

**New Hampshire Medicaid
MAC Price Research Request Form**

By submitting this form, I am requesting that Magellan Medicaid Administration research the New Hampshire 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: _____

PROVIDER INFORMATION

*** Provider Name:**

*** Contact Name:**

*** Phone Number:**

*** Fax Number:**

*** NPI Number:**

DRUG INFORMATION

*** 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 This Area

Response Date:

Response:

Return this form **with a copy of the invoice listing the current acquisition cost to:**

Magellan Medicaid Administration, Inc.

Attn: **MAC Department**

Fax: **888-656-1951**

Email: StateMACProgram@magellanhealth.com

New Hampshire Medicaid Pharmacy Services Portal: <https://newhampshire.magellanmedicaid.com>

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