A Public Entity
Inland Empire Health Plan

IEHP Maximum Allowable Charges (MAC) Appeal Request

Details of Request (Required):

Date of Request: _____

Pharmacy NPI#: _____

Pharmacy Name: _____

Contact Name: _____ Email: _____

Pharmacy Phone #: _____ Pharmacy Fax #: _____

Drug Name and Strength: _____

NDC: _____ Provider's Wholesaler Acquisition Cost: _____

Rx #: _____ Date of Claim Payment: _____

***Please Note: A MAC dispute request can ONLY be submitted within 14 days from receipt of payment for the claim in question.**

Reason for appeal: (Please select ONE of the following)

☐ **The drug does not meet the requirements of MAC drugs**

Please include**:**

- Copy of documentation showing why the drug does not meet requirements of MAC drugs (e.g. screenshot of drug's status in FDA's Orange Book database; document providing evidence drug is not available for purchase in the state from a national or regional wholesaler, or drug is obsolete)

☐ **MAC of the drug is below the lowest purchase price for the drug**

Please include:

- Copy of wholesale invoice, within the last 90 days, for the medication in question.
- Copy of the claim(s) initiating the inquiry for reimbursement review. Claim(s) must show Prescription RX#, NDC#, date of service, and amount paid.

Please fax this form and required information to IEHP Pharmaceutical Services Department at 909-891-1577 or submit to mac@iehp.org.