DOCUMENTATION FOR MAY 2019
JOINT TECHNICAL WORK GROUP MEETINGS

For a listing of meetings, dates, times and agendas, please visit the NCPDP web site at http://www.ncpdp.org/Events/Work-Group-Meeting.

To help prepare for the work group meetings, documentation is available on the NCPDP web site. The agendas link is above. The individual work group pages of working documents are below. Review of the documentation (available on each Work Group page) prior to the meeting will provide helpful background.

Please make sure you bring copies with you, as copies will not be provided. Some documents are still being developed and may not yet be available on the specified page. Please check back before work group meetings.

DERFs and New Project Development Forms:
Data Element Request Forms (DERFs) and New Project Development Forms submitted for review at the Joint Technical Work Group Meetings scheduled for May 5-6, 2019 in Scottsdale, AZ will be available on the website beginning April 21, 2019. To view and download the DERFs, log in to the website as a member, go to Work Group Lookup, select MC Maintenance and Control page and scroll down for the DERFs. For access to the information either download the zip file containing all the DERFs and New Project Development Forms or click on each item and download a copy. If you have any questions or need clarification on a DERF, please contact the Work Group Co-Chairs or the individual identified in the "submitter" section of the DERF.

Note the following new DERFs are External Code List (ECL) requests and will be discussed in the Work Group identified and voted on in MC Maintenance and Control.

DERF 001684/ECL 000291
DERF 001685/Emergency ECL 000292
DERF 001687/ECL 000293
DERF 001690/ECL 000294
DERF 001692/Emergency ECL 000295
DERF 001693/ECL 000296
DERF 001696/ECL 000297
DERF 001698/ECL 000298
DERF 001699/ Emergency ECL 000299
DERF 001700/Emergency ECL 000300
DERF 001701/Emergency ECL 000301
DERF 001708/ECL 000302
DERF 001713/ECL 000303
DERF 001714/ECL 000304

Please review the DERF/External Code List Process at http://www.ncpdp.org/NCPDP/media/pdf/Flow-For-DERF-website.pdf. If you are unable to attend the work group meeting, but have substantive comments on a DERF/ECL, please send those comments to the assigned Work Group Co-Chairs and Standards Development staff.

The final review of all DERFs is held in MC Maintenance and Control where modifications may be made.

PENDED DERFS	REQUEST	WORK GROUP ASSIGNMENT
Withdrawn ~~001636~~	~~This DERF proposes to provide a mechanism for a payer or plan to communicate an estimated adjustment amount to a pharmacy during adjudication for items such as processing/transaction fees, or direct or indirect remuneration (DIR) fees. Since these would be estimated amounts, the adjustments would NOT impact the response pricing~~	

	~~formula or Total Amount Paid (509-F9). There are two components to this DERF, a current version and a future version solution.~~	
001671	Request: Currently in the SCRIPT Standard, RxFill has two sections around when RxFill messages should be sent or requested. The proposal is to update the language in order to optimize workflow and streamline redundancies. Proposed updates: 5.8.3 Automated Triggering of RxFill Transaction within Pharmacy to Indicate a Fill • Updated proposal: RxFill messages are intended as a notification on an individual prescription or pharmacy activity based on trading partner agreements, prescriber preferred fill status selections, transferred prescription or regulatory-required pharmacy notices. The timing of the RxFill messages should coincide with the actual activity (or lack of activity), dispensing event or the failure to dispense at the point of sale. Outside of trading partner agreements and required regulatory notifications, it is NOT recommended to systematically automate the transmission of unsolicited RxFill messages. Doing so may result in alert fatigue for prescribers, which would defeat the purpose of the RxFill messages if critical intervention opportunities are missed. 5.8.6 Changes In Prescriber Workflow from RxFill • Updated proposal: RxFill messages are intended to inform the prescriber or representative healthcare system. Adherence monitoring processes within healthcare systems should be designed to fit workflow needs and provide information and/or notification via judicious use of safety alerts without causing alert fatigue. Programmatically automating requests outside of a trading partner agreement is discouraged to enable prescriber choice and control on volume and type of fill statuses being monitored.	WG11
001673	Purpose: The current AllergyOrAdverseEvent element does not allow for multiple reactions to a single allergen. Recommendation: After review, it was determined that the AllergyOrAdverseEvent element could be restructured to capture the reaction information in a more useable manner. This would apply to all messages that contain this element. In order to allow all messages to use the same composite, this DERF is also requesting the addition of a new ECL value for SourceofInformation.	WG11
Withdrawn ~~001674~~	~~In ONC's Interoperability Standards Advisory it is recommended that RxNorm values also be used for Allergies. https://www.healthit.gov/isa/representing-patient-allergies-and-intolerances-medications. There is a need in the industry to be able to send an RxNorm TTY type and value for the brand name of a drug.~~ ~~This DERF request RxNorm TTY (term type) "BN" be added to the list of RxNorm qualifiers as a value in the ECL to the AllergyDrugProductCodedQualifier.~~	
Withdrawn ~~001677~~	~~This DERF requests the addition of Prior Authorization duration and effective range to the Formulary and Benefit Standard Implementation Guide. The intent is to enable EHRs to determine automatically if a Prior Authorization coverage edit is really valid based on the patient's claims history.~~	
001680	Request: CMS will allow Medicare Part D formularies to use indication as part of the formulary design in 2020. This mirrors developments that have occurred in the commercial side. Per CMS: "Currently, Part D plans are required to cover every FDA-approved indication for each drug on their formulary. In the private sector, insurers frequently tailor formulary coverage based on specific patient condition, providing a negotiating lever with pharmaceutical manufacturers." https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/Downloads/HPMS-Memos/Weekly/SysHPMS-Memo-2018-Aug-29th.pdf This DERF is being submitted to support CMS' desire to support indication-based formularies based on the work from the previously approved Alternative by Indication DERF 001599. When implemented, if the indication code is known, then display the	WG11

