



Formulary Management Laws Chart: Summary of State Requirements

(As of July 23, 2020)

Background: Prescription drugs are an important part of medical treatment. Under the Affordable Care Act (ACA), every health insurance policy must include a comprehensive “essential health benefits” package covering ten categories of services, including prescription drug coverage. Health plans have arranged various utilization protocols and methods to assist in controlling health care costs and ensuring patient safety. One of the most important tools used by health plans to manage drug costs are drug formularies.

A formulary is a list of prescription drugs covered by a health plan offering prescription drug benefits. Formularies help ensure that prescription drugs covered by the health plan are safe, effective, and affordable. Health plans use nationally recognized care criteria, the input of a pharmacy and therapeutics committee (P&T) composed of physicians, pharmacists and other health care clinicians, and consideration of the latest medical evidence based on the highest standards of care to create formularies. Prescription drugs can move tiers or be added or removed from formularies based on new clinical evidence, warnings, the release of new prescription drugs, or when drugs are pulled from the market by the FDA due to safety issues.

This chart catalogs state restrictions and requirements on health plan’s use of formulary management processes. Additionally, included in this chart is NAIC model #22 *Health Carrier Prescription Drug Benefit Management Model Act* language.

Because of the complexity of these laws, it is possible that each state’s law listed below may not apply to all insurers, providers, or services. States may fall into multiple categories, if they have more than one law on this topic.

Please see each state’s entry or entries for more specifics about that state’s approach.

To date, 35 states have enacted some form of formulary management provisions (AZ, AR, CA, CO, CT, DE, GA, HI, IL, IN, KY, LA, ME, MD, MA, MI, MN, MO, NV, NH, NJ, NM, NY, NC, OK, OR, PA, RI, TN, TX, UT, VT, VA, WA, & WV).

Medical Exceptions: Twenty eight states (AZ, AR, CO, CT, DE, GA, IL, IN, KY, LA, ME, MD, MI, MN, NH, NJ, NM, NY, NC, OK, OR, PA, RI, TN, TX, UT, VA, & WA) have provisions implementing medical exception or appeals approval processes for drugs not included on a formulary.

Health Plan Notifications: Twenty states (AZ, AR, CA, CT, IL, IN, KY, LA, ME, MD, MO, NV, NH, NJ, NM, NY, RI, TN, TX, & VA) require notifications from health plans triggered by formulary changes.

Mental and Behavioral Health: Thirteen states (AR, CO, CT, DE, IL, ME, MD, MA, MN, MO, NY, OR, & WV) require prescription drug coverage for mental and behavioral health (including MAT) treatment.

Public Website Posting: Ten states (CA, CT, HI, IL, ME, MA, NJ, TX, VT, & WA) require health plans to publish formulary information on public websites.

Pharmacy and Therapeutics Committee: Seven states (CA, CT, ME, MD, NJ, NC, OK) require health plans to establish P&T committees to develop formulary lists.

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State	Affected Entities	Provisions
NAIC Model# 22	Health carriers	<p><i>Health Carrier Prescription Drug Benefit Management Model Act:</i> <i>Requirements for the Development and Maintenance of Prescription Drug Formularies and Other Pharmaceutical Benefit Management Procedures</i></p> <p>Each health carrier that provides coverage for prescription drugs and manages this benefit through the use of a formulary or other PBMP shall establish, or have established, one or more P&T committees.</p> <ul style="list-style-type: none"> • Any P&T committee shall include members the health carrier considers appropriate who represent a sufficient number of clinical specialties to adequately meet the needs of covered persons, the majority of which are practicing physicians, practicing pharmacists and other practicing health care professionals licensed to prescribe prescription drugs, to develop and maintain formularies or any other PBMP. • A P&T committee shall seek outside expert advice, as appropriate, to develop and maintain formularies or any other PBMP in accordance with the requirements of this section. • The health carrier shall ensure that any P&T committee has the following policies and disclosure requirements in place that address potential conflicts of interest that members of a P&T committee may have with the carrier and any pharmaceutical developer or manufacturer: <ul style="list-style-type: none"> ○ At least 20 percent of the P&T committee membership has no conflict of interest with respect to the health carrier and any pharmaceutical developer or manufacturer; ○ Prohibits any P&T committee member with a conflict of interest with respect to the health carrier or a pharmaceutical developer or manufacturer from voting on decisions with regard to a particular prescription drug or class of prescription drugs for which the conflict exists; and ○ Each P&T committee member, and any individual who advises the P&T committee, signs a conflict of interest statement, which reveals any economic or other relationships the P&T committee member, or other individual advising the P&T committee, has with any person affected by drug coverage decisions that could influence P&T committee decisions. • Each P&T committee shall establish procedures outlining its conflict of interest standards for its members and any individuals providing expert advice to the P&T committee. • The procedures shall require the P&T committee to have a system in place to maintain the signed conflict of interest statements and to document any P&T committee member recusals from voting. • The procedures and information shall be available for regulatory review and provided to the commissioner upon request. • The P&T committee shall meet at least quarterly and shall maintain documentation of its rationale for all decisions regarding formulary drug list development or revision. <p>Each health carrier that offers coverage for prescription drugs shall ensure that it offers a formulary based on the recommendations of the carrier's P&T committee and covers at least the greater of:</p> <ul style="list-style-type: none"> • One drug in every United States Pharmacopeia (USP) category and class; or

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		<ul style="list-style-type: none"> • The same number of prescription drugs in each category and class as the essential health benefits (EHB)-benchmark plan. • The health carrier shall ensure that any P&T committee has and uses a process and documents and procedures to base clinical decisions on the strength of: <ul style="list-style-type: none"> ○ Medical and scientific evidence concerning the safety and effectiveness of prescription drugs, including the FDA label indications of the prescription drug and a available comparative information on clinically similar prescription drugs, when deciding what prescription drugs to review and include on a formulary; and ○ Applicable medical and scientific evidence concerning the safety and effectiveness of prescription drugs and the therapeutic advantages of prescription drugs when developing any PBMP. • In the case of rare or ultra-rare diseases, the P&T committee process shall include the review, as the P&T committee considers appropriate and necessary, of clinically appropriate and relevant information when there is no or limited medical and scientific evidence concerning the safety and effectiveness of prescription drugs or drug classes used to treat rare and ultra-rare diseases. • The health carrier shall ensure that any P&T committee maintains documentation of the process to ensure appropriate prescription drug review and inclusion and makes any records and documents relating to the process available, upon request, to the health carrier for record keeping purposes. • The health carrier shall ensure that any P&T committee has and uses a process to enable it, in a timely manner, but at least annually, to consider the need for and implement appropriate updates and changes to the formulary or other PBMPs based on: <ul style="list-style-type: none"> ○ Newly available scientific and medical evidence or other information concerning prescription drugs currently listed on the formulary or subject to any other PBMP and scientific and medical evidence or other information on new FDA-approved prescription drugs and other prescription drugs not currently listed on the formulary or subject to any other PBMP to determine whether a change to the formulary or PBMP should be made; ○ The strength of medical and scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data and other such information the P&T committee considers appropriate; ○ Information received from the health carrier with respect to medical exception requests enable the P&T committee to evaluate whether the prescription drugs currently listed on the formulary or subject to any other PBMP are meeting the health care service needs of covered persons; and ○ Information relating to the safety and effectiveness of a prescription drug currently listed on the formulary or subject to any other PBMP or relating to clinically similar prescription drugs not currently listed on the formulary or subject to any other PBMP from the health carrier's quality assurance activities or claims data that was received since the date of the P&T committee's most recent review of that prescription drug. • The P&T committee also shall: <ul style="list-style-type: none"> ○ Review and approve appropriate updates and guidance related to the medical exceptions process and other utilization management processes, including any PBMP requirements such as drug utilization review, quantity limits and therapeutic interchange;
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		<ul style="list-style-type: none"> ○ Review and approve appropriate updates and changes to all clinical prior authorization criteria, step therapy protocols and quantity limit restrictions applied to each covered prescription drug; and ○ Review new FDA-approved prescription drugs and new uses for existing prescription drugs. <ul style="list-style-type: none"> ● A health carrier shall allow covered persons to access outpatient prescription drug benefits at in-network retail or mail order pharmacies, unless: <ul style="list-style-type: none"> ○ The drug is subject to restricted distribution by the FDA; or ○ The drug requires special handling, provider coordination or patient education that a retail pharmacy cannot provide. ● The health carrier may charge covered persons different cost-sharing amounts based on the distribution method used to obtain the covered prescription drug. All in-network cost-sharing amounts paid shall count towards the health benefit plan's annual limit on cost-sharing paid by the covered person and shall be included in the actuarial value calculated for that plan. <p>A health carrier may contract with another person to perform the functions of a P&T committee.</p> <p><i>Information to Prescribers, Pharmacies, Covered Persons and Prospective Covered Persons</i></p> <ul style="list-style-type: none"> ● A health carrier shall display on its website in plain language the prescription drug benefit information required. ● For a health benefit plan providing group market health insurance coverage, a health carrier may require: <ul style="list-style-type: none"> ○ A covered person to create or access an account or enter a plan or contract number to access the plan's formulary list and other prescription drug benefit information; and ○ A prospective covered person to access a plan's formulary list and other prescription drug benefit information by searching by plan name or contract number. ● For a health benefit plan providing individual market health insurance coverage, a health carrier may not require a covered person or prospective covered person to create or access an account or enter a plan or policy number to access a plan's formulary list or other prescription drug benefit information, but may require a covered person or prospective covered person to access a plan's formulary list and other prescription drug benefit information by searching, as appropriate, by plan name. ● The health carrier's formulary list(s) shall include each prescription drug covered under the carrier's plan(s) prescription drug benefit and outpatient medical benefit, which are prescription drugs administered by a health care professional or under the professional's direct supervision in an outpatient setting. ● The health carrier may provide the information pertaining to prescription drugs covered under a plan's outpatient medical benefit as an addendum or link to the formulary, if applicable, provided the information is prominently displayed. ● The formulary shall be electronically searchable by drug name and any other means required by the commissioner. ● The prescription drug benefit information shall include a notice for any individual reviewing the information that the inclusion of a prescription drug on a health benefit plan's formulary does not mean that a prescriber will prescribe that drug for the individual's specific medical condition.
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		<ul style="list-style-type: none"> • A health carrier shall include in the prescription drug benefit information how and what written documentation is required to be submitted in order for a covered person or the covered person’s authorized representative to file a request under the health carrier’s medical exceptions process. • The health carrier shall include in the prescription drug benefit information a description in plain language of how an individual can access the following benefit information: <ul style="list-style-type: none"> ○ An indication of whether the drug is preferred, if applicable, under the plan; ○ A disclosure of any prior authorization, step therapy, quantity limits, pharmacy restrictions or other PBMP requirement; and ○ The specific tier the drug falls under, if the plan uses a tiered formulary. • The health carrier shall include in the prescription drug benefit information a description in plain language of how an individual may find the benefit cost-sharing information for the prescription drugs on a formulary list that includes: <ul style="list-style-type: none"> ○ Whether the prescription drug is subject to a deductible, and if so, the amount of the deductible; ○ The amount of the prescription drug copayment; ○ The amount of the prescription drug coinsurance; and ○ The amount of any cost-sharing difference between the days’ supply of the prescription drug. • For a health benefit plan providing individual market health insurance coverage, a health carrier may meet the information requirements by referring the individual to a summary of the plan’s benefits and coverage displayed or linked to a place elsewhere on the carrier’s website, provided that a covered person or prospective covered person is not required to create or access an account or enter a policy or plan number to access this information. • A health carrier shall provide, upon request, a print copy of specifically requested prescription drug benefit information of a carrier’s current, accurate and complete formulary. • A health carrier may make available the prescription drug benefit information using electronic links associated with the specific health benefit plan for which the information applies. • A health carrier shall ensure a formulary list(s), whether in electronic or print format, shall accommodate individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency. • A health carrier shall ensure the formulary list itself: <ul style="list-style-type: none"> ○ Is accurate; ○ Updated, as needed, to reflect changes in a health benefit plan’s covered prescription drugs; and ○ Includes the date it was last updated. <p>Whenever the health carrier makes or approves a change in a formulary that causes a particular prescription drug not to be covered, applies a new or revised dose restriction that causes a prescription for a particular prescription drug not to be covered for the number of doses prescribed, or applies a new or revised step therapy or prior authorization requirement that causes a particular prescription drug not to be covered until the requirements of that PBMP have been met, unless the change is being made for safety reasons or because the prescription drug cannot be supplied by or has been withdrawn from the market by the drug’s manufacturer, the health carrier or its designee shall provide notice of that change to:</p> <ul style="list-style-type: none"> • Prescribers at least 60 days prior to the effective date of the change; and
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		<ul style="list-style-type: none"> • Pharmacies participating in the health carrier’s network prior to the effective date of the change. • Whenever a health carrier makes or approves a change in a formulary impacting prescription drug benefit coverage or PBMP administration, including, but not limited to, co-payment amounts, co-insurance percentage level, step therapy, drug substitution and mandatory generics, the health carrier or its designee shall do one of the following: <ul style="list-style-type: none"> ○ At least 60 days prior to its effective date, the health carrier or its designee shall notify covered persons impacted by the change currently receiving benefits for the drug of the change; or ○ The health carrier or its designee shall cover a refill of a drug impacted by the change for any covered person currently receiving benefits for the drug on the same terms as covered previously so long as the drug continues to be prescribed for the covered person and notify the covered person or the covered person’s authorized representative at the time of the refill of the change. • As part of the information to be provided in a notice, the health carrier or its designee shall include information on any available alternatives to the prescription drug impacted by the formulary change and direct the covered person to speak with the prescriber. • The notice provided shall include information on how and what written documentation is required to be submitted for the covered person or the covered person’s authorized representative to file a medical exceptions request in accordance with the health carrier’s medical exceptions process. • A health carrier or its designee shall not be required to cover a refill of a prescription drug whenever: <ul style="list-style-type: none"> ○ The prescription drug is being discontinued from coverage on the formulary for safety reasons; ○ The prescription drug is not available because the drug’s manufacturer no longer supplies the drug or has withdrawn the drug from the market; or ○ The change in or a new PBMP for the prescription drug is for safety reasons. <p>A health carrier or its designee electronically or in writing, upon request, shall include in any notice explaining in plain language that:</p> <ul style="list-style-type: none"> • Any formulary change impacting prescription drug benefit coverage or PBMP administration could impact the covered person’s out-of-pocket costs and the covered person may want to consider contacting his or her prescribing provider to determine whether continuation of that particular prescription drug impacted by the change is appropriate or whether there is an acceptable alternative prescription drug that can be used to treat the covered person’s disease or medical condition; • The covered person may want to review the health benefit plan’s formulary from time-to-time or contact the health carrier or its designee to obtain any updated formulary information prior to obtaining a refill for a particular prescription drug the covered person is currently using to find out if there has been any change in the requirements for obtaining coverage for the drug or if there has been a change in the covered person’s out-of-pocket costs for the drug and include the telephone number or electronic link that covered persons can use to contact the health carrier or its designee to obtain this information; and • The amount the covered person may be required to pay out-of-pocket for a particular prescription drug may change from time-to-time.
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		<p><i>Medical Exceptions Approval Process Requirements and Procedures</i></p> <p>Each health carrier that provides prescription drug benefits and manages this benefit through the use of a formulary or through the application of a dose restriction that causes a prescription for a particular drug not to be covered for the number of doses prescribed or step therapy requirement that causes a particular drug not be covered until the requirements of that PBMP have been met shall establish and maintain a medical exceptions process that allows covered persons or covered persons' authorized representatives to request approval for:</p> <ul style="list-style-type: none"> • Coverage of a prescription drug that is not covered based on the health carrier's formulary; • Continued coverage of a particular prescription drug that the health carrier is discontinuing coverage on the formulary except when coverage for the drug is being discontinued for safety reasons or because the drug's manufacturer is no longer supplying the prescription drug or the drug's manufacturer has withdrawn the prescription drug from the market; or • An exception to a PBMP that causes a prescription drug to not be covered until the step therapy requirement is satisfied or not be covered at the prescribed number of doses. <ul style="list-style-type: none"> • A covered person or the covered person's authorized representative may file, and the health carrier shall review, a request only if the covered person's prescribing provider has determined that the requested prescription drug is medically necessary to treat the covered person's disease or medical condition because: <ul style="list-style-type: none"> ○ There is not a prescription drug listed on the formulary to treat the covered person's disease or medical condition that is an acceptable clinical alternative; ○ The prescription drug alternative listed on the formulary or required to be used in accordance with step therapy requirements: <ul style="list-style-type: none"> ▪ Has been ineffective in the treatment of the covered person's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the covered person and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; ▪ Is contraindicated; or ▪ Has caused or based on sound clinical evidence and medical and scientific evidence is likely to cause an adverse reaction or other harm to the covered person in the prescriber's clinical judgment; ○ The number of doses that is available under a dose restriction for the prescription drug has been ineffective in the treatment of the covered person's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the covered person and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or ○ The covered person's condition and function are stable and based on the covered person's medical history a change in prescription drug would have the potential for adverse consequences or other risks. • A health carrier may require the covered person or the covered person's authorized representative upon request to provide a written certification from the covered person's prescribing provider of the determination. • The health carrier may require the written certification to include any of, but no more than, the following information:
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		<ul style="list-style-type: none"> ○ The patient’s name, group or contract number, subscriber number or other information necessary to identify the covered person; ○ Patient history; ○ The primary diagnosis related to the requested prescription drug that is the subject of the medical exceptions request; ○ Based on the reason: <ul style="list-style-type: none"> ▪ Why the formulary drug is not acceptable for the individual patient; ▪ If the medical exceptions request involves a step therapy requirement, why the prescription drug required to be used is not acceptable for the individual patient; or ▪ If the medical exceptions request involves a dose restriction, why the available number of doses for the prescription drug is not acceptable for the individual patient; ○ The reason why the prescription drug that is the subject of the medical exceptions request is needed for the individual patient or, if the medical exceptions request involves a dose restriction, why an exception to the dose restriction is needed for the individual patient; and ○ Any other information reasonably necessary to evaluate the medical necessity of the medical exceptions request. <ul style="list-style-type: none"> ● A prescriber may submit additional information the prescriber deems necessary to establish medical necessity for purposes of the medical exceptions request. ● Participation by a provider on behalf of a covered person in the medical exceptions process established under this section shall be construed as being the same as a provider’s advocating on behalf of a covered person within the utilization review process established by the health carrier. ● The health carrier shall ensure that the request is reviewed by appropriate health care professionals who, in reaching a decision on the request, shall take into account the specific facts and circumstances that apply to the covered person for whom the request has been made using documented clinical review criteria that: <ul style="list-style-type: none"> ○ Are based on sound clinical evidence and medical and scientific evidence; and ○ If available, appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, practice guidelines developed by the health carrier’s P&T committee or any other practice guidelines developed by the federal government, national or professional medical or pharmacist societies, boards and associations. ● The health care professional or professionals designated by the health carrier to review the request shall ensure that the decision reached on the request is consistent with the benefits and exclusions under the covered person’s health benefit plan with the health carrier. ● The medical exceptions process shall require the health carrier to make a decision on a request made and provide notice of the decision to the covered person or the covered person’s authorized representative as quickly as the covered person’s particular medical condition requires, but in no event later than 72 hours after the later of the date of receipt of the request or, if required by the health carrier, the date of receipt of the certification. ● A health carrier shall include in its medical exceptions process an expedited medical exceptions review based on exigent circumstances.
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		<ul style="list-style-type: none"> • Exigent circumstances exist when a covered person is suffering from a health condition that may seriously jeopardize the covered person’s life, health, or a ability to regain maximum function. • A health carrier shall make a decision on an expedited medical exceptions review request based on exigent circumstances and notify the covered person or the covered person’s authorized representative of its coverage decision no later than 24 hours following receipt of the request. • If the health carrier fails to make a decision on the request and provide notice of the decision within the required time frame: <ul style="list-style-type: none"> ○ The covered person shall be entitled to have coverage for, up to one month’s supply of the prescription drug that is the subject of the request; and ○ The health carrier shall make a decision on the request prior to the covered person’s completion of the supply. • If the health carrier fails to make a decision on the request and provide notice of the decision prior to the covered person’s completion of the supply provided for, the health carrier shall maintain coverage, on the same terms, on an ongoing basis, as long as the prescription drug continues to be prescribed for that covered person and is considered safe for the treatment of the covered person’s disease or medical condition until a decision is made on the request and notice of that decision is provided, unless there is a material change in the covered person’s terms of coverage or the applicable benefit limits have been exhausted. • Whenever a medical exception request is approved, the health carrier shall not require the covered person to request approval for a refill, or a new prescription to continue using the prescription drug after the refills for the initial prescription have been exhausted, for the same prescription drug that was previously approved for coverage or continued coverage or that was previously approved as an exception to the health carrier’s PBMP for that drug, subject to the terms of coverage under the health carrier’s health benefit plan for prescription drug benefits as long as: <ul style="list-style-type: none"> ○ The covered person’s prescribing provider continues to prescribe the prescription drug to treat the same disease or medical condition of the covered person; and ○ The prescription drug continues to be considered safe for treating the covered person’s disease or medical condition. • Whenever a medical exception request is approved, the health carrier shall provide coverage for the approved prescription drug [and count the covered person’s in-network cost-sharing for the drug toward the covered person’s annual limitation on cost-sharing]. • A health carrier shall not establish a special formulary tier or co-payment or other cost-sharing requirement that is applicable only to prescription drugs approved for coverage. • Any denial by a health carrier of a request: <ul style="list-style-type: none"> ○ Shall be provided to the covered person or, if applicable, the covered person’s authorized representative in writing or, if the covered person has agreed to receive information in this manner, electronically; ○ Shall be provided electronically to the covered person’s prescribing provider or, upon request, in writing; and ○ May be appealed by filing a grievance.
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		<ul style="list-style-type: none"> • The denial shall, in plain language, set forth: <ul style="list-style-type: none"> ○ The specific reason or reasons for the denial; ○ A reference to the evidence or documentation, including the clinical review criteria, including practice guidelines, and clinical evidence and medical and scientific evidence considered in reaching the decision to deny the request; ○ Instructions for requesting, a written statement of the clinical and medical or scientific rationale for the denial; and ○ A description of the process and procedures that must be followed for filing a grievance to appeal the denial including any time limits applicable to those procedures. <p>A health carrier that permits a covered person’s prescriber to make formulary and other PBMP exceptions without having to obtain a authorization from the carrier and that maintains on an ongoing basis in its administrative systems information about the exception status of a particular prescription drug for a particular covered person shall not be required to establish a medical exceptions process or required to comply with the provisions above with respect to the prescription drug orders of these prescribing participating providers.</p> <p>A health carrier shall not be required to establish a medical exceptions process or required to comply with the provisions above if the health carrier:</p> <ul style="list-style-type: none"> • Has an expedited utilization review process; and • Allows covered persons or their authorized representatives to use this process to seek a approval for coverage of a prescription drug that is not otherwise covered because of the health carrier’s formulary or because of any other PBMP requirement that restricts coverage of the prescription drug until the PBMP requirement has been met. <p>A covered person may not use the medical exception process to request coverage for:</p> <ul style="list-style-type: none"> • an investigational or a non-FDA-approved prescription drug; or • a prescription drug for a specifically excluded benefit under the covered person’s health benefit plan. <p><i>Nondiscrimination in Prescription Drug Benefit Design</i> A health carrier or its designee shall not adopt or implement a formulary or prescription drug benefit design that is discriminatory in violation of state or federal law.</p>
<p>Arizona A.R.S. § 20-841.05 & A.R.S. § 20-1057.02</p> <p>Effective 2015</p>	<p>Hospital service corporations, medical service corporations, dental service corporations, optometric service corporations and</p>	<p><i>Prescription Drug Formulary:</i> A health plan that uses a prescription drug formulary shall:</p> <ul style="list-style-type: none"> • Develop and maintain a process by which health care professionals may request authorization for a medically necessary formulary or nonformulary prescription drug during nonbusiness hours. If the corporation does not maintain that process, the corporation shall reimburse a subscriber for the subscriber's out-of-pocket expense minus any deductible or copayment for a prescription drug that was purchased by the subscriber without preauthorization but that was later approved by the corporation.

