IHE Pharmacy
Technical Framework Supplement

Pharmacy Prescription
(PRE)

Trial Implementation

Date: October 23, 2015
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Please verify you have the most recent version of this document. See here for Trial Implementation and Final Text versions and here for Public Comment versions.
Foreword

This is a supplement to the forthcoming IHE Pharmacy Technical Framework. Each supplement undergoes a process of public comment and trial implementation before being incorporated into the volumes of the Technical Frameworks.

This supplement is published on October 23, 2015 for trial implementation and may be available for testing at subsequent IHE Connectathons. The supplement may be amended based on the results of testing. Following successful testing it will be incorporated into the forthcoming Pharmacy Technical Framework. Comments are invited and may be submitted at http://www.ihe.net/Pharmacy_Public_Comments.

This supplement describes changes to the existing technical framework documents. “Boxed” instructions like the sample below indicate to the Volume Editor how to integrate the relevant section(s) into the relevant Technical Framework volume.

 Amend Section X.X by the following:

Where the amendment adds text, make the added text bold underline. Where the amendment removes text, make the removed text bold strikethrough. When entire new sections are added, introduce with editor’s instructions to “add new text” or similar, which for readability are not bolded or underlined.

General information about IHE can be found at: http://www.ihe.net.

Information about the IHE Pharmacy domain can be found at: http://www.ihe.net/IHE_Domains.

Information about the organization of IHE Technical Frameworks and Supplements and the process used to create them can be found at: http://www.ihe.net/IHE_Process and http://www.ihe.net/Profiles.

The current version of the IHE Pharmacy Technical Framework can be found at: http://www.ihe.net/Technical_Frameworks.
Introduction

The Pharmacy Prescription Document Profile (PRE) describes the content and format of a prescription document generated during the process in which a health care professional (in most cases, but not necessarily always, a medical specialist or a general practitioner) decides that the patient needs medication. A prescription is an entity that can be seen as an order to anyone entitled to dispense (prepare and hand out) medication to the patient.

Documents created according to this profile are intended to be used in the context of the “Community Prescription and Dispense” Integration Profile (CMPD). This supplement also references other documents\(^1\). The reader should have already read and understood these documents:

1. PHARM Common parts document
2. PHARM Community Prescription and Dispense Integration Profile (CMPD)
3. PCC Technical Framework Volume 1
4. PCC Technical Framework Volume 2
5. IT Infrastructure Technical Framework Volume 1
6. IT Infrastructure Technical Framework Volume 2
7. IT Infrastructure Technical Framework Volume 3
8. HL7® and other standards documents referenced in this document

Open Issues and Questions

- Prescription of non-medication products": shall they be covered by this Profile?
- Prescription Section Content Module: It is still in discussion, if it’s allowed to state the CCD® template as “parent”, or if we have to weaken it to “derived from”.

Closed Issues

- Substitution Handling: Evaluation if incorporating parts of the HL7® COCT_RM360000UV structure to provide a semantically better solution than now. -> The structure has been corrected in accordance with HL7® (see CP-PHARM-005_v2)

\(^1\) The first seven documents can be located on the IHE Website at http://ihe.net/Resources/Technical_Frameworks/. The remaining documents can be obtained from their respective publishers.
Volume 1 – Profiles

Add the following to Section 1.n

1.n Copyright Permissions

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Add the following to Section 2.5

2.5 Dependencies of the Pharmacy Integration Profiles

<table>
<thead>
<tr>
<th>Pharmacy Prescription (PRE)</th>
<th>PCC</th>
<th>Content definition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>This profile includes Section and Entry Content Modules of the Patient Care Coordination (PCC) domain.</td>
</tr>
</tbody>
</table>

Add the following to Section 2.7

2.7 History of Annual Changes

Add Section 3
3 Pharmacy Prescription Content Profile

The Pharmacy Prescription Document Profile (PRE) describes the content and format of a prescription document generated during the process in which a health care professional (in most cases, but not necessarily always, a medical specialist or a general practitioner) decides that the patient needs medication. A prescription is an entity that can be seen as an order to anyone entitled to dispense (prepare and hand out) medication to the patient.

Documents created according to this profile are intended to be used in the context of the “Community Prescription and Dispense” Integration Profile (CMPD).

3.1 Purpose and Scope

The Community Pharmacy Prescription and Dispense workflow starts with the creation of a prescription in case the health care professional decides that the patient needs medication.

A prescription document is issued by one ordering healthcare professional for one patient, in the context of zero or one administrative encounter (between the patient and the ordering physician and/or the healthcare institution). A prescription may contain one or more Prescription Items (lines on a paper prescription). Each line relates to one medication. A prescription is the outcome of a clinical decision.

This profile defines the content and format of such a prescription document.

For a detailed overview on the whole Pharmacy domain business processes, please refer to the “Common parts” document, which is accompanying this profile.
3.2 Process Flow

3.2.1 Use Case 1: Placing a prescription

During treatment of a patient, physicians or other allowed persons may have to prescribe drugs for the patient. The prescription shall contain one or more positions (Prescription Items) which contain the drug identified by a medication identifier, the dosing as well as other information necessary for correct dispensing and administering by the patient.

Usually the physician uses the prescribing module in the physician information system for preparing the prescription. After the prescription is completely assembled it shall be submitted to the Community Pharmacy Prescription and Dispense system to be validated and dispensed.

Refer to the Community Pharmacy Prescription and Dispense Integration Profile (CMPD) for detailed use case information.

3.3 Actors/Transactions

There are two actors in this profile, the Content Creator and the Content Consumer. Content is created by a Content Creator and is to be consumed by a Content Consumer. The sharing or transmission of content from one actor to the other is addressed by the appropriate use of IHE profiles described below, and is out of scope of this profile. A Document Source or a Portable Media Creator may embody the Content Creator. A Document Consumer, a Document Recipient or a Portable Media Importer may embody the Content Consumer. The sharing or transmission of content or updates from one actor to the other is addressed by the use of appropriate IHE profiles described in the section on Content Bindings with XDS, XDM and XDR in PCC TF-2:4.1.
3.4 Options

Options that may be selected for this content profile are listed in Table 3.4-1 along with the actors to which they apply. Dependencies between options when applicable are specified in notes.

<table>
<thead>
<tr>
<th>Actor</th>
<th>Option</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content Consumer</td>
<td>View Option (See Note 1)</td>
<td>PCC TF-2: 3.1.1</td>
</tr>
<tr>
<td></td>
<td>Document Import Option (See Note 1)</td>
<td>PCC TF-2: 3.1.2</td>
</tr>
<tr>
<td></td>
<td>Section Import Option (See Note 1)</td>
<td>PCC TF-2: 3.1.3</td>
</tr>
<tr>
<td></td>
<td>Discrete Data Import Option (See Note 1)</td>
<td>PCC TF-2: 3.1.4</td>
</tr>
<tr>
<td>Content Creator</td>
<td>No options defined</td>
<td></td>
</tr>
</tbody>
</table>

Note 1: The actor shall support at least one of these options.

3.5 Groupings

Content profiles may impose additional requirements on the transactions used when grouped with actors from other IHE Profiles.

3.5.1 Community Pharmacy Prescription and Dispense

Actors from the Pharmacy CMPD Profile embody the Content Creator and Content Consumer sharing function of this profile. A Content Creator or Content Consumer may be grouped with appropriate actors from the XDS, XDM or XDR Profiles to exchange the content described therein. The metadata sent in the document sharing or interchange messages has specific relationships or dependencies (which we call bindings) to the content of the clinical document described in the content profile.

The Patient Care Coordination Technical Framework defines the bindings to use when grouping the Content Creator of this profile with actors from the Pharmacy CMPD Integration Profiles.

3.6 Security Considerations

The PRE Integration Profile assumes that a minimum security and privacy environment has been established across all participants. There must exist security policies regarding the use of training, agreements, risk management, business continuity and network security that need to be already in place prior to the implementation of PRE.

