Know Your State
INTERACTIVE TOOL

Help patients learn about medication access and affordability options one state at a time

This interactive tool provides information on affordability options for patients. Topics covered include:

- Advocacy Connector
- Biosimilar Legislation
- Continuity of Care
- Low-Income Subsidy (LIS) Eligibility Information*
- Medicaid Expansion
- National Foundations & Other Non-profit Resources
- Oral Parity Laws
- Standard Prior Authorization (PA) Forms
- State Health Insurance Assistance Programs (SHIPs)
- State Legislature Resources
- State Pharmaceutical Assistance Programs (SPAPs)

*Only LIS plans listed as basic/$0 premium are included in this resource. Please visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2020-PDP-Landscape-Source-Files-v-10-15-19.zip to see all plans available in your state.
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Know Your State

NAVIGATION TIPS

Select the HOME button to go to the beginning of this document.

Select the MAP button to access the Affordability Options map page.

Select the BACK button to return to the page you viewed last.

Select the PREVIOUS button to go to the previous page.

Select the NEXT button to go to the next page.

To “zoom in” or “zoom out” on any page in this document, hold down the command key (Mac) or control key (Windows) and then also hold down the + or - key.

To make full screen, select the command key or control key with the number zero key also selected.

Please note, these zoom shortcuts are only applicable when viewing this document on desktop or laptop computers.

PLEASE NOTE
For the best possible navigation experience, this PDF should be opened using Adobe Acrobat Reader, which can be downloaded here.
Affordability Options
INTERACTIVE MAP

For general medication access and affordability options resources, please visit the National Foundations or the Advocacy Connector pages within this document.

CLICK ON A STATE IN THIS MAP TO LEARN MORE ABOUT STATE-SPECIFIC AFFORDABILITY OPTIONS*

* As of December 31, 2020
ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:

LOW-INCOME SUBSIDY (LIS) PROGRAMS

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Alabama include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, and WellCare Classic.

STANDARD PRIOR AUTHORIZATION (PA) FORM

• As of December 2020, a standard PA form has not been instituted in the state of Alabama.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:
• Alabama does not appear to have any laws or regulations specifically applicable to continuity of care/non-medical switching of prescription drugs.

STEP THERAPY:
• Alabama does not appear to have any laws or regulations specifically applicable to step therapy/fail-first requirements. However, the state Medicaid regulations provide for coverage of up to 10 brand name prescription drugs through overrides for specific drugs in cases where the prescribing physician documents medical necessity.

ORAL PARITY LAW

• As of December 2020, Alabama has not passed legislation regarding oral parity.

MEDICAID EXPANSION

• As of December 2020, Alabama has not expanded Medicaid.

BIOSIMILAR LAW

• Effective September 1, 2019, with the express permission of the prescribing practitioner, pharmacists may substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” by the U.S. Food and Drug Administration (FDA), is less expensive than the reference biologic, and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME:

State Health Insurance Assistance Program (SHIP)
Phone: 1-800-243-5463

ABOUT:
• Alabama has SHIP coordinators and insurance counselors. SHIP counselors are committed volunteers who are knowledgeable about issues affecting Medicare beneficiaries.
• SHIP counselors provide information to assist in making informed choices regarding insurance benefits. The counselors are not affiliated with any insurance companies and do not attempt to sell insurance. All counseling records are strictly confidential.
• SHIP is a partnership with the Centers for Medicare & Medicaid Services, the Alabama Department of Senior Services, and the Area Agencies on Aging.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

Alabama AIDS Drug Assistance Program
Phone: 1-866-574-9964

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials
ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

To view a glossary of common healthcare terms, visit: http://khn.org/glossary/

LOW-INCOME SUBSIDY (LIS) PROGRAMS

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Alaska include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxPlus, Express Scripts Medicare - Value, Humana Basic Rx Plan, and WellCare Classic.

STANDARD PRIOR AUTHORIZATION (PA) FORM

• As of December 2020, a standard PA form has not been instituted in the state of Alaska.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:
• Alaska does not appear to have any continuity of care provisions or non-medical switching limitations that apply specifically to prescription drug coverage.

STEP THERAPY:
• Alaska does not appear to have any laws or regulations specifically applicable to step therapy/fail-first requirements. Alaska Medicaid does have several provisions related to prior authorization with limited exceptions.

ORAL PARITY LAW

• Alaska enacted legislation, effective January 1, 2016, that directs health benefit plans that provide coverage for cancer chemotherapy treatment to extend coverage for orally administered anti-cancer medication at a cost equal to the cost of intravenously administered or injected anti-cancer medications.

MEDICAID EXPANSION

• Because Alaska has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Alaska, click here.

BIOSIMILAR LAW

• Effective January 1, 2019, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. The pharmacist must notify the prescribing practitioner and the patient about the substitution and obtain patient consent. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME:
State Health Insurance Assistance Programs (SHIP) & Senior Medicare Patrol (SMP)
Phone: 1-800-478-6065

ABOUT:
• Alaskans are helping Alaskans get more out of their Medicare via two programs: State Health Insurance Assistance Programs (SHIP) and Senior Medicare Patrol (SMP).
• SHIP provides one-on-one personalized counseling, education, and outreach to Medicare beneficiaries and their families, allowing them to better understand and utilize their Medicare benefits.
• A large network of counselors across the state helps beneficiaries understand and navigate Medicare and other health insurance programs and plans.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

Alaskan AIDS Assistance Association (ADAP)
Phone: 1-800-478-AIDS

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

References:
LOW-INCOME SUBSIDY (LIS) PROGRAMS

Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Arizona include: AARP® MedicareRx Saver Plus, Blue MedicareRx Value, Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxPlus, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

As of December 2020, a standard PA form has not been instituted in the state of Arizona.2

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/ NON-MEDICAL SWITCHING:

Arizona requires health insurers to cover a previously prescribed drug for 60 days after notice of the coverage change is made to the enrollee through the dispensing pharmacy.

STEP THERAPY:

Arizona does not appear to have any laws or regulations specifically applicable to step therapy/fail-first requirements, but does require health plans to develop and maintain a process by which enrollees, through their treating healthcare professionals, can request authorization for a medically necessary non-formulary drug. Plans must approve such requests if “the equivalent drug on the formulary has been ineffective in the treatment of the patient’s disease or condition” or has caused an adverse or harmful reaction.

ORAL PARITY LAW

On January 1, 2016, Arizona adopted an oral parity law to direct payers that provide coverage for cancer chemotherapy treatment to (1) extend coverage for orally administered anti-cancer medication at a cost equal to the cost of intravenously administered or injected anti-cancer medications, and (2) to maintain established cost-sharing rates and benefit classification for intravenous and/or injectable treatments (i.e., rates cannot be increased in order to comply with this legislation).2

MEDICAID EXPANSION

Because Arizona has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. However, Arizona has obtained federal approval to require that non-exempt individuals work a certain number of hours per month to be eligible for Medicaid benefits. As of January 2020, this work requirement has not yet been implemented. For more details on Medicaid expansion in Arizona, click here.3

BIOSIMILAR LAW

In Arizona, biosimilar substitution laws that went into effect on December 31, 2016, allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.4

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME: State Health Insurance Assistance Program (SHIP)
Phone: 1-800-432-4040
ABOUT:

• The Arizona SHIP is a free health benefits counseling service for Medicare beneficiaries.
• SHIP in Arizona can be contacted 24 hours a day. If a message is left, a SHIP volunteer will return the call.
• To locate local SHIP offices, click here.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

Arizona AIDS Drug Assistance Program (ADAP)
Phone: 1-800-334-1540 or 1-602-364-3610

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.
Arkansas law also prohibits an insurance policy that provides coverage for maintenance drugs unless the prescriber and enrollee agree to such a change. A maintenance drug is defined as a drug prescribed by a practitioner who is licensed to prescribe drugs for the treatment of metastatic cancer from limiting or excluding coverage for the prescribed reference biologic only if it is deemed to be an "interchangeable" by the U.S. Food and Drug Administration (FDA), would save costs for the patient, and meets other state law requirements. Currently, there are no interchangeable biological products. 2

ADDITIONAL PROGRAMS/RESOURCES

LOW-INCOME SUBSIDY (LIS) PROGRAMS
- Medicare patients who have limited income and resources may qualify for "Extra Help" to pay for prescription drugs. The LIS programs in California include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Elixir RxSecure, Humana Basic Rx Plan, SilverScript Choice, and WellCare Classic.

STANDARD PRIOR AUTHORIZATION (PA) FORM
- Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in California to help simplify and streamline the PA process for prescription drugs. The form is available here.

TREATMENT ACCESS: GET ON IT AND STAY ON IT
- California law protects against non-medical switching limitations by prohibiting health plans from "limiting or excluding" coverage for a previously prescribed drug as long as the provider continues to prescribe it, and the drug is considered "safe and effective" for the enrollee’s medical condition. However, this provision does not preclude a plan from "charging the enrollee a co-payment or deductible," and it remains unclear whether this means the provider can continue covering the excluded drug at the same patient cost sharing level. The prohibitions on formularies from discouraging the enrollment of individuals with health conditions is in place until January 1, 2024. Additionally, California law prohibits a drug formulary maintained by a healthcare service plan or a health insurer from containing more than four tiers and requires that an enrollee or insured not pay more than the retail price for a prescription drug if the pharmacy’s retail price is less than the applicable co-payment or coinsurance amount until January 1, 2024.

ORAL PARITY LAW
- Effective January 1, 2019, legislation raised the limit on co-payments and coinsurance payments that an enrollee may be charged for a 30-day supply of an oral anticancer medication to $250. The law will expire in 2024.

MEDICAID EXPANSION
- Because California has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid Expansion in California, click here.

BIOSIMILAR LAW
- In California, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an "interchangeable" biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)
- California Department of Aging’s Health Insurance Counseling and Advocacy Program (HICAP)
  Phone: 1-800-510-2020
- HICAP provides personalized counseling, community education, and outreach events for Medicare beneficiaries.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)
- California AIDS Drug Assistance Program (ADAP)
  Phone: 1-844-421-7050
- Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

ADDITIONAL PROGRAMS/RESOURCES
- For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following state issues requiring legislative intervention.
  - National Foundations
  - Advocacy Connector
  - Elected Officials

References:
ADDITIONAL PROGRAMS/RESOURCES

- Medicare patients who have limited income and resources may qualify for "Extra Help" to pay for prescription drugs. The LIS programs in Colorado include: AARP® Medicare Rx Saver Plus, Cigna Secure Rx, Eli Lilly RxPlus, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

- Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in Colorado to help simplify and streamline the PA process for prescription drugs. The form is available here.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:

- Colorado law does not appear to include any continuity of care provisions and/or limitations on non-medical switching for prescription drug coverage. A December 2015 bulletin indicates that "it is the position of the Division of Insurance" that "replacement plan carriers" for managed care plans will ensure a "seamless transition of previously approved therapies," including "biologic medical therapy." It is unclear how plans have implemented the Division’s directive, which would only apply in the limited context of a patient transitioning between health plans.

STEP THERAPY:

- Colorado prohibits an insurance carrier from requiring a covered person to undergo step therapy when being treated for a terminal condition, or if the covered person has tried a step therapy-required drug under a health benefit plan and the drug was discontinued by the manufacturer. Effective January 2019, an insurance carrier that covers treatment for stage-four advanced metastatic cancer may not require a patient to follow a step therapy protocol prior to receiving a drug approved for treatment.

ORAL PARITY LAW

- Colorado’s oral parity law applies to health policies issued or renewed on or after January 1, 2011, and requires payers that provide coverage for cancer treatment to extend coverage for orally administered anti-cancer medication at a cost no less favorable to intravenously administered or injected cancer medications. Additionally, plans may not increase the out-of-pocket cost of IV or injected cancer treatments to achieve compliance.

MEDICAID EXPANSION

- Because Colorado has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Colorado, click here.

BIOSIMILAR LAW

- In Colorado, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an "interchangeable" biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

- The SHIP Program helps people enrolled in Medicare with questions about health insurance. Topics addressed include Medicare, supplemental insurance (Medigap), Medicare assistance for people on Medicare, and long-term care insurance. Counselors provide assistance regarding public education presentations about Medicare, related health insurance, and Medicare fraud. Consumers may contact their regional community program by calling toll-free.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

- CDPHE State Drug Assistance Program (SDAP)
  Phone: 1-303-692-2716
  Email: CDPHE.State.Drug.Assistance.Program@co.gov

COLORADO BRIDGING THE GAP
  Phone: 1-303-692-2783 or 1-303-692-2716

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Connecticut include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Elixir RoSecure, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

• As of December 2020, a standard PA form has not been instituted in the state of Connecticut.2

• Because Connecticut has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Connecticut, click here.3

• Effective October 1, 2019, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. The pharmacist is required to notify the prescribing practitioner and the patient about the substitution. Currently, there are no interchangeable biological products.2

Currently, state law requires individual, group, and blanket health insurance policies to cover any medically appropriate drug approved by the FDA for any cancer treatment. Delaware includes: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

Because Delaware has expanded Medicaid, free or low-cost health care coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Delaware, click here.

In Delaware, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic if it is deemed to be an “interchangeable” biosimilar by the FDA and meets other state law requirements. Currently, there are no interchangeable biological products.

