STATE OF WEST VIRGINIA
Offices *of the* Insurance Commissioner
Company Analysis and Examinations Division

PHARMACY BENEFIT MANAGERS (PBM) RENEWAL APPLICATION

1. ______________________________
Name of Entity

____
Doing Business As Name

2. ______________ ______________
State of Domicile **FEIN**

3. ______________________________
Physical Address

____
Address Line 2

____
City, State & Zip Code

____
E-mail Address

____
Phone #

4. ______________________________
Mailing Address

____
Address Line 2

____
City, State & Zip Code

____
E-mail Address

____
Phone #

5. ______________________________
Administrative Contact Person

____
Mailing Address

____
Address Line 2

____
City, State & Zip Code

____
E-mail Address

____
Phone #

6. ______________________________
Complaint Contact Person

____
Mailing Address

____
Address Line 2

____
City, State & Zip Code

____
E-mail Address

____
Phone #

On or before JULY 15TH of the Filing Year (BIENNIALLY IN EVEN YEARS) please provide:

1. A non-refundable filing fee of $5,000.00 payable to the WV Offices of the Insurance Commissioner;
2. A copy of the most recent fiscal year-end audited financial statement of the PBM;
3. Evidence of financial responsibility in the sum of $1,000,000 in the form of one of the following:

    a. A cash or surety bond issued by a corporate surety authorized to issue surety bonds in the State of West Virginia, which shall be subject to lawful levy of execution by any party to whom the licensee has been found to be legally liable;
    b. Irrevocable Letter of Credit;
    c. Securities with minimum value of $1,000,000;
    d. Written Parental Guarantee;
    e. $1,000,000 in working capital and/or surplus as reflected in audited financials submitted to the Commissioner.

4. Proof of registration with the West Virginia Secretary of State;
5. A detailed description of the PBM's business model, services provided, customer base, Company structure listing all parent and child relationships, list of TPAs and their purpose, and a list of all PBMs contracted with and their purpose.
6. An updated description of the projected population or numbers of enrollees or beneficiaries to be administered by the PBM in this State on an annual basis for all covered entities with whom the PBM has contracted, and, if applicable, the population or number of covered individuals administered by the PBM in the previous year for a covered entity (please identify the numbers of enrollees by covered entity);
7. An updated description of the PBM's network's service areas by county in this State for a covered entity and the PBM's pharmacy provider directory list for a covered entity. The network and provider directory should be submitted using the templates located on our website at: PBM Network Templates
8. A statement of whether the PBM's network is (1) reasonably adequate, (2) provides for convenient patient access to pharmacies within a reasonable distance from a patient's residence, (3) not comprised of only of mail-order benefits and, (4) contains a mix of mail-order benefits and physical stores in this state - W.Va. Code §§33-51-8(d)(1).
9. A statement of whether the PBM engaged in "spread pricing" for a covered entity during the current licensure period. If yes, please provide an explanation regarding whether or not the PBM is assuming risk, if any, for payment of the covered prescription benefits of health benefit plans.

P.O. Box 50540 – Charleston, WV 25305-0540
Phone: (304) 558-2100 – Fax: (304) 558-1365
Email: OICPBM@wv.gov

Please provide the following, IF AMENDED after the prior Licensure Application:

10. 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, 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;

11. 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;

12. A copy of the bylaws, rules and regulations or similar document, if any, regulating the conduct of the internal affairs of the PBM;

13. A copy of the PBM's standard, generic contract template which it uses for contracts entered into by the PBM with pharmacists, pharmacies or pharmacy services administrative organizations in this State in administration of pharmacy benefits for covered entities, for the purpose ensuring that such contracts comply with W. Va. Code §33-51-9;

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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.

Check "Yes" or "No" for each of the following statements representing the PBMs compliance with the noted Rule during the current licensure period with the Commissioner:

- Yes ☐ No ☐ -- Pursuant to W. Va. Code of St. R. §§ 114-99-4.6 this PBM has maintained its financial responsibility, as noted under subdivision 4.2.e of this section, at all times during the current licensure period.
- Yes ☐ No ☐ -- Pursuant to W. Va. Code of St. R. §§ 114-99-4.2.o this PBM has not been refused a registration, license or certification to act as (or provide the services of) a PBM or third party administrator, has not had 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, or has not been sanctioned, fined, or penalized for any reason by any state or federal entity during the current licensure period. If no, attach specific details separately for each refusal or denial separately, including the date, nature and disposition of the action.
- Yes ☐ No ☐ -- Pursuant to W. Va. Code of St. R. §§ 114-99-4.2.p this PBM has not had a business relationship with an insurance company terminated for any legal finding or judgment of fraudulent or illegal activities in connection with the administration of a pharmacy benefits plan during the current licensure period. If no, attach specific details separately explaining this termination, including the date, and nature of the termination.

____
Print Name of Officer

____
Signature

____
Date

Subscribed and affirmed before me in the county of ______________________________,

State of ______________________, this ____________day of ____________ 20__________.

____
Signature of Notary

____
Date

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