

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

HOUSE BILL NO. 1323

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health, Welfare and Institutions

on _____)

(Patron Prior to Substitute--Delegate Orrock)

A BILL to amend and reenact §§ 32.1-325, 38.2-3408, 54.1-3303.1, and 54.1-3321 of the Code of Virginia, relating to pharmacists; initiation of treatment with and dispensing and administration of vaccines.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-325, 38.2-3408, 54.1-3303.1, and 54.1-3321 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of \$3,500 for the individual and an amount not in excess of \$3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life

27 insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of
28 such policies has been excluded from countable resources and (ii) the amount of any other revocable or
29 irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the
30 individual's or his spouse's burial expenses;

31 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically
32 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the
33 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used
34 as the principal residence and all contiguous property. For all other persons, a home shall mean the house
35 and lot used as the principal residence, as well as all contiguous property, as long as the value of the land,
36 exclusive of the lot occupied by the house, does not exceed \$5,000. In any case in which the definition of
37 home as provided here is more restrictive than that provided in the state plan for medical assistance
38 services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as
39 the principal residence and all contiguous property essential to the operation of the home regardless of
40 value;

41 4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who
42 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per
43 admission;

44 5. A provision for deducting from an institutionalized recipient's income an amount for the
45 maintenance of the individual's spouse at home;

46 6. A provision for payment of medical assistance on behalf of pregnant women which provides for
47 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most
48 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American
49 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards
50 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and
51 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the
52 children which are within the time periods recommended by the attending physicians in accordance with
53 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines

54 or Standards shall include any changes thereto within six months of the publication of such Guidelines or
55 Standards or any official amendment thereto;

56 7. A provision for the payment for family planning services on behalf of women who were
57 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such
58 family planning services shall begin with delivery and continue for a period of 24 months, if the woman
59 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the
60 purposes of this section, family planning services shall not cover payment for abortion services and no
61 funds shall be used to perform, assist, encourage or make direct referrals for abortions;

62 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow
63 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast
64 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a
65 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant.
66 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

67 9. A provision identifying entities approved by the Board to receive applications and to determine
68 eligibility for medical assistance, which shall include a requirement that such entities obtain accurate
69 contact information, including the best available address and telephone number, from each applicant for
70 medical assistance, to the extent required by federal law and regulations;

71 10. A provision for breast reconstructive surgery following the medically necessary removal of a
72 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained,
73 for all medically necessary indications. Such procedures shall be considered noncosmetic;

74 11. A provision for payment of medical assistance for annual pap smears;

75 12. A provision for payment of medical assistance services for prostheses following the medically
76 necessary complete or partial removal of a breast for any medical reason;

77 13. A provision for payment of medical assistance which provides for payment for 48 hours of
78 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of
79 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for
80 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring

81 the provision of inpatient coverage where the attending physician in consultation with the patient
82 determines that a shorter period of hospital stay is appropriate;

83 14. A requirement that certificates of medical necessity for durable medical equipment and any
84 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician
85 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 days
86 from the time the ordered durable medical equipment and supplies are first furnished by the durable
87 medical equipment provider;

88 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons
89 age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines
90 of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations,
91 all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA
92 testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

93 16. A provision for payment of medical assistance for low-dose screening mammograms for
94 determining the presence of occult breast cancer. Such coverage shall make available one screening
95 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through
96 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
97 X-ray examination of the breast using equipment dedicated specifically for mammography, including but
98 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average
99 radiation exposure of less than one rad mid-breast, two views of each breast;

100 17. A provision, when in compliance with federal law and regulation and approved by the Centers
101 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
102 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid
103 program and may be provided by school divisions;

104 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
105 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or
106 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and
107 application of the procedure in treatment of the specific condition have been clearly demonstrated to be

108 medically effective and not experimental or investigational; (iii) prior authorization by the Department of
109 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant
110 center where the surgery is proposed to be performed have been used by the transplant team or program
111 to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed
112 and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an
113 irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range
114 of physical and social functioning in the activities of daily living;

115 19. A provision for payment of medical assistance for colorectal cancer screening, specifically
116 screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate
117 circumstances radiologic imaging, in accordance with the most recently published recommendations
118 established by the American College of Gastroenterology, in consultation with the American Cancer
119 Society, for the ages, family histories, and frequencies referenced in such recommendations;

120 20. A provision for payment of medical assistance for custom ocular prostheses;

