DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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TO: Medicare-Medicaid Plans

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SUBJECT: Waiver of Part D Low-Income Subsidy Cost-Sharing Amounts by Medicare-Medicaid Plans and Operational Implications for Prescription Drug Event Data and Plan Benefit Package Submissions

As specified in previous guidance, including our January 25, 2012 HPMS memorandum, entitled, "Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans," Medicare-Medicaid Plans will be paid for Part D-covered drugs according to the standard Part D payment rules, with the exception that the direct subsidy will be based not on a bid submitted by each plan, but on the standardized national average bid monthly amount (NAMBA). The NAMBA will be risk adjusted according to the same rules that apply to all other Part D plans. Medicare-Medicaid Plan enrollees will be subject to standard low-income subsidy (LIS) copayment levels, absent any further reduction in cost sharing at plans' election.

Under the Capitated Financial Alignment Demonstration, CMS is working with States to test a new integrated payment and service delivery model that not only will reduce program expenditures for Medicare-Medicaid enrollees, but will also preserve or enhance the quality of care furnished to these individuals under the program. Reducing beneficiary cost sharing for prescription drugs has the potential for improving medication adherence for a particularly vulnerable population, and improved adherence has been linked to improved health outcomes and reduced overall health care expenditures, often through reduced inpatient hospital days and emergency department visits. By allowing Medicare-Medicaid Plans to further eliminate or reduce cost sharing for enrollees, CMS can evaluate the potential effects on overall health care utilization and expenditures.

Some States have expressed interest in allowing Medicare-Medicaid Plans this flexibility. For example, in both its request for proposal and memorandum of understanding (MOU) with CMS (see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf),

Massachusetts requires that prospective Medicare-Medicaid Plans assess the lesser of the LIS cost sharing amount or the Medicaid cost sharing amount applicable to that drug (which, in some cases – depending on the enrollee's LIS eligibility level – is lower than the statutory LIS cost sharing amount). Furthermore, Massachusetts has encouraged all plans to eliminate Part D cost-sharing entirely.

As specified in Appendix 4 of our MOU with Massachusetts, section 1860D-14(a)(1)(D) of the Social Security Act (the Act) and implementing regulations at 42 CFR Part 423, Subpart P, are waived under the demonstration, but only for purposes of waiving the implicit requirement that cost sharing for non-institutionalized individuals eligible for LIS be greater than $0. This waiver will permit Medicare-Medicaid Plans to reduce Part D cost sharing below the levels required under section 1860D-14(a)(1)(D)(ii) and (iii) of the Act. By waiving this requirement for positive LIS cost-sharing amounts, Medicare-Medicaid Plans will have the discretion to assess the LIS maximum amounts or some amount lower than that amount (e.g., either $0, or the Medicaid cost sharing amount, if less than the LIS cost sharing amount but greater than $0). We intend to offer this waiver to other States pursuing Capitated Financial Alignment Demonstrations.

Medicare-Medicaid Plans that choose to reduce cost sharing under this waiver will have the option to fund the difference between the statutory LIS cost sharing amount and the reduced cost sharing amount out of the Part D direct subsidy payment, similar to the way that some over-the-counter (OTC) drugs that are part of a step therapy protocol are currently funded from the administrative portion of the Part D direct subsidy payments to Part D sponsors. However, under this approach, Medicare-Medicaid Plans will not be required to forego the low-income cost sharing subsidy (LICS) that reimburses plans for the difference between the defined standard benefit's cost-sharing amount and the LIS statutory copayment amounts. This waiver will not further increase Federal costs, meaning that the LICS will not reimburse plans for the difference between the statutory LIS cost sharing amounts and the reduced cost sharing amounts.

We will allow prospective Medicare-Medicaid Plans in States that are implementing demonstrations in 2013 to modify their plan benefit packages (PBPs) one more time later this fall, after plan payment rate information for each State is made available. This final HPMS gate opening of the PBP will allow Medicare-Medicaid Plans to make modifications to their plan-covered supplemental benefit submissions, and plans can take advantage of this resubmission window to further reduce their prescription drug cost sharing levels consistent with the technical guidance in this memorandum.

