ACP
Congressional Network

Pharmacists

Use these forms to bring patient and pharmacy concerns about PBM "steering" and into mail-only programs to the attention of the state Attorney General.

Here's how:

1. Print the attached Patient Petition form and place copies at your pharmacy counter.
2. Encourage your patients to complete the form and return it to the counter.
3. Submit the completed forms to Brad Cameron at ACP via fax to **202-966-3336** or email to brad@ngrc.com.

Here are extra steps you can take to help:

The Association of Community Pharmacists is preparing a petition to your state Attorney General. The petition will ask the Attorney General to investigate unlawful use of patient data to steer patients into services they own, under-reimbursement to pharmacies for drug purchases, and failure to disclose profits obtained from government programs through "spread" pricing.

Help us by taking these extra steps:

1. Be sure to include the Pharmacy Owner Agreement Form when you return the patient petitions to ACP. That way, we can match the patient petitions to your pharmacy. We can also include you in our follow up efforts.
2. Fill out a Pharmacy Owner Survey. This one-page survey helps us identify specific examples where PBMs are under-reimbursing you for drug purchases. (make copies to submit more than one example).
3. Send a letter to your U.S. Representative. Send an email to brad@ngrc.com. He will draft the letter for you to print, sign, and fax. The letter asks your Rep. to cosponsor HR 4199, the "PHARMACY" Bill.

Pharmacy Owner Agreement Form

To: Brad Cameron
Association of Community Pharmacists

Fax: 202-966-3336

_____
Pharmacy Name

_____ _____
My Name Phone

_____
Address City State Zip

_____
Signature Email *(please write clearly)*

Check all that apply

◯ I want to be included in the petition to the state Attorney General.

◯ I will help recruit other pharmacists to join the petition.

◯ I have attached Patient Petition forms.

◯ I have attached one or more Pharmacy Survey forms.

Protect Your Rights As a Patient

Do not let insurance companies force you into mail-only prescription service

State and federal laws protect your right as a patient to privacy. That means insurance companies and their agents cannot use the information you provide to your pharmacy for any reason other than to verify your identity when providing benefits.

Has your access to prescription drugs changed?

Some patients have been notified by their insurance company or its pharmacy benefit manager (PBM) that they may only fill future prescriptions by mail or at pharmacies owned by the PBM. This may be illegal if the companies are using data you gave this pharmacy to cut off your access to our services. We need to let our state Attorney General know this is happening.

Protect your rights.

As your local care provider, we want to make sure that your access to local health care services is protected. You can help us protect your rights. Simply complete this form and provide it to your pharmacist so we can follow up with our Attorney General.

- ◯ I do not want my insurance company and PBMs to block my access to local pharmacy care.
- ◯ I do not want to be forced to receive my medications by mail-only.
- ◯ My insurance company informed me that I cannot fill prescriptions at my local pharmacy. I want to join the petition to make sure my state Attorney General will investigate this unfair change to my insurance plan.

Name of My Current Pharmacy _____ City _____ State _____

My Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Signature _____ Email (*Optional)* _____

Example of PBM Under-Payments

This form provides an example of how PBMs are under-paying pharmacies in our state to unlawfully destroy competition and force residents into their proprietary programs

Identification

1. The name of my pharmacy is: _____

2. My pharmacy location: _____
   Address City

   _____ _____ _____ _____
   State Zip Phone Email *(please write clearly)*

Case Study

3. Does this example relate to payments under a federal program? *(indicate program on this line):* _____

4. Does this example relate to payments under a state program? *(indicate program on this line):* _____

5. What was the drug product? _____ To treat what condition?_____

6. My cost to acquire drug_____ Reimbursement paid by PBM_____

   Co-Pay Paid by Patient_____ Dispensing fee paid by PBM_____

Anti-Competitive Effect on Pharmacy Operations to Be Investigated

7. Amount I lost by filling this prescription (amount of PBM "spread") _____

8. Did the PBM require you to sign a contract to prevent you from disclosing how much it pays your pharmacy for this drug? Yes _____ No _____

9. Does the PBM prevent you from competing for this patient's business by offering the same services (*e.g.*, 90-day prescriptions) that it offers? Yes _____ No _____

10. Do you believe this case demonstrates that the PBM is engaging in potentially unlawful anti-competitive behavior against your pharmacy? Yes _____ No _____

Impact on Consumer / State Resident

11. Please tell us about your customer/patient. What impact does this case have on him/her?

*Fax to Association of Community Pharmacists at **202-966-3336***