**Pharmacy Benefit Manager Disclosure Form**

Under 18 V.S.A. §9472(d), pharmacy benefit managers (PBMs) that provide pharmacy benefit management for health plans in Vermont are required to report to the health insurer, as well as the Department of Financial Regulation (DFR) and the Green Mountain Care Board (GMCB) (collectively, “the State”) on the aggregate amount the pharmacy benefit manager retained on all claims charged to the health insurer for prescriptions filled during the preceding calendar year in excess of the amount the pharmacy benefit manager reimbursed pharmacies. This disclosure form has been developed to provide a standardized and consistent means by which PBMs may implement this statutory requirement with respect the disclosures required to the State. This form does not contemplate nor make recommendations on how PBMs may seek to fulfill their obligation to report this information to the health insurers they conduct business with.

For the purposes of this form, the disclosure information provided should be pertinent to:

* Health insurers that are licensed in Vermont
* PBM services provided to Vermont members only
* Claims charged for the date range of January 1 to December 31 for the calendar year preceding the July 1 due date for the report

PBMs should complete the form as needed below, and then convert the form to a portable document format. Please route the completed forms, or any questions regarding them, to [GMCB.DATA@vermont.gov](mailto:GMCB.DATA@vermont.gov) and [DFR.CompLic@vermont.gov](mailto:dfr.complic@vermont.gov).

**PHARMACY BENEFIT MANAGER COMPANY INFORMATION**

**COMPANY**

Name:

Doing-Business-As Name:

Federal Employer Identification Number:

Street Address:

State Address (or Province):

ZIP or Postal Code:

Country:

**PARENT COMPANY**

Name:

**PERSON COMPLETING THIS FORM**

Name:

Title:

Street Address (if different from Company above):

State Address (or Province):

ZIP or Postal Code:

Country:

Phone Number:

Email Address:

**COMPANY COMPLIANCE CONTACT**

Name:

Title:

Street Address (if different from Company above):

State Address (or Province):

ZIP or Postal Code:

Country:

Phone Number:

Email Address:

**REPORTING PERIOD**

Claims charged reporting year:

**VERMONT HEALTH INSURER/HEALTH PLAN: Contract Client #1**

Insurer/Health Plan Name:

Aggregate amount retained by PBM in excess of the amount pharmacies were reimbursed:

**VERMONT HEALTH INSURER/HEALTH PLAN: Contract Client #2**

Insurer/Health Plan Name:

Aggregate amount retained by PBM in excess of the amount pharmacies were reimbursed:

**VERMONT HEALTH INSURER/HEALTH PLAN: Contract Client #3**

Insurer/Health Plan Name:

Aggregate amount retained by PBM in excess of the amount pharmacies were reimbursed:

*Add additional contract client numbers as necessary.*

**OTHER STATE REQUIREMENT CONCERNING PHARMACY BENEFITS MANAGERS**

Pharmacy Benefit Managers providing services to a total of 200 or more Vermont residents are required to register with the Green Mountain Care Board on an annual basis by December 31. The GMCB vendor for this capability hosts an on-line registration process via the following link.

<https://vt-registration.onpointhealthdata.org/>