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HOUSE BILL NO. 102
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Health, Welfare and Institutions
on _____)
(Patron Prior to Substitute--Delegate Greenhalgh)

A BILL to amend and reenact §§ 32.1-127 and 54.1-3303 of the Code of Virginia, relating to prescriptions;
off-label use.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-127 and 54.1-3303 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities;

25 2. Shall provide that at least one physician who is licensed to practice medicine in this
26 Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at
27 each hospital which operates or holds itself out as operating an emergency service;

28 3. May classify hospitals and nursing homes by type of specialty or service and may provide for
29 licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

30 4. Shall also require that each hospital establish a protocol for organ donation, in compliance with
31 federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42
32 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization
33 designated in CMS regulations for routine contact, whereby the provider's designated organ procurement
34 organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients
35 in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ
36 donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified
37 by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for
38 tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at
39 least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of
40 tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid
41 interference with organ procurement. The protocol shall ensure that the hospital collaborates with the
42 designated organ procurement organization to inform the family of each potential donor of the option to
43 donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall
44 have completed a course in the methodology for approaching potential donor families and requesting
45 organ or tissue donation that (a) is offered or approved by the organ procurement organization and
46 designed in conjunction with the tissue and eye bank community and (b) encourages discretion and
47 sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition,
48 the hospital shall work cooperatively with the designated organ procurement organization in educating the
49 staff responsible for contacting the organ procurement organization's personnel on donation issues, the
50 proper review of death records to improve identification of potential donors, and the proper procedures
51 for maintaining potential donors while necessary testing and placement of potential donated organs,

52 tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the
53 relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer
54 of the hospital or his designee knows of such opposition, and no donor card or other relevant document,
55 such as an advance directive, can be found;

56 5. Shall require that each hospital that provides obstetrical services establish a protocol for
57 admission or transfer of any pregnant woman who presents herself while in labor;

58 6. Shall also require that each licensed hospital develop and implement a protocol requiring written
59 discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall
60 require that the discharge plan be discussed with the patient and that appropriate referrals for the mother
61 and the infant be made and documented. Appropriate referrals may include, but need not be limited to,
62 treatment services, comprehensive early intervention services for infants and toddlers with disabilities and
63 their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et
64 seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent
65 possible, the other parent of the infant and any members of the patient's extended family who may
66 participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant
67 to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal
68 law restrictions, the community services board of the jurisdiction in which the woman resides to appoint
69 a discharge plan manager. The community services board shall implement and manage the discharge plan;

70 7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant
71 for admission the home's or facility's admissions policies, including any preferences given;

72 8. Shall require that each licensed hospital establish a protocol relating to the rights and
73 responsibilities of patients which shall include a process reasonably designed to inform patients of such
74 rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to
75 patients on admission, shall be consistent with applicable federal law and regulations of the Centers for
76 Medicare and Medicaid Services;

77 9. Shall establish standards and maintain a process for designation of levels or categories of care
78 in neonatal services according to an applicable national or state-developed evaluation system. Such

79 standards may be differentiated for various levels or categories of care and may include, but need not be
80 limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

81 10. Shall require that each nursing home and certified nursing facility train all employees who are
82 mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting
83 procedures and the consequences for failing to make a required report;

84 11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations,
85 or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication
86 or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute
87 to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period
88 of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or
89 hospital policies and procedures, by the person giving the order, or, when such person is not available
90 within the period of time specified, co-signed by another physician or other person authorized to give the
91 order;

92 12. Shall require, unless the vaccination is medically contraindicated or the resident declines the
93 offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the
94 administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal
95 vaccination, in accordance with the most recent recommendations of the Advisory Committee on
96 Immunization Practices of the Centers for Disease Control and Prevention;

97 13. Shall require that each nursing home and certified nursing facility register with the Department
98 of State Police to receive notice of the registration, reregistration, or verification of registration
99 information of any person required to register with the Sex Offender and Crimes Against Minors Registry
100 pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in
101 which the home or facility is located, pursuant to § 9.1-914;

102 14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission,
103 whether a potential patient is required to register with the Sex Offender and Crimes Against Minors
104 Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the
105 potential patient will have a length of stay greater than three days or in fact stays longer than three days;

106 15. Shall require that each licensed hospital include in its visitation policy a provision allowing
107 each adult patient to receive visits from any individual from whom the patient desires to receive visits,
108 subject to other restrictions contained in the visitation policy including, but not limited to, those related to
109 the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

