reviewed by a physician who is currently licensed as a physician and surgeon in a state, district, or territory of the United States.

(d) The appeal of an adverse determination requested by a physician regarding clinical or medical necessity of a drug, may only be reviewed by an individual who is currently licensed in a state, district, or territory of the United States as:

(i) a physician and surgeon; or

(ii) a pharmacist.

(e) An insurer shall ensure that an adverse preauthorization determination regarding clinical or medical necessity is made by an individual who:

(i) has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested; or

(ii) consults with a specialist who has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested regarding the request before making the determination.

(f) An insurer shall specify how long an authorization is valid.

(4) (a) An insurer that removes a drug from the insurer's formulary shall **Ŝ→ :**

(i) ←Ŝ permit an enrollee, an enrollee's designee, or an enrollee's network provider to request an exemption from the change to the formulary for the purpose of providing the patient with continuity of care **Ŝ→ [.] ;**

and

(ii) have a process to review and make a decision regarding an exemption requested under Subsection (4)(a)(i). ←Ŝ

(b) If an insurer makes a change to the formulary for a drug in the middle of a plan year, the insurer may not implement the changes for an enrollee that is on an active course of treatment for the drug unless the insurer provides the enrollee with notice at least 30 days before the day on which the change is implemented.

(5) Before April 1, 2021, and before April 1 of each year thereafter, an insurer with a preauthorization requirement shall report to the department, for the previous calendar year, the percentage of authorizations, not including a claim involving urgent care as defined in 29 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the request for authorization.

(6) An insurer may not have a preauthorization requirement for emergency health care as described in Section 31A-22-627.

Section 5. **Effective date.**