Illinois Department of Insurance

JB PRITZKER
Governor

DANA POPISH SEVERINGHAUS
Acting Director

COMPANY BULLETIN

TO: ALL COMMERCIAL HEALTH INSURERS

FROM: Dana Popish Severinghaus, Acting Director of Insurance dps

Date: June 25, 2021

RE: Company Bulletin 2021-09 – Uniform Electronic Prior Authorization Form for Prescription Benefits (50 Ill. Adm. Code Part 2018)

As enacted by Public Act 101-463, 215 ILCS 5/364.3 the Illinois Department of Insurance ("the Department") was required to develop a uniform electronic prior authorization form for prescription drug benefits to be used by commercial insurers.

The Department convened and facilitated workgroup meetings comprised of Illinois insurance companies and various health care providers representing physicians, psychiatrists, and pharmacists. The meetings were held on April 17, 2020, May 15, 2020, and June 19, 2020, via WebEx conference calls.

To implement the form, the Department created a rule prescribing its contents. After receiving a Certification of No Objection from the Joint Committee on Administrative Rules, the Department filed the final version of the rule with the Illinois Secretary of State, which has been adopted as 50 Ill. Adm. Code 2018 with an effective date of June 21, 2021. The adopted rule is appended to this bulletin.

Effective July 1, 2021, "every prescribing provider must use the uniform electronic prior authorization form to request prior authorization for coverage of prescription drug benefits and every insurer shall accept the uniform electronic prior authorization form as sufficient to request prior authorization for prescription drug benefits." 215 ILCS 5/364.3(c).

The PDF version of the Illinois Uniform Electronic Prior Authorization Form for Prescription Benefits can be found on the Department's website next to this Bulletin at: https://insurance.illinois.gov/CB/CompanyBulletins.html. Companies should add their contact and submission information to the first page before making the form available to providers.

Springfield Office
320 W. Washington Street
Springfield, Illinois 62767
(217) 782-4515

Chicago Office
122 S. Michigan Ave., 19th Floor
Chicago, Illinois 60603
(312) 814-2420

Please direct questions regarding this Bulletin to Deputy Director of Health Products Ryan Gillespie at Ryan.Gillespie@illinois.gov.

The adopted rule 50 Ill. Adm. Code 2018 follows below.

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

June 24, 2021

IL DEPT OF INSURANCE
SUE ANDERS
320 W WASHINGTON ST
SPRINGFIELD, IL 62767-0001

Dear SUE ANDERS

Your rules Listed below met our codification standards and have been published in Volume 45, Issue 27 of the Illinois Register, dated 7/2/2021.

ADOPTED RULES

Uniform Electronic Prior Authorization Form for Prescription Benefits
50 Ill. Adm. Code 2018 8024
Point of Contact: Sue Anders

If you have any questions, you may contact the Administrative Code Division at (217) 782 - 7017.

ILLINOIS REGISTER

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED RULES

1) Heading of the Part: Uniform Electronic Prior Authorization Form for Prescription Benefits

2) Code Citation: 50 Ill. Adm. Code 2018

3)

Section Numbers:	Adopted Actions:
2018.10	New Section
2018.20	New Section
2018.30	New Section

4) Statutory Authority: 215 ILCS 5/364.3 and 5/401.

5) Effective Date of Rule: JUN 21 2021

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted rulemaking, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal Published in Illinois Register: 44 Ill. Reg. 14406; September 11, 2020

10) Has JCAR issued a Statement of Objections to this Rulemaking? No

11) Differences between proposal and final version:

2018.30(b), 5th paragraph, italicize all text prior to the citation in the 7th line. 1st line, changed "complete" to "completed"; 3rd and 4th line, change "for urgent medication needs" to "(if the patient has urgent medication needs)"and change "for regular medication needs" to "(if the patient has regular medication needs)". 6th line, after "*granted.*" add "[215 ILCS 5/364.3(f)]".

2018.30(b), 6th paragraph, 7th line, changed to "patients related to responsiveness, adjudication and/or appeals."

2018.30(b), 7th paragraph, first line, after "authorization" added "alone".

