South Carolina Department of Insurance
1201 Main Street, Suite 1000
Columbia, SC 29201

Office of PBM Oversight
P.O. Box 100105, Columbia, SC 29202-3105
Telephone: (803) 734-0398

# Pharmacy External Review Request Form

This form is for pharmacies or pharmacists to request an external review of a denied internal appeal of provider reimbursements and appeals of recoupments arising out of audits conducted through its Pharmacy Benefits Manager (PBM).

To be eligible for an External Review, pharmacies are required under South Carolina law to exhaust a PBM's internal appeal process prior to requesting an external review with the SCDOI. A pharmacy must then file this form with the SCDOI within sixty (60) calendar days of the pharmacy's receipt of the PBM's final determination resolving the pharmacy's initial appeal or within thirty (30) calendar days of the pharmacy's receipt of the PBM's final audit report. Along with submitting this completed request form electronically to PBMExtReview@doi.sc.gov, you must provide the following:

(1) A cashier's check or money order made payable to the South Carolina Department of Insurance in the amount of $7.00.
(2) A copy of the written appeal decision rendered by the PBM.
(3) A copy of the invoice(s) showing the pharmacy's purchase price for the drug or medical product or device at issue, if applicable.
(4) A list of all discounts, price concessions, rebates or other reductions, excluding cash discounts, that were, or should have been, reported to the PBM including supporting documentation for each discount, price concession, rebate or other reduction, if applicable.
(5) Provide any other documentation or information requested by the SCDOI or Independent Review Organization regarding the pharmacy's appeal.

**THE EXTERNAL REVIEW REQUEST AND ALL DOCUMENTATION MUST BE SUBMITTED WITHIN 60 CALENDAR DAYS OF THE PHARMACY'S RECEIPT OF THE PBM'S FINAL DETERMINATION RESOLVING THE PHARMACY'S INITIAL APPEAL OR WITHIN 30 CALENDAR DAYS OF THE PHARMACY'S RECEIPT OF THE PBM'S FINAL AUDIT REPORT.** Failure to provide all the necessary information will result in processing delays and may result in denial of the external review request.

| | |
|---|---|
| **Pharmacy Name:** | **NPI#:** |
| **Mailing Address:** | **Contact Email:** |
| **Contact Person:** | **Phone #:** |

| **Name of PSAO (if filing on behalf of Pharmacy):** | **Contact Email:** |
|---|---|
| **Contact Person:** | **Phone #:** |

**Name of PBM:** _____ **PCN:** _____

**Rx Group No.:** _____ **BIN:** _____

**Please Note**: The SCDOI does not have regulatory authority over the following health plan types:
- Out-of-State Plans
- Government Healthcare Programs (e.g., Medicaid, Medicare, TRICARE, Veterans Health Administration, Indian Health Services, Children's Health Insurance Program and State Health Insurance)

**Reason for Appeal:**

_____ Initial appeal was denied.
_____ Initial appeal was approved by PBM, but reimbursement does not cover my cost.
_____ Discrepancy in Audit recoupment.
_____ Other, please specify _____

_____

**Complete the following information if applicable:**

Reimbursement Amount: _____

Date of Internal Appeal filing with PBM: _____

Date PBM Denied Internal Appeal (must provide copy of denial): _____

**Description and Details of the External Review Request** (include the relief requested and the basis upon which you believe you are due the relief)**:**

Does an attorney represent you in this matter? ___ Yes ___ No

**If yes, we will need written authorization from your attorney for us to intervene in this matter. You may have your attorney co-sign this form or include a signed letter of authorization that is on the attorney's letterhead with this form.**

I certify and declare under penalty of perjury that the information I have provided is true and accurate to the best of my knowledge. This information will be forwarded to an approved Independent Review Organization for a review of a denied internal appeal of this matter or recoupment. By submitting this form, I am authorizing the SC Department of Insurance to submit my appeal and any documents related to this appeal to an Independent Review Organization. Furthermore, I am authorizing other party(ies) named in the appeal to release all relevant information, documents, and records to the SC Department of Insurance and the Independent Review Organization assigned to review my appeal.

Signature of Contact: _____ Date: _____

Signature of Attorney (if applicable): _____ Date: _____

The information or data acquired during an examination or review is considered proprietary and confidential and is not subject to the South Carolina Freedom of Information Act, in accordance with Regulation 69-77 § II.C, 69-77 § VIII and Sections 38-71-2220, 38-71-2250 and 30-4-40 of the Code of Laws of South Carolina 1976, as amended.