121 21. A provision for payment for medical assistance for infant hearing screenings and all necessary
122 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United
123 States Food and Drug Administration, and as recommended by the national Joint Committee on Infant
124 Hearing in its most current position statement addressing early hearing detection and intervention
125 programs. Such provision shall include payment for medical assistance for follow-up audiological
126 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and
127 performed by a licensed audiologist to confirm the existence or absence of hearing loss;

128 22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer
129 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer
130 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease
131 Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under
132 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including
133 treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under
134 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise

135 eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v)
136 have not attained age 65. This provision shall include an expedited eligibility determination for such
137 women;

138 23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment
139 and services delivery, of medical assistance services provided to medically indigent children pursuant to
140 this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the
141 FAMIS Plan program in § 32.1-351. A single application form shall be used to determine eligibility for
142 both programs;

143 24. A provision, when authorized by and in compliance with federal law, to establish a public-
144 private long-term care partnership program between the Commonwealth of Virginia and private insurance
145 companies that shall be established through the filing of an amendment to the state plan for medical
146 assistance services by the Department of Medical Assistance Services. The purpose of the program shall
147 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for
148 such services through encouraging the purchase of private long-term care insurance policies that have
149 been designated as qualified state long-term care insurance partnerships and may be used as the first source
150 of benefits for the participant's long-term care. Components of the program, including the treatment of
151 assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and
152 applicable federal guidelines; and

153 25. A provision for the payment of medical assistance for otherwise eligible pregnant women
154 during the first five years of lawful residence in the United States, pursuant to § 214 of the Children's
155 Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

156 B. In preparing the plan, the Board shall:

157 1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided
158 and that the health, safety, security, rights and welfare of patients are ensured.

159 2. Initiate such cost containment or other measures as are set forth in the appropriation act.

160 3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the
161 provisions of this chapter.

162 4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations
163 pursuant to § 2.2-4007.05, the potential fiscal impact of such regulation on local boards of social services.
164 For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with
165 local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include
166 the projected costs/savings to the local boards of social services to implement or comply with such
167 regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

168 5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in
169 accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities
170 With Deficiencies."

171 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card,
172 or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each
173 recipient of medical assistance services, and shall upon any changes in the required data elements set forth
174 in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective
175 information as may be required to electronically process a prescription claim.

176 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement
177 for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,
178 regardless of any other provision of this chapter, such amendments to the state plan for medical assistance
179 services as may be necessary to conform such plan with amendments to the United States Social Security
180 Act or other relevant federal law and their implementing regulations or constructions of these laws and
181 regulations by courts of competent jurisdiction or the United States Secretary of Health and Human
182 Services.

183 In the event conforming amendments to the state plan for medical assistance services are adopted,
184 the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
185 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
186 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
187 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
188 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the

189 Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session
190 of the General Assembly unless enacted into law.

191 D. The Director of Medical Assistance Services is authorized to:

192 1. Administer such state plan and receive and expend federal funds therefor in accordance with
193 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the
194 performance of the Department's duties and the execution of its powers as provided by law.

195 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other
196 health care providers where necessary to carry out the provisions of such state plan. Any such agreement
197 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is
198 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new
199 agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement
200 or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

201 3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing
202 agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony,
203 or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider
204 as required by 42 C.F.R. § 1002.212.

205 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing
206 agreement or contract, with a provider who is or has been a principal in a professional or other corporation
207 when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-
208 315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
209 program pursuant to 42 C.F.R. Part 1002.

210 5. Terminate or suspend a provider agreement with a home care organization pursuant to
211 subsection E of § 32.1-162.13.

212 6. (Expires January 1, 2020) Provide payments or transfers pursuant to § 457 of the Internal
213 Revenue Code to the deferred compensation plan described in § 51.1-602 on behalf of an individual who
214 is a dentist or an oral and maxillofacial surgeon providing services as an independent contractor pursuant
215 to a Medicaid agreement or contract under this section. Notwithstanding the provisions of § 51.1-600, an

216 "employee" for purposes of Chapter 6 (§ 51.1-600 et seq.) of Title 51.1 shall include an independent
217 contractor as described in this subdivision.

218 For the purposes of this subsection, "provider" may refer to an individual or an entity.

219 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider
220 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. §
221 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative
222 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of
223 the date of receipt of the notice.

224 The Director may consider aggravating and mitigating factors including the nature and extent of
225 any adverse impact the agreement or contract denial or termination may have on the medical care provided
226 to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to
227 subsection D, the Director may determine the period of exclusion and may consider aggravating and
228 mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant
229 to 42 C.F.R. § 1002.215.

