Q&A: Uniform Prescription Drug Prior Authorization Laws

Background

Several states have passed legislation that requires certain health insurers to use uniform prior authorization forms for prescription drugs. Prior authorization is a common tool used by health insurers that requires members, through their healthcare providers, to obtain prior approval of coverage from the health insurer before receiving coverage for certain medications or medical services. Prior authorization processes and forms vary widely across health insurers, imposing significant administrative burden on healthcare providers and creating delays in patient access to care. Some states have passed laws and issued regulations to streamline prior authorization request forms and processes. These "Questions & Answers" address various topics related to prior authorization.

Q. What are prior authorization forms?

A. Prior authorization is an approval required by many health insurers before covering certain prescriptions or medical services. Prior authorizations for prescription drugs allow insurers to conduct a medical review to ensure the prescription drugs, any associated professional services, and how the drug is delivered are medically necessary for the patient based on the insurers' criteria. In an effort to minimize the administrative burden associated with seeking prior authorization, several states have enacted legislation requiring certain health insurers or plans to use one specific prior authorization form for any prior approval request for a prescription drug throughout the state.

Q. What health plans are required to use the prior authorization process and forms?

A. Laws and regulations mandating the use of uniform prior authorization forms vary across states. Many states require all state-regulated health insurers, carriers, and pharmacy benefit managers (PBMs) that cover prescription drug benefits to use the forms to implement any prior authorization requirement. Typically prior authorization laws do not, however, apply to self-funded employer-sponsored health plans or federal government-funded health plans, such as Medicare Part D plans.

Q. What do prior authorization laws typically address?

A. Prior authorization laws and regulations frequently provide for a standardized form to justify the request, and address the process through which providers request prior authorization. The laws sometimes specify the methods providers may use to submit the forms, timeframes that covered health insurers must follow when processing prescription drug prior authorization requests, and expedited processes and timeframes for "urgent" requests. Some state laws also require covered health insurers to make certain information available to prescribing providers online regarding the prior authorization requirements for prescription drugs. For example, a state may require a covered health insurer to maintain a listing of drugs that require prior authorization, including the clinical criteria and supporting references that the health insurer will use in making its prior authorization determination.[1]

Q. What information should providers include in the prior authorization form to document medical necessity?

A. Providers should pay careful attention to the specific items required by the prior authorization form and provide complete responses to each item. In general, to ensure the greatest likelihood of obtaining approval, providers should include the patient's comprehensive story, and fully describe the patient's clinical need for the prescription drug and professional services to be delivered in a specified setting. The provider should make sure to address the clinical criteria that the health insurer uses to determine whether to authorize the drug and services, to the extent the health insurer makes the criteria available.

Q. What states have enacted uniform prior authorization laws?

A. To date, 15 states have enacted legislation and/or implemented regulations requiring the use of uniform prior authorization standards. Three of these states require that, effective January 1, 2018, insurers accept prior authorization requests using the National Council for Prescription Drugs Programs SCRIPT standards for electronic prior

[1] *See, e.g.*, 3 Colo. Code Regs. § 702-4:4-2-49(5)(B)(2).

authorization (ePA) transactions. These states include Ohio,[2] Delaware,[3] and Indiana.[4] The remaining states require the use of a uniform prior authorization form. The following states have made available their uniform prior authorization forms, which may be accessed by clicking on the links: California,[5] Colorado,[6] Florida,[7] Iowa,[8] Massachusetts,[9] Michigan,[10] Minnesota,[11] New Mexico,[12] Oregon,[13] Texas,[14] and Vermont.[15] Effective July 1, 2017, New Hampshire will also require the use of a uniform prior authorization form.[16]

Q. Who can providers contact if they have additional questions about the uniform prescription drug prior authorization request form and process?

A. Providers should contact the individual health insurer through the applicable provider contact number if they have questions about the uniform prior authorization process and request form. Providers and patients may also contact the appropriate state regulatory body for further information.

[2] Ohio Rev. Code § 1751.72(B)(2)(a)-(b) (effective Jan. 1, 2018).

[3] Del. Code Title 18, § 3377 (effective Jan. 1, 2018).

[4] Ind. Code § 27-1-37.4-4 (effective Jan. 1, 2018).

[5] Cal. Health & Safety Code § 1367.241(c).

[6] Colo. Rev. Stat. § 10-16-124.5(1)(a); 3 Colo. Code Regs. § 702-4(5)(A)-(5)(B).

[7] Fla. Admin. Code Ann. r. § 69O-161.001, 69O-161.011.

[8] Iowa Code § 505.26(2).

[9] Mass. Gen. Laws ch. 1760, § 25(c).

[10] Mich. Comp. Laws § 500.2212c(1).

[11] Minn. Stat. § 62J.497(2)(a).

[12] N.M. Stat. §§ 59A-22-52(A); 59A-2-9.8(A).

[13] Or. Rev. Stat. § 743.035(1).

[14] Tex. Ins. Code § 1217.004(a)(1)-(a)(2).

[15] Vt. Stat. Title 18, § 9418b(g)(1)(A).

[16] N.H. Rev. Stat. § 420-E:4-(a)(I).