COMPILATION OF
STATE PHARMACY BENEFIT MANAGER
BUSINESS PRACTICE LAWS

March 2022

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WI	Wis. Stat. § 632.861(4)	DOI	**(4)** DRUG SUBSTITUTION.**(a)** Except as provided in par. (b), a disability insurance policy that offers a prescription drug benefit, a self-insured health plan that offers a prescription drug benefit, or a pharmacy benefit manager acting on behalf of a disability insurance policy or self-insured health plan shall provide to an enrollee advanced written notice of a formulary change that removes a prescription drug from the formulary of the policy or plan or that reassigns a prescription drug to a benefit tier for the policy or plan that has a higher deductible, copayment, or coinsurance. The advanced written notice of a formulary change under this paragraph shall be provided no fewer than 30 days before the expected date of the removal or reassignment and shall include information on the procedure for the enrollee to request an exception to the formulary change. The policy, plan, or pharmacy benefit manager is required to provide the advanced written notice under this paragraph only to those enrollees in the policy or plan who are using the drug at the time the notification must be sent according to available claims history. **(b)1.** A disability insurance policy, self-insured health plan, or pharmacy benefit manager is not required to provide advanced written notice under par. (a) if the prescription drug that is to be removed or reassigned is any of the following: **a.** No longer approved by the federal food and drug administration. **b.** The subject of a notice, guidance, warning, announcement, or other statement from the federal food and drug administration relating to concerns about the safety of the prescription drug. **c.** Approved by the federal food and drug administration for use without a prescription.**2.** A disability insurance policy, self-insured health plan, or pharmacy benefit manager is not required to provide advanced written notice under par. (a) if, for the prescription drug that is being removed from the formulary or reassigned to a benefit tier that has a higher deductible, copayment, or coinsurance, the policy, plan, or pharmacy benefit manager adds to the formulary a generic prescription drug that is approved by the federal food and drug administration for use as an alternative to the prescription drug or a prescription drug in the same pharmacologic class or with the same mechanism of action at any of the following benefit tiers: **a.** The same benefit tier from which the prescription drug is being removed or reassigned. **b.** A benefit tier that has a lower deductible, copayment, or coinsurance than the benefit tier from which the prescription drug is being removed or reassigned. **(c)** A pharmacist or pharmacy shall notify an enrollee in a disability insurance policy or self-insured health plan if a prescription drug for which an enrollee is filling or

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			refilling a prescription is removed from the formulary and the policy or plan or a pharmacy benefit manager acting on behalf of a policy or plan adds to the formulary a generic prescription drug that is approved by the federal food and drug administration for use as an alternative to the prescription drug or a prescription drug in the same pharmacologic class or with the same mechanism of action at any of the following benefit tiers:**1.** The same benefit tier from which the prescription drug is being removed or reassigned.**2.** A benefit tier that has a lower deductible, copayment, or coinsurance than the benefit tier from which the prescription drug is being removed or reassigned. **(d)** If an enrollee has had an adverse reaction to the generic prescription drug or the prescription drug in the same pharmacologic class or with the same mechanism of action that is being substituted for an originally prescribed drug, the pharmacist or pharmacy may extend the prescription order for the originally prescribed drug to fill one 30-day supply of the originally prescribed drug for the cost-sharing amount that applies to the prescription drug at the time of the substitution.

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CO	Colo. Rev. Stat. § 10-16-122.3(1)	DOI	**(1)(a)** A pharmacy benefit management firm shall not reimburse a pharmacy in an amount less than the amount that the pharmacy benefit management firm reimburses any affiliate for the same pharmacy services. **(b)** This subsection (1) does not prohibit a pharmacy benefit management firm from reimbursing an affiliate for satisfying the terms of a performance-based contract.
DE	Del. Code tit. 18, Chapter 33A § 3325A	DOI	(a) For purposes of this section: (1) "Affiliate" means a pharmacy or pharmacist that directly or indirectly, through 1 or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with, a pharmacy benefits manager. (2) "Pharmaceutical wholesaler" means a person that sells and distributes a pharmaceutical product and offers regular and private delivery to a pharmacy. (3) "Pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice. (4) "Pharmacy goods or services" means 1 or more of the following provided by a pharmacist or pharmacy: a. A single-sourced drug, multi-sourced drug, or compounded drug. b. A medical product. c. A medical device. d. A service. (b) A pharmacy benefits manager may not reimburse a pharmacist or pharmacy for pharmacy goods or services in an amount less than the amount the pharmacy benefits manager reimburses itself or an affiliate for the same pharmacy goods or services. (c) If the amount reimbursed by a pharmacy benefits manager for pharmacy goods or services is less than the pharmacy acquisition cost for the same pharmacy goods or services, a pharmacist or pharmacy may decline to provide the pharmacy goods or services to a patient. (d) A pharmacist or pharmacy acting under subsection (c) of this section shall do all of the following: (1) Inform the patient that the pharmacist or pharmacy has made the decision not to

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			provide pharmacy goods or services to the patient under subsection (c) of this section because of the costs associated with providing the pharmacy goods or services. (2) Provide the patient with a list of pharmacies in the area that may provide the pharmacy goods or services.
MD	MD. ANN. CODE § 15-1612	DOI	**(a)** This section applies only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier. **(b)** This section does not apply to reimbursement:**(1)** for specialty drugs;**(2)** for mail order drugs; or**(3)** to a chain pharmacy with more than 15 stores or a pharmacist who is an employee of the chain pharmacy. **(c)** A pharmacy benefits manager may not reimburse a pharmacy or pharmacist for a pharmaceutical product or pharmacist service in an amount less than the amount that the pharmacy benefits manager reimburses itself or an affiliate for providing the same product or service.
NM	N.M. Stat. § 59A-61-4(B)	DOI	**B.** A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service.
SC	SC Code § 38-71-2230(A)(3) (2020)	DOI	(A) A pharmacy benefits manager or representative of a pharmacy benefits manager shall not: (3) engage, with the express intent or purpose of driving out competition or financially injuring competitors, in a pattern or practice of reimbursing independent pharmacies or pharmacists in this State consistently less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services;

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AR	A.C.A. § 23-92-506(a)	DOI	**(1)** The Insurance Commissioner may review and approve the compensation program of a pharmacy benefits manager with a health benefit plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefit plan under the standards issued by rule of the State Insurance Department.**(2)** All information and data acquired during the review under subdivision (a)(1) of this section is:**(A)** Considered proprietary and confidential under § 23-61-107(a)(4) and § 23-61-207; and**(B)** Not subject to the Freedom of Information Act of 1967, § 25-19-101 et seq.
NJ	NJ Rev Stat § 17B:27F-8 (2020)	DOI	The Commissioner of Banking and Insurance may review and approve the compensation program of a pharmacy benefits manager with a health benefits plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefits plan.
NM	N.M. Stat. Ann. § 59A-61-4A and B	DOI	**A.** A pharmacy benefits manager shall determine a reimbursement amount for a generic drug based on objective and verifiable sources. **B.** A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service.

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ME	24-A Maine Rev. Stat. Ann. Chap 56-C §4349-2	DOI	**2. Fiduciary duty.** A carrier that contracts with a pharmacy benefits manager to perform any activities related to the carrier's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the carrier's agent and owes a fiduciary duty to the carrier in the pharmacy benefits manager's management of activities related to the carrier's prescription drug benefits.

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SC	SC Code § 38-71-2230(E) (2020)	DOI	(E) A pharmacy benefits manager may maintain more than one network for different pharmacy services. Each individual network may require different pharmacy accreditation standards or certification requirements for participating in the network provided that the pharmacy accreditation standards or certification requirements are applied without regard to a pharmacy's or pharmacist's status as an independent pharmacy or pharmacy benefits manager affiliate. Each individual pharmacy location as identified by its National Council for Prescription Drug Program identification number may have access to more than one network so long as the pharmacy location meets the pharmacy accreditation standards or certification requirements of each network.
WI	Wis. Stat. § 632.865(4)	DOI	A pharmacy benefit manager or a representative of a pharmacy benefit manager shall provide to a pharmacy, within 30 days of receipt of a written request from the pharmacy, a written notice of any certification or accreditation requirements used by the pharmacy benefit manager or its representative as a determinant of network participation. A pharmacy benefit manager or a representative of a pharmacy benefit manager may change its accreditation requirements no more frequently than once every 12 months.

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ME	24-A Maine Rev. Stat. Ann. Chap 56-C §4350-D	DOI	**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings. A. "Anticipated loss ratio" means the ratio of the present value of the future benefits payments to the present value of the future premiums of a policy form over the entire period for which rates are computed to provide health insurance coverage. B. "Pharmacy benefits manager compensation" means the difference between: (1) The value of payments made by a carrier of a health plan to its pharmacy benefits manager; and (2) The value of payments made by the pharmacy benefits manager to dispensing pharmacists for the provision of prescription drugs or pharmacy services with regard to pharmacy benefits covered by the health plan. **2. Pharmacy benefits manager compensation included as administrative cost.** If a carrier uses a pharmacy benefits manager to administer or manage prescription drug benefits provided for the benefit of covered persons, for purposes of calculating a carrier's anticipated loss ratio, any pharmacy benefits manager compensation: A. Constitutes an administrative cost incurred by the carrier in connection with a health plan; and B. May not constitute a benefit provided under a health plan. A carrier may claim only the amounts paid by the pharmacy benefits manager to a pharmacy or pharmacist as an incurred claim. **3. Calculation of pharmacy benefits manager compensation.** Each rate filing submitted by a carrier with respect to a health plan that provides coverage for prescription drugs or pharmacy services that is administered or managed by a pharmacy benefits manager must include: A. A memorandum prepared by a qualified actuary describing the calculation of the pharmacy benefits manager compensation; and B. Such records and supporting information as the superintendent reasonably determines is necessary to confirm the calculation of the pharmacy benefits manager compensation. **4. Records.** Upon request, a carrier shall provide any records to the superintendent that relate to the calculation of the pharmacy benefits manager compensation.

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			5. Documentation from pharmacy benefits manager. A pharmacy benefits manager shall provide any necessary documentation requested by a carrier that relates to pharmacy benefits manager compensation in order to comply with the requirements of this section.

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NH	New Hampshire Rev Stat § 402-N:5	DOI	I. Consumers may file a complaint related to a registered pharmacy benefit manager pursuant to RSA 400-A:15-e. II. The commissioner shall adopt rules to implement paragraph I. Such rules shall include procedures for addressing complaints, provisions for enforcement, the receipt of complaints referred to the insurance department under RSA 318:47-h, III(b), and for reporting to the board of pharmacy on the status of complaints referred.
OK	36 OK Stat. §36-6966	DOI	A. The Insurance Commissioner shall provide for the receiving and processing of individual complaints alleging violations of the provisions of the Patient's Right to Pharmacy Choice Act. B. The Commissioner shall establish a Patient's Right to Pharmacy Choice Advisory Committee to review complaints, hold hearings, subpoena witnesses and records, initiate prosecution, reprimand, place on probation, suspend, revoke and/or levy fines not to exceed Ten Thousand Dollars ($10,000.00) for each count for which any pharmacy benefits manager (PBM) has violated a provision of this act. The Advisory Committee may impose as part of any disciplinary action the payment of costs expended by the Insurance Department for any legal fees and costs including, but not limited to, staff time, salary and travel expense, witness fees and attorney fees. The Advisory Committee may take such actions singly or in combination, as the nature of the violation requires. C. The Advisory Committee shall consist of seven (7) persons appointed as follows: 1. Two persons who shall be nominated by the Oklahoma Pharmacists Association; 2. Two consumer members not employed or related to insurance, pharmacy or PBM nominated by the Office of the Governor; 3. Two persons representing the PBM or insurance industry nominated by the Insurance Commissioner; and 4. One person representing the Office of the Attorney General nominated by the Attorney General. D. Committee members shall be appointed for terms of five (5) years. The terms of the members of the Advisory Committee shall expire on the thirtieth day of June of the year designated for the expiration of the term for which appointed, but the member shall serve until a qualified successor has been duly appointed. No person shall be appointed to serve more than two consecutive terms. E. Hearings shall be held in the Insurance Commissioner's offices or at such other place as the Insurance Commissioner may deem convenient. F. The Insurance Commissioner shall issue and serve upon the PBM a statement of

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			the charges and a notice of hearing in accordance with the Administrative Procedures Act, Sections 250 through 323 of Title 75 of the Oklahoma Statutes. G. At the time and place fixed for a hearing, the PBM shall have an opportunity to be heard and to show cause why the Insurance Commissioner or his or her duly appointed hearing examiner should not revoke or suspend the PBM's license and levy administrative fines for each violation. Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person. H. All hearings will be public and held in accordance with, and governed by, Sections 250 through 323 of Title 75 of the Oklahoma Statutes. I. The Insurance Commissioner, upon written request reasonably made by the licensed PBM affected by the hearing and at such PBM's expense shall cause a full stenographic record of the proceedings to be made by a competent court reporter. J. If the Insurance Commissioner determines, based on an investigation of complaints, that a PBM has engaged in violations of this act with such frequency as to indicate a general business practice and that such PBM should be subjected to closer supervision with respect to such practices, the Insurance Commissioner may require the PBM to file a report at such periodic intervals as the Insurance Commissioner deems necessary.
SC	S.C. Code Regs. § 69-77 Section V. C.	DOI	C. Pharmacy Provider Complaints Related to Maximum Allowable Cost List Compliance under Section 38-71-2240 of the Code of Laws of South Carolina 1976, as amended. (1) The pharmacy benefits manager shall designate the name, address, and phone number, including an electronic mail contact, of the organization which shall be responsible for responding to the Department for complaints the Department has received from pharmacy providers for alleged Maximum Allowable Cost List violations. The pharmacy benefits manager shall be subject to Section 38-13-70 of the Code of Laws of South Carolina 1976, as amended related to the time period for a response to the Department. (2) A pharmacy provider or other person acting on its behalf shall make reasonable efforts to exhaust any internal appeal requirements of the pharmacy benefits manager prior to the filing of a complaint with the Department. However, a pharmacy provider shall not be required to exhaust internal appeal requirements of the pharmacy benefits manager if a pharmacy benefits manager has failed to abide by its Maximum Allowable Cost List appeal processes as described in Section 38-71-

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			2240. A pharmacy benefits manager shall not be held responsible for failure to provide communication or timely processing in the event that a provider or pharmacy has not submitted sufficient information for the pharmacy benefits manager to process the appeal. (3) The Department shall review the complaints, and upon determination of a violation of the Act or this regulation, institute regulatory action in accordance with the requirements set forth in Section VIII of this regulation. (4) The Department may refer any complaints to the Office of the South Carolina Attorney General for investigation or other enforcement action in accordance with Section 38-3-110 of the Code of Laws of South Carolina 1976, as amended.

PBM EXAMINATION AUTHORITY – MARCH 2022

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AL	AL Code § 27-45A-5 (2021)	DOI	(a) The commissioner may adopt rules necessary to implement this chapter. (b) The powers and duties set forth in this chapter shall be in addition to all other authority of the commissioner. (c) The commissioner shall enforce compliance with the requirements of this chapter and rules adopted thereunder. (d)(1) The commissioner may examine or audit any books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a health benefit plan as may be deemed relevant and necessary by the commissioner to determine compliance with this chapter. (2) Examinations conducted by the commissioner shall be pursuant to the same examination authority of the commissioner relative to insurers as provided in Chapter 2, including, but not limited to, the confidentiality of documents and information submitted as provided in Section 27-2-24; examination expenses shall be processed in accordance with Section 27-2-25; and pharmacy benefits managers shall have the same rights as insurers to request a hearing in accordance with Sections 27-2-28 et seq., and to appeal as provided in Section 27-2-32. (e) The commissioner's examination expenses shall be collected from pharmacy benefits managers in the same manner as those collected from insurers.
NH	New Hampshire Rev Stat § 402-N:7	DOI	The commissioner may examine and directly bill a pharmacy benefits manager required to be registered under this chapter for the costs of any examination pursuant to RSA 400-A:37 as necessary to determine and enforce compliance with this chapter. In addition, if the commissioner finds through an investigation or examination that a carrier has not received information required under RSA 420-J:7-b, XI from a pharmacy benefit manager, the commissioner may require that the pharmacy benefit manager provide the required information, and the commissioner may investigate or examine and directly bill the pharmacy benefit manager for the cost of any portion of the examination or investigation pertaining to obtaining the required information.
NM	N.M. Stat. § 59A-61-5I and N.M. Code R. § 13.10.30.18	DOI	Pursuant to the provisions of Section 59A-4-3 NMSA 1978, the superintendent, or the superintendent's designee, may examine the books, documents, policies, procedures and records of a pharmacy benefits manager to determine compliance with applicable law. The pharmacy benefits manager shall pay the costs of the examination. At the request of a person who provides information in response to a complaint, investigation or examination, the superintendent may deem the

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			information confidential.
OK	36 OK Stat § 36-6965	DOI	A. The Insurance Commissioner shall have power to examine and investigate into the affairs of every pharmacy benefits manager (PBM) engaged in pharmacy benefits management in this state in order to determine whether such entity is in compliance with the Patient's Right to Pharmacy Choice Act. B. All PBM files and records shall be subject to examination by the Insurance Commissioner or by duly appointed designees. The Insurance Commissioner, authorized employees and examiners shall have access to any of a PBM's files and records that may relate to a particular complaint under investigation or to an inquiry or examination by the Insurance Department. C. Every officer, director, employee or agent of the PBM, upon receipt of any inquiry from the Commissioner shall, within thirty (30) days from the date the inquiry is sent, furnish the Commissioner with an adequate response to the inquiry. D. When making an examination under this section, the Insurance Commissioner may retain subject matter experts, attorneys, appraisers, independent actuaries, independent certified public accountants or an accounting firm or individual holding a permit to practice public accounting, certified financial examiners or other professionals and specialists as examiners, the cost of which shall be borne by the PBM which is the subject of the examination.
SC	**S**.C. Code Regs. § 69-77 Section IV	DOI	A. Examination of Pharmacy Benefits Managers.(1) Pursuant to Section 38-71-2250 of the Code of Laws of South Carolina 1976, as amended, the Director or his designee may examine the affairs of a pharmacy benefits manager for compliance with the requirements of the Act, applicable South Carolina law or requirements of this regulation.(2) Any examination permitted under this Section shall follow the examination procedures and requirements applicable to health care insurers under Chapter 13, Title 38 of the Code of Laws of South Carolina 1976, as amended. B. A pharmacy benefits manager shall not be regularly examined under the same time periods as insurers as required under Section 38-13-10 of the Code of Laws of South Carolina 1976, as amended, however, the Director or his designee may examine the pharmacy benefits manager pursuant to Section 38-71-2250 at any time he or she believes it reasonably necessary to ensure compliance with the Act, the provisions of this regulation, or Title 38.

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VA	Section 38.2-3468A of the Code of Virginia (applies to a health carrier or a PBM contracting with the health carrier)	DOI	Each carrier, on its own or through its contract for pharmacy benefits, shall ensure that the Commissioner may examine or audit the books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a carrier that are relevant to determining if the pharmacy benefits manager is in compliance with this article. The carrier shall be responsible for the charges incurred in the examination, including the expenses of the Commissioner or his designee and the expenses and compensation of his examiners and assistants.

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AR	A.C.A. § 23-92-505(a)	DOI	(a) A pharmacy benefits manager shall provide: (1)(A) A reasonably adequate and accessible pharmacy benefits manager network for the provision of prescription drugs for a health benefit plan that shall provide for convenient patient access to pharmacies within a reasonable distance from a patient's residence. (B) A mail-order pharmacy shall not be included in the calculations determining pharmacy benefits manager network adequacy; and (2) A pharmacy benefits manager network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility in this state in the time and manner required by rule issued by the State Insurance Department.
DE	Del. Code tit. 18, Chapter 33A §§ 3361A – 3363A	DOI	§ 3361A. For purposes of this subchapter: (1) "Claim" means as defined under § 3321A of this title. (2) "Insured" means an individual covered by health insurance offered by an insurer. (3) "Insurer" means as defined under § 3321A of this title. (4) "Pharmacist" means as defined under § 2502 of Title 24. (5) "Pharmacy" means as defined under § 2502 of Title 24. (6) "Pharmacy benefits manager" means as defined under § 3302A of this title. (7) "Pharmacy benefits manager network" means a network of pharmacists or pharmacies that are offered by an agreement or contract to provide pharmacy goods or services. (8) "Pharmacy goods or services" means as defined under § 3325A of this title. (9) a. "Rebate" means a discount or other price concession, or a payment that is both of the following:1. Based on utilization of a prescription drug.2. Paid by a manufacturer or third party, directly or indirectly, to the pharmacy benefits manager, pharmacy services administrative organization, or pharmacy after a claim has been processed and paid at a pharmacy. b. "Rebate" includes incentives, disbursements, and reasonable estimates of a volume-based or category-based discount. § 3362A. (a) A pharmacy benefits manager shall provide a reasonably adequate and accessible pharmacy benefits manager network for the provision of prescription drugs, which provides for convenient patient access to pharmacies within a reasonable distance from a patient's residence.

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			(b) A pharmacy benefits manager may not deny a pharmacy the opportunity to participate in a pharmacy benefits manager network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the pharmacy benefits manager has established for other pharmacies as a condition of preferred network participation status. (c) A mail-order pharmacy may not be included in the calculations for determining pharmacy benefits manager network adequacy under this section. § 3363A. (a) A pharmacy benefits manager shall provide a pharmacy benefits manager network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility in this State. The Commissioner shall adopt regulations setting the time and manner for providing the report. (b) A pharmacy benefits manager shall report to the Commissioner on a quarterly basis all of the following information for each insurer: (1) The itemized amount of pharmacy benefits manager revenue sources, including professional fees, administrative fees, processing fees, audits, direct and indirect renumeration fees, or any other fees. (2) The aggregate amount of rebates distributed to the appropriate insurer. (3) The aggregate amount of rebates passed on to insureds of each insurer at the point of sale that reduced the insureds' applicable deductible, copayment, coinsurance, or other cost-sharing amount. (4) The individual and aggregate amount the insurer paid to the pharmacy benefits manager for pharmacy goods or services itemized by all of the following: a. Pharmacy. b. Product. c. Goods and services. (5) The individual and aggregate amount a pharmacy benefits manager paid for pharmacy goods or services itemized by all of the following: a. Pharmacy. b. Product. c. Goods and services.
NM	N.M. Stat. § 59A-61-5H	DOI	In a time and manner required by rules promulgated by the superintendent, a pharmacy benefits manager shall issue to the superintendent a network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility to insureds statewide.
OK	36 OK Stat. §36-6961 and 36 OK Stat. §36-6962A	DOI	§36-6961. A. Pharmacy benefits managers (PBMs) shall comply with the following retail pharmacy network access standards: 1. At least ninety percent (90%) of covered individuals residing in an urban service area live within two (2) miles of a retail pharmacy participating in the PBM's retail pharmacy

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			network; 2. At least ninety percent (90%) of covered individuals residing in an urban service area live within five (5) miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network; 3. At least ninety percent (90%) of covered individuals residing in a suburban service area live within five (5) miles of a retail pharmacy participating in the PBM's retail pharmacy network; 4. At least ninety percent (90%) of covered individuals residing in a suburban service area live within seven (7) miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network; 5. At least seventy percent (70%) of covered individuals residing in a rural service area live within fifteen (15) miles of a retail pharmacy participating in the PBM's retail pharmacy network; and 6. At least seventy percent (70%) of covered individuals residing in a rural service area live within eighteen (18) miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network. B. Mail-order pharmacies shall not be used to meet access standards for retail pharmacy networks. C. Pharmacy benefits managers shall not require patients to use pharmacies that are directly or indirectly owned by the pharmacy benefits manager, including all regular prescriptions, refills or specialty drugs regardless of day supply. D. Pharmacy benefits managers shall not in any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital or other providers unless it specifically lists all pharmacies, hospitals and providers participating in the preferred and nonpreferred pharmacy and health networks. §36-6962A. The Oklahoma Insurance Department shall review and approve retail pharmacy network access for all pharmacy benefits managers (PBMs) to ensure compliance with Section 4 of this act.

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AR	A.C.A. § 23-92-506(b)	DOI	A pharmacy benefits manager or representative of a pharmacy benefits manager shall not: (1) Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading; (2) Unless reviewed and approved by the commissioner, charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for: (A) The receipt and processing of a pharmacy claim; (B) The development or management of claims processing services in a pharmacy benefits manager network; or (C) Participation in a pharmacy benefits manager network; (3) Unless reviewed and approved by the commissioner in coordination with the Arkansas State Board of Pharmacy, require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the board; (4)(A) Reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services. (B) The amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number; (5)(A) Pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services less than the national average drug acquisition cost or, if the national average drug acquisition cost is unavailable, the wholesale acquisition cost. (B)(i) The Employee Benefits Division community pharmacy reimbursement model for pharmacist services in partnership with the University of Arkansas for Medical Sciences-based prescription drug program satisfies the intent of this subdivision (b)(5). (ii) A plan using the model described in subdivision (b)(5)(B)(i) of this section is exempt from complying with subdivision (b)(5)(A) of this section if the reimbursement model is maintained as determined by the Insurance Commissioner. (iii) If a plan deviates from this reimbursement model, the plan shall be subject to subdivision (b)(5)(A) of this section; (6) Make or permit any reduction of payment for pharmacist services by a pharmacy benefits manager or a healthcare payor directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including without limitation generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment; or (7) Do any combination of the actions listed in subdivisions (b)(1)-(6) of this section.

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DE	Del. Code tit. 18, Chapter 33A § 3372A	DOI	A pharmacy benefits manager or representative of a pharmacy benefits manager may not do any of the following: (1) Engage in spread pricing. (2) Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading. (3) Unless reviewed and approved by the Commissioner, charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including a fee for any of the following: a. The receipt and processing of a pharmacy claim. b. The development or management of claims processing services in a pharmacy benefits manager network. c. Participation in a pharmacy benefits manager network. (4) Unless reviewed and approved by the Commissioner in coordination with the Board of Pharmacy, require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the Board of Pharmacy. (5) Violate § 3325A(b) of this title. (6) Violate § 3362A of this title. (7) Pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services less than the national average drug acquisition cost, or if the national average drug acquisition cost is unavailable, the wholesale acquisition cost. (8) Make or permit any reduction of payment for pharmacy goods or services by a pharmacy benefits manager or an insurer directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment. (9) After adjudication of a claim for pharmacy goods or services, directly or indirectly retroactively deny or reduce the claim unless 1 or more of the following applies: a. The original claim was intentionally submitted fraudulently. b. The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacy goods or services. c. The pharmacy goods or services were not properly rendered by the pharmacy or pharmacist.
GA	GA Code § 33-64-11	DOI	(a) A pharmacy benefits manager shall be proscribed from: (1) Prohibiting a pharmacist, pharmacy, or other dispenser or dispenser practice from providing an insured individual information on the amount of the insured's cost share for such insured's prescription drug and the clinical efficacy of a more affordable alternative

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			drug if one is available. No pharmacist, pharmacy, or other dispenser or dispenser practice shall be penalized by a pharmacy benefits manager for disclosing such information to an insured or for selling to an insured a more affordable alternative if one is available; (2) Prohibiting a pharmacist, pharmacy, or other dispenser or dispenser practice from offering and providing delivery services to an insured as an ancillary service of the pharmacy or dispenser practice; (3) Charging or collecting from an insured a copayment that exceeds the total submitted charges by the network pharmacy or other dispenser practice for which the pharmacy or dispenser practice is paid; (4) Charging or holding a pharmacist or pharmacy or dispenser or dispenser practice responsible for a fee or penalty relating to the adjudication of a claim or an audit conducted pursuant to Code Section 26-4-118 , provided that this shall not restrict recoupments made in accordance with Code Section 26-4-118 ; (5) Recouping funds from a pharmacy in connection with claims for which the pharmacy has already been paid without first complying with the requirements set forth in Code Section 26-4-118 , unless such recoupment is otherwise permitted or required by law; (6) Penalizing or retaliating against a pharmacist or pharmacy for exercising rights under this chapter or Code Section 26-4-118 ; (7) Steering. This paragraph shall not be construed to prohibit a pharmacy benefits manager from entering into an agreement with an affiliated pharmacy or an affiliated pharmacy of another pharmacy benefits manager licensed pursuant to this chapter to provide pharmacy care to patients; (8) Transferring or sharing records relative to prescription information containing patient-identifiable and prescriber-identifiable data to an affiliated pharmacy for any commercial purpose; provided, however, that nothing shall be construed to prohibit the exchange of prescription information between a pharmacy benefits manager and an affiliated pharmacy for the limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review; (9) Knowingly making a misrepresentation to an insured, pharmacist, pharmacy, dispenser, or dispenser practice; (10) Taking any action in violation of subparagraphs (a)(21)(D) and (a)(21)(E) of Code Section 26-4-28 or charging a pharmacy a fee in connection with network enrollment; (11) Withholding coverage or requiring prior authorization for a lower cost therapeutically equivalent drug available to an insured or failing to reduce an insured's cost share when an insured selects a lower cost therapeutically equivalent drug; and (12) Removing a drug from a formulary or denying coverage of a drug for the purpose of incentivizing an insured to seek coverage from a different health plan.

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MD	MD. ANN. CODE § 15-1642	DOI	(a) It is a violation of this subtitle for a pharmacy benefits manager to:(1) misrepresent pertinent facts or policy provisions that relate to a claim or the compensation program at issue in a complaint or an appeal of a decision regarding a complaint;(2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;(3) fail to settle a claim or dispute promptly whenever liability is reasonably clear under one part of a policy or contract, in order to influence settlements under other parts of the policy or contract; or(4) fail to act in good faith.(b) It is a violation of this subtitle for a pharmacy benefits manager, when committed at a frequency to indicate a general business practice, to:(1) misrepresent pertinent facts or policy provisions that relate to a claim, the compensation program, or the coverage at issue in a complaint or an appeal of a decision regarding a complaint;(2) fail to make a prompt, fair, and equitable good-faith attempt to settle claims for which liability has become reasonably clear;(3) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy or contract, in order to influence settlements under other parts of the policy or contract; or(4) refuse to pay a claim for an arbitrary or capricious reason based on all available information.
ME	24-A Maine Rev. Stat. Ann. Chap 56-C §4348-A	DOI	A pharmacy benefits manager or representative of a pharmacy benefits manager may not cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading.
NM	N.M. Stat. §§ 59A-61-5E and 59A-61-7	DOI	A pharmacy benefits manager shall not:(1) cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;(2) require pharmacy validation and revalidation standards inconsistent with, more stringent than or in addition to federal and state requirements for licensure and operation as a pharmacy in this state;(3) prohibit a pharmacy or pharmacist from:(a) mailing or delivering drugs to a patient as an ancillary service;(b) providing a patient information regarding the patient's total cost for pharmacist services for a prescription drug; or(c) discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available;(4) require or prefer a generic drug over its generic therapeutic equivalent;(5) prohibit, restrict or limit disclosure of information by a pharmacist or pharmacy to the superintendent; or(6) prohibit, restrict or limit pharmacies or pharmacists from providing to state or federal government officials general information for public policy purposes.
OK	36 OK Stat § 36-6962B	DOI	A PBM, or an agent of a PBM, shall not: 1. Cause or knowingly permit the use of advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;

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			2. Charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for: a. The submission of a claim, b. Enrollment or participation in a retail pharmacy network, or c. The development or management of claims processing services or claims payment services related to participation in a retail pharmacy network; 3. Reimburse a pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM for providing the same covered services. The reimbursement amount paid to the pharmacy shall be equal to the reimbursement amount calculated on a per-unit basis using the same generic product identifier or generic code number paid to the PBM-owned or PBM-affiliated pharmacy; 4. Deny a pharmacy the opportunity to participate in any pharmacy network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the PBM has established for other pharmacies as a condition of preferred network participation status; 5. Deny, limit or terminate a pharmacy's contract based on employment status of any employee who has an active license to dispense, despite probation status, with the State Board of Pharmacy; 6. Retroactively deny or reduce reimbursement for a covered service claim after returning a paid claim response as part of the adjudication of the claim, unless: a. The original claim was submitted fraudulently, or b. To correct errors identified in an audit, so long as the audit was conducted in compliance with Sections 356.2 and 356.3 of Title 59 of the Oklahoma Statutes; or 7. Fail to make any payment due to a pharmacy or pharmacist for covered services properly rendered in the event a PBM terminates a pharmacy or pharmacist from a pharmacy benefits manager network.

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OR	Oregon Rev. Stat. § 735.536	DOI	(1) As used in this section, "out-of-pocket cost" means the amount paid by an enrollee under the enrollee's coverage, including deductibles, copayments, coinsurance or other expenses as prescribed by the Department of Consumer and Business Services by rule. (2) A pharmacy benefit manager registered under ORS 735.532: (a) May not require a prescription to be filled or refilled by a mail order pharmacy as a condition for reimbursing the cost of the drug. (b) Except as provided in paragraph (c) of this subsection, may require a prescription for a specialty drug to be filled or refilled at a specialty pharmacy as a condition for the reimbursement of the cost a drug. (c) Shall reimburse the cost of a specialty drug that is filled or refilled at a network pharmacy that is a long term care pharmacy. (d)(A) Shall allow a network pharmacy to mail, ship or deliver prescription drugs to its patients as an ancillary service. (B) Is not required to reimburse a delivery fee charged by a pharmacy for a delivery described in subparagraph (A) of this paragraph unless the fee is specified in the contract between the pharmacy benefit manager and the pharmacy. (e) May not require a patient signature as proof of delivery of a mailed or shipped prescription drug if the network pharmacy: (A)(i) Maintains a mailing or shipping log signed by a representative of the pharmacy; or (ii) Maintains each notification of delivery provided by the United States Postal Service or a package delivery service; and (B) Is responsible for the cost of mailing, shipping or delivering a replacement for a drug that was mailed or shipped but not received by the enrollee. (f) May not penalize a network pharmacy for or otherwise directly or indirectly prevent a network pharmacy from informing an enrollee of the difference between the out-of-pocket cost to the enrollee to purchase a prescription drug using the enrollee's pharmacy benefit and the pharmacy's usual and customary charge for the prescription drug. (3) The Department of Consumer and Business Services may adopt rules to carry out the provisions of this section. [2019 c.526 §2]
SC	SC Code § 38-71-2230(A) (2020)	DOI	(A) A pharmacy benefits manager or representative of a pharmacy benefits manager shall not: (1) cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading; (2) charge a pharmacist or pharmacy a fee related to the adjudication of a claim other than a reasonable fee for the receipt and processing of a pharmacy claim; (3) engage, with the express intent or purpose of driving out competition or financially injuring competitors, in a pattern or practice of reimbursing independent pharmacies or pharmacists in this State consistently less than the amount that the pharmacy benefits

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			manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services; (4) collect or require a pharmacy or pharmacist to collect from an insured a copayment for a prescription drug at the point of sale in an amount that exceeds the lesser of: (a) the contracted copayment amount; (b) the amount an individual would pay for a prescription drug if that individual was paying cash; or (c) the contracted amount for the drug. (5) require the use of mail order for filling prescriptions unless required to do so by the health benefit plan or the health benefit plan design; (6) charge a fee related to the adjudication of a claim without providing the cause for each adjustment or fee; (7) penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this chapter; (8) prohibit a pharmacist or pharmacy from offering and providing direct and limited delivery services including incidental mailing services, to an insured as an ancillary service of the pharmacy; or (9) any combination thereof.
UT	Utah Code Ann. § 31A-46-302(4), (5) and (6)	DOI	(4) (a) A pharmacy benefit manager may not prohibit or penalize the disclosure by a pharmacist of: (i) an insured customer's cost share for a covered prescription drug or prescription device; (ii) the availability of any therapeutically equivalent alternative medications; or (iii) alternative methods of paying for the prescription medication or prescription device, including paying the cash price, that are less expensive than the cost share of the prescription drug. (b) Penalties that are prohibited under Subsection (4)(a) include increased utilization review, reduced payments, and other financial disincentives. (5) A pharmacy benefit manager may not require an insured customer to pay, for a covered prescription drug or prescription device, more than the lesser of: (a) the applicable cost share of the prescription drug or prescription device being dispensed; (b) the applicable allowable claim amount of the prescription drug or prescription device being dispensed; (c) the applicable pharmacy reimbursement of the prescription drug or prescription device being dispensed; or (d) the retail price of the prescription drug or prescription device without prescription drug coverage. (6) For a contract entered into or renewed on or after May 12, 2020, a pharmacy benefit manager may not engage in direct or indirect remuneration that results in a reduction in total compensation received by a pharmacy from the pharmacy benefit manager for the sale of a drug, device, or other product or service unless the pharmacy benefit manager provides the pharmacy with at least 30 days notice of the direct or indirect remuneration.

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VA	Section 38.2-3467 of the Code of Virginia (applies to a health carrier or a PBM contracting with the health carrier)	DOI	A. No carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager shall: 1. Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue; 2. Charge a pharmacist or pharmacy a fee related to the adjudication of a claim other than a reasonable fee for an initial claim submission; 3. Reimburse a pharmacy or pharmacist an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services, calculated on a per-unit basis using the same generic product identifier or generic code number and reflecting all drug manufacturer's rebates, direct and indirect administrative fees, and costs and any remuneration; or 4. Penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this article. B. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall restrict participation of a pharmacy in a pharmacy network for provider accreditation standards or certification requirements if a pharmacist meets such accreditation standards or certification standards. C. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall include any mail order pharmacy or pharmacy benefits manager affiliate in calculating or determining network adequacy under any law or contract in the Commonwealth.

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AK	AK Stat § 21.27.945 (2020) and § 21.27.950 (Appeals)	DOI	§ 21.27.945.(a) A pharmacy benefits manager shall: (1) make available to each network pharmacy at the beginning of the term of the network pharmacy's contract, and upon renewal of the contract, the methodology and sources used to determine the drug pricing list; (2) provide a telephone number at which a network pharmacy may contact an employee of a pharmacy benefits manager to discuss the pharmacy's appeal; (3) provide a process for a network pharmacy to have ready access to the list specific to that pharmacy; (4) review and update applicable list information at least once every seven business days to reflect modification of list pricing; (5) update list prices within one business day after a significant price update or modification provided by the pharmacy benefits manager's national drug database provider; and (6) ensure that dispensing fees are not included in the calculation of the list pricing. (b) When establishing a list, the pharmacy benefits manager shall use (1) the most up-to-date pricing data to calculate reimbursement to a network pharmacy for drugs subject to list prices; (2) multi-source generic drugs that are sold or marketed in the state during the list period. § 21.27.950.(a) A pharmacy benefits manager shall establish a process by which a network pharmacy, or a network pharmacy's contracting agent, may appeal the reimbursement for a multi-source generic drug. A pharmacy benefits manager shall resolve an appeal from a network pharmacy within 10 calendar days after the network pharmacy or the contracting agent submits the appeal. (b) A network pharmacy, or a network pharmacy's contracting agent, may appeal a reimbursement from a pharmacy benefits manager for a multi-source generic drug if the reimbursement for the drug is less than the amount that the network pharmacy can purchase from two or more of its contracted suppliers. (c) A pharmacy benefits manager may grant a network pharmacy's appeal if an equivalent multi-source generic drug is not available at a price at or below the pharmacy benefits

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			manager's list price for purchase from national or regional wholesalers who operate in the state. If an appeal is granted, the pharmacy benefits manager shall adjust the reimbursement of the network pharmacy to equal the network pharmacy acquisition cost for each paid claim included in the appeal. (d) If the pharmacy benefits manager denies a network pharmacy's appeal, the pharmacy benefits manager shall provide the network pharmacy with the (1) reason for the denial; (2) national drug code of an equivalent multi-source generic drug that has been purchased by another network pharmacy located in the state at a price that is equal to or less than the pharmacy benefits manager's list price within seven days after the network pharmacy appeals the claim; and (3) name of a pharmaceutical wholesaler who operates in the state in which the drug may be acquired by the challenging network pharmacy. (e) A network pharmacy may request a hearing under AS 21.06.170 - 21.06.240 for an adverse decision from a pharmacy benefits manager within 30 calendar days after receiving the decision. The parties may present all relevant information to the director for the director's review. (f) The director shall enter an order that (1) grants the network pharmacy's appeal and directs the pharmacy benefits manager to make an adjustment to the disputed claim; (2) denies the network pharmacy's appeal; or (3) directs other actions considered fair and equitable.
AR	A.C.A. § 17-92-507	DOI	(a) As used in this section: (1) (A) "Maximum Allowable Cost List" means a listing of drugs or other methodology used by a pharmacy benefits manager, directly or indirectly, setting the maximum allowable payment to a pharmacy or pharmacist for a generic drug, brand-name drug, biologic product, or other prescription drug. (B) "Maximum Allowable Cost List" includes without limitation: (i) Average acquisition cost, including national average drug acquisition cost; (ii) Average manufacturer price;

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			(iii) Average wholesale price; (iv) Brand effective rate or generic effective rate; (v) Discount indexing; (vi) Federal upper limits; (vii) Wholesale acquisition cost; and (viii) Any other term that a pharmacy benefits manager or a healthcare insurer may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services; (2) "Pharmaceutical wholesaler" means a person or entity that sells and distributes prescription pharmaceutical products, including without limitation a full line of brand-name, generic, and over-the-counter pharmaceuticals, and that offers regular and private delivery to a pharmacy; (3) "Pharmacist" means a licensed pharmacist as defined in § 17-92-101; (4) "Pharmacist services" means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy as defined in § 17-92-101; (5) "Pharmacy" means the same as in § 17-92-101; (6) "Pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice; (7) "Pharmacy benefits manager" means an entity that administers or manages a pharmacy benefits plan or program; (8) "Pharmacy benefits manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager; and (9) "Pharmacy benefits plan or program" means a plan or program that pays for,

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			reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in this state. (b) Before a pharmacy benefits manager places or continues a particular drug on a Maximum Allowable Cost List, the drug: (1) If the drug is a generically equivalent drug as defined in § 17-92-101, shall be listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or "Green Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference; (2) Shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in Arkansas; and (3) Shall not be obsolete. (c) A pharmacy benefits manager shall: (1) Provide access to its Maximum Allowable Cost List to each pharmacy subject to the Maximum Allowable Cost List; (2) Update its Maximum Allowable Cost List on a timely basis, but in no event longer than seven (7) calendar days from an increase of ten percent (10%) or more in the pharmacy acquisition cost from sixty percent (60%) or more of the pharmaceutical wholesalers doing business in the state or a change in the methodology on which the Maximum Allowable Cost List is based or in the value of a variable involved in the methodology; (3) Provide a process for each pharmacy subject to the Maximum Allowable Cost List to receive prompt notification of an update to the Maximum Allowable Cost List; and (4) (A) (i) Provide a reasonable administrative appeal procedure to allow pharmacies to challenge Maximum Allowable Cost List and reimbursements made under a Maximum Allowable Cost List for a specific drug or drugs as: (a) Not meeting the requirements of this section; or (b) Being below the pharmacy acquisition cost.

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			(ii) The reasonable administrative appeal procedure shall include the following: (a) A dedicated telephone number, email address, and website for the purpose of submitting administrative appeals; (b) The ability to submit an administrative appeal directly to the pharmacy benefits manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization; and (c) No less than thirty (30) business days to file an administrative appeal. (B) The pharmacy benefits manager shall respond to the challenge under subdivision (c)(4)(A) of this section within thirty (30) business days after receipt of the challenge. (C) If a challenge is made under subdivision (c)(4)(A) of this section, the pharmacy benefits manager shall within thirty (30) business days after receipt of the challenge either: (i) If the appeal is upheld: (a) Make the change in the maximum allowable cost list payment to at least the pharmacy acquisition cost; (b) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; (c) Provide the National Drug Code that the increase or change is based on to the pharmacy or pharmacist; and (d) Make the change under subdivision (c)(4)(C)(i)(a) of this section effective for each similarly situated pharmacy as defined by the payor subject to the Maximum Allowable Cost List; (ii) If the appeal is denied, provide the challenging pharmacy or pharmacist the National Drug Code and the name of the national or regional pharmaceutical wholesalers operating in Arkansas that have the drug currently in stock at a price below the maximum allowable cost as listed on the Maximum Allowable Cost List; or

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			(iii) If the National Drug Code provided by the pharmacy benefits manager is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefits manager shall adjust the maximum allowable cost as listed on the Maximum Allowable Cost List above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged maximum allowable cost. (d) (1) A pharmacy benefits manager shall not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services. (2) The amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number. (e) A pharmacy or pharmacist may decline to provide the pharmacist services to a patient or pharmacy benefits manager if, as a result of a Maximum Allowable Cost List, a pharmacy or pharmacist is to be paid less than the pharmacy acquisition cost of the pharmacy providing pharmacist services. (f) (1) This section does not apply to a Maximum Allowable Cost List maintained by the Arkansas Medicaid Program or the Employee Benefits Division. (2) This section shall apply to the pharmacy benefits manager employed by the Arkansas Medicaid Program or the division if, at any time, the Arkansas Medicaid Program or the division engages the services of a pharmacy benefits manager to maintain a Maximum Allowable Cost List. (g) (1) A violation of this section is a deceptive and unconscionable trade practice under the Deceptive Trade Practices Act, § 4-88-101 et seq., and a prohibited practice under the Arkansas Pharmacy Benefits Manager Licensure Act, § 23-92-501 et seq., and the Trade Practices Act, § 23-66-201 et seq. (2) This section is not subject to § 4-88-113(f)(1)(B).

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CO	CO Rev Stat § 25-37-103.5	DOI	(1) (a) In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit manager, within ten days after any request, a current list of the sources used to determine maximum allowable cost pricing. The pharmacy benefit manager shall update the pricing information at least every seven days and provide a means by which contracted pharmacies may promptly review pricing updates in a format that is readily available and accessible. (b) A pharmacy benefit manager shall maintain a procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner in order to remain consistent with pricing changes in the marketplace. (2) In order to place a prescription drug on a maximum allowable cost list, a pharmacy benefit manager shall ensure that: (a) The drug is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the orange book, or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and (b) The drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete. (3) Each contract between a pharmacy benefit manager and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes: (a) A twenty-one-day limit on the right to appeal following the initial claim; (b) A requirement that the appeal be investigated and resolved within twenty-one days after the appeal; (c) A telephone number at which the pharmacy may contact the pharmacy benefit manager to speak to a person responsible for processing appeals; (d) A requirement that a pharmacy benefit manager provide a reason for any appeal denial and the identification of the national drug code of a drug that may be purchased by the pharmacy at a price at or below the benchmark price as determined by the pharmacy benefit manager; and

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			(e) A requirement that a pharmacy benefit manager make an adjustment to a date no later than one day after the date of determination. This requirement does not prohibit a pharmacy benefit manager from retroactively adjusting a claim for the appealing pharmacy or for another similarly situated pharmacy.
DE	Del. Code tit. 18, Chapter 33A §§ 3321A – 3324A	DOI	§ 3321A. As used in this subchapter: **(1)** "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or device.**(2)** "Contracted pharmacy" means a pharmacy that participates in the network of a pharmacy benefits manager through a contract with a pharmacy benefits manager, a pharmacy services administration organization, or a group purchasing organization.**(3)** "Drug shortage list" means a list of drug products listed on the federal Food and Drug Administration's Drug Shortages website.**(4)** "Insurer" means any entity that provides health insurance coverage in this State as defined in § 903 of this title. **(5)** "Maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacist or pharmacy for the cost of a multi-sourced drug, medical product, or device.**(6)** "Maximum allowable cost list" means the multi-source generic drugs, medical products, and devices for which a maximum allowable cost has been established by a pharmacy benefits manager or a purchaser.**(7)** "Network providers" means those pharmacists and pharmacies who provide covered health-care services or supplies to an insured or a member pursuant to a contract with an insurer or pharmacy benefits manager.**(8)** "Pharmacist" means as defined under § 2502 of Title 24.**(9)** "Pharmacy" means as defined under § 2502 of Title 24.**(10)** "Pharmacy benefits management services" means as defined under § 3351A of this title.**(11)** "Pharmacy benefits manager" means as defined under § 3302A of this title.**(12)** "Purchaser" means as defined under § 3351A of this title. § 3322A. This subchapter does not apply to the Department of Health and Human Services in the performance of its duties in administering fee-for-service Medicaid under Titles XIX and XXI of the Social Security Act. § 3323A. **(a)** To place a drug on a maximum allowable cost list, a pharmacy benefits manager must ensure that the drug meets all of the following requirements:**(1)** It is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference.**(2)** It is generally available for purchase by pharmacies in

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			this State from national or regional wholesalers.**(3)** It is not obsolete, temporarily unavailable, or listed on a drug shortage list as in shortage.**(4)** If it is manufactured by more than 1 manufacturer, the drug is 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 whom the pharmacy has an existing relationship.**(5)** If it is manufactured by only 1 manufacturer, the drug is generally available for purchase by a contracted pharmacy, including a contracted retail pharmacy, in this State from at least 2 wholesale distributors with a permit in this State. **(b)** A pharmacy benefits manager engaging in maximum allowable cost pricing must do all of the following:**(1)** Make available to each network provider at the beginning of the term of the network provider's contract, and upon renewal of the contract, the sources utilized to determine the maximum allowable cost pricing.**(2)** Provide a process for a network pharmacy provider to readily access the most recent maximum allowable cost specific to that provider in an electronic format as updated in accordance with the requirements of this section.**(3)** Review and update maximum allowable cost price information at least once every 7 business days and update the information when there is a modification of maximum allowable cost pricing.**(4)** Ensure that dispensing fees are not included in the calculation of maximum allowable cost.**(5)** On the next day after a pricing information update under paragraph (b)(3) of this section, use the updated pricing information in calculating the payments made to all contracted pharmacies.**(6)** Maintain a procedure to eliminate products from the maximum allowable cost list as necessary to do all of the following: **a.** Remain consistent with price changes. **b.** Remove from the maximum allowable cost list a drug that no longer meets the requirements of subsection (a) of this section. **c.** Reflect the most recent availability of drugs in the marketplace. § 3324A. **(a)** A pharmacy benefits manager must establish a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing. A contracted pharmacy has 10 calendar days after the applicable fill date to appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug. A pharmacy benefits manager must respond with notice that the appeal has been denied or granted within 10 calendar days of the contracted pharmacy making the claim for which an appeal has been submitted. **(b)** At the beginning of the term of a network provider's contract, and upon renewal, a pharmacy benefits manager must provide to network providers a telephone number and e-mail address at which a network provider can contact the pharmacy benefits manager to process an appeal under this section.**(c)** If an appeal is denied, the pharmacy benefits

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			manager must provide the reason for the denial and the name and national drug code number of the national or regional wholesalers operating in this State that have the drug in stock at a price below the maximum allowable cost.**(d)** If the appeal is granted the pharmacy benefits manger shall do the following:**(1)** For an appealing pharmacy, do all of the following: **a.** Adjust the maximum allowable cost for the drug as of the date of the original claim for payment. **b.** Without requiring the appealing pharmacy to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with the pharmacy benefits manager as follows:**1.** For the original claim, in the first remittance to the pharmacy after the date the appeal was granted.**2.** For subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was granted. **(2)** For a similarly situated contracted pharmacy in this State, do all of the following: **a.** Adjust the maximum allowable cost for the drug as of the date the appeal was granted. **b.** Provide notice to the pharmacy or the pharmacy's contracted agent of all of the following:**1.** That an appeal was granted.**2.** That without filing a separate appeal, the pharmacy or the pharmacy's contracted agent may reverse and rebill a similar claim. **(e)** A pharmacy benefits manager shall make available on its website information about the appeal process, including all of the following:**(1)** A telephone number at which the contracted pharmacy may contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual specifically or leave a message for an individual or office who is responsible for processing appeals.**(2)** An email address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access. **(f)** A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the re-adjudication of a claim resulting from a granted appeal under subsection (d) of this section or the granting of an appeal under subsection (h) of this section. **(g)** A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal to the pharmacy benefits manager under subsection (a) of this section or to the Commissioner under subsection (h) of this section. **(h)(1)** If a pharmacy benefits manager denies an appeal and a contracted pharmacy files an appeal with the Commissioner, the Commissioner shall do all of the following: **a.** Review the pharmacy benefits manager's compensation program to ensure that the reimbursement for pharmacy benefits management services paid to the pharmacist or a

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			pharmacy complies with this subchapter and the terms of the contract. **b.** Based on a determination made by the Commissioner under paragraph (h)(1)a. of this section, do 1 of the following.**1.** Deny the appeal.**2.** Grant the appeal and order the pharmacy benefits manager to pay the claim in accordance with the Commissioner's findings. **(2)** All pricing information and data collected by the Commissioner during a review required by paragraph (h)(1) of this section is confidential and not subject to subpoena or the Freedom of Information Act, Chapter 100 of Title 29.
KS	K.S.A. §§ 40-3829 - 40-3830	DOI	§ 40-3829. As used in this act: (a) "List" means the list of drugs for which maximum allowable costs have been established;(b) "maximum allowable cost" or "MAC" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug;(c) "network pharmacy" means a pharmacy that contracts with a pharmacy benefits manager; and(d) "pharmacy benefits manager" or "PBM" shall have the same meaning as K.S.A. 2020 Supp. 40-3822(e), and amendments thereto. § 40-3830. A pharmacy benefits manager: (a) Shall not place a drug on a MAC list unless there are at least two therapeutically equivalent multi-source generic drugs, or at least one generic drug available from at least one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers and the drug is not obsolete. (b) Shall provide to each network pharmacy at the beginning of the term of a contract and upon request thereafter, the sources utilized to determine the maximum allowable cost price. (c) Shall provide a process for each network pharmacy provider to readily access the maximum allowable price specific to that provider. (d) Shall review and update each applicable maximum allowable cost list every seven business days and apply the updates to reimbursements no later than one business day. (e) Shall ensure that dispensing fees are not included in the calculation of maximum allowable cost. (f) Shall establish a process by which a network pharmacy may appeal reimbursement for a drug subject to maximum allowable cost as follows: (1) The network pharmacy must file an appeal no later than 10 business days after the fill date. (2) The PBM shall provide a response to the appealing network pharmacy no later than 10 business days after receiving an appeal request containing information sufficient for the PBM to process the appeal as specified by the contract. (3) If the appeal is upheld, the PBM:

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			(A) Shall make the adjustment in the drug price effective no later than one business day after the appeal is resolved; (B) shall make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the plan sponsor or pharmacy benefits manager, as appropriate; and (C) permit the appealing pharmacy to reverse and rebill the appealed claim. (4) If the appeal is denied, the PBM shall provide the appealing pharmacy the national drug code number from a national or regional wholesaler operating in Kansas where the drug is generally available for purchase at a price equal to or less than the maximum allowable cost, and when applicable, may be substituted lawfully.
MD	MD. ANN. CODE § 15-1628.1 and §15-1628.2	DOI	§ 15-1628.1. (a) (1) In this section the following words have the meanings indicated. (2) "Drug shortage list" means a list of drug products listed on the federal Food and Drug Administration's Drug Shortages website. (3) (i) "Maximum allowable cost" means the maximum amount that a pharmacy benefits manager or a purchaser will reimburse a contracted pharmacy for the cost of a multisource generic drug, a medical product, or a device. (ii) "Maximum allowable cost" does not include dispensing fees. (4) "Maximum allowable cost list" means a list of multisource generic drugs, medical products, and devices for which a maximum allowable cost has been established by a pharmacy benefits manager or a purchaser. (b) In each participating pharmacy contract, the pharmacy benefits manager shall include the sources used to determine maximum allowable cost pricing. (c) A pharmacy benefits manager shall: (1) update its pricing information at least every 7 days; (2) establish a reasonable process by which a contracted pharmacy has access to the current and applicable maximum allowable cost price lists in an electronic format as updated in accordance with the requirements of this section; and (3) immediately after a pricing information update under item (1) of this subsection, use the updated pricing information in calculating the payments made to all contracted pharmacies. (d) (1) A pharmacy benefits manager shall maintain a procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing as necessary to: (i) remain consistent with pricing changes; (ii) remove from the list drugs that no longer meet the requirements of subsection (e) of

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			this section; and (iii) reflect the current availability of drugs in the marketplace. (2) A product on the maximum allowable cost list shall be eliminated from the list by the pharmacy benefits manager within 7 days after the pharmacy benefits manager knows of a change in the availability of the product. (e) Before placing a prescription drug on a maximum allowable cost list, a pharmacy benefits manager shall ensure that: (1) the drug is listed as "A" or "B" rated in the most recent version of the U.S. Food and Drug Administration's approved drug products with therapeutic equivalence evaluations, also known as the Orange Book, or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; (2) (i) if a drug is manufactured by more than one manufacturer, the drug is generally available for purchase by contracted pharmacies, including contracted retail pharmacies, in the State from a wholesale distributor with a permit in the State; or (ii) if a drug is manufactured by only one manufacturer, the drug is generally available for purchase by contracted pharmacies, including contracted retail pharmacies, in the State from at least two wholesale distributors with a permit in the State; and (3) the drug is not obsolete, temporarily unavailable, or listed on a drug shortage list as currently in shortage. (f) For disputes regarding maximum allowable cost pricing, each participating pharmacy contract must include a process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes: (1) a requirement that an appeal be filed by the contract pharmacy no later than 21 days after the date of the initial adjudicated claim; (2) a requirement that, within 21 days after the date the appeal is filed, the pharmacy benefits manager investigate and resolve the appeal and report to the contracted pharmacy on the pharmacy benefits manager's determination on the appeal; (3) a requirement that a pharmacy benefits manager make available on its website information about the appeal process, including: (i) a telephone number at which the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual or leave a message for an individual who is responsible for processing appeals; (ii) an e–mail address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and (iii) a notice indicating that the individual responsible for processing appeals shall return a call or an e–mail made by a contracted pharmacy to the individual within 3 business

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			days or less of receiving the call or e–mail; (4) a requirement that a pharmacy benefits manager provide: (i) a reason for any appeal denial; (ii) the national drug code of a drug and the name of the wholesale distributor from which the drug was available on the date the claim was adjudicated at a price at or below the maximum allowable cost determined by the pharmacy benefits manager; and (iii) the mathematical calculation used to determine the maximum allowable cost; and (5) if an appeal is upheld, a requirement that a pharmacy benefits manager: (i) for the appealing pharmacy: 1. adjust the maximum allowable cost for the drug as of the date of the original claim for payment; and 2. without requiring the appealing pharmacy to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with the pharmacy benefits manager: A. for the original claim, in the first remittance to the pharmacy after the date the appeal was determined; and B. for subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was determined; and (ii) for a similarly situated contracted pharmacy in the State: 1. adjust the maximum allowable cost for the drug as of the date the appeal was determined; and 2. provide notice to the pharmacy or pharmacy's contracted agent that: A. an appeal has been upheld; and B. without filing a separate appeal, the pharmacy or the pharmacy's contracted agent may reverse and rebill a similar claim. (g) A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal under this section or filing a complaint with the Commissioner under this subsection. (h) A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the readjudication of a claim or claims resulting from carrying out the requirement of a contract specified in subsection (f)(5) of this section or the upholding of an appeal under subsection (i) of this section. (i) (1) If a pharmacy benefits manager denies an appeal and a contracted pharmacy or a designee of the contracted pharmacy files a complaint with the Commissioner, the Commissioner shall: (i) review the compensation program of the pharmacy benefits manager to ensure that

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			the reimbursement for pharmacy benefits management services paid to the pharmacist or a pharmacy complies with this subtitle and the terms of the participating pharmacy contract; and (ii) based on a determination made by the Commissioner under item (i) of this paragraph, dismiss the appeal or uphold the appeal and order the pharmacy benefits manager to pay the claim or claims in accordance with the Commissioner's findings. (2) On request, the pharmacy benefits manager shall provide to the Commissioner all mathematical calculations, accounts, records, documents, files, logs, correspondence, or other information necessary to complete the Commissioner's review under paragraph (1) of this subsection. (3) All information and data collected by the Commissioner during a review: (i) is considered to be confidential and proprietary information; and (ii) is not subject to disclosure under the Public Information Act. § 15-1628.2. (a) For disputes regarding cost pricing and reimbursement under a participating pharmacy contract, each participating pharmacy contract must include a process to appeal, investigate, and resolve disputes regarding cost pricing and reimbursement that includes: (1) a requirement that an appeal be filed by the contract pharmacy not later than 21 days after: (i) the date a direct or indirect remuneration fee is charged; or (ii) another date as determined by the Commissioner; (2) a requirement that a pharmacy benefits manager make available on its website information about the appeal process, including: (i) a telephone number at which the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual or leave a message for an individual who is responsible for processing appeals; (ii) an e–mail address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and (iii) a notice indicating that the individual responsible for processing appeals shall return a call or an e–mail made by a contracted pharmacy to the individual within 3 business days or less after receiving the call or e–mail; (3) a requirement that a pharmacy benefits manager provide: (i) a reason for any appeal denial; and (ii) the mathematical calculation used to determine the amount of reimbursement; and (4) if an appeal is upheld, a requirement that a pharmacy benefits manager: (i) make adjustments as necessary to comply with the compensation program as stated in the participating pharmacy contract as of the date the appeal was determined; and (ii) provide notice to the pharmacy or pharmacy's contracted agent that an appeal has been upheld.

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			(b) A pharmacy benefits manager may not retaliate against a contracted pharmacy for exercising its right to appeal under this section or filing a complaint with the Commissioner under this section. (c) A pharmacy benefits manager may not charge a contracted pharmacy a fee related to the readjudication of a claim or claims resulting from the upholding of an appeal under subsection (d) of this section. (d) (1) If a pharmacy benefits manager denies an appeal and a contracted pharmacy or a designee of the contracted pharmacy files a complaint with the Commissioner, the Commissioner shall: (i) review the compensation program of the pharmacy benefits manager to ensure that the reimbursement for pharmacy benefits management services paid to the pharmacist or a pharmacy complies with this subtitle and the terms of the participating pharmacy contract; and (ii) based on a determination made by the Commissioner under item (i) of this paragraph, dismiss the appeal or uphold the appeal and order the pharmacy benefits manager to pay the claim or claims in accordance with the Commissioner's findings. (2) On request, the pharmacy benefits manager shall provide to the Commissioner all mathematical calculations, accounts, records, documents, files, logs, correspondence, or other information necessary to complete the Commissioner's review. (3) All information and data collected by the Commissioner during a review: (i) is considered to be confidential and proprietary information; and (ii) is not subject to disclosure under the Public Information Act.
ME	24-A Maine Rev. Stat. Ann. Chap 56-C §4350 (applies through a carrier contract with a PBM)	DOI	**1. Single maximum allowable cost list.** A carrier, or a pharmacy benefits manager under contract with a carrier, shall use a single maximum allowable cost list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same maximum allowable cost list for each pharmacy provider. **2. Listing of prescription drug.** A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if that prescription drug: A. Is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference;

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			and B. Is not obsolete and is generally available for purchase in this State from a national or regional wholesale distributor by pharmacies having a contract with the pharmacy benefits manager. **3. Changes to maximum allowable cost list.** A carrier, or a pharmacy benefits manager under contract with a carrier, shall establish a process for removing a prescription drug from a maximum allowable cost list or modifying a maximum allowable cost for a prescription drug in a timely manner to remain consistent with changes to such costs and the availability of the drug in the national marketplace. **4. Disclosure.** With regard to a pharmacy with which the carrier, or the pharmacy benefits manager under contract with a carrier, has entered into a contract, a carrier, or a pharmacy benefits manager under contract with a carrier, shall: A. Upon request, disclose the sources used to establish the maximum allowable costs; B. Provide a process for a pharmacy to readily obtain the maximum allowable payment available to that pharmacy under a maximum allowable cost list; and C. At least once every 7 business days, review and update maximum allowable cost list information to reflect any modification of the maximum allowable payment available to a pharmacy under a maximum allowable cost list used by the carrier or the pharmacy benefits manager under contract with a carrier. **5. Appeal procedure.** A carrier, or a pharmacy benefits manager under contract with a carrier, shall provide a reasonable administrative appeal procedure, including a right to appeal that is limited to 14 days following the initial claim, to allow pharmacies with which the carrier or pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified drug. **6. Resolution of appeals.** A carrier, or a pharmacy benefits manager under contract with a carrier, shall respond to, investigate and resolve an appeal under subsection 5 within 14 days after the receipt of the appeal. The carrier or pharmacy benefits manager shall respond to an appeal as follows: A. If the appeal is upheld, the carrier or pharmacy benefits manager shall make the appropriate adjustment in the maximum allowable cost and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; or [PL 2019, c. 469, B. If the appeal is denied, the carrier or pharmacy benefits manager shall provide the challenging pharmacy or pharmacist the national drug code from national or regional wholesalers of a comparable prescription drug that may be purchased at or below the maximum allowable cost. **7. Average wholesale price; use of a prescription drug not on maximum allowable cost list.** A carrier, or a pharmacy benefits manager under contract with a

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			carrier, shall use the average wholesale price to establish the maximum payment for a brand-name drug for which a generic equivalent is not available or a prescription drug not included on a maximum allowable cost list. In order to use the average wholesale price of a brand-name drug or prescription drug not included on a maximum allowable cost list, a carrier, or a pharmacy benefits manager under contract with a carrier, must use only one national drug pricing source during a calendar year, except that a carrier, or a pharmacy benefits manager under contract with a carrier, may use a different national drug pricing source if the original pricing source is no longer available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same national drug pricing source for each pharmacy provider and identify on its publicly accessible website the name of the national drug pricing source used to determine the average wholesale price of a prescription drug not included on the maximum allowable cost list. **8. Payment.** This subsection governs payments between a carrier or a carrier's pharmacy benefits manager and a pharmacy provider. A. The amount paid by a carrier or a carrier's pharmacy benefits manager to a pharmacy provider under contract with the carrier or the carrier's pharmacy benefits manager for dispensing a prescription drug must be the ingredient cost plus the dispensing fee less any cost-sharing amount paid by a covered person. B. The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and must be disclosed by the carrier's pharmacy benefits manager to the carrier. C. Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this subsection. D. A pharmacy provider may not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error.
NJ	N.J.S.A. §17B:27F-2	DOI	2. Upon execution or renewal of each contract, or at such a time when there is any material change in the term of the contract, a pharmacy benefits manager shall, with respect to contracts between a pharmacy benefits manager and a pharmacy services administrative organization, or between a pharmacy benefits manager and a contracted pharmacy: a. (1) include in the contract the sources utilized to determine multiple source generic drug pricing, brand drug pricing, and the wholesaler in the State of New Jersey where pharmacies may acquire the product including, if applicable, the brand effective rate, generic effective rate, dispensing fee effective rate, maximum allowable cost or any other pricing formula for pharmacy reimbursement;

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			(2) update that pricing information every seven calendar days; and (3) establish a reasonable process by which contracted pharmacies have a method to access relevant maximum allowable cost pricing lists, brand effective rate, generic effective rate, and dispensing fee effective rate, or any other pricing formulas for pharmacy reimbursement; and b. Maintain a procedure to eliminate drugs from the list of drugs subject to multiple source generic drug pricing and brand drug pricing, or modify maximum allowable cost rates, brand effective rate, generic effective rate, dispensing fee effective rate or any other applicable pricing formula in a timely fashion and make that procedure easily accessible to the pharmacy services administrative organizations or the pharmacies that they are contractually obligated with to provide that information according to the requirements of this section.
NM	N.M. Stat. § 59A-61-4	DOI	Pharmacy reimbursement practices for generic drugs; appeals process required. A. A pharmacy benefits manager shall determine a reimbursement amount for a generic drug based on objective and verifiable sources. B. A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service. C. A pharmacy benefits manager using maximum allowable cost pricing may place a drug on a maximum allowable cost list if the drug:(1) is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book", or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference;(2) is available for purchase by pharmacies in the state at the time of claim submission from national or regional wholesalers and is not obsolete; and(3) is a drug with not fewer than two "A" or "B" rated therapeutically equivalent drugs in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book". D. A pharmacy benefits manager using maximum allowable cost pricing shall:(1) upon a network pharmacy's request, provide that network pharmacy with the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;(2) review and update maximum allowable cost price information

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			at least once every seven business days to reflect any modification of maximum allowable cost pricing;(3) establish and maintain a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in at least seven business days to remain consistent with pricing changes and product availability in the marketplace;(4) provide a procedure that allows a pharmacy to choose the entity to which it will appeal reimbursement for generic drugs. A pharmacy may appeal:(a) directly to the pharmacy benefits manager; or(b) through a pharmacy services administrative organization;(5) provide an appeals process that, at a minimum, includes the following:(a) a dedicated telephone number and electronic mail address or website for the purpose of submitting appeals;(b) the ability to submit an appeal directly to the pharmacy benefits manager; and(c) the allowance of at least twenty-one business days to file an appeal after the date a pharmacy receives notice of the reimbursement amount;(6) grant an appeal if the pharmacy benefits manager fails to respond to a complete submission as defined by rules promulgated by the superintendent of the appealing party in writing within fourteen business days after the pharmacy benefits manager receives the appeal;(7) if an appeal is granted, notify the challenging pharmacy and its pharmacy services administrative organization, if any, that the appeal is granted and make the change in the maximum allowable cost effective for the appealing pharmacy and for each other pharmacy in its network and permit the appealing pharmacy to reverse and bill again the claim or claims that formed the basis of the appeal;(8) when an appeal is denied, provide the challenging pharmacy and its pharmacy services administrative organization, if any, the national drug code number and supplier that has the product available for purchase in New Mexico at or below the maximum allowable cost;(9) within one business day of granting or denying a network pharmacy's appeal, notify all network pharmacies of the decision;(10) upon granting an appeal, allow other similarly situated network pharmacies to reverse and bill again for like claims that formed the basis of the granted appeal; and(11) provide for each of its network pharmacy providers and the superintendent a process and mechanism to readily access the maximum allowable cost list specific to that provider. E. A maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefits manager is confidential. F. Pursuant to Section 59A-4-3 NMSA 1978, a pharmacy benefits manager shall provide information contained in a maximum allowable cost list to the superintendent upon request by the superintendent.

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OR	Oregon Rev. Stat. § 735.534 (2) and (4)	DOI	(2) A pharmacy benefit manager registered under ORS 735.532: (a) May not place a drug on a list unless there are at least two multiple source drugs, or at least one generic drug generally available for purchase. (b) Shall ensure that all drugs on a list are generally available for purchase. (c) Shall ensure that no drug on a list is obsolete. (d) Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the specific authoritative industry sources, other than proprietary sources, the pharmacy benefit manager uses to determine the maximum allowable cost set by the pharmacy benefit manager. (e) Shall make a list available to a network pharmacy upon request in a format that: (A) Is electronic; (B) Is computer accessible and searchable; (C) Identifies all drugs for which maximum allowable costs have been established; and (D) For each drug specifies: (i) The national drug code; and (ii) The maximum allowable cost. (f) Shall update each list maintained by the pharmacy benefit manager every seven business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in the format described in paragraph (e) of this subsection. (g) Shall ensure that dispensing fees are not included in the calculation of maximum allowable cost. (h) May not reimburse a 340B pharmacy differently than any other network pharmacy based on its status as a 340B pharmacy. (4) A pharmacy benefit manager must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to maximum allowable cost pricing. A network pharmacy may appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. The process must allow a network pharmacy a period of no less than 60 days after a claim is reimbursed in which to file the appeal. An appeal requested under this section must be completed within 30 calendar days of the pharmacy making the claim for which appeal has been requested. (5) A pharmacy benefit manager shall allow a network pharmacy to submit the documentation in support of its appeal on paper or electronically and may not: (a) Refuse to accept an appeal submitted by a person authorized to act on behalf of the network pharmacy; (b) Refuse to adjudicate an appeal for the reason that the appeal is submitted along with other claims that are denied; or

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			(c) Impose requirements or establish procedures that have the effect of unduly obstructing or delaying an appeal. (6) A pharmacy benefit manager must provide as part of the appeals process established under subsection (4) of this section: (a) A telephone number at which a network pharmacy may contact the pharmacy benefit manager and speak with an individual who is responsible for processing appeals; (b) A final response to an appeal of a maximum allowable cost within seven business days; and (c) If the appeal is denied, 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. (7)(a) If an appeal is upheld under this section, the pharmacy benefit manager shall: (A) Make an adjustment for the pharmacy that requested the appeal from the date of initial adjudication forward; and (B) Allow the pharmacy to reverse the claim and resubmit an adjusted claim without any additional charges. (b) If the request for an adjustment has come from a critical access pharmacy, as defined by the Oregon Health Authority by rule for purposes related to the Oregon Prescription Drug Program, the adjustment approved under paragraph (a) of this subsection shall apply only to critical access pharmacies. (8) This section does not apply to the state medical assistance program.
PA	40 Pa. Stat. § 4531	DOI	**(a) General rule.**--In order to place a particular drug on a multiple source generic list, a PBM shall, at a minimum, ensure that:(1) The drug is listed as "A" or "B" rated in the most recent version of the Food and Drug Administration's "Approved Drug Products with Therapeutic Equivalence Evaluations," commonly known as the orange book, or "NR" or "NA" rated, or similar rating, by a nationally recognized reference;(2) There are at least two therapeutically equivalent multiple source drugs or at least one generic drug available from only one manufacturer; and(3) The drug is available for purchase by all pharmacies in this commonwealth from national or regional wholesalers and is not obsolete or temporarily unavailable. **(b)Removal from listing.**--A PBM must maintain a procedure to eliminate drugs from the list of drugs subject to multiple source drug pricing or modify the maximum allowable cost in a timely fashion. **(c)Substitutions.**--A PBM may not penalize a pharmacist or pharmacy on audit if the pharmacist or pharmacy performs a generic substitution pursuant to the Act of November 24, 1976 (P.L. 1163, No.259), referred to as the Generic Equivalent Drug Law.

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SC	SC Code § 38-71-2240 (2020)	DOI	(A) Before a pharmacy benefits manager places or continues to place a particular drug on a Maximum Allowable Cost List, the drug must: (1) be listed as "A" or "B" rated in the most recent version of the Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or has an "NR" or "NA" rating, or a similar rating, by a nationally recognized reference; (2) be available for purchase in the State from national or regional wholesalers operating in this State; and (3) not be obsolete. (B) A pharmacy benefits manager shall: (1) provide a process for network pharmacy providers to readily access the maximum allowable cost specific to that provider; (2) update its Maximum Allowable Cost List at least once every seven calendar days; (3) provide a process for each pharmacy subject to the Maximum Allowable Cost List to access any updates to the Maximum Allowable Cost List; (4) ensure that dispensing fees are not included in the calculation of maximum allowable cost; and (5) establish a reasonable administrative appeal procedure by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing if the reimbursement for the drug is less than the net amount that the network provider paid to the suppliers of the drug. The reasonable administrative appeal procedure must include: (a) a dedicated telephone number and email address or website for the purpose of submitting administrative appeals; and (b) the ability to submit an administrative appeal directly to the pharmacy benefits manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization if the pharmacy service administrative organization has a contract with the pharmacy benefits manager that allows for the submission of such appeals. (C) A pharmacy must be allowed no less than ten calendar days after the applicable fill date to file an administrative appeal. (D) If an appeal is initiated, the pharmacy benefits manager shall within ten calendar days after receipt of notice of the appeal either: (1) if the appeal is upheld: (a) notify the pharmacy or pharmacist or his designee of the decision; (b) make the change in the maximum allowable cost effective as of the date the appeal is resolved; (c) permit the appealing pharmacy or pharmacist to reverse and rebill the claim in question; and

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			(d) make the change effective for each similarly situated pharmacy as defined by the payor subject to the Maximum Allowable Cost List effective as of the date the appeal is resolved; or (2) if the appeal is denied, provide the appealing pharmacy or pharmacist the reason for the denial, the National Drug Code number, and the name of the national or regional pharmaceutical wholesalers operating in this State. (E) The provisions of this section: (1) do not apply to the Maximum Allowable Cost List maintained by the State Medicaid Program, the Medicaid managed care organizations under contract with the South Carolina Department of Health and Human Services or the South Carolina Public Employee Benefit Authority; and (2) apply to the pharmacy benefits manager employed by the South Carolina Public Employee Benefit Authority if, at any time, the South Carolina Public Employee Benefit Authority engages the services of a pharmacy benefits manager to maintain the Maximum Allowable Cost List.
UT	Utah Code Ann. § 31A-46-302(1), (2) and (3) and § 31A-46-303	DOI	§ 31A-46-302. (1) If a pharmacy service entity engages in direct or indirect remuneration with a pharmacy, the pharmacy service entity shall make a reimbursement report available to the pharmacy upon the pharmacy's request. (2) For the reimbursement report described in Subsection (1), the pharmacy service entity shall: (a) include the adjusted compensation amount related to a claim and the reason for the adjusted compensation; and (b) provide the reimbursement report: (i) in accordance with the contract between the pharmacy and the pharmacy service entity; (ii) in an electronic format that is easily accessible; and (iii) within 120 days after the day on which the pharmacy benefit manager receives a report of a sale of a product or service by the pharmacy. (3) A pharmacy service entity shall, upon a pharmacy's request, provide the pharmacy with: (a) the reasons for any adjustments contained in a reimbursement report; and (b) an explanation of the reasons provided in Subsection (3)(a). § 31A-46-303. (1) An insurer and an insurer's pharmacy benefit manager is subject to the pharmacy audit provisions of Section 58-17b-622. (2) A pharmacy benefit manager shall not use maximum allowable cost as a basis for reimbursement to a pharmacy unless: (a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's approved drug products with therapeutic equivalent evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and (b) the drug is: (i) generally available for purchase in this state from a national or regional wholesaler; and (ii) not obsolete. (3) The maximum allowable cost may be determined using comparable and current data on drug

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			prices obtained from multiple nationally recognized, comprehensive data sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are available for purchase by pharmacies in the state. (4) For every drug for which the pharmacy benefit manager uses maximum allowable cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall: (a) include in the contract with the pharmacy information identifying the national drug pricing compendia and other data sources used to obtain the drug price data; (b) review and make necessary adjustments to the maximum allowable cost, using the most recent data sources identified in Subsection (4)(a), at least once per week; (c) provide a process for the contracted pharmacy to appeal the maximum allowable cost in accordance with Subsection (5); and (d) include in each contract with a contracted pharmacy a process to obtain an update to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily available and accessible. (5) (a) The right to appeal in Subsection (4)(c) shall be: (i) limited to 21 days following the initial claim adjudication; and (ii) investigated and resolved by the pharmacy benefit manager within 14 business days. (b) If an appeal is denied, the pharmacy benefit manager shall provide the contracted pharmacy with the reason for the denial and the identification of the national drug code of the drug that may be purchased by the pharmacy at a price at or below the price determined by the pharmacy benefit manager. (6) The contract with each pharmacy shall contain a dispute resolution mechanism in the event either party breaches the terms or conditions of the contract. (7) This section does not apply to a pharmacy benefit manager when the pharmacy benefit manager is providing pharmacy benefit management services on behalf of the Medicaid program.

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SC	S.C. Code §38-71-147(2) (applies to the health carrier through a contract to provide pharmacy services)	DOI	An individual or group accident and health or health insurance policy or a health maintenance organization plan may not deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services including, but not limited to, prescription drugs that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer.

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AK	AK Stat §§ 21.27.910 through 940 (2020)	DOI	§ 21.27.910. (a) When a pharmacy benefits manager conducts an audit of the records of a pharmacy, the period covered by the audit of a claim may not exceed two years from the date that the claim was submitted to or adjudicated by the pharmacy benefits manager, whichever is earlier. Except as required under AS 21.36.495, a claim submitted to or adjudicated by a pharmacy benefits manager does not accrue interest during the audit period. (b) A pharmacy benefits manager conducting an on-site audit shall give the pharmacy written notice of at least 10 business days before conducting an initial audit. (c) A pharmacy benefits manager may not conduct (1) an audit during the first seven calendar days of any month unless agreed to by the pharmacy; (2) more than one on-site audit of a pharmacy within a 12-month period; or (3) on-site audits of more than 250 separate prescriptions at one pharmacy within a 12-month period unless fraud by the pharmacy or an employee of the pharmacy is alleged. (d) If an audit involves clinical or professional judgment, the individual conducting the audit must (1) be a pharmacist who is licensed and in good standing under AS 08.80; or (2) conduct the audit in consultation with a pharmacist who is licensed and in good standing under AS 08.80. (e) A pharmacy, in responding to an audit, may use (1) verifiable statements or records, including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner, to validate the pharmacy record; (2) a legal prescription to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, prescriptions transmitted by facsimile, electronic prescriptions, or documented telephone calls from the prescriber or the prescriber's agent. (f) A pharmacy benefits manager shall audit each pharmacy under the same standards and parameters as other similarly situated pharmacies in a network pharmacy contract in this state. § 21.27.915. (a) When a pharmacy benefits manager conducts an audit of a pharmacy,

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			the pharmacy benefits manager shall base a finding of overpayment or underpayment by the pharmacy on the actual overpayment or underpayment and not on a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, except as provided in (b) of this section. (b) A pharmacy benefits manager may resolve a finding of overpayment or underpayment by entering into a settlement agreement with the pharmacy. The settlement agreement (1) must comply with the requirements of AS 21.36.125; and (2) may be based on a statistically justifiable projection method. (c) A pharmacy benefits manager may not include the dispensing fee amount in a finding of an overpayment unless (1) a prescription was not actually dispensed; (2) the prescriber denied authorization; (3) the prescription dispensed was a medication error by the pharmacy; or (4) the identified overpayment is solely based on an extra dispensing fee. § 21.27.920. (a) When a pharmacy benefits manager conducts an audit of a pharmacy, the pharmacy benefits manager shall base the recoupment of overpayments on the actual overpayment of the claim, except as provided in AS 21.27.915(b). (b) A pharmacy benefits manager conducting an audit of a pharmacy may not (1) use extrapolation in calculating recoupments or penalties for audits, unless required by state or federal contracts; (2) assess a charge-back, recoupment, or other penalty against a pharmacy solely because a prescription is mailed or delivered at the request of a patient; or (3) receive payment (A) based on a percentage of the amount recovered; or (B) for errors that have no actual financial harm to the patient or medical plan. § 21.27.925. (a) A pharmacy benefits manager shall deliver a preliminary audit report to the pharmacy audited within 60 days after the conclusion of the audit. (b) A pharmacy benefits manager shall allow the pharmacy at least 30 days following

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			receipt of the preliminary audit report to provide documentation to the pharmacy benefits manager to address a discrepancy found in the audit. A pharmacy benefits manager may grant a reasonable extension upon request by the pharmacy. (c) A pharmacy benefits manager shall deliver a final audit report to the pharmacy within 120 days after receipt of the preliminary audit report, settlement agreement, or final appeal, whichever is latest. § 21.27.930. (a) A pharmacy benefits manager conducting an audit shall establish a written appeals process. (b) Recoupment of disputed funds or repayment of funds to the pharmacy benefits manager by the pharmacy, if permitted by contract, shall occur, to the extent demonstrated or documented in the pharmacy audit findings, after final internal disposition of the audit, including the appeals process. If the identified discrepancy for an individual audit exceeds $15,000, future payments to the pharmacy may be withheld pending finalization of the audit. (c) A pharmacy benefits manager may not assess against a pharmacy a charge- back, recoupment, or other penalty until the pharmacy benefits manager's appeals process has been exhausted and the final report or settlement agreement issued. § 21.27.935. When a pharmacy benefits manager conducts an audit of a pharmacy, the pharmacy benefits manager may not consider unintentional clerical or record-keeping errors, including typographical errors, writer's errors, or computer errors regarding a required document or record, to be fraudulent activity. In this section, "fraudulent activity" means an intentional act of theft, deception, misrepresentation, or concealment committed by the pharmacy. § 21.27.940. The requirements of AS 21.27.901 - 21.27.955 do not apply to an audit (1) in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, a review of claims data, a statement, or another investigative method; or (2) of claims paid for under the medical assistance program under AS 47.07.
DE	Del. Code tit. 18 Chapter 33A §§ 3301A – 3310A	DOI	§ 3301A. The Pharmacy Audit Integrity Program is established to provide standards for an audit of pharmacy records carried out by a pharmacy benefits manager or any entity

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			that represents pharmacy benefits managers. § 3302A. For purposes of this subchapter: **(1)** "Entity" means a pharmacy benefits manager or any person or organization that represents these companies, groups, or organizations.**(2)** "Pharmacy benefits manager" or "PBM" means an entity that contracts with pharmacists or pharmacies on behalf of a person to do any of the following: **a.** Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists. **b.** Pay pharmacies or pharmacists for prescription drugs or medical supplies. **c.** Negotiate rebates with manufacturers for drugs paid for or procured as described in this chapter.**(3)** "Plan sponsor" means as defined under § 4405 of this title. § 3303A. An amendment to pharmacy audit terms in a contract between a PBM and a pharmacy must be disclosed to the pharmacy at least 60 days prior to the effective date of the proposed change. § 3304A. **(a)** Audit procedures. Unless otherwise prohibited by federal requirements or regulations, any entity conducting a pharmacy audit must adhere to the following procedures:**(1)** A pharmacy must be given notice 14 days before an initial on-site audit is conducted.**(2)** An audit that involves clinical or professional judgment must be conducted by or in consultation with a licensed pharmacist.**(3)** Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies.**(4)** A pharmacy must be given a range of prescription numbers in advance of the audit. **(b)** Audit process. Unless otherwise prohibited by federal requirements or regulations, for any entity conducting a pharmacy audit the following audit items apply:**(1)** The period covered by the audit may not exceed 24 months from the date that the claim was submitted to or adjudicated by the entity, unless a longer period is required under state or federal law.**(2)** If an entity uses random sampling as a method for selecting a set of claims for examination, the sample size must be appropriate for a statistically reliable sample. The auditing entity shall provide the pharmacy a masked list that provides a prescription number or date range that the auditing entity is seeking to audit.**(3)** An on-site audit may not take place during the first five business days of the month or on a federal holiday unless consented to by the pharmacy.**(4)** Auditors may not enter the pharmacy area unless escorted where patient-specific information is available and to the extent possible must be out of sight and hearing range of the pharmacy customers.**(5)** Any recoupment will not be deducted against future remittances until after the appeals process and both parties have received the results of the final

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			audit.**(6)** A PBM may not require information to be written on a prescription unless the information is required to be written on the prescription by state or federal law. Recoupment may be assessed for items not written on the prescription if the required information is not readily available in print or electronic form for the auditor at the time of the audit and one or more of the following conditions applies:**(i)** additional information is required in the provider manual.**(ii)** the information is required by the Food and Drug Administration (FDA).**(iii)** the information is required by the drug manufacturer's product safety program.**(7)** The auditing company or agent may not receive payment based on a percentage of the amount recovered. This section does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:**(i)** the plan sponsor and the entity conducting the audit have a contract that explicitly states the percentage charge or assessment to the plan sponsor; and**(ii)** a commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped. § 3305A. For recoupment or chargeback, the following criteria apply: **(1)** Audit parameters must consider consumer-oriented parameters based on manufacturer listings.**(2)** The reimbursable cost for a compounded medication shall be reflective of the ingredients, supplies and professional time reasonably required to create the finished product.**(3)** A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.**(4)** The entity conducting the audit shall not use extrapolation in calculating the recoupment or penalties for audits unless required by state or federal law or regulations.**(5)** Calculations of overpayments must not include dispensing fees unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a medication error by the pharmacy, or the identified overpayment is solely based on an extra dispensing fee.**(6)** An entity may not consider any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record as fraud, however such errors may be subject to recoupment.**(7)** In the case of errors that have no actual financial harm to the patient or plan, the PBM must not assess any chargebacks. Errors that are a result of the pharmacy failing to comply with a formal corrective action plan may be subject to recovery.**(8)** Interest may not accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.

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			§ 3306A. **(a)** To validate the pharmacy record and delivery, the pharmacy may use authentic and verifiable statements or records including medication administration records of a nursing home, assisted living facility, hospital, physician, or other authorized practitioner or additional audit documentation parameters located in the provider manual. **(b)** Any legal prescription that meets the requirements in this subchapter may be used to validate claims in connection with prescriptions, refills, or changes in prescriptions, including medication administration records, faxes, e-prescriptions, or documented telephone calls from the prescriber or the prescriber's agents. § 3307A. The entity conducting the audit must establish a written appeals process which must include appeals of preliminary reports and final reports. § 3308A. **(a)** A preliminary audit report must be delivered to the pharmacy within 30 days after the conclusion of the audit. The preliminary audit report shall contain claim level information for any discrepancy and an estimated recovery amount. **(b)** A pharmacy must be allowed at least 45 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. **(c)** A final audit report must be delivered to the pharmacy within 120 days after receipt of the preliminary audit report or final appeal, whichever is later. **(d)** An entity shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within 45 days after the appeals process has been exhausted and the final audit report has been issued. § 3309A. Where contractually required, an auditing entity must provide a copy to the plan sponsor of its claims that were included in the audit, and any recouped money shall be returned to the plan sponsor. § 3310A. This subchapter does not apply to any investigative audit that involves suspected fraud, willful misrepresentation, abuse, or any audit completed by the State.
MD	MD. ANN. CODE § 15-1629	DOI	**(a)** This section applies only to a pharmacy benefits manager that provides pharmacy benefits management services on behalf of a carrier. **(b)** This section does not apply to an audit that involves probable or potential fraud or willful misrepresentation by a pharmacy or pharmacist. **(c)** A pharmacy benefits manager shall conduct an audit of a pharmacy or pharmacist under contract with the pharmacy benefits manager in accordance with this section. **(d)** A pharmacy benefits manager may not schedule an onsite audit to begin during the

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			first 5 calendar days of a month unless requested by the pharmacy or pharmacist. **(e)** When conducting an audit, a pharmacy benefits manager shall:**(1)** if the audit is onsite, provide written notice to the pharmacy or pharmacist at least 2 weeks before conducting the initial onsite audit for each audit cycle;**(2)** employ the services of a pharmacist if the audit requires the clinical or professional judgment of a pharmacist;**(3)** permit its auditors to enter the prescription area of a pharmacy only when accompanied by or authorized by a member of the pharmacy staff;**(4)** allow a pharmacist or pharmacy to use any prescription, or authorized change to a prescription, that meets the requirements of COMAR 10.34.20.02 to validate claims submitted for reimbursement for dispensing of original and refill prescriptions;**(5)** for purposes of validating the pharmacy record with respect to orders or refills of a drug, allow the pharmacy or pharmacist to use records of a hospital or a physician or other prescriber authorized by law that are:**(i)** written; or**(ii)** transmitted electronically or by any other means of communication authorized by contract between the pharmacy and the pharmacy benefits manager;**(6)** audit each pharmacy and pharmacist under the same standards and parameters as other similarly situated pharmacies or pharmacists audited by the pharmacy benefits manager;**(7)** only audit claims submitted or adjudicated within the 2-year period immediately preceding the audit, unless a longer period is authorized under federal or State law;**(8)** deliver the preliminary audit report to the pharmacy or pharmacist within 120 calendar days after the completion of the audit, with reasonable extensions allowed;**(9)** in accordance with subsection (k) of this section, allow a pharmacy or pharmacist to produce documentation to address any discrepancy found during the audit; and**(10)** deliver the final audit report to the pharmacy or pharmacist:**(i)** within 6 months after delivery of the preliminary audit report if the pharmacy or pharmacist does not request an internal appeal under subsection (k) of this section; or**(ii)** within 30 days after the conclusion of the internal appeals process under subsection (k) of this section if the pharmacy or pharmacist requests an internal appeal. **(f)** If a contract between a pharmacy or pharmacist and a pharmacy benefits manager specifies a period of time in which a pharmacy or pharmacist is allowed to withdraw and resubmit a claim and that period of time expires before the pharmacy benefits manager delivers a preliminary audit report that identifies discrepancies, the pharmacy benefits manager shall allow the pharmacy or pharmacist to withdraw and resubmit a claim within 30 days after:**(1)** the preliminary audit report is delivered if the pharmacy or pharmacist does not request an internal appeal under subsection (k) of this section; or**(2)** the conclusion of the internal appeals process under subsection (k) of this section if the pharmacy or pharmacist requests an internal appeal. **(g)** During an audit, a pharmacy benefits manager may not disrupt the provision of

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			services to the customers of a pharmacy. **(h)(1)** A pharmacy benefits manager may not:**(i)** use the accounting practice of extrapolation to calculate overpayments or underpayments; or**(ii)** Except as provided in paragraph (2) of this subsection:**1.** share information from an audit with another pharmacy benefits manager; or**2.** use information from an audit conducted by another pharmacy benefits manager.**(2)** Paragraph (1)(ii) of this subsection does not apply to the sharing of information:**(i)** required by federal or State law;**(ii)** in connection with an acquisition or merger involving the pharmacy benefits manager; or**(iii)** at the payor's request or under the terms of the agreement between the pharmacy benefits manager and the payor. **(i)** The recoupment of a claims payment from a pharmacy or pharmacist by a pharmacy benefits manager shall be based on an actual overpayment or denial of an audited claim unless the projected overpayment or denial is part of a settlement agreed to by the pharmacy or pharmacist. **(j)(1)** In this subsection, "overpayment" means a payment by the pharmacy benefits manager to a pharmacy or pharmacist that is greater than the rate or terms specified in the contract between the pharmacy or pharmacist and the pharmacy benefits manager at the time that the payment is made.**(2)** A clerical error, record-keeping error, typographical error, or scrivener's error in a required document or record may not constitute fraud or grounds for recoupment of a claims payment from a pharmacy or pharmacist by a pharmacy benefits manager if the prescription was otherwise legally dispensed and the claim was otherwise materially correct.**(3)** Notwithstanding paragraph (2) of this subsection, claims remain subject to recoupment of overpayment or payment of any discovered underpayment by the pharmacy benefits manager. **(k)(1)** A pharmacy benefits manager shall establish an internal appeals process under which a pharmacy or pharmacist may appeal any disputed claim in a preliminary audit report.**(2)** Under the internal appeals process, a pharmacy benefits manager shall allow a pharmacy or pharmacist to request an internal appeal within 30 working days after receipt of the preliminary audit report, with reasonable extensions allowed.**(3)** The pharmacy benefits manager shall include in its preliminary audit report a written explanation of the internal appeals process, including the name, address, and telephone number of the person to whom an internal appeal should be addressed.**(4)** The decision of the pharmacy benefits manager on an appeal of a disputed claim in a preliminary audit report by a pharmacy or pharmacist shall be reflected in the final audit report.**(5)** The pharmacy benefits manager shall deliver the final audit report to the pharmacy or pharmacist within 30 calendar days after conclusion of the internal appeals process. **(l)(1)** A pharmacy benefits manager may not recoup by setoff any moneys for an

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			overpayment or denial of a claim until:**(i)** the pharmacy or pharmacist has an opportunity to review the pharmacy benefits manager's findings; and**(ii)** if the pharmacy or pharmacist concurs with the pharmacy benefits manager's findings of overpayment or denial, 30 working days have elapsed after the date the final audit report has been delivered to the pharmacy or pharmacist.**(2)** If the pharmacy or pharmacist does not concur with the pharmacy benefits manager's findings of overpayment or denial, the pharmacy benefits manager may not recoup by setoff any money pending the outcome of an appeal under subsection (k) of this section.**(3)** A pharmacy benefits manager shall remit any money due to a pharmacy or pharmacist as a result of an underpayment of a claim within 30 working days after the final audit report has been delivered to the pharmacy or pharmacist.**(4)** Notwithstanding the provisions of paragraph (1) of this subsection, a pharmacy benefits manager may withhold future payments before the date the final audit report has been delivered to the pharmacy or pharmacist if the identified discrepancy for all disputed claims in a preliminary audit report for an individual audit exceeds $25,000. **(m)(1)** The Commissioner may adopt regulations regarding:**(i)** the documentation that may be requested during an audit; and**(ii)** the process a pharmacy benefits manager may use to conduct an audit.**(2)** On request of the Commissioner or the Commissioner's designee, a pharmacy benefits manager shall provide a copy of its audit procedures or internal appeals process.
NM	N.M. Code R. § 13.10.30.18B	DOI	The superintendent may also examine the audits of pharmacies conducted by PBMs to determine whether they are in compliance with Section 61-11-18.2 NMSA 1978.
OR	OR Rev. Stat. §§ 735.540 through 735.552	DOI	§ 735.540. As used in ORS 735.540 to 735.552: (1) "Audit" means an on-site or remote review of the records of a pharmacy by or on behalf of an entity. (2) "Clerical error" means a minor error: (a) In the keeping, recording or transcribing of records or documents or in the handling of electronic or hard copies of correspondence; (b) That does not result in financial harm to an entity; and (c) That does not involve dispensing an incorrect dose, amount or type of medication or dispensing a prescription drug to the wrong person. (3) "Entity" includes: (a) A pharmacy benefit manager; (b) An insurer; (c) A third party administrator; (d) A state agency; or

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			(e) A person that represents or is employed by one of the entities described in this subsection. (4) "Fraud" means knowingly and willfully executing or attempting to execute a scheme, in connection with the delivery of or payment for health care benefits, items or services, that uses false or misleading pretenses, representations or promises to obtain any money or property owned by or under the custody or control of any person. [2013 c.570 §4] § 735.542. An entity that audits claims or an independent third party that contracts with an entity to audit claims: (1) Must establish, in writing, a procedure for a pharmacy to appeal the entity's findings with respect to a claim and must provide a pharmacy with a notice regarding the procedure, in writing or electronically, prior to conducting an audit of the pharmacy's claims; (2) May not conduct an audit of a claim more than 24 months after the date the claim was adjudicated by the entity; (3) Must give at least 15 days' advance written notice of an on-site audit to the pharmacy or corporate headquarters of the pharmacy; (4) May not conduct an on-site audit during the first five days of any month without the pharmacy's consent; (5) Must conduct the audit in consultation with a pharmacist who is licensed by this or another state if the audit involves clinical or professional judgment; (6) May not conduct an on-site audit of more than 250 unique prescriptions of a pharmacy in any 12-month period except in cases of alleged fraud; (7) May not conduct more than one on-site audit of a pharmacy in any 12-month period; (8) Must audit each pharmacy under the same standards and parameters that the entity uses to audit other similarly situated pharmacies; (9) Must pay any outstanding claims of a pharmacy no more than 45 days after the earlier of the date all appeals are concluded or the date a final report is issued under ORS 735.550 (3); (10) May not include dispensing fees or interest in the amount of any overpayment assessed on a claim unless the overpaid claim was for a prescription that was not filled correctly; (11) May not recoup costs associated with: (a) Clerical errors; or (b) Other errors that do not result in financial harm to the entity or a consumer; and (12) May not charge a pharmacy for a denied or disputed claim until the audit and the appeals procedure established under subsection (1) of this section are final.

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			§ 735.544. An entity's finding that a claim was incorrectly presented or paid must be based on identified transactions and not based on probability sampling, extrapolation or other means that project an error using the number of patients served who have a similar diagnosis or the number of similar prescriptions or refills for similar drugs. § 735.546 An entity that contracts with an independent third party to conduct audits may not: (1) Agree to compensate the independent third party based on a percentage of the amount of overpayments recovered; or (2) Disclose information obtained during an audit except to the contracting entity, the pharmacy subject to the audit or the holder of the policy or certificate of insurance that paid the claim. § 735.548. For purposes of ORS 735.540 to 735.552, an entity, or an independent third party that contracts with an entity to conduct audits, must allow as evidence of validation of a claim: (1) An electronic or physical copy of a prescription that complies with ORS chapter 689 if the prescribed drug was, within 14 days of the dispensing date: (a) Picked up by the patient or the patient's designee; (b) Delivered by the pharmacy to the patient; or (c) Sent by the pharmacy to the patient using the United States Postal Service or other common carrier; (2) Point of sale electronic register data showing purchase of the prescribed drug, medical supply or service by the patient or the patient's designee; or (3) Electronic records, including electronic beneficiary signature logs, electronically scanned and stored patient records maintained at or accessible to the audited pharmacy's central operations and any other reasonably clear and accurate electronic documentation that corresponds to a claim. § 735.550. (1)(a) After conducting an audit, an entity must provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The preliminary report must be received by the pharmacy no later than 45 days after the date on which the audit was completed and must be sent: (A) By mail or common carrier with a return receipt requested; or (B) Electronically with electronic receipt confirmation. (b) An entity shall provide a pharmacy receiving a preliminary report under this subsection no fewer than 45 days after receiving the report to contest the report or any findings in the report in accordance with the appeals procedure established under ORS 735.542 (1) and to provide additional documentation in support of the claim. The entity

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			shall consider a reasonable request for an extension of time to submit documentation to contest the report or any findings in the report. (2) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method, including facsimile, mail or electronic mail. (3) An entity must provide a pharmacy that is the subject of an audit with a final report of the audit no later than 60 days after the later of the date the preliminary report was received or the date the pharmacy contested the report using the appeals procedure established under ORS 735.542 (1). The final report must include a final accounting of all moneys to be recovered by the entity. (4) Recoupment of disputed funds from a pharmacy by an entity or repayment of funds to an entity by a pharmacy, unless otherwise agreed to by the entity and the pharmacy, shall occur after the audit and the appeals procedure established under ORS 735.542 (1) are final. If the identified discrepancy for an individual audit exceeds $40,000, any future payments to the pharmacy may be withheld by the entity until the audit and the appeals procedure established under ORS 735.542 (1) are final. § 735.552. ORS 735.540 to 735.552 do not: (1) Preclude an entity from instituting an action for fraud against a pharmacy; (2) Apply to an audit of pharmacy records when fraud or other intentional and willful misrepresentation is evidenced by physical review, review of claims data or statements or other investigative methods; or (3) Apply to a state agency that is conducting audits or a person that has contracted with a state agency to conduct audits of pharmacy records for prescription drugs paid for by the state medical assistance program.
PA	40 Pa. Stat. §§ 4511-4514	DOI	§ 4511. **(a) Procedure.**--An entity conducting a pharmacy audit under this chapter shall conform to the following rules:**(1)** Except as otherwise provided by federal or state law, an auditing entity conducting a pharmacy audit may have access to a pharmacy's previous audit report only if the report was prepared by that auditing entity.**(2)** Information collected during a pharmacy audit shall be confidential by law, except that the auditing entity conducting the pharmacy audit may share the information with the pharmacy benefits manager and the covered entity, for which a pharmacy audit is being conducted.**(3)** The auditing entity conducting a pharmacy audit may not solely compensate an employee or contractor with which an auditing entity contracts to conduct a pharmacy audit, solely based on the amount claimed or the actual amount recouped by the pharmacy being audited.**(4)** The auditing entity shall provide the pharmacy being audited with at least 14 calendar days' prior written

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			notice before conducting a pharmacy audit, unless both parties agree otherwise. if a delay is requested by the pharmacy, the pharmacy shall provide notice to the pbm within 72 hours of receiving notice of the audit. **(5)** The auditing entity may not initiate or schedule a pharmacy audit during the first five business days of any month for a pharmacy that averages in excess of 600 prescriptions filled per week, without the express consent of the pharmacy.**(6)** The auditing entity shall accept paper or electronic signature logs that document the delivery of prescription or nonproprietary drugs and pharmacist services to a health plan beneficiary or the beneficiary's caregiver or guardian.**(7)** The auditing entity shall provide to the representative of the pharmacy, prior to leaving the pharmacy at the conclusion of the on-site portion of the pharmacy audit, a complete list of pharmacy records reviewed.**(8)** A pharmacy audit that involves clinical judgment shall be conducted by or in consultation with a pharmacist.**(9)**A pharmacy audit may not cover:**(i)** A period of more than 24 months after the date a claim was submitted by the pharmacy to the pharmacy benefits manager or covered entity unless a longer period is required by law; or**(ii)** More than 250 prescriptions, provided that a refill does not constitute a separate prescription for the purposes of this subparagraph.**(10)** The auditing entity may not use extrapolation to calculate penalties or amounts to be charged back or recouped unless otherwise required by federal requirements or federal plans.**(11)** The auditing entity may not include dispensing fees in the calculation of overpayments unless a prescription is considered a misfill. As used in this paragraph, "misfill" means a prescription that was not dispensed, a prescription error, a prescription where the prescriber denied the authorization request or a prescription where an extra dispensing fee was charged.**(12)** A pharmacy may do any of the following when a pharmacy audit is performed:**(i)** To validate the pharmacy record and delivery, a pharmacy may use authentic and verifiable statements or records, including, but not limited to, medication administration records of a nursing home, assisted living facility, hospital or health care practitioner with prescriptive authority.**(ii)** To validate claims in connection with prescriptions or changes in prescriptions, or refills of prescription or nonproprietary drugs, a pharmacy may use any valid prescription, including, but not limited to, medication administration records, facsimiles, electronic prescriptions, electronically stored images of prescriptions, electronically created annotations or documented telephone calls from the prescribing health care practitioner or practitioner's agent. Documentation of an oral prescription order that has been verified by the prescribing health care practitioner shall meet the provisions of this subparagraph for the initial audit review. **(b)Written report.**--An auditing entity shall provide the pharmacy with a written

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			report of the pharmacy audit and comply with the following requirements:**(1)** A preliminary pharmacy audit report must be delivered to the pharmacy or its corporate parent within 60 calendar days after the completion of the pharmacy audit. The preliminary report shall include contact information for the auditing entity who conducted the pharmacy audit and an appropriate and accessible point of contact, including telephone number, facsimile number, e-mail, and auditing firm, so that audit results, discrepancies and procedures can be reviewed. The preliminary pharmacy audit report shall include, but not be limited to, claim level information for any discrepancy found and total dollar amount of claims subject to recovery.**(2)** A pharmacy shall be allowed 30 calendar days following receipt of the preliminary audit report to respond to the findings of the preliminary report.**(3)** A final audit report shall be delivered to the pharmacy or its corporate parent not later than 60 calendar days after any responses from the pharmacy or corporate parent are received by the auditing entity. The auditing entity shall issue a final pharmacy audit report that takes into consideration any responses provided to the auditing entity by the pharmacy or corporate parent.**(4)** The final audit report may be delivered electronically.**(5)** A pharmacy may not be subject to a charge-back or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical error, scrivener's error or computer error, unless the error resulted in overpayment to the pharmacy.**(6)** An auditing entity conducting a pharmacy audit or person acting on behalf of the entity may not charge-back or recoup or collect penalties from a pharmacy until the time period to file an appeal of a final pharmacy audit report has passed or the appeals process has been exhausted, whichever is later.**(7)** If an identified discrepancy in a pharmacy audit exceeds $25,000, future payments to the pharmacy in excess of that amount may be withheld pending adjudication of an appeal.**(8)** No interest shall accrue for any party during the audit period, beginning with the notice of the pharmacy audit and ending with the conclusion of the appeals process. § 4512. A pharmacy may appeal a final audit report in accordance with the procedures established by the entity conducting the pharmacy audit. § 4513. **(a) General rule.**--The provisions of this chapter do not apply to an investigative audit of pharmacy records when:**(1)** Fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or**(2)** Other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation. **(b) Federal law.**--This chapter does not supersede any audit requirements established

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			by federal law. § 4514. The department may promulgate regulations as necessary and appropriate to carry out this chapter.
SC	S.C. Code §38-71-1810(B) (applies to a health carrier or any entity that represents a responsible party)	DOI	**(A)** For the purposes of this article:**(1)** "Insurer" means an entity that provides health insurance coverage in this State as defined in Section 38-71-670(7) and Section 38-71-840(16).**(2)** "Responsible party" means the entity responsible for payment of claims for health care services other than:**(a)** the individual to whom the health care services were rendered; or**(b)** that individual's guardian or legal representative.**(3)** "Audit" means an evaluation, investigation, or review of claims paid to a pharmacy that takes place at the pharmacy location and does not include review of claims or claims payments that an insurer conducts as a normal course of business.**(4)** "Abuse" means any practice that:**(a)(i)** is inconsistent with sound fiscal or business practices; or**(ii)** fails to meet professionally recognized standards for pharmacy services; and**(b)** directly or indirectly causes financial loss to a responsible party. **(B)** If a managed care organization, insurer, third-party payor, or any entity that represents a responsible party conducts an audit of the records of a pharmacy, then, with respect to this audit, the pharmacy has a right to:**(1)** have at least fourteen days' advance notice of the initial audit for each audit cycle with no audit to be initiated or scheduled during the first five days of any month without the express consent of the pharmacy, which shall cooperate with the auditor to establish an alternate date if the audit would fall within the excluded days;**(2)** have an audit that involves clinical judgment be conducted with a pharmacist who is licensed and employed by or working under contract with the auditing entity;**(3)** not have clerical or record-keeping errors, including typographical errors, scrivener's errors, and computer errors, on a required document or record considered fraudulent in the absence of any other evidence or serve as the sole basis of rejection of a claim; however, the provisions of this item do not prohibit recoupment of fraudulent payments;**(4)** have the auditing entity to provide the pharmacy, upon request, all records related to the audit in an electronic format or contained in digital media;**(5)** submit records related to the audit in electronic format or by certified mail;**(6)** have the properly documented records of a hospital or of a person authorized to prescribe controlled substances for the purpose of providing medical or pharmaceutical care for their patients transmitted by any means of communication approved by the auditing entity in order to validate a pharmacy record with respect to a prescription or refill for a controlled substance or narcotic drug pursuant to federal and state regulations;**(7)** have a projection of an overpayment or

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			underpayment based on either the number of patients served with a similar diagnosis or the number of similar prescription orders or refills for similar drugs; however, the provisions of this item do not prohibit recoupments of actual overpayments unless the projection for overpayment or underpayment is part of a settlement by the pharmacy;**(8)** be free of recoupments based on either of the following subitems unless defined within the billing, submission, or audit requirements set forth in the pharmacy provider manual not inconsistent with current State Board of Pharmacy Regulations, except for cases of Food and Drug Administration regulation or drug manufacturer safety programs in accordance with federal or state regulations:**(a)** documentation requirements in addition to, or exceeding requirements for, creating or maintaining documentation prescribed by the State Board of Pharmacy;**(b)** a requirement that a pharmacy or pharmacist perform a professional duty in addition to, or exceeding, professional duties prescribed by the State Board of Pharmacy unless otherwise agreed to by contract with the auditing entity;**(9)** be subject, so long as a claim is made within the contractual claim submission time period, to recoupment only following the correction of a claim and to have recoupment limited to amounts paid in excess of amounts payable under the corrected claim unless a prescription error occurs. For purposes of this subsection, a prescription error includes, but is not limited to, wrong drug, wrong strength, wrong dose, or wrong patient;**(10)** be subject to reversals of approval, except for Medicare claims, for drug, prescriber, or patient eligibility upon adjudication of a claim only in cases in which the pharmacy obtained the adjudication by fraud or misrepresentation of claim elements;**(11)** be audited under the same standards and parameters as other similarly situated pharmacies audited by the same entity;**(12)** have at least thirty days following receipt of the preliminary audit report to produce documentation to address any discrepancy found during an audit;**(13)** have the option of providing documentation in electronic format or by certified mail;**(14)** have the period covered by an audit limited to twenty-four months from the date a claim was submitted to, or adjudicated by, a managed care organization, an insurer, a third-party payor, or an entity that represents responsible parties, unless a longer period is permitted by or under federal law;**(15)** have the preliminary audit report delivered to the pharmacy within one hundred twenty days after conclusion of the audit;**(16)** have a final audit report delivered to the pharmacy within ninety days after the end of the appeals period; and**(17)** not have the accounting practice of extrapolation used in calculating recoupments or penalties for audits, unless otherwise required by federal requirements or federal plans. **(C)** Notwithstanding Section 38-71-1840, the auditing entity shall provide the pharmacy, if requested, a masked list that provides a prescription number range the

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			auditing entity is seeking to audit.
UT	Utah Code Ann. § 31A-46-303	DOI	(1) An insurer and an insurer's pharmacy benefit manager is subject to the pharmacy audit provisions of Section 58-17b-622. (2) A pharmacy benefit manager shall not use maximum allowable cost as a basis for reimbursement to a pharmacy unless: (a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's approved drug products with therapeutic equivalent evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and (b) the drug is: (i) generally available for purchase in this state from a national or regional wholesaler; and (ii) not obsolete. (3) The maximum allowable cost may be determined using comparable and current data on drug prices obtained from multiple nationally recognized, comprehensive data sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are available for purchase by pharmacies in the state. (4) For every drug for which the pharmacy benefit manager uses maximum allowable cost to reimburse a contracted pharmacy, the pharmacy benefit manager shall: (a) include in the contract with the pharmacy information identifying the national drug pricing compendia and other data sources used to obtain the drug price data; (b) review and make necessary adjustments to the maximum allowable cost, using the most recent data sources identified in Subsection (4)(a), at least once per week; (c) provide a process for the contracted pharmacy to appeal the maximum allowable cost in accordance with Subsection (5); and (d) include in each contract with a contracted pharmacy a process to obtain an update to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily available and accessible. (5) (a) The right to appeal in Subsection (4)(c) shall be: (i) limited to 21 days following the initial claim adjudication; and (ii) investigated and resolved by the pharmacy benefit manager within 14 business days. (b) If an appeal is denied, the pharmacy benefit manager shall provide the contracted pharmacy with the reason for the denial and the identification of the national drug code of the drug that may be purchased by the pharmacy at a price at or below the price determined by the pharmacy benefit manager. (6) The contract with each pharmacy shall contain a dispute resolution mechanism in the event either party breaches the terms or conditions of the contract. (7) This section does not apply to a pharmacy benefit manager when the pharmacy benefit manager is providing pharmacy benefit management services on behalf of the Medicaid program.
WI	Wis. Stat. 632.865 (6)	DOI	Audits of pharmacies or pharmacists. **(a)** Definitions. In this subsection:

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			1. "Audit" means a review of the accounts and records of a pharmacy or pharmacist by or on behalf of an entity that finances or reimburses the cost of health care services or prescription drugs. **2.** "Entity" means a defined network plan, as defined in s. 609.01 (1b), insurer, self-insured health plan, or pharmacy benefit manager or a person acting on behalf of a defined network plan, insurer, self-insured health plan, or pharmacy benefit manager. **3.** "Self-insured health plan" has the meaning given in s. 632.85 (1) (c). **(b)** Procedures. An entity conducting an on-site or desk audit of pharmacist or pharmacy records shall do all of the following: **1.** If the audit is an audit on the premises of the pharmacist or pharmacy, notify the pharmacist or pharmacy in writing of the audit at least 2 weeks before conducting the audit. **2.** Refrain from auditing a pharmacist or pharmacy within the first 5 business days of a month unless the pharmacist or pharmacy consents to an audit during that time. **3.** If the audit involves clinical or professional judgment, conduct the audit by or in consultation with a pharmacist licensed in any state. **4.** Limit the audit review to no more than 250 separate prescriptions. For purposes of this subdivision, a refill of a prescription is not a separate prescription. **5.** Limit the audit review to claims submitted no more than 2 years before the date of the audit, unless required otherwise by state or federal law. **6.** Allow the pharmacist or pharmacy to use authentic and verifiable records of a hospital, physician, or other health care provider to validate the pharmacist's or pharmacy's records relating to delivery of a prescription drug and use any valid prescription that complies with requirements of the pharmacy examining board to validate claims in connection with a prescription, refill of a prescription, or change in prescription. **7.** Allow the pharmacy or pharmacist to document the delivery of a prescription drug or pharmacist services to an enrollee under a health benefit plan using either paper or electronic signature logs. **8.** Before leaving the pharmacy after concluding the on-site portion of an audit, provide to the representative of the pharmacy or the pharmacist a complete list of the pharmacy records reviewed. **(c)** Results of audit. An entity that has conducted an audit of a pharmacist or pharmacy shall do all of the following: **1.** Deliver to the pharmacist or pharmacy a preliminary report of the audit within 60 days after the date the auditor departs from an on-site audit or the pharmacy or pharmacist submits paperwork for a desk audit. A preliminary report under this subdivision shall include claim-level information for any discrepancy reported, the

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			estimated total amount of claims subject to recovery, and contact information for the entity or person that completed the audit so the pharmacist or pharmacy subject to the audit may review audit results, procedures, and discrepancies. **2.** Allow a pharmacist or pharmacy that is the subject of an audit to provide documentation to address any discrepancy found in the audit within 30 days after the date the pharmacist or pharmacy receives the preliminary report. **3.** Deliver to the pharmacist or pharmacy a final audit report, which may be delivered electronically, within 90 days of the date the pharmacist or pharmacy receives the preliminary report or the date of the final appeal of the audit, whichever is later. The final audit report under this subdivision shall include any response provided to the auditor by the pharmacy or pharmacist and consider and address the pharmacy's or pharmacist's response. **4.** Refrain from assessing a recoupment or other penalty on a pharmacist or pharmacy until the appeal process is exhausted and the final report under subd. 3. is delivered to the pharmacist or pharmacy. **5.** Refrain from accruing or charging interest between the time the notice of the audit is given under par. (b) 1. and the final report under subd. 3. has been delivered. **6.** Exclude dispensing fees from calculations of overpayments. **7.** Establish and follow a written appeals process that allows a pharmacy or pharmacist to appeal the final report of an audit and allow the pharmacy or pharmacist as part of the appeal process to arrange for, at the cost of the pharmacy or pharmacist, an independent audit. **8.** Refrain from subjecting the pharmacy or pharmacist to a recoupment or recovery for a clerical or record-keeping error in a required document or record, including a typographical or computer error, unless the error resulted in an overpayment to the pharmacy or pharmacist. **(d)** Confidentiality of audit. Information obtained in an audit under this subsection is confidential and may not be shared unless the information is required to be shared under state or federal law and except that the audit may be shared with the entity on whose behalf the audit is performed. An entity conducting an audit may have access to the previous audit reports on a particular pharmacy only if the audit is conducted by the same entity. **(e)** Cooperation with audit. If an entity is conducting an audit that is complying with this subsection in auditing a pharmacy or pharmacist, the pharmacy or pharmacist that is the subject of the audit may not interfere with or refuse to participate in the audit. **(f)** Payment of auditors. A pharmacy benefit manager or entity conducting an audit may not pay an auditor employed by or contracted with the pharmacy benefit manager

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			or entity based on a percentage of the amount recovered in an audit. **(g)** Applicability. **1.** This subsection does not apply to an investigative audit that is initiated as a result of a credible allegation of fraud or willful misrepresentation or criminal wrongdoing. **2.** If an entity conducts an audit to which a federal law applies that is in conflict with all or part of this subsection, the entity shall comply with this subsection only to the extent that it does not conflict with federal law.

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DE	Del. Code tit. 18, Chapter 33A § 3336A and § 3337A	DOI	§ 3336A A pharmacy benefit manager may not require prior authorization for coverage of a 72 hour supply of medication that is for a non-controlled substance in an emergency situation. § 3337A (a) A prior authorization form for a prescription medication shall include a question regarding whether the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient. (b) If a prescriber indicates on a prior authorization form that the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient, the pharmacy benefit manager may not request a reauthorization for the same prescription medication more frequently than every 12 months. (c) In the same communication in which a pharmacy benefit manager or the pharmacy benefit manager's agent requests a prior authorization for a prescription medication that has therapeutically equivalent medications that do not require a prior authorization from a prescriber, the pharmacy benefit manager or the pharmacy benefit manager's agent shall provide the prescriber with a list of alternative prescription medications of the same class and family as the requested medication. (d) Prescribers that utilize e-prescribing shall receive alternate medications from the pharmacy benefit manager for prescription medications that do not require a prior authorization before the completion of the e-prescribing transaction. (e) A pharmacy benefit manager or the pharmacy benefit manager's agent shall provide alternative medications for therapeutically equivalent medications to the pharmacy that require prior authorization on the National Council for Prescription Drug Programs response transaction to a denied claim for prior authorization.

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NM	N.M. Stat. § 59A-61-5F and § 59A-61-7	DOI	N.M. Stat. § 59A-61-5F. **F.** A pharmacy benefits manager or health benefit plan shall not impose a fee on a pharmacy for scores or metrics or both scores and metrics. Nothing in this subsection prohibits a pharmacy benefits manager or health benefit plan from offering incentives to a pharmacy based on a score or metric; provided that the incentive is equally available to all in-network pharmacies. N.M. Stat. § 59A-61-7. **A.** A pharmacy benefits manager shall not charge a pharmacy a fee related to the adjudication of a claim, including:**(1)** the receipt and processing of a pharmacy claim;**(2)** the development or management of a claim processing or adjudication network; or**(3)** participation in a claim processing or claim adjudication network. **B.** A pharmacy benefits manager shall not charge a pharmacy a fee for a service unless the fee for service is itemized in the pharmacy benefits management contract.

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MD	MD. ANN. CODE § 15-1628.3	DOI	**(a)** A pharmacy benefits manager or a carrier may not directly or indirectly charge a contracted pharmacy, or hold a contracted pharmacy responsible for, a fee or performance-based reimbursement related to the adjudication of a claim or an incentive program.**(b)** A pharmacy benefits manager or carrier may not make or allow any reduction in payment for pharmacy services by a pharmacy benefits manager or carrier or directly or indirectly reduce a payment for a pharmacy service under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payments.
NH	New Hampshire Rev Stat § 402-N:4	DOI	**I.** A pharmacy benefits manager or insurer shall require a contracted pharmacy to charge an enrollee or insured person the pharmacy's usual and customary price of filling the prescription or the contracted copayment, whichever is less. **II.** Once it has settled a claim for filling a prescription for an enrollee or insured person and notified the pharmacy of the amount the pharmacy benefits manager or insurer shall pay to the pharmacy for that prescription, the pharmacy benefits manager or insurer shall not lower the amount to be paid to the pharmacy by the pharmacy benefits manager or the insurer for such settled claim; provided, however, that this paragraph shall not apply if the claim was submitted fraudulently or with inaccurate or misrepresented information.
NJ	N.J.S.A. §17B:27F-7	DOI	**a.** After the date of receipt of a clean claim for payment made by a pharmacy, a pharmacy benefits manager shall not retroactively reduce payment on the claim, either directly or indirectly, through aggregated effective rate, direct or indirect remuneration, quality assurance program, or otherwise, except if the claim is found not to be a clean claim during the course of a routine audit performed pursuant to an agreement between the pharmacy benefits manager and the pharmacy. When a pharmacy adjudicates a claim at the point of sale, the reimbursement amount provided to the pharmacy by the pharmacy benefits manager shall constitute a final reimbursement amount. Nothing in this section shall be construed to prohibit any retroactive increase in payment to a pharmacy pursuant to a contract between the pharmacy benefits manager, and the pharmacy services administration organization, or a pharmacy. **b.** For the purpose of this section, "clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or other circumstance requiring special treatment, including, but not limited to, those listed in subsection d. of this section, that prevents timely payment from being made on the claim. **c.** A pharmacy benefit manager shall not recoup funds from a pharmacy in connection with claims for which the pharmacy has already been paid unless the recoupment is:**(1)** otherwise permitted or required by law;**(2)** the result of an audit, performed pursuant to a contract

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			between the pharmacy benefits manager and the pharmacy; or**(3)** the result of an audit, performed pursuant to a contract between the pharmacy benefits manager and the designated pharmacy services administrative organization. **d.** The provisions of this section shall not apply to an investigative audit of pharmacy records when:**(1)** fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or**(2)** other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation.
NM	N.M. Stat. Ann. § 59A-61-6	DOI	A pharmacy benefits manager shall not reduce or eliminate payment on an adjudicated claim except as permitted by Section 61-11-18.2.
SC	SC Code § 38-71-2230(C)	DOI	(C) This subsection may not be construed to limit overpayment recovery efforts as set forth in Section 38-59-250. A pharmacy may not be subject to a charge-back or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical or computer error, unless the error resulted in overpayment to the pharmacy.
UT	Utah Code Ann. § 31A-46-304	DOI	(1) A pharmacy benefit manager shall permit a pharmacy to collect the amount of a customer's cost share from any source. (2) A pharmacy benefit manager may not deny or reduce a reimbursement to a pharmacy or a pharmacist after the adjudication of the claim, unless: (a) the pharmacy or pharmacist submitted the original claim fraudulently; (b) the original reimbursement was incorrect because: (i) the pharmacy or pharmacist had already been paid for the pharmacy service; or (ii) an unintentional error resulted in an incorrect reimbursement; or (c) the pharmacy service was not rendered by the pharmacy or pharmacist. (3) Subsection (2) does not apply if: (a) any form of an investigation or audit of pharmacy records for fraud, waste, abuse, or other intentional misrepresentation indicates that the pharmacy or pharmacist engaged in criminal wrongdoing, fraud, or other intentional misrepresentation; or (b) the reimbursement is reduced as the result of the reconciliation of a reimbursement amount under a performance contract if: (i) the performance contract lays out clear performance standards under which the reimbursement for a specific drug may be increased or decreased; and (ii) the agreement between the pharmacy benefit manager and the pharmacy or pharmacist explicitly states, in a separate document that is signed by the pharmacy benefit manager and the pharmacy or pharmacist, that the provisions of Subsection (2) do not apply.

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KS	K.S.A. § 40-3831	DOI	(a) This section shall be known and may be cited as the Kansas pharmacy patients fair practices act. (b) As used in this section: (1) "Covered person" means the same as defined in K.S.A. 2020 Supp. 40-3822, and amendments thereto. (2) "Health carrier" means the same as defined in K.S.A. 2020 Supp. 40-2,195, and amendments thereto.(3) "Pharmacy benefits manager" means the same as defined in K.S.A. 2020 Supp. 40-3822, and amendments thereto. (c)(1) Co-payments applied by a health carrier for a prescription drug may not exceed the total submitted charges by the network pharmacy. (2) A pharmacy or pharmacist shall have the right to provide a covered person with information regarding the amount of the covered person's cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be proscribed by a pharmacy benefits manager from discussing any such information or for selling a more affordable alternative to the covered person if such an alternative is available. (d)(1) This section applies to any contract between a pharmacy benefits manager and a pharmacy, a pharmacy services administration organization or a group purchasing organization that is entered into or renewed on and after January 1, 2019. (2) The provisions of this section shall not apply to any policy or certificate that provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-2227, and amendments thereto, vision care or any other limited supplemental benefit nor to any Medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.
ME	24-A Maine Rev. Stat. Ann. Chap 56-C §4349-3 (applies through a carrier contract with a PBM) and §4349-4	DOI	**3. Contract requirements.** A carrier may not enter into a contract or agreement or allow a pharmacy benefits manager or any person acting on the carrier's behalf to enter into a contract or agreement that prohibits a pharmacy provider from: A. Providing a covered person with the option of paying the pharmacy provider's cash price for the purchase of a prescription drug and not filing a claim with the covered person's

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			carrier if the cash price is less than the covered person's cost-sharing amount; or [B. Providing information to a state or federal agency, law enforcement agency or the superintendent when such information is required by law. **4. Excess payments at point of sale prohibited.** A carrier or pharmacy benefits manager may not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of: A. The applicable cost-sharing amount for the prescription drug; B. The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts; and C. The total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or carrier, including the cost-sharing amount paid by a covered person.
OK	36 OK Stat § 36-6962C	DOI	The prohibitions under this section shall apply to contracts between pharmacy benefits managers and pharmacists or pharmacies for participation in retail pharmacy networks. 1. A PBM contract shall: a. Not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, an individual of any differential between the individual's out-of-pocket cost or coverage with respect to acquisition of the drug and the amount an individual would pay to purchase the drug directly, and b. Ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, a covered individual of any differential between the individual's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage. 2. A pharmacy benefits manager's contract with a participating pharmacist or pharmacy shall not prohibit, restrict or limit disclosure of information to the Insurance Commissioner, law enforcement or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements under the Patient's Right to Pharmacy Choice Act. 3. A pharmacy benefits manager shall establish and maintain an electronic claim inquiry processing system using the National Council for Prescription Drug Programs' current standards to communicate information to pharmacies submitting claim inquiries.

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SC	SC Code § 38-71-2220 (2020)	DOI	(A) In any participation contracts between pharmacy benefits managers and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted, or penalized in any way from disclosing to any covered person any health care information that the pharmacy or pharmacist deems appropriate within their scope of practice. (B) A pharmacy or pharmacist must not be proscribed by a pharmacy benefits manager from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available, but a pharmacy benefits manager may proscribe a pharmacy or pharmacist from sharing proprietary or confidential information. (C) A pharmacy benefits manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the director investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements pursuant to this act. The information or data acquired during an examination or review pursuant to this section is considered proprietary and confidential and is not subject to the South Carolina Freedom of Information Act.
WI	Wis. Stat. § 632.861 (2) (a); § 632.861 (2) (b); and 632.861(3)	DOI	**(2)** ALLOWING DISCLOSURES.**(a)** A disability insurance policy or self-insured health plan that provides a prescription drug benefit may not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to an enrollee in the policy or plan from informing, or penalize such pharmacy for informing, an enrollee of any differential between the out-of-pocket cost to the enrollee under the policy or plan with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.**(b)** A disability insurance policy or self-insured health plan that provides a prescription drug benefit shall ensure that any pharmacy benefit manager that provides services under a contract with the policy or plan does not, with respect to such policy or plan, restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to an enrollee in the policy or plan from informing, or penalize such pharmacy for informing, an enrollee of any differential between the out-of-pocket cost to the enrollee under the policy or plan with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage. **(3)** COST-SHARING LIMITATION. A disability insurance policy or self-insured health plan that provides a prescription drug benefit or a pharmacy benefit manager that provides services under a contract with a policy or plan may not require an enrollee to pay at the point of sale for a covered prescription drug an amount that is greater than the lowest of all of the following amounts:**(a)** The cost-sharing amount for the prescription drug for the

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			enrollee under the policy or plan.**(b)** The amount a person would pay for the prescription drug if the enrollee purchased the prescription drug at the dispensing pharmacy without using any health plan or health insurance coverage.

PROHIBITING SPREAD PRICING – MARCH 2022

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AR	A.C.A. § 23-92-505(c)	DOI	A pharmacy benefits manager is prohibited from conducting spread pricing in this state.
DE	Del. Code tit. 18, Chapter 33A § 3372A(1)	DOI	A pharmacy benefits manager or representative of a pharmacy benefits manager may not do any of the following: (1) Engage in spread pricing. *****
LA	LA Rev Stat § 22:1867 (2021)	DOI	A. A pharmacy benefit manager is prohibited from conducting or participating in spread pricing in this state unless the pharmacy benefit manager provides written notice as provided in Subsection B of this Section. B. The notice issued by a pharmacy benefit manager, or a health insurance issuer where the health insurance issuer has agreed to issue the notice, that utilizes spread pricing shall be: (1) Required for each health insurance issuer or plan provider in which the pharmacy benefit manager engaged or participated in spread pricing. (2) Delivered to the policy holder. (3) Provided at least biannually. (4) Indicative of the aggregate amount of spread pricing charged by the pharmacy benefit manager during the period. (5) Written in plain, simple, and understandable English. C. Any violation of this Section that is committed or performed with such frequency as to indicate a general business practice shall be subject to the provisions of the Unfair Trade Practices and Consumer Protection Law, R.S. 51:1401 et seq., as provided in R.S. 40:2870(B).
VA	Va. Code § 38.2-3467(D) (applies to the health carrier or through a contract with a PBM)	DOI	No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall conduct spread pricing in the Commonwealth.

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AR	A.C.A. § 23-92-506(c)	DOI	A claim or aggregate of claims for pharmacist services shall not be directly or indirectly retroactively denied or reduced after adjudication of the claim or aggregate of claims unless: **(1)** The original claim was submitted fraudulently; **(2)** The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services; or **(3)** The pharmacist services were not properly rendered by the pharmacy or pharmacist.
CO	Colo. Rev. Stat. § 10-16-122.3(2)	DOI	**(2)(a)** A contract or agreement, including a performance-based or value-based contract or agreement, between a pharmacy benefit management firm and a pharmacy or a pharmacy services administrative organization with respect to prescription drug benefits administered or managed by the pharmacy benefit management firm must provide that after the date the pharmacy benefit management firm receives a clean claim submitted by a pharmacy, the pharmacy benefit management firm shall not retroactively reduce payment on the claim after the point of sale except as the result of an audit conducted in accordance with section 10-16-122.5. **(b)** Nothing in this subsection (2) prohibits a pharmacy benefit management firm from retroactively increasing a payment to a pharmacy pursuant to a written agreement between the pharmacy benefit management firm and the pharmacy or making adjustments to claims in the case of a clerical error.
ME	24-A Maine Rev. Stat. Ann. Chap 56-C §4350-8D	DOI	8. Payment. This subsection governs payments between a carrier or a carrier's pharmacy benefits manager and a pharmacy provider. A. The amount paid by a carrier or a carrier's pharmacy benefits manager to a pharmacy provider under contract with the carrier or the carrier's pharmacy benefits manager for dispensing a prescription drug must be the ingredient cost plus the dispensing fee less any cost-sharing amount paid by a covered person. B. The ingredient cost may not exceed the maximum allowable cost or average wholesale price, as applicable, and must be disclosed by the carrier's pharmacy benefits manager to the carrier. C. Only the pharmacy provider that dispensed the prescription drug may retain the payment described in this subsection. D. A pharmacy provider may not be denied payment or be subject to a reduced payment retroactively unless the original claim was submitted fraudulently or in error.

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MN	Minn. Stat. 62W.13	DOI	No pharmacy benefit manager shall retroactively adjust a claim for reimbursement submitted by a pharmacy for a prescription drug, unless the adjustment is a result of a: (1) pharmacy audit conducted in accordance with section 62W.09; or (2) technical billing error.
NJ	N.J.S.A. §17B:27F-7	DOI	**a.** After the date of receipt of a clean claim for payment made by a pharmacy, a pharmacy benefits manager shall not retroactively reduce payment on the claim, either directly or indirectly, through aggregated effective rate, direct or indirect remuneration, quality assurance program, or otherwise, except if the claim is found not to be a clean claim during the course of a routine audit performed pursuant to an agreement between the pharmacy benefits manager and the pharmacy. When a pharmacy adjudicates a claim at the point of sale, the reimbursement amount provided to the pharmacy by the pharmacy benefits manager shall constitute a final reimbursement amount. Nothing in this section shall be construed to prohibit any retroactive increase in payment to a pharmacy pursuant to a contract between the pharmacy benefits manager, and the pharmacy services administration organization, or a pharmacy. **b.** For the purpose of this section, "clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or other circumstance requiring special treatment, including, but not limited to, those listed in subsection d. of this section, that prevents timely payment from being made on the claim. **c.** A pharmacy benefit manager shall not recoup funds from a pharmacy in connection with claims for which the pharmacy has already been paid unless the recoupment is:**(1)** otherwise permitted or required by law;**(2)** the result of an audit, performed pursuant to a contract between the pharmacy benefits manager and the pharmacy; or**(3)** the result of an audit, performed pursuant to a contract between the pharmacy benefits manager and the designated pharmacy services administrative organization. **d.** The provisions of this section shall not apply to an investigative audit of pharmacy records when:**(1)** fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or**(2)** other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation.

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OR	Oregon Rev. Stat. § 735.534(2)(i)	DOI	(2)(i) May not retroactively deny or reduce a claim for reimbursement of the cost of services after the claim has been adjudicated by the pharmacy benefit manager unless the: (A) Adjudicated claim was submitted fraudulently; (B) Pharmacy benefit manager's payment on the adjudicated claim was incorrect because the pharmacy or pharmacist had already been paid for the services; (C) Services were improperly rendered by the pharmacy or pharmacist; or (D) Pharmacy or pharmacist agrees to the denial or reduction prior to the pharmacy benefit manager notifying the pharmacy or pharmacist that the claim has been denied or reduced. (3) Subsection (2)(i) of this section may not be construed to limit pharmacy claim audits under ORS 735.540 to 735.552.
SC	SC Code § 38-71-2230(B) (2020)	DOI	(B) A claim for pharmacist services may not be retroactively denied or reduced after adjudication of the claim unless the: (1) original claim was submitted fraudulently; (2) original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services; (3) pharmacist services were not properly rendered by the pharmacy or pharmacist; or (4) adjustment was agreed upon by the pharmacy prior to the denial or reduction.
WI	Wis. Stat. § 632.865(5)	DOI	Unless required otherwise by federal law, a pharmacy benefit manager may not retroactively deny or reduce a pharmacist's or pharmacy's claim after adjudication of the claim unless any of the following is true: (a) The original claim was submitted fraudulently. (b) The payment for the original claim was incorrect. Recovery for an incorrect payment under this paragraph is limited to the amount that exceeds the allowable claim. (c) The pharmacy services were not rendered by the pharmacist or pharmacy. (d) In making the claim or performing the service that is the basis for the claim, the pharmacist or pharmacy violated state or federal law. (e) The reduction is permitted in a contract between a pharmacy and a pharmacy benefit manager and is related to a quality program.

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NH	New Hampshire Rev Stat § 402-N:3	DOI	I. All contracts between a carrier or pharmacy benefit manager and a contracted pharmacy shall include: (a) The sources used by the pharmacy benefit manager to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the carrier or pharmacy benefit manager. (b) A process to appeal, investigate, and resolve disputes regarding the maximum allowable cost pricing. The process shall include the following provisions: (1) A provision granting the contracted pharmacy or pharmacist at least 30 business days following the initial claim to file an appeal; (2) A provision requiring the carrier or pharmacy benefit manager to investigate and resolve the appeal within 30 business days; (3) A provision requiring that, if the appeal is denied, the carrier or pharmacy benefit manager shall: (A) Provide the reason for the denial; and (B) Identify the national drug code of a drug product that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost; and (4) A provision requiring that, if an appeal is granted, the carrier or pharmacy benefits manager shall within 30 business days after granting the appeal: (A) Make the change in the maximum allowable cost; and (B) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question. II. For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall: (a) Include in the contract with the pharmacy information identifying the national drug pricing compendia or sources used to obtain the drug price data. (b) Make available to a contracted pharmacy the actual maximum allowable cost for each drug. (c) Review and make necessary adjustments to the maximum allowable cost for every drug for which the price has changed at least every 14 days.
NM	N.M. Stat. § 59A-61-5A, B, C and D	DOI	**A.** A pharmacy benefits manager shall not require that a pharmacy participate in one contract in order to participate in another contract. **B.** A pharmacy benefits manager shall provide to a pharmacy by electronic mail, facsimile or certified mail, at least thirty calendar days prior to its execution, a contract written in plain English.

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			C. A contract between a pharmacy benefits manager and a pharmacy shall identify the industry standard reimbursement practice that the pharmacy benefits manager will use to determine a reimbursement amount, unless the contract is modified in writing to specify another industry standard practice. **D.** The provisions of the Pharmacy Benefits Manager Regulation Act shall not be waived, voided or nullified by contract.
PA	40 Pa. Stat. § 4532	DOI	(a)General rule.--Upon each contract execution or renewal, a PBM shall, with respect to contracts between a PBM and a pharmacy, or its representative, including a PSAO: (1) Include in the contract the sources utilized to determine multiple source drug pricing, including, if applicable, the maximum allowable cost or any successive pricing formula of the PBM.(2) Update the pricing information every seven calendar days.(3) Establish a reasonable process by which pharmacies have a method to access relevant or current maximum allowable cost pricing lists in effect and any successive pricing formulas in a timely fashion. (b)Confidentiality provision.--Nothing in this section may prohibit a PBM from establishing a reasonable confidentiality provision with a pharmacy or its representative , including a PSAO.

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AR	A.C.A. § 23-92-505(b)	DOI	**(1)** A pharmacy benefits manager shall report to the Insurance Commissioner on a quarterly basis for each healthcare payor the following information:**(A)** The aggregate amount of rebates received by the pharmacy benefits manager;**(B)** The aggregate amount of rebates distributed to the appropriate healthcare payor;**(C)** The aggregate amount of rebates passed on to the enrollees of each healthcare payor at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount;**(D)** The individual and aggregate amount paid by the healthcare payor to the pharmacy benefits manager for pharmacist services itemized by pharmacy, by product, and by goods and services; and**(E)** The individual and aggregate amount a pharmacy benefits manager paid for pharmacist services itemized by pharmacy, by product, and by goods and services.**(2)** The report required under subdivision (b)(1) of this section is: **(A)** Proprietary and confidential under § 23-61-107(a)(4) and § 23-61-207; and**(B)** Not subject to the Freedom of Information Act of 1967, § 25-19-101 et seq.
MD	MD. ANN. CODE § 15-1624	DOI	**(a)** If a purchaser has a rebate sharing contract, a pharmacy benefits manager shall offer to provide the purchaser a report for each fiscal quarter and each fiscal year that contains the amount of the:**(1)** net revenue of the pharmacy benefits manager from sales of prescription drugs to purchasers made through the pharmacy benefits manager's network of contractually affiliated retail pharmacies or through the pharmacy benefits manager's mail order pharmacies, with respect to the pharmacy benefits manager's entire client base of purchasers;**(2)** total prescription drug expenditures applicable to the purchaser;**(3)** total manufacturer payments earned by the pharmacy benefits manager during the applicable reporting period; and**(4)** total rebates applicable to the purchaser during the applicable reporting period.**(b)** If the exact amount of each item to be reported under subsection (a) of this section is not known by the pharmacy benefits manager at the time of its report, the pharmacy benefits manager shall offer to provide:**(1)** its current best estimate of the amount of each item; and**(2)** an updated report containing the exact amount of each item immediately after it becomes available.**(c)(1)** A pharmacy benefits manager shall provide the information described in subsections (a) and (b) of this section if requested by the purchaser.**(2)** Notwithstanding the provisions of paragraph (1) of this subsection, if a pharmacy benefits manager requires a nondisclosure agreement under which a purchaser agrees that the information in subsections (a) and (b) of this section is proprietary information, the pharmacy benefits manager may not be required to provide the information until the purchaser has signed the nondisclosure agreement.

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TX	Texas Insurance Code § 1369.502	DOI	(a) Not later than March 1 of each year, each pharmacy benefit manager shall file a report with the commissioner. The report must state for the immediately preceding calendar year: (1) the aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers; and (2) the aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were: (A) passed to: (i) health benefit plan issuers; or (ii) enrollees at the point of sale of a prescription drug; or (B) retained as revenue by the pharmacy benefit manager. (b) A report submitted by a pharmacy benefit manager may not disclose the identity of a specific health benefit plan or enrollee, the price charged for a specific prescription drug or class of prescription drugs, or the amount of any rebate or fee provided for a specific prescription drug or class of prescription drugs. (c) Not later than June 1 of each year, the commissioner shall publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's Internet website. The combined aggregated data from the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager.
UT	Utah Code Ann. § 31A-46-301	DOI	(1) Before April 1 of each year, a pharmacy benefit manager operating in the state shall report to the department, for the previous calendar year: (a) any insurer, pharmacy, or pharmacist in the state with which the pharmacy benefit manager had a contract; (b) the total value, in the aggregate, of all rebates and administrative fees that are attributable to enrollees of a contracting insurer; and (c) if applicable, the percentage of aggregate rebates that the pharmacy benefit manager retained under the pharmacy benefit manager's agreement to provide pharmacy benefits management services to a contracting insurer. (2) Records submitted to the commissioner under Subsections (1)(b) and (c) are a protected record under Title 63G, Chapter 2, Government Records Access and Management Act. (3) (a) The department shall publish the information provided by a pharmacy benefit manager under Subsection (1)(c) in the annual report described in Section 31A-2-201.2. (b) The department may not publish information submitted under Subsection (1)(b) or (c) in a manner that: (i) makes a specific submission from a contracting insurer or pharmacy benefit manager identifiable; or

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			(ii) is likely to disclose information that is a trade secret as defined in Section 13-24-2. (c) At least 30 days before the day on which the department publishes the data, the department shall provide a pharmacy benefit manager that submitted data under Subsection (1)(b) or (c) with: (i) a general description of the data that will be published by the department; (ii) an opportunity to submit to the department, within a reasonable period of time and in a manner established by the department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act: (A) any correction of errors, with supporting evidence and comments; and (B) information that demonstrates that the publication of the data will violate Subsection (3)(b), with supporting evidence and comments.
VA	Section 38.2-3468 B of the Code of Virginia (applies to a health carrier or through a contract for pharmacy benefits)	DOI	Any carrier, on its own or through its contract for pharmacy benefits, shall report to the Commissioner on a quarterly basis for each health benefit plan the following information: 1. The aggregate amount of rebates received by the pharmacy benefits manager; 2. The aggregate amount of rebates distributed to the appropriate health benefit plan; 3. The aggregate amount of rebates passed on to the enrollees of each health benefit plan at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount; 4. Upon the request of the Commission, the individual and aggregate amount paid by the health benefit plan to the pharmacy benefits manager for services itemized by pharmacy, by product, and by goods and services; and 5. Upon the request of the Commission, the individual and aggregate amount a pharmacy benefits manager paid for services itemized by pharmacy, by product, and by goods and services.

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NM	NM Stat § 59A-61-8 (2020)	DOI	A pharmacy services administrative organization shall register with the superintendent on a form and in a time frame and method of submission specified by the superintendent.

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DE	Del. Code tit. 18, Chapter 33A § 3363A(b)	DOI	(b) A pharmacy benefits manager shall report to the Commissioner on a quarterly basis all of the following information for each insurer: (1) The itemized amount of pharmacy benefits manager revenue sources, including professional fees, administrative fees, processing fees, audits, direct and indirect renumeration fees, or any other fees. (2) The aggregate amount of rebates distributed to the appropriate insurer. (3) The aggregate amount of rebates passed on to insureds of each insurer at the point of sale that reduced the insureds' applicable deductible, copayment, coinsurance, or other cost-sharing amount. (4) The individual and aggregate amount the insurer paid to the pharmacy benefits manager for pharmacy goods or services itemized by all of the following: a. Pharmacy. b. Product. c. Goods and services. (5) The individual and aggregate amount a pharmacy benefits manager paid for pharmacy goods or services itemized by all of the following: a. Pharmacy. b. Product. c. Goods and services.
NH	N. H. Rev. Stat. § 402-N:6	DOI	**I.** Each pharmacy benefits manager shall submit an annual report to the commissioner containing a list of health benefit plans it administered, and the aggregate amount of all rebates it collected from pharmaceutical manufacturers that were attributable to patient utilization in the state of New Hampshire during the prior calendar year. **II.** Information reported to the commissioner pursuant to this section shall be confidential and protected from disclosure under the commissioner's examination authority and shall not be considered a public record subject to disclosure under RSA 91-A. Based on this reporting, the commissioner shall make public aggregated data on the overall amount of rebates collected on behalf of covered persons in the state, but shall not release data that identifies a specific insurer or pharmacy benefit manager.

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TX	Texas Insurance Code § 1369.502	DOI	(a) Not later than March 1 of each year, each pharmacy benefit manager shall file a report with the commissioner. The report must state for the immediately preceding calendar year:(1) the aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers; and(2) the aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were:(A) passed to:(i) health benefit plan issuers; or(ii) enrollees at the point of sale of a prescription drug; or(B) retained as revenue by the pharmacy benefit manager.(a-1) Notwithstanding Subsection (a), the report due not later than February 1, 2020, under that subsection must state the required information for the immediately preceding three calendar years in addition to stating the required information for the preceding calendar year. This subsection expires September 1, 2021.(b) A report submitted by a pharmacy benefit manager may not disclose the identity of a specific health benefit plan or enrollee, the price charged for a specific prescription drug or class of prescription drugs, or the amount of any rebate or fee provided for a specific prescription drug or class of prescription drugs.(c) Not later than June 1 of each year, the commissioner shall publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's Internet website. The combined aggregated data from the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager.
UT	Utah Code Ann. § 31A-46-307	DOI	(1) A pharmacy benefit manager may not enter into or renew a contract with an insurer on or after January 1, 2021, to administer or manage rebate contracting or rebate administration unless the pharmacy benefit manager agrees to regularly report to the insurer information regarding pharmaceutical manufacturer rebates received by the pharmacy benefit manager under the contract. (2) The quality and type of information required under Subsection (1) shall be detailed, claims level information unless the pharmacy benefit manager and insurer agree to waive this requirement in a separate written agreement.
WI	Wis. Stat. 632.865 (7)	DOI	**(a)** Beginning on June 1, 2021, and annually thereafter, every pharmacy benefit manager shall submit to the commissioner a report that contains, from the previous calendar year, the aggregate rebate amount that the pharmacy benefit manager received from all pharmaceutical manufacturers but retained and did not pass through to health benefit plan sponsors and the percentage of the aggregate rebate amount that is retained rebates. Information required under this paragraph is limited to contracts held with pharmacies located in this state.

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			(b) Reports under this subsection shall be considered a trade secret under the uniform trade secret act under s. 134.90. **(c)** The commissioner may not expand upon the reporting requirement under this subsection, except that the commissioner may effectuate this subsection.

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NM	N.M. Code R. § 13.10.30.20 and § 13.10.30.21	DOI	§ 13.10.30.20. **A. Oversight required.** If a health insurance carrier utilizes the services of a PBM, the carrier shall ensure an adequate pharmaceutical network, timely and fair claims payment to pharmacies, appropriate appeals procedures, lack of retaliation against pharmacies and appropriate formulary development and tier structures. Assignment of the responsibilities of the carrier to a PBM as to any of these matters shall be set forth in the written agreement between the PBM and the carrier. **B. Program administration.** The ultimate responsibility for competent administration of a health insurance carrier's programs lies with the carrier. **C. Records maintenance.** A health insurance carrier shall maintain for a minimum of five years reviews conducted of the operations of its PBM(s). A carrier shall produce such records at the superintendent's request. § 13.10.30.21. Every PBM shall maintain at its principal administrative office for the duration of the written agreement referred to in Section 59A-12A-4 NMSA 1978 and five years thereafter adequate books and records of all transactions between it, health insurance carriers and pharmacies. Such books and records shall be maintained in accordance with prudent standards of insurance record keeping. The superintendent shall have access to such books and records for the purpose of examination, audit and inspection. Any trade secrets contained therein shall be deemed confidential, except that the superintendent may use such information in any proceedings instituted against the PBM. The health insurance carrier shall retain the right to continuing access to such books and records to permit the carrier to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurance carrier and the PBM regarding the proprietary rights of the parties in such books and records.
TX	Texas Insurance Code § 1369.502	DOI	**(a)** Not later than March 1 of each year, each pharmacy benefit manager shall file a report with the commissioner. The report must state for the immediately preceding calendar year:**(1)** the aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers; and**(2)** the aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were:**(A)** passed to:**(i)** health benefit plan issuers; or**(ii)** enrollees at the point of sale of a prescription drug; or**(B)** retained as revenue by the pharmacy benefit manager.**(a-1)** Notwithstanding Subsection (a), the report due not later than February 1, 2020, under that subsection must state the required information for the immediately preceding three calendar years in addition to stating the

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			required information for the preceding calendar year. This subsection expires September 1, 2021.**(b)** A report submitted by a pharmacy benefit manager may not disclose the identity of a specific health benefit plan or enrollee, the price charged for a specific prescription drug or class of prescription drugs, or the amount of any rebate or fee provided for a specific prescription drug or class of prescription drugs.**(c)** Not later than June 1 of each year, the commissioner shall publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's Internet website. The combined aggregated data from the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager.
UT	Utah Code Ann. § 31A-46-301 and § 31A-46-302	DOI	§ 31A-46-301. (1) Before April 1 of each year, a pharmacy benefit manager operating in the state shall report to the department, for the previous calendar year: (a) any insurer, pharmacy, or pharmacist in the state with which the pharmacy benefit manager had a contract; (b) the total value, in the aggregate, of all rebates and administrative fees that are attributable to enrollees of a contracting insurer; and (c) if applicable, the percentage of aggregate rebates that the pharmacy benefit manager retained under the pharmacy benefit manager's agreement to provide pharmacy benefits management services to a contracting insurer. (2) Records submitted to the commissioner under Subsections (1)(b) and (c) are a protected record under Title 63G, Chapter 2, Government Records Access and Management Act. (3) (a) The department shall publish the information provided by a pharmacy benefit manager under Subsection (1)(c) in the annual report described in Section 31A-2-201.2. (b) The department may not publish information submitted under Subsection (1)(b) or (c) in a manner that: (i) makes a specific submission from a contracting insurer or pharmacy benefit manager identifiable; or ii) is likely to disclose information that is a trade secret as defined in Section 13-24-2. (c) At least 30 days before the day on which the department publishes the data, the department shall provide a pharmacy benefit manager that submitted data under Subsection (1)(b) or (c) with: (i) a general description of the data that will be published by the department; (ii) an opportunity to submit to the department, within a reasonable period of time and in a manner established by the department by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act: (A) any correction of errors, with supporting evidence and comments; and (B) information that demonstrates that the publication of the data will violate Subsection

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			(3)(b), with supporting evidence and comments. § 31A-46-302. (1) If a pharmacy service entity engages in direct or indirect remuneration with a pharmacy, the pharmacy service entity shall make a reimbursement report available to the pharmacy upon the pharmacy's request. (2) For the reimbursement report described in Subsection (1), the pharmacy service entity shall: (a) include the adjusted compensation amount related to a claim and the reason for the adjusted compensation; and (b) provide the reimbursement report: (i) in accordance with the contract between the pharmacy and the pharmacy service entity; (ii) in an electronic format that is easily accessible; and (iii) within 120 days after the day on which the pharmacy benefit manager receives a report of a sale of a product or service by the pharmacy. (3) A pharmacy service entity shall, upon a pharmacy's request, provide the pharmacy with: (a) the reasons for any adjustments contained in a reimbursement report; and (b) an explanation of the reasons provided in Subsection (3)(a). (4) (a) A pharmacy benefit manager may not prohibit or penalize the disclosure by a pharmacist of: (i) an insured customer's cost share for a covered prescription drug or prescription device; (ii) the availability of any therapeutically equivalent alternative medications; or (iii) alternative methods of paying for the prescription medication or prescription device, including paying the cash price, that are less expensive than the cost share of the prescription drug. (b) Penalties that are prohibited under Subsection (4)(a) include increased utilization review, reduced payments, and other financial disincentives. (5) A pharmacy benefit manager may not require an insured customer to pay, for a covered prescription drug or prescription device, more than the lesser of: (a) the applicable cost share of the prescription drug or prescription device being dispensed; (b) the applicable allowable claim amount of the prescription drug or prescription device being dispensed; (c) the applicable pharmacy reimbursement of the prescription drug or prescription device being dispensed; or (d) the retail price of the prescription drug or prescription device without prescription drug coverage. (6) For a contract entered into or renewed on or after May 12, 2020, a pharmacy benefit

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			manager may not engage in direct or indirect remuneration that results in a reduction in total compensation received by a pharmacy from the pharmacy benefit manager for the sale of a drug, device, or other product or service unless the pharmacy benefit manager provides the pharmacy with at least 30 days notice of the direct or indirect remuneration.
WI	Wis. Stat. § 632.865(7)	DOI	(7) Transparency reports. (a) Beginning on June 1, 2021, and annually thereafter, every pharmacy benefit manager shall submit to the commissioner a report that contains, from the previous calendar year, the aggregate rebate amount that the pharmacy benefit manager received from all pharmaceutical manufacturers but retained and did not pass through to health benefit plan sponsors and the percentage of the aggregate rebate amount that is retained rebates. Information required under this paragraph is limited to contracts held with pharmacies located in this state. (b) Reports under this subsection shall be considered a trade secret under the uniform trade secret act under s. 134.90. (c) The commissioner may not expand upon the reporting requirement under this subsection, except that the commissioner may effectuate this subsection.