SCRIPT IMPLEMENTATION RECOMMENDATIONS

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

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1. PURPOSE

The recommendations in this document are expected to be followed by the industry for consistent and complete prescription transactions of the NCPDP SCRIPT Standard. As the electronic prescribing industry has matured, more robust requirements have been added to the transaction standards. It is recommended that a transaction that does not follow the recommendations be rejected as incomplete. These recommendations will be brought forward and it is anticipated that they will be reflected in future versions of the SCRIPT Standard. These recommendations provide a bridge to the future versions.

This document also contains editorial corrections, clarifications to the NCPDP SCRIPT Implementation Guide documents.

The SCRIPT Standard and all NCPDP standards are available with membership at www.ncpdp.org.

1.1 STRUCTURED AND CODIFIED SIG IMPLEMENTATION GUIDE VERSION 1.2

For implementing the Structured Sig Segment in SCRIPT versions 10.6 through 2011, the NCPDP Structured and Codified Sig Implementation Guide Version 1.2 should be referenced for more detailed explanation, situational rules and guidance.
2. RECOMMENDATIONS FOR CONSISTENT USE OF DRUG IDENTIFICATION FIELDS USED IN SCRIPT TRANSACTIONS

To increase efficiencies and reduce potential errors associated with electronic prescribing related to inconsistent use of the NCPDP SCRIPT Drug identification fields.

2.1 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.

See section “Frequently Asked Questions”.

2.1.1 EXAMPLE OF THE 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.

2.2 Recommendation Summary

1. Information transmitted must be clear and not cause confusion in patient safety.
2. The end result is that 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.
5. 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.

Important Note to implementers of SCRIPT version 10.6: These recommendations may not be in sync with the SCRIPT version 10.6 Implementation Guide (sections “DRU Drug Segment” and “Proper Transmission of Full Drug Name, Strength, and Form”) regarding the use of the Item Description (<DrugDescription>) and Item Number (<ProductCode>). The implementer is strongly recommended to use the guidance below to the best of their ability for best practices as the guidance will be incorporated into a future version of SCRIPT.

2.3 Recommendations to Drug Compendia

The following are recommendations to drug compendia for best practices so that 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:

<table>
<thead>
<tr>
<th>Element</th>
<th>Good examples</th>
<th>Bad examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product Name(s)</td>
<td>• Lipitor</td>
<td>• HCTZ</td>
</tr>
<tr>
<td></td>
<td>• Diltiazem HCl</td>
<td>• APAP</td>
</tr>
<tr>
<td></td>
<td>• APAP</td>
<td>• AZT</td>
</tr>
<tr>
<td>Strength and Strength Form</td>
<td>• 180 MG</td>
<td>• 180</td>
</tr>
<tr>
<td>(when necessary)</td>
<td>• 200MG/5ML or 200 mg/5 mL</td>
<td>• 200-S</td>
</tr>
<tr>
<td></td>
<td>• Adderall (note: mixed salts of a</td>
<td>• 40/ML</td>
</tr>
<tr>
<td></td>
<td>single-entity/amphetamine product</td>
<td></td>
</tr>
<tr>
<td></td>
<td>can be listed per label expression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>instead of the list of individual</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ingredients)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Arthrotec 50 Delayed-Release Tablet (note: product contains two active ingredients but name reflect only one with no mg designation.)</td>
<td></td>
</tr>
<tr>
<td>Dosage Form</td>
<td>• Tablets</td>
<td>• TB</td>
</tr>
<tr>
<td></td>
<td>• Capsules</td>
<td>• CP</td>
</tr>
<tr>
<td></td>
<td>• Kits (note: when more than one dosage form)</td>
<td>• KT</td>
</tr>
<tr>
<td></td>
<td>• 12 HR Delayed Release Tablets</td>
<td>• 12h</td>
</tr>
<tr>
<td></td>
<td>• 24 HR Extended Release Capsules</td>
<td>• TB24</td>
</tr>
<tr>
<td></td>
<td>• Each (Prevpac is provided as 14 cards of 8 tablets and capsules for a total quantity of 112 Each per NCPDP recommendations)</td>
<td>• EA</td>
</tr>
<tr>
<td>Route of Administration (when necessary)</td>
<td>• Oral</td>
<td>• PO</td>
</tr>
<tr>
<td></td>
<td>• Topical</td>
<td>• OR</td>
</tr>
<tr>
<td></td>
<td>• External</td>
<td>• Do not abbreviate oral as OR</td>
</tr>
</tbody>
</table>

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 and Term Type that relates to the compendia recommended ePrescribing Name. The RxCUI/Term Type should exactly match the ePrescribing Name concept. If the ePrescribing Name is for a brand product, then the RxNorm RxCUI and the corresponding Term Type should also all be for the same brand product. Similarly, if the ePrescribing Name is for a generic product, then the RxNorm RxCUI and the corresponding Term type should exactly match the generic product ePrescribing name.

Examples:
Drug Descriptions: Levoxyl 88 mcg oral tablet
RxNorm RxCUI: 966175
RxNorm Term Type: SBD
**SCRIPT Implementation Recommendations**

Drug Description: amoxicillin 500 mg oral capsule  
RxNorm RxCUI: 308191  
RxNorm Term Type: SCD

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.

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.

### 2.4 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. If an RxNorm concept does not exist, send a Representative NDC and the compendia recommended ePrescribing Name.
      ii. 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 compendium 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 using SCRIPT 10.6
      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. Future versions of SCRIPT support multi-ingredient compound exchange.

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 that 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.

6. 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.

### 2.5 Recommendations to 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 that 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 (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.

c. For compound drugs, no NDC or RxCUI is available for the entire formulation. For compound drugs, the ePrescribing Name for the entire formulation may be locally-agreed upon (e.g. magic mouthwash, butt cream). In this situation it is acceptable to not send an RxCUI or Representative NDC. This is only allowed in SCRIPT 10.6. In SCRIPT 10.7 there is support for multi-ingredient compound exchange.

2.6 FREQUENTLY ASKED QUESTIONS

2.6.1 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 that there may be manufacturers that choose to not provide identifiers to the industry.

2.6.2 WHAT IS A RECOGNIZED AUTHORITATIVE DRUG INFORMATION SOURCE?
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.

2.6.3 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
2.6.4 What is a Representative NDC?
Answer: Since prescribing systems typically operate at a label name level of specificity, it is not always necessary to supply all NDCs that tie to a given label name. In order to reduce the size of the formulary and benefit files, it is possible to use one or a subset of representative NDCs to define a category of medication. An NDC, by definition, is specific to a manufacturer/labeler, product, and associated packaging information. A representative NDC is an 11-digit NDC code that is intended to depict a category of medication regardless of package size and manufacturer/labeler. A representative NDC is not intended to infer specificity or preference to the imbedded manufacturer/labeler. In order to maximize the opportunity that the selected NDC exists among the various drug files, a representative NDC should be a nationally available product and not be a repackaged NDC, obsolete NDC, private label NDC or unit dose NDC unless it is the only NDC available identifying that category of medication. The drug description of the product must match the description of the representative NDC code value.

2.6.5 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.

2.6.6 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 10.11 and below (or the actual XML schema in SCRIPT 2010 and above) for the valid character set that can be transmitted.

2.6.7 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. The 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.

It is highly recommended that when populating the Drug Description field in electronic prescribing that ONE brand name or JUST the generic name is to be sent. Including both a brand and generic name in this field leads to ambiguity in the dispensing system (which does the prescriber intend to prescribe, the brand or the generic?). This is important because of state pharmacy laws that require the product written to be recorded and that dispensers clearly indicate to the patient if a substitution was made.
SCRIPT Implementation Recommendations

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:
1. Example 1
   <MedicationPrescribed>
   <DrugDescription>NIFEdipine (ADALAT CC/PROCARDIA XL) 60 mg SR tablet</DrugDescription>
   <DrugCoded>
   <ProductCode>54868453100</ProductCode>
   <ProductCodeQualifier>ND</ProductCodeQualifier>
   </DrugCoded>

2. 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 that 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 that 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):
1. 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>
   <DrugDBCodeQualifier>SCD</DrugDBCodeQualifier>
   </DrugCoded>
2. 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>
</MedicationPrescribed>
```

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>
</MedicationPrescribed>
```

2.6.8 MUST THE SAME CHARACTER CASE SUBMITTED ON A MESSAGE BE RETURNED IN THE RESPONSE?
Answer: No, the SCRIPT Standard supports both an upper and lower case character set so there is no need to mimic the character case from the request. Note: Trading partner agreements may require the use of upper case characters only.

2.6.9 HOW SHOULD TRANSPLANT AND/OR DISCHARGE DATE BE SUBMITTED IN AN ELECTRONIC PRESCRIPTION?
Answer: The transplant and discharge date, as it relates to the transplant, should be entered into the notes field as transplant:CCYYMMDD or discharge:CCYYMMDD. If the transplant or discharge date is not found in the notes field, the supplier should place a call to the prescriber to obtain the information.

2.6.10 HOW SHOULD PRESCRIBERS INDICATE THERAPEUTIC SUBSTITUTION IS PERMISSIBLE IN ORDER TO COMPLY WITH REQUIREMENTS (SUCH AS ARKANSAS) IN SCRIPT 10.6?
Answer: The prescriber should indicate therapeutic substitution in <Notes> in <MedicationPrescribed> as required by the specific State (“TSA” or “MSA” for Arkansas). NCPDP will look to add the ability to convey that therapeutic substitution is allowed in a future version of the SCRIPT Standard.

2.6.11 IF A REFILL APPROVAL RESPONSE IS RETURNED WITH 3 REFILLS AUTHORIZED FOR THE QUANTITY REQUESTED, HOW SHOULD THIS BE INTERPRETED BY THE PHARMACY? AS A TOTAL QUANTITY OF 4 FILLS (THE 30 IN THE ORIGINAL REQUEST + 3 REFILLS OF 30 FOR A TOTAL QUANTITY OF 120; OR AS 3 FILLS TOTAL OF THE QUANTITY IN THE REQUEST FOR TOTAL QUANTITY OF 90)?
Answer: As the SCRIPT Implementation Guide v10.6 states in section: DRU Drug Segment, Quantity Qualifier (DRU 060-1009-01-6063), the Quantity Qualifier of “A” (Additional Refills Authorized) is the only value allowed in a refill response (REFRES). In the example presented the pharmacy should interpret it as 3 refills total of the quantity in the request for total quantity of 90 or if generating a new prescription it is interpreted as an original fill and 2 refills.
The Quantity Qualifier value of “R” (Number of Refills) is not valid for a refill request (REFREQ) or
a refill response (REFRES).

2.6.12  **HOW SHOULD THE <RELATETOMESSAGEID> IN THE RXFILL MESSAGE BE POPULATED?**

**Answer:** The RelatesToMessageID in the RxFill message should always reference the MessageID that represents the valid prescription to be filled when available.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Transaction 1</th>
<th>Transaction 2</th>
<th>Transaction 3</th>
<th>Transaction 4</th>
</tr>
</thead>
</table>
| 1        | NewRx
- MessageID 123456 | RxFill
- MessageID 444333
- RelatesToMessageID 123456 | RenewalResponse (Approved, ApprovedWithChanges, Replace)
- MessageID 888333
- RelatesToMessageID 444333 | RxFill
- MessageID 999333
- RelatesToMessageID 888333 |
| 2        | NewRx
- MessageID 123456 | RenewalRequest
- MessageID 444333
- RelatesToMessageID 123456 | RenewalResponse (Approved or ApprovedWithChanges)
- MessageID 888333
- RelatesToMessageID 444333 |
| 3        | NewRx
- MessageID 123456 | RxFill
- MessageID 444555
- RelatesToMessageID 123456 | RenewalRequest
- MessageID 444333
- RelatesToMessageID 123456 |
| 4        | NewRx
- MessageID 123456 | RenewalRequest
- MessageID 444333
- RelatesToMessageID 123456 | RenewalResponse (Denied)
- MessageID 888333
- RelatesToMessageID 444333 |
| 5        | NewRx
- MessageID 123456 | RxChangeRequest
(all requests except PA)
- MessageID 444333
- RelatesToMessageID 123456 | RxChangeResponse – (Approved or ApprovedWithChanges)
- MessageID 888333
- RelatesToMessageID 444333 |
| 6        | NewRx
- MessageID 123456 | RxChangeRequest
(P = prior authorization needed)
- MessageID 444333
- RelatesToMessageID 123456 | RxChangeResponse – Approved – PA and NO change to medication
- MessageID 888333
- RelatesToMessageID 444333 |
| 7        | NewRx
- MessageID 123456 | RxChangeRequest (all message functions: G, T, P or D, S, OS, or U)
- MessageID 444333
- RelatesToMessageID 123456 | RxChangeResponse – Denied
- MessageID 888333
- RelatesToMessageID 444333 |
| 8        | NewRx
- MessageID 123456 | CancelRx
- MessageID 444333
- RelatesToMessageID 123456 | CancelRxResponse - Approved
- MessageID 888333
- RelatesToMessageID 444333 |
| 9        | NewRx
- MessageID 123456 | RxFill
- MessageID 888999
- RelatesToMessageID 123456 | CancelRx
- MessageID 444333
- RelatesToMessageID 123456 |
| 10       | NewRx
- MessageID 123456 | CancelRx
- MessageID 444333
- RelatesToMessageID 123456 | RxFill
- MessageID 999333
- RelatesToMessageID 123456 |
## 2.6.13 How should the textual representations of numeric values (i.e. quantity prescribed and date written) be communicated in electronic prescriptions?

**Answer:** Neither the currently named NCPDP SCRIPT Standard (10.6) nor any NCPDP approved standards provide discrete fields for textual representation for values already submitted numerically.

For example:

- to comply with requirement to submit the textual representation of prescribed quantity:
  QTY: followed by the textual quantity and the numeric quantity in parenthesis
  E.g. QTY: “QTY: ten (10) or QTY: five (5) or QTY: three and four tenths (3.4)

- to comply with the requirement to submit the textual representation of the date written month:
  MONTH: July

## 2.6.14 How should renewal requests for controlled substances be handled?

**Answer:** When a prescribing system receives a renewal request for a controlled substance transaction, the renewal request may not be used to pre-populate a renewal approval or a new prescription. Rather, the data in a renewal request may only be used by the prescribing system to indicate to a prescriber for which prescription the pharmacy is requesting a renewal. If the

### Table: Transaction Scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Transaction 1</th>
<th>Transaction 2</th>
<th>Transaction 3</th>
<th>Transaction 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>11*</td>
<td>NewRx -MessageID 123456</td>
<td>CancelRx -MessageID 444333</td>
<td>CancelRxResponse – Approved</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- RelatesToMessageID 123456</td>
<td>– MessageID 888333</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- MessageRequestCode C3</td>
<td>– RelatesToMessageID 444333</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ChangeOfPrescriptionStatusFlag C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12*</td>
<td>NewRx -MessageID 123456</td>
<td>CancelRx -MessageID 444333</td>
<td>CancelRxResponse – Approved</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- RelatesToMessageID 123456</td>
<td>– MessageID 888333</td>
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<td>- MessageRequestCode C1</td>
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<td>- ChangeOfPrescriptionStatusFlag D</td>
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<td>Resupply -MessageID 777111</td>
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<td>- RelatesToMessageID 123456</td>
<td>- MessageID 777111</td>
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<td>RxFill -MessageID 999333</td>
<td>RxFill -MessageID 999334</td>
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<td></td>
<td>- RelatesToMessageID - 123456</td>
<td>- MessageID 777111</td>
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<td></td>
<td>- RelatesToMessageID</td>
<td>- MessageID 777111</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

* Indicates LTPAC only usage
prescriber determines that a continuation of drug therapy is warranted, it is recommended the prescriber create a new prescription. While using the NCPDP SCRIPT 10.6 version, this can be facilitated using a DeniedNewPrescriptionToFollow RefillResponse transaction followed by a NewRx transaction. With the implementation of NCPDP SCRIPT version 2017071, this can be facilitated using a Replace RxRenewalResponse transaction.

2.6.15 IF A PROVIDER APPROVES A RENEWAL REQUEST BUT THE APPROVAL CANNOT BE SENT ELECTRONICALLY, HOW SHOULD THE PROVIDER CONVEY TO THE PHARMACY THAT A NEW PRESCRIPTION IS COMING VIA ANOTHER MEANS?

**Answer:** The provider should respond with a denial and the ReasonCode value of “AP” (AP Request already responded to by other means (e.g. phone or fax)).

2.6.16 WHY IS ADMINISTRATIONTIMINGNUMERICVALUE FOUND IN THE MEASUREMENTTIMING ELEMENTS IN BOTH SIG AND TITRATION?

**Answer:** Errors were found and are being corrected in a future version. The AdministrationTimingNumericValue in the MeasurementTiming element should actually be named the MeasurementTimingNumericValue. The appropriate value for MeasurementTimingNumericValue should populate the AdministrationTimingNumericValue in the message in version 2017071 until the correction can be made in future version. In addition the VariableMeasurementTimingModifier is required to be populated. In a future version it will be moved into the choice with MeasurementTimingNumericValue.

Measurement timing elements in 2017071:
The error will cause measurement timing to be populated as follows no matter if there are multiple timing values:

- `<MeasurementTimingNumericValue>1</MeasurementTimingNumericValue>`
- `<VariableMeasurementTimingModifier>TO</VariableMeasurementTimingModifier>`
- `<AdministrationTimingNumericValue>1</AdministrationTimingNumericValue>`

DERF 001631 requests modifications to the measurement timing elements that will result in the following:

This correction will allow the sending of `VariableMeasurementTimingModifier` and the second occurrence of `MeasurementTimingNumericValue` when there are multiple measurement times.
Example if only one MeasurementTimingNumericValue:

```xml
<MeasurementTimingNumericValue>1</MeasurementTimingNumericValue>
```

Example if multiple MeasurementTimingNumericValue:

```xml
<MeasurementTimingNumericValue>1</MeasurementTimingNumericValue>
<VariableMeasurementTimingModifier>TO</VariableMeasurementTimingModifier>
<MeasurementTimingNumericValue>5</MeasurementTimingNumericValue>
```

2.6.17 DOES THE `<ProhibitRenewalRequest>` FLAG PERTAIN TO THE ORIGINAL PRESCRIBER OR THE FOLLOW UP PRESCRIBER?

**Answer:** The `<ProhibitRenewalRequest>` flag pertains only to the original prescriber.

2.6.18 HOW SHOULD PRESCRIPTIONS FOR SUPPLIES BE COMMUNICATED WHEN A UPC OR OTHER PRODUCT IDENTIFIER IS NOT KNOWN?

**Answer:** Send a qualifier of UP in DrugCoded/ProductCode/Qualifier, and a code of SUPPLY in DrugCoded/ProductCode/Code
3. PRESCRIPTION REQUIREMENTS

The purpose of this section is that, with increased adoption of electronic prescribing, it is increasingly apparent that pharmacies are not receiving the information required by regulations to comply with their state pharmacy acts and as such, have requested the NCPDP SCRIPT Standard be enhanced to support the requirements.

The recommendations in this document are expected to be followed by the industry for consistent and complete prescriptions. It is recommended that a transaction that does not follow the recommendations be rejected as incomplete. These recommendations will be brought forward and it is anticipated that they will be reflected in future versions of the SCRIPT Standard.

3.1 OVERVIEW

3.1.1 NABP MODEL STATE PHARMACY ACT AND MODEL RULES

National Association of Boards of Pharmacy Model State Pharmacy Act and Model Rules ("The Model Act")

Section 3. Prescription Drug Order Processing.
(a) Prescription Drug Order
   A Prescription Drug Order shall contain the following information at a minimum:
   (1) full name, date of birth, and street address of the patient;
   (2) name, prescribing Practitioner's license designation, address, and, if required by law or rules of the Board, DEA registration number of the prescribing Practitioner;
   (3) date of issuance;
   (4) name, strength, dosage form, and quantity of Drug prescribed;
   (5) directions for use;
   (6) refills authorized, if any;
   (7) if a written Prescription Drug Order, prescribing Practitioner's signature;
   (8) if an electronically transmitted Prescription Drug Order, prescribing Practitioner’s electronic or digital signature;
   (9) if a hard copy Prescription Drug Order generated from electronic media, prescribing Practitioner’s electronic or manual signature. For those with electronic signatures, such Prescription Drug Orders shall be applied to paper that utilizes security features that will ensure the Prescription Drug Order is not subject to any form of copying and/or alteration.

3.2 IMPLEMENTATION TO THE SCRIPT STANDARD

The following section cites The Model Act italics with the requirement in gray. It then denotes the NCPDP SCRIPT Standard fields used to satisfy the requirement. As the industry is currently using SCRIPT version 8.1, preparing to move to SCRIPT version 10.6, and moving forward with enhancements for SCRIPT version 10.10, all three versions are listed to provide guidance to the implementer.

---

1 August 2014: http://www.nabp.net/publications/model-act Cited with permission by NABP.
The SCRIPT fields used to identify the drug product have evolved over the various versions of the standard. The following are excerpts from three specific versions and attempt to illustrate this evolution. However, a properly formatted drug name, based upon the discussions above, will contain the dosage form, strength, and strength unit of measure whenever possible. (Exceptions include, but may not be limited to products that have no specific strength or strength unit of measure, and products that contain multiple ingredients and strengths—e.g., prenatal vitamins.) The guidance in each section below indicates that a proper prescription drug order is to minimally contain these elements when appropriate to the drug product. The guidance does not state that these separate fields must be transmitted—they are conditional fields, meaning only to be sent if they further clarify the transaction. In fact, some argue that sending these separate fields only provides opportunity for confusion if they do not match with the information contained within the drug description itself.

3.2.1 SCRIPT 8.1

A Prescription Drug Order shall contain the following information at a minimum:

(1) full name, date of birth, and street address of the patient;

(2) name, prescribing Practitioner’s license designation, address, and, if required by law or rules of the Board, DEA registration number of the prescribing Practitioner;

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTT</td>
<td>030-I002-01-3036</td>
<td>Last Name</td>
<td>Mandatory</td>
</tr>
<tr>
<td>PTT</td>
<td>030-I002-02-3702</td>
<td>First Name</td>
<td>Mandatory</td>
</tr>
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<td>PTT</td>
<td>030-I002-03-3704</td>
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<td>PTT</td>
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<td>Name Suffix</td>
<td>Conditional</td>
</tr>
<tr>
<td>PTT</td>
<td>030-I002-03-3708</td>
<td>Name Prefix</td>
<td>Conditional</td>
</tr>
<tr>
<td>PTT</td>
<td>060-I004</td>
<td>Address</td>
<td>Conditional, with note to send whenever possible</td>
</tr>
<tr>
<td>PTT</td>
<td>020-2700</td>
<td>Century Date</td>
<td>Date of Birth. Conditional, with note to send whenever possible (Date of Birth is mandatory in future versions.)</td>
</tr>
</tbody>
</table>

Recommendation:

1. If patient is homeless, the text “HOMELESS” should be put in the Street Address.
2. The City, State, Zip should contain the local area.
3. If the address of the patient is unable to be obtained, the text “UNKNOWN” should be put in the Street Address.
4. The City, State, Zip should contain the local area. These rare conditions may affect the receiver’s matching of the patient, or will be different than what the receiver has on file.
**SCRIPT Implementation Recommendations**

<table>
<thead>
<tr>
<th>PVD</th>
<th>Field ID</th>
<th>Field Name</th>
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</tr>
</thead>
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<td>PVD</td>
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<td>Mandatory</td>
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<td>PVD</td>
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<td>PVD</td>
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<td>Name Prefix</td>
<td>Conditional</td>
</tr>
<tr>
<td>PVD</td>
<td>080-1004-01-3042</td>
<td>Street and Number/P.O. Box</td>
<td>Conditional</td>
</tr>
<tr>
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</tr>
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<td>PVD</td>
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<td>Place/Location Qualifier</td>
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<td>PVD</td>
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<td>Place/Location</td>
<td>Conditional</td>
</tr>
<tr>
<td>PVD</td>
<td>090-1016</td>
<td>Communication Number</td>
<td>PVD 090-1016-01-3148 Communication Number – Prescriber contact number – Mandatory for at least one occurrence</td>
</tr>
</tbody>
</table>

Recommendation:

1. There must be at least one character for the first name of the Prescriber.
2. The practicing address should be the same address listed within the prescriber directory(ies). This address is what the pharmacy uses to do prescriber matching.
3. The Provider Specialty Code contains the taxonomy applicable for the prescribing Practitioner’s license designation.

\(3)\) **date of issuance**;

**SCRIPT Fields and Designation:**

<table>
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<th>Segment</th>
<th>Field ID</th>
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<th>Designation</th>
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<td>Date</td>
<td>Mandatory</td>
</tr>
</tbody>
</table>

\(4)\) **name, strength, dosage form, and quantity of Drug prescribed**;

**SCRIPT Fields and Designation:**

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
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<td>DRU</td>
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<td>Item Description - drug name</td>
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</tr>
<tr>
<td>DRU</td>
<td>010-1013-06-4440</td>
<td>Free Text – Drug strength</td>
<td>Conditional</td>
</tr>
<tr>
<td>DRU</td>
<td>020-1009-02-8009</td>
<td>Item Quantity</td>
<td>Mandatory</td>
</tr>
</tbody>
</table>

Recommendation:

1. From the SCRIPT Implementation Guide the following is stated for the Item Description: “Is the self-contained full drug name, strength, and form.”
2. The NABP Model Act recommends “A Prescription Drug Order shall contain the following information at a minimum: name, strength, dosage form, and quantity of Drug prescribed”. The recommendation for an electronic
prescription is that 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.

(5) directions for use;

SCRIPT Fields and Designation:

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<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
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</thead>
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<td>Mandatory</td>
</tr>
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</table>

(6) refills authorized, if any;

SCRIPT Fields and Designation:

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<th>Field Name</th>
<th>Designation</th>
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</thead>
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<td>DRU</td>
<td>060-I018-02-8010</td>
<td>Quantity</td>
<td>Conditional Mandatory</td>
</tr>
</tbody>
</table>

(7) if a written Prescription Drug Order, prescribing Practitioner’s signature;

Not applicable

(8) if an electronically transmitted Prescription Drug Order, prescribing Practitioner’s
electronic or digital signature;

Signature electronically is identified by the authorization of the prescription on
the vendor system, and then the authorization and certification of use
established via the network intermediary.

(9) if a hard copy Prescription Drug Order generated from electronic media, prescribing
Practitioner’s electronic or manual signature. For those with electronic signatures, such
Prescription Drug Orders shall be applied to paper that utilizes security features that will
ensure the Prescription Drug Order is not subject to any form of copying and/or
alteration.

Not applicable

3.2.2 SCRIPT 10.6

Red font indicates a difference from SCRIPT 8.1.

A Prescription Drug Order shall contain the following information at a minimum:

(1) full name, date of birth, and street address of the patient;

SCRIPT Fields and Designation:

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<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
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<tr>
<td>PTT</td>
<td>030-I002-01-3036</td>
<td>Last Name</td>
<td>Mandatory</td>
</tr>
<tr>
<td>PTT</td>
<td>030-I002-02-3702</td>
<td>First Name</td>
<td>Mandatory</td>
</tr>
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<td>PTT</td>
<td>030-I002-03-3704</td>
<td>Middle Name</td>
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<td>PTT</td>
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<td>Name Suffix</td>
<td>Conditional</td>
</tr>
<tr>
<td>PTT</td>
<td>030-I002-03-3708</td>
<td>Name Prefix</td>
<td>Conditional</td>
</tr>
<tr>
<td>PTT</td>
<td>060-I004</td>
<td>Address</td>
<td>Conditional, with note to send</td>
</tr>
</tbody>
</table>
**SCRIPT Implementation Recommendations**

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
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<th>Designation</th>
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<td>Provider Specialty code</td>
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<td>PVD</td>
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<td>PVD</td>
<td>080-1004-01-3042</td>
<td>Street and Number/P.O.  Box</td>
<td>Conditional</td>
</tr>
<tr>
<td>PVD</td>
<td>080-1004-02-3164</td>
<td>City Name</td>
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<td>PVD</td>
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<td>PVD</td>
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<td>Communication Number</td>
<td>PVD 090-1016-01-3148 Communication Number – Prescriber contact number – Mandatory for at least one occurrence</td>
</tr>
</tbody>
</table>

Recommendation:
1. If patient is homeless, the text “HOMELESS” should be put in the Street Address.
2. The City, State, Zip should contain the local area.
3. If the address of the patient is unable to be obtained, the text “UNKNOWN” should be put in the Street Address.
4. The City, State, Zip should contain the local area. These rare conditions may affect the receiver’s matching of the patient, or will be different than what the receiver has on file.

**(2) name, prescribing Practitioner’s license designation, address, and, if required by law or rules of the Board, DEA registration number of the prescribing Practitioner;**

**SCRIPT Fields and Designation:**

Recommendation:
1. There must be at least one character for the first name of the Prescriber.
2. The practicing address should be the same address listed within the prescriber directory(ies). This address is what the pharmacy uses to do prescriber matching.
SCRIPT Implementation Recommendations

3. The Provider Specialty Code contains the taxonomy applicable for the prescribing Practitioner’s license designation.

(3) date of issuance;

SCRIPT Fields and Designation:

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRU</td>
<td>040-I006-02-2380</td>
<td>Date</td>
<td>Mandatory</td>
</tr>
</tbody>
</table>

(4) name, strength, dosage form, and quantity of Drug prescribed;

SCRIPT Fields and Designation:

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
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<td>Mandatory</td>
</tr>
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<td>DRU</td>
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<td>Free Text – Drug strength</td>
<td>Conditional</td>
</tr>
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<td>DRU</td>
<td>010-I013-14-7992</td>
<td>Item Form Code</td>
<td>Conditional</td>
</tr>
<tr>
<td>DRU</td>
<td>010-I013-16-7993</td>
<td>Item Strength Code</td>
<td>Conditional</td>
</tr>
<tr>
<td>DRU</td>
<td>020-I009-02-8009</td>
<td>Item Quantity</td>
<td>Mandatory</td>
</tr>
</tbody>
</table>

Recommendation:
1. From the SCRIPT Implementation Guide the following is stated for the Item Description: “Is the self-contained full drug name, strength, and form.”
2. The NABP Model Act recommends “A Prescription Drug Order shall contain the following information at a minimum: name, strength, dosage form, and quantity of Drug prescribed”. The recommendation for an electronic prescription is that 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.

(5) directions for use;

SCRIPT Fields and Designation:

<table>
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<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRU</td>
<td>030-I014-02</td>
<td>Sig instructions</td>
<td>Mandatory. Optional use of the SIG Segment.</td>
</tr>
</tbody>
</table>

(6) refills authorized, if any;

SCRIPT Fields and Designation:

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRU</td>
<td>060-I018-01-6063</td>
<td>Quantity Qualifier – Refills</td>
<td>Mandatory</td>
</tr>
<tr>
<td>DRU</td>
<td>060-I018-02-8010</td>
<td>Quantity</td>
<td>Conditional Mandatory</td>
</tr>
</tbody>
</table>

(7) if a written Prescription Drug Order, prescribing Practitioner’s signature;

Not applicable
(8) if an electronically transmitted Prescription Drug Order, prescribing Practitioner’s electronic or digital signature;

Signature electronically is identified by the authorization of the prescription on the vendor system, and then the authorization and certification of use established via the network intermediary.

(9) if a hard copy Prescription Drug Order generated from electronic media, prescribing Practitioner’s electronic or manual signature. For those with electronic signatures, such Prescription Drug Orders shall be applied to paper that utilizes security features that will ensure the Prescription Drug Order is not subject to any form of copying and/or alteration.

Not applicable

3.2.3 SCRIPT 10.10

Red font indicates a difference from SCRIPT 10.6.

A Prescription Drug Order shall contain the following information at a minimum:

(1) full name, date of birth and street address of the patient;

SCRIPT Fields and Designation:

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTT</td>
<td>030-I002-01-3036</td>
<td>Last Name</td>
<td>Mandatory</td>
</tr>
<tr>
<td>PTT</td>
<td>030-I002-02-3702</td>
<td>First Name</td>
<td>Mandatory</td>
</tr>
<tr>
<td>PTT</td>
<td>030-I002-03-3704</td>
<td>Middle Name</td>
<td>Conditional</td>
</tr>
<tr>
<td>PTT</td>
<td>030-I002-03-3706</td>
<td>Name Suffix</td>
<td>Conditional</td>
</tr>
<tr>
<td>PTT</td>
<td>030-I002-03-3708</td>
<td>Name Prefix</td>
<td>Conditional</td>
</tr>
<tr>
<td>PTT</td>
<td>060-I004</td>
<td>Address</td>
<td>Conditional, with note to send whenever possible</td>
</tr>
<tr>
<td>PTT</td>
<td>020-2700</td>
<td>Century Date</td>
<td>Date of Birth. Mandatory.</td>
</tr>
</tbody>
</table>

Recommendation:

1. If patient is homeless, the text “HOMELESS” should be put in the Street Address.
2. The City, State, Zip should contain the local area.
3. If the address of the patient is unable to be obtained, the text “UNKNOWN” should be put in the Street Address.
4. The City, State, Zip should contain the local area. These rare conditions may affect the receiver’s matching of the patient, or will be different than what the receiver has on file.

(2) name, prescribing Practitioner’s license designation, address, and, if required by law or rules of the Board, DEA registration number of the prescribing Practitioner;

SCRIPT Fields and Designation:

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVD</td>
<td>020-I001-01-1154</td>
<td>Reference Number</td>
<td>Mandatory</td>
</tr>
<tr>
<td>PVD</td>
<td>020-I001-02-1153</td>
<td>Reference Qualifier</td>
<td>Mandatory</td>
</tr>
</tbody>
</table>
Recommendation:
1. There must be at least one character for the first name of the Prescriber.
2. The practicing address should be the same address listed within the prescriber directory(ies). This address is what the pharmacy uses to do prescriber matching.
3. The Provider Specialty Code contains the taxonomy applicable for the prescribing Practitioner’s license designation.

(3) date of issuance;

SCRIPT Fields and Designation:

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRU</td>
<td>040-I006-02-2380</td>
<td>Date</td>
<td>Mandatory</td>
</tr>
</tbody>
</table>

(4) name, strength, dosage form, and quantity of Drug prescribed;

SCRIPT Fields and Designation:

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRU</td>
<td>010-I013-02-7008</td>
<td>Item Description - drug name</td>
<td>Mandatory</td>
</tr>
<tr>
<td>DRU</td>
<td>010-I013-06-4440</td>
<td>Free Text – Drug strength</td>
<td>Conditional</td>
</tr>
<tr>
<td>DRU</td>
<td>010-I013-14-7992</td>
<td>Item Form Code</td>
<td>Conditional</td>
</tr>
<tr>
<td>DRU</td>
<td>010-I013-16-7993</td>
<td>Item Strength Code</td>
<td>Conditional</td>
</tr>
<tr>
<td>DRU</td>
<td>020-I009-02-8009</td>
<td>Item Quantity</td>
<td>Mandatory</td>
</tr>
</tbody>
</table>

Recommendation:
1. From the SCRIPT Implementation Guide the following is stated for the Item Description: “Is the self-contained full drug name, strength, and form.”
2. The NABP Model Act recommends “A Prescription Drug Order shall contain the following information at a minimum: name, strength, dosage form, and quantity of Drug prescribed”. The recommendation for an electronic
prescription is that 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.

5. **directions for use**;

**SCRIPT Fields and Designation:**

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRU</td>
<td>030-1014-02</td>
<td>Sig instructions</td>
<td>Mandatory. Optional use of the SIG Segment.</td>
</tr>
</tbody>
</table>

6. **refills authorized, if any**;

**SCRIPT Fields and Designation:**

<table>
<thead>
<tr>
<th>Segment</th>
<th>Field ID</th>
<th>Field Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRU</td>
<td>060-1018-01-6063</td>
<td>Quantity Qualifier – Refills</td>
<td>Mandatory</td>
</tr>
<tr>
<td>DRU</td>
<td>060-1018-02-8010</td>
<td>Quantity</td>
<td>Conditional Mandatory</td>
</tr>
</tbody>
</table>

7. **if a written Prescription Drug Order, prescribing Practitioner’s signature**;

Not applicable

8. **if an electronically transmitted Prescription Drug Order, prescribing Practitioner’s electronic or digital signature**;

Signature electronically is identified by the authorization of the prescription on the vendor system, and then the authorization and certification of use established via the network intermediary.

9. **if a hard copy Prescription Drug Order generated from electronic media, prescribing Practitioner’s electronic or manual signature. For those with electronic signatures, such Prescription Drug Orders shall be applied to paper that utilizes security features that will ensure the Prescription Drug Order is not subject to any form of copying and/or alteration**.

Not applicable

### 3.3 **PROPER USE OF DAYS SUPPLY**

This is effective guidance for all version of SCRIPT Standard.

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 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.

### 3.4 Best Practices for Oral Liquid Medications

In March 2014, NCPDP published a white paper “NCPDP Recommendations and Guidance for Standardizing the Dosing Designations on Prescription Container Labels of Oral Liquid Medications”. This paper addresses patient safety concerns when medications are dispensed using non-metric measures such as teaspoon and tablespoon. Implementers of Structured and Codified Sig are encouraged to review the white paper and support sending oral liquid prescriptions using only milliliters (mL). Future versions of SCRIPT will remove teaspoon.
tablespoon, etc. from the available code set in order to systematically support this patient safety initiative.

3.5 **BEST PRACTICES FOR THE USE OF MEDICATION <NOTE> (OR FREE TEXT)**

*Best practices for the use of the <Note> in the Medication (or Free Text (DRU 090-4440) in DRU Segment) in NewRx or RefillResponse or ChangeResponse transactions.*

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. The <Note> should never conflict with other information in the transaction.

1. **<Note> (or Free Text) should be presented to the prescriber and used for *supplemental information* to the pharmacist regarding the patient, **not additional instructions or to relay values or information that can be completely, accurately, and unambiguously relayed in an element or segment available and implemented within the SCRIPT standard, e.g. (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 (Addressed in SCRIPT Standard v2016071).
      4. Multiple packaging (e.g. split up the quantity into one for school/one for home, etc.) (Addressed in SCRIPT Standard v2016071).
      5. Reminder to suspend use of contraindicated medication until other drug therapy complete.
      6. Expediated Partner Therapy designation on the prescription.

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 – Do Not Fill or <DoNotFill> should be used for this purpose. It is available for use in 10.6 (NCPDP External Code List has added values).
5. For prescriptions intended in a specific order (e.g. loading doses) – the Effective Date/<EffectiveDate> and Do Not Fill/<DoNotFill> should be used on subsequent prescriptions.
6. The structured Sig elements should be used for tapered doses.
7. Needed No Later Than/<NeedNoLaterThan> is available in SCRIPT version 10.6 and above for the facility to relay to the long term care pharmacy the timeframe when the medication is needed for delivery.
8. The Clinical Information transactions (see NCPDP Specialized Implementation Guide) should be used for exchanges of allergies or intolerances.
9. If a consistent use of <Note> is found that should be incorporated into the standard in discrete data fields, a Data Element Request Form (DERF) should be submitted. The NCPDP Data Element Request Form (DERF) may be found at http://www.ncpdp.org/standards-development-process.aspx.

### 3.5.1 COUPON/DISCOUNT INFORMATION EXCHANGE

**Question:** Can the Free Text (DRU 090-4440) (<Notes> in XML) field be used for coupon information?

**Response:** No, for SCRIPT v10.6 the Free Text (DRU 090-4440) (<Note>) is not to be used for coupon/discount information. Refer to the above section for best practices on the use of Free Text (DRU 090-4440) (<Notes>). Coupon information should be sent in the COO Segment (<BenefitsCoordination>) to relay patient BIN/PCN/Group etc. There is also a coupon number <PromotionNumber> if supported. Entities creating and exchanging coupons must be aware of laws and regulations as applicable. The prescriber must be aware of the coupon information being sent in the electronic transaction. It is recommended that the patient also be aware of the coupon and that there may be limitations on the applicability of the coupon.

### 3.6 RECOMMENDATIONS FOR ELECTRONIC PRESCRIBING IN PEDIATRICS

On March 25, 2013, the following article was published.

*Electronic Prescribing in Pediatrics: Toward Safer and More Effective Medication Management*

**COUNCIL ON CLINICAL INFORMATION TECHNOLOGY EXECUTIVE COMMITTEE, 2011 - 2012**

*Pediatrics* 2013;131;824; originally published online March 25, 2013; DOI: 10.1542/peds.2013-0192

The online version of this article, along with updated information and services, is located on the World Wide Web at: [http://pediatrics.aappublications.org/content/131/4/824.full.html](http://pediatrics.aappublications.org/content/131/4/824.full.html)
It contained the first 2 columns in Table 1 (below). NCPDP provided the following actions/recommendations to the categories. These recommendations are included below for industry use.
### TABLE 1 Pediatric Requirements for Safe and Effective e-Prescribing

<table>
<thead>
<tr>
<th>Category</th>
<th>Pediatric Requirements</th>
<th>NCPDP action/recommendation (current industry use of SCRIPT Version 10.6)</th>
<th>Future action/recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient information</td>
<td>Date of birth or age in units more specific than years</td>
<td>The electronic prescribing/EHR and pharmacy system should calculate age from the Date Of Birth contained in the transactions.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The SCRIPT Implementation Guide states that birth date should be sent whenever possible.</td>
<td></td>
</tr>
<tr>
<td>Weight in kilograms</td>
<td>Available for exchange in the Observation Segment. An example of the Observation Segment will be put in the NCPDP SCRIPT Implementations Recommendation document. Dosing calculations are also available for exchange in the structured and codified Sig Segment.</td>
<td>Completed - SCRIPT version 2013101 enhanced the Observation Segment to support LOINC and UCUM. Question to AAP – Does AAP recommend that the industry move towards the required use of metric measurements? If so, what actions are being taken to achieve this?</td>
<td></td>
</tr>
<tr>
<td>Height in centimeters</td>
<td>Available for exchange in the Observation Segment. An example of the Observation Segment will be put in the NCPDP SCRIPT Implementations Recommendation document. Dosing calculations are also available for exchange in the structured and codified Sig Segment.</td>
<td>Completed - SCRIPT version 2013101 enhanced the Observation Segment to support LOINC and UCUM. Question to AAP – Does AAP recommend that the industry move towards the required use of metric measurements? If so, what actions are being taken to achieve this?</td>
<td></td>
</tr>
<tr>
<td>Any history of intolerable adverse effects or allergy to Medications</td>
<td>Available for use - NCPDP has ClinicalInformation transactions where allergies, medical history, conditions are exchanged. Adverse events are captured at point of care (prescriber, pharmacy). Each SCRIPT transaction supports the DUE (Drug Use Evaluation) Segment for reporting interactions and actions between pharmacist and prescriber.</td>
<td>The task group is exploring the use of the existing Allergy Segment (contains allergies, problems, etc.) in electronic prescribing transactions in the future. The task group will explore the use of CDA as an attachment in other SCRIPT transactions.</td>
<td></td>
</tr>
<tr>
<td>Medication information</td>
<td>Indication-based dosing and individual and daily dose alerts, using a mg/kg per day or mg/m2 per day formula, unless inappropriate</td>
<td>DUE interrogation and alerts should be done at the point of care (prescriber, pharmacy). Use of industry drug database products is recommended.</td>
<td>N/A</td>
</tr>
<tr>
<td>Weight-based dosing calculations</td>
<td>Available for exchange in the Observation Segment. An example of the Observation Segment will be put in the NCPDP SCRIPT Implementations Recommendation document. Dosing calculations are also available for exchange in the structured and codified Sig Segment.</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
## SCRIPT Implementation Recommendations

<table>
<thead>
<tr>
<th>Category</th>
<th>Pediatric Requirements</th>
<th>NCPDP action/recommendation (current industry use of SCRIPT Version 10.6)</th>
<th>Future action/recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>All available formulations, including liquid formulations that may be specific brands</td>
<td>Use of industry drug database products and RxNorm are recommended. Done at the point of care (prescriber); may be an EHR certification or best practices recommendation.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Common formulations requiring extemporaneous compounding or combinations of active ingredients</td>
<td>See NCPDP SCRIPT Implementations Recommendation document on compound exchanges.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Cognitive support</td>
<td>Use of industry drug database products is recommended. Dosing calculations are also available for exchange in the structured and codified Sig Segment. Dose calculation maximums support height/weight/body surface area.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Automatic strength-to-volume conversions for liquid medications</td>
<td>Use of industry drug database products is recommended.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Adverse effect warnings specific to pediatric populations</td>
<td>Use of industry drug database products is recommended. Adverse events are captured at point of care (prescriber, pharmacy). Each SCRIPT transaction supports the DUE (Drug Use Evaluation) Segment for reporting interactions and actions between pharmacist and prescriber.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Alternative therapies based on ameliorable adverse effects</td>
<td>Use of industry drug database products is recommended.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Tall Man lettering to reduce medication selection errors</td>
<td>Use of industry drug database products is recommended.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Medication-specific indications to reduce ordering of soundalike Drugs</td>
<td>Use of industry drug database products is recommended. Indication fields are available for exchange in the structured and codified Sig. Also of interest <a href="http://www.ncpdp.org/Whitepaper.aspx">http://www.ncpdp.org/Whitepaper.aspx</a> - Universal Medication Schedule (UMS) white paper.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Pharmacy information</td>
<td>Pharmacies that will create extemporaneous compounds</td>
<td>Industry products may contain pharmacy demographic and service information to identifying compounding services. Trading partner directories may contain this information.</td>
<td>N/A</td>
</tr>
<tr>
<td>Data transmission</td>
<td>Use of messaging standards for data transmission to</td>
<td>Available for exchange in the Observation Segment and the structured and codified Sig Segment. The task group will explore the use of CDA as an attachment in other SCRIPT transactions.</td>
<td></td>
</tr>
</tbody>
</table>
## Pediatric Requirements

<table>
<thead>
<tr>
<th>NCPDP action/recommendation (current industry use of SCRIPT Version 10.6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of industry drug database products is recommended.</td>
</tr>
<tr>
<td>Liquid medication can be transmitted in metric units in SCRIPT.</td>
</tr>
<tr>
<td>See NCPDP SCRIPT Implementations Recommendation document on drug name and best practices for medication information.</td>
</tr>
<tr>
<td>Dosing calculations are also available for exchange in the structured and codified Sig.</td>
</tr>
<tr>
<td>NCPDP has another task group that is creating a white paper to support of the use of mL for volumetric measure in medication orders, electronic prescribing, patient instructions and prescription labeling. It is expected to be published in 2014 and would be available at <a href="http://www.ncpdp.org/Whitepaper.aspx">http://www.ncpdp.org/Whitepaper.aspx</a></td>
</tr>
</tbody>
</table>

### Recommendation: For pediatric patients

- As electronic prescribing/EHR systems capture this information, it is strongly recommended that the Observation Segment with current information for patient height and weight (and any other pertinent information) be sent on prescriber-initiated transactions for prescriptions. If the Observation Segment is sent, the measurement date is strongly recommended to be sent.

### 3.7 Recommendations for ePrescribing Best Practices of Patient Height, Weight, Contact, Insurance, and Diagnosis Information

#### 3.7.1 Inclusion of Patient Height and Weight Data

Currently, SCRIPT version 10.6 does not require that patient height and/or weight be sent, 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 it is recommended that the most recent patient height and patient weight be included on all new and renewal prescriptions sent from the prescriber to the pharmacy. The date
associated with the measures should 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”. See section “Clarification of Response Type” in the SCRIPT Standard Implementation Guide Version 10.6.

3.7.2 Inclusion of Patient Contact Information
SCRIPT version 10.6 requires that the patient last name and first name are sent. The street address of the patient is also required to be sent (see section “Implementation to the SCRIPT Standard”). A recommendation is 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 in SCRIPT version 10.6, 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).

3.7.3 Inclusion of Patient Insurance Information
SCRIPT version 10.6 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 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.

3.7.4 Inclusion of Diagnosis
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 and is required to be supported in the Health IT 2015 certification requirements. The 2015 Edition Health Information Technology (Health IT)
The SCRIPT Standard supports the transmission of two occurrences of diagnosis loop, each containing a primary and a secondary diagnosis.

