

NCPDP EMERGENCY PREPAREDNESS INFORMATION

VERSION 1.3

This document provides resource information for the pharmacy industry for a declared emergency.

March 2011

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NCPDP EMERGENCY PREPAREDNESS INFORMATION

Version 1.3

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1. INTRODUCTION

This document provides guidance for the pharmacy industry for resources available during a declared emergency. The intended audience is healthcare industry providers who would need resource information for eligibility and claims processing affecting displaced individuals. It will be updated as new information is available.

During the Katrina and Rita hurricanes, the pharmacy industry (as well as other participants) came together to offer products, services, and care to displaced individuals. During the 2006 NCPDP Annual Conference, an Educational Session was held of "A Panel Discussion on Disaster Preparedness: Lessons Learned from Mother Nature". While there were many areas that needed improvement in reacting to a disaster based on this panel's experience, and there are many aspects to a disaster, it was suggested that there were some actions the NCPDP community could provide for future disasters. The NCPDP Emergency Preparedness Committee was formed by the NCPDP Board of Trustees. The Committee began meeting and determining what aspects of preparation for a disaster would be within its purview. This document has been prepared by the Committee to assist in information sharing and processing. NCPDP is a standards development organization, which brings together many participants in the pharmacy services sector, to help find solutions to business problems.

This document outlines processes that must be daily occurrences rather than the "break glass" situations. Processes and procedures that are set up for use as part of daily routines could be invoked at a moment's notice, and some aspects of the emergency would not require new training.

For example, the payers/pharmacy benefit managers would have emergency criteria established within the "usual" plan establishment functions the industry performs routinely each day. The set up of plan parameters and routing information on a pharmacy system is a routine function today. By setting up the plan parameters and routing information for emergency situations now as part of normal procedures, this information would be available for use soon after the disaster was declared. Enrollment files that are updated routinely are therefore accessible at a declared disaster moment. Medication history information is available routinely to providers, so the functions can be used in an emergency as well. This document will provide resource information on some of these aspects.

If you have any questions regarding the availability or content of this document, see www.ncdp.org, or contact the Council office at (480) 477-1000 or via e-mail at ncdp@ncdp.org.

2. WHAT DO I NEED TO DO

During a disaster, it is recognized that many important steps must take place. This section provides a high level list of items covered in this document to assist in industry notification and processing of claims.

2.1 PHARMACIES/AUTHORIZED REPRESENTATIVE OF PHARMACIES

An authorized representative of a pharmacy might be the actual pharmacy owner, a representative of the chain or network headquarters, or a third party agency that has been asked by the pharmacy to contact the industry.

2.1.1 DURING EMERGENCY

See section "[Pharmacy Status Reporting](#)".

2.1.2 ONGOING

1. Verify payer/plan emergency information is loaded into pharmacy software and available for use.
2. If participating in a business relationship where medication history information is contributed regularly, provide current information timely.
3. If participating in a business relationship where medication history information is contributed upon a disaster, verify processes and procedures are in place and executable.

2.2 PAYERS

2.2.1 DURING EMERGENCY

1. See section "[Pharmacy Status Reporting](#)".

2.2.2 ONGOING

1. Verify payer/plan sheets for processing requirements for a disaster are up to date and available to industry participants.
2. If participating in a business relationship where medication history information is contributed regularly, provide current information.
3. If participating in a business relationship where medication history information is contributed upon a disaster, verify processes and procedures are in place and executable.

2.3 SWITCHES/CLEARINGHOUSES

Industry switches/clearinghouses have developed a process for reporting active pharmacies to Rx Response. Via a common spreadsheet format, switches/clearinghouses report pharmacies in a geographic area that have submitted at least one claim, to signify activity. The spreadsheet format contains very basic demographic information which Rx Response provides for patient care.

3. PHARMACY STATUS REPORTING

The purpose of the Pharmacy Status Reporting for a specific disaster is to provide public access to information on pharmacies that are operable in a disaster-impacted area as quickly and efficiently as possible. Consumers of this information include the general public in need of pharmacy care, public health and healthcare providers who are directing evacuees or others impacted by the disaster to locations that can provide pharmacy services and emergency management officials who are monitoring community resiliency as a part of response and recovery efforts.

The NCPDP Emergency Preparedness committee in conjunction with industry representatives has developed a protocol to utilize normal prescription billing processing to report on the status of pharmacies in a declared disaster (Automated Pharmacy Status Reporting).

3.1 CONCEPT OF OPERATIONS – AUTOMATED PHARMACY STATUS REPORTING

1. As part of initial disaster activation, Rx Response will contact the NCPDP Provider Services and the participating pharmacy switching companies of activation via email. Basic information on the nature and scope of the event, as well as the geographic location will be included in this email notification. A presidential disaster declaration is considered the baseline trigger for activation of the pharmacy status reporting, although incidents which do not rise to the level of a federal response may be considered if there is a request for pharmacy status reporting from State or Local Public Health or Emergency Management officials.

2. NCPDP will provide temporary access for Rx Response to their database for baseline data on pharmacies in the impacted area(s).

3. Switching agencies will provide a daily report of pharmacies billing prescriptions in the previous 24 hours in spreadsheet format via email to ALERTS@RXRESPONSE.ORG. For the purposes of information sharing, it is assumed that pharmacies that have billed for prescriptions are open for business. Fields included in the pharmacy status report:

- NCPDP ID
- National Provider ID
- Store Name
- Physical Address
- City
- State
- Zip
- Phone

4. Rx Response will provide mapping and reports free of charge to the public of pharmacies that are presumed open on the Rx Response website www.rxresponse.org. Reporting will be limited to the counties identified in the disaster declaration. Temporary pharmacies that have applied for and received an NCPDP ID number will be automatically included in the pharmacy status reporting.

3.2 REPORTING ADDITIONAL INFORMATION ON PHARMACY STATUS

If you are an authorized representative of a pharmacy and have additional information you would like to report about a pharmacy impacted by a disaster, please contact the Rx Response Operations Center at

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866-247-2694. Please be prepared to provide the pharmacy status report information above, as well as additional information that you wish to provide on pharmacy status, such as temporary location (tied to a pre-existing NCPDP ID) or barriers to continuing service (e.g., deliveries are not able to gain access to the disaster area).

