ATTACHMENT C

Implementation Questionnaire
For Supplemental Drug Program

Data Sharing Agreement

Version 10/24/05

Supplemental Drug Program Data Sharing Agreement Implementation Questionnaire

Supplemental Drug Program Name: _____

Date: _____

Please check all that apply:

I. Supplemental Drug Program Specific Information

☐ (Supplemental Drug Program offers a network prescription drug benefit.

☐ (Supplemental Drug 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 _____

☐ (Supplemental Drug 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 Supplemental Drug Program will submit prescription drug coverage of its Supplemental Drug Program Enrollees:

☐ (Supplemental Drug Program will satisfy its Data Sharing Agreement requirement to submit prescription drug coverage of its SPAP Enrollees using the Input file of the SPAP Data Sharing Agreement.

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

☐ (Supplemental Drug Program's PBM, named above, has (1) signed a Data Sharing Agreement with CMS and (2) signed an agreement with the Supplemental Drug Program stating they will satisfy the Supplemental Drug

Program's Data Sharing Agreement requirement to submit prescription drug coverage of its Supplemental Drug Program Enrollees.