



State of Rhode Island  
340B Drug Pricing Program - Mandated Covered Entity Reporting  
Mandated Reporting Cover Page

**Covered Entity 340B Drug Pricing Program Reporting Mandated by  
RI General Law Section 5-19.3-6.**

Covered Entity Name:	<input type="text"/>
Covered Entity Corporate Address:	<input type="text"/>
340B ID Number(s)	<input type="text"/>
Reporting for Calendar Year:	<input type="text"/>

**Covered Entity Required Information**

Date of most recent recertification with the Health Resources and Service Administration	<input type="text"/>
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Reporting Basis (i.e., Cash or Accrual)	<input type="text"/>
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**RHODE ISLAND**



**340B DRUG PRICING  
PROGRAM**



State of Rhode Island  
 340B Drug Pricing Program - Covered Entity Reporting  
 Schedule A - Aggregate Reporting Schedule

Schedule A

Covered Entity Name:

Reporting for Calendar Year:

Line No.	Data Element	Data Element Description	Schedule Ref	Amount	Unit
1	<b>Total Aggregated Acquisition Cost for All 340B Program Drugs</b>	Total aggregated cost to entity for drugs purchased under 340B (actual paid, incl. fees) during the previous calendar year.	<b>B</b>		USD
2	<b>Total Aggregated Payment Amount Received for Dispensed/Administered 340B Drugs</b>	Total payments (claim reimbursements) received for 340B drugs dispensed/ administered to patients with commercial medical insurance, Medical Assistance, and/or Medicare Supplemental plans.	<b>C</b>		USD
3	<b>Total Aggregated Payments to Contract Pharmacies for 340B Program Prescription Drugs</b>	Total payments made to contract pharmacies for dispensing 340B drugs.	<b>D</b>		USD
4	<b>Total Aggregated Payments to Outside Entities (Vendors) for 340B Program Management, Administration, or Facilitation</b>	Total payments to vendors managing, administering, or facilitating any aspect of the 340B covered entity's drug program.	<b>E</b>		USD
5	<b>Total Aggregated Administrative Expenses for 340B Program</b>	Total covered entity expenses for staffing, operations, and administration related to the 340B program.	<b>F</b>		USD
6	<b>Net 340B Revenue Calculation (Auto-Calculated)</b>	Payments Received (Line 2) - (Acquisition Costs (Line 1) + Administration Expenses (Lines 3, 4 & 5))		\$0.00	USD



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Schedule B

340B Drug Pricing Program - Covered Entity Reporting  
Schedule B - Acquisition Cost Detail Schedule

Covered Entity Name:

Reporting for Calendar Year:

*Instruction: Provide detail for all vendors (e.g. manufacturers, wholesalers) where the covered entity procured \$5,000 or more of prescription drugs from an individual vendor/pharmacy under the 340B program. Provide an aggregated total for vendors where procurement was less than \$5,000.*

Line No.	Vendor Name	Amount Paid	Unit
1			USD
2			USD
3			USD
4			USD
5			USD
6			USD
7			USD
8			USD
9			USD
10			USD
	<b>Total for vendors under \$5,000</b>	_____	USD
	<b>Total Aggregated Acquisition Cost for all 340B Program Drugs - (Supports Schedule A, Line 1)</b>	_____	USD
		Schedule A - Line 1	



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Schedule C

340B Drug Pricing Program - Covered Entity Reporting

Schedule C - Claim Reimbursements For 340B

Dispensed / Administered Drugs

Covered Entity Name:

Reporting for Calendar Year:

**Instruction: Provide detail (amount and number of individual claims) for all reimbursements relating to pharmaceuticals obtained under the 340B Drug Program from commercial insurance (including Medicare Supplemental plans), Medical Assistance, Medicare, and or other sources. This schedule should total all reimbursements relating to pharmaceuticals obtained under the 340B Drug Program.**

Line No.	Reimbursement Source	Amount Reimbursed	Unit	Count	Unit
1	Commercial Insurance		USD		Claims
2	Medical Assistance (i.e., Medicaid)		USD		Claims
3	Medicare		USD		Claims
4	Other Sources		USD		Claims
		_____		_____	
<b>Total Aggregated Payment Amount Received for Dispensed/Administered 340B Drugs (Supports Schedule A - Line 2)</b>		_____		_____	
		=====		=====	
		Schedule A - Line 2			



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Schedule D

340B Drug Pricing Program - Covered Entity Reporting

Schedule D - Payment to Contract Pharmacy Detail Schedule

Covered Entity Name:

Reporting for Calendar Year:

**Instruction: Provide detail for all payments made to contract pharmacies for dispensing 340B prescription drugs during the reporting period. Individually list any contract pharmacy paid \$5,000 or more. Aggregate payments to contract pharmacies paid less than \$5,000.**

Line No.	Contract Pharmacy Name	Amount Paid	Unit
1			USD
2			USD
3			USD
4			USD
5			USD
6			USD
7			USD
8			USD
9			USD
10			USD

**Total for contract pharmacies under \$5,000**

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**Total Aggregated Payments to Contract Pharmacies for 340B Program Prescription Drugs (Supports Schedule A - Line 3**

