OMB No: 0915-0294
Expiration Date: XX/XX/XXXX

AIDS DRUG ASSISTANCE PROGRAM

QUARTERLY DATA REPORT

HIV/AIDS Bureau
Division of Science and Policy
Health Resources and Services Administration
5600 Fishers Lane, Room 7-90
Rockville, MD 20857

COVER PAGE

All Ryan White HIV/AIDS Program ADAP grantees must complete this cover page if submitting a quarterly data report by paper.

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. Check the Report Quarter for which you are submitting data:

☐ **1st** (April 1 – June 30, report due July 31)

☐ **2nd** (July 1 – September 30, report due October 31)

☐ **3rd** (October 1 – December 31, report due January 31)

☐ **4th** (January 1 – March 31, report due April 30)

Section 1: Quarterly Submission

Section 1 (Items 1–12) should be completed for each quarter. Please review the Instructions for Completing the ADAP Quarterly Report to ensure that you respond to each item appropriately.

A. CLIENT UTILIZATION

1. For the current reporting quarter (ending [June 30, 2010]), please indicate the UNDUPLICATED number of:

a. Total clients enrolled in the ADAP at any time during the quarter _____

b. NEW clients enrolled in the ADAP _____

c. Clients who received at least one drug through the ADAP _____

d. NEW clients who received at least one drug through the ADAP _____

e. Clients who received any type of insurance service (premiums, co-pays, deductibles) _____

f. NEW clients who received any type of insurance service (premiums, co-pays, deductibles) _____

2. Gender distribution of total unduplicated ADAP clients:

Gender	(a) Total Enrolled Clients	(b) New Enrolled Clients	(c) Total Clients Served*	(d) New Clients Served*	(e) Insurance Clients	(f) New Insurance Clients
Males						
Females						
Transgender						
Unknown/unreported						
Total						

*Served clients must have received at least one drug through the ADAP.

3. Age distribution of total unduplicated ADAP clients:

Age	(a) Total Enrolled Clients	(b) New Enrolled Clients	(c) Total Clients Served*	(d) New Clients Served*	(e) Insurance Clients	(f) New Insurance Clients
Less than 2 years						
2–12 years						
13–24 years						
25–44 years						
45–64 years						
65 years or older						
Unknown/unreported						
Total						

*Served clients must have received at least one drug through the ADAP.

4. Racial distribution for total unduplicated Hispanic/Latino(a) ADAP clients:

Race	(a) Total Enrolled Clients	(b) New Enrolled Clients	(c) Total Clients Served*	(d) New Clients Served*	(e) Insurance Clients	(f) New Insurance Clients
White						
Black or African American						
Asian						
Native Hawaiian or Other Pacific Islander						
American Indian or Alaska Native						
More than one race						
Unreported						
Total						

*Served clients must have received at least one drug through the ADAP.

5. Racial distribution for total unduplicated non-Hispanic/Latino(a) ADAP clients:

Race/Ethnicity	(a) Total Enrolled Clients	(b) New Enrolled Clients	(c) Total Clients Served*	(d) New Clients Served*	(e) Insurance Clients	(f) New Insurance Clients
White						
Black or African American						
Asian						
Native Hawaiian or Other Pacific Islander						
American Indian or Alaska Native						
More than one race						
Unreported						
Total						

*Served clients must have received at least one drug through the ADAP.

6. Please list the total number of unduplicated clients served by the ADAP who were on the following regimens this reporting quarter:

Please note: The request for this information is not intended as a means to monitor the standard or quality of care being provided through the ADAP. Patients may not be prescribed HAART for a variety of valid reasons, such as HAART is not medically indicated, the patient refused, or the patient may not be ready to begin therapy and deal with the complexities of adherence. All of these reasons relate to the need for an informed client/clinician joint decision.

Regimen	Total Number of Clients
a. Non-HAART (1 or 2 antiretrovirals)	
b. HAART regimen (3 or 4 antiretrovirals)	
c. More than 4 antiretrovirals	

7. Please indicate the percentage of clients served during this report quarter whose annual household income was less than 200% of the Federal Poverty Level:

_____%

8. 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).

a. ☐ Enrollment cap Max number of enrollees _____

b. ☐ Waiting list Current number on waiting list _____

c. ☐ Capped expenditure Monetary cap $_____per client

d. ☐ Drug-specific enrollment caps ***(ARVs and Hep C meds)***
Medication #1 _____Max number of enrollees _____
Medication #2 _____Max number of enrollees _____
Medication #3 _____Max number of enrollees _____

9. Indicate which of the following developments or changes occurred in your program during this reporting quarter: *(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
- ☐ No changes or developments during this quarter

B. FUNDING

10. Please enter the funding *received* during this reporting quarter 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 contributions (other than Ryan White funds or Required State Match Funds)	$
d.	Carry-over of Ryan White funds from previous year	$
e.	Manufacturer Rebates	$
f.	All Insurance Reimbursements, including Medicaid	$
	Resources received this quarter (Total of a through f)	**$**

C. EXPENDITURES

11. For each of the following categories, please enter total expenditures for this quarter:

	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	$

12. From the list of ARVs, Hepatitis B and Hepatitis C medications provided below, indicate the medications you purchased and/or dispensed during this reporting quarter. *Please note that drug pricing data should now reflect the current reporting period (April 1 – June 30).* Enter the total cost *(not the unit cost)* of medication purchased during the reporting period. *Please note that the total cost is before rebates, must not include the dispensing and other administrative costs, and is unrelated to how many clients received the drug.*

For drugs you dispensed during this quarter, indicated the total number of clients who received this medication at least once during this quarter.

