

By Senator Cruz

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1 A bill to be entitled
2 An act relating to prescription drug price
3 transparency; amending s. 499.012, F.S.; prohibiting
4 permits for prescription drug manufacturers and
5 nonresident prescription drug manufacturers and for
6 certain wholesale distributors of prescription drugs
7 from being renewed unless specified requirements are
8 met; authorizing the Department of Business and
9 Professional Regulation to suspend or revoke
10 manufacturer permits and wholesale distributor permits
11 under specified circumstances; amending s. 499.0121,
12 F.S.; defining the term "price"; providing reporting
13 requirements for certain entities that engage in
14 wholesale distributions of prescription drugs;
15 authorizing the department to request certain
16 documentation and information; requiring the
17 department to prescribe by rule specified timeframes;
18 authorizing the department to extend specified
19 timeframes; specifying what constitutes violations of
20 specified laws; providing penalties and fines for
21 violations; providing disposition of such fines;
22 creating s. 499.026, F.S.; providing definitions;
23 providing requirements for notifications by
24 manufacturers of prescription drug price increases
25 under certain circumstances; providing reporting
26 requirements; requiring the department to compile a
27 list of specified drugs; authorizing the department to
28 request certain documentation and information;
29 requiring the department to prescribe by rule

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30 specified timeframes; authorizing the department to
31 extend specified timeframes; providing duties of the
32 department; specifying what constitutes violations of
33 specified laws; prohibiting certain prescription drugs
34 from being included in specified drug formularies;
35 providing an exception; providing penalties and fines
36 for violations; providing disposition of such fines;
37 requiring the department to adopt rules; amending s.
38 499.05, F.S.; requiring the department to adopt rules;
39 conforming provisions to changes made by the act;
40 amending s. 624.490, F.S.; providing definitions;
41 providing reporting requirements for registered
42 pharmacy benefit managers; authorizing the Office of
43 Insurance Regulation to request certain documentation
44 and information; requiring the Financial Services
45 Commission to prescribe by rule specified timeframes;
46 authorizing the office to extend specified timeframes;
47 requiring registered pharmacy benefit managers to
48 maintain a website for a specified purpose and to
49 update the information on the website under certain
50 circumstances; specifying what constitutes violations
51 of specified laws; providing penalties and fines for
52 violations; providing disposition of such fines;
53 creating ss. 627.42384 and 641.3131, F.S.; requiring
54 certain health insurers and health maintenance
55 organizations, respectively, to submit and update
56 contact information for single points of contact for a
57 specified use; requiring the office to maintain and
58 publish such points of contact; requiring such health

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59 insurers and health maintenance organizations to
60 notify certain insureds and subscribers, respectively,
61 within a specified timeframe of drug formulary
62 changes; providing applicability; amending ss.
63 627.64741, 627.6572, and 641.314, F.S.; defining the
64 term "net price"; providing additional requirements
65 for contracts between pharmacy benefit managers and
66 individual health insurers, group health insurers, and
67 health maintenance organizations, respectively;
68 providing applicability; amending ss. 110.12315,
69 409.815, 409.91195, 409.912, and 499.067, F.S.;
70 conforming provisions to changes made by the act;
71 providing an effective date.

72

73 Be It Enacted by the Legislature of the State of Florida:

74

75 Section 1. Paragraph (f) is added to subsection (1) of
76 section 499.012, Florida Statutes, to read:

77 499.012 Permit application requirements.—

78 (1)

79 (f)1. A permit for a prescription drug manufacturer or
80 nonresident prescription drug manufacturer may not be renewed
81 unless the prescription drug manufacturer or nonresident
82 prescription drug manufacturer meets the requirements of s.
83 499.026. The department may suspend or revoke the permit of a
84 manufacturer that fails to comply with the requirements of s.
85 499.026.

86 2. A permit for a prescription drug wholesale distributor,
87 out-of-state prescription drug wholesale distributor, retail

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88 pharmacy drug wholesale distributor, veterinary prescription
89 drug wholesale distributor, or limited prescription drug
90 veterinary wholesale distributor may not be renewed unless the
91 wholesale distributor meets the requirements of s. 499.0121(16).
92 The department may suspend or revoke the permit of a wholesale
93 distributor that fails to comply with the requirements of s.
94 499.0121(16).

95 Section 2. Subsection (16) is added to section 499.0121,
96 Florida Statutes, to read:

97 499.0121 Storage and handling of prescription drugs;
98 recordkeeping; prescription drug price report requirements;
99 penalties for noncompliance.—The department shall adopt rules to
100 implement this section as necessary to protect the public
101 health, safety, and welfare. Such rules shall include, but not
102 be limited to, requirements for the storage and handling of
103 prescription drugs and for the establishment and maintenance of
104 prescription drug distribution records.

105 (16) PRESCRIPTION DRUG PRICE REPORT AND PENALTIES FOR
106 NONCOMPLIANCE.—

107 (a) As used in this subsection, the term "price" means the
108 manufacturer's list price for a prescription drug to wholesalers
109 or direct purchasers in the United States, not including prompt
110 pay or other discounts, rebates, or reductions in price, for the
111 most recent month for which the information is available, as
112 reported in wholesale price guides or other publications of drug
113 or biological pricing data.

114 (b) By July 1 of each year, each prescription drug
115 wholesale distributor, out-of-state prescription drug wholesale
116 distributor, retail pharmacy drug wholesale distributor,

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117 prescription drug wholesale distributor, veterinary prescription
118 drug wholesale distributor, or limited prescription drug
119 veterinary wholesale distributor, or each manufacturer or
120 repackager that engages in the wholesale distribution of
121 prescription drugs, shall submit a report to the department on
122 each prescription drug for which the price, during the previous
123 calendar year:

124 1. Was \$100 or more for a 30-day supply or for a course of
125 treatment lasting less than 30 days; or

126 2. Increased by at least 10 percent over the previous
127 price.

128 (c) The report must include, at a minimum, the following
129 information:

130 1. The name and the price at the time of the report of each
131 prescription drug specified in paragraph (b) and the cumulative
132 percentage price increase during the previous calendar year.

133 2. The length of time the prescription drug has been on the
134 market.

135 3. The factors that contributed to the price increase.

136 4. The name of any generic version of the prescription drug
137 available on the market.

138 5. The total sales revenue for the prescription drug during
139 the previous calendar year.

