Pharmacist Appeal Form

DELAWARE DEPARTMENT OF INSURANCE

This appeal form shall only be used by pharmacists appealing Maximum Allowable Cost Pricing for Prescription Drugs after you have exhausted all internal appeals with the Pharmacy Benefits Manager (PBM).

Appellant Information

Pharmacy Name: _____
Pharmacy Contact: _____
Pharmacy Address: _____
_____
_____
Pharmacy Phone Number:_____
Pharmacy Email: _____

Complaint Details

PBM Name	
Policy Identification Number	
Drug Name	
Prescription Number	
Date Prescription was filled	
Date Prescription was Paid	
Amount Paid	
Is the drug available for purchase from national and/or regional wholesalers?	
Is the drug obsolete, temporarily unavailable, or listed on a drug shortage list as in shortage?	
If manufactured by more than1 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 who the appellant has an existing relationship?	
If manufactured by only 1 manufacturer, is the drug generally available for purchase by a contracted pharmacy, in this state from at least two wholesale distributors with a permit in this state?	

*At the beginning of your contract term or upon renewal of you PBM contract were you advised of the source utilized to determine the MAC pricing utilized by the PBM? Yes_____ No_____
*Did the PBM make the MAC list available in a format readily accessible? Yes_____ No_____

Appeal Details:

Date appellant requested appeal.	
Was this within 10 calendar days of the fill date?	
Name of appeal contact person	
Date PBM completed internal appeal.	
Was the appeal completed within 10 calendar days?	
Date internal appeal determination was sent to the pharmacy	
Amount in Dispute	
Date Appeal Decision sent to DOI.	

1. If the PBM refused to accept the appeal, what was the stated reason? _____
   _____
   _____
   _____
2. Describe what was submitted to the PBM to resolve the 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/petition in its entirety.
2. Include the proof of mailing to the PBM
3. Email this form and all supporting documents to: doipbm@delaware.gov, subject line: "MAC Appeal" as soon as possible.
4. **Incomplete forms will be rejected.**