On January 1, 2013, an oral parity law was enacted to direct payers to provide coverage for anti-cancer medications to extend coverage of oral anti-cancer treatments at a cost no less favorable than the cost of intravenous or injected anti-cancer medications.

Due to Delaware’s expansion of Medicaid, provider enrollment is no longer required for prescription drugs for Medicaid members. Providers can contact the Delaware AIDS Drug Assistance Program (ADAP) to request assistance or fill out the enrollment form online at https://www.adap.directory/directory. ADAP offers help in understanding eligibility requirements for Medicaid and other insurance programs. To find out if you qualify, visit the ADAP directory at https://www.adap.directory/directory.
For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

Florida AIDS Drug Assistance Program (ADAP):
Phone: 1-850-245-4422

Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Florida include: Cigna Secure Rx, Clear Spring Health Value Rx, Express Scripts Medicare - Value, SilverScript Choice, and WellCare Classic.

Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in Florida to help simplify and streamline the PA process for prescription drugs. The form is available here.

As of December 2020, Florida has not expanded Medicaid.

In Florida, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

As of December 2020, Florida has not expanded Medicaid.

In Florida, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

To view a glossary of common healthcare terms, visit: http://khn.org/glossary/
For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

Georgia AIDS Drug Assistance Program (ADAP)
Phone: 1-404-463-0416

Program Name: GeorgiaCares
Phone: 1-866-552-4464

About:
- GeorgiaCares is a private-public partnership administered by the Georgia Department of Human Services (DHS) Division of Aging Services (DAS).
- A volunteer-based program that provides free, unbiased and factual information, and assistance to Medicare beneficiaries and their caregivers.
- Local GeorgiaCares offices can be contacted at 1-800-669-8387.

Georgia AIDS Drug Assistance Program (ADAP)5
Phone: 1-404-463-0416

Continuity of Care/Non-Medical Switching:
- Georgia does not appear to have any continuity of care provisions or non-medical switching limitations that apply specifically to prescription drug coverage, but does have protection related to the continued treatment by a physician.

Step Therapy:
- Health benefit plans that cover treatment for stage four advanced metastatic cancer are prohibited from limiting or excluding coverage of an FDA approved drug by requiring a fail-first process. Under Georgia law, health plans must grant exceptions to their step therapy requirements under certain circumstances.

Low-Income Subsidy (LIS) Programs

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Georgia include: Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Humana Basic Rx Plan, Indy Health Saver Rx, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

Standard Prior Authorization (PA) Form

- As of December 2020, a standard PA form has not been instituted in the state of Georgia.

Treatment Access: Get On It and Stay On It

- Under Georgia law, health plans must grant exceptions to their step therapy requirements under certain circumstances.

Oral Parity Law

- Georgia’s oral parity law applies to health policies issued or renewed on or after January 1, 2015, and requires payers that provide coverage for cancer treatment to extend coverage for orally administered anti-cancer medication at a cost no less favorable to intravenously administered or injected cancer medications. This legislation also mandates payers to not increase cost-sharing for IV treatments or reclassify benefits. Providers are in compliance with the law if they charge no more than $200 per prescription for the orally administered anti-cancer treatment.

Medicaid Expansion

- As of December 2020, Georgia has not expanded Medicaid.

Biosimilar Law

- In Georgia, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an "interchangeable" biosimilar by the FDA and meets other state law requirements. Currently, there are no interchangeable biological products.

State Health Insurance Assistance Programs (SHIPs)

- GeorgiaCares
Phone: 1-866-552-4464

About:
- GeorgiaCares is a private-public partnership administered by the Georgia Department of Human Services (DHS) Division of Aging Services (DAS).
- A volunteer-based program that provides free, unbiased and factual information, and assistance to Medicare beneficiaries and their caregivers.
- Local GeorgiaCares offices can be contacted at 1-800-669-8387.

State Pharmaceutical Assistance Programs (SPAPs)

- Georgia AIDS Drug Assistance Program (ADAP)
Phone: 1-404-463-0416

About:
- Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:

To view a glossary of common healthcare terms, visit: http://khn.org/glossary/
For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

LEARN MORE

Hawaii AIDS Drug Assistance Program (HDAP)
Phone: 1-808-733-9360

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

References:

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ADDITIONAL PROGRAMS/RESOURCES

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- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

Idaho Ryan White Part B AIDS Drug Assistance Program (ADAP)
Phone: 1-208-334-5612

PROGRAM NAME:
Senior Health Insurance Benefits Advisors (SHIBA)
Phone: 1-800-247-4422

ABOUT:
- SHIBA offers free and unbiased information, counseling, and assistance regarding senior health insurance. Volunteers/advocates are trained to provide individual counseling to seniors and their caregivers. Coordinators make educational presentations and disseminate information on Medicare and other senior health insurance issues.

Visit the following links for additional information:

- DSS Medicaid Programs
- AARP Medicare Rx Locator
- SilverScript Choice
- ClearSpring Health
- Elixir RxPlus
- Express Scripts Medicare: Value
- Humana Basic Rx Plan
- WellCare Classic
- WellCare Medicare Rx Saver

Idaho

- Because Idaho has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Idaho, click here.
- In Idaho, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.
- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Idaho include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, ClearSpring Health Value Rx, Elixir RxPlus, Express Scripts Medicare: Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

To view a glossary of common healthcare terms, visit: http://khn.org/glossary/

References:
ADDITIONAL PROGRAMS/RESOURCES

LOW-INCOME SUBSIDY (LIS) PROGRAMS
- Medicare patients who have limited income and resources may qualify for "Extra Help" to pay for prescription drugs. The LIS programs in Illinois include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixan RxPlus, Express Scripts Medicare - Value, Humana Basic Rx Plan, Indy Health SaverRx, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM
- As of July 1, 2020, all commercial insurers must use a standard PA form developed by the state. As of July 1, 2021, every prescribing provider must use the standard PA form.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:
- Health insurers must grant a formulary exception if, among other reasons, "the patient is stable on a prescription drug selected by his or her healthcare provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan." Additionally, the healthcare plan shall not modify an enrollee’s coverage of a drug during the plan year if certain conditions are met.

STEP THERAPY:
- Illinois requires health insurers that offer qualified health plans to implement an exceptions process for step therapy requirements and formulary exclusions and insurers must grant requests under certain circumstances.

ORAL PARITY LAW
- On January 1, 2012, an oral parity law was enacted to direct payers that provide coverage for cancer chemotherapy treatment to (1) extend coverage to orally administered anti-cancer medication at a cost no less favorable than the cost of intravenously administered or injected anti-cancer medications, and (2) maintain established cost-sharing rates and benefit classification for intravenous and/or injectable treatments (i.e., rates cannot be increased in order to comply with this legislation).

MEDICAID EXPANSION
- Because Illinois has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Illinois, click here.

BIOSIMILAR LAW
- In Illinois, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an "interchangeable" biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)
- The Illinois Ryan White Part B AIDS Drug Assistance Program (ADAP-Medication Assistance)
  Phone: 1-217-782-4977

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

ADDITIONAL PROGRAMS/RESOURCES
For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:
- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
ADDITIONAL PROGRAMS/RESOURCES

STEP THERAPY 2:
• Certain health plans must establish an exception process for any situation.

CONTINUITY OF CARE/NON-MEDICAL SWITCHING 2:
• As of January 1, 2018, insurers must accept and respond to preauthorization requests under the pharmacy benefit through a secure electronic transmission using the National Council for Prescription Drug Program’s (NCPDP) SCRIPT standard ePA transactions.

TREATMENT ACCESS: GET ON IT AND STAY ON IT
CONTINUITY OF CARE/NON-MEDICAL SWITCHING:
• Indiana offers some protection against formulary changes by requiring plans to provide an enrollee with a 60-day supply of a prescription drug subject to the formulary removal or change under the terms that applied before the removal or change.

STEP THERAPY:
• Certain health plans must establish an exception process for any step therapy requirements and grant exception requests in certain situations.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)
PROGRAM NAME:
Senior Health Insurance Program (SHIP)
Phone: 1-800-452-4800
TDD: 1-866-846-0139
ABOUT:
• SHIP sites are located throughout the state of Indiana. Patients can visit a local SHIP site in order to arrange an in-person counselor meeting or to have questions answered by phone.
• Counselors are trained volunteers who can answer questions about Medicare, Medicare Advantage, Medicare supplemental insurance, Medicaid, long-term care insurance, prescription coverage, or low-income assistance.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)
Indiana AIDS Drug Assistance Program (ADAP)
Phone: 1-866-588-4948
HoosierRx
Phone: 1-866-267-4679 or 1-317-234-1381

ADDITIONAL PROGRAMS/RESOURCES

ORAL PARITY LAW
• Effective July 1, 2009, Indiana law requires that coverage for orally administered cancer chemotherapy must not be subject to limits less favorable than for chemotherapy administered intravenously or by injection. Coverage for oral chemotherapy must not be subject to dollar limits, co-payments, deductibles, or coinsurance provisions that are less favorable to enrollees than the provisions that apply for intravenous or injected chemotherapy treatments.

MEDICAID EXPANSION
• Because Indiana has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. However, Indiana has obtained federal approval to require that non-exempt individuals work a certain number of hours per week to be eligible for Medicaid benefits, effective 2019. For more details on Medicaid expansion in Indiana, click here.

BIOSIMILAR LAW
• In Indiana, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

LOW-INCOME SUBSIDY (LIS) PROGRAMS
• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Indiana include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Aetna Basic Rx Plan, Clear Spring Health Value Rx, Elixir RxSecure, Express Scripts Medicare, SilverScript Choice, and WellCare Classic.

STANDARD PRIOR AUTHORIZATION (PA) FORM
• As of January 1, 2018, insurers must accept and respond to preauthorization requests under the pharmacy benefit through a secure electronic transmission using the National Council for Prescription Drug Program’s (NCPDP) SCRIPT standard ePA transactions.

REFERENCES:

To view a glossary of common healthcare terms, visit: [http://khn.org/glossary/].
For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
## State Health Insurance Counseling for Kansas (SHICK)
**Phone:** 1-800-860-5260

**About:**
- SHICK is a free program offering older Kansans an opportunity to talk with trained, community volunteers and get answers to questions about Medicare and other insurance issues. SHICK provides many resources to assist with navigating Medicare.
- Trained volunteer counselors help people stay informed on changing conditions in healthcare insurance and to simplify the process. Volunteers do not work for any insurance companies. Their purpose is to educate and assist the public to make informed decisions.

## Kansas AIDS Drug Assistance Program (ADAP)
**Phone:** 1-785-296-6174

### Low-Income Subsidy (LIS) Programs
- Medicare patients who have limited income and resources may qualify for "Extra Help" to pay for prescription drugs. The LIS programs in Kansas include:
  - Cigna Secure Rx
  - Clear Spring Health Value Rx
  - Express Scripts Medicare - Value
  - Humana Basic Rx Plan
  - SilverScript Choice
  - WellCare Classic
  - WellCare Medicare Rx Saver

### Oral Parity Law
- On April 1, 2010, an oral parity law was enacted to direct payers that provide coverage for cancer chemotherapy treatments to extend coverage for prescribed, orally administered anti-cancer medications at a cost no less favorable than the cost of intravenously administered anti-cancer medications.2

### Medicaid Expansion
- As of December 2020, Kansas has not expanded Medicaid.3

### Biosimilar Law
- In Kansas, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an "interchangeable" biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products. The law also requires pharmacists to notify the patient and prescriber of the substitution of a biological product within 5 days of the exchange and establishes recording requirements. A pharmacist may not substitute a biosimilar product for a biologic if the provider notes "dispense as written" on the prescription.2

### State Pharmaceutical Assistance Programs (SPAPs)
- [LEARN MORE](#)

### Standard Prior Authorization (PA) Form
- As of December 2020, a standard PA form has not been instituted in the state of Kansas.3

### Treatment Access: Get on It and Stay on It
- **Continuity of Care/Non-Medical Switching:**
  - Kansas does not appear to have continuity of care provisions or non-medical switching limitations that apply specifically to prescription drug coverage.
- **Step Therapy:**
  - Kansas Medicaid (KanCare) allows for health insurers to engage in step therapy, but requires that they grant exception requests in certain situations and provides for a 72-hour expedited appeal process. Additionally, step therapy may not be used in certain situations if a patient is receiving treatment for multiple sclerosis.

### State Health Insurance Assistance Programs (SHIPs)
- [LEARN MORE](#)

### Oral Parity Law
- [LEARN MORE](#)

### Medicaid Expansion
- [LEARN MORE](#)

### Biosimilar Law
- [LEARN MORE](#)

### State Pharmaceutical Assistance Programs (SPAPs)
- [LEARN MORE](#)

### Low-Income Subsidy (LIS) Programs
- [LEARN MORE](#)

### Standard Prior Authorization (PA) Form
- [LEARN MORE](#)

### Treatment Access: Get on It and Stay on It
- [LEARN MORE](#)

### State Health Insurance Counseling for Kansas (SHICK)
- [LEARN MORE](#)

### Kansas AIDS Drug Assistance Program (ADAP)
- [LEARN MORE](#)

### Additional Programs/Resources
- Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. [Click here](#) for additional information.

