

**DEPARTMENT OF MANAGED HEALTH CARE  
OFFICE OF PLAN MONITORING  
DIVISION OF PLAN SURVEYS**

**TECHNICAL ASSISTANCE GUIDE**

**RX DRUG TAG MODULE  
ROUTINE MEDICAL SURVEY  
OF  
PLAN NAME**

**DATE OF SURVEY:**

**PLAN COPY**

*Issuance of this December 27, 2021 Technical Assistance Guide renders all other versions obsolete.*

# FULL SERVICE TAG

## PRESCRIPTION DRUG REQUIREMENTS

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### Requirement RX-001: Prior Authorization and Step Therapy Exception Requests Review Process

#### INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- UM Director
- Director or Manager of Pharmacy

#### DOCUMENTS TO BE REVIEWED

- Pharmacy management procedures
- Policies and procedures for reviewing requests for prior authorization for prescription drugs
- Policies and procedures for reviewing requests for an exception to the Plan's step therapy process for prescription drugs
- Delegate contracts (if the plan delegates financial risk and/or utilization management functions for prescription drug benefits)
- Policies and procedures for delegate oversight (if the plan delegates financial risk and/or utilization management functions for prescription drug benefits)
- Provider Manual
- The Plan's website
- The Plan's contracting Pharmacy Benefit Manager (PBM) website (if applicable)

#### **RX-001 - Key Element 1:**

1. The Plan has a process for providers to obtain prior authorization for requests for prescription drugs and exceptions to the Plan's step therapy process. CA Health and Safety Code section 1367.241(a)-(c), (e)-(f), and (h); CA Health and Safety Code section 1367.244(a); 28 CCR 1300.67.241(a)-(c), (e)-(f), (h)-(i), and (m)(1)-(2).

<b>Assessment Questions</b>	
1.1	Do the Plan's policies and procedures require providers to use Form No. 61-211 to submit prior authorization requests for prescription drugs?
1.2	Does the Plan allow providers to submit prior authorization requests for prescription drugs using an electronic prior authorization system?
1.3	Does the Plan utilize a step therapy process for prescription drugs?
1.3.1	If yes, does the Plan require providers to use Form No. 61-211 to submit step therapy exception requests?
1.3.2	Do the Plan's policies and procedures treat and respond to step therapy exception requests in the same manner as requests for prior authorization for prescription drugs?
1.3.3	Does the Plan have an expeditious process in place to authorize exceptions to step therapy when medically necessary?

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1.4	Do the Plan's policies and procedures require a response to exigent prior authorization and step therapy exception requests within 24 hours? <i>Does not apply to Medi-Cal plans/lines of business</i>
1.4.1	If yes, do the Plan's policies and procedures specify that, if the Plan fails to respond to the request within this timeframe, the request is deemed granted? <i>Does not apply to Medi-Cal plans/lines of business</i>
1.5	Do the Plan's policies and procedures require a response to non-urgent prior authorization and step therapy exception requests within 72 hours? <i>Does not apply to Medi-Cal plans/lines of business</i>
1.5.1	If yes, do the Plan's policies and procedures specify that, if the Plan fails to respond to the request within this timeframe, the request is deemed granted? <i>Does not apply to Medi-Cal plans/lines of business</i>
1.6	Does the Plan make Form 61-211 electronically available on its website(s)?
1.7	Does the Plan contract with a PBM to conduct prescription drug prior authorization or step therapy exception services?
1.7.1	If yes, does the Plan have written policies and procedures in place to ensure that the PBM complies with section 1367.241 of the KKA and Rule 1300.67.241?
1.7.2	Does the PBM make Form 61-211 electronically available on its website(s)?
1.8	Does the Plan: a. delegate financial risk for prescription drugs to a contracted physician group; b. contract with a physician group that uses its own internal prior authorization process; or c. delegate utilization management concerning any prescription drug, regardless of the delegation of financial risk, to a contracted physician group?
1.8.1	If yes, does the Plan's contract require the contracted physician group to comply with Rule 1300.67.241, subdivision (b)?

### End of Requirement RX-001: Prior Authorization and Step Therapy Exception Requests Review Processes

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### Requirement RX-002: Formulary Exception Request Authorization

#### INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- UM Director
- Director or Manager of Pharmacy

#### DOCUMENTS TO BE REVIEWED

- Policies and procedures for reviewing formulary exception requests, including pharmacy management procedures
- Formulary disclosures
- Evidence of Coverage
- Provider Manual
- The Plan's website
- The PBM's website (if applicable)
- Sample of formulary exception denial files to be reviewed on site
- Sample of external exception request review files to be reviewed on site, if applicable
- Formulary exception denial template letters

#### **RX-002 - Key Element 1:**

1. The Plan provides an expeditious process for providers to obtain authorization for medically necessary non-formulary prescription drugs. CA Health and Safety Code section 1342.71(c); CA Health and Safety Code section 1367.01(e); CA Health and Safety Code section 1367.22(a); CA Health and Safety Code sections 1367.24(a)-(d) and (k); CA Health and Safety Code section 1367.241(h)(2); CA Health and Safety Code section 1368.01(a) and (c); 45 CFR 156.122(c)(1)-(4).

Assessment Questions	
1.1	Do the Plan's policies and procedures provide an expeditious process for providers to obtain authorization for medically necessary non-formulary prescription drugs?
1.2	If the Plan offers any individual, small group, or large group product lines, do the Plan's policies and procedures require the Plan to respond to formulary exception requests within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.3	Do the Plan's policies and procedures require that, if the Plan grants a formulary exception request, the Plan not limit or exclude coverage if the prescribing provider continues to prescribe the drug and the drug is appropriately prescribed for treating the enrollee's medical condition?

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1.3.1	If the Plan offers any individual, small group, or large group product lines, do the Plan's policies and procedures require that, if the Plan grants a standard formulary exception request, the Plan provide coverage of the nonformulary drug for the duration of the prescription, including refills? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.3.2	If the Plan offers any individual, small group, or large group product lines, do the Plan's policies and procedures require that, if the Plan grants an expedited formulary exception request, the Plan provide coverage of the nonformulary drug for the duration the exigency? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.4	If the Plan offers any individual, small group, or large group product lines, do the Plan's policies and procedures provide a process for an enrollee, an enrollee's designee, or a prescribing provider to request that the original formulary exception request and subsequent denial of such request be reviewed by an independent review organization? <sup>1</sup> <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.4.1	Do the Plan's policies and procedures require the Plan to make its determination on the external exception review request and notify the enrollee or the enrollee's designee and the prescribing provider of its coverage determination no later than 72 hours following receipt of the request, if the original request was a standard request for nonformulary prescription drugs? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.4.2	Do the Plan's policies and procedures require the Plan to make its determination on the external exception review request and notify the enrollee or the enrollee's designee and the prescribing provider of its coverage determination no later than 24 hours following receipt of the request, if the original request was an expedited formulary exception request? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.4.3	Do the Plan's policies and procedures require that, if the Plan grants an external exception review request for a standard nonformulary request, the Plan provide coverage of the non-formulary drug for the duration of the prescription? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.4.4	Do the Plan's policies and procedures require that, if the Plan grants an external exception review request for an expedited nonformulary request, the Plan provide coverage of the non-formulary drug for the duration of the exigency? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.5	Does the Plan describe the process by which enrollees may obtain medically necessary non-formulary drugs in the Plan's evidence of coverage and disclosure forms?
1.5.1	If yes, is the information provided in the Plan's evidence of coverage and disclosure forms consistent with the Plan's policies and procedures for obtaining medically necessary nonformulary drugs?
1.6	Does the Plan provide a written description of its formulary exception request process, including timelines, to its prescribing providers?

