HB 2186 -- HEALTH INSURANCE PRIOR AUTHORIZATION FORMS

SPONSOR: Jones (50)

This bill requires every pharmacy benefit manager and health insurer offering or providing pharmaceutical coverage in this state to offer a single standardized form for providers to submit written prior authorization requests for pharmaceuticals for the purpose of establishing uniformity in submission of prior authorization forms.

The bill requires the one-page form to include specified information. The prior authorization form must 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 must submit a prior authorization form. Health insurers and pharmacy benefit plans must accept all completed prior authorization forms submitted by providers in accordance with these provisions and must respond to a prior authorization request within 72 hours.

If a health insurer or pharmacy benefit manager is unable to authorize or decline a prior authorization request within 72 hours, the health insurer or pharmacy benefit manager must notify the provider and the patient within 72 hours and provide a telephone number available to the provider and patient to obtain any necessary additional information. 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 72 hours after receipt of a completed prior authorization request, the prior authorization must be deemed granted by the health insurer or pharmacy benefit manager.