

SECTION B – 20 – OUTPNT DRUGS – BASE 1 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?  
 Yes  
 No

Select type of benefit:  
 Mandatory  
 Optional

Indicate the number of drug groupings that are offered:  
 1  
 2  
 3  
 4  
 5

Is there a Maximum Plan Benefit Coverage amount for drugs?  
 Yes  
 No

Indicate type of Maximum Plan Benefit Coverage:  
 All drug groups covered by plan  
 Combination of drug groups  
 Individual drug groups

Is the Maximum Plan Benefit Coverage net of the enrollee copay?  
 Yes  
 No

Indicate Maximum Plan Benefit Coverage periodicity for drugs:  
 Annually  
 Semi-annually  
 Quarterly  
 Monthly  
 Other, describe

Indicate Max Plan Benefit Cov amount annually for drugs:  
\_\_\_\_\_

Indicate Max Plan Benefit Cov amount semi-annually for drugs:  
\_\_\_\_\_

Indicate Max Plan Benefit Cov amount quarterly for drugs:  
\_\_\_\_\_

Indicate Max Plan Benefit Cov amount monthly for drugs:  
\_\_\_\_\_

Indicate Max Plan Benefit Cov amount for Other for drugs:  
\_\_\_\_\_

SECTION B – 20 – OUTPNT DRUGS – BASE 2 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Base 2

File

Can any unused amounts be carried forward to the next period within the contract period?

Yes

No

Select what combination of drug groups are included in the Maximum Plan Benefit:

Group 1

Group 2

Group 3

Group 4

Group 5

Indicate Maximum Plan Benefit Coverage periodicity for combination of drug groups:

Annually

Semi-annually

Quarterly

Monthly

Other, describe

Indicate Max Plan Benefit Cov amount annually for combination of drug groups:

\_\_\_\_\_

Indicate Max Plan Benefit Cov amount semi-annually for combination of drug groups:

\_\_\_\_\_

Indicate Max Plan Benefit Cov amount quarterly for combination of drug groups:

\_\_\_\_\_

Indicate Max Plan Benefit Cov amount monthly for combination of drug groups:

\_\_\_\_\_

Indicate Max Plan Benefit Cov amount for Other for combination of drug groups:

\_\_\_\_\_

SECTION B – 20 – OUTPNT DRUGS – BASE 3 SCREEN

**PBP 2008 Data Entry System - #20 Outpatient Drugs - Base 3**

File

Select the Coverage Basis for the Maximum Plan Benefit Coverage for all drug types and/or a combination of drug groups:

- Discount ( \_\_ %) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$ \_\_)
- Discount ( \_\_ %) of Published National AWP
- Medicare Fee Schedule
- MA Organization Acquisition Cost Plus (\$ \_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Is a selected group unlimited after the combination Maximum Plan Benefit Coverage amount has been reached?

- Yes
- No

Indicate the selected group(s) for which the Maximum Plan Benefit Coverage is waived:

- Group 1
- Group 2
- Group 3
- Group 4
- Group 5

Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage for combination of drug groups:

\_\_\_\_\_

Indicate Maximum Dispensing Fee amount for Maximum Plan Benefit Coverage for combination of drug groups:

\_\_\_\_\_

Does the enrollee incur a cost in addition to the Coinsurance or Copay for selecting a higher priced drug when a less expensive drug is available?

- Yes
- No

Is there a Maximum Enrollee Out-of-Pocket Cost?