Any questions on the contents of this memorandum should be directed to mmcocapsmodel@cms.hhs.gov.

Technical Guidance on Reporting Reduced Cost Sharing Amounts on Prescription Drug Events (PDEs)

Part D provides four mechanisms to pay plans for Part D basic benefits. The Prescription Drug Event (PDE) record is structured to report drug cost data to make these four payments. The four payment mechanisms are the direct subsidy, low income subsidy, reinsurance subsidy, and risk sharing. Part D payment is risk based, but also has some cost components. The current PDE file layout is available in the Appendix.

All PDEs are submitted to the Drug Data Processing System (DDPS), which has series of edits to ensure data quality and the appropriateness of the CMS reconciled payments to Part D plan sponsors. We have analyzed the editing code for DDPS and do not believe any modifications to the system's editing process are necessary at this time in order to accommodate submissions by Medicare-Medicaid Plans that wish to further reduce the LIS cost sharing amount to an amount less than the LIS statutory maximum.

Traditionally, there are 4 steps to calculating and reporting LICS on PDEs.[1] To that we add one additional step for Medicare-Medicaid Plans offering a cost sharing reduction beyond the LIS statutory cost sharing maximum.

Step 1: Calculate the non-LIS cost-sharing amount and the Covered D Plan Paid Amount (CPP) according to the benefit phase the beneficiary is in. Calculate both amounts as though the beneficiary were not eligible for LIS and had no other source of coverage. Cost-sharing and plan payment amounts often vary per benefit phase, so the plan must apply Year-To-Date (YTD) Gross Covered Drug Costs and incurred true out-of-pocket (TrOOP) costs to the plan's benefit structure to determine which benefit phase the beneficiary is in.

Step 2: Determine the LIS beneficiary's statutory maximum cost-sharing amount that corresponds to the category of assistance for which the beneficiary is eligible.

Step 3: Perform the "lesser of" test by comparing the amount of non-LIS cost-sharing to the amount of LIS statutory maximum cost-sharing. The lesser of these two amounts is the beneficiary liability, reported in the Patient Pay Amount field.

Note: In the "lesser of" test for a Category 4 beneficiary, the LIS cost-sharing includes either the statutory Category 4 deductible amount or, if less, the deductible under the PBP.[2]

Step 4: Using the LICS Amount formula, calculate the difference between the non LIS-beneficiary cost-sharing and the LIS beneficiary statutory maximum cost-sharing. This amount represents the amount of subsidy advanced by the plan at the point-of-sale (POS) and is reported

[1] Module 6 of the 2011 PDE Participant Guide (located at www.csscoperations.com → PDE →Training) describes in detail how LICS is to be reported on the PDE record.
[2] Note that we do not expect that Medicare-Medicaid Plans will include Category 4 individuals, meaning that this instruction will not be applicable to Medicare-Medicaid Plans.

as the LICS Amount on the PDE record. TrOOP increases by the amounts in the fields Patient Pay Amount and LICS Amount.

Step 5 (For Medicare-Medicaid Plans) If a Medicare-Medicaid Plan wishes to further reduce cost sharing for an LIS beneficiary beyond the LIS cost-sharing statutory maximum, this is done after CPP and LICS are calculated on the PDE. The Patient Pay Amount on the PDE becomes the reduced cost sharing amount. The difference between the original Patient Pay amount (calculated in Step 3) and the reduced amount is reported on the PDE as Non-Covered Plan Paid Amount (NPP).

Example:

In 2013, a Medicare-Medicaid Plan offers an Enhanced Alternative plan where the benefit parameters remain as in a defined standard plan and additional drugs are available beyond the Part D standard benefit. An LIS Level 1 beneficiary purchases a $100 brand covered drug while in the initial coverage phase (ICP). The Medicare-Medicaid Plan reduces the LIS beneficiary cost sharing to $1 for brand drugs.