140 6. The introductory price of the prescription drug when it
141 was approved by the United States Food and Drug Administration
142 and the cumulative yearly increase, by calendar year, in the
143 price of the drug during the previous 5 years or during the
144 number of years the drug has been on the market, whichever is
145 less.

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146 7. Any prompt pay or discount, rebate, or reduction in
147 price provided by the reporting wholesale distributor or
148 manufacturer or repackager that engages in the wholesale
149 distribution of prescription drugs when selling a prescription
150 drug to a manufacturer, pharmacy, pharmacy benefit manager, and
151 other entities.

152 8. The documentation necessary to support the information
153 reported under this paragraph.

154 (d) The department may make a written request to the
155 reporting wholesale distributor, manufacturer, or repackager for
156 supporting documentation or additional information concerning
157 the report. The department shall prescribe by rule the
158 timeframes for the department's request for documentation or
159 information and for the response by the reporting wholesale
160 distributor, manufacturer, or repackager. The department may
161 extend the timeframe, if necessary, for the response by the
162 wholesale distributor, manufacturer, or repackager.

163 (e) A wholesale distributor, or a manufacturer or
164 repackager that engages in the wholesale distribution of
165 prescription drugs, violates this subsection if the wholesale
166 distributor, manufacturer, or repackager:

167 1. Fails to timely submit the report required under this
168 subsection;

169 2. Fails to provide information required under this
170 subsection;

171 3. Fails to timely respond to a written request by the
172 department with regard to the report required under this
173 subsection; or

174 4. Provides inaccurate or incomplete information in the

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175 report required under this subsection.

176 (f)1. The department may deny an application for a renewal
177 permit or registration or suspend or revoke a registration
178 certificate or a permit of a prescription drug wholesale
179 distributor, or a manufacturer or repackager that engages in the
180 wholesale distribution of prescription drugs, for violating this
181 subsection.

182 2.a. The department may also impose an administrative fine,
183 not to exceed \$5,000 per violation per day, for a violation of
184 this subsection or a rule adopted to administer this subsection.
185 Each day the violation continues constitutes a separate
186 violation, and each such separate violation is subject to a
187 separate fine.

188 b. In determining the amount of fine to be levied for a
189 violation of this subsection, the department must consider the
190 following factors:

191 (I) The severity of the violation.

192 (II) Any action taken by the permittee to correct the
193 violation or to remedy complaints.

194 (III) Any previous violation.

195 c. All fines collected under this subparagraph shall be
196 deposited into the Public Medical Assistance Trust Fund
197 administered by the Agency for Health Care Administration, to be
198 used to help the uninsured pay for health care.

199 Section 3. Section 499.026, Florida Statutes, is created to
200 read:

201 499.026 Prescription drug price transparency.—

202 (1) As used in this section, the term:

203 (a) "Agency" means the Agency for Health Care

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204 Administration.

205 (b) "Division" means the Division of Consumer Services of
206 the Department of Agriculture and Consumer Services.

207 (c) "Drug" means a prescription drug.

208 (d) "Health insurer" means a health insurer issuing major
209 medical coverage through an individual or group policy or a
210 health maintenance organization issuing major medical coverage
211 through an individual or group contract, regulated under chapter
212 627 or chapter 641.

213 (e) "Medicaid" means the Agency for Health Care
214 Administration Medicaid program.

215 (f) "Office" means the Office of Insurance Regulation of
216 the Financial Services Commission.

217 (g) "Price" means the manufacturer's list price for a drug
218 to wholesalers or direct purchasers in the United States, not
219 including prompt pay or other discounts, rebates, or reductions
220 in price, for the most recent month for which the information is
221 available, as reported in wholesale price guides or other
222 publications of drug or biological pricing data.

223 (2) (a) At least 120 days before the effective date of any
224 single manufacturer increase of at least 10 percent in the price
225 of a drug, a manufacturer must provide notice of the upcoming
226 drug price increase to:

227 1. The department, the Department of Health, the agency,
228 the division, and the office.

229 2. Every health insurer that covers the drug. The
230 manufacturer shall use the contact list published by the office
231 under ss. 627.42384 and 641.3131 to provide notice to health
232 insurers. Notification shall be presumed to occur on the date

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233 that the manufacturer attempts to communicate with the
234 applicable point of contact published by the office.

235 (b) The notices must include, at a minimum, the following
236 information:

237 1. The name and current price of the drug.

238 2. The date that the increase will become effective.

239 3. The dollar amount of the intended increase in the price
240 of the drug.

241 4. The percentage price increase.

242 5. A statement of whether the price increase is
243 necessitated by a change or improvement of the drug and, if so,
244 a description of the change or improvement.

245 6. A description of any other factors that contributed to
246 the price increase.

247 7. The documentation necessary to support the information
248 reported under subparagraphs 5. and 6.

249 (3) (a) By July 1 of each year, a manufacturer shall submit
250 a report to the department, the Department of Health, the
251 agency, the division, and the office on each drug for which the
252 price, during the previous calendar year:

253 1. Was \$100 or more for a 30-day supply or for a course of
254 treatment lasting less than 30 days; or

255 2. Increased by at least 10 percent over the previous price
256 in a single manufacturer price.

257 (b) The report must include, at a minimum, the following
258 information:

259 1. The name and the price at the time of the report of each
260 drug specified in paragraph (a) and the cumulative percentage
261 price increase during the previous calendar year.

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- 262 2. The length of time the drug has been on the market.
- 263 3. The factors that contributed to the price increase.
- 264 4. The name of any generic version of the drug available on
265 the market.
- 266 5. The research and development costs associated with the
267 drug that were paid using public funds.
- 268 6. The direct costs incurred by the manufacturer to
269 manufacture, market, and distribute the drug and to ensure
270 ongoing safety and effectiveness research associated with the
271 drug.
- 272 7. The total sales revenue for the drug during the previous
273 calendar year.
- 274 8. The manufacturer's profit attributable to the drug
275 during the previous calendar year.
- 276 9. The introductory price of the drug when it was approved
277 by the United States Food and Drug Administration and the
278 cumulative yearly increase, by calendar year, in the price of
279 the drug during the previous 5 years or during the number of
280 years the drug has been on the market, whichever is less.
- 281 10. The 10 highest prices paid for the drug during the
282 previous year in other countries.
- 283 11. The documentation necessary to support the information
284 reported under this paragraph.
- 285 (4) (a) Before reviewing the data in the report filed under
286 subsection (3), the department, in consultation with the
287 Department of Health, the agency, and the office, shall compile
288 a list of drugs that have a significant cost to the state or
289 that are designated as being critical to public health. Such
290 drugs may be sourced from the Medicaid drug utilization data and

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291 drug spending data, the division's drug spending data, and the
292 drug spending data of health insurers and health plans and their
293 pharmacy benefit managers.

