ARKANSAS INSURANCE DEPARTMENT
ATTN: Legal Division
1 Commerce Way
Little Rock, AR 72202
501-371-2820
FAX: 501-371-2639

PHARMACY BENEFITS MANAGER LICENSURE APPLICATION

Business Entity Name: _____

Mailing Address:_____
Street and Number or P.O. Box **City** **State** **Zip**

Phone Number: _____

Please provide the following attached to the application with dividers between each section:

1. Non-refundable filing fee of $1,000.00 to AID

2. 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.

3. Contact Information
   To include names, titles, mailing addresses, email address, and direct phone numbers
   A. EIN number for Company
   B. MAC and NADAC complaints Contact for AR
   C. PBM Licensing Contact for AR
   D. Government Relations / Legal Contact for AR
   E. Board Members
   F. Board of Trustees
   G. Executive Committee
   H. Principal officers in the case of a corporation
   I. Partners or members in the case of a partnership or association

4. Proof of registration with the Arkansas Secretary of State.

5. 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.

6. A copy of the PBM's standard, generic contract template which it uses for contracts entered 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.

7. Recent fiscal year-end audited financial statement of the PBM, including a breakout schedule showing the financial position of the PBM and its subsidiaries, and a list identifying any parent company or companies, and any subsidiaries, and any affiliate. If not applicable; please reply "N/A".

8. 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).

9. The policy and procedure(s) which demonstrate that the PBM has compliant processes established to adhere to all the requirements in Ark. Code Ann. § 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.

10. A description or statement explaining how the PBM is following 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.

11. 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).

12. 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);

13. 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);

14. 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 _____, this ____ day of _____, 20____.

SEAL

_____

(Notary's official signature)

_____

(Commission Expiration)