PBM Appeal Response Form

DELAWARE DEPARTMENT OF INSURANCE

This appeal form shall only be used by Pharmacy Benefits Managers (PBM) to respond to a Maximum Allowable Cost Pricing for Prescription Drugs appeal by a Pharmacist after they have exhausted all internal appeals.

Respondent Information

Respondent Name: _____
Respondent Contact: _____
Respondent Address: _____
_____
_____
Respondent Phone Number:_____
Respondent Email: _____

Appeal/Claim Details

Pharmacy Name	
Policy Identification Number	
Drug Name	
Prescription Number	
Date Prescription was filled	
Date Prescription was Paid	
Amount Paid	
Is the drug listed as "A" or "B" rated (or) "NR" or "NA" rating by the FDA?	
Is the drug available for purchase from national and/or regional wholesalers?	
If manufactured by more than 1 manufacturer, is the drug available for purchase by a contracted pharmacy, including a contracted retail pharmacy, in this State from a wholesale distributor with a permit in this State, with whom the appellant has an existing relationship?	
If manufactured by only 1 manufacturer, is the drug generally available for purchase by a contracted pharmacy, including a contracted retail pharmacy, in this State from at least two wholesale distributors with a permit in this State?	
Is the drug obsolete, temporarily unavailable, or listed on a drug shortage list as in shortage?	

Appeal Details:

Date appellant requested appeal.	
Was this within 10 calendar days of the fill date?	
Name of appeal contact person	
Date PBM completed the internal appeal.	
Was the appeal completed within 10 calendar days?	
Date the internal appeal determination was sent to Pharmacist	

1. For what reason did the Respondent refuse to accept the internal appeal? _____
   _____
   _____
   _____
2. Describe what documentation and information the Respondent reviewed to determine the outcome of the internal MAC appeal prior to submission of this appeal (include a copy of the supporting documentation)? _____
   _____
   _____
   _____
   _____
3. What do you consider a fair resolution? _____
   _____
   _____
   _____

Directions for completing form:

1. Complete form/response in its entirety.
2. Include the proof of mailing to the appellant
3. Include a copy of the contract between the Respondent and the appellant along with any other supporting information.
4. **Incomplete forms will be rejected.**
5. Email this form and all supporting information to: doipbm@delaware.gov, subject line: "Respondent MAC Appeal" within 5 business days of receipt of the Pharmacist MAC Appeal form.