



Alaska Medicaid MAC Price Research Request Form

By submitting this form, I am requesting that Magellan Medicaid Administration research the Alaska Medicaid Maximum Allowable Cost (MAC) List price of the drug listed on this form and respond about product availability or a price modification based on information provided in the “Comments” section below.

*** DENOTES REQUIRED FIELDS**

DATE: _____

| <i>Provider Information</i> | | |
|-----------------------------|----------------|--------------|
| *PROVIDER NAME: | *CONTACT NAME: | |
| *PHONE NUMBER: | *FAX NUMBER: | *NPI NUMBER: |

| <i>Drug Information</i> | | | |
|-----------------------------|----------------------|---------------------|-------------------|
| *DRUG NAME: | *DRUG STRENGTH: | *DRUG DOSAGE FORM: | |
| *NDC NUMBER: | RECIPIENT ID NUMBER: | *RX NUMBER: | |
| *PROVIDER ACQUISITION COST: | *DAW CODE: | QUANTITY DISPENSED: | *DATE OF SERVICE: |

| Comments |
|----------|
| |

| Magellan Medicaid Administration's Use Only – Do Not Mark in this Area! |
|---|
| RESPONSE DATE: _____ |
| RESPONSE: _____ _____ _____ |

Note: Processing May Be Delayed if Information Submitted is Illegible or Incomplete.