The IHE ITI ATNA Integration Profile is required of the actors involved in the IHE transactions specified in this profile to protect node-to-node communication and to produce an audit trail of the PHI related actions when they exchange messages.

In addition, the IHE ITI DSG Integration Profiles can be applied to the actors involved in the transactions specified in this profile to securely identify individuals involved in transactions and verify document integrity and authorizations (DSG).
Interested parties should also read the detailed Security Considerations sections provided for each of the aforementioned profiles in the IHE ITI Technical Framework and its supplements. The PRE Profile does have a few security considerations of its own.

Pharmacy systems should be thoughtfully designed so that providers are able to review and verify information before it is imported into their Pharmacy system, and that positive user acknowledgements are made before import, and audit trails are recorded when imports occur.

Imported information should be traceable both to the source Pharmacy system, and the receiver that accepted it into the Pharmacy system. XDS Affinity domain policies should support policies and procedures for tracing information flows between Pharmacy systems.

Because the information being transferred is in XML, it will be common that different Pharmacy systems utilize different transformations to render the contents into human readable form. A Content Creator should make available the transforms used by the sending provider to review the documents, and a Content Consumer must support rendering the information as seen by the sending provider, allowing both providers to see what was sent in its original rendered form.

3.7 Content Modules

Content modules describe the content of a payload found in an IHE transaction. Content profiles are transaction neutral. They do not have dependencies upon the transaction that they appear in. These dependencies are reflected in the Bindings listed above.

All Pharmacy Prescriptions shall be structured and coded as required by the Pharmacy Prescription Document Content Module described in this profile. The inclusion of the specific coded attributes explicitly defined as optional, may be supported by specific implementations of Document Sources using an IHE identified coded terminology of their choice. The requirements and manner in which implementations support such capabilities is beyond the scope of this integration profile.
3.7.1 Structure of a Pharmacy Prescription Document

Pharmacy Prescription CDA Document
Pharmacy Prescription Content Module
(1.3.6.1.4.1.19376.1.9.1.1.1)

1..1

Prescription
Prescription Section Content Module
1.3.6.1.4.1.19376.1.9.1.2.1

1..n

Prescription Item
Prescription Item Entry Content Module
1.3.6.1.4.1.19376.1.9.1.3.2

:
Glossary

Add the following terms to the Glossary:

Dispense/Dispensation
Dispensation is the act of assigning a medication to a patient, normally as indicated in the corresponding prescription. Since prescriptions can span long periods of time, a single prescription may result in medicines dispensed several times.

Dispense Item
A Dispense Item belongs to one Dispensation and represents one dispensed medication. It contains the dispensed medicinal product including information such as product code, brand name and packaging information.

Dosage Instructions
Dosage Instructions are a set of data elements which together represent the dosage instructions to a medication such as duration of treatment, medication frequency, dose quantity and route of administration.

ICA
ICAs are Intolerances, Contra-indications and Allergies. An ICA may be considered as a relationship between a Patient and a Medicine. A detected problem in a Pharmaceutical Advice may refer to an ICA.

Medication Dispenser
In the domain of community pharmacy a Medication Dispenser is an abstract actor which dispenses prescribed medication to a patient (generally a healthcare professional, usually a pharmacist when the patient enters the pharmacy to get the prescribed medication).

Medication
A medication is part of a Prescription Item and defines the actual prescribed drug. It contains the brand or generic name of the drug, national and/or regional drug codes, unit strength, active ingredients and packaging information.

Medication Brand Name
The brand name is the name given to a medicine by the pharmaceutical company that makes it. This is also called the "proprietary name".

Medication Generic/Scientific Name
The generic or scientific name is the term given to the active ingredient in the medicine that is decided by an expert committee and is understood internationally. This is also called the "non-proprietary name". 
Pharmaceutical Adviser
A Pharmaceutical Adviser is an abstract actor which validates Prescription Items issued on a prescription (generally a healthcare professional, usually a pharmacist when the patient enters the pharmacy to get the prescribed medication).

Pharmaceutical Advice
A Pharmaceutical Advice document is the outcome of the validation or review of one Prescription- or Dispense Item. It contains the overall result of the validation or review which affects the further processing as well as additional information such as Intolerances, Contraindications and Allergies (ICAs) and all other information which was discovered during validation.

A Pharmaceutical Advice document is also used to manage Prescription- or Dispensation Items (e.g., change, cancel, etc.) as well as to document Medication Interaction Checking Issues and their resolutions.

Pharmaceutical Advice Item
A Pharmaceutical Advice Item belongs to one Pharmaceutical Advice and represents the validation outcome or management command regarding the referenced Prescription- or Dispense Item (e.g., change, cancel, etc.). It may also carry Medication Interaction Checking Issue information regarding the referenced item.

Pharmaceutical Advice Concern Item
A Pharmaceutical Advice Concern Item belongs to one Pharmaceutical Advice Item and represents the information to concerns (e.g., problems, allergies, etc.) which the Prescription- or Dispense Item referenced by the underlying Pharmaceutical Advice Item causes.

Pharmacy Medication list
A Pharmacy Medication list is a collection of Prescription- and Dispense items (and their related Pharmaceutical Advice Items) representing the Medication information of the patient at a certain point of time and according to business rules specified.

Prescriber
A prescriber is an abstract actor who issues a prescription to a patient (generally a healthcare professional, usually a physician during treatment of a patient).

Prescription
A prescription is issued by one ordering healthcare professional for one patient, in the context of zero or one administrative encounter (between the patient and the ordering physician and/or the healthcare institution).
**Prescription Item**

A Prescription Item belongs to one prescription and represents one prescribed medication. It may be associated with one or more observations. Prescription Item is the atomic entity for logistics, distribution and billing. It contains the prescribed medicine and dosage information as well as other information to the prescribed item such as patient- and fulfillment instructions and substitution handling.
Volume 3 – Content Modules

5.0 Namespaces and Vocabularies

<table>
<thead>
<tr>
<th>codeSystem</th>
<th>codeSystemName</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.6.1.4.1.19376.1.9</td>
<td>IHE Pharmacy Object Identifiers</td>
<td>This is the root OID for all IHE Pharmacy objects</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.4</td>
<td></td>
<td>Namespace OID used for IHE Extensions to CDA Release 2.0</td>
</tr>
</tbody>
</table>

See also the Namespaces and Vocabularies of the IHE PCC Technical Framework (PCC-TF2/Namespaces and Vocabularies).

5.1 IHE Format Codes

<table>
<thead>
<tr>
<th>Profile</th>
<th>Format Code</th>
<th>Media Type</th>
<th>Template ID</th>
</tr>
</thead>
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<tr>
<td>Pharmacy Prescription (PRE)</td>
<td>urn:ihe:pharm:pre:2010</td>
<td>text/xml</td>
<td>1.3.6.1.4.1.19376.1.9.1.1.1</td>
</tr>
</tbody>
</table>

6.0 Pharmacy Content Modules

6.3 HL7® Version 3.0 Content Modules

6.3.1 CDA® Document Content Modules

Add Section 6.3.1.1

6.3.1.1 Pharmacy Prescription Specification 1.3.6.1.4.1.19376.1.9.1.1.1

The Pharmacy Prescription specification includes a Prescription section to capture Prescription Items prescribed to a patient as well as supporting sections containing information related to this prescription (e.g., diagnosis, etc.).
### 6.3.1.1.1 Format Code

The XDSDocumentEntry format code for this content is `urn:ihe:pharm:pre:2010`.

### 6.3.1.1.2 Parent Template

This document is an instance of the `Medical Document` template.

