

## PDAB Patient Drug Submission Form (Full Submission)

The Prescription Drug Affordability Board (PDAB) encourages individuals to report drug price increases and affordability issues with a prescription drug. The Board needs to hear from patients like you to obtain important insight into the patient experience. This form is important because it will help the Board identify drugs that may be causing affordability issues.

This form is for one specific drug, if you are experiencing affordability issues with multiple prescription drug products please submit multiple forms.

**DISCLAIMER:** *Information submitted on this form is public record subject to disclosure under the Public Information Act (PIA). Certain information including sociological and medical information may be withheld or redacted in compliance with the PIA and applicable regulations.*

### Section One: General Information

1. 5 Digit Zip Code (required):

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2. Health Insurance Type (check the one that applies):

- Commercial Insurance
- Medicaid Insurance Coverage
- Medicare Insurance Coverage
- Uninsured
- Unsure

3. Would you like Board staff to reach out to you regarding potential assistance in affording your prescription drug? If so, please provide your Name and Preferred Contact Information in the next question (question 4).

- Yes
- No

4. Name and Preferred Contact (Email and/or Phone Number):

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**Section Two: Drug Information**

***This pertains to the drug presenting the affordability challenge. The prescription drug label on your prescription bottle contains this information.***

5. Name of Prescription Drug:

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6. NDC of prescription drug:

\_\_\_\_\_

7. Dosage of drug (example: 100mg):

\_\_\_\_\_

8. Quantity of drug (Number or Amount):

\_\_\_\_\_

**Section Three: *Most recent price you paid for the drug. The prescription drug label on your prescription bottle or your receipt may help you obtain this information.***

9. Most recent price you paid for the drug (in \$):

\_\_\_\_\_

10. Date you paid the most recent price (Example: January 7, 2024):

\_\_\_\_\_

11. 5 Digit Zip Code of Pharmacy:

\_\_\_\_\_

12. Did you use any coupons or program assistance to reduce the cost of your prescription drug?

- Yes
- No
- Other: \_\_\_\_\_

**Section Four: *This section will address if the drug was previously less expensive within the PAST YEAR. This refers to a price you paid previously (responses should be different than Section 3). The prescription drug label on your prescription bottle or receipt may help you obtain this information.***

13. Within the past 12 months, did you pay less for this drug?

Yes

No

If you answered yes to the previous question, please proceed. If you answered no, please skip to the next section (Section 5).

14. Previous price of the drug (in \$):

\_\_\_\_\_

15. Date you paid for the Drug (Example: January 7, 2024):

\_\_\_\_\_

16. 5 Digit Zip Code of Pharmacy:

\_\_\_\_\_

17. Did you use any coupons or program assistance to reduce the cost of your prescription drug?

Yes

No

Other: \_\_\_\_\_



**Section Five: Additional Information**

18. Please explain why you are reporting this drug. Check all that apply.

- The cost increased from the last time I filled my prescription.
- The cost increase is causing me stress about my personal finances.
- I have a high deductible insurance plan and my prescription drugs are very expensive.
- I experienced a formulary change that increased my cost.
- I am unable to pay the cost of this prescription.
- My insurance does not cover this prescription drug.
- I do not have insurance to cover this prescription drug and the cost is very high.
- Medication is out of stock.
- Not a cost issue but a prior authorization issue.
- Other

19. If you checked "other" in the previous question, please explain:

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20. What other steps or resources have you used to try to make your drugs more affordable? (Please explain)

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21. Is there any other additional information about this drug you would like the Board to know?

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