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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

LICENSING COMMITTEE REPORT

Stan Weisser, Licensee Member, Chairperson
Debbie Veale, Licensee Member, Vice-Chairperson
Lavanza Butler, Licensee Member
Ricardo Sanchez, Public Member
Albert Wong, Licensee Member

1. Call to Order and Establishment of Quorum

2. Public Comment for Items Not on the Agenda, Matters for Future Meetings

Note: The committee may not discuss or take action on any matter raised during the public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. [Government Code Sections 11125 and 11125.7(a)]

3. Discussion and Consideration of Retake Waiting Period for North American Pharmacist Licensure Examination (NAPLEX) and California Practice Standards and Jurisprudence Examination for Pharmacists (CPJE)

Attachment 1

Relevant Law

Business and Professions Code (BPC) section 4200 establishes requirements for licensure as a pharmacist and subsection (a)(6) further provides that a candidate shall have passed the NAPLEX and the CPJE.

BPC section 4200.4 specifies that an applicant who fails the national examination make not retake the examination for at least 90 days or for a period established by regulations adopted by the board in consultation with the Office of Professional Examination Services of the Department.

Background

On July 28, 2016, the NABP advised executive officers of changes to the NAPLEX program. Changes included transitioning to a new administration model that included increasing the number of test items, increasing the test administration time and increasing the fee. Further, readers were advised that the waiting period for the NAPLEX examination would be decreased to 45 days.

Prior Discussion

At the September 2016 Licensing Committee meeting, the committee discussed NABP's change in policy related to the waiting period for candidates who fail the NAPLEX. The

committee discussed that while NAPLEX decreased its waiting period to 45 days, California law will still require a 90-day waiting period for the NAPLEX. As part of its discussion, the committee considered whether the proposed change to the waiting period for the NAPLEX is appropriate. The committee also discussed if the board should consider a change to the waiting period for the CPJE. The committee discussed that, by statute, any changes to the current waiting period for the NAPLEX would require consultation with Office of Professional Examination Services (OPES). The committee requested that this item be referred back to the committee after consultation with OPES.

Recent Update

Board staff met with DCA OPES to discuss the rationale for proposed changes from a 90-day waiting period for both the NAPLEX and CPJE. OPES concluded that the 45-day waiting periods are reasonable. Further, board staff also consulted with the board's contracted psychometric firm (PSI) responsible for CPJE development and deployment. They reached a similar conclusion to that of OPES.

Staff Recommendation

Given the conclusions of both OPES and PSI, staff recommends seeking the necessary changes in statute to reduce the waiting period to 45 days. Should the committee and board agree, this change could be effectuated by amending BPC 4200.4. Provided below is language that could be used.

> 4200.4. An applicant who fails the ~~national examination~~ North American Pharmacist Licensure Examination and the California Practice Standards and Jurisprudence Examination for Pharmacists may not retake the examination for at least ~~90~~ 45 days or for a period established by regulations adopted by the board in consultation with the Office of Professional Examination Services of the ~~d~~Department.

Attachment 1 includes the NABP letter dated July 28, 2016, OPES memo dated June 9, 2017, and relevant law sections referenced.

4. Discussion and Consideration of Issuing Board Licenses Including Photos for Individual Licensees

Attachment 2

Background

The board has encountered instances of unlicensed individuals posing and working as a licensed pharmacist using a name and license number issued to someone else. In such cases the unlicensed individual has provided a fake license to the employer.

There are several programs within the DCA that currently issue licenses that include a photo of the individual. Samples are provided in **Attachment 2**.

For Committee Discussion and Information

Board staff would appreciate discussion from the committee to determine if it would be appropriate to implement photo licenses for individuals licensed by the board. Should the

committee and board agree photo licenses are appropriate, staff will begin working on implementation. It is anticipated that implementation could be in place by July of 2018. Staff would recommend a phased approach where newly licensed pharmacists will be issued the photo license upon licensure and current pharmacists will convert to the photo license as part of the renewal process.

5. Discussion and Consideration of Pharmacy Technician Duties and Possible Changes to Such Duties

Attachment 3

Relevant Law

BPC section 4038 defines a pharmacy technician as an individual who assists a pharmacist in a pharmacy in the performance of his or her related duties.

BPC section 4115 specifies that a pharmacist technician can perform packaging, manipulative, repetitive or other nondiscretionary tasks only while assisting and while under the direct supervision and control of a pharmacist.

CCR section 1793.2 specifies the allowable duties that are performed by a pharmacy technician in most pharmacy settings, including:

- Removing the drug or drugs from stock.
- Counting, pouring, or mixing pharmaceuticals.
- Placing the product into a container.
- Affixing the label or labels to the container.
- Packaging and repackaging.

Prior Committee Discussion

For several meetings, the board has discussed different facets of the pharmacy technician program. In June 2016, the licensing committee considered the duties of a pharmacy technician.

More recently, the committee held a summit focused on the role of pharmacy technicians in various settings. The summit provided the committee with the opportunity to learn about the functions pharmacy technicians perform in various state jurisdictions and practice settings.

The committee discussed the various settings where pharmacy technicians may be focused on different types of responsibilities to support a pharmacist – for example, a community pharmacy, hospital pharmacy, etc. – and requested input from the public on each of the settings.

The committee noted the need to review the current marketplace and anticipate future needs when assessing the issue while noting that any changes need to focus on how they will benefit consumers. Such benefits could include pharmacists being available to engage in more patient care activities.

The committee heard public comment about how the role of the technician is evolving in other states as well as recent studies in the area including tech-check-tech in the retail setting and a pilot program study in Iowa.

National View

According to a presentation at the NABP meeting earlier this year, pharmacy technician or technology assisted verification is allowed in seven states in the community setting and in 18 states in the institution setting. The latter includes California.

Further, 15 states allow pharmacy technicians to accept new verbal prescription orders and/or obtain clarification on prescription orders. Thirteen states allow for pharmacy technicians to transfer prescriptions in some fashion.

A summary comparison of neighboring states, large states and states that allow some of the above functions is included as an attachment. The comparison chart also includes if the respective state requires licensure and continuing education. Additionally, the National Association of Boards of Pharmacy compiles a survey of pharmacy law on an annual basis. As part of this annual survey, information on pharmacy technician roles, functions and licensure requirements is provided. Relevant portions of the survey are also provided in the attachment.

During this Meeting

The committee may consider changes to the duties a pharmacy technician performs and implementation strategies, and it may direct staff to make recommended edits to CCR 1793.2. As part of its discussion, the committee may wish to focus in specific areas of pharmacy practice, how the change would impact the operations of the pharmacy, and the resulting benefits to patients receiving care in those settings.

For example, if the committee considers allowing tech-check-tech in the community setting, the following questions may need to be considered:

1. Would this be limited based on the type of prescription, i.e., refill versus new, controlled substance versus noncontrolled, compounded medications?
2. Should the “supervising technician” require special licensure similar to an advanced practice pharmacist?
3. Should a pharmacist also be responsible for the functions performed by the “supervising technician” or just the PIC?
4. If the “supervising technician” is performing the final check, what impact does that have on current ratios, and should the “supervising technician” be included in a ratio?
5. How would this ultimately benefit the patient? Should the pharmacist be required to have patient contact on transactions?

Attachment 3 includes relevant sections of law, a copy of the minutes from the Technician Summit, relevant pages of the NABP’s Survey and comparison chart.

6. Discussion and Consideration of Pharmacy Technician Ratios in California

Attachment 4

Relevant Law

BPC section 4115 established the general conditions under which a pharmacy may use a pharmacy technician. Unless otherwise indicated, the ratio of pharmacists to pharmacy technicians is generally 1:1 for the first pharmacist. The ratio for each additional pharmacist on duty becomes 1:2.

CCR section 1793.7 allows the ratio for preparation of a prescription for an inpatient of a licensed health facility to be one pharmacist to two pharmacy technicians.

For Committee Discussion and Consideration

As the committee considers changes to the functions that a pharmacy technician is authorized to perform, changes to the ratio may also need to be considered.

Further, even if changes to functions are not recommended, legislation was introduced earlier this year that would have changed the ratio to 1:4 (pharmacist to pharmacy technician). The measure failed to meet a legislative deadline and will become a two-year bill.

The committee may wish to discuss how patient safety could be impacted by changes to the ratio. A review of the 2016 NABP Survey of Pharmacy Law indicates that some states do not have a ratio and of the states that do, the ratio varies from 1:2 (pharmacist to technician) to 1:6 (pharmacist to technician). A copy of the NABP Survey in included as **Attachment 4**.

7. Discussion and Consideration of Application and Renewal Requirements for Pharmacy Technicians

Attachment 5

Relevant Law

Business and Professions Code Section 4202 provides the general pathways to licensure as a pharmacy technician. In addition, California Code of Regulations (CCR) section 1793.5 further details the application requirements.

Background

The requirements for licensure as a pharmacy technician are fairly minimal and include:

- Application and fee.
- Fingerprint background check.
- Query from the National Practitioner Data Bank.
- Description on qualifications and supporting documents.

Acceptable qualifications include any of the following:

- Completion of a technician training program.

- Certification from a specified program (currently either PTCB or ExCPT).
- Associate degree in pharmacy technology.

Currently the only requirement for licensure renewal is a fee.

Pending Changes

The board currently has a regulation pending to update the renewal requirements to also include self-reporting of criminal and disciplinary information. The board adopted this regulation, and it is currently undergoing review by the DCA.

Further, the board is also in the process of updating the application form via regulation to update reference to certification programs as well as to modify Title 16 CCR section 1793.6 to strengthen the requirements of some pharmacy technician programs.

Prior Discussion

As part of its discussion during the last meeting, the committee discussed the licensure and renewal requirements for pharmacy technicians. The committee noted that one of the pathways to licensure, certification, did not require the individual to maintain certification. Further, the committee noted that there should be a mechanism where pharmacy technicians can expand their education. The committee also questioned if continuing education should be required as a condition of renewal.

For Discussion and Consideration

As the committee considers changes to the functions of a pharmacy technician and how best to implement such changes, it is appropriate to also consider licensure and renewal requirements.

A review of the NABP's Survey of Pharmacy Law indicates that the majority of states require either licensure or registration of pharmacy technicians. Some states (such as Idaho and Arizona) require both licensure or registration as well as certification. The requirement for continuing education varies as well, ranging from no CE requirement to 20 hours/two years.

Attachment 5 includes a copy of the relevant laws, pending regulation language and relevant portions of the NABP Survey.

8. Update on Development of Mandatory Board Provided Law and Ethics Continuing Education Courses

Relevant Law

Effective July 1, 2017, CCR section 1732.5 (b) Renewal Requirements for Pharmacists is amended to read:

(b) At least two (2) of the thirty (30) hours required for pharmacist license renewal shall be completed by participation in a board provided CE course in Law and Ethics. Pharmacists

renewing their licenses which expire on or after July 1, 2019, shall be subject to the requirements of this subdivision.

Background
The board requested that the Licensing Committee monitor the development and deployment of the training.

Recent Update
Staff fairly routinely provides continuing education on pharmacy law. Such training is generally done is person but can be scalable using other deployment options, including webinars. As the DCA's training department uses an interactive web based platform for training, board staff is exploring that option. Based on discussions with the department, board staff believe the course could be available by March 1, 2018.

As in-person training provides opportunities for outreach, staff believes it still is appropriate as one method of providing CE.

For Committee Discussion and Consideration
The committee may discuss the development of the law and ethics CE courses and methodologies in delivering the courses to pharmacists to meet license renewal requirements.

9. Discussion and Consideration of Pharmacist Consultation in Various Pharmacy Settings

Attachment 6

Relevant Law
CCR Section 1707.2 establishes the requirements for patient consultation including the conditions when such consultation must occur. Further, this section provides that when a patient or a patient's agent is not present in a pharmacy to receive consultation, the patient shall receive written notice of the patient's right to request consultation and a telephone number from which the patient may obtain oral consultation from a pharmacist who has ready access to the patient's record.

CCR Section 1713 provides the authority for a pharmacy to use an automated drug delivery system (ADDS) under specified condition and subsection (d)(5) establishes the requirement for such a pharmacy using an automated drug delivery system to provide an immediate consultation with a pharmacist, either in-person or via telephone, upon the require of a patient.

BPC Section 4112(h) requires the board to adopt regulations that apply the same requirements or standards for oral consultation to a nonresident pharmacy that dispenses medications to Californians consistent with the consultation requirements established for mail order pharmacies located within California. The board does not currently have such regulations.

Background

The board has frequently discussed the benefits of patient consultation as an important component of consumer protection and has expressed some frustration with what appears to be a lack of consultation.

Additionally, during the April 2017 Licensing Committee Pharmacy Technician Summit, the committee discussed changes in duties performed by pharmacy technicians in various settings (Agenda Item 6). The committee discussed whether expanding pharmacy technician duties to include more responsibilities while under the supervision of a pharmacist would allow pharmacists to provide more patient care services, including drug utilization review, patient profile review and patient consultation. As part of the discussion, the committee considered various settings including traditional community pharmacy, mail order and closed door pharmacy, inpatient, and other specialty pharmacy settings.

The committee was provided a summary of the workflow in Iowa's tech-check-tech pilot, where the pharmacist is involved at the first level interaction with the patient, performing the data and review prior to printing the label, and providing the final consultation. The committee was also presented with the pharmacist involvement for call-in prescriptions in Idaho. It was explained that in Idaho, the pharmacist would be at the DUR and PU1 station verifying the data entry. In regard to patient consultation there is a toll-free number that patients may call.

Mail order pharmacies were discussed and staff suggested the need to broaden consultation requirements for mail order pharmacies, noting that consumer complaints surrounding mail order pharmacies involve allegations of delays in therapies because the patient is unable to reach a pharmacist. The committee heard that medication reconciliation is performed in the mail order pharmacy setting by the pharmacy benefit managers who have access to patient records and would highlight if there was duplication in therapy.

For Committee Discussion and Consideration

Currently pharmacies are often structured and staffed so that the pharmacist is in the back of the pharmacy, and at the front of the pharmacy, interacting with patients, are the pharmacy technicians and cashiers. This is efficient for the cashiering functions, but it interrupts the flow of the pharmacy with respect to patient consultation. This service, and the important drug utilization review, must be performed by the pharmacist and are critical for patient care.

If technicians were to be trained and/or qualified to perform tech-check-tech, to handle insurance functions and perhaps function under a somewhat different ratio, the pharmacist could move forward within the pharmacy to provide more interaction with and services directly to patients. This would also allow pharmacists to perform patient-care functions authorized by protocol (immunizations, naloxone, etc.) or under protocol with primary care providers either as a pharmacist or advanced practice pharmacist. Cashiering functions could still be performed by non-pharmacist staff, but the actual handling of the medication

could occur by the pharmacist following DUR and during consultation. Not all pharmacists may prefer to organize their pharmacies under such a model, but it would permit a pharmacist who does so to focus on the duties he or she is most qualified to perform. It could also foster the board's long-term goal of increased rates of patient consultation.

As part of its discussion, the committee may wish to consider some of the following topics:

1. Are the requirements currently established in CCR 1707.2 appropriate or is revision necessary?
2. Should changes at the transactional level be considered to ensure pharmacist engagement with patients in the dispensing process?
3. Is the current requirement for a mail order pharmacy sufficient to ensure patients have access to a pharmacist for consultation?
4. Should the board promulgate regulations for nonresident pharmacies consistent with the provisions of BPC 4112?
5. Are the current requirements for the use of an ADDS system sufficient to ensure patients have access to a pharmacist for patient consultation?
6. Do patients discharged from a hospital given sufficient information about their medication by either a pharmacist or registered nurse?

Attachment 6 includes a copy of the relevant laws.

10. Discussion and Consideration of the Centers for Disease Control's Newly Released Guide for Pharmacist to Establish Collaborative Practice Agreements

Attachment 7

The Centers for Disease Control and Prevention (CDC) recently released a guide entitled "Advancing Team-Based Care Through Collaborative Practice Agreements -- A Resource and Implementation Guide for Adding Pharmacists to the Care Team." A copy of this guide is provided in **Attachment 7**.

The CDC guide notes the underused role of pharmacists in health care and the value of activating their knowledge through use of collaborative practice agreements and protocols with prescribers.

California has long recognized the value of protocols and collaborative practice agreements between pharmacists and prescribers as ways to achieve improved care of patients. Since before 1990, California has allowed pharmacists and physicians to enter into protocols for the drug therapy care of patients in the inpatient setting, and the environments in which protocols may be established has expanded several times. In 2013, SB 493 further expanded the role of pharmacists through the use of protocols and creation of the new licensure category of advance practice pharmacists. This law also directed the Board of Pharmacy to develop state protocols that, when approved by the Medical Board, allowed pharmacists to provide self-administered hormonal contraception, nicotine replacement therapy and (through AB 1535) naloxone.

Excerpts from the guide promoting the expanded use of collaborative practice agreements include the following:

- The evidence is strong that when pharmacists are members of the health care team, outcomes related to preventing or managing chronic disease (e.g., blood pressure, blood glucose, cholesterol, obesity, smoking cessation) and medication adherence improve. The purpose of this guide is to empower community pharmacists and collaborating prescribers to initiate collaborative practice agreements (CPAs) focused on caring for patients with chronic diseases . . .

- CPAs are built upon a foundation of trust between pharmacists and prescribers and serve as a useful mechanism for increasing efficiencies of team-based care. When designed correctly, CPAs are beneficial to the collaborative delivery of care through delegation by the physician or other prescriber of specific patient care services to pharmacists. This delegation can expand available services to patients and increase coordination of care.

  For example, the use of CPAs can decrease the number of requests to authorize refills, modify prescriptions, initiate therapeutic interchanges (in which the pharmacist can substitute another drug for the medication prescribed), and order and interpret laboratory tests while keeping the prescriber apprised of the pharmacist's actions through established communication mechanisms. This allows each member of the health care team to complement the skills and knowledge of the other members and more effectively facilitate patient care, resulting in improved patient outcomes.

- CPAs offer a unique opportunity for pharmacists to collaborate with prescribers in the treatment and management of chronic conditions, including CVD and hypertension.

The CDC has also developed additional resources to promote the use of collaborative practice agreements and team based care. These are also listed as examples of protocols and collaborative practice agreements.

11. Licensing Statistics

Attachment 8

Licensing Statistics for July 1, 2016 – June 30, 2017

Attachment 8 includes the licensing statistics for the 2016-2017 fiscal year as well as a three-year fiscal comparison.

In fiscal year 2016/2017, the board has received 17,504 applications, including:

- 2,462 intern pharmacists.
- 3,332 pharmacist exam applications.
- 256 advanced practice pharmacists.
- 6,262 pharmacy technicians.
- 7 outsourcing facilities.

- 33 nonresident outsourcing facilities.

As of June 30, 2017, the board has issued 11,784 licenses, renewed 64,206 licenses and has 139,164 active licenses, including:

- 6,584 intern pharmacists.
- 44,864 pharmacists.
- 130 advanced practice pharmacists.
- 72,562 pharmacy technicians.
- 6,663 pharmacies.
- 514 hospitals and exempt hospitals.
- 2 nonresident outsourcing facilities.

General processing information by license type will be provided at the committee meeting.

Also provided in attachment 8 is a three year comparison of the board's licensing programs. A review of the comparison details program growth in some areas while showing decline in others. A review of the number of licensed renewed shows an overall growth of 3%.

12. Future Committee Meeting Dates for 2018

The 2018 Licensing Committee meeting dates were put forth by the board at the May 2017 meeting. The dates are as follows:

- Jan. 16, 2018
- April 19, 2018
- June 26, 2018
- Sept. 26, 2018

As a reminder, the committee has a meeting scheduled for September 19, 2017.

Attachment 1

State of California

BUSINESS AND PROFESSIONS CODE

Section 4200

4200. (a) The board may license as a pharmacist an applicant who meets all the following requirements:

(1) Is at least 18 years of age.

(2) (A) Has graduated from a college of pharmacy or department of pharmacy of a university recognized by the board; or

(B) If the applicant graduated from a foreign pharmacy school, the foreign-educated applicant has been certified by the Foreign Pharmacy Graduate Examination Committee.

(3) Has completed at least 150 semester units of collegiate study in the United States, or the equivalent thereof in a foreign country. No less than 90 of those semester units shall have been completed while in resident attendance at a school or college of pharmacy.

(4) Has earned at least a baccalaureate degree in a course of study devoted to the practice of pharmacy.

(5) Has completed 1,500 hours of pharmacy practice experience or the equivalent in accordance with Section 4209.

(6) Has passed the North American Pharmacist Licensure Examination and the California Practice Standards and Jurisprudence Examination for Pharmacists on or after January 1, 2004.

(b) Proof of the qualifications of an applicant for licensure as a pharmacist shall be made to the satisfaction of the board and shall be substantiated by affidavits or other evidence as may be required by the board.

(c) Each person, upon application for licensure as a pharmacist under this chapter, shall pay to the executive officer of the board the fees provided by this chapter. The fees shall be compensation to the board for investigation or examination of the applicant.

(Amended by Stats. 2011, Ch. 350, Sec. 24. (SB 943) Effective January 1, 2012.)

State of California

BUSINESS AND PROFESSIONS CODE

Section 4200.4

4200.4. An applicant who fails the national examination may not retake the examination for at least 90 days or for a period established by regulations adopted by the board in consultation with the Office of Professional Examination Services of the department.

(Amended by Stats. 2009, Ch. 307, Sec. 45. (SB 821) Effective January 1, 2010.)

National Association of Boards of Pharmacy
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Tel: 847/391-4406 • Fax: 847/391-4502
Web Site: www.nabp.net

TO: EXECUTIVE OFFICERS – STATE BOARDS OF PHARMACY

FROM: Carmen A. Catizone, Executive Director/Secretary

DATE: July 28, 2016

RE: NAPLEX Program Notification

The National Association of Boards of Pharmacy (NABP) would like to notify the boards of pharmacy regarding the implementation of the upcoming changes to the North American Pharmacist Licensure Examination (NAPLEX) and the Association's efforts to alert candidates with open, active registrations for the current exam.

The NAPLEX program will transition to a new administration model in November 2016, and the upcoming changes were detailed in a memo sent to the member boards on March 3, 2016. Changes to the NAPLEX include an increase in the number of items from 185 to 250, an increase in testing time to six hours, and an increase in the registration fee from $505 to $575. In addition, effective November 1, 2016, the NAPLEX waiting period will be 45 days. Candidates must wait at least 45 days to schedule another attempt after obtaining a failing score on the NAPLEX.

Via email, NABP will be notifying candidates with open, active NAPLEX registrations of the following deadlines:

- The last day to take the current NAPLEX is October 22, 2016. Candidates wishing to take the current exam must:
  - Register by October 3, 2016,
  - Be granted eligibility and receive an Authorization to Test, and
  - Schedule and take the exam by October 22, 2016.
- The NAPLEX will not be administered October 24-31, 2016.
- The new NAPLEX will launch on November 1, 2016.

For candidates with open, active registrations who are unable to test by October 22, 2016, their registrations will remain active and they may schedule an appointment to take the new NAPLEX on or after November 1, 2016.

Candidates who graduate in 2017 should not register for the current NAPLEX since they are not eligible to sit for the current exam. Should any such candidates register for the current exam, their record will be closed and a partial refund granted per the NABP refund policy. The

candidate would then need to register for the new NAPLEX after November 1, 2016, and pay the new fee of $575.

Detailed information on the changes to the exam and the above deadlines will be published the week of August 1, 2016 on the NABP website (in the NAPLEX section, under Programs) and in the *NAPLEX/MPJE Candidate Registration Bulletin.* This information has also been provided to the schools and colleges of pharmacy.

If there are any questions regarding the updates to the NAPLEX program, please contact Maria Incrocci, competency assessment senior manager, at mincrocci@nabp.net or 847/391-4400.

cc: NABP Executive Committee
NABP Advisory Committee on Examinations

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

OFFICE OF PROFESSIONAL EXAMINATION SERVICES
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MEMORANDUM

DATE	June 9, 2017
TO	Virginia Herold, Executive Officer Board of Pharmacy
FROM	Heidi Lincer, Ph.D., Chief Office of Professional Examination Services
SUBJECT	**Change to North American Pharmacist Licensure Examination (NAPLEX) retest waiting period**

The Board of Pharmacy (Board) requested that the Office of Professional Examination Services (OPES) review upcoming changes to the NAPLEX examination administered by the National Association of Boards of Pharmacy (NABP). OPES was specifically asked to consult with the Board regarding the upcoming change to the waiting period from 90 to 45 days for candidates to retest after obtaining a failing score. The Board also requested that OPES approve a similar change for the California Practice Standards and Jurisprudence Examination (CPJE).

After reviewing the rationale for the proposed changes, OPES believes that the 45-day waiting periods are reasonable. The validity and reliability of the NAPLEX and CPJE examinations should not be compromised as long as professional guidelines and technical standards (*Standards for Educational and Psychological Testing* published by the American Educational Research Association, American Psychological Association, and National Council on Measurement in Education, 2014) are adhered to by the respective organizations maintaining these examinations.

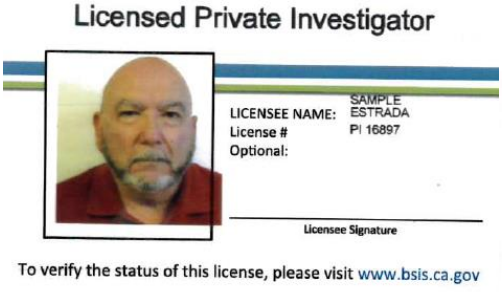
In accordance with Business and Professions Code section 4200.4, OPES has consulted with the Board and approves of the proposed retest waiting period change from 90 to 45 days for both the NAPLEX and CPJE.

cc: Tracy Montez, Ph.D., Chief, Division of Programs & Policy Review

Attachment 2

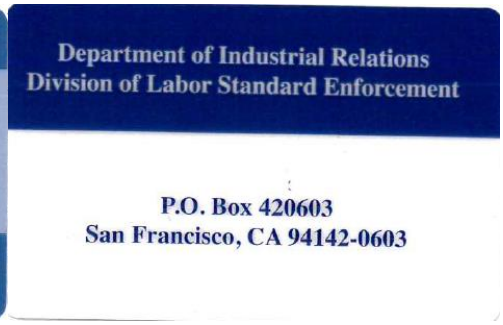
Sample of Photo Identification Cards through DCA's Vendor PSI

Sample 1 – Front and Back

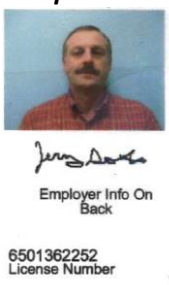


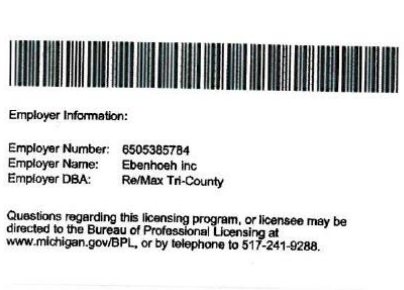
Sample 2 – Front and Back

Sample 3 – Front and Back

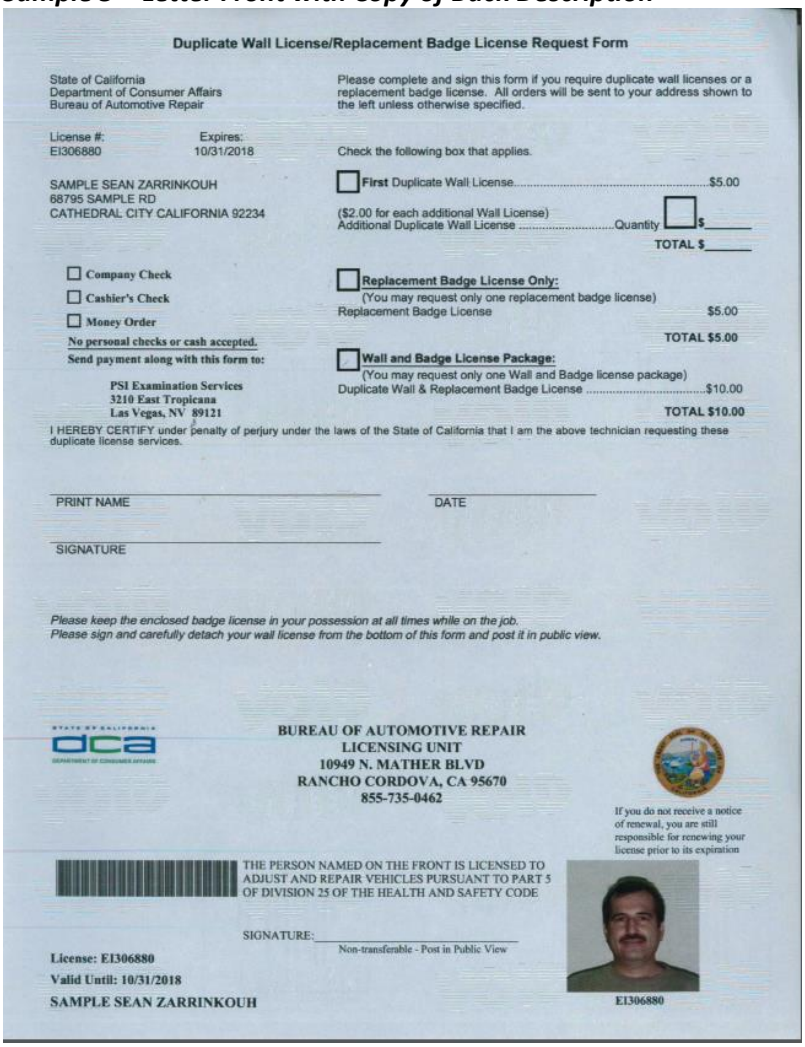


Sample 4 – Front and Back





Sample 5 – Letter Front with Copy of Back Description



Duplicate Wall License/Replacement Badge License Request Form

State of California
Department of Consumer Affairs
Bureau of Automotive Repair

Please complete and sign this form if you require duplicate wall licenses or a replacement badge license. All orders will be sent to your address shown to the left unless otherwise specified.

License #: EI306880 Expires: 10/31/2018

SAMPLE SEAN ZARRINKOUH
68795 SAMPLE RD
CATHEDRAL CITY CALIFORNIA 92234

Check the following box that applies.

☐ **First** Duplicate Wall License.....$5.00

($2.00 for each additional Wall License)
Additional Duplicate Wall License .....Quantity ☐ $_____

TOTAL $_____

☐ **Company Check**
☐ **Cashier's Check**
☐ **Money Order**

No personal checks or cash accepted.

Send payment along with this form to:

PSI Examination Services
3210 East Tropicana
Las Vegas, NV 89121

☐ **Replacement Badge License Only:**
(You may request only one replacement badge license)
Replacement Badge License $5.00

TOTAL $5.00

☐ **Wall and Badge License Package:**
(You may request only one Wall and Badge license package)
Duplicate Wall & Replacement Badge License $10.00

TOTAL $10.00

I HEREBY CERTIFY under penalty of perjury under the laws of the State of California that I am the above technician requesting these duplicate license services.

PRINT NAME _____ DATE _____

SIGNATURE _____

Please keep the enclosed badge license in your possession at all times while on the job.
Please sign and carefully detach your wall license from the bottom of this form and post it in public view.

BUREAU OF AUTOMOTIVE REPAIR
LICENSING UNIT
10949 N. MATHER BLVD
RANCHO CORDOVA, CA 95670
855-735-0462

If you do not receive a notice of renewal, you are still responsible for renewing your license prior to its expiration

THE PERSON NAMED ON THE FRONT IS LICENSED TO ADJUST AND REPAIR VEHICLES PURSUANT TO PART 5 OF DIVISION 25 OF THE HEALTH AND SAFETY CODE

SIGNATURE: _____
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Attachment 3

State of California

BUSINESS AND PROFESSIONS CODE

Section 4038

4038. (a) "Pharmacy technician" means an individual who assists a pharmacist in a pharmacy in the performance of his or her pharmacy related duties, as specified in Section 4115.

(b) A "pharmacy technician trainee" is a person who is enrolled in a pharmacy technician training program operated by a California public postsecondary education institution or by a private postsecondary vocational institution approved by the Bureau for Private Postsecondary and Vocational Education.

(Amended by Stats. 2005, Ch. 621, Sec. 48. Effective January 1, 2006.)

4115. Pharmacy Technician: Activities Permitted; Required Supervision; Activities Limited to Pharmacist; Registration; Requirements for Registration; Ratio

(a) A pharmacy technician may perform packaging, manipulative, repetitive, or other nondiscretionary tasks, only while assisting, and while under the direct supervision and control of a pharmacist. The pharmacist shall be responsible for the duties performed under his or her supervision by a technician.

(b) This section does not authorize the performance of any tasks specified in subdivision (a) by a pharmacy technician without a pharmacist on duty.

(c) This section does not authorize a pharmacy technician to perform any act requiring the exercise of professional judgment by a pharmacist.

(d) The board shall adopt regulations to specify tasks pursuant to subdivision (a) that a pharmacy technician may perform under the supervision of a pharmacist. Any pharmacy that employs a pharmacy technician shall do so in conformity with the regulations adopted by the board.

(e) No person shall act as a pharmacy technician without first being licensed by the board as a pharmacy technician.

(f) (1) A pharmacy with only one pharmacist shall have no more than one pharmacy technician performing the tasks specified in subdivision (a). The ratio of pharmacy technicians performing the tasks specified in subdivision (a) to any additional pharmacist shall not exceed 2:1, except that this ratio shall not apply to personnel performing clerical functions pursuant to Section 4116 or 4117. This ratio is applicable to all practice settings, except for an inpatient of a licensed health facility, a patient of a licensed home health agency, as specified in paragraph (2), an inmate of a correctional facility of the Department of Corrections and Rehabilitation, and for a person receiving treatment in a facility operated by the State Department of State Hospitals, the State Department of Developmental Services, or the Department of Veterans Affairs.

(2) The board may adopt regulations establishing the ratio of pharmacy technicians performing the tasks specified in subdivision (a) to pharmacists applicable to the filling of prescriptions of an inpatient of a licensed health facility and for a patient of a licensed home health agency. Any ratio established by the board pursuant to this subdivision shall allow, at a minimum, at least one pharmacy technician for a single pharmacist in a pharmacy and two pharmacy technicians for each additional pharmacist, except that this ratio shall not apply to personnel performing clerical functions pursuant to Section 4116 or 4117.

(3) A pharmacist scheduled to supervise a second pharmacy technician may refuse to supervise a second pharmacy technician if the pharmacist determines, in the exercise of his or her professional judgment, that permitting the second pharmacy technician to be on duty would interfere with the effective performance of the pharmacist's responsibilities under this chapter. A pharmacist assigned to supervise a second pharmacy technician shall notify the pharmacist in charge in writing of his or her determination, specifying the circumstances of concern with respect to the pharmacy or the pharmacy technician that have led to the determination, within a reasonable period, but not to exceed 24 hours, after the posting of the relevant schedule. No entity employing a pharmacist may discharge, discipline, or otherwise discriminate against any pharmacist in the terms and conditions of

employment for exercising or attempting to exercise in good faith the right established pursuant to this paragraph.

(g) Notwithstanding subdivisions (a) and (b), the board shall by regulation establish conditions to permit the temporary absence of a pharmacist for breaks and lunch periods pursuant to Section 512 of the Labor Code and the orders of the Industrial Welfare Commission without closing the pharmacy. During these temporary absences, a pharmacy technician may, at the discretion of the pharmacist, remain in the pharmacy but may only perform nondiscretionary tasks. The pharmacist shall be responsible for a pharmacy technician and shall review any task performed by a pharmacy technician during the pharmacist's temporary absence. Nothing in this subdivision shall be construed to authorize a pharmacist to supervise pharmacy technicians in greater ratios than those described in subdivision (f).

(h) The pharmacist on duty shall be directly responsible for the conduct of a pharmacy technician supervised by that pharmacist.

(i) In a health care facility licensed under subdivision (a) of Section 1250 of the Health and Safety Code, a pharmacy technician's duties may include any of the following:

(1) Packaging emergency supplies for use in the health care facility and the hospital's emergency medical system or as authorized under Section 4119.

(2) Sealing emergency containers for use in the health care facility.

(3) Performing monthly checks of the drug supplies stored throughout the health care facility. Irregularities shall be reported within 24 hours to the pharmacist in charge and the director or chief executive officer of the health care facility in accordance with the health care facility's policies and procedures.

§ 1793.2. Duties of a Pharmacy Technician.

"Nondiscretionary tasks" as used in Business and Professions Code section 4115, include:

(a) removing the drug or drugs from stock;

(b) counting, pouring, or mixing pharmaceuticals;

(c) placing the product into a container;

(d) affixing the label or labels to the container;

(e) packaging and repackaging.