110 16. Shall require that each nursing home and certified nursing facility shall, upon the request of
111 the facility's family council, send notices and information about the family council mutually developed by
112 the family council and the administration of the nursing home or certified nursing facility, and provided
113 to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice
114 up to six times per year. Such notices may be included together with a monthly billing statement or other
115 regular communication. Notices and information shall also be posted in a designated location within the
116 nursing home or certified nursing facility. No family member of a resident or other resident representative
117 shall be restricted from participating in meetings in the facility with the families or resident representatives
118 of other residents in the facility;

119 17. Shall require that each nursing home and certified nursing facility maintain liability insurance
120 coverage in a minimum amount of \$1 million, and professional liability coverage in an amount at least
121 equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries
122 and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum
123 insurance shall result in revocation of the facility's license;

124 18. Shall require each hospital that provides obstetrical services to establish policies to follow
125 when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling
126 patients and their families and other aspects of managing stillbirths as may be specified by the Board in
127 its regulations;

128 19. Shall require each nursing home to provide a full refund of any unexpended patient funds on
129 deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid
130 to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds
131 by the discharged patient or, in the case of the death of a patient, the person administering the person's
132 estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

133 20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol
134 that requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct
135 verbal communication between the on-call physician in the psychiatric unit and the referring physician, if
136 requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing
137 a request for such direct verbal communication by a referring physician and (ii) a patient for whom there
138 is a question regarding the medical stability or medical appropriateness of admission for inpatient
139 psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in
140 the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal
141 communication, either in person or via telephone, with a clinical toxicologist or other person who is a
142 Certified Specialist in Poison Information employed by a poison control center that is accredited by the
143 American Association of Poison Control Centers to review the results of the toxicology screen and
144 determine whether a medical reason for refusing admission to the psychiatric unit related to the results of
145 the toxicology screen exists, if requested by the referring physician;

146 21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall
147 develop a policy governing determination of the medical and ethical appropriateness of proposed medical
148 care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical
149 appropriateness of proposed medical care in cases in which a physician has determined proposed care to
150 be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed
151 medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and
152 a determination by the interdisciplinary medical review committee regarding the medical and ethical
153 appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision
154 reached by the interdisciplinary medical review committee, which shall be included in the patient's
155 medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make
156 medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical
157 record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate
158 in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or
159 the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to

160 represent the patient or from seeking other remedies available at law, including seeking court review,
161 provided that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-
162 2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days
163 of the date on which the physician's determination that proposed medical treatment is medically or
164 ethically inappropriate is documented in the patient's medical record;

165 22. Shall require every hospital with an emergency department to establish protocols to ensure that
166 security personnel of the emergency department, if any, receive training appropriate to the populations
167 served by the emergency department, which may include training based on a trauma-informed approach
168 in identifying and safely addressing situations involving patients or other persons who pose a risk of harm
169 to themselves or others due to mental illness or substance abuse or who are experiencing a mental health
170 crisis;

171 23. Shall require that each hospital establish a protocol requiring that, before a health care provider
172 arranges for air medical transportation services for a patient who does not have an emergency medical
173 condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized
174 representative with written or electronic notice that the patient (i) may have a choice of transportation by
175 an air medical transportation provider or medically appropriate ground transportation by an emergency
176 medical services provider and (ii) will be responsible for charges incurred for such transportation in the
177 event that the provider is not a contracted network provider of the patient's health insurance carrier or such
178 charges are not otherwise covered in full or in part by the patient's health insurance plan;

179 24. Shall establish an exemption, for a period of no more than 30 days, from the requirement to
180 obtain a license to add temporary beds in an existing hospital or nursing home when the Commissioner
181 has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing
182 home and that a public health emergency exists due to a shortage of hospital or nursing home beds;

183 25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical
184 procedure for which the patient can reasonably be expected to require outpatient physical therapy as a
185 follow-up treatment after discharge is informed that he (i) is expected to require outpatient physical

186 therapy as a follow-up treatment and (ii) will be required to select a physical therapy provider prior to
187 being discharged from the hospital;

188 26. Shall permit nursing home staff members who are authorized to possess, distribute, or
189 administer medications to residents to store, dispense, or administer cannabis oil to a resident who has
190 been issued a valid written certification for the use of cannabis oil in accordance with subsection B of §
191 54.1-3408.3 and has registered with the Board of Pharmacy;

