

Check appropriate box for license requested:

- Resident License
- Non-Resident License

Identify Home State:

Identify Home State License #:  
(if applicable)



**COMMONWEALTH OF KENTUCKY  
DEPARTMENT OF INSURANCE**

P. O. Box 517

Frankfort, Kentucky 40602-0517

email: [DOI.LicensingMail@ky.gov](mailto:DOI.LicensingMail@ky.gov)

<https://insurance.ky.gov>

Ph. 502-564-6004 Fax 502-564-6030  
(PLEASE PRINT OR TYPE)

**For Office Use Only**

Amt. Rec'd \_\_\_\_\_

Date Rec'd \_\_\_\_\_

Tracking No. \_\_\_\_\_

Cashier: \_\_\_\_\_

**PHARMACY BENEFIT MANAGER LICENSE APPLICATION**

**New License Application**

**Renewal Application**

**Section 1 – Demographic Information**

Entity Name	Incorporation/Formations Date (MM/DD/YY)			FEIN
If assigned, National Producer Number (NPN)	State of Domicile			UR Registration #:
List any other assumed, fictitious, alias or trade names under which you are doing business or intend to do business.				
Address of Home Office		City	State	ZIP Code
Business Address (Physical Street)		City	State	ZIP Code
Phone Number (include extension) (   ) -	Fax Number (   ) -	Business E-Mail Address		Business Website Address
Mailing Address		P.O. Box	City	State ZIP Code
Listing of entities/individuals for which the PBM provides services (within Kentucky only)				

**Applicant Background Information**

Attach a full explanation and/or the requested information for questions below as an attachment to this application. Failure to provide the required attachments or any omissions may result in the denial of this application.	
<p>Has the applicant been refused a registration, license or certification to act as (or provide the services of) a Pharmacy Benefit Manager, Pharmacy Benefit Management Plan, Pharmacy Benefits Processor, Third Party Administrator, Third Party Provider, etc., or has 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? (Attach specific details separately.)</p>	
<input type="checkbox"/> <input type="checkbox"/> <b>YES</b> <b>NO</b>	
<p>Has the applicant ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, illegal or dishonest activities in connection with the administration of pharmacy benefit management services? (Attach specific details separately.)</p>	
<input type="checkbox"/> <input type="checkbox"/> <b>YES</b> <b>NO</b>	
<p>Has the applicant had a business relationship with an insurance company terminated for any alleged fraudulent, illegal or dishonest activities in connection with the administration of pharmacy benefit management services? (Attach specific details separately.)</p>	
<input type="checkbox"/> <input type="checkbox"/> <b>YES</b> <b>NO</b>	
<p>Has the applicant, parent company or any company or organization controlling the operation of the Pharmacy Benefit Manager experienced any data security breaches or HIPAA security breaches? (If YES please attach all pertinent information concerning any data security breach. Any future data security breach must be reported immediately to the Kentucky Department of Insurance.)</p>	
<input type="checkbox"/> <input type="checkbox"/> <b>YES</b> <b>NO</b>	
<p>Does the applicant own, operate or affiliate with any pharmacy located outside of Kentucky that ships, mails or delivers in any manner, controlled substances, prescription or legend drugs or devices into Kentucky?</p>	
<input type="checkbox"/> <input type="checkbox"/> <b>YES</b> <b>NO</b>	

## Section 2 – Service of Process Agent for Pharmacy Benefit Manager

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone Number (      ) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

## Section 3 – Licensed Administrator Acting on Behalf of the Pharmacy Benefit Manager

According to KRS 304.9-133, a business entity shall have at least one licensed individual with same line of authority and shall have at least one licensed individual designated with the commissioner at all times. List primary licensed contact person(s) responsible for regulatory compliance on behalf of the Pharmacy Benefit Manager:

Name \_\_\_\_\_ Official Title \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ NPN or DOI ID#: \_\_\_\_\_

Name \_\_\_\_\_ Official Title \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ NPN or DOI ID#: \_\_\_\_\_

Name \_\_\_\_\_ Official Title \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ NPN or DOI ID#: \_\_\_\_\_

## Section 4 – Individuals Responsible for the Compliance and Conduct of Affairs for Pharmacy Benefit Manager

List all individuals responsible for the compliance/conduct of affairs, including members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association, and any other person who exercises control or influence over the affairs of the Pharmacy Benefit Manager.