If sent:
- The first diagnosis loop must include ICD-10 code(s)
- An optional second loop may include SNOMED CT® code(s).

If two diagnosis loops are sent:
- The primary diagnoses must be consistent
- The secondary diagnoses must be consistent.

A second occurrence of diagnosis loop cannot be used to specify a third (or fourth) diagnosis.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Example Value</th>
<th>Comment</th>
<th>Example Value</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ClinicalInformationQualifier</td>
<td>1</td>
<td>Must match first occurrence</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Primary Code</td>
<td>110</td>
<td>Alternate code for &lt;Primary&gt; &lt;Code&gt; in first occurrence</td>
<td>59621000</td>
<td></td>
</tr>
<tr>
<td>Qualifier</td>
<td>ABF ICD-10 LD SNOMED</td>
<td>Essential Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Essential (primary) hypertension</td>
<td>Essential Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Code</td>
<td>E876</td>
<td>Alternate code for &lt;Secondary&gt; &lt;Code&gt; in first occurrence</td>
<td>43339004</td>
<td></td>
</tr>
<tr>
<td>Qualifier</td>
<td>ABF ICD-10 LD SNOMED</td>
<td>Hypokalemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Hypokalemia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.8 **GENERAL RECOMMENDATIONS**

3.8.1 **ePRESCRIBING BEST PRACTICES WHEN THE PRESCRIBER WILL NOT HAVE A CONTINUED RELATIONSHIP WITH THE PATIENT OR WILL HAVE A TEMPORARY INTERRUPTION IN AN EXISTING RELATIONSHIP**

There are some clinical scenarios in which the prescriber will not maintain responsibility for refills or future management of the medication, for example:

- Prescribers seeing patients acutely for Urgent Care or Emergency Room encounters;
- Prescribers seeing patients in consultation, transferring further care back to the primary care provider;
- Prescribers transferring care of patients in the inpatient or rehab setting back to the primary care provider at time or discharge;
- Prescribers covering for another on vacation, sick, or leave of absence; or
- Prescribers covering for another (who moved to a new clinical setting, completed residency, retired, deceased, etc.) until patient is able to establish care with new healthcare provider.

When the prescriber will not have a continuing relationship with the patient or their existing relationship will be interrupted, the following is recommended:

1. The prescriber notifies the patient that they will not authorize renewals beyond those included in the original prescription.
2. The prescriber provides message content on the NewRx, RenewalResponse or ChangeResponse (in the Notes field):
   a. If known, providing the name of the prescriber following the patient. Recommended Notes field text is “Submit renewal requests to: xxxx” (where xxx is the follow up prescriber’s name, “PCP” or “Other Provider”), and
   b. Instructing the pharmacist not to request renewals from him/her. This request by the prescriber may contain authorized refills, but provides instruction that no further refill/renewal request (REFREQ) be sent to this prescriber via any means for this prescription.
3. Depending upon the reason for the relationship termination, the prescriber may also work with their intermediary to ensure that the appropriate service levels are supported (e.g. NEWRX only, not REFREQ/REFRES).
4. Should the prescriber receive a refill/renewal request (REFREQ), ReasonCode “AC” (Patient no longer under provider care) or other appropriate ReasonCode should be utilized in the refill/renewal response (REFRES).

Until a future version of the SCRIPT Standard is implemented that provides a flag to communicate this information, the pharmacy should interrogate the Notes field. Based upon the information provided by the prescriber in the Notes field (as in #2 above), pharmacist may then send the NewRx request or a RefillRequest/RenewalRequest (REFREQ) to the appropriate prescriber.
3.8.2 ePRESCRIBING BEST PRACTICES WHEN THE PATIENT REQUESTS THE PHARMACIST SEND REFILL REQUESTS TO A DIFFERENT PRESCRIBER OR THE PHARMACY IS FORCED TO DO SO BY CIRCUMSTANCES, SUCH AS PRESCRIBER TEMPORARY OR PERMANENT UNAVAILABILITY

When the patient asks the pharmacist to send a refill/renewal (REFREQ) request to a prescriber other than the current prescriber or is directed to do so by the original prescriber or prescriber office, the following is recommended:

1. The pharmacist sends a NewRxRequest to the indicated prescriber as directed.
2. The pharmacist may provide message content on the NewRxRequest (in the Notes field) communicating reason why the NewRxRequest is being sent to the new provider. Example Notes field text is “Patient prefers medication be managed by: xxxx (where xxxx is prescriber’s name, “PCP”, or other prescriber indicator such as “OB/GYN”).
3. If denied, the Prescriber sends a NewRxResponseDenied. The prescriber may provide message content on the NewRxResponseDenied indicating the reason for denial, such as “patient needs to be seen in clinic”, or instructing the pharmacist not to request renewals and providing the name of the prescriber following the patient, when known (in the Notes field).

Alternatively, a RefillRequest/RenewalRequest message may be redirected to the desired prescriber as instructed by the patient, the original prescriber or the original prescriber’s office. In this case, a Note should be added, clarifying the reason the RefillRequest/RenewalRequest has been directed to this new prescriber.

3.8.3 ePRESCRIBING BEST PRACTICES WHEN REJECTING A NEWRX WHEN THE PHARMACY IS UNABLE OR UNWILLING TO DISPENSE

Question: What methods are available to the pharmacist to electronically convey a message to the prescriber indicating the pharmacy cannot or will not dispense the patient’s prescription that was received as a NewRx, RxChangeResponse or RenewalResponse? (This question is not based on a scenario where prescription was not dispensed because the patient never picked it up (non-adherence).)

Response:
The NCPDP SCRIPT Standard supports electronic mechanisms to convey information from a pharmacist to a prescriber via the RxFill message or the RxChange message.

The RxFill message can be sent by the pharmacist to the prescriber notifying them that the pharmacist is unable/unwilling to dispense a prescription. In SCRIPT version 10.6, RxFill supports a <NotFilled> status with the <Note> field providing additional clarification to the prescriber as to the reason the pharmacist is unable/unwilling to dispense the prescription. This might occur when the pharmacy is out of stock of the
medication prescribed and it cannot be obtained in a clinically appropriate timeframe. Enhancements were added to this transaction in 2014+; see section “RxFill Recommendations”.

The RxChange message can be used by the pharmacist to request a change to a prescription when such a change is permitted by state and/or federal laws/regulations. This might occur when the pharmacy recognizes allergy, overutilization, when a package cannot be broken or other concerns that appear not to have been recognized or addressed by the prescriber or when pharmacy inventory levels are depleted (for example, CII prescription cannot be transferred in any state). Because of the potential for delay in drug therapy, all RxChange messages should be treated as urgent messages. See the NCPDP SCRIPT Implementation Guide for more information on the RxChange message.

For SCRIPT Version 10.6, the RxChange message should contain Therapeutic Interchange in the <ChangeRequestType> and add “the medication prescribed is out of stock and it cannot be obtained in a clinically appropriate timeframe” in the <MedicationPrescribed><Note>. For future versions of the SCRIPT Standard, the RxChange message should contain the value “OS” for “pharmacy is out of stock of the medication prescribed and it cannot be obtained in a clinically appropriate timeframe” in the <MessageRequestCode>.

If the pharmacist is unwilling to fill the prescription based on a controlled substance history report, they may suggest an alternative drug using the RxChange message with a note for clarification.

It is recognized that the industry is at various levels of adoption of these message types; however they are available and are recommended for use. Until there is more widespread adoption of these message types, the pharmacist will need to use the traditional processes available today to notify the prescriber of the inability to dispense a prescription.

### 3.8.4 ZERO REFILLS AUTHORIZED ON A RENEWAL REQUEST

Q: Per the Implementation and Recommendations Guides, the value transmitted in the Refills Value field must be “a number greater than zero”; however, it is not uncommon for a pharmacy to receive a “0” in the Value field, as in the example below:

```
<Refills>
  <Qualifier>R</Qualifier>
  <Value>0</Value>
</Refills>
```

This is not appropriate and could cause regulatory problems if the product were to be a controlled substance. The DEA may well not agree that we should fill a controlled substance Rx that was approved for “0” fills

How should a pharmacy process a renewal request (REFREQ) that has been approved for “0” fills, as in the example above?
R: The guidance clearly says the refill field should contain how many times the drug is to be dispensed and if it comes in with a zero, then it must be rejected following the table below.

### Error Message

<table>
<thead>
<tr>
<th>Code</th>
<th>EDIFACT</th>
<th>ECL before 201012</th>
<th>ECL 201012 - 201501</th>
<th>Future ECL</th>
</tr>
</thead>
<tbody>
<tr>
<td>STS-010</td>
<td>STS-010</td>
<td>900</td>
<td>900</td>
<td>900</td>
</tr>
<tr>
<td>STS-020</td>
<td>STS-020</td>
<td>144</td>
<td>2000</td>
<td>144</td>
</tr>
</tbody>
</table>

- **Description**: DRU refill quantity is invalid
  - Data format is valid for the element, but content is invalid for the situation/context
  - Number of refills invalid

### 3.8.5 State Controlled Substance Registration Number

Q: How should a State Controlled Substance Registration Number be submitted using SCRIPT v10.6?

R: The only prescriber identifier in SCRIPT 10.6 would be to use StateLicense with the appropriate abbreviation as defined by the associated State if necessary. If multiple IDs are required in the StateLicense element they must be separated with at least one space.

### 3.8.6 Best Practices for the Use of 340B Identifiers in SCRIPT v10.6

Q: How should the Office of Pharmacy Affairs ID number 340B drugs be communicated in SCRIPT v10.6?

A: Use the facility element to identify the prescription as originating from a 340B eligible site by putting the “Office of Pharmacy Affairs ID” preceded by “340B” in the <MutuallyDefined> Identification element (e.g. 340BXXXXXXXX where XXX is the Office of Pharmacy Affairs ID). The NPI of the clinic may also be sent in the facility element.

### 3.8.7 Trace Number Usage in SCRIPT 10.6 EDIFACT

#### Trace Number Usage

The Remarks in the UIB and UIH Segments above are to be followed for assigning, responding, and referencing transaction activity. In the UIB Segment above is a Mailbox note subsection. Further, the “Transmission Examples” section in the SCRIPT version 10.6 Implementation Guide should be reviewed for implementation and more detail. The following is summary guidelines of the usage.

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Transaction control reference (Message ID)</td>
<td>Unique reference identifier for the transmission, generated from the sender or the request and the sender of the response.</td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø2</td>
<td>Initiator reference identifier (Relates to Message ID)</td>
<td>Relates to message ID. Specific requirements for long term care.</td>
</tr>
</tbody>
</table>
**SCRIPT Implementation Recommendations**

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Transaction control reference (Message ID)</td>
<td>1234567</td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø2</td>
<td>Initiator reference identifier (Relates to Message ID)</td>
<td>1234567</td>
</tr>
<tr>
<td>UIB-Ø2Ø</td>
<td>Message Reference Number</td>
<td>11ØØ88</td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Dialogue Reference - Initiator control reference</td>
<td>11ØØ88</td>
</tr>
<tr>
<td>UIT-Ø1Ø</td>
<td>Message Reference Number</td>
<td>11ØØ81</td>
</tr>
</tbody>
</table>

**Example 1**

Based on “Example 26. Prescriber Sends the Original Order, then Changes the Original Order, Significantly (Direct Connect)

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>NEWRX from Prescriber</th>
<th>CANRX from Prescriber</th>
<th>NEWRX from Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Transaction control reference (Message ID)</td>
<td>1234567</td>
<td>1234569</td>
<td>1234568</td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø2</td>
<td>Initiator reference identifier (Relates to Message ID)</td>
<td>1234567</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UIB-Ø2Ø</td>
<td>Message Reference Number</td>
<td>11ØØ88</td>
<td>11ØØ88</td>
<td>11ØØ81</td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Dialogue Reference - Initiator control reference</td>
<td>11ØØ88</td>
<td>11ØØ88</td>
<td>11ØØ81</td>
</tr>
<tr>
<td>UIT-Ø1Ø</td>
<td>Message Reference Number</td>
<td>11ØØ81</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the examples that follow trace and reference numbers are shown to follow through in examples. No intelligence is implied in the values used, nor in any sequence.

**Example 2**
Based on “Example 16. Notify Prescriber A Prescription Has Been Partially Dispensed (Via Direct Connect)”).

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Value</th>
<th>RXFILL (partial fill) from Pharmacy</th>
<th>RXFILL (partial fill) from Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Transaction control reference (Message ID)</td>
<td>1234567</td>
<td>3311</td>
<td>3433</td>
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<tr>
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<td>Initiator reference identifier (Relates to Message ID)</td>
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<td>1234567</td>
<td>1234567</td>
</tr>
<tr>
<td>UIH-Ø2Ø</td>
<td>Message Reference Number</td>
<td>PH456</td>
<td>PH456</td>
<td>PH456</td>
</tr>
<tr>
<td>UIH-Ø3Ø-Ø1</td>
<td>Dialogue Reference - Initiator control reference</td>
<td>110Ø88</td>
<td>110Ø88</td>
<td>110Ø88</td>
</tr>
<tr>
<td>UIT-Ø1Ø</td>
<td>Message Reference Number</td>
<td>PH456</td>
<td>PH456</td>
<td>PH456</td>
</tr>
</tbody>
</table>

Example 3
Based on “Example 19. Pharmacy Requesting A Refill Authorization For A Specified Number Of Dispensings From A Prescriber And Prescriber Responding (No Mailboxing)

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Value</th>
<th>REFREQ from Pharmacy</th>
<th>REFRES from Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Transaction control reference (Message ID)</td>
<td>2222</td>
<td>A22</td>
<td>229Ø</td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø2</td>
<td>Initiator reference identifier (Relates to Message ID)</td>
<td>2222</td>
<td>A22</td>
<td></td>
</tr>
<tr>
<td>UIH-Ø2Ø</td>
<td>Message Reference Number</td>
<td>PH111</td>
<td>PH111</td>
<td></td>
</tr>
<tr>
<td>UIH-Ø3Ø-Ø1</td>
<td>Dialogue Reference - Initiator control reference</td>
<td>4444444</td>
<td>4444444</td>
<td>4444444</td>
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<tr>
<td>UIT-Ø1Ø</td>
<td>Message Reference Number</td>
<td>PH111</td>
<td>PH111</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Value</th>
<th>STATUS from Pharmacy</th>
<th>STATUS from Prescriber</th>
<th>STATUS from Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Transaction control reference (Message ID)</td>
<td>A99</td>
<td>2288</td>
<td>A45</td>
<td></td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø2</td>
<td>Initiator reference identifier (Message ID)</td>
<td>2222</td>
<td>A22</td>
<td></td>
<td>229Ø</td>
</tr>
</tbody>
</table>
### Example 4
Based on “Example 22. Prescriber Requests Medication History”

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Transaction control reference</td>
<td>991</td>
</tr>
<tr>
<td></td>
<td>(Message ID)</td>
<td></td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø2</td>
<td>Initiator reference identifier</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Relates to Message ID)</td>
<td></td>
</tr>
<tr>
<td>UIB-Ø2Ø</td>
<td>Message Reference Number</td>
<td></td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Dialogue Reference - initiator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>control reference</td>
<td></td>
</tr>
<tr>
<td>UIT-Ø1Ø</td>
<td>Message Reference Number</td>
<td></td>
</tr>
</tbody>
</table>

### Example 5
Based on “Example 3. Prescriber Sending A New Prescription To A Pharmacy (Via A Mailbox)” and “Example 15. Inform Prescriber A Prescription Has Not Been Dispensed And Will Be Returned To Stock (Via Mailbox)

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>UIB-Ø3Ø-Ø1</td>
<td>Transaction control reference (Message ID)</td>
<td>1234567</td>
</tr>
<tr>
<td>UIB-Ø3Ø-Ø2</td>
<td>Initiator reference identifier (Relates to Message ID)</td>
<td>1234567</td>
</tr>
<tr>
<td>UIH-Ø2Ø</td>
<td>Message Reference Number</td>
<td>PH456</td>
</tr>
<tr>
<td>UIH-Ø3Ø-Ø1</td>
<td>Dialogue Reference - Initiator control reference</td>
<td>110Ø88</td>
</tr>
<tr>
<td>UIT-Ø1Ø</td>
<td>Message Reference Number</td>
<td>PH456</td>
</tr>
</tbody>
</table>

### STATUS from Mailbox

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
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<td>UIB-Ø3Ø-Ø1</td>
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</tr>
<tr>
<td>UIB-Ø3Ø-Ø2</td>
<td>Initiator reference identifier (Relates to Message ID)</td>
<td>1234567</td>
</tr>
<tr>
<td>UIH-Ø2Ø</td>
<td>Message Reference Number</td>
<td>PH456</td>
</tr>
<tr>
<td>UIH-Ø3Ø-Ø1</td>
<td>Dialogue Reference - Initiator control reference</td>
<td>110Ø88</td>
</tr>
<tr>
<td>UIT-Ø1Ø</td>
<td>Message Reference Number</td>
<td>PH456</td>
</tr>
</tbody>
</table>

#### 3.8.8 EXPEDITED PARTNER THERAPY (EPT) ELECTRONIC PRESCRIPTIONS

NCPDP recognizes that certain states allow for prescriptions to be written for “expedited partner therapy”. To support the transmission of these prescriptions electronically, certain elements are required by the standard. In addition, State Law may require other elements be sent. It is recommended to use “Expedited Partner” as the patient name. When the State requires an EPT designation on the prescription, include “EPT” in the notes field.

For SCRIPT v10.6 required fields:
- First Name: Expedited
- Last Name: Partner
- Gender: use available values
Date of Birth: if known use actual birthdate, else use 1/1/1901

Future Version required fields:
First Name: Expedited
Last Name: Partner
Gender: use available values
Date of Birth: if known use actual birthdate, else use 1/1/1901
Street: “Pharmacy Should Request Address”
City, ST and Zip: default to the City, ST and Zip of prescriber or pharmacy

3.8.9 IN ORDER TO BE COMPLIANT WITH THE STANDARD, DO I HAVE TO BE ABLE TO SEND AND RECEIVE THE MINIMUM AND MAXIMUM FIELD LENGTH?

Answer:
When receiving a message, the maximum length of each field must be supported. When sending a message, the maximum length of each field is not required to be sent except when the data element being sent is required to echo the data received. Intermediaries are required to support sending and receiving the maximum length of each field. The length of each field is defined in the NCPDP Data Dictionary and additional guidance may be found in the schema, implementation guide or External Code List (ECL). The best practice is to support sending and receiving the minimum and maximum field lengths.

3.8.10 HOW SHOULD THE MA REQUIREMENT TO HAVE “PATIENT MAY FILL FOR LESS THAN THE FULL AMOUNT” FOR OPIOID PRESCRIPTIONS BE HANDLED ELECTRONICALLY?

Answer:
The <Notes> field in <MedicationPrescribed> should be used until the industry adopted SCRIPT Standard supports this in a codified manner.

3.8.11 DO YOU ALLOW THE STANDARD TO SUPPORT NON-COMMERCIALLY AVAILABLE PRODUCTS?

Response: The 10.6 SCRIPT Standard does not preclude the submission of non-commercially available products. See the Electronic Prescribing Best Practices document guidance (FAQ 2.6.5) for what a receiver can do if they receive a drug name that is not recognized or does not follow recommendations.
3.8.12  IS THERE A BEST PRACTICES RECOMMENDATION AROUND THE COMMUNICATION TO THE PHARMACY WHEN SENDING TWO ORDERS TO EQUAL A NON-COMMERCIALLY AVAILABLE DOSE?

Response: If the medication is not commercially available, the orders should be created using commercially available medications. Notes could be used to link the multiple orders together (i.e. 1 of x, 2 of x, etc. where x equals the total number of orders.). It is recommended the directions include a reference that more than one product equals the total dose prescribed (i.e. “Give 4mg tablet (Coumadin) with a 3mg tablet to equal the 7mg dose”. And then the next order directions would be “Give 3mg tablet (Coumadin) with a 4mg tablet to equal the 7mg dose.”) If the order arrives at a pharmacy as a non-commercially available product, it is up to the pharmacy to process this as multiple orders for the actual product dispensed and link the orders together (i.e. by the Prescriber Order Number).

Note: If a Prescriber writes or gives an oral order for a non-commercially available dose of medication (i.e. 7 mgs of warfarin (Coumadin)); it is recommended the Nurse verify with the prescriber which commercially available medications he/she is prescribing to equal the desired strength prior to entering the order and submitting it to the pharmacy.

3.8.13  WHERE SHOULD STATE SPECIFIC OPIOID EXEMPTION CODES BE POPULATED IN SCRIPT V10.6?

Response: A practitioner may use the notes field on the electronic prescription to indicate an approved condition or its corresponding code. A practitioner may also name the condition as part of the directions to the patient (sig. field).

3.8.14  I AM REQUIRED TO SEND EITHER A DIAGNOSIS CODE OR A CODE ON DENTAL PROCEDURES AND NOMENCLATURE (CDT CODE) ON CONTROLLED SUBSTANCES PRESCRIPTIONS. HOW DO I SEND THIS IN THE SCRIPT TRANSACTIONS?

Response: The diagnosis code can be sent using the <Diagnosis> element. SCRIPT does not support procedure codes, either CPT or CDT, so this information would need to be conveyed in the Notes field. NCPDP will look to add the ability to convey procedure codes in a future version of the SCRIPT Standard.

3.8.15  FOR A MEDICATION HISTORY RESPONSE, IF A VALUE OF “AQ” IS RETURNED IN THE RESPONSE IS ANOTHER MEDICATION HISTORY REQUEST SENT?

Response: To receive the additional data, a requesting system should send a new medication history request with a modified data range in the benefits coordination elements.
For example:
If the RxHistoryResponse indicates more medications are available (Response/Approved/ReasonCode = ‘AQ’) and the requestor desires to make a subsequent request for additional medications within the dates of the original request, the requesting system should send a new RxHistoryRequest with the EndDate in BenefitsCoordination equal to the LastFillDate of the oldest medication record returned in the RxHistoryResponse.

**Start and End Date:**

**Request 1 from Requesting System:**

- **StartDate** August 15 2017: StartDate is the beginning date for the desired history (up to 1 year ago from today’s date).
- **EndDate** August 15 2018: EndDate is the end date for the desired history (e.g., today’s date).

**EndDate** must be after the **StartDate**
PBM checks for drugs from the end date and goes back in time.

**Response 1: “AQ”**
January 4 2018 – Stopped sending on this date as PBM reached medication limit allowed in the response.

**Request 2:**

- **StartDate** August 15 2017: (StartDate equal to the original StartDate)
- **EndDate** January 4 2018: (LastFillDate of oldest medication record) – Note: Requestor desires to make a subsequent request for additional medications within the dates of the original request, a new RxHistoryRequest will need to be sent with the EndDate equal to the LastFillDate of the oldest medication record returned in the previous RxHistoryResponse.

**Summarized verbiage:**
**SCRIPT Implementation Recommendations**

| StartDate is the beginning date for the desired history (up to 1 year ago from today’s date). |
| If the RxHistoryResponse indicates more medications are available (Response/Approved/ReasonCode = ‘AQ’) and the requestor desires to make a subsequent request for additional medications within the dates of the original request, a new RxHistoryRequest will need to be sent with the StartDate equal to the original StartDate. |
| EndDate is the latest date in the time period requested for the desired history (e.g., today’s date). |
| EndDate must be after the StartDate. |
| If the RxHistoryResponse indicates more medications are available (Response/Approved/ReasonCode = ‘AQ’) and the requestor desires to make a subsequent request for additional medications within the dates of the original request, a new RxHistoryRequest will need to be sent with the EndDate equal to the LastFillDate of the oldest medication record returned in the RxHistoryResponse. |

Example of “oldest medication record returned”:

| Drug A: 06/04/2018 |
| Drug B: 04/04/2018 |
| Drug C: **01/04/2018** (LastFillDate of the **oldest** medication record returned in the RxHistoryResponse) |
3.8.16 HOW SHOULD THE MANDATORY ELEMENT OF CONSENT BE HANDLED IN A MEDICATION HISTORY RESPONSE?

Response: Consent is mandatory on the response. If Consent is sent in a response to a previous version where the element was mandatory, the value must echo back the value received in the RxHistoryRequest.
4. RXNORM GUIDANCE FOR SCRIPT

Pertinent data elements <XML> or (EDI):

- Drug name - <DrugDescription> (or DRU-010-I013-02-7008, 10, 11, 12 Item Description)
- NDC, UPC, HRI, etc – (<ProductCode> and <ProductQualifier>) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).
- RxNorm - (<DrugDBCode> <DrugDBCodeQualifier>) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).

For compounds

- Drug name of ingredient - <CompoundIngredientItemDescription> (or Compound Ingredient Item Description CPD-010-I017-02-8005)
- Ingredient ID and Qualifier - <ItemNumber> <CompoundProductIDQualifier> or (Compound Ingredient Item Number CPD-010-I017-03-7140 and Code List Responsibility Agency CPD-010-I017-04-3055)

<table>
<thead>
<tr>
<th>Message</th>
<th>Element (XML)</th>
<th>Guidance for Sender</th>
<th>Guidance for Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>NewRx</td>
<td>MedicationPrescribed</td>
<td>RxNorm should be sent if known in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</td>
<td>Pharmacy should use RxNorm to find the drug to dispense and use drug description received for validation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NDC is sent for reference only in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).</td>
<td>If No RxNorm use Name (&lt;DrugDescription&gt; or DRU-010-I013-02-7008, 10, 11, 12 Item Description).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name must be sent in &lt;DrugDescription&gt; (or DRU-010-I013-02-7008, 10, 11, 12 Item Description)</td>
<td>NDC is a just a representative NDC.</td>
</tr>
<tr>
<td>Refill Request</td>
<td>MedicationPrescribed</td>
<td>RxNorm should echo back what came in on the NewRx – but it may not exist in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</td>
<td>Prescriber should use RxNorm or NDC to find original Rx prescribed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NDC should echo back what came in the NewRx - but it may not exist in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).</td>
<td>This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name should echo back pharmacist’s interpretation of what came in the NewRx &lt;DrugDescription&gt; (or DRU-010-I013-02-7008, 10, 11, 12 Item Description)</td>
<td></td>
</tr>
<tr>
<td>Message</td>
<td>Element (XML)</td>
<td>Guidance for Sender</td>
<td>Guidance for Recipient</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MedicationDispensed</td>
<td>NDC dispensed shall be sent in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or</td>
<td>RxNorm should be sent if known in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</td>
<td>Prescriber should use RxNorm if present else NDC to Approve/Denied/DeniedNewRxToFollow</td>
</tr>
<tr>
<td></td>
<td>(DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).</td>
<td></td>
<td>Trading partners need to touch base with vendors to see if they just display what is send or do they map to something -- or might just pull up original prescription.</td>
</tr>
<tr>
<td>Refill Response</td>
<td>Prescriber should echo back RxNorm from request (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</td>
<td>RxNorm not used. NDC not used.</td>
<td></td>
</tr>
<tr>
<td>MedicationDispensed</td>
<td>Prescriber should echo back RxNorm from request (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</td>
<td>RxNorm not used. NDC not used.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prescriber should echo back NDC from request (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RxFill Request</td>
<td>RxNorm should echo back what came in on the NewRx -- but it may not exist in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</td>
<td>RxNorm used for reference. NDC used for reference.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NDC should echo back pharmacist’s interpretation of what came in the NewRx if known but NDC or RxNorm may not exist in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).</td>
<td>This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.</td>
<td></td>
</tr>
<tr>
<td>MedicationDispensed</td>
<td>NDC dispensed shall be sent in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or</td>
<td>RxNorm should be sent if known in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</td>
<td>Prescriber should use RxNorm for records. NDC is just for reference.</td>
</tr>
<tr>
<td>CancelRx Request</td>
<td>Always send RxNorm code if available in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</td>
<td>Should use prescriber order number of message id if possible. Use RxNorm if auto tie back is not available.</td>
<td></td>
</tr>
<tr>
<td>Message</td>
<td>Element (XML)</td>
<td>Guidance for Sender</td>
<td>Guidance for Recipient</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>RxChange Request - for TI and GS</td>
<td>Medication Prescribed</td>
<td>RxNorm should be sent if known in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier). The transaction shall echo back the pharmacist’s interpretation of the medication as sent in the original transaction.</td>
<td>Prescriber may use RxNorm for reference. This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.</td>
</tr>
<tr>
<td>RxChange Request for PA</td>
<td>Medication Prescribed</td>
<td>RxNorm should be sent if known in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier). The transaction shall echo back the pharmacist’s interpretation of the medication as sent in the original transaction.</td>
<td>Prescriber should use RxNorm for reference. This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.</td>
</tr>
<tr>
<td>RxChange Response</td>
<td>Medication Prescribed</td>
<td>RxNorm should be sent if known in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier). The transaction shall echo back the pharmacist’s interpretation of the medication as sent in the original transaction.</td>
<td>Pharmacy should use RxNorm to find drug to dispense if available else an appropriate alternate identifier (NDC, UPC, HRI).</td>
</tr>
<tr>
<td>RxHistory Response</td>
<td>Medication Prescribed</td>
<td>RxNorm should be sent if known in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier). The transaction shall echo back the pharmacist’s interpretation of the medication as sent in the original transaction.</td>
<td>Prescriber may use this for reference. This is needed to identify the medication that the patient was actually taking and that will be of importance in determining treatment.</td>
</tr>
<tr>
<td>Message</td>
<td>Element (XML)</td>
<td>Guidance for Sender</td>
<td>Guidance for Recipient</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>MedicationDispensed</td>
<td>RxNorm should be sent if known in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier). NDC dispensed must be sent in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).</td>
<td>Prescriber should use NDC dispensed. Pressed should use RxNorm to find to DUE CO Agent if available else an appropriate alternate identifier (NDC, UPC, HRI).</td>
<td></td>
</tr>
<tr>
<td>MedicationPrescribed</td>
<td>RxNorm should be sent if available in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier) else an alternate product identifier (NDC, UPC, HRI) should be sent in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency). Pharmacy should use this for reference.</td>
<td>Pharmacy should use RxNorm.</td>
<td></td>
</tr>
<tr>
<td>MedicationDispensed</td>
<td>RxNorm should be sent if known in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier). NDC dispensed must be sent in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency). Pharmacy should use NDC dispensed.</td>
<td>Pharmacy should use RxNorm.</td>
<td></td>
</tr>
<tr>
<td>Drug Administration</td>
<td>MedicationPrescribed</td>
<td>RxNorm should be sent if available in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier) else an alternate product identifier (NDC, UPC, HRI) should be sent in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency). Should use prescriber order number of Message ID if possible Use RxNorm if auto tie back is not available.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>XML Element</th>
<th>Field (EDI)</th>
<th>Guidance for Sender</th>
<th>Guidance for Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;CoAgentID&gt; and</td>
<td>DUE Co-Agent Qualifier DRU-100-5018-05-7884</td>
<td>RxNorm should be sent if available else an alternate product identifier (NDC, UPC, HRI) should be sent in (&lt;DrugDBCode&gt;)</td>
<td>Pharmacy should use RxNorm to find to DUE CO-Agent if available else an appropriate alternate identifier (NDC, UPC, HRI).</td>
</tr>
</tbody>
</table>
### SCRIPT Implementation Recommendations

| <ItemNumber> | Compound Ingredient Item Number CPD-010-I017-03-7140 and Code List Responsibility Agency CPD-010-I017-04-3055 | For each ingredient RxNorm should be sent in <ItemNumber> and <CompoundProductIDQualifier> if available else an alternate product identifier (NDC, UPC, HRI) should be sent. Name shall be sent in <CompoundingIngredientItemDescription> or Compound Ingredient Item Description CPD-010-I017-02-8005. | For each ingredient pharmacy should use the qualifier to determine how to find the ingredient for the compound and use compound ingredient description received for validation. |

#### Note: based on industry guidance or pilot results these recommendations may be brought forward and rules created for the SCRIPT Implementation Guide.

#### 4.1 Medications Source Vocabulary for Certification Testing

RxNorm is the preferred vocabulary for testing, although the other vocabularies may be used for certification testing in Meaningful Use. RxNorm is not required at this time. The 2013 directional guidance from the Office of the National Coordination (ONC) is to move to the use of RxNorm and remove the exchange of other proprietary vocabularies for meaningful use for testing purposes.

When the NCPDP External Code Lists were published for use in SCRIPT 8.1 and in SCRIPT 10.6, the government and the industry had not completed RxNorm pilots or provided recommendations. The early publications of the External Code Lists for SCRIPT 8.1 and SCRIPT 10.6 do not have RxNorm qualifier values listed. Once the pilot tests were completed and Meaningful Use cited, the industry evaluated the findings and RxNorm qualifier values were adopted in a more recent version publication of the External Code List (June 2010), for use in SCRIPT 8.1 and 10.6. The values below were adopted and for testing purposes are to be used. **Note:** The SCRIPT 10.6 schema was updated in April 2011 to include the RxNorm values in <DrugDBCodeQualifier>.

For the fields (<DrugDBCode> and <DrugDBCodeQualifier> in XML) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier in EDI) or for compound ingredients (<ItemNumber> <CompoundProductIDQualifier> in XML) or (Compound Ingredient Item Number CPD-010-I017-03-7140 and Code List Responsibility Agency CPD-010-I017-04-3055 in EDI):

- SCD - RxNorm Semantic Clinical Drug (SCD)
- SBD - RxNorm Semantic Branded Drug (SBD)
- GPK - RxNorm Generic Package (GPCK)
- BPK - RxNorm Branded Package (BPCK)
Meaningful Use testing cited the following vocabularies/code lists as incorporated into RxNorm. However, they are not within the NCPDP table of values. Some of the lists are not as appropriate for electronic prescribing. The industry does not wish to add more code lists in the exchange of medication information as the movement is to the use of RxNorm as a common terminology for prescribed medications. Therefore the following are not to be used in the testing of a NewRx, per NCPDP recommendations.

- GS – Gold Standard Alchemy
- MMX - Micromedex DRUGDEX
- MSH - Medical Subject Headings (MeSH)
- MTHFDA - FDA National Drug Code Directory
- MTHSPL - FDA Structured Product Labels
- NDFRT - Veterans Health Administration National Drug File - Reference Terminology
- SNOMED CT® - SNOMED Clinical Terms (drug information)
- VANDF - Veterans Health Administration National Drug File

These other vocabularies/code lists were cited for Meaningful Use testing, and are contained within the NCPDP External Code List, but for the same reasons above, are not to be used for testing, per NCPDP recommendations.

- MDDB - Medi-Span Master Drug Data Base (NCPDP value “MD”)
- MMSL - Multum MediSource Lexicon (NCPDP value “MC”)
- NDDF - First DataBank NDDF Plus Source Vocabulary (NCPDP value “FM”)

Note: The value of Blank (Not Specified) in the NCPDP External Code List table for 010-I013-09-1153 Reference Qualifier is not allowed to be exchanged in the tests.
5. CONTROLLED SUBSTANCE PRESCRIPTIONS

In March 2010, the DEA published an Interim Final Rule for electronic prescribing of controlled substances. In the regulation, they published two options for verification:

1. Digitally signing the prescription with the individual practitioner’s private key.
2. Verify that the practitioner signed the prescription by checking the data field that indicates the prescription was signed; or Display the field for the pharmacist’s verification.

The regulations are effective June 1, 2010. SCRIPT 8.1 is currently in use and the industry preparing for 10.6. How does the industry support transmission of prescriptions, with least impact?

NCPDP convened an industry task group of interested people. The task group reviewed the standard and considered multiple suggestions. The task group reached consensus to bring forward recommendations to the larger NCPDP work group body. NCPDP Work Group 11 ePrescribing and Related Transactions discussed, modified, and then approved recommendations during August Work Group meetings for industry support on consistent use to exchange transactions. Upon approval, the information was published in this document.

The NCPDP SCRIPT Standards support option 2. Option 1 is not supported at this time, since the industry has not brought forward recommendations for enhancements to the NCPDP SCRIPT Standard. If Option 1 is desired by the industry, the requested changes will need to be submitted, and upon approval, would be effective in a future version of SCRIPT.

Of interest: The DEA guidance website is http://www.deadiversion.usdoj.gov/ecomm/e_rx/index.html

5.1 INDUSTRY STANDARD METHODOLOGY FOR USING ELECTRONIC CONTROLLED SUBSTANCES IN NCPDP SCRIPT 8.1

The regulations required the functionality of

- Digital Signature Indicator
- Controlled Substance Indicator
- Earliest Fill Date
- Drug Abuse Treatment Indicator
- Medication Indication for GHB (Gamma-Hydroxybutyric acid)

To support using NCPDP SCRIPT -

**Digital Signature Indicator**

Use Drug Coverage Status – DRU-110-7885 (in EDI) or <DrugCoverageStatusCode> (in XML). This element repeats up to five times. A new value has been created:

SI – Signed Prescription – This indicates the prescription has been signed according to the DEA requirements for electronic prescribing of controlled substances.

In future versions of SCRIPT this will be in a separate data element.
**SCRIPT Implementation Recommendations**

**Controlled Substance Indicator**
Use Drug Coverage Status – DRU-110-7885 (in EDI) or <DrugCoverageStatusCode> (in XML) same as above. A new value has been created:

CS – Controlled Substance – This is a controlled substance as defined by the DEA or more restrictive applicable regulation.

DEA Schedule has been added in SCRIPT 10.5 and is to be used for this indicator in the future.

**Earliest Fill Date (For scheduled IIs)**
Use Date/Time Period Qualifier - DRU-040-I006-01-2005 with value 07 Effective Date (Begin)
With the appropriate Date/Time/Period – DRU-040-I006-02-2380 (in EDI) or <EffectiveDate> (in XML)

Note: DRU-040 Date occurs up to 5 times in SCRIPT 8.1 and up to 9 times in SCRIPT 10.6, so multiple occurrences are supported for NewRx requirements.

**Drug Abuse Treatment Identifier (For scheduled IIs)**
Use Free Text – DRU-090 (in EDI) or <Notes> (in XML)

For Schedule II usage
Use text “NADEAN:xxxxxxxxx” (Narcotics Addiction DEA Number)
The qualifier for Data 2000 Waiver ID (Used for prescriptions for opioid addiction treatment medications) was added to the External Code List (ECL) in January 2010 and that can be used when updating to a new ECL.

**Medication Indication for GHB** (Gamma-Hydroxybutyric acid)
Use Free Text – DRU-090 (in EDI) or <Notes> (in XML)
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.

5.2 **Industry Standard Methodology for Using Electronic Controlled Substances in NCPDP SCRIPT 10.6**
The only difference between the usage in SCRIPT 8.1 and SCRIPT 10.6 is the Controlled Substance Indicator is not used in SCRIPT 10.6. The DEA Schedule field is to be used.

5.3 **NCPDP XML**
To support the controlled substance electronic prescribing functionality, the NCPDP SCRIPT 8.1 – 10.6 schemas have been updated to support the new values added above. Note that the new values will have different requirements in future versions of SCRIPT.
5.4 Prescription Schedules

For the context of these questions, “signed” means a digitally signed or the controlled substance fields designated in the SCRIPT Standard (see above sections).

Question: How are pharmacies dealing with the difference between state and federal schedule differences today?

Response: Today, the pharmacy is required to confirm the prescription before filling. Today, the prescription is confirmed manually via phone or fax.

Once electronic controlled substance prescriptions are transmitted between parties,
   If the prescription was to be signed according to DEA requirements and is not signed according to DEA requirements, the pharmacy system must archive the electronic prescription order and reject the prescription. Upon this rejection, the pharmacy may choose to print out the prescription, call the prescriber and obtain the correct information, and then process the prescription manually. The prescription process must follow DEA requirements in regard to electronic failure.

   If the prescriber is not electronically enabled, the pharmacy is required to confirm the prescription before filling. Today, the prescription is confirmed manually via phone or fax. The prescription process must follow DEA requirements in regard to electronic failure.

   Difference between reject and an error – rejection may occur upon receiving the transaction, or as a free standing Error.

Question: What happens if the local/state rating is more stringent than the federal rating or vice versa? Will same process be used for 10.6?

Response: The more stringent rules are to be followed. The prescriber should always have the capability to digitally sign a prescription regardless of the indicated schedule, or when requested by the receiving pharmacy.

The prescription may still require a digital signature or the controlled substance fields (see section “Controlled Substance Prescriptions”) depending on regulations at either the prescriber or the pharmacy.

There are situations where the state is more stringent than the federal (e.g. where the state has designated the medication as CII, while the medication is federally designated as CIII). The pharmacy must use appropriate procedures to legitimize the prescription based on the state regulations.

In SCRIPT 8.1, there is only a flag for controlled substance (Drug Coverage Status DRU-110-7885 (in EDI) or <DrugCoverageStatusCode> (in XML)); it does not designate the schedule.

Question: If the data is not complete on an electronic scheduled prescription, how is this
handled?

**Response:** These are examples, but there may be other options.

- If the transmission is not complete/correct (message is syntactically incorrect)
  1. The best practice would be to send an Error transaction (denoting the rejection).
  2. The pharmacist would not know to manually follow up.
- If the prescriber system is digitally signed enabled, and the prescription for controlled substance is not sent with a digital signature,
  1. The best practice would be to send an Error transaction (denoting the rejection) and
  2. The pharmacist could follow up manually to obtain a valid controlled substance prescription.
- If the prescriber system is not digitally signed enabled, and the prescription is for a controlled substance, and transaction is missing the required EPCS fields\(^2\)
  1. The best practice would be to send an Error transaction (denoting the prescription cannot be filled using Denial Codes for the missing/invalid field(s) and
  2. The pharmacist could follow up manually to obtain a valid controlled substance prescription.
- If the prescriber system is digitally signed enabled, and the prescription for controlled substance is sent with a digital signature, but the pharmacy is not enabled, the transaction would be rejected.
  1. The best practice would be to send an Error transaction from the communication level. It may be a syntax or timeout error.
  2. The pharmacist would not know to manually follow up.

**Question:** When it gets to the processor; if the drug knowledge base provider only provides the federal schedule, is the pharmacy-provided state rating overwritten?

**Response:** The pharmacy does not supply a schedule on the claim. This is out of scope.

### 5.5 Renewal Request for an Electronic Prescription for Controlled Substances (EPCS)

When a prescribing system receives a renewal request, the renewal request may not be used to pre-populate a renewal approval or a new prescription. Rather, the data in a renewal request may only be used by the prescribing system to indicate to a prescriber for which prescription the pharmacy is requesting a renewal. If the prescriber determines that a continuation of drug therapy is warranted, it is recommended the prescriber deny the renewal request and create a new prescription.

\(^2\) Digital Signature Indicator, Controlled Substance Indicator, Earliest Fill Date (for scheduled IIs), Drug Abuse Treatment Identifier (For scheduled IIs), Medication Indication for GHB, (Gamma-Hydroxybutyric acid), DEA Schedule (SCRIPT v10.6)
6. **BRAND MEDICALLY NECESSARY FOR MEDICAID PRESCRIPTIONS**

Brand Medically Necessary and paper prescribing

Current regulations:

**42CFR Section 447.512(c) Certification of Brand Medically Necessary Drugs**

1. The upper limit for payment for multiple source drugs does not apply if a physician certifies in his own writing (or by an electronic alternative means approved by the Secretary) that a specific brand is medically necessary for a particular recipient.

2. The agency must decide what certification form and procedure are used.

3. A checkoff box on a form is not acceptable but a notation like “brand necessary” is allowable.

How will electronic prescribing perform the necessary steps required of Brand Medically Necessary for Medicaid patients?

NCPDP worked with CMS representation to determine functionality that would satisfy the intent of the regulation for electronic prescribing. The process below was approved in August 2010 at NCPDP meetings. CMS will provide updated guidance to the states to support this functionality.

**The necessary steps for all Medicaid programs when applicable for the prescription**

In the NCPDP SCRIPT New Prescription transaction,

If Product/Service Substitution, coded (DRU-050-4457 in EDI syntax) or Substitutions (XML syntax)

Is equal to = 1 (Substitution Not Allowed by Prescriber – This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is Medically Necessary to be Dispensed As Written. DAW 1 is based on prescriber instruction and not product classification)

Then Free Text (DRU-090-4440 in EDI syntax) or Note (in XML syntax)

Must contain "Brand Medically Necessary".

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

1. 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” as a Prescriber Note to the pharmacy. It should be placed at the start of the note with any additional notes appended, by the prescriber hand/system. (It is recommended a space be included to separate the text and any additional notes.)


d. The NCPDP SCRIPT field to be used is
   i. Note field (XML) or 090 4440 Free Text (EDI).

2. A Prescription Origin Code (419-DJ) on the Telecommunication claim indicating the electronic origin (the pharmacy is responsible to add the correct value to the claim and transmit the claim).

3. 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).

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

In SCRIPT version 2010 and above, with the approval of the ReasonForSubstitutionCodeUsed element, the use of the Free Text or Note requirement will be replaced with this requirement in the new field.
7. DISCUSSION OF WRITTEN DATE

In SCRIPT Version 2010121, support for clarification of WrittenDate was added. There are multiple sections that provide clarity. While this is effective with Version 2010121, the guidance is important for all versions.

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

<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.

On a RefillResponse or RxChangeResponse <Approved> or <ApprovedWithChanges>, the <WrittenDate> must indicate the date of approval and must not indicate the <WrittenDate> of the original prescription indicated in the request.

Note, in previous versions of the SCRIPT Standard, the EDI field for <WrittenDate> is DRU-040-I006-02-2380 Date/Time/Period value 85 = Date Issued (Written Date).
8. **OBSERVATION SEGMENT EXAMPLES IN SCRIPT 10.6**

The following columns show examples of the use of the Observation Segment in SCRIPT version 10.6 to 2013071. In SCRIPT 2013101 and above, the Observation Segment was reworked and enhanced.
<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Remarks</th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
<th>Example 4</th>
<th>Commentary based 10.6 SCRIPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>000-5019-01-0013</td>
<td>Segment code</td>
<td>Value: OBS</td>
<td>OBS</td>
<td>OBS</td>
<td>OBS</td>
<td>OOB</td>
<td>OBS</td>
</tr>
<tr>
<td>010-5017-01-6311</td>
<td>Measurement Dimension, coded</td>
<td>Qualifies the Measurement value. These are X12 values only for the original field/values version 1.0</td>
<td>HT</td>
<td>HT</td>
<td>WG</td>
<td>WG</td>
<td>ZZS</td>
</tr>
<tr>
<td>010-5017-02-6314</td>
<td>Measurement Value</td>
<td>Identifies code set of clinical physical findings.</td>
<td>60</td>
<td>152</td>
<td>145</td>
<td>65</td>
<td>771</td>
</tr>
<tr>
<td>010-5017-06-7887</td>
<td>Measurement Data Qualifier</td>
<td>Qualifies the Measurement Value (010-02-6314). Uses the Measurement Unit Code list values - easily found from the following website: <a href="http://evs.nci.nih.gov/ftp1/NCPDP/About.html">http://evs.nci.nih.gov/ftp1/NCPDP/About.html</a></td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>010-5017-07-7991</td>
<td>Source Code List</td>
<td>Code identifying the source organization.</td>
<td>AD</td>
<td>AD</td>
<td>AD</td>
<td>AD</td>
<td>AD</td>
</tr>
<tr>
<td>020-4440</td>
<td>Free Text</td>
<td>An..70 – two loops allowed</td>
<td>An..70 two loops allowed so 140 characters.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9. IMPLEMENTATION OF STRUCTURED AND CODIFIED SIG

9.1 BACKGROUND

The NCPDP Structured and Codified Sig Format standardizes the portion of an electronic prescription containing the directions for use. This is intended to facilitate communication between prescribers and pharmacists through use of accepted electronic transmission standards, such as NCPDP SCRIPT, to improve the efficiency of the prescribing and dispensing activities and to help reduce the opportunity for errors.

The intent of the Structured and Codified Sig Format is not to facilitate the reconstruction of the Sig to human readable form (English), but rather to communicate through electronic means the Sig components in a controlled, well-defined structure.

