OMB No.: 0915-0345

Expiration Date: XX/XX/20XX

AIDS Drug Assistance Program

ADR Grantee Report

Revised Grantee-Level Variables

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# Grantee Contact Information

1. Grantee name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Grant number:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |   |  |  |  |  |  |  |  |  |  |  |

1. D-U-N-S number:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | – |  |  |  | - |  |  |  |  |  |

1. Grantee address:
2. Street:
3. City: State:
4. ZIP Code: \_\_ \_\_ \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_
5. Contact information of person completing the Grantee Report:
6. Name:
7. Title:
8. Phone #: (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_
9. Fax #: (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_
10. E-mail:

|  |
| --- |
| Section 1: Programmatic Summary Submission |

All items in the Grantee Report should be reported for the most recent grant year. 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* None of these limits were applied to the ADAP during the reporting period
1. Please indicate the maximum ADAP eligibility requirements as a percentage of Federal Poverty Level (FPL):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ %

1. Please indicate the clinical eligibility criteria required to enroll in the ADAP in your State/Territory: *(Check all that apply)*
* CD4 (please specify the CD4 count requirement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* Viral load (please specify the VL count requirement \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* Other (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* No clinical eligibility criteria required to enroll in the ADAP

## b. PURCHASING MECHANISMS

1. Please check all that apply to your Drug Pricing Program: *(Check all that apply)*
* 340B (please specify below)
	+ Rebate
	+ Hybrid
	+ Direct purchase
		- Prime vendor
	+ Alternative Method Demonstration Project
* Department of Defense
* None of these apply to our Drug Pricing Program

**C. FUNDING**

1. 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. | Total contributions from ADAP Emergency Relief Funding | $ |
| e. | Total contribution from Part C/D grantees | $ |
| f. | State contributions for ADAP (other than Ryan White) | $ |
| g. | Carry-over of Ryan White funds from previous year | $ |
| h. | Manufacturer Rebates | $ |
|  |  |  |
| j. | All Insurance Reimbursements, excluding Medicaid | $ |
| k. | Medicaid Reimbursements | $ |
|  | **Resources received this reporting period (Total of a through k)** | **$** |

## D. EXPENDITURES

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

|  |  |  |
| --- | --- | --- |
|  | **Expenditure Category** | **Total Cost** |
| a. | Pharmaceuticals | $ |
| b. | Dispensing costs | $ |
| c. | Other administrative costs | $ |
| d. | Insurance coverage (including co-pays, deductibles, and premiums) | $ |
|  | **Total ADAP expenditures this reporting period** | $ |

E. ADAP MEDICATION FORMULARY

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.

1. **Grantee-level Formulary Information – Antiretroviral Medications**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Included In Formulary** | **GENERIC NAME**  | **BRAND NAME** | **Drug Identification Number**  | **Added to Formulary this Reporting Period** |
| **Med Added?** | **Date Added** |
|  | abacavir | Ziagen | d04376 |  | MM/DD/YYYY |
|  | abacavir/lamivudine/zidovudine | Trizivir | d04727 |  | MM/DD/YYYY |
|  | abacavir/lamivudine | Epzicom | d05354 |  | MM/DD/YYYY |
|  | atazanavir | Reyataz | d04882 |  | MM/DD/YYYY |
|  | darunavir | Prezista | d05825 |  | MM/DD/YYYY |
|  | delavirdine | Rescriptor | d04119 |  | MM/DD/YYYY |
|  | didanosine | Videx/Videx EC | d00078 |  | MM/DD/YYYY |
|  | dolutegravir | Tivicay | d08117 |  | MM/DD/YYYY |
|  | efavirenz | Sustiva | d04355 |  | MM/DD/YYYY |
|  | Efavirenz/emtricitabine/tenofovir | Atripla | d05847 |  | MM/DD/YYYY |
|  | Elvitegravir/cobicistat/tenofovir/ emtricitabine | Stribild | d07899 |  | MM/DD/YYYY |
|  | emtricitabine | Emtriva | d04884 |  | MM/DD/YYYY |
|  | Emtricitabine/rilpivirine/tenofovir | Complera | d07796 |  | MM/DD/YYYY |
|  | Emtricitabine/tenofovir | Truvada | d05352 |  | MM/DD/YYYY |
|  | Enfuvirtide | Fuzeon | d04853 |  | MM/DD/YYYY |
|  | Etravirine | Intelence | d07076 |  | MM/DD/YYYY |
|  | Fosamprenavir | Lexiva | d04901 |  | MM/DD/YYYY |
|  | Indinavir | Crixivan | d03985 |  | MM/DD/YYYY |
|  | lamivudine | Epivir | d03858 |  | MM/DD/YYYY |
|  | Lamivudine/zidovudine | Combivir | d04219 |  | MM/DD/YYYY |
|  | Lopinavir/ritonavir | Kaletra | d04717 |  | MM/DD/YYYY |
|  | maraviroc | Selzentry | d06852 |  | MM/DD/YYYY |
|  | nelfinavir | Viracept | d04118 |  | MM/DD/YYYY |
|  | nevirapine | Viramune/Viramune XR | d04029 |  | MM/DD/YYYY |
|  | Raltegravir | Isentress | d07048 |  | MM/DD/YYYY |
|  | rilpivirine | endurant | d07776 |  | MM/DD/YYYY |
|  | ritonavir | Norvir | d03984 |  | MM/DD/YYYY |
|  | Saquinavir | Fortovase/invirase | d03860 |  | MM/DD/YYYY |
|  | stavudine | Zerit | d03773 |  | MM/DD/YYYY |
|  | tenofovir | Viread | d04774 |  | MM/DD/YYYY |
|  | Tipranavir | aptivus | d05538 |  | MM/DD/YYYY |
|  | zidovudine | Retrovir | d00034 |  | MM/DD/YYYY |

