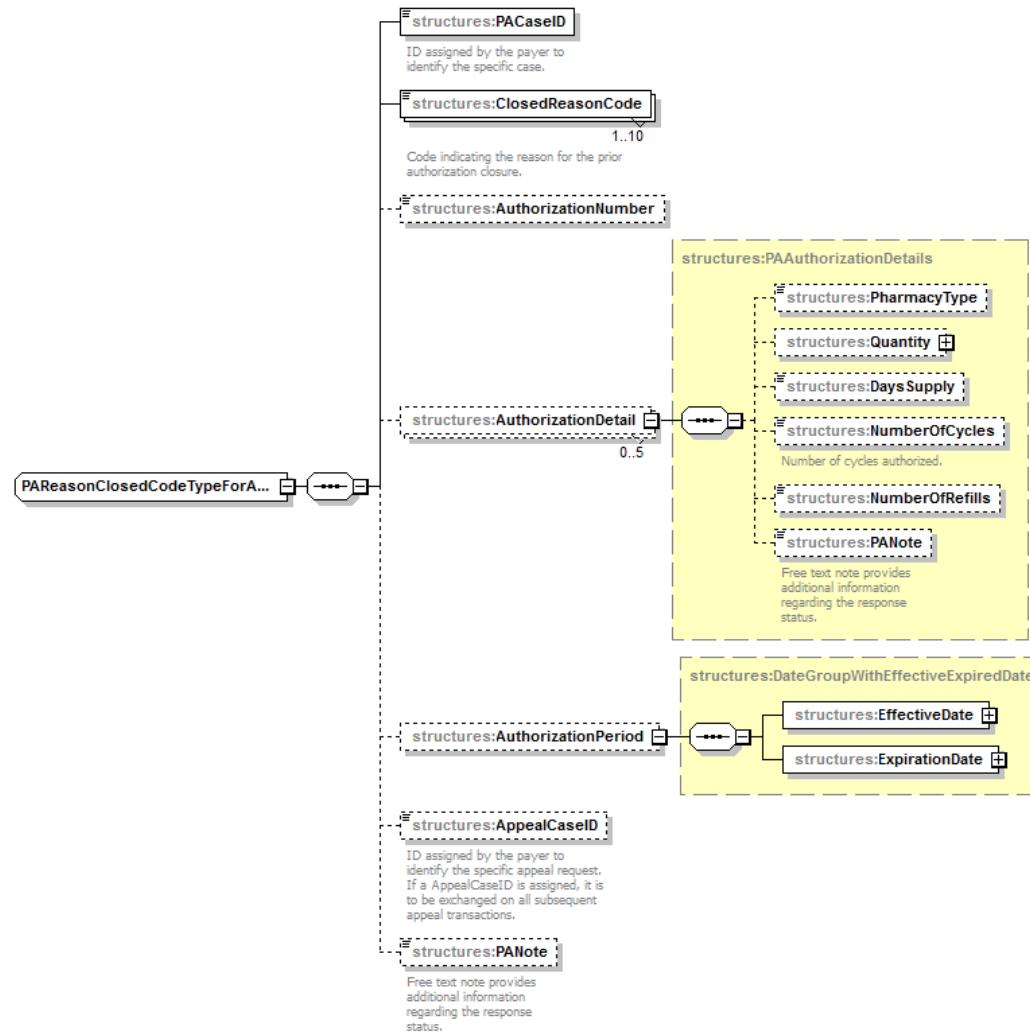
- <ClosedReasonCode> - This element indicates the closure reason.

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- **<AuthorizationNumber>** - This optional element holds a payer-assigned authorization number. This element is only used if there is already a current prior authorization for the patient and medication - the <ClosedReasonCode> is “4” (Prior Authorization duplicate/approved).
- **<AuthorizationDetail>** - This optional composite contains authorization details of the approval granted. Either <AuthorizationDetail> or <AuthorizationPeriod> must be sent. <AuthorizationDetail> may repeat if authorization details are provided for more than one pharmacy type. This element is only used if there is already a current prior authorization for the patient and medication - the <ClosedReasonCode> is “4” (Prior Authorization duplicate/approved). All elements in the composite are optional and used if they apply to the case. Included elements:
  - <PharmacyType> - This element repeats to indicate if only certain pharmacy types are approved to dispense the medication.
  - <Quantity> - This indicates the approved quantity of the requested medication.
  - <DaysSupply> - This indicates the approved days supply of the requested medication.
  - <NumberOfCycles> - This indicates the number of dispensing cycles approved.
  - <NumberOfRefills> - This indicates the number of approved refills.
  - <PANote> - This element provides additional textual clarifications.
- **<AuthorizationPeriod>** - This optional composite provides the authorization start and end dates. Either <AuthorizationDetail> or <AuthorizationPeriod> must be sent. This element is only used if there is already a current prior authorization for the patient and medication - the <ClosedReasonCode> is “4” (Prior Authorization duplicate/approved).
- **<PANote>** - This optional element is used to provide additional information about the closed status.



**Figure 98 PAAppeal Closed Response Type**

## 9.13 PACANCEL TRANSACTION ELEMENTS

The electronic prior authorization process enables the prescriber to cancel a prior authorization process that has already been initiated. The cancellation can occur at any stage of the process.

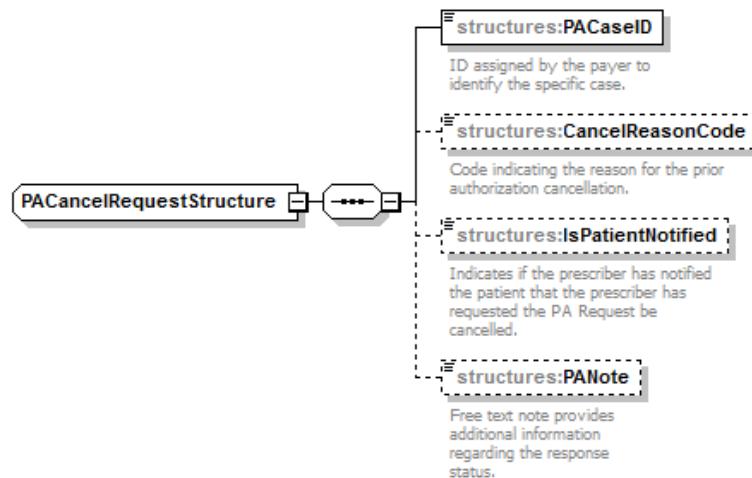
### 9.13.1 KEY PACANCELREQUEST ELEMENTS

<PACaseID> is the same PACaseID assigned by the payer, which enables the prescriber to cancel a previously submitted request.

<PACancelReasonCode> is used to indicate the reason the prescriber wishes to cancel the PA process.

<PANote> This element enables the prescriber to share additional information about the cancellation.

<IsPatientNotified> This element indicates that the patient has been made aware of the cancellation request.



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**Figure 99 PACancelRequest**

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### 9.13.2 KEY PACANCELRESPONSE ELEMENTS

<PACaseID> is the same PACaseID assigned by the payer, which enables the prescriber to cancel a previously submitted request.  
<ResponseStatus> is used to indicate the outcome of the cancelation request (Approved or Denied).

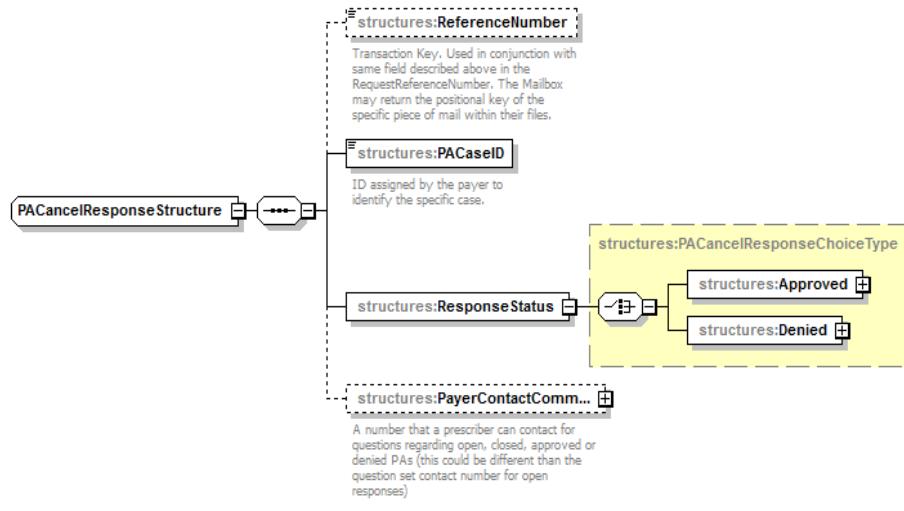


Figure 100 PACancelResponse Types

<PANote> (in Approved and Denied statuses). This element enables the payer to share additional information about the outcome of the cancelation.

<ReasonCode> (only in <Denied>). This element indicates the reason why the cancelation request could not be acted upon. For example, the process may have completed prior to the payer's receipt of the PACancelRequest transaction.

## **10. SPECIFIC RXTRANSFER ELEMENT DISCUSSION**

### **10.1 GENERAL INFORMATION**

Compounds are out of scope at this time for RxTransferRequest/Response/Confirm transactions due to complexity.

<Header><RxReferenceNumber> is not used in the RxTransferRequest/Response/Confirm transactions.

<Header><PrescriberOrderNumber> is not used in the RxTransferRequest/Response/Confirm transactions.

The high level <**Pharmacy**> (<script><Pharmacy>) occurs twice and contains the *transfer to* and the *transfer from* pharmacies (differentiated by <TransferType>). This information is sent in RxTransferRequest and echoed in the RxTransferResponse and RxTransferConfirm transactions.



Figure 101 <script><Pharmacy> Occurs 2

## **10.2 RxTRANSFERREQUEST**

See section "[Which Prescription\(s\) to Transfer?](#)"

If <TransferRequest> is "ALL", no <Medication> elements are sent.

If multiple "SPECIFIC" prescriptions are to be transferred, but not "ALL" prescriptions, a separate RxTransferRequest must be sent for each specific prescription.

If <TransferRequest> is "SPECIFIC", <MedicationTransferRequested> contains as much information is available to assist the *transfer from* pharmacy to determine which prescription, if possible is being requested for transfer. If <TransferRequest> is "SPECIFIC", the <Prescriber> information can be sent, if known, to help specify the prescription. <TransferRequest> is echoed from the RxTransferRequest to the RxTransferResponse and RxTransferConfirm transactions.

When <TransferType> is "SPECIFIC" and the *requested to be transferred prescription number is known*, the prescription number is placed in the <MedicationTransferRequested><Pharmacy><RxReferenceNumber>.

The <Pharmacist> demographic information (name, telephone, etc.) contains the pharmacist requesting the transfer. It can be sent when required by regulation, or if desired.

## **10.3 RxTRANSFERRESPONSE**

If <Pharmacist> is used, it is to contain the *transfer from* pharmacist. The <Pharmacist> demographic information (name, telephone, etc.) can be sent on a denial if specific follow up is required by contacting a specific pharmacist (e.g. <ReasonCode> "CQ" (Transfer needs to be discussed. Please call with information provided.).)

<MedicationPrescribed> contains as much information is available from the *transfer from* pharmacy to assist the *transfer to* pharmacy in aspects of the prescription. Elements such as, but not limited to <DEASchedule>, <PriorAuthorization>, <ReasonForSubstitutionCodeUsed> and dates informs the *transfer to* pharmacy. The *transfer to* pharmacy system determines what information is pertinent.

### **10.3.1 <MEDICATIONTRANSFERRED>**

<MedicationTransferred> occurs 0 to 300 times. It follows a similar looping construct to medication in RxHistoryResponse. One RxTransferResponse transaction may contain 0 to 300 prescriptions that are being transferred. Within each prescription that is being transferred, multiple dispensings/fills may be reported (0 to 300 for consistency).

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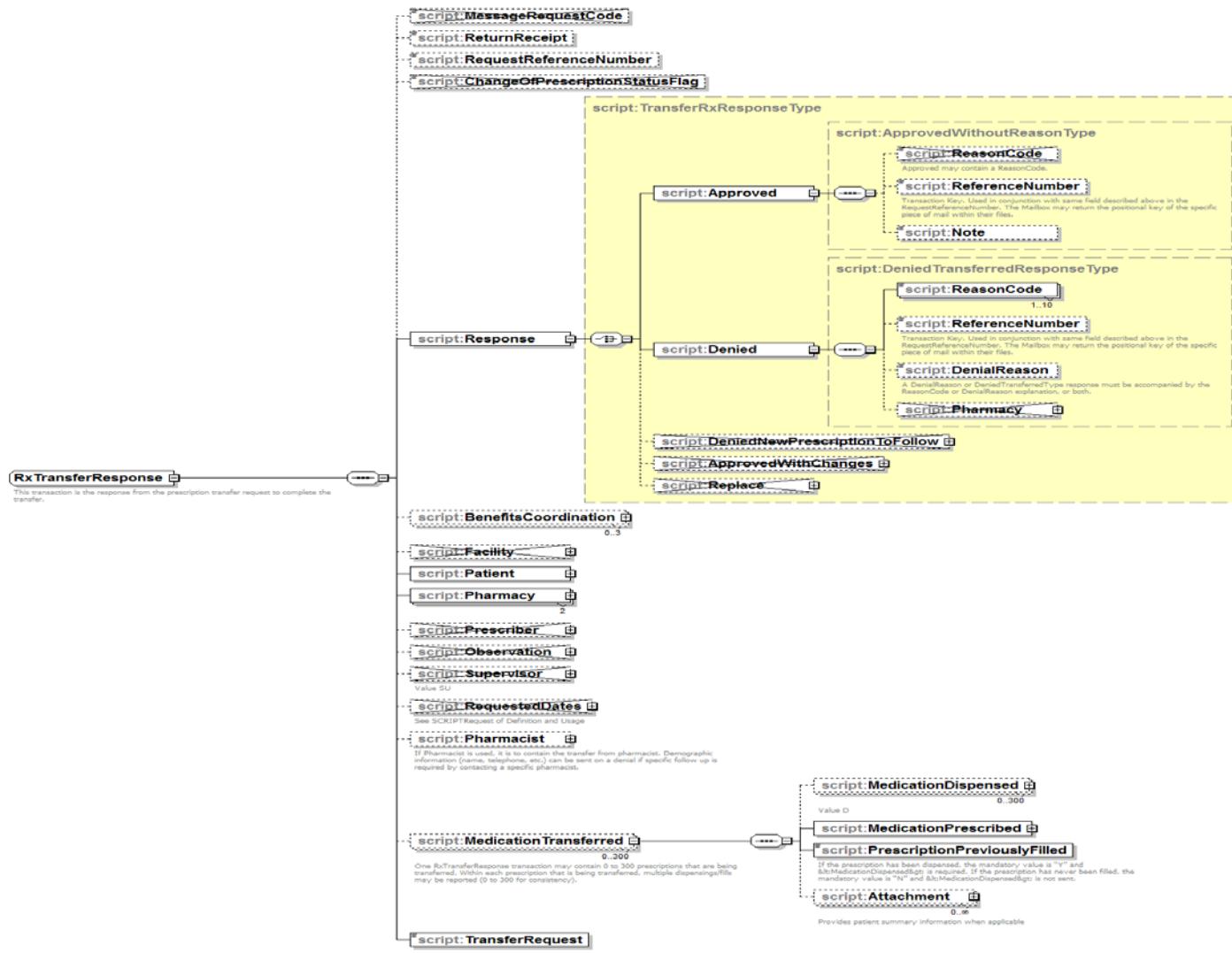


Figure 102 Responses and <MedicationTransferred>

If <Denied>, no <Medication> elements are sent.

If <Approved>, <MedicationPrescribed> is sent and occurs once. It contains information that was obtained from the prescriber and information from the pharmacy system.

If the medication has been dispensed 1 to many <MedicationDispensed> are sent for each dispensing.

When both <MedicationPrescribed> and <MedicationDispensed> are sent, there are some elements that are optional in each (e.g. <DaysSupply>, <OtherMedicationDateQualifier> value of <ExpirationDate>, etc.) If the implementer chooses to send these elements in both <MedicationPrescribed> and <MedicationDispensed>, the data cannot contradict. The data may complement, but cannot contradict.

Prescription number:

When a prescription number is assigned **by the *transferring from pharmacy***, <MedicationPrescribed><RxReferenceNumber> is used. Some pharmacies do not assign a prescription number and therefore the element is optional.

When the transferring from pharmacy is reporting transfers to other pharmacies, the <HistorySource><SourceReferenceNumber> contains the other pharmacy's prescription number when known.

<PrescriptionPreviouslyFilled> - Mandatory. If the prescription has been dispensed, the mandatory value is "Y" and <MedicationDispensed> is required.

If the prescription has never been filled, the mandatory value is "N" and <MedicationDispensed> is not sent.

<Attachments> - Used for regulatory requirements of original hard copy images. Attachments are supported in prescription transfers. The sender sends the type of attachment they have and the receiver upon interrogation of the transaction will determine if they support the attachment sent. If not, the attachment would be ignored. See section "[Attachment](#)".

Original Fill Date – Is ascertained by the *transfer to pharmacy* using <LastFillDate>. The earliest <LastFillDate> is the original fill date reported.

Element	<MedicationPrescribed> occurs 1	<MedicationDispensed> occurs 0 to 300
<DEASchedule>	Sent if prescriber designates.	This field is mandatory if a controlled substance prescription. It is the schedule effective from the transferring pharmacy's perspective.
<DoNotFill>	Sent if prescriber designates. The field is situational. Value "H" (Hold) is the only practical value for transfer. Note Value Y (Yes) may not	If the prescription has been dispensed, it is not used.

Element	<MedicationPrescribed> occurs 1	<MedicationDispensed> occurs 0 to 300
	be practical for transfer, but could be informational, but not fillable, so prescription should not be transferred. Value E (Do not hold) is not transferrable.	
<OtherMedicationDateQualifier> value of <ExpirationDate>	Sent if prescriber designates. Based on the transferring pharmacy state rules and/or prescriber's directions (whichever is more stringent). It is obtained from the pharmacy system calculating. If the prescription has never been filled, the field is situational based on regulation if applicable.	If the prescription has been dispensed, the field is not used.
<LastFillDate>	N/A	If the prescription has been dispensed, it is mandatory (date of this fill/dispensing.)
<Quantity> values		
<Quantity> - value "38" (Original Quantity)	Mandatory This is at the prescription level, not the fill level.	N/A
<Quantity> - value "87" (Quantity Received)	N/A	Mandatory
<Quantity> - value "40" (Remaining Quantity)	Mandatory This is at the prescription level, not the fill level.	N/A
<Quantity> - value "QT" (Quantity Transferred)	Mandatory The amount to be transferred. This may/not contain a whole number. This is at the prescription level, not the fill level.	N/A
<NumberOfRefills>	Mandatory This is at the prescription level, not the fill level.	N/A
<RefillsRemaining>	Mandatory This is at the prescription level, not the fill level.	N/A
<RxFillIndicator>	Sent if known. This is at the prescription level, not at the fill level and when used, represents the most recent status of the prescription fill status designated by the prescriber.	N/A
<HistorySource>	N/A	The <HistorySource> is used to relay the fill history. It may reflect two perspectives when applicable. <ol style="list-style-type: none"> <li>1. The first perspective is the transferring pharmacy and contains its information.</li> <li>2. The second perspective is to relay pharmacy(s) that have been transferred previous fills.</li> </ol>
<Reference>	N/A	Contains the pharmacy's identification. If no fills have been transferred, it contains the

Element	<MedicationPrescribed> occurs 1	<MedicationDispensed> occurs 0 to 300
		transferring pharmacy's identification. If fill(s) have been transferred, each <FillNumber> identifies whether the transferring pharmacy's identification or the <i>transfer to</i> pharmacy's identification.
<SourceQualifier>	N/A	<SourceQualifier> is always "P2" (Pharmacy).
<SourceReference>	N/A	Mandatory. Some states require the source pharmacy prescription number even if not filled; pharmacies often assign a prescription number even if not filled. If no fills have been transferred, it contains the transferring pharmacy's prescription number. If fill(s) have been transferred, each <FillNumber> identifies whether the transferring pharmacy's prescription number or the <i>transfer to</i> pharmacy's prescription number.
<FillNumber>	N/A	Mandatory. It contains the transferring pharmacy's appropriate fill number.
<Substitutions>	Mandatory	Mandatory. Note it could change per fill.
<WrittenDate>	If the prescription has never been filled, the field is mandatory.	N/A - If the prescription has been dispensed, it is not used.
<RxReferenceNumber>	If the transferring pharmacy assigns a prescription number, this field is sent.	N/A

#### 10.3.1.1 Example Scenarios

The transfer is based on what was prescribed, not on the plan benefit.

Total units prescribed - Total units dispensed = Total units remaining.

Total units remaining/Quantity Written = Refills Remaining.

Total quantity prescribed = Original Prescribed Quantity + (Number of Refills \* Original Prescribed Quantity)

The following scenarios are examples of the use of these fields. *Italicized rows* are not data elements in the transaction, but provide clarity to the reader.

For <RefillsRemaining> see section "[Prescription Transfer Medication Elements and Refill Elements](#)".

#1	Prescription that has never been filled by Pharmacy 2:	<MedicationP rescribed>	<MedicationD ispensed>
	<PrescriptionPreviouslyFilled>	N	
	<Quantity> value Original Quantity	90	
	<NumberOfRefills>	2	
	<RefillsRemaining>	2	
	<i>Total Quantity Prescribed = Original Prescribed Quantity + (Number of Refills * Original Prescribed Quantity)</i>	270	
	<Quantity> value Quantity Received	not used	
	<Quantity> value Quantity Transferred	270	
	<Quantity> value Remaining Quantity <i>= Total Quantity Prescribed - sum of all "Dispensed Quantity" fields</i>	270	
	<LastFillDate>	not used	

#2	Prescription that has been filled once (in full) by Pharmacy 2:	<MedicationP rescribed>	<MedicationD ispensed>
	<PrescriptionPreviouslyFilled>	Y	
	<Quantity> value Original Quantity	90	not used
	<NumberOfRefills>	2	not used
	<RefillsRemaining>	2	not used
	<i>Total Quantity Prescribed = Original Prescribed Quantity + (Number of Refills * Original Prescribed Quantity)</i>	270	not used
	<Quantity> value Quantity Received	not used	90
	<Quantity> value Quantity Transferred	180	not used
	<Quantity> value Remaining Quantity <i>= Total Quantity Prescribed - sum of all "Dispensed Quantity" fields</i>	180	not used
	<LastFillDate>	not used	01/01/2013

#3	Prescription that has been filled twice (in full) by Pharmacy 2:	<MedicationPrescribed>	<MedicationDispensed>	<MedicationDispensed>
	<PrescriptionPreviouslyFilled>	Y		
	<Quantity> value Original Quantity	90	not used	not used
	<NumberOfRefills>	2	not used	not used
	<RefillsRemaining>	1	not used	not used
	<i>Total Quantity Prescribed = Original Prescribed Quantity + (Number of Refills * Original Prescribed Quantity)</i>	270	<i>not used</i>	<i>not used</i>
	<Quantity> value Quantity Received	not used	90	90
	<Quantity> value Quantity Transferred	90	not used	not used
	<Quantity> value Remaining Quantity <i>= Total Quantity Prescribed - sum of all "Dispensed Quantity" fields</i>	90	not used	not used
	<LastFillDate>	not used	01/01/2013	04/01/2013

#4	Prescription that has been "short" filled by Pharmacy 2:	<MedicationPrescribed>	<MedicationDispensed>	<MedicationDispensed>
	<PrescriptionPreviouslyFilled>	Y		
	<Quantity> value Original Quantity	90	not used	not used
	<NumberOfRefills>	2	not used	not used
	<RefillsRemaining>	2.333	not used	not used
	<i>Total Quantity Prescribed = Original Prescribed Quantity + (Number of Refills * Original Prescribed Quantity)</i>	270	<i>not used</i>	<i>not used</i>
	<Quantity> value Quantity Received	not used	30	30
	<Quantity> value Quantity Transferred	210	not used	not used
	<Quantity> value Remaining Quantity <i>= Total Quantity Prescribed - sum of all "Dispensed Quantity" fields</i>	210	not used	not used
	<LastFillDate>	not used	01/01/2013	02/01/2013

#5	Prescription that has been filled once (in full) by Pharmacy 2 - New York single transfer rules apply:	<MedicationP rescribed>	<MedicationD ispensed>
	<PrescriptionPreviouslyFilled>	Y	
	<Quantity> value Original Quantity	90	not used
	<NumberOfRefills>	2	not used
	<RefillsRemaining>	2	not used
	Total Quantity Prescribed $= \text{Original Prescribed Quantity} + (\text{Number of Refills} * \text{Original Prescribed Quantity})$	270	not used
	<Quantity> value Quantity Received	not used	90
	<Quantity> value Quantity Transferred	90	not used
	<Quantity> value Remaining Quantity $= \text{Total Quantity Prescribed} - \text{sum of all "Dispensed Quantity" fields}$	180	not used
	<LastFillDate>	not used	01/01/2013

#6	ENBREL 25 MG/0.5 ML SYRINGE prescription that has been filled once by Pharmacy 2	<MedicationP rescribed>	<MedicationD ispensed>	NY state transfer - 1 fill to Pharmacy 1			NY state transfer - 1 fill to Pharmacy 3	
				<MedicationP rescribed>	<MedicationD ispensed>	Y	<MedicationP rescribed>	<MedicationD ispensed>
	<PrescriptionPreviouslyFilled>	Y					Y	
	<Quantity> value Original Quantity	4.08	not used		4.08	not used		4.08 not used
	<NumberOfRefills>	2	not used		2	not used		2 not used
	<RefillsRemaining>	2	not used		2	not used		1 not used
	Total Quantity Prescribed $= \text{Original Prescribed Quantity} + (\text{Number of Refills} * \text{Original Prescribed Quantity})$	12.24	not used		12.24	not used		12.24 not used
	<Quantity> value Quantity Received	not used	4.08		not used	4.08		not used 4.08
	<Quantity> value Quantity Transferred	8.16	not used		4.08	not used		4.08 not used
	<Quantity> value Remaining Quantity $= \text{Total Quantity Prescribed} - \text{sum of all "Dispensed Quantity" fields}$	8.16	not used		8.16	not used		4.08 not used
	<LastFillDate>	not used	01/01/2013		not used	01/01/2013		not used 01/01/2013

As of this example creation NY allows fills to be transferred to different pharmacies. This is for example only. Please consult regulations and pharmacy laws for transfer requirements.

Pharmacy 3 is told about the transfer to Pharmacy 1 during the transfer of the fill to Pharmacy 3.

Note Medication History could provide further information of what was dispensed at each pharmacy.

#7	PREVPAC PATIENT PACK prescription that has been filled once by Pharmacy 2	<MedicationPrescribed>	<MedicationDispensed>
	<PrescriptionPreviouslyFilled>	Y	
	<Quantity> value Original Quantity	336	not used
	<NumberofRefills>	2	not used
	<RefillsRemaining>	2	not used
	Total Quantity Prescribed $= \text{Original Prescribed Quantity} + (\text{Number of Refills} * \text{Original Prescribed Quantity})$	1008	not used
	<Quantity> value Quantity Received	not used	336
	<Quantity> value Quantity Transferred	672	not used
	<Quantity> value Remaining Quantity $= \text{Total Quantity Prescribed} - \text{sum of all "Dispensed Quantity" fields}$	672	not used
	<LastFillDate>	not used	01/01/2013

## 10.4 RxTRANSFERCONFIRM

RxTransferConfirm contains the mandatory <Pharmacist> information because the *transfer to* pharmacy is to confirm to the transferring pharmacy that the prescription transfer was received, the pharmacist of the transfer, and when required by regulation, the identification of the pharmacist. One pharmacist is sent per RxTransferConfirm.

<RxFillConfirmIndicator> - mandatory “Y” (Yes) or “N” (No) to indicate the *transfer to* pharmacy supports Fill Status transactions. See the discussion at section “[Prescription Transfer and Fill Status Notification](#)”.

## **11. DIGITAL SIGNATURE INFORMATION**

Per the 21 CFR Parts 1300, 1304, 1306, and 1311 Electronic Prescriptions for Controlled Substances; Final Rule<sup>1</sup> the prescribing application attaches either a digital signature or a validation that two-factor authentication was used to digitally sign **components** of the prescription, providing assurance that the prescription originates from an authorized DEA-registered prescriber (21 CFR 1311.115).

The Electronic Prescriptions for Controlled Substances (EPCS) regulation supports two methods of signing the prescription.

1. An indicator that the prescription has been signed according to the DEA requirements for electronic prescribing of controlled substances.
2. A digital signature

To support the two methods, the digital signature is an optional tag added to the Header. The <DigitalSignature> element uses either the <DigitalSignatureIndicator> or the actual signature (<DigestValue>, <SignatureValue>, <X509Data>).

The <DigitalSignature> element is used for controlled substances for <MedicationPrescribed> or <MedicationResponse> information in

- NewRx
- RxChangeResponse and
- RxRenewalResponse transactions as these are “fillable” prescription transactions per the regulation.

Transactions that are not fillable are not required to be signed.

The signature block includes a digital certificate from the sender of the transaction. The signature and the certificate are to be validated by the receiver to verify that the transaction was created by the owner of the signing key. The EPCS regulation requirements for exchange of digitally signed transactions are to be followed for controlled substance prescriptions.

The regulations required the functionality, implemented in these elements, of

- Digital Signature Indicator (<DigitalSignatureIndicator>) or the actual signature (<DigestValue>, <SignatureValue>, <X509Data>)
- Controlled Substance Indicator (<DEASchedule>)
- Earliest Fill Date (<OtherMedicationDateQualifier> value **of** <EffectiveDate>)
- Drug Abuse Treatment Indicator – see below

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<sup>1</sup> <http://www.gpo.gov/fdsys/pkg/FR-2010-03-31/pdf/2010-6687.pdf>

- Medication Indication for GHB (Gamma-Hydroxybutyric acid) – see below

**Drug Abuse Treatment Identifier (For Schedule II's)**

<Notes>

*For Schedule II usage*

Use text “NADEAN:xxxxxxxx” (Narcotics Addiction DEA Number)

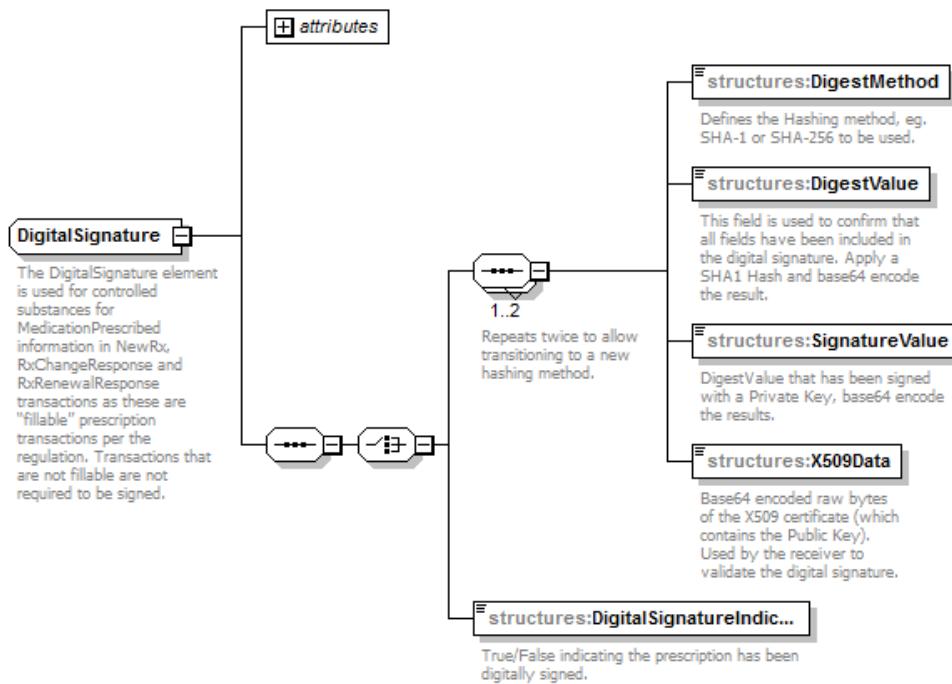
**Medication Indication for GHB (Gamma-Hydroxybutyric acid)**

<Notes>

This is a free text description of the medical need for GHB.

In the future we will discuss whether to add a free text field specifically for this indication, or use indication fields in the Structured Sig.

## 11.1 DIGITAL SIGNATURE ELEMENTS



Generated by XMLSpy

[www.altova.com](http://www.altova.com)**Figure 103** DigitalSignature

The following table shows the use of the <DigitalSignatureIndicator>.

Element	DataType	Mandatory/Conditional	Comment
<DigitalSignature>	Complex Type	C	The three tags under Digital Signature <DigestValue>, <SignatureValue>, and <X509Data> are required to have their data base64 encoded.
<DigitalSignatureIndicator>		M	True/False indicating the prescription has been digitally signed

Example using <DigitalSignatureIndicator>:

```

<transport:DigitalSignature Version="1.1">
    <structures:DigitalSignatureIndicator>true</structures:DigitalSignatureIndicator>
</transport:DigitalSignature>

```

The following table shows the use of the digital signature elements when including the actual signature (<DigestValue>, <SignatureValue>, <X509Data>).

Element	DataType	Mandatory/Conditional	Comment
<DigitalSignature>	Complex Type	C	The three tags under Digital Signature <DigestValue>, <SignatureValue>, and <X509Data> are required to have their data base64 encoded.
<DigestMethod>	an1..10	M	Defines the Hashing method to be used. e.g. SHA-1 or SHA-256
<DigestValue>	an1..35	M	DigestValue Concatenate all fields listed below in the specified order, apply a SHA1 Hash, base64Encode the result. This field is used to confirm that all fields have been included in the digital signature. DigestValue is composed of fields concatenated together and then encoded. - The DigestValue is the results of the hash method defined in the DigestMethod field.
<SignatureValue>	String	M	DigestValue that has been signed with a Private Key, base64 encode the results.
<X509Data>	String	M	Base64 encoded raw bytes of the X509 certificate (which contains the Public Key). Used by the receiver to validate the digital signature as described below.

Example using digital signature:

```

<transport:DigitalSignature Version="1.1">
    <structures:DigestValue>xxxxxxxxxxxxxx</structures:DigestValue>
    <structures:SignatureValue>xxxxxxxxxxxxxx</structures:SignatureValue>
    <structures:X509Data>xxxxxxxxxxxx</structures:X509Data>
</transport:DigitalSignature>

```

The data elements required for signing are based on sections 21 CFR Parts 1306.05 (a), 1306.05 (b), 1306.05 (c) and 1311.120(b) (9) of the regulation.

For Date elements listed below, either the Date or the DateTime element is sent and therefore to be signed, not both.

Data Elements Required for Signing	
Element Name	Comment
<Prescriber>	
DEA	<Identification><DEANumber>
SSN	<Identification><SocialSecurity>
Last Name	<LastName>
First Name	<FirstName>
Address Line 1	<AddressLine1>
Address Line 2	<AddressLine2>
City	<City>

State	<StateProvince>
Postal Code	<PostalCode>
<b>&lt;Patient&gt;</b>	
Last Name	<LastName>
First Name	<FirstName>
Address Line 1	<AddressLine1>
Address Line 2	<AddressLine2>
City	<City>
State	<StateProvince>
Postal Code	<PostalCode>
<b>&lt;MedicationPrescribed&gt; or &lt;MedicationResponse&gt;</b>	
Drug Name	<DrugDescription>
Drug Strength	<Strength><StrengthValue>
Quantity	<Quantity><Value>
Sig Text	<SigText> <b>(Note the Structured Sig is not included in the signed information.)</b>
Date Written (Date)	
Date Written – Year CCYY	<WrittenDate><Date> positions 1-4
Date Written – Month MM	<WrittenDate><Date> positions 6-7
Date Written – Day DD	<WrittenDate><Date> positions 9-10
Date Written (DateTime)	
Date Written – Year CCYY	<WrittenDate><DateTime> positions 1-4
Date Written – Month MM	<WrittenDate><DateTime> positions 6-7
Date Written – Day DD	<WrittenDate><DateTime> positions 9-10
<OtherMedicationDateQualifier> value of Effective Date (Date)	
Effective Date – Year CCYY (Earliest Fill Date)	<OtherMedicationDateQualifier> <EffectiveDate><Date> positions 1-4
Effective Date – Month MM	<OtherMedicationDateQualifier> <EffectiveDate><Date> positions 6-7
Effective Date – Day DD	<<OtherMedicationDateQualifier> EffectiveDate><Date> positions 9-10
<OtherMedicationDateQualifier> value of Effective Date (DateTime)	
Effective Date – Year CCYY (Earliest Fill Date)	<OtherMedicationDateQualifier> <EffectiveDate><DateTime> positions 1-4
Effective Date – Month MM	<OtherMedicationDateQualifier> <EffectiveDate><DateTime> positions 6-7
Effective Date – Day DD	<OtherMedicationDateQualifier> <EffectiveDate><DateTime> positions 9-10
<b>Refill Quantity</b>	
<b>Refill Quantity Qualifier</b>	<b>For backward compatibility, this field is hardcoded to "R". This field was removed in 10.11. This field needs to be signed with a value of R. Other values from lower versions are not supported or translated to this version.</b>
Number of Refills	<NumberOfRefills>

Notes	<Note> Free text comments to Pharmacist or Prescriber. This is where the Drug Abuse Treatment Identifier and GHB reason is stored. See above section.
<MedicationPrescribed><Compound> or <MedicationResponse><Compound>	Would repeat up to 25 times for each ingredient
Drug Name	<CompoundIngredient><CompoundIngredientItemDescription>
Drug Strength	<CompoundIngredient><Strength><StrengthValue>
Quantity	<Compound><Quantity><Value>

## **11.2 GENERATING THE DIGITAL SIGNATURE**

A visual description is available at [http://en.wikipedia.org/wiki/File:Digital\\_Signature\\_diagram.svg](http://en.wikipedia.org/wiki/File:Digital_Signature_diagram.svg)

The EPCS regulation, the Internet, and various entities offer much more information and expertise about digital signature implementation. Basic information is provided below, but those resources should be consulted for more information.

To generate a digital signature the following steps are performed.

1. Concatenate the fields to be signed and create a single plain text string.
  - a. The value of the fields listed in the above table **with their Xpaths<sup>2</sup>** are required in the order specified and concatenated into a single plain text string.
  - b. The plain text string is not to include field separators or additional characters that are not in the data field.
  - c. The fields are required to be constrained to the alpha-numeric character set matching the pattern [ !~]\* or a more restrictive pattern as defined by the XML schema or this guide. Trailing and leading whitespace is to be included exactly as sent in the transaction.
  - d. The plain text string should not use XML escaping.
    - i. If the prescriber wishes to send the literal value of “> 100 degrees” in a field, do not change this to “&gt; 100 degrees” when creating the plain text string.
    - ii. If the field is constrained to a code set, then the value of the code is included in the plain text string.
2. Calculate the <DigestValue> of the plain text string
  - a. The ASCII encoded plain text string will be reduced to a unique <DigestValue> using a SHA-1 hash.
3. Calculate the <Signature Value>
  - a. The encrypted <SignatureValue> is calculated by encrypting the result of SHA-1 Hash with the prescriber’s private key. This encryption is required to be done with RSASSA-PKCS1-v1\_5. This standard is implemented by the RSACryptoServiceProvider in Microsoft.Net, Java Cryptography Extension (JCE) and many other popular development platforms.
4. Format the Transaction
  - a. The results of the SHA-Hash, the Signature Value and the Prescriber’s X.509 Public Certificate are required to each be base64 encoded and included in the XML message header.

---

<sup>2</sup> Xpath information is available at [www.wikipedia.org](http://www.wikipedia.org) and other internet resources.

## **11.3 VALIDATING THE DIGITAL SIGNATURE**

Validating a signature is similar to creating a signature. In both cases, information is identified and run through a secure hashing function. When validating, the resulting hash is compared with the hash contained in the transaction, which is obtained by decrypting the <SignatureValue> using the public key in the certificate that is sent within the transaction header. The first two steps are identical to the signature generation.

1. Steps 1-3 are followed from above.
2. Decrypt the <SignatureValue>
  - a. The <SignatureValue> is an encrypted version of the hash of the signed information (the concatenation of all the fields in the table including their Xpaths). The hash value is also in the <DigestValue> (for troubleshooting purposes). The sender's private key is what was used to encrypt the digest to create the <SignatureValue>. The <SignatureValue> can only be decrypted with the sender's public key, which is contained in the attached digital certificate in the <X509Data> element.
3. Compare the Digests
  - a. The <DigestValue> that the recipient calculates will match the <DigestValue> from the decrypted signature if the signature is valid.
4. Validate the Certificate
  - a. In addition to validating the signature, the receiving application is required to also ensure that the certificate used to sign the transaction is valid. Some applications may choose to perform this step before validating the signature. A transaction should only be accepted as valid if it has been signed and verified with a valid digital certificate.

## **12. TRANSMISSION EXAMPLES**

See the SCRIPT Standard Examples Guide for transmission examples.

## **13. FREQUENTLY ASKED QUESTIONS (FAQ'S)**

### **13.1 WHAT IS SCRIPT?**

SCRIPT is a standard data set for the interchange of prescription data and related information in the medical provider community. (SCRIPT is not an acronym for anything).

### **13.2 WHAT IS THE FUNCTIONALITY OF SCRIPT?**

See section *“Business Environment”*.

### **13.3 DOES SCRIPT ALLOW FOR DUR MESSAGES TO BE SENT?**

The ability to send Drug Utilization Review (DUR) was added in version 3.1 - DrugUseEvaluation and DrugCoverageStatusCode information.

### **13.4 WHAT HAPPENS IF THE STATE IN WHICH I PRACTICE DOES NOT ALLOW FOR AN ELECTRONIC PRESCRIPTION, CAN I STILL USE SCRIPT?**

No. If your state does not allow for an electronic prescription, SCRIPT cannot be used. However, the industry is working with the State Boards of Pharmacy in many states to gain acceptance of the NCPDP **SCRIPT Standard Implementation Guide**. Currently, most states allow for an electronic prescription exchange.

### **13.5 How Is PACKET USED?**

If the product being provided can be quantified as something other than a tablet or capsule, then the <StrengthForm> would reflect something other than “C48542” (Tablet Dosing Form) or “C48480” (Capsule Dosing Form) such as “C64908” (Powder for Oral Suspension Form) as seen in the example below. The <QuantityUnitOfMeasure> describes the dosing unit, In this example, 60 4-gram “C48521” (Packet Unit) packets are being prescribed.

#### **Example of Use of Packet**

Element	SCRIPT Remarks	SCRIPT value	Comment
Medication occurrence	Prescribed Dispensed Requested DispensedAndAdministered		
DrugDescription		Cholestyramine Powder	
ProductCode and Qualifier	Values for NDC, UPC, MFG		
Strength,	Drug Strength Measurement value	4	
StrengthForm	Pharmaceutical Dosage Form	C64908	Powder for Oral Suspension form  NCPDP Drug Dosage Form Terminology
StrengthUnitOfMeasure		C458155	Gram  NCPDP Drug

			StrengthUnitOfMeasure Terminology
Quantity	Dispense Quantity Count of drug form dispensed	60	60
QuantityUnitOfMeasure		C48521	Packet Unit NCPDP QuantityUnitOfMeasure Terminology

## **13.6 WHAT DO EACH OF THESE VALUES REALLY MEAN IN QUANTITY CODELISTQUALIFIER (DO 38 AND 87 MEAN THE SAME THING)?**

Quantity

Values:

- 38 = Original Quantity
- 40 = Remaining Quantity
- 87 = Quantity Received

**Response:**

The meanings are different.

38 is the quantity prescribed by prescriber on the new prescription order

87 is the quantity actually dispensed by pharmacist. It is generally the same, but not always. For example, the pharmacy may not have enough in stock or the patient or payer may not be willing to pay for the entire amount prescribed.

## **13.7 HOW TO LINK THE CANCELRx TRANSACTION TO THE NEWRx**

This rule only applies if the new prescription was sent electronically as the trace and reference numbers are used to link.

See the SCRIPT Standard Examples Guide - “Example 20. Prescriber Sends the Original Order, then Changes the Original Order, Significantly (Direct Connect)”.

The <MessageID> and the <PrescriberOrderNumber> from the original prescription must be returned on the CancelRx. In the CancelRx the <RelatesToMessageID> will contain the <MessageID> of the original prescription. Also the <PrescriberOrderNumber> will be the <PrescriberOrderNumber> from the original prescription.

## **13.8 MEDICATION ELEMENTS FAQs**

### **13.8.1 WHY DOESN'T A PRODUCT HAVE AN IDENTIFIER?**

**Answer:**

It may be a new product to market and the updates to product or drug files at the various constituents just take time. A possible other problem identified is there may be manufacturers that choose to not provide identifiers to the industry.

### **13.8.2 WHAT IS A RECOGNIZED AUTHORITATIVE DRUG INFORMATION SOURCE?**

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**Answer:**

A recognized authoritative drug information source is defined as a comprehensive listing of the Food and Drug Administration-approved drugs and biologicals. Such listings are published by a variety of sources including drug information from RxNorm, drug knowledgebase, drug compendia companies, etc.

### **13.8.3 WHERE SHOULD THE COMMERCIALLY AVAILABLE PRODUCT NAME BE OBTAINED IF NOT FROM A DRUG COMPENDIA?**

**Answer:**

If not using a drug compendium, RxNorm is to be used (<http://www.nlm.nih.gov/research/umls/rxnorm/index.html>).

Additional sources of representative product labeling are

- DailyMed - <http://dailymed.nlm.nih.gov/dailymed/>
- drugs@fda - <http://www.accessdata.fda.gov/scripts/cder/drugsatfda/>

### **13.8.4 WHAT SHOULD THE RECEIVER DO IF THEY RECEIVE A DRUG NAME THAT IS NOT RECOGNIZED OR DOES NOT FOLLOW THE RECOMMENDATIONS?**

**Answer:** The receiver has options to use the Error transaction with appropriate reject information and/or to follow normal business practices to clarify the prescription.

### **13.8.5 CAN ANY SYMBOL BE INCLUDED IN THE EPREScribing DRUG NAME?**

**Answer:** Symbols that a computer could translate to a computer command or control character should not be sent. See section “*Standard Conventions*” in **SCRIPT Version 10.11** and below (or the actual XML schema in **SCRIPT 2010** and above) for the valid character set that can be transmitted.

### **13.8.6 HOW SHOULD THE DRUG DESCRIPTION FIELD BE POPULATED IN ELECTRONIC MESSAGES?**

**Answer:** EHR and electronic prescribing systems are strongly encouraged to use a commercial compendium source, and to use the compendium’s recommended ePrescribing Drug Name as published (is not to be modified). The product identifiers must relate to the compendia recommended ePrescribing Name (See Chapter “*Recommendations for Consistent Use of Drug Identification Fields used in SCRIPT Transactions*”).) See <http://www.ncpdp.org/Education/Whitepaper for Dosing Designations-Oral Liquid Medication Labels white paper and NCPDP Recommendations for Improved Prescription Container Labels for Medicines Containing Acetaminophen white paper>.

Multiple brand names in the drug description field also can cause ambiguity because they are often not AB-rated in Orange Book; this will again cause confusion at the dispensing end that will often result in a call for clarification.

**Incorrect Examples:**

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**Example 1**

```
<MedicationPrescribed>
  <DrugDescription>NIFEdipine (ADALAT CC/PROCARDIA XL) 60 mg SR tablet</DrugDescription>
  <DrugCoded>
    <ProductCode>54868453100</ProductCode>
    <ProductCodeQualifier>ND</ProductCodeQualifier>
  </DrugCoded>
```

**Example 2**

```
<MedicationPrescribed>
  <DrugDescription>potassium chloride (K-DUR,KLOR-
CON) 10 mEq sustained release tablet</DrugDescription>
  <DrugCoded>
    <ProductCode>62037071001</ProductCode>
    <ProductCodeQualifier>ND</ProductCodeQualifier>
  </DrugCoded>
```

The above actual examples are incorrect because

Adalat CC and Procardia XL are not AB rated products; this means they are not substitutable in Orange Book states and liability for any adverse events is assumed by the pharmacist in non-Orange Book states. Essentially, these prescriptions MUST be clarified in some states and WILL be in others.

K-DUR and Klor-Con have different release designs and are not AB rated products; again, they are not substitutable in Orange Book states and liability for any adverse events is assumed by the pharmacist in non-Orange Book states. Essentially, these prescriptions too MUST be clarified in some states and WILL be in others.

**Correct Examples (including the RxNorm Code):****Example 1**

If the Adalat brand was intended:

```
<MedicationPrescribed>
  <DrugDescription>ADALAT CC 30 MG TABLET</DrugDescription>
  <DrugCoded>
    <ProductCode>00085170102</ProductCode>
    <ProductCodeQualifier>ND</ProductCodeQualifier>
    <DrugDBCode>672916</DrugDBCode>
    <DrugDBCodeQualifier>SBD</DrugDBCodeQualifier>
  </DrugCoded>
```

If the generic was intended:

```
<MedicationPrescribed>
  <DrugDescription>NIFEDIPINE ER 30 MG TABLET </DrugDescription>
  <DrugCoded>
    <ProductCode>00093205701 </ProductCode>
    <ProductCodeQualifier>ND</ProductCodeQualifier>
    <DrugDBCode>198034</DrugDBCode>
```

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```
<DrugDBCodeQualifier>SCD</DrugDBCodeQualifier>
</DrugCoded>
```

**Example 2**

If the Klor-Con brand was intended:

```
<MedicationPrescribed>
  <DrugDescription>KLOR-CON 10 MEQ TABLET</DrugDescription>
  <DrugCoded>
    <ProductCode>00245004101</ProductCode>
    <ProductCodeQualifier>ND</ProductCodeQualifier>
    <DrugDBCode>628958</DrugDBCode>
    <DrugDBCodeQualifier>SBD</DrugDBCodeQualifier>
  </DrugCoded>
```

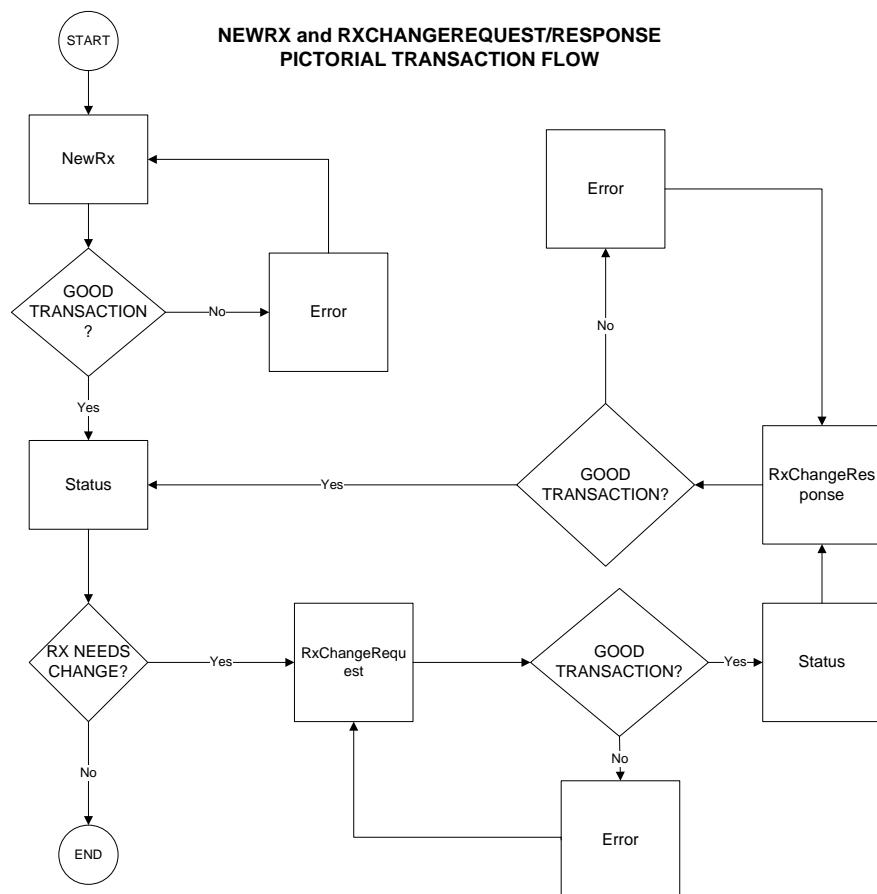
If the generic was intended:

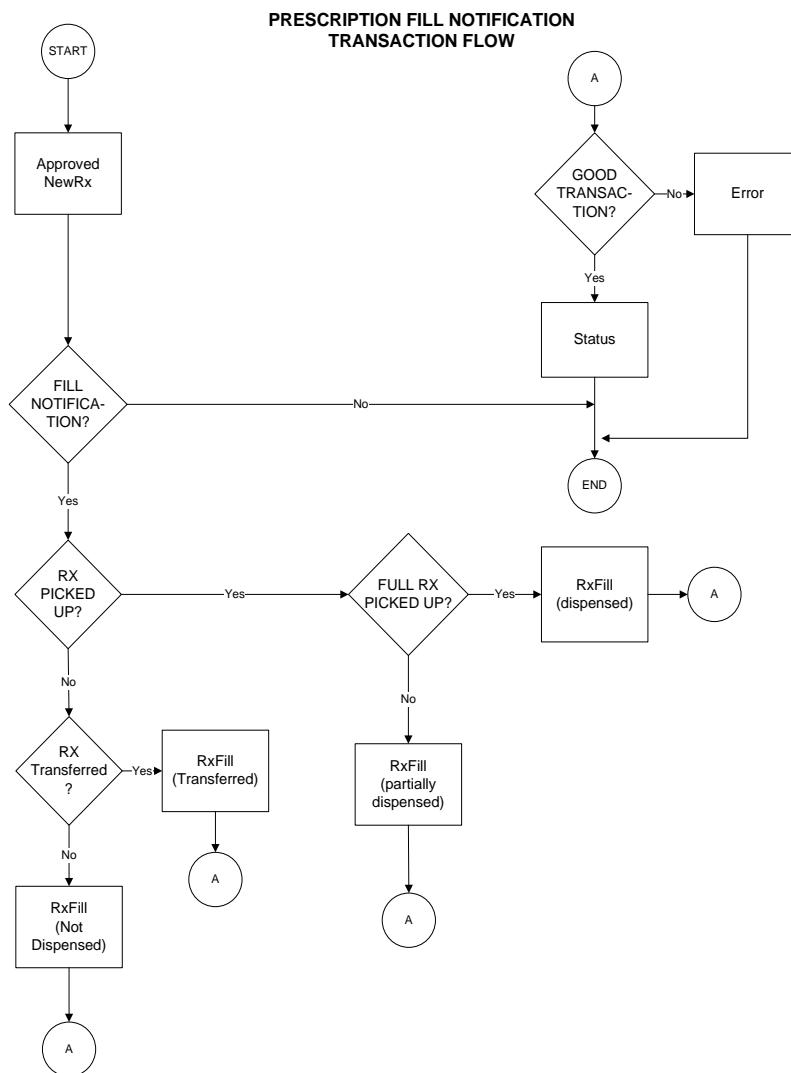
```
<MedicationPrescribed>
  <DrugDescription>POTASSIUM CL ER 10 MEQ TABLET</DrugDescription>
  <DrugCoded>
    <ProductCode>00781571001</ProductCode>
    <ProductCodeQualifier>ND</ProductCodeQualifier>
    <DrugDBCode>628953</DrugDBCode>
    <DrugDBCodeQualifier>SCD</DrugDBCodeQualifier>
  </DrugCoded>
```

## **14. UPDATES AND CORRECTIONS TO STANDARDS**

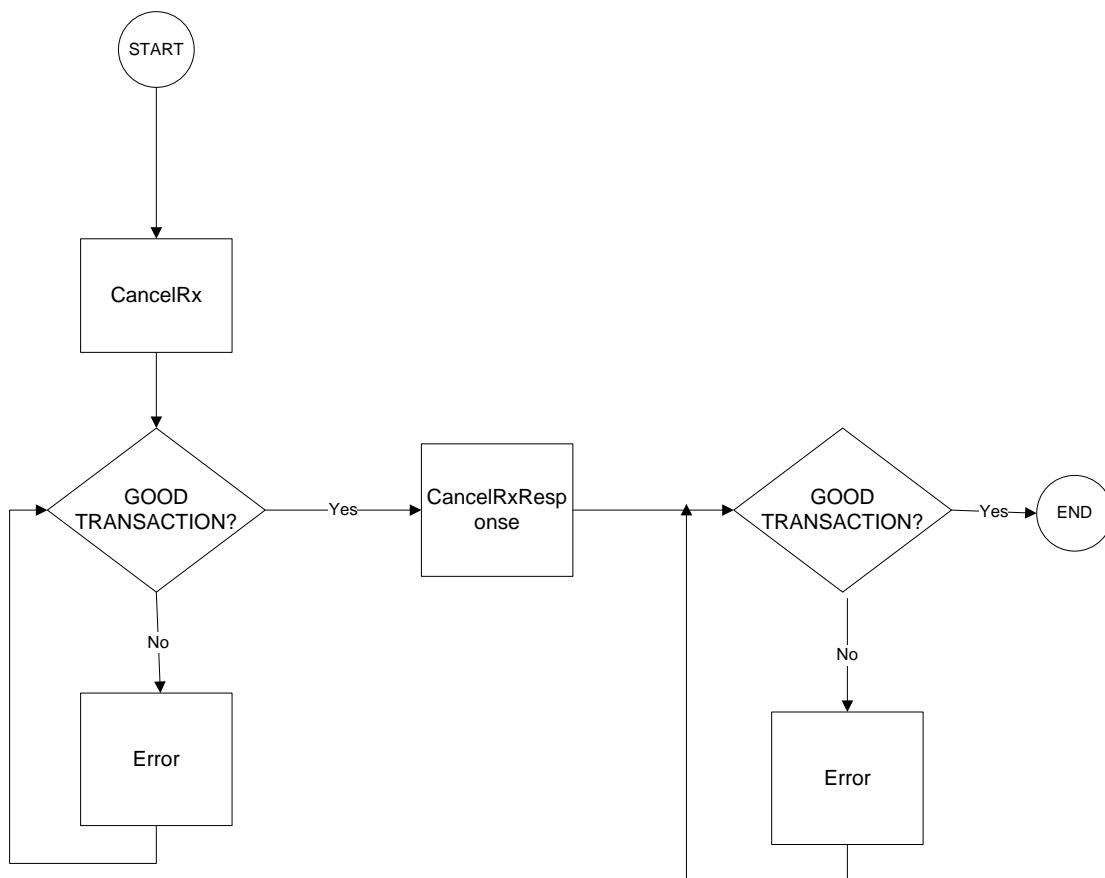
The Data Element Request Form (DERF) provides the mechanism for changing NCPDP standards and using or requesting new data elements and new code set values in business functions. To request a change in NCPDP standards, complete an NCPDP Data Element Request Form, available at [www.ncpdp.org](http://www.ncpdp.org). Appropriate NCPDP Work Groups consider information submitted on the DERF. The Data Element Request Form process makes it possible for NCPDP Work Groups to adequately address these concerns before accepting or approving new information requests into a standard. The final acceptance of new requests into the standard is made by NCPDP at the suggestion or recommendation of the Work Group, and must be approved by consensus or consensus ballot of the membership.

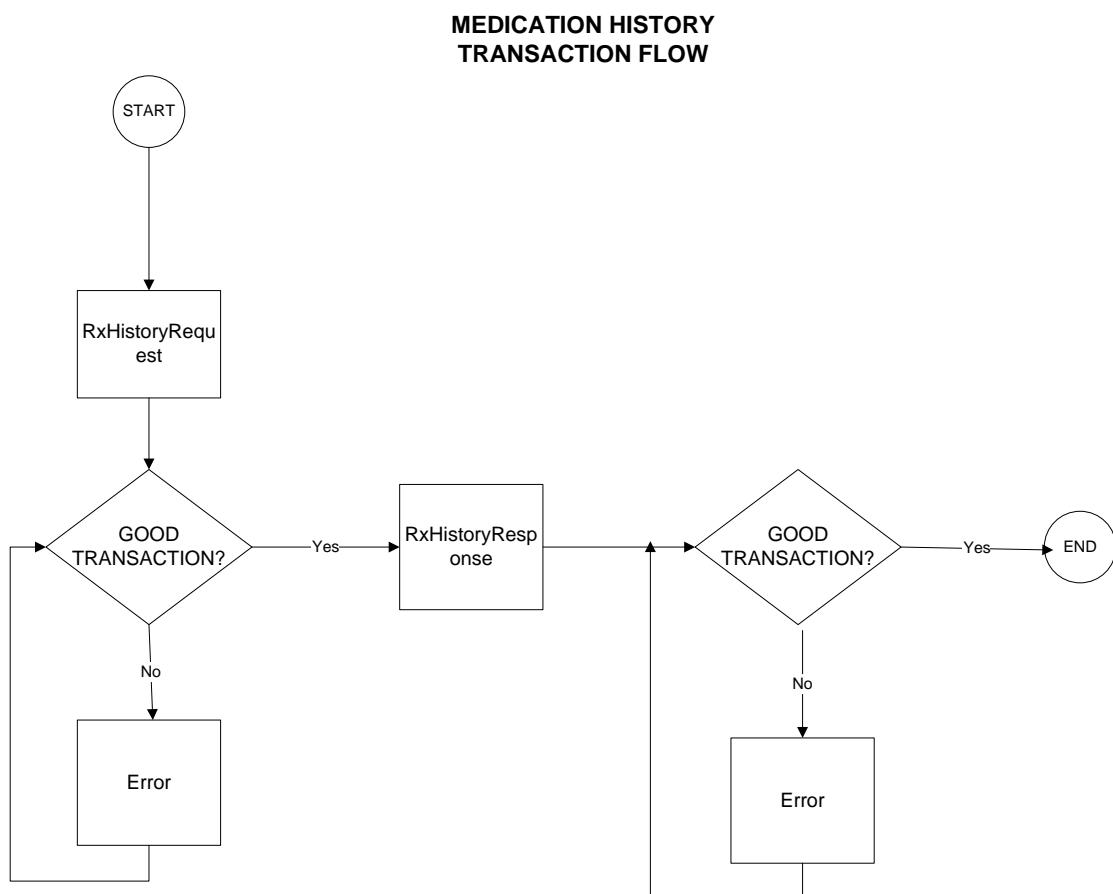
## **15. APPENDIX A. PICTORIAL TRANSACTION FLOW**



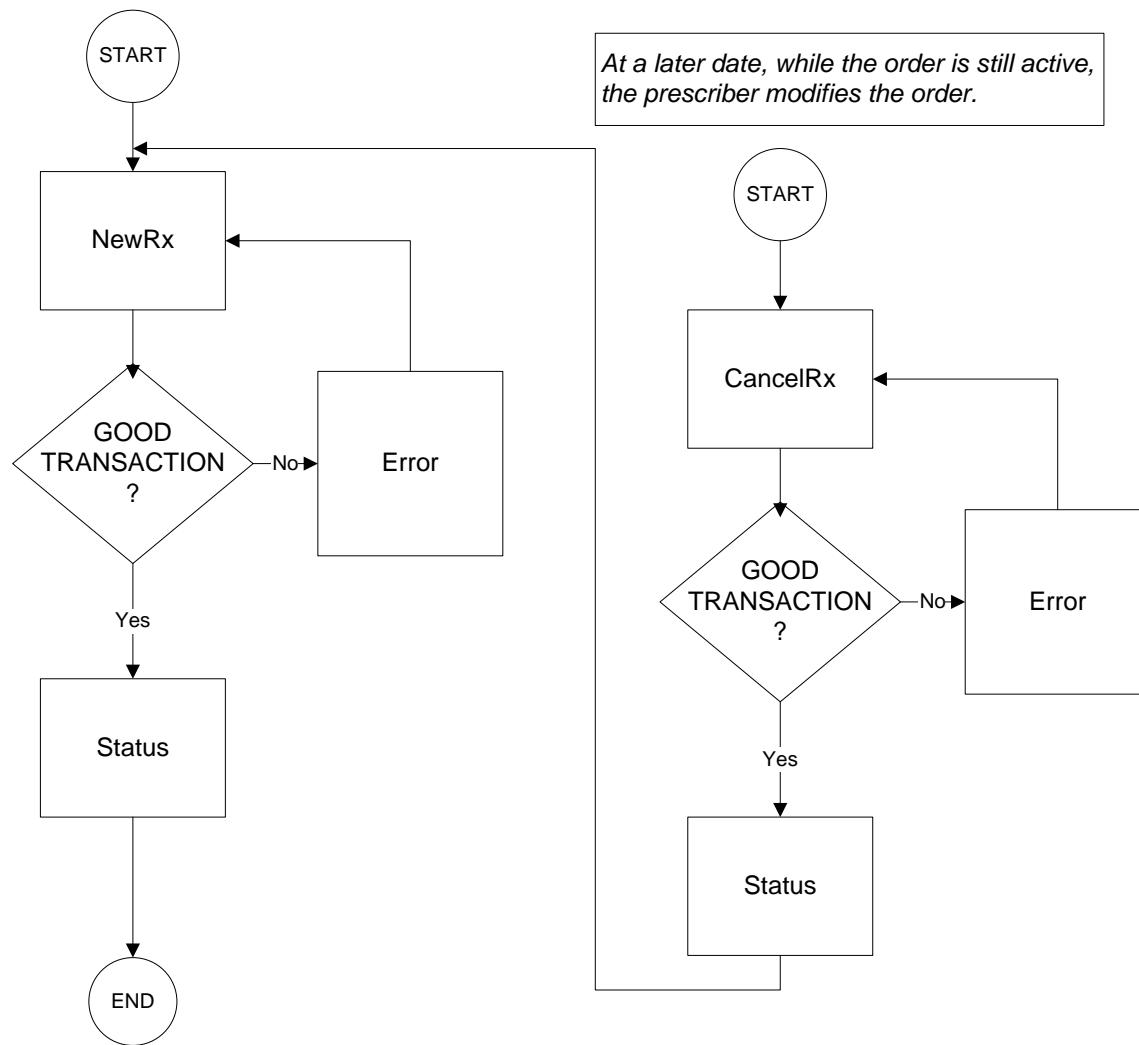


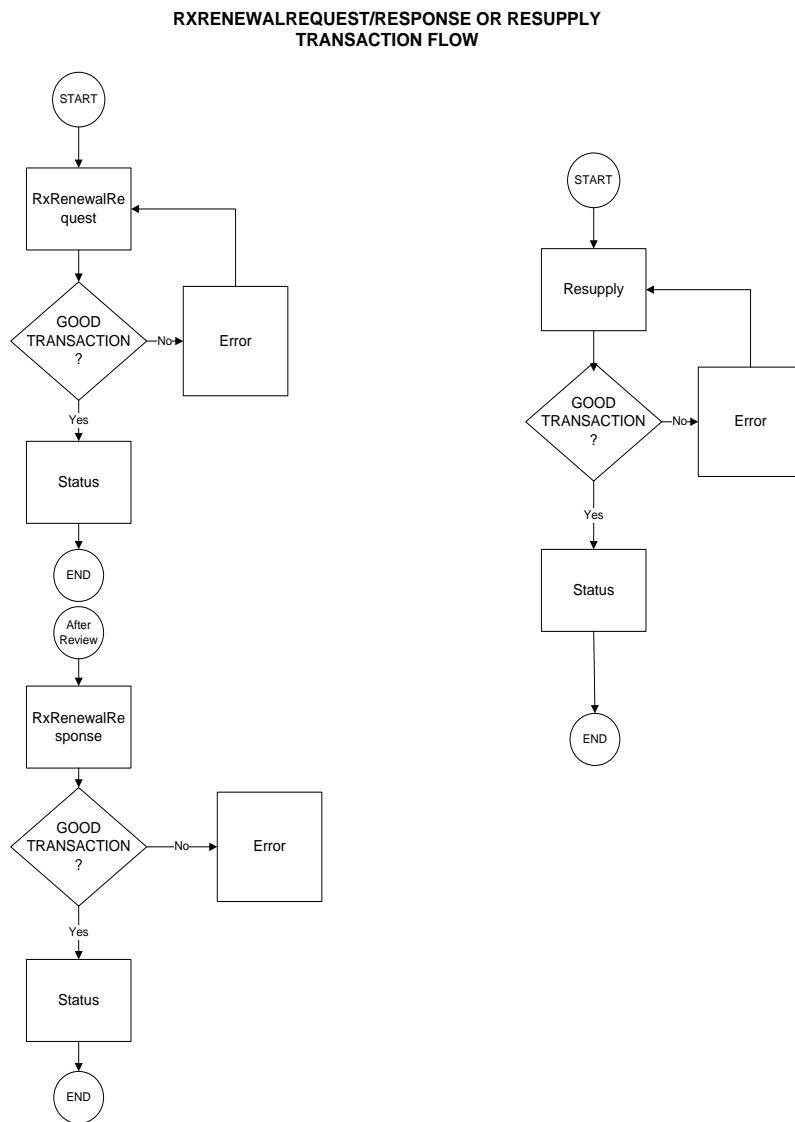
**PREScription CANCELLATION  
TRANSACTION FLOW**



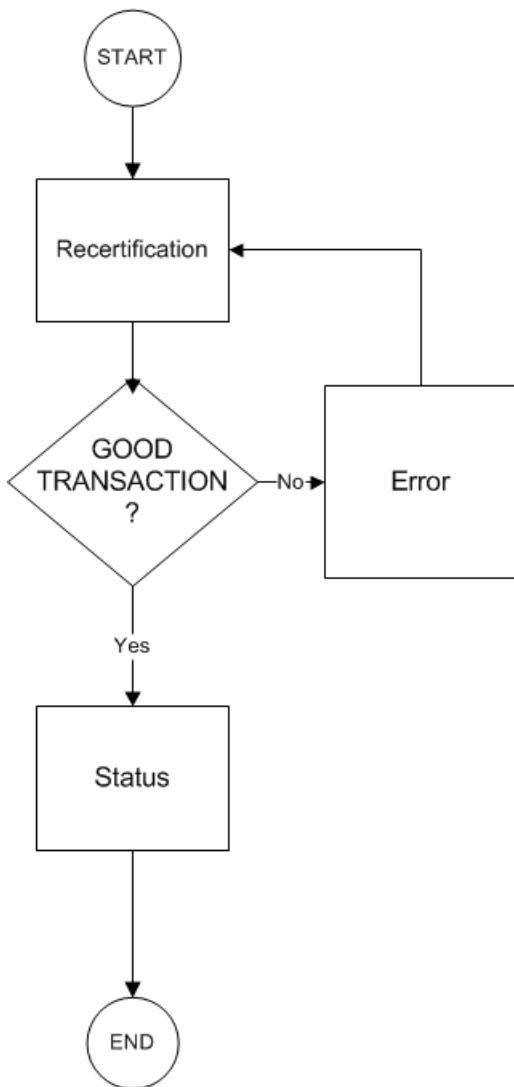


## PRESCRIBER-SYSTEM TRIGGERED CHANGE TRANSACTION FLOW

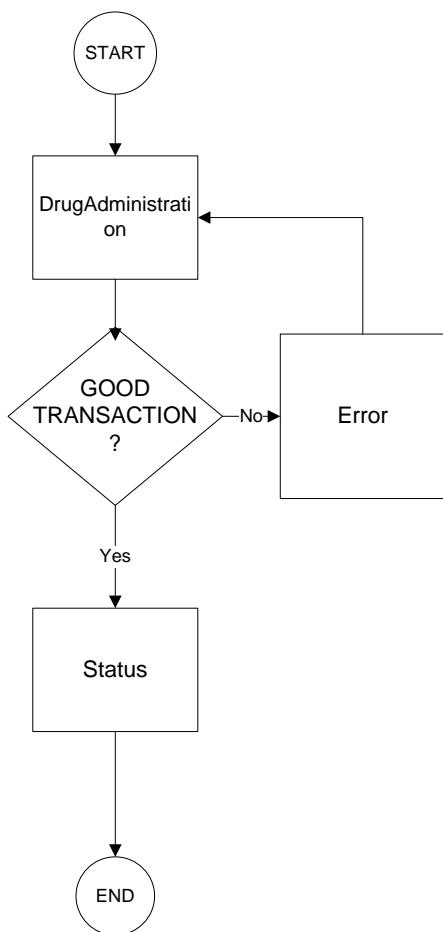




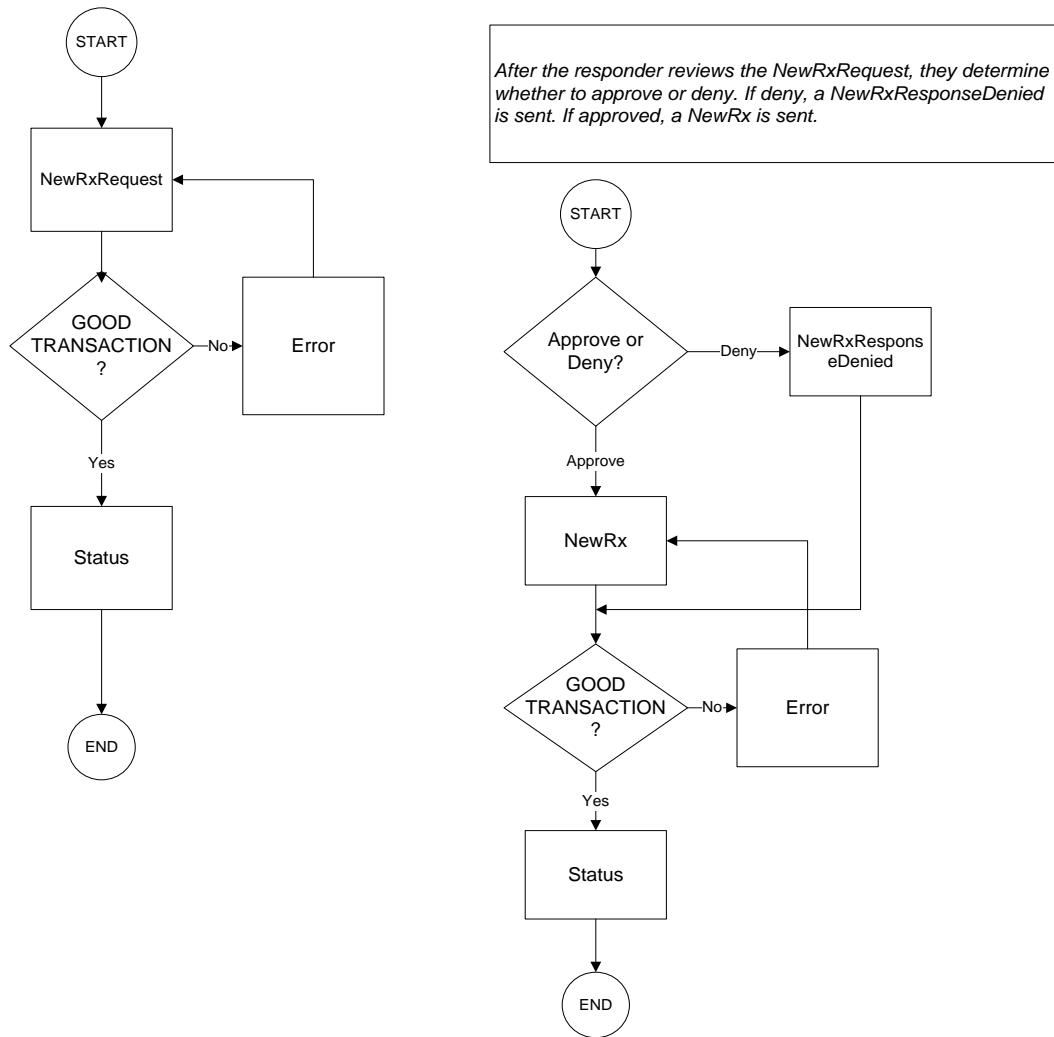
## **RECERTIFICATION TRANSACTION FLOW**

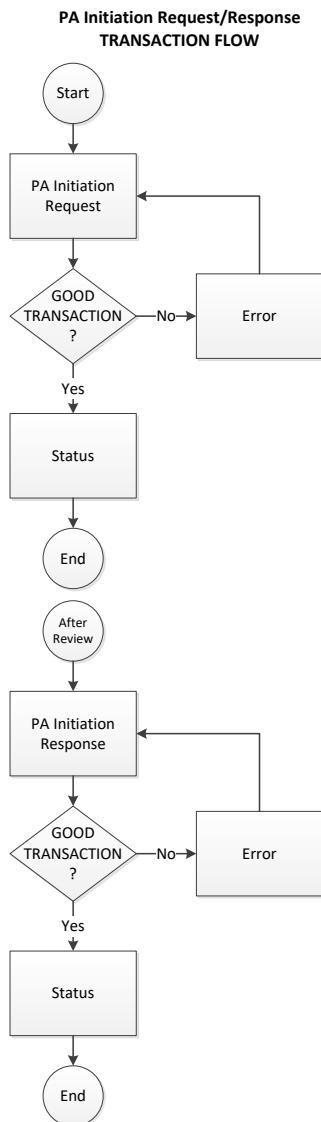


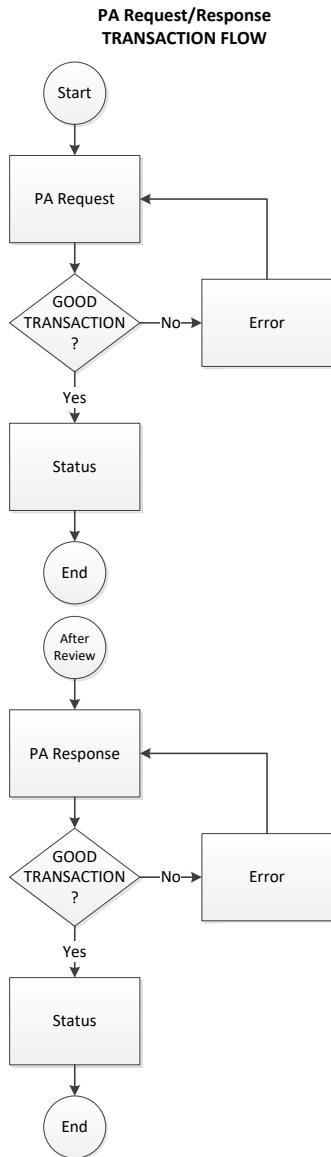
**DRUG ADMINISTRATION NOTIFICATION  
TRANSACTION FLOW**

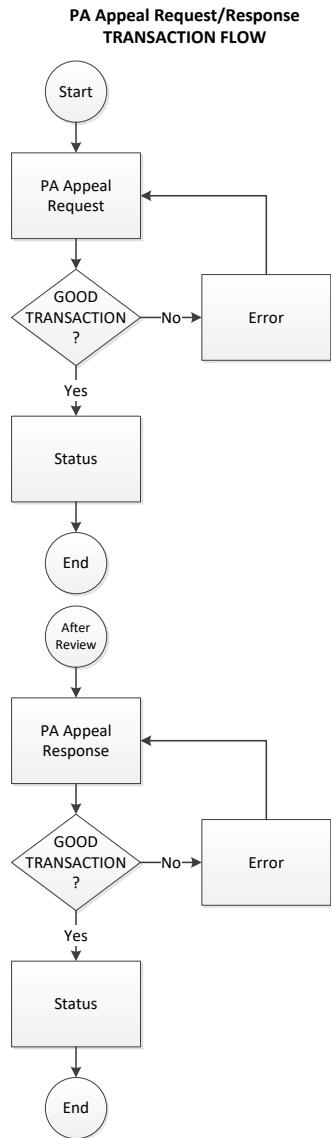


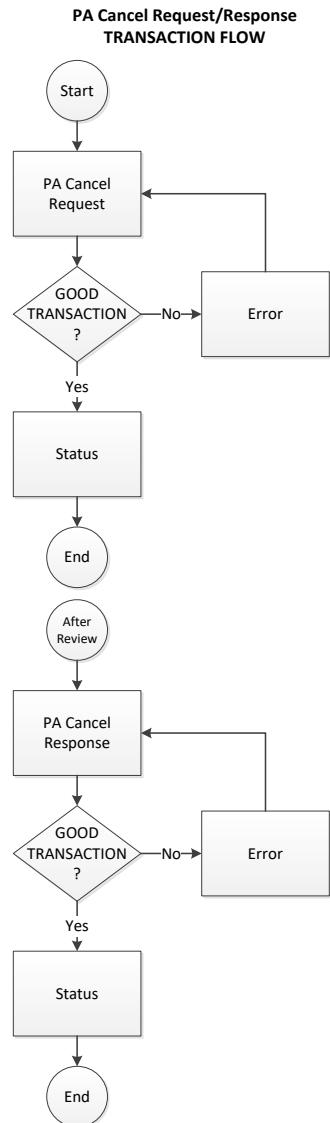
**NEWRXREQUEST/RESPONSE  
TRANSACTION FLOW**

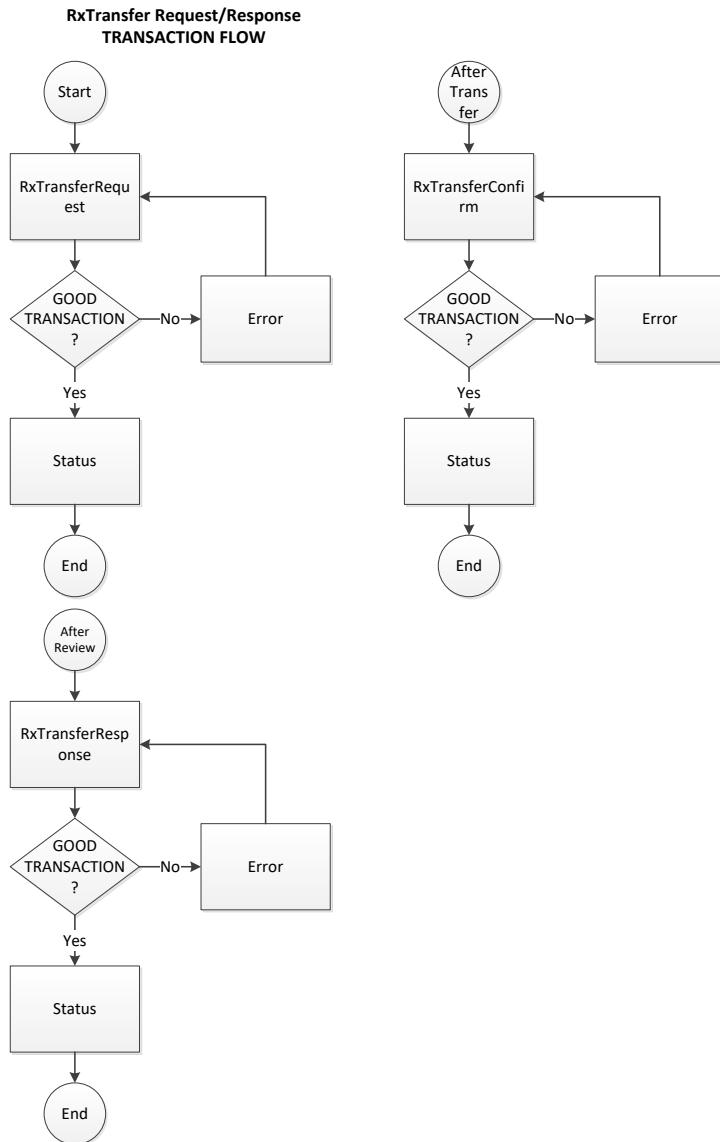












## **16. APPENDIX B. HISTORY OF IMPLEMENTATION GUIDE CHANGES**

### **16.1 VERSION 1.2**

Changes to the NCPDP **SCRIPT Standard Implementation Guide** reflective of Version 1.2 - comments for clarification or values that were italicized in the Version 1.0 Specification have been removed. The comments or values have been added to the NCPDP **SCRIPT Standard Implementation Guide**. See section "Specific Segment Discussion".

### **16.2 VERSION 1.3**

This release includes the definition of the Prescription Fill Status Notification, Cancel Prescription Request and Response transactions. It also includes additional appendix tables to list X12 and other code set values.

### **16.3 VERSION 1.4**

Appendix J. Error Codes has been added to the NCPDP **SCRIPT Standard Implementation Guide**. Appendix H Response Code Values - Codes AA, AB, AC, and AF description changed from "Provider" to "Prescriber". Example 10 Note explanation for value AC changed from "provider" to "prescriber".

### **16.4 VERSION 1.5**

"*Specific Segment Discussion*" section, "*Specific Field Discussion*" sub-section, "DRU Drug Segment". Added Multum MMDC and Multum Drug ID to Reference Number Remarks. Added value MM and MC to Reference Number Qualifier.

### **16.5 VERSION 2.0**

Version 2.0 included the change to the CommunicationNumber field in the CommunicationNumber composite in the PTT and PVD segments. The CommunicationNumber was increased from an..25 to an..80. The value of "EM" (Electronic Mail) was added to the Code List Qualifier. See below.

I016	CommunicationNumber	C	>1
01	3148 CommunicationNumber	C	an..80
02	1131 Code List Qualifier	C	an..3

Version 2.0 also included changes to the DRU segment. The segment has been increased from 3 repetitions to 10 repetitions, for specific usage. The field 7009 Item Description Identification, value of "R" (Requested) allows the multiple repetitions. The values of "P" (Prescribed) and "D" (Dispensed) are not allowed to repeat.

DRU Drug Segment			
<b>010</b>	I013	Drug	C 10
01	7009	Item Description Identification	M 1 M an..7

This change allows the pharmacy to return a list of alternative choices to a prescriber's original request. Sections "Segment Usage In Each Transaction", "Prescription Change Request Transaction", and "Specific Field Discussion" have been updated to reflect rules and application of using this change. Example 18 has been added to demonstrate this change.

## **16.6 VERSION 3.0**

In Version 3.0 the COO segment may loop up to 3 times. The field 010 1153 Reference Qualifier has been unshaded.

COO Coordination of Benefits Segment			
<b>000</b>	S019 SEGMENT TAG	M 1	C 3
01	0013 Segment code	M a3	
<b>010</b>	I001 Reference Number	C 1	
01	1154 Reference Number	M an..35	
02	1153 Reference Qualifier	C an..3	

When the COO is repeated, the first loop must contain the identification number and qualifier of the primary payer. If a second loop is used, it must contain the number and qualifier of the secondary payer. If a third loop is used, it must contain the number and qualifier of the tertiary payer.

Appendix G has been modified to include the new values of "NC", "2U", "BO", "HI", and "NF". Reject code 098 already existed to support the Reference Qualifier. Example 4 and 16 have been modified to show the usage of the reference number and qualifier in a primary situation.

## **16.7 VERSION 3.1**

Version 3.1 added the following composite and simple data element to the DRU segment. Section "Specific Field Discussion" lists the new fields, values, and comments. The section "Segment Usage In Each Transaction" includes clarification of these new fields.

<b>100</b>	S018 Drug Use Evaluation	C 5
01	7880 DUE Reason For Service Code	M an2
02	7881 DUE Professional Service Code	C an2
03	7882 DUE Result Of Service Code	C an2
04	7883 DUE Co-Agent ID	C an..19
05	7884 DUE Co-Agent ID Qualifier	C an2
<b>110</b>	7885 Drug Coverage Status Code	C 5 an2

In addition Version 3.1 also added the following values to Drug Dosage Form in Appendix D.

Aerosol	
Aerosol with adapter	Ring
Bar	Shampoo
Capsule, extended release	Sponge
Concentrate	Spray
Cream	Suppository(ies)
Cream with applicator	Suspension
Crystal	Suspension, extended release
Enteric coated capsule	Tablet, chewable
	Tablet, coated particles
Film	Tablet, disintegrating
Film, extended release	Tablet, effervescent
Foam	Tablet, extended release
Foam with applicator	Tampon
Gel	Tape
Gel forming solution	Test
Gel with applicator	Tincture
Granule for reconstitution	Wafer
Granule, effervescent	Capsule, sprinkle
Granule, extended release	Flakes
Gum	Tar
Implant	Wax
Insert	Lollipop
Kit	Pellet
Lotion	Spirit
Oil	Leaves
Ointment	Troche
Ointment w/applicator	Lozenge
Pad	
Paste	
Powder	
Powder for injection	
Powder for reconstitution	

Appendix D. Dosage Form Code currently supports value 30 = Lozenge or Troche. The value 159 = Troche and the value 129 = Lozenge will be added.

Version 3.1 added the following values to Unit of Measure in Appendix E.

Applicatorful	Puff(s)
Dose(s)	Scoop(s)
Gum	Spray(s)
Inhalation(s)	Thin layer

Reject Codes of 211-216 were added to Appendix J.

## **16.8 VERSION 4.0**

Version 4.0 introduces a new value of “00” (Not Specified) to Appendix E Unit or Basis for Measurement Code in the NCPDP **SCRIPT Standard Implementation Guide**. An implementation of this value might be used with a drug that has a dose quantity and a clinical route of administration, but no unit of measurement for dispensing quantity. An example might be “1 injection”.

Version 4.0 also corrects the 6060 Quantity fields. The field was originally defined as n..15. According to the UN/EDIFACT dictionary, the field should be an..35. This change is reflected in any 6060 Quantity fields.

The value of “PH” (Pack) has been added to Appendix E Unit or Basis for Measurement Code in the NCPDP **SCRIPT Standard Implementation Guide** for Quantity Qualifier.

New values and a comment have been added to the Quantity Qualifier field 6063 (060-01-6063) in the DRU segment.

D = Refill for n Day(s)

W = Refill for n Week(s)

M = Refill for n Month(s)

Y = Refill for n Year(s)

where n = Number of Refills Quantity.

Note: it is not possible to encode “6 months refills requested by pharmacy.” If a value for a time period is used, it should be interpreted as the total amount of time for which the prescription should be refilled. For example, if the prescription is for 30 days supply, and the refills are specified for 6 months, the original prescription and 5 refills (total 6 months) should be inferred.

In the DRU segment only, field 6314 Measurement Value (010-06-6314) has been replaced with 010-06-4440 Free Text. It was determined that the numeric 18 (n..18) field size was not long enough to support multiple ingredient medications and for strengths per liquid measure. The Free Text field is an..70 and will be defined as the Measurement Value. The new field occurs in the same position of the composite, 010-06.

Appendix D1 has been added to show Appendix D values sorted by Description.

Appendix E1 has been added to show Appendix E values sorted by Description. Appendix F1 has been added to show Appendix F values sorted by Description.

Appendix G1 has been added to show Appendix G values sorted by Description.

In Appendix D and D1, the values of 89 (External powder), 109 (Enteric coated capsule), and 145 (Suspension) were found to be duplicates and these values have been changed to “Not Used”. The values will be available for reuse in the future.

The question “How is the value of “PH” (Pack) for Quantity Qualifier (Appendix E Unit or Basis for Measurement Code) used?” has been added to the “Frequently Asked Questions (FAQ's)” section.

## **16.9 VERSION 4.1**

Version 4.1 added additional values to section “*Appendix D Dosage Form Code*”. The new values are

- |     |                     |
|-----|---------------------|
| 160 | Aerosol Solution    |
| 161 | Extract             |
| 162 | Nebulize Solution   |
| 163 | Powder Effervescent |
| 164 | Strip               |

## **16.10 VERSION 4.2**

Version 4.2 changes the field identification of Time Offset from “xxxx” to 0336. The field is shaded, therefore not supported. Time Offset occurs In the UIB and UIH segments.

Version 4.2 also modifies qualifiers in the DRU segment to clarify definitions used.

Reference Qualifier (010-09-1153)

New Value Definition:

- |    |   |
|----|---|
| E  | Micromedex/Medical Economics Generic Formulation Code (GFC)       |
| G  | Micromedex/Medical Economics Generic Master (GM)                  |
| MD | First DataBank Drug Descriptor Identifier (DDID)                  |
| MG | First DataBank MDDB Product Line Generic Product Identifier (GPI) |

With note: MDDB is not an acronym.

Code List Qualifier (070-03-1131)

New Value Definition:

- |   |                                  |
|---|----------------------------------|
| E | Micromedex/Medical Economics     |
| M | First DataBank MDDB Product Line |

With note: MDDB is not an acronym.

## **16.11 VERSION 4.3**

Version 4.3 adds the value “AM” (Patient needs appointment.) to section “*Appendix H Response Code Values*”.

The DRU Quantity fields (020-02-6060 and 060-02-6060) have been given a reference note to “See sections “*Representation*” and “*Truncation*” for syntax and decimal usage.”

## **16.12 VERSION 4.4**

Version 4.4 supports the use of lower case alphanumeric data representation (upper case already supported). Lower case was added to section “*Syntax Rules*”, subsection “*Representation*”, to the subsection “*Character Set*”.

Section “*Field Implementation Usage*”, subsection “*Specific Field Discussion*”, subsection “*RES Response Segment*”:

- 010-4343, Response Type, coded has a new value “N” (Denied, new prescription to follow) for the Refill Response only.
- Clarification has been added to define which data elements may be modified within the

scope of existing value “A” (Approved) and “C” (Approved with changes) in a new subsection “Clarification of “Approved”, “Approved with changes” and “Denied””.

Version 4.4 clarifies in section “*Specific Segment Discussion*”, subsection “*Specific Field Discussion*”, subsection “DRU Drug Segment” the usage of DRU 060-02-6060 Quantity (refill quantity) by clarifying the definition of its qualifier field, 060-01-6063 Quantity Qualifier (values “R” (Number of Refills), “A” (Additional Refills Authorized), and “P” (Pharmacy Requested Refills)).

Section “*COO Segment Usage*” has been moved to section “*Specific Segment Discussion*”, subsection “*Specific Field Discussion*”, subsection “COO Coordination of Benefits Segment”.

Section “*DRU Segment Usage*” has been moved to section “*Specific Segment Discussion*”, subsection “*Specific Field Discussion*”, subsection “DRU Drug Segment”.

Example 8 has been modified to “*Example 8. Pharmacy Requesting a Refill Authorization for an Unspecified Number of Dispensings from a Prescriber and Prescriber Responding*”.

“*Example 19. Pharmacy Requesting a Refill Authorization for a specified number of dispensings from a Prescriber and Prescriber Responding (no mailboxing)*” has been added.

Minor editorial changes were made to clean up extra spaces in sentences or the use of “that” instead of “which”.

## **16.13 VERSION 5.0**

Version 5.0 supports a new value added to Appendix H. Response Code Values RES segment 020 Code List Qualifier – “AN” (Prescriber not associated with this practice or location.) for use in a Refill Response transaction.

To properly display the full drug name, strength and form when the existing 35 characters are not sufficient, three Item Description fields are added. Specific guidance is given in the NCPDP **SCRIPT Standard Implementation Guide** for using the 02 Item Description, and the 10-12 Item Description fields.

010	I013	Drug	M	1
01	7009	Item Description Identification	M	an..7
02	7008	Item Description	M	an..35
03	7140	Item Number	C	an..35
04	3055	Code List Responsibility Agency	C	an..3
05	1131	Code List Qualifier	C	an..3
06	4440	Free Text	C	an..70
07	1131	Code List Qualifier	C	an..3
08	1154	Reference Number	C	an..35
09	1153	Reference Qualifier	C	an..3
10	<b>7008</b>	<b>Item Description</b>	<b>C</b>	<b>an..35</b>
11	<b>7008</b>	<b>Item Description</b>	<b>C</b>	<b>an..35</b>
12	<b>7008</b>	<b>Item Description</b>	<b>C</b>	<b>an..35</b>

In the STS Segment, field 010 Status Type, coded, a new value was added of 010 (Successful – accepted by ultimate receiver). The subsection “STS Segment Notes” was added.

Data Element 235 - Product/Service ID Qualifier:

Value of “ID” changed to “DX” = “International Classification of Diseases-9- Clinical Modifications-Diagnosis”

Value of “ABF” = International Classification of Diseases-10- Clinical Modifications” added.

Removed specific reference to “ASC X12N version 3060” in the NCPDP **SCRIPT Standard Implementation Guide**.

Appendices C through J were removed from the NCPDP **SCRIPT Standard Implementation Guide** and any listed values in the section “*Specific Segment Discussion*” for fields that were deemed appropriate for the ECL were moved to the External Code List (ECL).

The *SCRIPT Standard Specification* and *SCRIPT Standard Implementation Guide* were combined into this one document.

In “*Example 6. Prescription Change Transaction (Via Mailbox)*” a typographical error was corrected. The REQ+G+’ string incorrectly listed the last +. The string has been corrected to “REQ+G’.

In “*Example 13. Prescription Change Transaction For Therapeutic Intervention (Via Direct Connect)*” a typographical error was corrected. The REQ+T+’ string incorrectly listed the last +. The string has been corrected to “REQ+T’.

In the following examples, a typographical error was corrected. The PVD string “PVD+PC+6666666:OB....” for example, contained 0B instead of 0B”.

“*Example 6. Prescription Change Transaction (Via Mailbox)*”

“*Example 7. Prescription Request (Via Direct Connect)*”

“*Example 9. Refill Prescription Transaction With Return Receipt Requested*”

“*Example 13. Prescription Change Transaction For Therapeutic Intervention (Via Direct Connect)*”

“*Example 14. Inform Prescriber A Prescription Has Been Filled (Via Direct Connect)*”

“*Example 16. Notify Prescriber A Prescription Has Been Partially Filled (Via Direct Connect)*”

“*Example 18. Pharmacy Requests Alternative Drug To Prescribed*”.

## **16.14 VERSION 6.0**

This version added the ability to request a Prior Authorization utilizing the RXCHG message.

In the REQ Segment, to the field 010-4343 Message Function, coded a value of “P” (Prior Authorization required) was added. A new value was added to Response Code Values RES segment 020 Code List Qualifier – “AO” (No attempt will be made to obtain Prior Authorization).

“*Example 20. Prescription Change Request From Pharmacy For Prior Authorization (Excerpt)*” was added.

In section “Prescription Change Request Transaction”, the opening paragraph was modified to support “fillable” prescriptions and prior authorizations by rewording to “The prescription change request transaction is originated by the pharmacy. This transaction is used to request a change of a new prescription or a “fillable” prescription. This request may be used when the pharmacy needs a change to the prescription. This change might be requesting a switch from brand to generic, or based on the pharmacy's participation in formulary programs, or due to a therapeutic intervention. It may also be utilized to request a Prior Authorization on a prescription. The REQ segment, Message Function field (010 4343), is used to differentiate between Generic Substitution or Therapeutic Interchange or Prior Authorization.”

Subsection “Discussion of Prior Authorization” was added. In section “Specific Segment Discussion”, subsection “Specific Field Discussion”, subsection “RES Response Segment” the note “C = Approved with changes cannot be utilized for a prior authorization RXCHG” was added to 010-4343 Response Type, Coded.

In section “Prescription Change Response Transaction”, the opening paragraph was modified to support “fillable” prescriptions and prior authorizations by rewording to “The prescription change response transaction is originated by the prescriber. It is in response to the pharmacy requesting changes to a prescription, via the prescription change request transaction. The prescription change response transaction is used to either approve, approve with change or to decline the requested change in the prescription change request or prior authorization request. The response may or may not be sent with additional comments in the text field.”

In section “Business Functions”, subsection “Introduction”, Prescription Change Request Transaction was modified to “Sends a request from a pharmacy to a prescriber asking for a change in a new prescription or a “fillable” prescription. It may also be utilized to request a Prior Authorization on a prescription.” Prescription Change Response Transaction was modified to “Response from a prescriber to a pharmacy for a prescription change. It may also be used to send a response to a request for a Prior Authorization back to the pharmacy.”

In section “Transactions”, subsection “Get Message Transaction”, a prescription change request message was modified to “A prescription change request indicates the desire on the part of the pharmacy to alter or clarify a new prescription or an existing “fillable” prescription. The pharmacy may request a substitution, alert of a therapeutic or DUR interchange, which may require the change of a new prescription recently processed. It may also be utilized to request a Prior Authorization on a prescription.”

Section “Structure Quick Reference”, subsection “Prescription Change Request” modified the opening paragraph to “This transaction is sent from a pharmacy to a prescriber to request a change on a new prescription, for example, to request generic substitution. It may request a change on a “fillable” prescription. It may also be utilized to request a prior authorization on a prescription.”

In this same section, subsection "*Prescription Change Response*" modified the opening paragraph to "This transaction is sent from the prescriber to the pharmacy in response to a request for a change of a new prescription or a "fillable" prescription. It may also be sent from the prescriber to the pharmacy in response to a request for a prior authorization on a prescription."

*"Example 21. Prescription Change Request From Pharmacy For An Existing "Fillable" Prescription (Excerpt)" was added.*

Based on comments made on the re-circulation ballot, clarification was made to the prior authorization statements. The document originally said: "It may also be utilized to request a Prior Authorization on a prescription." The request from the pharmacy to the prescriber is not for a Prior Authorization (PA), it is for the prescriber to request a prior authorization. This statement was changed to "It may also be utilized to request a prescriber to review the drug requested, and obtain a Prior Authorization from the payer for the prescription." The following sections were clarified:

*"Business Functions", subsection "Introduction"*  
*"Transactions", subsection "Get Message Transaction"*  
*"Transactions, subsection "Prescription Change Request Transaction"*  
*"Structure Quick Reference", subsection "Segment Usage In Each Transaction", subsection "Prescription Change Request (RXCHG)"*

## **16.15 VERSION 7.0**

The Provider Segment was modified from 2 to 3 loops in section "*Transmission from Sender to Receiver Structure*", "*Segment Layouts*", "*Provider Segment*".

In the following sub-sections to "*Structure Quick Reference*", a note was added to the PVD Segment for "One loop may be needed to relay the supervisor."

*"New Prescription Request (NEWRX)",  
"Refill Request (REFREQ)",  
"Refill Response (REFRES)",  
"Prescription Change Request (RXCHG)",  
"Prescription Change Response (CHGRES)",  
"Prescription Fill Status Notification (RXFILL)",  
"Cancel Prescription Request (CANRX)"*

PVD	Provider Segment	Y	One loop required for the prescriber. One loop may be needed to relay the supervisor.
-----	------------------	---	---

Section "*Specific Segment Discussion*", subsection "*Specific Field Discussion*", "*PVD Provider Segment*", was modified to support three loops of the PVD. The third loop supports the use of the supervisor. The opening note was changed to "*This segment may occur three times. One occurrence is prescriber and one is pharmacist and one occurrence may be the supervisor. Supervisor information may be needed based upon state law. A supervisor is the supervising physician under whose authority the prescription is being prescribed by the primary care provider.*"

The following fields "Remarks" were modified to support the reporting of the supervisor.

020-I001-02-1153	Reference Qualifier
050-I002	Name
050- I002-01-3036	Party Name

The following fields “Remarks” were modified from “authorizing prescriber agent” to “designated agent”, with further guidance.

100-I002	Name
100-I002-01-3036	Party Name

A subsection *PVD Segment Notes* was added to show examples of reporting prescriber, supervising physician, and designated agent.

## **16.16 VERSION 7.1**

Section “*Specific Segment Discussion*”, subsection “*Specific Field Discussion*”, “*RES Response Segment*”, field Response Type, Coded (010-4343) had the following note added:

Note: A “Denied” (D or N) response **must** be accompanied by the Code List Qualifier (020-1131) **or** Free Text (040-4440) explanation, **or both**.

A new FAQ was added, “*What do each of these code qualifiers really mean in the DRU-020-03 (do 38 and 87 mean the same thing)?*”

In section “*Specific Segment Discussion*”, subsection “*Specific Field Discussion*”, any supported field (non-gray) in the standard was included in the charts for each segment. The fields added include:

STS Segment  
030-4440 Free Text

PVD Segment  
050-I002-02-3702 First Name  
050-I002-03-3704 Middle Name  
050-I002-04-3706 Name Suffix  
050-I002-06-3708 Name Prefix  
080-I004 Address  
080-I004-01-3042 Street and Number/P.O. Box  
080-I004-02-3164 City Name  
100-I002-02-3702 First Name  
100-I002-03-3704 Middle Name  
100-I002-04-3706 Name Suffix  
100-I002-05-3708 Name Prefix

PTT Segment  
030-I002-02-3702 First Name  
030-I002-03-3704 Middle Name  
030-I002-04-3706 Name Suffix  
030-I002-05-3708 Name Prefix

DRU Segment

040-I006-02-2380 Date/Time/Period

070-I015-04-6813 Clinical Information – secondary

090-4440 Free Text

OBS Segment

010-S017-02-6314 Measurement Value

010-S017-04-2380 Date/Time/Period

020-4440 Free Text

## **16.17 VERSION 8.0**

A new Response Type, coded (Response Segment 020-1131) was added to the External Code List of “AP” of “Request already responded to by other means (e.g. phone or fax)”. This is for situations where a prescriber system will respond to a REFREQ or RXCHG by a means other than a REFRES or CHGRES (e.g., by telephone or by issuing a new prescription). To clear the prescriber’s queue and to complete the loop with the requesting pharmacy, a reject response is transmitted.

Section “*Specific Segment Discussion*” was modified to provide implementation references to the supported transactions. For each segment, columns have been added for the transactions that use the segment. Values of Mandatory, Conditional, Conditional Mandatory, and Not Used occur according to the standard format. Section “*PVD Segment As The Prescriber, Supervisor*” and “*PVD Segment As The Pharmacy*” were added to differentiate between the usages of the segment. Further differentiation may be made in the future.

The Medication History request and response transactions were added to the format. Updated sections to include medication history transaction information include

“Introduction”

“Background”

“Business Operations”

“Figure 1. Connection of SCRIPT Exchange Parties” was updated

“Participants”

“Identifiers”

“Business Functions”

“Transaction Types”

“STATUS”

“ERROR”

“Transactions”, “Medication History Request and Response Transaction” was added

“Transmission From Sender To Receiver Structure”

“Structure Quick Reference”

“Specific Segment Discussion”

A new example was added to “Transmission Examples”, “Prescriber Requests Medication History”.

In the UIB Segment,

Interchange Sender - Sender identification - level one (060-01-0004) supports a Mutually

Defined identifier, with Level one identification code qualifier (060-02-0007) supporting a new qualifier of “ZZZ” (Mutually Defined).

Interchange Recipient - Recipient ID - level one (070-01-0010) supports a Mutually Defined identifier, with Level one identification code qualifier (070-02-0007) supporting a new qualifier of “ZZZ” (Mutually Defined).

In the UIH Segment,

Message function (010-04-0326) supports the values of “RXHREQ” and “RXHRES”.

In the PVD Segment, section “*PVD Segment As The Prescriber, Supervisor*”, notes were added in the first row to provide guidance for the use of this segment in Medication History.

In the PVD Segment, section “*PVD Segment As The Pharmacy*”, the column RXHREQ was added. Notes were added in the first row to provide guidance for the use of this segment in Medication History.

In the RES Segment,

A new Response Type, coded (Response Segment 020-1131) was added to the External Code List of “AQ” of “More Medication History Available”.

In the COO Segment, the fields

Date (090-1006)

Condition/Response, coded (130-4711) are available for use (no longer grayed).

Condition/Response, coded (130-4711) contains the Patient Consent Indicator. Values will be added to the External Code List (ECL).

Y	Patient gave consent for prescriber to receive the medication history from any prescriber.
N	Patient consent not given.
P	Patient gave consent for prescriber to only receive the medication history this prescriber prescribed.
X	Parental/Guardian consent on behalf of a minor for prescriber to receive the medication history from any prescriber.
Z	Parental/Guardian consent on behalf of a minor for prescriber to only receive the medication history this prescriber prescribed.

Note: If Patient Consent = N, it is expected the Medication History transactions would not be sent.

The new field of

Patient Identifier (140-7886) was added with the definition of “Payer assigned Unique Member ID”.

In the DRU Segment,

Date/Time/Period (040-02-2380) supports a date usage note “For Medication History Response (RXHRES): If the entity has fill history, Last Fill Date must be used. If the entity

has prescribing data, date authorized (Date Written) must be used.”

In the STS Segment,

Code List Qualifier (020-1131) reject code values were added for the Medication History transactions, the new field Patient Identifier and the fields that became available.

In section “*Specific Segment Discussion*”, the subheadings were renamed to the actual segment names.

A typographical error was found and corrected in this guide and the *External Code List* for 040-01-2005 Date/Time Period Qualifier Qualification of Date/Time field 2380 X12 DE 423. The correct X12 DE assignation is 432.

Section “*Structure Quick Reference*”, subsection “*Medication History Response (RXHRES)*” contained a typographical error in the DRU loop. The original verbiage stated that “*Drug Loop – Loops through up to 300 times. Each loop may have 1 corresponding PVD Segment.*” This has been corrected to “*Drug Loop – Loops through up to 300 times. Each loop may have 2 corresponding PVD Segments.*”

An error was corrected in “*Example 17. Cancel A Prescription Previously Sent To The Pharmacy*”, which has been present since the first publication. In this example, the CANRES contains segments which are not present in the response (PWD, PTT, DRU). These have been removed.

## **16.18 VERSION 8.1**

The implementation guide provides more clarification on the use of the Fill Status Notification transactions. Clarifications include the use of the term dispensed/not dispensed/partially dispensed instead of the term filled/not filled/partially filled. The transaction did not change, just the wording of the intent, since these transactions were always intended to be at the dispensing action, not the filling action, but the original wording had been retained. The following sections were updated:

“*Business Operations*”

“*Introduction*”

“*Transaction Types*”

“*Prescription Fill Status Notification Transaction*” with new sections for “*Definitions*”, “*Assumptions*”, and “*General Requirements*”

“*Prescription Fill Status Notification Transaction – Dispensed*” with new section for “*General Requirements*”

“*Prescription Fill Status Notification Transaction – Not Dispensed*” with new section for “*General Requirements*”

“*Prescription Fill Status Notification Transaction – Partially Dispensed*” with new section for “*General Requirements*”

“*Prescription Fill Status Notification (RXFILL)*”

“*Transaction Examples*”

“*Example 14. Notify Prescriber A Prescription Has Been Dispensed (Via Direct Connect)*”

“*Example 15. Notify Prescriber A Prescription Has Not Been Dispensed And Will Be*

*Returned To Stock (Via Mailbox)"*

*"Example 16. Notify Prescriber A Prescription Has Been Partially Dispensed (Via Direct Connect"*

*"Frequently Asked Question", "What Is The Functionally Of SCRIPT?"*

Based on review by a task group and then the work group, section “*Specific Segment Discussion*” was modified to cite, for each transaction applicable to that segment, the specific field usage of mandatory, conditional mandatory, conditional, or not used. Where the specific field usage is different than the standard format, the item is cited in bold italics. This is to provide more guidance for implementation. As a note, in the DRU Segment, Quantity (060-02-6060) is Conditional Mandatory (CM) with a note “Note: This field is mandatory except when DRU 060-01-6063 Quantity Qualifier = PRN. No quantity is required for PRN.”

## **16.19 VERSION 9.0**

The values of “D”, “W”, “M”, and “Y” and the comments pertaining to the time period have been removed from DRU-060-01-6063 Quantity Qualifier because the values are for different purposes - units (PRN, M, D, etc.) versus purpose (R, P, A) that could cause a conflict that would prevent the possibility of using multiple loops of DRU-060.

## **16.20 VERSION 10.0**

In the OBS Segment, level 06-7887 Measurement Data Qualifier was added.

<b>010</b>	<b>S017 OBSERVATION</b>	<b>C 10</b>
01	6311 Measurement Dimension, coded	M an..3
02	6314 Measurement Value	M n..18
03	6411 Measurement Unit qualifier	M an..3
04	2380 Date/Time/Period	C an..35
05	2379 Date/Time/Period Format Qualifier	C an..3
<b>06</b>	<b>7887 Measurement Data Qualifier</b>	<b>C an..3</b>

Values are contained in the External Code List are

Value	Definition	Comment
“1”	X12 Data Element Measurement Dimension, coded (DE 738)	
“2”	SNOMED	Systematized Nomenclature of Medicine-- Clinical Terms (SNOMED) is available at <a href="http://www.nlm.nih.gov/research/umls/">http://www.nlm.nih.gov/research/umls/</a> or <a href="http://www.snomed.org">www.snomed.org</a>
“3”	LOINC	Logical Observation Identifiers Names and Codes (LOINC®) is available at <a href="http://www.regenstrief.org/loinc/">http://www.regenstrief.org/loinc/</a>
“4”	Other	

To support the above change, Measurement Dimension, coded 010-01-6311 no longer contains the note “X12 DE 738” as it is now a value for 06-7887 Measurement Data Qualifier.

**Needs were brought forward for long-term care.**

## ***SCRIPT Standard Implementation Guide***

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In the Patient Segment, PTT-050-02-1153 Reference Qualifier, additional patient identifier qualifier values were added from ASC X12 Data Element 128, Values are contained in the External Code List are

Value	Definition	Comment
"EA"	Medical Record Identification Number (EHR)	A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records
"1J"	Facility ID Number (ID number assigned by the LTC Facility to the patient)	
"EJ"	Patient Account Number (ID assigned by the CPOE system)	A unique number assigned to each patient by the provider of service to facilitate retrieval of individual case records tracking of claims submitted to a payer and posting of payment

In the Drug Segment, DRU-040-01-2005 Date/Time Period Qualifier, additional values were added. Values are contained in the External Code List are

Value	Definition	Comment
"35"	Delivered on This Date (Date prescription received at facility)	
"BE"	Validated (Date reviewed at facility)	The date when material obligations were verified

DRU-040 repetitions were increased from 5 to 9 to accommodate more date qualifiers.

A qualifier value was added to Date/Time/Period Format Qualifier (data element 2379) in the External Code List.

Value	Definition	Comment
"203"	CCYYMMDDHHMM	Calendar date including time with minutes: C=Century; Y=Year; M=Month; D=Day; H=Hour; M=Minutes.

In a facility, there is a need to identify a specific unit room and bed for medication delivery.  
Fields to be added to Patient Segment.

PTT 080S020 Location

C 1

01	7888 Facility Unit	C	an..35
02	7889 Room	C	an..10
03	7890 Bed	C	an..10

Fields to be added to the Drug Segment.

DRU 120-7891 Prior Authorization Status

C an1

Values are contained in the External Code List are

Value	Definition	Comment
"A"	Approved	
"D"	Denied	
"R"	Requested	
"N"	Not Required	
"F"	Deferred	

DRU 130-7892 Do Not Fill/Profile Flag

C an1

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Values are contained in the External Code List are

Value	Definition	Comment
"Y"	Yes	Used for medications ordered by a prescriber but not requiring dispensing at this time, but required for administration and available for drug-to-drug interactions

Fields to be added to REQ segment

REQ 060-7893 Change of Prescription Status Flag

C an1

Values are contained in the External Code List are

Value	Definition	Comment
"D"	Discontinue	
"C"	Cancel	

This field is used in the CANRX message when the prescriber wishes to notify the pharmacy to no longer continue dispensing any open refills on an active prescription or to cancel a prescription that has not yet been dispensed. This guidance has been added to section "Transactions", subsection "Cancel Prescription Request Transactions".

The PVD loops were increased from 3 to 4 to allow support of an occurrence for facility. 010-4705 Provider Coded current value "SK" (Skilled Nursing) denotes the facility. While Provider Coded contains many values, the possible 4 occurrences could support a prescriber, a clinic or a facility, a pharmacy, and a pharmacist (4).

Section "Structure Quick Reference" was updated to reflect the field requirements when a facility loop appears.

"Transmission From Sender To Receiver Structure" and "Specific Segment Discussion" sections were updated to support the addition of fields and modification of occurrences.

New Reject Codes were added to support the new fields above.

## **16.21 VERSION 10.1**

CENSUS Update Transaction was added. The Census Update Transaction is originated by the facility in a long term care environment. The transaction notifies the pharmacy about census events. The transaction can be used in three cases - to notify the pharmacy of a new resident, a change to demographic information of a resident, or the discharge of a resident.

Support for the Long Term Care (LTC) Medication Change Process was added.

For long term care settings, a new transaction type of "Resupply Request" was added, which looks like a Refill Request, but no response is necessary.

Sections throughout the document were updated to include the new request message of CENSUS, the LTC Medication Change Process, and the Resupply Request.

*"Introduction"*

*"Background"*

*"Business Operations"*

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“Business Functions”

“Transaction Types”

“STATUS”

“ERROR”

“Transactions”, “Census Update Transaction”, “Long Term Care (LTC) Medication Change Process”, and “Resupply Transaction” were added

“Structure Quick Reference”

“Specific Segment Discussion”

New examples were added to “Transmission Examples”, “Example 23. New Admit of a Resident”, “Example 24. Update of a Current Resident”, and “Example 25. Discharge of a Resident”, and “Example 26. Significantly Change an Order”.

#### In the UIH Segment

010-S306-04-0326	Message function	<p>In UN/EDIFACT definition, this field is conditional. However in NCPDP implementation of the SCRIPT format, the Message function is Mandatory.</p> <p>Values:</p> <p>NEWRX, REFREQ, REFRES, RXFILL, GETMSG, VERIFY, STATUS, PASCHG, ERROR, RXCHG, CHGRES, CANRX, CANRES, RXHREQ, RXHRES, CENSUS, RESUPP</p>
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Field values were added to the REQ Segment for the CENSUS transaction.

010-4343	Message Function, coded	<p>Used in Prescription Change Request transactions, to request a change to the original new prescription.</p> <p>Values: See External Code List</p> <p><b>For the CENSUS Transaction, used to indicate type of census event. Note: For a Change Transaction, the patient demographic and coverage information sent should be all information known, not just the changed information.</b></p>
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Values were added:

A: Admit

C: Change

D1: Discharge – Expired

D2: Discharge – Return Not Anticipated

D3: Discharge – Return Anticipated

D4: Discharge Other

Fields added to the REQ Segment for the CENSUS transaction.

<b>070</b>	I006	Date	C	1
01	2005 Date/Time/Period Qualifier		M	an..3
02	2380 Date/Time Period		M	an..35
03	2379 Date/Time/Period Format qualifier		C	an..3

Date/Time/Period Qualifier (2005) - For CENSUS, value 07 = Effective Date (Begin) is used.

In the COO Segment, new field values were added for the CENSUS transaction.

010-I001-02-1153	Reference Qualifier	A complete list can be found in the NCPDP External Code List (X12 DE 128).  IP – Individual Policy Number C1 – Commercial  For Private Pay, this will be empty
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In the COO Segment, Party Name became a composite. It changed from

<b>050</b>	3036	Party Name	C	1	an..35
to					
<b>050</b>	I002	Name	M	1	
	01	3036 Party Name	C		an..35
	02	3702 First Name	C		an..35
	03	3704 Middle Name	C		an..35
	04	3706 Name Suffix	C		an..10
	05	3708 Name Prefix	C		an..10

In the COO Segment, **070** Party Name (Group Name) is available for use (was shaded).

In the COO Segment, Address is now available for use (was shaded) and is used for the responsible party's address.

<b>080</b>	I004	Address	C	1	
	01	3042 Street and Number/P.O. Box	C		an..35
	02	3164 City Name	C		an..35
	03	3229 Country Sub-entity Identification	C		an..9
	04	3251 Postcode Identification	C		an..11
	05	3227 Place/Location Qualifier	C		an..3
	06	3224 Place/Location	C		an..35

In the COO Segment, Insurance Type, coded is now available for use (was shaded), and values added.

<b>100</b>	4703	Insurance Type, coded	C	1	an..3	
100-4703		Insurance Type, coded	X12 DE 1138. For CENSUS - Indicates Primary  Values: See External Code List			

Values added:

- P: Primary
- S: Secondary
- T: Tertiary
- U: Unknown
- PP: Private Pay

In the COO Segment, CommunicationNumber has been added.

<b>150</b>	I016	CommunicationNumber	C >1
01	3148	CommunicationNumber	C an..80
02	1131	Code List Qualifier	C an..3

**For Long Term Care (LTC) Medication Change Process, in the UIH Segment**

030-S032-01-0300	Dialogue Reference - Initiator control reference	<p><i>Trace number assigned by sender.</i> This field may be used as a trace number for the Message. It is a reference field which can uniquely identify at any point to the sender the transaction being referenced. While this data element is not mandatory, it is mandatory that if sent on a request, it should be returned on any conversation referencing this request.</p> <p><b>For Long Term Care (LTC) Medication Change Process - If Prescriber is changing an original Script, this is the Order id of the original Script.</b></p>
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In the REQ Segment, the following values have been added.

010-4343	Message Function, coded	<b>For Long Term Care (LTC) Medication Change Process (Prescriber initiated CHANGE Request), the NEWRX and the CANCEL will use this field to indicate the level of the change.</b>
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Values added

- C1: Significant change (Any changes to the Drug, form, strength, dosage, or route)
- C2: Frequency Change (Any change to the frequency or hours of administration for the drug)
- C3: Insignificant Change (All other changes)

In the DRU Segment, an enhancement was made for Medication History Response transactions.

080-I001-01-1154	Reference Number	<p>This number is used to store the Prior Authorization or Sample Prescription number <b>or the Prescriber Order Number, if used.</b> Used in conjunction with 02-1153 qualifier field.</p> <p><b>The Prescriber Order Number resides in this field in a RXHRES transaction only.</b> This field cannot be used for the prescriber order number in other transactions; these occur in the UIH Segment.</p> <p><b>For RXHRES in each loop of the medication - If the Prescriber Order Number is used, the qualifier of "94" (Pharmacy or Prescriber File ID) is required. The field is used to convey the prescriber order number in a Medication History response.</b></p>
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For Resupply Request transaction, the following additional notes have been made.

In the UIB Segment

030-S303-02-0303	Initiator reference identifier	<p>This reference field may be used as a secondary identifier, based on trading partner agreements or need of the originating system.</p> <p><b>For RESUPP - In the LTC environment this field is the prescription number assigned by the pharmacy.</b></p>
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In the UIH Segment

020-0062	Message Reference Number	<i>Rx Number or Unique ID from doctor.</i> This field contains a reference number for the Message, which may be the Prescription Number or Patient Folio number. It is a reference field which can uniquely identify at any point to the sender the transaction being referenced. See "Transmission Examples" section for usage.  <b>For RESUPP - This field assigned by the prescriber system.</b>
030-S032-04-0304	Responder control reference	This field may be used as a trace number between trading partners.  <b>For RESUPP - In the LTC environment this is the prescription number assigned by the facility.</b>

DRU 020-01-6063 Quantity Qualifier uses the same base list (Unit of Measure X12 DE 355), but uses a subset list for this field. See the NCPDP **External Code List**.

DRU 060-01-6063 Quantity Qualifier added a new value for number of refills remaining on a prescription, for use in Medication History Responses.

060-I009-01-6063	Quantity Qualifier (continued)	<b>REM = Number of refills remaining on a prescription</b>  To relay a value of refills remaining as part of the information that comes on a medication history record.
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## 16.22 VERSION 10.2

In the long term care environment, ordered medications are delivered to the facilities by the pharmacy, usually on a fixed delivery schedule. Because of this model, information is available for the facility and LTC pharmacy if the facility, when submitting a NEWRX or RESUPP, to indicate when the medication is needed. The pharmacy would then know if the order requires a special delivery or if it could go out with the next scheduled delivery.

In the DRU Segment, the following fields were added.

<b>140</b>	I006      Needed No Later Than	C      1
01	2005 Date/Time/Period Qualifier	C      an..3
02	2380 Date/Time/Period	C      an..35
03	2379 Date/Time/Period Format Qualifier	C      an..3
<b>150</b>	E034 TIME ZONE	C      1
01	2029 Time Zone Identifier	M      an..3
02	2116 Time Zone Difference Quantity	C      n..4
<b>160</b>	7894 Needed No Later Than Reason	C      an..70

Section “Sign” was added to “Numeric Representation” to provide information about the use of the negative sign in the Time Zone Difference Quantity. Section “Time Zone” was added to “Requirement Designation”.

## **16.23 VERSION 10.3**

Medication History Response (RXHRES) transaction includes Source and Fill Number information so the receiver’s system when appropriate to send, so receivers will be able to de-duplicate records from multiple sources that reflect the same medication dispensing, and better determine patient compliance for the medication. The information also assists the receiver if follow-up contact is required regarding the medication records. A new segment was added “Source”.

SRC	Source Segment	C 1
<b>000</b>	S019 SEGMENT TAG	M 1
	01 0013 Segment code	M a3
<b>010</b>	S021 Source	C 1
	01 7895 Source Qualifier	M an..3
	02 7896 Source Description	C an..35
	03 1154 Reference Number	C an..35
	04 1153 Reference Qualifier	C an..3
<b>020</b>	1154 Reference Number	C an..35
<b>030</b>	7897 Fill Number	C n..2

Section “Structure Quick Reference”, “Medication History Response (RXHRES)” added the Source Segment to the charts. Section “Specific Segment Discussion”, added the subsection “SRC Source Segment”. Is subsection includes specific rules for the use of the Source Segment depending on the sender. Examples

- Prescriber Requests Medication History with Source Segment
  - Pharmacy Requests Medication History with Source Segment
- have been added in section “*Transmission Examples*”.

Section “Structure Quick Reference”, subsection “Medication History Response (RXHRES)” modified to “*Drug Loop – Loops through up to 300 times. Each loop may have 1 SRC Segment, 2 corresponding PVD Segments.*”

Added to DRU 020-03-1131 Code List Qualifier on the NEWRX message, characterizing the quantity being described in the DRU-020 Quantity Composite, value “QS” to be used to indicate that the quantity is to be determined by the pharmacy according to an established protocol between the prescriber and the pharmacy/pharmacist. Section “Quantity Sufficient” was added to “Specific Segment Discussion”, “DRU Drug Segment”.

## **16.24 VERSION 10.4**

To the field in the Coordination of Benefits Segment 010-02 Reference Qualifier, a value of “ADI” (Processor Identification Number – Processor Control Number assigned by the processor) has been added for use.

The Reference Number loop in the Coordination of Benefits Segment 010-I001 has been expanded to > 1 to allow multiple loops (such as for BIN and Processor Control Number). Section “Specific Segment Discussion”, “COO Coordination of Benefits Segment” includes verbiage explaining this in the Reference Qualifier row of the chart and the notes following the chart.

010	I001	Reference Number	C	>1
01	1154	Reference Number	M	an..35
02	1153	Reference Qualifier	C	an..3

A new conditional segment has been added to section “Transmission from Sender to Receiver Structure”.

### **SIG Structured Sig Segment**

Function: To codify the elements of the Sig

<b>000</b>	S019 SEGMENT TAG Identification of the Segment 01      0013 Segment code	M	1	
<b>010</b>	S022 REPEATING SIG 01      7898 Sig Sequence Position Number 02      7899 Multiple SIG Modifier	M	1	
<b>020</b>	S023 CODE SYSTEM COMPOSITE 01      7900 SNOMED Version 02      7901 FMT Version	C	an..14	
<b>030</b>	S024 FREE TEXT 01      7902 Sig Free Text String Indicator 02      7989 Sig Free Text	M	1	
		M	n1	
		M	an..140	
<b>040</b>	S025 DOSE 01      7903 Dose Composite Indicator 02      7904 Dose Delivery Method Text 03      7905 Dose Delivery Method Code Qualifier 04      7906 Dose Delivery Method Code 05      7907 Dose Delivery Method Modifier Text	M	1	
		M	n1	
		C	an..50	
		C	an..2	
		C	an..15	
		C	an..50	

	06	7908 Dose Delivery Method Modifier Code Qualifier C		an..2
	07	7909 Dose Delivery Method Modifier Code C		an..15
	08	7910 Dose Quantity C		n..18
	09	7911 Dose Form Text C		an..50
	10	7912 Dose Form Code Qualifier C		an..2
	11	7913 Dose Form Code C		an..15
	12	7914 Dose Range Modifier C		an..50
<b>050</b>	<b>S026 DOSE CALCULATION</b>		<b>C 1</b>	
	01	7915 Dosing Basis Numeric Value C		n..18
	02	7916 Dosing Basis Unit of Measure Text C		an..50
	03	7917 Dosing Basis Unit of Measure Code Qualifier C		an..2
	04	7918 Dosing Basis Unit of Measure Code C		an..15
	05	7919 Body Metric Qualifier C		n1
	06	7920 Body Metric Value C		n..18
	07	7921 Calculated Dose Numeric C		n..18
	08	7922 Calculated Dose Unit of Measure Text C		an..50
	09	7923 Calculated Dose Unit of Measure Code Qualifier C		an..2
	10	7924 Calculated Dose Unit of Measure Code C		an..15
	11	7925 Dosing Basis Range Modifier C		an..50
<b>060</b>	<b>S027 VEHICLE</b>		<b>C 1</b>	
	01	7926 Vehicle Name C		an..50
	02	7927 Vehicle Name Code Qualifier C		an..2
	03	7928 Vehicle Name Code C		an..15
	04	7929 Vehicle Quantity C		n..18
	05	7930 Vehicle Unit Of Measure Text C		an..50
	06	7931 Vehicle Unit Of Measure Code Qualifier C		an..2
	07	7932 Vehicle Unit Of Measure Code C		an..15
	08	7933 Multiple Vehicle Modifier C		an..50
<b>070</b>	<b>S028 ROUTE OF ADMINISTRATION</b>		<b>C 1</b>	
	01	7934 Route of Administration Text C		an..50
	02	7935 Route of Administration Code Qualifier C		an..2
	03	7936 Route of Administration Code C		an..15
	04	7937 Multiple Route of Administration Modifier C		an..50
<b>080</b>	<b>S029 SITE OF ADMINISTRATION</b>		<b>C 1</b>	
	01	7938 Site of Administration Text C		an..50
	02	7939 Site of Administration Code Qualifier C		an..2
	03	7940 Site of Administration Code C		an..15
	04	7941 Multiple Site of Administration Timing Modifier C		an..50
<b>090</b>	<b>S030 TIMING</b>		<b>C 1</b>	
	01	7942 Administration Timing Text C		an..50
	02	7943 Administration Timing Code Qualifier C		an..2

03	7944 Administration Timing Code	C	an..15
04	7945 Multiple Administration Timing Modifier	C	an..50
05	7946 Rate of Administration	C	an..11
06	7947 Rate Unit of Measure Text	C	an..50
07	7948 Rate Unit of Measure Code Qualifier	C	an..2
08	7949 Rate Unit of Measure Code	C	an..15
09	7950 Time Period Basis Text	C	an..50
10	7951 Time Period Basis Code Qualifier	C	an..2
11	7952 Time Period Basis Code	C	an..15
12	7953 Frequency Numeric Value	C	an..11
13	7954 Frequency Units Text	C	an..50
14	7955 Frequency Units Code Qualifier	C	an..2
15	7956 Frequency Units Code	C	an..15
16	7957 Variable Frequency Modifier	C	an..50
17	7958 Interval Numeric Value	C	n..18
18	7959 Interval Units Text	C	an..50
19	7960 Interval Units Code Qualifier	C	an..2
20	7961 Interval Units Code	C	an..15
21	7962 Variable Interval Modifier	C	an..50
<b>100</b>	<b>S031 DURATION</b>	<b>C 1</b>	
01	7963 Duration Numeric Value	M	an..11
02	7964 Duration Text	M	an..50
03	7965 Duration Text Code Qualifier	M	an..2
04	7966 Duration Text Code	M	an..15

<b>110</b>	S033 MAXIMUM DOSE RESTRICTION	C	1
01	7967 Maximum Dose Restriction Numeric Value	M	n..18
02	7968 Maximum Dose Restriction Units Text	M	an..50
03	7969 Maximum Dose Restriction Code Qualifier	M	an..2
04	7970 Maximum Dose Restriction Units Code	M	an..15
05	7971 Maximum Dose Restriction Variable Numeric Value	C	n..18
06	7972 Maximum Dose Restriction Variable Units Text	C	an..50
07	7973 Maximum Dose Restriction Variable Units Code Qualifier	C	an..2
08	7974 Maximum Dose Restriction Variable Units Code	C	an..15
09	7975 Maximum Dose Restriction Variable Duration Modifier	C	an..50
<b>120</b>	S034 INDICATION	C	1
01	7976 Indication Precursor Text	C	an..50
02	7977 Indication Precursor Code Qualifier	C	an..2
03	7978 Indication Precursor Code	M	an..15
04	7979 Indication Text	C	an..50
05	7980 Indication Text Code Qualifier	C	an..2
06	7981 Indication Text Code	C	an..15
07	7982 Indication Value Text	C	an..50
08	7983 Indication Value Unit	C	n..18
09	7984 Indication Value Unit of Measure Text	C	an..50
10	7985 Indication Value Unit of Measure Code Qualifier	C	an..2
11	7986 Indication Value Unit of Measure Code	M	an..15
12	7987 Indication Variable Modifier	C	an..50
<b>130</b>	S035 STOP	C	1
01	7988 Stop Indicator	M	an1

The Structured Sig Segment is conditional and may be used in transactions that have a DRU Segment for the drug prescribed or the drug dispensed. See section “Structure Quick Reference”. Section “Specific Segment Discussion” includes a usage chart for the Structured Sig Segment. Notes were added in section “Specific Segment Discussion”, “DRU Drug Segment” 030-02 and 030-03 Dosage (Sig instructions) and “SIG Structured Sig Segment” to guide the implementer in the use of the DRU Sig text fields and the SIG Structured Sig Segment. Reject Codes were added to the *External Code List*.

In the COO Coordination of Benefits Segment, the first Service Type was made available for use in Medication History transactions.

<b>030</b>	I011 Service Type Coded	C	1
01	7701 Service Type, coded	M	an..3

In section “Transmission Examples”, “Example 30. Pharmacy Requests Current Medication List” has been added. Reject Codes were added to the *External Code List*.

## **16.25 VERSION 10.5**

The NCPDP SCRIPT **XML Companion Guide** has been incorporated into this document as section “XML Implementation”. The NCPDP SCRIPT **XML Companion Guide** will be sunsetted as a document. Further updates to the XML syntax of SCRIPT will be done in this document package.

Based on review of this document for the American National Standards Institute Healthcare Information Technology Standards Panel (ANSI HITSP) standard selection process of a use case for Medication Management, the following changes were made to this document. HITSP, for given use cases, are selecting standards for the United States, to provide a consistent approach in healthcare. As review of the selection of SCRIPT, questions were asked about the constraint of fields or the code values used.

- PVD Segment (Pharmacy)
  - Prescription Fill Status Notification (RXFILL) – PVD Segment (Pharmacy) – changed to mandatory.
  - PVD Segment As The Prescriber, Supervisor - 020-02-1153 Reference Qualifier (the prescriber qualifier) – an additional note has been added “If the prescriber has an NPI, one occurrence must contain the value “HPI” (NPI). If the prescriber has a DEA number, one occurrence must contain the value “DH” (DEA Number). Not every entity allowed to prescribe may have an NPI or DEA. If this is the case, the other identifiers can be used.”
  - HITSP has named the Health Care Provider Taxonomy code set as the standard code set for provider specialty. The Health Care Provider Taxonomy code is larger than the existing SCRIPT field size. The PVD Segment 040-02-4707 Provider Specialty, coded – this field is sunsetted (shaded) and a new field added 040-03-7990 Provider Specialty code with a size of an..10. 040-01-4709 Agency Qualifier, coded contains a new qualifier for “Health Care Provider Taxonomy code set”. The other code values are sunsetted. The External Code List points to the list available from the Washington Publishing Company at [www.wpc-edi.com/taxonomy/more\\_information](http://www.wpc-edi.com/taxonomy/more_information)”.

### PVD Segment

040	I007	Provider Specialty	C	1
	01	4709 Agency Qualifier, coded	M	an..3
	02	4707 Provider Specialty, coded and sunsetted	M	an..3 – shaded
	03	7990 Provider Specialty code for taxonomy code new size	M	an.. 10 – added

- PVD Segment As The Pharmacy - 020-02-1153 Reference Qualifier (the pharmacy qualifier) – an additional note has been added “On the mandatory transactions: One occurrence must contain the value “D3” (NCPDP Provider ID Number). One occurrence must contain the value “HPI” (National Provider ID).” See 040 composite of PVD Segment above.
- UIB Segment
  - UIB Interactive Interchange Control Header - 080-01-0017 Date of initiation and

Version 2017071

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080-02-0114 Event Time – the Standard Format lists these fields as Conditional.  
In all SCRIPT Transactions, these fields are Mandatory.

- In all segments, where the field 3229 Country Sub-entity identification is used, the field is constrained to a specific code list - APPENDIX C - UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS of the External Code List.
- In all segments, where the field 3148 CommunicationNumber is used, the Code List Qualifier notes that “One occurrence is “TE” (Telephone). Other occurrences are optional and would contain other values.”

Based on the HITSP standards harmonization recommendation on the AHIC Consumer Empowerment Use Case to use the Federal Medication Terminologies (FMT), NCPDP formed the FMT and ECL Analysis Task Group under Maintenance and Control to analyze the FMT against the currently used codes and vocabularies in the NCPDP standards and other documents to determine the potential implications of any changes. The following changes were made.

- DRU Segment
  - 05 1131 Code List Qualifier C an..3 – shaded and sunsetted
    - 13 7991 Source Code List C an..3 – added to qualify 14
    - 14 7992 Item Form Code C an..15 – added for Drug Form new size
  - 07 1131 Code List Qualifier C an..3 – shaded and sunsetted
    - 15 7991 Source Code List C an..3 – added to qualify 16
    - 16 7993 Item Strength Code C an..15 – added for Drug Strength new size
  - 01 6063 Quantity Qualifier M an..3 – shaded and sunsetted
    - 04 7991 Source Code List M an..3 – added to qualify 05
    - 05 7994 Potency Unit Code M an..15 – added for Quantity Qualifier new size
- OBS Segment
  - 03 6411 Measurement Unit qualifier M an..3 – shaded and sunsetted
    - 07 7991 Source Code List M an..3 – added to qualify 08
    - 08 7995 Measurement Unit Code M an..15 – added for Measurement Unit new size

The statement “When the DRU 020-03-1131 value “QS” value is used, DRU 020-01-6063 Quantity Qualifier must equal “C38046” (Unspecified). DRU 020-1009-02-6060 Quantity must equal “0”” has been changed to “When the DRU 020-03-1131 value “QS” value is used, DRU 020-05-7994 Potency Unit Code must equal “C38046”. DRU 020-02-6060 Quantity must equal “0”.

Examples have been modified to support these changes.

References to “Prescriber/Pharmacist Interface” as a title of this document have been removed.  
“SCRIPT Standard” will be the only title used.

The field DEA Schedule has been added to the DRU Segment.

17 7996 DEA Schedule

C an..15

DRU- 060-01-6063 Qualifier – in the REFREQ column, the designation of “M” (Mandatory) has been changed to “C” (Conditional) to align with the note for “P = Pharmacy Requested Refills”. Because the note stated a condition, this correction has been made.

The field-level comment for DRU 060-1009-02-6060 has been modified from "...Note: This field is mandatory except when DRU 060-1009-01-6063 Quantity Qualifier = PRN. **No quantity is required for PRN.**" to "Note: This field is mandatory except when DRU 060-1009-01-6063 Quantity Qualifier = PRN. **If DRU 060-1009-01-6063 Quantity Qualifier = PRN, DRU-060-02 must NOT be present.**"

REQ-010-4343 Message Function, coded field values have been further constrained by transaction.

More diagrams have been added to "[Appendix A. Pictorial Transaction Flow](#)".

In the DRU Segment, 040-01-2005 Date/Time Period Qualifier for RXHRES was “C” (conditional). It should have been “M” Mandatory to align with the date time field.

## **16.26 VERSION 10.6**

A value of “06” (Sold Date) has been added into DRU Segment Date/Time Period Qualifier 040-01-2005. This value is only allowed to be used in Medication History Response, Fill Status Notification, and Refill Request transactions.

Enhancements were made to the DUE composite of the DRU Segment enabling a physician to include prescribing-time DUR alerts and comments to the pharmacist when communicating a prescription.

<b>100</b>	S018	Drug Use Evaluation	C	5
	06	7997 DUE Clinical Significance Code	C	an1
	07	7998 DUE Acknowledgement Reason	C	an..100

Examples of DUE situations have been added to section "[Drug Use Evaluation Composite](#)".

An Allergy Segment has been added. It is available for use in the following transaction.

- CENSUS

Section "[Structure Quick Reference](#)" has been updated for this transaction. Section "[Specific Segment Discussion](#)" includes the Allergy Segment.

<b>ALG</b>	<b>Allergy Segment</b>	<b>C &gt; 1</b>
<b>000</b>	S019 SEGMENT TAG	M 1
	01 0013 Segment code	M a3
<b>010</b>	7999 No Known Allergies	C a1
<b>020</b>	8000 Source of Information	C a1

<b>030</b>	S036	Adverse Event Date	C	2
01	2005 Date/Time/Period Qualifier		M	an..3
02	2380 Date/Time Period		M	an..35
03	2379 Date/Time/Period Format qualifier		C	an..3
<b>040</b>	S037	Adverse Event Type	C	1
01	8001 Item Description Long		M	an..255
02	7140 Item Number		C	an..35
03	3055 Code List Responsibility Agency		C	an..3
<b>050</b>	S038	Drug – Product Coded	C	1
01	8001 Item Description Long		M	an..255
02	7140 Item Number		C	an..35
03	3055 Code List Responsibility Agency		C	an..3
<b>060</b>	S039	Reaction Coded	C	1
01	8001 Item Description Long		M	an..255
02	7140 Item Number		C	an..35
03	3055 Code List Responsibility Agency		C	an..3
<b>070</b>	S040	Severity Coded	C	1
01	8001 Item Description Long		M	an..255
02	7140 Item Number		C	an..35
03	3055 Code List Responsibility Agency		C	an..3

A Diagnosis Segment has been added. It is available for use in the following transactions.

- o CENSUS

Section "Structure Quick Reference" has been updated for these transactions. Section "Specific Segment Discussion" includes the Diagnosis Segment.

<b>DIA</b>	<b>Diagnosis Segment</b>	<b>C &gt; 1</b>	
<b>000</b>	S019 SEGMENT TAG	M	1
01	0013 Segment code	M	a3
<b>010</b>	8000 Source of Information	C	a1
<b>020</b>	I006 Problem Date	C	2
01	2005 Date/Time/Period Qualifier	M	an..3
02	2380 Date/Time Period	M	an..35
03	2379 Date/Time/Period Format qualifier	C	an..3
<b>030</b>	S041 Problem Type	C	
01	8001 Item Description Long	M	an..255
02	7140 Item Number	C	an..35
03	3055 Code List Responsibility Agency	C	an..3

<b>040</b>	S042	Problem Name Coded	M	2
01	8001	Item Description Long	M	an..255
02	7140	Item Number	C	an..35
03	3055	Code List Responsibility Agency	C	an..3

The CENSUS Transaction has been updated to require a PVD Segment for the Facility. Section “Structure Quick Reference” has been updated. Section “Specific Segment Discussion”, “PVD Segment As The Facility” has been updated. The PVD Segment designated agent composite is now “not used” for the facility environment.

The following examples have been updated with the Facility PVD Segment:

- [Example 23. Facility Sending A New Resident Admit To A Pharmacy \(Direct Connect\)](#)
- [Example 24. FACILITY Sending An Update To a Resident Record To A Pharmacy \(Direct Connect\)](#)
- [Example 25. Facility Sending Resident Discharge To A Pharmacy \(Direct Connect\)](#)

Correction made:

For the VERIFY transaction, Status Type, Coded 010-9015 was Mandatory and Code List Qualifier (020-1131) was Conditional. Per the note in the segment discussion section “Verification (VERIFY)”, the correct designations are Conditional and Not used.

010-9015	Status Type, coded	<p>Codes used to relay successful or rejected communications.</p> <p>Values: See External Code List</p> <p>Is not required in a VERIFY transaction. If used, Status Type (010/9015) must be 000 and Reject Codes (020/1131) may not be used. Free Text (030/4440) may be used.</p>	M	C	M	M
020-1131	Code List Qualifier	<p>Reject Codes used by responder who takes responsibility for transaction.</p> <p>Values: See External Code List</p> <p>Is not required in a VERIFY transaction. If used, Status Type (010/9015) must be 000 and Reject Codes (020/1131) may not be used. Free Text (030/4440) may be used.</p>	C	N	C	C

#### SigSequencePositionNumber

SigSequencePositionNumber was defined as n..2 and it should be n..2M. This has been corrected in the 201106 SCRIPT 10.6 schema and the SCRIPT 2010123 and above schemas.

#### PotencyUnitCode or QuantityUnitOfMeasure

PotencyUnitCode was defined as an..15 and it should be an..15M. This has been corrected in the 201106 SCRIPT 10.6 schema. The element is QuantityUnitOfMeasure in the SCRIPT 2011xx#+ schema and has been corrected in the SCRIPT 2010123 and above schemas to not allow an empty tag to be sent.

SoldDate

SoldDate was inadvertently listed in the Resupply transaction. It was missing in the RefillRequest. This has been corrected in the 201106 SCRIPT 10.6 schema and the and the SCRIPT 2010123 and above schemas. In the SCRIPT 2010123 and above schemas, SoldDate was inadvertently listed in the RefillResponse. This has been corrected.

## 16.27 VERSION 10.7

In the UIT Segment field the “All Transactions” designation did not match the “Remarks”.

UIT INTERACTIVE MESSAGE TRAILER				
Field Number	Field Name	Remarks	STANDARD FORMAT	ALL TRANSACTIONS
000-S019-01-0013	Segment code	Value: UIT	M	M
010-0062	Message Reference Number	Must be the same value as in UIH 0062. <del>This field is Mandatory.</del>	C	C
020-0074	Number of Segments in Message	Mandatory field. This is the count of the number of segments in the message including the UIH and UIT.	C	C

The note “This field is mandatory” has been removed. The requirement “must be the same value as in the UIH 0062” satisfies. The UIT Segment has been updated to include the column for REFREQ or RESUPP, and REFRES, like the UIH Segment. The field Number of Segments in Message has been updated to Mandatory.

The UIT Segment fields now show:

UIT INTERACTIVE MESSAGE TRAILER						
Field Number	Field Name	Remarks	STANDARD FORMAT	ALL TRANSACTIONS (except REFREQ, RESUPP, and REFRES)	REFREQ or RESUPP	REFRES
000-S019-01-0013	Segment code	Value: UIT	M	M	M	M
010-0062	Message Reference Number	Must be the same value as in UIH 0062.	C	C	M	M
020-0074	Number of Segments in Message	Mandatory field. This is the count of the number of segments in the message including the UIH and UIT.	C	M	M	M

Prescription Delivery Method (8002) was added to the STS Segment.

**040** 8002 Prescription Delivery Method C 1 n1

Support for multi-ingredient compounds was added with rules in the DRU Segment and the new Compound Ingredient Segment.

Section “Structure Quick Reference” has been updated for this transaction. Section “Specific Segment Discussion” includes the Compound Segment. Example 31 was added for compound prescriptions.

The following was added to the DRU Segment:

<b>170</b>	S043 Other Compound Information	C	1
01	8003 Compound Code	C	n1
02	7991 Source Code List	C	an..3
03	8004 Final Compound Pharmaceutical Dosage Form C 3		an..70
<b>180</b>	S044 Compounded Prescription Route of Administration	C	1
01	7934 Route of Administration Text	C	an..50
02	7935 Route of Administration Code Qualifier	C	an..2
03	7936 Route of Administration Code	C	an..15
04	7937 Multiple Route of Administration Modifier	C	an..50

The new CPD Compound Ingredient Segment was added.

**CPD Compound Ingredient Segment** C >1

Function: To codify the elements of the Sig

**25 PER DRU (REQUESTED/PRESCRIBED/DISPENSED)**

<b>000</b>	S019 SEGMENT TAG	M	1
01	0013 Segment code	M	a3
<b>010</b>	I017 Compound Ingredient	M	
01	7009 Item Description Identification	M	an..7
02	8005 Compound Ingredient Item Description	M	an..105
03	7140 Item Number	C	an..35
04	3055 Code List Responsibility Agency	C	an..3
05	4440 Free Text	C	an..70
06	7991 Source Code List	C	an..3
07	7992 Item Form Code	C	an..15
08	7991 Source Code List	C	an..3
09	7993 Item Strength Code	C	an..15
10	7996 DEA Schedule	C	an..15
<b>020</b>	I009 Quantity	C	2
01	6060 Quantity	M	an..35
02	1131 Code List Qualifier	C	an..3
03	7991 Source Code List	M	an..3
04	7994 Potency Unit Code	M	an..15

<b>030</b>	S018	Drug Use Evaluation	C	5
01	7880	DUE Reason For Service Code	M	an2
02	7881	DUE Professional Service Code	C	an2
03	7882	DUE Result Of Service Code	C	an2
04	7883	DUE Co-Agent ID	C	an..19
05	7884	DUE Co-Agent ID Qualifier	C	an2
06	7997	DUE Clinical Significance Code	C	an1
07	7998	DUE Acknowledgement Reason	C	an..100

The following was added to the UIB Segment:

<b>110</b>	S045	Sender Software	M	1
01	8006	Sender Software Developer	M	1 an..35
02	8007	Sender Software Product	M	1 an..35
03	8008	Sender Software Version Release	M	1 an..50

Every example was updated to include this now mandatory composite.

There were inconsistencies found in the Quantity Composite (020-I009) of the DRU Segment. The composite was marked “Conditional” for the VERIFY and RXHRES transactions, with no guidance for the situation. Further a note on the Quantity (020-02-6060) field did not provide guidance for “Conditional Mandatory” use. To be consistent, the VERIFY and RXHRES transactions now support the Quantity Composite and fields in the same way as the other transactions. The strikeout signifies what is to be changed. (Note, structurally the syntax declared the Quantity Composite as conditional; this is why the Standard Format column shows “C”. For transaction usage, the Quantity Composite is mandatory “M”).

These same changes were made in the Compound CPD Segment for consistency.

DRU DRUG SEGMENT													
Field Number	Field Name	Remarks	STANDARD FORMAT	NEWRX	REFREQ	REFRES	RESUPP	RXFFILL	VERIFY	RXCHG	CHGRES	CANRX	RXHRES
020-I009	Quantity Composite	This composite is for the count of tablets or number of grams.	C	<b>M</b>	<b>M</b>	<b>M</b>	<b>M</b>	<b>M</b>	€	<b>M</b>	<b>M</b>	<b>M</b>	€
020-I009-01-6063	Quantity Qualifier	<i>No longer supported.</i>	N	N	N	N	N	N	N	N	N	N	N
020-I009-02-6060	Quantity	If Quantity is not submitted, the entire 020-I009 composite is not submitted. Changed to an .35 in Version 4.0.  See sections “ <i>Representation</i> ” and “ <i>Truncation</i> ” for syntax and decimal point usage.  If Compound Code = 2 (Compound), Quantity must contain the <b>final compound quantity</b> .	CM	<b>M</b>	<b>M</b>	<b>M</b>	<b>M</b>	<b>M</b>	€M	<b>M</b>	<b>M</b>	<b>M</b>	€M

DRU DRUG SEGMENT													
Field Number	Field Name	Remarks	STANDARD FORMAT	NEWRX	REFREQ	REFRES	RESUPP	RXFILL	VERIFY	RXCHG	CHGRES	CANRX	RXHRES
020-I009-03-1131	Code List Qualifier	X12 DE 673.  Values: See External Code List  On NEWRX, when the DRU 020-03-1131 value "QS" value is used, DRU 020-05-7994 Potency Unit Code must equal "C38046" (Unspecified). DRU 020-02-6060 Quantity must equal "0". See section " <u>Quantity Sufficient</u> " below for important usage.  "QS" is not used in the DRU Segment for retail pharmacy NEWRX messages.  If Compound Code = 2 (Compound), Code List Qualifier must contain "CF" ( <b>Compound Final Quantity</b> ).	C	M	M	M	M	M	C	M	M	M	C
020-I009-04-7991	Source Code List	Code identifying the source organization. Required if Potency Unit Code (020-05-7994) is used.  Values: See External Code List	CM	M	M	M	M	M	C4	M	M	M	C4

DRU DRUG SEGMENT													
Field Number	Field Name	Remarks	STANDARD FORMAT	NEWRX	REFREQ	REFRES	RESUPP	RXFILL	VERIFY	RXCHG	CHGRES	CANRX	RXHRES
020-I009-05-7994	Potency Unit Code	Unit of measure. Potency Unit. Qualified by Source Code List (7991).  Values: See External Code List  If Compound Code = 2 (Compound), Potency Unit Code must contain the <b>final units of measure</b> .	CM	M	M	M	M	M	C	M	M	M	C

The chart now shows:

DRU DRUG SEGMENT													
Field Number	Field Name	Remarks	STANDARD FORMAT	NEWRX	REFREQ	REFRES	RESUPP	RXFILL	VERIFY	RXCHG	CHGRES	CANRX	RXHRES
020-I009	Quantity Composite	This composite is for the count of tablets or number of grams.	C	M	M	M	M	M	M	M	M	M	M
020-I009-01-6063	Quantity Qualifier	<i>No longer supported.</i>	N	N	N	N	N	N	N	N	N	N	N
020-I009-02-6060	Quantity	See sections " <u>Representation</u> " and " <u>Truncation</u> " for syntax and decimal point usage.  If Compound Code = 2 (Compound), Quantity must contain the <b>final compound quantity</b> .	CM	M	M	M	M	M	M	M	M	M	M

DRU DRUG SEGMENT													
Field Number	Field Name	Remarks	STANDARD FORMAT	NEWRX	REFREQ	REFRES	RESUPP	RXFILL	VERIFY	RXCHG	CHGRES	CANRX	RXHRES
020-I009-03-1131	Code List Qualifier	X12 DE 673.  Values: See External Code List  On NEWRX, when the DRU 020-03-1131 value "QS" value is used, DRU 020-I009-05-7994 Potency Unit Code must equal "C38046" (Unspecified). DRU 020-02-6060 Quantity must equal "0". See section " <u>Quantity Sufficient</u> " below for important usage.  "QS" is not used in the DRU Segment for retail pharmacy NEWRX messages.  If Compound Code = 2 (Compound), Code List Qualifier must contain "CF" ( <b>Compound Final Quantity</b> ).	C	M	M	M	M	M	M	M	M	M	M
020-I009-04-7991	Source Code List	Code identifying the source organization. Required if Potency Unit Code (020-05-7994) is used.  Values: See External Code List	CM	M	M	M	M	M	M	M	M	M	M

DRU DRUG SEGMENT													
Field Number	Field Name	Remarks	STANDARD FORMAT	NEWRX	REFREQ	REFRES	RESUPP	RXFILL	VERIFY	RXCHG	CHGRES	CANRX	RXHRES
020-I009-05-7994	Potency Unit Code	<p>Unit of measure. Potency Unit. Qualified by Source Code List (7991).</p> <p>Values: See External Code List</p> <p>If Compound Code = 2 (Compound), Potency Unit Code must contain the <b>final units of measure</b>.</p>	CM	M	M	M	M	M	M	M	M	M	M

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## 16.28 VERSION 10.8

### DRU (and CPD) Segment modifications:

In section “Structure Quick Reference”, “Refill Request (REFREQ)” and “Resupply (RESUPP)” have been separated due to clarifications in the usage of the DRU Segment for Refill Request. The Resupply section did not change. The DRU Segment (with CPD Segment and SIG Segment) in the Refill Request has been modified from

DRU	Drug Segment	Y	One loop required for the drug prescribed.	
	CPD	Compound Segment	N	Segment is required if a multi-ingredient prescription.
	SIG	Sig Segment	N	Segment(s) may be included to codify the SIG information.

DRU	Drug Segment	N	One loop for the drug dispensed. Is not mandatory, but can be used for clarification.	
	CPD	Compound Segment	N	Segment is required if the Drug Segment (dispensed) is sent and a multi-ingredient prescription.
	SIG	Sig Segment	N	Segment(s) may be included to codify the SIG information.

To

DRU	Drug Segment	N	One loop for the drug prescribed. Is not mandatory, but can be used for clarification.	
	CPD	Compound Segment	N	Segment is required if DRU Segment (prescribed) is sent and a multi-ingredient prescription.
	SIG	Sig Segment	N	Segment(s) may be included to codify the SIG information.

DRU	Drug Segment	Y	One loop required for the drug dispensed.	
	CPD	Compound Segment	N	Segment is required if the Drug Segment (dispensed) is sent and a multi-ingredient prescription.
	SIG	Sig Segment	N	Segment(s) may be included to codify the SIG information.

“Example 11. Error -- Sender Is Unknown To Mailbox” was modified to support the above change (added a DRU dispensed loop).

In section “Structure Quick Reference”, “Refill Response (REFRES)” has been modified to clarify the DRU Segment (dispensed) usage. The DRU Segment (dispensed) (with CPD Segment and SIG Segment) has been modified from

DRU	Drug Segment	N	One loop for the drug dispensed. Is not mandatory, but can be used for clarification.	
	CPD	Compound Segment	N	Segment is required if the Drug Segment (dispensed) is sent and a multi-ingredient prescription.
	SIG	Sig Segment	N	Segment(s) may be included to codify the SIG information.

To

