TROY DOWNING
CSI
COMMISSIONER OF SECURITIES & INSURANCE
OFFICE OF THE MONTANA STATE AUDITOR

840 Helena Avenue
Helena, Montana 59601
csimt.gov
csi@mt.gov

APPLICATION FOR LICENSE—PHARMACY BENEFIT MANAGER

APPLICATION REQUIREMENTS

1. Submission of a completed application for a Montana Pharmacy Benefit Manager (PBM).
2. Submission of required documentation.
3. Submission of a nonrefundable fee of $1,000.

To the COMMISSIONER OF SECURITIES AND INSURANCE

1. Name of Applicant _____
(Name under which business is to be transacted and registration is to be issued.)

2. Federal Employer Identification Number (FEIN) _____

3. State of Domicile _____

4. Address of Principal Administrative Office _____

5. Telephone Number of Principal Administrative Office _____

6. Name of Principal Contact Person _____

7. Address of Principal Contact Person _____

8. Telephone Number of Principal Contact Person _____

9. E-mail Address of Principal Contact Person _____

10. Registered Name _____
(Name of the PBM or DBA (if applicable) registered with the Montana Secretary of State's office.)

11. Type of business organization registered with the Montana Secretary of State's office (select one):
☐ Corporation ☐ LLC ☐ Partnership ☐ Other _____

12. Is applicant currently registered in Montana as a third-party administrator? ☐ Yes ☐ No

13. Has applicant 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? ☐ Yes ☐ No

If yes, attach specific details separately for each denial, suspension, etc., including the date, nature, and disposition of the action.

14. Has applicant entered into a judgement or consent agreement with a state while providing the services of a PBM or a third-party administrator? ☐ Yes ☐ No

If yes, attach specific details explaining the judgement of consent agreement including the date, nature, and disposition of the action.

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15. Has applicant had a business relationship with a health carrier, plan sponsor, workers' compensation carrier, or other entity that was terminated for any alleged fraudulent, illegal, or dishonest activities in connection with the administration of a pharmacy benefit plan? ☐ Yes ☐ No

If yes, attach specific details separately explaining the termination, including the date and nature of the termination.

16. Full names, titles, and addresses of, as applicable, all members of the board of directors, board of trustees, executive committee, and other governing board or committee; or all principal officers of the corporation; or all partners or members of the partnership or association (attach additional sheets as necessary).

FULL NAME	TITLE	ADDRESS

I hereby certify that, under penalty of perjury, I am the person named below and know the contents of this application, and that all of the information submitted in this application and the attachments are true and complete. I attest that I have the authority and capacity to execute this certification on behalf of the applicant. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license denial or revocation and may subject me to civil or criminal penalties.

Name of Applicant: _____

Signature of Officer or Authorized Representative: _____

Printed Name: _____ Title: _____

Date: _____

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REQUIRED DOCUMENTATION FOR APPLICATION FOR LICENSE—PHARMACY BENEFIT MANAGER

The following materials must be submitted with the application:

- ☐ A list of all health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state.
- ☐ A projection of the number of enrollees and injured workers to be administered by the PBM in this state on an annual basis for each health carrier client, plan sponsor client, and workers' this insurance carrier client.
- ☐ Pharmacy Network Template.
- ☐ Accessibility Report.
- ☐ Proof of registration with the Montana Secretary of State's office.
- ☐ Applicant was refused a registration, etc.
- ☐ Applicant subject to regulatory action.
- ☐ A copy of the policies and procedures demonstrating the PBM has established processes to comply with §§ 33-22-170 through 33-22-177, MCA, and § 33-22-180, MCA, concerning maximum allowable costs lists, including the appeals process required under § 33-22-173, MCA.
- ☐ Disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary, in a pharmacy or mail-order pharmacy that is part of the PBM's pharmacy network.
- ☐ Disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary, by a health carrier or workers' compensation insurance carrier in the PBM or by the PBM in a health carrier or workers' compensation insurance carrier.
- ☐ An NAIC biographical affidavit for each person listed in question 15 or 16 depending on the application.
- ☐ PBM's process for monitoring and ensuring on an ongoing basis a sufficient and adequate pharmacy network to meet the pharmacist services.
- ☐ The criteria the PBM used to build a pharmacy network, including the criteria used to select pharmacies for participation in the pharmacy network.
- ☐ The criteria the PBM used to build any preferred pharmacy network, including the criteria used to place pharmacies in subsets, groups, or tiers.
- ☐ A copy of the most recent fiscal year-end audited financial statement of the PBM.
- ☐ The criteria the PBM used to select pharmacies to dispense specialty drugs in the pharmacy network.
- ☐ A PBM must provide electronic address for the online directories for the pharmacies network where the general public is able to view all pharmacies included in each pharmacy network through a clearly identifiable link or tab, without creating an account or entering a policy or contract number.