Pharmaceutical Transactions Data Specification (Version 3.03)

Effective
1 July 2024

Contents

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Background

A. This version of the PTDS (3.03) has been issued to reflect the addition of the 'M' and 'C' Patient Category definitions that are required to support the removal of co-payment for Mental Health patients and rapid response treatments, e.g. Covid.

B. Version 3.03 will apply from 1 July 2024, and will replace the terms of version 3.02 of the PTDS from that date.

Definitions

Terms defined in the Pharmacy Services Agreement have the same meaning where they are used in this version of the PTDS.

Commencement

This version is to take effect from **1 July 2024.**

Pharmaceutical Transactions Data Specification (Version 3.03)

1 Introduction

This Pharmaceutical Transactions Data Specification details the file formats and data to be passed to the Ministry of Health for the purposes of processing claims in accordance with Part H of this Agreement. This version (3.03) replaces all previous versions of the Pharmaceutical Transactions Data Specification and takes effect from 1 July 2024.

2 Document Guide

Detailed in this section are the standards used throughout this specification.

2.1 Notes/Developers' Information

Notes or information provided specifically for aiding software developers are contained in boxes throughout this schedule.

Example

2.2 Field Indicators

All references to extract data fields within the text are bracketed with square brackets, for example: [data field]

2.3 Transaction Record Summary

The transaction record summary shows:

a. All fields required within the transaction lines of the data file;

b. Field numbers and an indication of a new field;

c. Categories of fields – System, Prescriber, Service User, Prescription, Dispensing and Claim fields;

d. Field type and size;

e. Mandatory status;

f. Resubmission status: – indicates whether a transaction needs to be resubmitted to the Ministry of Health if a field's content changes;

g. Security– indicates that extra security needs to be placed on the content of the fields within the system.

3 Information Required

3.1 File Structure

a. The file should be comprised of comma-separated variable width text fields.

b. Each record must be delimited by a carriage return/line feed. Each field within the record should be terminated by a comma except the last field, which should be terminated by the end-of-record CR/LF.

c. All fields with the type “CHAR” should be surrounded by double quotation marks (“”).

d. The file should be organised according to the following structure:

- File Header
- Dispensing Record
- Non-dispensing Record
- File Trailer

e. An example of the record sequence of the file is as follows:

- 19301
- 05
- 06
- 09

The file is opened by the File Header, followed by as many transaction records as apply to that File Header. The last record is then the File Trailer.

3.2 Mandatory Fields

The requirements as to mandatory and non-mandatory fields are as follows:

P	Mandatory
C	Conditional
P/A	Mandatory where provided to you or where available to you
P/D	Proposed delay
D	Delete
F/U	Future use.

3.3 Data Formats

3.3.1 Dates

a. Specified as DATE.

b. All dates must be formatted DDMMCCYY e.g. 31031943.

3.3.2 Integers

a. Specified as INT.

b. These are integer numbers.

c. There should be no decimal points or commas included.

d. All values should be expressed as positives.

3.3.3 Numbers

a. Specified as NO.

b. These are numbers including decimal places.

c. The number of decimal places will be indicated where a number field is specified.

d. There should be no decimal points or commas included.

e. Values submitted need to be right padded so that values are submitted with the correct number of decimals.

f. All values should be expressed as positives.

3.3.4 Currency Values

a. Specified as $.

b. All currency values should be expressed as cents unless otherwise stated.

c. There should be no decimal points or commas included.

d. All values should be inclusive of Goods and Services Tax (GST) unless otherwise stated.

3.3.5 Character Values

a. Specified as CHAR.

b. Character fields should be surrounded by double quotes e.g. “example”.

c. Character fields must not contain any commas.

3.4 File Naming Convention

3.4.1 File Name Format

All file names should be in the 8.3 format. That is, the file name should consist of an 8-character name, a full stop and a 3-character suffix.

3.4.2 File Name Content

a. The 8-character name should be a concatenation of the leftmost 2 digits of the [Header Record Type] field and the rightmost 6 digits of the [File ID] (right zero-filled where applicable) as set out in the header record.

b. The 3-character suffix should be “DHB”.

