

APPENDIX XVI – Applicant Submission of P&T Committee Member List and Certification Statement

This appendix summarizes CMS policy on Part D Applicant/Sponsor and PBM submission of P&T Committee membership, and the accountability that each Part D Applicant/Sponsor holds regarding the integrity of the P&T Committee whose membership is submitted either directly by the Part D Applicant/Sponsor or by the applicant/sponsor's PBM. This appendix also instructs Part D Applicants (or their PBM's) on how to submit the Applicant's P&T Committee membership list, and a Certification of P&T Integrity and Quality in the event the Applicant is planning to operate under a confidentiality agreement with its PBM (such that the PBM does not disclose the membership to the Applicant).

I. P&T Committee Member Disclosure to CMS

As provided in the regulation at 42 CFR 423.120(b)(1), a Part D Sponsor's P&T Committee list must contain a majority of members who are practicing physicians and/or pharmacists, include at least one practicing physician and one practicing pharmacist who are experts regarding care of the elderly or disabled individuals, and includes at least one practicing physician and one practicing pharmacist who are independent and free of conflict relative to the Part D Sponsor or Plan and pharmaceutical manufacturers.

In the event the Part D Applicant/Sponsor has entered into a confidential agreement such that the PBM will not disclose its P&T Committee membership to the Part D Applicant/Sponsor, then it is the Part D Sponsor's responsibility to notify CMS that this information will be submitted by the Sponsor's PBM. Moreover, the Part D Applicant/Sponsor must ensure that the PBM notifies CMS of the P&T Committee membership. Also, the Part D Applicant/Sponsor should ensure that the PBM notifies the Sponsor that this information has been successfully submitted to CMS.

II. Instructions to Plans and PBMs

- A.** If the Part D Applicant sub-contracts with a PBM for its P&T Committee and operates under a Confidentiality Agreement (such that its members are not disclosed to the Part D Applicant) then the Applicant must (1) complete the attached Certification in HPMS, and (2) forward the attached P&T Committee Member Disclosure form to the sub-contracted PBM and direct the PBM to submit the form to CMS by the application due date. The PBM should email the P&T Committee Member Disclosure form to the following email box:
PartD_Applications@cms.hhs.gov.
- B.** In the event of any future changes to the membership of the Part D Sponsor's P&T Committee or the PBM's P&T Committee, Part D Sponsors must (or in the case of a confidential agreement the Part D Sponsor) assure that the PBM will notify the appropriate CMS account manager (to be assigned at a future date) and make the

correct changes in HPMS on the Contract Management/Part D Data page within 30 days of the effective date of such change.

III. PHARMACY AND THERAPEUTICS COMMITTEE MEMBER DISCLOSURE

PBM must email the following form to PartD_Applications@cms.hhs.gov by the application due date.

Name of Part D Plan or PBM: _____

If Part D Plan, provide Part D Contract number(s): _____

Contact Person: _____

Phone Number: _____

Email: _____

A. Complete the table below.

PROVIDE THE NAMES OF THE MEMBERS OF YOUR ORGANIZATION'S P&T COMMITTEE. INDICATE WHICH MEMBERS ARE PRACTICING PHYSICIANS OR PRACTICING PHARMACISTS. FURTHER, INDICATE WHICH MEMBERS ARE EXPERTS IN THE CARE OF THE ELDERLY OR DISABLED, AND FREE OF ANY CONFLICT OF INTEREST WITH YOUR ORGANIZATION AND PHARMACEUTICAL MANUFACTURERS. (APPLICANTS SHOULD MARK THE INFORMATION AS PROPRIETARY.) SUBMIT THIS DATA BY CREATING A SPREADSHEET IN MICROSOFT EXCEL THAT MIMICS THE TABLE BELOW.

Full Name of Member Start Date and End Date	Practicing Physician	Practicing Pharmacist	Elderly/Disabled Expert	Free of Any Conflict of Interest With Your Organization?	Free of Any Conflict of Interest With Pharmaceutical Manufacturers?

B. Complete the table below if a PBM submitting on behalf of Part D plan.

PROVIDE THE NAMES OF THOSE APPLICANTS FOR THE PART D BENEFIT FOR WHICH YOUR ORGANIZATION IS PROVIDING PHARMACY BENEFIT MANAGEMENT SERVICES, THE TYPE OF APPLICATION, AND THE CONTRACT NUMBER(S). ADD ADDITIONAL ROWS AS NECESSARY.

Organization Name	Type of Application	Contract Number(s)

Applicant must upload in HPMS:

**CERTIFICATION FOR PART D SPONSORS USING A PHARMACY BENEFIT
MANAGER'S PHARMACY & THERAPEUTICS COMMITTEE UNDER A
CONFIDENTIALITY AGREEMENT**

I, attest, on behalf of LEGAL NAME OF PART D SPONSOR APPLICANT ("Applicant"), to the following:

I certify that APPLICANT has entered into a contract with LEGAL NAME OF PBM ("PBM") to perform pharmacy benefit management services related to the operation of a Medicare Part D benefit plan(s) on behalf of APPLICANT.

I agree, to the best of my knowledge, that "PBM," has a Pharmacy and Therapeutics (P&T) Committee that contains a majority of members who are practicing physicians and/or pharmacists, includes at least one practicing physician and one practicing pharmacist who are experts regarding the care of the elderly or disabled individuals, and includes at least one practicing physician and one practicing pharmacist who are independent and free of conflict relative to my plan and organization and pharmaceutical manufacturers.

I agree that the PBM will supply to CMS the following information, including but not limited to, the full legal name of each member of its P&T Committee designated as a practicing physician or pharmacist specializing in elderly and/or disabled care. Each member must also disclose any conflict of interest with my organization, and/or pharmaceutical manufacturers.

I agree that my organization has policies and procedures to ensure and confirm the ongoing integrity, qualifications and expertise of the PBM's P&T Committee.

I agree that in the event CMS identifies a PBM's P&T Committee member is listed on the OIG exclusion list, my organization will be notified by CMS of such a problem. In such an instance, my organization must assure that the PBM takes appropriate steps to correct the problem or my organization will be at risk of being subject to a corrective action plan and sanctions, depending on the nature of the problem.

I agree that CMS may inspect the records and premises of my organization or my subcontractor (first tier, downstream and related entities) to ensure compliance with the statements to which I have attested above.

I certify that I am authorized to sign on behalf of the Applicant.

Part D Applicant's Contract Number: _____

Authorized Representative Name (printed)

Title

Authorized Representative Signature

Date (MM/DD/YYYY)