

## Article - Insurance

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§15–142.

(a) (1) In this section the following words have the meanings indicated.

(2) “Step therapy or fail–first protocol” means a protocol established by an insurer, a nonprofit health service plan, or a health maintenance organization that requires a prescription drug or sequence of prescription drugs to be used by an insured or an enrollee before a prescription drug ordered by a prescriber for the insured or the enrollee is covered.

(3) “Step therapy drug” means a prescription drug or sequence of prescription drugs required to be used under a step therapy or fail–first protocol.

(4) “Supporting Medical Information” means:

(i) a paid claim from an entity subject to this section for an insured or an enrollee;

(ii) a pharmacy record that documents that a prescription has been filled and delivered to an insured or an enrollee, or a representative of an insured or an enrollee; or

(iii) other information mutually agreed on by an entity subject to this section and the prescriber of an insured or an enrollee.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(c) An entity subject to this section may not impose a step therapy or fail–first protocol on an insured or enrollee if:

(1) the step therapy drug has not been approved by the U.S. Food and Drug Administration for the medical condition being treated; or

(2) a prescriber provides supporting medical information to the entity that a prescription drug covered by the entity:

(i) was ordered by a prescriber for the insured or enrollee within the past 180 days; and

(ii) based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition.

(d) This section may not be construed to require coverage for a prescription drug that is not:

(1) covered by the policy or contract of an entity subject to this section; or

(2) otherwise required by law to be covered.

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