Implementation Questionnaire –
State Pharmaceutical Assistance Program (SPAP)

Version 3/19/07

SPAP Data Sharing Agreement Implementation Questionnaire

SPAP Name: _____

Date: _____

Please check all that apply:

I. SPAP Specific Information

☐ SPAP offers a network prescription drug benefit.

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

      Rx BIN _____
      PCN   _____

SPAP offers a network prescription drug benefit and shall provide its TrOOP Rx BIN and/or PCN below. (If you have more than one TrOOP RxBIN or PCN, please submit all of the numbers to the CMS on a separate attached Word document.)

      TrOOP Rx BIN _____
      TrOOP PCN   _____

II. How will the SPAP satisfy its Data Sharing Agreement requirement to submit the prescription drug coverage of its SPAP Enrollees?

☐ SPAP will submit prescription drug coverage of its SPAP Enrollees using the Input file of the SPAP Data Sharing Agreement.

☐ SPAP's PBM, named below, (1) has signed a Data Sharing Agreement with CMS and (2) has signed an agreement with the SPAP stating that it will submit the required data regarding the SPAP's prescription drug coverage of its SPAP Enrollees to CMS on behalf of the SPAP.

☐ SPAP contracts with a Pharmacy Benefit Manager (PBM) to pay prescription drug benefits in a pharmacy network. Please provide the name of the PBM: _____.