This section contains information to assist implementers in their efforts to adopt and broadly use the Structured and Codified Sig Format. It provides practical guidance related to the applicability of the segment to common prescriptions, and the use of SNOMED CT® (Systemized Nomenclature of Medicine Clinical Terms) within it to convey timing, indications and other clinical concepts in a standard way. In the future, guidance will be provided that addresses the use of the Structured and Codified Sig Format with more complex Sig strings, including those with rates of administration or dose calculations.

The WG11 Implementation of Structured and Codified Sig Task Group found that a majority of prescriptions filled in retail and mail order pharmacies contain a relatively small number of Sig strings. The task group chose to focus its efforts on these Sig strings and created examples for these (in XML) to assist implementers. In addition, the task group reviewed work related to the Universal Medication Schedule.

9.1.1 RETAIL AND MAIL ORDER SIGS

Task group participants from retail and mail order pharmacies provided de-identified Sig data for analysis. Upon review, it was found that 24 Sig strings represented approximately 50% of the prescription volume processed by the pharmacies. This list was used as basis for generating example SCRIPT Version 10.6 XML message excerpts containing the structured Sig composite and applicable SNOMED CT® Concept IDs and FMT Codes. The task group added route of administration to the strings, as route will be mandatory in future versions of the Structured and Codified Sig Format.

Below are the 24 Sig strings:

<table>
<thead>
<tr>
<th>Original String</th>
<th>String with Elements Added for a More Complete Sig</th>
<th>Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take 1 tablet daily</td>
<td>Take 1 tablet by mouth 1 time per day</td>
<td>While “daily” and “per day” are synonymous.</td>
</tr>
<tr>
<td>Original String</td>
<td>String with Elements Added for a More Complete Sig</td>
<td>Clarification</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1 Take 1 tablet twice a day</td>
<td>Take 1 tablet by mouth twice a day</td>
<td>since this is expressing a frequency, “day” is more precise</td>
</tr>
<tr>
<td>2 Take 1 tablet at bedtime</td>
<td>Take 1 tablet by mouth at bedtime</td>
<td></td>
</tr>
<tr>
<td>3 Take 1 tablet 3 times a day</td>
<td>Take 1 tablet by mouth 3 times a day</td>
<td></td>
</tr>
<tr>
<td>4 Take as directed</td>
<td>Take as per medical encounter instructions</td>
<td>While the original sig is commonly used, it is not specific enough because the dose and route are not included. This is modified assuming the instructions were given per the encounter with the patient.</td>
</tr>
<tr>
<td>5 Take 1 tablet every morning</td>
<td>Take 1 tablet by mouth every morning</td>
<td></td>
</tr>
<tr>
<td>6 Take 1 tablet every evening</td>
<td>Take 1 tablet by mouth every evening</td>
<td></td>
</tr>
<tr>
<td>7 Take 1 tablet every 6 hours as needed for pain</td>
<td>Take 1 tablet by mouth every 6 hours as needed for pain</td>
<td></td>
</tr>
<tr>
<td>8 Take 2 tablets as one dose on the first day then take one tablet daily thereafter</td>
<td>Take 2 tablets by mouth as one dose on the first day then take one tablet per day thereafter</td>
<td></td>
</tr>
<tr>
<td>9 Take 2 tablets every 5 days</td>
<td>Take 2 tablets by mouth every 5 days</td>
<td></td>
</tr>
<tr>
<td>10 Take 2 tablets daily</td>
<td>Take 2 tablets by mouth daily</td>
<td></td>
</tr>
<tr>
<td>11 Take 1 tablet 4 times a day</td>
<td>Take 1 tablet by mouth 4 times a day</td>
<td></td>
</tr>
<tr>
<td>12 Take 1 tablet every 6 hours as needed</td>
<td>Take 1 tablet by mouth every 6 hours as needed for cough</td>
<td>Indication added to provide more completeness, and to assist implementers in using SNOMED CT®.</td>
</tr>
<tr>
<td>13 Take 2 tablets twice daily</td>
<td>Take 2 tablets by mouth twice daily</td>
<td></td>
</tr>
<tr>
<td>14 Take 1 tablet every 4 to 6 hours as needed for pain</td>
<td>Take 1 tablet by mouth every 4 to 6 hours as needed for pain</td>
<td></td>
</tr>
<tr>
<td>15 Take 1 tablet twice a day for 10 days</td>
<td>Take 1 tablet by mouth twice a day for 10 days</td>
<td></td>
</tr>
<tr>
<td>16 Take 1 to 2 tablets every 4 to 6 hours as needed for pain</td>
<td>Take 1 to 2 tablets by mouth every 4 to 6 hours as needed for pain</td>
<td></td>
</tr>
<tr>
<td>17 Take 1 tablet 3 times a day as needed</td>
<td>Take 1 tablet by mouth 3 times a day as needed for headache</td>
<td>Indication added to provide more completeness, and to assist implementers in using SNOMED CT®.</td>
</tr>
<tr>
<td>18 Take 1 tablet every 12 hours</td>
<td>Take 1 tablet by mouth every 12 hours</td>
<td></td>
</tr>
<tr>
<td>19 Take 1 tablet twice a day as needed</td>
<td>Take 1 tablet by mouth twice a day as needed for nausea</td>
<td>Indication added to provide more completeness, and to assist implementers in using SNOMED CT®.</td>
</tr>
<tr>
<td>20 Take 1 tablet daily as directed</td>
<td>Take 1 tablet by mouth per day as per medical encounter instructions</td>
<td>Clarifying assumption that directions were provided during medical/clinical encounter.</td>
</tr>
</tbody>
</table>
Because typical prescription directions are straightforward—containing dose quantities and simple timing—they can be represented using a small subset of structured Sig elements. The Structured and Codified Sig Format that is part of the SCRIPT Version 10.6 contains over 90 unique elements that can be combined to convey complex dosing schedules and administration instructions. But the common Sigs reviewed by the task group could be represented using 20-30 of those information elements. The example Sig strings that included multiple administration periods (for example, an initial loading dose followed by a different maintenance dose) used the same small subset of data elements, but repeated for each dosing period.

9.1.2 **UNIVERSAL MEDICATION SCHEDULE (UMS)**

The Universal Medication Schedule (UMS) is a methodology that simplifies medication administration instructions for the patient and/or their caregiver. The goal of UMS is to increase patient understanding and adherence of their medication instructions, thus resulting in improved health outcomes. Administration instructions using UMS are standardized to provide explicit timing with standard intervals (morning, noon, evening, bedtime). The consistent and widespread use of UMS and Sig will assist patients in understanding and adhering to their medication regimen. As an example, instructions that indicate “take one pill in the morning and take one pill in the evening” are clearer than “take twice a day” and are easily supported by the Structured and Codified Sig Format. More information on UMS can be found at [http://www.ncpdp.org/Education/Whitepaper](http://www.ncpdp.org/Education/Whitepaper).

9.2 **BENEFITS**

Adoption of the Structured and Codified Sig minimizes ambiguity and assists in the standardization of sigs. Standardization minimizes permutations, facilitates accuracy, promotes patient safety and improves efficiency. Standardized, structured data reduces the potential for transcription errors, and enables automated monitoring of quality metrics.

When prescription directions are transmitted using a structured data format and standard terminologies, their meaning is preserved in a system-processable form. Because the clinical components such as route of administration and administration timing are represented as standardized
terms, every receiving system interprets the information in the same way. And each receiver can map the sig components to its internal data structures to support clinical alerts, dispensing automation or other processing. The Sig is part of any prescription transfer, is reviewed during medication reconciliation and may be included when exchanging medication histories.

Reducing the manual processes currently used to support renewal requests and medication reconciliation will improve efficiency and user satisfaction with their system. The need for system interoperability is increasing, and having the Sig available in a structured and codified form will support many services provided by pharmacists, such as medication therapy management and immunization administration.

9.3 **BEST PRACTICES**

The task group discussed a number of practical issues related to the implementation of the Structured and Codified Sig. Task Group participants considered likely workflow issues and changes to the format that are already reflected in future versions of SCRIPT. The following are recommendations to be considered when implementing Structured and Codified Sig:

- The complete sig must be displayed to prescriber before the prescription can be sent.
- The text sig must not conflict with other discrete elements in the prescription (for example the text sig should not say “by mouth” when the route of administration text says “topical”).
- Route of Administration should always be sent. This is mandatory in future versions.
- Adhere to the principles of the Universal Medication Schedule.
- Sigs that only indicate “As directed” or “As needed” are considered incomplete and may not be allowed in certain states.
- Recognize trading partners may be at different stages of implementation of the structured sig, such as the difference between accepting the structured sig fields in the transactions and actually utilizing these fields as an aid to understanding and creating the sig for the patient.

9.4 **FMT USE FOR SCRIPT IMPLEMENTATION**

The Federal Medication (FedMed) collaboration is developing shared FedMed Terminology (FMT) and standards to improve the exchange and public availability of medication information. FedMed is a joint effort of these Federal partner agencies:

- Food and Drug Administration (FDA)
- National Library of Medicine (NLM)
- Veterans Health Administration (VHA)
FedMed resources and standards encompass medication and ingredient names, codes, routes of administration, dosage forms, units of presentation, mechanisms of action, physiologic effects, and structure. Key components of the FedMed initiative are:

- FDA’s Unique Ingredient Identifier (UNII) codes for drug ingredients (see FDA Terminology Web page) and National Drug Codes (NDC) for prescription medications.
- NLM’s RxNorm, for clinical drug names, and DailyMed, for viewing and downloading SPL-encoded drug labels.
- NCI Thesaurus (NCIt) for a range of supporting terminology sets and investigational agents. The FedMed-related SPL subsets of NCIt are described and accessible on the FDA Terminology Web page.

The National Cancer Institute (NCI) has created a subset of FMT dose forms (NCIt Codes) for use in the NCPDP SCRIPT <DoseFormCode> element; this subset is named the Drug StrengthForm Terminology. This is the only field within the Structured and Codified Sig Format where FMT is applicable:

<table>
<thead>
<tr>
<th>Structured and Codified Sig Format - Field Name</th>
<th>FMT Term from NCI for Dose Form Code Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose Form Code (with Dose Form Text)</td>
<td>Previously referenced as Unit of Presentation</td>
</tr>
<tr>
<td></td>
<td>Refer to NCPDP DoseUnitOfMeasure Terminology</td>
</tr>
</tbody>
</table>

### 9.5 DoseForm and DoseUnitOfMeasure

In the NCPDP SCRIPT Standard with versions prior to v2015071, the field <DoseForm> in the Sig Segment is represented by an NCI subset of “NCPDP Drug StrengthForm Terminology”. Upon further review, it has been determined that this subset is not appropriate as it does not include all applicable dose forms or needed quantities (i.e. “non-dosage form” units of measure) such as puff, drop, spray. A new subset has been created “NCPDP DoseUnitOfMeasure Terminology” and should be used by all implementers beginning with SCRIPT v10.6. In addition, beginning
with SCRIPT v2015071, <DoseForm> has been renamed <DoseUnitOfMeasure> and will continue to point to the NCI subset “NCPDP DoseUnitOfMeasure Terminology”.

9.6 **SNOMED® CT Use for SCRIPT Implementation**

The Structured and Codified Sig Format uses SNOMED CT® (Systemized Nomenclature of Medicine Clinical Terms), a clinical healthcare terminology that was selected for its comprehensive content and accepted use.

SNOMED CT® is a multi-lingual terminology used internationally and managed by the International Health Terminology Standards Development Organization (IHTSDO), with US-specific extensions maintained by the National Library of Medicine. Revisions are released twice per year (usually in January and July).

SNOMED CT® Concept IDs are used in all SCRIPT transactions that include the structured Sig content (i.e. NewRx, Refill Request, Refill Response).

9.6.1 **SNOMED CT® Resources**

**SNOMED CT® Documentation**

IHTSDO, the organization that manages the SNOMED CT® terminology, provides useful documentation on its website. The SNOMED CT® E-Learning Center and SNOMED CT® Document Library offer a number of resources, from high-level overviews of the terminology to detailed implementation guidance.


The SNOMED CT® Starter Guide (which can be found in the Document Library noted above) is a helpful introduction to SNOMED CT® that includes basics of the terminology, describes the concept hierarchy, and contains other helpful information.

**SNOMED CT Browsers**

The IHTSDO site also lists a number of tools that enable a user to search for SNOMED CT® concepts and browse through the concept hierarchy.
IHTSDO offers its own online browser ([http://browser.ihtsdotools.org](http://browser.ihtsdotools.org)), which presents the international version of SNOMED CT®.

Another is an online browser offered by the National Library of Medicine—the US member of IHTSDO that distributes SNOMED CT® for use in this country and maintains the SNOMED CT® extension that supports US-specific concepts. This browser, which contains both the international release and the US extension, is located at [https://uts.nlm.nih.gov/snomedctBrowser.html](https://uts.nlm.nih.gov/snomedctBrowser.html). In order to use it, one must first sign up online for an account [https://uts.nlm.nih.gov/license.html](https://uts.nlm.nih.gov/license.html).

A downloadable browser used by many, even though it is no longer officially supported by its developer, is CliniClue Xplore ([http://www.cliniclue.com](http://www.cliniclue.com)). This tool is easy to use, but it does not directly support browsing of the US SNOMED CT® extension (though it can be manually brought into the tool).

HealthTerm ([http://www.healthterm.com/](http://www.healthterm.com/)) is a mobile browser available for iPhone and Android devices. It enables searching of SNOMED CT® as well as other health terminologies.

### 9.6.2 Conventions for Use of SNOMED CT® Terms and Identifiers

Each piece of clinical information is captured by a SNOMED CT® Concept Identifier. This identifier conveys the essence of the information independent of how it may be defined in different locales or languages. The NCPDP Structured Sig composite uses SNOMED CT® Concept IDs as the primary means for conveying timing, indications, and other administration aspects. In the SCRIPT Implementation Guide where it refers to SNOMED CT® Code this is synonymous with SNOMED CT® Concept ID.

In addition, SNOMED CT® provides multiple text descriptions for each SNOMED CT® Concept ID. The Fully Specified Name is a complete—though sometimes ungainly—reflection of the concept’s meaning. Additional Synonyms are provided, with one noted as the Preferred Term. In the NCPDP Structured Sig composite, this textual description accompanies each SNOMED CT® Concept ID.

Industry use and other standards do not force the SNOMED CT® preferred term to be sent as the text description accompanying the SNOMED CT® Concept ID. Organizations may have their own preference on whether to send the preferred term, a SNOMED CT®-identified synonym, or a local description. Users should not expect that the receiving system will display the exact text that was sent; the receiving system may instead choose to display the SNOMED CT® preferred term related to the Concept ID or a synonym appropriate for its locale and user base (e.g. “oral route”, “orally”, “by mouth”, etc.).
The important thing to remember is that the receiving system will use the SNOMED CT® Concept ID as the “source of truth” for information being sent, and may or may not make use of the textual description. Receiving systems should retain a record of what was sent to support auditing and troubleshooting needs.

9.7 Locating SNOMED CT® Concepts for Use in Structured Sig

SNOMED CT® concepts are organized into hierarchies. At the top of the hierarchy is the base "SNOMED CT® Concept" which is the super type (parent) of the top-level concepts (including clinical finding, procedure, body structure, qualifier value, etc.) and all the concepts beneath them (their subtypes). As the hierarchies are descended, the concepts within them become increasingly specific.

For example, many of the concepts that are contained in medication directions are located in SNOMED CT®’s Qualifier Value hierarchy which contains concepts such as

- Route of administration value i.e. oral route
- Dosing instruction imperative i.e. take, chew
- Administration timing i.e. morning, evening
- Dosing intervals and frequencies i.e. day, week, daily, weekly.

9.7.1 Relevant SNOMED CT® Hierarchies for Common Retail and Mail Pharmacy Sigs

This section describes the branches of the SNOMED CT® hierarchy that hold concepts related to Sig elements used in the common direction strings reviewed by the task group.

Because this guidance focuses specifically on the 24 example Sig strings it does not cover all concepts that a full structured Sig implementation will require. Use the referenced resources in this section to locate other concepts to represent information in directions not covered here.

Always rely on IHTSDO-provided materials as the source for guidance on implementing SNOMED CT®. This chapter provides a starting set of recommendations; more industry experience will likely result in adjustments to this guidance over time.

Each Structured and Codified Sig Format element below (shaded) is followed by an illustration of the SNOMED CT® hierarchy “branch” that holds related concepts.
SCRIPT StructuredSig Element: <DoseDeliveryMethodCode>

Example: “Take” SNOMED CT® Concept ID = 419652001

Hierarchy:Qualifier value/dosing instruction fragment/dosing instruction imperative

Related values:
- “Apply” = 417924000
- “Chew” = 419747000
- “Inhale” = 421134003
- “Inject” = 422145002
- “Swish” = 421805007
SCRIPT StructuredSig Element: <RouteofAdministrationCode>

Example: “Oral Route” (by mouth, orally) SNOMED CT® Concept ID = 26643006

Hierarchy: Qualifier value/route of administration value

Related values:
- “Topical” = 6064005
- “Nasal” = 46713006
SCRIPT Implementation Recommendations

SCRIPT StructuredSig Element: <AdministrationTimingCode>
Example: “Bedtime” = 21029003

Hierarchy: Qualifier value/timeframe
Qualifier value/descriptor/time patterns/temporal periods/temporal periods of day

Related values:
- “Morning” = 73775008
- “Evening” = 3157002
SCRIPT StructuredSig Elements: `<FrequencyUnitsCode>`, `<IntervalUnitsCode>`, `<DurationTextCode>`

Example: “Day” SNOMED CT Concept ID® = 258703001

Hierarchy: Qualifier value/unit/unit of time/non-SI unit of time

Related values:
- “Hour” = 258702006
- “Week” = 258705008
- “Month” = 258706009
SCRIPT StructuredSig Element: <IndicationPrecursorCode>
Example: “as needed for” SNOMED CT® Concept ID = 420449005

Hierarchy: Qualifier value/descriptor/time patterns/frequencies/irregular frequency

SCRIPT StructuredSig Element: <IndicationTextCode>
Example: “pain” SNOMED CT® Concept ID = 22253000

Hierarchy: Clinical finding/neurological finding/sensory nervous system finding/pain/sensation finding

Below is a summary of the SNOMED CT® concepts used in the common direction strings reviewed by the task group:

<table>
<thead>
<tr>
<th>Code</th>
<th>SNOMED CT® Concept Hierarchy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Code Implementation Recommendations

<table>
<thead>
<tr>
<th>Code Code</th>
<th>SNOMED CT® Concept Hierarchy</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;DoseDeliveryMethodCode&gt;</td>
<td>• SNOMED CT® Concept</td>
</tr>
<tr>
<td></td>
<td>o qualifier value</td>
</tr>
<tr>
<td></td>
<td>o dosing instruction fragment</td>
</tr>
<tr>
<td></td>
<td>o dosing instruction imperative</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>• SNOMED CT® Concept</td>
</tr>
<tr>
<td></td>
<td>o qualifier value</td>
</tr>
<tr>
<td></td>
<td>o route of administration value</td>
</tr>
<tr>
<td>&lt;AdministrationTimingCode&gt;</td>
<td>• SNOMED CT® Concept</td>
</tr>
<tr>
<td></td>
<td>o qualifier value</td>
</tr>
<tr>
<td></td>
<td>o time frame</td>
</tr>
<tr>
<td></td>
<td>o time patterns</td>
</tr>
<tr>
<td></td>
<td>o temporal periods</td>
</tr>
<tr>
<td></td>
<td>o temporal periods of day</td>
</tr>
<tr>
<td>&lt;FrequencyUnitsCode&gt;</td>
<td>• SNOMED CT® Concept</td>
</tr>
<tr>
<td></td>
<td>o qualifier value</td>
</tr>
<tr>
<td></td>
<td>o descriptor</td>
</tr>
<tr>
<td></td>
<td>o time patterns</td>
</tr>
<tr>
<td></td>
<td>o frequencies</td>
</tr>
<tr>
<td>&lt;DurationTextCode&gt;</td>
<td>• SNOMED CT® Concept</td>
</tr>
<tr>
<td></td>
<td>o qualifier value</td>
</tr>
<tr>
<td></td>
<td>o Unit</td>
</tr>
<tr>
<td></td>
<td>o unit of time</td>
</tr>
<tr>
<td>&lt;IndicationPrecursorCode&gt;</td>
<td>• SNOMED CT® Concept</td>
</tr>
<tr>
<td></td>
<td>o qualifier value</td>
</tr>
<tr>
<td></td>
<td>o descriptor</td>
</tr>
<tr>
<td></td>
<td>o time patterns</td>
</tr>
<tr>
<td></td>
<td>o frequencies</td>
</tr>
<tr>
<td>&lt;IndicationTextCode&gt;</td>
<td>• SNOMED CT® Concept</td>
</tr>
<tr>
<td></td>
<td>o clinical finding</td>
</tr>
<tr>
<td>&lt;Interval&gt;</td>
<td>• SNOMED CT® Concept</td>
</tr>
<tr>
<td></td>
<td>o qualifier value</td>
</tr>
<tr>
<td></td>
<td>o descriptor</td>
</tr>
<tr>
<td></td>
<td>o time patterns</td>
</tr>
<tr>
<td></td>
<td>o frequencies</td>
</tr>
</tbody>
</table>
9.8 **RECOMMENDATIONS FROM SCRIPT VERSION 2013+ FOR THE IMPLEMENTER OF SCRIPT VERSION 10.6 TO BE AWARE**

Listed below is a summary of the changes supported in SCRIPT 2013+. There are several fields that were added in SCRIPT 2013 which cannot be implemented in lower versions of SCRIPT (including SCRIPT Version 10.6).

- **Within “Route”:**
  - Required the use of the Route element, except in cases where the patient is instructed to follow either the manufacturer package labeling or directions provided as part of a clinical encounter.

- **Within “Dose”:**
  - Added the ability to indicate that the patient is to follow either manufacturer package labeling or information provided as part of a clinical encounter.
    - Until SCRIPT Version 2013+ is implemented, NCPDP has identified SNOMED CT® Concept IDs that allow for this information to be communicated. See section “Where do I send the SNOMED CT® Concept ID for “Per Manufacturer Package Instructions” or “Per Instructions Provided in Medical Encounter”?”
  - Added the ability to indicate that the dose amount is not quantifiable in metric units, i.e. “a pea-sized amount”.
    - Until SCRIPT Version 2013+ is implemented, the Structured Sig is not used and the sig is sent as free text.

- **Within “Timing”:**
  - Clarified the use of the Timing element.
  - Added the ability to indicate that the duration may not be quantifiable, i.e. “until gone”.
    - Until SCRIPT Version 2013+ is implemented, the Structured Sig is not used and the sig is sent as free text.
  - Added the ability to include more specificity including events and timing modifiers.

- Within each appropriate segment grouping, a clarifying free text element was added to support the inclusion of information that cannot be codified.

There are also changes to optionality that implementers may want to consider when implementing SCRIPT Version 10.6.

- It is recommended that the most recent version of the Code System be used; if not, trading partner agreement is required to specify which version is used.
- It is recommended that both SNOMED CT® Version (<SNOMEDVersion>) and FMT Version (<FMTVersion>) be treated as mandatory elements.
In the newer version of the Structured and Codified Sig Imp Guide (which impacts SCRIPT 2013+) there were lessons learned from the pilot and therefore clarifications made that hopefully help show the intent of the free text fields.

The revisions included changes to the use of text to better reflect the requirements of the users. Also considered were structural support, as the format moved from EDI to XML, and requirements of state boards of pharmacy.

**Note:** Sig Free Text String Indicator is now called Sig Text Indicator and Sig Free Text is now called Sig Text. The allowable and updated values that are available for Sig Text Indicator are:

Value 2. Generated from structured Sig. The Sig Text is used and is a textual representation of structured Sig values and will not necessarily be grammatically correct nor pharmacist/patient friendly. **It is strongly recommended the generated Sig Text conform to the Sig grammar recommendations by NCPDP for consistency.** The generation may include clarifying free text fields.

Value 3. Pure free text. If a structured Sig cannot be generated, then the complete free text instructions are to be conveyed in the Sig Text field. When Sig Text String Indicator = 3 only the Sig Text is populated; no other Sig elements are populated.

In newer versions of the Structured and Codified Sig Imp Guide (which impacts SCRIPT 2013+) the Sig Text String Indicator value 1 (Capture what the MD ordered) was removed. It was determined that this value was no longer needed and the ambiguity associated with it has been resolved through other changes in the format.

Version 2.0 adds clarifying free text elements to allow for greater specificity and to support situations that may not be codifiable.

**9.8.1 <INDICATIONVALUEUNITOFMEASURECODE>**

In SCRIPT Version 10.6, <INDICATIONVALUEUNITOFMEASURECODE> is mandatory. Since then, the Structured and Codified Sig Format Implementation Guide Version 1.2 and SCRIPT Version 2011091 were modified as follows:

Indication Value Unit Of Measure Code was changed from “Required when segment is used” to “Required when segment is used and when Units are applicable to the Indication” as there are situations when the code is not applicable.

For use in SCRIPT Version 10.6 until SCRIPT Version 2011091, when you cannot quantify the unit of measure (e.g. pain, nausea, insomnia, depression, dizziness), the recommendation is to always use “present” for the Indication Value Unit of Measure Text.

An example default for pain where item 1-6 specify “as needed for pain” and 7-9 provide for a non-measurable unit of measure:
1. Indication Precursor Text = as needed for
2. Indication Precursor Code Qualifier = 1
3. Indication Precursor Code = 420449005 (as needed for)
4. Indication Text = pain
5. Indication Text Code Qualifier = 1
6. Indication Text Code = 22253000 (pain)
7. Indication Value Unit Of Measure Text = present
8. Indication Value Unit of Measure Code Qualifier = 1
9. Indication Value Unit of Measure Code = 52101004 (present)

If the unit of measure is non-quantifiable always use “present” (in SCRIPT Version 10.6 until SCRIPT Version 2011091).

An example for a measurable unit of measure:

1. Indication Precursor Text = as needed for
2. Indication Precursor Code Qualifier = 1
3. Indication Precursor Code = 420449005 (as needed for)
4. Indication Text = fever
5. Indication Text Code Qualifier = 1
6. Indication Text Code = 386661006 (fever)
7. Indication Value Unit Of Measure Text = 101.5
8. Indication Value Unit of Measure Code Qualifier = 1
9. Indication Value Unit of Measure Code = 258712004 (Degrees fahrenheit)
9.9 **STRUCTURED SIG EXAMPLES**

Listed below are XML examples of some of the most commonly used sigs in community pharmacy settings. These examples, such as take one tablet daily, or take one tablet every morning before breakfast, appear to comprise between 40%-60% of the prescriptions routinely processed by retail and mail order pharmacies.

In the examples,

1. `<Qualifier>` value is SNOMED® or FMTDOSEFORM.
2. Only the elements necessary to relay the structured Sig are shown. Conditional elements are not shown when not applicable to the Sig.
3. The text at the top of each example may not exactly match the SigFreeTextString, as that field is a concatenation of the elements in the structure.
4. It is recommended that the most recent version of the Code System be used; if not, trading partner agreement is required to specify which version is used.
5. 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 CT® Concept ID or FMT Term from NCI for dose form. However, the recommendation is that both `<SNOMEDVersion>` and `<FMTVersion>` are mandatory elements. Each system that supports structured Sig will need to support the SNOMED CT® Concept ID and FMT Term from NCI for dose form for Sigs they will send or receive. Therefore, the system should have the ability to populate a default version they support.
6. **Important:** In the examples, there are situations where the `<SigFreeText>` string is not an exact match to the discrete data elements (such as oral route versus by mouth, daily versus per day, morning versus every morning).
   
a. Industry use and other standards do not force the SNOMED CT® preferred term to be sent as the text description accompanying the SNOMED CT® Concept ID. Organizations may have their own preference on whether to send the preferred term, a SNOMED CT® -identified synonym, or a local description. Users should not expect that the receiving system will display the exact text that was sent; the receiving system may instead choose to display the SNOMED CT® preferred term related to the concept ID or a synonym appropriate for its locale and user base (e.g. “oral route”, “orally”, “by mouth”, etc.).
   
b. The important thing to remember is that the receiving system will use the SNOMED CT® Concept ID as the “source of truth” for information being sent, and may or may not make use of the textual description. Receiving systems should retain a record of what was sent to support auditing and troubleshooting needs.

9.9.1 **TAKE 1 TABLET BY MOUTH DAILY**

```xml
<StructuredSig>
    ...
</StructuredSig>
```
**SCRIPT Implementation Recommendations**

<RepeatingSIG>
  <SigSequencePositionNumber>0</SigSequencePositionNumber>
</RepeatingSIG>

<CodeSystem>
  <SNOMEDVersion>20160301</SNOMEDVersion>
  <FMTVersion>16.03d</FMTVersion>
</CodeSystem>

<FreeText>
  <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
  <SigFreeText>Take 1 tablet oral route 1 day</SigFreeText>
</FreeText>

<Dose>
  <DoseCompositeIndicator>1</DoseCompositeIndicator>
  <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
  <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
  <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
  <DoseQuantity>1</DoseQuantity>
  <DoseFormText>Tablet</DoseFormText>
  <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
  <DoseFormCode>C4854</DoseFormCode>
</Dose>

<RouteofAdministration>
  <RouteofAdministrationText>oral route</RouteofAdministrationText>
  <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
  <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>

<Timing>
  <FrequencyNumericValue>1</FrequencyNumericValue>
  <FrequencyUnitsText>Day</FrequencyUnitsText>
  <FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
  <FrequencyUnitsCode>258703001</FrequencyUnitsCode>
</Timing>

</StructuredSIG>

**Notes:**

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time daily (one administration per day). See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
</tr>
</tbody>
</table>

---

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February 2019
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Page: 91
9.9.2 **TAKE 1 TABLET BY MOUTH TWICE A DAY**

```xml
<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take 1 tablet oral route 2 day</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
    <DoseQuantity>1</DoseQuantity>
    <DoseFormText>Tablet</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C48542</DoseFormCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>oral route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
  </RouteofAdministration>
  <Timing>
    <FrequencyNumericValue>2</FrequencyNumericValue>
    <FrequencyUnitsText>day</FrequencyUnitsText>
    <FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
    <FrequencyUnitsCode>258703001</FrequencyUnitsCode>
  </Timing>
</StructuredSIG>
```

Notes:
9.9.3 **TAKE 1 TABLET BY MOUTH AT BEDTIME**

```xml
<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take 1 tablet oral route bedtime 1 day</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
    <DoseQuantity>1</DoseQuantity>
    <DoseFormText>Tablet</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C48542</DoseFormCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>oral route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
  </RouteofAdministration>
  <Timing>
    <AdministrationTimingText>Bedtime</AdministrationTimingText>
    <AdministrationTimingCodeQualifier>1</AdministrationTimingCodeQualifier>
    <AdministrationTimingCode>21029003</AdministrationTimingCode>
    <FrequencyNumericValue>1</FrequencyNumericValue>
    <FrequencyUnitsText>Day</FrequencyUnitsText>
  </Timing>
</StructuredSIG>
```
Notes:

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time daily at bedtime (one administration per day). See FAQ “How do you express similar but distinct concepts?”</td>
</tr>
</tbody>
</table>

9.9.4 **TAKE 1 TABLET BY MOUTH 3 TIMES A DAY**
9.9.5 **TAKE AS DIRECTED – PER MEDICAL ENCOUNTER INSTRUCTIONS**

```xml
<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take oral route provider medication administration instructions</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>oral route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
  </RouteofAdministration>
  <Timing>
    <AdministrationTimingText>Provider medication administration instructions</AdministrationTimingText>
    <AdministrationTimingCodeQualifier>1</AdministrationTimingCodeQualifier>
    <AdministrationTimingCode>422037009</AdministrationTimingCode>
  </Timing>
</StructuredSIG>
```

---

**Notes:**

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 3 times daily (three administrations per day). See FAQ “How do you express similar but distinct concepts?”</td>
</tr>
</tbody>
</table>
Notes:

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying take as directed – SNOMED CT® Concept ID – 422037009 - Provider medication administration instructions.</td>
</tr>
</tbody>
</table>

9.9.6 **TAKE 1 TABLET BY MOUTH EVERY MORNING**

```xml
<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <SNOMEDVersion>20160301</SNOMEDVersion>
  <FMTVersion>16.03d</FMTVersion>
  <CodeSystem>
    <FreeText>
      <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
      <SigFreeText>Take 1 tablet oral route morning 1 day</SigFreeText>
    </FreeText>
    <Dose>
      <DoseCompositeIndicator>1</DoseCompositeIndicator>
      <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
      <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
      <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
      <DoseQuantity>1</DoseQuantity>
      <DoseFormText>Tablet</DoseFormText>
      <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
      <DoseFormCode>C48542</DoseFormCode>
    </Dose>
    <RouteofAdministration>
      <RouteofAdministrationText>oral route</RouteofAdministrationText>
    </RouteofAdministration>
    <Timing>
      <AdministrationTimingText>Morning</AdministrationTimingText>
    </Timing>
  </CodeSystem>
</StructuredSIG>
```
<AdministrationTimingCode>73775008</AdministrationTimingCode>
<FrequencyNumericValue>1</FrequencyNumericValue>
<FrequencyUnitsText>Day</FrequencyUnitsText>
<FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
<FrequencyUnitsCode>258703001</FrequencyUnitsCode>
</Timing>
</StructuredSIG>

Notes:

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time daily every morning (one administration per day). See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
</tr>
</tbody>
</table>

9.9.7 **TAKE 1 TABLET BY MOUTH EVERY EVENING**

<StructuredSIG>

<Timing>
</StructuredSIG>

Dose

<CompositeIndicator>1</CompositeIndicator>
<DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
<DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
<DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
<DoseQuantity>1</DoseQuantity>
<DoseFormText>Tablet</DoseFormText>
<DoseFormCodeQualifier>2</DoseFormCodeQualifier>
<DoseFormCode>C48542</DoseFormCode>
</Dose>

RouteofAdministration

<Text>oral route</Text>
Notes:

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time daily every evening (one</td>
</tr>
<tr>
<td></td>
<td></td>
<td>administration per day). See FAQ &quot;How do you express similar but</td>
</tr>
<tr>
<td></td>
<td></td>
<td>distinct concepts?&quot;</td>
</tr>
</tbody>
</table>

9.9.8 **TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN**
<DoseFormText>Tablet</DoseFormText><DoseFormCodeQualifier>2</DoseFormCodeQualifier><DoseFormCode>C48542</DoseFormCode>
</Dose>

<RouteofAdministration>
<RouteofAdministrationText>oral route</RouteofAdministrationText>
<RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier><RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>

<Timing>
<IntervalNumericValue>6</IntervalNumericValue>
<IntervalUnitsText>hour</IntervalUnitsText>
<IntervalUnitsCodeQualifier>1</IntervalUnitsCodeQualifier><IntervalUnitsCode>258702006</IntervalUnitsCode>
</Timing>

<Indication>
<IndicationPrecursorText>as needed for</IndicationPrecursorText>
<IndicationPrecursorCodeQualifier>1</IndicationPrecursorCodeQualifier><IndicationPrecursorCode>420449005</IndicationPrecursorCode>
<IndicationText>pain</IndicationText>
<IndicationTextCodeQualifier>1</IndicationTextCodeQualifier><IndicationTextCode>22253000</IndicationTextCode>
<IndicationValueUnitofMeasureCode>52101004</IndicationValueUnitofMeasureCode>
</Indication>

<StructuredSIG>

Notes:

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>26643006</td>
<td>Elements contain data relaying a 6 hour interval</td>
</tr>
<tr>
<td>&lt;Indication&gt; elements</td>
<td></td>
<td>Elements contain data relaying as needed for pain (see section &quot;&lt;IndicationValueUnitOfMeasureCode&gt;&quot;).</td>
</tr>
</tbody>
</table>

9.9.9 **TAKE 2 TABLETS BY MOUTH AS ONE DOSE ON THE FIRST DAY THEN TAKE ONE TABLET DAILY**

<StructuredSIG>

<RepeatingSIG>

<SigSequencePositionNumber>1</SigSequencePositionNumber>

<MultipleSigModifier>THEN</MultipleSigModifier>

</RepeatingSIG>

<CodeSystem>
<FreeText><SigFreeTextStringIndicator>2</SigFreeTextStringIndicator><SigFreeText>Take 2 tablet oral route 1 day 1 day</SigFreeText></FreeText><Dose><DoseCompositeIndicator>1</DoseCompositeIndicator><DoseDeliveryMethodText>Take</DoseDeliveryMethodText><DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier><DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode><DoseQuantity>2</DoseQuantity><DoseDeliveryMethodText>oral route</DoseDeliveryMethodText><DoseFormText>Tablet</DoseFormText><DoseFormCodeQualifier>2</DoseFormCodeQualifier><DoseFormCode>C48542</DoseFormCode><FrequencyNumericValue>1</FrequencyNumericValue><FrequencyUnitsText>Day</FrequencyUnitsText><FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier><FrequencyUnitsCode>258703001</FrequencyUnitsCode></Dose>
### SCRIPT Implementation Recommendations

```xml
<FreeText>
 SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
 SigFreeText take 1 tablet oral route 1 day</SigFreeText>
</FreeText>

```xml
<Dose>
 <DoseCompositeIndicator>1</DoseCompositeIndicator>
 <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
 <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
 <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
 <DoseQuantity>1</DoseQuantity>
 <DoseFormText>Tablet</DoseFormText>
 <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
 <DoseFormCode>C48542</DoseFormCode>
</Dose>

```xml
<RouteofAdministration>
 <RouteofAdministrationText>Oral Route</RouteofAdministrationText>
 <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
 <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>

```xml
<Timing>
 <FrequencyNumericValue>1</FrequencyNumericValue>
 <FrequencyUnitsText>Day</FrequencyUnitsText>
 <Timing>
</Timing>
</StructuredSIG>
```

### Notes:

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;SigSequencePositionNumber&gt;</td>
<td>1</td>
<td>First loop.</td>
</tr>
<tr>
<td>&lt;MultipleSigModifier&gt;</td>
<td>THEN</td>
<td>There are two loops for the different instructions per day. The modifier joins the loops.</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>Elements contain data relaying for 1 time daily (one administration per day) (first loop). See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
<td></td>
</tr>
<tr>
<td>&lt;Duration&gt; elements</td>
<td>Elements contain data relaying for 1 day.</td>
<td></td>
</tr>
<tr>
<td>&lt;SigSequencePositionNumber&gt;</td>
<td>2</td>
<td>Second loop.</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
</tbody>
</table>
```

---

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Page: 101
9.9.10 Take 2 Tablets by Mouth Every Day for 5 Days

<StructuredSIG>
<RepeatingSIG>
<SigSequencePositionNumber>0</SigSequencePositionNumber>
</RepeatingSIG>
</CodeSystem>
<SNOMEDVersion>20160301</SNOMEDVersion>
<FMTVersion>16.03d</FMTVersion>
</CodeSystem>
<FreeText>
<SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
<SigFreeText>Take 2 Tablet oral route 1 day 5 day </SigFreeText>
</FreeText>
<Dose>
<DoseCompositeIndicator>1</DoseCompositeIndicator>
<DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
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<DoseQuantity>2</DoseQuantity>
<DoseFormText>Tablet</DoseFormText>
<DoseFormCodeQualifier>2</DoseFormCodeQualifier>
<DoseFormCode>C48542</DoseFormCode>
</Dose>
<RouteofAdministration>
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<RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
<RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>
<Timing>
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<FrequencyUnitsText>Day</FrequencyUnitsText>
<FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
<FrequencyUnitsCode>258703001</FrequencyUnitsCode>
</Timing>
<Duration>
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<DurationText>Days</DurationText>
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<DurationTextCode>258703001</DurationTextCode>

Notes:

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time daily (one administration per day). See FAQ “How do you express similar but distinct concepts?”</td>
</tr>
<tr>
<td>&lt;Duration&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 5 days.</td>
</tr>
</tbody>
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9.9.11  **TAKE 2 TABLETS BY MOUTH DAILY**

```xml
<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take 2 Tablet oral route 1 day</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
    <DoseQuantity>2</DoseQuantity>
    <DoseFormText>Tablets</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C48542</DoseFormCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>oral route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
  </RouteofAdministration>
  <FrequencyNumericValue>1</FrequencyNumericValue>
</StructuredSIG>
```
9.9.12 TAKE 1 TABLET BY MOUTH 4 TIMES A DAY

<StructuredSIG>
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<RepeatingSIG>
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<SNOMEDVersion>20160301</SNOMEDVersion>
<FMTVersion>16.03d</FMTVersion>
</CodeSystem>
<FreeText>
<SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
<SigFreeText>Take 1 Tablet oral route 4 day</SigFreeText>
</FreeText>
<Dose>
<DoseCompositeIndicator>1</DoseCompositeIndicator>
<DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
<DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
<DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
<DoseQuantity>1</DoseQuantity>
<DoseFormText>Tablet</DoseFormText>
<DoseFormCodeQualifier>2</DoseFormCodeQualifier>
<DoseFormCode>C48542</DoseFormCode>
</Dose>
<RouteofAdministration>
<RouteofAdministrationText>oral route</RouteofAdministrationText>
<RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
<RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>
9.9.13  **TAKE ONE TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR COUGH**

```
<Timing>
  <FrequencyNumericValue>4</FrequencyNumericValue>
  <FrequencyUnitsText>Day</FrequencyUnitsText>
  <FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
  <FrequencyUnitsCode>258703001</FrequencyUnitsCode>
</Timing>

<RouteofAdministrationCode>26643006</RouteofAdministrationCode>

<Notes>
  Oral route versus by mouth
</Notes>

<StructuredSIG>
  Take 1 Tablet oral route 6 hours as needed for cough present
</StructuredSIG>
```

Elements contain data relaying for 4 times daily (four administrations per day).
See FAQ "How do you express similar but distinct concepts?"
<RouteofAdministrationCode>26643006</RouteofAdministrationCode>

<Timing>
  <IntervalNumericValue>6</IntervalNumericValue>
  <IntervalUnitsText>hour</IntervalUnitsText>
  <IntervalUnitsCodeQualifier>1</IntervalUnitsCodeQualifier>
  <IntervalUnitsCode>258702006</IntervalUnitsCode>
</Timing>

<Indication>
  <IndicationPrecursorText>as needed for</IndicationPrecursorText>
  <IndicationPrecursorCodeQualifier>1</IndicationPrecursorCodeQualifier>
  <IndicationPrecursorCode>420449005</IndicationPrecursorCode>
  <IndicationText>cough</IndicationText>
  <IndicationTextCodeQualifier>1</IndicationTextCodeQualifier>
  <IndicationTextCode>49727002</IndicationTextCode>
  <IndicationValueUnitOfMeasureCode>52101004</IndicationValueUnitOfMeasureCode>
  <IndicationValueUnitOfMeasureText>present</IndicationValueUnitOfMeasureText>
</Indication>

<StructuredSIG>
  Notes:
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<tr>
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<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying a 6 hour interval</td>
</tr>
<tr>
<td>&lt;Indication&gt; elements</td>
<td></td>
<td>Elements contain data relaying as needed for cough (see section &quot;&lt;IndicationValueUnitOfMeasureCode&gt;&quot;.</td>
</tr>
</tbody>
</table>

9.9.14  TAKE 2 TABLETS BY MOUTH TWICE DAILY
  <StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    Take 2 Tablet oral route 2 day</FreeText>
  </FreeText>
<Dose>
  <DoseCompositeIndicator>1</DoseCompositeIndicator>
  <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
  <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
  <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
  <DoseQuantity>2</DoseQuantity>
  <DoseFormText>Tablet</DoseFormText>
  <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
  <DoseFormCode>C48542</DoseFormCode>
</Dose>

<RouteofAdministration>
  <RouteofAdministrationText>oral route</RouteofAdministrationText>
  <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
  <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>

<Timing>
  <FrequencyNumericValue>2</FrequencyNumericValue>
  <FrequencyUnitsText>Day</FrequencyUnitsText>
  <FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
  <FrequencyUnitsCode>258703001</FrequencyUnitsCode>
</Timing>
</StructuredSIG>

**Notes:**

<table>
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<th>Value</th>
<th>Note</th>
</tr>
</thead>
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<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for twice daily (two administrations per day). See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
</tr>
</tbody>
</table>

**9.9.15  TAKE 1 TABLET BY MOUTH EVERY 4 TO 6 HOURS AS NEEDED FOR PAIN**

<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>1</SigSequencePositionNumber>
  </RepeatingSIG>
</StructuredSIG>
<SigFreeText>Take 1 tablet oral route 4 hour TO as needed for pain present</SigFreeText>
</FreeText>
<Dose>
<DoseCompositeIndicator>1</DoseCompositeIndicator>
<DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
<DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
<DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
<DoseQuantity>1</DoseQuantity>
<DoseFormText>Tablet</DoseFormText>
<DoseFormCodeQualifier>2</DoseFormCodeQualifier>
<DoseFormCode>C48542</DoseFormCode>
</Dose>
<RouteofAdministration>
<RouteofAdministrationText>oral route</RouteofAdministrationText>
<RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
<RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>
<Timing>
<IntervalNumericValue>4</IntervalNumericValue>
<IntervalUnitsText>hour</IntervalUnitsText>
<IntervalUnitsCodeQualifier>1</IntervalUnitsCodeQualifier>
<IntervalUnitsCode>258702006</IntervalUnitsCode>
<VariableIntervalModifier>TO</VariableIntervalModifier>
</Timing>
<Indication>
<IndicationPrecursorText>as needed for</IndicationPrecursorText>
<IndicationPrecursorCodeQualifier>1</IndicationPrecursorCodeQualifier>
<IndicationPrecursorCode>420449005</IndicationPrecursorCode>
<IndicationText>pain</IndicationText>
<IndicationTextCodeQualifier>1</IndicationTextCodeQualifier>
<IndicationTextCode>22253000</IndicationTextCode>
<IndicationValueUnitofMeasureText>present</IndicationValueUnitofMeasureText>
<IndicationValueUnitofMeasureCodeQualifier>1</IndicationValueUnitofMeasureCodeQualifier>
<IndicationValueUnitofMeasureCode>52101004</IndicationValueUnitofMeasureCode>
</Indication>
</StructuredSIG>
<StructuredSIG>
<RepeatingSIG>
<SigSequencePositionNumber>2</SigSequencePositionNumber>
</RepeatingSIG>
</StructuredSIG>
<CodeSystem>
<SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
<SigFreeText> take 1 tablet oral route 6 hour as needed for pain present</SigFreeText>

<StructuredSIG>

Notes:
**SCRIPT Implementation Recommendations**

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<th>Element</th>
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<th>Note</th>
</tr>
</thead>
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<tr>
<td><code>&lt;SigSequencePositionNumber&gt;</code></td>
<td>1</td>
<td>First loop.</td>
</tr>
<tr>
<td><code>&lt;RouteofAdministrationCode&gt;</code></td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td><code>&lt;Timing&gt;</code> elements</td>
<td></td>
<td>Elements contain data relaying for 4 hours TO daily (first loop)</td>
</tr>
<tr>
<td><code>&lt;Indication&gt;</code> elements</td>
<td></td>
<td>Elements contain data relaying as needed for pain (see section</td>
</tr>
<tr>
<td><code>&lt;SigSequencePositionNumber&gt;</code></td>
<td>2</td>
<td>Second loop.</td>
</tr>
<tr>
<td><code>&lt;RouteofAdministrationCode&gt;</code></td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td><code>&lt;Timing&gt;</code> elements</td>
<td></td>
<td>Elements contain data relaying for the second part (6 hours) (second loop)</td>
</tr>
</tbody>
</table>

**9.9.16  TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 10 DAYS**

```xml
<StructuredSIG>
    <RepeatingSIG>
        <CodeSystem>
            <SNOMEDVersion>20160301</SNOMEDVersion>
            <FMTVersion>16.03d</FMTVersion>
            <CodeSystem>
                <FreeText>
                    <SigFreeTextStringEncoding>2</SigFreeTextStringEncoding>
                    <SigFreeText>Take 1 Tablet oral route 2 day 10 day</SigFreeText>
                </FreeText>
                <Dose>
                    <DoseCompositeIndicator>1</DoseCompositeIndicator>
                    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
                    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
                    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
                    <DoseQuantity>1</DoseQuantity>
                    <DoseFormText>Tablet</DoseFormText>
                    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
                    <DoseFormCode>C48542</DoseFormCode>
                </Dose>
                <RouteofAdministration>
                    <RouteofAdministrationText>oral route</RouteofAdministrationText>
                </RouteofAdministration>
            </CodeSystem>
        </CodeSystem>
    </RepeatingSIG>
</StructuredSIG>
```
Notes:

<table>
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<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for twice a day (two administrations per day). See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
</tr>
<tr>
<td>&lt;Duration&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 10 days</td>
</tr>
</tbody>
</table>

9.9.17 **Take 1 to 2 tablets by mouth every 4 to 6 hours as needed for pain**
<DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
<DoseQuantity>1</DoseQuantity>
<DoseFormText>Tablet</DoseFormText>
<DoseFormCodeQualifier>2</DoseFormCodeQualifier>
<DoseFormCode>C48542</DoseFormCode>
<DoseRangeModifier>TO</DoseRangeModifier>
</Dose>

<RouteofAdministration>
<RouteofAdministrationText>oral route</RouteofAdministrationText>
<RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
<RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>

<Timing>
<IntervalNumericValue>4</IntervalNumericValue>
<IntervalUnitsText>hour</IntervalUnitsText>
<IntervalUnitsCodeQualifier>1</IntervalUnitsCodeQualifier>
<IntervalUnitsCode>258702006</IntervalUnitsCode>
<IndicationValueUnitofMeasureText>present</IndicationValueUnitofMeasureText>
<VariableIntervalModifier>TO</VariableIntervalModifier>
</Timing>

<Indication>
<IndicationPrecursorText>as needed for</IndicationPrecursorText>
<IndicationPrecursorCodeQualifier>1</IndicationPrecursorCodeQualifier>
<IndicationPrecursorCode>420449005</IndicationPrecursorCode>
<IndicationText>pain</IndicationText>
<IndicationTextCodeQualifier>1</IndicationTextCodeQualifier>
<IndicationTextCode>22253000</IndicationTextCode>
<IndicationValueUnitofMeasureCode>52101004</IndicationValueUnitofMeasureCode>
</Indication>

<StructuredSIG>
<RepeatingSIG>
<SigSequencePositionNumber>2</SigSequencePositionNumber>
</RepeatingSIG>
</StructuredSIG>
<Dose>
  <DoseCompositeIndicator>1</DoseCompositeIndicator>
  <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
  <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
  <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
  <DoseQuantity>2</DoseQuantity>
  <DoseFormText>Tablet</DoseFormText>
  <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
  <DoseFormCode>C48542</DoseFormCode>
</Dose>

<RouteofAdministration>
  <RouteofAdministrationText>oral route</RouteofAdministrationText>
  <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
  <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>

<Timing>
  <IntervalNumericValue>6</IntervalNumericValue>
  <IntervalUnitsText>hour</IntervalUnitsText>
  <IntervalUnitsCodeQualifier>1</IntervalUnitsCodeQualifier>
  <IntervalUnitsCode>258702006</IntervalUnitsCode>
</Timing>

<Indication>
  <IndicationPrecursorText>as needed for</IndicationPrecursorText>
  <IndicationPrecursorCodeQualifier>1</IndicationPrecursorCodeQualifier>
  <IndicationPrecursorCode>420449005</IndicationPrecursorCode>
  <IndicationText>pain</IndicationText>
  <IndicationTextCodeQualifier>1</IndicationTextCodeQualifier>
  <IndicationTextCode>22253000</IndicationTextCode>
  <IndicationValueUnitofMeasureCode>52101004</IndicationValueUnitofMeasureCode>
  <IndicationValueUnitofMeasureText>present</IndicationValueUnitofMeasureText>
</Indication>
</StructuredSIG>

Notes:
**SCRIPT Implementation Recommendations**

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<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
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<tr>
<td><code>&lt;SigSequencePositionNumber&gt;</code></td>
<td>1</td>
<td>First loop.</td>
</tr>
<tr>
<td><code>&lt;Dose&gt;</code> elements</td>
<td></td>
<td>Elements contain data relaying 1 TO (first loop)</td>
</tr>
<tr>
<td><code>&lt;RouteOfAdministrationCode&gt;</code></td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td><code>&lt;Timing&gt;</code> elements</td>
<td></td>
<td>Elements contain data relaying for 4 hours TO daily (first loop)</td>
</tr>
<tr>
<td><code>&lt;Indication&gt;</code> elements</td>
<td></td>
<td>Elements contain data relaying as needed for pain (see section &quot;&lt;IndicationValueUnitOfMeasureCode&gt;&quot;).</td>
</tr>
<tr>
<td><code>&lt;SigSequencePositionNumber&gt;</code></td>
<td>2</td>
<td>Second loop.</td>
</tr>
<tr>
<td><code>&lt;RouteOfAdministrationCode&gt;</code></td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td><code>&lt;Dose&gt;</code> elements</td>
<td></td>
<td>Elements contain data relaying for the second part (2) (second loop)</td>
</tr>
<tr>
<td><code>&lt;Timing&gt;</code> elements</td>
<td></td>
<td>Elements contain data relaying for the second part (6 hours) (second loop)</td>
</tr>
<tr>
<td><code>&lt;Indication&gt;</code> elements</td>
<td></td>
<td>Elements contain data relaying as needed for pain (see section &quot;&lt;IndicationValueUnitOfMeasureCode&gt;&quot;).</td>
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</table>

**9.9.18**  **TAKE 1 TABLET BY MOUTH 3 TIMES A DAY AS NEEDED FOR HEADACHE**

```xml
<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
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    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take 1 Tablet oral route 3 Day as needed for headache present</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
    <DoseQuantity>1</DoseQuantity>
    <DoseFormText>Tablet</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C48542</DoseFormCode>
  </Dose>
</StructuredSIG>
```
<RouteofAdministrationText>oral route</RouteofAdministrationText>  
<RouteofAdministrationCode>26643006</RouteofAdministrationCode>  
<Timing>  
<FrequencyNumericValue>3</FrequencyNumericValue>  
<FrequencyUnitsText>Day</FrequencyUnitsText>  
<FrequencyUnitsCode>258703001</FrequencyUnitsCode>  
<Indication>  
<IndicationPrecursorText>as needed for</IndicationPrecursorText>  
<IndicationValueUnitOfMeasureCode>52101004</IndicationValueUnitOfMeasureCode>  
</Indication>  
</Timing>  

Notes:  
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<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
</tbody>
</table>
| <Timing> elements             | Elements contain data relaying for 3 times daily (three administrations per day). See FAQ "How do you express similar but distinct concepts?"
| <Indication> elements         | Elements contain data relaying as needed for headache (see section "<IndicationValueUnitOfMeasureCode>"."