4. File Header Record

4.1 File Header Record Summary

Field No	Name	Type	Field Size	Mandatory
1	Record Type	CHAR	5	P
2	Sequence No	NO	8	P
3	File ID	CHAR	8	P
4	Agreement Number / Alternate Contract Number	CHAR	7	P
5	File date	DATE	8	P
6	Sender ID	CHAR	10	P/D
7	Role	CHAR	2	P/D
8	Payee Number	CHAR	7	P/D
9	System	CHAR	10	P
10	System Version	CHAR	6	P
11	Schedule Date	DATE	8	P
12	Claim Date	DATE	8	P

4.2 File Header Record Detail

1 Record Type

- Defines whether a record in a file is a header, detail or trailer record. For header records this field also determines the type of file. The list of valid codes is as follows:

Code	Description
19301	Pharmaceutical Claim Header
05	Dispensing Record
06	Non-dispensing Record
09	Trailer Record

- The header code is made up from 19 which relates to the type of Service Provider (19 = Pharmacy) at the Ministry of Health and 301 which is the version of this data specification.

2 Sequence No

- The number "1" for the header.
- Indicates the absolute record number of this record within the file.
- Sequence number continues to increment for each ingredient of a compound.

Example:

The first transaction line will have a sequence number of 2.

3 File ID

- A unique ID for a particular claim file.
- Each claim file must be sequentially numbered. No two files should have the same [File ID].
- This should be a system reference number for extract to permit the ease of matching extract files to system extract batches.
- If the system is upgraded the sequential [File ID] number should continue from last used number and not be refreshed.
- If the file is regenerated/recompiled from the Service Provider's system, the file must have a new [File ID]. If the file is not regenerated but recopied from the system to disk the [File ID] must remain the same as when initially generated.

4 Agreement Number/Alternate Contract Number

- Pharmacy Agreement identifier.
- Identifies the Agreement from which payment and processing rules will be sought.
- This field should be populated with the agreement number or alternate contract number as advised by the Ministry of Health from time to time. It will not necessarily be the same number as recorded on the agreement between the DHB and Service Provider.

- This information may change from time to time. The Service Provider's system does need to store historical agreement numbers.

5 File Date

- Date the claim file is generated.
- If a claim file is regenerated, this date should be the date of regeneration.

6 Sender ID

- Deferred.

7 Role

- Deferred.

8 Payee Number

- Deferred.

9 System

- An abbreviated name of the Service Provider's software used to generate this claim file, e.g.
  - LOTS; or
  - TONIQ; or
  - WinCAPP; or
  - AIRFLOW; or
  - SIMPLICITY.
- This will be case sensitive.

10 System Version

- The version number of the Service Provider's software used to generate this claim file.
- Service Providers are required source this number individually from their software vendor.

11 Schedule Date

- The release date of the Pharmaceutical Schedule that was used in the calculations of this claims file, as set by PHARMAC.

12 Claim Date

- Date which identifies the claim period.

- The Claim date should be one of the dates specified within your Pharmacy Services Agreement.

5. Dispensing Transaction Record

Each transaction remains as one line as in previous releases of the Pharmaceutical Transactions Data Specification, however the fields have been logically grouped for ease of understanding.

5.1 Dispensing Transaction Record Summary

Field Type	Field No	Name	Type	Field Size	Mandatory
System	20	Record Type	CHAR	5	P
	21	Sequence No	INT	8	P
	22	Unique Transaction Number	INT	13	P
	23	Transaction Category	CHAR	1	P
	24	Component Number	INT	2	P
	25	Total Component Number	INT	2	P
	26	Balance Owing	NO	6 + 4	P/A
	27	Compound Classification	CHAR	5	P/A
Prescriber	28	Prescriber ID	CHAR	10	P/A
	29	Health Professional Group Code	CHAR	2	P/A
	30	Locum ID	CHAR	10	P/A
	31	Group ID	CHAR	10	P/A
	32	Leave Blank			
	33	Leave Blank			
	34	Specialist ID	CHAR	10	P/A
	35	Date of Endorsement	DATE	8	P/A
	36	Prescriber Flag	CHAR	1	P/A
	37	Leave Blank			
Patient	38	NHI	CHAR	7	P
	39	Patient category	CHAR	1	P
	40	CSC Or PHO Status Flag	CHAR	1	P
	41	CSC Number	INT	16	P/D
	42	CSC Expiry Date	DATE	8	P/D
	43	HUHC Status Flag	CHAR	1	P
	44	HUHC Number	INT	7	P/D
	45	HUHC Expiry Date	DATE	8	P/D
	46	Prescription Subsidy Card Flag	CHAR	1	P
	47	Prescription Subsidy Card Number	INT	6	P/D
	48	Special Authority Number	INT	10	P/A