294 (b) After receiving the report required under subsection
295 (3), the department:

296 1. May make a written request to the manufacturer for
297 supporting documentation or additional information concerning
298 the report. The department shall prescribe by rule the
299 timeframes for the department's request for documentation or
300 information and for the manufacturer's response to the request.
301 The department may extend the timeframe, if necessary, for the
302 manufacturer's response.

303 2. Shall review the costs and the factors contributing to
304 each drug price or drug price increase in the report.

305 3. Shall review the price and price increase of each drug
306 on the list compiled under paragraph (a) and each drug on the
307 lists reported by wholesale distributors and other entities
308 engaged in wholesale distribution of prescription drugs and by
309 registered pharmacy benefit managers under ss. 499.0121(16) and
310 624.490(6)(b), respectively, to make sure that any drug on the
311 compiled and reported lists which fits the criterion in
312 subparagraph (3)(a)1. or subparagraph (3)(a)2. is also reported
313 by the drug's manufacturer under subsection (3).

314 4. Shall, in consultation with the Department of Health,
315 the division, and the office, determine whether the manufacturer
316 has violated this section.

317 (5) A manufacturer violates this section if the
318 manufacturer:

319 (a) Fails to timely submit notices or reports required

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320 under this section;

321 (b) Fails to provide information required under this
322 section;

323 (c) Fails to timely respond to a written request by the
324 department with regard to the notices or report required under
325 this section; or

326 (d) Provides inaccurate or incomplete information in the
327 notices or report required under this section.

328 (6) A drug for which the manufacturer does not comply with
329 the notification or reporting requirements under this section
330 may not be included in the Medicaid's and state group health
331 insurance's drug formularies unless the drug is the most
332 clinically appropriate, clinically effective, and lowest net-
333 cost drug.

334 (7) (a) The department may deny an application for a renewal
335 permit or suspend or revoke a permit of a prescription drug
336 manufacturer or nonresident prescription drug manufacturer for
337 violating this section.

338 (b)1. The department may also impose an administrative
339 fine, not to exceed \$5,000 per violation per day, for a
340 violation of this section or a rule adopted under this section.
341 Each day the violation continues constitutes a separate
342 violation, and each such separate violation is subject to a
343 separate fine.

344 2. In determining the amount of fine to be levied for a
345 violation of this section, the department, in consultation with
346 the Department of Health, the agency, the division, and the
347 office, must consider the following factors:

348 a. The severity of the violation.

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349 b. Any action taken by the permittee to correct the
350 violation or to remedy complaints.

351 c. Any previous violation.

352 3. All fines collected under this section shall be
353 deposited into the Public Medical Assistance Trust Fund
354 administered by the agency, to be used to help the uninsured pay
355 for health care.

356 (8) The department shall adopt rules to administer this
357 section.

358 Section 4. Paragraph (m) of subsection (1) of section
359 499.05, Florida Statutes, is amended, and paragraph (o) is added
360 to that subsection, to read:

361 499.05 Rules.—

362 (1) The department shall adopt rules to implement and
363 enforce this chapter with respect to:

364 (m) Wholesale distributor reporting requirements of s.
365 499.0121(14) and (16) ~~s. 499.0121(14).~~

366 (o) Manufacturer notification and reporting requirements of
367 s. 499.026(2) and (3).

368 Section 5. Subsection (6) of section 624.490, Florida
369 Statutes, is renumbered as subsection (7), and a new subsection
370 (6) is added to that section, to read:

371 624.490 Registration of pharmacy benefit managers;
372 prescription drug price report and public access requirements;
373 penalties for noncompliance.—

374 (6) (a) As used in this subsection, the term:

375 1. "Negotiated price" means the value at which a
376 prescription drug is sold by a prescription drug manufacturer,
377 prescription drug wholesale distributor, or pharmacy, under a

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378 prescription drug benefits coverage administered by a pharmacy
379 benefit manager, before any tax or cost is added and any
380 discount, rebate, or reduction in price, including a rebate
381 offered to the pharmacy benefit manager, is subtracted.

382 2. "Net price" means the value at which a prescription drug
383 is sold by a prescription drug manufacturer, prescription drug
384 wholesale distributor, or pharmacy, under a prescription drug
385 benefits coverage administered by a pharmacy benefit manager,
386 after all taxes and other costs are added and all discounts,
387 rebates, and reductions in price are subtracted, including any
388 rebate offered to the pharmacy benefit manager which is passed
389 on to the health insurer or health maintenance organization.

390 3. "Rebate offered to a pharmacy benefit manager" means a
391 direct payment by a prescription drug manufacturer, prescription
392 drug wholesale distributor, or pharmacy to a pharmacy benefit
393 manager for a prescription drug dispensed to an insured or
394 subscriber. Such payment serves an incentive for the pharmacy
395 benefit manager to promote use of the prescription drug, and the
396 pharmacy benefit manager may choose to keep the payment or to
397 pass it on, in full or in part, to the health insurer or health
398 maintenance organization.

399 (b)1. By July 1 of each year, a registered pharmacy benefit
400 manager shall submit a report to the office on each prescription
401 drug for which the negotiated price, during the previous
402 calendar year:

403 a. Was \$100 or more for a 30-day supply or for a course of
404 treatment lasting less than 30 days; or

405 b. Increased by at least 10 percent over the previous
406 negotiated price.

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407 2. The report must include, at a minimum, the following
408 information:

409 a. The name and the negotiated price at the time of the
410 report of each prescription drug specified in subparagraph 1.
411 and the cumulative percentage negotiated price increase during
412 the previous calendar year.

413 b. The name of any generic version of the prescription drug
414 available on the market.

415 c. The total sales revenue of the pharmacy benefit manager
416 for the prescription drug during the previous calendar year.

417 d. The documentation necessary to support the information
418 reported under this paragraph.

419 3. The office may make a written request to the pharmacy
420 benefit manager for supporting documentation or additional
421 information concerning the report. The commission shall
422 prescribe by rule the timeframes for the office's request for
423 documentation or information and for the pharmacy benefit
424 manager's response to the request. The office may extend the
425 timeframe, if necessary, for the pharmacy benefit manager's
426 response.

