Utah Department of
Health & Human Services
Integrated Healthcare

Ultra High-Cost Drug Invoice Submission Form

Providers must submit this form and a copy of its invoice showing the **actual acquisition cost** (AAC) for the Ultra High-Cost Drug administered to a Medicaid member. Submit the completed form via fax to 855-828-4992 or via email to medicaidpharmacy@utah.gov.

For specific coverage information please refer to the PRISM Coverage and Reimbursement Code Lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php in addition to the Pharmacy Provider Manual and Medicaid Information Bulletins: https://medicaid.utah.gov/utah-medicaid-official-publications/?p=Medicaid%20Provider%20Manuals/.

All fields are required

Requesting Provider/Facility Name:		NPI:
PRISM Provider ID:		
Address:		
Office Contact Name:		Phone Number:
Fax Number:		Email:
Member Full Name		Member DOB:
Member ID:		Service Date(s):
Applicable ICD-10 Code(s):		
Brand & Generic Medication Name:		
NDC:	HCPCS Code:	Units per dose:
Total number of units:		Days supply:
Did the provider use 340B supply? ☐ Yes, provide supporting documentation ☐ No		
Are/Were there rebates associated with this drug? ☐ Yes, provide supporting documentation ☐ No		
Are/Were there negotiated discounts anticipated for this drug? ☐ Yes, provide supporting documentation ☐ No		
Were/are there any other elements that would reduce the AAC for this drug? ☐ Yes, provide supporting documentation ☐ No		
AAC* Reimbursement Requested:		

*The **actual acquisition cost** must be net of any discounts the provider may receive to offset its acquisition cost (i.e., 340B, rebates, negotiated discounts, etc.). Supporting documentation must detail how the net AAC amount was determined.

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Attestation of completeness and accuracy of the above information

I swear under penalty of perjury and law, including but not limited to U.C.A. § 76-10-1801, § 76-6-412, and § 76-8-504, that the foregoing is true and correct and that by my signature I acknowledge and affirm that I executed this instrument in my capacity or an authorized capacity for the provider.

_____
Provider Name

_____
Signatory Printed Name & Title

_____
Signatory Signature & Date

Jurat

State of Utah, County of _____

Signed and sworn to before me on _____ (date) by

_____ (name of document signer and title); I further acknowledge that the signer was personally known to me or did prove based on satisfactory evidence, has made in my presence a voluntary signature and taken an oath or affirmation vouching to the truthfulness of this document.

_____
(Signature of Notary Public) (Notary Seal)

_____
(Commission Expires)

Written Claim of Business Confidentiality

Providers may also complete and submit the *Ultra High-Cost Drug U.C.A. § 63G-2-309 Written Claim of Business Confidentiality Form* located here https://medicaid.utah.gov/pharmacy/resource-library.