<u>New law</u>, relative to prior authorization forms, provides for definitions as follows:

"Health insurance issuer" means an entity that offers health insurance coverage through a plan, policy, or certificate of insurance subject to state law regulating the business of insurance. Includes health maintenance organizations as defined in <u>prior law</u> in such definition.

"Health benefit plan", "plan", "benefit" or "health insurance coverage" means services consisting of medical care provided directly through insurance or reimbursement, or otherwise, including items and services paid for as medical care under a hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer. Specifies that excepted benefits are not included as a health benefit plan.

"Prior authorization" means a utilization management criteria utilized to seek permission or waiver of a drug to be covered under a health benefit plan that provides prescription drug benefits.

 "Prior authorization form" means a standardized, uniform application developed by a health insurance issuer for the purposes of obtaining prior authorization.

<u>New law</u>, applicable on and after January 1, 2013, requires a health insurance issuer that provides prescription drug benefits to use only a single, standardized prior authorization form for obtaining any prior authorization for prescription drug benefits. Provides that such form shall not exceed two pages in length, exclusive of instructions or guiding documentation, may be accessible through multiple computer operating systems, and be filed with the Department of Insurance on or after January 1, 2013. Further provides that replacements or modifications of a prior authorization form must be filed with the department within 15 days prior to use or implementation.

Effective upon signature of the governor (May 25, 2012).

(Adds R.S. 22:1006.1)