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Schedule A - Line 3



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Schedule E

340B Drug Pricing Program - Covered Entity Reporting  
Schedule E - Payments to Outside Entities (Vendors) for 340B Program  
Management, Administration, or Facilitation

Covered Entity Name:

Reporting for Calendar Year:

**Instruction: Aggregate detail by service/contractor category for all payments made to vendors/contractors relating to the management, administration, and/or facilitation of any aspect of the Covered Entity's participation in the 340B Program. Examples of services/contractors to be aggregated include contracted pharmacies, split billing vendors, consultants, third-party administrators, and other vendors. For consultants and other vendors, provide a brief description of service provided. Aggregate payments for service/contractor categories individually paid less than \$5,000.**

Line No.	Program Management, Administration, or Facilitation Category	Description For Other / Consultants	Amount	Unit
1				USD
2				USD
3				USD
4				USD
5				USD
6				USD
7				USD
8				USD
	<b>Total Vendor Categories individually under \$5,000</b>		_____	
	<b>Total Aggregated Payments to Outside Entities (Vendors) for 340B Program Management, Administration, or Facilitation (Supports Schedule A - Line 4)</b>		_____	
			=====	Schedule A - Line 4



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Schedule F

340B Drug Pricing Program - Covered Entity Reporting  
Schedule F - Administrative Expenses for 340B Program

Covered Entity Name:

Reporting for Calendar Year:

***Instruction: Provide detail for all covered entity expenses (noncontracted) relating to the administration of the 340B program including staffing, operational, and administrative expenses. Detail individual expense categories with expenses of \$5,000 or more. Aggregate expense categories individually less than \$5,000.***

Line No.	Expense Category Description	Amount/Value	Unit
1			USD
2			USD
3			USD
4			USD
5			USD
6			USD
7			USD
8			USD
9			USD
10			USD
	<b>Total for expense categories individually under \$5,000</b>	_____	
	<b>Total Aggregated Administrative Expenses for 340B Program</b>	=====	
		Schedule A - Line 5	



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Schedule G

340B Drug Pricing Program - Covered Entity Reporting

Schedule G - Detail of Prescription Drugs Relating to Covered Entity Participation in the 340B Program Dispensed or Administered During the Period.

Covered Entity Name:

Reporting for Calendar Year:

**Instruction: List all prescription drugs relating to Covered Entity participation in the 340B Program during the period. Detail the total amount (cost of prescription drug obtained through the 340B program) and count of individual prescription drug claims dispensed or administered during the period. Aggregate all prescription drugs where reimbursements for the particular drug were less than \$5,000.**

Line No.	Prescription Drug Name	National Drug Code Number	Amount	Unit	Count	Unit
1				USD		Claims
2				USD		Claims
3				USD		Claims
4				USD		Claims
5				USD		Claims
6				USD		Claims
7				USD		Claims
8				USD		Claims
9				USD		Claims
10				USD		Claims
	<b>Total Prescription Drugs individually under \$5,000</b>		_____	USD	_____	Claims
	<b>Total Prescription Drugs Obtained Through 340B Program Claimed for Reimbursement</b>		=====		=====	

Mandated by  
RIGL § 5-19.3-6



State of Rhode Island

Schedule H

340B Drug Pricing Program - Covered Entity Reporting

Schedule H - 340B Program Savings Usage by Covered Entity to Benefit Patients and/or its Community Through Programs, Projects, and/or Services.

Covered Entity Name:

Reporting for Calendar Year:

**Instruction: List all programs, projects, and/or services provided by the Covered Entity through 340B Program savings that benefited patients and/or its community. Detail individual programs, projects, and/or services provided and the related costs incurred by the covered entity. Individually list programs, projects, and services with costs of \$5,000 or more. Aggregate all other programs, projects, and services where costs totaled less than \$5,000.**

<u>Line No.</u>	<u>340B Net Revenue Usage Description</u>	<u>Amount/Value</u>	<u>Unit</u>
1	Health Services Expansion		USD
2	Community and Public Health Programs		USD
3	Improving Patient Access		USD
4	Facility Upgrades		USD
5	Technology Upgrades		USD
6	Subsidize Losses - Medicaid and Medicare Program Underpayments		USD
7	Research and Innovation		USD
8	Community Programs		USD
9	Charity Care/Uncompensated Care		USD
10	Other		USD
	<b>Other programs, projects, and services where costs totaled less than \$5,000.</b>		USD
	<b>Total Aggregate Costs of Programs, Projects, and/or Services Supported by 340B Net Revenue</b>		

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Mandated by RIGL § 5-19.3-6.



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340B Drug Pricing Program - Covered Entity Reporting

Schedule I - Covered Entity Certification Page

Schedule I

Covered Entity Name:

Reporting for Calendar Year:

Two empty rectangular boxes for entering the Covered Entity Name and Reporting for Calendar Year.

Line No.	Covered Entity Certification	YES	NO	If Yes, explain any noncompliance noted.
1	During the reporting period, did the covered entity conduct a self-audit of their participation in the 340B Program as required by the Health Resources and Services Administration (HRSA)?			
2	During the reporting period, was the covered entity audited by HRSA or subject to a drug manufacturer audit approved by HRSA?			

**I certify, to the best of my knowledge and belief, that the information reported in this reporting package is materially complete and accurate?**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Title

\_\_\_\_\_  
Email