	F&B data based on the indication code. If the indication code is not known, then the EHR may either ignore indication-based logic or display F&B grouped by indication.	
NEW DERF/ ECL	**REQUEST**	**WORK GROUP ASSIGNMENT**
001683	Request: This DERF is requesting a new Response Provider Segment to include two (2) new situational data elements, along with applicable ECL values to communicate additional information to pharmacies, and, in turn, prescribers, regarding the Point of Service provider-related rejection.	WG1
001684 ECL 000291	Request: This DERF is requesting the addition of two new Additional Message Information Qualifier (132-UH) values (XX – Invalid Provider Data Source and XX – Invalid Provider Data Source State Code) to communicate additional information to pharmacies, and, in turn, prescribers, regarding the Point of Service provider-related rejection.	WG1
001685 Emerg. ECL 000292	This DERF is requesting an update to the descriptions of existing reject codes 648 and 649, simply removing the reference to "CII", or Schedule II. This update would allow the reject codes to be used in the current standards and also in future versions of the standards when the Quantity Prescribed field (460-ET) will be used for additional drug schedules. This DERF is also requesting to sunset reject code 647 (Quantity Prescribed Required For CII Prescription), as the use case for this reject code already exists with reject code ET (M/I Quantity Prescribed). **Sunset Reject Code 647 (Quantity Prescribed Required For CII Prescription)** Update Reject Code 648: Current Description: Quantity Prescribed Does Not Match Quantity Prescribed On Original CII Dispensing **Updated Description: Quantity Prescribed Does Not Match Quantity Prescribed On Original Dispensing** Update Reject Code 649: Current Description: Cumulative Quantity For This CII Rx Number Exceeds Quantity Prescribed **Updated Description: Cumulative Quantity For This Rx Number Exceeds Total Prescribed Quantity**	WG1
001686	This DERF requests to update ***Section 28.3.3 Other Payer Amount Paid (431-DV)*** of the *Telecommunication Standard Implementation Guide vF4* and inclusion in the *Telecommunication Standard Version F2 and above Editorial and Best Practices* document. Changes include: • Modifications to some language • Updated examples to include additional fields and removed some fields to improve readability • Replaced Other Payer Amount Paid (431-DV) Reporting Order Chart with two new charts o Steps a **payer** would take to calculate the Other Payer Amount Recognized (566-J5) when using Other Payer Amount Paid (OPAP) COB processing. o Steps a **pharmacy** would take to calculate the Other Payer Amount Paid (431-DV) values for Percentage Tax and Drug Benefit.	WG1
001687 ECL 000293	Request: A solution is needed for the Telecommunication Standard vD.0 in regard to NDC changes and post-consumption billing. NDC Changes primarily occur when there are shorter cycles being dispensed throughout the month but then billed retrospectively at the end of the month. In between the shorter cycles, the pharmacy may exhaust their supply of one NDC and need to dispense a different one for the same product. When the pharmacy submits multiple transactions for those different NDCs, the patient is sometimes charged an additional copay.	WG1 (of interest to WG14)

	In situations where the NDC changed throughout the dispensing period in a post-consumption billing scenario, we are requesting a new Submission Clarification Code (420-DK) value to be used on subsequent claim(s) to explain there are multiple claims due to NDC change(s). The processor can use this information to resolve any duplicate therapy/refill too soon issues as well as correctly assess copayment. In instances where there may be different RX numbers, the processor should have logic built in that can identify multiple claims for same drug, same strength, and different NDC (similar to logic used for duplicate therapy).	
001688	This DERF requests to sunset the CMS Part D Defined Qualified Facility (997-G2) field. The WG14 LTPAC Current Billing Issues Task Group recently completed an in-depth review of the purpose and use of the CMS Part D Defined Qualified Facility (997-G2) field. The definition for the field is *"Indicates that the patient resides in a facility that qualifies for the CMS Part D benefit."* The task group has concluded the following through their recent research and discussion: The field was originally created to identify a patient who resides in a nursing facility. In task group and work group discussions over the past several years, no steps were taken to sunset this field in the event that it may be necessary if CMS were ever to include Assisted Living Patients in the definition of a skilled facility. The task group has since concluded that the Patient Residence (384-4X) field has enough detail to support any previously intended uses of this field. Therefore, the task group's recommendation is to sunset the CMS Part D Defined Qualified Facility (997-G2) field.	WG1 (of interest to WG14)
001689	This DERF is requesting the creation of a new field, "Transition Benefit End Date", as part of the "Response Claim Segment" in the Telecommunication Standard. The purpose of this new field will be to aid in the communication of upcoming member transition benefit ending dates, mitigating access to care and adherence risks.	WG1
001690 ECL 000294	This DERF is requesting the addition of a new Additional Message Information Qualifier (132-UH) value (XX – Transition Benefit End Date) to proactively communicate the member's end date of a transition benefit. This DERF is also requesting a value limitation be added to the existing Approved Message Codes 004-007 to provide guidance on the use of these Approved Message Code values with the new Additional Message Information Qualifier.	WG1
001691	This DERF requests the definition and name of field 555-AT Formulary Alternative Cost Share Incentive field be modified to better align with the industry usage of the field. We recommend the name be changed from Formulary Alternative Cost Share Incentive to Formulary Alternative Estimated Patient Cost Share and the definition from "Amount of patient's copay/cost-share incentive for the formulary alternative" to "The estimated Patient Pay Amount (505-F5) for the formulary alternative". Currently: 555-AT Formulary Alternative Cost Share Incentive- Amount of patient's copay/cost-share incentive for the formulary alternative. Proposed: 555-AT Formulary Alternative Estimated Patient Cost Share- The estimated Patient Pay Amount (505-F5) for the formulary alternative.	WG1
001692 Emerg. ECL 000295	Request: In the 2020 CMS Final Call Letter, CMS is requiring that all treatments that originate from an Opioid Treatment Facility be paid through Medicare Part B, while claims originating from other facilities may be covered through Part D. In order to guide the appropriate payment of these claims and not interrupt treatment, we are proposing two new Submission Clarification Code values to inform the payer of the origination of the treatment, if known. The requested Submission Clarification Code values would be: xx-Opioid Treatment Facility Claim xx-Non-Opioid Treatment Facility Claim	WG1 (of interest to WG9)
001693 ECL 000296	Request: This DERF is requesting a new ECL value to identify a claim as a synchronization fill within the NCPDP vD0 and future versions of the standard. For vD0	WG1