<sup>1</sup> Also known as an external exception review request.

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### **RX-002 - Key Element 2:**

- 2. The Plan timely reviews and responds to formulary exception requests.**  
**CA Health and Safety Code section 1367.01(e); CA Health and Safety Code sections 1367.01(e) and (h)(4); CA Health and Safety Code sections 1367.24(a), (b), and (k); CA Health and Safety Code section 1368.01(a) and (c); CA Health and Safety Code section 1368.02(b); CA Health and Safety Code section 1374.30(i); 45 CFR 156.122(c)(1)-(4); 28 CCR 1300.67.241(e)(4)(A)-(E).**

<b>Assessment Questions</b>	
2.1	Do the Plan’s denial files validate that only licensed physicians or licensed health care professionals (competent to evaluate the clinical issues) make decisions to deny medically necessary non-formulary drugs?
2.2	For standard formulary exception requests, does the Plan notify the enrollee or the enrollee’s designee and the prescribing provider of the Plan’s decision within 72 hours after the Plan receives the request? <i>(Does not apply to Medi-Cal plans/lines of business – see Section 1367.01(h) for applicable requirements.)</i>
2.3	For exigent formulary exception requests, does the Plan notify the enrollee or the enrollee’s designee and the prescribing provider of the Plan’s coverage determination within 24 hours after the Plan receives the request? <i>(Does not apply to Medi-Cal plans/lines of business – see Section 1367.01(h) for applicable requirements.)</i>
2.4	If the Plan denies a provider’s formulary exception request as not medically necessary, do the Plan’s denial notices include a clear and concise explanation of the reasons for the Plan’s decision?
2.5	Do the Plan’s denial notices include a description of the criteria and/or guidelines used for the Plan’s decision?
2.6	Do the Plan’s denial notices include the clinical reasons for the denial?
2.7	Do the Plan’s denial notices to the prescribing provider include the name and the direct telephone number or telephone extension of the professional that made the determination?
2.8	Do the Plan’s denial notices indicate that the enrollee may file a grievance to the Plan if the enrollee objects to the disapproval, including any alternative drug or treatment offered by the Plan?
2.9	Do the Plan’s denial notices indicate that the enrollee may file a grievance seeking an external exception request review? <i>(Does not apply to Medi-Cal plans/lines of business)</i>
2.10	Do the Plan’s denial notices include information as to how the enrollee may file a grievance with the Plan, including how to seek an external exception request review by an independent review organization? <i>(Does not apply to Medi-Cal plans/lines of business)</i>
2.11	Do the Plan’s denial letters include the paragraph required by section 1368.02(b)?

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### **RX-002 - Key Element 3:**

- 3. The Plan provides for timely reviews of formulary exception request denials by an independent review organization.  
CA Health and Safety Code section 1367.24(k); CA Health and Safety Code section 1368.01(a) and (c); 45 CFR 156.122(c)(3)(i)-(ii).**

<b>Assessment Questions</b>	
3.1	Are all external exception request reviews completed by an independent review organization?
3.2	If the enrollee, the enrollee's designee, or the prescribing provider requests an external exception request review for a standard formulary exception request, does the Plan notify the enrollee or the enrollee's designee and the prescribing provider of the Plan's coverage determination within 72 hours after the Plan receives the request?
3.3	If the enrollee, the enrollee's designee, or the prescribing provider requests an external exception request review for an expedited formulary exception request, does the Plan notify the enrollee or the enrollee's designee and the prescribing provider of the Plan's coverage determination within 24 hours after the Plan receives the request?

### **End of Requirement RX-002: Formulary Exception Request Authorization**



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### Requirement RX-003: Plan's Obligations Relating to Drug Previously Approved for Enrollee Medical Condition

#### INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- None

#### DOCUMENTS TO BE REVIEWED

- Policies and procedures for approving prescriptions previously approved for coverage by the plan for the medical condition.
- EOC sections referencing prescription coverage

#### **RX-003 - Key Element 1:**

1. The Plan does not limit or exclude coverage for a drug the Plan previously approved for an enrollee for the medical condition.  
CA Health and Safety Code section 1367.22(a).

<b>Assessment Questions</b>	
1.1	Do the Plan's policies and procedures require coverage of a prescription previously approved for coverage by the Plan for the enrollee's medical condition if the Plan's prescribing provider continues to prescribe the drug and the drug is appropriately prescribed for treating the enrollee's medical condition?

### End of Requirement RX-003: Plan's Obligations Relating to Drug Previously Approved for Enrollee Medical Condition

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### Requirement RX-004: Coverage for Pain Management Medications for Terminally Ill Patients

#### INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- UM Director
- Director or Manager of Pharmacy

#### DOCUMENTS TO BE REVIEWED

- Policies and procedures for approving non-formulary drugs and pain management medication for the terminally ill
- Pharmacy management procedures
- EOC sections referencing prescription coverage
- Sample of prescription pain management denial files to be reviewed on site

#### **RX-004 - Key Element 1:**

1. The Plan has policies and procedures to ensure timely processing of requests for prescribed pain management for terminally ill patients.  
CA Health and Safety Code section 1367.01(e); CA Health and Safety Code section 1367.215(a); CA Health and Safety Code section 1367.241(b); 28 CCR 1300.67.241(e)(4)(A)-(F), and (I).

<b>Assessment Questions</b>	
1.1	Do the Plan's policies and procedures specify that requests by providers for authorization of appropriately prescribed pain management medications for an enrollee who has been determined to be terminally ill shall be approved or denied in a timely fashion, appropriate for the nature of the enrollee's condition, not to exceed 72 hours of the Plan's receipt of the information requested by the Plan to make the decision?
1.2	Do the Plan's policies and procedures specify that only licensed physicians or health care professionals (competent to evaluate the clinical issues) make decisions to deny pain management for terminally ill patients?
1.3	Do the Plan's policies and procedures stipulate that if the request is denied, or if additional information is required, the Plan is required to contact the requesting provider within one working day of the Plan's determination, with an explanation of the determination, and the reason for the denial or the need for additional information?
1.3.1	Do the Plan's policies and procedures stipulate that if the request is denied, or if additional information is required, the Plan is required to contact the requesting provider within one working day of the Plan's determination, and no later than within 72 hours of receipt of the request (whichever is sooner), with an

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	explanation of the determination, and the reason for the denial or the need for additional information? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.3.2	Do the Plan's policies and procedures require the Plan notify the prescribing provider and the enrollee or the enrollee's designee of its decision within 24 hours of receipt of an exigent request? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.3.3	Do the Plan's policies and procedures require the Plan notify the prescribing provider and the enrollee or the enrollee's designee of its decision within 72 hours of receipt of a non-urgent request? <i>Does not apply to Medi-Cal plans/lines of business.</i>
1.4	Do the Plan's policies and procedures stipulate that the requested treatment shall be deemed authorized if the Plan fails to make a determination as of the expiration of the applicable timeframe?

