DEPARTMENT OF HEALTH AND SOCIAL SERVICES

CHANGES TO REGULATIONS

7 AAC 105, 120, 145, 160. Pharmacy Reimbursement.

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ADOPTED REGULATIONS

November 18, 2013

Although these proposed changes to regulations have been adopted by the Department of Health and Social Services, after opportunity for public review and comment, they are not yet final. These changes must first be reviewed and approved by attorneys at the Department of Law, and additional changes are likely. After the Department of Law completes its review, the regulations, with any additional changes made by the Department of Law, will be filed by the Lieutenant Governor and will take effect 30 days after filing (unless a later effective date is specified). For the official version of any State of Alaska regulation, please refer to the most current edition of the Alaska Administrative Code.

7 AAC 105.610(a)(4) is repealed and readopted to read:

(4) $0.50 for each prescription for each covered outpatient drug that is filled or refilled with a payment for service of $50.00 or less or $3.50 for each prescription for each covered outpatient drug that is filled or refilled with a payment for service of greater than $50.00. Prescriptions for covered outpatient drugs for recipients eligible for Chronic and Acute Medical Assistance under 7 AAC 48.560 and covered vaccines administered by pharmacists under 7 AAC 120.110(c) have no copay. (Eff. 2/1/2010, Register 193; am _____/_____/2014, Register _____)

Authority: AS 47.05.010 AS 47.07.020 AS 47.07.042

7 AAC 120.110 is repealed and readopted to read;

7 AAC 120.110. Covered outpatient drugs and home infusion therapy. (a) Except as provided in (d) of this section, the department will pay for

(1) a covered outpatient drug;

(2) a compounded prescription, if

(A) at least one ingredient is a covered outpatient drug and the recipient's drug therapy needs cannot be met by commercially available dosage strengths or forms of the therapy;

(B) claims for compound prescriptions are submitted using the national drug code (NDC) number and quantity for each covered outpatient drug in the compound;

(C) no more than 25 covered outpatient drugs are reimbursed in any compound; and

(D) reimbursement for each covered outpatient drug is determined in accordance with 7 AAC 145.400;

(3) insulin;

(4) except for a recipient who is in a long-term care facility or an intermediate care facility for the intellectually and developmentally disabled, a drug that has been prescribed even if that drug may be sold without a prescription, as follows:

(A) prenatal vitamins for pregnant and nursing women;

(B) nonoxynol-9 contraceptive creams, gels, foams, and sponges;

(C) respiratory saline products;

(D) tobacco cessation drugs for nicotine replacement therapy;

(E) loratadine;

(F) fexofenadine; and

(G) cetirizine.

(b) The department will pay for tobacco cessation medication therapy management

(1) if initially ordered by a physician, an advanced nurse practitioner, or a physician assistant in addition to a tobacco cessation drug;

(2) if provided by a pharmacist who

(A) has successfully completed a continuing education course in tobacco

cessation;

(B) provides practical counseling in person to a recipient for at least three minutes and no more than 10 minutes; practical counseling must be in accordance with *Quick Reference Guide for Clinicians: Treating Tobacco Use and Dependence*, adopted by reference under 7 AAC 160.900; and

(C) maintains a record of the delivered practical counseling; and

(3) no more than once per 30-day period for a recipient.

(c) The department will pay for vaccine administration if provided to a recipient under 21 years of age by a pharmacist whom the Board of Pharmacy has approved to exercise collaborative practice authority under 12 AAC 52.240. However, the department will pay for recipients 21 years of age or older under 7 AAC 110.405(b)(2) and (3).

(d) Notwithstanding (a) – (c) of this section, the department will not pay for the following:

(1) a drug used to treat infertility, obesity, or baldness;

(2) a hair or wrinkle remover;

(3) drugs not meeting the definition of a covered outpatient drug under 7 AAC 120.110(*l*);

(4) covered outpatient drugs for which more than a 34-day supply is ordered per prescription unless the covered outpatient drug is listed on the Alaska Medicaid 90 Day Generic Prescription Medication List, adopted by reference in 7 AAC 160.900;

(5) drugs used for the symptomatic relief of coughs and colds;

(6) non-prescription drugs, vitamins, and dietary or herbal supplements, except as listed in (a)(4) of this section;

(7) a brand-name covered outpatient drug if a therapeutically equivalent generic covered outpatient drug is on the market, unless

(A) the brand name covered outpatient drug is included as a preferred medication on the *Alaska Medicaid Preferred Drug List*, adopted by reference in 7 AAC 160.900; or

(B) the prescriber writes on the prescription "brand-name medically necessary"; the information may be submitted electronically or telephonically; if the information is submitted telephonically, the prescriber must document it in the recipient's record; the department may require prior authorization under 7 AAC 120.130 for a brand name covered outpatient drug with a therapeutically equivalent generic covered outpatient drug on the market;

(8) a covered outpatient drug for which, as described in 7 AAC 105.110(18), payment under CMS' drug rebate program is unavailable.

(e) Covered outpatient drugs payable under Medicaid that are not prescribed by electronic transmission in accordance with 12 AAC 52.490 or by verbal communication must be tamper-resistant by being executed on tamper-resistant paper or being printed on plain paper with tamper-resistant features generated through an electronic medical record practice system in order to be paid by the department as the primary or secondary payor. Each prescription form

must contain the prescriber's National Provider Identifier (NPI) number under 45 C.F.R. 162.402 - 162.414.

(f) The requirements in (e) of this section do not apply to a

(1) prescription for which retroactive Medicaid eligibility has been determined under 7 AAC 100.072, except for refills that are filled after the retroactive eligibility determination date; or

(2) prescription prepared in an institutional pharmacy, if the prescriber writes the prescription into the medical record, the medical staff gives the order directly to the institutional pharmacy, and the patient does not handle or have the opportunity to handle the prescription; in this paragraph, "institutional pharmacy" has the meaning given in 12 AAC 52.995(a).

(g) The tamper-resistant paper or tamper-resistant printing required under (e) of this section must include at least one industry-recognized feature designed to prevent unauthorized copying of a completed prescription, at least one industry-recognized feature designed to prevent the erasure or modification of information written on the prescription by the prescriber, and at least one industry-recognized feature designed to prevent the use of counterfeit prescription forms. Any one feature may not be used more than once for proof of tamper resistance. For purposes of this subsection, industry-recognized features designed to prevent

(1) unauthorized copying of a completed or blank prescription form include

(A) high-security watermarks on the reverse side of blank prescriptions;

(B) thermochromic ink that changes color or disappears when warmed;

(C) security patterns;

(D) "void", "copy", or "illegal" pantographs, with or without a reverse prescription;

(E) microprinting with a font size of 0.5 point or less;

(F) prismatic printing; and

(G) lenticular patterns;

(2) erasure or modification of information written on the prescription by the prescriber include tamper-resistant background ink that shows erasures or attempts to change written information in accordance with any of the following techniques:

(A) toner anchorage used to complicate the removal of toner;

(B) chemical stains used to reveal chemical eradication attempts against ink or toner;

(C) laid lines used to reveal cut-paste attempts on an item;

(D) chemical reactive inks used to reveal washing attacks;

(E) overcoatings, laminates, and varnishes used to secure written content on the item;

(F) erasable ink backgrounds used to reveal attempts at ink and toner removal;

(G) borders and fill characters used to complicate attempts to add-on extra information;

(H) on-item encodation techniques, bar codes, and patterns used to validate item content; and

(I) quantity check-off boxes; and

(3) the use of counterfeit prescription forms include

(A) serially numbered blanks;

(B) duplicate or triplicate blanks;

(C) thermochromic ink that changes color or disappears when warmed;

(D) color-shifting ink that changes color when viewed from different angles; and

(E) security features and descriptions listed on the prescription.

(h) The department will pay a provider for filling a prescription that does not comply with (e) - (g) of this section if the pharmacy verifies the authenticity of the prescription by

(1) contacting the prescriber; and

(2) documenting on the prescription form

(A) the name of the prescriber or prescriber's representative who verified the prescription; and

(B) the date the prescription was verified.

(i) If a written prescription does not comply with (e) - (h) of this section, the monetary value of that prescription claim may be recouped by the department during pre- or postpayment review.

(j) For purposes of billing for covered outpatient drugs, the date of service is the date a prescription is filled. If the recipient or the recipient's representative does not receive the covered

outpatient drug during the 10-day period that begins on the date the prescription is filled, the pharmacy shall reverse the claim and refund the payment to the department.

