Challenges and Opportunities for Stakeholders Regarding ePrescribing Technologies and Formulary Compliance

Version 1.0
August 2013

This paper offers guidance to the pharmacy industry on challenges regarding e-prescribing technologies and formulary compliance.
Challenges And Opportunities For Stakeholders Regarding ePrescribing Technologies And Formulary Compliance

Version 1.0
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The writers of this paper will review and possibly update their recommendations should any significant changes occur.

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1. PURPOSE

NCPDP (National Council for Prescription Drug Programs) has been involved with the development of standards in the pharmacy services sector for several decades and has been instrumental in the transition of manual, paper processes to more efficient, electronic transactions from start to finish in the life of a prescription or a claim. These efforts include the organization’s tremendous focus involving electronic prescribing in Work Group 11 ePrescribing & Related Transactions.

NCPDP membership includes constituents directly involved in prescribing and dispensing transactions, and others not directly involved, including pharmaceutical and device manufacturers. These companies participate in a value-exchange with some payers involving contractually determined rebates and incentives that reduce the effective price in exchange for volume or access opportunities. Work Group 7 Manufacturer and Associated Trading Partner Transaction Standards has advanced the issues of data exchange important to the payer-manufacturer contractual relationship for many years. Work Group 7 initiated an electronic prescribing task group to explore the impact of electronic prescribing on contracts and the trading partner relationships with this collaborative white paper as the final result.

Due to the growth and influence of Electronic Health Records and electronic prescribing technologies, the point of impact of the formulary is moving away from the “Point of Sale” in the pharmacy to the “Point of Prescribing” (typically in the physician’s office). The purpose of this white paper is to illumine the related challenges and opportunities to current business processes, especially those potentially impacting the proprietary agreements between manufacturers and formulary managers/processors/payers for pricing discounts or rebates requiring specific management of product-formulary depictions and coverage.

The main concepts requiring discussion in this paper can be separated into three key areas:

1. Standard solution concepts that support current standards and business needs:
   a. NCPDP through its collaborative process with stakeholders across the industry has already developed a body of work, guidelines and standards that describe how information can be efficiently exchanged between parties involving the formulary, the member’s benefit, and rebate agreements. These standards have been adopted and implemented in proprietary systems used by stakeholders. Current standards are described in greater detail in section “Electronic Prescribing Standards”, including the NCPDP SCRIPT Standard, the NCPDP Formulary and Benefit Standard, the NCPDP Manufacturer Rebate Standard and other standards supported in the industry, including ASC X12N 270/271, and HL7 Clinical Document Architecture.

2. Data solution concepts that involve the actual data used to support established and evolving business processes:
   a. The contract language between manufacturers and payers is generally loose and proprietary, which creates variability in some components of data exchanged in support of the invoicing and payment processes.
   b. Contracts between parties often establish rebate/discount eligibility based upon how therapy options are depicted in a formulary drug class, offering differential discounts based on whether rules have been properly applied in the formulary. (For example, a higher rebate is applied if the product is one of two in a preferred category, versus one of three.) They may also employ language that spells out requirements regarding how the product should be displayed to the prescriber.
   c. Each of the concepts described in this document involve the management of dynamic data which must be used to illustrate, for any point in time, an accurate depiction of how a product or many products are depicted in any version of a Formulary, and how the patient’s benefit and coverage rules (including out-of-pocket, copay or co-insurance amounts) are impacted by the formulary.
d. Formulary information is made available to EHR/electronic prescribing vendors with various levels of data elements supplied by processors/payers and plans, and at variable intervals.

e. Formulary information is provided at the point-of-care by third parties.

3. **Display solution concepts that involve how the data is depicted to the end user/prescriber, providing input to their next actions:**

   o EHR/electronic prescribing vendors. Payers have some influence over EHR/electronic prescribing vendors through network switch certification processes, confidentiality and data use agreements. Over the past decade, a number of stakeholders have worked to foster minimum levels of drug, formulary and benefit presentation expectations and work flow requirements. Thus, some collaborative thought has already been applied to the presentation of electronic prescribing related data to the prescriber. However, some EHR/electronic prescribing vendors try to meet the literal minimum standard versus meeting the intent of the certification requirements. Every EHR/electronic prescribing vendor has implemented the certification requirements differently. To be efficient, many have chosen to provide symbols or icons to indicate the formulary status of the medications being considered. This symbolization of F&B elements, in conjunction with a ‘click’ to access additional details like coverage information may not fully represent the contracted status of medications and impacts the clarity of prescribing options.
2. OVERVIEW

Critical information relating to formulary status is necessary to process contractually-driven manufacturer rebates paid to payers. Often, however, additional types of information related to the formulary are necessary for manufacturers to confirm and pay these rebates rather than just merely knowing a product is “On Formulary,” “Preferred” or “Preferred Level 1, 2, 3…”

For example, an agreement between a manufacturer and trading partner may require that there is at least a certain dollar differential to the patient between 2nd tier and 3rd tier formulary positions in order for a prescription claim dispensed to be eligible for a rebate. While this type of information is often categorized as “formulary” data, it may also be appropriately categorized as benefit design data, formulary management data, or plan controls data. While this type of information is generally recognized by manufacturers as critical to validate eligibility of rebate data, the current NCPDP manufacturer rebate standards provide only basic formulary information, and more importantly, are not generally utilized by trading partners.

Furthermore, due to the growing adoption of electronic prescribing, where the prescriber selects the preferred product for a specific patient, additional challenges have been identified by Work Group 7 Manufacturer and Associated Trading Partner Transaction Standards for patients regarding how physicians visualize the formulary status of branded products as conveyed by their electronic prescribing/EHR (electronic health record) software.

The business challenges of product visibility, access and contract compliance may be considered as separate concerns. However, each are directly related to the other formulary data challenges described above.

2.1 INTRODUCTION AND HISTORY

Today’s managed care pharmacy landscape is a complex array of virtually every health care stakeholder, including the state and federal government, employers, health plans, processors/payers, manufacturers, prescribers, and patients. Through the use of sophisticated technology and supported by NCPDP standards, the key business processes to select, adjudicate, and dispense prescriptions are well established (having been developed over the past thirty years) thereby driving efficiency throughout the entire value chain. With the emergence of electronic prescribing, some of these processes are changing. These changes add a new medium of communication between traditional stakeholders.