- Yes
- No

Indicate Minimum Dispensing Fee amount for Maximum Plan Benefit Coverage for combination of drug groups:

\_\_\_\_\_

Indicate percentage Discount of AWP for Maximum Plan Benefit Coverage for combination of drug groups:

\_\_\_\_\_

Select what combination of drug groups applies for Maximum Enrollee Out-of-Pocket Cost:

- Group 1
- Group 2
- Group 3
- Group 4
- Group 5
- Medicare Covered Benefits

Indicate amount over MA Organization Acquisition Cost for Maximum Plan Benefit Coverage for combination of drug groups:

\_\_\_\_\_

SECTION B – 20 – OUTPNT DRUGS – BASE 5 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Base 4

File

Indicate Maximum Enrollee Out-of-Pocket Cost amount: <input type="text"/>	Select the Coinsurance Coverage Basis for Medicare Covered Benefits: <input type="radio"/> Discount ( __ %) of Published Retail Price <input type="radio"/> Published Retail Price <input type="radio"/> Published Wholesale Price <input type="radio"/> Published National Average Wholesale Price (AWP) <input type="radio"/> Published National AWP plus Dispensing Fee (\$ __) <input type="radio"/> Discount ( __ %) of Published National AWP <input type="radio"/> Medicare Fee Schedule <input type="radio"/> MA Organization Acquisition Cost Plus (\$ __) <input type="radio"/> Published MA Organization Fee/Charge Schedule <input type="radio"/> Other, describe	
Select the Maximum Enrollee Out-of-Pocket Cost periodicity: <input type="radio"/> Every three years <input type="radio"/> Every two years <input type="radio"/> Every year <input type="radio"/> Every six months <input type="radio"/> Every three months <input type="radio"/> Every month <input type="radio"/> Other, describe	Indicate percentage Discount of Published Retail Price for Coinsurance for Medicare Covered Benefits: <input type="text"/>	Indicate percentage Discount of AWP for Coinsurance for Medicare Covered Benefits: <input type="text"/>
Is there an enrollee Coinsurance for Medicare Covered Benefits? <input type="radio"/> Yes <input type="radio"/> No	Indicate Minimum Dispensing Fee amount for Coinsurance for Medicare Covered Benefits: <input type="text"/>	Indicate amount over MA Organization Acquisition Cost for Coinsurance for Medicare Covered Benefits: <input type="text"/>
Indicate Coinsurance percentage for Medicare Covered Benefits: <input type="text"/>	Indicate Maximum Dispensing Fee amount for Coinsurance for Medicare Covered Benefits: <input type="text"/>	

SECTION B – 20 – OUTPNT DRUGS – BASE 5 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Base 5

File

Is there an enrollee Deductible?  
 Yes  
 No

Select what combination of drug groups applies for Deductible:  
 Group 1  
 Group 2  
 Group 3  
 Group 4  
 Group 5  
 Medicare Covered Benefits

Indicate Deductible amount:

Is there an enrollee Copayment for Medicare Covered Benefits?  
 Yes  
 No

Indicate Minimum Copayment amount for Medicare Covered Benefits:

Indicate Maximum Copayment amount for Medicare Covered Benefits:

Enrollee must receive Authorization for drugs from one or more of the following:  
 None  
 Primary Care Physician (Internist/Family Practice, General Practice)  
 Physician Specialist/Dentist  
 Organization Medical Director/Utilization Management/Utilization Review  
 Other, describe

**SECTION B – 20 – OUTPNT DRUGS – NOTES (OPTIONAL)**

PBP 2008 Data Entry System - #20 Outpatient Drugs - Notes (Optional)

File

Outpatient Drugs Notes

Notes (Optional):

Import Text

SECTION B – 20 – OUTPNT DRUGS – GROUP 1- BASE 1 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 1 - Base 1

File

Select a label for Group 1:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand
- Brand
- Tier 1
- Tier 2

Select the drug type(s) covered for Group 1:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 1?

- Yes
- No

Indicate Maximum Plan Benefit Coverage for Group 1 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 1: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage monthly amount for Group 1: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 1: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 1: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 1: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage amount for Other for Group 1: \_\_\_\_\_

SECTION B – 20 – OUTPNT DRUGS – GROUP 1- BASE 2 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 1 - Base 2

File

Select the Coverage Basis for Maximum Plan Benefit Coverage for Group 1:

- Discount (\_\_\_%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$\_\_\_)
- Discount (\_\_\_%) of Published National AWP
- Medicare Fee Schedule
- MA Organization Acquisition Cost Plus (\$\_\_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Select from where Group 1 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 1?