2018.30(b), after 7th paragraph, added a new paragraph as follows: "Please refer to the plan's website for additional information that may be necessary for review. Please note

that sending this form with insufficient clinical information may result in an extended review period or adverse determination. Insurers may require additional information based on the type of prescription drug being requested that may require follow-up inquiries with the provider."

2018.30(c), 6th line, deleted "his or her".

2018.30(e)(8), deleted "The form will provide options for Male or Female.".

2018.30(f)(8), deleted "and" and added a new paragraph after that as follows:
"9) Contact Email Address (optional); and". In the next paragraph, changed "9)" to "10)".

2018.30(j), 1st line, after "Therapies", add ", if applicable in the provider's opinion".

2018.30(k), 2nd line: after "other information", added "in the prescribing provider's professional opinion". 4th line, added a closing quotation mark after "etc." and deleted "Please refer to the plan's website for additional information that may be necessary for review. Please note that sending this form with insufficient clinical information may result in an extended review period or adverse determination. Insurers may require additional information based on the type of prescription drug being requested that may require follow-up inquiries with the provider.""

2018.30(l): 2nd line, changed "may" to "must"; 3rd line, after "submission of the form" and before the period, added "and any links to the insurer's prior authorization form and guidelines".

2018.30(n)(5): after "Approved by" and before the semicolon, added "(name and credentials)"

2018.30(n)(6): after "Denied by" and before the semicolon, added "(name and credentials)"

After 2018.30(n)(6), added a new paragraph as follows:
"7) Reviewed by (name and credentials);". Renumbered the remaining paragraphs.

12) Have all changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rule currently in effect? No

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED RULES

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of rulemaking: Under Pub. Act 101-0463, the Department of Insurance was directed to develop a uniform electronic prior authorization form for prescription benefits. This form is intended to simplify exchanges of information between prescribing providers and insurers for prior authorization requests. As required by statute, the Department developed this form with input from interested parties, who were present at multiple public meetings.

The adopted rules do not apply to any health insurance coverage that does not require prior authorization for any prescription benefits.

Beginning July 1, 2021, insurers will be required to accept and use this form. They also will be required to ensure that any person performing prior authorization on their behalf accepts and uses this form. Beginning July 1, 2021, the statute will require prescribing providers to use this form when requesting prior authorization for prescriptions covered by a patient's health insurance coverage.

The adopted rules list the information and the prompts that must be included in the form, which the Department will format and post on its website as a PDF. The form will include the following: a title, an explanatory introduction about the purposes and limitations of the form, a selection between a Standard or Expedited Review Request, a Reason for Request, Patient Demographics, Prescribing Provider Information, Pharmacy Information, Requested Prescription Drug Information, Rationale for Prior Authorization, a listing of Failed or Contraindicated Therapies, Other Pertinent Information, Insurer Contact and Submission Information, a Representation clause, and a Health Plan Use Only section where the approval or denial will be reported.

16) Information and questions regarding this adopted rulemaking shall be directed to:

Ryan Gillespie
Deputy Director of Health Products
Department of Insurance
320 West Washington Street
Springfield, Illinois 62767-0001

(217) 558-2746

The full text of the Adopted Rules begins on the next page.

Illinois Department of Insurance

JB PRITZKER
Governor

DANA POPISH SEVERINGHAUS
Acting Director

CERTIFICATE OF ADOPTED RULES

The Illinois Department of Insurance certifies that the attached hereto is a true and correct copy of:

Heading of Part: Uniform Electronic Prior Authorization Form for Prescription Benefits

Code Citation: 50 Ill. Adm. Code 2018

Sections Involved:
2018.10
2018.20
2018.30

which was duly adopted by this Agency.

Statutory Authority: Implementing Section 364.3 and authorized by Sections 364.3 and 401 of the Illinois Insurance Code [215 ILCS 5].

DEPARTMENT OF INSURANCE
of the State of Illinois;

[redacted]

Dana Popish Severinghaus
Acting Director

EFFECTIVE DATE
JUN 21 2021
SOS-CODE DIV.

RECEIVED
JUN 21 2021
SOS-CODE DIV.

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2018
UNIFORM ELECTRONIC PRIOR AUTHORIZATION FORM FOR PRESCRIPTION BENEFITS

Section

AUTHORITY: Implementing Section 364.3 and authorized by Sections 364.3 and 401 of the Illinois Insurance Code [215 ILCS 5].

SOURCE: Former Part repealed at 32 Ill. Reg. 7715, effective May 5, 2008; new Part adopted at 45 Ill. Reg. 8024, effective JUN 21 2021.

EFFECTIVE DATE
JUN 21 2021
SOS-CODE DIV.

RECEIVED
JUN 21 2021
SOS-CODE DIV.

Section 2018.10 Purpose and Applicability

a) This Part provides the contents of the electronic form that an insurer imposing prior authorization requirements on prescription benefits is required to utilize and accept for any health insurance coverage beginning July 1, 2021 under Section 364.3 of the Code. This form is intended to simplify exchanges of information between prescribing providers and insurers for prior authorization requests.

b) This Part does not apply to any health insurance coverage that does not require prior authorization for any prescription benefits.

Section 2018.20 Definitions

"Code" means the Illinois Insurance Code [215 ILCS 5].

"Department" means the Illinois Department of Insurance.

"Insurer" means a "health insurance issuer" as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act [215 ILCS 97].

"Health insurance coverage" has the meaning ascribed in Section 5 of the Illinois Health Insurance Portability and Accountability Act.

"Prescribing provider" has the meaning ascribed in Section 364.3(a) of the Code.

"Prescription" has the meaning ascribed in Section 3(e) of the Pharmacy Practice Act [225 ILCS 85].

Section 2018.30 Uniform Electronic Prior Authorization Form for Prescription Benefits

On and after July 1, 2021, an insurer that imposes prior authorization requirements on prescription benefits in any health insurance coverage shall utilize and accept the uniform electronic prior authorization form containing the elements listed in this Section. An insurer shall require any person conducting prior authorization of prescription drug benefits on its behalf to utilize and accept this form. If any prescribing provider fails to use this form to request prior authorization of prescription benefits, the insurer will not be subject to the requirements of Section 364.3 of the Code for that request. Only the version of the PDF that is posted on the Department's website shall satisfy the requirements of this Part. The posted PDF shall consist of the following elements:

a) The title, which will be: "Illinois Uniform Electronic Prior Authorization Form for Prescription Benefits".

b) An explanatory introduction, which will contain the following text:

This form is made available for use by prescribing providers to initiate a prior authorization request with a commercial health insurance issuer ("insurer") regulated by the Illinois Department of Insurance.

"Prior authorization request" means a request for pre-approval from an insurer for a specified prescription or quantity of a prescription before the prescription is dispensed.

"Prescribing provider" has the meaning ascribed in Section 364.3 of the Illinois Insurance Code [215 ILCS 5].

"Prescription" has the meaning ascribed in Section 3(e) of the Pharmacy Practice Act [225 ILCS 85].

If, upon receipt of a completed and accurate electronic prior authorization request from a prescribing provider pursuant to the submission of this form, an insurer fails to use or accept the uniform electronic prior authorization form or fails to respond within 24 hours (if the patient has urgent medication needs), or within 72 hours (if the patient has regular medication needs), then the prior authorization request shall be deemed to have been granted. [215 ILCS 5/364.3(f)] The prescribing provider should only provide its direct contact number and initials if requesting an Expedited Review Request.

The provisions of this form do not serve as a replacement for the step therapy and formulary exception requests that may require additional information and forms as provided in Sections 25(a)(3) and 45.1 of the Managed Care Reform and Patient Rights Act [215 ILCS 134]. Nothing in this form shall be construed to alter or nullify any provisions of federal or Illinois law that impose obligations on insurers, prescribing providers, or patients related to responsiveness, adjudication and/or appeals.

Prior authorization alone is not a guarantee of benefits or payment. Actual availability of benefits is always subject to other requirements of the health plan, such as limitations and exclusions, payment of premium, and eligibility at the time services are provided. The applicable terms of a patient's plan control the benefits that are available. At the time the claims are submitted, they will be reviewed in accordance with the terms of the plan.

Please refer to the plan's website for additional information that may be necessary for review. Please note that sending this form with insufficient clinical information may result in an extended review period or adverse determination. Insurers may require additional information based on the type of prescription drug being requested that may require follow-up inquiries with the provider.

PRESCRIBING PROVIDERS: PLEASE SUBMIT THIS FORM TO THE PATIENT'S HEALTH PLAN ONLY. Please do not send forms to the Department of Insurance.

c) A section to indicate whether the prescribing provider is making a Standard Review Request or an Expedited Review Request. For an Expedited Review Request, the following certification shall appear: "I hereby certify that a standard review period may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function." The certification shall have spaces for the prescribing provider to add initials and a direct telephone number to contact the prescribing provider.

d) A section entitled "Reason for Request", which will contain options for an Initial Authorization Request, a Renewal Request, and a Dispense As Written (DAW). The section will also have a note that states: "Note: This form does not apply to requests for medical exceptions under Sections 25(a)(3) or 45.1 of the Managed Care Reform and Patient Rights Act [215 ILCS 134]. Please contact the patient's health plan to obtain the appropriate forms."

e) A section entitled "Patient Demographics", which will request the following information:

1) Whether the patient is hospitalized;

2) Patient Name;

3) Patient Date of Birth;

4) Patient Health Plan ID;

5) Patient Health Plan Group Number (if applicable);

6) Patient Address;

7) Patient Phone; and

8) Patient Sex.

f) A section entitled "Prescribing Provider Information", which will request the following information:

1) Prescribing Provider Name;

2) NPI;

3) Specialty;

4) DEA Number (required for controlled substance requests only);

5) Contact Name;

6) Contact Phone;

7) Contact Fax;

8) Contact Address;

9) Contact Email Address (optional); and

10) Health Plan Provider ID (if accessible).

g) A section entitled "Pharmacy Information", which will request the following information:

1) Pharmacy Name; and

2) Pharmacy Phone.

h) A section entitled "Requested Prescription Drug Information", which will request the following information:

1) Drug Name;

2) Strength;

3) Dosing Schedule;

4) Duration;

5) Diagnosis (specific with ICD#);

6) Place of infusion/injection (if applicable);

7) Facility Provider ID/NPI;

8) Ingredients within drug; and

9) Whether the patient has already started the medication and, if so, when.

i) A section entitled "Rationale for Prior Authorization", which will request information such as history of present illness, past medical history, current medications, etc. The section will indicate that the prescribing provider may also attach chart notes to support the request if the provider believes the notes will assist in the review process.

j) A section entitled "Failed/Contraindicated Therapies", if applicable in the provider's opinion, which will request the following information:

1) Drug name;

2) Strength;

3) Dosing Schedule;

4) Duration; and

5) Adverse Event/Specific Failure.

k) A section entitled "Other Pertinent Information", which will contain the following text: "Optional: To be filled out if other information in the prescribing provider's professional opinion is necessary, such as relevant diagnostic labs, measures, response to treatment, etc." The section will contain blank space for the prescribing provider to provide this information.

l) A section entitled "Insurer Contact and Submission Information", where an insurer must provide its unique contact information, including any electronic portal it may use for submission of the form and any links to the insurer's prior authorization form and guidelines. The insertion of this information is the only alteration that an insurer may make to the PDF posted on the Department's website before furnishing it to a prescribing provider.

m) A section entitled "Representation", which will contain the following text: "I represent to the best of my knowledge and belief that the information provided is true, complete, and fully disclosed. A person may be committing insurance fraud if false or deceptive information with the intent to defraud is provided." The section will include spaces for the prescribing provider to insert the following:

1) Prescribing Provider Name;

2) Signature; and

3) Date.

n) A section entitled "For Health Plan Use Only", which will request the following information from the insurer in response to a submitted form:

1) Request date;

2) Limitation of Benefits (LOB);

3) Approved;

4) Denied;

5) Approved by (name and credentials);

6) Denied by (name and credentials);

7) Reviewed by (name and credentials);

8) Effective date;

9) Reason for denial; and

10) Additional comment, if any.

o) The month and year of the version of the form.