### 6.3.1.1.3 Standards

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HL7V3 NE2009</td>
<td>HL7 V3 2009 Normative Edition</td>
</tr>
<tr>
<td>CDAR2</td>
<td>HL7 CDA Release 2.0</td>
</tr>
<tr>
<td>CCD</td>
<td>ASTM/HL7 Continuity of Care Document</td>
</tr>
<tr>
<td>XMLXSL</td>
<td>Associating Style Sheets with XML documents</td>
</tr>
</tbody>
</table>

### 6.3.1.1.4 Data Element Index

<table>
<thead>
<tr>
<th>Data Elements</th>
<th>CDA Release 2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Information</td>
<td>recordTarget/patientRole</td>
</tr>
<tr>
<td>Patient Administrative Identifiers</td>
<td>recordTarget/patientRole/id</td>
</tr>
<tr>
<td>Patient Name</td>
<td>recordTarget/patientRole/patient/name</td>
</tr>
<tr>
<td>Patient Gender</td>
<td>recordTarget/patientRole/patient/administrativeGenderCode</td>
</tr>
<tr>
<td>Patient Birth Date</td>
<td>recordTarget/patientRole/patient/birthTime</td>
</tr>
<tr>
<td>Patient Address</td>
<td>recordTarget/patientRole/addr</td>
</tr>
<tr>
<td>Patient Telecom</td>
<td>recordTarget/patientRole/telecom</td>
</tr>
<tr>
<td>HCP Person Information</td>
<td>author</td>
</tr>
<tr>
<td>HCP ID(s)</td>
<td>author/assignedAuthor/id</td>
</tr>
<tr>
<td>HCP Profession</td>
<td>author/functionCode</td>
</tr>
<tr>
<td>HCP Name</td>
<td>author/assignedAuthor/assignedPerson/name</td>
</tr>
<tr>
<td>HCP Telecom</td>
<td>author/assignedAuthor/telecom</td>
</tr>
<tr>
<td>HCP Specialty</td>
<td>author/assignedAuthor/code</td>
</tr>
<tr>
<td>HCP Represented Organization</td>
<td>author/assignedAuthor/representedOrganization</td>
</tr>
<tr>
<td>HCP Organization Name</td>
<td>author/assignedAuthor/representedOrganization/name</td>
</tr>
<tr>
<td>HCP Organization Address</td>
<td>author/assignedAuthor/representedOrganization/addr</td>
</tr>
<tr>
<td>HCP Organization Telecom</td>
<td>author/assignedAuthor/representedOrganization/telecom</td>
</tr>
<tr>
<td>Data Elements</td>
<td>CDA Release 2.0</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Service Event</td>
<td>documentationOf/serviceEvent</td>
</tr>
<tr>
<td>Date of Service Event</td>
<td>documentationOf/serviceEvent/effectiveTime</td>
</tr>
<tr>
<td>Service Event Code</td>
<td>documentationOf/serviceEvent/code</td>
</tr>
<tr>
<td><strong>Encounter in the healthcare institution</strong></td>
<td>componentOf/encompassingEncounter</td>
</tr>
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<td>ID of the encounter</td>
<td>componentOf/encompassingEncounter/id</td>
</tr>
<tr>
<td>Date of Admission/Encounter start date</td>
<td>componentOf/encompassingEncounter/effectiveTime/low</td>
</tr>
<tr>
<td>Date of Discharge/Encounter end date</td>
<td>componentOf/encompassingEncounter/effectiveTime/high</td>
</tr>
<tr>
<td>Authorization</td>
<td>authorization/consent</td>
</tr>
<tr>
<td>Patient contacts</td>
<td>guardian</td>
</tr>
<tr>
<td>Payers</td>
<td>PAYMENT SOURCES</td>
</tr>
<tr>
<td>General Medical Information</td>
<td>VITAL SIGNS</td>
</tr>
<tr>
<td>Height, Weight</td>
<td></td>
</tr>
<tr>
<td>Allergies and Drug Sensitivities</td>
<td>ALLERGIES, ADVERSE REACTIONS, ALERTS</td>
</tr>
<tr>
<td>Active Problems</td>
<td>PROBLEM LIST</td>
</tr>
<tr>
<td>Resolved Problems</td>
<td>HISTORY OF PAST ILLNESS</td>
</tr>
<tr>
<td>Immunizations</td>
<td>HISTORY OF IMMUNIZATIONS</td>
</tr>
<tr>
<td>Pregnancy History</td>
<td>HISTORY OF PREGNANCIES</td>
</tr>
<tr>
<td>Prescription</td>
<td>PRESCRIPTIONS</td>
</tr>
</tbody>
</table>

**6.3.1.1.5 Data Element Specification**

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<th>Template ID</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>R</td>
<td>1.3.6.1.4.1.19376.1.5.3.1.1.1</td>
</tr>
<tr>
<td>Personal Identification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HCP Person Information</strong></td>
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</tr>
<tr>
<td>Name</td>
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<td>HCP Identification</td>
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<td><strong>HCP Organization Information</strong></td>
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<td>Address</td>
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<td>Organization Identifier</td>
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</tr>
<tr>
<td>Contact Information</td>
<td></td>
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</tr>
</tbody>
</table>

2 Service Event is optional and may contain service event information of the medical event in which context the prescription has been taken.

3 Encounter is optional and shall contain encounter information if applicable.
<table>
<thead>
<tr>
<th>Data Element Name</th>
<th>Opt</th>
<th>Template ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Information</td>
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<td></td>
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<tr>
<td>Address</td>
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<tr>
<td>Contact Information</td>
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<tr>
<td>HCP Person Information</td>
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<td>Profession</td>
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<tr>
<td>Patient Information</td>
<td>O</td>
<td>1.3.6.1.4.1.19376.1.5.3.1.1.1</td>
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<tr>
<td>Marital Status</td>
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<td>Race</td>
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<td>Contact Information</td>
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<td>Allergies and Other Adverse Reactions</td>
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<td>History of Past Illness</td>
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<td>Pregnancy History</td>
<td>O</td>
<td>1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4</td>
</tr>
<tr>
<td>Prescription</td>
<td>R</td>
<td>1.3.6.1.4.1.19376.1.9.1.2.1</td>
</tr>
</tbody>
</table>

Additional explanation:

The sections “Coded Vital Signs”, “Allergies and Drug Sensitivities”, “Active Problems”, “Resolved Problems”, “Immunizations”, “Pregnancy History” are considered as sections containing medical information of the patient.

Although real-world projects may require some of these information, no stricter constraints as optional (O) could been applied to these sections in the profile due to the large degree of diversity in business requirements and privacy issues among different current.

4 In case the patient is governed by a guardian, this element is R and shall contain the information about the guardian

5 The Coded Vital Signs section should contain at least the height and weight of the patient.

6 In case the patient is currently pregnant, this element is R and shall contain information about the current pregnancy. It shall not be used to document past pregnancies.
6.3.1.1.6 Conformance

CDA® Release 2.0 documents that conform to the requirements of this content module shall indicate their conformance by the inclusion of the appropriate <templateId> elements in the header of the document. This is shown in the sample document below. A CDA® Document may conform to more than one template. This content module inherits from the Medical Summary content module, and so must conform to the requirements of that template as well, thus all <templateId> elements shown in the example below shall be included.

```
<ClinicalDocument xmlns='urn:hl7-org:v3'>
  <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.1'/>
  <templateId root='1.3.6.1.4.1.19376.1.9.1.1.1'/>
  <id root=' ' extension=' '/>
  <code code='57833-6' displayName='Prescription for medication'
    codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
  <title>Pharmacy Prescription</title>
  <effectiveTime value='20100719012005'/>
  <confidentialityCode code='N' displayName='Normal'
    codeSystem='2.16.840.1.113883.5.25' codeSystemName='Confidentiality' />
  <languageCode code='en-US'/>
  :<component>
    <structuredBody>
      :
    </structuredBody>
  </component>
</ClinicalDocument>
```

6.3.2 CDA® Header Content Modules

6.3.3 CDA® Section Content Modules

Add Section 6.3.3.1

6.3.3.1 Prescription Section Content Module (1.3.6.1.4.1.19376.1.9.1.2.1)

<table>
<thead>
<tr>
<th>Template ID</th>
<th>1.3.6.1.4.1.19376.1.9.1.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Template</td>
<td>CCD 3.9 (2.16.840.1.113883.10.20.1.8)</td>
</tr>
<tr>
<td></td>
<td>1.3.6.1.4.1.19376.1.5.3.1.3.19</td>
</tr>
<tr>
<td>General Description</td>
<td>The Prescription Section contains a description of the medications in a given prescription for the patient. It includes entries for Prescription Items as described in the Prescription Item Entry Content Module.</td>
</tr>
<tr>
<td>LOINC Code</td>
<td>Opt</td>
</tr>
<tr>
<td>Description</td>
<td>Description</td>
</tr>
<tr>
<td>57828-6</td>
<td>R</td>
</tr>
<tr>
<td>Entries</td>
<td>Opt</td>
</tr>
<tr>
<td>Description</td>
<td>Description</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.9.1.3.2</td>
<td>R</td>
</tr>
</tbody>
</table>
6.3.3.1.1 Parent Templates

The parents of this template are CCD® 3.9 and PCC 1.3.6.1.4.1.19376.1.5.3.1.3.19 except the requirement CCD-CONF-301 ("The value for 'section/code' SHALL be "10160-0" "History of medication use").