Note: Authority cited: Sections 4005, 4007, 4038, 4115 and 4202, Business and Professions Code. Reference: Sections 4005, 4007, 4038, 4115 and 4202, Business and Professions Code. Operative 10-22-2004

State	Tech check Tech	Transfer Prescriptions	Accept New Prescriptions	License/Registration	Continuing Education
Arizona	No	Yes (both settings)	No	Y	20 hours
Colorado	Yes (both settings)	No	No	Y	None
Florida	No	No	No	Y	20 hours
Idaho	Yes (both settings)	Yes (both settings)	Yes (both settings)	Y	As required by the PTCB
Iowa	Yes (both settings)	No	Yes (both settings)	Y	None
Michigan	Yes (both settings)	Yes (both settings)	Yes (both settings)	N	None
New York	No	No	No	N	None
Nevada	No	No	No	Y	None, but in-service hours required
North Dakota	Yes (both settings)	Yes (both settings)	Yes (both settings)	Y	10 hours/year
Oregon	Yes (hospital only)	No	No	Y	20 hours/2 years Must Include: 2 hours in pharmacy law and 2 hours in patient safety or error prevention
South Carolina	Yes (both settings)	Yes (both settings)	Yes (both settings)	Y	10 hours/year
Texas	Yes (hospital only)	No	No	Y	20 hours/2 years
Washington	Yes (both settings)	No	No	Certification	10 hours

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STATE BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
LICENSING COMMITTEE
PHARMACY TECHNICIAN SUMMIT
MINUTES

DATE: April 4, 2017

LOCATION: Department of Consumer Affairs (DCA) Headquarters
First Floor Hearing Room
1625 North Market Blvd.
Sacramento, CA 95834

COMMITTEE MEMBERS PRESENT: Stanley Weisser, Chairperson, Licensee Member
Debbie Veale, Vice Chairperson, Licensee Member
Albert Wong, Pharm D, Licensee Member
Lavanza Butler, Licensee Member
Ricardo Sanchez, Public Member

STAFF MEMBERS PRESENT: Virginia Herold, Executive Officer
Anne Sodergren, Assistant Executive Officer
Laura Freedman, DCA Staff Counsel

1. Call to Order and Establishment of Quorum

Chairperson Weisser called the meeting to order at 9:07 a.m. Roll call was taken with the following members present: Stan Weisser, Debbie Veale, Lavanza Butler, Ricardo Sanchez and Albert Wong.

2. Public Comment for Items Not on the Agenda, Matters for Future Meetings*

**(Note: the committee may not discuss or take action on any matter raised during the public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. Government Code Sections 11125 and 11125.7(a))*

A member of the public requested clarification of Business and Professions Code (BPC) section 4115.5 (Pharmacy Technician Trainee; Placement; Supervision; Requirements), specifically as it pertains to a pharmacy technician trainee, an individual enrolled in a program that is not licensed. Some such individuals are limited in their ability to participate in externships at various practice settings. Public comment noted the challenges in placing individuals desiring additional experiential training in

additional practice settings once they have been issued a license, noting that pharmacy technician to pharmacist ratios then become a factor. The commenter noted that some individuals going through pharmacy technician training programs are having some challenges completing the training requirements within the 12 months currently specified as a condition for a pharmacy technician trainee because many community college programs are on a semester system.

Chairperson Stan Weisser noted both items will be included on the agenda for a future meeting.

3. Overview of the Pharmacy Technician Application and Renewal Requirements for Licensure

Chairperson Weisser provided an overview of the pharmacy technician application and renewal requirements. Specifically, Mr. Weisser reminded the committee that the application requirements include the application and fee; fingerprint background check; query from the National Practitioner Data Bank; and a description of the qualifications and supporting documents. Chairperson Weisser reminded the committee that the acceptable qualifications included either completion of a technician training program, certification from a specified program (currently either PTCB or ExCPT) or an associate degree in pharmacy technology. Chairperson Weisser noted that currently only a fee is required for renewal.

Chairperson Weisser reminded the committee of two pending regulations that also impact pharmacy technicians, the first regarding changes to the renewal requirement to require a pharmacy technician to self-disclose convictions or disciplinary action. Chairperson Weisser provided a general description of the second pending regulation that relates to application requirements, including updating the application form as well as increasing the requirements for specified pharmacy technician training programs.

The committee noted that one of the pathways to licensure is certification as a pharmacy technician, but under current law, there is no requirement for the certification to be maintained. Members of the committee noted that there should be some sort of mechanism where pharmacy technicians can expand their education and they questioned if continuing education (CE) should be required as a condition of renewal. The committee discussed the possibility of developing a survey to elicit feedback from pharmacy technicians on the issue of continuing education that could be used if public comment during the meeting did not address the issue.

Marian Mobley-Smith, director of strategic alliances, Pharmacy Technician Certification Board (PTCB), was invited to comment on whether states require certification as a condition of the pharmacy technician license. Dr. Mobley-Smith explained that in some states, CE requirements for pharmacy technician licensure renewal mimic PTCB certification requirements. The committee discussed maintenance of a license versus maintaining certification. Dr. Mobley-Smith explained that 20 hours of CE are required for PTCB certification every two years. She said that individual state requirements vary but added that many states align with the current PTCB requirements. Dr. Mobley-Smith estimated that 75 percent to 80 percent of PTCB members maintain their certification. When queried about the number of technicians that maintain their certification as a condition of employment versus

a licensing renewal requirement, Ms. Mobley-Smith said she could check to see if PTCB has information but indicated she is aware of at least one large employer that requires maintenance of the certification as a condition of employment.

When queried about the cost impact to individuals wishing to complete continuing educated, she explained that the availability of CE is vast both online and in print, including free and low-cost courses. Dr. Mobley-Smith spoke about the importance of completing continuing education that is related to functions of a pharmacy technician (referred to a "T accredited"). She noted that nationally there are a number of organizations that offer such accredited CE, and the availability continues to grow. Dr. Mobley explained the route by which someone could seek approval of a CE course that is not otherwise accredited. The committee questioned if PTCB would consider CE as a condition of renewal a hurdle, and the committee was advised that PTCB would not consider it a hurdle given the availability of courses available many of which can be done online at low or no costs. Ms. Herold asked about employer based continuing education and was advised that the PTCB no longer accepts employer based training for purposes of fulfilling the CE requirement as it generally fails to have specified parameters in line with accreditation standards. However Dr. Mobley-Smith noted that this prohibition would not extend to an employer that partners with an accredited provider to provide the CE.

Chairman Weisser inquired about the availability of continuing education courses that may be available for pharmacy technicians that work in either a compounding pharmacy or acute care setting and was advised that there is not the same level of availability for those types of courses. Dr. Mobely-Smith noted that as states grapple with identifying expanded roles for pharmacy technicians, such changes need to be accompanied by commensurate training opportunities so technicians can take advantage of the new and expanded roles. Development of such training opportunities is needed. When queried about types of specialized courses for pharmacy technicians, the committee was advised that such could be in the area of compounding, pharmacy informatics, etc.

The committee heard from Loriann De Martini, California Society of Health-System Pharmacists (CSHP), along with Jeannie Le and Paul Sabitini, pharmacy technician leaders within CSHP. Dr. DeMartini noted that evaluation of pharmacy technician roles is long overdue, noting some of the areas where pharmacy technicians engage in health care including as part of the medication reconciliation process. She noted that there is greater interface with patient care and pharmacy technicians than in the past. The committee inquired if CSHP had comments specific to consideration of continuing education as a condition of renewal for pharmacy technicians. Dr. De Martini explained that CE is offered by CSHP during an annual seminar and noted that the seminar planning committee includes a pharmacy technician member. The committee was advised that as part of the course objectives for CE offered during the annual seminar, presenters need to ensure learning objectives are specified and met for both pharmacists and pharmacy technicians as a condition of the course accreditation. When queried about the cost of such courses, the committee was advised that four-day admittance to the meeting would be $240 and an estimated 20 to 25 hours of CE courses are designated as technician appropriate. The speakers concurred that CE is encouraged among CSHP members and noted that individuals seem to demonstrate a level of confidence once certification is obtained because of the accomplishment of achieving the certification.

Steve Norris advised the committee that pharmacy technicians at his employer are provided access to free continuing education. When queried about how technicians are classified within his organization, the committee was advised that an entry-level pharmacy technician would be similar to a technician in a community pharmacy; a mid–level pharmacy technician would most likely be akin to a technician working in an inpatient setting working with acute patients and other health care providers; and the highest level of technicians perform some administrative work and are required to be certified as a condition of employment.

4. Overview, Discussion and Consideration of Possible Changes to Duties Performed by a Pharmacy Technician in the Following Settings:

a. Pharmacy Technician Duties in a Traditional Community Pharmacy Setting

Chairperson Weisser summarized relevant laws and provided a description of pharmacy technician duties. Specifically Chairman Weisser noted that BPC section 4038 defines a pharmacy technician as an individual who assists a pharmacist in a pharmacy in the performance of his or her related duties; BPC section 4415 specifies that a pharmacist technician can perform packaging, manipulative, repetitive or other nondiscretionary tasks, only while assisting, and while under the direct supervision and control of a pharmacist; and CCR section 1793.2 further specifies the allowable duties that performed by a pharmacy technician in most pharmacy setting. Mr. Weisser listed the allowable duties that may be performed by a pharmacy technician as removing the drug or drugs from stock; counting, pouring, or mixing pharmaceuticals; placing the product into a container; affixing the label or labels to the container; packaging; and repackaging

Chairperson Weisser reminded the committee of its discussion in June 2016, when the committee heard that tasks performed by pharmacy technicians vary nationwide. For example, in Alabama pharmacy technicians may not have controlled substances. In Utah, in addition to duties consistent with pharmacy technician duties in California, pharmacy technicians may also counsel for over the counter drugs and dietary supplements under the direct supervision of a pharmacist as well as accept new prescription drug orders left on a voice-mail for pharmacist review. In Alaska, if a pharmacy technician will assist in the preparation of sterile pharmaceuticals, the technician must have completed 40 hours of on-the-job training in the preparation, sterilization, aseptic technique, and admixture of parenteral and other sterile pharmaceuticals. The committee noted that the regulations (CCR section 1793.2 Duties of a Pharmacy Technician) have remained essentially unchanged. Mr. Weisser stated that the discussion should consider various types of responsibilities in different settings to support a pharmacist and asked to hear from the public on any suggested changes.

The committee noted the need to look to the future when discussing pharmacy technician responsibilities because there have been significant changes in complexity, demand and requirements in the industry. The committee considered if expanding pharmacy technician duties to include more responsibilities while under the supervision of a pharmacist would allow pharmacists to provide more patient care services, including drug utilization review, patient profile review and patient consultation. The committee added that changes to the pharmacy technician duties could allow for pharmacists to practice at a higher level without having to change existing regulations for the pharmacist.

The committee discussed the possibility of establishing a supervising pharmacy technician and whether it would be appropriate to allow such an individual to verify prescription refills filled by a pharmacy technician or verify the work of a clerk typist. The committee noted that these duties are allowable in Utah.

The committee noted that pharmacy technician standards need to be higher if duties and responsibilities are increased and indicated that such standards should include an education component. The committee noted the need to balance the board's regulation versus what should be left to the employer to determine the duties of a pharmacy technician as well as the standards that must be met. Staff noted that the board has taken different approaches to meeting a balance. For example, with the advanced practice pharmacist license, the policy approach was to only allow an individual to perform the expanded duties if an additional license was secured. However, the board's approach with compounding was not to require a special license for a pharmacist or pharmacy technician, but rather, as related to specifically the training portion, establish the training requirement that must be met prior to performing functions. (In such a case a separate license for the individual is not currently required.)

Ms. Herold recommended that the board reinforce its expectations of pharmacist to consult and oversee the process, and outline those expectations through policy.

The committee and public both noted the changes in law that have expanded duties of pharmacists. The committee was advised that discussions are occurring on the national level both regarding expanding the duties of a pharmacist as well as the duties of pharmacy technicians.

The committee was advised that in Idaho pharmacy technician duties have expanded to include authorization to take new orders from a physician; transfer and clarify prescriptions; immunize; extend pharmacy hours to include time when a pharmacist is not physically present in the pharmacy but is available via tele-pharmacy; perform CLIA (Clinical Laboratory Improvement Amendments of 1988) waived tests; and perform tech-check-tech duties. It was explained that Idaho has three levels of licensure (some levels requiring additional education); recently, Idaho changed its requirements and now pharmacy technicians must become nationally certified within three years of licensure and that such certification must be maintained once received.

The board inquired about the number of pharmacy technicians in Idaho and was advised that while it was estimated to be about 2,500, the population was nearly double that prior to the certification requirement and that the drop was due in part to part-time pharmacy technicians not pursuing certification. The committee was advised that existing Idaho pharmacy technicians were grandfathered in and that these technicians cannot perform the expanded duties and are not required to secure certification. In addition to the different levels of pharmacy technician licenses in Idaho, pharmacy technicians performing immunizations and other expanded duties require additional training Additionally, for tech-check-tech, employer-based training is required to demonstrate competency.

The committee inquired about the length of time it takes for a technician-in-training to complete training in Idaho. It was explained that the tech-in-training is currently three years; however there is a

proposal to reduce the training requirement to two years since most individuals complete the training within two years. The committee inquired about the requirements of an expanded technician in terms of education. It was noted that national certification (PTCB or EXCPT) was required.

Ms. Veale commented that Idaho's model would be a good starting point and added that grandfathering in individuals offered a solution for the large number of pharmacy technicians in California.

Dr. DeMartini shared with the committee that tech-check-tech currently is permissible in the retail setting in five states. She continued that in Iowa, Walgreens is conducting a tech-check-tech study in an environment where a majority of its pharmacies are participating. She noted another 2011 study by the American Society of Health-System Pharmacists (ASHP) looked at the number of tech-check-tech settings.

Dr. Wong inquired about pharmacist-to-pharmacy-technician ratios. Dr. De Martini provided that Idaho has a 5:1 ratio, Arizona does not have a ratio, and additional states would need to be checked. Public comment provided that in Idaho, its intention was to hold the pharmacy technician verifying the medication filling accuracy tech-check-tech responsible in lieu of the pharmacist. Dr. De Martini stated that direct supervision and pharmacist oversight does not go away. Chairperson Weisser inquired how the pharmacist interacts with the patient in regard to the tech-check-tech system. He was provided a summary of the workflow used in the pilot stores in Iowa including the pharmacist involved at the first level interaction with the patient, performs the data and review prior to printing the label, providing the final consultation.

Public comment shared highlights of tech-check-tech provisions in Idaho, including new prescriptions that could be filled by a pharmacy technician as long as a pharmacist has conducted the DUR and data entry checks and tech-check-automation that would apply to mail-order pharmacies. One speaker said that in Illinois and other states, there was allowance for the use automation where a medication is dispense with no pharmacist check and noted virtually no errors were made.

Mr. Weisser inquired about the pharmacist involvement for call-in prescriptions. It was explained that in Idaho, the pharmacist would be at the DUR and PU1 station verifying the data entry. In regard to patient consultation there is a toll-free number that patients may call. The speaker explained that tech-check-tech and tech-check-automation was implemented so that pharmacists could perform expanded duties.

Ms. Herold commented that there is a tele-pharmacy bill that will be brought to the board that would allow two pharmacy technicians to run a pharmacy with a remote pharmacist for underserved areas. A public comment was made regarding the success of existence of tele-pharmacies in other states including Iowa and North Dakota, where there are approximately 100 tele-pharmacies.

The committee raised concern over higher pharmacy technician to-pharmacist ratios, such as 6:1 in Idaho. Dr. DeMartini explained that the 6:1 ratio was rarely used and that the norm was closer to 4:1. It was also noted that the higher ratio was less feasible for retail pharmacies but beneficial for closed-door pharmacies and hospitals.

Public comment added that Iowa is considering abolishing its 6:1 ratio to become the 21st state that has no ratio. The committee voiced concern over allowing a pharmacy technician to be responsible for other pharmacy technicians and placing the pharmacist at risk of losing his or her license. The committee discussed leaving room for the pharmacist to make the appropriate ratio determination.

The committee discussed the issue of pharmacist-to-pharmacy technician ratios and was advised that legislation has been introduced that would require the board to conduct research and report on pharmacist to pharmacy technician ratios including any recommendation for changes based on the research findings.

b. Pharmacy Technician Duties in a Mail Order Pharmacy or Closed Door Pharmacy

The committee noted that there are different pharmacy business models and that practice settings may differ but the functions performed are the same.

The committee heard public comment from an individual that has experience in a traditional community pharmacy and now works at a pharmacy that focuses primarily on pharmacy services for patients in long-term care facilities. She said a long-term care pharmacy is generally a closed-door pharmacy - meaning patients do not come to the pharmacy to have their prescriptions filled). The commenter noted that while the ratios are the same in the closed-door pharmacy environment, 80 percent of prescriptions in long-term care pharmacies are refills and are dispensed every 30 days. The commenter noted struggles with managing the workload and the need to have pharmacists perform tasks that otherwise could be completed by a pharmacy technicians. She asked that the board consider items specifically for long-term care facilities and provided specific areas of consideration regarding the automated drug delivery systems, tech-check-tech and ratios.

Chairperson Weisser asked for clarification on how the pharmacist is involved in the workflow of the dispensing process in a closed-door pharmacy. It was explained that parameters would need to be in place and also that it would depend. The speaker provided an example where in the case of pre-packs and unit-dosing, an initial check is conducted by a pharmacist; however the pre-packs are rechecked by the pharmacist before going into the QV. In another example, it was stated that the pharmacist would be involved in the final review for new prescriptions. She stated that some technicians could do a better job than a pharmacist when it came to production tasks.

The committee discussed mail order pharmacies. Ms. Herold noted that nonresident pharmacies shipping product into California must comply with the pharmacist-to-pharmacy technician ratio specified in the resident state, and that may create an unfair advantage for such entities from a workload perspective. Ms. Herold asked if maintaining the current ratios was at the expense of California pharmacies or at the risk of the patient safety. Chairperson Weisser inquired if mail order pharmacies could be regulated to place them on similar footing as California pharmacies. He was advised that the committee could look at establishing a regulation model similar to its approach with patient-centered labeling, where all prescriptions dispensed to Californians, irrespective of where the prescription is filled must comply with California labeling requirements. Ms. Herold suggested the

need to broaden consultation requirements for mail order pharmacies, and Ms. Sodergran noted that some of the consumer complaints received by the board regarding mail order pharmacies involve allegations of delays in therapies because the patient is unable to reach a pharmacist. Chairperson Weisser stated that patients should expect the same level of service everywhere.

Ms. Sodergren inquired how often a mail order pharmacy performs medication reconciliation with their patients to determine if any changes have occurred. Dr. DeMartini responded that this function is most likely done by pharmacy benefits managers (PBMs) that have access to patient records that would highlight if there was duplication in therapy.

There was one additional public comment regarding the value of consultation by the pharmacist.

5. Overview, Discussion and Consideration of Current Duties Performed by a Pharmacy Technician in an Inpatient Setting and Possible Changes to Such Duties

Mr. Weisser stated that in the inpatient setting, pharmacy technicians may be more focused on performing compounding duties and possibly also performing "tech check tech" roles. He continued that although there has been some expansion in the duties a pharmacy technician may have in such a setting, it was appropriate to consider if such duties are still appropriate as well as if there are opportunities for changes. Mr. Weisser stated that it is anticipated that attendees will offer suggestions for changes in their respective areas of pharmacy for the committee to consider as part of its discussion and noted the provisions of CCR section 1793.8 in the attachment.

The committee was provided with history behind the tech-check-tech provisions currently allowed in a hospital setting, including studies that confirmed the safety for tech-check-tech in inpatient settings.

Mr. Weisser , referencing an article entitled *Tragic Pharmacy Technician Error Sparks Pursuit of Strengthened Regulations* that was included in the meeting materials, inquired if the article was regarding a tech-check-tech program. Ms. Sodergren clarified that the article seemed to be more about the state (Ohio) in the article seeking standardization of requirements.

The committee discussed concerns regarding the tech-check-tech in certain settings and recognized that it has been in place in California in the hospital setting since 2007 (CCR section 1793.8 Technicians in Hospitals with Clinical Pharmacy Programs).

The committee heard from a member of the public who believes, based on her experience, that pharmacy technicians are better at checking for dispensing errors than the pharmacist. She said that many times a pharmacist is pulled away to answer phone inquiries, speak with doctors and resolve issues with inpatient orders, while a pharmacy technician can focus on performing the final check without such interruptions.

The committee also heard comment from a pharmacy technician who works in an inpatient setting. He said the hospital uses scanning technology instead of tech check tech provisions. The commenter noted that use of such technology provides an important safeguard. The committee asked the

commenter about his experience working with pharmacy technicians who are also certified versus those who are not. The individual noted that he believes errors are higher for noncertified pharmacy technicians, but a pharmacy technician that is passionate about the job could also perform at a higher level.

The committee heard from a member of the audience who provided an explanation of his employer's use of pharmacy technicians. In this case, the employer used different levels of pharmacy technician job classifications, where the duties and pay were associated with the level of the job classification. The committee was advised that the commenter believed requiring certification of a pharmacy technician would be beneficial.

Vickie Ferraresi, introduced herself as president of CSHP. She noted that a job description mandates if technicians require certification to work in certain settings. Ms. Ferraresi opined that as standards have been developed in the profession, standards for technicians should evolve and be consistent among various technicians. Ms. Ferraresi noted current minimum standards are 18 years old, high school graduation, and completion of the exam; therefore, the range of experience is vast. The committee inquired if Ms. Ferraresi thought that PTCB certification and continuing education as a condition of renewal would be appropriate as a minimum requirement for pharmacy technicians performing final verification in a tech-check-tech program. She responded that while certification was a good start, there were experienced and intelligent technicians who were not certified but could also perform the function appropriately.

The committee heard from Dr. DeMartini regarding the evolution of the tech check tech regulations, which ensured that pharmacy technicians were properly trained. She provided that implementation of the tech-check-tech in a hospital setting released the pharmacist to be involved in clinical care. She provided an example of a pharmacist who was released to be a part of a pediatric transplant patient care team.

Dr. De Martini encouraged the board to consider expanding the roles and responsibilities of the pharmacy technician and noted the need for the hospital to properly train and follow up on training to ensure the competency of the pharmacy technician. Dr. DeMartini indicated that pharmacy technicians are conducting duties that have expanded to include such things as assisting in transitioning care and comprehensive medication management. Dr. DeMartini advised the committee of a grant received by USC to manage high-risk elderly patients with a team consisting of a pharmacist, pharmacy intern, and pharmacy technician. It was explained that the duties are not granted with a license but rather that the employer finds value in an individual who has a license qualification.

Chairperson Weisser inquired if Dr. DeMartini would recommend the committee/board avoid being prescriptive. Dr. De Martini encouraged the board to allow institutions to outline how patient safety is ensured. She reminded the committee to consider how to advance the profession to meet the future demands of the population. Dr. De Martini applauded the board for its current efforts.

Ms. Sodergren inquired, if under Title 22 a specific pharmacy department is responsible for the functions related medication adherence for the transfer of exiting patients to nursing home or in-home care. She noted that it sounded like hospitals use pharmacy technicians for that purpose. Dr. De

Martini indicated that the entire continuum of medication use lies with the pharmacy department and the pharmacist

Ms. Ferraresi added that it is always in the patient's best interest to have counseling about medications upon discharge. However she shared her experience around patients and their lack of understanding of their prescriptions as well as their retention of such information once received.

Dr. Mobley-Smith added that the regulations should be drafted in a manner to allow the practice to evolve. She stated that she thinks of hospitals as health systems where pharmacy technicians are involved in medication therapy management. She noted that there is a difference between technical judgement and clinical judgement. In terms of medication therapy management, Dr. Mobley-Smith indicated that the pharmacy technician assists the pharmacist in gathering data and medication history. The pharmacist could in turn make decisions and work with patients to provide optimal care. To highlight the difference between technician judgment versus clinical judgment, Dr. Mobley-Smith noted that the administration of an immunization was more of a technical task, where the pharmacy technician is not deciding which drugs or dose to administer, nor would they be determining things such as side effects. She added that medical technicians administer immunization; however, they are trained in CPR.

Dr. Mobley-Smith listed numerous areas where pharmacy technicians are involved in the health care system .She said these duties were provided to demonstrate how pharmacy technician responsibilities are evolving, and she encouraged the board to allow the profession to continue to grow.

The committee inquired if PTCB had similar CE requirements for renewal of certification as it did for initial certification. Dr. Mobley-Smith replied that PTCB does have renewal of certification for a certain number of hours and that PTCB recently voted to add patient safety as part of recertification. The committee asked if PTCB was supplying continuing education in extensive list of duties and was advised that PTCB is a certification organization rather than an education provider and that PTCB could direct individuals to resources but that PTCB does not provide the continuing education itself.

The committee contemplated the benefits to both uniformity of training as well as specialized training for pharmacy technicians performing final verification through a tech-check-tech program.

The committee discussed the benefits of high standards for pharmacy technicians involved in tech-check-tech duties such as certification and completion of an associate of arts degree to protect consumers. The member of the public supported having an AA degree to have a higher caliber technician but added that some lower income students might not be able to afford to go to school. DCA legal counsel Laura Freedman explained that the education could be justified if pharmacy technician duties could demonstrate the need for public protection.

6. Overview, Discussion and Consideration of Current Duties Performed by a Pharmacy Technician in Other Specialty Pharmacy Settings and Possible Changes to Such Duties

Chairperson noted that similar to the inpatient setting, pharmacy technicians may be more focused on specific tasks in a specialty pharmacy. He continued that it is anticipated that attendees will offer suggestions for changes in their respective areas of pharmacy for the committee to consider as part of its discussion. He said it may be appropriate to consider if duties are still appropriate, as well as if there are opportunities for changes.

Chairperson Weisser explained that this was the same general discussion with a focus on other specialty pharmacy settings. Ms. Veale acknowledged that requirements may be similar for different settings. The committee discussed revisiting specific duties and responsibilities in different settings - specifically, those duties in Idaho provided under Agenda Item 4 (new orders from a physician, transfer and clarify prescriptions, immunize, extend pharmacy hours via tele-pharmacy, perform CLIA waived tests, and tech-check-tech) and focusing on community pharmacy, mail order, closed-door setting, and education in other states. Ms. Sodergren indicated that staff would analyze comparisons in terms of patient benefit. She continued that the staff would present a comparison between an occupation and the profession, as this tied to accountability.

No public comment was received.

7. Discussion and Consideration of Possible Changes to the Pharmacy Technician Application and Renewal Requirements for Licensure Including Implementation Strategies for Identified Changes.

Chairperson Weisser introduced this item and stated that after discussion on the respective areas, the committee would return to the application and renewal requirements to determine whether to recommend changes to the licensing and/or renewal requirements.

The committee agreed additional time was necessary to review the attachments (SEIU letter dated January 24, 2017; article entitled *Tragic Pharmacy Technician Error Sparks Pursuit of Strengthened Regulations)*, as there may be unintended impacts on certain groups. Ms. Sodergren offered to pull MQs as part of state comparison. One public comment, from Kate Anhill, urged the board to ensure technicians include email addresses. The committee tabled this item for a future meeting.

8. Future Committee Meeting Dates for 2017

- June 29, 2017
- September 19, 2017

The meeting adjourned at 3:26 pm.

13. Status of Pharmacy Technicians

State	Designation	Does State: License Technicians?	Does State: Register Technicians?	Does State: Require Certification?	Technician Registration Fee	Registration Renewal Schedule
Alabama	Pharmacy Technician	No	Yes	No	$60	Biennial II
Alaska	Pharmacy Technician	Yes	No	No	$50 HH, UU	Biennial
Arizona	Pharmacy Technician	Yes	No	Yes RRR	B	Biennial B
Arkansas	Pharmacy Technician	No	Yes	No	$70 II; $35 YY	Biennial
California	Pharmacy Technician	Yes	Yes	No VVV	$105	Biennial
Colorado	Pharmacy Technician	No	No	No	N/A	N/A
Connecticut	Pharmacy Technician	No	Yes	No	$100	Annual - 3/31
Delaware	Pharmacy Technician	No	No	No	None	N/A
District of Columbia	Ancillary Personnel	No BBB	Yes BBB	Yes BBB	$50	Annual
Florida	Pharmacy Technician	No	Yes	No	$100	Biennial
Georgia	Pharmacy Technician	No	Yes	No	$100	Biennial
Guam	Pharmacy Technician	No	Yes	No †	J	J
Hawaii	Pharmacy Technician	No	No	No	N/A	N/A
Idaho	Pharmacy Technician	No	Yes M	Yes LLL	$35	Annual
Illinois	Pharmacy Technician	Yes	No	Yes SSS	$40 initial; $25 renewal	Annual
Indiana	Pharmacy Technician	Yes AAA	No	Yes FFF	$25 WW	Biennial
Iowa	Pharmacy Technician	No	Yes	Yes PPP	$40, $20 trainee	Z
Kansas	Pharmacy Technician	No	Yes	No †	$20	Biennial
Kentucky	Pharmacy Technician	No	Yes	Yes GGG	$25	Annual
Louisiana	Pharmacy Technician	Yes	No	Yes FF	$100	Annual
Maine	Pharmacy Technician	Yes	No	—	$25	Annual
Maryland	Pharmacy Technician	No	Yes	Yes NNN	$45	Biennial G
Massachusetts	Pharmacy Technician	No	Yes	No	$60	Biennial G
Michigan	Pharmacy Personnel	No	No	MMM	—	—
Minnesota	Pharmacy Technician	No	Yes	No TTT	$37.50	Annual
Mississippi	Pharmacy Technician L	No	Yes	Yes LLL	$50	Annual
Missouri	Pharmacy Technician	No	Yes	No	$35 W	Annual
Montana	Pharmacy Technician	No	Yes	Yes AA	$60 initial; $50 renewal	Annual
Nebraska	Pharmacy Technician	No	Yes	Yes MMM	$25	Biennial RR
Nevada	Pharmaceutical Technician L	No	Yes	No	$40	Biennial
New Hampshire	Pharmacy Technician	No	Yes	No	$50	Annual
New Jersey	Pharmacy Technician	No	Yes	No	$70	Biennial
New Mexico	Pharmacy Technician N	Yes	No	Yes A	$30	Biennial
New York	Unlicensed Person	No	No	No	N/A	N/A
North Carolina	Pharmacy Technician	No	Yes	No EEE	$30	Annual
North Dakota	Registered Pharmacy Technician	No	Yes	Yes DDD	$35	Annual
Ohio	Qualified Pharmacy Technician	No	No	No LL	N/A	N/A
Oklahoma	Pharmacy Technician	No	Yes O	No	$40	GG
Oregon	Pharmacy Technician	Yes WWW	No	Yes JJJ	$50 VV	Biennial †
Pennsylvania	Pharmacy Technician	No	No	No	N/A	N/A
Puerto Rico	Pharmacy Technician	No	Yes	Yes	$50	3 years
Rhode Island	Pharmacy Technician	Yes	No	RRR	$25	Annual
South Carolina	Pharmacy Technician	No	Yes	No	$40 initial; $15 renewal	Annual
South Dakota	Pharmacy Technician	No	Yes	Yes CCC	$25	Annual
Tennessee	Pharmacy Technician	No	Yes	No	$75 biennial	Cyclical
Texas	Pharmacy Technician	No	Yes	Yes KKK	$80 initial; $77 renewal	Biennial
Utah	Pharmacy Technician	Yes	No	No	$60 TT	Biennial
Vermont	Pharmacy Technician	No	Yes	No	$50	Biennial
Virginia	Pharmacy Technician	No	Yes	No QQQ	$25	Annual
Washington	Pharmacy Technician	No	No	Yes	$60 initial; $50 renewal	Annual
West Virginia	Pharmacy Technician	No	Yes	Yes	$25 W, X	Biennial
Wisconsin	Pharmacy Technician	No	No	No	—	—
Wyoming	Registered Pharmacy Technician K	Yes KK	Yes KK	Yes DDD, RRR	$50	Annual

Colored text denotes change from 2016 edition.
† Other comments noted in 2016 edition no longer apply.
— Indicates information is not available.

13. Status of Pharmacy Technicians (cont.)

State	Technician Training Requirements	Technician CPE Requirements	Technician Examination Requirement	Can Board Deny, Revoke, Suspend, or Restrict Technician Registration?	Maximum Ratio of Technician(s) to Pharmacist in an: Ambulatory Care Setting	Maximum Ratio of Technician(s) to Pharmacist in an: Institutional Care Setting
Alabama	No	3 hrs/yr MM	—	Yes	3:1*	3:1*
Alaska	Yes S	10 hrs/2 yrs	No	Yes	None	None
Arizona	Yes	NN	Yes FF	Yes	None	None
Arkansas	No	None	No	Yes	2:1	2:1
California	Yes CC	No	No CC	Yes	Varies*	2:1
Colorado	No	N/A	No	N/A	3:1	3:1
Connecticut	Yes S	No	No	Yes	2:1* or 3:1	3:1*
Delaware	Yes	N/A	No	N/A	None	None
District of Columbia	Yes BBB	Yes BBB	Yes BBB	Yes	—	—
Florida	Yes Q	20 hrs/2 yrs	No	Yes	3:1*	3:1*
Georgia	No	None	No	N/A	3:1*	3:1*
Guam	No J	None J	No	Yes	None J	None J
Hawaii	No	No	No	No	None	None
Idaho	Yes OO	Yes	Yes	Yes	6:1*	6:1*
Illinois	Yes PP	No	Yes QQ	Yes	None	None
Indiana	Yes	No	No U	Yes	6:1*	6:1*
Iowa	Yes H	No	No	Yes	None	None
Kansas	Yes	Yes YYY	No	Yes	2:1 or 3:1*	2:1 or 3:1*
Kentucky	No	None	No	Yes	None	None
Louisiana	No	10 hrs OOO	Yes FF	Yes	3:1*	3:1*
Maine	Yes UUU	No	No	Yes	None	None
Maryland	Yes	Yes	Yes	Yes	None	None
Massachusetts	Yes	No BB	Yes	Yes	4:1	4:1
Michigan	No	—	—	—	None	None
Minnesota	Yes	Yes	No	Yes	3:1 †	3:1 †
Mississippi	No I	No	No	Yes	2:1	2:1
Missouri	Yes HHH	None	No	Yes	None*	None*
Montana	Yes** T	Yes SS	Yes AA	Yes	3:1*	3:1*
Nebraska	Yes** I	No	No	Yes ZZZ	3:1	3:1
Nevada	Yes	Yes Y	No	Yes	3:1*	3:1
New Hampshire	Yes	Yes P	Yes P	Yes	None	None
New Jersey	No	No	No	Yes	Varies	Varies
New Mexico	Yes**	None	Yes AA	Yes	None	None
New York	No	No	No	No	2:1	2:1
North Carolina	Yes	None	No	Yes	2:1*	2:1*
North Dakota	Yes R	Yes 10 hrs/1 yr	Yes	Yes	3:1	4:1
Ohio	Yes	No	Yes	No	None	None
Oklahoma	Yes	None	Yes	Yes JJ	2:1	2:1
Oregon	Yes III	Yes P	Yes P	Yes	None	None
Pennsylvania	Yes ZZ	None	No	N/A	None	None
Puerto Rico	Yes F	20 hrs/3 yrs	Yes	Yes	5:1	5:1
Rhode Island	Yes	Yes BB	Yes V	Yes	None	None
South Carolina	Yes DD	10 hrs/yr EE	Yes DD	Yes	3:1*	Varies*
South Dakota	Yes D	None	Yes D	Yes	3:1	2:1*
Tennessee	No	None	No	Yes	2:1*	2:1*
Texas	Yes C	20 hrs/2 yrs XXX †	Yes	Yes	3:1*	None
Utah	Yes	20 hrs/2 yrs	Yes E	Yes	*	*
Vermont	No	No	No	Yes	None	None
Virginia	Yes V	5 hrs/yr	Yes V	Yes	4:1	4:1
Washington	Yes	Yes XX	Yes AA	Yes	3:1*	3:1*
West Virginia	Yes I, K	None	Yes	Yes	4:1	4:1
Wisconsin	No	—	—	—	4:1	4:1
Wyoming	Yes ZZ	6 hrs	Yes FF	Yes	3:1	3:1

* See "Footnotes (*)" on page 43.

** Contact the state board of pharmacy office to obtain requirements.

Colored text denotes change from 2016 edition.

† Other comments noted in 2016 edition no longer apply.

— Indicates information is not available.

13. Status of Pharmacy Technicians (cont.)

LEGEND

A — All new pharmacy technicians have one year after initial licensure to obtain national certification.

B — Technician trainee – $36, Technician – $72. Technician trainee may reapply for licensure no more than one time.

C — A person may be a technician trainee for no more than two years while seeking certification through PTCB. Contact the Board for specific on-site training requirements.

D — Same as PTCB requirements.

E — PTCB examination or the ExCPT and Utah law examination.

F — 1,000 hours of internship under direct supervision of a registered pharmacist and passing an examination prepared by the Board are required for certification. Designated pharmacy technician intern for three years maximum.

G — Biennial at birthday. (MD – First renewal 10 CE, all other renewals 20 CE.)

H — Technicians must be under the immediate and personal supervision of the pharmacist. Technician training must be documented and maintained. National certification of all technicians by nationally accredited certifying body required by December 31, 2013.

I — Training requirements developed by training pharmacies and approved by the board. (WV – PTCB or National Healthcareer Association certified pharmacy technician certification. As of July 1, 2014, technician must have graduated from a competency-based pharmacy technician training and education program or completed training requirements stated above.)

J — The Board is proposing/developing regulations.

K — Designated as a "technician-in-training" prior to meeting requirements for licensure.

L — The term "Support Personnel" is also used.

M — May register as "technician-in-training" while working towards certification. This registration is renewable twice.

N — A "Pharmacy Technician" is a subset of "Supportive Personnel."

O — Technicians are not considered "registered," but are issued a "permit."

P — Required for certified pharmacy technicians, but not pharmacy technicians. (OR – Must become certified by the second June 30.)

Q — Pharmacy technicians may register in Florida if they complete a Board-approved training program.

R — Technicians must complete ASHP-accredited program.

S — On-the-job training by PIC appropriate to technician's duties.

T — Technician utilization plan filed with Board or didactic course.

U — Passage of the PTCB examination is one way to become certified as a technician in this state. Must also file application for licensure.

V — To be eligible for registration a pharmacy technician must either hold current PTCB certification or must have passed a training program and examination approved by the Board.

W — Plus a fingerprint fee paid to a contracted agency.

