



Expanding Pharmacists' Prescriptive Authority: Options for Reform

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The COVID-19 pandemic has made it difficult for people to access medications and refill prescriptions owing to stay-at-home orders, financial pressures, and diminished access to medical facilities.¹ For example, there has been a significant decline in new patients initiating therapies, and patients have been more likely to discontinue use of many medicines.² However, a solution may be hiding in plain sight: pharmacists can play a greater role in delivering care. Whereas there were around 228,000 primary care physicians (PCPs) nationwide in 2019,³ there were 315,470 pharmacists in 2020.⁴ Pharmacists tend to have more touch points with patients than do physicians. For instance, Medicare beneficiaries visit a community pharmacist almost twice as often as they do a PCP,⁵ and these differences are larger in rural areas. Thus, many patients have more experience and perhaps greater comfort dealing with their pharmacist than they do with their own physician.

Despite having a high level of medical training and interacting routinely with patients, pharmacists are constrained in terms of the amount of care they can offer. Most states have adopted a precautionary approach to pharmacist prescriptive authority, for example. In most places, pharmacist prescribing of medications is banned by default, with exceptions sometimes allowed for specific medications.

Idaho, however, is a state that stands apart from other states for adopting what might be described as a “permissionless innovation” approach to pharmacist prescribing. Under Idaho law, pharmacists are free to prescribe medications as they deem appropriate, so long as the situation and medicines fall within certain broad guardrails established by the state legislature and overseen by the state board of pharmacy.

The purpose of this policy brief is to explain why states may want to consider expanding pharmacists' prescriptive authority, as Idaho did, and to present an array of options available to those policymakers wishing to do so. Importantly, a state need not go as far as Idaho did, which now has some of the least restrictive laws in this area in the nation. Rather, a state can adopt more modest reforms or can take an incremental approach that moves in the direction of Idaho's pharmacy regime in steps. Indeed, Idaho did not reform its pharmacy laws in one fell swoop. Rather, it took the better part of a decade for the state to move from having a precautionary regulatory approach, as is common in most US states today, to a permissionless innovation approach to pharmacy regulation.

REASONS TO EXPAND PHARMACISTS' PRESCRIPTIVE AUTHORITY

Competence of Pharmacists

Licensed pharmacists in the United States must hold a doctor of pharmacy degree (PharmD),⁶ which to obtain requires four years of pharmacy school preceded by undergraduate prerequisite courses. Thus, pharmacists are, by definition, experts in pharmaceutical products. Moreover, whereas physicians' continuing medical education concerns the study of a variety of issues relevant to health maintenance, including but not only drugs, pharmacists' continuing education primarily concerns drug therapies and disease management.⁷ Therefore, pharmacists are well equipped to treat patients with common illnesses and to stay up to date with the latest developments in modern medicine.

High-Quality Care

Insufficient follow up and insufficient adherence to treatment have a significant negative impact on the health of Americans. Expanding pharmacist prescriptive authority can fill these gaps in US healthcare. For instance, research has found that granting pharmacists the ability to prescribe statins can enhance the health outcomes of diabetic patients ages 40–75, because statins can reduce cardiovascular disease and mortality in people with diabetes.⁸

Better Access for Patients, Especially in Rural Areas

As noted earlier, there are more pharmacists per capita than physicians in the United States, so expanding pharmacists' prescriptive authority would likely enhance patients' access to care. This is especially true in rural areas. According to a 2020 report from the National Community Pharmacists Association, 77 percent of independent community pharmacies serve areas with populations less than 50,000.⁹ Because community pharmacies constitute about 35 percent of retail pharmacies in the country,¹⁰ this finding suggests that at least a quarter of all retail pharmacies in the United States are located in low-population areas. By contrast, just 11 percent of the coun-

try's physicians practice in rural areas.¹¹ Thus, empowering pharmacists to provide more care to patients would disproportionately benefit rural patients. Indeed, lack of access for rural residents was a key reason New Mexico was an early mover in expanding pharmacists' scope of practice to include some prescribing.¹²

Shorter Wait Times and Less Hassle

One notable advantage of pharmacist-provided care is that pharmacies are convenient one-stop shops. In many states, patients must wait days or even weeks to secure appointments with a PCP.¹³ When pharmacists provide care, often no appointment is needed. Furthermore, pharmacies have longer operating hours, including on weekends.¹⁴ Thus, patients need not take time off work, delay care owing to appointment availability, or travel to a doctor's office, which is often farther away than a pharmacy.