6.3.3.1.2 Prescription ID

A Prescription identifier SHALL be represented in the section <id> Element. The data type of the ID is II. Although HL7® allows for multiple identifiers, one and only one shall be used.

If this section is used in a Prescription document, this identifier shall be set equal to the document ID (ClinicalDocument/id).

6.3.3.1.3 Prescriber

<author>...</author>
In the case where the prescriber or the timestamp of a prescription is different from the author and timestamp of the prescription-document, the prescriber and timestamp of the prescription shall be represented by the `<author>` element of the section.

<table>
<thead>
<tr>
<th>Data element</th>
<th>HL7 V3 Data Type</th>
<th>CDA Body position (relative XPath expression)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber Profession</td>
<td>CE</td>
<td><code>author/functionCode</code></td>
</tr>
<tr>
<td>Timestamp of prescribing</td>
<td>TS</td>
<td><code>author/time</code></td>
</tr>
<tr>
<td>Prescriber ID</td>
<td>II</td>
<td><code>author/assignedAuthor/id</code></td>
</tr>
<tr>
<td>Prescriber Specialty</td>
<td>CE</td>
<td><code>author/assignedAuthor/code</code></td>
</tr>
<tr>
<td>Prescriber Name</td>
<td>PN</td>
<td><code>author/assignedAuthor/assignedPerson/name</code></td>
</tr>
<tr>
<td>Prescriber Organization Identifier</td>
<td>II</td>
<td><code>author/assignedAuthor/representedOrganization/id</code></td>
</tr>
<tr>
<td>Prescriber Organization Name</td>
<td>ON</td>
<td><code>author/assignedAuthor/representedOrganization/name</code></td>
</tr>
<tr>
<td>Prescriber Organization Address</td>
<td>AD</td>
<td><code>author/assignedAuthor/representedOrganization/addr</code></td>
</tr>
</tbody>
</table>

### 6.3.4 CDA® Entry Content Modules

**Add Section 6.3.4.1**

**6.3.4.1 Medicine Entry Content Module (1.3.6.1.4.1.19376.1.9.1.3.1)**

A Medicine entry describes a medicine and is used within Prescription- or Dispensation Items. It describes either a medicinal product, a generic/scientific name or a magistral preparation/compound medicine and contains information such as name, medication form, packaging information and active ingredients.

This entry uses the structure of the HL7® V3 R_Medication Universal Common Message Element (CMET), Release 2.

This structure is part of the HL7® V3 2009 Normative Edition (COCT_RM230100UV). The incorporation of this structure is done according to section 1.4 CDA Extensibility of the HL7® CDA® standard. Such an extension of the base CDA® standard is an accepted practice in IHE (e.g., in the XD* Lab specification).

For the purposes of IHE Pharmacy this extension is necessary to satisfy the requirements for Prescription, Pharmaceutical Advice and Dispense data elements to represent required information which is not supported by the base CDA® standard, such as packaging information, generic equivalent and ingredients.
The rules of section 1.4 CDA Extensibility require the designation of a new XML namespace for the XML elements in this structure. For the purposes of documentation, the namespace urn:ihe:pharm:medication shall be used.

The following specification and constraints are applied to the structures of the CMET.

6.3.4.1.1 Standards
This part describes the general structure for a Prescription Item. It is based on the following standards:

| HL7V3 NE2009 | HL7 V3 2009 Normative Edition |

6.3.4.1.2 Parent Template
This entry content module has no parent structure.
6.3.4.1.3 Specification

```xml
<manufacturedProduct xmlns:pharm="urn:ihe:pharm:medication" classCode="MANU">
  <templateId root="1.3.6.1.4.1.19376.1.5.3.1.4.7.2"/>
  <templateId root="2.16.840.1.113883.10.20.1.53"/>
  <manufacturedMaterial classCode="MMAT" determinerCode="KIND">
    <!-- National medicinal product code (brand-level) -->
    <code code=" " displayName=" " codeSystem=" " codeSystemName=" ">
    <!-- Brand name -->
    <name>...</name>
    <!-- Pharmaceutical dose form -->
    <pharm:formCode code=" " displayName=" " codeSystem=" " codeSystemName=" ">
      <lotNumberText>...</lotNumberText>
      <pharm:expirationTime value=' ' />
    </pharm:formCode>
    <!-- Container information -->
    <pharm:asContent classCode="CONT">
      <pharm:containerPackagedMedicine classCode="CONT" determinerCode="INSTANCE">
        <!-- Medicinal product code (package-level) -->
        <pharm:code code=" " displayName=" " codeSystem=" " codeSystemName=" ">
        <!-- Brand name (package) -->
        <pharm:name>...</pharm:name>
        <pharm:formCode code=" " displayName=" " codeSystem=" " codeSystemName=" ">
          <pharm:capacityQuantity value=' ' unit=' '/>
        </pharm:formCode>
        <pharm:asSuperContent>
          <pharm:containerPackagedMedicine classCode='CONT'
            determinerCode='INSTANCE'>
            <pharm:capacityQuantity value=' ' unit=' '/>
          </pharm:containerPackagedMedicine>
        </pharm:asSuperContent>
      </pharm:containerPackagedMedicine>
    </pharm:asContent>
    <!-- These are optional generic equivalents -->
    <pharm:asSpecializedKind classCode="GRIC">
      <pharm:generalizedMedicineClass classCode="MMAT">
        <pharm:code code=" " displayName="Generic Equivalent" codeSystem=" " codeSystemName=" ">
        </pharm:generalizedMedicineClass>
      </pharm:asSpecializedKind>
    </pharm:asSpecializedKind>
    <!-- This is the list of active ingredients -->
    <pharm:ingredient classCode="ACTI">
      <!-- strength of ingredient -->
      <pharm:quantity>
        <numerator xsi:type="PQ" value=' ' unit=' '/>
        <denominator xsi:type="PQ" value=' ' unit=' '/>
      </pharm:quantity>
    </pharm:ingredient>
  </manufacturedMaterial>
</manufacturedProduct>
```
6.3.4.1.3.1 Medicine Entry General Specification

<manufacturedProduct xmlns:pharm="urn:ihe:pharm:medication"
   classCode="MANU">
  <templateId root="1.3.6.1.4.1.19376.1.5.3.1.4.7.2"/>
  <templateId root="2.16.840.1.113883.10.20.1.53"/>
  <manufacturedMaterial classCode="MMAT" determinerCode="KIND">
    ...
  </manufacturedMaterial>
</manufacturedProduct>

The <manufacturedProduct> element of the Medicine Entry SHALL contain a XML namespace “pharm” having the value “urn:ihe:pharm:medication”.
See PCC TF2, Product Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7.2) specification.

6.3.4.1.3.2 Medicine Entry Template ID

<templateId root='1.3.6.1.4.1.19376.1.9.1.3.1'/>

The Template ID for a Medicine Entry SHALL be provided.

