



**Department of Consumer and Business Services**

**Division of Financial Regulation**

P.O. Box 14480, Salem, Oregon 97309-0405

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[dfr.oregon.gov](http://dfr.oregon.gov)

New application.

Renewal application.

**Pharmacy Benefit Manager  
Registration Application**

**Applicant:**

Applicant name

Business address

FEIN

City

State

ZIP

**Applicant's principal officers**

Officer name

Job title

Officer name

Job title

Business address

Business address

City

State

ZIP

City

State

ZIP

Officer name

Job title

Officer name

Job title

Business address

Business address

City

State

ZIP

City

State

ZIP

**Applicant's officer/employee to be contacted regarding regulatory compliance concerns:**

Name

Job title

Business address

City

State

ZIP

Phone Number

Email

**Provide business telephone number and business e-mail address where Applicant's personnel directly responsible for the processing of maximum allowable cost appeals may be contacted, if different from above.**

Phone number

Email

**Applicant shall respond “Yes” or “No” to each of the following questions, and shall explain any “Yes” response in the Supplemental Information space provided below.** Has Applicant or any person with control of the Applicant:

1. Ever falsified an application for registration or for the renewal of a registration or engaged in any dishonest act in relation to the application?  Yes  No
2. Ever engaged in dishonesty, fraud or gross negligence in the conduct of business as a pharmacy benefit manager?  Yes  No
3. Ever engaged in conduct that resulted in a conviction of a felony under the laws of any state or of the United States, to the extent that such conduct may be considered under ORS 670.280?  Yes  No
4. Ever been convicted under the laws of any state or of the United States of any crime of which an essential element is dishonesty or fraud?  Yes  No
5. Ever had a certificate of authority or authority to conduct business as a pharmacy benefit manager denied, revoked or suspended in another state?  Yes  No
6. Ever failed to pay a civil penalty imposed by final order of the department or to comply with the terms of suspension set by the department?  Yes  No
7. Ever failed to meet the terms of a consent decree approved by a court of competent jurisdiction in this state, or a consent order made between the department and the pharmacy benefit manager?  Yes  No
8. Ever refused to be examined or to produce accounts, records or files for examination, including the refusal by any officer of the applicant or registrant to give information with respect to the affairs of the pharmacy benefit manager, or refused to perform any other legal obligation with respect to an examination by the department?  Yes  No
9. Ever violated any rule or order of the department or any provision of the Insurance Code?  Yes  No

**Supplemental Information (with cross reference as appropriate). Attach additional pages, if needed:**

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List all other jurisdictions in which the Applicant is or has been registered, licensed or certified to transact business as a pharmacy benefit manager within the past ten (10) years.

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**Certification of applicant:** Applicant certifies that the information contained in this Application is true and correct according to the best of Applicant’s knowledge, information and belief. Applicant understands that Applicant is required to provide written notification to the department of any change in such information.

**Application submitted by (person authorized to submit this application):**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Job title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Application fee:**  
The application fee is \$1,100

**Make check or money order payable to:**  
**Department of Consumer and Business Services.**

**Mail registration with payment to:**  
DCBS — Fiscal Services  
P.O. Box 14610  
Salem, OR 97309-0445

**Secure fax for credit card payments:**  
**503-947-2333**

If paying by credit card, applicant must sign credit-card information box.

<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover	Phone: _____
_____ Cardholder signature		_____ Expiration date	
_____ Name of cardholder as shown on credit card			
_____ Credit card number		\$	_____ Amount

<b>Fiscal use only: 92010/1582</b>
<b>Fee: \$1,100</b>