Cost-Effective Care

Another advantage of one-stop-shop pharmacy-provided care is that it likely reduces the cost of care. Typically, patients must first go to the doctor's office in order to receive a prescription for treatment, resulting in an average charge of \$106 in 2016.¹⁵ By bypassing the doctor's office for health issues that have a straightforward diagnosis and course of treatment, patients and insurers can secure significant savings, especially in light of the fact that drug prices are growing more slowly than medical service prices.¹⁶ Research has found that pharmacists who have a collaborative practice agreement in place with a physician (which allows pharmacists to offer services that are usually outside of their legal authority) can provide timely and low-cost medical testing and treatment for illnesses such as strep throat and the flu.¹⁷

Enhanced Feedback on Patient Health

Loosening restrictions on pharmacists enables them to more fully participate in the provision of care, which fosters a beneficial feedback loop from patients to pharmacists and from pharmacists to physicians and other healthcare providers. With proper communication requirements in place, empowering pharmacists can lead to better and more regular collection of information about patient health, ultimately leading to better-informed healthcare providers who are empowered to serve their patients.

OPTIONS FOR REFORM

Several states are worth considering as models for expanding pharmacists' prescriptive authority. Two notable examples are Idaho and Oregon. Over the past decade, Idaho implemented a set of

reforms that have made the state's prescribing policies for pharmacists the least restrictive in the country. An attractive aspect of Idaho's pharmacy reforms is that they took place in stages and are replicable for other states that want to follow Idaho as a model but would rather take their time and make reforms in steps. Oregon is noteworthy for having a public health advisory committee that oversees a state formulary of medicines pharmacists may prescribe. The Canadian province of Alberta has also expanded prescriptive authority for pharmacists and may provide a model for US states.

The following are some reforms that states might want to consider, given in order from least to most ambitious.¹⁸

Piecemeal Approach: Expand Prescriptive Authority for Medications One at a Time through Legislation

Description. The legislature expands pharmacists' prescriptive authority by enacting laws that redefine the practice of pharmacy in the state to include prescribing authority for specific pharmaceutical products.

Advantages. This cautious and deliberative approach allows legislators to gradually expand pharmacists' practice authority and monitor the effects of those changes over time before proceeding to further expand scope or halt expansion efforts. This process also provides stakeholders, including patients, physicians, insurance companies, and other healthcare entities, an opportunity to assess the merits of the proposed expansions before they are implemented, thereby reducing some risks and allowing for a transparent implementation.

Disadvantages. The piecemeal approach can be slow for patients and labor-intensive for legislators, as it requires the legislature to explicitly authorize the prescribing of any new medications by pharmacists one at a time. The piecemeal approach restricts access to drugs that may benefit patients, who may go without needed treatment during the time the legislature is deliberating on whether to allow a particular medication. The piecemeal approach invites opposition from interest groups such as medical associations,¹⁹ medical professionals, and insurance companies, who have a financial stake in limiting competition from pharmacists or limiting spending on medicines. Other state agencies that have developed close relationships with these stakeholders over time sometimes also oppose these reforms.²⁰ Together these groups can present a united front against expanded pharmacist prescriptive authority and testify in opposition to it, despite the benefits for patients.

Examples. Idaho began its pharmacy reforms by employing the piecemeal approach and passing legislation authorizing pharmacists to prescribe specific pharmaceutical treatments. In 2011, the Idaho legislature allowed pharmacists to prescribe fluoride supplements for people whose drink-

ing water is fluoride deficient, as well as agents for immunizing certain susceptible individuals ages 12 and older.²¹ In 2015, the Idaho legislature allowed pharmacists to prescribe opioid antagonists.²² In 2016, pharmacists became authorized to prescribe immunizations to children ages 6 and older (down from 12 and older).²³ That same year, epinephrine auto-injectors (e.g., EpiPen) were added to the list of medications that pharmacists are allowed to prescribe.²⁴ In 2017, tuberculosis tests and tobacco cessation products were also added to the list.²⁵ Eventually, the legislature tired of revisiting these issues year after year and opted for a broader set of reforms.