X — $25 initial; $30 renewal/2 years.

Y — However, technicians must complete six hours of in-service training per year and one hour of jurisprudence as do pharmacists. (NV – See Section 11, Continuing Pharmacy Education Requirements.)

Z — Biennial by birth month; trainee registration 1 year, not reusable.

AA — PTCB or ExCPT certification required. (WA – Exams administered by program accredited by NCCA.)

BB — However, "certified pharmacy technicians" must maintain certification.

CC — Educational training and/or PTCB examination are ways to qualify for technician registration.

DD — To be certified as a pharmacy technician an individual must have worked for 1,000 hours under the supervision of a licensed pharmacist as a technician and must have completed a Board of Pharmacy-approved technician course as provided for in subsection (D); a high school diploma or equivalent; and passed the National Pharmacy Technician Certification Examination or a Board of Pharmacy-approved examination and has maintained current certification; and fulfilled CE requirements as provided for in Section 40-43-130(G).

EE — As a condition of registration renewal, a registered pharmacy technician shall complete 10 hours of ACPE-accredited CE or CME Category I each year. A minimum of four hours of the total hours must be obtained through attendance at lectures, seminars, or workshops.

FF — Requires PTCB examination. (AZ – Or another Board-approved exam.)

GG — Annual (by birth month).

HH — Plus one-time application fee of $50.

II — Odd numbered years.

JJ — Revoked 28 pharmacy technician permits, 0 probations, 0 suspensions, and 0 fines.

KK — "Technicians-in-Training" are registered until they meet the requirements for licensure. The technician-in-training permit is valid for no more than two years from date of issue.

LL — Ohio does not license, register, or certify pharmacy technicians. There is no legal requirement to be licensed, registered, or certified as a pharmacy technician in the state of Ohio. However, the Board does require a technician to be "qualified."

MM — One hour must be live CE. No carry-over hours.

Legend continued on page 42

13. Status of Pharmacy Technicians (cont.)

LEGEND — cont.

NN — Twenty hours, of which two hours must be pharmacy law ACPE or Board-approved providers.
OO — Must be 18 years of age unless waived; a high school graduate unless waived or equivalent; of good moral character; and employed.
PP — Refer to 225 ILCS 85/9.5 and 85/17.1 and 68 Illinois Administrative Code Sections 1330.210 and 1330.220.
QQ — Beginning on January 1, 2010, within two years after initial registration as a registered technician, must become certified by successfully passing the PTCB or other Board-approved examination and registering as a certified pharmacy technician with the department. Does not apply to pharmacy technicians registered prior to January 1, 2008. Refer to 225 ILCS 85/9.
RR — Biennial, January 1 of odd years.
SS — Must be PTCB-approved or ICPT-approved.
TT — Additional $40 for criminal background check.
UU — Application fees are reevaluated June of even-numbered years.
VV — Plus $52 fingerprinting fee.
WW — Indiana State Police collect an additional fee for a background check.
XX — Beginning in 2013-2014 renewal cycle. 10 hours of CE credit with one hour in law/ethics.
YY — Even numbered years.
ZZ — On-the-job training in permitted activities.
AAA — As of July 1, 2014, switched from certification. Must still hold technician-in-training permit or be PTCB- or ExCPT-certified prior to licensure.
BBB — D.C. Law §17-99.
CCC — Does not apply to those registered prior to July 1, 2011.
DDD — PTCB only.
EEE — North Carolina recognizes PTCB certification, which allows pharmacy technician to perform additional duties.
FFF — See IC 25-26-19-5.
GGG — Required to perform certain functions.
HHH — For sterile compounding.
III — See OAR 855-025-0025(6).
JJJ — For initial license as a certified technician, but not for license renewal. Not required for nonrenewable technician license.
KKK — Applicants for pharmacy technician registration must have taken and passed PTCB's national Pharmacy Technician Certification Examination and have a current certificate. Contact Board for additional requirements.
LLL — With grandfather exemption.
MMM — Regulations pending.
NNN — Or provide satisfactory proof to the Board of successful completion of a pharmacy technician training program approved by the Board.
OOO — Must be technician-specific and ACPE accredited.
PPP — One-year technician trainee registration permitted.
QQQ — Only required to be actively certified through PTCB or ExCPT at time of initial application if using this option for application of registration. 18VAC110-20-101.
RRR — Only for pharmacy technicians. Not required for pharmacy technician trainees. (RI – National certification required for pharmacy technician II, not for pharmacy technician I.)
SSS — See 225 ILCS 85/9.
TTT — However, if at least one technician is certified, a pharmacy can exceed the base technician-to-pharmacist ratio by having one additional technician on duty within the pharmacy.
UUU — See Maine Pharmacy Rules 02 392, Chapter 7, Section 2, Training.
VVV — PTCB certification is one qualifying method for licensure, but certification is not required.
WWW — All new pharmacy technicians have up to two years/the second June 30 after initial licensure to obtain national certification. Pharmacy technician licenses are nonrenewable.
XXX — One hour must be related to Texas pharmacy laws or rules.
YYY — Twenty hours (approved) per biennial renewal period. No carry-over. Must be earned in prior registration period.
ZZZ — Board recommends to Department of Health and Human Services, Division of Public Health.

Footnotes (*)

AL — 3:1 if one technician is PTCB-certified. All technicians must be at least 17.

Footnotes continued on page 43

NABP*LAW* Online Search Terms

Status of Pharmacy Technicians *(type as indicated below)*

- technician certification
- technician fee
- technician license
- technician registration
- technician renewal
- technician requirements
- technician training

Note: "ancillary personnel"; "non-licensed personnel"; and "support personnel" can be substituted for "technician."

13. Status of Pharmacy Technicians (cont.)

Footnotes (*) — cont.

CA — In community pharmacy, the ratio is 1:1 for the first pharmacist on duty, then 2:1 for each additional pharmacist on duty. 2:1 if pharmacy services patients of skilled nursing facilities or hospices. A pharmacist may also supervise one pharmacy technician trainee gaining required practical experience.

CT — Refer to Section 20-576-36 of the Regulations of Connecticut State Agencies. In summary, ratio not to exceed 2:1 when both technicians are registered. Ratio of 3:1 permitted when there are two registered technicians and one certified technician. However, a pharmacist is permitted to refuse the 3:1 ratio for the 2:1 ratio. In an institutional outpatient pharmacy, ratio is 2:1. The pharmacist manager may petition the Commission to increase ratio to 3:1 in a licensed or institutional outpatient pharmacy. Inpatient pharmacy ratio is 3:1 generally, but pharmacy can petition for ratio of up to 5:1; satellite pharmacy 3:1, but can petition for up to 5:1.

FL — Rule 64B16-27.410 outlines the acceptable ratios as follows:
Three to one (3:1) ratio: Any pharmacy or any pharmacist engaged in sterile compounding shall not exceed a ratio of up to three (3) registered pharmacy technicians to one (1) pharmacist (3:1).
Four to one (4:1) ratio: Any pharmacy or any pharmacist may allow a supervision ratio of up to four (4) registered pharmacy technicians to one (1) pharmacist (4:1), as long as the pharmacist or pharmacy is not engaged in sterile compounding.
Six to one (6:1) ratio:
(a) Non-dispensing pharmacies. Any pharmacy which does not dispense medicinal drugs, and the pharmacist(s) employed by such pharmacy, may allow a supervision ratio of up to six (6) registered pharmacy technicians to one (1) pharmacist (6:1), as long as the pharmacy or pharmacist is not involved in sterile compounding.
(b) Dispensing pharmacies. A pharmacy which dispenses medicinal drugs may utilize a six to one (6:1) ratio in any physically separate area of the pharmacy from which medicinal drugs are not dispensed. A "physically separate area" is a part of the pharmacy which is separated by a permanent wall or other barrier which restricts access between the two areas.

GA — One of the three pharmacy technicians must be certified. Board may consider and approve an application to increase the ratio in a hospital pharmacy.

ID — Ratio includes technicians, technicians-in-training, and student pharmacists. No longer allowed cashiers/clerks in pharmacy.

IN — Technicians must be under the immediate and personal supervision of the pharmacist.

KS — The ratio may be 3:1 if at least two of the pharmacy technicians have a current certification issued by PTCB or a current certification issued by any other pharmacy technician certification organization approved by the Board.

LA — If pharmacy technician candidate is present, then maximum ratio for technicians is 2:1. If not, then the maximum ratio for technicians is 3:1.

MO — Technician must be under the direct supervision and responsibility of a pharmacist.

MT — Ratio is 3:1. Licensee may ask Board for variance based on established criteria or greater upon Board approval.

NC — Ratio may be increased above 2:1 if additional technicians are certified and the Board approves the increase in advance.

NV — Technician to pharmacist ratio is now 3:1; however, initial prescription data input can now only be done by a registered pharmaceutical technician or a pharmacist. A clerk may enter demographic and insurance data only on new prescriptions.

SC — The PIC shall develop and implement written policies and procedures to specify the duties to be performed by pharmacy technicians. The duties and responsibilities of these personnel shall be consistent with their training and experience. These policies and procedures shall, at a minimum, specify that pharmacy technicians are to be personally supervised by a licensed pharmacist who has the ability to control and who is responsible for the activities of pharmacy technicians and that pharmacy technicians are not assigned duties that may be performed only by a licensed pharmacist. One pharmacist may not supervise more than three pharmacy technicians at a time; at least two of these three technicians must be state certified. If a pharmacist supervises only one or two pharmacy technicians, these technicians are not required to be state certified. Pharmacy technicians do not include personnel in the prescription area performing only clerical functions, including data entry up to the point of dispensing, as defined in Section 40-43-30(14).

SD — Ratio to be determined by pharmacist-in-charge in long-term care, hospital, and mail service pharmacies.

TN — Up to 4:1 if two technicians are certified.

TX — 4:1 if at least one of the technicians is not a pharmacy technician trainee.

UT — Pharmacist determined for licensed pharmacy technicians, only one technician-in-training per supervising pharmacist.

WA — A pharmacy may use more technicians than the standard 3:1 ratio if its service plan is approved by the Commission.

14. Pharmacy Technicians in Hospital/Institutional Setting

State	May Pharmacy Technicians in the Hospital/Institutional Setting: Accept Called-in Prescription From Physician's Office?	Enter Prescription Into Pharmacy Computer?	Check the Work of Other Technicians?
Alabama	No	Yes	No
Alaska	No	Yes G	No
Arizona	No	Yes B	No
Arkansas	No	Yes	No
California	No	Yes E	Yes E, BB
Colorado	No	Yes G	Yes G
Connecticut	No K	Yes	No
Delaware	No	Yes E	No
District of Columbia	No	Yes G	No
Florida	No	Yes	No
Georgia	No	Yes	No
Guam	No	Yes E, G	No †
Hawaii	No	Yes E, G	No
Idaho	Yes JJ	Yes	Yes S
Illinois	Yes E	Yes E	No
Indiana	No J	Yes	No
Iowa	Yes G	Yes G	Yes O
Kansas	No	Yes G	Yes G, BB
Kentucky	No K	Yes E	Yes X
Louisiana	Yes	Yes	No
Maine	No J	Yes J	No J
Maryland	No	Yes	No
Massachusetts	Yes AA	Yes G	No
Michigan	Yes G	Yes G	Yes G
Minnesota	No	Yes	No C
Mississippi	No	Yes E, G	No
Missouri	Yes E, G	Yes E, G	No
Montana	Z, DD	Yes	Yes O
Nebraska	No	Yes	No
Nevada	No	Yes	No
New Hampshire	Yes U	Yes G	No
New Jersey	No	Yes G	No
New Mexico	No	Yes	No
New York	No	Yes G	No
North Carolina	Yes U	Yes	Yes II
North Dakota	Yes	Yes	Yes G
Ohio	No	Yes G	No
Oklahoma	No	Yes	No
Oregon	No	Yes	Yes EE
Pennsylvania	No	Yes E, G	No
Puerto Rico	No N	Yes N	No
Rhode Island	Yes G, U	Yes	No
South Carolina	Yes Y, AA	Yes E	Yes M
South Dakota	No	Yes G	No C
Tennessee	Yes U	Yes G	No
Texas	No	Yes	Yes V
Utah	No GG	Yes G, I	Yes BB
Vermont	No	Yes E	No
Virginia	No	Yes G	No
Washington	No D	Yes	Yes HH
West Virginia	No	Yes E, G	No E, G
Wisconsin	Z	Yes	No
Wyoming	No	Yes E, G	No

Colored text denotes change from 2016 edition.

† Other comments noted in 2016 edition no longer apply.

14. Pharmacy Technicians in Hospital/Institutional Setting (cont.)

State	May Pharmacy Technicians in the Hospital/Institutional Setting: Call Physician for Refill Authorization?	Compound Medications for Dispensing?	Transfer Prescription Orders?
Alabama	No H	Yes G	No
Alaska	Yes D, G	Yes G	No
Arizona	Yes B	Yes B, FF	Yes Y
Arkansas	Yes D	Yes	No
California	Yes E	Yes E	No
Colorado	Yes D	Yes G	No
Connecticut	Yes D	Yes E	No
Delaware	No	Yes F	No
District of Columbia	No G	Yes G	No
Florida	Yes	Yes CC	No
Georgia	No	No W	No
Guam	No	Yes E, G	No †
Hawaii	No	Yes E, G	No
Idaho	Yes	Yes	Yes JJ
Illinois	Yes E	Yes E	No
Indiana	Yes	Yes	No
Iowa	Yes G	Yes G	No
Kansas	Yes D	Yes G	No
Kentucky	Yes E, D	Yes E	No
Louisiana	Yes	Yes E	Yes Y
Maine	Yes J	Yes J	No J
Maryland	Yes	Yes G	No
Massachusetts	Yes	Yes B, G	No
Michigan	No	Yes G	Yes Q
Minnesota	Yes	Yes P	No
Mississippi	Yes E, G	Yes E, G	No
Missouri	Yes E, G	Yes E, G	Yes E, G, Y
Montana	Yes D, DD	Yes DD	No
Nebraska	Yes	Yes BB	No
Nevada	Yes	Yes	No
New Hampshire	Yes U	Yes G	No
New Jersey	Yes D	Yes E, G	No
New Mexico	No	Yes	No
New York	No	No	No
North Carolina	Yes U	Yes E	Yes U
North Dakota	Yes	Yes G	Yes
Ohio	No	Yes E	No
Oklahoma	Yes D	Yes L	No
Oregon	Yes D	Yes	No
Pennsylvania	No	Yes E, F, G	No
Puerto Rico	No	Yes N	Yes N
Rhode Island	Yes	Yes G	Yes I
South Carolina	Yes M, Y	Yes E	Yes M, Y
South Dakota	Yes	Yes G	No
Tennessee	Yes G	Yes G	Yes U
Texas	Yes D	Yes E, R	No
Utah	Yes D	Yes G	No
Vermont	No	Yes A, B	No
Virginia	Yes D, Z	Yes E, G	No
Washington	Yes D	Yes T	No
West Virginia	Yes D	Yes G, T	No
Wisconsin	D, Z	Yes B, G	No
Wyoming	Yes D, E, G	Yes E, G, FF	Yes Y

Colored text denotes change from 2016 edition.

† Other comments noted in 2016 edition no longer apply.

14. Pharmacy Technicians in Hospital/Institutional Setting (cont.)

LEGEND

A — Activities not addressed in statutes or regulations.

B — Subject to approved policy and procedure manuals, pharmacy technician training, and pharmacist final verification and initialing.

C — Only after obtaining a variance from the board. (In limited situations.)

D — If there are any changes to the prescription and/or if professional consultation is involved, the pharmacist must handle the call. (OR – For controlled substances. WA – Professional consultation/judgment.)

E — Allowed activity must be under the direct supervision of a licensed pharmacist. (HI – "Immediate supervision." KY – Direct supervision if technician is not certified by the PTCB; if certified, then technician may perform activity under indirect supervision. LA – "Direct and immediate" supervision and shall not compound high-risk sterile preparations, as defined by the USP.)

F — Compounding is the responsibility of the pharmacist or pharmacy intern under the direct supervision of the pharmacist. The pharmacist may utilize the assistance of supportive personnel under certain conditions. Contact the board for requirements.

G — Pharmacist must verify, check, and/or is responsible for allowed activities. (DC – Pharmacist must call for refill authorization for Schedule III through V. Pharmacist must receive oral prescription for Schedule II. RI – Except in the case of Schedule II controlled substances, only a pharmacist may receive an oral prescription.)

H — If there are any changes to the prescription and/or if professional consultation is involved, the pharmacist must handle the call. May fax a refill request to a physician's office if approved by the pharmacist. A refill is considered to be an authorization for a new prescription. Technicians may not take verbal orders from an agent or a physician for a new prescription.

I — Allowed activity must be under the general supervision of a licensed pharmacist.

J — New rules regarding allowed activities for technicians adopted December 11, 2013.

K — Allowed activity limited to pharmacist interns.

L — Bulk compounding allowed.

M — A supervising pharmacist may authorize a certified pharmacy technician to (1) receive and initiate verbal telephone orders; (2) conduct one-time prescription transfers; (3) check a technician's refill of medications if the medication is to be administered by a licensed health care professional in an institutional setting; and (4) check a technician's repackaging of medications from bulk to unit dose in an institutional setting.

N — Pharmacy Act allows pharmacy technicians to perform the tasks assigned by the pharmacist under his or her direct supervision. Puerto Rico Supreme Court has recognized that only pharmacists are prepared to do patient counseling.

O — Board approval required before implementation of tech-check-tech program.

P — Stage checking required for certain high-risk compounded products.

Q — If there are policies and procedures in place that allow delegation and that comply with Board Administrative Rules 338.490 and 338.3162.

R — Must have special training. Contact the Board for training requirements.

S — Verification Technician Program.

T — Bulk compounding and intravenous preparation are allowed, but "extemporaneous" compounding is not allowed.

U — Certified technicians only.

V — Contact the Board for requirements.

W — May compound IV admixtures only if pharmacist verifies the final product for accuracy, efficacy, patient utilization, and has a mechanism to verify the measuring of active ingredients added to the IV mixture.

Legend continued on page 47

NABP*LAW* Online Search Terms

Pharmacy Technicians in Hospital/Institutional Setting *(type as indicated below)*

- technician duties hospital
- technician registration hospital
- technician requirements hospital
- technician training hospital

Note: "ancillary personnel," "non-licensed personnel," and "support personnel" can be substituted for "technician"; "institutional" can be substituted for "hospital."

14. Pharmacy Technicians in Hospital/Institutional Setting (cont.)

LEGEND — cont.

X — Limitation 201 KAR 2:045.
Y — Non-controlled only. (AZ – May only do electronic transfers of non-controlled drugs between pharmacies owned by the same company using a common or shared database.)
Z — Can accept refills if no changes. (WI – New prescriptions must be recorded.)
AA — Certified technicians only with supervising pharmacist authorization.
BB — Board allows for a specifically trained technician to check the work of another technician in an acute care hospital under certain conditions. (UT – Only in hospital pharmacy.)
CC — The pharmacy technician may only assist with compounding under the direct supervision of a pharmacist.
DD — Technicians can work up to 30 minutes alone in the pharmacy while a pharmacist has a mandatory lunch break (up to 30 minutes) on the premises.
EE — Hospitals may apply to the Board for approval of technician checking validation programs that meet certain conditions. This is available for unit-dose drug distribution systems, including automated distribution carts and nonemergency kits and trays.
FF — Technicians only. Technician trainees cannot compound.
GG — (1) may take refill orders; (2) may accept new prescription drug orders telephonically or electronically submitted for a pharmacist to review; and (3) may not receive new verbal prescriptions or medication orders, clarify prescriptions or medication orders, nor perform a drug utilization review.
HH — Hospitals may apply to the Commission for approval of technician programs that meet certain conditions. This is available for unit-dose drug distribution systems.
II — Board rule allows technicians with an AAS degree in pharmacy technology to check other technicians' work in certain non-patient-specific distributive functions at inpatient hospitals.
JJ — Pending rules adopted by Board in October 2016; subject to legislative review in January 2017.

15. Pharmacy Technicians in Community Setting

State	May Pharmacy Technicians in the Community Setting: Accept Called-in Prescription From Physician's Office?	Enter Prescription Into Pharmacy Computer?	Check the Work of Other Technicians?
Alabama	No	Yes	No
Alaska	No	Yes E	No
Arizona	No	Yes B	No
Arkansas	No	Yes	No
California	No	Yes D	No
Colorado	No	Yes E	Yes E
Connecticut	No	Yes D, E	No
Delaware	No	Yes D	No
District of Columbia	No	Yes E	No
Florida	No	Yes	No
Georgia	No	Yes	No
Guam	No	Yes D, E	No
Hawaii	No	Yes D, E	No
Idaho	Yes GG	Yes	Yes GG
Illinois	Yes I	Yes I	No
Indiana	No G	Yes	No
Iowa	Yes E	Yes E	Yes E, J, X
Kansas	No G	Yes E	No
Kentucky	No H	Yes D	No
Louisiana	Yes	Yes	No
Maine	No S	Yes S	No S
Maryland	No	Yes	No
Massachusetts	Yes R	Yes E	No
Michigan	Yes E	Yes E	Yes E
Minnesota	No	Yes	No
Mississippi	No	Yes D, E	No
Missouri	Yes D, E	Yes D, E	No
Montana	No	Yes I, V	No
Nebraska	No	Yes	No
Nevada	No	Yes	No
New Hampshire	Yes R	Yes E	No
New Jersey	No	Yes E	No
New Mexico	No	Yes	No
New York	No	Yes E	No
North Carolina	Yes R	Yes	No
North Dakota	Yes	Yes	Yes E
Ohio	No	Yes E	No
Oklahoma	No H	Yes	No
Oregon	No	Yes	No
Pennsylvania	No	Yes D, E	No
Puerto Rico	Yes O	Yes O	No
Rhode Island	Yes R	Yes	No
South Carolina	Yes K, R	Yes D	Yes T
South Dakota	No	Yes D	No
Tennessee	Yes E, R	Yes E	No
Texas	No	Yes	No
Utah	No DD	Yes E	No
Vermont	No	Yes	No
Virginia	No	Yes E	No
Washington	No M	Yes	Yes FF
West Virginia	No	Yes D, E	No D, E
Wisconsin	M, Y	Yes	No
Wyoming	No	Yes D, E	No

Colored text denotes change from 2016 edition.

15. Pharmacy Technicians in Community Setting (cont.)

State	May Pharmacy Technicians in the Community Setting: Call Physician for Refill Authorization?	Compound Medications for Dispensing?	Transfer Prescription Orders?
Alabama	No Q	Yes E	No
Alaska	Yes E, M	Yes E	No
Arizona	Yes B	Yes B, EE	Yes AA
Arkansas	Yes M	Yes D, E	No
California	Yes D	Yes D, E	No
Colorado	Yes	Yes E	No
Connecticut	Yes M	Yes D, E	No
Delaware	No	Yes F	No
District of Columbia	No E	Yes E	No
Florida	Yes	Yes BB	No
Georgia	No	No	No
Guam	No	Yes D, E	No †
Hawaii	No	Yes D, E	No
Idaho	Yes	Yes	Yes GG
Illinois	Yes I	Yes I	No
Indiana	Yes	Yes	No
Iowa	Yes E	Yes E	No
Kansas	Yes	Yes E	No
Kentucky	Yes D, M	Yes D	No
Louisiana	Yes	Yes D	Yes K
Maine	Yes S	Yes S	No S
Maryland	Yes W	Yes E	No
Massachusetts	Yes U	Yes E	Yes CC
Michigan	No	Yes E	Yes C
Minnesota	Yes	Yes	No
Mississippi	Yes D, E	Yes D, E	No
Missouri	Yes D, E	Yes D, E	Yes D, E, K
Montana	Yes M, V	Yes L, V	No
Nebraska	Yes	Yes BB	No
Nevada	Yes	Yes	No
New Hampshire	No	Yes E	No
New Jersey	Yes M	Yes D, E	No
New Mexico	Yes E	Yes	No
New York	No	No	No
North Carolina	Yes R	Yes E	Yes R
North Dakota	Yes	Yes E	Yes
Ohio	No	Yes D	No
Oklahoma	Yes M	Yes L	No
Oregon	Yes M	Yes	No Z
Pennsylvania	No	Yes D, E, F	No
Puerto Rico	Yes O	Yes O	Yes O
Rhode Island	Yes	Yes E	Yes I
South Carolina	Yes K, R	Yes D	Yes K, T
South Dakota	Yes	Yes E	No
Tennessee	Yes	Yes E	Yes R
Texas	Yes M	Yes D, N	No
Utah	Yes M	Yes E	No
Vermont	No	Yes A, B	No
Virginia	Yes M	Yes D, E	No
Washington	Yes M	Yes P	No
West Virginia	Yes D, E, M	Yes D, E, P	No
Wisconsin	Yes M, Y	Yes B	No
Wyoming	Yes D, E, M	Yes D, E	Yes K, EE

Colored text denotes change from 2016 edition.
† Other comments noted in 2016 edition no longer apply.

15. Pharmacy Technicians in Community Setting (cont.)

LEGEND

A — Activities are not addressed in laws or statutes.

B — Subject to approved policy and procedure manuals, pharmacy technician training, and pharmacist final verification and initialing.

C — Yes, if there are policies and procedures in place that allow delegation and that comply with Board Administrative Rules 338.490 and 338.3162.

D — Allowed activity must be under the direct supervision of a licensed pharmacist. (HI – "Immediate supervision." KY – Direct supervision if technician is not certified; if certified by the PTCB, then technician may perform activity under indirect supervision. LA – "Direct and immediate" supervision. Shall not compound high-risk sterile preparations, as defined by the United States Pharmacopeia.)

E — Pharmacist must verify, check, and/or is responsible for allowed activities. (DC – pharmacist must obtain oral authorization for Schedule III through V refill. Pharmacist must receive oral prescription for Schedule II.)

F — Compounding is the responsibility of the pharmacist or pharmacy intern under the direct supervision of the pharmacist. The pharmacist may utilize the assistance of supportive personnel under certain conditions. Contact board for requirements.

G — Unless it is regarding a refill.

H — Allowed activity limited to pharmacists and interns. (KY – Under direct supervision.)

I — Allowed activity must be under the supervision of a licensed pharmacist.

J — Rules/regulations currently being developed/proposed and may alter these answers.

K — Non-controlled only.

L — Bulk compounding allowed.

M — If there are any changes to the prescription and/or if professional consultation is involved, the pharmacist must handle the call. (WA – Professional consultation/judgment.)

N — Must have special training. Contact the Board for training requirements.

O — Pharmacy Act allows pharmacy technicians to perform the tasks assigned by the pharmacist under his or her supervision. Puerto Rico Supreme Court has recognized that only pharmacists are prepared to do patient counseling.

P — Bulk compounding and intravenous preparation are allowed, but "extemporaneous" compounding is not allowed.

Q — If there are any changes to the prescription and/or if professional consultation is involved, the pharmacist must handle the call. May fax a refill request to a physician's office if approved by the pharmacist. A refill is considered to be an authorization for a new prescription. Technicians may not take verbal orders from an agent or a physician for a new prescription.

R — If technician is certified. (SC – Only with supervising pharmacist authorization.)

S — New rules regarding allowed activities for technicians expected in 2014.

T — A supervising pharmacist may authorize a certified pharmacy technician to (1) receive and initiate verbal telephone orders; (2) conduct one-time prescription transfers; (3) check a technician's refill of medications if the medication is to be administered by a licensed health care professional in an institutional setting; (4) check a technician's repackaging of medication from bulk to unit dose in an institutional setting.

U — Provided no change in therapy.

V — Technicians can now work up to 30 minutes alone in the pharmacy while a pharmacist has a mandatory lunch break (up to 30 minutes) on the premises.

W — Pharmacy technician may call for refills for prescriptions other than controlled dangerous substances. May not accept refill authorization that changes the order.

X — Board-approved pilot project for tech-check-tech for 18 months. 657-8.40(3) permits the Board to approve an extension or renewal of a project.

Legend continued on page 51

NABP*LAW* Online Search Terms

Pharmacy Technicians in Community Setting *(type as indicated below)*

- technician duties
- technician registration
- technician requirements
- technician training

Note: "ancillary personnel," "non-licensed personnel," and "support personnel" can be substituted for "technician."

15. Pharmacy Technicians in Community Setting (cont.)

LEGEND — cont.

Y — Refills only with no changes. New prescriptions must be recorded.
Z — May assist pharmacist.
AA — Only electronic transfers of non-controlled drugs between pharmacies owned by the same company using a common or shared database.
BB — The pharmacy technician may only assist with compounding under the direct supervision of a pharmacist.
CC — A certified pharmacy technician may assist in the transfer of a refill for a Schedule VI prescription (Massachusetts considers all drugs not in Schedule II-V to be Schedule VI) upon request by a consumer.
DD — (1) may take refill orders; (2) may accept new prescription orders telephonically or electronically submitted for a pharmacist to review; and (3) may not receive new verbal prescriptions or medication orders, nor perform a drug utilization review.
EE — Technicians only. Technician trainees cannot compound.
FF — Pharmacy may apply to the Commission for approval of tech-check-tech programs that meet certain conditions. This is available for unit-dose drug distribution systems.
GG — Pending rules adopted by Board in October 2016; subject to legislative review in January 2017.

Attachment 4

13. Status of Pharmacy Technicians (cont.)

State	Technician Training Requirements	Technician CPE Requirements	Technician Examination Requirement	Can Board Deny, Revoke, Suspend, or Restrict Technician Registration?	Maximum Ratio of Technician(s) to Pharmacist in an: Ambulatory Care Setting	Maximum Ratio of Technician(s) to Pharmacist in an: Institutional Care Setting
Alabama	No	3 hrs/yr MM	—	Yes	3:1*	3:1*
Alaska	Yes S	10 hrs/2 yrs	No	Yes	None	None
Arizona	Yes	NN	Yes FF	Yes	None	None
Arkansas	No	None	No	Yes	2:1	2:1
California	Yes CC	No	No CC	Yes	Varies*	2:1
Colorado	No	N/A	No	N/A	3:1	3:1
Connecticut	Yes S	No	No	Yes	2:1* or 3:1	3:1*
Delaware	Yes	N/A	No	N/A	None	None
District of Columbia	Yes BBB	Yes BBB	Yes BBB	Yes	—	—
Florida	Yes Q	20 hrs/2 yrs	No	Yes	3:1*	3:1*
Georgia	No	None	No	N/A	3:1*	3:1*
Guam	No J	None J	No	Yes	None J	None J
Hawaii	No	No	No	No	None	None
Idaho	Yes OO	Yes	Yes	Yes	6:1*	6:1*
Illinois	Yes PP	No	Yes QQ	Yes	None	None
Indiana	Yes	No	No U	Yes	6:1*	6:1*
Iowa	Yes H	No	No	Yes	None	None
Kansas	Yes	Yes YYY	No	Yes	2:1 or 3:1*	2:1 or 3:1*
Kentucky	No	None	No	Yes	None	None
Louisiana	No	10 hrs OOO	Yes FF	Yes	3:1*	3:1*
Maine	Yes UUU	No	No	Yes	None	None
Maryland	Yes	Yes	Yes	Yes	None	None
Massachusetts	Yes	No BB	Yes	Yes	4:1	4:1
Michigan	No	—	—	—	None	None
Minnesota	Yes	Yes	No	Yes	3:1 †	3:1 †
Mississippi	No I	No	No	Yes	2:1	2:1
Missouri	Yes HHH	None	No	Yes	None*	None*
Montana	Yes** T	Yes SS	Yes AA	Yes	3:1*	3:1*
Nebraska	Yes** I	No	No	Yes ZZZ	3:1	3:1
Nevada	Yes	Yes Y	No	Yes	3:1*	3:1
New Hampshire	Yes	Yes P	Yes P	Yes	None	None
New Jersey	No	No	No	Yes	Varies	Varies
New Mexico	Yes**	None	Yes AA	Yes	None	None
New York	No	No	No	No	2:1	2:1
North Carolina	Yes	None	No	Yes	2:1*	2:1*
North Dakota	Yes R	Yes 10 hrs/1 yr	Yes	Yes	3:1	4:1
Ohio	Yes	No	Yes	No	None	None
Oklahoma	Yes	None	Yes	Yes JJ	2:1	2:1
Oregon	Yes III	Yes P	Yes P	Yes	None	None
Pennsylvania	Yes ZZ	None	No	N/A	None	None
Puerto Rico	Yes F	20 hrs/3 yrs	Yes	Yes	5:1	5:1
Rhode Island	Yes	Yes BB	Yes V	Yes	None	None
South Carolina	Yes DD	10 hrs/yr EE	Yes DD	Yes	3:1*	Varies*
South Dakota	Yes D	None	Yes D	Yes	3:1	2:1*
Tennessee	No	None	No	Yes	2:1*	2:1*
Texas	Yes C	20 hrs/2 yrs XXX †	Yes	Yes	3:1*	None
Utah	Yes	20 hrs/2 yrs	Yes E	Yes	*	*
Vermont	No	No	No	Yes	None	None
Virginia	Yes V	5 hrs/yr	Yes V	Yes	4:1	4:1
Washington	Yes	Yes XX	Yes AA	Yes	3:1*	3:1*
West Virginia	Yes I, K	None	Yes	Yes	4:1	4:1
Wisconsin	No	—	—	—	4:1	4:1
Wyoming	Yes ZZ	6 hrs	Yes FF	Yes	3:1	3:1

* See "Footnotes (*)" on page 43.

** Contact the state board of pharmacy office to obtain requirements.

Colored text denotes change from 2016 edition.

† Other comments noted in 2016 edition no longer apply.

— Indicates information is not available.

13. Status of Pharmacy Technicians (cont.)

LEGEND

A — All new pharmacy technicians have one year after initial licensure to obtain national certification.

B — Technician trainee – $36, Technician – $72. Technician trainee may reapply for licensure no more than one time.

C — A person may be a technician trainee for no more than two years while seeking certification through PTCB. Contact the Board for specific on-site training requirements.

D — Same as PTCB requirements.

E — PTCB examination or the ExCPT and Utah law examination.

F — 1,000 hours of internship under direct supervision of a registered pharmacist and passing an examination prepared by the Board are required for certification. Designated pharmacy technician intern for three years maximum.

G — Biennial at birthday. (MD – First renewal 10 CE, all other renewals 20 CE.)

H — Technicians must be under the immediate and personal supervision of the pharmacist. Technician training must be documented and maintained. National certification of all technicians by nationally accredited certifying body required by December 31, 2013.

I — Training requirements developed by training pharmacies and approved by the board. (WV – PTCB or National Healthcareer Association certified pharmacy technician certification. As of July 1, 2014, technician must have graduated from a competency-based pharmacy technician training and education program or completed training requirements stated above.)

J — The Board is proposing/developing regulations.

K — Designated as a "technician-in-training" prior to meeting requirements for licensure.

L — The term "Support Personnel" is also used.

M — May register as "technician-in-training" while working towards certification. This registration is renewable twice.

N — A "Pharmacy Technician" is a subset of "Supportive Personnel."

O — Technicians are not considered "registered," but are issued a "permit."

P — Required for certified pharmacy technicians, but not pharmacy technicians. (OR – Must become certified by the second June 30.)

Q — Pharmacy technicians may register in Florida if they complete a Board-approved training program.

R — Technicians must complete ASHP-accredited program.

S — On-the-job training by PIC appropriate to technician's duties.

T — Technician utilization plan filed with Board or didactic course.

U — Passage of the PTCB examination is one way to become certified as a technician in this state. Must also file application for licensure.

V — To be eligible for registration a pharmacy technician must either hold current PTCB certification or must have passed a training program and examination approved by the Board.

W — Plus a fingerprint fee paid to a contracted agency.

X — $25 initial; $30 renewal/2 years.

Y — However, technicians must complete six hours of in-service training per year and one hour of jurisprudence as do pharmacists. (NV – See Section 11, Continuing Pharmacy Education Requirements.)

Z — Biennial by birth month; trainee registration 1 year, not reusable.

AA — PTCB or ExCPT certification required. (WA – Exams administered by program accredited by NCCA.)

BB — However, "certified pharmacy technicians" must maintain certification.

CC — Educational training and/or PTCB examination are ways to qualify for technician registration.

DD — To be certified as a pharmacy technician an individual must have worked for 1,000 hours under the supervision of a licensed pharmacist as a technician and must have completed a Board of Pharmacy-approved technician course as provided for in subsection (D); a high school diploma or equivalent; and passed the National Pharmacy Technician Certification Examination or a Board of Pharmacy-approved examination and has maintained current certification; and fulfilled CE requirements as provided for in Section 40-43-130(G).

EE — As a condition of registration renewal, a registered pharmacy technician shall complete 10 hours of ACPE-accredited CE or CME Category I each year. A minimum of four hours of the total hours must be obtained through attendance at lectures, seminars, or workshops.

FF — Requires PTCB examination. (AZ – Or another Board-approved exam.)

GG — Annual (by birth month).

HH — Plus one-time application fee of $50.

II — Odd numbered years.

JJ — Revoked 28 pharmacy technician permits, 0 probations, 0 suspensions, and 0 fines.

KK — "Technicians-in-Training" are registered until they meet the requirements for licensure. The technician-in-training permit is valid for no more than two years from date of issue.

LL — Ohio does not license, register, or certify pharmacy technicians. There is no legal requirement to be licensed, registered, or certified as a pharmacy technician in the state of Ohio. However, the Board does require a technician to be "qualified."

MM — One hour must be live CE. No carry-over hours.

Legend continued on page 42

13. Status of Pharmacy Technicians (cont.)

LEGEND — cont.