Proponents from the pharmacy, medical, and technology sectors have been promoting electronic prescribing since the 1980’s. The Medicare Modernization Act (MMA) of 2003 may have launched the most notable catalyst when it created a federal expectation for its widespread adoption by introducing financial incentives to the physician office for the adoption of electronic prescribing and encouraged the adoption of uniform standards by a 2009 deadline.¹

The MMA goal was to accelerate adoption of these technologies so that virtually all new prescriptions created and filled by 2013 would be done through electronic prescribing. In fact, while the uptake has been slower than hoped for by national leaders, significant progress has been made. For example, by the end of 2012, an estimated 44% of prescriptions dispensed were routed electronically in the United States.² This compares to a value of approximately 6.6% of the 1.57 billion eligible prescriptions in 2008.³,⁴ This is almost a 7 fold increase in just 4 years.

³ Shores, Todd et al. The evolving e-prescribing landscape: Challenges, incentives, and the opportunities for industry stakeholders. 2010 Deloitte Development LLC.
Other significant Federal and State regulatory factors are actively encouraging the uptake of electronic prescribing and technology in health care. For example, “Two key government programs — the Medicare Improvements for Patients and Providers Act (MIPPA) and Health Information Technology for Economic and Clinical Health (HITECH) — currently allow healthcare professionals to receive incentives through the adoption and use of e-prescribing technology.” The Accountable Care Act extends these incentives broadly to “meaningful uses” of technology in health care.

- The carrot: MIPPA went into effect January 1, 2009 and offered physicians financial incentives (with additional reimbursements of up to 2% for Medicare payments through 2013) to implement electronic prescribing practices over the course of 2009 and 2010.
- The stick: Those prescribers who do not send a minimum of 10 electronic prescriptions by June 1, 2011 will suffer a penalty on their Medicare reimbursements starting at one percent. Further, the Medicare Fee Schedule for 2011, published in November of 2010, illustrates how the failure to use electronic prescribing in 2011 will be used to determine payment reductions in all physician Medicare claims paid out in 2012 and 2013.

It is fair to expect that the use of this technology will likely be associated with ninety-plus percent of all new Medicare-related prescriptions in the next several years and given the magnitude of change, electronic prescribing will become a “new norm”, potentially resulting in the establishment of new contractual terms between stakeholders along with new types of data exchanged to ensure contractual compliance.

To best understand the current situation regarding the challenges that electronic prescribing brings to the prescription product selection, adjudication, and dispensing processes, it is important to first understand some key managed care pharmacy concepts. Specifically, in this white paper, common definitions of formulary, formulary management, and benefit design will be established, and then a framework of how they work together within today’s technology environment to potentially influence the ultimate dispensing of a prescription will be discussed. With an understanding of how these managed care tools work together to potentially influence drug utilization in today’s environment, we will examine the emerging role of electronic prescribing and how electronic prescribing, along with its supporting technologies, can potentially alter existing points of influence.

### 2.2 How the Formulary Works with a Benefit Design - Definitions

**Definitions**

Key terms used to establish the common framework for the topic just described.

- **Formulary**: A continually updated list of medications which represent the current clinical judgment of physicians and other experts in the diagnosis and treatment of disease and preservation of health (www.amcp.org)
- **Formulary Management**: An integrated patient care process which enables physicians, pharmacists and other healthcare professionals to work together to promote clinically sound, cost-effective pharmaceutical care (www.amcp.org).
- **Benefit Design**: A process of determining what level of coverage or type of service should be included within a health plan or specific product, at specified rates of reimbursement, based on a multiple of relatively un-standardized and often unique factors, such as market pressure, cost, clinical effectiveness and medical evidence, legislated mandate, medical necessity, and preventive value (www.amcp.org).

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ePrescribing Technologies and Formulary Compliance Challenges and Opportunities

- **ePrescribing**: is defined by CMS as “a prescriber's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care.” Per NCPDP, it is the computer-to-computer transfer of prescription data between pharmacies, prescribers, and payers. It is not the use of an email or a facsimile transaction.

- **Qualified Systems**: According to the CMS website, eligible electronic prescribing systems will afford the following capabilities for the prescriber:
  1. Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts.
  2. Providing information related to lower cost, therapeutically appropriate alternatives (if any). (The availability of an electronic prescribing system to receive tiered formulary information, if available, would meet this requirement for 2011.)
  3. Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

- **EHR/electronic prescribing Vendor**: an entity that provides software and perhaps hardware to pharmacies or prescribers that enables electronic processing of business functions such as electronic prescribing, electronic medical records, appointments and scheduling, and billing functions. (www.ncpdp.org)

- **Intermediary/Switch**: an entity that accepts an electronic transaction from another organization and electronically routes the transaction to a receiving entity. An Intermediary/Switch (or Value Added Network) may provide other services such as translation of one message format to another, or conversion of one message version to another. (www.ncpdp.org)

Electronic prescribing offers significant positive benefit to various stakeholders. The value is focused in at least three areas: (1) patient safety, (2) increased physician office and dispensing pharmacy efficiency resulting in enhanced patient convenience and (3) reduced cost due to product selection of lower-cost alternatives at the point of prescribing.

### 2.3 **How Electronic Prescribing is Initiated**

The ability to generate an electronic prescription is made available to the physician/prescriber in different ways. Most commonly, the software application driving the process resides within the physician’s practice management system, as part of the patient’s Electronic Health Record (EHR) which may be associated with an internally produced or commercial application coming from a vendor. Freestanding or standalone electronic prescribing software may perform some of the additional components, in addition to electronic prescription routing and product selection.

In 2012, for example, 87% of electronic prescribing prescribers used a system associated with the EHR system rather than a standalone electronic prescribing software application. There are roughly 200 vendors supplying electronic prescribing services, although not all of them uniformly provide all components of electronic prescribing, which include:

1. The ability to check for the patient’s eligibility and benefit for a product allows prescribers to choose medications that are on formulary and are covered by a patient’s drug benefit. This may also include co-pay and coverage restrictions like prior authorization or quantity limits.

---

6 CMS E-Prescribing Overview. Taken from the URL: [https://www.cms.gov/eprescribing](https://www.cms.gov/eprescribing) on 10/15/2011 at 8:47:48 AM.


8 E Prescribing Incentive Program, How to Get Started. Taken from the URL: [https://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp](https://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp) on October 16, 2011.


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2) The ability to check (with a patient’s consent) the medication history allowing a more complete record via an electronic request of historical information from payers and community pharmacies and
3) Electronic prescription routing to the pharmacy of the patient’s choice.