192 27. Shall require each hospital with an emergency department to establish a protocol for the
193 treatment and discharge of individuals experiencing a substance use-related emergency, which shall
194 include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-
195 related emergencies to identify medical interventions necessary for the treatment of the individual in the
196 emergency department and (ii) recommendations for follow-up care following discharge for any patient
197 identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which
198 may include, for patients who have been treated for substance use-related emergencies, including opioid
199 overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for
200 overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription
201 for and information about accessing naloxone or other opioid antagonist used for overdose reversal,
202 including information about accessing naloxone or other opioid antagonist used for overdose reversal at a
203 community pharmacy, including any outpatient pharmacy operated by the hospital, or through a
204 community organization or pharmacy that may dispense naloxone or other opioid antagonist used for
205 overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also
206 provide for referrals of individuals experiencing a substance use-related emergency to peer recovery
207 specialists and community-based providers of behavioral health services, or to providers of
208 pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

209 28. During a public health emergency related to COVID-19, shall require each nursing home and
210 certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with
211 guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare
212 and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions,

213 including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility,
214 and community, under which in-person visits will be allowed and under which in-person visits will not be
215 allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will
216 be required to comply to protect the health and safety of the patients and staff of the nursing home or
217 certified nursing facility; (iii) the types of technology, including interactive audio or video technology,
218 and the staff support necessary to ensure visits are provided as required by this subdivision; and (iv) the
219 steps the nursing home or certified nursing facility will take in the event of a technology failure, service
220 interruption, or documented emergency that prevents visits from occurring as required by this subdivision.

221 Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and
222 in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each
223 patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit
224 visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a
225 requirement that each nursing home and certified nursing facility publish on its website or communicate
226 to each patient or the patient's authorized representative, in writing or via electronic means, the nursing
227 home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

228 29. Shall require each hospital, nursing home, and certified nursing facility to establish and
229 implement policies to ensure the permissible access to and use of an intelligent personal assistant provided
230 by a patient, in accordance with such regulations, while receiving inpatient services. Such policies shall
231 ensure protection of health information in accordance with the requirements of the federal Health
232 Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the
233 purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device
234 and a specialized software application designed to assist users with basic tasks using a combination of
235 natural language processing and artificial intelligence, including such combinations known as "digital
236 assistants" or "virtual assistants"; ~~and~~

237 30. During a declared public health emergency related to a communicable disease of public health
238 threat, shall require each hospital, nursing home, and certified nursing facility to establish a protocol to
239 allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or

240 sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for
241 Medicare and Medicaid Services and subject to compliance with any executive order, order of public
242 health, Department guidance, or any other applicable federal or state guidance having the effect of limiting
243 visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be
244 conducted virtually using interactive audio or video technology. Any such protocol may require the person
245 visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital,
246 nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients,
247 and staff of the hospital, nursing home, or certified nursing facility; and

248 31. Shall prohibit a hospital from denying, revoking, terminating, diminishing, or curtailing in any
249 way any professional or clinical privilege of any licensed health care provider with prescriptive authority
250 or authority to dispense drugs solely on the grounds that such health care provider prescribes, administers,
251 or dispenses a drug that has been approved for a specific use by the U.S. Food and Drug Administration
252 for an off-label use, provided that such prescribing, administering, or dispensing is in accordance with §
253 54.1-3303 and is to improve health care outcomes.

254 C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and
255 certified nursing facilities may operate adult day care centers.

256 D. All facilities licensed by the Board pursuant to this article which provide treatment or care for
257 hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot
258 numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to
259 be contaminated with an infectious agent, those hemophiliacs who have received units of this
260 contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot
261 that is known to be contaminated shall notify the recipient's attending physician and request that he notify
262 the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return
263 receipt requested, each recipient who received treatment from a known contaminated lot at the individual's
264 last known address.

265 E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for
266 the provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

267 **§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic**
268 **purposes only.**

269 A. A prescription for a controlled substance may be issued only by a practitioner of medicine,
270 osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled
271 substances, a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed certified midwife pursuant
272 to § 54.1-2957.04, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist
273 pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32.

274 B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona
275 fide practitioner-patient relationship or veterinarian-client-patient relationship. If a practitioner is
276 providing expedited partner therapy consistent with the recommendations of the Centers for Disease
277 Control and Prevention, then a bona fide practitioner-patient relationship shall not be required.

278 A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused
279 to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the
280 benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate
281 examination of the patient, either physically or by the use of instrumentation and diagnostic equipment
282 through which images and medical records may be transmitted electronically; and (iv) initiated additional
283 interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side
284 effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii)
285 shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in
286 the same group as the practitioner prescribing the controlled substance, or a consulting practitioner.

287 A practitioner who has established a bona fide practitioner-patient relationship with a patient in
288 accordance with the provisions of this subsection may prescribe Schedule II through VI controlled
289 substances to that patient.