In the future, Rx Response will also have a reporting capability for pharmacies available on the Rx Response website.

3.3 IMPACT OF DISASTER LIST TO NCPDP PHARMACY DATABASE PROCESSES

1. Closed or destroyed pharmacies in the area.
 - a. If your pharmacy has been closed or destroyed due to the natural disaster, you can logon to NCPDPonline.org and request that your pharmacy be deactivated. If you do not have computer access, you can call NCPDP at 480.477.1000. If your pharmacy is scheduled to reopen, your NCPDP number will be reinstated at no charge.
 - b. Deactivation will avoid the potential for fraudulent activity or inaccurate status reporting using that pharmacy's identifier.
2. The temporary location of an existing pharmacy (with an existing NCPDP ID number) where evacuees can call to get existing prescriptions refilled and pick them up.
 - a. The temporary address as well as on the physical address from the NCPDP Pharmacy Database (the "Database"). The Mailing Address of the pharmacy on the Database may or may not change, depending on the wishes of the pharmacy.
 - b. When and if the store moves back to the previous location or any other location, the physical location will be changed in the Database.
3. Information on new locations of new temporary or mobile pharmacies.
 - a. These pharmacies will receive an NCPDP ID number (and NPI) from NCPDP at no charge and be added to the Database as well as the Excel File.
 - a. If these pharmacies are eventually closed, their NCPDP ID (and NPI) must be deactivated on NCPDPonline.org.
 - b. If these pharmacies move, the pharmacy will logon to NCPDPonline.org and update their physical address change. The NCPDP ID and NPI will remain the same.

3.4 SWITCH/CLEARINGHOUSE REPORTING TO RX RESPONSE

What if a pharmacy does not use a switch/clearinghouse for any claims?

If a pharmacy sends 100% of their claims directly to all payers they do business with and therefore does not use a switch, the pharmacy would need to self report as active to Rx Response directly (see "[Reporting Additional Information on Pharmacy Status](#)").

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4. MEDICATION HISTORY INFORMATION

There are key areas that need to be addressed to adequately deliver medication history on a real time, event driven basis to clinicians for evacuees on a nation-wide basis.

4.1 CONNECTIVITY

Connectivity can be established in several ways and will change as ePrescribing and Electronic Health Record (EHR) adoption increases. Eprescribing and EHR technology vendors that have established connectivity with the various medication history databases (PBM claims databases or retail pharmacy databases) will have the ability to transact on a real time basis as part of daily business. Patients who seek care from physicians who have already deployed such technology will have the ability to access medication history in the normal course of work flow.

4.2 PORTAL

Clinicians and pharmacies that have not adopted ePrescribing or EHR technology will need to access medication history via another mode made available in the aftermath of a natural disaster. Following Hurricane Katrina, KatrinaHealth.org was established in coordination between The Markle Foundation and Gold Standard Multimedia, to deliver medication histories from Surescripts and state Medicaid. The AMA coordinated authentication for clinicians. The product, ICERx.org was made available. As of this publication, ICERx.org is no longer available.

Connectivity to the existing medication history databases will need to be coordinated, but past experience shows that this is technologically possible in a short period of time. It is recommended that all medication history sources (PBMs Health Plans, Pharmacy Chains, Independent Pharmacies, and State Medicaids) utilize the most recent NCPDP SCRIPT Standard in order to facilitate medication history data transfer. Clinicians using certified ePrescribing applications should also make sure that they are using application versions which support the latest NCPDP SCRIPT Standard for medication history display.

4.3 AUTHENTICATION

In order to comply with federal, state and local security and privacy laws, authentication of the medication history requester is necessary. For those clinicians using a certified and connected ePrescribing or EHR application, user authentication is the responsibility of the application vendor and is well managed today.

4.4 ADDITIONAL LIVES

At the time following a disaster, some payers and pharmacies that are not currently connected to a network or hub to transfer medication history, may want to contribute medication history because of geographical considerations. It is recommended that these entities have the processes and procedures in place and tested so that upon a declaration of an emergency, they can provide medication history information for the requested areas timely. This would allow for rapid addition of additional lives that can be accessed by clinicians and pharmacies seeing evacuees in need of care.

5. ELIGIBILITY VERIFICATION

Eligibility information must be verified before sending a claim to the Emergency Prescription Assistance Program (EPAP). The NCPDP Telecommunication Standard Eligibility Verification (E1) transaction, web portals connected to centralized locations, telephone systems, help desks, are all in use by the industry.

Eligibility information in this context includes patient information and insurance information, including supplemental insurance information. Payers send eligibility to a central site(s). With the functionality today of transaction routing, there does not need to be one central site. As long as the sites are connected, transactions can be routed between the central sites until the answer is obtained. There are models working today, using the real-time transactions or portals. The provider initiating the request uses the tools of their system or their choice, and the response is obtained via the systems behind the scenes routing requests.

The following steps need to be occur before billing an EPAP transaction

1. Ask the patient for their pharmacy ID cards
2. If the patient does not have any pharmacy ID cards, perform an eligibility request (E1)
3. If the patient does not have private insurance, such as individual health insurance policy or employer-sponsored coverage, public insurance, such as Medicare, Medicaid, or other third party coverage and they are from a "declared" disaster area identified by the EPAP Processor, bill the transaction to the EPAP. Refer to the EPAP processor payer sheet and instructions sent by the EPAP processor.

Real-time updated commercial and Medicare eligibility information is available at www.ernetwork.com. This website offers an easy to use user form to request pharmacy eligibility by entering the patient's name, gender date of birth and zip code. eRx Network has a special web login for any disaster-affected pharmacy to assist them with commercial and Medicare eligibility inquiries. eRxNetwork makes this service available at no charge for any pharmacy servicing patients impacted by disasters.

Phone: 1-866.eRxNetwork (1-866-379-6389)

6. STATE EMERGENCY PROCESSES

As each state may invoke their own programs, it is recommended that the state Medicaid Agency, the state Board of Pharmacy, or the state emergency agencies should be contacted for specifics.

