

215 ILCS 175 Organ Transplant Medication Notification Act

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Sec. 5. Applicability. This Act shall apply solely to cases of immunosuppressive therapy when

- (i) an immunosuppressant drug has been prescribed to a patient to prevent the rejection of transplanted organs and tissues and
- (ii) as set forth in Section 15 of this Act, a prescribing physician has indicated on a prescription "may not substitute". This Act does not apply to medication orders issued for immunosuppressant drugs for any in-patient care in a licensed hospital.

Sec. 10. Definitions.

For the purpose of this Act:

"Health insurance policy or health care service plan" means any policy of health or accident insurance subject to the provisions of the Illinois Insurance Code, Health Maintenance Organization Act, Voluntary Health Services Plan Act, Counties Code, Municipal Code, School Code, and State Employees Group Insurance Act.

"Immunosuppressant drugs" mean drugs that are used in immunosuppressive therapy to inhibit or prevent the activity of the immune system. "Immunosuppressant drugs" are used clinically to prevent the rejection of transplanted organs and tissues. "Immunosuppressant drugs" do not include drugs for the treatment of autoimmune diseases or diseases that are most likely of autoimmune origin.

Sec. 15. Quality assurance in patient care.

In accordance with the Pharmacy Practice Act, when a prescribing physician has indicated on a prescription "may not substitute", a health insurance policy or health care service plan that covers immunosuppressant drugs may not require or cause a pharmacist to interchange another immunosuppressant drug or formulation issued on behalf of a person to inhibit or prevent the activity of the immune system of a patient to prevent the rejection of transplanted organs and tissues without notification and the documented consent of the prescribing physician and the patient, or the parent or guardian if the patient is a child, or the spouse of a patient who is authorized to consent to the treatment of the person.

Except as provided by subsections (a), (b), and (c) of Section 20 of this Act, patient co-payments, deductibles, or other charges for the prescribed drug for which another immunosuppressant drug or formulation is not interchanged shall remain the same for the enrollment period established by the health insurance policy or plan.

Sec. 20. Provision of notice; formulary changes.

(a) At least 60 days prior to making any formulary change that alters the terms of coverage for a patient receiving immunosuppressant drugs or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving, a policy or plan sponsor must, to the extent

possible, notify the prescribing physician and the patient, or the parent or guardian if the patient is a child, or the spouse of a patient who is authorized to consent to the treatment of the patient. The notification shall be in writing and shall disclose the formulary change, indicate that the prescribing physician may initiate an appeal, and include information regarding the procedure for the prescribing physician to initiate the policy or plan sponsor's appeal process.

(b) As an alternative to providing written notice, a policy or plan sponsor may provide the notice electronically if, and only if, the patient affirmatively elects to receive such notice electronically. The notification shall disclose the formulary change, indicate that the prescribing physician may initiate an appeal, and include information regarding the procedure for the prescribing physician to initiate the policy or plan sponsor's appeal process.

(c) At the time a patient requests a refill of the immunosuppressant drug, a policy or plan sponsor may provide the patient with the written notification required under subsection (a) of this Section along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

(d) Nothing in this Section shall prohibit insurers or pharmacy benefit managers from using managed pharmacy care tools, including, but not limited to, formulary tiers, generic substitution, therapeutic interchange, prior authorization, or step therapy, so long as an exception process is in place allowing the prescriber to petition for coverage of a non-preferred drug if sufficient clinical reasons justify an exception to the normal protocol.

(Source: P.A. 96-766, eff. 1-1-10.)