NN — Twenty hours, of which two hours must be pharmacy law ACPE or Board-approved providers.
OO — Must be 18 years of age unless waived; a high school graduate unless waived or equivalent; of good moral character; and employed.
PP — Refer to 225 ILCS 85/9.5 and 85/17.1 and 68 Illinois Administrative Code Sections 1330.210 and 1330.220.
QQ — Beginning on January 1, 2010, within two years after initial registration as a registered technician, must become certified by successfully passing the PTCB or other Board-approved examination and registering as a certified pharmacy technician with the department. Does not apply to pharmacy technicians registered prior to January 1, 2008. Refer to 225 ILCS 85/9.
RR — Biennial, January 1 of odd years.
SS — Must be PTCB-approved or ICPT-approved.
TT — Additional $40 for criminal background check.
UU — Application fees are reevaluated June of even-numbered years.
VV — Plus $52 fingerprinting fee.
WW — Indiana State Police collect an additional fee for a background check.
XX — Beginning in 2013-2014 renewal cycle. 10 hours of CE credit with one hour in law/ethics.
YY — Even numbered years.
ZZ — On-the-job training in permitted activities.
AAA — As of July 1, 2014, switched from certification. Must still hold technician-in-training permit or be PTCB- or ExCPT-certified prior to licensure.
BBB — D.C. Law §17-99.
CCC — Does not apply to those registered prior to July 1, 2011.
DDD — PTCB only.
EEE — North Carolina recognizes PTCB certification, which allows pharmacy technician to perform additional duties.
FFF — See IC 25-26-19-5.
GGG — Required to perform certain functions.
HHH — For sterile compounding.
III — See OAR 855-025-0025(6).
JJJ — For initial license as a certified technician, but not for license renewal. Not required for nonrenewable technician license.
KKK — Applicants for pharmacy technician registration must have taken and passed PTCB's national Pharmacy Technician Certification Examination and have a current certificate. Contact Board for additional requirements.
LLL — With grandfather exemption.
MMM — Regulations pending.
NNN — Or provide satisfactory proof to the Board of successful completion of a pharmacy technician training program approved by the Board.
OOO — Must be technician-specific and ACPE accredited.
PPP — One-year technician trainee registration permitted.
QQQ — Only required to be actively certified through PTCB or ExCPT at time of initial application if using this option for application of registration. 18VAC110-20-101.
RRR — Only for pharmacy technicians. Not required for pharmacy technician trainees. (RI – National certification required for pharmacy technician II, not for pharmacy technician I.)
SSS — See 225 ILCS 85/9.
TTT — However, if at least one technician is certified, a pharmacy can exceed the base technician-to-pharmacist ratio by having one additional technician on duty within the pharmacy.
UUU — See Maine Pharmacy Rules 02 392, Chapter 7, Section 2, Training.
VVV — PTCB certification is one qualifying method for licensure, but certification is not required.
WWW — All new pharmacy technicians have up to two years/the second June 30 after initial licensure to obtain national certification. Pharmacy technician licenses are nonrenewable.
XXX — One hour must be related to Texas pharmacy laws or rules.
YYY — Twenty hours (approved) per biennial renewal period. No carry-over. Must be earned in prior registration period.
ZZZ — Board recommends to Department of Health and Human Services, Division of Public Health.

Footnotes (*)

AL — 3:1 if one technician is PTCB-certified. All technicians must be at least 17.

Footnotes continued on page 43

NABP*LAW* Online Search Terms

Status of Pharmacy Technicians *(type as indicated below)*

- technician certification
- technician fee
- technician license
- technician registration
- technician renewal
- technician requirements
- technician training

Note: "ancillary personnel"; "non-licensed personnel"; and "support personnel" can be substituted for "technician."

13. Status of Pharmacy Technicians (cont.)

Footnotes (*) — cont.

CA — In community pharmacy, the ratio is 1:1 for the first pharmacist on duty, then 2:1 for each additional pharmacist on duty. 2:1 if pharmacy services patients of skilled nursing facilities or hospices. A pharmacist may also supervise one pharmacy technician trainee gaining required practical experience.

CT — Refer to Section 20-576-36 of the Regulations of Connecticut State Agencies. In summary, ratio not to exceed 2:1 when both technicians are registered. Ratio of 3:1 permitted when there are two registered technicians and one certified technician. However, a pharmacist is permitted to refuse the 3:1 ratio for the 2:1 ratio. In an institutional outpatient pharmacy, ratio is 2:1. The pharmacist manager may petition the Commission to increase ratio to 3:1 in a licensed or institutional outpatient pharmacy. Inpatient pharmacy ratio is 3:1 generally, but pharmacy can petition for ratio of up to 5:1; satellite pharmacy 3:1, but can petition for up to 5:1.

FL — Rule 64B16-27.410 outlines the acceptable ratios as follows:
Three to one (3:1) ratio: Any pharmacy or any pharmacist engaged in sterile compounding shall not exceed a ratio of up to three (3) registered pharmacy technicians to one (1) pharmacist (3:1).
Four to one (4:1) ratio: Any pharmacy or any pharmacist may allow a supervision ratio of up to four (4) registered pharmacy technicians to one (1) pharmacist (4:1), as long as the pharmacist or pharmacy is not engaged in sterile compounding.
Six to one (6:1) ratio:
(a) Non-dispensing pharmacies. Any pharmacy which does not dispense medicinal drugs, and the pharmacist(s) employed by such pharmacy, may allow a supervision ratio of up to six (6) registered pharmacy technicians to one (1) pharmacist (6:1), as long as the pharmacy or pharmacist is not involved in sterile compounding.
(b) Dispensing pharmacies. A pharmacy which dispenses medicinal drugs may utilize a six to one (6:1) ratio in any physically separate area of the pharmacy from which medicinal drugs are not dispensed. A "physically separate area" is a part of the pharmacy which is separated by a permanent wall or other barrier which restricts access between the two areas.

GA — One of the three pharmacy technicians must be certified. Board may consider and approve an application to increase the ratio in a hospital pharmacy.

ID — Ratio includes technicians, technicians-in-training, and student pharmacists. No longer allowed cashiers/clerks in pharmacy.

IN — Technicians must be under the immediate and personal supervision of the pharmacist.

KS — The ratio may be 3:1 if at least two of the pharmacy technicians have a current certification issued by PTCB or a current certification issued by any other pharmacy technician certification organization approved by the Board.

LA — If pharmacy technician candidate is present, then maximum ratio for technicians is 2:1. If not, then the maximum ratio for technicians is 3:1.

MO — Technician must be under the direct supervision and responsibility of a pharmacist.

MT — Ratio is 3:1. Licensee may ask Board for variance based on established criteria or greater upon Board approval.

NC — Ratio may be increased above 2:1 if additional technicians are certified and the Board approves the increase in advance.

NV — Technician to pharmacist ratio is now 3:1; however, initial prescription data input can now only be done by a registered pharmaceutical technician or a pharmacist. A clerk may enter demographic and insurance data only on new prescriptions.

SC — The PIC shall develop and implement written policies and procedures to specify the duties to be performed by pharmacy technicians. The duties and responsibilities of these personnel shall be consistent with their training and experience. These policies and procedures shall, at a minimum, specify that pharmacy technicians are to be personally supervised by a licensed pharmacist who has the ability to control and who is responsible for the activities of pharmacy technicians and that pharmacy technicians are not assigned duties that may be performed only by a licensed pharmacist. One pharmacist may not supervise more than three pharmacy technicians at a time; at least two of these three technicians must be state certified. If a pharmacist supervises only one or two pharmacy technicians, these technicians are not required to be state certified. Pharmacy technicians do not include personnel in the prescription area performing only clerical functions, including data entry up to the point of dispensing, as defined in Section 40-43-30(14).

SD — Ratio to be determined by pharmacist-in-charge in long-term care, hospital, and mail service pharmacies.

TN — Up to 4:1 if two technicians are certified.

TX — 4:1 if at least one of the technicians is not a pharmacy technician trainee.

UT — Pharmacist determined for licensed pharmacy technicians, only one technician-in-training per supervising pharmacist.

WA — A pharmacy may use more technicians than the standard 3:1 ratio if its service plan is approved by the Commission.

Attachment 5

4202. Pharmacy Technician: License Requirements for Education, Experience; Board Regulations; Criminal Background Check; Discipline

(a) The board may issue a pharmacy technician license to an individual if he or she is a high school graduate or possesses a general educational development certificate equivalent, and meets any one of the following requirements:

(1) Has obtained an associate's degree in pharmacy technology.

(2) Has completed a course of training specified by the board.

(3) Has graduated from a school of pharmacy recognized by the board.

(4) Is certified by a pharmacy technician certifying organization offering a pharmacy technician certification program accredited by the National Commission for Certifying Agencies that is approved by the board.

(b) The board shall adopt regulations pursuant to this section for the licensure of pharmacy technicians and for the specification of training courses as set out in paragraph (2) of subdivision (a). Proof of the qualifications of any applicant for licensure as a pharmacy technician shall be made to the satisfaction of the board and shall be substantiated by any evidence required by the board.

(c) The board shall conduct a criminal background check of the applicant to determine if an applicant has committed acts that would constitute grounds for denial of licensure, pursuant to this chapter or Chapter 2 (commencing with Section 480) of Division 1.5.

(d) The board may suspend or revoke a license issued pursuant to this section on any ground specified in Section 4301.

(e) Once an individual is licensed as a pharmacist, the pharmacy technician registration is no longer valid and the pharmacy technician license shall be returned to the board within 15 days.

§ 1793.5. Pharmacy Technician Application.

The “Pharmacy Technician Application” (Form 17A-5 (Rev. 10/15)), incorporated by reference herein, required by this section is available from the Board of Pharmacy upon request.

(a) Each application for a pharmacy technician license shall include:

(1) Information sufficient to identify the applicant.
(2) A description of the applicant's qualifications and supporting documentation for those qualifications.
(3) A criminal background check that will require submission of fingerprints in a manner specified by the board and the fee authorized in Penal Code section 11105(e).
(4) A sealed, original Self-Query from the National Practitioner Data Bank (NPDB) dated no earlier than 60 days of the date an application is submitted to the board.

(b) The applicant shall sign the application under penalty of perjury and shall submit it to the Board of Pharmacy.

(c) The board shall notify the applicant within 30 days if an application is deficient; and what is needed to correct the deficiency. Once the application is complete, and upon completion of any investigation conducted pursuant to section 4207 of the Business and Professions Code, the board will notify the applicant within 60 days of a license decision.

(d) Before expiration of a pharmacy technician license, a pharmacy technician must renew that license by payment of the fee specified in subdivision (r) of section 4400 of the Business and Professions Code.

Note: Authority cited: Sections 163.5, 4005, 4007, 4038, 4115, 4202, 4207 and 4400, Business and Professions Code. Reference: Sections 163.5, 4005, 4007, 4038, 4115, 4202, 4207, 4402 and 4400, Business and Professions Code; and Section 11105, Penal Code.

Board of Pharmacy
Modified Text

Changes made to the originally proposed language are shown by ~~double strikethrough~~ for deleted language and double underline for added language. Additionally, the changes are shown in red for color printing.

Amend Section 1702 of Article 5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1702. Pharmacist Renewal Requirements

(a) A pharmacist applicant for renewal who has not previously submitted fingerprints as a condition of licensure or for whom an electronic record of the licensee's fingerprints does not exist in the Department of Justice's criminal offender record identification database shall successfully complete a state and federal level criminal offender record information search conducted through the Department of Justice by the licensee's or registrant's renewal date ~~that occurs on or after December 7, 2010~~.

(1) A pharmacist shall retain for at least three years as evidence of having complied with subdivision (a) either a receipt showing that he or she has electronically transmitted his or her fingerprint images to the Department of Justice or, for those who did not use an electronic fingerprinting system, a receipt evidencing that his or her fingerprints were recorded and submitted to the Board.

(2) A pharmacist applicant for renewal shall pay the actual cost of compliance with subdivision (a).

(3) As a condition of petitioning the board for reinstatement of a revoked or surrendered license, or for restoration of a retired license, an applicant shall comply with subdivision (a).

(4) The board may waive the requirements of this section for licensees who are actively serving in the United States military. The board may not return a license to active status until the licensee has complied with subdivision (a).

(b) As a condition of renewal, a pharmacist applicant shall disclose on the renewal form whether he or she has been convicted, as defined in Section 490 of the Business and Professions Code, of any violation of the law in this or any other state, the United States, or other country, since his or her last renewal . ~~omitting t~~Traffic infractions ~~under~~ ~~$300~~ ~~$500~~ not involving alcohol, dangerous drugs, or controlled substances do not need to be disclosed.

(c) As a condition of renewal, a pharmacist applicant shall disclose on the renewal form any disciplinary action against any license issued to the applicant by a government agency. For the purposes of this section, "disciplinary action" means an adverse licensure or certification action that resulted in a restriction or penalty being placed on the license, such as revocation, suspension, probation or public reprimand or reproval.

(d) Failure to provide all of the information required by this section renders an application for renewal incomplete and the board shall not renew the license and shall issue the applicant an inactive pharmacist license. An inactive pharmacist license issued pursuant to this section may only be reactivated after compliance is confirmed for all licensure renewal requirements.

Authority: Sections 4001.1 and 4005, Business and Professions Code.
Reference: Sections 490, 4036, 4200.5, 4207, 4301, 4301.5 and 4400, Business and Professions Code; and Sections 11105(b)(10) and 11105(e), Penal Code.

Adopt Section 1702.1 of Article 5 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

1702. 1 Pharmacy Technician Renewal Requirements

(a) A pharmacy technician applicant for renewal who has not previously submitted fingerprints as a condition of licensure or for whom an electronic record of the licensee's fingerprints does not exist in the Department of Justice's criminal offender record identification database shall successfully complete a state and federal level criminal offender record information search conducted through the Department of Justice by the licensee's or registrant's renewal date that occurs on or after July 1, 2017~~4~~.

(1) A pharmacy technician shall retain for at least three years as evidence of having complied with subdivision (a) either a receipt showing that he or she has electronically transmitted his or her fingerprint images to the Department of Justice or, for those who did not use an electronic fingerprinting system, a receipt evidencing that his or her fingerprints were recorded and submitted to the Board.

(2) A pharmacy technician applicant for renewal shall pay the actual cost of compliance with subdivision (a).

(3) As a condition of petitioning the board for reinstatement of a revoked or surrendered license an applicant shall comply with subdivision (a).

(4) The board may waive the requirements of this section for licensees who are actively serving in the United States military. The board may not return a license to active status until the licensee has complied with subdivision (a).

(b) As a condition of renewal, a pharmacy technician applicant shall disclose on the renewal form whether he or she has been convicted, as defined in Section 490 of the Business and Professions Code, of any violation of the law in this or any other state, the United States, or other country, since his or her last renewal . Traffic infractions ~~under $500~~ not involving alcohol, dangerous drugs, or controlled substances do not need to be disclosed.

(c) As a condition of renewal, a pharmacy technician applicant shall disclose on the renewal form any disciplinary action against any license issued to the applicant by a government agency. For the purposes of this section, "disciplinary action" means an adverse licensure or certification action that resulted in a restriction or penalty against the license or certification such as revocation, suspension, probation or public reprimand or reproval.

(d) Failure to provide all of the information required by this section renders an application for renewal incomplete and the board shall not renew the license until the licensee demonstrates compliance with all requirements.

Authority: Sections 4001.1 and 4005, Business and Professions Code.
Reference: Sections 490, 4038, 4115, 4202, 4207, 4301, 4301.5 and 4400, Business and Professions Code; and Sections 11105(b)(10) and 11105(e), Penal Code.

13. Status of Pharmacy Technicians

State	Designation	Does State: License Technicians?	Does State: Register Technicians?	Does State: Require Certification?	Technician Registration Fee	Registration Renewal Schedule
Alabama	Pharmacy Technician	No	Yes	No	$60	Biennial II
Alaska	Pharmacy Technician	Yes	No	No	$50 HH, UU	Biennial
Arizona	Pharmacy Technician	Yes	No	Yes RRR	B	Biennial B
Arkansas	Pharmacy Technician	No	Yes	No	$70 II; $35 YY	Biennial
California	Pharmacy Technician	Yes	Yes	No VVV	$105	Biennial
Colorado	Pharmacy Technician	No	No	No	N/A	N/A
Connecticut	Pharmacy Technician	No	Yes	No	$100	Annual - 3/31
Delaware	Pharmacy Technician	No	No	No	None	N/A
District of Columbia	Ancillary Personnel	No BBB	Yes BBB	Yes BBB	$50	Annual
Florida	Pharmacy Technician	No	Yes	No	$100	Biennial
Georgia	Pharmacy Technician	No	Yes	No	$100	Biennial
Guam	Pharmacy Technician	No	Yes	No †	J	J
Hawaii	Pharmacy Technician	No	No	No	N/A	N/A
Idaho	Pharmacy Technician	No	Yes M	Yes LLL	$35	Annual
Illinois	Pharmacy Technician	Yes	No	Yes SSS	$40 initial; $25 renewal	Annual
Indiana	Pharmacy Technician	Yes AAA	No	Yes FFF	$25 WW	Biennial
Iowa	Pharmacy Technician	No	Yes	Yes PPP	$40, $20 trainee	Z
Kansas	Pharmacy Technician	No	Yes	No †	$20	Biennial
Kentucky	Pharmacy Technician	No	Yes	Yes GGG	$25	Annual
Louisiana	Pharmacy Technician	Yes	No	Yes FF	$100	Annual
Maine	Pharmacy Technician	Yes	No	—	$25	Annual
Maryland	Pharmacy Technician	No	Yes	Yes NNN	$45	Biennial G
Massachusetts	Pharmacy Technician	No	Yes	No	$60	Biennial G
Michigan	Pharmacy Personnel	No	No	MMM	—	—
Minnesota	Pharmacy Technician	No	Yes	No TTT	$37.50	Annual
Mississippi	Pharmacy Technician L	No	Yes	Yes LLL	$50	Annual
Missouri	Pharmacy Technician	No	Yes	No	$35 W	Annual
Montana	Pharmacy Technician	No	Yes	Yes AA	$60 initial; $50 renewal	Annual
Nebraska	Pharmacy Technician	No	Yes	Yes MMM	$25	Biennial RR
Nevada	Pharmaceutical Technician L	No	Yes	No	$40	Biennial
New Hampshire	Pharmacy Technician	No	Yes	No	$50	Annual
New Jersey	Pharmacy Technician	No	Yes	No	$70	Biennial
New Mexico	Pharmacy Technician N	Yes	No	Yes A	$30	Biennial
New York	Unlicensed Person	No	No	No	N/A	N/A
North Carolina	Pharmacy Technician	No	Yes	No EEE	$30	Annual
North Dakota	Registered Pharmacy Technician	No	Yes	Yes DDD	$35	Annual
Ohio	Qualified Pharmacy Technician	No	No	No LL	N/A	N/A
Oklahoma	Pharmacy Technician	No	Yes O	No	$40	GG
Oregon	Pharmacy Technician	Yes WWW	No	Yes JJJ	$50 VV	Biennial †
Pennsylvania	Pharmacy Technician	No	No	No	N/A	N/A
Puerto Rico	Pharmacy Technician	No	Yes	Yes	$50	3 years
Rhode Island	Pharmacy Technician	Yes	No	RRR	$25	Annual
South Carolina	Pharmacy Technician	No	Yes	No	$40 initial; $15 renewal	Annual
South Dakota	Pharmacy Technician	No	Yes	Yes CCC	$25	Annual
Tennessee	Pharmacy Technician	No	Yes	No	$75 biennial	Cyclical
Texas	Pharmacy Technician	No	Yes	Yes KKK	$80 initial; $77 renewal	Biennial
Utah	Pharmacy Technician	Yes	No	No	$60 TT	Biennial
Vermont	Pharmacy Technician	No	Yes	No	$50	Biennial
Virginia	Pharmacy Technician	No	Yes	No QQQ	$25	Annual
Washington	Pharmacy Technician	No	No	Yes	$60 initial; $50 renewal	Annual
West Virginia	Pharmacy Technician	No	Yes	Yes	$25 W, X	Biennial
Wisconsin	Pharmacy Technician	No	No	No	—	—
Wyoming	Registered Pharmacy Technician K	Yes KK	Yes KK	Yes DDD, RRR	$50	Annual

Colored text denotes change from 2016 edition.
† Other comments noted in 2016 edition no longer apply.
— Indicates information is not available.

13. Status of Pharmacy Technicians (cont.)

State	Technician Training Requirements	Technician CPE Requirements	Technician Examination Requirement	Can Board Deny, Revoke, Suspend, or Restrict Technician Registration?	Maximum Ratio of Technician(s) to Pharmacist in an: Ambulatory Care Setting	Maximum Ratio of Technician(s) to Pharmacist in an: Institutional Care Setting
Alabama	No	3 hrs/yr MM	—	Yes	3:1*	3:1*
Alaska	Yes S	10 hrs/2 yrs	No	Yes	None	None
Arizona	Yes	NN	Yes FF	Yes	None	None
Arkansas	No	None	No	Yes	2:1	2:1
California	Yes CC	No	No CC	Yes	Varies*	2:1
Colorado	No	N/A	No	N/A	3:1	3:1
Connecticut	Yes S	No	No	Yes	2:1* or 3:1	3:1*
Delaware	Yes	N/A	No	N/A	None	None
District of Columbia	Yes BBB	Yes BBB	Yes BBB	Yes	—	—
Florida	Yes Q	20 hrs/2 yrs	No	Yes	3:1*	3:1*
Georgia	No	None	No	N/A	3:1*	3:1*
Guam	No J	None J	No	Yes	None J	None J
Hawaii	No	No	No	No	None	None
Idaho	Yes OO	Yes	Yes	Yes	6:1*	6:1*
Illinois	Yes PP	No	Yes QQ	Yes	None	None
Indiana	Yes	No	No U	Yes	6:1*	6:1*
Iowa	Yes H	No	No	Yes	None	None
Kansas	Yes	Yes YYY	No	Yes	2:1 or 3:1*	2:1 or 3:1*
Kentucky	No	None	No	Yes	None	None
Louisiana	No	10 hrs OOO	Yes FF	Yes	3:1*	3:1*
Maine	Yes UUU	No	No	Yes	None	None
Maryland	Yes	Yes	Yes	Yes	None	None
Massachusetts	Yes	No BB	Yes	Yes	4:1	4:1
Michigan	No	—	—	—	None	None
Minnesota	Yes	Yes	No	Yes	3:1 †	3:1 †
Mississippi	No I	No	No	Yes	2:1	2:1
Missouri	Yes HHH	None	No	Yes	None*	None*
Montana	Yes** T	Yes SS	Yes AA	Yes	3:1*	3:1*
Nebraska	Yes** I	No	No	Yes ZZZ	3:1	3:1
Nevada	Yes	Yes Y	No	Yes	3:1*	3:1
New Hampshire	Yes	Yes P	Yes P	Yes	None	None
New Jersey	No	No	No	Yes	Varies	Varies
New Mexico	Yes**	None	Yes AA	Yes	None	None
New York	No	No	No	No	2:1	2:1
North Carolina	Yes	None	No	Yes	2:1*	2:1*
North Dakota	Yes R	Yes 10 hrs/1 yr	Yes	Yes	3:1	4:1
Ohio	Yes	No	Yes	No	None	None
Oklahoma	Yes	None	Yes	Yes JJ	2:1	2:1
Oregon	Yes III	Yes P	Yes P	Yes	None	None
Pennsylvania	Yes ZZ	None	No	N/A	None	None
Puerto Rico	Yes F	20 hrs/3 yrs	Yes	Yes	5:1	5:1
Rhode Island	Yes	Yes BB	Yes V	Yes	None	None
South Carolina	Yes DD	10 hrs/yr EE	Yes DD	Yes	3:1*	Varies*
South Dakota	Yes D	None	Yes D	Yes	3:1	2:1*
Tennessee	No	None	No	Yes	2:1*	2:1*
Texas	Yes C	20 hrs/2 yrs XXX †	Yes	Yes	3:1*	None
Utah	Yes	20 hrs/2 yrs	Yes E	Yes	*	*
Vermont	No	No	No	Yes	None	None
Virginia	Yes V	5 hrs/yr	Yes V	Yes	4:1	4:1
Washington	Yes	Yes XX	Yes AA	Yes	3:1*	3:1*
West Virginia	Yes I, K	None	Yes	Yes	4:1	4:1
Wisconsin	No	—	—	—	4:1	4:1
Wyoming	Yes ZZ	6 hrs	Yes FF	Yes	3:1	3:1

* See "Footnotes (*)" on page 43.

** Contact the state board of pharmacy office to obtain requirements.

Colored text denotes change from 2016 edition.

† Other comments noted in 2016 edition no longer apply.

— Indicates information is not available.

13. Status of Pharmacy Technicians (cont.)

LEGEND

A — All new pharmacy technicians have one year after initial licensure to obtain national certification.

B — Technician trainee – $36, Technician – $72. Technician trainee may reapply for licensure no more than one time.

C — A person may be a technician trainee for no more than two years while seeking certification through PTCB. Contact the Board for specific on-site training requirements.

D — Same as PTCB requirements.

E — PTCB examination or the ExCPT and Utah law examination.

F — 1,000 hours of internship under direct supervision of a registered pharmacist and passing an examination prepared by the Board are required for certification. Designated pharmacy technician intern for three years maximum.

G — Biennial at birthday. (MD – First renewal 10 CE, all other renewals 20 CE.)

H — Technicians must be under the immediate and personal supervision of the pharmacist. Technician training must be documented and maintained. National certification of all technicians by nationally accredited certifying body required by December 31, 2013.

I — Training requirements developed by training pharmacies and approved by the board. (WV – PTCB or National Healthcareer Association certified pharmacy technician certification. As of July 1, 2014, technician must have graduated from a competency-based pharmacy technician training and education program or completed training requirements stated above.)

J — The Board is proposing/developing regulations.

K — Designated as a "technician-in-training" prior to meeting requirements for licensure.

L — The term "Support Personnel" is also used.

M — May register as "technician-in-training" while working towards certification. This registration is renewable twice.

N — A "Pharmacy Technician" is a subset of "Supportive Personnel."

O — Technicians are not considered "registered," but are issued a "permit."

P — Required for certified pharmacy technicians, but not pharmacy technicians. (OR – Must become certified by the second June 30.)

Q — Pharmacy technicians may register in Florida if they complete a Board-approved training program.

R — Technicians must complete ASHP-accredited program.

S — On-the-job training by PIC appropriate to technician's duties.

T — Technician utilization plan filed with Board or didactic course.

U — Passage of the PTCB examination is one way to become certified as a technician in this state. Must also file application for licensure.

V — To be eligible for registration a pharmacy technician must either hold current PTCB certification or must have passed a training program and examination approved by the Board.

W — Plus a fingerprint fee paid to a contracted agency.

X — $25 initial; $30 renewal/2 years.

Y — However, technicians must complete six hours of in-service training per year and one hour of jurisprudence as do pharmacists. (NV – See Section 11, Continuing Pharmacy Education Requirements.)

Z — Biennial by birth month; trainee registration 1 year, not reusable.

AA — PTCB or ExCPT certification required. (WA – Exams administered by program accredited by NCCA.)

BB — However, "certified pharmacy technicians" must maintain certification.

CC — Educational training and/or PTCB examination are ways to qualify for technician registration.

DD — To be certified as a pharmacy technician an individual must have worked for 1,000 hours under the supervision of a licensed pharmacist as a technician and must have completed a Board of Pharmacy-approved technician course as provided for in subsection (D); a high school diploma or equivalent; and passed the National Pharmacy Technician Certification Examination or a Board of Pharmacy-approved examination and has maintained current certification; and fulfilled CE requirements as provided for in Section 40-43-130(G).

EE — As a condition of registration renewal, a registered pharmacy technician shall complete 10 hours of ACPE-accredited CE or CME Category I each year. A minimum of four hours of the total hours must be obtained through attendance at lectures, seminars, or workshops.

FF — Requires PTCB examination. (AZ – Or another Board-approved exam.)

GG — Annual (by birth month).

HH — Plus one-time application fee of $50.

II — Odd numbered years.

JJ — Revoked 28 pharmacy technician permits, 0 probations, 0 suspensions, and 0 fines.

KK — "Technicians-in-Training" are registered until they meet the requirements for licensure. The technician-in-training permit is valid for no more than two years from date of issue.

LL — Ohio does not license, register, or certify pharmacy technicians. There is no legal requirement to be licensed, registered, or certified as a pharmacy technician in the state of Ohio. However, the Board does require a technician to be "qualified."

MM — One hour must be live CE. No carry-over hours.

Legend continued on page 42

13. Status of Pharmacy Technicians (cont.)

LEGEND — cont.

NN — Twenty hours, of which two hours must be pharmacy law ACPE or Board-approved providers.
OO — Must be 18 years of age unless waived; a high school graduate unless waived or equivalent; of good moral character; and employed.
PP — Refer to 225 ILCS 85/9.5 and 85/17.1 and 68 Illinois Administrative Code Sections 1330.210 and 1330.220.
QQ — Beginning on January 1, 2010, within two years after initial registration as a registered technician, must become certified by successfully passing the PTCB or other Board-approved examination and registering as a certified pharmacy technician with the department. Does not apply to pharmacy technicians registered prior to January 1, 2008. Refer to 225 ILCS 85/9.
RR — Biennial, January 1 of odd years.
SS — Must be PTCB-approved or ICPT-approved.
TT — Additional $40 for criminal background check.
UU — Application fees are reevaluated June of even-numbered years.
VV — Plus $52 fingerprinting fee.
WW — Indiana State Police collect an additional fee for a background check.
XX — Beginning in 2013-2014 renewal cycle. 10 hours of CE credit with one hour in law/ethics.
YY — Even numbered years.
ZZ — On-the-job training in permitted activities.
AAA — As of July 1, 2014, switched from certification. Must still hold technician-in-training permit or be PTCB- or ExCPT-certified prior to licensure.
BBB — D.C. Law §17-99.
CCC — Does not apply to those registered prior to July 1, 2011.
DDD — PTCB only.
EEE — North Carolina recognizes PTCB certification, which allows pharmacy technician to perform additional duties.
FFF — See IC 25-26-19-5.
GGG — Required to perform certain functions.
HHH — For sterile compounding.
III — See OAR 855-025-0025(6).
JJJ — For initial license as a certified technician, but not for license renewal. Not required for nonrenewable technician license.
KKK — Applicants for pharmacy technician registration must have taken and passed PTCB's national Pharmacy Technician Certification Examination and have a current certificate. Contact Board for additional requirements.
LLL — With grandfather exemption.
MMM — Regulations pending.
NNN — Or provide satisfactory proof to the Board of successful completion of a pharmacy technician training program approved by the Board.
OOO — Must be technician-specific and ACPE accredited.
PPP — One-year technician trainee registration permitted.
QQQ — Only required to be actively certified through PTCB or ExCPT at time of initial application if using this option for application of registration. 18VAC110-20-101.
RRR — Only for pharmacy technicians. Not required for pharmacy technician trainees. (RI – National certification required for pharmacy technician II, not for pharmacy technician I.)
SSS — See 225 ILCS 85/9.
TTT — However, if at least one technician is certified, a pharmacy can exceed the base technician-to-pharmacist ratio by having one additional technician on duty within the pharmacy.
UUU — See Maine Pharmacy Rules 02 392, Chapter 7, Section 2, Training.
VVV — PTCB certification is one qualifying method for licensure, but certification is not required.
WWW — All new pharmacy technicians have up to two years/the second June 30 after initial licensure to obtain national certification. Pharmacy technician licenses are nonrenewable.
XXX — One hour must be related to Texas pharmacy laws or rules.
YYY — Twenty hours (approved) per biennial renewal period. No carry-over. Must be earned in prior registration period.
ZZZ — Board recommends to Department of Health and Human Services, Division of Public Health.

Footnotes (*)

AL — 3:1 if one technician is PTCB-certified. All technicians must be at least 17.

Footnotes continued on page 43

NABP*LAW* Online Search Terms

Status of Pharmacy Technicians *(type as indicated below)*

- technician certification
- technician fee
- technician license
- technician registration
- technician renewal
- technician requirements
- technician training

Note: "ancillary personnel"; "non-licensed personnel"; and "support personnel" can be substituted for "technician."

13. Status of Pharmacy Technicians (cont.)

Footnotes (*) — cont.

CA — In community pharmacy, the ratio is 1:1 for the first pharmacist on duty, then 2:1 for each additional pharmacist on duty. 2:1 if pharmacy services patients of skilled nursing facilities or hospices. A pharmacist may also supervise one pharmacy technician trainee gaining required practical experience.

CT — Refer to Section 20-576-36 of the Regulations of Connecticut State Agencies. In summary, ratio not to exceed 2:1 when both technicians are registered. Ratio of 3:1 permitted when there are two registered technicians and one certified technician. However, a pharmacist is permitted to refuse the 3:1 ratio for the 2:1 ratio. In an institutional outpatient pharmacy, ratio is 2:1. The pharmacist manager may petition the Commission to increase ratio to 3:1 in a licensed or institutional outpatient pharmacy. Inpatient pharmacy ratio is 3:1 generally, but pharmacy can petition for ratio of up to 5:1; satellite pharmacy 3:1, but can petition for up to 5:1.

FL — Rule 64B16-27.410 outlines the acceptable ratios as follows:
Three to one (3:1) ratio: Any pharmacy or any pharmacist engaged in sterile compounding shall not exceed a ratio of up to three (3) registered pharmacy technicians to one (1) pharmacist (3:1).
Four to one (4:1) ratio: Any pharmacy or any pharmacist may allow a supervision ratio of up to four (4) registered pharmacy technicians to one (1) pharmacist (4:1), as long as the pharmacist or pharmacy is not engaged in sterile compounding.
Six to one (6:1) ratio:
(a) Non-dispensing pharmacies. Any pharmacy which does not dispense medicinal drugs, and the pharmacist(s) employed by such pharmacy, may allow a supervision ratio of up to six (6) registered pharmacy technicians to one (1) pharmacist (6:1), as long as the pharmacy or pharmacist is not involved in sterile compounding.
(b) Dispensing pharmacies. A pharmacy which dispenses medicinal drugs may utilize a six to one (6:1) ratio in any physically separate area of the pharmacy from which medicinal drugs are not dispensed. A "physically separate area" is a part of the pharmacy which is separated by a permanent wall or other barrier which restricts access between the two areas.

GA — One of the three pharmacy technicians must be certified. Board may consider and approve an application to increase the ratio in a hospital pharmacy.

ID — Ratio includes technicians, technicians-in-training, and student pharmacists. No longer allowed cashiers/clerks in pharmacy.

IN — Technicians must be under the immediate and personal supervision of the pharmacist.

KS — The ratio may be 3:1 if at least two of the pharmacy technicians have a current certification issued by PTCB or a current certification issued by any other pharmacy technician certification organization approved by the Board.

LA — If pharmacy technician candidate is present, then maximum ratio for technicians is 2:1. If not, then the maximum ratio for technicians is 3:1.

MO — Technician must be under the direct supervision and responsibility of a pharmacist.

MT — Ratio is 3:1. Licensee may ask Board for variance based on established criteria or greater upon Board approval.

NC — Ratio may be increased above 2:1 if additional technicians are certified and the Board approves the increase in advance.

NV — Technician to pharmacist ratio is now 3:1; however, initial prescription data input can now only be done by a registered pharmaceutical technician or a pharmacist. A clerk may enter demographic and insurance data only on new prescriptions.

SC — The PIC shall develop and implement written policies and procedures to specify the duties to be performed by pharmacy technicians. The duties and responsibilities of these personnel shall be consistent with their training and experience. These policies and procedures shall, at a minimum, specify that pharmacy technicians are to be personally supervised by a licensed pharmacist who has the ability to control and who is responsible for the activities of pharmacy technicians and that pharmacy technicians are not assigned duties that may be performed only by a licensed pharmacist. One pharmacist may not supervise more than three pharmacy technicians at a time; at least two of these three technicians must be state certified. If a pharmacist supervises only one or two pharmacy technicians, these technicians are not required to be state certified. Pharmacy technicians do not include personnel in the prescription area performing only clerical functions, including data entry up to the point of dispensing, as defined in Section 40-43-30(14).

SD — Ratio to be determined by pharmacist-in-charge in long-term care, hospital, and mail service pharmacies.

TN — Up to 4:1 if two technicians are certified.

TX — 4:1 if at least one of the technicians is not a pharmacy technician trainee.

UT — Pharmacist determined for licensed pharmacy technicians, only one technician-in-training per supervising pharmacist.

WA — A pharmacy may use more technicians than the standard 3:1 ratio if its service plan is approved by the Commission.

Attachment 6

1707.2 Duty to Consult.

(a) A pharmacist shall provide oral consultation to his or her patient or the patient's agent in all care settings:

(1) upon request; or

(2) whenever the pharmacist deems it warranted in the exercise of his or her professional judgment.

(b)(1) In addition to the obligation to consult set forth in subsection (a), a pharmacist shall provide oral consultation to his or her patient or the patient's agent in any care setting in which the patient or agent is present:

(A) whenever the prescription drug has not previously been dispensed to a patient; or

(B) whenever a prescription drug not previously dispensed to a patient in the same dosage form, strength or with the same written directions, is dispensed by the pharmacy.

(2) When the patient or agent is not present (including but not limited to a prescription drug that was shipped by mail) a pharmacy shall ensure that the patient receives written notice: of his or her right to request consultation; and a telephone number from which the patient may obtain oral consultation from a pharmacist who has ready access to the patient's record.