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7. FEDERAL EMERGENCY PRESCRIPTION ASSISTANCE PROGRAM (EPAP)

The EPAP must be activated by the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR) before it can be used. It will not be automatically activated, even when a Presidential Declaration is made. It is event specific. The website is <http://www.phe.gov/Preparedness/planning/epap/Pages/default.aspx>

Upon receipt of an activation notice, the EPAP Processor will inform the providers of the activation. If you have questions regarding EPAP activation information, eligibility, covered drugs and durable medical equipment, claim submission, whether you are an eligible pharmacy provider or if pharmacies would like to inquire how to become a contract provider for EPAP, please contact the **EPAP help line at 1-866-935-4135** for more information.

The EPAP payer sheet below provides the general guidance for entities to use common requirements, to set up the emergency plan in their system ahead of time, and insert the particular emergency parameters when the emergency is activated by the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR). EPAP is used after the pharmacy has determined the patient does not have other 3rd party insurance coverage.

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8. EMERGENCY PAYER SHEET TEMPLATES

The following pages contain two emergency payer sheet templates which can be used by payers as guidance for creating their own payer sheets for eligibility and claims processing.

1. [NCPDP Emergency Preparedness Payer Sheet for Patient's Current Payer](#)
2. [NCPDP Emergency Preparedness Payer Sheet for the Emergency Prescription Assistance Program \(EPAP\)](#)

The emergency payer sheet templates are based on NCPDP *Telecommunication Standard Implementation Guide Version D.0*, since that is the current version in use under HIPAA. For emergency payer sheet templates for NCPDP *Telecommunication Standard Implementation Guide Version 5.1*, see a previous version of this document, since version 5.1 will be sunsetted as of 01/01/2012 for HIPAA transactions.

Important guidance on NCPDP Payer Sheet Templates can be found on the NCPDP web page at http://www.ncdp.org/news_hipaa_trans_current.aspx#PayerST

8.1 NCPDP EMERGENCY PREPAREDNESS PAYER SHEET FOR PATIENT'S CURRENT PAYER

This payer sheet is used in emergency situations when the provider knows the patient's payer for prescription benefits.

The use of the payer sheet is to standardize emergency procedures. The standard procedures are to clarify the use of the patient address, prior authorization numbers and the prescriber id when the pharmacy is the prescriber.

Guidance is given in the Patient Segment for the demographic information from which the patient has been displaced. This may/may not be where the patient is residing during the emergency.

Note the guidance given in the Claim Segment for field Prior Authorization Number Submitted (462-EV).

In the Prescriber Segment, guidance is given for submission of the pharmacy's NPI in emergency situations when the pharmacist may prescribe.

8.2 NCPDP EMERGENCY PREPAREDNESS PAYER SHEET FOR THE EMERGENCY PRESCRIPTION ASSISTANCE PROGRAM (EPAP)

This payer sheet is used in emergency situations when the provider has determined that the patient does not have private insurance, such as an individual health insurance policy or employer-sponsored coverage, public insurance, such as Medicare, Medicaid, or other third party pharmaceutical coverage.

The use of the payer sheet is to standardize an emergency payer process to provide medication and limited durable medical equipment to displaced patients that do not have any financial means of paying for prescriptions.

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The standard procedures are to clarify the use of the BIN Number, patient address, prior authorization numbers and the prescriber id when the pharmacy is the prescriber.

The allowable Dates of Service will be determined on an event-by-event basis.

Guidance is given in the Patient Segment for the demographic information from which the patient has been displaced. This may/may not be where the patient is residing during the emergency. This would **only** be used in the Emergency the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR)/FEMA Payer environment.

Note the guidance given in the Claim Segment for field Prior Authorization Number Submitted (462-EV). A note is suggested on the Days Supply (405-D5), which may be tailored based on the formal establishment of this emergency payer.

In the Prescriber Segment, guidance is given for submission of the pharmacy's NPI in emergency situations when the pharmacist may prescribe.

Eligible patients will receive coverage under the EPAP with \$0 copayments. Pharmacies will receive reimbursement commensurate with their applicable processor network contract.

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NCPDP Emergency Preparedness Payer Sheet for Patient's Current Payer

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This payer sheet is used in emergency situations when the provider knows the patient's payer for prescription benefits.

The use of the payer sheet is to standardize emergency procedures. The standard procedures are to clarify the use of the patient address, prior authorization numbers and the prescriber id when the pharmacy is the prescriber. This payer sheet is a recommendation for payer's to begin with.

GENERAL INFORMATION

Payer Name: Name	Date: Date of Publication of this Template	
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Plan Name/Group Name: Plan Name/Group Name	BIN:	PCN:
Processor: Processor/Fiscal Intermediary		
Effective as of: Date that the Plan will begin accepting transactions using this payer sheet	NCPDP Telecommunication Standard Version/Release #: D.0	
NCPDP Data Dictionary Version Date: Date of Publication	NCPDP External Code List Version Date: Date of Publication	
Contact/Information Source: Other references such as Provider Manuals, Payer phone number, web site, etc.		
Certification Testing Window: Certification Testing Dates		
Certification Contact Information: Certification phone number and information		
Provider Relations Help Desk Info: Phone number and information		
Other versions supported: Other versions of Telecommunication Standard Supported (if applicable) and information		

OTHER TRANSACTIONS SUPPORTED

Payer: Please list each transaction supported with the segments, fields, and pertinent information on each transaction.

Transaction Code	Transaction Name

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	R	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	RW	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template.

CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used		

Transaction Header Segment	Claim Billing/Claim Rebill
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Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	If more than one BIN/PCN <u>but all plans use the same segments and fields and situations</u> , enter multiple BIN/PCNs under General Information above.	M	Utilize processor current BIN number
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	Billing Transaction
1Ø4-A4	PROCESSOR CONTROL NUMBER	Specify how this field is used, if not blanks.	M	
1Ø9-A9	TRANSACTION COUNT	Specify max # of transactions supported for each transaction code.	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	Specify value supported for this plan.	M	
2Ø1-B1	SERVICE PROVIDER ID		M	
4Ø1-D1	DATE OF SERVICE		M	
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Specify how this field is used, if not blanks.	M	

Insurance Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	

Insurance Segment Identification (111-AM) = "Ø4"		Claim Billing/Claim Rebill		
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø2-C2	CARDHOLDER ID		M	
3Ø1-C1	GROUP ID		RW	<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p>Required if needed for pharmacy claim processing and payment.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
3Ø3-C3	PERSON CODE		RW	<p><i>Imp Guide:</i> Required if needed to uniquely identify the family members within the Cardholder ID.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
3Ø6-C6	PATIENT RELATIONSHIP CODE		RW	<p><i>Imp Guide:</i> Required if needed to uniquely identify the relationship of the Patient to the Cardholder.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

Patient Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Patient Segment Identification (111-AM) = "Ø1"		Claim Billing/Claim Rebill		
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		RW	<i>Imp Guide:</i> Required when the patient has a first name.