2.4 WHO ARE THE PARTICIPANTS/STAKEHOLDERS IN ELECTRONIC PRESCRIBING?

There are a variety of participants in the electronic prescribing process who are typically divided into five primary categories: the patient, prescribers, network intermediaries, dispensing pharmacies, and the paying health plan. A core reason for the development of this white paper is to add the missing sixth party: the pharmaceutical or device manufacturer. They are usually invisible during the prescribing process, but often pay a significant portion of the product cost via contractual terms in downstream processes.

The Electronic Exchanges

In the most basic terms, electronic prescribing works by allowing a physician (or other prescriber) to interact with a technical interface to select a product (after potentially reviewing the patient’s medical and medication history, confirming the patient’s eligibility, formulary, benefit and medical protocol), generate a prescription, send it to an electronic “switch” so that it arrives for fulfillment at a pharmacy of the patient’s choosing. That technical interface can reside on a handheld device, a standalone or web enabled application, or most commonly, a module within the office’s electronic health system.
Apart from the individual patient or physician, there are various systems and vendors with specific roles in the electronic prescribing technical ecosystem. The diagram illustrates the moving parts and some of the operational stakeholders. This diagram (see Figure 2) omits Pharmaceutical and Device manufacturers because they are not directly involved in the electronic prescribing transaction, but are down-stream stakeholders based on contracting with other stakeholders. For the purposes of the diagram, third party entities might be formulary aggregators or suppliers who provide access or files to electronic prescribing/EHR vendors, or drug database compendia that may provide formulary statuses.

Figure 2: Electronic Prescribing Operational System Stakeholders
2.5 **Electronic Prescribing Standards**

Electronic prescribing has already been facilitated by various standards including the following:

1) **NCPDP SCRIPT Standard**: The NCPDP SCRIPT Standard was first published in 1997 and has been updated annually based on the business needs identified by the industry. SCRIPT is a standard created to facilitate the transfer of prescription data between pharmacies, prescribers, intermediaries, and payers. The current standard supports messages regarding new prescriptions, prescription changes, refill requests/responses, prescription fill status notification, prescription cancellation, medication history, and transactions for long term care environments.\(^9\)

2) **NCPDP Formulary and Benefit Standard**: The NCPDP Formulary and Benefit Standard provides prescription benefit information to physicians at the point of care. The purpose is to inform the physician regarding the formulary, coverage and co-pay information during the prescribing process, so that he/she can make the most appropriate drug choice for the patient. Formulary and benefits data can consist of the following types:
   - Formulary Status
   - Alternatives (payer-specified)
   - Copay
   - Coverage Types
     - Text Message
     - Product Exclusion
     - Prior Authorization
     - Step Medications
     - Quantity Limits
     - Age Limits
     - Gender Limits
     - Resource Link (URL link)

3) **NCPDP Specialized Standard**: The Specialized Standard Implementation Guide document was developed for transmitting information electronically between prescribers, providers, and other entities. The standard addresses the electronic transmission of census information about a patient between a facility and a pharmacy, medication therapy management transactions between providers, payers, pharmacies, and other entities. It includes transactions for clinical information exchanges. It will include other transactions for electronic exchanges between these entities in the future.

4) **ASC X12N 270/271**: ASC X12N 270 Health Care Eligibility/Benefit Inquiry and ASC X12N 271 Health Care Eligibility/Benefit Response used for a prescriber system to request eligibility information about a patient, in this case, specifically for pharmacy benefit eligibility information. The response contains the eligibility information as well as pointers used in the NCPDP Formulary and Benefit file exchanges.\(^10\)

5) **Clinical Document Architecture**: The HL7 Clinical Document Architecture is a document markup standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange between healthcare providers and patients.\(^11\) The Continuity of Care Document implementation guide describes constraints on the HL7 Clinical Document Architecture. The ability to include a clinical information attachment has been added in SCRIPT and the Specialized Standard.

6) **Electronic Prior Authorization**: Electronic Prior Authorization transactions for the electronic transfer of prior authorization requirements information between stakeholders based on a given patient and medication were officially approved as part of the NCPDP SCRIPT Standard in July 2013.

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\(^10\) This standard is maintained by the Accredited Standards Organization (ASC) X12. [www.x12.org](http://www.x12.org).

\(^11\) [http://www.hl7.org/implement/standards/cda.cfm](http://www.hl7.org/implement/standards/cda.cfm)
2.6 WHAT ARE THE BASIC MECHANICS FOR ELECTRONIC PRESCRIBING?

The diagram below in Figure 3 (attributable to a 2010 Deloitte Development LLC report entitled, "The evolving e-Rx landscape: Challenges, incentives, and the opportunities for industry stakeholders") was created during the e-Health Initiative to graphically illustrate the medication management process as outlined by Douglas Bell, MD, PhD and can be found in various places in the electronic prescribing literature. The flow depicts a high-level view of the process from prescribing to transmitting an electronic prescription to dispensing to monitoring prescription drug utilization. It illustrates the key actors involved in the process, as well as the influence of information from formularies, drug information from commercially available compendia and patient history (along the top of the graphic). A cursory review illustrates the complexity of the process for product selection, prescribing, transmitting, and dispensing of prescriptions in the electronic prescribing universe. 

There are two entities that are not directly involved in the prescription process but assume the financial risks and exchange of value based on which product was selected and paid. They are the health plan and the pharmaceutical/device manufacturer. The health plan typically assumes the majority of the risk of payment. The pharmaceutical/device manufacturer produces the product and supplies a price concession, if contracted, to the health plan. Typically, the EHR/electronic prescribing vendors are the interface that prescribers use to select and send prescriptions.

![Figure 3: Electronic Prescribing Workflow from Product Selection to Monitoring](image)

2.7 POINTS OF FOCUS FOR UTILIZATION CONTROLS

Various utilization controls that impact product selection or dispensing can be grouped into several segments depending on the point of focus, as outlined in the table Figure 4 below. The effectiveness of these traditional controls may be altered by the uptake of electronic prescribing activities in the marketplace, modifying how stakeholders choose to implement formularies, benefit designs, and formulary management activities.

<table>
<thead>
<tr>
<th>Point of Focus</th>
<th>Typical Controls Imposed by the Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>Plan-Specific Eligibility of Patient on Service Date</td>
</tr>
</tbody>
</table>

13 Shores, Todd et al. *The evolving e-prescribing landscape: Challenges, incentives, and the opportunities for industry stakeholders*. 2010 Deloitte Development LLC.
2.8 EPREScribing UTILIZATION CONTROLS

With electronic prescribing, there are major strategic departures from the traditional business model discussed above. These factors have a direct impact on rebate/incentive agreements which exist in the current value exchange between manufacturers and their payer trading partners.