Virginia has also taken a piecemeal approach, allowing pharmacists to initiate certain treatments.²⁶ In that state, a pharmacist may prescribe naloxone, epinephrine, and several other categories of drugs the legislature has approved if the pharmacist follows a statewide protocol written by the state board of pharmacy.²⁷

Many other states have also passed piecemeal legislation along these lines. For example, tobacco cessation products and naloxone for opioid overdoses are commonly allowed drugs that pharmacists may prescribe.²⁸

Arkansas has likewise passed several bills that significantly expand pharmacists' role in providing access to treatment. In 2021, the legislature authorized pharmacists to prescribe and administer vaccines and medications against adverse reactions to vaccines to people ages three and older.²⁹ Supplemental legislation extended vaccination authority to pharmacy technicians under the supervision of a pharmacist.³⁰

Grant the State Board of Pharmacy the Right to Authorize a List of Products and Medicines That Pharmacists May Prescribe

Description. The legislature establishes general parameters or describes certain situations that can be used to determine whether a pharmacist can prescribe a particular medication or device. The legislature then delegates responsibility to the state board of pharmacy or a new pharmacy advisory committee to decide which medications meet the legislature's broad criteria. Once endowed with this authority from the legislature, the board of pharmacy may decide the specific medicines, tests, or products pharmacists may prescribe.³¹ Licensed pharmacists across the state are then endowed with this practice authority. The board may also establish additional rules that govern pharmacists' prescriptive authority, educational requirements for prescribing pharmacists, and record-keeping and notification requirements, as well as disciplinary measures for malpractice.³²

Advantages. By delegating certain decisions about the prescriptive authority of pharmacists to the state board of pharmacy, legislators can insulate the decision-making process from politics and reduce interference from special interest groups. This approach places decisions in the hands of experts—in this case, pharmacists at the state board of pharmacy—who may have greater knowl-

edge than legislators about treatments and how patients could benefit from them in a safe and timely manner.

Disadvantages. This approach places decision-making power in the hands of a regulatory body whose unelected members are less accountable to the public than elected representatives in the legislature. This approach may still invite opposition from interest groups that can lobby the board of pharmacy to erect barriers to care, even when those barriers do not reflect patients' best interests. If the objective is to rapidly deliver results for patients, regulatory agencies such as the state board of pharmacy or a pharmacy advisory committee still represent a layer of bureaucracy between patients and pharmacists that may prove prohibitive.

Examples. Pharmacists licensed and living in Oregon can prescribe FDA-approved drugs and devices that appear on a state formulary or that have a statewide protocol for pharmacists to follow.³³ State law authorizes the Oregon Board of Pharmacy to create such a formulary and protocols under the oversight of a Public Health and Pharmacy Formulary Advisory Committee.³⁴ Allowed medications and devices include diabetic blood sugar testing supplies, inhalation spacers, and nebulizers, among others. Licensed pharmacists may also prescribe tobacco cessation products, travel medications, and HIV pre- and postexposure prophylaxis, as well as other categories of FDA-approved drugs.

A similar example comes from Idaho during 2017 to 2019. In 2017, the Idaho legislature passed HB 191, through which it gave the Idaho Board of Pharmacy rulemaking authority to add drugs, drug categories, and devices to a list of treatments that pharmacists can prescribe so long as they are for conditions that (a) do not require a new diagnosis, (b) are minor and generally self-limiting, (c) have a test that is used to guide diagnosis or decision-making and is waived under the federal Clinical Laboratory Improvement Amendments (CLIA) of 1988, or (d) are an immediate threat to the patient's health if the prescription cannot be issued right away.³⁵ Once authorized by the legislature, the Idaho Board of Pharmacy created a prescribing framework and issued piecemeal regulations allowing pharmacists to prescribe a number of devices (including but not limited to inhalation spacers and diabetes blood sugar testing supplies), CLIA-waived tests for influenza and pharyngitis, statins, noncontrolled travel drugs, a variety of supplements to infusion orders (infusion pumps, agents for catheter occlusion, etc.), a number of emergency drugs (after contacting emergency medical services), and Lyme disease prophylaxis.³⁶

A similar framework was established in law in Utah in 2021.³⁷ The new law requires the Utah Division of Occupational and Professional Regulation (which includes the Utah Board of Pharmacy) to make rules designating drugs and devices that may be prescribed by a pharmacist. Rules must outline notification requirements, methods to prevent overprescription—including for antibiotics—and when a pharmacist must refer a patient to another healthcare provider. The rules must be made in collaboration with pharmacists' and physicians' groups.

