THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.2212c Prescription drug prior authorization workgroup; creation; development of methodology; prior authorization request; definitions.

Sec. 2212c. (1) By January 1, 2015, the workgroup shall develop a standard prior authorization methodology for use by prescribers to request and receive prior authorization from an insurer if a health benefit plan requires prior authorization for prescription drug benefits. The workgroup shall include in the standard prior authorization methodology the ability for the prescriber to designate the prior authorization request for expedited review. In order to designate a prior authorization request for expedited review, the prescriber shall certify that applying the review period under section 2212e(10) may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

(2) A prescription drug prior authorization workgroup is created. The department of health and human services and the department shall work together and appoint members to the workgroup. The workgroup must consist of a member who represents the department of health and human services, a member who represents the department, and members who represent insurers, prescribers, pharmacists, hospitals, and other stakeholders as determined necessary by the department of health and human services and the department. The workgroup shall appoint a chairperson from among its members. The chairperson of the workgroup shall schedule workgroup meetings. The department of health and human services and the department shall organize the initial meeting of the workgroup and shall provide administrative support for the workgroup.

(3) In developing the standard prior authorization methodology under subsection (1), the workgroup shall consider all of the following:

(a) Existing and potential technologies that could be used to transmit a standard prior authorization request.

(b) The national standards pertaining to electronic prior authorization developed by the National Council for Prescription Drug Programs.

(c) Any prior authorization forms and methodologies used in pilot programs in this state.

(d) Any prior authorization forms and methodologies developed by the Centers for Medicare and Medicaid Services.

(4) Beginning March 14, 2014, an insurer may specify in writing the materials and information necessary to constitute a properly completed standard prior authorization request if a health benefit plan requires prior authorization for prescription drug benefits.

(5) If the workgroup develops a paper form as the standard prior authorization methodology under subsection (1), the paper form must meet all of the following requirements:

(a) Consist of not more than 2 pages. However, an insurer may request and require additional information beyond the 2-page limitation of this subdivision, if that information is specified in writing by the insurer under subsection (4). As used in this subdivision, "additional information" includes, but is not limited to, any of the following:

(*i*) Patient clinical information including, but not limited to, diagnosis, chart notes, lab information, and genetic tests.

(*ii*) Information necessary for approval of the prior authorization request under plan criteria.

(*iii*) Drug specific information including, but not limited to, medication history, duration of therapy, and treatment use.

(b) Be electronically available.

(c) Be electronically transmissible, including, but not limited to, transmission by facsimile or similar device.

(6) Beginning July 1, 2016, if an insurer uses a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system, the prior authorization methodology described in subsection (5) does not apply. Subsection (4) and section 2212e apply to a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system.

(7) Beginning July 1, 2016, except as otherwise provided in subsection (6), an insurer shall use the standard prior authorization methodology developed under subsection (1) if a health benefit plan requires prior authorization for prescription drug benefits.

(8) As used in this section:

(a) "Health benefit plan" means that term as defined in section 2212e.

(b) "Insurer" means any of the following:

(*i*) An insurer that delivers, issues for delivery, renews, or administers a health benefit plan.

(*ii*) A health maintenance organization.

(*iii*) A health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(*iv*) For purposes of this section and section 2212e only, a third party administrator of prescription drug benefits. As used in this subparagraph, "third party administrator" means that term as defined in section 2 of the third party administrator act, 1984 PA 218, MCL 550.902.

(c) "Prescriber" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(d) "Prescription drug" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(e) "Prescription drug benefit" means the right to have a payment made by an insurer for a prescription drug listed on the applicable formulary in accordance with coverage contained within a health benefit plan delivered, issued for delivery, or renewed in this state.

(f) "Workgroup" means the prescription drug prior authorization workgroup created under subsection (2).

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