Field Type	Field No	Name	Type	Field Size	Mandatory
	49	Patient Flag	CHAR	1	P
	50	Patient Cohort	CHAR	10	
Prescription	51	Prescription Code	INT	13	F/U
	52	Prescription Code Standard	CHAR	1	F/U
	53	Prescription Quantity	INT	9	F/U
	54	Prescription Date	DATE	8	F/U
	55	Dispensings Required	INT	2	P/A
	56	Repeats Expiry	DATE	8	P/A
	57	Dose (Base units per use)	NO	6+4 Dec	P
	58	Daily Dose (Base units per day)	NO	6+4 Dec	P
	59	Formulation Units (Base unit of measure)	CHAR	8	P
	60	Prescription Flag	CHAR	1	P/A
	61	Dose Flag	CHAR	1	P
Dispensing	62	Prescription ID	INT	9	P
	63	Prescription ID Suffix	INT	2	P
	64	Date of Service	DATE	8	P
	65	Claim Code	INT	16	P
	66	Code Standard	CHAR	1	P
	67	Quantity Dispensed	NO	6+4 Dec	P
	68	Quantity Claimed	NO	6+4 Dec	P
	69	Total Quantity Prescribed	NO	6+4 Dec	P/A
	70	Pack Unit of Measure	CHAR	8	P[1]
	71	Extended Supply	CHAR	1	P/A
	72	Leave Blank			
	73	SIG	CHAR	30	P/D
	74	Leave blank			
	75	Leave blank			
Claim	76	Order Type	INT	1	P
	77	Wastage Quantity	NO	6+4 Dec	P/A
	78	Claim Amount	$	9	P
	79	CBS Subsidy	$	9	P
	80	CBS Packsize	NO	6+4 Dec	P[1]
	81	Funder	CHAR	3	P
	82	Originating Agreement Number	CHAR	7	P

[1] Exceptions to a field being mandatory are listed in the entry for that field. Where an exception applies, the field will be considered P/A.

Field Type	Field No	Name	Type	Field Size	Mandatory
	83	Service Agreement Number	NO	5	P
	84	Health Insurance Claim Number	INT	15	F/U
	85	Form Number	INT	9	P

5.2 Dispensing Transaction Record Detail

20 Record Type

- Refer to [Record Type] in File Header Detail section.

21 Sequence Number

- Refer to [Sequence Number] in File Header Detail section.

22 Unique Transaction Number

- A number that uniquely identifies the record within the Service Provider's software.
- This will be a different number for each repeat of the same prescription item.

Audit/Resubmission Requirements:

If any field is changed and requires a resubmission (as indicated in the Transaction Record Summary section of this document) the historical data for the record needs to be saved with the old [Unique Transaction Number] and a new record created in the Service Provider's system with the changed contents of the record and a new [Unique Transaction Number].

Refer to the [Transaction Category] for how this impacts resubmission.

Future Use:

As this is used to uniquely identify the record in the Service Provider's system for which a claim record relates to, this will be used for future electronic reconciliation and for audit purposes.

23 Transaction Category

- Indicates whether the claim is a standard claim, credit transaction, non-claim item or a resubmission of a previous claim.
- The appropriate codes are:

Transaction Category	Code
Standard claim	I or Null
Credit transaction	C
Non claim transactions	N
Resubmission	R
Owed balance	O

Standard Claim

- First time submitted claim lines need to be submitted with a [Transaction Category] = “I” for Invoice.

Credit Transactions

- Credit line transactions are used to credit a previously submitted claim transaction.
- These may either be used independently, to credit a previous transaction claimed, or as part of a resubmission.
- Credit line transactions need only contain the following data elements in the Transaction Record of a claim file:

Field No	Name	Notes
10	Record Type	Refer field 1.
21	Sequence No	Refer field 2.
22	Unique transaction number	Must be the same [Unique Transaction Number] of the transaction to be credited. If a Credit as part of a resubmission, the [Unique Transaction Number] must be number of the historical record (refer to [Unique Transaction Number] for further explanation).
23	Transaction Category	= “C”
62	Prescription ID	Must be the same [Prescription ID] as the transaction to be credited.
63	Prescription ID suffix	Must be the same [Prescription ID Suffix] as the transaction to be credited.

Non Claim Transactions

- If the item is not to be charged to the Service Provider’s DHB, or is not being reprocessed, the transaction is to be specified with a [Transaction Category] = “N” for Non Claim Transaction.
- All data elements are to be included in the transaction record of the claim file, following the same rules as a Standard Claim.

Resubmitting Transactions

- Transactions may be resubmitted if the transaction field contents have changed.
  - Only items that have been submitted with incorrect data should be resubmitted
  - Items that have been rejected by the system do not need to be resubmitted through this procedure
  - If a transaction is resubmitted, the resubmission must be transferred as two transactions.

1st Line

- The first transaction needs to have a [Transaction Category] = C, for Credit. This need only contain data elements defined for Credit Transactions.

2nd Line

- The second transaction needs to have a [Transaction Category] = "R" for resubmission. All data elements need to be submitted in the 2nd line of a resubmission following the same rules as a Standard Claim and noting the following criteria.

Field No	Name	Notes
12	Unique transaction number	Must be the [Unique Transaction Number] of the new transaction in the Service Provider's system (Refer [Unique Transaction Number] for further explanation).

Owed Balance Transaction

- The quantity remaining still to be claimed from a previously claimed transaction.
- Transaction Category O will allow payment to be made for the quantity of the pharmaceutical but no associated fees.
- The [Prescription ID Suffix] must be the same as the original transaction where the balance owing completes the quantity prescribed.

24 Component Number

- This field is used in conjunction with field 25 [Total Component Number].
- The [Component Number] and [Total Component Number] fields are used to define a transaction that belongs to a group of transactions (as in a compound).
- [Component Number] defines where the transaction fits into a group of transactions, i.e., line 1 of a group, line 2 of a group, etc.
- [Total Component Number] defines how many transactions are in the group.

Example - Single line transaction:

Single line transaction [Component Number] = 1 [Total Component Number] = 1

Example - 4 line compound:

Ingredient a [Component Number] = 1 [Total Component Number] = 4

Ingredient b [Component Number] = 2 [Total Component Number] = 4

Ingredient c [Component Number] = 3 [Total Component Number] = 4

Ingredient d [Component Number] = 4 [Total Component Number] = 4

- The first transaction line of a compound should include all the data fields required for a single line transaction, including the quantity amount for this component.

- Subsequent line transactions of a compound should only supply the data required for that compound, i.e., no [CSC or PHO Status Flag] etc. is required.

25 Total Component Number

- Refer to [Component Number].

26 Balance Owing

- Indicates that there is a balance owing on this item.

- The field should contain zeros when there is no balance owing on the transaction record.

27 Compound Classification

- Indicates what type of compound is being presented.

Compound Classification Type	Code
Grasby Pump	GRASB

28 Prescriber ID

- The registration number of the prescriber.

- If a locum wrote this prescription the [Prescriber ID] needs to show the prescriber the locum is standing in for.

- This field must be completed where provided on the prescription by the prescriber.

- The appropriate registration numbers are:

Type of Prescriber	Number to use	Note
Medical Practitioner	New Zealand Medical Council Number	
Temporary Medical Practitioner	New Zealand Medical Council Number	
Midwife	Nursing Council of New Zealand Number or Midwifery Council of New Zealand Number	Include leading characters[2]

[2] Midwife Rule: Use the Nursing Council number if the Midwife previously used the Nursing Council number otherwise use the Midwifery Council number. Where the Midwifery Council number is used the '1' and the 'hyphen' must be removed prior to submission (i.e. 15-23456 becomes 523456).

Type of Prescriber	Number to use	Note
Dentist	Dental Council Number	Include leading characters
Temporary Dentist	Dental Council Number	Include leading characters
Specialist	New Zealand Medical Council Number	
Nurse Prescriber	Nursing Council of New Zealand Number	Include leading characters
Optometrist Prescriber	Optometrists and Dispensing Opticians Board Number	
Podiatrist	Podiatrist Board Number	
Pharmacist	Pharmacy Council Number	
Dietitian	Dietitians Board Number	
Physiotherapist	Physiotherapy Board Number	
Psychologist	Psychologists Board Number	
Chiropractor	Chiropractic Board Number	
Medical Radiation Technologist	Medical Radiation Technologists Board Number	
Medical Laboratory Scientist and Technician	Medical Laboratory Science Board Number	
Occupational Therapist	Occupational Therapy Board Number	
Osteopath	Osteopathic Council Number	

29 Health Professional Group Code

- In the transaction record the [Health Professional Group Code] is used to define the Registration Body used to identify the Prescriber.

- Below are the valid [Health Professional Group Code] to be used to identify the Registration Body of the prescriber.

HPGC	Registration Body
MC	Medical Council of New Zealand
NC	Nursing Council of New Zealand
DC	Dental Council of New Zealand
MX	Temporary NZMC
DX	Temporary Dentists
OP	Optometrists and Dispensing Opticians Board
WF	Midwifery Council
FT	Podiatrists Board
PC	Pharmacy Council
ET	Dietitians Board
IO	Physiotherapy Board
SY	Psychologists Board
KI	Chiropractic Board
RD	Medical Radiation Technologists Board
LB	Medical Laboratory Science Board
JB	Occupational Therapy Board
BK	Osteopathic Council

30 Locum

- Registration number of the prescriber if the prescriber was a locum.

