

**First Regular Session  
Sixty-ninth General Assembly  
STATE OF COLORADO**

**ENGROSSED**

*This Version Includes All Amendments Adopted  
on Second Reading in the House of Introduction*

LLS NO. 13-0886.01 Christy Chase x2008

**SENATE BILL 13-277**

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**SENATE SPONSORSHIP**

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**HOUSE SPONSORSHIP**

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**Senate Committees**  
Health & Human Services

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**A BILL FOR AN ACT**

101     **CONCERNING THE DEVELOPMENT OF A PRIOR AUTHORIZATION**  
102             **PROCESS TO BE USED IN OBTAINING PRIOR APPROVAL FROM**  
103             **CARRIERS FOR COVERAGE OF DRUG BENEFITS.**

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**Bill Summary**

*(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://www.leg.state.co.us/billsummaries>.)*

The bill requires the commissioner of insurance (commissioner) to develop, by July 31, 2014, and prescribing providers, carriers, and, if applicable, pharmacy benefit management firms (PBMs), to use, by January 1, 2015, a uniform prior authorization process for purposes of

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.  
*Capital letters indicate new material to be added to existing statute.*  
*Dashes through the words indicate deletions from existing statute.*

SENATE  
Amended 2nd Reading  
April 29, 2013

submitting and receiving requests for prior coverage approval of a drug benefit.

The commissioner is directed to adopt rules to establish the prior authorization process, which is to include specified components aimed at creating uniformity and reducing administrative burdens on prescribing providers, carriers, and PBMs, as well as making the criteria used for deciding prior authorization requests transparent and establishing a procedure for waiving the process under extenuating circumstances.

To assist in developing the process, the commissioner is to appoint a work group of various stakeholders to make recommendations on specified aspects of the process that the commissioner is to consider, including national standards for electronic prior authorization.

Once the prior authorization process is established, the request is deemed granted if a carrier or PBM fails to use or accept the prior authorization process, fails to notify the prescribing provider within a specified period that the request is approved or denied or that additional information is required to process the request, or fails to notify the prescribing provider within a specified period after receipt of the required additional information that the request is approved or denied. An approved prior authorization is valid for at least 180 days after the date of approval.

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1 *Be it enacted by the General Assembly of the State of Colorado:*

2 **SECTION 1. Legislative declaration.** (1) The general assembly  
3 hereby finds that:

4 (a) Carriers and pharmacy benefit management firms routinely  
5 require health care providers to request prior authorization when  
6 prescribing medications or treatments not routinely covered by health  
7 plan formularies;

8 (b) Each carrier and pharmacy benefit management firm has its  
9 own prior authorization process, and the multiplicity of prior  
10 authorization processes imposes a significant administrative burden on  
11 health care providers, resulting in delayed patient access to medication  
12 and increased administrative costs; and

13 (c) A standardized prior authorization process that any health care

1 provider can use, regardless of the carrier, pharmacy benefit management  
2 firm, or health plan that covers that provider's patient, will simplify the  
3 administrative process and improve patient care by allowing health care  
4 providers to devote less time to administrative duties and more time to  
5 patient care.

6 **SECTION 2.** In Colorado Revised Statutes, **add** 10-16-124.5 as  
7 follows:

8 **10-16-124.5. Prior authorization form - drug benefits - rules**  
9 **of commissioner - definition.** (1) (a) NOTWITHSTANDING ANY OTHER  
10 PROVISION OF LAW BUT SUBJECT TO PARAGRAPH (b) OF THIS SUBSECTION  
11 (1), ON AND AFTER JANUARY 1, 2015, A CARRIER OR, IF A CARRIER  
12 CONTRACTS WITH A PHARMACY BENEFIT MANAGEMENT FIRM TO PERFORM  
13 PRIOR AUTHORIZATION SERVICES FOR DRUG BENEFITS, THE PHARMACY  
14 BENEFIT MANAGEMENT FIRM, SHALL UTILIZE THE PRIOR AUTHORIZATION  
15 PROCESS DEVELOPED PURSUANT TO SUBSECTION (3) OF THIS SECTION  
16 WHEN REQUIRING PRIOR AUTHORIZATION FOR DRUG BENEFITS.

17 (b) THIS SECTION DOES NOT APPLY TO A NONPROFIT HEALTH  
18 MAINTENANCE ORGANIZATION WITH RESPECT TO MANAGED CARE PLANS  
19 THAT PROVIDE A MAJORITY OF COVERED PROFESSIONAL SERVICES  
20 THROUGH A SINGLE CONTRACTED MEDICAL GROUP.