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References:
Kentucky

ADDITIONAL PROGRAMS/RESOURCES

• Kentucky has limitations on step therapy protocols, including requiring
  • STEP THERAPY 2:
  • Kentucky does not appear to have any continuity of care provisions
  • As of December 2020, a standard PA form has not been instituted in the

LOW-INCOME SUBSIDY (LIS) PROGRAMS

• Medicare patients who have limited income and resources may qualify
  for “Extra Help” to pay for prescription drugs. The LIS programs in

STANDARD PRIOR AUTHORIZATION (PA) FORM

• As of December 2020, a standard PA form has not been instituted in the state of Kentucky. 2

ORAL PARITY LAW

• Kentucky passed oral parity legislation for health policies issued
  or renewed on or after January 1, 2015. This law directs payers that
  provide coverage for cancer treatment to extend coverage for
  prescribed, orally administered anti-cancer medications at a cost to
  patients no less favorable than that of those receiving intravenously
  administered or injected anti-cancer therapies. 2
  • Additionally, if the total amount paid for oral anti-cancer medications
  is limited to $100 per prescription, they are also in compliance with
  the law. Plans may not increase the out-of-pocket cost to patients
  or reclassify benefits to achieve compliance. Finally, if a consumer
  purchases a high deductible health plan, the deductible must be met
  before the cap applies. 2

MEDICAID EXPANSION

• Because Kentucky has expanded Medicaid, free or low-cost health
  coverage is available to people with incomes below a certain level
  regardless of disability, family status, financial resources, and other
  factors that are usually taken into account in Medicaid eligibility
  decisions. For more details on Medicaid expansion in Kentucky,
  click here. 2

BIOSIMILAR LAW

• In Kentucky, biosimilar substitution laws allow pharmacists to
  substitute a biological product for the prescribed reference
  biologic only if it is deemed to be an “interchangeable” biosimilar
  by the U.S. Food and Drug Administration (FDA) and meets other
  state law requirements. Currently, there are no interchangeable
  biological products. 3

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

• Kentucky SHIP provides information, counseling, and assistance to
  seniors and disabled individuals, their family members, and caregivers.
  This service is provided at no charge.
  • The program seeks to educate the general public and Medicare
  beneficiaries so they are able to make informed decisions about their
  healthcare. SHIP does not sell anything. SHIP also works in partnership
  with the Kentucky Medicare Partners to provide outreach and
  education to people with Medicare.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

• Kentucky AIDS Drug Assistance Program (KADAP)
  Phone: 1-866-510-0005

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well
as questions or concerns regarding state issues requiring legislative
intervention, please visit the following
pages within this document:
• National Foundations
• Advocacy Connector
• Elected Officials

Eligible veterans may be able to receive care
from participating community providers
through the Veteran Community Care
Program. Click here for additional
information.

• Medicare patients who have limited income and resources may qualify for "Extra Help" to pay for prescription drugs. The LIS programs in Louisiana include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, ClearSpring Health Value Rx, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.1

STANDARD PRIOR AUTHORIZATION (PA) FORM
• Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in Louisiana to help simplify and streamline the PA process for prescription drugs. The form is available here.2

TREATMENT ACCESS: GET ON IT AND STAY ON IT
CONTINUITY OF CARE/NON-MEDICAL SWITCHING:
• Louisiana offers a transition period and appeals process for enrollees faced with a non-medical switching situation. Health plans are required to cover a prescription drug that had been previously approved for coverage at the same level “until the enrollee’s renewal date.” Additionally, state law requires plans to give 60-days’ notice to enrollees affected by a coverage change for drugs or “intravenous infusions” to allow the enrollee to file an appeal to continue on previously prescribed therapy.

STEP THERAPY:
• Louisiana imposes certain limitations on step therapy protocols, including by requiring a clear and convenient exception process, and an override in certain circumstances. Health plans are required to abide by certain standards in developing step therapy protocols. Additionally, plans are prohibited from using step therapy to restrict any prescription benefit for the treatment of stage-four advanced, metastatic cancer or associated conditions if use of the prescribed drug is consistent with certain best practices and supported by peer-reviewed, evidence-based medical literature. If a prescribed drug is denied by a health plan based upon step therapy, the plan must provide the prescriber with a list of the alternative drugs. Medicaid managed care plans must have an exceptions policy for drugs that are not included on the formulary. Effective January 1, 2013, Louisiana implemented a law that directs health insurers who provide coverage for cancer treatment to extend coverage for prescribed orally administered anti-cancer medications to cost at patients that is no less favorable than that of those receiving intravenously administered or injected anti-cancer therapies.

• Additionally, if a health plan limits the total amount paid for oral anti-cancer medications to $100 per prescription, the plan is also in compliance with the law. However, high deductible health plans and plans purchased through the Exchange are excluded. Plans may not increase cost-sharing for IV medications or reclassify benefits to reach compliance, nor can plans apply prior authorization measures that don’t also apply to IV medications.3

BIOSIMILAR LAW
• In Louisiana, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.2

References:
**ADDITIONAL PROGRAMS/RESOURCES**

**LOW-INCOME SUBSIDY (LIS) PROGRAMS**

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Maine include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Eli Lilly RxSecure, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, and WellCare Classic.1

**STANDARD PRIOR AUTHORIZATION (PA) FORM**

- As of December 2020, a standard PA form has not been instituted in the state of Maine.2

**TREATMENT ACCESS: GET ON IT AND STAY ON IT**

**CONTINUITY OF CARE/ NON-MEDICAL SWITCHING:**

- Maine requires health plans to cover previously approved prescription drugs for transitioning enrollees until a new insurance carrier conducts a review of the previous carrier’s prior authorization. Further, the prior authorization of the previous carrier must be honored for up to six months if requested during the review by the enrollee’s provider. If a health plan removes a drug from its formulary, it must notify enrollees of their right to request a formulary exception. If an enrollee has already obtained prior authorization for a drug that is later removed from the formulary, the plan must honor the prior authorization until it expires (with limited exceptions).

**STEP THERAPY:**

- Under Maine law, health plans must base step therapy protocols on clinical practice guidelines or peer-reviewed publications. Enrollees and prescribers must have access to a clear and abbreviated exception process, and exceptions must be granted under certain circumstances. Additionally, Maine requires health plans to provide explanations of step therapy requirements online.

**ORAL PARITY LAW**

- Maine passed legislation that applies to insurance plans issued or renewed on or after January 1, 2015. The law directs payers that provide coverage for cancer chemotherapy treatment to extend coverage for orally administered anti-cancer medication at a cost equal to the cost of intravenously administered or injected anti-cancer medications. Additionally, plans may not increase cost-sharing to patients for IV medications or reclassify benefits to be in compliance.2

**MEDICAID EXPANSION**

- Because Maine has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid Expansion in Maine, click here.7

**BIOSIMILAR LAW**

- Effective September 19, 2019, pharmacists may substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.2

**STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)**

**PROGRAM NAME:**

State Health Insurance Assistance Program (SHIP)

**Phone:** 1-800-262-2232

**ABOUT:**

- Maine citizens with Medicare insurance can get free health insurance counseling by calling the Legal Services for the Elderly Hotline or the Area Agency on Aging. Staff will answer questions about Medicare, Medicare drug discounts, supplemental insurance, MaineCare, long-term care, and other health insurance.

**STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)**

**Maine AIDS Drug Assistance Program (ADAP)**

**Phone:** 1-207-287-3747

**Maine Low Cost Drugs for the Elderly or Disabled Program**

**Phone:** 1-866-796-2463

**ADDITIONAL PROGRAMS/RESOURCES**

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:

ADDITIONAL PROGRAMS/RESOURCES

• Medicare patients who have limited income and resources may qualify for "Extra Help" to pay for prescription drugs. The LIS programs in Maryland include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Express Scripts Medicare, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

• As of December 2020, a standard PA form has not been instituted in the state of Maryland.1

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/ NON-MEDICAL SWITCHING:

• Maryland law requires health insurers to give members 30 days' notice when prescription drugs are removed from the formulary or moved to a higher tier and implement a process for members to request exceptions. Additionally, health insurers must honor a prior authorization granted to a member from a previous insurer for at least 30 days after the member has switched health insurance plans. Insurers are also required to honor their own prior authorizations under certain circumstances.

Maryland law also provides protections against non-medical switching by limiting the circumstances under which pharmacy benefits managers may make "therapeutic interchanges" involving prescription drugs.

STEP THERAPY:

• Health plans must allow prescribers to override step therapy protocols under certain circumstances. Maryland prohibits the use of step therapy if the prescription drug is used to treat stage-four, advanced metastatic cancer and the use is consistent with best practices. Additionally, health insurers must establish and implement a process by which an enrollee may receive a prescription drug that is not on formulary.

ORAL PARITY LAW

• On October 1, 2012, an oral parity law was enacted to direct payers that provide coverage for cancer chemotherapy treatments to extend coverage to prescribed, orally administered anti-cancer medications at a cost no less favorable than the cost of intravenously administered anti-cancer medications. The law also prohibits payers from increasing cost-sharing for IV treatments or reclassifying benefits in order to comply.2

MEDICAID EXPANSION

• Because Maryland has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Maryland, click here.3

BIOSIMILAR LAW

• Effective October 1, 2017, a pharmacist may substitute a biosimilar for the prescribed reference biologic if: (1) the U.S. Food and Drug Administration (FDA) has determined that it is “interchangeable” with the prescribed biologic; (2) the biosimilar is less expensive than the prescribed biologic; and (3) the prescribing provider has not indicated that no substitution can be made. The pharmacist would be required to notify the prescribing practitioner and the patient about the substitution within 5 days of the substitution and meet certain reporting requirements. Currently, there are no interchangeable biological products.2

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

 Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

To view a glossary of common healthcare terms, visit: http://khn.org/glossary/

References:

Massachusetts

LOW-INCOME SUBSIDY (LIS) PROGRAMS

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Massachusetts include: AARP MedicareRx Saver Plus, Cigna Secure Rx, Eliixir RxSecure, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA FORM)

• Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in Massachusetts to help simplify and streamline the PA process for prescription drugs. The form is available here.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:

• Massachusetts does not appear to have continuity of care provisions or limitations on non-medical switching that apply to prescription drug coverage.

STEP THERAPY:

• Massachusetts does not appear to have any provisions limiting the use of step therapy protocols. Massachusetts does provide that managed care plans must provide easy access to current formularies in writing, via the internet, and by phone. Also, the state has a catastrophic prescription drug plan, which allows elderly individuals to obtain a non-preferred drug at the co-payment level of a preferred drug and provides for an appeal of the exclusion of any prescription drug from any formulary established under the program.

ORAL PARITY LAW

• On May 1, 2013, Massachusetts implemented oral parity legislation to direct payers that provide coverage for cancer chemotherapy to extend coverage for prescribed, orally administered anti-cancer medications at a cost to the patient that is no less favorable than those receiving intravenously administered or injected cancer medications. Additionally, plans may not increase the out-of-pocket cost to patients to achieve compliance.

MEDICAID EXPANSION

• Because Massachusetts has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Massachusetts, click here.

BIOSIMILAR LAW

• In Massachusetts, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME:

Serving the Health Insurance Needs of Everyone (SHINE)
Phone: 1-800-243-4636
TTY/ASCII: 1-800-439-2370

Massachusetts HIV Drug Assistance Program (HDAP)
Phone: 1-617-502-1700

Massachusetts Prescription Advantage
Phone: 1-800-243-4636, ext. 2

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

Massachusetts HIV Drug Assistance Program (HDAP)
Phone: 1-617-502-1700

Massachusetts Prescription Advantage
Phone: 1-800-243-4636, ext. 2

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials
Michigan

LOW-INCOME SUBSIDY (LIS) PROGRAMS LEARN MORE

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Michigan include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Express Scripts Medicare Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM LEARN MORE

• Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in Michigan to help simplify and streamline the PA process for prescription drugs. The form is available here.

TREATMENT ACCESS: GET ON IT AND STAY ON IT LEARN MORE

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:

• Michigan does not appear to have continuity of care provisions or non-medical switching limitations specifically applicable to prescription drugs. Michigan’s Medicaid program, MI Health Link (MHL), provides for continuity of care for treatment initiated prior to enrollment, which must be authorized by the MHL health plan.

STEP THERAPY:

• Michigan does not appear to have any laws limiting the use of step therapy protocols. Health plans in Michigan must provide for exceptions to a formulary limitation when a non-formulary alternative is medically necessary and appropriate, but this does not prevent a plan from imposing a prior authorization process or higher cost-sharing.

ORAL PARITY LAW LEARN MORE

• As of December 2020, Michigan has not passed legislation regarding oral parity.

MEDICAID EXPANSION LEARN MORE

• Because Michigan has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. However, Michigan has obtained federal approval to require that non-exempt individuals work a certain number of hours per month to be eligible for Medicaid benefits, effective January 2020. For more details on Medicaid expansion in Michigan, click here.