- Yes
- No

Indicate Coinsurance percentage for Group 1 Designated Retail Pharmacy:

\_\_\_\_\_

Indicate Coinsurance percentage for Group 1 HMO-Owned Pharmacy:

\_\_\_\_\_

Indicate Coinsurance percentage for Group 1 Mail Order:

\_\_\_\_\_

Indicate Coinsurance percentage for Group 1 Other:

\_\_\_\_\_

Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage for Group 1:

\_\_\_\_\_

Indicate percentage Discount of AWP for Maximum Plan Benefit Coverage for Group 1:

\_\_\_\_\_

Indicate Minimum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 1:

\_\_\_\_\_

Indicate amount over MA Organization Acquisition Cost for Maximum Plan Benefit Coverage for Group 1:

\_\_\_\_\_

Indicate Maximum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 1:

\_\_\_\_\_



SECTION B – 20 – OUTPAT DRUGS – GROUP 1- BASE 3 SCREEN

**PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 1 - Base 3**

File

Select the Coinsurance Coverage Basis for Group 1:

- Discount (\_\_\_%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$\_\_\_)
- Discount (\_\_\_%) of Published National AWP
- Medicare Fee Schedule
- MA Organization Acquisition Cost Plus (\$\_\_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Indicate percentage Discount of Published Retail Price for Coinsurance for Group 1:

Indicate percentage Discount of AWP for Coinsurance for Group 1:

Indicate Minimum Dispensing Fee amount for Coinsurance for Group 1:

Indicate amount over MA Organization Acquisition Cost for Coinsurance for Group 1:

Indicate Maximum Dispensing Fee amount for Coinsurance for Group 1:

Is there an enrollee Copayment for Group 1?  
 Yes  
 No

Indicate Copayment amount for Group 1 Designated Retail Pharmacy:

Indicate Copayment amount for Group 1 HMO-Owned Pharmacy:

Indicate Copayment amount for Group 1 Mail Order:

Indicate Copayment amount for Group 1 Other:

Up to a \_\_\_\_\_ day supply covered for Group 1 Designated Retail Pharmacy:

Up to a \_\_\_\_\_ day supply covered for Group 1 HMO-Owned Pharmacy:

Up to a \_\_\_\_\_ day supply covered for Group 1 Mail Order:

Up to a \_\_\_\_\_ day supply covered for Group 1 Other:

SECTION B – 20 – OUTPNT DRUGS – GROUP 2- BASE 1 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 2 - Base 1

File

Select a label for Group 2:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand
- Brand
- Tier 1
- Tier 2

Select the drug type(s) covered for Group 2:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 2?

- Yes
- No

Indicate Maximum Plan Benefit Coverage for Group 2 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 2: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage monthly amount for Group 2: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 2: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 2: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 2: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage amount for Other for Group 2: \_\_\_\_\_

SECTION B – 20 – OUTPNT DRUGS – GROUP 2- BASE 2 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 2 - Base 2

File

Select the Coverage Basis for Maximum Plan Benefit Coverage for Group 2:

- Discount ( \_\_%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$\_\_)
- Discount ( \_\_%) of Published National AWP
- Published Red Book Price
- MA Organization Acquisition Cost Plus (\$\_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Indicate Maximum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 2:

Indicate percentage Discount of AWP for Maximum Plan Benefit Coverage for Group 2:

Indicate amount over MA Organization Acquisition Cost for Maximum Plan Benefit Coverage for Group 2:

Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage for Group 2:

Indicate Minimum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 2:

SECTION B – 20 – OUTPNT DRUGS – GROUP 2- BASE 3 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 2 - Base 3

File

Select from where Group 2 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 2?

