MARYLAND MEDICAID PHARMACY PROGRAM
PHARMACIST HIGH-COST DRUG DISPENSING RECORD

A six-month high-cost drug dispensing record must accompany each factor invoice that is submitted to the Program. Drug strength/Vial potencies and lot numbers must be documented on this sheet. The balance of units on hand must be given by the Recipient or Caregiver to the pharmacist when placing a new order.

Recipient:_____MA#:_____Phone# (____)_____-_____
Address: _____
Physician:_____Phone# (____)_____-_____Fax#(_____)_____-_____
Address:_____
Case Manager:_____Phone# (_____)_____-_____Fax# (____)_____-____

Date of Service	**Drug/Strength**	**Lot Number**	**Quantity Dispensed**	**Quantity On- Hand as reported by Recipient**	**Side-effects & Drug levels or bio-chemical markers required for drug monitoring.**

I certify that all data submitted are accurate and that I will be monitoring the recipient's proper drug utilization. Supporting documentation available for State audits.

Pharmacist's Original Signature: _____Date:_____/_____/_____
Pharmacist Name:_____