

# New Hampshire AIDS Drug Assistance Program (NH ADAP) MAC Price Research Request Form

By submitting this form, I am requesting that Magellan Medicaid Administration research the New Hampshire ADAP 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 in 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 or

E-mail: [StateMACProgram@magellanhealth.com](mailto:StateMACProgram@magellanhealth.com)

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

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