

**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:**

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

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](mailto:doipbm@delaware.gov), subject line: "Respondent MAC Appeal" within 5 business days of receipt of the Pharmacist MAC Appeal form.