Step 1: Since the beneficiary is in the ICP, the non-LIS cost sharing is calculated as $100 * .25 = $25. The Covered Plan Paid Amount (CPP) reported on the PDE is $100 * .75 = $75

Step 2: Because the beneficiary is LIS level 1, the maximum LIS cost sharing for a brand drug is $3.50 in 2013.

Step 3: The maximum LIS cost sharing of $3.50 is less than the non-LIS cost sharing of $75. The preliminary beneficiary liability is $3.50 (prior to further reduction by the Medicare-Medicaid Plan).

Step 4: The difference between the non-LIS cost sharing and LIS cost sharing is $25 - $3.50 = $21.50. Therefore, $21.50 is reported as LICS on the PDE record.

Step 5: Finally, the Medicare-Medicaid Plan reduces the beneficiary cost sharing to $1, which is an amount below the LIS cost sharing maximum for this beneficiary, for this drug. $1 is reported in the final PDE as the Patient Pay Amount. The difference between the original beneficiary liability calculated in Step 3 and the reduced patient pay amount offered by the Medicare-Medicaid Plan ($3.50 - $1 = $2.50) is reported on the PDE as NPP.

The final PDE is populated as follows:

Patient Pay	LICS	CPP	NPP
$1	$21.50	$75	$2.50

Patient Pay and LICS are TrOOP eligible costs and are added to the TrOOP Accumulator in preparation for adjudicating the next claim.

Appendix

PDE File Layout for 2012

FIELD NO.	FIELD NAME	NCPDP FIELD	POSITION	PICTURE	LENGTH	NCPDP, CMS OR PDFS DEFINED	DEFINITION / VALUES
1	RECORD ID		1 - 3	X(3)	3	PDFS	"DET"
2	SEQUENCE NO		4 - 10	9(7)	7	PDFS	Must start with 0000001
3	CLAIM CONTROL NUMBER		11 - 50	X(40)	40	CMS	Optional Field
4	HEALTH INSURANCE CLAIM NUMBER (HICN)		51 - 70	X(20)	20	CMS	Medicare Health Insurance Claim Number or Railroad Retirement Board (RRB) number.
5	CARDHOLDER ID	302-C2	71 - 90	X(20)	20	NCPDP	Plan identification of the enrollee. Assigned by plan.
6	PATIENT DATE OF BIRTH (DOB)	304-C4	91 - 98	9(8)	8	NCPDP	CCYYMMDD Optional Field
7	PATIENT GENDER CODE	305-C5	99 - 99	9(1)	1	NCPDP	1 = M 2 = F Unspecified or unknown values are not accepted
8	DATE OF SERVICE (DOS)	401-D1	100 - 107	9(8)	8	NCPDP	CCYYMMDD
9	PAID DATE		108 - 115	9(8)	8	CMS	CCYYMMDD. The date the plan paid the pharmacy for the prescription drug. Mandatory for Fallback plans. Optional for all other plans.
10	PRESCRIPTION SERVICE REFERENCE NO	402-D2	116 - 127	9(12)	12	NCPDP	The field length of 12 will be implemented in DDPS on January 1, 2011 in anticipation of the implementation of the NCPDP D.0 standard in 2012 . Field will be right justified and filled with 5 leading zeroes. Applies to all PDEs submitted January 1, 2011 and after.
11	FILLER		128 - 129	X(2)	2		SPACES

12	PRODUCT SERVICE ID	407-D7 or 489-TE	130 - 148	X(19)	19	NCPDP	Submit 11 digit NDC only. Fill the first 11 positions, no spaces or hyphens, followed by 8 spaces. Format is: MMMMMDDDDDPP. DDPS will reject the following billing codes for compounded legend and/or scheduled drugs: 99999999999, 99999999992, 99999999993, 99999999994, 99999999995, and 99999999996.
13	SERVICE PROVIDER ID QUALIFIER	202-B2	149 - 150	X(2)	2	NCPDP	The type of pharmacy provider identifier used in field 14. 01 = National Provider Identifier (NPI) 06 = UPIN 07 = NCPDP Provider ID 08 = State License 11 = Federal Tax Number 99 = Other (Reported Gap Discount must = 0) Mandatory for standard format. For standard format, valid values are 01 - NPI or 07 - NCPDP Provider ID. For non-standard format any of the above values are acceptable.
14	SERVICE PROVIDER ID	201-B1	151 - 165	X(15)	15	NCPDP	When Plans report Service Provider ID Qualifier = “99” - Other, populate Service Provider ID with the default value “PAPERCLAIM” defined for TrOOP Facilitation Contract. When Plans report

