

**AVERAGE ACQUISITION COST PROGRAM – REQUEST FOR MEDICAID REIMBURSEMENT REVIEW**

Pharmacy providers should use this form to report changes in drug pricing.

**NOTE: ALL FIELDS MARKED WITH AN ASTERISK (\*) MUST BE COMPLETED FOR PROPER SUBMISSION OF THIS FORM. PLEASE DO NOT INCLUDE ANY PERSONAL HEALTH INFORMATION (PHI) WITH SUBMITTED FORM OR INVOICE.**

**Pharmacy Provider Information**

Pharmacy Name			
NPI	*		
City	*	State	*
Phone	*	Email	

**Drug Information:** *Please enter information for one (1) drug per submitted form*

Drug Name							
National Drug Code (NDC)		-		-		*	(e.g., 12345-6789-10)

**Provider Cost Information**

Cost Per Package	\$	*
Package Size		*
Date of Purchase		*

**Claim Information**

Dispense Date	
Quantity Dispensed	
Dispensing Fee	\$
Total Reimbursement for claim (including disp. fee)	\$
Medicaid co-pay due from recipient	\$

Is this a recent change in reimbursement? **Yes / No \***

Has there been a recent increase in acquisition cost? **Yes / No \***

IF yes, what was your old acquisition cost prior to rate increase? \$

Are there availability issues? **Yes / No \***

IF yes, reason for the issue?

Are you able to purchase alternate NDCs? **Yes / No \***

IF yes, what alternate NDCs are available? - - (e.g., 12345-6789-10)

IF no, do you have a secondary wholesaler? **Yes / No**

IF no, can you get a secondary wholesaler? **Yes / No**

**Comments:**

**Please print and fax this form to 317-571-8481 (attention: Pharmacy Unit) or e-mail this form to [mdpharmacy@mslc.com](mailto:mdpharmacy@mslc.com). Be sure to include copies of your purchase records that confirms your acquisition costs in addition to alternate NDC information.**

Once complete information is received, we will evaluate your inquiry and respond within 24 hours. For questions or to check the status of an inquiry, please contact us by e-mail at [mdpharmacy@mslc.com](mailto:mdpharmacy@mslc.com) or by phone at **800-591-1183**.

**Person Submitting this Request**