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	<p>hospital, medical, dental and optometric service corporations, and health care services organizations</p>	<ul style="list-style-type: none"> • Develop and maintain a process by which health care professionals may request authorization for medically necessary nonformulary prescription drugs. The corporation shall approve an alternative prescription drug when either of the following conditions is met: <ul style="list-style-type: none"> ○ The equivalent prescription drug on the formulary has been ineffective in the treatment of the subscriber's disease or condition. ○ The equivalent prescription drug on the formulary has caused an adverse or harmful reaction in the subscriber. <p>If the subscriber's treating health care professional makes a determination that the subscriber meets any of the conditions above, any denial to cover the nonformulary prescription drug by the corporation shall be made in writing by a licensed pharmacist or medical director. The written denial shall contain an explanation of the denial, including the medical or pharmacological reasons why the authorization was denied, and the licensed pharmacist or medical director who made the denial shall sign it. The corporation shall send a copy of the written denial to the subscriber's treating health care professional who requested the authorization. The corporation shall maintain copies of all written denials and shall make the copies available to the department for inspection during regular business hours.</p> <p>Any subscription contract that is issued, amended or renewed by a corporation and that includes prescription drug benefits shall not limit or exclude coverage for at least 60 days after the corporation's notice or the pharmacy's notice to the subscriber, whichever occurs first, for a prescription drug for a subscriber to refill a previously prescribed drug if the prescription drug was previously approved for coverage under the drug formulary or pharmacy benefit plan for the subscriber's medical condition and the health care professional continues to prescribe the prescription drug for the same medical condition. The limitation or exclusion prohibited by this subsection applies if the prescription drug is appropriately prescribed and is considered safe and effective for treating the subscriber's medical condition. This subsection does not prohibit the health care professional from prescribing another prescription drug that is covered by the drug formulary and that is medically appropriate for the subscriber, including generic drug substitutions.</p> <p>A health plan shall provide written notice of the removal of any prescription drug from the corporation's drug formulary to each pharmacy vendor with which the corporation has a contract. On notice from the corporation, the contracted pharmacy vendor at the point of dispensing a prescription drug that has been removed from the drug formulary shall notify the subscriber by means of a verbal consultation or other direct communication with a subscriber that the subscriber may be required to consult with a health care professional to obtain a new prescription for a replacement drug after the 60 day period. The notice prescribed in this subsection is not required if the pharmacy vendor is a pharmacy that is owned by the corporation or a corporate affiliate of that corporation.</p>
<p>Arkansas A.C.A. § 23-99-409 Effective 1997</p>	<p>Healthcare insurers</p>	<p><i>Prescription Drug Formulary:</i> When a healthcare insurer uses a formulary for prescription drugs, the insurer shall include a written procedure whereby covered persons can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:</p> <ul style="list-style-type: none"> • The formulary's equivalent has been ineffective in the treatment of the covered person's disease or condition; or

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		<ul style="list-style-type: none"> The formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the covered person.
<p>Arkansas A.C.A. § 23-79-159</p> <p>Effective 2014</p>	Health benefit plans	<p>Notification of Drug Formulary Changes: A health benefit plan that provides prescription drug coverage or contracts with a third party for prescription drug services with tiered copayments shall notify an enrollee presently taking a prescription drug, in writing or electronically at the request of the enrollee, at least 60 days before an increase in the enrollee's financial responsibility as a result of a modification by the health benefit plan to the health benefit plan's drug formulary.</p>
<p>Arkansas A.C.A. § 23-99-1119</p> <p>Effective 2019</p>	Healthcare insurers	<p>Medication-Assisted Treatment (MAT) for Opioid Treatment: A healthcare insurer utilizing a tiered drug formulary shall place on the lowest-cost benefit tier at least one product for each of the following medications that is approved by the FDA:</p> <ul style="list-style-type: none"> Buprenorphine; Naloxone; Naltrexone; Methadone; and A product containing both buprenorphine and naloxone.
<p>California West's Ann. Cal. Ins. Code § 10123.192</p> <p>Effective 2016</p>	Health insurer	<p>Formulary Requirements / Formulary Template: A health insurer that provides prescription drug benefits and maintains one or more drug formularies shall do all of the following:</p> <ul style="list-style-type: none"> Post the formulary or formularies for each product offered by the insurer on the insurer's Internet Web site in a manner that is accessible and searchable by potential insureds, insureds, providers, the general public, the department, and federal agencies as required by federal law or regulations. Update the formularies with any change to those formularies on a monthly basis. No later than six months after the date that a standard formulary template is developed, use that template to display the formulary or formularies for each product offered by the insurer. <p>The department and the Department of Managed Health Care shall jointly, and with input from interested parties from at least one public meeting, develop a standard formulary template. In developing the template, the department and Department of Managed Health Care shall take into consideration existing requirements for reporting of formulary information established by the federal Centers for Medicare and Medicaid Services. To the extent feasible, in developing the template, the department and the Department of Managed Health Care shall evaluate a way to include on the template, cost-sharing information for drugs subject to coinsurance.</p> <p>The standard formulary template shall include a notification that the presence of a drug on the insurer's formulary does not guarantee that an insured will be prescribed that drug by his or her prescribing provider for a particular</p>

Formulary Management Laws Chart: Summary of State Requirements

		<p>medical condition. As applied to a particular formulary for a product offered by an insurer, the standard formulary template shall do all of the following:</p> <ul style="list-style-type: none"> • Include information on cost-sharing tiers and utilization controls, including prior authorization or step therapy requirements, for each drug covered by the product. • Indicate any drugs on the formulary that are preferred over other drugs on the formulary. • Include information to educate insureds about the differences between drugs administered or provided under a health insurer's medical benefit and drugs prescribed under a health insurer's prescription drug benefit and about how to obtain coverage information about drugs that are not covered under the health insurer's prescription drug benefit. • Include information to educate insureds that health insurers that provide prescription drug benefits are required to have a method for insureds to obtain prescription drugs not listed in the health insurer's drug formulary if the drugs are deemed to be medically necessary by a clinician. • Include information on which medications are covered, including both generic and brand name. • Include information on what tier of the health insurer's drug formulary each medication is in.
<p>California West's Ann. Cal. Ins. Code § 10123.201</p> <p>Effective 2016</p>	<p>Insurers</p>	<p><i>Pharmacy and Therapeutics Committee / Records:</i> <i>P&T</i></p> <p>An insurer shall maintain a pharmacy and therapeutics committee that shall be responsible for developing, maintaining, and overseeing any drug formulary list. If the insurer delegates responsibility for the formulary to any entity, the obligation of the insurer to comply with this part shall not be waived.</p> <p>The pharmacy and therapeutics committee board membership shall conform with both of the following:</p> <ul style="list-style-type: none"> • Represent a sufficient number of clinical specialties to adequately meet the needs of insureds. • Consist of a majority of individuals who are practicing physicians, practicing pharmacists, and other practicing health professionals who are licensed to prescribe drugs. <p>Members of the board shall abstain from voting on any issue in which the member has a conflict of interest with respect to the issuer or a pharmaceutical manufacturer.</p> <p>At least 20 percent of the board membership shall not have a conflict of interest with respect to the issuer or any pharmaceutical manufacturer.</p> <p>The pharmacy and therapeutics committee shall meet at least quarterly and shall maintain written documentation of the rationale for its decisions regarding the development of, or revisions to, the formulary drug list.</p> <p>The pharmacy and therapeutics committee shall do all of the following:</p> <ul style="list-style-type: none"> • Develop and document procedures to ensure appropriate drug review and inclusion. • 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.

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		<ul style="list-style-type: none"> • Consider the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs. • Review policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange. • Evaluate and analyze treatment protocols and procedures related to the insurer's formulary at least annually. • Review and approve all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug. • Review new FDA-approved drugs and new uses for existing drugs. • Ensure the insurer's formulary drug list or lists cover a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states and does not discourage enrollment by any group of insureds. • Ensure the insurer'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. <p><i>Records</i> Every health insurer that provides prescription drug benefits shall maintain all of the following information, which shall be made available to the commissioner upon request:</p> <ul style="list-style-type: none"> • The complete drug formulary or formularies of the insurer, if the insurer maintains a formulary, including a list of the prescription drugs on the formulary of the insurer by major therapeutic category with an indication of whether any drugs are preferred over other drugs. • Records developed by the pharmacy and therapeutic committee of the insurer, 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 insureds of the insurer, that fully describe the reasoning behind formulary decisions. • Any insurer arrangements with prescribing providers, medical groups, individual practice associations, pharmacists, contracting pharmaceutical benefit management companies, or other entities that are associated with activities of the insurer to encourage formulary compliance or otherwise manage prescription drug benefits. <p>If an insurer provides prescription drug benefits, the commissioner shall, as part of its market conduct examination, review the performance of the insurer in providing those benefits, including, but not limited to, a review of the procedures and information maintained pursuant to this section, and describe the performance of the insurer as part of its report issued as part of its market conduct examination.</p> <p>The commissioner shall not publicly disclose any information reviewed that is determined by the commissioner to be confidential pursuant to state law.</p>
<p>California <i>West's</i> <i>Ann. Cal. Ins. Code</i> <i>§ 10123.1932</i></p>	<p>Nongrandfathered health insurance plans in the individual or</p>	<p><i>Drug Formularies to Include Fourth Tier:</i> If a policy of health insurance offered, sold, or renewed in the nongrandfathered individual or small group market maintains a drug formulary grouped into tiers that includes a fourth tier, a policy of health insurance shall use the following definitions for each tier of the drug formulary:</p>

Formulary Management Laws Chart: Summary of State Requirements

<p>Effective 2019</p>	<p>group policy market</p>	<ul style="list-style-type: none"> • Tier one shall consist of most generic drugs and low-cost preferred brand name drugs. • Tier two shall consist of nonpreferred generic drugs, preferred brand name drugs, and any other drugs recommended by the health insurer's pharmacy and therapeutics committee based on safety, efficacy, and cost. • Tier three shall consist of nonpreferred brand name drugs or drugs that are recommended by the health insurer's pharmacy and therapeutics committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier. • Tier four shall consist of drugs that are biologics, drugs that the FDA or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the insured to have special training or clinical monitoring for self-administration, or drugs that cost the health insurer more than \$600 net of rebates for a one-month supply. <p>A policy of health insurance may maintain a drug formulary with fewer than four tiers. A policy of health insurance shall not maintain a drug formulary with more than four tiers.</p>
<p>California 10 CCR § 2594.4</p> <p>Effective 2013</p>	<p>Individual or small group health insurance policy</p>	<p>Prescription Drug Coverage: A health insurer shall submit all of the following to the Commissioner together with a health insurance policy form, and annually on July 1 thereafter:</p> <ul style="list-style-type: none"> • A list reporting the number of chemically distinct prescription drugs covered in each United States Pharmacopeia category and class and an attestation to the truth and accuracy of the list. • Any prescription drug list and/or formulary associated with the policy form. • Consumer documents describing prescription drug benefits and limitations on coverage, including any prescription drug list and/or formulary associated with the policy form that is provided to consumers.
<p>California 10 CCR § 2218.80, 10 CCR § 2218.82, & 10 CCR § 2218.83</p> <p>Effective 2018</p>	<p>Health Insurers</p>	<p>Standard Prescription Drug Formulary Template: <i>Scope of the article</i> This article establishes minimum standards for a prescription drug formulary that is maintained by a health insurer. A health insurer may implement additional provisions in a prescription drug formulary that exceed these standards.</p> <p><i>Structure and content</i> A formulary shall include all of the following sections in the order listed:</p> <ul style="list-style-type: none"> • Title page. • Table of contents. • Informational section. • Categorical list of prescription drugs. • Alphabetical index of prescription drugs. <p><i>Title page</i> The title page of a formulary shall include all of the following contents:</p> <ul style="list-style-type: none"> • A title.

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		<ul style="list-style-type: none"> • The name of the health insurer that maintains the formulary. • The name of each health insurance product to which the formulary applies. • The date the formulary was last updated. • Notice that the formulary is subject to change and all previous versions of the formulary are no longer in effect. • A direct website link for the location of the electronic version of the formulary posted on the health insurer's public website. • Instructions for contacting the health insurer's customer service department. • A direct website link for the location of, or specific instructions for locating, plan-specific coverage documents that include cost sharing applicable to prescription drugs for each plan to which the formulary applies, and that are posted on a health insurer's public website. <p><i>Informational section</i></p> <p>The informational section of a formulary shall include all of the following contents:</p> <ul style="list-style-type: none"> • Definitions for terms. • Definitions for any additional or different terms used in the formulary that are necessary for comprehending the formulary. • Instructions on how to locate a prescription drug in the categorical list of prescription drugs. • A description of the manner in which drugs are listed in the categorical list of prescription drugs. • A description of the drug tiers in the formulary, if drugs are grouped into tiers. • A description of all utilization management procedures that the health insurance product imposes on prescription drug coverage, including, but not limited to, prior authorization, step therapy, quantity limits, and network limitations on access including specialty pharmacy restrictions. • Information about the differences between drugs covered under the medical benefit of the product and drugs covered under the outpatient prescription drug benefit of the product, and instructions on how to obtain coverage information for drugs covered under the medical benefit. • Notice that the health insurer must update the formulary with changes on a monthly basis. The notice shall include a description of the types of changes a health insurer may make to the formulary during the plan or policy year, and the dates on which such changes are effective. The notice may also include a description of any prior notification a health insurer will provide an affected insured of a formulary change. • An explanation that the presence of a prescription drug on the formulary does not guarantee that an insured will be prescribed that prescription drug by his or her prescribing provider for a particular medical condition. • Notice that the health insurer must cover a non-formulary drug when medically necessary and a detailed description of the process for submitting an exception request. • Instructions on how to locate and fill a prescription through a network retail pharmacy, mail order pharmacy, and specialty pharmacy, as applicable. • A detailed description of the process for requesting prior authorization or a step therapy exception. The description shall state that if a health insurer fails to respond to a completed prior authorization or step therapy exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on
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Formulary Management Laws Chart: Summary of State Requirements

		<p>exigent circumstances, the request is deemed approved and the health insurer may not deny the request thereafter.</p> <ul style="list-style-type: none"> • Notice of an insured's rights concerning step therapy. • In a formulary applicable to a health insurance product to which section 10112.27 of the Insurance Code applies, notice that a health insurer may not limit or exclude coverage for a drug if the health insurer previously approved coverage of the drug for an insured's medical condition and the prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is a appropriately prescribed and safe and effective for treating the insured's medical condition. • A description of the coverage provided under the outpatient prescription drug benefit for drugs, devices, and FDA-approved products, including any over-the-counter drugs, devices, and FDA-approved products that must be covered pursuant to those sections. The description shall include a detailed description of the process required to acquire those drugs, devices, and FDA-approved products through the outpatient prescription drug benefit. • A description of the limit on cost sharing for orally administered anti-cancer drugs. • 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. • An annotated legend or key to all tier numbers, abbreviations, and designations used in the formulary. <p><i>Categorical list of prescription drugs</i></p> <ul style="list-style-type: none"> • Organization of categorical list. • The categorical list shall include a complete list of all prescription drugs covered under the outpatient prescription drug benefit of the product, including both generic and brand name drugs. A formulary may include prescription drugs that are covered only under the medical benefit of the product, provided that each of those drugs is clearly identified as a drug that is covered only under the medical benefit. A formulary may include non-formulary prescription drugs, provided that each of those drugs is clearly identified as a non-formulary drug. • The "Prescription Drug Name" column shall include all covered dosage forms and strengths for each prescription drug. • "Drug Tier" column. • The "Coverage Requirements and Limits" column shall include abbreviations or designations for all utilization management procedures that the health insurer imposes on prescription drug coverage, including, but not limited to, prior authorization, step therapy, quantity limits, and network limitations on access including specialty pharmacy restrictions, in addition to any other relevant information applicable to the coverage provided for a prescription drug. For each prescription drug that is subject to one or more quantity limits, the applicable quantity limits shall be described with specificity. • The annotated legend or key to all tier numbers, abbreviations, and designations used in the formulary shall appear on each page of the categorical list. <p><i>Alphabetical index of prescription drugs</i></p>
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Formulary Management Laws Chart: Summary of State Requirements

		<p>The index shall list each covered brand name and generic drug by respective brand name or established name in alphabetical order and include the page number for the location of the drug in the categorical list of prescription drugs.</p> <p><i>Review by the commissioner</i> No later than six months following the date this article is adopted, a health insurer that maintains prescription drug formularies shall submit all prescription drug formularies for health insurance products in which it has covered lives enrolled in the state of California to the commissioner for review for compliance with this article. Following review, a health insurer shall not implement any provisions in its prescription drug formularies that the commissioner has determined are inconsistent with this article or other applicable law.</p>
<p>Colorado <i>C.R.S.A. § 10-16-148</i></p> <p>Effective 2019</p>	Carriers	<p>MAT: Beginning January 1, 2020, a carrier that provides prescription drug benefits for the treatment of substance use disorders shall, for prescription medications that are on the carrier's formulary:</p> <ul style="list-style-type: none"> • Not impose prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders; • Not impose any step therapy requirements as a prerequisite for coverage for a prescription medication approved by the FDA for the treatment of substance use disorders; • Place at least one covered prescription medication approved by the FDA for the treatment of substance use disorders on the lowest tier of the drug formulary developed and maintained by the carrier; and • Not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered.
<p>Colorado <i>3 CCR 702-4:4-2-42</i></p> <p>Effective 2013</p>	Carriers	<p>Drug / Formulary Review: Carriers must submit their formularies to the Division annually, by June 30 of each year. If a formulary changes by more than five percent in a calendar year, the carrier must submit a filing to the Division supporting that its formulary has the required number of drugs in each category to comply with the EHB requirement.</p>
<p>Colorado <i>3 CCR 702-4:4-2-49</i></p> <p>Effective 2014</p>	Health benefit plans	<p>Special Exception Processes for Non-formulary Drug Authorization Requests: Carriers shall have standard and expedited exception processes that allow a covered person, the covered person's designee, or the covered person's prescribing provider (or other prescriber) to request and gain access to clinically-appropriate drugs not otherwise covered by his or her health benefit plan.</p> <p><i>Standard exception requests</i></p> <ul style="list-style-type: none"> • A carrier shall make its determination on a standard exception request and shall notify the covered person or the covered person's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following receipt of the request.