21 (2) (a) EXCEPT AS PROVIDED IN PARAGRAPH (b) OF THIS  
22 SUBSECTION (2), A PRIOR AUTHORIZATION REQUEST IS DEEMED GRANTED  
23 IF A CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM FAILS TO:

24 (I) UTILIZE THE PRIOR AUTHORIZATION PROCESS DEVELOPED  
25 PURSUANT TO SUBSECTION (3) OF THIS SECTION;

26 (II) FOR PRIOR AUTHORIZATION REQUESTS SUBMITTED  
27 ELECTRONICALLY:

1           (A) NOTIFY THE PRESCRIBING PROVIDER, WITHIN TWO BUSINESS  
2 DAYS AFTER RECEIPT OF THE REQUEST, THAT THE REQUEST IS APPROVED,  
3 DENIED, OR INCOMPLETE, AND IF INCOMPLETE, INDICATE THE SPECIFIC  
4 ADDITIONAL INFORMATION, CONSISTENT WITH CRITERIA POSTED  
5 PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (a) OF SUBSECTION (3)  
6 OF THIS SECTION, THAT IS REQUIRED TO PROCESS THE REQUEST; OR

7           (B) NOTIFY THE PRESCRIBING PROVIDER, WITHIN TWO BUSINESS  
8 DAYS AFTER RECEIVING THE ADDITIONAL INFORMATION REQUIRED BY THE  
9 CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM PURSUANT TO  
10 SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (II), THAT THE REQUEST  
11 IS APPROVED OR DENIED;

12           (III) FOR NONURGENT PRIOR AUTHORIZATION REQUESTS  
13 SUBMITTED ORALLY OR BY FACSIMILE OR ELECTRONIC MAIL, NOTIFY THE  
14 PRESCRIBING PROVIDER, WITHIN THREE BUSINESS DAYS AFTER RECEIPT OF  
15 THE REQUEST, THAT THE REQUEST IS APPROVED OR DENIED; AND

16           (IV) FOR URGENT PRIOR AUTHORIZATION REQUESTS SUBMITTED  
17 ORALLY OR BY FACSIMILE OR ELECTRONIC MAIL, NOTIFY THE PRESCRIBING  
18 PROVIDER, WITHIN ONE DAY AFTER RECEIPT OF THE REQUEST, THAT THE  
19 REQUEST IS APPROVED OR DENIED.

20           (b) IF A CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM  
21 NOTIFIES THE PRESCRIBING PROVIDER PURSUANT TO SUB-SUBPARAGRAPH  
22 (A) OF SUBPARAGRAPH (II) OF PARAGRAPH (a) OF THIS SUBSECTION (2)  
23 THAT A PRIOR AUTHORIZATION REQUEST IS INCOMPLETE AND THAT  
24 ADDITIONAL INFORMATION IS REQUIRED, THE PRESCRIBING PROVIDER  
25 SHALL SUBMIT THE ADDITIONAL INFORMATION WITHIN TWO BUSINESS  
26 DAYS AFTER RECEIPT OF THE NOTICE FROM THE CARRIER OR PHARMACY  
27 BENEFIT MANAGEMENT FIRM. IF THE PRESCRIBING PROVIDER FAILS TO

1 SUBMIT THE REQUIRED ADDITIONAL INFORMATION WITHIN TWO BUSINESS  
2 DAYS AFTER RECEIPT OF THE NOTICE, THE REQUEST IS NOT DEEMED  
3 GRANTED PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (2). AFTER  
4 RECEIPT OF THE REQUIRED ADDITIONAL INFORMATION, THE CARRIER OR  
5 PHARMACY BENEFIT MANAGEMENT FIRM SHALL RESPOND TO THE PRIOR  
6 AUTHORIZATION REQUEST IN ACCORDANCE WITH SUB-SUBPARAGRAPH (B)  
7 OF SUBPARAGRAPH (II) OF PARAGRAPH (a) OF THIS SUBSECTION (2).

8 (3) (a) ON OR BEFORE JULY 31, 2014, THE COMMISSIONER SHALL  
9 DEVELOP, BY RULE, A UNIFORM PRIOR AUTHORIZATION PROCESS THAT:

10 (I) IS MADE AVAILABLE ELECTRONICALLY BY THE CARRIER OR  
11 PHARMACY BENEFIT MANAGEMENT FIRM BUT THAT DOES NOT REQUIRE THE  
12 PRESCRIBING PROVIDER TO SUBMIT A PRIOR AUTHORIZATION REQUEST  
13 ELECTRONICALLY;

14 (II) REQUIRES EACH CARRIER AND PHARMACY BENEFIT  
15 MANAGEMENT FIRM TO MAKE THE FOLLOWING AVAILABLE AND  
16 ACCESSIBLE IN A CENTRALIZED LOCATION ON ITS WEB SITE:

17 (A) ITS PRIOR AUTHORIZATION REQUIREMENTS AND RESTRICTIONS,  
18 INCLUDING A LIST OF DRUGS THAT REQUIRE PRIOR AUTHORIZATION;

19 (B) WRITTEN CLINICAL CRITERIA THAT ARE EASILY  
20 UNDERSTANDABLE TO THE PRESCRIBING PROVIDER AND THAT INCLUDE THE  
21 CLINICAL CRITERIA FOR REAUTHORIZATION OF A PREVIOUSLY APPROVED  
22 DRUG AFTER THE PRIOR AUTHORIZATION PERIOD HAS EXPIRED; AND

23 (C) THE STANDARD FORM FOR SUBMITTING REQUESTS;

24 (III) ENSURES THAT CARRIERS AND PHARMACY BENEFIT  
25 MANAGEMENT FIRMS USE EVIDENCE-BASED GUIDELINES, WHEN POSSIBLE,  
26 WHEN MAKING PRIOR AUTHORIZATION DETERMINATIONS;

27 (IV) PERMITS, BUT DOES NOT REQUIRE, A PRESCRIBING PROVIDER

1 TO SUBMIT A REQUEST FOR A PRIOR AUTHORIZATION FOR DRUG BENEFITS  
2 ELECTRONICALLY TO THE CARRIER OR PHARMACY BENEFIT MANAGEMENT  
3 FIRM;

4 (V) REQUIRES CARRIERS AND PHARMACY BENEFIT MANAGEMENT  
5 FIRMS, WHEN NOTIFYING THE PRESCRIBING PROVIDER OF ITS DECISION TO  
6 APPROVE A PRIOR AUTHORIZATION REQUEST, TO INCLUDE IN THE NOTICE  
7 A UNIQUE PRIOR AUTHORIZATION NUMBER ATTRIBUTABLE TO THE  
8 PARTICULAR REQUEST, SPECIFICATION OF THE PARTICULAR DRUG BENEFIT  
9 APPROVED, THE NEXT DATE FOR REVIEW OF THE APPROVED DRUG BENEFIT,  
10 AND A LINK TO THE CURRENT CRITERIA THAT THE PRESCRIBING PROVIDER  
11 WILL NEED TO SUBMIT FOR REAPPROVAL OF THE PRIOR AUTHORIZATION;

12 AND

13

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14 (VI) REQUIRES CARRIERS AND PHARMACY BENEFIT MANAGEMENT  
15 FIRMS, WHEN NOTIFYING A PRESCRIBING PROVIDER OF ITS DECISION TO  
16 DENY A PRIOR AUTHORIZATION REQUEST, TO INCLUDE A NOTICE THAT THE  
17 COVERED PERSON HAS A RIGHT TO APPEAL THE ADVERSE DETERMINATION  
18 PURSUANT TO SECTIONS 10-16-113 AND 10-16-113.5.

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20 (b) IN DEVELOPING THE UNIFORM PRIOR AUTHORIZATION PROCESS,  
21 THE COMMISSIONER SHALL TAKE INTO CONSIDERATION THE  
22 RECOMMENDATIONS, IF ANY, OF THE WORK GROUP ESTABLISHED  
23 PURSUANT TO SUBSECTION (4) OF THIS SECTION AND THE FOLLOWING:

24 (I) NATIONAL STANDARDS PERTAINING TO ELECTRONIC PRIOR  
25 AUTHORIZATION, INCLUDING, BUT NOT LIMITED TO, STANDARDS  
26 REFERENCED IN FEDERAL LAW;

27 (II) WHETHER THE PRIOR AUTHORIZATION PROCESS SHOULD

1 REQUIRE CARRIERS AND PHARMACY BENEFIT MANAGEMENT FIRMS, WHEN  
2 REVIEWING A PRIOR AUTHORIZATION REQUEST, TO USE CLEARLY  
3 ACCESSIBLE, CONSISTENTLY APPLIED, AND WRITTEN CLINICAL CRITERIA  
4 BASED ON MEDICAL NECESSITY OR THE APPROPRIATENESS OF THE DRUG  
5 BENEFIT FOR THE COVERED PERSON;

6 (III) WHETHER THE PRIOR AUTHORIZATION PROCESS SHOULD  
7 REQUIRE CARRIERS TO TAKE INTO ACCOUNT, IN DETERMINING CRITERIA  
8 FOR PRIOR AUTHORIZATIONS, THE COLORADO PART B MEDICARE  
9 CONTRACTOR LOCAL COVERAGE DETERMINATIONS, THE FEDERAL CENTERS  
10 FOR MEDICARE AND MEDICAID SERVICES NATIONAL COVERAGE  
11 DETERMINATIONS, AND SPECIALTY SOCIETY GUIDELINES, SUCH AS THOSE  
12 OF THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY; AND

13 (IV) WHETHER CARRIERS AND PHARMACY BENEFIT MANAGEMENT  
14 FIRMS COULD USE A RULES ENGINE WITH CRITERIA-DRIVEN QUESTIONS  
15 THAT LEAD TO AN IMMEDIATE DETERMINATION OF A PRIOR  
16 AUTHORIZATION REQUEST OR REQUEST FOR SUBMITTAL OF SPECIFIC  
17 ADDITIONAL INFORMATION NEEDED TO MAKE THE DETERMINATION.

18 (c) IN ADDITION TO THE PRIOR AUTHORIZATION PROCESS, THE  
19 COMMISSIONER SHALL DEVELOP, BY RULE, A STANDARDIZED PRIOR  
20 AUTHORIZATION FORM, NOT TO EXCEED TWO PAGES IN LENGTH, FOR USE  
21 IN SUBMITTING ELECTRONIC AND NONELECTRONIC PRIOR AUTHORIZATION  
22 REQUESTS. IN DEVELOPING THE FORM, THE COMMISSIONER SHALL TAKE  
23 INTO CONSIDERATION EXISTING FORMS, INCLUDING EXISTING PRIOR  
24 AUTHORIZATION FORMS ESTABLISHED BY THE FEDERAL CENTERS FOR  
25 MEDICARE AND MEDICAID SERVICES OR THE DEPARTMENT OF HEALTH  
26 CARE POLICY AND FINANCING.

27 (4) (a) WITHIN THIRTY DAYS AFTER THE EFFECTIVE DATE OF THIS

1 SECTION, THE COMMISSIONER SHALL ESTABLISH A WORK GROUP  
2 COMPRISED OF REPRESENTATIVES OF:

3 (I) THE DIVISION OF INSURANCE;

4 (II) LOCAL AND NATIONAL CARRIERS;

5 (III) CAPTIVE AND NONCAPTIVE PHARMACY BENEFIT  
6 MANAGEMENT FIRMS;

7 (IV) PROVIDERS, INCLUDING HOSPITALS, PHYSICIANS, ADVANCED  
8 PRACTICE NURSES WITH PRESCRIPTIVE AUTHORITY, AND PHARMACISTS;

9 (V) DRUG MANUFACTURERS;

10 (VI) MEDICAL PRACTICE MANAGERS;

11 (VII) CONSUMERS; AND

12 (VIII) OTHER STAKEHOLDERS DEEMED APPROPRIATE BY THE  
13 COMMISSIONER.

14 (b) THE WORK GROUP SHALL ASSIST THE COMMISSIONER IN  
15 DEVELOPING THE PRIOR AUTHORIZATION PROCESS AND SHALL MAKE  
16 RECOMMENDATIONS TO THE COMMISSIONER ON THE ITEMS SET FORTH IN  
17 PARAGRAPH (b) OF SUBSECTION (3) OF THIS SECTION. THE WORK GROUP  
18 SHALL REPORT ITS RECOMMENDATIONS TO THE COMMISSIONER NO LATER  
19 THAN SIX MONTHS AFTER THE COMMISSIONER APPOINTS THE WORK GROUP  
20 MEMBERS. REGARDLESS OF WHETHER THE WORK GROUP SUBMITS  
21 RECOMMENDATIONS TO THE COMMISSIONER, THE COMMISSIONER SHALL  
22 NOT DELAY OR EXTEND THE DEADLINE FOR THE ADOPTION OF RULES  
23 CREATING THE PRIOR AUTHORIZATION PROCESS AS SPECIFIED IN  
24 PARAGRAPH (a) OF SUBSECTION (3) OF THIS SECTION.

25 (5) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, ON AND  
26 AFTER JANUARY 1, 2015, EVERY PRESCRIBING PROVIDER SHALL USE THE  
27 PRIOR AUTHORIZATION PROCESS DEVELOPED PURSUANT TO SUBSECTION



1 (3) OF THIS SECTION TO REQUEST PRIOR AUTHORIZATION FOR COVERAGE  
2 OF DRUG BENEFITS, AND EVERY CARRIER AND PHARMACY BENEFIT  
3 MANAGEMENT FIRM SHALL USE THAT PROCESS FOR PRIOR AUTHORIZATION  
4 FOR DRUG BENEFITS.

5 (6) UPON APPROVAL BY THE CARRIER OR PHARMACY BENEFIT  
6 MANAGEMENT FIRM, A PRIOR AUTHORIZATION IS VALID FOR AT LEAST ONE  
7 HUNDRED EIGHTY DAYS AFTER THE DATE OF APPROVAL. IF, AS A RESULT  
8 OF A CHANGE TO THE CARRIER'S FORMULARY, THE DRUG FOR WHICH THE  
9 CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM HAS PROVIDED PRIOR  
10 AUTHORIZATION IS REMOVED FROM THE FORMULARY OR MOVED TO A LESS  
11 PREFERRED TIER STATUS, THE CHANGE IN THE STATUS OF THE PREVIOUSLY  
12 APPROVED DRUG DOES NOT AFFECT A COVERED PERSON WHO RECEIVED  
13 PRIOR AUTHORIZATION BEFORE THE EFFECTIVE DATE OF THE CHANGE FOR  
14 THE REMAINDER OF THE COVERED PERSON'S PLAN YEAR. NOTHING IN THIS  
15 SUBSECTION (6) LIMITS THAT ABILITY OF A CARRIER OR PHARMACY  
16 BENEFIT MANAGEMENT FIRM, IN ACCORDANCE WITH THE TERMS OF THE  
17 HEALTH BENEFIT PLAN, TO SUBSTITUTE A GENERIC DRUG, WITH THE  
18 PRESCRIBING PROVIDER'S APPROVAL AND PATIENT'S CONSENT, FOR A  
19 PREVIOUSLY APPROVED BRAND-NAME DRUG.

20 (7) FOR PURPOSES OF THIS SECTION, A PRIOR AUTHORIZATION  
21 REQUEST IS SUBMITTED "ELECTRONICALLY" IF THE PRESCRIBING PROVIDER  
22 SUBMITS THE REQUEST TO THE CARRIER OR PHARMACY BENEFIT  
23 MANAGEMENT FIRM THROUGH A SECURE, WEB-BASED INTERNET PORTAL.  
24 A PRIOR AUTHORIZATION REQUEST SUBMITTED BY ELECTRONIC MAIL IS  
25 NOT SUBMITTED "ELECTRONICALLY".

26 (8) AS USED IN THIS SECTION:

27 (a) "PRESCRIBING PROVIDER" MEANS A PROVIDER WHO IS:

1 (I) AUTHORIZED BY LAW TO PRESCRIBE ANY DRUG OR DEVICE TO  
2 TREAT A MEDICAL CONDITION OF A COVERED PERSON; AND

3 (II) ACTING WITHIN THE SCOPE OF THAT AUTHORITY.

4 (b) "URGENT PRIOR AUTHORIZATION REQUEST" MEANS A REQUEST  
5 FOR PRIOR AUTHORIZATION OF A DRUG BENEFIT THAT, BASED ON THE  
6 REASONABLE OPINION OF THE PRESCRIBING PROVIDER WITH KNOWLEDGE  
7 OF THE COVERED PERSON'S MEDICAL CONDITION, IF DETERMINED IN THE  
8 TIME ALLOWED FOR NONURGENT PRIOR AUTHORIZATION REQUESTS,  
9 COULD:

10 (I) SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE COVERED  
11 PERSON OR THE ABILITY OF THE COVERED PERSON TO REGAIN MAXIMUM  
12 FUNCTION; OR

13 (II) SUBJECT THE COVERED PERSON TO SEVERE PAIN THAT CANNOT  
14 BE ADEQUATELY MANAGED WITHOUT THE DRUG BENEFIT THAT IS THE  
15 SUBJECT OF THE PRIOR AUTHORIZATION REQUEST.

16 **SECTION 3. No appropriation.** The general assembly has  
17 determined that this act can be implemented within existing  
18 appropriations, and therefore no separate appropriation of state moneys  
19 is necessary to carry out the purposes of this act.

20 **SECTION 4. Safety clause.** The general assembly hereby finds,  
21 determines, and declares that this act is necessary for the immediate  
22 preservation of the public peace, health, and safety.