

The Pharmacy System Switching Kit

How to change your pharmacy management system without losing your data, your staff, or your margin. For any pharmacy, any system, any time you are considering a move.

Should you switch?

An honest gate, and the cheaper alternative.

What it takes

Realistic timelines, real costs, and the traps.

How to do it

Checklists, questions and a worksheet you can print.

2026 Edition · A publication of NaviRx LLC · rxsoftwarereport.com

Written for retail, compounding, long-term care, specialty, infusion and DME pharmacies.

What is in this kit

Work it in order. It is built to be used, not admired.

1	Should you switch at all? The honest gate — and the cheaper alternative most pharmacies never try
2	How long it takes A realistic timeline model, plus the calendar traps
3	What matters for your pharmacy type Retail, compounding, LTC, specialty, DME, infusion, 340B, multi-store
4	Building your shortlist How to narrow 79 systems to three
5	Running a demo that tells you something Including the questions vendors find hardest
6	Data conversion, explained What it is, what breaks, and your four options
7	Contract red flags Twelve terms to settle before you sign
8	What switching actually costs A budget model, including the cost nobody invoices you for
9	Negotiation leverage What you have, and when it expires
10	Go-live and the first 30 days Timing, staffing, and the switchover nobody warns you about
11	The things pharmacies forget Short list, painful consequences
12	Planning worksheet Print, assign, date, review weekly
A	Appendix: forced migrations If your system is being retired

The one thing to do this week. Find your current contract and read the termination and notice provisions. Everything in this kit assumes you know how much notice you owe and what you are entitled to take with you. Pharmacies routinely discover a 90- or 180-day notice requirement far too late to use it — and that discovery alone can cost a year.

A note on independence. RxSoftwareReport does not accept payment from software vendors for placement, scores, or coverage, and does not consult for the vendors it covers. Nothing in this kit is a recommendation of a particular system. It is the process — and the questions — we would want a pharmacy owner to have before signing anything.

1. Should you switch at all?

Switching is expensive, disruptive, and occasionally the wrong answer. Start here.

Reasons that usually justify switching

- Your system is being retired or is no longer supported — you have no choice, only a timeline.
- Support has degraded and you have escalated formally, in writing, without resolution.
- A capability gap is actively blocking a business line: DME, LTC, 340B, compounding, specialty.
- Cost is materially out of line with the market and the vendor will not move at renewal.
- Vendor instability — ownership churn, product-line consolidation, or a roadmap that no longer includes you.
- Contract terms that will damage the value of your pharmacy when you sell it.

Reasons that usually do not

- One bad support experience, however memorable.
- A feature you have never formally requested.
- A price you have never actually tried to renegotiate.
- A competitor's demo looking better than your daily reality — every demo does.
- Staff frustration with a workflow that is functioning correctly but was never properly trained.
- A new owner or manager wanting to change things on principle.

Try the cheaper option first. Most pharmacies have never seriously renegotiated. Before you run a six-to-nine-month project, ask your current vendor — in writing, before your renewal window — for a price reset, a support-tier upgrade, refresher training for your team, removal of modules you do not use, and a written response to your specific complaints. Getting a competing quote first makes that conversation dramatically more productive. If they will not move, you have lost two weeks and gained real leverage. If they do move, you have saved a year of disruption.

If you are being forced. When your system is sunsetting, the decision is made and only the timeline is yours. Skip to section 2, and read Appendix A — being early is worth real money when an entire installed base has to migrate at once.

2. How long it takes

A realistic model for a single-store retail pharmacy, and what adds time.

Baseline: six to nine months, done properly

Phase	Duration	What happens
Assess	4–6 weeks	Read your contract. Document what you actually use. Write one page of requirements, separating must-have from nice-to-have.
Shortlist & demo	6–8 weeks	Narrow to three. Demo each properly, with your staff and your scenarios. Collect written quotes with the full add-on menu.
Negotiate & sign	3–4 weeks	Competing quotes, contract review, red-flag checklist. Do not compress this phase — it is where the money is.
Convert & train	10–16 weeks	Conversion scope agreed in writing, test conversion, verification, staff training, interface rebuilds.
Go-live & stabilise	4–6 weeks	Live operation with elevated support, issue log, and legacy access retained.

Phases overlap slightly in practice. A compressed emergency switch can be done in about four months, but everything that protects you — competitive quotes, negotiation, a test conversion, adequate training — is what gets cut.

Add time for complexity

If you are...	Add	Why
Multiple locations	+2–6 weeks	Central pricing, cross-store lookup, and phased go-lives all add calendar time.
Long-term care	+6–12 weeks	Facility interfaces and eMAR connections (PointClickCare, MatrixCare and similar) are rebuilt, re-tested and re-certified.
DME / Part B billing	+8 weeks	You are likely selecting a second system, not just a PMS. Decide the architecture before you shortlist.
Compounding	+4–8 weeks	Formulas and ingredient-level records rarely convert cleanly and are often rebuilt by hand.
340B contract pharmacy	+4–6 weeks	The TPA integration and accumulator feeds must be rebuilt and reconciled, with the covered entity involved.
Packaging or dispensing robotics	+4–8 weeks	Interfaces to pouch packagers, robots and smart cabinets need re-certification by both vendors.
Specialty accreditation	+4–8 weeks	Accreditation documentation and manufacturer reporting must be re-established and evidenced.

