FLORIDA MEDICAID

MAC Pricing Request Form

RON DESANTIS
GOVERNOR

By submitting this form, I am requesting that the Medicaid Pharmacy Policy Section research the Florida Medicaid Maximum Allowable Cost (MAC) List price of the drug listed on this form. This form cannot be used for prior authorizations (PAs) or dispense as written (DAW) pricing override requests. **Requests must be submitted no more than seven (7) business days after the Date of Service.**

DATE: ______________________________

*** Denotes required fields**

Provider Information		
***Pharmacy Name:**		***Pharmacy Contact Name:**
***Phone Number:**	***Fax Number:**	***Pharmacy NPI Number:**

Drug Information			
***Drug Name:**	***Drug Strength:**		***Drug Dosage Form:**
***Rx Number:**	***Date of Service:**	***Patient ID:**	***Quantity Dispensed:**
***NDC Number:**	***Pharmacy Acquisition Cost:**		***Wholesaler Name:**

Comments

Administrative Use Only – Do Not Mark in this Area
Response Date: ______________________________
Response: ______________________________

Return this form with a copy of the invoice listing the current acquisition cost to
Medicaid Pharmacy Policy
Fax: 800-332-1024