	this would be a new Submission Clarification Code (420-DK) value. For versions F2 and greater, this would be a new Submission Type Code (D17-K8) value. Business Need: Regulatory and plan benefit requirements require plans to pro-rate the patient cost share for shortened day supply as a result of a synchronization fill as well as provide a means to prevent or to override a refill too soon reject as a result of the timing of the synchronization fill. While the below current Submission Clarification Code values can be used to override the point of service reject for refill too soon, it does not support a means to specifically identify the claim as a synchronization fill. 47 Shortened Days Supply Dispensed Only used to request an override to plan limitations when a shortened days supply is being dispensed. 48 Dispensed Subsequent to a Shortened Days Supply Dispensing Only used to request an override to plan limitations when a dispensing subsequent to a shortened days supply is being dispensed. A new Submission Clarification Code value is needed in vD0 to specifically identify the claim as a synchronization fill, allowing the payer to apply applicable plan benefit rules and regulatory requirements to this fill type. For vF2 and greater, the same value /description would be reported in the Submission Type Code field, versus the Submission Clarification Code field that is used as an override request.	
001694	Request: This DERF is requesting modifications to the DUR/PPS Response segment to capture within codified fields critical detail regarding the DUR conflict that is currently being returned in 30 and 100 byte text fields. Moving this information into codified fields will increase patient safety, workflow efficiencies and better support harmonization of the DUR information communicated between the payer, pharmacy, prescriber and patient. Summary of Changes (see additional documentation for specific Data Dictionary, ECL and Implementation Guide modifications): • Add 15 new fields to Telecom DUR/PPS *RESPONSE* Segment 1. DUR/DUE Co-Agent Description 2. Other Pharmacy ID Qualifier 3. Other Pharmacy ID 4. Other Pharmacy Name 5. Other Pharmacy Telephone 6. Other Prescriber Last Name 7. Other Prescriber ID Qualifier 8. Other Prescriber ID 9. Other Prescriber Telephone 10. DUR/DUE Compound Product ID 11. DUR/DUE Compound Product ID Qualifier 12. DUR/DUE Maximum Daily Dose Quantity 13. DUR/DUE Maximum Daily Dose Unit of Measure 14. DUR/DUE Minimum Daily Dose Quantity 15. DUR/DUE Minimum Daily Dose Unit of Measure • Modify field name of 476-H6 DUR Co-Agent ID and 475-J9 DUR Co-Agent ID Qualifier • Expand usage of 476-H6 DUR Co-Agent ID and 475-J9 DUR Co-Agent ID Qualifier to include in the *RESPONSE* transaction (currently only in request) • Modify field name and length of 544-FY DUR Free Text Message • Sunset 570-NS DUR Additional Text	WG1
001695	Request: This DERF is requesting the creation of a new field, "Formulary Alternative Effective Date", as part of the "Response Claim Segment" in the Telecommunication Standard. The purpose of this new field will be to aid in the proactive communication of upcoming formulary change information with both patients and prescribers, mitigating access to care and adherence risks.	WG1

001696 ECL 000297	Request: This DERF is requesting the addition of a new Additional Message Information Qualifier (132-UH) value (XX – Preferred Product Effective Date) to proactively communicate the effective date of an upcoming formulary change. In addition, it is requesting a value limitation be added to the existing Approved Message Code (548-6F) value 002 - Non-Formulary Drug to provide guidance on the use of the value with the new qualifier.	WG1
001697	Request: When the Part B claim is processed using the NCPDP real time claim transaction, pharmacies need to know if the beneficiary is a full dual eligible when a claim is paid under Part B in order to coordinate benefits. In this instance the pharmacy should not collect the 20% Part B copay from the beneficiary and instead should coordinate with Medicaid to cover the 20% copay. A distinct claim response field is necessary to communicate this information to the pharmacy when the claim is paid under a Medicare Part B benefit. A similar business case was previously recognized for purposes of the Medicare E1 claim response, where the Response Other Related Benefit Detail Segment and fields D32-MS: Other Benefit Detail Information Qualifier and D27-MK: Other Benefit Detail Information were established in the Telecommunication Standard. However, the situations defined for the fields within this segment are currently limited to the E1 Approved Response. The DERF requests the RESPONSE OTHER RELATED BENEFIT DETAIL SEGMENT and all associated fields be available within the following Claim Billing and Service Billing responses: • Accepted/Paid • Accepted/Captured • Accepted/Rejected The segment will be situational on the response transaction. The situations of use for these fields should mirror the situations already defined for the E1 Accepted/Accepted Response. Refer to matrix outlined below. To address this QMB business case, add new values to Other Benefit Detail Information Qualifier (D32-MS).	WG1 (of interest to WG9)
001698 ECL 000298	Request: When a claim rejects because the beneficiary is in Hospice, returning the Hospice Provider NPI in the response may allow the pharmacy to coordinate benefits with the hospice provider. This DERF recommends a method to communicate this information in Telecommunication Standard versions D.0 and F. DERF 001697 has been submitted for a future version of the Telecommunication Standard. This DERF requests a new Additional Message Information Qualifier (132-UH) to identify the Hospice Information that can be returned on a claim response. The data that should be returned in the corresponding Additional Message Information field 526-FQ represents the Hospice Provider Number and the Hospice Effective Date This information should be structured in the manner below: NPI:11111111111;COVED:CCYYMMDD This information corresponds with fields that have been requested to be made available in the claim response in the version after F.	WG1 (of interest to WG9)
001699 Emerg. ECL 000299	Request: In response to the Office of Inspector General (OIG), Department of Health and Human Services (HHS) Proposed Rule (file code OIG–0936–P) entitled “Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees”, NCPDP reviewed the proposed rule specifically as it relates to new safe harbor for price reductions on prescription pharmaceutical products that meet certain new proposed criteria. NCPDP’s response outlined proposed approaches/methods to support the proposed definition of a chargeback. In order to distinctly identify a chargeback amount within the Telecommunication Standard pricing segment, this DERF requests two new qualifiers for Other Payer Amount Paid Qualifier (342-HC) and Other Amount Paid Qualifier (564-J3) to	WG1 (of interest to WG9)

