# Clotting Factors Standard Invoice: Patient Clinical/Rx Information

*Incomplete forms will be returned.*

**Maryland Medicaid Pharmacy Program**
Fax: (410) 333-5398
Phone: (833) 325-0105

Date: ___________________

## Participant Information

Name: ___________________________________ MA#: ___________________ DOB: _________Weight (kg): ________

Diagnosis: ❑ Hemophilia A ❑ Hemophilia B ❑ von Willebrand Disease ❑ Other: ______________________

## Pharmacy provider

Name: ___________________________________________ Medicaid Provider#: ___________________________________

Contact person: _____________________________________ Phone: ________________ Fax: _______________________

## Prescription Information

Medication: ________________________________ Date of service: ______________ ❑ Prophylaxis ❑ PRN bleeding

| Prescription # | NDC | Strength (unit/vial) | Number of vials | Total quantity (IU, mg, etc.) | Days' supply |
|---|---|---|---|---|---|
| | | | | | |
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## Pricing information

***All fields must be completed.***

Direct price charged by manufacturer: $ ________ per unit

All discounts, chargebacks, rebates received: $ ________ per unit

Actual acquisition cost (AAC): $ ________ per unit

Requested total reimbursement amount based on AAC: $___________ *This is not a guaranteed reimbursement amount. Reimbursement is made according to COMAR 10.09.03.07*

## Please attach copies of the following documents to each claim

❑ Pharmacist Clotting Factor Dispensing Record
❑ Recipient-Kept Factors Administration Record (Infusion Log)
❑ Clotting factor prescription order
❑ Proof of delivery
❑ Copy of purchase invoice
❑ If applicable, copies of discounts, chargebacks, or rebates received

## I attest

❑ A valid prior authorization is on file for the date of service,
❑ The pricing information above is accurate and the supporting document is available for the State audits,
❑ The information provided on this form is true and accurate to the best of my knowledge and I will be monitoring the recipient's therapy.

MDH and signatory acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Pharmacist or designee name: ________________________________ Signature: ____________________ Date: _________

## Instructions For Completing the Clotting Factor Standard Invoice

1. Assign different Rx# per NDC dispensed. Vials from different lot numbers that have the same NDC must be combined and billed under the same Rx#. To avoid confusion and claim rejections, do not use refill numbers rather submit all claims as an original prescription as the quantity billed for each fill can vary from one month to another.
2. A new prescription is needed for any change affecting the drug, dosage, or frequency.
3. The maximum day supply allowed per claim is 34.
4. ‘As Needed (PRN)’ use of Hemophilia agents must be justified based on the severity of disease condition.
5. Providers must maintain adequate records of submitted documents and have them available upon request.
6. Fax all supporting documents listed on the Standard Invoice Form to **(410) 333-5398**.

## On-Line Billing Instructions for Clotting Factor

1. Bill 1 claim per Rx# per NDC. If multiple NDCs are being dispensed for the same drug, bill as multiple claims, one per NDC. If different drugs are being dispensed, please bill separately, and send a separate Clotting Factor Standard Invoice.
2. Enter Rx number and all required data elements. Submit the claim with compound code 0 or 1.
3. Use the actual NDC. If different lot numbers for the same NDC are dispensed, combine the vials and bill under the same RX #. Create a different Rx# for each clotting factor refill. Payments will be released based on the units billed per NDC.
4. Enter the usual and customary charge (U/C). Claims will be denied with NCPDP error code 75, “Prior-Authorization is required”, error code M5 “Requires Manual Claim-Forward paper claim to the State”, and error code 78, “Cost exceeds maximum”. The system has been programmed to reject all clotting factor claims for manual pricing and review.
5. Any DUR alerts and claim submission errors must be resolved before the claim is rejected for manual review.
6. Maryland Medicaid Pharmacy Program will use submitted invoice and information to calculate the total reimbursement amount according to COMAR 10.09.03.07