MARYLAND MEDICAID PHARMACY PROGRAMS

STANDARD INVOICE FOR ALL IV COMPOUNDS

(For use for all IV therapies including total parenteral nutrition-Form may be duplicated)

1. Pharmacy Name: _____Phone#:_____
2. Patient: _____Age:____MA#_____
   Patient Location: ___Residence; ___Hospital;___Nursing Home; ___Other:_____
3. Rx: Drug/strength:_____Diluent_____
   Dosage frequency:_____Route of adm.: IM__; IV__; SQ_; Oral inhalation__;
   Type of container**: Gravity bag_____; TPN bag_____**; **Bag for Repackaging**_____; **Elast. pump**:_____;
   Mechanical syringe/slow infusion with inf. pump:_____;**Cassette**:_____;**Prefilled syringe** :_____.
   # of containers dispensed:_____; # of dose(s/container:____; Days supply:_____days
4. Amount of Drug Wastage/Overfill: _____; Reason: _____
5. On-line Required Data Elements: **(Claim must deny for review. Please attach copy of signed order)**.

Rx#_____ Service Provider #:_____ NABP Provider#_____ **Date of service:** **Use Compd Code 2 & 99 in Subm. Clarif. Code Field**	**NDC (Most expensive active drug):** _____ **Reimbursement Unit** For liquid: **ml** For powder: **each**	**Qty of most expensive drug for whole batch:** _____ **Must be exact fractional units** Do not round up-Enter exact decimal units)	**Determination of Quantity or exact fractional units to be billed on-line:** Total # mg of drug needed for batch divided by drug concentration in mg (powder) per vial or mg/ml (liquid).	U/C (Usual and Customary Charge for entire batch): $ _____ (charge to the general public)

6. Compound Cost Itemization**:** List all ingredients in IV compounds. For TPN list only main 3 active ingredients (Amino acid, dextrose, and lipids). List type of container used (i.e. cassettes, elastomeric pumps, etc).

Active Drugs /Strength Pkg Size(List only main 3 ingredients forTPN)	**NDC # -11 digits- Do not list NDCs for diluents)**	**Quantity Per Container Units are: ml for liquids; ea. for powders- Fractional units apply**	**Quantity Per Batch (Use correct units)**	**Acquisition Cost for Entire Batch**
Drug Cost per Container:	$_____ X	_____ # of containers	Total Drug Cost:	**$_____**
Supplies (Do not bill under DME/DMS)	**Type of Container (bag, cassette, etc.)**	**Flat Rate per Container** (Cost of electrolytes included in TPN bag rate)	**# of Containers**	**Supply Flat Rate Reimbursement**
	_____ _____	_____ _____	_____ _____	Omit if already billed under DME/DMS $_____
Dispensing Fees :	**True IV Cmpds : $7.25/per day or per container, the lesser of**	**Non-True Non-Nursing Home IV cmpds: $4.69/generic/batch** **$3.69/brand/batch**	**Nursing Home Non-True IV Cmpds: $ 4.65/brand/batch** **$ 5.65/generic/batch**	**$ _____** **Omit if billed under DME/DMS**
Total Charges	**Deduct any other third party liability or secondary insurance**	**Third Party Liability (TPL): $_____ (0 if none)**		**U/C* Charges:** **$ _____**

***Usual and Customary Charges do not equal cost of drug ingredients + cost of supply+ dispensing fees as they also include a mark-up.**

FOR INTERNAL USE

Approved Quantity*:_____Approved Amount:$_____ *** will be adjusted if quantity billed in error**	**Date:_____/_____/_____ Initials:_____**

Pharmacists: Please certify the validity of the data as submitted by signing below:

Dispensing Pharmacist's original signature:_____Date:_____

Form to be mailed to: OOE- P.O. Box 2158, Baltimore, MD 21203 along with a copy of the signed IV order.