	communicate the amount is a chargeback and whether or not a PBM/plan is paying/fronting the chargeback amount as part of their payment. Updated editorial guidance will need to be created as will harmonization with the X12 835 values if none are currently available.	
001700 Emerg. ECL 000300	Request: In response to the Office of Inspector General (OIG), Department of Health and Human Services (HHS) Proposed Rule (file code OIG–0936–P) entitled "Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees", NCPDP reviewed the proposed rule specifically as it relates to new safe harbor for price reductions on prescription pharmaceutical products that meet certain new proposed criteria. NCPDP's response outlined proposed approaches/methods to support the proposed definition of a chargeback. In order to distinctly identify a chargeback amount within the Telecommunication Standard pricing segment, in DERF 001699/ECL 000299 two qualifiers were requested to communicate the amount is a chargeback based on whether or not a PBM is paying/fronting the chargeback amount as part of their payment. This DERF is to request new values for 522-FM Basis of Reimbursement Determination to indicate the chargeback amount has reduced the ingredient cost and the chargeback amount should be added to ingredient cost to determine contracted ingredient cost.	WG1 (of interest to WG9)
001701 Emerg. ECL 000301	Request: In response to the Office of Inspector General (OIG), Department of Health and Human Services (HHS) Proposed Rule (file code OIG–0936–P) entitled "Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees", NCPDP reviewed the proposed rule specifically as it relates to new safe harbor for price reductions on prescription pharmaceutical products that meet certain new proposed criteria. NCPDP comments outlined proposed approaches/methods to support the proposed definition of a chargeback. In order to communicate the amount of the chargeback and the patient savings as a result of the chargeback when the claim is processed under Approach 1/Method 2, new Additional Message Information Qualifiers (132-UH) are being requested. • Approach 1/Method 2: This method would function similarly to the first method, having one payment to the dispensing pharmacy by the PBM for both the benefit liability and the chargeback amount in the point-of-sale transaction. However, unlike Method 1 the chargeback amount would not be visible to the pharmacy. This method will not require any modifications to the existing HIPAA named standard.	WG1 (of interest to WG9)
001702	Request: In an effort to streamline the communication of provider enrollment data from State Medicaid agencies to the applicable stakeholders, this DERF is requesting approval of a new standard, the State Medicaid Provider File Standard. The following documents are attached: • State Medicaid Provider File Standard Implementation Guide Version 10 • Outline of the new Data Elements and values to be created as part of the State Medicaid Provider File Standard • Outline of the modifications to existing Data Dictionary and ECL values as part of the State Medicaid Provider File Standard	WG9
001703	Request: Hub Services - Drugs in a payer's Specialty Tier are becoming a larger portion of prescription drug spend, yet medications on the payer's specialty tier present a variety of challenges related to patient access. Presently, specialty Hubs/Portals provide important services to facilitate access to specialty tier medications. In order to convey information to the prescriber regarding specialty tier access and Hub/Portal Services, this DERF is requesting the creation of a new file in the F&B Standard. See Attachment, but Overall: Add Hub Services Products File (HS) Add Hub Products ID to Cross reference and Header of Hub Services Products File	WG11

	In Hub Services File. Add: Product/NDC Hub Services Provider Hub Services Provider ID Hub Services	
001704	Request: The Food and Drug Administration Amendments Act of 2007 gave FDA the authority to require a Risk Evaluation and Mitigation Strategy (REMS) from manufacturers to ensure that the benefits of a drug or biological product outweigh its risks. Per the FDA: "a REMS is a safety strategy to manage a known or potential serious risk associated with a medicine and to enable patients to have continued access to such medicines by managing their safe use." The industry does not have a good way to indicate to the prescriber when a REMS requirement exists, nor identify the administrator of the REMS program. This DERF is proposing to add a new REMS Products File type to the F&B Standard to indicate that a REMS program applies and to identify the administrator of that program. Effectively, streamlining the process. See Attachment, but Overall: Add REMS Products File Type (RE) Add REMS Products ID to Header of REMS File Type and Cross Reference File In REMS File, Add: Product/Service ID – NDC, if NDC is present, REMS is required. This change is not addressed below. REMS Administrator REMS Administrator ID Add values to 601-04 Record Type for REMS Products Header, REMS Products Detail and REMS Products Trailer	WG11
001705	Request: As complex specialty medications become more commonly prescribed, we have identified a need for other constituents to participate in the ePrescribing process. Historically, the PBMs/Payers have been the only constituents providing Formulary & Benefit information to prescribers via their e-prescribing modules at the point of care. Recognizing other stakeholders can provide valuable information that can decrease time to care, this DERF proposes modifying the Responsibility of Participants section to allow other stakeholders to participate in the formulary and benefit process. See implementation guide changes below. The changes include the addition of a new section under business functions: 4.2.6 - Third Party Provided Files	WG11
001706	Request: Drugs in a payer's specialty tier are becoming a larger portion of prescription drug spend, yet patients struggle with timely access. Presently the dispensing of drugs in a specialty tier could be limited by the payer or by the manufacturer. The purpose of this DERF is to make it easier for prescribers to identify restrictions on dispensing drugs in the specialty tier and act on that information during therapy selection. See below for modification, but Overall Modifications to the Specialty Products File in the F&B Standard. These modifications will allow the payer to specify if a specific NDC is covered at specific pharmacies or specific pharmacy networks: Modify Specialty Products File to include: Distribution Indicator Pharmacy ID Service Provider ID Service Provider ID Qualifier Create a Specialty Product Distribution File. This file will supplement the information in the specialty product file. If the NDC is limited distribution per the manufacturer, the manufacturer or third party can provide the Specialty Product Distribution file containing the NDCs and their specific distribution channels. Fields can be reused from above, but there will be a limit on distribution indicator: Distribution Indicator Pharmacy ID Service Provider ID Service Provider ID Qualifier	WG11