Calendar traps — when not to go live

- **January.** Plan-year changes, deductible resets and insurance chaos. The worst month in the year to also be learning new software.
- **Flu and immunisation season.** Your volume peak is not your training window.
- **The first few days of any month.** Refill surges and benefit changes cluster there.
- **Mondays.** The heaviest day in most pharmacies.
- **When key staff are on leave** — or immediately before someone leaves for good.
- **Around a DIR, reconciliation or accreditation deadline.**
- **Best windows:** late spring, or early autumn before immunisation volume builds. Midweek, in a quieter week of the month.

3. What matters for your pharmacy type

Every pharmacy needs a system that dispenses competently. What separates the shortlists is everything else.

If you are a...	What you must evaluate specifically	What to watch out for
Retail / community	Speed of the fill workflow, adjudication and rejection handling, POS integration, refill/IVR, delivery, DIR and reconciliation reporting, perpetual inventory with wholesaler EDI.	A demo that only shows a clean new prescription. Insist on seeing a rejected claim, a partial fill, a transfer, and a return.
Multi-store	Central management, centralised pricing and item files, cross-store patient lookup, inter-store transfers, consolidated reporting, and one place to administer users.	Per-store pricing that scales badly; "multi-store" that is really several single stores with separate databases.
Compounding	Formula/recipe management, ingredient-level inventory with lot tracking, batch records, USP 795/797/800 documentation, ingredient-based pricing, waste and beyond-use dating.	General PMS compounding modules are often thin. If compounding is core, look at purpose-built options and be blunt about volume in the demo.
Long-term care	Cycle fill and short-cycle dispensing, eMAR integration with the facilities you actually serve, facility billing and split billing, med-pass workflow, delivery manifests, packaging-automation interfaces.	Confirm the eMAR integration by facility name and version, not by brand. "We integrate with PointClickCare" is not the same as integrating with your building.
Specialty	Accreditation documentation (URAC/ACHC), clinical assessments and care plans, prior authorisation and financial-assistance workflow, manufacturer and limited-distribution reporting, cold-chain handling, lot and serial tracking.	Many pharmacies need a PMS plus a specialty layer. Price and plan for both, and confirm the integration is live in production.
DME / HME	Medicare Part B DMEPOS billing with rental-cycle logic, serialised and rental asset tracking, CMN and documentation management, capped rentals, resupply, delivery with electronic proof of delivery.	No mainstream retail PMS does this well. Decide your architecture — second system, billing bridge, or one of the very few dual-capable systems — before you shortlist anything.
Home infusion	Compounded IV and TPN billing, per-diem and nursing coordination, pump and equipment management, and the ability to bill both pharmacy (NCPDP) and medical claims.	Retail-first systems generally cannot do this. Expect to look at infusion-capable platforms rather than adapting a community PMS.
340B contract pharmacy	Clean inventory segregation, reliable data feed to your TPA, accumulator reconciliation, and reporting that survives an audit.	The PMS does segregation and reporting; the TPA does split billing. Confirm your specific TPA integration is supported before signing.
Cash / DPC / cost-plus	Transparent pricing tools, simplified or bypassed adjudication, e-commerce and delivery integration, and low per-script cost structure.	Systems priced on claim volume can penalise a cash model. Ask how pricing works when you are not billing insurance.

The DME question decides your architecture, so answer it first. If you bill Medicare Part B for durable medical equipment, note that no mainstream retail pharmacy system handles Part B billing and serialised rental-asset tracking well. Your realistic choices are: run a dedicated DME system alongside your PMS; use a medical-billing bridge and accept that the equipment-inventory gap stays unfilled; or evaluate the very few systems that attempt both. This decision changes your shortlist entirely — make it before you take a single demo.

Write your requirements down before you look at anything. One page. Must-have on the left, nice-to-have on the right, and a line at the bottom for the two or three things that would make you walk away. Vendors are extremely good at reframing your priorities around their strengths; a written list you wrote first is the antidote.

4. Building your shortlist

Getting from a market of dozens to a shortlist of three.

1. **Rule out on non-negotiables first.** DME, LTC eMAR, compounding depth, 340B, multi-store centralisation. These eliminate faster than any feature comparison, and most systems will fail at least one.
2. **Decide your ownership tolerance.** Much of this market is now owned by a small number of private-equity-backed groups. Some pharmacies deliberately shortlist at least one independent vendor; others prefer the resources of a larger platform. Either is defensible — deciding on purpose is the point.
3. **Check wholesaler alignment.** Some tools route ordering through one distributor. If you may change wholesalers, avoid building dependency on tools that assume you will not.
4. **Match the vendor to your size.** A platform built for 200-store chains will not prioritise your single store; a two-person vendor may not survive a decade. Ask directly about the customer profile they serve best.
5. **Ask about continuity.** For smaller vendors: who owns the company, what is the succession plan, and what happens if the founder retires? It is a fair question and the answer is revealing.
6. **Shortlist three.** Two gives you no leverage. Four wastes your time and your staff's.

Find references the vendor did not choose. Every vendor reference is a happy customer, hand-picked. Ask instead for a list of pharmacies in your state running your configuration, and pick two yourself. If a vendor will not do that, treat it as information. Independent-pharmacy owner groups, your state association, and your buying group are the other honest sources.