Grant Pharmacists Unrestricted Category-Specific Authority (within the Confines of a Framework)

Description. Instead of granting the board of pharmacy the power to decide which medications pharmacists may prescribe, the legislature directly allows pharmacists to prescribe medications that meet criteria outlined by the legislature, the board of pharmacy, or both. Then pharmacists may prescribe freely within those confines, except in cases where particular medications or situations are expressly prohibited by the legislature or board of pharmacy.

Advantages. This approach is more insulated from politics than the previous two approaches because prescribing decisions are made by individual pharmacists in consultation with their patients and with physicians as needed. Thus, this approach limits unnecessary layers of bureaucracy between medical professionals and patients. By extension, it may also allow for more flexibility and opportunities for course correction as treatment progresses. The approach also broadens access to care for patients by empowering the type of medical professional patients see most regularly.

Disadvantages. Increased access to healthcare could result in budgetary pressures for insurers or public healthcare programs. That said, these forces may be counterbalanced to some extent as the increase in supply of healthcare lowers prices and precludes costly inpatient services. Another disadvantage is that if categories are too narrow, prescriptive authority will remain limited.

Examples. Idaho HB 182 in 2019 extended pharmacists' prescriptive authority to any medication that fit within the broad, established criteria set by the state legislature and the state board of pharmacy.³⁸ Pharmacists are now allowed to prescribe medications within these categories unless expressly prohibited by the board of pharmacy or legislature. Similar legislation has been introduced in Kansas but has yet to pass into law.³⁹

Some Canadian provinces have been expanding pharmacist scope of practice over the past 15 years, focusing on enabling pharmacists to provide more care to patients and to prescribe under certain circumstances. The Canadian province of Alberta expanded scope of practice through legislation in 2006, with implementation beginning in 2007.⁴⁰ The legislation allowed pharmacists to adapt a prescription, thereby allowing a pharmacist to make changes to an original prescription, such as by suggesting generic or therapeutic substitutions for the medicine or changing the dosage. They may also initiate drug therapy when proof of the pharmacist's competency has been established. In either case, pharmacists must inform the relevant physician of changes.

POTENTIAL CONCERNS ABOUT INCREASED PRESCRIPTIVE AUTHORITY

Expanded pharmacist prescriptive authority is opposed by certain groups, typically those representing other interests in the medical profession that might compete with pharmacists to deliver

care. Here we explore several common arguments made by opponents of pharmacist scope of practice reform.

Concerns about Patient Safety

One central argument against pharmacist prescribing is that, although pharmacists may be able to *treat* diseases, they are less skilled in *diagnosing* them than are other healthcare professionals, such as physicians, nurse practitioners, and physician assistants.

Even for minor ailments, opponents of expanded prescriptive authority argue that, when assessing common symptoms, pharmacists risk mistaking minor ailments such as the flu with more severe conditions. For instance, when Idaho allowed pharmacists to treat mild acne, policymakers received a complaint from a dermatology association arguing that pharmacists may mistake rosacea for mild acne.⁴¹

However, in general, where pharmacist prescriptive authority has been expanded, it has been to cover diseases that do not require a diagnosis (for instance, preventative care such as vaccines), are postdiagnostic (such as add-on therapy for people with diagnosed diabetes), are diagnosable through simple tests (such as the flu and strep throat), or are minor. For the latter, risks can be mitigated via protocols that set thresholds for referral. For example, when the patient's temperature is above a certain threshold or when the patient is above or below a certain age, the protocol could require referral to a more appropriate venue of care.