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • A carrier that grants a standard exception request shall provide coverage of the non-formulary drug for the duration of the prescription, including refills, as long as the covered person remains covered under the individual or small group health benefit plan. <p><i>Expedited exception requests</i></p> <ul style="list-style-type: none"> • A carrier shall have a process for a covered person, the covered person's designee, or the covered person's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances. • A carrier shall make its coverage determination on an expedited exception request and shall notify the covered person or the covered person'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. • A carrier that grants an exception based on exigent circumstances shall provide coverage of the non-formulary drug for the duration of the exigency. <p><i>External exception request reviews</i></p> <ul style="list-style-type: none"> • If the carrier denies a request for a standard exception or for an expedited exception, it shall have a process for the covered person, the covered person's designee, or the covered person'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. • A carrier shall ensure that the independent review organization makes its determination on the external exception request and notifies the covered person or the covered person'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 or no later than 24 hours following its receipt of the request, if the original request was an expedited exception request. • If the independent review organization overturns the carrier's denial of a standard exception request, the carrier shall provide coverage of the non-formulary drug for the duration of the prescription as long as the covered person remains covered under the individual or small group health benefit plan. • If the independent review organization overturns the carrier's denial of an expedited exception request, the carrier shall provide coverage of the non-formulary drug for the duration of the exigency as long as the covered person remains covered under the individual or small group health benefit plan.
<p>Connecticut <i>C.G.S.A. § 38a-492f</i></p> <p>Effective 2013</p>	<p>Individual and group health insurers</p>	<p><i>Mandatory Coverage for Certain Prescription Drugs Removed from Formulary:</i> Each individual and group health insurance policy providing coverage of the type in this state that provides coverage for outpatient prescription drugs shall not deny coverage for an insured for any drug that the insurer removes from its list of covered drugs, or otherwise ceases to provide coverage for, if:</p> <ul style="list-style-type: none"> • the insured was using the drug for the treatment of a chronic illness prior to the removal or cessation of coverage, • the insured was covered under the policy for the drug prior to the removal or cessation of coverage, and • the insured's attending health care provider states in writing, after the removal or cessation of coverage, that the drug is medically necessary and lists the reasons why the drug is more medically beneficial than the drugs on the

Formulary Management Laws Chart: Summary of State Requirements

		list of covered drugs. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies.
<p>Connecticut C.G.S.A. § 38a-476b</p> <p>Effective 2001</p>	Health Insurance Plans	<p><i>Standards Re Psychotropic Drug Availability in Health Plans:</i> No mental health care benefit provided under state law may, through the use of a drug formulary, list of covered drugs or any other means:</p> <ul style="list-style-type: none"> • Limit the availability of psychotropic drugs that are the most effective therapeutically indicated pharmaceutical treatment with the least probability of adverse side effects; or • require utilization of psychotropic drugs that are not the most effective therapeutically indicated pharmaceutical treatment with the least probability of adverse side effects
<p>Connecticut Regs. Conn. State Agencies § 38a-481-11 & Regs. Conn. State Agencies § 38a-513-6</p> <p>Effective 2018</p>	Health Insurance Plans	<p><i>Minimum Standards for Formularies:</i> No individual or group health insurance policy that offers prescription drug coverage that is subject to a formulary shall be delivered or issued for delivery in this state if the formulary does not meet the following required minimum standards:</p> <ul style="list-style-type: none"> • The formulary shall be easily searchable and posted online, accessible to members and non-members. • The medications within the formulary shall be grouped in alphabetical order by therapeutic class. • Definitions or explanations, or both, of each prescription drug tier, including specialty drug tiers, shall be clearly stated. • Definitions for utilization controls, including, but not limited to, quantity or dosage controls, prior authorization, and step therapy shall be clearly stated. • Tier coverage and utilization controls for each medication (by dosage, if applicable) shall be clearly stated. • The formulary shall include information on how to obtain drugs that are off formulary. • The formulary shall specify if and how drugs may be obtained through mail order pharmacy. • The formulary shall clearly state when it was created, when it was last updated, and when the next anticipated update will be. • The formulary shall provide customer service contact information. • The formulary shall meet all additional requirements as set by the Commissioner.
<p>Connecticut Regs. Conn. State Agencies § 38a-481-13 & Regs. Conn. State Agencies § 38a-513-8</p> <p>Effective 2018</p>	Insurance Companies	<p><i>Notice to Insureds Regarding Formulary Changes:</i> Insurers that deliver, issue for delivery, renew, amend or continue any individual health insurance policy that includes prescription drug coverage and utilizes a formulary shall provide at least 60 days' advance notice to each insured and to each participating provider under the policy utilizing a prescription drug within the formulary before the insurer may remove such prescription drug from the formulary or make any change to the structure of prescription drug benefits under such policy.</p>

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<p>Connecticut <i>Regs. Conn. State Agencies § 38a-481-12 & Regs. Conn. State Agencies § 38a-513-7</i></p> <p>Effective 2018</p>	<p>Insurance Companies</p>	<p><i>Minimum Standards for Pharmaceutical and Therapeutics Committees:</i> No insurer shall utilize a P&T committee that does not have a appropriate membership.</p> <ul style="list-style-type: none"> • A majority of P&T committee members shall be practicing physicians, pharmacists, and other professionals who are licensed to prescribe drugs. <ul style="list-style-type: none"> ○ P&T committee members shall represent a sufficient number of clinical specialties to adequately meet the needs of enrollees. ○ Insurers shall put in place a process to ensure that there is no conflict of interest among members of the P&T committee with respect to the issuer or any pharmaceutical manufacturer. The process shall include an explanation of how conflicts of interest are dealt with if they arise. ○ Insurers shall put in place a process to ensure that P&T committee members abstain from voting if there is a conflict of interest. <p>The P&T committee shall meet regularly.</p> <ul style="list-style-type: none"> • Insurers shall put in place a process, including timeframes, to ensure that the P&T committee meets and makes decisions on new FDA-approved drugs within a reasonable time frame after the drug is released into the market. • The P&T committee shall meet at least quarterly and maintain written documentation of the rationale for its decisions regarding the development of, or revisions to, the formulary. • The P&T committee shall evaluate and analyze treatment protocols and procedures related to the plans' formulary at least annually. <p>Insurers shall develop and document procedures to ensure a appropriate formulary drug review and inclusion.</p> <ul style="list-style-type: none"> • Insurers shall provide a copy of the policies and procedures in place to ensure that the P&T committee: <ul style="list-style-type: none"> ○ Bases 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. ○ Considers the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs. ○ Reviews new FDA-approved drugs and new FDA-approved uses for existing drugs. ○ Reviews policies that guide exceptions and other utilization management processes, including, but not limited to, drug utilization review, quantity limits, prior authorizations, step therapies, generic substitutions, and therapeutic interchange. • Insurers shall provide information on how often the formulary is updated on the company website and whether timeframes vary depending on whether the changes are advantageous to the enrollee. • Insurers shall develop a process to ensure the formulary recommended by the P&T committee: <ul style="list-style-type: none"> ○ Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommends drug treatment regimens that treat all disease states. ○ Does not discourage enrollment of any group of enrollees through discriminatory tiering and utilization management processes.
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Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> ○ Includes multiple drugs, strengths and dosage forms for each therapeutic class and, if multiple drugs are available to treat a disease, they are not all placed in the highest cost share tier. ○ Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time and based on use of a tool set forth by the Commissioner.
<p>Connecticut <i>Regs. Conn. State Agencies § 38a-481-10 & Regs. Conn. State Agencies § 38a-513-5</i></p> <p>Effective 2018</p>	Insurance Companies	<p><i>Formulary Annual Filing Requirements:</i> Insurers that deliver, issue for delivery, renew, amend or continue any individual health insurance policy that includes prescription drug coverage and utilizes a formulary shall submit an annual report to the Commissioner regarding the development and use of formularies and P&T committees. Such report shall be in a form prescribed by the commissioner and shall be submitted with the annual form filing.</p>
<p>Delaware <i>18 Del.C. § 3580 & 18 Del.C. § 3364</i></p> <p>Effective 2014</p>	Health Plan	<p><i>Specialty Tier Prescription Coverage:</i> A health plan that provides coverage for prescription drugs and utilizes a specialty drug formulary shall implement an exceptions process that allows enrollees to request an exception to the formulary. Under such an exception, a nonformulary specialty drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual, or would have adverse effects for the individual, or both. In the event an enrollee is denied an exception, such denial shall be considered an adverse event and will be subject to the health plan internal review process and the state external review process.</p>
<p>Delaware <i>18 Del.C. § 3571V & 18 Del.C. § 3343</i></p> <p>Effective 2019</p>	Carriers and Health Benefit Plans	<p><i>Medication Assisted Treatment for Drug and Alcohol Dependencies:</i> If group health insurance coverage provides prescription medication benefits for the treatment of mental illness and drug and alcohol dependencies, a health insurer must place at least one formulation of a medication-assisted treatment on the lowest tier of the drug formulary developed and maintained by the carrier, including each of the following:</p> <ul style="list-style-type: none"> ● Buprenorphine. ● Naltrexone. ● Naloxone. ● A product containing both buprenorphine and naloxone. <p>A health insurer shall provide benefits under this section as follows:</p> <ul style="list-style-type: none"> ● Not impose a prior authorization requirement. ● Must authorize coverage of prescription medicine without imposing a step therapy requirement for at least one formulation of each prescription medication for medication-assisted treatment that is on each tier of the drug formulary developed and maintained by the health insurer.

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<p>Delaware 18 Del.C. § 3559 & 18 Del.C. § 3342A</p> <p>Effective 2018</p>	<p>Carriers and Health Benefit Plans</p>	<p>Contraceptive Coverage: Carriers shall provide coverage for contraceptive methods in all health benefit plans delivered or issued for delivery in this State. Coverage for contraceptive methods must include all of the FDA-approved contraceptive drugs, devices, and other products as follows:</p> <ul style="list-style-type: none"> • If the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, the health benefit plan is not required to include all such therapeutically equivalent versions in its formulary as long as at least one is included and covered without cost-sharing and in accordance with this section. • If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, the health benefit plan may provide coverage for more than one drug, device, or other product and may impose cost-sharing requirements as long as at least one drug, device, or other product for that method is available without cost-sharing. If, however, an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the health benefit plan shall provide coverage for the prescribed contraceptive drug, device, or product without cost-sharing.
<p>Georgia Ga. Code Ann., § 33-21-18.1 & Ga. Code Ann., § 33-20A-9</p> <p>Effective 2006</p>	<p>Health Benefits Plans & Managed Care Plans</p>	<p>Required Provisions of Health Benefits Plans: When a HMO uses a restrictive formulary for prescription drugs, such use shall include a written procedure whereby patients can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:</p> <ul style="list-style-type: none"> • The formulary's equivalent has been ineffective in the treatment of the patient's disease or condition; or • The formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the patient.
<p>Hawaii HRS § 431:10A-140 & HRS § 432:1-620</p> <p>Effective 2019</p>	<p>Health Insurers</p>	<p>Formulary/Accessibility Requirements: Each insurer shall provide the following information via a public website and through a toll-free number that is posted on the insurer's website:</p> <ul style="list-style-type: none"> • Its formulary; provided that notice of any changes due to the addition of a new drug or deletion of any existing drug shall be made available no later than seventy-two hours after the effective date of the change; provided further that notice of other changes, including drug strength or form, shall be made available within fourteen calendar days of the effective date of the change; • Provide a system that allows an insured or potential insured to determine whether prescription drugs are covered under the plan's medical benefits and typically administered by a provider, along with any cost-sharing imposed on such drugs; • Indicate a dollar amount range of cost-sharing typically paid by an insured of each specific drug included on the formulary based on the information the insurer has available, as follows: <ul style="list-style-type: none"> ○ \$100 and under: \$; ○ Over \$100 to \$250: \$\$; ○ Over \$250 to \$500: \$\$\$;

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> ○ Over \$500 to \$1,000: \$\$\$\$; and ○ Over \$1,000: \$\$\$\$\$; and ● Display standardized content for the formulary for each product offered by the plan pursuant to recommendations made by the formulary accessibility working group.
<p>Illinois 215 ILCS § 134/25</p> <p>Effective 2018</p>	Health care plans	<p><i>Transition of Services:</i></p> <p><i>Formulary removal</i> A health care plan is not prohibited from removing a drug from its formulary or denying an enrollee coverage if the FDA has issued a statement about the drug that calls into question the clinical safety of the drug, the drug manufacturer has notified the FDA of a manufacturing discontinuance or potential discontinuance of the drug, or the drug manufacturer has removed the drug from the market.</p> <p><i>Formulary removal notifications</i> During an enrollee's plan year, a health care plan shall not remove a drug from its formulary or negatively change its preferred or cost-tier sharing unless, at least 60 days before making the formulary change, the health care plan:</p> <ul style="list-style-type: none"> ● Provides general notification of the change in its formulary to current and prospective enrollees; ● Directly notifies enrollees currently receiving coverage for the drug, including information on the specific drugs involved and the steps they may take to request coverage determinations and exceptions, including a statement that a certification of medical necessity by the enrollee's prescribing provider will result in continuation of coverage at the existing level; and ● Directly notifies by first class mail and through an electronic transmission, if available, the prescribing provider of all health care plan enrollees currently prescribed the drug affected by the proposed change; the notice shall include a one-page form by which the prescribing provider can notify the health care plan by first class mail that coverage of the drug for the enrollee is medically necessary. <p>The formulary change notification may direct the prescribing provider to an electronic portal through which the prescribing provider may electronically file a certification to the health care plan that coverage of the drug for the enrollee is medically necessary.</p> <p><i>Formulary additions</i> A health care plan is not prohibited from adding prescription drugs to a health care plan's list of covered drugs during the coverage year.</p> <p><i>Medical necessity</i> If the prescribing provider certifies to the health care plan either in writing or electronically that the drug is medically necessary for the enrollee, a health care plan shall authorize coverage for the drug prescribed based solely on the prescribing provider's assertion that coverage is medically necessary, and the health care plan is prohibited from making modifications to the coverage related to the covered drug, including, but not limited to:</p> <ul style="list-style-type: none"> ● Increasing the out-of-pocket costs for the covered drug; ● Moving the covered drug to a more restrictive tier; or

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> Denying an enrollee coverage of the drug for which the enrollee has been previously approved for coverage by the health care plan.
<p>Illinois 215 ILCS 5/155.37, § 215 ILCS 5/370t, 215 ILCS 5/511.114 & 215 ILCS 105/8.7</p> <p>Effective 2002</p>	Accident and health insurers	<p>Drug Formulary Notice: Insurance companies that provide coverage for prescription drugs through the use of a drug formulary must notify insureds of any change in the formulary. A company may comply with this by posting changes in the formulary on its website.</p>
<p>Illinois 215 ILCS 175/20</p> <p>Effective 2010</p>	Health insurance policy or health care service plan	<p>Provision of Notice/ Formulary Changes:</p> <ul style="list-style-type: none"> At least 60 days prior to making any formulary change that alters the terms of coverage for a patient receiving immunosuppressant drugs or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving, a policy or plan sponsor must, to the extent possible, notify the prescribing physician and the patient, or the parent or guardian if the patient is a child, or the spouse of a patient who is authorized to consent to the treatment of the patient. The notification shall be in writing and shall disclose the formulary change, indicate that the prescribing physician may initiate an appeal, and include information regarding the procedure for the prescribing physician to initiate the policy or plan sponsor's appeal process. As an alternative to providing written notice, a policy or plan sponsor may provide the notice electronically if, and only if, the patient affirmatively elects to receive such notice electronically. The notification shall disclose the formulary change, indicate that the prescribing physician may initiate an appeal, and include information regarding the procedure for the prescribing physician to initiate the policy or plan sponsor's appeal process. At the time a patient requests a refill of the immunosuppressant drug, a policy or plan sponsor may provide the patient with the written notification required above, along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.
<p>Illinois 215 ILCS 134/45.1</p> <p>Effective 2018</p>	Health care plans	<p>Medical Exceptions Procedures Required: Every insurer shall establish and maintain a medical exceptions process that allows covered persons or their authorized representatives to request any clinically appropriate prescription drug when:</p> <ul style="list-style-type: none"> the drug is not covered based on the health benefit plan's formulary; the health benefit plan is discontinuing coverage of the drug on the plan's formulary for reasons other than safety or other than because the prescription drug has been withdrawn from the market by the drug's manufacturer; the prescription drug alternatives required to be used in accordance with a step therapy requirement: <ul style="list-style-type: none"> has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics

Formulary Management Laws Chart: Summary of State Requirements

		<p>of the enrollee, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or,</p> <ul style="list-style-type: none"> ○ has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to the enrollee; or, ● the number of doses available under a dose restriction for the prescription drug: <ul style="list-style-type: none"> ○ has been ineffective in the treatment of the enrollee's disease or medical condition; or, ○ based on both sound clinical evidence and medical and scientific evidence, the known relevant physical and mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
<p>Illinois 215 ILCS 5/370c</p> <p>Effective 2019</p>	Health benefit plans	<p><i>Mental and Emotional Disorders:</i> An individual or group health benefit plan shall place all prescription medications approved by FDA prescribed or administered for the treatment of substance use disorders on, for brand medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers brand medications and, for generic medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers generic medications.</p>
<p>Illinois 215 ILCS 5/370c.1</p> <p>Effective 2019</p>	Accident and health insurers	<p><i>Mental, Emotional, Nervous, or Substance Use Disorder or Condition Parity:</i> With respect to mental, emotional, nervous, or substance use disorders or conditions, an insurer shall use policies and procedures for the election and placement of mental, emotional, nervous, or substance use disorder or condition treatment drugs on their formulary that are no less favorable to the insured as those policies and procedures the insurer uses for the selection and placement of drugs for medical or surgical conditions and shall follow the expedited coverage determination requirements for substance abuse treatment drug.</p>
<p>Indiana IC 27-13-38-7</p> <p>Effective 2016</p>	Insurers and HMOs	<p><i>Removal of a Prescription Drug from an Insurer's Formulary:</i> An insurer shall not remove a prescription drug from the insurer's formulary, change the cost sharing requirements that apply to a prescription drug, or change the utilization review requirements that apply to a prescription drug unless the insurer does at least one of the following:</p> <ul style="list-style-type: none"> ● At least 60 days before the removal or change is effective, send written notice of the removal or change to each insured for whom the prescription drug has been prescribed during the preceding 12-month period. ● At the time an insured for whom the prescription drug has been prescribed during the preceding 12-month period requests a refill of the prescription drug, provide to the insured: <ul style="list-style-type: none"> ○ written notice of the removal or change; and ○ a 60-day supply of the prescription drug under the terms that applied before the removal or change
<p>Indiana IC 27-8-5-31.5</p> <p>Effective 07/21/2020</p>	Accident and sickness insurers	<p><i>Frozen Formulary:</i> An insurer shall not remove a prescription drug from the insurer's formulary or change the cost sharing requirements that apply to a prescription drug unless the insurer does the following:</p> <ul style="list-style-type: none"> ● At least 60 days before the removal or change is effective, sends written notice of the removal or change to each insured for whom the prescription drug has been prescribed during the plan year.

