

REFERENCE TITLE: prescription drugs; multitiered formularies

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011

SB 1594

Introduced by
Senators Barto: Driggs, McComish, Murphy; Representative Smith D

AN ACT

AMENDING SECTIONS 20-841.05 AND 20-1057.02, ARIZONA REVISED STATUTES;
AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING
SECTION 20-1342.07; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED
STATUTES, BY ADDING SECTIONS 20-1402.05 AND 20-1404.05; RELATING TO
PRESCRIPTION DRUGS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-841.05, Arizona Revised Statutes, is amended to
3 read:

4 20-841.05. Prescription drug formulary; definitions

5 A. A corporation with a prescription drug benefit that uses a drug
6 formulary as a component of the subscription contract shall provide to its
7 subscribers notice in the contract and any disclosure form regarding the
8 applicable drug formulary. The corporation shall write the notice so that
9 the language and format are easy to understand. The notice shall include an
10 explanation of what a drug formulary is, how the corporation determines which
11 prescription drugs are included or excluded and how often the corporation
12 reviews the contents of the drug formulary.

13 B. A corporation described in subsection A of this section shall:

14 1. Develop and maintain a process by which health care professionals
15 may request authorization for a medically necessary formulary or nonformulary
16 prescription drug during nonbusiness hours. If the corporation does not
17 maintain that process, the corporation shall reimburse a subscriber for the
18 subscriber's out-of-pocket expense minus any deductible or copayment for a
19 prescription drug that was purchased by the subscriber without
20 preauthorization but that was later approved by the corporation.

21 2. Develop and maintain a process by which health care professionals
22 may request authorization for medically necessary nonformulary prescription
23 drugs. The corporation shall approve an alternative prescription drug when
24 either of the following conditions is met:

25 (a) The equivalent prescription drug on the formulary has been
26 ineffective in the treatment of the subscriber's disease or condition.

27 (b) The equivalent prescription drug on the formulary has caused an
28 adverse or harmful reaction in the subscriber.

29 C. If the subscriber's pharmacy benefit plan does not require
30 authorization, subsection B, paragraph 2 of this section does not apply.

31 D. If the subscriber's treating health care professional makes a
32 determination that the subscriber meets any of the conditions described in
33 subsection B of this section, any denial to cover the nonformulary
34 prescription drug by the corporation shall be made in writing by a licensed
35 pharmacist or medical director. The written denial shall contain an
36 explanation of the denial, including the medical or pharmacological reasons
37 why the authorization was denied, and the licensed pharmacist or medical
38 director who made the denial shall sign it. The corporation shall send a
39 copy of the written denial to the subscriber's treating health care
40 professional who requested the authorization. The corporation shall maintain
41 copies of all written denials and shall make the copies available to the
42 department for inspection during regular business hours.

43 E. Any subscription contract that is issued, amended or renewed by a
44 corporation and that includes prescription drug benefits shall not limit or
45 exclude coverage for at least sixty days after the corporation's notice or

1 the pharmacy's notice pursuant to subsection F of this section to the
2 subscriber, whichever occurs first, for a prescription drug for a subscriber
3 to refill a previously prescribed drug if the prescription drug was
4 previously approved for coverage under the drug formulary or pharmacy benefit
5 plan for the subscriber's medical condition and the health care professional
6 continues to prescribe the prescription drug for the same medical condition.
7 The limitation or exclusion prohibited by this subsection applies if the
8 prescription drug is appropriately prescribed and is considered safe and
9 effective for treating the subscriber's medical condition. This subsection
10 does not prohibit the health care professional from prescribing another
11 prescription drug that is covered by the drug formulary and that is medically
12 appropriate for the subscriber, including generic drug substitutions.

13 F. A corporation shall provide written notice of the removal of any
14 prescription drug from the corporation's drug formulary to each pharmacy
15 vendor with which the corporation has a contract. On notice from the
16 corporation, the contracted pharmacy vendor at the point of dispensing a
17 prescription drug that has been removed from the drug formulary shall notify
18 the subscriber by means of a verbal consultation or other direct
19 communication with a subscriber that the subscriber may be required to
20 consult with a health care professional to obtain a new prescription for a
21 replacement drug after the sixty day period prescribed in subsection E of
22 this section. The notice prescribed in this subsection is not required if
23 the pharmacy vendor is a pharmacy that is owned by the corporation or a
24 corporate affiliate of that corporation.

25 G. A CORPORATION WITH A PRESCRIPTION DRUG BENEFIT THAT USES A
26 MULTITIERED DRUG FORMULARY AS A COMPONENT OF A SUBSCRIPTION CONTRACT SHALL
27 NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG TO A DIFFERENT
28 TIER OF THE FORMULARY DURING THE TERM OF THE SUBSCRIPTION CONTRACT. IF A
29 CORPORATION PLANS TO RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION
30 DRUG TO A DIFFERENT TIER OF THE FORMULARY IN A SUBSEQUENT TERM OF THE
31 SUBSCRIPTION CONTRACT, THE CORPORATION SHALL GIVE THE SUBSCRIBER SIXTY DAYS'
32 NOTICE REGARDING THE IMPENDING CHANGE.

33 ~~G.~~ H. This section does not:

34 1. Prohibit a corporation from applying deductibles, coinsurance or
35 other cost containment or quality assurance measures.

36 2. Apply to a corporation that provides a multitiered benefit plan
37 that allows access to prescription drugs without authorization by the
38 corporation.

39 3. Apply to any corporation that holds a certificate of authority to
40 operate either as a dental service corporation or an optometric service
41 corporation.

42 ~~H.~~ I. For the purposes of this section:

43 1. "Health care Professional" means a person who has an active
44 nonrestricted license pursuant to title 32 and WHO is authorized to write
45 drug prescriptions to treat medical conditions.

1 2. "Prescription drug" means any prescription medication as defined in
2 section 32-1901 that is prescribed by a health care professional to a
3 subscriber to treat the subscriber's condition.

4 Sec. 2. Section 20-1057.02, Arizona Revised Statutes, is amended to
5 read:

6 20-1057.02. Prescription drug formulary: definitions

7 A. A health care services organization with a prescription drug
8 benefit that uses a drug formulary as a component of the evidence of coverage
9 shall provide to its enrollees notice in the evidence of coverage and the
10 disclosure form prescribed in section 20-1076 regarding the applicable drug
11 formulary. The health care services organization shall write the notice so
12 that the language and format are easy to understand. The notice shall
13 include an explanation of what a drug formulary is, how the health care
14 services organization determines which prescription drugs are included or
15 excluded and how often the health care services organization reviews the
16 contents of the drug formulary.

17 B. A health care services organization described in subsection A of
18 this section shall:

19 1. Develop and maintain a process by which health care professionals
20 may request authorization for a medically necessary formulary or nonformulary
21 prescription drug during nonbusiness hours. If the health care services
22 organization does not maintain that process, the health care services
23 organization shall reimburse an enrollee for the enrollee's out-of-pocket
24 expense minus any deductible or copayment for a prescription drug that was
25 purchased by the enrollee without preauthorization but that was later
26 approved by the health care services organization.

27 2. Develop and maintain a process by which health care professionals
28 may request authorization for medically necessary nonformulary prescription
29 drugs. The health care services organization shall approve an alternative
30 prescription drug when either of the following conditions is met:

31 (a) The equivalent prescription drug on the formulary has been
32 ineffective in the treatment of the enrollee's disease or condition.

33 (b) The equivalent prescription drug on the formulary has caused an
34 adverse or harmful reaction in the enrollee.

35 C. If the health care services organization's pharmacy benefit plan
36 does not require authorization, subsection B, paragraph 2 of this section
37 does not apply.

38 D. If the enrollee's treating health care professional makes a
39 determination that the enrollee meets any of the conditions described in
40 subsection B of this section, any denial to cover the nonformulary
41 prescription drug by the health care services organization shall be made in
42 writing by a licensed pharmacist or medical director. The written denial
43 shall contain an explanation of the denial, including the medical or
44 pharmacological reasons why the authorization was denied, and the licensed
45 pharmacist or medical director who made the denial shall sign it. The health

1 care services organization shall send a copy of the written denial to the
2 enrollee's treating health care professional who requested the authorization.
3 The health care services organization shall maintain copies of all written
4 denials and shall make the copies available to the department for inspection
5 during regular business hours.

6 E. Any evidence of coverage that is issued, amended or renewed by a
7 health care services organization and that includes prescription drug
8 benefits shall not limit or exclude coverage for at least sixty days after
9 the health care services organization's notice or the pharmacy's notice
10 pursuant to subsection F of this section to the enrollee, whichever occurs
11 first, for a prescription drug for an enrollee to refill a previously
12 prescribed drug if the prescription drug was previously approved for coverage
13 under the drug formulary or pharmacy benefit plan for the enrollee's medical
14 condition and the health care professional continues to prescribe the
15 prescription drug for the same medical condition. The limitation or
16 exclusion prohibited by this subsection applies if the prescription drug is
17 appropriately prescribed and is considered safe and effective for treating
18 the enrollee's medical condition. This subsection does not prohibit the
19 health care professional from prescribing another prescription drug that is
20 covered by the drug formulary and that is medically appropriate for the
21 enrollee, including generic drug substitutions.

22 F. A health care services organization shall provide written notice of
23 the removal of any prescription drug from the health care services
24 organization's drug formulary to each pharmacy vendor with which the health
25 care services organization has a contract. On notice from the health care
26 services organization, the contracted pharmacy vendor at the point of
27 dispensing a prescription drug that has been removed from the drug formulary
28 shall notify the enrollee by means of a verbal consultation or other direct
29 communication with an enrollee that the enrollee may be required to consult
30 with a health care professional to obtain a new prescription for a
31 replacement drug after the sixty day period prescribed in subsection E of
32 this section. The notice prescribed in this subsection is not required if
33 the pharmacy vendor is a pharmacy that is owned by a health care services
34 organization or a corporate affiliate of that health care services
35 organization.

36 G. A HEALTH CARE SERVICES ORGANIZATION WITH A PRESCRIPTION DRUG
37 BENEFIT THAT USES A MULTITIERED DRUG FORMULARY AS A COMPONENT OF AN EVIDENCE
38 OF COVERAGE SHALL NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION
39 DRUG TO A DIFFERENT TIER OF THE FORMULARY DURING THE TERM OF THE EVIDENCE OF
40 COVERAGE. IF A HEALTH CARE SERVICES ORGANIZATION PLANS TO RECLASSIFY
41 BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG TO A DIFFERENT TIER OF THE
42 FORMULARY IN A SUBSEQUENT TERM OF THE EVIDENCE OF COVERAGE, THE HEALTH CARE
43 SERVICES ORGANIZATION SHALL GIVE THE ENROLLEE SIXTY DAYS' NOTICE REGARDING
44 THE IMPENDING CHANGE.

1 ~~G.~~ H. This section does not:

2 1. Prohibit a health care services organization from applying
3 deductibles, coinsurance or other cost containment or quality assurance
4 measures.

5 2. Apply to a health care services organization that provides a
6 multitiered benefit plan that allows access to prescription drugs without
7 authorization by the health care services organization.

8 ~~H.~~ I. For the purposes of this section:

9 1. "Health care professional" means a person who has an active
10 nonrestricted license pursuant to title 32 and WHO is authorized to write
11 drug prescriptions to treat medical conditions.

12 2. "Prescription drug" means any prescription medication as defined in
13 section 32-1901 that is prescribed by a health care professional to an
14 enrollee to treat the enrollee's condition.

15 Sec. 3. Title 20, chapter 6, article 4, Arizona Revised Statutes, is
16 amended by adding section 20-1342.07, to read:

17 20-1342.07. Prescription medications; formularies; notice

18 A DISABILITY INSURER WITH A PRESCRIPTION DRUG BENEFIT THAT USES A
19 MULTITIERED DRUG FORMULARY AS A COMPONENT OF A DISABILITY INSURANCE POLICY
20 SHALL NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG TO A
21 DIFFERENT TIER OF THE FORMULARY DURING THE TERM OF THE POLICY. IF A
22 DISABILITY INSURER PLANS TO RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED
23 PRESCRIPTION DRUG TO A DIFFERENT TIER OF THE FORMULARY IN A SUBSEQUENT TERM
24 OF THE DISABILITY INSURANCE POLICY, THE DISABILITY INSURER SHALL GIVE THE
25 INSURED SIXTY DAYS' NOTICE REGARDING THE IMPENDING CHANGE.

26 Sec. 4. Title 20, chapter 6, article 5, Arizona Revised Statutes, is
27 amended by adding sections 20-1402.05 and 20-1404.05, to read:

28 20-1402.05. Prescription medications; formularies; notice

29 A GROUP DISABILITY INSURER WITH A PRESCRIPTION DRUG BENEFIT THAT USES A
30 MULTITIERED DRUG FORMULARY AS A COMPONENT OF A GROUP DISABILITY POLICY SHALL
31 NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG TO A DIFFERENT
32 TIER OF THE FORMULARY DURING THE TERM OF THE POLICY. IF A GROUP DISABILITY
33 INSURER PLANS TO RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG
34 TO A DIFFERENT TIER OF THE FORMULARY IN A SUBSEQUENT TERM OF THE GROUP
35 DISABILITY POLICY, THE DISABILITY INSURER SHALL GIVE THE INSURED SIXTY DAYS'
36 NOTICE REGARDING THE IMPENDING CHANGE.

37 20-1404.05. Prescription medications; formularies; notice

38 A BLANKET DISABILITY INSURER WITH A PRESCRIPTION DRUG BENEFIT THAT USES
39 A MULTITIERED DRUG FORMULARY AS A COMPONENT OF A BLANKET DISABILITY POLICY
40 SHALL NOT RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED PRESCRIPTION DRUG TO A
41 DIFFERENT TIER OF THE FORMULARY DURING THE TERM OF THE POLICY. IF A BLANKET
42 DISABILITY INSURER PLANS TO RECLASSIFY BIOLOGICS OR A PLASMA-DERIVED
43 PRESCRIPTION DRUG TO A DIFFERENT TIER OF THE FORMULARY IN A SUBSEQUENT TERM
44 OF THE BLANKET DISABILITY POLICY, THE BLANKET DISABILITY INSURER SHALL GIVE
45 THE INSURED SIXTY DAYS' NOTICE REGARDING THE IMPENDING CHANGE.