(3) A pharmacist is not required by this subsection to provide oral consultation to an inpatient of a health care facility licensed pursuant to section 1250 of the Health and Safety Code, or to an inmate of an adult correctional facility or a juvenile detention facility, except upon the patient's discharge. A pharmacist is not obligated to consult about discharge medications if a health facility licensed pursuant to subdivision (a) or (b) of Health and Safety Code Section 1250 has implemented a written policy about discharge medications which meets the requirements of Business and Professions Code Section 4074.

(c) When oral consultation is provided, it shall include at least the following:

(1) directions for use and storage and the importance of compliance with directions; and

(2) precautions and relevant warnings, including common severe side or adverse effects or interactions that may be encountered.

(d) Whenever a pharmacist deems it warranted in the exercise of his or her professional judgment, oral consultation shall also include:

(1) the name and description of the medication;

(2) the route of administration, dosage form, dosage, and duration of drug therapy

(3) any special directions for use and storage;

(4) precautions for preparation and administration by the patient, including techniques for self-monitoring drug therapy;

(5) prescription refill information;

(6) therapeutic contraindications, avoidance of common severe side or adverse effects or known interactions, including serious potential interactions with 207 known nonprescription medications and therapeutic contraindications and the action required if such side or adverse effects or interactions or therapeutic contraindications are present or occur;

(7) action to be taken in the event of a missed dose.

(e) Notwithstanding the requirements set forth in subsection (a) and (b), a pharmacist is not required to provide oral consultation when a patient or the patient's agent refuses such consultation.

Authority cited: Sections 4005, 4076 and 4122, Business and Professions Code. Reference: Sections 4005, 4076 and 4122, Business and Professions Code.

§ 1713. Receipt and Delivery of Prescriptions and Prescription Medications.

(a) Except as otherwise provided in this Division, no licensee shall participate in any arrangement or agreement, whereby prescriptions, or prescription medications, may be left at, picked up from, accepted by, or delivered to any place not licensed as a retail pharmacy.

(b) A licensee may pick up prescriptions at the office or home of the prescriber or pick up or deliver prescriptions or prescription medications at the office of or a residence designated by the patient or at the hospital, institution, medical office or clinic at which the patient receives health care services. In addition, the Board may, in its sole discretion, waive application of subdivision (a) for good cause shown.

(c) A patient or the patient's agent may deposit a prescription in a secure container that is at the same address as the licensed pharmacy premises. The pharmacy shall be responsible for the security and confidentiality of the prescriptions deposited in the container.

(d) A pharmacy may use an automated delivery device to deliver previously dispensed prescription medications provided:

(1) Each patient using the device has chosen to use the device and signed a written consent form demonstrating his or her informed consent to do so.

(2) A pharmacist has determined that each patient using the device meets inclusion criteria for use of the device established by the pharmacy prior to delivery of prescription medication to the patient.

(3) The device has a means to identify each patient and only release that patient's prescription medications.

(4) The pharmacy does not use the device to deliver previously dispensed prescription medications to any patient if a pharmacist determines that such patient requires counseling as set forth in section 1707.2(a)(2).

(5) The pharmacy provides an immediate consultation with a pharmacist, either in-person or via telephone, upon the request of a patient.

(6) The device is located adjacent to the secure pharmacy area.

(7) The device is secure from access and removal by unauthorized individuals.

(8) The pharmacy is responsible for the prescription medications stored in the device.

(9) Any incident involving the device where a complaint, delivery error, or omission has occurred shall be reviewed as part of the pharmacy's quality assurance program mandated by Business and Professions Code section 4125.

(10) The pharmacy maintains written policies and procedures pertaining to the device as described in subdivision (e).

(e) Any pharmacy making use of an automated delivery device as permitted by subdivision (d) shall maintain, and on an annual basis review, written policies and procedures providing for:

(1) Maintaining the security of the automated delivery device and the dangerous drugs within the device.

(2) Determining and applying inclusion criteria regarding which medications are appropriate for placement in the device and for which patients, including when consultation is needed.

(3) Ensuring that patients are aware that consultation with a pharmacist is available for any prescription medication, including for those delivered via the automated delivery device.

(4) Describing the assignment of responsibilities to, and training of, pharmacy personnel regarding the maintenance and filing procedures for the automated delivery device.

(5) Orienting participating patients on use of the automated delivery device, notifying patients when expected prescription medications are not available in the device, and ensuring that patient use of the device does not interfere with delivery of prescription medications.

(6) Ensuring the delivery of medications to patients in the event the device is disabled or malfunctions.

(f) Written policies and procedures shall be maintained at least three years beyond the last use for an automated delivery device.

(g) For the purposes of this section only, “previously-dispensed prescription medications” are those prescription medications that do not trigger a non-discretionary duty to consult under section 1707.2(b)(1), because they have been previously dispensed to the patient by the pharmacy in the same dosage form, strength, and with the same written directions.

Note: Authority cited: Section 4005, 4075 and 4114, Business and Professions Code. Reference: Sections 4005, 4052, 4116 and 4117, Business and Professions Code.

4112. Nonresident Pharmacy: Registration; Provision of Information to Board; Maintaining Records; Patient Consultation

(h) The board shall adopt regulations that apply the same requirements or standards for oral consultation to a nonresident pharmacy that operates pursuant to this section and ships, mails, or delivers any controlled substances, dangerous drugs, or dangerous devices to residents of this state, as are applied to an in-state pharmacy that operates pursuant to Section 4037 when the pharmacy ships, mails, or delivers any controlled substances, dangerous drugs, or dangerous devices to residents of this state. The board shall not adopt any regulations that require face-to-face consultation for a prescription that is shipped, mailed, or delivered to the patient. The regulations adopted pursuant to this subdivision shall not result in any unnecessary delay in patients receiving their medication.

Attachment 7

Attachment 9.2

Advancing Team-Based Care Through Collaborative Practice Agreements

A Resource and Implementation Guide for Adding Pharmacists to the Care Team

Dear Pharmacists and Collaborating Prescribers:

Nearly one in every three deaths in the United States is caused by cardiovascular disease (CVD).[1] Sixty percent of preventable heart disease and stroke deaths happen to people under age 65.[2] With the burden of chronic disease in the US increasing, we need new ways to empower patients and improve care. Pharmacists have long been identified as an underutilized public health resource.[3] Pharmacists are well positioned to help fill the chronic disease management gap and can make a difference when they are actively engaged as part of a team-based care approach.

Collaborative practice agreements increase the efficiencies of team-based care and formalize practice relationships between pharmacists and collaborating prescribers. For this reason, the **National Alliance of State Pharmacy Associations (NASPA), American Pharmacists Association (APhA), American Medical Association (AMA), the American Association of Nurse Practitioners (AANP),** the **Network for Public Health Law – Eastern Region, and University of Maryland Francis King Carey School of Law** have collaborated with the **Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention,** to develop this guide, **Advancing Team-Based Care through Collaborative Practice Agreements.**

The guide is a resource for pharmacists to use in developing and executing collaborative practice agreements in the spirit of advancing team-based care. It provides a customizable template that can be used as a starting point to developing a collaborative practice agreement.

The collaborating organizations recognize the value of pharmacists as a necessary member of the patient care team and endorse use of this guide to form collaborative practice agreements. Together, we can work to improve the quality of patient care, better prevent and treat chronic disease and improve population health.

National Alliance of State Pharmacy Associations (NASPA)

American Pharmacists Association (APhA)

American Medical Association (AMA)

American Association of Nurse Practitioners (AANP)

Network for Public Health Law – Eastern Region

University of Maryland Francis King Carey School of Law

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1 Centers for Disease Control and Prevention. National Statistics Report: Deaths: Final Data for 2014. 2016(June);65(4). Chamblee, GA: CDC, U.S. Department of Health and Human Services; 2016. Accessed December 19, 2016.
2 Centers for Disease Control and Prevention. Vital Signs: Preventable Deaths from Heart Disease & Stroke. Accessed December 19, 2016.
3 American Public Health Association. APHA policy 8024: The Role of the Pharmacist in Public Health. 1981; 71:213–6. American Journal of Public Health.

Executive Summary

Rationale

Chronic diseases are the leading causes of death and disability in the United States, accounting for seven of every ten deaths in this country. In 2014, one in every three deaths was due to cardiovascular disease (CVD). One in three U.S. adults has high blood pressure, and almost half of these individuals do not have this condition under control. Team-based care results in personalized, timely, and empowered patient care—and it facilitates communication and coordination among team members. The evidence is strong that when pharmacists are members of the health care team, outcomes related to preventing or managing chronic disease (e.g., blood pressure, blood glucose, cholesterol, obesity, smoking cessation) and medication adherence improve. The purpose of this guide is to empower community pharmacists and collaborating prescribers to initiate collaborative practice agreements (CPAs) focused on caring for patients with chronic diseases, including CVD.

Collaborative Practice Agreements

CPAs create a formal practice relationship between a pharmacist and a prescriber, who is most often a physician, although a growing number of states are allowing for CPAs between pharmacists and other health professionals, such as nurse practitioners. The agreement specifies what functions (in addition to the pharmacist's typical scope of practice) can be delegated to the pharmacist by the collaborating prescriber. The terms used and the functions provided under a CPA vary from state to state based on the pharmacist's and prescriber's scope of practice and the state's collaborative practice laws. Most often, the functions delegated to pharmacists by prescribers include initiating, modifying, or discontinuing medication therapy. Ordering and interpreting laboratory tests may also be included if those services are not already authorized in the pharmacist's regular scope of practice.

CPAs Support Team-Based Care

CPAs are built upon a foundation of trust between pharmacists and prescribers and serve as a useful mechanism for increasing efficiencies of team-based care. When designed correctly, CPAs are beneficial to the collaborative delivery of care through delegation by the physician or other prescriber of specific patient care services to pharmacists. This delegation can expand available services to patients and increase coordination of care. For example, the use of CPAs can decrease the number of requests to authorize refills, modify prescriptions, initiate therapeutic interchanges (in which the pharmacist can substitute another drug for the medication prescribed), and order and interpret laboratory tests, while keeping the prescriber apprised of the pharmacist's actions through established communication mechanisms. This allows each member of the health care team to complement the skills and knowledge of the other members and more effectively facilitate patient care, resulting in improved patient outcomes.

Scope of Service and Requirements

Many pharmacists' services do not require a CPA. For example, assessing medication therapy for drug-related problems, performing hypertension and cholesterol screenings, and educating patients are already within pharmacists' regular scope of practice. A CPA is not required for pharmacists or practitioners to collaborate in providing care. The only requirement is cooperation toward achieving a common goal—providing optimal patient care. While it is important to have shared goals,

clear roles, effective communication, and measurable processes and outcomes, the degree of trust within the relationship is often the deciding factor for turning collaborative relationships into contractual CPAs.

Building trust is often a progressive process. For example, a collaborative relationship may begin with a pharmacist dispensing a prescriber's prescription, followed by an exchange of medication information. This advances to a prescriber accepting a pharmacist's recommendations for medication therapy, and then to a prescriber delegating disease management responsibilities and granting authority for medication therapy management to a pharmacist under a formal CPA. Trustworthiness, role specification, and professional interactions are three critical factors to establishing trust within a collaborative relationship.

Components of a CPA and Applicable Laws

Pharmacists interested in pursuing CPAs with prescribers should seek to understand the laws on CPAs within their state, identify prescribers with whom a relationship already exists or build a relationship with prescribers with mutual interests, and consider offering basic services (e.g., refill authorizations, therapeutic interchange) as an initial step. Seeking to identify and understand the prescriber's unmet needs and demonstrating competency as it relates to the prescriber's patient population and the services provided will help to facilitate the uptake of a CPA. Finally, pharmacists can anticipate prescribers' concerns related to delegating authority for care and be prepared to respond to those concerns in an effective manner.

Steps to Implementation

A CPA template and sample language for each component are included in this resource guide. The implementation of a CPA involves a series of steps that depend on state laws and pharmacist-prescriber preferences. The implementation steps may include registering the CPA with the board of pharmacy or some other governing body, developing data sharing and business associate agreements, obtaining a pharmacist National Provider Identifier number, and identifying a business model that sustains the agreed-upon scope of services.

CPAs offer a unique opportunity for pharmacists to collaborate with prescribers in the treatment and management of chronic conditions, including CVD and hypertension. This guide offers resources to develop and implement a CPA between pharmacists and prescribers for the purpose of advancing public health and improving patient outcomes, quality and process measures, efficacy, and patient and provider satisfaction.

A formal CPA can have many components including the following:

Scope of Agreement

- Parties to the agreement
- Patient inclusion criteria
- Patient care functions authorized

Legal Components

- Authority and purpose
- Liability insurance
- Informed consent of the patient
- Review of the agreement and maximum period of validity
- Rescindment or alteration of agreement
- Signatures of the parties to the agreement

Administrative Components

- Training and education
- Documentation
- Communication
- Quality assurance (or quality measurement)
- Retention of records

Acknowledgments

The Division for Heart Disease and Stroke Prevention within the Centers for Disease Control and Prevention in collaboration with ChangeLab Solutions, the National Alliance of State Pharmacy Associations, the American Pharmacists Association, the Network for Public Health Law – Eastern Region, and the University of Maryland Francis King Carey School of Law developed this guide.

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Overview

Impact of Chronic Disease

Chronic diseases are the leading causes of death and disability in the United States, accounting for seven of every ten deaths.[1] In 2012, 117 million Americans (about half of the adult population) had at least one chronic illness.[2] An estimated 25% of U.S. adults with chronic conditions have one or more limitations in daily activities.[2] In 2014, one in every three deaths was due to cardiovascular disease (CVD).[3,4]

Hypertension, hyperlipidemia, and smoking are key risk factors for CVD, and 47% of Americans have at least one of these three risk factors.[5] One in three U.S. adults has high blood pressure, and almost half of these individuals do not have this condition under control.[5] Another 11.5 million of these adults are neither aware of their hypertension nor taking antihypertensive medications.[3,5] In addition, only one third of people with high cholesterol have adequate control of their hyperlipidemia, and 17% of U.S. adults smoke cigarettes.[6,7,8] Improved control of the risk factors for CVD requires an expanded effort from health care systems and health care professionals in the health system, including pharmacists.[6]

Value of Pharmacists' Patient Care Services

Interventions to manage and control hypertension and other risk factors for CVD can focus on removing health care professional- and patient-related barriers.[9,10,11] A team-based model organizes care around patient needs and commonly involves systems that support clinical decision making through collaborations between health care professionals or between these professionals and their patients. There is strong evidence that when pharmacists are part of the health care team, outcomes related to preventing or managing chronic diseases (e.g., blood pressure, blood glucose, cholesterol, obesity, smoking cessation) and adherence to medication improve.[12,13] Team-based care results in personalized, timely, and empowered patient care and facilitates communication and coordination among team members.

In 1981, the American Public Health Association declared that pharmacists were an underutilized resource in promoting public health. Since then, several public health needs—such as public access to immunizations—have been addressed by community pharmacists. One of the reasons that pharmacists can address emerging public health needs is that they are among the most accessible health care professionals in the United States. Notably, an estimated 86% of the U.S. population lives within 5 miles of a community pharmacy.[14] While examples of pharmacists practicing in team-based environments exist, there remains an opportunity to increase and accelerate the inclusion of pharmacists as part of the patient care team.

In 2011, the chief pharmacist officer of the U.S. Public Health Service authored a report, titled *Improving Patient and Health System Outcomes Through Advanced Pharmacy Practice*, to the U.S. surgeon general.[15] This report highlighted the efficacy of pharmacists in advanced practice roles and advocated for intensified utilization of pharmacists in alleviating our nation's imminent primary care provider crisis. The findings of the report were promptly endorsed and supported by the 18th surgeon general, Vice Admiral Dr. Regina Benjamin, who recommended that health leadership and policy makers optimize the pharmacist's role.[16] Vice Admiral Benjamin recommended that this be done through implementation of collaborative practice models; recognition of pharmacists as providers, clinicians, and essential members of the health care team; and exploration of additional compensation models to support pharmacists in these expanded roles.

Advancing Pharmacists in Team-Based Care

The Centers for Disease Control and Prevention (CDC) recognizes the role of pharmacists in team-based care for chronic disease management. The CDC Division for Heart Disease and Stroke Prevention has created resources to encourage pharmacists and prescribers (physicians and others who prescribe drugs) to work collaboratively and formalize those relationships through collaborative practice agreements (CPAs), when possible. These resources include:

- A Program Guide for Public Health: Partnering with Pharmacists in the Prevention and Control of Chronic Diseases. This resource provides examples of how pharmacists can work within the four public health domains (i.e., environmental approaches, health systems, community-clinical linkages, and epidemiology and surveillance) to have a positive effect on patient health outcomes.[17]
- How Pharmacists Can Improve Our Nation's Health. This resource (a CDC Public Health Grand Rounds presentation) provides examples of the roles that pharmacists can play in team-based care.[18]
- Collaborative Practice Agreements and Pharmacists' Patient Care Services. This resource provides an overview of CPAs.[19]
- Collaborative Drug Therapy Management: Case Studies of Three Community-Based Models of Care.[20] This resource illustrates how CPAs have been successfully implemented in three pharmacy practice settings.

Purpose and Development Process

The purpose of this resource guide is to empower community pharmacists and collaborating prescribers to initiate CPAs that are focused on caring for patients with chronic diseases. CVD and its risk factors are used as an example throughout the resource guide. The primary audience is pharmacists practicing in states where existing regulations permit them to engage in CPAs for the monitoring and management of chronic disease.

The information contained in this resource guide was collected in these four ways: (1) reviewing existing literature and resources; (2) analyzing laws and regulations on collaborative practice; (3) reviewing examples of CPAs currently in use; and (4) holding roundtable meetings with pharmacists, physicians, public health professionals, academicians, and payer representatives in five states (i.e., Kentucky, Minnesota, Tennessee, Washington, and Wisconsin).

CPA-related Terminology

Other terms for a CPA include:

- Collaborative pharmacy practice agreement.
- Collaborative care agreement.
- Consult agreement.
- Physician-pharmacist agreement.
- Standing order or protocol.
- Delegation of authority by physician.

Terms used to describe the services provided under a CPA include:

- Collaborative drug therapy management.
- Drug therapy management.
- Pharmaceutical care.
- Medication therapy services.
- Collaborative pharmacy practice.[22]

About Collaborative Practice Agreements

Definition of a CPA

CPAs create a formal practice relationship between a pharmacist and a prescriber. The agreement specifies what functions—in addition to the pharmacist's typical scope of practice—are delegated to the pharmacist by the collaborating prescriber. The collaborating prescriber is most often a physician, but a growing number of states are allowing for CPAs between pharmacists and nurse practitioners or other nonphysicians. This resource guide uses the term "prescriber" to reference the collaborating provider who is delegating patient care services to the pharmacist under the CPA.

The functions provided under the agreement vary from state to state based on the pharmacist's scope of practice and the state's collaborative practice laws.[21]

Most often, CPAs are used in the context of authorizing pharmacists to initiate, modify, or discontinue medication therapy. Functions performed under a CPA may also include ordering and interpreting laboratory tests if those services are not already authorized in the pharmacist's scope of practice.

Using CPAs to Facilitate Team-Based Patient Care[22]

When trust has been established, CPAs are a useful way to increase the efficiency of team-based care. When designed correctly, CPAs benefit the collaborative delivery of care by delegating specific patient care services to pharmacists. This delegation can expand available services to patients and increase the efficiency and coordination of care. For example, CPAs can decrease the number of phone calls required to authorize refills or modify prescriptions, thus allowing each member of the health care team to complement the skills and knowledge of the other member(s) and more effectively facilitate patient care, resulting in improved patient outcomes.

Terminology

This resource guide uses the term "collaborative practice agreement," "collaborative agreement," or "CPA" to describe a practice relationship in which a prescriber delegates selected patient care services to a pharmacist. The terminology used to describe this authority varies among states as do the terms used to describe the services provided under a CPA.

States Permitting CPAs

As of May 2016, 48 states permit some type of pharmacist-prescriber collaborative practice authority. However, some of these states' laws and regulations may not support the implementation of a CPA. For example, in Alabama and Delaware, prescribers cannot delegate authority to pharmacists via a CPA, and in Florida and Oklahoma, pharmacists are restricted to providing only limited services under a CPA.

State laws for CPAs vary widely; the key variables in these laws are below. Thus, the terms of the written CPA will need to be customized to the laws and regulations of a given state.

Finding the Applicable State Laws and Regulations

Before entering into a CPA, pharmacists and prescribers may benefit by reviewing their state's current laws and regulations pertaining to CPAs. Appendix A contains CPA laws for each state (as of December 31, 2015). State boards of pharmacy and medicine and state pharmacy and medical associations can serve as points of contact for the most up-to-date information on CPA authority. To obtain access to a specific state's current pharmacy laws and regulations, visit the National Association of Boards of Pharmacy website.

Pharmacy Services Under CPAs

A variety of pharmacist-provided services can be performed under a CPA. CVD-related services are used as examples below to illustrate how pharmacists may define pharmacy services within a CPA. Because of variations in state laws, some of the services may be permitted under a pharmacist's regular scope of practice in some states but represent an expansion of practice in others.

Authorization of refills. In this service, the prescriber authorizes the pharmacist to extend refills based on the pharmacist's assessment (e.g., using the pharmacists' patient care process) of the patient. For example, under the terms of a CPA, a pharmacist may be permitted to extend refills of a patient's medications for treating chronic hypertension and hypercholesterolemia, thereby removing delays in therapy and administrative barriers and potentially increasing medication adherence. Without a CPA, in most states, pharmacists would need to contact the prescriber to obtain authorization for a refill.

Variables in State CPA Laws and Regulations

CPA Participants
- Number of pharmacists.
- Number of prescribers.
- Number of patients.
- Types of prescribers.
- Relationship between patient and prescriber.
- Pharmacist-to-prescriber ratio.

Authorized Functions
- Modify medication therapy.
- Initiate medication therapy.
- Discontinue medication therapy.
- Conduct physical assessment.
- Order laboratory studies.
- Interpret laboratory studies.
- Perform laboratory tests.

Requirements and Restrictions
- Continuing education.
- Qualifications of pharmacist.
- Liability insurance.
- Disease state of patient.
- Practice setting.
- Medications to be managed.
- Involvement of patient.
- Agreements approved or reported, and to which entity.
- Length of time that agreement is valid.
- Documentation.
- Communications.
- Review by physician.

Therapeutic interchange. Here the prescriber authorizes the pharmacist, under a CPA, to substitute another drug in the same drug class (e.g., angiotensin-converting enzyme inhibitors to treat hypertension) for the medication originally prescribed. This usually happens because of the variability in a particular health plan's formulary of accepted drugs. The pharmacist's clinical knowledge of medications informs his or her choice of medication within a particular class of drugs.

Hypertension management. In this service, the prescriber authorizes the pharmacist to initiate, modify, or discontinue medications. For example, under the terms of a CPA, a pharmacist may be permitted to add therapies if the patient's hypertension is uncontrolled, adjust doses of medication, or discontinue medications that are not working or cause side effects. The medications or medication classes that pharmacists are permitted to initiate, modify, or discontinue may be indicated in the agreement. Without the CPA, the pharmacist would have to assess the patient and make a recommendation to the prescriber. The prescriber would then have to act on the recommendation in order for the pharmacist to make a change in therapy. The CPA leverages the pharmacist's medication and health-related expertise to extend the care of the prescriber's patients while coordinating care with the prescriber.

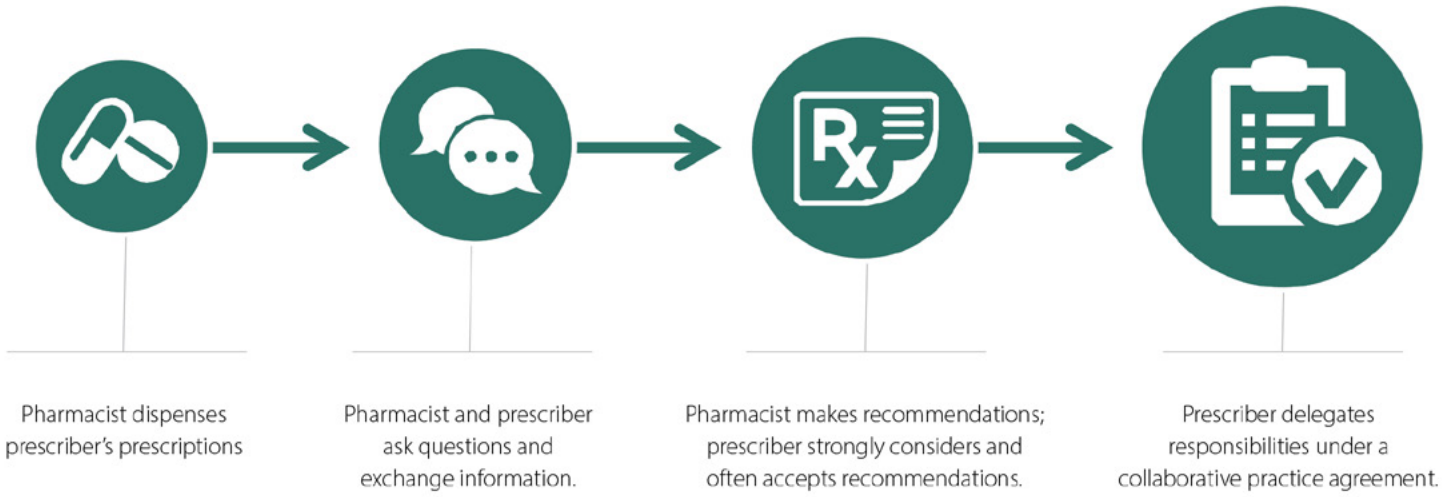
Ordering laboratory tests.
Here the CPA may authorize the pharmacist to order and interpret laboratory tests that are essential for effectively monitoring medications or the status of chronic conditions. For example, as part of a hypertension CPA, the pharmacist could order urine and blood analyses to test for electrolyte levels, fluid balance, and kidney function.

Note that some pharmacists' CVD-related services, such as assessing medication therapy for medication-related problems, performing hypertension and cholesterol screenings, and educating the patient, are within pharmacists' regular scope of practice.

State Scope of Practice & CPAs

The patient care functions that pharmacists are authorized to perform with and without a CPA are highly variable from state to state. A function that a pharmacist can perform only if authorized under a CPA in one state may be a function that a pharmacist can perform autonomously in another state. This resource guide's primary focus is on developing a CPA to facilitate those patient care functions required by state law to be delegated to the pharmacist through a written CPA. However, it is important to note that pharmacists and other health care professionals may still choose to formalize their collaboration with an agreement—to outline communications, documentation, and other pertinent subjects—even if the activities the parties agree to collaborate on can be performed autonomously by the pharmacist pursuant to the state pharmacy practice act. Pharmacists should consult with the state board of pharmacy or a licensed attorney when there is a question regarding whether an agreement must comply with a given state's CPA laws.

Figure 1: Level of Professional Interaction Reflects Degree of Trust Between the Pharmacist and the Prescriber



Collaborative Care as a Basis for CPAs

The World Health Organization has stated that "Collaborative care in health care occurs when multiple health providers from different professional backgrounds provide comprehensive services by working with patients, their families, care providers, and communities to deliver the highest quality of care across settings."[23] Thus, a CPA is not required for practitioners to collaborate in providing care. The only requirement is cooperation toward achieving a common goal—providing optimal patient care. As part of collaboration, it is important to have shared goals, clear roles, effective communication, and measurable processes and outcomes. The degree of trust within the relationship is often the deciding factor for collaborative relationships becoming contractual CPAs.[24] Figure 1 illustrates the relationship between greater trust within a collaborative relationship and a higher degree of professional interactions.

Developing the Relationship and Building Trust

Once an initial relationship is established, the collaborating providers can work together to develop mutual trust. Three factors that may be important to the development of a working clinical relationship are trustworthiness, role specification, and professional interactions.[24,25,26,27,28,29]

Trustworthiness. The development of trust requires time and the demonstration of competence.[29] Physicians may be more trusting when they know the amount of training, experience, and credentials that the pharmacist has.[24,25,26,27,28,29] Pharmacists may recognize this tendency and be open to sharing this information about themselves.

Patients also benefit from developing trust with the members of their care team. One way to accomplish

this is for the prescriber and pharmacist to meet with the patient together. If a joint appointment is not possible, the prescriber can advise the patient of the benefits from seeing the pharmacist. Regardless, the expectation is that trust will be built gradually among pharmacists, providers, and patients.

Role specification. Defining which activities will be performed by pharmacists and which by the prescriber enables both parties to have shared expectations about how they will collaborate. When first establishing a collaborative relationship, health care professionals may choose to begin with focusing on basic services until trust can be established. As both health care professionals work together to understand each other's skills and competence, trust will grow, and more complex services can be introduced.[30] Many pharmacists have reported that as prescribers experience pharmacists' skills firsthand, the prescribers begin to offer ideas for more collaboration.

Professional interactions. Direct interactions between pharmacists, prescribers, and their patients are essential to growing trust and collaboration. Effective communication is key to building professional interactions and demonstrating trustworthiness. When pharmacists and physicians start their collaborative relationship, frequent in-person communication may be ideal.[25] For example, pharmacists may consider practicing in the prescriber's office for a specific time frame (e.g., a half day each week for 2 months) to learn the prescriber's approach to patient care and style of communication. When building the relationship, pharmacists can consider providing an example of the type of communication the prescriber can expect to receive after patient visits. This may serve as a conversation starter when developing the CPA.[25] Communication between providers can be initiated by either party; communication could include, for example, sharing relevant patient information, discussing drug-related problems, or requesting a pharmacist consultation. Increasing professional interactions leads to increased collaboration.[28]

Formalizing Collaborative Relationships Through CPAs

Once pharmacists and prescribers have established collaborative relationships built upon trust, they may choose to enter into a formalized CPA to facilitate the pharmacist's ability to care for the prescriber's patients in accordance with mutually established role specifications. In the beginning of the collaborative relationship, the pharmacist will likely initiate the conversation about the CPA; he or she should be prepared to make the case for the value of formalizing the relationship. Pharmacists should be aware that the collaborating prescriber would be increasing his or her own liability by entering into a CPA, and so it will be important to let the prescriber ask questions, voice concerns, and help to shape the scope of the CPA. When first establishing a formal collaborative arrangement, pharmacists and prescribers may choose to begin with focusing on basic services such as authorization for refills or therapeutic interchange.

Identifying Partners

Finding and approaching a potential collaborator without having a prior relationship with that person can seem daunting. One approach is for pharmacists to work with prescribers they already know. This familiarity might come from collaborating on initiatives, such as the delivery of immunizations, or through mutual involvement in community organizations or local coalitions.[25] In addition, pharmacists can approach prescribers in their community with whom they do not have a prior relationship but where common goals exist.

Pharmacists' ability to improve metrics of quality—both clinical and financial—can also create opportunities for collaboration. Hospitals are increasingly under pressure to reduce readmissions, and the services of pharmacists can help here. Pharmacists can meet with the medical director and pharmacy director from local hospitals to explore collaboration on transitions of care from the hospital to an outpatient/office or clinic setting. Clinics and physicians' offices, as well as hospitals, are held to quality measurements that pharmacists' services can often improve. Other potential collaborators include state and local public health agencies, accountable care organizations, and patient-centered medical homes. It can be helpful for pharmacists to understand the metrics for which potential collaborators are responsible and then think of ways to help them improve those scores.

When identifying providers for new collaborative relationships, pharmacists may consider those provisions in state CPA laws that limit which prescribers can enter into CPAs with pharmacists. In all states, pharmacists may partner with physicians in their community to deliver collaborative care. Additionally, in states where nurse practitioners and physician assistants can enter into CPAs with pharmacists, these prescribers may be familiar candidates for collaboration because they were previously required to have CPAs with physicians in order to prescribe. Table 1 in Appendix A describes state laws and regulations, including those governing which prescribers can authorize a CPA.

Initiating the Relationship

Pharmacists seeking to start a collaborative model of care delivery may benefit from taking the first step in initiating the relationship.[25,26] To initiate discussions, a face-to-face meeting should be held with the prospective collaborating prescriber. The meeting can be scheduled in advance by the pharmacist, and might take place over lunch or dinner and include other staff members whose buy-in may be important.[25]

During the initial meeting with a prospective collaborator, the pharmacist should be prepared to articulate specific goals and benefits of collaboration and discuss how the collaboration can lead to enhanced patient care. He or she should consider focusing on unmet patient needs in the prescriber's practice and in the community. Where are there gaps that the pharmacist could fill? If the pharmacist has worked with other prescribers in the past, using examples of how that collaboration worked can spark conversation. For example, a pharmacist can use the first collaborating prescriber as a reference for future potential collaborations. If this is a new endeavor, one place to start is for the pharmacist to assist with improving medication adherence for patients in the prescriber's practice. Improving medication adherence is a service that pharmacists can provide without a CPA. In brief, it is a way to engage in offering a basic service with the intent to demonstrate success, build trust, and work collaboratively before a CPA is started. In a study reported in 2011, physicians' belief that collaboration with pharmacists could result in increased patient adherence to medication regimens was a predictor of a positive attitude toward collaboration.[27] Regardless, pharmacists should expect that prescribers, especially those who have not previously worked in collaborative relationships, might have many questions. It is important to consider each of the questions set forth on the next page titled "Anticipating the Concerns of Prescribers" before meeting with a prescriber and to have a well-formulated response to each one.

Garnering the support of prescribers for entering into a CPA might require various approaches and timelines. Once the partners agree to formalize their collaboration, creating the legal agreement may require consideration of the components included in state CPA laws (Appendix A). Figure 2 presents a sample CPA and sample language that may be customized by pharmacists and prescribers using their specific state laws to create a CPA.

Anticipating the Concerns of Prescribers

1. **What is the pharmacist's training, and what credentials does the pharmacist have?**
   Pharmacists can educate the prescriber on the pharmacist s training and focus on the skills and credentials of the particular pharmacist(s) who would be working in the practice.

2. **What has been the pharmacist's experience in delivering various patient care services?**
   Pharmacists can explain how their experience aligns with the needs of the patient population cared for by the prescriber and elaborate on how that experience can benefit the patient and improve outcomes.

3. **What is the pharmacist's scope of practice in the state?**
   Pharmacists can educate the prescriber about which patient care functions pharmacists can perform pursuant to the state s pharmacy practice act as well as the functions that can be authorized in a CPA. Providing specific examples can be very helpful.

4. **How will the pharmacist communicate with the prescriber?**
   Pharmacists can discuss the prescriber s preferred method of communication and review opportunities for using health information technology to facilitate the exchange of information. In addition, they should provide examples of how pharmacists communicate (using health information technology and other means) with prescribers in collaborative care models.

5. **Will the prescriber incur additional liability?**
   In a collaborative care relationship that is not governed by a CPA, the prescriber is not likely to incur additional liability for any actions of the pharmacist. This is because the prescriber must approve any recommendations made by the pharmacist before medication therapy is initiated or modified. In this scenario, the risk may be lower because care is likely to be better coordinated in a collaborative care relationship. When using a CPA, pharmacists should discuss terms of liability—which can be clearly described in the CPA—to mitigate risk and any concerns of either party to the agreement.

6. **What costs will be incurred by the prescriber in collaborating with the pharmacist?**
   The prescriber is likely to bring up issues of cost and reimbursement. Costs may vary depending on where the pharmacist will practice (e.g., within the physician s office or remotely). Pharmacists should be prepared to discuss needs for resources and payment. During this discussion, it may be important to include the value that pharmacists can bring to the practice. Appendix B provides general information about payment for pharmacy services.[28]

1 in 3 adults

has high blood pressure

1 in every 3 deaths

was from cardiovascular disease

Adapting a Template CPA for a Hypertension and Cardiovascular Disease Service*

This section provides examples of language that can be used to draft a CPA. Figure 2, the sample CPA, demonstrates how the language options presented in the following call-out boxes can be applied to create a customized CPA. (Note that Figure 2 uses Virginia's provisions as an example and thus would not meet the requirements in all states.)

The language in the call-out boxes was adapted from CPAs that are currently in use and from feedback received at the roundtable meetings. This language is provided solely for educational purposes and is only for use as an example. Pharmacists may benefit from consulting legal counsel when drafting a CPA based on the laws and regulations in the jurisdiction where the CPA will be implemented. To get a better understanding of state laws and regulations—as of December 2015— those drafting a CPA should refer to the tables in Appendix A and be sure to check the current laws and regulations.

Not every state addresses every component that appears in these tables. The word "silent" indicates that the state has not addressed that particular issue in its laws and regulations. In these cases, pharmacists and prescribers should work within their scope of practice, use their judgment while developing a CPA, and keep the best interests of the patient in mind.

*Disclaimer: The information contained in this document does not constitute legal advice. Use of any provision herein should be contemplated only in conjunction with advice from legal counsel. The CPA language in the text boxes below was provided by attorneys at the University of Maryland Francis King Carey School of Law as example CPA language for educational purposes only and is adapted from CPA language from multiple states. Provisions may need to be modified, supplemented, or replaced to ensure appropriate citation of or compliance with relevant laws, to accurately reflect the intent of the parties to a particular agreement, or to otherwise address the needs or requirements of a specific jurisdiction.

Figure 2: Sample Collaborative Practice Agreement for Hypertension/Cardiovascular Disease (Continued on next page)

COLLABORATVE PRACTICE AGREEMENT

for authorization of therapy continuation and therapeutic interchange

A. AUTHORITY AND PURPOSE

I, Dr. Susan Patel and Jessica Johnson authorize the pharmacist(s) named herein, who hold an active license to practice from the Commonwealth of Virginia, to manage and/or treat patients pursuant to the parameters outlined in this agreement. This authority follows the laws and regulations of the Commonwealth of Virginia. The purpose of this agreement is to facilitate consistent access to medications for the collaborating providers' mutual patients.