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • Provides a timely appeal process through which an insured may request an extension of coverage for the prescription drug through the end of the plan year. The appeal process must consider the following: <ul style="list-style-type: none"> ○ Clinical appropriateness that is evidence based. ○ Whether the insured has been adherent to the prescription drug regimen long enough that discontinuation of the prescription drug would cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care. ○ Whether discontinuation of the prescription drug would worsen a comorbid condition of the insured. ○ Whether discontinuation of the prescription drug would decrease the insured's ability to achieve or maintain reasonable functional ability to perform daily activities. <p>If the request for an extension made by an insured is supported by documentation from the prescribing health care provider, the insurer shall make a determination concerning the insured's request:</p> <ul style="list-style-type: none"> • in an urgent care situation, not more than one business day after receiving the request; or • in a non-urgent situation, not more than three business days after receiving the request. <p>If an appeal is granted, the insurer shall notify the insured and the insured's health care provider of the authorization for coverage of the prescription drug that was the subject of the appeal.</p> <p>An extension of coverage of a prescription drug through the end of the plan year under this section is permitted only once and may not be repeated unless otherwise provided by the insurer.</p> <p>Nothing under this section prohibits an insurer from removing a prescription drug from its formulary or denying an insured coverage if:</p> <ul style="list-style-type: none"> • the FDA has issued a statement about the prescription drug that calls into question the clinical safety of the prescription drug; • the manufacturer of the prescription drug has notified the FDA of a manufacturing discontinuance or potential discontinuance of the prescription drug as required by the FD&C Act; or • the manufacturer of the prescription drug has removed the prescription drug from the market. <p>This chapter does not prohibit a pharmacist from substituting:</p> <ul style="list-style-type: none"> • a generically equivalent drug product for a brand name drug under IC 16-42-22; or • a biosimilar biological product for a prescribed biological product
<p>Indiana <i>IC 27-13-38-1</i></p> <p>Effective 1998</p>	<p>HMOs</p>	<p><i>P&T/ Drug and Devices Formularies:</i> A HMO may apply a formulary to the prescription drug and devices benefits provided by the HMO if the formulary is developed, reviewed, and updated:</p> <ul style="list-style-type: none"> • in consultation with; and • with the approval of; <p>a pharmacy and therapeutics committee, a majority of whose members are licensed physicians.</p>

Formulary Management Laws Chart: Summary of State Requirements

		<p>If a HMO maintains one or more drug and devices formularies, the HMO shall do the following:</p> <ul style="list-style-type: none"> • Disseminate to participating providers and pharmacists the complete drug and devices formulary or formularies maintained by the HMO, including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices. • Establish and maintain an expeditious process or procedure that allows an enrollee to obtain, without penalty or additional cost sharing beyond that provided for in the enrollee's covered benefits with the HMO, coverage for a specific, medically necessary and appropriate nonformulary drug or device without prior approval from the HMO.
<p>Kentucky <i>KRS § 304.17A-535</i></p> <p>Effective 2000</p>	Managed care plans	<p><i>Application to Drug Formulary:</i> A managed care plan that restricts pharmacy benefits to a drug formulary shall have an exceptions policy through which the managed care plan may cover a prescription drug not included on the formulary.</p>
<p>Kentucky <i>806 Ky. Admin. Regs. 17:250</i></p> <p>Effective 2000</p>	Managed care plans	<p><i>Notification Requirements:</i> A managed care plan shall provide advance written notice to an enrollee of the following changes:</p> <ul style="list-style-type: none"> • The removal of a maintenance prescription medication from its drug formulary; • A change that restricts or reduces the quantity or dosage of a prescription medication supplied when a prescription is filled; or • A requirement for prior authorization of a prescription medication is added. <p>A written notification shall be mailed to an enrollee:</p> <ul style="list-style-type: none"> • At least 30 but no more than 60 days prior to the effective date of a formulary change for an enrollee who is dispensed a prescription for the drug within six months prior to the notification date; and • Within 30 days following the effective date of a formulary change for an enrollee who is dispensed a prescription for the drug after the notification date. <p>A written notification shall include:</p> <ul style="list-style-type: none"> • A clear explanation of the action being taken by the managed care plan; • The name and phone number of a contact person to answer questions; and • A description of the exceptions policy to the drug formulary.
<p>Louisiana <i>LSA-R.S. 22:1657</i></p>	Pharmacy benefits managers	<p><i>Pharmacy Benefits Managers:</i> For each of a pharmacy benefit manager's contractual or other relationships with a health benefit plan or health insurance issuer, the pharmacy benefit manager shall provide the department with the health benefit plan's formulary and provide timely notification of formulary changes and product exclusions. The information provided pursuant to</p>

Formulary Management Laws Chart: Summary of State Requirements

Effective 01/01/2020		this Subsection shall be made available in a centralized location on the department's website in a format that allows for consumer access, including links to pharmacy benefit manager websites.
<p>Louisiana <i>La. Admin Code. tit. 37, Pt XIII, § 14109, 14111, 14113, 14115, & 14117</i></p> <p>Effective 2012</p>	Health insurance Issuers and HMOs	<p><i>Regulation 100 – Coverage of Prescription Drugs Through a Drug Formulary:</i></p> <p><i>Required notices</i></p> <ul style="list-style-type: none"> • There shall be three different and distinct types of notice that a health insurance issuer is required to provide to every applicable enrollee. Each notice shall be filed with and approved by the Department of Insurance prior to use in Louisiana. • Notice and Disclosure of Drug Formulary. A health insurance issuer shall file a “Notice and Disclosure of Drug Formulary” form with the Department of Insurance as a part of its coverage documentation. The “Notice and Disclosure of Drug Formulary” shall contain all of the information enumerated in R.S. 22:1060.2. A health insurance issuer shall submit this form for approval by the commissioner. Once the form is approved by the commissioner, the health insurance issuer shall only utilize said form. A health insurance issuer shall maintain written evidence such as a record, report or data compilation of enrollees who request disclosure or information about any specific drug that is included in a formulary. The written evidence such as a record, report, or data compilation shall include the name of the enrollee, the date of request, the date of response by the health insurance issuer and the specific drug requested. A health insurance issuer shall provide a copy of the written evidence such as a record, report or data compilation as described herein to the commissioner within 15 days of written request by the commissioner. • Notice that Enrollee Has Right to Continuation of Coverage. A health insurance issuer shall notify an enrollee as a part of coverage documentation that the enrollee shall have the right to continue the coverage of any prescription drug that was approved or covered by the health insurance issuer, and that the coverage of such prescription drug shall be at the contracted benefit level until the renewal of the enrollee's current plan. A health insurance issuer shall maintain written evidence such as a record, report or data compilation of enrollees who request continuation of coverage and the name of the specific drug. The written evidence such as a record, report, or data compilation shall include the name of the enrollee, the date of request, the date of response by the health insurance issuer and the name of the specific drug requested. A health insurance issuer shall provide a copy of the written evidence such as a record, report or data compilation as described herein to the commissioner within 15 days of written request by the commissioner. • Notice of Modification-Group Market and Individual Market. A “Notice of Modification of Benefit Coverage or Drug Coverage of a Particular Product” form is required to contain the information required in R.S. 22:1068(D)(3) and 22:1074(D)(3). Such form used by a health insurance issuer shall be approved by the commissioner and no form may be used until approved by the commissioner. For group policies, such notice shall be delivered to the affected covered small group or large group employer and all enrollees at the last known address no later than the 60th day before any modification of benefit coverage or drug coverage of a particular product is to become effective. For individual policies, such notice shall be delivered to each affected individual at the last known address no later than the 60th day before any modification of benefit coverage or drug coverage of a particular product is to become effective. <p><i>Requirements for modifying an individual insurance product</i></p>

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		<p>A health insurance issuer may modify its drug coverage offered to individuals if each of the following conditions is met.</p> <ul style="list-style-type: none"> • The modification occurs at the time of coverage renewal. • The modification is approved by the commissioner. • The modification is consistent with state law. • The modification is effective on a uniform basis among all individuals with that policy form. • The health insurance issuer, on a form approved by the Department of Insurance, notifies each affected individual of the modification no later than the 60th day before the date the modification is to become effective. <p><i>Enrollee's right to appeal adverse determination</i></p> <ul style="list-style-type: none"> • The refusal of a health insurance issuer to provide benefits to an enrollee for a prescription drug is an adverse determination relative to medical necessity review organizations, if each of the following conditions is met. <ul style="list-style-type: none"> ○ The drug is not included in a drug formulary used by the health benefit plan. ○ The enrollee's physician or other authorized prescriber has determined the drug is medically necessary. • An enrollee may appeal the adverse determination relative to medical necessity review organizations.
<p>Louisiana <i>LSA-R.S.</i> 22:1060.2, 1060.3, 1060.4, 1060.5, 1060.6, & 1060.7</p> <p>Effective 2012</p>	<p>Health insurance issuer</p>	<p><i>Coverage of Prescription Drugs Through a Drug Formulary:</i> <i>Notice and Disclosure of Certain Information Required</i></p> <p>A health insurance issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:</p> <ul style="list-style-type: none"> • Provide in plain language in the coverage documentation provided to each enrollee each of the following: <ul style="list-style-type: none"> ○ Notice that the plan uses one or more drug formularies. ○ An explanation of what a drug formulary is. ○ A statement regarding the method the health insurance issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary. ○ A statement of how often the health insurance issuer reviews the contents of each drug formulary. ○ Notice, on a form approved by the Department of Insurance, that an enrollee may contact the health insurance issuer to determine whether a specific drug is included in a particular drug formulary. • Disclose to an individual upon request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary. • Notify an enrollee and any other individual who requests information pursuant to this Section that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's physician or other authorized prescriber will prescribe the drug for a particular medical condition or mental illness. <p><i>Continuation of coverage required/ other drugs not precluded</i></p> <p>A health insurance issuer of a health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or medical illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.</p>

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • A health insurance issuer proposing to change its coverage of a particular prescription drug or intravenous infusion based on medical necessity shall give notice of the proposed change to an insured currently using that prescription drug or intravenous infusion who the health insurance issuer determines the change may affect if the health insurance issuer has covered the drug or intravenous infusion for the insured for at least the preceding 60 days. Such notice shall be sent at least 60 days prior to the effective date of the proposed change. • Any insured receiving such a notice from a health insurance issuer shall have the right to appeal the proposed change during the 60-day notification period. In filing such an appeal, the insured shall document that his physician or a authorized prescriber considers continued use of the drug or intravenous infusion to be medically necessary. <p><i>Specialty drug tiers/prohibitions/limits on copayments</i> A health insurance issuer of a health benefit plan that covers prescription drugs and utilizes a formulary tier that is higher than a preferred or non-preferred brand drug tier, sometimes known as a specialty drug tier, shall limit any required copayment or coinsurance applicable to drugs on such tier to an amount not to exceed \$150 per month for each drug up to a 30-day supply of any single drug. This limit shall be inclusive of any copayment or coinsurance. This limit shall be applicable after any deductible is reached and until the individual's maximum out-of-pocket limit has been reached.</p> <p>A health care issuer of a health benefit plan that covers prescription drugs, and utilizes specialty tiers shall be required to implement an exceptions process that allows enrollees to request an exception to the formulary. Under such an exception, a non-formulary specialty drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual, would have adverse effects for the individual, or both. In the event an enrollee is denied an exception, such denial shall be considered an adverse event and shall be subject to the health plan internal review process and the state external review process.</p> <p><i>Prescription medication for chronic pain</i></p> <ul style="list-style-type: none"> • Notwithstanding any provision of law to the contrary, when a licensed physician prescribes a nonopioid medication for the treatment of chronic pain, it shall be unlawful for a health insurance issuer to deny coverage of the nonopioid prescription drug in favor of an opioid prescription drug. • When an opioid prescription is deemed medically necessary and prescribed by a licensed physician, it shall be unlawful for an insurer to deny a prescribed medication and attempt to substitute an alternative medication that requires any of the following: <ul style="list-style-type: none"> ○ An increased number of pills per prescription. ○ A higher Drug Enforcement Administration schedule medication than the one prescribed. ○ The substitution of an extended release medication that does not have defined abuse deterrent properties for a prescription of a medication that does have defined abuse deterrent properties.
Maine	Health Plans	<i>Access to Prescription Drugs</i>

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<p>24-A M.R.S.A. § 4311</p> <p>Effective 2019</p>		<p>If a health plan provides coverage for prescription drugs but the coverage limits such benefits to drugs included in a formulary, a carrier shall:</p> <ul style="list-style-type: none"> • Ensure participation of participating physicians and pharmacists in the development of the formulary; • Provide exceptions to the formulary limitation when a nonformulary alternative is medically indicated, consistent with the utilization review standards in section 4304; • Provide an enrollee with at least 60 days' written notice of an adverse change to a formulary, except that a carrier may provide less than 60 days' notice when a prescription drug is being removed from the formulary because of concerns about safety. The notice must use a conspicuous font and inform the enrollee of the adverse change to the formulary and advise the enrollee to consult with the enrollee's provider about the change; • If a prescription drug is removed from a formulary, notify an enrollee affected by the change of the enrollee's ability to request an exception to the formulary limitation and provide a form for the enrollee to use to request an exception. If an enrollee has already received prior authorization for that drug, the carrier shall continue to honor the existing authorization until it expires, as long as the enrollee continues to be covered under the same health plan and the drug has not been removed from the formulary because of concerns about safety; and • Except when a drug has been removed because of concerns about safety, if a drug has been removed from a formulary and a request for an exception to a formulary limitation submitted by or on behalf of an enrollee is received prior to the effective date of the proposed change, continue to provide coverage for that drug until the carrier has rendered a decision on the enrollee's request for an exception to the formulary limitation
<p>Maine 24-A M.R.S.A. § 4303</p> <p>Effective 2019</p>	<p>Health Plans</p>	<p><i>Information About Prescription Drugs</i> Consistent with the requirements of the federal Affordable Care Act, a carrier offering a health plan in this State shall provide the following information to prospective enrollees and enrollees with respect to prescription drug coverage on its publicly accessible website.</p> <p>A carrier shall post each prescription drug formulary for each health plan offered by the carrier. The prescription drug formularies must be posted in a manner that allows prospective enrollees and enrollees to search the formularies and compare formularies to determine whether a particular prescription drug is covered under a formulary. When a change is made to a formulary, the updated formulary must be posted on the website within 72 hours.</p>
<p>Maine 24-A M.R.S.A. § 4350-B</p> <p>Effective 01/01/2020</p>	<p>Health plans and PBMs</p>	<p><i>Prescription Drug Formularies:</i> A carrier, or a pharmacy benefits manager under contract with a carrier, shall establish a pharmacy and therapeutics committee. A carrier shall require its pharmacy and therapeutics committee or the pharmacy and therapeutics committee of the carrier's pharmacy benefits manager to use one or more formularies.</p>
<p>Maine 24-A M.R.S.A. § 4320-J</p>	<p>Health plans</p>	<p><i>Coverage for Abuse-Deterrent Opioid Analgesic Drug Products:</i> A carrier offering a health plan in this State shall provide coverage for abuse-deterrent opioid analgesic drug products listed on any formulary, preferred drug list or other list of drugs used by the carrier on a basis not less favorable than</p>

Formulary Management Laws Chart: Summary of State Requirements

Effective 2015		that for opioid analgesic drug products that are not abuse-deterrent and are covered by the health plan. An increase in enrollee cost sharing to achieve compliance with this section may not be implemented.
<p>Maryland <i>MD Code, Insurance, § 15-831</i></p> <p>Effective 2019</p>	Insurers, nonprofit health service plans, or HMOs	<p><i>Prescription Drugs or Devices Outside of Formulary:</i> <i>Procedure by which member may receive prescription drug or device</i></p> <p>Each insurer that limits its coverage of prescription drugs or devices to those in a formulary shall establish and implement a procedure by which a member may:</p> <ul style="list-style-type: none"> • receive a prescription drug or device that is not in the entity's formulary or has been removed from the entity's formulary in accordance with this section; or • continue the same cost sharing requirements if the entity has moved the prescription drug or device to a higher deductible, copayment, or coinsurance tier. <p><i>Prescription drugs or devices outside of formulary</i></p> <p>The procedure shall provide for coverage for a prescription drug or device in the judgment of the authorized prescriber:</p> <ul style="list-style-type: none"> • there is no equivalent prescription drug or device in the entity's formulary in a lower tier; • an equivalent prescription drug or device in the entity's formulary in a lower tier: <ul style="list-style-type: none"> ○ has been ineffective in treating the disease or condition of the member; or ○ has caused or is likely to cause an adverse reaction or other harm to the member; or • for a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is medically necessary for the member to adhere to the appropriate use of the prescription drug or device. <p><i>Decision not to provide access or coverage an adverse decision</i></p> <p>A decision by an insurer not to provide access to or coverage of a prescription drug or device constitutes an adverse decision if the decision is based on a finding that the proposed drug or device is not medically necessary, appropriate, or efficient.</p> <p><i>Notice of removal of drug from formulary or a move of prescription drug or device to a benefit tier that requires a member to pay a higher deductible, copayment, or coinsurance</i></p> <p>An insurer that removes a drug from its formulary or moves a prescription drug or device to a benefit tier that requires a member to pay a higher deductible, copayment, or coinsurance amount for the prescription drug or device shall provide a member who is currently on the prescription drug or device and the member's health care provider with:</p> <ul style="list-style-type: none"> • notice of the change at least 30 days before the change is implemented; and • in the notice required, the process for requesting an exemption through the procedure adopted.
<p>Maryland <i>MD Code, Insurance, § 15-1617</i></p>	Insurers, nonprofit health service plans, or HMOs	<p><i>Policies and Procedures of Pharmacy and Therapeutics Committee:</i> A pharmacy benefits manager shall ensure that its pharmacy and therapeutics committee has:</p>

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<p>Effective 2008</p>		<ul style="list-style-type: none"> • policies and procedures, including disclosure requirements, to address potential conflicts of interest that members of the pharmacy and therapeutics committee may have with developers or manufacturers of prescription drugs; • a process to evaluate medical and scientific evidence concerning the safety and effectiveness of prescription drugs, including a available comparative information on clinically similar prescription drugs, when deciding what prescription drugs to recommend to include on a formulary; • a process to evaluate medical and scientific evidence concerning the safety and effectiveness of prescription drugs when recommending utilization review requirements, dose restrictions, and step therapy requirements; and • a process to enable the pharmacy and therapeutics committee to consider the need to recommend a formulary change to a purchaser in a timely manner but at least annually.
<p>Maryland <i>MD Code, Insurance, § 15-849</i></p> <p>Effective 2016</p>	<p>Insurers, nonprofit health service plans, or HMOs</p>	<p><i>Coverage Requirements for Abuse-Deterrent Opioid Analgesic Drug Products</i></p> <p><i>Coverage requirements</i></p> <ul style="list-style-type: none"> • Insurers shall provide coverage for: <ul style="list-style-type: none"> ○ at least two brand name abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for brand name prescription drugs on the entity's formulary for prescription drug coverage; and ○ if available, at least two generic abuse-deterrent opioid analgesic drug products, each containing different analgesic ingredients, on the lowest cost tier for generic drugs on the entity's formulary for prescription drug coverage. • An insurer may not require an insured or an enrollee to first use an opioid analgesic drug product without a buse-deterrent labeling before providing coverage for an abuse-deterrent opioid analgesic drug product covered on the entity's formulary for prescription drug coverage. <p><i>Utilization review</i></p> <p>An insurer may undertake utilization review, including preauthorization, for an abuse-deterrent opioid analgesic drug product covered by the entity, if the same utilization review requirements are applied to non-abuse-deterrent opioid analgesic drug products covered by the entity in the same formulary tier as the a buse-deterrent opioid analgesic product.</p>
<p>Massachusetts <i>M.G.L.A. 175 § 47EE, M.G.L.A. 32A § 17L, M.G.L.A. 176G § 4Y, M.G.L.A. 176B § 4GG & M.G.L.A. 176A § 8GG</i></p>	<p>Insurers</p>	<p><i>Coverage for Abuse Deterrent Opioid Drug Products:</i></p> <p>Any policy, contract, a greement, plan or certificate of insurance issued, delivered or renewed within the commonwealth, shall provide coverage for a buse deterrent opioid drug products listed on the formulary on a basis not less fa vorable than non-abuse deterrent opioid drug products that are covered by such policy, contract, a greement, plan or certificate of insurance. An increase in patient cost sharing shall not be allowed to achieve compliance with this section.</p>

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Massachusetts <i>M.G.L.A. 176B § 4W, M.G.L.A. 176A § 8W, M.G.L.A. 175 § 47W, & M.G.L.A. 176G § 4O</i> Effective 2017	Insurers	<p><i>Approved Prescription Contraceptive Drugs or Devices:</i></p> <p>If the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device or product, an individual or group medical service agreement shall not be required to include all such therapeutically equivalent version in its formulary as long as at least one is included and covered without cost-sharing.</p>
Massachusetts <i>211 CMR 52.13</i> Effective 2013	Carriers	<p><i>Evidence of Coverage Requirements:</i></p> <p>An evidence of coverage shall contain a clear, concise and complete statement of all of the information described at 211 CMR 52.13(3)(a) through (aa). In addition, for limited, regional and tiered network plans, an evidence of coverage shall also contain any information by 211 CMR 152.00: Health Benefit Plans Using Limited, Regional or Tiered Provider Networks.</p> <ul style="list-style-type: none"> • A list of prescription drugs excluded from any closed or restricted formulary available to insureds under the health benefit plan; provided, that the carrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the closed or restricted formulary. A carrier will be deemed to have met the requirements of 211 CMR 52.13(3)(q) if the carrier does all of the following: <ul style="list-style-type: none"> ○ provides a complete list of prescription drugs that are included in any closed or restricted formulary; ○ clearly states that all other prescription drugs are excluded; ○ provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; ○ provides an internet website that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and ○ clearly states that there shall be no financial penalty for a patient's choice to receive a lesser quantity of any opioid.
Michigan <i>M.C.L.A. 500.3406o</i> Effective	Insurers	<p><i>Coverage for Prescription Drugs / Formulary Limitations:</i></p> <p>An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for prescription drugs and limits those benefits to drugs included in a formulary shall do all of the following:</p> <ul style="list-style-type: none"> • Provide for participation of participating physicians, dentists, and pharmacists in the development of the formulary.