BIOSIMILAR LAW LEARN MORE

• In Michigan, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs) LEARN MORE

PROGRAM NAME:
Medicare/Medicaid Assistance Program (MMAP)

Phone: 1-800-803-7174

ABOUT:
• MMAP provides free health benefit counseling services to those 65 years of age and older, those who are Medicare beneficiaries due to disability, and their families. MMAP provides information and support so that beneficiaries can make informed healthcare decisions. Information and assistance is provided in the areas of Medicare, Medicare+Choice (managed care options), Medigap insurance, and Medicaid long-term care insurance.
• Counselors at local agencies provide information about benefits, comparative information about insurance products and managed care plans, and assistance with claims, denials of services, and other insurance-related problems. The above number can be called to obtain the services of an MMAP counselor.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs) LEARN MORE

Michigan HIV/AIDS Drug Assistance Program (MIDAP)

Phone: 1-888-826-6565

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:
• National Foundations
• Advocacy Connector
• Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

• Prescribers can submit a standard drug PA request form for prescription drugs. The form was implemented in Minnesota to help simplify and streamline the PA process for prescription drugs. The form is available here.

• Medicare patients who have limited income and resources may qualify for "Extra Help" to pay for prescription drugs. The LIS programs in Minnesota include: AARP MedicareRx Saver Plus, Cigna Secure Rx, ClearSpring Health Value Rx, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

• Prescribers can submit a standard drug PA request form for prescription drugs. The form was implemented in Minnesota to help simplify and streamline the PA process for prescription drugs. The form is available here.

• Because Minnesota has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Minnesota, click here.

• In Minnesota, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an "interchangeable" biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

• Effective 2021, health plans are required to honor a former plan’s prior authorization of health care services for at least 60 days. If a health plan changes its coverage terms for a health care service, it may not apply the new terms as to an enrollee who has already received prior authorization until the next plan year (with limited exceptions).

• Health plans must provide a clear, readily accessible, and convenient step therapy override process, and must grant an override in certain clinical situations. However, the law does not prohibit plans from requiring enrollees to try a generic or biosimilar prior to providing coverage for a brand name drug. Minnesota prohibits the use of step therapy if the prescription drug is used to treat stage-four, advanced metastatic cancer and the use is consistent with best practices.


To view a glossary of common healthcare terms, visit: http://khn.org/glossary/
For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.
ADDITIONAL PROGRAMS/RESOURCES

• Missouri requires health plans to establish a step therapy override

• Missouri does not appear to have continuity of care provisions or

• As of December 2020, a standard PA form has not been instituted in the

Moore patients who have limited income and resources may qualify

for “Extra Help” to pay for prescription drugs. The LIS programs in

Missouri include: Cigna Secure Rx, Clear Spring Health Value Rx,
Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript
Choice, and WellCare Classic. ¹

STANDARD PRIOR AUTHORIZATION (PA) FORM

• As of December 2020, a standard PA form has not been instituted in the

state of Missouri. ²

TREATMENT ACCESS:
GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING ²:

• Missouri does not appear to have continuity of care provisions or

limitations on non-medical switching that apply to prescription
drug coverage. Health insurers must notify enrollees currently taking

a drug at least 30 days prior to any changes in coverage that would

affect them.

STEP THERAPY ²:

• Missouri requires health plans to establish a step therapy override

process and grant an exception in certain circumstances. Additional

documentation may be requested and the requested therapy must

be on the formulary. Health plans must make information regarding

step therapy requirements available online or through a provider

portal. Missouri limits the use of step therapy for medication-assisted

treatment of a substance use disorder.

LOW-INCOME SUBSIDY (LIS) PROGRAMS

ORAL PARITY LAW

• Health policies issued or renewed on or after January 1, 2015, that

provide coverage for cancer treatment must extend coverage to orally

administered anti-cancer medication at a cost no less favorable than

intravenously administered or injected cancer medications. A health

benefit plan is also in compliance if they charge no more than $75 per

prescription for the orally administered anti-cancer treatment. Insurers

may increase the cap annually based on the Consumer Price Index

(CPI). The law prohibits payers from increasing cost-sharing for IV

treatments or reclassifying benefits in order to comply. ³

MEDICAID EXPANSION

• Missouri has adopted measures to expand Medicaid, but has not

implemented Medicaid expansion. Missouri voters approved a ballot

measure on August 4, 2020 which adds Medicaid expansion to the

state’s constitution. The amendment requires the state to submit all

SPAs necessary to implement expansion to CMS no later than March

1, 2021 and for expansion coverage to begin July 1, 2021. Language in

the amendment prohibits the imposition of any additional burdens or

restrictions on eligibility or enrollment for the expansion population.

For more details on Medicaid expansion in Missouri, click here. ¹

BIOSIMILAR LAW

• In Missouri, biosimilar substitution laws allow pharmacists to

substitute a biological product for the prescribed reference

biologic only if it is deemed to be an “interchangeable” biosimilar

by the U.S. Food and Drug Administration (FDA) and meets other

state law requirements. Currently, there are no interchangeable

biological products. ²

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME:
Community Leaders Assisting the Insured of Missouri (CLAIM)
Phone: 1-800-390-3330

ABOUT:
• CLAIM has been the official State Health Insurance Assistance

Program (SHIP) for Missouri since 1993. It is a non-profit providing

free, unbiased information about Medicare to Missourians. The goal

is to provide local counselors to help patients get the most from their

Medicare benefits. CLAIM also hosts “Welcome to Medicare” events.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

Missouri Department of Health and Senior Services Through the HIV/
AIDS Case Management Program ³
Phone: 1-573-751-6439

Missouri Rx Plan ⁴
Phone: 1-800-375-1406

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well

as questions or concerns regarding state issues requiring legislative

intervention, please visit the following

pages within this document:

• National Foundations

• Advocacy Connector

• Elected Officials

Eligible veterans may be able to receive care from participating

community providers through the Veteran Community Care

Program. Click here for additional information.


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ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the _Veteran Community Care Program_. Click here for additional information.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

- **Montana State Health Insurance Assistance Program (SHIP)**
  - Phone: 1-406-444-4077
  - **ABOUT**: The Montana SHIP is a free health benefits counseling and advocacy service for Medicare beneficiaries and their families or caregivers.

- **Montana AIDS Drug Assistance Program (ADAP)**
  - Phone: 1-406-444-3565

- **Montana Big Sky Rx Program**
  - Phone: 1-866-369-1233 or 1-406-444-1233

- **Montana Mental Health Services Plan (MHSP)**
  - Phone: 1-406-444-3964 or 1-800-866-0328

LOW-INCOME SUBSIDY (LIS) PROGRAMS

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Montana include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

- **Montana AIDS Drug Assistance Program (ADAP)**
  - Phone: 1-406-444-3565

- **Montana Big Sky Rx Program**
  - Phone: 1-866-369-1233 or 1-406-444-1233

- **Montana Mental Health Services Plan (MHSP)**
  - Phone: 1-406-444-3964 or 1-800-866-0328

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

- **Montana State Health Insurance Assistance Program (SHIP)**
  - Phone: 1-406-444-4077
  - **ABOUT**: The Montana SHIP is a free health benefits counseling and advocacy service for Medicare beneficiaries and their families or caregivers.

ADDITIONAL PROGRAMS/RESOURCES

- Eligible veterans may be able to receive care from participating community providers through the _Veteran Community Care Program_. Click here for additional information.

**References**:

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LEARN MORE
• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Nebraska include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

• As of December 2020, a standard PA form has not been instituted in the state of Nebraska.

• Medicaid coverage under expansion became effective on October 1, 2020. Because Nebraska has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. Nebraska has received federal approval for a Section 1115 waiver to implement expansion with program elements that differ from what is allowed under federal law, including a tiered benefit structure that requires beneficiaries to meet work and healthy behavior requirements to access benefits. Certain waiver elements will go into effect on April 1, 2021, and others, including the work requirements, will go into effect April 1, 2022. For more details on Medicaid expansion in Nebraska, click here.

• Effective January 1, 2018, a pharmacist may substitute a biosimilar for the prescribed reference biologic if: (1) the U.S. Food and Drug Administration (FDA) has determined that it is “interchangeable” with the prescribed biologic; and (2) the prescribing provider has not indicated that no substitution can be made. The pharmacist will be required to notify the prescribing practitioner and the patient about the substitution within 3 days of the substitution and meet certain reporting requirements. Currently, there are no interchangeable biological products.

• On April 2, 2012, Nebraska implemented oral parity, which requires payers to cover orally administered anti-cancer medication at a cost to patients equal to intravenously administered or injected anti-cancer medications.

• Effective January 1, 2018, a pharmacist may substitute a biosimilar for the prescribed reference biologic if: (1) the U.S. Food and Drug Administration (FDA) has determined that it is “interchangeable” with the prescribed biologic; and (2) the prescribing provider has not indicated that no substitution can be made. The pharmacist will be required to notify the prescribing practitioner and the patient about the substitution within 3 days of the substitution and meet certain reporting requirements. Currently, there are no interchangeable biological products.

• On April 2, 2012, Nebraska implemented oral parity, which requires payers to cover orally administered anti-cancer medication at a cost to patients equal to intravenously administered or injected anti-cancer medications.

• Nebraska does not appear to have any continuity of care provisions or limitations on non-medical switching specific to prescription drugs.

• Health plans are prohibited from using step therapy to require an enrollee to use a method of contraception other than the method prescribed. Plans may, however, impose higher cost-sharing for certain contraceptive drugs. Effective 2020, Nevada is required to evaluate step therapy protocols for use in the Medicaid program based on clinical evidence and best practices, without consideration of cost.

• Nebraska does not appear to have any continuity of care provisions or limitations on non-medical switching specific to prescription drugs.

LOW-INCOME SUBSIDY (LIS) PROGRAMS

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Nevada include: AARP® Medicare Rx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

• As of December 2020, a standard PA form has not been instituted in the state of Nevada.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:

• Nevada provides that, under certain circumstances, a health plan may not limit or exclude coverage for a drug if it had previously been approved by the plan. In addition, Nevada places limitations on moving a drug to a higher-cost formulary tier.

STEP THERAPY:

• Health plans are prohibited from using step therapy to require an enrollee to use a method of contraception other than the method prescribed. Plans may, however, impose higher cost-sharing for certain contraceptive drugs. Effective 2020, Nevada is required to evaluate step therapy protocols for use in the Medicaid program based on clinical evidence and best practices, without consideration of cost.

ORAL PARITY LAW

• Nevada implemented legislation for health policies issued or renewed on or after January 1, 2015. This law requires payers that provide coverage for chemotherapy to treat cancer to establish cost-sharing of no more than $100 per prescription for orally administered anti-cancer treatment. Additionally, plans may not increase the out-of-pocket cost for IV chemotherapy treatments to over $100 to achieve compliance.

MEDICAID EXPANSION

• Because Nevada has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Nevada, click here.

BIOSIMILAR LAW

• Effective January 1, 2018, a pharmacist may substitute a biosimilar for the prescribed reference biologic if: (1) the U.S. Food and Drug Administration (FDA) has determined that it is “interchangeable” with the prescribed biologic; (2) the biosimilar is less expensive than the prescribed biologic; and (3) the prescribing provider has not indicated that no substitution can be made orally or by writing “dispense as written” or “d.a.w.” on the prescription. The pharmacist will be required to notify the prescribing practitioner and the patient about the substitution within 3 days of the substitution and meet certain reporting requirements. The pharmacist must prescribe the substitute if the pharmacist is being paid by a government agency. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME:
State Health Insurance Assistance Program (SHIP)
Phone: 1-800-307-4444 or 1-775-687-4210 (Carson City)

ABOUT:
• SHIP provides information, counseling, and assistance to Medicare beneficiaries in Nevada, involving a statewide network of volunteers.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

Nevada AIDS Drug Assistance Program
Phone: 1-775-684-5928
Nevada Senior Rx Program
Phone: 1-866-303-6323 or 1-775-687-4210
Nevada Disability Rx
Phone: 1-866-303-6323 or 1-775-687-4210

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
LOW-INCOME SUBSIDY (LIS) PROGRAMS

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in New Hampshire include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Elixir RxSecure, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, and Wellcare Classic.2

STANDARD PRIOR AUTHORIZATION (PA) FORM

- Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in New Hampshire to help simplify and streamline the PA process for prescription drugs. The form is available here.2

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:

- Health plans must provide an exceptions process through which an enrollee can obtain coverage for a nonformulary drug that was on the formulary within the last 12 months, within 48 hours. A health plan must notify a covered person of a change in the formulary and must allow at least 45 days before implementation of any formulary deletions. Every health benefit plan that provides prescription drug benefits shall provide notice of deletions to the plan list or plan formulary to all covered persons at least annually.

STEP THERAPY:

- Health plans may not require failure of the same drug more than once. Health plans must provide an exceptions process through which an enrollee can obtain coverage for a nonformulary drug that was on the formulary within the last 90 days in the event the plan requires prior authorization and the prior authorization has neither been approved nor denied, if a pharmacist has determined that the medication is essential. Effective January 2021, health plans must respond to a prior authorization request for a formulary drug within 2 business days.