230 F. When the services provided for by such plan are services which a marriage and family therapist,
231 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed
232 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,
233 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or
234 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter
235 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which
236 reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social
237 workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon
238 reasonable criteria, including the professional credentials required for licensure.

239 G. The Board shall prepare and submit to the Secretary of the United States Department of Health
240 and Human Services such amendments to the state plan for medical assistance services as may be
241 permitted by federal law to establish a program of family assistance whereby children over the age of 18

242 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of
243 providing medical assistance under the plan to their parents.

244 H. The Department of Medical Assistance Services shall:

245 1. Include in its provider networks and all of its health maintenance organization contracts a
246 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have
247 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse
248 and neglect, for medically necessary assessment and treatment services, when such services are delivered
249 by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a
250 provider with comparable expertise, as determined by the Director.

251 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an
252 exception, with procedural requirements, to mandatory enrollment for certain children between birth and
253 age three certified by the Department of Behavioral Health and Developmental Services as eligible for
254 services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

255 3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to
256 contractors and enrolled providers for the provision of health care services under Medicaid and the Family
257 Access to Medical Insurance Security Plan established under § 32.1-351.

258 I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible
259 recipients with special needs. The Board shall promulgate regulations regarding these special needs
260 patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special
261 needs as defined by the Board.

262 J. Except as provided in subdivision A 1 of § 2.2-4345, the provisions of the Virginia Public
263 Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Director authorized by
264 subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law
265 and regulation.

266 K. When the services provided for by such plan are services related to initiation of treatment with
267 or dispensing or administration of a vaccination by a pharmacist, pharmacy technician, or pharmacy intern
268 in accordance with § 54.1-3303.1, the Department shall provide reimbursement for such service in an

269 amount that is no less than the reimbursement amount for such service by a health care provider licensed
270 by the Board of Medicine.

271 **§ 38.2-3408. Policy providing for reimbursement for services that may be performed by**
272 **certain practitioners other than physicians.**

273 A. If an accident and sickness insurance policy provides reimbursement for any service that may
274 be legally performed by a person licensed in this Commonwealth as a chiropractor, optometrist, optician,
275 professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist,
276 clinical nurse specialist, audiologist, speech pathologist, certified nurse midwife or other nurse
277 practitioner, marriage and family therapist, or licensed acupuncturist, reimbursement under the policy
278 shall not be denied because the service is rendered by the licensed practitioner.

279 B. If an accident and sickness insurance policy provides reimbursement for a service that may be
280 legally performed by a licensed pharmacist, reimbursement under the policy shall not be denied because
281 the service is rendered by the licensed pharmacist, provided that (i) the service is performed for an insured
282 for a condition under the terms of a collaborative agreement, as defined in § 54.1-3300, (ii) the service is
283 for the administration of vaccines for immunization, or (iii) the service is provided in accordance with §
284 54.1-3303.1. If the service is for the initiation of treatment with or dispensing or administration of vaccines
285 by a pharmacist, pharmacy technician, or pharmacy intern in accordance with § 54.1-3303.1, such policy
286 shall provide reimbursement in an amount that is no less than the reimbursement amount for such service
287 by a health care provider licensed by the Board of Medicine.

288 C. This section shall not apply to Medicaid, or any state fund.

289 **§ 54.1-3303.1. Initiating of treatment with and dispensing and administering of controlled**
290 **substances by pharmacists.**

291 A. Notwithstanding the provisions of § 54.1-3303, a pharmacist may initiate treatment with,
292 dispense, or administer the following drugs, devices, controlled paraphernalia, and other supplies and
293 equipment to persons 18 years of age or older in accordance with a statewide protocol developed by the
294 Board in collaboration with the Board of Medicine and the Department of Health and set forth in
295 regulations of the Board:

- 296 1. Naloxone or other opioid antagonist, including such controlled paraphernalia, as defined in §
297 54.1-3466, as may be necessary to administer such naloxone or other opioid antagonist;
- 298 2. Epinephrine;
- 299 3. Injectable or self-administered hormonal contraceptives, provided the patient completes an
300 assessment consistent with the United States Medical Eligibility Criteria for Contraceptive Use;
- 301 4. Prenatal vitamins for which a prescription is required;
- 302 5. Dietary fluoride supplements, in accordance with recommendations of the American Dental
303 Association for prescribing of such supplements for persons whose drinking water has a fluoride content
304 below the concentration recommended by the U.S. Department of Health and Human Services;
- 305 6. Drugs as defined in § 54.1-3401, devices as defined in § 54.1-3401, controlled paraphernalia as
306 defined in § 54.1-3466, and other supplies and equipment available over-the-counter, covered by the
307 patient's health carrier when the patient's out-of-pocket cost is lower than the out-of-pocket cost to
308 purchase an over-the-counter equivalent of the same drug, device, controlled paraphernalia, or other
309 supplies or equipment;
- 310 ~~7. Vaccines included on the Immunization Schedule published by the Centers for Disease Control~~
311 ~~and Prevention or that have a current emergency use authorization from the U.S. Food and Drug~~
312 ~~Administration;~~
- 313 ~~8.~~ Tuberculin purified protein derivative for tuberculosis testing; and
- 314 ~~9.~~ 8. Controlled substances for the prevention of human immunodeficiency virus, including
315 controlled substances prescribed for pre-exposure and post-exposure prophylaxis pursuant to guidelines
316 and recommendations of the Centers for Disease Control and Prevention.
- 317 B. A pharmacist who initiates treatment with or dispenses or administers a drug or device pursuant
318 to this section shall notify the patient's primary health care provider that the pharmacist has initiated
319 treatment with such drug or device or that such drug or device has been dispensed or administered to the
320 patient, provided that the patient consents to such notification. No pharmacist shall limit his ability to send
321 such notification by requiring the use of secure electronic mail or an electronic mail system that complies
322 with the requirements of the federal Health Insurance Portability and Accountability Act, 42 U.S.C. §

323 1320d et seq. If the patient does not have a primary health care provider, the pharmacist shall counsel the
324 patient regarding the benefits of establishing a relationship with a primary health care provider and, upon
325 request, provide information regarding primary health care providers, including federally qualified health
326 centers, free clinics, or local health departments serving the area in which the patient is located. If the
327 pharmacist is initiating treatment with, dispensing, or administering injectable or self-administered
328 hormonal contraceptives, the pharmacist shall counsel the patient regarding seeking preventative care,
329 including (i) routine well-woman visits, (ii) testing for sexually transmitted infections, and (iii) pap
330 smears.

331 C. Notwithstanding the provisions of § 54.1-3303, a pharmacist may initiate treatment with or
332 dispense or administer to persons five years of age or older in accordance with a statewide protocol
333 developed by the Board in consultation with the Board of Medicine and the Department of Health and set
334 forth in regulations of the Board vaccines authorized by the U.S. Food and Drug Administration, including
335 vaccines authorized for emergency use in response to a public health emergency, or may cause such
336 vaccines to be administered by a pharmacy technician or pharmacy intern under the direct supervision of
337 the pharmacist. A pharmacist who administers a vaccination pursuant to ~~subdivision A 7~~ this subsection
338 shall report such administration to the Virginia Immunization Information System in accordance with the
339 requirements of § 32.1-46.01.

340 D. A pharmacist who initiates treatment with or dispenses or administers a drug or device pursuant
341 to this section shall obtain a history from the patient, including information regarding any known allergies,
342 adverse reactions, contraindications, or diagnoses or conditions of the patient that would be adverse to the
343 initiation of treatment, dispensing, or administration of a drug or device pursuant to this section.

344 E. A pharmacist who initiates treatment with or dispenses or administers a drug or device pursuant
345 to this section shall have an established referral relationship with a physician or other appropriate health
346 care provider to address patient adverse reactions or complications from such initiation of treatment,
347 dispensing, or administration, including a toll-free telephone number that is available 24 hours a day
348 through which the patient may contact a registered nurse who can connect the patient with a physician.

349 physician assistant, or nurse practitioner licensed by the Board of Medicine regarding any adverse reaction
350 or complication.

351 **§ 54.1-3321. Registration of pharmacy technicians.**

352 A. No person shall perform the duties of a pharmacy technician without first being registered as a
353 pharmacy technician with the Board. Upon being registered with the Board as a pharmacy technician, the
354 following tasks may be performed:

355 1. The entry of prescription information and drug history into a data system or other record keeping
356 system;

357 2. The preparation of prescription labels or patient information;

358 3. The removal of the drug to be dispensed from inventory;

359 4. The counting, measuring, or compounding of the drug to be dispensed;

360 5. The packaging and labeling of the drug to be dispensed and the repackaging thereof;

361 6. The stocking or loading of automated dispensing devices or other devices used in the dispensing
362 process;

363 7. The acceptance of refill authorization from a prescriber or his authorized agency, so long as
364 there is no change to the original prescription; ~~and~~

365 8. The administration of vaccines included on the Immunization Schedule published by the Centers
366 for Disease Control and Prevention or that have approval or a current emergency use authorization from
367 the U.S. Food and Drug Administration to persons five years of age or older, as set forth in regulations of
368 the Board, under the supervision of a pharmacist who is present at the same physical location as the
369 pharmacy technician at the time such vaccine is administered, and consistent with the requirements of §
370 54.1-3303.1; and

371 9. The performance of any other task restricted to pharmacy technicians by the Board's regulations.