Furthermore, research has so far not detected a significant risk increase in places that have implemented reforms in this area; instead, expanded authority seems to be associated with positive health outcomes and lower prices.⁴² Very often, expansions of pharmacist prescriptive authority have been accompanied by regulations ensuring competence, increasing liability for malpractice, requiring communication between the pharmacists and other healthcare providers, and requiring maintenance of documentation on encounters with patients.⁴³

Pharmacists have strong incentives and oversight systems that encourage them to maintain a high quality of care, and these do not change with expanded prescribing ability. Additionally, oversight from state boards of pharmacy and federal and state regulations would remain intact or even be strengthened. Pharmacists and pharmacies would expose themselves to malpractice medical liability if they were reckless in their treatment of patients. In some cases, additional education requirements exist for pharmacists who can prescribe. Although pharmacists have a financial incentive to treat more customers—as do all medical professionals to some extent—their ambition to play a greater role in the delivery of care makes sense because they know their own competencies and they are in the business of caring for patients.

Concerns about Overprescribing

Contrary to some of the more extreme claims, expanded authority does not equal a blanket authorization for pharmacists to prescribe any medications they see fit, including controlled substances, let alone to perform medical procedures for which they have no training. In fact, pharmacists are authorized to prescribe opioid antagonists, such as naloxone, in many states already, thereby expanding patient access to opioid overdose prevention services.⁴⁴ And controlled substances such as opioids have not been on the lists of medications that pharmacists are allowed to prescribe. Overprescribing of antibiotics can be a concern, but some studies have shown that pharmacists prescribe antibiotics more appropriately than other professions.⁴⁵ In one study, pharmacists had to modify over 40 percent of the prescriptions written by physicians for urinary tract infections to better conform with clinical guidelines.⁴⁶ Thus, concerns regarding overprescribing should be dealt with through education of pharmacists, not limiting access for patients in genuine need of medications.

Concerns about Breakdowns in Communication

Sometimes opponents to expanded prescriptive authority argue such an expansion would lead to a breakdown in care coordination and in communication between providers and state regulatory boards, which could result in duplicative treatment and misallocation of medical services.⁴⁷ However, pharmacists are required to notify the prescribing physician of any changes made to treatments as a condition for having expanded scope of practice. For example, regulatory guardrails ensure that proper documentation is maintained and exchanged among providers. If anything, this seems likely to lead to more communication, not less, between pharmacists and physicians. Indeed, some pharmacists report increased levels of communication with PCPs following reforms.⁴⁸ This is not surprising, given that expanded prescriptive authority is accompanied by requirements that pharmacists maintain documentation and contact a patient's physician when there is any change in treatment.

OTHER OPTIONS

Other options are also available to states wishing to expand pharmacists' prescribing authority. As of 2016, all states, with the exception of Delaware,⁴⁹ allow expanded pharmacy practice when pharmacists have in place a collaborative practice agreement with a supervising physician. Such an expansion often includes some prescribing authority, as is the case in Florida, for example.⁵⁰ Arkansas, Idaho, Kentucky, and Washington allow therapeutic interchange,⁵¹ whereby a drug or product with a substantially equivalent therapeutic effect is allowed to be substituted for another, often because it is of lower cost. Meanwhile, Colorado allows some prescribing authority in the case of emergencies.⁵²

Other states, such as California or New Mexico,⁵³ make it possible for pharmacists to prescribe in limited situations if they obtain an additional license or certificate after undergoing additional train-

ing. This policy brief has focused on reforms that do not require collaborative practice agreements or additional licenses or certifications because we assume that pharmacists have adequate training and skills to perform these tasks already and because, outside of settings where physicians and pharmacists work for the same organization, the conflict of interest physicians face in this area (because pharmacists represent a source of competition) may limit the effectiveness of these reforms.

CONCLUSION

Letting pharmacists provide care is a smart and fast way to improve access to necessary medications. However, it is not always politically feasible to do what is best for patients all at once. Given the opposition to expanding healthcare services that often comes from some special interest groups, legislators and regulators should work to make improvements on the margins that are politically feasible today, with an eye toward taking incremental steps in the direction of more medical freedom. Idaho and a number of other states offer a road map to follow, as do some other countries, such as Canada. These examples illustrate that there is a menu of options available for state policymakers looking to increase care for their residents.

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