1. There are two main places where formulary and plan design plays an important role: the prescriber and the pharmacy.
   a. The EHR application or a standalone electronic prescribing application ("electronic prescribing model") uses a standard which does not provide real time information but information in batch form that is then stored in or available to the system. Many EHR/electronic prescribing systems have the ability for the prescriber to see formulary and benefit information at the point of care. However, there are limitations to what is seen by the prescriber. The formulary seen by the prescriber is a representative formulary that may or may not be the formulary of that particular patient and much of the benefit information may not be provided. The formulary seen at the point of care is most likely not patient specific and may still lead to call backs from the pharmacy. In a 2005 ePA study, it showed that ~60% of PA notifications through the electronic prescribing formulary system resulted in false positives.¹

   b. The "traditional model" – the pharmacy. At the point of sale, the pharmacies use real time claim adjudication to see if a particular medication is covered and also to determine the exact cost to the patient based on the contracted plan terms. The goal is to close the information gap between what is available to the EHR/electronic prescribing vendors and to the pharmacy system. This will minimize the administrative burden encouraging shared decision making between the prescriber and patient based on accurate information and providing a ‘clean’ prescription at the pharmacy.

<table>
<thead>
<tr>
<th>Control Type</th>
<th>Electronic Prescribing Model</th>
<th>Implications</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify Eligibility of Patient on/near Service Date</td>
<td>Eligibility is confirmed using electronic prescribing</td>
<td>• Variability of electronic prescribing system used by prescriber.</td>
<td>• Timely quality eligibility information</td>
</tr>
<tr>
<td></td>
<td>Requires that the date of service on/near the patient encounter date</td>
<td>• Inaccurate/incomplete/unavailable patient identification information prevents a positive eligibility response</td>
<td>• Current industry practice supports minimum level of certification for EHR/electronic prescribing vendors capabilities</td>
</tr>
</tbody>
</table>

¹ National Council for Prescription Drug Programs, Inc. (2005)
### Formulary Design
- Representative formulary and benefit (not patient specific)
- A formulary status communicated during product selection process
- Non formulary or not covered products can be displayed with other therapeutic alternatives
- May show additional coverage information like co-pay and coverage restrictions (PA, Step, etc...)

- Products may not be depicted as contractually stated depending upon the data source
- EHR/electronic prescribing vendors use a mix of push and pull technologies to update formularies which may cause an inconsistency in timing and implementation
  - Push: Formularies are updated frequently from a central point and made available at the point of care
  - Pull: The ‘Client-Server’ platform requires the physician’s office to remember to periodically retrieve the new formulary and drug database update
- The number of formulary files and the file sizes may be a factor for implementation timing.

### Step Therapy
- Communicated during product selection process such that non-preferred product is not considered by prescriber
- May or may not be reliable due to lack of patient specificity
- Variability of electronic prescribing systems used by prescriber
- Formulary updates should be current

- Information exchange and use must be automated and timely
- Minimum level of certification for EHR/electronic prescribing vendors
- Trading partners agreements should incorporate clear implementation expectations regarding formulary data sources, frequency, and format
- Electronic prescribing systems will need to be sufficiently granular in terms of formulary visibility in order to process

### Claim Adjudication Online Messaging
- Should not be relevant, adjudication should be seamless because prescriber has already jumped edit hurdles, in theory
- F&B supports the ability for the payer to include text messages or resource links for URLs
- Variability of electronic prescribing systems used by prescriber
- Patient specific formulary data not available
- Formulary updates might not be current

- Trading partners agreements should incorporate clear implementation expectations regarding formulary data sources, frequency, and format
- Electronic prescribing systems will need to be able to support the real time benefit check.

### Formulary Design (Open/Closed/Tiered)
- Represented by both formulary status and co-pay
- Variability of electronic prescribing systems used by prescriber
- Patient specific formulary designs not available
- Formulary updates might not be current

- Information exchange and use must be automated and timely
- Trading partners agreements should incorporate clear implementation expectations regarding formulary data sources, frequency, and format
- Electronic prescribing systems will need to be able to support the real time benefit check.
2. Given the shift described above during the product selection process with the prescriber, he or she will consider new information (e.g., formulary options) when using electronic prescribing along with new information that can be pushed by the EHR/electronic prescribing vendor to view during the prescription selection process (e.g., patient history, clinical protocols, etc.). See possible implications in Figure 6 below.

<table>
<thead>
<tr>
<th>Information Type</th>
<th>Potential Issue</th>
<th>Implications</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formulary Design</td>
<td>Not displayed as contracted for by manufacturer with Payer due to file freshness or an external source</td>
<td>Provider does not see an accurate formulary - Lower utilization than expected for “preferred” products or higher than expected utilization for “non-preferred” products</td>
<td>Information exchange and use must be automated and timely</td>
</tr>
<tr>
<td></td>
<td>Physicians may believe the information presented is specific to patient’s formulary</td>
<td></td>
<td>Minimum level of certification for EHR/electronic prescribing vendors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Trading partners agreements should incorporate clear implementation expectations regarding formulary data sources, frequency, and format</td>
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<td></td>
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<td></td>
<td>Electronic prescribing systems will need to be able to support the real time benefit check</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication History</td>
<td>Member history (Fill data/Rx claims/medical) information is not available in all electronic prescribing systems</td>
<td>Variable benefit, depending on electronic prescribing vendor. History may be integrated or stand-alone</td>
<td>Minimum level of standardization for EHR/electronic prescribing vendors capabilities</td>
</tr>
<tr>
<td></td>
<td>Not all fills have claims so medication history record is incomplete</td>
<td></td>
<td>Information exchange and use must be automated and timely</td>
</tr>
<tr>
<td></td>
<td>Member history may not migrate if member changes plan</td>
<td></td>
<td>EHR/electronic prescribing vendors must retrieve fill history from both pharmacies and payers</td>
</tr>
<tr>
<td>Inconsistent</td>
<td>Confusion on the part of</td>
<td>Requires awareness of</td>
<td>Standardize offering of</td>
</tr>
</tbody>
</table>

Figure 5: Controls under the Traditional Model vs. Electronic Prescribing Face Variable Challenges
### Protocols Compared with Other Published Materials