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2016		<ul style="list-style-type: none"> • Disclose to health care providers and upon request to insureds the nature of the formulary restrictions. • Provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative. This subdivision does not prevent an insurer from establishing prior authorization requirements or another process for consideration of coverage or higher cost-sharing for nonformulary alternatives. <p>On a request for an expedited review of coverage for a nonformulary alternative based on exigent circumstances, an insurer shall make a determination and notify the enrollee or the enrollee's designee and the prescribing physician, or other prescriber, as appropriate, of the determination within 24 hours after the insurer receives all information necessary to determine whether the exception should be granted.</p> <p>An insurer shall make a determination on coverage for a nonformulary alternative and notify the enrollee or the enrollee's designee and the prescribing physician, or other prescriber, as appropriate, of the determination within 72 hours after the insurer receives all information necessary to determine whether the exception should be granted.</p>
<p>Michigan M.C.L.A. 500.3406q & M.C.L.A. 550.1416c</p> <p>Effective 2016</p>	Insurers	<p>Coverage for Off-Label Use of FDA-Approved Drugs: An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides pharmaceutical coverage shall provide coverage for an off-label use of a FDA approved drug and the reasonable cost of supplies medically necessary to administer the drug.</p> <p>Coverage for a drug applies if all of the following conditions are met:</p> <ul style="list-style-type: none"> • The drug is approved by the FDA. • The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following: <ul style="list-style-type: none"> ○ A life-threatening condition if the drug is medically necessary to treat the condition and the drug is on the plan formulary or accessible through the insurer's formulary procedures. ○ A chronic and seriously debilitating condition if the drug is medically necessary to treat the condition and the drug is on the plan formulary or accessible through the insurer's formulary procedures.
<p>Michigan M.C.L.A. 550.1401h</p> <p>Effective 1999</p>	Health care corporation	<p>Development of Formulary/ Disclosure of Restrictions/ Exceptions: A health care corporation that provides coverage for prescription drugs and limits those benefits to drugs included in a formulary shall do all of the following:</p> <ul style="list-style-type: none"> • Provide for participation of participating physicians, dentists, and pharmacists in the development of the formulary. • Disclose to health care providers and upon request to members the nature of the formulary restrictions. • Provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative. Notice as to whether or not an exception under this subdivision has been granted shall be given by the health care corporation within 24 hours after receiving all information necessary to determine whether the exception should be granted.
Minnesota	Group purchaser	Electronic Prescription Drug Program:

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<p><i>M.S.A. § 62J.497</i></p> <p>Effective 2016</p>		<p><i>Development and use of uniform formulary exception form</i> The commissioner of health, in consultation with the Minnesota Administrative Uniformity Committee, shall develop a uniform formulary exception form that allows health care providers to request exceptions from group purchaser formularies using a uniform form. Upon development of the form, all health care providers must submit requests for formulary exceptions using the uniform form, and all group purchasers must accept this form from health care providers.</p> <p>The uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions.</p>
<p>Minnesota <i>M.S.A. § 62Q.527</i></p> <p>Effective 2001</p>	<p>Health plans</p>	<p><i>Nonformulary Antipsychotic Drugs / Required Coverage:</i> <i>Required coverage for antipsychotic drugs</i> A health plan that provides prescription drug coverage must provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the drug is in the health plan's drug formulary, if the health care provider prescribing the drug:</p> <ul style="list-style-type: none"> • indicates to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated; and • certifies in writing to the health plan company that the health care provider has considered all equivalent drugs in the health plan's drug formulary and has determined that the drug prescribed will best treat the patient's condition. <p>The health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.</p> <p>For drugs covered under this section, no health plan company that has received a certification from the health care provider may:</p> <ul style="list-style-type: none"> • impose a special deductible, co-payment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or • require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition. <p><i>Continuing care</i> Enrollees receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, co-payment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit:</p> <ul style="list-style-type: none"> • the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan;

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		<ul style="list-style-type: none"> • the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing that the prescription must be dispensed as communicated; and • the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition. <p>The continuing care benefit shall be extended annually when the health care provider prescribing the drug:</p> <ul style="list-style-type: none"> • indicates to the dispensing pharmacist, orally or in writing that the prescription must be dispensed as communicated; and • certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition. <p>The health plan company is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.</p> <p><i>Exception to formulary</i> A health plan company must promptly grant an exception to the health plan's drug formulary for an enrollee when the health care provider prescribing the drug indicates to the health plan company that:</p> <ul style="list-style-type: none"> • the formulary drug causes an adverse reaction in the patient; • the formulary drug is contraindicated for the patient; or • the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.
<p>Minnesota <i>Minnesota Rules, part 4685.0700</i></p> <p>Effective 2007</p>	<p>HMOs</p>	<p><i>Comprehensive Health Maintenance Services:</i> <i>Permissible limitations</i></p> <p>The following health services may be limited, but cannot be excluded:</p> <ul style="list-style-type: none"> • A HMO may limit outpatient prescription drug benefits through the use of a formulary. <ul style="list-style-type: none"> ○ The formulary must be periodically reviewed and updated by physicians and pharmacists to determine that formulary drugs are, at a minimum, safe and effective. ○ The formulary must contain all prescription drugs needed to provide medically necessary care. ○ A HMO shall promptly grant an exception to the formulary when the formulary drug causes an adverse reaction, when the formulary drug is contraindicated, or when the prescriber demonstrates that a prescription drug must be dispensed as written to provide maximum medical benefit to the enrollee. <ul style="list-style-type: none"> ▪ A HMO shall have written guidelines and procedures for granting an exception to the formulary that shall be available to the enrollee and prescriber upon request. ▪ When a HMO grants an exception to the formulary, it may charge the enrollee the approved flat fee copayment or a copayment that does not exceed 25 percent of the provider's charge
<p>Missouri <i>V.A.M.S. 191.1165</i></p>		<p><i>Medication-Assisted Treatment / Formulary Medications and Requirements:</i></p> <p>Medication-assisted treatment shall include pharmacologic therapies. A formulary used by a health insurer or managed by a pharmacy benefits manager, or medical benefit coverage in the case of medications dispensed through an opioid treatment program, shall include:</p>

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<p>Effective 2019</p>		<ul style="list-style-type: none"> • Buprenorphine tablets; • Methadone; • Naloxone; • Extended-release injectable naltrexone; and • Buprenorphine/naloxone combination. <p>All MAT medications required shall be placed on the lowest cost-sharing tier of the formulary managed by the health insurer or the pharmacy benefits manager.</p>
<p>Missouri V.A.M.S. 376.392</p> <p>Effective 2008</p>	<p>Health Carrier and Health benefit plans</p>	<p><i>Prescription Drug Formularies / Enrollees to be Notified of Changes to:</i> For any health carrier or health benefit plan that provides prescription drug coverage or contracts with a third-party for prescription drug services, the health carrier or health benefit plan shall notify enrollees presently taking a prescription drug electronically, or in writing, upon request of the enrollee, at least 30 days prior to any deletions, other than generic substitutions, in the health carrier's or health benefit plan's prescription drug formulary that affect such enrollees.</p>
<p>Nevada N.R.S. 689C.455, 695A.255, 689C.281, 689A.405, 695G.163, 689B.0283, 695F.153, 695B.176, & 695C.1703</p> <p>Effective 2019</p>	<p>Health insurers</p>	<p><i>Coverage for Prescription Drugs / Provision of Notice and Information Regarding Use of Formulary:</i> A carrier that offers or issues a contract which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the carrier. The notice must:</p> <ul style="list-style-type: none"> • Be in a language that is easily understood and in a format that is easy to understand; • Include an explanation of what a formulary is; and • If a formulary is used, include: <ul style="list-style-type: none"> ○ An explanation of: <ul style="list-style-type: none"> ▪ How often the contents of the formulary are reviewed; and ▪ The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and ○ The telephone number of the carrier for making a request for information regarding the formulary. <p>If a carrier offers or issues a contract which provides coverage for prescription drugs and a formulary is used, the carrier shall:</p> <ul style="list-style-type: none"> • Provide to any insured or participating provider of health care, upon request: <ul style="list-style-type: none"> ○ Information regarding whether a specific drug is included in the formulary. ○ Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the carrier shall notify the requester that a choice of formulary lists is available.

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		<ul style="list-style-type: none"> Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition
<p>Nevada <i>N.R.S. 687B.4095</i></p> <p>Effective 2019</p>		<p><i>Policies of Health Insurance Including Prescription Drug Coverage/ Restrictions on Moving Prescription Drug from Lower-Cost Tier to Higher-Cost Tier:</i></p> <p>If a policy for a prescription drug pursuant to a formulary with more than one cost tier, the insurer may move the prescription drug from a lower cost tier to a higher cost tier only:</p> <ul style="list-style-type: none"> On January 1; On July 1; and On any date on which the insurer adds to the formulary a generic prescription drug that: <ul style="list-style-type: none"> Has been approved by the FDA for use as an alternative to the original prescription drug; and Is being added to the formulary at: <ul style="list-style-type: none"> The same cost tier from which the original prescription drug is being moved; or A cost tier which has a smaller deductible, copayment or coinsurance than the cost tier from which the original prescription drug is being moved. <p>The provisions of this section do not prevent an insurer, at any time, from:</p> <ul style="list-style-type: none"> Moving a prescription drug from a higher cost tier of a formulary to a lower cost tier of the formulary; Removing a prescription drug from a formulary; or Adding a prescription drug to a formulary.
<p>Nevada <i>N.R.S. 687B.408</i></p> <p>Effective 2009</p>	Health Insurers	<p><i>Notifications Required Concerning Changes Related to Prescription Drugs Used for Transplanted Organs:</i></p> <p>If a policy of health insurance issued includes coverage for a prescription drug that is necessary for an insured to prevent the rejection of a transplanted organ, the insurer must notify the insured and, if known, the physician of the insured who prescribed the drug at least 30 days before a change in the formulary of the insurer within the plan year which affects that prescription becomes effective.</p>
<p>Nevada <i>N.R.S. 687B.407</i></p> <p>Effective 01/01/2020</p>	Health benefit plans	<p><i>Use of List of Preferred Prescription Drugs Developed by Department as Formulary:</i></p> <p>A nonprofit health benefit plan may use the list of preferred prescription drugs developed by the Department of Health and Human Services as its formulary and obtain prescription drugs through the purchasing agreements negotiated by the Department pursuant to that section by notifying the Department in the form prescribed by the Department</p>
<p>Nevada <i>NAC 695C.175 & NAC 689A.425</i></p> <p>Effective 2016</p>		<p><i>Health Maintenance Organization: Removal of Prescription Drug from Approved Formulary Prohibited / Exception / Movement to Different Tier in Formulary / Addition of Drug to Formulary:</i></p> <p>A HMO that offers a health benefit plan in the individual market which provides coverage for prescription drugs and uses a formulary that has been approved by the Commissioner shall not:</p> <ul style="list-style-type: none"> Remove a prescription drug from the formulary; or

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		<ul style="list-style-type: none"> • If the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a drug to a tier with a larger deductible, copayment or coinsurance, during the plan year for which the formulary was approved by the Commissioner. <p>A HMO may:</p> <ul style="list-style-type: none"> • Remove a prescription drug from a formulary at any time if: <ul style="list-style-type: none"> ○ The drug is not approved by the FDA; ○ The FDA issues a notice, guidance, warning, announcement or any other statement about the drug which calls into question the clinical safety of the drug; or ○ The prescription drug is approved by the FDA for use without a prescription. • If the HMO's formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a brand name prescription drug to a tier with a larger deductible, copayment or coinsurance if the HMO adds to the formulary a generic prescription drug that is approved by the FDA for use as an alternative to the brand name prescription drug at: <ul style="list-style-type: none"> ○ The benefit tier from which the brand name prescription drug is being moved; or ○ A benefit tier that has a smaller deductible, copayment or coinsurance than the benefit tier from which the brand name prescription drug is being moved.
<p>New Hampshire <i>N.H. Rev. Stat. § 420-J:7-b</i></p> <p>Effective 2019</p>	<p>Health carriers</p>	<p><i>Prescription Drugs</i> Every health benefit plan that provides prescription drug benefits is required to provide prospective enrollees, and covered persons, a description of the prescription drug benefit plan. Among the specific items that shall be included in the description are:</p> <ul style="list-style-type: none"> • The procedure a covered person must follow to obtain drugs and medications that are subject to a plan list or plan formulary. • A description of the drug formulary and the plan's exception process. • A description of the extent to which a covered person will be reimbursed for the cost of a drug that is not on a plan list or formulary. <p>Health carriers shall provide upon request additional information to covered persons related to specific drugs that are not on the formulary.</p> <p>Every health benefit plan that provides prescription drug benefits shall maintain an expeditious exception process, not to exceed 48 hours, by which covered persons may obtain coverage for a medically necessary nonformulary prescription drug or for a nonformulary prescription drug that was available during the previous 12 months. The exception process shall begin when the prescribing provider has submitted a request with a clinical rationale for the exception to the health benefit plan. The exception process shall also begin when a covered person has submitted a non-clinical request for access to a drug approved by the FDA for treating a specific condition when such drug was available on the formulary during the previous 12 months. A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.</p>

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		<p>No health benefit plan that provides prescription drug benefits and establishes the specific sequence in which prescription drugs for a medical condition are to be prescribed shall require failure on the same medication on more than one occasion for patients continuously enrolled in the plan.</p> <p>Every health plan that provides prescription drug benefits shall provide written notice to covered persons affected by deletions to the plan list or plan formulary, provide an explanation of the exception process by which a covered person can access nonformulary medically necessary prescription drugs, and provide a toll-free telephone number through which a covered person can request additional information. Upon notification to covered persons, the health benefit plan shall allow at least 45 days before implementation of any formulary deletions; provided, however, that advance notice shall not be required if the FDA has determined that a prescription drug on the health benefit plan's formulary is unsafe.</p> <p>Every health benefit plan that provides prescription drug benefits shall maintain, as part of its records, all of the following information, which shall be made available to the commissioner upon request: the complete drug formulary or formularies of the plan, if the plan maintains a formulary, including a list of the prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over the other drugs.</p> <p>Every health benefit plan that provides prescription drug benefits shall provide notice of deletions to the plan list or plan formulary to all covered persons at least annually.</p> <p>Every health benefit plan that provides prescription drug coverage shall also provide notice of additions to the plan list or formulary to all covered persons at least annually. However, the requirements of this paragraph shall not apply to any health benefit plan that adds prescription drugs to its plan list or formulary upon approval by the FDA.</p> <p>Every health benefit plan that provides prescription drug benefits shall allow its covered persons to purchase an up-to-90-day supply of covered prescription drugs on the covered person's health benefit plan formulary at one time at a pharmacy of the insured's choice within the insurer's network, provided that the insured can demonstrate that such drug has been taken by the insured for a continuous period of one year and provided that such drug is not subject to the health benefit plan's utilization management, prior authorization, or pre-certification requirements. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this paragraph.</p> <p>Every health benefit plan that provides prescription drug benefits shall allow its covered persons to obtain an emergency prescription for up to a 72-hour supply of covered prescription drugs on the covered person's health benefit plan formulary or a prescription drug that was deleted from the formulary within the last 90 days in the event a prescription requires prior authorization or an exception by an insurance carrier and the prior authorization or exception has neither been approved nor denied and a pharmacist has determined the medication is essential. Such reimbursement shall be according to the payment rates of the provider contract. If authorization or exception is subsequently denied, the carrier shall reimburse the pharmacist for the prescription as given based on the pro-rated amount they would have otherwise received under the terms of the provider contract.</p>
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		<p>The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:</p> <ul style="list-style-type: none"> • Agents when used for anorexia, weight loss, or weight gain. • Agents when used to promote fertility. • Agents when used for cosmetic purposes or hair growth. • Agents when used for the symptomatic relief of cough and colds. • Agents when used to promote smoking cessation. • Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations. • Nonprescription drugs, except, in the case of pregnant women when recommended by or under the supervision of a physician, agents approved by the FDA under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation. • Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. • Barbiturates. • Benzodiazepines. • Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the FDA.
<p>New Hampshire <i>N.H. Rev. Stat. § 420-J:7-b</i></p> <p>Effective 2014</p>	Health insurers	<p><i>90-Day Supply of Covered Prescription Drugs:</i> An insurer issuing or renewing accident and health insurance policies shall allow its insureds to purchase an up-to-90-day supply of covered prescription drugs on the covered person's health plan formulary at one time at a pharmacy of the insured's choice within the insurer's network, provided that the insured can demonstrate that such drug has been taken by the insured for a continuous period of one year and provided that such drug is not subject to the health plan's utilization management, prior authorization, or pre-certification requirements.</p>
<p>New Hampshire <i>N.H. Code Admin. R. Ins 403.04</i></p> <p>Effective 2009</p>		<p><i>Standard Wellness Plan:</i> The standard wellness plan shall include prescription drugs, including covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy, subject to:</p> <ul style="list-style-type: none"> • The following copays: <ul style="list-style-type: none"> ○ A \$10 copay for generic drugs; ○ A \$35 copay for non-generic formulary drug brands; and ○ A \$50 copay for non-formulary brand drugs. • Drugs that are considered maintenance shall be available for a supply greater than 30 days; • The copay shall be applied to each 30-day supply of the drugs except when drugs are purchased through a mail-order facility that offers a reduction of copay(s) for purchasing through the mail-order facility; and • For formulary brand and non-formulary brand at least two brand drugs shall be available for each therapeutic class covered under the HealthFirst benefit plan.