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	Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill
<i>Field</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				<i>Payer Requirement: (any unique payer requirement(s))</i>
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		O	<i>Imp Guide: Optional.</i> <i>Payer Requirement: (any unique payer requirement(s))</i> The street address of patient's home from where they were displaced.
323-CN	PATIENT CITY ADDRESS		O	<i>Imp Guide: Optional.</i> <i>Payer Requirement: (any unique payer requirement(s))</i> The city of patient's home from where they were displaced.
324-CO	PATIENT STATE / PROVINCE ADDRESS		O	<i>Imp Guide: Optional.</i> <i>Payer Requirement: (any unique payer requirement(s))</i> The state of patient's home from where they were displaced.
325-CP	PATIENT ZIP/POSTAL ZONE		O	<i>Imp Guide: Optional.</i> <i>Payer Requirement: (any unique payer requirement(s))</i> The zip/postal code of patient's home from where they were displaced.
3Ø7-C7	PLACE OF SERVICE		RW	<i>Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.</i> <i>Payer Requirement: (any unique payer requirement(s))</i>
384-4X	PATIENT RESIDENCE		RW	<i>Imp Guide: Required if this field could result in different coverage, pricing, or patient financial responsibility.</i> <i>Payer Requirement: (any unique payer requirement(s))</i>

Claim Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
This payer supports partial fills		
This payer does not support partial fills		

	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	1 = Rx Billing	M	<i>Imp Guide: For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).</i>
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER		M	
436-E1	PRODUCT/SERVICE ID QUALIFIER		M	
4Ø7-D7	PRODUCT/SERVICE ID		M	
456-EN	ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER			<i>Imp Guide: Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)).</i>

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	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. <i>Payer Requirement: (any unique payer requirement(s))</i>
457-EP	ASSOCIATED PRESCRIPTION/SERVICE DATE			<i>Imp Guide:</i> Required if the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)). Required if Associated Prescription/Service Reference Number (456-EN) is used. Required if the Dispensing Status (343-HD) = "P" (Partial Fill) and there are multiple occurrences of partial fills for this prescription. <i>Payer Requirement: (any unique payer requirement(s))</i>
442-E7	QUANTITY DISPENSED		R	
4Ø3-D3	FILL NUMBER		R	
4Ø5-D5	DAYS SUPPLY		R	
4Ø6-D6	COMPOUND CODE		R	
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE		R	
414-DE	DATE PRESCRIPTION WRITTEN		R	
415-DF	NUMBER OF REFILLS AUTHORIZED			<i>Imp Guide:</i> Required if necessary for plan benefit administration. <i>Payer Requirement: (any unique payer requirement(s))</i>
3Ø8-C8	OTHER COVERAGE CODE	2, 3, 4, 5, 6, 7, 8		<i>Imp Guide:</i> Required if needed by receiver, to communicate a summation of other coverage information that has been collected from other payers. Required for Coordination of Benefits. <i>Payer Requirement: (any unique payer requirement(s))</i>
461-EU	PRIOR AUTHORIZATION TYPE CODE	9 = Emergency Preparedness		<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i>
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	*For value "9=Emergency Preparedness" Field 462-EV Prior Authorization Number Submitted supports the following values when an emergency healthcare disaster has been officially declared by the appropriate U.S. government agency. 911ØØØØØØØØ = Emergency Preparedness (EP) Refill Extension Override Note: Use value 911ØØØØØØØØ to allow refill beyond refill		<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i>

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	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
		limit on benefit. 911ØØØØØØØØ1= Emergency Preparedness (EP) Refill Too Soon Edit Override Note: Use value 911ØØØØØØØØ1 when the patient needs medication because of emergency and processor returns a reject. 911ØØØØØØØØ2 = Emergency Preparedness (EP) Prior Authorization Requirement Override 911ØØØØØØØØ3 = Emergency Preparedness (EP) Accumulated Quantity Override 911ØØØØØØØØ4 = Emergency Preparedness (EP) Step Therapy Override 911ØØØØØØØØ5= Emergency Preparedness (EP) Note: Use Value 911ØØØØØØØØ5 to remove restriction for refill limit, Prior Authorization, Refill Too Soon, Accumulated Quantity and Step Therapy.		
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID			<i>Imp Guide:</i> Required for overriding an authorized intermediary system edit when the pharmacy participates with an intermediary. Required if Intermediary Authorization ID (464-EX) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
464-EX	INTERMEDIARY AUTHORIZATION ID			<i>Imp Guide:</i> Required for overriding an authorized intermediary system edit when the pharmacy participates with an intermediary. <i>Payer Requirement:</i> (any unique payer requirement(s))
343-HD	DISPENSING STATUS			<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription. <i>Payer Requirement:</i> (any unique payer requirement(s))
344-HF	QUANTITY INTENDED TO BE DISPENSED			<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription. <i>Payer Requirement:</i> (any unique payer requirement(s))
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED			<i>Imp Guide:</i> Required for the partial fill or the completion fill of a prescription. <i>Payer Requirement:</i> (any unique payer requirement(s))

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	Claim Segment Segment Identification (111-AM) = "Ø7"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				requirement(s))

