

AB 97 PHARMACY DRUG EXEMPTION APPLICATION						Submit Form MC 3153 and Supporting Documentation using one of the methods below: Mail to: Pharmacy Benefits Division, MS 4604 P. O. Box 997413 Sacramento, CA 95899-7413 Attn: AB 97 Drug Exemption Applications or Email to: ab97pharmacy@dhcs.ca.gov or Fax to: (916) 552-9563					
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.											
1. Date Application Submitted											
2. Drug NDC		3. Package Drug Name				4. Package Size		5. Drug Package Lot Number			
6. Provider Business Name						7. Provider NPI					
8. Pharmacy Type (Choose Type)		9. Provider Business Address				City		State		Zip	
10. Contact Name			11. Contact Phone Number			12. Contact Email					
13. Wholesaler Name											
14. Wholesaler Address						City		State		Zip	
15. Wholesaler Invoice Date		16. Wholesaler Invoice Number		17. Wholesaler Invoice Price		18. Wholesaler Drug Acquisition Unit Cost		19. Provider Drug Acquisition Unit Cost		20. Provider Drug Net Acquisition Unit Cost	
				\$		\$		\$		\$	
21. If unit cost is different in fields 19 and 20, please attach justification and documentation.											
22. AB 97 Drug Review Application : (please select all that apply below):											
<input type="checkbox"/> AB 97 payment reduction results in reimbursement less than actual acquisition cost <input type="checkbox"/> Beneficiary access negatively impacted											
23. Exemption Criteria: (please select all that apply below):										24. Total Number of Pages Submitted Including Form	
<input type="checkbox"/> Drugs for which documentation exists that the ten percent reduction will result in reimbursement below the acquisition cost generally available to the Medi-Cal pharmacy provider community.											
<input type="checkbox"/> Drugs that are only dispensed through limited or specialized networks of pharmacy providers.											
<input type="checkbox"/> Drugs that are used to treat unique clinical conditions with relatively low prevalence in the Medi-Cal population. <input type="checkbox"/> Drugs for which immediate or rapid negative clinical impact(s) will occur if consistent and ongoing access is impeded (e.g. drugs used to treat cancer, life-threatening infections, end stage renal disease, hemophilia, etc.).											
25. Provider Certification Statement											
By signing below, the provider acknowledges that the above information is required by Medi-Cal to review drug product(s) subject to the AB 97 ten percent payment reductions, 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 AB 97 ten percent payment reduction 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	
DHCS REVIEW (DEPARTMENT USE ONLY)											
DHCS Review Date		DHCS Decision:				Date Contacted Provider:		Provider Contacted By:			
		<input type="checkbox"/> Drug exemption approved <input type="checkbox"/> Drug exemption denied						<input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Fax			
Comments:											
DHCS Reviewer Printed Name:						DHCS Reviewer Signature:					

INSTRUCTIONS FOR COMPLETION OF THE AB 97 DRUG EXEMPTION APPLICATION (MC 3153) (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 AB 97 pharmacy payment reduction drug exemption application 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.

1. Insert date application submitted.
2. “Drug NDC” is the package National Drug Code.
3. “Drug Name” is the drug name listed on the product package.
4. “Package size” is the quantity of the drug in the package.
5. Insert drug package lot number.
6. “Provider Business Name” is the legal name of the business.
7. “Provider NPI” is the National Provider Identifier, a unique identification number for health care providers.
8. “Pharmacy Type”. Please indicate if you are a Chain Pharmacy or an Independent Pharmacy. A Chain Pharmacy is part of an organization controlling 5 or more retail outlets, whereas, an Independent Pharmacy is a retail pharmacy that is not directly affiliated with any chain of pharmacies.
9. Provider Business Address is the physical address of the pharmacy.
10. “Contact Name”. To assist in the timely processing of the application package, enter the name of the individual who can be contacted by PBD 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.
11. Insert contact phone number.
12. Insert contact email address.
13. “Wholesaler Name” is the business name of the wholesaler.
14. “Wholesaler Address” is the business address of the wholesaler.
15. “Wholesaler Invoice Date” is the most recent wholesaler invoice showing the current purchase price for the Drug NDC.
16. Insert wholesaler invoice number.
17. “Wholesaler Invoice Price” is the price on the invoice.
18. “Wholesaler Drug Acquisition Unit Cost” is the invoice price for drug package size divided by number of units in drug package.
19. “Provider Drug Acquisition Unit Cost” is the Wholesaler Drug Acquisition Unit Cost adjusted to consider provider related costs for shipping, handling, storage and delivery.
20. “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.
21. If unit cost is different in fields 19 and 20, please attach justification and documentation.
22. Select the appropriate response.
23. Exemption Criteria. Please indicate which of the required criteria has been met.
24. Insert total number of pages enclosed including the form.
25. Please read Provider Certification Statement.
26. Signature of provider or person authorized by provider to bind provider by signature below to statements and conditions contained on this form.
27. Insert date application is signed.

Remember to attach any supporting documentation or invoices.

For more information regarding the Medi-Cal AB 97 drug exemption criteria established by State Plan Amendment 12-014, please visit the DHCS [webpage](#).