6.3.4.1.3.3 Code

<code code='' displayName='' codeSystem='' codeSystemName=''>
  <originalText>
    <reference value=''/>
  </originalText>
</code>

The <code> element of the <manufacturedMaterial> element SHALL be present and describes the code of the medication.

The medication may be either

- a brand/product or
- described as a generic/scientific name or
- a descriptor of a magistral preparation/compound medicine
The <originalText> shall contain a <reference> whose URI value points to the name and strength of the medication, or just the name alone if strength is not relevant.

If the medicine is uncoded (e.g., magistral preparations, compound medicine, …) nullFlavor="NA" SHALL be used.

**6.3.4.1.3.4 Name**

```
<name>...</name>
```

The element SHALL contain the name of the medication (e.g., "Adol 500mg Caplet"). The medication may be either

- a brand/product or
- described as a generic/scientific name or
- a descriptor of a magistral preparation/compound medicine

If the medicine has no brand name (e.g., magistral preparations, compound medicine, …) nullFlavor="NA" SHALL be used.

**6.3.4.1.3.5 Form Code**

```
<pharm:formCode code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>
```

This code represents the pharmaceutical dose form (e.g., tablet, capsule, liquid) and SHOULD be present, if not implied by the product. It MAY be present if implied by the product. The value of this code affects the units used in the substance administration quantity element.

**6.3.4.1.3.6 Lot Number**

```
<lotNumberText>...</lotNumberText>
```

The <lotNumberText> element MAY be present and is a string representation of a lot number of this specific instance of the product.

The provided lot number SHALL refer to the primary packaged item described in the Packaging element.

**6.3.4.1.3.7 Expiration Date**

```
<pharm:expirationTime value=' '/>
```

The <pharm:expirationTime> element MAY be present and SHALL contain a value attribute containing the date (e.g., specific date, specific date including time) of expiration of this specific instance of the product.

The value given in the <pharm:expirationTime> element SHALL refer to the primary packaged item described in the Medicine Packaging element.
6.3.4.1.3.8 Packaging

This structure describes the packaging of the medication and MAY be present. It represents the primary description of the packaging of the medicine (e.g., the medicine is packaged in ampoules of 50ml volume each) and may include additional packaging information of how many of the primary packaged items are within an outer package (e.g., 5 ampoules are packaged in a box).

The primary description of the package SHOULD be consistent with the given pharmaceutical dose form (<pharm:formCode> of the medication, see chapter “Medication Form Code”). Example: a consistent pharmaceutical dose form to the package form “Ampoules” would be e.g., “Solution for injection”.

In case the package describes a product, the <pharm:code> element provides the code for the product and SHOULD be present.

In case the package describes a product, and the package has a brand name, it SHOULD be described in the <pharm:name> element (e.g., Xylocaine 1% with Adrenaline Inj, 5 injections package).

The <pharm:formCode> element represents the form of the package (e.g., tablet container, bottle, ...) and SHOULD be present, if not implied by the product. It MAY be present if implied by the product. It SHALL be present if the <asSuperContent> element is present.

The <pharm:capacityQuantity> element SHALL be present and describes the capacity of the packaging.

If the capacityQuantity is given in countable units, the unit attribute SHALL NOT be present. If the capacityQuantity is given in non-countable units, the unit attribute SHALL be present and the value SHALL be out of the UCUM code system.
A `<pharm:asSuperContent>` element MAY be present to represent the quantity of the given primary packaged item (e.g., ampoule of 50ml) within an outer package (e.g., 5 ampoules in a box). It SHALL contain a `<pharm:containerPackagedMedicine>` element which SHALL contain a `<pharm:capacityQuantity>` element describing the quantity of the given primary packaged item present in the outer package. If the capacityQuantity is given in countable units, the unit attribute SHALL NOT be present. If the capacityQuantity is given in non-countable units, the unit attribute SHALL be present and the value SHALL be out of the UCUM code system.

**Examples:**

For example, to represent a medicinal product with pharmaceutical dose form "Tablets", available as a “Tablet container” with 30 tablets the `<asContent>` data elements would be set to:

```xml
<pharm:asContent classCode='CONT'>
  <pharm:containerPackagedMedicine classCode='CONT' determinerCode='INSTANCE'>
    <pharm:formCode code=' ' displayName='Tablet container' codeSystem=' '/>
    <pharm:capacityQuantity value='30'/> <!-- 30 tablets in the package -->
  </pharm:containerPackagedMedicine>
</pharm:asContent>
```

For example, to represent a medicinal product with pharmaceutical dose form "Solution for injection", available as “Ampoules” with 50ml volume, packaged as 5 ampoules per box, the `<asContent>` data elements would be set to:

```xml
<pharm:asContent classCode='CONT'>
  <pharm:containerPackagedMedicine classCode='CONT' determinerCode='INSTANCE'>
    <pharm:formCode code=' ' displayName='Ampoules' codeSystem=' '/>
    <pharm:capacityQuantity value='50' unit='ml'/> <!-- 50ml per ampoule -->
    <pharm:asSuperContent>
      <pharm:containerPackagedMedicine classCode='CONT' determinerCode='INSTANCE'>
        <pharm:capacityQuantity value='5'/> <!-- 5 ampoules in a box -->
      </pharm:containerPackagedMedicine>
    </pharm:asSuperContent>
  </pharm:containerPackagedMedicine>
</pharm:asContent>
```

Note: The “Ampoule” can be seen as a container representing a volume and as the “unit of use”/“unit of presentation”. In this example it only represents container packaging.
6.3.4.1.3.9 Generic Equivalent

The classCode of "GRIC" identifies this structure as the representation of a generic equivalent of the medication described in the current Medicine entry.

One or more elements MAY be present.

The <pharm:code> element contains the coded representation of the generic medicine, and the <pharm:name> element may be used for the plain text representation.

6.3.4.1.3.10 Active Ingredient List

One or more active ingredients SHOULD be represented with this structure. The classCode of "ACTI" indicates that this is an active ingredient.

The <pharm:code> element SHOULD be present and contains the coded representation of the active ingredient. The <pharm:name> element SHALL be present and is used for the plain text representation. The WHO ATC terminology SHOULD be used to code the active ingredients, where applicable.

The medication strength is represented as the ratio of the active ingredient(s) to a unit of medication. The <pharm:quantity> element SHOULD be present and represents the strength of the active ingredient(s) as the ratio of the active ingredient(s) to a unit of medication. The <pharm:quantity> element contains the numerator and denominator of the strength ratio.

The following example shows the strength of 10 mg of the ingredient per ml of the medication:
The following examples show the strength of the ingredient in 1 unit of the given medication.

2% of the ingredient (e.g., XYLOPHIL 2% GEL):

```
<pharm:quantity>
  <numerator xsi:type="PQ" value="2" unit="%"/>
  <denominator xsi:type="PQ" value="1"/>
</pharm:quantity>
```

5mg of the ingredient (e.g., XYZAL 5MG F.C.TABLET):

```
<pharm:quantity>
  <numerator xsi:type="PQ" value="5" unit="mg"/>
  <denominator xsi:type="PQ" value="1"/>
</pharm:quantity>
```

Add Section 6.3.4.2

### 6.3.4.2 Prescription Item Entry Content Module (1.3.6.1.4.1.19376.1.9.1.3.2)

A Prescription Item belongs to one prescription and represents one prescribed medication. It may be associated with one or more observations. Prescription Item is the atomic entity for logistics, distribution and billing. It contains the prescribed medicine and dosage information as well as other information to the prescribed item such as patient- and fulfillment instructions and substitution handling.

