

**MARYLAND MEDICAID PHARMACY PROGRAM  
PHARMACIST HIGH-COST DRUG DISPENSING RECORD**

A six-month high-cost drug dispensing record must accompany each factor invoice that is submitted to the Program. Drug strength/Vial potencies and lot numbers must be documented on this sheet. The balance of units on hand must be given by the Recipient or Caregiver to the pharmacist when placing a new order.

**Recipient:** \_\_\_\_\_ MA#: \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Address: \_\_\_\_\_  
**Physician:** \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax#(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Address: \_\_\_\_\_  
**Case Manager:** \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax# (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Service	Drug/Strength	Lot Number	Quantity Dispensed	Quantity On- Hand as reported by Recipient	Side-effects & Drug levels or bio-chemical markers required for drug monitoring.

I certify that all data submitted are accurate and that I will be monitoring the recipient’s proper drug utilization. Supporting documentation available for State audits.

**Pharmacist’s Original Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Pharmacist Name: \_\_\_\_\_