



Pharmacy Benefit Manager (PBM) State Specific Requirements for Initial License

Please complete the application below in addition to the NIPR Uniform Application. All requested documents must be emailed to PBMDept@doi.sc.gov. Note that the maximum file size accepted via email is 40MB, so you may need to send multiple emails or combine documents into a zip file.

Refer to the [PBM Application Requirements Checklist](#) on the S.C. Department of Insurance website for specific documents required to be submitted in support of this application.

This application must be completed in its entirety. Failure to fully complete this application and provide all required supporting documents will result in an incomplete application and will delay issuance of a PBM license and may result in denial of the application.

Section 1. Applicant Demographic Information:

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| Name of PBM: | Doing Business As (DBA): |
| Name and Title of Business Contact (must be officer/director): | Business Contact Direct Telephone and Email: |
| Name and Title of Primary Contact: | Primary Contact Direct Telephone and Email: |
| Indicate the type(s) of services the PBM will provide to clients: <input type="checkbox"/> Claims Processing and Adjudication <input type="checkbox"/> Formulary Management <input type="checkbox"/> Appeals <input type="checkbox"/> Utilization Management <input type="checkbox"/> Rebate and discount negotiation <input type="checkbox"/> Clinical Programs <input type="checkbox"/> Pharmacy Network Management <input type="checkbox"/> Benefit Plan Design <input type="checkbox"/> Mail-order and specialty pharmacies <input type="checkbox"/> Other (please specify): _____ _____ | |
| Does the PBM hold any other licenses in South Carolina? (if yes, list all other license types, attaching additional sheets if necessary) | |
| Name of PBM's Parent Company (if applicable): | |



Applicant's agent for service of process in South Carolina:

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

Contact information for each person with management or control over the PBM (attach additional sheets if necessary):

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

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

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

Contact information for on each person with a beneficial ownership interest in the PBM (attach additional sheets if necessary): (If there are no persons with a beneficial ownership interest, please check this box)

| | |
|-------------------|-----------------------|
| Name: | FEIN (if applicable): |
| Direct Telephone: | Contact Email: |

| | |
|-------------------|-----------------------|
| Mailing Address: | |
| | |
| Name: | FEIN (if applicable): |
| Direct Telephone: | Contact Email: |
| Mailing Address: | |
| | |
| Name: | FEIN (if applicable): |
| Direct Telephone: | Contact Email: |
| Mailing Address: | |
| | |

Maximum Allowable Cost List Appeals Process Contact Information:
Note: All pharmacy and PSAO complaints, whether MAC related or not, received by the SCDOI against the PBM will be forwarded to this contact for investigation and response as outlined in S.C. Code Ann. Regs. 69-77.V.

| | | |
|-----------------------------------|----------------|-------------------|
| Name of MAC List Appeals Contact: | Title: | Direct Telephone: |
| Mailing Address: | Contact Email: | |

Market Conduct and Other Compliance Matters Contact Information:
Note: The SCDOI will contact this person regarding market conduct and other compliance matters.

| | | |
|-----------------------------|----------------|-------------------|
| Name of Compliance Contact: | Title: | Direct Telephone: |
| Mailing Address: | Contact Email: | |

Consumer Complaint Contact Information:
Note: The SCDOI will contact this person regarding consumer complaints received by the SCDOI against the PBM.

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| Name of Compliance Contact: | Title: | Direct Telephone: |
| Mailing Address: | Contact Email: | |

PBM Contact Information for Pharmacy Providers:

Pursuant to S.C. Code Ann. § 38-71-2235(B), the PBM must provide a phone number through which a pharmacy or pharmacist can obtain answers within a reasonable time to questions regarding networks, patient benefits, appeals, and other contractual or service issues.

