191—79.3 (505) Prior authorization protocols. All health carriers, health benefit plans and pharmacy benefits managers must accept the approved prior authorization form from health care providers.

79.3(1) *Duration of approved prior authorization request.* Health carriers, health benefit plans, and pharmacy benefits managers shall provide that approval of a prior authorization request shall be valid for a minimum of 12 months or for a duration that is clinically appropriate for the condition being treated, in accordance with the rules adopted pursuant to Iowa Code section 505.26 as amended by 2015 Iowa Acts, House File 632, section 9. Updates on disease progression must be provided with each renewal request.

79.3(2) *Posting of prior authorization form.* The approved prior authorization form shall be made available electronically on the Web site of the division and on the Web site of each health carrier, health benefit plan or pharmacy benefits manager that uses the form. Health carriers, health benefit plans and pharmacy benefits managers shall allow health care providers to submit a prior authorization request electronically.

79.3(3) *Assignment of identification number.* The health carrier, health benefit plan or pharmacy benefits manager shall assign to each prior authorization request a unique electronic identification number that a provider may use during the prior authorization process to track the request electronically, through a call center, or by fax. This unique identifier may include a format that consists of a patient's first name, last name and date of birth.

79.3(4) *Posting of required information.* Health carriers, health benefit plans, and pharmacy benefits managers shall make the following available and accessible on their Internet sites:

a. Prior authorization requirements and restrictions, including a list of drugs that require prior authorization.

b. 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.

c. 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 Iowa Code 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 Iowa Code chapter 514J. Appeal standards as provided in Iowa Code chapter 514J are set out in Appendix A herein.

79.3(5) *Urgent claims.* Prior authorization requests for urgent claims shall be approved or denied as soon as possible, but in no case later than 72 hours after receipt of the request.

79.3(6) *Nonurgent claims.* Prior authorization requests for nonurgent claims shall be approved or denied as soon as possible, but in no case later than five calendar days after receipt of the request.

79.3(7) *Incomplete or additional information.* If a request for a prescription drug prior authorization is incomplete or additional information is required, the health carrier, health benefit plan, or pharmacy benefits manager may request additional information within the applicable time periods provided in this rule. Once the additional information is submitted, the applicable time period for approval or denial shall begin again.

79.3(8) *Prescription drug benefits provided by a qualified health plan.* A QHP shall have procedures in place that comply with the health insurance issuer standards related to expedited review based on exigent circumstances and coverage determinations no later than 24 hours after receipt of requests as provided for in 45 CFR 156.122(c).

79.3(9) *Prior authorization granted.* If a health carrier, health benefit plan or pharmacy benefits manager does not approve or deny a completed prior authorization request or request additional information from a health care provider within the time limits set forth in this rule, the prior authorization request shall be deemed to have been granted.

79.3(10) *Denial of prior authorization request.* In the case of a denial of a prior authorization request, the health carrier, health benefit plan or pharmacy benefits manager shall provide the reason for

the denial, information regarding the denial and, if formulary alternatives are available, direction on how to contact the health carrier or health benefit plan.

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