MARYLAND MEDICAL ASSISTANCE PHARMACY PROGRAM
CLOTTING FACTORS STANDARD INVOICE
PATIENT CLINICAL/Rx INFORMATION

Phone: 410-767-1455 or 1-800-492-5231 Option 3

Recipient:_____Age____ On Medicare? Yes___No___Other insurance:___
MA # : _____(11 digit #)- Current Body Weight:_____lbs or _____kg
Address: _____Tel.#: (_____)_____ -_____
Diagnosis: Hemophilia A__; Hemophilia B__; Hemophilia with inhibitors to Factor(s)___; von Willebrandt ___
List degree of severity based on Factor blood level:_____iu/ml – Test date:_____
___ Severe (plasma Factor levels <0.01 iu/ml or <1% of normal)
___ Moderate (plasma Factor levels between 0.01-0.05 iu/ml or 1-5% of normal)
___ Mild (plasma Factor levels between 0.05 and 0.4 iu/ml or 5-40% of normal)
Name of clotting factor:_____Is Recipient enrolled in a clinical trial? □ Yes; □ No
AHF Factor VIII___Factor IX conc.___Anti-inhibitor Coagulant Complex___Other_____
Dose range:_____AHF IU/dose based on:_____AHF/kg of BW
Dosage frequency: _____(Ut dict not acceptable-Prn orders must have an approximate
% correction factor desired:_____% dosage frequency or specified max daily doses);
Most recent Factor Level:_____Date:_____Factor Inhibitor Level:_____Date:___
Prophylactic use: Yes___ No___ No more than 6 doses per claim to be kept for "On-demand or "prn use"
All initiation and continuation of immune tolerance induction therapies must be prior-authorized by the State.

MANDATORY PRICING INFORMATION

Complete and sign the following mandatory section for clotting factor:

Direct price charged by manufacturer for factor/high-cost drug: $_____per unit.
All discounts, chargebacks, rebates received: $_____per unit.
Actual acquisition cost paid for the factor: $ _____ per unit.
I attest that the above pricing information is accurate. Supporting documentation as to the pricing information is available for State audits.

_____ _____ (_____) _____-_____
Purchasing Representative's original signature Date Phone #
Name of Purchasing Representative: _____

CLAIM INFORMATION

Service Provider # :_____ Tel # (_____)_____-_____Fax# (_____)_____-_____
Provider NPI #: _____Pharmacy Name:_____
Date of Service: _____Date Written:_____(If possible, do not use refills on clotting factor Rx)
Days Supply:_____days- **Use a separate Rx# per drug NDC for the same clotting factor Rx** which is valid for a year.
Rx#:_____ NDC_____ Units/vial*_____#vials:____Quantity:_____
Rx#: _____NDC_____ Units/vial*_____#vials:_____Quantity::_____
Rx#_____NDC_____ Units/vial*_____#vials:_____Quantity:_____
Rx#_____NDC_____ Units/vial*_____#vials:_____Quantity:_____
* **Vials with the same NDC although from different lot numbers must be combined and billed under the same Rx #.**

I certify that the units dispensed are accurate and that I will be monitoring the recipient's therapy.
_____ _____ (_____) _____- _____
Dispensing Pharmacist's signature Date Phone #

Please attach copies of the following documents to each Clotting Factor and High-Cost Drug Standard Invoice and send to:

DHMH - Office of Operations, Systems and Pharmacy, PO Box 2158 Baltimore, MD 21201:

- □ **Mandatory Pharmacist Clotting Factor Dispensing Record**
- □ **Mandatory Recipient-Kept Factors Administration Record (Infusion Log).**
- □ **Mandatory clotting factor prescription order.**
- □ **Mandatory proof of delivery.**
- □ **Mandatory copy of purchase invoice showing direct cost paid for the factor.**