	Generic Name	Brand Name	Drug Code	Total Cost	Unduplicated # of Clients
	ARVs				
☐	amprenavir	Agenerase	d04428		
☐	efavirenz, tenofovir disoproxil fumarate, emtricitabine	Atripla	d05847		
☐	tipranavir	Aptivus	d05538		
☐	lamivudine, zidovudine	Combivir	d04219		
☐	indinavir	Crixivan	d03985		
☐	emtricitabine	Emtriva	d04884		
☐	lamivudine	Epivir	d03858		
☐	lamivudine, abacavir sulfate	Epzicom	d05354		
☐	saquinavir	Fortovase	d03860		
☐	enfuvirtide	Fuzeon	d04853		
☐	zalcitabine	Hivid	d00127		
☐	saquinavir (as mesylate)	Invirase	d03860		
☐	Raltegravir (RGV or MK-0518)	Isentress	d07048		
☐	ritonavir, lopinavir	Kaletra	d04717		
☐	fosamprenavir calcium	Lexiva	d04901		
☐	ritonavir	Norvir	d03984		
☐	darunavir	Prezista	d05825		
☐	delavirdine	Rescriptor	d04119		
☐	zidovudine	Retrovir	d00034		
☐	atazanavir sulfate	Reyataz	d04882		
☐	maraviroc	Selzentry or Celsentri	d06852		
☐	efavirenz	Sustiva	d04355		
☐	abacavir sulfate, lamivudine, zidovudine	Trizivir	d04727		
☐	tenofovir disoproxil fumarate, emtricitabine	Truvada	d05352		
☐	didanosine	Videx/Videx EC	d00078		
☐	nelfinavir	Viracept	d04118		
☐	nevirapine	Viramune	d04029		
☐	tenofovir disoproxil fumarate	Viread	d04774		
☐	stavudine	Zerit	d03773		
☐	abacavir sulfate	Ziagen	d04376		
☐	Etravirine (TMC-125)	Intelence			

	Generic Name	Brand Name	Drug Code	Total Cost	Unduplicated # of Clients
	Hepatitis B or C Treatment Medications:				
☐	entecavir	Baraclude	d05525		
☐	lamivudine	Epivir-HBV	d03858		
☐	interferon alfa-2b	Intron A	d01369		
☐	adefovir dipivoxil	Hepsera	d04814		
☐	peginterferon alfa-2a	Pegasys	d04821		
☐	telbivudine	Tyzeka	d05912		
☐	interferon alfa-2b	Intron A	d01369		
☐	recombinant interferon alfa-2a	Roferon-A	d01368		
☐	consensus interferon or interferon alfacon-1	Infergen	d04224		
☐	peginterferon alfa-2a	Pegasys	d04821		
☐	peginterferon alfa-2b	PEG-Intron	d04746		
☐	peginterferon alfa-2a + ribavirin	Copegus and Pegasys	d00085		
☐	peginterferon alfa-2b and ribavirin	Pegintron and Rebetol	d00085		
☐	interferon alfa-2b and ribavirin	Intron A and Rebetol	d00085		
☐	recombinant interferon alfa-2a and ribavirin	Roferon and Ribavirin			

9. Comments or clarifications:

Use this space to provide additional information that you feel it is important to report or to explain how you arrived at data that do not comply with Items 1–11 as described in the Instruction Manual. Please be sure to specify which item(s) you are discussing.

_____

_____

_____

_____

_____

STOP HERE if this is the second, third, or fourth quarter data report.

Section 2: Annual Submission

*Section 2 (Items 13-21) should be completed only **once** each year and submitted with the **first** quarterly report.*

A. FUNDING

10. Please enter the 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)	$

11. ADAP formulary

Using the Excel spreadsheet provided, upload a list of the drugs in your ADAP formulary.

12. Annual Cost Per Client

For clients enrolled and receiving medications for a full 12-month period, please **estimate** the annual ADAP cost per client in the previous grant year:

a. Rebate (Only) States:

i. Cost per client before cost-saving strategies: $_____ per client

ii. Cost per client after cost-saving strategies: $_____ per client

b. Direct Purchase(Only) States:

i. Annual cost per client: $_____ per client

c. Rebate and Direct Purchase Hybrids:

i. Cost per client before cost-saving strategies: $_____ per client

ii. Cost per client after cost-saving strategies: $_____ per client

B. ELIGIBILITY REQUIREMENTS

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

_____ %

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

- ☐ Annual
- ☐ Semiannual *(every 6 months)*
- ☐ Other (please specify: _____

15. 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: _____)

C. COST SAVING STRATEGIES

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

- ☐ Rebate
- ☐ Direct purchase
- ☐ Prime vendor
- ☐ Alternative Method Demonstration Project
- ☐ Other drug discount program (not 340B) (please specify: _____)

17. Please indicate which of the following methods 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 Pharmacy Assistance Program

18. Comments or clarifications:

Use this space to provide additional information about data for Items 13-19 that do not comply with what is requested as described in the Instruction Manual.