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<p>New Jersey <i>N.J.A.C. 11:22-5.9</i></p> <p>Effective 2006</p>	<p>Insurance companies, health service corporations, medical service corporations, hospital service corporations, dental service corporations, dental plan organizations, prepaid prescription service organizations, and HMOs</p>	<p><i>Prescription Drug Benefits:</i></p> <p>Health benefit plans and stand-alone prescription drug plans that provide benefits for prescription drugs listed on a formulary may provide higher benefits for formulary drugs than for nonformulary drugs, provided:</p> <ul style="list-style-type: none"> • The benefit for all tiers of formulary and nonformulary drug coverage shall result in a cost to the covered person of no more than 50 percent of the plan's contracted cost of the drug, after application of any deductibles, for prescription drugs provided by network providers. For prescription drugs provided by out-of-network providers, coinsurance shall not exceed 50 percent. • If a health benefit plan has a separate deductible for prescription drugs, or a stand-alone prescription drug plan has a deductible, such deductible shall not exceed \$250.00 per calendar year for all tiers of formulary drugs and \$250.00 per year for all tiers of nonformulary drugs; and • If a health benefit plan or a stand-alone prescription drug plan has a benefit maximum for prescription drugs, the maximum shall be the same for formulary and nonformulary drugs. <p>Health benefit plans and stand-alone prescription drug plans that provide prescription drug benefits through use of a formulary, shall meet the following criteria :</p> <ul style="list-style-type: none"> • The formulary shall be developed by a pharmacy and therapeutics committee composed of health care professionals with recognized knowledge and expertise in clinically appropriate prescribing, dispensing and monitoring of outpatient drugs or drug use review, evaluation and intervention. The membership of the committee shall consist of at least two-thirds licensed and actively practicing physicians and pharmacists, and shall consist of at least one pharmacist. If the carrier contracts with a third party to develop the formulary, the carrier shall be responsible for guaranteeing that the third party complies with all requirements relating to formularies as set forth in this subsection. • All drugs in a formulary shall be approved under the Federal Food, Drug and Cosmetic Act. • The most preferred tier of a formulary, that is, the tier with the lowest cost sharing, shall include more than one drug used to treat each covered disease state where more than one drug is available. • A drug may be excluded from the most preferred tier of a formulary only if, it does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome of treatment for the specific condition for which the drug is intended over other drugs included in the formulary, and there is a written explanation of the basis for the exclusion that is available to providers and covered persons upon request. • Each health benefit plan utilizing selective contracting arrangements that provides benefits for formulary drugs shall also provide benefits for nonformulary drugs. There shall be no difference in benefit level between formulary and nonformulary drugs obtained from out-of-network providers. • The carrier shall establish an approval process to enable health care providers and covered persons to obtain coverage of nonformulary drugs at the same level as formulary drugs where the prescribing health care provider certifies the medical necessity of the drug. <ul style="list-style-type: none"> ○ A nonformulary drug shall be considered medically necessary if: <ul style="list-style-type: none"> ▪ It is approved under the Federal Food, Drug and Cosmetic Act; or its use is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: The American Hospital Formulary Service Drug
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Formulary Management Laws Chart: Summary of State Requirements

		<p>Information or the United States Pharmacopoeia—Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed professional journal; and</p> <ul style="list-style-type: none"> ▪ The prescribing health care provider states that all formulary drugs used to treat each disease state have been ineffective in the treatment of the covered person's disease or condition, or all such drugs have caused or are reasonably expected to cause adverse or harmful reactions in the covered person. ○ The approval process for nonformulary drugs shall provide that the carrier respond to the prescribing health care provider by telephone or other telecommunication device within one business day of a request for prior authorization. Failure to respond within one business day shall be deemed an approval of the request. Initial denials shall also be provided to the prescribing health care provider and covered person in writing within five business days of receipt of the request for approval of a nonformulary drug, and shall include the clinical reason for the denial. Such denials are appealable to the Independent Health Care Appeals Program in the Department of Health and Senior Services. • The carrier shall publish and distribute, at least quarterly, either its current formulary or a list of nonformularies to network providers. Such list shall clearly indicate whether the drugs included are formulary or nonformulary. Alternatively, the carrier may annually distribute new formularies or a list of nonformularies, and quarterly updates, to network providers. The current formulary or list of nonformulary drugs shall be provided by the carrier to covered persons upon request. • The contract and evidence of coverage form shall disclose the existence of the drug formulary, describe the approval process to obtain coverage of nonformulary drugs as formulary drugs and describe the process to appeal a denial of a request for approval of a nonformulary drug, including the right to appeal to the Independent Health Care Appeals Program in the Department of Health and Senior Services. The contract and evidence of coverage form shall state that a copy of the formulary will be provided by the carrier to a covered person upon request. <p>Health benefit plans and stand-alone prescription drug plans may provide higher benefits for generic drugs than for brand name drugs provided:</p> <ul style="list-style-type: none"> • The benefit for both generic and brand name drugs must result in a cost to the covered person of no more than 50 percent of the plan's contracted cost of the medication for prescription drugs obtained from network providers. A deductible does not need to be considered in calculating the covered person's cost. For prescription drugs provided by out-of-network providers, coinsurance shall not exceed 50 percent. • If a health benefit plan has a separate deductible for prescription drugs or a stand-alone prescription drug plan has a deductible, such deductible shall not exceed \$250.00 per calendar year for generic drugs and \$250.00 per calendar year for non-generic drugs. • If a health benefit plan or a stand-alone prescription drug plan has a benefit maximum for prescription drugs, the maximum shall be the same for generic and brand name drugs.
<p>New Jersey <i>N.J.A.C. 11:24–18.3</i></p>	<p>HMOs</p>	<p><i>Distribution of Formulary:</i></p> <ul style="list-style-type: none"> • The HMO shall publish and distribute, at least quarterly, either its current formulary or a list of nonformularies, to all network providers in electronic or paper form. Such list shall clearly indicate whether the medications included are formulary or nonformulary. Alternatively, the HMO may annually distribute new formularies or a

Formulary Management Laws Chart: Summary of State Requirements

<p>Effective 1994</p>		<p>list of nonformularies, and quarterly updates, to all network providers. Publication of a current formulary or list of nonformularies on the internet shall satisfy the requirements of this subsection.</p> <ul style="list-style-type: none"> • The current formulary or list of nonformulary medications shall be provided by the HMO to covered persons and contractholders upon request. • The contract and evidence of coverage form shall disclose the existence of the formulary, describe the approval process to obtain coverage of nonformulary medications as formulary medications and describe the process to appeal a denial of a request for approval of a nonformulary medication, including the right to appeal to the Independent Health Care Appeals Program in the Department. The contract and evidence of coverage form shall state that a copy of the formulary will be provided by the HMO to a covered person and contractholder upon request.
<p>New Jersey <i>N.J.A.C. 11:24–18.1</i></p> <p>Effective 1994</p>	<p>HMOs</p>	<p><i>Development of Formulary:</i> A formulary provided pursuant to a health benefits plan issued by an HMO shall be developed by a pharmacy and therapeutics committee composed of health care professionals with recognized knowledge and expertise in clinically appropriate prescribing, dispensing and monitoring of outpatient drugs or drug use review, evaluation and intervention. The membership of the committee shall consist of at least two-thirds licensed and actively practicing physicians and pharmacists, and shall consist of at least one pharmacist. If the HMO contracts with a third party to develop the formulary, the HMO shall be responsible for guaranteeing that the third party complies with all requirements relating to formularies as set forth in this subchapter.</p> <p>All drugs in a formulary shall be approved under the Federal Food, Drug and Cosmetic Act.</p> <p>A formulary shall include more than one medication used to treat each covered disease state where more than one medication is available.</p> <p>A medication may be excluded from a formulary only if it does not have a significant clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome of treatment for the specific condition for which the medication is intended over other medications included in the formulary, and there is a written explanation of the basis for the exclusion that is available to providers and covered persons upon request.</p>
<p>New Jersey <i>N.J.A.C. 11:24–18.2</i></p> <p>Effective 1994</p>	<p>HMOs</p>	<p><i>Nonformulary Medications:</i> Every health benefits plan issued by an HMO that provides benefits for formulary medications shall also provide benefits for nonformulary medications. Increased benefits may apply to formulary medications provided the difference between the total benefit value of formulary medication coverage and the total benefit value of nonformulary medication coverage does not exceed 30 percent. Compliance with this requirement shall be demonstrated by submitting to the Department a completed Actuarial Justification of Benefit Differentials form.</p> <p>The HMO shall establish an approval process to enable health care providers and covered persons to obtain coverage of nonformulary medications at the same level as formulary medications where the prescribing health care provider certifies the medical necessity of the medication.</p>

Formulary Management Laws Chart: Summary of State Requirements

		<p>A nonformulary medication shall be considered medically necessary if:</p> <ul style="list-style-type: none"> • It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in the American Hospital Formulary Service Drug Information or the United States Pharmacopoeia—Drug Information, or it is recommended by a clinical study or review article in a major peer reviewed professional journal; and • The prescribing health care provider states that all formulary medications used to treat a disease state have been ineffective in the treatment of the covered person's disease or condition, or all such medications have caused or are reasonably expected to cause adverse or harmful reactions in the covered person. <p>The approval process for nonformulary medications shall provide that the HMO approve or deny the request by communicating such approval or denial to the prescribing health care provider by telephone or other telecommunication device within five business days of a request for prior authorization. Failure to approve or deny the request within five business days shall be deemed an approval of the request. Initial denials shall also be provided to the prescribing health care provider and covered person in writing within five business days of receipt of the request for approval of a nonformulary medication, and shall include the clinical reason for the denial. Such denials are appealable to the Independent Health Care Appeals Program in the Department.</p> <p>The HMO shall file with the Department a report summarizing all formulary appeals and their resolutions for the preceding year on forms prescribed by the Department. Such report shall be included as a separate page with the HMO's annual report</p>
<p>New Mexico <i>N. M. S. A. 1978, § 59A-23-7.13, § 59A-22-49.4, § 59A-47-45.4, & § 59A-46-50.4</i></p> <p>Effective 2013</p>	<p>Insurers</p>	<p><i>Prescription Drugs / Prohibited Formulary Changes / Notice Requirements:</i></p> <p>An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state and that provides prescription drug benefits categorized or tiered for purposes of cost-sharing through deductibles or coinsurance obligations shall not make any of the following changes to coverage for a prescription drug within 120 days of any previous change to coverage for that prescription drug, unless a generic version of the prescription drug is available:</p> <ul style="list-style-type: none"> • reclassify a drug to a higher tier of the formulary; • reclassify a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary; • increase the cost-sharing, copayment, deductible or co-insurance charges for a drug; • remove a drug from the formulary; • establish a prior authorization requirement; • impose or modify a drug's quantity limit; or • impose a step-therapy restriction. <p>The insurer shall give the affected insured at least 60 days' advance written notice of the impending change when it is determined that one of the following modifications will be made to a formulary:</p>

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • reclassification of a drug to a higher tier of the formulary; • reclassification of a drug from a preferred classification to a non-preferred classification, unless that reclassification results in the drug moving to a lower tier of the formulary; • an increase in the cost-sharing, copayment, deductible or coinsurance charges for a drug; • removal of a drug from the formulary; • addition of a prior authorization requirement; • imposition or modification of a drug's quantity limit; or • imposition of a step-therapy restriction for a drug. <p>The insurer may immediately and without prior notice remove a drug from the formulary if the drug:</p> <ul style="list-style-type: none"> • is deemed unsafe by the federal food and drug administration; or • has been removed from the market for any reason. <p>The insurer shall provide to each affected insured the following information in plain language regarding prescription drug benefits:</p> <ul style="list-style-type: none"> • notice that the insurer uses one or more drug formularies; • an explanation of what the drug formulary is; • a statement regarding the method the insurer uses to determine the prescription drugs to be included in or excluded from a drug formulary; and • a statement of how often the insurer reviews the contents of each drug formulary.
<p>New Mexico N. M. S. A. 1978, § 59A-22B-5</p> <p>Effective 2019</p>	Insurers	<p><i>Prior Authorization Requirements:</i> An insurer may automatically deny a covered person's prior authorization request that is electronically submitted and that relates to a prescription drug that is not on the covered person's health benefits plan formulary; provided that the insurer shall accompany the denial with a list of alternative drugs that are on the covered person's health benefits plan formulary.</p> <p>Upon denial of a covered person's prior authorization request based on a finding that a prescription drug is not on the covered person's health benefits plan formulary, a health insurer shall notify the person of the denial and include in a conspicuous manner information regarding the person's right to initiate a drug formulary exception request and the process to file a request for an exception to the denial.</p>
<p>New Mexico N. M. S. A. 1978, § 59A-46-43 & § 59A-22-41</p> <p>Effective 1998</p>	Health insurers and HMOs	<p><i>Coverage for Individuals with Diabetes:</i> When new or improved equipment, appliances, prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the FDA, each individual or group HMO contract shall:</p> <ul style="list-style-type: none"> • maintain an adequate formulary to provide these resources to individuals with diabetes; and • guarantee reimbursement or coverage for the equipment, appliances, prescription drug, insulin or supplies within the limits of the health care plan, policy or certificate

Formulary Management Laws Chart: Summary of State Requirements

<p>New Mexico <i>N.M. Admin Code 13.10.13</i></p> <p>Effective 1997</p>	<p>Managed health care plans (MHCP)</p>	<p>Prescription Drugs: Every MHCP must allow covered persons to obtain drugs not on the formulary as though the drug were included in the formulary, based on the type of drug, how the drug is administered, and the medically necessary services, when the treatment for which the drug is prescribed is a covered benefit, and when the participating provider in consultation with the MHCP determines that:</p> <ul style="list-style-type: none"> • the formulary drug has been or is reasonably expected to be less effective for the covered person; or • the formulary drug has caused or is reasonably expected to cause adverse reactions in the covered person.
<p>New York <i>McKinney's Insurance Law § 4329 & § 3242</i></p> <p>Effective 01/01/2020</p>	<p>Health insurers</p>	<p>Prescription Drug Coverage: Every health insurer that issues a contract that provides coverage for prescription drugs shall, with respect to the prescription drug coverage, publish an up-to-date, accurate, and complete list of all covered prescription drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a manner that is easily accessible to insureds and prospective insureds. The formulary drug list shall clearly identify the preventive prescription drugs that are available without an annual deductibles or coinsurance, including co-payments.</p> <p>Every contract issued by a health insurer that provides coverage for prescription drugs shall include in the contract a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to request a formulary exception. With respect to the process for such a formulary exception, a corporation shall follow the process and procedures for utilization review and external appeal.</p> <p>A health insurer shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request a standard review that is not based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the contract.</p> <p>A health insurer that grants an exception based on exigent circumstances shall provide coverage of the non-formulary prescription drug for the duration of the exigent circumstances.</p> <p>An external appeal agent shall make an external appeal determination. When making a determination, the external appeal agent shall consider whether the formulary prescription drug covered by the corporation will be or has been ineffective, would not be as effective as the non-formulary prescription drug, or would have adverse effects.</p> <p>If an external appeal agent overturns the corporation's denial of a standard exception request, then the corporation shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills. If an external appeal agent overturns the corporation's denial of an expedited exception request, then the corporation shall provide coverage of the non-formulary prescription drug for the duration of the exigent circumstances.</p>
<p>New York</p>	<p>Health insurers</p>	<p>Benefits: <i>Substance abuse disorder</i></p>

Formulary Management Laws Chart: Summary of State Requirements

<p><i>McKinney's Insurance Law § 4303, § 3221, § 3216</i></p> <p>Effective 04/03/2020</p>		<p>Every contract that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall include immediate access, without prior authorization, to the formulary forms of prescribed medications covered under the contract for the treatment of substance use disorder, including a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization, except where otherwise prohibited by law. Further, coverage without prior authorization shall include formulary forms of medication for opioid overdose reversal otherwise covered under the contract prescribed or dispensed to an individual covered by the contract.</p> <p><i>Contraceptive Coverage:</i> Every contract that provides medical, major medical, or similar comprehensive type coverage shall provide coverage for all of the following services and contraceptive methods:</p> <ul style="list-style-type: none"> • All FDA-approved contraceptive drugs, devices, and other products. This includes all FDA-approved over-the-counter contraceptive drugs, devices, and products as prescribed or as otherwise authorized under state or federal law. The following applies to this coverage: <ul style="list-style-type: none"> ○ where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a contraceptive drug, device, or product, a contract is not required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing.
<p>New York <i>McKinney's Insurance Law § 4322</i></p> <p>Effective 04/01/2020</p>	<p>HMOs</p>	<p><i>Standardization of individual enrollee direct payment contracts offered by health maintenance organizations which provide out-of-plan benefits:</i> HMOs may provide prescription drugs pursuant to a drug formulary; however, HMOs must implement an appeals process so that the use of non-formulary prescription drugs may be requested by a physician or other provider.</p>
<p>New York <i>11 NYCRR 52.73</i></p> <p>Effective 2018</p>	<p>Health insurers</p>	<p><i>Formulary Exception Process for Medication for the Detoxification or Maintenance Treatment of a Substance Use Disorder:</i> Every insurer that delivers or issues for delivery in this state an accident and health insurance policy that provides hospital, surgical, or medical expense coverage and also provides coverage for medication for the detoxification or maintenance treatment of a substance use disorder shall include in the policy processes that allow an insured, the insured's designee, or the insured's prescribing physician (or other prescriber, as appropriate) to request a formulary exception and gain access to clinically appropriate medication for the detoxification or maintenance treatment of a substance use disorder not otherwise covered by the policy (a request for formulary exception).</p> <p><i>Standard formulary exception request</i> An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing physician (or other prescriber) to request a standard review of a decision that a medication for the detoxification or maintenance treatment of a substance use disorder drug is not covered by the policy.</p>

Formulary Management Laws Chart: Summary of State Requirements

		<p>An insurer shall make a determination on a standard exception request and notify the insured or the insured's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following receipt of the request.</p> <p>An insurer that grants a standard exception request shall provide coverage of the non-formulary medication for the detoxification or maintenance treatment of a substance use disorder for the duration of the prescription, including refills.</p> <p><i>Expedited formulary exception request</i> An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing physician (or other prescriber) to request an expedited review of a decision that a medication for the detoxification or maintenance treatment of a substance use disorder is not covered by the policy based on exigent circumstances.</p> <p>An insurer shall make a determination on an expedited review request based on exigent circumstances and notify the insured or the insured'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.</p> <p>An insurer that grants an exception based on exigent circumstances shall provide coverage of the non-formulary medication for the detoxification or maintenance treatment of a substance use disorder for the duration of the exigency.</p> <p><i>Notice</i> An insurer that denies an exception request shall provide written notice of its determination to the insured or the insured's designee and the prescribing physician (or other prescriber, as appropriate). The written notice shall be considered a final adverse determination. Written notice shall also include the name or names of clinically appropriate medications for the detoxification or maintenance treatment of a substance use disorder covered by the insurer to treat the insured.</p> <p><i>External appeal</i> If an insurer denies a request for an exception, then the insurer shall have a process for the insured, the insured's designee, or the insured's prescribing physician (or other prescriber) to request that the denial of such request be reviewed by an external appeal agent certified by the Superintendent.</p> <p>An external appeal agent shall make a determination on the external appeal and notify the insurer, the insured or the insured's designee, and the prescribing physician (or other prescriber, as appropriate) of its determination no later than:</p> <ul style="list-style-type: none"> • 72 hours following the agent's receipt of the request, if the original request was a standard exception request; or • 24 hours following the agent's receipt of the request, if the original request was an expedited exception request and the prescribing physician (or other prescriber) attests that exigent circumstances exist.
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Formulary Management Laws Chart: Summary of State Requirements

		<p><i>An external appeal agent shall make a determination</i></p> <p>When making a determination, the external appeal agent shall also consider whether the formulary medication for the detoxification or maintenance treatment of a substance use disorder covered by the insurer will be or has been ineffective, would not be as effective as the non-formulary medication for the detoxification or maintenance treatment of a substance use disorder, or would have adverse effects.</p> <p>If an external appeal agent overturns the insurer's denial of a standard exception request, then the insurer shall provide coverage of the non-formulary medication for the detoxification or maintenance treatment of a substance use disorder for the duration of the prescription, including refills. If an external appeal agent overturns the insurer's denial of an expedited exception request, then the insurer shall provide coverage of the non-formulary medication for the detoxification or maintenance treatment of a substance use disorder for the duration of the exigency.</p>
<p>New York 11 NYCRR 52.74</p> <p>Effective 01/01/2020</p>	Health insurers	<p><i>Coverage of Contraceptive Drugs, Devices, or Products:</i></p> <p>Every policy that provides medical, major medical, or similar comprehensive type coverage shall provide coverage for all FDA-approved contraceptive drugs, devices, and other products. Where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a contraceptive drug, device, or product, an insurer shall not be required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, as long as at least one is included and covered without cost-sharing. If the covered contraceptive drug, device, or product is not available or is deemed medically inadvisable, an insurer shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing.</p>
<p>North Carolina N.C.G.S.A. § 58-3-221</p> <p>Effective 10/01/2020</p>	Insurers	<p><i>Access to Nonformulary and Restricted Access Prescription Drugs:</i></p> <p>If an insurer (i) maintains one or more closed formularies for or restricts access to covered prescription drugs or devices or (ii) requires an enrollee in a plan with an open or closed formulary to use a prescription drug or sequence of prescription drugs, other than the drug the enrollee's health care provider recommends, before the insurer provides coverage for the recommended prescription drug, then the insurer shall do all of the following:</p> <ul style="list-style-type: none"> • Develop the formularies or protocols and any restrictions on access to covered prescription drugs or devices in consultation with and with the approval of a pharmacy and therapeutics committee. • Make available to participating providers, pharmacists, and enrollees the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices, as well as any utilization management program indicators. • Update protocols based on a review of new evidence, research, and newly developed treatments. • An insurer, or a pharmacy benefits manager under contract with an insurer, shall require that its pharmacy and therapeutics committee either meet the requirements for conflict of interest set by the Center for Medicare and Medicaid Services or meet the accreditation standards of the National Committee for Quality Assurance or another independent accrediting organization.

