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Moving From Fax to Fully Compliant EPCS

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Your speaker

Simon Chang, DO — internal medicine physician and co-founder of eNavvi, a clinical technology company in the e-prescribing space.

I see compounded prescribing from both sides: as a physician who writes compounds, and as someone building the tools pharmacies receive them on.

Disclosure: I am a co-founder of eNavvi. This session is educational; specific product details are reserved for the final few minutes.

Learning objectives

Describe how compounded medications are transmitted today — and why fax and free-text persist.

Trace how NCPDP SCRIPT support for compounds has evolved, from 2006 to 2026.

Explain the controlled-substance EPCS mandates and the asymmetric compliance risk between prescriber and pharmacy.

Identify structured-data and monograph pathways that move compounds from fax to fully compliant EPCS.

Before we begin: two quick polls

Poll 1 — Who's joining today?

Prescriber · Pharmacy · EHR or PMS vendor · Regulatory / compliance · Payer or processor

Poll 2 — How do you transmit or receive compounds today?

ePrescribing · Fax · Phone · A mix of methods

We'll keep these open briefly, then look at the results together.

Section 1 — Today’s reality

The compound prescription that still travels by fax

Why compounds are still manual

- A compounded medication is made for one patient — a specific strength, base, and delivery vehicle. It has no NDC and usually no entry in the drug database the EHR is searching.
- So the prescriber has two unstructured outlets: select the closest commercial product as a placeholder and describe the real formula in free-text, or print and fax a compound form.
- The gap isn't the prescriber's intent — the interface in front of them was never designed to build a compound.

What travels isn’t what’s needed

- The prescriber sees a confirmation that the prescription “went out.” The pharmacy receives a manufactured product — with a paragraph in the notes describing what to actually make.
- The payload that crosses the wire is not the same as what’s displayed: structured fields can be present yet invisible if the receiving system shows only the free-text.
- The pharmacy reinterprets and re-enters — translating percentages to mg/g and decoding shorthand such as “BLT cream,” “Magic Mouthwash,” or Bi-est 80:20 versus 50:50.
- Every translation is a chance for error — the game of Telephone, with a patient at the end of the line.

The patient absorbs the gap

- **When the electronic order is incomplete, the workflow reverts to manual — and the patient absorbs the delay.**
- A clarification call adds 24 to 72 hours on top of a typical three-to-five-day compound turnaround — days without therapy.
- A pediatric oral suspension dispensed at an ambiguous strength; a hormone-therapy patient whose two-week gap interrupts the clinical trajectory.
- These are loop failures, not clinical errors. The patient never sees the SCRIPT transaction or the fax queue — only a medication that was late, or wrong.

Section 2 — The standards landscape

The standard has spent twenty years catching up

Twenty years of structured compounds

- **2006–2017:** free-text and fax under SCRIPT v8.1 / v10.6 — limited structured support.
- **2018:** v2017071 adopted, introducing structured compound ingredients (CMS-4182-F).
- **2020:** national migration to structured workflows at scale.
- **2024:** v2023011 named in the CMS final rule — modernized structured SIG; compliance by January 1, 2028.
- **2026:** added mg / mcg quantity qualifiers for greater precision.

Sources: CMS-4182-F; CMS final rule adopting NCPDP SCRIPT v2023011; NCPDP SCRIPT Implementation Guide.

Where does your organization sit?

- **The standard already supports structured compounds. The bottleneck is implementation — not capability.**
- **Poll —** Which NCPDP SCRIPT version are you on today? v2017071 · v2023011 · An older version · I'm not sure
- We've moved from "can we transmit compounds?" to "can we transmit them with production-grade precision?" — yet most workflows haven't followed, because the market pressure hasn't been there.

Section 3 — Where inefficiency becomes liability

Now add a controlled substance

For a controlled substance, fax isn’t compliant

- **35+ states** mandate EPCS for controlled substances.
- **70%** is the CMS Part D e-prescribing threshold for Schedule II–V.
- **January 1, 2028** is the SCRIPT v2023011 compliance deadline.
- **A paper or fax prescription for a Schedule II–V compound is a DEA violation** — regardless of how the pharmacy files it.

Sources: DEA 21 CFR Part 1311; SUPPORT Act (2018); CMS Part D e-prescribing requirements.

Your pharmacy is compliant. Is your prescriber?

- **The compliance burden is asymmetric — and it sits with the prescriber.**
- **The pharmacy** receives the faxed compound controlled-substance Rx, logs it, fills it, files the paper Rx, and feels compliant.
- **The prescriber** wrote a Schedule II–V compound on paper or fax — where EPCS is required by the DEA and 35+ states — and is exposed to a DEA audit, license risk, and CMS clawback.
- The pharmacy thinks the system worked. The prescriber is one audit away from a finding.

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The 503A blind spot

- Standard EPCS software was never built to receive a compound: no structured compound builder on the prescriber side, and no purpose-built receive-and-verify terminal on the 503A side.
- There is no engine to check a prescriber's jurisdiction against the various state EPCS rules — and a paper or fax trail breaks the closed-loop audit record controlled substances require.
- So even prescribers and pharmacies who want a compliant electronic path for compounded controlled substances often cannot get one from the tools they already own.

Section 4 — The path forward

From fax to fully compliant EPCS

What a compliant compound loop looks like

- **1. Authenticate —** DEA two-factor authentication with IAL2 / AAL2 identity proofing.
- **2. Build structured —** ingredients, strengths, base, and ratios as discrete data.
- **3. Check the mandate —** validate the prescriber's jurisdiction against state EPCS rules.
- **4. Transmit EPCS —** on NCPDP SCRIPT v2023011, for Schedule II–V.
- **5. Receive and verify —** structured data flows into the pharmacy system.
- Every step logged, every prescription traceable — both sides protected.

Standardized monographs: a practical first step

- A standardized monograph is essentially a defined product — ingredients, concentrations, and beyond-use date already specified, with no clinical ambiguity for the prescriber to introduce.
- Get those monographs into the EHR and pharmacy databases as selectable, structured objects: the prescriber selects one, it arrives structured, and it maps to the pharmacy's formulation record.
- **One honest caveat:** each pharmacy still sources its own APIs, so a matching layer remains. Monographs narrow the gap significantly — they don't erase it.

One thing this week

- **Prescribers:** ask your EHR team which compound fields are actually populated in your SCRIPT transactions.
- **Pharmacies:** document the delta between what you receive and what you need — then bring it to your software vendor.
- **Everyone:** audit where you sit on the v2023011 adoption curve, and engage the NCPDP standards process — WG11 and the SCRIPT Implementation Recommendations (SIR) Task Group.

Where eNavvi fits

- **eNavvi is building this path —** EPCS-compliant compound prescribing, native to NCPDP SCRIPT v2023011.
- **White-label prescriber portal:** DEA-compliant two-factor authentication, IAL2 / AAL2 identity proofing, a structured compound Rx builder, a state-mandate engine, and an audit-ready log for every prescription.
- **503A pharmacy terminal:** structured receive-and-verify with a built-in controlled-substance log.
- The point isn't the product — it's the principle: compliance for compounded controlled substances shouldn't be a competitive advantage. It should be the standard.

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Thank you

Questions?

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