31 Group ID

- May indicate a PCO, PHO, practice or other group.

- The Service Provider's DHB will allocate the codes to practitioners, practices or groups where classification is necessary.

- This field must be completed where provided on the prescription by the prescriber.

- The vendor system must be robust enough to allow a Service Provider to change the [Group ID] at the time of dispensing.

32 Leave Blank

33 Leave Blank

34 Specialist ID

- New Zealand Medical Council Number of the specialist who recommended the prescription.
- Required only for circumstances set out in the Pharmaceutical Schedule.

35 Date of Endorsement

- Date on which the specialist recommended the prescription.
- Required only for circumstances set out in the Pharmaceutical Schedule.
- Only month and year are required for this field.
- Format for this field is MMCCYY.

Programmer Note:

Date of Endorsement is not specified as a DATE, as per 3.3 Date Formats.

36 Prescriber Flag

- [Prescriber Flag], [Patient Flag] and [Prescription Flag] are to be set within Service Providers' systems to allow a transaction to specify that a condition or rule has been abided.

Note:

To be used where a rule set by PHARMAC cannot be checked either because of the limiting data collected or that it needs an indication from the pharmacist.
Such cases will be specified in the Pharmaceutical Schedule.

Programmer Note:

This will permit rules to be implemented without continual changes to Service Providers' software.

PHARMAC Note:

New rules will still need to be set in the Rules section of the PHARMAC database and will still need to be programmed into ProClaim. Therefore, before rules are implemented, there will be a suitable lead-time for the above to happen.
To ensure the integrity of the use of these flags, disciplines will need to be set and followed to ensure the correct flag or flag combinations are used.
The mechanisms for the use of these flags will be worked out between PHARMAC, the Ministry of Health, and Service Providers.

- PHARMAC has notified that the [Prescriber Flag] must be used to:

- To specify that Practitioner Supply Order is for use in a rural area, in this circumstance the [Prescriber Flag] should be set to Y, or

- To specify that the prescriber has endorsed the Prescription Form to dispense the pharmaceutical Close Control in accordance with the Pharmaceutical Schedule.

37 Leave Blank

38 NHI (Service User ID)

- National Health Index number of the Service User.

- The required format is AAANNNN, where A is an uppercase alphabetic character (excluding 'I' and 'O') and N is numeric

- If the NHI number on a Prescription Form or Quit Card is different from the NHI the Service Provider already has for that Service User, the Service Provider will use the latest NHI number they have received.

39 Patient Category

- Indicates the Service User's age category at the time of the initial dispensing.

- The appropriate codes are:

Category	**Code**	**Note**
Senior	S	Service Users aged 65 years and over
Adult	A	Service Users aged 18 to 64 years
Junior	J	For dates of service from 1 July 2015 to 30 November 2018: Service Users aged 13 to 17 years For dates of service on or after 1 December 2018: Service Users aged 0 to 13 years
Younger	Y	For dates of service before from 1 July 2015 to 30 November 2018: Service Users aged 0 to 12 years For dates of service on or after 1 December 2018: Service Users aged 0 to 13 years
Permanent resident of Hokianga	H	This code is only to be used for: Service Users who are usually resident in the Hokianga Ward of the Far North District, and Where the Prescription Form has been written by a Medical Practitioner employed by, and on a form supplied by, the Hokianga Medical Trust.

Mental Health	M	Used for funding Mental Health Services
Consultation	C	Used for funding rapid response treatments, e.g. Covid
Contraception	O	Used when patient falling within category 'Y' has been prescribed an oral contraceptive.
Wastage	W	

- "O" is transposed to an "A" except in the case where a patient falling within category 'Y' has been prescribed an oral contraceptive.

40 CSC or PHO Status Flag

- Indicates whether Service User:
  - Has a Community Services Card (CSC) or not at the time of initial dispensing, or
  - Is eligible for reduced cost primary health services
  - Is not covered by any of the categories listed in (a), (b) or (c) above.
- The appropriate codes are:

Category	Code	Note	Priority
Is eligible for reduced cost primary health services	Q	The service user must be eligible for reduced cost primary health services.	1
Has a Community Services Card	Y		2
None of the Above	N		3

- Where a patient could be classed under multiple categories the highest priority category, as noted above, must be used.