ORAL PARITY LAW

- New Hampshire limits the ability of an insurer to charge more for an oral chemotherapy drug than it does for an anti-cancer medication that is injected or intravenously administered. No insurer that provides coverage for anti-cancer medications that are injected or intravenously administered can require a higher co-payment, deductible, or coinsurance amount for patient administered oral anti-cancer treatment. If the cost-sharing requirements for orally administered anti-cancer medications do not exceed $200 per prescription fill, the health plan will be deemed to comply with this law. This law applies only to oral anti-cancer medications where an intravenously administered or injected anticancer medication are not medically appropriate. The oral parity law will automatically be repealed in 2021.2

MEDICAID EXPANSION

- Because New Hampshire has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. However, New Hampshire has obtained federal approval to require that non-exempt individuals work a certain number of hours per week to be eligible for Medicaid benefits, effective 2019. For more details on Medicaid expansion in New Hampshire, click here.2

BIOSIMILAR LAW

- Effective January 1, 2019, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. The pharmacist is required to notify the prescribing practitioner. Currently, there are no interchangeable biological products.2

ADDITIONAL PROGRAMS/RESOURCES

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in New Hampshire include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Elixir RxSecure, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, and Wellcare Classic.2


STATE MEDICAID EXPANSION PROGRAMS (SHIPs) LEARN MORE

NH CARE Program®
Phone: 1-603-271-4502 or 1-800-852-3345, ext. 4502

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:
- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

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To view a glossary of common healthcare terms, visit: http://khn.org/glossary/
ADDITIONAL PROGRAMS/RESOURCES

• New Jersey does not appear to have any limitations on the use of step therapy.
• New Jersey does not appear to have continuity of care protections.

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:

• As of December 2020, a standard PA form has not been instituted in the state of New Jersey.

STEP THERAPY:

• New Jersey does not appear to have any limitations on the use of step therapy for prescribed drugs. Health plans must provide for an exceptions process for non-formulary medications that are deemed “medically necessary” according to specified criteria.

ORAL PARITY LAW

• New Jersey implemented legislation effective July 16, 2012, requiring payers to cover orally administered anti-cancer medication at a cost to patients equal to intravenously administered or injected anti-cancer medications. Additionally, orally administered anti-cancer medications must not be subject to any prior approval, dollar limit, co-payment, deductible or coinsurance provision that does not apply to intravenously administered or injected anti-cancer medications. Finally, plans may not increase the out-of-pocket cost to patients to achieve compliance.

MEDICAID EXPANSION

• Because New Jersey has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in New Jersey, click here.

BIOSIMILAR LAW

• In New Jersey, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

• SHIP provides free help to New Jersey Medicare beneficiaries who have problems with, or questions about, their health insurance.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

• Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in New Mexico include: AARP® Medicare Rx Saver Plus, Cigna Secure Rx, Elixir RxPlus, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

• Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in New Mexico to help simplify and streamline the PA process for prescription drugs. The form is available here.

• Because New Mexico has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in New Mexico, click here.

• Effective June 16, 2017, a pharmacist may substitute a biosimilar for the prescribed reference biologic if: (1) the U.S. Food and Drug Administration (FDA) has determined that it is “interchangeable” with the prescribed biologic; (2) the biosimilar is less expensive than the prescribed biologic, and (3) the prescribing provider has not indicated that no substitution can be made by writing “no substitution” or “no sub” on the prescription. The pharmacist will be required to notify the prescribing practitioner and the patient about the substitution within 5 days of the substitution and meet certain reporting requirements. Currently, there are no interchangeable biological products.

• New Mexico law directs payers that provide coverage for cancer treatment to extend coverage to orally administered anti-cancer medication at a cost no less favorable than intravenously administered or injected cancer medications. Plans may not increase out-of-pocket costs for anti-cancer medications to comply with the law.

References:
For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- **National Foundations**
- **Advocacy Connector**
- **Elected Officials**

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

**References:**
For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

North Carolina

**LOW-INCOME SUBSIDY (LIS) PROGRAMS**
- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in North Carolina include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Exemplar Health Basic, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

**STANDARD PRIOR AUTHORIZATION (PA) FORM**
- As of December 2020, a standard PA form has not been instituted in the state of North Carolina.

**TREATMENT ACCESS: GET ON IT AND STAY ON IT**
- As of December 2020, North Carolina has not expanded Medicaid.

**ORAL PARITY LAW**
- As of December 2020, North Carolina has not passed legislation regarding oral parity.

**MEDICAID EXPANSION**
- As of December 2020, North Carolina has not expanded Medicaid.

**BIOSIMILAR LAW**
- In North Carolina, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

**STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)**
- The Seniors’ Health Insurance Information Program (SHIIP)
  - Phone: 1-855-408-1212
  - ABOUT:
    - SHIIP counsels Medicare beneficiaries and caregivers about Medicare, Medicare supplemental insurance, Medicare Advantage, Medicare Part D, and long-term care insurance. The counselors offer free information regarding Medicare healthcare products. Through the North Carolina Senior Medicare Patrol Program (SMP), counselors also assist in recognizing and preventing Medicare billing errors and possible fraud and abuse.

**STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)**
- North Carolina HIV Medication Assistance Program
  - Phone: 1-877-466-2232 or 1-919-733-9161

**LOW-INCOME SUBSIDY (LIS) PROGRAMS**

**STANDARD PRIOR AUTHORIZATION (PA) FORM**

**TREATMENT ACCESS: GET ON IT AND STAY ON IT**

**ORAL PARITY LAW**

**MEDICAID EXPANSION**

**BIOSIMILAR LAW**

**ADDITIONAL PROGRAMS/RESOURCES**

**References**
North Dakota

To view a glossary of common healthcare terms, visit: [http://khn.org/glossary/](http://khn.org/glossary/)

**LOW-INCOME SUBSIDY (LIS) PROGRAMS**

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in North Dakota include: AARP® Medicare Rx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

**STANDARD PRIOR AUTHORIZATION (PA) FORM**

- As of December 2020, a standard PA form has not been instituted in the state of North Dakota.

**TREATMENT ACCESS: GET ON IT AND STAY ON IT**

**CONTINUITY OF CARE/NON-MEDICAL SWITCHING**: North Dakota does not appear to have any continuity of care provisions or non-medical switching limitations that apply specifically to prescription drug coverage.

**STEP THERAPY**: Pharmacy benefits managers are prohibited from imposing step therapy requirements on an FDA-approved drug used to treat metastatic cancer. The North Dakota Medicaid program must grant prior authorization requests under certain circumstances.

**ORAL PARITY LAW**

- North Dakota passed legislation for health policies issued or renewed on or after August 1, 2015. This legislation requires payers in North Dakota that cover cancer chemotherapy treatments to provide coverage for oral chemotherapy at a cost-sharing rate for patients that does not exceed that of their IV treatments. Additionally, plans may not reclassify benefits or increase cost-sharing in order to be in compliance.

**MEDICAID EXPANSION**

- Because North Dakota has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in North Dakota, click here.

**BIOSIMILAR LAW**

- In North Dakota, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

**STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)**

- The State Health Insurance Counseling Program (SHIC) of North Dakota offers free help with Medicare and other health insurance. Trained counselors who work through local sponsoring organizations can help answer patient questions. SHIC counselors have no connection with any insurance company or product. Patients can contact SHIC at the number above to schedule an appointment or to locate the SHIC program sponsor nearest them.

**STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)**

- North Dakota Department of Health, HIV/AIDS Program

**ADDITIONAL PROGRAMS/RESOURCES**

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

**REFERENCES**

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Ohio include: Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, SilverScript Choice, and WellCare Classic.

• As of January 1, 2018, insurers must accept and respond to preauthorization requests under the pharmacy benefit through a secure electronic transmission using the National Council for Prescription Drug Program’s (NCPDP) SCRIPT standard ePA transactions.

• Because Ohio has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. However, Ohio has obtained federal approval to require that non-exempt individuals work a certain number of hours per week to be eligible for Medicaid benefits, effective March 2019. For more details on Medicaid expansion in Ohio, click here.

• For health plans issued or renewed after January 1, 2015, Ohio law directs payers that provide coverage for cancer treatments to extend coverage to orally administered anti-cancer medication at a cost no less favorable than intravenously administered or injected cancer medications. Plans may not increase the out-of-pocket cost for IV chemotherapy to achieve compliance.

• In Ohio, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. A biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements.

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
ADDITIONAL PROGRAMS/RESOURCES

LOW-INCOME SUBSIDY (LIS) PROGRAMS

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Oregon include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

- Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in Oregon to help simplify and streamline the PA process for prescription drugs. The form is available here.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:

- Oregon law does not appear to include any specific continuity of care provisions or non-medical switching limitations for prescription drug benefits. However, managed care plans are required to provide continuity of care in the event the plan terminates its relationship with a healthcare provider or under other listed circumstances.

STEP THERAPY:

- Healthcare coverage plans in Oregon are required to adopt policies for enrollees and prescribers to request exceptions for coverage of non-formulary drugs and detail the procedure and documentation required.

ORAL PARITY LAW

- On January 1, 2008, Oregon adopted an oral parity law that requires payers that provide coverage for cancer chemotherapy treatment to extend coverage to orally administered anti-cancer medication at a cost no less favorable than intravenously administered or injected cancer medications. Plans may not increase patient out-of-pocket costs to achieve compliance.

MEDICAID EXPANSION

- Because Oregon has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Oregon, click here.

BIOSIMILAR LAW

- In Oregon, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME:
Senior Health Insurance Benefits Assistance (SHIBA)
Phone: 1-800-722-4134

ABOUT:
- The SHIBA program provides free counseling to people with Medicare and those who assist them.
- The phone number above can be called to receive one-on-one counseling and assistance from state office staff or local, trained SHIBA volunteers.
- Volunteers can help patients select a Medicare prescription drug plan, compare Medicare Advantage plans, compare Medicare supplemental plans, and apply for Medicare Savings Programs, including Extra Help with Medicare prescription drug coverage. They also assist patients with reviewing medical bills and filing appeals or complaints.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

CAREAssist: Oregon’s AIDS Drug Assistance Program
Phone: 1-971-673-0144

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
Pennsylvania

**ADDITIONAL PROGRAMS/RESOURCES**

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Pennsylvania include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Express Scripts Medicare, Humana Basic Rx Plan, Indy Health Saver Rx, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

- On January 1, 2016, an oral parity law was enacted to direct payers that provide coverage for cancer chemotherapy treatments to extend coverage to prescribed, orally administered anticancer medications at a cost no less favorable than the cost of intravenously administered or injected anti-cancer medications.²

- Because Pennsylvania has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Pennsylvania, click here.³

- In Pennsylvania, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the FDA and meets other state law requirements. Currently, there are no interchangeable biological products.²


To view a glossary of common healthcare terms, visit: http://khn.org/glossary/
ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
ADDITIONAL PROGRAMS/RESOURCES

**LOW-INCOME SUBSIDY (LIS) PROGRAMS**

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in South Dakota include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

**STANDARD PRIOR AUTHORIZATION (PA) FORM**

- As of December 2020, a standard PA form has not been instituted in the state of South Dakota.

**TREATMENT ACCESS: GET ON IT AND STAY ON IT**

**CONTINUITY OF CARE/NON-MEDICAL SWITCHING:**

- South Dakota does not appear to have any laws addressing non-medical switching or continuity of care for prescription drugs. However, managed care plans are required to provide continuity of care in the event the plan terminates its relationship with a health carrier or provider.

**STEP THERAPY:**

- Health plans that have a formulary must provide for an exception process in exigent circumstances. Group health plans are prohibited from imposing step therapy requirements with respect to a mental health or substance use disorder unless the requirement is comparable to and applied more stringently than factors used in applying the requirement in medical or surgical benefits classifications.

Additionally, health plans issued, amended, or renewed on or after January 1, 2021 that use step therapy protocols must have an exceptions process and shall have access to a clear, readily accessible, and convenient process to request a step therapy override exception. The process shall be made easily accessible on the website of the health carrier, health benefit plan, or utilization review organization.

**ORAL PARITY LAW**

- South Dakota law requires insurance plans issued or renewed on or after January 1, 2016, that provide coverage for cancer chemotherapy treatment to extend coverage to orally administered anti-cancer medications at a cost equal to the cost of intravenously administered or injected anti-cancer medications. Plans cannot reclassify or increase cost-sharing inconsistent with annual increases in healthcare costs to comply with the law.

**MEDICAID EXPANSION**

- As of December 2020, South Dakota has not expanded Medicaid.

**BIOSIMILAR LAW**

- A pharmacist dispensing a prescription drug order for a biological product prescribed by its brand or proper name may select an interchangeable biological product. Within five business days following the dispensing of a biological product, the pharmacist must notify the prescriber regarding the specific product provided to the patient, including the name of the product and the manufacturer. Currently, there are no interchangeable biological products.

**STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)**

**PROGRAM NAME:**

Senior Health Information & Insurance Education (SHIINE)

**ABOUT:**

- The mission of SHIINE is to inform and assist consumers with Medicare, related health information, and insurance issues so they can make informed decisions and access resources to meet their needs.
- The website (accessed by clicking on program name above) has a calendar of events related to understanding Medicare.

**STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)**

**Ryan White Part B CARE Program, South Dakota Department of Health**

Phone: 1-800-592-1861 or 1-605-773-3737

**ADDITIONAL PROGRAMS/RESOURCES**

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.
ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
ADDITIONAL PROGRAMS/RESOURCES

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Texas include: Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Exemplar Health Basic, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, and WellCare Classic.

