B: ADR Web Application Screen Shots

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ALL ACTIVITIES

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Grantee Contact Information

1. Grantee Name: Alabama Department of Public Health

2. Grantee Address: 201 Monroe St, Montgomery, AL 36104-3735

3. Grant Number: H89HA00000

4. ADAP Number: 1234

5. DUNS Number: 12-345-6789

6. ADAP Coordinator/Administrator

a. Contact Name:* Michael Dols

b. Contact Title:* Software Architect

c. Contact Email:* Michael.J.Dols@saic.com

d. Contact Telephone:* (301) 230-4753

e. Contact Fax:

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Product: HAB ADAP Data Report | **Build #:** 1.0.0.0 | **Environment:** Development

HRSA

Last Login: 5/20/2011 2:46:00 PM ET **Context:** 1234 | H89HA00000 | 12-345-6789 | Alabama Department of Public Health | 123 Main Street, Birmingham, AL 12345-6789

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Section 1 - Program Summary

Section 1 (Items 1–7) should be completed for each six month period. Please review the Instructions for Completing the ADAP Grantee Report to ensure that you respond to each item appropriately.

A. PROGRAM ADMINISTRATION

1. Please indicate which of the following limits applied to your ADAP during the reporting period. For each item that applied, complete the blank with the information requested on that limit.

Check all that apply:

- ☐ Waiting list anytime during the reporting period
- ☐ Enrollment cap — Max enrollees: ______
- ☐ Capped expenditure — Monetary cap per client: ______
- ☐ Drug-specific enrollment caps for ARVs or Hepatitis C medications - Please specify below for each medication that has an enrollment cap:

Generic Name	Brand Name	Maximum Enrollees
abacavir	Ziagen	
abacavir, Zidovudine, and lamivudine	Trizivir	
abacavir/Lamivudine	Epzicom	
acyclovir	Zovirax	
adefovir dipivoxil	Hepsera	
amphotericin B	Fungizone	
Amprenavir	Agenerase	
Atazanavir sulfate	Reyataz	
azithromycin	Zithromax	
cidofovir	Vistide	

* Drug list continues on web page

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Section 1 - Program Summary (continued)

Section 1 (Items 1–7) should be completed for each six month period. Please review the Instructions for Completing the ADAP Grantee Report to ensure that you respond to each item appropriately.

A. PROGRAM ADMINISTRATION

2. Indicate which of the following developments or changes occurred in your program during this reporting period:

Check all that apply:

- ☐ Project budget deficit
- ☐ Change in income eligibility criteria, please specify:
- ☐ Change in medical eligibility criteria, please specify:
- ☐ Added medications to the formulary
- ☐ Deleted medications from the formulary

3. Please indicate the maximum ADAP eligibility requirements as a percentage of Federal Poverty Level (FPL):

4. Please indicate which of the following activities your ADAP uses to coordinate with Medicaid or a State-only Pharmacy Assistance Program:

Check all that apply:

- ☐ Online interface
- ☐ Dual application
- ☐ Coordinated benefits
- ☐ Retroactive billing
- ☐ We have no coordination with Medicaid or State-only ADAP
- ☐ Other, please specify:

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Section 1: Program Summary (continued)

C. FUNDING

5. Please enter the funding received during this reporting period from each of the following sources (if no funding was received enter "0"):

	Funding Source	Amount Received (to nearest dollar)
a.	Total contributions from Part A EMA(s)/TGAs	
b.	Total contributions from Part B Base Funding	
c.	State contribution (other than Ryan White or Required State Match Funds)	
d.	Carry-over of Ryan White funds from previous year	
e.	Manufacture Rebates	
f.	All Insurance Reimbursements, including Medicaid	
	Resources received this reporting period (Total of a through f)	

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Section 1: Program Summary (continued)

D. EXPENDITURES

6. For each of the following categories, please enter total expenditures for this reporting period:

	Expenditure Category	Total Cost
a.	Pharmaceuticals	
b.	Dispensing and other administrative costs	
c.	Insurance coverage (including co-pays, deductibles, and premiums)	
d.	Under the ADAP Flexibility Policy - Adherence	
e.	Under the ADAP Flexibility Policy - Access	
f.	Under the ADAP Flexibility Policy - Monitoring	
	Total ADAP expenditures this quarter	

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Section 1: Program Summary (continued)

D. ADAP MEDICATION FORMULARY - Antiretroviral Medications

7. Please provide information on Antiretroviral (ARV), hepatitis B, hepatitis C and "A1-OI" medications currently on your ADAP formulary. If you added an ARV medication to your ADAP formulary during this reporting period, please note that and provide the date that it was added.