41 CSC Number

- The number of the Service User's CSC card.
- Deferred.

42 CSC Expiry Date

- The expiry date of the Service User's CSC card.
- Deferred.

43 HUHC Status Flag

- Indicates whether Service User has a High Use Health Card (HUHC) or not at the time of the initial dispensing.

- The appropriate codes are:

Has HUHC	Code
Yes	Y
No	N

- This code will also be used in the future to indicate people who are eligible for Care Plus services through their PHO. DHBs will notify Service Providers when this change comes into effect.

44 HUHC Number

- The number of the Service User's HUHC card.

- Deferred.

45 HUHC Expiry Date

- The expiry date of the Service User's HUHC card.

- Deferred.

46 Prescription Subsidy Card Flag

- Indicates whether person has a Prescription Subsidy Card (PSC) or not at the time of the initial dispensing. Where the person is entitled to a PSC for some of the prescription items on a prescription form or a Quitline Card, only these items must be classified as having a PSC.

- The appropriate codes are:

Has PSC	Code
Yes	Y
No	N

47 Prescription Subsidy Card Number

- The number of the Service User's Prescription Subsidy Card.

- Deferred.

48 Special Authority Number

- The special authority number allocated to the Service User for the item(s) dispensed. The following applies to this field:

- The Special Authority Number is required only for circumstances set out in the Pharmaceutical Schedule.

- The authority type prefix and date suffix should both be excluded.

Example:

HOSP0175432/JUN98 should be provided as 0175432

Programmer Note:

This numeric value may not necessarily stay at 7 digits, and the authority type prefix and date suffix may not stay at the current lengths, therefore it may be safer to have a separate field for the numeric component of the Special Authority Number.

49 Patient Flag

- Refer [Prescriber Flag].

- Current Use: To specify a Pharmacode where the pharmaceutical is used as an oral contraceptive rather than a hormone treatment.

50 Patient Cohort

- Indicates the cohort for which the patient belongs.

- The valid codes will be published separately.

51 Prescription Code

Future Use:

It is proposed that this field is used to transmit the code that was used to prescribe the Pharmaceutical dispensed

52 Prescription Code Standard

Future Use:

To identify the [Prescription Code] being used.

53 Prescription Quantity

Future Use:

To identify the quantity of the [Prescription Code] that was prescribed.

54 Prescription Date

Future Use:

To state the date of the prescription.

55 Dispensings Required

- The total number of dispensings required. This includes the initial dispensing and all repeats.
- Unlimited repeats should be indicated as 99.

56 Repeats Expiry

- The date after which repeats will not be subsidised for this item.

57 Dose

- The [Dose] contains the amount of units prescribed to be used at each use.
- The units should be expressed in [Formulation Units] as defined by PHARMAC.
- Where the [Dose] is not able to be expressed, such as in the case of "Take as needed" or PRN medications, this field should be set to "0".
- Where [Dose] is set to 0 the [Dose Flag] should be set to Y.
- Where the number of units is a range, the higher amount should be used.

58 Daily Dose (Base Units Per Day)

- The [Daily Dose] contains the amount of units prescribed to be used per day.
- The units should be expressed in [Formulation Units] as defined by PHARMAC.
- Where the [Daily Dose] are not able to be expressed, such as in the case of "Take as needed" or PRN medications, this field should set to "0".
- Where [Daily Dose] is set to 0 the [Dose Flag] should be set to Y.
- Where the number of units is a range, the higher amount should be used.

Programmer Note:

If the units are spread over alternate days (e.g. every other day, or Monday, Wednesday and Friday) then the value should represent this. For example, one unit every other day will equate to 0.5 of a unit. For example, Monday, Wednesday and Friday will equate to 0.4285.

As this field requires data expressed to 4 decimal places with no decimal points, 0.5 of a unit would appear in the data file as 5000, and 0.4285 would appear as 4285.

59 Formulation Units (Base unit of measure)

- The [Formulation Units] must contain the PHARMAC definition of the Unit of Measure used in the calculations for the [Dose] and [Daily Dose] fields.

- This should be the allocated [Formulation Units] for the Pharmacode dispensed.

- This should be the allocated [Formulation Units] relating to the [Claim Code] dispensed.

PHARMAC note:

The [Formulation Units] refers to the [Units] field from the [Formulation] table of the Schedule database available from PHARMAC.

60 Prescription Flag

- Refer [Prescriber Flag].

- [Prescription Flag] is to be set when the Prescriber has endorsed the prescription and when confirmation is required by the Pharmaceutical schedule

61 Dose Flag

- Indicates whether a prescription has provided dose directions sufficient to place information in the [Dose] and [Daily Dose] fields.