427 (c) A registered pharmacy benefit manager shall maintain a
428 website that provides public access to the net price of each
429 prescription drug. The registered pharmacy benefit manager shall
430 update the net price of a prescription drug on the website at
431 least 90 days before the net price of the prescription drug
432 changes.

433 (d) A registered pharmacy benefit manager violates this
434 subsection if the registered pharmacy benefit manager:

435 1. Fails to timely submit the report required under

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436 paragraph (b);

437 2. Fails to provide information required under paragraph
438 (b);

439 3. Fails to timely respond to a written request by the
440 office with regard to the report required under paragraph (b);

441 4. Provides inaccurate or incomplete information in the
442 report required under paragraph (b); or

443 5. Fails to maintain a website for access to net prices of
444 prescription drugs or to update the net prices on the website,
445 as required under paragraph (c).

446 (e)1. The office may deny an application for renewal
447 registration or suspend or revoke a registration certificate of
448 a pharmacy benefit manager for violating this subsection.

449 2.a. The office may also impose an administrative fine, not
450 to exceed \$5,000 per violation per day, for a violation of this
451 subsection or a rule adopted to administer this subsection. Each
452 day the violation continues constitutes a separate violation,
453 and each such separate violation is subject to a separate fine.

454 b. In determining the amount of fine to be levied for a
455 violation of this subsection, the office must consider the
456 following factors:

457 (I) The severity of the violation.

458 (II) Any action taken by the pharmacy benefit manager to
459 correct the violation or to remedy complaints.

460 (III) Any previous violation.

461 c. All fines collected under this subsection shall be
462 deposited into the Public Medical Assistance Trust Fund
463 administered by the Agency for Health Care Administration, to be
464 used to help the uninsured pay for health care.

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465 Section 6. Section 627.42384, Florida Statutes, is created
466 to read:

467 627.42384 Formulary changes resulting from drug price
468 increases.-

469 (1) A health insurer issuing a major medical individual or
470 group policy shall submit, and update as necessary, contact
471 information for a single point of contact for use by
472 prescription drug manufacturers to comply with s. 499.026. The
473 office shall maintain and publish on its website a list of such
474 points of contact.

475 (2) A health insurer issuing a major medical individual or
476 group policy must provide written notice to each affected
477 insured and each prescribing health care provider at least 90
478 days before making a drug formulary change that results from a
479 prescription drug price increase reported by a drug manufacturer
480 under s. 499.026(2).

481 (3) This section applies to policies entered into or
482 renewed on or after January 1, 2023.

483 Section 7. Paragraph (b) of subsection (1) of section
484 627.64741, Florida Statutes, is redesignated as paragraph (c),
485 subsection (5) is amended, a new paragraph (b) is added to
486 subsection (1), and paragraphs (c) through (f) are added to
487 subsection (2) of that section, to read:

488 627.64741 Pharmacy benefit manager contracts.-

489 (1) As used in this section, the term:

490 (b) "Net price" means the value at which a prescription
491 drug is sold by a prescription drug manufacturer, prescription
492 drug wholesale distributor, or pharmacy, under a prescription
493 drug benefits coverage administered by a pharmacy benefit

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494 manager, after all taxes and other costs are added and all
495 discounts, rebates, and reductions in price are subtracted,
496 including any rebate offered to the pharmacy benefit manager
497 which is passed on to the health insurer.

498 (2) A contract between a health insurer and a pharmacy
499 benefit manager must require that the pharmacy benefit manager:

500 (c) Maintain a website that provides public access to the
501 net price of each covered prescription drug and update the net
502 price of a covered prescription drug on the website at least 90
503 days before the net price of the covered prescription drug
504 changes.

505 (d) Provide written notice to each affected insured and
506 each prescribing health care provider at least 90 days before
507 making a change in the drug formulary or in the net price of a
508 covered prescription drug, including a change that results from
509 a price increase of a covered prescription drug reported by a
510 drug manufacturer under s. 499.026(2).

511 (e) Inform an affected insured, in writing, of the net
512 price of each covered prescription drug for which the insured
513 has made a payment.

514 (f) Provide in writing to each insured and each prescribing
515 health care provider the address of the pharmacy benefit
516 manager's website where the list of the net prices of all
517 prescription drugs is posted.

518 (5) This section applies to contracts entered into or
519 renewed on or after July 1, 2022 ~~July 1, 2018~~.

520 Section 8. Paragraph (b) of subsection (1) of section
521 627.6572, Florida Statutes, is redesignated as paragraph (c),
522 subsection (5) is amended, a new paragraph (b) is added to

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523 subsection (1), and paragraphs (c) through (f) are added to
524 subsection (2) of that section, to read:

525 627.6572 Pharmacy benefit manager contracts.—

526 (1) As used in this section, the term:

527 (b) "Net price" means the value at which a prescription
528 drug is sold by a prescription drug manufacturer, prescription
529 drug wholesale distributor, or pharmacy, under a prescription
530 drug benefits coverage administered by a pharmacy benefit
531 manager, after all taxes and other costs are added and all
532 discounts, rebates, and reductions in price are subtracted,
533 including any rebate offered to the pharmacy benefit manager
534 which is passed on to the health insurer.

535 (2) A contract between a health insurer and a pharmacy
536 benefit manager must require that the pharmacy benefit manager:

537 (c) Maintain a website that provides public access to the
538 net price of each covered prescription drug and update the net
539 price of a covered prescription drug on the website at least 90
540 days before the net price of the covered prescription drug
541 changes.

542 (d) Provide written notice to each affected insured and
543 each prescribing health care provider at least 90 days before
544 making a change in the drug formulary or in the net price of a
545 covered prescription drug, including a change that results from
546 a price increase of a covered prescription drug reported by a
547 drug manufacturer under s. 499.026(2).

548 (e) Inform an insured, in writing, of the net price of each
549 covered prescription drug for which the insured has made a
550 payment.

551 (f) Provide in writing to each insured and each prescribing

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552 health care provider the address of the pharmacy benefit
553 manager's website where the list of the net prices of all
554 covered prescription drugs is posted.

555 (5) This section applies to contracts entered into or
556 renewed on or after July 1, 2022 ~~July 1, 2018~~.

