[Ariz. Rev. Stat. § 20-1057.02.]

§ 20-1057.02. Prescription drug formulary; definitions: Health Care Services Organizations

A. A health care services organization with a prescription drug benefit that uses a drug formulary as a component of the evidence of coverage shall provide to its enrollees notice in the evidence of coverage regarding the applicable drug formulary. The health care services organization shall write the notice so that the language and format are easy to understand. The notice shall include an explanation of what a drug formulary is, how the health care services organization determines which prescription drugs are included or excluded and how often the health care services organization reviews the contents of the drug formulary.

B. A health care services organization described in subsection A of this section shall:

1. 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 health care services organization does not maintain that process, the health care services organization shall reimburse an enrollee for the enrollee's out-of-pocket expense minus any deductible or copayment for a prescription drug that was purchased by the enrollee without preauthorization but that was later approved by the health care services organization.

2. Develop and maintain a process by which health care professionals may request authorization for medically necessary nonformulary prescription drugs. The health care services organization shall approve an alternative prescription drug when either of the following conditions is met:

(a) The equivalent prescription drug on the formulary has been ineffective in the treatment of the enrollee's disease or condition.

(b) The equivalent prescription drug on the formulary has caused an adverse or harmful reaction in the enrollee.

C. If the health care services organization's pharmacy benefit plan does not require authorization, subsection B, paragraph 2 of this section does not apply.

D. If the enrollee's treating health care professional makes a determination that the enrollee meets any of the conditions described in subsection B of this section, any denial to cover the nonformulary prescription drug by the health care services organization 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 health care services organization shall send a copy of the written denial to the enrollee's treating health care professional who requested the authorization. The health care services organization shall maintain

copies of all written denials and shall make the copies available to the department for inspection during regular business hours.

E. Any evidence of coverage that is issued, amended or renewed by a health care services organization and that includes prescription drug benefits shall not limit or exclude coverage for at least sixty days after the health care services organization's notice or the pharmacy's notice pursuant to subsection F of this section to the enrollee, whichever occurs first, for a prescription drug for an enrollee 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 enrollee'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 enrollee'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 enrollee, including generic drug substitutions.

F. A health care services organization shall provide written notice of the removal of any prescription drug from the health care services organization's drug formulary to each pharmacy vendor with which the health care services organization has a contract. On notice from the health care services organization, the contracted pharmacy vendor at the point of dispensing a prescription drug that has been removed from the drug formulary shall notify the enrollee by means of a verbal consultation or other direct communication with an enrollee that the enrollee may be required to consult with a health care professional to obtain a new prescription for a replacement drug after the sixty day period prescribed in subsection E of this section. The notice prescribed in this subsection is not required if the pharmacy vendor is a pharmacy that is owned by a health care services organization or a corporate affiliate of that health care services organization.

G. This section does not:

1. Prohibit a health care services organization from applying deductibles, coinsurance or other cost containment or quality assurance measures.

2. Apply to a health care services organization that provides a multitiered benefit plan that allows access to prescription drugs without authorization by the health care services organization.

H. For the purposes of this section:

1. "Health care professional" means a person who has an active nonrestricted license pursuant to title 32 and who is authorized to write drug prescriptions to treat medical conditions.

2. "Prescription drug" means any prescription medication as defined in section 32-1901 that is prescribed by a health care professional to an enrollee to treat the enrollee's condition.