

WAC 284-43-5060 General prescription drug benefit requirements.

A health carrier must not offer, renew, or issue a health benefit plan providing a prescription drug benefit, which the commissioner determines results or can reasonably be expected to result in an unreasonable restriction on the treatment of patients. A carrier may restrict prescription drug coverage based on contract or plan terms and conditions that otherwise limit coverage, such as a preexisting condition waiting period, or medical necessity.

(1) A carrier must ensure that a prescription drug benefit covers Federal Drug Administration approved prescribed drugs, medications or drug therapies that are the sole prescription drug available for a covered medical condition.

(2) A prescription drug benefit that only covers generic drugs constitutes an unreasonable restriction on the treatment of patients.

(3) A prescription drug benefit or formulary must not exclude coverage for a nonformulary drug or medication if the only formulary drug available for an enrollee's covered condition is one that the enrollee cannot tolerate or that is not clinically efficacious for the enrollee.

(4) Nothing in this chapter is intended to limit or deter the use of "Dispense as Written" prescriptions, subject to the terms and conditions of the health plan.

[WSR 16-01-081, recodified as § 284-43-5060, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.02.062, 48.18.140, 48.43.525, 48.44.050, 48.44.440(2), 48.44.460(2), 48.46.200, and 48.46.510. WSR 12-21-019 (Matter No. R 2012-03), § 284-43-816, filed 10/8/12, effective 11/8/12.]