SECOND REGULAR SESSION

HOUSE BILL NO. 2186

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE JONES (50).

6367L.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to health insurance prior authorization forms.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Chapter 376, RSMo, is amended by adding thereto one new section, to be known as section 376.382, to read as follows:

376.382. 1. To establish uniformity in submission of prior authorization forms, every pharmacy benefit manager and health insurer offering or providing pharmaceutical coverage in this state shall offer a single standardized form for providers to submit written prior authorization requests for pharmaceuticals. The one-page form shall, at a minimum, include the following:

(1) Patient information: the patient's first and last name, the patient's telephone number, and the identification number of the patient's health insurer or pharmacy benefit manager;

(2) Prescriber information: the prescriber's name, the prescriber's National Provider Identification (NPI) number, the prescriber's telephone and facsimile numbers, and the prescriber's address with state and zip code;

(3) Diagnosis;

(4) The International Classification of Diseases (ICD) code;

(5) A description of the drug and strength being requested;

(6) The quantity requested;

(7) The day supply requested;

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

(8) Other medications or therapies tried and the reason for failure, and any other information the prescriber deems important to the review;

(9) The prescriber's signature;

(10) Date of the request;

(11) Office contact name;

(12) Contact telephone number; and

(13) Contact telephone and facsimile numbers of the health insurer or pharmacy benefit manager, which shall be prominently displayed.

2. The prior authorization form shall be made available from health insurers or pharmacy benefit managers to providers via paper or electronic copies. To initiate a prior authorization request, a provider shall submit a prior authorization form. Health insurers and pharmacy benefit plans shall accept all completed prior authorization forms submitted by providers in accordance with this section and shall respond to such prior authorization request within seventy-two hours.

3. If a health insurer or pharmacy benefit manager is unable to authorize or decline a prior authorization request within seventy-two hours, the health insurer or pharmacy benefit manager shall notify the provider and the patient within seventy-two hours and provide a telephone number available to the provider and patient to obtain any necessary additional information.

4. If a health insurer or pharmacy benefit manager fails to use or accept a prior authorization form or fails to respond as soon as reasonably possible, but in no event more than seventy-two hours after receipt of a completed prior authorization request, the prior authorization shall be deemed granted by the health insurer or pharmacy benefit manager.

5. As used in this section, "health insurer" means a health carrier or health benefit plans as defined in section 376.1350.

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