Pricing Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent	X	

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		R	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. <i>Payer Requirement:</i> (any unique payer requirement(s))
433-DX	PATIENT PAID AMOUNT SUBMITTED		R	<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility. <i>Payer Requirement:</i> (any unique payer requirement(s))
438-E3	INCENTIVE AMOUNT SUBMITTED			<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. <i>Payer Requirement:</i> (any unique payer requirement(s))
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	Maximum count of 3.	R	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted Qualifier (479-H8) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER		R	<i>Imp Guide:</i> Required if Other Amount Claimed Submitted (48Ø-H9) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED		R	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. <i>Payer Requirement:</i> (any unique payer requirement(s))
481-HA	FLAT SALES TAX AMOUNT SUBMITTED		R	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. <i>Payer Requirement:</i> (any unique payer requirement(s))
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED		R	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. <i>Payer Requirement:</i> (any unique payer requirement(s))
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED		R	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Basis Submitted (484-JE) are used. Required if this field could result in different

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	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX). <i>Payer Requirement: (any unique payer requirement(s))</i>
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED		R	<i>Imp Guide:</i> Required if Percentage Sales Tax Amount Submitted (482-GE) and Percentage Sales Tax Rate Submitted (483-HE) are used. Required if this field could result in different pricing. Required if needed to calculate Percentage Sales Tax Amount Paid (559-AX). <i>Payer Requirement: (any unique payer requirement(s))</i>
426-DQ	USUAL AND CUSTOMARY CHARGE		R	<i>Imp Guide:</i> Required if needed per trading partner agreement. <i>Payer Requirement: (any unique payer requirement(s))</i>
430-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		R	<i>Imp Guide:</i> Required if needed for receiver claim/encounter adjudication. <i>Payer Requirement: (any unique payer requirement(s))</i>

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational		

	Prescriber Segment Segment Identification (111-AM) = "03"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
466-EZ	PRESCRIBER ID QUALIFIER	12	RW	<i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
411-DB	PRESCRIBER ID		RW	<i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i> Use pharmacy NPI, in cases where pharmacist is allowed to prescribe

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Coordination of Benefits/Other Payments Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational		Required only for secondary, tertiary, etc claims.
Scenario 1 - Other Payer Amount Paid Repetitions Only		
Scenario 2 - Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only		
Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)		

If the Payer supports the Coordination of Benefits/Other Payments Segment, only one scenario method shown above may be supported per template. The template shows the Coordination of Benefits/Other Payments Segment that must be used for each scenario method. The Payer must choose the appropriate scenario method with the segment chart, and delete the other scenario methods with their segment charts. See section [Coordination of Benefits \(COB\) Processing](#) for more information.

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill Scenario 1 - Other Payer Amount Paid Repetitions Only <i>Payer Situation</i>
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER			<i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
34Ø-7C	OTHER PAYER ID			<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication. <i>Payer Requirement: (any unique payer requirement(s))</i>
443-E8	OTHER PAYER DATE			<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. <i>Payer Requirement: (any unique payer requirement(s))</i>
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.		<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER			<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
431-DV	OTHER PAYER AMOUNT PAID			<i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. <i>Payer Requirement: (any unique payer requirement(s))</i>
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used.

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	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill
				Scenario 1 - Other Payer Amount Paid Repetitions Only
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				<i>Payer Requirement: (any unique payer requirement(s))</i>
472-6E	OTHER PAYER REJECT CODE			<i>Imp Guide:</i> Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered). <i>Payer Requirement: (any unique payer requirement(s))</i>

	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill
				Scenario 2- Other Payer-Patient Responsibility Amount Repetitions and Benefit Stage Repetitions Only
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER			<i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
34Ø-7C	OTHER PAYER ID			<i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication. <i>Payer Requirement: (any unique payer requirement(s))</i>
443-E8	OTHER PAYER DATE			<i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication. <i>Payer Requirement: (any unique payer requirement(s))</i>
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
472-6E	OTHER PAYER REJECT CODE			<i>Imp Guide:</i> Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered). <i>Payer Requirement: (any unique payer requirement(s))</i>
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.		<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER			<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>

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Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT			<p><i>Imp Guide:</i> Required if necessary for patient financial responsibility only billing.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p>Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.		<p><i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
393-MV	BENEFIT STAGE QUALIFIER			<p><i>Imp Guide:</i> Required if Benefit Stage Amount (394-MW) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
394-MW	BENEFIT STAGE AMOUNT			<p><i>Imp Guide:</i> Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>

Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	Maximum count of 9.	M	
338-5C	OTHER PAYER COVERAGE TYPE		M	
339-6C	OTHER PAYER ID QUALIFIER			<p><i>Imp Guide:</i> Required if Other Payer ID (34Ø-7C) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
34Ø-7C	OTHER PAYER ID			<p><i>Imp Guide:</i> Required if identification of the Other Payer is necessary for claim/encounter adjudication.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
443-E8	OTHER PAYER DATE			<p><i>Imp Guide:</i> Required if identification of the Other Payer Date is necessary for claim/encounter adjudication.</p>

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	Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"			Claim Billing/Claim Rebill
				Scenario 3 - Other Payer Amount Paid, Other Payer-Patient Responsibility Amount, and Benefit Stage Repetitions Present (Government Programs)
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				<i>Payer Requirement: (any unique payer requirement(s))</i>
341-HB	OTHER PAYER AMOUNT PAID COUNT	Maximum count of 9.		<i>Imp Guide:</i> Required if Other Payer Amount Paid Qualifier (342-HC) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER			<i>Imp Guide:</i> Required if Other Payer Amount Paid (431-DV) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
431-DV	OTHER PAYER AMOUNT PAID			<i>Imp Guide:</i> Required if other payer has approved payment for some/all of the billing. Not used for patient financial responsibility only billing. Not used for non-governmental agency programs if Other Payer-Patient Responsibility Amount (352-NQ) is submitted. <i>Payer Requirement: (any unique payer requirement(s))</i>
471-5E	OTHER PAYER REJECT COUNT	Maximum count of 5.		<i>Imp Guide:</i> Required if Other Payer Reject Code (472-6E) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
472-6E	OTHER PAYER REJECT CODE			<i>Imp Guide:</i> Required when the other payer has denied the payment for the billing, designated with Other Coverage Code (3Ø8-C8) = 3 (Other Coverage Billed – claim not covered). <i>Payer Requirement: (any unique payer requirement(s))</i>
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Maximum count of 25.		<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount Qualifier (351-NP) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER			<i>Imp Guide:</i> Required if Other Payer-Patient Responsibility Amount (352-NQ) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT			<i>Imp Guide:</i> Required if necessary for patient financial responsibility only billing. Required if necessary for state/federal/regulatory agency programs. Not used for non-governmental agency programs if Other Payer Amount Paid (431-DV) is submitted. <i>Payer Requirement: (any unique payer requirement(s))</i>