							Federal Tax Number (TIN), use the following format: ex: 999999999 (do not report embedded dashes).
15	FILL NUMBER	403-D3	166 - 167	9(2)	2	NCPDP	Values = 0 - 99.
16	DISPENSING STATUS	343-HD	168 - 168	X(1)	1	NCPDP	On PDEs with DOS on or after January 1, 2011, must be blank. On PDEs with DOS prior to January 1, 2011, valid values are: Blank = Not Specified P = Partial Fill C = Completion of Partial Fill
17	COMPOUND CODE	406-D6	169 - 169	9(1)	1	NCPDP	0=Not specified 1=Not a Compound 2=Compound
18	DISPENSE AS WRITTEN (DAW) PRODUCT SELECTION CODE	408-D8	170 - 170	X(1)	1	NCPDP	0=No Product Selection Indicated 1=Substitution Not Allowed by Prescriber 2=Substitution Allowed - Patient Requested Product Dispensed 3=Substitution Allowed - Pharmacist Selected Product Dispensed 4=Substitution Allowed - Generic Drug Not in Stock 5=Substitution Allowed - Brand Drug Dispensed as Generic 6=Override 7=Substitution Not Allowed - Brand Drug Mandated by Law 8=Substitution Allowed Generic Drug Not Available in Marketplace 9=Other
19	QUANTITY DISPENSED	442-E7	171 - 180	9(7)V999	10	NCPDP	Number of Units, Grams, Milliliters,

							other. If compounded item, total of all ingredients will be supplied as Quantity Dispensed.
20	FILLER		181 - 182	X(2)	2		SPACES
21	DAYS SUPPLY	405-D5	183 - 185	9(3)	3	NCPDP	0 – 999
22	PRESCRIBER ID QUALIFIER	466-EZ	186 - 187	X(2)	2	NCPDP	The type of prescriber identifier used in field 23. 01 = National Provider Identifier 06 = UPIN 08 = State License Number 12 = Drug Enforcement Administration (DEA) number Mandatory for standard format. Optional when Non-Standard Format Code = "B", "C", "P", or "X".
23	PRESCRIBER ID	411-DB	188 - 202	X(15)	15	NCPDP	Mandatory for standard format. Mandatory for non-standard format (Non-Standard Format Code = "B", "C", "P" or "X") when Prescriber ID Qualifier is present and valid, otherwise optional.
24	DRUG COVERAGE STATUS CODE		203 - 203	X(1)	1	CMS	Coverage status of the drug under Part D and/or the PBP. C = Covered E = Supplemental drugs (reported by Enhanced Alternative plans only) O = Over-the-counter drugs
25	ADJUSTMENT DELETION CODE		204 - 204	X(1)	1	CMS	A = Adjustment D = Deletion Blank = Original PDE