(k) A pharmacy shall maintain documentation of receipt of covered outpatient drugs by recipients. The documentation may be kept as a signature log showing which prescription numbers are received or as mailing labels if covered outpatient drugs are mailed to the recipient.

(*l*) In this section, "covered outpatient drug" means a drug which may be dispensed only upon a prescription; and for which

(A) the United States Food and Drug Administration (FDA) requires a national drug code (NDC) number;

(B) the drug is listed electronically with the FDA;

(C) the manufacturer has obtained a new drug application or an abbreviated new drug application from the FDA; and

(D) federal Medicaid matching funds are available for the drug.

(Eff. 2/1/2010, Register 193; am 6/13/2010, Register 194; am 7/7/2010, Register 195; am 1/1/2011, Register 196; am 9/7/2011, Register 199; am 1/4/2012, Register 201; am _____/_____/2014, Register _____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 145.400 is repealed and readopted to read:

7 AAC 145.400. Covered outpatient drug payment rates and home infusion therapy drug rates. (a) In addition to complying with the requirements of 7 AAC 105.220, and before submitting a claim for payment from the department, a pharmacy provider shall bill any third-party prescription drug plan in which the recipient is enrolled and that is in effect on the date of service. After the pharmacy provider receives notification from the third-party prescription drug plan of the amount, if any, that the third-party prescription drug plan will pay, the pharmacy provider may submit a claim for payment from the department for the remaining cost of service. The department will pay the pharmacy provider the lesser of the difference between the payment by the third-party prescription drug plan and the department-calculated allowable payment, minus any recipient cost-sharing amounts imposed under AS 47.07.042 by the department or the remaining patient liability amount, minus any recipient cost-sharing amounts imposed under AS 47.07.042 by the department. The department will consider the payment to be payment in full.

(b) The department will pay the provider for reasonable and necessary postage or freight shipping, up to $16 per prescription for a covered outpatient drug, incurred in the delivery of the prescription for a covered outpatient drug from the dispensing pharmacy to the recipient if the pharmacy services are not available in the recipient's community. If multiple prescriptions for covered outpatient drugs are shipped in a single package the postage or freight shipping costs must be divided by the number of prescriptions for covered outpatient drugs shipped and the partial postage amount is to be billed on each prescription claim.

(c) The department may establish a state maximum allowable cost for a covered outpatient drug. The state maximum allowable cost will be established by reviewing pricing sources, including the wholesale acquisition cost, purchase invoices, or direct price for the covered outpatient drug as identified in the First Data Bank *National Drug Data File (NDDF) Plus*, taking into consideration the cost of the most frequently dispensed drugs.

(d) The department, the department's contractor, or the party responsible for the state maximum allowable cost will maintain on its website a current listing of covered outpatient drugs and their corresponding state maximum allowable costs.

(e) The payment for covered outpatient drugs is the lowest of the following:

(1) the submitted covered outpatient drug cost plus the dispensing fee set under 7 AAC 145.410;

(2) the federal upper limit established by CMS plus the dispensing fee;

(3) the estimated acquisition cost of the covered outpatient drug plus the dispensing fee;

(4) the state maximum allowable cost plus the dispensing fee.

(f) The department will pay for vaccines at the lowest of the following:

(1) the submitted vaccine cost plus the submitted vaccine administration fee under 7 AAC 145.410;

(2) the state maximum allowable cost plus the vaccine administration fee;

(3) the federal upper limit established by CMS plus the submitted vaccine administration fee;

(4) the estimated acquisition cost plus the vaccine administration fee.

(g) The payment for brand names of multiple-source covered outpatient drugs specified by the prescriber in accordance with 42 C.F.R. 447.512, adopted by reference, is the lowest of the following:

(1) the submitted covered outpatient drug cost plus the dispensing fee set under 7 AAC 145.410;

(2) the estimated acquisition cost of the covered outpatient drug plus the dispensing fee.