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Coordination of Benefits/Other Payments Segment Segment Identification (111-AM) = "Ø5"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
				requirement(s)
392-MU	BENEFIT STAGE COUNT	Maximum count of 4.		Imp Guide: Required if Benefit Stage Amount (394-MW) is used. Payer Requirement: (any unique payer requirement(s))
393-MV	BENEFIT STAGE QUALIFIER			Imp Guide: Required if Benefit Stage Amount (394-MW) is used. Payer Requirement: (any unique payer requirement(s))
394-MW	BENEFIT STAGE AMOUNT			Imp Guide: Required if the previous payer has financial amounts that apply to Medicare Part D beneficiary benefit stages. This field is required when the plan is a participant in a Medicare Part D program that requires reporting of benefit stage specific financial amounts. Required if necessary for state/federal/regulatory agency programs. Payer Requirement: (any unique payer requirement(s))

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational		

DUR/PPS Segment Segment Identification (111-AM) = "Ø8"				Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.		Imp Guide: Required if DUR/PPS Segment is used. Payer Requirement: (any unique payer requirement(s))
439-E4	REASON FOR SERVICE CODE			Imp Guide: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. Payer Requirement: (any unique payer requirement(s))
44Ø-E5	PROFESSIONAL SERVICE CODE			Imp Guide: Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. Payer Requirement: (any unique payer requirement(s))

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	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				requirement(s)
441-E6	RESULT OF SERVICE CODE			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement: (any unique payer requirement(s))</i>
474-8E	DUR/PPS LEVEL OF EFFORT			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement: (any unique payer requirement(s))</i>
475-J9	DUR CO-AGENT ID QUALIFIER			<i>Imp Guide:</i> Required if DUR Co-Agent ID (476-H6) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
476-H6	DUR CO-AGENT ID			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement: (any unique payer requirement(s))</i>

Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational		

	Compound Segment Segment Identification (111-AM) = "1Ø"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER		M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST			<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed.

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Compound Segment Segment Identification (111-AM) = "10"				Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				<i>Payer Requirement: (any unique payer requirement(s))</i>
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION			<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed. <i>Payer Requirement: (any unique payer requirement(s))</i>
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Maximum count of 10.		<i>Imp Guide:</i> Required when Compound Ingredient Modifier Code (363-2H) is sent. <i>Payer Requirement: (any unique payer requirement(s))</i>
363-2H	COMPOUND INGREDIENT MODIFIER CODE			<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i>

Clinical Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational		

Clinical Segment Segment Identification (111-AM) = "13"				Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.		<i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. <i>Payer Requirement: (any unique payer requirement(s))</i>
492-WE	DIAGNOSIS CODE QUALIFIER			<i>Imp Guide:</i> Required if Diagnosis Code (424-DO) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
424-DO	DIAGNOSIS CODE			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i>

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**NCPDP Emergency Preparedness Payer Sheet
for the Emergency Prescription Assistance Program (EPAP) Payer**
Revision 03/2011

This payer sheet is used in emergency situations when the provider has determined that the patient does not have private insurance, such as an individual health insurance policy or employer-sponsored coverage, public insurance, such as Medicare, Medicaid, or other third party coverage.

The use of the payer sheet is to standardize an emergency payer process to provide medication to displaced patients that do not have any financial means of paying for prescriptions.

The standard procedures are to clarify the use of the BIN Number, patient address, prior authorization numbers and the prescriber id when the pharmacy is the prescriber.

GENERAL INFORMATION

Payer Name: ACS	Date: tbd
Plan Name/Group Name: Plan Name/Group Name	BIN: PCN:
Plan Name/Group Name: All	BIN: PCN:
Effective as of: tbd	NCPDP Telecommunication Standard Version/Release #: D.0
NCPDP Data Dictionary Version Date: Date of Publication	NCPDP External Code List Version Date: Date of Publication
Contact/Information Source: 1-866-935-4135	
Certification Testing Window: Certification Testing Dates	
Certification Contact Information: Certification phone number and information	
Provider Relations Help Desk Info: Phone number and information	
Other versions supported: Other versions of Telecommunication Standard Supported (if applicable) and information	

OTHER TRANSACTIONS SUPPORTED

Payer: Please list each transaction supported with the segments, fields, and pertinent information on each transaction.

Transaction Code	Transaction Name

FIELD LEGEND FOR COLUMNS

Payer Usage Column	Value	Explanation	Payer Situation Column
MANDATORY	M	The Field is mandatory for the Segment in the designated Transaction.	No
REQUIRED	R	The Field has been designated with the situation of "Required" for the Segment in the designated Transaction.	No
QUALIFIED REQUIREMENT	RW	"Required when". The situations designated have qualifications for usage ("Required if x", "Not required if y").	Yes

Fields that are not used in the Claim Billing/Claim Rebill transactions and those that do not have qualified requirements (i.e. not used) for this payer are excluded from the template.

CLAIM BILLING/CLAIM REBILL TRANSACTION

The following lists the segments and fields in a Claim Billing or Claim Rebill Transaction for the NCPDP *Telecommunication Standard Implementation Guide Version D.0*.