26	NON-STANDARD FORMAT CODE		205 - 205	X(1)	1	CMS	Format of claims originating in a non-standard format. B = Beneficiary submitted claim C = COB claim P = Paper claim from provider X = X12 837 Blank = NCPDP electronic format
27	PRICING EXCEPTION CODE		206 - 206	X(1)	1	CMS	M= Medicare as Secondary Payer O = Out-of-network pharmacy (Medicare is Primary) Blank = In-network pharmacy (Medicare is Primary)
28	CATASTROPHIC COVERAGE CODE		207 - 207	X(1)	1	CMS	Optional for PDEs with DOS January 1, 2011 and forward. Mandatory on PDEs with DOS prior to January 1, 2011. Valid values are: A = Attachment Point met on this event C = Above Attachment Point Blank = Attachment Point not met
29	INGREDIENT COST PAID	506-F6	208 - 215	S9(6)V99	8	NCPDP	Amount the pharmacy is paid for the drug itself. Dispensing fees or other costs are not included in this amount.
30	DISPENSING FEE PAID	507-F7	216 - 223	S9(6)V99	8	NCPDP	Amount the pharmacy is paid for dispensing the medication. The fee may be negotiated with pharmacies at the plan or PBM level. Additional fees may be charged for compounding/mixing multiple drugs. Do not include administrative fees. Vaccine Administration Fee

							reported in Field 41.
31	TOTAL AMOUNT ATTRIBUTED TO SALES TAX		224 - 231	S9(6)V99	8	CMS	Depending on jurisdiction, sales tax may be calculated in different ways or distributed in multiple NCPDP fields. Plans will report the total sales tax for the PDE regardless of how the tax is calculated or reported at point-of-sale.
32	GROSS DRUG COST BELOW OUT- OF-POCKET THRESHOLD (GDCB)		232 - 239	S9(6)V99	8	CMS	Reports covered drug cost at or below the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCA. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = blank, this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax +

							Vaccine Administration Fee falling at or below the OOP threshold. Any remaining portion is reported in GDCA. This amount increments the Total Gross Covered Drug Cost Accumulator amount.
33	GROSS DRUG COST ABOVE OUT-OF-POCKET THRESHOLD (GDCA)		240 - 247	S9(6)V99	8	CMS	Reports covered drug cost above the out of pocket threshold. Any remaining portion of covered drug cost is reported in GDCB. Covered drug cost is the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee. For DOS prior to January 1, 2011, when the Catastrophic Coverage Code = 'C', this field equals the sum of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine Administration Fee above the OOP threshold. When the Catastrophic Coverage Code = 'A', this field equals the portion of Ingredient Cost Paid + Dispensing Fee Paid + Total Amount Attributed to Sales Tax + Vaccine

							Administration Fee falling above the OOP threshold. Any remaining portion is reported in GDCB. This amount increments the Total Gross Covered Drug Cost Accumulator amount.
34	PATIENT PAY AMOUNT	505-F5	248 - 255	S9(6)V99	8	NCPDP	Payments made by the beneficiary or by family or friends at point of sale. This amount increments the True Out-of-Pocket Accumulator amount.
35	OTHER TROOP AMOUNT		256 - 263	S9(6)V99	8	CMS	Other health insurance payments by TrOOP-eligible other payers (e.g. SPAPs). This field records all third party payments that contribute to a beneficiary's TrOOP except LICS, Patient Pay Amount, and Reported Gap Discount. This amount increments the True Out-of-Pocket Accumulator amount.
36	LOW INCOME COST SHARING SUBSIDYAMOUNT (LICS)		264 - 271	S9(6)V99	8	CMS	Amount the plan advanced at point-of-sale due to a beneficiary's LIS status. This amount increments the True Out-of-Pocket Accumulator amount.

37	PATIENT LIABILITY REDUCTION DUE TO OTHER PAYER AMOUNT (PLRO)		272 - 279	S9(6)V99	8	CMS	Amounts by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Part D. Examples of non-TrOOP-eligible payers: group health plans, governmental programs (e.g. VA, TRICARE), Workers' Compensation, Auto/No-Fault/Liability Insurances.
38	COVERED D PLAN PAID AMOUNT (CPP)		280 - 287	S9(6)V99	8	CMS	The net Medicare covered amount which the plan has paid for a Part D covered drug under the Basic benefit. Amounts paid for supplemental drugs, supplemental cost-sharing and Over-the-Counter drugs are excluded from this field.
39	NON COVERED PLAN PAID AMOUNT (NPP)		288 - 295	S9(6)V99	8	CMS	The amount of plan payment for enhanced alternative benefits (cost sharing fill-in and/or non-Part D drugs). This dollar amount is excluded from risk corridor calculations.
40	ESTIMATED REBATE AT POS		296 - 303	S9(6)V99	8	CMS	The estimated amount of rebate that the plan sponsor has elected to apply to the negotiated price as a reduction in the drug price made available to the beneficiary at the point of sale. This estimate should reflect the rebate amount that the plan sponsor reasonably expects to receive from a pharmaceutical

