MEDICAL PHARMACY COMPONENT FOR REFERENCE YEAR 2009

CONTACT GUIDE FOR PHARMACIES

Q1. [1] (ASK IF NOT OBVIOUS) Have I reached (PHARMACY NAME)?

☐ YES → VERIFY ADDRESS AND THEN CONTINUE WITH Q2

☐ NO → VERIFY TELEPHONE NUMBER, ADDRESS, AND NAME OF PHARMACY. IF PHARMACY IS DIFFERENT, RECORD PROBLEM WITH THE PHARMACY AND TERMINATE CALL. CONTACT DIRECTORY ASSISTANCE. IF NO BETTER NUMBER CAN BE FOUND, MARK FOR SUPERVISOR REVIEW.

Q2. [2] May I please speak to the pharmacist?

☐ SPEAKING TO PHARMACIST → RECORD NAME AND VERIFY TELEPHONE NUMBER

(May I please have your name?) (IF ONLY FIRST NAME GIVEN PROBE FOR FULL NAME)

NAME: _____

The telephone number that I dialed is (FILL TELEPHONE NUMBER). Is that the best number at which to reach you?

TELEPHONE NUMBER: (_____)_____ EXT: _____

YES → CONTINUE WITH Q3

☐ PHARMACIST NOT AVAILABLE → RECORD CALLBACK INFORMATION

What would be the best day and time to call back to speak with the pharmacist?

DAY:_____ DATE:_____ R's TIME: _____ AM/PM

Thank you for that information. I will call back then.
END CALL

Q3. [3] (Hello,) my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We are conducting MEPS which is a study about how people in the United States use and pay for health care. [NUMBER] of your customers identified (PHARMACY NAME) as a place where they received prescribed medication during 2009. (The/Each) patient signed an authorization form allowing us to contact you for information. Would you or someone in your office be able to provide this type of information?

YES 1
NO ..... 2 (GO TO Q3a)

I would like to fax the authorization forms to you, along with additional information explaining the study.

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[INTERVIEWER: READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) first. Once you have received the form(s), then we can arrange for the collection of the data.

PHARMACY MAINTAINS THE INFORMATION:

FAX AUTHORIZATION FORM(S) ..... 1 (GO TO Q4)
MAIL AUTHORIZATION FORM(S) ..... 2 (GO TO Q5)

PHARMACY DOES NOT MAINTAIN THE INFORMATION:

NEED TO CONTACT OTHER DEPARTMENT / CORPORATE OFFICE FOR AUTHORIZATION... 3 (GO TO Q7)
THIS TYPE OF INFORMATION IS NOT AVAILABLE (RECORD:) .....4 (TERMINATE CALL AND MARK FOR SUPERVISOR REVIEW) _____
_____

Q3a. [3a] Who would we contact to obtain this information?

NAME: _____
TITLE:_____
DEPARTMENT: _____
TELEPHONE: (_____)_____

Thank you very much for your help. [END CONTACT; FOLLOW-UP WITH THE CONTACT NAMED IN Q3a.]

Q4. [4] I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT: _____

GO TO Q6

NO → Please tell me to whom I should fax this information.

NAME: _____
TITLE:_____
DEPARTMENT: _____
FAX NUMBER: (_____)_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

GO TO Q6

Q5. [5] I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME: _____
TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Q6. [6] Once you have received the authorization form(s), we will call back to collect the data over the phone. We are interested in collecting profiles for each patient that includes the amount paid by the patient and the amount paid by any third party payers for all prescriptions in 2009. We are also interested in collecting the NDC, date filled or refilled, quantity dispensed with dosage form. We would appreciate it if you could also include the types of the third parties.

What would be the best day and time to call back to collect this information by phone?

DAY:_____ DATE:_____ R's TIME: _____ AM/PM

IF PHARMACY DOESN'T WANT TO PROVIDE DATA OVER THE PHONE, OFFER FAX OR MAIL

You can send us the data by either fax or mail.

PROVIDER WILL RESPOND:

BY PHONE..... 1
BY FAX..... 2
BY MAIL 3

IF POINT OF CONTACT (POC) WILL RESPOND BY PHONE READ:
Thank you very much. We will allow time for you to receive and review the authorization form(s), and then we will call you back to collect the data.

IF POC WILL RESPOND BY FAX OR MAIL READ:
We hope you can send the profiles to our office within two weeks. We will include an instruction sheet when we (fax/mail) the authorization form(s). If you have any questions about what to send us, please call our toll-free number on the instruction sheet. We may call again if other patients identify this pharmacy as a source of prescribed medication. Thank you very much for your help.

