

ATTACHMENT C

Implementation Questionnaire For Patient Assistance Program

Data Sharing Agreement

Version 11/27/06

Patient Assistance Program Data Sharing Agreement Implementation Questionnaire

Patient Assistance Program Name: _____
Date: _____

Please check all that apply:

I. Patient Assistance Program Specific Information

- ☐ Patient Assistance Program offers a network prescription drug benefit.
- ☐ Patient Assistance Program offers a network prescription drug benefit and shall provide its Rx BIN and/or PCN below. (If you have more than one BIN/PCN, please submit all of these numbers to the CMS in a separate attached Word document).

Rx BIN _____
PCN _____

- ☐ Patient Assistance Program offers a network prescription drug benefit and shall provide its TrOOP Rx BIN and/or PCN below. (If you have more than one TrOOP BIN/PCN, please submit all of these numbers to the CMS in a separate attached Word document).

TrOOP Rx BIN _____
TrOOP PCN _____

II. Questions regarding how Patient Assistance Program will submit prescription drug coverage of its Program Enrollees:

- ☐ Patient Assistance Program will satisfy its Data Sharing Agreement requirement to submit prescription drug coverage of its PAP Enrollees using the Input file of the PAP Data Sharing Agreement.
- ☐ Patient Assistance Program contracts with a Pharmacy Benefit Manager (PBM) to pay prescription drug benefits in the pharmacy network. Please provide the name of the PBM _____.
- ☐ Patient Assistance Program's PBM, named above, has (1) signed a Data Sharing Agreement with CMS and (2) signed an agreement with the Patient Assistance Program stating they will satisfy the Patient Assistance Program's Data Sharing Agreement requirement to submit prescription drug coverage of its Patient Assistance Program Enrollees.