STANDARD PRIOR AUTHORIZATION (PA) FORM

• Prescribers can submit a standard drug PA request form for prescription drug benefits. This form was implemented in Texas to help simplify and streamline the PA process for prescription drugs. The form is available here.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/(NON-MEDICAL SWITCHING)

• Texas has a limited continuity of care provision that requires plans to cover “at the contracted benefit level” a prescription drug that has been removed from coverage for an enrollee until the enrollee’s plan renewal date. In addition, health plans must provide notice when they make modifications to drug coverage, including removing a drug from a formulary and adding a prior authorization requirement.

STEP THERAPY:

• Texas requires that health benefit plan issuers that use step therapy protocols have an exceptions process and grant exception requests under certain situations. The exceptions process must be in a user-friendly format that is readily accessible to the patient and the prescribing provider. Further, a health benefit plan that provides coverage for the treatment of stage-four advanced metastatic cancer may not require an enrollee to fail to successfully respond to a different drug, or prove a history of failure of a different drug, before providing coverage of a U.S. Food and Drug Administration (FDA) approved prescription drug, if use of the prescribed drug is consistent with best practices and supported by peer-reviewed, evidenced-based medical literature.

ORAL PARITY LAW

• On September 1, 2011, Texas enacted an oral parity law that requires payers that provide coverage for cancer chemotherapy treatment to extend coverage to orally administered anti-cancer medication at a cost no less favorable than the cost of intravenously administered or injected cancer medications.

• As of December 2020, Texas has not expanded Medicaid.

BIOSIMILAR LAW

• In Texas, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the FDA and meets other state law requirements. Currently, there are no interchangeable biological products.

MEDICAID EXPANSION

• Texas has a limited continuity of care provision that requires plans to cover “at the contracted benefit level” a prescription drug that has been removed from coverage for an enrollee until the enrollee’s plan renewal date. In addition, health plans must provide notice when they make modifications to drug coverage, including removing a drug from a formulary and adding a prior authorization requirement.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

• Medicaid patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Texas include: Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Exemplar Health Basic, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, and WellCare Classic.

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Texas include: Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Exemplar Health Basic, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, and WellCare Classic.

Additional programs and resources

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.


LOW-INCOME SUBSIDY (LIS) PROGRAMS

Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Utah include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxPlus, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

As of December 2020, a standard PA form has not been instituted in the state of Utah.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

Continuity of Care/Non-Medical Switching:

• Utah law does not appear to have any continuity of care provisions or limitations on non-medical switching applicable to prescription drug coverage.

Step Therapy:

• Utah does not appear to have any laws or regulations that apply specifically to step therapy/fail-first requirements.

ORAL PARITY LAW

Utah implemented an oral parity law for health policies issued or renewed on or after October 1, 2013. This law requires payers to provide orally administered anti-cancer medications at a cost to the patient equal to intravenous or injected therapies. Plans may not increase the out-of-pocket cost for IV treatments to achieve compliance.

MEDICAID EXPANSION

Because Utah has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Utah, click here.

BIOSIMILAR LAW

In Utah, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

Program Name: Utah Senior Health Insurance Program
Phone: 1-800-541-7735

About:

• Utah provides online resources covering the various options in Medicare, Medigap, and Medicare Advantage plans that seniors can choose. Resources include publications from the Centers of Medicare & Medicaid Services (CMS) and state resources.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

AIDS Drug Assistance Program
1-800-538-6197

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

• National Foundations
• Advocacy Connector
• Elected Officials

To view a glossary of common healthcare terms, visit: http://khn.org/glossary/
ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:

Vermont

LOW-INCOME SUBSIDY (LIS) PROGRAMS

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Vermont include: AARP® MedicareRx Saver Plus, Clonia Secure Rx, Elixir RxSecure, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

- Each insurer must accept either the national standard transaction information for prior authorizations electronically via online portal or accept the uniform prior authorization form approved by Vermont. For more details, click here.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:
- Vermont does not appear to have any explicit continuity of care laws that apply to prescription drugs.

STEP THERAPY:
- An insurer requiring the use of step therapy is not permitted to require failure on the same medication on more than one occasion for continuously enrolled patients.

ORAL PARITY LAW

- Vermont implemented legislation, effective April 1, 2010, requiring health insurers that provide coverage for cancer chemotherapy treatment to provide coverage for prescribed, orally administered anti-cancer medications on a financial basis no less favorable than intravenously administered or injected anti-cancer medications covered under the insured’s plan.²

MEDICAID EXPANSION

- Because Vermont has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Vermont, click here.

BIOSIMILAR LAW

- In Vermont, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STANDARD PRIOR AUTHORIZATION (PA) FORM

- Each insurer must accept either the national standard transaction information for prior authorizations electronically via online portal or accept the uniform prior authorization form approved by Vermont. For more details, click here.

ORAL PARITY LAW

- Vermont implemented legislation, effective April 1, 2010, requiring health insurers that provide coverage for cancer chemotherapy treatment to provide coverage for prescribed, orally administered anti-cancer medications on a financial basis no less favorable than intravenously administered or injected anti-cancer medications covered under the insured’s plan.²

MEDICAID EXPANSION

- Because Vermont has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Vermont, click here.

BIOSIMILAR LAW

- In Vermont, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

- The SHIP program is designed to provide help with questions or concerns about Medicare-related issues to those 65 years of age and over and/or those with disabilities.

NEW HAMPSHIRE

TREATMENT ACCESS: GET ON IT AND STAY ON IT

- Vermont does not appear to have any explicit continuity of care laws that apply to prescription drugs.

STEP THERAPY:
- An insurer requiring the use of step therapy is not permitted to require failure on the same medication on more than one occasion for continuously enrolled patients.

ORAL PARITY LAW

- Vermont implemented legislation, effective April 1, 2010, requiring health insurers that provide coverage for cancer chemotherapy treatment to provide coverage for prescribed, orally administered anti-cancer medications on a financial basis no less favorable than intravenously administered or injected anti-cancer medications covered under the insured’s plan.²

MEDICAID EXPANSION

- Because Vermont has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Vermont, click here.

BIOSIMILAR LAW

- In Vermont, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STANDARD PRIOR AUTHORIZATION (PA) FORM

- Each insurer must accept either the national standard transaction information for prior authorizations electronically via online portal or accept the uniform prior authorization form approved by Vermont. For more details, click here.

ORAL PARITY LAW

- Vermont implemented legislation, effective April 1, 2010, requiring health insurers that provide coverage for cancer chemotherapy treatment to provide coverage for prescribed, orally administered anti-cancer medications on a financial basis no less favorable than intravenously administered or injected anti-cancer medications covered under the insured’s plan.²

MEDICAID EXPANSION

- Because Vermont has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Vermont, click here.

BIOSIMILAR LAW

- In Vermont, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and meets other state law requirements. Currently, there are no interchangeable biological products.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

- Vermont Medication Assistance Program (VMAP)
- Healthy Vermonters and VPharm

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:

- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.
ADDITIONAL PROGRAMS/RESOURCES

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:
Virginia requires plans to cover a medically necessary non-formulary drug for an enrollee who has been receiving the drug for at least six months prior to the formulary change, provided the prescribing physician determines that the formulary drug is an “inappropriate therapy” for the patient or that changing drug therapy “presents a significant health risk to the specific patient.” The law specifically exempts substituting the “generic equivalent drug,” which has been approved by the U.S. Food and Drug Administration (FDA), for a branded version of such drug. Thus, a biosimilar version of a reference biological would presumably be subject to this law.

STEP THERAPY:
Carriers that use step therapy protocols must have an exceptions process and grant exceptions in certain situations. When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a carrier or utilization review organization through the use of a step therapy protocol, the patient and prescribing provider shall have access to a clear, readily accessible, and convenient process to request a step therapy exception. A carrier or utilization review organization may use its existing medical exceptions process to satisfy this requirement. The process shall be consistently applied within the same plan.

ORAL PARITY LAW:
Virginia implemented legislation, effective July 1, 2012, requiring group and individual health insurance plans, corporations providing group or individual insurance plans, and HMOs to cover oral chemotherapy drugs on the same terms as they cover cancer chemotherapy drugs that are administered intravenously or by injection. Specifically, the law requires that coverage must be consistently applied within the same plan.

PHARMACY PRIOR AUTHORIZATION (PA) FORM:
As of January 1, 2018, insurers must accept and respond to preauthorization requests under the pharmacy benefit through a secure electronic transmission using the National Council for Prescription Drug Program’s (NCPDP) SCRIPT standard ePA transactions.

VIRGINIA AIDS DRUG ASSISTANCE PROGRAMS (ADAPs):
In Virginia, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the FDA and meets other state law requirements. Currently, there are no interchangeable biological products.

LOW-INCOME SUBSIDY (LIS) PROGRAMS:
Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Virginia include: AARP® Medicare Rx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Humana Basic Rx Plan, SilverScript Choice, and WellCare Classic.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs):
The Virginia Division for the Aging (VDA) assists patients with selecting insurance, determining how much coverage they need, and understanding medical bills. Individual insurance counseling is available through the VICAP. Counselors can help resolve claims or billing problems, assist with filing for benefits, and help sort through complicated statements and notices.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs):
Virginia AIDS Drug Assistance Program
Phone: 1-855-362-0658

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document: [National Foundations](#), [Advocacy Connector](#), [Elected Officials](#).

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. [Click here](#) for additional information.

References:
ADDITIONAL PROGRAMS/RESOURCES

• Washington State Early Intervention Program
  Washington State Early Intervention Program
  Phone: 1-877-376-9316 or 1-360-236-3426

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME:
Statewide Health Insurance Benefits Advisors (SHIBA)
Phone: 1-800-562-6900

ABOUT:
• SHIBA understands healthcare coverage and provides free, unbiased healthcare coverage counseling to people of all ages. They assist with understanding healthcare coverage options and rights, finding affordable healthcare coverage, and evaluating and comparing health insurance plans. Volunteers are part of the SHIBA HelpLine.

LOW-INCOME SUBSIDY (LIS) PROGRAMS

LEARN MORE

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Washington include: AARP® MedicareRx Saver Plus, Clina Secure Rx, Clear Spring Health Value Rx, Elixir RxSecure, Express Scripts Medicare, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

LEARN MORE

• As of December 2020, a standard PA form has not been instituted in the state of Washington.

TREATMENT ACCESS:
GET ON IT AND STAY ON IT

LEARN MORE

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:
• If a drug is removed from a carrier’s formulary for a reason other than withdrawal of the drug from the market, availability of the drug over-the-counter, or the issue of black box warnings by the U.S. Food and Drug Administration (FDA), a carrier must continue to cover the drug for the time period required for an enrollee to use a carrier’s substitution process to request continuation of coverage for the removed medication, and receive a decision through that process, unless patient safety requires swifter replacement. Additionaly, when a carrier changes or newly limits drug coverage, prior notice of the change must be provided as soon as is practicable to enrollees who filled a prescription for the drug within the prior three months.

STEP THERAPY:
• Carriers that use step therapy protocols must have an exceptions process and grant exceptions in certain situations. Such processes must “not unreasonably restrict an enrollee’s access to non-formulary or alternate medications” for situations where the enrollee is unresponsive to treatment. Washington law also limits the ability of a health plan to charge excessive co-payments in administering their step therapy plans.

Additionally, health plans delivered, issued for delivery, or renewed on or after January 1, 2021 that use step therapy protocols must have an exceptions process and grant exceptions in certain situations. When coverage of a prescription drug for the treatment of any medical condition is subject to step therapy protocol, the covered person and the prescribing health care professional shall have access to a clear, readily accessible, and convenient process to request an exception. A carrier or utilization review organization may use its existing medical exceptions process to satisfy this requirement. The process must be easily accessible on the website of the health carrier, and prescription drug management organization. Further, approval criteria must be clearly posted in plain language and understandable to providers and patients.

ORAL PARITY LAW

LEARN MORE

• On January 1, 2012, an oral parity law was enacted to direct payers that provide coverage for cancer chemotherapy treatments to extend coverage for prescribed, orally administered anti-cancer medications at a cost no less favorable than the cost of intravenously administered or injected anti-cancer medications.

MEDICAID EXPANSION

LEARN MORE

• Because Washington has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in Washington, click here.

BIOSIMILAR LAW

LEARN MORE

• In Washington, biosimilar substitution laws allow pharmacists to substitute a biological product for the prescribed reference biologic only if it is deemed to be an “interchangeable” biosimilar by the FDA and meets other state law requirements. Currently, there are no interchangeable biological products.

References:
ADDITIONAL PROGRAMS/RESOURCES

LOW-INCOME SUBSIDY (LIS) PROGRAMS

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in West Virginia include: AARP MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Elixis RxSecure, Express Scripts Medicare, - Value, Humana Basic Rx Plan, Indy Health Saver Rx, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

- As of December 2020, a standard PA form has not been instituted in the state of West Virginia. 2

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/NON-MEDICAL SWITCHING:

- West Virginia does not appear to have any continuity of care provisions or limitations on non-medical switching applicable to prescription drug coverage.