Formulary Management Laws Chart: Summary of State Requirements

		<p>An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary or restricted access drug or device as provided in this section.</p> <p><i>Exception Process:</i> Each insurer shall establish and maintain an expeditious process or procedure, published on either the insurer's Web site or in policies provided to health care providers, that allows an enrollee or the enrollee's prescribing provider acting on behalf of the enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device or the drug requested by the prescribing provider, if it is determined to be medically necessary and appropriate by the enrollee's prescribing provider and the prescription drug is covered under the current health benefit plan.</p> <p>An insurer shall grant an exception request if the prescribing provider's submitted justification and supporting clinical documentation are sufficient to demonstrate any of the following:</p> <ul style="list-style-type: none"> • The enrollee has tried the alternate drug or drugs while covered by the current or the previous health benefit plan. • The formulary or alternate drug or drugs has been ineffective in the treatment of the enrollee's disease or condition. • The formulary or alternate drug or drugs causes or is reasonably expected by the prescribing provider to cause a harmful or adverse clinical reaction in the enrollee. • Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure. • The enrollee's prescribing provider certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been detrimental to the enrollee's health or has been ineffective in treating the same condition and, in the opinion of the prescribing health care provider, is likely to be detrimental to the enrollee's health or ineffective in treating the condition again. • Nothing in this section shall preclude an insurer from requiring prior authorization for the coverage of a prescribed drug that was covered by the enrollee's previous health benefit plan. <p>Pharmaceutical drug samples or patient incentive programs, including coupons or debit cards, shall not be considered trial and failure of a preferred prescription drug in lieu of trying the formulary-preferred prescription drug.</p> <p><i>Exception process requirements:</i></p> <ul style="list-style-type: none"> • The insurer, health benefit plan, or utilization review organization may request relevant documentation from the patient or health care provider to support the exception request. Relevant information includes the results of any patient examination, clinical evaluation, or second opinion that may be required. • A licensed physician or licensed pharmacist shall evaluate the clinical appropriateness of the exception request. • For nonurgent exception requests for a prospective or concurrent review:
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Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> ○ The insurer shall communicate to the enrollee's health care provider if additional information is required within 72 hours after the insurer receives the exception request. ○ The insurer shall communicate an exception request determination to the enrollee's providers within 72 hours after receiving all relevant information. ● In the case of an urgent review: <ul style="list-style-type: none"> ○ The insurer shall communicate to the enrollee's health care provider if additional information is required within 24 hours after the insurer receives the exception request. ○ The insurer shall communicate an exception request determination to the enrollee's providers within 24 hours after receiving all relevant information.
<p>Oklahoma 36 Okl.St. Ann. § 6964</p> <p>Effective 2019</p>	Health insurers	<p><i>Formulary to Identify Drugs That Offer Greatest Value:</i> A health insurer's P&T committee shall establish a formulary, which shall be a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value.</p> <p>A health insurer shall prohibit conflicts of interest for members of the P&T committee.</p> <ul style="list-style-type: none"> ● A person may not serve on a P&T committee if the person is currently employed or was employed within the preceding year by a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor. ● A health insurer shall require any member of the P&T committee to disclose any compensation or funding from a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor. Such P&T committee member shall be recused from voting on any product manufactured or sold by such pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.
<p>Oklahoma 36 Okl.St. Ann. § 6850.1</p> <p>Effective 2013</p>	Health benefit plans	<p><i>Notification of Deletions in Prescription Coverage:</i> Any health benefit plan that provides prescription drug coverage or contracts with a third-party for prescription drug services shall notify an enrollee presently taking a prescription drug of any deletions, other than generic substitutions, in the health benefit plan's prescription drug formulary. Such notification shall be made in writing, or electronically upon request of the enrollee, at least 60 days prior.</p>
<p>Oregon O.R.S. § 743B.250</p> <p>Effective 2017</p>	Insurers	<p><i>Insurer Offering Health Benefit Plan / Requirements:</i> All insurers offering a health benefit plan in this state shall establish procedures, in accordance with requirements adopted by the department, for making coverage determinations and resolving grievances that provide for:</p> <ul style="list-style-type: none"> ● At least one but not more than two levels of internal appeal for group health benefit plans and one level of internal appeal for individual health benefit plans and for any denial of an exception to a prescription drug formulary. If an insurer provides: <ul style="list-style-type: none"> ○ Two levels of internal appeal, a person who was involved in the consideration of the initial denial or the first level of internal appeal may not be involved in the second level of internal appeal; and ○ No more than one level of internal appeal, a person who was involved in the consideration of the initial denial may not be involved in the internal appeal.

Formulary Management Laws Chart: Summary of State Requirements

<p>Oregon OAR 836-053-1020</p> <p>Effective 2016</p>	<p>Insurers</p>	<p><i>Drug Formularies:</i></p> <p>An insurer that uses an open formulary must have a written procedure that includes the written criteria or explains the review process established by the insurer for determining when an item will be limited or excluded pursuant to the insurer's policy regarding medical appropriateness.</p> <p>An insurer that uses a closed formulary must have a written procedure stating that FDA approved prescription drug products are covered only if they are listed in the formulary. The procedure must also describe how the insurer determines the content of the closed formulary and how the insurer determines the application of a medical exception. The procedure must describe how a provider may request inclusion of a new item in the closed formulary and must ensure that the insurer will issue a timely written response to a provider making such a request.</p> <p>An insurer that uses a mandatory closed formulary must have a written procedure stating that FDA approved prescription drug products are covered only if they are listed in the formulary and that no exception is allowed. The procedure must describe how the insurer determines the content of the mandatory closed formulary. The procedure must also describe how a provider may request inclusion of a new item in the formulary and must ensure that the insurer will issue a timely written response to a provider making such a request.</p> <p>An insurer must furnish a copy of the procedures it has adopted under this rule to a provider with authority to prescribe drugs and medications, upon the request of the provider.</p> <p>A formulary must comply with the requirements of 45 CFR 156.122 and include the greater of:</p> <ul style="list-style-type: none"> • At least one drug in every United States Pharmacopeia therapeutic category and class; or • The same number of drugs in each United States Pharmacopeia category and class as the prescription drug benefit of the plan. <p>An insurer that issues a small group or individual health benefit plan formulary that does not comply with this rule must file with the Director of the Department of Consumer and Business Services the form entitled “Formulary-Inadequate Category/Class Count Justification” as set forth on the website of the Department of Consumer and Business Services at www.insurance.oregon.gov. The director, in the director's discretion, may consider approval of a formulary that does not meet the requirements of this rule if:</p> <ul style="list-style-type: none"> • Drugs in a category or class have been discontinued by the manufacturer; • Drugs in a category or class have been deemed unsafe by the FDA or removed from market by the manufacturer due to safety concerns; • Drugs in a category or class have a Drug Efficacy Study Implementation classification; • Drugs in a category or class have become available as generics; or • Drugs in a category or class are provided in a medical setting and are covered under the medical provisions of the plan.
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Formulary Management Laws Chart: Summary of State Requirements

		<p>An insurer that issues a small group or individual health benefit plan formulary does not comply with the nondiscrimination requirements of OAR 836-053-0012 if most or all drugs to treat a specific condition are placed in the highest cost tier.</p> <p>A health benefit plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate prescription drugs not covered by the health plan.</p>
<p>Oregon OAR 836-053-0013</p> <p>Effective 2016</p>	Insurers	<p><i>Oregon Standard Bronze and Silver Health Benefit Plans:</i> Insurers must submit the formulary drug list for review and approval. The formulary drug list must comply with filing requirements posted on the Department of Consumer and Business Services website.</p>
<p>Oregon OAR 836-053-1405</p> <p>Effective 2016</p>	Health insurers	<p><i>General Requirements for Coverage of Mental or Nervous Conditions and Chemical Dependency:</i> The following standards apply in determining whether coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions is provided at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions:</p> <ul style="list-style-type: none"> • Classification of prescription drugs into open, closed, or tiered drug benefit formularies, for drugs intended to treat mental or nervous conditions and chemical dependency, including alcoholism, must be by the same process as drug selection for formulary status applied for drugs intended to treat other medical conditions, regardless of whether such drugs are intended to treat mental or nervous conditions, chemical dependency, including alcoholism, or other medical conditions.
<p>Pennsylvania 28 Pa. Code § 9.673</p> <p>Effective 2001</p>	Managed care organizations	<p><i>Plan Provision of Prescription Drug Benefits to Enrollees:</i> An enrollee, a prospective enrollee, or health care provider may make a written or verbal inquiry to a plan asking whether a specific drug is on the plan's formulary. The plan shall respond in writing to the request within 30 days from the date of its receipt of the request. If the drug that is the subject of the inquiry is not on the plan's formulary, the plan's response shall include a listing of the drugs in the same class that are on the formulary or instruct the enrollee how to access the formulary.</p> <p>A plan utilizing a drug formulary shall have a written policy that includes an exception process by which a health care provider may prescribe and obtain coverage for the enrollee for specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the formulary for prescription drugs or biologicals when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee. The following standards apply when an exception is sought:</p> <ul style="list-style-type: none"> • Exception requests are to be considered requests for prospective UR decisions and shall be processed within 2-business days.

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • If the exception is granted, the plan shall provide coverage in the amount disclosed by the plan for the nonformulary alternative. • A letter denying the request shall include the basis and clinical rationale for the denial and instructions on how to file a complaint or a grievance. <p>The plan shall distribute its policy and process to each participating health care provider who prescribes. A plan shall provide a description of the process to be used to obtain coverage of a drug that is an exception to the formulary to an enrollee or prospective enrollee upon request. If a drug, class of drugs or drugs used to treat a specific condition are specifically excluded from coverage in the enrollee contract, appeals for coverage of specific exclusions shall be considered complaints. If no specific exclusion exists, the appeal of a denial of a physician's request for an exception to the formulary based on medical necessity and appropriateness, shall be considered to be a grievance.</p> <p>A plan shall provide at least 30 days notice of formulary changes to health care providers, except when the change is due to a approval or withdrawal of a approval of the Food and Drug Administration of a drug.</p>
<p>Rhode Island <i>Gen.Laws 1956, § 27-41-51, § 27-19-42, § 27-20.1-15, § 27-20-37, & § 27-18-50</i></p> <p>Effective 2017</p>	<p>Insurers</p>	<p><i>Drug Coverage:</i> Any insurer that utilizes a formulary of medications for which coverage is provided under an individual or group-plan, master contract shall require any physician or other person authorized by the department of health to prescribe medication to prescribe from the formulary. A physician or other person authorized by the department of health to prescribe medication shall be allowed to prescribe medications previously on, or not on, the insurer's formulary if he or she believes that the prescription of non-formulary medication is medically necessary. An insurer shall be required to provide coverage for a non-formulary medication only when the non-formulary medication meets the insurer's medical-exception criteria for the coverage of that medication.</p> <p>An insurer's medical-exception criteria for the coverage of non-formulary medications shall be developed in accordance with § 23-17.13-3(c)(3).</p> <p>Prior to removing a prescription drug from its plan's formulary or making any change in the preferred or tiered, cost-sharing status of a covered prescription drug, an insurer must provide at least 30 days' notice to authorized prescribers by established communication methods of policy and program updates and by updating a available references on web-based publications. All adversely affected members must be provided at least 30 days' notice prior to the date such change becomes effective by a direct notification:</p> <ul style="list-style-type: none"> • The written or electronic notice must contain the following information: <ul style="list-style-type: none"> ○ The name of the affected prescription drug; ○ Whether the plan is removing the prescription drug from the formulary, or changing its preferred or tiered, cost-sharing status; and ○ The means by which subscribers may obtain a coverage determination or medical exception, in the case of drugs that will require prior authorization or are formulary exclusions respectively.

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> An insurer may immediately remove from its plan formularies covered prescription drugs deemed unsafe by the insurer or the FDA, or removed from the market by their manufacturer, without meeting the requirements of this section.
<p>Rhode Island <i>Gen.Laws 1956, § 27-18.8-3</i></p> <p>Effective 2018</p>	Health care entity	<p><i>Certification of Network Plans:</i> The commissioner shall establish standards and procedures for the certification of network plans that have demonstrated the ability to ensure that health care services will be provided in a manner to ensure availability and accessibility, adequate personnel and facilities, and continuity of service, and have demonstrated arrangements for ongoing quality-assurance programs regarding care processes and outcomes. These standards shall consist of, but are not limited to, the following:</p> <ul style="list-style-type: none"> As to each network plan, a health care entity must maintain a process, policies, and procedures for the modification of formularies to include notices to beneficiaries and providers when formularies change in accordance with all state and federal laws.
<p>Rhode Island <i>Gen.Laws 1956, § 27-18.9-7 & 230-RICR-20-30-14.7</i></p> <p>Effective 2018</p>	Health insurers	<p><i>Internal Appeal Requirements:</i> For the appeal of an adverse benefit determination decision that a drug is not covered, the review agent shall complete the internal-appeal determination and notify the claimant of its determination:</p> <ul style="list-style-type: none"> No later than 72 hours following receipt of the appeal request; or No later than 24 hours following the receipt of the appeal request in cases where the beneficiary is suffering from a health condition that may seriously jeopardize the beneficiary's life, health, or ability to regain maximum function or when an beneficiary is undergoing a current course of treatment using a non-formulary drug. And if approved on appeal, coverage of the non-formulary drug must be provided for the duration of the prescription, including refills unless expedited then for the duration of the exigency.
<p>Rhode Island <i>Gen.Laws 1956, § 27-18.9-8 & 230-RICR-20-30-14.8</i></p> <p>Effective 2018</p>	Health insurers	<p><i>External Appeal Requirements:</i> For an external appeal of an internal appeal decision that a drug is not covered, the IRO shall complete the external appeal determination and notify the claimant of its determination:</p> <ul style="list-style-type: none"> No later than 72 hours following receipt of the external appeal request; or No later than 24 hours following the receipt of the external appeal request if the original request was an expedited request; and If approved on external appeal, coverage of the non-formulary drug must be provided for the duration of the prescription, including refills, unless expedited then for the duration of the exigencies.
<p>Rhode Island <i>230-RICR-20-30-9.6</i></p> <p>Effective 2018</p>	Health insurers	<p><i>Network Plan General Requirements:</i> For each network plan, health care entities must evidence to the Office its adherence to the following formulary requirements:</p> <ul style="list-style-type: none"> Network plan providers shall have input to formulary development;

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • Prior to making any formulary changes for a network plan, a health care entity must provide at least 30 calendar days direct notice to prescribers of the affected medications and a diversely affected beneficiaries must be given at least 30 calendar days direct notice prior to effective date of change; • All formulary change notifications to beneficiaries must include the following: • The familiar name of the medication(s); • A description of the change being made in easy to understand language; and • An explanation of the formulary exception process in easy to understand language.
<p>Tennessee T. C. A. § 56-7-2359</p> <p>Effective 2016</p>	Managed health insurance issuer or health insurance issuer	<p>Pharmacy and Pharmacy Access: If a managed health insurance issuer or health insurance issuer revises its drug formulary to remove a drug from a previously approved formulary, the health insurance issuer or managed health insurance issuer shall allow a subscriber or enrollee an opportunity to file a grievance relative to the decision to remove the drug. The grievance must be filed within 60 days after notification to the provider that the drug is being removed. If the grievance is filed with a managed health insurance issuer or health insurance issuer within ten days after the subscriber or enrollee knows or should have known that the drug is being removed, the subscriber or enrollee may continue to receive the drug that is being removed from the formulary until the managed health insurance issuer or health insurance issuer completes the grievance process. This subsection shall not apply to any drug removed from a previously approved formulary when the reason for the removal is due to patient care concerns or other potentially detrimental effects of the drug.</p>
<p>Tennessee T. C. A. § 56-7-3117</p> <p>Effective 2019</p>	PBMs	<p>Advance Notice Required of Material Changes to Certain Contract Terms: A covered entity or pharmacy benefits manager shall disclose to a pharmacy or pharmacist in its network, at least 30 days before the date the change becomes effective, any material change to a contract provision that affects the terms of reimbursement, the process for verifying benefits and eligibility, the dispute resolution procedure, the procedure for verifying drugs included in the formulary, and the procedure for contract termination. Nothing in this section prohibits a covered entity or pharmacy benefits manager from taking a action without notice against a pharmacy or pharmacist in its network for a fraudulent claim or service.</p>
<p>Texas 28 TAC § 21.3020; 21.3022; 21.3023; 21.3030; 21.3031; 21.3032; & 21.3033</p> <p>Effective 2019</p>	Insurance issuers	<p>Prescription Drug Formulary Coverage and Disclosure Requirements: <i>Nonformulary Prescription Drugs / Adverse Determination</i> If the issuer of a health benefit plan, its delegated entity, or its employees or agents refuses to provide coverage for a prescription drug that is not included in a drug formulary, and the enrollee's physician or other health care provider with prescriptive authority has determined the prescription drug is medically necessary to treat a condition covered by the enrollee's health benefit plan, the refusal to provide coverage for the prescription drug constitutes an adverse determination. An enrollee may appeal the adverse determination, and the issuer of the health benefit plan, and its employees or agents, must review and resolve the appeal.</p> <p><i>Availability of Formulary Information</i></p> <ul style="list-style-type: none"> • An issuer of a health benefit plan, or its delegated entity, that covers prescription drugs and uses one or more drug formularies must provide disclosures in plain language. The plain language disclosure must be in the

