

505.26 Prior authorization for prescription drug benefits — standard process and form — response requirements.

1. As used in this section:
 - a. “Facility”, “health benefit plan”, “health care professional”, “health care provider”, “health care services”, and “health carrier” mean the same as defined in [section 514J.102](#).
 - b. “Pharmacy benefits manager” means the same as defined in [section 510B.1](#).
2. The commissioner shall develop, by rule, a process for use by each health carrier and pharmacy benefits manager that requires prior authorization for prescription drug benefits pursuant to a health benefit plan, to submit, on or before January 1, 2015, a single prior authorization form for approval by the commissioner; that each health carrier or pharmacy benefits manager shall be required to use beginning on July 1, 2015. The process shall provide that if a prior authorization form submitted to the commissioner by a health carrier or pharmacy benefits manager is not approved or disapproved within thirty days after its receipt by the commissioner, the form shall be deemed approved.
3. The commissioner shall develop, by rule, a standard prior authorization process which meets all of the following requirements:
 - a. Health carriers and pharmacy benefits managers shall allow health care providers to submit a prior authorization request electronically.
 - b. Health carriers and pharmacy benefits managers shall provide that approval of a prior authorization request shall be valid for a minimum length of time in accordance with the rules adopted under [this section](#). In adopting the rules, the commissioner may consult with health care professionals who seek prior authorization for particular types of drugs, and as the commissioner determines to be appropriate, negotiate standards for such minimum time periods with individual health carriers and pharmacy benefits managers.
 - c. Health carriers and pharmacy benefits managers shall make the following available and accessible on their internet sites:
 - (1) Prior authorization requirements and restrictions, including a list of drugs that require prior authorization.
 - (2) Clinical criteria that are easily understandable to health care providers, including clinical criteria for reauthorization of a previously approved drug after the prior authorization period has expired.
 - (3) Standards for submitting and considering requests, including evidence-based guidelines, when possible, for making prior authorization determinations.
 - d. Health carriers shall provide a process for health care providers to appeal a prior authorization determination as provided in [chapter 514J](#). Pharmacy benefits managers shall provide a process for health care providers to appeal a prior authorization determination that is consistent with the process provided in [chapter 514J](#).
4. In adopting a standard prior authorization process, the commissioner shall consider national standards pertaining to electronic prior authorization, such as those developed by the national council for prescription drug programs.
5. A prior authorization form approved by the commissioner shall meet all of the following requirements:
 - a. Not exceed two pages in length, except that a prior authorization form may exceed that length as determined to be appropriate by the commissioner.
 - b. Be available in electronic format.
 - c. Be transmissible in an electronic format or a fax transmission.
6. Beginning on July 1, 2015, each health carrier and pharmacy benefits manager shall use and accept the prior authorization form that was submitted by that health carrier or pharmacy benefits manager and approved for the use of that health carrier or pharmacy benefits manager by the commissioner pursuant to [this section](#). Beginning on July 1, 2015, health care providers shall use and submit the prior authorization form that has been approved for the use of a health carrier or pharmacy benefits manager, when prior authorization is required by a health benefit plan.
7. The commissioner shall adopt rules pursuant to [chapter 17A](#) that provide requirements, not to exceed seventy-two hours for urgent claims and five calendar days for nonurgent claims, for a health carrier or pharmacy benefits manager to respond to a health care

provider's request for prior authorization of prescription drug benefits or to request additional information from a health care provider concerning such a request.

[2014 Acts, ch 1140, §98, 101](#); [2015 Acts, ch 128, §9, 50, 51](#)

Referred to in [§510B.9, 514E7](#)