### **RX-004 - Key Element 2:**

- 2. The Plan provides coverage for appropriately prescribed pain management medication for terminally ill patients when medically necessary.**  
**CA Health and Safety Code section 1367.01(e) and (h)(3)-(4); CA Health and Safety Code section 1367.215(a); CA Health and Safety Code section 1367.241(b); 28 CCR 1300.67.241(e)(4)(A)-(E), (k) and (l).**

<b>Assessment Questions</b>	
2.1	Does the Plan approve or deny requests by providers for authorization of appropriately prescribed pain management medication for an enrollee who has been determined to be terminally ill within 72 hours of receipt of the request? <i>Does not apply to Medi-Cal plans/lines of business.</i>
2.2	<i>For Medi-Cal Plans only:</i> does the Plan approve or deny requests by providers for authorization of appropriately prescribed pain management medication for an enrollee who has been determined to be terminally ill within 72 hours of receipt of the information requested by the Plan to make the decision?
2.3	If additional information is required, do the Plan's files demonstrate that the Plan contacts the requesting provider within one business day of the Plan's determination, with an explanation of the determination, and the reason for the need for additional information?
2.4	If the request is denied, do the Plan's files demonstrate that the Plan contacts the requesting provider within one working day of the determination, with an explanation of the determination, and the reason for the denial?
2.4.1	Do the Plan's files demonstrate that the Plan notifies the requesting provider of its decision within 72 hours of receipt of the request? <i>Does not apply to Medi-Cal plans/lines of business.</i>
2.5	Do the Plan's files demonstrate that the Plan notifies the enrollee of its decision in writing within 72 hours of receipt of the request? <i>Does not apply to Medi-Cal plans/lines of business.</i>

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2.5.1	<i>For Medi-Cal Plans Only:</i> If the Plan delays, denies, and/or modifies the request, do the Plan's files demonstrate that the Plan notifies the enrollee in writing within two (2) business days?
2.6	If the Plan delays, denies, and/or modifies the request, do the Plan's written notices include a clear and concise explanation of the reasons for the Plan's decision?
2.7	If the Plan delays, denies, and/or modifies the request, do the Plan's written denials include a description of the criteria or guidelines used for the decision?
2.8	If the Plan delays, denies, and/or modifies the request, do the Plan's written denials specify the clinical reasons for the decision regarding medical necessity?
2.9	If delayed, denied, or modified, do the Plan's written notices to the requesting provider include the name and the direct telephone number or telephone extension of the professional that made the determination?
2.10	If the Plan failed to make a determination within the applicable time frame, do the Plan's files demonstrate that the Plan authorizes the requested treatment?

### **End of Requirement RX-004: Coverage for Pain Management Medications for Terminally Ill Patients**

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### Requirement RX-005: Formulary Development

#### INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- UM Director
- Director or Manager of Pharmacy
- Pharmacy and Therapeutics Committee Member (if feasible)
- PBM Representative, if applicable

#### DOCUMENTS TO BE REVIEWED

- Pharmacy management procedures
- Policies and procedures for developing and modifying the Plan's formulary
- Resumes of members of the Plan's Pharmacy and Therapeutics Committee or other formulary decision-making body
- Policies and/or procedures governing conflicts of interest on the Plan's Pharmacy and Therapeutics Committee or other formulary decision-making body
- Minutes of the Pharmacy and Therapeutics Committee or other formulary decision-making body
- Plan's website
- Policies and/or procedures for updating the Plan's formulary or formularies
- EOC sections referencing the Plan's formulary and prescription coverage
- Plan's formulary or formularies for nongrandfathered individual and small group products

#### **RX-005 - Key Element 1:**

1. The Plan maintains a pharmacy and therapeutic committee responsible for developing, maintaining, and overseeing the Plan's formulary or formularies. CA Health and Safety Code section 1363.5(b); CA Health and Safety Code section 1367.41(a)-(f); CA Health and Safety Code section 1367.24(e)(2); 28 CCR 1300.67.24(b)(2) and (3).

Assessment Questions	
1.1	Does the Plan maintain a pharmacy and therapeutics committee?
1.2	Does the membership of the Plan's pharmacy and therapeutics committee board represent a sufficient number of clinical specialties to adequately meet the needs of enrollees?
1.2.1	Does the Plan's pharmacy and therapeutics committee membership include psychiatrists, pediatricians, and/or other mental health-prescribing practitioners?
1.3	Does the Plan's pharmacy and therapeutic committee consist of at least a majority of practicing physicians, practicing pharmacists, and other practicing health professionals licensed to prescribe drugs?

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1.4	Does the Plan maintain policies and/or procedures to identify whether a member of the Plan's pharmacy and therapeutics committee has a conflict of interest with respect to a pharmaceutical drug issuer or manufacturer?
1.5	Does at least 20% of the Plan's pharmacy and therapeutics committee have no conflict of interest with respect to any pharmaceutical issuer or manufacturer?
1.6	Does the Plan maintain policies requiring a member of the pharmacy and therapeutics committee to abstain from voting on any issue in which the member has a conflict of interest with respect to a pharmaceutical issuer or manufacturer?
1.7	Does the Plan's pharmacy and therapeutics committee meet at least quarterly?
1.8	Does the Plan's pharmacy and therapeutics committee document its rationale for decisions regarding the development of, or revisions to, the Plan's formulary list?
1.9	Does the pharmacy and therapeutics committee develop and document procedures to ensure appropriate drug review and inclusion?
1.10	Does the pharmacy and therapeutics committee review policies that guide exceptions and other utilization processes, including drug utilization review, quantity limits, and therapeutic interchange?
1.11	Does the pharmacy and therapeutics committee review and analyze treatment protocols and procedures related to the Plan's formulary list at least annually?
1.12	Does the pharmacy and therapeutics committee review and approve all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to covered prescription drugs?

### **RX-005 - Key Element 2:**

- 2. The Plan posts its formulary or formularies for each product on its website in a manner that is accessible and searchable by potential enrollees, enrollees, providers, the general public, the Department, and federal agencies. CA Health and Safety Code section 1367.20; CA Health and Safety Code section 1367.205(a)(1)-(3), (b)(1); 28 CCR 1300.67.205(b)(1)-(5), (c)(1)-(7), (d)(1), (2), (4)-(13), (15), (16), (18) and (19).**

<b>Assessment Questions</b>	
2.1	Does the Plan post its formulary or formularies for each product on its website?
2.2	Are each of the Plan's formularies accessible and searchable?
2.3	Does the Plan update its formulary or formularies with any changes on a monthly basis?

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2.4	Do each of the Plan's formularies include the following sections in the order listed: (1) Cover page; (2) Table of contents; (3) Informational section; (4) Categorical list of prescription drugs; and (5) Index of prescription drugs.
2.5	Does each formulary include a cover page?
2.5.1	Does the cover page include the title of the document?
2.5.2	Does the coverage page include the name of the health plan offering the formulary?
2.5.3	Does the cover page include the name of each health plan product to which the formulary applies?
2.5.4	Does the cover page include the date the formulary was last updated?
2.5.5	Does the cover page include a notice that the formulary is subject to change and all previous versions of the formulary are no longer in effect?
2.5.6	Does the cover page include a direct website link/URL for the location of the electronic version of the formulary posted on the Plan's public website?
2.5.7	Does the cover page include either: (a) a direct website link/URL for the location of plan-specific coverage documents that include cost sharing applicable to prescription drugs for each health plan product to which the formulary applies; OR (b) specific instructions for locating plan-specific coverage documents that include cost sharing applicable to prescription drugs for each health plan product to which the formulary applies?
2.6	Does the informational section for each formulary include instructions for contacting the Plan's customer service department?
2.7	Does the informational section for each formulary include a definition section?
2.8	Does the informational section for each formulary include instructions for locating a prescription drug in the categorical list of prescription drugs?
2.9	Does the informational section for each formulary include a description of how drugs are listed in the categorical list of prescription drugs?
2.9.1	Does the description explain a drug is listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs?
2.9.2	Does the description explain the generic name of a brand name drug is included after the brand name in parenthesis in all bold and italicized lowercase letters?
2.9.3	Does the description explain if a generic equivalent for a brand name is available, and both the brand name and generic equivalents are covered, the generic drug will be listed separately from the brand name drug in all bold and italicized lower case letters?

