§ 1342.74. Preexposure and postexposure HIV prophylaxis

(a)(1) Notwithstanding Section 1342.71, a health care service plan shall not subject antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy, except as provided in paragraph (2).

(2) If the United States Food and Drug Administration has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV, this section does not require a health care service plan to cover all of the therapeutically equivalent versions without prior authorization or step therapy, if at least one therapeutically equivalent version is covered without prior authorization or step therapy.

(b) Notwithstanding any other law, a health care service plan shall not prohibit, or permit a delegated pharmacy benefit manager to prohibit, a pharmacy provider from dispensing preexposure prophylaxis or postexposure prophylaxis.

(c) A health care service plan shall cover preexposure prophylaxis and postexposure prophylaxis that has been furnished by a pharmacist, as authorized in Sections 4052.02 and 4052.03 of the Business and Professions Code, including the pharmacist's services and related testing ordered by the pharmacist. A health care service plan shall pay or reimburse, consistent with the requirements of this chapter, for the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health care service plan has an out-of-network pharmacy benefit.

(d) This section does not require a health care service plan to cover preexposure prophylaxis or postexposure prophylaxis by a pharmacist at an out-of-network pharmacy, unless the health care service plan has an out-of-network pharmacy benefit.

(e) This section shall not apply to Medi-Cal managed care plans contracting with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that the services described in this section are excluded from coverage under the contract between the Medi-Cal managed care plans and the State Department of Health Care Services.

HISTORY:
Added Stats 2019 ch 532 § 4 (SB 159), effective January 1, 2020. Amended Stats 2024 ch 1 § 2 (SB 339), effective February 6, 2024.

§ 1342.75. Coverage for certain medications without prior authoriza- tion or utilization review

(a) Notwithstanding any other law, a group or individual health care service plan offering an outpatient prescription drug benefit shall provide coverage for at least one medication approved by the United States Food and Drug Administration in each of the following categories without prior authorization, step therapy, or utilization review:

(1) Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.

(2) Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.

(3) A long-acting buprenorphine product.

(4) A long-acting injectable naltrexone product.

(b) This section does not prohibit a health care service plan from selecting an AB-rated generic equivalent, biosimilar, as defined in Section 262(i)(2) of Title 42 of the United States Code, or interchangeable biological product, as defined in Section 262(i)(3) of Title 42 of the United States Code, to meet the requirements of subdivision (a).

HISTORY:
Added Stats 2024 ch 633 § 1 (AB 1842), effective January 1, 2025.