Yes  
 No

Indicate Coinsurance percentage for Group 2 for Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 2 for HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 2 for Mail Order:

Indicate Coinsurance percentage for Group 2 for Other:

Select the Coinsurance Coverage Basis for Group 2:

- Discount ( \_\_%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$\_\_)
- Discount ( \_\_%) of Published National AWP
- Published Red Book Price
- MA Organization Acquisition Cost Plus (\$\_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Indicate percentage Discount of Published Retail Price for Coinsurance for Group 2:

Indicate percentage Discount of AWP for Coinsurance for Group 2:

Indicate Minimum Dispensing Fee amount for Coinsurance for Group 2:

Indicate amount over MA Organization Acquisition Cost for Coinsurance for Group 2:

Indicate Maximum Dispensing Fee amount for Coinsurance for Group 2:

SECTION B – 20 – OUTPNT DRUGS – GROUP 2- BASE 4 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 2 - Base 4

File

Is there an enrollee Copayment for Group 2? <input type="radio"/> Yes <input type="radio"/> No	Up to a ____ day supply covered for Group 2 Designated Retail Pharmacy: <input type="text"/>
Indicate Copayment amount for Group 2 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 2 HMO-Owned Pharmacy: <input type="text"/>
Indicate Copayment amount for Group 2 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 2 Mail Order: <input type="text"/>
Indicate Copayment amount for Group 2 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 2 Other: <input type="text"/>
Indicate Copayment amount for Group 2 Other: <input type="text"/>	

SECTION B – 20 – OUTPNT DRUGS – GROUP 3- BASE 1 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 3 - Base 1

File

Select a label for Group 3:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand
- Brand
- Tier 1
- Tier 2

Select the drug type(s) covered for Group 3:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 3?

- Yes
- No

Indicate Maximum Plan Benefit Coverage Group 3 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 3: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage monthly amount for Group 3: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 3: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 3: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 3: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage amount for Other for Group 3: \_\_\_\_\_

SECTION B – 20 – OUTPNT DRUGS – GROUP 3- BASE 2 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 3 - Base 2

File

Select the Coverage Basis for Maximum Plan Benefit Coverage for Group 3:

- Discount ( \_\_%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$\_\_)
- Discount ( \_\_%) of Published National AWP
- Published Red Book Price
- MA Organization Acquisition Cost Plus (\$\_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage for Group 3:

\_\_\_\_\_

Indicate Minimum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 3:

\_\_\_\_\_

Indicate Maximum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 3:

\_\_\_\_\_

Indicate percentage Discount of AWP for Maximum Plan Benefit Coverage for Group 3:

\_\_\_\_\_

Indicate amount over MA Organization Acquisition Cost for Maximum Plan Benefit Coverage for Group 3:

\_\_\_\_\_

SECTION B – 20 – OUTPNT DRUGS – GROUP 3- BASE 3 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 3 - Base 3

File

Select from where Group 3 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 3?

- Yes
- No

Indicate Coinsurance percentage for Group 3 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 3 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 3 Mail Order:

Indicate Coinsurance percentage for Group 3 Other:

Select the Coinsurance Coverage Basis for Group 3:

- Discount (\_\_\_%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$\_\_\_)
- Discount (\_\_\_%) of Published National AWP
- Published Red Book Price
- MA Organization Acquisition Cost Plus (\$\_\_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Indicate percentage Discount of Published Retail Price for Coinsurance for Group 3:

Indicate percentage Discount of AWP for Coinsurance for Group 3:

Indicate Minimum Dispensing Fee amount for Coinsurance for Group 3:

Indicate amount over MA Organization Acquisition Cost for Coinsurance for Group 3:

Indicate Maximum Dispensing Fee amount for Coinsurance for Group 3:



SECTION B – 20 – OUTPNT DRUGS – GROUP 3- BASE 4 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 3 - Base 4

File

Is there an enrollee Copayment for Group 3? <input type="radio"/> Yes <input type="radio"/> No	Up to a ____ day supply covered for Group 3 Designated Retail Pharmacy: <input type="text"/>
Indicate Copayment amount for Group 3 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 3 HMO-Owned Pharmacy: <input type="text"/>
Indicate Copayment amount for Group 3 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 3 Mail Order: <input type="text"/>
Indicate Copayment amount for Group 3 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 3 Other: <input type="text"/>
Indicate Copayment amount for Group 3 Other: <input type="text"/>	

SECTION B – 20 – OUTPNT DRUGS – GROUP 4- BASE 1 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 4 - Base 1

File

Select a label for Group 4:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand
- Brand
- Tier 1
- Tier 2

Select the drug type(s) covered for Group 4:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 4?