557 Section 9. Section 641.3131, Florida Statutes, is created
558 to read:

559 641.3131 Formulary changes resulting from drug price
560 increases.-

561 (1) A health maintenance organization issuing a major
562 medical or other comprehensive coverage contract shall submit,
563 and update as necessary, contact information for a single point
564 of contact for use by prescription drug manufacturers to comply
565 with s. 499.026. The office shall maintain and publish on its
566 website a list of such points of contact.

567 (2) A health maintenance organization issuing a major
568 medical or other comprehensive coverage contract must provide
569 written notice to each affected subscriber and each prescribing
570 health care provider at least 90 days before making a drug
571 formulary change that results from a prescription drug price
572 increase reported by a drug manufacturer under s. 499.026(2).

573 (3) This section applies to contracts entered into or
574 renewed on or after January 1, 2023.

575 Section 10. Paragraph (b) of subsection (1) of section
576 641.314, Florida Statutes, is redesignated as paragraph (c),
577 subsection (5) is amended, a new paragraph (b) is added to
578 subsection (1), and paragraphs (c) through (f) are added to
579 subsection (2) of that section, to read:

580 641.314 Pharmacy benefit manager contracts.-

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581 (1) As used in this section, the term:

582 (b) "Net price" means the value at which a prescription
583 drug is sold by a prescription drug manufacturer, prescription
584 drug wholesale distributor, or pharmacy, under a prescription
585 drug benefits coverage administered by a pharmacy benefit
586 manager, after all taxes and other costs are added and all
587 discounts, rebates, and reductions in price are subtracted,
588 including any rebate offered to the pharmacy benefit manager
589 which is passed on to the health maintenance organization.

590 (2) A contract between a health maintenance organization
591 and a pharmacy benefit manager must require that the pharmacy
592 benefit manager:

593 (c) Maintain a website that provides public access to the
594 net price of each covered prescription drug and update the net
595 price of a covered prescription drug on the website at least 90
596 days before the net price of the covered prescription drug
597 changes.

598 (d) Provide written notice to each affected subscriber and
599 each prescribing health care provider at least 90 days before
600 making a change in the drug formulary or in the net price of a
601 covered prescription drug, including a change that results from
602 a price increase of a covered prescription drug reported by a
603 drug manufacturer under s. 499.026(2).

604 (e) Inform a subscriber in writing of the net price of each
605 covered prescription drug for which the subscriber has made a
606 payment.

607 (f) Provide in writing to each subscriber and each
608 prescribing health care provider the address of the pharmacy
609 benefit manager's website where the list of the net prices of

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610 all prescription drugs is posted.

611 (5) This section applies to contracts entered into or
612 renewed on or after July 1, 2022 ~~July 1, 2018~~.

613 Section 11. Subsections (3) and (4) and paragraph (a) of
614 subsection (9) of section 110.12315, Florida Statutes, are
615 amended to read:

616 110.12315 Prescription drug program.—The state employees'
617 prescription drug program is established. This program shall be
618 administered by the Department of Management Services, according
619 to the terms and conditions of the plan as established by the
620 relevant provisions of the annual General Appropriations Act and
621 implementing legislation, subject to the following conditions:

622 (3) The department shall maintain the generic, preferred
623 brand name, and the nonpreferred brand name lists of drugs and
624 supplies to be used in the administration of the state
625 employees' prescription drug program. These lists may not
626 include a prescription drug for which the prescription drug
627 manufacturer does not comply with the requirements of s. 499.026
628 unless the prescription drug is the most clinically appropriate,
629 clinically effective, and lowest net-cost prescription drug.

630 (4) The department shall maintain a list of maintenance
631 drugs and supplies. The list may not include a drug for which
632 the prescription drug manufacturer does not comply with the
633 requirements of s. 499.026 unless the prescription drug is the
634 most clinically appropriate, clinically effective, and lowest
635 net-cost prescription drug.

636 (a) Preferred provider organization health plan members may
637 have prescriptions for maintenance drugs and supplies filled up
638 to three times as a supply for up to 30 days through a retail

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639 pharmacy; thereafter, prescriptions for the same maintenance
640 drug or supply must be filled for up to 90 days either through
641 the department's contracted mail order pharmacy or through a
642 retail pharmacy.

643 (b) Health maintenance organization health plan members may
644 have prescriptions for maintenance drugs and supplies filled for
645 up to 90 days either through a mail order pharmacy or through a
646 retail pharmacy.

647 (9) (a) Beginning with the 2020 plan year, the department
648 must implement formulary management for prescription drugs and
649 supplies. Such management practices must require prescription
650 drugs to be subject to formulary inclusion or exclusion and,
651 beginning with the 2023 plan year, must require a prescription
652 drug for which the prescription drug manufacturer does not
653 comply with the requirements of s. 499.026 to be subject to
654 formulary exclusion, but may not restrict access to the most
655 clinically appropriate, clinically effective, and lowest net-
656 cost prescription drugs and supplies. Drugs excluded from the
657 formulary must be available for inclusion if a physician,
658 advanced practice registered nurse, or physician assistant
659 prescribing a pharmaceutical clearly states on the prescription
660 that the excluded drug is medically necessary. Prescription
661 drugs and supplies first made available in the marketplace after
662 January 1, 2020, may not be covered by the prescription drug
663 program until specifically included in the list of covered
664 prescription drugs and supplies.

665 Section 12. Paragraph (n) of subsection (2) of section
666 409.815, Florida Statutes, is amended to read:

667 409.815 Health benefits coverage; limitations.—

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668 (2) BENCHMARK BENEFITS.—In order for health benefits
669 coverage to qualify for premium assistance payments for an
670 eligible child under ss. 409.810-409.821, the health benefits
671 coverage, except for coverage under Medicaid and Medikids, must
672 include the following minimum benefits, as medically necessary.

673 (n) *Prescribed drugs*.—

674 1. Coverage shall include drugs prescribed for the
675 treatment of illness or injury when prescribed by a licensed
676 health practitioner acting within the scope of his or her
677 practice.

678 2. Prescribed drugs may be limited to generics if available
679 and brand name products if a generic substitution is not
680 available, unless the prescribing licensed health practitioner
681 indicates that a brand name is medically necessary.

682 3. Prescribed drugs covered under this section shall
683 include all prescribed drugs covered under the Florida Medicaid
684 program.

685 4. Prescribed drugs may not include a prescription drug for
686 which the manufacturer does not comply with the requirements of
687 s. 499.026 unless the prescription drug is the most clinically
688 appropriate, clinically effective, and lowest net-cost
689 prescription drug or unless a physician, advanced practice
690 registered nurse, or physician assistant prescribing the drug
691 clearly states on the prescription that the excluded drug is
692 medically necessary.