STEP THERAPY:

- Health plans that use step therapy protocols must have an exceptions process and grant exceptions in certain situations. When coverage of a prescription drug for the treatment of any medical condition is restricted by a health plan issuer or utilization review organization, the patient and the prescribing healthcare provider shall have access to a clear and convenient process to request a step therapy exception determination. The process shall be made easily accessible on the health plan issuer’s or utilization review organization’s website. The health plan issuer or utilization review organization must provide a prescription drug for treatment of the medical condition at least until the step therapy exception determination is made.

ORAL PARITY LAW

- Health policies issued or renewed on or after January 1, 2016, that provide coverage for cancer treatment must extend coverage to orally administered anti-cancer medication at a cost no less favorable than intravenously administered or injected anti-cancer medications. 2

MEDICAID EXPANSION

- Because West Virginia has expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of disability, family status, financial resources, and other factors that are usually taken into account in Medicaid eligibility decisions. For more details on Medicaid expansion in West Virginia, click here. 3

BIOSIMILAR LAW

- Except as limited by the prescriber and unless instructed otherwise by the patient, a pharmacist who receives a prescription for a specific biological product shall select a less expensive interchangeable biological product unless in the exercise of his or her professional judgment the pharmacist believes that the less expensive drug is not suitable for the particular patient. The pharmacist shall provide notice to the patient or the patient’s designee regarding the selection of a less expensive biological product. 

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME:

State Health Insurance Assistance Programs (SHIPs)
Phone: 1-877-987-4463 or 1-304-558-3317

ABOUT:

- West Virginia’s Medicare information, counseling, and assistance program began in 1992. The website (accessed by clicking on program name above) has a zip code searchable database for locating a counselor.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

AIDS Drug Assistance Program
Phone: 1-304-232-6822

ADDITIONAL PROGRAMS/RESOURCES

For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:
- National Foundations
- Advocacy Connector
- Elected Officials

Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
### Wisconsin

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**Low-Income Subsidy (LIS) Programs**
- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Wisconsin include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Eligix RxSecure, Express Scripts Medicare - Value, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

**Standard Prior Authorization (PA) Form**
- As of December 2020, a standard PA form has not been instituted in the state of Wisconsin.

**Treatment Access: Get on It and Stay on It**
- Wisconsin does not appear to have any continuity of care provisions or limitations on non-medical switching applicable to prescription drug coverage.

**Oral Parity Law**
- Wisconsin passed oral parity legislation for health policies issued or renewed on or after January 1, 2015, that requires payers to provide coverage for orally administered anti-cancer medication at a cost equal to intravenously administered or injected cancer medications. A plan is also in compliance with the law if they charge no more than $100 per prescription for the orally administered anti-cancer treatment. Additionally, plans may not increase the out-of-pocket cost to patients to achieve compliance.

**Medicaid Expansion**
- As of December 2020, Wisconsin has not expanded Medicaid.

**Biosimilar Law**
- A pharmacist shall dispense every prescription using either the biological product prescribed or an interchangeable biological product, if the interchangeable biological product is lower in price to the consumer than the biological product prescribed, and shall inform the consumer of the options available in dispensing the prescription. A prescribing practitioner may indicate, by writing on the face of the prescription order or, with respect to a prescription order transmitted electronically, by designating in electronic format the phrase “No Substitutions” or words of similar meaning or the initials “N.S.,” that no substitution of the biological product prescribed may be made under substitution. If such indication is made, the pharmacist shall dispense the prescription with the specific biological product prescribed. No preprinted statement regarding biological product substitution may appear on the face of the prescription order.

**State Health Insurance Assistance Programs (SHIPs)**
- Division of Public Health: ADAP
  - Phone: 1-800-242-1060
- Wisconsin SeniorCare
  - Phone: 1-608-267-6875 or 1-800-991-5532

**State Pharmaceutical Assistance Programs (SPAPs)**
- Wisconsin SeniorCare
  - Phone: 1-800-657-2038

**Additional Programs/Resources**
- For general medication access and affordability options resources, as well as questions or concerns regarding state issues requiring legislative intervention, please visit the following pages within this document:
  - National Foundations
  - Advocacy Connector
  - Elected Officials

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References:
1. 2021 Medicare Part D Stand-Alone Prescription Drug Plans: [https://www.cms.gov/Medicare/Prescription-Drugs-Coverage/PrescriptionDrugCoverage](https://www.cms.gov/Medicare/Prescription-Drugs-Coverage/PrescriptionDrugCoverage)
4. ADAP Advocacy Association (AAA) AIDS Drug Assistance Programs (ADAP) Directory: [http://adas.directory](http://adas.directory)
5. Wisconsin SeniorCare: [http://khn.org/glossary/](http://khn.org/glossary/)
8. State Health Insurance Assistance Programs: [https://www.medicare.gov/](https://www.medicare.gov/)
10. Wisconsin SeniorCare: [http://www.seniorsresourceguide.com/directories/](http://www.seniorsresourceguide.com/directories/)
11. State Pharmaceutical Assistance Programs: [https://www.medicare.gov/state-pharmaceutical-assistance-program/state-programs.aspx](https://www.medicare.gov/state-pharmaceutical-assistance-program/state-programs.aspx)
Wyoming

To view a glossary of common healthcare terms, visit: http://khn.org/glossary/

LOW-INCOME SUBSIDY (LIS) PROGRAMS

- Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The LIS programs in Wyoming include: AARP® MedicareRx Saver Plus, Cigna Secure Rx, Clear Spring Health Value Rx, Humana Basic Rx Plan, SilverScript Choice, WellCare Classic, and WellCare Medicare Rx Saver.

STANDARD PRIOR AUTHORIZATION (PA) FORM

- As of December 2020, a standard PA form has not been instituted in the state of Wyoming.

TREATMENT ACCESS: GET ON IT AND STAY ON IT

CONTINUITY OF CARE/ NON-MEDICAL SWITCHING:
- Wyoming does not appear to have any continuity of care provisions or non-medical switching limitations that apply specifically to prescription drug coverage.

STEP THERAPY:
- Wyoming does not appear to have any laws or regulations that apply specifically to step therapy/fail-first requirements.

ORAL PARITY LAW

- Health policies issued or renewed on or after July 1, 2015, that cover cancer chemotherapy treatments cannot require higher cost-sharing for their coverage for oral chemotherapy than they do for intravenous or injected chemotherapy. Additionally, plans cannot reclassify benefits or increase their cost-sharing for intravenous drugs in order to comply.

MEDICAID EXPANSION

- As of December 2020, Wyoming has not expanded Medicaid.

BIOSIMILAR LAW

- Pharmacists may substitute a biological product for the prescribed reference biologic if it is deemed to be an “interchangeable” biosimilar by the U.S. Food and Drug Administration (FDA) and other state law requirements are met, unless certain exceptions apply. Currently, there are no interchangeable biological products.

STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPs)

PROGRAM NAME:
- Wyoming State Health Insurance Information Program (WSHIIP)

Phone: 1-800-856-4398

ABOUT:
- WSHIIP is a federally mandated program, set up to help seniors and others on Medicare understand their rights and answer their questions. There are over 80 volunteers in most of the Wyoming counties who will counsel beneficiaries and help solve problems confidentiality and free of cost. Trained counselors promote consumer understanding of Medicare, Medicaid, Medicare supplemental insurance, and long-term care insurance.

STATE PHARMACEUTICAL ASSISTANCE PROGRAMS (SPAPs)

HIV Services Program

Phone: 1-307-777-5856

ADDITIONAL PROGRAMS/RESOURCES

- Eligible veterans may be able to receive care from participating community providers through the Veteran Community Care Program. Click here for additional information.

References:
How to apply if your state hasn’t expanded

Each state has coverage options that could work for your patients, particularly if they have children, are pregnant, or have a disability. In all states, patients can apply for Medicaid coverage in 1 of 2 ways:

1. Directly to the state Medicaid agency, using the “select your state” drop-down menu at [https://www.healthcare.gov/medicaid-chip/eligibility/](https://www.healthcare.gov/medicaid-chip/eligibility/) to locate the contact information, or
2. By filling out an online application at [https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/](https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/), located under the option to “Apply for Medicaid coverage, even if your state hasn’t expanded.”

States with expanded Medicaid

The states colored in blue have implemented Medicaid expansion.

Key facts

- The Affordable Care Act provides states with additional federal funding to expand their Medicaid programs to cover adults under 65 years of age with incomes up to 133% of the Federal Poverty Level (FPL), which is effectively 138% of the FPL due to calculation method. Children (18 years of age and under) are eligible up to that income level or higher in all states.1
- In states with expanded Medicaid, free or low-cost health coverage is available to people with incomes below a certain level regardless of other factors usually taken into account in Medicaid eligibility decisions.1

Support in states that have expanded

- Patients can qualify based on income alone in states that have expanded Medicaid. Patients earning below 133% of the FPL will likely qualify for coverage. (In 2021, the FPL is $12,880 a year as a single person or $26,500 for a family of four. Alaska and Hawaii use a different income limit.) Click here to learn more.
- Patients earning more than these amounts can buy a private insurance plan in the Marketplace, and/or may be eligible for tax credits that lower the cost of monthly premiums and out-of-pocket costs.1

Support in states that haven’t expanded

- Patients earning more than 100% of the FPL will be able to buy a private health insurance plan in the Marketplace and may qualify for premium tax credits and other savings based on household size and income.
- Patients earning less than 100% of the FPL won’t qualify for lower costs for private insurance based on income, but may be eligible for Medicaid, even without the expansion, based on the state’s existing rules.1

References:
State Pharmaceutical Assistance Programs (SPAPs)

Don’t give up—there may be assistance options for patients without insurance who are not eligible for government programs.

KEY FACTS
- SPAPs offer prescription drug assistance for state residents who lack insurance coverage for medicines, or who were not eligible for other government programs. Low-income, elderly patients, and patients with disabilities who do not qualify for Medicaid are often assisted by SPAPs.1
- SPAPs utilize state funds to pay for a portion of insurance costs, usually for a defined population that meets certain enrollment criteria.1

ADDITIONAL INFORMATION
- Some states offer programs that can help people with certain illnesses pay for their prescription drugs. HIV/AIDS Drug Assistance Programs (ADAPs) and programs for people suffering from end-stage renal disease (ESRD) are programs in this category.1
- States that offer SPAPs often coordinate their SPAPs with Medicare Part D drug benefits. Check with the individual state program to see how it works with Part D.
- If a drug is covered by both your patient’s SPAP and Part D plan, the patient’s payment plus the SPAP payment for the drug will count towards the out-of-pocket maximum your patient is required to reach before his or her Medicare drug costs go down.2

CHALLENGES
- An increasing number of states use discounts or bulk purchasing approaches that do not draw upon state funds for the drug purchases.
- Since the passage of the federal Affordable Care Act (ACA), state legislatures have been less active on SPAP issues.3

STATES WITH SPAP/ADAP PROGRAMS
All 50 states currently have SPAPs and/or ADAPs in place.1,3,4

EFFECT OF LIS ON PATIENT COSTS (CONTINUED)

• Patients who qualify for full LIS are entitled to a premium subsidy equal to 100% of the plan’s premium for basic prescription drug coverage, or the regional low-income premium subsidy amount, also called the “benchmark premium.”

Partial LIS

• A patient may qualify for a partial subsidy if he or she has an annual income below 150% of the FPL and his or her resources do not exceed the limitations specified by the SSA for the plan year.

• Partial subsidy-eligible patients may be eligible for a premium subsidy ranging from 25% to 100% of the premium subsidy amount.

APPLYING FOR “EXTRA HELP”

There is no cost to apply for this program. Patients should start the process early to ensure that the benefit is in place by January 1 of the next Part D plan year. If a patient is having trouble paying for his or her medications, he or she should be aware of the following application options:

• To apply online, visit https://secure.ssa.gov/i1020/start

• To apply by telephone, call 1-800-772-1213. (TTY users should call 1-800-325-0778)

LIS PLANS PER STATE

LIS plans are active in all U.S. states. To see plans that are active in your state, select the orange U.S. map icon on the top of this page, and then select your state within the map page.*

KEY FACTS

• Medicare patients who have limited income and resources may qualify for “Extra Help” to pay for prescription drugs. The Medicare LIS program provides financial assistance for patients who may otherwise be unable to afford the costs associated with their Medicare Part D plan.

• Eligible patients may receive assistance paying their monthly premium, have a reduced or no deductible, have reduced or no prescription coinsurance and co-payments, and have no gap in coverage.

ELIGIBILITY

LIS for prescription drug costs is available in two ways:

1) Automatic eligibility, or 2) By application.

• For more information, please visit: http://www.medicare.gov/ and https://www.ssa.gov/

EFFECT OF LIS ON PATIENT COSTS

A Medicare patient may be eligible for 1 of 2 different levels of “Extra Help” – the full subsidy or the partial subsidy.

Full LIS

• Patients deemed automatically eligible for LIS qualify for the full subsidy. A patient may also qualify if he or she has an annual income below 135% of the Federal Poverty Level (FPL) and his or her resources do not exceed limits set by the Social Security Administration (SSA).

• Patients who qualify for full LIS are entitled to a premium subsidy equal to 100% of the plan’s premium for basic prescription drug coverage, or the regional low-income premium subsidy amount, also called the “benchmark premium.”