290 A practitioner who has established a bona fide practitioner-patient relationship with a patient in
291 accordance with the provisions of this subsection may prescribe Schedule II through VI controlled
292 substances to that patient via telemedicine if such prescribing is in compliance with federal requirements
293 for the practice of telemedicine and, in the case of the prescribing of a Schedule II through V controlled

294 substance, the prescriber maintains a practice at a physical location in the Commonwealth or is able to
295 make appropriate referral of patients to a licensed practitioner located in the Commonwealth in order to
296 ensure an in-person examination of the patient when required by the standard of care.

297 A prescriber may establish a bona fide practitioner-patient relationship for the purpose of
298 prescribing Schedule II through VI controlled substances by an examination through face-to-face
299 interactive, two-way, real-time communications services or store-and-forward technologies when all of
300 the following conditions are met: (a) the patient has provided a medical history that is available for review
301 by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the
302 prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care
303 expected of in-person care as appropriate to the patient's age and presenting condition, including when the
304 standard of care requires the use of diagnostic testing and performance of a physical examination, which
305 may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the
306 prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a
307 member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or
308 carrier as a participating provider and the diagnosing and prescribing meets the qualifications for
309 reimbursement by the health plan or carrier pursuant to § 38.2-3418.16; (g) upon request, the prescriber
310 provides patient records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all
311 other state and federal laws and regulations; (h) the establishment of a bona fide practitioner-patient
312 relationship via telemedicine is consistent with the standard of care, and the standard of care does not
313 require an in-person examination for the purpose of diagnosis; and (i) the establishment of a bona fide
314 practitioner patient relationship via telemedicine is consistent with federal law and regulations and any
315 waiver thereof. Nothing in this paragraph shall apply to (1) a prescriber providing on-call coverage per an
316 agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber
317 consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-
318 patients or in-patients.

319 For purposes of this section, a bona fide veterinarian-client-patient relationship is one in which a
320 veterinarian, another veterinarian within the group in which he practices, or a veterinarian with whom he

321 is consulting has assumed the responsibility for making medical judgments regarding the health of and
322 providing medical treatment to an animal as defined in § 3.2-6500, other than an equine as defined in §
323 3.2-6200, a group of agricultural animals as defined in § 3.2-6500, or bees as defined in § 3.2-4400, and
324 a client who is the owner or other caretaker of the animal, group of agricultural animals, or bees has
325 consented to such treatment and agreed to follow the instructions of the veterinarian. Evidence that a
326 veterinarian has assumed responsibility for making medical judgments regarding the health of and
327 providing medical treatment to an animal, group of agricultural animals, or bees shall include evidence
328 that the veterinarian (A) has sufficient knowledge of the animal, group of agricultural animals, or bees to
329 provide a general or preliminary diagnosis of the medical condition of the animal, group of agricultural
330 animals, or bees; (B) has made an examination of the animal, group of agricultural animals, or bees, either
331 physically or by the use of instrumentation and diagnostic equipment through which images and medical
332 records may be transmitted electronically or has become familiar with the care and keeping of that species
333 of animal or bee on the premises of the client, including other premises within the same operation or
334 production system of the client, through medically appropriate and timely visits to the premises at which
335 the animal, group of agricultural animals, or bees are kept; and (C) is available to provide follow-up care.

336 C. A prescription shall only be issued for a medicinal or therapeutic purpose in the usual course of
337 treatment or for authorized research. A prescription not issued in the usual course of treatment or for
338 authorized research is not a valid prescription. A practitioner who prescribes any controlled substance
339 with the knowledge that the controlled substance will be used otherwise than for medicinal or therapeutic
340 purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions
341 of law relating to the distribution or possession of controlled substances.

342 D. No prescription shall be filled unless a bona fide practitioner-patient-pharmacist relationship
343 exists. A bona fide practitioner-patient-pharmacist relationship shall exist in cases in which a practitioner
344 prescribes, and a pharmacist dispenses, controlled substances in good faith to a patient for a medicinal or
345 therapeutic purpose within the course of his professional practice.

346 In cases in which it is not clear to a pharmacist that a bona fide practitioner-patient relationship
347 exists between a prescriber and a patient, a pharmacist shall contact the prescribing practitioner or his
348 agent and verify the identity of the patient and name and quantity of the drug prescribed.

349 Any person knowingly filling an invalid prescription shall be subject to the criminal penalties
350 provided in § 18.2-248 for violations of the provisions of law relating to the sale, distribution or possession
351 of controlled substances.

