[215 Ill. Comp. Stat. § 134/45.1.]

§ 134/45.1. Medical exceptions procedures required: Managed Care Reform and Patient Rights Act

(a) Notwithstanding any other provision of law, on or after the effective date of this amendatory Act of the 99th General Assembly, every insurer licensed in this State to sell a policy of group or individual accident and health insurance or a health benefits plan shall establish and maintain a medical exceptions process that allows covered persons or their authorized representatives to request any clinically appropriate prescription drug when (1) the drug is not covered based on the health benefit plan's formulary; (2) 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of the drug on the plan's formulary for reasons other than safety or other than because the prescription drug has been withdrawn from the market by the drug's manufacturer; (3) the prescription drug alternatives required to be used in accordance with a step therapy requirement (A) has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 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 (B) has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to the enrollee; or (4) the number of doses available under a dose restriction for the prescription drug (A) has been ineffective in the treatment of the enrollee's disease or medical condition or (B) 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 effective or patient compliance.

(b) The health carrier's established medical exceptions procedures must require, at a minimum, the following:

(1) Any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals.

(2) The health carrier must, within 72 hours after receipt of a request made under subsection (a) of this Section, either approve or deny the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(3) In the case of an expedited coverage determination, the health carrier must either approve or deny the request within 24 hours after receipt of the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(c) A step therapy requirement exception request shall be approved if:

(1) the required prescription drug is contraindicated;

(2) the patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance; or

(3) the patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

(d) Upon the granting of an exception request, the insurer, health plan, utilization review organization, or other entity shall authorize the coverage for the drug prescribed by the enrollee's treating health care provider, to the extent the prescribed drug is a covered drug under the policy or contract up to the quantity covered.

(e) Any approval of a medical exception request made pursuant to this Section shall be honored for 12 months following the date of the approval or until renewal of the plan.

(f) Notwithstanding any other provision of this Section, nothing in this Section shall be interpreted or implemented in a manner not consistent with the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those Acts.

(g) Nothing in this Section shall require or authorize the State agency responsible for the administration of the medical assistance program established under the Illinois Public Aid Code to approve, supply, or cover prescription drugs pursuant to the procedure established in this Section.