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2.9.4	Does the description explain that, in the event a generic drug is marketed under a proprietary, trademark protected brand name, the brand name will be listed in all CAPITAL letters after the generic name in parentheses and regular typeface with first letter of each word capitalized?
2.9.5	Does the description include an example of a drug available both as a brand name drug and a generic equivalent to illustrate how such a drug is listed?
2.10	Does the informational section for each formulary include a description of the drug tiers (if the drugs are grouped into tiers) that (i) accurately describes the types of prescription drugs placed in each tier and (ii) explains how to determine which (A) prescription drugs are preferred drugs and (B) the cost sharing for each drug tier?
2.11	Does the informational section of each formulary include a description of all utilization management restrictions the Plan imposes on prescription drug coverage, including, but not limited to, prior authorization requirements, step therapy requirements, quantity limits, and network limitations on access including specialty pharmacy restrictions?
2.12	Does the informational section of each formulary include information about the differences between drugs covered under the medical benefit and drugs covered under the outpatient benefit and instructions on how to obtain coverage information concerning drugs covered under the medical benefit?
2.13	Does the informational section of each formulary include notice that the health plan will update the formulary with any changes on a monthly basis?
2.13.1	Does the informational section include a description of the types of changes a health plan may make to the formulary during the policy year and the dates on which such changes shall be effective, including (at a minimum) (A) change in drug or dosage form; (B) changes in tier placement of a drug that results in an increase in cost sharing; and (C) any changes of utilization management restrictions, including any additions of these restrictions?
2.14	Does the informational section include an explanation that the presence of a prescription drug on the formulary does not guarantee an enrollee will be prescribed the prescription drug by their prescribing provider for a particular medical condition?
2.15.1	Does the description state that the Plan shall notify the enrollee or the enrollee's designee and the enrollee's prescribing provider of its coverage determination within 24 hours of receipt of exigent request and within 72 hours of receipt of all other requests? <i>Does not apply to Medi-Cal plans/lines of business.</i>
2.16	Does the informational section of each formulary include instructions on how to locate and fill a prescription through a network retail pharmacy, mail order pharmacy, and specialty pharmacy, as applicable?
2.17	Does the informational section of each formulary include a detailed description of the process for requesting prior authorization or a step therapy exception?
2.17.1	Does the description state that if the Plan fails to respond to a completed prior authorization or step therapy exception request within 72 hours of receiving a



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	non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request is deemed granted? <i>Does not apply to Medi-Cal plans/lines of business.</i>
2.18	Does the informational section of each formulary include notice that a health plan may not limit or exclude coverage for a drug if the health plan previously approved coverage of the drug for the enrollee's medical condition and the prescribing provider continues to prescribe the drug for the medical condition, provided the drug is appropriately prescribed and safe and effective for treating the enrollee's medical condition?
2.19	Does the informational section of each formulary include a description of the coverage provided under the outpatient prescription drug benefit for drugs, devices, and FDA-approved products for preventative, contraceptive, and diabetes care?
2.19.1	Does this description include a detailed explanation of the requirements and process to acquire these drugs, devices, and products through the outpatient prescription drug benefit?
2.20	Does the informational section of each formulary include a detailed description of the process for requesting coverage and obtaining drugs that are subject to specialty pharmacy restrictions or other network limitations on coverage, if applicable to any drugs listed on the formulary?
2.21	Does the informational section of each formulary include an annotated legend or key to all abbreviations, symbols, and notations used in the formulary?

### End of Requirement RX-005: Formulary Development

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### Requirement RX-006: Coverage for Mental Health Parity Prescriptions

#### INDIVIDUAL(S)/ POSITIONS TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- UM Director
- Director or Manager of Pharmacy

#### DOCUMENTS TO BE REVIEWED

- Policies, procedures and protocol documents related to application of limits
- Member materials regarding prescription benefit limits
- Pharmacy management procedures

#### **RX-006 - Key Element 1:**

1. The Plan provides prescription coverage for the diagnosis and medically necessary treatment of mental health parity diagnoses under the same terms and conditions applied to other medical conditions.

CA Health and Safety Code sections 1374.72(a) and (b)(4). [Effective until 12/31/2020]

CA Health and Safety Code sections 1374.72(a) and (b)(3). [Effective as of 01/01/2021]

Assessment Question
1.1 Are the Plan's coverage limits and co-payments for psycho-pharmacologic drugs consistent with or not more stringent than limits for medical prescriptions?

End of Requirement RX-006: Coverage for Mental Health Parity Prescriptions

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### Statutory/Regulatory Citations

#### **CA Health and Safety Code section 1342.71(c)**

(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.

#### **CA Health and Safety Code sections 1342.71(j)**

(j) In the provision of outpatient prescription drug coverage, a health care service plan may utilize formulary, prior authorization, step therapy, or other reasonable medical management practices consistent with this chapter.

#### **CA Health and Safety Code section 1363.5(b)**

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

- (1) Be developed with involvement from actively practicing health care providers.
- (2) Be consistent with sound clinical principles and processes.
- (3) Be evaluated, and updated if necessary, at least annually.
- (4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.
- (5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

#### **CA Health and Safety Code section 1367.41(a)-(f)**

(a) Commencing January 1, 2017, a health care service plan shall maintain a pharmacy and therapeutics committee that shall be responsible for developing, maintaining, and overseeing any drug formulary list. If the plan delegates responsibility for the formulary to any entity, the obligation of the plan to comply with this chapter shall not be waived.

(b) The pharmacy and therapeutics committee board membership shall conform with both of the following:

- (1) Represent a sufficient number of clinical specialties to adequately meet the needs of enrollees.
- (2) Consist of a majority of individuals who are practicing physicians, practicing pharmacists, and other practicing health professionals who are licensed to prescribe drugs.

(d) At least 20 percent of the board membership shall not have a conflict of interest with respect to the issuer or any pharmaceutical manufacturer.

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(e) The pharmacy and therapeutics committee shall meet at least quarterly and shall maintain written documentation of the rationale for its decisions regarding development of, or revisions to, the formulary drug list.

(f) The pharmacy and therapeutics committee shall do all of the following:

(1) Develop and document procedures to ensure appropriate drug review and inclusion.

(2) Base clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other related information.

(3) Consider the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs.

(4) Review policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange.

(5) Evaluate and analyze treatment protocols and procedures related to the plan's formulary at least annually.

(6) Review and approve all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug.

(7) Review new United States Food and Drug Administration-approved drugs and new uses for existing drugs.

(8) Ensure that the plan's formulary drug list or lists cover a range of drugs across a broad distribution of therapeutic categories and classes and recommend drug treatment regimens that treat all disease states and do not discourage enrollment by any group of enrollees.

(9) Ensure that the plan's formulary drug list or lists provide appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

### **CA Health and Safety Code section 1367.20**

Every health care service plan that provides prescription drug benefits and maintains one or more drug formularies shall provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary of the plan by major therapeutic category, with an indication of whether any drugs on the list are preferred over other listed drugs. If the health care service plan maintains more than one formulary, the plan shall notify the requester that a choice of formulary lists is available.

### **CA Health and Safety Code section 1367.205(a)(1)-(3)**

(a) In addition to the list required to be provided under Section 1367.20, a health care service plan that provides prescription drug benefits and maintains one or more drug formularies shall do all of the following:

(1) Post the formulary or formularies for each product offered by the plan on the plan's Web site in a manner that is accessible and searchable by potential enrollees, enrollees, providers, the general public, the department, and federal agencies as required by federal law or regulations.

(2) Update the formularies posted pursuant to paragraph (1) with any change to those formularies on a monthly basis.

(3) No later than six months after the date that the standard formulary template is developed under subdivision (b), use that template to display the formulary or formularies for each product offered by the plan.

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### **CA Health and Safety Code section 1367.205(c)**

(c) For purposes of this section, “formulary” means the complete list of drugs preferred for use and eligible for coverage under a health care service plan product and includes the drugs covered under the pharmacy benefit of the product.