B. PARTIES TO THE AGREEMENT

The following providers agree to the parameters outlined in this agreement:

Pharmacists:	Prescribers:
James Lee, PharmD	Susan Patel, MD
Alexa Garcia, PharmD	Jessica Johnson, ANP

C. PATIENTS

Patients whose therapy may be managed pursuant to this agreement include those who are currently receiving hypertension or dyslipidemia therapy prescribed by a prescriber listed in Section B of this agreement.

D. PATIENT CARE FUNCTIONS AUTHORIZED

Pharmacist(s) included in Section B of this agreement will have the authority to manage and/or treat patients in accordance with this section.

In managing and/or treating patients, the pharmacist(s) may authorize continuation of drug therapy and modification of drug therapy to a therapeutic alternative medication (defined as a medication in the same class with an equivalent dose), if appropriate, based on current literature and clinical judgment.

D.1. Dyslipidemia[1]

The pharmacist(s) will evaluate dyslipidemia as outlined by 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults and other nationally recognized standards of care as supported by current literature. Pharmacist(s) will have authority to authorize continuation of therapy or therapeutic interchange for the treatment of lipids which may include, but are not limited to the following classes: HMG-CoA reductase inhibitors (statins), bile-acid sequestrants, cholesterol absorption inhibitors, fibrates, omega-3 fatty acids, niacin.

D.2. Hypertension[2]

The pharmacist(s) will evaluate hypertension therapy as outlined in 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8) and other nationally recognized standards of care as supported by current literature. Pharmacist(s) will have authority to authorize continuation of therapy or therapeutic interchange for the treatment of hypertension which may include, but are not limited to the following classes: beta-blockers, calcium channel blockers, ACE inhibitors, angiotensin II receptor blockers, direct renin inhibitors, diuretics, alpha-blockers, α_1- centrally active agents.

E. TRAINING/EDUCATION

All parties to this agreement are expected to maintain up-to-date competencies and knowledge of current guidelines for disease states covered under this agreement.

F. LIABILITY INSURANCE

All parties to this agreement shall maintain at least $1,000,000 (per occurrence) of professional liability insurance during the term of the agreement which specifically covers drug therapy.

G. PATIENT INFORMED CONSENT

The pharmacist shall obtain written informed consent from the patient upon first meeting with the patient. A record of provision of care by a pharmacist shall be maintained in the patient's pharmacy record, which is available to the pharmacist.

Figure 2: Sample Collaborative Practice Agreement for Hypertension/Cardiovascular Disease (Continued from previous page)

H. DOCUMENTATION
The pharmacist(s) shall document each continuation or modification of therapy authorization in the patient's pharmacy record.

I. COMMUNICATION
The pharmacists shall provide the patient's original prescriber with notification in the form of fax or secure email when their patient's therapy is continued or therapeutically interchanged pursuant to this agreement. In this notification, the pharmacists will include any relevant information that was collected from the patient such as current blood pressure, adherence issues, or any socioeconomic challenges identified.
The pharmacist shall report any new patient complaints and/or deterioration in the patient's condition to the patient's primary care provider and/or other provider immediately after learning of the new condition or as soon as possible thereafter.

J. QUALITY ASSURANCE
Care provided as a result of this collaborative practice agreement will be routinely evaluated to assure delivery of high quality patient care. Annual evaluation of pharmacist(s) may include clinical outcomes, number of patients treated, and satisfaction surveys of patients and providers as appropriate.

K. AGREEMENT REVIEW AND DURATION
This agreement shall be valid for a period not to exceed two years from the effective date. However, it may be reviewed and revised at any time at the request of any signatories.

L. RECORD RETENTION
Each signatory to this agreement shall keep a signed copy, written or electronic, of this agreement on file at their primary place of practice. Record of each therapeutic interchange made for a specific patient shall be maintained in the patient's pharmacy record.

M. RESCINDMENT OR ALTERATION OF AGREEMENT
A signatory may rescind from this agreement or a patient may withdraw from treatment under this agreement at any time. The prescriber(s) may override this agreement whenever he or she deems such action necessary or appropriate for a specific patient without affecting the agreement relative to other patients.

N. REFERENCES

1. Stone NJ, Robinson J, Lichtenstein AH, et al. "2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults." *Circulation* (2013) [Epub ahead of print: http://www.ncbi.nlm.nih.gov/pubmed/24222016?dopt=Abstract.
2. James PA, Oparil S, Carter BL, et al. 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8). *JAMA*. doi:10.1001/jama.2013.284427. Published online December 18, 2013

O. AGREEMENT SIGNATURES
This agreement includes patients under the care of the practitioner(s) and extends for a period of two (2) years from this date unless rescinded earlier in writing.

Signatures:

[Prescriber name and credentials]	[Prescriber Signature]	License #	Date
[Prescriber name and credentials]	[Prescriber Signature]	License #	Date
[Pharmacist name and credentials]	[Pharmacist Signature]	License #	Date
[Pharmacist name and credentials]	[Pharmacist Signature]	License #	Date

A. Authority and Purpose

This section is not required by law to be included in a CPA but may help the collaborating providers establish their vision for the purpose of the agreement.

AUTHORITY AND PURPOSE:

I, [INSERT PRESCRIBER NAMES], authorize the pharmacist(s) named herein, who hold an active license to practice issued by [STATE NAME], to manage and/or treat patients pursuant to the parameters outlined in this agreement. This authority follows the laws and regulations of [STATE NAME]. The purpose of this agreement is to facilitate consistent access to medications for the collaborating providers' mutual patients.

OR-

PURPOSE:

In order to enhance collaborative patient care and optimize medication-related outcomes, patient care services will be provided by the pharmacists listed in Section B of this agreement in collaboration with the prescribers listed in Section B of this agreement. Services will include those listed in Section D of this agreement. The pharmacists will deliver these services in a manner consistent with the parameters outlined in this collaborative practice agreement and in compliance with the protocols included in the appendices to this agreement.

B. Parties to the Agreement

Both the pharmacists and the prescribers who are participating in the CPA are identified in this section. In some states, a medical director may be authorized to sign onto an agreement on behalf of the providers within a given practice. In this case, each practitioner may or may not have to individually sign the agreement, depending on state laws and regulations. Which prescribers may authorize a CPA and how many pharmacists and prescribers may be on an agreement varies from state to state.

See Table 1 in Appendix A for more information on the authority and restrictions in a particular state.

PARTIES TO THE AGREEMENT:

The following parties agree to the parameters outlined in this agreement:

Pharmacists:	Prescribers:

C. Patients

In this section, either the specific patient(s) or the defined population of patients that will receive care can be specified. Some state laws restrict eligibility to only those patients who are actively being treated by the collaborating provider. Others specify that each patient who will receive care under the parameters of the agreement be listed in the agreement. Still others may even require that the agreement be specific to a single patient and disease state. Drafters of a CPA should see Table 1 in Appendix A for more information on their state.

PATIENTS [PRESCRIBER'S PATIENT PANEL]:

Patients whose therapy may be managed pursuant to this agreement include those who are currently receiving hypertension or dyslipidemia therapy prescribed by one of the prescribers listed in Section B of this agreement.

OR-

PATIENTS [SPECIFIC LIST OF PATIENTS]:

The pharmacists listed in Section B of this agreement are authorized to provide care to the following patients, pursuant to this agreement:

OR-

PATIENTS [SPECIFIC TO A SINGLE PATIENT]:

Pursuant to this agreement, the pharmacist(s) listed in Section B of this agreement are authorized to provide care, in the manner outlined in this agreement, to [INSERT PATIENT], a patient of [AUTHORIZING PRESCRIBER].

D. Patient Care Functions Authorized

Role specification allows for mutual understanding of each provider's role in care delivery. As trust develops and the collaborative relationship grows, providers can become interdependent, and their roles can evolve over time.[27,29] Setting expectations for each provider's role can help all parties to feel more comfortable with moving forward. Note that it may be helpful to set expectations for when the initial role specification will be assessed and adjusted. Setting such expectations allows for open communication and continual process improvement.

All CPAs define the scope of the patient care functions that pharmacists are authorized to provide pursuant to the agreement. In the sample agreement, pharmacists are authorized to continue prescription therapy for a medication that does not have refills remaining and make a therapeutic substitution for medications in the same drug class as that prescribed.

Not all states require that a treatment protocol be used as part of a CPA. For example, in Michigan and Wisconsin, physicians can delegate any patient care service to a pharmacist, and the pharmacist's authority does not require the use of a treatment protocol. Even in states where such a protocol is required, providing general guidance, such as referring to evidence-based guidelines, may be appropriate.

Additionally, some states require that the CPA specify which drugs the pharmacist may initiate and/or modify. If this is required, the list of drugs could be included in the "Patient Care Functions Authorized" or in an appendix to the agreement.

It may also be useful to include language covering the instances when the pharmacist refers the patient back to the prescriber. This language would discuss issues outside the scope of the agreement.

Those interested in drafting a CPA should look at Table 2 in Appendix A for more information on what patient care functions can be authorized under such an agreement.

PATIENT CARE FUNCTIONS AUTHORIZED:

Pharmacist(s) included in Section B of this agreement will have the authority to manage and/or treat patients in accordance with this section. In managing and/or treating patients, the pharmacist(s) may [INSERT PATIENT CARE FUNCTIONS AUTHORIZED, SUCH AS INITIATE, MODIFY, OR DISCONTINUE DRUG THERAPY], if appropriate, based on current literature and clinical judgment. The pharmacist(s) will refer the patient back to her/his prescriber for issues that are outside the scope of this agreement. [DEPENDING ON STATE LAW, IT MAY BE NECESSARY TO LIST THE DRUGS, DRUG CLASSES, AND/OR TREATMENT PROTOCOLS AS WELL. THESE ELEMENTS COULD BE INCLUDED IN AN APPENDIX TO THE AGREEMENT.]

E. Training/Education

Some states require that specific education and/or training be completed before a pharmacist is allowed to enter into a CPA. In other states, the education and training that is appropriate for each situation should be determined by the collaborating prescribers. In the example CPA in Figure 2, Virginia does not require any specific education or training. Thus, the collaborating prescribers wrote the agreement so that the responsibility rested with each provider to ensure that he or she actively maintained his or her clinical competencies. Those interested in developing a CPA should see Table 3 in Appendix A for the requirements in their state.

TRAINING/EDUCATION:

All parties to this agreement are expected to maintain up-to date competencies and knowledge of current guidelines for disease states covered under this agreement.

F. Liability Insurance

State laws/regulations in some states require that providers maintain professional liability insurance in order to participate in a CPA. Regardless of whether it is required by law, health care professionals may want to maintain

liability insurance and may consider including that as a requirement in the CPA. Those interested in developing a CPA should see Table 3 in Appendix A for the requirements in their state.

LIABILITY INSURANCE:
All parties to this agreement shall maintain at least $1,000,000 (per occurrence) of professional liability insurance during the term of the agreement, which specifically covers drug therapy.

G. Informed Consent of the Patient

Although obtaining a written informed consent from the patient is not required in all states, it is beneficial for patients to have an understanding of how their care is delivered. Even in states where a specific form of patient consent is not mandated, health care professionals can discuss whether it needs to be obtained at the first meeting with the patient and the procedure that will be used. Those interested in creating a CPA should see Table 3 in Appendix A for the requirements in their state.

INFORMED CONSENT OF THE PATIENT [WRITTEN CONSENT REQUIRED]:
The pharmacist shall obtain written informed consent from the patient upon first meeting with that patient. A record of provision of care by a pharmacist shall be maintained in the patient's pharmacy record, which is available to the pharmacist.
-OR-
INFORMED CONSENT OF THE PATIENT [WRITTEN CONSENT NOT REQUIRED]:
At the start of care provided by the pharmacist, each new patient will be provided with an explanation of the collaborative relationship between the pharmacist and the collaborating prescriber. Patients will be informed of their right to opt out of care.

H. Documentation

Several states have specific laws and regulations pertaining to the documentation of care delivered under a CPA (see Table 3 in Appendix A for more information). Regardless of whether it is required by law, thorough documentation of clinical activities is considered standard practice. Clinical documentation is a relatively new concept for the community pharmacy setting, however, especially beyond formal medication therapy management services. Documentation can be performed using electronic software systems or in a paper chart, although some states require that services provided pursuant to a CPA be documented in an electronic health record. It is sometimes required that the collaborating prescriber and pharmacist both have access to the patients' medical records. Documentation can be done in the traditional subjective, objective, assessment, plan (SOAP note) method or using forms that are more tailored to the specific service(s) the pharmacist is providing.[31]

It can be beneficial to include specifications on documentation and the maintenance of records in the CPA. Some states may require it and even have a minimum duration for retaining records.[32] Table 3 in Appendix A lists state requirements for documentation and the maintenance of records associated with CPAs. Because provisions related to documentation are often complex, those interested in a CPA should refer to the actual legal language in their state to be sure that they are in compliance with the requirements.

DOCUMENTATION [SIMPLE]:
The pharmacist(s) shall document each continuation or modification of an authorization for therapy in the patient's pharmacy record.

OR-

DOCUMENTATION [NO SHARED ACCESS TO AN ELECTRONIC RECORD]:
The pharmacist will complete a progress note for each patient encounter. For each visit, the pharmacist will record subjective/objective information, the assessment, and the plan. Following each visit, the pharmacist will communicate (e.g., fax) the visit note to the referring provider.

OR-

DOCUMENTATION [SHARED ACCESS TO AN ELECTRONIC RECORD]:
The pharmacist shall document each scheduled visit with the patient in the patient's medical record. The documentation contained in the medical record shall include medical and medication history, assessment, recommendations, monitoring, educational interventions, and documentation of decisions made, including medications initiated, modified, or discontinued.

OR-

DOCUMENTATION [SHARED ACCESS TO AN ELECTRONIC RECORD; PRESCRIBER REVIEW REQUIRED]:
The pharmacist shall document each scheduled visit with the patient in the patient's medical record. The documentation contained in the medical record shall include medical and medication history, assessment, recommendations, monitoring, educational interventions, and documentation of decisions made, including medications initiated, modified, or discontinued. The collaborating prescriber will review and cosign all notes in the patient chart and provide feedback to the pharmacist on a regular basis.

I. Communication

As discussed earlier, communication among providers can be helpful for building trust, and it is essential for providing high-quality care. Without efficient and consistent communications, care can become fragmented, duplicative, ineffective, or even harmful.[24] Communication can occur through a variety of media, such as mutually accessed patient records, telephonic and live conversations, email, and text messages or instant messaging.[24] Expectations for the methods used, their frequency, and the timing of communications can be discussed among providers and, when appropriate, outlined in the CPA. When initiating work under a CPA, there may need to be more collaboration on individual clinical decisions and, therefore, more regular communications. Once both parties are comfortable with the care plan and each other's communication needs, the communication procedures outlined in the CPA could be reexamined.

Some states do have specific requirements for communications between providers (see Table 3 in Appendix A and relevant state laws and regulations, as these provisions can be complex).

COMMUNICATION:
The pharmacist shall provide the patient's original prescriber with notification in the form of a fax or secure email when her/his patient's therapy is continued or there is a therapeutic interchange pursuant to this agreement. In this notification, the pharmacist will include any relevant information that was collected from the patient, such as current blood pressure, adherence issues, or any socioeconomic challenges identified.

The pharmacist shall report any new patient complaints and/or deterioration in the patient's condition to the patient's primary care provider and/or other provider/prescriber immediately after learning of the new condition or as soon as possible thereafter.

J. Quality Assurance [and/or Quality Measurement]

Although a specific plan for quality assurance is not required in most states, it may be best to implement a program for continuous quality improvement.

A few states specifically require that a section on quality assurance be included in the CPA (see Table 3 in Appendix A).

Additionally, practitioners may consider collecting and analyzing data related to outcomes. This information can be used to assess the effectiveness of interactions, to market services in the future, and to demonstrate value to payers, patients, and potential collaborating prescribers. It may be helpful to consider a variety of outcome measures, including those that are economic (e.g., reduction in overall health costs), clinical (e.g., adherence measures, reduction in blood pressure), and personal (e.g., patient satisfaction, quality of life). More information about quality measurements related to pharmacy and to health care in general can be found on the Pharmacy Quality Alliance website and the Agency for Healthcare Research and Quality website.

QUALITY ASSURANCE [MORE GENERAL LANGUAGE]:

Care provided as a result of this collaborative practice agreement will be routinely evaluated to assure delivery of high-quality patient care. Annual evaluation of pharmacist(s) may include clinical outcomes, number of patients treated, and surveys of patient and provider satisfaction, as appropriate.

-OR-

QUALITY ASSURANCE [MORE SPECIFIC LANGUAGE]:

Care provided as a result of this collaborative practice agreement will be routinely evaluated to assure delivery of high-quality patient care. For each visit with the patient, parties to this agreement will collect and share information, including the patient's blood pressure, recent hospital admissions, and days missed from work or school. Outcomes will be analyzed and discussed among the parties to the agreement at least once per year.

K. Review of the Agreement and Maximum Period of Validity

About half of the states have set a maximum length of time that agreements are valid — typically 1 to 2 years. Even in those states where it is not required, the parties to the agreement may find it beneficial to discuss and agree upon a period for review and renewal of the agreement.

Those interested in creating a CPA should review Table 3 in Appendix A for their state's requirements.

REVIEW OF THE AGREEMENT AND MAXIMUM PERIOD OF VALIDITY:

This agreement shall be valid for a period not to exceed 2 years from the effective date. However, it may be reviewed and revised at any time at the request of any signatories.

L. Retention of Records

Some states have provisions regarding how long and in what manner patient records should be maintained (see Table 3 in Appendix A). In addition to any state requirements, pharmacists should know that if any insurer contracts are in place, these contracts may include separate requirements for maintenance of records. Record retention methods should be compliant with federal laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), state laws and regulations, and any payer contracts in place.

RETENTION OF RECORDS:
Each signatory to this agreement shall keep a signed copy, written or electronic, of this agreement on file at his/her primary place of practice. A record of each therapeutic interchange made for a specific patient shall be maintained in the patient's pharmacy record.

M. Rescindment or Amendment of Agreement

It may be beneficial to have a method for providers to withdraw their participation in the agreement and a procedure for altering the terms of that agreement.

RESCINDMENT OR AMENDMENT OF AGREEMENT:
A signatory may rescind this agreement or a patient may withdraw from treatment under this agreement at any time. Prescribers may override this agreement whenever they deem such action necessary or appropriate for a specific patient without affecting the agreement relative to other patients.

N. References

If any clinical guidelines are referred to within the text of the agreement, it may be advisable to include the sources so that providers can quickly reference them and ensure that the most up-to-date resources are being used.

O. Signatures of the Parties to the Agreement

The providers or designees of organizations (e.g., medical directors) who are listed as parties to the agreement must sign the agreement in this section. Note that there are some states that also require the patient(s) to sign the agreement. Because this requirement can make implementation of the agreement challenging in the community setting, providers may want to work together to create a procedure that allows for compliance with this requirement.

The parties should see Table 3 in Appendix A for their state's requirements regarding patient signatures on the CPA.

Facilitating the Use of CPAs: Other Considerations

While writing the agreement is the key step for entering into a CPA, other logistical steps may be considered. The list below outlines several of these steps, although there may be others, depending on the circumstances.

Registering With State Agencies

Some states require registration with the board of pharmacy or a similar body for the pharmacist to qualify for participation in a CPA. Others require that the CPA be submitted to or approved by such a body. Those interested in developing a CPA should see Table 3 in Appendix A for their state's requirements.

Data Sharing and Business Associate's Agreements

Per HIPAA, protected health information can be shared with a health care provider for treatment of an individual patient. Covered entities include health plans, health care clearinghouses, and certain health care providers.[33]

According to the U.S. Department of Health & Human Services, "The Privacy Rule does not require you to obtain a signed consent form before sharing information for treatment purposes. Health care providers can freely share information for treatment purposes without a signed patient authorization."[34] However, if patient health information is used by or is accessible to an organization that is not a covered entity, such as legal counsel or a firm of certified public accountants, a business associate agreement may already be in place. Sample business associate agreements are available from the U.S. Department of Health & Human Services.[35]

Sustainability of Pharmacists' Patient Care Services

The focus of this resource guide is to help pharmacists establish CPAs to facilitate the treatment and management of chronic conditions. For any services to be incorporated into a pharmacist's practice, it also can be beneficial to have a viable business model in place, regardless of whether there is a CPA. Appendix B of this resource guide provides an introduction to the topic as well as recommendations for other resources that are available.

Pharmacist's National Provider Identifier Number

If the pharmacist is the provider listed on a prescription, his or her National Provider Identifier (NPI) number may need to be updated to reflect the appropriate taxonomy code. Pharmacists should consult Appendix C for information on why and how to update their NPI number.

Conclusion

CPAs offer a unique opportunity for pharmacists and prescribers to collaborate in a formal way. Such collaboration increases the efficiency of team-based care in the treatment and management of chronic conditions, including CVD and hypertension. This resource guide provides pharmacists with information and resources to empower them to initiate CPAs with collaborating prescribers. Although the target audience is community pharmacists, CPAs can be used in all pharmacy practice settings, such as long-term care facilities, primary care offices or clinics, specialty clinics, and general and specialty hospitals. Each of these practice settings has its own nuances, challenges, and opportunities.

CVD and hypertension were used in this resource guide as examples of disease states that can be managed using a CPA, but the concepts presented here can be applied to many other chronic conditions, treatments for acute illness, and preventive health measures as well.

No two collaborative relationships look exactly the same, and the development process will vary.[28] The information in this resource guide is intended to provide ideas and spur innovation, but it is not intended to be rigid steps in a process. Pharmacists attempting to initiate collaborative relationships should have patience and be flexible. Both the collaborative relationship and the CPA are likely to change over time. By keeping patients and a continuous improvement in their outcomes the central goal of therapy, it is clear that collaborative care delivery, facilitated by CPAs, can result in improved health, efficiency, and patient and provider satisfaction.[28]

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Appendix A: Collaborative Practice Agreement Authority Tables

Table 1: Participants

State	Site restrictions	Pharmacist qualifications	Multiple or single pharmacist(s)	Which prescribers (MD, NP, PA?)	Multiple or single prescriber(s)?	Multiple or single patient(s)?	Prescriber–Patient Relationship defined?
AK	Silent	Yes - H	Multiple	All prescribers	Multiple	Multiple - T	Silent
AL	CPAs not allowed under state law.						
AZ	Silent	Silent	Single	Physician + NP	Single	Single	Yes - LL
AR	Silent	Silent	Single	All prescribers - U	Single	Single - HH	Silent
CA	Silent	Yes - I	Single	All prescribers - V	Single	Single	Yes - MM
CO	Yes - A	Yes - I	Multiple	Physician + NP	Multiple	Multiple	Yes - NN
CT	Silent	Yes - J	Multiple	Physician	Multiple	Single - II	Yes - OO
DC	Silent – E3	Silent – E3	Single – E3	Physician, others – E3, F3	Single	Silent – E3	Silent – E3
DE	CPAs not allowed under state law.						
FL	Silent	Silent	Multiple	Physician	Single	Single	Yes - PP
GA	Silent	Yes - K	Single	Physician	Single	Multiple - T, JJ	Yes - QQ
HI	Silent	Silent	Multiple	Physician	Single	Single	Yes - RR
ID	Silent	Silent	Multiple	All prescribers	Multiple	Multiple	Silent
IL	Silent	Silent	Multiple	Physician	Single	Multiple	Silent
IN	Yes - A	Yes - L	Multiple	Physician, others - W	Multiple	Multiple	Yes - RR
IA	Yes - A	Yes - M	Multiple - S	Physician	Multiple	Single	Yes - MM
KS	Silent	Silent	Multiple	Physician	Multiple	Single	Yes - SS
KY	Silent	Silent	Multiple - T	All prescribers - X	Multiple	Multiple - T	Yes - TT
LA	Yes - B	Yes - N	Single	Physician	Single	Single	Yes - UU
ME	No - C	Yes - I	Multiple	All prescribers - Y	Single	Multiple - T	Yes - QQ
MD	Silent	Yes - I	Multiple - GG	Physician, others - Z	Multiple - GG	Single	Yes - VV
MA	Yes - A	Yes - J, O	Single	Physician - C3	Single	Single	Yes - WW
MI	Silent	Silent	Multiple	Physician	Single	Silent	Silent
MN	Silent	Silent	Multiple	Physician, others - AA	Multiple	Silent	Silent
MS	Silent	Yes - I	Multiple	All prescribers - BB	Multiple	Single - KK	Silent
MO	Yes - A, B	Yes - I	Multiple	Physician	Multiple	Single	Yes - QQ
MT	Yes - B	Silent	Multiple	Medical practitioner - CC	Multiple	Silent	Silent
NE	Silent	Silent	Single	Medical practitioner	Single	Silent	Silent
NV	No - D	Silent	Single	All prescribers	Single	Single	Silent
NH	Yes - E	Yes - J, O, P	Single	All prescribers	Single	Single	Yes - OO
NJ	Silent	Yes - I	Multiple - T	Physician	Multiple - T	Single	Yes - MM
NM	Silent	Yes - I	Multiple	Physician	Multiple	Multiple	Silent
NY	Yes - F	Yes - I	Single	Physician	Single	Single	Yes - MM
NC	Silent	Yes - I	Single - A3	Physician - DD, A3	Single	Single	Yes - XX
ND	Silent	Yes - M	Multiple - S, B3	Physician + NP - A3	Multiple - S	Silent	Silent
OH	Silent	Yes - D3	Multiple	Physician	Multiple	Multiple	Yes - SS
OK	Silent	Silent	Silent	Physicians	Silent	Silent	Silent
OR	Silent	Yes - Q	Multiple - S	Physician - EE	Multiple - S	Single	Silent
PA	Silent	Silent	Single	Physician	Single	Multiple	Yes - TT
RI	No - C	Yes - I	Single	All prescribers	Multiple	Single	Silent
SC	Silent	Silent	Silent	All prescribers	Multiple	Silent	Silent
SD	Silent	Silent	Silent	All prescribers	Single	Silent	Silent
TN	Silent	Silent	Multiple	All prescribers - C3	Multiple	Multiple	Silent
TX	Yes - E	Yes - R	Single	Physician	Single	Single	Yes - YY
UT	Silent	Silent	Multiple	All prescribers	Multiple	Multiple	Silent

State	Site restrictions	Pharmacist qualifications	Multiple or single pharmacist(s)	Which prescribers (MD, NP, PA?)	Multiple or single prescriber(s)?	Multiple or single patient(s)?	Prescriber–Patient Relationship defined?
VT	Silent	Silent	Single	All prescribers	Multiple	Multiple	Silent
VA	Yes - G	Silent	Multiple - S	All prescribers - FF	Multiple	Multiple - ZZ	Yes - TT, ZZ
WA	Silent	Silent	Multiple	All prescribers	Single	Multiple	Silent
WV	Yes - A	Yes - I	Multiple	Physician	Multiple	Single	Silent
WI	Silent	Silent	Multiple	Physician	Multiple	Silent	Silent
WY	Silent	Silent	Multiple	All prescribers	Multiple	Single	Yes - TT, XX

Key for Table 1: Participants

A	Allowed in most or all settings but with different rules for some
B	Physician must be nearby the collaborating pharmacist - see law/regulations for more details
C	Site must be specifically identified in the agreement
D	Nearly all locations allowed
E	Not allowed in community pharmacy settings
F	Limited to teaching hospitals
G	If multiple pharmacists are included in an agreement, all must be at a single physical location where patients receive services
H	Unless the board is satisfied that the pharmacist has been adequately trained in the procedures outlined in the written protocol, the board will specify and require completion of additional training that covers those procedures before issuing approval of the protocol
I	Complicated requirements - see state law/regulations for details
J	Nearly all pharmacists would qualify - see state law/regulations for details
K	Application to board of pharmacy, additional continuing education, and a fee required - see state law/regulations for details
L	Physician responsible for ensuring pharmacist is properly trained to administer the protocol
M	Nearly all pharmacists would qualify, extra requirements for non-PharmD
N	Must register with the board and renew annually
O	Additional logistical requirements - see law/regulations for details
P	Must register with the board
Q	As specified in the agreement
R	Additional continuing education required
S	All must work within the same practice
T	All must be listed on the agreement
U	Practitioner authorized to prescribe drugs and responsible for the delegation of disease state management
V	Patient's treating prescriber
W	Physician, nurse practitioner, physician assistant
X	Medical/osteopathic physicians, dentists, chiropodists, veterinarians, optometrists when administering or prescribing pharmaceutical agents, advanced practice registered nurses, physician assistants when administering or prescribing pharmaceutical agents, and other health care professionals who are residents of and actively practicing in a state other than Kentucky and who are licensed and have prescriptive authority under the professional licensing laws of another state
Y	Any individual who is licensed, registered, or otherwise authorized in the appropriate jurisdiction to prescribe and administer drugs in the course of professional practice
Z	Licensed physician, licensed podiatrist, or certified advanced practice nurse with prescriptive authority
AA	Dentist, optometrists, physicians, podiatrists, veterinarians, nurse practitioners, physician assistants
BB	Physician, dentist, veterinarian, or other health care provider authorized by law to diagnose and prescribe drugs
CC	Any person licensed by the state of Montana to engage in the practice of medicine, dentistry, osteopathy, podiatry, optometry, or a nursing specialty
DD	Must be approved by the board - see law/regulations for details
EE	Physician or group of physicians
FF	Any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in §32.1-276.3 (Virginia Law), provided such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working as part of a patient care team as defined in § 54.1-2900 (Virginia Law), involved directly in patient care which authorizes cooperative procedures with respect to patients of such practitioners
GG	One plus a designated alternate
HH	A standard protocol may be used, or the attending practitioner may develop a disease state management protocol for the individual patient
II	Multiple patients under one agreement; protocol is patient specific
JJ	Multiple but each patient's diagnoses and current medication list must be listed in agreement
KK	Single in community setting, multiple in institutional setting
LL	Collaborating prescriber must be acting as a primary care provider
MM	Individual patient's treating prescriber
NN	All physicians who are actively involved in the management of the relevant conditions shall be parties to the agreement
OO	Physician-patient relationship narrowly defined - see law/regulations for details
PP	Individualized assessment
QQ	Patient specific information must be included in the protocol/agreement - see laws/regulations for details
RR	Agreement must be related to the condition(s) for which the patient has been seen by the collaborating prescriber/physician
SS	Established "physician-patient relationship"
TT	Referral from collaborating prescriber required
UU	Patient/ drug/disease or condition specific order set prepared by the physician must be based on a face-to-face visit with the patient
VV	Directly involved in patient care
WW	Referral required, must include a diagnosis from the supervising physician
XX	Diagnosis and initial drug therapy must be prescribed
YY	The delegation must follow a diagnosis, initial patient assessment, and drug therapy order by the physician. The physician must have an established a physician-patient relationship with each patient who is provided drug therapy management by a delegated pharmacist. Physician-patient relationship must be maintained.
ZZ	Pharmacist may only implement drug therapy post diagnosis by the prescriber
A3	Limited to one physician to three pharmacists
B3	A pharmacist may have an agreement with one or more physicians, the number of which may be limited by the board based on individual circumstances
C3	Pharmacies can't hire physicians to maintain CPAs
D3	Training and experience related to the particular diagnosis for which drug therapy is prescribed
E3	For immunization or vaccination written protocols: multiple pharmacists may participate, pharmacists must be board certified and meet continuing education requirements; a written immunization or vaccination protocol may apply to individual or groups of patients; some setting limitations apply; patient informed consent required. Board of pharmacy and board of medicine are required to issue regulations jointly governing the implementation and use of CPAs between a pharmacist and physician; however, as of 11/2016, no new rules have been promulgated.
F3	Additional licensed health practitioners with independent prescriptive authority may participate in CPAs if authorized by rule (none authorized as of 11/2016)

Table 2: Functions Authorized

State	Modify Existing Therapy	Initiate New Therapy	Perform a Physical Assessment	Order Laboratory Tests	Interpret Laboratory Tests	Perform Laboratory Tests
AK	Yes - W, AA	Yes - W, AA	Silent	Silent	Silent	Silent
AL	CPAs not allowed under state law.					
AZ	Yes - W, AA	Yes - A, W, AA	Silent	Yes	Silent	Silent
AR	Yes - V, AA	Yes - A, V, AA	Silent	Silent	Silent	Silent
CA	Yes - Z	Yes - A, Z	Yes	Yes	Yes	Silent
CO	Yes - A, V, AA	Yes - A, M, V, AA	Yes - G	Yes - I, M	Yes - I, M	Silent
CT	Yes - B, W, AA	Yes - W, AA	Silent	Yes	Silent	Silent
DC	Yes - DD	Yes - DD	Silent	Silent	Silent	Silent
DE	CPAs not allowed under state law.					
FL	No	No - GG	Silent	Yes	Yes	Silent
GA	Yes - W, AA	Yes - W, AA	Silent	Silent	Silent	Silent
HI	Yes	Yes	Yes - H	Yes	Silent	Silent
ID	Yes - AA	Yes - AA	Yes - I	Silent	Silent	Yes
IL	Yes - A	Yes - A	Silent	Yes - I	Yes - I	Silent
IN	Yes	Yes	Silent	Silent	Silent	Silent
IA	Yes - BB	Yes - BB	Yes	Yes	Yes	Yes
KS	Silent	Silent	Silent	Silent	Silent	Silent
KY	Yes - AA	Yes - AA	Silent	Yes	Silent	Silent
LA	Yes - C, W, CC	No	Yes	Yes	Yes - P	Silent
ME	Yes - D, V, AA	Yes - D, V, AA	Yes	Yes	Yes - P, Q	Silent
MD	Yes - A, V, AA	Silent	Yes - J	Yes - I	Yes, I	Silent
MA	Yes - X, FF	Yes - X, FF	Yes - G	Yes - N	Yes - P	Silent
MI	Yes	Yes	Silent	Silent	Silent	Silent
MN	Yes	Yes	Silent	Silent	Silent	Yes
MS	Yes - AA	Yes - AA	Silent	Yes	Silent	Silent
MO	Yes - E, W, CC	Yes - E, W, CC	Yes	Yes	Yes	Yes
MT	Yes - W, AA	Yes - W, AA	Silent	Silent	Silent	Silent
NE	Yes - W	Yes - W	Silent	Silent	Silent	Silent
NV	Yes - AA	Yes - AA	Yes - K	Yes	Yes	Silent
NH	Yes - W, AA	Yes - W, AA	Silent	Yes	Silent	Silent
NJ	Yes - W, AA	No	Silent	Yes	Yes - Q	Yes
NM	Yes - W, AA	Yes - W, AA	Silent	Yes - I	Yes	Silent
NY	Yes - F, W, AA	No - F	Yes - I	Yes	Yes - R	Silent
NC	Yes - U, AA	Yes - U, AA	Silent	Yes - I	Silent	Silent
ND	Yes - BB	Yes - BB	Silent	Silent	Silent	Silent
OH	Yes - W	Yes - W	Silent	Yes	Yes - P	Silent
OK	No	No - EE	Silent	Silent	Silent	Silent
OR	Yes - W, AA	Yes - W, AA	Silent	Yes - I	Yes - I	Silent
PA	Yes - AA	No	Yes	Yes	Silent	Yes
RI	Yes - W, AA	No	Yes - G	Yes	Yes - R	Yes
SC	Yes - DD	Yes - DD	Silent	Silent	Silent	Silent
SD	Yes	Yes	Silent	Silent	Silent	Silent
TN	Yes	Yes	Yes	No	Silent	Silent
TX	Yes - W, AA	Yes - A, W, AA	Yes - H	Yes	Silent	Silent
UT	Yes	Yes	Yes - G	Yes	Yes - S	Silent

State	Modify Existing Therapy	Initiate New Therapy	Perform a Physical Assessment	Order Laboratory Tests	Interpret Laboratory Tests	Perform Laboratory Tests
VT	Yes - W, AA	Yes - W, AA	Yes	Yes - I	Yes - I	Silent
VA	Yes - Y, AA	Yes - Y, AA	Silent	Yes	Silent	Silent
WA	Yes - W, AA	Yes - A, W, AA	Yes - G	Yes	Yes - R	Silent
WV	Yes - CC	No	Yes - L	Yes - O	Yes - T	Yes
WI	Yes	Yes	Silent	Silent	Silent	Silent
WY	Yes - W, AA	Yes - A, W, AA	Yes	Yes	Silent	Yes

Key for Table 2: Functions Authorized

A	Drugs limited to those in the protocol
B	Notify physician within 24 hours if therapy is discontinued
C	Therapeutic substitution not allowed without the physicians explicit consent
D	First 3 months limited to monitoring
E	State specific rules regarding initiation and modification of a prescription - refer to state laws/regulations for details
F	Therapeutic substitution allowed but not initiation of new therapy
G	Obtaining and checking vital signs
H	Ordering or performing routine drug therapy–related patient assessment procedures
I	As specified in the agreement/protocol
J	Other patient care management measures related to monitoring or improving the outcomes of drug or device therapy
K	Examinations
L	The protocol may authorize the pharmacist to check only these findings: vital signs, oximetry, or peak flows that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions, or determine if the patient should be referred to the patient's physician for follow-up. Pharmacists shall not conduct any physical examination of the patient other than taking vital signs.
M	Protocol requirements outlined in the regulations are very prescriptive - see Colorado regulations before initiating a CPA
N	Under the supervision of, or in direct consultation with, a physician, ordering and evaluating the results of laboratory tests directly related to drug therapy when performed in accordance with approved protocols applicable to the practice setting and when the evaluation shall not include a diagnostic component
O	Ordering screening laboratory tests that are dose related and specific to the patient's medication or are protocol driven and are also specifically set out in the collaborative pharmacy practice agreement between the pharmacist and physician
P	Evaluate but not to be used for diagnosis
Q	In direct consultation with the physician
R	Evaluate
S	Ordering and evaluating the results of laboratory tests directly applicable to the drug therapy, when performed in accordance with approved protocols applicable to the practice setting
T	Laboratories utilized by the pharmacist may be in a pharmacy or pharmacy center. All laboratory results obtained are to be sent to the physician within 48 hours, except that any severely abnormal or critical values shall be sent by the pharmacist to the physician immediately.
U	Agreement is disease specific
V	Disease states limited to those defined in agreement for each individual patient
W	Disease states limited to those specified in protocol or agreement
X	Disease states limited to those specified in the protocol or agreement; restrictions for community pharmacists only
Y	Diseases states limited to those with a defined standard of care required or the protocol must be approved by the board of pharmacy
Z	Restricted to conditions for which the patient has first been seen by a physician
AA	Medications limited to those specified in agreement or protocol
BB	Does not include CIIs
CC	Does not include any controlled substances
DD	Medications limited to those specified in the therapeutic plan
EE	Limited to administering immunizations and therapeutic injections
FF	Restrictions for community pharmacists only
GG	Therapy initiation is limited to a defined list of drugs but does not require a collaborative agreement