001707	Request: When adding the pharmacist-initiated electronic prior authorization functionality, the Task Group realized the ePA portions of the SCRIPT Standard Implementation Guide needed to be updated. Very few changes have been made to this content since the July 2013 publication of the Guide. The task group reviewed the different sections related to electronic prior authorization focusing on clarity, consistency, and readability. As a result, the Implementation Guide has been modified to consolidate content, reorganized for readability and clarity and errors corrected. This DERF is requesting to modify the electronic prior authorization sections of the SCRIPT Standard Implementation Guide.	WG11
001708 ECL 000302	Request: There is a need for a prescriber to indicate on an LTPAC order that a therapeutic interchange consistent with the facility's formulary is NOT allowed within a NewRx message. In this case the pharmacy cannot make a therapeutic interchange, but a generic substitution is okay. The pharmacy has a signed agreement with the facility that they can make therapeutic changes but for a specific patient and a specific medication it is not allowed. This DERF is requesting a new value be added to PatientCodifiedNoteQualifier "Therapeutic interchange not allowed."	WG11 (of interest to WG14)
001709	Request: Drug identifiers such as NDC and RxNorm are key complements to the drug description and are essential to facilitate interoperability between a sender and receiver when communicating about medications. Drug identifiers are permissible in the current standard, v10.6, via the DrugCoded/ProductCode and ProductCodeQualifier fields. In SCRIPT version 10.6, allowable qualifiers include ND = NDC11, MF = MFG and UP = UPC. In addition, drug identifiers specific to RxNorm are also permissible via the DrugCoded/DrugDBCode and DrugDBCodeQualifier fields. Although the standard allows its use and facilitates the transmission of this important information, these are optional fields. Note that, more than one health information network intermediary, requires the transmission of an NDC unless the prescription is for a compound or supply. As the standard evolves and new drug identifiers have come into play, it is important for the standard to require this important piece of information. Recommendation: • Add a product choice list of DrugCode, Compound and Supplies. • Create a separate field under DrugCode to send the NDC number, allowing it to be mandatory for certain messages. • Move all drug identifiers from the DrugDBCode to the DrugCoded/ProductCode and corresponding qualifier fields (including RxNorm). • Remove proprietary drug codes from the DrugCoded/ProductCode and CompoundIngredientProductCodeQualifier but retain them in the DrugDBQualifier. • In addition, the DrugCoded/ProductCode and qualifier field will repeat up to 5 times allowing additional drug identifiers to be sent. Recommend sunsetting the following values in DrugDBCodeQualifier due to redundancies, lack of utilization and to eliminate confusion. • E = Truven/Micromedex Generic Formulation Code (GFC) • FD = First DataBank Routed Dosage Form ID (FDB RoutedDosage Form Med ID) • FG = First DataBank Clinical Formulation ID Sequence Number (GCN_SEQNO) • FS = First DataBank Smartkey • MC = Multum Drug ID • MG = Medi Span's Generic Product Identifier (GPI)	WG11
001710	Request: In review of the Census guidance many terms and explanations were noted to be out of date or in need of revision for clarity of use. The guidance for the Census transaction is currently located in the Specialized Implementation Guide and has not had wide spread industry adoption as was the intent and purpose of adding the message as a standard. With improved guidance this transaction may have better understanding of value and need for utilization of a single standard for communicating from a care setting to a pharmacy; the relevant information for a resident/patient.	WG11

001711	Request: In the current SCRIPT 2017071 Implementation Guide Section 8.1.6.4, has verbiage stating: "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." However, since more EHR systems have deployed their compendium's E-Prescribing Names (EPNs), reported issues have arisen with particular compendium-established EPNs for certain products that were confusing or ambiguous to both prescribers and pharmacist which led to risks for misinterpretation. The recently published updated Guidelines for Safe Electronic Communication of Medication Information from the Institute for Safe Medication Practices (ISMP) in January of 2019 recommends the following: "When the drug description field allows for both brand and generic names on product selection menus and search choices, display the brand name of a generic product, and/or the generic name of a brand product, to aid in recognition of the correct drug, particularly for combination products, drugs with look-alike names, vaccines, and other medications with names that might otherwise be confused. The brand or generic product intended to be prescribed should be listed first, and the reference drug name provided for clarification should appear in parentheses after the intended product. The intended e-prescribing drug name and the reference drug name in parentheses should be sourced from compendia in a standardized format." Thus, in certain instances for certain products with potentially-ambiguous EPNs, e.g., multi-ingredient combination drugs, look-alike-sound-alike drugs, drugs that have multiple release formulations such as extended-release metformin (generics for Fortamet, Glucophage XR, Glumetza), or diltiazem (generics for Cartia XT, Cardizem CD, Tiazac, etc.), having a reference name would be useful (and recommended by ISMP) to provide additional clarity for improved selection accuracy and safety. In the current schema, there is only one field, <DrugDescription>, specifically for the drug product name information, which is where the EPN would currently be entered. Compendia who are working with their customers who wish to implement additional logic for appending a reference name in parentheses after the EPN for better clarity and accuracy will need to concatenate both the reference name and the EPN together into this one field, per ISMP's recommendation. RECOMMENDATION #1: The verbiage in the SCRIPT 2017071 Implementation Guide should therefore be updated to reflect the new safety recommendations from ISMP. See below for suggested verbiage changes to both guides to address those recommendations: "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. 2. The recommended ePrescribing Drug Name is not to be modified; however, additional drug name information may need to be appended to supplement the ePrescribing Drug Name in certain situations. 3. For certain products where the compendium's EPN alone may not always provide sufficient clarity, e.g., when distinguish between similar multi-ingredient products or products with different formulations. Thus, to prevent inadvertent misfills and selection errors and ensure patient safety and selection accuracy of the intended prescribed product, one standardized reference drug name sourced from the compendia should be conditionally included in parentheses to supplement the EPN. 4. 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. "	WG11