#### 6.3.4.2.1 Standards

This part describes the general structure for a Prescription Item. It is based on the following standards:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HL7V3 NE2009</td>
<td>HL7 V3 2009 Normative Edition</td>
</tr>
<tr>
<td>CCD</td>
<td>ASTM/HL7 Continuity of Care Document</td>
</tr>
<tr>
<td>IHE PCC</td>
<td>Medications Entry (1.3.6.1.4.1.19376.1.5.3.1.4.7)</td>
</tr>
</tbody>
</table>

#### 6.3.4.2.2 Parent Template

This entry content module is based on the HL7® CCD® template medication activity 2.16.840.1.113883.10.20.1.24 and inherits the structure of the Medication Entry Content Module, 1.3.6.1.4.1.19376.1.5.3.1.4.7.
6.3.4.2.3 Specification

This section makes use of the medicine and instruction entry content modules.

This specification relies on the PCC Medication Entry Content Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification and only describes additional constraints.

The chapters below identify and describe these fields, and indicate the constraints on whether or not they are required to be sent. The fields are listed in the order that they appear in the CDA® XML content.
<templateId root='2.16.840.1.113883.10.20.1.24'/>
<templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7'/>
<templateId root='1.3.6.1.4.1.19376.1.9.1.3.2'/>
<templateId root='1.3.6.1.4.1.19376.1.9.1.3.6'/>
<id root=' ' extension=' '/>
<code code=' ' codeSystem=' ' displayName=' ' codeSystemName=' '/>
<text><reference value='#med-1'/></text>
<statusCode code='completed'/>
<effectiveTime xsi:type='IVL_TS'>
<low value=' '/>
<high value=' '/>
</effectiveTime>
<repeatNumber value=' '/>
<routeCode code=' ' codeSystem=' ' displayName=' ' codeSystemName=' '/>
<approachSiteCode code=' ' codeSystem=' ' displayName=' ' codeSystemName=' '/>
<doseQuantity value=' ' unit=' '/>
<rateQuantity value=' ' unit=' '/>
<consumable>
</consumable>
<!-- Medicine Entry Module (1.3.6.1.4.1.19376.1.9.1.3.1) -->

<!-- Author of the prescription in case of usage elsewhere as in a PRE document -->

<!-- 0..* entries describing the components -->

<!-- An optional entry relationship that indicates the reason for use -->

<!-- Reference to a related prescription activity (supply) -->

<!-- Optional instructions for the patient -->

<!-- Optional instructions for Pharmacist -->

...
6.3.4.2.3.1 Prescription Item Entry General Specification

<substanceAdministration classCode='SBADM' moodCode='INT'>

</substanceAdministration>

The moodCode SHALL be set to INT.

See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification.

6.3.4.2.3.2 Prescription Item Entry TemplateID

<templateId root='2.16.840.1.113883.10.20.1.24'/> <!-- CCD -->
<templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7'/> <!-- PCC -->
<templateId root='1.3.6.1.4.1.19376.1.9.1.3.2'/> <!-- PHARM -->

A templateId of '1.3.6.1.4.1.19376.1.9.1.3.2' SHALL be present to indicate that this entry is conforming to the Prescription Item Entry Content Module.

See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification.

6.3.4.2.3.3 Prescription Item Entry Additional Template ID

<templateId root=' '/>

The <templateId> element identifies this <entry> as a particular type of medication event, allowing for validation of the content.

The templateId must use one of the values in the table below for the root attribute.
<table>
<thead>
<tr>
<th>Root</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.7.1</td>
<td>A &quot;normal&quot; &lt;substanceAdministration&gt; act that may not contain any subordinate &lt;substanceAdministration&gt; acts.</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.8</td>
<td>A &lt;substanceAdministration&gt; act that records tapered dose information in subordinate &lt;substanceAdministration&gt; acts.</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.9</td>
<td>A &lt;substanceAdministration&gt; act that records split dose information in subordinate &lt;substanceAdministration&gt; acts.</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.10</td>
<td>A &lt;substanceAdministration&gt; act that records conditional dose information in subordinate &lt;substanceAdministration&gt; acts.</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.11</td>
<td>A &lt;substanceAdministration&gt; act that records combination medication component information in subordinate &lt;substanceAdministration&gt; acts.</td>
</tr>
</tbody>
</table>

See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification.

6.3.4.2.3.4 Prescription Item ID

```
<id root=' ' extension=' '/>
```

This ID represents the Prescription Item ID and SHALL be present.

See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification.

6.3.4.2.3.5 Code

```
<code code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>
```

See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification.

6.3.4.2.3.6 Narrative Text

```
<text><reference value=' '/></text>
```

This element SHALL be present. The URI given in the value attribute of the <reference> element points to an element in the narrative content that contains the complete text describing the medication prescribed.

See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification.

6.3.4.2.3.7 Status Code

```
<statusCode code='completed'/>
```

See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification.

Please note that this element does NOT represent the status of the Prescription Item (e.g., still open, already dispensed, etc.). There is no dedicated data element to record such a status, please refer to the Community Medication Prescription and Dispense (CMPD) Profile for more information.
6.3.4.2.3.8 Dosage Instructions

The Prescription Item SHALL contain dosage instructions according to the specification of the dosage instructions in the Dosage Instructions Content Module (1.3.6.1.4.1.19376.1.9.1.3.6).

Note: The following elements part of the Dosage Instructions:

- Prescription Item Entry Additional Template ID
- Effective Time (Duration of Treatment)
- Medication Frequency
- Route of Administration
- Approach Site Code
- Dose Quantity
- Rate Quantity
- Related Components

6.3.4.2.3.9 Number of repeats/refills

The `<repeatNumber value='' />` element SHALL be present, and SHALL contain the number of allowed repeats/refills of the Prescription Item.

If the `<repeatNumber>` element has a value of zero no repeat/refill is allowed (single dispense). The total number of dispenses will be thus equal to the repeat number plus one.

6.3.4.2.3.10 Consumable

The `<consumable>` element SHALL be present, and shall contain a medication entry, conforming to the Medicine Entry template (1.3.6.1.4.1.19376.1.9.1.3.1).

See PHARM-TF3, Medicine Entry Module (1.3.6.1.4.1.19376.1.9.1.3.1) specification.

6.3.4.2.3.11 Prescriber

In the case that the Prescription Item is used within a Prescription document according to the “Pharmacy Prescription” (PRE) Profile this element SHALL NOT be present.
In all other cases (e.g., when used in a “Pharmacy Medication List” document according to the PML Profile or in medication sections of other documents as for example Discharge Summaries, etc.) this element SHOULD be present and represent the prescriber of the Prescription Item. It SHALL contain the author and the timestamp of the Prescription document in which the Prescription Item was described (or, if given, the author of the Prescription section within the Prescription document).

<table>
<thead>
<tr>
<th>Data element</th>
<th>HL7 V3 Data Type</th>
<th>CDA Body position (relative XPath expression)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber Profession</td>
<td>CE</td>
<td>author/functionCode</td>
</tr>
<tr>
<td>Timestamp of prescribing</td>
<td>TS</td>
<td>author/time</td>
</tr>
<tr>
<td>Prescriber ID</td>
<td>II</td>
<td>author/assignedAuthor/id</td>
</tr>
<tr>
<td>Prescriber Specialty</td>
<td>CE</td>
<td>author/assignedAuthor/code</td>
</tr>
<tr>
<td>Prescriber Name</td>
<td>PN</td>
<td>author/assignedAuthor/assignedPerson/name</td>
</tr>
<tr>
<td>Prescriber Organization Identifier</td>
<td>II</td>
<td>author/assignedAuthor/representedOrganization/id</td>
</tr>
<tr>
<td>Prescriber Organization Name</td>
<td>ON</td>
<td>author/assignedAuthor/representedOrganization/name</td>
</tr>
<tr>
<td>Prescriber Organization Address</td>
<td>AD</td>
<td>author/assignedAuthor/representedOrganization/addr</td>
</tr>
</tbody>
</table>

6.3.4.2.3.12 Reason

```xml
<entryRelationship typeCode='RSON'>
  <act classCode='ACT' moodCode='EVN'>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.4.1'/>
    <id root=' ' extension=' '/>
  </act>
</entryRelationship>
```

See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification.

6.3.4.2.3.13 Reference to a related prescription activity (supply)

```xml
<entryRelationship typeCode='REFR'>
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7.3'/>
</entryRelationship>
```
See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification. This element SHALL NOT be present.

### 6.3.4.2.3.14 Patient Medication Instructions

At most one instruction MAY be provided for each `<substanceAdministration>` entry. When present, this entry relationship SHALL contain a [Patient Medication Instructions](1.3.6.1.4.1.19376.1.5.3.1.4.3) entry.

Patient Medication Instructions (used in a Prescription Item) are comments from “prescriber to patient” and may contain the following information:

- Human readable dosage instructions (e.g., a representation of the structured dosage instructions as narrative text, any special dosage instructions which could not have been represented in structured way, etc.)
- General comments by the prescriber to the patient (e.g., “take with food”, etc.)

### 6.3.4.2.3.15 Fulfillment Instructions

At most one instruction MAY be provided for each `<substanceAdministration>` entry. When present, this entry relationship SHALL contain a [Fulfillment Instructions](1.3.6.1.4.1.19376.1.5.3.1.4.3) entry.

Fulfillment Instructions (used in a Prescription Item) are comments from “prescriber to patient” and may contain the following information:

- Human readable dosage instructions (e.g., a representation of the structured dosage instructions as narrative text, any special dosage instructions which could not have been represented in structured way, etc.)
- General comments by the prescriber to the patient (e.g., “take with food”, etc.)
At most one instruction MAY be provided for each <substanceAdministration> entry. When present, this entry relationship SHALL contain a Medication Fulfillment Instructions (1.3.6.1.4.1.19376.1.5.3.1.4.3.1) entry.

Fulfillment Instructions (used in a Prescription Item) are comments from “prescriber to dispenser” and may contain the following information:

- A proposal of a product/brand including information about substitution in case of prescribing Generic/Scientific names (e.g., Prescriber prescribes the generic “Paracetamol” but proposes the product “Adol 500mg Caplet” to be dispensed because the patient is used to that medicine)

- Information to the preparation of compound medicine (e.g., “20 capsules of phenytoin, 20 ml glycerin, 2ml alcohol, Q.S. Syrup to 200ml”)

- General comments by the prescriber to the dispenser (e.g., if the patient is very old: “Patient is instructed about the dosing, but please repeat the instruction to ensure that the patient understood how to intake the medicine”)

6.3.4.2.3.16 Amount of units of the consumable to dispense

<entryRelationship typeCode='COMP'>
  <supply classCode='SPLY' moodCode='RQO'>
    <independentInd value='false'/>
    <quantity value=' ' unit=' '/>
  </supply>
</entryRelationship>

This element MAY be present and describes the amount of units to be dispensed. The medication in the <consumable> element describes either (1) a manufactured medication (e.g., “Adol 500mg Caplet”), (2) a generic/scientific name (Paracetamol) or (3) a descriptor of a magistral preparation/compound medicine. It also may contain package information (e.g., “Adol 500mg Caplet, 30 tablets package”) in the <pharm:asContent> element. The following rules shall indicate to which the <quantity> element relates to (either medication or package):

- If the <consumable> - element also contains package information, the <quantity> element SHALL contain the amount of primary packaged items of the medication. The value shall refer to the primary layer of the package information given in the <pharm:asContent> element of the consumable (e.g., if the value is 2 and the <pharm:asContent> element describes a blister containing 30 tablets, this means that 2 blisters (with each 30 tablets in it) have been prescribed). Eventually present sub- or super layers of packaging (subContent, asSuperContent elements below the asContent element) are not affected. In this case the unit attribute SHALL NOT be present.

- If the <consumable> - element does not contain package information, the <quantity> element SHALL contain the amount of consumable units of the medication. In this case
the unit attribute MAY be present, if the quantity is in non-countable units. The value of the unit SHALL be out of the UCUM code system.

6.3.4.2.3.17 Substitution handling

<entryRelationship typeCode='COMP'>
  <supply classCode="SPLY"
    moodCode="RQO">
    <independentInd value="false" />
    <pharm:subjectOf4>
      <pharm:substitutionPermission
        classCode="SUBST"
        moodCode="PERM">
        <pharm:code code=' '
          displayName=' '
          codeSystem='2.16.840.1.113883.5.1070'
          codeSystemName='HL7 Substance Admin Substitution'/>
      </pharm:substitutionPermission>
    </pharm:subjectOf4>
  </supply>
</entryRelationship>

One or more <entryRelationship> elements, each containing one and only one <pharm:subjectOf4> element, MAY be present and describe the substitution handling. The <value> element identifies what sort of change is permitted between the therapy that was ordered and the therapy that will be provided. It shall be coded in HL7® terminology for substance substitution.

Technical note: A part of an HL7® Medication Order (PORX_MT010120UV) is used within the entryRelationship/supply element to express Substitution Handling.

6.3.4.2.3.18 ID of parent container (Prescription document)

<reference typeCode='XCRPT'>
  <externalDocument>
    <id root=' ' extension=' '/>
  </externalDocument>
</reference>
In the case that the Prescription Item is used within a Prescription document according to the “Pharmacy Prescription” (PRE) Profile this element SHALL NOT be present. In all other cases (e.g., when used in a “Pharmacy Medication List” document according to the PML Profile or in medication sections of other documents as for example Discharge Summaries, etc.) this element SHOULD be present and contain the identifier of the Prescription document, the Prescription Item initially has been created.

6.3.4.2.3.19 Precondition Criterion

```xml
<precondition>
  <criterion>
    <text>
      <reference value=' '></reference>
    </text>
  </criterion>
</precondition>
```

In a CDA® document, the preconditions for use of the medication are recorded in the `<precondition>` element. The value attribute of the `<reference>` element is a URL that points to the CDA® narrative describing those preconditions. This element MAY be present.

See PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification.

6.3.4.5 Dosage Instructions Content Module (1.3.6.1.4.1.19376.1.9.1.3.6)

Dosage Instructions are a set of data elements which together represent the dosage instructions to a medication such as duration of treatment, medication frequency, dose quantity, route of administration, etc.

Note: Dosage Instructions may be provided structured and/or narrative. This chapter describes structured dosage instructions. If dosage instructions are provided narrative only, the Dosage Instructions data elements SHALL NOT be present as a whole are either null flavored or omitted.

6.3.4.5.1 Standards

This part describes the general structure for a Dosage Instructions. It is based on the following standards:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HL7V3</td>
<td>HL7 V3 2009 Normative Edition</td>
</tr>
<tr>
<td>NE2009</td>
<td></td>
</tr>
<tr>
<td>CDAR2</td>
<td>HL7 CDA Release 2.0</td>
</tr>
</tbody>
</table>

6.3.4.5.2 Parent Template

This content module has no parent structure.
6.3.4.5.3 Specification

The chapters below identify and describe these fields, and indicate the constraints on whether or not they are required to be sent. The fields are listed in the order that they appear in the CDA® XML content.

```xml
<substanceAdministration classCode='SBADM' moodCode='INT|EVN'>
  <templateId root='1.3.6.1.4.1.19376.1.9.1.3.6'/>
  <effectiveTime xsi:type='IVL_TS'>
    <low value=' '/>
    <high value=' '/>
  </effectiveTime>
  <effectiveTime operator='A' xsi:type='TS|PIVL_TS|EIVL_TS|PIVL_PPD_TS|SXPR_TS'>
  </effectiveTime>
  <routeCode code=' ' codeSystem=' ' displayName=' ' codeSystemName=' '/>
  <approachSiteCode code=' ' codeSystem=' ' displayName=' ' codeSystemName=' '/>
  <doseQuantity value=' ' unit=' '/>
  <rateQuantity value=' ' unit=' '/>
  <!-- 0..* entries describing the components -->
  <entryRelationship typeCode='COMP'>
    <sequenceNumber value=''/>
    <consumable>
      <manufacturedProduct>
        <manufacturedMaterial nullFlavor='NA'/>
      </manufacturedProduct>
    </consumable>
  </entryRelationship>
</substanceAdministration>
```

6.3.4.5.3.1 Dosage Instructions General Specification

The Dosage Instructions are part of a `<substanceAdministration>` element.

The `<substanceAdministration>` element itself as well as additional constraints applying to this `<substanceAdministration>` element (e.g., other applying content module constraints such as IHE PHARM “Prescription Item”) are specified in the parent specification using this content module.

6.3.4.5.3.2 Dosage Instructions TemplateID

The `<templateId>` element identifies this `<entry>` as a particular type of event, allowing for validation of the content.

<!-- PHARM -->
The templateId SHALL be set to the value 1.3.6.1.4.1.19376.1.9.1.3.6.1115

**6.3.4.5.3.3 Dosage Instructions Additional Template ID**

```
<templateId root=' '/>
```

This templateId declares which type of dosage instructions (“normal dosing”, “split dosing”, etc.) is used.

The templateId SHALL be present.

In case (structured) dosage instructions are not provided (e.g., because they are only provided as narrative text), this element SHALL be set to “Normal Dosing”.

The templateId SHALL use one of the values in the table below for the root attribute.

<table>
<thead>
<tr>
<th>Root</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.7.1</td>
<td>A &quot;normal&quot; <code>&lt;substanceAdministration&gt;</code> act that may not contain any subordinate <code>&lt;substanceAdministration&gt;</code> acts.</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.8</td>
<td>A <code>&lt;substanceAdministration&gt;</code> act that records tapered dose information in subordinate <code>&lt;substanceAdministration&gt;</code> act.</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.9</td>
<td>A <code>&lt;substanceAdministration&gt;</code> act that records split dose information in subordinate <code>&lt;substanceAdministration&gt;</code> acts.</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.10</td>
<td>A <code>&lt;substanceAdministration&gt;</code> act that records conditional dose information in subordinate <code>&lt;substanceAdministration&gt;</code> acts.</td>
</tr>
<tr>
<td>1.3.6.1.4.1.19376.1.5.3.1.4.11</td>
<td>A <code>&lt;substanceAdministration&gt;</code> act that records combination medication component information in subordinate <code>&lt;substanceAdministration&gt;</code> acts.</td>
</tr>
</tbody>
</table>

The constraints defined for this element in PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification apply to this element.

**6.3.4.5.3.4 Effective Time (Duration of Treatment)**

```
<effectiveTime xsi:type='IVL_TS'>
```

In case the (structured) dosage instructions include a dose regime this element SHALL be present and specify the entire duration of the medication treatment. In case the Duration of Treatment is unknown the `<low>` and `<high>` sub-elements of this element SHALL be set to null flavor “UNK”.

If dosage instructions are provided *narrative only*, this element SHALL NOT be present.

In all other cases this element MAY be present.

The constraints defined for this element in PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification apply to this element.

---

7 For the scope of this Content Module, “dose regime” groups the data elements Medication Frequency, Dose Quantity and Rate Quantity, provided in a certain type of dosing (“Normal dosing”, “Split dosing”, etc.)
6.3.4.5.3.5 Medication frequency

```xml
<effectiveTime operator='A'
xsi:type='TS|PIVL_TS|EIVL_TS|PIVL_PPD_TS|SXPR_TS' />
```

In case the (structured) dosage instructions include a dose regime using “Normal Dosing”, this element SHALL be present and SHALL NOT be null flavor.

If dosage instructions are provided *narrative only*, this element SHALL NOT be present.

In all other cases this element MAY be present.

1140 The constraints defined for this element in PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification apply to this element.

6.3.4.5.3.6 Route of Administration

```xml
<routeCode code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>
```

If dosage instructions are provided *narrative only*, this element SHALL NOT be present.

In all other cases this element MAY be present.

1150 The constraints defined for this element in PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification apply to this element.

6.3.4.5.3.7 Approach Site Code

```xml
<approachSiteCode code=' ' displayName=' ' codeSystem=' ' codeSystemName=' '/>
```

If dosage instructions are provided *narrative only*, this element SHALL NOT be present.

In all other cases this element MAY be present.

1155 The constraints defined for this element in PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification apply to this element.

6.3.4.5.3.8 Dose Quantity

```xml
<doseQuantity value=' ' unit=' '/>
```

In case the (structured) dosage instructions include a dose regime using “Normal Dosing”, this element SHALL be present and SHALL NOT be null flavor.

If dosage instructions are provided *narrative only*, this element SHALL NOT be present.

In all other cases this element MAY be present.

1160 The constraints defined for this element in PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification apply to this element.

6.3.4.5.3.9 Rate Quantity

```xml
<rateQuantity value=' ' unit=' '/>
```
In case the (structured) dosage instructions include a dose regime using “Normal Dosing”, this element SHALL be present and SHALL NOT be null flavor.

If dosage instructions are provided narrative only, this element SHALL NOT be present.

In all other cases this element MAY be present.

The constraints defined for this element in PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification apply to this element.

6.3.4.5.3.10 Related components

<entryRelationship typeCode='COMP'>
  <sequenceNumber value=''/>
  :
  <consumable>

  <manufacturedProduct>
    <manufacturedMaterial nullFlavor='NA'/>
  </manufacturedProduct>

  </consumable>

  :
</entryRelationship>

In case the (structured) dosage instructions include a dose regime using “Normal Dosing”, subordinate <substanceAdministration> entries SHALL NOT be present.

If dosage instructions are provided narrative only, subordinate <substanceAdministration> entries SHALL NOT be present.

In case the (structured) dosage instructions include a dose regime using other types than “Normal Dosing”, one or more subordinate <substanceAdministration> entries SHALL be present.

In case subordinate <substanceAdministration> entries are present, the <consumable> element of subordinate <substanceAdministration> entries SHALL NOT contain a medicine, but the <manufacturedProduct/manufacturedMaterial> element SHALL be set to nullFlavor='NA'.

The constraints defined for this element in PCC TF2, Medication Entry Module (1.3.6.1.4.1.19376.1.5.3.1.4.7) specification apply to this element.
Appendices
Appendix A Validating CDA® Documents using the Framework

A.1 Validating Documents
For validation of document content modules please refer to PCC-TF2, Appendix A.1.

A.2 Validating Sections
For validation of section content modules please refer to PCC-TF2, Appendix A.2.

A.3 Phases of Validation and Types of Errors
For the phases of validation and types of errors please refer to PCC-TF2, Appendix A.3.
Appendix B Extensions to CDA® Release 2

B.1 IHE PHARM Extensions

All Extensions to CDA® Release 2.0 created by the IHE PHARM Technical Committee are in the namespace urn:ihe:pharm:medication.

The approach used to create extension elements created for the PHARM Technical Framework is the same as was used for the PCC Technical Framework, the HL7® Care Record Summary (see Appendix E) and the ASTM/HL7® Continuity of Care Document (see Section 7.2).

B.1.1 Used for Medicine Entry Content Module

The extensions of CDA® Release 2 used for the Medicine Entry Content Module are derived of a medication structure based on a standard HL7® V3 Common Message Element Type (CMET) created by the HL7® Pharmacy group. The used CMET is “R_Medication Universal” (COCT_MT230100UV), Release 2 and fits within the overall entry by extending the "Manufactured Product" structure of the CDA® “substanceAdministration” branch.

This structure is part of the HL7® V3 2009 Normative Edition (COCT_RM230100UV). The incorporation of this structure is done according to Section 1.4 CDA Extensibility of the HL7® CDA® standard. Such an extension of the base CDA® standard is an accepted practice in IHE (e.g., in the XD* Lab specification).

The rules of Section 1.4 CDA Extensibility require the designation of a new XML namespace for the XML elements in this structure. For the purposes of documentation, the namespace urn:ihe:pharm:medication shall be used.
The detailed usage is shown in the specification of the Medicine Entry Content Module (1.3.6.1.4.1.19376.1.9.1.3.1) within the PHARM Technical Framework.