



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

Date:

Re: Out of State Pharmacy Requirements

Dear Applicant:

The Colorado Medical Assistance Program Pharmacy Provider Network is open to pharmacies located within the State of Colorado and certain out of state pharmacies (10 C.C.R. 2505-10, Section 8.820). In order to provide services to Colorado Medical Assistance Program clients, the out of state pharmacy must meet one or more of the following criteria:

- (1) Is located in one of the towns that border Colorado’s state lines that are listed in Appendix F of the Colorado Medical Assistance Program Manual Appendices section;
- (2) Is providing emergency pharmacy services to a Colorado Medical Assistance Program client who is traveling out of state;
- (3) Is providing services for foster care children or other Medical Assistance Program clients who permanently reside in other states and are wards of Colorado;
- (4) Is providing a service that is not available through pharmacies within Colorado; or
- (5) Is a mail order pharmacy.

If you are providing emergency services, please indicate below the client’s name and Medical Assistance Program state identification number. Also please estimate the length of time that the client will need such services. The Colorado Medical Assistance Program will reimburse the pharmacy for the drugs dispensed to treat the emergency only.

Name: _____ Client’s ID Number: _____ Time Estimate: _____
 Name: _____ Client’s ID Number: _____ Time Estimate: _____
 Name: _____ Client’s ID Number: _____ Time Estimate: _____
 Name: _____ Client’s ID Number: _____ Time Estimate: _____

If you are providing services for foster care children or other Medical Assistance Program clients who permanently reside in other states and are wards of Colorado, please indicate below the client’s name and Medical Assistance Program identification number. The Colorado Medical Assistance Program will only reimburse the pharmacy for the drugs dispensed to the clients listed below.

Name: _____ Client’s State ID Number: _____
 Name: _____ Client’s State ID Number: _____
 Name: _____ Client’s State ID Number: _____
 Name: _____ Client’s State ID Number: _____

If you are providing a service that is not available through pharmacies in Colorado, please describe those services below:

Regardless of the reason why you want to enroll your pharmacy as a Colorado Medical Assistance Program provider, the pharmacy must also meet all requirements outlined in the Medical Assistance Program Provider application. To provide the proposed services, the pharmacy must also either be registered with the Colorado Board of Pharmacy or you must certify that your pharmacy does not need to be registered with the Board of Pharmacy. If your pharmacy is registered, please provide a copy of your Colorado Pharmacy Registration as issued by the Colorado Board of Pharmacy. If you do not believe that your pharmacy needs to be registered with the Colorado Board of Pharmacy, please execute the certification below:

I, _____, on behalf of _____ (Name of Pharmacy), have sufficiently and adequately investigated whether the pharmacy needs to be registered as a pharmacy with the Colorado State Board of Pharmacy and I certify that I do not believe this pharmacy needs to be registered.

Please understand that any information that you provide in connection with this letter is part of your Medical Assistance Program provider application. Your certification on the application that all provided information is correct also applies to any information provided in connection with this letter.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

Approved:

Angela (Chris) Ukoha
Medicaid Pharmacy Liaison

Denied:

Angela (Chris) Ukoha
Medicaid Pharmacy Liaison