<table>
<thead>
<tr>
<th>Protocols Compared with Other Published Materials</th>
<th>the prescriber when the formulary information does not correspond to other published medication information.</th>
<th>Protocols Used for Product, Schedule, Frequency and Dose Selection</th>
<th>EHR/electronic prescribing vendors with commercially available compendia and/or plan coverage policy documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Information</td>
<td>Benefit information may be depicted at a higher level, rather than at a group/patient-specific level (i.e., contraceptives not covered, prior authorization or maximum quantity thresholds)</td>
<td>Requires awareness of benefit specifics (thresholds, exclusions, limitations) during prescribing process</td>
<td>Work with formulary sources to improve depth of data at the point of care. Information exchange and use must be automated and timely</td>
</tr>
<tr>
<td>Eligibility Information</td>
<td>Patient eligibility match cannot be established (keying error, patient not in master patient index, etc.)</td>
<td>Mechanism to obtain formulary and benefit information at the levels provided by the source. Confirm pharmacy benefit coverage for the patient (e.g., retail/specialty/long term care, mail, etc.)</td>
<td>Information exchange and use must be automated and timely. Eligibility for all patients available as appropriate. Industry follow established rules for eligibility search criteria</td>
</tr>
</tbody>
</table>

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**2.9 How is a Product Depicted Within the Electronic Prescribing Environment?**

What does the prescriber see within the electronic prescribing module when he or she needs to make a specific treatment decision for a specific patient? EHR/electronic prescribing vendors utilize various, proprietary ways to guide the prescriber to the product selection screen; it may not matter to the prescriber or to the EHR/electronic prescribing vendors as long as the desired product is found and ordered and the prescriber is satisfied.

There are over 500\(^{14}\) EHR/electronic prescribing vendors and each one may depict the same payer’s formulary status relating to a product in various ways. The EHR/electronic prescribing vendors use terminology that may be unique to their system and utilize different graphical elements (like red, yellow or green highlights, dollar signs or stars, or 1\(^{st}\), 2\(^{nd}\), 3\(^{rd}\)) to guide decisions and to illustrate formulary status and coverage information, such as “Step Therapy” or “Prior Authorization” requirements. Product options could be arranged in generic or brand name order, by therapeutic class, or by a cost metric. Depending on the patient’s benefit, the formulary status could be interpreted and displayed incorrectly.

Manufacturer and Payer stakeholders have reason to be concerned about the variation in display of formulary and benefit drug status. Certification requirements support a minimum display of core information, but user interface is at the discretion of the EHR/electronic prescribing vendor, which may require a ‘click’ to access additional information. As a result, this may not in practice fully represent the contracted status of medications and therefore may not clarify prescribing options sufficiently.

\(^{14}\) CCHIT ONC Certified EHR Technology [http://www.cchit.org/find-onc](http://www.cchit.org/find-onc)

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3. DISCUSSION

3.1 CHALLENGES

3.1.1 COMPLEXITIES OF FORMULARY & BENEFIT

The manner in which the formulary is displaying a contracted drug under a prescribing scenario may be outside of the control of both of the trading partners and primarily in the hands of the EHR/electronic prescribing vendor. The intended terms of the rebate or incentive contract may not be known by the EHR/electronic prescribing vendors. EHR/electronic prescribing vendors are not aware of these contracts and compliance checks do not take into account business relationships between manufacturers and the processor/payer. This is described graphically in a modification of the earlier workflow below in Figure 7 below.

![Figure 7: EHR/Electronic Prescribing Vendors Are Once-Removed from Trading Partner Relationship](image)

There are many touch points before NCPDP’s Formulary and Benefit Standard (F&B) data reaches the prescriber. The F&B Standard is not intended to instruct an EHR/electronic prescribing vendor how to display formulary, copay or coverage information. The ‘art’ and usability of each system’s user interface is the responsibility of each EHR/electronic prescribing vendor. Large networks may have minimum certification requirements that also include user interface requirements so EHR/electronic prescribing vendors have to meet a minimum threshold. The EHR/electronic prescribing vendor user interfaces vary based on their user feedback and historical evolution. Adding F&B to their existing user interfaces is a challenge due to the interpretation and understanding of the value behind compliance. Some EHR/electronic prescribing vendors literally “meet” the requirements but miss the intent, leading to ineffective presentation of F&B data.

There are a number of stakeholders involved in the sharing, processing and display of formulary and benefit (F&B) information. The main stakeholders are:
Formulary sources include:
- Formulary source
- Intermediary/switch
- EHR/electronic prescribing vendors
- Prescriber (end user)
- Patient
- Manufacturer

Formulary sources may be a health plan, a Pharmacy Benefit Manager, or a third party supplier. They provide F&B information to either an intermediary/switch or directly to EHR/electronic prescribing vendors. Formulary sources are responsible for thousands of different benefit programs with some very complex designs. Sometimes only a subset of the coverage types is submitted to the intermediary/switch, leading to inconsistent information being presented to the prescriber. Today this data is provided in a batch file versus in a real-time transaction, often using NCPDP’s Formulary & Benefit Standard though not exclusively. The data is sent on a regular basis depending on payer processing. The files may be refreshed as often as daily but more likely on a weekly or monthly schedule. The F&B data represents a payer’s membership though the representation can vary from payer to payer. One payer may publish representative F&B data at a client level where another payer could publish F&B data at a group level, which is the lowest common denominator and the most accurate before being patient specific. Third party sources may or may not obtain data directly from health plans, are often used in absence of an eligibility response and may not reflect how the data is displayed by EHR/electronic prescribing vendors.

Intermediaries/switches receive F&B data from the formulary sources and enable the exchange of data between the formulary source and the EHR/electronic prescribing vendors. There are still a number of public and private health plans that are not participating in this exchange. Intermediaries/switches provide certification of the formulary source and EHR/electronic prescribing vendors as part of their services. The robustness of certification by the Intermediaries will influence how the EHR/electronic prescribing vendors display F&B data.

EHR/electronic prescribing vendors retrieve the data from the intermediaries/switches and are responsible for displaying the data according to their certified user interface conventions. EHR/electronic prescribing vendors are challenged by frequent updates by a myriad of payers, large batch file sizes and the ability to update individual practices/sites. Depending on the EHR/electronic prescribing vendor’s functionality, timeliness of F&B data updates can be an issue. Many EHR/electronic prescribing vendors require the individual practice site to update the F&B data files, while some automatically push the updated F&B data to practice site. EHR/electronic prescribing vendors may “roll-up” drug information in F&B files in different ways to reduce file sizes which may cause confusion on specific products. Another challenge includes the match rate of the patient eligibility to tie F&B data for presentation.

