Illinois Department of Human Services

Prescription Monitoring Program

Electronic Reporting Manual
For
Controlled Substance Schedules II, III, IV and V

Prepared by:
Atlantic Associates, Inc.
8030 S. Willow St.
Manchester, NH 03103
(888) 492-7341

Updated October 1, 2007

Illinois Prescription Monitoring Program

Effective April 1, 2000, in accordance with Illinois Public Act 91-0576, the Illinois Department of Human Services (State) initiated an electronic, prescription monitoring program (PMP) for Schedule II medications.

Effective January 1, 2008, in accordance with Illinois Public Act 95-0442, the State will expand PMP to monitor all controlled substance medications (Schedules II through V). This information should be reported on the same day each week after the initial reporting period.

- **THE PROGRAM IMPLEMENTATION SCHEDULE**

Initial Reporting Period	Jan. 1- Jan. 5, 2008
Initial Reporting Deadline	Jan. 9, 2008
Next Reporting Period	Jan. 6 – Jan 12, 2008
Reported by	Jan. 16, 2008
Subsequent reporting	the same day *each week*

Attention: Software Vendors, Chain Pharmacies, and Multiple Pharmacies

- **What's new for Illinois?**
  - Report **Schedule II through V** controlled substance medications.
  - **Pharmacy DEA Number** must be used.
  - All transactions must be reported **weekly.**
  - **Birth date, Patient ID number and Rx number are now required.**

- **REPORTING THE DATA**

  - Atlantic Associates, Inc. (AAI), a private contractor, will continue to manage technical aspects of data collection. AAI will forward verified data to PMP.

  - **All transactions must be submitted weekly (every seven days)**.

    - The Pharmacy DEA number must be used as the identifying number.
    - Only Schedule II through V prescription information is to be submitted.
    - Any retail pharmacy doing business in Illinois, which dispenses Schedule II through V controlled substance medications, is required to report.
    - If no controlled substance medication is dispensed, no report is required.
    - **NOTICE:** Email submissions of data will no longer be accepted.
    - Dispensers shall submit the information by one (1) of the four (4) following methods.

- **DATA SUBMISSION OPTIONS**

1. **Secure File Transfer Protocol (SFTP) – *PREFERRED***

The file name ***must*** be your Pharmacy DEA number followed by a date stamp (the date that the file was created) and then **".txt"** as an extension (example: AB1234567 123101.TXT). This will prevent the possibility of overwriting a file if more than one is sent at the same time by the same pharmacy.

The pharmacy will need the following in order to use the FTP submission option:

a. Access to the Internet and
b. A secure SFTP client application

Please contact AAI for the required username and password. For security purposes a pharmacy *may not* use its own username and password.

Free SFTP Application Software

Filezilla - http://sourceforge.net/projects/filezilla
(Set up and configuration examples are included herein.)
WinSCP - http://winscp.net/eng/download.php
CoreFTPLite - http://www.coreftp.com/download.html - free version

Commercial SFTP Application Software

CuteFTP http://www.cuteftp.com/products/ftp_clients.asp
WS_FTP http://www.ipswitch.com/products/file-transfer.asp

The SFTP application software will need to be configured so that data may be sent to AAI to assist with set up, contact AAI for instructions to install FileZilla *only*.

Download and installation instructions for the other programs will be obtained by AAI as needed.

2. **CD-Rom or Diskette**

- Submit a CD-Rom or Diskette (3 ½" DOS Formatted).
  - Use the ASAP R.5/95 format.
  - A carriage return and line feed is required at the end of each record.
- The file name should be:
  - The first eight (8) characters of the pharmacy DEA number
  - Followed by **".txt"** (example: AB123456.txt).
- The **"label"** must contain:
  - Pharmacy/Dispenser Name,
  - Pharmacy DEA Number and
  - Number of Prescriptions

3. **Data Transmission**

- Data may be transmitted at speeds up to 9,600 baud using ASAP R.5/95 data transmission protocols. These protocols are available upon request. A data link may be established by dialing **1-888-608-0574.** Additional modem numbers are also available.

