West Virginia Offices of the Insurance Commissioner

West Virginia NADAC Quarterly Report Template																		
PBM Name:	**MedImpact Healthcare Systems, Inc.**																	
SBS Number:	**512080966**																	
Product NDC Number (complete 11 digit number)	**Product Name** (the complete NDC Description)	**Fill Date**	**Quantity of the Drug Dispensed** (expressed in metric decimal units)	**Pharmacy Name**	**Pharmacy Provider ID**	**Amount the Pharmacy was Reimbursed by the PBM** (per Unit or Dosage)	**Amount of Pharmacy Fees**	**Total Amount of Dispensing Fee Paid**	**Total Amount of Dispensing Fee Paid by PBM**	**Total Amount of Dispensing Fee Paid by Member**	**Total Amount of Member Cost Share**	**NADAC** (from CMS survey report as provided by the OIC) **or WAC if no NADAC is available**	**NADAC/WAC Report Date** (date of the CMS Report used to determine the "NADAC" rate**, date of WAC if no NADAC is available)**	**Pricing Source (either NADAC or WAC)**	**Below 10% Actual Percentage of NADAC Reimbursement**	**10% and Above Actual Percentage of NADAC Reimbursement**	**Affiliate Pharmacy** (Yes / No)	**Dispensed Pursuant to Federal, State or Local Government Health Plan** (Yes / No)
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	#VALUE!	#VALUE!	N/A	N/A
								0							#DIV/0!	#DIV/0!		
								0							#DIV/0!	#DIV/0!		
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