

OFFICIAL USE ONLY
FEE PAID:

**APPLICATION FORM FOR PHARMACY BENEFIT MANAGER REGISTRATION
CALIFORNIA HEALTH AND SAFETY CODE SECTION 1385.005¹
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT**

Dated:

Original Application Form for Pharmacy Benefit Manager Registration

The Department of Managed Health Care (DMHC) will begin review of the original Application Form for Pharmacy Benefit Manager² Registration upon receipt of the \$3,500 flat filing fee. The DMHC will bill for time spent reviewing the PBM's responses and changes requested by the DMHC at a variable hourly rate, depending on the reviewer's classification, up to \$500. The fees to review an initial Application Form for PBM Registration are capped at \$4,000. [See Section 1385.005(f)].

Amendment to Application Form for Pharmacy Benefit Manager Registration

Pharmacy Benefit Manager Registration Number:

After a PBM is registered with the DMHC, a PBM submitting changes to the DMHC pursuant to Section 1385.005(g) will be billed at a variable hourly rate, depending on the reviewer's classification, and any of the PBM's responses and changes requested by the DMHC. The fees to review an amendment to Application Form for PBM Registration are not capped. [See Section 1385.005(f)].

Date of the most recently submitted Application Form for Pharmacy Benefit Manager Registration:

Note: A Pharmacy Benefit Manager Registration obtained pursuant to Section 1385.005 is not transferable. [See Section 1385.005(b)].

1. Legal name of the PBM (Person or Entity) [See Section 1385.005(c)(1)]:

¹ California Health and Safety Code sections 1340 et seq. (the "Act"). References herein to "Section" are to sections of the Act.

² Pharmacy Benefit Manager (PBM) is defined at Section 1385.001.

Fictitious name(s) used in connection with the operation of the PBM [See Section 1385.005(c)(1)]:

If none, specify "N/A"

2. Address of the PBM [See Section 1385.005(c)(2)]:

Street Address or PO Box Number

City, State and Zip Code

Mailing Address, if different [See Section 1385.005(c)(2)]:

Street Address or PO Box Number

City, State and Zip Code

Phone Number of PBM (include area code) [See Section 1385.005(c)(2)]:

Email Address of PBM:

3. Identify by legal name and dba each health care service plan³ with which the PBM contracts in the state of California. (If space is insufficient, please file an attachment to the application form and title the attachment "Response to Item 3").

³ Health care service plan is defined at Section 1345(f).

4. Identify all of the health care service plans' product lines for which the PBM contracts in the state of California. Check all that apply.

EPO Individual	EPO Large Group	EPO Small Group
HMO Individual	HMO Large Group	HMO Small Group
HSP Individual	HSP Large Group	HSP Small Group
Medi-Cal	POS Individual	POS Large Group
POS Small Group	PPO Individual	PPO Large Group
PPO Small Group	IHSS	Cal-MediConnect
Healthy Kids	MCAP (AIM)	Medicare
MRMIP	Other (please specify)	

5. Name of the PBM's agent for service of process in the state of California [See Section 1385.005(c)(3)]:

Address of the PBM's agent for service of process in the state of California [See Section 1385.005(c)(3)]:

Street Address or PO Box Number

City, State and Zip Code

Mailing Address, if different [See Section 1385.005(c)(3)]:

Street Address or PO Box Number

City, State and Zip Code

6. Name and address of each person beneficially interested⁴ (Person or Entity) in the PBM, but limit to including those persons who own the five largest interests in the PBM. (The DMHC reserves the right to request the names and addresses of all persons beneficially interested.). If there are fewer than five persons beneficially interested, the PBM need not use all of the fields provided below. [See Section 1385.005(c)(4)]:

a.i. Name of person beneficially interested [See Section 1385.005(c)(4)]:

Full Name - First, Middle, and Last Name or Entity

a.ii. Address [See Section 1385.005(c)(4)]:

Street Address or PO Box Number

City, State and Zip Code

a.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

b.i. Name of person beneficially interested [See Section 1385.005(c)(4)]:

Full Name - First, Middle, and Last Name or Entity

⁴ For purposes of this section, "person beneficially interested" with respect to a PBM means and includes the following [See Section 1385.005(h)]:

1. If the PBM is a partnership or other unincorporated association, each partner or member [See Section 1385.005(h)(1)].
2. If the PBM is a corporation, each of its officers, directors, and stockholders, provided that a natural person shall not be deemed to be beneficially interested in a nonprofit corporation [See Section 1385.005(h)(2)].
3. If the PBM is a limited liability company, each officer, manager, or member [See Section 1385.005(h)(3)].

b.ii. Address [See Section 1385.005(c)(4)]:

Street Address or PO Box Number

City, State and Zip Code

b.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

c.i. Name of person beneficially interested [See Section 1385.005(c)(4)]:

Full Name - First, Middle, and Last Name or Entity

c.ii. Address [See Section 1385.005(c)(4)]:

Street Address or PO Box Number

City, State and Zip Code

c.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

d.i. Name of person beneficially interested [See Section 1385.005(c)(4)]:

Full Name - First, Middle, and Last Name or Entity

d.ii. Address [See Section 1385.005(c)(4)]:

Street Address or PO Box Number

City, State and Zip Code

d.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

e.i. Name of person beneficially interested [See Section 1385.005(c)(4)]:

Full Name - First, Middle, and Last Name or Entity

e.ii. Address [See Section 1385.005(c)(4)]:

Street Address or PO Box Number

City, State and Zip Code

e.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

7. Names and addresses of the five key persons with management or control over the PBM. (The DMHC reserves the right to request the names and addresses of all persons with management or control over the PBM). If there are fewer than five key persons, the PBM need not use all of the fields provided below. [See Section 1385.005(c)(5)]:

a.i. Name of person with management or control over PBM [See Section 1385.005(c)(5)]:

Full Name - First, Middle, and Last Name or Entity

a.ii. Address [See Section 1385.005(c)(5)]:

Street Address or PO Box Number

City, State and Zip Code

a.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

b.i. Name of person with management or control over PBM [See Section 1385.005(c)(5)]:

Full Name - First, Middle, and Last Name or Entity

b.ii. Address [See Section 1385.005(c)(5)]:

Street Address or PO Box Number

City, State and Zip Code

b.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

c.i. Name of person with management or control over PBM [See Section 1385.005(c)(5)]:

Full Name - First, Middle, and Last Name or Entity

c.ii. Address [See Section 1385.005(c)(5)]:

Street Address or PO Box Number

City, State and Zip Code

c.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

d.i. Name of person with management or control over PBM [See Section 1385.005(c)(5)]:

Full Name - First, Middle, and Last Name or Entity

d.ii. Address [See Section 1385.005(c)(5)]:

Street Address or PO Box Number

City, State and Zip Code

d.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

e.i. Name of person with management or control over PBM [See Section 1385.005(c)(5)]:

Full Name - First, Middle, and Last Name or Entity

e.ii. Address [See Section 1385.005(c)(5)]:

Street Address or PO Box Number

City, State and Zip Code

e.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

8. Indicate whether the PBM is structured as any of the following entities [See Section 1385.005(d)]:

Partnership

Other unincorporated association

Limited Liability Company

Corporation

Other – please describe

9. Does the PBM have more than 5 partners, members, or stockholders? [See Section 1385.005(d)]:

Yes

If yes, please provide the name, address, usual occupation, and professional qualifications of each of the five partners, members, or stockholders who own **the 5 largest interests** in the PBM's entity in the fields provided below [See Section 1385.005(d)].

No

If no, please provide the DMHC with the name, address, usual occupation, and professional qualifications of **each** of the partners, members, or stockholders in the fields provided below. Please note, if PBM is responding no, the PBM need not use all of the fields provided below [See Section 1385.005(d)].

a.i. Name of partner, member, or stockholder [See Section 1385.005(d)]:

Full Name - First, Middle, and Last Name or Entity

a.ii. Address [See Section 1385.005(d)]:

Street Address or PO Box Number

City, State and Zip Code

a.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

a.iv. Usual Occupation [See Section 1385.005(d)]:

a.v. Professional Qualifications [See Section 1385.005(d)]:

b.i. Name of partner, member, or stockholder [See Section 1385.005(d)]:

Full Name - First, Middle, and Last Name or Entity

b.ii. Address [See Section 1385.005(d)]:

Street Address or PO Box Number

City, State and Zip Code

b.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

b.iv. Usual Occupation [See Section 1385.005(d)]:

b.v. Professional Qualifications [See Section 1385.005(d)]:

c.i. Name of partner, member, or stockholder [See Section 1385.005(d)]:

Full Name - First, Middle, and Last Name or Entity

c.ii. Address [See Section 1385.005(d)]:

Street Address or PO Box Number

City, State and Zip Code

c.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

c.iv. Usual Occupation [See Section 1385.005(d)]:

c.v. Professional Qualifications [See Section 1385.005(d)]:

d.i. Name of partner, member, or stockholder [See Section 1385.005(d)]:

Full Name - First, Middle, and Last Name or Entity

d.ii. Address [See Section 1385.005(d)]:

Street Address or PO Box Number

City, State and Zip Code

d.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

d.iv. Usual Occupation [See Section 1385.005(d)]:

d.v. Professional Qualifications [See Section 1385.005(d)]:

e.i. Name of partner, member, or stockholder [See Section 1385.005(d)]:

Full Name - First, Middle, and Last Name or Entity

e.ii. Address [See Section 1385.005(d)]:

Street Address or PO Box Number

City, State and Zip Code

e.iii. Mailing Address, if different:

Street Address or PO Box Number

City, State and Zip Code

e.iv. Usual Occupation [See Section 1385.005(d)]:

e.v. Professional Qualifications [See Section 1385.005(d)]:

10. Has the PBM been convicted of a felony or violated any of the provisions of Article 6.1? [See Section 1385.005(e)]:

No

Yes

If yes, state the violation or describe the reason(s) that prevent the PBM from being able to comply with the requirements [See Section 1385.005(e)]:

11. PBM affirmations. Check below to affirm:

a. The PBM exercises good faith and fair dealing in the performance of its contractual duties to a health care service plan. [See Section 1385.004(a)(3)].

Yes

No

If no, explain:

b. The PBM complies with the requirements of Chapter 9.5 (commencing with Section 4430) of Division 2 of the California Business and Professionals Code, as applicable. [See Section 1385.004(a)(4)].

Yes

No

If no, explain:

- c. The PBM informs all pharmacists under contract with or subject to contracts with the PBM of the pharmacist's rights to submit complaints to the DMHC under Section 1371.39 and of the pharmacist's rights as a provider under Section 1375.7. [See Section 1385.004(a)(5)].

Yes

No

If no, explain:

- d. The PBM will notify a health care service plan in writing of any activity, policy, or practice of the PBM that directly or indirectly presents a conflict of interest that interferes with the discharge of the PBM's duty to the health care service plan to exercise good faith and fair dealing in the performance of its contractual duties. [See Section 1385.004(b)].

Yes

No

If no, explain:

12. Identify the name, title, address and telephone number of representative who may be contacted concerning this Application Form for Pharmacy Benefit Manager Registration:

Contacts Name:

Contacts Full Name - First, Middle, and Last Name

Contacts Title:

Title

Mailing Address:

Street Address or PO Box Number

City, State and Zip Code

Phone Number (include area code):

Name of Person/Entity Filing Application Form for Pharmacy Benefit Manager
Registration:

Full Name - First, Middle, and Last Name or Entity

Signed By:

Full Name - First, Middle, and Last Name

Title:

Application Form for Pharmacy Benefit Manager Registration Declaration

I certify (or declare) under penalty of perjury under the laws of the State of California that I have read the information contained in this Application Form for Pharmacy Benefit Manager Registration including its attachments and know the contents thereof and that the statements therein are true and correct.

I further declare hereby that the PBM will notify in writing the DMHC within 30 days of a change in any of the information disclosed to the DMHC in the Application Form for Pharmacy Benefit Manager Registration. [See Section 1385.005(g)].

PBM Name:

Signature of Authorized Person:

Printed Name and Title of Authorized Person:

Executed at (City and State):

Date: