Senate Engrossed

pharmacy benefits; prescribing; exemption

State of Arizona
Senate
Fifty-seventh Legislature
First Regular Session
2025

CHAPTER 5

SENATE BILL 1102

AN ACT

AMENDING TITLE 20, CHAPTER 25, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-3335 AND 20-3336; RELATING TO PHARMACY BENEFIT MANAGERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Title 20, chapter 25, article 2, Arizona Revised Statutes, is amended by adding sections 20-3335 and 20-3336, to read:

20-3335. Pharmacy benefit managers; prescribing; formulary change; notice; exemption enforcement; applicability; definitions

A. A PHARMACY BENEFIT MANAGER THAT ENTERS INTO AN AGREEMENT WITH A HEALTH CARE INSURER TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES TO COVERED INDIVIDUALS ON BEHALF OF THE PHARMACY BENEFIT MANAGER OR A HEALTH CARE INSURER MAY NOT LIMIT OR EXCLUDE COVERAGE OF A PRESCRIPTION DRUG FOR ANY COVERED INDIVIDUAL WHO IS ON A SPECIFIC PRESCRIPTION DRUG IF BOTH OF THE FOLLOWING APPLY:

1. THE PRESCRIPTION DRUG WAS PREVIOUSLY APPROVED BY THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER FOR COVERAGE FOR THE COVERED INDIVIDUAL.

2. THE COVERED INDIVIDUAL CONTINUES TO BE AN INSURED, ENROLLEE OR SUBSCRIBER OF THE HEALTH CARE INSURER THAT THE PHARMACY BENEFIT MANAGER HAS CONTRACTED WITH TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES.

B. IF SUBSECTION A OF THIS SECTION APPLIES, THE DRUG COVERAGE SHALL CONTINUE FOR A COVERED INDIVIDUAL'S SPECIFIC PRESCRIPTION DRUG THROUGH THE LAST DAY OF THE COVERED INDIVIDUAL'S HEALTH CARE PLAN YEAR.

C. A PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER MAY NOT CHANGE A COVERED INDIVIDUAL FROM THE PREVIOUSLY COVERED PRESCRIPTION DRUG IF THE COVERED INDIVIDUAL'S PRESCRIBING HEALTH CARE PROVIDER PROVIDES ELECTRONIC OR WRITTEN NOTICE TO THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER NOTIFYING THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER THAT THE COVERED INDIVIDUAL WILL CONTINUE ON THE CURRENT PRESCRIPTION DRUG.

D. IF A PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER MAKES ANY FORMULARY CHANGE THAT LIMITS OR EXCLUDES COVERAGE OF A PRESCRIPTION DRUG, THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER SHALL PROVIDE ELECTRONIC OR WRITTEN NOTICE OF THE REMOVAL OF OR CHANGE FOR ANY PRESCRIPTION DRUG ON THE DRUG FORMULARY TO EACH IMPACTED COVERED INDIVIDUAL AND THE IMPACTED COVERED INDIVIDUAL'S PRESCRIBING HEALTH CARE PROVIDER AT LEAST SIXTY DAYS BEFORE THE FORMULARY CHANGE. THE NOTICE SHALL DO BOTH OF THE FOLLOWING:

1. SET FORTH THE PROCESS BY WHICH THE COVERED INDIVIDUAL'S HEALTH CARE PROVIDER MAY NOTIFY THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER FOR THE CONTINUED USE OF THE NONFORMULARY PRESCRIPTION DRUGS.

2. INCLUDE NOTIFICATION TO THE PRESCRIBING HEALTH CARE PROVIDER THAT IF THE HEALTH CARE PROVIDER NOTIFIES THE PHARMACY BENEFIT MANAGER OR HEALTH CARE INSURER THAT THE INSURED, ENROLLEE OR SUBSCRIBER WILL CONTINUE ON THE NONFORMULARY PRESCRIPTION DRUG FOR THE REMAINDER OF THE HEALTH CARE PLAN YEAR, THE HEALTH CARE PROVIDER WILL NEED TO APPLY FOR A FORMULARY EXCEPTION PURSUANT TO SECTION 20-3336 FOR THE CONTINUED USE OF THE NONFORMULARY PRESCRIPTION DRUG ON RENEWAL OF THE HEALTH CARE PLAN.

E. THIS SECTION DOES NOT:

1. PREVENT A HEALTH CARE PROVIDER FROM PRESCRIBING ANOTHER PRESCRIPTION DRUG THAT IS COVERED BY THE HEALTH CARE INSURER OF THE PHARMACY BENEFIT MANAGER IF THE HEALTH CARE PROVIDER DEEMS THE PRESCRIPTION DRUG MEDICALLY NECESSARY FOR THE COVERED INDIVIDUAL.

2. PREVENT A HEALTH CARE INSURER OR PHARMACY BENEFIT MANAGER THAT IS CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES FROM:

(a) ADDING A PRESCRIPTION DRUG TO ITS FORMULARY.

(b) REMOVING A PRESCRIPTION DRUG FROM ITS FORMULARY IF THE DRUG MANUFACTURER HAS REMOVED THE PRESCRIPTION DRUG FOR SALE IN THE UNITED STATES.

(c) MAKING ANY FORMULARY CHANGES FOR PATIENTS WHO ARE NOT ON A PREVIOUSLY APPROVED PRESCRIPTION DRUG.

F. IF A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT VIOLATES THIS SECTION, THE DIRECTOR MAY ENFORCE THIS SECTION PURSUANT TO SECTION 20-3333 OR CHAPTER 15, ARTICLE 1 OF THIS TITLE, AS APPLICABLE.

G. THIS SECTION APPLIES ONLY TO PHARMACY BENEFIT MANAGERS THAT ARE SUBJECT TO SECTION 20-3333.

H. FOR THE PURPOSES OF THIS SECTION:

1. "HEALTH CARE INSURER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-2501.

2. "HEALTH CARE PLAN" MEANS A POLICY, CONTRACT OR EVIDENCE OF COVERAGE THAT A HEALTH CARE INSURER ISSUES TO AN INSURED, ENROLLEE OR SUBSCRIBER.

3. "LIMIT OR EXCLUDE COVERAGE" MEANS TO:

(a) LIMIT OR REDUCE THE MAXIMUM COVERAGE OF PRESCRIPTION DRUG BENEFITS.

(b) INCREASE COST SHARING FOR A COVERED PRESCRIPTION DRUG.

(c) REQUIRE AN ADDITIONAL PRIOR AUTHORIZATION FOR A PATIENT WHO IS CURRENTLY APPROVED FOR A PRESCRIPTION DRUG BASED SOLELY ON THE MOVEMENT OF THE PRESCRIPTION DRUG TO A MORE RESTRICTIVE FORMULARY TIER.

(d) REMOVE A PRESCRIPTION DRUG FROM A FORMULARY UNLESS EITHER OF THE FOLLOWING APPLIES:

(i) THE UNITED STATES FOOD AND DRUG ADMINISTRATION REVOKES APPROVAL FOR OR REMOVES A PRESCRIPTION DRUG FROM THE PRESCRIPTION DRUG MARKET.

(ii) THE PRESCRIPTION DRUG MANUFACTURER NOTIFIES THE UNITED STATES FOOD AND DRUG ADMINISTRATION OF A MANUFACTURING DISCONTINUATION OR A POTENTIAL DISCONTINUATION AS REQUIRED BY SECTION 506C OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT (21 UNITED STATES CODE SECTION 356c).

4. "UTILIZATION REVIEW AGENT" MEANS A UTILIZATION REVIEW AGENT AS DEFINED IN SECTION 20-2530 THAT IS CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES FOR A HEALTH CARE INSURER.

20-3336. Pharmacy benefit managers; prescribing; formulary exception process requirements; exception; enforcement; definitions

A. ON RENEWAL OF A HEALTH CARE PLAN, A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL PROVIDE A COVERED INDIVIDUAL AND PRESCRIBING HEALTH CARE PROVIDER WITH ACCESS TO A CLEAR AND CONVENIENT PROCESS TO REQUEST A FORMULARY EXCEPTION PROCESS. THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT MAY USE ITS EXISTING FORMULARY EXCEPTION PROCESS TO SATISFY THIS REQUIREMENT IF THE MEDICAL EXCEPTIONS PROCESS IS CONSISTENT WITH THE REQUIREMENTS PRESCRIBED IN THIS SECTION.

B. A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL RESPOND TO A FORMULARY EXCEPTION DETERMINATION REQUEST WITHIN SEVENTY-TWO HOURS AFTER RECEIVING THE FORMULARY EXCEPTION REQUEST AND RELEVANT CLINICAL DOCUMENTATION. THE COVERED INDIVIDUAL OR THE COVERED INDIVIDUAL'S PRESCRIBING HEALTH CARE PROVIDER MAY REQUEST AN EXPEDITED REVIEW IN CASES WHERE EXIGENT CIRCUMSTANCES EXIST, AND THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL RESPOND WITHIN TWENTY-FOUR HOURS AFTER RECEIVING THE FORMULARY EXCEPTION REQUEST AND RELEVANT CLINICAL DOCUMENTATION.

C. FOR A COVERED INDIVIDUAL WHO RENEWS THE SAME HEALTH CARE PLAN, A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL APPROVE A FORMULARY EXCEPTION FOR THE COVERED INDIVIDUAL IF THE COVERED INDIVIDUAL HAS BEEN PREVIOUSLY APPROVED TO RECEIVE THE NONFORMULARY PRESCRIPTION DRUG UNDER THE SAME HEALTH CARE PLAN AND THE PRESCRIBING HEALTH CARE PROVIDER USES THE FORMULARY EXCEPTION PROCESS AND PROVIDES RELEVANT CLINICAL DOCUMENTATION TO CERTIFY ALL OF THE FOLLOWING:

1. THE COVERED INDIVIDUAL HAS TRIED A FORMULARY EQUIVALENT PRESCRIPTION DRUG THAT WAS A PART OF THE COVERED INDIVIDUAL'S PRESCRIPTION DRUG BENEFIT AT THE TIME OF THE TRIAL, THE FORMULARY EQUIVALENT PRESCRIPTION DRUG WAS NOT EFFECTIVE IN THE TREATMENT OF THE COVERED INDIVIDUAL'S MEDICAL CONDITION AND THE HEALTH CARE PROVIDER SPECIFIES THE CONTRAINDICATION OR ADVERSE OR HARMFUL REACTION IN THE COVERED INDIVIDUAL.

2. THE COVERED INDIVIDUAL HAS EXPERIENCED A POSITIVE THERAPEUTIC OUTCOME ON THE REQUESTED DRUG FOR MORE THAN NINETY DAYS.

3. FORMULARY EQUIVALENT PRESCRIPTION DRUGS ARE CONTRAINDICATED OR WILL LIKELY CAUSE A SERIOUS ADVERSE REACTION.

D. IF A COVERED INDIVIDUAL DOES NOT QUALIFY FOR A FORMULARY EXCEPTION PURSUANT TO SUBSECTION C OF THIS SECTION, THE COVERED INDIVIDUAL MAY STILL APPLY FOR A FORMULARY EXCEPTION USING THE HEALTH CARE INSURER'S, PHARMACY BENEFIT MANAGER'S OR UTILIZATION REVIEW AGENT'S FORMULARY EXCEPTION PROCESS. WHEN EVALUATING WHETHER THE COVERED INDIVIDUAL SHOULD QUALIFY FOR A FORMULARY EXCEPTION TO CONTINUE ON A NONFORMULARY PRESCRIPTION DRUG, THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL CONSIDER THE FOLLOWING FACTORS:

1. WHETHER THE COVERED INDIVIDUAL HAS EXPERIENCED A POSITIVE THERAPEUTIC OUTCOME ON THE PREVIOUSLY APPROVED DRUG.

2. WHETHER THE FORMULARY PRESCRIPTION DRUG IS NOT IN THE BEST INTEREST OF THE COVERED INDIVIDUAL BASED ON MEDICAL NECESSITY BECAUSE THE COVERED INDIVIDUAL'S USE OF THE FORMULARY PRESCRIPTION DRUG IS EXPECTED TO CAUSE EITHER OF THE FOLLOWING:

(a) A NEGATIVE IMPACT ON THE COVERED INDIVIDUAL'S COMORBID CONDITION.

(b) A CLINICALLY PREDICTABLE NEGATIVE DRUG INTERACTION.

3. WHETHER THE FORMULARY PRESCRIPTION DRUG IS CONTRAINDICATED OR WILL LIKELY CAUSE A SERIOUS ADVERSE REACTION.

E. A HEALTH CARE INSURER'S OR PHARMACY BENEFIT MANAGER'S DENIAL OF COVERAGE FOR A NONFORMULARY PRESCRIPTION DRUG SHALL BE MADE IN WRITING TO THE COVERED INDIVIDUAL BY A LICENSED PHARMACIST OR MEDICAL DIRECTOR WHO MADE THE DECISION TO DENY COVERAGE. THE WRITTEN DENIAL SHALL CONTAIN AN EXPLANATION OF THE DENIAL THAT INCLUDES THE MEDICAL OR PHARMACOLOGICAL REASONS WHY THE AUTHORIZATION WAS DENIED. THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL SEND A COPY OF THE WRITTEN DENIAL TO THE COVERED INDIVIDUAL'S TREATING HEALTH CARE PROVIDER WHO REQUESTED THE FORMULARY EXCEPTION. THE HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL MAINTAIN COPIES

OF ALL WRITTEN DENIALS AND SHALL MAKE THE COPIES AVAILABLE TO THE DEPARTMENT FOR INSPECTION. A COVERED INDIVIDUAL OR THE COVERED INDIVIDUAL'S AUTHORIZED REPRESENTATIVE MAY APPEAL ANY DETERMINATION TO DENY A FORMULARY EXCEPTION UNDER CHAPTER 15, ARTICLE 2 OF THIS TITLE. THE WRITTEN NOTIFICATION SHALL INCLUDE THE PROCESS BY WHICH A COVERED INDIVIDUAL MAY APPEAL THE DETERMINATION.

F. A FORMULARY EXCEPTION FOR A COVERED INDIVIDUAL THAT IS AUTHORIZED BY A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT SHALL BE IN EFFECT UNTIL THE END OF THE COVERED INDIVIDUAL'S PLAN YEAR. THE APPROVAL OF A FORMULARY EXCEPTION SHALL BE IN WRITING AND DELIVERED TO THE COVERED INDIVIDUAL AND THE COVERED INDIVIDUAL'S TREATING HEALTH CARE PROVIDER.

G. THIS SECTION DOES NOT:

1. PREVENT A HEALTH CARE PROVIDER FROM PRESCRIBING ANOTHER PRESCRIPTION DRUG THAT IS COVERED BY THE HEALTH CARE INSURER OR THE PHARMACY BENEFIT MANAGER IF THE HEALTH CARE PROVIDER DEEMS THE PRESCRIPTION DRUG MEDICALLY NECESSARY FOR THE COVERED INDIVIDUAL.

2. PREVENT A HEALTH CARE INSURER OR PHARMACY BENEFIT MANAGER THAT IS CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES FROM MANAGING ITS FORMULARY IN COMPLIANCE WITH THIS SECTION, INCLUDING:

(a) ADDING A PRESCRIPTION DRUG TO ITS FORMULARY.

(b) REMOVING A PRESCRIPTION DRUG FROM ITS FORMULARY IF THE DRUG MANUFACTURER HAS REMOVED THE PRESCRIPTION DRUG FOR SALE IN THE UNITED STATES.

(c) SETTING THE COST SHARING FOR NONFORMULARY PRESCRIPTION DRUGS.

H. IF A HEALTH CARE INSURER, PHARMACY BENEFIT MANAGER OR UTILIZATION REVIEW AGENT VIOLATES THIS SECTION, THE DIRECTOR MAY ENFORCE THIS SECTION PURSUANT TO SECTION 20-3333 OR CHAPTER 15, ARTICLE 1 OF THIS TITLE, AS APPLICABLE.

I. A POLICY THAT IS ISSUED OR RENEWED BY A DISABILITY INSURER DOES NOT INCLUDE A POLICY THAT PROVIDES LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.

J. THIS SECTION APPLIES ONLY TO PHARMACY BENEFIT MANAGERS THAT ARE SUBJECT TO SECTION 20-3333.

K. FOR THE PURPOSES OF THIS SECTION:

1. "EXIGENT CIRCUMSTANCES" MEANS A COVERED INDIVIDUAL IS SUFFERING FROM A HEALTH CONDITION THAT MAY SERIOUSLY JEOPARDIZE THE COVERED INDIVIDUAL'S LIFE, HEALTH OR ABILITY TO REGAIN MAXIMUM FUNCTION OR WHEN A

COVERED INDIVIDUAL IS UNDERGOING A CURRENT COURSE OF TREATMENT USING A NONFORMULARY PRESCRIPTION DRUG.

2. "FORMULARY EXCEPTION" MEANS THAT HEALTH PLAN COVERAGE OF A HEALTH CARE PROVIDER'S SELECTED PRESCRIPTION DRUG IS GRANTED.

3. "HEALTH CARE INSURER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-2501.

4. "HEALTH CARE PLAN" MEANS A POLICY, CONTRACT OR EVIDENCE OF COVERAGE THAT A HEALTH CARE INSURER ISSUES TO AN INSURED, ENROLLEE OR SUBSCRIBER.

5. "UTILIZATION REVIEW AGENT" MEANS A UTILIZATION REVIEW AGENT AS DEFINED IN SECTION 20-2530 THAT IS CONTRACTED TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES FOR A HEALTH CARE INSURER.

Sec. 2. Applicability

This act applies to contracts, policies or evidences of coverage that are entered into, amended, extended or renewed on or after December 31, 2025.

APPROVED BY THE GOVERNOR MARCH 25, 2025.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 25, 2025.