**9.9.19 TAKE 1 TABLET BY MOUTH EVERY 12 HOURS**
<FreeText>Take 1 Tablet oral route 12 hour</FreeText>

<StructuredSIG>
<RepeatingSIG>
<SigSequencePositionNumber>0</SigSequencePositionNumber>
</RepeatingSIG>
</StructuredSIG>

Notes:

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<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>Elements</td>
<td>Elements contain data relaying a 12 hour interval</td>
</tr>
</tbody>
</table>

9.9.20  **TAKE 1 TABLET BY MOUTH TWICE A DAY AS NEEDED FOR NAUSEA**

<StructuredSIG>
<RepeatingSIG>
<SigSequencePositionNumber>0</SigSequencePositionNumber>
</RepeatingSIG>
</StructuredSIG>
Take 1 Tablet oral route 2 Day as needed for nausea present

Notes:
9.9.21 **TAKE 1 TABLET BY MOUTH PER DAY AS PER MEDICAL ENCOUNTER INSTRUCTIONS**

```
<StructuredSIG>
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    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take 1 tablet oral route 1 day provider medication administration instructions</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
    <DoseQuantity>1</DoseQuantity>
    <DoseFormText>Tablet</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C48542</DoseFormCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>oral route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
  </RouteofAdministration>
  <Timing>
    <AdministrationTimingText>Provider medication administration instructions</AdministrationTimingText>
    <AdministrationTimingCodeQualifier>1</AdministrationTimingCodeQualifier>
    <AdministrationTimingCode>422037009</AdministrationTimingCode>
    <FrequencyNumericValue>1</FrequencyNumericValue>
  </Timing>
</StructuredSIG>
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<FrequencyUnitsText>Day</FrequencyUnitsText>
<FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
<FrequencyUnitsCode>258703001</FrequencyUnitsCode>

</Timing>
</StructuredSIG>

Notes:

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<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying take as directed – SNOMED CT® Concept ID – 422037009 - Provider medication administration instructions.</td>
</tr>
</tbody>
</table>

9.9.22  TAKE 1 TABLET BY MOUTH AT BEDTIME AS NEEDED FOR SLEEP

<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take 1 Tablet oral route Bedtime 1 day as needed for sleep present</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
    <DoseQuantity>1</DoseQuantity>
    <DoseFormText>Tablet</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C48542</DoseFormCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>oral route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
  </RouteofAdministration>
SCRIPT Implementation Recommendations

</RouteofAdministration>
<Timing>
<AdministrationTimingText>Bedtime</AdministrationTimingText>
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<AdministrationTimingCode>21029003</AdministrationTimingCode>
<FrequencyNumericValue>1</FrequencyNumericValue>
<FrequencyUnitsText>Day</FrequencyUnitsText>
<FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
<FrequencyUnitsCode>258703001</FrequencyUnitsCode>
</Timing>
<Indication>
<IndicationPrecursorText>as needed for</IndicationPrecursorText>
<IndicationPrecursorCodeQualifier>1</IndicationPrecursorCodeQualifier>
<IndicationPrecursorCode>420449005</IndicationPrecursorCode>
<IndicationText>sleep</IndicationText>
<IndicationTextCodeQualifier>1</IndicationTextCodeQualifier>
<IndicationTextCode>258158006</IndicationTextCode>
<IndicationValueUnitofMeasureCode>52101004</IndicationValueUnitofMeasureCode>
<IndicationValueUnitofMeasureText>present</IndicationValueUnitofMeasureText>
</Indication>
</StructuredSIG>

Notes:

<table>
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<tr>
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<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time daily at bedtime (one administration per day). See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
</tr>
<tr>
<td>&lt;Indication&gt; elements</td>
<td></td>
<td>Elements contain data relaying as needed for sleep (see section &quot;&lt;IndicationValueUnitOfMeasureCode&gt;.&quot;)</td>
</tr>
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9.9.23 **TAKE 1 TABLET BY MOUTH PER WEEK**

<StructuredSIG>
<RepeatingSIG>
<SigSequencePositionNumber>0</SigSequencePositionNumber>
</RepeatingSIG>
</StructuredSIG>
Take 1 Tablet oral route 1

Notes:

<table>
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<th>Value</th>
<th>Note</th>
</tr>
</thead>
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<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time weekly (one administration per week). See FAQ “How do you express similar but distinct concepts?”</td>
</tr>
</tbody>
</table>

9.9.24 TAKE ½ TABLET BY MOUTH DAILY

Notes:
Notes:

<table>
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<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time daily (one administration per day). See FAQ “How do you express similar but distinct concepts?”</td>
</tr>
</tbody>
</table>

### 9.10 ADDITIONAL, MORE COMPLEX SIGS

After the 24 Sig strings were identified and recommendations published in this document, the task group participants provided additional, more complex de-identified Sig data for analysis. This list was used as basis for generating example SCRIPT Version 10.6 XML message excerpts containing the structured Sig composite and applicable SNOMED CT® Concept IDs and FMT Codes. The task group added route of administration to the strings, as route will be mandatory in future versions of the Structured and Codified Sig Format.
Below are the additional Sig strings:
In some cases, the original string was incomplete. Further analysis provided the medication and the more complete sig was created as an example.

<table>
<thead>
<tr>
<th>Original String</th>
<th>String with Elements Added for a More Complete Sig</th>
<th>Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Instill 1 drop in both eyes twice daily</td>
<td>Instill 1 drop in both eyes 2 times per day</td>
<td></td>
</tr>
<tr>
<td>2. Take 1 tablet every other day</td>
<td>Take 1 tablet by mouth every other day</td>
<td></td>
</tr>
<tr>
<td>3. Use 2 inhalations every 4-6 hours as needed</td>
<td>Inhale 2 puffs by mouth 1 hour prior to exercise</td>
<td>Indication and timing modified to provide more completeness, and to assist implementers in using SNOMED CT®.</td>
</tr>
<tr>
<td>4. Apply one patch transdermally two times a day as directed</td>
<td>Apply one patch to skin two times a day as directed for pain</td>
<td>Indication added to provide more completeness, and to assist implementers in using SNOMED CT®.</td>
</tr>
<tr>
<td>5. Apply 1 patch as directed once each week</td>
<td>Apply 1 patch to skin once per week as directed per medical encounter.</td>
<td>This is modified assuming the instructions were given per the encounter with the patient. Indication added to provide more completeness, and to assist implementers in using SNOMED CT®.</td>
</tr>
<tr>
<td>6. Inject 1.8MG subcutaneously once a day</td>
<td>Inject 0.4 mL under the skin once a day</td>
<td>Dose amount changed for accuracy and to assist implementers.</td>
</tr>
<tr>
<td>7. Apply to the affected area two times a day</td>
<td>Apply sparingly to the affected area two times a day</td>
<td></td>
</tr>
<tr>
<td>8. Take 1 tablet on Monday, Wednesday, and Friday</td>
<td>Take 1 tablet by mouth on Monday, Wednesday, and Friday</td>
<td></td>
</tr>
<tr>
<td>9. Dissolve 1 tablet under the tongue as directed for chest pain</td>
<td>Dissolve 1 tablet under the tongue as directed for chest pain</td>
<td></td>
</tr>
<tr>
<td>10. Apply to face twice a day</td>
<td>Apply to face twice a day</td>
<td></td>
</tr>
<tr>
<td>11. Instill 1 drop in left ear twice daily</td>
<td>Instill 1 drop in left ear 2 times per day for 10 days</td>
<td>Duration added to provide more completeness, and to assist implementers in using SNOMED CT®.</td>
</tr>
<tr>
<td>12. Take 1 tablet three times a week</td>
<td>Take 1 tablet by mouth 3 times a week</td>
<td></td>
</tr>
<tr>
<td>13. Take 1 tablet every morning on an empty stomach</td>
<td>Take 1 tablet by mouth every morning on an empty stomach</td>
<td></td>
</tr>
<tr>
<td>14. Use 2 sprays in each nostril daily</td>
<td>Use 2 sprays in each nostril per day</td>
<td>While “daily” and “per day” are synonymous, since this is expressing a frequency, “day” is more precise</td>
</tr>
<tr>
<td>15. Apply 1 application in both eyes at bedtime</td>
<td>Apply ⅛ inch strip of ointment in both eyes at bedtime</td>
<td></td>
</tr>
<tr>
<td>16. Apply 1 patch as needed</td>
<td>Apply 1 patch behind ear every 72 hours for motion sickness</td>
<td>Indication and timing added to provide more completeness, and to assist implementers in using SNOMED CT®.</td>
</tr>
</tbody>
</table>
### 9.11 Additional, More Complex Structured Sig Examples

In the examples,

1. `<Qualifier> value is SNOMED® or FMTDOSEFORM.
2. Only the elements necessary to relay the structured Sig are shown. Conditional elements are not shown when not applicable to the Sig.
3. The text at the top of each example may not exactly match the SigFreeTextString, as that field is a concatenation of the elements in the structure.
4. It is recommended that the most recent version of the Code System be used; if not, trading partner agreement is required to specify which version is used.
5. 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 CT® Concept ID or FMT Term from NCI for dose form. However, the recommendation is that both `<SNOMEDVersion>` and `<FMTVersion>` are mandatory elements. Each system that supports structured Sig will need to support the SNOMED CT® Concept ID and FMT Term from NCI for dose form for Sigs they will send or receive. Therefore, the system should have the ability to populate a default version they support.
6. **Important:** In the examples, there are situations where the `<SigFreeText>` string is *not* an exact match to the discrete data elements (such as oral route versus by mouth, daily versus per day, morning versus every morning).
   a. Industry use and other standards do not force the SNOMED CT® preferred term to be sent as the text description accompanying the SNOMED CT® Concept ID. Organizations may have their own preference on whether to send the preferred term, a SNOMED CT®-identified synonym, or a local description. Users should not expect that the receiving system will display the exact text that was sent; the receiving system may instead choose to display the SNOMED CT® preferred term related to the concept ID or a synonym appropriate for its locale and user base (e.g. “oral route”, “orally”, “by mouth”, etc.).
   b. The important thing to remember is that the receiving system will use the SNOMED CT® Concept ID as the “source of truth” for information being sent, and may or may not make use of the textual description. Receiving systems should retain a record of what was sent to support auditing and troubleshooting needs.

<table>
<thead>
<tr>
<th></th>
<th>Insert 1 ring vaginally and leave in place for 3 weeks, then remove for 1 ring-free week</th>
<th>Insert 1 ring vaginally and leave in place for 3 weeks, then remove for 1 ring-free week</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Take 4 capsules 1 hour prior to appointment and take 2 capsules 6 hours later</td>
<td>Take 4 capsules by mouth 1 hour prior to appointment and take 2 capsules by mouth 6 hours later</td>
</tr>
</tbody>
</table>

### 9.11.1 Instill 1 Drop in Both Eyes Two Times per Day

<StructuredSig>
<SigFreeText>Instill 1 Drop Ophthalmic route Both eyes, entire 2 day</SigFreeText>

Notes:
### 9.11.2  **TAKE 1 TABLET BY MOUTH EVERY OTHER DAY**

```
<StructuredSIG>
  <RepeatingSIG>
    <SequencePositionNumber>0</SequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take 1 Tablet oral route Every Other Day</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
    <DoseQuantity>1</DoseQuantity>
    <DoseFormText>Tablet</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C48542</DoseFormCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>oral route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
  </RouteofAdministration>
  <Timing>
    <FrequencyUnitsText>Every Other Day</FrequencyUnitsText>
  </Timing>
</StructuredSIG>
```
Notes:

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>339230011</td>
<td>Elements contain data relaying for 1 every other day.</td>
</tr>
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</table>

9.11.3 INHALE 2 PUFFS BY MOUTH 1 HOUR PRIOR TO EXERCISE

<StructuredSIG>
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    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
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    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Inhale 2 puff oral route before exercising 1 Hour</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Inhale</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>421134003</DoseDeliveryMethodCode>
    <DoseQuantity>2</DoseQuantity>
    <DoseFormText>Puff</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C65060</DoseFormCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>oral route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
  </RouteofAdministration>
  <Timing>
<AdministrationTimingText>Before exercising</AdministrationTimingText>
<AdministrationTimingCodeQualifier>1</AdministrationTimingCodeQualifier>
<AdministrationTimingCode>307166007</AdministrationTimingCode>
<FrequencyNumericValue>1</FrequencyNumericValue>
<FrequencyUnitsText>Hour</FrequencyUnitsText>
<FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
<FrequencyUnitsCode>258702006</FrequencyUnitsCode>
</Timing>

Notes:

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<tr>
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<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;DoseDeliveryMethodCode&gt;</td>
<td>421134003</td>
<td>Inhale</td>
</tr>
<tr>
<td>&lt;DoseFormCode&gt;</td>
<td>C42944</td>
<td>Inhalant</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>258702006</td>
<td>Elements contain data relaying 1 hour. See FAQ “How do you express similar but distinct concepts?”</td>
</tr>
<tr>
<td></td>
<td>307166007</td>
<td>Before exercising</td>
</tr>
</tbody>
</table>

9.11.4 Apply 1 Patch to Skin Two Times a Day as Directed for Pain

<StructuredSIG>
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</RepeatingSIG>
<CodeSystem>
<SNOMEDVersion>20160301</SNOMEDVersion>
<FMTVersion>16.03d</FMTVersion>
</CodeSystem>
<FreeText>
<SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
<SigFreeText>Apply 1 Patch Transdermal 2 Day as directed for pain present</SigFreeText>
</FreeText>
<Dose>
<DoseCompositeIndicator>1</DoseCompositeIndicator>
<DoseDeliveryMethodText>Apply</DoseDeliveryMethodText>
<DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
<DoseDeliveryMethodCode>417924000</DoseDeliveryMethodCode>
<DoseQuantity>1</DoseQuantity>
<DoseFormText>Patch</DoseFormText>
<DoseFormCodeQualifier>2</DoseFormCodeQualifier>
<DoseFormCode>C48524</DoseFormCode>
</Dose>
<RouteofAdministration>
<RouteofAdministrationText>Transdermal</RouteofAdministrationText>
<RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
<RouteofAdministrationCode>45890007</RouteofAdministrationCode>
</RouteofAdministration>
<Timing>
<FrequencyNumericValue>2</FrequencyNumericValue>
<FrequencyUnitsText>Day</FrequencyUnitsText>
<FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
<FrequencyUnitsCode>258703001</FrequencyUnitsCode>
</Timing>
<Indication>
<IndicationPrecursorText>as directed for</IndicationPrecursorText>
<IndicationPrecursorCodeQualifier>1</IndicationPrecursorCodeQualifier>
<IndicationPrecursorCode>422135004</IndicationPrecursorCode>
<IndicationText>pain</IndicationText>
<IndicationTextCodeQualifier>1</IndicationTextCodeQualifier>
<IndicationTextCode>22253000</IndicationTextCode>
<IndicationValueUnitofMeasureCode>52101004</IndicationValueUnitofMeasureCode>
<IndicationValueUnitofMeasureText>present</IndicationValueUnitofMeasureText>
</Indication>
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Notes:

<table>
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<th>Note</th>
</tr>
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<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>45890007</td>
<td>Transdermal</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>45890007</td>
<td>Elements contain data relaying 2 times per day.</td>
</tr>
<tr>
<td>&lt;Indication&gt; elements</td>
<td>45890007</td>
<td>Elements contain data relaying as needed for pain (see section &quot;&lt;IndicationValueUnitOfMeasureCode&gt;&quot;).</td>
</tr>
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</table>

9.11.5 **APPLY 1 PATCH TO SKIN ONCE PER WEEK AS DIRECTED PER MEDICAL ENCOUNTER INSTRUCTIONS**

<StructuredSIG>
<RepeatingSIG>
<SigSequencePositionNumber>0</SigSequencePositionNumber>
</RepeatingSIG>
</StructuredSIG>
< SigFreeTextStringIndicator > 2 </ SigFreeTextStringIndicator >
< SigFreeText > Apply 1 patch transdermal provider medication administration instructions 1 week. </ SigFreeText >
< Dose >
< DoseCompositeIndicator > 1 </ DoseCompositeIndicator >
< DoseDeliveryMethodText > Apply </ DoseDeliveryMethodText >
< DoseDeliveryMethodCodeQualifier > 1 </ DoseDeliveryMethodCodeQualifier >
< DoseDeliveryMethodCode > 41794000 </ DoseDeliveryMethodCode >
< DoseQuantity > 1 </ DoseQuantity >
< DoseFormText > Patch </ DoseFormText >
< DoseFormCodeQualifier > 2 </ DoseFormCodeQualifier >
< DoseFormCode > C42968 </ DoseFormCode >
< RouteofAdministration >
< RouteofAdministrationText > Transdermal </ RouteofAdministrationText >
< RouteofAdministrationCodeQualifier > 1 </ RouteofAdministrationCodeQualifier >
< RouteofAdministrationCode > 45890007 </ RouteofAdministrationCode >
</ RouteofAdministration >
< Timing >
< AdministrationTimingText > Provider medication administration instructions </ AdministrationTimingText >
< AdministrationTimingCodeQualifier > 1 </ AdministrationTimingCodeQualifier >
< AdministrationTimingCode > 422037009 </ AdministrationTimingCode >
< FrequencyUnitsText > week </ FrequencyUnitsText >
< FrequencyUnitsCodeQualifier > 1 </ FrequencyUnitsCodeQualifier >
< FrequencyUnitsCode > 258705008 </ FrequencyUnitsCode >
</ Timing >
</ StructuredSIG >

Notes:
### 9.11.6 INJECT 0.4ML UNDER THE SKIN ONCE A DAY

```xml
<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Inject 0.4 milliliter Subcutaneous route 1 Day</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Inject</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>422145002</DoseDeliveryMethodCode>
    <DoseQuantity>0.4</DoseQuantity>
    <DoseFormText>Milliliter</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C28254</DoseFormCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>Subcutaneous route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>263887005</RouteofAdministrationCode>
  </RouteofAdministration>
  <Timing>
    <FrequencyNumericValue>1</FrequencyNumericValue>
    <FrequencyUnitsText>Day</FrequencyUnitsText>
    <FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
  </Timing>
</StructuredSIG>
```
9.11.7 APPLY SPARINGLY TO THE AFFECTED AREA TWO TIMES A DAY

<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
    <RepeatingSIG>
      <FMTVersion>16.03d</FMTVersion>
      <SNOMEDVersion>20160301</SNOMEDVersion>
      <CodeSystem><SNOMEDVersion>20160301</SNOMEDVersion>
      <FMTVersion>16.03d</FMTVersion>
      <CodeSystem>
      <FreeText>
        <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
        <SigFreeText>Apply Sparingly Affected site 2 Day</SigFreeText>
        <FreeText>
        <Dose>
          <DoseCompositeIndicator>1</DoseCompositeIndicator>
          <DoseDeliveryMethodText>Apply</DoseDeliveryMethodText>
          <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
          <DoseDeliveryMethodCode>417924000</DoseDeliveryMethodCode>
          <DoseDeliveryMethodModifierText>Sparingly</DoseDeliveryMethodModifierText>
          <DoseDeliveryMethodModifierCodeQualifier>1</DoseDeliveryMethodModifierCodeQualifier>
          <DoseDeliveryMethodModifierCode>420883007</DoseDeliveryMethodModifierCode>
        </Dose>
        <SiteofAdministration>
          <SiteofAdministrationText>Affected site</SiteofAdministrationText>
          <SiteofAdministrationCodeQualifier>1</SiteofAdministrationCodeQualifier>
          <SiteofAdministrationCode>263583002</SiteofAdministrationCode>
        </SiteofAdministration>
      </FreeText>
    </RepeatingSIG>
  </RepeatingSIG>
</StructuredSIG>

Notes:

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<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;DoseDeliveryMethodCode&gt;</td>
<td>422145002</td>
<td>Inject</td>
</tr>
<tr>
<td>&lt;DoseQuantity&gt;</td>
<td>0.4 mL</td>
<td>obtained via the drug StrengthForm element.</td>
</tr>
<tr>
<td>&lt;DoseFormCode&gt;</td>
<td>C28254</td>
<td>Milliliter</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>263887005</td>
<td>Subcutaneous (under the skin)</td>
</tr>
</tbody>
</table>

Elements contain data relaying 1 time per day. See FAQ “How do you express similar but distinct concepts?”
9.11.8 **TAKE 1 TABLET BY MOUTH ON MONDAY, WEDNESDAY, AND FRIDAY**

```xml
<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take 1 Tablet oral route Three times a week on Monday, Wednesday, Friday 1 Day</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
    <DoseQuantity>1</DoseQuantity>
    <DoseFormText>Tablet</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C48542</DoseFormCode>
  </Dose>
</StructuredSIG>
```

Notes:

<table>
<thead>
<tr>
<th>Element</th>
<th>Value</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;Dose Form&gt;</td>
<td>420883007</td>
<td>Sparingly</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying 2 times per day (2 administrations per day). See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
</tr>
<tr>
<td>&lt;SiteOfAdministrationCode&gt;</td>
<td>263583002</td>
<td>Affected site</td>
</tr>
</tbody>
</table>
<RouteofAdministration>
  <RouteofAdministrationText>oral route</RouteofAdministrationText>
  <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
  <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>

<Timing>
  <AdministrationTimingText>Three times a week on Monday, Wednesday and Friday</AdministrationTimingText>
  <AdministrationTimingCodeQualifier>1</AdministrationTimingCodeQualifier>
  <AdministrationTimingCode>444763000</AdministrationTimingCode>
  <FrequencyNumericValue>1</FrequencyNumericValue>
  <FrequencyUnitsText>Day</FrequencyUnitsText>
  <FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
  <FrequencyUnitsCode>258703001</FrequencyUnitsCode>
</Timing>

Notes:

<table>
<thead>
<tr>
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<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>444763000</td>
<td>Elements contain data relaying for 1 time daily (one administration per day) three times a week on Monday, Wednesday, and Friday. See FAQ “How do you express similar but distinct concepts?”</td>
</tr>
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9.11.9  **DISSOLVE 1 TABLET UNDER THE TONGUE AS DIRECTED FOR CHEST PAIN**

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  <CodeSystem>
    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Dissolve 1 Tablet sublingual route as directed for chest pain present-route as directed for chest pain present</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Dissolve</DoseDeliveryMethodText>
  </Dose>

Notes:

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<th>Note</th>
</tr>
</thead>
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<tr>
<td>&lt;DoseDeliveryMethodCode&gt;</td>
<td>421682005</td>
<td>Dissolve</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>37839007</td>
<td>Sublingual route</td>
</tr>
<tr>
<td>&lt;Indication&gt; elements</td>
<td>29857009</td>
<td>Elements contain data relaying as needed for chest pain (see section &quot;&lt;IndicationValueUnitOfMeasureCode&gt;&quot;).</td>
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9.11.10 APPLY TO FACE TWICE A DAY

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</StructuredSIG>
SCRIPT Implementation Recommendations

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<FMTVersion>16.03d</FMTVersion>
</CodeSystem>
</FreeText>
<SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
<SigFreeText> Apply Topical route Entire Face 2 Day </SigFreeText>
</FreeText>
</Dose>
</RouteofAdministration>
<RouteofAdministration>Topical route</RouteofAdministration>
</RouteofAdministrationCode>
</RouteofAdministration>
</SiteofAdministration>
<SiteofAdministration>Entire Face</SiteofAdministration>
</SiteofAdministrationCode>
</SiteofAdministration>
</Timing>
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</Timing>
</StructuredSIG>

Notes:
### 9.11.11 Instill 1 Drop in Left Ear 2 Times per Day for 10 Days

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  </RepeatingSIG>
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    <SNOMEDVersion>20160301</SNOMEDVersion>
    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Instill 1 metric drop otic route Left ear structure 2 Day 10 Day</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Instill</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>421538008</DoseDeliveryMethodCode>
    <DoseQuantity>1</DoseQuantity>
    <DoseFormText>Metric Drop</DoseFormText>
    <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
    <DoseFormCode>C48491</DoseFormCode>
  </Dose>
  <RouteofAdministration>
    <RouteofAdministrationText>Otic route</RouteofAdministrationText>
    <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
    <RouteofAdministrationCode>10547007</RouteofAdministrationCode>
  </RouteofAdministration>
  <SiteofAdministration>
    <SiteofAdministrationText>Left ear structure</SiteofAdministrationText>
  </SiteofAdministration>
</StructuredSIG>
```

Notes:

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</thead>
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<td>421538008</td>
<td>Instill</td>
</tr>
<tr>
<td>&lt;DoseFormCode&gt;</td>
<td>C48491</td>
<td>Metric Drop</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>10547007</td>
<td>Otic route</td>
</tr>
<tr>
<td>&lt;SiteofAdministrationCode&gt;</td>
<td>89644007</td>
<td>Left ear structure</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>Elements contain data relaying for 2 times daily (two administrations per day). See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
<td></td>
</tr>
<tr>
<td>&lt;Duration&gt; elements</td>
<td>Elements relaying for 10 days.</td>
<td></td>
</tr>
</tbody>
</table>

9.11.12 TAKE 1 TABLET THREE TIMES A WEEK.

<StructuredSIG><RepeatingSIG><SigSequencePositionNumber>0</SigSequencePositionNumber></RepeatingSIG><CodeSystem><SNOMEDVersion>20160301</SNOMEDVersion><FMTVersion>16.03d</FMTVersion></CodeSystem><FreeText><SigFreeTextStringIndicator>2</SigFreeTextStringIndicator><SigFreeText>Take 1 tablet oral route three times weekly 1 day</SigFreeText>
<Dose>
  <DoseCompositeIndicator>1</DoseCompositeIndicator>
  <DoseDeliveryMethodText>Take</DoseDeliveryMethodText>
  <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
  <DoseDeliveryMethodCode>419652001</DoseDeliveryMethodCode>
  <DoseQuantity>1</DoseQuantity>
  <DoseFormText>Tablet</DoseFormText>
  <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
  <DoseFormCode>C48542</DoseFormCode>
</Dose>

<RouteofAdministration>
  <RouteofAdministrationText>oral route</RouteofAdministrationText>
  <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
  <RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>

<Timing>
  <AdministrationTimingText>Three times weekly</AdministrationTimingText>
  <AdministrationTimingCodeQualifier>1</AdministrationTimingCodeQualifier>
  <AdministrationTimingCode>617542011</AdministrationTimingCode>
  <FrequencyNumericValue>1</FrequencyNumericValue>
  <FrequencyUnitsText>Day</FrequencyUnitsText>
  <FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
  <FrequencyUnitsCode>258703001</FrequencyUnitsCode>
</Timing>
</StructuredSIG>

Notes:

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<th>Note</th>
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</thead>
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<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>617542011</td>
<td>Elements contain data relaying for 1 time daily (one administration per day) three times weekly. See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
</tr>
</tbody>
</table>

9.11.13 TAKE 1 TABLET BY MOUTH EVERY MORNING ON AN EMPTY STOMACH

<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>0</SigSequencePositionNumber>
  </RepeatingSIG>
</StructuredSIG>
<SigFreeText>Take 1 tablet oral route morning 1 day on empty stomach present</SigFreeText>
**SCRIPT Implementation Recommendations**

<IndicationValueUnitofMeasureCode>52101004</IndicationValueUnitofMeasureCode>
</Indication>
</StructuredSIG>

Notes:

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<td>&lt;DoseDeliveryMethodText&gt;</td>
<td>419652001</td>
<td>Take</td>
</tr>
<tr>
<td>&lt;DoseFormText&gt;</td>
<td>C42998</td>
<td>Tablet</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>26643006</td>
<td>Oral route versus by mouth</td>
</tr>
<tr>
<td>&lt;AdministrationTimingText&gt;</td>
<td>73775008</td>
<td>Morning</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time daily (one administration per day) every morning. See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
</tr>
<tr>
<td>&lt;Indication&gt; elements</td>
<td>XXXXX</td>
<td>On empty stomach Note: SNOMED code has been requested will be updated when received. Elements contain data relaying on an empty stomach (see section &quot;&lt;IndicationValueUnitOfMeasureCode&gt;&quot;).</td>
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9.11.14 USE 2 SPRAYS IN EACH NOSTRIL PER DAY

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    <FMTVersion>16.03d</FMTVersion>
  </CodeSystem>
  <FreeText>
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    <SigFreeText>Use 2 nasal spray nasal route both anterior nares 1 day</SigFreeText>
  </FreeText>
  <Dose>
    <DoseCompositeIndicator>1</DoseCompositeIndicator>
    <DoseDeliveryMethodText>Use</DoseDeliveryMethodText>
    <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
    <DoseDeliveryMethodCode>419385000</DoseDeliveryMethodCode>
    <DoseQuantity>2</DoseQuantity>
  </Dose>
<DoseFormText>Nasal Spray</DoseFormText>
<DoseFormCodeQualifier>2</DoseFormCodeQualifier>
<DoseFormCode>C91157</DoseFormCode>
</Dose>
<RouteofAdministration>
<RouteofAdministrationText>Nasal route</RouteofAdministrationText>
<RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
<RouteofAdministrationCode>46713006</RouteofAdministrationCode>
</RouteofAdministration>
<SiteofAdministration>
<SiteofAdministrationText>Both anterior nares</SiteofAdministrationText>
<SiteofAdministrationCodeQualifier>2</SiteofAdministrationCodeQualifier>
<SiteofAdministrationCode>C0595944</SiteofAdministrationCode>
</SiteofAdministration>
<Timing>
<FrequencyNumericValue>1</FrequencyNumericValue>
<FrequencyUnitsText>Day</FrequencyUnitsText>
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<FrequencyUnitsCode>258703001</FrequencyUnitsCode>
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Notes:

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<th>Note</th>
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<td>419385000</td>
<td>Use</td>
</tr>
<tr>
<td>&lt;DoseFormCode&gt;</td>
<td>C91157</td>
<td>Nasal Spray</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>46713006</td>
<td>Nasal route</td>
</tr>
<tr>
<td>&lt;SiteofAdministration&gt;</td>
<td>C0595944</td>
<td>Both anterior nares</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td></td>
<td>Elements contain data relaying for 1 time daily (one administration per day). See FAQ &quot;How do you express similar but distinct concepts?&quot;</td>
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9.11.15 APPLY ½ INCH STRIP OF OINTMENT IN BOTH EYES AT BEDTIME

<StructuredSIG>
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</RepeatingSIG>
<SigFreeTextStringIndicator>2</SigFreeTextStringIndicator><SigFreeText>Apply .25 inch strip ophthalmic route both eyes, entire bedtime 1 day</SigFreeText>
</FreeText>
<Dose>
   <DoseCompositeIndicator>1</DoseCompositeIndicator>
   <DoseDeliveryMethodText>Apply</DoseDeliveryMethodText>
   <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
   <DoseDeliveryMethodCode>417924000</DoseDeliveryMethodCode>
   <DoseQuantity>.25</DoseQuantity>
   <DoseFormText>Inch strip</DoseFormText>
   <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
   <DoseFormCode>C124231</DoseFormCode>
</Dose>
<RouteofAdministration>
   <RouteofAdministrationText>Ophthalmic route</RouteofAdministrationText>
   <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
   <RouteofAdministrationCode>54485002</RouteofAdministrationCode>
</RouteofAdministration>
<SiteofAdministration>
   <SiteofAdministrationText>Both eyes, entire</SiteofAdministrationText>
   <SiteofAdministrationCodeQualifier>1</SiteofAdministrationCodeQualifier>
   <SiteofAdministrationCode>362508001</SiteofAdministrationCode>
</SiteofAdministration>
<Timing>
   <AdministrationTimingText>Bedtime</AdministrationTimingText>
   <AdministrationTimingCodeQualifier>1</AdministrationTimingCodeQualifier>
   <AdministrationTimingCode>21029003</AdministrationTimingCode>
   <FrequencyNumericValue>1</FrequencyNumericValue>
   <FrequencyUnitsText>Day</FrequencyUnitsText>
   <FrequencyUnitsCodeQualifier>1</FrequencyUnitsCodeQualifier>
   <FrequencyUnitsCode>258703001</FrequencyUnitsCode>
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<th>Note</th>
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<td>417924000</td>
<td>Apply</td>
</tr>
<tr>
<td>&lt;DoseQuantity&gt;</td>
<td>.25</td>
<td>1/4 represented as .25 as element is numeric expression.</td>
</tr>
<tr>
<td>&lt;DoseFormText&gt;</td>
<td>C124231</td>
<td>Inch strip</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>54485002</td>
<td>Ophthalmic route</td>
</tr>
<tr>
<td>&lt;SiteofAdministrationCode&gt;</td>
<td>362508001</td>
<td>Both eyes, entire</td>
</tr>
</tbody>
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9.11.16 APPLY 1 PATCH BEHIND EAR EVERY 72 HOURS FOR MOTION SICKNESS

```
<StructuredSIG>
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  </RepeatingSIG>
  <CodeSystem>
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    <FMTVersion>14.01d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Apply 1 patch transdermal behind ear 72 hour as needed for motion sickness</SigFreeText>
  </FreeText>
</StructuredSIG>
```

```
<Dose>
  <DoseCompositeIndicator>1</DoseCompositeIndicator>
  <DoseDeliveryMethodText>Apply</DoseDeliveryMethodText>
  <DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
  <DoseDeliveryMethodCode>417924000</DoseDeliveryMethodCode>
  <DoseQuantity>1</DoseQuantity>
  <DoseFormText>Patch</DoseFormText>
  <DoseFormCodeQualifier>2</DoseFormCodeQualifier>
  <DoseFormCode>C42968</DoseFormCode>
</Dose>
```

```
<RouteofAdministration>
  <RouteofAdministrationText>Transdermal</RouteofAdministrationText>
  <RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
  <RouteofAdministrationCode>45890007</RouteofAdministrationCode>
</RouteofAdministration>
```
<StructuredSIG>
  <SiteofAdministration>
    <SiteofAdministrationText>Behind ear</SiteofAdministrationText>
    <SiteofAdministrationCodeQualifier>2</SiteofAdministrationCodeQualifier>
    <SiteofAdministrationCode>Xxxx</SiteofAdministrationCode>
  </SiteofAdministration>
  <Timing>
    <IntervalNumericValue>72</IntervalNumericValue>
    <IntervalUnitsText>hour</IntervalUnitsText>
    <IntervalUnitsCodeQualifier>1</IntervalUnitsCodeQualifier>
    <IntervalUnitsCode>258702006</IntervalUnitsCode>
  </Timing>
  <Indication>
    <IndicationPrecursorText>as needed for</IndicationPrecursorText>
    <IndicationPrecursorCodeQualifier>1</IndicationPrecursorCodeQualifier>
    <IndicationPrecursorCode>2617867013</IndicationPrecursorCode>
    <IndicationText>motion sickness</IndicationText>
    <IndicationTextCodeQualifier>1</IndicationTextCodeQualifier>
    <IndicationTextCode>37031009</IndicationTextCode>
    <IndicationValueUnitOfMeasureCode>52101004</IndicationValueUnitOfMeasureCode>
  </Indication>
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<th>Note</th>
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<td>&lt;DoseFormCode&gt;</td>
<td>C42968</td>
<td>Patch</td>
</tr>
<tr>
<td>&lt;RouteofAdministrationCode&gt;</td>
<td>45890007</td>
<td>Transdermal</td>
</tr>
<tr>
<td>&lt;SiteofAdministration&gt;</td>
<td>Xxxx</td>
<td>Behind ear Note: SNOMED code has been requested will be updated when received.</td>
</tr>
<tr>
<td>&lt;Timing&gt; elements</td>
<td>258702006</td>
<td>Elements contain data relaying every 72 hours</td>
</tr>
<tr>
<td>&lt;Indication&gt; elements</td>
<td>37031009</td>
<td>Elements contain data relaying as needed for motion sickness (see section &quot;&lt;IndicationValueUnitOfMeasureCode&gt;&quot;).</td>
</tr>
</tbody>
</table>

9.11.17 INSERT 1 RING VAGINALLY AND LEAVE IN PLACE FOR 3 WEEKS, THEN REMOVE FOR 1 RING-FREE WEEK

<StructuredSIG>
  <RepeatingSIG>
    <SigSequencePositionNumber>1</SigSequencePositionNumber>
  </RepeatingSIG>
</StructuredSIG>

<CodeSystem>
  <SNOMEDVersion>20130731</SNOMEDVersion>
  <FMTVersion>14.01d</FMTVersion>
</CodeSystem>
Insert 1 ring vaginal route 3 week then remove 1 ring vaginal route 1 week.
<SigFreeText>Insert 1 ring vaginal route 3 week then remove 1 ring vaginal route 1 week</SigFreeText>
</FreeText>
<Dose>
<DoseCompositeIndicator>1</DoseCompositeIndicator>
<DoseDeliveryMethodText>Then Remove</DoseDeliveryMethodText>
<DoseDeliveryMethodCodeQualifier>1</DoseDeliveryMethodCodeQualifier>
<DoseDeliveryMethodCode>450831000124105</DoseDeliveryMethodCode>
<DoseQuantity>1</DoseQuantity>
<DoseFormText>Ring</DoseFormText>
<DoseFormCodeQualifier>2</DoseFormCodeQualifier>
<DoseFormCode>C60988</DoseFormCode>
</Dose>
<RouteofAdministration>
<RouteofAdministrationText>vaginal route</RouteofAdministrationText>
<RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
<RouteofAdministrationCode>16857009</RouteofAdministrationCode>
</RouteofAdministration>
<Duration>
<DurationNumericValue>1</DurationNumericValue>
<DurationText>Week</DurationText>
<DurationTextCodeQualifier>1</DurationTextCodeQualifier>
<DurationTextCode>258705008</DurationTextCode>
</Duration>
</StructuredSIG>

Notes:
SCRIPT Implementation Recommendations

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<td>First occurrence</td>
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<td>421257003</td>
<td>Insert</td>
</tr>
<tr>
<td><code>&lt;DoseFormCode&gt;</code></td>
<td>C60988</td>
<td>Ring</td>
</tr>
<tr>
<td><code>&lt;RouteofAdministrationCode&gt;</code></td>
<td>16857009</td>
<td>Vaginal route</td>
</tr>
<tr>
<td><code>&lt;Duration&gt;</code> elements</td>
<td>258705008</td>
<td>Elements contain data for duration of 3 weeks.</td>
</tr>
<tr>
<td><code>&lt;SigFreeTextStringIndicator&gt;</code></td>
<td>2</td>
<td>Second occurrence</td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
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<td>421139008</td>
<td>Remove</td>
</tr>
<tr>
<td><code>&lt;DoseFormCode&gt;</code></td>
<td>C60988</td>
<td>Ring</td>
</tr>
<tr>
<td><code>&lt;RouteofAdministrationCode&gt;</code></td>
<td>16857009</td>
<td>Vaginal route</td>
</tr>
<tr>
<td><code>&lt;Duration&gt;</code> elements</td>
<td>258705008</td>
<td>Elements contain data for duration of 1 week.</td>
</tr>
</tbody>
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9.11.18 Take 1 capsules by mouth 1 hour prior to appointment and take 2 capsules by mouth 6 hours later

```xml
<StructuredSIG>
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  </RepeatingSIG>
  <CodeSystem>
    <SNOMEDVersion>20130731</SNOMEDVersion>
    <FMTVersion>14.01d</FMTVersion>
  </CodeSystem>
  <FreeText>
    <SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
    <SigFreeText>Take 1 capsule oral route next appointment 1 hour and take 2 capsule oral route after 6 hour</SigFreeText>
  </FreeText>
</Dose>
```
<DoseFormText>Capsule</DoseFormText>
<DoseFormCodeQualifier>2</DoseFormCodeQualifier>
<DoseFormCode>C25158</DoseFormCode>
</Dose>

<RouteofAdministration>
<RouteofAdministrationText>oral route</RouteofAdministrationText>
<RouteofAdministrationCodeQualifier>1</RouteofAdministrationCodeQualifier>
<RouteofAdministrationCode>26643006</RouteofAdministrationCode>
</RouteofAdministration>

<Timing>
<AdministrationTimingText>Next appointment</AdministrationTimingText>
<AdministrationTimingCodeQualifier>1</AdministrationTimingCodeQualifier>
<AdministrationTimingCode>390840006</AdministrationTimingCode>
<IntervalNumericValue>1</IntervalNumericValue>
<IntervalUnitsText>hour</IntervalUnitsText>
<IntervalUnitsCodeQualifier>1</IntervalUnitsCodeQualifier>
<IntervalUnitsCode>258702006</IntervalUnitsCode>
</Timing>
</StructuredSIG>

<StructuredSIG>
<RepeatingSIG>
<SigSequencePositionNumber>2</SigSequencePositionNumber>
</RepeatingSIG>

<CodeSystem>
<SNOMEDVersion>20160301</SNOMEDVersion>
<FMTVersion>16.03d</FMTVersion>
</CodeSystem>

<FreeText>
<SigFreeTextStringIndicator>2</SigFreeTextStringIndicator>
<SigFreeText>Take 1 capsule oral route next appointment 1 hour and take 2 capsule oral route after 6 hour</SigFreeText>
</FreeText>

<Dose>
</Dose>
### 9.12 Frequently Asked Questions

#### 9.12.1 Where Do I Obtain the SNOMED CT® Code Set Used in Structured Sig?


SNOMED CT® starter guide (54 pp): **http://ihtsdo.org/fileadmin/user_upload/doc/**

#### 9.12.2 How Do I State the SNOMED CT® Version in Structured Sig?

The `<SNOMEDVersion>` element should be populated with the date of the SNOMED CT® release used when creating the message content. The format of the date should be CCYYMMDD, for example:

- 20130731

#### 9.12.3 Where Do I Obtain the FMT Code Set Version?

The FMT Code Set is provided as a spreadsheet and CSV file. The FMT Code Set Version is provided as the name of the spreadsheet tab, and in

For example:
FMT version – listed on the files as
- 10.11e
- 11.05e
- 12.07d
- 13.08d

9.12.4 **<Frequency> What if the Frequency is not specified, i.e. “take 1 tablet at bedtime”**

If frequency is not filled in, it does not need to be specified. In the example given, the frequency does not need to specified as it is assumed to be per “day”.

