



**State of Montana  
 Department of Public Health and Human Services  
 Allied Health Services Bureau – Outpatient Prescription Drug Program  
 Dispensing Fee Questionnaire**

**IMPORTANT – Failure to respond to the survey will result in an assignment of the minimum dispensing fee of \$2.00 as stated in ARM 37.86.1105 (2)(a) and (3)**

*\*This questionnaire is intended to calculate the average cost to dispense a prescription in retail pharmacies. Pharmacies In Home Infusion Therapy or Hospital settings should complete the survey as completely as possible and attach a cover letter offering additional explanation of their prescription dispensing costs. Call 406-444-2738 with questions. **Please complete a separate questionnaire for each Montana pharmacy in your corporation.** Please complete and return the survey to our office by **October 27, 2014.***

**Please return completed questionnaire to:**

Attn: Medicaid Pharmacy Program Officer  
 Montana DPHHS  
 1400 Broadway  
 P.O. Box 202951  
 Helena, Montana 59620-2951  
[khawkins@mt.gov](mailto:khawkins@mt.gov)  
 406-444-1861 Fax

Pharmacy Information		
Pharmacy Name	NPI #	
Store Address	Store Phone	
Store City	Store State	Store Zip
Other Address	Other Phone	
Other City	Other State	Other Zip
Email Address	Data Time Period <sup>1</sup> to	

<sup>1</sup>Provide most recent **fiscal/calendar year** data

Part I – General Data			
Check as applicable, is your facility an: <input type="checkbox"/> Independent Pharmacy <input type="checkbox"/> Chain Drug Store <input type="checkbox"/> Mail Order Pharmacy	Do you deliver prescriptions?	Yes	No
	Do you prepare compounded prescriptions?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you dispense unit dose prescriptions?	<input type="checkbox"/>	<input type="checkbox"/>
The number of pharmacies your company operates: In Montana _____ Nationally _____	Do you have access to 340B Drug Pricing?	Yes	No
	<b>If yes</b> , do you Carve-Out Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>
Number of prescriptions dispensed during the time period stated above. Please include the totals for <b>ALL</b> prescriptions dispensed, Medicaid <b>and</b> Non-Medicaid.			
New	_____		
Refill	_____		
Total	_____		



**PRESCRIPTION DRUG PROGRAM  
DISPENSING FEE QUESTIONNAIRE INSTRUCTIONS**

**\*\*Please note if you own more than one Pharmacy please fill out a separate form for each Pharmacy\*\***

**PHARMACY INFORMATION:**

**Pharmacy Name:** The name of your independent pharmacy or if your pharmacy is a chain please put the legal name of the pharmacy.

**Store Address:** The physical address of the pharmacy you are reporting information for.

**Store Phone Number:** The phone number of the store.

**NPI #:** The National Provider Identifier for the Pharmacy.

**Other Address:** The address of corporate headquarters, if this is a chain pharmacy the P.O. Box number or physical address where pharmacy mail is received.

**Time Period of Data:** Please provide the most recent **fiscal/calendar year**.

- *Exception for new pharmacies that will be providing 6 months of information.*

**E-Mail Address:** Please provide the e-mail address for the main point of contact or where you would like updates sent.

**PART I – GENERAL DATA:**

**Do you deliver prescriptions?** Is delivery of prescriptions to consumers a service that is offered by your pharmacy?

**Do you prepare compounded prescriptions?** Compounded prescriptions fit the unique or special needs of a patient. Custom compounded medicines are formulated to provide an alternative when commercially available medications are not available. A compounding pharmacy specializes in making custom tailored drugs per a practitioner's order to fit individual requirements in a dosage form that insures efficacy and compliance.

**Do you dispense unit dose prescriptions?** A unit dose is the amount of a medication administered to a patient in a single dose. Unit-dose packaging is the packaging of a single dose in a non-reusable container.

**Are you an Independent Pharmacy, Chain Drug Store, or Mail Order Pharmacy?** Do you currently operate on your own, are you associated with a chain of pharmacies such as Wal-Mart, Target, Walgreens etc. Or is your business predominantly mail order?

**Number of pharmacies:** Please indicate both the number of stores your company operates in Montana and the number of stores your company operates nationally.

**Number of prescriptions dispensed last fiscal or calendar year:** Please use the number of new and refilled prescriptions during the same time period that you used above for "Time Period of Data"

*\*After entering the information, please add the number of new prescriptions and refilled prescriptions to get your total.*

**PART II – PERSONNEL EXPENSE:**

Please add the total hours worked for each pharmacist in the pharmacy and divide by the number of pharmacists you have to get your percentage of total hours worked in the pharmacy department. Then add all pharmacist salaries together and put the total in the Gross Annual Salary column. Please do this for each profession listed in the Personnel Expense section. Please add each section to get your total at the bottom. Please note the Gross Annual Salary includes benefits, bonuses, employment taxes, etc.

**PART III – EXPENSES ALLOCATED DIRECTLY TO THE PRESCRIPTION DEPARTMENT:**

**Prescription containers, labels, bags:** This would be the total expense for these items during the time period used in “Time Period of Data” listed above.

**Professional licenses, dues, subscriptions:** Please include all costs incurred for professional personnel only. In this section please include pharmacy professional liability insurance; permit licenses’ R.Ph. Owners registration; DEA license; National, State and Local Pharmacy Association dues; journal subscriptions, reference texts.

**Travel to professional meetings (continuing education, etc.):** In this section please include all personnel listed under Part II that attended meetings and/or training.

**Telephone/Fax costs used exclusively by the RX department:** Include internet, fax and telephone for the pharmacy you are reporting for. If you are a chain pharmacy only report the expenses for your store.

**Total delivery costs for deliveries containing prescriptions:** This section should include vehicle license and registration, insurance, gas, oil, tires, repairs and maintenance, auto depreciation, etc. Do not include wages for a delivery driver in this section (that would be included in Part II under Personnel Expenses).

**Advertising or promotion of RX Department Only:** Any advertising related specifically to the Pharmacy department would be included in this section. Advertising may include posters, flyers, radio announcements, television commercials, newspaper ads, newsletters, etc.

**Computer Costs:** This includes hardware and software for the pharmacy only. Do not include internet in this section (that is included in telephone costs). Only calculate computer related costs during the time period reported (i.e. if you bought a new computer during the calendar year).

**PART IV – ANNUAL STORE PROPORTIONATE EXPENSE:**

**Rent/Lease directly allocated to pharmacy department:** Only include the costs of rent for your business. If you share building space with another business you would need to figure your cost (e.g., \$1,000/month rent for pharmacy and grocery store, pharmacy rent = \$500/month).

**All other expenses:** This section may include anything not listed above. Please include any other expenses associated with the daily operations of your pharmacy (e.g., utilities, interest, bad debt, depreciation, bookkeeping, accounting fees, legal fees, collection agency fees, security personnel or security system, maintenance, business license, nonprofessional dues, professional attire (i.e., Pharmacist Lab Coats), laundry, dry cleaning).