Each provider must complete a single Data Report for all clients served during the reporting period.

OMB No: 0915-0294
Expiration Date: 02/28/2011

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

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 number. The OMB control number for this project is 0915-0294. Public reporting burden for this collection of information is estimatedas 7.5 hours per respondent per year. These estimates include the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments to HRSA Reports Clearance Officer, Health Resources and Services Administration, Room 14-43, 5600 Fishers Lane, Rockville, MD. 20857.

COVER PAGE

All Ryan White Care Act grantees must complete this cover page if submitting a quarterly data report by paper

Grantee Contact Information

1. Grantee name:

adap

2. Grant number:

1									

3. ADAP number:

5	5	5	

4. D-U-N-S number:

5	5	–	5	5	5	–	5	5	5	5

5. Grantee address:

a. Street: 354 ERIE Street

b. City: Yeppers State: Louisiana

c. ZIP Code: 74034 –

6. Contact information for the ADAP Coordinator/Administrator:

a. Name: ADAT

b. Title: MT

c. Phone #: (555) 555 – 5555

d. Fax #: ( ) –

e. E-mail: ASD@GRGR.ORG

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 [06/30/2014]), please indicate the UNDUPLICATED number of:

a.	Total clients enrolled in the ADAP at any time during the quarter	1420
b.	NEW clients enrolled in the ADAP	2
c.	Clients who received at least one drug through the ADAP	1413
d.	NEW clients who received at least one drug through the ADAP	2
e.	Clients who received any type of insurance service (premiums, co-pays, deductibles)	128
f.	NEW clients who received any type of insurance service (premiums, co-pays, deductibles)	1

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	656	1	652	1	70	1
Females	685	1	684	1	50	0
Transgender	79	0	77	0	8	0
Unknown/unreported	0	0	0	0	0	0
Total	1420	2	1413	2	128	1

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

3. Age 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
Less than 2 years	0	0	0	0	0	0
2–12 years	10	0	10	0	1	0
13–24 years	802	2	798	2	67	1
25–44 years	297	0	294	0	29	0
45–64 years	255	0	255	0	26	0
65 years or older	56	0	56	0	5	0
Unknown/unreported	0	0	0	0	0	0
Total	1420	2	1413	2	128	1

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

4. Racial distribution for total unduplicated 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	61	0	60	0	7	0
Black or African American	90	1	90	1	8	1
Asian	3	0	3	0	0	0
Native Hawaiian or Other Pacific Islander	14	0	14	0	1	0
American Indian or Alaska Native	13	0	13	0	1	0
More than one race	49	0	48	0	5	0
Unreported	56	1	56	1	0	0
Total	286	2	284	2	22	1

*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	566	0	566	0	59	0
Black or African American	257	0	254	0	25	0
Asian	25	0	25	0	2	0
Native Hawaiian or Other Pacific Islander	22	0	22	0	2	0
American Indian or Alaska Native	53	0	53	0	7	0
More than one race	58	0	56	0	8	0
Unreported	153	0	153	0	3	0
Total	1134	0	1129	0	106	0

*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)	0
b. HAART regimen (3 or 4 antiretrovirals)	0
c. More than 4 antiretrovirals	0

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:

0 %

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 1000

b. ☐ Waiting list — Current number on waiting list

c. ☑ Capped expenditure — Monetary cap $100 per client

d. ☑ Drug-specific enrollment caps ***(ARVs and Hep C meds)***

Medication #1 Triumeq — Max number of enrollees 100

Medication #2 Abacavir — Max number of enrollees 100

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	$700,000
b.	Total contributions from Part B Base Funding	$300,000
c.	State contributions (other than Ryan White funds and State-required match for supplement)	$1,000,000
d.	Carry-over of Ryan White funds from previous year	$500,000
e.	Manufacturer Rebates	$100,000
f.	All Insurance Reimbursements, including Medicaid	$1,000,000
	Resources received this quarter (Total of a through f)	$3,600,000

B. FUNDING

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

	Expenditure Category	Total Cost
a.	Pharmaceuticals	$2,000,000
b.	Dispensing and other administrative costs	$500,000
c.	Insurance coverage (including co-pays, deductibles, and premiums)	$1,000,000
d.	Under the ADAP Flexibility Policy - **Adherence**	$10,000
e.	Under the ADAP Flexibility Policy - **Access**	$10,000
f.	Under the ADAP Flexibility Policy - **Monitoring**	$10,000
	Total ADAP expenditures this quarter	$10,000

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. Enter the total cost for medications purchased during the reporting period (Do not include the Dispensing and other administrative fees).

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
A	**B**	**C**	**D**	**E**	**F**
ARVs					
☐	stavudine	Zerit	d03773		0
☐	ritonavir	Norvir	d03984		0
☐	efavirenz/emtricitabine/tenofovir	Atripla	d05847		0
Hepatitis B and C treatment Medications					

13. 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 hat 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

14. 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	$1,000,000.00
b.	ADAP Supplemental Drug Treatment Grant Award	$1,000,000.00
c.	State Match for Supplemental Drug Treatment Award	$100,000.00
	ADAP resources received (total of a through c)	$2,100,000.00

15. ADAP formulary

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

16. 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 States and Hybrids:

i. Cost per client before cost-saving strategies: $85.00 per client

ii. Cost per client after cost-saving strategies: $55.00 per client

B. Direct Purchase States:

i. Annual cost per client: $85.00 per client

B. ELIGIBILITY REQUIREMENTS

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

5 %

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

☑ Annually

☐ Semiannually *(every 6 months)*

☐ Other, please specify _____

19. Please indicate the clinical eligibility criteria required to enroll in the ADAP in your State/Territory? *(Check all that apply.)*

- [x] HIV+
- [ ] CD4 (what is your CD4 count requirement? _____)
- [ ] Viral load (what is your VL count requirement? _____)
- [ ] Other (please specify: _____)

B. ELIGIBILITY REQUIREMENTS

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

- [x] Rebate
- [ ] Direct purchase
- [x] Prime vendor
- [ ] Alternative Method Demonstration Project
- [ ] State does not participate in 340B Drug Pricing Program
- [ ] Other drug discount program (not 340B) (please specify _____)

21. 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
- [x] Coordinated benefits
- [ ] Retroactive billing
- [ ] Other (please specify _____)
- [ ] We have no coordination with Medicaid or State-only ADAP

22. Comments or clarifications:

Use this space to provide additional information about data for Items 13-20 that do not comply with what is requested as described in the Instruction Manual.