4. **Universal Claim Form (or other approved paper reports) – 25 or less per *month***
   A dispenser, which does not have an automated record keeping system, may submit prescription information on the industry standard Universal Claim form or other approved paper reports. **Please contact AAI if you have more than 25 per *month* and no electronic reporting system.**

   Please mail completed Universal Claim Forms to: Atlantic Associates, Inc.
   Prescription Collection
   8030 S. Willow St.
   Manchester NH 03103

Rejection: Only the records in error will be rejected. The submitter will be notified, in writing, of the reason for failure. Only the records in error will be required for resubmission. If this is not possible, the entire file may be resubmitted.

Program Transmittal Forms (for CD-ROMs, diskette or paper submissions).

- A Program Transmittal Form should accompany all CD-Rom's, diskettes, or universal claim form submissions
- An on-line submission does not require this form.
- Please make copies of the enclosed, blank Program Transmittal Form for future use.

Confirming Submissions

An acknowledgment postcard will be mailed to the pharmacy confirming the receipt of the submission (see example below). Please contact AAI at 1-888-492-7341 if you have NOT received a written confirmation of your submission, we may not be receiving your data.

Example of confirmation postcard➔

Illinois Electronic Prescription Monitoring Program

Your transmission of __________ prescriptions was received by Atlantic Associates, Inc. on _________.

IF this differs from the number of prescriptions sent, please contact us at 1-888-492-7341. Thank you.

- Please contact AAI for specific information regarding the program at:

ATLANTIC ASSOCIATES, INC.
PRESCRIPTION COLLECTION
8030 S. WILLOW STREET
MANCHESTER, NH 03103
Phone: (888) 492-7341
Fax: (877) 508-6704

ASSISTANCE AND SUPPORT

1. AAI is available to provide assistance to any entities required to submit data to the State. Technical support is available to help meet the program requirements. Questions concerning interpretation of technical and compliance matters may be referred to AAI.

2. The State will act as the final interpreter of the procedures. Unresolved disagreements between a dispenser and AAI will be resolved by the State.

3. Individual pharmacies are advised to contact their software vendor to obtain modifications and instructions on compliance and participation. AAI will answer questions from software vendors.

COMMON QUESTIONS AND ANSWERS

1. WHAT IF THE PHARMACY/DISPENSER **DID NOT FILL** ANY CONTROLLED PRESCRIPTIONS IN THE REPORTING PERIOD?
   - **Do not send a report.**
2. WHERE CAN I OBTAIN PROGRAM TRANSMITTAL FORMS?
   - Use the attached form or call Atlantic Associates, Inc (toll-free) at 1-888-492-7341.
3. ARE NURSING HOME PRESCRIPTIONS REQUIRED TO BE REPORT?
   - Nursing home (long term care) pharmacies are not exempt.
4. ARE HOSPITAL PRESCRIPTIONS REQUIRED TO REPORT?
   - Dispensed **inpatient** prescriptions are exempt.
   - Dispensed **outpatient** prescriptions must be reported.
5. HOW ARE COMPOUND PRESCRIPTIONS TO BE RECORDED?
   - Controlled substance prescriptions compounded by a pharmacist must be reported.
   - The controlled substance ingredient's NDC number must appear in the NDC field.
   - The metric quantity of the controlled substance used is reported in the quantity field.
   - If more than one controlled substance is used, the net total of all scheduled ingredients is reported as the quantity, and the NDC number is reported as eleven "9"s (99999999999).
   - If the NDC number is unknown report as eleven "9"s (99999999999) in the NDC field.
6. WHAT DATA IS MANDATORY?

- The State of Illinois <u>requires</u> the following data for each submitted prescription:

1. Patient First Name.
2. Patient Last Name.
3. Patient Street Address.
4. Patient State.
5. Patient Zip Code (including 4 digit suffixes, if available).
6. *** Patient Date of Birth (yyyymmdd**).
7. *** Patient ID number – this may be the SSN#, DL#, Pat. Telephone or unique pharmacy system id #.**
8. Date Rx Issued (yyyymmdd).
9. NDC Number.
10. Date Rx Filled (yyyymmdd).
11. *** Rx Number (for over the counter, enter OTC).**
12. Metric Quantity (ml, mg or # of tabs).
13. DEA number of Pharmacy/Dispenser.
14. DEA number of Prescriber (if OTC, enter pharmacy DEA number).
15. Patient Gender (sex code)