Transaction Header Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Payer Issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Switch/VAN issued		
Source of certification IDs required in Software Vendor/Certification ID (110-AK) is Not used		

Transaction Header Segment	Claim Billing/Claim Rebill
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Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
1Ø1-A1	BIN NUMBER	004410	M	
1Ø2-A2	VERSION/RELEASE NUMBER	DØ	M	
1Ø3-A3	TRANSACTION CODE	B1	M	Billing Transaction
1Ø4-A4	PROCESSOR CONTROL NUMBER	EPAP	M	
1Ø9-A9	TRANSACTION COUNT	Specify max # of transactions supported for each transaction code.	M	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	01	M	
2Ø1-B1	SERVICE PROVIDER ID		M	NPI
4Ø1-D1	DATE OF SERVICE		M	Date of Service must fall within the declared emergency period.
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	Specify how this field is used, if not blanks.	M	

Patient Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	
This Segment is situational		

Patient Segment Segment Identification (111-AM) = "Ø1"			Claim Billing/Claim Rebill	
Field	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø4-C4	DATE OF BIRTH		R	
3Ø5-C5	PATIENT GENDER CODE		R	
31Ø-CA	PATIENT FIRST NAME		RW	Imp Guide: Required when the patient has a first name. Payer Requirement: (any unique payer requirement(s))
311-CB	PATIENT LAST NAME		R	
322-CM	PATIENT STREET ADDRESS		O	Imp Guide: Optional. Payer Requirement: (any unique payer requirement(s)) The street address of patient's home from where they were displaced.
323-CN	PATIENT CITY ADDRESS		O	Imp Guide: Optional. Payer Requirement: (any unique payer requirement(s)) The city of patient's home from where they were displaced.
324-CO	PATIENT STATE / PROVINCE ADDRESS		O	Imp Guide: Optional. Payer Requirement: (any unique payer requirement(s)) The state of patient's home from where they were displaced.
325-CP	PATIENT ZIP/POSTAL ZONE		R	Imp Guide: Optional. Payer Requirement: (any unique payer requirement(s)) The zip/postal code of patient's home from where they were displaced.

Insurance Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent	X	

Insurance Segment Segment Identification (111-AM) = "Ø4"			Claim Billing/Claim Rebill	

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NCPDP EMERGENCY PREPAREDNESS INFORMATION 1.3

Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
3Ø2-C2	CARDHOLDER ID	Beneficiary's First Initial from First Name + First Initial from Last Name + Year (YYYY) of Date of Birth + Month (MM) of Date of Birth + Day (DD) of Date of Birth.	M	Member ID
3Ø1-C1	GROUP ID		R	<p><i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs.</p> <p>Required if needed for pharmacy claim processing and payment.</p> <p><i>Payer Requirement:</i> Emergency Group ID as defined by the emergency processor per emergency</p>

Claim Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent	X	
This payer supports partial fills		
This payer does not support partial fills		

Field #	Claim Segment Segment Identification (111-AM) = "Ø7"	NCPDP Field Name	Value	Payer Usage	Payer Situation	Claim Billing/Claim Rebill
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER		1 = Rx Billing	M		<i>Imp Guide:</i> For Transaction Code of "B1", in the Claim Segment, the Prescription/Service Reference Number Qualifier (455-EM) is "1" (Rx Billing).
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER			M		
436-E1	PRODUCT/SERVICE ID QUALIFIER			M		
4Ø7-D7	PRODUCT/SERVICE ID			M		
442-E7	QUANTITY DISPENSED			R		
4Ø3-D3	FILL NUMBER			R		Refills may be extended depending upon the extent of the disaster
4Ø5-D5	DAYS SUPPLY			R		Limited to 3Ø days supply that may be extended depending upon specific disaster
4Ø6-D6	COMPOUND CODE			R		
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE			R		
414-DE	DATE PRESCRIPTION WRITTEN			R		
415-DF	NUMBER OF REFILLS AUTHORIZED					<p><i>Imp Guide:</i> Required if necessary for plan benefit administration.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
461-EU	PRIOR AUTHORIZATION TYPE CODE		1 = Prior Authorization			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.</p> <p><i>Payer Requirement:</i></p>
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED					<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, or patient financial responsibility.</p> <p><i>Payer Requirement:</i></p>

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NCPDP EMERGENCY PREPAREDNESS INFORMATION 1.3

Prescriber Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational	X	

	Prescriber Segment Segment Identification (111-AM) = "Ø3"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
466-EZ	PRESCRIBER ID QUALIFIER	12	RW	<p><i>Imp Guide:</i> Required if Prescriber ID (411-DB) is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
411-DB	PRESCRIBER ID		RW	<p><i>Imp Guide:</i> Required if this field could result in different coverage or patient financial responsibility.</p> <p>Required if necessary for state/federal/regulatory agency programs.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p> <p>Use pharmacy NPI, in cases where pharmacist is allowed to prescribe</p>

DUR/PPS Segment Questions	Check	Claim Billing/Claim Rebill If Situational, Payer Situation
This Segment is always sent		
This Segment is situational		

	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
Field #	NCPDP Field Name	Value	Payer Usage	Payer Situation
473-7E	DUR/PPS CODE COUNTER	Maximum of 9 occurrences.		<p><i>Imp Guide:</i> Required if DUR/PPS Segment is used.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
439-E4	REASON FOR SERVICE CODE			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
44Ø-E5	PROFESSIONAL SERVICE CODE			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.</p> <p>Required if this field affects payment for or documentation of professional pharmacy service.</p> <p><i>Payer Requirement:</i> (any unique payer requirement(s))</p>
441-E6	RESULT OF SERVICE CODE			<p><i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.</p>

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	DUR/PPS Segment Segment Identification (111-AM) = "Ø8"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement: (any unique payer requirement(s))</i>
474-8E	DUR/PPS LEVEL OF EFFORT			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement: (any unique payer requirement(s))</i>
475-J9	DUR CO-AGENT ID QUALIFIER			<i>Imp Guide:</i> Required if DUR Co-Agent ID (476-H6) is used. <i>Payer Requirement: (any unique payer requirement(s))</i>
476-H6	DUR CO-AGENT ID			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome. Required if this field affects payment for or documentation of professional pharmacy service. <i>Payer Requirement: (any unique payer requirement(s))</i>

Pricing Segment Questions	Check	Claim Billing/Claim Rebill <i>If Situational, Payer Situation</i>
This Segment is always sent	X	

