Sec. 38a-513-7. Minimum standards for pharmaceutical and therapeutics committees

(a) (1) No insurer shall utilize a P&T committee that does not have appropriate membership.

(A) The majority of P&T committee members shall be practicing physicians, pharmacists, and other professionals who are licensed to prescribe drugs.

(B) P&T committee members shall represent a sufficient number of clinical specialties to adequately meet the needs of enrollees.

(2) Insurers shall put in place a process to ensure that there is no conflict of interest among members of the P&T committee with respect to the issuer or any pharmaceutical manufacturer. The process shall include an explanation of how conflicts of interest are dealt with if they arise.

(3) There shall be a process in place to ensure that P&T committee members abstain from voting if there is a conflict of interest.

(b) The P&T committee shall meet regularly.

(1) Insurers shall put in place a process, including timeframes, to ensure that the P&T committee meets and makes decisions on new FDA-approved drugs within a reasonable time frame after the drug is released into the market.

(2) The P&T committee shall meet at least quarterly and maintain written documentation of the rationale for its decisions regarding the development of, or revisions to, the formulary.

(3) The P&T committee shall evaluate and analyze treatment protocols and procedures related to the plans' formulary at least annually.

(c) Insurers shall develop and document procedures to ensure appropriate formulary drug review and inclusion.

(1) Insurers shall provide a copy of the policies and procedures in place to ensure that the P&T committee:

(A) Bases clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other related information.

(B) Considers the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs.

(C) Reviews new FDA-approved drugs and new FDA-approved uses for existing drugs.

(D) Reviews policies that guide exceptions and other utilization management processes, including, but not limited to, drug utilization review, quantity limits, prior authorizations, step therapies, generic substitutions, and therapeutic interchange.

(2) Insurers shall provide information on how often the formulary is updated on the company website and whether timeframes vary depending on whether the changes are advantageous to the enrollee.

(3) Insurers shall develop a process to ensure the formulary recommended by the P&T committee:

(A) Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommends drug treatment regimens that treat all disease states.

(B) Does not discourage enrollment of any group of enrollees through discriminatory tiering and utilization management processes.

(C) Includes multiple drugs, strengths and dosage forms for each therapeutic class and, if multiple drugs are available to treat a disease, they are not all placed in the highest cost share tier.

(D) Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time and based on use of a tool set forth by the Commissioner.

(Effective December 3, 2018)