***These three fields are new as required fields**.

Field Name	Field Format	Field Length	Positions
Identifier	A/N	3	001 - 003
Bin	N	6	004 - 009
Version Number	N	2	010 - 011
Transaction Code	N	2	012 - 013
**Pharmacy/Dispenser Number	A/N	12	014 - 025
**Patient ID Number	A/N	20	026 - 045
Zip Code	A/N	3	046 - 048
**Birth Date	N	8	049 - 056
**Sex Code	N	1	057 - 057
**Date Filled	N	8	058 - 065
**Rx Number	N	7	066 - 072
New - Refill Code	N	2	073 - 074
**Metric Quantity	N	5	075 - 079
Days Supply	N	3	080 - 082
Compound Code	N	1	083 - 083
**NDC Number	N	11	084 - 094
**Prescriber DEA Number	A/N	10	095 - 104
DEA Suffix	A/N	4	105 - 108
**Date Rx Written	N	8	109 - 116
Number of Refills Authorized	N	2	117 - 118
Rx Origin Code	N	1	119 - 119
Patient Location	N	2	120 - 121
Diagnosis Code	A/N	7	122 - 128
Alternate Prescriber #	A/N	10	129 - 138
**Patient Last Name	A/N	15	139 - 153
**Patient First Name	A/N	15	154 - 168
**Patient Street Address	A/N	30	169 - 198
**Patient State	A/N	2	199 - 200
**Patient Zip Code (Extended)	A/N	9	201 - 209
Triplicate Serial Number	A/N	12	210 - 221
Filler	A/N	1	222 - 222

NOTE: All **A/N** fields must be left justified, right blank filled, and
All **N** fields are right justified, left zero filled.

**** Required Field (applicable to the State of Illinois).**

State of Illinois / ASAP R.5/95 Telecommunications Format Field Definitions

Field Name	Definition	Values/Comments

Identifier		②
BIN		②
Version Number		②
Transaction Code		②
Pharmacy Number	Drug Enforcement Agency (DEA) number assigned to the Pharmacy/Dispenser	①
Patient ID Number	Patient Identification Number - this may be the SSN#, DL#, Pat. Telephone or unique pharmacy system id #.	①
Zip Code	3 digit US Postal Code identifying the state code	②
Birth Date	Patient's birth date	① - YYYYMMDD
Sex Code	Sex / Gender of the patient	①1=Male 2=Female 3=Animal
Date Filled	Date the prescription was filled	① - YYYYMMDD
Rx #	Prescription number assigned by the pharmacy	①
New-Refill Code	Code indicating whether the prescription is new or refill	②
Metric Quantity	Number of metric units of drug being dispensed	①
Days Supply	Estimated number of days the prescription will last	②
Compound Code	Code indicating whether or not the prescription is a compound medication	②
NDC Number	National Drug Code of the drug dispensed	① - (5-4-2) format
Prescriber ID	DEA # of the prescribing physician	①
DEA Suffix	DEA Suffix	②
Date Rx Written	Date the Rx was written	① - YYYYMMDD
Refills Authorized	Number of refills authorized by Prescriber	②
Rx Origin Code	Code indicating the origin of the prescription	②
Patient Location	Code indicating location of patient	②
Diagnosis Code	ICD-9 or CPT code provided by Prescriber	②
Alternate Prescriber	State license number or HIN. To be included if DEA number field is for an institution rather than the prescriber.	②
Patient Last Name	Patient Last Name	①
Patient First Name	Includes middle initial and suffix	①
Patient Address	Street or PO Box #	①
Patient State	Standard 2-digit State abbreviation (example: IL).	①
Patient Zip Code	Full zip code (including 4-digit suffix if available).	①
Serial #	# Assigned to triplicate Rx document by States with triplicate programs.	②
Filler	Filler	②

①. **Required Field for Illinois SCHEDULE II-V reporting.**
②. Optional field for Illinois SCHEDULE II-V reporting.

Controlled Substance Tracking Program

Program Transmittal Form

Date: _________________ For the Month of: ____________

Pharmacy Information: CD/Disk/Paper

DEA#:
Name:
Address:
City, St., Zip

Phone: _____________________ Contact: _________________________

Number of Prescription included: ______________

Date Range from: ___________ to: ____________

PLEASE COMPLETE THIS FORM AND
INCLUDE WITH YOUR CD, DISK OR PAPER

MAIL TO:
ATLANTIC ASSOCIATES, INC
8030 SOUTH WILLOW ST BLDG 3
MANCHESTER, NH 03103

(Please keep a copy of this form for your records)
(Make copies for future use)