- Where the pharmaceutical is an ointment or lotion or the [Dose] and [Daily Dose] fields cannot be expressed, such as in the case of “Take as Required” medications, this field should be set to Y.

- The appropriate codes are:

Dose Flag	Code
Yes	Y
No	N

62 Prescription ID

- Unique ID for each prescription item as annotated on a prescription or Quitline Card by the pharmacist.

- This code is generated by the Service Provider’s software, and should be the full system number regardless of how the number is concatenated on script labels.

- Where a number of pharmaceutical items are combined or compounded, each item should have the same Prescription ID.

63 Prescription ID Suffix

- Suffix to the Prescription ID.

- The appropriate codes are:

Dispensing	Code
Stat	0

Initial dispensing	1
Subsequent dispensing	Sequential number for each dispensing

- [Prescription ID Suffix] should allow up to 98 repeats.

64 Date of Service

- Dispensing date.

65 Claim Code

- Indicates the pharmaceutical dispensed.

- The "Pharmacode" administered by the Pharmacy Guild of New Zealand Incorporated is currently the only valid code to be used.

66 Code Standard

- The [Code Standard] field specifies the type of claim code used in Field 63 [Claim Code].

- The valid codes are:

Code Standard	Definition	Note
P	PharmaCode	To be used
E	EAN Codes	Not currently accepted

Note:
If this field is set to Null it will default to P for Pharmacode.

67 Quantity Dispensed

- The [Quantity Dispensed] field must specify the quantity of the [Claim Code] dispensed.

- This must be defined using the [Pack Units of Measure] relating to the [Claim Code] as specified by PHARMAC.

68 Quantity Claimed

- The [Quantity Claimed] field must specify the quantity of the [Claim Code] that is claimed for in this transaction line.

- This must be defined using the [Pack Units of Measure] relating to the [Claim Code] as specified by PHARMAC.

69 Total Quantity Prescribed

- The [Quantity Prescribed] field must specify the total quantity of the [Claim Code] prescribed, including what is prescribed for repeats.

- This must be defined using the [Pack Units of Measure] relating to the [Claim Code] as specified by PHARMAC.

- Needs only to be on the initial dispensing.

70 Pack Unit of Measure

- The [Pack Units of Measure] must contain the PHARMAC definition of the Unit of Measure as set out in the Pharmaceutical Schedule relating to the [Claim Code] as used in the calculations for the [Quantity Dispensed], [Quantity Claimed] and [Quantity Prescribed] fields.

Programmer Note:

The [Pack Unit of Measure] data refers to the [Units] field from the [Formulation] table from the Schedule database, available from PHARMAC.

- The [Pack Unit of Measure] is mandatory for all items except Exceptional Circumstances pharmaceuticals not listed on the Pharmaceutical Schedule. For these items the [Pack Unit of Measure] is considered a P/A field.

71 Extended Supply

- Indicates whether the period of supply may exceed the appropriate dosage period as specified in the Pharmaceutical Schedule or in the Service Provider's Agreement with their DHB.

- Indicates where greater than 30 days supply has been supplied.

- The appropriate codes are:

Has Extended Supply	Code
Yes	Y
No	N

Business Rule:

Current uses include Access Exemption or Certified Exemption and greater than 30 days supplied.

72 Leave Blank

73 SIG

- Long SIG code.

74 Leave Blank

75 Leave Blank

76 Order Type

- Indicates the type of prescription or order.
- The appropriate codes are:

Description	Code
Prescription / NRT Quit Card	1
Practitioner's supply order (MPSO)	3
Bulk supply order (BSO)	4
Wholesale supply order (WSO)	5

77 Wastage Quantity

- The amount of wastage claimed for of the [Claim Code].
- This must be specified using the [Pack Units of Measure].

78 Claim Amount

- Total value of service provided for this item, which is chargeable to the Service Provider's DHB.
- Includes the payment expected to be made by the Service Provider's DHB for the pharmaceutical, all fees and GST.
- Is less the Service User's co-payment.
- Where the item is compounded, only the last item should contain the [Claim Amount].
- Expressed in cents;
- May be a negative number where appropriate.

Example Formula:

[Claim Amount] = Pharmaceutical subsidy + Markups + Professional fee x Multiplier + GST – Service User's Co-payments.

Programmer Note:

Mark ups and Professional fees may differ with each Pharmacy Services Agreement. Therefore, Service Provider's software should allow parameters to be set for the Markups and Fees.