### **CA Health and Safety Code section 1367.215(a)**

(a) Every health care service plan contract that covers prescription drug benefits shall provide coverage for appropriately prescribed pain management medications for terminally ill patients when medically necessary. The plan shall approve or deny the request by the provider for authorization of coverage for an enrollee who has been determined to be terminally ill in a timely fashion, appropriate for the nature of the enrollee's condition, not to exceed 72 hours of the plan's receipt of the information requested by the plan to make the decision. If the request is denied or if additional information is required, the plan shall contact the provider within one working day of the determination, with an explanation of the reason for the denial or the need for additional information. The requested treatment shall be deemed authorized as of the expiration of the applicable timeframe.

### **CA Health and Safety Code section 1367.22(a)**

(a) A health care service plan contract, issued, amended, or renewed on or after July 1, 1999, that covers prescription drug benefits shall not limit or exclude coverage for a drug for an enrollee if the drug previously had been approved for coverage by the plan for a medical condition of the enrollee and the plan's prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions as authorized by Section 4073 of the Business and Professions Code. For purposes of this section, a prescribing provider shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4059 of the Business and Professions Code, to treat a medical condition of an enrollee.

### **CA Health and Safety Code section 1367.24(e)(2)**

(e) Every health care service plan that provides prescription drug benefits shall maintain, as part of its books and records under Section 1381, all of the following information, which shall be made available to the director upon request:

(2) Records developed by the pharmacy and therapeutic committee of the plan, or by others responsible for developing, modifying, and overseeing formularies, including medical groups, individual practice associations, and contracting pharmaceutical benefit management companies, used to guide the drugs prescribed for the enrollees of the plan, that fully describe the reasoning behind formulary decisions.

### **CA Health and Safety Code section 1367.24(k)**

(k) For any individual, small group, or large health plan contracts, a health care service plan's process described in subdivision (a) shall comply with the request for exception and external exception request review processes described in subdivision (c) of

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Section 156.122 of Title 45 of the Code of Federal Regulations. This subdivision shall not apply to Medi-Cal managed care health care service plan contracts as described in subdivision (l).

### **CA Health and Safety Code section 1367.241(a)-(c), (e)-(f), and (h)<sup>2</sup>**

(a) Notwithstanding any other law, on and after January 1, 2013, a health care service plan that provides coverage for prescription drugs shall accept only the prior authorization form developed pursuant to subdivision (c), or an electronic prior authorization process described in subdivision (e), when requiring prior authorization for prescription drugs. This section does not apply in the event that a physician or physician group has been delegated the financial risk for prescription drugs by a health care service plan and does not use a prior authorization process. This section does not apply to a health care service plan, or to its affiliated providers, if the health care service plan owns and operates its pharmacies and does not use a prior authorization process for prescription drugs.

(b) If a health care service plan or a contracted physician group fails to respond within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization request from a prescribing provider, the prior authorization request shall be deemed to have been granted. The requirements of this subdivision shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code. Medi-Cal managed care health care service plans that contract under those chapters shall not be required to maintain an external exception request review as provided in Section 156.122 of Title 45 of the Code of Federal Regulations.

(c) On or before January 1, 2017, the department and the Department of Insurance shall jointly develop a uniform prior authorization form. Notwithstanding any other law, on and after July 1, 2017, or six months after the form is completed pursuant to this section, whichever is later, every prescribing provider shall use that uniform prior authorization form, or an electronic prior authorization process described in subdivision (e), to request prior authorization for coverage of prescription drugs and every health care service plan shall accept that form or electronic process as sufficient to request prior authorization for prescription drugs.

(e) A prescribing provider may use an electronic prior authorization system utilizing the standardized form described in subdivision (c) or an electronic process developed specifically for transmitting prior authorization information that meets the National Council for Prescription Drug Programs' SCRIPT standard for electronic prior authorization transactions.

(f) Subdivision (a) does not apply if any of the following occurs:

- (1) A contracted physician group is delegated the financial risk for prescription drugs by a health care service plan.
- (2) A contracted physician group uses its own internal prior authorization process rather than the health care service plan's prior authorization process for plan enrollees.

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<sup>2</sup> All health care service plans are required to start using Form 61-211 (Revised 12/16) by January 1, 2018. The revised form can be found here: [Prescription Prior Authorization Request Form](#). Up until they implement the revised form, all health care service plans were required to use Form 61-211 (New 08/13).

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(3) A contracted physician group is delegated a utilization management function by the health care service plan concerning any prescription drug, regardless of the delegation of financial risk.

(h) For purposes of this section:

(1) "Prescribing provider" shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an enrollee.

(2) "Exigent circumstances" exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(3) "Completed prior authorization request" means a completed uniform prior authorization form developed pursuant to subdivision (c), or a completed request submitted using an electronic prior authorization system described in subdivision (e), or, for contracted physician groups described in subdivision (f), the process used by the contracted physician group.

### **CA Health and Safety Code sections 1367.24(a)-(d) and (k)**

(a) Every health care service plan that provides prescription drug benefits shall maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary nonformulary prescription drug. On or before July 1, 1999, every health care service plan that provides prescription drug benefits shall file with the department a description of its process, including timelines, for responding to authorization requests for nonformulary drugs. Any changes to this process shall be filed with the department pursuant to Section 1352. Each plan shall provide a written description of its most current process, including timelines, to its prescribing providers. For purposes of this section, a prescribing provider shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an enrollee.

(b) Any plan that disapproves a request made pursuant to subdivision (a) by a prescribing provider to obtain authorization for a nonformulary drug shall provide the reasons for the disapproval in a notice provided to the enrollee. The notice shall indicate that the enrollee may file a grievance with the plan if the enrollee objects to the disapproval, including any alternative drug or treatment offered by the plan. The notice shall comply with subdivision (b) of Section 1368.02. Any health plan that is required to maintain an external exception request review process pursuant to subdivision (k) shall indicate in the notice required under this subdivision that the enrollee may file a grievance seeking an external exception request review.

(c) The process described in subdivision (a) by which prescribing providers may obtain authorization for medically necessary nonformulary drugs shall not apply to a nonformulary drug that has been prescribed for an enrollee in conformance with the provisions of Section 1367.22.

(d) The process described in subdivision (a) by which enrollees may obtain medically necessary nonformulary drugs, including specified timelines for responding to prescribing provider authorization requests, shall be described in evidence of coverage and disclosure forms, as required by subdivision (a) of Section 1363, issued on or after July 1, 1999.

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(k) For any individual, small group, or large health plan contracts, a health care service plan's process described in subdivision (a) shall comply with the request for exception and external exception request review processes described in subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. This subdivision shall not apply to Medi-Cal managed care health care service plan contracts as described in subdivision (l).

### **CA Health and Safety Code section 1367.241(b)**

(b) If a health care service plan or a contracted physician group fails to respond within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization request from a prescribing provider, the prior authorization request shall be deemed to have been granted. The requirements of this subdivision shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code. Medi-Cal managed care health care service plans that contract under those chapters shall not be required to maintain an external exception request review as provided in Section 156.122 of Title 45 of the Code of Federal Regulations.

### **CA Health and Safety Code section 1367.241(h)(2)**

(h) For purposes of this section:

(2) "Exigent circumstances" exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

### **CA Health and Safety Code section 1367.244(a)**

(a) A request for an exception to a health care service plan's step therapy process for prescription drugs may be submitted in the same manner as a request for prior authorization for prescription drugs pursuant to Section 1367.241, and shall be treated in the same manner, and shall be responded to by the health care service plan in the same manner, as a request for prior authorization for prescription drugs.