Prescribers are the main users of F&B data to make informed decisions based on the patient’s condition and their insurance benefit. Prescribers may need to interpret the F&B data provided to them despite the inconsistencies of quality and completeness. Prescriber decision-making may be limited if payers do not send all of the available F&B data such as tier status, copay, alternatives, and restrictions. EHR/electronic prescribing vendors need to present F&B options clearly (e.g., the prescriber will want to be aware of a plan’s prior authorization requirement before prescribing a specific drug for the patient). Prescribers may assume patient-level F&B data since they are electronically connected to payers, however patient specific data is not normally provided today.

Patients obtain the medication prescribed. Since there is not a direct connection between the pharmacy system when it submits a claim and the EHR/electronic prescribing vendor, discrepancies can occur between the product prescribed and the patient’s benefit plan coverage. This can create an administrative burden for the pharmacy, prescriber, patient and payer to reconcile. It may also lead to compliance issues due to medication delay or abandonment if the patient is not able to obtain the medication in a timely manner. The patient may be ultimately impacted by inconsistency of information that may occur at the points of care.
The rebate and incentive agreements between the payer and the manufacturer represent an important means to manage drug spend and drive mutual value. They have evolved since the late 1980’s based on the expectation that the payer is either protecting a product from disadvantage (e.g., third tier or non-formulary status) or affording an advantage to the product on the drug formulary (e.g., second tier placement without a prior authorization requirement). Manufacturers are not directly involved in the electronic prescribing process. They are disconnected from the actual F&B data presented to the prescriber via their EHR/electronic prescribing vendors. If the F&B data or its display does not support the agreed contractual terms for formulary status, then neither payers nor manufacturers may be receiving the anticipated contracted value. As a display example, if the contracted product is a brand on third tier copay, the prescriber may not be able to easily navigate to a window that permits visualizing it as a therapeutic option, even when it might be most clinically appropriate. Thus, the product is not even visible for consideration. This may be perceived as a ‘non-compliant’ formulary position from the manufacturer’s viewpoint. The EHR/electronic prescribing vendor and the prescriber are each once-removed from the financial repercussions of the product selection decision. While all of these contractual nuances may not reasonably be represented to prescribers using today’s EHR/electronic prescribing vendors, the intent is to communicate the formulary and benefit information to encourage optimal therapy and formulary compliance decisions.

### 3.1.2 Lack of Consistent Terminology

Part of the challenge for the stakeholders within the industry (especially EHR/electronic prescribing vendors), is that the terms typically used to describe the status of a product on a given formulary may be confusing, can be used interchangeably and/or are not standardized. For example, what one payer describes as a “Preferred” placement on formulary may be deemed “Equal Access” by another payer. While this type of information is often categorized as “formulary” data, it may also be appropriately perceived as benefit design data or as formulary management data. No matter how they’re categorized, however, the expectations of a manufacturer is that they all work together, consistent with pharmaceutical manufacturer contracts, to impact the sales volume (or from the payer’s perspective, the “drug spend”) of individual products to a greater or lesser degree through utilization controls imposed on the patient by the health plan. Increasingly the contract impact is executed at the point of prescribing, through formulary and benefit rather than in the pharmacy.

![Figure 9: the Formulary, Benefit Design, & Art of Formulary Management Work Together to Control Utilization](image)

### 3.1.3 Prescriber System Challenges

**Formulary vs. Preferred Drug Lists.** A specific employer group within a plan may share the same formulary as the entire plan; however, that employer group may have a “customized preferred list” stored in the claims adjudication system that the benefit design uses. Many payers will argue this is a benefit design and not a formulary issue. The two sides may not agree in this regard, and it could become confusing to the prescriber, depending on the electronic prescribing presentation of this nuance. For example, in a drug category of three preferred products, only one is on the customized preferred list yet the prescriber would prefer to use one of the two not listed. In this scenario the prescriber may be confused about what is available to the member.
3.1.4 Point of Sale Challenges

After the prescription has been transmitted to the pharmacy for dispensing, the pharmacy and the payer perform customary claims adjudication functions. There are still a number of concerns regarding the manufacturer and payer’s contract compliance. A few of these key challenges are listed below.

1. **Point of Sale Formulary Lists.** Some formulary managers/processors/payers only use a “negative” formulary list (depicting only products not covered) in claims adjudication. The effective use of electronic prescribing requires the payer to create and maintain a “positive” formulary list to use in all other tools and applications. These differences in formulary design (provided to prescribers) and benefit (used at pharmacy for adjudication) levels, could create a mismatch in what is occurring at the Point of Sale and what is being shared with prescribers, patients, and websites.

2. **Benefit vs. Formulary.** There is a continued need for differentiation between what benefit design is and what formulary is. There is a very distinct thought process between what a benefit design allows and what is deemed formulary. For example, one plan manages hundreds or thousands of benefit designs and all benefit designs use the same formulary. This is not uncommon because of the amount of work and expense involved in maintaining a formulary. However, some employer groups will not pay a benefit on specific drugs or therapeutic classes (e.g., oral contraceptives or fertility agents). A formulary will list a therapeutic class for oral contraceptives and will have various copay tiers applied to the formulary. However, the employer group does not cover oral contraceptives. Just because the drug is listed on the plan level formulary, does not mean that it is allowed for coverage. F&B addresses this specific situation with the drug exclusion list though it may not be widely used. The drug exclusion file overrides the formulary and copay file indicating that the drug is not covered. The patient may know if there is non-coverage of certain drugs/classes; however, it will only really become apparent at the point of sale, or if the plan has a sophisticated website that can apply a member specific benefit design upon doing a drug search. How will this nuance be depicted at the point-of-care, when the prescriber chooses a product? Will this later be submitted to a manufacturer for a rebate, if it is non-compliant?

3.1.5 Trading Partner Challenges

1. **Information Management.** The barriers for a payer to provide all of the information (formularies, benefit parameters and preferred drug lists for a specific customer) to pharmaceutical manufacturers are high. There are a number of practical challenges in even providing this information between trading partners: benefit designs are confidential and proprietary as written in the insurance riders, there may be thousands of designs offered by a payer, the data does not reside in one single and simple location, and advanced knowledge on the structure of the benefit designs is required to interpret the data.