- Yes
- No

Indicate Maximum Plan Benefit Coverage Group 4:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 4: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage monthly amount for Group 4: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 4: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage amount per prescription for Group 4: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage quarterly amount for Group 4: \_\_\_\_\_

Indicate Maximum Plan Benefit Coverage amount for Other for Group 4: \_\_\_\_\_

SECTION B – 20 – OUTPNT DRUGS – GROUP 4- BASE 2 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 4 - Base 2

File

Select the Coverage Basis for Maximum Plan Benefit Coverage for Group 4:

- Discount ( \_\_%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$\_\_)
- Discount ( \_\_%) of Published National AWP
- Published Red Book Price
- MA Organization Acquisition Cost Plus (\$\_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Indicate Maximum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 4:

Indicate percentage Discount of AWP for Maximum Plan Benefit Coverage for Group 4:

Indicate amount over MA Organization Acquisition Cost for Maximum Plan Benefit Coverage for Group 4:

Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage for Group 4:

Indicate Minimum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 4:

SECTION B – 20 – OUTPNT DRUGS – GROUP 4- BASE 3 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 4 - Base 3

File

Select from where Group 4 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 4?

- Yes
- No

Indicate Coinsurance percentage for Group 4 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 4 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 4 Mail Order:

Indicate Coinsurance percentage for Group 4 Other:

Select the Coinsurance Coverage Basis for Group 4:

- Discount ( \_\_%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$ \_\_)
- Discount ( \_\_%) of Published National AWP
- Published Red Book Price
- MA Organization Acquisition Cost Plus (\$ \_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Indicate percentage Discount of Published Retail Price for Coinsurance for Group 4:

Indicate percentage Discount of AWP for Coinsurance for Group 4:

Indicate Minimum Dispensing Fee for Coinsurance for Group 4:

Indicate amount over MA Organization Acquisition Cost for Coinsurance for Group 4:

Indicate Maximum Dispensing Fee for Coinsurance for Group 4:

SECTION B – 20 – OUTPNT DRUGS – GROUP 4- BASE 4 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 4 - Base 4

File

Is there an enrollee Copayment for Group 4? <input type="radio"/> Yes <input type="radio"/> No	Up to a ____ day supply covered for Group 4 Designated Retail Pharmacy: <input type="text"/>
Indicate Copayment amount for Group 4 Designated Retail Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 4 HMO-Owned Pharmacy: <input type="text"/>
Indicate Copayment amount for Group 4 HMO-Owned Pharmacy: <input type="text"/>	Up to a ____ day supply covered for Group 4 Mail Order: <input type="text"/>
Indicate Copayment amount for Group 4 Mail Order: <input type="text"/>	Up to a ____ day supply covered for Group 4 Other: <input type="text"/>
Indicate Copayment amount for Group 4 Other: <input type="text"/>	

SECTION B – 20 – OUTPNT DRUGS – GROUP 5- BASE 1 SCREEN

File

Select a label for Group 5:

- Formulary Generic
- Formulary Preferred Brand
- Formulary Brand
- Non-formulary Generic
- Non-formulary Brand
- Generic
- Preferred Brand
- Brand
- Tier 1
- Tier 2

Select the drug type(s) covered for Group 5:

- Generic
- Preferred Brand
- Brand

Is there a Maximum Plan Benefit Coverage amount for Group 5?