1. **Grantee-level Formulary Information – A1-OI Medications**

|  |  |  |  |
| --- | --- | --- | --- |
| **Included In Formulary** | **GENERIC NAME**  | **BRAND NAME** | **Drug Identification Number**  |
|
|  | acyclovir  | Zovirax | d00001 |
|  | amphotericin B deoxycholate | Fungizone | d00077 |
|  | amphotericin B(liposomal)  | Ambisome | d04238 |
|  | amphotericin B lipid complex  | Abelcet/Amphotec/Ampholip | d03870 |
|  | azithromycin  | Zithromax | d00091 |
|  | cidofovir  | Vistide | d04028 |
|  | clarithromycin  | Biaxin | d00097 |
|  | clindamycin | Cleocin | d00043 |
|  | Ethambutol | Myambutol | d00068 |
|  | famciclovir | Famvir  | d03775 |
|  | fluconazole  | Diflucan | d00071 |
|  | flucytosine  | Ancobon | d00038 |
|  | foscarnet  | Foscavir  | d00065 |
|  | ganciclovir  | Cytovene  | d00066 |
|  | Isoniazid (INH)  | Lanizid, Nydrazid | d00101 |
|  | itraconazole  | Sporonox | d00102 |
|  | leucovorin calcium  | Wellcovorin | d00275 |
|  | Norfloxacin | Noroxin/Chibroxin | d00113 |
|  | pentamidine  | Nebupent | d00030 |
|  | posaconazole | Noxafil | d05853 |
|  | prednisone | Deltasone, Liquid Pred, Metocorten, Orasone, Panasol, Prednicen-M, Sterapred | d00350 |
|  | Primaquine | Primaquine | d00351 |
|  | Probenecid | Benemid | d00031 |
|  | pyrazinamide (PZA)  | Rifater | d00117 |
|  | pyrimethamine  | Daraprim | d00364 |
|  | rifabutin  | Mycobutin | d01097 |
|  | rifampin (RIF)  | Rifadin, Rimactane | d00047 |
|  | sulfadiazine (oral generic)  | Microsulfon | d00118 |
|  | trimethoprim-sulfamethoxazole (TMP/SMX)  | Bactrim, Septra | d00124 |
|  | valacyclovir  | Valtrex | d03838 |
|  | valganciclovir  | Valcyte | d04755 |

1. **Grantee-level Formulary Information – Hepatitis B and C Medications**

|  |  |  |  |
| --- | --- | --- | --- |
| **Included In Formulary** | **GENERIC NAME**  | **BRAND NAME** | **Drug Identification Number**  |
|
|  | adefovir | Hepsera | d04814 |
|  | boceprevir | victrelis | d07774 |
|  | entecavir  | Baraclude | d05525 |
|  | interferon alfa-2a | Roferon-A | d01368 |
|  | interferon alfa-2b  | Intron A | d01369 |
|  | interferon alfa-2b/ribavirin  | Rebetron | d04321 |
|  | lamivudine  | Epivir HBV | d03858 |
|  | peginterferon alfa-2a  | Pegasys/Pegasys Proclick Autoinjector | d04821 |
|  | peginterferon alfa-2b | Pegasys/Pegintron Redipen/Sylatron | d04746 |
|  | Ribavirin | Copegus/RIbapik/Virazole/Ribatab/Rebetol | d00085 |
|  | Simeprevir | Olysio | d08182 |
|  | Sofosbuvir | Sovaldi | d08184 |
|  | Telaprevir | Incivek | d07777 |
|  | telbivudine  | Tyzeka | d05912 |
|  | Interferon alfacon-1 | infergen | d04224 |

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