

SMAC Research Request Form

By submitting this form, I am requesting that NYS Medicaid Pharmacy Policy & Operations staff research the NY SMAC List price of the drug listed on this form and respond about product availability or a price modification based on information provided in the "Issue" section below.

DATE: _____

PROVIDER NAME*: _____

PROVIDER MEDICAID NUMBER*: _____

PROVIDER PHONE*: - -

PROVIDER FAX*: - -

PROVIDER NCPDP #:

PROVIDER CONTACT*: _____

DRUG NAME, STRENGTH

And DOSAGE FORM*: _____

NDC#*:

RECIPIENT ID # _____ RX# _____

PROVIDER COST: _____ **DATE OF SERVICE*:** _____

ISSUE:

Return this form to Medicaid Pharmacy Policy & Operations Staff:

FAX: 518-473-5508

E-MAIL: ppno@nyhealth.gov (Place "SMAC" as subject of e-mail)

RESPONSE DATE: _____

RESPONSE: _____

*REQUIRED FIELD