372 B. To be registered as a pharmacy technician, a person shall submit:

373 1. An application and fee specified in regulations of the Board;

374 2. (Effective July 1, 2022) Evidence that he has successfully completed a training program that is
375 (i) an accredited training program, including an accredited training program operated through the

376 Department of Education's Career and Technical Education program or approved by the Board, or (ii)
377 operated through a federal agency or branch of the military; and

378 3. Evidence that he has successfully passed a national certification examination administered by
379 the Pharmacy Technician Certification Board or the National Healthcareer Association.

380 C. The Board shall promulgate regulations establishing requirements for:

381 1. Issuance of a registration as a pharmacy technician to a person who, prior to the effective date
382 of such regulations, (i) successfully completed or was enrolled in a Board-approved pharmacy technician
383 training program or (ii) passed a national certification examination required by the Board but did not
384 complete a Board-approved pharmacy technician training program;

385 2. Issuance of a registration as a pharmacy technician to a person who (i) has previously practiced
386 as a pharmacy technician in another U.S. jurisdiction and (ii) has passed a national certification
387 examination required by the Board; and

388 3. Evidence of continued competency as a condition of renewal of a registration as a pharmacy
389 technician.

390 D. The Board shall waive the initial registration fee for a pharmacy technician applicant who works
391 as a pharmacy technician exclusively in a free clinic pharmacy. A person registered pursuant to this
392 subsection shall be issued a limited-use registration. A pharmacy technician with a limited-use registration
393 shall not perform pharmacy technician tasks in any setting other than a free clinic pharmacy. The Board
394 shall also waive renewal fees for such limited-use registrations. A pharmacy technician with a limited-use
395 registration may convert to an unlimited registration by paying the current renewal fee.

396 E. Any person registered as a pharmacy technician prior to the effective date of regulations
397 implementing the provisions of this section shall not be required to comply with the requirements of
398 subsection B in order to maintain or renew registration as a pharmacy technician.

399 F. A pharmacy technician trainee enrolled in a training program for pharmacy technicians
400 described in subdivision B 2 may engage in the acts set forth in subsection A for the purpose of obtaining
401 practical experience required for completion of the training program, so long as such activities are directly
402 monitored by a supervising pharmacist.

403 G. To be registered as a pharmacy technician trainee, a person shall submit an application and a
404 fee specified in regulations of the Board. Such registration shall only be valid while the person is enrolled
405 in a pharmacy technician training program described in subsection B and actively progressing toward
406 completion of such program. A registration card issued pursuant to this section shall be invalid and shall
407 be returned to the Board if such person fails to enroll in a pharmacy technician training program described
408 in subsection B.

409 H. A pharmacy intern may perform the duties set forth for pharmacy technicians in subsection A
410 when registered with the Board for the purpose of gaining the practical experience required to apply for
411 licensure as a pharmacist.

412 **2. That the Board of Pharmacy, in collaboration with the Board of Medicine and the Department**
413 **of Health Professions, shall establish a statewide protocol for the initiation of treatment with and**
414 **dispensing and administering of drugs and devices by pharmacists in accordance with § 54.1-3303.1**
415 **of the Code of Virginia, as amended by this act, by November 1, 2022, and shall promulgate**
416 **regulations to implement the provisions of the first enactment of this act to be effective within 280**
417 **days of its enactment. Such regulations shall include provisions for continuing education and**
418 **training modules for pharmacists regarding the provisions of the first enactment of this act,**
419 **recordkeeping requirements, and provisions for ensuring that physical settings in which treatment**
420 **is provided pursuant to this act shall be in compliance with the federal Health Insurance Portability**
421 **and Accountability Act, 42 U.S.C. § 1320d et seq., as amended.**

422 **3. That the Board of Pharmacy (the Board) shall establish a work group consisting of**
423 **representatives of the Board, the Board of Medicine, the Department of Health Professions, and**
424 **such other stakeholders as may be appropriate to provide recommendations regarding development**
425 **of the protocols for the initiation of treatment with and the dispensing and administering by**
426 **pharmacists of drugs and devices in accordance with this act. Representation of the Board, the**
427 **Board of Medicine, and the Department of Health Professions on such work group shall be equal.**

428 **4. That the provisions of the first enactment of this act shall become effective upon expiration of the**
429 **federal public health emergency related to COVID-19.**

430

#