STATE OF MAINE
Bureau of Insurance

Submit this form to:
Violet Hyatt, Public Health Nurse
Consumer Health Care Division
Maine Bureau of Insurance
e-mail: Violet.M.Hyatt@maine.gov
phone: (207)-624-8459

Private Courier (FedEx, UPS) Overnight delivery:
76 Northern Ave.
Gardiner, ME 04345.

USPS Express overnight deliveries
34 State House Station
Augusta, ME 04333.

For content questions contact: Violet Hyatt
e-mail: Violet.M.Hyatt@maine.gov
phone: (207) 624-8459

Pharmacy Benefits Manager (PBM)
Application for License

A $100 LICENSE FEE IS DUE WITH YOUR APPLICATION;
$100 RENEWAL IS REQUIRED EVERY THREE YEARS
--Please Make Payable to Treasurer State of Maine—

PLEASE INCLUDE A COMPLETED COPY OF THE PBM CHECKLIST WITH THIS APPLICATION

Section 1. Applicant Information:

Name of PBM:	
DBA/Trade Name (if applicable): -- Please list all used. Use separate sheet if necessary--	Federal ID#:
Name of PBM's Parent Company (if applicable):	
Business Address: (including City, State, Zip)	Mailing Address (if different): (including City, State, Zip)
State Incorporated in:	Corporate Offices Direct Telephone:
Name of Contact for PBM, Email and Telephone Number:	
Does the PBM hold any other licenses in Maine? (if yes, what type) -- Please list all used. Use separate sheet if necessary	

Applicant's agent for service of process in Maine (must be an agent located in Maine):

Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	

Information on each person beneficially interested in the applicant (e.g. ownership of 10% or more of voting securities) (attach additional pages if necessary):

Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	
Name:	Title:
Direct Telephone:	Contact Email:

Mailing Address:

Information on each officer and director (attach additional pages as necessary):

Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	
Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	

Name:	Title:
Direct Telephone:	Contact Email:
Mailing Address:	

Section 2. Applicant Qualifications:

Attach to the application a full explanation and/or the requested information for questions below. Failure to provide the required information or any omissions may result in the denial of this application.

A. Organization & Background

1. Copies of the basic organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents, including all amendments, bylaws, rules, regulations, and/or procedures regulating the internal conduct of the applicant.

2. Has the applicant ever been refused a registration, license or certification to act as a provider of pharmacy benefit management services in another state or has such license, registration or certification ever been revoked?

3. Has the applicant ever had a business relationship with an insurance company terminated due to alleged fraud, illegal, or dishonest activities in connection with the administration of pharmacy benefit management services? (If so, attach specific details explaining the termination, its nature, and date.)

4. Has the applicant ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, illegal, or dishonest activities in connection with the administration of pharmacy benefit management services?

5. Has the applicant, or any company or organization controlling the operation of the applicant, experienced any data security breaches or HIPAA security breaches? (If yes, please attach all pertinent information regarding the breach.)

6. Does the applicant own, operate, or affiliate with any pharmacy located outside Maine which ships, mails, or delivers in any manner, controlled substances, prescription or legend drugs or devices into Maine.

B. Expertise

Please provide the following:

1. A copy of the applicant's standard contract template which the applicant uses in this State for contracts with pharmacies or pharmacy services organizations in the administration of pharmacy services for insurers. If any client contract provision deviates materially from the standard contract, provide a description of the material deviations.

2. A current client list.

3. The number of projected enrollees or beneficiaries in this State to be serviced by the applicant during the upcoming year for all contracted insurers. If applicable, provide the actual number of enrollees or beneficiaries administered by the applicant for each insurer during the previous calendar year.

4. A copy of the applicant's network service areas by Maine county for each contracted insurer and the applicant's pharmacy directory list. (A mail order pharmacy may not be included in determining the adequacy of a retail pharmacy network. All mail order pharmacies must be listed separately.)

5. A description of how the applicant intends to comply with 24-A M.R.S. § 4349(4) and any relevant written procedures. (A carrier or pharmacy benefits manager may not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of: A) The applicable cost-sharing amount for the prescription drug; B) The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts; and C) The total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier, including the cost - sharing amount paid by a covered person.)

6. A description of how the applicant intends to comply with each portion of 24-A M.R.S. § 4350, including applicable procedures required by § 4350(3) (changes to the maximum allowable cost list), and §§ 4350(5) and (6) (the appeals process), § 4350(7) (prescription drugs not on maximum allowable cost list; and § 4350(8) (payment).

7. A description of how the applicant intends to comply with each portion of §4350-A and any applicable procedures. (Responsibility to use compensation for benefit of covered persons.)

8. Documentation showing that the applicant has established a pharmacy and therapeutics committee and implemented conflict of interest/compensation procedures as required by § 4350(B).

Section 3. Financial Integrity:

Please provide the following:

1. A copy of the applicant's most recent fiscal year-end audited financial statement.

2. Does the applicant handle claims and/or collect premium? If so, a Third-Party Administrator License Application must be completed.

3. An explanation of how the applicant has the necessary financial integrity to supply its proposed services. Please include a description of the applicant's business plan and attach any relevant documents in addition to the applicant's most recent fiscal year-end audited financial statement.

Signature:

As the authorized representative of the Applicant, I hereby certify that all of the information submitted in this application and attachments is true and complete.

Signature	**Date**
Printed Name	**Title**