2. **Post Adjudication Information Management for Rebate Purposes.** After the claim has been processed, payers/pharmacy benefit managers store, display and handle the benefit information differently. The payer/pharmacy benefit manager may not have the capability to provide to the manufacturer what the specific benefit is on the claim; only a benefit code may appear, and only what the patient paid and plan paid will appear on a claim, not the differential between the tiers. This becomes a challenge later when rebate contract compliance is considered and the manufacturer seeks to confirm, for example, a contractual provision that states that the differential copay between tiers cannot be less than a specific amount, say $20.

3.2 Issues and Proposed Solutions

As electronic prescribing has evolved and become widely adopted, a number of issues have become apparent. Routine stakeholder processes that were sufficient ten years ago are showing their limitations and impeding prescriber reliance (and thus trading partner confidence) by not consistently meeting accuracy expectations for F&B related information across all EHR/electronic prescribing systems industry.
wide. While there is no easy solution to the business problems presented by electronic prescribing to the trading partners, the NCPDP Work Group 7 Manufacturer and Associated Trading Partner Transaction Standards Formulary/e-Prescribing & Tracking Task Group believes that some practical steps can be taken to help address them.

If solutions to the practical challenges described in this paper are not identified and implemented, there is some risk that certain stakeholders will identify and adopt practices that may not advance the electronic prescribing benefits anticipated for the patient, the provider, the payer or the pharmaceutical manufacturer. The chart below lists a number of recognized problems cited, proposed solutions and the area(s) that represent the root cause(s) for them. Understanding the root cause of the challenge may enable parties to better resolve them.

The root cause category in the table columns are characterized as follows:
- **Technology Challenge (T)** – relating to the creation, storage and exchange of data
- **Process Challenge (P)** – relating to how people work or information flows or how data/information is extracted/shared/exchanged/presented to end-users.
- **Relationship Challenge (R)** – relates to an underlying business or legal constraint between the parties. (e.g., two parties without a formal business relationship must rely upon the accuracy of the other’s work)

<table>
<thead>
<tr>
<th>Business Issue (s)</th>
<th>Sample Solutions</th>
<th>Root Cause Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rebate contract language is not followed at the point of care</td>
<td>• Contract language</td>
<td>P, R</td>
</tr>
<tr>
<td>2. Inconsistent usage of F&amp;B data elements within a payer, across payers and level of representation displayed at the point of care</td>
<td>• Certification Process • Best Practices</td>
<td>P, R</td>
</tr>
<tr>
<td>3. Data Inaccuracies: a. Third party (non-payer) formulary providers are once removed from the data sources and may use proprietary data formats. b. F&amp;B accuracy and timeliness may be issues. c. Patient-to-formulary matching may not be concise or is supplied at a representative level</td>
<td>• Disclose the data source • Certification Requirements • Best Practices</td>
<td>All</td>
</tr>
<tr>
<td>4. F&amp;B batch data size and impact of representative NDCs at the point of care</td>
<td>• Cross-reference across Drug DBs • Use of RxNorm • Any drug roll-up must show the most preferred status and all potentially relevant coverage messages. Over the counter products (OTCs) and medical supplies should have the appropriate identifier. • Real time F&amp;B information</td>
<td>All</td>
</tr>
<tr>
<td>5. Lack of timely F&amp;B updates</td>
<td>• Certification Process • Eliminate manual updates</td>
<td>T, P</td>
</tr>
<tr>
<td>6. Incomplete/unclear F&amp;B display on point of care screen</td>
<td>• Certification process should include the rules, logic, display rules and guidelines the certified EHR/electronic prescribing vendor must follow in order to integrate F&amp;B into their system.</td>
<td>T, R</td>
</tr>
</tbody>
</table>
### 7. Lack of understanding of the stakeholders involved and process for issue escalation protocol at the point of care

- Escalation Process

| All |

### 8. Ambiguity of stakeholders involved in contract for audit inquiries between Trading Partners

- The certification process should review and document all parties and processes involved in the process of getting the F&B data to the prescriber’s system. This will enable direct and indirectly impacted parties to understand where gaps are in how the drug information is displayed, and at what point in the process the problems might be occurring.
- The certification process, the data elements, and the procedures to update the formulary status and refresh the data are available between trading partners.

| P, R |

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**Rebate Reference Guide.** It is impractical and outside of the scope of this white paper to describe in detail the many technical, contractual, and process related challenges that further define the eight business issues in the table above. These electronic prescribing related concerns are already impacting contracted trading partners. For that reason, attention may be given to them in either future white papers or utilizing the Rebate Reference Guide available at [www.ncpdp.org](http://www.ncpdp.org). The Reference Guide provides guidance on a variety of manufacturer rebate scenarios and issues found in the pharmaceutical industry and features proposed business or technical solutions recommended by members of the NCPDP member community.

**Improved Certification of EHR/electronic prescribing vendors.** For the most effective use of the F&B data itself, special consideration should be given to the following elements:

1. More robust and comprehensive certification procedures for EHR/electronic prescribing vendors should be adopted by the industry
   - Identification of user interface minimum requirements
   - Formulary update frequency that uses an automated “push” model
2. Implementation of a transparent post-certification compliance process.
3. Implementation of a mechanism determined by all stakeholders (EHR/electronic prescribing vendors, payer/data source) to research, identify, and rectify concerns raised by trading partners with respect to the display of the F&B information at the point of care.

By focusing on implementing these recommendations and leveraging the current standard, F&B data certification will honor EHR/electronic prescribing vendors systems’ proprietary user interfaces. Each EHR/electronic prescribing vendors system has differentiating features and benefits that need to adhere and support effective and accurate display at the point of care with that said this paper does not have the intention of dictating design or workflow that could be seen as taking away any EHR/electronic prescribing vendor’s competitive advantage or ability to innovate in the marketplace. EHR/electronic prescribing vendors are recommended to display (or make available) the source of the formulary and benefit information. A specialized white paper (written with EHR/electronic prescribing vendor involvement and facilitated by NCPDP) should focus exclusively on best practices/key elements around the user display of F&B information.

