**ATTACHMENT 98**

# MEDICAL EXPENDITURE PANEL SURVEY

# MEDICAL PROVIDER COMPONENT

# DATA FORM

# FOR

# PHARMACIES

# FOR

# REFERENCE YEAR 2017

**OMB**

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

(Public reporting burden for this collection of information is estimated to average 3 minutes per response, the estimated time required to complete the survey. 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0118) AHRQ, 5600 Fishers Lane, Rockville, MD 20857.)

**Q1.** Date Filled

OMB Statement link

MONTH DAY YEAR

**Q2.** Prescription information will be identified using:

1 = NDC
2 = Drug Name, Strength/Unit, and Dosage Form

NOTE: TRY TO OBTAIN NDC. USE DRUG NAME ONLY IF NDC NOT AVAILABLE.

**Q2a.** NDC

ENTER 11-DIGIT NDC WITHOUT DASHES OR SPACES.

NDC IS UNKNOWN OR REFUSED, RETURN TO PREVIOUS SCREEN AND SELECT **DRUG NAME** OPTION

OMB Statement

## NDC ROUTE
## IF Q2 = 1 (NDC COLLECTED)

**The NDC you specified:**
**NDC: [FILL NDC]**
**DESCRIPTION: [SMZ/TMP DS TAB 800-160]**

**DCS: Please confirm that the drug names matches what is in the record (if specified in the record). If it does not, please click on Previous and correct the NDC number entered.**

**Q3a.** Quantity:

**Q4.** How many days were supplied?

IF PRESCRIPTION WAS TO BE USED "AS NEEDED" ENTER 999

**Q5. Patient Payment:** $

**Q5a. Were there any 3rd party payers?** **$**


## DRUG NAME ROUTE
## IF Q2 = 3 (DRUG NAME COLLECTED)

**Q2b.** Drug Name:

**Q2b_1**

**Compound drug?** ●

**Durable Medical Equipment** ●

IF DURABLE MEDICAL EQUIPMENT GO TO Q3a***

**MJ?** ●

IF MJ GO TO Q3a***

**Q2c.** Strength

**Q2d.** Unit:

**Q2c1.** Strength 2:

**Q2d2.** Unit 2:

**Q2e.** Dosage Form:

**Q3a.** Quantity:

**Q3b** Unit:

**Q4.** How many days were supplied?

IF PRESCRIPTION WAS TO BE USED “AS NEEDED” ENTER 999

**Q5. Patient Payment:** $

**Q5a. Were there any 3rd party payers?** **$**

PRESCRIPTION INFO/Path_DrugName

Q2b. **Drug Name** F6 F7 F8

☐ **Compound drug?**

**Durable Medical Equipment (DME)?**
☐ IF DURABLE MEDICAL EQUIPMENT GOTO Q3a***

**MJ ?**
☐ IF MJ GOTO Q3a*** F6 F7 F8

| | | |
|---|---|---|
| Q2c. | **Strength** | F6 F7 F8 |
| Q2d. | **Unit** | -Select One- F6 F7 F8 |
| | Other, specify | F6 F7 F8 |
| Q2c2. | **Strength 2** | F6 F7 F8 |
| Q2d2. | **Unit 2** | -Select One- F6 F7 F8 |
| | Other, specify | F6 F7 F8 |
| Q2e. | **Dosage Form** | -Select One - F6 F7 F8 |
| | Other, specify | F6 F7 F8 |
| Q3a. | ***Quantity** | F6 F7 F8 |
| Q3b. | ***Quantity Unit** | -Select One- F6 F7 F8 |
| | Other, specify | F6 F7 F8 |

Q4. ***Days Supplied? F6 F7 F8

Q5. ***Patient Payment F6 F7 F8

Q5a. **Any 3rd party payers?**

1 YES

2 NO

F6 F7 F8

Previous Next Breakoff Validate

**FINAL SCREEN**

**Q6. Type of 3rd Party Payer**
Other Specify Source

**Q7. 3rd Party Payment** $

NOTE: IF PATIENT PAYMENT WAS $1 OR LESS, EXPECT THE 3rd PARTY PAYER TO BE A PUBLIC PROGRAM, E.G., MEDICAID OR OTHER STATE/LOCAL GOVT, ETC.

Any more 3rd Party Payers?
1 YES
2 NO

**FINISH SCREEN**
PRESS VALIDATE TO
COMPLETE THIS EVENT FORM.