9.12.5 **How do I select the Correct Sig Free Text String Indicator in SCRIPT Version 10.6?**

The SCRIPT Standard Implementation Guide Version 10.6 (page 175) addresses the “Sig Free Text String Indicator”. It states there are three options for the value that may be entered here and the definition for each is provided. It is recommended that for those implementing Sig with SCRIPT Version 10.6, value 2 be used.

Value 1. Capture what the MD ordered. **This value is sunsetted in future versions of SCRIPT, so its use is not recommended.**

Value 2. Reconstructed from the structured Sig. Use of this value indicates that the Sig Free Text String is created by constructing the string from the individual elements of the Sig.

Value 3. Pure free text. **Value 3 is not used in the SCRIPT Standard Version 10.6.** If the structured Sig cannot be generated, the segment is not used.
9.12.6 HOW DO I SEND A PRESCRIPTION THAT INCLUDES A FREQUENCY (TWICE PER DAY) AND SPECIFIED TIMES, SUCH AS “TAKE TWICE DAILY AT 9:00 A.M. AND 5:00 P.M.”?

For clarity, it is recommended that if the prescriber is directing specific times, the hours are specified in the Administration Timing segment. The additional “twice daily” is redundant and can cause confusion. If the prescriber is not directing specific times, the administration information (9 am and 5 pm in this example) are administration instructions, but not part of the sig directed by the prescriber and as such are not included in the Sig.

In long term care, the prescriber may specify a sig of “Twice Daily”. The facility, acting as an agent, includes the administration timing per established protocol (e.g. 9:00 a.m. and 5:00 p.m.). This information is not included in the Sig.

9.12.7 HOW DO I SEND A STRUCTURED SIG IF THE TEXT IS GREATER THAN 140 CHARACTERS?

If information related to the sig does not fit, <Note> should not be used. An alternate method of sending the prescription should be used.

In SCRIPT Standard Implementation Guide Version 10.6, the <Directions> element is limited to 140 characters, which can be a challenge for long directions/Sigs. This issue has been addressed in a future version of the SCRIPT Standard.

See section “Directions/Sig” for more guidance that can be used in any applicable setting.

9.12.8 CAN I INCLUDE THE PATIENT’S HEIGHT AND/OR WEIGHT IF I AM NOT Sending a DOSE CALCULATION FORMULA?

Patient’s height and/or weight can be sent in the Observation Segment in any prescription, regardless of whether dose calculation is included. See sections

- “Recommendations for ePrescribing Best Practices of Patient Height, Weight, Contact, Insurance, and Diagnosis Information”
- “Best Practices for the Use of Medication <Note> (or Free Text)” and
- “Directions/Sig”.

9.12.9 WHAT IF THE DOSE AMOUNT AND/OR DURATION ARE NOT QUANTIFIABLE?
In SCRIPT Standard Implementation Guide Version 10.6, these fields are numeric only. If the dose amount and/or duration are not quantifiable, i.e. “pea-sized amount” “until gone”, then Structured Sig is not used. The sig should be sent as free text. This issue has been addressed in a future version of the SCRIPT Standard.

**9.12.10 Where do I send the SNOMED CT® Concept ID for “Per Manufacturer Package Instructions” or “Per Instructions Provided in Medical Encounter”?

The SNOMED CT® Concept ID should be sent only in the <DoseDeliveryMethodCode> field and <DoseCompositeIndicator> Value 1 = Specified. The text field should always contain the textual representation of the code. Including this in other fields, such as <AdministrationTiming> may cause confusion to the receiver.

For “Take as per medical encounter instructions”
  Use SNOMED CT® Concept ID for “Provider medication administration instructions”.  
  The code is 422037009.

For “Take as per manufacturer package instructions.”
  Use SNOMED CT® Concept ID for “Instructions from the medication manufacturer”.  
  The code is 446291000124107.

**9.12.11 How do you express similar but distinct concepts?

There are multiple ways to express similar ideas especially in the written/spoken language. SNOMED CT® Concept IDs are precise and the ramifications of the nuances between the concepts should be considered.

For example, the intents of “daily”, “1 time per day”, and “once a day” represent the same idea stated different ways. However, there are different SNOMED CT® Concept IDs in cases where similar words have different meanings in different contexts.

“Day” represents a time frame (i.e. “1 time per day”, “once a day”). “Daily” represents a time pattern. The SNOMED CT® Concept ID for “day” (258703001) is to be used rather than the Concept ID for “daily” (69620002) when relaying a unit of measure.

**9.12.12 Does duration support just length of therapy, or also number of doses?

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*SCRIPT Implementation Recommendations*

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<Duration> is defined as the “duration of use/therapy” and duration is generally defined as “the length of time something continues or exists”. Therefore, &lt;DURATION&gt; should only be used to support length of therapy. The Maximum Dose Restriction elements should be used when the number of doses is limited by the prescriber.

9.12.13 **WHEN THERE ARE MULTIPLE LOOPS NEEDED TO COMMUNICATE THE SIG, (E.G. TAKE 2 TABLETS AS ONE DOSE ON FIRST DAY, THEN TAKE ONE TABLET DAILY) _WHAT SHOULD BE POPULATED IN SIGFREE TEXT FOR EACH LOOP?**

Inconsistencies in the following documents have been identified and are being corrected: NCPDP SCRIPT Implementation Guide v10.6, SCRIPT Implementation Recommendations Document v1.35 and Structured and Codified Sig Format Implementation Guide v1.2. The guidance that should be followed is that of the Structured and Codified Sig Format Implementation Guide, which states: “When multiple iterations of the Sig Segment are used, the free text string must contain information relevant to that iteration only.”

The MultipleSigModifier should be included in the preceding loop.

Please refer to 8.2 EXAMPLE 2: PREDNISONE TAPERING DOSE SIG in Structured and Codified Sig Format Implementation Guide v 1.2. Also refer to examples Take 2 Tablets By Mouth As One Dose On the First Day Then Take One Tablet Daily, Take 1 Tablet By Mouth Every 4 To 6 Hours As Needed For Pain and Take 1 To 2 Tablets By Mouth Every 4 To 6 Hours As Needed For Pain in this document.

9.12.14 **SHOULD THE TEXTSTRING REFLECT THE SAME CONTENT WHEN THE SIG IS “TAKE ONE TABLET ORALLY TWICE PER DAY”, “TAKE ONE TABLET ORALLY EVERY TWO DAYS” OR “TAKE ONE TABLET ORALLY FOR TWO DAYS”?**

Yes, the strings would be the same: take 1 oral route 2 day. When the string is sent the following guidance is recommended. It will help support transmission and interpretation of the prescribers intended sig. If both the sender and receiver support structured sig, both systems would have the correct code for the applicable timing element (frequency, interval, duration).

- Frequency is events per unit of time.
- Interval is the time between events.

In order to assist implementers, the following is suggested when constructing the TextString:

- When the timing element specifies the frequency add “per” before the &lt;FrequencyUnitsText&gt;
- When the timing element specifies the interval add “every” before the &lt;IntervalNumericValue&gt;
- When the timing element specifies the duration add “for” before the &lt;DurationNumericValue&gt;
When concatenating free text, you may add additional language to make the sig readable to a system not processing the structured sig, provided it does not conflict with data in the structured sig. For example, you may use the following logic:

- **Added before Numeric Value**
  - Take 1 tablet oral route every 2 day (Interval)
  - Take 1 tablet oral route for 2 day (Duration)*

- **Added before Units Text**
  - Take 1 tablet oral route 2 per day (Frequency)

*Note: this example is being used for demonstration purposes: including duration without additional timing instructions is not recommended.

### 9.12.15 How do I send a structured sig for “As Needed” prescriptions without an indication for use?

It is recommended, and required in some care settings, that an indication be included on the prescription whenever the administration instructions state “as needed” or “PRN” to designate the specific circumstances or conditions for when the medication administration is needed. Prescribers should be aware that sending “as needed” without an indication may result in contact from the pharmacy to obtain clarification. If the prescriber still wishes to send an “as needed” or “as required” prescription without a specific indication, it can be sent as follows.

For SCRIPT 10.6:

Use the SNOMED code of 225761000 in the `<IndicationPrecursorCode>` and its associated text string of “as required” in `<IndicationPrecursorText>` and do not populate anything within either `<IndicationText>` and `<IndicationTextCode>`. Send the SNOMED code of 2667000 within the `<IndicationValueUnitofMeasureCode>` and its corresponding text translation of “absent” within the `<IndicationValueUnitofMeasureText>`. Note: `<IndicationValueUnitofMeasureText>`, `<IndicationValueUnitofMeasureCodeQualifier>` and `<IndicationValueUnitofMeasureCode>` are required in the schema whenever the `<Indication>` Composite is utilized, so they must be transmitted although no indication for use is specified. The value within the `<IndicationValueUnitofMeasureText>` will not be included in the `<SigFreeText>`, as this text string is technically not part of the prescriber’s instructions for how to take or administer the prescribed product and may introduce additional confusion if it is interjected and read along with actual patient medication instructions.

Similarly, when indications are sent in the message and paired with the `<IndicationValueUnitofMeasureCode>` of “52101004”, the corresponding value within `<IndicationValueUnitofMeasureText>` shall not be included in the final string within the `<SigFreeText>` either.
9.12.16 **WHAT SIG INFORMATION SHOULD BE SENT IN MESSAGES FROM THE PHARMACY (E.G. REFILL REQUEST, CHANGE REQUEST, FILL STATUS)?**

- Pharmacies that support Structured Sig should **echo** the StructuredSig elements sent by the prescriber in the MedicationPrescribed loop and **build** the StructuredSig data elements in the MedicationDispensed loop based on the sig used for dispensing medications to the patients.
- Pharmacies that do not support Structured Sig should send the SigText String in both the MedicationPrescribed and MedicationDispensed loops.


If “as directed” is part of the Sig, e.g. “take one tablet daily as directed”, then the structured sig, using `<DoseAdministration>` should be followed including “as directed” as `<ClarifyingFreeText>`. In this situation, the prescriber is providing some detail as to how the prescription is to be administered, and it is presumed supplemented with other information the prescriber gave the patient.

9.12.18 **HOW DOES THE STRUCTURE WORK IF THE DOSE AMOUNT IS NOT SPECIFIED? E.G. “APPLY TO AFFECTED AREA”**

If the dose amount is not specified for topical products, the SNOMED value of 10003008 “Unspecified” should be used. Unspecified must not be used for oral dose forms. When appropriate, the DoseDeliveryModifier should also be used, i.e. liberally, sparingly.

9.12.19 **IF MY SIG DOES NOT HAVE A SPECIFIC DISCRETE DOSE VALUE (I.E. FOR TOPICAL MEDICATIONS) OR A ROUTE OF ADMINISTRATION (I.E. FOR DURABLE MEDICATION EQUIPMENT OR TESTING SUPPLIES), AND I ENTER THE SNOMED CT CODE FOR “UNSPECIFIED” IN A REQUIRED FIELD, SHOULD THE TEXTUAL TRANSLATION OF THIS CODE BE INCLUDED IN THE SIG TEXT FIELD FOR THE COMPLETE SIG OVERALL?**

No, the inclusion of the text string “Unspecified” in the Sig Text field (e.g. Apply sparingly unspecified to the lower left arm twice daily as needed for pruritus) is not considered appropriate, as the recipient does not derive any value or benefit from the inclusion of the “Unspecified” text string, and may even experience confusion from its inclusion as part of the overall Sig text. Thus, systems implementing Codified Sig should develop logic to ensure the textual translation of the SNOMED CT code for “Unspecified” (including any synonyms) is excluded from the final string in the <Sig Text> field.

9.12.20 **IF THERE IS NOT A SNOMED CODE FOR A PARTICULAR ELEMENT HOW DO I USE STRUCTURED AND CODIFIED SIG?**

If possible use the ClarifyingFreeText field for the element not coded in SNOMED and contact SNOMED to request the addition. If ClarifyingFreeText is not sufficient, then directions must be populated in the SigText field and the structured fields would not be populated.
9.12.21 **DOES THE WAY THAT MY SYSTEM CREATES THE WORDING OF THE <SigText> FIELD NEED TO MATCH WHAT THE NCPDP STYLE SHEET REFLECTS?**

No. The <SigText> must contain either completely free text with no corresponding structured content OR be generated from the structured Sig that contains all the elements semantically captured by and corresponding to the codified elements and clarifying free text fields. 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 representations must semantically match with the string in the <SigText>. THE NCPDP Style Sheet is provided as guidance; neither its use nor conformance is required.

- Route of Administration is required unless “Per Medical Encounter Instructions” or “Per Manufacturer Package Instructions” is used. How should Route of Administration be populated if the prescribed product does not have a Route of Administration, such as for durable medical equipment?

In this case, the SNOMED code of 10003008 for unspecified should be used. This is only to be used for products that do not have a route of administration and dose form, such as diabetic supplies and durable medical equipment.

9.12.22 **IS IT POSSIBLE TO CREATE A SIG THAT INCLUDES MORE THAN ONE DoseUnitOfMeasure? FOR EXAMPLE, IF THE PRESCRIPTION IS FOR NYSTATIN SUSPENSION, DOES THE STRUCTURED AND CODIFIED SIG SUPPORT “GIVE 1ML (100,000 UNITS) BY MOUTH THREE TIMES A DAY”?**

No, structured and codified Sig does not support more than one DoseUnitOfMeasure. For the example provided, you must specify the dose, in DoseUnitOfMeasure in either mL or Units, but not both, using the appropriate code.

9.12.23 **ARE ROUTE OF ADMINISTRATION AND SITE OF ADMINISTRATION INTERCHANGEABLE IF I CAN ONLY ACCOMMODATE ONE AND NOT BOTH IN MY SYSTEM’S SIG-BUILDER TOOL?**

No. While they are very closely related, <RouteOfAdministration> and <SiteOfAdministration> are two separate composites in the schema intended to accommodate two different aspects of the Sig. For example, if a Sig states “Instill 1 drop into left eye three times a day”, the Site of Administration in this Sig would be “Left Eye”, while the Route of Administration would be “Ophthalmic”, which is implicit, albeit not explicitly stated in this particular Sig free-text string. This is also exemplified in Sigs such as “Instill 1 drop in both ears once daily” or “Apply a pea-sized amount to affected areas of the skin three times a day”, where the Sites of Administration would be “both ears” and
“affected areas of the skin” respectively, and the implicit Routes of Administrations would be “Otic” and “Topical”, respectively. When building out the codification and mappings for the Sig, if a Sig builder tool can only accommodate the specifying of a Site by the prescriber, the SNOMED CT code for <RouteOfAdministration> may be also implicitly associated with the Site as described above – e.g. “Otic” for Sites of Administration related to “both ears”, “left ear”, “right ear”, etc. and “Ophthalmic” for Sites of Administration related to “both eyes”, “left eye”, and “right eye”.
10. ELECTRONIC PRIOR AUTHORIZATION (ePA) GUIDANCE

Information on the ePA overview and process is available at http://www.ncpdp.org/Resources/ePrescribing under NCPDP Resources and at http://www.ncpdp.org/Resources/Hot-Topics

Recommendations from the National Committee on Vital and Health Statistics to the Secretary of the Department of Health and Human Services May 15, 2014:

Recommendation 1: HHS should name the NCPDP SCRIPT Standard Version 2013101 Prior Authorization transactions as the adopted standard for the exchange of prior authorization information between prescribers and processors for the pharmacy benefit.

Recommendation 2: HHS should adopt Recommendation 1 under the most appropriate regulatory sections and processes that would enable prompt industry implementation and at the earliest possible implementation time.

10.1 CLOSED IN PAInitiationResponse

Question: Are payers able to adjudicate a PA without having to process a PARequest? If not, why are there composites for <AuthorizationNumber>, <AuthorizationDetails>, and <AuthorizationPeriod> in the PAInitiationResponse?

Answer: No. These fields are not used to indicate that the payer is approving the requested PAInitiationRequest. These fields are only to be used in the PAInitiationResponse 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.

10.2 RESPONSE TO PA REQUEST TRANSACTIONS

Question: Can the response to a PA request transaction (i.e., PAInitiationRequest, PARequest, PAAppealRequest and PACancelRequest) be a PA response transaction (i.e., PAInitiationResponse, PAResponse, PAAppealResponse and PACancelResponse), or does the response have to be a Status, Error or Verify transaction?

Answer: The response to a PA request transaction is either a Status, Error or Verify transaction. This applies to the PA response transactions as well – the response to a PA response transaction is either a Status or Error or Verify transaction. The Status transaction indicates the PA request/response transaction was successfully received and accepted for processing. The Error transaction indicates the PA request/response transaction was not successfully delivered or was not accepted for processing. The Verify transaction communicates to the sender that the receiver has received the transaction. More information on the Status, Error, and Verify transactions is available in the NCPDP XML Standard document.
SCRIPT Implementation Recommendations

The SCRIPT Standard Implementation Guide reflects this transaction flow for the PA transactions in the figures throughout section 5.18 and the PA transaction examples in sections 11.31 – 11.35. This transaction flow provides a consistent response to the prescriber system and the prescriber regardless of the payer they send a PA request transaction to or the amount of time needed by the payer to process the PA request transaction and return a PA response transaction.

10.3 DEnyINg A PACancelResponse

**Question:** Some of our participants are asking about the use case for a payer denying a PACancelRequest. The payer can send a <Denied> PACancelResponse for the following reasons:

1) BZ – Can’t find PA Case ID
2) CA – Unable to locate based on insufficient information/identifiers do not match
3) CB – Request already processed/final determination has been made
4) BY – Other

If the payer responds with anything but CB, what is the expectation for the prescriber vendor?

**Response:** The expectation for the reject scenario, as with other SCRIPT transactions, is to fix whatever was wrong and send a corrected PACancelRequest. If the transaction cannot be corrected, manual procedures should be used. The payer may return a help desk number for more assistance.

10.4 Best Practices for the Use of Attachments in Electronic Prior Authorizations

To maximize automation and reduce administrative burdens for both providers and payers, attachments should only be used when the required information cannot be sent in a discrete field within the SCRIPT ePA transactions or when the review criteria clearly requires progress notes, lab results, imaging and other supporting information that is not transferable to a discrete field within the transaction. Payers considering use of attachments in ePA should first closely review the ePA question set capabilities to ensure the required data cannot be captured within a discrete field. The industry should work towards exclusive use of structured data (either in discrete fields in the SCRIPT ePA transactions or in codified, structured HL7 C-CDA attachments) in the SCRIPT ePA transactions by 2019 to eliminate the need for manual processing of PA requests.
10.5 Partially Denied Electronic Prior Authorization for v10.6

**Question:** How should a partially denied ePa be handled in SCRIPT versions prior to the 2015 versions?

**Response:** When a plan approves a prior authorization but with some limitations the PA is considered partially denied. Until there is a discrete <ResponseStatus> in the PAResponse for partially denied, plan will not send back partial prior authorization denials.

The EMR can expect that any PAResponse returned by the plan in an <Approved> status approves the requested medication. This ensures that EMRs do not have to develop special logic to compare the authorization details returned by the plan in the PAResponse with the medication prescribed in the PAInitiationRequest.

10.6 Modification to a Recently Sent Electronic Prior Authorization

**Question:** A prescriber initiates an electronic prior authorization or sends an electronic prior authorization request. The prescriber then determines that some of the details need to be modified. For example, the quantity or day supply need to be modified. How should this be done?

**Response:** If the prescriber wants to modify details such as quantity or days supply for which a PAInitiationResponse or a PAResponse has been received, a PACancelRequest must be sent to cancel the initial <PACaseID>. The prescriber should then submit a new PAInitiationRequest with the revised information. 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. While it is ideal for the prescriber to wait for a PACancelResponse prior to sending a new PAInitiationRequest, a delay may prevent a patient from receiving the medications needed, thus in this case the PAInitiationRequest may be sent prior to receiving the PACancelResponse.

10.7 Pharmacist Initiated Electronic Prior Authorization

**Question:** Can a pharmacist initiate/request an ePA?

**Response:** Yes, as the transaction supports the submission of prescriber, provider and pharmacy information. The header information identifies the sender and receiver. The prescriber and pharmacy segments are required.
When the pharmacist is submitting on behalf of the prescriber, the provider segment must be populated with the submitting pharmacist’s information, the prescriber segment must be populated with the prescriber’s information and the pharmacy segment must be populated with the dispensing pharmacy’s information.

When the pharmacist is the prescriber, the prescriber segment must be populated with the pharmacist’s information and the pharmacy segment must be populated with the dispensing pharmacy’s information; the provider segment is not sent.

If the receiver (i.e. PBM, PA Processor) does not accept PA requests from pharmacists, they should respond to the message (PAInitiationRequest, PARequest) using ReasonCode10 “BY” (Other) and a note stating “Pharmacist is not allowed to submit ePA request.”

### 10.8 EXPECTED BEHAVIOR FOR THE `<RANGECOMPARISON>` ELEMENTS

**Question:** What is the expected behavior for the `<RangeComparison>` element when there are multiple comparisons?

**Response:** Expected usage of And/Or when using two comparison operators in a range comparison is shown in the table below:

<table>
<thead>
<tr>
<th>LowerBoundComparisonOperator</th>
<th>UpperBoundComparisonOperator</th>
<th>AND/OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>LT</td>
<td>GT</td>
<td>OR</td>
</tr>
<tr>
<td>LT</td>
<td>GE</td>
<td>OR</td>
</tr>
<tr>
<td>GT</td>
<td>LT</td>
<td>AND</td>
</tr>
<tr>
<td>GT</td>
<td>LE</td>
<td>AND</td>
</tr>
<tr>
<td>LE</td>
<td>GT</td>
<td>OR</td>
</tr>
<tr>
<td>LE</td>
<td>GE</td>
<td>OR</td>
</tr>
<tr>
<td>GE</td>
<td>LE</td>
<td>AND</td>
</tr>
<tr>
<td>GE</td>
<td>LT</td>
<td>AND</td>
</tr>
</tbody>
</table>

All other combinations would be invalid and should be represented using a single comparison instead.

### 10.9 DOSESPerDay AND PADaysSupply

**Q:** Since there are duplicative elements for days supply, i.e. existing DaysSupply vs new PADaysSupply, how should EHRs and PBMs handle
A: An error has been found in the schema which requires both DaysSupply and DosesPerDay within the PADaysSupplyDosePerDay composite. The schema will be corrected to accurately reflect that either DaysSupply or DosesPerDay can be sent when populating this composite. Also, the PADaysSupplyDosePerDay composite is unbound and it will be updated to one loop when populating with DaysSupply and/or DosePerDay. It is strongly recommended that the PADaysSupplyDosePerDay composite be used in place of the single DaysSupply element within the MedicationPrescribed segment for PA transactions.
11. EDITORIAL MODIFICATIONS

11.1 XML MODIFICATIONS

11.1.1 DATE ISSUED (WRITTEN DATE) ANNOTATION
In the SCRIPT Imp Guide, in 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.

11.1.2 ADVERSE EVENT
Under Census->Allergy AdverseEvent is marked as mandatory. This should be optional because if No Known Allergies is set to Yes, then this is the only tag that is sent. This error has been corrected in SCRIPT XML 10.6 and then in 10.11 and above.

11.1.3 DIAGNOSIS PRIMARY
An error was noted into the XML for SCRIPT 10.6 and previous for the values of this element. Previous XML versions supported all four values for ICD, two of which were duplicative.

The 10.6 list has
E|F|M|ABF|DX|ICD9|ICD10
which means
ICD9 and ICD10 were duplicative of DX and ABF.

The correct values are the DX and the ABF, since the list came from X12. The correction was made to the ECL in May 2004, and is in SCRIPT Imp Guide version 5.0. The XML wasn’t corrected. DX and ABF are the correct values.

“DX=“International Classification of Diseases-9- Clinical Modifications-Diagnosis (ICD-9-CM-Diagnosis)”
“ABF= International Classification of Diseases-10- Clinical Modifications (ICD-10-CM)”

This was corrected in SCRIPT 2010121 XML release.
11.1.4 **PACodedReferenceCode**
The correct value is ABF, but was inadvertently listed as ABX. It is listed in the External Code List under CodedReferenceQualifier. This has been corrected in 2013101 and above.

11.1.5 **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.

11.1.6 **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 2011 schema and has been corrected in the SCRIPT 2010123 and above schemas to not allow an empty tag to be sent.

11.1.7 **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.

11.1.1 **ResponsibleParty**
A typographical error was found in the element <ResponsibleParty> it was listed as <ResponsibileParty>. This was been corrected in 201109 SCRIPT 10.6 schema and in the model-driven schemas of 201012 and above.

11.1.2 **SourceQualifier**
A typographical error was found in the element <SourceQualifier> it was listed as <SourceQualifer>. This was been corrected in 201109 SCRIPT 10.6 schema and in the model-driven schemas of 201012 and above.

11.1.3 **RxHistoryRequest and Response - <Prescriber> and <Pharmacy>**
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 in schemas for versions SCRIPT 10.6 and above 201203.
11.1.4 RXHISTORYRESPONSE <MEDICATION> CHOICE

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” in the SCRIPT Implementation Guide and the schema have been updated in SCRIPT version 2013101 updated May 2014 and in versions above. This is effective for all versions of the schema. The choice is optional. The corrected diagram is shown below.
11.1.5 **<PATIENT> FIELDS ORDER**
An error was found in the <Patient> order of fields in SCRIPT version 10.6 in some of the transactions. The correct order is <PatientRelationship> <Identification> <Name> <Gender> <DateOfBirth> <Address> <CommunicationNumbers> <PatientLocation>. The October 2012 publication of the SCRIPT version 10.6 schema has been corrected.

11.1.6 **<PASSWORDREQUESTTYPE> AS A CHOICE**
An error was found from the original schemas from the industry that NCPDP incorporated into the standard. In the PasswordChange transaction, the <PasswordRequestType> was a choice. It should have been a sequence, in sync with the EDI format (in a Password Change transaction the old and new passwords are submitted). This transaction has limited use and was not caught originally. The December 2012 SCRIPT 10.6 xsd was corrected. The 2010+ model driven schemas were already correct.

```xml
<xs:complexType name="PasswordRequestType">
  <xs:choice>
    <xs:element name="OldPassword"/>
    <xs:element name="NewPassword"/>
  </xs:choice>
</xs:complexType>
```

was changed to the sequence:

```xml
<xs:complexType name="PasswordRequestType">
  <xs:sequence>
    <xs:element name="OldPassword" type="datatypes:an"/>
    <xs:element name="NewPassword" type="datatypes:an"/>
  </xs:sequence>
</xs:complexType>
```

11.1.7 **<APPROVEDWITHCHANGESTYPE>**
An error was found in the SCRIPT 8.1 through 10.9 schemas where this type included the element <DenialReasonCode>. It should have been <ReasonCode>. While the tag appears incorrect (a denial in an approved situation), the code sets for both are the same. This was corrected in SCRIPT 10.10 and above.

11.1.8 **<ADDRESSTYPEQUALIFIER>**
A typographical error was found in the annotation of this element. Value P is for Pharmacy, not Prescriber. It has been corrected in version 2013 and above, but should be noted for any version with the typo.
11.1.9 <SUBSTITUTIONS>
In Version 20120111, 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:

- NewRxPrescribedMedication
- HistoryPrescribedMedication
- PrescribedMedication
- ResupplyMedication

This was incorrect. Substitutions were meant to be limited to values of 0 and 1 in all SCRIPT transactions. This has been corrected.
11.1.10 STATUS, ERROR, AND VERIFY ANNOTATION CLARIFICATIONS

The annotations in the Status, Error, and Verify transactions for <Code> and <Description> were clarified; the intent was not changed. An example was removed in the Verify guidance in the annotation for Status or Error. These are applicable to all versions of SCRIPT but will be published in the XML files above 201307.
11.1.11 <RelatesToMessageID> in Electronic Prior Authorization Examples

A correction was made to section “Trace Number Usage”, subsection “Example 15” and “Example 16” in the <RelatesToMessageID> in the XML Standard above version 2014041. This is applicable to all previous versions with these examples.

Example 15:

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;MessageID&gt;</td>
<td>123</td>
</tr>
<tr>
<td>&lt;RelatesToMessageID&gt;</td>
<td>123</td>
</tr>
<tr>
<td>&lt;PAReferenceNumber&gt;</td>
<td>XYZ</td>
</tr>
<tr>
<td>&lt;PACaseID&gt;</td>
<td>999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status from Processor</td>
<td>Status from Prescriber</td>
</tr>
<tr>
<td>&lt;MessageID&gt;</td>
<td>111</td>
</tr>
<tr>
<td>&lt;RelatesToMessageID&gt;</td>
<td>123</td>
</tr>
</tbody>
</table>

Example 16:

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;MessageID&gt;</td>
<td>123</td>
</tr>
<tr>
<td>&lt;RelatesToMessageID&gt;</td>
<td>123</td>
</tr>
<tr>
<td>&lt;PAReferenceNumber&gt;</td>
<td>XYZ</td>
</tr>
<tr>
<td>&lt;PACaseID&gt;</td>
<td>999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status from Processor</td>
<td>Status from Prescriber</td>
</tr>
<tr>
<td>&lt;MessageID&gt;</td>
<td>111</td>
</tr>
<tr>
<td>&lt;RelatesToMessageID&gt;</td>
<td>123</td>
</tr>
</tbody>
</table>

11.1.12 <ItemNumber> in <CompoundIngredient>

An error was corrected in the xml schema. It affects version 201310 and above. Because the industry is actively implementing version 2013101 for ePA transactions, a new version was created of 2013102 with the modification so that the change was noted. In version 201404 and above
the xml schema was republished since these versions were not in use. 〈ItemNumber〉 inadvertently dropped the subelements of 〈Code〉 and 〈Qualifier〉 in these versions. It has been corrected.

11.1.13 PATIENTCODIFIEDNOTES
An error was corrected in the xml schema. It affects version 2017071. The conditionality of the elements 〈Qualifier〉 and 〈Value〉 were incorrect. 〈Qualifier〉 is mandatory and 〈Value〉 is optional.

11.1.14 V20170712 REPUBLICATION MODIFICATIONS
The following modification were made to the 2017071 schema resulting in v20170712

Correct typo in 〈ClinicalInfoTypesRequested〉 value of “TransplantHealthCareFacilityDischargeDateNonMedicare”. The “l” was missing from Health.

Correct typo in 〈OtherMedicationDateQualifier〉 value of “AnticipatedHealthCareDischargeDate”TransplantHealthCareFacilityDischargeDateNonMedicare”. The “l” was missing from Health.

Correct issues with 〈Identification〉 in 〈FollowUpPrescriber〉. 〈Identification〉 is optional with a maximum repeat of 1.

Removed 〈SelfAdministrationAllowed〉 from the following Medication composites:
- DrugAdministrationMedication
- Medication
- MedicationAbstract
- NewRxPrescribedMedication
- NewRxRequestedMedication
- OptionalMedication
- PrescribedMedication
- PrescribedMedicationForCancelRx
In the RxFill message added annotation of “When Medication Prescribed Loop is not sent, Written date must be sent. When sending Fill Status types of Dispensed or Partially Dispensed, the Medication Dispensed segment must be sent. When sending Fill Status types Not Dispensed or Transferred, then the Medication Prescribed or Medication Dispensed may be sent.”


- FollowUpPrescriber
- HistoryPrescriber
- MandatoryPrescriber
- OptionalPrescriber
- Prescriber
- PrescriberGeneral
- Provider
- Supervisor
- SupervisorMandatoryAddress
- SupervisorOptional
11.1.15 V20170713 REPUBLICATION MODIFICATIONS – MAY 2018
Updated the annotation for CoAgentQualifier value “33” to: *A six-character numeric indicator that identifies a unique combination of active ingredients, irrespective of the manufacturer, package size, dosage form, route of administration, or strength.*

Updated the annotation on NeedNoLaterThanDate to: *For the facility to relay to the long term care pharmacy the timeframe when medication is needed for delivery. When a facility transmits either a new medication order (NEWRX) or request for the re-supply of a medication (RESUPPLY) to a pharmacy, it would optionally indicate the time by which the medication is needed. The facility could also provide a textual reason why the medication is needed by the time specified.*

The long term care pharmacy would then use this information to determine whether a special delivery is required, or whether the order could go out with the next scheduled delivery.

Updated the annotations on the following REMS transactions as follows:
- REMSInitiationRequest: *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.*
- REMSRequest: *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.).*

11.1.16 V20170714 REPUBLICATION MODIFICATIONS – JULY 2018
- Updated FillStatus/PartiallyDispensed to point to NoteTypeWithReasonCode21
- Updated annotations for ProductCoded and DrugDBCoded to remove the reference to If CompoundCoded = 2.
- Updated annotation on MessageRequestSubCode to: *To further clarify the MessageRequestCode.*
11.2 **EXTERNAL CODE LIST CLARIFICATIONS**

11.2.1 **INTERNATIONAL UNIT**

In previous versions of the External Code List (ECL), the DRU-020-01 Units of Measure field used a list from ASC X12 stating that value F2 was “International Unite”. ASC X12 modified the typo in a future version to “International Unit”. More recent versions of the ECL have already sunsettied the field. This entry is just to acknowledge that the value corrected is “International Unit”.

Units of Measure

*Please use time qualifiers, units of measure and strength units where appropriate.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>BG</td>
<td>Bag</td>
</tr>
<tr>
<td>BO</td>
<td>Bottle</td>
</tr>
<tr>
<td>BX</td>
<td>Box</td>
</tr>
<tr>
<td>AV</td>
<td>Capsule</td>
</tr>
<tr>
<td>CQ</td>
<td>Cartridge</td>
</tr>
<tr>
<td>CH</td>
<td>Container</td>
</tr>
<tr>
<td>X4</td>
<td>Drop</td>
</tr>
<tr>
<td>GR</td>
<td>Gram</td>
</tr>
<tr>
<td>IH</td>
<td>Inhaler</td>
</tr>
<tr>
<td>F2</td>
<td>International Unit should be International Unite</td>
</tr>
</tbody>
</table>

11.2.2 **PACODEDREFERENCECODE**

The correct value is ABF, but was inadvertently listed as ABX. It is listed in the External Code List under CodedReferenceQualifier. This has been corrected in 2013101 and above.

11.3 **IMPLEMENTATION GUIDE CLARIFICATIONS**

11.3.1 **CLARIFICATION OF NUMERIC REPRESENTATION**

The section “Numeric Representation” in the SCRIPT Implementation Guide (version 10.11 and below) or in the XML Standard (2010121 and above) has clarified the Example. For other versions, this document provides the clarification.

From

Example. Consider the following possible values for a 5 digit field.

To

Example. Consider the following possible formats for a 5 digit numeric field.

**Numeric Representation**

A period is used to denote the decimal point. The decimal point, when present, must be counted when computing the maximum length of a data element. The decimal point should only be used when there are significant digits to the right of the decimal. It should not be used with whole numbers. If the decimal point is necessary, there must be at least one digit before and after the decimal point (i.e., 0.5).

Example. Consider the following possible formats for a 6 character numeric field.

Recommended:  1.2345, 123.45, 12345, 0.1234, 1.2, 1234.5

Not Recommended: .123, 12345., 1.00

11.3.2 **TIME FORMAT**

EDIFACT uses HHMMSS,S, where “,S” is milliseconds. Example 101522,6.

11.3.3 **SOURCE QUALIFIER (010-5021-01-7895) VALUE**

From the SCRIPT Imp Guide - 020-1154 - Prescription Number associated to medication history record.
If Source Qualifier (010-S021-01-7895) value is “P2” (Pharmacy), if sent, this field must contain the pharmacy’s prescription number.

**Question:**
Does this statement mean that if P2 is sent, then the field must contain prescription number?  
**OR**
Does it mean that you never need to send this field, but if you choose to send it and source is “P2”, then it must be populated with the pharmacy prescription number?

If Source Qualifier (010-S021-01-7895) value is “PC” (Prescriber), this field is not sent. The Prescriber Order Number is found in DRU-080-I001-01-1154 Reference Number.

If Source Qualifier (010-S021-01-7895) value is “PY” (Payer), if sent, this field must contain the pharmacy’s prescription number from the payer system from claims processing.  
*Same questions as above but related to PY.*

**Response:**
“If the submitter chooses to send this field and source qualifier is “P2”, then it must be populated with the pharmacy prescription number. Otherwise, the field is not sent.” (This also applies to the Fill Number from the pharmacy.)

If the source is the prescriber, this field is not sent.

If the source is the payer, this field contains the pharmacy’s prescription number from the payer system from claims processing. (This also applies to the Fill Number from the pharmacy.)

**11.3.4 COO SEGMENT**

**Question:**
What is the correct order for the EDIFACT COO Segment? Some tables it after the OBS Observation Segment; others show it after the PTT Segment and before the DRU Segment. Examples show it before the DRU Drug Segment.

**Response:**
The EDIFACT syntax doesn’t appear to care inside the headers. The table in section “*Structure Quick Reference*” is the best resource. For testing NIST will adjust for the COO Segment after the OBS Segment.

**11.3.4.1 CLARIFICATION OF CARDHOLDER ID (COO-04-I001-01-1154) DESIGNATION**

**Question:**
Cardholder ID has the designation of CM but is it part of a composite?

**Response:**
Yes it is part of a composite. See section “*Transmission from Sender to Receiver Structure*” in the SCRIPT Imp Guide. The chart in section “*Specific Segment Discussion*” just does not show the not used field.

<table>
<thead>
<tr>
<th>Segment</th>
<th>Reference</th>
<th>Qualifier</th>
<th>Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>040 I001</td>
<td>Reference Number</td>
<td>C</td>
<td>1</td>
</tr>
<tr>
<td>01</td>
<td>1154 Reference Number</td>
<td>M</td>
<td>an..35</td>
</tr>
<tr>
<td>02</td>
<td>1153 Reference Qualifier</td>
<td>C</td>
<td>an..3</td>
</tr>
</tbody>
</table>

**COO COORDINATION OF BENEFITS SEGMENT**
11.3.5 Clarification of UIT Fields

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Remarks</th>
<th>STANDARD FORMAT</th>
<th>NE RX</th>
<th>REFREQ or RESUPP</th>
<th>RX CHG</th>
<th>RX HREQ</th>
<th>RX HRES</th>
<th>CENSUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>04-0001-01-1154</td>
<td>Reference Number</td>
<td>Cardholder ID</td>
<td>CM</td>
<td>CM</td>
<td>CM</td>
<td>CM</td>
<td>CM</td>
<td>CM</td>
<td>CM</td>
</tr>
</tbody>
</table>

UIT Interactive Message Trailer

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Field Name</th>
<th>Remarks</th>
<th>STANDARD FORMAT</th>
<th>ALL TRANSACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>000-5019-01-0013</td>
<td>Segment code</td>
<td>Value: UIT</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>010-0062</td>
<td>Message Reference Number</td>
<td>Must be the same value as in UIH 0062. This field is Mandatory.</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>020-0074</td>
<td>Number of Segments in Message</td>
<td>Mandatory field. This is the count of the number of segments in the message including the UIH and UIT.</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

Clarification: For all versions of SCRIPT that contain the EDIFACT syntax

- 010-0062 Message Reference Number is conditionally required (it must be mirrored based on the UIH 0062 field).
- 020-0074 Number of Segments in Message is Mandatory. All Transactions column should be M.

11.3.6 CoAgentIDQualifier

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. This has been corrected in SCRIPT 2013 and above.

11.3.7 <Substitutions>

See section “<Substitutions>” for an important modification.

11.3.8 Multiple Repetitions of the DRU Segment

In SCRIPT Implementation Guides prior to 2010, this section contained the statement

The values of “P”, “D” may only occur once, according to appropriate need in a transaction. A transaction may contain a loop of “P” and “D” for example, in the Prescription Change Request, where the prescriber prescribed x and the pharmacy filled y. But a transaction may not contain multiple “P” or “D”.

The Prescription Change Request does not contain the “P” and “D” DRU Segments. This should have stated

...for example, in the Refill Request, where the prescriber prescribed x and the pharmacy filled y. But a transaction may not contain multiple “P” or “D”.

11.3.9 Transmission Examples

11.3.9.1 Drug Dosage Form

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. This was corrected in SCRIPT Implementation Guides above 2013071.
11.3.9.2 **Example 6 Refill**

In the SCRIPT Implementation Guide “Example 6. Pharmacy Requesting A Refill Authorization For 4 Additional Dispensings From A Prescriber And Prescriber Responding” was corrected in version 2014 and above. It should have been <ApprovedWithChanges> since <PharmacyRequestedRefills> was sent in the RefillRequest. This change applies to version 2010121 and above.

11.3.10 **Lower and Upper Bound Comparison Operators**

<LowerBoundComparisonOperator> and <UpperBoundComparisonOperator> explanation contained a typographical error. “LT” (less than or equal to) should be “LE” in section “Key Question Set Elements”. This was corrected in SCRIPT 2014+ but is effective for all applicable versions.

11.3.11 **<AdditionalFreeTextIndicator>**

In the SCRIPT Implementation Guide, a typo was corrected that <AdditionalFreeTextIndicator>, the three values are M, O, and NA. This was corrected in SCRIPT 2013101 but is effective for all applicable versions.

11.3.12 **Example 33. Prior Authorization Denial and Appeal Correction**

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. This was corrected in SCRIPT 2014+. The corrected XML appears below.

```xml
<?xml version="1.0" encoding="UTF-8"?>
<!--Sample XML file generated by XMLSpy v2010 (http://www.altova.com)-->
  <transport:Header>
    <transport:To Qualifier="C">7777777</transport:To>
    <transport:From Qualifier="ZZZ">PAYER123</transport:From>
    <transport:MessageID>8892</transport:MessageID>
    <transport:RelatesToMessageID>1234571</transport:RelatesToMessageID>
    <transport:Security>
      <transport:UsernameToken>
        <transport:Password Type="PasswordDigest">String</transport:Password>
        <transport:Created>2001-12-17T09:30:47Z</transport:Created>
      </transport:UsernameToken>
    </transport:Security>
    <transport:Sender>
      <transport:SecondaryIdentification>PASSWORDA</transport:SecondaryIdentification>
    </transport:Sender>
    <transport:SenderSoftware>
      <transport:SenderSoftwareDeveloper>MD80SYSTEM</transport:SenderSoftwareDeveloper>
      <transport:SenderSoftwareProduct>80</transport:SenderSoftwareProduct>
      <transport:SenderSoftwareVersionRelease>15.2</transport:SenderSoftwareVersionRelease>
    </transport:SenderSoftware>
  </transport:Header>
  <transport:PAAppealResponse>
    <script:PAReferenceID>99QQQ</script:PAReferenceID>
    <script:BenefitsCoordination>
      <structures:PBMMemberID>333445555</structures:PBMMemberID>
    </script:BenefitsCoordination>
    <script:Patient>
      <structures:Identification>
        <datatypes:SocialSecurity>333445555</datatypes:SocialSecurity>
      </structures:Identification>
      <structures:Name>
        <datatypes:LastName>SMITH</datatypes:LastName>
      </structures:Name>
      <structures:Gender>
        <datatypes:DateOfBirth>1954-12-25</datatypes:DateOfBirth>
      </structures:Address>
    </script:Patient>
  </transport:PAAppealResponse>
</transport:Message>
```
</script:Patient>

<script:Pharmacy>
<script:Identification>
<datatypes:NCPDPID>7701630</datatypes:NCPDPID>
<datatypes:NPI>7878787878</datatypes:NPI></script:Identification>
<script:BusinessName>MAIN STREET PHARMACY</script:BusinessName>
<script:CommunicationNumbers><datatypes:PrimaryTelephone><datatypes:Number>6152205656</datatypes:Number></datatypes:PrimaryTelephone></script:CommunicationNumbers></script:Pharmacy>

<script:Prescriber>
<script:Identification>
<datatypes:NPI>666666666</datatypes:NPI></script:Identification>
<script:Name>
<datatypes:LastName>JONES</datatypes:LastName><datatypes:FirstName>MARK</datatypes:FirstName></script:Name>
<script:CommunicationNumbers><datatypes:PrimaryTelephone><datatypes:Number>6152219800</datatypes:Number></datatypes:PrimaryTelephone></script:CommunicationNumbers></script:Prescriber>

<script:MedicationPrescribed>
<structures:DrugDescription>SYMBICORT 80/4.5 METERED DOSE INHALER, 60 ACTUAT</structures:DrugDescription>
<structures:DrugCoded>
<structures:DaysSupply>30</structures:DaysSupply>
<structures:Sig><structures:SigText>TWO INHALATIONS TWICE DAILY</structures:SigText></structures:Sig>
</script:MedicationPrescribed>

<script:Response>
<pa-structures:ResponseStatus>
<pa-structures:AuthorizationDetail>
<pa-structures:NumberOfRefills>11</pa-structures:NumberOfRefills>
<pa-structures:PANote>Prior authorization is granted for the medication as prescribed, for one year's supply.</pa-structures:PANote>
</script:Response>

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11.3.13 <relatestomessageid> in Electronic Prior Authorization Examples

A correction was made to the following Prior Authorization Examples in the <relatestomessageid> in the SCRIPT Implementation Guide above version 2014041. 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 X53 Message ID from the PAInitiationResponse.
PAAppealRequest (from Prescriber)
RelatesToMessageID 8890 Message ID from the PAResponse.

“Example 34. Prior Authorization with Coded Reference”
PARequest (from Prescriber)
RelatesToMessageID X53 Message ID from the PAInitiationResponse.

“Example 35. PA Process Cancelation”
PACancelRequest (from Prescriber)
RelatesToMessageID X53 Message ID of PAInitiationResponse.

11.3.14 <digestvalue> Correction

In section “Digital Signature Elements” of the SCRIPT Implementation Guide, <digestvalue> size was stated as 30 but it is 35. It has been corrected in versions after 2014041 but is applicable to all versions containing digital signature information.

11.3.15 Digital Signature

An error or oversight was discovered in the NCPDP Implementation Guide regarding the digital signature. There is a note on page 314.

“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.”

The language has been modified to:

For backward compatibility, this field is hardcoded to “A” for RxRenewalResponse and “R” for NewRx and RxChangeResponse. This field was removed in 10.11. This field needs to be signed with a value of R or A. Other values from lower versions are not supported or translated to this version.

11.3.16 InjuryRelated

In V2019011 and editorial correction was made to add guidance for the use of the InjuryRelated element. For V2017071 through V2018071 the following should be followed:
InjuryRelated should be sent only when the prescription is related to a Workers’ Compensation, auto or other third-party injury.

11.3.17 BENEFITSCORDINATION LOOPS
V2017071 through 2019011 have had the number of loops modified from 3 to 4 in the Section: Inclusion of Patient Insurance Information

11.3.18 VERSION 2018041
Corrected the version number associated with the SCRIPT Standard Examples Guide

11.4 XML STANDARD MODIFICATIONS
An error was corrected in section “Representation”. This has been corrected in the version 2013 and above publication, but is effective for all. In this table

In addition, the following representations are found in the schema:

<table>
<thead>
<tr>
<th>Representation</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>xsd:boolean</td>
<td>the type of an expression with two possible values, &quot;true&quot; and &quot;false&quot;.</td>
</tr>
<tr>
<td>BooleanCode</td>
<td>NCPDP-defined backwards compatible type of expression with two possible values, &quot;T&quot; and &quot;F&quot;. Should be &quot;Y&quot; and &quot;N&quot;.</td>
</tr>
<tr>
<td>DateTime</td>
<td>Format = CCYY-MM-DD THH:MM:SS</td>
</tr>
<tr>
<td>Date - Format</td>
<td>Format = CCYY-MM-DD</td>
</tr>
</tbody>
</table>

11.4.1 STATUS IN RESPONSE TO ERROR
The XML Standard clarified that the Status transaction can be used as a response to an Error. This was added in version 2013 and above, but is effective for all.
12. SPECIFIC TRANSACTION DISCUSSION

12.1 CancelRx

The cancel prescription request transaction is used to notify the pharmacy that a previously prescribed prescription should be canceled and no additional product should be dispensed. The transaction is originated by the prescribing system as a Cancel Prescription Request Message (CancelRx).

The cancel prescription response transaction, initiated by the pharmacy system as a Cancel Prescription Response Message, is used to respond to the prescription cancellation request from the prescribing system.

It is assumed the prescribing and pharmacy systems will update the patient medication profiles with the details of the prescription cancel request and cancel response and that any additional product dispensing is canceled for that prescription.

Pharmacy systems should ensure that filled but not dispensed prescriptions are reversed from third party payers prior to allowing the deactivating/canceling of prescription records according to applicable laws. Renewal requests should not be sent for canceled prescriptions.

12.1.1 Use Case for CancelRx

Prescriber or their agent issues a NewRx, RxRenewal Response or RxChange Response prescription but determines prescribed therapy was inappropriate or not needed and cancels the entire prescription.

CancelRx WORKFLOW

1. Prescriber or their agent concludes there is a prescription need and conveys a prescription to the patient's pharmacy of choice.
2. Prescriber or their agent determines that the prescription is inappropriate or not needed.
3. Prescriber or their agent initiates a CancelRx Request (CancelRx) message to the pharmacy to cancel the prescription.
4. Pharmacy receives the CancelRx Request and determines how to respond.
5. Prescribing system receives the CancelRx Response (CancelRxResponse).
<table>
<thead>
<tr>
<th>#</th>
<th>Detailed Scenarios</th>
<th>CancelRx Response</th>
<th>CancelRx Denial Reason Code v10.6</th>
<th>CancelRx Denial Reason Code v2017071</th>
<th>Notes/ DenialReason³</th>
<th>Information for Post Prescriber⁴</th>
<th>Recommended Prescriber Action⁵</th>
<th>Information for Facility⁶</th>
<th>Recommended Post LTC Facility Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Active prescription found; no prior dispensing</td>
<td>Approved</td>
<td>Not sent</td>
<td>Not sent</td>
<td>No prior dispensing.</td>
<td>Rx canceled per request; Patient has not received product</td>
<td>None</td>
<td>Rx canceled per request;</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>Active prescription found; prior dispensing has occurred</td>
<td>Approved</td>
<td>Not sent</td>
<td>Not sent</td>
<td>Some or all of Rx received: mm/dd/yy</td>
<td>Rx canceled per request; Patient has received some product</td>
<td>Contact Patient</td>
<td>Rx canceled per request; Facility has received some product</td>
<td>None</td>
</tr>
<tr>
<td>3</td>
<td>Prescription found, but no longer active; no prior dispensing has occurred</td>
<td>Approved</td>
<td>Not sent</td>
<td>Not sent</td>
<td>Some or all of Rx received: mm/dd/yy</td>
<td>Rx canceled per request; Patient has received some product</td>
<td>Contact Patient</td>
<td>Rx canceled per request; Facility has received some product</td>
<td>None</td>
</tr>
<tr>
<td>4</td>
<td>Prescription found, but no longer active; no prior dispensing</td>
<td>Approved</td>
<td>Not sent</td>
<td>Not sent</td>
<td>No prior dispensing.</td>
<td>Rx canceled per request; Patient has not received product</td>
<td>None</td>
<td>Rx canceled per request; Facility has not received product</td>
<td>None</td>
</tr>
<tr>
<td>5</td>
<td>Unable to match to a patient; Prescription NOT found</td>
<td>Denied</td>
<td>AA – patient unknown to provider</td>
<td>AA - Patient unknown to provider</td>
<td>not sent</td>
<td>Rx not canceled per request; No matching Patient found</td>
<td>Contact Pharmacy</td>
<td>Rx not canceled per request; No matching Patient found</td>
<td>Contact Pharmacy (or pharmacy contacts facility)</td>
</tr>
</tbody>
</table>

³ Date is representative of when medication left the dispensers possession.
⁴ Prescriber initiates CancelRx Request and notifies patient to stop med administration. Patient receives dispensed meds directly from pharmacy and self-administers.
⁵ Patient contact may depend on Dispense Date, if Dispense Info is sent
⁶ Facility initiates CancelRx Request and stops med administration. In LTC, Facility receives dispensed meds & administers to patients.
<table>
<thead>
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</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>Prescription NOT found</td>
<td>Denied</td>
<td>N/A – Unable to cancel prescription due to miscellaneous reason (must have free text reason)</td>
<td>Prescription not found. Contact Pharmacy by other means</td>
<td>Rx not canceled per request; No matching Rx found</td>
<td>Contact Pharmacy</td>
<td>Rx not canceled per request; Patient is found, but no matching Rx found</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rx Transferred &amp; Not Canceled</td>
<td>7</td>
<td>Prescription found, but has been transferred to another pharmacy; prior dispensing has occurred at THIS pharmacy</td>
<td>Denied</td>
<td>AC – prescription has been transferred to another pharmacy</td>
<td>Some or all of Rx received: mm/dd/yy + Transfer Pharmacy info</td>
<td>Rx not completely canceled per request; Rx transferred to another pharmacy; Patient has picked up product from this pharmacy</td>
<td>Contact Patient + Contact OTHER Pharmacy</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Prescription found, but has been transferred to another pharmacy; no prior dispensing at THIS pharmacy</td>
<td>Denied</td>
<td>AC – prescription has been transferred to another pharmacy</td>
<td>Transfer Pharmacy info</td>
<td>Rx not completely canceled per request; Rx transferred to another pharmacy; Patient has not picked up product from this pharmacy</td>
<td>Contact OTHER Pharmacy</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>High Level Scenarios</td>
<td>#</td>
<td>Detailed Scenarios</td>
<td>CancelRx Response</td>
<td>CancelRx Denial Reason Code v10.6</td>
<td>CancelRx Denial Reason Code v2017071</td>
<td>Notes/ DenialReason³</td>
<td>Information for Post Prescriber⁴</td>
<td>Recommended Prescriber Action⁵</td>
<td>Information for Facility⁶</td>
<td>Recommended Post LTC Facility Action</td>
</tr>
<tr>
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</tr>
<tr>
<td>Rx Not Canceled</td>
<td></td>
<td>Prescription found, but has been transferred to another pharmacy (unable to send other pharmacy info electronically); no prior dispensing has occurred at THIS pharmacy</td>
<td>Denied</td>
<td>AC – prescription has been transferred to another pharmacy</td>
<td>AR – prescription has been transferred to another pharmacy</td>
<td>Some or all of Rx received: mm/dd/yy</td>
<td>Rx not completely canceled per request; Rx transferred to another pharmacy; Patient has picked up product from this pharmacy</td>
<td>Contact Patient + Contact THIS Pharmacy</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prescription found, but has been transferred to another pharmacy (unable to send other pharmacy info electronically); no prior dispensing at THIS pharmacy</td>
<td>Denied</td>
<td>AC – prescription has been transferred to another pharmacy</td>
<td>AR – prescription has been transferred to another pharmacy</td>
<td>No prior dispensing.</td>
<td>Rx not completely canceled per request; Rx transferred to another pharmacy; Patient has not picked up product from this pharmacy</td>
<td>Contact THIS Pharmacy</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Any other reason why pharmacy cannot honor CANRX/CancelRx request</td>
<td>Denied</td>
<td>N/A – Unable to cancel prescription due to miscellaneous reason (must have free text reason)</td>
<td>N/A – Unable to cancel prescription due to miscellaneous reason (must have free text reason)</td>
<td>DenialReason (provide text)</td>
<td>Rx not canceled per request due to [reason in note]</td>
<td>Contact Pharmacy</td>
<td>Rx not canceled per request due to [reason in note]</td>
<td>Contact Pharmacy (or pharmacy contacts facility)</td>
</tr>
</tbody>
</table>
12.1.2 **BEST PRACTICES CANCELRX AND CANCELRXRESPONSE**

- Prescriber systems should not send a CancelRx for a prescription that is expired according to federal or state regulations.
- There should be programmatic checks in place to prevent the automated transmission of Cancel Requests after the expiration or stop date of the prescription based on the written and/or stop dates of the prescription. CancelRx requests should be sent to the pharmacy only when a determination has been made that a patient should not receive or continue to receive a specific unexpired prescription previously sent to the pharmacy.
  - For example, the DEA requires a Controlled Substance prescription be filled within 6 months from the date written, and most states limit the filling of non-controlled prescriptions to 1 year from the date written. The prescriber’s system should not automatically send a CancelRx message after the proper time period has elapsed.
  - As another example, if the prescription is for a 7-day antibiotic therapy, the prescriber’s system should not automatically send a CancelRx message after the 7-day period has elapsed.
- The prescriber should notify the patient or caregiver to inform them of the cancellation of a prescription.
  - The CancelRx is not intended to relieve the prescriber of the responsibility of notifying the patient or caregiver of the drug therapy change – it is only intended as a backup to prevent inadvertent therapy continuation or unintended resumption at a later date.
- Whenever the MessageID and PrescriberOrderNumber from the most current NewRx, RxRenewalResponse or RxChangeResponse is available, prescribing systems should include this information as the RelatesToMessageID and PrescriberOrderNumber in the CancelRequest so the pharmacy is able to more easily identify the prescription to be canceled.
  - See the NCPDP XML Standard for guidance on using the `<RelatesToMessageID>`.
- The use of the ChangeOfPrescriptionStatusFlag (REQ060) is limited to the Long Term and Post-Acute Care settings.
- CancelRx should not be faxed unless electronic means are not available.
- Pharmacies should always treat incoming CancelRx messages as a high priority.
- Pharmacies should respond to all CancelRx within two business days. Pharmacies should not delete a CancelRx message from a processing queue without a response being generated to the requesting system.
  - Pharmacy edits should be put in place to prevent the dispensing of a product to the patient even if a CancelRxResponse has not yet been sent.
  - For urgent situations, the prescriber may contact the pharmacy through another means to confirm the cancelation has been received.
- SCRIPT 10.6 supports the optional element ApprovalReasonCode (RES020), but it is not recommended in the Approved workflow since the element was removed in a future version.
If the prescriber or their agent received a denial code indicating the prescription was transferred to a different pharmacy, the prescriber or their agent may be given the option to route the CancelRx message to the new pharmacy if it is known and supports the CancelRx message.

Pharmacies should not send any Refill/RxRenewal Request messages for any Rxs that have been canceled.

The 10.6 version of SCRIPT also includes an “approved with changes” response in the CancelRxResponse message, which was removed in later versions of the standard. It is not used by implementers of SCRIPT 10.6, based on industry convention.

The CancelRx should contain the RxNorm, RxCUI in the <DrugCoded>. If the prescription number is available, it should be sent in the RxReferenceNumber.

If the original prescription was not electronic, the CancelRx must contain sufficient information for the pharmacy to be able to identify the prescription in their system, such as patient, medication (name, strength, dosage form), date written and effective date. If the pharmacy cannot definitively determine the prescription to be canceled, manual processes, including prescriber contact, should be invoked to verify the cancelation.

### 12.1.3 Original Prescriber Only Allowed to Send the Cancel Request?

**Question:** Is only the original prescribing doctor allowed to send the Cancel Request?

**Response:**

A prescriber who has assumed responsibility for the patient’s care may potentially cancel any prescription. It remains up to the pharmacy to determine if sufficient information is provided to identify the appropriate prescription.

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

### 12.1.4 Medication Prescribed Notes

**Question:** On a CancelRx, should the MedicationPrescribed/Note contain the Note from the original authorized prescription (ex: NewRx) or should it represent a cancel note from the prescriber to the pharmacy?

**Response:** The MedicationPrescribed should contain all the same information from the original prescribed prescription.

### 12.1.5 WrittenDate Population on CancelRxResponse
**Question:** In the CancelRx, should the WrittenDate be populated with the date the cancel request was initiated or with the WrittenDate from the original NewRx, RxRenewal Response or RxChange Response prescription?

**Response:** The CancelRx WrittenDate should be populated with the same date from the original NewRx, RxRenewal Response or RxChange Response prescription. This will allow the pharmacy to match the cancel prescription request to the original prescription if they are not able to match on other identifying information.

**12.1.6 CancelRx for original prescription as well as a Renewal Response**

**Question:** Do I need to send a CancelRx message for the original prescription as well as my renewal response when I receive a renewal request?

**Response:** When a prescriber receives a Refill Renewal Request, a Cancel Rx should not be returned for the original prescription when a prescriber intends to approve the request. Unless a clinical determination is made that requires a prescription to be canceled in the pharmacy system, a Refill/Renewal Response is the only transaction that should be sent in response to a Refill/Renewal Request. CancelRx should be sent to the pharmacy only when a determination has been made that a patient should not receive or continue to receive a specific prescription previously sent to the pharmacy.
12.2 Refill Request

12.2.1 Last Fill Date on a Refill Request

Question:
The issue is in regards to requiring the last fill date on a Refill Request. It seems there are cases where the Refill Request is sent but the prescription was never filled. An example:
The prescription is sent to a pharmacy and filed in the patient’s prescription record because it wasn't needed at the time (e.g., an allergy medication). There would not be a last fill date because it was only filed. A year later the patient might come in and say that they needed the prescription at that time. The pharmacy might then pull up that record and learn that it was more than a year old and thus needed to be renewed. It would then be appropriate to send a Refill Request, but this Refill Request would not contain the last fill date. Regardless of the type of positive response that the prescriber might send, the pharmacy should treat said response as a new prescription because the original had expired (sending a Refill Request is correct in this case).

Response:
At this point, NCPDP WG11 suggests handling this with a phone call because they do not believe this happens very often. In the future the pharmacy could send a NewRxRequest transaction.

12.2.2 Prescribed Medication Information on a Refill Request

Question:
What medication should be provided in the Prescribed Medication in a Refill Request?

Discussion:
Should the prescribed medication in the Refill Request contain the information that the prescriber actually provided in the NewRx transaction or should this be the pharmacist’s interpretation of the product ordered?

During task group discussion, some systems store exactly what the prescriber sent, so that when echoed back in the Refill Request prescribed medication it facilitates matching in the prescriber system. However, not all pharmacies store the originally provided information in a readily retrievable manner. Some prescriptions require follow up to clarify, to modify, etc. For this reason some systems support the pharmacist interpretation of what the prescriber ordered and send this information in the Refill Request.

In the refill, the prescriber is required to check the dispensed medication. There was some concern that if the pharmacy provided the prescribed medication information it may be used to approve the prescription without the prescriber reviewing what was actually dispensed. There was also a concern that if a prescribing clarification or error had been identified, sending what the prescriber provided could perpetuate the lack of clarity or error to the patient’s detriment.

Response:
It is recommended 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. The reasons for this are:

1. The information provided in the Drug Description field for the Medication Prescribed by the prescriber is often not consistent with industry standards.
   a. It often contains discontinued brand names for products that are only on the market as generic or other branded products (e.g. Accutane).
   b. It does not always reflect that correct dosage form such as extended or sustained release, which are later determined by the pharmacist.
   c. It sometimes contains confusing information such as the generic and brand name such as: “generic name (Brand Name) strength and dosage form.”
2. Providing the pharmacist’s interpretation of the medication ordered promotes patient safety as it allows the prescriber to see the pharmacist’s interpretation of the original order and to compare it with what was intended. The prescriber will know what is being authorized for refill (the product dispensed, as per NCPDP Implementation guidance) and can take appropriate actions if this is not what was intended.
3. The pharmacist’s interpretation of the medication ordered has been provided in refill requests for over the past decade and is the way the vast majority of pharmacy systems continue to provide this information today.
4. String comparisons are one of the least reliable methods of determining if the information provided matches database information.
5. The prescriber use the Prescriber Order number or RelatesToMessageID (PrescriberOrderNumber, RelatesToMessageID), when available, to compare what was ordered with what is being requested for refill. In other instances, the patient’s profile may need to be reviewed.
6. Once a national standard for product ID and nomenclature has been more widely implemented (such as RxNorm) this could resolve much of the confusion in the industry. The description of what the prescriber ordered should be more closely reflected in the Medication Prescribed field of the refill request. However, since misinterpretations could still occur we may decide to continue with the recommendation to always send the pharmacist’s interpretation of the medication ordered in the Medication Prescribed field. The process described above provides for a consistent, safe and more normalized product description.

### 12.3 REFILL RESPONSE

#### 12.3.1 REFILLRESPONSE WITH DRUG NAME DIFFERENT

**Question:**
A prescriber vendor is sending a "Denied, new prescription to follow" on a Refill Response due to the prescriber's drug name being different than the pharmacy's drug name. The prescriber is not making any changes on the Refill Response; the prescriber's intent is to approve the Refill Request. Is it appropriate for the prescriber to send a "Denied, new prescription to follow", or should the prescriber be sending an "Approved" response?

**For example:**

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

**Response:**
The response is “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.

See the recommendations in section “Recommendations for Consistent Use of Drug Identification Fields Used in SCRIPT Transactions” of this document.

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.

See also enhancements to RxRenewalResponse in SCRIPT 2014+.

**12.3.2 REFILLRESPONSE AS NEWLY AUTHORIZED PRESCRIPTION**

**Question:**
Is it legal to use a Refill Response as a newly authorized prescription?

**Response:**
When the prescriber responds with an <Approved> or <ApprovedWithChanges> message to a RefillRequest, it is considered authorization for a new prescription. Therefore the approval date is the <WrittenDate>. In future versions, RefillRequest/Response was modified to RxRenewalRequest/Response.

**12.4 RXFILL**
See section “RxFill Recommendations”.

**12.5 RXCHANGE**
The Rx Change Request message is originated by the pharmacy. This message is used to request a change to a prescription and may be used when a pharmacy identifies a need to make a change to a prescription/order in progress or being dispensed (hereafter referred to as the original prescription), regardless of how the prescription was received.

An Rx Change Response message is used to respond to an Rx Change Request message. The three codes available in the standard for Rx Change are Therapeutic Interchange, Generic Substitution, and Prior Authorization. However, because there are more than three use cases, other use cases have been combined into Therapeutic Interchange as shown below.

Use cases are described below, along with how to populate the pertinent fields. These use cases are for example only; professional judgement should be exercised to ensure compliance with prevailing laws and regulations.

Approved and Approved Change Responses indicate a new prescription for all use cases except prior authorizations.
12.5.1 Use Cases – Therapeutic Interchange (Rx Change Request Type = T)

12.5.1.1 Use Case #1: DUR (Drug Utilization Review)

When the pharmacy and/or payer detects a DUR concern related to the written product, the pharmacy can send an Rx Change Request – Therapeutic Interchange type to the prescriber requesting a switch to an alternative product that will treat the condition with less severe, fewer or no likely adverse effects. Possible concerns include: allergies, side effects, dose alerts, product interactions, and product-disease state interactions.

- REQ-010 <ChangeRequestType> = T
- At least one loop of MedicationRequested should be populated. It should contain either the prescribed product or the recommended alternative(s).
- Use DRU-100 <DrugUseEvaluation> of each product requested segment to document further explanation, conflict, or clarification of services related to product use evaluation.
- Use DRU-090 <Note> of each MedicationRequested segment to indicate DUR event.

12.5.1.2 Use Case #2: Formulary Compliance Change to an On Formulary or Preferred Product

When the pharmacy receives a claim reject (or even paid) message which identifies preferred alternative products, the pharmacy can send an Rx Change Request – Therapeutic Interchange type to the prescriber requesting a switch to one of the preferred products.

- REQ-010 <ChangeRequestType> = T
- At least one loop of MedicationRequested should be populated. It should contain either the prescribed product or the recommended alternative(s).
- Use DRU-090 <Note> of each MedicationRequested segments to indicate Formulary Compliance.

12.5.1.3 Use Case #3: Days Supply Change From 30 Days to 90 Days Supply

When the pharmacy receives a prescription indicating a 30-day supply, but the patient or payer has a 90-day supply, the pharmacy can send an Rx Change Request – Therapeutic Interchange type to the prescriber requesting a switch to a 90-day supply.

- REQ-010 <ChangeRequestType> = T
- At least one loop of MedicationRequested must be populated with at minimum the new Quantity and Days Supply.
- Use DRU-090 <Note> of the MedicationRequested segment to indicate why the change is requested.

12.5.1.4 Use Case #4: Therapy Change – Daily Dose Alternative

When the pharmacy receives a prescription for a one 10 MG Tablet twice a day, but the patient prefers to take one 20 MG tablet once a day, the pharmacy can send an Rx Change Request – Therapeutic Interchange type to the prescriber requesting a switch to one 20 MG Tablet once a day.

- REQ-010 <ChangeRequestType> = T
- At least one loop of MedicationRequested must be populated with the requested product.
- Use DRU-090 <Note> of the MedicationRequested segment to indicate why the change is requested.
12.5.1.5  **USE CASE #5: SCRIPT CLARIFICATION**

When the pharmacy is unsure of the prescriber’s intent; e.g. Prozac weekly once a day for 200 MG versus 20 MG, which could be an error, the pharmacy can send an Rx Change – Therapeutic Interchange type to the prescriber requesting clarification.

- **REQ-010 <ChangeRequestType>= T**
- Use the MedicationRequested segment to indicate what the pharmacy thought the prescriber intended.
- Use DRU-090 <Note> of the MedicationRequested segment to indicate a prescription clarification.

12.5.2  **WORKFLOW – THERAPEUTIC INTERCHANGE**

1) Pharmacist determines which one of the following applies: DUR (Drug Utilization Review), Formulary Compliance Change to an on Formulary or Preferred Product, Days Supply from 30 Days to 90 Days Supply, Therapy Change – Daily Dose Alternative or Script Clarification, and wishes to request a change.

2) Rx Change Request is sent for Therapeutic Interchange.

- **REQ-010 <ChangeRequestType>= T**
  i) If the prescription was received electronically, the RelatesToMessageID must be the MessageID of the prescription.
  ii) If the prescription was received electronically and included the PrescriberOrderNumber, it will be sent in the request.
  iii) If the prescription was enumerated (given a number), the pharmacy will send the RxReferenceNumber of the prescription.

3) Refer to appropriate Use Case for data element usage.

4) For each Requested Medication, the Drug Description, Quantity, Directions, Notes, and Number of Refills are (must be) sent.

5) Prescriber receives request – possible responses:

- **Approved** (no changes to the requested prescription) Note: Optional fields do not need to be returned, such as days supply. Representative NDC may change due to differences in compendia as long as it refers to the same product.
  i) The prescriber may only send Approved status type if the prescriber selects one of the MedicationRequested product and all information in the MedicationRequested is approved by the prescriber.
  ii) Approved status type is an indication to the pharmacy to discontinue dispensing and cancel the prescription and begin dispensing the new prescription as included in the Rx Change Response.
  iii) When the prescriber responds with Approved, the prescriber must send the Medication Prescribed for one of the products requested by the pharmacy.
  iv) If the prescriber selects one of the MedicationRequested product but wishes to change one of the requested element values (e.g. Directions from “take one tablet every day” to “take two tablets every day”), the prescriber should instead specify Approved With Changes status type (see below).
• **Approved with changes** (anything can be changed in the prescription. The intended patient must remain the same.
  
i) The prescriber should send **Approved With Changes** status type if the prescriber wishes to approve the change request, and wishes to:
  
  • Prescribe a product that differs from any of the MedicationRequested products.
  
  • Select one of the MedicationRequested products AND change one of the requested element values (e.g. Directions from take one tablet every day to take two tablets every day).
  
  ii) **Approved with Changes** status type is an indication to the pharmacy to discontinue dispensing and cancel the prescription in process and to begin dispensing the new prescription included in the Rx Change Response.
  
  iii) **Approved with Changes** is not to be used when one of the MedicationRequested segments is selected and none of the fields are changed. Instead, use **Approved** status type as described above.

• **Denied**
  
i) **Denied** is an indication to the pharmacy to not make a change and to continue dispensing the prescription, unless otherwise notified (via CancelRx or other means)
  
  ii) On a **Denied** response, no product information is required.
  
  iii) A note or reason code explaining the denial is required.
  
  iv) If the prescriber wishes to discontinue the prescription or cancel the product therapy, then a **Denied** Rx Change Response should be sent; a denied response does not cancel the prescription. If the prescriber wishes to cancel the prescription, a Cancel transaction should be sent. If a Cancel transaction cannot be sent, then the prescriber should follow up with the pharmacy.
  
  v) In the DUR scenario, the **Denied** implies the prescriber is aware of the DUR but wants to continue dispensing the prescription, unless otherwise notified (via CancelRx or other means).

6). Prescriber sends back response.
  
  • Appropriate status (approved, approved with changes, denied) type is sent
  
  • The RelatesToMessageID must be set to the MessageID of the Rx Change Request.

12.5.3 **USE CASES – GENERIC AND INTERCHANGEABLE SUBSTITUTION (Rx Change Request Type = G)**

12.5.3.1 **USE CASE #1: SWITCHING FROM BRAND TO GENERIC OR INTERCHANGEABLE BIOLOGIC OR BIOSIMILAR**

When the pharmacy receives a prescription for which a substitution is not allowed by prescriber or regulations, but an alternative is available, the pharmacy can send an Rx Change Request – Generic Substitution type to the prescriber requesting that the alternative be allowed to be dispensed.

• REQ-010 <ChangeRequestType> = G
  
  • At least one loop of MedicationRequested should be populated with a recommended alternative.
12.5.3.2 USE CASE #2: NEW GENERIC OR BIOLOGIC/BIOSIMILAR PRODUCT AVAILABLE OR FORMULARY STATUS CHANGE

The prescription was written for a product with no legally substitutable or interchangeable biologic/biosimilar alternatives. After the prescription was written, a new generic or biologic/biosimilar becomes available or a formulary change occurs; in this case the pharmacy can send an Rx Change Request – Generic Substitution type to the prescriber, requesting that the alternative be allowed to be dispensed.

- REQ-010 <ChangeRequestType> = G
- At least one loop of MedicationRequested must be populated with a recommended alternative.

12.5.3.3 USE CASE #3: DISPENSE AS WRITTEN (DAW)

The prescription was written for a multi-source product and the prescriber indicated substitution is not allowed.

The pharmacy can send an Rx Change Request – Generic Substitution type to the prescriber requesting the generic be allowed to be dispensed when:

- The brand is not covered by the payer
- Payer returns exceptionally high patient financial responsibility and the patient requests the generic
- Prescribed product is unavailable

- REQ-010 <ChangeRequestType> = G
- At least one loop of MedicationRequested must be populated with a recommended alternative.

12.5.4 WORKFLOW – GENERIC

1) Pharmacist/Pharmacy application determines there is a substitutable product or biologic/biosimilar alternative available. If the prescription allows substitution then the pharmacy may be able to change to an alternative product without sending this message, depending upon the substitution laws in the pharmacy’s state location. If the prescription was marked as “substitution not allowed”, then an Rx Change Request – Generic Substitution type is sent.

2) Rx Change Request is sent for Generic or Interchangeable Substitution

- REQ-010 <ChangeRequestType> = G
  i). If the prescription was received electronically, the RelatesToMessageID will be set to the MessageID of that prescription.
  ii). If the prescription was received electronically and included the PrescriberOrderNumber (PON) that will be sent in the request.
  iii). If the prescription was enumerated, the pharmacy will send the RxReferenceNumber of that prescription.

3) Medication Prescribed from the prescription is sent.

4) The requested generic or interchangeable products are sent by the pharmacist in Medication Requested elements.

5) Prescriber receives request – possible responses:
• **Approved (no changes to requested product)** Note: Optional fields do not need to be returned, such as days supply. Representative NDC may change due to differences in compendia, as long as it refers to the same product.
  i) *Approved* is an indication to the pharmacy to discontinue dispensing the prescription and to dispense the new prescription. The pharmacy will need to ensure that the prescription is canceled in their system.
  ii) The prescriber may only send *Approved* status type if the prescriber selects one of the MedicationRequested products and all information from the MedicationRequested for that product is approved by the prescriber.
  iii) If the prescriber selects one of the MedicationRequested product but wishes to change one of the requested element values (e.g. Directions from “take one tablet every day” to “take two tablets every day”), the prescriber should instead specify *Approved With Changes* status type (see below).

• **Approved with changes (anything can be changed on requested product)** the intended patient must remain the same.
  i) The prescriber should send *Approved With Changes* status type if the prescriber wishes to approve the change request, but also wishes to:
    • Prescribe a product that differs from any of the MedicationRequested products.
    • Select one of the MedicationRequested products AND change one of the requested element values (e.g. Directions from “Take one tablet by mouth every day.” To ”Take two tablets by mouth every day.”).
  ii) *Approved with Changes* status type indicates to the pharmacy to discontinue dispensing and cancel the prescription and to dispense the new prescription as sent in the Rx Change Response.
  iii) *Approved with Changes* is not to be used when one of the MedicationRequested segments is selected and none of the fields are changed. Instead, use *Approved* status type as described above.

• **Denied**
  i) *Denied* is an indication to the pharmacy to not make a change and to continue dispensing the new prescription from the Rx Change Response, unless otherwise notified (via CancelRx or other means).
  ii) On a *Denied* response, no product information is required.
  iii) A note or reason code explaining the denial is required.
  iv) If the prescriber wishes to discontinue the prescription or cancel the product therapy, then a *Denied* Rx Change Response should be sent; a denied response does not cancel the prescription. If the prescriber wishes to cancel the prescription, a Cancel transaction should be sent. If a Cancel transaction cannot be sent, then the prescriber should follow up with the pharmacy.

6). Prescriber sends back response.
• Appropriate status (approved, approved with changes, denied) type is sent.
• The RelatesToMessageID must be the MessageID of the Rx Change Request.
12.5.5 Use Case – Prior Authorization (Change Request Type = P)
When the pharmacy determines a Prior Authorization is required, the pharmacy can request the prescriber obtain Prior Authorization from the payer.
- REQ-010 <ChangeRequestType> = P

12.5.6 Workflow – Prior Authorization
1) Pharmacist determines a Prior Authorization is required for this prescription. This is usually determined from a claim response with a message of “Prior Authorization Required”
2) Rx Change Request is sent for Prior Authorization.
   - REQ-010 <ChangeRequestType> = P
     i) If the prescription was received electronically, the RelatesToMessageID must be the MessageID of that prescription.
     ii) If the prescription was received electronically and included the PrescriberOrderNumber, it will be sent on the Rx Change Request.
     iii) If the prescription was enumerated, the pharmacy will send the RxReferenceNumber for that prescription
3). The COO <BenefitsCoordination> information is sent to identify the payer or the benefits administrator.
4). Prescriber or representative receives request – possible responses:
   - Approved
     o The prescriber or representative has obtained prior authorization from the Payer for this product.
     o The Medication Prescribed segment is returned in the Rx Change Response.
     o If a prior authorization number is provided by the payer, this number should be included in the Medication Prescribed segment in the <PriorAuthorization>.
   - Denied (Payer Contacted)
     o The prescriber or representative contacted the payer but the payer denied the request.
   - Denied (Payer not Contacted)
     o RES-020 <DenialReasonCode> No attempt will be made by the prescriber or representative to obtain Prior Authorization. This is an existing code (AO) in the NCPDP External Code List.
   - Denied
     o On a Denied response, no product information is required.
     o A note or reason code explaining the denial is required.
     o The prescription remains valid.
5). Prescriber or representative sends back response.
   - Appropriate status type is sent.
   - The RelatesToMessageID must be the MessageID of the Rx Change Request.

12.5.7 Rx Change Best Practices
1) Notes specific to the reason for the request should go in the MedicationRequested segment as defined in the use cases above. MedicationRequested notes field is intended to allow for information on the product in that particular loop.
2) When sending a change request for a Prior Authorization, the COO (BenefitsCoordination) should be included so the prescriber or representative knows which payer determined the need for a PA. The payer details not available in the COO segment may be included in the Notes field. For all other change request types, we recommend the COO segment be included so the prescriber knows which payer determined coverage/pricing.

3) If the Rx Change for Therapeutic Interchange or Generic Substitution is approved, this replaces the original prescription. The prescriber should create a new PrescriberOrderNumber; the old one becomes inactive for this approval. If the Rx Change for Prior Authorization is approved, the original prescription can still be used.

4) A (RxChange) denial does not make the prescription invalid or stop therapy. If the prescriber wishes to stop therapy, the prescriber should notify the pharmacy either by sending a cancel message for the Rx or using other means.

5) An Approved with Changes Response (RES-010 = C) should not be used for Prior Authorization request; it has been removed in a future version of SCRIPT.

6) Even though the request segment is optional, it should be sent to identify the type of request and it should be returned on the response.

7) A pharmacy may send an Rx Change Request for controlled substances (EPCS) regardless of whether the prescriber or pharmacy is certified for EPCS. Except for the PA ChangeRequest type, approvals received by prescribers not certified for EPCS should be denied electronically (status type "denied") and an indication in the free text field that a replacement prescription will follow. If the prescriber is certified for EPCS or the ChangeResponse is for a PA approval, they can approve the change request. Except for the PA ChangeRequest type, an approval automatically should replace the original prescription because the approved change becomes the authorized prescription replacement and a CancelRx Request must NOT be sent.

8) If a pharmacy dispenses the original prescription following the submission of an RxChangeRequest and before the prescriber responds with an RxChangeRequest Approval, the pharmacy records would be inconsistent with the prescriber’s records. The pharmacy just uses traditional means to contact the prescriber to ensure consistency of records, to determine the future drug therapy, and any necessary patient communication.

9) For all Change Request types except PA
   a) If the prescriber approves the change request, the change response should be treated just like a new prescription.
   b) In a change response, there are no limits or requirements around what can or cannot change.
   c) The pharmacy system should process the response data to capture all the necessary information the prescriber sent.
13. **RXFILL RECOMMENDATIONS**

The following are recommendations for RxFill transactions and workflow in the ambulatory setting. The long term post-acute care settings will bring forward updates to this section in the future.

**13.1 PURPOSE**

To highlight and provide a general overview of issues in the implementation of RxFill transactions for both new and refill prescription transactions. This chapter does not provide recommendations to resolve each issue, but rather introduces topics for informational purposes and for further review.

**13.2 INTRODUCTION**

As the Task Group for RxFill clarification researched and discussed the use of RxFill transactions in “real-life” scenarios, a number of discussion points were introduced that assisted the group in understanding RxFill and making clarifications to the SCRIPT Implementation Guide. While important to the overall understanding of the subject, many of the discussion items were not appropriate for inclusion into the Implementation Guide itself. This chapter was created to preserve this information and make those discussion points available for users of the Implementation Guide to enhance their understanding of RxFill.

These discussion points are best understood within the context of the base RxFill information incorporated and updated in the SCRIPT Implementation Guide. It is recommended that the reader review the SCRIPT Implementation Guide requirements and information on RxFill along with reviewing these discussion points. RxFill applies to all pharmacies.

**13.3 DEFINITIONS**

Terms requiring clarification as used in this document.

*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’. This definition applies for this chapter.

*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

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.

*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”.

Transfer – 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.

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.

13.4 Discussion of RxFill Operational Issues

13.4.1 Opt-In for the Prescriber (Available in SCRIPT Version 2014+)

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 if they request RxFill status messages in SCRIPT version 2014+:

<table>
<thead>
<tr>
<th>Description</th>
<th>Dispensed</th>
<th>Partially Dispensed</th>
<th>Not Dispensed</th>
<th>Transferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>All RxFill status messages</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>All RxFill status messages but Transferred</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dispensed and Partially Dispensed</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partially Dispensed and Not Dispensed</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Dispensed or Transferred</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Partially Dispensed Only</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Not Dispensed Only</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Cancel all RxFill Statuses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

13.4.2 Cancel/Modify RxFill by the Prescriber (Available in SCRIPT Version 2014+)

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
cancelation or modification to a previously sent <RxFillIndicator> value for a specific patient/medication combination.

13.4.3 **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 that 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.

13.4.4 **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 that 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.

13.4.5 **TRIGGERING OF THERAPEUTIC, BIOLOGIC OR BIOSIMILAR SUBSTITUTION**
RxFill transactions are intended to be sent by the pharmacy to the prescriber to indicate that a Biologic or Biosimilar product has been substituted in lieu of the original product prescribed. The RxFill transaction will include the reason code “DG” (Therapeutic Interchange/Substitution) or “GW” (Biologic/Biosimilar Substitution), for the status of <Dispensed> and <PartiallyDispensed>.

13.4.6 **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.

13.4.7 **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.

13.4.8 **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 or not dispensed 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 (available in SCRIPT version 2014+)** – 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.

The volume of RxFill transactions could be high if fully implemented for all situations.

### 13.4.9 RXFILL AND TRANSFERS (AVAILABLE IN SCRIPT VERSION 2014+)

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 that dispensing pharmacy has changed 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.

### 13.4.10 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.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>NewRx from Prescriber</th>
<th>RxFill (partial fill) from Pharmacy</th>
<th>RxFill (partial fill) from Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;MessageID&gt;</td>
<td>1234567</td>
<td>3311</td>
<td>3433</td>
</tr>
<tr>
<td>&lt;RelatesToMessageID&gt;</td>
<td>1234567</td>
<td>1234567</td>
<td></td>
</tr>
<tr>
<td>&lt;RxReferenceNumber&gt;</td>
<td>PH456</td>
<td>PH456</td>
<td></td>
</tr>
<tr>
<td>&lt;PrescriberOrderNumber&gt;</td>
<td>110088</td>
<td>110088</td>
<td>110088</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Status from Pharmacy</th>
<th>Status from Prescriber</th>
<th>Status from Prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;MessageID&gt;</td>
<td>ABC11</td>
<td>8899</td>
<td>9988</td>
</tr>
<tr>
<td>&lt;RelatesToMessageID&gt;</td>
<td>1234567</td>
<td>3311</td>
<td>3433</td>
</tr>
<tr>
<td>&lt;RxReferenceNumber&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;PrescriberOrderNumber&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**13.4.11 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 through them.
  - 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.
    - May 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 it 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.

### 13.4.12 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.
14. RESUPPLY

14.1 WHAT SHOULD BE SENT ON A RESUPPLY MESSAGE WHEN THE NEWRx HAD A QUANTITY QUALIFIER OF “QS” AND A QUANTITY OF “0”?

The quantity in the Resupply message should contain the exact same value as sent in the NewRx.
15. PRODUCT CONCEPT QUALIFIER RECOMMENDATIONS FOR ELECTRONICALLY TRANSMITTED PRESCRIPTIONS

A goal of electronic prescribing, along with the interoperability between various medical and pharmacy systems, is to provide the means for a prescriber to transmit a prescription where all of the comprised components are presented with content and format that are unambiguous. The exchange of the field Quantity Qualifier is an area where improvements are needed to reach this goal. This guidance applies to all transactions containing prescription or prescription-related information where a quantity is included.

| NCPDP QuantityUnitOfMeasure Terminology | A set of terminology for NCPDP that contains concepts of the intended or actual dispensed quantity unit of measure (e.g., 17 grams, 30 tablets, 473 mL, 3 Eaches. Upon billing, this data is translated to Milliliters, Grams, for Eaches. Days supply is not allowed as a prescribed quantity for eRx. (Dispensed quantity from claims likely constrained to these values). | Drug: Victoza 18MG/3ML Pen Prescribed Quantity: 6 ML SIG: Inject 1.2 mg twice a day |

It is important that pharmacies receive the prescription Quantity and Quantity Qualifier 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.
  - Inappropriate quantity or quantity unit of measure can lead to potential underdose or overdose of therapy, which may result in poor outcomes or serious harm to the patient
- **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, Prescribers and Pharmacies are highly urged to follow.

### 15.1 DRUG COMPENDIA

The drug compendia should ensure that 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](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 are responsible for providing drug product information as agreed to by trading partners.

15.2 EHR AND PRESCRIBING SYSTEM VENDORS

It is recommended that EHR and Prescribing System Vendors follow the below guidance when transmitting electronic prescriptions:

When abbreviating Quantity Unit of Measures with descriptions of GM, ML, and EA, it should be noted that the Institute for Safe Medication Practices (ISMP) prefers that these terms be expressed to an end-user using their standard: GM=g, ML=mL and EA=ea. It is the decision of the implementer which interpretation of the description of the Quantity Unit of Measure to display in their end-user applications.

- Use a commercial compendium as a source for drug information.
- Ensure regularly scheduled updates from the compendia should be processed and available to load into a prescribers’ system.

General Recommendations:

- For drugs/items that are measured in volume (ML) or weight/mass (GM), the Quantity Unit of Measure will be represented by the metric measurement.
- For drugs/items that are measured as eaches (EA) where a more specific Quantity Unit Of Measure such as tablets or capsules are available in the NCI code set, it is recommended that the Quantity Unit of Measure be represented as the more specific Quantity Unit of Measure.
- For drugs/items that are commercially available in unit of use package(s), the precise prescription quantity options displayed to the prescriber should be representative of only label sizes commercially available from the pharmaceutical company for the drug/item prescribed (e.g. eye drops – 5 ML, 10 ML or 15 ML).
- Initiators of electronic messages shall use the correct QuantityUnitOfMeasure for the product. Use of the Unspecified QuantityUnitOfMeasure (C38046) should be restricted due to the unavailability of a QuantityUnitOfMeasure value.
- C64933 (Each) is only to be used when a product:
  - Cannot be measured in volume or weight
  - Does not have a QuantityUnitOfMeasure in the current version of NCIt that would be expected to be measured in individual
    - Examples: DME supplies, such as canes, wheel chairs, various braces or orthotics, etc. and other one-offs, such as a new device without a current NCIt value
- The Product Quantity and Quantity Unit of Measure description should be displayed to the end user. Only the Quantity and Quantity Unit of Measure code information is transmitted in the prescription from the prescriber to the pharmacy.
- Package descriptions alone are strongly discouraged from being available to select as a Quantity Unit of Measure description.
Examples of package descriptions that should not be available for selection or transmission:

- Can
- Bottle
- Box
- Tube

The table below provides examples of how to implement these recommendations. In the column “Example of Appropriate 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.)

<table>
<thead>
<tr>
<th>Product Example</th>
<th>Inappropriate Quantity Unit of Measure to Display and Transmit</th>
<th>Appropriate Quantity Unit of Measure to Display to the prescriber</th>
<th>Quantity needed to fulfill prescription</th>
<th>Appropriate Quantity to transmit to the pharmacy</th>
<th>Appropriate Quantity Unit of Measure Code Value to transmit to the pharmacy</th>
<th>Corresponding Quantity Unit of Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxcillin 250 mg/5 ML for Oral Suspension</td>
<td>1 Bottle</td>
<td>100 ML Bottle</td>
<td>100 ML Bottle</td>
<td>100</td>
<td>C28253</td>
<td>ML</td>
</tr>
<tr>
<td>Hydroxyzine Hydrochloride 10 mg/5 ML Solution</td>
<td>4 oz</td>
<td>120 ML Bottle</td>
<td>80 ML</td>
<td>80</td>
<td>C28253</td>
<td>ML</td>
</tr>
<tr>
<td>Albuterol Sulfate HFA 108 mcg/act Inhalation Aerosol</td>
<td>1 canister</td>
<td>18 GM Canister</td>
<td>18 GM Canister</td>
<td>18</td>
<td>C48155</td>
<td>GM</td>
</tr>
<tr>
<td>Timolol Maleate 0.5% Ophthalmic Solution</td>
<td>1 Bottle</td>
<td>10 ML Bottle</td>
<td>20 ML</td>
<td>20</td>
<td>C28253</td>
<td>ML</td>
</tr>
<tr>
<td>Fluocinonide 0.05% Cream</td>
<td>1 Tube</td>
<td>30 GM Tube</td>
<td>60 GM</td>
<td>60</td>
<td>C48155</td>
<td>GM</td>
</tr>
<tr>
<td>Triamcinolone Acetonide 0.025% Cream</td>
<td>1 Jar</td>
<td>454 GM Jar</td>
<td>454 GM</td>
<td>454</td>
<td>C48155</td>
<td>GM</td>
</tr>
<tr>
<td>Flunisolide 0.025% Nasal Spray</td>
<td>1 Bottle</td>
<td>25 ML Bottle</td>
<td>25 ML</td>
<td>25</td>
<td>C28253</td>
<td>ML</td>
</tr>
<tr>
<td>Cholestryramine 4 gm Powder</td>
<td>1 Can</td>
<td>378 GM Can</td>
<td>378 GM</td>
<td>378</td>
<td>C48155</td>
<td>GM</td>
</tr>
<tr>
<td>Cholestryramine 4 gm Powder Packet</td>
<td>1 Box</td>
<td>120 Packet Box</td>
<td>120 Packets</td>
<td>120</td>
<td>C48521</td>
<td>PACKET</td>
</tr>
<tr>
<td>Blood Glucose Test Strips</td>
<td>1 Box</td>
<td>50 Strip Box</td>
<td>50 Strips</td>
<td>50</td>
<td>C48538</td>
<td>STRIP</td>
</tr>
<tr>
<td>Promethazine 25 mg Suppository</td>
<td>1 Box</td>
<td>12 Suppository Box</td>
<td>5 Suppositories</td>
<td>5</td>
<td>C48539</td>
<td>SUPPOSITORY</td>
</tr>
<tr>
<td>Incontinence Brief / Large</td>
<td>1 Package</td>
<td>25 EA Package</td>
<td>25 Briefs</td>
<td>25</td>
<td>C64933</td>
<td>EA</td>
</tr>
<tr>
<td>Lovenox 60 MG/ 0.6ML Syringe</td>
<td>1 Syringe</td>
<td>0.6 ML syringe</td>
<td>12 syringes</td>
<td>7.2</td>
<td>C28253</td>
<td>ML</td>
</tr>
<tr>
<td>Azithromycin Dosepak</td>
<td>1 EA</td>
<td>6 Tablets</td>
<td>6 Tablets</td>
<td>6</td>
<td>C48542</td>
<td>TABLET</td>
</tr>
</tbody>
</table>

- SCRIPT version 10.6 does not have the capability for the prescriber to indicate that multiple units of a particular Quantity and Quantity Unit of Measure are to be dispensed. Until a future SCRIPT version includes fields to accommodate these scenarios, the examples and tables below provide guidance on how they are to be handled.
  - 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 Qualifier 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.)

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

- 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 Qualifier 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.)

<table>
<thead>
<tr>
<th>Product Example</th>
<th>Inappropriate Quantity Unit of Measure to Display and Transmit</th>
<th>Appropriate Quantity Unit of Measure to Display to the Prescriber</th>
<th>Quantity needed to fulfill prescription</th>
<th>Appropriate Quantity to transmit to the pharmacy</th>
<th>Appropriate Quantity Code Value to transmit to the pharmacy</th>
<th>Corresponding Quantity Unit of Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enoxaparin 40 MG/0.4 ML Solution for Injection</td>
<td>1 Syringe</td>
<td>0.4 ML Syringe</td>
<td>10 Syringes</td>
<td>4</td>
<td>C28253</td>
<td>ML</td>
</tr>
</tbody>
</table>

- 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.)

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

- 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.)

<table>
<thead>
<tr>
<th>Example of Drug/Item</th>
<th>Example of Correct Quantity to Display to the Prescriber</th>
<th>Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription</th>
<th>Quantity to Dispense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cyanocobalamin 1000 mcg/ML injectable solution</td>
<td>2 x 1 ML</td>
<td>2 ML</td>
<td>2 Vial of 1 ML</td>
</tr>
</tbody>
</table>

- 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 as defined by the NCPDP Billing Unit Standard section 5.5.1, which are designed with the intent to be dispensed and billed as a unit of “each”. 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.)
Either may be transmitted with the prescription, but the more descriptive is the preferred (e.g. Capsules, Tablets, Patches).

<table>
<thead>
<tr>
<th>Drug/Item</th>
<th>Quantity Unit of Measure</th>
<th>Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin 500 mg Capsule</td>
<td>30 Capsule</td>
<td>30 EA</td>
</tr>
<tr>
<td>Enalapril 10 mg Tablet</td>
<td>90 Tablet</td>
<td>90 EA</td>
</tr>
<tr>
<td>Lidocaine 5% Patch</td>
<td>30 Patch</td>
<td>30 EA</td>
</tr>
<tr>
<td>Avonex Kit</td>
<td>1 KIT</td>
<td>1 EA</td>
</tr>
</tbody>
</table>

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

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.)

<table>
<thead>
<tr>
<th>Examples of Drugs/Items</th>
<th>Example of Correct Quantity and Quantity Unit of Measure to Transmit with the Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxycycline Hyclate 100Mg Capsule</td>
<td>30 Capsule</td>
</tr>
<tr>
<td>Doxycycline Hyclate 100Mg Tablet</td>
<td>30 Tablet</td>
</tr>
</tbody>
</table>

### 15.3 Implementation Timeline – Quantity Unit of Measure

Although the sunsetting values will be available until October 1, 2019 in SCRIPT version 10.6, the recommendations are to migrate to the above guidance and the allowable qualifier codes as soon as possible to remove them from circulation and facilitate the transition.

The NCI Subset list with the acceptable Quantity Unit of Measure preferred term recommendations. (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).

**From Version 14.01d**

<table>
<thead>
<tr>
<th>NCIt Subset Code</th>
<th>NCit Code</th>
<th>NCPDP Subset Preferred Term</th>
<th>NCPDP Preferred Term</th>
<th>NCit Preferred Term</th>
<th>NCit Definition</th>
<th>Quantity Qualifier in ePrescribing (sent from a Prescriber)</th>
<th>Keep or sunset?</th>
<th>Equivalent Billing Unit</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCIt Subset Code</td>
<td>NCIt Code</td>
<td>NCPDP Subset Preferred Term</td>
<td>NCIt Preferred Term</td>
<td>NCIt Definition</td>
<td>Quantity Qualifier in ePrescribing (sent from a Prescriber)</td>
<td>Keep or Sunset?</td>
<td>Equivalent Billing Unit</td>
<td>Comment</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
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<td>---------</td>
<td></td>
</tr>
<tr>
<td>C89510</td>
<td>C48473</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Ampule</td>
<td>Ampule Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in an ampule.</td>
<td>No</td>
<td>Sunset</td>
<td>ML or EA</td>
<td>An ampule may contain a powder or a liquid and the quantities within an ampule can vary. Example: Lasix ampules come in 2, 4 and 10 mL sizes.</td>
</tr>
<tr>
<td>C89510</td>
<td>C62412</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Applicator</td>
<td>Applicator Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a single applicator.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Silver Nitrate Applicator</td>
</tr>
<tr>
<td>C89510</td>
<td>C78783</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Applicatorful</td>
<td>Applicatorful Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a full applicator.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML</td>
<td>An applicatorful is a dosage measurement and dose size can vary. Example: An applicatorful of estradiol vaginal cream can contain 1, 2, or 4 grams.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48474</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Bag</td>
<td>Bag Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a bag.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML</td>
<td>The amount of substance in a bag may vary. Example: A bag of IV solution can contain 25, 50, 100, 250, 500, or 1000 mL.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48475</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Bar</td>
<td>Bar Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a bar.</td>
<td>No</td>
<td>Sunset</td>
<td>EA</td>
<td>Translates to EA 1:1. NCPDP Work Group 2 defines a bar as 1 EA: Bars have a billing unit of “each”. Commonly, bars also include the weight in grams of the bar on the package; there had been confusion if the billing unit should be “each” or ‘gram”. This was researched as a project by the work group and it was determined that “each” was the appropriate billing unit since bars are dispensed as a whole unit and are not broken apart. Thus, all bars have been standardized to have a billing unit of “each”.</td>
</tr>
<tr>
<td>C89510</td>
<td>C53495</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Bead</td>
<td>Bead Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a bead.</td>
<td>No</td>
<td>Sunset</td>
<td>GM</td>
<td>Discontinued dosage form that is not quantifiable. Example: The now obsolete product Debrisan Beads contained a packet of beads that was measured by grams. It was never measured by the bead.</td>
</tr>
<tr>
<td>C89510</td>
<td>C54564</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Blister</td>
<td>Blister Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a blister.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Advair Diskus or Breo Ellipta</td>
</tr>
<tr>
<td>NCI Subset Code</td>
<td>NCI Subset Code</td>
<td>NCPDP Subset Preferred Term</td>
<td>NCPDP Preferred Term</td>
<td>NCIT Preferred Term</td>
<td>NCIT Definition</td>
<td>Quantity Qualifier in ePrescribing (sent from a Prescriber)</td>
<td>Keep or sunset?</td>
<td>Equivalent Billing Unit</td>
<td>Comment</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
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<td>--------------------</td>
<td>----------------</td>
<td>-----------------------------------------------------------</td>
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<td>------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>CB89510</td>
<td>C53498</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Block</td>
<td>Block Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a block.</td>
<td>No</td>
<td>Sunset</td>
<td>EA</td>
<td>Term does not quantify a measurable size for dispense. Example: Camphor Blocks</td>
</tr>
<tr>
<td>CB89510</td>
<td>C48476</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Bolus</td>
<td>Bolus Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a bolus.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Term does not quantify an actual size and is a measure of dose rather than dispense quantity.</td>
</tr>
<tr>
<td>CB89510</td>
<td>C48477</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Bottle</td>
<td>Bottle Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a bottle.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Term does not quantify a measurable size for dispense. Example: A bottle of Robitussin may contain 120 ML or 240 ML.</td>
</tr>
<tr>
<td>CB89510</td>
<td>C48478</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Box</td>
<td>Box Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a box.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense. Example: A box of syringes may contain 30 EA or 100 EA.</td>
</tr>
<tr>
<td>CB89510</td>
<td>C48479</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Can</td>
<td>Can Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a can.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense. Example: OxiFoam may have 50 GM or 100 GM in a can.</td>
</tr>
<tr>
<td>CB89510</td>
<td>C62413</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Canister</td>
<td>Canister Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a canister.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML</td>
<td>Term does not quantify a measurable size for dispense. Example: A canister of albuterol inhaler may contain 3.7 GM or 6.7 GM.</td>
</tr>
<tr>
<td>CB89510</td>
<td>C64696</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Caplet</td>
<td>Caplet Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a caplet.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1 Example: Tylenol Caplet</td>
</tr>
<tr>
<td>CB89510</td>
<td>C48480</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Capsule</td>
<td>Capsule Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a capsule.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1 Example: Amoxicillin capsule</td>
</tr>
<tr>
<td>CB89510</td>
<td>C54702</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Carton</td>
<td>Carton Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a carton.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense. Example: A carton of alcohol swabs may contain 100 EA or 200 EA.</td>
</tr>
<tr>
<td>CB89510</td>
<td>C48481</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Cartridge</td>
<td>Cartridge Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a cartridge.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Term does not quantify a measurable size for dispense. Example: An insulin cartridge may contain 1.5 ML or 3 ML.</td>
</tr>
<tr>
<td>CB89510</td>
<td>C62414</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Case</td>
<td>Case Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a case.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense. Example: A case of intravenous solution may contain 12 X 250 ML or 24 X 250 ML.</td>
</tr>
<tr>
<td>NCIt Subset Code</td>
<td>NCIt Code</td>
<td>NCPDP Subset Preferred Term</td>
<td>NCPDP Preferred Term</td>
<td>NCIt Preferred Term</td>
<td>NCIt Definition</td>
<td>Quantity Qualifier in ePrescribing (sent from a Prescriber)</td>
<td>Keep or sunset?</td>
<td>Equivalent Billing Unit</td>
<td>Comment</td>
</tr>
<tr>
<td>-----------------</td>
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<td>-------------------------------------------------------------</td>
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<td>---------</td>
</tr>
<tr>
<td>C9510</td>
<td>C69093</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Cassette</td>
<td>Cassette Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a cassette.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense. A cassette may contain any number of discrete units, for example, a 10 ml or 20 mL cassette of fentanyl injection for PCA (patient controlled analgesia).</td>
</tr>
<tr>
<td>C9510</td>
<td>C48484</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Container</td>
<td>Container Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) in a container.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a specific measurable size. A container may have many different metric amounts. Example: A container of dietary supplement may contain 120 ML or 240 ML.</td>
</tr>
<tr>
<td>C9510</td>
<td>C48489</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Cylinder</td>
<td>Cylinder Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a cylinder.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a specific measurable size. A cylinder of oxygen may contain 20,000 ML or 40,000 ML.</td>
</tr>
<tr>
<td>C9510</td>
<td>C16830</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Device</td>
<td>Device</td>
<td>Any physical object that is useful for prevention, diagnosis, monitoring, or treatment of disease, delivery of drug or other conditions.</td>
<td>Yes</td>
<td>Sunset</td>
<td>EA</td>
<td>NCPDP Billing Unit</td>
</tr>
<tr>
<td>C9510</td>
<td>C48490</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Disk</td>
<td>Disk Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a disk.</td>
<td>No</td>
<td>Sunset</td>
<td>EA</td>
<td>Discontinued dosage form.</td>
</tr>
<tr>
<td>C9510</td>
<td>C62417</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Dose Pack</td>
<td>Dose Pack Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a dose pack.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size. A dose pack may have many different metric amounts contained within it.</td>
</tr>
<tr>
<td>C9510</td>
<td>C96265</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Dual Pack</td>
<td>Dual Pack Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) in a product containing two individual units.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size. A dual pack represents 2 of another other unit of measurement.</td>
</tr>
<tr>
<td>C9510</td>
<td>C64933</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Each</td>
<td>Each</td>
<td>Used to refer to every member of a group of people or things, considered individually.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>NCPDP Billing Unit</td>
</tr>
<tr>
<td>C9510</td>
<td>C53499</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Film</td>
<td>Film Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a film.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. No current example</td>
</tr>
<tr>
<td>C9510</td>
<td>C48494</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Fluid Ounce</td>
<td>Fluid Ounce US</td>
<td>A traditional unit of liquid volume equal in the US customary system to 1/16 pint, or 1.804 687 cubic inches or 29.573 531 milliliters.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Not a preferred metric unit of measure. Convert prescriptions written in ounces to ML using number of ounces x 30.</td>
</tr>
<tr>
<td>NCIt Subset Code</td>
<td>NCIt Code</td>
<td>NCPDP Subset Preferred Term</td>
<td>NCPDP Preferred Term</td>
<td>NCIt Preferred Term</td>
<td>NCIt Definition</td>
<td>Quantity Qualifier in ePrescribing (sent from a Prescriber)</td>
<td>Keep or sunset?</td>
<td>Equivalent Billing Unit</td>
<td>Comment</td>
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<tr>
<td>C89510</td>
<td>C101680</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>French</td>
<td>French Catheter Gauge</td>
<td>A number representing the outer diameter of a catheter where each integer represents 1/3 of a millimeter.</td>
<td>No</td>
<td>Sunset</td>
<td>EA</td>
<td>Term does not quantify a dispense unit, it is the size of a urinary catheter.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48580</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Gallon</td>
<td>Gallon US</td>
<td>The US unit of liquid volume legally defined as 3785.411784 milliliters (3.785 411 784 liters), or 231 cubic inches. The US gallon holds 4 liquid quarts; the gallon of water gallon weighs approximately 8.33 pounds.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Not a preferred metric unit of measure. Convert prescriptions written in ounces to ML using number of gallons x 128 ounces x 30 ML</td>
</tr>
<tr>
<td>C89510</td>
<td>C48155</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Gram</td>
<td>Gram</td>
<td>The metric unit of mass equal to one thousandth of a kilogram. One gram equals approximately 15.432 grains or 0.035 273 966 ounce.</td>
<td>Yes</td>
<td>Keep</td>
<td>GM</td>
<td>NCPDP Billing Unit</td>
</tr>
<tr>
<td>C89510</td>
<td>C69124</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Gum</td>
<td>Gum Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a gum.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example Nicorette Gum</td>
</tr>
<tr>
<td>C89510</td>
<td>C48499</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Implant</td>
<td>Implant Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in an implant.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Ozurdex intraocular implant.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48501</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Inhalation</td>
<td>Inhalation Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in an inhalation.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C62275</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Inhaler</td>
<td>Inhaler Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in an inhaler.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C62418</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Inhaler Refill</td>
<td>Inhaler Refill Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in an inhaler refill.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C62276</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Insert</td>
<td>Insert Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in an insert.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Lacrisert.</td>
</tr>
<tr>
<td>C89510</td>
<td>C67283</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Intravenous Bag</td>
<td>Intravenous Bag Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in an intravenous bag.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Term does not quantify a measurable size for dispense. An intravenous bag may contain 250 ML or 500 ML.</td>
</tr>
<tr>
<td>NCIt Subset Code</td>
<td>NCIt Code</td>
<td>NCPDP Subset Preferred Term</td>
<td>NCPDP Preferred Term</td>
<td>NCIT Preferred Term</td>
<td>NCIT Definition</td>
<td>Quantity Qualifier in ePrescribing (sent from a Prescriber)</td>
<td>Keep or sunset?</td>
<td>Equivalent Billing Unit</td>
<td>Comment</td>
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</tr>
<tr>
<td>C89510</td>
<td>C28252</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Kilogram</td>
<td>Kilogram</td>
<td>A basic SI unit of mass. It is defined as the mass of an international prototype in the form of a platinum-iridium cylinder kept at Sevres in France. A kilogram is equal to 1,000 grams and 2.204 622 6 pounds.</td>
<td>No</td>
<td>Sunset</td>
<td>GM</td>
<td>Not a preferred metric unit of measure. Convert kilograms to grams using the kilogram measurement x 1000.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48504</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Kit</td>
<td>Kit Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a kit.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Hard to quantify, as NCPDP Billing Unit Standard has all 3 units for kits based on rules, but should be understood by receiving pharmacies.</td>
</tr>
<tr>
<td>C89510</td>
<td>C120263</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Lancet</td>
<td>Lancet</td>
<td>A small, sharp, needle-like instrument that is used to puncture the skin.</td>
<td>Yes</td>
<td>EA</td>
<td>Translates to EA 1:1.</td>
<td>Translates to EA 1:1. Example : Cepacol Lozenges</td>
</tr>
<tr>
<td>C89510</td>
<td>C48505</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Liter</td>
<td>Liter</td>
<td>The non-SI unit of volume accepted for use with SI. One liter is equal to cubic decimeter, or one thousandth of cubic meter, or 1000 cubic centimeters, or approximately 61.023 744 cubic inches.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Not a preferred metric unit of measure. Convert liters to milliliters using the liter measurement x 1000.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48506</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Lozenge</td>
<td>Lozenge Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a lozenge.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example : Cepacol Lozenges</td>
</tr>
<tr>
<td>C89510</td>
<td>C48491</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Metric Drop</td>
<td>Metric Drop</td>
<td>A unit of volume used in pharmacy and equal to 0.05 milliliter (20 drops/ml).</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48512</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Milliequivalent</td>
<td>Milliequivalent</td>
<td>A unit of relative amount of a substance equal to one thousandth of an equivalent weight.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C28253</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Milligram</td>
<td>Milligram</td>
<td>A metric unit of mass equal to one thousandth of a gram or 1000 micrograms. One milligram equals approximately 0.015432 grain or 35.274 x 10E-6 ounce.</td>
<td>No</td>
<td>Sunset</td>
<td>GM</td>
<td>Not a preferred metric unit of measure. Convert milligrams to grams using the milligram measurement/1000.</td>
</tr>
<tr>
<td>C89510</td>
<td>C28254</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Milliliter</td>
<td>Milliliter</td>
<td>A unit of volume equal to one millionth (10E-6) of a cubic meter, one thousandth of a liter, one cubic centimeter, or 0.061023 7 cubic inch. A cubic centimeter is the CGS unit of volume.</td>
<td>Yes</td>
<td>Keep</td>
<td>ML</td>
<td>NCPDP Billing Unit</td>
</tr>
<tr>
<td>NCIt Subset Code</td>
<td>NCIt Code</td>
<td>NCPDP Subset Preferred Term</td>
<td>NCPDP Preferred Term</td>
<td>NCIt Preferred Term</td>
<td>NCIt Definition</td>
<td>Quantity Qualifier in ePrescribing (sent from a Prescriber)</td>
<td>Keep or sunset?</td>
<td>Equivalent Billing Unit</td>
<td>Comment</td>
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<tr>
<td>C89510</td>
<td>C28251</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Millimeter</td>
<td>Millimeter</td>
<td>A metric unit of length equal to one thousandth of a meter (10E-3 meter) or approximately 0.03937 inch.</td>
<td>No</td>
<td>Sunset</td>
<td>EA</td>
<td>Not a measurement of quantity. It is a measurement of length.</td>
</tr>
<tr>
<td>C89510</td>
<td>C71204</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Nebule</td>
<td>Nebule Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a nebule.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Term does not quantify a measurable size for dispense. Example: A nebule of albuterol may contain 0.5 ML or 2.5 ML.</td>
</tr>
<tr>
<td>C89510</td>
<td>C100052</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Needle Free Injection</td>
<td>Needle Free Injection Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a single needle free injection unit.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C69086</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Ocular System</td>
<td>Ocular System Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) in an ocular system.</td>
<td>No</td>
<td>Sunset</td>
<td>EA</td>
<td>Discontinued dosage form.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48519</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Ounce</td>
<td>Ounce</td>
<td>The traditional unit of mass. The avoirdupois ounce is equal to 1/16 pound, or 28.3495 grams, or 0.911 457 troy ounce.</td>
<td>No</td>
<td>Sunset</td>
<td>GM</td>
<td>Not a preferred metric unit of measure. Convert prescriptions written in ounces to GM using number of ounces x 30.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48520</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Package</td>
<td>Package Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a package.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48521</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Packet</td>
<td>Packet Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a packet.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Questran Powder Packets.</td>
</tr>
<tr>
<td>C89510</td>
<td>C65032</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Pad</td>
<td>Pad Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a pad.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Pacnex HP Cleansing Pads.</td>
</tr>
<tr>
<td>C89510</td>
<td>C82484</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Paper</td>
<td>Paper Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a piece of paper.</td>
<td>No</td>
<td>Sunset</td>
<td>EA</td>
<td>Term does not quantify a measurable size for dispense. This dose form is no longer used.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48524</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Patch</td>
<td>Patch Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a patch.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Transderm-Nitro.</td>
</tr>
<tr>
<td>C89510</td>
<td>C120126</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Pen Needle</td>
<td>Pen Needle</td>
<td>A single use, hollow needle embedded in a plastic hub, which is then attached to a preloaded syringe (pen) to facilitate the delivery of medication.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48529</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Pint</td>
<td>Pint</td>
<td>A United States liquid unit equal to 16 fluid ounces; two pints equal one quart.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Not a preferred metric unit of measure. Convert prescriptions written in pints to ML using number of pints x 480.</td>
</tr>
<tr>
<td>NCIt Subset Code</td>
<td>NCIt Code</td>
<td>NCPDP Subset Preferred Term</td>
<td>NCPDP Preferred Term</td>
<td>NCIt Preferred Term</td>
<td>NCIt Definition</td>
<td>Quantity Qualifier in ePrescribing (sent from a Prescriber)</td>
<td>Keep or sunset?</td>
<td>Equivalent Billing Unit</td>
<td>Comment</td>
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</tr>
<tr>
<td>C89510</td>
<td>C48530</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Pouch</td>
<td>Pouch Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a pouch.</td>
<td>No Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
<td></td>
</tr>
<tr>
<td>C89510</td>
<td>C48531</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Pound</td>
<td>Pound</td>
<td>The traditional unit of mass. By international agreement, one avoirdupois pound is equal to exactly 0.453 592 37 kilogram, 16 ounces, or 1.215 28 troy pounds.</td>
<td>No Sunset</td>
<td>GM</td>
<td>Not a preferred metric unit of measure. Convert prescriptions written in pounds to GM using number of pounds x 454.</td>
<td></td>
</tr>
<tr>
<td>C89510</td>
<td>C97717</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Pre-filled Pen Syringe</td>
<td>Pre-filled Pen Syringe</td>
<td>A syringe that lacks a conventional plunger, resembles a writing pen, and is designed to dispense a pre-loaded dose of a drug. It may be designed to deliver a single dose or be designed for repeated use.</td>
<td>No Sunset</td>
<td>ML</td>
<td>Term does not quantify a measurable size for dispense.</td>
<td></td>
</tr>
<tr>
<td>C89510</td>
<td>C65060</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Puff</td>
<td>Puff Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a puff.</td>
<td>No Sunset</td>
<td>GM or ML</td>
<td>Term does not quantify a measurable size for dispense.</td>
<td></td>
</tr>
<tr>
<td>C89510</td>
<td>C111984</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Pump</td>
<td>Pump Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in one actuation of a pumping device.</td>
<td>No Sunset</td>
<td>GM or ML</td>
<td>Term does not quantify a measurable size for dispense.</td>
<td></td>
</tr>
<tr>
<td>C89510</td>
<td>C48534</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Quart</td>
<td>Quart</td>
<td>A United States liquid unit equal to 32 fluid ounces; four quarts equal one gallon.</td>
<td>No Sunset</td>
<td>ML</td>
<td>Not a preferred metric unit of measure. Convert prescriptions written in pints to ML using number of quarts x 960.</td>
<td></td>
</tr>
<tr>
<td>C89510</td>
<td>C62609</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Ring</td>
<td>Ring Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a ring.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: NuvaRing.</td>
</tr>
<tr>
<td>C89510</td>
<td>C71324</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Sachet</td>
<td>Sachet Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a sachet</td>
<td>No Sunset</td>
<td>EA</td>
<td>Translates to EA 1:1. This term is not currently used in the United States, but is similar to the packet dosing unit.</td>
<td></td>
</tr>
<tr>
<td>C89510</td>
<td>C48536</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Scoopful</td>
<td>Scoopful Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained typically in a spoon-shaped object.</td>
<td>No Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
<td></td>
</tr>
<tr>
<td>C89510</td>
<td>C53502</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Sponge</td>
<td>Sponge Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a sponge.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. No current example.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48537</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Spray</td>
<td>Spray Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a spray.</td>
<td>No Sunset</td>
<td>GM or ML</td>
<td>Term does not quantify a measurable size for dispense.</td>
<td></td>
</tr>
<tr>
<td>NCIt Subset Code</td>
<td>NCIt Code</td>
<td>NCPDP Subset Preferred Term</td>
<td>NCPDP Preferred Term</td>
<td>NCIT Preferred Term</td>
<td>NCIT Definition</td>
<td>Qualifier in ePrescribing (sent from a Prescriber)</td>
<td>Keep or sunset?</td>
<td>Equivalent Billing Unit</td>
<td>Comment</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td>---------------------</td>
<td>----------------</td>
<td>--------------------------------------------------</td>
<td>----------------</td>
<td>-------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>C89510</td>
<td>C53503</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Stick</td>
<td>Stick Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a stick.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Silver Nitrate Stick.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48538</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Strip</td>
<td>Strip Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a strip.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Glucose Testing Strip.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48539</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Suppository</td>
<td>Suppository Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a suppository.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Promethazine rectal suppositories.</td>
</tr>
<tr>
<td>C89510</td>
<td>C53504</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Swab</td>
<td>Swab Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a swab.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Alcohol swab.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48540</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Syringe</td>
<td>Syringe Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a single syringe.</td>
<td>No</td>
<td>Sunset</td>
<td>ML or EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48541</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Tablespoon</td>
<td>Tablespoon Dosing Unit</td>
<td>A unit of volume informally used in pharmacy. Under the metric system the tablespoon has been standardized at 15 milliliters in the US, Britain, Canada, and New Zealand, and at 20 milliliters in Australia and some European countries.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Not a preferred metric unit of measure. Convert prescriptions written in tablespoons to ML using number of tablespoons x 15.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48542</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Tablet</td>
<td>Tablet Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a tablet.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Tenormin 50 mg tablet.</td>
</tr>
<tr>
<td>C89510</td>
<td>C62421</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Tabminder</td>
<td>Tabminder Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) administered by a tabminder.</td>
<td>No</td>
<td>Sunset</td>
<td>EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48543</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Tampon</td>
<td>Tampon Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a tampon.</td>
<td>No</td>
<td>Sunset</td>
<td>EA</td>
<td>Translates to EA 1:1. No current example of a medicated tampon.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48544</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Teaspoon</td>
<td>Teaspoon Dosing Unit</td>
<td>A unit of volume used in pharmacy and equal to 5 milliliters.</td>
<td>No</td>
<td>Sunset</td>
<td>ML</td>
<td>Not a preferred metric unit of measure. Convert prescriptions written in teaspoons to ML using number of teaspoons x 5.</td>
</tr>
<tr>
<td>C89510</td>
<td>C54704</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Tray</td>
<td>Tray Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained on a tray.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48548</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Troche</td>
<td>Troche Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a troche.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Clotrimazole Troche</td>
</tr>
<tr>
<td>NCIt Subset Code</td>
<td>NCIt Code</td>
<td>NCPDP Subset Preferred Term</td>
<td>NCPDP Preferred Term</td>
<td>NCIt Preferred Term</td>
<td>NCIt Definition</td>
<td>Quantity Qualifier in ePrescribing (sent from a Prescriber)</td>
<td>Keep or sunset?</td>
<td>Equivalent Billing Unit</td>
<td>Comment</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td>---------------------</td>
<td>----------------</td>
<td>-------------------------------------------------</td>
<td>---------------</td>
<td>-------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>C89510</td>
<td>C48549</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Tube</td>
<td>Tube Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a tube.</td>
<td>No</td>
<td>Sunset</td>
<td>GM or ML or EA</td>
<td>Term does not quantify a measurable size for dispense.</td>
</tr>
<tr>
<td>C89510</td>
<td>C38046</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Unspecified</td>
<td>Unspecified</td>
<td>Not stated explicitly or in detail.</td>
<td>Yes</td>
<td>Keep</td>
<td>GM or ML or EA</td>
<td>This term is to be used only if the dosage form or measurement is not listed elsewhere on this sheet. It was placed here to provide flexibility for an occasion when a new Quantity Unit Of Measure is not yet available and none of the existing terms fit the amount prescribed. Use of this term may set an auditing flag if used indiscriminately.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48551</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Vial</td>
<td>Vial Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a single vial.</td>
<td>No</td>
<td>Sunset</td>
<td>ML or EA</td>
<td>A vial may contain a powder or a liquid and the quantities within a vial can vary. Example: Furosemide vials come in 2, 4, and 10 mL sizes.</td>
</tr>
<tr>
<td>C89510</td>
<td>C48552</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Wafer</td>
<td>Wafer Dosing Unit</td>
<td>A dosing unit equal to the amount of active ingredient(s) contained in a wafer.</td>
<td>Yes</td>
<td>Keep</td>
<td>EA</td>
<td>Translates to EA 1:1. Example: Metamucil Wafer.</td>
</tr>
</tbody>
</table>
16. ASSISTANCE WITH THE USE OF SCRIPT IN THE LONG TERM AND POST ACUTE CARE SETTINGS
To transition to SCRIPT Standard Implementation Guide Version 10.6 for the long term and post-acute care (LTPAC) implementers, the NCPDP WG14 LTPAC ePrescribing Task Group makes the following recommendations.

16.1 DEMOGRAPHIC AND CONTACT INFORMATION FOR PHARMACY, FACILITY, PRESCRIBER AND SUPERVISOR
The following tables provide the recommended 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.
- The <Supervisor> should be sent for all extenders (non-physician prescribers), as required.

Legend:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Conditional – specific conditions appear at end of table</td>
</tr>
<tr>
<td>F</td>
<td>Follow SCRIPT Standard Implementation Guide for specific requirements</td>
</tr>
<tr>
<td>M</td>
<td>Mandatory</td>
</tr>
<tr>
<td>N</td>
<td>Not Used</td>
</tr>
<tr>
<td>O</td>
<td>Optional</td>
</tr>
<tr>
<td>R</td>
<td>Required for LTPAC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field</th>
<th>Pharmacy</th>
<th>Facility</th>
<th>Prescriber</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;StoreName&gt;</td>
<td>M</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>&lt;ClinicName&gt;</td>
<td>N</td>
<td>N</td>
<td>C</td>
<td>O</td>
</tr>
<tr>
<td>&lt;FacilityName&gt;</td>
<td>N</td>
<td>R</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>&lt;Specialty&gt;</td>
<td>N</td>
<td>N</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>&lt;LastName&gt;</td>
<td>N</td>
<td>N</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>&lt;FirstName&gt;</td>
<td>N</td>
<td>N</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>&lt;MiddleName&gt;</td>
<td>N</td>
<td>N</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>&lt;Suffix&gt;</td>
<td>N</td>
<td>N</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>&lt;Prefix&gt;</td>
<td>N</td>
<td>N</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>&lt;AddressLine1&gt;</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
</tr>
<tr>
<td>&lt;AddressLine2&gt;</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>&lt;City&gt;</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
</tr>
</tbody>
</table>
### 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.

#### 16.2 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.

### 16.3 Patient Demographics and Identification

The following table provides the recommended usage for all demographic and contact information fields for patients.

Legend:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Conditional – specific conditions appear at end of table</td>
</tr>
<tr>
<td>F</td>
<td>Follow SCRIPT Standard Implementation Guide for specific requirements</td>
</tr>
<tr>
<td>M</td>
<td>Mandatory</td>
</tr>
<tr>
<td>N</td>
<td>Not Used</td>
</tr>
<tr>
<td>O</td>
<td>Optional</td>
</tr>
<tr>
<td>R</td>
<td>Required for LTPAC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td><code>&lt;PatientRelationship&gt;</code></td>
<td>O</td>
</tr>
<tr>
<td><code>&lt;Identification&gt;</code></td>
<td>R</td>
</tr>
<tr>
<td><code>&lt;LastName&gt;</code></td>
<td>M</td>
</tr>
<tr>
<td><code>&lt;FirstName&gt;</code></td>
<td>M</td>
</tr>
<tr>
<td><code>&lt;MiddleName&gt;</code></td>
<td>O</td>
</tr>
<tr>
<td><code>&lt;Suffix&gt;</code></td>
<td>O</td>
</tr>
<tr>
<td><code>&lt;Prefix&gt;</code></td>
<td>O</td>
</tr>
<tr>
<td><code>&lt;Gender&gt;</code></td>
<td>M</td>
</tr>
<tr>
<td><code>&lt;DateOfBirth&gt;</code></td>
<td>R</td>
</tr>
<tr>
<td><code>&lt;AddressLine1&gt;</code></td>
<td>O</td>
</tr>
<tr>
<td><code>&lt;AddressLine2&gt;</code></td>
<td>O</td>
</tr>
<tr>
<td><code>&lt;City&gt;</code></td>
<td>O</td>
</tr>
<tr>
<td><code>&lt;State&gt;</code></td>
<td>O</td>
</tr>
<tr>
<td><code>&lt;ZipCode&gt;</code></td>
<td>O</td>
</tr>
<tr>
<td><code>&lt;CommunicationNumber&gt;</code> value</td>
<td>O</td>
</tr>
<tr>
<td>Beeper</td>
<td></td>
</tr>
<tr>
<td>Cellular</td>
<td></td>
</tr>
<tr>
<td>eMail</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Field</td>
<td>Patient</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>&lt;CommunicationNumber&gt; value Home</td>
<td>0</td>
</tr>
<tr>
<td>&lt;CommunicationNumber&gt; value Telephone</td>
<td>M</td>
</tr>
<tr>
<td>&lt;CommunicationNumber&gt; value Work</td>
<td>0</td>
</tr>
<tr>
<td>&lt;FacilityUnit&gt;</td>
<td>C</td>
</tr>
<tr>
<td>&lt;Bed&gt;</td>
<td>C</td>
</tr>
<tr>
<td>&lt;Room&gt;</td>
<td>C</td>
</tr>
</tbody>
</table>

Conditional Usage:
- <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:
In SCRIPT Standard Implementation Guide Version 10.6, the <Patient><Identifiers> element supports up to two occurrences. The following identifiers are recommended for use 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.

16.4 PRESCRIPTION/OPTER MESSAGE
The following guidance applies to the SCRIPT Standard Implementation Guide Version 10.6 <NewRx> message—used to convey a new medication order to the pharmacy—as well as other SCRIPT messages that contain prescription content (e.g. <CancelRx>, <RxFill>, <RxChangeRequest>, and <RxChangeResponse>).

16.4.1 MEDICATION DESCRIPTION AND IDENTIFIERS
In addition to the mandatory <DrugDescription> element, populate <DrugCoded><DrugDBCode> with the RxNorm identifier and <DrugCoded><DrugDBCodeQualifier> with the associated RxNorm term type for the prescribed medication when one exists. If an RxNorm code has not been assigned to the medication, populate the <DrugCoded><ProductCode> element with a representative NDC code—an NDC reflecting the medication name, strength and dose form of the prescribed medication.
For more information on the use of the Medication Description and Identifiers see the following sections in this guide:

- “Recommendations for Consistent Use of Drug Identification Fields Used in SCRIPT Transactions”
- “RxNorm Guidance for SCRIPT”

16.4.2 DIRECTIONS/SIG

In SCRIPT Standard Implementation Guide Version 10.6, the <Directions> element is limited to 140 characters, which can be a challenge for long directions/Sigs. This issue has been addressed in a future version of the SCRIPT Standard, but until that is available for use, below is the recommended approach:

- If the complete Sig cannot be provided in the space allotted, the prescription should be sent in an alternative method (written/phone/etc.).
- Supplemental administration information such as hours of administration do not need to be sent to the pharmacy. It is recommended to send the pharmacy the required directions for the dispensing and labeling of the medication.
- Do not include compounding instructions, diagnosis related information, facility administration details, etc. in the <MedicationPrescribed><Directions> element.

Economizing physician’s directions is extremely important to fit the standard field length. Direction efficiency points include:

- State the verb, such as “Give”, “Instill”, “Inject”, only once.
- State the route of administration only once
- Do not state an indication of use in the <Directions> for routine orders
- On tapering orders, replace “THEN” with “;”
- On tapering orders, state a repeating frequency only once

Prednisone Taper Example:
Long version:
GIVE 6 TABS BY MOUTH EVERY MORNING FOR 4 DAYS THEN GIVE 4 TABS BY MOUTH EVERY MORNING FOR 3 DAYS THEN GIVE 2 TABS BY MOUTH EVERY MORNING FOR 3 DAYS THEN GIVE 1 TAB BY MOUTH EVERY MORNING FOR 3 DAYS THEN GIVE 0.5 TABLETS BY MOUTH EVERY MORNING FOR 4 DAYS

Shortened by using suggested efficiency points:
GIVE BY MOUTH EVERY MORNING AS DIRECTED – 6 TABS FOR 4 DAYS; 4 TABS FOR 3 DAYS; 2 TABS FOR 3 DAYS; 1 TAB FOR 3 DAYS; 0.5 TAB FOR 4 DAYS; STOP
16.4.3 PRESCRIBED QUANTITY AND AUTHORIZED REFILLS

16.4.3.1 FIXED QUANTITY ORDERS
When an order is specified for a particular quantity (e.g., dispense 10 tablets), the <Quantity><CodeListQualifier> is populated with the value 38 (Prescribed Quantity). When this value is used, the <Quantity><Value> element must hold a specific quantity to dispense.

- Example:
  - <Directions> contains “2 tabs daily for 6 days”
  - <Quantity><Value> element contains “12”
  - <PotencyUnitCode> contains “C48542” (code indicating “tablet”)

Additionally, the <MedicationPrescribed><Refills> element can be used to authorize dispensing of additional refills after the initial quantity is used.

16.4.3.2 PHARMACY DETERMINES QUANTITY ORDERS
SCRIPT Standard Implementation Guide Version 10.6 supports a <Quantity><Qualifier> value of “QS” (Quantity Sufficient) directing the pharmacy to dispense the “quantity sufficient” to support the patient needs according to dosing described in the <Directions> element. When the <Quantity><CodeListQualifier> element is populated with “QS”, <Quantity><Value> must be populated with the value “0”.

Additionally, the <MedicationPrescribed><Refills> composite must be used to authorize dispensing of additional refills after the initial quantity is used, based on the pharmacy’s determination by setting the <Refills><Qualifier> value to “PRN” and <Refills><Value> must not be sent.

16.4.4 ORDER DATE
The <MedicationPrescribed><WrittenDate> is used to communicate the date on which the prescriber ordered the medication.

16.4.5 DELIVERY
The <NeededNoLaterThan> date element can be used to indicate a desired delivery date/time. SCRIPT also has an element in which the reason for the requested delivery timing can be provided. For more information see the SCRIPT Standard Implementation Guide Version 10.6.

If a medication is needed immediately (i.e., is a “Stat” order), the facility should contact the pharmacy by phone to ensure the fastest possible delivery.
16.4.6 **DIAGNOSIS**
Diagnosis is required for medication administration and should be sent on all electronic medications orders. For LTPAC, it is recommended the SCRIPT message must contain at least one loop populated with the primary diagnosis related to the prescription in <MedicationPrescribed><Diagnosis><Primary>.
- Only ICD-9 or ICD-10, when mandated, should be used to indicate the diagnosis.
- SNOMED CT® diagnosis codes are not supported in SCRIPT 10.6.

16.4.7 **PRESCRIPTION-RELATED ALERT/DUR INFORMATION**

16.4.8 **OTHER PRESCRIPTION-RELATED CLINICAL INFORMATION**
The SCRIPT Standard Implementation Guide Version 10.6 new prescription message (NewRx) does not contain elements to convey other clinical information that may be related to a patient prescription (except limited information in the Observation Segment, which has been enhanced in a future version). However, the Census message does enable the facility to share the following patient information with their pharmacy:
- Patient allergy information
- Patient conditions

16.5 **CHANGES TO EXISTING ORDERS**
The SCRIPT Standard includes elements that can be used to:
- Link the separate SCRIPT “discontinue” <CancelRx> and “new order” <NewRx> messages used to communicate an order change to the pharmacy.
- Indicate the nature of the order change in the <CancelRx> message that starts the change communication—so that the pharmacy can determine the appropriate action to take. For example, certain order changes may be handled through a modification of the existing prescription record in the pharmacy system, and others may require cancelation of the existing prescription and replacement with a new prescription.

When discontinuing a previously dispensed medication:
- The <Request><ChangeOfPrescriptionStatusFlag> must be set to “D” (Discontinue).
- Both the pharmacy’s prescription number <RxReferenceNumber> and the prescribing system-assigned order number <PrescriberOrderNumber> must be included in the <CancelRx> message.

When canceling a medication order before it has been dispensed by the pharmacy:
- The <Request><ChangeOfPrescriptionStatusFlag> must be set to “C” (Cancel).
• The prescribing system-assigned order number <PrescriberOrderNumber> must be included in the <CancelRx> message.

Refer to section “Long Term Care (LTC) Medication Change Process” in the SCRIPT Standard Implementation Guide Version 10.6 or Version 2017071 for additional details.

16.6 **COMPOUND GUIDANCE FOR V2017071**

For compound prescriptions originating in an LTPAC setting:
While it is recommended to submit compound name as well as ingredients in the DrugDescription, if no compound ingredients were detailed or if the provider does not specify the ingredients then the pharmacy will use their pre-set formula to fill the prescription.
Example of the LTPAC compound where compound name & ingredients are all listed in the DrugDescription, separate compound loops are not present:

Example 1: Compound with CF Qualifier and value of 0, pharmacy to determine quantity and dispensing.
<DrugDescription> Magic Mouthwash</DrugDescription>
<Quantity>
<Value>0</Value>
<CodeListQualifier>CF</CodeListQualifier>
<QuantityUnitOfMeasure>
<Code>C38046</Code>
</QuantityUnitOfMeasure>
</Quantity>

Examples 2: Compound with CF Qualifier and a value greater than 0
<DrugDescription> Magic Mouthwash #1</DrugDescription>
<Quantity>
<Value>100</Value>
<CodeListQualifier>CF</CodeListQualifier>
<QuantityUnitOfMeasure>
<Code>C28254</Code>
</QuantityUnitOfMeasure>
</Quantity>
Example 3: Compound with ingredients listed in the drug description with CF Qualifier and value of 0, pharmacy to determine quantity and dispensing.

<DrugDescription> Magic Mouthwash (BENADRYL/NYSTATIN/VISCOUS L)</DrugDescription>
<Quantity>
<Value>0</Value>
<CodeListQualifier>CF</CodeListQualifier>
<QuantityUnitOfMeasure>
<Code>C38046</Code>
</QuantityUnitOfMeasure>
</Quantity>

16.7 FREQUENTLY ASKED QUESTIONS

16.7.1 USAGE OF FACILITY ADDRESS ON DISCHARGE ORDERS

**Question:** Should the Facility Address info be Included on the discharge orders?

**Response:** When transmitting a discharge prescription(s) for a patient from a LTPAC facility ePrescribing application, it is recommended that all applicable facility information, including address, is sent in the facility segment in addition to all required patient attributes in the patient segment. If the discharge medications are to be delivered to the nursing facility address an indication of that request should be included in the Delivery Request and DeliveryLocatopm fields.

16.7.2 TRANSMITTING STANDARD MEDICATION ADMINISTRATION TIME CODES

**Question:** Is it illegal for a LTPAC facility to electronically transmit standard medication administration time codes to the pharmacy?

**Response:** The standard does not prevent the sending of standard medication administration time codes. However, if a specific administration time is specified in the Sig, then it must be transmitted electronically as part of the legal order.
16.7.3 **RXHistory Request from a Hospital**  
**Question:** How should a hospital be identified as the requestor for the RxHistory transactions?  
**Response:** The facility name should be entered into the Prescriber Last Name field and then enter the organization NPI in the Prescriber Identification element.

16.7.4 **<NumberOfRefills> Field on Open Ended Orders**  
**Question:** How should it be populated for open ended orders in LTPAC where the number of refills are designated since in V2017071 <NumberOfRefills> field is defined as a numeric field with a length of 2 with no qualifiers?  
**Response:** For open ended long term care orders, the <NumberOfRefills> would be equal to “99”.

16.7.5 **Quantity Sufficient in Resupply Transaction**  
**Question:** Can the CodeListQualifier of QS and Value of “0” be sent in a Resupply Transaction?  
**Response:** The Resupply transaction may contain a <CodeListQualifier> of QS and corresponding <Value> of 0 to indicate the need for inventory on an open order. If the prescription was previously set as a predetermined amount such as 90 tabs and the Resupply message is simply requesting 30 of those tabs then the  <CodeListQualifier> would be 38  and corresponding <Value> would be 30.

16.7.6 **Purpose of the <Mailbox><AcknowledgementID> in Resupply**  
**Question:** What is the purpose of the <Mailbox><AcknowledgementID> in the Resupply message?  
**Response:** The <Mailbox><AcknowledgementID> is an optional element used when the messages are mailboxed. It is up to trading partner agreements to determine if or how this element is populated. A DERF is being submitted to update the SCRIPT Implementation Guide and the definition of the element for a future version.

16.7.7 **Prescriber on a Recertification Message**  
**Question:** Can I transmit a Recertification transaction for a prescriber that is different than the original prescriber of the prescription?
Response: Yes. For example, if prescriber A is the prescriber of the original order (NewRx), and prescriber B does the recertification, then Recertification transaction will contain information of only prescriber B who is authorizing the continuation of therapy. The Recertification transaction does not have prescriptive authority and this scenario does not change the prescribing practitioner.

16.7.8 ASCII 7-Bit Character Set

Question: Does the standard support a character set other than the basic ASCII 7-bit?
Response: No. The submitting system when transmitting an NCPDP standard must send using the basic ASCII 7-bit character set. For example, a person known by the last name of Pérez, would have to be transmitted without the accents.

The NCPDP SCRIPT schema currently does not allow use of the ASCII extended character set. While XML notation allows extended characters to be represented with escape sequences, this practice must not be used outside of trading partner agreements. Unless both systems support, and use escaped extended characters this practice would result in system errors or matching problems (e.g. Pérez is not the same as Perez).

Allowed ASCII characters are:
<space>
0123456789
ABCDEFGHIJKLMNOPQRSTUVWXYZ
~!@#$%^&*()_=-+\{|}';",.<>/?
abcdefghijklmnopqrstuvwxyz

Disallowed ASCII character codes include 0 - 31 (0 - 1F hex) are considered to be control characters and are not allowed in a transaction. Likewise, characters higher than ASCII 126 (higher than 7E hex) must not be used.
17. EXTERNAL CODE LIST ASSISTANCE

This brief overview appears in the NCPDP External Code List document to help the implementer navigate to the appropriate URL to obtain info. While guidance on external code lists of other organizations or companies is not NCPDP's expertise, we do try to work with federal agencies to provide input to make the use of federally named code sets easier for the implementer.

17.1 NCI THESAURUS CODE LISTS

The Federal Medication Terminologies (FMT) is a set of controlled terminologies and code sets from component vocabulary systems developed and maintained by the Food and Drug Administration, National Library of Medicine, Veterans Health Administration, National Cancer Institute and Agency for Healthcare Research and Quality. The National Cancer Institute component terminology within the FMT is the NCI Thesaurus (NCIt) and is pointed to within the External Code List publications for obtaining values for applicable data elements.

NCI Thesaurus terminologies may be found at http://evs.nci.nih.gov/. This link provides access to all terminologies within the NCI Thesaurus. The NCI Term Browser http://nciterms.nci.nih.gov/ncitbrowser/pages/multiple_search.jsf enables one to browse, search, and visualize terminologies in the library.

Beginning with SCRIPT version 10.5 and Telecommunication Standard version D.3, NCPDP has adopted terminology sets from NCI Thesaurus (NCIt), aligning with FDA Structured Product Labeling (SPL) and the Federal Medications Terminologies (FMT) standards.

Recommendation: NCI has provided a link to subset files specific to the NCPDP standards usage at http://www.cancer.gov/cancertopics/terminologyresources/page7 The subsets were created by NCI terminologists to provide smaller sets of concepts for ease of use. The files can be downloaded from http://evs.nci.nih.gov/ftp1/NCPDP/ or http://evs.nci.nih.gov/ftp1/NCPDP/About.html.

Subset files include (but are not limited to): Drug StrengthForm, StrengthUnitOfMeasure, QuantityUnitOfMeasure, DEASchedule, and MeasurementUnitCode Terminology.

Note: The NCI database is reconciled the last Monday of every month; this is the database from which a version is generated to correspond to the files posted on the ftp site. The files will be posted during the following two weeks. It is important to note that the NCPDP subsets may change slightly on occasion as a definition might be tweaked or a new synonym created. However, the substance of the NCPDP subsets will not change unless a concept is brought forward to NCI that may impact NCPDP subsets. NCI will notify NCPDP if an addition or change is requested.
When a new version of the subsets are created, the previous version of the subsets will go into the Archive (http://evs.nci.nih.gov/ftp1/NCPDP/Archive/) and the new dated release will be listed on the ftp site (http://evs.nci.nih.gov/ftp1/NCPDP/). NCI will also include a file that will show the modifications.

17.1.1 SCRIPT FIELD REFERENCES
This section displays the old or new data element, and the old or new reference. The new reference provides the link for the subset files.