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| Direct Telephone: | Hours of Operation: |
|-------------------|---------------------|

Section 2. Organization Structure:

Pursuant to S.C. Code Ann. § 38-71-2210(A)(2)(f), a PBM applicant that is a partnership or other unincorporated association, limited liability company, or corporation, and has five or more partners, members, or stockholders must complete the following section:

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| Specify legal structure of applicant: | |
| Provide total number of partners, members or stockholders who, directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10% or more of the voting securities of any other person. | |
| *By submitting this application, the PBM agrees that, upon request by the Department, the PBM will provide information regarding the name, address, usual occupation, and professional qualifications of any other partners, members, or stockholders who, directly or indirectly, own, control, hold with the power to vote, or hold proxies representing 10% or more of the voting securities of any other person. | |

Section 3. Applicant Qualifications:

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

A. Applicant Background:

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| 1. Has any officer with management or control of the PBM been refused or denied a registration, license, or certification to act as (or provide the services of) a PBM or Third-Party Administrator in any state? If yes, attach specific details separately for each such refusal or denial, including the date, nature, and disposition of the action. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Has the applicant or officer with management or control had any registration, license, or certification to act as (or provide the services of) a PBM or Third-Party Administrator suspended, revoked, or nonrenewed for any reason by any state or federal entity? If yes, attach specific details separately for each such suspension, revocation, or nonrenewal, including the date, nature, and disposition of the action, and attach a copy of any relevant final order or similar document imposing the suspension, revocation, or nonrenewal. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Has the applicant had a business relationship with an insurer terminated for any fraudulent or illegal activities relating to the administration of a pharmacy benefits plan? If yes, attach specific details separately explaining this termination, including the date, and nature of the termination. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Has an officer with management or control of the PBM been convicted of a felony or violated any of the requirements of state law, regardless of the state, applicable to Pharmacy Benefit Managers? If yes, attach a signed statement describing the relevant conviction or violation. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

B. Administration and Operation: The following documentation must be submitted with this application in addition to the other supporting documents listed on the Pharmacy Benefit Manager Application Requirement Checklist.

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| 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, organizational, or similar document(s), if any, regulating the conduct or the internal affairs of the applicant. |

A copy of the PBM's:

- provider manual and written agreement(s), excluding pricing information, but including audit procedures, which it uses for contracts entered into with pharmacists, pharmacies, or pharmacy services administrative organizations in administration of pharmacy benefits for health care insurers in this State; **or**
- a representative written agreement and provider manual, excluding pricing information, but including audit procedures, for each type of network provider, which it uses for contracts entered into with pharmacists, pharmacies, or pharmacy services administrative organizations in administration of pharmacy benefits for health care insurers in this State.

For the two preceding calendar years, a listing of health care insurers, PBMs, TPAs, and other entities with which the PBM was contracted in this State to perform claims processing services and the number of enrollees or beneficiaries covered by each entity.

For the two preceding calendar years, a listing of TPAs, PBMs, and any other entities to which you delegate any of your contracted PBM services. Please include a description of the duties you delegate to each.

The relevant documentation, such as a policies and procedures manual, that demonstrates the PBM has adopted processes to ensure compliance with the requirements in S.C. Code Ann. § 38-71-2240, including any written policies or procedures describing the appeals dispute resolution process for in-network or contracted pharmacists or pharmacies. This documentation must include an example of 1) the notice that is provided to pharmacies or pharmacists upon the denial of an internal appeal that notifies the pharmacy or pharmacist of the right to request an external review of the internal appeal and 2) the supporting documents provided to pharmacies or pharmacists upon the denial of an internal appeal that notifies the pharmacy or pharmacist describing the external review process.

Section 4. Attestations:

I, the undersigned, do hereby swear or affirm under oath that the information submitted in this application, including all documents submitted in support of this application, is true and accurate to the best of my knowledge and belief. If there is any material modification of this information, a notice will be filed with the Department within ten (10) days of occurrence unless another reporting requirement is outlined in law. Furthermore, I, the undersigned, do hereby swear or affirm under oath that the entity applying for licensure as a PBM is in compliance with all laws and regulations related to its operations in the State of South Carolina, including, but not limited to those found in S.C. Code Ann. §§ 38-71-2200, *et seq.*; S.C. Code Ann. §§ 38-71-1810, *et seq.*; and S.C. Code Ann. Regs. 69-77.

| | |
|---|--------|
| Print Name of Officer or Authorized Representative: | Date: |
| Signature: | Title: |

All proprietary information submitted shall be considered confidential pursuant to S.C. Code Ann. Regs. 69-77.II.C; S.C. Code Ann. § 38-71-2250; and S.C. Code Ann. § 30-4-40.

Subscribed and sworn to me before this _____ day of _____, 20_____.

Notary Signature _____

My Commission Expires _____

County of _____

State of _____

(Notary Seal Affixed Here)