a. Grantee-level Formulary Information - Antiretroviral Medications

Included in Formulary	Generic Name	Brand Name	Category	Added to Formulary this Reporting Period	
				Med Added?	Date Added
☐	abacavir	Ziagen	NRTIs	☐	
☐	abacavir, Zidovudine, and lamivudine	Trizivir	NRTIs	☐	
☐	abacavir/Lamivudine	Epzicom	NRTIs	☐	
☐	didanosine, ddl, dideoxyinosine	Videx	NRTIs	☐	
☐	Efavirenz, emtricitabine, tenofovir disoproxil fumarate	Atripla	NRTIs	☐	
☐	FTC, emtricitabine	Emtriva	NRTIs	☐	
☐	Lamivudine and zidovudine	Combivir	NRTIs	☐	
☐	Lamivudine, 3TC	Epivir	NRTIs	☐	
☐	Stavudine, d4T	Zerit	NRTIs	☐	
☐	Tenofovir disoproxil fumarate	Viread	NRTIs	☐	

* Drug list continues on web page

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Section 1: Program Summary (continued)

D. ADAP MEDICATION FORMULARY - A1-OI Medications

7. Please provide information on Antiretroviral (ARV), hepatitis B, hepatitis C and "A1-OI" medications currently on your ADAP formulary. If you added an ARV medication to your ADAP formulary during this reporting period, please note that and provide the date that it was added.

b. Grantee-level Formulary Information - A1-OI Medications

Included in Formulary	Generic Name	Brand Name
☐	acyclovir	Zovirax
☐	amphotericin B	Fungizone
☐	azithromycin	Zithromax
☐	cidofovir	Vistide
☐	clarithromycin	Biaxin
☐	clindamycin	Cleocin
☐	famciclovir	Famvir
☐	fluconazole	Diflucan
☐	flucytosine	Ancobon
☐	fomivirsen	Vitravene

* Drug list continues on web page

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Section 1: Program Summary (continued)

D. ADAP MEDICATION FORMULARY - Hepatitis B Medications

7. Please provide information on Antiretroviral (ARV), hepatitis B, hepatitis C and "A1-OI" medications currently on your ADAP formulary. If you added an ARV medication to your ADAP formulary during this reporting period, please note that and provide the date that it was added.

c. Grantee-level Formulary Information - Hepatitis B Medications

Included in Formulary	Generic Name	Brand Name
☐	entecavir	Baraclude
☐	lamivudine	Epivir-HBV
☐	Interferon alfa-2b	Intron A
☐	adefovir dipivoxil	Hepsera
☐	Peginterferon alfa-2a	Pegasys
☐	telbivudine	Tyzeka

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Section 1: Program Summary (continued)

D. ADAP MEDICATION FORMULARY - Hepatitis C Medications

7. Please provide information on Antiretroviral (ARV), hepatitis B, hepatitis C and "A1-OI" medications currently on your ADAP formulary. If you added an ARV medication to your ADAP formulary during this reporting period, please note that and provide the date that it was added.

d. Grantee-level Formulary Information - Hepatitis C Medications

Included in Formulary	Generic Name	Brand Name
☐	Interferon alfa-2b	Intron A
☐	Recombinant interferon alfa-2a	Roferon-A
☐	Consensus interferon or interferon alfacon-1	Infergen
☐	Peginterferon alfa-2a	Pegasys
☐	Peginterferon alfa-2b	PEG-Intron
☐	Peginterferon alfa-2a + ribavirin	Copegus an Pegasys
☐	Peginterferon alfa-2b and ribavirin	PEG-Intron and Rebetol
☐	Interferon alfa-2b and ribavirin	Intron A and Rebetol
☐	Recombinant interferon alfa-2a and ribavirin	Roferon and Ribavirin

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Section 2 - Annual Submission

Section 2 (Items 8–11) should be completed only once each year for the previous 12–month period.

A. PROGRAM ADMINISTRATION

8. Please indicate the frequency of re-certification of client eligibility:

Check all that apply:

- ☐ Annual
- ☐ Semiannual (every 6 months)
- ☐ Other, please specify: [ ]

9. Please indicate the clinical eligibility criteria required to enroll in the ADAP in your State/Territory:

Check all that apply:

- ☐ HIV+
- ☐ CD4 (what is your CD4 count requirement?) [ ]
- ☐ Viral load (what is your VL count requirement?) [ ]
- ☐ Other, please specify: [ ]

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Section 2 - Annual Submission (continued)

Section 2 (Items 8–11) should be completed only once each year for the previous 12–month period.

B. COST SAVING STRATEGIES

10. Please check all that apply to your Drug Pricing Program:

Check all that apply:

- [ ] 340B Rebate
- [ ] Direct purchase
- [ ] Prime vendor
- [ ] Alternate Method Demonstration Project
- [ ] Other drug discount program (not 340B), please specify:

C. SOURCES AND AMOUNTS OF ADAP FUNDING – THIS WILL BE PREPOPULATED BY HAB AND IS FOR REVIEW PURPOSES ONLY.

11. ADAP funding received for this fiscal year from each of the following Ryan White HIV/AIDS program sources:

	Funding Source	Amount Received (to nearest dollar)
a.	ADAP earmark	
b.	ADAP Supplemental Drug Treatment Grant Award	
c.	State Match for Supplemental Drug Treatment Award	
	ADAP resources received (total of a through c)	

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