Formulary Management Laws Chart: Summary of State Requirements

		<p>coverage documentation provided to each enrollee and include the address and telephone number where the enrollee may contact the issuer of the health benefit plan, or its delegated entity, to determine if a specific prescription drug is on the formulary.</p> <ul style="list-style-type: none"> • An issuer of an individual health benefit plan must allow a current or prospective enrollee to obtain a paper copy of the formulary information by calling the toll-free number listed on the summary health plan document. • An issuer may elect to exclude the plan-level cost-sharing information from the paper format if the document provides a toll-free number through which a current or prospective enrollee may obtain formulary information including the plan-specific cost-sharing information for any formulary drug. <p><i>Formulary Information Website</i></p> <ul style="list-style-type: none"> • An issuer of an individual health benefit plan must display the formulary information on a website that is publicly accessible to enrollees, prospective enrollees, and others without requiring the use of paid software, a password, user name, or personally identifiable information. • Each summary health plan document must include a direct electronic link to the website that contains the formulary information. The direct electronic link must deliver the user directly to the formulary information associated with the health benefit plan described by the health plan document, without requiring additional navigation or user input. • As an alternative to displaying specific cost sharing information alongside the formulary information on the website, an individual health benefit plan issuer may elect to make plan-specific cost-sharing information available through a web-based tool. A direct electronic link to the web-based tool must be included on each page of the formulary disclosure that lists each drug. The purpose of this alternative method is to encourage the provision of the most timely and accurate drug price information. In order to qualify for this alternative method, a web-based tool must: <ul style="list-style-type: none"> ○ be publicly accessible to enrollees, prospective enrollees, and others without requiring the use of paid software or the necessity of a password, user name, or personally identifiable information; ○ allow consumers to electronically search formulary information by the name under which the health benefit plan is marketed; ○ include the following plan-specific cost-sharing information for each drug: <ul style="list-style-type: none"> ▪ whether the drug is subject to a pharmacy or medical deductible and where the deductible may be found; ▪ the full price of the drug, based on the plan's median allowed amount or the actual cost for the drug using the most up-to-date data available, and a statement as to whether the price is based on the median or the actual cost; ▪ the cost-sharing amount the enrollee will owe for each drug under the pharmacy or medical benefit in a retail, mail order, or physician- or practitioner-administered setting, if applicable, excluding any deductible requirement, including as applicable: <ul style="list-style-type: none"> • the dollar amount of a copayment; and • for a drug subject to coinsurance, the dollar amount of cost sharing the enrollee will owe, calculated based on the full price of the drug and the cost-sharing parameters under the enrollee's health benefit plan for the tier under which the drug is assigned; and
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Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • include, prominently displayed on the web page under the header "Formulary by Health Benefit Plan," a direct electronic link to a chart that displays each formulary that applies to each individual health benefit plan issued by the issuer and includes a direct electronic link to the Summary of Benefits and Coverage and formulary document for each health plan listed. This chart may be limited to health benefit plans being sold in the market in which the applicable health benefit plan is issued. <p><i>Formulary Disclosure Requirements for Individual Health Benefit Plans</i></p> <ul style="list-style-type: none"> • The formulary information must include each prescription drug covered under the plan that is dispensed in a network pharmacy or administered by a physician or health care provider and clearly differentiate between drugs covered under the plan's pharmacy benefits and medical benefits. Information pertaining to drugs covered under the plan's medical benefits may be provided as an addendum or link to the formulary and must include each parameter that is applicable. • The formulary information must include the following coverage information for each drug: <ul style="list-style-type: none"> ○ an explanation of coverage under the health benefit plan; ○ an indication of whether the drug is preferred, if applicable, under the plan; ○ a disclosure of any prior authorization, step therapy, or other protocol requirement; and ○ the specific tier the drug falls under, if the plan uses a multitier formulary. • The formulary information must include the following plan-specific cost-sharing information for each drug: <ul style="list-style-type: none"> ○ whether the drug is subject to a pharmacy or medical deductible and where the deductible may be found; ○ the cost-sharing amount for each drug under the pharmacy or medical benefit, in a retail, mail order, or physician- or practitioner-administered setting, if applicable, excluding any deductible requirement, including, as applicable: <ul style="list-style-type: none"> ▪ the dollar amount of a copayment; and ▪ for a drug subject to coinsurance: <ul style="list-style-type: none"> • an enrollee's cost-sharing amount stated in dollars; or • a cost-sharing range denoted as follows: <ul style="list-style-type: none"> ○ under \$100 \$; ○ \$100-\$250 \$\$; ○ \$251-\$500 \$\$\$; ○ \$501-\$1,000 \$\$\$\$; or ○ over \$1,000 \$\$\$\$\$; • Cost-sharing amounts must reflect the cost to the consumer, rounded to the next highest dollar amount, for a month-long supply unless otherwise noted. Cost-sharing information reflecting the cost for a different duration supply should indicate the applicable duration. The cost-sharing amount for a given drug must be calculated based on the plan's median allowed amount or the actual cost for the drug, using the most up-to-date data available and the cost-sharing parameters under the enrollee's health benefit plan for the tier under which the drug is assigned. The information must include whether the cost-sharing amount is based on the median or the actual cost.
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Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • Any formulary information presented using abbreviations must provide a legend on each page explaining the meaning of each abbreviation used, including the dollar amounts that correspond to the cost-sharing range. <p><i>Comparison Shopping</i></p> <p>The formulary disclosure requirements for individual health benefit plans must include a summary titled "Summary of Formulary Benefits" that includes this statement: "The information in this document is designed to help you understand the prescription drug benefits offered under this plan and to compare these benefits to those offered by other plans. Information contained in this summary is designed to help you compare both the value and scope of formulary benefits." The summary must also include, in the following order:</p> <ul style="list-style-type: none"> • Under the header, "How to Find Information on the Cost of Prescription Drugs," a description of how a consumer may use the plan's summary health plan document, formulary information, and web-based tool, if applicable, to determine the cost sharing they may owe, and an explanation that cost-sharing information reflects a consumer's share of the cost excluding any deductible requirement, calculated using an estimate of the full price of the drug, which is based on the plan's median or the actual cost allowed amount at a given point in time. • Under the header, "Formulary by Health Benefit Plan," a chart that displays each formulary that applies to each individual health benefit plan issued by the issuer and includes a direct electronic link to the Summary of Benefits and Coverage for each individual health plan listed. This chart may be limited to individual health benefit plans being sold in the market in which the applicable health benefit plan is issued. • Under the header, "Drugs by Cost-Sharing Tier," if the drug formulary is a multitier formulary, a summary that displays the percent of drugs in each cost-sharing tier for all drugs in the formulary. • Under the header, "How Prescription Drugs are Covered under the Plan": <ul style="list-style-type: none"> ○ Under a section titled, "Formulary Composition," an explanation of the method the issuer uses to determine the prescription drugs to be included in or excluded from the formulary, an explanation of whether the formulary is open or closed, and a statement of how often the issuer reviews the contents of the formulary. ○ Under a section titled, "Right to Appeal," an explanation that if a drug is not covered under the formulary, but the enrollee's physician has determined that the drug is medically necessary, the consumer has the right to appeal. A statement of how cost sharing will be determined for drugs covered as a result of a successful appeal. ○ Under a section titled, "Continuation of Coverage," an explanation of a consumer's right to continued coverage for a prescription drug at the coverage level or tier at which the drug was covered at the beginning of the plan year, until the enrollee's plan renewal date. ○ Under a section titled, "Off-Label Drug Use," an explanation of how formulary drugs are covered under the plan, including an explanation of coverage for off-label drug use. ○ Under a section titled, "Cost Sharing," an explanation of how cost sharing is determined under the plan, including whether a deductible applies to prescription drug coverage; how cost sharing for prescription drugs counts towards the plan's deductible; how drugs are categorized into each of the formulary tiers or cost-sharing levels, whether the drug formulary is a multitier formulary; the difference between preferred and nonpreferred drugs, if applicable; the difference in coverage for drugs dispensed from in-network and out-of-network pharmacies; and the difference in coverage for drugs dispensed in a retail pharmacy and a mail-order pharmacy, if applicable.
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Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> ○ Under a section titled, "Medical Management Requirements," an explanation of each type of medical management requirement used by the individual health benefit plan, including prior authorization, step therapy, or other protocol requirements that limit access to prescription drugs, as applicable. ● Formulary information must include the summary information beginning on the first page of the formulary document under the title, "Summary of Formulary Benefits."
<p>Texas V.T.C.A., Insurance Code § 1369.079</p> <p>Effective 2017</p>	<p>Health benefit plans</p>	<p><i>Formulary Disclosure Requirements:</i> The commissioner shall develop and adopt by rule requirements to promote consistency and clarity in the disclosure of formularies to facilitate comparison shopping among individual health benefit plans.</p> <p>The requirements must apply to each prescription drug:</p> <ul style="list-style-type: none"> ● included in a formulary and dispensed in a network pharmacy; or ● covered under an individual health benefit plan and typically administered by a physician or health care provider. <p>The formulary disclosures must:</p> <ul style="list-style-type: none"> ● be electronically searchable by drug name; ● include for each drug the information required below in order; and ● indicate each formulary that applies to each individual health benefit plan issued by the issuer. <p>The formulary disclosures must include for each drug:</p> <ul style="list-style-type: none"> ● the cost-sharing amount for each drug, including as applicable: <ul style="list-style-type: none"> ○ the dollar amount of a copayment; or ○ for a drug subject to coinsurance: <ul style="list-style-type: none"> ▪ an enrollee's cost-sharing amount stated in dollars; or ▪ a cost-sharing range, denoted as follows: <ul style="list-style-type: none"> ● under \$100 \$; ● \$100-\$250 \$\$; ● \$251-\$500 \$\$\$; ● \$501-\$1,000 \$\$\$\$; or ● over \$1,000 \$\$\$\$\$; ● a disclosure of prior authorization, step therapy, or other protocol requirements for each drug; ● if the individual health benefit plan uses a tier-based formulary, the specific tier for each drug listed in the formulary; ● a description of how prescription drugs will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs for a prescription drug that may not apply to the deductible; ● identification of preferred formulary drugs; and ● an explanation of coverage of each formulary drug.

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		<p>The commissioner by rule may allow an alternative method of making disclosures required relating to cost-sharing through a web-based tool that must:</p> <ul style="list-style-type: none"> • be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information; • allow consumers to electronically search formulary information by the name under which the individual health benefit plan is marketed; and • be accessible through a direct link that is displayed on each page of the formulary disclosure that lists each drug.
<p>Texas V.T.C.A., <i>Insurance Code §</i> <i>1369.054</i></p> <p>Effective 2011</p>	Health insurance issuer	<p><i>Notice and Disclosure of Certain Information Required:</i> An issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:</p> <ul style="list-style-type: none"> • provide in plain language in the coverage documentation provided to each enrollee: <ul style="list-style-type: none"> ○ notice that the plan uses one or more drug formularies; ○ an explanation of what a drug formulary is; ○ a statement regarding the method the issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary; ○ a statement of how often the issuer reviews the contents of each drug formulary; and ○ notice that an enrollee may contact the issuer to determine whether a specific drug is included in a particular drug formulary; • disclose to an individual on request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary; and • notify an enrollee and any other individual who requests information under this section that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's health care provider will prescribe that drug for a particular medical condition or mental illness.
<p>Texas V.T.C.A., <i>Insurance Code §</i> <i>1369.078</i></p> <p>Effective 2017</p>	Health insurance issuer	<p><i>Formulary Information on Internet Website:</i></p> <ul style="list-style-type: none"> • A health benefit plan issuer shall display on a public Internet website maintained by the issuer formulary information for each of the issuer's individual health benefit plans as required by the commissioner by rule. • A direct electronic link to the formulary information must be displayed in a conspicuous manner in the electronic summary of benefits and coverage of each individual health benefit plan issued by the health benefit plan issuer on the health benefit plan issuer's Internet website. The information must be publicly accessible to enrollees, prospective enrollees, and others without necessity of providing a password, a user name, or personally identifiable information.
<p>Texas V.T.C.A., <i>Insurance Code §</i> <i>1369.055</i></p>	Health insurance issuer	<p><i>Continuation of Coverage Required:</i> An issuer of a health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.</p>

Formulary Management Laws Chart: Summary of State Requirements

<p>Effective 2017</p>		
<p>Utah U.C.A. 1953 § 31A-22-650</p> <p>Effective 01/01/2020</p>	<p>Insurers</p>	<p>Health Care Preauthorization Requirements: An insurer that removes a drug from the insurer's formulary shall:</p> <ul style="list-style-type: none"> • Permit an enrollee, an enrollee's designee, or an enrollee's network provider to request an exemption from the change to the formulary for the purpose of providing the patient with continuity of care; and • Have a process to review and make a decision regarding an exemption request. • If an insurer makes a change to the formulary for a drug in the middle of a plan year, the insurer may not implement the changes for an enrollee that is on an active course of treatment for the drug unless the insurer provides the enrollee with notice at least 30 days before the day on which the change is implemented.
<p>Vermont Vt. Admin. Code 4-3-57:4</p> <p>Effective 2016</p>	<p>Health insurers</p>	<p>Online Posting Requirements:</p> <ul style="list-style-type: none"> • Health Insurers must post their prescription drug formularies online. • Health Insurers must update the posted formularies at least quarterly. • Posted formularies must be searchable by enrollees, potential enrollees, and health care providers. • Posted formularies must include information about covered prescription drugs, applicable cost-sharing amounts, drug tiers, and any requirements for prior authorization, step therapy or other utilization management. • Each Health Insurer shall post cost sharing amounts that are specific to each of the qualified plans that are certified by DVHA. The health insurer may provide a narrative explanation of any additional impacts on cost sharing such as, but limited to, choice of deductibles, federal or state cost sharing reduction programs or federal cost sharing programs for Native Americans. • Each Health Insurer shall post cost sharing by dosage and strength. • Each Health Insurer shall display online cost sharing amounts for each individual drug and in the aggregate for all drugs that an individual is searching.
<p>Virginia VA Code Ann. § 38.2-3407.9:01</p> <p>Effective 2014</p>	<p>Insurers, corporations, & HMOs</p>	<p>Prescription Drug Formularies: Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) HMO providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the insurer, corporation, or HMO if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed pharmacists, physicians and other licensed health care providers.</p> <p>If an insurer, corporation, or HMO maintains one or more closed drug formularies, each insurer, corporation, or HMO shall:</p>

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		<ul style="list-style-type: none"> • Make available to participating providers and pharmacists and to any nonpreferred or nonparticipating pharmacists, the complete, current drug formulary or formularies, or any updates thereto, maintained by the insurer, corporation, or HMO, including a list of the prescription drugs on the formulary by major therapeutic category that specifies whether a particular prescription drug is preferred over other drugs; • Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug if the formulary drug is determined by the insurer, corporation, or HMO, after reasonable investigation and consultation with the prescribing physician, to be an inappropriate therapy for the medical condition of the enrollee. The insurer, corporation or HMO shall act on such requests within one business day of receipt of the request; and • Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug when the enrollee has been receiving the specific nonformulary prescription drug for at least six months previous to the development or revision of the formulary and the prescribing physician has determined that the formulary drug is an inappropriate therapy for the specific patient or that changing drug therapy presents a significant health risk to the specific patient. After reasonable investigation and consultation with the prescribing physician, the insurer, corporation or HMO shall act on such requests within one business day of receipt of the request. For purposes of this subsection, substituting the generic equivalent drug, which has been approved by the FDA, for a branded version of such drug shall not constitute a change in drug therapy. <p>Each insurer, corporation, or HMO that applies a formulary to the prescription drug benefits shall provide to each affected group health benefit plan policyholder or contract holder or each affected individual health benefit plan policyholder or contract holder not less than 30 days' prior written notice of a modification to a formulary that results in the movement of a prescription drug to a tier with higher cost-sharing requirements. This section does not apply to modifications that occur at the time of coverage renewal.</p>
<p>Washington WAC 284-43-5100</p> <p>Effective 2012</p>	<p>Health carrier and health plans</p>	<p><i>Formulary Changes:</i> An issuer is not required to use a formulary as part of its prescription drug benefit design. If a formulary is used, an issuer must, at a minimum, comply with these requirements when a formulary change occurs.</p> <ul style="list-style-type: none"> • An issuer must not exclude or remove a medication from its formulary if the medication is the sole prescription medication option available to treat a disease or condition for which the health benefit plan, policy or a agreement otherwise provides coverage, unless the medication or drug is removed because the drug or medication becomes a available over-the-counter, is proven to be medically ineffective, or for documented medical risk to patient health. • If a drug is removed from an issuer's formulary for a reason other than withdrawal of the drug from the market, a availability of the drug over-the-counter, or the issue of black box warnings by the FDA, an issuer must continue to cover a drug that is removed from the issuer's formulary for the time period required for an enrollee who is taking the medication at the time of the formulary change to use an issuer's substitution process to request continuation of coverage for the removed medication, and receive a decision through that process, unless patient safety requires swifter replacement.

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • Formularies and related preauthorization information must be posted on an issuer or issuer's contracted pharmacy benefit manager web site and must be current. Unless the removal is done on an immediate or emergency basis or because a generic equivalent becomes available without prior notice, formulary changes must be posted thirty days before the effective date of the change. In the case of an emergency removal, the change must be posted as soon as practicable, without unreasonable delay. • An issuer must make current formulary information electronically available for loading into e-prescribing applications/electronic health records utilizing the National Council for Prescription Drug Programs (NCPDP) formulary and benefit standard transaction. Issuers must include all required data elements as well as the following information, to the extent supported by the transaction: <ul style="list-style-type: none"> ○ Tier level; ○ Contract exclusions; ○ Quantity limits; ○ Preauthorization required; ○ Preferred/step therapy.
<p>Washington WAC 284-43-5110</p> <p>Effective 2012</p>	Health carrier and health plans	<p><i>Cost-sharing for Prescription Drugs:</i></p> <ul style="list-style-type: none"> • When an enrollee requests a brand name drug from the formulary in lieu of a therapeutically equivalent generic drug or a drug from a higher tier within a tiered formulary, and there is not a documented clinical basis for the substitution, a carrier may require the enrollee to pay for the difference in price between the drug that the formulary would have required, and the covered drug, in addition to the copayment. This charge must reflect the actual cost difference. • When a carrier approves a substitution drug, whether or not the drug is in the carrier's formulary, the enrollee's cost-sharing for the substitution drug must be adjusted to reflect any discount agreements or other pricing adjustments for the drug that are available to a carrier. Any charge to the enrollee for a substitution drug must not increase the carrier's underwriting gain for the plan beyond the gain contribution calculated for the original formulary drug that is replaced by the substitution. • If a carrier uses a tiered formulary in its prescription drug benefit design, and a substitute drug that is in the formulary is required, the enrollee's cost sharing may be based on the tier in which the carrier has placed the substitute drug.
<p>Washington WAC 284-43-5170</p> <p>Effective 2012</p>	Health carrier and health plans	<p><i>Prescription Drug Benefit Disclosures:</i></p> <p>A carrier must include the following information in the certificate of coverage issued for a health benefit plan, policy or agreement that includes a prescription drug benefit. The commissioner may disapprove any contract if the requirements of this subsection are not met.</p> <ul style="list-style-type: none"> • A clear statement explaining that the health benefit plan uses the following in its coverage of drugs (as applicable): <ul style="list-style-type: none"> ○ Exclusion of certain brand name or other medications from its formulary; ○ Mid-plan year formulary changes.

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> • A clear explanation of the substitution process that the enrollee or their provider must use to seek coverage of a prescription drug or medication that is not in the formulary or is not the carrier's preferred drug or medication for the covered medical condition. • The process for developing coverage standards and formularies, including the principal criteria by which drugs are selected for inclusion, exclusion, restriction or limitation. • The process of changing formularies and coverage standards, including changes in the use of substitute drugs. If the plan has provisions for “grandfathering” certain ongoing prescriptions or other coverage exceptions, these practices must be disclosed. <p>When a carrier eliminates a previously covered drug from its formulary, or establishes new limitations on coverage of the drug or medication, at a minimum a carrier must ensure that prior notice of the change will be provided as soon as is practicable, to enrollees who filled a prescription for the drug within the prior three months.</p>
<p>Washington WAC 284-43-5080</p> <p>Effective 2012</p>	<p>Health carrier and health plans</p>	<p><i>Prescription Drug Benefit Design:</i></p> <ul style="list-style-type: none"> • A carrier may design its prescription drug benefit to include cost control measures, including requiring preferred drug substitution in a given therapeutic class, if the restriction is for a less expensive, equally therapeutic alternative product available to treat the condition. • A carrier may include elements in its prescription drug benefit design that, where clinically feasible, create incentives for the use of generic drugs. • A carrier must establish a process that a provider and enrollee (or their designee) may use to request a substitution for a prescribed therapy, drug or medication that is not on the formulary. <ul style="list-style-type: none"> ○ The process must not unreasonably restrict an enrollee's access to nonformulary or alternate medications for refractory conditions. ○ For an individual or small group plan, a carrier must make its determination on a standard exception and notify the enrollee or the enrollee's designee and the prescribing provider (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following receipt of the request. A carrier that grants a standard exception request must provide coverage of the nonformulary drug for the duration of the prescription, including refills. ○ For an individual or small group plan, a carrier must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing provider (or other prescriber) to request an expedited review based on exigent circumstances. <ul style="list-style-type: none"> ▪ A carrier must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designees and the prescribing provider (or other prescriber) of its coverage determination no later than 24 hours following receipt of the request. ▪ A carrier that grants an exception based on exigent circumstances must provide coverage of the nonformulary drug for the duration of the exigency. • Subject to the terms and conditions of the policy that otherwise limit or exclude coverage, the carrier must permit substitution of a covered generic drug or formulary drug if: <ul style="list-style-type: none"> ○ An enrollee does not tolerate the covered generic or formulary drug; or

Formulary Management Laws Chart: Summary of State Requirements

		<ul style="list-style-type: none"> ○ An enrollee's provider determines that the covered generic or formulary drug is not therapeutically efficacious for an enrollee. A carrier may require the provider to submit specific clinical documentation as part of the substitution request; or ○ The provider determines that a dosage is required for clinically efficacious treatment that differs from a carrier's formulary dosage limitation for the covered drug. A carrier may require the provider to submit specific clinical documentation as part of the substitution request and must review that documentation prior to making a decision.
<p>Washington WAC 284-43-5640 & WAC 284-43-5642</p> <p>Effective 2013</p>	Health carrier and health plans	<p><i>Essential Health Benefit Categories:</i> An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the base-benchmark plan formulary, both as to U.S. Pharmacopoeia therapeutic category and classes covered and number of drugs in each class. If the base-benchmark formulary does not cover at least one drug in a category or class, an issuer must include at least one drug in the uncovered category or class.</p> <ul style="list-style-type: none"> • An issuer must file its formulary quarterly. • An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.
<p>Washington WAC 284-43-5150</p> <p>Effective 2001</p>	Health carrier and health plans	<p><i>Unfair Practice Relating to Health Coverage:</i> Health carriers may use, and health plans may limit coverage to, a closed formulary for prescription contraceptives if they otherwise use a closed formulary, but the formulary shall cover each of the types of prescription contraception</p>
<p>Washington WAC 284-43-5060</p> <p>Effective 2012</p>	Health carrier and health plans	<p><i>General Prescription Drug Benefit Requirements:</i> A prescription drug benefit or formulary must not exclude coverage for a nonformulary drug or medication if the only formulary drug available for an enrollee's covered condition is one that the enrollee cannot tolerate or that is not clinically efficacious for the enrollee</p>
<p>West Virginia W. Va. Code, § 33-16-3z, § 33-15-4n, § 33-25A-8n, § 33-24-7o & § 33-25-8l</p> <p>Effective 2016</p>	Health insurers	<p><i>Deductibles, Copayments and Coinsurance for Abuse-deterrent Opioid Analgesic Drugs:</i> Any provision of any group accident and sickness insurance policy issued by an insurer:</p> <ul style="list-style-type: none"> • Coverage shall be provided for at least one abuse-deterrent opioid analgesic drug product for each active opioid analgesic ingredient; • Cost-sharing for brand name abuse-deterrent opioid analgesic drug products shall not exceed the lowest tier for brand name prescription drugs on the entity's formulary for prescription drug coverage; • Cost-sharing for generic abuse-deterrent opioid analgesic drug products covered shall not exceed the lowest cost-sharing level applied to generic prescription drugs covered under the applicable health plan or policy; and

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		<ul style="list-style-type: none">• An entity subject to this section may not require an insured or enrollee to first use an opioid analgesic drug product without abuse-deterrent labeling before providing coverage for an abuse-deterrent opioid analgesic drug product covered on the entity's formulary for prescription drug coverage.
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