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

Q1. Date Filled

MONTH F6 F7 F8
DAY F6 F7 F8
YEAR F6 F7 F8
○ I NDC○ Drug Name, Strength/Unit, and Dosage Form
Q2a.NDC ENTER 11-DIGIT NDC WITHOUT DASHES OR SPACES

NDC ROUTE IF Q2 = 1 (NDC COLLECTED)

The	NDC	you	spec	cifie	d:

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?

PRECODIRETION INFO (D-+h NDO

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

Q5. Patient Payment: \$

Q5a. Were there any 3rd party payers?

QЗа.	Quantity		F6 F7 F8
Q4.	How many days were supplied?		F6 F7 F8
Q5.	Patient Payment		F6 F7 F8
Q5a.	Were there any 3rd party payers?	-Select- ▼ E	6 F7 F8

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

Q2b. Drug Name:

Q2b_1

Compound drug? ●

Durable Medical Equipment •

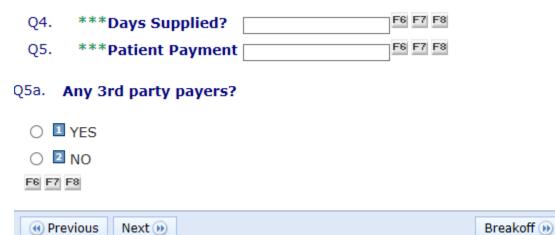
IF DURABLE MEDICAL EQUIPMENT GO TO Q3a***

MJ? ●

IF MJ GO TO Q3a***

Return to Test

Q2c.	Strength						
	Q2d	Unit:					
	Q2c	L. Strength 2:					
	Q2d	2. Unit 2:					
	Q2e.	Dosage Form:					
	Q3a.	Quantity:					
	Q3b	Unit:					
	Q4.	How many days wer	e supplied?				
	IF PI	RESCRIPTION WAS T	O BE USED "	AS NEE	DED" ENTE	ER 999	
	Q5.	Patient Payment:			\$		
	O5a	Were there any 3rd	narty naver	s?	\$		
- 005		_		.	•		
Ø PRE	SCRI	PTION INFO/Path_DrugNa	me				
Q2b	. D i	rug Name				F6 F7 F8	
	omp	ound drug?					
		o <mark>le Medical Equipm</mark> e RABLE MEDICAL EQUI) Q3a**	*		
	1J ?						
	F MJ (GOTO Q3a*** 🕫 F7 F	-8				
Q20	. S	trength					F6 F7 F8
Q20	l. U	nit	-Select One-	∨ F6 F7	F8		
	0	ther, specify			F6 F7 F8		
Q2d	2. S	trength 2					F6 F7 F8
Q2d	12. U	nit 2	-Select One-	∨ F6 F7	F8		
	0	ther, specify			F6 F7 F8		
Q2e	e. D	osage Form	-Select One -			y F6 F7 F8	
	0	ther, specify			F6 F7 F8		
Q3a	a. *	**Quantity			F6 F7 F8		
Q3b). *	**Quantity Unit	-Select One-	~ !	F6 F7 F8		
	0	ther, specify			F6 F7 F8		



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.

Validate