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DRU	Drug Segment	Y	One loop required for the drug dispensed (will contain drug dispensed from Refill Request).	
	CPD	Compound Segment	N	Segment is required if the Drug Segment (dispensed) is sent and a multi-ingredient prescription.
	SIG	Sig Segment	N	Segment(s) may be included to codify the SIG information.

"Example 9. Refill Prescription Transaction With Return Receipt Requested", "Example 10. Refill Prescription Transaction - Patient No Longer Under Prescriber's Care" were modified to support the above change (added a DRU dispensed loop).

In section "Structure Quick Reference", "Prescription Change Response (CHGRES)" has been modified to clarify the DRU Segment (prescribed) usage. The DRU Segment (prescribed) (with CPD Segment and SIG Segment) has been modified from

DRU	Drug Segment	N	One loop for the drug prescribed.	
	CPD	Compound Segment	N	Segment is required if the Drug Segment (prescribed) is sent and a multi-ingredient prescription.
	SIG	Sig Segment	N	Segment(s) may be included to codify the SIG information.

To

DRU	Drug Segment	N	If an approved Prescription Change Response (DRU 010-4343 Response Type, Coded value A (Approved) or C (Approved with changes)), one loop required for the drug prescribed.  If a denied Prescription Change Response (DRU 010-4343 Response Type, Coded value D (Denied)), the DRU Segment does not need to be sent, or if the DRU Segment is sent it must contain the prescribed loop from the Prescription Change Request that is being denied.	
	CPD	Compound Segment	N	Segment is required if the Drug Segment is sent and a multi-ingredient prescription.
	SIG	Sig Segment	N	Segment(s) may be included to codify the SIG information.

"Example 6. Prescription Change Transaction (Via Mailbox)", "Example 7. Prescription Change Request (Via Direct Connect)", "Example 13. Prescription Change Transaction For Therapeutic Interaction (Via Direct Connect)", "Example 20. Prescription Change Request From Pharmacy For Prior Authorization (Excerpt)" were modified to support the above change.

In section "Structure Quick Reference", "Prescription Fill Status Notification (RXFILL)" has been modified to clarify the DRU Segment usage. The DRU Segment (with CPD Segment and SIG Segment) has been modified from

DRU	Drug Segment	N	One loop for the drug prescribed may be sent as clarification.	
	CPD	Compound Segment	N	Segment is required if the Drug Segment (prescribed) is sent and a multi-ingredient prescription.
	SIG	Sig Segment	N	Segment(s) may be included to codify the SIG information.
DRU	Drug Segment	N	One loop for the drug dispensed may be sent as clarification. For Prescription Fill Status Notification Transactions - Partially Dispensed only, the quantity received is required by the prescriber.	



The Product/Service Substitution (DAW) field was modified from an..3 to an..1 and was made mandatory in all applicable transactions.

**050 4457 Product/Service Substitution, coded**      C 1 an..1

**PVD Segment modifications:**

In section "*Structure Quick Reference*", "New Prescription Request (NEWRX)" has been modified to clarify the PVD Segment. The PVD Segment has been modified from

PVD	Provider Segment	Y	One loop required for the prescriber. One loop may be needed to relay the supervisor. In long-term care settings, one loop may be the facility.
PVD	Provider Segment	N	One loop may be required for the pharmacy. In most implementations, the pharmacy PVD segment is required. In some specialized implementations, the prescriber loop is required, but the pharmacy loop is optional or not required.

To

PVD	Provider Segment	Y	One loop required for the prescriber. One loop may be needed to relay the supervisor. In long-term care settings, one loop may be the facility.
PVD	Provider Segment	N	When the recipient is a pharmacy, one loop is required for the pharmacy.

In section "*Structure Quick Reference*", "Refill Response (REFRES)" has been modified to clarify the PVD Segment. The PVD Segment has been modified from

PVD	Provider Segment	Y	One loop required for the prescriber. One loop may be needed to relay the supervisor. In long-term care settings, one loop may be the facility.
PVD	Provider Segment	N	One loop may be echoed back for the pharmacy for clarification.

To

PVD	Provider Segment	Y	One loop required for the prescriber. One loop may be needed to relay the supervisor. In long-term care settings, one loop may be the facility.
PVD	Provider Segment	Y	One loop is required for the pharmacy.

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In section “*Structure Quick Reference*”, “*Prescription Change Response (CHGRES)*” has been modified to clarify the PVD Segment. The PVD Segment has been modified from

PVD	Provider Segment	Y	One loop required for the prescriber. One loop may be needed to relay the supervisor. In long-term care settings, one loop may be the facility.
PVD	Provider Segment	N	One loop may be echoed back for the pharmacy for clarification.

To

PVD	Provider Segment	Y	One loop required for the prescriber. One loop may be needed to relay the supervisor. In long-term care settings, one loop may be the facility.
PVD	Provider Segment	Y	One loop is required for the pharmacy.

In section “*Structure Quick Reference*”, “*Cancel Prescription Request (CANRX)*” has been modified to clarify the PVD Segment. The PVD Segment has been modified from

PVD	Provider Segment	Y	One loop required for the prescriber. One loop may be needed to relay the supervisor. In long-term care settings, one loop may be the facility.
PVD	Provider Segment	N	One loop may be echoed back for the pharmacy for clarification.

To

PVD	Provider Segment	Y	One loop required for the prescriber. One loop may be needed to relay the supervisor. In long-term care settings, one loop may be the facility.
PVD	Provider Segment	N	When the recipient is a pharmacy, one loop is required for the pharmacy.

### **VERIFY modifications:**

In section “*Structure Quick Reference*”, “*Verification (VERIFY)*” has been modified to clarify segment usage. It has been modified from

SEGMENT	DEFINITION	REQUIRED	COMMENT
UNA	Service String Advice	Y	Must be present on all transactions in this implementation usage. Is a fixed length segment.
UIB	Interactive Interchange Control Header	Y	Designates sender and receiver IDs, trace numbers, date, time stamps at the interchange level.
UIH	Interactive Message Header	Y	Designates the type of message. For Verify, Message function = VERIFY. Also indicates trace numbers at the message level.
STS	Status Segment	N	Is not required in a Verify transaction. If used, Status Type (010/9015) must be 000 and Reject Codes (020/1131) may not be used. Free Text (030/4440) may be used.
PVD	Provider Segment	N	Is not required in a Verify transaction, but may be echoed back for clarification.
PTT	Patient Segment	N	Is not required in a Verify transaction, but may be echoed back for clarification.

DRU	Drug Segment	N	Is not required in a Verify transaction, but may be echoed back for clarification.	
	CPD	Compound Segment	N	Is not required in a Verify transaction, but may be echoed back for clarification.
	SIG	Sig Segment	N	Is not required in a Verify transaction, but may be echoed back for clarification. Segment(s) may be included to codify the SIG information.
UIT	Interactive Message Trailer	Y	Designates the message trace number and number of segments in the message.	
UIZ	Interactive Interchange Trailer	Y	Designates the interchange trace number and the number of messages in the transaction.	

To

SEGMENT	DEFINITION	REQUIRED	COMMENT
UNA	Service String Advice	Y	Must be present on all transactions in this implementation usage. Is a fixed length segment.
UIB	Interactive Interchange Control Header	Y	Designates sender and receiver IDs, trace numbers, date, time stamps at the interchange level.
UIH	Interactive Message Header	Y	Designates the type of message. For Verify, Message function = VERIFY. Also indicates trace numbers at the message level.
STS	Status Segment	N	Is not required in a Verify transaction. If used, Status Type (010/9015) must be 010 and Reject Codes (020/1131) may not be used. Free Text (030/4440) may be used.
UIT	Interactive Message Trailer	Y	Designates the message trace number and number of segments in the message.
UIZ	Interactive Interchange Trailer	Y	Designates the interchange trace number and the number of messages in the transaction.

In this section and in the “*Specific Segment Discussion*”, the note “Is not required in a Verify transaction. If used, Status Type (010/9015) must be 010 and Reject Codes (020/1131) may not be used. Free Text (030/4440) may be used” was changed. It previously said Status Type must be 000; it now reads 010.

#### Other modifications:

In the PVD Segment (Prescriber/Supervisor), the composite Name (050-I002) and Party Name 050-01-3036 (Last Name) are mandatory for REFREQ or RESUPP.

In the UIH Segment, Test Indicator (060-0035) is shaded to no longer be used.

Date of Birth (Century Date 020-2700) is mandatory in all applicable transactions.

In section "*Structure Quick Reference*", the "Required" column has been modified to "Mandatory/Conditional" to be clearer.

RES-010-4343 Response Type, coded was changed from Mandatory to Conditional in the structure. It is Not Used in RXFILL transactions. The RXFILL examples were modified to remove the value in this field.

RES-020-1131 Code List Qualifier is Mandatory in RXFILL transactions to relay the fill status.

## **16.29 VERSION 10.9**

In date composites, there were editorial errors with consistency of the conditional mandatory designation of the date/time/period qualifier and date/time/period fields (were listed as "C" and should have been "CM"). These have been corrected.

### **DRUADM Message:**

The Drug Administration (DRUADM) Notification Message has been added. The document has been updated throughout to support this new transaction. In the REQ Segment, the 070 Date has changed from one occurrence to two to support a suspense and resume date.

<b>070</b>	I006	Date	C	<b>2</b>
	01	2005 Date/Time/Period Qualifier	M	an..3
	02	2380 Date/Time Period	M	an..35
	03	2379 Date/Time/Period Format qualifier	C	an..3

The following have been added to REQ Segment:

<b>080</b>	E034 TIME ZONE		C	1
	01	2029 Time Zone Identifier	M	an..3
	02	2116 Time Zone Difference Quantity	C	n..4
<b>090</b>	8011	Reason Code	C	an..2
<b>100</b>	8012	Reason Text	C	an..100

A pictorial flow has been added to "*Appendix A. Pictorial Transaction Flow*". Examples have been added to the "*Sample XML Messages*" section and to "*Transmission Examples*".

### **Trace Number Modifications:**

There was confusion in the use of the UIB and UIH trace numbers. The following modifications were made in section "Specific Segment Discussion" to clarify usage. Subsection "Mailbox Note" was added to the UIB Segment in this section. Subsection "Trace Number Usage" was added to the UIH Segment in this section.

**UIB**

Transaction control reference (UIB-030-01-0306) added (Message ID) to the field name in section "Specific Segment Discussion" and Remarks were changed from

*Trace number.* This reference is generated from the initial sender. When a STATUS or ERROR message is generated as a response, the response transaction's Transaction control reference will be echoed back to the sender. In Mailbox scenarios where mail is being retrieved, the Transaction control reference number of the response transaction will contain the original Transaction control reference from the sender. Please see "Transmission Examples" section for specific scenarios.

**to**

*Trace number.* A unique reference identifier for the transmission, generated from the sender of the request and the sender of the response. When generated from the sender, it is then echoed back in the response message in the field UIB-030-02 Initiator reference identifier. The value in this field must be present in UIB-030-02 Initiator reference identifier (Relates to Message ID) on subsequent transactions (such as REFREQ, CANRX, etc.) to tie back to an original transmission. See "Transmission Examples" section for specific scenarios.

Initiator reference identifier (UIB-030-02-0303) added (Relates to Message ID) to the field name in section "Specific Segment Discussion" and Remarks were changed from

This reference field may be used as a secondary identifier, based on trading partner agreements or need of the originating system.

For RESUPP - In the LTC environment this field is the prescription number assigned by the pharmacy.

**to**

On a direct response transaction (such as ERROR, STATUS, MEDICATION HISTORY RESPONSE) or a subsequent follow up response (such as CHANGE RESPONSE, REFILL RESPONSE, CANCEL RESPONSE) or a subsequent follow up transaction (such as RXFILL, VERIFY), this field is mandatory and is used to link the original message (value in UIB-030-01 Transaction control reference (Message ID)) from request to the response or to the subsequent follow up transaction.

On the CANRX and NEWRX messages used in the long term care order change process, this field is mandatory and contains the prescribing system's order ID associated with the original prescription.

On requests (such as REFREQ, CANRX, RXCHG), this field can only be sent if the message it relates to was electronic. For example, if the prescription was via paper or telephone, a subsequent refill request message would not have a relates to identifier.

On other transactions that do not have a paired follow up message (such as NEWRX, PASCHG, GETMSG, CENSUS) , this field is an optional secondary identifier based on trading partner agreements or need of the originating system.

**UIH**

Message Reference Number (UIH-020-0062) remarks were changed from

*Rx Number or Unique ID from doctor.* This field contains a reference number for the Message, which may be the Prescription Number or Patient Folio number. It is a reference field which can uniquely identify at any point to the sender the transaction being referenced. See "Transmission Examples" section for usage.

For RESUPP - This field assigned by the prescriber system.

**to**

This is the prescription number assigned by the pharmacy system. Must be the same value as in UIT-010-0062 Message Reference Number.

Dialogue Reference - Initiator control reference (UIH-030-01-0300) remarks were changed from

*Trace number assigned by sender.* This field may be used as a trace number for the Message. It is a reference field which can uniquely identify at any point to the sender the transaction being referenced. While this data element is not mandatory, it is mandatory that if sent on a request, it should be returned on any conversation referencing this request.

## ***SCRIPT Standard Implementation Guide***

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For Long Term Care (LTC) Medication Change Process - If Prescriber is changing an original Script, this is the Order id of the original Script.

**to**

If this composite is sent, this field is mandatory.

This is the reference number assigned by the prescribing system. Note: Some vendors carry through life of prescription; others change per prescription order.

In any transaction that a reference number assigned by the prescribing system is not applicable, this field is not used.

### **UIT**

#### **Message Reference Number (UIT-010-0062) remarks were changed from**

Must be the same value as in UIH 0062.

**to**

Must be the same value as in UIH-020-0062 Message Reference Number, which is the prescription number assigned by the pharmacy system.

In any transaction that a prescription number assigned by the pharmacy is not applicable, this field is not used.

#### **The following verbiage was modified from**

All messages have two "tie back" fields. The first is in the trace number in the UIB segment, which will be referenced at the communications layer. The second "tie back" field is the reference number in the UIH segment. It is referenced at the application or business level. In the case of a change password transaction, both levels are the same.

**to**

All requests and responses have two "tie back" fields. The first is Transaction control reference (Message ID) (UIB-030-01-0306) which relates to the transmission. The second "tie back" field is Initiator reference identifier (Relates to Message ID) (UIB-030-02-0303) which is used to link messages. See "[UIB Interactive Interchange Control Header](#)" for usage rules.

#### **The following verbiage was modified from**

- \* An error message-Error messages can be received under two different conditions. It is necessary to examine the source (Segment UIB Field 070/01/0010) and trace number (Segment UIB Field 030/01/0306) to determine its meaning. If the source is Mailbox and the trace number refers to the just sent Get Message, then an error has been discovered by Mailbox in the Get Message request itself.

**to**

- \* An error message-Error messages can be received under two different conditions. It is necessary to examine the source Interchange Recipient – Recipient ID – level one (UIB-070-01-0010) and **Transaction control reference (Message ID) (UIB-030-01-0306)** to determine its meaning. If the source is Mailbox and the trace number refers to the just sent Get Message, then an error has been discovered by Mailbox in the Get Message request itself.

#### **The following verbiage was modified from**

The differentiation of the three use cases is with the use of Message Function, coded (REQ-010). If a NEWRX or CANRX does not have a C1, C2, or C3 indicator, it is treated as a normal CANRX and/or NEWRX, regardless if it has a reference to an original order in the Initiator control reference (UIH-030-01).

**to**

The differentiation of the three use cases is with the use of Message Function, coded (REQ-010). If a NEWRX or CANRX does not have a C1, C2, or C3 indicator, it is treated as a normal CANRX and/or NEWRX, regardless if it has a reference to an original order in the Initiator reference identifier (Relates to Message ID) (UIB-030-02).

**"Transmission Examples"** were updated to support the above modifications.

A new Frequently Asked Question was added "[How to Link the Cancel Prescription Message \(CANRX\) to the New Prescription Message \(NEWRX\)](#)".

## 16.30 VERSION 10.10

### PVD Segment

Due to possible identifiers needed for prescribers, in the PVD Segment, the 020 loop was increased from 3 to 10.

<b>020</b>	I001	Reference Number	C 10
01	1154	Reference Number	M an..35
02	1153	Reference Qualifier	C an..3

A new value was added to Reference Qualifier (020-02-1153) for a Certificate to Prescribe identifier.

Also in the PVD Segment

<b>010</b>	4705	Provider Coded	C 1 an..3
------------	------	----------------	-----------

was modified to disconnect from X12 DE 1221 code list based on discussion with X12 representatives, and pull from an NCPDP-defined code list. The values were not changed but the list was shortened to only applicable values for this field.

### COO Segment

In the COO Segment, the field was inadvertently marked as Mandatory. It has been corrected to Conditional.

<b>140</b>	7886	Patient Identifier	C an..80
------------	------	--------------------	----------

In the COO Segment there was inconsistency in how the loops of a payer were identified in the CENSUS transaction, and then in other transactions. Insurance Type, coded (4703) was sunsetted and Payer Responsibility Code (8014) was added.

<b>100</b>	4703	Insurance Type, coded	C 1 an..3
------------	------	-----------------------	-----------

<b>100</b>	8014	Payer Responsibility Code	C 1 an..3
------------	------	---------------------------	-----------

This field was made conditional in all transactions that use the COO Segment. Usage notes were modified.

010-I001-02-1153	Reference Qualifier	<p>Qualifier identifying the Reference Number. Primary payer information, if used, must be in first loop of the COO Segment. Secondary payer information, if used, must be in second loop of the COO Segment. Tertiary payer information, if used, must be in third loop of the COO Segment. Within each COO Segment, the Reference Number (010-I001) repeats &gt;1 times. For a given Primary Payer loop of the COO Segment, the Reference Number and Qualifier are used to denote identification of the payer, for example with a BIN Number and a Processor Control Number (if applicable). The Reference Number and Reference Qualifier will loop twice if there is a BIN Number (one loop of (010-I001)) and a Processor Control Number (second loop of (010-I001)) to report. If the payer does not use a Processor Control Number, the Reference Number (010-I001) would only loop once, containing the BIN Number.</p> <p>See below.</p>
------------------	---------------------	--

010-I001-02-1153	Reference Qualifier (continued)  Qualifier identifying the Reference Number. Primary payer information, if used, must be in first loop of the COO Segment. Secondary payer information, if used, must be in second loop of the COO Segment. Tertiary payer information, if used, must be in third loop of the COO Segment.  Reference Identification Qualifier X12 DE 128.  For CENSUS - for Private Pay, this will be empty.  Values: See External Code List
------------------	---

The COO segment may loop up to three times, with specific rules. If used, the COO segment field 010-1153 Reference Qualifier should contain the code for primary payer in the first loop of the COO Segment, with the appropriate number in 1154 Reference Number.

If secondary payer information is sent, the second loop of the COO Segment must contain the code and number for the secondary payer. If tertiary payer information is sent, the third loop of the COO Segment must contain the code and number for the tertiary payer.

This composite can be used in the RXCHG transaction and may contain the responsible party or the payer's phone number.

150	I016 CommunicationNumber	C >1
01	3148 CommunicationNumber	C an..80
02	1131 Code List Qualifier	C an..3

#### DRU and CPD Segment

No business need had been found for the DRU-020 Quantity Composite loop (This composite is for the count of tablets or number of grams) and CPD-020 Quantity Composite (Composite for ingredient information) to repeat. The loop was changed from 2 occurrences to 1 occurrence.

020	I009 Quantity	C 2 1
-----	---------------	-------

No business need had been found for the DRU-060 Refill Quantity Composite loop (This composite is used for refill information). The loop was changed from 2 occurrences to 1 occurrence.

060	I018 Refill Quantity	C 2 1
-----	----------------------	-------

#### CENSUS Transaction Modifications

Implementers of the Census transaction have identified opportunities to enhance the message to provide additional useful information related to resident leaves of absence, and also to support a common pharmacy dispensing action associated with the event. Additional guidance has been added for currently-supported discharge events—specifically with respect to order discontinuation at the time of discharge. Section "Census Update Transaction" was modified.

Added to REQ Segment:

110	8013 Dispensing Request Code	C an..3
-----	------------------------------	---------

Date/Time/Period Qualifier (REQ-070-I006-01-2005) added the following:

For CENSUS, Message Function, Coded (REQ-010) values D3 (Discharge – Return Anticipated), D4 (Discharge Other), LT (Therapeutic Leave of Absence) and LG (Hospital Leave of Absence), - value AR (Anticipated Patient Return Date/Time) is

used in the second Date loop. When populated, the second date loop indicates the date and time of the resident's anticipated return to the facility, using value "AR".

A new value for Anticipated Patient Return Date/Time was added.

Time Zone (REQ-080) and subfields are now conditional in CENSUS. Use of Time Zone is also referenced in section "*Time*".

An editorial correction was made to the Party Name and First Name in the PTT Segment in section "Specific Segment Discussion". The standard format requires the Name composite as mandatory, which requires some part of the name to be sent. RXHRES column inadvertently had Party Name and First Name listed as conditional. They have been changed to Mandatory.

Qualifiers were marked Conditional were changed to Conditional Mandatory since they are tied to the field they are qualifying.

## **16.31 VERSION 10.11**

In the Sig Segment, there was a typo in the verbiage "when/how often/frequently/at what rate - the medication is to taken" was modified to "when/how often/frequently/at what rate - the medication is to be taken" ("be" was missing).

A new use case for Medication History Request and Response from a Pharmacy to a Prescriber was added to request all medications dispensed and/or administered under the prescriber's direction. Item Description Identification (7009) in the DRU Segment and CPD Segment added value "A" (Dispensed and Administered). Example 33. Pharmacy Requests Medication History with Source Segment from a Prescriber (Direct Connect) was added.

In the PTT Segment, the patient's primary language has been added. While the original request limited the use to some transactions, to allow uniformity in the PTT Segment, the field has been made conditional in all transactions that use the PTT Segment.

**090      3453     Language name code**

**C    1    an..3**

In the RES Segment, Response Type, Coded (010-4343) added the following note: Note: C = Approved with changes **cannot** be utilized for a Cancel Response (CANRES).

The Cancel Response Transaction supports the ability to deny the cancel request due to the prescription being transferred to another organization's pharmacy. The PVD Segment (Pharmacy) has been added as a conditional segment. In the RES Segment, Code List Qualifier 020-1131 has a new value "AR" (Unable to cancel prescription; prescription was transferred to another pharmacy.)

The New Prescription (NEWRX) message adds an order capture method element that describes how the medication order was defined and entered into the electronic prescribing system for long-term and post-acute care settings. In the DRU Segment, the following was added.

**190      8015 Order Capture Method**

**C    an..2**

In section "Transmission Examples" examples that cited "P1" as the pharmacy have been

corrected to “P2”. “P1” is Pharmacist. (In previous versions “P1” and “P2” have been used interchangeably for Pharmacy and Pharmacist, but “P2” is the correct value for pharmacy.)

Support for RxNorm code specific qualifiers have been added to field 1153 as a mechanism to transition from text Item Descriptions to a code system. The RxNorm generic qualifier has been sunsetted. References in field 3055 to “X12 DE 235” have been removed.

Individual Relationship, coded (9701) has been sunsetted in the PTT Segment and moved to the COO Segment. Person Code (8016) has been added to the COO Segment.

**160** 9701 Individual Relationship, coded C 1 an..3

**170** 8016 Person Code C 1 n..3

The patient Address fields (060-I004) are mandatory in a NEWRX. “[Transmission Examples](#)” section has been updated as appropriate.

For PVD Segment (Prescriber, Supervisor), Reference Qualifier (020-I001-02-1153), the Remarks have been modified from

Defines the Reference number, field 1154. X12 DE 128.

Values: See External Code List

One occurrence is the prescriber number. One occurrence may be used to identify the clinic. One occurrence may be used to identify a supervisor.

If the prescriber has an NPI, one occurrence must contain the value “HPI” (NPI). If the prescriber has a DEA number, one occurrence must contain the value “DH” (DEA Number). Not every entity allowed to prescribe may have an NPI or DEA. If this is the case, the other identifiers can be used.

to

Defines the Reference number, field 1154. X12 DE 128.

Values: See External Code List

One occurrence is the prescriber number. One occurrence may be used to identify the clinic. One occurrence may be used to identify a supervisor.

At least one occurrence of the PVD-020-01 and –02 must contain “HPI” (NPI). Prescriber individual (not organizational) NPI Number is mandatory. This is mandatory for the PVD (PC), not the PVD (SU).

For all transactions except RXHRES, if the prescriber has an NPI, one occurrence must contain the value “HPI” (NPI).

For all transactions except RXHRES, if the prescriber has a DEA number, one occurrence must contain the value “DH” (DEA Number).

Follow-Up Request (8017) has been added to the REQ Segment. Section “[Follow-Up Request Use](#)” has been added.

**120** 8017 Follow-Up Request C n1

Subsection “[Trace Number Usage](#)” added an example to show use of this field.

Do Not Fill/Profile Flag (7892) definition was modified slightly, and a new value of “H” (Hold) was added. From:

Used for medications ordered by a prescriber but not requiring dispensing at this time, but required for administration and available for drug-to-drug interactions.

Values: See External Code List

To:

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Used for medications ordered by a prescriber but not requiring dispensing at this time, but may be required for administration and may be available for DUR/DUE interactions.

If the prescriber knows the patient does not need the prescription filled right away, then they should send the pharmacy this indicator.

Values: See External Code List

An example was added on the field.

Example: This indicator will often be used when the prescriber wishes to write a new prescription for a patient, but the patient currently has supply on hand for a previously authorized prescription. Once the patient's supply is depleted, the patient will contact the pharmacy to request the prescription on hold be filled.

### Quantity

Quantity Qualifier (DRU 060-I018-01-6063) no longer supports the value of "PRN" (As Needed). Section "Medication Occurrences and Quantity Qualifier (060-I018-01-6063)" has been added with important usage information. In addition, the Quantity and the Qualifier are now "not used" in RESUPP and DRUADM transactions.

Also, Quantity (060-I018-02-8010) had the note

Note: This field is mandatory except when DRU 060-01-6063 Quantity Qualifier = PRN. If DRU 060-01-6063 Quantity Qualifier = PRN, DRU-060-02 must NOT be present.

Since PRN is no longer supported, this note has been modified to

Note: This field is mandatory when the Quantity Qualifier (060-I018-01-6063) is sent.

Based on review of this modification, changes were made in section "Medication History Response (RXHRES)" to denote for the DRU Segment, prescribed, dispensed, or dispensed and administered may be the segments sent in the history, depending on the sender's perspective. Section "Transmission Examples" was updated based on the clarifications for Quantity Qualifier.

### PVD Segment (Prescriber or Supervisor)

The Name composite (050-I002) in the PVD (Prescriber or Supervisor) Segment is now mandatory on RXHRES transactions. On all applicable transactions, the First Name (050- I002-02-3702) is mandatory and includes a requirement that the field must contain at least one letter. Address (080-I004) includes a requirement that the prescriber address on a NEWRX must be the practice address.

Section "Transmission Examples" was updated based on the clarifications for Name and Address.

The XML schema was updated to include the Compound elements where missing on medication prescribed, dispensed, or requested elements.

### Date Issued (Written Date) Annotation

Date/Time/Period (DRU 040-I006-02-2380), the rule is stated "For all transactions - At least one loop must contain 85 = Date Issued (Written Date)." In SCRIPT XML, this note should have been on the Medication Prescribed not on the Medication Requested for RxChangeRequest. Other transactions were reviewed and clarified as well. This error has been corrected in SCRIPT XML 10.11.

### AdverseEvent

Under Census->Allergy AdverseEvent is marked as mandatory. This should be optional because if No Known Allergies is set to Yes, then is the only tag that is sent. This error has been corrected in SCRIPT XML 10.11.

## **16.32 VERSION 2010121**

The EDI syntax of SCRIPT has been sunsetted. Only the XML syntax will proceed with this version. The XML schemas are created from the NCPDP model. The schemas are transport, datatypes, structures, ecl, script, and specialized. The versioning was changed to date-based for consistency. To facilitate validation, the transport schema contains

TransportVersion
DatatypesVersion
TransactionVersion
StructuresVersion
ECLVersion

Where the version will contain the date-based NCPDP published version of the schema used.

TransactionDomain
-------------------

This field contains which domain is being used – SCRIPT or Specialized.

The NCPDP **XML Standard** was created. Section “*Trace Number Usage*” was moved into the NCPDP **XML Standard**. GetMessage, Verify, Status, and Error transaction guidance was moved into the NCPDP **XML Standard**.

Census transaction was moved into the NCPDP **Specifications Implementation Guide**.

Support for clarification of WrittenDate was added. Section “*Discussion of Written Date*” was added to the Prescription Change Response. Section “*Discussion of Written Date*” was added to the Refill Prescription Response. A paragraph clarifying the use of WrittenDate was added in section “*Clarification of Response Type, Coded*”. Section “*WrittenDate*” was added in the “*Drug Segment*”. The examples were updated as well.

The slashed 0 has been replaced by 0 in the examples. While the slashed 0 was easier to read, it was harder to search.

References to NCI code lists in examples were modified to be clearer, to reflect their intent, and to reflect the NCPDP subset files created by NCI. See the NCPDP **External Code List**, section “**Introduction**” for important guidance on the NCI terminologies.

NCI values of Diagnostic, Therapeutic, and Research Equipment - Pharmaceutical Dosage Form (<http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml> - NCI Thesaurus) – source value  
NCPDP: AA

**Change to**

NCPDP Drug **StrengthForm** Terminology - available at  
<http://www.cancer.gov/cancertopics/terminologyresources/page7>

NCI values of Units of Presentation (<http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml>  
- NCI Thesaurus) – source value NCPDP: AB

**Change to**

NCPDP Drug **StrengthUnitOfMeasure** Terminology - available at  
<http://www.cancer.gov/cancertopics/terminologyresources/page7>

NCI values of Property or Attribute - Unit of Measure - Unit of Category - Potency Unit

(<http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml>)

- NCI Thesaurus) – source value NCPDP: AC

**Change to**

NCPDP Drug **QuantityUnitOfMeasure** Terminology - available at  
<http://www.cancer.gov/cancertopics/terminologyresources/page7>

NCI values of Units of Presentation (<http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml>)

- NCI Thesaurus) – source value NCPDP: AB

**Change to**

NCPDP **MeasurementUnitCode** Terminology - available at  
<http://www.cancer.gov/cancertopics/terminologyresources/page7>

The SCRIPT schema had various “RequestTypes” and “ResponseTypes”. These have been flattened out from the model for implementers reuse.

Description – used in Error transaction - size changed to xs:string to handle XML parser errors.

Higher level element tag changes:

There were two FacilityTypes, with a difference of an Identification mandatory in one and not in another. The XML TG reviewed and recommended that an Identification should be present. Therefore, the two FacilityTypes were flattened to one FacilityType with Identification mandatory.

Two PrescriberTypes that were identical, so PrescriberType survives.

Two SupervisorTypes were joined. Renamed MandatorySupervisorType to SupervisorTypeMandatoryAddress.

There were two RxHistoryPatientTypes that had patient name as optional. SCRIPT EDI required name, so it was felt this was an error. These types joined to PatientType.

Multiple MedicationTypes that had commonality. Merged into PrescribedMedicationType.

Element name changes:

ChangeRequestType is MessageRequestCode to be reusable

StoreName to BusinessName to more correctly reflect the usage.

The model generates the XML elements (previously thought of as segments) and these are now in the order from the model.

In SCRIPT XML elements that had a forced (one value only supported) for a qualifier, the xsd environment now has just the code and the text elements. The type defines the code set in the name (e.g. SNOMEDCode). When this is the case, the code is mandatory and the text is optional (e.g. Allergy, Diagnosis elements in Census) – in the Specialized.xsd supported with the new **Specialized Standard Implementation Guide**.

On optional elements that have a code and qualifier only, the code and qualifier are mandatory. (If you are going to send the optional element, you have to send the code and qualifier subelements). See DrugUseEvaluation – CoAgent.

BenefitsCoordinationRequestType and BenefitsCoordinationResponseType should both have optional CardholderName per the imp guide. For consistency, when GroupID is exchanged, GroupName can also be exchanged (BenefitsCoordination). Added. Different BenefitCoordinationTypes were making the model confusing and not consistent. Make one BC for RxHistory and one for all others.

RxHistoryRequest – BenefitsCoordination – there was a choice box of EffectiveDate and ExpirationDate –The dates were stuck in Benefits because in the EDI the COO was the better place to put it; but that doesn't need to continue in XML. The two dates are now in a type at a higher level and renamed to RequestedDates with subelements of StartDate and EndDate. If you send one; you must send the other, but will not be a choice box.

Drug Segment –

180	S044 Compounded Prescription Route of Administration	C 1
	01 7934 Route of Administration Text	C an..50
	02 7935 Route of Administration Code Qualifier	C an..2
	03 7936 Route of Administration Code	C an..15
	04 7937 Multiple Route of Administration Modifier	C an..50

Error – the Multiple Route of Administration Modifier should not have been included. It doesn't make sense to have the “and” “or” in the DRU Segment when this is the FINAL route of administration. This does not repeat in the DRU Segment. This was copied from Sig, where it is appropriate, and does loop. This was wrong in SCRIPT 10.7 and above. It has been corrected.

Any free text sigs in old examples that had Latin – removed the Latin.

“Reject Codes” – XML does not need default rejects; the XML parser handles syntax errors. Application-level errors were analyzed. The new list is below. (In SCRIPT verbiage this was 1131 – Code List Qualifier – Reject Code - STS Segment).

Syntax: these are errors that would be caught by the XML parser. Xpath of the element must accompany.

500	XML syntax error – Parser error
-----	---------------------------------

Application: these are errors that would be caught after the XML parser, by the application software.

008	Request timed out before response could be received
210	Unable to process transaction. Please resubmit.
220	Message is a duplicate Change to Transaction is a duplicate

Application: these are errors that would be caught after the XML parser, by the application software. Xpath of the element must accompany. These are “categories” of errors; with intentional gaps in case there is a need to assign specific codes under a category.

1000	Unable to identify based on the information submitted
2000	Data format is valid for the element, but content is invalid for the situation/context

3000	Does not follow NCPDP standard or implementation guide rules.
------	---

HighestVersionSupported was sunsetted as it is not used and can be confusing. It was an EDIFACT field.

New elements added:

- ReasonForSubstitutionCodeUsed – for Brand Medically Necessary requirements of Medicaid patient prescriptions when applicable. Section “*Brand Medically Necessary for Medicaid Prescriptions*” was added.
- ProhibitRefillRequest – the prescriber can indicate to the pharmacy that the prescriber should not be contacted for refills for this prescription. Used in urgent care, emergency department, clinic etc. where prescriptions are only written for a one-time visit.
- ChangeReasonText – explanation for the change. Modifications were made to section “*Prescription Change Request Transaction*”. The sentence “The request may or may not be sent with additional questions/comments in the Note field” was replaced with “**The <ChangeReasonText field> is only allowed to be used for global messages. For drug specific messages, the <Note> field is to be used.”**

On a RxChangeRequest, in <MedicationRequested>, the <Sig> and <Quantity> have been changed to optional as there are times the pharmacist would prefer that the prescriber define the sig and quantity.

<MessageRequestCode> is now mandatory in RxChangeRequest and RxChangeResponse transactions. New values of “D” (DUE) and “C” (Script Clarification) have been added. RxChangeResponse must contain the <MessageRequestCode> sent on the RxChangeRequest.

## **16.33 VERSION 2011071**

The section “*Query Introduction*” was added. NewRxRequest and NewRxResponseDenied transactions were added, with examples.

The element <SplitScript> was added to <MedicationPrescribed> for bridge scripts; used when a retail order is for a limited supply of the medication until the mail order prescription arrives.

The element <DaysSupply> length has been modified from the original an..35 to n..3.

## **16.34 VERSION 2011091**

<IndicationValueUnitOfMeasureCode> was changed to optional in the schema.

A new value “E” was added to <DoNotFill>. Section “*DoNotFill*” added guidance for this value usage.

## **16.35 VERSION 2012011**

<MultipleAdministrationTimingModifier> was corrected to  
<MultipleSiteOfAdministrationModifier> in <StructuredSig>. In the External Code List,

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Substitutions was limited to only values of 0 and 1 allowed for SCRIPT Standard for these classes:

NewRxPrescribedMedication  
HistoryPrescribedMedication  
PrescribedMedication  
ResupplyMedication

## **16.36 VERSION 2012031**

The examples in section “Source Element” were updated to reflect the actual tag names to the <HistorySourceID>.

<HistoryPrescriberOrderNumber> was changed to an1..35 from an ID-based element since it no longer needs to be ID-based. It is also supported in RxHistoryResponse transactions.

Section “Transmission Examples” was updated in examples that showed samples or prior authorizations since the PriorAuthorizationID structure was modified in the schema.

See NCPDP **XML Standard** for other modifications for this version. Section “Transmission Examples” was updated in examples that were affected by these changes.

## **16.37 VERSION 2013011**

Section “Diagnosis Element” was added. It states that if a SNOMED code is sent, the corresponding ICD must also be sent and the ICD should be what the doctor would use for their billing transaction.

The order of the <Supervisor> elements were modified to line up with the <Prescriber> elements.

To allow for additional identifiers, including but not limited to, standard email addresses in the <From> and <To> field of SCRIPT and Specialized transactions, the validation has been relaxed to (mailto:)?[^\.]{1,35}(\.[^@]{1,3})?(@[A-Za-z0-9]+\.[A-Za-z]{2,4})? to allow for any alphanumeric string up to 80 characters.

<PrimaryDiagnosisCodeQualifierCode> removed values of E (Micromedex/Medical Economics), F (First DataBase), M (Medi-Span Product Line), and added value LD (SNOMED).  
<SecondaryDiagnosisCodeQualifierCode> added value LD (SNOMED).  
<CoAgentQualifier> removed value 22 (Medi-Span Product Line Diagnosis Code).

Updates were made to the <Sig> based on industry recommendations to the NCPDP Structured and Codified Sig Implementation Guide version 2.0. While there are many changes, the end result is a method to handle text-based sigs or structured Sigs in a consistent manner. The use of the structured Sig introduces an XSLT which is used to a grammar for consistent generation of text from a structured Sig.

<StructuredSig> has been renamed to <Sig>.

<Directions> has been sunsetted from the <Medication> element. <Sig> is used for all directions. For those entities only using a textual-based sig, the <SigText> is used instead of <Directions>. In any transaction where <Directions> was mandatory, <Sig> is now mandatory. The same rule follows for optional or not used.

The following note was added to section "<SigText> Rules".

Note: As this standard proceeded for approval, the membership approved the <SigText> with a limit of 1000 bytes. If the Sig is:

- Generated from pure free text and is over 1000 bytes, or
- Generated from the structured Sig and is over 1000 bytes or
- Signed as part of controlled substance procedures and is over 1000 bytes

The prescribing system will need to arrange for the prescription or the Sig to be sent manually.

Final <RouteOfAdministrationText> and <RouteOfAdministrationCode> were sunsetted as the route is now contained in the <Sig>.

The following elements were added:

InstructionIndicator	TriggerTextCode
AdministrationIndicator	TriggerTextQualifier
AdministrationTimingNumericValue	TriggerText
DoseAmountTextCode	DurationClarifyingFreeText
DoseAmountTextQualifier	MaximumDoseRestrictionClarifyingFreeText
DoseAmountText	IndicationValueQualifier
ClarifyingFreeText	IndicationValueCode
AdministrationTimingClarifyingFreeText	IndicationClarifyingFreeText
DoseClarifyingFreeText	StopIndicatorTextQualifier
DoseCalculationClarifyingFreeText	StopIndicatorTextCode
VehicleClarifyingFreeText	StopIndicatorText
RouteOfAdministrationClarifyingFreeText	MaximumDoseRestrictionFormQualifier
SiteOfAdministrationClarifyingFreeText	MaximumDoseRestrictionFormCode
TimingClarifyingFreeText	MaximumDoseRestrictionFormText
AdministrationTimingModifierCode	VehiclePrepositionQualifier
AdministrationTimingModifierQualifier	VehiclePrepositionCode
AdministrationTimingModifierText	VehiclePrepositionText

The following elements were modified:

Element	Removed extraneous word "code" from qualifier element name	Definition	Size	Values	Format
SNOMEDVersion		X	X		
FMTVersion		X	X		
SigFreeText to SigText		X	X		
MultipleSigModifier to MultipleInstructionModifier		X	X		

Element	Removed extraneous word "code" from qualifier element name	Definition	Size	Values	Format
DoseDeliveryMethodCode			X		
DoseDeliveryMethodQualifier	X		X	X	
DoseDeliveryMethodText			X		
DoseDeliveryMethodModifierCode			X		
DoseDeliveryMethodModifierQualifier	X		X	X	
DoseDeliveryMethodModifierText		X	X		
DoseFormCode		X	X		
DoseFormQualifier	X		X	X	
DoseFormText		X	X		
DoseRangeModifier			X		
DosingBasisUnitOfMeasureCode		X	X		
DosingBasisUnitOfMeasureQualifier	X		X	X	
DosingBasisUnitOfMeasureText		X	X		
DosingBasisRangeModifier			X		
BodyMetricValue					X
BodyMetricQualifier			X		
CalculatedDoseUnitOfMeasureCode		X	X		
CalculatedDoseUnitOfMeasureQualifier	X		X	X	
CalculatedDoseUnitOfMeasureText		X	X		
VehicleNameCode to VehicleCode		X	X		
VehicleNameCodeQualifier to VehicleQualifier	X		X	X	
VehicleName to Vehicle		X	X		
VehicleUnitOfMeasureCode		X	X		
VehicleUnitOfMeasureQualifier	X		X	X	
VehicleUnitOfMeasureText		X	X		
MultipleVehicleModifier		X	X		
RouteOfAdministrationCode		X	X		
RouteOfAdministrationQualifier	X		X	X	
RouteOfAdministrationText		X	X		
MultipleAdministrationTimingModifier to MultipleTimingModifier		X	X		
SiteOfAdministrationCode		X	X		
SiteOfAdministrationQualifier	X		X	X	
SiteOfAdministrationText			X		
AdministrationTimingUnitsCode		X	X		
AdministrationTimingUnitsQualifier	X		X	X	
AdministrationTimingUnitsText		X	X		
AdministrationTimingCode to AdministrationTimingEventCode		X	X		
AdministrationTimingCodeQualifier to AdministrationTimingEventQualifier			X		
AdministrationTimingText to AdministrationTimingEventText		X	X		
RateUnitOfMeasureCode			X		
RateUnitOfMeasureQualifier	X		X	X	
RateUnitOfMeasureText		X	X		
TimePeriodBasisCode		X	X		
TimePeriodBasisQualifier	X		X	X	

Element	Removed extraneous word "code" from qualifier element name	Definition	Size	Values	Format
TimePeriodBasisText		X	X		
FrequencyNumericValue			X		
FrequencyUnitsCode		X	X		
FrequencyUnitsQualifier	X		X	X	
FrequencyUnitsText			X		
VariableFrequencyModifier			X		
IntervalUnitsCode			X		
IntervalUnitsQualifier	X		X	X	
IntervalUnitsText			X		
DurationTextCode			X		
DurationTextQualifier	X		X	X	
DurationText			X		
MaximumDoseRestrictionUnitsCode		X	X		
MaximumDoseRestrictionCodeQualifier to MaximumDoseRestrictionUnitsQualifier			X	X	
MaximumDoseRestrictionUnitsText		X	X		
MaximumDoseRestrictionVariableNumericValue to MaximumDoseRestrictionDurationValue		X			
MaximumDoseRestrictionVariableUnitsCode to MaximumDoseRestrictionDurationUnitsCode		X	X		
MaximumDoseRestrictionVariableUnitsQualifier to MaximumDoseRestrictionDurationUnitsQualifier			X	X	
MaximumDoseRestrictionVariableUnitsText to MaximumDoseRestrictionDurationUnitsText		X	X		
IndicationPrecursorCode		X	X		
IndicationPrecursorQualifier	X		X	X	
IndicationPrecursorText			X		
IndicationTextCode to IndicationCode			X		
IndicationTextCodeQualifier to IndicationQualifier			X	X	
IndicationText		X	X		
IndicationValueText		X	X		
IndicationValueUnitOfMeasureCode		X	X		
IndicationValueUnitOfMeasureQualifier	X		X	X	
IndicationValueUnitOfMeasureText		X	X		
VariableIntervalModifier			X		
DurationNumericValue			X		
IndicationVariableModifier			X		

The following elements were sunsetted:

Directions  
 SigSequencePositionNumber  
 DoseCompositeIndicator  
 StopIndicator  
 Directions  
 SigFreeTextStringIndicator  
 MaximumDoseRestrictionVariableDurationModifier  
 MultipleRouteOfAdministrationModifier

## MultipleSiteOfAdministrationModifier

MultipleVehicleModifier added value “TO”.

Examples were modified to remove <Directions> and support <Sig>. Some of the sig examples were renumbered, to be more in sync with the NCPDP *Structured and Codified Sig Implementation Guide*.

To support standardized demographic fields, the following modifications were made.

- CommunicationNumber has been modified to unique element tags.
- AddressLine1 was modified from an1..35 to an1..40.
- AddressLine2 was modified from an1..35 to an1..40.
  - Section “*General Element*” subsection “Address” was added with usage notes.
- ClinicName was modified from an1..35 to an1..70.
- FacilityName was modified from an1..35 to an1..70.
- GroupName was modified from an1..35 to an1..70.
- PayerName was modified from an1..35 to an1..70.

Added **NCPDP SCRIPT Implementation Recommendations** document to section “Document Scope”.

An error was found in the RxHistoryRequest and Response transactions. The <Prescriber> and <Pharmacy> elements were, per the imp guide, optional. This has been corrected.

## **16.38 VERSION 2013012**

The following elements were added which are all textual representations of the Code they support:

- <CoAgentCodeDescription>
- <PrimaryDiagnosisCodeDescription>
- <SecondaryDiagnosisCodeDescription>

In any example the decimal point in an ICD diagnosis code was removed. Per the owner - ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is **not** included in the code. The reporting of the decimal between the third and fourth characters is unnecessary because it is implied. This statement was added in section “Diagnosis Element”.

<QuantityValue> in the Medication segment is n1..11. <CompoundQuantityValue> expanded from n1..11 to n1..14 to be consistent with the expansion in the Telecommunication Standard for the compound ingredient quantity only.

## **16.39 VERSION 2013041**

Section “Updates and Corrections to Standards” was added.

International address support was added with the following changes. Examples have been updated.

- <State> element name was changed to <StateProvince>
  - <StateProvince> changed from a defined value list in the ecl.xsd to a pointer to an international list.

- Added annotation that the State must be mailable in the country (e.g. when exchanging US States, the two digit alpha code is to be used, in Canada the “two space two” Province code is to be used). (ISO-3166-2 link from [http://www.iso.org/iso/country\\_codes](http://www.iso.org/iso/country_codes) or [http://en.wikipedia.org/wiki/ISO\\_3166-2](http://en.wikipedia.org/wiki/ISO_3166-2))
- <StateProvince> size changed to (string) an.
- Appendix. C in the ECL document points to ISO-3166-2 link.
- <ZIPCode> element name change to <PostalCode>
  - PostalCode size changed to (string) an.
  - The pattern was removed.
  - Added annotation that the PostalCode must be mailable in the country (e.g. for US, the PostalCode length is 5 or 9, when used for Canadian Postal Code – This left justified field contains the three-digit forward sortation area (FSA) followed by a space, then followed by a Local Delivery Unit. (Format AOA 0AO, where A is a letter and 0 is a digit, with a space separating the third and fourth characters.))
- New element <CountryCode> was added
  - Size an1..2.
  - Annotation note points to ISO-3166-1 [http://www.iso.org/iso/country\\_codes](http://www.iso.org/iso/country_codes).
  - Annotation note “Required if country is not “US” is placed on CountryCode when it is in an optional address type.
- The current mandatory/optional rules on fields in addresses did not change. Field designations in addresses did not change. Examples
  - If <MandatoryAddressType> (all pertinent address elements are mandatory) – CountryCode is mandatory.
  - If optional AddressType – CountryCode is optional.

In Version 2012011, it is noted that in the External Code List, Substitutions was limited to only values of 0 and 1 allowed for SCRIPT Standard for these classes:

This was incorrect. Substitutions were meant to be limited to values of 0 and 1 in all SCRIPT transactions. This has been corrected.

## **16.40 VERSION 2013071**

Prior authorization transactions and associated implementation guide sections were added.

- PAInitiationRequest
- PAInitiationResponse
- PAResponse
- PAResponse
- PAAppealRequest
- PAAppealResponse
- PACancelRequest
- PACancelResponse

Pa-structures.xsd was added to the schema files.

New values were added to <ReasonCode> for conscientious objection reasons. Values below have been sunsetted as the XML structure for RxFill supports <FillStatus> choices and values are not needed.

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AH	Patient has picked up prescription
AJ	Patient has picked up partial fill of prescription
AK	Patient has not picked up prescription, drug returned to stock

The <PriorAuthorization> element has been clarified. <PriorAuthorizationCodeValue> is now <PriorAuthorization>. <PriorAuthorizationCodeQualifier> has been sunsetted. Values PPONumber, Mutually Defined, IndividualPolicyNumber, Commercial, and DentistLicenseNumber have been sunsetted.

<PromotionNumber> has been renamed to <CouponNumber>.

PayerIdentification sequence has been changed from 0 to infinity to 1 to 1 to be in sync with other identification sequences. PayerIdentification size has been increased from 35 to 80. Value SecondaryCoverage has been sunsetted.

Existing field <PBMMemberID> is now available in the NewRx transaction.

In section “DrugUseEvaluation Element”, example subsections, there was a typographical error in the <CoAgentIDQualifier>. Value ND has been corrected to 03 or 38, 39, 40, or 41, DX has been corrected to 20 or 21.

“SCRIPT” to “script” was changed in the namespace prefix of the script.xsd to be consistent with other xsd e.g., transport, datatypes. The URI was changed from “SCRIPT” to “script” and “Transport” to “transport” to be consistent. The examples were updated.

Removed reference to NHIN.

Upon review, “Provider Elements” section clarified the use of the <Provider> and the <PrescriberAgent>. “Question Set and Coded Reference Support” section provided clarification of the concept of a coded reference. Section “Prior Authorization Introduction” included a note about the concept of a prescriber system. It also added a note about sending attachments when applicable. It also added guidance on returning a reason why a request was closed. Section “PA Cancel Request and Response Transactions” clarified the cancellation. Section “Prior Authorization Transactions” clarified that electronic prior authorization is not used for medication alternatives. Section “General Recommendations” added clarification about priority. Section “Key Question Set Elements” provided clarity for <AdditionalFreeTextIndicator>. “Coded Reference Usage” included a sentence about final review.

## **16.41 VERSION 2013101**

<To> and <From> (<AddressTypeQualifier>) added a value for “PY” (Payer) and “DIRECT” to the NCPDP **External Code List** for SCRIPT and Specialized. The field size changed from 80 to 255.

Additional <DescriptionCode> values were added to the NCPDP **External Code List** for SCRIPT and Specialized:

4000	Intermediary is unable to deliver transaction to the recipient
4010	Intermediary is unable to process response from recipient
4020	Intermediary system error
4030	Sender not allowed to send this transaction type

4040	Receiver does not support receiving this transaction type
------	---

A <TransactionErrorCode> value was added to the NCPDP **External Code List** for SCRIPT and Specialized:

700	Configuration Error
-----	---------------------

Section “*Digital Signature Information*” was added. <DigitalSignature> was added to the Header for controlled substances for specific fields in NewRx, RxChangeResponse and RefillResponse transactions. The two options cited in the EPCS regulation are provided. Notes were added to <SigText> and <Notes> in the table in this section. For backward compatibility, a hardcoded “R” for Refill Quantity Qualifier is supported. The guidance from the NCPDP **SCRIPT Implementation Recommendations** document for EPCS was added for the use of Drug Abuse Treatment Identifier and Medication Indication for GHB in the <Notes>. Limited information on generating and validating a digital signature is provided as there is more information available in the regulations, the internet, and other sources.

<Observation> was modified to a more practical structure and use from the original EDI-based structure. Section “*Observation Element*” was added. Elements <VitalSign>, <LOINCVersion>, <UnitOfMeasure>, and <UCUMVersion> were added. <MeasurementValue> is no longer a qualified field in the NCPDP **Data Dictionary**. <MeasurementDimension>, <MeasurementDataQualifier> and <MeasurementCode> were sunsetted.

A typographical error was found in the examples for the NCPDP Drug Dosage Form for “Aerosol, Metered”. The code was C42970. It has been corrected to C42960.

## **16.42 VERSION 2013101 MAY 2014**

A typographical error was found and corrected in the RxHistoryResponse structure. The choice for <MedicationDispensed>, <MedicationDispensedAdministered>, <MedicationPrescribed> should be optional. The diagram in section “*RxHistoryResponse Transaction*” and the schema have been updated.

## **16.43 VERSION 2014041**

The annotation in <DrugDescription> for any Medication type changed based on the recommendations approved in the NCPDP **SCRIPT Implementation Recommendations** document:

**Old:** Is the self-contained full drug name, strength, and form. If CompoundCoded = 2 (Compound), this field must contain “0” (zero means zero).

**New:** The appropriate source data element should contain the description from the commercially available product name (or the name that appeared when it was commercially available). It may generally contain the drug name, strength unit, and form, as appropriate. If CompoundCoded = 2 (Compound), this field must contain “0” (zero means zero).

The annotation in <CompoundingIngredientItemDescription> changed:

**Old:** CompoundingIngredientItemDescription is the self-contained full drug name, strength, and form of the ingredient.

**New:** The appropriate source data element should contain the description from the commercially available product name (or the name that appeared when it was commercially available). It may generally contain the drug name, strength unit, and form, as appropriate.

<ReasonCode> values were restricted to appropriate transaction types in the NCPDP **External Code List**. <ReasonCode> uses a standardized approach to supporting values. Charts have been added to the NCPDP **External Code List**. To support this standardized approach, the following data elements have been sunsetted from NCPDP **Data Dictionary** and **External Code List**.:

<CancelReasonCode> – will use <ReasonCode13>  
<ClosedReasonCode> – will use <ReasonCode10> for PAInitiationResponse; will use <ReasonCode11> for all other PA transactions as appropriate.  
<DeniedForCancelReasonCode> – will use <ReasonCode12>

In addition, <DenialReason> was removed from <DeniedNewPrescriptionToFollow> as there was no <ReasonCode> value usage. <Notes> was added to be consistent with other transactions. <RxFill><FillStatus><NotFilled> - <ReasonCode> was added (uses <ReasonCode7>) for consistency in use.

There is a business need to consolidate the RefillResponse <DeniedNewPrescriptionToFollow> process into one transaction instead of two to simplify the transaction flow and support only a refill request and response without the additional NewRx transaction. This change adds a new response type <Replace> to RefillResponse and will eventually sunset the <DeniedNewPrescriptionToFollow> response type in a future version. When <Replace> is sent the pharmacy treats this as a NewRx and cancels out the existing request. For backwards compatibility the <DeniedNewPrescriptionToFollow> will not be sunsetted until the industry is on a SCRIPT version supporting <Replace>.

RefillResponse no longer supports <MedicationPrescribed> or <MedicationDispensed>. It supports a new element <MedicationResponse>. Appropriate sections were updated including section “Discussion of WrittenDate”.

The element <AdditionalRefillsAuthorized> is sunsetted. <MedicationResponse> uses <NumberOfRefills> consistently.

Section “Refill Prescription Request Transaction” was modified to remove the last sentence:

From:  
**RefillRequest should never be responded to with a NewRx. If the RefillRequest is denied, the prescriber could then follow up with a NewRx.**

To:  
**RefillRequest should never be responded to with a NewRx. If there are any changes beyond what is outlined in section “Response Element”, the <Replace> response should be used.**

Important mapping information was added in section “<DeniedNewPrescriptionToFollow> Use and Sunset”.

Section “Clarification of ResponseType” modifications:

<Approved> in the table changed  
From:  
Grant the RefillRequest **as requested** by the pharmacy, or, when the pharmacy does not request a specific number of fills (<PharmacyRequestedRefills> is not present) and the prescriber approves any number of fills.

To:

Grant the RefillRequest **as requested** by the pharmacy, or, when the pharmacy does not request a specific number of fills (<PharmacyRequestedRefills> is not present) and the prescriber approves any number of fills.

The only conditions where an <Approved> response should be sent by the prescriber system in a RefillResponse –

- (1) When (<PharmacyRequestedRefills>) is greater than 0 and the prescriber concurs with the request by the pharmacy. The prescriber must submit a RefillResponse that includes a <NumberOfRefills> equal to what the pharmacy requested. <WrittenDate> must be updated when the current date differs from the one on the RefillRequest.
- (2) When <PharmacyRequestedRefills> is not present in RefillRequest, the prescriber must submit a RefillResponse that includes a <NumberOfRefills> greater than zero. <WrittenDate> must be updated when the current date differs from the one on the RefillRequest.

See the <Replace> response for any changes in a RefillResponse beyond what is stated here.

<ApprovedWithChanges> in the table changed

From:

Grant the RefillRequest, approving a <NumberOfRefills> different than the number specifically requested by the pharmacy. This will flag the software system that something has changed from the transaction request.

If the pharmacy did not request a specific number of refills (i.e., if the pharmacy omitted <PharmacyRequestedRefills> on the RefillRequest), <ApprovedWithChanges> is an inappropriate response.

To:

Grant the RefillRequest, approving a <NumberOfRefills> different than the <PharmacyRequestedRefills> requested by the pharmacy. This response type will flag the pharmacy system that the <NumberOfRefills> differs from what was sent in the RefillRequest.

If the pharmacy did not request a specific number of refills (<PharmacyRequestedRefills> is not present on the RefillRequest), <ApprovedWithChanges> is an inappropriate response.

The only condition where an <ApprovedWithChanges> response should be sent by the prescriber system in a RefillResponse –

- (1) When the number of <PharmacyRequestedRefills> requested by the pharmacy system (greater than zero) is a different number than the response <NumberOfRefills>. The prescriber must submit a RefillResponse that includes a <NumberOfRefills> (greater than zero and that differs from what the pharmacy requested). <WrittenDate> must be updated when the current date differs from the one on the RefillRequest.

See the <Replace> response for any changes in a RefillResponse beyond what is stated here.

<Denied> in the table changed

From:

In a <Denied> or <DeniedNewPrescriptionToFollow> response, the only new meaning that should be conveyed to the pharmacy is information that explains the denial. The meaning of clinically significant fields should not be changed in the RefillResponse.

To:

In a <Denied> response, the only new meaning that should be conveyed to the pharmacy is information that explains the denial. It is recommended that the prescribing software update the <NumberOfRefills> to zero and leave all other data as is in the RefillResponse.

<Denied> in the table changed

From:

Deny the RefillRequest as requested by the pharmacy (with no intention of issuing a new prescription). The meaning or intent of significant clinical fields will not be changed in the RefillResponse

To:

Deny the RefillRequest as requested by the pharmacy.

In a <Denied> response, the only new meaning that should be conveyed to the pharmacy is information that explains the denial. It is recommended that the prescribing software update the <NumberOfRefills> to zero and leave all other data as is in the RefillResponse.

<DeniedNewPrescriptionToFollow> in the table added that “This will be sunsetted in a future version”.

<Replace> was added in the table with explanatory information.

Removed:

It is important to define the phrases “some differences” and “substantive differences” in the *Prescriber’s Intent* column of the foregoing table in terms of specific data elements. In either case, “difference” is a difference in *meaning*, not a difference in *form*. For example, if the <DrugDescription> in a RefillRequest contains “CIPRO TABS 250mg” and the <DrugDescription> in the RefillResponse contains “CIPRO 250mg TABLETS”, there is no difference for purposes of this discussion. Similarly, if the patient <DateOfBirth> in the RefillRequest is 1949-07-27 and the patient <DateOfBirth> in the RefillResponse is 1949-03-27, there is no difference for purposes of this discussion *unless the prescriber believes he is referencing a different patient than the pharmacy*.

<WrittenDate> usage was highlighted and changed.

From:

When the prescriber responds <Approved> or <ApprovedWithChanges> the prescriber MUST set the <MedicationPrescribed> and <MedicationDispensed> <WrittenDate> to the date of the

approval. It is incorrect to echo the <MedicationPrescribed> or <MedicationDispensed> <WrittenDate> from the original request or send the start date of therapy in the <MedicationPrescribed> or <MedicationDispensed> <WrittenDate> element.

To:

When the prescriber responds <Approved> or <ApprovedWithChanges> the prescriber MUST set the <Medication> <WrittenDate> to the date of the approval. When the prescriber responds <Replace>, the <WrittenDate> indicates the date of the replacement prescription. It is incorrect to echo the <MedicationResponse> <WrittenDate> from the original request or send the start date of therapy in the <MedicationResponse> <WrittenDate> element.

The following was removed:

When the prescriber intent or meaning has changed from what the pharmacy has requested – this is not allowed in <Approved> or <ApprovedWithChanges> responses. Substantive differences in these fields will result in a <Denied> response. These data elements have been selected because they contain the key clinical information of the prescription order.

Drug Name
• <DrugDescription>
Drug Strength
• <StrengthValue>
• <StrengthForm>
• <StrengthUnitOfMeasure>
<MedicationPrescribed>
• <Quantity>
<Sig>
<Substitutions>
<AdditionalRefillsAuthorized> versus <NumberOfRefills>
Permanent change to Prescriber information
Any Other Elements relating to the prescription order (in Patient, Medication, or Provider elements)

Example 2 and 3 were modified from <AdditionalRefillsAuthorized> to <NumberOfRefills>.

Example 4 and 5 responses were changed from <DeniedNewPrescriptionToFollow> to <Replace>.

In section “*Medication Elements and Refill Elements*”

- <AdditionalRefillsAuthorized> was sunsetted in all tables as <NumberOfRefills> is used in the RefillResponse.
- <MedicationPrescribed> - RefillResponse was changed to N; <NumberOfRefills> changed to N.
- <MedicationDispensed> - RefillResponse was change to N.
- <MedicationResponse> chart was added.

Transmission Examples were updated as appropriate. “Example 6. Pharmacy Requesting A Refill Authorization For 4 Additional Dispensings From A Prescriber And Prescriber Responding” was corrected. It should have been <ApprovedWithChanges> since <PharmacyRequestedRefills> was sent in the RefillRequest.

<MedicationResponse> was added to the *Data Elements Required for Signing* table in section “Digital Signature Elements”.

<LowerBoundComparisonOperator> and <UpperBoundComparisonOperator> explanation contained a typographical error. “LT” (less than or equal to) should be “LE” in section “Key Question Set Elements”. <AdditionalFreeTextIndicator>, the three values are M, O, and NA.

In section “Example 33. Prior Authorization Denial and Appeal” the XML example for the PAAppealResponse incorrectly used a PAResponse. The XML example has been corrected. The Notes table below was already correct.

## **16.44 VERSION 2014071**

The Prescription Transfer transactions were added (section “Prescription Transfer Transactions”) and associated sections.

- RxTransferRequest
- RxTransferResponse
- RxTransferConfirm

Prescription Fill Status Notification (RxFill) transactions were modified from <Filled>, <NotFilled>, and <PartialFill> to <Dispensed>, <NotDispensed>, and <PartiallyDispensed>. Examples were updated. Transferred was added as an option (section “Prescription Fill Status Notification Transaction – Transferred”) and in all appropriate sections. Section “General Requirements” was clarified.

The RxFillIndicatorChange transaction was added (section “Change in Prescription Fill Status Notification Transaction”). In appropriate other transaction sections the verbiage was added

“<RxFillIndicator> informs the pharmacy of the prescriber’s intent for fill status notifications for a specific patient/medication.”

The RefillRequest and RefillResponse transactions were renamed to RxRenewalRequest and RxRenewalResponse. Associated verbiage was updated from “refill” to “renewal” when appropriate.

The functions (transactions) described in bullets in section “*Business Functions*” subsection “*Introduction*” were removed as they are redundant to the list of transactions in this same section “*Transaction Types*”.

<OfficeOfPharmacyAffairsID> was added to <MedicationPrescribed> or <MedicationResponse> to relay the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA) Identification Code associated with the eligibility of this prescription for drugs purchased pursuant to rights under Section 340B of the Public Health Service Act of 1992. Section “OfficeOfPharmacyAffairsID” was added.

<Source> references were modified to <HistorySource> to be concise. Examples 20, 21, and 26 clarified HistorySource in the example title.

Examples with CALAN SR were made consistent (Sig text, etc.).

The following value was added to <PayerIdentification> - StandardUniqueHealthPlanIdentifier - Code indicating that the information to follow is the HIPAA mandated Health Plan Identifier (HPID) or the Other Entity Identifier (OEID).

Section "Attachment" was moved under "*Specific Element Discussion*".

Table of Figures was added.

A correction was made to the following Prior Authorization Examples in the <RelatesToMessageID>. This is applicable to all previous versions with these examples.

**"Example 32. Prior Authorization Initiation, Request and Approval"**

**PARequest (from Prescriber)**

The trace number <MessageID> assigned by the prescribing system when they sent the PAInitiationRequest was **1234567X53**.

RelatesToMessageID **1234567X53** Prescriber trace number is used to link the original transaction (PAInitiationRequestResponse) (MessageID) to this subsequent transaction.

**"Example 33. Prior Authorization Denial and Appeal"**

**PARequest (from Prescriber)**

RelatesToMessageID **1234567X53** Message ID from the PAInitiationRequestResponse.

**PAAppealRequest (from Prescriber)**

RelatesToMessageID **12345698890** Message ID from the PARequestResponse.

**"Example 34. Prior Authorization with Coded Reference"**

**PARequest (from Prescriber)**

RelatesToMessageID **1234567X53** Message ID from the PAInitiationRequestResponse.

**"Example 35. PA Process Cancelation"**

**PACancelRequest (from Prescriber)**

RelatesToMessageID **1234567X53** MessageID of PAInitiationRequestResponse.

In section "Digital Signature Elements", <DigestValue> size was stated as 30 but it is 35.

## **16.45 VERSION 2014072**

Veterinarian prescription support:

A new ProviderType with a choice list of NonVeterinarians or Veterinarians was added to the schema to support differentiation of use of National Provider ID (NPI). The annotation for Prescriber was modified to

One occurrence is the prescriber number. One occurrence may be used to identify the clinic. At least one occurrence must contain the Prescriber individual (not organizational) NPI Number. DEANumber is sent when applicable.

Per CMS, Veterinarians do not meet the regulatory definition of “Health Care Provider” and are thus ineligible for NPI numbers (unless they meet the definition in some other capacity). Reference: <HTTP://ATWORK.AVMA.ORG/2013/08/06/NEW-FEDERAL-GUIDANCE-NPI-NUMBERS-NOT-FOR-VETERINARIANS/> or <HTTP://WWW.NABP.NET/NEWS/VETERINARIANS-NOT-ELIGIBLE-FOR-NPIS-CMS-CLARIFIES>

The annotation for Supervisor/SupervisingPrescriber was removed. The schema imposes on the Identification for Supervisor/SupervisingPrescriber the StateLicenceNumber is mandatory; the DEANumber is optional. The DEANumber is sent when applicable.

A new PatientType with a choice list of HumanPatient or NonHumanPatient was added. For HumanPatient, no subelements were modified.

Section “Veterinarian Prescriptions” was added. A new element <Species> was added.

Elements <DeliveryRequest> and <DeliveryLocation> were added to the NewRx. See section “DeliveryRequest and DeliveryLocation Usage”.

<FillNumber> was changed to n2 in the schema – the size is always 2 significant digits.

## **16.46 VERSION 2014101**

Section “WrittenDate” was updated

From:

On a NewRx the <WrittenDate> indicates the date the prescriber created the prescription.

To:

On a NewRx the <WrittenDate> indicates the date the prescriber created **the this** prescription **being transmitted**.

It is recommended that transmission of the NewRx should be within 72 hours of the <WrittenDate>, with exceptions for state/federal regulations timeframe requirements. <WrittenDate> must precede or be equal to the transmission date. For future dating, see <EffectiveDate>.

<EffectiveDate>: The date or date/time after which this prescription being transmitted can be dispensed (i.e. do not fill before date) as authorized by the prescriber.

For receipt of prescriptions with transmission of the NewRx greater than 72 hours of the <WrittenDate>, the RxChange transaction can be used for clarification with the prescriber.

**EXCEPTION:** Electronic prescriptions for patients receiving Long Term Care Pharmacy Services are exempt from the <EffectiveDate> usage stated above.

Support was added for data elements for diabetic supply prescriptions and includes elements which could be required for the pharmacy during the dispensing process. Section “Items for Diabetes Management” was added. Data elements were added:

- <TestingFrequency>
- <TestingFrequencyNotes>
- <SupplyIndicator>

- <InsulinDependent>
- <HasAutomatedInsulinDevice>

In Diagnosis, the following data element was added to primary and secondary:

- <DateOfLastOfficeVisit>

<ObservationDate> is now mandatory when Observation Segment <Measurement> is sent.

The annotation “Patient Primary Telephone Number is to be sent if patient has a phone number” was added to Patient.

A FormerName complex type was added. See section “FormerName”.

<ReasonCode10> and <ReasonCode11> added a new code for “Prior authorization duplicate/denied.”

<RelatesToMessageID> definition was clarified in the Data Dictionary and XML Standard.

A <MessageID> chart was added to all examples.

Corrections of typos in examples were made.

**Example 4:**

RxChangeResponse (from ~~Pharmacy~~Prescriber)

**Example 5:**

Status (from ~~Prescriber~~Pharmacy)

**Example 6:**

Status (from ~~Mailbox~~Prescriber)

~~Per the rules, the Mailbox assigns their own trace number <MessageID> and echoes back the pharmacy trace number <RelatesToMessageID>.~~

~~Per the rules, the Mailbox assigns their own trace number <MessageID> and echoes back the prescriber trace number <RelatesToMessageID>.~~

On the RxRenewalResponse from Prescriber, a new <PrescriberOrderNumber> is shown in the example.

<transport:PrescriberOrderNumber>444444444499</transport:PrescriberOrderNumber>

PrescriberOrderNumber      444444444499      This is the reference number assigned by the prescribing system.

**Example 7:**

~~Per the rules, the Mailbox assigns their own trace number <MessageID> and echoes back the pharmacy trace number <RelatesToMessageID>.~~

~~Per the rules, the Mailbox assigns their own trace number <MessageID> and echoes back the prescriber trace number <RelatesToMessageID>.~~

On the RxRenewalResponse from Prescriber, a new <PrescriberOrderNumber> is shown in the example.

<transport:PrescriberOrderNumber>444444444499</transport:PrescriberOrderNumber>

PrescriberOrderNumber      444444444499      This is the reference number assigned by the prescribing system.

On the Verify, <PrescriberOrderNumber> and <RxReferenceNumber> were removed as not needed. <RelatesToMessageID> was changed from A22 to 2290.

**Example 10:**

Status (from ~~Prescriber~~Pharmacy)

**Example 15:**

Since the pharmacy might not have assigned a <RxReferenceNumber> on this prescription, the value was removed from RxChangeRequest and Response.

RxReferenceNumber      PH211      This is the prescription number assigned by the Not yet assigned by pharmacy system.

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**Example 18:**

Request:  
**MessageID** 9991 Prescriber system trace number for the transmission. Echoed back in the response transaction in **RelatesToMessageID**.

Response:  
**RelatesToMessageID** 9991 Prescriber trace number is used to link the (MessageID) from request to the response.

**Example 21:**

RxHistoryRequest (from **Prescriber**Pharmacy)

**Example 25:**

NewScriptRx (from Prescriber)

**Example 30:**

Added the Status response to the NewRxRequest from Pharmacy and separated the NewRxResponseDenied transaction.

**Example 34:**

<PAREferenceID> is 22AAB99QQQ  
PACaseID A1042

**Example 35:**

PACaseID A1042

## **16.47 VERSION 2015041**

<AllergyOrAdverseEvent> has been added as optional on NewRx, RenewalResponse, ChangeRequest, ChangeResponse, and Resupply transactions. Section "Allergy or Adverse Event Element" was added. "Example 2. Prescriber Sending A New Prescription To A Pharmacy (Direct Connect)" added <AllergyOrAdverseEvent> as an example.

External Code List updates:

- <ReactionCoded> value description was updated to include SNOMED CT® concepts in the Situation with Explicit Context (243796009) hierarchy to allowed values. The linkage to the CORE Problem list subset to be used was updated:
  - SNOMEDCode - SNOMED - Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the Health Terminology Standards Development Organisation (IHTSDO) <http://www.ihtsdo.org/snomed-ct/>
  - Values come from the ProblemListSubset from SNOMED – listed in Excel format at [http://www.nlm.nih.gov/research/umls/Snomed/core\\_subset.html](http://www.nlm.nih.gov/research/umls/Snomed/core_subset.html). The values shall be coded using the CORE Problem list subset of SNOMED CT®, and shall be terms that descend from clinical finding (404684003) concept or SNOMED CT® concepts in the Situation with Explicit Context (243796009) hierarchy to allowed values.
- Product Qualifier appendix included this comment “A value descending from the NDF-RT concept types of “Mechanism of Action - N0000000223”, “Physiologic Effect - N0000009802” or “Chemical Structure - N0000000002” in National Drug File Reference (NDF-RT). ”

The NewRxRequest transaction added <Quantity>, <LastFillDate>, <Substitutions>, and <Sig> as optional elements. Section "NewRxRequest Transaction" was updated with guidance on use of these elements.

An annotation was added on the schema on LastFillDate in the NewRxRequest transaction:

“Last fill date may contain the last known fill date if the requesting pharmacy is leveraging information from the prescription label that was presented by the patient/caregiver.”

Section "PA Cancel Request and Response Transactions" was modified

From:

These transactions enable the prescriber to cancel a previously submitted PARequest for which a PAResponse hasn't been received, notifying the payer that prior authorization is no longer needed. This can be used in cases such as when the prescriber prescribes an alternative to the initially requested medication.

To:

These transactions enable the prescriber to cancel a previously submitted request for which the prescriber has obtained a <PACaseID>, notifying the payer that prior authorization is no longer needed. This can be used in cases such as when the prescriber prescribes an alternative to the initially requested medication.

Section "Key PACancelRequest Elements" and "Key PACancelResponse Elements" were modified

From:

<PACaseID> is the same PACaseID assigned by the payer when processing the PA request that the prescriber now wishes to cancel.

To:

<PACaseID> is the same PACaseID assigned by the payer, which enables the prescriber to cancel a previously submitted request.

## **16.48 VERSION 2015071**

Appendix of changes For SCRIPT

The following elements were sunsetted

- <ClinicName> has been replaced with a new composite <PracticeLocation> which contains <BusinessName>
- <Smoker> has been replaced with a new composite <SubstanceUse>
- <OtherReason> has been sunsetted

Modifications to existing elements

Element	Added to SCRIPT	Definition	Size	Values
BusinessName			X	
DeliveryLocation				X
LabelCode	X			
LabelGraphicCode	X			
LabelPriority	X			
LabelText	X			
QuantityValue		X		
ReasonCode				X
ReasonForServiceCode	X			
ReasonForMTMServiceCodeQualifier	X			
ReasonForMTMServiceFreeText	X			
ReasonForMTMServiceText	X			
TargetedTypeOfServiceCode	X			
TargetedTypeOfServiceCodeQualifier	X			X
TargetedTypeOfServiceFreeText	X			
TargetedTypeOfServiceText	X			
TypeOfServiceCode	X			
TypeOfServiceCodeQualifier	X			X
TypeOfServiceFreeText	X			
TypeOfServiceGroupSetting	X			
TypeOfServiceText	X			

The following new elements were added:

AlternateContactRelationship	PaymentType
AnticipatedDischargeDate	ProphylacticOrEpisodic
CurrentTreatmentCycle	ReportURL
DiluentAmountValue	ScoreName
DiluentAmountQuantityUnitOfMeasureCode	ScoreValue
DispensedPackageMethod	SelfAdministrationAllowed
GestationalAge	SpecificAdministrationGauge
HospiceIndicator	SubstanceLevelCode
InjuryRelated	SubstanceLevelQualifier
IVAccessTypeCode	SubstanceTypeCode
IVAccessTypeText	SubstanceTypeQualifier
NumberOfLumens	SubstanceTypeText
NumberOfPackagesDispensed	TreatmentIndicator
NumberOfPackagesToBeDispensed	

The following modifications were made in Section *Business Operations*:

- Removed “send a resupply request from a facility to a pharmacy” from Prescriber
- Added new grouping:

Long Term or Post-acute Care (LTPAC) Organization

The LTPAC organization typically will:

- initiate a request for a resupply of a medication
- initiate a recertification for a medication order

Modified Section: *Compliance*:

To:

Electronic prescribing is legal in all states, however, many states have legal requirements that application vendors and/or end users must adhere to in order to engage in e-prescribing communications. Examples of such legal obligations include requirements that: (1) vendors apply for approval of their applications prior to doing business in a state, (2) specific data elements be included in e-prescribing transactions, (3) protect transaction security and patient confidentiality, (4) address prescriber choice of medication and patient choice of pharmacy. Accordingly, all industry stakeholders are strongly encouraged to perform legal due diligence with respect to state and local laws prior to engaging in e-prescribing communications in a locale.

Section: *Introduction* had support added for Resupply and Recertification.

Section: *Transaction Types*:

To:

RxFill	This transaction is sent to the prescriber or long term or post-acute care (LTPAC) organization from the pharmacy and indicates the status of the prescriptions dispensing (dispensed, partially dispensed, not dispensed, transferred). It is the notification from a pharmacy to a prescriber when the prescription has been dispensed (medication picked up by patient), partially dispensed (partial amount of medication picked up by the patient), not dispensed (medication not picked up by
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	patient) and medication returned to stock, or transferred to another pharmacy. For long term or post- acute (LTPAC), It is the notification from a pharmacy to a LTPAC organization when the prescription has been dispensed (medication to be delivered to the specified facility or medication has been added to profile for administration to the patient), partially dispensed (partial amount of medication to be delivered to the specified facility), not dispensed (medication will not be delivered to the specified facility) or transferred to another pharmacy.
<b>Resupply</b>	This transaction is a request from a Long Term or Post-acute Care (LTPAC) organization to a pharmacy to send an additional supply of medication for an existing order. An example use case is when a medication supply for a resident is running low (2-3 doses) and a new supply is needed from the pharmacy, the LTPAC organization need a way to notify the pharmacy that an additional supply for the medication is needed.

Added new transaction type for Recertification:

<b>Recertification</b>	This transaction is a notification from a facility, on behalf of a prescriber, to a pharmacy recertifying the continued administration of a medication order. An example use is when an existing medication order has been recertified by the prescriber for continued use. Long term or post-acute care use only.
------------------------	--

Modified Section: *Resupply Transaction* under Section: *Transactions*:

To:

In the long term care environment there is a need for a Long Term or Post-acute Care (LTPAC) organization to send a resupply request for an additional supply of a medication from an existing authorized order to a pharmacy. An example use case is when a medication supply for a resident is running low (2-3 doses) and a new supply is needed from the pharmacy, the LTPAC organization needs a way to notify the pharmacy that an additional supply for the medication is needed. Typically, the physician is not involved in this process until the end of the month when all of the resident's orders are signed in batch.

<RxFillIndicator> informs the pharmacy of the prescriber's current intent for fill status notifications for a specific patient/medication. This may be a change to the current fill status or a cancellation of further RxFill notifications.

Added new Section: *Recertification Transaction* under Section: *Transactions*.

Modified Section: *Prescription Fill Status Notification Transaction Introduction*:

To:

The RxFill transaction is originated by the pharmacy. The transaction notifies the prescriber or long term or post-acute care (LTPAC) organization about the status of a prescription - either new, refill or resupply. The transaction can be used in cases when

1. Initially requested - to notify of a dispensed prescription (the patient picked up the medication) or (the medication will be delivered to the specified LTPAC organization),
2. To notify of a partially dispensed prescription (patient picked up part of the medication) or (part of the medication will be delivered to the specified LTPAC organization),
3. To notify of a prescription never dispensed (patient did not pick up the medication or (the medication will not be dispensed at the present time), and/or

4. To notify a prescriber that the prescription has been transferred to another pharmacy.

Added Section: *Assumption for Long Term or Post-acute Care (LTPAC) Organization Receipt of RxFill Transactions*

Added Section: *General Requirement for Long term or Post-acute Care*

Modified Section: *Prescription Fill Status Notification Transaction – Dispensed:*

To:

The RxFill is originated by the pharmacy. This transaction is used to notify the prescriber or long term or post-acute care organization when a prescription has been **dispensed**. The RxFill can be used to notify dispensed status of new prescriptions, refills or medication resupply requests.

### **General Requirements**

- RxFill <FillStatus><Dispensed> would be sent for all **dispensed** prescriptions including each refill/resupply, but, excluding partial fills, which are represented by a separate RxFill.
- RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and not simply filled and waiting. Therefore, the RxFill <FillStatus><Dispensed> should not be triggered simply by label printing or adjudication in the pharmacy, but, through an action such as a point of sale transaction, electronic signature capture at pickup, a will call bin management action, or similar positive indication of actual dispensing. For long term or post-acute care RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and/or filled and approved for administration to the patient by the LTPAC organization.

Modified Section: *Prescription Fill Status Notification Transaction – Not Dispensed:*

To:

The RxFill Transaction <NotDispensed> is originated by the pharmacy. This transaction is used when the pharmacy has not **dispensed** a previously filled prescription and the pharmacy will return the medication to stock. This might occur if the patient never picks up the prescription. This transaction is used in long term or post-acute care when the pharmacy will not dispense a prescription to notify the LTPAC organization the status and reason the prescription will not be dispensed. RxFill can be used to notify dispensing status of new prescriptions, refills resupply requests.

### **General Requirements**

- RxFill <FillStatus><NotDispensed> would be sent when a pharmacy does not successfully **dispense** or does not intend to dispense a prescription that has been received and/or processed by the pharmacy, and, has been waiting for patient pickup.
- RxFill <FillStatus><NotDispensed> should be triggered by the return to stock process of the pharmacy, which indicates the patient has not picked up the prescription within the time period set by the pharmacy for their return to stock

procedures.

- RxFill <FillStatus><NotDispensed> should be sent for any prescription (first fill, refill, partial fill, etc.) that is processed by the pharmacy during return to stock procedures.
- RxFill <FillStatus><NotDispensed> should not be sent by the pharmacy system in the case where a prescription is being reversed but with the intent of subsequent reprocessing and dispensing. An example would be a change in payment coverage requested by the patient at the time of pickup.
- RxFill <FillStatus><NotDispensed> should not be sent by the pharmacy system to indicate that the patient has not requested his/her next refill based on elapsed time since the patient's previous refill. For example, if the pharmacy dispensed a 30 day supply to the patient but more than 30 days have elapsed and the patient has not requested another refill, the pharmacy system should not automatically generate an RxFill <NotDispensed>. The pharmacy system should use the specific actions of the patient when sending RxFill, and, not inferences in every case possible.
- RxFill <FillStatus><NotDispensed> in LTPAC should be triggered by events as determined by the pharmacy at the time of processing. Examples include Drug Use Evaluation conflicts that could not be resolved, the medication order has expired, the pharmacy has no intent to stock the prescribed medication or a prior authorization was required for the prescribed medication and the payer has denied.
- Since return to stock procedures and timing differ between pharmacies, the timing of the RxFill <FillStatus><NotDispensed> will also vary.

Modified Section: *Prescription Fill Status Notification Transaction – Partially Dispensed:*

To:

The RxFill Transaction <FillStatus><PartiallyDispensed> is originated by the pharmacy. This transaction is used to notify the prescriber or long term or post-acute care organization when a prescription has only been **partially dispensed**. RxFill can be used to notify dispensing status of new prescriptions, refills or resupply requests. An RxFill <FillStatus><PartiallyDispensed> can be repeatedly initiated until the prescription has been completely dispensed or the remaining quantity is returned to stock, thereby requiring an RxFill <FillStatus><PartiallyDispensed> for the remaining quantity. RxFill requires that, at a minimum, the dispensed drug with the quantity received be included in the RxFill. It is suggested that the <MedicationPrescribed> element be included for clarification.

Modified title of Section: Long Term Care (LTC) Medication Change Process to *Long Term or Post-acute Care (LTPAC) Medication Change Process*. Modified section:

To:

In Long Term or Post-acute Care (LTPAC) there is a need for the physician to make changes to active orders. These changes need to be transmitted to the pharmacy for processing. The changes would include the significant change of dose, form, strength, or route, or the modifications of frequency, or minor change related to the order. The prescriber system will always send a CancelRx and a NewRx, regardless of the type of change. The pharmacy, upon reviewing these changes, would determine if the original order needs to be canceled or if it can be modified.

In Long Term or Post-acute Care, prescription orders are typically open orders with no end date or a date far in the future. At times, a prescriber has the need to modify this order and notify the pharmacy. This process is accomplished through the CancelRx and the NewRx with some additional data requirements. This process differs from the RxChangeRequest because it is initiated from the prescriber not the pharmacy. With the request coming from the prescriber, there is no need for a response approving the request.

Modified Section: *Resupply Transaction* under Section: *Long Term or Post-acute Care (LTPAC) Medication Change Process*:

In the long term care environment there is a need to send a renewal request from a facility to a pharmacy. An example use case is when a medication supply for a resident is running low (2-3 doses) and a new supply is needed from the pharmacy, the nurse needs a way to notify the pharmacy that a renewal for the medication is needed. Typically, the physician is not involved in this process until the end of the month when all of the resident's orders are signed in batch.

The Resupply transaction acts like the RxRenewalRequest transaction. Wherever the RxRenewalRequest is cited in this guide from the pharmacy to the prescriber, the Resupply transaction is the long term care flow of facility to pharmacy. Please follow the guidance in sections which discuss the RxRenewalRequest transaction.

To:

In the long term care environment there is a need for a Long Term or Post-acute Care (LTPAC) organization to send a request for an additional supply of a medication from an existing authorized order to a pharmacy. An example use case is when a medication supply for a resident is running low (2-3 doses) and a new supply is needed from the pharmacy, the LTPAC organization needs a way to notify the pharmacy that an additional supply for the medication is needed from the pharmacy.

Added Section: *Recertification Transaction* under Section: *Long Term or Post-acute Care (LTPAC) Medication Change Process*.

Added additional recommendation to Section: *PAInitiationResponse Transaction*:

2. It is recommended that the payer use the <AuthorizationNumber>, <AuthorizationDetails>, and <AuthorizationPeriod> fields only in scenarios where the payer is indicating that the requested PA has already been adjudicated. For example, if the payer has already approved the PA, in the PAInitiationResponse they would send back a <Closed> response with a <ReasonCode> of "CF" (Prior Authorization duplicate/approved). The payer could then include (optionally) the authorization details for that approved PA.

Added pictorial of *Recertification Transaction* to Section: *Element Usage In Each Transaction*  
Updated pictorial of *RxHistoryRequest Transaction* and *RxHistoryResponse Transaction* in Section: *Element Usage In Each Transaction*.

Added the following new sections under Section: *Specific Element Discussion*:  
Section: *AlternateContact*

Section: SubstanceUse

Modified Section: WrittenDate under Section: Medication Element(s):

To:

EXCEPTION: Electronic prescriptions for patients receiving Long Term or Post-acute Care (LTPAC) Pharmacy Services are exempt from the <EffectiveDate> usage stated above. LTPAC pharmacies may dispense prior to the <EffectiveDate> to ensure availability for medication administrations.

Modified Section: DeliveryRequest and DeliveryLocation Usage:

To:

These elements are used on the NewRx to indicate whether the patient requests delivery of prescription and if so, which location. These elements are sent if the prescriber and the patient have discussed to relay to the pharmacy. Delivery and shipment may have the same meaning. It is acknowledged that the pharmacy will need to consider workflow and data integrity when receiving this information.

If a patient desires delivery, <DeliveryLocation> designates the location for the delivery. The pharmacy may have to work with the patient before the delivery is made or the pharmacy would use their protocols, etc., if not an established relationship.

If <DeliveryLocation> = “HOME” the information specified in the <PatientAddress> is to be used.

If <DeliveryLocation> = “FACILITY” the information specified in the <FacilityAddress> is to be used. Facility may be, but is not limited to, a hospital, hospice, care facility, etc. The Patient <FacilityUnit>, <Room> and <Bed> may also be designated as applicable.

If <DeliveryLocation> = “CONTACT PATIENT FOR DELIVERY” the contact information for the patient must be sent in the Patient Segment.

If <Delivery Location> = “AGENCY OF SERVICE” the information specified in the <AgencyOfServiceAddress> is to be used.

If <DeliveryLocation> = “PROVIDER” the information specified in the <ProviderAddress> is to be used.

Added Section: Use of Number of Packages Element

Added new element <PaymentType> to all the examples under Section: HistorySourceElement.

Added Section: Agency of Service and Type of Service Elements.

Added Section: IV Administration Element Usage.

Modified Section: PAResponse Elements from (along with associated Figure(s)):

To:

<Approved> indicates that the prior authorization has been approved “as is” by the payer. The elements associated with the <Approved> status are:

- <AuthorizationNumber> - This optional element contains a payer-assigned authorization number.

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- <**AuthorizationPeriod**> - This optional composite provides the authorization start and end dates.
- <**Appeal**> - This mandatory composite indicates whether this determination can be further appealed. The <IsEAppealSupported> element is mandatory, and the composite also includes an optional <ExpirationDate> element indicating the deadline for appealing and a <PANote> element for addition information regarding the appeal process.
- <**PANote**> - This optional element is used to provide additional information about the approval.

<**PartiallyDenied**> indicates that the prior authorization has been approved by the payer, but with some limits. These limits may include pharmacy type, quantity, days supply, number of cycles, or refills. The elements associated with the <PartiallyDenied> status are:

- <**AuthorizationNumber**> - This optional element contains a payer-assigned authorization number.
- <**AuthorizationDetail**> - This optional composite contains authorization details of the approval granted. Either <AuthorizationDetail> or <AuthorizationPeriod> must be sent. <AuthorizationDetail> may repeat if authorization details are provided for more than one pharmacy type. All elements in the composite are optional and used if they apply to the case.  
Included elements:
  - <PharmacyType> - This element repeats if needed to indicate if only certain pharmacy types are approved to dispense the medication.
  - <Quantity> - This indicates the approved quantity of the requested medication.
  - <DaysSupply> - This indicates the approved days supply of the requested medication.
  - <NumberOfCycles> - This indicates the number of dispensing cycles approved.
  - <NumberOfRefills> - This indicates the number of approved refills.
  - <PANote> - This element provides additional textual clarifications regarding the authorization details.
- <**AuthorizationPeriod**> - This optional composite provides the authorization start and end dates. Either <AuthorizationDetail> or <AuthorizationPeriod> must be sent.
- <**Appeal**> - This mandatory composite indicates whether this determination can be further appealed. The <IsEAppealSupported> element is mandatory, and the composite also includes an optional <ExpirationDate> element indicating the deadline for appealing and a <PANote> element for addition information regarding the appeal process.
- <**PANote**> - This optional element is used to provide additional information about the approval.

<**Denied**> indicates that the prior authorization has been denied by the payer. The elements in the <Denied> status are:

- **<Appeal>** - This mandatory composite indicates whether this determination can be further appealed. The **<IsEAppealSupported>** element is mandatory, and the composite also includes an optional **<ExpirationDate>** element indicating the deadline for appealing and a **<PANote>** element for additional information regarding the appeal process.
- **<PANote>** - This optional element is used to provide additional information about the denial.

**<Open>** indicates that the prior authorization is being processed by the payer. The elements in the **<Open>** status are:

- **<MoreInformationRequired>** - This mandatory composite indicates that the payer needs additional information from the prescriber in order to complete processing of the prior authorization request. The composite provides a **<QuestionSet>** for completion by the prescriber for additional information. More information may be required when a prior authorization is pended or a Deferred situation occurs.
  - A Deferred situation may occur when regulatory requirements prevent the denying of the prior authorization. An appeal must be filed to either approve this prior authorization or the prescriber would need to prescribe a different medication.
- **<PANote>** - This optional element is used to provide additional information about the **<Open>** status.

Modified Section: *Key Appeal Transaction Elements* (along with Figures):

To:

**<Open>** indicates that the appeal is being processed by the payer. The elements in the **<Open>** status are:

- **<MoreInformationRequired>** - This mandatory composite indicates that the payer needs additional information from the prescriber in order to complete processing of the appeal request. The composite provides a **<QuestionSet>** for completion by the prescriber for additional information. More information may be required when a prior authorization appeal is pended or a Deferred situation occurs.
- **<PANote>** - This optional element is used to provide additional information about the **<Open>** status.

Updated the following examples to reflect the QuantityUnitsOfMeasure from the *SCRIPT Implementation Recommendation Document*:

Section: *Example 10. Prescription Change Transaction For Therapeutic Interaction (Via Direct Connect)*

Section: *Example 21. Pharmacy Requests Medication History with HistorySource Element*

Section: *Example 23. Pharmacy Requests Current Medication List*

Section: *Example 24. Examples of New Prescriptions for Compound Ingredients*

Section: *Example 26. Pharmacy Requests Medication History with HistorySource Element from a Prescriber (Direct Connect)*

Section: *Example 32. Prior Authorization Initiation, Request and Approval*

- Section: [Example 33. Prior Authorization Denial and Appeal](#)  
Section: [Example 34. Prior Authorization with Coded Reference](#)  
Section: [Example 35. PA Process Cancelation](#)  
Section: [Example 37. RxTransfer \(ALL – Multiple Prescriptions\)](#)  
Section: [Example 39. RxTransferResponse with Two Transfers](#)

Modified Frequently Ask Question “How Is Packet Used in QuantityUnitOfMeasureCode?”:

To:

**How Is Packet Used?**

If the product being provided can be quantified as a tablet, then the <StrengthForm> must be “C48542” (Tablet Dosing Form). The <QuantityUnitOfMeasure> describes the dosing unit, In this example, a packet of 21 or 28, depending on their inventory.

Note in the example below, Quantity is a value of 1, with a QuantityUnitOfMeasureCode of “C48521” (Packet). It would be incorrect to specify a Quantity with a value of 28, with a QuantityUnitOfMeasureCode of “C48521” (Packet), as this would mean “28 Packets” instead of “1 Packet”.

Example of Use of Packet

	SCRIPT Remarks	SCRIPT value	Comment
Medication occurrence	Prescribed Dispensed Requested DispensedAndAdministered		
DrugDescription		Ortho Novum 7/7/7	
ProductCode and Qualifier	Values for NDC, UPC, MFG		
Strength,	Drug Strength Measurement value	0.5-0.75-1	
StrengthForm	Pharmaceutical Dosage Form	C48542	Tablet dosing form  NCPDP Drug Dosage Form Terminology
StrengthUnitOfMeasure		C28253	Milligram  NCPDP Drug StrengthUnitOfMeasure Terminology
Quantity	Dispense Quantity Count of drug form dispensed	1	1
QuantityUnitOfMeasure		C48521	Tablet Dosing Unit  NCPDP QuantityUnitOfMeasure Terminology

Added Recertification Transaction Flow.

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Section: [Document Scope](#)

- Schemas Used table was modified to remove pa-structures.xsd which was merged into structures.xsd.

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- Added the following as additional references:

**RISK EVALUATION & MITIGATION STRATEGIES (REMS) REFERENCE GUIDE FOR TELECOMMUNICATION STANDARD**

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While this document was created as a reference for claim billing processes, it provides background information on REMS that may be of interest.

***PRODUCT IDENTIFIERS STANDARD IMPLEMENTATION GUIDE***

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The NCPDP *Product Identifier Standard Implementation Guide* provides education and general guidance for consistent formatting and utilization of product identifiers in healthcare. Additionally, it provides rules to avoid changes to identifiers that would disrupt the provision of healthcare and have negative effects on patient care.

New fields and values added to Medication for wound care:

- WoundLocationText
- WoundLocationCode
  - SNOMED
- WoundLateralityText
- WoundLateralityCode
  - 255549009-Anterior
  - 7771000-Left
  - 255561001-Medial
  - 255551008-Posterior
  - 24028007-Right
- WoundLength
- WoundWidth
- WoundDepth

New fields and values to PA transactions:

- PAPriorityIndicator
  - S-Standard Priority
  - X-Urgent / Expedited Priority
- ExpiringPACaseID

Existing fields are now available for Medication Fields

- ManufacturerName
- LotNumber
- LotExpiration

New field added to CommunicationNumbers element

- DirectAddress

New value added to DescriptionCode:

- 144-Number of refills invalid.

New fields and values added to IVAdministration

- SpecificAdministrationBrand
- SpecificAdministrationLength
- SpecificAdministrationPump
- IVAccesCathetherTipCode
  - SNOMED
- IVAccesCathetherTipDescription
- IVAccesCathetherTipText
- IVAccesDeviceTypeCode
  - SNOMED
- IVAccesDeviceTypeDescription
- IVAccesDeviceTypeText
- IVInfusionTypeCode
  - SNOMED
- IVInfusionTypeDescription
- IVInfusionTypeText

New fields and values added to Medication for the titration of medications by the pharmacy

- PharmacyToTitrateDose
  - Y-Yes
  - N-No
- MeasurementDurationClarifyingFreeText
- MeasurementDurationNumericValue
- MeasurementDurationText
- MeasurementDurationTextCode
- MeasurementDurationTextQualifier
  - SNOMED
- MeasurementDurationTriggerText
- MeasurementDurationTriggerTextCode
- MeasurementDurationTriggerTextQualifier
  - SNOMED
- MeasurementFrequencyNumericValue
- MeasurementFrequencyUnitsCode
- MeasurementFrequencyUnitsQualifier
  - SNOMED
- MeasurementFrequencyUnitsText
- MeasurementIntervalNumericValue
- MeasurementIntervalUnitsCode
- MeasurementIntervalUnitsQualifier
  - SNOMED
- MeasurementIntervalUnitsText
- MeasurementTimingClarifyingFreeText
- MeasurementTimingEventCode
- MeasurementTimingEventQualifier
  - SNOMED
- MeasurementTimingEventText

- MeasurementTimingModifierCode
- MeasurementTimingModifierQualifier
  - SNOMED
- MeasurementTimingModifierText
- MeasurementTimingNumericValue
- MeasurementTimingUnitsCode
- MeasurementTimingUnitsQualifier
  - SNOMED
- MeasurementTimingUnitsText
- TitrationDoseMaximumValue
- TitrationDoseMeasurementNotes
- TirationDoseMeasurementValue
- TitrationoDoseMeasurementValueUnitOfMeasureCode
- TitrationDoseMeasurementVitalSign
- TitrationDoseMinimumMeasurementValue
- VariableMeasurementFrequencyModifier
  - And
  - Or
  - To
- VariableMeasurementIntervalModifier
  - And
  - Or
  - To
- VariableMeasurementTimingModifier
  - And
  - Or
  - To

New transactions added to BodyType for REMS:

- REMSInitiationRequest
- REMSInitiationResponse
- REMSRequest
- REMSResponse

New fields and values added for REMS

- REMSCaseID
- REMSNote
- REMSPatientRiskCategory
  - AFRP- Adult female of reproductive potential
  - AFNRP- Adult female not of reproductive potential
  - AM-Adult Male
  - MC-Male Child
  - CFRP- Child female of reproductive potential
  - CFNRP- Child female not of reproductive potential
- REMSReferenceID
- REMSAuthorizationID

- PrescriberCheckedREMS
  - A-Prescriber has checked REMS and the prescriber's actions have been completed
  - B- Prescriber has checked REMS and the prescriber's actions are not yet completed
  - C- Prescriber has not checked REMS

Existing elements with value additions:

- AddressTypeQualifier – REMS
- PatientIdentification - REMSPatientID
- FacilityIdentification - REMSHospitalSettingEnrollmentID
- PrescriberIdentification – REMSHospitalProviderEnrollmentID

Added new Section: REMS to Section: Background

Section: Business Operations had the following added to Prescriber:

- initiate a request for information required to submit a REMS request to a REMS Administrator
- initiate a request for REMS verification to a REMS Administrator

Section: Business Operations had a new entity for REMS Administrator:

A REMS Administrator typically will:

- respond to an initiation request with information required to submit a REMS request
- respond to a REMS request

Section: Business Functions subsection Introduction had the following added:

- REMS Functions

Section: Business Functions subsection Transaction Types had the following added:

<b>REMSInitiation Request</b>	This transaction is a request to the REMS Administrator for the information required to submit a REMSRequest. It is a request for the information required to submit a REMS request for a specified patient and drug.
<b>REMSInitiationResponse</b>	This transaction is a response from the REMS Administrator with the information required to submit a REMSRequest. It is a response with the information required to submit a REMS request for a specified patient and drug.
<b>REMSRequest</b>	This transaction is a request to the REMS Administrator with information (answers to question set; clinical documents) to make a REMS determination (approved, denied, pended, etc.).
<b>REMSResponse</b>	This transaction is a response from the REMS Administrator to a REMSRequest.

Section: Prescription Change Response Transaction had the following added:

If the REMS Administrator has provided authorization to the prescriber-submitted REMSRequest with an authorization, this can be placed in the <REMSAuthorizationNumber> on the RxChangeResponse. <PrescriberCheckedREMS> identifies if the prescribing system has performed an inquiry to the REMS Administrator in order to verify the REMS component of the prescription.

Section: Renewal Prescription Response Transaction had the following added:

If the REMS Administrator has provided authorization to the prescriber-submitted REMSRequest with an authorization, this can be placed in the <REMSAuthorizationNumber> on the RxRenewalResponse. <PrescriberCheckedREMS> identifies if the prescribing system has performed an inquiry to the REMS Administrator in order to verify the REMS component of the prescription.

Section Prescription Fill Status Notification Transaction Introduction contains the following changes:

- New subsections Opt-In For The Prescribers, Cancel/Modify Rxfill By The Prescriber, Automated Triggering Of Rxfill Transactions Within Pharmacy To Indicate A Fill, Triggering Of Rxfill Transaction When An Item Has Been Returned To Stock, Prescriber System Matching, Changes In Prescriber Workflow From RxFill, Volume Of RxFill Transactions, RxFill And Transfers, Associating A NewRx With An RxFill Transaction, Usage With The Medication History Transaction, Changing Physicians,
- Subsection Definitions had the following definitions added and or modified:

Dispensed modified from:

*Dispensed* - in the context of the RxFill, means the medication is no longer in the possession of the pharmacy and has been handed, shipped, or delivered to the patient (or the patient's caregiver/representative). If the medication is still located in the pharmacy, it is not yet 'dispensed'.

To:

*Dispensed* - in the context of the RxFill transaction, a medication that has been handed, shipped, or delivered to the patient (or the patient's caregiver/representative) and the pharmacy no longer has possession of it. If the medication is still located in the pharmacy, it has not yet been 'dispensed'.

Return/Returned to Stock modified from:

*Returned to Stock* – the procedure of the pharmacy when the patient does not pick up a medication that has already been processed and has been waiting for patient pickup when the medication is either returned to inventory or destroyed.

To:

*Returned to Stock* – the procedure of the pharmacy when the patient does not pick up a medication that has already been processed and has been waiting for patient pickup when the medication is either returned to inventory or destroyed.

New Definitions added for:

*Medication History* – transactions used to provide details of medications previously provided to a patient. The medication history result includes medications that were dispensed or obtained by a patient within a timeframe. Medication history can include adjudicated and/or cash and carry, prescribed, administered and/or sample medications.

*On Hold* – a status denoting an interruption occurring in the pharmacy dispensing procedure prior to dispensing for various reasons that include but

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are not limited to:

- prescriptions pending additional information
- resolving a conflict with other medications
- future filling

Section: Cancel Prescription Request Transaction had the following add:

A prescriber who did not write the original prescription but has assumed responsibility for the patient's care may potentially cancel any prescription. It remains up to the pharmacy to determine if the CancelRx from the prescriber is appropriate.

The CancelRx must contain pertinent information for the pharmacy to be able to find the prescription in their system.

If the original prescription was electronic, the CancelRx must contain the RelatesToMessageID if available. The CancelRx should contain the RxNorm in the <DrugCoded>. If the prescription number is available, it should be sent.

If the original prescription was not electronic, the CancelRx must contain pertinent information for the pharmacy to be able to find the prescription in their system (patient, medication (name, strength, dosage form), prescriber). If the pharmacy cannot definitively determine the prescription to be canceled, manual processes will occur to verify the cancellation. If the prescription number is available, it should be sent.

Prescribers should not send a CancelRequest for a prescription that is expired based on federal or state regulations.

- There should be programmatic checks in place to allow a CancelRequest up to the expiration date of the prescription based off of the written date of the prescription.
  - For example, the DEA requires Controlled Substance Rx to be filled within 6 months from the date written, and most states limit the filling of non-controlled Rx's to 1 year from the date written.

The prescriber should notify the patient or caregiver to inform them of the cancellation of a prescription.

- The Cancel Request was not intended to relieve the prescriber of the responsibility of notifying the patient or caregiver to advise of the drug therapy change – it is only intended as a backup to prevent inadvertent drug therapy continuation or resumption at a later date.

If the prescriber received a denial code indicating the prescription was referred to a different pharmacy, the prescriber could be given the option to route the Cancel Request message to the new pharmacy.

Prescribers should include the most recent "relates to message ID" and most recent prescriber order number (where possible) on Cancel Requests where the original NewRx was electronic, so the pharmacy is able to more easily identify the original NewRx being cancelled.

- See the NCPDP **XML Standard** for guidance on using the <RelatesToMessageID>.

Section: Cancel Prescription Response Transaction had the following added:

- Pharmacy should provide clear denial reasons on CancelRxResponse denial responses.
- Pharmacy should respond to all Cancel Requests within 48 hours. Pharmacies should not delete a Cancel Request message from a processing queue without a response being generated to the requestor.
  - Pharmacy edits should be put in place to not allow a medication to be provided to the patient if a Cancel Response has not been sent.
- As with all appropriate messages, the pharmacy should respond with a Status or Verify message containing code 010 as soon as they receive a Cancel Request.
- The pharmacy should always include a <Note> in an “A” (Approval) Cancel Response message when responding to a Cancel Request message if the patient has ever received a fill of the medication and the pharmacy is cancelling the remaining refills on the prescription.

Section: Cancellation Received But Prescription Has Been Transferred had the following added:

Note the Description of <DenialReasonCode> is the description of the value defined in the NCPDP **External Code List**. If the <DenialReasonCode> is sent, the <DenialReason> should not contain the echoing of this description as it adds no information.

Scenario	Scenario Description	<DenialReasonCode> Value	External Code List Value Description	<DenialReason> textual intent recommendation for display to prescriber user
Denied	Patient is unknown or cannot be determined by the pharmacy.	AA	Patient unknown to the provider	Patient is unknown to the pharmacy.
Denied	Patient is found, but no prescription is found that matches the drug on the cancel request.	AE	Medication never prescribed for the patient	Unable to Cancel Rx. Prescription not found at pharmacy.
Denied	Prescription was transferred to another pharmacy.	AC	Patient no longer under provider care.	Unable to Cancel Rx. Rx transferred. Include available pharmacy contact information.
Denied	Prescription was already responded to by a non-electronic workflow.	AP	Request already responded to by other means (e.g. Phone or Fax)	N/A – <DenialReasonCode> Description provides enough clarity.
Denied	All other denials	N/A (Send free text reasoning)	N/A	Unable to Cancel Rx. Please contact Pharmacy.

Section: Prior Authorization Transactions:

New Section Renewal of Existing Prior Authorization was added.

The following modifications were also made:

Each transaction supports a particular step in the prior authorization process:

- The PAInitiationRequest transaction is used by the prescriber, in the solicited model, to initiate the prior authorization process, by notifying the payer of the patient and the medication for which prior authorization is being requested, along with the prescriber's information and other related details.

- In the PAInitiationResponse transaction, the payer indicates the information needed from the prescriber to determine approval or denial of the authorization. In some cases, the payer indicates to the prescriber that prior authorization is not required for the requested medication and patient. The PAInitiationResponse is for the medication (name, strength, dosage form) indicated in the PAInitiationRequest. The payer should not respond for an equivalent to the medication (e.g., generic product equivalent to brand product) indicated in the PAInitiationRequest.

To:

Each transaction supports a particular step in the prior authorization process:

- The PAInitiationRequest transaction is used by the prescriber, in the solicited model, to initiate the prior authorization process, by notifying the payer of the patient and the medication for which prior authorization is being requested, along with the prescriber's information and other related details.
  - In the PAInitiationResponse transaction:
    - In the first use case, the payer indicates the information needed from the prescriber to determine approval or denial of the authorization. In some cases, the payer indicates to the prescriber that prior authorization is not required for the requested medication and patient. The PAInitiationResponse is for the medication (name, strength, dosage form) indicated in the PAInitiationRequest. The payer should not respond for an equivalent to the medication (e.g., generic product equivalent to brand product) indicated in the PAInitiationRequest.
    - In the second use case, the payer may send PAInitiationResponse transaction without receiving PAInitiationRequest from the prescriber to renew an existing PA that will be expiring soon.

Subsection Solicited Model was modified from:

In the solicited model, the prescriber initiates the request for prior authorization by providing information about the patient and the medication requested. In response, the payer sends a list of required information the prescriber must supply to support the decision process. The prescriber system gathers the needed information from the prescriber and/or the patient's electronic medical record using coded references and returns it to the payer. The payer then notifies the prescriber of the determination.

To:

In the solicited model, the prescriber initiates the request for prior authorization by providing information about the patient and the medication requested. In response, the payer sends a list of required information the prescriber must supply to support the decision process. The payer may send a list of required information without receiving a request from the prescriber for renewal of an existing expiring PA. The prescriber system gathers the needed information from the prescriber and/or the patient's electronic medical record using coded references and returns it to the payer. The payer then notifies the prescriber of the determination.

Subsection Mirror Data from Request name was modified to Mirror Data From Transaction and

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the content was modified from:

All elements in the body of the transaction sent to initiate the prior authorization process (PAInitiationRequest in the solicited model; PAResponse in the unsolicited model) except those noted below are echoed in the response transaction (PAInitiationResponse in the solicited model; PAResponse in the unsolicited model) and all subsequent prior authorization transactions in the prior authorization process.

Exceptions:

- <RequestReferenceNumber> is populated when a mailbox is part of the communication process and its value is set according to mailbox processing rules (see the NCPDP XML Standard Implementation Guide).
- When the PAInitiationResponse or PAResponse indicates that the receiver is not the prior authorization processor for the patient or medication, the <BenefitsCoordination> may be sent with information about the party that does process prior authorization for the requested patient/medication combination, if known.

To:

All elements in the body of the transaction sent to initiate the prior authorization process except those noted below are echoed in all subsequent prior authorization transactions in the prior authorization process.

Exceptions:

- <RequestReferenceNumber> is populated when a mailbox is part of the communication process and its value is set according to mailbox processing rules (see the NCPDP XML Standard Implementation Guide).
- When the PAInitiationResponse or PAResponse indicates that the receiver is not the prior authorization processor for the patient or medication, the <BenefitsCoordination> may be sent with information about the party that does process prior authorization for the requested patient/medication combination, if known.
- The <ATTACHMENT> element should not be mirrored if submitted in the PAREQUEST or PAAPPEALREQUEST. This allows trading partners to submit relevant supporting documentation only when necessary. If an Attachment is returned this allows the payer to return a different Attachment than the one submitted by the prescriber system.

Section: PA Initiation Request and Response was modified from:

These transactions enable the prescriber system to initiate the prior authorization process by notifying the payer of the patient and the medication for which prior authorization is being requested and providing basic request information. This initial request enables the payer to indicate the information needed from the prescriber to support authorization.

The payer may use the response to indicate that prior authorization is not required for the requested medication and patient.

To:

The PAInitiationRequest transaction enables the prescriber system to initiate the prior

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authorization process by notifying the payer of the patient and the medication for which prior authorization is being requested by providing basic request information. This PAInitiationRequest enables the payer to indicate the information needed from the prescriber to support authorization.

The payer may send PAInitiationResponse transaction without receiving PAInitiationRequest from the prescriber for renewal of an existing expiring PA. The payer may use this transaction to indicate that prior authorization is not required for the requested medication and patient.

Section: PAInitiationResponse Transaction was modified from:

After receiving the PAInitiationRequest, the payer returns a PAInitiationResponse. As this transaction contains the set of questions which have already been established by the payer for the prior authorization, the PAInitiationResponse should be sent from the payer to the prescriber timely. This will typically contain a set of questions to be completed by the prescriber, or, information that could be obtained from the patient's electronic medical record using coded references and sent in lieu of the prescriber answering one or more questions.

To:

Either, after receiving the PAInitiationRequest or for existing expiring PA, the payer returns a PAInitiationResponse. As this transaction contains the set of questions which have already been established by the payer for the prior authorization, the PAInitiationResponse should be sent from the payer to the prescriber timely. This will typically contain a set of questions to be completed by the prescriber, or, information that could be obtained from the patient's electronic medical record using coded references and sent in lieu of the prescriber answering one or more questions.

And from this:

When providing the question set to the prescriber, the payer must return a <PACaseID> containing a unique identification for the prior authorization case opened based on the PAInitiationRequest. This tracking identifier will be used on other transactions as a unique reference to this prior authorization case.

To:

When providing the question set to the prescriber, the payer must return a <PACaseID> containing a unique identification for the prior authorization case opened based on the PAInitiationRequest. This tracking identifier will be used on other transactions as a unique reference to this prior authorization case. If payer is providing the question set for renewal of an existing expiring PA, the payer shall also return <ExpiringPACaseID> which is the original <PACaseID> and the expiration date of the PA in <ExpirationDate>.

Section: PA Cancel Request and Response Transactions was modified from:

These transactions enable the prescriber to cancel a previously submitted request for which the prescriber has obtained a <PACaseID>, notifying the payer that prior authorization is no longer needed. This can be used in cases such as when the prescriber prescribes an alternative to the initially requested medication.

To:

These transactions enable the prescriber to cancel a PA for which the prescriber has

obtained a <PACaseID>, notifying the payer that prior authorization is no longer needed. This can be used in cases such as when the prescriber prescribes an alternative to the initially requested medication.

Section Prescription Transfer Response Transaction was modified to include the following:

If the REMS Administrator has provided authorization to the prescriber-submitted REMSRequest with an authorization, this can be placed in the <REMSAuthorizationNumber> on the RxTransferResponse. <PrescriberCheckedREMS> identifies if the prescribing system has performed an inquiry to the REMS Administrator in order to verify the REMS component of the prescription.

Added new Section: REMS Introduction which include the following subsections:

REMS Transaction

REMS Initiation Request and Response Transaction

REMS Request and Response Transactions

Section: Structure Quick Reference had the following pictures added:

REMSInitiationRequest Transactions

REMSInitiationResponse Transaction

REMSRequest Transaction

REMSResponse Transaction

Added new Section: Patient Element(s) along with subsections for Patient Contact Information and Inclusion of Patient Insurance Information

Added new Section: Recommendations for Consistent Use of Drug Identification Fields

Section: Diagnosis Element was modified from:

For each SNOMED code sent in the <Diagnosis><Primary> or <Secondary>, **the corresponding ICD must also be sent**. It is recommended that the ICD should be what the doctor would use for their billing transaction.

Note: ICD codes do have a decimal; however, for transaction/submission of the codes the decimal is **not** included in the code. The reporting of the decimal between the third and fourth characters is unnecessary because it is implied.

To:

To document and communicate the reason for the prescription, NCPDP strongly recommends that diagnosis and indication be included in all prescriptions. Communicating this information will improve patient safety, enhance efficiency and expedite prior authorization. Inclusion of this information will reduce the need for the pharmacist to contact the prescriber for missing information such as that needed for prior authorization or claim processing.

Including the indication/diagnosis can also support providing patient friendly language for the medication label and patient information leaflet.

If a SNOMED CT® code is sent in the <Diagnosis><Primary> or <Secondary>, the corresponding ICD code for each SNOMED CT® code must also be sent. If no diagnosis is sent and the Structured and Codified Sig is not sent, the indication would be sent in the free text field.

When the ICD code is sent, it should be the diagnosis code pertaining specifically to the medication being prescribed. The medication level diagnosis code may be needed by the patient's prescription benefit plan to determine coverage. Note: ICD-10 codes do have a decimal; however, for transaction/submission of the codes, the decimal is not included in the code. The reporting of the decimal between the third and fourth characters is unnecessary because it is implied.

When the SNOMED CT® code is sent, it must correspond to the problem or indication for which the medication is being prescribed. If the Structured and Codified Sig Format is being used (see NCPDP **Structured and Codified Sig Format Implementation Guide** <IndicationForUse>), the SNOMED CT® code corresponding to the patient's problem or indication for the prescribed medication is transmitted in <IndicationForUse> and be consistent with the ICDs sent in the diagnosis element(s).

Added new Section: Quantity and Quantity Qualifiers

Added new Section: Days Supply

Section: Medication Elements and Refill Elements had the following added:

<LastFillDate> - If the prescription was filed but never filled, a Last Fill Date is not available and the transaction should not be sent.

<MedicationPrescribed> - **SCRIPT** transactions sent from the pharmacy to the prescriber **should not** contain the literal prescribed medication information that was provided by the prescriber on a NewRx but instead should include the pharmacist's interpretation of the medication ordered by the prescriber. For example,

Prescriber drug name: simvastatin (aka Zocor) 20 mg tablet oral

Pharmacy drug name: simvastatin 20mg tablet

In this case, the Renewal Response should be approved as the **medication intent is the same** in this example. The **SCRIPT Implementation Guide** indicates this difference in drug name is a difference in form, not meaning. The system should leverage the RxNorm code in the transaction and not key on a textual field. It is noted that established code sets may support synonym descriptions. The Prescriber Order Number is used to tie back.

Add new Section: Use of Manufacturer Name and LotNumber

Added new Section: Medication Note

Added new Section: REMS

Added new Section: Use of WoundLocation, WoundWidth and WoundLength

Section: Sig Elements updated all references to DoseForm to DoseUnitOfMeasure and replaced Figure 64 and Figure 68.

Added new Section: Patient Height and Weight

Section: IV Administration had the following added:

<IVAccessDeviceTypeDescription> would be sent to indicate the specific device used for central IV access, if applicable i.e. implanted port, PICC line, tunneled line, non-tunneled line.

<IVAccessCatheterTipTypeDescription> would be sent to indicate the specific structure of the catheter tip for the specific device used for central or midline IV access., if applicable i.e. valved, non-valved.

<IVInfusionTypeDescription> would be sent to indicate the intended type of IV infusion i.e. continuous, intermittent, TOTAL parenteral nutrition (TPN), PARTIAL parenteral nutrition (PPN), maintenance.

<SpecificAdministrationGauge> would be sent to indicate the size of the needle or catheter being used for medication administration, i.e. 14, 18, 20.

<SpecificAdministrationBrand> would be send to indicate the Brand of the PICC line used for central IV access.

<SpecificAdministrationLength> would be sent to indicate the length of the PICC line used for central IV access.

Exchange of clinical/protocol data:

The Clinical Information exchange can be sent at the time the prescription is sent and can include information such as: past medical history, including other related drug therapies attempted, diagnoses/problem lists, lab and drug level results, additional disease/condition information, flushing protocol parameters, guidelines for dosing parameters or drug level ranges. Information is exchanged via attachments.

If discrete clinical data is to be exchanged, the **SCRIPT Standard** supports elements such as: primary and secondary medication related diagnoses <Diagnosis>. A diagnosis, such as diabetes, may be important for the pharmacy to know what diluent to mix medication in if not specified. The SCRIPT Standards support patient allergies <Allergy>. The SCRIPT Standards also supports measurement information via <Observation>.

Added new Section: Titration

Added new Section: Specific Long Term Care Element Discussion

Added new Section: Specific Guidance For Compounds

Section: <PAReferenceID> was updated from:

This element is mandatory in all prior authorization transactions. The <PAReferenceID> is assigned by the prescribing system on the initial transaction and is used as a tracking identifier on all prior authorization request and response transactions to tieback related prior authorization transactions. It is the identifier established by the prescribing system sending a PAInitiationRequest in the solicited model or PARequest in the unsolicited model to initiate the process to request prior authorization. The identifier must be echoed in any subsequent prior authorization transactions related to that request for prior authorization (including prior authorization appeal and cancel transactions). The identifier must be unique per prescribing system.

To:

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This element is mandatory in all prior authorization transactions except PAInitiationResponse. The <PAReferenceID> is assigned by the prescribing system on the initial transaction and is used as a tracking identifier on all prior authorization request and response transactions to tieback related prior authorization transactions. It is the identifier established by the prescribing system sending a PAInitiationRequest in the solicited model or PAResponse in the unsolicited model to initiate the process to request prior authorization. The identifier must be echoed in any subsequent prior authorization transactions related to that request for prior authorization (including prior authorization appeal and cancel transactions). The identifier must be unique per prescribing system. If the <PAReferenceID> is not present on the PAInitiationResponse, it is because the payer is renewing an expiring PA.

Added new Section: <ExpiringPACaseID>

Added new Section: PAPriorityIndicatorUsage

Section: Transmission Examples had the following added to the opening paragraph:

The codes used in the examples are those as of the date the document was published and are subject to change.

Section: Transmission Examples had new examples added for the REMS transaction and all examples were updated to reflect the change to pa-structures.

Frequently Asked Question was modified from:

What Is The Functionality Of SCRIPT?

To:

What Is The Functionality Of SCRIPT?

Section: Updates and Corrections to Standards was modified from:

The Data Element Request Form (DERF) provides the mechanism for changing NCPDP standards and using or requesting new data elements and new code set values in business functions. To request a change in NCPDP standards, complete an NCPDP Data Element Request Form, available at [www.ncpdp.org](http://www.ncpdp.org). Appropriate NCPDP Work Groups and Committees consider information submitted on the DERF. The Data Element Request Form process makes it possible for NCPDP working committees to adequately address these concerns before accepting or approving new information requests into a standard. The final acceptance of new requests into the standard is made by NCPDP at the suggestion or recommendation of the Work Group or Committee, and must be approved by consensus or consensus ballot of the membership.

To:

The Data Element Request Form (DERF) provides the mechanism for changing NCPDP standards and using or requesting new data elements and new code set values in business functions. To request a change in NCPDP standards, complete an NCPDP Data Element Request Form, available at [www.ncpdp.org](http://www.ncpdp.org). Appropriate NCPDP Work Groups consider information submitted on the DERF. The Data Element Request Form process makes it possible for NCPDP Work Groups to adequately address these concerns before accepting or approving new information requests into a standard. The final acceptance

of new requests into the standard is made by NCPDP at the suggestion or recommendation of the Work Group, and must be approved by consensus or consensus ballot of the membership.

**Section Prescription Fill Status Not Dispensed Transaction:**

- 3. To notify of a prescription never dispensed (patient did not pick up the medication) or (the medication will be delivered to the specified LTPAC organization), and/or

TO:

- 3. To notify of a prescription never dispensed (patient did not pick up the medication) or (the medication will not be delivered to the specified LTPAC organization), and/or

**Section: Assumption for Long Term or Post-acute Care (LTPAC) Organization Receipt of RxFill Transactions**

- Implementation of RxFill is standard in LTPAC pharmacy/organization communication and is used to inform the LTPAC organization of medication review and pharmacy approval for dispensing. In addition, this message indicates that a medication order has/not been dispensed by the pharmacy.

TO:

- Implementation of RxFill is standard in LTPAC pharmacy/organization communication and is used to inform the LTPAC organization of medication review and pharmacy approval for dispensing/administration. In addition, this message indicates that a medication order has/not been dispensed by the pharmacy.

**Section: Prescription Fill Status Notification Transaction – Dispensed – General Requirements**

- RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and not simply filled and waiting. Therefore, the RxFill <FillStatus><Dispensed> should not be triggered simply by label printing or adjudication in the pharmacy, but, through an action such as a point of sale transaction, electronic signature capture at pickup, a will call bin management action, or similar positive indication of actual dispensing. For long term or post-acute care RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and/or filled and approved for administration to the patient by the LTPAC organization.

TO:

- RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and not simply filled and waiting. Therefore, the RxFill <FillStatus><Dispensed> should not be triggered simply by label printing or adjudication in the pharmacy, but, through an action such as a point of sale transaction, electronic signature capture at pickup, a will call bin management action, or similar positive indication of actual dispensing. For long term or post-acute care RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and/or approved for administration to the patient by the LTPAC organization.

**Section: Prescription Fill Status Notification Transaction – Partially Dispensed**

Corrected typographical error in post-acute care

Editorial correction modifying SNOMED CT to SNOMED CT®.

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## **16.50 VERSION 2016071**

New elements added to the Standard include:

- PAProcessorIdentification
- DigestMethod
- PayerContactCommunicationNumber composite
- UrgencyIndicatorCode
- FlavoringRequested

For consistency modified the following throughout the document:

- Long-term care modified to long term care
- Post-acute care modified to post-acute care

Section Prescription Fill Status Notification Transaction Introduction modified the following from

3. To notify of a prescription never dispensed (patient did not pick up the medication) or (the medication will be delivered to the specified LTPAC organization), and/or

To

3. To notify of a prescription never dispensed (patient did not pick up the medication) or (the medication will not be delivered to the specified LTPAC organization), and/or

Section Definitions added the following definition:

*Not Dispensed* – reported when a pharmacy does not dispense the prescription as ordered. This could occur when in conjunction with a return to stock, manufacturer backorder, pharmacy out of stock and not able to get in a timely manner or has no intention to stock, drug recalled, and conscientious objection.

Section Assumption for Long Term or Post-Acute Care (LTPAC) Organization Receipt of RxFill Transactions modified the first bullet from:

- Implementation of RxFill is standard in LTPAC pharmacy/organization communication and is used to inform the LTPAC organization of medication review and pharmacy approval for dispensing. In addition, this message indicates that a medication order has/not been dispensed by the pharmacy.

To

- Implementation of RxFill is standard in LTPAC pharmacy/organization communication and is used to inform the LTPAC organization of medication review and pharmacy approval for dispensing/administration. In addition, this message indicates that a medication order has/not been dispensed by the pharmacy.

Section Prescription Fill Status Notification Transaction – Dispensed was modified from:

The RxFill Transaction <FillStatus><Dispensed> is originated by the pharmacy. This transaction is used to notify the prescriber or long term or post-acute care (LTPAC) organization when a prescription has been **dispensed**. The RxFill can be used to notify dispensed status of new prescriptions, refills or medication supply requests.

To:

The RxFill Transaction <FillStatus><Dispensed> is originated by the pharmacy. This transaction is

used to notify the prescriber or long term or post-acute care (LTPAC) organization when a prescription has been **dispensed**. RxFill can be used to notify dispensing status of new prescriptions, refills or resupply requests. For RxFill <FillStatus><Dispensed><ReasonCode> value “DH” (Profile Medication) requires, at a minimum, the <MedicationDispensed> element with the quantity dispensed to be “0”.

Section General Requirements the second bullet was modified from:

- RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and not simply filled and waiting. Therefore, the RxFill <FillStatus><Dispensed> should not be triggered simply by label printing or adjudication in the pharmacy, but, through an action such as a point of sale transaction, electronic signature capture at pickup, a will call bin management action, or similar positive indication of actual dispensing. For long term or post-acute care RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and/or filled and approved for administration to the patient by the LTPAC organization.

To:

- RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and not simply filled and waiting. Therefore, the RxFill <FillStatus><Dispensed> should not be triggered simply by label printing or adjudication in the pharmacy, but, through an action such as a point of sale transaction, electronic signature capture at pickup, a will call bin management action, or similar positive indication of actual dispensing. For long term or post-acute care RxFill <FillStatus><Dispensed> should be triggered by a specific action in the pharmacy that indicates that the prescription was dispensed and/or approved for administration to the patient by the LTPAC organization.

Section Prescription Fill Status Notification Transaction – Not Dispensed was modified from:

The RxFill Transaction <NotDispensed> is originated by the pharmacy. This transaction is used when the pharmacy has not **dispensed** a previously filled prescription and the pharmacy will return the medication to stock. This might occur if the patient never picks up the prescription. This transaction is used in the long term post-acute care when the pharmacy will not dispense a prescription to notify the LTPAC organization the status and reason the prescription will not be dispensed. RxFill can be used to notify dispensing status of new prescriptions, refills or resupply requests.

To:

The RxFill Transaction <FillStatus><NotDispensed> is originated by the pharmacy. This transaction is used when the pharmacy has not **dispensed** either a new prescription or a previously filled prescription. This transaction is used to notify the prescriber or long term post-acute care organization the status and reason the prescription will not be dispensed. RxFill can be used to notify dispensing status of new prescriptions, refills or resupply requests.

Section Prescription Fill Status Notification Transaction – Partially Dispensed was modified from:

The RxFill Transaction <FillStatus><PartiallyDispensed> is originated by the pharmacy. This transaction is used to notify the prescriber or long term or post acute care organization (LTPAC) when a prescription has only been **partially dispensed**. RxFill can be used to notify dispensing status of new prescriptions, refills or resupply requests. An RxFill

<FillStatus><PartiallyDispensed> can be repeatedly initiated until the prescription has been completely dispensed or the remaining quantity is returned to stock, thereby requiring an RxFill <FillStatus><PartiallyDispensed> for the remaining quantity. RxFill requires that, at a minimum, the dispensed drug with the quantity received be included in the RxFill. It is suggested the <MedicationPrescribed> element be included for clarification.

To:

The RxFill Transaction <FillStatus><PartiallyDispensed> is originated by the pharmacy. This transaction is used to notify the prescriber or long term or post-acute care organization (LTPAC) when a prescription has been **partially dispensed**. RxFill can be used to notify dispensing status of new prescriptions, refills or resupply requests. An RxFill <FillStatus><PartiallyDispensed> should be repeated until the prescribed quantity of each fill has been completely dispensed or is returned to stock. RxFill <FillStatus><PartiallyDispensed> requires, at a minimum, the <MedicationDispensed> element with the quantity dispensed be included and it is suggested that the <MedicationPrescribed> element be included for clarification.

Section *Use of FlavoringRequested* was added.

The <FlavoringRequested> element is only to be included when the prescriber has had a conversation with the patient and/or their care giver, and is recommending flavoring be added to the product being prescribed.

<FlavoringRequested> is optional and the only acceptable value is “Y”.

For Refill Request and Change messages, the pharmacy should echo back what the prescriber sent in the NewRx.

Section *Use of UrgencyIndicator* was added.

The UrgencyIndicatorCode element must only be sent when the sender deems the request to be of an urgent nature for which a delay of therapy could result in a potential adverse health outcome.

Section *Receiver Is Not The PA Processor* was added:

In some cases, the receiving payer may not be the prior authorization processor for the patient and/or medication identified. For example:

- another entity may process all prior authorizations for a given member, or
- another entity may process prior authorizations for particular medications.

In these instances, the <ReasonCode> must be populated with the values that support the situations.

For example:

- **“CO” (The receiver is not the PA processor for this patient)** - This code indicates that the receiver is not the prior authorization processor for any medications for the patient identified in the PARequest.

Or

- **“CP” (The receiver is not the PA processor for this patient and medication combination)** - This code indicates that the receiver is not the prior authorization

processor for the requested medication, though it does serve as the prior authorization processor for other medications for the identified patient.

If known, the payer should return the <PAProcessor> elements in the response to identify the entity that acts as the prior authorization processor for the requested member and medication:

**<PAProcessor>** -

- **<PAProcessorIdentification>** This optional element is the identification number for the prior authorization processor.
- **<BusinessName>** This mandatory element is the name of the prior authorization processor.
- **<Address>** This mandatory composite is the address of the prior authorization processor.
- **<CommunicationNumbers>** This mandatory composite is the prior authorization processor's contact telephone number and optionally the email address or fax.

The PAProcessor element is included in the following message and response statuses:

```
<PAInitiationResponse><ResponseStatus><Closed>
  <PAResponse><ResponseStatus><Closed>
  <PAResponse><ResponseStatus><Approved>
  <PAResponse><ResponseStatus><Denied>
  <PAResponse><ResponseStatus><PartiallyDenied>
<PAAppealResponse><ResponseStatus><Closed>
```

Section PAInitiationResponseElements was modified from:

**PAInitiationResponse population when the receiving payer is not the prior authorization processor for the requested member or medication**

In some cases, the receiving payer may not be the prior authorization processor for the patient and/or medication identified in the PAInitiationRequest. For example:

- another entity may process all prior authorizations for a given member, or
- another entity may process prior authorizations only for particular medications.

In these instances, the payer must follow the PAInitiationResponse population convention below.

<ResponseStatus><Closed> must be populated.

<ReasonCode> must be populated with the values that support the situations.

For example:

- **"CO" (The receiver is not the PA processor for this patient)** - This code indicates that the receiver is not the prior authorization processor for any medications for the patient identified in the PAInitiationRequest.

or

- **"CP" (The receiver is not the PA processor for this patient and medication combination)** - This code indicates that the receiver is not the prior authorization processor for the requested medication, though it does serve as the prior authorization processor for other medications for the identified patient.

If known, the payer should return a <BenefitsCoordination> in the PAInitiationResponse to identify the entity that acts as the prior authorization processor for the requested member and medication:

- <PayerIdentification><ProcessorIdentificationNumber> for the correct prior authorization processor's identifier
- <PayerName> for the correct prior authorization processor's name
- <CommunicationNumbers> for the correct prior authorization processor's contact telephone number and optionally email address.

To:

**See Section *Receiver Is Not the PA Processor* when the receiving payer is not the prior authorization processor for the requested member or medication.**

Section *PAResponse Elements* was modified from:

**PAResponse population when the receiving payer is not the prior authorization processor for the requested member or medication (in unsolicited model)**

In some cases, the receiving payer may not be the prior authorization processor for the patient and/or medication identified in the PARRequest. For example:

- another entity may process all prior authorizations for a given member, or
- another entity may process prior authorizations only for particular medications.

In these instances, the payer should follow the PAResponse population convention below.

<ResponseStatus><Closed> must be populated.

<ReasonCode> must be populated with the values that support the situations.

For example:

- **"CO" (The receiver is not the PA processor for this patient)** - This code indicates that the receiver is not the prior authorization processor for any medications for the patient identified in the PARRequest.  
or
- **"CP" (The receiver is not the PA processor for this patient and medication combination)** - This code indicates that the receiver is not the prior authorization processor for the requested medication, though it does serve as the prior authorization processor for other medications for the identified patient.

If known, the payer should return a <BenefitsCoordination> in the PAResponse to identify the entity that acts as the prior authorization processor for the requested member and medication:

- <PayerIdentification><ProcessorIdentificationNumber> for the correct prior authorization processor's identifier
- <PayerName> for the correct prior authorization processor's name
- <CommunicationNumbers> for the correct prior authorization processor's contact telephone number and optionally email address.

To:

**See Section *Receiver Is Not the PA Processor* when the receiving payer is not the prior**

authorization processor for the requested member or medication.

Section *Key Appeal Transaction Elements* the following was removed:

**PAAppealResponse population when the receiving payer is not the prior authorization appeals processor for the requested member or medication (in unsolicited model)**

In some cases, the receiving payer may not be the prior authorization appeals processor for the patient and/or medication identified in the PAAppealRequest. For example:

- another entity may process all prior authorizations including appeals for a given member, or
- another entity may process prior authorizations including appeals only for particular medications.

In these instances, the payer must follow the PAAppealResponse population convention below.

**<ResponseStatus><Closed>** must be populated.

**<ReasonCode>** must be populated with the values that support the situations.

For example:

- “**CO**” (**The receiver is not the PA processor for this patient**) - This code indicates that the receiver is not the prior authorization processor for any medications for the patient identified in the PARequest.

or

- “**CP**” (**The receiver is not the PA processor for this patient and medication combination**) - This code indicates that the receiver is not the prior authorization processor for the requested medication, though it does serve as the prior authorization processor for other medications for the identified patient.

If known, the payer should return a **<BenefitsCoordination>** in the PAAppealResponse to identify the entity that acts as the prior authorization appeals processor for the requested member and medication:

- **<PayerIdentification><ProcessorIdentificationNumber>** for the correct prior authorization processor’s identifier
- **<PayerName>** for the correct prior authorization processor’s name
- **<CommunicationNumbers>** for the correct prior authorization processor’s contact telephone number and optionally email address.

Section *Digital Signature Elements* was modified from:

The following table shows the use of the **<DigitalSignatureIndicator>**.

Element	DataType	Mandatory/Conditional	Comment
<b>&lt;DigitalSignature&gt;</b>	Complex Type	C	The three tags under Digital Signature <b>&lt;DigestValue&gt;</b> , <b>&lt;SignatureValue&gt;</b> , and <b>&lt;X509Data&gt;</b> are required to have their data base64 encoded.
<b>&lt;DigitalSignatureIndicator&gt;</b>		M	True/False indicating the prescription has been digitally signed

Example using **<DigitalSignatureIndicator>**:

```
<transport:DigitalSignatureVersion="1.0">
    <structures:DigitalSignatureIndicator>true</structures:DigitalSignatureIndicator>
</transport:DigitalSignature>
```

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The following table shows the use of the digital signature elements when including the actual signature <DigestValue>, <SignatureValue>, <X509Data>).

Element	DataType	Mandatory/Conditional	Comment
<DigitalSignature>	Complex Type	C	The three tags under Digital Signature < DigestValue>, <SignatureValue>, and <X509Data> are required to have their data base64 encoded.
<DigestValue>	an	M	DigestValue Concatenate all fields listed below in the specified order, apply a SHA1 Hash, base64Encode the result. This field is used to confirm that all fields have been included in the digital signature. DigestValue is composed of fields concatenated together and then encoded. - The DigestValue is the result of a SHA-1 Hash, which is always 160 bits or 20 bytes.
<SignatureValue>	String	M	DigestValue that has been signed with a Private Key, base64 encode the results.
<X509Data>	String	M	Base64 encoded raw bytes of the X509 certificate (which contains the Public Key). Used by the receiver to validate the digital signature as described below.

Example using digital signature:

```
<transport:DigitalSignature Version="1.0">
    <structures:DigestValue>xxxxxxxxxxxxxx</structures:DigestValue>
    <structures:SignatureValue>xxxxxxxxxxxxxx</structures:SignatureValue>
    <structures:X509Data>xxxxxxxxxxxxxx</structures:X509Data>
</transport:DigitalSignature>
```

To:

The following table shows the use of the <DigitalSignatureIndicator>.

Element	DataType	Mandatory/Conditional	Comment
<DigitalSignature>	Complex Type	C	The three tags under Digital Signature <DigestValue>, <SignatureValue>, and <X509Data> are required to have their data base64 encoded.
<DigitalSignatureIndicator>		M	True/False indicating the prescription has been digitally signed

Example using <DigitalSignatureIndicator>:

```
<transport:DigitalSignature Version="1.1">
    <structures:DigitalSignatureIndicator>true</structures:DigitalSignatureIndicator>
</transport:DigitalSignature>
```

The following table shows the use of the digital signature elements when including the actual signature (<DigestValue>, <SignatureValue>, <X509Data>).

Element	DataType	Mandatory/Conditional	Comment
<DigitalSignature>	Complex Type	C	The three tags under Digital Signature <DigestValue>, <SignatureValue>, and <X509Data> are required to have their data base64 encoded.
<DigestMethod>	an1..10	M	Defines the Hashing method, e.g. SHA-1 or SHA-256 to be used.
<DigestValue>	an1..35	M	DigestValue Concatenate all fields listed below in the specified order, apply a SHA1 Hash, base64Encode the result. This field is used to confirm that all fields have been included in the digital signature. DigestValue is composed of fields concatenated together and

			then encoded. - The DigestValue is the results of the hash method defined in the DigestMethod field.
<SignatureValue>	String	M	DigestValue that has been signed with a Private Key, base64 encode the results.
<X509Data>	String	M	Base64 encoded raw bytes of the X509 certificate (which contains the Public Key). Used by the receiver to validate the digital signature as described below.

Example using digital signature:

```

<transport:DigitalSignature Version="1.1">
    <structures:DigestValue>xxxxxxxxxxxxxx</structures:DigestValue>
    <structures:SignatureValue>xxxxxxxxxxxxxx</structures:SignatureValue>
    <structures:X509Data>xxxxxxxxxxxxxx</structures:X509Data>
</transport:DigitalSignature>

```

Add a new Example 14: RxFill – Dispensed Medication (from Pharmacy to LTPAC facility). The result of this new example renumbered all remaining examples.

```

<?xml version="1.0" encoding="UTF-8"?>
<!--Sample XML file generated by XMLSpy v2010 (http://www.altova.com)-->
<transport:Message StructuresVersion="String" ECLVersion="String" DatatypesVersion="String" TransactionDomain="SCRIPT"
TransactionVersion="String" TransportVersion="String" xsi:schemaLocation="http://www.ncpdp.org/schema/transport transport.xsd"
xmlns:transport="http://www.ncpdp.org/schema/transport" xmlns:datatypes="http://www.ncpdp.org/schema/datatypes"
xmlns:script="http://www.ncpdp.org/schema/script" xmlns:structures="http://www.ncpdp.org/schema/structures"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
    <transport:Header>
        <transport:To Qualifier="C">77777777</transport:To>
        <transport:From Qualifier="">7701630</transport:From>
        <transport:MessageID>A66</transport:MessageID>
        <transport:RelatesToMessageID>1234567</transport:RelatesToMessageID>
        <transport:SentTime>2010-11-01T09:15:22</transport:SentTime>
        <transport:Security>
            <transport:UsernameToken>
                <transport:Password Type="PasswordDigest">String</transport:Password>
                <transport:Created>2001-12-17T09:30:47Z</transport:Created>
            </transport:UsernameToken>
            <transport:Sender>
                <transport:SecondaryIdentification>PASSWORDQ</transport:SecondaryIdentification>
            </transport:Sender>
        </transport:Security>
        <transport:SenderSoftware>
            <transport:SenderSoftwareDeveloper>ACE SOFTWARE</transport:SenderSoftwareDeveloper>
            <transport:SenderSoftwareProduct>ACE1</transport:SenderSoftwareProduct>
            <transport:SenderSoftwareVersionRelease>1.1</transport:SenderSoftwareVersionRelease>
        </transport:SenderSoftware>
        <transport:RxReferenceNumber>PH888</transport:RxReferenceNumber>
        <transport:PrescriberOrderNumber>110072</transport:PrescriberOrderNumber>
    </transport:Header>
    <transport:Body>
        <transport:RxFill>
            <script:FillStatus>
                <structures:Dispensed>
                    <datatypes>Note>PROFILE MEDICATION APPROPRIATE FOR ADMINISTRATION</datatypes>Note>
                    <datatypes:ReasonCode>DH</datatypes:ReasonCode>
                </structures:Dispensed>
            </script:FillStatus>
            <script:Patient>
                <structures:HumanPatient>
                    <structures:Identification>
                        <datatypes>SocialSecurity>333445555</datatypes>SocialSecurity>
                    </structures:Identification>
                    <structures>Name>
                        <datatypes>LastName>SMITH</datatypes>LastName>
                        <datatypes>FirstName>MARY</datatypes>FirstName>
                    </structures>Name>
                </structures:HumanPatient>
            </script:Patient>
        </transport:RxFill>
    </transport:Body>
</transport:Message>

```

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```
<structures:Gender>F</structures:Gender>
<structures:DateOfBirth>
    <datatypes>Date>1954-12-25</datatypes>Date>
</structures:DateOfBirth>
<structures:Address>
    <datatypes:AddressLine1>45 EAST ROAD SW</datatypes:AddressLine1>
    <datatypes:City>CLANCY</datatypes:City>
    <datatypes:StateProvince>WI</datatypes:StateProvince>
    <datatypes:PostalCode>54999</datatypes:PostalCode>
</structures:Address>
<structures:CommunicationNumbers>
    <datatypes:PrimaryTelephone>
        <datatypes:Number>6512551122</datatypes:Number>
    </datatypes:PrimaryTelephone>
</structures:CommunicationNumbers>
</structures:HumanPatient>
</script:Patient>
<script:Pharmacy>
    <structures:Identification>
        <datatypes:NCPDPID>7701630</datatypes:NCPDPID>
        <datatypes:NPI>7878787878</datatypes:NPI>
    </structures:Identification>
    <structures:BusinessName>MAIN STREET PHARMACY</structures:BusinessName>
    <structures:Address>
        <datatypes:AddressLine1>5400 S 121 ST</datatypes:AddressLine1>
        <datatypes:City>HALES CORNERS</datatypes:City>
        <datatypes:StateProvince>TN</datatypes:StateProvince>
        <datatypes:PostalCode>37122</datatypes:PostalCode>
        <datatypes:CountryCode>US</datatypes:CountryCode>
    </structures:Address>
    <structures:CommunicationNumbers>
        <datatypes:PrimaryTelephone>
            <datatypes:Number>6152205656</datatypes:Number>
        </datatypes:PrimaryTelephone>
    </structures:CommunicationNumbers>
</script:Pharmacy>
<script:Prescriber>
    <structures:NonVeterinarian>
        <structures:Identification>
            <datatypes:NPI>6666666666</datatypes:NPI>
        </structures:Identification>
        <structures:Name>
            <datatypes:LastName>JONES</datatypes:LastName>
            <datatypes:FirstName>MARK</datatypes:FirstName>
        </structures:Name>
        <structures:Address>
            <datatypes:AddressLine1>211 CENTRAL ROAD</datatypes:AddressLine1>
            <datatypes:City>JONESVILLE</datatypes:City>
            <datatypes:StateProvince>TN</datatypes:StateProvince>
            <datatypes:PostalCode>37777</datatypes:PostalCode>
        </structures:Address>
        <structures:CommunicationNumbers>
            <datatypes:PrimaryTelephone>
                <datatypes:Number>6152219800</datatypes:Number>
            </datatypes:PrimaryTelephone>
        </structures:CommunicationNumbers>
    </structures:NonVeterinarian>
</script:Prescriber>
<script:MedicationDispensed>
    <structures:DrugDescription>PCE 333 MG</structures:DrugDescription>
    <structures:DrugCoded>
        <datatypes:Strength>
            <datatypes:StrengthValue>333</datatypes:StrengthValue>
            <datatypes:StrengthForm>
                <datatypes:Code>C42998</datatypes:Code>
            </datatypes:StrengthForm>
            <datatypes:StrengthUnitOfMeasure>
                <datatypes:Code>C28253</datatypes:Code>
            </datatypes:StrengthUnitOfMeasure>
        </datatypes:Strength>
    </structures:DrugCoded>
    <structures:Quantity>
        <datatypes:Value>0</datatypes:Value>
    </structures:Quantity>
</script:MedicationDispensed>
```

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```

<datatypes:CodeListQualifier>87</datatypes:CodeListQualifier>
<datatypes:QuantityUnitOfMeasure>
    <datatypes:Code>C48542</datatypes:Code>
</datatypes:QuantityUnitOfMeasure>
</structures:Quantity>
<structures:DaysSupply>30</structures:DaysSupply>
<structures:WrittenDate>
    <datatypes:Date>2010-10-01</datatypes:Date>
</structures:WrittenDate>
<structures:Substitutions>0</structures:Substitutions>
<structures:NumberOfRefills>0</structures:NumberOfRefills>
<structures:Sig>
    <structures:SigText>TAKE ONE TABLET THREE TIMES A DAY UNTIL GONE</structures:SigText>
</structures:Sig>
</script:MedicationDispensed>
</transport:RxFill>
</transport:Body>
</transport:Message>

```

**Notes:**

Only pertinent elements are shown.

Element	Value	Note
To	77777777:C	This is the Clinic ID of the receiver; C means it is a Clinic.
From	7701630:P	NCPDP Provider ID Number of pharmacy; P means it is a pharmacy. This is the sender. It must be the pharmacy ID.
MessageID	A67	<b>Pharmacy system trace number for the transmission. Echoed back in the response transaction in RelatesToMessageID.</b>
RelatesToMessageID	1234567	<b>Prescriber trace number is used to link the original transaction (NewRx) (MessageID) to this subsequent transaction.</b>
SecondaryIdentification	PASSWORDQ	This is the password of the pharmacy.
RxFill	RxFill	The transaction type: Prescription Fill Status Notification.
SentTime	2010-11-02T09:15:22	Date and time transaction was sent 11/02/2010 09:15:22 A.M.
SenderSoftwareDeveloper,	ACE	Sender Software Developer: ACE SOFTWARE
SenderSoftwareProduct,	SOFTWARE:ACE1:1.1	Sender Software Product: ACE1
SenderSoftwareVersionRel ease		Sender Software Version Release: 1.1
PrescriberOrderNumber	110088	<b>This is the reference number assigned by the prescribing system.</b>
RxReferenceNumber	PH888	<b>This is the prescription number assigned by the pharmacy system.</b>
Dispensed	Dispensed	Denoting the prescription has been dispensed.
ReasonCode	DH	Denoting profile medication.
Note	Profile medication.	The prescription has been place on the patients profile for possible dispensing on a future date.
MedicationDispensed		
Quantity	0:87	The quantity is 0, this is a profile medication. 87 is the code value for Quantity Received.

**Status (from Prescriber)**

```

<?xml version="1.0" encoding="UTF-8"?>
<!--Sample XML file generated by XMLSpy v2010 (http://www.altova.com)-->
<transport:Message StructuresVersion="String" ECLVersion="String" DatatypesVersion="String" TransactionDomain="SCRIPT"
TransactionVersion="String" TransportVersion="String" xsi:schemaLocation="http://www.ncpdp.org/schema/transport.transport.xsd"
xmlns:transport="http://www.ncpdp.org/schema/transport" xmlns:datatypes="http://www.ncpdp.org/schema/datatypes"
xmlns:script="http://www.ncpdp.org/schema/script" xmlns:structures="http://www.ncpdp.org/schema/structures"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
    <transport:Header>
        <transport:To Qualifier="P">7701630</transport:To>
        <transport:From Qualifier="C">77777777</transport:From>
        <transport:MessageID>33333</transport:MessageID>
        <transport:RelatesToMessageID>A66</transport:RelatesToMessageID>
        <transport:SentTime>2010-11-01T09:15:23</transport:SentTime>
        <transport:SenderSoftware>
            <transport:SenderSoftwareDeveloper>MDLITE</transport:SenderSoftwareDeveloper>
            <transport:SenderSoftwareProduct>443</transport:SenderSoftwareProduct>
            <transport:SenderSoftwareVersionRelease>2.1</transport:SenderSoftwareVersionRelease>
        </transport:SenderSoftware>
    </transport:Header>
    <transport:Body>

```

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```
<transport>Status>
<transport:Code>000</transport:Code>
</transport>Status>
</transport:Body>
```

Updated Frequently Asked Question *How Is Packet Used?* from:

**How Is Packet Used?**

If the product being provided can be quantified as a tablet, then the <StrengthForm> must be “C48542” (Tablet Dosing Form). The <QuantityUnitOfMeasure> describes the dosing unit, In this example, a packet of 21 or 28, depending on their inventory.

Note in the example below, Quantity is a value of 1, with a QuantityUnitOfMeasureCode of “C48521” (Packet). It would be incorrect to specify a Quantity with a value of 28, with a QuantityUnitOfMeasureCode of “C48521” (Packet), as this would mean “28 Packets” instead of “1 Packet”.

**Example of Use of Packet**

Element	SCRIPT Remarks	SCRIPT value	Comment
Medication occurrence	Prescribed Dispensed Requested DispensedAndAdministered		
DrugDescription		Ortho Novum 7/7/7	
ProductCode and Qualifier	Values for NDC, UPC, MFG		
Strength	Drug Strength Measurement value	0.5-0.75-1	
StrengthForm	Pharmaceutical Dosage Form	C48542	Tablet dosing form  NCPDP Drug Dosage Form Terminology
StrengthUnitOfMeasure		C28253	Milligram  NCPDP Drug StrengthUnitOfMeasure Terminology
Quantity	Dispense Quantity Count of drug form dispensed	1	1
QuantityUnitOfMeasure		C48521	Tablet Dosing Unit  NCPDP QuantityUnitOfMeasure Terminology

To:

**How Is Pack Used?**

If the product being provided can be quantified as a tablet, then the <StrengthForm> must be “C48542” (Tablet Dosing Form). The <QuantityUnitOfMeasure> describes the dosing unit.

Updated diagrams in sections:

NewRX Transaction

RxRenewalRequest Transaction

RxRenewalResponse Transaction

Resupply Transaction

RxChangeRequest Transaction

[RxChangeResponse Transaction](#)  
[CancelRx Transaction](#)  
[CancelRxResponse Transaction](#)  
[NewRxRequest Transaction](#)  
[NewRxRequestDenied Transaction](#)

Updated Figure:

Figure 89 Approved Response Types  
Figure 90 Denied Response Types  
Figure 91 Open Response Types  
Figure 92 Closed Response Types  
Figure 100 PACancelResponse Types

## **16.51 VERSION 2017011**

New Data Elements:

- ExpectedResponseDate
- DosesPerDay
- OrderGroupReason
- AttachmentRequired
- AttachmentNotes

Renamed/Redefined Data Element

- PositionInOrderGroup – ItemCountInOrderGroup
- FollowUpRequest and MessageId definitions were modified to reference a Rx renewal instead of the refill request.

Sunsetted Data Elements:

- CompoundCode
- CouponNumber

Modified Data elements:

- ComparisonValue, LowerBoundComparisonValue, UpperBoundComparisonValue, and PrescriberProvidedNumericAnswer have been modified to allow for negative values. If the value is negative, the sign must precede the value.
- PayerType is now available in both Specialized and SCRIPT in the BenefitsCoordination element.

Transmission Examples have been moved to SCRIPT Standard Examples Guide document and incorporated by reference [Document Scope](#).

The following sections were modified:

- [Prior Authorization Introduction](#)
- [Prior Authorization Transactions](#)
- [Question Set and Coded Reference Support](#)
- [PA Request and Response Transactions](#)
- [PA Cancel Request and Response Transactions](#)

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- [PACancelRequest Transaction](#)
- [PACancelResponse Transaction](#)
- [Quantity and Quantity Qualifier](#)
- [Use of Number of Packages Element](#)
- [Patient Height and Weight](#)
- [Specific Guidance for Compounds](#)
- [Medication Elements](#)
- [Key Question Set Elements](#)
- [Digital Signature Elements](#)

New Sections added:

- [Coupons and Discount Programs](#)
- [Grouping of Prescription Orders](#)

Figures were updated to reflect the change in the schema.

## **16.52 VERSION 2017071**

### **New Data Elements:**

PatientCodifiedNoteValue  
PatientCodifiedNoteQualifier  
HoursOfAdministrationText  
HoursOfAdministrationTextCode  
HoursOfAdministrationTextQualifier  
HoursOfAdministrationTextValue  
OtherMedicationDate  
OtherMedicationDateQualifier  
PlaceOfServiceNonSelfAdministeredProduct  
RequestorRole  
PrescriberPlaceOfService  
MessageRequestSubCode  
FollowUpPrescriberIdentification  
PrescriberExplicitAuthorizationToAdminister

### **New External Code List Elements with values:**

PatientCodifiedNoteQualifier  
HoursOfAdministrationTextQualifier  
OtherMedicationDateQualifier  
PlaceOfServiceNonSelfAdministeredProduct  
RequestorRole  
PrescriberPlaceOfService  
MessageRequestSubCode  
FollowUpPrescriberIdentification

### **Modified Data Elements**

ProhibitRefillRequest was modified to ProhibitRenewalRequest

### **Sunset Data Elements (\*Note all were moved to OtherMedicationDateQualifier)**

\*AnticipatedDischargeDate  
\*DateValidated  
\*DeliveredOnDate  
\*PeriodEnd  
\*SoldDate  
SelfAdministrationAllowed

### **New Values were added or definitions/name changed to the following External Code List elements:**

ClinicalInfoTypesRequested  
Consent  
ReasonCode  
PayerIdentification

PAProcessorIdentification  
MessageRequestCode

Editorial Correction in Section: Patient Element(s) to modify “describers” to “describes”.

Modified the definition of RxChangeRequest and RxChangeResponse in section: Transaction Types

Sections: Prescription Change Request Transaction and Prescription Change Response Transaction was updated to reflect the use for validation of prescriber credentials.

Sections NewRxRequest Transactions, Written Date, Medication Note, Grouping of Prescription Orders, MedicationTransferred, and Digital Signature Information were modified to reference <OtherMedicationDateQualifier> and the appropriate value.

All references to BIN and or BINLocationNumber were updated to reflect IIN Number or IINNumber.

Pictures were updated in the following sections:

- NewRx Transaction
- RxRenewalRequest Transaction
- RxRenewalResponse Transaction
- Resupply Transaction
- Recertification Transaction
- RxChangeRequest Transaction
- RxChangeResponse Transaction
- RxFill Transaction
- CancelRx Transaction
- CancelRxResponse Transaction
- RxHistoryRequest Transaction
- RxHistoryResponse Transaction
- DrugAdministration Transaction
- NewRxRequest Transaction
- NewRxResponseDenied Transaction
- RxTransferRequest Transaction
- RxTransferResponse Transaction
- RxTransferConfirm Transaction

New Sections added:

- Clarification of RxChangeResponse Type
- Use of PatientCodifiedNotes
- RequestorRole
- Facility Specific Hours of Administration
- Prescriber Authorization Status Response Reason Codes
- Specific Guidance on Use of FollowUpPrescriber

Quantity Qualifier was modified through the document where applicable to reflect Quantity Unit of Measure.

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Sections Use of the Sig Element, Sig Grammar Tool and <SigText> Rules were updated.

**16.53 VERSION 2017071 REPUBLICATION MAY 2018**

Corrected spelling of PAInitiaionResponse was missing a “t”.

Added change log for Version 2017011