California MAIC Rate Review Application (CAMRRA) (MC 3150)

Page updated: September 2020

The information requested on this form is required by the Department of Health Care Services, Pharmacy Benefits Division, for purposes of identification and document processing.

Submit Original form MC 3150 and Supporting Documentation to:

Pharmacy Benefits Division, MS 4604
P. O. Box 997413
Sacramento, CA 95899-7413
Attn: MAIC PROGRAM

Email: maicprogram@dhcs.ca.gov or
fax: (916) 552-9563

Form MC 3150

1. MAIC Drug Name____
2. MAIC Drug Effective Date____________________
3. Provider Business Name____
4. Provider NPI______________________________
5. Date Application Submitted__________________
6. Pharmacy Type (choose type)___________________________
7. Provider Business Address____
   a) City____________________________
   b) State___________________________
   c) Zip_____________________________
8. Contact Name____
9. Contact Phone Number____________________________
10. Contact Email____
11. Drug NDC_______________________________
12. Package Drug Name____
13. Package Size______________________________
14. Drug Package Lot Number____

15. Wholesaler Name____
16. Wholesaler Address____
    a) City_______________________________
    b) State______________________________
    c) Zip________________________________
17. Wholesaler Invoice Date______________________________
18. Wholesaler Invoice Number____________________________
19. Wholesaler Invoice Price______________________________
20. Wholesaler Drug Acquisition Unit Cost____________________
21. Provider Drug Acquisition Unit Cost______________________
22. Provider Drug Net Acquisition Unit Cost___________________
23. If unit cost is different in fields 19 and 20, please include justification and documentation:
    ____
    ____
    ____
24. MAIC review application is requested because of (please select all that apply below):

    Drug Availability Issue
    Alternative NDCs not available
    Established MAIC rate is lower than any other reimbursement accepted by provider from any other 3rd party payor
    Other (Please specify)

    ____
    ____
    ____

Page updated: September 2020

25. Provider Certification Statement:
By signing below, the provider acknowledges that the above information is required by Medi-Cal to review an already established MAIC rate of reimbursement, that the information contained above is true, accurate, and complete, and that Medi-Cal's review may be delayed or the review may not occur if the form is not completed with true, accurate, and complete information. The provider also acknowledges that a change in reimbursement may occur based on the above information; that payment of a drug claim subject to an MAIC will be from Federal and/or State Funds, and that any falsification, or concealment of material fact, may be prosecuted under Federal and/or state laws; and that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, physical or mental disability. The provider agrees to keep for a minimum period of three years from the date signed below, all records which are necessary to disclose fully the extent of information provided to Medi-Cal. The provider agrees to furnish these records and any information regarding payments claimed for the drug(s) in question, on request, to California Department of Health Care Services: Medi-Cal Fraud Unit, California Department of Justice, Medi-Cal Audits Project, Office of State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives.

26. Provider Signature
(*Signature of provider or person authorized by provider to bind provider by signature below to statements and conditions contained on this form.*)

____

27. Date Signed________________________

Enclosure Checklist

Invoice
Other Supporting Documentation
____

DHCS Review (Department Use Only)

DHCS Review Date___________________________

DHCS Decision:

- ☐ MAIC Change Warranted
- ☐ MAIC Change Not Warranted

Date Contacted Provider_________________________________

Provider Contacted By:

- ☐ Email_____________________________________
- ☐ Mail______________________________________
- ☐ Phone____________________________________
- ☐ Fax______________________________________

Comments

____
____
____
____

DHCS Reviewer Printed name____

DHCS Reviewer Signature____

Instructions for MC 3150

(Please Read Carefully)

The information on this form will be used by the Department of Health Care Services (DHCS) Pharmacy Benefits Division (PBD) for purposes of identification and document processing under the policy of the MAIC Rate Review program.

Do not use correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date, and initial in ink.

Do not leave any questions, boxes, lines, etc blank. Enter N/A if not applicable to you.

Table of California MAIC Rate Review Application (MC 3150) Form Items

Numbered Item	Description
1 .	"MAIC Drug Name" is the drug name listed on the MAIC listing.
2.	Insert MAIC Drug Effective Date.
3.	"Provider Business Name" is the legal name of the business.
4.	Insert Provider NPI number.
5.	Insert date application submitted
6.	"Pharmacy Type". Please indicate if you are an Independent Pharmacy or Chain Pharmacy. An independent pharmacy is a retail pharmacy that is not directly affiliated with any chain of pharmacies.
7.	"Contact Name". To assist in the timely processing of the Application package, enter the name of the individual who can be contacted by Pharmacy Benefits staff to answer questions regarding the application package. Failure to provide this information may result in the application being returned for deficit item(s) that an applicant can readily provide by fax or telephone.
8.	Insert contact phone number.
9.	Insert contact email address.
10.	"Drug NDC" is the package national drug code
11.	"Package Drug Name" is the name on the drug package
12.	Insert package size.
13.	Insert drug package lot number.
14.	"Wholesaler Name" is the business name of the wholesaler.
15.	"Wholesaler address" is the business address of the wholesaler.
16.	"Wholesaler Invoice Date" is the most recent Wholesaler Invoice showing the current purchase price for the Drug NDC
17.	Insert wholesaler invoice number.
20.	"Provider Drug Acquisition Unit Cost" is the Wholesaler Drug Acquisition Unit Cost adjusted to consider provider related costs for shipping, handling, storage and delivery.

Table of California MAIC Rate Review Application (MC 3150) Form Items (continued)

Numbered Item	Description
21.	“Provider Drug Net Acquisition Unit Cost” is the Provider Drug Acquisition Unit Cost adjusted by discounts, rebates, and early payment settlements received by provider from Wholesaler.
22.	If unit cost is different in fields 19 and 20, please include a justification and documentation.
23.	Select the appropriate response.
24.	Please read Provider Certification Statement.
25.	Signature of provider or person authorized by provider to bind provider by signature below to statements and conditions contained on this form.
26.	Insert date application is signed.

Note: Remember to attach any supporting documentation or invoices.