Stakeholder confidence in the provision of accurate and timely F&B data - displayed effectively at the point of care by EHR/electronic prescribing vendors - is particularly important to the manufacturer and trading partner contracting process.
Timely and accurate F&B information should be complete. Manufacturers, plans, physicians and patients would benefit from fuller use of the F&B standard preferably at the patient level or minimally at the group level for EHR/electronic prescribing vendors. F&B information may include: drug formulary status, copay, copay tier, alternative drugs and coverage information including any restrictions. Patients and prescribers may understand tier status along with a dollar co-pay amount versus a smiley icon or “on-off” formulary since it directly relates the amount that the patient can expect to pay at the pharmacy. Obtaining more accurate and complete benefit level information from the processor/payer will allow improved shared decision making between the patient and physician and better compliance for the health plan.

Figure 8: Visualization Option Example Depicting Formulary Information in electronic prescribing

Figure 8 represents a typical portion of a vendor’s electronic prescribing screen for illustrative purposes only of a specific formulary for a sample member. This is an example of a display post intermediary industry certification. The prescriber may select a therapeutic class or by a specific drug name to treat a condition. The drugs appropriate for treatment (in this case specifically SSRIs), are listed. Vendors typically sort drugs by formulary status then alphabetical order. Formulary status and copay are required by payers to be presented fully without user action. Copay tiers are often represented as the drug copay compared to the maximum number of copay tiers in a health plan design. For example, Celexa has a tier two cost for the patient out of three potential cost tiers. Type indicates if the product is a drug and if it is a branded or generic product. Copays may also be presented as a flat dollar or a percentage copay instead of, or in addition to, tiers. Vendors have greater latitude with coverage elements since they can be lengthy, especially text messages. In the sample above, drug names are displayed and the prescriber can further drill in to a drug to select the appropriate dosage/form before continuing to prescribe a drug.

High level recommendations have been included in the following section.
4. RECOMMENDATIONS

1. Stakeholders should leverage this framework to define the appropriate data elements for trading partners to exchange F&B data.

2. Work Group 7 Manufacturer and Associated Trading Partner Transaction Standards are incorporating the Formulary and Benefit Standard files into the NCPDP Manufacturer Rebate Standard Implementation Guide.

3. Parties to the contract should develop a process to confirm and resolve formulary and benefit accuracy concerns.

4. EHR/electronic prescribing vendors should work with pharmaceutical companies and payers to resolve concerns related to F&B accuracy.

5. Stakeholders should strongly encourage the industry to fully utilize the F&B standard that more closely reflects the patient's true benefit at the EHR/electronic prescribing vendors.

6. Stakeholders should collaborate on the development of a real time eligibility formulary and benefit check for EHR/electronic prescribing vendors.

7. NCPDP should remain as the convener of the stakeholders, coordinating this work through a combined effort between WG11 and WG7.
5. APPENDIX A: SAMPLE INTERMEDIARY PROCEDURES

Purpose:
To provide the WG7 task group a description of the role an intermediary plays in the: 1) distribution of
formulary and benefits data between a data source and the point of care applications and 2) certification
and compliance on the formulary and benefits data display at the point of care.

Definitions:
Intermediary: A central switch that serves as conduit between data source and point of care
application.
Formulary and Benefits: For the purpose of this document the Formulary and Benefits list types
that are supported by the NCPDP Formulary and Benefit Standard (F&B).
Actors: EHR/electronic prescribing Vendor, Intermediary, Processor/Payer

Description of what an intermediary does related to the publication and display of formulary data
to the point of care:
The intermediary has a certification and compliance process that applies to the end points on the network
(i.e. the EHR/electronic prescribing vendor and processor/payer). The first part of the certification is
focused on the validation of the F&B data file loads that are published to the intermediary by the
processors/payers. The intermediary validates that each list type, (e.g. formulary status (required), and
cost-pay, alternatives, coverage list types (optional)), meets the syntax and mandatory data elements as
defined by the NCPDP standard. The intermediary does not validate the data integrity contained within
the different formulary and benefits list types. The processors/payers, working with their health plan
customers and other parties, are responsible for validating the data integrity and determining the benefits
data that will be published to the intermediary. The intermediary does not get involved with the
processor’s/payer’s use when constructing their benefits structures.

Once the processors/payers have completed certification with the intermediary on the F&B upload, the
intermediary approves the file syntax, and publishes them. Processors/payers have different schedules
for publishing data; it can be weekly, monthly, or quarterly.

EHR/electronic prescribing vendors are certified by the intermediary to validate that they
1. are able to support a weekly download of the F&B data,
2. have implemented a commercially available compendia source,
3. are aware of the best practices for applying monthly updates from the compendia source,
4. display the F&B data per the intermediary’s certification requirements.

The intermediary may require certain display certification requirements. NCPDP recommends that the
EHR/electronic prescribing vendors and Processor/Payers review the intermediary’s published
certification requirements for any application requirements.

The intermediary certification scenarios should validate that once a medication is searched for and/or
selected that all applicable formulary and benefits information is displayed to the prescriber:

- Formulary status – appropriate status must be displayed for each drug name, dosage form,
  and strength
- Payer specified alternatives for non-reimbursable, non-formulary medications - appropriate
  ordering and formulary status, copay, coverage assignment for each drug alternative
- Therapeutic Alternatives - When payer specified alternatives are not available, the
  EHR/electronic prescribing vendor, utilizing a commercially available drug compendia can
  identify alternatives based on therapeutic classification and display all formulary alternatives,
  ordering by highest formulary status, and if available will display coverage and copay
  information
ePrescribing Technologies and Formulary Compliance Challenges and Opportunities

- Coverage - Test that all of the supported coverage factors such as Prior Authorization, Age Limit, Gender Limit, Quantity Limit, Step Therapy, etc. are associated with and displayed when available for a given medication.
- Copay - Test drug specific and summary level copay is displayed when available for a given medication. The intermediary confirms that percentage, dollars, and Tier copay factors as provided by the processors/payers are displayed accurately to the prescriber.

The intermediary manages and executes the certification of the EHR/electronic prescribing vendors. The processors/payers do not interface or participate with the EHR/electronic prescribing vendors as part of the intermediary’s certification. The intermediary owns the certification requirements that EHR/electronic prescribing vendors are held accountable to meet.

The intermediary has a compliance program that monitors EHR/electronic prescribing vendors once they are live in production to validate that they are still in compliance with all of the certification requirements. The intermediary’s compliance program is based on contracts with the EHR/electronic prescribing vendors and the certification requirements. Compliance audits are done on an ad-hoc or scheduled basis. These compliance audits are conducted in production. The compliance check uses the same certification scenarios that were utilized during certification.

The intermediary’s compliance program does not validate the data integrity and the benefits design as determined by the processor/payer, health plan, and manufacturers.