	Pricing Segment Segment Identification (111-AM) = "11"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
4Ø9-D9	INGREDIENT COST SUBMITTED		R	
412-DC	DISPENSING FEE SUBMITTED		R	<i>Imp Guide:</i> Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. <i>Payer Requirement: (any unique payer requirement(s))</i>
426-DQ	USUAL AND CUSTOMARY CHARGE		R	<i>Imp Guide:</i> Required if needed per trading partner agreement. <i>Payer Requirement: (any unique payer requirement(s))</i>
43Ø-DU	GROSS AMOUNT DUE		R	
423-DN	BASIS OF COST DETERMINATION		R	<i>Imp Guide:</i> Required if needed for receiver claim/encounter adjudication. <i>Payer Requirement: (any unique payer requirement(s))</i>

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Compound Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational		

	Compound Segment Segment Identification (111-AM) = "10"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE		M	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR		M	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	Maximum 25 ingredients	M	
488-RE	COMPOUND PRODUCT ID QUALIFIER		M	
489-TE	COMPOUND PRODUCT ID		M	
448-ED	COMPOUND INGREDIENT QUANTITY		M	
449-EE	COMPOUND INGREDIENT DRUG COST			<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed. <i>Payer Requirement:</i> (any unique payer requirement(s))
490-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION			<i>Imp Guide:</i> Required if needed for receiver claim determination when multiple products are billed. <i>Payer Requirement:</i> (any unique payer requirement(s))
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Maximum count of 10.		<i>Imp Guide:</i> Required when Compound Ingredient Modifier Code (363-2H) is sent. <i>Payer Requirement:</i> (any unique payer requirement(s))
363-2H	COMPOUND INGREDIENT MODIFIER CODE			<i>Imp Guide:</i> Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement:</i> (any unique payer requirement(s))

Clinical Segment Questions	Check	Claim Billing/Claim Rebill If Situational, <i>Payer Situation</i>
This Segment is always sent		
This Segment is situational		

	Clinical Segment Segment Identification (111-AM) = "13"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
491-VE	DIAGNOSIS CODE COUNT	Maximum count of 5.		<i>Imp Guide:</i> Required if Diagnosis Code Qualifier (492-WE) and Diagnosis Code (424-DO) are used. <i>Payer Requirement:</i> (any unique payer requirement(s))
492-WE	DIAGNOSIS CODE QUALIFIER			<i>Imp Guide:</i> Required if Diagnosis Code (424-DO) is used. <i>Payer Requirement:</i> (any unique payer requirement(s))
424-DO	DIAGNOSIS CODE			<i>Imp Guide:</i> Required if this field could result in different coverage, pricing, patient financial responsibility, and/or drug utilization review outcome.

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	Clinical Segment Segment Identification (111-AM) = "13"			Claim Billing/Claim Rebill
<i>Field #</i>	<i>NCPDP Field Name</i>	<i>Value</i>	<i>Payer Usage</i>	<i>Payer Situation</i>
				Required if this field affects payment for professional pharmacy service. Required if this information can be used in place of prior authorization. Required if necessary for state/federal/regulatory agency programs. <i>Payer Requirement: (any unique payer requirement(s))</i>

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9. MEDICATION DELIVERY IN AN EMERGENCY

9.1 RX RESPONSE

Rx Response partners are committed to working together with local, state and federal officials as well as volunteer organizations to help support the continued delivery of medicines to people who need them in the event of such an emergency – whether it is caused by a natural disaster, terrorist incident or health emergency such as a pandemic.

Rx Response provides an information-sharing and problem-solving forum for the private pharmaceutical supply system, disaster relief agencies and government to help ensure the continued delivery of critical medicines to patients whose health is threatened by a severe public health emergency. The cornerstone of Rx Response is the reliance on the existing pharmaceutical supply system to provide for the continued flow of medicine in a major public health emergency; Rx Response can be used during a severe natural disaster, a large-scale terrorist attack, or a pandemic that creates disruptions to the normal supply of essential medicines.

The program provides a single point of contact for the private sector pharmaceutical supply system, enabling requests for information, pharmaceutical supply status, or pharmacy status.

Rx Response offers the following resources:

- Pharmaceutical supply system status report on event impacts on critical medication supplies.
- Communications network to the pharmaceutical system to share information.
- Pharmacy status reporting (see section "[Pharmacy Status Reporting](#)")

Website: www.rxresponse.org

10. MANUFACTURER PROGRAMS

10.1 THE PARTNERSHIP FOR PRESCRIPTION ASSISTANCE (PPA)

The PPA helps uninsured and financially struggling patients who lack prescription coverage get access to prescription assistance programs that offer medicines for free or nearly free. The PPA is free, confidential, and it is easy for patients to find programs for which they may be eligible to apply. Offers a single point of access to information on 475 public and private patient assistance programs, including nearly 200 programs offered by pharmaceutical companies. PPA member programs offer more than 2,500 brand-name medicines, including a wide range of generics. Helps patients contact government programs such as Medicaid and Medicare. More than 40 of the assistance programs focus on the medication and health care needs of children. The PPA provides information on nearly 10,000 free health care clinics and has connected more than 241,000 patients with clinics and health care providers in their communities. Assists patients with chronic disease in learning about the types of new medicines in development that may help them.

A user-friendly Web site (www.pparx.org) enables patients to find prescription assistance programs for which they may be eligible to apply. The PPA has dedicated a website to make it easier for patients to learn about help available for children, (kids.pparx.org). Patients can download and print out patient assistance program applications immediately.

Patients can call toll free (**1-888-4PPA-NOW**) to talk with a trained specialist who will guide them through the application process. The call centers accept calls in English, Spanish and approximately 150 other languages

11. APPENDIX A. HISTORY OF DOCUMENT CHANGES

11.1 VERSION 1.1

Section [NCPDP Emergency Preparedness Payer Sheet for the Emergency Prescription Assistance Program \(EPAP\) Payer](#) has been updated to include the possibility of using a "Red Cross ID". This section has been updated to change from the Patient's Social Security Number to the Patient's "Red Cross ID".

Section [Eligibility Information](#) has been added.

11.2 VERSION 1.2

Information on Rx Response has been added.

Reporting functionality to NCPDP has been modified.

Modifications to notification of closed pharmacies has been made with the incorporation of Rx Response processes.

Emergency Prescription Assistance Program (EPAP) information has been updated.

11.3 VERSION 1.3

EPAP information has been updated to change from CMS references to the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR).

References to ICERx have been removed as we have been advised this program is no longer operating.