### **CA Health and Safety Code sections 1367.01(e) and (h)(3)**

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for



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concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

### **CA Health and Safety Code sections 1367.01(e), (h)(3)-(4)**

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an

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administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

### **CA Health and Safety Code section 1368.01(a) and (c)**

(a) The grievance system shall require the plan to resolve grievances within 30 days, except as provided in subdivision (c).

(c) A health care service plan contract in the individual, small group, or large group markets that provides coverage for outpatient prescription drugs shall comply with subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. This subdivision shall not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

### **CA Health and Safety Code section 1368.02(b)**

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(insert health plan's telephone number)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online."

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### **CA Health and Safety Code section 1374.30(i)**

(i) No later than January 1, 2001, every health care service Plan shall prominently display in every Plan member handbook or relevant informational brochure, in every Plan contract, on enrollee evidence of coverage forms, on copies of Plan procedures for resolving grievances, on letters of denials issued by either the Plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers

### **CA Health and Safety Code section 1374.72(a) and (b)(4)**

[Effective **until** 12/31/2020]

(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(b) These benefits shall include the following:

(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

### **CA Health and Safety Code section 1374.72(a) and (b)(3)**

[Effective **as of** 01/01/2021]

(a)(1) Every health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions as specified in subdivision (c). (b) The benefits that shall be covered pursuant to this section shall include, but not be limited to, the following:

(3) Prescription drugs, if the plan contract includes coverage for prescription drugs.

### **CA Health and Safety Code section 1374.721**

(a) A health care service plan that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health care service plan shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional,

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conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a health care service plan purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the plan shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every health care service plan shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and health care service plan enrollees.

(4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision. (f) The following definitions apply for purposes of this section:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 1374.72.

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(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.

(4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health care service plan to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a health care service plan contract, including prescription drugs.

(h) This section applies to a health care service plan that conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on behalf of a health care service plan.

(i) The director may assess administrative penalties for violations of this section as provided for in Section 1368.04, in addition to any other remedies permitted by law. (j) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(k) This section does not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

### **28 CCR 1300.67.205(b)(1)-(5), (c)(1)-(7), (d)(1), (2), (4), (6)-(13), (15), (16), (18) and (19).**

The following standards are minimum standards, and unless otherwise noted, apply to all health plan formularies subject to section 1367.205 of the Health and Safety Code. A health plan may implement additional provisions exceeding these requirements.

(b) Format of the formulary. The formulary shall be in a searchable format and shall include the following sections in the order listed:

- (1) Cover page;
- (2) Table of contents;
- (3) Informational section;
- (4) Categorical list of prescription drugs; and
- (5) Index of prescription drugs.

(c) Cover page. The cover page of the formulary shall include all of the following:

- (1) The title of the document.
- (2) The name of the health plan offering the formulary.
- (3) The name of each health plan product to which the formulary applies.
- (4) The date the formulary was last updated.

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(5) A notice that the formulary is subject to change and all previous versions of the formulary are no longer in effect.

(6) A direct website link/URL for the location of the electronic version of the formulary posted on the health plan's public website. The formulary shall be accessible to potential enrollees, enrollees, providers, and the general public. The formulary is accessible if it can be viewed on the website through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number, and if the health plan offers more than one health plan product, when an individual can easily discern which formulary applies to which health plan product.

(7) A direct website link/URL for the location of, or specific instructions for locating, plan-specific coverage documents that include cost sharing applicable to prescription drugs for each health plan product to which the formulary applies.

(d) Informational section. The informational section of the formulary shall include all of the following:

(1) Instructions for contacting the health plan's customer service department. A health plan shall have customer service representatives readily available during normal business hours to provide accurate, specific information concerning prescription drug benefits, including but not limited to:

(A) information concerning drugs covered under the medical benefit of the enrollee's contract;

(B) the actual dollar amount of cost sharing under the enrollee's contract for drugs subject to a copayment or coinsurance; and

(C) the process for submitting an exception request and requesting prior authorization and step therapy exceptions.

(2) Definitions. The informational section of the formulary shall have a definition section as prescribed below. A health plan may request an omission, deviation, or substitutions of the stated definitions to the Director for review and approval.

(A) "Brand name drug" is a drug that is marketed under a proprietary, trademark protected name. The brand name drug shall be listed in all CAPITAL letters.

(B) "Coinsurance" is a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

(C) "Copayment" is a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

(D) "Deductible" is the amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

(E) "Drug Tier" is a group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.

(F) "Enrollee" is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

(G) "Exception request" is a request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing health care provider submits an exception request for

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coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

(H) "Exigent circumstances" are when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(I) "Formulary" is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list,

(J) "Generic drug" is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in bold and italicized lowercase letters.

(K) "Nonformulary drug" is a prescription drug that is not listed on the health plan's formulary.

(L) "Out-of-pocket cost" are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

(M) "Prescribing provider" is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

(N) "Prescription" is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

(O) "Prescription drug" is a drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.

(P) "Prior Authorization" is a health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

(Q) "Step therapy" is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

(R) "Subscriber" means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(4) Instructions for locating a prescription drug in the categorical list of prescription drugs. The instructions shall explain: (A) if a prescription drug may be located by looking up the therapeutic category and class of the drug or the brand or generic name of the drug in the alphabetical index; and (B) if a generic equivalent for a brand name drug is not available or is not covered, the drug will not be separately listed by its generic name.

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(5) A description of how drugs are listed in the categorical list of prescription drugs. At minimum, the description shall explain: (A) a drug is listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs; (B) the generic name of a brand name drug is included after the brand name in parenthesis and all bold and italicized lowercase letters; (C) if a generic equivalent for a brand name drug is available, and both the brand name and generic equivalents are covered, the generic drug will be listed separately from the brand name drug in all bold and italicized lowercase letters; and (D) in the event a generic drug is marketed under a proprietary, trademark protected brand name, the brand name will be listed in all CAPITAL letters after the generic name in parentheses and regular typeface with first letter of each word capitalized. The description shall include an example of a drug available both as a brand name drug and a generic equivalent to illustrate how such a drug is listed.

(6) A description of the drug tiers in the formulary, if the drugs are grouped into tiers. The description shall include tier numbers designating the tiers and shall accurately describe the types of prescription drugs placed in each tier. The same description shall be used in the corresponding coverage documents. The description shall explain how to determine the following: (A) which prescription drugs on the formulary are preferred drugs; and (B) the cost sharing for each drug tier, including any applicable dollar maximum amounts for products subject to sections 1342.71 and 1342.73 of the Health and Safety Code. If the formulary has four tiers and is subject to sections 1342.71 and 1342.73 of the Health and Safety Code, drugs shall be placed in tiers consistent with the drug tier definitions in those sections of the Knox-Keene Act.

(7) A description of all utilization management restrictions the health plan imposes on prescription drug coverage, including but not limited to, prior authorization requirements, step therapy requirements, quantity limits, and network limitations on access including specialty pharmacy restrictions.

(8) Information about the differences between drugs covered under the medical benefit and drugs covered under the outpatient prescription drug benefit of the health plan product and instructions on how to obtain coverage information concerning drugs covered under the medical benefit.

(9) Notice that the health plan will update the formulary with any changes on a monthly basis. The notice shall include a description of the types of changes a health plan may make to the formulary during the policy year, the dates on which such changes shall be effective, and may include a description of any prior notification a health plan will provide an affected enrollee of a formulary change. At minimum, the notice shall include, but not be limited to, the following information: (A) change in drug or dosage form; (B) changes in tier placement of a drug that results in an increase in cost sharing; and (C) any changes of utilization management restrictions, including any additions of these restrictions.