(h) A provider may not submit a charge to the department in excess of the amount applicable to a specific covered outpatient drug under 7 AAC 145.020 or the provider's usual and customary charge for the covered outpatient drug. The usual and customary charge is the lowest amount a provider charges to the general public and reflects all advertised savings, discounts, special promotions, or other programs. The department will pay the lesser of the calculated allowed amount under (f) - (n) of this section less any cost sharing amount under 7 AAC 105.610, the charged amount submitted under 7 AAC 145.020 less any cost sharing amount under 7 AAC 105.610, or the provider's usual and customary charge less any cost sharing amount under 7 AAC 105.610.

(i) The department will pay for compound prescriptions the sum of the dispensing fee set under 7 AAC 145.410 and the cost of each covered outpatient drug, with the cost of each covered outpatient drug set at the lowest of the following:

(1) the submitted cost for that covered outpatient drug;

(2) the federal upper limit established by CMS for that covered outpatient drug;

(3) the state maximum allowable cost for that covered outpatient drug;

(4) the estimated acquisition cost for that covered outpatient drug.

(j) A provider that dispenses covered outpatient drugs in unit doses to a recipient in a long-term care facility shall return unused covered outpatient drug to the pharmacy, and the claim will be adjusted.

(k) The department will pay a provider for home infusion therapy covered outpatient drugs for patients in a long-term care facility the sum of the dispensing fee set under 7 AAC 145.410 and the cost of each covered outpatient drug, with the cost of each covered outpatient drug set at the lowest of the following:

(1) the submitted cost for that covered outpatient drug;

(2) the state maximum allowable cost for that covered outpatient drug;

(3) the federal upper limit established by CMS for that covered outpatient drug;

(4) the estimated acquisition cost for that covered outpatient drug.

(*l*) The department will pay, for home infusion therapy covered outpatient drugs for patients outside a long-term care facility, the sum of the covered outpatient drug costs without a dispensing fee, with the cost of each covered outpatient drug set at the lowest of the following:

(1) the submitted cost for that covered outpatient drug;

(2) the state maximum allowable cost for that covered outpatient drug;

(3) the federal upper limit established by CMS for that covered outpatient drug;

(4) the estimated acquisition cost for that covered outpatient drug.

(m) If a facility is a covered entity as described in 42 U.S.C. 256b and indicates to the United States Department of Health and Human Services that it will use covered outpatient drugs purchased through the 340B drug pricing program to bill Medicaid, the facility must notify the department and may not submit a charge to Medicaid for more than the actual acquisition cost of the covered outpatient drug and a dispensing fee calculated under 7 AAC 145.410. If a covered entity as defined in 42 U.S.C. 256b notifies the United States Department of Health and Human Services, Health Resources and Services Administration, Office of Pharmacy Affairs of any changes in their enrollment or participating in the program, including that the entity's pharmacy is not included under 42 U.S.C. 256b, the entity's pharmacy is going to begin using covered outpatient drugs purchased through the 340B program to bill Medicaid, or the pharmacy is no longer going to use covered outpatient drugs purchased through the 340B program to bill Medicaid, the entity shall also notify the department. Payment for covered outpatient drugs from a facility indicating to the United States Department of Health and Human Services that it will use covered outpatient drugs purchased through the 340B drug pricing program to bill Medicaid will be the lesser of the following:

(1) the submitted actual acquisition covered outpatient drug cost plus the dispensing fee set under 7 AAC 145.410;

(2) the federal upper limit established by CMS plus the dispensing fee;

(3) the estimated acquisition cost plus the dispensing fee;

(4) the state maximum allowable cost plus the dispensing fee.

(n) If a facility purchases medications through the Federal Supply Schedule or drug

pricing program under Section 601, 602, or 603 of the Veterans Health Care Act of 1992 other than through the 340B drug pricing program, the facility must notify the department. The facility must notify the department of any changes in participation in purchasing medications through the Federal Supply Schedule or drug pricing program under Section 601, 602, or 603 of the Veterans Health Care Act of 1992. Payment for covered outpatient drugs from a facility purchasing medications through the Federal Supply Schedule or drug pricing program under Section 601, 602, or 603 of the Veterans Health Care Act of 1992 other than through the 340B drug pricing program will be the lesser of the following:

(1) the submitted covered outpatient drug cost plus the dispensing fee set under 7 AAC 145.410;

(2) the federal upper limit established by CMS plus the dispensing fee;

(3) the wholesale acquisition cost of the covered outpatient drug minus twenty percent plus the dispensing fee;

(4) the state maximum allowable cost plus the dispensing fee.

