

§ 58-56A-3. Consumer protections.

(a) A pharmacy or pharmacist shall have the right to provide an insured information regarding the amount of the insured's cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be penalized by a pharmacy benefits manager for discussing any information described in this section or for selling a lower-priced drug to the insured if one is available.

(b) A pharmacy benefits manager shall not, through contract, prohibit a pharmacy from offering and providing direct and limited delivery services to an insured as an ancillary service of the pharmacy, as delineated in the contract between the pharmacy benefits manager and the pharmacy.

(b1) A pharmacy benefits manager shall not prohibit a pharmacist or pharmacy from charging a minimal shipping and handling fee to the insured for a mailed or delivered prescription if the pharmacist or pharmacy discloses all of the following to the insured before delivery:

- (1) The fee will be charged.
- (2) The fee may not be reimbursed by the health benefit plan, insurer, or pharmacy benefits manager.
- (3) The charge is specifically agreed to by the health benefit plan or pharmacy benefits manager.

(c) A pharmacy benefits manager shall not charge, or attempt to collect from, an insured a copayment that exceeds the total submitted charges by the network pharmacy.

(c1) When calculating an insured's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other applicable cost-sharing requirement, the insurer or pharmacy benefits manager shall include any amounts paid by the insured, or on the insured's behalf, for a prescription that is either:

- (1) Without an AB-rated generic equivalent.
- (2) With an AB-rated generic equivalent if the insured has obtained authorization for the drug through any of the following:
 - a. Prior authorization from the insurer or pharmacy benefits manager.
 - b. A step therapy protocol.
 - c. The exception or appeal process of the insurer or pharmacy benefits manager.

This subsection shall not apply to an insured covered by a high deductible health plan, as that term is defined in section 223 of the Internal Revenue Code, if its application would render the insured ineligible for a health savings account under section 223 unless (i) the insured has satisfied the minimum deductible under section 223 or (ii) the prescription qualifies as preventive care under section 223.

(c2) For purposes of this section, the term "generic equivalent" means a drug that has an identical amount of the same active ingredients in the same dosage form; meets applicable standards of strength, quality, and purity according to the United States Pharmacopeia or other nationally recognized compendium; and which, if administered in the same amount, would provide comparable therapeutic effects. The term "generic equivalent" does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the Administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

(d) Any contract for the provision of a network to deliver health care services between a pharmacy benefits manager and insurer shall be made available for review by the Department.

(e) Repealed by Session Laws 2021-161, s. 1(b), effective October 1, 2021, and applicable to any contracts entered into, renewed, or amended on or after that date. (2017-116, s. 2; 2021-161, s. 1(b); 2023-134, s. 30.10.)