SUBCHAPTER S. FORMS TO REQUEST PRIOR AUTHORIZATION

DIVISION 1. TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORMS 28 TAC §19.1803

DIVISION 3. TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS 28 TAC 19.1820

§19.1803. Definitions.

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise:

[~~(1) BIN--Processor Identification Number.~~]

(1) [~~(2)~~] CDT--Current Dental Technology Terminology code set maintained by the American Dental Association.

(2) [~~(3)~~] CPT--Current Procedural Terminology code set maintained by the American Medical Association.

(3) [~~(4)~~] Department or TDI--Texas Department of Insurance.

(4) [~~(5)~~] Form--In Division 2 of this subchapter, the Texas Standard Prior Authorization Request Form for Health Care Services. In Division 3 of this subchapter, the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits.

(5) [~~(6)~~] HCPCS--Healthcare Common Procedure Coding System.

(6) [~~(7)~~] Health benefit plan--

(A) a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a small or large employer group contract or similar coverage document offered by a health benefit plan issuer.

(B) Health benefit plan also includes:

(i) group health coverage made available by a school district in accord with Education Code §22.004;

(ii) coverage under the child health program in Health and Safety Code Chapter 62, or the health benefits plan for children in Health and Safety Code Chapter 63;

(iii) a Medicaid managed care program operated under Government Code Chapter 533, or a Medicaid program operated under Human Resources Code Chapter 32;

(iv) a basic coverage plan under Insurance Code Chapter 1551;

(v) a basic plan under Insurance Code Chapter 1575;

(vi) a primary care coverage plan under Insurance Code Chapter 1579; and

(vii) basic coverage under Insurance Code Chapter 1601.

(7) [~~(8)~~] Health benefit plan issuer--An entity authorized under the Insurance Code or another insurance law of this state that delivers or issues for delivery a health benefit plan or other coverage described in Insurance Code §1217.002 or Insurance Code §1369.252.

(8) [~~(9)~~] Health care service--A service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that is provided by a physician or other health care provider. The term includes medical or health care treatments, consultations, procedures, drugs, supplies, imaging and diagnostic services, inpatient and outpatient care, medical devices other than those included in the definition of prescription drugs in Occupations Code §551.003, and durable medical equipment. The term does not include prescription drugs or devices as defined by Occupations Code §551.003.

(9) [~~(10)~~] ICD--International Classification of Diseases.

(10) [~~(11)~~] Issuer--A health benefit plan issuer and the agent of a health benefit plan issuer that manages or administers the issuer's health care services or prescription drug benefits.

(11) [~~(12)~~] NDC--National Drug Code.

(12) [~~(13)~~] NPI number--A provider's or facility's National Provider Identifier.

[~~(14) PCN--Processor Control Number.~~]

(13) [~~(15)~~] Prescription drug--Has the meaning assigned by Occupations Code §551.003.

DIVISION 3. TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS

28 TAC §19.1820

§19.1820. Prior Authorization Request Form for Prescription Drug Benefits, Required Acceptance, and Use.

(a) Form requirements. The commissioner adopts by reference the Prior Authorization Request Form for Prescription Drug Benefits[~~form~~], Rev. 5/2021, to be accepted and used by an issuer in compliance with subsection (b) of this section. The form and its instruction sheet are on TDI's website at www.tdi.texas.gov/forms/form10.html [~~; or the form and its instruction sheet can be requested by mail from the Texas Department of Insurance, Rate and Form Review Office, Mail Code 106-1E, P.O. Box 149104, Austin, Texas 78714-9104~~]. The form must be reproduced without changes. The form provides space for the following information:

(1) the name of the issuer or the issuer's agent that manages prescription drug benefits, telephone number, and facsimile (fax) number;

(2) the date the request is submitted;

(3) identification of whether the review requested is an expedited/urgent review or a non-expedited/non-urgent review with a signature line for the prescribing provider or the prescribing provider's designee to certify:

(A) in the case of a request for an expedited/urgent review, that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function; or

(B) in the case of a request for a non-expedited/non-urgent review, that applying the standard review time frame is medically appropriate [~~a place to request an expedited or urgent review if the prescribing provider or the prescribing provider's designee certifies that applying the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function~~];

(4) the patient's name, contact telephone number, date of birth, sex, address, and identifying insurance information [~~, and, if available, BIN, PCN, and pharmacy ID numbers~~];

(5) the prescribing provider's name, NPI number, specialty, telephone and fax numbers, address, and contact person's name and telephone number;

(6) for a prescription drug [~~, its~~]:

(A) drug name;

(B) strength;

(C) route of administration;

(D) quantity;

(E) number of days' supply;

(F) expected therapy duration; and

(G) whether the medication is:

(i) a new therapy; or

(ii) continuation of therapy, and if so [~~,~~]:

(I) the approximate date therapy was initiated;

(II) a statement that the patient is complying with the drug therapy regimen; and

(III) a statement that the drug therapy regimen is effective;

(7) for a provider administered drug, the HCPCS code, NDC number, and dose per administration;

(8) for a prescription compound drug, its name, ingredients, and each ingredient's NDC number and quantity;

(9) for a prescription device, its name, expected duration of use, and if applicable, its HCPCS code;

(10) the patient's clinical information, including:

(A) diagnosis, ICD version number (if more than one version is allowed by the U.S. Department of Health and Human Services), and ICD code;

(B) to the best of the prescribing provider's knowledge, the drugs the patient has taken for this diagnosis, including:

(i) drug name, strength, and frequency;

(ii) the approximate dates or duration the drugs were taken;

(iii) patient's response, reason for failure, or allergic reaction;

(C) the patient's drug allergies, if any; and

(D) the patient's height and weight, if relevant;

(11) a list of relevant lab tests, and their dates and values; and

(12) a place for the prescribing provider to:

(A) include pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency;

(B) explain any comorbid conditions and contraindications for formulary drugs; or

(C) provide details regarding titration regimen or oncology staging, if applicable.

(13) A prescribing provider may also attach supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.).

(b) Acceptance and use of the form.

(1) If a prescribing provider submits the form to request prior authorization of a prescription drug benefit for which the issuer's plan requires prior authorization, the issuer must accept and use the form for that purpose. An issuer may also have on its website another electronic process a prescribing provider may use to request prior authorization of a prescription drug benefit.

(2) This form may be used by a prescribing provider to request prior authorization of:

(A) a prescription drug;

(B) a prescription device;

(C) formulary exceptions;

(D) quantity limit overrides; and

(E) step-therapy requirement exceptions.

(3) This form may not be used by a prescribing provider to:

(A) request an appeal;

(B) confirm eligibility;

(C) verify coverage;

(D) ask whether a prescription drug or device requires prior authorization; or

(E) request prior authorization of a health care service.

(c) Effective date. An issuer must accept a request for prior authorization of prescription drug benefits made by a prescribing provider using the form on or after the effective date of this rule. An issuer must accept a request using the form that was in place prior to the effective date of this rule for 90 days after the effective date [~~September 1, 2015~~].

(d) Availability of the form.

(1) A health benefit plan issuer must make the form available electronically on its website.

(2) A health benefit plan issuer's agent that manages or administers prescription drug benefits must make the form available electronically on its website.