COLORADO
Department of Regulatory Agencies
Division of Insurance

PBM Complaint Form

Colorado Division of Insurance: PBM Compliance Unit
dora_pbm_compliance@state.co.us

Before Submitting a Complaint

Before you file a Pharmacy Benefit Management Company (PBM) complaint with the Colorado Department of Insurance (DOI), you should first contact the PBM to resolve the issue. Document phone calls to the company, keep copies of all written communications, and complete all levels of contractual appeals available. If you are still unable to resolve your complaint, you may contact the DOI for assistance. Refer to Section III of the complaint form for a list of laws and regulations applying to PBMs for which the DOI can provide assistance.

Instructions for Filing a PBM Complaint

To file a complaint against a PBM for violation of law or rule, (1) fill out this PBM Complaint Form in its entirety and (2) submit it to the DOI via email at dora_pbm_compliance@state.co.us along with any supporting documentation you wish to include.

- If you have multiple Covered Individuals who are served by the same PBM, you may use this additional spreadsheet to submit batch information to the DOI.

*Note: You must download a pdf of this PBM Complaint Form to access the fillable sections.

Supporting Documentation

Be sure to include as much relevant information as possible to support the Division's investigation of your complaint. Depending on the nature of your complaint, the appropriate supporting documents may vary. Please send copies, not originals of:

- Details of any previous contact with the PBM regarding the matter.
- Copies of documents that help verify or explain the problem.
- Copies of invoices, MAC appeals, and replies from PBM with your complaint.

Section I: Complainant Information

Name of Complainant: _____

I am filing this complaint as:

☐ Covered Individual ☐ Pharmacy ☐ Other

_____ _____
Address City, State, Zip

_____ _____ _____
Email Daytime phone number Alternate phone number

Are you represented by legal counsel in this matter? ☐ Yes ☐ No

- If yes, name of attorney: _____

Have you previously reported this problem to our office or any other agency? ☐ Yes ☐ No

- If yes, to whom? _____
- File number (if applicable): _____

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Section II: General Information

Covered Individual Information

If you have multiple Covered Individuals served by the same PBM with the same type of issues, you may skip this question and use the spreadsheet at the end of this form.

Patient ID #:_____ Date of Birth:_____

Rx#:_____ Drug Name:_____

Quantity Dispensed:_____ Claim #:_____

Pharmacy Information

Pharmacy Name: _____ NABP/NCPDP #: _____

Pharmacist/Authorized Contact: _____

_____ _____
Address City, State, Zip

_____ _____ _____
Email Daytime phone number Alternate phone number

PBM Information

Name of Pharmacy Benefits Manager (PBM): _____

PBM Plan Code:_____ PBM Bin #:_____

_____ _____
PBM Contact Name PBM Phone Number

_____ _____
Address City, State, Zip

_____ _____
Email Address Business Phone Number

Insurance Information

Does your complaint involve a Self-Funded Health Benefit Plan?

☐ Yes ☐ No ☐ Unsure

Name of Health Insurance Company: _____

Plan Type:

☐ Individual Plan ☐ Group Plan

Name of group/employer (if applicable): _____

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Group Contract #: _____ Policy #: _____

Rx Bin: _____ PCN #: _____

NDC #: _____ Other: _____

Section III: Complaint Details

The Division of Insurance assists individuals and pharmacies with concerns related to violations of law or rule. The following are types of violations of which the DOI can assist. Please select all of the applicable reasons for your complaint below.

- ☐ Pharmacy Network Requirements C.R.S.§ 10-16-122
- ☐ PBM Registration Requirement C.R.S.§ 10-16-122.1
- ☐ Reimbursement to Non-Affiliated Pharmacies C.R.S.§ 10-16-122.3
- ☐ Formulary Modifications C.R.S.§ 10-16-122.4
- ☐ Audit Requirements C.R.S.§ 10-16-122.5
- ☐ Maximum Allowable Cost Pricing C.R.S.§ 10-16-122.6
- ☐ Disclosure of Alternative Drugs C.R.S.§ 10-16-122.7
- ☐ Access to Benefit Information C.R.S.§ 10-16-122.9
- ☐ Prior Authorization Processes C.R.S.§ 10-16-124.5
- ☐ Step Therapy Processes C.R.S.§ 10-16-145
- ☐ Rebate Pass-Through C.R.S.§ 10-16-156
- ☐ Spread Pricing Prohibition C.R.S.§ 10-16-163
- ☐ Calculations of Cost-Sharing and OOP Requirements (Co-Pay Accumulators) C.R.S.§ 10-16-161
- ☐ 340B Anti-Discrimination Prohibition C.R.S.§ 10-16-1501--1506
- ☐ Other: Please describe below if your complaint does not fall into the above categories

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Details of PBM Problem

Please describe your PBM problem in detail and list events in the order they happened.

Appeals Information

Please provide as many details as possible regarding any appeal processes you have engaged with the PBM.

Have you filed an appeal with the PBM? ☐ Yes ☐ No

- Date of Appeal: _____
- Date PBM responded to appeal (if received): _____

Outcome of Appeal. *Please provide the details of your appeal, along with the PBM's response. Supporting documentation can be included in the following section.*

Desired Resolution

What do you consider to be a fair resolution for your complaint?

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Section V: Authorization

This complaint form, all documents you send us, and any document received by our office as a result of handling your complaint may be a public record, subject to Colorado's Public Records Act. This law requires all public records to be available for inspection by anyone, upon request.

To the best of my knowledge the above statement is correct. I authorize the Colorado Division of Insurance to review and release any information to any company, agency, or licensee involved in this matter. I authorize the health carrier to release all records (including protected health information) relating to this complaint to DOI in order to resolve this complaint. I represent that I have the proper authority to execute this release.

_____	_____	_____
Signature	Tile/Position	Date