	RECOMMENDATION #2: Create a new field for future versions of SCRIPT called <ReferenceDrugName> that is 105 alpha-numeric characters and Conditional, where the Reference drug name sourced from the compendium may be populated. This would avoid pushing certain long EPNs from going past the 105-character limit of the <DrugDescription> field and ensure the information in the <DrugDescription> field is not overly cluttered. The EPN/product name in the <DrugDescription> field is still understood to be the prescribed product intended by the prescriber and that aligns with the drug identifier(s) sent; the information in the <ReferenceDrugName> field is only intended for additional clarity to help guide selection accuracy - (e.g., to dispense the generic for Fortamet, and not Glumetza, etc.).	
001712	Request: The patient portion of the financial responsibility for a prescription purchase has increased over time and pharmacy benefit structures have become increasingly sophisticated and dynamic (i.e. percentage copay, deductibles, formulary tiers, prior authorizations, etc.) and therefore hard to understand. Currently, patients rely almost exclusively on their pharmacy to identify their financial responsibility for a prescription, at which point the patient cost for a prescription may not be tenable or there may be a formulary exclusion or prior authorization requirements that prevents them from initiating therapy. Physicians prescribe drugs with little knowledge of their costs to their patients or to the payers. Increasingly, prescribers receive requests from pharmacies to prescribe a less expensive medication, prescribe a medication that is on formulary, or assist with a prior authorization review. Prescribers spend countless resources responding to these patient and pharmacy inquiries, yet pharmacies receive this information in real-time and in their workflow. There is an unfulfilled business need to deliver patient and payer medications costs to prescribers at the point of care. Point of care real-time prescription benefit processing is needed to facilitate the selection of medications. This DERF is requesting the creation of Real Time Prescription Benefit Standard to meet two industry needs within the pharmacy services sector: to facilitate the ability for pharmacy benefit payers/processors to communicate formulary and benefit information to providers and to ensure a consistent implementation of the standard throughout the industry. The Standard will support two formats, EDI and XML, but will have a single implementation guide and common data content.	MC
001713 ECL 000303	Request: California Senate Bill 179 (https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB179) states: This bill, on January 1, 2019, would require an applicant for an original driver's license or renewal of a driver's license to choose a gender category of female, male, or nonbinary, as specified, and would require the department to adopt regulations to provide a process for an amendment to a gender category under these provisions. The bill would also require the enrollment form for the California Organ and Tissue Donor Registry to instead require an applicant to mark his or her gender. In order to align with the California regulation, this DERF is requesting a new valid value be added to the: Patient Gender Code (305-C5) field- new ECL valid value of "N" for "non-binary" with a description of "Nonbinary- an umbrella term for people with gender identities that fall somewhere outside of the traditional conceptions of strictly either female or male." (this definition is from the SB179 language). Purchaser Gender Code (595-YY) field- new ECL valid value of "N" for "non-binary" with a description of "Nonbinary- an umbrella term for people with gender identities that fall somewhere outside of the traditional conceptions of strictly either female or male." (this definition is from the SB179 language). Gender Code (721-MD) field- new ECL valid value of "N" for "non-binary" with a description of "Nonbinary- an umbrella term for people with gender identities that fall somewhere outside of the traditional conceptions of strictly either female or male." (this definition is from the SB179 language).	MC (of interest to WG11)

	Conditional Gender Code (C08-4T) field - new ECL valid value of "N" for "non-binary" with a description of "Nonbinary- an umbrella term for people with gender identities that fall somewhere outside of the traditional conceptions of strictly either female or male." (this definition is from the SB179 language). Gender Field – Element in the Patient Segment. New ECL valid value of "N" for "non-binary" with a description of "Nonbinary- an umbrella term for people with gender identities that fall somewhere outside of the traditional conceptions of strictly either female or male." (this definition is from the SB179 language).	
001714 ECL 000304	Request: Pharmacies need to know if the beneficiary is full dual eligible when a claim is paid under Part B in order to coordinate benefits. In this instance, the pharmacy should not collect the 20% Part B copay from the beneficiary and instead should coordinate with Medicaid to cover the 20% copay. This DERF request a new Additional Message Information Qualifier value to identify Qualified Medicare Beneficiary status.	WG1 (of interest to WG9)

Of Special Note:

NCPDP EDvocacy Update
The NCPDP EDvocacy Update is scheduled for Monday, May 6, 2019 from 7:00 a.m. to 7:30 a.m.

CMS Discussion
The CMS Discussion is scheduled for Monday, May 6, 2019 from 7:30 a.m. to 8:00 a.m.

Frequently Asked Questions (FAQ) Documents
Multiple task groups develop Frequently Asked Questions documents for Work Group review and publication. These FAQs should be reviewed during task group calls and prior to Work Group meetings as discussion time is limited.

Ballot Responses
The results of the ballots will be reviewed as follows:

Ballots WG010081, WG010082 and WG010083 – WG1 Telecommunication
Ballot WG070013 – WG7 Manufacturer and Associated Trading Partner Transaction Standards
Ballot WG090012 – WG9 Government Programs
Ballot WG110082 – WG11 ePrescribing & Related Transactions
Ballot WG180002 – WG18 Specialty Pharmacy

The ballot results will be posted to the appropriate web pages prior to the Work Group meetings.

SPECIFIC WORK GROUP DISCUSSION ITEMS:
The detailed work group documentation is accessible from the Member Portal page http://www.ncpdp.org/members/member-info.aspx. Select the Work Group from the dropdown at the left side of the screen.

On each Work Group page, you will see the May 2019 Meeting Materials with a zip file. Download the zip file as copies are not provided.

Previous meeting minutes are also available on each page. **Please note you may need to check work group website pages just before work group meetings, as recent work is being posted in the zip files, as well as the ballot results**.

WG1 Telecommunication

Work Group 1 Telecommunication develops and maintains standards and guidelines to accommodate the collection, transmission, and processing of information that may be exchanged electronically or in written formats. The information exchanged may be used for, but is not strictly limited to, such purposes as administering and certifying eligibility, establishing prior authorization for products and services, pharmacy claim billing, payment

determination, denial of compensation with explanations, drug use review and the exchange of adjudicated data between business associates.

During the May Work Group meetings, WG1 will hear updates from the following task groups:

- Telecommunication FAQ Task Group
- Coordination of Benefits (COB) Task Group
- Information Reporting Problems Task Group
- Post Adjudication Task Group
- Definition of a Valid Prescriber Task Group
- Eligibility Verification Enhancements Task Group
- Benefit Integration Task Group
- Standardized Subrogation Task Group
- Compound Task Group
- Usage of Submission Clarification Code Task Group
- Expand Dollar Fields Task Group
- Clinical & Safety Edits Task Group

WG1 will also:

- Adjudicate Ballots WG010081, WG010082 and WG010083
- Discuss new DERFs
- Discuss DSMO Requests
- Discuss questions and answers from various task groups for inclusion in the Version D Editorial document and/or Telecommunication Implementation Guide
- Discuss action items from any task group
- Next Generation of the Telecommunication Standard
- Project Development Form 000051 – Payer-Generated Individualized Written Denial Notice at Pharmacy Point of Sale

Documents for discussion that are on the WG1 page include:

- 201905 WG1 zip file containing:
  - Agenda
  - Task Group Recaps
  - 2018-2019 Work Group Accomplishments
  - Next Generation Presentation
  - Project Development Form 000051
- See web page for all available documentation.

WG2 Product Identification

Work Group 2 Product Identification deals with issues relating to the identification of drugs and health related products within NCPDP's stated mission. Identification consists of how the product is billed (billing units, quantity designations), product identification systems, and any type of descriptive data which serves to uniquely identify a product with the intent to establish standards for product identification such that there is no ambiguity in distinguishing one product from another.

During the May Work Group meetings, WG2 will hear updates from the following task groups:

- Structured Product Labeling Activities Task Group
- Product Review and Billing Unit Exception Task Group
- SPL REMS Task Group
- Naming Standards for Drugs, Biologics and Biosimilars Task Group
- Application of BUS Clarification Task Group
- Update WG11 REMS Workflow to Transaction Task Group

- Update MC NDC Scarcity Task Group
- Update MC Digital Therapeutics Task Group

WG2 will also:

- Receive Industry and Government Activities Updates
- Hear a presentation on Aimmune Peanut Allergy Therapy

Documents for discussion that are available on the WG2 page include:

- 201905 WG2 zip file containing:
  - Agenda
  - Task Group Recaps
  - 2018-2019 Work Group Accomplishments
- See web page for all available documentation

WG7 Manufacturer and Associated Trading Partner Transaction Standards

Work Group 7 Manufacturer and Associated Trading Partner Transaction Standards develops, monitors, and maintains standards for the electronic exchange of data between manufacturers and data providers, and/or trading partners. Additionally, the work group will facilitate the implementation and education of the standards and process.

During the May Work Group meetings, WG7 will hear updates from the following task groups:

- Medicaid Drug Rebate Program Task Group
  - Review white paper, *Medicaid Drug Rebate Program – Challenges Across the Industry*
- Medical Rebate Task Group
- Manufacturer Rebate Standard Task Group

WG7 will also:

- Adjudicate Ballot WG070013
- Receive WG9 340B Task Group Update
- Receive WG18 Specialty Pharmacy Work Group Update
- Receive Drug Supply Chain Security Act (DSCSA) Update

Documents for discussion that are available on the WG7 page include:

- 201905 WG7 zip file containing
  - Agenda
  - Task Group Recaps
  - 2018-2019 Work Group Accomplishments
- See web page for all available documentation

WG9 Government Programs

Work Group 9 Government Programs, in conjunction with Work Group 1 Telecommunication, guides and advises Federal and State funded pharmacy programs and their agents on standards implementation, supports data processing initiatives, and provides design alternatives for standards, which support government requirements.

During the May Work Group meetings WG9 will receive updates from the following task groups:

- 340B Task Group
  - Review/approve the 340B Information Exchange Reference Guide
- Government Programs Encounter Reporting Standard Task Group
- Hospice Task Group
- Medicaid Frequently Asked Questions Task Group

- Medicaid Subrogation FAQ Task Group
- Medicare Financial Information Reporting Task Group
- Medicare Part D FAQ Task Group
- Medicare Prescription Drug Event Task Group
- Medicare Standardized Fraud, Waste and Abuse Training Attestation Task Group
- Prescription Drug Monitoring Programs Task Group
- Medicare Card Project Task Group
- Coordination of Benefits Contractor (COBC)/Benefits Coordination & Recovery Center (BCRC) Task Group
- Medicare Part D Multi-Payer Reconciliation Task Group
- OIG Report OEI-05-12-00540 Task Group (on hiatus)

WG9 will also adjudicate Ballot WG090012 and review new DERFs.

Documents for discussion that are available on the WG9 page include:

- 201905 WG9 zip file containing
  - Agenda
  - Task Group Recaps
  - 2018-2019 Work Group Accomplishments
- See web page for all available documentation

WG10 Professional Pharmacy Services

Work Group 10 Professional Pharmacy Services assists in the development and maintenance of standards to support electronic documentation and transmission of data for professional pharmacy services.

During the May Work Group meetings, WG10 will hear updates from the following task groups:

- MTM and Pharmacist Clinical Services Task Group
- mL White Paper Task Group
- USP Allergy Update
- Universal Medication Schedule White Paper Task Group
- Electronic Referral Task Group
- WG18 Specialty Requirements- eRx Task Group
- Update WG14 Consultant Pharmacist Interoperability Task Group
- Update Joint WG14/WG10 Standardized Medication Profile Task Group

WG10 will:

- Receive Industry Updates

Documents for discussion that are available on the WG10 page include:

- 201905 WG10 zip file containing
  - Agenda
  - Task Group Recaps
  - 2018-2019 Work Group Accomplishments
- See web page for all available documentation

WG11 ePrescribing & Related Transactions

Work Group 11 ePrescribing & Related Transactions develops standardized messages for prescribers, pharmacists, payers and/or other interested parties to exchange information related to a prescribing event or patient encounter.

During the May Work Group meetings, WG11 will hear updates from the following task groups:

- WG14/11 LTCPAC ePrescribing Task Group

- Formulary and Benefit Task Group
- XML Task Group
- SCRIPT Implementation Recommendations Task Group
- REMS Workflow to Transaction Task Group
- Electronic Prior Authorization Workflow to Transactions Task Group
- Implementation of Structured Sig Task Group
- ePrescribing Regulatory Task Group
- X12 270/271 Version 7030 Review Task Group
- Dispensed Medication Reporting Task Group
- WG11/WG14 RxFill Task Group

WG11 will:

- Review new and pended DERFs
- Adjudicate Ballot WG110082
- Receive a status on industry activities
- Discuss questions and answers for inclusion in the SCRIPT Implementation Recommendations and Formulary and Benefit Implementation Recommendations documents (if applicable)
- Receive an update from the WG18 Specialty Requirements for ePrescribing Task Group and the MC Patient Gender Transition Task Group

Documents for discussion that are available on the WG11 page include:

- 201905 WG11 zip file containing:
  - Agenda
  - Task Group Recaps
  - 2018-2019 Work Group Accomplishments
  - DSMO Change Requests (if applicable)
  - Modifications since Version 2017071 log
  - QuantityUnitOfMeasure Code List values to be sunset on October 1, 2019
- See web page for all available documentation

WG14 Long Term and Post Acute Care (LTPAC)

Work Group 14 Long Term and Post Acute Care (LTPAC), in conjunction with the other Work Groups, guides and advises payers, processors, and providers of the long term care industry and institutional pharmacy programs and their agents on standards implementation and supports data processing initiatives.

During the May Work Group meetings, WG14 will hear updates from the following task groups:

- LTPAC Current Billing Issues Task Group
- LTPAC ePrescribing Task Group
- Consultant Pharmacist Interoperability Task Group
- Standardized Medication Profile Task Group
- RxFill Task Group

WG14 will:

- Receive an update from the WG1 Eligibility Verification Task Group, WG9 Hospice Task Group, WG9 Medicare Part D FAQ Task Group, WG1 Morphine Equivalent Dosing Task Group and WG11 X12 270/271 version 7030 Review Task Group
- Discuss Industry/Regulatory Updates
- Discuss creation of a new task group for LTPAC Interoperability

Documents for discussion that are on the WG14 web page include:

- 201905 WG14 zip file containing
    - Agenda
    - Task Group Recaps
    - 2018-2019 Work Group Accomplishments
- See web page for all available documentation.

WG16 Property and Casualty/Workers' Compensation

Work Group 16 Property and Casualty/Workers' Compensation will ascertain, monitor and analyze regulatory requirements to develop correlating fields to be supported in the Telecommunication Standard format; evaluate, and maintain a Property and Casualty/Workers' Compensation standard paper claim form; proactively promote and educate pharmacy industry stakeholders and regulatory policy makers on the form and format standards found in Property and Casualty/Workers' Compensation (including but not limited to uniform billing, state reporting policies and the overall delivery of pharmacy services/care.)

During the May Work Group meetings, WG16 will receive updates on the following:

- Legislative/Regulatory Monitoring and Education Task Group
- Billing and State Reporting Task Group
- Future Development Needs for WC/PC Task Group

WG16 will also:

- Discuss Rule Comments and Advocating for NCPDP Standards
- Receive IAIABC and Industry Updates

Documents for discussion that are on the WG16 web page include:

- 201905 WG16 zip file containing
    - Agenda
    - Task Group Recaps
    - 2018-2019 Work Group Accomplishments
- See web page for all available documentation.

WG18 Specialty Pharmacy

Develops, monitors and maintains existing and new standards and guidance for the electronic exchange of data amongst providers, pharmacies, manufacturers, payers/processors and other stakeholders to facilitate patient access to specialty products and related business processes.

The work group, in conjunction with other NCPDP Work Groups, guides and advises stakeholders on standards implementation and supports data processing initiatives. The work group may request modifications to other NCPDP standards as necessary.

During the May Work Group meetings, WG18 will hear updates from the following task groups:

- Specialty Requirements for ePrescribing Task Group
- Specialty Pharmacy Data Exchange Task Group
- Stakeholder Outreach and Education Task Group
- Benefit Coverage Identification Task Group

WG18 will:

- Adjudicate Ballot WG180002

Documents for discussion that are on the WG18 web page include:

- 201905 WG18 zip file containing
    - Agenda
    - Task Group Recaps

    - 2018-19 WG Accomplishments
- See web page for all available documentation.

WG45 External Standards Assessment, Harmonization and Implementation Guidance

Work Group 45 External Standards Assessment, Harmonization and Implementation Guidance reviews, assesses and works to continually monitor the development of standards and/or operating rules by other Standards Development Organizations (SDOs) and/or other Non-NCPDP entities that may impact the pharmacy industry.

The Work Group

- Communicates SDO and other external entities developments and identifies actions that may be needed by this or other NCPDP work groups. These include, but are not limited to, the ASC X12N Implementation Guides and the Health Level Seven International (HL7) Standards.
- Develops and maintains guidelines for the pharmacy industry to accommodate pharmacy implementation of the Health Insurance Portability and Accountability Act (HIPAA) and Affordable Care Act (ACA) mandated electronic data interchange (EDI) transactions and operating rules not developed by NCPDP as determined by the membership.
- Contributes to the development and maintenance of operating rules that impact the pharmacy industry.

To this end, Work Group 45 External Standards Assessment, Harmonization and Implementation Guidance will collaborate with other SDOs, operating rules entities or other Non-NCPDP entities to provide the pharmacy perspective and represent the industry needs in the development of standards and guidelines.

During the May Work Group meetings, WG45 will hear updates from the following task groups:

- Document Revision Task Group
- Pharmacy ID Card Task Group
- X12 7030 834/835 Task Group
- 834/835 FAQ Task Group
- DSMO Change Request Task Group
- DIR 835 Reporting Task Group

WG45 will receive the following reports:

- Industry Updates (WEDI, NCPDP SNIP, X12, CAQH CORE)
- Inter-SDO Process
- Legislation

Documents available on the WG45 web page include:

- 201905 WG16 zip file containing
    - Agenda
    - Task Group Recaps
    - 2018-2019 Work Group Accomplishments
    - NCPDP Direct/Indirect Remuneration Recommendations Document
    - NCPDP Payer Audit Reporting Transaction Document
- See web page for all available documentation.

MC Maintenance and Control

MC Maintenance and Control monitors and maintains the development of NCPDP standards, implementation guides and reference documents, promotes consistent business and technical administration, makes recommendations to the Standardization Co-Chairs on development procedures, due process compliance, as well as ethical and legal matters. MC provides a forum

for updates of work group activities, resolution of inter-Work Group issues and discussion of legislative, regulatory, policy, and court decisions which may affect the pharmacy industry.

During the May Work Group meetings, MC will hear a status from the following task groups:

- Education/Legislation/Regulations Task Group
- Real-Time Prescription Benefit Standard Task Group
- API Task Group
- Emergency Preparedness Task Group
- X12 TR3 Comment Coordination Task Group
- ECL Task Group
- Gender Transition Task Group
- Patient Identification Task Group
- Harmonization Formation Task Group
- Digital Therapeutics Task Group
- NDC Scarcity Task Group

MC will also:

- Review new and pended DERFs
- Receive daily WG updates
- Receive updates on HIPAA
- Receive an update from the Board of Trustees
- Receive an update from the NCPDP SNIP Committee
- Receive an update on DSMO Change Requests 1201 and 1202
- Receive an update on Project Development Forms 000050 and 000051

Documents for discussion that are on the MC page include:

- 201905 MC zip file containing
    - Agenda
    - Task Group Recaps
    - 2018-19 WG Accomplishments
- See web page for all available documentation