FOR INTERNAL USE ONLY- Approved:$_____Date:_____/_____/_____
c:\.Word\ClottingFactorsStandardInvNov08 Rejected_____ Returned_____ Date:_____ /_____/_____

MARYLAND MEDICAL ASSISTANCE PROGRAM

INSTRUCTIONS FOR COMPLETING THE CLOTTING FACTOR STANDARD INVOICE

This form is mandatory and must be filled out by the dispensing pharmacist when dispensing clotting factors. Providers may create a template of this form for computer generated claims. Important points to note:

- The original signatures of the dispensing pharmacist and the drug purchasing agent or representative of the pharmacy are mandatory on all clotting factor standard invoices.
- Each Rx is valid for up to 365 days of therapy. Effective December 1, 2008, providers must assign a different Rx# per drug NDC dispensed. All vials from different lot numbers but corresponding to the same NDC must be combined and billed under the same Rx#. To avoid confusion and claim rejections, and because the quantity billed for each fill is different from one month to another, it is recommended that providers do not use refill numbers on clotting factor claims. Make all claims the original prescriptions. The maximum day supply allowed per claim is 34. Claim submitted for greater than 34 days will be rejected. Use the same Date of Service as the Date Written.
- The original Rx must be filled within 120 days of the date written. It may be faxed directly by the prescriber to the pharmacy but may not be called in. Any change affecting the drug used, dosage, and dosage frequency requires a new signed prescription. Orders written "as directed" are not acceptable and claims will be returned for clarification of dosage. Orders written "As needed" must have an approximate dosage frequency and/or a limit on the number of doses per day or per month.
- The number of units dispensed must reflect the dosage and dosage frequencies prescribed.
- Prophylactic use of clotting factors must be justified based on the severity of disease condition. Initiation and continuation of all immune tolerance induction therapies must be prior-authorized by the State.
  Pertinent factor levels and factor inhibitor levels with updates on the recipient's bleeding status must be faxed to the Program routinely when the clinical information is available.
- Document any drug adverse effects, drug shortage/surplus, any waste of medication, any unusual bleeding or any compliance issues on the Clotting Factor Administration Record.
- Submission of a copy of the factor purchase invoice, the Recipient-Kept Factor Administration Record, the clotting factor order, the Pharmacist Clotting Factor Dispensing Record, and proof of delivery are mandatory. The recipient, caregiver, and/or case manager must assist the pharmacist with information on actual usage when requesting a refill. All information documented on any forms must be accurate and valid as it is subject to audit by the State.

ON-LINE BILLING INSTRUCTIONS FOR CLOTTING FACTOR AND HIGH-COST DRUG CLAIMS

Bill as one claim per Rx# per drug NDC of the same product. If the product calls for use of various potencies necessitating multiple drug NDCs being dispensed, bill multiple claims, one per drug NDC, per month as called for:

1. Enter Rx number and all required data elements. Submit claim with compound code 0 or 1.
2. Use the actual NDC for factor or high-cost drug. 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 because the quantity dispensed on each refill may not be the same as the quantity on the original Rx due to various assays. Payments will be released based on the units billed per drug NDC.
3. Enter the usual and customary charge (U/C). Claim will deny 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- Contact ACS at 1-800-932-3918" However, there is no need to call for PA. The system has been programmed to reject all high cost drug claims for manual pricing and review. Any DUR alerts and claim submission errors must be resolved before the claim is rejected for manual review. Providers are to ship the drug provided that the recipient's therapy is medically necessary and the recipient meets the criteria for clotting factors replacement. Complete the Clotting Factor Standard Invoice and mail to OSOP, PO Box 2158, Baltimore, MD 21203 with the required documents. DO NOT FAX CLAIMS TO THE STATE. Claim will be returned if the required documents are missing. Keep all dispensing records with the original signed prescriptions on file for six years. Payments will be manually released by the State.

Questions concerning completion of this form should be directed to the Maryland Pharmacy Program, Department of Health and Mental Hygiene at 410-767-5701.

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