S-0840.2

SENATE BILL 5757

State of Washington 65th Legislature 2017 Regular Session

By Senator Rivers

Read first time 02/08/17. Referred to Committee on Health Care.

1 AN ACT Relating to use of step therapy in prescription drug
2 coverage; and adding a new section to chapter 48.43 RCW.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
5 RCW to read as follows:
6 (1) When coverage of a prescription drug for the treatment of a
7 medical condition is restricted for use by a carrier or utilization
8 review organization through the use of a step therapy protocol, the
9 patient and prescribing practitioner must have access to a clear,
10 readily accessible, and convenient process to request a step therapy
11 exception override determination. A carrier or utilization review
12 organization may use its existing medical exceptions process to
13 satisfy this requirement. The process must be made easily accessible
14 on the carrier's or utilization review organization's web site.
15 (2) A step therapy override exception determination request for
16 atypical antipsychotics, antidepressants, antianxiety, or mood
17 stabilizing medications must be granted if:
18 (a) The required prescription drug is contraindicated or will
19 likely cause an adverse reaction by, or physical or mental harm to,
20 the patient;

1 (b) The required prescription drug is expected to be ineffective
2 based on the known clinical characteristics of the patient and the
3 known characteristics of the prescription drug regimen;
4 (c) The patient has tried the required prescription drug while
5 under a current or a previous health insurance or health benefit
6 plan, or another prescription drug in the same pharmacologic class or
7 with the same mechanism of action, and such prescription drug was
8 discontinued due to lack of efficacy or effectiveness, diminished
9 effect, or an adverse event;
10 (d) The required prescription drug is not in the best interest of
11 the patient, based on medical necessity; or
12 (e) The patient is stable on a prescription drug selected by his
13 or her health care provider for the medical condition under
14 consideration while on a current or previous health insurance or
15 health benefit plan.
16 (3) Upon the granting of a step therapy override exception
17 determination, the carrier or utilization review organization must
18 authorize coverage for the prescription drug prescribed by the
19 patient's treating health care provider.
20 (4) Any step therapy override exception determination is eligible
21 for appeal by an insured.
22 (5) This section does not prevent:
23 (a) A carrier or utilization review organization from requiring a
24 patient to try an AB-rated generic equivalent before providing
25 coverage for the equivalent branded prescription drug;
26 (b) A health care provider from prescribing a prescription drug
27 that is determined to be medically appropriate.
28 (6) The definitions in this subsection apply throughout this
29 section unless the context clearly requires otherwise.
30 (a) "Step therapy override exception determination" means a
31 determination as to whether a step therapy protocol should apply in a
32 particular situation, or whether the step therapy protocol should be
33 overridden in favor of immediate coverage of the health care
34 provider's selected prescription drug. This determination is based on
35 a review of the patient's or prescriber's request for an override,
36 along with supporting rationale and documentation.
37 (b) "Step therapy protocol" means a program that establishes the
38 specific sequence in which prescription drugs for a specified medical
39 condition that are medically appropriate for a particular patient and
40 are covered as a pharmacy or medical benefit, including self-

1 administered and physician-administered drugs, are covered by an
2 insurer or health plan.
3 (c) "Utilization review organization" means an entity that
4 conducts utilization review, other than a carrier performing
5 utilization review for its own health benefit plans.
6 (7) This section applies to health insurance and health benefit
7 plans issued or renewed on or after January 1, 2018.

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