### 7996 - DEA Schedule (EDI) or NCPDP DEASchedule (XML) Terminology

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value defining the DEA schedule of the medication.</td>
<td>an..1S</td>
<td>S</td>
<td>Field and values may be used in SCRIPT Standard Version 10.5 or greater but not in lower versions.</td>
</tr>
</tbody>
</table>

#### Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>C38046</td>
<td>Unspecified</td>
<td>Not Specified</td>
</tr>
<tr>
<td>C48672</td>
<td>Schedule I Substance</td>
<td>SPL DEA Schedule I, Schedule I</td>
</tr>
<tr>
<td>C48675</td>
<td>Schedule II Substance</td>
<td>SPL DEA Schedule II, Schedule II</td>
</tr>
<tr>
<td>C48676</td>
<td>Schedule III Substance</td>
<td>SPL DEA Schedule III, Schedule III</td>
</tr>
<tr>
<td>C48677</td>
<td>Schedule IV Substance</td>
<td>SPL DEA Schedule IV, Schedule IV</td>
</tr>
<tr>
<td>C48679</td>
<td>Schedule V Substance</td>
<td>SPL DEA Schedule V, Schedule V</td>
</tr>
</tbody>
</table>

Clarification:

### 8004 – Final Compound Pharmaceutical Dosage Form (EDI) or NCPDP Drug StrengthForm (XML) Terminology

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Page: 234
### Definition of Field

<table>
<thead>
<tr>
<th>Field</th>
<th>Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final compound drug form, in a code. Dosage form code. Pharmaceutical Dosage Form. Qualified by Source Code List (7991).</td>
<td>an..70</td>
<td>S</td>
<td>Field and values may be used in SCRIPT Standard Version 10.7 or greater but not in lower versions.</td>
</tr>
</tbody>
</table>

### Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>

**Clarification:**
For NCPDP Specific Terminology

Used in SCRIPT DRU 170

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>C</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>7991 Source Code List</td>
<td></td>
<td>an..3</td>
</tr>
<tr>
<td>03</td>
<td>8004 Final Compound Pharmaceutical Dosage Form</td>
<td>C</td>
<td>an..70</td>
</tr>
</tbody>
</table>

#### 7992 - Item Form Code (EDI) or NCPDP Drug StrengthForm (XML) Terminology

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug form, in a code. Dosage form code. Pharmaceutical Dosage Form. Qualified by Source Code List (7991).</td>
<td>an..15</td>
<td>S</td>
<td>Field and values may be used in SCRIPT Standard Version 10.5 or greater but not in lower versions. For SCRIPT Standard Versions 5.0 through 10.4 refer to 1131 – Code List Qualifier – Drug Form - DRU Segment (X12 DE 1330) in Section III-B.</td>
</tr>
</tbody>
</table>

### Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>

**Clarification:**
For NCPDP Specific Terminology
### 7993 - Item Strength Code (EDI) or NCPDP Drug StrengthUnitOfMeasure (XML) Terminology

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug strength qualifier. Units of Presentation. Qualified by Source Code List (7991).</td>
<td>an..15 S</td>
<td>Field and values may be used in SCRIPT Standard Version 10.5 or greater but not in lower versions. For SCRIPT Standard Versions 5.0 through 10.4 refer to 1131 – Code List Qualifier – used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier in Section III-B.</td>
<td></td>
</tr>
</tbody>
</table>

### Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB</td>
<td>NCI values of Units of Presentation <a href="http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml">http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml</a> - NCI Thesaurus – source value NCPDP: AB</td>
</tr>
</tbody>
</table>

**Clarification:**

### Used in SCRIPT

#### DRU-010
- 13 7991 Source Code List C an..3
- 14 7992 Item Form Code C an..15

#### CPD-010
- 06 7991 Source Code List C an..3
- 07 7992 Item Form Code C an..15

### 7995 - Measurement Unit Code (EDI) or NCPDP MeasurementUnitCode (XML) Terminology

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basis for measurement code. Units of</td>
<td>an..15 S</td>
<td>Field and values may be used in SCRIPT Standard Version</td>
<td></td>
</tr>
</tbody>
</table>
### Definition of Field

<table>
<thead>
<tr>
<th>Field</th>
<th>Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation. Qualified by Source Code List (7991).</td>
<td></td>
<td></td>
<td>10.5 or greater but not in lower versions.</td>
</tr>
</tbody>
</table>

#### Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD</td>
<td>NCI values of Units of Presentation (<a href="http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml">http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml</a>) – source value NCPDP: AB</td>
</tr>
</tbody>
</table>

**Clarification:**


For NCPDP Specific Terminology

The Measurement Unit Code would include codes for patient height, weight – inches, pounds, may include a blood pressure – systolic, diastolic. Different measurements you might send about a patient.

### 7994 - Potency Unit Code (EDI) or NCPDP QuantityUnitOfMeasure (XML) Terminology

#### Definition of Field

<table>
<thead>
<tr>
<th>Field</th>
<th>Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit of measure. Potency Unit. Qualified by Source Code List (7991).</td>
<td></td>
<td></td>
<td>Field and values may be used in SCRIPT Standard Version 10.5 or greater but not in lower versions. For SCRIPT Standard Versions 5.0 through 10.4 refer to 1131 – Code List Qualifier – used for 6063 - Quantity Qualifier (X12 DE 355) in Section III-B.</td>
</tr>
</tbody>
</table>

#### Values:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>AC</td>
<td>NCI values of Property or Attribute - Unit of Measure - Unit of Category - Potency Unit (<a href="http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml">http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml</a> - NCI Thesaurus) – source value NCPDP: AC</td>
</tr>
</tbody>
</table>

**Clarification:**
For NCPDP Specific Terminology

Used in SCRIPT DRU 020

| 04 | 7991 Source Code List | M | an..3 |
| 05 | 7994 Potency Unit Code | M | an..15 |

And CPD 020

| 03 | 7991 Source Code List | M | an..3 |
| 04 | 7994 Potency Unit Code | M | an..15 |

7991 - Source Code List (NCPDP source list values noted above)

<table>
<thead>
<tr>
<th>Definition of Field</th>
<th>Field Format</th>
<th>Standard/Version Formats</th>
<th>Field Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code identifying the source organization.</td>
<td>an..3</td>
<td>S</td>
<td>Field and values may be used in SCRIPT Standard Version 10.5 or greater but not in lower versions. For SCRIPT Standard Versions 5.0 through 10.4 refer to 1131 – Code List Qualifier – Drug Form - DRU Segment (X12 DE 1330), 1131 – Code List Qualifier – used for Drug Strength Qualifier, 6411 - Measurement Unit Qualifier, and 1131 – Code List Qualifier – used for 6063 - Quantity Qualifier (X12 DE 355) in Section III-B.</td>
</tr>
</tbody>
</table>

Values:

<table>
<thead>
<tr>
<th>CODES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>NCI values of Diagnostic, Therapeutic, and Research Equipment - Pharmaceutical Dosage Form (<a href="http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml">http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml</a> - NCI Thesaurus) For NCPDP Specific Terminology</td>
</tr>
</tbody>
</table>

**Clarification:**
For NCPDP Specific Terminology
<table>
<thead>
<tr>
<th>CODES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB</td>
<td>NCI values of Units of Presentation (<a href="http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml">http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml</a> - NCI Thesaurus) For NCDEX Specific Terminology</td>
</tr>
<tr>
<td>AC</td>
<td>NCI values of Property or Attribute - Unit of Measure - Unit of Category - Potency Unit (<a href="http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml">http://bioportal.nci.nih.gov/ncbo/faces/index.xhtml</a> - NCI Thesaurus) For NCDEX Specific Terminology</td>
</tr>
<tr>
<td></td>
<td>Was added in SCRIPT 2011 and above.</td>
</tr>
</tbody>
</table>

**17.2 SCRIPT VERSION 10.6 AND ECL VERSION RECOMMENDATION**

For SCRIPT 10.6, trading partners may use any External Code List (ECL) version starting with 10/2008 as an industry recommendation. Existing 10.6 data elements may have had additional values added in newer ECL versions to address business needs.

These values may not have not been added to the 10.6 schema to “freeze” the schema, but were added in future versions of the SCRIPT schema to the ecl.xsd. These values are allowed for use in 10.6 as appropriate to the data element and the business case, should trading partners choose to use this functionality.

Note, if testing with the NIST validation tool, see the NIST ECL allowable list and testing guidance.

Note, the ECL has undergone publication changes in 2010 as the “EDI” syntax of SCRIPT was sunsetted and the “XML” syntax is the only syntax supported. ECLs from this timeframe forward only reflect the XML elements. If the values for an “EDI” field is sought, earlier versions of the ECL should be used that contain the “EDI” field reference.
18. NEXT VERSION OF SCRIPT

Next Version of SCRIPT Implementation Planned


- Changes since SCRIPT 10.6
- Timeframe Considerations
- New Standard Process

The New Standard Process document was updated and the attendees then discussed and agreed to this new time frame as a recommended timeline for the regulatory process. Please note the Data Element Request Forms (DERFs) need to be submitted for the February 2015 Work Group meetings to be considered for the next version to be requested to be named in MMA. When the November WG11 minutes are published, they can be referenced for detailed discussion of the topic.

The industry is preparing for this timeline.
19. MODIFICATIONS TO THIS DOCUMENT

19.1 VERSION 1.1
The document was enhanced to include editorial corrections and clarifications to the NCPDP SCRIPT Implementation Guide documents.

19.2 VERSION 1.2
The section “RxNorm Guidance for SCRIPT” was added.

19.3 VERSION 1.3 AUGUST 2010
The section “Controlled Substance Prescriptions” was added.
The section “Brand Medically Necessary for Medicaid Prescriptions” was added.
The section “External Code List Assistance” was added.

19.4 VERSION 1.3 SEPTEMBER 2010
The section “Controlled Substance Prescriptions” was clarified to name the exact EDI fields. It was also clarified to remove a reference to the COO Segment that was confusing and added verbiage.

Earliest Fill Date (For scheduled IIs)
Use Effective Date – DRU-040 (in EDI) or <EffectiveDate> (in XML)

This date is only used on Medication History Messages in the COO Segment for the starting date of the query. In the future we will add a new date for Earliest Fill Date.

To
Earliest Fill Date (For scheduled IIs)
Use Date/Time Period Qualifier - DRU-040-I006-01-2005 with value

| 07 | Effective Date (Begin) |

With the appropriate Date/Time/Period – DRU-040-I006-02-2380 (in EDI)
or <EffectiveDate> (in XML)
Note: DRU-040 Date occurs up to 5 times in SCRIPT 8.1 and up to 9 times in SCRIPT 10.6, so multiple occurrences are supported for NewRx requirements.

19.5 Version 1.4
Additional guidance was added in the section “Medications Source Vocabulary for Certification Testing”.

19.6 Version 1.5
Section “Diagnosis Primary” was added to “Editorial Modifications”, subsection “XML Modifications”.

19.7 Version 1.6
Clarifications were added to section “RxNorm Guidance for SCRIPT” charts to identify the specific fields/elements.

19.8 Version 1.7
Section “SigSequencePositionNumber”, “PotencyUnitCode or QuantityUnitOfMeasure”, “SoldDate” were added to “Editorial Modifications”, subsection “XML Modifications”.

19.9 Version 1.8
Section “AdverseEvent” was updated to correct the error for SCRIPT XML 10.6 and then in 10.11 and above.

19.10 Version 1.9
In SCRIPT Version 2010121, support for clarification of WrittenDate was added. While this is effective with Version 2010121, the guidance is important for all versions. See section “Discussion of Written Date” for an overview.

19.11 Version 1.10
Section “International Unite” was added.

Section “ResponsibleParty” and “SourceQualifier” were added under “XML Modifications”.

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19.12 Version 1.11
Section “Implementation Guide Clarifications” was added.

19.13 Version 1.12
Section “Prescription Schedules” was added.

19.14 Version 1.13
Section “Use of Diagnosis Code” was added.
Section “RxHistoryRequest and Response - <Prescriber> and <Pharmacy>” was added.

19.15 Version 1.14
A clarification was made in section “Prescription Requirements”, subsection “SCRIPT 10.6” and subsection “SCRIPT 10.10” to usage of the SIG Segment. The Designation was clarified from “Mandatory or SIG Segment” to “Mandatory.” “Optional use of the SIG Segment”.

19.16 Version 1.15
Section “<Patient> Fields Order” was added under “XML Modifications”.

19.17 Version 1.16
Section “Specific Transaction Discussion” was added with subsection “Last Fill Date on a Refill Request”.

Subsection “Time Format” was added to “Implementation Guide Clarifications”. Section “Clarification of UIT Fields” was added. Section “COO Segment” was added, with subsection “Clarification of Cardholder ID (COO- 04-I001-01-1154) Designation” added.

Section “SCRIPT Version 10.6 and ECL Version Recommendation” has been added.

19.18 Version 1.17
Section “<PasswordRequestType> as a Choice” was added under “XML Modifications”.

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### 19.19 Version 1.18

In section “Editorial Modifications”, a new subsection of “XML Standard Modifications” was added. Subsection “CoAgentIDQualifier” was added to section “Implementation Guide Clarifications”.

Subsection “<ApprovedWithChangesType>” was added.

Section “RxNorm Guidance for SCRIPT” was updated. Revisions are marked below. Question “Prescribed Medication Information on a Refill Request” was added.

---

<table>
<thead>
<tr>
<th>Refill Request</th>
<th>MedicationPrescribed</th>
<th>RxNorm should echo back what came in on the NewRx – but it may not exist in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</th>
<th>Prescriber should use RxNorm or NDC to find original Rx prescribed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NDC should echo back what came in the NewRx - but it may not exist in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).</td>
<td>This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name should echo back what came in the NewRx &lt;DrugDescription&gt; (or DRU-010-I013-02-7008, 10, 11, 12 Item Description).</td>
<td>This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name should echo back pharmacist’s interpretation of what came in the NewRx &lt;DrugDescription&gt; (or DRU-010-I013-02-7008, 10, 11, 12 Item Description).</td>
<td>This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RxFill Request</th>
<th>MedicationPrescribed</th>
<th>RxNorm should echo back what came in on the NewRx – but it may not exist in (&lt;DrugDBCode&gt; &lt;DrugDBCodeQualifier&gt;) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).</th>
<th>RxNorm used for reference.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NDC should echo back what came in the NewRx if known but NDC or RxNorm may not exist in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).</td>
<td>NDC used for reference.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NDC should echo back pharmacist’s interpretation of what came in the NewRx if known but NDC or RxNorm may not exist in (&lt;ProductCode&gt; and &lt;ProductQualifier&gt;) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).</td>
<td>This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.</td>
</tr>
</tbody>
</table>

| RxChange Request - for TI and GS | MedicationPrescribed | RxNorm should be sent if known in (<DrugDBCode> <DrugDBCodeQualifier>) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153) | Prescriber may use RxNorm for reference. |

---

Refill Request

MedicationPrescribed

RxNorm should echo back what came in on the NewRx – but it may not exist in (<DrugDBCode> <DrugDBCodeQualifier>) or (DRU-010-I013-08-1154 Reference Number and DRU-010-I013-09-1153 Reference Qualifier).

NDC should echo back what came in the NewRx - but it may not exist in (<ProductCode> and <ProductQualifier>) or (DRU-010-I013-03-7140 Item Number and DRU-010-I013-04-3055 Code List Responsibility Agency).

Name should echo back what came in the NewRx <DrugDescription> (or DRU-010-I013-02-7008, 10, 11, 12 Item Description). This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.

Name should echo back pharmacist’s interpretation of what came in the NewRx <DrugDescription> (or DRU-010-I013-02-7008, 10, 11, 12 Item Description). This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.

RxNorm used for reference. NDC used for reference.

This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.

Prescriber may use RxNorm for reference.
### RxChange Request for PA

**Medication Prescribed**

- RxNorm should be sent if known in \(<\text{DrugDBCode} >\text{DrugDBCodeQualifier}>\)
  - or \((\text{DRU-010-I013-08-1154 Reference Number} \text{and DRU-010-I013-09-1153 Reference Qualifier})\)

  - The transaction shall echo back the medication as sent in the original transaction.
  - The transaction shall echo back the pharmacist’s interpretation of the medication as sent in the original transaction.

**Prescriber** should use RxNorm for reference.

*This will allow the prescriber to evaluate whether the initial order was interpreted correctly and take appropriate actions if it was not.*

### RxHistory Response

**MedicationPrescribed**

- RxNorm should be sent if known in \(<\text{DrugDBCode} >\text{DrugDBCodeQualifier}>\)
  - or \((\text{DRU-010-I013-08-1154 Reference Number} \text{and DRU-010-I013-09-1153 Reference Qualifier})\)

  - The transaction shall echo back the medication as sent in the original transaction.
  - The transaction shall echo back the pharmacist’s interpretation of the medication as sent in the original transaction.

**Prescriber** may use this for reference.

*This is needed to identify the medication that the patient was actually taking and that will be of importance in determining treatment.*

---

**19.20 VERSION 1.19**

In section “*Editorial Modifications*”, a typographic error was noted in “*<AddressTypeQualifier>*”. Section “*Multiple Repetitions of the DRU Segment*” was added. Section “*Status in Response to Error*” was added to “*XML Standard Modifications*”.

An important correction was made in section “*Editorial Modifications*, “*<Substitutions>*” for External Code List values. It is also referenced in section “*Implementation Guide Clarifications*”.

Section “*Recommendations for Consistent Use of Drug Identification Fields Used in SCRIPT Transactions*” was added.

The paragraph “The SCRIPT fields used to identify the drug product have evolved....” was added to section “*Implementation to the SCRIPT Standard*”. In this same section under “Recommendation” the second item “The NABP Model Act recommends....” was added to each version.
19.21 Version 1.20
Subsection “Transmission Examples” was added to section “Editorial Modifications” subsection “Implementation Guide Clarifications” with a typographical error found in examples for NCPDP Drug Dosage Form for “Aerosol, Metered”.

In section “Editorial Modifications”, “XML Standard Modifications” annotations were clarified for the Status, Verify, and Error transactions in section “Status, Error, and Verify Annotation Clarifications”.

Section “Proper Use of Days Supply” was added.

19.22 Version 1.21
Subsection “Transmission Examples” “Example 6 Refill” was added.
Subsection “Lower and Upper Bound Comparison Operators” was added.

19.23 Version 1.22
In section “Editorial Modifications”, subsection “XML Modifications” and section “External Code List Clarifications” a typographical error was noted in subsection “PACodedReferenceCode”. Also added “AdditionalFreeTextIndicator” section.

Section “Best Practices for the Use of Medication <Note> (or Free Text)”, subsection “Coupon Information Exchange” and “Recommendations for Electronic Prescribing in Pediatrics” were added to section “Prescription Requirements”.

Section “CancelRx” was added to “Specific Transaction Discussion”.

Section “Observation Segment Examples in SCRIPT 10.6” was added.

19.24 Version 1.23
In section “Proper Use of Days Supply”, the statement “The value 0 should not be sent.” was added to item 3.

Section “Recommendations for Electronic Prescribing in Pediatrics” added the Recommendation section after the table.
19.25 Version 1.24
Section “Example 33. Prior Authorization Denial and Appeal Correction” was added to “Editorial Modifications”.

19.26 Version 1.25
Section “Editorial Modifications” subsection “XML Modifications” subsection “<RelatesToMessageID> in Electronic Prior Authorization Examples” was added.
Section “Editorial Modifications” subsection “Implementation Guide Clarifications” subsection “<RelatesToMessageID> in Electronic Prior Authorization Examples” was added.

19.27 Version 1.26
Subsection “CancelRx and CancelRxResponse Recommendations” was added to section “Specific Transaction Discussion”.
Section “Discussion of WrittenDate” was updated.
On a NewRx the <WrittenDate> indicates the date the prescriber created the 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.

Section “RxFill Recommendations” was added.

Question “How Should the Drug Description field be Populated in Electronic Messages?” was added to section “Frequently Asked Questions”.
Section “Recommendations for Electronic Prescribing in Pediatrics” updated the Recommendation section after the table to change from “new or renewal prescriptions” to “prescriber-initiated transactions for prescriptions”.

A typographical correction was made to the RxHistoryResponse. See section “RxHistoryResponse <Medication> Choice”.

A typographical correction was noted to <DigestValue> in section “<DigestValue> Correction”.

19.28 VERSION 1.27

Section “QuantityQualifier Recommendations for Electronically Created Prescriptions” was added. Implementers should be aware and planning for the implementation timeframe.

Section “Assistance with the Use of SCRIPT version 10.6 in the Long Term and Post-Acute Care Settings” was added.

Section “RefillResponse with Drug Name Different” was added under “Specific Transaction Discussion”.

“What is a Representative NDC?” was clarified to add:

A representative NDC is not intended to infer specificity or preference to the imbedded manufacturer/labeler. In order to maximize the opportunity that the selected NDC exists among the various drug files, a representative NDC should be a nationally available product and not be a repackaged NDC, obsolete NDC, private label NDC or unit dose NDC unless it is the only NDC available identifying that category of medication. The drug description of the product must match the description of the representative NDC code value.

Section “Recommendations for ePrescribing Best Practices of Patient Height, Weight, Contact, Insurance, and Diagnosis Information” was added to section “Prescription Requirements”.

19.29 VERSION 1.28

See section “<ItemNumber> in <CompoundIngredient>”.

A reference was also added to the Structured and Codified Sig Implementation Guide v1.2. See section “Purpose”.

19.30 VERSION 1.29

Section “Next Version of SCRIPT” was added.
Section “Prescription Requirements” subsections dealing with the Model Pharmacy Act have been updated with the August 2014 Act verbiage which was updated:

**Section 3. Prescription Drug Order Processing.**

(a) Prescription Drug Order

A Prescription Drug Order shall contain the following information at a minimum:

1. full name, **date of birth**, and street address of the patient;
2. name, **prescribing Practitioner’s license designation**, address, and, if required by law or rules of the Board, DEA registration number of the prescribing Practitioner;
3. date of issuance;
4. name, strength, dosage form, and quantity of Drug prescribed;
5. directions for use;
6. refills authorized, if any;
7. if a written Prescription Drug Order, prescribing Practitioner’s signature;
8. if an electronically transmitted Prescription Drug Order, prescribing Practitioner’s electronic or digital signature;
9. if a hard copy Prescription Drug Order generated from electronic media, prescribing Practitioner’s electronic or manual signature. For those with electronic signatures, such Prescription Drug Orders shall be applied to paper that utilizes security features that will ensure the Prescription Drug Order is not subject to any form of copying and/or alteration.

Section “EHR and Prescribing System Vendors” clarified the Quantity Qualifier code value C38406 (Unspecified) to add

- Translation is the mapping process used when either converting between different versions of SCRIPT Standard, or when adopting these recommendations for the code set migration.
  - C64933 (Each) is only to be used for conveying specific units that do not meet the recommendations criteria identified, such as:
    - Measured in volume or weight
    - Translated value is not available within the current version of NCIt.
    - Items without specific values in the current version of NCIt that would be expected to be measured in units of one/each
      - Examples: DME supplies, such as canes, wheel chairs, various braces or orthotics, etc. and other one-offs, such as a new device without a current NCIt value

Section “General Recommendations” was added with question “ePrescribing Best Practices When the Prescriber Will Not Have a Continued Relationship With the Patient”.
Section “Implementation of Structured & Codified Sig” was added.

Section “Electronic Prior Authorization (ePA) Guidance” was added with the questions “Closed in PAInitiationResponse” and “Response to PA Request Transactions”.

19.31 VERSION 1.30
Section “Denying a PACancelResponse” was added to “Electronic Prior Authorization (ePA) Guidance”.

Question: Some of our participants are asking about the use case for a payer denying a PACancelRequest. The payer can send a <Denied> PACancelResponse for the following reasons:

1) BZ – Can’t find PA Case ID
2) CA – Unable to locate based on insufficient information/identifiers do not match
3) CB – Request already processed/final determination has been made
4) BY – Other

If the payer responds with anything but CB, what is the expectation for the prescriber vendor?

Response: The expectation for the reject scenario, as with other SCRIPT transactions, is to fix whatever was wrong and send a corrected PACancelRequest. If the transaction cannot be corrected, manual procedures should be used. The payer may return a help desk number for more assistance.

Question: What methods are available to the pharmacist to electronically convey a message to the prescriber indicating the pharmacy cannot or will not dispense the patient’s prescription that was received as a NewRx, RxChangeResponse or RenewalResponse? (This question is not based on a scenario where prescription was not dispensed because the patient never picked it up (non-adherence).)

Response:
The NCPDP SCRIPT Standard supports electronic mechanisms to convey information from a pharmacist to a prescriber via the RxFill message or the RxChange message.

The RxFill message can be sent by the pharmacist to the prescriber notifying them that the pharmacist is unable/unwilling to dispense a prescription. In SCRIPT version 10.6, RxFill supports a <NotFilled> status with the <Note> field providing additional clarification to the prescriber as to the reason the pharmacist is unable/unwilling to dispense the prescription. This might occur when the pharmacy is out of stock of the medication prescribed and it cannot be obtained in a clinically appropriate timeframe. Enhancements were added to this transaction in 2014+; see section “RxFill Recommendations”.

The RxChange message can be used by the pharmacist to request a change to a prescription when such a change is permitted by state and/or federal laws/regulations. This might occur when the pharmacy recognizes allergy, overutilization, when a package cannot be broken or other concerns that appear not to have been recognized or addressed by the prescriber or when pharmacy inventory levels are depleted (for example, CII prescription cannot be transferred in any state). See the NCPDP SCRIPT Implementation Guide for more information on the RxChange message.

If the pharmacist is unwilling to fill the prescription based on a controlled substance history report, they may suggest an alternative drug using the RxChange message with a note for clarification.

It is recognized that the industry is at various levels of adoption of these message types; however they are available and are recommended for use. Until there is more widespread adoption of these message types, the pharmacist will need to use the traditional processes available today to notify the prescriber of the inability to dispense a prescription.

**19.32 Version 1.31**

In Section Implementation Timeline, updated the header in column 9 from “Preferred term for ePrescribing” to Equivalent Billing Unit and added two new values:

<table>
<thead>
<tr>
<th>C89510</th>
<th>C120263</th>
<th>NCPDP QuantityUnitOfMeasure Terminology</th>
<th>Lancet</th>
<th>Lancet</th>
<th>A small, sharp, needle-like instrument that is used to puncture the skin.</th>
<th>Yes</th>
<th>EA</th>
<th>Translates to EA 1:1.</th>
</tr>
</thead>
<tbody>
<tr>
<td>C89510</td>
<td>C120126</td>
<td>NCPDP QuantityUnitOfMeasure Terminology</td>
<td>Pen Needle</td>
<td>Pen Needle</td>
<td>A single use, hollow needle embedded in a plastic hub, which is then attached to a preloaded syringe</td>
<td>Yes</td>
<td>EA</td>
<td>Translates to EA 1:1.</td>
</tr>
</tbody>
</table>
Updated Section Inclusion of Diagnosis from:
SCRIPT version 10.6 has a field for a primary and secondary diagnosis code in the Prescribed Medication Segment, which is optional and infrequently populated. EHR/ePrescribing vendors are encouraged to populate this field with the diagnosis(es) associated to the prescription when transmitting all prescriptions to the pharmacy. By doing this, the industry will improve patient safety, enhance efficiency and expedite prior authorization. As it pertains to specialty, inclusion of this information will reduce the need for the pharmacist to contact the prescriber for missing information such as that needed prior authorization, claim processing, or manufacturer-required reporting. See also section “Use of Diagnosis Code”.

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® code is sent in the <Diagnosis><Primary> or <Secondary>, the corresponding ICD for each SNOMED® 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 being transmitted in <IndicationForUse> and be consistent with the ICDs sent in the diagnosis element(s).
See section “Use of Diagnosis Code”.

Add the following to Section Use of Diagnosis Codes
Diagnosis code fields must adhere to the owner’s code set rules and formats. 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.

Added the following to frequently asked questions:
Section Zero Refills Authorized on a Renewal Request
Q: Per the Implementation and Recommendations Guides, the value transmitted in the Refills Value field must be a “a number greater than zero”; however, it is not uncommon for a pharmacy to receive a “0” in the Value field, as in the example below:

```
<Refills>
 <Qualifier>R</Qualifier>
 <Value>0</Value>    This is not appropriate and could cause regulatory problems if the product were to be a controlled substance. The DEA may well not agree that we should fill a controlled substance Rx that was approved for “0” fills
</Refills>
```

How should a pharmacy process a renewal request (REFREQ) that has been approved for “0” fills, as in the example above?
R: The guidance clearly says the refill field should contain how many times the drug is to be dispensed and if it comes in with a zero, then it must be rejected following the table below.

<table>
<thead>
<tr>
<th>Error Message</th>
<th>XML Code</th>
<th>EDIFACT Code</th>
<th>ECL before 201012</th>
<th>ECL 201012 - 201501</th>
<th>Future ECL</th>
</tr>
</thead>
<tbody>
<tr>
<td>DescriptionCode: DRU refill quantity is invalid</td>
<td>STS-000</td>
<td>030</td>
<td>900</td>
<td>900</td>
<td>900</td>
</tr>
<tr>
<td>Description: Data format is valid for the element, but number of refills is</td>
<td>STS-020</td>
<td>144</td>
<td>2000</td>
<td>144</td>
<td>144</td>
</tr>
</tbody>
</table>


Section **State Controlled Substance Registration Number:**

Q: How should a State Controlled Substance Registration Number be submitted using SCRIPT v10.6?
R: The only prescriber identifier in SCRIPT 10.6 would be to use StateLicense with the appropriate abbreviation as defined by the associated State if necessary. If multiple IDs are required in the StateLicense element they must be separated with at least one space.

Updated “Where do I send the SNOMED CT® Concept ID for “Per Manufacturer Package Instructions” or “Per Instructions Provided in Medical Encounter”?“ to include the SNOMED CT® Concept ID.

**Answer:**
The SNOMED CT® Concept ID should be sent only in the <DoseDeliveryMethodCode> field and <DoseCompositeIndicator> Value 1 = Specified. The text field should always contain the textual representation of the code. Including this in other fields, such as <AdministrationTiming> may cause confusion to the receiver.

For “Take as per medical encounter instructions“
Use SNOMED CT® Concept ID for “Provider medication administration instructions”.
The code is 422037009.

For “Take as per manufacturer package instructions.”
Use SNOMED CT® Concept ID for “Instructions from the medication manufacturer”.
The code is 446291000124107.

**19.33 Version 1.32**
New Section **Best Practices for Oral Liquid Medications** was added.
In March 2014, NCPDP published a white paper “NCPDP Recommendations and Guidance for Standardizing the Dosing Designations on Prescription Container Labels of Oral Liquid Medications”. This paper addresses patient safety concerns when medications are dispensed using
non-metric measures such as teaspoon and tablespoon. Implementers of Structured and Codified Sig are encouraged to review the white paper and support sending oral liquid prescriptions using only milliliters (mL). Future versions of SCRIPT will remove teaspoon, tablespoon, etc. from the available code set in order to systematically support this patient safety initiative.

Section Inclusion of Diagnosis was modified to remove the word being from the following sentence:
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 being transmitted in <IndicationForUse> and be consistent with the ICDs sent in the diagnosis element(s). See also section “Use of Diagnosis Code”.

Section Zero Refills Authorized on a Renewal Request was modified to remove an extra ‘a’ from the following sentence:
Q: Per the Implementation and Recommendations Guides, the value transmitted in the Refills Value field must be a “a number greater than zero”; however, it is not uncommon for a pharmacy to receive a “0” in the Value field, as in the example below:

Section State Controlled Substance Registration Number response was modified from:

R: The only prescriber identifier in SCRIPT 10.6 would be to use StateLicense with the appropriate abbreviation as defined by the associated State if necessary. If multiple IDs are required in the StateLicense element they must be separated with at least one space.

To:
R: The only prescriber identifier available to use in SCRIPT 10.6 would be StateLicense with the appropriate abbreviation as defined by the associated State if necessary. If multiple IDs are required in the StateLicense element they must be separated with at least one space.

19.34 VERSION 1.33
Section “Implementation of Structured and Codified Sig” modifications:
• Section “Best Practices” modified the last bullet point from
  • Recognize trading partners may be at different stages of implementation of the structured sig, such as the difference with taking in (accepting the fields) a transaction containing a structured sig versus actually consuming (using the fields) the structured sig.
To:

- Recognize trading partners may be at different stages of implementation of the structured sig, such as the difference between accepting the structured sig fields in the transactions and actual utilizing these fields as an aid to understanding an creating the sig for the patient.

- Section "DoseForm and DoseUnitOfMeasure" was added:
  In the NCPDP SCRIPT Standard with versions prior to v2015071, the field <Dose Form> is represented by an NCI subset of "NCPDP Drug StrengthForm Terminology". Upon further review, it has been determined that this subset is not appropriate as it does not include all applicable dose forms or needed quantities (i.e. “non-dosage form” units of measure) such as puff, drop, spray. A new subset has been created “NCPDP DoseUnitOfMeasure Terminology” and should be used by all implementers beginning with SCRIPT v10.6. In addition, beginning with SCRIPT v2015071, <DoseForm> has been renamed <DoseUnitOfMeasure> and will continue to point to the NCI subset “NCPDP DoseUnitOfMeasure Terminology”.

- Section "Frequently Asked Questions" had the following question added:
  Does Duration support just length of therapy, or also number of doses?

  Answer:
  <Duration> is defined as the “duration of use/therapy” and duration is generally defined as “the length of time something continues or exists”. Therefore, <DURATION> should only be used to support length of therapy. The Maximum Dose Restriction elements should be used when the number of doses is limited by the prescriber.

- Section "Additional More Complex Sigs" and "Structured Sig Examples" were added.

  Added Section "Best Practices for the Use of Attachments In Electronic Prior Authorizations"
  To maximize automation and reduce administrative burdens for both prescribers and payers, attachments should only be used when the required information cannot be sent in a discrete field within the SCRIPT ePA transactions or when the review criteria clearly requires progress notes, lab results, imaging and other supporting information that is not transferable to a discrete field within the transaction. Payers considering use of attachments in ePA should first closely review the ePA question set capabilities to ensure that the required data cannot be captured within the transaction.

- Section “Implementation Timeline” the table had new value add for Device.

**19.35 Version 1.34**

Section: Use of Diagnosis Code was removed. All remaining sub-sections were renumbered accordingly.
For each SNOMED® code sent in the diagnosis, **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 - The value for SNOMED® is not available for use in SCRIPT Standard until version 2013011 and above.

Diagnosis code fields must adhere to the owner’s code set rules and formats. 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.

**Section: Inclusion of Diagnosis** was modified from:

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® code is sent in the <Diagnosis><Primary> or <Secondary>, the corresponding ICD for each SNOMED® 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). See also section “**Use of Diagnosis Code**”.
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 and is required to be supported in the Health IT 2015 certification requirements. The 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications may be found at the following location: http://federalregister.gov/a/2015-25597.

If a SNOMED® code is sent in the <Diagnosis><Primary> or <Secondary>, the corresponding ICD-10 for each SNOMED® 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-10 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).

Section: ePrescribing Best Practices when Rejecting a NewRx when the Pharmacy Is Unable or Unwilling to Dispense was modified from:

The NCPDP SCRIPT Standard supports electronic mechanisms to convey information from a pharmacist to a prescriber via the RxFill message or the RxChange message.

The RxFill message can be sent by the pharmacist to the prescriber notifying them that the pharmacist is unable/unwilling to dispense a prescription. In SCRIPT version 10.6, RxFill supports a <NotFilled> status with the <Note> field providing additional
clarification to the prescriber as to the reason the pharmacist is unable/unwilling to dispense the prescription. This might occur when the pharmacy is out of stock of the medication prescribed and it cannot be obtained in a clinically appropriate timeframe. Enhancements were added to this transaction in 2014+; see section “RxFill Recommendations”.

The RxChange message can be used by the pharmacist to request a change to a prescription when such a change is permitted by state and/or federal laws/regulations. This might occur when the pharmacy recognizes allergy, overutilization, when a package cannot be broken or other concerns that appear not to have been recognized or addressed by the prescriber or when pharmacy inventory levels are depleted (for example, CII prescription cannot be transferred in any state). See the NCPDP SCRIPT Implementation Guide for more information on the RxChange message.

If the pharmacist is unwilling to fill the prescription based on a controlled substance history report, they may suggest an alternative drug using the RxChange message with a note for clarification.

It is recognized that the industry is at various levels of adoption of these message types; however they are available and are recommended for use. Until there is more widespread adoption of these message types, the pharmacist will need to use the traditional processes available today to notify the prescriber of the inability to dispense a prescription.

TO:

The NCPDP SCRIPT Standard supports electronic mechanisms to convey information from a pharmacist to a prescriber via the RxFill message or the RxChange message.

The RxFill message can be sent by the pharmacist to the prescriber notifying them that the pharmacist is unable/unwilling to dispense a prescription. In SCRIPT version 10.6, RxFill supports a <NotFilled> status with the <Note> field providing additional clarification to the prescriber as to the reason the pharmacist is unable/unwilling to dispense the prescription. This might occur when the pharmacy is out of stock of the medication prescribed and it cannot be obtained in a clinically appropriate timeframe. Enhancements were added to this transaction in 2014+; see section “RxFill Recommendations”.

The RxChange message can be used by the pharmacist to request a change to a prescription when such a change is permitted by state and/or federal laws/regulations. This might occur when the pharmacy recognizes allergy, overutilization, when a package cannot be broken or other concerns that appear not to have been recognized or addressed by the prescriber or when pharmacy inventory levels are depleted (for example, CII prescription cannot be transferred in any state). Because of the potential for
delay in drug therapy, all RxChange messages should be treated as an urgent message. See the NCPDP SCRIPT Implementation Guide for more information on the RxChange message.

For SCRIPT Version 10.6, the RxChange message should contain Therapeutic Interchange in the <ChangeRequestType> and add “the medication prescribed is out of stock and it cannot be obtained in a clinically appropriate timeframe” in the <MedicationPrescribed><Note>.

For future versions of the SCRIPT Standard, the RxChange message should contain the value “X” for “pharmacy is out of stock of the medication prescribed and it cannot be obtained in a clinically appropriate timeframe” in the <MessageRequestCode>.

If the pharmacist is unwilling to fill the prescription based on a controlled substance history report, they may suggest an alternative drug using the RxChange message with a note for clarification.

It is recognized that the industry is at various levels of adoption of these message types; however they are available and are recommended for use. Until there is more widespread adoption of these message types, the pharmacist will need to use the traditional processes available today to notify the prescriber of the inability to dispense a prescription.

Section: DoseForm and DoseUnitOfMeasure

In the NCPDP SCRIPT Standard with versions prior to v2015071, the field <Dose Form> is represented by an NCI subset of “NCPDP Drug StrengthForm Terminology”. Upon further review, it has been determined that this subset is not appropriate as it does not include all applicable dose forms or needed quantities (i.e. “non-dosage form” units of measure) such as puff, drop, spray. A new subset has been created “NCPDP DoseUnitOfMeasure Terminology” and should be used by all implementers beginning with SCRIPT v10.6. In addition, beginning with SCRIPT v2015071, <DoseForm> has been renamed <DoseUnitOfMeasure> and will continue to point to the NCI subset “NCPDP DoseUnitOfMeasure Terminology”.

TO:

In the NCPDP SCRIPT Standard with versions prior to v2015071, the field <DoseForm> in the Sig Segment is represented by an NCI subset of “NCPDP Drug StrengthForm Terminology”. Upon further review, it has been determined that this subset is not appropriate as it does not include all applicable dose forms or needed quantities (i.e. “non-dosage form” units of measure) such as puff, drop, spray. A new subset has been created “NCPDP DoseUnitOfMeasure Terminology” and should be used by all implementers beginning with SCRIPT v10.6. In addition, beginning with SCRIPT v2015071, <DoseForm> has been renamed <DoseUnitOfMeasure> and will continue to point to the NCI subset “NCPDP DoseUnitOfMeasure Terminology”.
19.36 **Version 1.35**
Section: State Controlled Substance Registration Number was updated to remove a duplicate sentence.
Added Section: Best Practices the use of 340B Identifiers in SCRIPT v10.6
Added Section: Trace Number Usage in SCRIPT v10.6 Edifact
Updated hyperlinks in Sections: Structured Sig Examples and Additional, More Complex Sigs

19.37 **Version 1.36**
Updated Section: Recommendations to Drug Compendia with additional guidance on the ePrescribing Name
Corrected typo in Section: SNOMED® CT Use for SCRIPT Implementation
Updated Section: Structured Sig Examples and Section: Additional, More Complex Structured Sig Examples for accuracy
Added seven additional Sig examples to Section: Additional, More Complex Structured Sig Examples
Added new Section: Partially Denied Electronic Prior Authorization for v10.6
Added new Section: Modification to a recently sent Electronic Prior Authorization
Added new Section: Frequently Asked Questions to Section: Assistance with the use of SCRIPT version 10.6 in the Long Term and Post-Acute Care Settings

19.38 **Version 1.37**
Added the following Frequently Asked Questions:
- Must the same character case submitted on a message be returned in the response?
- How should transplant and discharge date be submitted in an electronic prescription?
- When there are multiple loops needed to communicate the Sig, (E.G. Take 2 Tablets as one dose on the first day, then take one table daily) what should be populated in SigFreeText for each loop?
- Should the TextString reflect the same content when the Sig is “Take one tablet twice per day”, “Take one tablet orally every two days” or “Take one tablet orally for two days”?

Added additional guidance to:
- Best Practices for the Use of Medication <Note> (or Free Text)

Add new Section: Expedited Partner Therapy (EPT) Electronic Prescriptions
Updated Sig Examples:

- Take 2 Tablets by Mouth as One Dose on the First Day Then Take One Tablet Daily
- Take 1 Tablet by Mouth Every 4 to 6 Hours as Needed For Pain
- Take 1 to 2 Tablets by Mouth Every 4 to 6 Hours as Needed For Pain

**19.39 Version 1.38**

Updated Section: [ePrescribing Best Practices When the Prescriber Will Not Have a Continued Relationship with the Patient](#) to include guidance when there is a temporary interruption in an existing relationship.

Add Section: [ePrescribing Best Practices When the Patient Requests the Pharmacist Send Refill Request to a Different Prescriber or the Pharmacy is forced to do so by Circumstances, such as Prescriber Temporary or Permanent Unavailability.](#)

Updated Sig Example: Insert 1 Ring Vaginally and Leave in Place for 3 Weeks, then Remove for 1 Ring-Free Week

Sunsetted the following values for QuantityUnitOfMeasure in Section: [Implementation Timeline](#)

- Bar
- Kilogram
- Liter
- Milligram
- Sachet
- Tampon

Add new FAQS:

- In order to be compliant with the Standard, do I have to be able to send and receive the minimum and maximum field length?
- How should the MA requirement to have “Patient may fill for less than the full amount” for opioid prescriptions be handled electronically?
- How do I send a structured sig for “as needed” prescriptions without an indication for use?
- What sig information should be sent in message from the pharmacy (e.g. Refill Request, Change Request, Fill Status)?
Updated Section: Best Practices for the Use of Attachments in Electronic Prior Authorizations

**19.40 Version 1.39**

Added additional guidance to Section: *ePrescribing Best Practices When the Prescriber Will Not Have a Continued Relationship With the Patient or Will Have a Temporary Interruption in an Existing Relationship.*

Added additional guidance to Section: *ePrescribing Best Practices When the Patient Requests the Pharmacist send Refill Requests to a Different Prescriber or the Pharmacy is Forced to do so by Circumstances, such as Prescriber Temporary or Permanent Unavailability.*

Updated Section: Trace Number Usage in SCRIPT 10.6 Edifact to reflect the Transmissions Examples in the SCRIPT version 10.6 Implementation Guide

Updated Section: Quantity Qualifier Recommendations for Electronically Created Prescriptions title to Product Concept Qualifier Recommendations for Electronically Transmitted Prescriptions

   All sub-sections have updated guidance

Section: Implementation Timeline – Quantity Unit of Measure was updated to include a new sunset date of October 1, 2019 and the table was updated accordingly.

**19.41 Version 1.40**

Add new Frequently Asked Question: RefillResponse as Newly Authorized Prescription

Add new Section: RxChange

**19.42 Version 1.41**

Added new Frequently Ask Questions:

- RxHistory Request From a Hospital
- Pharmacist Initiated Electronic Prior Authorization

Added new Section: Triggering of Biologic or Biosimilar Substitution
Updated Section: **Clarification of Numeric Representation** for decimal formats
Removed references to WG11 Prescription Requirements Task Group
Clarified language in Section: **RxChange**
Updated language in Section: **EHR and Prescribing System Vendors** for the use of the Unspecified Quantity Unit Of Measure.

**19.43 Version 1.42**

Added new Frequently Asked Questions:

- **State Specific Opioid Exemption Code for SCRIPT v10.6**
- **Diagnosis Code or Code on Dental Procedure and Nomenclature (CDT Code) on Controlled Substance Prescription**

Moved the following Frequently Asked Questions to the appropriate section:

- **Do You Allow the Standard to Support Non-Commercially Available Products?**
- **Is there a Best Practices Recommendation Around the Communication to the Pharmacy When Sending Two Orders to Equal a Non-Commercially Available Dose?**

Updated <CouponNumber> to <PromotionNumber> in **Section: Coupon/Discount Information Exchange**

Updated prescriber system-assigned order number to prescribing system-assigned order number in **Section: Changes to Existing Orders**
**Section: PatientCodifiedNotes** was added to **Section: XML Modifications**

**19.44 Version 1.43**

New FAQs were added:

- **How should prescribers indicate therapeutic substitution is permissible in order to comply with requirements (such as Arkansas) in SCRIPT 10.6?**
- **If a refill approval response is returned with 3 refills authorized for the quantity requested, how should this be interpreted by the Pharmacy?**
- **How should the <RelatesToMessageID> in the RxFill message be populated?**
Section: Digital Signature was added.

Section: Triggering of Biologic and Biosimilar Substitutions was renamed to Triggering of Therapeutic, Biologic or Biosimilar Substitution and the language was updated accordingly.

19.45 Version 1.44
Added Section: V20170712 Republication Modifications and V20170713 Republication Modifications

Added new Frequently Asked Questions:
- How should the textual representation of numeric values (i.e. quantity prescribed and date written) be communicated in electronic prescriptions.
- How should renewal requests for controlled substances be handled?

Updated Section: Inclusion of Diagnosis

Updated Section: ePrescribing best practices when rejecting a NewRx when the pharmacy is unable or unwilling to dispense to include including the correct value of “OS” for &lt;MessageRequestCode&gt;.

Updated and added new Frequently Asked Questions for Structured and Codified Sig usage to Section: Frequently Asked Questions

Updated Section: CancelRx

Added new Section: Renewal Request for an Electronic Prescription for Controlled Substances (EPCS)

19.46 Version 1.45
The following FAQ’s were updated:
- How should renewal requests for controlled substances be handled?”
• **Coupon/Discount Information Exchange**

Added the following new FAQs:

• **If a provider approves a renewal request but the approval cannot be sent electronically, how should the provider convey to the pharmacy that a new prescription is coming via another means?**

• **Why is AdministrationTimingNumericValue Found in the MeasurementTiming elements in both Sig and Titration?**

• **Does the <ProhibitRenewalRequest> flag pertain to the original prescriber or the follow up prescriber?**

• **Expected Behavior for the <RangeComparison> Elements**

• **<NumberOfRefills> field on open ended orders**

• **Quantity sufficient in resupply transaction**

References to Version 10.6 was removed from Assistance with the Use of SCRIPT in the Long Term and Post Acute Care Settings. Compound Guidance was added for v2017071 for long term and post acute care settings.

Added Section: V20170714 Republication Modifications – July 2018

**19.47 Version 1.46**

• Replaced the table in the FAQ “How should the <RelatesToMessageID> in the RxFill message be populated?”.

• Add new FAQs:
  • **For a medication history response, if a value of “AQ” is returned in the response is another medication history request sent?**
  • **How should the mandatory element of consent be handled in a Medication History Response?**
  • **DosePerDay and PADaysSupply**
  • **WrittenDate Population on CancelRxResponse**

• Updated Section: Workflow – Prior Authorization to modify <PriorAuthorizationValue> to <PriorAuthorization>

• Updated Section: Usage with the Medication History Transaction to remove the following language:
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.

- Updated Section: Changes to Existing Orders to remove specific section number and include Version 2017071.

**19.48 Version 1.47**

New/Updated Frequently Asked Questions:
- How should prescription for supplies be communicated when a UPC or other product identifier is not known?
- CancelRx for original prescription as well as a Renewal Response
- Usage of Facility Address on Discharge Orders
- Purpose of the <Mailbox><AcknowledgementID> in Resupply
- Prescriber and Recertification Message
- ASCII 7-Bit Character Set

Section added/updated:
- Injury Related
- Best Practices CancelRx and CancelRxResponse

**19.49 VERSION 1.48**

Made the following updated for Editorial Modifications
- Added Section: BenefitsCordination Loops
- Add Section: Version 2018041

Corrected Section: Best Practices CancelRx and CancelRxResponse to add missing word “after”.