(o) For purposes of this section,

(1) "home infusion therapy" means drugs that require the use of a laminar flow hood or clean room for the protection of either the product or preparing personnel, and include cancer chemotherapy drugs, intravenous antibiotics, and hyperalimentation drugs;

(2) "estimated acquisition cost" means the wholesale acquisition cost plus one percent;

(3) "wholesale acquisition cost" means the manufacturer's list price for the drug

to wholesalers or direct purchasers in the United States, not including prompt-pay or other discounts, rebates, or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug pricing data;

(4) "actual acquisition covered outpatient drug cost" means the unit cost the medication was purchased for by the enrolled pharmacy provider net all discounts; providers may establish written protocols for establishing, or calculating, their actual acquisition drug cost based on averages, such as a monthly or quarterly average, of their actual acquisition drug cost; written protocols and calculations may not include an inflation factor, mark-up, spread or margin to be added to the providers actual purchase price net all discounts;

(5) "covered outpatient drug" means a drug which may be dispensed only upon a prescription; and for which

(A) the United States Food and Drug Administration (FDA) requires a national drug code (NDC) number;

(B) the drug is listed electronically with the FDA;

(C) the manufacturer has obtained a new drug application or an abbreviated new drug application from the FDA; and

(D) federal Medicaid matching funds are available for the drug.

(Eff. 2/1/2010, Register 193; am 1/1/2011, Register 196; am _____/_____/2014, Register _____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

Editor's note: The *American Druggist Blue Book* is a service subscribed to by the department that provides weekly updated comprehensive electronic data on available drugs, drug classifications, national drug code (NDC) numbers, and wholesale pricing. To see how this information is used, an individual must make arrangements for an in-person visit by contacting the office of the Department of Health and Social Services, Division of Health Care Services, 4501 Business Park Boulevard, Suite 24, Anchorage, Alaska 99503-7167.

7 AAC 145.410 is repealed and readopted to read:

7 AAC 145.410. Dispensing fee. (a) The department will pay a dispensing fee to a pharmacy in accordance with the following schedule:

(1) for a pharmacy located on the road system, the dispensing fee is $13.36, to be paid no more than once every 22 days per pharmacy per covered outpatient drug;

(2) for a pharmacy not located on the road system, the dispensing fee is $21.28, to be paid no more than once every 22 days per pharmacy per covered outpatient drug;

(3) the dispensing fee for an out-of-state pharmacy is $10.76, to be paid no more than once every 22 days per pharmacy per covered outpatient drug;

(4) the dispensing fee for a mediset pharmacy is $16.58, to be paid no more than once every 14 days per pharmacy per covered outpatient drug;

(5) the dispensing fee for a compounded covered outpatient drug is the applicable fee listed in (1) - (4) of this subsection;

(6) claims submitted by a provider for a recipient for the same covered outpatient

drug for which a dispensing fee was paid within the last 14 or 22 days, will be paid without the dispensing fee listed in (1) - (5) of this subsection if the claim satisfies all coverage criteria under 7 AAC 120.110 – 7 AAC 120.140.

(b) The department will pay, under (a), (c), or (g) of this section, the lesser of the assigned dispensing fee or the submitted dispensing fee.

(c) Upon request by the department, a pharmacy shall produce business records and invoice information relevant to the cost of drugs and the cost of dispensing. If a pharmacy does not provide cost of drugs or dispensing fee data as requested by the department, the department may assign that pharmacy the dispensing fee of $3.45 and sanction the pharmacy as provided under 7 AAC 105.400 - 7 AAC 105.490.

(d) A pharmacy may not refuse to fill an interim prescription for a covered outpatient drug occurring before the end of the 14 or 22 days because an additional dispensing fee will not be paid.

(e) In addition to a dispensing fee under (a) - (c) of this section for a tobacco cessation covered outpatient drug, the department will pay for tobacco cessation medication therapy management that meets the requirements of 7 AAC 120.110(b) at the rate of $16, no more than once every 30 days.

(f) The department will pay for vaccine administration if provided by a pharmacist to a recipient and reimbursed under 7 AAC 145.400(g). The vaccine administration fee is $17.46.

