ARKANSAS INSURANCE DEPARTMENT
LEGAL DIVISION
1 COMMERCE WAY
LITTLE ROCK, AR 72202
PHONE: 501-371-2820
FAX: 501-371-2639

PBM-L1

PHARMACY BENEFITS MANAGER
LICENSURE APPLICATION

1. **BUSINESS ENTITY NAME:** ____

2. **MAILING ADDRESS:** ____
   Street and Number or P.O. Box City State Zip

3. **PHONE NUMBER:** ____________________

4. **DATE:** ______________

DATE RECEIVED BY DEPARTMENT

____

PLEASE PROVIDE:

(1) A non-refundable filing fee of $1,000.00;

(2) The following evidence of financial responsibility: a cash surety bond issued by a corporate surety authorized to issue surety bonds in the State of Arkansas, in the sum of $1,000,000.00, which shall be subject to lawful levy of execution by any party to whom the licensee has been found to be legally liable;

PLEASE STATE:

(3) The name of the PBM, the contact information of the PBM, including business address and phone number of the PBM, and name, address and contact information for the principal contact person of the PBM for purposes of compliance with requirements by the Arkansas Insurance Department;

PLEASE PROVIDE THE FOLLOWING, WHICH MAY BE ATTACHED TO THE APPLICATION:

(4) Proof of registration with the Arkansas Secretary of State;

(5) A list of the names, addresses and official positions of the person who are to be responsible for the conduct of the affairs of the PBM applicant, including all members of the board of the directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

PLEASE ATTACH THE FOLLOWING ITEMS TO THIS APPLICATION:

(6) A copy of the basic organizational document of the PBM, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents, and all amendments thereto; a copy of the bylaws, rules and regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(7) A copy of the PBM's standard, generic contract template which it uses for contracts entered into by the PBM with Pharmacies or Pharmacy services administrative organizations in this State in administration of pharmacy benefits for Healthcare insurers, for the purpose only of the Department's review that such contracts comply with Ark. Code Ann. §§ 23-92-506(b), 23-92-506(c), 23-92-507, 4-88-1004 and 17-92-507;

(8) A copy of the most recent fiscal year-end audited financial statement of the PBM;

(9) A description of the projected population or numbers of enrollees or beneficiaries to be administered by the PBM in this State to be serviced on an annual basis for all Healthcare insurers with whom the PBM has contracted, and, if applicable, the population or numbers of enrollees administered by the PBM in the previous year for a Healthcare insurer (please identify the numbers of enrollees by Healthcare insurer);

(10) The policy and procedure(s) which demonstrate that the PBM has compliant processes established to adhere to all of the requirements in Ark. Code Aim. § 17-92-507, concerning Maximum Allowable Cost Lists, and provide a description, including any written policies or procedures describing the appeals dispute resolution process for in-network or contracted pharmacists;

(11) A description or statement explaining how the PBM is in compliance with Ark. Code Ann. § 23-92-507, concerning Anti-Gag clauses, in its contracts with pharmacists in administration of pharmacy benefits for Health benefit plans issued by Healthcare insurers in this State;

(12) A description of the PBM's network's service areas by county in this State for a Healthcare insurer and the PBM's pharmacy provider directory list for a Healthcare insurer (this requirement may be satisfied if such information is submitted to the Department by the Healthcare insurer for the Healthcare insurer's network adequacy requirements);

PLEASE PROVIDE A WRITTEN EXPLANATION OF THE FOLLOWING, IF APPLICABLE:

(13) If the PBM is engaged in "spread pricing" for a Health benefit plan, please explain whether or not the PBM is assuming risk, if any, for payment of the covered prescription benefits of Health benefit plans;

PLEASE PROVIDE:

(14) A statement of whether the applicant has been refused a registration, license or certification to act as (or provide the services of) a PBM or third party administrator, or has any registration, license or certification to act as such been denied, suspended, revoked or non-renewed for any reason by any state or federal entity (if so, attach specific details separately for each refusal or denial separately, including the date, nature and disposition of the action);

(15) A description of whether the applicant had a business relationship with an insurance company terminated for any alleged fraudulent, illegal or dishonest activities in connection with the administration of a pharmacy benefits plan (if so, attach specific details separately explaining this termination, including the date, and nature of the termination);

(16) Please provide a Public, Redacted Version of this Application which does not include proprietary information.

AFFIDAVIT

I, the undersigned, do hereby swear or affirm under oath that the information submitted above is true and accurate to the best of my knowledge and belief.

OFFICER NAME: ______________________________________

Please Print

____

Please Sign

DATE SIGNED: ______________________________________

NOTARY SECTION:

Subscribed and affirmed before me in the county of__________ ______________
State of Arkansas, this ___________ day of____________________ , 20 ___
(Notary's official signature)

(Commission Expiration) ______________________________

SEAL

____