OFFICE OF THE DIRECTOR
Arizona Department of Insurance and Financial Institutions
100 North 15th Avenue, Suite 261, Phoenix, AZ 85007-2630
Phone: (602) 364-3100 | Web: https://difi.az.gov

Douglas A. Ducey, Governor
Evan G. Daniels, Director

REGULATORY BULLETIN 2022-01(INS)[1]

Pursuant to Arizona Revised Statutes ("A.R.S.") § 41-1091, the Arizona Department of Insurance and Financial Institutions ("Department") occasionally issues Substantive Policy Statements to express the Department's position on current industry practices and to provide the Department's interpretation regarding Arizona law requirements. The Department's Substantive Policy Statements are intended to promote a level playing field and uniform application of statutory provisions to consumers and industry stakeholders in Arizona.

I. Purpose

The purpose of this Substantive Policy Statement is to (1) adopt and publish the two standardized prior authorization request forms, as required by A.R.S. § 20-3406; and (2) to highlight Arizona's prior authorization laws' requirements.

II. Scope

This Substantive Policy Statement is intended to disseminate the two uniform prior authorization request forms and provide regulatory guidance to all individual and group health insurers, health care services organizations, disability insurers, hospital service corporations, medical service corporations, utilization review agents, insurance trade associates and all other interested parties.

III. Background

HB2621 (Ch 115, Laws 2021), specifically A.R.S. § 20-3406(A), requires that on or before January 1, 2022, the Department approve two uniform prior authorization request forms for the following types of prior authorization requests:

1. Prescription drugs, devices and durable medical equipment, and
2. All other health care procedures, treatment and services.

The law further prescribes that any uniform prior authorization request forms approved by the Department must meet the following requirements:

- Not exceed two printed pages, although that does not apply to or include a provider's notes or documentation submitted in support of a prior authorization request.
- Meet the electronic submission and acceptance requirements prescribed by A.R.S. § 20-3403.

[1] This Substantive Policy Statement is advisory only. A Substantive Policy Statement does not include internal procedural documents that only affect the internal procedures of the Agency, and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the Arizona Administrative Procedure Act. If you believe that this Substantive Policy Statement does impose additional requirements or penalties on regulated parties you may petition the agency under A.R.S. § 41-1033 to review the Statement.

IV. Department Guidance

All health care services plans shall adopt, and providers shall use, the forms attached to this Substantive Policy Statement beginning January 1, 2023.

A. Development of the forms

HB2621 required the Department to seek input from a wide variety of stakeholders before adopting the final approved uniform prior authorization request forms. In developing draft forms for stakeholder input, the Department researched forms already adopted by other states that (1) had been developed utilizing robust stakeholder engagement, including those stakeholders from whom HB2621 requires the Department to seek input; (2) met the Department's statutory two-page directive; and, (3) have been in use for over a year in the respective states. The Department then widely circulated the draft versions of the forms to obtain feedback from the following stakeholders as required by HB2621: health care providers, health care services plans, utilization review agents, pharmacists and pharmacy benefit managers. All feedback was reviewed and incorporated into the forms as long as it did not conflict with statutory requirements or functionality.

B. Use of the forms

The uniform prior authorization request forms attached to this Substantive Policy Statement meet all requirements prescribed under Arizona's prior authorizations laws. Pursuant to A.R.S. § 20-3406(A), all providers shall exclusively use the forms attached to this Substantive Policy Statement and all health care services plans and their utilization review agents shall only accept and process the forms attached here. Prior authorization requests that are submitted on forms other than these approved forms on or after January 1, 2023 are invalid pursuant to A.R.S. § 20-3406(A). The Department acknowledges that health care services plans may seek to make non-substantive changes, such as appropriately identifying the applicable insurer on any Department-approved form or adding scrolling text fields for allowing the collection of sufficient information, however, any changes to the forms cannot substantively alter the content and layout of the form and must remain consistent with the attached versions.

A.R.S. § 20-3403 requires all health care services plans to make the Department-approved uniform prior authorization request forms accessible to providers through an electronic software system and allow for at least one other form of access to request a prior authorization, including telephone, fax or other electronic means. Furthermore, A.R.S. § 20-3403(A)(4) requires the health care service plans and their utilization agents to implement emergency after-hours procedures to request a prior authorization.

Pursuant to subsections (A) and (B) of A.R.S. § 20-3403, a health care services plan or its utilization review agent shall accept and respond to prior authorization requests for all health care services (including prescriptions) through a secure electronic transmission. However, a health care services plan may enter into a contractual arrangement with a provider and process and respond to prior authorization requests that are not submitted electronically if it shows the financial hardship that electronic submission or prior authorization requests would create for the provider or because connectivity is limited or unavailable where the provider is located. A.R.S. § 20-3403(C).

In accordance with A.R.S. § 20-3403(A), health care services plans, or their utilization review agents, must also make a listing of all prior authorization requirements available via a website and/or a provider portal. The listing shall clearly identify all health care services, drugs or devices to which a prior authorization requirement exists, including specific information or documentation that a provider must submit in order for the prior authorization request to be considered complete.

Applicable insurers are urged to provide comprehensive instructions to accompany the prior authorization request forms to facilitate understanding of the data being requested, the process for submitting the requests, and the insurer's process for reviewing and approving the requests. Finally, health care services plans and their utilization review agents are reminded to review A.R.S. § 20-3404 for information on the deadlines and notification requirements for processing/approving provider prior authorization requests.

C. Definitions

The following terms used in this Substantive Policy Statement have the same meaning as prescribed under A.R.S. §§ 20-3401 and 20-2501.

"Authorization" means a determination by a health care services plan or its utilization review agent that a health care service has been reviewed and, based on the information provided, satisfies the health care services plan's requirements for medical necessity and appropriateness and that payment under the plan will be made for that health care service. Authorization does not include any different or additional procedures, services or treatments beyond those specifically reviewed and approved by the health care services plan.

"Health care service" means a health care procedure, treatment or service that is covered under a health care services plan, including a prescription drug, device or durable medical equipment that is covered under a health care services plan.

"Health care services plan" is a plan offered by a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation or medical service corporation that contractually agrees to pay or make reimbursements for health care services expenses for one or more individuals residing in this state. Benefits under limited benefit plans defined in A.R.S. § 20-1137 are not health care service plans for purposes of providing prior authorization.

"Medically necessary" or "medical necessity" means covered health care services provided by a licensed provider acting within the provider's scope of practice in this state to prevent or treat disease, disability or other adverse conditions or their progression or to prolong life. It does not include services that are experimental or investigational or prescriptions that are prescribed off label.

"Prior authorization requirement" means a practice implemented by a health care services plan or its utilization review agent in which coverage of a health care service is dependent on an enrollee or a provider obtaining approval from the health care services plan before the service is performed, received or prescribed, as applicable. Prior authorization review includes preadmission review, pretreatment review, prospective review or utilization review procedures conducted by a health care services plan or its utilization review agent before providing a health care service, but it excludes case management or step therapy protocols.

"Provider" means a physician, health care institution or other person or entity that is licensed or otherwise authorized to furnish health care services in this state.

"Utilization review agent" has the same meaning prescribed in A.R.S. § 20-2501.

Questions pertaining to this Substantive Policy Statement may be directed to erin.klug@difi.az.gov or lifehealth@difi.az.gov.

Issued January 3, 2022

ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:

SECTION II — REASON FOR REQUEST

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	
Request Type: ☐ Initial ☐ Extension/Renewal/Amendment	Prev. Auth. #:	

SECTION III — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify 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.

Signature of Prescriber or Prescriber's Designee: _____

SECTION IV — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female
Member Name (if different from Section I):	Member ID #:	Group Name or Number:	

SECTION V — PROVDER INFORMATION

Requesting Provider or Facility		**Service Provider or Facility**	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Service Care Provider's Name:	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION VI — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other:_____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions: _____ Duration:_____ Frequency:_____ Other:_____

☐ Home Health: Order Attached? ☐ Yes ☐ No Nursing Assessment Attached? ☐ Yes ☐ No

Number of Visits: _____ Duration:_____ Frequency:_____ Other:_____

SECTION VII — CLINICAL DOCUMENTATION (Attach additional documentation as needed)

ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:

SECTION II — REASON FOR REQUEST

Check one:	☐ Initial Request	☐ Continuation/Renewal Request

Reason for request: (check all that apply)

☐ Step Therapy, Formulary Exception

☐ Quantity Exception

☐ Specialty Drug

☐ Prior Authorization

☐ Medical Device

☐ Durable Medical Equipment (DME)

☐ Other *(please specify)*_____

SECTION III — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify 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.

Signature of Prescriber or Prescriber's Designee: _____

SECTION IV — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female	
Address:	City:		State:	ZIP Code:
Subscriber Name (if different from Section I):	Member ID #:	Group Name or Number:		
BIN # (if available):	PCN (if available):	Rx ID # (if available):		

SECTION V — PRESCRIBER/ORDERING PROVDER INFORMATION

Name:		NPI #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION VI — PRESCRIPTION DRUG INFORMATION

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

□ New therapy □ Continuation of therapy (approximate date therapy initiated:_____)

For Provider Administered Drugs Only:

HCPCS Code:_____ NDC #:_____ Dose Per Administration: _____

ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

SECTION VII — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:					
Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

SECTION VIII — PRESCRIPTION DME or MEDICAL DEVICE INFORMATION

Requested DME or Medical Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

SECTION IX — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:
Patient's diagnosis related to this request:	ICD Version:	ICD Code:

Drugs patient has taken for this diagnosis: *(Provide the following information to the best of your knowledge)*

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION X — JUSTIFICATION (Provide or attach any additional justification here: Notes, Treatment plans, lab/test results, etc)