693 Section 13. Subsection (8) of section 409.91195, Florida
694 Statutes, is amended to read:

695 409.91195 Medicaid Pharmaceutical and Therapeutics
696 Committee.—There is created a Medicaid Pharmaceutical and

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697 Therapeutics Committee within the agency for the purpose of
698 developing a Medicaid preferred drug list.

699 (8) The committee shall develop its preferred drug list
700 recommendations by considering the clinical efficacy, safety,
701 and cost-effectiveness of a product and the manufacturer's
702 prescription drug price transparency, as required under s.
703 499.012.

704 Section 14. Paragraph (a) of subsection (5) of section
705 409.912, Florida Statutes, is amended to read:

706 409.912 Cost-effective purchasing of health care.—The
707 agency shall purchase goods and services for Medicaid recipients
708 in the most cost-effective manner consistent with the delivery
709 of quality medical care. To ensure that medical services are
710 effectively utilized, the agency may, in any case, require a
711 confirmation or second physician's opinion of the correct
712 diagnosis for purposes of authorizing future services under the
713 Medicaid program. This section does not restrict access to
714 emergency services or poststabilization care services as defined
715 in 42 C.F.R. s. 438.114. Such confirmation or second opinion
716 shall be rendered in a manner approved by the agency. The agency
717 shall maximize the use of prepaid per capita and prepaid
718 aggregate fixed-sum basis services when appropriate and other
719 alternative service delivery and reimbursement methodologies,
720 including competitive bidding pursuant to s. 287.057, designed
721 to facilitate the cost-effective purchase of a case-managed
722 continuum of care. The agency shall also require providers to
723 minimize the exposure of recipients to the need for acute
724 inpatient, custodial, and other institutional care and the
725 inappropriate or unnecessary use of high-cost services. The

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726 agency shall contract with a vendor to monitor and evaluate the
727 clinical practice patterns of providers in order to identify
728 trends that are outside the normal practice patterns of a
729 provider's professional peers or the national guidelines of a
730 provider's professional association. The vendor must be able to
731 provide information and counseling to a provider whose practice
732 patterns are outside the norms, in consultation with the agency,
733 to improve patient care and reduce inappropriate utilization.
734 The agency may mandate prior authorization, drug therapy
735 management, or disease management participation for certain
736 populations of Medicaid beneficiaries, certain drug classes, or
737 particular drugs to prevent fraud, abuse, overuse, and possible
738 dangerous drug interactions. The Pharmaceutical and Therapeutics
739 Committee shall make recommendations to the agency on drugs for
740 which prior authorization is required. The agency shall inform
741 the Pharmaceutical and Therapeutics Committee of its decisions
742 regarding drugs subject to prior authorization. The agency is
743 authorized to limit the entities it contracts with or enrolls as
744 Medicaid providers by developing a provider network through
745 provider credentialing. The agency may competitively bid single-
746 source-provider contracts if procurement of goods or services
747 results in demonstrated cost savings to the state without
748 limiting access to care. The agency may limit its network based
749 on the assessment of beneficiary access to care, provider
750 availability, provider quality standards, time and distance
751 standards for access to care, the cultural competence of the
752 provider network, demographic characteristics of Medicaid
753 beneficiaries, practice and provider-to-beneficiary standards,
754 appointment wait times, beneficiary use of services, provider

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755 turnover, provider profiling, provider licensure history,
756 previous program integrity investigations and findings, peer
757 review, provider Medicaid policy and billing compliance records,
758 clinical and medical record audits, and other factors. Providers
759 are not entitled to enrollment in the Medicaid provider network.
760 The agency shall determine instances in which allowing Medicaid
761 beneficiaries to purchase durable medical equipment and other
762 goods is less expensive to the Medicaid program than long-term
763 rental of the equipment or goods. The agency may establish rules
764 to facilitate purchases in lieu of long-term rentals in order to
765 protect against fraud and abuse in the Medicaid program as
766 defined in s. 409.913. The agency may seek federal waivers
767 necessary to administer these policies.

768 (5) (a) The agency shall implement a Medicaid prescribed-
769 drug spending-control program that includes the following
770 components:

771 1. A Medicaid preferred drug list, which shall be a listing
772 of cost-effective therapeutic options recommended by the
773 Medicaid Pharmacy and Therapeutics Committee established
774 pursuant to s. 409.91195 and adopted by the agency for each
775 therapeutic class on the preferred drug list. At the discretion
776 of the committee, and when feasible, the preferred drug list
777 should include at least two products in a therapeutic class. The
778 agency may post the preferred drug list and updates to the list
779 on an Internet website without following the rulemaking
780 procedures of chapter 120. Drugs for which the manufacturer does
781 not comply with the requirements of s. 499.026 are excluded from
782 the preferred list, unless the drug is the most clinically
783 appropriate, clinically effective, and lowest net-cost

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784 prescription drug. Antiretroviral agents are excluded from the
785 preferred drug list. The agency shall also limit the amount of a
786 prescribed drug dispensed to no more than a 34-day supply unless
787 the drug products' smallest marketed package is greater than a
788 34-day supply, or the drug is determined by the agency to be a
789 maintenance drug in which case a 100-day maximum supply may be
790 authorized. The agency may seek any federal waivers necessary to
791 implement these cost-control programs and to continue
792 participation in the federal Medicaid rebate program, or
793 alternatively to negotiate state-only manufacturer rebates. The
794 agency may adopt rules to administer this subparagraph. The
795 agency shall continue to provide unlimited contraceptive drugs
796 and items. The agency must establish procedures to ensure that:

797 a. There is a response to a request for prior authorization
798 by telephone or other telecommunication device within 24 hours
799 after receipt of a request for prior authorization; and

800 b. A 72-hour supply of the drug prescribed is provided in
801 an emergency or when the agency does not provide a response
802 within 24 hours as required by sub-subparagraph a.

803 2. A provider of prescribed drugs is reimbursed in an
804 amount not to exceed the lesser of the actual acquisition cost
805 based on the Centers for Medicare and Medicaid Services National
806 Average Drug Acquisition Cost pricing files plus a professional
807 dispensing fee, the wholesale acquisition cost plus a
808 professional dispensing fee, the state maximum allowable cost
809 plus a professional dispensing fee, or the usual and customary
810 charge billed by the provider.