Q7. [7] Since we will need to get in touch with the person or office that can provide the information we need, what is the name of the person and/or office that we should contact and their telephone number?

NAME: _____

TITLE: _____

NAME OF DEPARTMENT/OFFICE: _____

TELEPHONE (_____) _____ EXT: _____

Thank you very much for your help.
END CONTACT AND MARK FOR SUPERVISOR REVIEW

CALL BACK TO CONFIRM AUTHORIZATION FORM(S) RECEPIT

Q8. [9] May I please speak to (POC)?

Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Did you receive the authorization form(s) we (faxed/sent)?

YES ..... (GO TO Q9 IF MODE = PHONE; GO TO Q11 IF MODE = FAX OR MAIL)
NO ..... (GO TO Q12)

IF MODE = PHONE, READ Q9

Q9. [14/15] If it is convenient for you, we can just go ahead and complete the data forms together over the phone right now. I'd be happy to hold on while you get the information you need from your profiles.

WILL COMPLETE BY PHONE NOW ..... 1 (GO TO EVENT FORM)
WILL COMPLETE BY PHONE IN THE FUTURE..... 2 (GO TO A21)

Q10. [16] What would be the best day and time to call you back?

DAY:_____ DATE:_____ R's TIME: _____ AM/PM

Thank you very much for your help. I will call you back then.

IF MODE = FAX or MAIL, READ Q11

Q11. [N/A] Our records indicate that you will (fax/mail) the profiles to us. We hope you can do so within two weeks. Thank you very much for your help.

Q12. [10] I'm sorry. Let me (re-fax/re-send) the authorization form(s) to you.

FAX AUTHORIZATION FORM(S) ..... 1 (GO TO Q13)
MAIL AUTHORIZATION FORM(S)..... 2 (GO TO Q14)

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) first. Once you have received the form(s), then we can arrange for the collection of the data.

Q13. [10] IF FAXED PREVIOUSLY: Before I send the authorization form(s) again, I would like to verify the information to include on the fax cover page.
CONFIRM PRELOAD INFORMATION

FAX NUMBER: (_____)_____
NAME: _____
TITLE:_____
DEPARTMENT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

IF MAILED PREVIOUSLY: I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT: _____

NO → Please tell me to whom I should fax this information.

NAME: _____
TITLE:_____
DEPARTMENT: _____
FAX NUMBER: (_____)_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

Q14. [12] IF MAILED PREVIOUSLY: Before I send the authorization form(s) again, I would like to verify the information on the mailing label.
CONFIRM PRELOAD INFORMATION

NAME:_____
TITLE: _____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

IF FAXED PREVIOUSLY: I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT: _____
ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME: _____

TITLE:_____

DEPARTMENT: _____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

RECONTACT PROVIDER OFFICE [N/A]

INCORRECT INFORMATION

Hello may I speak to (POC)? This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Thank you for providing the contact information for (OTHER DEPARTMENT / CORPORATE). Unfortunately we were unable to locate (OTHER DEPARTMENT / CORPORATE) with the information you provided. Could you please verify the contact information we currently have for (OTHER DEPARTMENT / CORPORATE)?

PERSON'S NAME: _____

TITLE: _____

NAME OF DEPARTMENT/OFFICE: _____

TELEPHONE (_____) _____ EXT: _____

SAME INFORMATION CONFIRMED – That is currently the information we have on file. Do you know of any other way we can get in touch with (OTHER DEPARTMENT / CORPORATE)?

YES → COLLECT OTHER CONTACT INFORMATION

PERSON'S NAME: _____

TITLE: _____

NAME OF DEPARTMENT/OFFICE: _____

TELEPHONE (_____) _____ EXT: _____

NO → END CONTACT AND MARK FOR SUPERVISOR REVIEW

Thank you very much for your help.

DID NOT MAINTAIN PROFILES

Hello may I speak to (POC)? This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Thank you for providing the contact information for (OTHER DEPARTMENT / CORPORATE). We were able to locate (OTHER DEPARTMENT / CORPORATE) with the information you provided. However, they reported that they did not maintain the profiles for (PHARMACY NAME) in 2009. Could you please check to see if another department handled profiles for (PHARMACY NAME) in 2009?

OTHER DEPARTMENT PROVIDED →

What is the name of a contact person, their title, department/office, and their telephone number?

PERSON'S NAME: _____

TITLE: _____

NAME OF DEPARTMENT/OFFICE: _____

TELEPHONE (_____) _____ EXT: _____

Thank you very much for your help.

NO OTHER DEPARTMENT PROVIDED → END CONTACT AND MARK FOR SUPERVISOR REVIEW