(10) An explanation that the presence of a prescription drug on the formulary does not guarantee an enrollee will be prescribed that prescription drug by his or her prescribing provider for a particular medical condition.

(11) Notice that the health plan shall cover nonformulary drugs when medically necessary and a detailed description of the process for requesting coverage of a nonformulary drug. Subject to the exception in subdivision (k) of section 1367.24 of the Health and Safety Code, the description shall state that: (A) the health plan shall notify the enrollee or his or her designee and the enrollee's prescribing provider of its



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coverage determination within 24 hours of receipt of a request based on exigent circumstances and within 72 hours of receipt of all other requests; (B) the health plan shall provide coverage pursuant to a non-urgent request for the duration of the prescription, including refills; and (C) the health plan shall provide coverage, including refills, pursuant to a request based on exigent circumstances for the duration of the exigency. The description shall also state an enrollee may file a grievance or complaint, pursuant to section 1368 of the Health and Safety Code, relating to denial of a coverage request and that the coverage documents provide information on appeal rights and procedures.

(12) Instructions on how to locate and fill a prescription through a network retail pharmacy, mail order pharmacy, and specialty pharmacy, as applicable.

(13) A detailed description of the process for requesting prior authorization or a step therapy exception. Subject to the exceptions in subdivision (b) of section 1367.241 of the Health and Safety Code, the description shall state that if a health plan fails to respond to a completed prior authorization or step therapy request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request is deemed granted.

(15) Notice pursuant to section 1367.22 of the Health and Safety Code that a health plan may not limit or exclude coverage for a drug if the health plan previously approved coverage of the drug for the enrollee's medical condition and the prescribing provider continues to prescribe the drug for the medical condition, provided the drug is appropriately prescribed and safe and effective for treating the enrollee's medical condition.

(16) A description of the coverage provided under the outpatient prescription drug benefit for drugs, devices, and FDA-approved products pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code. The description shall include a detailed explanation of the requirements and process to acquire those drugs, devices, and FDA-approved products through the outpatient prescription drug benefit.

(18) If applicable to any drugs listed on the formulary, a detailed description of the process for requesting coverage and obtaining drugs that are subject to specialty pharmacy restrictions or other network limitations on coverage.

(19) An annotated legend or key to all abbreviations, symbols, and notations used in the formulary.

### **28 CCR 1300.67.24(b)(2) and (3)**

(b) Standards for outpatient prescription drug benefit plans

(2) All clinical aspects of a plan's prescription drug benefit shall be developed by qualified medical and pharmacy professionals in accordance with good professional practice. The plan shall establish and document an internal process for ongoing review by qualified medical and pharmacy professionals of the clinical aspects of the prescription drug benefit, including review of limitations and exclusions, and the safety, efficacy, and utilization of outpatient prescription drugs.

(3) Plans seeking to establish limitations or exclusions on outpatient prescription drug benefits shall do so consistent with up-to-date evidence-based outcomes and current published, peer-reviewed medical and pharmaceutical literature.

### **28 CCR 1300.67.24(d)(2)**

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### (d) Limitations

Plans that provide coverage for outpatient prescription drug benefits may apply the following limitations:

(2) When there is more than one drug that is appropriate for the treatment of a medical condition, a plan may require step therapy. A plan that requires step therapy shall have an expeditious process in place to authorize exceptions to step therapy when medically necessary and to conform effectively and efficiently with continuity of care requirements of the Act and regulations. In circumstances where an enrollee is changing plans, the new plan may not require the enrollee to repeat step therapy when that enrollee is already being treated for a medical condition by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective for the enrollee's condition. Nothing in this section shall preclude the new plan from imposing a prior authorization requirement pursuant to Section 1367.24 for the continued coverage of a prescription drug prescribed pursuant to step therapy imposed by the former plan, or preclude the prescribing provider from prescribing another drug covered by the new plan that is medically appropriate for the enrollee. For purposes of this section, "step therapy" means a type of protocol that specifies the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are to be prescribed.

### **28 CCR 1300.67.241(c)**

(c)(1) A prescribing provider may use an electronic prior authorization system compliant with the SCRIPT standard as described in Health and Safety Code 1367.241, subdivision (e), in place of Form 61-211.

(2) A prescribing provider may submit prescription drug prior authorization or step-therapy exception request using the contracted physician group's process for those groups described in section 1367.241, subdivision (f)(1)-(3) of the Act.

### **28 CCR 1300.67.241(e)(4)(A)-(E)**

(e) Beginning January 1, 2018, a health plan that maintains the financial risk for prescription drug or step therapy exception benefits and its contracted pharmacy benefit managers shall do the following:

(4) Notify the prescribing provider and the enrollee or the enrollee's designee within 24 hours for exigent circumstances or 72 hours for non-urgent requests of receipt of a prescription drug prior authorization or step therapy exception request, including requests submitted to subdivision (c) of this regulation, that either:

(A) The prescribing provider's request is approved; or

(B) The prescribing provider's request is disapproved as not medically necessary or not a covered benefit; or

(C) The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the prescription drug prior authorization or step therapy exception request; or

(D) The patient is no longer eligible for coverage; or

(E) The prescription drug prior authorization or step therapy exception request was not submitted on the required form. Please resubmit your request on the attached Form 61-211 or on a form or process compliant with subdivision (c) of this regulation;

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### **28 CCR 1300.67.241(e)(4)(A)-(F) and (I)**

(e) Beginning January 1, 2018, a health plan that maintains the financial risk for prescription drug or step therapy exception benefits and its contracted pharmacy benefit managers shall do the following:

(4) Notify the prescribing provider and the enrollee or the enrollee's designee within 24 hours for exigent circumstances or 72 hours for non-urgent requests of receipt of a prescription drug prior authorization or step therapy exception request, including requests submitted to subdivision (c) of this regulation, that either:

(A) The prescribing provider's request is approved; or

(B) The prescribing provider's request is disapproved as not medically necessary or not a covered benefit; or

(C) The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the prescription drug prior authorization or step therapy exception request; or

(D) The patient is no longer eligible for coverage; or

(E) The prescription drug prior authorization or step therapy exception request was not submitted on the required form. Please resubmit your request on the attached Form 61-211 or on a form or process compliant with subdivision (c) of this regulation;

(F) This subdivision (e)(4) shall not apply to Medi-Cal managed care contracts or any contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(I) In the event the health plan or contracted physician group fails to send the notice of disapproval, consistent with the requirements of subdivisions (e) and (c), to the prescribing provider 24 hours for exigent circumstances or 72 hours for non-urgent requests, the prescription drug prior authorization or step therapy exception request shall be deemed approved. This subdivision (I) shall not apply to Medi-Cal managed care contracts or any contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

### **28 CCR 1300.67.241(a)-(c), (e)-(f), (h)-(i), and (m)(1)-(2)**

(a) Health plans that utilize a prescription drug prior authorization or step therapy exception process shall use and accept only the Prescription Drug Prior Authorization or Step Therapy Exception Request Form, numbered 61-211 (Revised 12/16), which is incorporated by reference and referred to hereafter in this section as "Form 61-211."

(c)(1) A prescribing provider may use an electronic prior authorization system compliant with the SCRIPT standard as described in Health and Safety Code 1367.241, subdivision (e), in place of Form 61-211.

(2) A prescribing provider may submit prescription drug prior authorization or step-therapy exception request using the contracted physician group's process for those groups described in section 1367.241, subdivision (f)(1)-(3) of the Act.

(e) Beginning January 1, 2018, a health plan that maintains the financial risk for prescription drug or step therapy exception benefits and its contracted pharmacy benefit managers shall do the following:

(1) Make Form 61-211 electronically available on their websites.