811 3. The agency shall develop and implement a process for
812 managing the drug therapies of Medicaid recipients who are using

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813 significant numbers of prescribed drugs each month. The
814 management process may include, but is not limited to,
815 comprehensive, physician-directed medical-record reviews, claims
816 analyses, and case evaluations to determine the medical
817 necessity and appropriateness of a patient's treatment plan and
818 drug therapies. The agency may contract with a private
819 organization to provide drug-program-management services. The
820 Medicaid drug benefit management program shall include
821 initiatives to manage drug therapies for HIV/AIDS patients,
822 patients using 20 or more unique prescriptions in a 180-day
823 period, and the top 1,000 patients in annual spending. The
824 agency shall enroll any Medicaid recipient in the drug benefit
825 management program if he or she meets the specifications of this
826 provision and is not enrolled in a Medicaid health maintenance
827 organization.

828 4. The agency may limit the size of its pharmacy network
829 based on need, competitive bidding, price negotiations,
830 credentialing, or similar criteria. The agency shall give
831 special consideration to rural areas in determining the size and
832 location of pharmacies included in the Medicaid pharmacy
833 network. A pharmacy credentialing process may include criteria
834 such as a pharmacy's full-service status, location, size,
835 patient educational programs, patient consultation, disease
836 management services, and other characteristics. The agency may
837 impose a moratorium on Medicaid pharmacy enrollment if it is
838 determined that it has a sufficient number of Medicaid-
839 participating providers. The agency must allow dispensing
840 practitioners to participate as a part of the Medicaid pharmacy
841 network regardless of the practitioner's proximity to any other

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842 entity that is dispensing prescription drugs under the Medicaid
843 program. A dispensing practitioner must meet all credentialing
844 requirements applicable to his or her practice, as determined by
845 the agency.

846 5. The agency shall develop and implement a program that
847 requires Medicaid practitioners who issue written prescriptions
848 for medicinal drugs to use a counterfeit-proof prescription pad
849 for Medicaid prescriptions. The agency shall require the use of
850 standardized counterfeit-proof prescription pads by prescribers
851 who issue written prescriptions for Medicaid recipients. The
852 agency may implement the program in targeted geographic areas or
853 statewide.

854 6. The agency may enter into arrangements that require
855 manufacturers of generic drugs prescribed to Medicaid recipients
856 to provide rebates of at least 15.1 percent of the average
857 manufacturer price for the manufacturer's generic products.
858 These arrangements shall require that if a generic-drug
859 manufacturer pays federal rebates for Medicaid-reimbursed drugs
860 at a level below 15.1 percent, the manufacturer must provide a
861 supplemental rebate to the state in an amount necessary to
862 achieve a 15.1-percent rebate level.

863 7. The agency may establish a preferred drug list as
864 described in this subsection, and, pursuant to the establishment
865 of such preferred drug list, negotiate supplemental rebates from
866 manufacturers that are in addition to those required by Title
867 XIX of the Social Security Act and at no less than 14 percent of
868 the average manufacturer price as defined in 42 U.S.C. s. 1936
869 on the last day of a quarter unless the federal or supplemental
870 rebate, or both, equals or exceeds 29 percent. There is no upper

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871 limit on the supplemental rebates the agency may negotiate. The
872 agency may determine that specific products, brand-name or
873 generic, are competitive at lower rebate percentages. Agreement
874 to pay the minimum supplemental rebate percentage guarantees a
875 manufacturer that the Medicaid Pharmaceutical and Therapeutics
876 Committee will consider a product for inclusion on the preferred
877 drug list. However, a pharmaceutical manufacturer is not
878 guaranteed placement on the preferred drug list by simply paying
879 the minimum supplemental rebate. Agency decisions will be made
880 on the clinical efficacy of a drug and recommendations of the
881 Medicaid Pharmaceutical and Therapeutics Committee, as well as
882 the price of competing products minus federal and state rebates.
883 The agency may contract with an outside agency or contractor to
884 conduct negotiations for supplemental rebates. For the purposes
885 of this section, the term "supplemental rebates" means cash
886 rebates. Value-added programs as a substitution for supplemental
887 rebates are prohibited. The agency may seek any federal waivers
888 to implement this initiative.

889 8.a. The agency may implement a Medicaid behavioral drug
890 management system. The agency may contract with a vendor that
891 has experience in operating behavioral drug management systems
892 to implement this program. The agency may seek federal waivers
893 to implement this program.

894 b. The agency, in conjunction with the Department of
895 Children and Families, may implement the Medicaid behavioral
896 drug management system that is designed to improve the quality
897 of care and behavioral health prescribing practices based on
898 best practice guidelines, improve patient adherence to
899 medication plans, reduce clinical risk, and lower prescribed

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900 drug costs and the rate of inappropriate spending on Medicaid
901 behavioral drugs. The program may include the following
902 elements:

903 (I) Provide for the development and adoption of best
904 practice guidelines for behavioral health-related drugs such as
905 antipsychotics, antidepressants, and medications for treating
906 bipolar disorders and other behavioral conditions; translate
907 them into practice; review behavioral health prescribers and
908 compare their prescribing patterns to a number of indicators
909 that are based on national standards; and determine deviations
910 from best practice guidelines.

911 (II) Implement processes for providing feedback to and
912 educating prescribers using best practice educational materials
913 and peer-to-peer consultation.

914 (III) Assess Medicaid beneficiaries who are outliers in
915 their use of behavioral health drugs with regard to the numbers
916 and types of drugs taken, drug dosages, combination drug
917 therapies, and other indicators of improper use of behavioral
918 health drugs.

919 (IV) Alert prescribers to patients who fail to refill
920 prescriptions in a timely fashion, are prescribed multiple same-
921 class behavioral health drugs, and may have other potential
922 medication problems.

923 (V) Track spending trends for behavioral health drugs and
924 deviation from best practice guidelines.

925 (VI) Use educational and technological approaches to
926 promote best practices, educate consumers, and train prescribers
927 in the use of practice guidelines.

928 (VII) Disseminate electronic and published materials.

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929 (VIII) Hold statewide and regional conferences.

930 (IX) Implement a disease management program with a model
931 quality-based medication component for severely mentally ill
932 individuals and emotionally disturbed children who are high
933 users of care.

934 9. The agency shall implement a Medicaid prescription drug
935 management system.