1. Name \_\_\_\_\_ Official Title \_\_\_\_\_

Address \_\_\_\_\_ Professional Qualifications \_\_\_\_\_

2. Name \_\_\_\_\_ Official Title \_\_\_\_\_

Address \_\_\_\_\_ Professional Qualifications \_\_\_\_\_

3. Name \_\_\_\_\_ Official Title \_\_\_\_\_

Address \_\_\_\_\_ Professional Qualifications \_\_\_\_\_

4. Name \_\_\_\_\_ Official Title \_\_\_\_\_

Address \_\_\_\_\_ Professional Qualifications \_\_\_\_\_

5. Name \_\_\_\_\_ Official Title \_\_\_\_\_

Address \_\_\_\_\_ Professional Qualifications \_\_\_\_\_

6. Name \_\_\_\_\_ Official Title \_\_\_\_\_

Address \_\_\_\_\_ Professional Qualifications \_\_\_\_\_

7. Name \_\_\_\_\_ Official Title \_\_\_\_\_

Address \_\_\_\_\_ Professional Qualifications \_\_\_\_\_

8. Name \_\_\_\_\_ Official Title \_\_\_\_\_

Address \_\_\_\_\_ Professional Qualifications \_\_\_\_\_

(Attach additional sheets if necessary)

**Section 5 - Administration and Operation: The following documentation shall be submitted with this application.**

The documentation required to be submitted in this section shall be submitted as a Portable Document Format (PDF) bookmarked document in accordance with the items listed below and submitted to the Department via email to [DOI.PharmacyBenefitManager@ky.gov](mailto:DOI.PharmacyBenefitManager@ky.gov).

1. Attach a detailed description of the generic drug pricing dispute appeal process to be used by contracted pharmacies, pharmacy services and administration organizations or group purchasing organization, including the appeals policy and procedure, pursuant to KRS 304.17A-162 (1) (b).
2. Attach the policy and procedure used for making price updates warranted as a result of an appeal granted under KRS 304.17A-162, including PBM's means of providing notification to all other contracted pharmacies in the network.
3. Identify the national drug pricing compendia or sources used to obtain drug price data for every drug for which the PBM establishes a maximum allowable cost to determine the product reimbursement, pursuant to KRS 304.17A-162(3).
4. Identify the location of PBM's comprehensive list of every drug subject to generic drug pricing, per KRS 304.17A-162(4).
5. Attach the policy and procedure to be used for updating generic drug pricing every seven days and the PBM's ability to provide notification to all contracted pharmacies (KRS 304.17A-162 (6) and (7)).
6. Attach the policy and procedure that ensures that every drug subject to generic drug pricing meets requirements set forth in KRS 304.17A-162(8) through KRS 304.17A-162(13).
7. Attach the policy and procedure relating to the resolution of generic drug pricing complaints which are filed with the Kentucky Department of Insurance, including timeframes and sample appeal response letter. Provide a contact person's name, address, email, and telephone number for complaints.
8. Attach the *Exceptions Policy* that allows an enrollee, designee, or prescribing provider to gain access to clinically appropriate drugs not otherwise covered by the plan, and includes a standard and expedited procedure. (45 CFR 156.122 and KRS 304.17A-535).
9. Provide the policy that explains the process that gives the ability to access prescriptions from an in-network retail, unless special handling or another reason proves that the prescription cannot be provided by a retail pharmacy. (45 CFR 156.122).
10. Attach the policy explaining any Pharmacy and Therapeutics committee membership standards and duties, including how often the committee meets, structure, and the decision-making process. (45 CFR 156.122)
11. Provide a listing of any delegated/contracted companies that perform part of the PBM services.
12. Attach proof of financial responsibility in the amount of one million dollars (\$1,000,000).
13. Attach proof of a registered agent and office with the Kentucky Secretary of State in accordance with KRS 14A.4-010
14. Attach \$11,000 non-refundable fee (KRS 304.9-200(4)), made payable to the Kentucky State Treasurer, or paid electronically through Kentucky eServices account. **Please note, if the PBM provides services limited to workers' compensation plans, the PBM will only need to submit a \$1,000 non-refundable fee made payable to the Kentucky State Treasurer, or paid electronically through Kentucky eServices account.**

**When the PBM application is emailed, pay fees through the eServices account. When the PBM application is mailed to DOI, make check payable to Kentucky State Treasurer, and include with the mailing. Checks shall never be mailed without explanation, application, or documentation.**

**Section 6 - Applicant's Certification and Attestation**

**On behalf of the Pharmacy Benefit Manager, applicant hereby certifies, under penalty of perjury, that:**

1. All of the information submitted in this application and attachments is true and complete and I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license or registration revocation and may subject me and the applicant to civil or criminal penalties.
2. The applicant grants permission to the Kentucky Department of Insurance or other appropriate party in the Commonwealth of Kentucky to verify any information supplied with any federal, state, or local government agency, current or former employer, or insurance company.
3. I authorize the Kentucky Department of Insurance to give any information they may have concerning me, as permitted by law, to any federal, state or municipal agency, or any other organization and I release the Kentucky Department of Insurance, and any person acting on their behalf, from any and all liability of whatever nature by reason of furnishing such information.
4. I acknowledge that I understand and shall comply with the insurance laws and regulations of Kentucky.
5. I hereby certify that I will furnish any additional information upon request.

**Shall be signed by an officer, director, or partner of the entity, or member or manager of a limited liability company who has authority to act on behalf of the entity:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Typed or Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Address line 1

\_\_\_\_\_  
Address line 2

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP