



## **CATALYST RX MAC Pricing Appeal Process**

If your pharmacy holds an Independent contract with CATALYST RX, you may appeal directly to CATALYST RX. If you are part of a chain, franchise, third party network or PSAO, please direct your appeals to your corporate office or third party network.

### **Criteria for MAC Appeal:**

1. Claim was paid based on MAC pricing
2. Total paid (CATALYST RX Payment plus Patient Co-pay plus Dispensing Fee) must be less than the acquisition cost (Verified via First Data Bank wholesale pricing or YOUR invoice)

### **Documentation required for MAC Appeal:**

1. Claim Information: Rx Number, NCPDP Number & Pharmacy Name, Rx Date, Drug Name, Drug NDC
2. Contact Name & Contact information for individual appealing
3. Copy of invoice for specific NDC you are appealing

If MAC appeals are being sent by Chains, Third party networks, or PSAO's, it is expected that they will be screened PRIOR to being forwarded to CATALYST RX. Claims reimbursed at contracted rates based on AWP discounts, Usual and Customary or Ingredient Costs as submitted by the pharmacies do NOT qualify for review or appeals unless it is suspected that our claims adjudication system processed incorrectly.

MAC appeals can be sent to [crx-pbm-mac@catalystrx.com](mailto:crx-pbm-mac@catalystrx.com). In the subject, please put MAC APPEAL or they may also be faxed to 847-572-4160 using the **attached form** for your convenience.

If you have an open issue with our call center, please reference that issue # on your appeal.

Thank you.

**MAC APPEAL FORM FOR CATALYST RX CONTRACTED PHARMACIES**

|                                   |   |
|-----------------------------------|---|
| Date:                             |   |
| Your Name:                        |   |
| <b>Pharmacy or Chain Name:</b>    |   |
| Your Phone Number:                |   |
| Your Fax Number:                  |   |
|                                   |   |
| <b>NCPDP#:</b>                    |   |
| <b>RX #:</b>                      |   |
| <b>DOS:</b>                       |   |
| <b>Drug Name:</b>                 |   |
| <b>Drug NDC:</b>                  |   |
| <b>Comments:</b>                  |   |
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| Invoice Attached:                 | If the invoice is not attached, your appeal will not be considered. |
| Number of Pages Total:            |   |
|                                   |   |
| <b>Appeal Review Information:</b> | <b>FOR USE ONLY BY APPEALS COMMITTEE AT CATALYST RX</b>             |
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Thank you for submitting a complete appeal form. We will attempt to notify you (one time only at the contact information listed above) of the results of the appeal.