352 E. Notwithstanding any provision of law to the contrary and consistent with recommendations of
353 the Centers for Disease Control and Prevention or the Department of Health, a practitioner may prescribe
354 Schedule VI antibiotics and antiviral agents to other persons in close contact with a diagnosed patient
355 when (i) the practitioner meets all requirements of a bona fide practitioner-patient relationship, as defined
356 in subsection B, with the diagnosed patient and (ii) in the practitioner's professional judgment, the
357 practitioner deems there is urgency to begin treatment to prevent the transmission of a communicable
358 disease. In cases in which the practitioner is an employee of or contracted by the Department of Health or
359 a local health department, the bona fide practitioner-patient relationship with the diagnosed patient, as
360 required by clause (i), shall not be required.

361 F. A pharmacist may dispense a controlled substance pursuant to a prescription of an out-of-state
362 practitioner of medicine, osteopathy, podiatry, dentistry, optometry, or veterinary medicine, a nurse
363 practitioner, or a physician assistant authorized to issue such prescription if the prescription complies with
364 the requirements of this chapter and the Drug Control Act (§ 54.1-3400 et seq.).

365 G. A licensed nurse practitioner who is authorized to prescribe controlled substances pursuant to
366 § 54.1-2957.01 may issue prescriptions or provide manufacturers' professional samples for controlled
367 substances and devices as set forth in the Drug Control Act (§ 54.1-3400 et seq.) in good faith to his patient
368 for a medicinal or therapeutic purpose within the scope of his professional practice.

369 H. A licensed physician assistant who is authorized to prescribe controlled substances pursuant to
370 § 54.1-2952.1 may issue prescriptions or provide manufacturers' professional samples for controlled
371 substances and devices as set forth in the Drug Control Act (§ 54.1-3400 et seq.) in good faith to his patient
372 for a medicinal or therapeutic purpose within the scope of his professional practice.

373 I. A TPA-certified optometrist who is authorized to prescribe controlled substances pursuant to
374 Article 5 (§ 54.1-3222 et seq.) of Chapter 32 may issue prescriptions in good faith or provide
375 manufacturers' professional samples to his patients for medicinal or therapeutic purposes within the scope
376 of his professional practice for the drugs specified on the TPA-Formulary, established pursuant to § 54.1-
377 3223, which shall be limited to (i) analgesics included on Schedule II controlled substances as defined in
378 § 54.1-3448 of the Drug Control Act (§ 54.1-3400 et seq.) consisting of hydrocodone in combination with
379 acetaminophen; (ii) oral analgesics included in Schedules III through VI, as defined in §§ 54.1-3450 and
380 54.1-3455 of the Drug Control Act (§ 54.1-3400 et seq.), which are appropriate to relieve ocular pain; (iii)
381 other oral Schedule VI controlled substances, as defined in § 54.1-3455 of the Drug Control Act,
382 appropriate to treat diseases and abnormal conditions of the human eye and its adnexa; (iv) topically
383 applied Schedule VI drugs, as defined in § 54.1-3455 of the Drug Control Act; and (v) intramuscular
384 administration of epinephrine for treatment of emergency cases of anaphylactic shock.

385 J. The requirement for a bona fide practitioner-patient relationship shall be deemed to be satisfied
386 by a member or committee of a hospital's medical staff when approving a standing order or protocol for
387 the administration of influenza vaccinations and pneumococcal vaccinations in a hospital in compliance
388 with § 32.1-126.4.

389 K. Notwithstanding any other provision of law, a prescriber may authorize a registered nurse or
390 licensed practical nurse to approve additional refills of a prescribed drug for no more than 90 consecutive
391 days, provided that (i) the drug is classified as a Schedule VI drug; (ii) there are no changes in the
392 prescribed drug, strength, or dosage; (iii) the prescriber has a current written protocol, accessible by the
393 nurse, that identifies the conditions under which the nurse may approve additional refills; and (iv) the
394 nurse documents in the patient's chart any refills authorized for a specific patient pursuant to the protocol
395 and the additional refills are transmitted to a pharmacist in accordance with the allowances for an
396 authorized agent to transmit a prescription orally or by facsimile pursuant to subsection C of § 54.1-
397 3408.01 and regulations of the Board.

398 L. A prescriber may prescribe, administer, or dispense and a pharmacist may dispense a drug that
399 has been approved for a specific use by the U.S. Food and Drug Administration for an off-label use when

400 the prescriber or pharmacist determines, in his professional judgment, that such off-label use is appropriate
401 for the standard of care and such prescribing, administering, or dispensing is to improve health care
402 outcomes.

403 #