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- (2) Accept Form 61-211 or a form or a process compliant with subdivision (c) of this regulation through any reasonable means of transmission, including, but not limited to, paper, electronic transmission, telephone, web portal, or another mutually agreeable accessible method of transmission.
- (3) Request from the prescribing provider only the minimum amount of material information necessary to approve or disapprove the prescription drug prior authorization or step therapy exception request. If state or federal law requires additional information for dispensing restricted prescription drugs, that information shall be submitted as part of section 3. of Form 61-211 or as specified in subdivision (c) of this regulation.
- (4) Notify the prescribing provider and the enrollee or the enrollee's designee within 24 hours for exigent circumstances or 72 hours for non-urgent requests of receipt of a prescription drug prior authorization or step therapy exception request, including requests submitted pursuant to subdivision (c) of this regulation, that either:
- (A) The prescribing provider's request is approved; or
  - (B) The prescribing provider's request is disapproved as not medically necessary or not a covered benefit; or
  - (C) The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the prescription drug prior authorization or step therapy exception request; or
  - (D) The patient is no longer eligible for coverage; or
  - (E) The prescription drug prior authorization or step therapy exception request was not submitted on the required form. Please resubmit your request on the attached Form 61-211 or on a form or process compliant with subdivision (c) of this regulation;
  - (F) This subdivision (e)(4) shall not apply to Medi-Cal managed care contracts or any contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.
- (f) Definitions. The following definitions are applicable for this regulation:
- (1) Exigent circumstances shall mean the circumstances described in section 1367.241, subdivision (h) of the Act.
  - (2) Step therapy exception is the exception to the step therapy process and the determination of whether the exception shall be granted, taking into consideration the enrollee's needs and medical circumstances, along with the professional judgment of the enrollee's provider.
  - (3) Electronic I.D. Verification shall mean a unique identification number that clearly identifies the prescribing provider on the prescription drug prior authorization or step therapy exception request to allow verification by the health plan or pharmacy benefit manager.
  - (h) A health plan that offers a prescription drug prior authorization or step therapy exception process telephonically or through a web portal shall not require the prescribing provider to provide more information than is required by Form 61-211 or a form or process compliant with subdivision (c) of this regulation.
  - (i) Notices to the prescribing provider required under this regulation shall be delivered in the same manner as the prescription drug prior authorization or step therapy exception request was submitted, or another mutually agreeable accessible method of notification.
  - (m) Review and Enforcement.

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(1) A health plan or physician group that contracts with a pharmacy benefit manager to conduct prescription drug prior authorization or step therapy exception services shall include a provision in the contract requiring the pharmacy benefit manager to comply with section 1367.241 of the Act and this regulation.

(2) A health plan or contracted physician group that contracts with a pharmacy benefit manager to conduct prescription drug prior authorization or step therapy exception services shall have written policies and procedures in place to ensure that the contracted pharmacy benefit managers comply with section 1367.241 of the Act and this regulation.

(D) The patient is no longer eligible for coverage; or

(E) The prescription drug prior authorization or step therapy exception request was not submitted on the required form. Please resubmit your request on the attached Form 61-211 or on a form or process compliant with subdivision (c) of this regulation.

### **CCR 1300.67.241(e)(4)(A) through (E), (I), and (k)**

(e) Beginning January 1, 2018, a health plan that maintains the financial risk for prescription drug or step therapy exception benefits and its contracted pharmacy benefit managers shall do the following:

(4) Notify the prescribing provider and the enrollee or the enrollee's designee within 24 hours for exigent circumstances or 72 hours for non-urgent requests of receipt of a prescription drug prior authorization or step therapy exception request, including requests submitted pursuant to subdivision (c) of this regulation, that either:

(A) The prescribing provider's request is approved; or

(B) The prescribing provider's request is disapproved as not medically necessary or not a covered benefit; or

(C) The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the prescription drug prior authorization or step therapy exception request; or

(D) The patient is no longer eligible for coverage; or

(E) The prescription drug prior authorization or step therapy exception request was not submitted on the required form. Please resubmit your request on the attached Form 61-211 or on a form or process compliant with subdivision (c) of this regulation;

(k) In the event the prescribing provider's prescription drug prior authorization or step therapy exception request is disapproved pursuant to (e)(4)(B), the notice of disapproval shall contain an accurate and clear written explanation of the specific reason(s) for disapproving the prescription drug prior authorization or step therapy exception request.

In the event the prescribing provider's prescription drug prior authorization or step therapy exception request is disapproved pursuant to (e)(4)(C), the notice of disapproval shall contain an accurate and clear written explanation of the specific material information that is necessary to approve the request.

(l) In the event the health plan or contracted physician group fails to send the notice of disapproval, consistent with the requirements of subdivisions (e) and (c), to the prescribing provider 24 hours for exigent circumstances or 72 hours for non-urgent requests, the prescription drug prior authorization or step therapy exception request shall be deemed approved. This subdivision (l) shall not apply to Medi-Cal managed care contracts or any contracts entered into pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75

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(commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

### **45 CFR 156.122(c)(2)(ii)**

(2) Expedited exception request.

(ii) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

### **45 CFR 156.122(c)(3)(i)-(ii)**

(c) A health plan providing essential health benefits must have the following processes in place that allow an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by the health plan (a request for exception).

(3) External exception request review. For plans years beginning on or after January 1, 2016:

(i) If the health plan denies a request for a standard exception under paragraph (c)(1) of this section or for an expedited exception under paragraph (c)(2) of this section, the health plan must have a process for the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

(ii) A health plan must make its determination on the external exception request and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following its receipt of the request, if the original request was a standard exception request under paragraph (c)(1) of this section, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request under paragraph (c)(2) of this section.

### **45 CFR 156.122(c)(1)-(4)**

(c) A health plan providing essential health benefits must have the following processes in place that allow an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by the health plan (a request for exception). In the event that an exception request is granted, the plan must treat the excepted drug(s) as an essential health benefit, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing under § 156.130 and when calculating the plan's actuarial value under § 156.135.

(1) *Standard exception request.* For plans years beginning on or after January 1, 2016:

(i) A health plan must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request a standard review of a decision that a drug is not covered by the plan.

(ii) A health plan must make its determination on a standard exception and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as

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appropriate) of its coverage determination no later than 72 hours following receipt of the request.

(iii) A health plan that grants a standard exception request must provide coverage of the non-formulary drug for the duration of the prescription, including refills.

### (2) *Expedited exception request.*

(i) A health plan must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances.

(ii) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

(iii) A health plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following receipt of the request.

(iv) A health plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

### (3) *External exception request review.* For plans years beginning on or after January 1, 2016:

(i) If the health plan denies a request for a standard exception under paragraph (c)(1) of this section or for an expedited exception under paragraph (c)(2) of this section, the health plan must have a process for the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

(ii) A health plan must make its determination on the external exception request and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following its receipt of the request, if the original request was a standard exception request under paragraph (c)(1) of this section, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request under paragraph (c)(2) of this section.

(iii) If a health plan grants an external exception review of a standard exception request, the health plan must provide coverage of the non-formulary drug for the duration of the prescription. If a health plan grants an external exception review of an expedited exception request, the health plan must provide coverage of the non-formulary drug for the duration of the exigency.

### (4) *Application of coverage appeals laws.*

(i) A State may determine that a health plan in the State satisfies the requirements of this paragraph (c) if the health plan has a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan that is compliant with the State's applicable coverage appeals laws and regulations that are at least as stringent as the requirements of this paragraph (c) and include:

(A) An internal review;

(B) An external review;

(C) The ability to expedite the reviews; and

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(D) Timeframes that are the same or shorter than the timeframes under paragraphs (c)(1)(ii), (c)(2)(iii), and (c)(3)(ii) of this section.