Department of Consumer and Business Services
Division of Financial Regulation
P.O. Box 14480, Salem, Oregon 97309-0405
Phone: 503-947-7984, Fax: 503-378-4351
888-877-4894 (toll-free)
350 Winter St. NE, Salem, Oregon
Email: pbm.complaint@oregon.gov

Department use only

File # _____

Analyst # _____

This complaint form should only be used for complaints related to drugs on the MAC list after you have exhausted all appeal rights with the Pharmacy Benefit Manager (PBM). This complaint form should not be used for a complaint related to Medicare Part D. A complaint submitted against a PBM shall be deemed confidential under ORS 731.264.

Complaint: Maximum Allowable Cost (MAC) Appeal

Complainant Information:		
Pharmacy Name:		
Pharmacy Address:		
Pharmacy Contact:	Phone:	Email:

Complaint Details:
Pharmacy Benefit Manager Name:
Insurer Name:
Subscriber ID or Policy No.:
Plan Name (if known):
Drug Name and Prescription No.:
Net amount pharmacy paid for the drug:
Date the claim was submitted to the PBM:
Date the PBM reimbursed the pharmacy:
Amount paid to the pharmacy:
1a. Is the drug generally available for purchase by pharmacies in Oregon from national or regional wholesalers? ☐ Yes ☐ No
1b. Were there at least two therapeutically equivalent, not obsolete, multiple source drugs, or at least one generic drug, not obsolete, available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers? ☐ Yes ☐ No
2. At the beginning of the term of your contract, and upon renewal of the contract, did the PBM make available the sources utilized to determine the maximum allowable cost pricing of the PBM? ☐ Yes ☐ No
3. Did the PBM make the MAC list available upon request in a format that is readily accessible and usable? ☐ Yes ☐ No
Appeal Details:
4. Date of appeal to PBM:
5. Did you submit your appeal to the PBM within 30 calendar days of making the claim for which appeal had been requested? ☐ Yes ☐ No
6. Did the PBM provide a telephone number at which you were able to contact the PBM and speak with an individual who is responsible for processing appeals? ☐ Yes ☐ No Who did you speak to?
7. Did you receive a final response to the appeal within seven business days? ☐ Yes ☐ No
8. If the appeal was denied, were you provided with the reason for the denial and the national drug code of a drug that may be purchased by similarly situated pharmacies at a price that is equal to or less than the maximum allowable cost? ☐ Yes ☐ No ☐ N/A
9. What was the reason for the denial?

10. If the PBM refused to accept your appeal, what was the stated reason?

11. Describe your efforts to resolve the claim/MAC appeal prior to submission of this complaint (be specific and use additional pages if necessary):

12. What do you consider to be a fair resolution?

Attach documentation that supports this complaint. Are you under any contractual obligation to keep certain claim-related information confidential (proprietary information, trade secrets, etc.)? ☐ Yes ☐ No
Complaints submitted to DCBS are subject to ORS 731.264 (Confidentiality of Complaints).

Complaint submitted by:	
Signature:	Date:
Printed Name:	Relationship to Pharmacy:

Note: A copy of this complaint will be sent to the Pharmacy Benefit Manager or agent involved.

DCBS Consumer and Business Services