936 a. The agency may contract with a vendor that has
937 experience in operating prescription drug management systems in
938 order to implement this system. Any management system that is
939 implemented in accordance with this subparagraph must rely on
940 cooperation between physicians and pharmacists to determine
941 appropriate practice patterns and clinical guidelines to improve
942 the prescribing, dispensing, and use of drugs in the Medicaid
943 program. The agency may seek federal waivers to implement this
944 program.

945 b. The drug management system must be designed to improve
946 the quality of care and prescribing practices based on best
947 practice guidelines, improve patient adherence to medication
948 plans, reduce clinical risk, and lower prescribed drug costs and
949 the rate of inappropriate spending on Medicaid prescription
950 drugs. The program must:

951 (I) Provide for the adoption of best practice guidelines
952 for the prescribing and use of drugs in the Medicaid program,
953 including translating best practice guidelines into practice;
954 reviewing prescriber patterns and comparing them to indicators
955 that are based on national standards and practice patterns of
956 clinical peers in their community, statewide, and nationally;
957 and determine deviations from best practice guidelines.

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958 (II) Implement processes for providing feedback to and
959 educating prescribers using best practice educational materials
960 and peer-to-peer consultation.

961 (III) Assess Medicaid recipients who are outliers in their
962 use of a single or multiple prescription drugs with regard to
963 the numbers and types of drugs taken, drug dosages, combination
964 drug therapies, and other indicators of improper use of
965 prescription drugs.

966 (IV) Alert prescribers to recipients who fail to refill
967 prescriptions in a timely fashion, are prescribed multiple drugs
968 that may be redundant or contraindicated, or may have other
969 potential medication problems.

970 10. The agency may contract for drug rebate administration,
971 including, but not limited to, calculating rebate amounts,
972 invoicing manufacturers, negotiating disputes with
973 manufacturers, and maintaining a database of rebate collections.

974 11. The agency may specify the preferred daily dosing form
975 or strength for the purpose of promoting best practices with
976 regard to the prescribing of certain drugs as specified in the
977 General Appropriations Act and ensuring cost-effective
978 prescribing practices.

979 12. The agency may require prior authorization for
980 Medicaid-covered prescribed drugs. The agency may prior-
981 authorize the use of a product:

- 982 a. For an indication not approved in labeling;
983 b. To comply with certain clinical guidelines; or
984 c. If the product has the potential for overuse, misuse, or
985 abuse.

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987 The agency may require the prescribing professional to provide
988 information about the rationale and supporting medical evidence
989 for the use of a drug. The agency shall post prior
990 authorization, step-edit criteria and protocol, and updates to
991 the list of drugs that are subject to prior authorization on the
992 agency's Internet website within 21 days after the prior
993 authorization and step-edit criteria and protocol and updates
994 are approved by the agency. For purposes of this subparagraph,
995 the term "step-edit" means an automatic electronic review of
996 certain medications subject to prior authorization.

997 13. The agency, in conjunction with the Pharmaceutical and
998 Therapeutics Committee, may require age-related prior
999 authorizations for certain prescribed drugs. The agency may
1000 preauthorize the use of a drug for a recipient who may not meet
1001 the age requirement or may exceed the length of therapy for use
1002 of this product as recommended by the manufacturer and approved
1003 by the Food and Drug Administration. Prior authorization may
1004 require the prescribing professional to provide information
1005 about the rationale and supporting medical evidence for the use
1006 of a drug.

1007 14. The agency shall implement a step-therapy prior
1008 authorization approval process for medications excluded from the
1009 preferred drug list. Medications listed on the preferred drug
1010 list must be used within the previous 12 months before the
1011 alternative medications that are not listed. The step-therapy
1012 prior authorization may require the prescriber to use the
1013 medications of a similar drug class or for a similar medical
1014 indication unless contraindicated in the Food and Drug
1015 Administration labeling. The trial period between the specified

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1016 steps may vary according to the medical indication. The step-
1017 therapy approval process shall be developed in accordance with
1018 the committee as stated in s. 409.91195(7) and (8). A drug
1019 product may be approved without meeting the step-therapy prior
1020 authorization criteria if the prescribing physician provides the
1021 agency with additional written medical or clinical documentation
1022 that the product is medically necessary because:

1023 a. There is not a drug on the preferred drug list to treat
1024 the disease or medical condition which is an acceptable clinical
1025 alternative;

1026 b. The alternatives have been ineffective in the treatment
1027 of the beneficiary's disease; or

1028 c. Based on historic evidence and known characteristics of
1029 the patient and the drug, the drug is likely to be ineffective,
1030 or the number of doses have been ineffective.

1031
1032 The agency shall work with the physician to determine the best
1033 alternative for the patient. The agency may adopt rules waiving
1034 the requirements for written clinical documentation for specific
1035 drugs in limited clinical situations.

1036 15. The agency shall implement a return and reuse program
1037 for drugs dispensed by pharmacies to institutional recipients,
1038 which includes payment of a \$5 restocking fee for the
1039 implementation and operation of the program. The return and
1040 reuse program shall be implemented electronically and in a
1041 manner that promotes efficiency. The program must permit a
1042 pharmacy to exclude drugs from the program if it is not
1043 practical or cost-effective for the drug to be included and must
1044 provide for the return to inventory of drugs that cannot be

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1045 credited or returned in a cost-effective manner. The agency
1046 shall determine if the program has reduced the amount of
1047 Medicaid prescription drugs which are destroyed on an annual
1048 basis and if there are additional ways to ensure more
1049 prescription drugs are not destroyed which could safely be
1050 reused.

1051 Section 15. Subsection (9) of section 499.067, Florida
1052 Statutes, is amended to read:

1053 499.067 Denial, suspension, or revocation of permit,
1054 certification, or registration.—

1055 (9) (a) The department may deny, suspend, or revoke a permit
1056 under this part if it finds the permittee has not complied with
1057 the reporting requirements of, or knowingly made a false
1058 statement in a report required by, s. 499.0121(14).

1059 (b) The department may deny an application for a renewal
1060 permit or suspend or revoke a permit if it finds the permittee
1061 has not complied with the reporting requirements of, or
1062 knowingly made a false statement in a report required by, s.
1063 499.0121(16).

1064 (c) The department may deny an application for a renewal
1065 permit or suspend or revoke a permit if it finds the permittee
1066 has not complied with the notification or reporting requirements
1067 of, or knowingly made a false statement in a notice or report
1068 required by, s. 499.026(2) or (3), respectively.

1069 Section 16. This act shall take effect July 1, 2022.