							manufacturer or other entity.
41	VACCINE ADMINISTRATION FEE		304 - 311	S9(6)V99	8	CMS	The amount reported by a pharmacy, physician, or provider to cover the cost of administering a vaccine, excluding the ingredient cost and dispensing fee.
42	PRESCRIPTION ORIGIN CODE	419-DJ	312 - 312	X(1)	1	NCPDP	Required on PDEs with DOS January 1, 2010 and forward. Valid values are: "1" = Written "2" = Telephone "3" = Electronic "4" = Facsimile "5" = Pharmacy On PDEs with DOS prior to January 1, 2010, "0" = Not Specified and blank are also allowed.
43	DATE ORIGINAL CLAIM RECEIVED		313 - 320	9(8)	8	CMS	Date sponsor received original claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros. Required for all LI NET PDEs submitted January 1, 2011 and after, regardless of DOS.
44	CLAIM ADJUDICATION BEGAN TIMESTAMP		321 - 346	X(26)	26	CMS	Date and time sponsor began adjudicating the claim in Greenwich Mean Time. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.

45	TOTAL GROSS COVERED DRUG COST ACCUMULATOR		347 - 355	S9(7)V99	9	CMS	Sum of beneficiary's covered drug costs for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
46	TRUE OUT-OF-POCKET ACCUMULATOR		356 - 363	S9(6)V99	8	CMS	Sum of beneficiary's incurred costs (Patient Pay Amount, LICS, Other TrOOP Amount, Reported Gap Discount) for the benefit year known immediately prior to adjudicating the claim. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank or zeros.
47	BRAND/GENERIC CODE		364 - 364	X(1)	1	CMS	Plan reported value indicating whether the plan adjudicated the claim as a brand or generic drug. B – Brand G – Generic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.

48	BEGINNING BENEFIT PHASE		365 - 365	X(1)	1	CMS	Plan-defined benefit phase in effect immediately prior to the time the sponsor began adjudicating the individual claim being reported. D – Deductible N - Initial Coverage Period G - Coverage Gap C - Catastrophic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
49	ENDING BENEFIT PHASE		366 - 366	X(1)	1	CMS	Plan-defined benefit phase in effect upon the sponsor completing adjudication of the individual claim being reported. D – Deductible N - Initial Coverage Period G - Coverage Gap C – Catastrophic Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
50	REPORTED GAP DISCOUNT		367 - 374	S9(6)V99	8	CMS	The reported amount that sponsor advanced at point of sale for the Gap Discount for applicable drugs. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011 must be blank or zeros. This amount increments the True Out-of-Pocket Accumulator amount.

51	TIER		375 - 375	X(1)	1	CMS	Formulary tier in which the sponsor adjudicated the claim. Values = 1-6. Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
52	FORMULARY CODE		376 - 376	X(1)	1	CMS	Indicates if the drug is on the plan's formulary. F - Formulary N - Non-Formulary Required on PDEs with DOS January 1, 2011 and forward. On PDEs with DOS prior to January 1, 2011, must be blank. Applies to covered drugs only.
53	GAP DISCOUNT PLAN OVERRIDE CODE		377 - 377	X(1)	1	CMS	For future use - values TBD. Must be blank.
54	FILLER		378-512	X(135)	135	CMS	SPACES

Notes:

For any field that references NCPDP values, please refer to the appropriate NCPDP specification to ensure compliance.

All dollar fields are mandatory. If the field is not applicable, report a default value of zeroes. Since the field is a signed field, plans must utilize the appropriate overpunch signs as specified in the NCPDP Telecommunications Standard, Version 5.1.