AIDS Drug Assistance Program
ADAP Grantee Report
Proposed Grantee-Level Variables

C: ADR Grantee Report

COVER PAGE

Grantee Contact Information

1. Grantee name:

____

2. Grant number:

3. ADAP number:

4. D-U-N-S number:

☐☐ – ☐☐☐ - ☐☐☐☐

5. Grantee address:

a. Street: ____

b. City: _________________________________ State: _____ _____

c. ZIP Code: __ __ __ __ __ - __ __ __ __

6. Contact information for the ADAP Coordinator/Administrator:

a. Name:

b. Title: _

c. Phone #: (__ __ __) __ __ __ - __ __ __ __

d. Fax #: (__ __ __) __ __ __ - __ __ __ __

e. E-mail: _______

7. Indicate the six month reporting period for which you are submitting data:

☐ April 1 – September 30

☐ October 1 – March 31

Section 1: Programmatic Summary Submission

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 number of 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:

  Medication _____________________Max number of enrollees ______

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
- ☐ Other (please specify _____________________________)
- ☐ We have no coordination with Medicaid or State-only ADAP

B. 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.	Total contributions from Part B Supplemental Funding	$
d.	State contributions (other than Ryan White or Required State Match Funds)	$
e.	Carry-over of Ryan White funds from previous year	$
f.	Manufacturer Rebates	$
g.	Other Negotiated Rebates	$
h.	All Insurance Reimbursements, including Medicaid	$
	Resources received this reporting period (Total of a through h)	**$**

C. 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	$

D. ADAP MEDICATION FORMULARY

7. Please provide information on Antiretroviral (ARV), hepatitis B, h**epatitis 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	☐	MM/DD/YYYY
☐	abacavir, zidovudine, and lamivudine	Trizivir	NRTIs	☐	MM/DD/YYYY
☐	abacavir/lamivudine	Epzicom	NRTIs	☐	MM/DD/YYYY
☐	didanosine, ddI, dideoxyinosine	Videx	NRTIs	☐	MM/DD/YYYY
☐	efavirenz, emtricitabine, tenofovir disoproxil fumarate	Atripla	NRTIs	☐	MM/DD/YYYY
☐	FTC, emtricitabine	Emtriva	NRTIs	☐	MM/DD/YYYY
☐	lamivudine and zidovudine	Combivir	NRTIs	☐	MM/DD/YYYY
☐	lamivudine, 3TC	Epvir	NRTIs	☐	MM/DD/YYYY
☐	stavudine, d4T	Zerit	NRTIs	☐	MM/DD/YYYY
☐	tenofovir disoproxil fumarate	Viread	NRTIs	☐	MM/DD/YYYY
☐	tenofovir disoproxil/emtricitabine	Truvada	NRTIs	☐	MM/DD/YYYY
☐	zalcitabine, ddC, dideoxycytidine	Hivid	NRTIs	☐	MM/DD/YYYY
☐	zidovudine, AZT, azidothymidine, ZDV	Retrovir	NRTIs	☐	MM/DD/YYYY
☐	delavirdine, DLV	Rescriptor	NNRTIs	☐	MM/DD/YYYY
☐	efavirenz	Sustiva	NNRTIs	☐	MM/DD/YYYY
☐	Etravirine (TMC-125)	Intelence	NNRTIs	☐	MM/DD/YYYY
☐	nevirapine, BI-RG-587	Viramune	NNRTIs	☐	MM/DD/YYYY

Included In Formulary	GENERIC NAME	BRAND NAME	Category	Added to Formulary this Reporting Period	
				Med Added?	Date Added
☐	amprenavir	Agenerase	PIs	☐	MM/DD/YYYY
☐	atazanavir sulfate	Reyataz	PIs	☐	MM/DD/YYYY
☐	darunavir	Prezista	PIs	☐	MM/DD/YYYY
☐	Fosamprenavir Calcium	Lexiva	PIs	☐	MM/DD/YYYY
☐	indinavir, IDV, MK-639	Crixivan	PIs	☐	MM/DD/YYYY
☐	lopinavir and ritonavir	Kaletra	PIs	☐	MM/DD/YYYY
☐	nelfinavir mesylate, NFV	Viracept	PIs	☐	MM/DD/YYYY
☐	ritonavir, ABT-538 r	Norvi	PIs	☐	MM/DD/YYYY
☐	saquinavir	Fortovase	PIs	☐	MM/DD/YYYY
☐	saquinavir mesylate, SQV	Invirase	PIs	☐	MM/DD/YYYY
☐	tipranavir	Aptivus	PIs	☐	MM/DD/YYYY
☐	enfuvirtide, T-20	Fuzeon	FIs	☐	MM/DD/YYYY
☐	Raltegravir (RGV or MK-0518)	Isentress	Integrase Inhibitors	☐	MM/DD/YYYY
☐	maraviroc	Selzentry or Celsentri	CCR5 Antagonists	☐	MM/DD/YYYY

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
☐	foscarnet	Foscavir
☐	ganciclovir	Cytovene
☐	Isoniazid (INH)	Lanizid, Nydrazid
☐	itraconazole	Sporonox
☐	leucovorin calcium	Wellcovorin
☐	peginterferon alfa-2a	PEG-Intron
☐	pentamidine	Nebupent
☐	pentavalent antimony	—
☐	prednisone	Deltasone, Liquid Pred, Metocorten, Orasone, Panasol, Prednicen-M, Sterapred

☐	probenecid	—
Included in Formulary	**GENERIC NAME**	**BRAND NAME**
☐	pyrazinamide (PZA)	—
☐	pyrimethamine	Daraprim, Fansidar
☐	ribavirin	Virazole, Rebetol, Copegus
☐	rifabutin	Mycobutin
☐	rifampin (RIF)	Rifadin, Rimactane
☐	sulfadiazine (oral generic)	Microsulfon
☐	trimethoprim-sulfamethoxazole (TMP/SMX)	Bactrim, Septra
☐	valacyclovir	Valtrex
☐	valganciclovir	Valcyte

“A1" Opportunistic Infection Medications*

“* *A – Both strong evidence for efficacy and substantial clinical benefit support recommendation for use; should always be offered*

1 –Evidence from ≥1correctly randomized, controlled trials.

Source*:*
Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons – 2002; Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America”.

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

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 and 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

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:

- ☐ Annual
- ☐ Semiannual *(every 6 months)*
- ☐ Other, please specify ________________________________

7. 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: ______________________________)

B. COST SAVING STRATEGIES

8. Please check all that apply to your Drug Pricing Program: *(Check all that apply)*

- ☐ 340B Rebate
- ☐ Direct purchase
- ☐ Prime vendor
- ☐ Alternative 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.

9. 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)	$