PHARMAC Note:

If the schedule updates can differentiate between Hospital and Community drugs the Service Provider's software should be able to apply the correct Markups and fees when generating the claim file.

79 CBS Subsidy

- To be used for:
  - Those items listed as CBS in the Pharmaceutical Schedule, or
  - Those items where the pharmaceutical is subsidised under Exceptional Circumstances and the pharmaceutical is not listed on the Pharmaceutical Schedule.
- For those items listed as CBS in the Pharmaceutical Schedule, this field is to be submitted less all Markups, this value may be less than the Service Provider sees on the supplier's invoice.
- For those items where the pharmaceutical is subsidised under Exceptional Circumstances and the pharmaceutical is not listed on the Pharmaceutical Schedule, this field is to be submitted stating the GST exclusive invoice price to the Service Provider of the minimum purchase order of the Pharmaceutical required to satisfy the requirements of the prescription as at the date of Dispensing.

80 CBS Packsize

- To be used for:
- Those items listed as CBS in the Pharmaceutical Schedule, or
- Those items where the pharmaceutical is subsidised under Exceptional Circumstances and the pharmaceutical is not listed on the pharmaceutical schedule.
- For those items listed as CBS in the Pharmaceutical Schedule this field:
  - Is mandatory.
  - Must express the pack size that the [CBS Subsidy] value relates to.
  - Must be specified in [Pack Units of Measure].
- [CBS Packsize] is considered a P/A field for Exceptional Circumstance items that are not listed on the Pharmaceutical Schedule.

81 Funder

- The code to identify the funding body for this claim.
- The [Funder] should default to "DHB".

82 Originating Agreement Number

- Indicates the Service Provider which made the original dispensing.
- Allows the correct payment of repeats in cases of Service Provider amalgamation and/or change of ownership.

83 Service Agreement Number

- Indicates under which payment Service Agreement the claim is priced.

- Allows a single pharmaceutical to be claimed under the correct Service Agreement when a Service Provider has more than one service for the single item.

84 Health Insurance Claim Number

- For Future Use.

85 Form Number

- A unique number for a claimant which identifies the form or source document for all pharmaceuticals dispensed.

- All pharmaceutical items from the same form (e.g. prescription form) including repeat items should have the same form number.

6. Non-dispensing Record

This structure has been designed to support the submission of non-dispensing service fee payments, such as the Core service fee introduced in the 2012 Community Pharmacy Services Agreement. The future creation of additional non-dispensing FFS services is anticipated.

6.1 Non-dispensing Record Summary

The submission of a non- dispensing record is optional.

Field No	Name	Type	Field Size	Mandatory
20	Record Type	CHAR	5	P
21	Sequence No	INT	8	P
22	Unique Transaction Number	INT	13	P
23	NHI	CHAR	7	C
24	Date of Service	DATE	8	C
25	Claim Code	CHAR	15	P
26	Quantity Claimed	INT	7	P
27	Claim Amount	$	9	P

6.2 Non-dispensing Record Detail

20 Record Type

- Refer to [Record Type] in File Header Detail section.

21 Sequence Number

- Refer to [Sequence Number] in File Header Detail section.

22 Unique Transaction Number

- A number that uniquely identifies the record within the Service Provider's software.

23 NHI (Service User ID)

- National Health Index number of the Service User.
- Reserved for future use.

24 Date of Service

- Date on which the service was provided.
- Reserved for future use.

25 Claim Code

- Indicates the non-dispensing service being claimed.
- The valid codes will be published separately

26 Quantity Claimed

- Must be an integer.

27 Claim Amount

- Includes the expected payment amount.
- This field may be negative where appropriate.

7. File Trailer Record

7.1 File Trailer Record Summary

Field No	Name	Type	Field Size	Mandatory
90	Record Type	CHAR	5	P
91	Sequence No	NO	8	P
92	Number of Lines	NO	8	P
93	Total Claim Value	$	9	P
94	PS Cards Issued	NO	4	P

7.2 File Trailer Detail

90 Record Type

- Refer to [Record Type].

91 Sequence Number

- Refer to [Sequence Number].

92 Number of Lines

- Total number of lines in the file.

> **Programmer Note:**
>
> To check the integrity of the claim file the value in the [Number of Lines] field should be the same as the [Sequence No] in the File Trailer.

93 Total Claim Value

- Total value of the claim.
- Should be the total of all the [Claim Amounts] in the file.

94 PS Cards Issued

- Number of Prescription Subsidy Cards, which have been issued by Service Provider within the claim period.