Table 3: Requirements

State	Additional continuing education requirements	Requirement for liability insurance?	Documentation and/or notification requirements	Patient involvement in agreement – signature or opt out?	Must agreements be sent to or approved by a state agency?	Length of time agreement is valid defined?
AK	Silent	Silent	Yes - I, O, AA	Silent	Yes - WW	Yes - ZZ
AL	CPAs not allowed under state law.					
AZ	Silent	Silent	Yes - Z	Silent	Silent	Silent
AR	Silent	Silent	Yes - O, P, Q, Z	Silent	Yes - UU	Yes - YY
CA	Silent	Silent	Yes - R, S	Silent	Silent	Silent
CO	Silent	Yes - L	Yes - T, U, Y	Yes - QQ	Yes - UU	Yes - YY
CT	No - A	Silent	Yes - V, W, X	Silent	Yes - UU	Silent
DC	Silent - E3	Silent	Yes - E3	Silent - E3	Silent - E3	Silent - E3
DE	CPAs not allowed under state law.					
FL	Silent	Silent	Yes - BB, Z	Silent	Silent	Silent
GA	Yes - B	Silent	Yes - H, Z, CC	Yes - RR	Silent	Yes - ZZ
HI	Silent	Silent	Yes - R	Silent	Silent	Silent
ID	Silent	Silent	Yes - S, Z	Silent	Yes - UU	Yes - YY
IL	Silent	Silent	Silent	Silent	Silent	Silent
IN	Silent	Silent	Yes - S, DD	Silent	Silent	Yes - YY
IA	Silent	Silent	Yes - I	Yes - SS	Yes - UU	Yes - ZZ
KS	Silent	Silent	Silent	Silent	Silent	Silent
KY	Silent	Silent	Yes - H, EE	Yes - SS	Yes - UU	Silent
LA	Silent	Silent	Yes - H	Yes - SS	Yes - UU	Yes - YY
ME	Yes - C	Yes - M	Yes	Silent	Yes - VV	Yes - I
MD	Silent - D3	Silent - D3	Yes – H, D3	Yes – SS, D3	Yes – VV, D3	Yes – YY, D3
MA	Yes - D	Yes - L	Yes - H	Yes - TT	Yes - UU	Yes - ZZ
MI	Silent	Silent	Silent	Silent	Silent	Silent
MN	Silent	Silent	Yes - FF	Silent	Silent	Silent
MS	Yes - E	Silent	Yes - I	Yes - RR	Yes - WW	Yes - YY
MO	Yes - F	Silent	Yes - H	Silent	Yes - VV	Yes - YY
MT	Silent	Silent	Yes - I, Y	Yes - SS	Yes - VV	Yes - YY
NE	Silent	Silent	Silent	Silent	Yes - VV	Yes - YY
NV	Silent	Silent	Yes - Z, GG	Silent	Yes - WW	Silent
NH	Yes - G	Yes - L	Yes - I, HH	Yes - SS	Yes - UU	Yes - ZZ
NJ	Yes - H	Silent	Yes - I, Y	Yes - TT	Yes - UU	Yes - YY
NM	Yes - H	Silent	Yes - I	Silent	Yes - VV	Yes - ZZ
NY	Silent	Silent	Yes - I, II	Yes - SS	Silent	Silent
NC	Yes - H	Silent	Yes - NN	Yes - RR	Yes - UU	Silent
ND	Silent	Silent	Yes - JJ, E3	Silent	Yes - WW	Yes - A3
OH	Silent	Silent	Yes - B3, F3	Yes - SS	Yes - UU	Yes - ZZ
OK	Silent	Silent	Silent	Silent	Yes - UU	Silent
OR	Yes - I	Silent	Yes - I	Silent	Yes - UU	Yes - ZZ
PA	Silent	Yes - L	Yes - I, KK, C3	Yes - RR	Yes - VV	Yes - ZZ
RI	Yes - J	Yes - M	Yes - I	Yes - TT	Yes - VV	Yes - ZZ
SC	Silent	Silent	Silent	Silent	Silent	Silent
SD	Silent	Silent	Silent	Silent	Yes - WW	Silent
TN	Silent	Silent	Yes - S, KK	Silent	Check	Yes - ZZ
TX	Yes - K	Silent	Yes - I, X, LL	Silent	Yes - VV	Yes - YY
UT	Silent	Silent	Silent	Silent	Silent	Silent
VT	Silent	Silent	Yes - OO	Silent	Silent	Yes - YY

State	Additional continuing education requirements	Requirement for liability insurance?	Documentation and/or notification requirements	Patient involvement in agreement – signature or opt out?	Must agreements be sent to or approved by a state agency?	Length of time agreement is valid defined?
VA	Silent	Silent	Yes - I	Yes - TT	Yes - XX	Silent
WA	Silent	Silent	Yes - I	Silent	Yes - VV	Yes - ZZ
WV	Silent	Yes - N	Yes - I, V, W, MM, PP	Yes - TT	Yes - WW	Yes - ZZ
WI	Silent	Silent	Silent	Silent	Silent	Silent
WY	Silent	Silent	Yes - I, O	Yes - SS	Yes - WW	Yes - YY

Key for Table 3: Requirements

A	Continuing education is mentioned in CPA language but the requirements are the same as for licensure
B	Annual completion of 0.3 CEUs regarding modification of drug therapy
C	Fifteen hours per year: 2 hours in drug administration, 5 hours in the areas of practice covered by agreement
D	Five additional contact hours of continuing education that addresses areas of practice generally related to collaborative practice agreements
E	Biennial basis: obtain recertification in each disease state by completing a continuing education program consisting of not less than 6 hours focusing on nationally recognized updates
F	Biennial recertification required (6 hours of continuing education in medication therapy management)
G	Complete at least 5 contact hours or 0.5 CEUs of board-approved continuing education each year; such continuing education shall address the area or areas of practice generally related to the collaborative pharmacy practice agreement or agreements
H	Complicated requirements - see law/regulations for details
I	As specified in the agreement
J	Five hours of continuing education each year that must be in the practice area covered by the agreement; documentation must be maintained and available for inspection at the practice site
K	Six hours of continuing education related to drug therapy
L	At least $1,000,000 of professional liability insurance
M	Agreement must include proof that liability insurance is maintained by all parties to the agreement
N	Personally have or have employer coverage of at least $1,000,000 of professional liability insurance coverage
O	Documentation/patient records maintained for 2 years
P	Documentation recorded within a reasonable time of each intervention
Q	Documentation may be on the patient medication record, patient medical chart, or in a separate logbook
R	Written notification to patient's treating prescriber or entry into electronic patient record shared by the prescriber of any drug initiation within 24 hours
S	Medical records of the patient must be available to both the patient's treating prescriber and the pharmacist
T	Notification to the physician within 24 hours of modification of therapy
U	Physician must review and document acceptance or rejection of the drug therapy modification within 72 hours
V	All activities performed by the pharmacist in conjunction with the protocol shall be documented in the patient's medical record
W	The pharmacist shall report at least every 30 days to the physician regarding the patient's drug therapy management
X	Protocol must include a plan for periodic review, feedback, and quality assurance
Y	Records maintained for 7 years
Z	Physician notification/review as specified in agreement
AA	Physician review of pharmacist's decisions at least every 3 months
BB	Transferrable patient record for orders and progress notes
CC	Patient records maintained for 10 years after protocol is terminated
DD	Document in patient record immediately after making a change to drug therapy
EE	Records maintained for 5 years
FF	Document change of therapy in medical record or report to patient's provider
GG	Specific requirements for protocols developed for use in care transitions - see laws/regulations for details
HH	All agreements must include provisions for documentation of any initiation, modification, or discontinuation of a patient's medications in the patient's permanent medical record; community pharmacists must maintain a written record of the individual patient referral and the patients' written informed consent
II	Must immediately enter into the patient record any change or changes made to the patient's drug therapy and notify the physician (and the patient's other physicians)
JJ	The practitioner and the pharmacist must have access to the patient's appropriate medical records; the care provided to the patient by the pharmacist must be recorded in the patient's medical records and communicated to the practitioner
KK	Document as soon as possible, no longer than 72 hours after a change is made, as specified in the agreement
LL	The delegating physician must receive, as appropriate, a periodic status report on each patient, including any problem or complication encountered as defined in the protocol. Documentation shall be recorded within a reasonable time of each intervention and may be performed on the patient medication record, patient medical chart, or in a separate log book.
MM	Notify the treating physician of any discontinuation of drug therapy
NN	Agreement must include a plan and schedule for weekly quality control, review and countersignature of all orders written by the CPP in a face-to-face conference between the physician and CPP
OO	Annual quality assurance review by the collaborating practitioner
PP	All evaluation notes shall be in the physician's patient's chart within 1 week of the evaluation and drug management change
QQ	Patients must be informed of their right to refuse care under the agreement; patient's signature on the institution's general consent may be used
RR	Patient notification required
SS	Written consent required
TT	Informed consent required
UU	Maintained and available upon request
VV	Copy of agreement must be submitted to the relevant board(s)
WW	Agreement must be reported to and approved by the relevant board(s)
XX	Protocol only needs to be approved for conditions for which there is no accepted standard of care
YY	Agreement can only be valid for up to 1 year
ZZ	Agreement can only be valid for up to 2 years
A3	Agreement can only be valid for up to 4 years
B3	Records maintained for 3 years
C3	Records maintained in an electronic medical record
D3	Extensive requirements regarding components of the agreement - see regulations for details
E3	Pharmacist must notify the prescriber within 24 hours of initiating or modifying therapy; CPA may clarify some situations where notice within 72 hours is acceptable
F3	Communication must occur between providers on a regular basis - see laws/regulations for details

Appendix B: Sustainability of Pharmacists' Services Delivered Under Collaborative Practice Agreements

Sustainable business models are needed to support pharmacists' patient care services, including those services delivered under collaborative practice agreements (CPAs). While CPAs can be very helpful in providing expanded authority for pharmacists to provide care to patients, a viable business model is critical for supporting the time commitment of the pharmacist and the expertise that he or she brings as part of a health care team. CPAs can improve access to care as well as facilitate efficiencies in the delivery of coordinated team-based care and sufficient payment to sustain pharmacists' services over the long term.

If revenue sources are already available for the services that pharmacists will be delivering under a CPA, then development of the CPA may focus on the operational aspects of the agreement. If revenue sources are not available, the negotiation phase of the CPA can also include discussions about the business model for compensating the pharmacist. Focus areas to consider include potential sources of direct payment and the value-added benefits that the pharmacist can provide. This appendix covers three key areas: potential payment sources for pharmacists' services, development of a value proposition, and monitoring the return on investment.

Potential Payment Sources

The health care system is undergoing significant changes in payment models for health care. The long-standing fee-for-service (FFS) model is shifting toward value-based models that pay for services provided by health care providers based on the value of those services in meeting quality measures, improving outcomes, and containing costs. In addition, bundled payments to organizations to cover the medical management of a patient population are becoming more common. Many payment models are currently a mix of FFS and value-based incentives.

Traditional FFS Payment Opportunities for Pharmacists

- FFS is currently the predominant compensation mechanism for health care providers in the United States. Under this model, health care providers are reimbursed for the number and array of clinical services they provide, typically through the use of specific billing codes that correspond to the level and type of services provided.[1] Commercial, public, and private insurers, along with pharmacy benefits managers and managed care organizations, all have potential to be payers for pharmacists' services. FFS payment opportunities for pharmacists' patient care services have been sporadic to date, however. As of 2016, many payers view pharmacists as being eligible for compensation only for dispensing medications, not for the provision of collaborative patient care services.[2]

Among the list of services below that pharmacists can currently provide, direct payment opportunities are available only for medication therapy management (MTM) and, in some cases, training in diabetes self-management. The other listed services are Medicare Part B services, where physicians or other qualified providers bill for the pharmacist's service under specific billing requirements:

- MTM.
- Training in diabetes self-management.
- A service incident to physician services in a physician-based practice or hospital outpatient clinic.
- Transitional care management as part of a team-based bundled payment.
- Chronic care management.
- Annual wellness visit.[1]

Potential payers for pharmacists' patient care services include those described below:

- **Centers for Medicare & Medicaid Services (CMS) Part B**—Pharmacists' services are not currently recognized for payment through Medicare Part B (where outpatient health care professionals' services are covered). Under specific circumstances, physicians and qualified nonphysician practitioners (NPPs) can utilize their National Provider Identifier number to bill for pharmacists' services performed under the direct or general supervision of the physician or NPP (depending on the service). This process is often referred to as "incident to" billing, and the setting is either a physician-based practice or a hospital outpatient clinic.
  - Because specific requirements for this type of billing must be met, and the requirements vary by the service, it is extremely important to consult applicable resources. Pharmacists must be in an employed, contracted, or leased arrangement in order for the physician to bill for the pharmacist's services.[1]
  - For services requiring direct supervision, the physician or NPP must be present in the office suite or in the building and immediately available to the pharmacist. In contrast, under general supervision, the physician provides overall direction and control, but the physician's presence is not required. Community pharmacists under the general supervision of the physician or NPP could perform Medicare services with a general supervision requirement (e.g., chronic care management, transitional care management) in the pharmacy.
  - **CMS Medicare Part D**—CMS contracts with Part D Prescription Drug Plans (PDPs) to provide MTM services for eligible beneficiaries. PDPs can then contract with pharmacies or pharmacists to provide MTM services. MTM service opportunities are variable but, where present, could be a revenue source to support the pharmacist working under a CPA with a prescriber. Pharmacists would bill directly for any MTM services provided to the patient.
- **State Medicaid programs**—Some state Medicaid programs provide payment to pharmacists for various services, which can include medication management, chronic condition management, and wellness services. There also may be opportunities in some state Medicaid programs for physicians to bill for pharmacists' services under an "incident to" arrangement. Pharmacists should check with state boards of pharmacy or state pharmacy associations to learn about available opportunities in a given state.

- **Commercial health plans and self-insured employers**—Commercial health plans may cover pharmacists' services delivered in an "incident to" arrangement with a prescriber. It will be helpful for pharmacists to become familiar with the requirements for specific plans because commercial health plans often follow CMS's guidelines but may have their own requirements. In addition, some commercial health plans are involved in pilot programs to pay pharmacists directly for certain services, such as diabetes management. Many state pharmacy associations are working to address payment barriers for pharmacists' services. For example, the state of Washington recently implemented a law that requires commercial health plans in that state to cover pharmacists' services if the service is within the pharmacist's scope of practice and that same service is covered for other health care practitioners. Self-insured employers are another potential source of payment for services such as the management of chronic conditions and wellness services. Pharmacists interested in these opportunities may benefit from networking to learn about available programs.

Funding Opportunities in New Models for Delivering Care

In new care delivery models, such as accountable care organizations and patient-centered medical homes, various health care practitioners are compensated for delivering quality, affordable, and coordinated care to patients under new payment models. In these models, the focus is on "pay for value" instead of the "pay for volume" approach in FFS. Pharmacists may be able to contract directly with an organization for specific services or integrate directly into the organization as salaried employees. This will depend on the nature of the care provided and the interest of the collaborating providers or insurers.[2]

New care delivery models may include a mix of FFS payment, incentive payments for meeting quality metrics and cost targets, and payments for managing and coordinating the care of populations of patients. The incentive payments may be provided through payments for nontraditional services, higher rates for contracted services, lump sum payments, additional per-member per-month payments, shared savings when expected expenditures are below actual costs, or other pay-for-performance incentives.[2]

Payment models are not mutually exclusive. For example, a pharmacist may be contracted by a medical group to provide patient care services 3 days per week. Each time the pharmacist conducts services that are currently paid under the fee-for-service model, the medical group bills the insurer to recover reimbursement for the provided service. If the pharmacist improves the outcomes of patients who are part of an integrated care model, the medical group will earn an incentive payment. The reimbursement received by the medical group may be used to offset the cost of the pharmacist or may be shared with the pharmacist as a bonus payment, depending on the terms of the contract.

Pharmacists who plan to seek payment within integrated care models will benefit from being prepared to document, monitor, and improve specific quality measures that drive incentive payments. Because many care delivery organizations receive capitated payments to cover a patient population, there is a greater focus on keeping the population healthy and achieving better health outcomes. Pharmacists may want to focus on understanding the organization's relevant quality measures and how pharmacists' services can improve specific metrics and increase savings.

Assessing Payer Mix

If the source of payment for pharmacists' services will come from the physician's practice, it will be helpful to understand the types of payers (the payer mix) in the practice in order to build a business model. For example, in a practice that has a payer mix of 60% Medicare, 30% commercial health plans, and 10% Medicaid, a pharmacist working in the practice might want to collaborate with the physician to deliver annual wellness visits (incident to physician services) and chronic care management services to the practice's Medicare beneficiaries. A pharmacist might collaborate to deliver chronic care management services and transitional care management while assisting the practice with meeting selected quality metrics. Payment opportunities available through Medicaid or commercial health plans could be considered as well. The pharmacist's contributions to meeting quality metrics could be covered through incentive payments.

Formulating the Value Proposition[3,4,5]

With an understanding of potential payment sources, pharmacists can begin building the business case for collaborating with physicians to deliver services under a CPA. The value proposition is composed of the most persuasive reasons why a physician should consider entering into a business agreement with the pharmacist to deliver services under a CPA. Value propositions can also be developed for approaching payers directly for coverage of pharmacists' services. Potential elements of the value proposition include the following:

- Specific patient care services that the pharmacist can provide.
- Unique benefits that the pharmacist can bring to the practice, such as assistance with meeting quality metrics, providing drug information, and assistance with meeting evidence-based guidelines.
- Revenue opportunities and potential ROI as well as other factors that help to justify the business case for making the decision.

The value proposition is often summarized in an executive summary of one or two pages that creates a compelling case to be used during negotiations. A pro forma that projects anticipated revenues for specific services over a specified timeline is a helpful addition to the executive summary.

Monitoring the Return on Investment (ROI)

A physician practice that is contemplating paying for the services of a pharmacist may be interested in the ROI, which is the ratio of the gains (revenue and other benefits) to the total costs of the collaborative services. An ROI greater than 1 indicates that the investment is beneficial, and the higher the ROI above 1, the better the investment.

ROI = Gains (revenues and other benefits)/Costs

Costs may include payment to the pharmacist, the physical space used by the pharmacist, health information technology, and staff to support the pharmacist. Gains, which can be more difficult to quantify, can include direct revenues from pharmacists' services, cost savings to the practice, and indirect benefits such as physician efficiencies, patient and physician satisfaction, and meeting quality metrics. Published studies, previously collected data, and case studies can be used to help estimate these components to provide the overall "gains" in the ROI calculation. Pharmacists can anticipate that it may take time to reach a positive ROI, and tracking mechanisms should be in place to track the ROI over time.

Appendix B: References

1. U.S. Department of Health & Human Services. Health information privacy: business associate contracts website. https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html. Accessed September 1, 2016.

2. Carrier E, Dowling MK, Pham HH. Care coordination agreements: barriers, facilitators, and lessons learned. *Am J Manag Care*. 2012;18(11):e398-e404.

3. Schumock GT, Butler MG, Meek PD, et al. Evidence of the economic benefit of clinical pharmacy services: 1996-2000. *Pharmacotherapy*. 2003;23(1):113-132.

4. Academy of Managed Care Pharmacy. Practice Advisory on Collaborative Drug Therapy Management. Alexandria, VA: Academy of Managed Care Pharmacy; 2012. http://www.amcp.org/workarea/downloadasset.aspx?id=14710. Accessed November 21, 2016.

5. Adams AJ, Klepser M, Klepser D. Physician-pharmacist collaborative practice agreements: a strategy to improve adherence to evidence-based guidelines. *Evidence-Based Med Public Health*. 2015;1:e923.

Appendix C: Updating a National Provider Identifier Number

If the pharmacist will be the signatory on prescriptions that are initiated or modified under a collaborative practice agreement, it may be beneficial for him or her to obtain an updated National Provider Identifier (NPI). The updated NPI number will indicate to pharmacy benefit managers that the pharmacist has an expanded scope of practice that may include authority to write prescriptions. Although updating the NPI number will not ensure coverage of prescriptions written with that NPI number, it may increase the likelihood that the pharmacy benefit manager identifies the pharmacist as a valid prescriber. Having an NPI is also important for billing.

The instructions below outline how to update an existing NPI number. If the pharmacist is applying for an NPI for the first time, he or she should follow the instructions found on the NPI website (https://nppes.cms.hhs.gov/NPPES/), taking note of the instructions below to select the correct provider taxonomy.

Step 1: Pharmacists should log into their NPI account at https://nppes.cms.hhs.gov/NPPES/. Note: Because passwords expire every 60 days, the pharmacist may need to go through the "lost password" process available on this page.

Step 2: Select view/modify NPI data.

Step 3: *Most important step*. Update taxonomy. The pharmacist can add multiple taxonomies and should choose the taxonomy code for the primary taxonomy that most appropriately fits his or her position. Pharmacists in the community setting who are participating in medication initiation and/or modification should consider the pharmacist clinician (PhC)/clinical pharmacy specialist as their primary taxonomy. Note: More information about the provider taxonomies is available at http://www.wpc-edi.com/reference/.

Step 4: Update other information (e.g., password, profile, mailing address, practice location).

Step 5: Complete the certification statement.

Step 6: Submit and log off.


DEPARTMENT OF HEALTH & HUMAN SERVICES USA
CDC

Attachment 8

Board of Pharmacy Licensing Statistics - Fiscal Year 2016/17

APPLICATIONS

Received	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	34	52	37	44	23	36	33	32	58	43	43	53	488
Designated Representatives Vet (EXV)	2	0	2	0	1	0	4	1	0	0	0	0	10
Designated Representatives-3PL (DRL)	7	10	6	8	6	5	6	2	6	10	4	5	75
Intern Pharmacist (INT)	62	564	597	393	67	76	82	114	138	138	136	95	2462
Pharmacist (exam applications)	187	203	217	182	123	125	141	148	167	342	1075	422	3332
Pharmacist (initial licensing applications)	133	132	686	115	253	86	117	51	74	33	98	87	1865
Advanced Practice Pharmacist (APH)	n/a	n/a	n/a	n/a	n/a	32	51	26	55	19	32	41	256
Pharmacy Technician (TCH)	507	576	465	502	407	415	517	529	529	517	551	747	6262
Centralized Hospital Packaging (CHP)	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinics (CLN)	6	7	20	8	3	5	2	6	10	5	4	6	82
Clinics Exempt (CLE)	6	1	13	1	0	0	1	1	7	0	0	3	33
Drug Room (DRM)	0	0	0	0	0	1	0	0	0	0	0	0	1
Drug Room -Temp	0	0	0	0	0	1	0	0	0	0	0	0	1
Drug Room Exempt (DRE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospitals (HSP)	1	1	1	1	1	1	0	3	3	3	2	0	17
Hospitals - Temp	1	2	1	0	1	1	0	3	3	0	2	0	14
Hospitals Exempt (HPE)	0	0	0	0	0	0	0	0	1	0	0	0	1
Hypodermic Needle and Syringes (HYP)	2	1	0	0	3	0	3	8	2	0	1	0	20
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Correctional Pharmacy (LCF)	0	0	1	0	1	0	1	1	0	1	0	0	5
Outsourcing Facility (OSF)	n/a	n/a	n/a	n/a	n/a	0	0	2	3	0	1	1	7
Outsourcing Facility - Temp	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Outsourcing Facility Nonresident (NSF)	n/a	n/a	n/a	n/a	n/a	3	5	9	7	3	4	2	33
Outsourcing Facility Nonresident - Temp	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Pharmacy (PHY)	44	567	85	136	40	27	41	32	37	33	41	56	1139
Pharmacy - Temp	14	540	56	25	93	9	9	10	23	9	17	29	834
Pharmacy Exempt (PHE)	0	1	0	0	1	1	0	0	0	0	1	0	4
Pharmacy Nonresident (NRP)	10	9	14	8	13	8	12	7	15	11	6	11	124
Pharmacy Nonresident Temp	1	1	4	2	5	4	5	2	3	2	0	3	32
Sterile Compounding (LSC)	4	5	8	5	4	0	2	10	10	10	7	8	73
Sterile Compounding - Temp	2	3	2	0	0	0	0	5	11	0	3	5	31
Sterile Compounding Exempt (LSE)	0	0	0	0	0	0	0	1	0	0	0	0	1
Sterile Compounding Nonresident (NSC)	3	2	4	1	2	2	0	2	2	1	1	3	23
Sterile Compounding Nonresident Temp	1	1	1	1	0	0	0	0	0	0	0	1	5
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0	0	0	0	0	0	0	0	0	0	0
Third-Party Logistics Providers (TPL)	1	0	0	3	0	2	1	0	0	0	0	0	7
Third-Party Logistics Providers - Temp	1	0	0	0	0	2	0	0	0	0	0	0	3
Third-Party Logistics Providers Nonresident (NPL)	2	1	1	3	1	0	2	1	2	1	0	3	17
Third-Party Logistics Providers Nonresident Temp	0	0	0	0	0	0	1	0	0	0	0	2	3
Veterinary Food-Animal Drug Retailer (VET)	0	0	0	0	1	0	0	0	0	0	0	0	1
Veterinary Food-Animal Drug Retailer - Temp	0	0	0	0	0	0	0	0	0	0	0	0	0
Wholesalers (WLS)	4	4	11	3	7	7	3	2	11	5	8	6	71
Wholesalers - Temp	1	0	4	0	0	1	2	1	3	1	2	1	16
Wholesalers Exempt (WLE)	0	0	0	0	0	0	0	0	0	1	0	0	1
Wholesalers Nonresident (OSD)	4	10	10	17	10	15	11	10	14	9	8	15	133
Wholesalers Nonresident - Temp	0	0	5	4	1	1	3	3	6	1	2	1	27
Total	1040	2693	2251	1462	1067	866	1055	1022	1200	1198	2049	1606	17509

All change of location applications are reported under the license type as a new license is issued effective 11/1/2014

APPLICATIONS (continued)

Issued	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	25	26	30	32	35	35	22	17	54	22	60	22	380
Designated Representatives Vet (EXV)	0	3	0	1	0	1	0	2	1	0	3	0	11
Designated Representatives-3PL (DRL)	6	13	8	8	9	4	6	1	10	3	8	3	79
Intern Pharmacist (INT)	100	389	327	658	141	99	75	77	103	68	74	113	2224
Pharmacist (initial licensing applications)	17	244	291	505	167	188	117	73	75	35	81	35	1828
Advanced Practice Pharmacist (APH)	n/a	n/a	n/a	n/a	n/a	0	0	11	15	35	37	32	130
Pharmacy Technician (TCH)	453	672	490	445	577	490	390	495	437	534	542	468	5993
Centralized Hospital Packaging (CHP)	2	0	0	0	0	0	0	0	0	0	0	0	2
Clinics (CLN)	26	12	10	28	7	9	1	3	8	10	6	1	121
Clinics Exempt (CLE)	0	3	2	11	1	1	0	0	3	2	3	2	28
Drug Room (DRM)	0	0	0	0	0	0	0	0	1	0	0	0	1
Drug Room-Temp	0	0	0	0	1	1	0	0	0	0	0	0	2
Drug Room Exempt (DRE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospitals (HSP)	1	2	2	1	0	2	0	1	0	1	0	1	11
Hospitals - Temp	0	5	2	0	0	0	1	0	0	0	6	0	14
Hospitals Exempt (HPE)	1	1	0	0	0	0	0	0	0	0	0	0	2
Hypodermic Needle and Syringes (HYP)	1	2	0	0	0	1	1	0	5	2	3	0	15
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Correctional Pharmacy (LCF)	0	0	0	1	1	0	0	0	0	1	1	0	4
Outsourcing Facility (OSF)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Outsourcing Facility - Temp	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Outsourcing Facility Nonresident (NSF)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	2	2
Outsourcing Facility Nonresident - Temp	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Pharmacy (PHY)	24	27	36	41	22	21	27	25	30	20	26	34	333
Pharmacy - Temp	4	12	6	7	7	91	8	6	10	12	15	16	194
Pharmacy Exempt (PHE)	2	0	0	0	1	1	0	2	0	0	1	0	7
Pharmacy Nonresident (NRP)	5	3	5	5	4	9	8	8	16	11	12	6	92
Pharmacy Nonresident Temp	1	1	0	4	4	1	4	0	6	5	2	0	28
Sterile Compounding (LSC)	4	6	3	7	2	3	1	3	5	2	0	4	40
Sterile Compounding - Temp	0	7	5	1	1	0	1	0	0	0	16	0	31
Sterile Compounding Exempt (LSE)	2	0	0	0	0	0	0	0	0	0	1	0	3
Sterile Compounding Nonresident (NSC)	4	3	0	1	0	3	1	0	0	1	1	1	15
Sterile Compounding Nonresident Temp	0	1	1	1	0	1	2	1	0	0	0	0	7
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0	0	0	0	0	0	0	0	0	0	0
Third-Party Logistics Providers (TPL)	0	0	0	0	1	1	0	3	0	0	1	0	6
Third-Party Logistics Providers-Temp	0	0	0	0	0	0	1	0	0	0	0	0	1
Third-Party Logistics Providers Nonresident (NPL)	1	0	0	0	2	0	0	1	0	1	1	0	6
Third-Party Logistics Providers Nonresident Temp	0	0	0	0	0	0	0	0	0	0	0	0	0
Veterinary Food-Animal Drug Retailer (VET)	0	1	0	0	0	0	0	0	0	0	0	0	1
Veterinary Food-Animal Drug Retailer - Temp	0	0	0	0	0	0	0	0	0	0	0	0	0
Wholesalers (WLS)	3	5	4	9	7	1	6	7	4	5	8	4	63
Wholesalers - Temp	0	0	0	0	0	1	0	0	0	1	3	0	5
Wholesalers Exempt (WLE)	0	0	0	0	0	0	0	0	0	0	0	1	1
Wholesalers Nonresident (OSD)	5	9	1	9	3	6	12	12	10	14	12	2	95
Wholesalers Nonresident - Temp	0	0	0	1	2	0	1	2	0	0	3	0	9
Total	687	1447	1223	1776	995	970	685	750	793	785	926	747	11784

APPLICATIONS (continued)

Pending	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
Designated Representatives (EXC)	247	258	263	281	268	258	257	269	267	272	260	286
Designated Representatives Vet (EXV)	6	1	3	2	3	2	6	5	4	4	1	1
Designated Representatives-3PL (DRL)	100	94	90	90	86	84	84	84	80	86	85	79
Intern Pharmacist (INT)	156	218	557	283	175	146	139	153	162	210	240	211
Pharmacist (exam applications)	1253	1169	1292	1160	1248	1188	1232	1148	1232	1278	1784	1553
Pharmacist (eligible exam(Status A))	2107	2061	1713	1425	1226	1164	1050	1104	1022	1190	1532	2108
Advanced Practice Pharmacist (APH)	n/a	n/a	n/a	n/a	n/a	32	80	96	131	117	111	121
Pharmacy Technician (TCH)	1574	1378	1417	1488	1261	1270	1351	1336	1412	1380	1325	1641
Centralized Hospital Packaging (CHP)	8	8	8	8	8	8	8	8	6	6	5	5
Clinics (CLN)	73	66	70	46	42	37	37	45	41	37	35	39
Clinics Exempt (CLE)	21	20	28	12	11	10	10	11	10	13	10	10
Drug Room (DRM)	4	4	4	4	3	3	2	2	0	0	0	0
Drug Room Exempt (DRE)	0	0	0	0	0	0	0	0	0	0	0	0
Hospitals (HSP)	16	8	5	5	7	6	5	7	9	11	5	4
Hospitals Exempt (HPE)	1	0	0	0	0	0	0	0	1	1	1	1
Hypodermic Needle and Syringes (HYP)	11	6	6	6	9	8	10	18	15	12	10	9
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0	0	0	0	0	0	0	0	0
Correctional Pharmacy (LCF)	1	1	2	1	0	1	1	2	2	2	1	1
Outsourcing Facility (OSF)	n/a	n/a	n/a	n/a	n/a	0	0	2	5	5	5	6
Outsourcing Facility Nonresident (NSF)	n/a	n/a	n/a	n/a	n/a	0	0	15	21	26	29	28
Pharmacy (PHY)	171	693	728	820	826	723	726	721	714	713	701	133
Pharmacy Exempt (PHE)	4	5	5	5	3	3	3	1	1	1	1	1
Pharmacy Nonresident (NRP)	120	128	135	130	134	129	127	127	114	106	95	100
Sterile Compounding (LSC)	43	33	31	27	28	24	24	30	34	42	30	34
Sterile Compounding - Exempt (LSE)	4	4	4	3	3	3	4	4	6	6	4	5
Sterile Compounding Nonresident (NSC)	35	32	31	30	30	28	24	21	21	17	16	18
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0	0	0	0	0	0	0	0	0	0
Third-Party Logistics Providers (TPL)	11	12	12	14	13	14	15	12	9	9	8	8
Third-Party Logistics Providers Nonresident (NPL)	42	41	42	42	41	41	42	42	43	43	40	43
Veterinary Food-Animal Drug Retailer (VET)	2	1	1	1	1	1	1	1	1	1	1	1
Wholesalers (WLS)	71	70	76	60	56	55	44	36	42	39	36	38
Wholesalers Exempt (WLE)	0	0	0	0	0	0	0	0	0	1	1	0
Wholesalers Nonresident (OSD)	118	119	127	129	119	112	98	83	82	77	69	81
Total	6199	6430	6650	6072	5601	5350	5380	5383	5487	5705	6441	6565

The number of temporary applications are included in the primary license type.

APPLICATIONS (continued)

Withdrawn	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	6	8	1	2	0	1	8	1	7	7	0	0	41
Designated Representatives Vet (EXV)	0	1	0	0	0	0	0	0	0	0	0	0	1
Designated Representatives-3PL (DRL)	1	1	1	0	0	1	1	0	0	1	0	7	13
Intern Pharmacist (INT)	0	0	1	2	30	1	0	1	3	0	1	1	40
Pharmacist (exam applications)	0	0	0	0	2	0	1	0	1	1	0	1	6
Advanced Practice Pharmacist (APH)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Pharmacy Technician (TCH)	14	3	6	5	5	3	6	6	14	7	4	9	82
Centralized Hospital Packaging (CHP)	0	0	0	0	0	0	0	0	2	0	1	0	3
Clinics (CLN)	0	0	3	6	1	0	1	0	0	0	0	0	11
Clinics Exempt (CLE)	0	0	0	5	0	0	1	0	0	0	0	0	6
Drug Room (DRM)	0	0	0	0	0	0	1	0	1	0	0	0	2
Drug Room Exempt (DRE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospitals (HSP)	2	2	0	0	0	0	0	0	1	0	1	0	6
Hospitals Exempt (HPE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Hypodermic Needle and Syringes (HYP)	0	4	0	0	0	0	1	0	0	1	0	1	7
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Correctional Pharmacy (LCF)	0	0	0	0	0	0	0	0	0	0	0	0	0
Outsourcing Facility (OSF)	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0
Outsourcing Facility Nonresident (NSF)	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0
Pharmacy (PHY)	4	6	4	1	1	4	2	4	5	3	9	577	620
Pharmacy Exempt (PHE)	1	0	0	0	1	0	0	0	0	0	0	0	2
Pharmacy Nonresident (NRP)	1	1	1	5	1	1	2	1	3	3	1	1	21
Sterile Compounding (LSC)	0	2	0	0	0	0	0	1	0	0	1	0	4
Sterile Compounding Exempt (LSE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Sterile Compounding Nonresident (NSC)	0	0	3	0	1	0	2	3	1	3	2	2	17
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0	0	0	0	0	0	0	0	0	0	0
Third-Party Logistics Providers (TPL)	0	0	0	0	0	0	0	0	3	0	0	0	3
Third-Party Logistics Providers Nonresident (NPL)	0	2	1	1	0	0	1	0	1	0	2	0	8
Veterinary Food-Animal Drug Retailer (VET)	0	0	0	0	1	0	0	0	0	0	0	0	1
Wholesalers (WLS)	1	0	0	3	4	5	8	3	1	0	0	0	25
Wholesalers Exempt (WLE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Wholesalers Nonresident (OSD)	1	1	0	6	11	12	13	11	1	1	1	0	58
Total	31	31	21	36	58	28	48	31	44	27	23	599	977

The number of temporary applications withdrawn is reflected in the primary license type.