(g) Claims for a covered outpatient drug dispensed by a dispensing provider to a recipient for outpatient use will be reimbursed according to 7 AAC 145.400 with no dispensing

fee. A covered outpatient drug administered to an outpatient recipient by a physician, nurse practitioner, physician assistant or nurse midwife billed using a covered CPT or HCPCS code will be reimbursed at the estimated acquisition cost defined at 7 AAC 145.400(o)(2) for the amount administered with no dispensing fee.

(h) In this section,

(1) "congregate living home" includes a long-term care facility, an assisted living home licensed under AS 47.32, a residential psychiatric treatment center, or other group home;

(2) "covered outpatient drug" means a drug which may be dispensed only upon a prescription; and for which

(A) the United States Food and Drug Administration (FDA) requires a national drug code (NDC) number;

(B) the drug is listed electronically with the FDA;

(C) the manufacturer has obtained a new drug application or an abbreviated new drug application from the FDA; and

(D) federal Medicaid matching funds are available for the drug.

(3) "mediset" means a quantity or unit dose of a prescription covered outpatient drug that the provider repackages into single-dose packing to help a recipient adhere to difficult dosing regimens;

(4) "mediset pharmacy" means a pharmacy dispensing 75 percent or more of the total annual Medicaid prescriptions for covered outpatient drugs in prescriber-ordered medisets or unit doses to a recipient living in a congregate living home, a recipient of home and community-based waiver services, a recipient eligible for Medicaid under a category set out in 7 AAC 100.002(b) or (d) who is blind or disabled, a recipient who is an adult experiencing a serious mental illness, or a recipient who is a child experiencing a severe emotional disturbance;

(5) "out-of-state pharmacy" means an enrolled pharmacy physically located in any state other than Alaska;

(6) "pharmacy located on the road system" means a pharmacy that is physically located in a city, town, or village that is directly or indirectly connected to Anchorage by road;

(7) "pharmacy not located on the road system" means a pharmacy that is physically located in a city, town, or village that is not connected to Anchorage by road;

(8) "unit dose" means a quantity of a covered outpatient drug that the provider re-packages into single dosage packing. (Eff. 2/1/2010, Register 193; am 1/1/2011, Register 196; am 9/7/2011, Register 199; am 1/4/2012, Register 201; am _____/_____/2014, Register _____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 160.900(a)(22) is repealed:

(22) repealed____/____/2014;

7 AAC 160.900(d) is amended by adding a new paragraph to read:

(51) the *Alaska Medicaid 90 Day Generic Prescription Medication List*, dated 6/27/2013.

(Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 12/1/2010, Register 196; am 1/1/2011, Register 196; am 1/15/2011, Register 197; am 2/9/2011, Register 197; am 3/1/2011, Register 197; am 10/1/2011, Register 199; am 12/1/2011, Register 200; am 1/26/2012, Register 201; am 3/8/2012, Register 201; am 4/1/2012, Register 201; add'l am 4/1/2012, Register 201; am am 5/11/2012, Register 202; am 10/16/2012, Register 204; am 11/3/2012, Register 204; am 12/1/2012, Register 204; am 12/2/2012, Register 204; am 1/1/2013, Register 204; am 1/16/2013, Register 205; am 7/1/2013, Register 206; add'l am 7/1/2013, Register 206; am _____/_____/2013, Register _____; am _____/_____/2014, Register _____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040
AS 47.05.012

The editor's note following 7 AAC 160.900 is amended b adding a new paragraph to read:

The department's *Alaska Medicaid 90 Day Generic Prescription Medication List*, adopted by reference in 7 AAC 160.900, may be obtained from the Department of Health and Social Services, Division of Health Care Services, 4501 Business Park Boulevard, Suite 24, Anchorage,

AK 99503-7167; or may be obtained at the department's Internet site at http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx.

(***Publisher:*** *In the editor's note that follows 7 AAC 160.900, please delete the 33rd paragraph, as follows*:)

[THE MAGELLAN MEDICAID ADMINISTRATION *ALASKA MEDICAID MAC PRICE RESEARCH REQUEST FORM* MAY BE OBTAINED FROM FIRST HEALTH SERVICES, MAGELLAN MEDICAID ADMINISTRATION AT: HTTP://WWW.MEDICAIDALASKA.COM]