

AIDS Drug Assistance Program ADR Grantee Report Revised Grantee-Level Variables

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915–0345. Public reporting burden for this collection of information is estimated to average 6 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, MD 20857.

COVER PAGE (All Values Autopopulated)

Grantee Contact Information

1. Grantee name: _____

2. Grant number:

--	--	--	--	--	--	--	--	--	--

3. D-U-N-S number:

		-				-				
--	--	---	--	--	--	---	--	--	--	--

4. Grantee address:

a. Street: _____

b. City: _____ State: _____

c. ZIP Code: _____ - _____

5. Contact information of person completing the Grantee Report:

a. Name: _____

b. Title: _____

c. Phone #: (____) _____ - _____

d. Fax #: (____) _____ - _____

e. 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

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

_____ %

3. 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

4. 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

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.	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

6. 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.

a. 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
<input type="checkbox"/>	abacavir	Ziagen	d04376	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	abacavir/lamivudine/zidovudine	Trizivir	d04727	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	abacavir/lamivudine	Epzicom	d05354	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	atazanavir	Reyataz	d04882	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	darunavir	Prezista	d05825	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	delavirdine	Rescriptor	d04119	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	didanosine	Videx/Videx EC	d00078	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	dolutegravir	Tivicay	d08117	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	efavirenz	Sustiva	d04355	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Efavirenz/emtricitabine/tenofovir	Atripla	d05847	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Elvitegravir/cobicistat/tenofovir/emtricitabine	Stribild	d07899	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	emtricitabine	Emtriva	d04884	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Emtricitabine/rilpivirine/tenofovir	Complera	d07796	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Emtricitabine/tenofovir	Truvada	d05352	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Enfuvirtide	Fuzeon	d04853	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Etravirine	Intelence	d07076	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Fosamprenavir	Lexiva	d04901	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Indinavir	Crixivan	d03985	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	lamivudine	Epivir	d03858	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Lamivudine/zidovudine	Combivir	d04219	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Lopinavir/ritonavir	Kaletra	d04717	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	maraviroc	Selzentry	d06852	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	nelfinavir	Viracept	d04118	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	nevirapine	Viramune/ Viramune XR	d04029	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Raltegravir	Isentress	d07048	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	rilpivirine	endurant	d07776	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	ritonavir	Norvir	d03984	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Saquinavir	Fortovase/ invirase	d03860	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	stavudine	Zerit	d03773	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	tenofovir	Viread	d04774	<input type="checkbox"/>	MM/DD/YYYY
<input type="checkbox"/>	Tipranavir	aptivus	d05538	<input type="checkbox"/>	MM/DD/YYYY

<input type="checkbox"/>	zidovudine	Retrovir	d00034	<input type="checkbox"/>	MM/DD/YYYY
--------------------------	------------	----------	--------	--------------------------	------------

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

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

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

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