Partial LIS

• A patient may qualify for a partial subsidy if he or she has an annual income below 150% of the FPL and his or her resources do not exceed the limitations specified by the SSA for the plan year.

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• A patient may qualify for a partial subsidy if he or she has an annual income below 150% of the FPL and his or her resources do not exceed the limitations specified by the SSA for the plan year.

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APPLYING FOR “EXTRA HELP”

There is no cost to apply for this program. Patients should start the process early to ensure that the benefit is in place by January 1 of the next Part D plan year. If a patient is having trouble paying for his or her medications, he or she should be aware of the following application options:

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LIS PLANS PER STATE

LIS plans are active in all U.S. states. To see plans that are active in your state, select the orange U.S. map icon on the top of this page, and then select your state within the map page.*

* This resource only includes basic LIS plans that have a $0 premium with full LIS. Please visit https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn and download “2021 PDP Landscape Source Files” to see all plans available in your state.

State Health Insurance Assistance Programs (SHIPs)

Free information. Free counseling. Learn about an outstanding resource for providers and patients with Medicare or Medicare-related health insurance questions.

KEY FACTS

- State Health Insurance Assistance Program (SHIPs) provide free, in depth, one-on-one insurance counseling and assistance to Medicare beneficiaries, their families, friends, and caregivers. These are grant-funded projects of the federal U.S. Department of Health & Human Services (HHS), and the U.S. Administration for Community Living (ACL).1

- SHIPs provide free information and counseling for providers and patients with questions or concerns about Medicare or Medicare-related health insurance. SHIPs can also help beneficiaries save on Medicare costs.1

STATES WITH SHIP

SHIPs operate in all 50 states, and also in the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands.1 To access SHIP descriptions and contact information, visit https://www.shiptacenter.org/.

**Standard Prior Authorization (PA) Form**

**States with a Standard PA Form**

The states colored in blue are the only states that have a standard PA form.1

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**Key Facts**

- A standardized, or “uniform,” PA form may be required in certain states to submit PA requests to a health plan for review, along with the necessary clinical documentation. These standard forms can be used across payers and health benefit managers (this includes health insurers, prepaid managed care organizations, third-party administrators, entities that establish self-insurance plans, healthcare clearinghouses, and other entities that perform claims processing and other administrative functions).

- A standardized PA form assists providers by streamlining the data submission process for selected services that require PA.

- Standardized PA forms may help medical practices assist patients in receiving their necessary medical and healthcare services in a timely manner and with less administrative complexity.

**Limitations**

- Most standardized PA forms are only applicable to prescription drug benefits, but some states have standardized PA forms for other medical services.

- Standardized PA forms are typically not applicable to self-funded employer-sponsored health plans, Medicare Part D plans, and Medicaid fee-for-service plans.

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Foundations & Other Non-profit Resources

No co-pay assistance? There are still options that may be available. Learn about non-profit or other options available to assist patients with prescription drug costs.

KEY FACTS
- In recent years, healthcare choices have expanded significantly, many due to advances in pharmaceutical treatments. Although prescription drug expense represents only a small portion of total U.S. healthcare spending,1 the out-of-pocket costs for individual patients can be significant. These are some of the resources that are available to assist patients with their prescription drug costs.

FOUNDATIONS & FUNDS (continued)

Good Days provides co-pay assistance to underinsured patients who require the use of expensive, specialty therapeutics. Good Days maintains separate funds for each of the disease states covered and all disease/drug options may not always be available. Each disease and the medications covered are defined using proprietary guidelines.

2611 Internet Blvd., Suite 105
Frisco, TX 75034
Phone: 1-877-968-7233
Fax: 1-214-570-3621
E-mail: info@mygooddays.org
Website: www.mygooddays.org

HealthWell Foundation is a co-payment assistance foundation that provides financial assistance to eligible individuals to cover coinsurance, co-payments, and deductibles for certain medications and therapies. Patients must be insured to participate.

P.O. Box 489
Buckeystown, MD 21717
Phone: 1-800-675-8416
Fax: 1-800-282-7692
E-mail: grants@healthwellfoundation.org
Website: www.healthwellfoundation.org

FOUNDATIONS & FUNDS

The Assistance Fund, Inc. provides eligible underinsured individuals with financial assistance to cover all or part of the individuals’ out-of-pocket cost for the supported medications. Patients must meet financial criteria and be diagnosed with a program-related illness.

4700 Millenia Blvd., Suite 410
Orlando, FL 32839
Phone: 1-855-845-3663
Fax: 1-833-865-3757
Website: www.tafcares.org

CancerCare is a non-profit organization that helps people being treated for cancer afford co-payments for chemotherapy and targeted treatment drugs. Covered diagnoses may vary. Patients must be insured. Financial and clinical eligibility criteria apply.

275 Seventh Avenue
22nd Floor
New York, NY 10001
Phone: 1-800-813-HOPE (4673)
Fax: 1-212-712-8495
E-mail: info@cancercare.org
Website: www.cancercare.org

Click here for next page of Foundations & Other Non-profit Resources

The Leukemia & Lymphoma Society (LLS) offers help with premiums and co-pays for patients who meet financial qualifying criteria and have an LLS Co-Pay Program-covered blood cancer diagnosis confirmed by a physician. Prescription drugs supplied to the patient by a pharmacy or administered in an office or hospital by a healthcare provider are included. The program cannot provide financial assistance for drugs not included on the patient’s insurance plan or drug formulary. Prescription insurance coverage is required to qualify.

Phone: 1-800-955-4572
Website: www.lls.org

Patient Access Network Foundation provides financial support for out-of-pocket costs associated with a wide range of drugs to treat a number of conditions.

805 15th Street, NW, Suite 500
Washington, DC 20005
Phone: 1-866-316-PANF (1-866-316-7263)
E-mail: info@panfoundation.org
Website: www.panfoundation.org

The Patient Advocate Foundation (PAF) Co-Pay Relief Program (CPR), a division of the Patient Advocate Foundation, provides financial assistance with co-payments, coinsurance, and deductibles for insured patients, including Medicare Part D beneficiaries, who financially and medically qualify. Pharmacies or providers may enroll patients online.

421 Butler Farm Road
Hampton, VA 23666
Phone: 1-757-952-0118
Toll free: 1-866-512-3861
Fax: 1-757-952-0119
E-mail: cpr@patientadvocate.org
Website: www.copays.org

Patient Services Inc., offers premium assistance as well as a variety of co-pay assistance programs. Assistance is disease-specific and the type and availability of programs can vary.

P.O. Box 5930
Midlothian, VA 23112
Phone: 1-800-366-7741
Fax: 1-804-744-9388
Website: www.patientservicesinc.org

For a complete list of not-for-profit local, national, and state resources, please visit https://www.cancer.com/support-tools/advocacy-connector.
Oral Parity Laws

Looking to limit patient costs influencing chemotherapy decisions? See how states are helping to equalize patient costs between oral and intravenous chemotherapy.

KEY FACTS

• Oral parity laws require payers to equalize patient cost-sharing between oral chemotherapy and intravenous (IV) chemotherapy under a given health plan.1

• Patients are often required to pay more under their insurance plans for oral chemotherapy than for physician-administered treatment.2

• Health plans typically cover IV chemotherapy as a medical benefit with patients charged for treatment as part of an outpatient visit, usually requiring a flat co-payment that covers both the drug and the administration.3 Average costs for the patient are $20–$40 per visit.4

• Oral parity laws are designed to address this discrepancy, enabling patients and physicians to choose the most effective treatment option without regard to potential cost.5

• Health plans typically cover oral chemotherapy under their pharmacy benefit. A health plan’s pharmacy benefit will usually require a patient to pay a percentage of the drug’s cost, rather than a flat co-payment.

LIMITATIONS

• State oral parity laws only govern health insurance plans that are subject to state oversight. This includes private individual, small group, and large group plans. Employer self-insured plans are generally regulated by the federal Employment Retirement Income Security Act (ERISA) and are not subject to state oversight. Medicare Part D is a public, federal program and is not subject to state insurance regulatory requirements. Note that eligibility criteria varies by state.

• Oral parity laws do not require health plans to offer chemotherapy services. Rather, they ensure that when chemotherapy services are offered, cost-sharing is comparable regardless of how they are administered.6

STATES WITH ORAL PARITY LAWS

All states colored in blue have passed oral parity laws.6

KEY FACTS

• The Advocacy Connector website provides an interactive questionnaire that, when completed, identifies resources targeted to oncology patient needs. Available resources include financial, legal, and insurance assistance, among others.

• The Advocacy Connector makes it as easy as possible for you to find and contact the advocacy groups most relevant to your patient’s needs. All you need to do is enter information about your patient’s illness and the types of resources the patient is looking for, and the site will generate a list of groups and resources.

WEBSITE

https://www.cancer.com/support-tools/advocacy-connector
Biosimilar Legislation

Learn more about how states are planning to regulate substitution of biologic drugs.

KEY FACTS
• States regulate the use of brand-name and generic prescription drugs through statutes and rules about substitution of generics for brand-name prescriptions. However, regulating biologic drug substitution raises more complex issues. Biologic drugs are much more difficult to replicate than small molecule drugs. While identical “generic” versions of biologics are currently virtually impossible to produce, manufacturers may obtain U.S. Food and Drug Administration (FDA) approval for biological products that are “highly similar” (but not identical) to brand-name biological products. In addition, the FDA can deem a biosimilar product “interchangeable” with a brand-name product, which is an even more stringent standard.
• Traditional statutes regulating “generic drugs” could possibly be misapplied to new biosimilar products that are not identical.
• There are initiatives underway to amend older state laws to address the medical and chemical characteristics of “biologics,” as well as any future generic-style “follow-on biologics” or “biosimilars.”
• Since 2013, at least 49 states have considered legislation to establish standards for substitution of a “biosimilar” prescription product.1
• As of December 31, 2017, fewer than 10 drugs have gained full approval by the FDA as biosimilars in the United States. No products have been deemed interchangeable.1

COMMON FEATURES OF STATE LEGISLATION 2013-2018
• Any biosimilar product under consideration for substitution must first be approved as “interchangeable” by the FDA.
• The prescriber would still be able to request the innovator product by stating “dispense as written,” “brand medically necessary,” or other similar language.
• The prescriber must be notified of any allowable substitution made at a pharmacy.
• The individual patient must be notified that a substitute or switch has been made. In some cases, state law would require patient consent before any such switch is made.
• In some states, the pharmacist and physician must retain records of substituted biologic medications.
• Some state legislation provides immunity for pharmacists who make a biologic substitution in compliance with state law.
• Some state legislation requires the pharmacist to explain the cost or price of the biologic and the interchangeable biosimilar.
• Some state legislation requires that the state must maintain a public or web-based list of permissible interchangeable products.

CURRENT STATE LAWS AND LEGISLATION
All states colored in blue have enacted legislation for biologics and biosimilar substitution.1,2

Treatment Access: Continuity of Care, Non-Medical Switching, and Step Therapy

State-specific legislation may help patients to receive uninterrupted medical services in some situations.

KEY FACTS

• Patients are more likely to qualify for continuity of care when undergoing medical services for major illnesses or procedures. Patients with non-acute medical conditions they would like treated (such as treatment for an ear infection) may not qualify for continuity of care.

• To determine if medical services for a patient’s particular illness or procedure qualify for continuity of care, it is best for the patient to check with his or her healthcare professional and health plan.

• Non-medical switching is a change in a patient’s prescribed medicine that is driven by factors other than the clinical safety and effectiveness of the product, such as a health plan’s removal of the drug from its formulary, or when a patient changes health plans and is subject to new formulary rules.

• Continuity of care protections may help to ensure that established patients can remain on their prescribed drug regimen when medically appropriate to do so.

• Step therapy or a fail-first protocol is an insurer’s policy that requires a patient to try therapies in a specific order (i.e., try a less expensive generic or biosimilar version of a therapy before moving up a “step” to the more expensive therapy) and is often imposed as part of the prior authorization process.

• Some states have passed laws that restrict the use of step therapy and fail-first protocols, such as by requiring payers to provide a process through which patients and providers can obtain an exception.¹

STATES WITH CONTINUITY OF CARE/NON-MEDICAL SWITCHING PROTECTIONS

All states colored in blue have instituted continuity of care and/or non-medical switching protections.¹

STATES WITH STEP THERAPY PROTECTIONS

All states colored in blue have instituted step therapy protections.¹

For more questions or concerns regarding state issues requiring legislative intervention, visit the sites below.

CONTACT YOUR STATE LEGISLATURE
Visit the sites below to find your elected officials:

- U.S. SENATORS:
  https://www.senate.gov/general/contact_information/senators_cfm.cfm

- U.S. REPRESENTATIVES:
  http://www.house.gov/representatives/

- STATE LEGISLATURE WEBSITES:
  https://www.congress.gov/state-legislature-websites

For additional information regarding the Veteran Community Care Program, visit the sites below.

- For general information regarding the Veteran Community Care Program, including eligibility requirements:
  https://www.va.gov/COMMUNITYCARE/programs/veterans/General_Care.asp

- If you are a veteran who is interested in receiving care through the Veteran Community Care Program:

- If you are a community provider interested in providing services to eligible veterans through the Veteran Community Care Program:
  https://www.va.gov/COMMUNITYCARE/providers/index.asp