- Yes
- No

Indicate Maximum Plan Benefit Coverage for Group 5 periodicity:

- Annually
- Semi-annually
- Quarterly
- Monthly
- Per Prescription
- Other, describe

Indicate Maximum Plan Benefit Coverage annual amount for Group 5: <input type="text"/>	Indicate Maximum Plan Benefit Coverage monthly amount for Group 5: <input type="text"/>
Indicate Maximum Plan Benefit Coverage semi-annual amount for Group 5: <input type="text"/>	Indicate Maximum Plan Benefit Coverage amount per prescription for Group 5: <input type="text"/>
Indicate Maximum Plan Benefit Coverage quarterly amount for Group 5: <input type="text"/>	Indicate Maximum Plan Benefit Coverage amount for Other for Group 5: <input type="text"/>

SECTION B – 20 – OUTPNT DRUGS – GROUP 5- BASE 2 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 5 - Base 2

File

Select the Coverage Basis for Maximum Plan Benefit Coverage for Group 5:

- Discount ( \_\_ %) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$ \_\_)
- Discount ( \_\_ %) of Published National AWP
- Published Red Book Price
- MA Organization Acquisition Cost Plus (\$ \_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Indicate Maximum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 5:

Indicate percentage Discount of AWP for Maximum Plan Benefit Coverage for Group 5:

Indicate amount over MA Organization Acquisition Cost for Maximum Plan Benefit Coverage for Group 5:

Indicate percentage Discount of Published Retail Price for Maximum Plan Benefit Coverage for Group 5:

Indicate Minimum Dispensing Fee amount for Maximum Plan Benefit Coverage for Group 5:

SECTION B – 20 – OUTPNT DRUGS – GROUP 5- BASE 3 SCREEN

PBP 2008 Data Entry System - #20 Outpatient Drugs - Group 5 - Base 3

File

Select from where Group 5 Drugs can be acquired:

- Designated Retail Pharmacy
- HMO-Owned Pharmacy
- Mail Order
- Other, describe

Is there an enrollee Coinsurance for Group 5?

- Yes
- No

Indicate Coinsurance percentage for Group 5 Designated Retail Pharmacy:

Indicate Coinsurance percentage for Group 5 HMO-Owned Pharmacy:

Indicate Coinsurance percentage for Group 5 Mail Order:

Indicate Coinsurance percentage for Group 5 Other:

Select the Coinsurance Coverage Basis for Group 5:

- Discount (\_\_\_%) of Published Retail Price
- Published Retail Price
- Published Wholesale Price
- Published National Average Wholesale Price (AWP)
- Published National AWP plus Dispensing Fee (\$\_\_\_)
- Discount (\_\_\_%) of Published National AWP
- Published Red Book Price
- MA Organization Acquisition Cost Plus (\$\_\_\_)
- Published MA Organization Fee/Charge Schedule
- Other, describe

Indicate percentage Discount of Published Retail Price for Coinsurance for Group 5:

Indicate percentage Discount of AWP for Coinsurance for Group 5:

Indicate Minimum Dispensing Fee amount for Coinsurance for Group 5:

Indicate amount over MA Organization Acquisition Cost for Coinsurance for Group 5:

Indicate Maximum Dispensing Fee amount for Coinsurance for Group 5:



SECTION B – 20 – OUTPNT DRUGS – GROUP 5- BASE 4 SCREEN

File

Is there an enrollee Copayment for Group 5?  
 Yes  
 No

Indicate Copayment amount for Group 5 Designated Retail Pharmacy:  
\_\_\_\_\_

Indicate Copayment amount for Group 5 HMO-Owned Pharmacy:  
\_\_\_\_\_

Indicate Copayment amount for Group 5 Mail Order:  
\_\_\_\_\_

Indicate Copayment amount for Group 5 Other:  
\_\_\_\_\_

Up to a \_\_\_\_\_ day supply covered for Group 5 Designated Retail Pharmacy:  
\_\_\_\_\_

Up to a \_\_\_\_\_ day supply covered for Group 5 HMO-Owned Pharmacy:  
\_\_\_\_\_

Up to a \_\_\_\_\_ day supply covered for Group 5 Mail Order:  
\_\_\_\_\_

Up to a \_\_\_\_\_ day supply covered for Group 5 Other:  
\_\_\_\_\_