APPLICATIONS (continued)

Denied	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	0	0	0	0	0	0	0	0	0	0	0	0	0
Designated Representatives Vet (EXV)	0	0	0	0	0	0	0	0	0	0	0	0	0
Designated Representatives-3PL (DRL)	0	0	0	0	0	0	0	0	0	0	0	0	0
Intern Pharmacist (INT)	0	0	0	0	1	1	3	0	0	0	0	0	5
Pharmacist (exam applications)	1	0	1	0	0	0	0	1	0	0	0	2	5
Pharmacist (eligible)	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Practice Pharmacist (APH)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Pharmacy Technician (TCH)	1	2	2	4	1	5	7	5	8	6	3	2	46
Centralized Hospital Packaging (CHP)	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinics (CLN)	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinics Exempt (CLE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Drug Room (DRM)	0	0	0	0	0	0	0	0	0	0	0	0	0
Drug Room Exempt (DRE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospitals (HSP)	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospitals Exempt (HPE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Hypodermic Needle and Syringes (HYP)	0	0	0	0	0	0	0	0	0	0	0	0	0
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Correctional Pharmacy (LCF)	0	0	0	0	0	0	0	0	0	0	0	0	0
Outsourcing Facility (OSF)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	1	0	1
Outsourcing Facility Nonresident (NSF)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Pharmacy (PHY)	1	0	0	1	0	2	0	1	1	1	3	3	13
Pharmacy Exempt (PHE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy Nonresident (NRP)	0	0	1	0	0	0	1	0	0	0	0	0	2
Sterile Compounding (LSC)	0	0	0	0	0	1	0	0	1	0	0	0	2
Sterile Compounding Exempt (LSE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Sterile Compounding Nonresident (NSC)	0	0	1	0	0	0	0	1	0	0	0	0	2
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0	0	0	0	0	0	0	0	0	0	0
Third-Party Logistics Providers (TPL)	0	0	0	0	0	0	0	0	0	0	0	0	0
Third-Party Logistics Providers Nonresident (NPL)	0	0	0	0	0	0	0	0	0	0	0	0	0
Veterinary Food-Animal Drug Retailer (VET)	0	0	0	0	0	0	0	0	0	0	0	0	0
Wholesalers (WLS)	0	0	0	0	0	0	0	0	1	0	0	0	1
Wholesalers Exempt (WLE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Wholesalers Nonresident (OSD)	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	3	2	5	5	2	9	11	8	11	7	7	7	77

Board of Pharmacy Licensing Statistics - Fiscal Year 2016/17

RESPOND TO STATUS REQUESTS

A. **Email Inquiries**	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Pharmacist/Intern Received	566	675	691	552	429	372	434	380	452	619	779	957	6906
Pharmacist/Intern Responded	402	508	515	417	388	344	382	317	396	582	604	770	5625
Pharmacy Technician Received	421	433	482	424	386	404	466	358	471	444	658	368	5315
Pharmacy Technician Responded	441	529	535	355	277	622	432	392	242	429	137	60	4451
Pharmacy Received	575	516	760	651	579	568	594	492	690	604	334	559	6922
Pharmacy Responded	555	517	709	636	549	647	540	563	760	542	288	559	6865
Sterile Compounding/Outsourcing Received	334	499	401	460	335	339	360	331	429	439	426	163	4516
Sterile Compounding/Outsourcing Responded	312	427	341	594	401	415	308	296	378	401	426	131	4430
Wholesale/Clinic/Hypodermic/3PL Received	538	619	355	451	450	239	307	319	378	346	346	321	4669
Wholesale/Clinic/Hypodermic/3PL Responded	479	446	446	373	391	472	354	248	284	609	410	320	4832
Pharmacist-in-Charge Received	135	209	191	139	52	117	186	133	101	128	122	103	1616
Pharmacist-in-Charge Responded	94	113	130	115	21	81	120	68	27	186	83	73	1111
Change of Permit Received	364	251	411	463	403	392	521	381	516	446	478	403	5029
Change of Permit Responded	321	218	258	359	320	302	408	308	349	372	330	270	3815
Renewals Received	293	297	349	354	324	372	433	322	412	447	433	313	4349
Renewals Responded	227	261	291	282	220	266	308	230	332	338	345	247	3347

B. **Telephone Calls Received**	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Pharmacist/Intern	109	128	50	30	13	22	38	31	45	91	103	378	1038
Pharmacy	89	100	135	108	94	72	102	101	88	67	79	71	1106
Sterile Compounding/Outsourcing	74	54	63	108	66	52	38	38	30	47	12	20	602
Wholesale/Clinic/Hypodermic/3PL	75	103	117	75	96	76	66	76	60	54	69	72	939
Pharmacist-in-Charge	70	90	86	68	76	47	64	36	12	18	117	38	722
Change of Permit	63	46	70	63	93	41	69	42	38	67	54	50	696
Renewals	565	591	647	741	643	646	712	538	465	401	487	513	6949

Board of Pharmacy Licensing Statistics - Fiscal Year 2016/17

UPDATE LICENSING RECORDS

A. Change of Pharmacist-in-Charge	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	175	194	199	195	206	162	194	193	194	172	214	192	2290
Processed	235	190	208	181	192	242	287	62	75	272	213	164	2321
Approved	242	189	195	161	223	225	254	115	63	206	271	171	2315
Pending	231	240	238	269	247	193	137	226	362	327	267	286	286

B. Change of Desig. Representative-in-Charge	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	17	14	19	8	18	15	9	14	6	10	11	14	155
Processed	17	12	22	6	18	22	7	4	0	19	19	11	157
Approved	17	9	21	9	11	17	16	6	0	12	24	7	149
Pending	19	28	28	28	35	33	24	34	40	38	24	30	30

C. Change of Responsible Manager	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	3	0	1	0	3	2	2	2	0	1	3	1	18
Processed	1	3	0	1	0	3	4	1	0	2	4	1	20
Approved	0	1	0	4	0	0	1	1	0	2	2	2	13
Pending	7	4	5	1	4	6	7	8	8	7	8	6	6

D. Change of Permits	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	122	150	86	203	105	176	84	157	211	209	115	227	1845
Processed	192	40	115	182	76	351	73	35	223	276	118	108	1789
Approved	138	57	225	126	73	179	136	116	195	303	267	27	1842
Pending	844	892	752	888	852	890	840	869	907	847	716	910	910

E. Discontinuance of Business	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Received	22	32	28	31	42	32	33	34	42	30	34	42	402
Processed	35	24	37	18	43	35	35	17	0	62	47	41	394
Approved	39	17	47	19	27	37	44	31	0	36	59	31	387
Pending	86	91	85	98	113	108	96	103	146	135	109	120	120

F. Requests Approved	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Address/Name Changes	1154	1247	975	1005	833	811	1097	834	917	766	997	922	11558
Off-site Storage	41			97			71			5			214
Transfer of Intern Hours	0	19	3	15	2	8	4	0	3	2	1	3	60
License Verification	158	83	134	255	105	212	104	197	104	131	114	136	1733

Board of Pharmacy Licensing Statistics - Fiscal Year 2016/17

Revenue Received

(Revenue available through August 2016)

A. Revenue Received	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Applications	139,305	288,693	848,737	386,324	263,757	224,014	211,683	288,015	310,586	270,685	311,722	615,689	$4,159,207
Renewals	679,896	1,674,124	1,158,389	1,395,199	1,720,126	1,209,204	995,643	1,009,075	1,102,408	1,090,991	433,929	147,859	$12,616,842
Cite and Fine	84,702	67,793	201,577	153,811	236,863	195,688	125,127	180,206	154,819	147,091	135,577	410,944	$2,094,197
Probation/Cost Recovery	50,102	28,646	46,712	75,913	168,105	146,774	136,662	72,087	97,012	156,307	46,955	179,305	$1,204,580
Request for Information/Lic. Verification	2,330	1,770	1,590	2,790	5,860	2,180	3,845	2,160	3,590	1,500	2,040	4,740	$34,395
Fingerprint Fee	4,704	7,514	9,408	7,497	8,771	4,949	7,150	9,016	11,735	10,829	12,537	16,268	$110,378

B. Licenses Renewed	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	166	266	171	199	170	182	221	212	244	210	214	222	2,477
Designated Representatives Vet (EXV)	5	7	5	2	1	3	2	6	4	5	9	11	60
Designated Representatives-3PL (DRL)	13	18	26	6	12	12	7	9	11	9	26	32	181
Pharmacist (RPH)	1565	1988	1735	1504	1314	1796	1883	1376	1800	1643	1647	1778	20,029
Advanced Practice Pharmacist (APH)	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	2	0	1	3
Pharmacy Technician (TCH)	2533	3080	2381	2684	2109	2607	2839	2161	2689	2469	2434	2680	30,666
Centralized Hospital Packaging (CHP)	1	0	0	2	0	0	2	0	1	0	0	0	6
Clinics (CLN)	67	101	70	98	45	58	99	94	86	68	102	104	992
Clinics Exempt (CLE)	2	1	90	97	10	4	1	4	3	1	0	4	217
Drug Room (DRM)	4	1	2	0	1	2	1	2	2	2	3	1	21
Drug Room Exempt (DRE)	0	0	6	4	1	0	0	0	0	0	0	0	11
Hospitals (HSP)	17	23	23	78	30	19	43	27	34	22	35	25	376
Hospitals Exempt (HPE)	0	3	49	25	5	0	1	0	1	1	0	0	85
Hypodermic Needle and Syringes (HYP)	12	31	20	27	21	18	30	20	20	16	18	27	260
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Correctional Pharmacy (LCF)	0	1	33	17	3	0	0	0	0	1	0	0	55
Outsourcing Facility (OSF)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Outsourcing Facility Nonresident (NSF)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Pharmacy (PHY)	182	287	693	1095	191	910	200	716	392	988	235	264	6,153
Pharmacy Exempt (PHE)	0	0	80	36	2	2	1	0	1	1	1	0	124
Pharmacy Nonresident (NRP)	26	30	40	30	37	32	35	35	46	34	36	44	425
Sterile Compounding (LSC)	51	39	46	154	52	44	48	64	53	51	58	64	724
Sterile Compounding Exempt (LSE)	0	4	1	100	3	2	0	0	0	2	4	0	116
Sterile Compounding Nonresident (NSC)	5	4	4	9	7	10	3	6	5	5	9	9	76
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0	0	0	1	0	0	0	0	0	0	1
Third-Party Logistics Providers (TPL)	4	0	5	0	1	0	2	0	0	1	3	1	17
Third-Party Logistics Providers Nonresident (NPL)	4	6	8	7	3	3	13	1	3	1	7	3	59
Veterinary Food-Animal Drug Retailer (VET)	0	1	2	2	1	1	1	0	6	2	0	1	17
Wholesalers (WLS)	50	51	27	40	25	30	26	30	43	34	37	41	434
Wholesalers Exempt (WLE)	0	1	5	4	1	0	0	0	0	0	1	1	13
Wholesalers Nonresident (OSD)	46	53	52	67	49	41	51	35	54	57	44	59	608
Total	4753	5996	5574	6287	4094	5777	5509	4798	5498	5625	4923	5372	64206

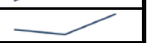
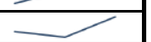
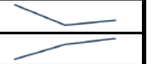
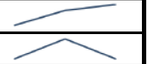
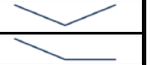
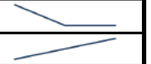
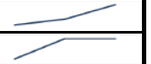
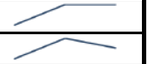
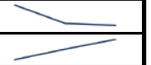
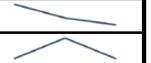
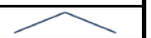
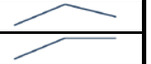
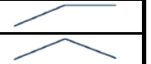
Board of Pharmacy Licensing Statistics - Fiscal Year 2016/17

Current Licensees

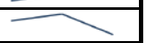
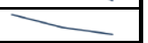
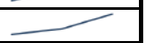
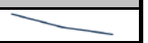
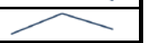
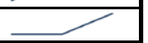
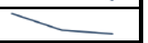
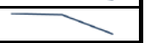
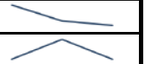
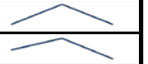
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FYTD
Designated Representatives (EXC)	3008	3040	3062	3091	3126	3161	2964	2986	3034	2966	2983	2970	2970
Designated Representatives Vet (EXV)	63	66	66	67	67	68	67	69	70	70	72	72	72
Designated Representatives-3PL (DRL)	204	221	225	233	241	245	251	253	262	265	275	255	255
Intern Pharmacist (INT)	6377	6607	6625	6859	6783	6802	6790	6839	6857	6891	6900	6584	6584
Pharmacist (RPH)	43802	43974	44167	44621	44836	44868	44934	44920	44905	44882	44904	44864	44864
Advanced Practice Pharmacist (APH)	n/a	n/a	n/a	n/a	n/a	n/a	0	11	25	71	104	130	130
Pharmacy Technician (TCH)	73277	73318	73173	73177	73064	72892	72740	72633	72434	72595	72452	72562	72562
Centralized Hospital Packaging (CHP)	9	8	8	8	8	8	8	8	8	8	8	8	8
Clinics (CLN)	1101	1102	1102	1089	1092	1095	1092	1094	1091	1097	1098	1097	1097
Clinics Exempt (CLE)	237	236	237	237	237	238	237	235	238	240	240	237	237
Drug Room (DRM)	23	23	23	22	22	23	22	22	23	23	23	23	23
Drug Room Exempt (DRE)	13	13	12	11	11	11	11	11	11	11	11	11	11
Hospitals (HSP)	396	395	397	396	396	397	397	397	398	397	396	396	396
Hospitals Exempt (HPE)	86	87	87	85	85	85	85	84	84	84	84	84	84
Hypodermic Needle and Syringes (HYP)	286	287	287	285	286	286	287	287	290	292	294	294	294
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0	0	0	0	0	0	0	0	0	0
Correctional Pharmacy (LCF)	55	55	55	56	56	56	56	57	57	58	59	59	59
Outsourcing Facility (OSF)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	0	0
Outsourcing Facility Nonresident (NSF)	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0	0	2	2
Pharmacy (PHY)	6442	6444	6442	6455	6456	6447	6452	6464	6479	6468	6459	6480	6480
Pharmacy Exempt (PHE)	124	124	124	123	122	121	121	123	123	124	124	124	124
Pharmacy Nonresident (NRP)	508	510	511	502	505	504	506	512	521	527	530	534	534
Sterile Compounding (LSC)	788	787	786	787	782	783	774	774	775	773	766	768	768
Sterile Compounding Exempt (LSE)	121	121	121	122	122	121	117	117	117	117	116	116	116
Sterile Compounding Nonresident (NSC)	95	93	93	92	91	92	90	91	90	90	90	91	91
Surplus Medication Collection Distribution Intermediary (SME)	1	1	1	1	1	1	1	1	1	1	1	1	1
Third-Party Logistics Providers (TPL)	16	16	16	17	18	19	20	22	22	23	23	23	23
Third-Party Logistics Providers Nonresident (NPL)	61	61	61	61	63	63	62	63	63	64	65	64	64
Veterinary Food-Animal Drug Retailer (VET)	23	23	23	23	23	23	23	23	23	23	23	23	23
Wholesalers (WLS)	556	553	553	561	539	538	533	535	536	539	534	536	536
Wholesalers Exempt (WLE)	16	16	16	16	16	16	16	16	16	16	17	16	16
Wholesalers Nonresident (OSD)	731	734	726	735	714	716	720	729	733	739	740	740	740
Total	138419	138915	138999	139732	139762	139679	139376	139376	139286	139454	139391	139164	139164

BOARD OF PHARMACY LICENSING STATISTICS

FISCAL YEAR COMPARISON	FY 14/15	FY 15/16	FY 16/17	% CHANGE	TREND LINES
APPLICATIONS					
A. Received					
Designated Representatives (EXC)	446	503	488	9%	
Designated Representatives Vet (EXV)	9	7	10	11%	
Designated Representatives-3PL (DRL)	85	199	75	n/a	
Intern Pharmacist (INT)	2329	2361	2462	6%	
Pharmacist (exam applications)	3122	3028	3332	7%	
Pharmacist (initial licensing applications)	2093	1959	1865	-11%	
Advanced Practice Pharmacist (APH)	n/a	n/a	256	n/a	
Pharmacy Technician (TCH)	7151	6257	6262	-12%	
Centralized Hospital Packaging (CHP)	5	1	0	-100%	
Clinics (CLN)	101	119	82	-19%	
Clinics Exempt (CLE)	16	21	33	106%	
Drug Room (DRM)	1	3	1	0%	
Drug Room -Temp	0	1	1	n/a	
Drug Room Exempt (DRE)	0	0	0	0%	
Hospitals (HSP)	34	28	17	-50%	
Hospitals - Temp	21	12	14	-33%	
Hospitals Exempt (HPE)	5	3	1	-80%	
Hypodermic Needle and Syringes (HYP)	32	14	20	-38%	
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0%	
Correctional Pharmacy (LCF)	0	2	4	n/a	
Outsourcing Facility (OSF)	n/a	n/a	7	n/a	
Outsourcing Facility - Temp	n/a	n/a	0	n/a	
Outsourcing Facility Nonresident (NSF)	n/a	n/a	33	n/a	
Outsourcing Facility Nonresident - Temp	n/a	n/a	0	n/a	
Pharmacy (PHY)	1532	754	1139	-26%	
Pharmacy - Temp	1233	419	834	-32%	
Pharmacy Exempt (PHE)	9	9	4	-56%	
Pharmacy Nonresident (NRP)	146	171	124	-15%	
Pharmacy Nonresident Temp	27	35	32	19%	
Sterile Compounding (LSC)	148	89	73	-51%	
Sterile Compounding - Temp	58	38	31	-47%	
Sterile Compounding Exempt (LSE)	19	7	1	-95%	
Sterile Compounding Nonresident (NSC)	22	37	23	5%	
Sterile Compounding Nonresident Temp	7	9	5	-29%	
Surplus Medication Collection Distribution Intermediary (SME)	0	1	0	0%	
Third-Party Logistics Providers (TPL)	11	14	7	-36%	
Third-Party Logistics Providers - Temp	0	0	3	n/a	
Third-Party Logistics Providers Nonresident (NPL)	57	52	17	-70%	
Third-Party Logistics Providers Nonresident Temp	1	1	3	200%	
Veterinary Food-Animal Drug Retailer (VET)	1	6	1	0%	
Veterinary Food-Animal Drug Retailer - Temp	0	5	0	0%	
Wholesalers (WLS)	85	97	71	-16%	
Wholesalers - Temp	7	12	16	129%	
Wholesalers Exempt (WLE)	1	0	1	0%	
Wholesalers Nonresident (OSD)	112	122	133	19%	
Wholesalers Nonresident - Temp	13	28	27	108%	
Total	18939	16424	17504	-8%	

APPLICATIONS (continued)	FY 14/15	FY 15/16	FY 16/17	% CHANGE	TREND LINES
B. Issued					
Designated Representatives (EXC)	301	422	380	26%	
Designated Representatives Vet (EXV)	5	3	11	120%	
Designated Representatives-3PL (DRL)	11	187	79	618%	
Intern Pharmacist (INT)	2389	2116	2224	-7%	
Pharmacist (RPH)	2021	1978	1828	-10%	
Advanced Practice Pharmacist (APH)	n/a	n/a	130	n/a	
Pharmacy Technician (TCH)	8028	5851	5993	-25%	
Centralized Hospital Packaging (CHP)	2	3	2	0%	
Clinics (CLN)	57	96	121	112%	
Clinics Exempt (CLE)	18	14	28	56%	
Drug Room (DRM)	1	2	1	0%	
Drug Room -Temp	0	2	2	n/a	
Drug Room Exempt (DRE)	1	0	0	-100%	
Hospitals (HSP)	14	10	11	-21%	
Hospitals - Temp	0	10	14	n/a	
Hospitals Exempt (HPE)	2	4	2	0%	
Hypodermic Needle and Syringes (HYP)	15	14	15	0%	
Hypodermic Needle and Syringes Exempt (HYE)	3	0	0	-100%	
Correctional Pharmacy (LCF)	0	2	4	n/a	
Outsourcing Facility (OSF)	n/a	n/a	0	n/a	
Outsourcing Facility - Temp	n/a	n/a	0	n/a	
Outsourcing Facility Nonresident (NSF)	n/a	n/a	2	n/a	
Outsourcing Facility Nonresident - Temp	n/a	n/a	0	n/a	
Pharmacy (PHY)	1433	671	333	-77%	
Pharmacy - Temp	0	57	194	n/a	
Pharmacy Exempt (PHE)	5	7	7	40%	
Pharmacy Nonresident (NRP)	68	113	92	35%	
Pharmacy Nonresident Temp	0	22	28	n/a	
Sterile Compounding (LSC)	101	46	40	-60%	
Sterile Compounding - Temp	0	16	31	n/a	
Sterile Compounding Exempt (LSE)	15	7	3	-80%	
Sterile Compounding Nonresident (NSC)	15	16	15	0%	
Sterile Compounding Nonresident Temp	0	7	7	n/a	
Surplus Medication Collection Distribution Intermediary (SME)	0	1	0	0%	
Third-Party Logistics Providers (TPL)	0	15	6	n/a	
Third-Party Logistics Providers - Temp	0	1	1	n/a	
Third-Party Logistics Providers Nonresident (NPL)	2	58	6	200%	
Third-Party Logistics Providers Nonresident Temp	0	0	0	0%	
Veterinary Food-Animal Drug Retailer (VET)	0	5	1	n/a	
Veterinary Food-Animal Drug Retailer - Temp	0	0	0	0%	
Wholesalers (WLS)	52	64	63	21%	
Wholesalers - Temp	0	0	5	n/a	
Wholesalers Exempt (WLE)	1	0	1	0%	
Wholesalers Nonresident (OSD)	39	88	95	144%	
Wholesalers Nonresident - Temp	0	3	9	n/a	
Total	14599	11911	11784	-19%	

began collecting data for temporary licenses issued in FY 15/16. A three year comparison is currently not available for temporary licenses issued.

APPLICATIONS (continued)	FY 14/15	FY 15/16	FY 16/17	% CHANGE	TREND LINES
C. Pending					
Designated Representatives (EXC)	226	248	286	27%	
Designated Representatives Vet (EXV)	3	4	1	-67%	
Designated Representatives-3PL (DRL)	140	101	79	-44%	
Intern Pharmacist (INT)	161	208	211	31%	
Pharmacist (exam applications)	1046	1326	1553	48%	
Pharmacist (eligible)	1821	1902	2108	16%	
Advanced Practice Pharmacist (APH)	n/a	n/a	121	n/a	
Pharmacy Technician (TCH)	1467	1530	1641	12%	
Centralized Hospital Packaging (CHP)	16	9	5	-69%	
Clinics (CLN)	70	95	39	-44%	
Clinics Exempt (CLE)	8	16	10	25%	
Drug Room (DRM)	2	3	0	-100%	
Drug Room Exempt (DRE)	0	0	0	0%	
Hospitals (HSP)	24	19	4	-83%	
Hospitals Exempt (HPE)	4	1	1	-75%	
Hypodermic Needle and Syringes (HYP)	17	10	9	-47%	
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0%	
Correctional Pharmacy (LCF)	0	1	1	n/a	
Outsourcing Facility (OSF)	n/a	n/a	6	n/a	
Outsourcing Facility Nonresident (NSF)	n/a	n/a	28	n/a	
Pharmacy (PHY)	227	165	133	-41%	
Pharmacy Exempt (PHE)	4	5	1	-75%	
Pharmacy Nonresident (NRP)	219	121	100	-54%	
Sterile Compounding (LSC)	42	44	34	-19%	
Sterile Compounding Exempt (LSE)	7	6	5	-29%	
Sterile Compounding Nonresident (NSC)	37	36	18	-51%	
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0	0%	
Third-Party Logistics Providers (TPL)	13	10	8	-38%	
Third-Party Logistics Providers Nonresident (NPL)	57	46	43	-25%	
Veterinary Food-Animal Drug Retailer	1	2	1	0%	
Wholesalers (WLS)	53	72	38	-28%	
Wholesalers Exempt (WLE)	0	0	0	0%	
Wholesalers Nonresident (OSD)	73	117	81	11%	
Total	5738	6097	6565	14%	
* The number of temporary applications pending is reflected in the number reported for the primary license type.					

APPLICATIONS (continued)	FY 14/15	FY 15/16	FY 16/17	% CHANGE	TREND LINES
D. Withdrawn					
Designated Representatives (EXC)	96	51	41	-57%	
Designated Representatives Vet (EXV)	0	3	1	n/a	
Designated Representatives-3PL (DRL)	0	7	13	n/a	
Intern Pharmacist (INT)	8	1	40	400%	
Pharmacist (Exam)	61	3	6	-90%	
Advanced Practice Pharmacist (APH)	n/a	n/a	0	n/a	
Pharmacy Technician (TCH)	373	286	82	-78%	
Centralized Hospital Packaging (CHP)	0	2	3	n/a	
Clinics (CLN)	27	6	11	-59%	
Clinics Exempt (CLE)	9	0	6	-33%	
Drug Room (DRM)	0	0	2	n/a	
Drug Room Exempt (DRE)	0	0	0	0%	
Hospitals (HSP)	7	5	6	-14%	
Hospitals Exempt (HPE)	0	1	0	0%	
Hypodermic Needle and Syringes (HYP)	1	8	7	600%	
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0%	
Correctional Pharmacy (LCF)	0	0	0	0%	
Outsourcing Facility (OSF)	n/a	n/a	0	n/a	
Outsourcing Facility Nonresident (NSF)	n/a	n/a	0	n/a	
Pharmacy (PHY) **	45	38	620	1278%	
Pharmacy Exempt (PHE)	0	0	2	n/a	
Pharmacy Nonresident (NRP)	3	128	21	600%	
Sterile Compounding (LSC)	16	17	4	-75%	
Sterile Compounding Exempt (LSE)	0	1	0	0%	
Sterile Compounding Nonresident (NSC)	2	13	17	750%	
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0	0%	
Third-Party Logistics Providers (TPL)	1	1	3	200%	
Third-Party Logistics Providers Nonresident (NPL)	0	5	8	n/a	
Veterinary Food-Animal Drug Retailer (VET)	0	0	1	n/a	
Wholesalers (WLS)	25	8	25	0%	
Wholesalers Exempt (WLE)	4	0	0	-100%	
Wholesalers Nonresident (OSD)	42	15	58	38%	
Total	720	599	977	36%	

* The number of temporary applications withdrawn is reflected in the number reported for the primary license type.

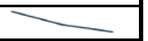
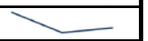
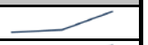
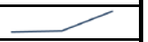
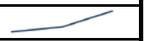
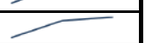
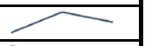
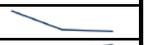
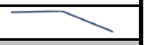
** In FY 16/17, there were 577 pharmacy applications withdrawn as a result of a corporate change of ownership cancellation.

APPLICATIONS (continued)	FY 14/15	FY 15/16	FY 16/17	% CHANGE	TREND LINES
E. Denied					
Designated Representatives (EXC)	3	1	0	-100%	
Designated Representatives Vet (EXV)	0	0	0	0%	
Designated Representatives-3PL (DRL)	0	0	0	0%	
Intern Pharmacist (INT)	3	4	5	67%	
Pharmacist (exam applications)	9	10	5	-44%	
Pharmacist (eligible)	2	1	0	-100%	
Advanced Practice Pharmacist (APH)	n/a	n/a	0	n/a	
Pharmacy Technician (TCH)	56	62	46	-18%	
Centralized Hospital Packaging (CHP)	1	0	0	-100%	
Clinics (CLN)	0	0	0	0%	
Clinics Exempt (CLE)	0	0	0	0%	
Drug Room (DRM)	0	0	0	0%	
Drug Room Exempt (DRE)	0	0	0	0%	
Hospitals (HSP)	0	0	0	0%	
Hospitals Exempt (HPE)	0	0	0	0%	
Hypodermic Needle and Syringes (HYP)	0	0	0	0%	
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0%	
Correctional Pharmacy (LCF)	0	0	0	0%	
Outsourcing Facility (OSF)	n/a	n/a	1	n/a	
Outsourcing Facility Nonresident (NSF)	n/a	n/a	0	n/a	
Pharmacy (PHY)	20	17	13	-35%	
Pharmacy Exempt (PHE)	0	0	0	0%	
Pharmacy Nonresident (NRP)	0	2	2	n/a	
Sterile Compounding (LSC)	6	0	2	-67%	
Sterile Compounding Exempt (LSE)	0	0	0	0%	
Sterile Compounding Nonresident (NSC)	0	2	2	n/a	
Surplus Medication Collection Distribution Intermediary (SME)	0	0	0	0%	
Third-Party Logistics Providers (TPL)	0	0	0	0%	
Third-Party Logistics Providers Nonresident (NPL)	0	0	0	0%	
Veterinary Food-Animal Drug Retailer (VET)	0	0	0	0%	
Wholesalers (WLS)	1	0	1	0%	
Wholesalers Exempt (WLE)	0	0	0	0%	
Wholesalers Nonresident (OSD)	1	0	0	-100%	
Total	102	99	77	-25%	
* The number of temporary applications denied is reflected in the number reported for the primary license type.					

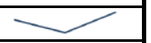
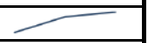
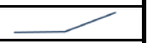
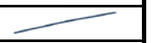
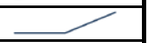
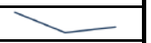
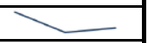
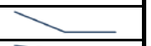
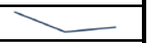
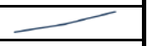
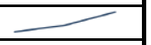
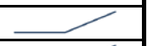
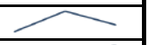
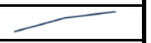
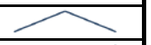
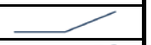
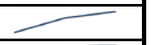
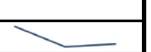
RESPOND TO STATUS REQUESTS	FY 14/15	FY 15/16	FY 16/17	% CHANGE	TREND LINES
A. Email Inquiries					
Pharmacist/Intern Received	3102	4856	6906	123%	
Pharmacist/Intern Responded	n/a	n/a	5625	n/a	
Pharmacy Technician Received	480	1943	5315	1007%	
Pharmacy Technician Responded	n/a	n/a	4451	n/a	na
Pharmacy Received	1961	4631	6922	253%	
Pharmacy Responded	n/a	n/a	6865	n/a	na
Sterile Compounding/Outsourcing Received	n/a	n/a	4353	n/a	na
Sterile Compounding/Outsourcing Responded	n/a	n/a	4299	n/a	na
Wholesale/Clinic/Hypodermic/3PL Received	2767	4293	4669	69%	
Wholesale/Clinic/Hypodermic/3PL Responded	n/a	n/a	4832	n/a	na
Pharmacist-in-Charge Received	1832	1438	1616	-12%	
Pharmacist-in-Charge Responded	n/a	n/a	1111	n/a	na
Change of Permit Received	n/a	3747	5029	n/a	na
Change of Permit Responded	n/a	n/a	3815	n/a	na
Renewals Received	1218	1990	4349	257%	
Renewals Responded	n/a	n/a	3347	n/a	na
B. Telephone Calls Received					
Pharmacist/Intern	n/a	n/a	1038	na	na
Pharmacy	1169	1600	1106	-5%	
Sterile Compounding/Outsourcing	n/a	n/a	582	n/a	na
Wholesale/Clinic/Hypodermic/3PL	604	1511	939	55%	
Pharmacist-in-Charge	733	1035	722	-2%	
Change of Permit	n/a	1035	696	n/a	na
Renewals	6154	7678	6949	13%	

*Data is not available for areas that are listed as 'n/a".

UPDATE LICENSING RECORDS

A. Change of Pharmacist-in-Charge					
Received	1963	2391	2290	17%	
Processed	1549	2428	2321	50%	
Approved	2943	2515	2315	-21%	
Pending	342	303	286	-16%	
B. Change of Designated Representative-in-Charge					
Received	142	173	155	9%	
Processed	192	181	157	-18%	
Approved	313	209	149	-52%	
Pending	51	23	30	-41%	
C. Change of Responsible Managing Employee					
Received	n/a	2	18	n/a	
Processed	n/a	1	20	n/a	
Approved	n/a	3	13	n/a	
Pending	n/a	2	6	n/a	
D. Change of Permit					
Received	1390	1870	1845	33%	
Processed	1262	2079	1789	42%	
Approved	661	1717	1842	179%	
Pending	579	849	910	57%	
E. Discontinuance of Business					
Received	294	432	402	37%	
Processed	364	423	394	8%	
Approved	970	439	387	-60%	
Pending	75	102	120	60%	
F. Requests Processed					
Address/Name Changes	12249	11992	11558	-6%	
Off-site Storage	242	163	214	-12%	
Transfer of Intern Hours	135	59	60	-56%	
License Verification	2001	2019	1733	-13%	

Revenue Received	FY 14/15	FY 15/16	FY 16/17	% CHANGE	TREND LINES
A. Revenue Received	#########	#########	$20,219,599	9%	
Applications	$4,291,854	$3,630,120	$4,159,207	-3%	
Renewals	#########	#########	$12,616,842	6%	
Cite and Fine	$1,606,121	$2,146,938	$2,094,197	30%	
Probation/Cost Recovery	$468,145	$901,834	$1,204,580	157%	
Request for Information/Lic. Verification	$41,290	$39,928	$34,395	-17%	
Fingerprint Fee	$112,529	$114,196	$110,378	-2%	
B. Renewals Received					
Designated Representatives (EXC)	2645	2502	2477	-6%	
Designated Representatives Vet (EXV)	54	66	60	11%	
Designated Representatives-3PL (DRL)	n/a	53	181	n/a	
Pharmacist (RPH)	19103	20400	20029	5%	
Advanced Practice Pharmacist (APH)	n/a	n/a	3	n/a	
Pharmacy Technician (TCH)	30718	30914	30666	0%	
Centralized Hospital Packaging (CHP)	0	0	6	n/a	
Clinics (CLN)	980	975	992	1%	
Clinics Exempt (CLE)	206	212	217	5%	
Drug Room (DRM)	21	19	21	0%	
Drug Room Exempt (DRE)	1	12	11	1000%	
Hospitals (HSP)	388	388	376	-3%	
Hospitals Exempt (HPE)	86	81	85	-1%	
Hypodermic Needle and Syringes (HYP)	260	259	260	0%	
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0%	
Correctional Pharmacy (LCF)	52	53	55	6%	
Outsourcing Facility (OSF)	n/a	n/a	0	n/a	
Outsourcing Facility Nonresident (NSF)	n/a	n/a	0	n/a	
Pharmacy (PHY)	5213	6227	6153	18%	
Pharmacy Exempt (PHE)	118	123	124	5%	
Pharmacy Nonresident (NRP)	398	391	425	7%	
Sterile Compounding (LSC)	711	761	724	2%	
Sterile Compounding Exempt (LSE)	113	115	116	3%	
Sterile Compounding Nonresident (NSC)	79	76	76	-4%	
Surplus Medication Collection Distribution Intermediary (SME)	0	0	1	n/a	
Third-Party Logistics Providers (TPL)	0	1	17	n/a	
Third-Party Logistics Providers Nonresident (NPL)	0	12	59	n/a	
Veterinary Food-Animal Drug Retailer	18	24	17	-6%	
Wholesalers (WLS)	484	455	434	-10%	
Wholesalers Exempt (WLE)	13	9	13	0%	
Wholesalers Nonresident (OSD)	666	601	608	-9%	
Total	62327	64729	64206	3%	

License Population	FY 14/15	FY 15/16	FY 16/17	% CHANGE	TREND LINES
Designated Representatives (EXC)	3050	3055	2970	-3%	
Designated Representatives Vet (EXV)	69	64	72	4%	
Designated Representatives-3PL (DRL)	12	198	255	2025%	
Intern Pharmacist (INT)	6354	6364	6584	4%	
Pharmacist (RPH)	42521	43818	44864	6%	
Advanced Practice Pharmacist (APH)	n/a	n/a	130	n/a	
Pharmacy Technician (TCH)	74586	73289	72562	-3%	
Centralized Hospital Packaging (CHP)	3	8	8	167%	
Clinics (CLN)	1158	1073	1097	-5%	
Clinics Exempt (CLE)	244	235	237	-3%	
Drug Room (DRM)	24	23	23	-4%	
Drug Room Exempt (DRE)	14	13	11	-21%	
Hospitals (HSP)	399	395	396	-1%	
Hospitals Exempt (HPE)	86	87	84	-2%	
Hypodermic Needle and Syringes (HYP)	279	285	294	5%	
Hypodermic Needle and Syringes Exempt (HYE)	0	0	0	0%	
Correctional Pharmacy (LCF)	53	55	59	11%	
Outsourcing Facility (OSF)	n/a	n/a	0	n/a	
Outsourcing Facility Nonresident (NSF)	n/a	n/a	2	n/a	
Pharmacy (PHY)	6449	6440	6480	0%	
Pharmacy Exempt (PHE)	123	126	124	1%	
Pharmacy Nonresident (NRP)	453	509	534	18%	
Sterile Compounding (LSC)	814	796	768	-6%	
Sterile Compounding Exempt (LSE)	122	121	116	-5%	
Sterile Compounding Nonresident (NSC)	91	92	91	0%	
Surplus Medication Collection Distribution Intermediary (SME)	0	0	1	n/a	
Third-Party Logistics Providers (TPL)	0	16	23	n/a	
Third-Party Logistics Providers Nonresident (NPL)	2	60	64	3100%	
Veterinary Food-Animal Drug Retailer	24	23	23	-4%	
Wholesalers (WLS)	623	556	536	-14%	
Wholesalers Exempt (WLE)	16	16	16	0%	
Wholesalers Nonresident (OSD)	824	726	740	-10%	
Total	138393	138443	139164	1%